Bundle Quality, Patient Experience and Safety Committee 31 October 2023

Agenda attachments

ITEM 0 Open Quest Agenda - 31 October 2023 file replaced

0 09:30 - OPENING ITEMS

1 Chair's welcome, apologies, and confirmation of quorum

2 Declarations of Interest
Declarations of Interest

3 Minutes of the Previous Meeting – 10 August 2023
ITEM 3 Draft Open QUEST Committee Minutes - 10 August 2023

4 Action Log and Matters Arising
Item 4 Action Log
Item 4.1 Committee Highlight report
ITEM 4 Quest Action Log
ITEM 4.1 Quest Committee Highlight Report August 2023

5 09:40 - Operations Directorate Quarterly Report Q2 2023/24
ITEM 5 Operations Quarterly Report for Committees 23-24 Q2

5.1 ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION

6 09:50 - Patient Story

7 10:20 - Putting Things Right Report Quarter 2, July – September 2023
ITEM 7 Putting Things Right Report, Quarter 2, July - September 2023

8 10:40 - Quality Impact Assessments
8.1 Financial Savings - Non-Emergency Patient Transport Service (NEPTS) Capacity Management Plan
8.2 Financial Savings - Mid and West Wales Fire and Rescue Services
ITEM 8.1 Financial Savings - NEPTS Capacity Management Plan
ITEM 8.1a Financial Savings - NEPTS Capacity Management Plan - Annex 1
ITEM 8.2 Financial Savings - Mid and West Wales Fire and Rescue Services
ITEM 8.2a Financial Savings - Mid and West Wales Fire and Rescue Services - Annex 1

9 10:55 - Spotlight on Clinical Indicators:
Return of Spontaneous Circulation (ROSC) rates
ITEM 9 Focus on CIs - ROSC at hospital 31.10.2023

10 11:10 - Monthly Integrated Quality Performance Report
ITEM 10 MIQPR SBAR QUEST August September 2023
ITEM 10.1 Annex 1 MIQPR QUEST August September 2023

11 11:25 - Learning From Mortality Reviews update
ITEM 11 Learning from Mortality Reviews Update

12 11:40 - Duty of Quality/Duty of Candour Implementation
ITEM 12 Duty of Quality-Duty of Candour Implementation
ITEM 12.1 Duty of Quality-Duty of Candour Implementation - Appendix 1

13 11:55 - Mental Health and Dementia Annual Report
ITEM 13 Mental Health and Dementia Annual Report
ITEM 13.1 Mental Health and Dementia Annual Report - Annex 1

14 12:15 - Patient Experience and Community Involvement (PECI) Bi- Annual (April - September) report
ITEM 14 PECI Bi-Annual Report (April - September 2023)
ITEM 14.1 PECI Bi-Annual Report (April - September 2023)- Annex 2

15 12:30 - Clinical Audit Monitoring Report - Quarter 2
ITEM 15 Clinical Audit Plan 2023-24 SBAR
ITEM 15.1 Clinical Audit Plan 2023 - 24 Q2_October 2023
ITEM 15.2 Clinical Audit Action Tracker 17.10.2023

16 12:40 - Information Governance Report
ITEM 16 IG and InfoSec KPI Reporting Oct23 v2

17 12:50 - Risk Management and Board Assurance Framework Report
ITEM 17 Executive Summary Risk Management Report QuEST 311023

18.1 All-Wales Aseptic Non-Touch Technique Policy
18.2 Medicines Management Policy
18.3 Information Security Policy

ITEM 18.1 SBAR ANTT policy update 091023
ITEM 18.1a 2023 Model Policy Aseptic Non-Touch Technique (ANTT)
ITEM 18.2 Executive Summary Medicines Management Policy
ITEM 18.2a Medicines Management Policy v3.0
ITEM 18.3 Executive Summary IT Info Sec Policy 251023
ITEM 18.3a Information Security Policy

19 13:10 - Internal Audit Tracker Update
No Internal Audit Reports
Full Tracker to be circulated by e mail.

ITEM 19 SBAR re Audit Tracker to QUEST October 2023
ITEM 19.1 Audit Tracker 2.0 July-September 2023
ITEM 19.2 Audit Tracker 2.0 July-September 2023 HIW Tab

20 13:25 - EMS Clinical Contact Centre Health Inspectorate Wales update

ITEM 20 Executive Summary HIW EMSCCC Patient Safety Review
ITEM 20.1 HIW Action Plan Welsh Ambulance Service Trust - Local Review 2019-2020

20.1 13:30 - CONSENT ITEMS
The items that follow are for information only. Should a member wish to discuss any of these items they are requested to notify the Chair so that time may be allocated to do so.

21 Committee Priorities and Cycle of Business Monitoring Report

ITEM 21 QuEST Priorities and Cycle Monitoring Report
ITEM 21.1 Quest Committee Cycle of Business 2023-24 - Monitoring Report

22 Patient Story Updates

ITEM 22 Bethan Hews story driver diagram

22.1 13:35 - CLOSING ITEMS

23 Key Messages for Board Decisions & Actions

24 Reflections of the Meeting

25 Any Other Business

26 Date and Time of Next Meeting: - 8 February 2024 at 09:30

MEETING OF THE OPEN QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE
Held on **31 October 2023** from **09:30 – 13:45**
Meeting held virtually via Microsoft Teams

Comfort Breaks 5 Minutes on the hour

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 – 10 August 2023	Approval	Bethan Evans	Paper	
4.	Action Log & Matters Arising 4.1 Committee Highlight Report from 10 August 2023	Review	Bethan Evans	Paper	
5.	Operations Directorate Quarterly Report Q2 2023/24	Information	Sonia Thompson	Paper	10 Mins
ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION					
6.	Patient Story	Discussion	Liam Williams	Video	30 Mins
7.	Putting Things Right Report Quarter 2, July – September 2023	Assurance	Wendy Herbert	Paper	20 Mins
8.	Quality Impact Assessments 8.1 Financial Savings – Non-Emergency Patient Transport Service (NEPTS) Capacity Management Plan 8.2 Financial Savings – Mid and West Wales Fire and Rescue Services	Assurance	Liam Williams	Paper	15 Mins
9.	Spotlight on Clinical Indicators: Return of Spontaneous Circulation (ROSC) rates	Assurance	Duncan Robertson	Presentation	15 Mins

No.	Agenda Item	Purpose	Lead	Format	Time
10.	Monthly Integrated Quality Performance Report	Assurance	Hugh Bennett	Paper	15 Mins
11.	Learning From Mortality Reviews update	Assurance	Liam Williams	Paper	15 Mins
12.	Duty of Quality/Duty of Candour Implementation	Assurance	Liam Williams Kate Blackmore	Paper	15 Mins
13.	Mental Health and Dementia Annual Report	Assurance	Wendy Herbert	Paper	20 Mins
14.	Patient Experience and Community Involvement (PECI) Bi- Annual (April – September) report	Assurance	Leanne Hawker	Paper	15 Mins
15.	Clinical Audit Monitoring Report Quarter 2	Assurance	Andy Swinburn	Paper	10 Mins
16.	Information Governance Report	Assurance	Jonny Sammut	Paper	10 Mins
17.	Risk Management and Board Assurance Framework Report	Assurance	Julie Boalch	Paper	10 Mins
18.	Policies for Approval/Adoption: 18.1. All-Wales Aseptic Non-Touch Technique Policy 18.2. Medicines Management Policy 18.3. Information Security Policy	 Adoption Approval Approval	 Liam Williams Andy Swinburn Jonny Sammut	 Paper Paper Paper	10 Mins
19.	Internal Audit Tracker Update *No Internal Audit Reports*	Assurance	Trish Mills	Paper	15 Mins
20.	EMS Clinical Contact Centre Health Inspectorate Wales update	Information	Sonia Thompson	Paper	5 Mins
CONSENT ITEMS **The items that follow are for information only. Should a member wish to discuss any of these items they are requested to notify the Chair so that time may be allocated to do so.**					
21.	Committee Priorities and Cycle of Business Monitoring Report	Information	Trish Mills	Paper	5 Mins
22.	Patient Story Updates	Information	Liam Williams	Paper	
CLOSING ITEMS					
23.	Key Messages for Board Decisions & Actions	Discussion	Bethan Evans	Verbal	10 Mins
24.	Reflections of the Meeting	Discussion	Bethan Evans	Verbal	
25.	Any Other Business	Discussion	Bethan Evans	Verbal	
26.	Date and Time of Next Meeting:	Information	Bethan Evans	Verbal	

No.	Agenda Item	Purpose	Lead	Format	Time
	8 February 2024 at 09:30				

Lead Presenters

Name	Position
Julie Boalch	Head of Risk/Deputy Board Secretary
Kate Blackmore	Senior Quality Governance Lead
Sonia Thompson	Assistant Director of Operations EMS
Bethan Evans	Non-Executive Director and Committee Chair
Leanne Hawker	Head of Patient Experience & Community Involvement
Wendy Herbert	Assistant Director of Quality and Nursing
Hugh Bennett	Assistant Director Commissiong and Performance
Trish Mills	Board Secretary
Duncan Robertson	Assistant Director of Clinical Development
Jonny Sammut	Director of Digital Services
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 10 AUGUST 2023 VIA TEAMS

Meeting started 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:

Julie Boalch	Head of Risk/Deputy Board Secretary
Lee Brooks	Executive Director of Operations
Andrew Clement	Partners in Healthcare, Resource Development Coordinator
Colin Dennis	Chair of Trust Board
Nikki Harvey	Head of Safeguarding (Item 41/23 only)
Leanne Hawker	Head of Patient Experience and Community Involvement
Wendy Herbert	Assistant Director of Quality and Nursing
Fflur Jones	Audit Wales
Alison Kelly	Business and Quality Manager
Brendan Lloyd	Executive Medical Director
Rhian Lewis	Internal Audit
Mark Marsden	Trade Union Partner
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Cheryl Merrick	Llais Wales
Trish Mills	Board Secretary
Edward O'Brian	Clinical Lead Palliative and End of Life Care (Item 32/23 only)
Jane Palin	Assistant Director of Quality and Nursing
Hugh Parry	Trade Union Partner
Alex Payne	Corporate Governance Manager
Duncan Robertson	Assistant Director of Clinical Development
Leanne Smith	Interim Director of Digital
Marinela Stoicheci	Risk Officer
Gareth Thomas	Patient Experience and Community Involvement Manager
Lisa Trounce	Business Manager

DRAFT

Jonathan Turnbull-Ross	Assistant Director of Quality Governance
Liam Williams	Executive Director of Quality and Nursing

Apologies:

Ian James	Trade Union Partner
Andy Swinburn	Director of Paramedicine

30/23 PROCEDURAL MATTERS

The Chair extended a warm welcome to everyone advising that the meeting was being recorded. Apologies were noted from Ian James and Andy Swinburn.

Declarations of Interest

There were no further declarations of interest to those listed in the register.

Minutes

The Minutes of the meeting held on 11 May 2023 were confirmed as a correct record.

Action Log

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

Action 004/23a: Patient safety report, backlog of National Reportable Incidents; the Committee requested an update to be given at the next meeting. Verbal update provided with a further update to be given at the 10 August meeting. Liam Williams agreed to update the Committee within the next few days. Action Closed.

Action 14/23: Red calls Rural Response Deep Dive - response and impact on patients plan to build into future reports, it was agreed to include details within the MIOPR. Details were provided in Item 7.1 on the agenda. Action closed.

Action 16/23: Agreed that a meeting be coordinated with the Quest Committee and the People and Culture Committee to discuss the situation regarding the challenges faced by the Putting Things Right (PTR) Team. Liam Williams provided a verbal update which assured the Committee additional support had been given to colleagues dealing with the most stressful and distressing cases. He added that the challenges within the Team remained significant; in the meantime, funding was being requested to consider additional resources across the wider organisation. The Committee recognised the challenges also being faced by operational staff. Action was to remain open with a further update at the 31 October 2023 meeting.

Action 21/23: Quality Strategy progress report. An update was provided on the action log. Action closed.

DRAFT

The Chair drew the Committee's attention to the contents of the AAA report for their information; this highlighted the key points from the Committee's last meeting on 11 May 2023. Attention was drawn to the two items in the alert section; risks around patient safety and the PTR response times.
Comments:

RESOLVED: That

(1) apologies were recorded for Ian James and Andy Swinburn:

(2) the Minutes of the Open meeting held on 11 May 2023 were confirmed as a correct record; and

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

31/23 OPERATIONS DIRECTORATE QUARTERLY REPORT – 2022-23 Q4

Lee Brooks introduced the Operations Quarterly Report as read, and drew attention to the following pertinent elements:

1. The Manchester Arena Inquiry update report is due to be presented at the Finance and Performance Committee on 18 September 2023. As a result of the Inquiry two new posts have been appointed: one at an Operations Manager level and the other in a supporting officer role. In terms of the recommendations from the inquiry, 71 were being progressed with some already being closed off.

2. Joint working between the Operations Directorate and the Quality and Nursing Directorate to address the timely turnaround of concerns responses will likely see an improvement going forward.

3. The Trust has recently submitted its application for the three year accreditation in respect of its Emergency Dispatch system and it was expected once again to receive accreditation for the Medical Priority Dispatch System (MPDS).

4. WAST facilitation of Extended Transfer of Care. Lee Brooks referred to this in the report noting that several discussions had previously taken place on this matter.

5. In terms of the Non-Emergency Patient Transfer Services (NEPTS) quality dashboard, this was progressing well.

Comments:

The Committee sought clarity regarding the point in the report which mentions that WAST was not licensed for systematic care delivery inside the hospital. Lee Brooks commented it related to the Trust's function as an out of hospital provider and agreed to provide more information at the next meeting.

The Committee held a discussion which focused on recruitment and retention with EMS Coordination, particularly the Band 3 role which remained a concern noting that the attrition rate had, over a rolling 12 month period (July 2022 – June 2023) remained above 22% until May 2023. There were plans to address this issue noting that it remained a risk and a challenge going forward.

RESOLVED: That the report was received.

32/23 STAFF EXPERIENCE

Edward O'Brian introduced the story which was a video made by one of the Specialist Palliative Care Team paramedics, Beth Hews, who recalled her experience regarding a call via the advice line she had taken from a worried family member. The call took place within the Swansea Bay University Health Board (SBUHB). The caller explained that the patient had deteriorated and had also called 999 and was waiting for the ambulance.

Beth explained that during the conversation several concerns were raised and upon hearing those immediately left and arrived at the patient's house before the ambulance had arrived.

Following an assessment of the patient it became obvious that the patient was dying and was too weak to carry out normal functions. The patient, whilst reluctant, realised she could no longer remain at home.

In the meantime, the ambulance was cancelled, and contact was made with the patient's GP. Working with the family and further discussing their concerns a plan was formulated. This included new medications, equipment to assist the patient whilst she remained at home and access for carers.

By the time Beth left, the patient was pain free and content in the knowledge that she could remain at home.

It was noted that 85% of patients seen by the Specialist Palliative Care Team paramedics remained in their own care setting and only 3% of those patients admitted, went to the Emergency Department.

Comments:

Members thanked Beth for sharing her story and noted that the work of the Specialist Palliative Care Team (SPCT) was having such a huge benefit on people.

Following a query in terms of the team being rolled across other Health Boards (HB), Edward O'Brian explained that whilst the other HB's recognised the clear benefits, it was a funding issue.

Edward O'Brian further added that statistics have shown each year, patients with a

palliative condition in the last 7 days of life, on average 295 were being admitted to hospital each month. Patients in the last 2 days of life on average, 151 were being admitted to hospital. From a practical point it would be fair to assume that the majority of those in their last 2 days of life would be better off remaining in the comfort of their own home; this had the potential to return a significant amount of hours back to WAST.

Members were keen to understand if it was possible to obtain investment from within the charity sector to fund additional SPCT paramedics.

Edward O'Brian explained that each HB manages palliative care differently. For example, in SBUHB funding was provided by the HB itself and in Cardiff and Vale University Health Board this was funded by City Hospice and Marie Curie.

Liam Williams reiterated the positive impact the SPCT was making in SBUHB. He added that the work WAST was taking on with End of Life care sat within Goal 3 (clinically safe alternatives to admission to hospital) of the 6 Goals set by Welsh Government for Urgent and Emergency Care, a 5 year transformation programme implemented in April 2022. Also, there was a programme of work underway which will consider how to support staff in a different way.

Members thanked Edward O'Brian and his team for all the work they do recognizing the significant value of the service provided by the SPCT.

RESOLVED: That the STAFF story was noted.

33/23 MONTHLY INTEGRATED QUALITY PERFORMANCE REPORT

Rachel Marsh presented the latest Monthly Integrated Performance Report (MIQPR) and highlighted the following:

1. The new metrics had been agreed at a recent Trust Board meeting.

2. 111 call answering times were improving, with the call abandonment rate of 5% being achieved in July 2023.

3. The capacity lost to handover outside Emergency Department (ED) continue to remain extreme; 19,118 hours were lost during July 2023.

4. In terms of clinical indicators, there continued to be improvement in the Return of Spontaneous Circulation (ROSC) rates.

Comments:

1. Assurance was sought in respect of the timelines for stroke indicators. Duncan Robertson confirmed that the data was ready and would be reviewed by the Clinical Intelligence Assurance Group at which point it would be decided how

the data will be presented as an indicator. Further details of timelines were being covered off in a later presentation during the meeting.

2. In terms of the full roll out of CHARU and the timelines Lee Brooks explained at this stage there was no definitive timeline. Due to the current financial position a different approach has been taken. Work was ongoing to address this with the implementation of a rotational model which will resource CHARU staff within the Trust's existing establishment. This will initially begin in the Powys area.

3. Immediate Release Directions continued to be a concern and whilst there was a noticeable improvement in red, the number of ambers declined remained significant. The Committee discussed this further and would monitor this closely going forward.

4. Whilst the Committee recognised that Complaints response times were still far below satisfactory, the current trajectory has shown some improvement.

5. The Committee queried that whilst it was noted there was a slight improvement in system pressures and handover delays, the red 8 minute response had deteriorated. Rachel Marsh explained there was a significant number of factors affecting red response; it was felt the main three factors were demand, capacity and lost capacity. Members further recognised that the practical issues such as road works which would influence and impact on response times.

Deep Dive on red rural calls

Rachel Marsh pointed out that rural performance and the model of service in rural areas continued to be a focus of the Trust; the Committee were assured that every demand and capacity review contained discussions regarding red rural calls.

Red performance in particular, was lower in rural areas when compared to urban areas. Correspondingly it was noted that amber response times were slightly better in rural areas. It was recognised that due to current resources it would be unlikely to reach the 65% target in the small villages in parts of Wales; however, in terms of Health Boards the target of 60% was achievable.

Rachel Marsh reminded the Committee that the demand and capacity work was based on achieving 60% in each Health Board area and overall in Wales 65%. The work involved designing the rosters in such a way that the capacity met the demand. At the moment the Trust was struggling to recruit into those rosters in some of the rural areas. Further work was continuing to enhance this recruitment.

The Committee also noted that the performance in rural areas was impacted to an extent by handover delays; particularly in the Powys area.

There were Community First Responders (CFR) who support red calls; however, the modelling completed previously didn't suggest that expanding the CFR response in a rural area would necessarily make a difference.

Comments

Brendan Lloyd commented that an area of focus in rural areas should be on patients who suffer a stroke and how to improve outcomes.

It was queried whether the relief gap in Powys which was 26% and compared to other areas it was 18% and has this since changed as a result of work conducted. Lee Brooks explained there was no longer a relief gap as long as the Trust was fully established. He added that the staff abstraction such as leave and sickness required close management in order to fill the rosters on the proviso the establishment was there. Following further discussion on the relief gap it was noted this would be monitored at the People and Culture Committee going forward.

Lee Brooks further commented that the Emergency Medical Technician (EMT) to Paramedic pathway should be reconsidered to be more geographically focused; for example, focus on the areas where it was a challenge to recruit Newly Qualified Paramedics.

The Committee recognised the challenges of recruiting to rural areas and looked forward to receiving updates going forward.

RESOLVED: The Committee;

(1) Considered the June/July 2023 Integrated Quality and Performance report and remained concerned on performance, noting there were some improvements in some areas;

(2) Noted that the new metrics had been agreed at the Trust Board meeting of 27 July 2023; and

(3) Noted the Deep Dive on red rural calls.

34/23 PUTTING THINGS RIGHT REPORT Q1

Liam Williams presented the report and drew attention to the following areas:

1. There has been an improvement in the 5 day acknowledgement of response to concerns.

2. There was a continued upward trend in Coroner's requests for information. The Trust received two Regulation 28 Reports during this period, both of which related to delays in responding to patients in the community, including a case were the patient was also significantly delayed outside of the hospital on arrival.

3. A continuing number of incidents were being reviewed at the Serious Case Incident Forum (SCIF) and Joint Investigations passed to Health Boards.

4. There was an increase in the number of road traffic incident and personal injury

claims with the latter increasing in complexity and value.

5. A recent report from the Ombudsman illustrated external validation for the Trust in showing that it continues to provide a high standard of documentation.

Comments

Further detail and an explanation were sought in terms of the open patient safety incidents responses that were overdue. Liam Williams explained that the next report would be updated to understand better the level of delay with more explanation as to why.

With reference to the outstanding coroner statements and if there was any update on progress; Liam Williams added that this has been addressed with extra resource to deal with the backlog.

The Committee expressed their grave concern in respect of waiting times noting it was important to take on board and learn lessons from this going forward.

Liam Williams added that in moving to the Joint Investigation Framework, it was anticipated that Health Boards would receive greater involvement from Local Authorities in dealing and understanding the system pressure issues; however, this has not been forthcoming.

Spotlight on Clinical Indicators

Duncan Robertson referred the Committee to the slide presentation in the agenda pack.

He explained further the current clinical indicators, ambulance service indicators, the care bundles and individual metrics for STEMI (ST-elevation myocardial infarction), stroke, NOF (fractured neck of femur) and hypoglycaemia, as well as the ROSC (return of spontaneous circulation) at hospital indicator. Work was ongoing to improve the clinical indicator STEMI.

The Clinical indicators in development were call to door time for STEMI and stroke. Others in consideration included older fallers, paediatric trauma/pain management, and advanced paramedic practitioner (condition specific compliance).

The Committee was reminded of the journey from paper record to digital pens to the now electronic patient clinical record (ePCR) and the improvements that has been made to the capture of data. Exploration of ways in which artificial intelligence and machine learning can improve compliance were being developed.

The Committee noted continued improvement in ROSC rates at 22.2% in June whereas previously they have been below 10%. This was an area which Cymru High Acute Response Unit (CHARU) was targeting in terms of providing better outcomes for the most seriously ill patients.

DRAFT

Comments:

The Committee, from a Quest perspective, suggested it would be useful to see the 'so what' aspect in terms of the indicators going forward.

In terms of the validity of the data from ePCR the Committee recognised the importance of this going forward.

RESOLVED: That the reports were received and noted.

35/23 DUTY OF QUALITY/DUTY OF CANDOUR IMPLEMENTATION

Jonathan Turnbull-Ross presented the report which provided assurance for the Committee in terms of the Trust's progress following the implementation of the Duty of Quality and the Duty of Candour which came into force on 1 April 2023.

A technical specification template was being designed by key stakeholders to ensure compliance and a consistent approach to data quality standards for current and future quality measures.

A set of Performance and Quality Standards were currently being developed for the Duty of Candour designed to collect data and information consistently at a local and national level and create a dashboard.

Going forward the Trust was working towards completing the Welsh Government (WG) Baseline Road Map with a forthcoming milestone in September 2023; progress was regularly monitored through the Trust Quality and Performance Steering Group and the Clinical and Quality Governance Group.

Comments:

The Committee were pleased to see the rolling out of education and training into the Trust's existing structures.

The Committee sought what the level of awareness was across the Trust and whether there had been any specific risks identified. Jonathan Turnbull-Ross assured the Committee that awareness training was ongoing, adding that there was a need to 'hold the tone' of the Duty of Quality and Duty of Candour. He added that the new quality leads would play an important role in this.

Following a query in terms of the forthcoming milestone in September regarding the completion of the WG Baseline Road Map, Liam Williams advised due to the number of incidents it was not expected that the Trust would be dealing with moderate harm in September at a level the legislation would expect. He added that the Trust was doing everything within its own gift to demonstrate compliance in respect of governance.

RESOLVED: The Committee;

(1) Received and noted the report; and

(2) Noted that the Trust was working towards the baseline assessment criteria as set by the Welsh Government Road Map, with a forthcoming milestone in September 2023.

36/23 INFORMATION GOVERNANCE REPORT

Leanne Smith explained that the report contained details of how the Trust protected its patient and staff data through the implementation of several measures and governance processes.

The report also provided an overview of information governance in terms of accountability, assurance, and compliance. The Committee were also presented with a new set of metrics.

In terms of particular note from the update the Committee were advised of the following key points:

1. The annual Welsh Information Governance Toolkit compliance assessment for 2023/23 demonstrated the Trust did not meet the minimum expectations for some areas including policies and procedures. Whilst the information security policy was in the latter stages of review currently, there were other policies and guidance that required updating and development for data protection, freedom of information and environmental information requests.

2. In terms of the Key Performance Indicators (KPI) illustrated at Appendix one to the update, the Committee noted that the expected criteria to assessed against this year may differ in subsequent years.

3. Training and awareness standards were also not meeting minimum expectations. The improvement plan to address these areas would be reviewed by the Information Governance Steering Group and Executive Management Team.

4. An internal audit of records management and requests was underway and will come to the next meeting. A reasonable assurance rated internal audit was received recently on cyber security and reviewed by the Finance and Performance Committee (FPC) who has cyber security in their remit. FPC will focus more broadly on the Trust's systems and their resilience with a focus also on digital information.

5. There were 172 responses to requests under the Freedom of Information Act in 2022/23 and metrics are being developed to provide trend analysis.

Comments:

In terms of the Level of preparedness in terms of cyber security it was queried whether a KPI could be implemented to measure this. Leanne Smith advised this would be part of the business continuity plan reported to FPC and could be included in that report going forward. The Trust continued to learn lessons from other ambulance services regarding cyber attacks ensuring staff are made aware. There were potentially still further metrics which could be developed around the training and education of staff regarding cyber security.

The Committee were keen to understand the timelines for the completion of the action plan in respect of the Information Governance (IG) toolkit. Leanne Smith explained that worked had commenced prioritising the highest risks and adding those into the improvement plan; there were no timescales as such as this was being conducted internally. In terms of risks, one of the main ones was not meeting the statutory and mandatory training for (IG), work to manage this was being addresses.

RESOLVED: That

The Committee considered the proposed metrics in the KPI report (as per Appendix 1) against the context supplied in this paper and agreed that quarterly reporting in this form met the assurance needs of Quest; with clarity in the reports regarding the delineation between the responsibilities of the Quest Committee and FPC.

37/23 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK REPORT

Trish Mills presented the report noting that the two substantial risks, 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) both rated at 25, had been the subject of discussion earlier in the meeting.

Comments:

Lee Brooks added that from a Health Board (HB) perspective and following some recent data analysis on a comparative basis, and based upon that, it was unlikely that any HB would score less than 25 for Risk 223. Liam Williams added that work to review the mitigations against this particular risk was ongoing to ensure they were correctly positioned in the relevant directorate.

RESOLVED: The Committee reviewed and considered the contents of the report.

38/23 INTERNAL AUDIT TRACKER UPDATE

Trish Mills explained that the audit tracker was currently undergoing a full review and, together with audit guidance for the organisation, will be available for the 14 September Audit Committee for scrutiny.

The Committee noted the work being undertaken in collaboration with Internal Audit colleagues to review and close off historical audit recommendations.

Pain Management Internal Audit Report - Limited Assurance

Duncan Robertson gave an overview of the progress on management actions in order to address the limited assurance review.

A task and finish group has been established to develop and design a pain management framework. This will enable the ability to build on the work in terms of measuring pain management.

Comments:

The Committee reviewed the recommendations and recognised the tight timeframes in completing the actions.

Trish Mills explained that part of the audit tracker review work was to have a better understanding on the impact of closed actions.

RESOLVED:

(1) Noted the work planned and in train for the audit tracker and guidance document which the Audit Committee will review on 14 September; and

(2) Noted the Pain Management Internal Audit Report.

39/23 HEALTH INSPECTORATE WALES (HIW) – UPDATE ON PATIENT SAFETY, PRIVACY, DIGNITY AND EXPERIENCE WHILST WAITING IN AMBULANCES DURING DELAYED HANDOVER

Liam Williams gave an update on progress against recommendations raised from the HIW Emergency Services Clinical Contact Centre EMSCCC Patient Safety Review. The principal objective of the 2019/20 review was to assess how patients were managed by EMS Coordination (EMSCCC) encompassing the period from the time the call was received through to an operational response arriving with the patient.

A secondary objective was consideration of how staff working in EMSCC were resourced and supported. There were two actions outstanding which the Committee were assured were progressing.

WAST Local Review 2019-2020

Lee Brooks explained there were two outstanding actions as shown below and updated the Committee on progress towards completion:

1. Complete the North Wales EMS CCC estate strategy and identify opportunities for improvements.

2. Continue with the work of the CAD Phase 3 project to realign workloads within the EMSCCC for more efficient operation.

RESOLVED: The Committee

(1) Noted the Health Inspectorate Wales (HIW) – update on patient safety, privacy, dignity and experience whilst waiting in ambulances during delayed handover report and confirmed agreement with the assurance provided and closure of the action plan;

(2) The National Policy on Patient Safety Incident Reporting and Management was approved; and

(3) The update on the WAST local review 2019-2020 actions was noted.

40/23 ANNUAL INFECTION PREVENTION AND CONTROL REPORT

Liam Williams presented the Infection Prevention and Control (IPC) Annual Report for 2022/23. The report included the transition from the Covid-19 Pandemic response to business as usual and noted how the Trust supported outbreaks of Monkeypox and invasive Group A Streptococcus.

The Committee also noted and were assured the Trust was actively driving towards a consistent IPC culture, one in which high standards of patient care and staff safety were maintained.

Comments:

Bethan Evans, IPC Board Champion and Chair of the Committee commended the team and recognised there had been significant and sustained improvement in this area.

The Committee recorded a note of thanks to Louise Coulson and her team in their work on Infection Prevention and Control and the significant improvement shown.

RESOLVED: The Committee noted the update and received assurance that the Trust was actively driving towards a consistent IPC culture, one in which high standards of patient care and staff safety were maintained and that the focus for the next year would be on monitoring, audit and assurance.

41/23 ANNUAL SAFEGUARDING REPORT

The Committee received the annual safeguarding report as presented by Nikki Harvey. The following points were drawn to their attention:

1. The report provided assurance on safeguarding activities, engagement, and collaborative working with the Trust's partner agencies; as well as the necessary

assurances that the statutory duties under the relevant safeguarding legislation and guidance were being fulfilled.

2. Safeguarding metrics were reviewed regularly by the Committee via the Monthly Integrated Quality and Performance Report.

3. The data evidenced within this year's report demonstrated a further year on increase in the total number of reports submitted by Trust staff since the initial launch of Doc Works (digitalised system).

Comments:

Members recognised that the report had demonstrated a large breadth of collaboration and co-production across agency boundaries.

Liam Williams commented on the commitment made by the safeguarding team in supporting the most vulnerable. This was reiterated by Paul Hollard, Safeguarding Board Champion, and other Committee members, who commended the team and the compassionate way they approached their work in what were often very difficult circumstances.

RESOLVED: The Committee approved the Trust's Safeguarding Annual Report for 2022/23.

42/23 CLINICAL AUDIT PLAN – UPDATE

The Clinical audit plan update was received with no escalations. Nine actions were open and on track, with one action off target but progressing which was in relation to the funding for user interface changes to be made to the ePCR.

The Committee took assurance that good progress was being made.

RESOLVED: The Committee noted and were assured by the update.

43/23 POLICY REPORT

Trish Mills explained that the purpose of the report was to update Members on the current status of the Trust's policies.

Following the Trust's revised policy process being implemented in 2017, there was a significant improvement in the number of policies within their review date. However, the rate of review fell below reasonable levels during the pandemic as policy work was largely paused and efforts directed to support the response.

DRAFT

A prioritisation exercise has taken place based on a risk assessment, and a revised governance process for policies and delegations for approvals was underway.

Whilst only 14% of policies were currently within their review date, the Committee noted that policies do not 'expire' and that extant but overdue for review policies have undergone rigorous review prior to their approval and as a result, except for legislative or national policy changes which automatically required policy updates, would likely stand the test of time with minor amendments.

Members noted that this Committee would receive policies relevant to it for approval noting that the Audit Committee would have overall oversight of the framework and the progress of policies.

The Committee were made aware of some process issues which required fine tuning to improve the approval and flow system.

Comments:

Trish Mills, in response to how any legislative changes would affect policies, assured the Committee that the necessary procedures and structures were in place to accomplish and ensure compliance.

The Committee were assured that the process in place to progress the Trust's policies was totally suitable and were content to support the programme of work.

National Policy on Patient Safety Incident reporting and Management.

Liam Williams explained that the policy was reflective of all the legislative requirements, and the guidance from an all Wales level and was submitted for approval and adoption.

RESOLVED: The Committee

(1) Considered the contents of the report and the programme of work in development to mitigate risk and bring policies in line with appropriate review dates; and

(2) Approved the adoption of the National Policy on Patient Safety Incident reporting and Management.

44/23 COMMITTEE PRIORITIES AND CYCLE OF BUSINESS MONITORING REPORT

The Committee priorities and cycle of business monitoring report was received by the Committee.

RESOLVED: The Committee received the priorities and cycle of business monitoring report.

45/23 GROUNDHOG DAY 2: AN OPPORTUNITY FOR CULTURAL CHANGE IN COMPLAINT HANDLING

The Groundhog Day 2: an opportunity for cultural change in complaint handling report was received by the Committee.

RESOLVED: The Groundhog Day 2: an opportunity for cultural change in complaint handling report was received by the Committee.

46/23 REFLECTIONS & SUMMARY OF DECISIONS & ACTIONS

Actions

The following new actions were recorded:

1. Clarification was sought on the licences regarding transfer of care.
2. PTR Reports: Future reports to indicate whether any external issues and factors that have contributed to delays.
3. Clinical Indicators: Spotlight on Clinical Indicators. As work developed beyond the five indicators currently reported on, ongoing updates would be provided.
4. Internal Audit Tracker: Update on how the Trust was dealing with historical actions. To be included in the report.
5. Policy report: Details of the current number of policies outside their review date be captured within the alert section of the AAA report.

47/23 KEY MESSAGES FOR BOARD

Trish Mills would draft the update which will be presented to the Board via the Committee's AAA highlight report.

48/23 ANY OTHER BUSINESS

None.

Date of Next meeting: 31 October 2023

Meeting concluded at 13:20

DRAFT

ACTION LOG - UPDATE FOR 31 OCTOBER 2023
QUEST COMMITTEE

Minute Ref	Date	Agenda Item	Action Note	Responsible	Due Date	Progress/Comment	Status
16/23	11 May 2023	MIQPR	Agreed that a meeting be coordinated with quest and PCC to discuss the situation regarding the challenges faced by the PTR team.	Liam Williams	31 October 2023	Update for 10 August 2023 Verbal update to be provided at the meeting. Liam Williams gave a verbal update assuring the Committee of the work being undertaken and it was agreed this would be considered outside of the meeting. Liam Williams advised this issue was being addressed in liaison t=with the People and Culture Committee. An organisational Change Policy has been generated and will be considered by EMT. Once further information was known, Quest will be updated. Update for 31 October 2023 PTR Recurrent investment and associated OCP approved by ELT and OCP in progress. Recommend to close.	Open
34/23	10 August 2023	PTR Reports	Future reports to indicate whether any external issues and factors that have contributed to delays.	Liam Williams	31 October 2023	Update for 31 October 2023 Reporting being updated to reflect requested information. Recommend to close.	Open
34/23a	10 August 2023	Clinical Indicators	Spotlight on Clinical Indicators. As work developed beyond the five indicators currently reported on, ongoing updates would be provided.	Duncan Robertson	31 October 2023	Update for 31 October 2023 First update will cover the clinical indicator on Return of Spontaneous Circulation (ROSC) rates, on agenda. The Broad business for spotlight on clinical indicators is on the Quest Committee cycle of business. Recommend for closure.	Open
38/23	10 August 2023	Internal Audit Tracker	Update on how the Trust was dealing with historical actions. To be included in the report.	Trish Mills	31 October 2023	Update for 31 October 2023 Details included in the report, recommend for closure.	Open
43/23	10 August 2023	Policy Report	Details of the current number of policies outside their review date be captured within the alert section of the AAA report.	Trish Mills	31 October 2023	Update for 31 October 2023 Details included in the AAA from August, recommend for closure.	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	28 September 2023
Committee Meeting Date	10 August 2023
Chair	Bethan Evans

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. With handover delays at 19,118 hours in July they are still far in excess of what is acceptable and so remain in this alert section. These delays coupled with many patients waiting in excess of four hours outside Emergency Departments **continues to present patient safety risks and extended waits in the community.** The Committee is aware of the actions being taken by WAST to mitigate harm and of the escalations and actions in the system. Progress against these actions is a focus at each public Trust Board meeting, however the number of amber immediate release direction refusals, and a high number of concerns raised, and incidents linked to timeliness of response demonstrates the continued need for more pace to address the issue at a system and strategic level. Members will continue to challenge on any further actions that can be put in place by the Trust and its influence on system partner actions and raise the issue in their respective forums.

2. Following the Trust's revised policy process being implemented in 2017 there was a significant improvement in the number of policies within their review date. However, the rate of review fell below reasonable levels during the pandemic as policy work was largely paused and efforts directed to support the response. This, coupled with a challenging Winter and prolonged industrial action has led to a significant number of **policies past their review date**. A prioritisation exercise has taken place on the basis of a risk assessment, and a revised governance process for policies and delegations for approvals is underway. The risk assessments were based on known risks, internal audits completed and those planned for 2023/24. Whilst only 14% of policies are currently within their review date, the Committee noted that policies do not 'expire' and that extant but overdue for review policies have undergone rigorous review prior to their approval and as a result would likely stand the test of time with minor amendments. The policies relevant for this Committee were reviewed and the priority order agreed. The Audit Committee will oversee the improvement plans to ensure we have a robust policy framework.

ADVISE

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

3. The **Committee heard from Beth Hews**, Palliative Care Paramedic about her experience attending a patient with metastatic bowel cancer who had been referred to Specialist Palliative Care Team (SPCT) for pain management. Through the intervention of the SPCT they were able to keep this patient in her own home rather than have her taken to hospital by ambulance, providing a holistic plan which enabled her to die with dignity and in comfort. Current statistics suggest around 85% of patients seen by the SPCT Paramedics remain in their own care setting, thereby avoiding a likely 999 call and hospital admission. The Committee thanked Beth for sharing her story, the rest of the SPCT for their excellent work, and Ed O'Brien, Clinical Lead Palliative and End of Life Care for giving the Committee a broader context on the work of the SPCT. The Committee will keep this area on it radar to watch progress and take the opportunity to promote this area of our practice.

4. The Committee received the quarterly **Operational Update** as a standing agenda item. High levels of attrition in Emergency Medical Services (EMS) Coordination will be explored further in the People and Culture Committee at their next meetings. The development of the Non-Emergency Patient Transport Service (NEPTS) dashboard was noted, as was its focus on a range of measures including patient experience.

5. The **Infection Prevention and Control (IPC) Annual Report for 2022/23** was presented to the Committee and is attached at Annex 1 for the Board's attention. The report includes the transition from the pandemic to business as usual and how the Trust managed outbreaks of Monkeypox and Strep A. The Committee noted and were assured the Trust is actively driving towards a consistent IPC culture, one in which high standards of patient care and staff safety are maintained. Bethan Evans, IPC Board Champion and Chair of the Committee commended the team and recognised there has been significant improvement in this area.

6. The **Safeguarding Annual Report for 2022/23** was presented to the Committee and is attached at Annex 2 for the Board's attention. The report provides assurance on 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 are being fulfilled. Safeguarding metrics are reviewed regularly by the Committee via the Monthly Integrated Quality and Performance Report. Paul Hollard, Safeguarding Board Champion, commended the team and the compassionate way they approach their work in what are often very difficult circumstances.

7. An update was provided on the **Health Inspectorate Wales (HIW) Review: Patient Safety, Privacy, Dignity and Experience whilst waiting in ambulances during delayed handover (2021)**. There was an expectation from HIW that the recommendations made would be considered at a system level and an Emergency Ambulance Services Committee (EASC) task and finish group was established to respond to the review. The Trust's particular management actions are reported to that group and HIW have concluded that sufficient assurance has been received in response to the findings identified within the review report for the Trust for the stage

one review. A stage two review will be initiated by HIW in the coming weeks.

8. An update was received on progress against recommendations raised from the **HIW Emergency Services Clinical Contact Centre EMSCCC Patient Safety Review**. The principal objective of the 2019/20 review was to assess how patients are managed by EMS Coordination (EMSCCC) encompassing the period from the time the call is received through to an operational response arriving with the patient. A secondary objective was consideration of how staff working in EMSCC are resourced and supported. There are two actions outstanding which the Committee were assured were progressing.

9. The **National Policy on Patient Safety Incident Reporting and Management** was approved.

10. Members' **reflections** on the meeting included:

- The introduction of a review of the agenda and timings with the Chair closer to the meeting. This will enable the Chair to review placement and timing of items;
- Helpfully, areas of greatest focus and where strong assurance was required were placed higher in the agenda which enabled some good discussion, however more time could be given to some items to enable members to drill down further on performance.
- Good succinct discussion; and
- The desire to reduce the volume of papers, recognising however the Committee has a substantial remit. The Board's risk appetite as to the level of assurance required could be reviewed.

ASSURE

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

11. The Health and Care (Quality and Engagement) (Wales) Act 2020 and hence the **duty of quality and duty of candour** came into force on 1 April 2023. Work is progressing regarding 'Always On' reporting with the development of a scalable digital dashboard specification based on the Quality Standards 2023 reflective of strategic, tactical, and operational quality requirements. A technical specification template is being designed by key stakeholders to ensure compliance and consistent approach to data quality standards for current and future quality measures. A set of Performance and Quality Standards are currently being developed for the duty of candour to form a dashboard to collect data and information consistently at a local and national level. Progress on the Welsh Government milestones was said to be amber/green. It was recognised that there was a need to continue to 'hold the tone' of the duty of quality and duty of candour and that the new quality leads will play a pinnacle role in this.

12. The Committee receives assurance reporting by way of the **Monthly Integrated Performance Report** (MIQPR) for June/July and the **Q1 Putting Things Right Report**. The organisational learning from clinical reviews was set out in the latter report. The Trust Board will note the escalation in the alert section regarding continued handover delays. The Committee noted:

- Continued achievement of the clinical call back time target for the highest priority 111 calls,

while the priority 2 and 3 call back times also achieved the 90% performance target in July.

- The myriad of factors that influence the red 8 minute response were discussed given the slight improvement in terms of system pressure and handover delays not equating to improvement in red response. The primary influencers of demand, capacity and lost capacity remain a focus which the Committee will monitor.
- A new five-day acknowledgement for concerns has been introduced but due to the fragile position the two-day target will be retained internally until compliance is sustained. Improved processes in the EMS Co-ordination and Resourcing Centre have seen a timelier response and there has been some improvement in the 30-day response to concerns, however it remains some off target at 43% for June against a target of 75%. The overwhelming theme through the majority of concerns remains timeliness to responding to calls in the community. Themes are also emerging in respect of Ambulance Care regarding cancellation of transport.
- The Committee raised an alert following their last meeting as to effect of the backlog and volume of concerns on the teams dealing with them. The Executive Management Team will review a proposed organisational change process to support these teams before the next Committee meeting and will update members thereafter.
- A continuing number of incidents are being reviewed at the Serious Case Incident Forum (SCIF) and Joint Investigations passed to Health Boards.
- An increase in the number of road traffic incident and personal injury claims with the latter increasing in complexity and value.
- There is a continued upward trend in Coroner's requests for information. The Trust received two Regulation 28 Reports during this period, both of which relate to delays in responding to patients in the community, including a case were the patient was also significantly delayed outside of the hospital on arrival.
- Changes in the Operations Directorate have started to see a positive impact on outstanding coroner statements.

13. A **deep dive on red rural performance** was presented following a request by the Committee at the last meeting. The Committee noted that performance consistently tracks below pan-Wales performance and below the 65% target. By contrast however, Amber 1 performance is consistently better than more urban areas. Members recognised that whilst red rural performance remains an issue, actions are being taken to address this. The Committee was assured there was focus on this including demand led rosters, rosters that are recruited to and efficient use of that resource (in particular, handover lost hours, but also internal efficiencies like abstractions and mobilisation times). The forthcoming EMS demand and capacity review explicitly includes rurality in its terms of reference. The People and Culture Committee will look at the effect of rurality on abstractions, recruitment and retention.

14. A **focus on clinical indicators** was agreed at the last effectiveness review and the first report was presented at this meeting. The current clinical indicators and ambulance service indicators are the care bundles and individual metrics for STEMI (ST-elevation myocardial infarction), stroke, #NOF (fractured neck of femur) and hypoglycemia, as well as the ROSC (return of spontaneous circulation) at hospital indicator. Clinical indicators in development are call to door time for STEMI and stroke. Others in consideration include older fallers, paediatric trauma/pain management, and advanced paramedic practitioner (condition specific compliance). The Committee was reminded of the journey from paper record to digital pens to the now electronic

patient clinical record (ePCR) and the improvements that has made to the capture of data. Exploration of ways in which artificial intelligence and machine learning can improve compliance are being developed. The Committee noted continued improvement in ROSC rates at 22.2% in June whereas previously they have been in the sub-10%. This is an area which CHARU is targeting in terms of providing better outcomes for the most seriously ill patients.

15. The **Clinical audit plan update** was received with no escalations. Nine actions were open and on track, with one action off target but progressing.

16. The Committee reviewed the position, plans and proposed reporting for **Information Security and Information Governance** which is an area that was expanded in its remit in 2022. The comprehensive report provided an overview of information governance in terms of accountability, assurance and compliance and the Committee agreed a set of metrics. The Committee noted:

- The annual Welsh Information Governance Toolkit compliance assessment for 2023/23 demonstrates the Trust did not meet the minimum expectations for some areas including policies and procedures. Whilst the information security policy is in the latter stages of review currently, there are other policies and guidance that require updating and development for data protection, freedom of information and environmental information requests. Training and awareness standards are also not meeting minimum expectations. The improvement plan to address these areas will be reviewed by the Information Governance Steering Group and Executive Management Team.
- An internal audit of records management and requests is underway and will come to the next meeting. A reasonable assurance rated internal audit was received recently on cyber security and reviewed by the Finance and Performance Committee who has cyber security in their remit.
- There were 172 responses to requests under the Freedom of Information Act in 2022/23 and metrics are being developed to provide trend analysis.

Metrics were agreed for ongoing reporting and assurance on information governance and information security. Ceri Jackson, Digital Board Champion welcomed the dashboard.

17. An update was received on a revised process for the **Audit tracker** which will be before the Audit Committee for approval on 14 September. The Committee's attention was drawn to historical overdue audits which were the subject on discussion with Internal Audit following this meeting. The Committee also noted the upcoming internal audit reviews within the remit of this committee for the remainder of 2023/24.

18. The limited assurance **Pain Management internal audit** was presented to this meeting following it's discussion at the Audit Committee on 25 July. The Committee reviewed the recommendations and actions, welcoming the tight timeframes within which these would be closed given the limited nature of the audit.

19. The **Committee's priorities for 2023/24** (implementation of the quality strategy, and the duty of quality and duty of candour) are progressing well. The Committee also reviewed its progress against its cycle of business.

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 and are part of the escalation section of this report. The Executive Director of Operations and the Executive Director of Quality and Nursing updated the Committee that these risks had been reviewed this week and reiterated the need for the scores to remain at 25. A comparison had been done of risk 223 from the time it was first developed at a score of 20, through its escalation to 25 and at the current time on Health Board data and there was nothing in that analysis to support a reduction in the score for any Health Board area.

New Risks Identified: Challenges and risks in achieving, maintaining and assurance compliance of data protection were drawn out in the Information Governance and Information Security paper.

The papers for this meeting can be found by following this link to the Committee page on our website.

COMMITTEE AGENDA FOR MEETING		
Feedback from Chair on escalations from Committee to Board in March	Operations Directorate Quarterly Report for Q1	Patient (staff) experience
Monthly Integrated Quality Performance Report	Putting Things Right Report Q1	Spotlight on Clinical Indicators
Duty of Quality and Duty of Candour Implementation	Information Governance Report	Risk Management and BAF
Internal Audit Tracker update and Pain Management Internal Audit	HIW report updates: Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover and EMS CCC patient safety review	Annual Infection Prevention and Control Report
Annual Safeguarding Report	Clinical Audit Plan Update	Policy Report and National Policy on Patient Safety and Incident Reporting and Management
Committee priorities update and monitoring report for cycles of business	Groundhog Day 2: An opportunity for cultural change in complaint handling	

COMMITTEE ATTENDANCE				
NAME	**11 MAY 2023**	**10 AUGUST 2023**	**9 NOVEMBER 2023**	**8 FEBRUARY 2024**
Bethan Evans				
Kevin Davies				
Paul Hollard				
Ceri Jackson				
Liam Williams				
Andy Swinburn		Duncan Robertson		
Lee Brooks	Steve Clinton			
Leanne Smith	Jon Hopkins			
Rachel Marsh				

Trish Mills				
Mark Marsden				
Hugh Parry				
Ian James				

	Attended
	Deputy attended
	Apologies received
	No longer member

OPERATIONS DIRECTORATE
QUARTERLY REPORT FOR COMMITTEES
2023-24 Q2 (July - Sept 2023)

National Operations & Support

Challenges

Manchester Arena Inquiry Report (MAI)

Work is progressing on the 71 recommendations that the Trust has determined as relevant to WAST, with 9 recommendations completed and 17 recommendations have been assessed as needing national guidance to complete. We have agreed the reporting and governance processes for the recommendations and WAST continues to work with colleagues from the blue light services within Wales and EPRR colleagues across the UK to assess and implement the recommendations.

General Update

EPRR - Exercise Dollhouse

Exercise Dollhouse was undertaken in July with representatives from across the Trust participating. This exercise tested our response to a Manchester Arena style attack and our collaboration with multiagency colleagues using JESIP. Overall, the exercise showed that our commanders have a robust understanding of the need to deploy front line staff quickly but safely in the event of a Marauding Terrorist Attack environment to save lives and narrow the care gap identified during the MAI.

EPRR - Mass Casualty Arrangement Exercise

The EPRR team is currently working with colleagues from the Health Boards across Wales and Welsh Government to develop and deliver an exercise to test the Casualty Dispersal Plan within Wales. This exercise is intended to test the capability of the Health Boards to accept patients within the first two hours of a mass casualty incident and the arrangements in place to efficiently disperse patients from a scene post the initial 2 hours.

Volunteering

We have recruited a replacement Operations Manager for the Volunteer Car Service who will plan to increase the number of active VCS volunteers from 100 to more than 200 by the end of the year. Q2 recruitment has already improved from 4 drivers across 22/23 to 19 drivers in Q2 of 23/24.

Our Operations Manager with a focus on alternative responders was appointed in Q2 and is focussed on the new Community Welfare Responder volunteer role which is currently under development as phase one of the Connected Support Cymru project.

A grant application of £315,000 has been awarded to the volunteering team through NHS Charities Together in support of the Community Welfare Responder project. This will fund the fixed term recruitment for new Support Officer roles which will commence in Q3.

Planning is underway for two volunteer conferences including recognition for volunteers demonstrating WAST behaviours (as provided to staff at CEO roadshows) to be held in Q3 in Llandudno and Swansea, hosted by the volunteer team and supported by colleagues across the Trust.

Operational Delivery Unit

During quarter 2 we welcomed a new National Delivery Manager to the team, completing our team with no current vacancies. The ODU team continue to support the implementation of the NHS Wales System Escalation Framework. We expect to see the first iteration of the new Urgent and Emergency Care Dashboard during Quarter 3 which will complement the escalation framework and build upon the live reporting tools available to inform situational awareness and decision making across the unscheduled care system.

Resourcing & EMS Coordination

Challenges

Concerns Team Outstanding Tasks

The workload for the Operations Quality (OQ) Concerns Team remains high at 200 outstanding tasks. This is however a reduction from 283 in 2022/23 Q4. The OQ Team continues to work closely with the Putting Things Right (PTR) Team to prioritise work to meet deadlines and requests. At the time of preparing this report, all concerns outstanding are now within PTR's Tier 1 target which is positive. The demand for coroner's statements across Wales continues to remain high with 18 statements currently with OQ that require completion. The due date has lapsed for 13 of these. The team has been supported by wider Operations team colleagues to complete these statements, which has resulted in an improved position from over 40 outstanding at the end of 2022/23 Q4.

Ineffective Breathing

During a levelling exercise delivered by the International Academy of Emergency Dispatch (IAED), it was identified that there is a widespread issue relating to the compliance of audits relating to breathing problems. Auditors have been over-auditing breathing problems and marking them as non-compliant due to ineffective breathing descriptors which is now recognised to be incorrect. An report is being constructed by the Service Manager, Operations Quality (SMOQ) to share the work and learning around ineffective breathing which will go to operational and clinical governance groups; Clinical Prioritisation Assessment Software Group (CPAS), Clinical Quality Governance Group (CQGG), Senior Operations Team (SOT) and Senior Leadership Team (SLT). Additionally, reviews of the audits of over half of the outstanding 38 Nationally Reportable Incidents (NRIs) sitting with OQ are required as they relate to ineffective breathing. An approach is being worked through with PTR to ensure transparency and accuracy.

Recruitment and Retention

Recruitment and retention within EMS Coordination remains a concern with the attrition rate for the rolling 12-month period (Aug 22 to July 23) improved to 16.84% peaking in September and December 22. This attrition figure only relates to external attrition and does not account for internal moves or staff who leave their FTE position but retain a bank contract.

Significant recruitment initiatives have been implemented since September 2022 with more than 100 staff being recruited in the same period (36% of the current establishment for EMSC). Despite this, we continue to see withdrawals during the recruitment process, during induction and during training which further impacts our establishment position. Workforce plans are in place for the year based on our attrition rate, however due to the 3-month lead in time for recruitment and one month notice period for these staff groups, we are often in an under-established position.

Intentions to recruit to levels above attrition rates have not been realised due to high levels of attrition, withdrawals from cohorts and new recruits being unable to meet the appropriate

standard leading to redeployment and/or resignation. This continues to be an area of focus but remains a risk and challenge.

The inability to identify funding streams for the EMSC restructure, retention plans and increased staffing levels to meet the aggregated demand means that this recruitment and retention challenge has a significant impact on the wellbeing of staff within the EMS Coordination environment. Sickness absence in July 23 increased to 9.2% above the stable position of 8% which had been maintained since February 23. This has been driven by an increase in Long Term Sickness absence with Anxiety/Stress/Depression remaining the number one cause of sickness absence in EMSC.

IMTP

EMS Coordination Culture Programme

The EMSC Culture Programme has commenced with meetings chaired by the Director of People and Culture. Senior Leaders in the EMSC team have met with Trade Union Partners to discuss culture, behaviours, and concerns to design an action plan for improvement. As part of this work a Staff Experience agenda item has been added to the EMSC Quality Meeting which will be Chaired by the Service Manager for Operations Quality from September 23 onwards. This forum gives a platform for EMSC staff to share their experiences of working in EMSC and the challenges this presents to the Senior Leadership Team as well as other key stakeholders. The Group has heard powerful presentations from the Carmarthen EMSC Culture Champion and a North 999 Call handler and hope to have a representative from Vantage Point House at the next meeting in September 23.

General Update

IAED Accreditation

All Trust activities required for submission to the Academy for reaccreditation have been completed. The Academy has fed back that WAST is leading nationally in its submission of the required evidence. The Trust obtained ACE in Good Standing for April/May/June 2023 which is the highest achievable level and bodes the Trust well in its application for reaccreditation as an Accredited Centre of Excellence with the IAED.

SOPs Review

EMS Coordination teams have undertaken a robust review of their Standard Operating Procedures, and these are now moving through governance processes for approval. Led by the Business Support Manager, the work involved EMSC teams as well as managers and operations quality colleagues reviewing all SOPs to absorb learning and guidance previously communicated via bulletin as well as to absorb the transformational changes impacting the operations directorate including CHARU, Falls Responders, Community Welfare Responders, and Immediate Release Guidelines.

Emergency Medical Service

Challenges

Continued System Pressures

Delayed handover of care at Emergency Departments across Wales remains a significant challenge in being able to provide a safe level of emergency service. 33,081 hours were lost in April 2023, 20,397 in May 2023, 18,543 in June 2023, and 19,118 in July 2023. The impacts of these pressures is regularly discussed at Committee and Trust Board.

Red performance and Amber response

While handover delays have seen a degree of improvement since April 2023, this has not fully translated into improved red performance. However, while it is recognised that there have been improvements in red response ,overall the red performance falls short of 65%. Significant focus is being applied by EMS and EMS Coordination to improve the response to our sickest patients.

Since April 2023, the amber median trend has seen improved community response times to these categories of patients. This would partly be due to the slight improvement in handover delays at hospitals.

Reduced overtime allocation due to Financial Savings Plan resulting in reduced UHP

As part of the financial savings plan EMS has controlled the level of overtime allocation. Original data identified predicted UHP levels because of controls. The reduced overtime allocation commenced on 1 July 2023 and the resultant UHP levels for the month of July were extremely close to the predicted levels with abstraction variation across the 7 Health Board areas between 30% to 39%, with a Trust average of 35.62%.

IMTP

An innovative process is being considered to combine a CHARU and EA rota for interested paramedics within the rural community. This will support paramedics to undertake a dual role working in both roles to support retention and provide this level of clinical response. This process will be reviewed and could pave the way for similar working practices in other areas.

Absence Trajectory

A considerable amount of work has been done by the team in collaboration with People Services and Occupational Health to reduce the sickness absence trajectory. In December 2022 the sickness level was at 11.05% which reduced to 10.08% by March 2023 and then to 8.57% in July 2023.

It is recognised that we are not where we need to be at this stage, but a lot of effort and scrutiny continues to improve the sickness absence trajectory and abstractions generally.

Managing Sexual Safety and Improving Culture

Following the Sexism and Sexual Safety at Work Survey and WAST Voices, action plans have been implemented across the four territories to raise awareness on the subject of sexual safety, and to positively influence behaviour and culture within the Trust. Local sessions have been conducted by the Trust's Organisational Development Team with locality managers and DOMs to support them to undertake appropriate local actions.

General Update

Delivering on Financial Savings Plan

EMS continues to lead on the Operations Directorate's Financial Savings plan and are supporting the non-pay and non-patient facing pay savings. Each health board area has been allocated a daily/weekly overtime allowance that is allocated in line with demand forecasting, UHP, local events, and civil contingency requirements as examples. This is a robust process with all overtime allocated recorded in detail to support monitoring and review. As part of these plans a 'Reserve Allowance' has been established to ensure that we can meet the fluctuating demands, dips in UHP and significant events with associated risk.

Ambulance Care

Challenges

Net Centre

Call taking via the NET Centre continues to challenge. Although a really good period of stability and performance have been achieved through July and August, the small size of the national team is significantly impacted by any spikes in sickness and staff loses. August has seen a dip in performance but the national manager has been working on alternative solutions to mitigate the reductions in staff.



Demand

Demand continues to gradually move back towards pre pandemic levels but changes in health board service delivery through different journey/clinic destinations has increased demand on the resource availabilty. This has caused increases in late cancellation of journeys, in particalr in the Aneruin Bevan area where rosters need better alignment to the demand. Additionally, the focus on maintaining financial balance has restricted historic movement to costly additional provision to convey all, including ineligilbe patients.

General Update

CMP (Capacity Management Plan)

Following the introduction of the CMP to manage eligibility within Ambulance Care, the team have reviewed and implemented changes to improve the management of activity. This is allowing Ambulance Care to ensure eligible users are prioritised above ineligible. This is also enabling Ambulance Care to maintain focus on financial stability through the year. The changes were taken through the Delivery Assurance Group for information and consultation where it encompassed support and no resistance. Work continues to improve the NEPTS application of the eligibility criteria.

Vehicles development

The delivery and operational commencement of the new MAN B class Ambulances has been delayed. This was due to supplier issues but now following delivery in August WAST has been able to fit the relevant communication requirements/kit and they are now ready for service. A training plan will now be devised via the Educational and Development team and a roll out programme for both Barry and Bassaleg Station where these vehicles will be operationally based and evaluated. The evaluation will inform any future developments and procurement.

Integrated Care

Challenges

111 SALUS Operations Implementation

Despite some challenges within the wider implementation 111 operations have continued to work with colleagues across the Trust to prepare for implementation of the product. In particular, 23 new Standard Operating procedures have been developed in readiness for the commencement of train-the-trainer.

IMTP

ECNS Accreditation

All Trust activities required for submission to the Academy for Emergency Nurse Communications System Accreditation have now been completed. The Academy is undergoing due diligence in relation to the evidence we have provided in our submission. All 21 ACE points have been achieved and random audits are now being undertaken by the Academy as the final element of ratification. The Trust is aiming for Accreditation in September 2023.

111 Urgent Dental Development

During quarter two 111 operations and clinical colleagues have been heavily involved in the national review into access to urgent dental care. This work aims to expand the current dental services provided by 111 into one consistent pan-Wales model across all Health Boards. Through co-design a new model for one of the health boards for which 111 manages urgent dental access has been developed which will improve patient and staff experience and increase the number of patients booked directly into face to face care through 111. Work alongside the six goals team to develop this on a national scalable basis continues in Q3.

General Update

NHS 111 Wales Performance

During quarter two 23/24 111 have seen a sustained improvement in many areas of its service performance following work on rostering, system efficiencies and individual performance. 111 call abandonment has been below the KPI for June, July, and August both for the months and weeks. Across the quarter only 8 days have exceeded the 5% abandonment KPI and this includes the bank holidays and weekends which have historically been severely challenged. There has been similar improvement in the percentage of calls answered within 60 seconds with seven months of sustained improvement. Whilst further work is required to achieve the KPI the improvement is marked.

Time to triage performance has again seen an improving position with consistent achievement of the 90% KPI.

Police Pilot

During quarter 4 2022/23 CSD engaged in a small-scale pilot with South Wales Police within the Vale of Glamorgan. The purpose of the trial was to broaden the Remote Clinical Support offer to Police for circumstances where Officers on scene with a patient waiting for an ambulance response.

In its evaluation the report detailed that the pilot was not well utilised by police colleagues deemed partially due to the size of the geography covered and as such it has been agreed through the Joint Emergency Services Group (JESG) that CSD supports a further pilot with both South Wales and Gwent Police forces. This trial is due to commence mid-September 2023.

Connected Support Cymru

Known locally as the “Community Welfare Responder (CWR)”, this pilot has been supported by CSD since the beginning of May 2023 and to date over 313 calls attended with 173 resulting in non-conveyance. Consult and Close was 41.6% of all activity. 469 hours have been provided by CWR responses during the same period with a utilisation from 1st August-21st August utilisation being 54% (total time available v's committed to incidents). CSD will continue to support this activity into winter and continue the development of the service as it moves into phase 2 of the pilot.

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

PUTTING THINGS RIGHT REPORT
QUARTER 2, JULY-SEPTEMBER 2023

MEETING	Quality, Patient Experience & Safety Committee
DATE	31 October 2023
EXECUTIVE	Liam Williams, Executive Director of Quality & Nursing
AUTHOR	Wendy Herbert, Assistant Director of Quality & Nursing
CONTACT	Wendy.Herbert3@wales.nhs.uk

EXECUTIVE SUMMARY

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

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 sustained increase in the number of concerns, and a backlog remains at processing stage for September 2023.
- A continuing high volume 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.
- A sustained increase in the number of Road Traffic Incident claims.
- The Trust received 3 Regulation 28 Reports during this period.
- The PTR Organisational Change Process commenced on 25 September 2023.

RECOMMENDED: That the Quality, Patient Experience & Safety Committee receives the report for discussion and identifies any additional assurance requirements.

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) The significant improvement in our five-day acknowledgement of concerns has been impacted by capacity in the team, resulting in the data in respect of concerns being incomplete for the September 2023 period. (iv) Our thirty-day compliance remains lower than the 75% target. (v) Delivery of functions remains a significant challenge due to capacity, demand and competing priorities.

REPORT APPROVAL ROUTE	
Clinical and Quality Governance Group	25 October 2023
Quality, Patient Experience & Safety Committee	31 October 2023

REPORT APPENDICES
ANNEX 1 - SBAR 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)	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

SITUATION

1. This Putting Things Right (PTR) Report covers the period from 1 July to 30 September 2023. Table 1 & the 'PTR Overview' overleaf provide a 'at a glance brief' of comparison data quarter on quarter and over on a twelve month rolling period across each of the functions.

2. This Report covers the PTR functions which broadly includes:

    - Patient Safety (proactive & reactive).
    - Patient / family complaints.
    - Patient / family compliments.
    - Ombudsman relationships, information sharing, reports, and responses.
    - Coroner relationships, information sharing, reports, and responses.
    - Redress cases.
    - Claims cases.
    - Organisational learning (including Learning from Events).

3. Please note that the data contained within this report is accurate at the time of reporting. There is a currently a backlog in processing complaints which has impacted on the September 2023 data. This will be updated and reflected in the quarter three report. Additionally, data may be subject to change following the investigation process including regrading of incidents.

BACKGROUND

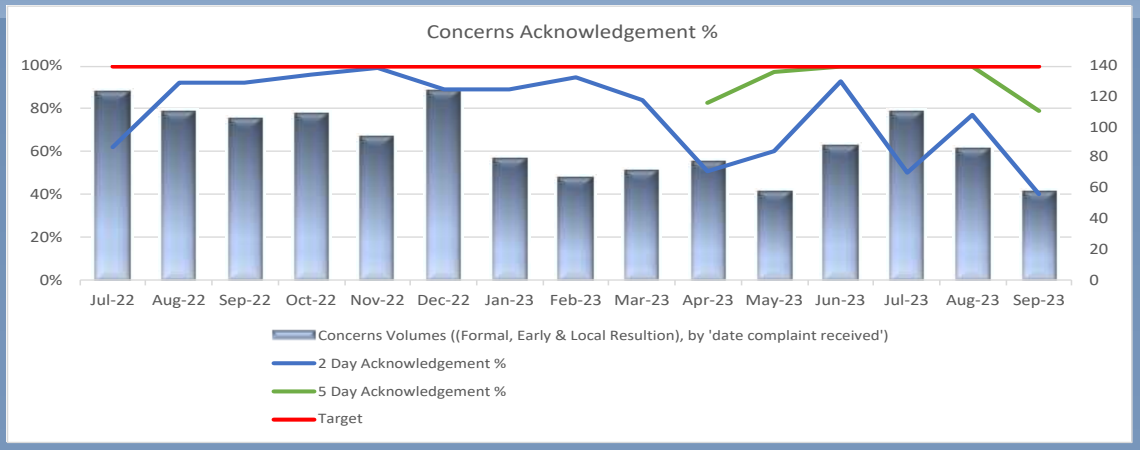
4. The PTR Team are currently in the consultation phase of an organisational change process which aims to provide additional leadership, capacity and development opportunities across the functions.

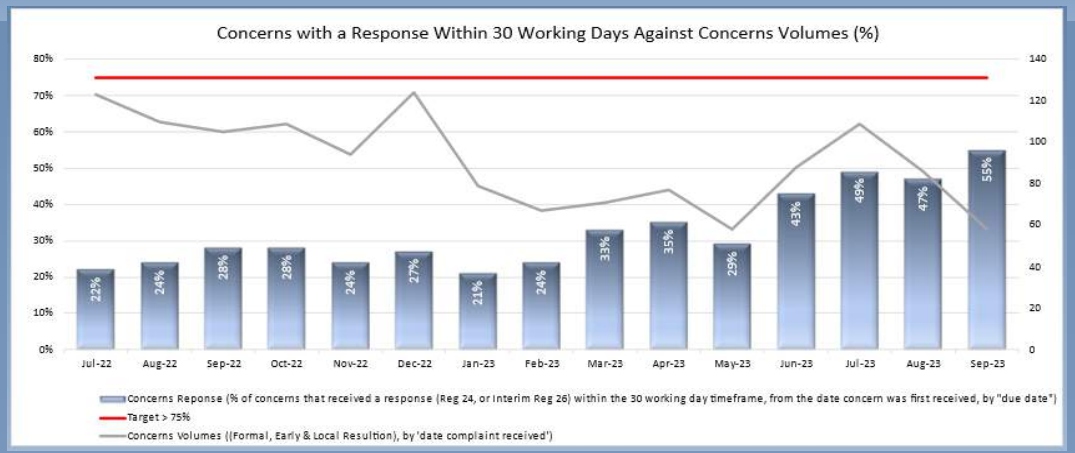
5. The ambition in future reports is to move to aggregated thematic reviews, in order to determine patterns and trends corporately and at service and health board levels.

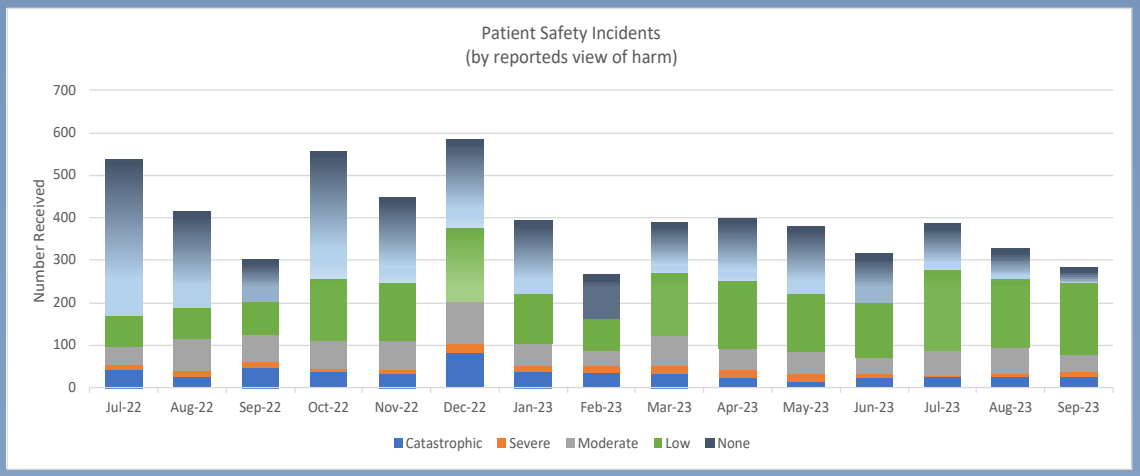
Table 1

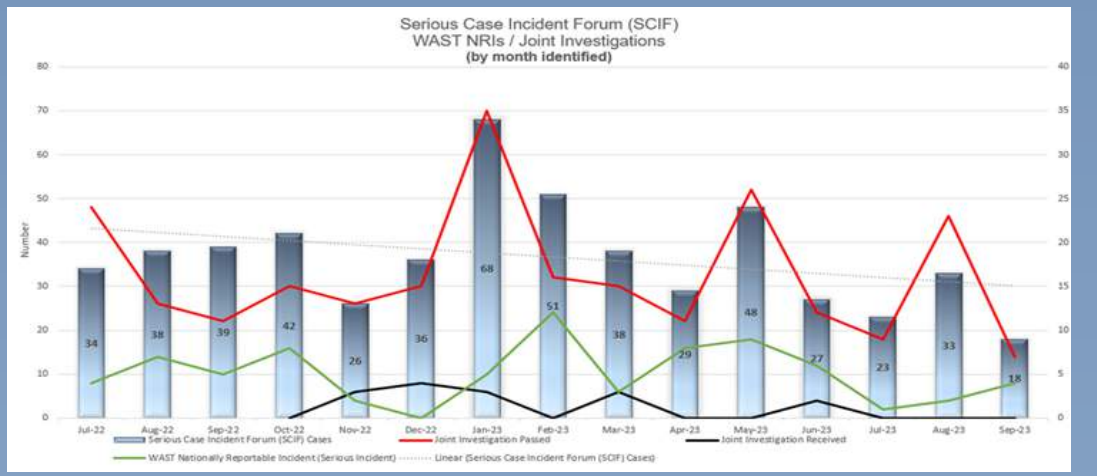
PUTTING THINGS RIGHT						
Comparison of Data Quarter / Year	Quarter 2, 2022-23			Quarter 2, 2023-24		
	July	August	September	July	August	September
	2022	2022	2022	2023	2023	2023
Patient Safety Incidents (Reporters view of harm)						
Catastrophic	41	28	48	26	26	28
Severe	10	10	12	4	7	11
Moderate	46	79	67	58	63	41
Low	71	71	75	189	160	166
None	368	228	101	109	73	39
Total	536	416	303	386	329	285
Concerns						
Total Received	123	110	105	109	86	58
Political Concerns	6	5	7	3	8	1
2 Day Acknowledgment %	62%	92%	92%	50%	77%	40%
5 Day Acknowledgement % (new April 2023)	-	-	-	100%	100%	79%
30 Day Response due %	22%	24%	28%	49%	47%	56%
Ombudsman						
Cases Received	1	4	1	4	0	1
Cases Closed	4	2	1	4	0	2
Reports Received	1	0	1	1	0	0
Coroners						
Information Requests	128	137	152	146	171	183
Identified as Interested Party	21	19	20	41	42	39
Staff Attending	5	4	3	7	7	6
Regulation 28 Issued	1	0	0	2	0	1
Response to Regulation 28 outside 56 working days	0	0	0	0	0	0
Nationally Reportable Incidents (NRIs) to NHS Wales Executive (Reporting date)						
Serious Case Incident Forums held	5	8	7	4	7	5
Serious Case Incident Forums Cases	34	38	39	22	33	18
WAST NRIs reportable to Delivery Unit	2	10	7	4	2	4
Joint Investigation Framework - Passed	26	10	15	9	23	7
Joint Investigation Framework - Received	0	0	0	0	0	0
NRI Closures Submitted - Total	26	1	2	3	0	6
Claims						
Personal Injury – Received	1	2	5	1	2	1
Personal Injury – Closed	1	0	2	1	0	6
Clinical Negligence - Received	0	3	0	4	4	2
Clinical Negligence - Closed	0	1	0	1	0	0
Road Traffic Collision & Damage to Property – Received	20	17	22	27	21	11
Road Traffic Collision & Damage to Property – Closed	17	10	15	7	9	9

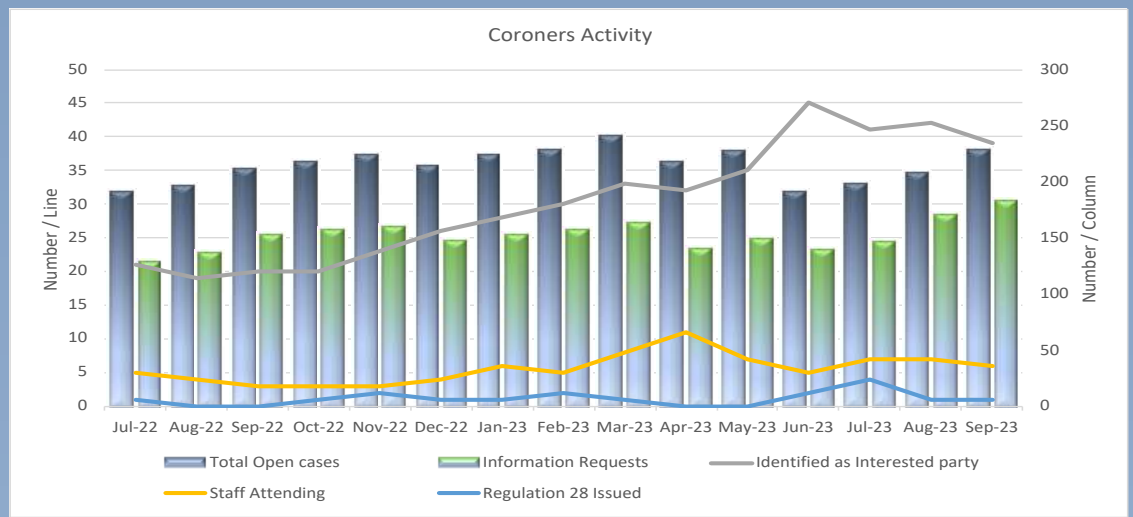
Putting Things Right Overview

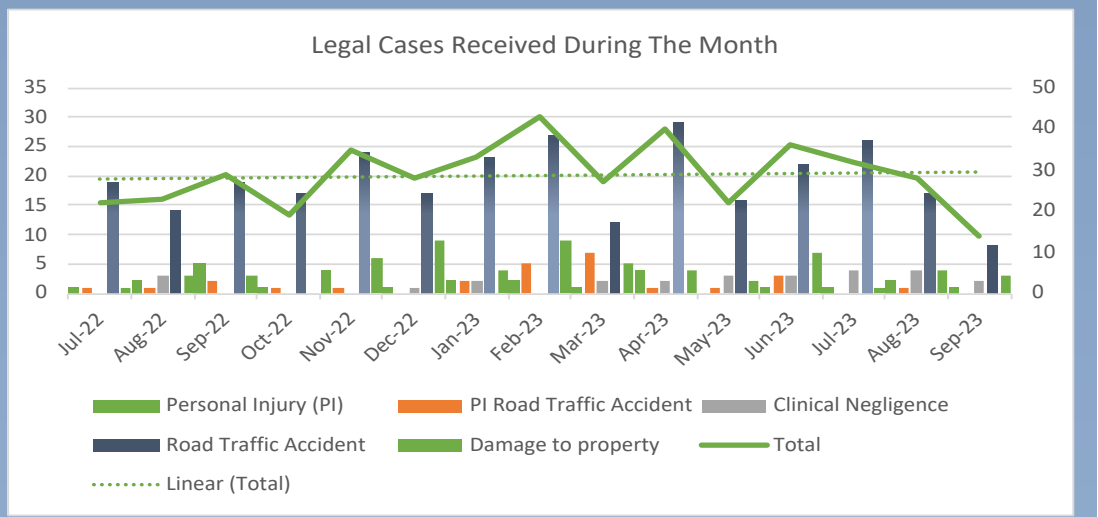












ASSESSMENT

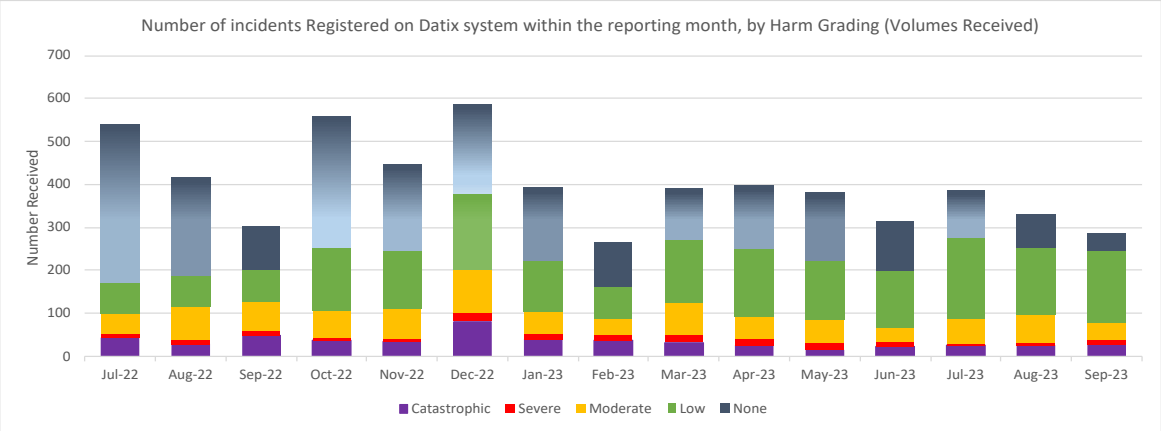
Patient Safety Incidents

6. 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).

7. During this period a total of 1,000 patient safety incidents were reported, 386 in July, 329 in August and 285 in September. It must be noted that the harm grading may change subject to the outcome of any investigation.

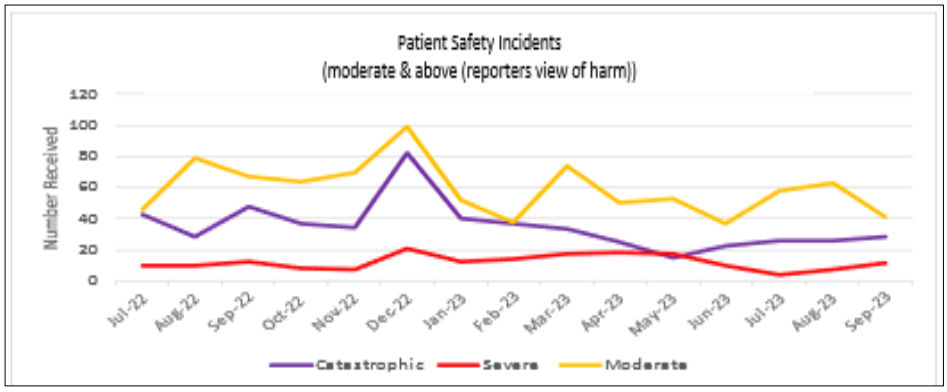
8. The graph below illustrates the number of patient safety incidents reported on a rolling basis from July 2022 by initial grading (reporters view of harm). Themes continue to be timeliness to response and handover of care delays.

Graph 1



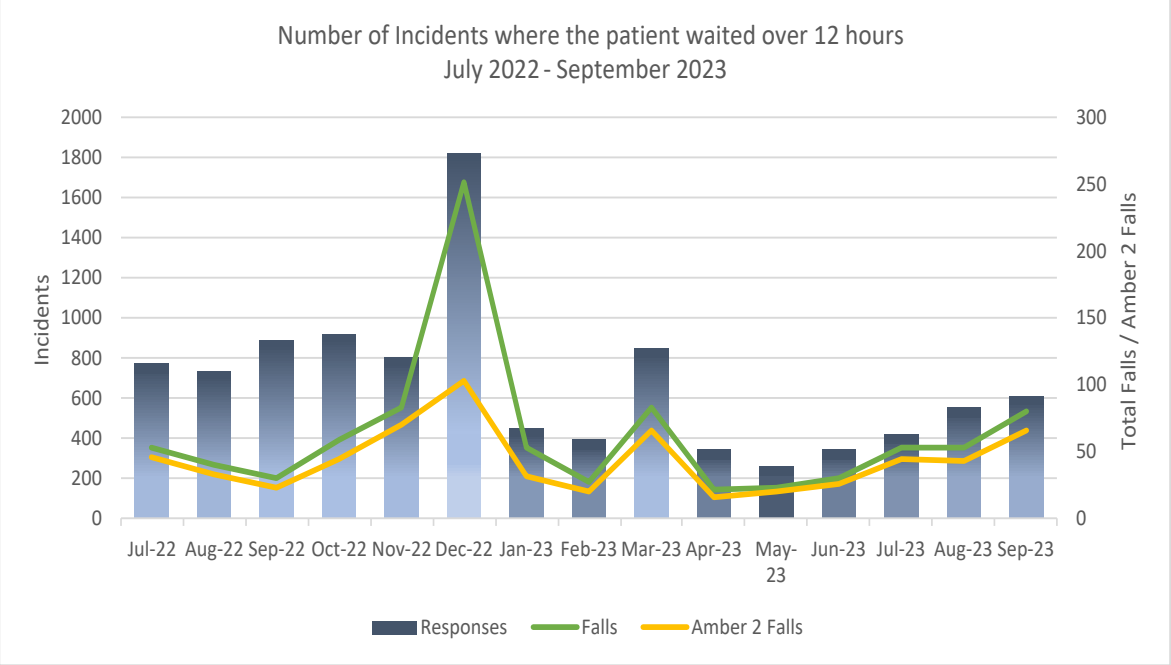
9. Graph 2 below details the number of patient safety incidents rated moderate and above. The Patient Safety Team continue to review incidents graded moderate and above to determine any Duty of Candour (DOC) requirements. In respect of the dashboards the expectation is these will be included in the next quarterly report.

Graph 2



10. Patients waiting for extended periods of time in the community continues as detailed in Graph 3 below. During this period 1588 patients received a response or wait over 12 hours.

Graph 3



11. 186 of the patients waiting over 12 hours had experienced a fall, with the longest waiting patient being 39 hours and 59 minutes. 154 of the patients were in the Amber2 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. Table 2 provides a breakdown of where patients waited by Health Board area.

Table 2

Health Board Area	Number of Patients who have fallen and waited over 12 hours for a response. July to September 2023
Aneurin Bevan UHB	36
Betsi Cadwaladr UHB	46
Cardiff & Vale UHB	10
Cwm Taf Morgannwg UHB	39
Hywel Dda UHB	27
Powys Teaching HB	4
Swansea Bay UHB	24
Total	186

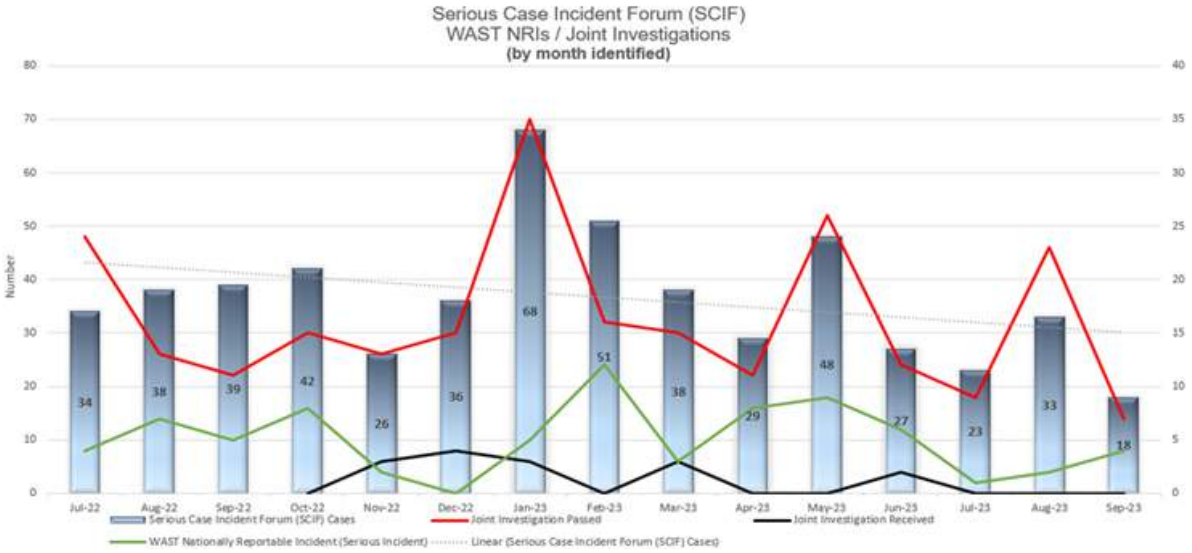
12. Identification of patient harm across the whole urgent care pathway is challenging, as impacts are not always immediately apparent. The Patient Safety Team are working with tissue viability colleagues nationally to explore the contribution from WAST in providing data and information to inform investigations of patients who have developed pressure damage. Currently reviews undertaken by panels in Health Boards focus on the inpatient episode and community patients on the district nursing caseload – there is no data capture for care within WAST, unless there is a pre-assessed and identified pressure ulcer, as this should not be expected for the short episodes of care delivered by a pre-hospital emergency and urgent care ambulance service.

13. WAST met with the Chair of the All Wales Tissue Viability Network on 2 August 2023 and it was agreed that further work would take place. It was noted that WAST are working with an external organisation to develop training and support packages for our staff working with frail patients undertaking extended journeys or episodes of care and, that WAST is assisting in the development of a dynamic pressure relieving mattress for use in an ambulance.

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

14. Graph 4 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.

Graph 4



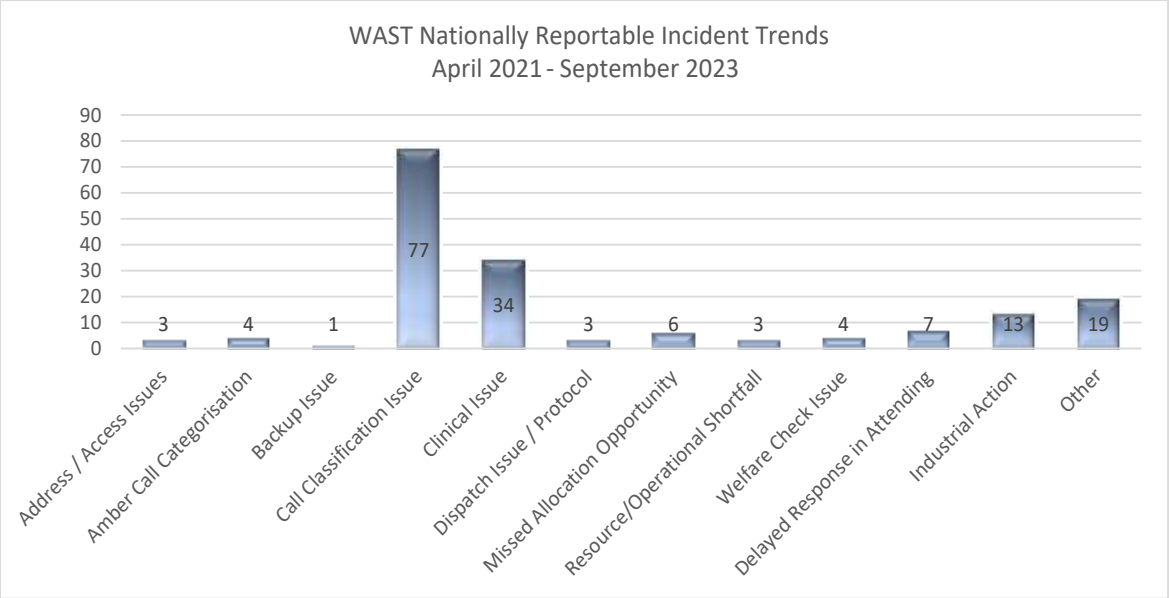
15. During this reporting period there were 16 SCIF meetings held, with 73 incidents discussed. 10 incidents have been reported as NRIs to the NHS Wales Executive and 39 incidents were referred under the Joint Investigation Framework to the

respective Health Board. No incidents linked directly to the refusal of immediate release requests were identified.

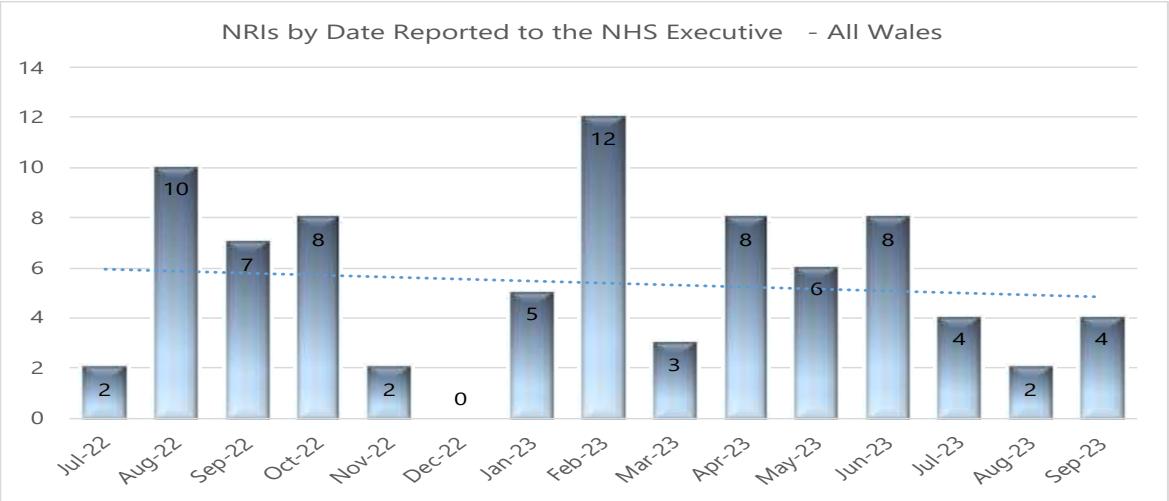
16. General themes received from Health Boards following joint investigations are over-crowded emergency departments and wider system pressures resulting in hospitals being in very high levels of escalation.

17. Graph 5 below provides an overview of the themes of Nationally Reportable Incidents (NRIs) from April 2021. Graph 6 provides the numbers of NRIs reported over a rolling twelve month period. During this quarter 10 NRIs were reported to the NHS Executive and the themes remain similar including call categorisation and clinical care issues. 'Other' categories relate to the previous WAST Datix codes.

Graph 5



Graph 6

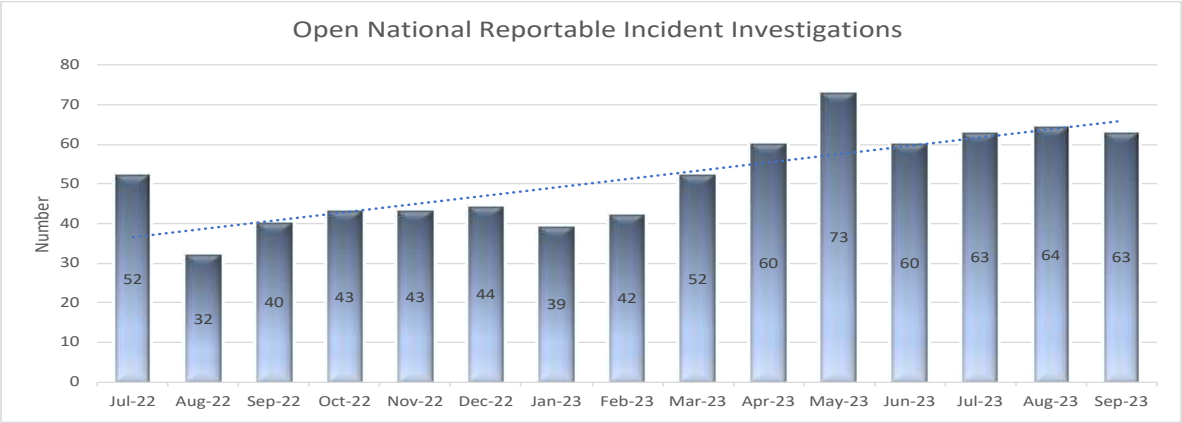


18. The International Academy of Emergency Dispatch has been requested to review the Trust's ineffective breathing calls which have resulted in NRIs. An update will be provided to the Clinical Quality Governance Group.

Patient Safety Investigations

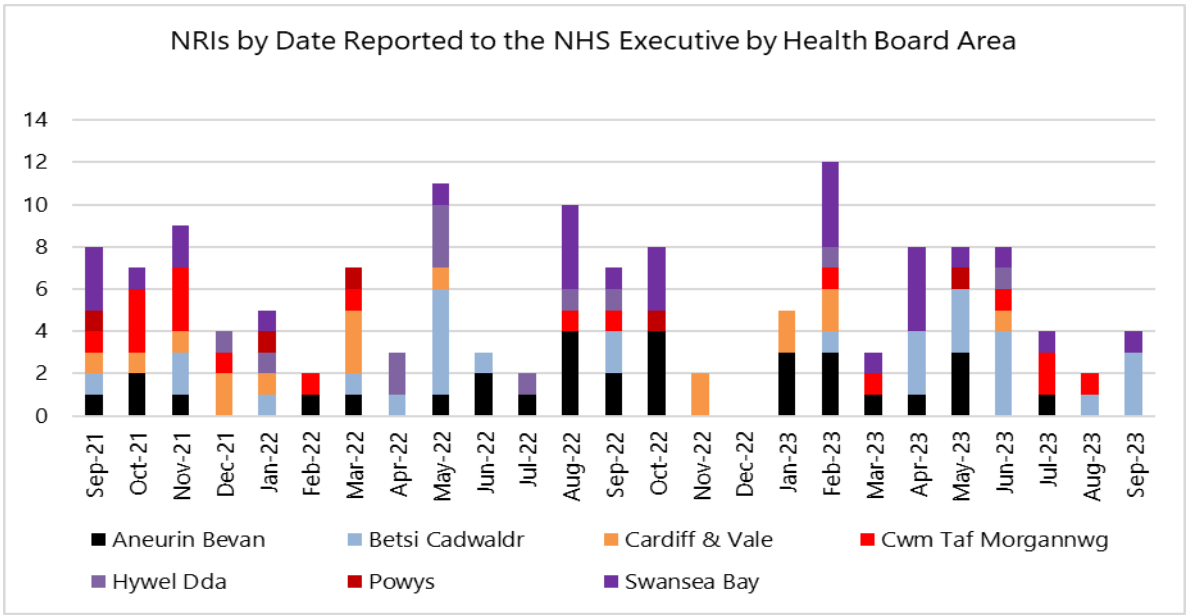
19. The Trust currently have a total of 63 open NRI investigations. Graph 7 below details the number of open NRI cases over time, with a rising trajectory overall.

Graph 7



20. Graph 8 below details the number of NRI reported to the NHS Executive by Health Board area.

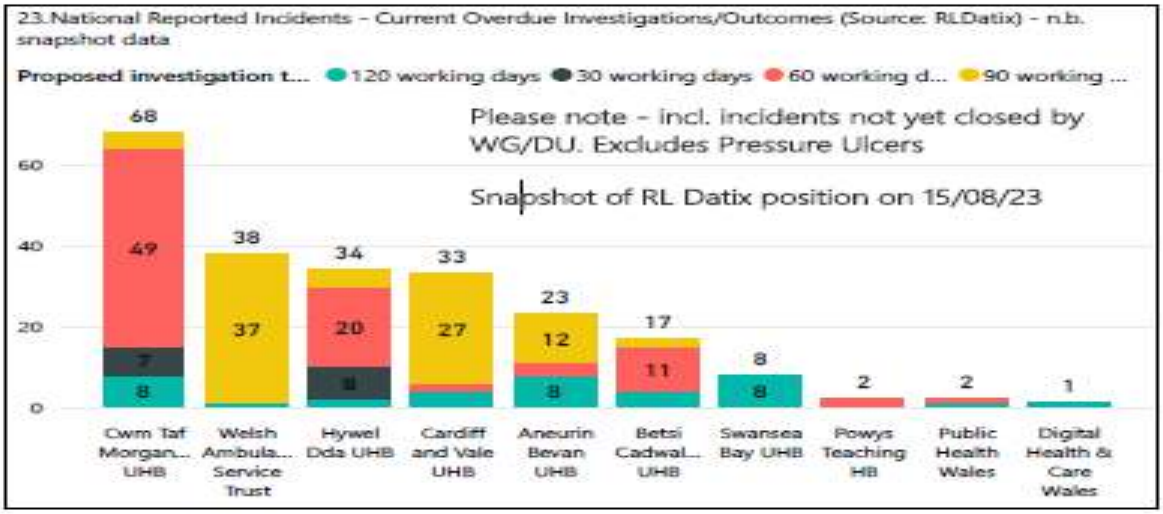
Graph 8



21. The Trust currently have a number of overdue NRI investigations (n=38). There are multiple factors but predominately these are due to capacity, demand and competing pressures.

22. Graph 9 is extracted from the 'NHS Wales Dashboard (15 August 2023)' and provides details on the Trust's position in relation to overdue investigations, with a comparison to other NHS organisations.

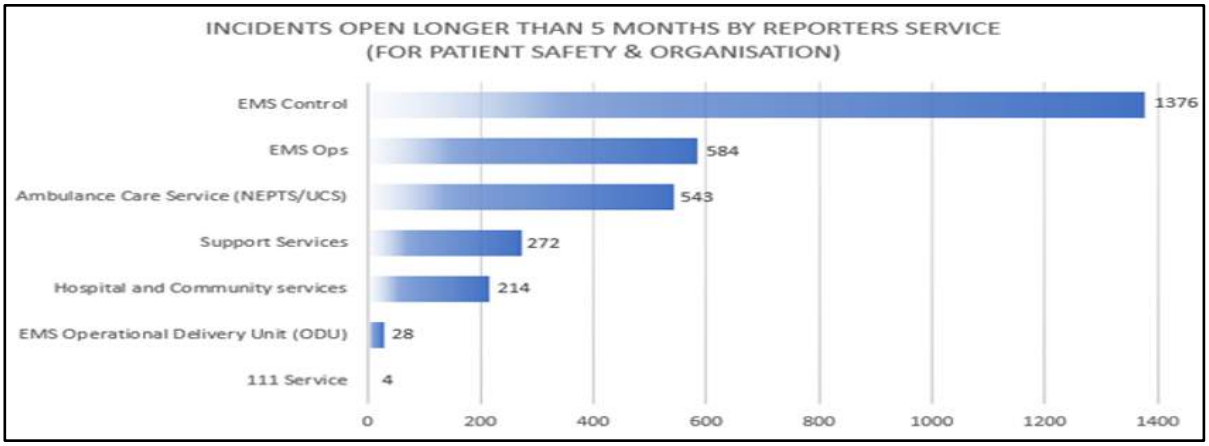
Graph 9



23. Organisational pressures are also impacting on teams' capacity to undertake investigations of incidents graded as no harm, low harm and moderate harm. A number of investigations are past the timescales set out in Trust policies and procedures.

24. Graph 10 provides a breakdown of the current position in respect of investigations overdue by five months or more. This has been discussed at Clinical Quality Governance Group with monitoring and oversight occurring at the Senior Operations Team.

Graph 10



Duty of Candour

25. The Duty of Quality and Duty of Candour (DoC) Welsh Government Roadmap is updated on a monthly basis with oversight from the Clinical Quality Governance Group. Progress in respect of DoC is also monitored locally through the PTR work programme.

26. Following the updates to key policies and procedures in April 2023 a further refresh of the Trust's key policies is planned following the consultation by Welsh Government and publication of the revised Putting Things Right Regulations (2011).

27. DoC education is available on the Electronic Staff Record and the plan is to change this to mandatory status by the end of the calendar year.

28. The Trust is represented on the All Wales DoC Network which meets monthly. At this meeting a set of performance and quality standards are currently being developed to form a dashboard in the Datix Cymru System to collect data and information consistently at a local and national level.

29. It is expected that data from the national DOC dashboard will be available for inclusion in the quarter 3 report.

NHS Wales Patient Safety Alerts / Notices

30. Oversight of alerts and notices occurs at the Clinical Quality Governance Group. As of 10.10.2023 the Trust has one Patient Safety Alert outstanding:

    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).

31. Actions taken / planned:
    A Clinical Notice covering the alert was issued in January 2023 by the Clinical Directorate. A multidisciplinary risk assessment has now been undertaken with operational colleagues at the Senior Operations Team meeting and a closure form will be submitted to the next All Wales Patient Safety Solutions Review Group (AWPSSRG) in October 2023 by the Head of Patient Safety and Concerns (interim).

Learning from Deaths (Mortality Reviews and the Medical Examiner Service)

32. A detailed update on the mortality review process is presented under a separate QuESt agenda item (meeting 31.10.2023).

33. Refreshed terms of reference have been developed for the Learning from Deaths (mortality reviews) Forum with reporting and oversight occurring at the Clinical Quality Governance Group.

34. The Forum intends to identify categories of deaths in our care that would always trigger a review by the Group outside of a Medical Examiner request. Additionally, through the opportunities provided by the ePCR and other data sets the aim is to develop our data and information to determine any emerging patterns, themes and trends.

35. To date the Trust has not received any requests to undertake a Level 2 mortality review of patients in our care under the new processes in place across NHS Wales. Currently the focus of the Medical Examiner Service is undertaking mortality reviews in the acute care setting. By April 2024 when the Medical Examiner Service becomes a statuary body all non-coronial deaths, including community deaths will be reviewed and a significant increase in activity is expected by the Trust.

36. Themes from the feedback from the Medical Examiners is similar to the themes and trends in incidents and complaints which include delays in the community and outside emergency departments, call categorisation and end of life care (patients being transferred to acute care).

37. The Trust is engaging with other UK ambulance services in learning from deaths with a meeting planned on 26 October 2023.

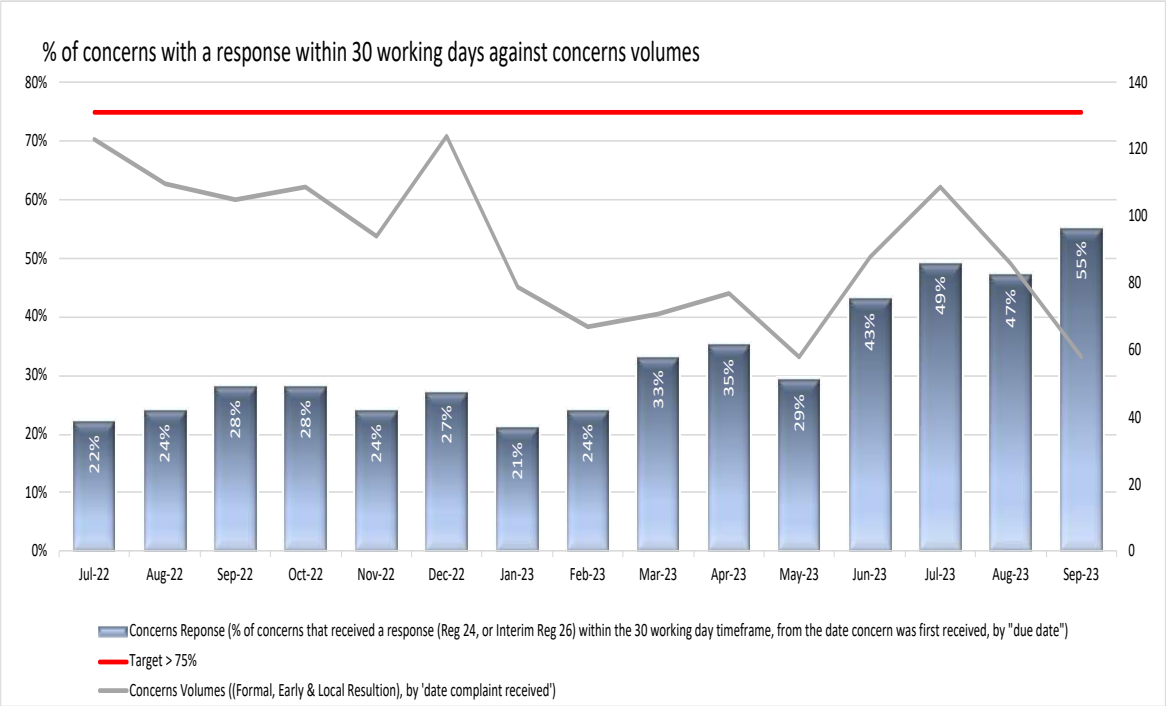
Early Resolution (ER), Local Resolution (LR) and Formal Concerns

38. 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.

39. Graph 11 below provides the concerns position over time. The Trust continues to receive a steady number of concerns with 253 being received during this reporting period.

Graph 11



40. The acknowledgement date target has been amended nationally to five working days. During this reporting period the five-day acknowledgement performance was 88%, 96% and 99% (100% target) with the 30-day target achieving 49%, 47% and 55% respectively (75% target).

41. Due to a backlog in processing concerns in September 2023 the data is not complete and will be refreshed in the quarter 3 report.

42. The PTR organisational change process commenced on 25.09.2023 and aims to provide additional leadership, resilience and capacity across all of the PTR functions, including concerns management. The Trust is working to a very stringent project plan that will ensure all existing staff are in their new posts by the end of November 2023 and all vacancies advertised for recruitment in December.

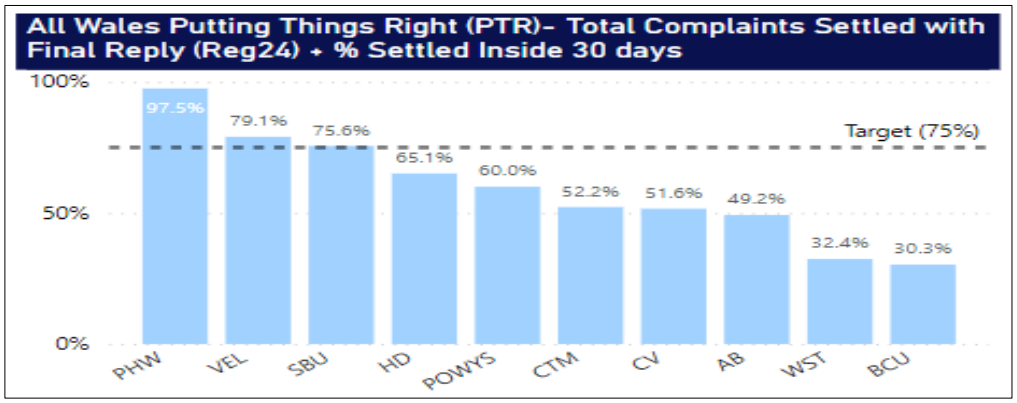
43. The overwhelming themes and trends through the majority of concerns remains timeliness to responding to calls in the community.

44. Themes were emerging in respect of Ambulance Care regarding cancellation of transport. Through collaborative working the PTR Team and Senior NEPTS managers there has been a significant improvement in the number of open

outstanding NEPTS concerns which were predominately in Aneurin Bevan University Health Board area.

45. The national position in response to concerns (complaints) is detailed in Graph 12 below. This is an extract from the NHS Executive Quality Metrics Dashboard (quarter 1 2023/24) and provides a comparison across Health Boards and Trusts.

Graph 12



EMS Co-ordination and Resourcing Centre Concerns & Coroners Activity

Prepared by the Service Manager, Operations Quality.

46. The Operations Quality (OQ) Concerns Team has made significant improvements on the outstanding backlog of work from. Additionality to the Investigation Supervising Officer (ISO) cohort has been approved, increasing the establishment from 4 permanent to 7 permanent and 1 fixed term (12 months).

47. All outstanding concerns are now within the Welsh Government Tier 1 Target. There are 17 outstanding concerns down from 41 in Q1 and circa 170 in January 2023.There has been a concerted effort by the team to prioritise concerns work, the implementation of automation using Blue Prysm has streamlined processes, and a review meeting which identifies concerns suitable for concise investigations happens weekly.

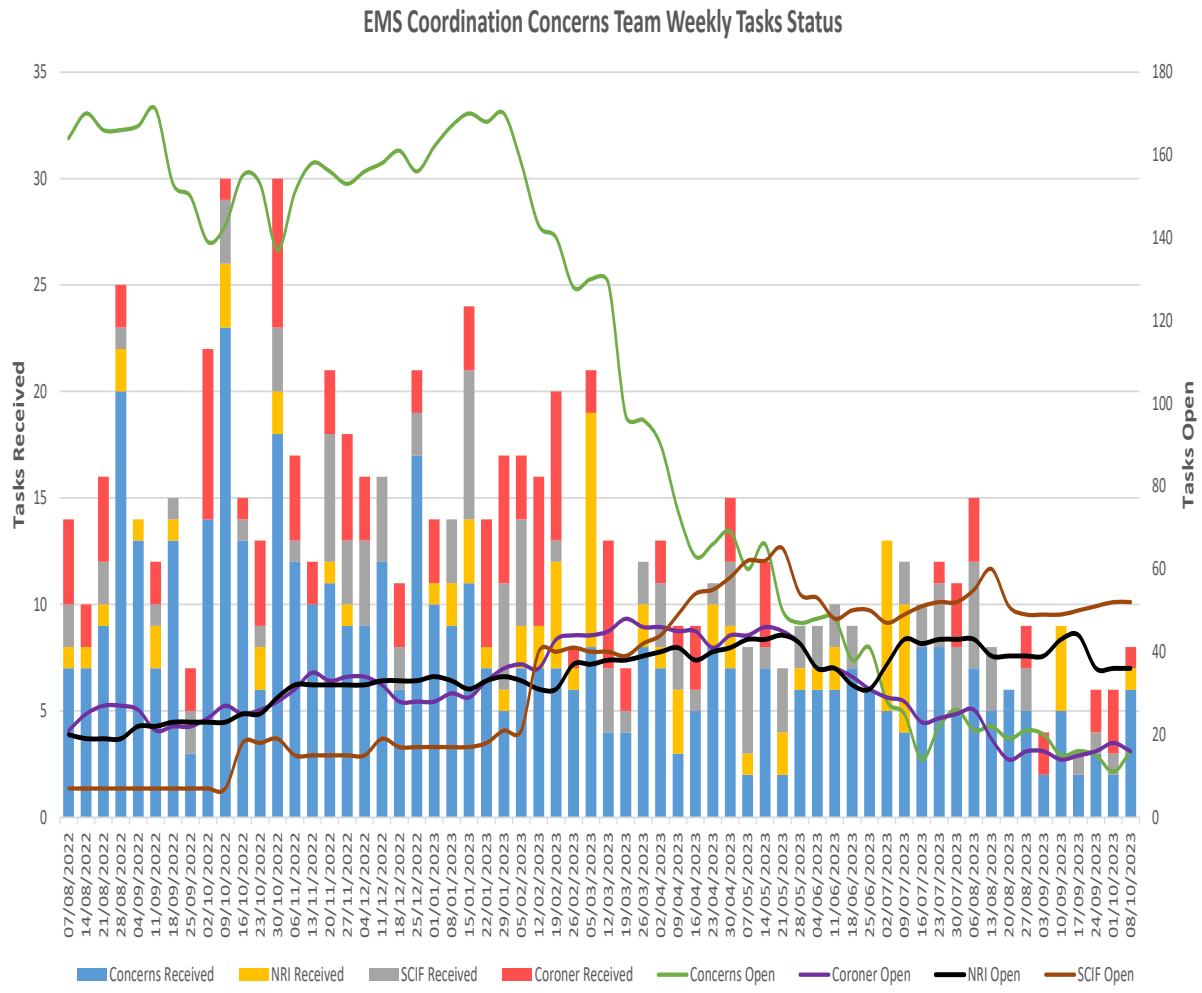
48. The concerns team is putting additional focus on NRIs of which there are 36 outstanding. 9 of these are relating to ineffective breathing. The Service Manager, Operations Quality (SMOQ) has requested a position statement from the International Academy of Emergency Dispatch (IAED) as this is a national issue and has been raised at Clinical Focus Group (CFG) by other Trusts. The SMOQ is writing an assurance SBAR on this which will include any immediate and longer-term actions for resolve.

49. There remains a number of outstanding coroner statements sitting with the Operations Quality and EMS Coordination teams. There are currently 16 outstanding down from 30 in Q1 and 48 in March 2023. 9 of the outstanding statements are outside of the request date. Only 3 are remaining from the initial backlog and these are with Legal Services for QA.

50. Identified learning from concerns investigations is shared with the OQ Learning & Development and Quality Audit teams to formulate learning material to cascade to EMS Coordination Teams via appropriate methods, as well as amongst the EMS Coordination and OQ Senior teams during the EMS Coordination Quality Meeting. The OQ Team meets weekly to identify themes and trends to ensure learning is being actioned, and it is anticipated that a review of the EMD and MPDS Standard Operating Procedures (SOPs) will be completed by the end of October 2023.

51. Graph 13 below provides an overview of the activity of the Team up until 08.10.2023.

Graph 13

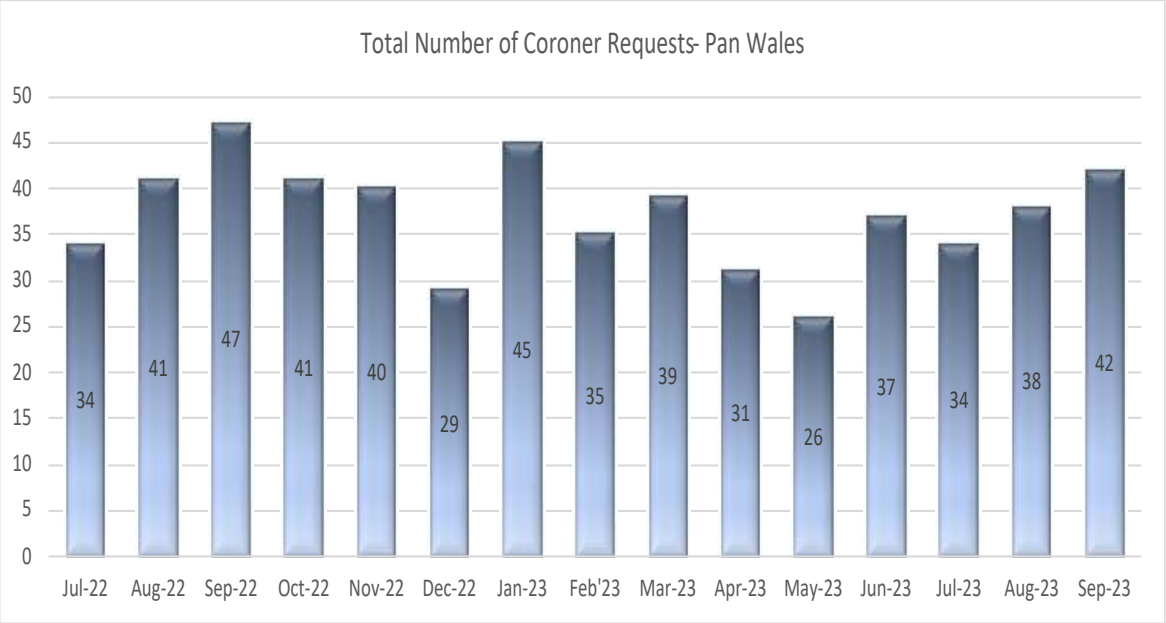


Organisational Legal Activity and Coroners

52. The number of approaches received from Coroners has increased 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.

53. Activity has increased month on month (Graph 14) 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.

Graph 14



Prevention of Future Death Reports (Regulation 28)

54. During the reporting period the Trust received 3 Regulation 28 (Prevention of Future Deaths) Reports from Coroners in North Wales. The specific issues to be addressed have been shared with the appropriate manager with a timescale incorporated, to ensure that the Trust responds in a timely manner.

55. Two reports were issued to the Trust, Betsi Cadwaladr University Health Board and the North Wales Local Authorities due to extended community response and handover of care delays.

Ref 1: ER (date of report: 06.07.2023)

'Whilst there was no direct evidence at the inquest to establish whether or not the outcome may have been different if Mr Roberts had received earlier medical care and attention, the delay in the attendance of the ambulance is significant and unacceptable.

It is recognised that the reasons for such delay are multifactorial and both I and my Assistant Coroners have issued multiple previous reports for the prevention of future deaths expressing similar concerns. One of my earliest such reports expressing concern regarding ambulance response times, was in relation to a death in March 2013 and yet more than ten years later this problem has become significantly worse rather than better.

It is understood that the matter of ambulance delays is not solely a matter for WAST hence this report being sent to those organisations involved in its impact across the Health Board area (to include the provision of social care where patients are medically fit for discharge from hospitals but without adequate placements / care in the community).

I remain significantly concerned not only that delays are continuing and that deaths will continue to occur into the future, but also that there is inadequate cohesive forward thinking or planning either in relation short term pressures (e.g. winter pressures) or with a view to finding longer term solutions.'

Ref 2: MJ (date of report: 10.07.2023)

'This is a further Report, of several by me, as both Senior Coroner for North West Wales and Assistant Coroner for North Wales East & Central relating to matters of ambulance delays and inability to offload patients in a timely manner into Emergency Departments across North Wales.

Evidence was heard at the Inquest that the initial delays experienced by Mary Elizabeth Jones whilst awaiting an ambulance and waiting in the rear of the ambulance possibly contributed indirectly to her existing frailty. Whilst not in themselves causative of Mrs Jones' death it remains a significant concern that despite evidence of improvements by the Health Board and WAST upon which I have previously been provided, that even as recently as December 2022, unacceptably lengthy delays remain such as in the case of Mary Elizabeth Jones.

I have still not been presented with any meaningful evidence on the involvement of Local Authorities in the considerations by WAST and BCUHB of lack of patient flow due to social care deficiencies.'

Ref 3: RB (date of report: 12.09.2023)

'The Trust utilises the Medical Priority Dispatch System (MPDS) and there are specific instructions within the same in relation to a varicose vein bleed namely "Elevate the affected leg/arm above heart level on a cushion pillow or other soft object"

Although from the outset this was recognised to be a varicose vein bleed, this advice was not given in at least two of the first four calls due to human error and it appears from the evidence that until the 5th call was made at 20.04, that no such clinically beneficial advice was given to those family members who were attending to the deceased.

Evidence was provided that a memo/reminder had been issued to staff regarding this error, however there was no evidence as to the effectiveness of such a reminder in the reduction of human error and I am concerned that deaths may occur as a result of failures to provide advice available within MPDS due to handlers not following the correct/most appropriate pathway.'

56. The Legal Services Team coordinate the responses to the Coroners, ensuring information is submitted with in the defined timescales.

Complex Case Panel

57. When the Trust is investigating a concern (complaint, incident or claim) and identifies an error or omission, it is incumbent on us to consider whether to make an offer of Redress. All such considerations are undertaken by the Trust Complex Case Panel (CCP).

58. A total of 51 cases that resulted in Redress decisions (April to September 2023), 25% of the cases have triggered Redress, being either an offer of Redress or the suggestion of a jointly instructed expert. Therefore, the majority of the errors or omissions identified do not cause harm to our patients.

59. Themes, trends and learning include:

- Documentation: Both within the allocation cases and clinical cases, there continues to be issues with documentation of decisions being made, providing rationale for actions taken. This can be such things as allocating out of order or what is considered an unsafe discharge of care. The Trust is then unable to defend the decision as there is no evidence to support mitigation.

- Allocation/Dispatch: The first half of this financial year has seen an increase in cases presented where it has been identified that there has been a failure to allocate across health board area, in line with Clinical Response Model, caused a delay in an ambulance attending. (4 cases and 8 "missed" allocations within those cases).

- Call Handling: There is a continued theme issue in relation to ineffective breathing not being identified and has resulted in an under-prioritisation of the calls (9 cases). The first half of this year also saw 4 cases where under prioritisation occurred due to failure to record that the patient was not fully alert.

60. All cases where a qualifying liability in tort is identified has a Learning from Events (LFE) Report submitted to the Welsh Risk Pool Services Learning Advisory Panel irrespective of the level of damages paid out.

61. The Trust now has 4 months to submit a Learning from Events Report on our cases, as opposed to the previous 60 days to Welsh Risk Pool. Any late submissions may result in financial penalties.

62. Outcomes of the Welsh Risk Pool Committee meeting in September are detailed in section 70 of this report.

Legal Claims

Table 3

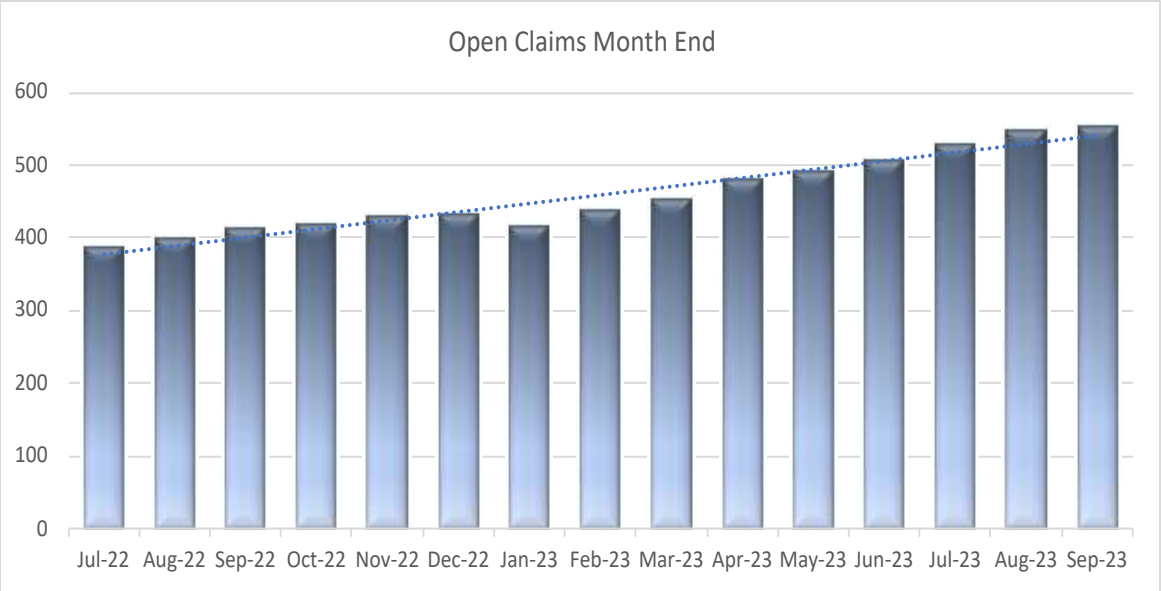
Legal Claims Overview		Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Claims opened	Personal Injury (PI)	1	2	5	1	4	1	2	2	1	4	0	1	1	2	1
	PI Road Traffic Accident	1	1	2	1	1	0	2	5	7	1	1	3	0	1	0
	Clinical Negligence	0	3	0	0	*	1	2	0	2	2	3	3	4	4	2
	Road Traffic Accident	19	14	19	17	24	17	23	27	12	29	16	22	26	17	8
	Damage to property	1	3	3	0	6	9	4	9	5	4	2	7	1	4	3
Claims closed	Personal Injury (PI)	1	0	2	0	0	4	1	0	6	3	0	7	1	0	6
	PI Road Traffic Accident	0	0	0	0	0	1	1	1	0	1	0	2	0	0	5
	Clinical Negligence	0	1	0	4	*	0	0	0	0	0	0	1	1	0	0
	Road Traffic Accident	14	10	11	15	22	11	47	17	11	8	3	11	5	8	4
	Damage to property	3	0	4	1	15	9	4	5	2	4	1	3	2	1	5
Claims open at the end of the month	Personal Injury (PI)	70	72	75	76	80	77	78	80	75	76	76	70	70	72	67
	PI Road Traffic Accident	44	45	47	47	48	47	48	52	59	59	60	61	61	62	56
	Clinical Negligence	105	107	105	109	119	120	122	122	124	126	129	131	134	138	140
	Road Traffic Accident	147	151	163	165	173	180	159	170	177	203	210	223	244	253	269
	Damage to property	21	24	23	22	8	8	9	13	16	16	17	21	20	23	21
		387	*399*	*413*	*419*	*428*	*432*	*416*	*437*	*451*	*480*	*492*	*506*	*529*	*548*	*553*

63. Table 3 provides an overview of the activity in Legal Services. 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.

64. This includes the potential cases that could not be considered under the Redress Regulations, as each potential claim has a potential value in excess of £25,000.00. The trend of increased numbers of personal injury claims continues, the numbers alone do not capture the increased complexity and value in the legal claims.

65. Graph 15 details the current position in respect of open claims which continues on an upward trajectory.

Graph 15



Ombudsman Investigations

66. There are currently 9 open Ombudsman cases. During the period 5 cases were received, 6 cases were closed, and 1 report was received. The Legal Services Team oversee the submissions Public Service Ombudsman for Wales (PSOW) ensuring timescales are met.

Organisational Learning

67. Organisational learning occurs through several routes. Examples of learning and improvement actions are detailed throughout this section.

68. 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.

69. The Trust is engaged in the Welsh Risk Pool Enhancing Learning programme which is a national programme providing resource for organisations to enable the release of staff to focus on learning processes within their organisation and network and share good practice. The programme commenced in September 2023 and concludes in March 2024.

70. Learning from investigations - the following notices have been issued this period:

- CN 26/23 Stroke Telemedicine Pilot Cardiff and Vale
- CN 27/23 Suspension of Homebirth Services in Cardiff and Value University Health Board
- CN 28/23 Paramedic Same Day Emergency Care Service (SDEC) Ysbyty Gwynedd Referral Pathway
- CN 29/23 Corpuls Defibrillator Bluetooth and CPR Feedback Sensor (PUCK) Upgrade

71. Examples of learning from clinical reviews are detailed overleaf in Table 4.

Table 4 **- Clinical Reviews**

	Number	**Brief Description**	Themes	Learning Opportunities
Aneurin Bevan	1	• Poor clinical decision making	• Failure to examine patient adequately	
Betsi Cadwaladr	4	• South Gwynedd trauma patient conveyed to rural trauma unit at Bronglais instead of Bangor/Wrexham • CHARU paramedic experienced extreme case of CPR Induced Consciousness (CPRIC). The coroner is aware	• Failure to examine patient adequately. • Unusual presentation of CPRIC during resuscitation	• Identified the need to expand SW based Trauma desk into North, thus affording all staff access/support to the desk. • Would be a useful case example to share wider.
Cardiff and Vale	2	• Concern raised by HB relating to the decision making of paramedics in that the patient was not transported to ED. A review of the ePCR indicates that the decision was shared with a clear description to support a balanced view. The social situation of the patient was	• Decision making • Safety netting • Contact with GP • Poor management of cardiac arrest	• Importance of contact with the GP/OOH for additional clinical views and as part of the safety netting. • Improved understanding of timely defibrillation • Recognition of VF/fine VF • Better understanding of the ROLE policy and when

		considered with robust safety netting advice. However, the patient's own GP/GP OOH was not contacted. • Management of cardiac arrest, VF not recognised and significantly poor communication and situational awareness.		resuscitation can be terminated. • Improved understanding of ventilation rate during ALS • Improved ePCR completion
Cwm Taf	2	• Difficult incident surrounding the recognition of death with conflicting reports by witnesses. • GP admission that deteriorated outside hospital	• Absence of usage of senior on call process • Pre-alert guidance • Failure to identify deteriorating patient	• Appropriate use of a tympanic and blood glucose monitor • Adherence to the senior clinical on call process • Improved identification of a deteriorating patient • Appropriate ways of escalating the situation
Hywel Dda	0	No new clinical reviews to report		
Powys	0	No new clinical reviews to report		

Swansea Bay	0	No new clinical reviews to report		

Welsh Risk Pool Learning from Events Reports & WRP Committee Outcomes

72. 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.

73. 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.

74. WRP have started to apply financial penalties to organisations that do not provide the requested learning within the 6-month period.

WRP Committee Outcomes (20.09.22023) & Current Position of Cases Overall

Table 5

Learning from Events	Number approved	Number Amber Deferred (requesting some additional information minutes, confirmation of sharing learning, training etc.)	Number Red Deferred (to be represented to the LAP with additional evidence, answers to questions etc.)
Claims	2	0	0
Redress	9	2*	1**
Previously Deferred Claims	0	0	0
Previously Deferred Redress	0	0	0
Total	11	2	1

*****Evidence of any training / reflection requested,
******Learning from events report and supporting evidence is awaited.

75. Tale 5 provides an overview of the position of cases to date. In total the Trust have 4 amber deferred cases and 1 red deferred case awaiting evidence of learning. Oversight of the status of cases is undertaken by the Legal Services Team.

76. A new forum to engage clinical staff and managers in the Learning from Events process has recently been established.

Horizon Scanning & Key Documents

77. During the period the following key documents / consultations have been published:

- Putting Things Right Regulations (2011): Consultation by Welsh Government on the overhaul of the Regulations. The PTR Team are engaged in the workshops and contributing / feeding back on the current Regulations. Next step will be public consultation.

- Healthcare Safety Investigation Branch (August 2023) 'Harm caused by delays in transferring patients to the right place of care' (NHS England). The investigation found that there was no overall system oversight of patient safety through the health and social care system in the region. While each individual healthcare organisation (ambulance and hospital) was responsible for the safety of patients in their care, there was not a safety management system in place that crossed organisational boundaries.

- The Healthcare Safety Investigation Branch (HSIB) (NHS England commissioned) becomes the Health Services Safety Investigations Body (HSSIB) on 01.10.2023 and maternity investigations have moved under the Care Quality Commission (CQC). HSIB work on handover of care delays is referenced in the CEO's Mitigating Patient Harm paper which is presented to each Trust Board.

- The Report of the Independent Review in to Alleged Failures of Patient Safety and Governance at the North East Ambulance Service (NEAS) NHS Foundation Trust was published on 12 July 2023 and a review of the recommendations is planned.

- NHS England Chief Executive Amanda Pritchard wrote to senior leaders across NHS England on 18 July 2023 following the verdict in the trial of Lucy Letby setting out that NHS leaders and Boards must urgently ensure:

- All staff have easy access to information on how to speak up.
- Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
- Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.

- Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.
- Boards are regularly reporting, reviewing and acting upon available data.

78. From a patient safety perspective early learning from this case has been considered in the updated version of the terms of reference of the Learning from Deaths Forum.

79. In respect of data and information the ambition is to include thematic analysis of aggregated data and information in future reports at service and health board level which will inform any patterns and trends.

AGENDA ITEM No	**8.1**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**1**

FINANCIAL SAVINGS - NON-EMERGENCY PATIENT TRANSPORT SERVICE CAPACITY MANAGEMENT PLAN

MEETING	Quality Patient Experience & Safety Committee (QUEST)
DATE	31 October 2023
EXECUTIVE	Liam Williams, Executive Director of Quality and Nursing
AUTHOR	Alessandro Di Ronato, Business Manager
CONTACT	Alessandro Di Ronato Alessandro.DiRonato2@wales.nhs.uk

EXECUTIVE SUMMARY

1. The purpose of this paper is to present the Quality Impact Assessment (QIA) undertaken to implement a revised approach to the application of the Non-Emergency Patient Transport Service (NEPTS) eligibility criteria and a revised Capacity Management Plan. This requirement has been defined to ensure that the Welsh Ambulance Services NHS Trust (WAST) is able to meet the 2023/24 Integrated Medium Term Plan (IMTP) budget requirements approved by the Trust Board, to meet the Welsh Government requirement for all NHS organisations to maximise financial efficiency opportunities in this financial year and, to prepare for a challenging financial settlement in 2024/25.

RECOMMENDED that the Quality, Patient Experience & Safety Committee note the QIA and the approval by WAST Executive Leadership Team to implement the commissioned NEPTS eligibility criteria.

KEY ISSUES/IMPLICATIONS

The assumptions that we have made within this paper are based on the engagement process undertaken with stakeholders and partners to identify the impact on the areas outlined in the QIA criteria:

i) Patient safety

This may result in some non-eligible patients not being able to always access their appointments having previously been able to access discretionary transport through WAST.

Despite there being a process for review of the decision made and quality assurance processes in place, there may still be instances where decisions are not correctly made.

Positive - for patients that are eligible for transport the quality of the service will improve as there will be less patients to accommodate and runs will be more manageable and timelier. For patients not eligible, there will be greater clarity on transport availability and provision, thereby reducing some of the complaints received when transport offers are cancelled due to eligible patient priority.

ii) Equitable care:

Patients in communities that have poorer public transport networks may find accessing alternative transport more challenging.

This may be more of an issue for those patients who have chosen to access care at a location further from their homes.

iii) Timely Care:

Patients may not always be able to access alternative options to access their healthcare and be able to access their appointments at first opportunity, particularly if booked at short notice.

Positive - for patients that are eligible for transport the quality of the service will improve as there will be less patients to accommodate and runs will be more manageable and timelier. For patients not eligible, there will be greater clarity on transport availability and provision, thereby reducing some of the complaints received when transport offers are cancelled due to eligible patient priority.

iv) Workforce:

The proposal could mean that our teams are subjected to increased patient and family frustrations when patients are informed that they are not eligible and that their booking will not be taken.

The reduction in non-eligible conveyance will improve the ability of the planners to manage workloads more effectively and ensure more patients with an eligible need for transport arrive on time.

REPORT APPROVAL ROUTE

Clinical and Quality Governance Group	29 September 2023
Operations Senior Leadership Team	17 October 2023
Clinical and Quality Governance Group	25 October 2023 (For noting)
Quality, Patient Experience & Safety Committee	31 October 2023

REPORT APPENDICES
ANNEX 1 - Quality Impact Assessment - NEPTS Capacity Management 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)	YES	Financial Implications	YES
Environmental/Sustainability	YES	Legal Implications	YES
Estate	YES	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	YES

AGENDA ITEM No	
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	

Quality Impact Assessment (QIA) - NEPTS CAPACITY MANAGEMENT PLAN

MEETING	**Clinical & Quality Governance Group (CQGG)**
DATE	**29 September 2023**
EXECUTIVE	**Lee Brooks, Executive Director of Operations**
AUTHOR	Mark Harris, Assistant Director of Operations
CONTACT DETAILS	**Mark.harris5@wales.nhs.uk**
CORPORATE OBJECTIVE	**Insert**
CORPORATE RISK (Ref if appropriate)	**Insert**
QUALITY THEME	**Governance Leadership and Accountability**
Quality Health & Care Standards 2023 **Domains**	**Safe** **Timely** **Effective** **Efficient** **Equitable** **Person Centred Care**
Quality Health & Care Standards 2023 **Enablers**	**Leadership** **Culture** **Workforce** **Information** **Whole System** **Learning Improvement and Research**
REPORT PURPOSE	**1. CONSIDER and APPROVE this QIA.**

CLOSED MATTER REASON	Insert if appropriate	
REPORT APPROVAL ROUTE		
WHERE	**WHEN**	**WHY**
Clinical & Quality Governance Group	**29.09.2023**	**To provide governance, clinical leadership, and accountability in support of insert**
WAST Executive Leadership Team		**To provide governance, clinical leadership, and accountability in support of Insert**

ANNEXES: Insert

Annex 2 – Part 1 QIA Screening Tool & Part 2 Full QIA

Governance, Leadership & Accountability	
Title of service change/proposal	**Introduction of a revised approach to the application of the NEPTS eligibility criteria and a revised capacity management plan**
Date of QIA assessment:	**3rd August 2023**
Date logged on central QIA digital repository. (For all completed part one and part 2)	**Insert**
Project overview (summary)	**Situation and Background** The Capacity Management Plan (CMP) provides a framework for Ambulance Care to respond to situations where the demand for services is greater than the available resources. The current CMP plan allows provisional bookings from non-eligible service users. The current process is allows all transport requests to be taken, these requests can be taken months in advance of the journey date. Non-Eligible patients are marked as a provisional booking and advised that the booking is provisional and may be cancelled. The plan is then open 48 hours before the travel

date, it is at this stage that resources are matched to the journeys and provisional journeys may be cancelled but this can happen up to 24 hours before the date of travel. There are also occasions when non-eligible patients receive transport due to their increased mobility but eligible patients with more decreased mobility and complex needs may be cancelled due to insufficient resources.

Eligibility is assessed via a Patient Needs Assessment (PNA), the criteria of the PNA is set out by Welsh Government in Welsh Health Circular (2007)005.

The proposed change would stop bookings for non-eligible users and sign post these non-eligible users to alternative transport solutions.

Summary of Proposed Change
Service users deemed non-eligible will no longer be entitled to Non-Emergency Patient Transport.
Non-eligible patients can request to have a review of their non-eligible status.
Provisional bookings will now only be for Eligible Patients who have requested transport after the 48hour cut off period.

Objective
Modify the approach to eligibility and Ambulance Care Capacity Management Plan to provide governance to only take bookings from eligible patients according to the Welsh Health Circular(2007)005 and to ensure non-eligible patients attempting to book Non-Emergency Patient Transport are signposted to alternative transport solutions

Governance arrangements
The detailed work to analyse the change request by WAST's EMT and to report this QIA has been completed by Ambulance Care Service Managers.
The proposed change will be monitored via Qlik, Cleric and PTR complaints. Journey cancellations will be monitored and expect to see a reduction of eligible patients transport requests being cancelled due to No resource.

Quality Assurance process
The Capacity Management Plan is a process that is already in place, the proposed change of only accepting transport requests from WHC eligible patients and non-eligible patients being sign posted to alternative transport solutions have been agreed by the Ambulance Care Delivery Assurance Group (DAG), whose membership includes external stakeholders and commissioners. This change will allow additional capacity on NEPTS resources to ensure eligible transport requests are honoured and the non-eligible requests are given the correct information of alternative transport available to them, this

	may include community transport, local bus routes or information on how to claim via Healthcare Travel Costs Scheme. **Scope of the change** The proposed changes apply to NEPTS transport bookings ONLY. This will affect all service users of Non-Emergency Patient Transport Service (NEPTS) **Main Operational System Change** The main operational system that will need to be re-configured is the Patient Needs Assessment and the criteria review process. The Criteria Review process will be introduce for those Non-Eligible patients who feel they should be eligible for transport, a more in depth review will take place with a team leader who will not only review their eligibility under WHC Circular (2007)005 but will apply additional criteria to take into consideration, this will include Alternative transport solutions in their area, distance from treatment centre, type of treatment. The patient needs assessment will now need to advise that non-eligible patients will be provided with alternative transport solutions. **Proposed Changes Implemented – 'Go Live'** Changes to journey booking scripts and planning processes **Target Audience** • WAST EMT • WAST CQGG • ALL WAST Staff • WAST Commissioners of Services **To Read in Conjunction With** • Capacity Management Plan • Attached Flow charts– provides current and proposed process • Welsh Health Circular 2007(005)
Reporting route (oversight group of QIA and monitoring of quality measures)	Senior Operations Team and Senior Leadership Team, ongoing monitoring through Quality dashboards via SOT and SLT QUEST and Finance & performance Committee also monitor quality, patient experience and performance
How will quality measures be obtained? (Full QIA only)	Quality Performance Indicators, PTR Reports, DATIX, HI Data, Patient Surveys.

Executive lead	Lee Brooks, Executive Director of Operations
Project lead(s)	Mark Harris, Assistant Director of Operations
Outcome of QIA (screen only or full QIA)	**Full QIA**
Comments (including brief rationale for not progressing to full QIA if appropriate) Log commencement on central QIA digital repository	**N/A**
Date submitted to Clinical Quality Governance Group (full QIAs) and inclusion on QIA Database (all QIAs) by CQGG secretariat. Quality.amb@wales.nhs.uk	**N/A**

Annex 2 – Part 1 QIA Screening Tool continued

Health & Care Standards Domains 2023	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

Safe **1 Patient Safety** Our healthcare system is a high quality, highly reliable and safe system that avoids preventable harm, maximising the things that go right and learning from when things go wrong to prevent them occurring again. People's health, safety and welfare are actively promoted and protected; risks are identified and monitored and where possible, risks to safety are reduced or prevented. We promote and protect the wellbeing, and safety of children and adults who become vulnerable or at risk at any time. Where children or adults may be experiencing or are at risk of abuse or neglect, we take appropriate, timely action and report concerns.	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?	Adverse – some non-eligible patients may not be able to always access their appointments without provision of transport by WAST. Despite there being a process for review of the decision made and quality assurance processes in place, there may still be instances where decisions are not correctly made. Positive – for patients that are eligible for transport the quality of the service will improve as there will be less patients to accommodate and runs will be more manageable and timely.	**4** **Not scored**	**3** **Not scored**	**12** **Not scored**	**12** **Not scored**
Effective **Care** Our healthcare system ensures decision-making, care and treatment reflects evidence-based best practice, to ensure that people receive the right care to achieve the optimal and possible outcomes that matter to them. We design transformative, evidenced-based, whole-of-life pathways that cover prevention, care and treatment, rehabilitation and embed these into local service delivery.	Could the service change impact on evidence-based practice, clinical standards (NICE/JRCALC), clinical leadership and/or engagement?	**Neutral**	**Not scored**	**Not scored**	**Not scored**	**Not scored**

Efficient Our health care system takes a value-based approach to improve outcomes that matter most to people in a way that is as sustainable as possible and avoids waste. We make the most effective use of resources to achieve best value in an efficient way. We only do what is needed and undertake treatments that ensure any interventions represent the best value that will improve outcomes for people.	Does this proposal increase waste? Does this proposal improve value- based approach?	**Positive**	**Not scored**	**Not scored**	**Not scored**	**Not scored**
Equitable Our healthcare system provides everyone with an equal opportunity to attain their full potential for a healthy life which does not vary in quality by organisation providing care, location where care is delivered or personal characteristics (such as age, gender, sexual orientation, race, language preference, disability, religion or beliefs, socio-economic status, political affiliation). We embed equality and human rights in our health care system. **Person-centred** Our health care system meets people's needs and ensures that their preferences, needs and values guide decision-making that is made in partnership between individuals and the workforce. We care about the well-being of individuals, their families, carers, and our staff. We ensure that everyone is always treated with kindness, empathy and compassion and we respect their privacy, dignity, and human rights. We are committed to working better together to put people and their families at the centre of decisions, seeing them as experts working alongside professionals to get the best outcome and 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 on promoting good community relations /positive attitudes? For example, if people could be treated differently in terms of race, religion, disability, gender, sexual orientation pregnancy, gender reassignment, civil partnerships, or age. (This can be a separate assessment, but the outcome recorded in the QIA)	Adverse – patients in communities that have poorer public transport networks may find accessing alternative transport more challenging. This may be more of an issue for those patients who have chosen to access care at a location further from their homes.	**4**	**3**	**12**	**12**
Timely Care Our healthcare system ensures people have access to the high-quality advice, guidance and care they need quickly and easily, in the right place, first time. We care for those with the greatest health need first, and where treatment is identified as necessary, we treat people based on their identified and agreed clinical priority.	Could the proposal impact on care being provided in a timely way?	Adverse – Patients may not always be able to access alternative options to access their healthcare and be able to access their appointments at first opportunity, particularly if booked at short notice. Positive – for patients that are eligible for transport the quality of the service will improve as there will be less	**4**	**3**	**12**	**12**

		patients to accommodate and runs will be more manageable and timely				
Workforce Our healthcare system recruits, retains, develops, and extends roles to ensure we have enough, confident people with the right knowledge and skills available at the right time to deliver safe care. We value our people and the commitment and resilience they demonstrate in the care they provide. We care about their wellbeing, protect their rights, and support them to feel well and happy at work; and provide them with the tools, systems, and environment to work safely and effectively. Our workforce planning focuses on investing in our people and nurturing, growing, and transforming our workforce to create a sustainable workforce for the future.	Could the proposal impact on staff satisfaction and/or sickness retention and recruitment skill and knowledge to undertake the proposal. Public perception of the Trust or its services? Wellbeing Safe systems at work to safeguard staff and prevent harm? serious incidents & reporting and learning?	Adverse – the proposal could mean that our teams are subjected to increased verbal abuse when booking transport from patients unhappy that their booking will not be taken. However, as reduction in non-eligible conveyance will also improve the ability of the planners to be able to manage workloads more effectively and will ensure more patients with an eligible need for transport will arrive in a more timely fashion. Positive – for patients that are eligible for transport the quality of the service will improve as there will be less patients to accommodate and runs will be more manageable and timely. This will allow planning and operational staff to improve the quality of service provided	**3**	**2**	**6**	**N/A**
Summary rating = highest individual risk score						***9***

Health and Care Standard Enablers- no requirement to score only to reference any impact.

Enabler	Potential impact	Narrative
Leadership	**Could the proposal impact.**	In the longer term no additional impacts are anticipated. However, in the short term additional focus will be required to provide oversight, leadership and support to service delivery teams.

Our health care system has visible and focused leadership at all levels, with its activities driven by the organisations' vision and values for quality. Our leaders and managers take a long-term, stakeholder-centric view to develop a clear organisational vision. They have the appropriate skills and capacity to create the conditions for a functioning quality management system. We ensure our governance, leadership and accountability is effective in sustainably delivering care.	• **leadership of the service** • **Trust Quality Management System** • **Governance arrangements**	In particular this will be required to support any patient facing, non-operational roles. The service has developed a robust quality team to oversee service delivery and this will be adequate to support the proposal.
Culture Our healthcare system creates the right climate and culture to nurture and encourage quality and system safety, valuing people in a supportive, collaborative, and inclusive workplace so that our people feel psychologically safe to raise concerns and try out new ideas and approaches. Relationships within teams and with the people we serve are effective and based on transparency, accountability, ethical behaviour, trust and just culture, where people can thrive.	**Will the proposal effect the culture of the Trust?**	The proposal will require a shift in the culture in some people where there exists an attitude that the service should be available to all and eligibility should not be applied. However, this is already active, so the shift will be more an escalation as opposed to a new culture.
Whole System Approach Our healthcare system ensures safety in healthcare goes beyond individual patient safety. We will look within and beyond our organisational boundaries to learn how we can continually, reliably, and sustainably meet the evolving needs of people. We will strengthen relationships and work with all our partners to achieve good outcomes. Our policies incorporate the broader ambitions within the seven well-being goals and five ways of working in the Well-being of Future Generations Act.	**Are we working with external as well as internal partners as part of the proposal?** **Does it impact on the Trust Policies i.e.? Well-being goals and five ways of working in the Well-being of Future Generations Act.**	There is a risk that the proposal will not align with health board priorities and the system will not join up effectively e.g. If HBs want more people through their planned care system at all costs then this change will not support that and will jeapordise achievement of their organisational priorities. There needs to be alignment in the entire system approach on this matter.
Information Our healthcare system ensures information is available and shared appropriately for all who need it. We turn data to knowledge by triangulating quantitative and qualitative performance, experience, and outcome measures to understand the quality of services, efficacy of improvement work and impact of decisions made. We monitor, report, and escalate indicators through our governance structures to ensure that appropriate action is taken at every level in terms of learning, improvement, and accountability.	**Will the proposal data to knowledge by triangulating quantitative and qualitative performance, experience, and outcome measures to understand the quality of services, efficacy of improvement work and impact of decisions made?**	The NEPTS service has operated on a balanced scorecard approach for some time and evaluation of the service is undertaken across many different types of indicator. These indicators offer a more balanced view of service delivery than one that just focused on finance or performance.

		Required indicators anticipated are already active and available.
Learning Improvement and Research Our healthcare system creates the conditions and capacity for an organisation and system-wide approach to continuous learning, quality improvement and innovation, which it actively promotes. We use new knowledge to influence improvements in practice and to inform our decision-making. We ensure our learning and improvement activity is linked to our strategic vision to deliver transformational, organisation-wide change. We commit to participating in research because research-active organisations provide improved quality of care and outcomes for people.	**Does the proposal evidence continuous learning, quality improvement and innovation?**	By reviewing the data as described above, then learning will be obtained to both provide insight into current delivery as well as inform future requirements/good practice.

Annex 2 – Part 2 Full QIA Tool

To be completed for each Quality Health and Care standard Domain that has an adverse score of >8.

QIA Part 2: Health & Care Quality Standards 2023 Domain: Safe Care								
		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.	Some non-eligible patients may not be able to always access their appointments without provision of transport by WAST. Despite there being a process for review of the decision made and quality assurance processes in place, there may still be	4	3	12	Alternative solutions available and on WAST website, which is communicated out to public Eligibility criteria should ensure that those in most need are provided transport Ability to request a live review of decision making process	3	3	9

	instances where decisions are not correctly made				PTR process for escalated concerns Journey Booking QA process to test quality & consistency QA dashboard to oversee quality delivery & PTR concerns Review of cancellations under CMP through local service, weekly Ops SLT reviews and through the MIQPR process.			

Quality measures (monitoring unintended consequences and positive impacts)-

The NEPTS service has an established quality dashboard with historical data on patient satisfaction across different aspects of service delivery. This will include volumes of concerns raised through putting things right. The data within this also informs the trust MIQPR dashboard.

Data within this report comes from patient feedback as well as other data sources driven by outputs from the Cleric CAD system. There are also Qlik dashboards available and routine regular weekly reporting through to the service management team, operations management team, executive management team and wider throughout the trust including at committee level. The dashboard is also shared with commissioners through the NEPTS DAG bimonthly.

Patient feedback is captured through a survey and there are a number of ways that patients can access this including:

- QR codes within vehicles and at liaison sites
- WAST website links
- Random mail drop through PECI
- Renal birthday calls

Any further mitigations planned (with accountabilities and timescales)?

- Communications to patients to support roll out of any changes. To start once change agreed and be ongoing. Ambulance Care Project Manager to oversee
- Engagement with Llais and other community bodies to start once change agreed. ADO Ambulance Care to lead
- Link up with Health Boards on both messaging and patient feedback/service impact – Through NEPTS DAG and Tier meetings via Service Managers
- Patient Safety Team to be included in discussions relating to patient safety as part of the implementation plan and in relation to how the criteria is being applied to patients in health board population areas.

Comments								
QIA Part 2: Health & Care Quality Standards 2023 Domain: Equitable and Person Centred 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.	Patients in communities that have poorer public transport networks may find accessing alternative transport more challenging. This may be more of an issue for those patients who have chosen to access care at a location further from their homes.	4	3	12	Alternative solutions available and on WAST website, which is communicated out to public Eligibility criteria should ensure that those in most need are provided transport Ability to request a live review of decision making process and apply local discretion if rurality/access is a major factor PTR process for escalated concerns Journey Booking QA process to test quality & consistency QA dashboard to oversee quality delivery & PTR concerns Review of cancellations under CMP through local service, weekly Ops SLT reviews and through the MIQPR process.	2	3	6

Quality measures (monitoring unintended consequences and positive impacts) - How will you source these metrics?

The NEPTS service has an established quality dashboard with historical data on patient satisfaction across different aspects of service delivery. This will include volumes of concerns raised through putting things right. The data within this also informs the trust MIQPR dashboard.

Data within this report comes from patient feedback as well as other data sources driven by outputs from the Cleric CAD system. There are also Qlik dashboards available and routine regular weekly reporting through to the service management team, operations management team, executive management team and wider throughout the trust including at committee level. The dashboard is also shared with commissioners through the NEPTS DAG bimonthly.

Patient feedback is captured through a survey and there are a number of ways that patients can access this including:

- QR codes within vehicles and at liaison sites
- WAST website links
- Random mail drop through PECI
- Renal birthday calls

Any further mitigations planned (with accountabilities and timescales)?

- Communications to patients to support roll out of any changes. To start once change agreed and be ongoing. Ambulance Care Project Manager to oversee
- Engagement with Llais and other community bodies to start once change agreed. ADO Ambulance Care to lead
- Link up with Health Boards on both messaging and patient feedback/service impact – Through NEPTS DAG and Tier meetings via Service Managers

Comments

QIA Part 2: Health & Care Quality Standards 2023 Domain: Timely Care

		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.	Patients may not always be able to access alternative options and be able to access their appointments at first opportunity, particularly if booked at short notice.	4	3	12	Alternative solutions available and on WAST website, which is communicated out to public Eligibility criteria should ensure that those in most need are provided transport Ability to request a live review of decision making process PTR process for escalated concerns Journey Booking QA process to test quality & consistency QA dashboard to oversee quality delivery & PTR concerns Review of cancellations under CMP through local service, weekly Ops SLT reviews and through the MIQPR process.	3	3	9

Quality measures (monitoring unintended consequences and positive impacts)-

The NEPTS service has an established quality dashboard with historical data on patient satisfaction across different aspects of service delivery. This will include volumes of concerns raised through putting things right. The data within this also informs the trust MIQPR dashboard.

Data within this report comes from patient feedback as well as other data sources driven by outputs from the Cleric CAD system. There are also Qlik dashboards available and routine regular weekly reporting through to the service management team, operations management team, executive management team and wider throughout the trust including at committee level. The dashboard is also shared with commissioners through the NEPTS DAG bimonthly.

Patient feedback is captured through a survey and there are a number of ways that patients can access this including:

- QR codes within vehicles and at liaison sites
- WAST website links
- Random mail drop through PECI
- Renal birthday calls

Any further mitigations planned (with accountabilities and timescales)?

- **What are the mitigations?**
- **Who is accountable to monitor?**
- **What are the timescales**

Comments

- Communications to patients to support roll out of any changes. To start once change agreed and be ongoing. Ambulance Care Project Manager to oversee
- Engagement with Llais and other community bodies to start once change agreed. ADO Ambulance Care to lead
- Link up with Health Boards on both messaging and patient feedback/service impact – Through NEPTS DAG and Tier meetings via Service Managers

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

AGENDA ITEM No	**8.2**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**1**

FINANCIAL SAVINGS - MID AND WEST WALES FIRE AND RESCUE SERVICES

MEETING	Quality Patient Experience & Safety Committee
DATE	31 October 2023
EXECUTIVE	Liam Williams, Executive Director of Quality and Nursing
AUTHOR	Alessandro Di Ronato, Business Manager
CONTACT	Alessandro Di Ronato Alessandro.DiRonato2@wales.nhs.uk

EXECUTIVE SUMMARY

1. The purpose of this paper is to present the Quality Impact Assessment undertaken for the decommissioning of Mid and West Wales Fire and Rescue Services (M&WWF&RS) support to the Welsh Ambulance Services NHS Trust (WAST) emergency responses. This requirement has been defined to ensure that WAST is able to meet the 2023/24 Integrated Medium Term Plan (IMTP) budget requirements approved by the Trust Board, to meet the Welsh Government requirement for all NHS organisations to maximise financial efficiency opportunities in this financial year and, to prepare for a challenging financial settlement in 2024/25.

RECOMMENDED that the Quality, Patient Experience & Safety Committee note the contents of this QIA and the Executive Leadership Team decision to approve the decommissioning of M&WWF&RS

KEY ISSUES/IMPLICATIONS

The assumptions made within this paper are based on the engagement process undertaken with stakeholders and partners to identify the impact on the areas outlined in the QIA criteria:

i) Patient safety

Ceasing of M&WWF&RS agreements will reduce resource capacity to respond and likely to mean that patients could wait longer for a falls or Out of Hours Health Care Assistant (OOHCA) response.

ii) Equitable care:

The loss of resource and associated reduction in response times may impact on community confidence and relations between WAST and wider stakeholders in the area. It is noted that there may also be a political response arising from elected members and Local Authority Officers because of the loss of income to M&WWF&RS.

iii) Timely Care:

Removing M&WWF&RS is likely to result in a reduction in service, resulting in patients likely to wait longer.

iv) Workforce:

There is a reputational risk of adverse relationships with stakeholders, including M&WWF&RS, Local Community Groups and elected members who have had high involvement in this scheme over time.

REPORT APPROVAL ROUTE	
Clinical and Quality Governance Group	29 September 2023
Operations Senior Leadership Team	17 October 2023
Clinical and Quality Governance Group	25 October 2023 (For noting)
Quality, Patient Experience & Safety Committee	31 October 2023

REPORT APPENDICES
ANNEX 1 - Quality Impact Assessment - Financial Savings - Mid and West Wales Fire and Rescue Services

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)	YES	Financial Implications	YES
Environmental/Sustainability	YES	Legal Implications	YES
Estate	YES	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	YES

AGENDA ITEM No	
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	

Quality Impact Assessment (QIA) - Financial Savings – Mid and West Wales Fire and Rescue Services	
MEETING	**Clinical & Quality Governance Group (CQGG)**
DATE	**25 October 2023**
EXECUTIVE	**Lee Brooks, Executive Director of Operations**
AUTHOR	Judith Bryce, Assistant Director of Operations
CONTACT DETAILS	Judith.bryce@wales.nhs.uk
CORPORATE OBJECTIVE	**Financial sustainability**
CORPORATE RISK (Ref if appropriate)	
QUALITY THEME	**Governance Leadership and Accountability**
Quality Health & Care Standards 2023 **Domains**	**Safe** **Timely** **Effective** **Efficient** **Equitable** **Person Centred Care**
Quality Health & Care Standards 2023 **Enablers**	**Leadership** **Culture** **Workforce** **Information** **Whole System** **Learning Improvement and Research**
REPORT PURPOSE	**1. CONSIDER and APPROVE this QIA.**

CLOSED MATTER REASON	

REPORT APPROVAL ROUTE		
WHERE	**WHEN**	**WHY**
CQGG		**To provide governance, clinical leadership, and accountability in support of insert**
WAST EMT		**To provide governance, clinical leadership, and accountability in support of Insert**

ANNEXES: Insert

Annex 2 – Part 1 QIA Screening Tool & Part 2 Full QIA

Governance, Leadership & Accountability	
Title of service change/proposal	**Financial Savings – Mid and West Wales Fire and Rescue Services (MWWFRS)**
Date of QIA assessment:	**August 2023**
Date logged on central QIA digital repository. (For all completed part one and part 2)	TBC
Project overview (summary)	**Situation and Background** In response to Pan Wales forecast financial deficits, WAST have been asked to model further options to save more money, over and above the current £6m savings plan. An options exercise has taken place across the Operations directorate, with outputs endorsed at EMT and Trust Board and have been

submitted to Welsh Government for consideration. This QIA is in support of the option relating to MWWFRS.

Summary of Proposed Change

To cease any in year spend against the MWWFRS SLAs where there is no contractual commitment to continue to spend. There are SLAs in place with MWWFRS to provide services on behalf of WAST for Out of Hospital Cardiac Arrest and Falls across the central/west area of Wales. This is the only FRS across Wales which provides a response for WAST, and there is a long history of response with MWWFRS which has evolved over time to the current model, in line with the scope of the WG thematic review of fire and rescue services "Broadening the Role of Firefighters in Wales"

https://www.gov.wales/sites/default/files/publications/2021-11/broadening-of-the-role%20of-firefighters-in-wales.pdf

Objective

Financial savings

Governance arrangements
Via SLT and CQGG

Quality Assurance process

Via SLT and CQGG

Scope of the change

To cease any in year spend against the MWWFRS SLAs where there is no contractual commitment to continue to spend.

Main Operational System Change
To cease in year spend on the SLAs in place with MWWFRS to include OOHCA and falls.

Proposed Changes Implemented – 'Go Live'
To be determined.

	Target Audience Operations SLT/CQGG **To Read in Conjunction With** Other financial options and the Ref 4 workbook, which includes the PESTLE analysis
Reporting route (oversight group of QIA and monitoring of quality measures)	Operations SLT, CQGG
How will quality measures be obtained? (Full QIA only)	
Executive lead	Executive Director of Operations
Project lead(s)	Judith Bryce, Assistant Director of Operations.
Outcome of QIA (screen only or full QIA)	Full QIA
Comments (including brief rationale for not progressing to full QIA if appropriate) Log commencement on central QIA digital repository	
Date submitted to Clinical Quality Governance Group (full QIAs) and inclusion on QIA Database (all QIAs) by CQGG secretariat. **Quality.amb@wales.nhs.uk**	TBC

Annex 2 – Part 1 QIA Screening Tool continued

Health & Care Standards Domains 2023	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
Safe **1 Patient Safety** Our healthcare system is a high quality, highly reliable and safe system that avoids preventable harm, maximising the things that go right and learning from when things go wrong to prevent them occurring again. People's health, safety and welfare are actively promoted and protected; risks are identified and monitored and where possible, risks to safety are reduced or prevented. We promote and protect the wellbeing, and safety of children and adults who become vulnerable or at risk at any time. Where children or adults may be experiencing or are at risk of abuse or neglect, we take appropriate, timely action and report concerns.	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?	**Adverse - Ceasing of MWWFRS agreements will reduce resource capacity to respond and likely to mean that patients could wait longer for a falls or OOHCA response.**	**3**	**4**	**12**	**Full QIA**
Effective **Care** Our healthcare system ensures decision-making, care and treatment reflects evidence-based best practice, to ensure that people receive the right care to achieve the optimal and possible outcomes that matter to them. We design transformative, evidenced-based, whole-of-life pathways that cover prevention, care and treatment, rehabilitation and embed these into local service delivery.	Could the service change impact on evidence-based practice, clinical standards (NICE/JRCALC), clinical leadership and/or engagement?	**Neutral**				

Efficient Our health care system takes a value-based approach to improve outcomes that matter most to people in a way that is as sustainable as possible and avoids waste. We make the most effective use of resources to achieve best value in an efficient way. We only do what is needed and undertake treatments that ensure any interventions represent the best value that will improve outcomes for people.	Does this proposal increase waste? Does this proposal improve value- based approach?	**Positive – patients will continue to receive a response from WAST and there will be an efficiency gain from reduced spend.**				
Equitable Our healthcare system provides everyone with an equal opportunity to attain their full potential for a healthy life which does not vary in quality by organisation providing care, location where care is delivered or personal characteristics (such as age, gender, sexual orientation, race, language preference, disability, religion or beliefs, socio-economic status, political affiliation). We embed equality and human rights in our health care system. **Person-centred** Our health care system meets people's needs and ensures that their preferences, needs and values guide decision-making that is made in partnership between individuals and the workforce. We care about the well-being of individuals, their families, carers, and our staff. We ensure that everyone is always treated with kindness, empathy and compassion and we respect their privacy, dignity, and human rights. We are committed to working better together to put people and their families at the centre of decisions, seeing them as experts working alongside professionals to get the best outcome and 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 on promoting good community relations /positive attitudes? For example, if people could be treated differently in terms of race, religion, disability, gender, sexual orientation pregnancy, gender reassignment, civil partnerships, or age. (This can be a separate assessment, but the outcome recorded in the QIA)	**Adverse – likely adverse impact on community relations (reduction in services)** **However, it could be argued that by reducing the service, this brings this geographical area in line with the rest of Wales given that this is the only FRS commissioned to respond on behalf of WAST.** **Furthermore, it's important to consider the potential political response, which may encompass the loss of income to fire and rescue service and generation of concerns raised with local councillors and MPs.**	**3**	**3**	**9**	**Full QIA**
Timely Care Our healthcare system ensures people have access to the high-quality advice, guidance and care they need quickly and easily, in the right place, first time. We care for those with the greatest health need first, and where treatment is identified as necessary, we treat people based on their identified and agreed clinical priority.	Could the proposal impact on care being provided in a timely way?	**Adverse – MWWFRS – reduction in service, patients likely to wait longer**	**3**	**3**	**9**	**Full QIA**

Workforce Our healthcare system recruits, retains, develops, and extends roles to ensure we have enough, confident people with the right knowledge and skills available at the right time to deliver safe care. We value our people and the commitment and resilience they demonstrate in the care they provide. We care about their wellbeing, protect their rights, and support them to feel well and happy at work; and provide them with the tools, systems, and environment to work safely and effectively. Our workforce planning focuses on investing in our people and nurturing, growing, and transforming our workforce to create a sustainable workforce for the future.	Could the proposal impact on staff satisfaction and/or sickness retention and recruitment skill and knowledge to undertake the proposal. Public perception of the Trust or its services? Wellbeing Safe systems at work to safeguard staff and prevent harm? serious incidents & reporting and learning?	**Adverse – Reputational risk of adverse relationships with stakeholders including FRS, local community groups and politicians who have had high involvement in this scheme over time** **High political adverse consequence**	**3**	**3**	**9**	**Full QIA**
Summary rating = highest individual risk score						***12***

Health and Care Standard Enablers- no requirement to score only to reference any impact.

Enabler	Potential impact	Narrative
Leadership Our health care system has visible and focused leadership at all levels, with its activities driven by the organisations' vision and values for quality. Our leaders and managers take a long-term, stakeholder-centric view to develop a clear organisational vision. They have the appropriate skills and capacity to create the conditions for a functioning quality management system. We ensure our governance, leadership and accountability is effective in sustainably delivering care.	**Could the proposal impact.** • **leadership of the service** • **Trust Quality Management System** • **Governance arrangements**	**Minimal impact, but financial constraints per se will require leadership across the Trust.**

Culture Our healthcare system creates the right climate and culture to nurture and encourage quality and system safety, valuing people in a supportive, collaborative, and inclusive workplace so that our people feel psychologically safe to raise concerns and try out new ideas and approaches. Relationships within teams and with the people we serve are effective and based on transparency, accountability, ethical behaviour, trust and just culture, where people can thrive.	**Will the proposal effect the culture of the Trust?**	**No**
Whole System Approach Our healthcare system ensures safety in healthcare goes beyond individual patient safety. We will look within and beyond our organisational boundaries to learn how we can continually, reliably, and sustainably meet the evolving needs of people. We will strengthen relationships and work with all our partners to achieve good outcomes. Our policies incorporate the broader ambitions within the seven well-being goals and five ways of working in the Well-being of Future Generations Act.	**Are we working with external as well as internal partners as part of the proposal?** **Does it impact on the Trust Policies i.e.? Well-being goals and five ways of working in the Well-being of Future Generations Act.**	**If agreed, there will be a requirement for stakeholder management both with MWWFRS as a partner agency, and with local communities and political stakeholders.** **There is a significant and protracted history of high political interest in MWWFRS schemes.**
Information Our healthcare system ensures information is available and shared appropriately for all who need it. We turn data to knowledge by triangulating quantitative and qualitative performance, experience, and outcome measures to understand the quality of services, efficacy of improvement work and impact of decisions made. We monitor, report, and escalate indicators through our governance structures to ensure that appropriate action is taken at every level in terms of learning, improvement, and accountability.	**Will the proposal data to knowledge by triangulating quantitative and qualitative performance, experience, and outcome measures to understand the quality of services, efficacy of improvement work and impact of decisions made?**	**n/a**
Learning Improvement and Research Our healthcare system creates the conditions and capacity for an organisation and system-wide approach to continuous learning, quality improvement and innovation, which it actively promotes. We use new knowledge to influence improvements in practice and to inform our decision-making. We ensure our learning and improvement activity is linked to our strategic vision to deliver transformational, organisation-wide change. We commit to	**Does the proposal evidence continuous learning, quality improvement and innovation?**	**n/a**

participating in research because research-active organisations provide improved quality of care and outcomes for people.		

Annex 2 – Part 2 Full QIA Tool

To be completed for each Quality Health and Care standard Domain that has an adverse score of >8.

QIA Part 2: Health & Care Quality Standards 2023 Domain: Patient 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.	**Ceasing of MWWFRS agreements likely to mean that patients could wait longer for a falls, co-responder or OOHCA response. Likely increase in waiting times for patients, or increase in SAIs/NRIs**	3	4	12	• **This cohort of patients would continue to receive a WAST response – including EA, CFRs, and others**. Under the current SLA arrangements, MWWFRS is deployed only when SJAC or CFR responses aren't available. As a result, there's a potential for patients to experience longer waiting times. • **Recruitment of additional CFRs**: The number of volunteers available has increased by 220 across Wales in the last twelve months, and we anticipate this number will reach almost 700 active CFRs by the end of the financial year.	2	4	8

Commented [LW1]: I recall discussion at CQGG requesting that we quantified this risk further as the later point highlights Red contribution of this service is limited

Quality measures (monitoring unintended consequences and positive impacts)-

- What are the quality outcome measures?
- What is the source data for the quality metrics?
- How often will they be monitored?
- Where will they be reported for monitoring and discussion?
- How will you capture patient feedback?
- How will you capture staff feedback?

Red, amber performance monitoring
Job cycle times – rural performance, travel times
SAIs and NRIs

Commented [LW2]: None of this is quantified

Any further mitigations planned (with accountabilities and timescales)?

- **What are the mitigations?**
- **Who is accountable to monitor?**
- **What are the timescales**

Comments

Impact on red performance minimal – see Timely Care
Recruitment of additional CFRs will increase numbers of available volunteers; forecast to reach 700 Pan Wales by end March 2024

QIA Part 2: Health & Care Quality Standards 2023 Domain: Equitable								
		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.	Whilst this is a reduction in service for patients across MWW, this is a service which is not in place in North Wales or South Wales. However, the reduction in service is likely to be viewed negatively in the communities of MWW, and will impact on organisational / professional relationships.	3	3	9	CFR Resource Optimisation: CFR response times have improved, opening an opportunity for resource optimisation.	2	3	6

Quality measures (monitoring unintended consequences and positive impacts) - How will you source these metrics?

- What are the quality outcome measures?
- What is the source data for the quality metrics?
- How often will they be monitored?
- Where will they be reported for monitoring and discussion?
- How will you capture patient feedback?
- How will you capture staff feedback?

PTR correspondence
Concerns
Political concerns

Any further mitigations planned (with accountabilities and timescales)?

- **What are the mitigations?**
- **Who is accountable to monitor?**
- **What are the timescales**

Commented [LW3]: This doesn't reflect the concern raised at CQGG that within this footprint our CFR coverage is low and that community participation in our CFR scheme is discouraged by those responding through the FRS

Commented [LW4]: None of this is quantified

Comments

Stakeholder management plan required
May require JESG discussion – potential concerns from DP Police on displaced demand

QIA Part 2: Health & Care Quality Standards 2023 Domain: Timely Care								
		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.	Likely adverse impact on provision of timely care for patients in Mid and West Wales who may wait longer for a response due to a reduction in service.	3	3	9	SJAC falls response remains available to falls patients – likely increase in utilisation here, but feasible. WAST response remains available – including CFRs, EA, CHARU etc. CFR growth will increase availability of volunteers pan Wales. Small volume/contribution to red performance – circa 150 red responses in 6/12 – less than 0.1% contribution to activity. 1st on scene in only 73 of these incidents.	2	3	6

Quality measures (monitoring unintended consequences and positive impacts)-

- What are the quality outcome measures?
- What is the source data for the quality metrics?
- How often will they be monitored?
- Where will they be reported for monitoring and discussion?
- How will you capture patient feedback?
- How will you capture staff feedback

Job cycle times
SJAC falls utilisation monitoring – expect the utilisation rate to increase, but scope to increase given utilisation rate rarely exceeds 60%

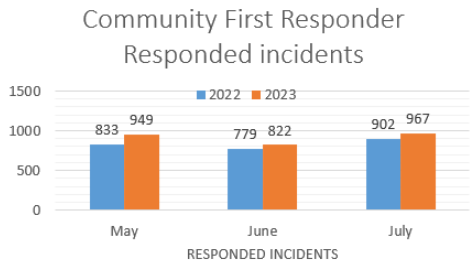
Any further mitigations planned (with accountabilities and timescales)?

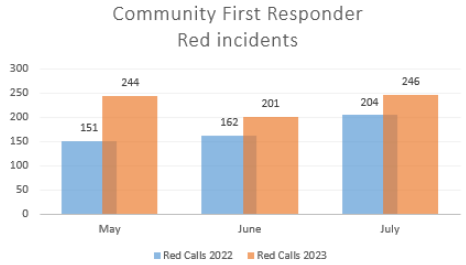
- **What are the mitigations?**
- **Who is accountable to monitor?**
- **What are the timescales**

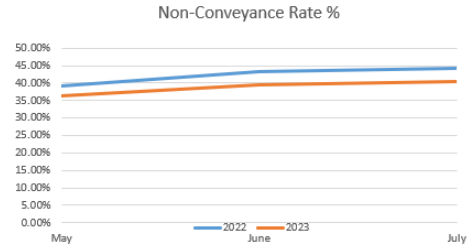
Weekly performance meeting
SJAC falls monthly reporting dashboard in place

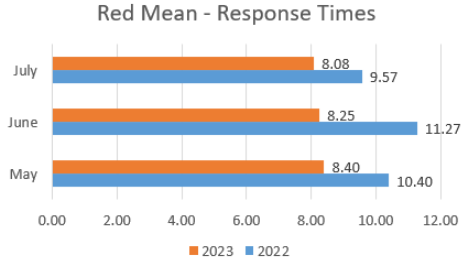
Comments

CFR red mean response times have improved from 9.57 minutes in 2022 to 8.08 minutes in 2023.









QIA Part 2: Health & Care Quality Standards 2023 Domain: Workforce								
		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.	**No impact on staff** **Reputational risk of adverse relationships with stakeholders** **High political adverse consequence**	3	3	9	PTR implementation Stakeholder management plan JESG relationships	2	3	6

Quality measures (monitoring unintended consequences and positive impacts)-

- What are the quality outcome measures?
- What is the source data for the quality metrics?
- How often will they be monitored?
- Where will they be reported for monitoring and discussion?
- How will you capture patient feedback?
- How will you capture staff feedback

Any further mitigations planned (with accountabilities and timescales)?

- **What are the mitigations?**
- **Who is accountable to monitor?**
- **What are the timescales**

Comments

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

Welsh Ambulance Services NHS Trust



Clinical Indicators
Focus on ROSC (at hospital)

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
NHS Trust

Clinical Indicators – Focus on ROSC (at hospital)
Version 3.0
Released: October 2023

Kevin Webb
Head of Clinical Intelligence & Assurance
Kevin.webb@wales.nhs.uk

Introduction

The first Clinical Indicator (CI) for the 'Focus on CIs series' is Return of Spontaneous Circulation (ROSC) at hospital.

Within this we will highlight:

- ✓ **What we measure (criteria)**
- ✓ **Data quality and reporting**
- ✓ **Improvements to date**
- ✓ **Next steps to improvement**



What we measure (*criteria*)

- **Numbers of cardiac arrest cases which include a documented resuscitation attempt**
  - **Relevant section completed on the TerraPACE ePCR**
    Or
  - **Where the Diagnostic Code for Cardiac Arrest is used**

- **Numbers (and rates) of return of documented spontaneous circulation (ROSC) <u>at hospital</u> amongst the above cases with a resuscitation attempt**





Data quality and reporting

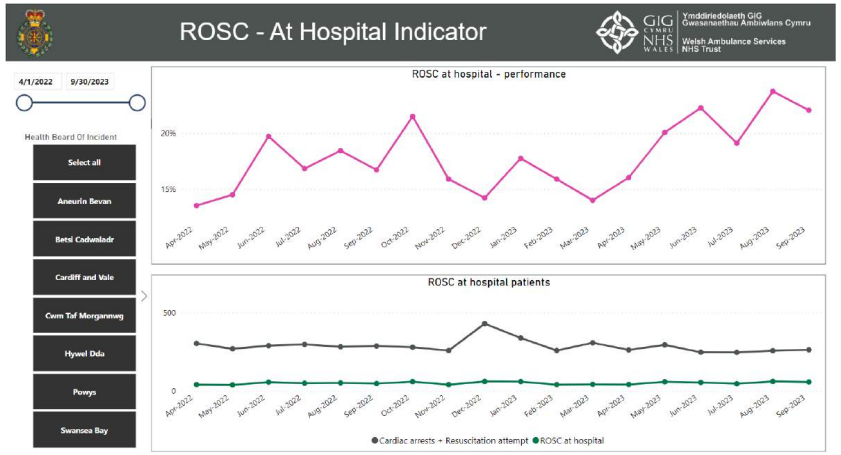
- **An ePCR technical specification was created to match the Utstein* standard field definitions and reporting format**
  - * *Utstein provides uniform terms and definitions for out-of-hospital resuscitation*

- **This has been improved in a documented iterative process after:**

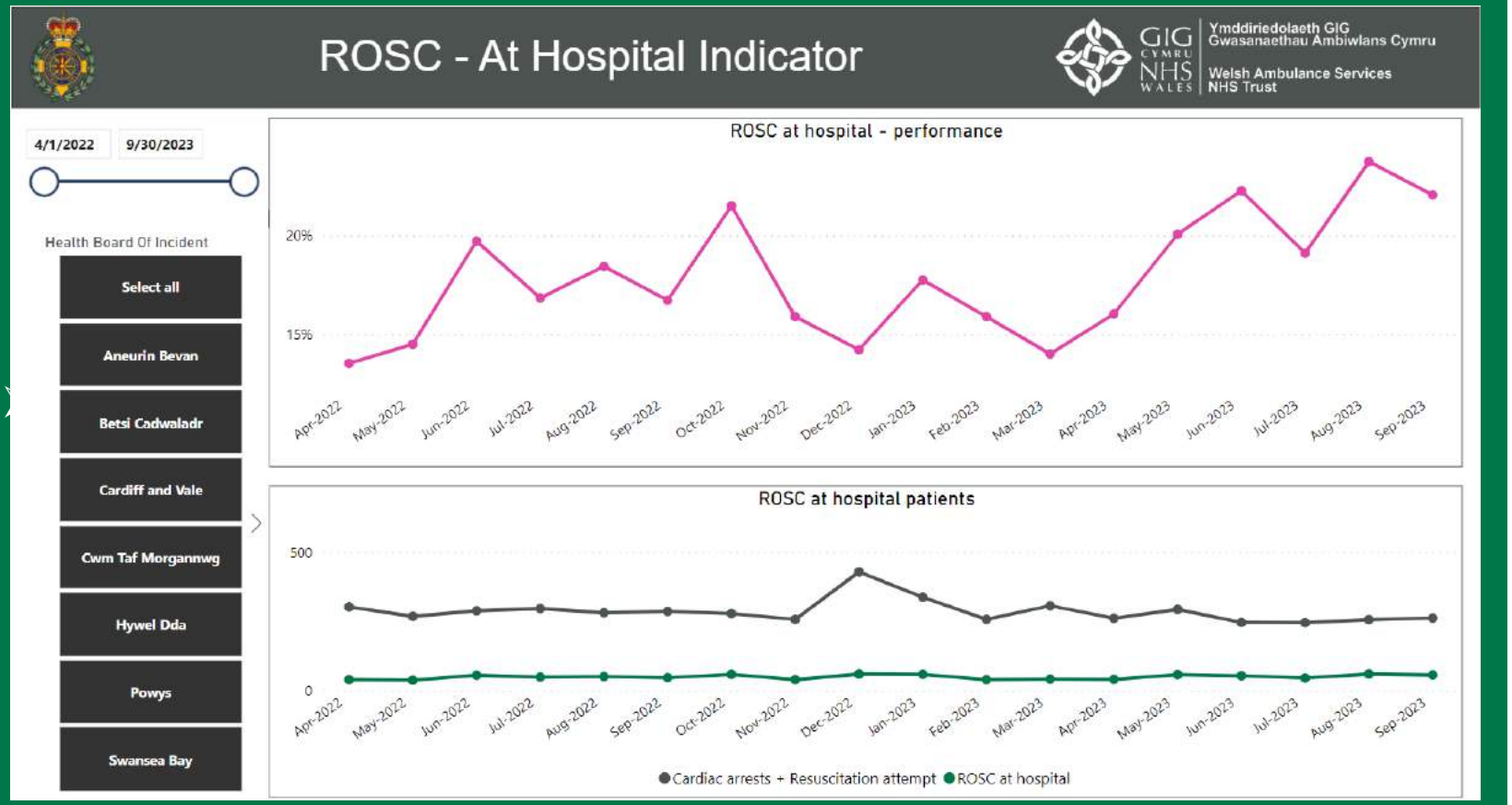
  - **A scripting review (*QA*)**

  - **ePCR Clinical Data Assurance audit (CAED22_005)**
    - **Review of ePCR narrative where cardiac arrest documented but not completed the relevant sections**
    - **Review of the User Interface and submit a change request for**
      - **Improving data collection across core fields**
      - **Improving data quality for resuscitation outcomes**
    - **Clarification of clock start definitions (*Utstein standard*)**

  - **Development of a Clinical Indicator dashboard (*v1*)**



ePCR implemented Trust wide since April 2022



Due to the nature of this metric, common cause variation occurs which can result in a marked reduction in performance from small numbers of unsuccessful resuscitations attempts.

The factors that influence this may include:

- Response Times
- Bystander Resuscitation
- Response Type/Numbers

In previous years performance has been significantly lower. As an example, in March 2021 performance was at 6.6%

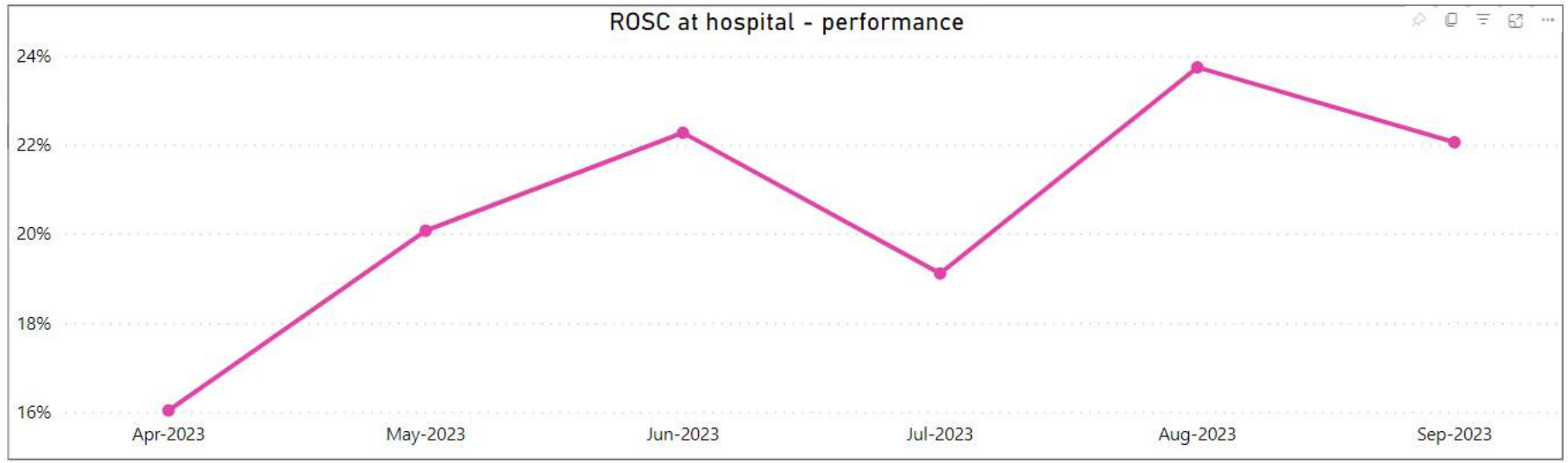
ROSC - At Hospital Indicator

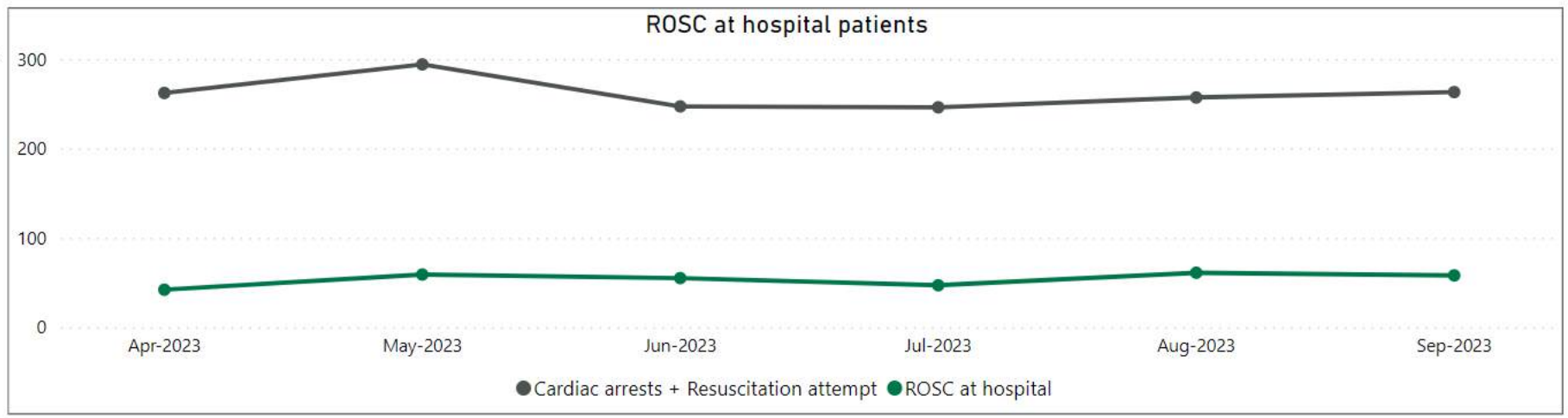
Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services NHS Trust

4/1/2023 9/30/2023

Health Board Of Incident

- Select all
- Aneurin Bevan
- Betsi Cadwaladr
- Cardiff and Vale
- Cwm Taf Morgannwg
- Hywel Dda
- Powys
- Swansea Bay





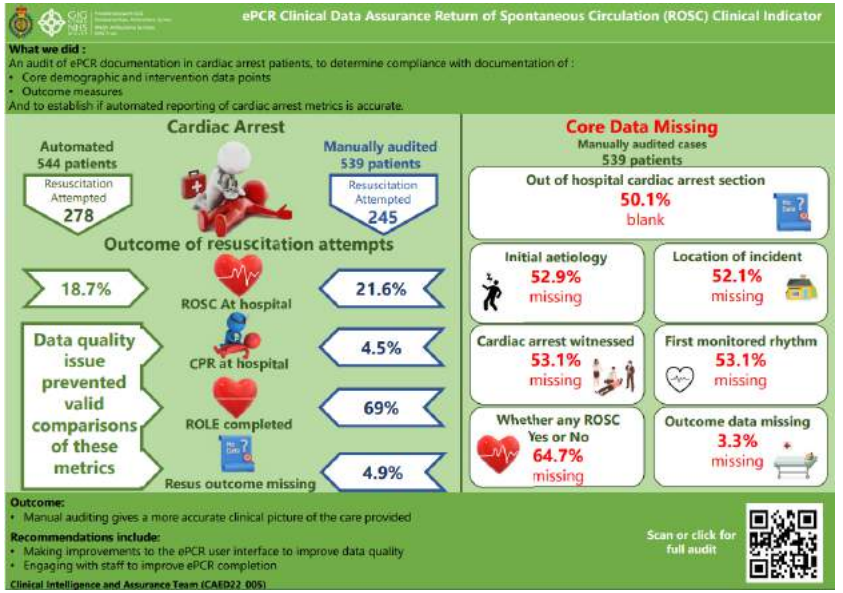
Improvements to date

- **October 2022 - CHARU rolled out**
- **October 2022 – Relaunch of GoodSAM (*Paused during Covid-19*) to include all responders in Wales (*not just WAST staff*). Over 1,000 WAST staff signed up to GoodSAM. A snapshot taken by GoodSAM one Friday afternoon reported 10,000 responders available in Wales at that time**
- **November 2022 - ePCR Clinical Data Assurance clinical audit completed**
- **December 2022 - Improvement plan developed to include reminding staff to accurately complete ePCR cardiac arrest sections**
- **February 2023 – Defibruary (*help people become more defib-aware by encouraging them to either 'Learn', 'Locate' or 'Donate'*)**
- **April 2023 – Clinical leadership and supervision during Senior Paramedic ride outs leading to improved clinical decisions to reduce futile resuscitation attempts**



GoodSAM





Improvements to date

- **April 2023 – Mandatory in Service Training (MIST) – (*Resuscitation*)**
- **May 2023 – Increase in numbers of CHARU availability**
- **July 2023 – 8,000 Public Access Defibrillators available for deployment via CAD (*up from 3,500 in November 2019*)**
- **July 2023 – Collaborative work with Save A Life Cymru and The Circuit – 80% of Public Access Defibrillator sites have a registered guardian (*improved governance & reduced time to become available after use*)**
- **October 2023 - Restart a Heart Day (*16th October 2023*). For the seventh year running, to mark the World-Wide Restart a Heart Day with the support of volunteers**









Next steps to improvement

- **Complete the User Interface change to the ePCR (***scheduled during October 2023***)**
  - **Implement (***CR0038***), a facility to improve ePCR compliance for specific fields on the User Interface (***at point of ePCR closure***)**
  - **Consider funding (***CR0023***) to implement the recommendations from the ePCR Clinical Data Assurance audit (***CAED22_005***)**
- **Continue to support clinical leadership and enhance the use of CHARU**
- **Continued engagement with Senior Paramedics to influence more direct clinical supervision during ride outs**
- **Consider future reporting to include:**
  - **Increased metrics other than ROSC (at hospital)**
  - **Specific breakdown for ROSC (*at hospital*), not only ALL resuscitation attempts**

Thank you for listening

Any questions or comments ?

AGENDA ITEM No	10
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	1

MONTHLY INTEGRATED QUALITY & PERFORMANCE DASHBOARD – August/September 2023

MEETING	Quality, Patient Experience and Safety Committee
DATE	31st October 2023
EXECUTIVE	Rachel Marsh – Executive Director of Strategy, Planning & Performance
AUTHOR	Hugh Bennett – Assistant Director of Commissioning & Performance Mark Thomas – Commissioning & Performance Manager
CONTACT	Hugh.bennett2@wales.nhs.uk Mark.Thomas12@wales.nhs.uk

EXECUTIVE SUMMARY

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 **August/September 2023.**

2. The indicators used at this high-level show an increase of system pressure (and warning signs for winter), in particular, with increasing handover lost hours and therefore worsening quality and performance for the Emergency Medical Service (EMS). 111 is showing continuous improvement throughout 2023 with abandonment rates and call answer times achieving the best performance since February 2022.

3. Ambulance Care, in particular, Non-Emergency Patient Transport Service's (NEPTS) performance has been stable, but with demand increasing to pre-Covid levels, performance has dipped slightly over the past two months. Overall, the picture remains one in which the Trust can demonstrate clear improvement over things it controls, but a more mixed picture where there are system dependencies e.g., handover lost hours.

RECOMMENDATION: The Committee is asked to: -

Consider the August/September 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 **August/September 2023.**

BACKGROUND

2. This Integrated Quality & Performance Report contains information on 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. A revised set were recently agreed, which are now being built into the report on an iterative basis.

ASSESSMENT

<u>Our Patients – Quality, Safety and Patient Experience</u>

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** call answering times, having been challenging at the end of last year, improved significantly, achieving the 6 second answering target, however, in the second half of the calendar year the 95th percentile has began to worsen; in August 2023 it was 31 seconds with a small improvement to 28 seconds in September 2023.

7. **111 call answering is improving,** with the call abandonment target of 5% being achieved again in September (3.4%) and 65.4% of calls being answered within 60 seconds, although this still remains significantly below target (95%). Negotiations with commissioners have indicated that funding is available for 198 call handlers and recruitment has been underway to secure this number, but there remain a number of vacancies. It has recently been agreed to recruit another cohort in November, with the aim of getting closer to the 198 level.

Further work is required to reduce capacity lost through sickness absence (particular improvement now being seen in call handlers), aligning capacity with demand and improving the efficient use of resource. A priority is now re-rostering 111, which is dependent on commissioners funding a third party (the third party has been identified via procurement process).

8. **111 Clinical response:** the Trust continues to see achievement of the clinical call back time target for the highest priority 111 calls (P1CT – 99%) , and pleasingly, other priorities of calls (P2 and P3) are also achieving or very close to the 90% performance target in September 2023, with the respective figures being 89.3% and 93.2%. This improvement has been driven by more efficient working practices and the alignment of capacity to demand. The numbers of clinicians are now broadly at agreed establishment levels (recently agreed as 100 WTE).

9. **Ambulance Response** (safety / patient experience): the Red 8-minute response performance for September 2023 was 48.6%, a slight drop when compared to August 2023, remaining below the 65% target. However, it is worth noting that as red demand has increased over recent years, so the overall numbers of patients who we have attended within 8-minutes has increased too, rising to 2,131 in September 2023. The number of Red incidents attended within 8-minutes has increased to a monthly average of 2,024 in 2023 compared to 1,921 in 2022 and 1,813 in 2021. The Amber 1 median was 1 hour 17 minutes (ideal 18 minutes) and the Amber 1 95th percentile was 6 hours 54 minutes, with both of these being increases when compared to August 2023. These long response times have a direct impact on outcomes for many patients. Actions within the Trust's control include:

   Capacity:

   - Recruitment: Confirmation has been received of further non recurrent funding in 2023/24 to support the 100 WTE staff recruited in 2022/23. Work will continue through the year to ensure that establishment remains at commissioned levels.
   - Some additional funding has also been made available to pilot the new Connected Support Cymru service in partnership with St John Cymru. Efficiency (rosters, abstractions/sickness absence and post-production lost hours)
   - The Managing Attendance Programme continues, which includes 10 work-streams. This did see a reduction in overall sickness levels during the early part of 2023, and although increases have been seen over the past two months, further work is still on-going to reduce to 6% during 2023/24. There remain risks associated with delivery of this level of improvement.

   Demand Management

   - The increase in Clinical Support Desk capacity has meant that the Trust was able to increase its consult and close rate through last year, however, it has

declined in recent months, achieving 12.6% in September 2023, with an increased ambition of 17% in 2023/24 (quarter 4). Action plans are in place within the service, but there are some risks emerging in terms of delivery.

- The Trust launched its Community Welfare Responder (CWR) volunteer pilot on 16 October 2023. The aim is total of 12 teams pan-Wales. The consult & close rate for this resource is 34.6%. This pilot forms part of the wider Connected Support Cymru project, including working with St John Ambulance Cymru.

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), with the current estimated staff in post (including those in training) of 127 FTEs.
- Red review. This is being undertaken within additional resource, when possible, but ideally, as previously modelled, would require additional FTEs.
- A more efficient response logic, which went live on 19 June 2023, is reducing the number of multiple attendances to certain categories of red call, releasing resource to respond to other calls.

10. One of the key factors in relation to response times is the capacity lost to **handover outside Emergency Departments**. 19,610 hours were lost during September 2023, an increase compared to the 19,233 hours lost in August 2023 and the third monthly increase in a row. These levels remain so extreme that all the actions within the Trust's control cannot mitigate or offset this level of loss. There has been a noticeable improvement in Cardiff & Vale's handover lost hours linked to an organisational focus, with other health boards reporting that they are seeking to learn lessons. Reduced hours lost to handover and a reduction of pressure within the system, has particularly manifested itself in improvement in both Amber 1 and 2 performance, where a strong correlation exists with reduced handover hours. There has been some challenge from health boards where improvements in handover have been seen in terms of not seeing the improvement in response times that they were expecting. However, the data is showing that as handovers reduce, the service is able to respond to more patients (fewer cancellations / Clinical Safety Plan (CSP) no sends), and this is an important factor.

11. Wales Immediate Release figures for September 2023 were: Red 156 accepted and 5 declined; and Amber 1, 156 accepted and 291 declined.

12. Modelling has indicated that red performance could improve by 7% to around 58% as a result of the CHARU implementation, red logic changes and a reduction to 15,000 lost hours. Further seasonal modelling has also now been completed and due to be reported to November's Finance & Performance Committee and to November's EASC.

13. **Ambulance Care (formally NEPTS) (Patient Experience)**: Oncology performance dropped below the 70% target in September 2023 (65.8%). Renal performance also decreased to 73%, as did Discharge journey performance declining slightly to 78% (target 90%). Overall demand for the service continues to increase, and in June 2023 demand was at levels not seen since 2019. 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.

14. **National Reportable Incidents (NRIs) / Concerns Response**: the Trust reported four NRIs to the NHS Executive in September 2023, and 7 serious patient safety incidents were referred to health boards under the Joint Investigation Framework. In September 2023 complaint response times increased to 55%, although still did not meet the 75% target. Reviews of lower graded concerns are being undertaken to ensure proportionate investigations are undertaken. The Trust has put more capacity into the Putting Things Right (PTR) team, which has had a positive impact for the Legal Team until periods of long-term sickness absence. The Concerns Administrators responding to patients and families continue to have lengthy and repeated calls due to protracted response times in the community, compounded by an inability to always respond in a timely manner to their concerns and questions. The Trust is concerned for the welfare of the team, given the nature and volume of the PTR work across all functions and a number of supportive actions are progressing/planned for both the corporate team and EMS Coordination & Resourcing.

15. **Clinical outcomes**: The percentage of suspected stroke patients who are documented as receiving an appropriate stroke care bundle was 75.7% in September 2023, a slight increase from the 74.6% seen in August 2023, but remaining below the 95% performance target. Work is ongoing to improve reporting and compliance through the Electronic Patient Care Record (ePCR) system. The return to spontaneous circulation (ROSC) rate dropped to 22.1% in September 2023 compared to 23.8% in August 2023. The patient experience reported measures (PREMS) system is now live, but in development. The Trust is using the CIVICA patient feedback system to develop the qualitative data.

<u>Our People (workforce resourcing, experience, and safety)</u>

16. **Hours Produced**: The Trust produced 113,421 Ambulance Response unit hours in September 2023, a marginal decrease from the 113,830 produced in August 2023. Emergency ambulance unit hours production (UHP) was 89% in September 2023, thus failing to achieve the 95% target. CHARU UHP increased to 135% (note this is of the commissioned level, not full roll out). Key to the number of hours produced are roster abstractions, which remain above benchmark, but are reducing i.e. improving.

17. **Response Abstractions:** EMS abstraction levels decreased to 33.59% in September 2023, but remains above the 30% benchmark. EMS Response sickness abstractions stood at 9.5% (benchmark 5.99%).

18. **Trust sickness absence:** the Trust's overall sickness percentage was 9.22% in August 2023, a deterioration from the 8.23% recorded in July 2023. Actions within the Integrated Medium Term Plan (IMTP) concentrate on staff well-being with an aim to start to reduce this level.

19. **Staff training and PADRs:** PADR rates did not achieve the 85% target in September 2023 (70%), while compliance for Statutory and Mandatory training increased slightly to 76.21%.

20. **People & Culture Plan:** the Trust has formally launched its People & Culture Plan. This plan will be supported by a series of metrics to help the Trust assess the success of the plan, in particular, the culture shift that the Trust is seeking to achieve.

21. **Strategic Workforce Plan:** the Trust is also in the process of developing its strategic workforce plan with a target date of 31 March 2024, which is also being supported by improved workforce monitoring arrangements via the Integrated Technical Planning Group.

Finance and Value

22. **Financial Balance**: The reported outturn performance at Month 6 is a surplus of £77k, with a forecast to the year-end of breakeven.

Partnerships/ System Contribution

23. **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 was made through last year in increasing **consult and close** rates after 999 calls; but these rates have dropped to 12.6% in September 2023.

24. In September 2023, 9,284 patients cancelled their ambulance, and the Trust was unable to send an ambulance due to application of CSP levels to approximately 628 callers.

25. In the longer term, the Trust believes that transformation of its service offer, delivered in partnership with others, is critical to improving the service offered to patients and reducing harm. Work continues on the development of this offer and in engaging with key stakeholders to identify ways of securing support to deliver on these ambitions.

Summary

26. The indicators used at this high-level highlight an increase of system pressure, in particular, handover lost hours, and therefore worsening quality and performance for the Emergency Medical Service (EMS) during the early part of 2023/24. 111 is continuing to show improvement with abandonment rates continuing to achieve target levels. Ambulance Care, in particular, Non-Emergency Patient Transport Service's (NEPTS) performance has been relatively stable, but with performance deteriorating slightly this month. Overall, the picture remains one in which the Trust can demonstrate clear improvement over some things it controls, but a more mixed picture where there are system dependencies e.g. handover lost hours.

RECOMMENDATIONS: The Committee is asked to:

Consider the August/September 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**
31 October-23	**QUEST**

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

August/September 2023

Annex 1 – Top Indicator Dashboard



Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
NHS Trust

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

by Commissioning & Performance Department

Section 1: Monthly Indicators / Top Indicator Dashboard

Top Monthly Indicators	Target 2023/24	2 Year Average	Aug-23	Sep-23	RAG
Our Patients					
Timeliness Indicators					
NHS111 Call Handling Abandonment Rates	< 5%	15.0%	3.2%	3.4%	G
111 Clinical Triage Call Back Time (P1)	90%	96.7%	99.2%	99.0%	G
999 Call Answer Times 95th Percentile	00:06	00:45	00:31	00:28	R
999 Red Response within 8 minutes	65%	50.9%	50.4%	48.6%	R
999 Amber 1 Median	00:18	01:23	01:14	01:17	R
Oncology Journeys arriving within 45 mins and up to 15 minutes after appointment time	70%	74.7%	71.9%	65.8%	A
Discharge & Transfer journeys collected less than 60 minutes after booked time (NEPTS)	90%	85.9%	79.0%	78.0%	R
Clinical Outcomes / Quality Indicators					
Return of Spontaneous Circulation (ROSC)	Increasing Trend	16.8%	23.8%	22.1%	A
Stroke Patients with Appropriate Care	95%	79.5%	76.6%	75.7%	R
Acute Coronary Syndrome Patients with Appropriate Care	95%	46.8%	43.4%	46.0%	R
National Reportable Incidents reports (NRI)	Reduction Trend	6	2	4	A
Can't Send & Cancelled by Patient Volumes	Reduction Trend	11211	10727	10895	A
Concerns Response within 30 Days	75%	40%	47%	55%	R
Our People					
Capacity					
Hours Produced for Emergency Ambulances	95-100%	95%	87%	89%	A

Top Monthly Indicators	Target 2023/24	2 Year Average	Aug-23	Sep-23	RAG
Health & Well-being					
Sickness Absence *(all staff)*	6.0%	9.67%	9.22%	N/A	A
Mental Health Absence Rates	Reduction Trend	2.33%	2.73%	N/A	A
Staff Turnover Rate	Reduction Trend	10.45%	9.48%	9.28%	G
Statutory & Mandatory Training	>85%	80.60%	75.78%	76.21%	R
PADR/Medical Appraisal	>85%	67.99%	70.6%	70.0%	R
Number of Shift Overruns	Reduction Trend	3750	4005	3961	A
Inclusion & Engagement / Culture					
NHS111 % of Total Calls Answered in Welsh	Increasing Trend	0.44%	0.92%	0.88%	G
NEPTS % of Total Calls Answered in Welsh	Increasing Trend	1.1%	1.3%	1.4%	G
Value					
Financial balance - annual expenditure YTD as % of budget expenditure YTD	100%	100%	100%	100%	G
EMS Utilisation Metric (All Vehicles)	Increasing Trend	60%	57.1%	57.5%	A
Average Jobs per Shift (All Vehicles)	Increasing Trend	2.44	2.42	2.41	A
NEPTS on the Day Cancellations	Reduction Trend	19.3%	19.2%	20.2%	A
Partnerships / System Contribution					
Inverting the Traingle					
Successful Consult & Close Outcome	17.0%	13.0%	12.9%	12.6%	R
% Of Total Conveyances taken to a Service Other Than a Type One Emergency Department	Increasing Trend	11.3%	10.95%	10.79%	A
Number of Handover Lost Hours	15,000	22,807	19,233	19,610	R
NHS111					
NHS111 Dental Calls	TBD	5,877	7,603	6,750	TBD
Consult & Close Volumes by NHS111	Increasing Trend	1,135	986	987	A

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)

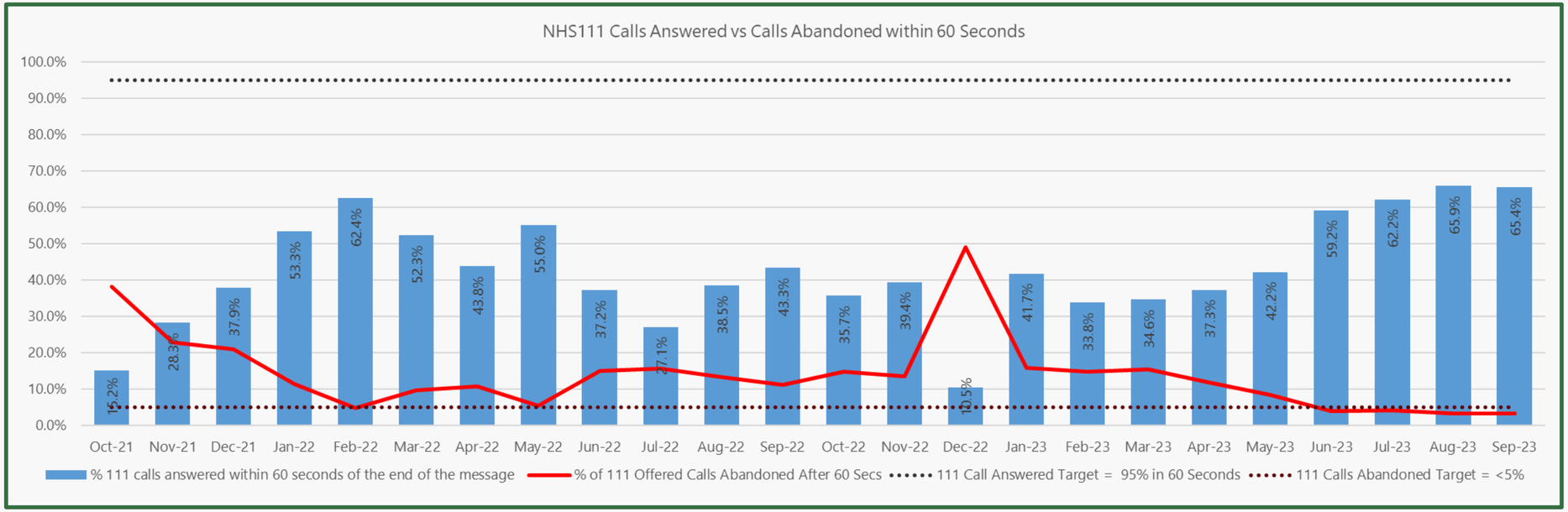
Our Patients: Quality, Patient Safety & Experience
111 Call Answering/Abandoned Performance Indicators

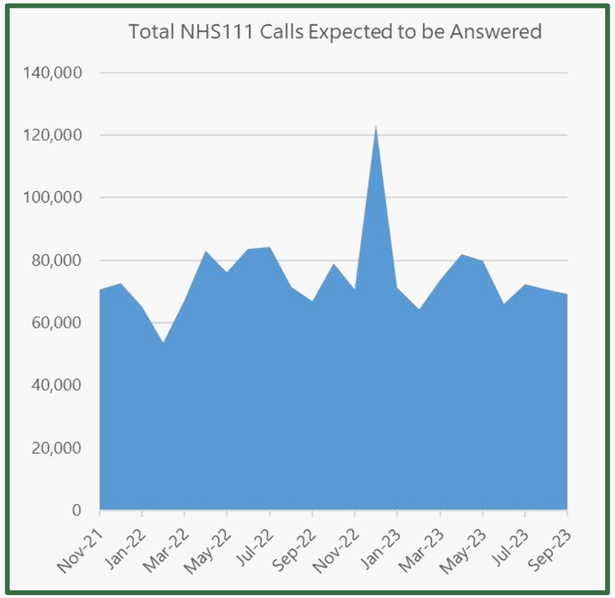
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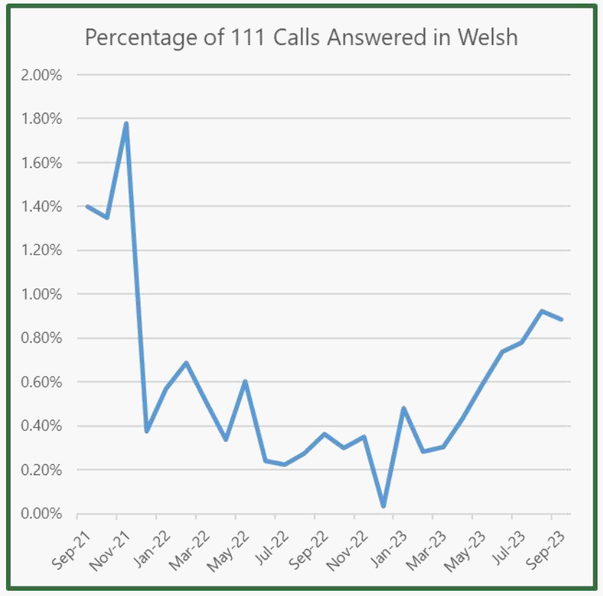
Abandonment Rate G

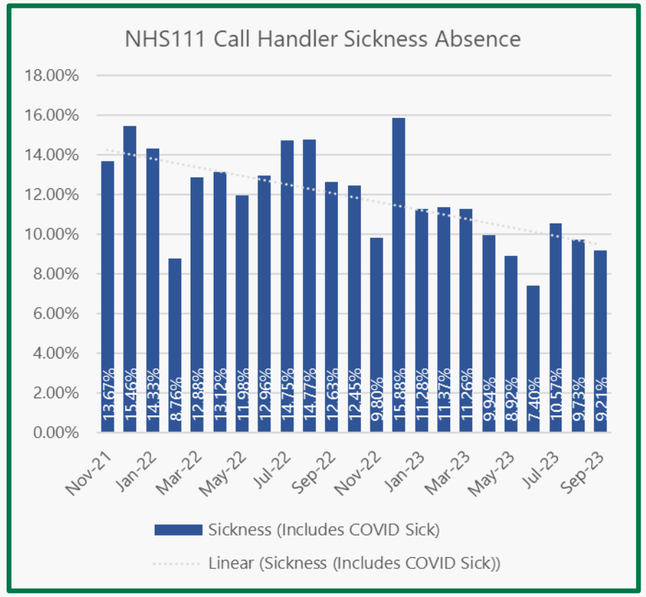
FPC

Influencing Factors – Demand and Call Handling Hours Produced









Analysis

111 call abandonment is a key patient safety indicator for the service. September 2023 saw an **abandonment rate of 3.4%,** remaining below the 5% target. It is also the second lowest monthly figure recorded during the 2-year recording period.

The percentage of 111 calls answered within 60 seconds of the end of the message in September 2023 staying broadly the same at 65.4%.

The percentage of 111 calls answered in Welsh fell slightly from 0.92% in August 2023 to 0.88% in September 2023.

Abstractions due to sickness absence reduced, continuing a longer-term trend in this direction.

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 198 WTE call handlers will be funded in 2023/24. The Trust is currently 21.25 FTE short of establishment. The Trust is aiming to address this in quarter three.
- Work continues on sickness absence in line with the Trust's managing absence work programme with an IMTP aim to get organisational sickness down to 6%
- A roster review in three parts is due to start, in collaboration 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. Funding now an issue.
- 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.

Expected Performance Trajectory

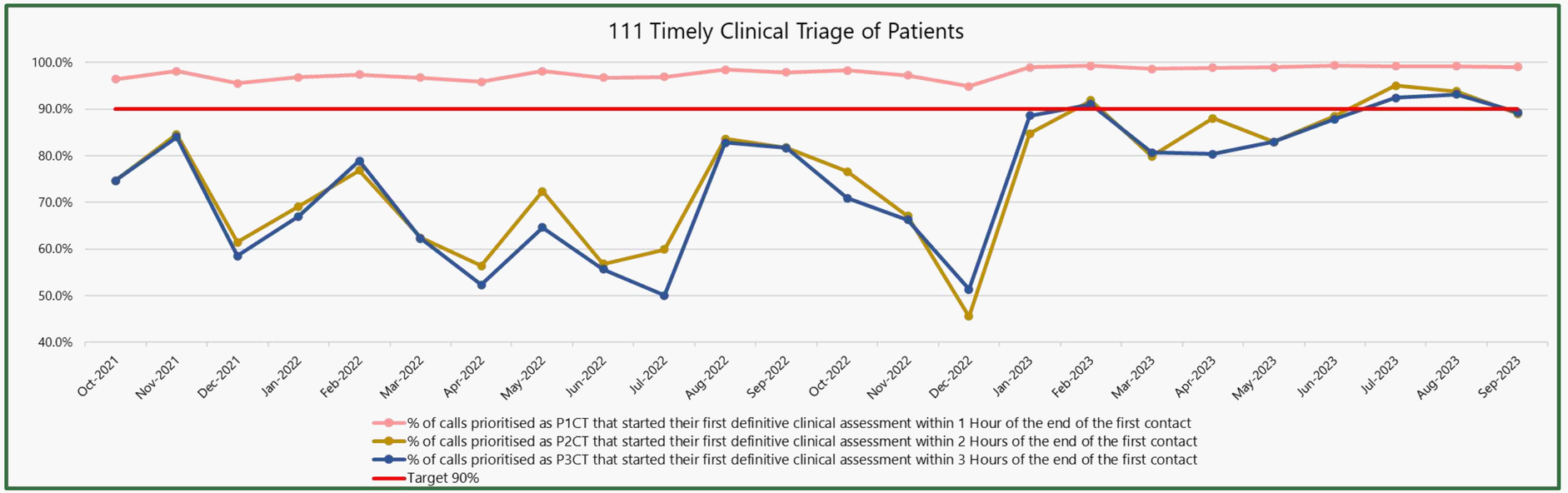
The Trust is now moving into the winter period. The Trust has improved ICT, compared to last winter, and improved processes and is recruiting up towards the commissioned FTE totals. In December 2022 there was a very severe spike in demand, not seen the previous winter.

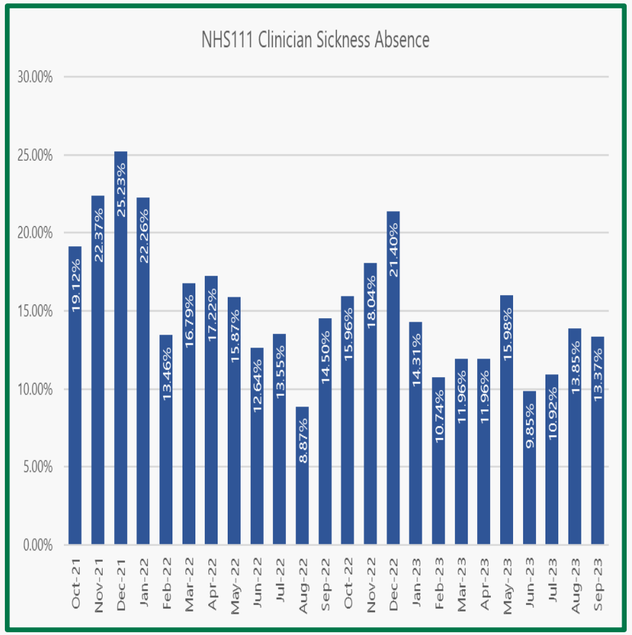
Our Patients: Quality, Safety & Patient Experience
111 Clinical Assessment Start Time Performance Indicators

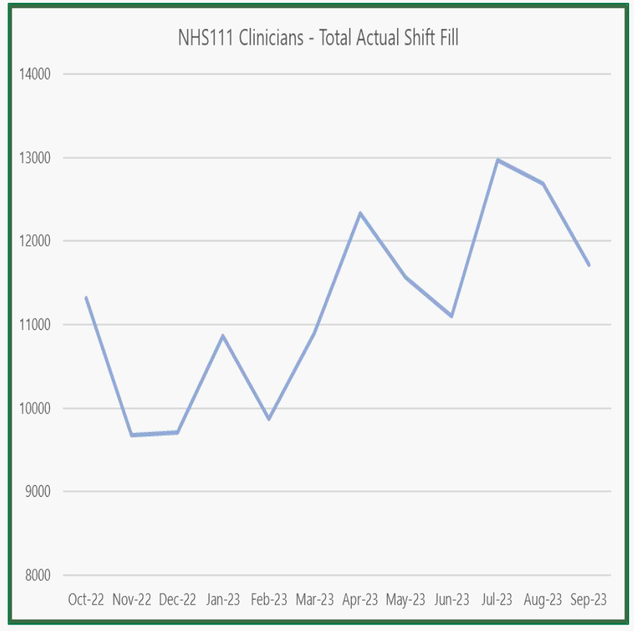
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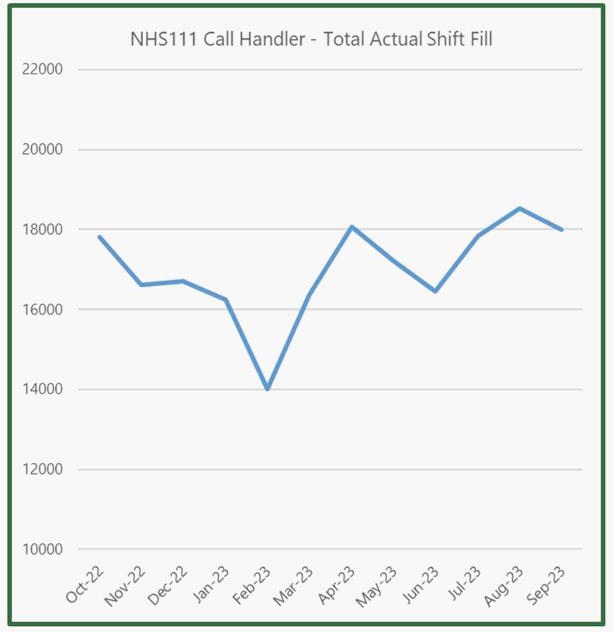
P1CT G FPC

Influencing Factors – Demand and Clinical Hours Produced









Analysis

The highest priority calls, P1CT, continues to achieve the 90% target (99%).

For lower category calls P2CT decreased slightly to 89% in September 2023 when compared to 94% in August 2023, P3CT decreased slightly to 89.3% in September 2023 compared to 93.2% in August 2023.

Clinical staff capacity decreased to 12,687 hours during September 2023, a drop of 969 hours when compared to August 2023. Clinician sickness absence decreased to 13.37% in September 2023 from the 13.85% reported in August 2023.

Total capacity measured through call handler shift fill decreased in September to 17,993 hours, which remains above the 12-month average.

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 100.71 FTE (Sep-23) nurses and paramedics are in post, and commissioners have indicated that they have funding available for 102 WTE.

Expected Performance Trajectory

The Trust is now moving into the winter period. The Trust has improved ICT, compared to last winter, and improved processes and is recruiting up towards the commissioned FTE totals. In December 2022 there was a very severe spike in demand, not seen the previous winter. The lack of capacity to develop and maintain the 111 website, in particular, the symptom checkers is an identified risk, with Executives in discussions with 111 commissioners currently.

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

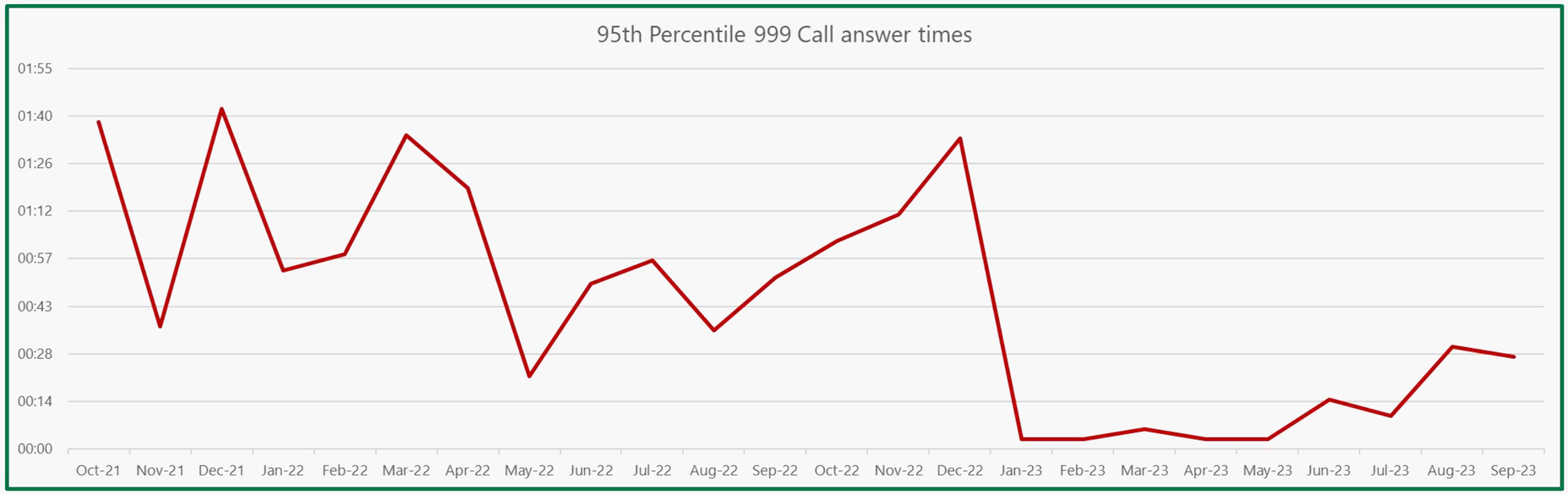
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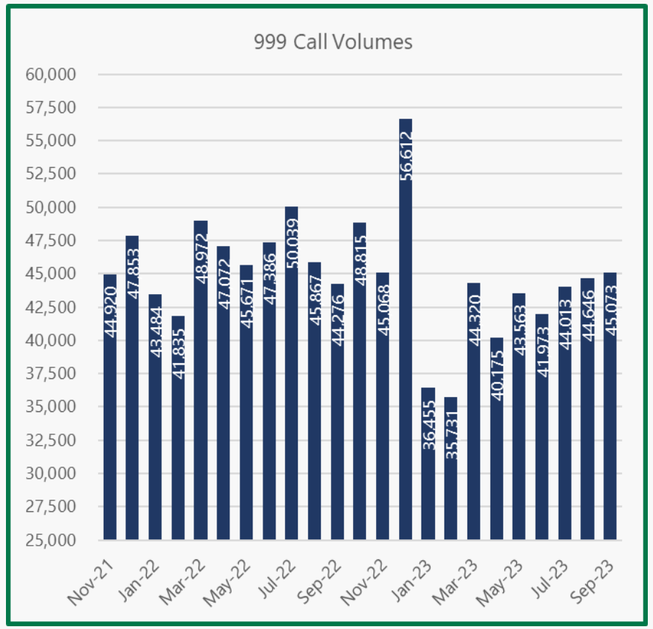
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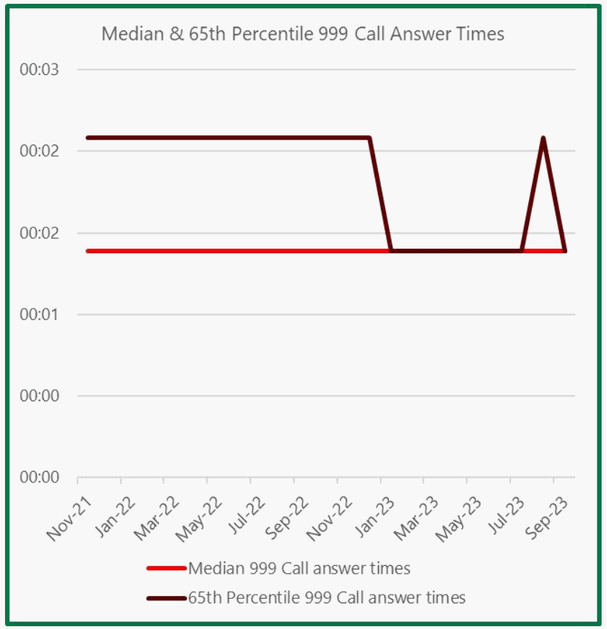
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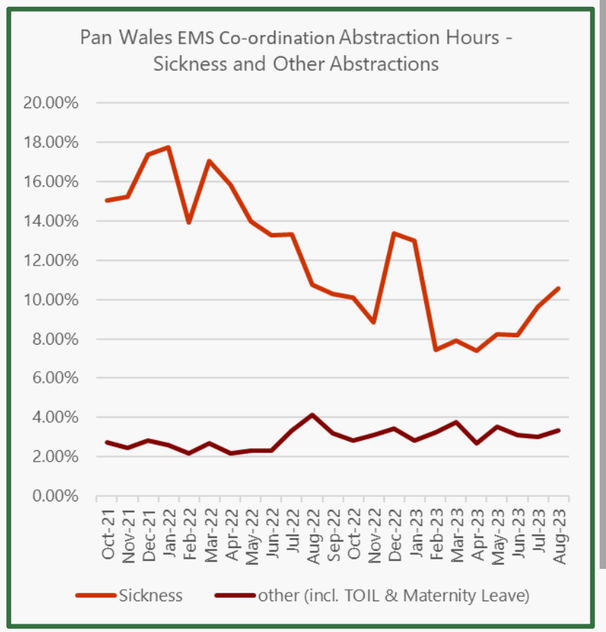
CI

Influencing Factors – Demand and Hours Produced









Analysis

The 95th percentile 999 call answering performance decreased to 28 seconds in September 2023, down from 31 seconds in August 2023 but remained above the 6 second target. The median call answer time for the 999 service remains consistent at 2 seconds.

The Trust received 45,073 emergency 999 calls in September 2023, a slight increase from the 44,646 calls received during August 2023 and the third consecutive month that demand has increased.

Overall sickness abstractions within the EMS Coordination have risen over the past three months, after being on a downward trajectory till April 2023 rising to 10.59% in August 2023. This means the service has been above the 8% target for the past 4 months.

Remedial Plans and Actions

- EMD FTE is currently 119.89 against a funded establishment of 111.76; however, this includes new starters still in the sign off period. Once qualified, experienced staff will be re-aligned to vacant dispatcher posts.
- Intelligent Routing Platform is now in operation following configuration changes.
- A cohort of 12 went live last week with a cohort of 9 commencing in North at the end of October go live end of November, and a further course of 12 arranged for November with go live 25 December; however, the teams are still experiencing attrition.
- Three workstreams are being progressed through the EMS Reconfiguration project (the complete reconfiguration has not commenced due to cost pressures required to fund the agreed model approved by ELT). This is on hold currently but will re commence in the next few weeks pending outcome and approval of a proposed new Structure for EMSC. This will require consultation.

Roster Review. Having successfully implemented an EMD roster review in February 23 the project has now progressed to commencing a dispatch roster review for Allocators and Dispatchers, however, this is currently on hold due to reviewing a potential for a new structure for EMSC as per 4th bullet point above

Boundary changes. EMS Coordination intend to realign dispatch boundaries to balance workload and pressures for individual dispatch teams. Currently on hold, as above.

Broader Ways of Working. This project is looking to create efficiency, effectiveness and improved productivity through a review of processes and procedures as well as providing consistency and lack of variation across centres. Currently on hold, as above.

Expected Performance Trajectory

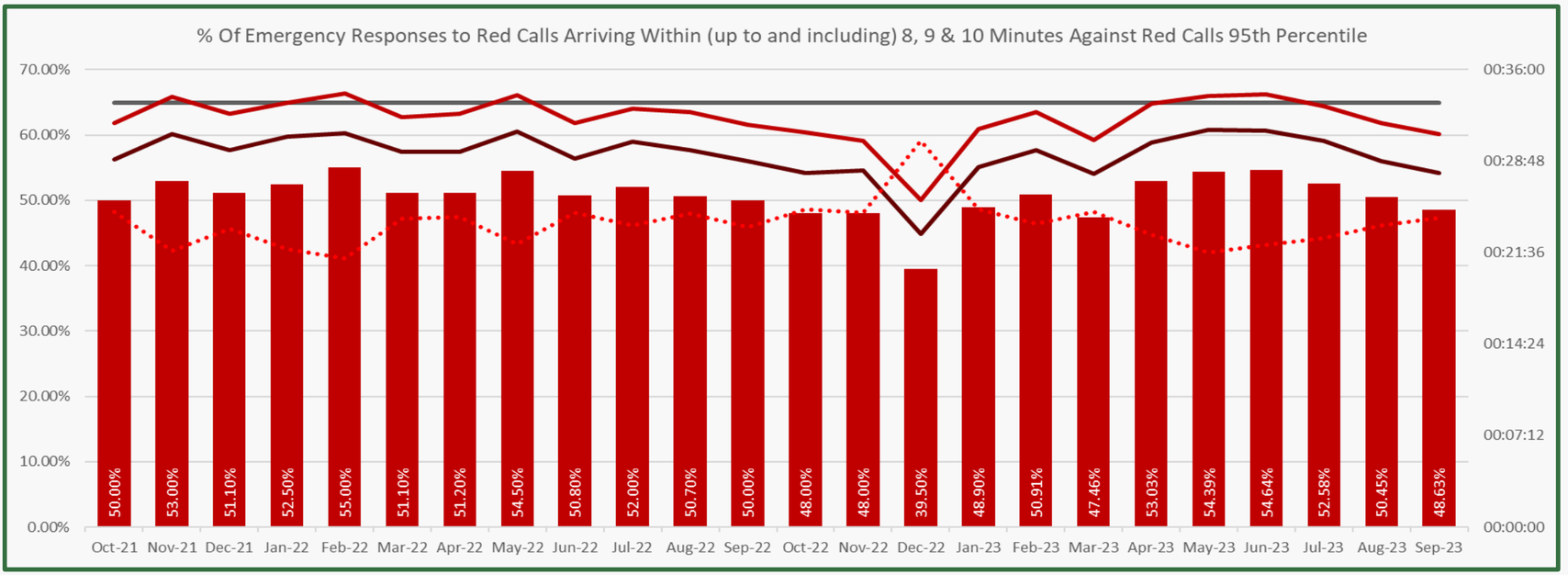
Performance is expected to remain on track, subject to continued good work around capacity management.

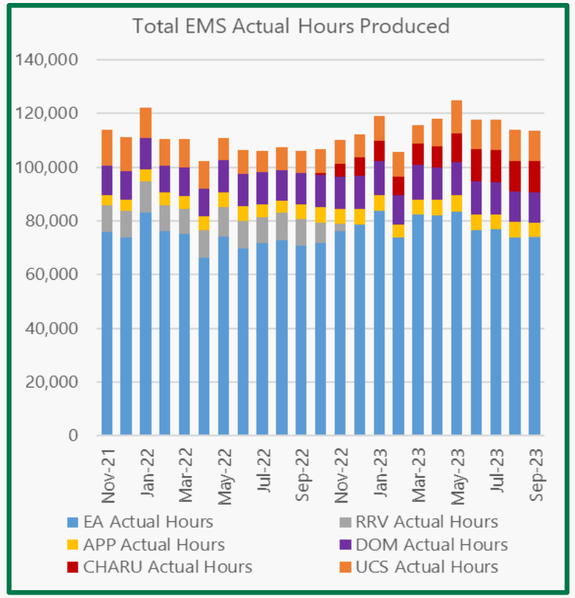
Our Patients: Quality, Safety & Patient Experience
Red Performance Indicators

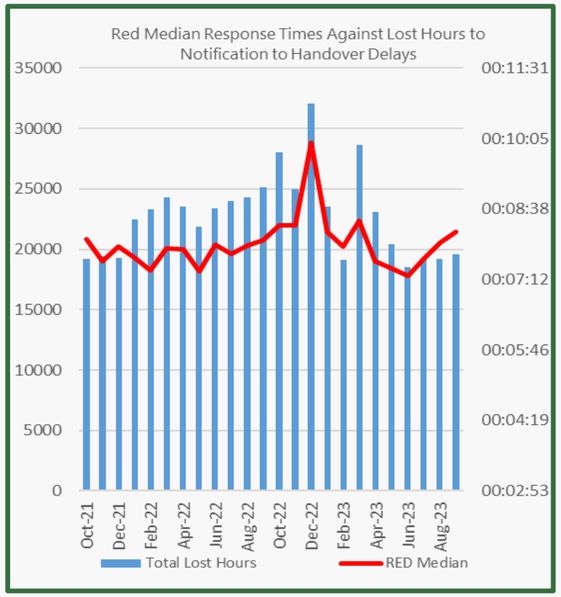
(Responsible Officer: Lee Brooks)

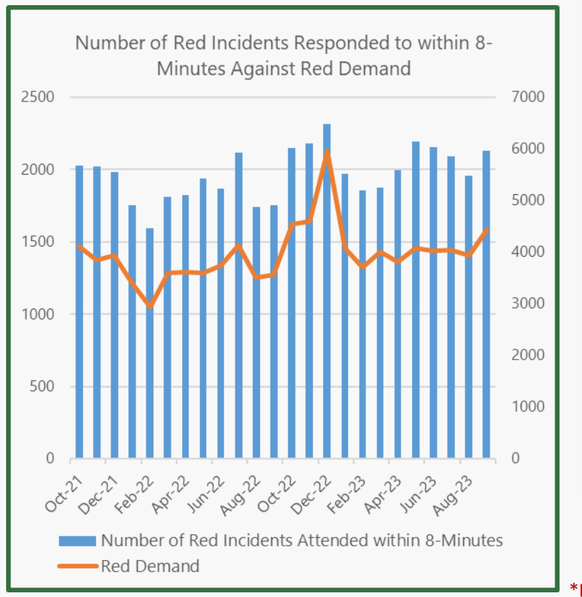
65% R | 95% R | QUEST | FPC | CI

Influencing Factors – Demand, Hours Produced and Hours Lost









Analysis

Red performance declined slightly in September 2023 at 48.63% and continues to remain below the 65% target. Although there was variation, none of the seven health boards achieved this target. Red 10-minute performance was 60.1% for September 2023, down from 61.8% in August 2023.

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

Red demand has generally shown a slight increase over the past two years, reaching a peak in December 2022. Over the same period the number of Red incidents being responded to within 8-minutes has also seen an increase, with the figure for September 2023 (2131) being 21.6% higher than during the same month in 2022 (1753).

Hours produced decreased to 113,421 hours in September 2023, although this remains slightly above the 2-year monthly average.

The lower centre graph demonstrates the correlation between overall Red performance and hospital handover lost hours. Lost hours are now lower than their peak in December, but September 2023 saw a further small increase to 19,610 lost hours compared to a figure of 19,233 in August 2023. This was the third month in a row that has seen an increase, meaning these levels continue to remain significantly above where they need to be.

Remedial Plans and Actions

The main improvement actions are:

- To maintain commissioned establishment levels overall. WG have confirmed funding for the additional 100 will remain in place for this financial year
- Full roll out of the Cymru High Acuity Response Unit (CHARU), now largely complete (127 FTEs v target of 153 FTEs) with the exception of some hard-to-reach areas. Further actions to address;
- Changes to the response logic and clinical screening of red calls, which are now live (19 June 2023);
- Reduce hours lost through sickness absence via managing attendance programme – trajectory for improvement in place as part of the IMTP (6% Mar-24);
- Working closely with Health Boards to support reduction in lost hours and a reduction in conveyances to ED. This is undertaken within local Integrated Commissioning Action Plan meetings and will include work on improvements in referrals to Same Day Emergency Care Units (SDECs).

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. Including a reduction in lost hours to 15,000.

*NB: Data correct at time of abstraction

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

(Responsible Officer: Lee Brooks)

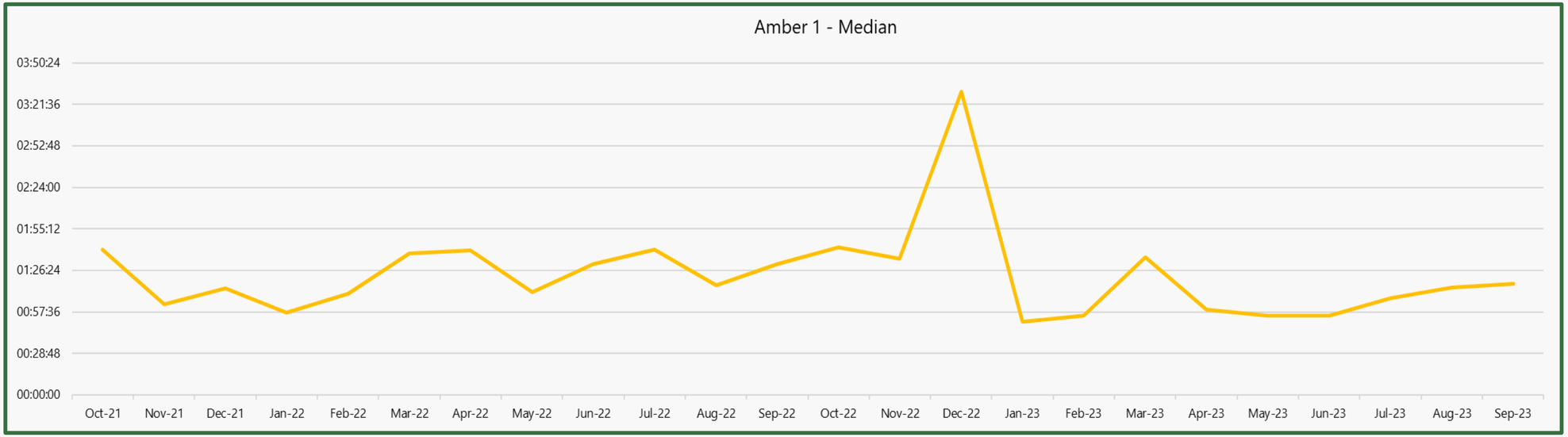
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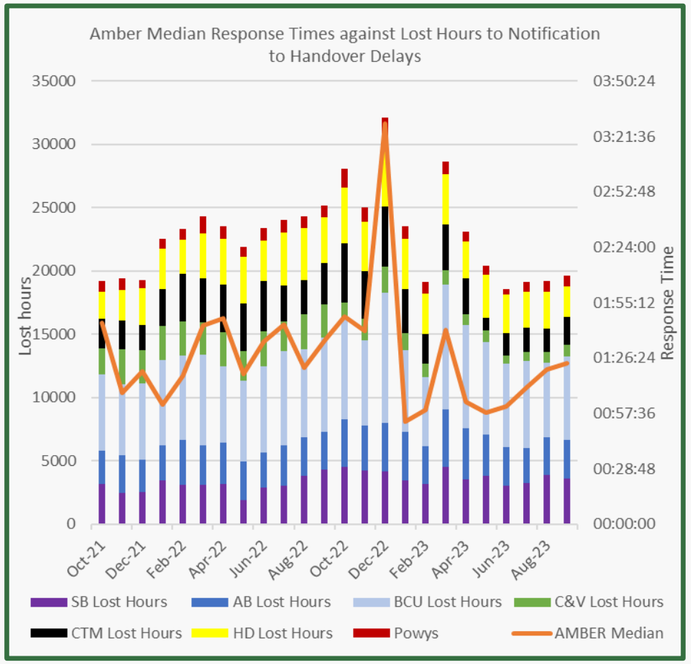
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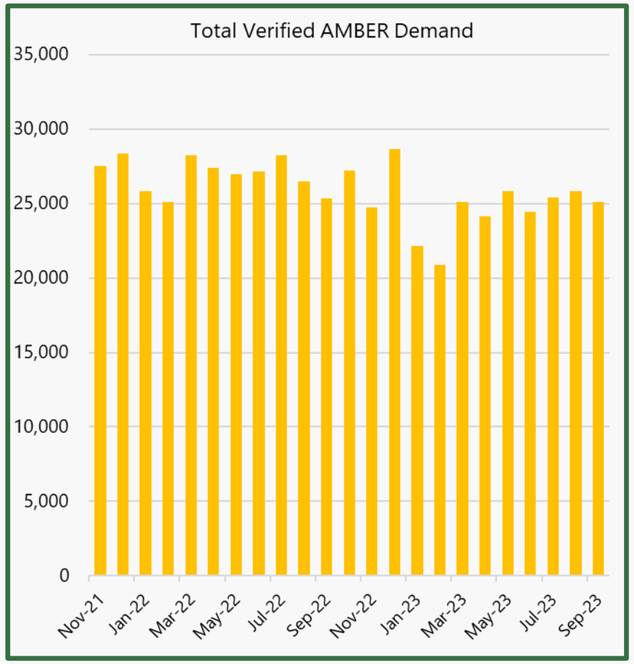
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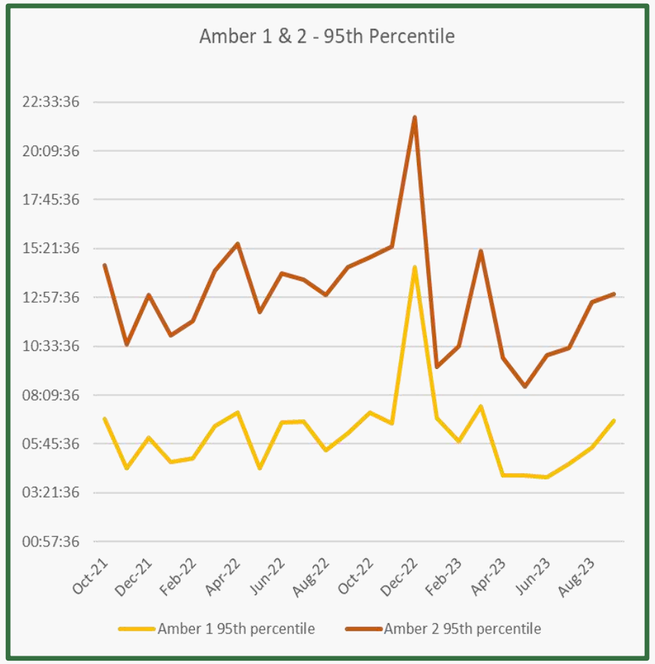
QUEST

Influencing Factors – Demand, Hours Produced and Hours Lost









Analysis

Amber 1 median performance declined during September 2023 to 1 hour 17 minutes, from the 1 hour 14 minutes recorded in August 2023. The ideal Amber 1 median response time is 18 minutes. The 95th percentile also rose to 6 hours and 54 minutes.

There were some long patient waits in September 2023, with 2,362 patients (all categories, not just Amber) waiting over 4 hours, an increase on the 1,475 recorded in August 2023.

Amber demand increased in September 2023 to 25,089 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 actions being taken are largely the same as those related to Red performance on the previous slide.

Expected Performance Trajectory

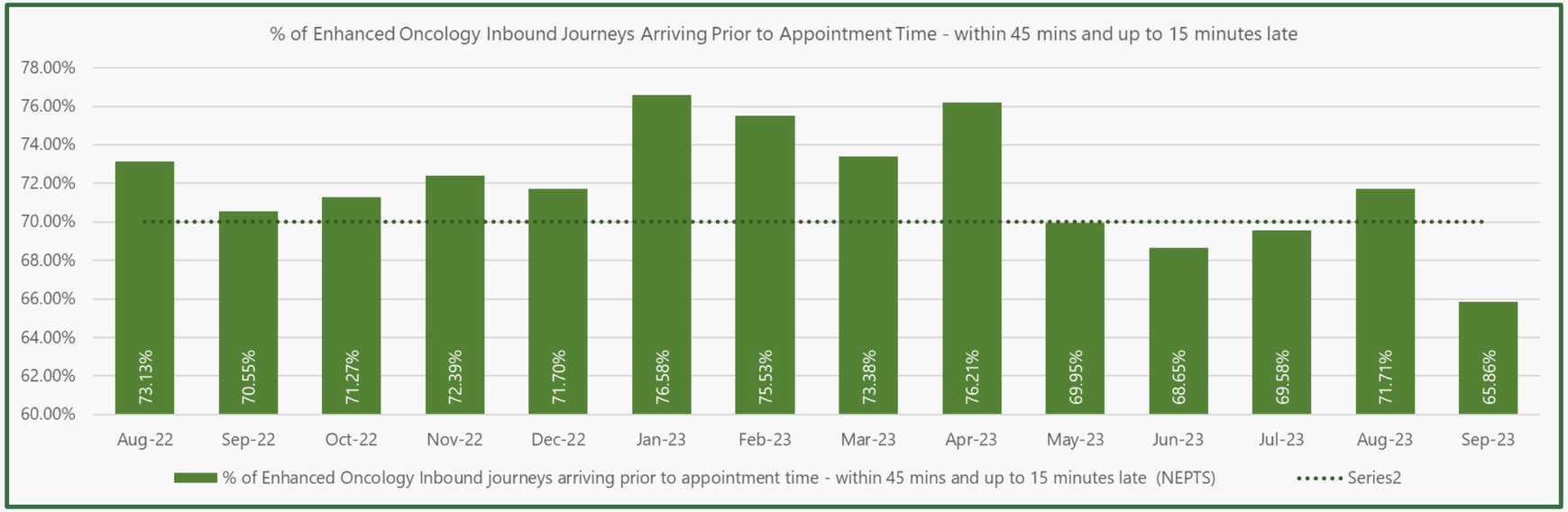
The EMS Operational Transformation Programme is the Trust's key strategic response to Amber. As per the commentary on Red performance delivering these benchmarks is dependent on a range of investments and system efficiencies, not all of which are within the Trust's control.

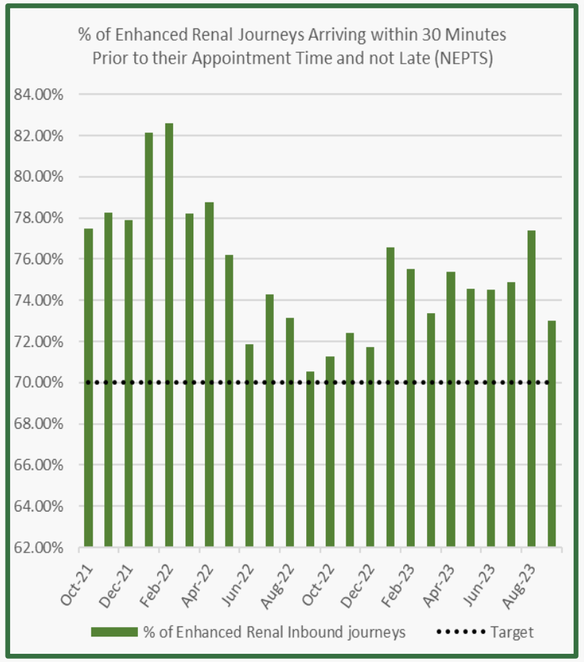
Our Patients: Quality, Safety & Patient Experience
Ambulance Care Indicators

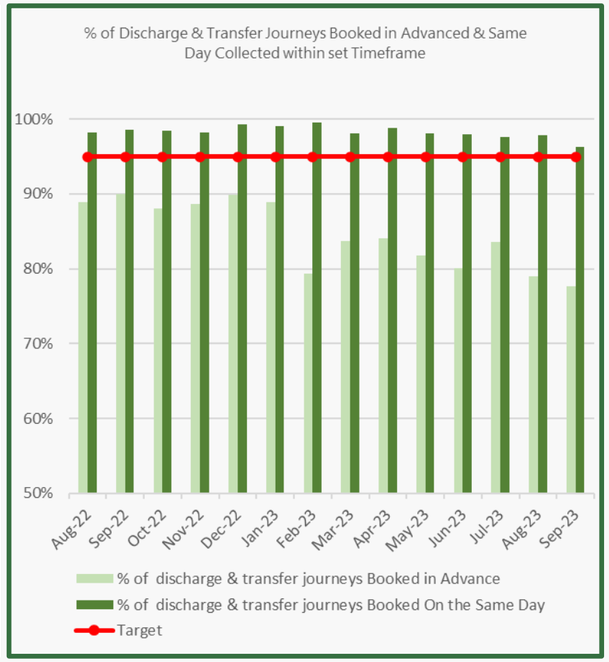
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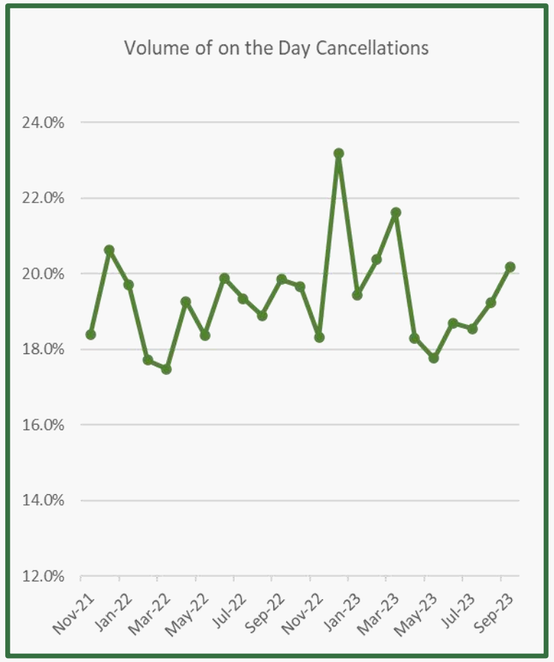
Oncology G | D&T R | FPC | CI

Patient Experience









Analysis

Ambulance Care (NEPTS element) performance reduced slightly during September 2023. 65.8% of enhanced oncology journeys arrived within 45 minutes prior and up to 15 minutes late to their appointment time, down from 71.7% in August 2023, and not achieving the 70% target. Enhanced Renal journeys also saw a reduction, from 74.9% in August 2023 to 73% in September 2023.

78% of discharge & transfer journeys booked in advance were collected within 60 minutes of their booked ready time, a decrease compared to August 2023 (79%), and below the 95% target. 96% of discharge & transfer journeys booked on the same day were collected within 4 hours of their booked ready time, a decrease compared to August 2023 (98%), but above the 95% target.

Same day cancellations increased slightly from 19.2% in August 2023 to 20.2% in September 2023.

Overall demand has continued to increase as the planned care system continues to reset. In particular:-

- Completed journeys for Patients requiring Ambulance Transport – Non T1 & C3 mobility (exc. Discharge & Transfer) are at or in excess of levels seen prior to the pandemic.
- Oncology journeys in particular have increased significantly since April 2023 and in June 2023 were at levels not seen since 2019.
- There has been a notable increase in requests for discharges from the ED. This correlates with EMS no longer facilitating these requests.

Remedial Plans and Actions

- Demand & Capacity Project: roster review of NEPTS transport paused as part of IMTP prioritisation exercise.
- Transfer and Discharge Service: work is in progress with regards to the modelling (initial results received, modelling now complete).
- The service has implemented a performance standard implementation plan to support the roll out of the new parameters. This plan is focused on ensuring the entire team are aware of the standards and their role in delivering them.
- 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.

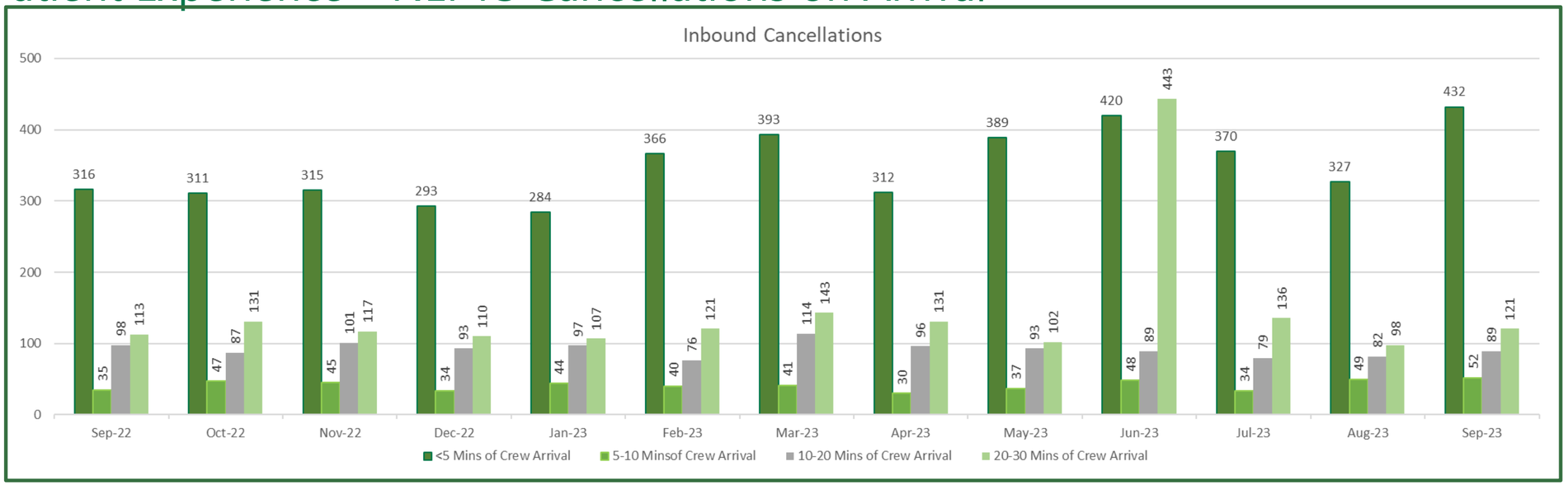
Expected Performance Trajectory

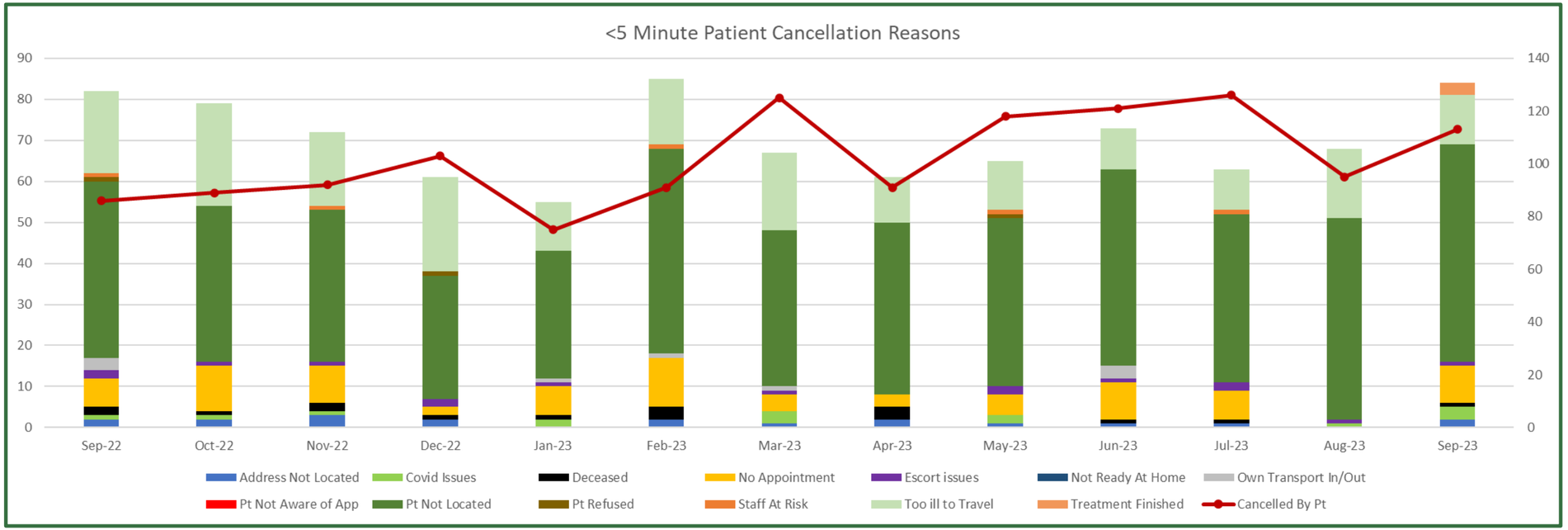
At present, the uncertainty around demand as health boards move through system recovery following the pandemic, with the potential addition of austerity and a move to different performance parameters, means that it is difficult to forecast performance. WAST will continue to work with the HBs through the commissioning DAG (NCCU) to deliver the best performance possible for the patient.

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

(Responsible Officer: Lee Brooks)

Patient Experience – NEPTS Cancellations on Arrival





Analysis

Inbound cancellations of 5 minutes or less of the crew arrival time saw an increase in September 2023 to 432, compared to 327 in August 2023. The total number of cancellations within 30 minutes also increased from 694 in September 2023 from 556 in August 2023.

Cancellations within 5-minutes of arrival appears to have seen an overall increase during the past 12 months. In September 2023 there were 113 cancelled by patient* entries made within 5-minutes of crew arrival an increase compared to the previous month of 18. The top reasons for less than 5-minute cancellations included: 53 patient not located, 12 too ill to travel and 9 no appointment.

During the past 12 months there has been a minimum of 30 patients not located in the 5-minutes or less each month.

Remedial Plans and Actions

The loss of hours through late notice cancellations is disruptive to the service and a number of actions have already been implemented including text reminders, call ahead by crew and pre-travel calls by admin staff as resource allows.

In addition, the enhanced service hub undertakes focused actions to identify and address incidences of enhanced patients late notice cancellations.

However, what is needed to really improve this position is alignment between WAST and HB systems so that cancellations flow and HB staff not booking discharges where transport is not assured, or cancellation occurs due to a change in patient circumstances. A trial is being worked on with BCU & CTM to try and improve this locally and develop a national model.

Expected Performance Trajectory

Until this work is completed, we do not anticipate a significant shift in the trajectory.

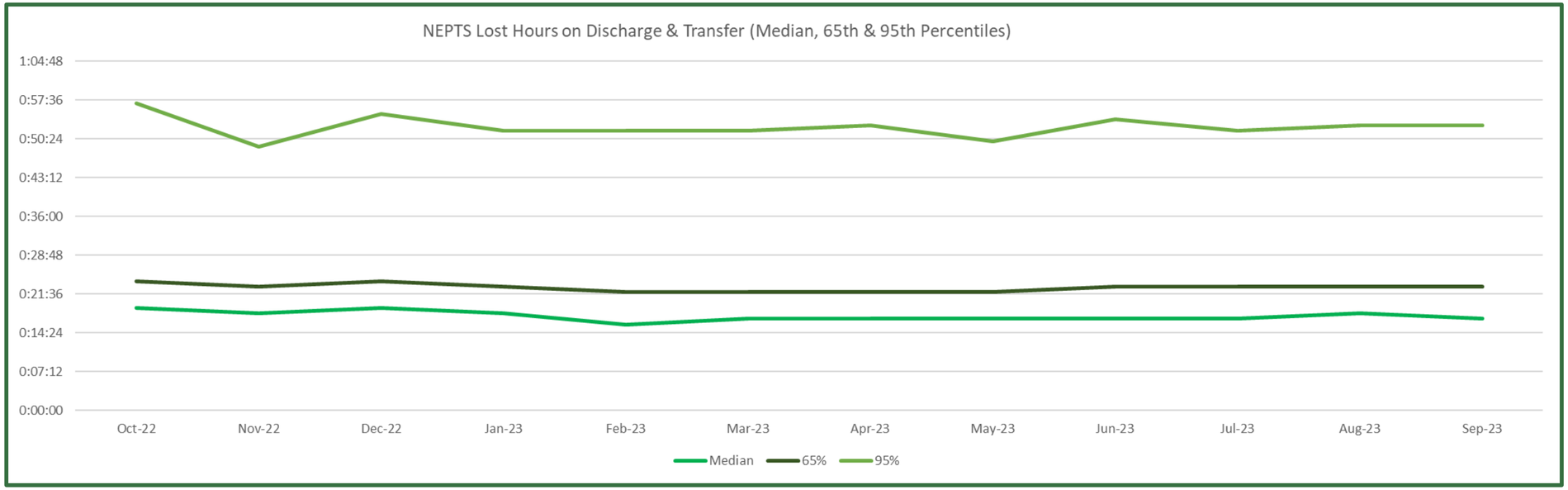
Please note that that figures may be lower than overall totals due to some records having no cancellation date.

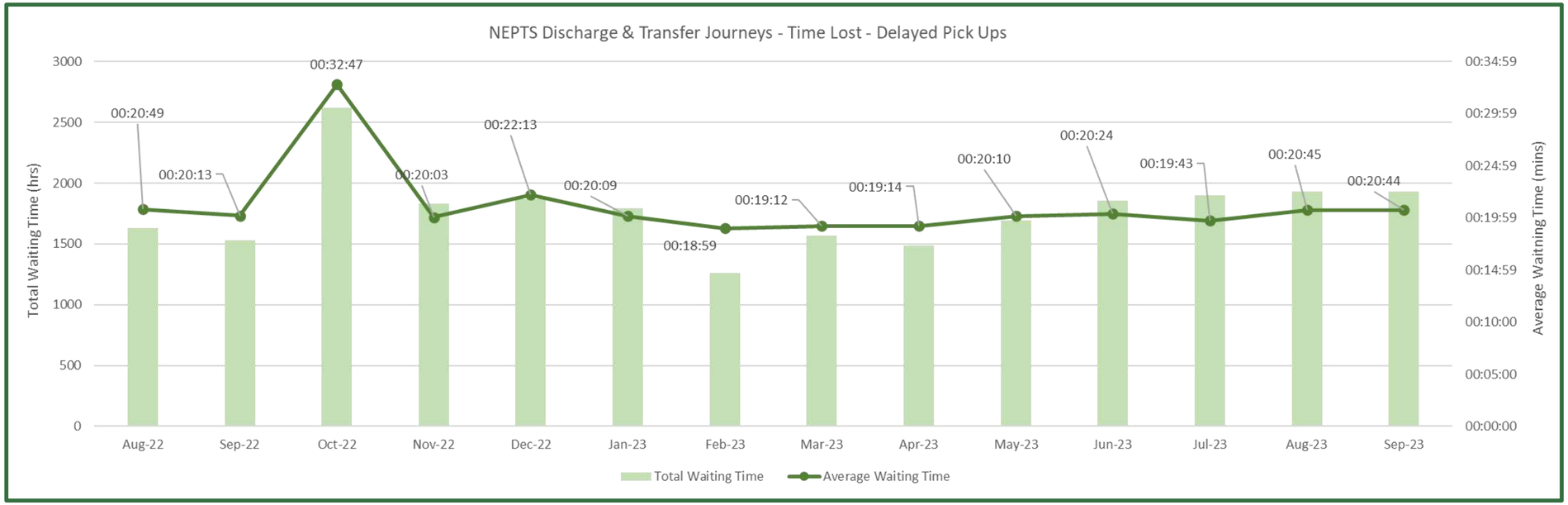
**Please note that MDTs do not appear to provide specific cancellation reasons for either inbound or outbound journeys. There are at present multiple and duplicated reasons both crews, control and the liaison desk can select.*

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

(Responsible Officer: Lee Brooks)

Patient Experience – Hospital>Hospital Transfer Waiting Times





Analysis

Time lost on discharge and transfer pickup has remained consistent for some time now with minimal variation experienced.

The data shows us that the average time lost is 20 mins, which includes time from arrival at site to when the patient is loaded on the vehicle. Our hope is that over time we can reduce this to 15 minutes, however we do not feel that the figure can go any lower than this.

Where sites have discharge lounges, it may be possible to reduce current performance and we see some sites where this occurs regularly.

The main area of concern are those sites where no discharge lounge exists or where the discharge lounge are poorly located in addition to sites that have no robust process to make sure that a patient and their accompanying requirements are ready when our crews arrive

Remedial Plans and Actions

We have started work with BCU at YGC and CTM to develop an optimal discharge model to minimise this figure as close to the 15 minutes as is possible.

This model can then be rolled out across all areas of Wales.

In addition, our teams are refining our processes including making it clear to crews when to input to their MDT, the rollout of MDVS will assist with this.

Expected Performance Trajectory

Until the model is developed and rolled out, we do not anticipate any significant variation in this data. However, we continue to work with sites and the teams to identify opportunities to reduce.

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

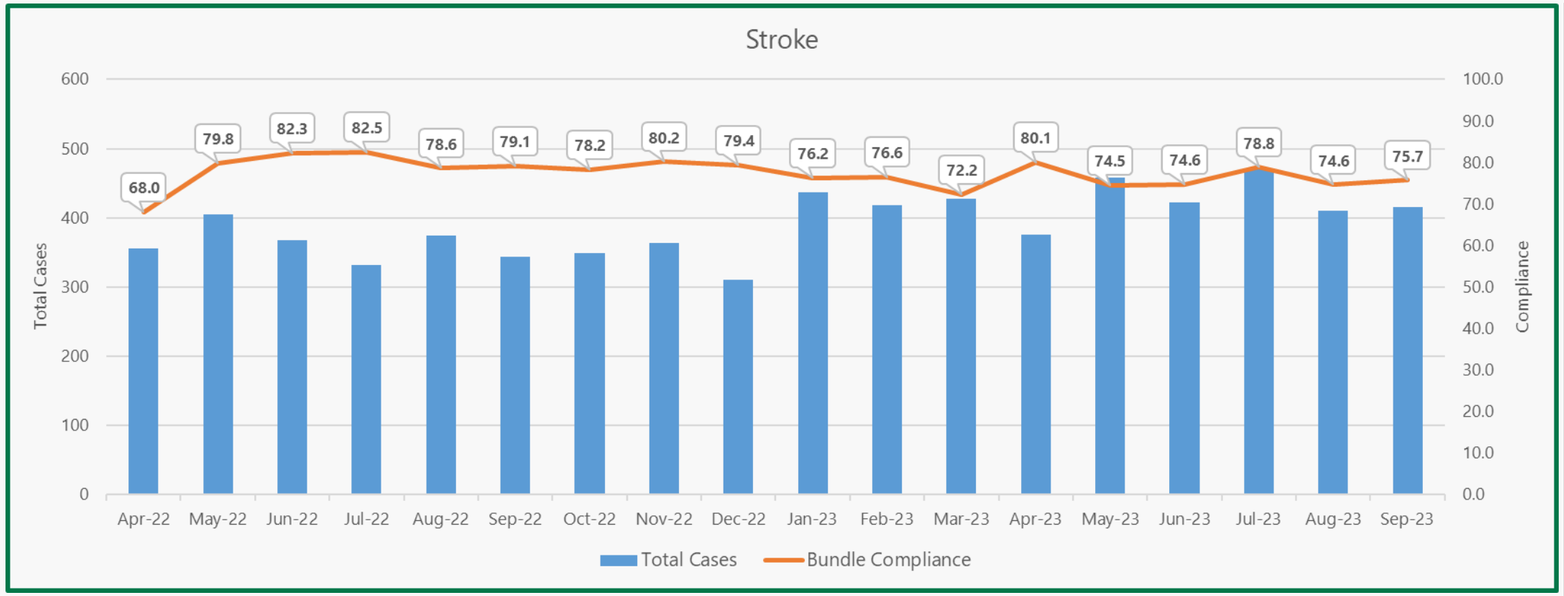
(Responsible Officer: Andy Swinburn)

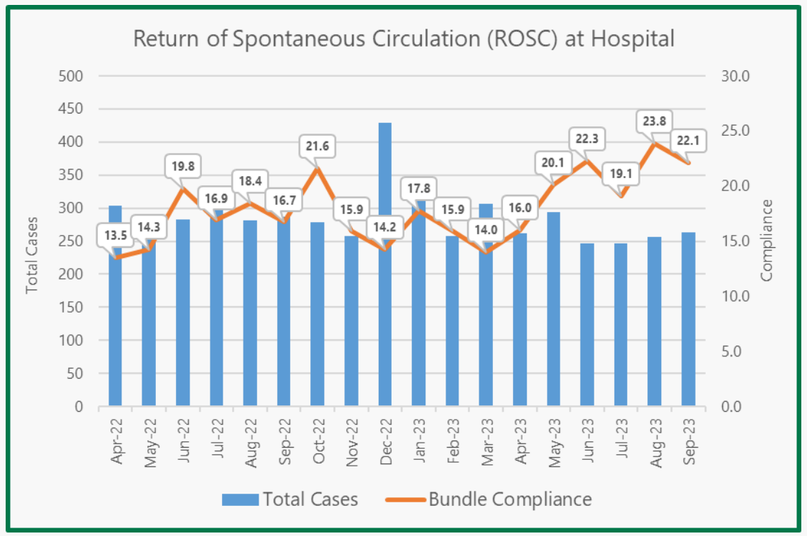
Stroke/Hip Fracture/Hypoglycaemic
R

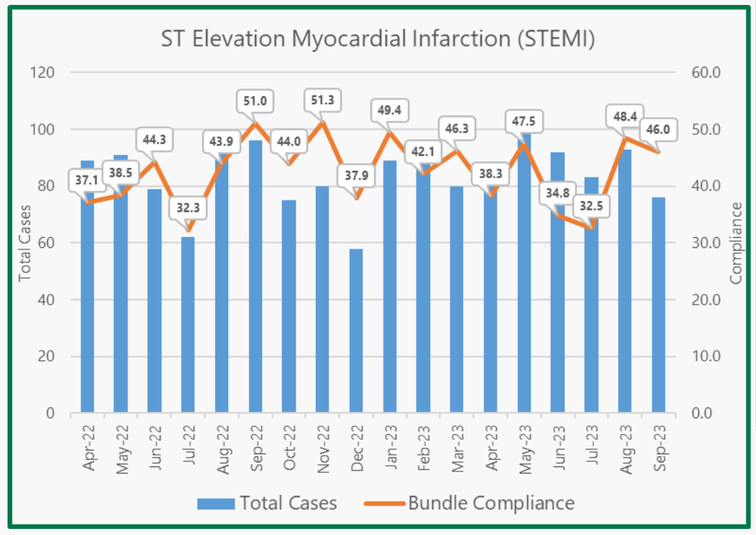
Self-Assessment: Strength of Internal Control: Moderate

QUEST

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







Analysis

The percentage of suspected stroke patients receiving an appropriate stroke care bundle in September 2023 was 75.7% which was a slight improvement on the 74.6% recorded for August 2023, but remains below the 95% performance target. This was against a total case number of 416 during the month of September.

The ROSC rate declined marginally to 22.1% in September 2023 after achieving its highest rate of 23.8% in August 2023.

The STEMI rate also decreased to 46% in September 2023 compared to 48.4% in August 2023, this at the same time as total cases also declined.

Work on reporting a new clinical indicator relating to call to door times for STEMI and Stroke continues and is planned to be included shortly once approved.

Remedial Plans and Actions

It is likely that as the ePCR system continues to embed within clinical practice, data points might be missed. An improvement approach has been taken, 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 (CIAG) prior to approving and 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 improved data capture in future versions of the application, this work is being progressed with Terrafix, the next updates to the ePCR are scheduled for implementation by the end of October 2023.

In relation to the new clinical indicators, a further review is ongoing to ensure data points are correct and in line with other national reporting systems.

In addition, the Trust is scoping out the potential for three new Clinical Indicators: -
a) Older fallers discharged at scene. This was part of a pilot undertaken along with English Ambulance trusts but due to differing criteria WAST will look at specific CIs.
b) Advanced Paramedic Practitioner – discussions are taking place to establish a specific metric.
c) Pain management/trauma – discussions taking place to establish specific criteria.

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
Patient National Reportable Incidents & Patient Concerns
Responses Indicators

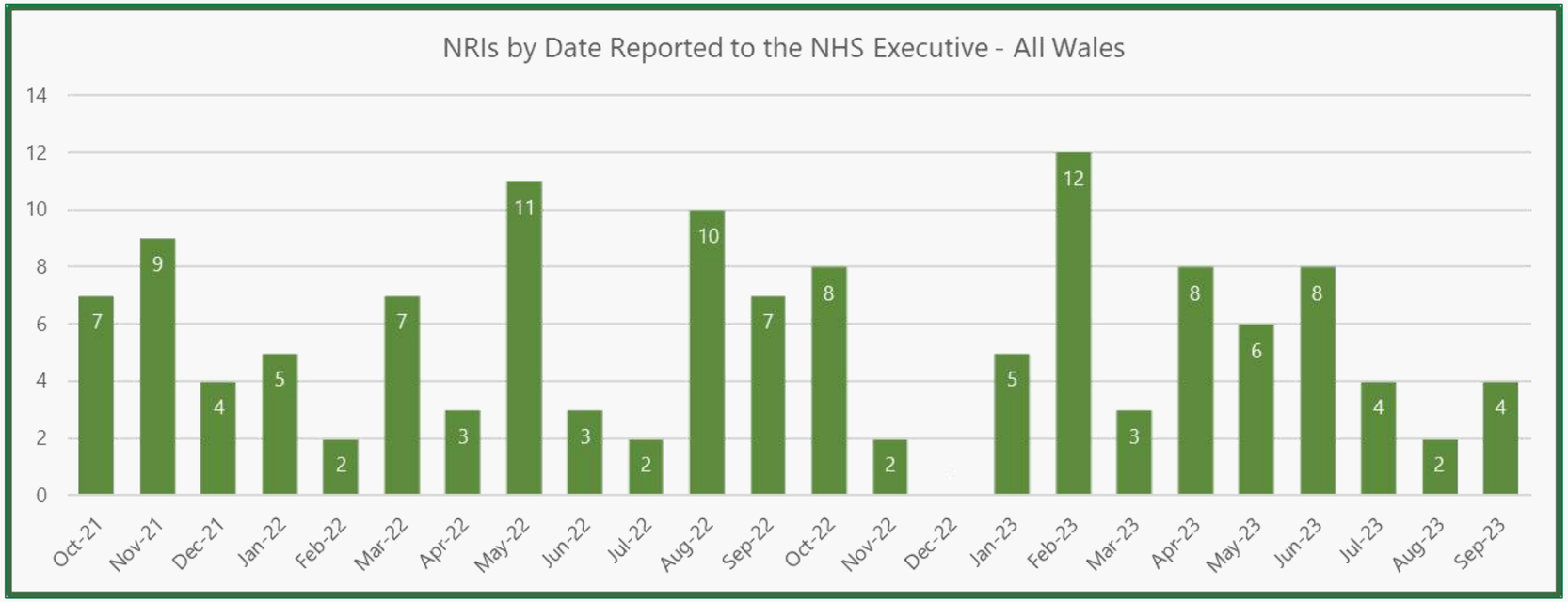
(Responsible Officer: Liam Williams)

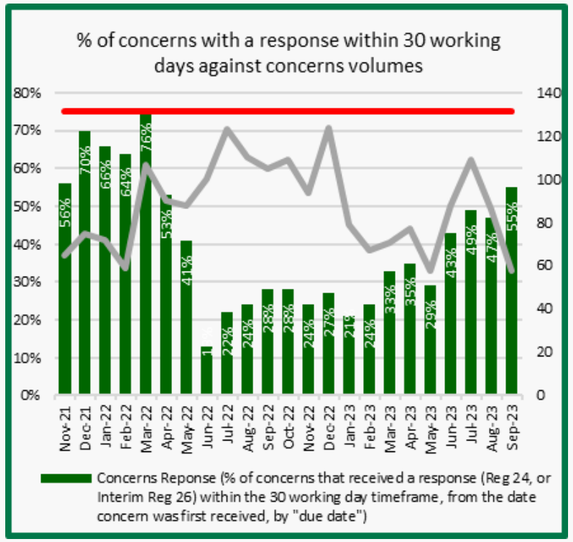
NRI. A

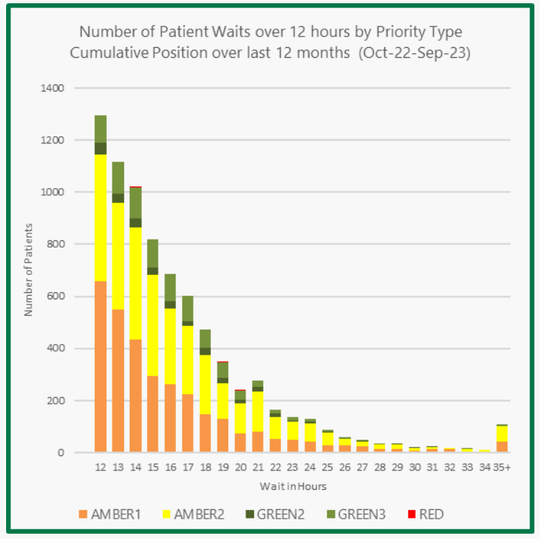
Self-Assessment: Strength of Internal Control: Moderate

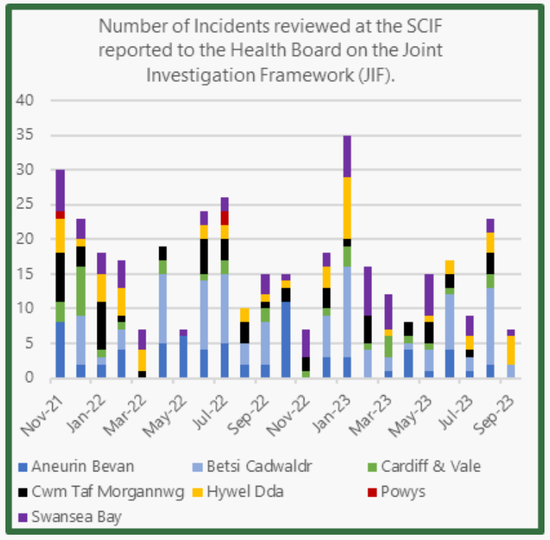
QUEST

Health & Care Standard
Health - Safe Care / Timely Care









Analysis

The percentage of responses to concerns in September 2023 is 55% against a 75% target (30-day response) which is a slightly improved position, however there is currently a backlog in recording concerns due to limited capacity in the team. This will impact on the data and information presented for this period and this will be updated in future reports. 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 has slightly decreased with 58 complaints being received and processed in September 2023 (the backlog of concerns to be processed will also impact the data to date). These complaints are frequently complex with our concerns administrators taking lengthy calls from distressed patients or family members for up to one hour per call. The 5-day acknowledgement measure for September 2023 is currently 79% (this data will be impacted by the backlog).

Five Serious Case Incident Forums (SCIF) were held during the month and eighteen cases were discussed. Following discussion four serious patient safety incidents were reported to the NHS Wales Executive and seven cases were referred to Health Boards for investigation under the Joint Investigation Framework. The Trust received no referrals from Health Boards under the Joint Investigation Framework during the period. The last referral by a Health Board was in June 2023. Learning from the Joint Investigation Framework process remains limited with Health Boards cited high levels of escalation as causal factors.

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 and contact patients and families as appropriate.

Themes relating to serious patient safety incidents reported to the NHS Wales Executive (Delivery Unit) as Nationally Reportable Incidents (NRIs) include delayed community response times and call categorisation, predominately ineffective breathing which is being discussed at national ambulance forums as a consistent theme.

In September 2023, 609 patients waited over 12 hours for an ambulance response and 40 compliments were received from patients and/or their families.

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 Operations Quality Team. Following financial agreement at the Executive Leadership Team in September 2023 an organisational change process commenced in the Putting Things Right Team on 25.09.2023.

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, both are considered at Board sub-committee level and at Trust Board. 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 which are detailed on the Corporate Risk Register.

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: 30 Day Compliance reported from Power BI and therefore data is not yet validated*

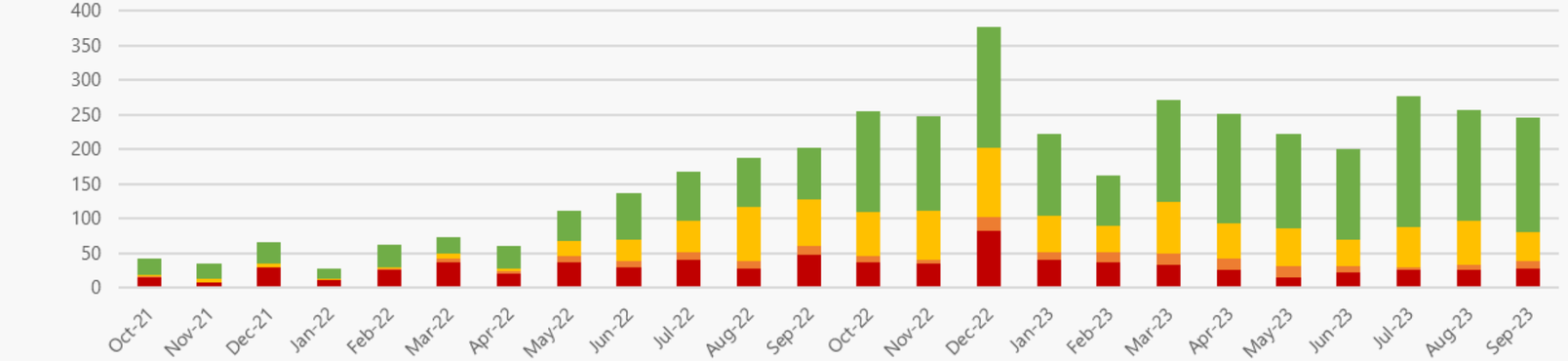
Our Patients: Quality, Safety & Patient Experience
Patient & People Safety Indicators

(Responsible Officer: Liam Williams)

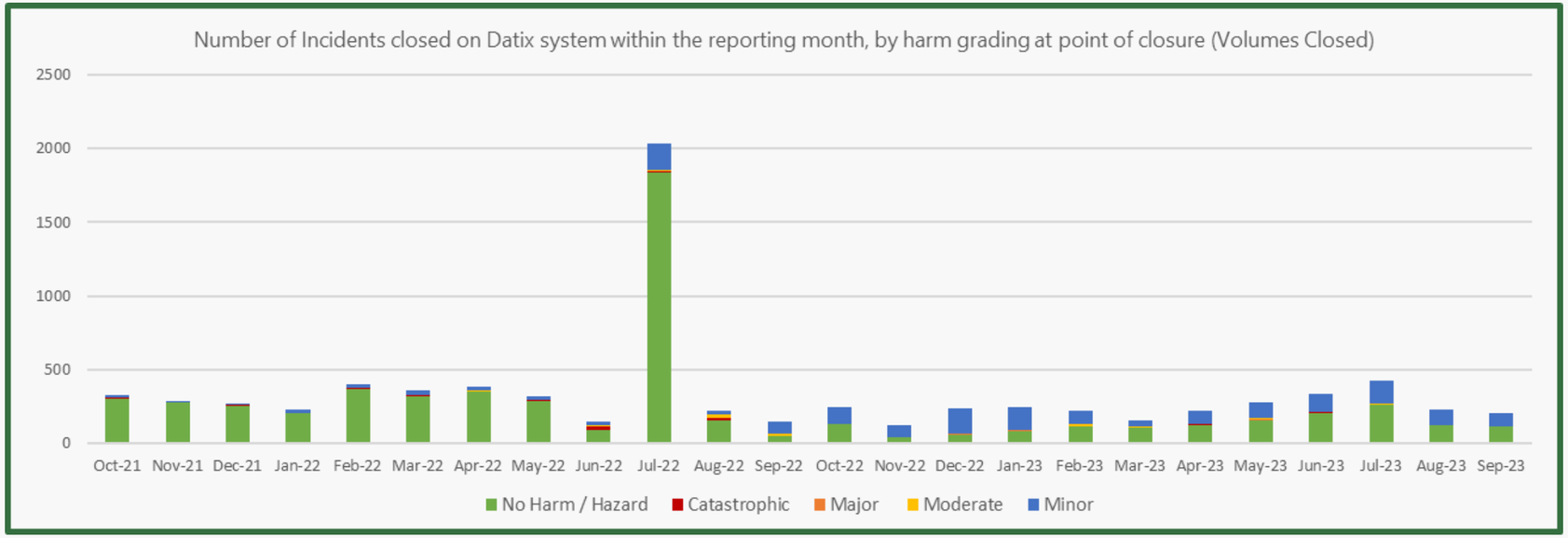
Self-Assessment: Strength of Internal Control: Moderate

PCC

Health & Care Standard
Health – Safe Care



	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	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Minor	24	22	30	15	33	23	33	44	66	71	71	75	146	136	175	119	74	147	159	137	132	189	160	166
Moderate	2	5	5	1	3	7	5	22	32	46	79	67	64	70	99	52	38	74	50	53	37	58	63	41
Severe	2	0	0	0	1	6	3	9	9	10	10	12	8	7	21	12	14	17	18	17	10	4	7	11
Catastrophic	14	8	30	12	26	37	20	36	29	41	28	48	37	34	82	40	37	33	25	15	22	26	26	28



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 and contact patients and families. The Datix Cymru System has recently been updated nationally to allow Duty of Candour to be captured and reported and further work to develop a dashboard is in progress. Monthly volumes should be interpreted with caution as incidents can be duplicated on the system (for example two crews submitting the same incident).

- No harm or hazard – 39
- Minor harm – 166
- Moderate harm - 41
- Severe Outcomes - 11
- Catastrophic - 28

(*NB: Volumes received).

The bottom graph highlights the 203 Incidents that were closed on the Datix system in September 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 Putting Things Right concerns which are frequently complex. It is expected that the combination of the implementation of the Duty of Candour, Duty of Quality and the Medical Examiner Service will involve additional activity for the Putting Things Right Team.

The Putting Things Right Team organisational change process commenced on 25.09.2023 and will consider our local and national priorities and resources to meet the needs of our patients and families.

The Trust is represented at national networks including Duty of Candour, Complaints, Ombudsman, Learning, Mortality, Claims, Redress and Datix Cymru development groups as resources allow. Work is progressing in respect of the development of dashboards and the aggregation of data and information to inform patterns, trends and learning opportunities as part of the quality management system.

Expected Performance Trajectory

The Trust will continue to identify quality and safety improvements through the Putting Things Right 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

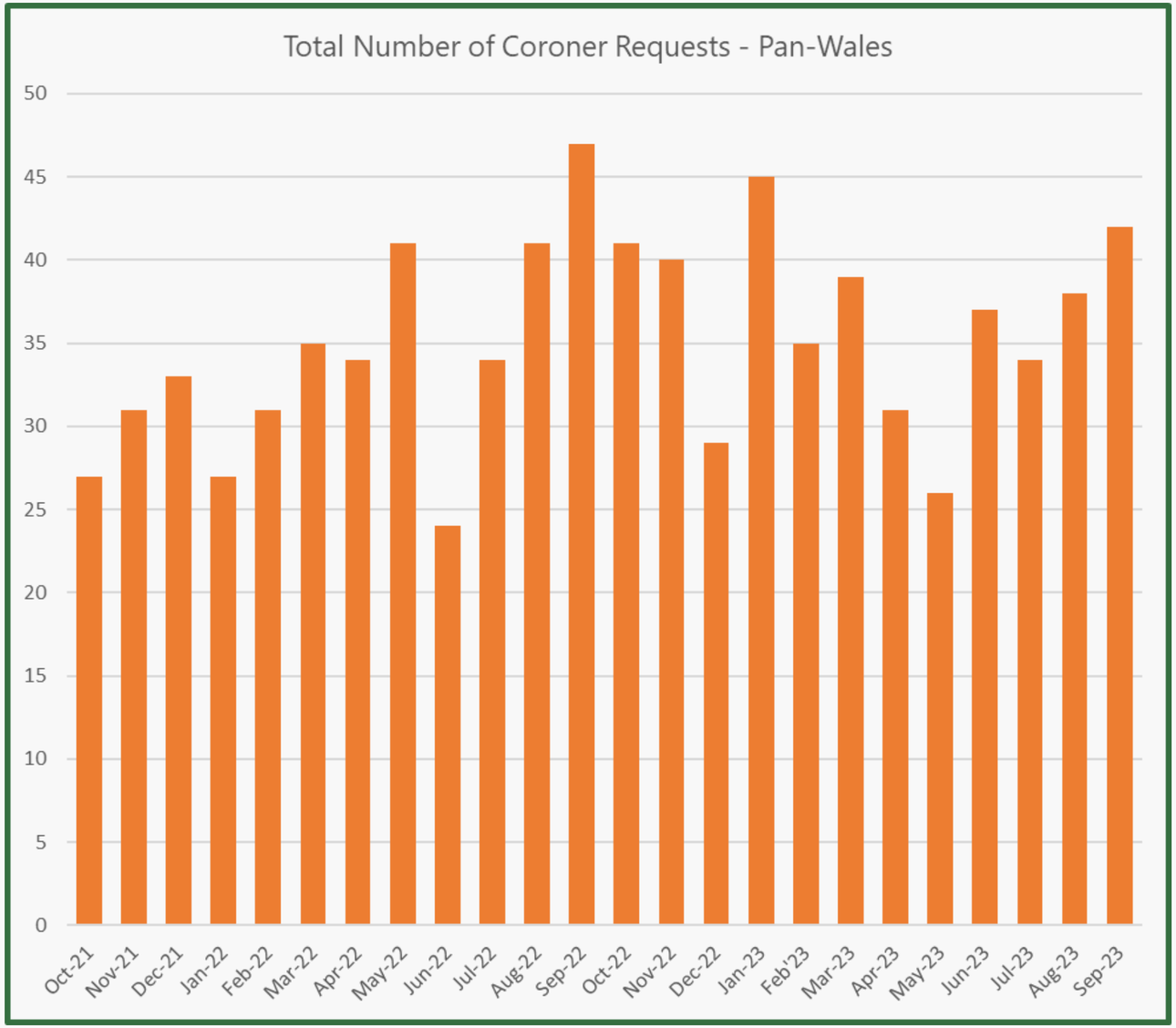
(Responsible Officer: Liam Williams)

Coroners Self-Assessment: Strength of Internal Control: Moderate

Mortality Self-Assessment: Strength of Internal Control: Moderate

QUEST

Health & Care Standard
Health – Safe Care



*NB: Temporary graph at All-Wales level: The Trust is currently unable to report Coroner requests at Health Board level due to the implementation of the new Datix system

Analysis

Coroners: As anticipated this month has seen a further increase in the number of approaches from the coroner. The complexity remains high, with multiple statements and actions per approach. This is in addition to the additional work required to manage cases where the Trust has been given IP status.

Ombudsman: There are currently 9 open Ombudsman cases in September 2023. There has been a reduction in initial approaches to the Trust by the PSOW. All PSOW cases are now being managed via Datix Cymru. A draft report has been received and the content is currently being considered by the Trust.

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 as available. Data and information is also provided by the Trust as required to the Medical Examiner Service to inform their reviews of deaths in acute care. As of September, the Trust has received 631 requests for information or feedback from the Medical Examiner Service with themes and trends so far including timeliness in response to patients in the community, handover of care delays and patients on the end-of-life care pathway being conveyed to acute care.

The All-Wales Mortality Review Group at which WAST has representation has recently commissioned 'A Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) All-Wales Thematic Review' selecting cases covering January 2022 to January 2023. This review encompasses all Health Boards, and the final report will be provided by the end of 2023 (delayed nationally was expected October 2023). To date the Trust has not received any requests to undertake any Level 2 mortality reviews of patients in our care under the new processes in place across NHS Wales. Currently the focus of the Medical Examiner Service 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 Medical Examiner Service by April 2024 when the Service becomes a statutory body. An increase in activity for requests / reviews for the Trust is expected when this occurs.

Remedial Plans and Actions

Coroners: Cases continue to be registered and distributed and the Team has had to introduce a new process surrounding the notification of summons to inquest. At the national network , all Health Bodies reported an increase in both volume and complexity of the coronial work post pandemic. The Team continues to ensure that we are meeting the dates for the production of statements, and escalating should difficulties be experienced.

Ombudsmen: *All cases are recorded and monitored on the Datix system.*

Mortality Review: The Trust is in the process of developing the internal mechanisms in order to facilitate mortality reviews under the new approach and our internal framework has been approved at the Clinical Quality Governance Group. Representation and contribution by the Trust at the All-Wales Mortality Working Group continues and a task and finish group has been established to review the process for contacting families following their meetings with the Medical Examiners. Additionally, the Patient Safety Team are engaged in the meetings lead by the Once for Wales Datix Cymru team who are developing the Datix Cymru Mortality Module currently.

Internally the Trusts Learning from Deaths Group is set to commence from November 2023 with the terms of reference drafted and going through approval processes.

Expected Performance Trajectory

Coroners: This level of activity seems to be the new normal and will continue to be monitored.

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

Mortality Review: Whilst the multiple benefits of the Medical Examiner Service 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 by April 2024 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 Putting Things Right processes internally through the Serious Case Incident Forum.

Data source: Datix

Mortality Reviews Data source: Internal Web Application

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

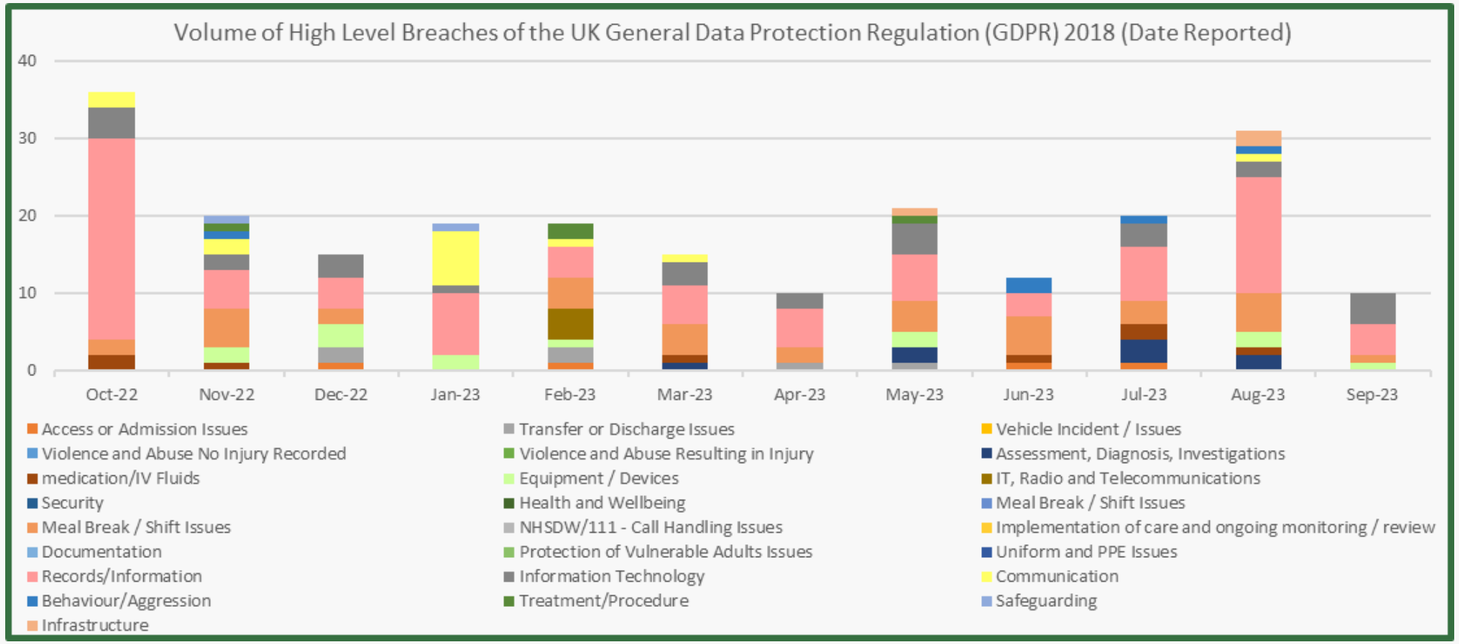
(Responsible Officer: Liam Williams)

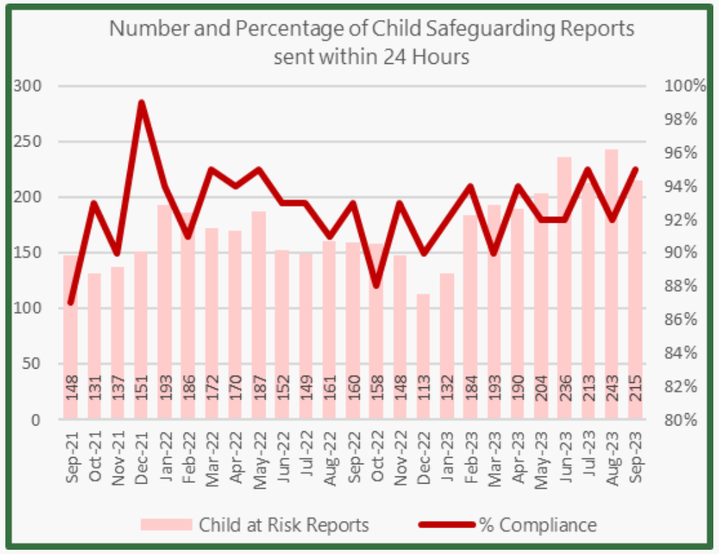
Self-Assessment: Strength of Internal Control: Strong

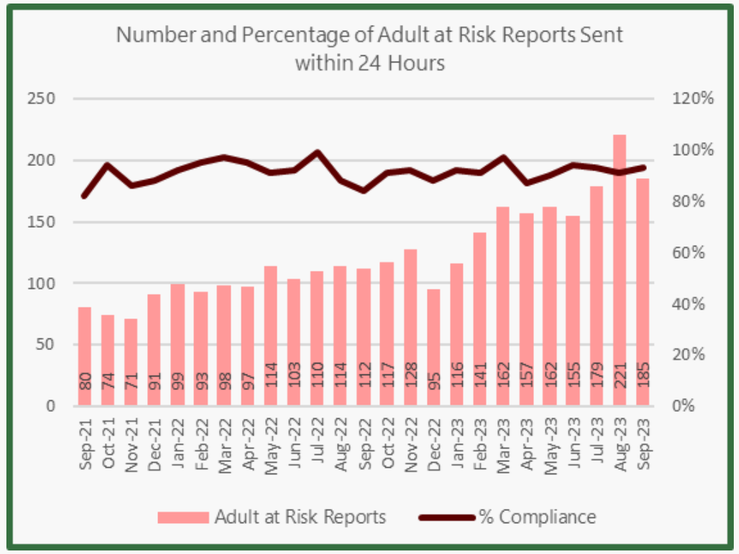
QUEST

Health & Care Standard
Health – Safe Care

Safeguarding Data source: Doc Works







Analysis

Safeguarding: In September 2023 staff completed a total of 185 Adult at Risk Reports, 93% of these were processed within 24 hours. Whilst the Trust does not report on Adult Social Need reports, 486 referrals were received and processed to the local authority during this reporting period. There have been 215 Child Safeguarding Reports in September 2023, 95% of these were processed within 24 hours.

Data Governance: In September 2023 there were 10 information governance (IG) related incidents reported on Datix Cymru categorised as an Information Governance (IG) breach. Of these 10 breaches, 1 related to information governance/confidentiality, 4 records/information, 4 Information Technology, and 1 equipment.

Public Engagement: During September, the Patient Experience and Community Involvement Team attended 24 community engagement opportunities, engaging with approximately 1,348 people. This month engagement has included attendance at student freshers' fairs, talking to young people moving to Wales and living independently for the first time about appropriate use of services and how NHS services in Wales work. We have visited Dementia groups to talk with people living with dementia and their carers; attended Third Sector Mental Health forums; supported Trust representation at Cardiff 999 Day; have continued to engage with Llais, the citizen voice body for Wales and have met with the Hindu Cultural Association about a collaborative piece of work aimed at that community. At engagement events throughout the month, we continued to use engagement opportunities to listen to people's experiences of using our services, capture feedback, encourage people to complete PREMs surveys and to recruit people to join our People & Community Network. During September we also continued to make a range of Patient Experience Surveys (PREMs) available, asking people to provide feedback about their interactions with our services. Engagement and survey outcomes remain largely 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, but that people are happy with the care they eventually receive. 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 longer than wanted delays when waiting for their transport home following their appointment.

Remedial Plans and Actions

Safeguarding: The Trust primarily manages all safeguarding reports digitally via Docworks Scribe 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 10-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 will continue to review and provide advice on reported incidents where applicable.

Public Engagement: Community involvement and engagement with patients/public forms 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. Response rates to some of our PREM's surveys is disappointingly low and we acknowledge that this means we cannot report a truly reflective picture of what it feels like to be a user of some of our services. We are actively working with colleagues across the Trust in a number of different departments to try and agree on solutions that would allow us to directly contact more patients to ask for feedback about their experiences 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 new submission for FY23-24 IG Toolkit is open with a new question set compared to the previous year. An action plan has been developed based on the new question set which continues to be worked on.

**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*

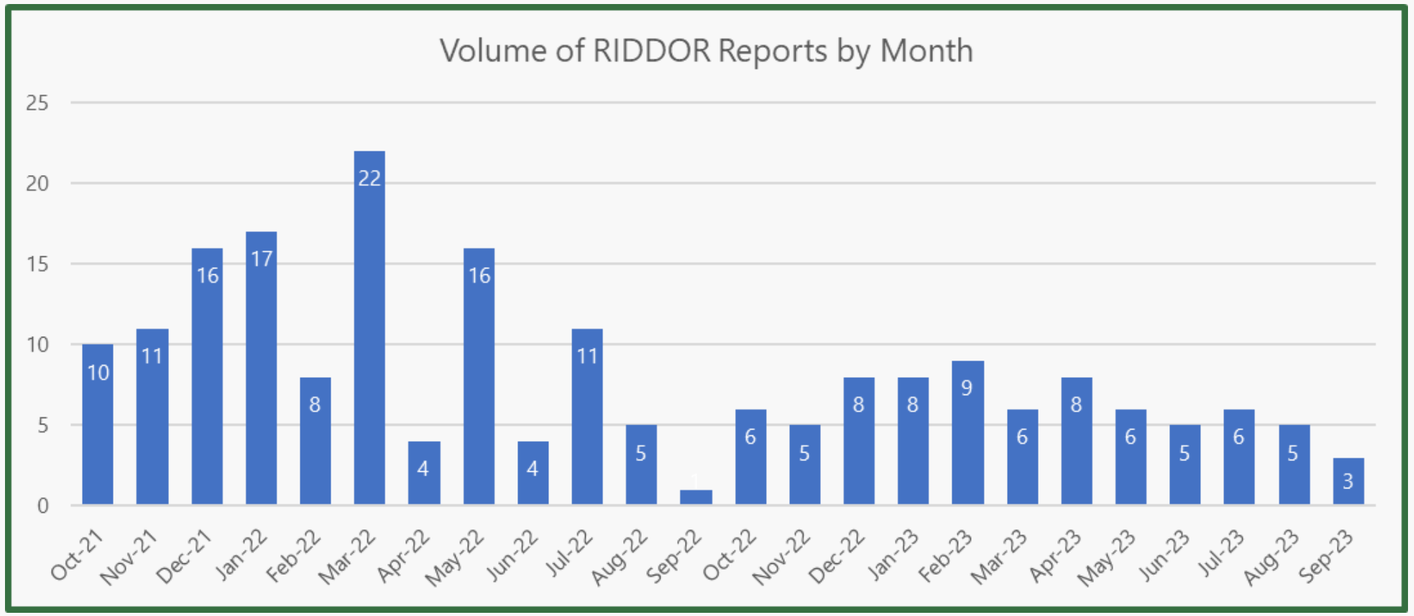
Our Patients: Quality, Safety & Patient Experience
Health & Safety (RIDDORS) Indicators

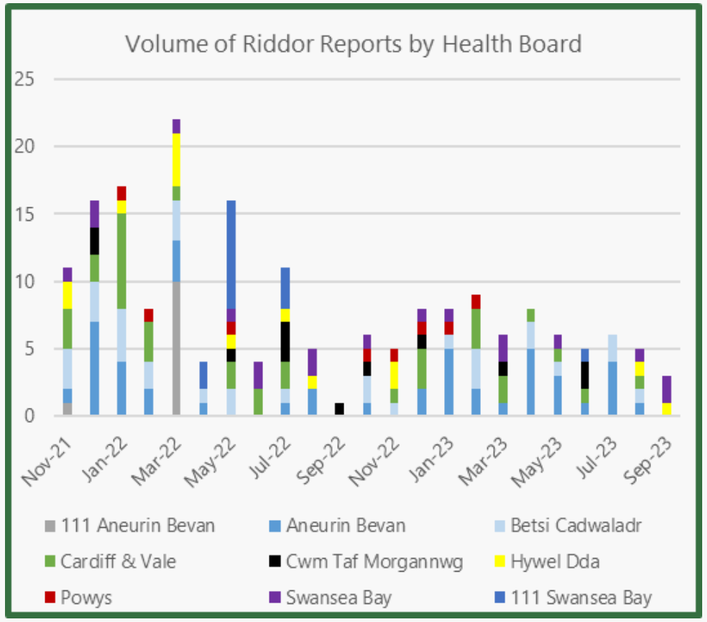
(Responsible Officer: Liam Williams)

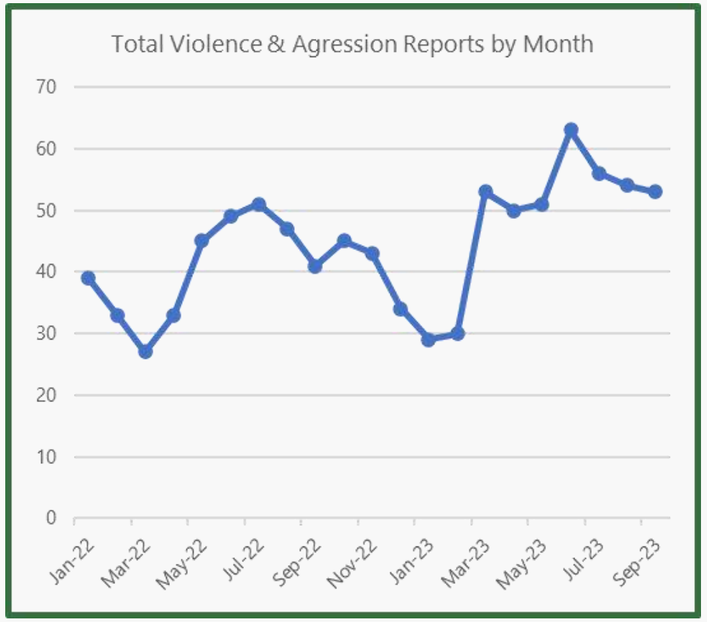
Self-Assessment: Strength of Internal Control: Moderate

PCC

Health & Care Standard
Health – Safe Care







Analysis

RIDDOR: There were 3 incidents requiring reporting under RIDDOR during September 2023 due to staff being absent from work for over 7 days as a result of their injury. One incident of note was an injury due to a fall injury whilst carrying the response bag. As we approach winter we can expect a rise in slip, trip and fall incidents as the weather worsens.
68% of the incidents reported were notified to the HSE within the reporting required time frames. One report did not meet the reporting time frame due to delay in information being provided to the Safety Team. The Health and Safety team will continue to work with Incident Handlers to ensure reports are submitted within the required timescales.

Violence and Aggression: A total of 53 incidents have been reported of V&A in September 2023. Four Physical Assaults on staff were reported during the month with incidents of aggressive and threatening behavior amounting to 21. Betsi Cadwaladr remains the highest reporting areas with a total of 26 incidents followed in September by Swansea Bay with a total of 10 incidents Three incidents were reported as Severe in harm, one noted being asked to attend a property where the patient was recorded as having a knife but there was no Police back up.

Remedial Plans and Actions

RIDDOR: The risks associated with winter weather are to be addressed in the up coming Health and Safety newsletters.
RIDDOR performance continues to be presented in monthly reports and service units business meetings.

Violence and Aggression: Collaborative working with AACE regarding V&A training continues with the aim of improving the current training to better support staff. Particularly around clinical restrictive physical intervention.
The Case Manager continues to actively support staff who are involved cases being heard at Court to ensure they are given any help they require.

Expected Performance Trajectory

RIDDOR: The reporting of missed meal breaks is lower than previous months. This is due in part to a change the Datix reporting form. Missed meal breaks can now only be recorded as a patient safety incident, an infrastructure incident or occurrence of ill health. Those coded as a patient safety incident are being recoded by the Datix QA Team as appropriate.

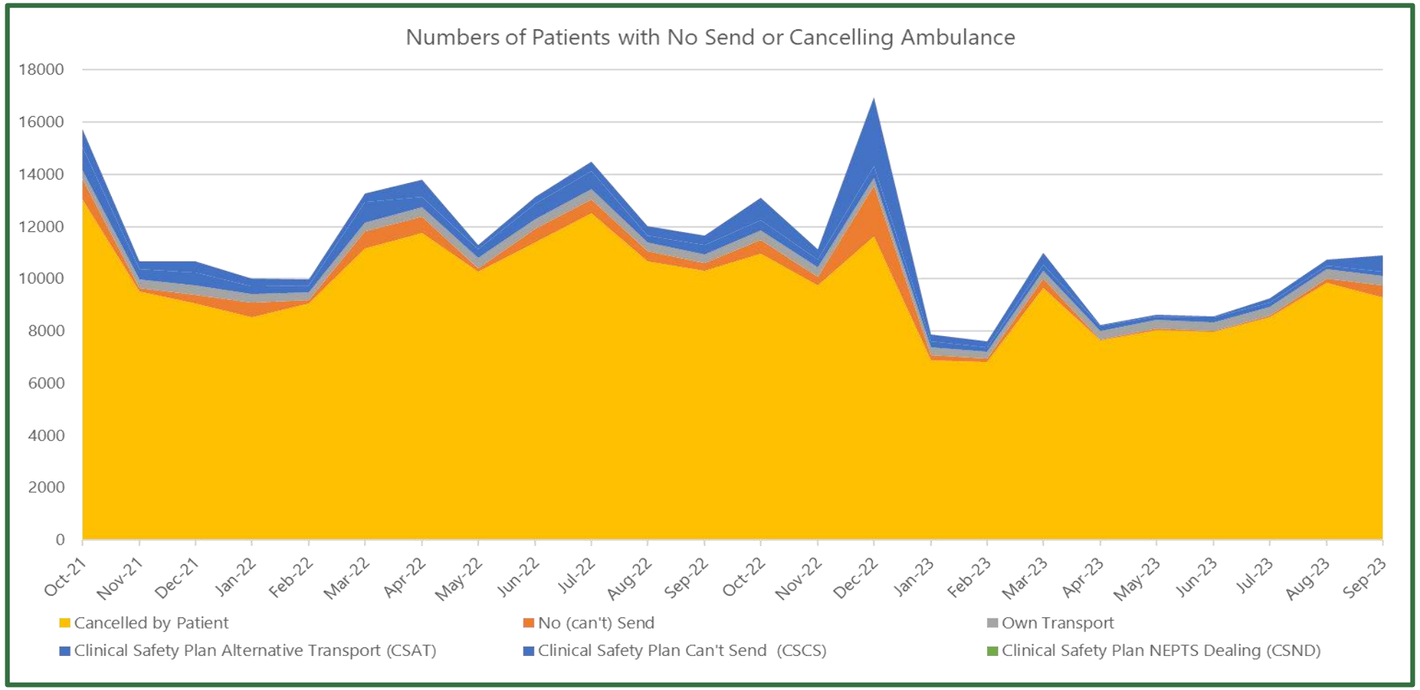
Violence and Aggression: Toolbox talks, raising awareness of case management continue to take place across the Region by the Case Manager & V&A Manager to support staff and raise awareness, it is planned to establish regular interaction with staff directly affected by incidents of V&A. With the aim of improving the help and support available to staff.

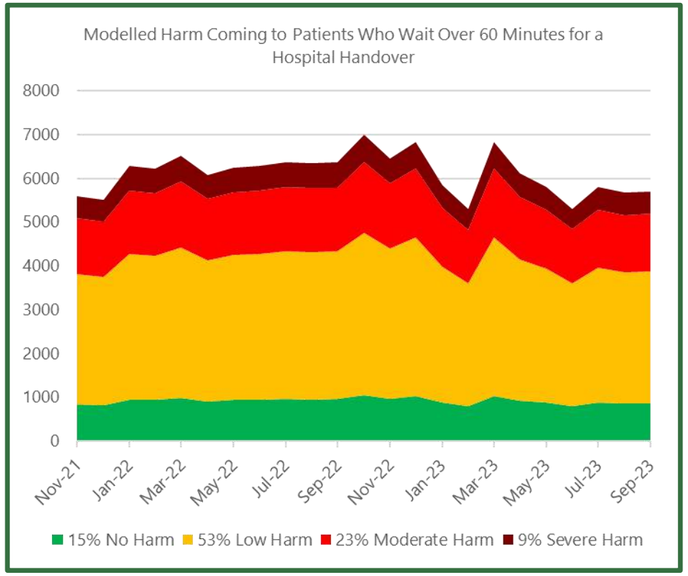
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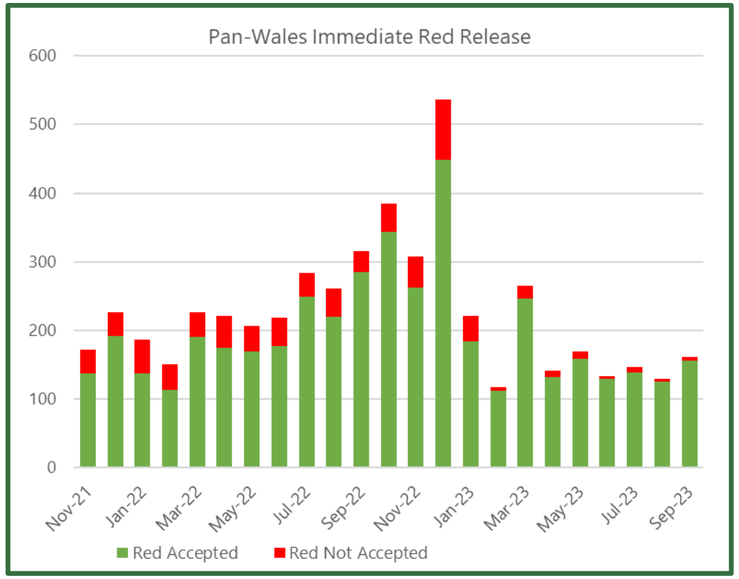
**NB: Data correct on the date and time it was extracted; therefore, these figures are subject to change*

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

(Responsible Officer: Andy Swinburn) TBD FPC







Analysis

In September 2023, 151 ambulances were stopped due to Clinical Safety Plan (CSP) alternative transport and 628 were stopped as a result of CSP 'Can't Send' options. In addition, 9,284 ambulances were cancelled by patients (including patients refusing treatment at scene) and 380 patients made their way to hospital using their own transport.

There were 608 requests made to Health Board EDs for immediate release of Red or Amber 1 calls in September 2023. Of these 156 were accepted and released in the Red category, with 5 not being accepted. Further to this, 156 ambulances were released to respond to Amber 1 calls, but 291 were not.

The graph in the bottom left shows that in September 2023 of the 5,710 patients who waited outside an ED for over an hour to be handed over to the care of the hospital, the Trust could assume that 15% (857 patients) would experience no harm, 53% (3,026 patients) would experience low harm, 23% (1,3013 patients) would experience moderate harm and 9% (514 patients) would experience severe harm.

In September 2023 CSP levels for the Trust were:



CSP Level	RED	AMBER 1	AMBER 2	GREEN	HCP
0	Business As Usual				
1	Respond	Respond	ETA - ALT Transport Respond to Exceptions		
2a	Respond	Respond	ETA - ALT Transport Respond to Exceptions		
2b	Respond	65th ETA Script ALT Transport Respond to Exceptions			
2c	Respond	65th ETA Script ALT Transport Respond to Exceptions		Can't Send Can't Send	 Pass to ROU or EMG
3a	Respond	90th ETA Script ALT Transport Respond to Exceptions	Clinical Screening	Can't Send	
3b	Respond	Clinical Screening	Can't Send		
4a	Clinical Screening		Can't Send		
4b	Clinical Screening	Can't Send			

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 Patients: Quality, Safety & Patient Experience
Patient Experience Surveys

(Responsible Officer: Liam Williams)

Self-Assessment: Strength of Internal Control: Moderate

PCC

Health & Care Standard
Health – Safe Care

September 2023		
NEPTS (137 responses)	Benchmark	Score
How long did you wait for your transport to take you home after your appointment.	85	64
Were you happy with the transport you received?	85	93
999 (4 responses)	Benchmark	Score
The 999-call taker who answered your call was reassuring.	85	100
The 999-call taker who answered your call explained what was going to happen next.	85	100
You felt confident in the call taker ability to manage your call and provide appropriate advice.	85	100
The length of time I waited for an ambulance to arrive was acceptable.	85	100
111 (4 responses)	Benchmark	Score
Do you feel your call to 111 Wales was helpful?	85	66
Did you follow the advice given to you by NHS Direct Wales?	85	100
Would you consider using NHS 111 Wales again?	85	100
WAST Overall - Friends & Family Test How was your overall experience with the service today?	Ranked from very poor to very good.	
○ Ambulance care	85.6% Good	8% Poor
○ Integrated Care (NHS 111 Wales Telephone line only)	100% Good	0% Poor
○ EMS (including CSD)	100% Good	0% Poor
○ NHS 111 Wales Online	57.14% Good	14.29% Poor
	* Where totals above do not add up to 100%, this is because a 'Do Not Know' answer was given, these are excluded from overall total.	

Analysis

Within the NEPTs survey the responses provided did not hit the benchmark in relation to the question 'How long did you wait for your transport to take you home after your appointment, therefore not providing the level of service the patient expected. However, 93% were happy with the transport they did receive.

It is acknowledged that the small number of respondents for the 999 and 111 surveys does not provide a great enough response to reflect a true patient experience picture, but work is currently underway to develop a process that will increase response rates and make them more meaningful.

Remedial Plans and Actions

We continue to make available 4 core Patient Experience surveys, covering the Trust's main service delivery areas:

- 999 EMS Response (incorporating CSD)
- Ambulance Care (NEPTS)
- NHS 111 Wales Telephony
- NHS 111 Wales Online

The Civica Experience platform provides some enhanced reporting facilities, including the ability to weight questions and produce 'Heat Maps' based on responses. A benchmark is set of 85, with aggregated scores of 85 and above representing a positive response. WAST is currently working through the requirements to add the SMS functionality within the Civica experience platform and other systems as well as strengthening information governance arrangements to increase the data experience returns.

The aim is to increase the number of patient experience feedback returns and to further integrate systems with Civica to push email/text surveys to patients. However, this requires input from the ePCR team to look at opportunities to capture patient permissions to participate in experience surveys.

These surveys are mandatory requirements; Under the Health and Social Care (Quality and Engagement) (Wales) Act 2020. WAST has a duty to secure quality in its services and must exercise its functions with a view to securing improvement in the quality of its services. The Duty of Quality includes the experiences of individuals to whom health services are provided.

Expected Performance Trajectory

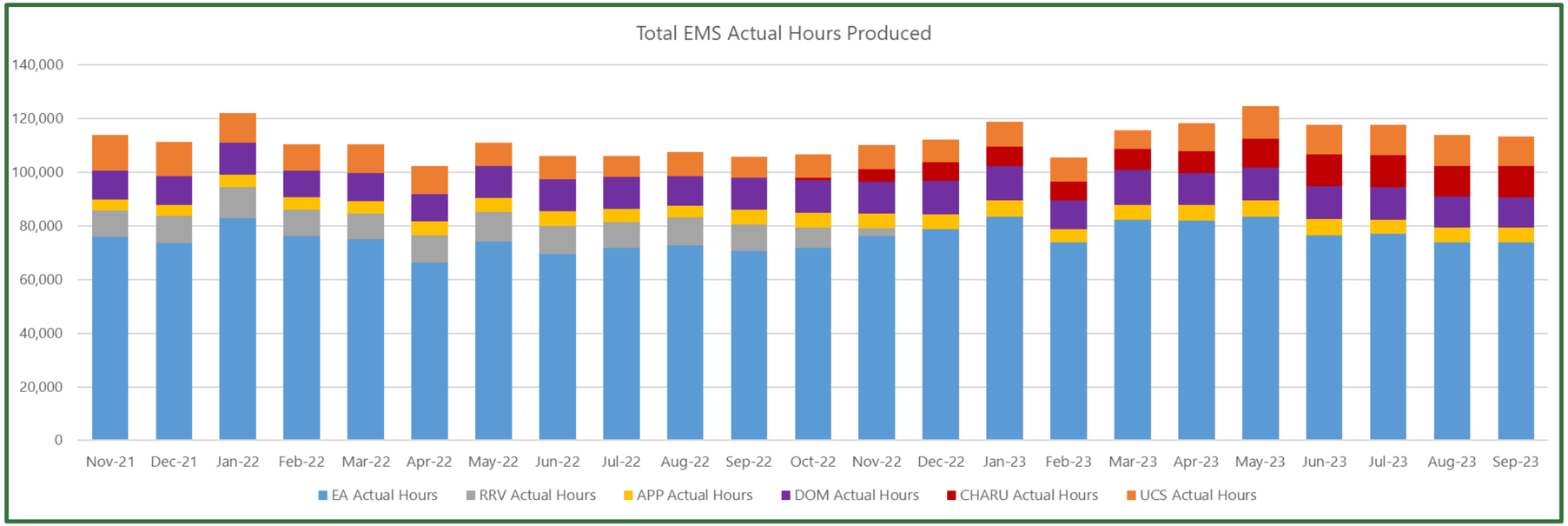
It is hoped the ongoing work will increase the number of surveys completed over the next few months to improve the overall significance of the surveys.

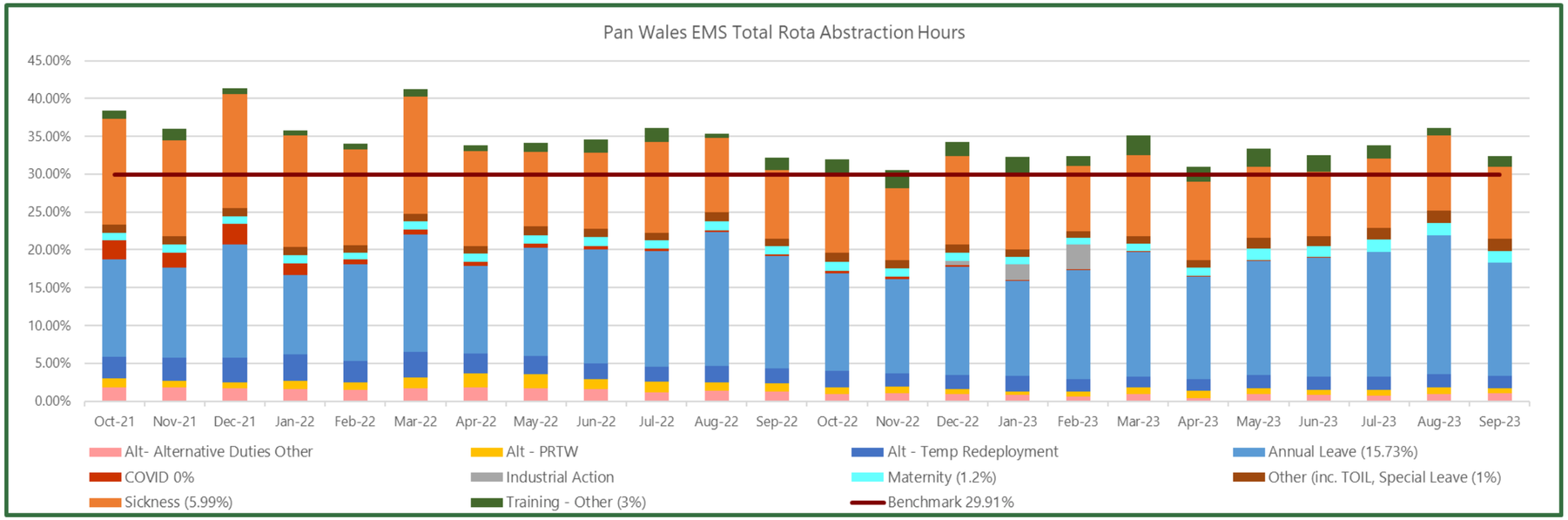
Our People
Capacity - Ambulance Abstractions and Production Indicators

(Responsible Officer: Lee Brooks)

EA Production	Abstractions
G	R

CI PCC FPC





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 September 2023, total EMS abstractions (excluding Induction Training) stood at 33.59%. This was a decrease from the 37.46% recorded in August 2023. This percentage continues to remain above the 30% benchmark figure set in the Demand & Capacity Review. The highest proportion of abstractions was due to annual leave at 14.9% followed by sickness at 9.5%. This figure for sickness abstractions for September 2023 was an increase when compared to the same month last year (9.1%).

Emergency Ambulance Unit Hours Production (UHP) was 89% in September 2023 (73,956) Actual Hours). CHARU UHP achieved 135% (11,671 Actual Hours) compared to 128% in August 2023 (this is the commissioned level not the modelled level). The total hours produced is a key metric for patient safety. The Trust produced 113,421 hours in September 2023, which is a reduction from the 113,830 hours produced in August 2023.

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 had a budgeted establishment of 1,761 FTEs for 2022-23. This is unchanged for 2023/24.

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.

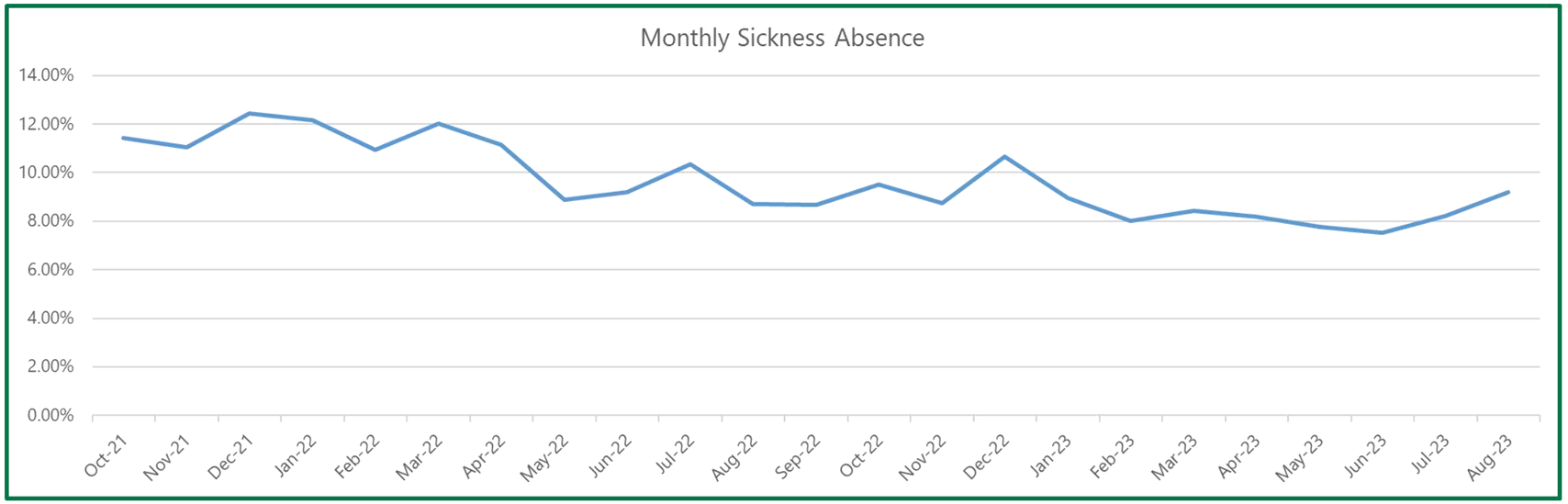
Our People
Capacity - Sickness Absence Indicators

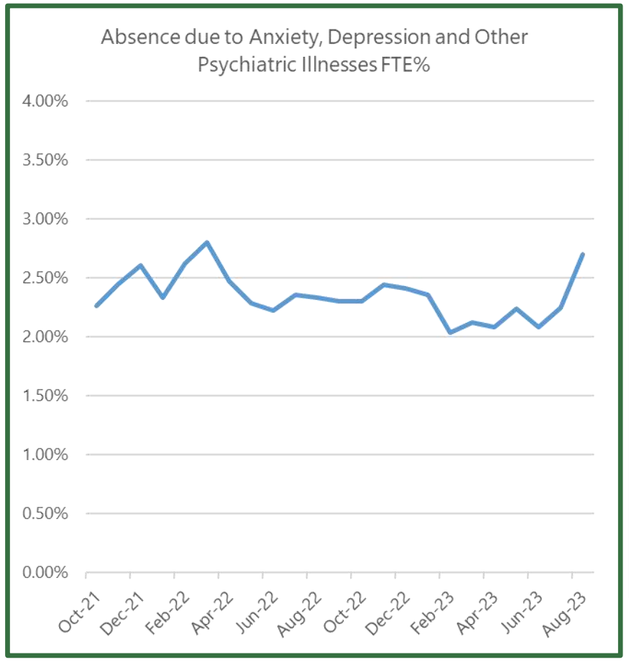
(Responsible Officer: Angela Lewis)

G

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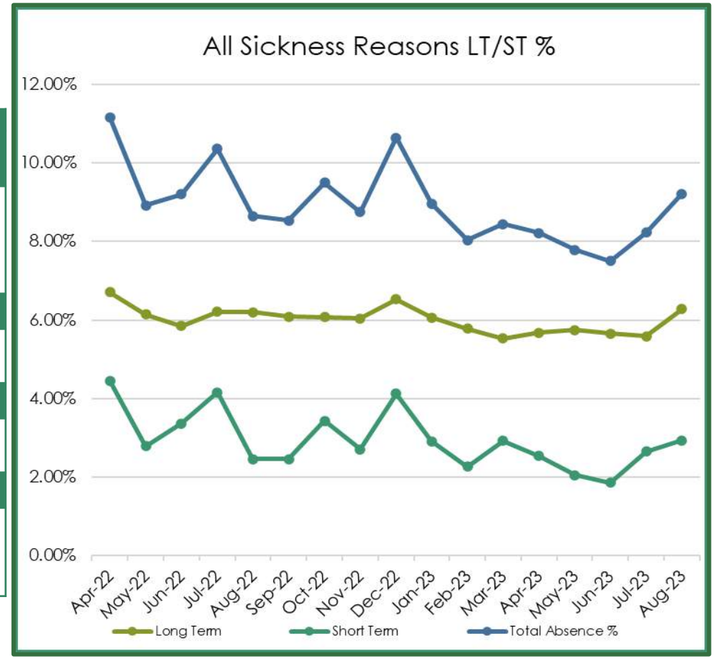
NB: Sickness data will always be reported one month in arrears.





Average working days lost per FTE (Annual)	
19.75 days	
Single month Absence %	
9.22%	
Long Term	**Short Term**
6.28%	2.93%
Mental Health	**Other MSK**
(S10 Stress/Anxiety)	(excluding Back)
2.73%	1.25%

August 2023



Analysis

There was a rise in sickness absence in August 2023, increasing from 8.23% in July 2023 to 9.21% in August 2023. Short-term absence increased slightly from 2.65% in July 2023 to 2.93% in August 2023, long-term absence, also increased from 5.59% in July 2023 to 6.28% in August.

Indicative figures for September 2023 show a decrease in short term absence to 2.90% and long-term absence to 5.81%.

The highest reason for short term absence in July & August was Gastrointestinal issues, with Anxiety/ Stress/ Depression and Cold/ Cough/ Flu as the next highest reasons. Covid related short term absences remained high in July 2023 (17 absences) and August (18 absences). Headache, Musculoskeletal and Chest/ respiratory account for the next highest levels.

Physiotherapy: 27 referrals were received in August 2023- the same volume as July 2023

Remedial Plans and Actions

- MAAW training and bitesize training sessions continue to be scheduled on a bi-monthly (MAAW) and monthly basis (Bitesize sessions).
- In line with the Improving Attendance Action Plan, the People Services Advisors have undertaken audits on short term absence occurrences within the Operations Directorate.
  - The findings of the audit displayed common themes across all areas within the Operational Directorate, including missing paperwork, no return-to-work meeting and inappropriate discretion applied.
  - Audits for all Directorates, will be undertaken on a monthly basis over the next 6 months and the People Services Team will provide targeted support to line managers on reasonable adjustments and the appropriate use of discretion in areas identified as hot spots.

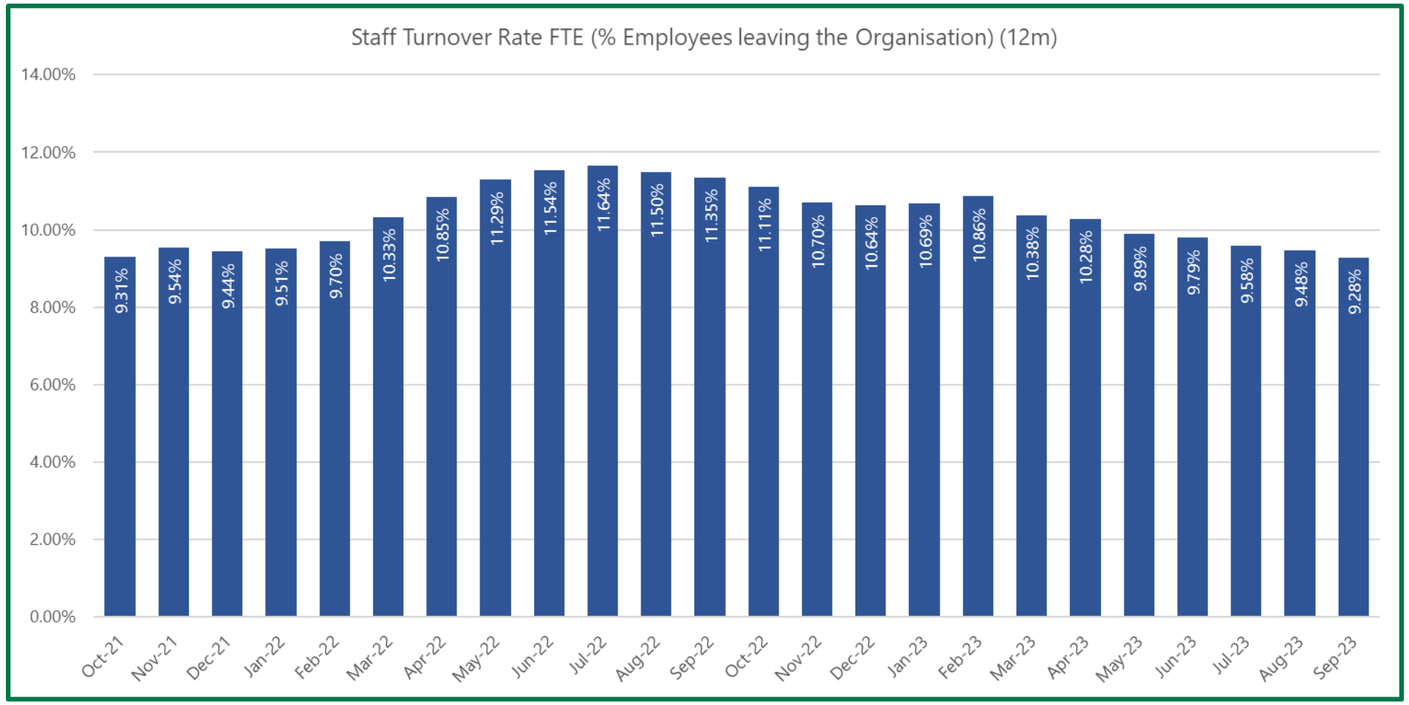
Expected Performance Trajectory

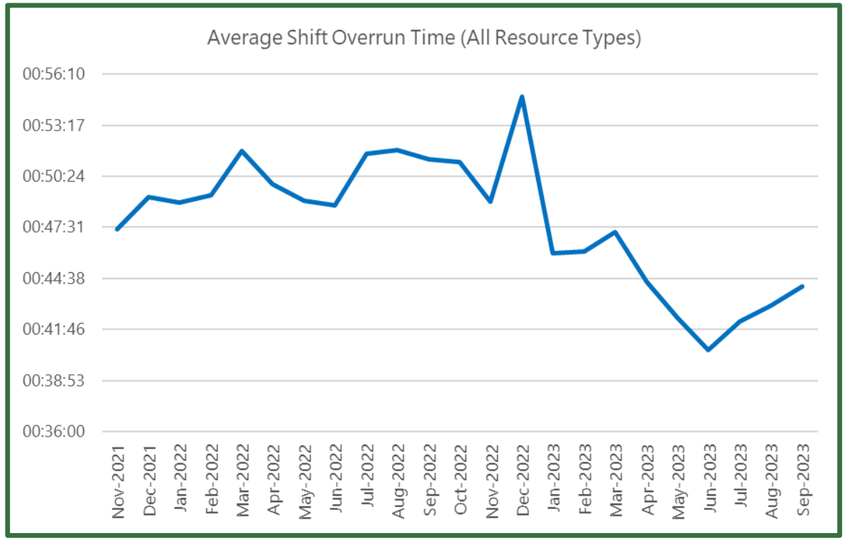
The Trust has indicated through its IMTP that sickness levels will fall in this financial year, but that there remain risks to delivery.

Our People
Capacity - Turnover

(Responsible Officer: Angela Lewis)

A





Sep-23 Org L4	FTE by Post
020 Ambulance Care L4 (NX10)	888.66
020 Emergency Medical Services L4 (DX04)	1,787.98
020 Integrated Care L4 (DX03)	441.18
020 National Operations & Support L4 (DX02)	134.45
020 Resourcing & EMS Coordination L4 (DX05)	345.69
Grand Total	**3,597.96**
Ambulance Response	**1519.19**
020 Ambulance Care L4 (NX10) ACA2/Team Leaders	**264.03**

Analysis

Staff turnover rates in September 2023 were 9.28%. Rates have gradually been declining since they peaked in July 2022, with the current monthly rate being the lowest reported within the two-year reporting period. Staff leave the Trust for a variety of reasons including promotions, relocations, culture and due to the pressures of NHS working.

WAST remains committed to colleague wellbeing, and ensuring appropriate provisions are in place to support colleagues. We have an EAP which enables our people to access support 24/7, with access to counselling. We continue to deliver workshops for colleagues on stress, and wellbeing and resilience to support them in their roles. We have had guest speakers join our Circle of Support and Women's Health Group this month, delivering talks on cold water swimming and how to deal with chronic pain. We continue to run health promotion, having focused on mental health awareness week and men's health more recently.

Shift overrun average times have been steadily decreasing between the peak of 54 minutes 55 seconds in December 2022 and June 2023, when they reached a two year low of 40 minutes 36 seconds. However, the past two months have seen small increases in shift overruns, with the average figure for September 2023 standing at 44 minutes and 12 seconds.

The Integrated Technical Planning Group are receiving monthly workforce data, and this is being integrated into a Power BI platform to enable the reader to more easily interpret the FTE table opposite.

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.

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.

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
Culture - Staff Vaccination Indicators

(Responsible Officer: Angela Lewis)

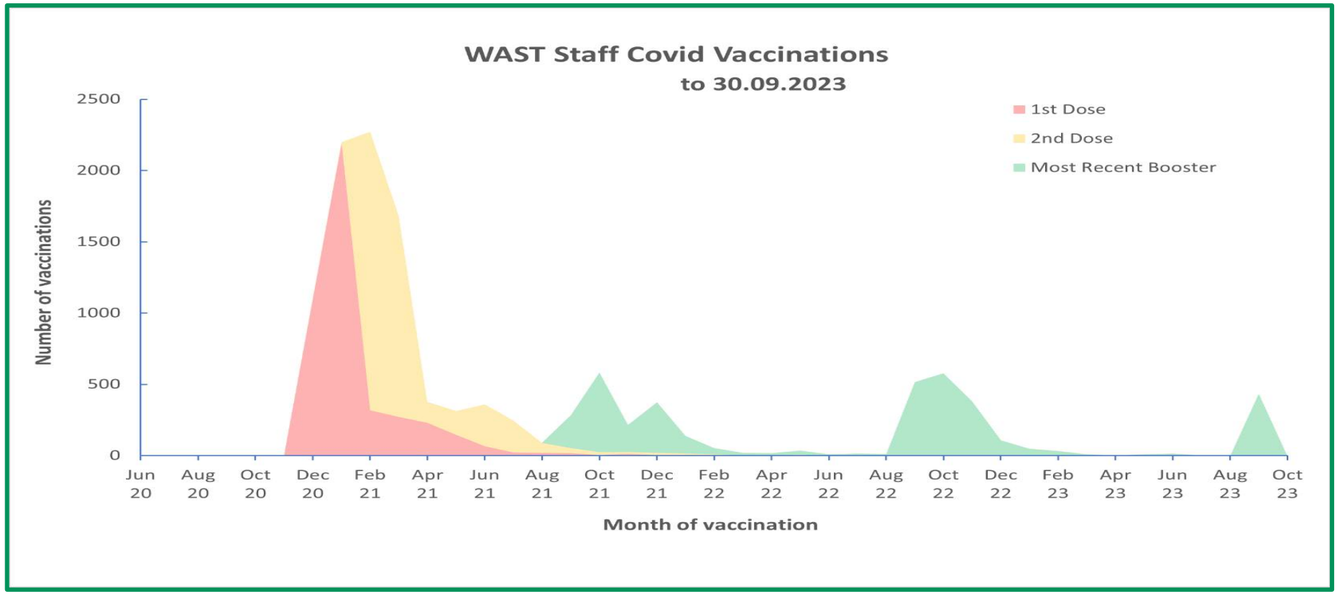
Self-Assessment: Strength of Internal Control: Moderate

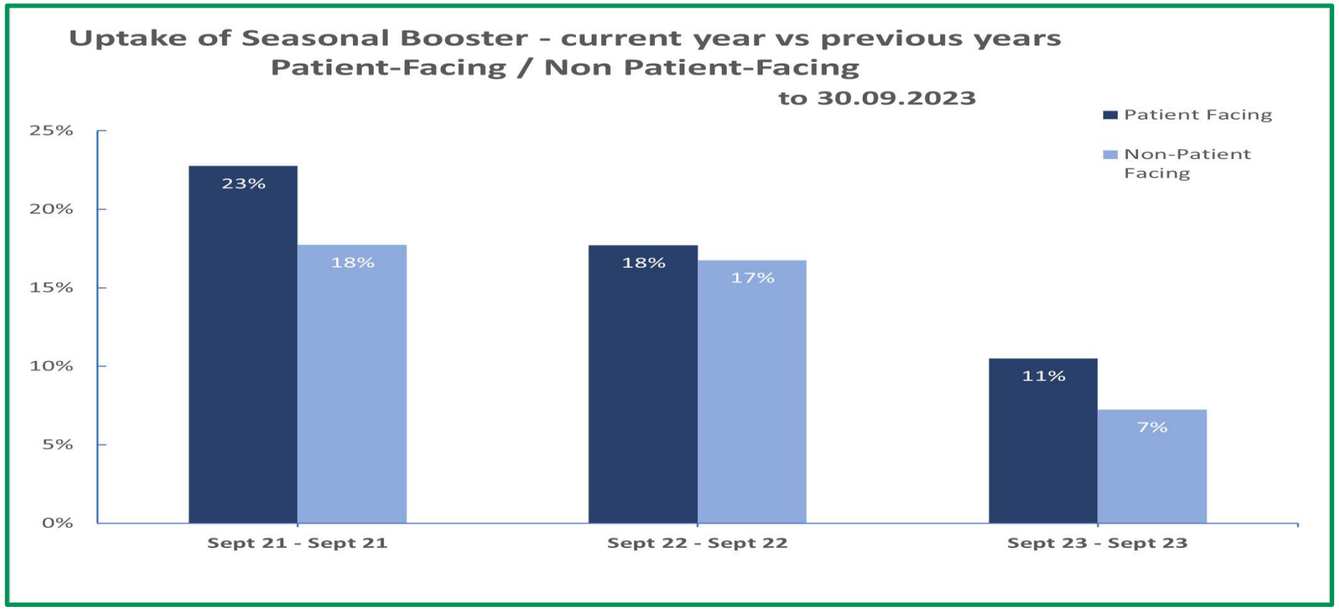
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Health & Care Standard - Health (PPI)





Analysis

Flu: The 2023-24 Flu Campaign is officially live and both Occupational Health vaccinators and Peer Vaccinators are holding clinics and undertaking ad-hoc vaccinations. So far during the campaign, 714 flu vaccines have been administered by our Vaccinators (including flu vaccines administered to PHW staff / Students / HCS staff etc.) Of these vaccines administered within the Trust, 486 have been received by WAST staff and a further 98 have been given to WAST staff elsewhere (i.e., GP surgery / COVID Booster setting) therefore, a total of 584 WAST staff have received the vaccination against flu, equating to 13.5% of the overall workforce. Additional engagement has been received from 67 WAST staff completing the Microsoft Form indicating that they have chosen to opt-out of having the flu vaccine, meaning the campaign has reached a 15.0% engagement rate so far.

COVID-19: As of the end of September 2023, 94% of all WAST staff have received both the first and second COVID-19 vaccination dose. These percentages are the same for both Patient-Facing and Non-Patient Facing Staff. 86% of all WAST staff have received at least one of the Covid-19 boosters offered in the last 3 years. Once again, this percentage is the same for both Patient-Facing and Non-Patient Facing Staff.

Since September 2023, 11% of Patient-Facing staff and 7% of Non-Patient Facing staff have received this season's Covid-19 Booster. This is compared to 18% and 17%, respectively, for the same time-period in 2022 and 23% and 18%, respectively, for the same time-period in 2021.

Remedial Plans and Actions

Flu: Though many staff have received their flu vaccine in the workplace so far, there is still a vast majority of the workforce to engage with. Therefore, in line with this campaign's Communications Plan, additional notices and posters will be circulated to staff. One poster that will be shared with staff will include information on this campaign's incentive to encourage staff to complete the Microsoft Form by entering all staff who complete the form into a prize draw at the end of the flu campaign; the prizes will comprise of 6x tier one vouchers of £250 each and 60x tier two vouchers of £20 each.

Currently 34 approved Peer Vaccinators (comprising of Healthcare Professionals in EMS, NHSD 111 and Clinical Directorate) are administering the flu vaccine and we have a number of additional staff who have been nominated to be flu Peer Vaccinators this year, so the aim is to increase the number of approved Peer Vaccinators, in order for even more vaccines to be administered in the workplace.

COVID-19: The four UK CMOs agreed it was appropriate to pause the alert level system, which was suspended on 30th March 2023.

Routine testing was also paused for all symptomatic health and social care workers, care home residents, prisoners and staff and residents in special schools during the spring of 2023.

Expected Performance Trajectory

During the 2022-23 flu campaign 1,813 flu vaccines administered by Occupational Health Vaccinators and Peer Vaccinators and 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. Consequently, by communicating further to staff and increasing the number of Peer Vaccinators, the aim is to improve on last year's uptake.

***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
Capability - PADR and Training Rates Indicators

(Responsible Officer: Angela Lewis)

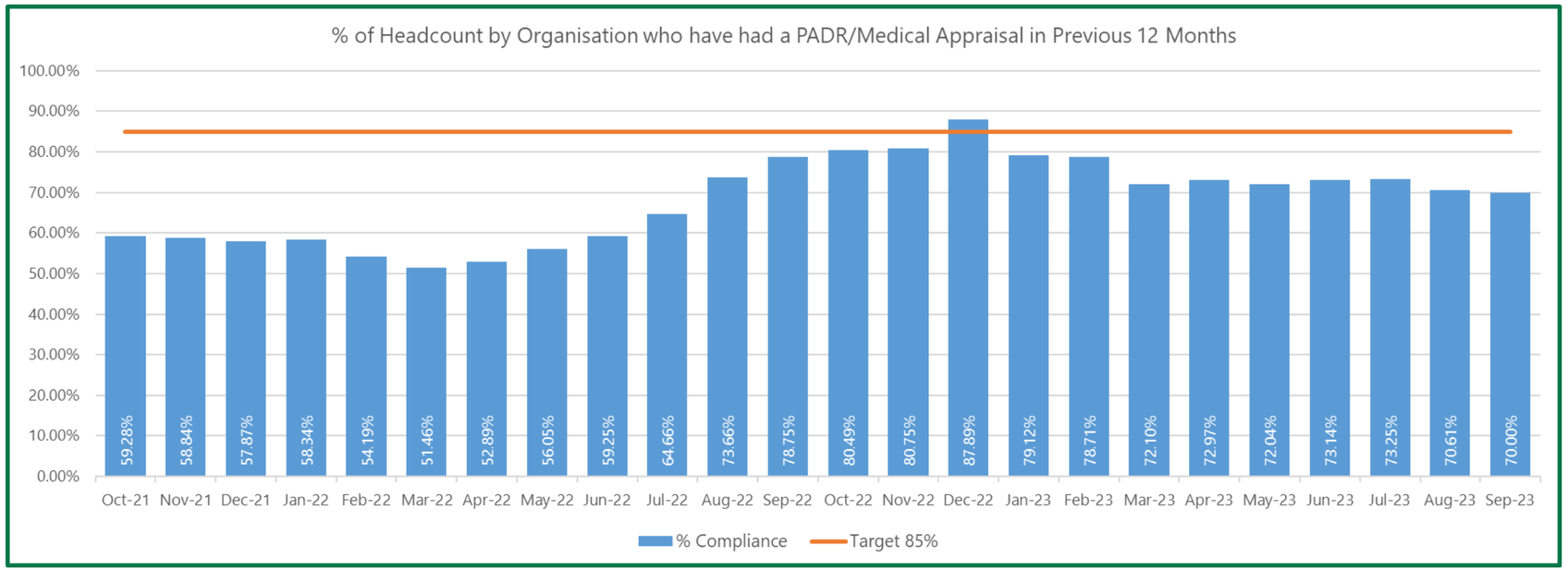
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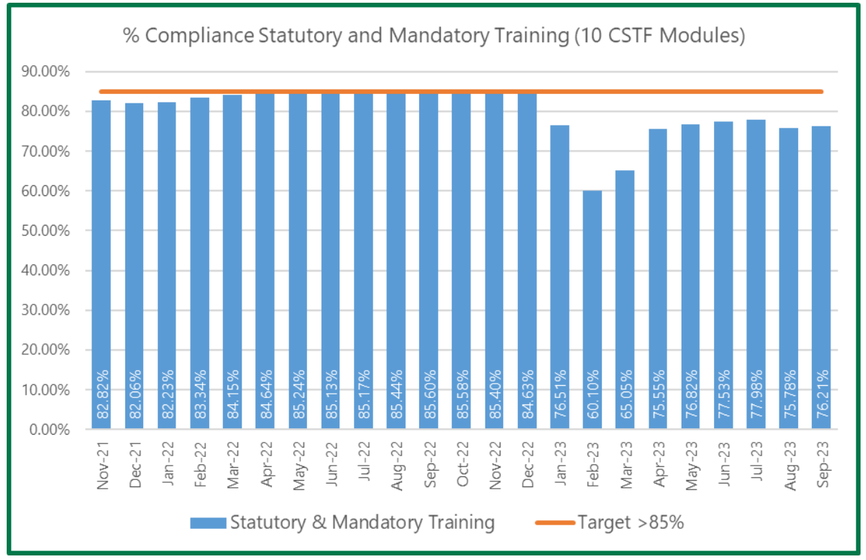
Self-Assessment: Strength of Internal Control: Strong

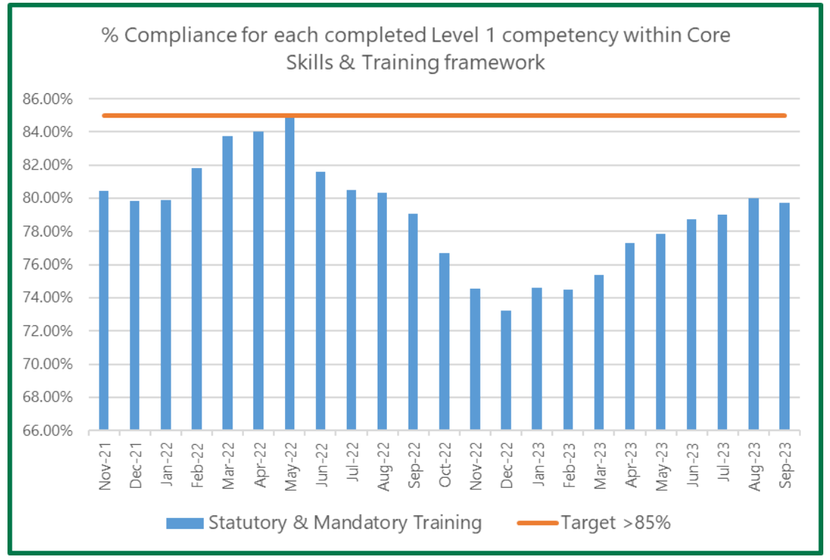
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PCC

Health & Care Standard
Health – Staff & Resources







Analysis

PADR rates for September 2023 decreased when compared to the previous month to 70% and remain below the 85% target. Over the reporting period this target has only been achieved once, in December 2022, although current rates remain higher than during the same period last year.

In September 2023 Statutory & Mandatory Training rates reported a combined compliance of 76.21%; with Safeguarding Adults (91.73%), Dementia Awareness (92.30%) and Violence Against Women, Domestic Abuse & Sexual Violence (85.31%) all achieving the 85% target. Moving & Handling (78.58%), Fire Safety (76.82%), Equality & Diversity (77.88%), Information Governance (71.40%), and Paul Ridd (57.29%) all remain below this target. The Paul Ridd course is new and is the reason for a reduction in overall compliance.

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

Throughout August the Workforce Education and Development team opened and have been assisting colleagues in using the self-service booking system for the 2023/24 Mandatory In-Service Training (MIST) annual refresher programme. As of the end of August, 685 members of staff from ACA1, ACA2, EMT and Paramedic roles have booked their face-to-face day. MIST 2023/24 commenced on the 4th of September; sufficient MIST sessions will be provided to enable all those requiring a place to secure one. MIST provision is planned to be closed mid Q3, subject to Operational pressures and demand. Communications via Yammer and Siren are in place to make people aware of dates/how to book on. Progress toward 100% compliance is tracked and communicated throughout the MIST 'window' via a combination of update reports and presentations detailing performance and gain assurance that under-performance will be addressed locally. For road-based colleagues who attend MIST sessions, the opportunity will be taken to encourage individuals to complete any E-learning statutory or mandatory areas they are not compliant with.

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

The ESR statistics at the end of July are as follows, 67.4% of operational colleagues had completed their Tail Lift Refresher Training, 55.4% if all colleagues had completed their Paul Ridd Learning Disability Awareness Training, and 43.7% of all colleagues have completed their Welsh Language Awareness.

Expected Performance Trajectory

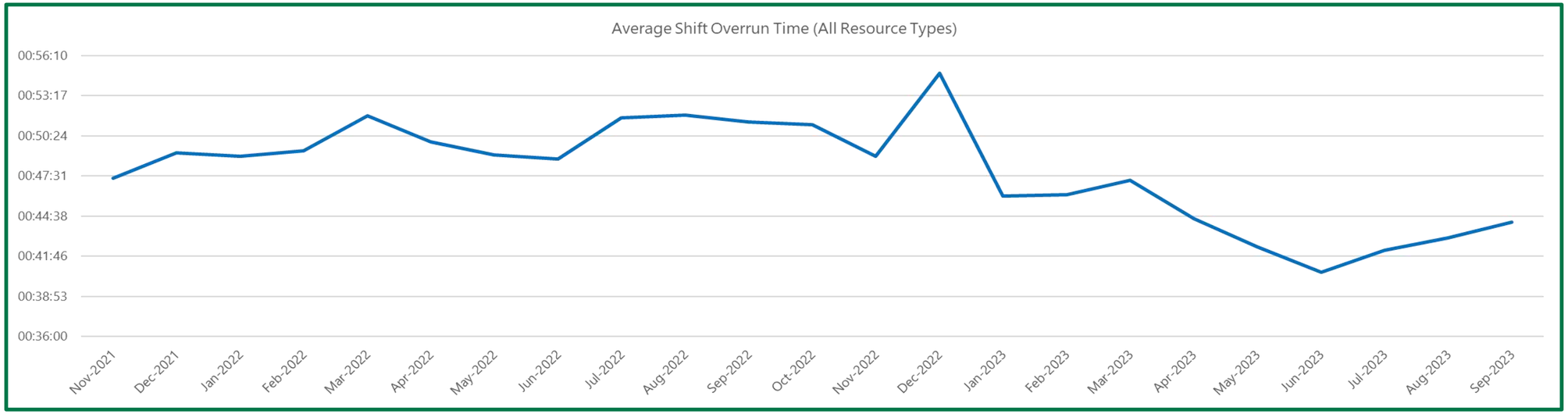
Performance is improving as compliance has risen in relation to Paul Ridd

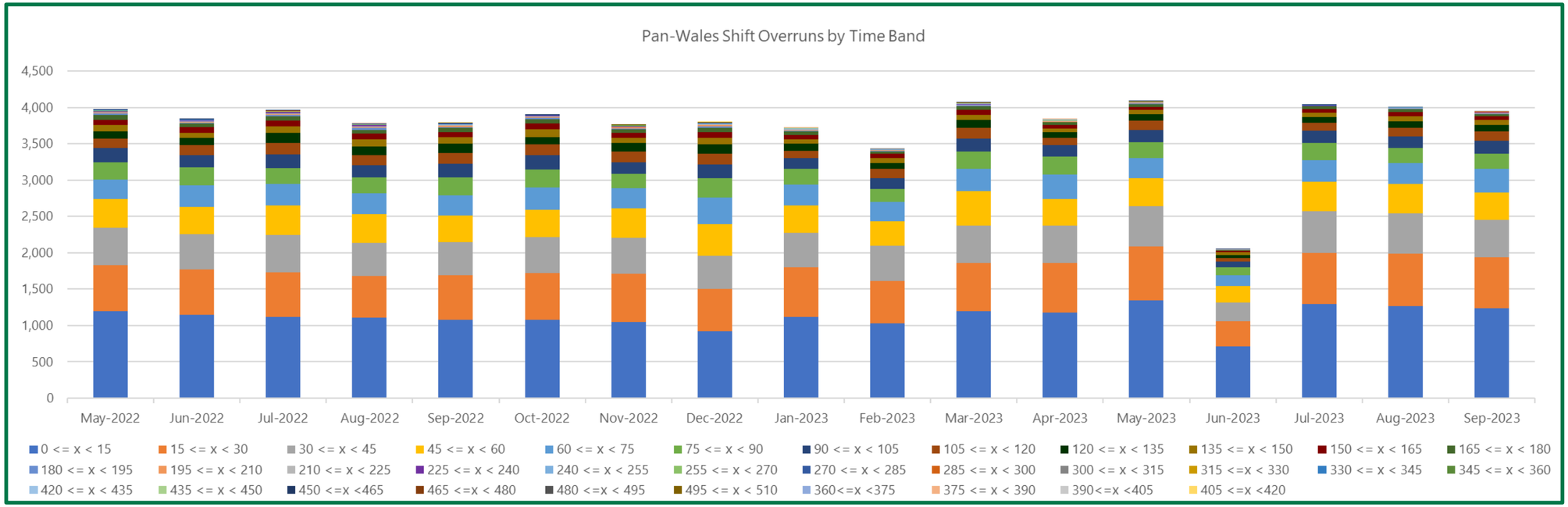
Data source: ESR

Our People
Health and Well-being – Shift Overruns

(Responsible Officer: Angela Lewis)

CI





Analysis

The average shift overrun (for all resource types) in September 2023 was 44 minutes and 12 seconds, an increase when compared to the previous month (43 minutes and 6 seconds).

The highest volume of shift overruns occur within the 0 to 60-minute category, accounting for 71.6% of the total. 21.4% fall within the 61 to 120-minute category, 5.9% in the 121 to 180-minute category, 0.6% in the 181 to 240-minute category and 0.3% in the 241 minutes and over category.

Remedial Plans and Actions

Shift overruns are a key element of staff wellbeing and work is ongoing to mitigate these in conjunction with handovers, as although not shown here there is a clear correlation.

Expected Performance Trajectory

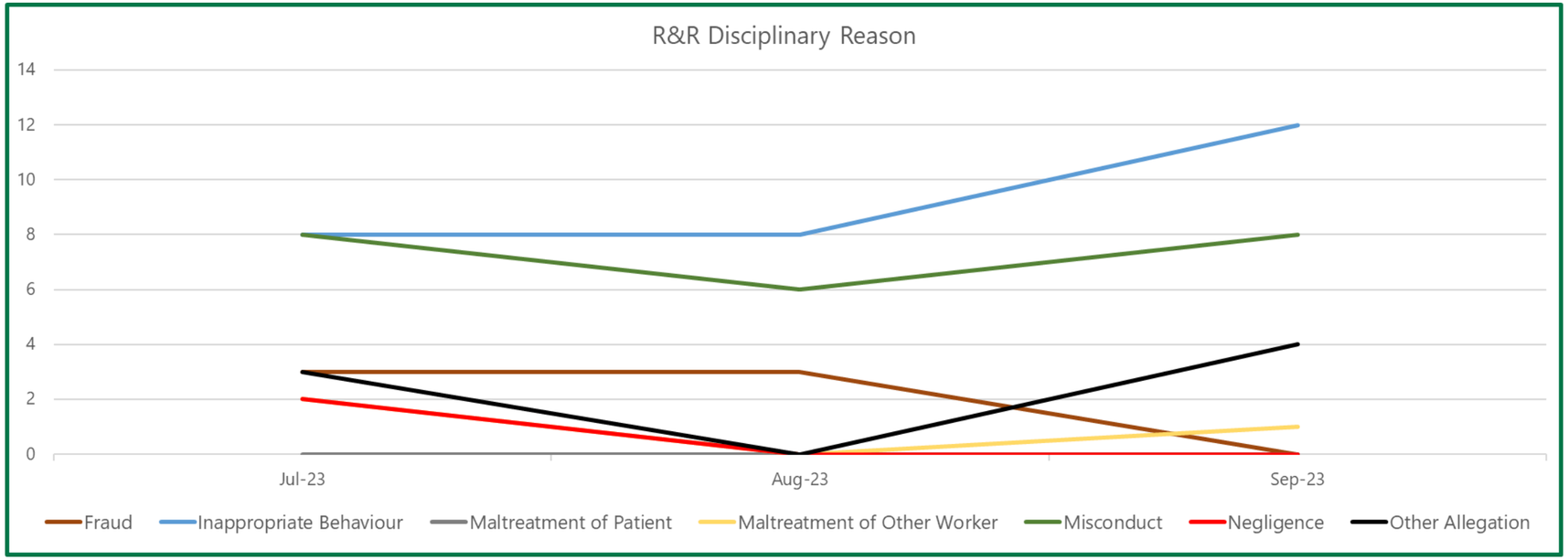
A new People and Culture Plan is due to be launched in the coming months along with an accompanying enabling framework that covers People and Culture Directorate Plans that focus on our people.

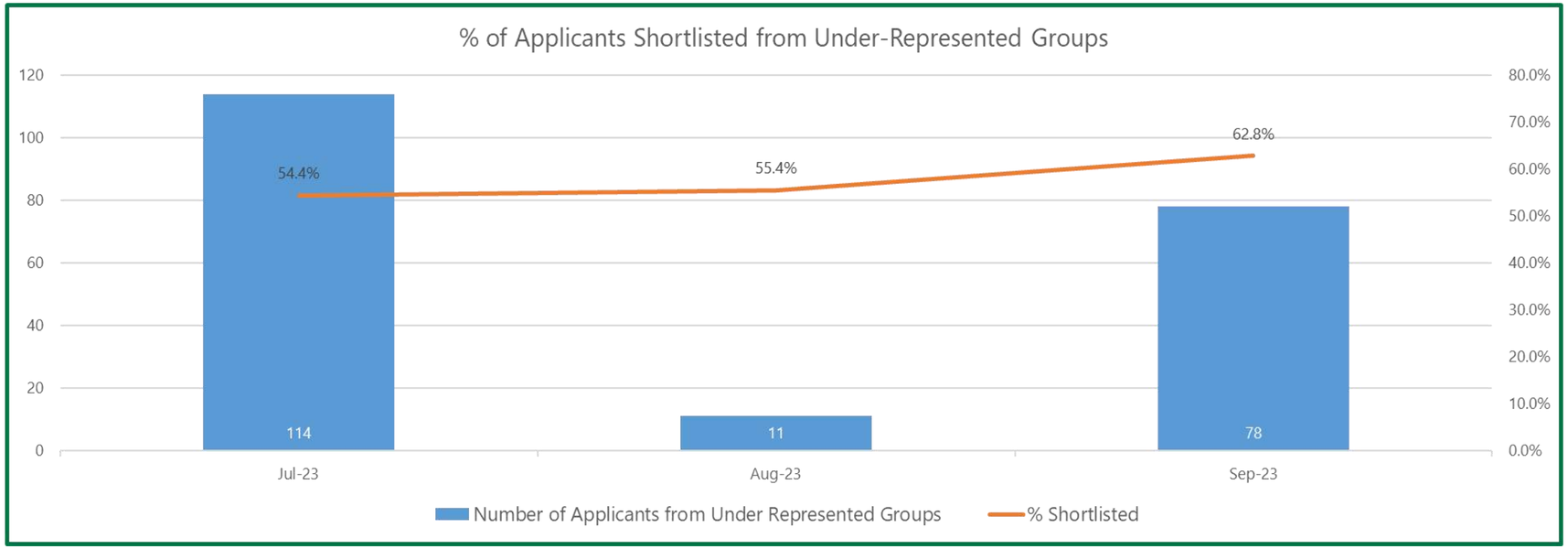
Our People
Culture – Number of R&R Disciplinary Hearings and Number of Applicants Shortlisted from Under-Represented Groups

(Responsible Officer: Angela Lewis)

Self-Assessment: Strength of Internal Control: Moderate

PCC





Analysis

There were 28 open formal disciplinary cases recorded at the end of September 2023, an increase compared to the month of August 2023 where 23 open cases were recorded. Of these Disciplinary cases, the majority were due to allegations of inappropriate behaviour, followed by misconduct.

There were 7 open formal Respect and Resolution cases submitted by employees, which was a decrease to the 13 cases that were recorded in August. The majority of these cases were categorised as "Policy and Procedure".

In September 2023, 62.8% of all applications from under-represented groups made it through shortlisting and were invited for interview. This was an increase from the 55.4% in August 2023, while the volume of applications rose from 11 to 78.

Of the 78 total applications from under-represented groups in September 2023, 38 were in the category of Ethnicity, 18 within Disability and 22 within sexual Orientation.

Remedial Plans and Actions

Continue to monitor. The Trust has a substantial programme of work in place, connected to behaviours.

Expected Performance Trajectory

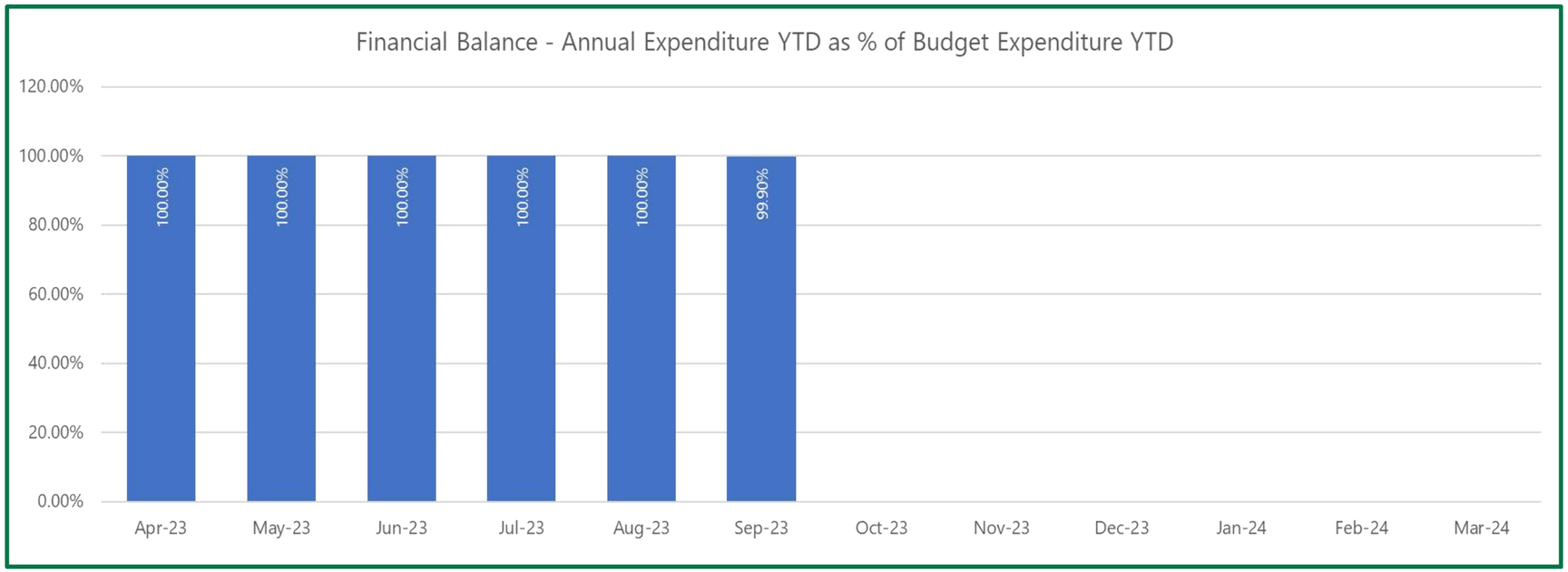
Continue to monitor levels, no trajectory for this measure.

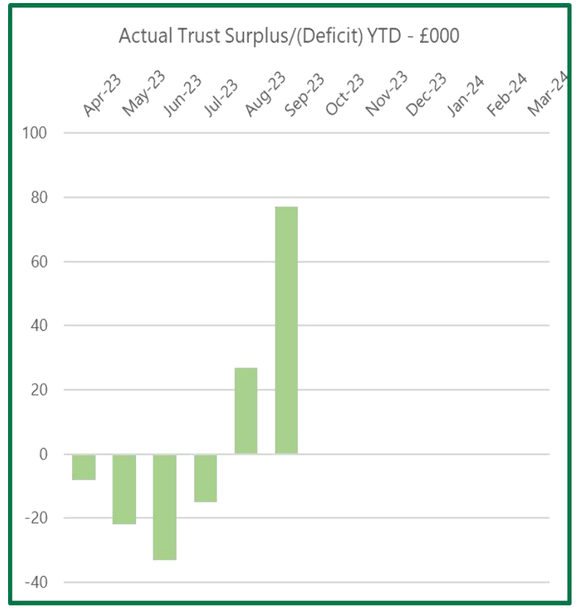
Finance, Resources and Value
Value - Finance Indicators

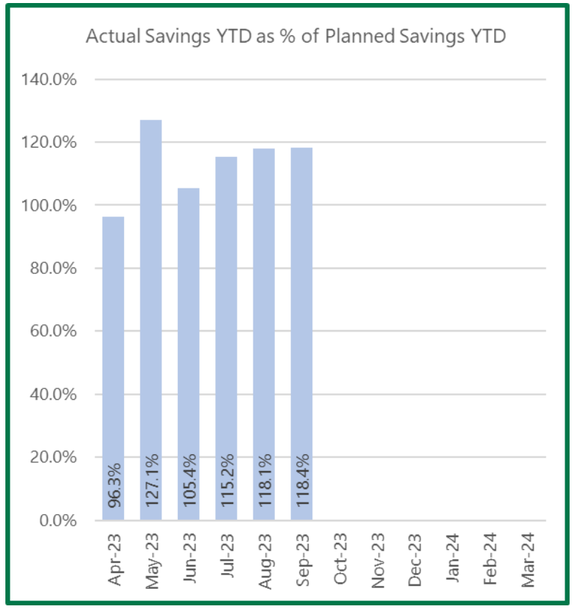
(Responsible Officer: Chris Turley)

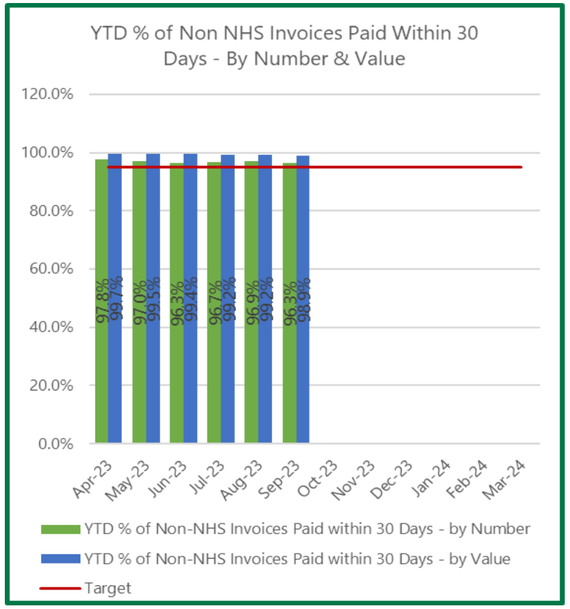
G

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Analysis

The reported outturn performance at Month 6 is a surplus of £77k, with a forecast to the year-end of breakeven.

For Month 6 the Trust is reporting planned savings of £2.615m and actual savings of £3.097m (an achievement rate of 118.4%).

The Trust's cumulative performance against PSPP as at Month 6 is 96.3% against a target of 95%.

At Month 6 the Trust is forecasting achievement of both its External Financing Limit and its Capital Resource Limit.

Remedial Plans and Actions

The Trust's financial plan for 2023-26 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 2023-26 financial plan was submitted to WG following Board sign off on 31st March 2023.

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:

- 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 via the Financial Sustainability Program (FSP);

Expected Performance Trajectory

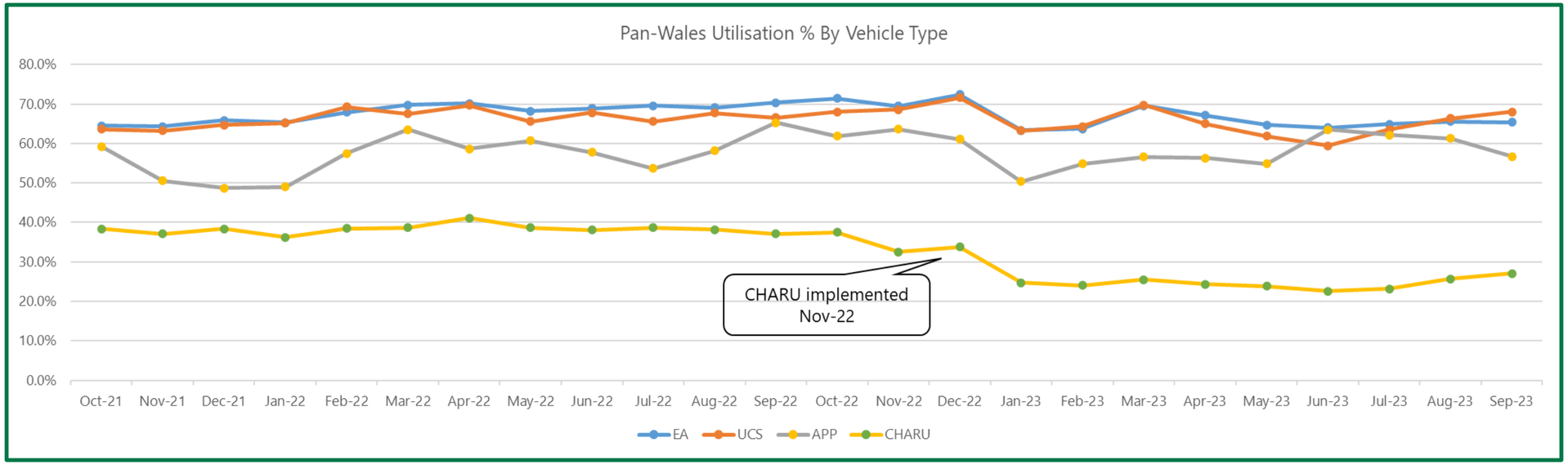
The expectation is that the Trust will continue to meet its statutory financial duties, as outlined in its IMTP for the 2023/24 financial year; however, it is expected that the Trust will continue to operate in a challenging financial environment and will need to deliver further significant level of savings into the 2024/25 financial year.

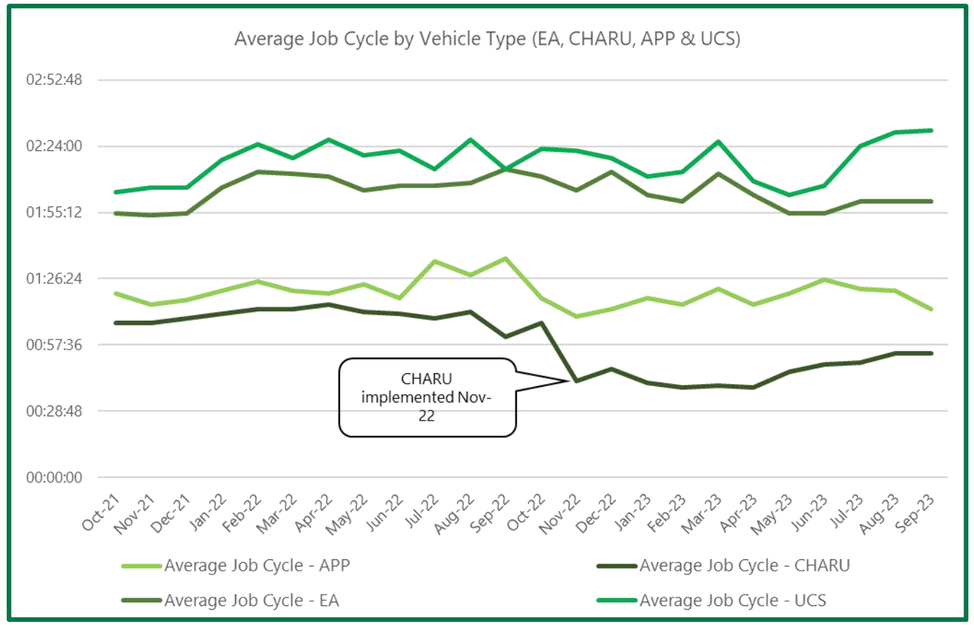
Finance, Resources and Value
EMS Utisation & Average Job/Shift Times

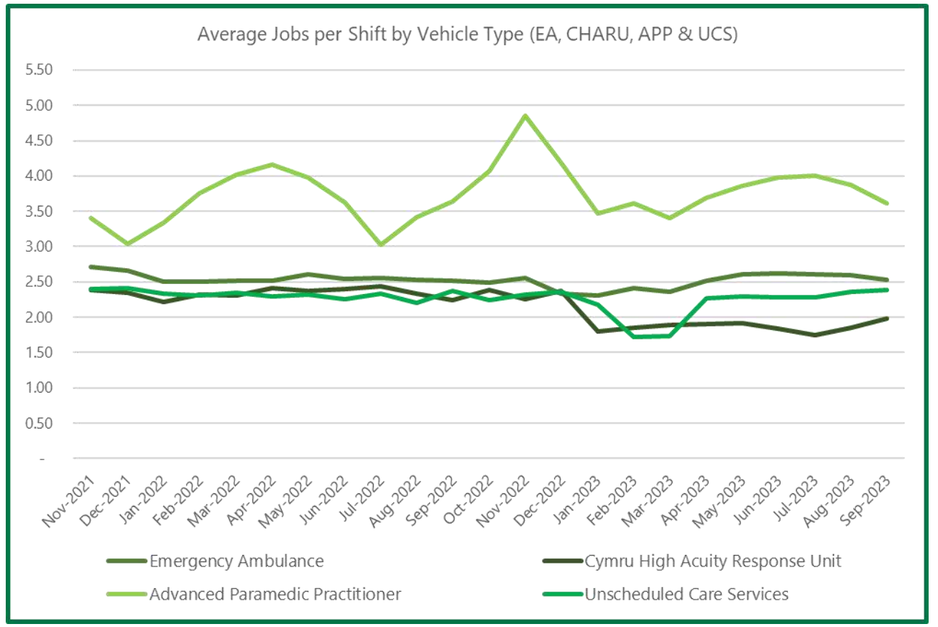
(Responsible Officer: Lee Brooks)

Utilisation
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Analysis

Pan Wales Utilisation metrics in September 2023 was 57.5% for all vehicles types, a slight increase from 57.1% in August 2023. UCS achieved the highest rate during the month at 68% while EA was at 65.4%. Both have seen a generally stable trend over the past two years. The optimal utilisation rate for EAs needs to lower so that they are free to respond to incoming calls.

As demonstrated in the bottom left graph, the average job cycle in September 2023 remained static at 2 hours for EA, and CHARU, increased slightly for UCS and decreased for APP. UCS crews saw their average increase to 2 hours 31 minutes, CHARUs remained at 54 minutes while APP reduced from 1 hour 22 to 1 hour 13.

Overall average jobs per shift was 2.41 in September 2023, a slight decrease from the 2.42 recorded in August 2023. APPs attended on average 3.61 jobs per shift, EAs 2.53 jobs per shift, UCS crews 2.39 jobs per shift and CHARU's 1.98 jobs per shift.

Overall average jobs per shift has remained relatively static with APP & CHARU resources having a job cycle that is half that of conveying resource.

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.

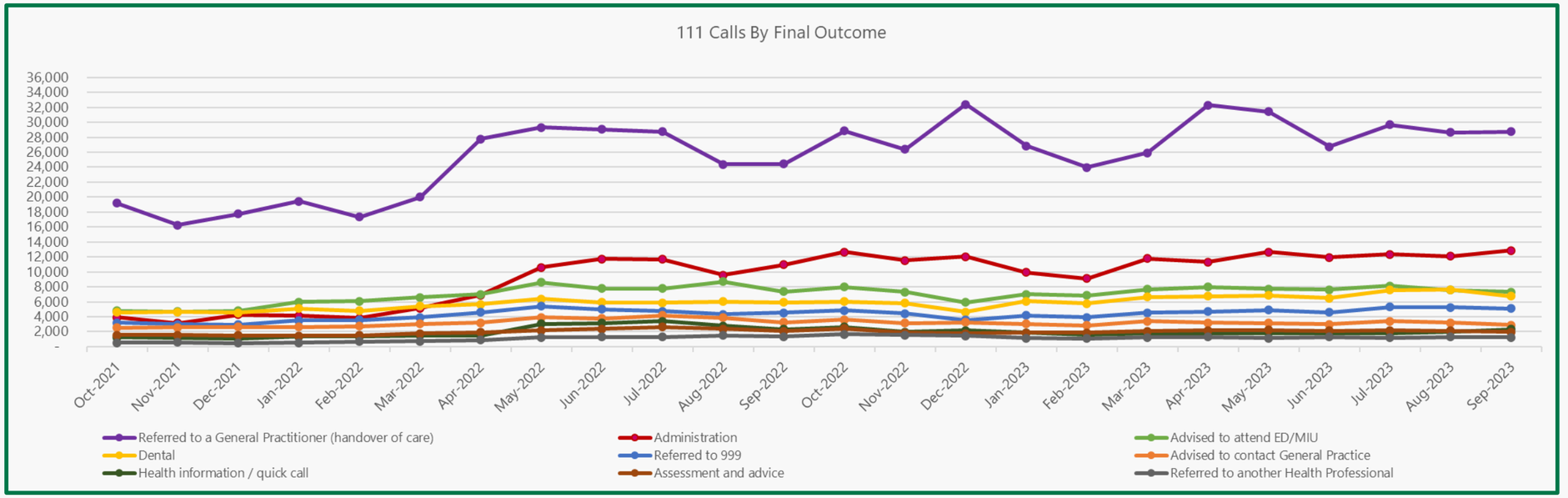
Partnerships / System Contribution
NHS111 Hand Off Metrics and NHS111 Consult & Close Indicators

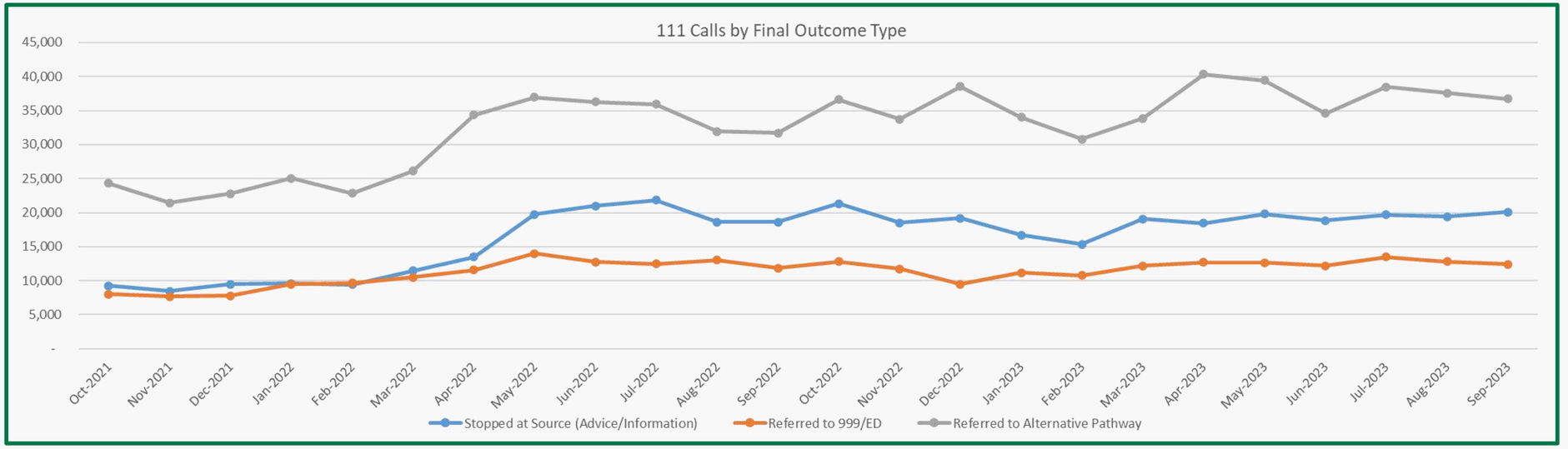
(Responsible Officer: Lee Brooks)

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Influencing Factors – Demand and Clinical Hours Produced





Analysis

69,217 calls were received into the 9 categories displayed in the graph opposite during September 2023, a decrease compared to the 69,799 received during August 2023. This was above the average volume of calls seen over the past 12 months (67,124).

In September 2023, calls Referred to a General Practitioner (handover of care) continued to be the top outcome for NHS111 accounting for 42% of all calls.

As the bottom graph highlights, in September 2023, 20,074 calls into 111 were provided with information or advice, with no onward referral.

Remedial Plans and Actions

There is currently a 111 Measures Task and Finish Group. This is a collaborative meeting between WAST its commissioners and DCHW. The focus is the development of a Nationally reportable 111 data set. Similar to what is currently in place for ASIs. Part of this work involves looking at the reporting of disposition final outcomes.

Expected Performance Trajectory

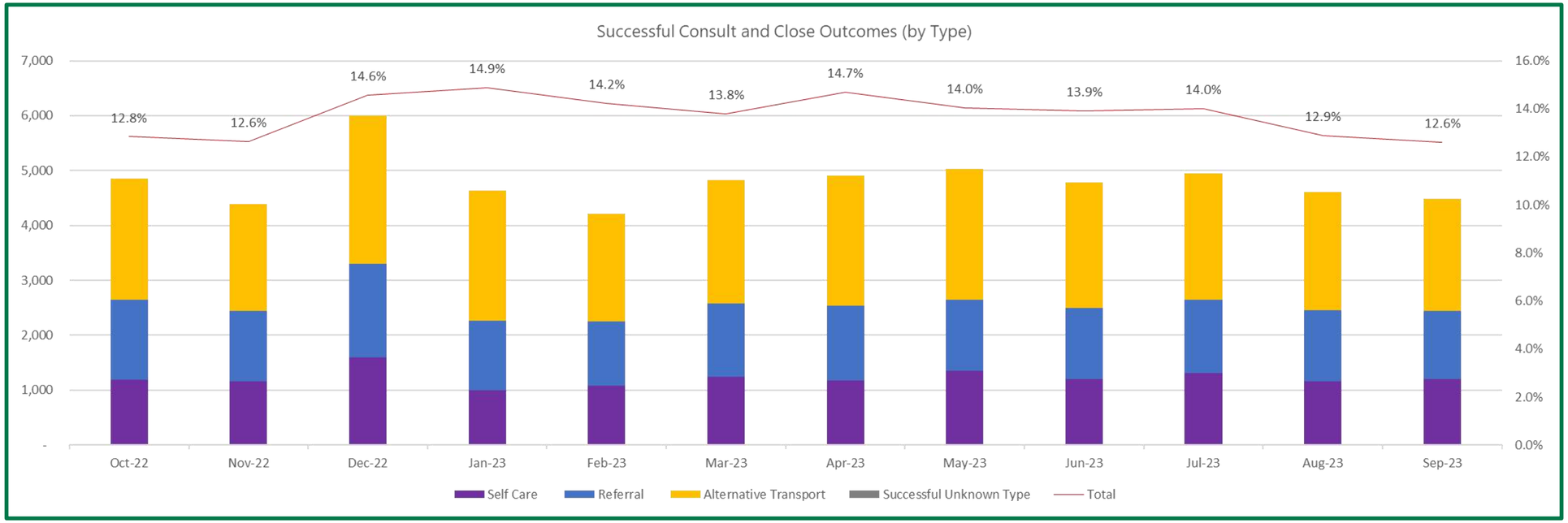
No performance trajectory is set at this time, as the Trust develops is measures and systems around these metrics. Once these have been developed there will be an opportunity to develop benchmarks. The focus remains to shift left, where it is clinically safe and appropriate to do so.

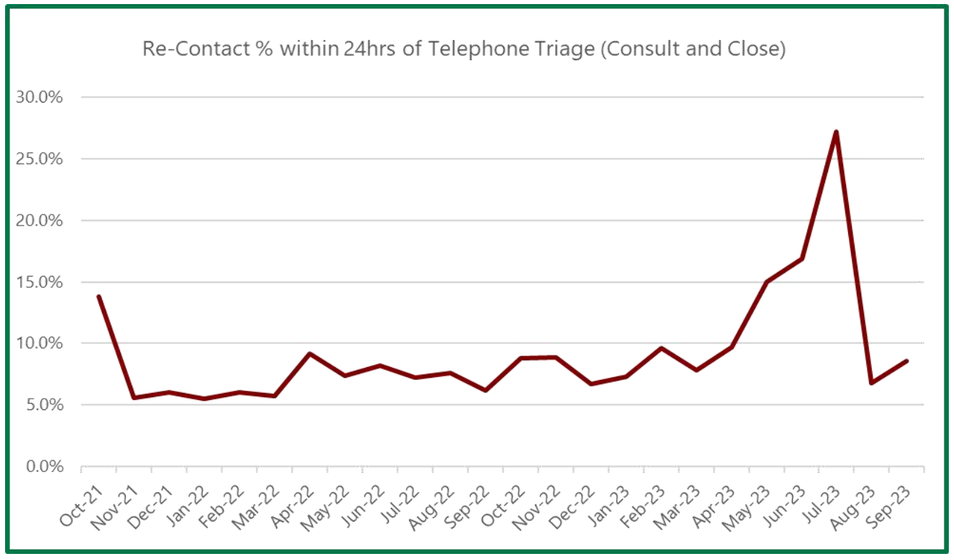
Partnerships / System Contribution
Consult & Close Indicators

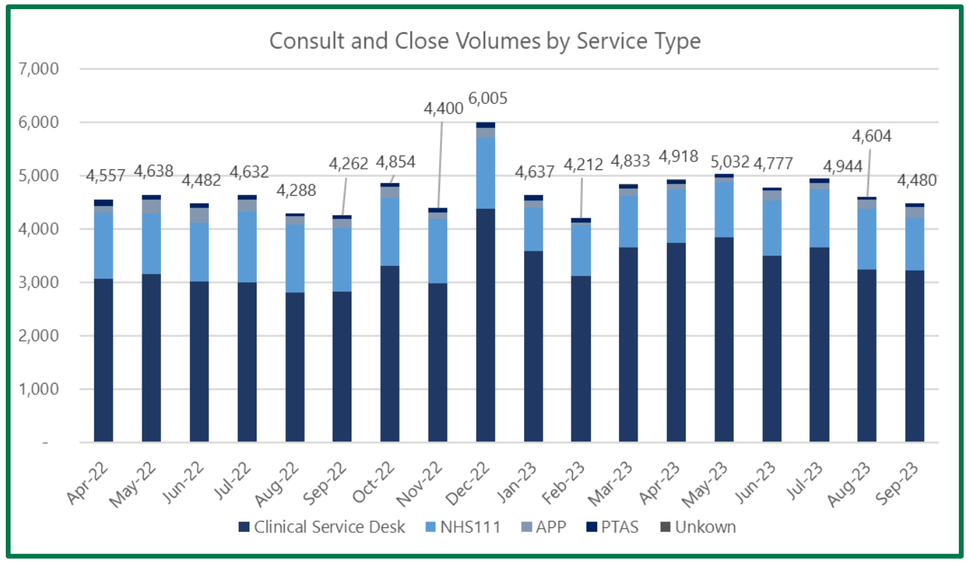
(Responsible Officer: Lee Brooks)

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Analysis

Consult and Close, with contributions from Clinical Support Desk (CSD) (9%), NHS111 (2.8%), WAST APP (0.6%) and the Health Boards using Physician Triage and Streaming Service (PTAS) (0.2%) achieved 12.6% in September 2023. This was a decrease on the 12.8% seen during August 2023 and remained short of the new 17% target. In September 2023, the number of 999 calls resulting in a Consult and Close outcome was 4,408, down from 4,604 in August 2023.

Of the calls successfully closed in August 2023, 1,208 patients received an outcome of self-care; 1,236 patients were referred to other services (including to Minor Injury Units and SDEC) and 2,044 were advised to seek alternative transport services in order to acquire treatment.

Re-contact rates in September 2023 were 8.6%, a slight increase on the 6.8% seen in August 2023. The sharp spike in July 2023 has been identified to be repeat callers.

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.
- Commissioners have recently completed an independent review of the CSD, which has identified a range of management actions. The Trust will formally respond to the review in advance of November's EASC. Ops SLT is also focused on corrective actions to improve performance.

Expected Performance Trajectory

An improvement is expected, but the 17% ambition looks more distance currently.

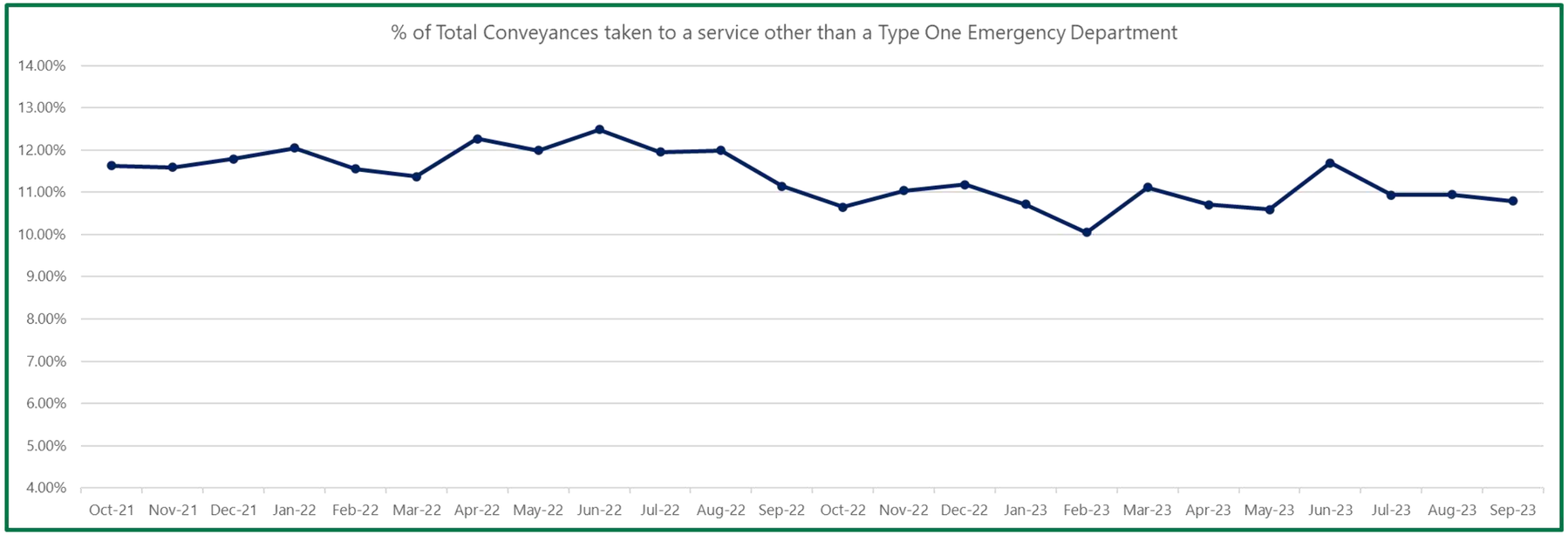
Partnerships / System Contribution
Conveyance to ED Indicators

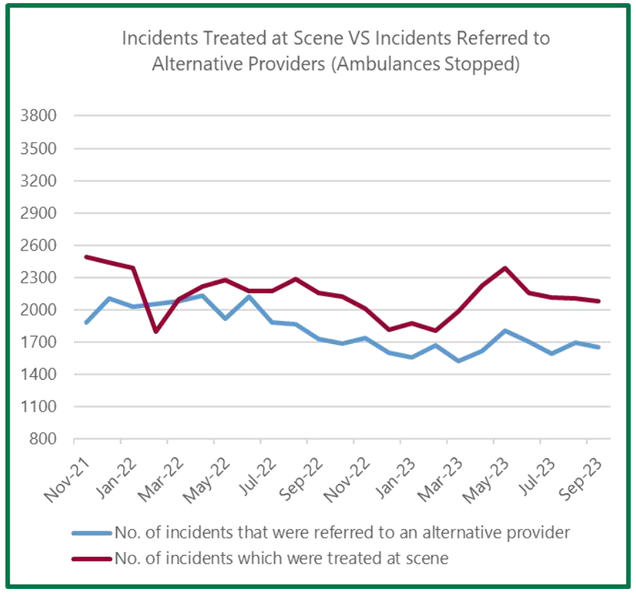
(Responsible Officer: Andy Swinburn)

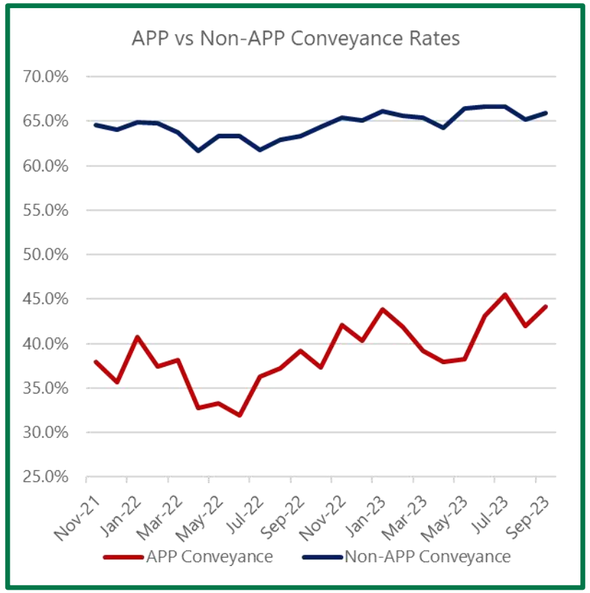
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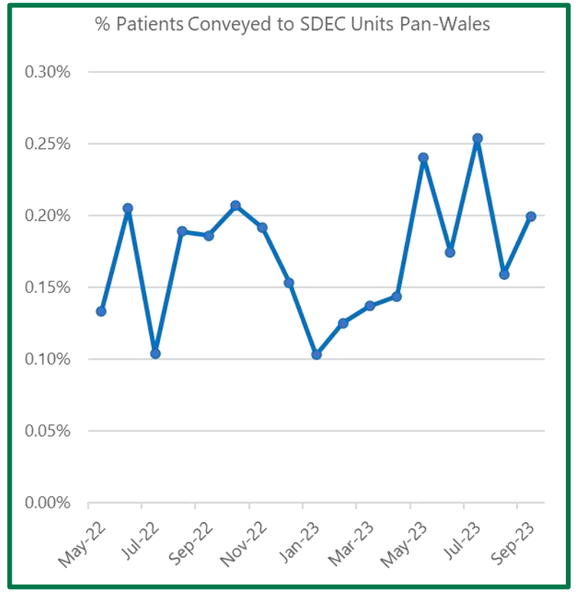
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Ministerial Measure









Analysis

In September 2023 10.79% of patients (1,579) were conveyed to a service other than a Type One ED, while 36.65% of patients were conveyed to a major ED, as a percentage of verified incidents.

The combined number of incidents treated at scene or referred to alternate providers decreased slightly, from 3,752 in August 2023 to 3,642 in September 2023.

APP conveyance rates increased to 44.2% in September 2023, which is in line with the general increase seen in rates in recent months due to increased levels of CSP, which results in patients choosing to transport themselves to the ED, with only patients who do not have this ability (usually sicker) receiving a response.

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 0.5%. 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 such as 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 starting position of 67).

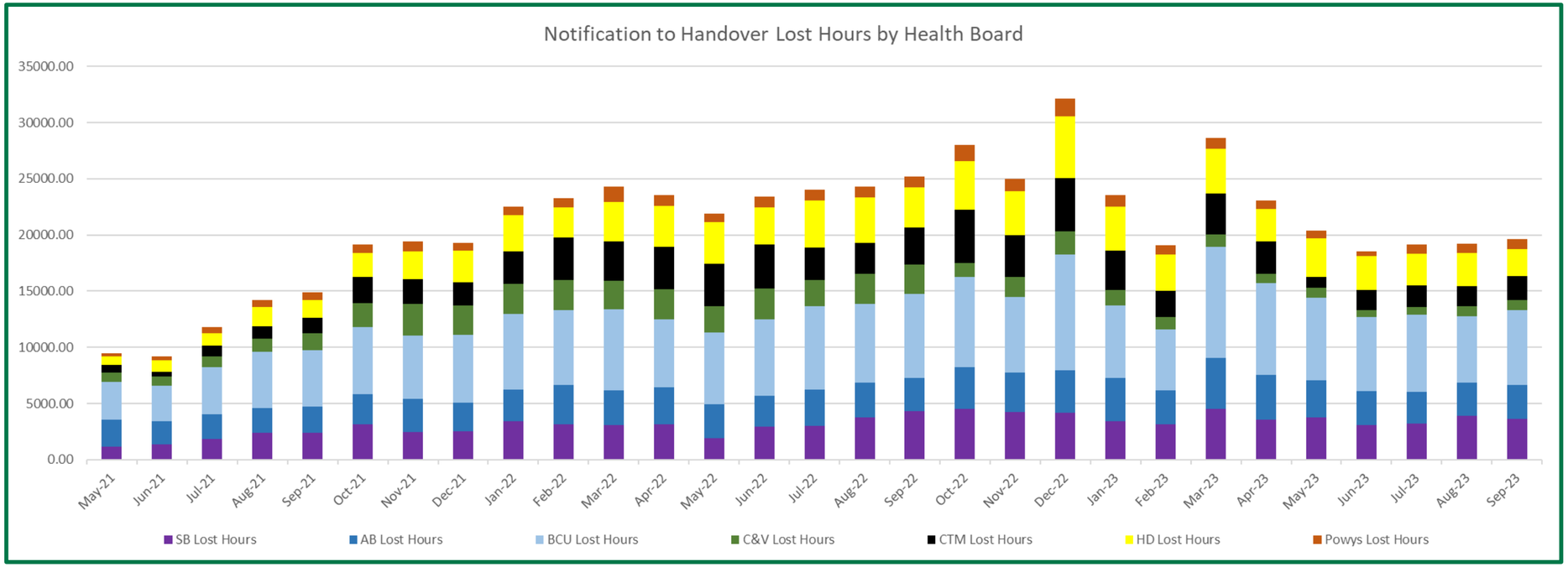
Partnerships / System Contribution Handover Indicators

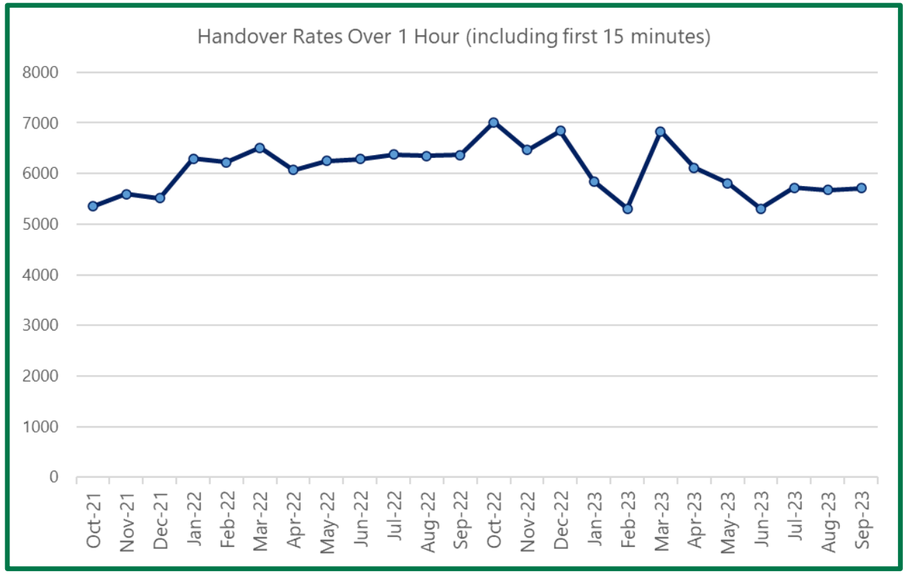
(Responsible Officer: Health Boards)

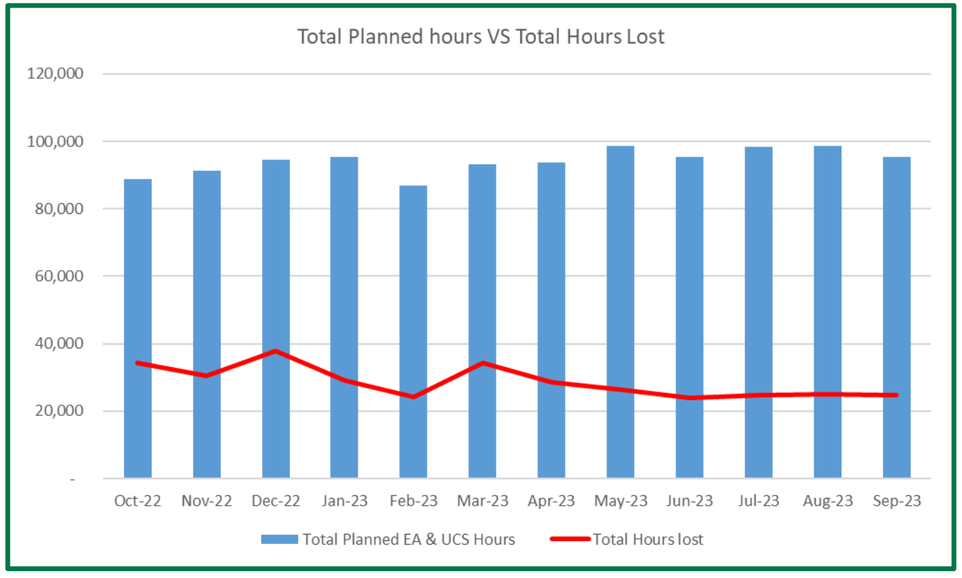
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Analysis

276,394 hours were lost to Notification to Handover, i.e., hospital handover delays, over the last 12 months (Oct-22 to Sept-23), compared to 270,267 over the same timeframe the previous year. 19,610 hours were lost in September 2023, an increase from the 19,233 lost in August 2023. This is the third month in a row the figure has increased, following a significant decline between March and June 2023.

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

- Morriston Hospital (SBUHB) at 3,515 lost hours
- The Grange University Hospital (ABUHB) at 2,878 lost hours
- Wrexham Maelor Hospital (BCUHB) at 2,616 lost hours
- Glan Clwyd Hospital (BCUHB) at 2,526 lost hours

Notification to handover lost hours averaged 654 hours per day during September 2023 compared to 620 hours a day in August 2023.

In September 2023, the Trust could have responded to approximately 6,391 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).

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.*

Partnerships / System Contribution

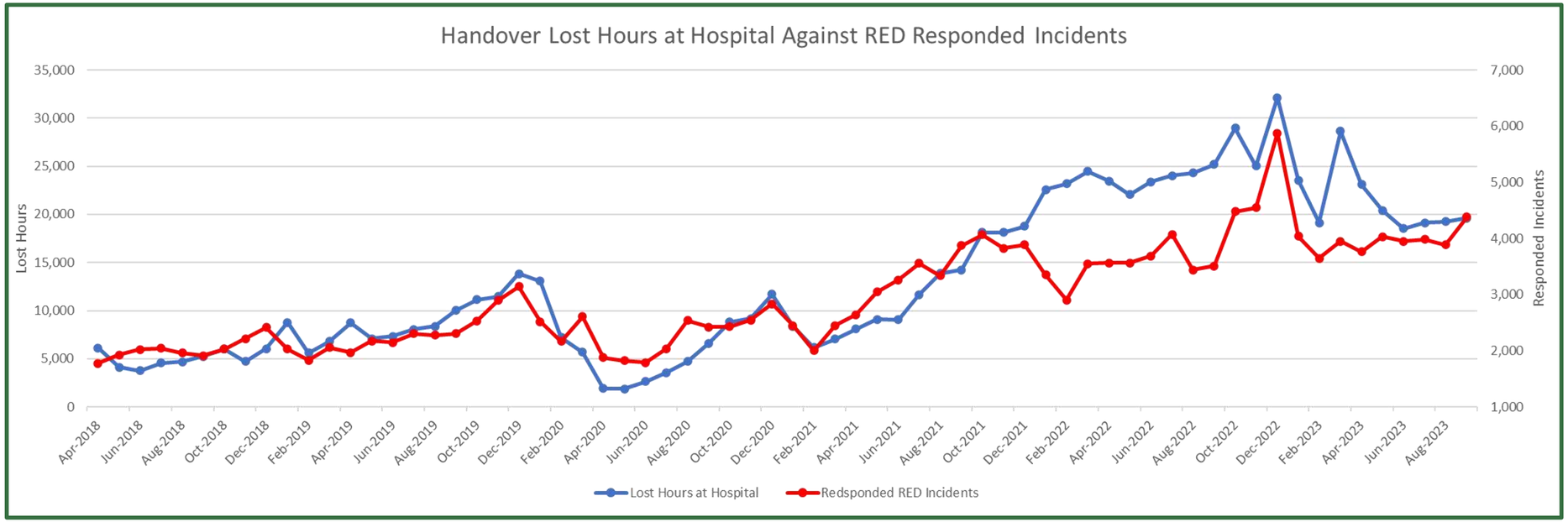
Handover Lost Hours Against Red & Amber 1 Responded Incidents

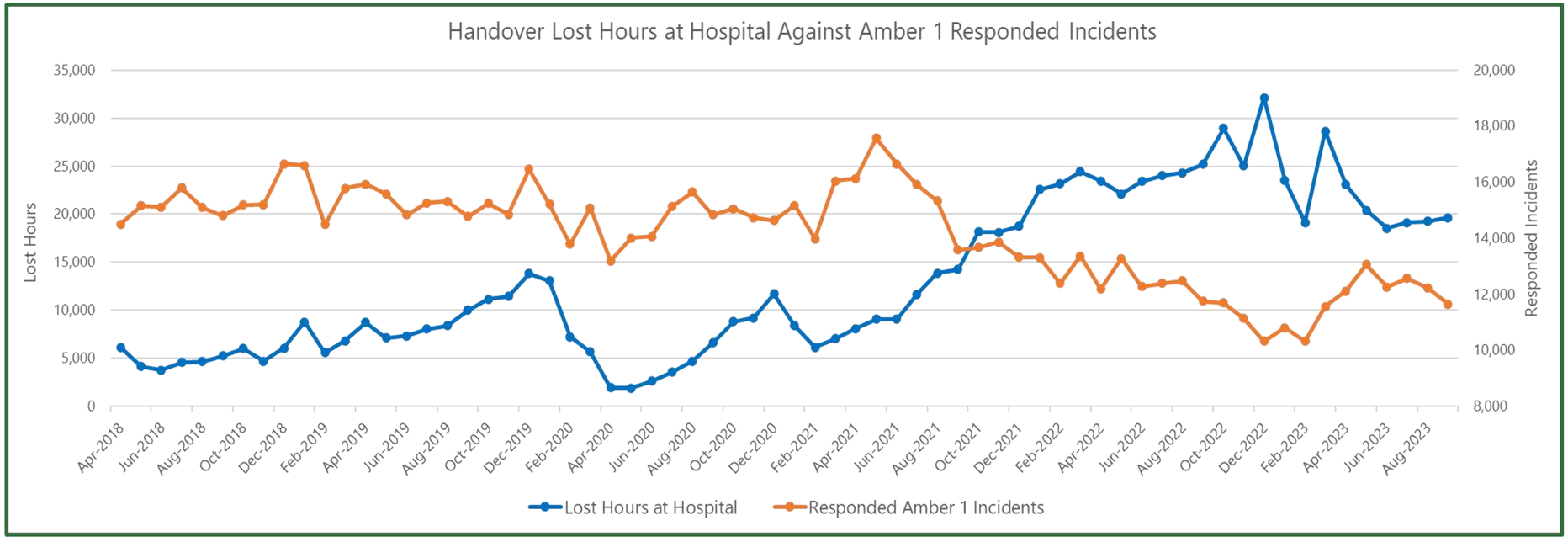
(Responsible Officer: Health Boards)

R

CI

QUEST





Analysis

The top graph highlights that as handover lost hours have increased since May 2021, so too have the number of Red incidents being responded to. This shows that when CSP is in periods of high demand and hospital handover increases, Red responses are protected, even during high pressure within the system. However, as the bottom graph illustrates, as the response to Red increases, there is an impact on Amber 1 responses, particularly at times of high demand, such as during December 2022. During these periods, the number of Amber 1 incidents attended decreases, notwithstanding that some of these patients within the Amber 1 category will still be seriously ill.

The bottom graph also highlights that as lost hours have increased since mid-2021, so Amber 1 responses have declined, due to the increased system pressures. However, as lost hours reduced during the first half of 2023, so Amber 1 responses increased, from 10,326 in December 2022 to 13,055 in May 2023. Therefore, it was possible to see the reduction of pressure within the system and subsequent performance improvement through the Amber 1 metric.

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.

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	Health 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.		
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	**11**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**1**

LEARNING FROM MORTALITY REVIEWS UPDATE

MEETING	Quality, Patient Experience and Safety Committee
DATE	31 October 2023
EXECUTIVE	Liam Williams, Executive Director of Quality & Nursing
AUTHOR	Wendy Herbert, Assistant Director Quality & Nursing
CONTACT	Wendy Herbert Wendy.Herbert3@wales.nhs.uk

EXECUTIVE SUMMARY

This paper sets out the current position and plans internally and externally in respect of learning from both Mortality Reviews and the feedback received from the Medical Examiner Service. This includes:

1. Previous independent inquiries and early learning from the Countess of Chester Hospitals NHS Foundation Trust Case.
2. Overview of the Reviews undertaken by the Medical Examiner Service (MES), including interaction with Coroners.
3. The Forward Plan for the Trust considering learning from previous approaches to Mortality Reviews, National Policy and determine the potential opportunities of ePCR data extraction to inform trends, patterns and themes.
4. The paper also outlines the Mortality Governance Process.

RECOMMENDED that the Quality, Patient Experience and Safety Committee discuss the Forward Plan for Mortality Reviews and outputs from the Medical Examiner Service and highlight any further assurance requirements.

KEY ISSUES/IMPLICATIONS

(i) The critical importance of good governance and data analysis in respect of Mortality Review Processes have been highlighted in a number of high profile NHS independent inquiries and reviews and more recently at the Countess of Chester Hospitals NHS Foundation Trust.

(ii) Analysis and aggregation of mortality data and information is crucial in identifying patterns or trends and learning opportunities.

(iii) The NHS Wales Learning from Mortality Reviews Framework is iterative and updates to include primary care and changes in regulations are currently being included by the NHS Wales Executive.

(iv) The Mortality Review Process will form an important part of the Trust's Quality Management System, which is currently in development.

REPORT APPROVAL ROUTE	
Clinical and Quality Governance Group	25 October 2023
Quality, Patient Experience & Safety Committee	31 October 2023

REPORT APPENDICES
Annex 1 - SBAR 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)	N/A	Financial Implications	N/A
Environmental/Sustainability	N/A	Legal Implications	YES
Estate	N/A	Patient Safety/Safeguarding	YES
Ethical Matters	YES	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

SITUATION

1. The Trust has adopted the NHS Wales Learning from Mortality Reviews Framework (the Framework) (2022) which outlines the new approach in NHS Wales to undertaking Mortality Reviews. The NHS Wales Executive highlighted the development of the document would be done in collaboration, as an iterative document running alongside the establishment of the Medical Examiner Service.

2. The Trust's version of the Framework was approved by the Clinical Quality Governance Group on 30 September 2022 and to date reviews of patient deaths has occurred at a patient level through the Serious Case Incident Forum with reviews of individual care triggering local investigations or joint investigations.

3. This paper seeks to provide an update and assurances on the developments internally and externally in respect of Mortality Reviews and mortality governance, critically ensuring the Trust has processes in place to capture data, analyse patterns, themes and trends and implement appropriate sustainable improvements informed by the learning.

BACKGROUND

4. Recommendations from numerous inquiries including the Shipman Inquiry (2003), Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013), Morecambe Bay Investigation (2015) and The Gosport Independent Panel (2018) have called for strengthening of safeguards for the public by providing additional independent scrutiny of the medical circumstances and cause of deaths.

5. More recently the Government in England confirmed in September 2023 that it is launching a statutory inquiry into the Countess of Chesters Hospitals NHS Foundation Trust, with the Health Secretary stating that the inquiry will 'examine the cases' wider circumstances', including 'the conduct of the wider NHS and its regulators'.

6. The NHS Chief Executive in NHS England referenced in a letter to Board Members in August 2023 across NHS England that the national roll-out of Medical Examiners (commenced 2021) has created additional safeguards by ensuring independent scrutiny of all deaths not investigated by a Coroner and improving data quality, making it easier to spot potential problems. Additionally, there was a strong focus in the communication on the importance of Boards seeking assurances that staff can speak up with confidence and whistleblowers are treated well.

Mortality Review

7. A Mortality Review is a means of reviewing data and intelligence pertaining to mortality at an individual or organisational level. The intention is to identify variation in patient outcomes and opportunities for improvement, such as early recognition and escalation of the deteriorating patient, and appropriate and timely end of life care. Reviews often highlight aspects of excellent care, and it is important that learning from both areas of excellence, as well as those in need of improvement, are shared across the Trust and wider healthcare system.

Medical Examiner Service

8. The Medical Examiner Service is hosted by NHS Wales Shared Services Partnership and will provide independent scrutiny of all deaths in Wales that are not investigated by the Coroner.

9. Scrutiny is undertaken by a Medical Examiner, who is an experienced Doctor with additional training in death certification and the review of documented circumstances of death. The Medical Examiners ensure that an accurate cause of death of recorded, identify any concerns surrounding the death itself which can then be further investigated if required, and take the views of the bereaved into consideration.

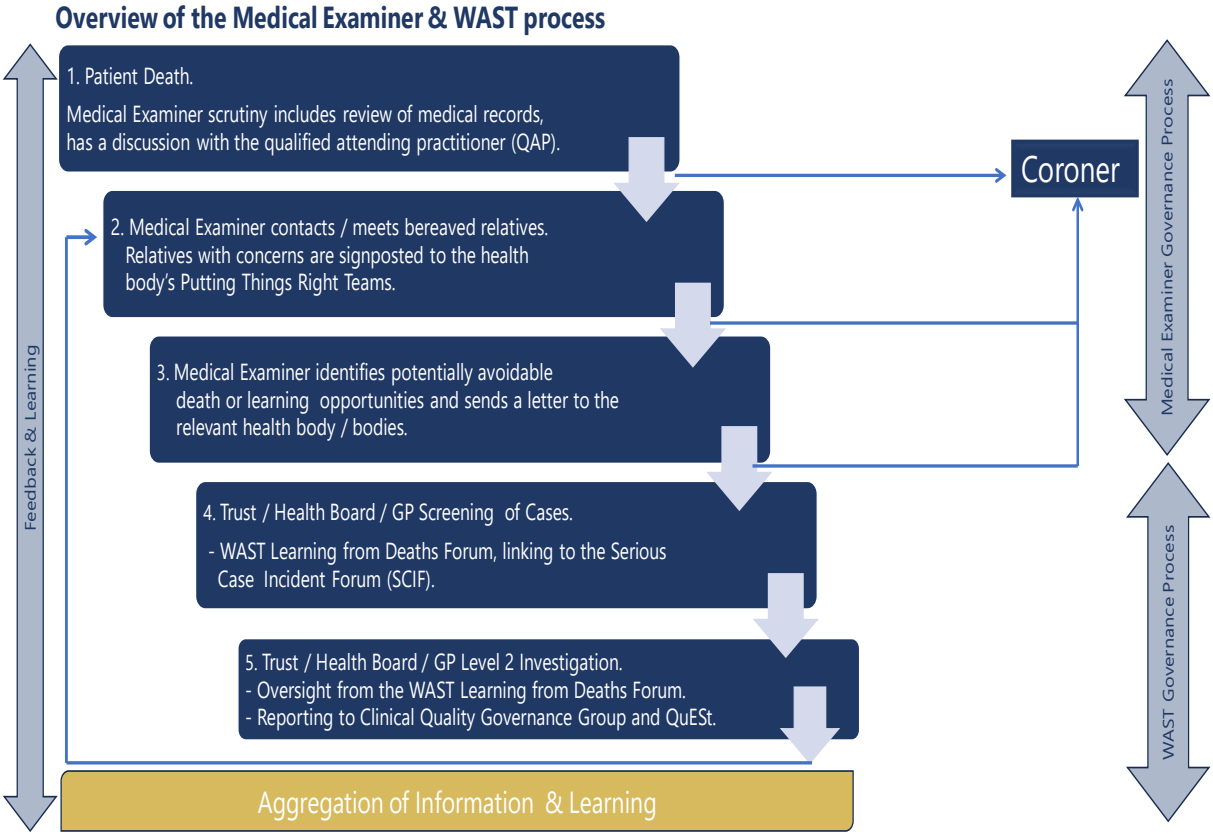
10. The introduction of the Medical Examiner Service in 2019 (which will be a statutory function by April 2024) is designed to:

    i) Provide bereaved families with greater transparency and opportunities to raise concerns.
    ii) Improve the quality/accuracy of medical certification of cause of death.
    iii) Ensure referrals to Coroners are appropriate.
    iv) Support local learning/improvement by identifying matters in need of clinical governance and related processes.
    v) 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.
    vi) Align with related systems such as the Learning from Deaths Framework and Universal Mortality Reviews.

11. Typically, the Medical Examiner's scrutiny process will take between 24 and 72 hours but it will not delay registration beyond any legal requirements (currently 5 calendar days) and will not delay the release of a body where religious or cultural beliefs require it. In these circumstances there is a system in place to prioritise certain cases for fast-track review.

12. The diagram below provides an overview of the Medical Examiner Service process. Following the independent review of a death the Medical Examiner will determine one of three routes:

i) Cause of death accepted without any concerns being raised.
ii) Concerns raised and addressed without requiring discussion with a Coroner.
iii) Concerns raised that require the death to be discussed with a Coroner.



ASSESSMENT

13. Updates on the current position and key work nationally and locally in respect of learning from Mortality Reviews are included below.

National Mortality Review Working Group

14. This group meets monthly and is hosted by the NHS Wales Executive and is attended by a member of the Trust's Patient Safety Team. The scope of the Group includes:

- Responsibility for the development and updating of the National Framework next steps are to reflect Duty of Candour arrangements and include processes for Mortality Reviews in primary care (this has been delayed due to the restructure and formation of the NHS Executive).

- Encouraging collaborative working across the system, sharing approaches and connecting with Medical Examiner Service colleagues.
- Undertaking a thematic review of do not attempt cardiopulmonary resuscitation (DNACPR) cases pan NHS Wales - the report due to be published by the end of the calendar year.
- Exploring the use of Consultant Connect to address the communication problems relating to primary care to acute.
- Advising on the development of the Mortality Module with the Datix Cymru System.
- Future work will include a Peer Review by Learning Disability Leads.

Welsh Risk Pool Enhancing Learning Programme

15. Welsh Risk Pool has recently launched an Enhancing Learning Programme which includes funding to release a member of staff in each Health Board/Trust on a short-term, part-time basis (one day per week) to scrutinise the approach to learning and assurances within their health body to share approaches and ideas across NHS Wales.

16. The Trust has nominated a member of the Patient Safety Team to undertake this work and the Programme will include learning from Mortality Reviews. The Programme will run until March 2024.

Once for Wales Datix Cymru System

17. The Datix Cymru System contains a Mortality Module for use by the Medical Examiner Service and NHS organisations. NHS Wales is the first country to commission a Module on the system for Mortality Reviews and as such it is still developing. The National Mortality Review Working Group provide advice and links in with the Once for Wales Datix Cymru Team.

Medical Examiner Service - Sharing Learning

18. In the acute sector in NHS Wales the Medical Examiner Service will start meeting with Medical Directors on a quarterly basis to feedback on the Mortality Reviews undertaken. Additionally, the Medical Examiner Service are keen to undertake thematic reviews and share learning on a national basis.

19. The Medical Examiner Service is a joint service covering NHS England & NHS Wales, with a National Medical Examiner who has oversight of the introduction of the Medical Examiner System in England and Wales. NHS Wales has a Lead Medical Examiner in place.

20. In May 2023 the National Medical Examiner's Report (2022) covering NHS England and NHS Wales was published and included the following common themes needing action at local or system level:

- Deaths related to sepsis, and in the winter period, high numbers of deaths linked to COVID-19 and influenza.
- Difficulties achieving timely Medical Certificate of Cause of Death (MCCD) completion, often as a result of post pandemic pressures, along with reversion to standard death certification processes after the emergency Coronavirus Act measures ended in March 2022.
- Deficiencies in end-of-life care in the community, resulting in inappropriate admissions.
- Staff vacancies, sickness and absence, including of Junior Doctors impacting service delivery.
- Deaths featuring delays in care have been highlighted across a number of Medical Examiner offices.

21. Feedback from bereaved families and stakeholders in NHS England and NHS Wales is overwhelmingly positive. Bereaved families appreciate the independence and expertise of Medical Examiner Teams and the time they take to discuss concerns with them.

22. Doctors completing MCCDs often benefit from Medical Examiners' support to ensure causes of death are recorded accurately, particularly where cases are complex.

23. The Trust continues to receive requests for data and information from the Medical Examiner Service to support the reviews of acute deaths and we also receive feedback on our part of the patient's pathway. Following the expansion of the service to include all non-coronial deaths it is expected the Trust will see a significant rise in requests for data and information and see an increase in feedback and potentially requests to undertake Level 2 investigations.

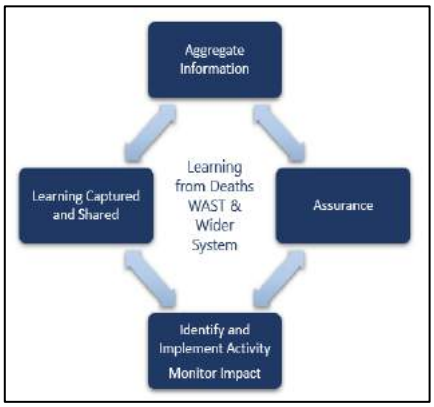
24. To date the Trust has not received a trigger to undertake a Level 2 Mortality Review.

25. Themes of concerns raised by families to the Medical Examiners to date include:

- Extended waiting times for an ambulance
- Handover of care delays
- Pressure damage due to delays
- Call categorisation issues
- Family concerns over the hospital the patient was conveyed to.
- Implementation of the End of Life Care Pathway
- Families taking sick relatives by car.

Next Steps: Mortality Reviews & Learning from Deaths in the Welsh Ambulance Services NHS Trust (WAST)

26. The Trust's Learning from Deaths (LfD) Forum will be established from October 2023, reporting to the Clinical Quality Governance Group through the Alert, Advise and Assure reporting process and the Putting Things Right Quarterly Report.



27. The LfD Forum will initially be chaired by the Assistant Director of Quality & Nursing who also leads the Serious Case Incident Forum (SCIF).

28. The remit of the LfD Forum and Work Programme is outlined below.

WAST Learning from Deaths Forum	
1	Develop and implement a Programme of Work to determine the opportunities available through ePCR and other organisational, or statutory partners data sets, to give organisational assurance of service quality.
2	To review data and wider intelligence, including data modelling, variation analysis, thematic reviews and DATIX Incidents/Speaking Up Safely reporting, to consider interventions and strategies that have the potential to reduce avoidable deaths and improve patient safety.
3	Identify criteria and categories of patient deaths which would trigger a Mortality Review over all phases of Trust care. This includes any Referral from the Medical Examiner Service for a Level 2 review and any family or staff concerns.
4	Consider the mortality data in conjunction with other clinical and patient safety data and information to identify areas for further investigation at an individual, team, regional or organisational level. At all times the Executive Director of Quality and Nursing should be immediately informed of concerns that might require consideration by the Executive Leadership Team.
5	Oversee the timely, Multidisciplinary Reviews of patient deaths identifying local and system learning (including good practice), to inform Improvement Actions, Trust Plans and influencing change system wide.
6	Provide advice, guidance and leadership to further develop and implement systematic, structured processes for undertaking Mortality Reviews, working collaboratively with the NHS Wales Executive, Health Board colleagues and Medical Examiners across NHS Wales.

7	Ensure Trust engagement and contribution to the national Mortality Review Working Group.
8	Determine if the Duty of Candour threshold has been met and liaise with the *Putting Things Right* Team to ensure families are informed and supported to engage in specified Mortality Reviews.
9	Ensure subject matter expert contribution to the development of the Datix Cymru Mortality Module nationally.
10	Ensure that processes and arrangements are in place to enable learning from Mortality Reviews, Medical Examiner and Coroner Reports across the organisation.

AGENDA ITEM No	**12**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**2**

DUTY OF QUALITY/DUTY OF CANDOUR IMPLEMENTATION

MEETING	Quality, Patient Experience & Safety Committee
DATE	31 October 2023
EXECUTIVE	Liam Williams, Executive Director of Quality and Nursing
AUTHOR	Kate Blackmore, Senior Quality Governance Lead
CONTACT	Kate Blackmore Kate.Blackmore@wales.nhs.uk

EXECUTIVE SUMMARY

1. The Health and Social Care (Quality and Engagement) Act 2020 came into force on 1 April 2023. The Act comprises of four key components: Duty of Quality, Duty of Candour, Citizens Voice and Vice-Chairs.

2. This Report considers the implementation of the Duty of Candour and Duty of Quality to provide assurance on Welsh Ambulance Services NHS Trust's (WAST's) compliance with the Act.

3. As part of the Organisational Change Process within the Quality, Safety & Patient Experience Directorate a Senior Quality Governance Lead was appointed and commenced on 4 September 2023. A subsequent review of the baseline assessments was undertaken to ascertain the organisation's compliance to the legislation and agreed milestones.

4. The Welsh Government (WG) Highlight Report for August 2023 (submitted in September 2023) Red, Amber, Green (RAG) rated our progress as Yellow. This is defined as 'organisation has identified that delivery is at risk but manageable OR behind schedule but within tolerance'. This is in line with other NHS organisations across Wales working to achieve compliance to the legislation.

5. A 'fully developed and signed off Implementation Plan for the duty' is a key requirement and recent work has been undertaken to clearly document an Implementation Plan for all elements of the legislation, with documented Implementation Leads and specific actions.

6. The Highlight Report template now also includes nine additional deliverables that had not been reported in previous template submissions. The Road Map

includes detailed requirements of the legislation, and it is to be expected that the Highlight Report will continue to be expanded as additional deliverables approach milestones.

7. The review of arrangements has highlighted the importance of the implementation being assessed and reported through regular meetings of the Quality Management Group to update and/or identify issues or risks impacting our ability to implement the legislation as required.

RECOMMENDATION: That the Committee:

(1) Receives and notes the report, and

(2) Takes assurance on the progress made to deliver the Duty of Quality and Duty of Candour.

KEY ISSUES/IMPLICATIONS

(i) Current reported level is Yellow 'organisation has identified that delivery is at risk but manageable, OR behind schedule but within tolerance'.
(ii) There has previously been no bespoke Implementation Plan in addition to the 'Welsh Government Implementation Road Map', but this has now been developed to support delivery.

REPORT APPROVAL ROUTE

Clinical and Quality Governance Group	29 September 2023
Executive Leadership Team	24 October 2023
Quality, Patient Experience & Safety Committee	31 October 2023

Future updates will flow through Senior Quality Team to Senior Quality Leadership Team.

REPORT APPENDICES

ANNEX 1 - SBAR providing an overview of the Duty of Quality/Duty of Candour implementation progress.
APPENDIX 1 - Welsh Government Highlight Report submission for August 2023.

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	YES
Environmental/Sustainability	N/A	Legal Implications	YES
Estate	N/A	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 implementation of the Duty of Quality and Duty of Candour to provide assurance on Welsh Ambulance Services NHS Trust's (WAST's) compliance with the Health & Social Care (Quality and Engagement) Act 2020.

BACKGROUND

2. The Health and Social Care (Quality and Engagement) Act 2020 came into force on 1 April 2023. The Act comprises of four key components: Duty of Quality, Duty of Candour, Citizens Voice and Vice-Chairs.

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

4. To support the implementation of the Duty of Quality and Duty of Candour, Welsh Government provided a 'Road Map' with key milestone targets.

5. Previous submissions to the Quality, Patient Experience & Safety Committee (QuESt) have used the 'Road Map' to assess WASTs progress against the expected outcomes. The next key milestone is December 2023.

ASSESSMENT

6. As part of the Organisational Change Process (OCP) within the Quality, Safety & Patient Experience (QSPE) Directorate a Senior Quality Governance Lead was appointed. The successful candidate commenced on 4 September 2023 and has undertaken a review to ascertain the organisations compliance to the legislation. Additionally, the OCP has orientated other roles within the QSPE Team to the delivery and requirements arising from the legislation and this process completed in October 2023.

7. A Highlight Report is submitted monthly by WAST to Welsh Government using a centralised 'Road Map' to track progress against deliverables. The Highlight Report for August 2023 (submitted in September 2023) RAG rated our progress as Yellow; this is defined as 'organisation has identified that delivery is at risk but manageable OR behind schedule but within tolerance'.

8. This report, which commenced in January 2023 for December submission, also allows for escalation of risks and issues however WAST submissions since inception have not specified entries in these sections.

9. The Highlight Report sets out the need for a 'fully developed and signed off Implementation Plan for the duty'. While this is only explicitly set out for the Duty of Candour 'Road Map', further recent work has been undertaken to clearly document an Implementation Plan for all elements of the legislation, with documented Implementation Leads and specific actions determining what needs to be completed for the organisation to have confidence that the legislative requirements have been met.

10. The organisation is currently reporting this element as 'Yellow' which is defined as 'implementing and operationalising'. This has been the reported position since February 2023.

11. Whilst progress to date against the legislation has been in reference to the Welsh Government 'Road Map', the full Implementation Action Plan against legislation identifies areas for action. The impacts and requirements of both the Duty of Quality and the Duty of Candour crosses all Directorates and it is important to have a clear Implementation Plan, with accountable and responsible Management Leads to prevent duplication, or oversight, of required actions.

12. The table below sets out the latest position reported in the monthly Highlight Report for Welsh Government:

Theme	Duty	Number of outcomes and Current rating				
		Green	Yellow	Amber	Red	N/A
Leadership & Culture	Candour	4	0	0	0	0
	Quality	1	2	0	0	0
Decision Making	Quality	2	0	0	0	0
Governance & Accountability Structures	Candour	1	2	0	0	1
	Quality	2	0	0	0	0
Reporting and Information	Candour	1	1	0	0	1
	Quality	0	3	1	0	0
Commissioning	Candour	1	0	0	0	0
	Quality	0	2	0	0	0
Hosting	Candour	1	0	0	0	0
	Quality	0	2	0	0	0
Quality Standards	Quality	0	3	0	0	0
Quality Management System (General)	Quality	0	2	0	0	0
Communication & Engagement	Candour	1	2	0	0	0
	Quality	1	0	0	0	0
Training & Education	Candour	1	1	0	0	0
	Quality	2	1	0	0	0

	Total	**18**	**21**	**1**	**0**	**2**

13. Of the 21 Yellow rated elements, seven deliverables are due for delivery in (or after) September 2023. The amber rated deliverable is not due for delivery until April 2024. The amber rating is defined as 'planning and resourcing'.

14. With the revised Implementation Plan, with detailed actions and owners, the monthly report is monitored through a Quality Management Group with a clear planning cycle and objective monitoring tools and data, linked to the quadrants of quality management system and key deliverables of the Duty of Quality Road Map, to evidence achievement.

15. Previous Reports on the implementation of Duty of Quality and Duty of Candour refer to the Quality and Performance Steering Group (QPSG) monitoring the progress of the relevant requirements. A review of the Terms of Reference for this group specifically references the Quality and Performance Management Framework, which incorporates how the Trust complies with regulatory requirements, whilst ensuring the Work Programme is reflective of the Health and Social Care (Quality and Engagement) Act 2020. Work is being undertaken through the Integrated Governance Review to ensure that effective reporting and compliance to assurance requirements.

16. The July 2023 Highlight Report indicated that the commissioning and hosting deliverables for Duty of Quality were fully implemented (green). This was based on requirements being incorporated into the Trust arrangements through ongoing reviews, reflective of any associated contracts and agreements held by the Trust. However, following further review there is a lack of clarity/consistency around which elements had been completed across the varied commissioned/hosted services and as a result a revised report of 'implementing and operationalising' was submitted for August 2023. This change is reflected in the table above (paragraph 12).

17. The Duty of Candour Report has rated progress against the same deliverable (commissioning and hosting) as fully implemented (green) however, the narrative advises that while we have a clear understanding of the changes required, we continue to work with Commissioners to identify requirements.

18. The Highlight Report template now includes nine additional deliverables that had not been reported in previous template submissions. These are:

    - Demonstratable evidence that all strategic decisions and plans have been made through quality lens.
    - First Duty of Quality Annual Report published post March 2024.
    - All commissioning arrangements incorporate Duty of Quality requirements by September 2023.

- All hosting arrangements incorporate Duty of Quality requirements by September 2023.
- Quality infrastructure clearly aligned to Quality Standards 2023 by September 2023.
- Routinely monitored, system wide understanding of what good quality looks like for the broad range of services by December 2023.
- Quality Management System Road Map agreed and implemented by September 2023.
- Board trained, knowledgeable and operationalising Duty of Quality requirements by June 2023.
- All staff trained to determined appropriate level by December 2023.

19. Utilising the Highlight Report template as the method of monitoring delivery will not provide appropriate levels of assurance or reassurance against the organisation's trajectory for implementation of the Duty of Quality or Duty of Candour. The Road Map includes detailed requirements of the legislation, and it is to be expected that the Highlight Report will continue to be expanded as additional deliverables approach milestones. In order to be able to provide assurance to Welsh Government and Health Inspectorate Wales on our trajectory for implementation, we must have taken action prior to the template update.

20. While this paper sets out some of the delivery and governance challenges in demonstrating progress to achieving compliance, it should be acknowledged that work continues across the organisation in multiple Directorates on initiatives that will respond to the legislation. The review of arrangements has highlighted the importance of the implementation being coordinated and reviewed centrally.

21. This forum alongside QMG and QPSG creates a greater infrastructure for quality supporting the Quality and Performance Management Framework to embed a robust Quality Management System.

22. The People and Culture Plan and Quality Strategy will also be pivotal in demonstrating our focus on quality led decision making and implementing the Quality Standards throughout the organisation.

23. Oversight of the Implementation Plan will report through the Executive Director of Quality and Nursing into the Executive Leadership Team (ELT) and Quality, Patient Experience & Safety Committee (QuESt).

Health and Social Care (Quality and Engagement) (Wales) Act 2020

Highlight Report: **Welsh Ambulance Service**
Reporting Officer: **Caroline Miftari**

DUTY OF CANDOUR

Overall

Period Ending	RAG Status	Previous RAG Status
August 2023		

Theme	Minimum requirement by April 2023	Baseline @ April 2023	Position @ May 2023	Position @ June 2023	Position @ July 2023	Position @ Aug 2023	Comments for latest update
Leadership and culture	Senior responsible leadership in place and driving implementation work						
	Strategic lead identified and trained (IM or Non-Exec)						
	Operational lead identified (executive officer level)						
	Board awareness training completed.						

DRAFT

Theme	Minimum requirement by April 2023	Baseline @ April 2023	Position @ May 2023	Position @ June 2023	Position @ July 2023	Position @ Aug 2023	Comments for latest update
Governance and accountability structures	Fully developed and signed off Implementation plan for the duty						Organisational Change Process in planning phase for Putting Things Right Team. Next steps to agree proposed structure within financial envelope considering the Duty of Candour Regulations.
	Implementation of the actions in the implementation plan due to enable duty to be enacted in April.						
	Policy-ratified and published						The National Patient Safety Policy and supporting appendices were adopted by the Trust at the Clinical Quality Governance Group in June 2023 and approved at the Quality, Patient Experience & Safety Committee in August 2023. Updates are planned to internal documents following revised PTR Regulations release.
	Any additional SOP's or policies completed						
Theme	**Minimum requirement by April 2023**	**Baseline @ April 2023**	**Position @ May 2023**	**Position @ June 2023**	**Position @ July 2023**	**Position @ Aug 2023**	**Comments for latest update**
Reporting and information (data	Training Needs analysis for reporting requirements for the duty						A Trust wide training needs analysis and training plan is

to knowledge)							required and forms part of the work streams to support the cascade of Welsh Government education packages (awareness videos and e-learning package). All the PTR team have undergone training and provided links and support to local managers continues.
	Candour-related information validation and mechanisms for escalation in place, with plans for review and consideration at appropriate level						Patient Safety Team review all incidents and escalate to Serious Incident Case Forum as required which meets on at least a weekly basis chaired by the AD Quality & Nursing.
Theme	**Minimum requirement by April 2023**	**Baseline @ April 2023**	**Position @ May 2023**	**Position @ June 2023**	**Position @ July 2023**	**Position @ Aug 2023**	**Comments for latest update**
	Facilities for primary care providers in place and functionality tested						N/A
	Mechanism and publication schedule / plan in place for Candour Reporting Requirements.						The Quarterly Putting Things Right Report is published in the public domain via the Quality Patient & Safety Experience Committee (QuEST). Duty of Candour

							data and information forms part of this report. Dashboard development required on an all-Wales basis and the Trust continues to contribute to the development of this with the Once for Wales Team.
Commissioning	A clear and corporately agreed understanding of changes required to incorporate DoC requirements into all commissioning arrangements						The Trust have a clear understanding of the changes required for the DOC. Working with Commissioners (NCCU) to identify requirements.
Theme	**Minimum requirement by April 2023**	**Baseline @ April 2023**	**Position @ May 2023**	**Position @ June 2023**	**Position @ July 2023**	**Position @ Aug 2023**	**Comments for latest update**
Hosting	A clear and corporately agreed understanding of changes required to incorporate DoC requirements into hosting arrangements						Trust commissioning and hosting arrangements through the ongoing reviews taking place reflective of any associated contracts and agreements held by the Trust.
Communication and engagement	All staff are aware of key DoC messages tailored to their organisation						Circulation of leaflet via Trust Communications – front page of intranet site. Agenda on key meetings continues.

							National Duty of Candour leaflet and video link to be shared with all local managers by the area Patient Safety Managers. The Trust are engaged in and contribute to the National DoC Network (Head of Patient Safety / Deputy Head of Patient Safety).
Theme	**Minimum requirement by April 2023**	**Baseline @ April 2023**	**Position @ May 2023**	**Position @ June 2023**	**Position @ July 2023**	**Position @ Aug 2023**	**Comments for latest update**
	Engagement with workforce and key stakeholders e.g., Service Users						The Patient Engagement and Community Involvement Team (PECI) already have a programme of work in place which includes obtaining and sharing patient stories at Quality Patient Experience & Safety Committee with monitoring of improvement actions. The Trust are implementing the Civica patient feedback IT solution.
Training and education	Training Needs analysis for the duty						All the PTR team have undergone training and provided links and support to local managers. Wider TNA required & implementation

							programme required – target December 2023
	Based on training needs analysis key and specialist staff training identified and completed						

DUTY OF QUALITY

Overall

Period Ending	RAG Status	Previous RAG Status
August 2023	Green/yellow	Green/yellow

Theme	Minimum requirement by April 2023	Baseline @ April 2023	Position @ May 2023	Position @ June 2023	Position @ July 2023	Position @ Aug 2023	Comments for latest update
Leadership and culture	Senior responsible leadership in place and driving implementation work						
	All staff recognise and understand the organisation's Quality vision, and their roles within it						The DoQ and DoC intranet pages are now available to all staff. E-learning Platform available via NHS Executive, roll out plan to be developed. QIA page available to staff on share point explaining its importance and how to use.

							Quality Strategy available on- line. Further work required to evaluate knowledge of all staff relating to the Quality vision DOQ.
	Commitment, resources, and infrastructure in place to implement Duty effectively						Leadership committed to the implementation of the DOQ. All Quality posts recruited too and currently undertaking induction programme. Weekly Quality Management Meeting in place
Decision-making	Processes and systems in place to provide demonstrable evidence that Board decisions have been made through Quality lens						The Trust quality governance infrastructure has been reviewed by the Board Secretary in relation to the new legislation. Discussions have taken place regarding the quality decision making tool. QIA Guidelines and Template used throughout the Trust. Reporting through the governance structure.
	Demonstrable evidence that all strategic decisions and plans have been made through Quality lens.						Quality Impact Assessment utilised, reporting through the framework and template in place. Microsoft forms in development to digitalise the QIA template and enable central repository
Governance and	Board is assured that DoQ is being considered across system						Quality and Performance Steering Group oversee the DOQ requirements.

accountability structures							Clinical Quality Governance Group oversee full QIAs, reporting to EMT and Quest via Triple AAA Initial Quality Control (QMS) in development focusing on the MQIPR in stage 1
	Routine governance documentation is DoQ-ready						The Trust quality governance infrastructure has been reviewed by the Board Secretary in relation to the new legislation. Discussions have taken place regarding the quality decision making tool and its incorporation into the Paper templates
Reporting and information (data to knowledge)	Mechanism and publication schedule / plan in place for sharing DoQ progress information externally						Publication schedule forming part of the Quality and Performance Management Steering group TOR. Further development to ensure trust have appropriate channel (web presence / infrastructure) for reporting DoQ progress externally. Develop and share roll-out plan for the publication of routine "always on" qualitative and quantitative information to include for example: • Patient experience information / PREMS • Progress against quality priorities

							• Infections and mortality rates etc "You said, we did"
	Quality-related information escalation mechanisms in place, with plans for review and consideration at appropriate level						Governance structures in place to support escalation of quality related information. • Quality Management Group • Quality and Performance Management Steering group • Clinical Quality Governance Group • Quest. Dashboard development in progress to support quality control aspect of QMS
	First DoQ Annual report published - March 2024						Currently planning and resourcing
Commissioning	A clear and corporately agreed understanding of changes required to incorporate DoQ requirements into all commissioning arrangements						The Trust are reviewing the commissioning arrangements with. • NCCU • The '6 goals national programme' for 111 • The Ambulance Care frameworks for 365 • NWSSP about any commissioned services procured.
	All commissioning arrangements incorporate DoQ						Working with Commissioners (NCCU) to identify requirements

	requirements – Sept 2023						
Hosting	A clear and corporately agreed understanding of changes required to incorporate DoQ requirements into hosting arrangements						The Trust are reviewing arrangements with 111Wales. Alternative Response Teams (CWR/Falls/PTAS/CSC) EMERTS
	All hosting arrangements incorporate DoQ requirements – Sept 2023						Working with procurement (Shared Services) to identify and confirm requirements
Quality Standards	A clear understanding of changes required to existing quality infrastructure and agreed programme of work to align with Quality Standards 2023						Development of a technical specification document reflective of the Trust quality outcome measures supporting the services the Trust is commissioned to deliver and aligned to the Quality Standards 2023 (domains/enablers). The technical specification will inform the Trust "Always On "reporting and digital dashboard scalable solution.
	Quality infrastructure clearly aligned to Quality Standards 2023 – Sept 2023						
	Routinely monitored, system-wide						

	understanding of what good quality looks like for the broad range of services - Dec 2023						
Quality management system – general	A clear understanding of, and commitment to, a quality management system, with plans in place to identify requirements and current gaps						Led by the Quality and Performance Management Steering Group at the strategic level to ensure oversight of quality planning, quality control, quality assurance and quality improvement. Quality Management Group to be led by Senior Quality Governance lead to develop the QMS at an operational level. Agreement on Trust Quality Outcome measures at all levels in progress for the Technical Specification Document.
	Quality Management System Road map agreed and implemented – Sept 2023						QMS Road Map will be agreed in the Quality and Performance Steering Group
Communication and engagement	All staff are aware of key DoQ messages tailored to their organisation						The DoQ and DoC intranet pages are now available to all staff. Further work to be undertaken to embedded into meetings such as Operations wider leadership group. QIA added

Training and education	At least one member of Board trained, knowledgeable and able to influence Board in relation to DoQ						
	Board trained, knowledgeable and operationalising DoQ requirements – June 2023						
	All staff trained to determined appropriate level – Dec 2023						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. Development work required to engage with: • learning and development forums? • L&D Hub • Integrated care coaching team • EMS C Operations Quality team

Progress Against Deliverables – This table details the key deliverables / minimum requirements for the implementation of the Duty of Quality by April 2023. The table should be completed using the key below:

Stage	Definition	
1	Exploring and preparing	
2	Planning and resourcing	
3	Implementing and operationalising	
4	Full implementation	

RISK: Description	Score	Mitigation

ISSUES: Description	Score	Mitigation

Guidance on Completion

Highlight reports should be very simple presentations of the key achievements, issues, and risks. The principle of reporting by exception (only those items outside of plan or expectation) should be used when reporting.

The RAG (red, amber, green) status key below should be used to establish a rating for the reporting period. RAG is not a detailed breakdown of risk but rather a considered assessment of the likelihood of meeting the objectives in the agreed timeframes.

RAG Status key	
Description	**Status**
Organisation is confident that Deliverable/Key milestone can be delivered	
Organisation has identified that delivery is as risk but manageable OR behind schedule but within tolerance	
Organisation has identified that delivery is at risk with certain aspects having no mitigation or outside of tolerance.	
Organisation has little confidence on delivery AND/OR significantly behind schedule AND/OR critical issue with no mitigation currently available	

The scores and colours in the issue and risk tables are not drawn from this key but from the risk register and risk management plan and therefore do not necessarily read across. Top 3 risks and issues with scores should be drawn from your risk register and issues log.

Progress Against Deliverables – This table details the key deliverables / minimum requirements for the implementation of the Duty of Quality by April 2023. The table should be completed using the key below:

Stage	**Definition**	

1	Exploring and preparing	
2	Planning and resourcing	
3	Implementing and operationalising	
4	Full implementation	

Achievements - This should be kept to only those items achieved, tasks complete. Reporting on a latest meeting or draft out to stakeholders is too detailed for a highlight report.

Issues - Issues are those risks that have already happened so in essence the worst that have now come to pass. This will be where the group is directed to focus their energies.

Tasks for next period - Keep this to key definable and achievable tasks. Ie consultation to have begun, training needs analysis to be agreed.

AGENDA ITEM No	**13**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**1**

MENTAL HEALTH AND DEMENTIA ANNUAL REPORT

MEETING	Quality, Patient Experience & Safety Committee
DATE	31 October 2023
EXECUTIVE	Liam Williams, Executive Director of Quality and Nursing
AUTHOR	Mark Jones, Consultant Clinician for Mental Health
CONTACT	Mark Jones Mark.jones34@wales.nhs.uk

EXECUTIVE SUMMARY

1. The Mental Health & Dementia Plan 2021-2024 continues to drive mental health & dementia as a key policy area. With over 30,000 mental health contacts per year to 999 alone, the Welsh Ambulance Services NHS Trust (WAST) responds to more mental health crisis calls than any other NHS or public sector organisation. In addition to this, mental health demand in 111/NHS Direct Wales and the Non-Emergency Patient Transport Service (NEPTS) is significant.

2. Mental Health and Dementia continues to be one of the 21st centuries biggest healthcare challenges. We are working towards improving the experience for people living with dementia who use our services, as well as considering the impact it will have on our workforce. WAST continues to improve our response to people with mental health conditions and dementia between 2021-2024. This Plan has been developed following continued engagement and consultation across WAST services and external stakeholders e.g., Hafal/Wales Alliance for Mental Health, as well as service users and carers. Within it, we set out our high-level objectives and more detailed plans for improving mental health and dementia services for people across Wales of all ages who call 111 or 999.

3. The Mental Health and Dementia (MHD) Team works collaboratively with Senior Managers and colleagues within WAST to promote an unequivocal positive mental health culture, both articulated and lived at each level in the organisation. External partnership working is also integral to the team's role, WAST contribution to the work of our partner agencies will be highlighted in this report.

RECOMMENDATION that the Committee note developments of the Mental Health & Dementia Team and progress to date.

KEY ISSUES/IMPLICATIONS
(i) **Education** - The Mental Health & Dementia Team continues to provide face to face or virtual sessions to all colleagues across the Trust. (ii) **See & Treat** - We have recruited and trained Mental Health Practitioners to deliver high quality 'hear and treat' services to people who call 999. This is in order to help people with mental health problems in more effective ways than just directing people to Emergency Departments (EDs). (iii) **Hear & Treat** - Ambulance Trusts in England have recognised their sub-optimal approach to mental health calls to 999 and most have now implemented Mental Health Practitioners in 'consult and close' roles. All English Ambulance Trusts are now working with NHS England/Improvement (NHSE/I) to implement Mental Health Response Vehicles (MHRVs) as well. (iv) **RITA** - Working in partnership with My Improvement Network, we are piloting 25 Reminiscence Interactive Therapy Activities (RITA) tablets to trial reminiscence therapy with people living with dementia. It is a user-friendly interactive tablet blending entertainment with therapy and to assist patients in recalling and sharing events from their past through listening to music, historical events, playing games, watching old TV shows and watching films in order to support patients who may be distressed or agitated when in our care, through positive distraction. (v) **Dementia Friendly Environments** - Our Non-Emergency Patient Transport Service vehicles take people to and from their routine hospital appointments and discharge people home after a stay in hospital. New design features include dementia-friendly flooring, blinds and colour schemes, while improved safety features like seatbelt warning systems, CCTV and driver assistance systems now come as standard. (vi) **ED Pathways** - There has been partnership working with Cardiff & Vale Health Board to explore ED dementia admissions to improvements to the handovers, training and environments.

REPORT APPROVAL ROUTE	
Clinical and Quality Governance Group	29 September 2023
Quality, Patient Experience & Safety Committee	31 October 2023

REPORT APPENDICES
ANNEX 1 - Mental Health and Dementia Annual 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)	N/A	Financial Implications	YES
Environmental/Sustainability	N/A	Legal Implications	N/A
Estate	N/A	Patient Safety/Safeguarding	YES
Ethical Matters	N/A	Risks (Inc. Reputational)	N/A
Health Improvement	YES	Socio Economic Duty	N/A
Health and Safety	YES	TU Partner Consultation	N/A

Welsh Ambulance Services NHS Trust



Mental Health & Dementia Annual Report 2023

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
NHS Trust

Amb_mentalhealth@wales.nhs.uk

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Introduction

With over 30,000 mental health contacts per year to 999 alone, the Welsh Ambulance Services NHS Trust (WAST) responds to more mental health crisis calls than any other NHS or public sector organisation. In addition to this, mental health demand in 111/NHS Direct Wales and the Non-Emergency Patient Transport Service (NEPTS) is significant.

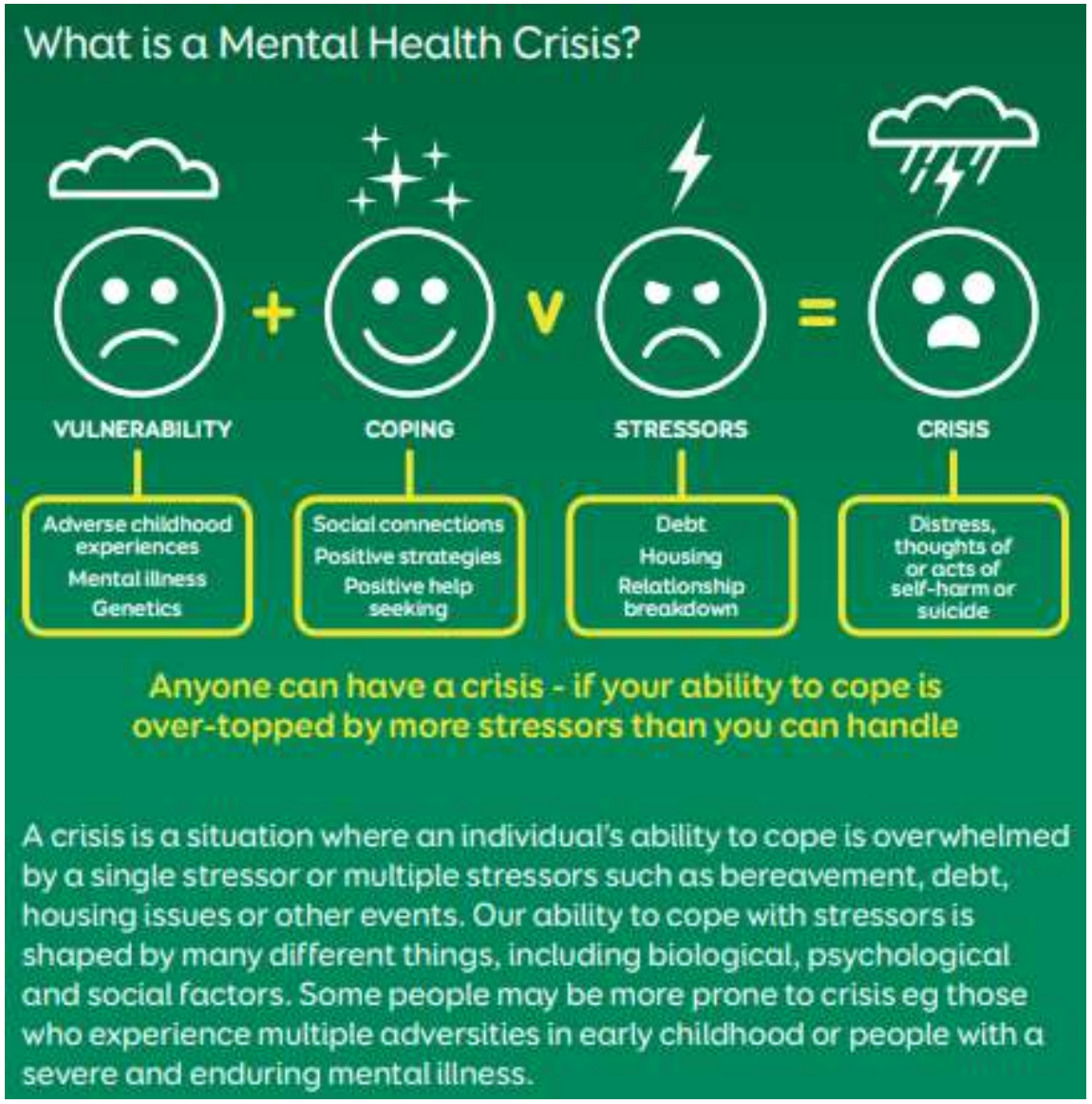
Dementia continues to be one of the 21st century biggest healthcare challenges. We are working towards improving the experience for people living with dementia who use our services, as well as considering the impact it will have on our workforce.

WAST continues to improve our response to people with mental health conditions and dementia between 2021-2024. This plan has been developed following continued engagement and consultation across WAST services and external stakeholders eg Hafal/Wales Alliance for Mental Health, as well as service users and carers. Within it, we set out our high level objectives and more detailed plans for improving mental health and dementia services for people across Wales of all ages who call 111 or 999.

The Mental Health and Dementia (MHD) Team works collaboratively with senior managers and colleagues within WAST to promote an unequivocal positive mental health culture, both articulated and lived at each level in the organisation. External partnership working is also integral to the team's role, WAST contribution to the work of our partner agencies will be highlighted in this report.



1. What is a Mental Health Crisis?



A crisis is a situation where an individual's ability to cope is overwhelmed by a single stressor or multiple stressors such as bereavement, debt, housing issues or other events. Our ability to cope with stressors is shaped by many different things, including biological, psychological and social factors. Some people may be more prone to crisis eg those who experience multiple adversities in early childhood or people with a severe and enduring mental illness.

Crises can be avoided by using positive coping strategies such as self-soothing, problem solving, connecting with others and help-seeking, or made worse by others including consuming alcohol or non-prescribed drugs, or self-harm.

Some people have built in risk factors for crisis, which could be caused by high levels of stress hormones whilst in the womb or in the first two years of life. Others have higher social vulnerability because of loneliness, isolation, worklessness, or lack of purpose.

However, anyone can end up in a mental health crisis.

Any member of staff who needs help for themselves or a colleague should access our #WASTkeeptalking portal where they can find all of the mental health resources available to you, face to face and online. For more information, the WAST Wellbeing Strategy can be accessed on our staff intranet page.



2. Education and Training

The Trust's annual training plan continues to support Mental Health awareness raising. Working in partnership with our dedicated training teams across WAST to establish a robust training program for all aspects of mental health.

Mental Health Training

The mental health & dementia Team continue to provide face to face or virtual sessions to all colleagues across the Trust. In addition, to this the MHD team has developed an extensive mental health online learning resource which has been utilized by staff in the following way:

On Click – E-Learning	Numbers
• Mental Health Legislation	– **997**
• Mental Health	– **1331**
• Self-Harm	– **1030**
• Substance Misuse	– **995**
• Suicide Intervention	– **1609**
• Alcohol Brief Intervention	– **515**
• Dementia	– **1106**
• Total	– **7583**

We are currently developing two other mental health learning modules – Child & adolescents + Perinatal

Paramedic Mental Health Training

The mental health & dementia Team continue to provide ongoing support to the development of the mental health curriculum for undergraduate paramedic students in partnership with Swansea University.

Mental Health Practitioners Induction/ support

Over the last 18 months Mental Health Practitioners (MHP) have been employed by the trust and have been inducted, signed off and clinically supported by the MHD team.

Induction involves completing mandatory training, WAST computer systems, shadowing different staff groups who work with the call centres and shadowing current MHPs. Finally new MHPs are supervised and assessed before being signed off for working autonomously within the clinical support desk.

MHPs are line managed by the operational service, however, all are clinically supervised by MHD staff.

Suicide First Aid Training

During this reporting period the team also delivered SFA training to 140 staff. Prior to this 235 staff have received training.

A total of 375 staff from different parts of the organisation have been provided with this training.

SFA courses run every week and can accommodate up to 16 staff members. Currently these are being run virtually but we are looking at running face to face classes in the future.

"Incredibly valuable worthwhile session. I have learnt so much"

"I feel that as a call handler I am now in a better position to talk with someone who has suicidal thoughts."



In addition, 466 WAST staff have accessed the MCA training via WAST Learning Zone

3. Working towards equity



Working towards equity

In Wales and across the UK, some groups experience greater difficulty in accessing health services than others eg people from Welsh speaking communities, people with sensory loss; and some groups have poorer mental health than others eg people from ethnically diverse communities, Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ+) people. Indeed, some of these same groups also have poorer outcomes and experiences when they do access healthcare.

Our equality strategy "Treating People Fairly" sets out our approach to improving outcomes for all of the people of Wales, and how we will achieve our commitment to the Public Sector Equality Duty. Some key objectives in the strategy are:

By 2024...

... we will take action to maximise health opportunities and strengthen the voice of all citizens and staff to ensure the people who use our services have equity of access and improved experience with access to services that are sensitive to the needs of all.

By 2024...

... we will take action to increase awareness and tackle key equalities issues that may arise from a person's 'protected characteristics' to ensure our services, our culture and our people understand and are responsive to the needs of all.

"Treating People Fairly" includes a specific action to "work in partnership to improve our understanding of the experience of mental health service users, and also of those living with dementia".

Inequality is complex, multi-factorial and entrenched in many ways, and it is only through working together, under the stewardship of our equality strategy, Equality Impact Assessment and Welsh Language Strategy that we will begin to reduce inequality and improve outcomes and experience. Inequality is an important dimension in every key deliverable in this plan.

4. Emerging from Covid-19 Pandemic

Emerging from the Covid-19 pandemic

As this plan is published in 2021, Wales is just emerging from its third lockdown of the global Covid-19 pandemic. It is well reported that the pandemic, and the measures taken to combat it, have and will continue to impact on people's mental health for years to come. We have seen a large decrease in people's psychological wellbeing compared to pre-Covid-19 levels. Issues such as social isolation and financial stress, as well as people experiencing major Covid-19 symptoms (and 'long Covid') have all taken a toll on the wellbeing of the people of Wales. During the pandemic, people who already had mental health conditions were more than four times more likely to be distressed compared to those without one. Public Health Wales is anticipating increases in alcohol deaths and in mental health conditions across the board, and expects some of these effects to last for up to a decade.

People affected by dementia have been amongst those hit the hardest by the pandemic. From the high death rate in care homes, to significant cognitive decline in people who live in isolation and the pressures on unpaid carers, the pandemic has had a severe impact. There has been evidence of a surge in loneliness and isolation, and some people have reported a decline in concentrating, memory loss, agitation and stress/ depression.



4. Emerging from Covid-19 Pandemic

Mental Health

The data show high levels of psychological distress during the COVID-19 pandemic, with around 50% of the population reporting clinically significant levels of psychological distress:

50%

50% reporting clinically significant levels of psychological distress

20%

20% showing "severe" effects

33%

33% younger people reported 'severe' levels of psychological distress

Psychological distress is also higher in women and those from deprived areas

Dementia



83% increase in dementia deaths vs previous year

20% of all Covid-19 deaths had a diagnosis of dementia in England and Wales



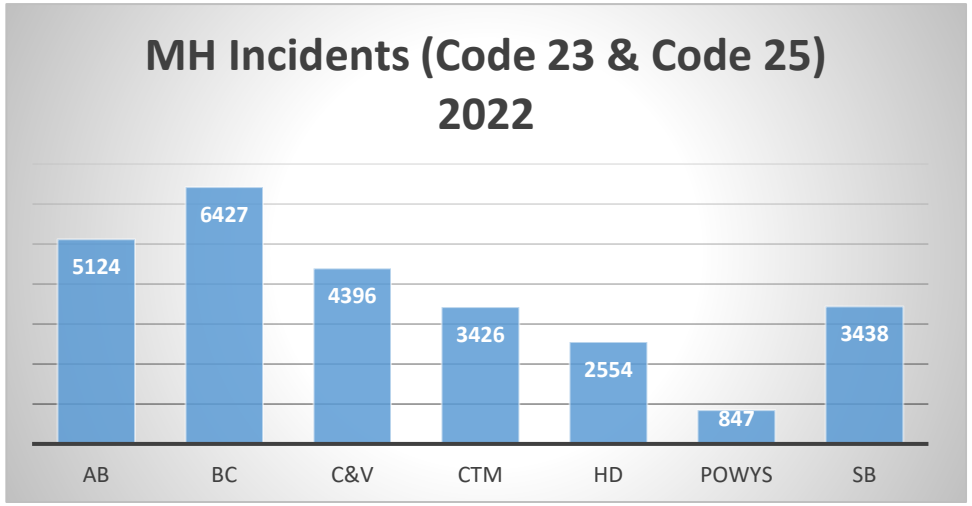
Post Pandemic

We are now facing a period of considerable uncertainty. The challenging circumstances in the economy will impact on us all. Younger people whose education has been disrupted might experience challenges to their life chances. Growing unemployment will impact on mental health and wellbeing, and isolation will have lasting effects for older people.

4. Emerging from Covid-19 Pandemic

Current Mental Health Demand

Demand highest from urbanised UHBs

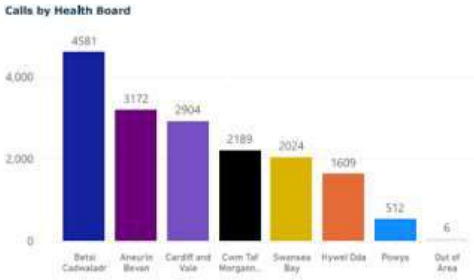


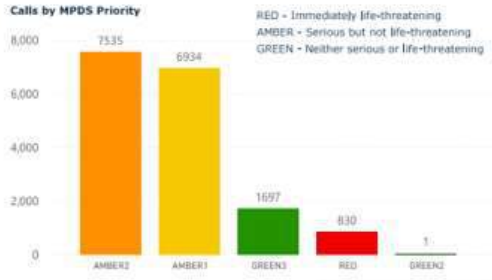
Increasing demand



The data below show calls received by the Welsh Ambulance Services NHS Trust through the 999 telephony system

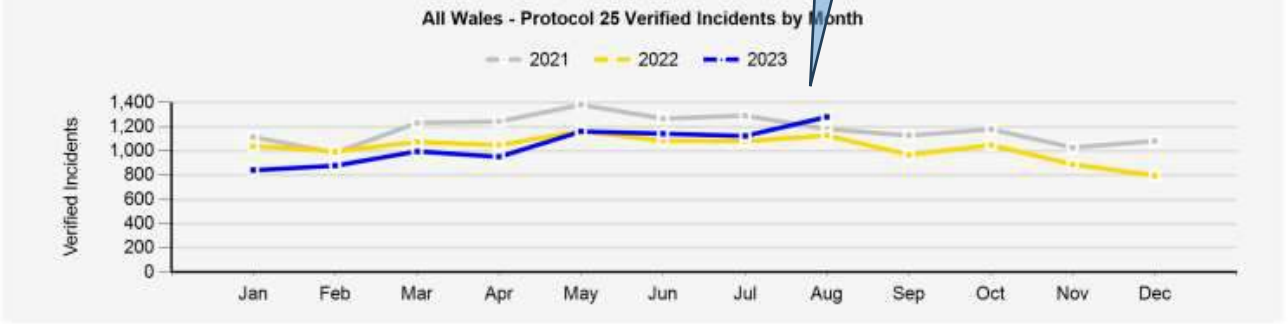
Overdose / Ingestion	Resource Attended Scene	Resource Attended Hospital
8,486	5,038	3,032
Psychiatric / Suicide Attempt	**Resource Attended Scene**	**Resource Attended Hospital**
8,511	3,126	1,452





All Wales - Protocol 25

Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
2022	1,043	996	1,075	1,049	1,163	1,085	1,081	1,127	969	1,048	890	796	**12,322**
2023	841	879	997	952	1,161	1,143	1,124	1,281	-	-	-	-	**8,378**
Variance	-19.4%	-11.7%	-7.3%	-9.2%	-0.2%	5.3%	4.0%	13.7%	-	-	-	-	**-32.0%**



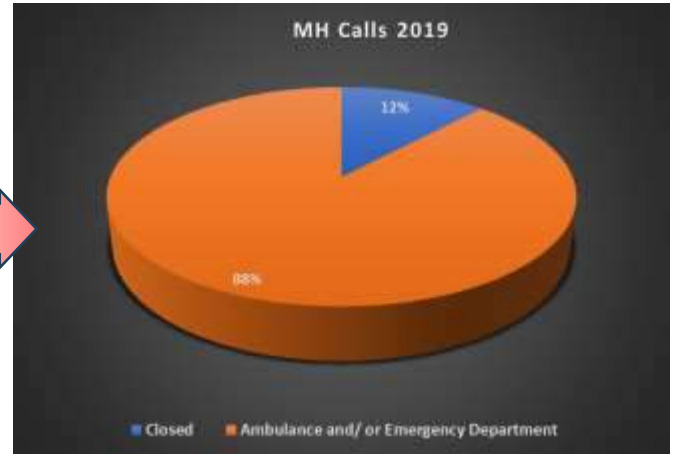
4(i). Mental Health Practitioners

We have recruited and trained mental health practitioners to deliver high quality 'hear and treat' services to people who call 999. This is in order to help people with mental health problems in more effective ways than just directing people to ED.

Their implementation has improved our 'hear and treat' outcomes for people who call 999 in a mental health/dementia crisis. The MHD team continue to support, clinically supervise, deliver ongoing learning and audit for mental health practitioners working in 'hear and treat' roles.

Previously around 88% of mental health calls were directed to ED/ and or conveyed by ambulance.

People with mental health problems spend waits of 5 hours on average in ED and are twice as likely to spend more than 12 hours waiting in ED.

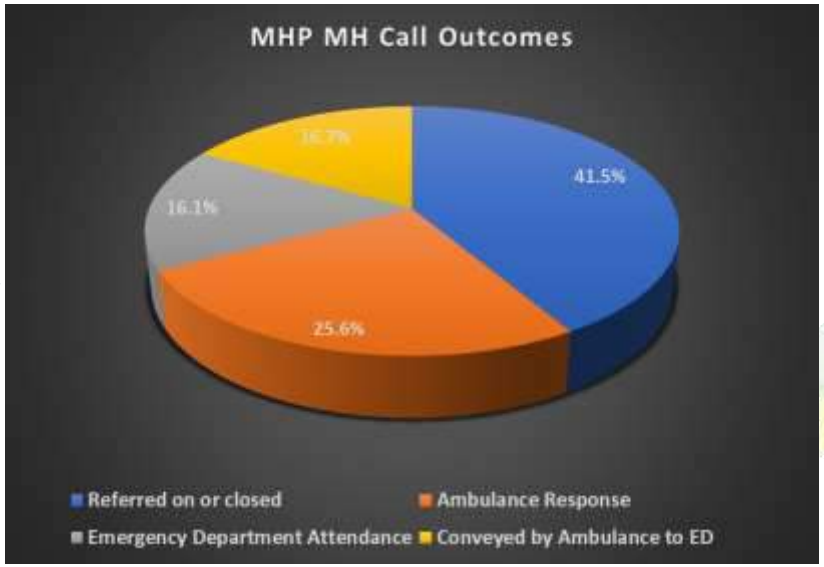


WAST mental health practitioner impact

1. Looking at the data from June 2022 to May 2023 and only during the hours of operation of the service (13.00 to 01.00 7 days a week) we can see a significant change in the 'consult and close' rate for psychiatric calls. MHPs are, on average, achieving a 'consult and close' rate of circa 41%.

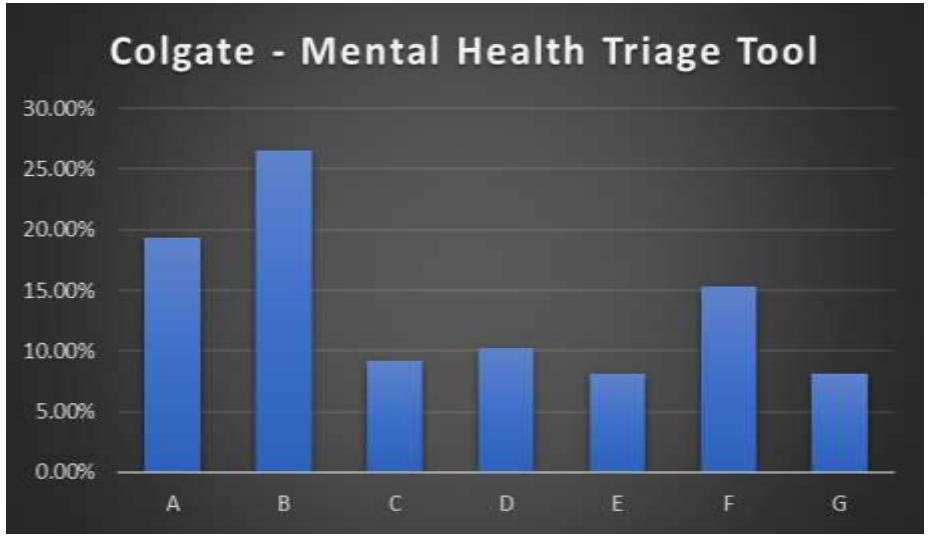
2. MHPs are twice as likely to consult and close and they tend to use less ambulance resource and refer people directly to psychiatric services for assessments (4.2%). However, they do not use primary care or community provides as much. Other indicators have broadly similar outcomes.

Future: Enhance the service – follow up calls/ outpatients + Independent prescribers



4(i). Mental Health Practitioners

The Colgate Mental Health Triage Scale is a tool designed to guide decision-making in mental health screening assessments. Below highlights calls triaged by MHPs into response type and need.

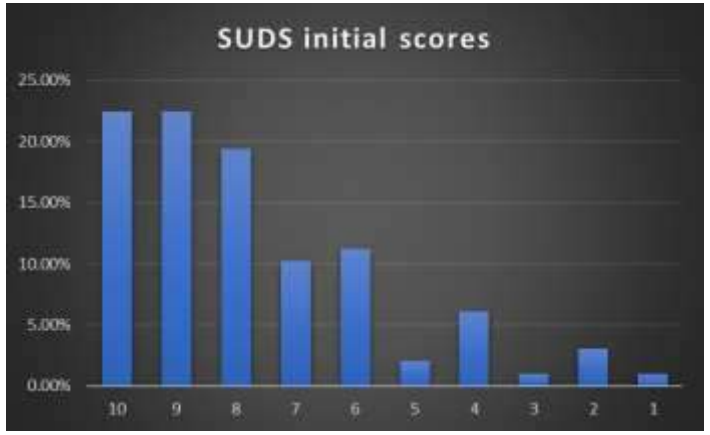


A emergency **B** very urgent <4h **C** urgent <24h **D** moderate <72h

E low <4weeks **F** Signpost (no time) **G** info only (no time)

The Subjective Units of Distress scale (SUDS) is a tool for measuring the intensity of distress, psychological disturbance and painful feelings. The scale ranges from 0 to 10, with zero indicating no distress and 10 being the most intense distress a person can experience. SUDS are frequently used in a range of psychological therapies as a benchmark for evaluating both distress and also progress of an intervention.

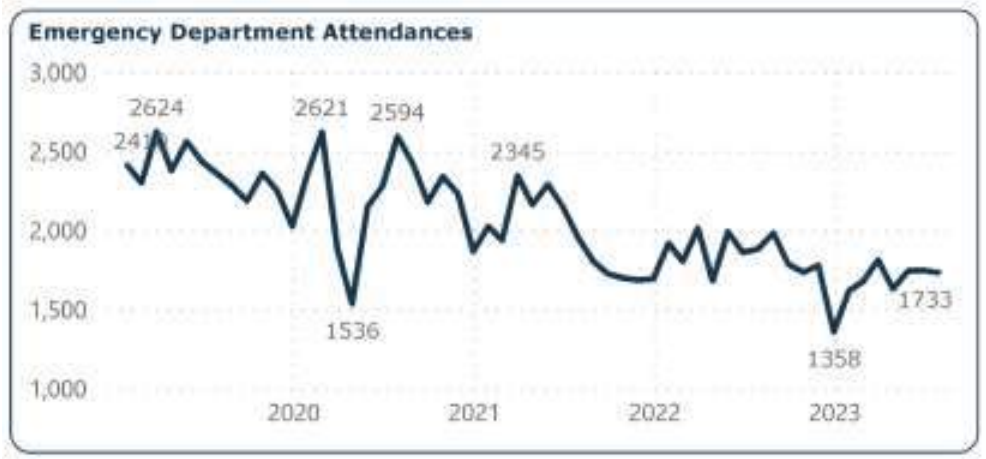
Below highlights the initial and exit patient SUDS scores.





Callers were asked their SUDS at an early stage in the call, and again at the end. The mean SUDS rating at the beginning of the call was 7.73 and this reduced to 5.47 at the end of the call, a reduction of 2.23 points.

4(i). Mental Health Practitioners



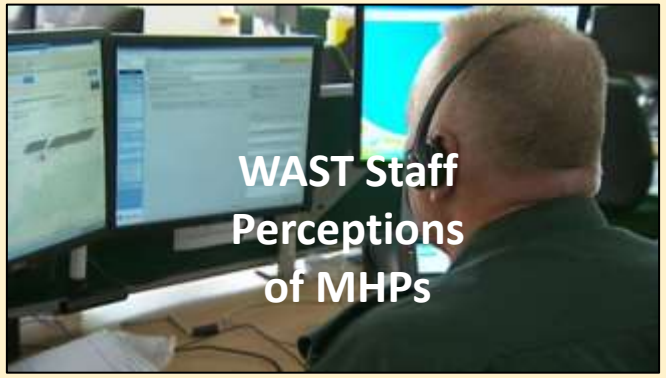
Since 2019 ED attendances pertaining to mental health diagnosis has reduced. MHPs in WAST have contributed towards this reduction.



Qualitative impact of MHPs

"I think it was a better experience for the patient"

"Rather than triaging, she was able to offer skilled help over the phone"



"I've noticed we are responding to a lot less mental health calls than we used to" (Paramedic)

"I feel it boosted morale when we know that mental health clinicians were on"

4(i). Mental Health Practitioners

The Future of Mental Health Practitioner Service within WAST:

Enhance the service:

- Follow up calls/ outpatients
- Independent prescribers

Mental Health Assessment Tool
The WAST MHD team have developed a MH tool to be used within the ECNS system. This tool has been shared national experts.

Digital Dashboard:
(for live information and better supervision)

- Phase 1 completed
- Phase 2 outlined – on schedule to be built

Whilst the MHPs within CSD are already delivering significant improvements for patients, it remains the case that a significant proportion of our mental health calls will require a 'See and Treat' service

4(ii). Mental Health Response Vehicles (MHRV)



1. Ambulance Trusts in England have recognised their sub-optimal approach to mental health calls to 999, and most have now implemented mental health practitioners in 'consult and close' roles. All English ambulance Trusts are now working with NHSE/I to implement mental health response vehicles as well.

2. The MHRV outcomes from the most mature service (London) are quite instructive. Since 2020 14,800 patients have been seen by their MHRVs with an 85% see and treat rate and no serious incidents. In addition to this the staff wellbeing factor is significant with a 95% staff positive experience rating and a 100% staff perception that service users had benefitted from the MHRV service. LAS have concluded that the majority of patients seen and treated did not go on to present at an ED within 7 days. London has also identified operational efficiencies, with MHRVs being a less expensive resource to deploy (£53 less per deployment) and avoiding ED admission saving £193 per episode.

MHJRC-Review-Final-12082020.pdf (aace.org.uk)



See and Treat

The table below provides the key outcomes measures from the 2018/19 pilot evaluation:

	Mental Health Pioneer Service Pilot	BAU response
ED conveyance rate	19%	54%
See & treat and non-convey	77%	38%
See & convey to 'other'	3.7%	7.6%
Referral to MH pathway	19%	4%
Job cycle time	96 minutes	98 minutes
Utilisation	69%	87%
Incidents per shift	5.05	6.05

4(ii). Mental Health Response Vehicles (MHRV)

See and Treat – WAST – current position

WAST MHD Team have been Benchmarking ambulance trusts in England where MHRVs have already been adopted

+

WAST MHD Team have developed a local MHRV protocol

Ongoing discussions with UHBs to develop this further



BCU

- Target areas of highest need
- Interest expressed by BCU
- Engaging with mental health teams
- Wrexham identified as potential test of change area due to demand
- Potential to utilise some under spend from mental health and dementia budgets to support small test of change

AB

- Request from AB to commission a pilot prior to onset of winter
- Initial meeting with AB and included in ICAPs
- Model requested to cover all of AB
- Proposed operational from 1-1 in line with MHPs in CSD.
- Potential rotational model with AB MH staff
- Costings been prepared by finance
- Ops exploring feasibility of vehicle to support pilot

5. Dementia

Dementia position in Wales

The Dementia Action Plan: Strengthening Provision in Response to COVID-19 document was published in 2021 and is a companion document to the Dementia Action Plan for Wales. The work in this plan strengthens existing priorities where the pandemic has had a particular impact. The WAST dementia work plan is in line with national policy.

The All-Wales Dementia Care Pathway of Standards was published in 2021. The co-produced pathway promotes a whole systems integrated care approach and the implementation is being supported nationally and regionally by the Dementia National Steering Group and by five workstreams:

- Community Engagement,
- Memory Assessment Services,
- Dementia Connector,
- Hospital Charter,
- Workforce / measurement.

WAST attends national workstream meetings to have oversight on all workstream developments. We also attend a range of regional and local network meetings to explore local developments. For example, a partnership with Cardiff & Vale Regional Dementia Partnership exploring the emergency admission process for dementia patients has led to a joint action plan for improvement.

WAST are represented at Dementia Oversight of Implementation & Impact Group (DOIIG), where work is underway to evaluate the initial Dementia Plan for Wales, and to develop priorities for the next plan.

Our role in risk reduction

There are currently around 900,000 people living with dementia in the UK, with an estimated 50,000 people in Wales It mainly affects people over the age of 65. One in 14 people aged over 65 has dementia. This rises to 1 in 6 for people aged over 80.
Young onset dementia affects around 1 in 20 people with dementia who are younger than 65. There are more than 42,000 people in the UK under 65 with dementia, with 2-3000 people in Wales. (Alzheimer's Society, 2023)

We have a role to play to raise awareness across Wales, and indeed within our service to promote risk reduction in dementia. This includes:

- Sharing information with communities about dementia through our NHS Wales 111 Dementia Guide
- Supporting a range of campaigns and initiatives such as Dementia Action Week and International Alzheimer's Month
- Working with our People and Cultures colleagues to make sure we have workforce policies, procedures and systems to support staff who may develop dementia or who are carers of loved ones.





Reminiscence Therapy

Working in partnership with My Improvement Network, we are piloting 25 RITA tablets to trial reminiscence therapy with people living with dementia. RITA stands for Reminiscence Interactive Therapy Activities and is an all-in-one touch screen solution which offers digital reminiscence therapy. It is a user-friendly interactive touch screen 10" tablets to blend entertainment with therapy and to assist patients in recalling and sharing events from their past through listening to music, watching significant historical events, listening to historical speeches, playing games, watching old TV shows and sporting events, viewing old maps and photographs, and watching films.

We hope this pilot will demonstrate how we can better support patients who may be distressed or agitated when in our care, where we can provide distraction and occupation for their emotional and wellbeing needs.

The next phase of this work is evaluating the use of the RITA tablets, and this will be available soon.

A patient with dementia and symptoms of delirium, who was very abrupt and it was difficult to calm her. We watched some food clips - she told me she used the ingredients and could even tell me the year these products came out, and at what stages in the recipe it would be brought into the mix, when she baked with her grandmother. She was so excited!

A 96-year old lady with dementia, whose first language was Welsh. She enjoyed listening to the Welsh songs on-route to the hospital and outside during a handover delay.



Other reminiscence projects





Reminiscence apps are available on staff iPads so that a wider range of colleagues can access reminiscence activities to support patients.
We are also exploring the development of a *Patient Activity Toolkit* which would support a wider range of patients with distraction and occupation activities.

6. Education and Training – Dementia

Our goal is to be an organisation that responds to both the clinical and emotional needs of people living with dementia, their carers and families. Our workforce needs to be dementia aware with skills and knowledge to deliver a compassionate and person-centred service.

Dementia Training offer

We deliver a range of learning opportunities to our workforce with role specific content on induction, continuing professional development opportunities and a comprehensive programme for BSc Paramedicine students. We ensure that the voice of people affected by dementia is strong through these learning opportunities and service users regularly attend learning opportunities. This year we have connected with the Volunteer workforce to plan dementia learning opportunities, and have developed a dementia course for the 111 workforce

"Really enjoyed today's session. I plan to take the information learnt and transfer it into good practice when out on the road. Thank you so much"

"I have really enjoyed it today. It has been very informative and heartwarming hearing from Ceri, Andy and Andy. They are inspirational and a credit to themselves. "

Podcasts

We have launched 2 podcasts to date, which focus on the voices of people living with dementia and their carers,. These provide our colleagues with an awareness of how dementia can impact on a person and family life, from diagnosis to ongoing support that people need.
2 further podcasts are being planned and will focus on communication skills and using reminiscence therapy with our patients, and will be developed in partnership with dementia specialists.

Webinars

We have delivered 3 webinars from dementia awareness, to a UK reminiscence therapy session with partners from across the UK.

ESR compliance
WAST has achieved 92% compliance for dementia training during this reporting period.

WAST learning zone
WELSH AMBULANCE SERVICES NHS TRUST

GIG CYMRU NHS WALES
Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services NHS Trust

We have developed role specific dementia content on our e-learning platform for our workforce, which is tailored for staff delivering 'see and treat' and 'hear and treat' services.

Dementia-Friendly Environments

Our goal is to create more optimal environments for people affected by dementia, as feedback tells us they can find it difficult being in our vehicles, particularly on a long delay outside hospital.

New Non-Emergency transport vehicles

Our Non-Emergency Patient Transport Service vehicles take people to and from their routine hospital appointments and discharge people home after a stay in hospital. New design features include dementia-friendly flooring, blinds and colour schemes, while improved safety features like seatbelt warning systems, CCTV and driver assistance systems now come as standard.





Working in partnership with the Ceredigion Dementia Community

We are working across the Ceredigion community to make dementia-friendly changes to Non-Emergency Transport vehicles. This work involves partnerships with local dementia groups, third sector partners, local care homes as well as our own workforce who will co-produce the work with us. We hope to introduce art, music and reminiscence therapy opportunities to support dementia patients., and images from the local community will be available on vehicle windows, such as this image of Aberystwyth beach

Evaluating the impact of this work will be essential to make sure the improvements have a positive impact on patient experiences and outcomes

Celebrating achievements

Professional Excellence

The Trust's Dementia Team won the Dementia Hero Award for Professional Excellence (Organisation) at the Alzheimer's Society Awards 2023. The Dementia Hero Awards celebrate the involvement and participation of people affected by dementia and the impact they have for others living with the condition.



Reminiscence Therapy

The Trust's Dementia Team were named the winner of the most innovative use of Reminiscence Therapy Interactive Activities (RITA) for 2022 at the RITA User Group Conference and Awards.

Mike Hamilton from My Improvement Network says: *"We are thrilled to be working with the Welsh Ambulance Service to introduce RITA into the service. It is well documented that more complex patients such as those living with dementia who are admitted into hospital arrive very anxious and distressed. These patients are susceptible to stress, agitation and in many cases delirium, therefore, innovative solutions such as RITA are needed to ensure that their needs are met in a patient-centred way whilst keeping them calm, informed, stimulated and distracted on the way to hospital. RITA has been evidenced to significantly reduce incidences of challenging behaviour and safeguarding incidents such as falls by offering appropriate therapeutic distraction."*

Dementia Improvement Projects

Referrals into specialist dementia services

We are working in partnership with Alzheimer's Society Cymru on a referral process for any of our staff groups into the All-Wales Dementia Support team. This referral can be from anyone in our service who is concerned about someone's dementia, memory loss, confusion or issues with daily living. The referral is also available for carer and families who may require additional support. The Dementia Support service is an all-Wales bilingual telephone service but also connects to local face to face services. The referral pathway will be available on staff iPads and a desktop form and will be launched in the Autumn 2023.

Working with Royal National Institute for the Blind – Common sight loss conditions

A partnership project with RNIB has enabled us to develop short video-clips on key sight loss conditions, including macular degeneration, cataracts and glaucoma to improve awareness across our workforce. Also included in these mini-learning videos are 'sight loss and dementia'; and 'falls, sight loss and the environment'

Improving the information we capture about people with dementia who contact 999

We have developed additional features on our electronic Patient Care Record to gather important information that we collect about people with dementia who call 999 for an emergency response. The new features will allow us to document different information about a patients dementia symptoms and diagnosis for us to have a better view of the dementia related calls coming through our service. The new function will launch September 2023.

Through 2022-2023 we have identified 18, 783 people living with dementia when providing care through our 999 service

7. Connecting with other works across Wales

A Healthier Wales

The Welsh Government's long-term plan for health and social services in Wales sets out the vision of a 'whole system approach to health and social care' which is focused on health and wellbeing, and on preventing physical and mental illness. A Healthier Wales' 'Quadruple Aim' is to deliver an inclusive, engaged, sustainable, flexible and responsive workforce in health and social care, which is reflected in this plan.

For further information CLICK HERE A healthier Wales: long term plan for health and social care | GOV.WALES

Together for Mental Health

Together for Mental Health (T4MH) is a cross-Government Strategy setting out goals for improving mental health and mental health services in Wales. It is the first Mental Health Strategy that covers all ages; children and young people, adults of working age and older people. In addition to being a plan for all ages T4MH has also adopted a focus on early intervention.

For further information CLICK HERE Together for mental health: our mental health strategy | GOV.WALES

The Dementia Action Plan for Wales

The action plan is a result of working with and listening to a wide range of stakeholders. It is ambitious, person-centred and was developed with people living with dementia, their families and carers as equal partners. This is an approach we have adopted throughout our own work in both mental health and dementia.

For further information CLICK HERE https://gov.wales/sites/default/files/publications/2019-04/dementia-action-plan-for-wales.pdf

The Crisis Care Concordat for Wales

The Concordat is a shared statement of commitment, endorsed by senior leaders from organisations that are most involved in responding to and supporting people of any age who experience a mental health crisis.. The Concordat sets out the ways in which partner agencies should work together to deliver a high-quality response to this group of people who require assessment and/or intervention. This approach is reflected under the 'partnerships' section of the plan.

For further information CLICK HERE wales-crisis-care-concordat-national-action-plan-2019-2022.pdf (gov.wales)

Beyond the Call

This report into crisis care in Wales estimated that around 100,000 people end up in a crisis in Wales each year. It recommended that 111 become the first point of contact for people in a crisis, and we are working with Welsh Government and others on implementation of this recommendation (which is included in our delivery plan).

For further information CLICK HERE https://gov.wales/sites/default/files/publications/2020-12/beyond-the-call.pdf

Welsh Language Standards

In line with the Welsh Language Standards and the Welsh Language Measure (2011), we recognise the importance of delivering all parts of the plan in both Welsh and English including but not limited to the plan itself, training and education for staff and engagement with service users who communicate through the medium of Welsh.

For further information CLICK HERE FOI release: Welsh Language Standards | GOV.WALES

More Than Just Words

Welsh Government's original strategic framework for Welsh language services in health, social services and social care, launched in 2012, has led to a number of improvements which help ensure Welsh speakers receive health, and social care services in their first language.

For further information CLICK HERE More than just words (wales.nhs.uk)

WAST Digital Strategy

This strategy has been developed to ensure that WAST can deliver on its existing digital ambitions, whilst also creating the environment to embrace digital change and transform our services to deliver excellent patient care.

For further information CLICK HERE 261120-WAST Digital Strategy-Final.pdf (wales.nhs.uk)

8. Partnership Working



The Mental Health & Dementia Team sits within the Quality, Safety and Patient Experience Directorate. Our commitment to delivering high quality care has been clearly demonstrated by achievements highlighted in previous reporting periods. Effective, compassionate leadership, courageous management and innovation have been integral to our success.

We reach our objectives by effectively working together with a wide range of services and professionals, ensuring good outcomes for people who have contact with our service.

MHD Team has established strong relationships with all departments in our organisation as well as within the wider mental health & dementia arena across Wales.

Our achievements obtained through improved knowledge, skills and attitudes as well as the promotion of mental health & dementia services and pathways across Wales has fortified our working relationships both at an operational and strategic level.

The Wider Mental Health & Dementia Arena

National Ambulance Mental Health Group (NAMHG)

The purpose of this group is to promote a consistent approach to Mental Health across the UK ambulance services. To connect, support and guide mental health practice of its practitioners across the UK.

WAST Mental Health and Dementia Team contribute to the work of the group and participate in promoting evidence-based practice/ NICE guidelines to ensure services are providing high standards and quality of care across all trusts and promote continuous improvement.

Welsh Chief Officers Group

This group provides mental health updates and information sharing from all four police services across Wales. The aim of the group is to provide a framework for organisations to learn from mental health strategies and evidence-based ways of working.

A Senior Professional from the MHD Team is part of the task and finish group for this group.

Dementia Oversight of Implementation and impact group

This group informs and monitors progress against the dementia action plan in Wales. It provides the opportunity to promote WAST dementia work at a national level, and to share and learn with partners.

All Wales Blue Light Dementia Network

This group connects all blue light partners in Wales including Police, Fire, Mountain Rescue and Natural Resources Wales to focus on personal, home and community safety initiatives with people living with dementia at the heart.

Welsh Government

Together for Mental Health is a mental health policy framework for Wales. It was introduced in 2012 and outlines the Welsh Government's vision and strategy for improving mental health and well-being in Wales.

The policy focuses on various aspects of mental health, including prevention, early intervention, and support for individuals experiencing mental health issues. It emphasizes the importance of reducing stigma and discrimination, promoting mental well-being, and providing effective mental health services.

TfMH was a 10-year plan and is currently being evaluated and a renewed plan set forth. WAST MHD staff are engaged with this on a national basis.



9. Quality Improvement

The MHD team's approach to quality and quality improvement for this reporting period has been to focus on achieving the requirements set within the MHD work plan 2022/23. This aims to achieve our targets within the WAST Quality Strategy (2021-24) and prioritises our contribution in delivering the Integrated Medium Term Plan; as well as to identify any actual or potential risks to deliverables during this reporting period and beyond.

The MHD work plan provides the focus for improving quality as part of the organisation's internal strategy but also incorporates the requirements included in standards and outcomes set by external reporting mechanisms. The MHD work plan & assurance framework is mapped to Together for Mental Health (2012). MHD sits within the Quality Themes: Effective/ Individual/ Timely/ Dignified and Safe Care. It also sits with Prudent Healthcare the outcome of which is to ensure *our service users are protected from harm and protect themselves from harm.*



The following table illustrates the priority areas for achieving this by focussing on the key deliverables specified within the MHD work plan for 2022/23

Safe Care and Prudent Healthcare

Operational Process	Training and Education	Policy and Procedure	National Collaboration

Progress 2022/23

Operational Process
- SCIF/ clinical support/ clinical supervision/ Managerial supervision.
- Assessment algorithm

Training
- SFA
- Induction of MHPs
- On-Click
- F2F sessions

Policies and Procedures
- Required review and updates ongoing – MCA Policy being developed for WAST

National Collaboration
- AWSNAG/ NAMHG/ Welsh Chief Officers/ Together for MH
- 111#2 – national steering group – Developed transfer protocol between 111#2 and 999 services

Building the Team

Chella Rowles

Dementia Coordinator



Chella Rowles joined WAST in September 2019 as Dementia Coordinator. After graduating with a Law degree from University of Wales, Aberystwyth, Chella has worked in a variety of advice, volunteer management, training and project coordinating roles, and led on the Dementia Friends initiative delivery in Wales for Alzheimer's Society.

Chella's role will support the implementation of the Trust's Dementia Plan to ensure people affected by dementia, both staff and those accessing the service, receive the best possible support. Since starting with WAST Chella has completed a PGCE in Post Compulsory Education and Training at Cardiff Metropolitan University, graduating with the award for Academic Excellence.

Building The Team

Simon Amphlett

Specialist Clinical Lead - Mental Health



Simon is a Senior Registered Mental Health Nurse with a robust portfolio of nursing, operational and service management experience. His career has allowed development across the main pillars of the NHS from working in the clinical setting, operational responsibility, staff management and service performance improvement.

He is a skilled and knowledgeable Mental Health Professional with extensive experience working within various areas of Psychiatry and acquiring invaluable expertise in most areas relating to General Adult Mental Health, the last twelve years working predominately within unscheduled care and Crisis Services.

Simon is enthusiastic about his continuing and professional development and takes every opportunity to further his skills and experience. He is currently studying for his MSc and has just started the Remote Clinical Decision-Making Module.

Building The Team

Mark Jones

Consultant Mental Health Nurse



Mark is a senior mental health nurse who has worked in both UHB senior management roles and national roles within public health Wales. He is passionate about mental health services that are flexible, responsive, and effective for service users within the 21st century and has strived to develop himself through education obtaining a doctorate, masters and degrees within mental health practice.

He believes that good mental health can be achieved through early intervention proactive services and is part of the Bevan exemplar currently looking at how WAST can further meeting the increasing demand of mental health care.

Building The Team

Natasha McBeth

Mental Health & Dementia Administrator



Natasha Joined WAST in December 2015 appointed as the Mental Health Administrator in December 2018 prior to this Natasha was the receptionist for WAST. Since 2015 Natasha has worked independently towards achieving work-based qualifications and gained NVQ L2, NVQ L3 and NVQ L4 in Business Admin, IQT Bronze, Welsh Level 1 and is a qualified Agile Project Manager.

Natasha's role is to support the Mental Health & Dementia Team with any administration, support the team with their projects to ensure the team have all the tools and information available to help them and currently overseeing the Suicide First Aid project to help manage the delivery of it to the workforce.

Building the Team

Alison Johnstone

Programme Manager for Dementia



Alison has worked as the Programme Manager for Dementia for a few years now and has been with the Welsh Ambulance Service since 2007. She leads the Dementia Plan for the Trust, giving a stronger voice to people living with dementia and their carers/families, so that they can influence the work of the service.

As a Trust, we are working towards improving the experience for people living with dementia who use our services, as well as considering the impact it will have on our workforce. Key work areas include training and development; co-production and partnership working.

As part of the Emergency Services Strategic Commitment on Dementia, Alison chairs the All Wales Blue Light Dementia group, bringing together all key emergency service providers. Please click here for more information.

We were proud to win the Alzheimer's Society Dementia Hero Award for Professional Excellence in 2023, as well as a Gold Award for our use of reminiscence therapy in ambulance services Welsh Ambulance Service Dementia Team wins Gold - Welsh Ambulance Services NHS Trust

10. Conclusion

In conclusion the Mental Health & Dementia annual report reflects the significant contribution which the Trust, MHD Team and WAST colleagues have made in ensuring people are treated for their mental health problems in the best way possible. There is much to celebrate in the achievements highlighted throughout the report.

The MHD Team's collaborative partnership working continues to be significant. Our achievements obtained through continuous improvements, capitalising on evidence-based practice and successfully implementing these ways of working.

MHD team is dedicated to working with partners and organisations across Wales and the UK to facilitate patient pathways and ensure best practice is adopted in a timely manner for the benefit of our patients.

MHD team also provides dedicated continual advice, guidance and support to colleagues at all levels within WAST.

The work streams commenced during this reporting period provide focus for the team to continue to progress in 2023-24 and the development of the next Mental Health & Dementia 3-year Plan.



Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
NHS Trust

Amb_mentalhealth@wales.nhs.uk

11. Moving Forward 2023/2024

- To continue to progress See and Treat + Hear and Treat
- To continue to promote WAST Mental Health & Dementia National Collaboration
- To continue to update Mental Health & Dementia training and methods of delivery
- To ensure the resilience and required resources for the Team



AGENDA ITEM No	**14**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**2**

PATIENT EXPERIENCE & COMMUNITY INVOLVEMENT BI-ANNUAL REPORT (APRIL - SEPTEMBER 2023)

MEETING	Quality, Patient Experience & Safety Committee
DATE	31 October 2023
EXECUTIVE	Liam Williams, Executive Director of Quality and Nursing
AUTHOR	Leanne Hawker, Head of Patient Experience & Community Involvement
CONTACT	Leanne Hawker Leanne.Hawker@wales.nhs.uk

EXECUTIVE SUMMARY

1. This report provides an overview of the work undertaken over the last six months in capturing and responding to patient experiences. It is not an exhaustive list; it does not contain 'business as usual' but an insight into the work undertaken by the Patient Experience & Community Involvement (PECI) Team that demonstrates how it is supporting the Trusts principles of providing the highest quality of care and service user experience as a driver for change and meeting the differing needs of each of our communities we serve without prejudice or discrimination.

2. Patient experience is a 'golden thread' that runs throughout the Trust's Integrated Medium Term Plan (IMTP) and is at the heart of our services. 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

(1) To note the activities to date and acknowledge that PECI Reports will be shared publicly through the Trusts People & Community Network; and

(2) To receive the report and accept the assurances that the Trust is meeting its statutory duties/responsibilities to consult; engage and involve the public/patients in its work.

KEY ISSUES/IMPLICATIONS

(i) We need to increase the volume of patient experience returns. The Trust had previously purchased the core Civica patient experience system, and we are now seeking funding to include SMS Text/IVR/and Email bundles as add-ons. This will enable Civica to integrate better with the Welsh Ambulance Services NHS Trust (WAST) data warehouse and *push* surveys out to patients instead of expecting people to look for our online surveys themselves.

(ii) There is also information governance consideration. We acknowledge that contacting 999 callers is complicated for many reasons. The National Ambulance Information Governance Groups (NAIGG) had previously advised not to survey 999 callers; however, an Ambulance Service in England is surveying 999 callers and we are seeking to learn from their experience.

(iii) Their Data Protection Impact Assessment (DPIA) seems to rely on the National Data Opt-Out which only applies in England. The National Data Opt-Out allows a patient to choose if they do not want their confidential patient information to be used for purposes beyond their individual care and treatment such as research and planning. We are currently awaiting feedback from the Trusts Information Governance Lead on this point.

REPORT APPROVAL ROUTE	
Clinical and Quality Governance Group	25 October 2023
Quality, Patient Experience & Safety Committee	31 October 2023

REPORT APPENDICES
ANNEX 1 - SBAR Providing an overview of patient experience and community involvement
ANNEX 2 - PECI Bi-Annual 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)	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

SITUATION

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

2. Key themes from feedback of service users continues to be repetitive questioning and response times. Linked to response time are estimated time of arrivals (ETAs) given to patients not being accurate, (it should be noted that explanations are provided on why this happens). Regarding the Non-Emergency Patient Transport Service (NEPTS), it is the wait time for transport home following a patient's appointment that is a regular feedback theme.

3. With the introduction of the Duty of Quality, the Health & Care Standards are replaced with the Quality Standards (2023). The PECI Work Programme has been mapped against the Quality Standards to provide 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
- Community Involvement using a co-productive approach.

4. Patient Reported Experience Measures (PREMs) for this period are included within the PECI Bi-annual Report (**Annex 2**).

BACKGROUND

5. 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

6. The contribution and key deliverables of the PECI Team towards improving patient experiences, quality of services and enhancing the reputation of the Trust across communities is included within the Bi-Annual Report (**Annex 2**).

RECOMMENDATION

The Committee is:

(1) To note the activities to date and acknowledge that PECI Reports will be shared publicly through the Trusts People & Community Network; and

(2) To receive the report and accept the assurances that the Trust is meeting its statutory duties/responsibilities to consult; engage and involve the public/patients in its work.



Patient Experience & Community Involvement (PECI)

Bi-annual report April – September 2023

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
NHS Trust

PECI.TEAM@Wales.nhs.uk

PECI Bi-Annual Report

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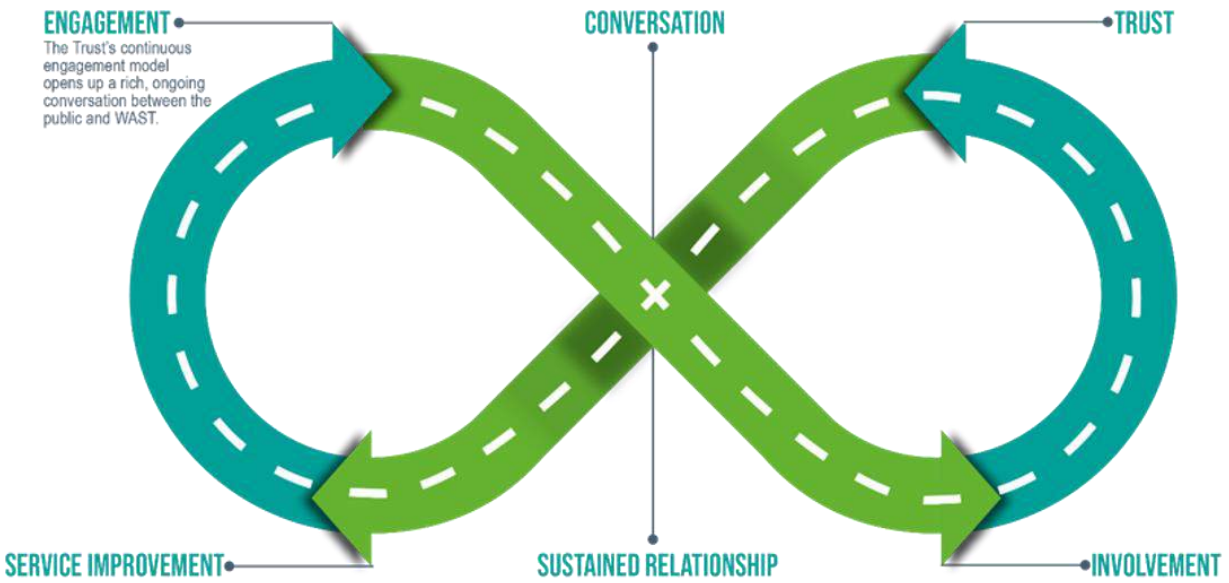
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- The Bevan Commission 16

Patient Experience within the Welsh Ambulance Service

Patient experience at the Welsh Ambulance Service (WAST) is influenced by the many interactions people have with our staff, their expectations when in need, and their first and lasting impressions of those interactions.

The patient experience within this report is defined by what it feels like for people to access and receive care from WAST, it is based on their perceptions of their care and treatment.

Experience has been reported directly by patients, their families and carers and though this is a subjective indicator of quality, it provides an insight into how our service processes, procedures and staff impact on peoples' perception of a quality service and patient experience.



Performance Measure Learning Disabilities – Improving the lives of people with learning disabilities.

- The extensive programme of engagement and development work underway within WAST to continue to improve the experiences and outcomes for those with a learning disability accessing Trust service continues.

- In September representatives were invited and presented to the Learning Disability Ministerial Advisory Group on progress made in key areas and the Trusts ambitions for how it might meet the needs of people with a learning disability moving forward.

- The presentation was well received and lead to discussions including flagging of individuals, systems that speak to each other so clinicians can learn about individuals' needs, frequent callers, the intersectionality of learning disability and ethnic minority communities and further engagement and networking opportunities.







Future Generation's Commissioner & Children's Commissioner

Future Generation's Commissioner Well-being goal (A Healthier Wales)

- **Shoctober.**

A WAST led primary education campaign supporting Children's Rights and contributing to resilient communities. Expressions of interest from schools this year is up by 194% (highest level recorded since its launch in 2016)

- **Food Fun Wales.**

Supporting Cardiff school-based education programme providing enrichment sessions from external agencies during the school summer holidays.

This summer, WAST engaged with 10 schools and over 400 learners discussing how other community NHS services can help, what happens when you call 999 and life-saving skills of what they can do while help is on its way.

Children's Commissioner 'The Right Way' a children's rights approach

- **The Right Way - case study**

The Children's Commissioner's office is updating case studies on their website to ensure best case examples are reflective of how different organisations across Wales are putting **The Right Way** into practice.

PECI have been invited to submit a short case study on its implementation of some of the principles to empower children we engage with and to improve participation of children in WAST services.

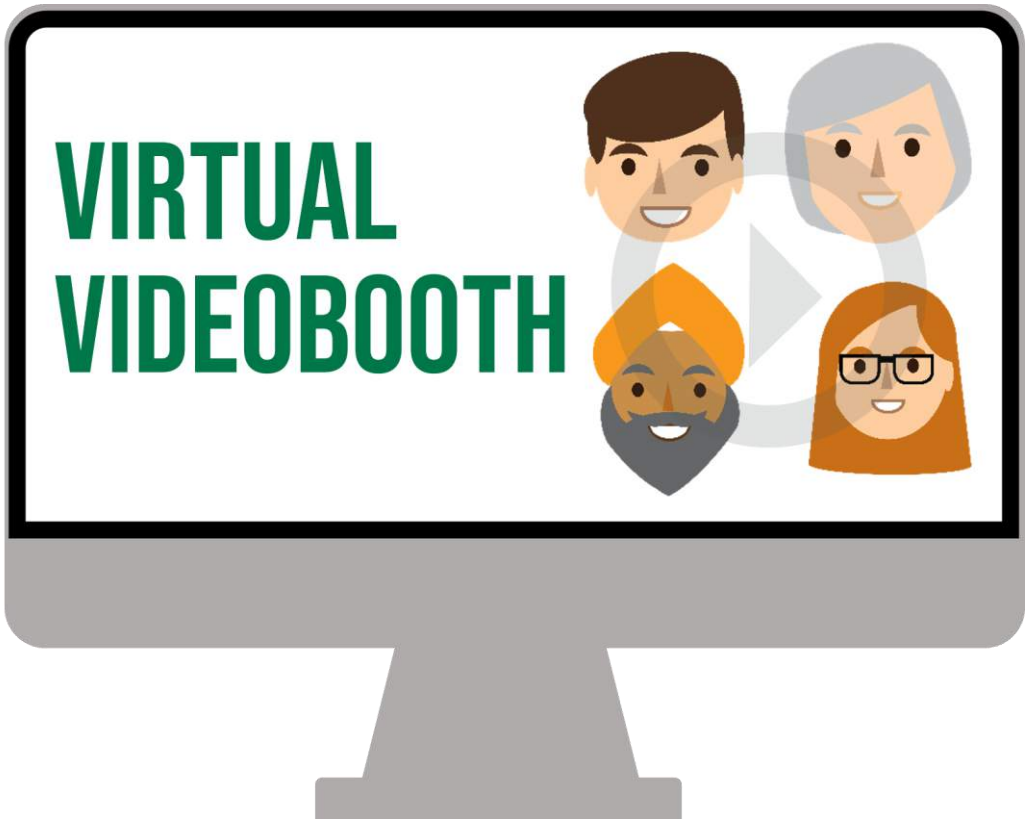
Framework for Assuring Service User Experience

CIVICA - Patient Stories

- A new feature of Civica version 8 is the patient stories video functionality.

  The key functions of the patient stories feature are the ability to upload videos from external sources; ability to categorise/sort stories; option to play videos directly within the experience platform; ability to download videos for use within a health board; share videos between organisations (currently only apply to NHS Wales) and process for managing patient consent for video stories.

  The new feature will not allow patients to directly record and upload stories themselves into the system. This means we will likely need to retain access to the 'Virtual Video Booth' system we have in place that allows patients to record their stories online.



Framework for Assuring Service User Experience

CIVICA – Patient Experience Surveys

Palliative End of Life Care (PEOLC)

- The Palliative End of Life Care experience survey is a national survey running across NHS Wales. The survey is currently live in all Health Board and Trust's Civica accounts and is being promoted to palliative care service users.

  At the last PEOLC Survey Experience meeting clarity was sought about WAST's role in this survey and where feedback about contact with WAST's Palliative Care Paramedics on rotation should be recorded.

National Patient Experience Surveys

- Following the roll out of the National Palliative End of Life Care experience survey, several requests are being received for Civica to host national patient experience surveys, across Wales. To scrutinise these requests further and help decide if Civica will host these surveys with national support from Patient Experience Teams a
- cross Wales, a National Survey Editorial Board has been established.

  PECI representative has been forward to be part of the proposed Editorial Board to ensure WAST's role in national surveys is considered.

Framework for Assuring Service User Experience

CIVICA – WAST Patient Experience Surveys

We continue to promote 3 core Patient Experience Surveys covering WAST's main service delivery areas:

999 EMS Experience Survey

This survey is currently made available to members of the public online through the WAST website and social media channels. We do not have a robust governance process in place allowing us to directly contact 999 users to ask for feedback, as a result service users must use their own initiative and seek out the survey themselves to provide feedback.

This means that responses to the survey remain consistently low. We use social media and all other mechanisms available to promote the survey and continue to explore options to develop a governance process that will allow us to directly contact 999 service users to ask for feedback. In this reporting period 19 of responses to this survey were received. A full breakdown can be found in Appendix 1.

NHS 111 Wales Experience Survey

There are two surveys in place for NHS 111 Wales, separately collecting feedback about people's online experience and telephony experience.

Again, we do not yet have a governance process in place allowing us to directly contact 111 callers to ask for feedback. People must show initiative and find the survey online themselves if they want to give feedback.

Responses to this survey for this reporting period were deemed too low to report. We will work with the NHS 111 Wales Service Manager and Information Governance colleagues to explore solutions to directly contact 111 users to ask for their feedback.

The online experience survey is available through the NHS 111 Wales website, users are prompted to leave feedback using a pop up that appears on screen. In this reporting period 195 responses to this survey were received. A full breakdown can be found in Appendix 1.

Framework for Assuring Service User Experience

CIVICA – WAST Patient Experience Surveys

NEPTS

An established governance process is in place which allows us to contact people who have received transport to their appointment and ask for feedback. This contact is made either by SMS Text or by posting a hard copy survey to the patient at home. The survey is also freely accessible online, all NEPTS vehicles now also have a sticker onboard containing a QR Code which directs people to the feedback survey.

Response rate to this survey remains good and provides overall assurance that people are content with the service received. An obvious area of concern with patients is wait time for transport home following their appointment. In this reporting period 673 of responses to this survey were received. A full breakdown can be found in Appendix 1.

Thinking about the Non-Emergency Patient Transport Service, how was your overall experience of our service the last time you used it?



Available Answers	Responses	Score (%)
Very Good	451	76.18%
Good	70	11.82%
Neither Good nor Poor	17	2.87%
Poor	14	2.36%
Very poor	31	5.24%
Don't Know	9	1.52%

Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services NHS Trust

Health and Social Care (Quality and Engagement) (Wales) Act 2020-21

Citizens Voice Body - 'LLAIS'

We have been and continue to reach out and engage with Patient & Public Engagement Officers at Llais, the new citizen voice body for health & social Care in Wales.

Llais are working to ensure there is a consistent approach across Wales regarding structures and engagement.

- Awaiting named individual/s from Llais to be a member of the WAST Citizens Voice Group
- PECI members will continue to meet regularly (bi-monthly) to share dates for events and activities; share plans for surveys/feedback as necessary.
- Have committed to promoting Llias and its activities within the communities and groups we engage with.

Sharing good practice

- In July approval was given following a request from the Head of Communications and Engagement at North West Ambulance Service NHS Trust to use our easy read '999 leaflet' developed by PECI team for use with the public.
- In September, a formal request from a Director for Dementia Training in Australia Ambulance service to use a previous patient dementia experience story for use in training first responders has been given approval.

People & Community Network

- Plans to grow the Network is underway to ensure it is representative of the diverse communities we serve across Wales, with a focus on age, gender and location is in progress. It will also include accessibility for the Learning Disability community and for those whose first language is not English or Welsh.
- Have continued with internal promotion to raise the profile of the network with colleagues across the Trust, identifying opportunities for members to participate in.

Health and Social Care (Quality and Engagement) (Wales) Act 2020-21

Patient Reported Experience Measures (PREMS)

- The Centre for Healthcare Evaluation, Device Assessment and Research (CEDAR) are working with Welsh Government and the Welsh Value in Health Centre to lead the refresh of the National PREM set.

- As part of this project, they will initially be undertaking focus groups and afterwards, sending out a draft PREM for comment.

- PECI have been invited to take part in a focus group and link the People and Community Network volunteers with this exercise.

Person-Centred Care

- One of the six quality domains within the Duty of Quality, is 'person-centred'. This places a focus on getting the best outcome and experience, treating everyone with kindness, empathy, and compassion, respecting people's privacy, dignity, and human rights. Being person-centred means delivering the best service and creating a positive patient experience.

- Discussions are ongoing to include compliments within the NHS Quality Dashboard. In preparation for this we have requested a change to Datix to be able to set up a report for compliments registered which show the staff involved. We will be able to then identify 'experience makers' and demonstrate how many compliments had been received by individual staff members to encourage good practice and provide an evidence base for person-centred care reporting.

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Welsh Ambulance Services NHS Trust

Community Involvement & Co-production

Minority Communities:

- A Welcome Pack for diverse communities and people whose first language is not English, will be formally launched in conjunction with the Ethnic Youth Support Team (EYST) on November 2nd at an event being held at the Selwyn Samuel Centre, Llanelli. This pack was conceived through engagement with Syrian families being resettled in Wales and other ethnic minority communities across Wales.

Hindu Cultural Association (HCA), Cardiff & Vale Regional Partnership Board (CAVRPB) and Welsh Ambulance Service Collaboration

- Starting in October 2023 WAST (represented by PECI) will collaborate with HCA and CAVRPB on a project which aims to identify knowledge and skill gaps in community members attending the India Centre, Splott, Cardiff and co-design a programme of skill and awareness raising sessions based on community need, co-creating solutions to accessing services and building community resilience.

Coproduction Network for Wales

@CoproNetWales AELOD MEMBER 2023-24

- PECI are organisational members of the Coproduction Network for Wales, representing WAST with its operational commitment to coproduction and public involvement.

The network also acts as a critical support providing annual check-in on our co-production aims, aspirations, and development needs.

National Principles for Public Engagement in Wales

- WCVA and WLGA have commissioned a refresh of the evaluation of engagement toolkit. This toolkit accompanies the refresh of the National principles for Public Engagement in Wales and its' accompanying manual.

PECI have participated in sessions to look at the draft form of the toolkit and put forward proposals that would benefit WAST when evaluating engagement.

IMTP – Community Engagement

Integrated Medium Term Plan (IMTP)

- As Part of the IMTP process we have shared information about our public involvement and engagement activities with colleagues in Performance and Planning. To support the IMTP update we have been using our engagement sessions to capture feedback from the pubic on what they expect from the ambulance service and will feed this information into the Performance & Planning Team.

- Plans are underway to host two 'Come and Meet' events in partnership with the Experience and Engagement Teams at BCUHB and SBUHB. Working in partnership with Health Board colleagues, these events will have a broader focus than just services delivered by WAST, but will provide opportunity to demonstrate how WAST's services integrate with and support services delivered by the Health Board.

These events will allow opportunity to place a greater focus on providing the public with opportunities to hear about WAST's future plans and for the public to share feedback.



BEVAN COMMISSION – Big Conversation

Comisiwn Bevan Commission

- The Bevan Commission is currently exploring the future sustainable model for health and care in Wales. Phase 1 has started with activity on gathering insight from the public using a survey. Hosting workshops from September – October with an online virtual event in November.

- All Patient experience leads have been requested to support this work. WAST and health board experience leads have been meeting regularly with the Bevan Commission.

- PECI will be assisting by disseminating their survey to its patient/community links and networks with invitations to the town hall style events and virtual online event.

- PECI will be in attendance, listening and note-taking at the town hall events.

Dates of regional 'Town Hall' events are:

BCUHB
Venue Cymru, Llandudno
29 September 2023. 10.00-12.30

PTHB
Theatr Brycheiniog, Brecon
3 October 2023. 10.30-13.00

HDUHB
Halliwell Conference Centre, Carmarthen
10 October 2023. 1030-1300

CAVUHB
Memo Arts Centre, Barry
19 October 2023. 1030-1300

CTMUHB
Orbit Business Centre, Merthyr Tydfil
26 October 2023. 1030-1300

ABUHB
Newbridge Memo, Newbridge
12 October 2023. 1030-1300

SBUHB
Village Hotel, Swansea
24 October 2023. 1030-1300

Online (Zoom)
7 November 2023. 1800-2030



Bi-annual report April – September 2023

APPENDIX 2, PREMs DATA

GIG CYMRU NHS WALES

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
NHS Trust

PECI.TEAM@Wales.nhs.uk

Your experience of calling 999

From April to September 2023 19 people used the survey to provide feedback. This is a disappointingly low response rate, and we acknowledge that this does not provide a truly representative picture of what it feels like to be an EMS service user. We are currently unable to directly contact 999 users to ask for feedback and rely on them seeking out opportunities to provide feedback independently. We are actively seeking a solution and are engaging with Information Governance Team. Based on the low numbers during this reporting period, responses were received from all Health Board areas across Wales.

- **79% of respondents said they felt confident in the ability of the person who answered their call to manage the call and provide appropriate advice.**
- **64% 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, 80% said they felt they were given enough advice about what to do next.**
- **Of those who said an ambulance was sent, 91% said they felt safe whilst in the care of the ambulance crew.**
- **87% of people who completed the survey rated their overall experience as 'Good' or 'Very Good'.**

As part of the work to support national surveys, there is an increased reliance on the interaction with patient contact information and the transmission of survey invites via SMS text messaging. To be effective, all Civica Experience Wales systems should benefit from SMS transmission capability. WAST does not currently have the SMS functionality installed. As NHS Wales transition to an increased reliance on SMS messaging, it will become more important for this functionality to be available to us. We are currently working through the requirements for WAST to add this functionality to our systems.

Your experience of calling 999

The Civica Experience platform provides us with some enhanced reporting facilities, including the ability to weight questions and produce 'Heat Maps' based on responses. We set a benchmark of 85, with aggregated scores of 85 and above representing a positive response.

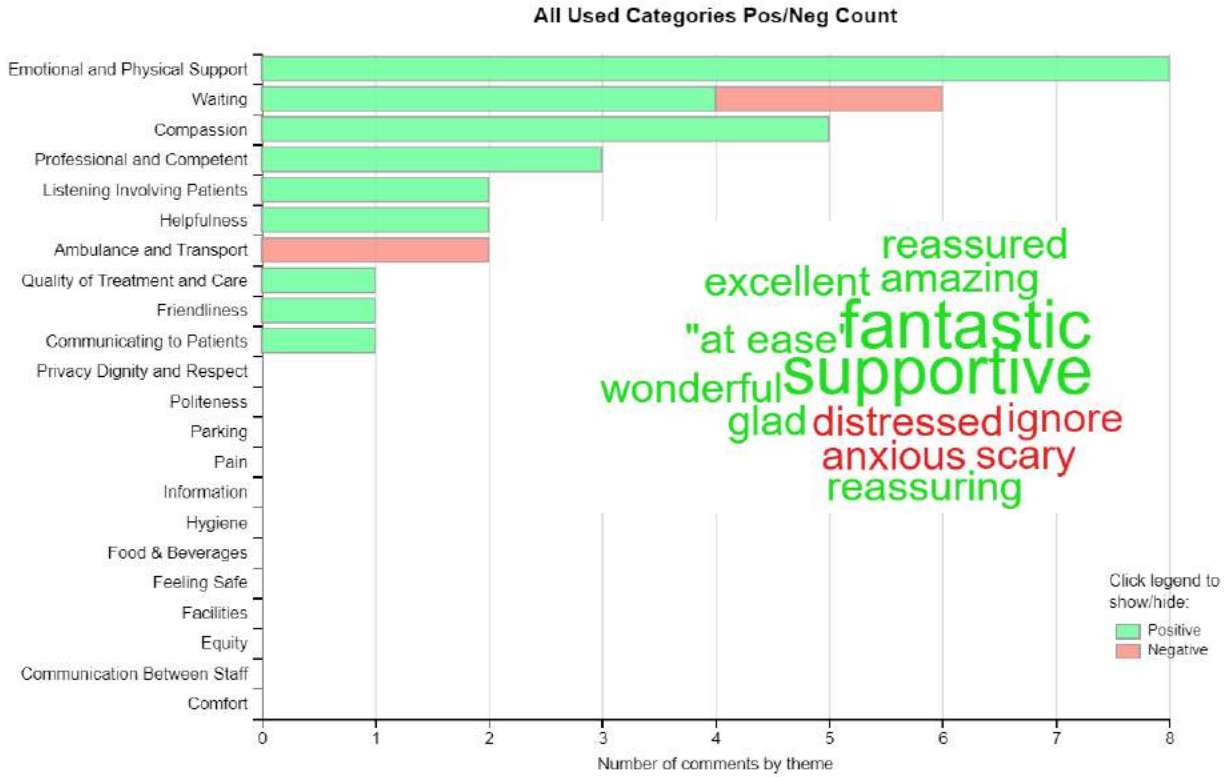
From the Heat Maps below we can see that the benchmark was reached in all areas except waiting time for an ambulance response.

	Overall Experience	EMS Coordination				CSD			
Responses	**Thinking of the last time you called 999. Overall, how would you rate your experience of the service**	**The 999 call taker who answered your call listened carefully**	**The 999 call taker who answered your call was reassuring**	**The 999 call taker who answered your call explained what was going to happen next**	**You felt confident in the 999 call takers ability to manage your call and provide appropriate advice**	**Was the Clinical Advisor you spoke with polite?**	**Did you feel that you were listened to by the Clinical Advisor?**	**Did the Clinical Advisor explain why an ambulance would or would not be sent to you on this occasion**	**Do you feel you were given enough advice on the telephone about what to do next?**
19	87	92	90	90	90	100	100	88	100
Benchmarks	**85**	**85**	**85**	**85**	**85**	**85**	**85**	**85**	**85**

EMS Response								
The length of time I waited for the ambulance to arrive was acceptable	**I understood the explanation of the care and treatment provided**	**I felt safe whilst in the care of the ambulance staff**	**The ambulance staff were professional and reassuring**	**The ambulance journey was comfortable**	**Overall, I was happy with the service received from Welsh Ambulance Service**	**Overall, I felt that I was treated with dignity and respect**	**Did the Paramedic or ambulance service staff clearly explain why you were not being taken to hospita**	**Before leaving you at home, did the Paramedic or ambulance service staff provide you with enough inf**
77	90	100	100	93	90	93	100	100
85	**85**	**85**	**85**	**85**	**85**	**85**	**85**	**85**

Your experience of calling 999

The Civica Experience platform also uses Akumen pansensic text analysis, which uses advanced emotion analytics to scan text-data, identifying emotions, sentiment, themes and behavioural indicators to provide a previously unavailable level of understanding about our feedback.



What people said:

"There was a 3 hour wait for an ambulance to arrive, but the call handler I spoke to and the staff that arrived were all amazing".

"I was naturally very distressed and everyone who dealt with me were calm, professional, supportive, kind, well-informed and I had every faith in their capabilities. I can't praise them highly enough. I would really like this to be passed on to the call and ambulance team if possible".

"It was a really scary situation to be in and everyone who I spoke with and who came to help was great, I couldn't have asked for better".

Your NEPTS experience

We have continued to work with colleagues in the Non-Emergency Patient Transport Service (NEPTS) to survey NEPTS users, helping us to build a better understanding of their experiences, identifying areas of good practice and quality improvement opportunities.

Between April and September 2023, a total of 673 NEPTS patient experience surveys were completed. The responses received 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. Stickers asking patients to provide feedback are now also displayed in all NEPTS vehicles, the stickers contain show a QR code which people can use to access the survey online, alternatively the phone number for the Patient Experience & Community Involvement Team is displayed for people who prefer to use this method.

- **Responses were received from all Health Board areas, higher levels of engagement with the survey continue in the Betsi Cadwaladr and Aneurin Bevan areas. With Swansea Bay and Powys again receiving the fewest responses.**
- **94% found the booking process easy. Those who answered negatively here said it was because of long delays for booking calls to be answered.**
- **93% said they were happy with the transport they received.**
- **A 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.

Your NEPTS experience

The NEPTS Patient Experience survey now also contains a number of weighted questions, allowing us to produce Heat Map reports. These heat maps also use a benchmark of 85 to indicate a positive response.

From the heat map below, we can see the benchmark has been reached in most areas. Being reminded about wearing a seatbelt has just reached its benchmark, suggesting more can be done to ensure staff are consistently delivering this message. Especially as we know in recent months there have been numerous reported patient safety incidents relating to appropriate use of seat belts and restraints.

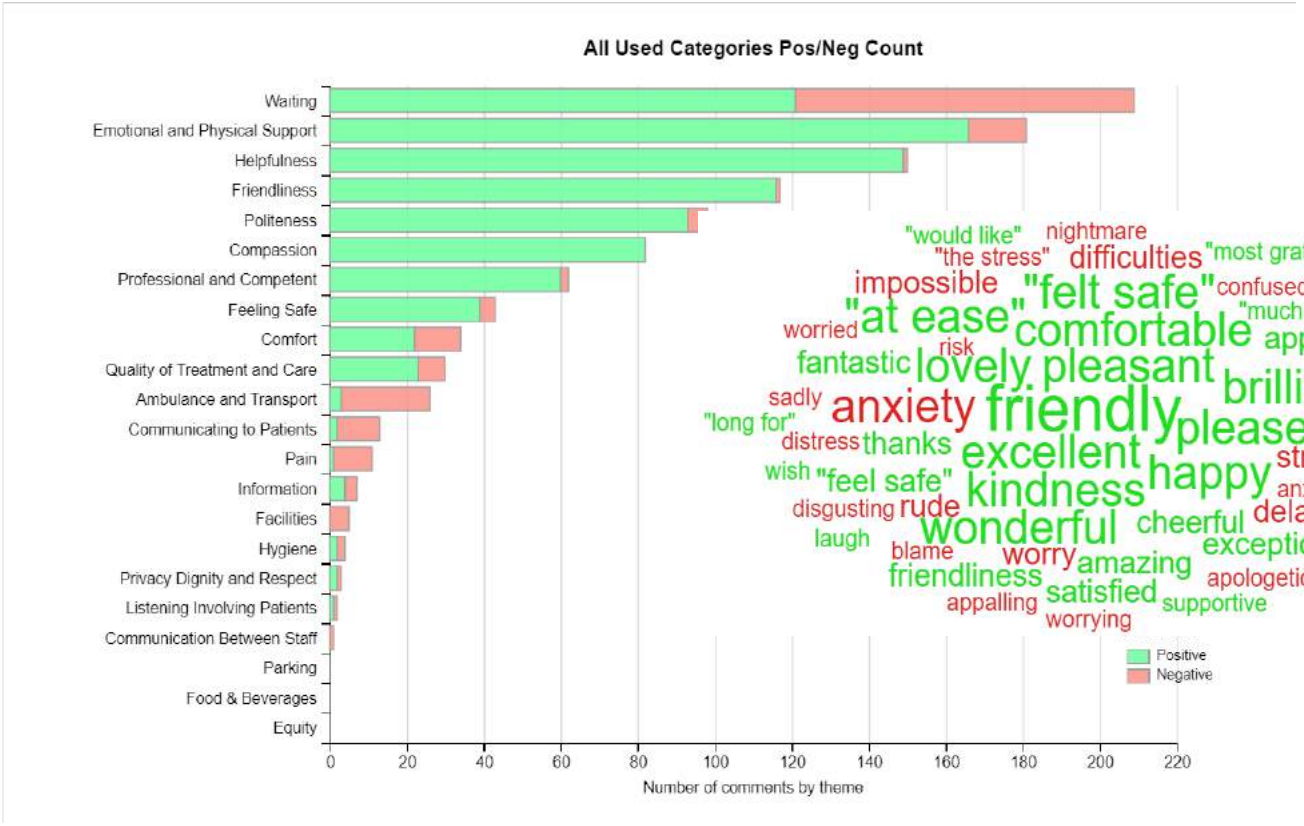
The only area where the benchmark has not been reached is satisfaction with wait times for transport home following an appointment. Patient satisfaction in this area is currently falling very short of the benchmark, we can monitor to see if this result improves over the next 6 months; or if this benchmark continues to be missed, we can alert the NEPTS management Teams that this is an area where patients want us focus improvements.

	Booking			Transport & Journey							Overall Experience	
Responses	Did you find your booking experience easy?	Was our call handler polite and courteous during the call?	Do you feel you were given all of the information you required prior to your journey?	Were you happy with the transport you received?	Did you feel that the crew were polite and helpful towards you?	Were you given support to meet any additional needs you have? For example: communication; mobility;	If you asked for assistance, did you get it when you needed it?	How clean was the vehicle you travelled on?	During your journey, were you reminded/prompted about wearing your seatbelt?	How long did you wait for your transport to take you home after your appointment?	Thinking about the Non-Emergency Patient Transport Service, how was your overall experience of our s	Using a scale of 0-10 (0 being bad and 10 being excellent), how would you rate your overall experien
670	94	98	94	93	98	96	99	96	88	62	88	90
Benchmarks	85	85	85	85	85	85	85	85	85	85	85	85

Your NEPTS experience

Akumen pansesic text analysis of comments left shows us that people spoke about waiting times, emotional & physical support, helpfulness and friendliness in positive tones.

Waiting, comfort, the transport and pain were areas where people left comments which had more negative sentiment behind them.



What people said:

"Drivers are somewhat late picking me up and had not allowed enough extra time for other pick-ups, so that I was almost always late for my appointment. The worst one arrived at the hospital 1.5 hours late and didn't seem to care. He was very uncommunicative and gave me no assistance getting in or out of car".

"Last time, had to wait approximately 2.5 hours to travel home. The ambulance driver was extremely apologetic however".

"Your driver was professional, courteous, on time. A very nice person, very helpful. The service you provide is excellent".

Your experience of NHS 111 Wales Online

Throughout this reporting period we have continued to make available a patient experience survey asking people to share their views with us about accessing health information and advice through the NHS 111 Wales website. **Between April and September 2023 195 people completed a website experience survey.**

- 53% told us that they didn't find it easy to find the information they were looking for on the website
- In contrast, 37% of respondents said they found it either 'Extremely' or 'Very' easy to find the information they needed
- 42% of people said they intended to follow the follow the advice they found on the website.
- 49% 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:
  - ***"Looking for pictures of rashes, site said there are 18 pictures. This just doesn't work on iPhone. Very poor. Still have an unexplained rash. Money wasted!"***
  - ***"Sorry for the language but the only way I can tell you is it's a crap website that only frustrates users and you don't do anything about it"***
- 36% 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:
  - ***"Website is fantastic and informative; I truly appreciate the NHS and all the staff that support it"***
  - ***"Could easily find the symptoms straight away, will keep an eye on bite and if symptoms worsen/do not improve with treatment will call 111 as advised"***

NHS 111 Wales Online

It should be noted that the Website and its associated content is currently not being updated due to ongoing issues, which means we are not able to respond to concerns users have regarding content and navigation. Currently, the NHS 111Wales website is unfunded and the supporting digital team was decommissioned this year.

In addition to technical challenges associated with its ageing content management system (CMS), no clinical digital specialists or content managers are working to stabilise, modernise or maintain existing and new content.

There are no ongoing assurance processes for clinical content, including the online symptom checkers. Several examples of peer-reviewed expert recommendation reports for content have not been enacted, and readability challenges and service user feedback have not been explored.

Given the Welsh Government's policy on digital-first, the introduction of the Welsh NHS App, and the future impact a fit-for-purpose website could offer, this represents a significant and ongoing risk and challenge.

These risks are documented and discussions are ongoing with Commissioners.

AGENDA ITEM No	**15**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**2**

Clinical Audit Plan 2023-2024 – Monitoring Report Quarter 2

MEETING	Quality, Patient Experience and Safety Committee
DATE	31 October 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 note the Clinical Monitoring plan and action tracker for Quarter 2.

KEY ISSUES/IMPLICATIONS

Many of the audits and re-audits can be undertaken solely by the Clinical Intelligence Assurance Team. 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 – 12 October 2023
Clinical Quality Governance Group – Scheduled for 25 October 2023

REPORT APPENDICES

Annex 1: WAST Clinical Audit Plan 2023-2024 Q2 Monitoring report.
Annex 2: WAST Clinical Audit Plan 2023-2024 Action Tracker.

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

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
NHS Trust

Welsh Ambulance Services NHS Trust

Clinical Audit Plan

2023/2024
Quarter 2

Version 1.0 Last Updated 05 October 2023

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					
22_006	2	A review of TXA administration within the South Wales Trauma Network (SWTN)	Tim Austin Senior Trauma Paramedic	Greg Lloyd Assistant Director Clinical Delivery	March 2023					
22_007	1	Diagnostic code compliance - ePCR	Clinical Intelligence & Assurance Team	Duncan Robertson Assistant Director of Clinical Development	February 2023					
23_001	1	Evaluation of Non-Conveyance & ROLE forms with ePCR	Kevin Webb Head of Clinical Intelligence & Assurance	Duncan Robertson Assistant Director of Clinical Development	April 2023					
TBC	1	Re-audit ePCR clinical data assurance - #NOF	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	*To commence after ePCR changes implemented*	N/A	N/A	N/A	N/A	N/A
TBC	1	Re-audit ePCR clinical data assurance - Stroke	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	*To commence after ePCR changes implemented*	N/A	N/A	N/A	N/A	N/A

TBC	1	Re-audit ePCR clinical data assurance - STEMI	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	*To commence after ePCR changes implemented*	N/A	N/A	N/A	N/A	N/A
TBC	1	Re-audit ePCR clinical data assurance - Hypoglycaemia	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	*To commence after ePCR changes implemented*	N/A	N/A	N/A	N/A	N/A
TBC	1	Re-audit ePCR clinical data assurance – ROSC (at hospital)	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	*To commence after ePCR changes implemented*	N/A	N/A	N/A	N/A	N/A
23_002	1	Re-audit of Bronchiolitis Pathway – Compliance to the All-Wales Guideline for Ambulance Service Management	Richard Teulon Clinical Intelligence & Assurance Co-ordinator	Greg Lloyd Assistant Director Clinical Delivery	*Indicative Q2 2023/24*	N/A	N/A			
TBC	1	Re-audit of assurance for the recording of a Clinical Frailty Score (CFS) in patients aged ≥ 65 years	Claire Muxworthy Clinical Intelligence & Assurance Co-ordinator	Duncan Robertson Assistant Director of Clinical Development	*Indicative Q3 2023/24*	N/A	N/A	N/A		
23_006	1	Appropriate administration of Methoxyflurane (Penthrox®) Clinical Audit	Andeep Chohan Project Manager	Paula Jeffery Consultant Paramedic	*Indicative Q3 2023/24*	N/A	N/A			
23_010		Morphine Administration (Recording accuracy).	Chris Moore Head of Medicines Management	Chris Moore Head of Medicines Management	*Indicative Q3 2023/24*	N/A	N/A	N/A		

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 Intelligence & Assurance Co-ordinator	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. CM – data captured Report being compiled to include both sets of results (10.02.23) CM meeting with GJP to discuss report and compile recommendations Report approved at CIAG 14th June 2023.
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 Intelligence & Assurance Data Specialist	*Indicative Q4 2022/23*	A proposal form is being developed, criteria and data being identified. RT 23/2/23 – audit completed, spreadsheet data being cleansed. Some cases for TA review on his return from leave 1/3/23 Report approved at CIAG 13th April 2023.

Ref	Clinical Audit Title	Rationale / Drivers	Clinical Audit Author	Clinical Audit Contact / Support	Audit Start Date	Comments
22_007	Diagnostic code compliance - ePCR	All ePCRs should have a diagnostic code, enabling many of the clinical audits undertaken within WAST by allowing for selection by condition type. In addition, diagnostic codes 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 diagnostic code rate, if '000' is used whether a suitable code was available, provide opportunities to revise the code 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. CM – audit completed, results being analysed and report written (14.02.23) Report approved at CIAG 13th April 2023.
23_001	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	Kevin Webb Head of Clinical Intelligence & Assurance	Ruth Saele Clinical Intelligence & Assurance Data Specialist	April 2023	A proposal form is being developed, criteria and data being identified. Audit commenced April 2023. Records reviews completed. Scheduled for completion by the end of Q3

Ref	Clinical Audit Title	Rationale / Drivers	Clinical Audit Author	Clinical Audit Contact / Support	Audit Start Date	Comments
		on the ePCR and also evaluate the quality of the information documented on form.				
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	*To commence after ePCR changes implemented*	ePCR UI changes scheduled for implementation in October 2023
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	*To commence after ePCR changes implemented*	ePCR UI changes scheduled for implementation in October 2023
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	*To commence after ePCR changes implemented*	ePCR UI changes scheduled for implementation in October 2023
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	*To commence after ePCR changes implemented*	ePCR UI changes scheduled for implementation in October 2023.
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	*To commence after ePCR changes implemented*	ePCR change request awaiting funding approval
23_002	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.	Richard Teulon Clinical Intelligence & Assurance Co-ordinator	Ruth Saele Clinical Intelligence & Assurance Data Specialist	*Indicative Q2 2023/24*	Scoping ePCR data from winter 2022/23. Developing proposal and criteria. This will inform the audit for winter 2023/24. Results & analysis in early Q3.

Ref	Clinical Audit Title	Rationale / Drivers	Clinical Audit Author	Clinical Audit Contact / Support	Audit Start Date	Comments
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 Intelligence & Assurance Co-ordinator	Ruth Saele Clinical Intelligence & Assurance Data Specialist	*Indicative Q3 2023/24*	Scoping ePCR data to inform the audit when previous actions completed.
23_006	Appropriate administration of Methoxyflurane (Penthrox®) Clinical Audit	Methoxyflurane has been introduced into WAST to enable non-registrant responders to provide analgesia. The audit aims to audit the safe and effective care of patients who self-administered Methoxyflurane (Penthrox®) analgesia.	Andeep Chohan Project Manager	Claire Muxworthy Clinical Intelligence & Assurance Co-ordinator	*Indicative Q3 2023/24*	Pilot audit commenced September 2023 to test data prior to full audit.
23_010	Morphine Administration (Recording accuracy).	Audit agreed in the Ambulance Practice Steering Group. This audit aims to test comparative accuracy between recording of morphine sulphate administered in WAST ePCR, against vehicle CD02 registers.	Chris Moore Head of Medicines Management	Claire Muxworthy Clinical Intelligence & Assurance Co-ordinator	*Indicative Q3 2023/24*	Data has been supplied in Q2 but due to commence in Q3

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.*

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.*

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.*
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	

Welsh Ambulance Services NHS Trust
Clinical Audit Action Tracker

High
Medium
Low

Last updated 17th October 2023

Progress and delivery to actions key:
Red - Off track and not likely to deliver
Amber - Off track and recovery action taken
Green - On track for delivery as planned
Blue - Action complete

ID	Date Approved	Reference	Title	Action No.	Action Priority	Action	Accountable Manager	Date Due	Comments	Progress to Actions RAG-B
A	21/01/2022	CAED 20_002	Baseline assurance audit for the recording of a Clinical Frailty Score (CFS) in patients aged ≥ 65 years (2020)	1		Include the Clinical Frailty Score on the ePCR in the falls and social history sections for ease of access to support clinicians.	Duncan Robertson	31/01/2022	Included on the ePCR app during the pilot phase and prior to full ePCR rollout	
				2		Promote staff use of the JRCALC Plus app via Health Board Clinical Leads and Senior Paramedics for reading and acknowledging Clinical Notices.	Duncan Robertson	31/03/2022	email from DR to HBCLs	
				3		Work with the Older Person's Lead to develop further educational materials and approaches to embed the application of the Clinical Frailty Scale into practice.	Duncan Robertson	31/12/2023	Work has commenced and this involves a variety of educational materials to be developed throughout the year. This work will continue into Q4 and the due date extended until 31/03/2023. It is reassuring to see an increased use of frailty scores being documented since the implementation of the ePCR. Update 06.10.23 - Following the return to work of the Older Person's Lead this work can now progress. Due date amended to 31/12/23.	
				4		Undertake a re-audit using ePCR data once the system is rolled out across WAST and when sufficient ePCR data for frailty is available.	Kevin Webb	31/12/2022	Included on the Clinical Audit Plan 2023/24	
B	11/11/2022	CAED 22_005	ePCR Clinical Data Assurance – ROSC (at hospital) Clinical Indicator (2022)	1		This clinical audit to be shared and made available via the Trust Intranet page	Duncan Robertson	30/11/2022	Posted on the Intranet and Yammer 16/11/2022	
				2		All EMS staff using the ePCR are reminded to ensure that : • Wherever there is an out-of-hospital cardiac arrest, the OOHCA section of the ePCR is completed • the OOHCA section always has a documented outcome • Where the patent is declared as deceased, the relevant ROLE (1-4) is documented. • an appropriate condition code is assigned and the record is then closed correctly • In cases where records cannot be closed due to technical reasons, a DATIX form is completed	Duncan Robertson	31/12/2022	The Clinical Improvement Team have developed and are implementing an Improvement plan, initially linked to each of the audits for a condition specific focus each month.	
				3		Submit the change request drafted in response to the crossed records (para 41) to the ePCR Operational Change Manager for consideration by the ePCR Clinical Reference Group	Kevin Webb	31/12/2022	Included on the ePCR CRG agenda - 24/11/2022	
				4		CAED to identify and propose some UI changes of the OOHCA and ROLE sections to improve data quality - highlighting core fields in order to improve data completeness and accuracy. These should be considered through the usual routes, with a change request being submitted to the ePCR Clinical Reference Group	Kevin Webb	31/12/2022	A Change Request Form specifically relating to the cardiac arrest element of the ePCR was presented to the Clinical Reference Group (27/07/2023). Funding for the changes will need to be agreed.	
				5		CAED to report the name data quality issue (para 57) to the Principal Data Warehouse Developer and the Data Quality Lead.	Kevin Webb	31/12/2022	KC email 11/1/2023 to SG & SB	
				6		CIAG to consider the benefits of reporting internally and externally both • the full ROSC-at-hospital metric (all resuscitations) • the subset ROSC-at-hospital Utstein comparator group (patients of presumed cardiac aetiology with a bystander witnessed cardiac arrest and a shockable rhythm)	Kevin Webb	31/03/2024	Linked to action 4. When the UI changes have been made/data reviewed/internal dashboards available, CIAG can agree on what should be reported on. Due date amended to 31/03/2024 as discussions are ongoing to make the appropriate UI changes.	
				7		The Trust to evaluate alternative (more accurate) approaches for monitoring individual clinician standards of care.	Duncan Robertson	30/09/2023	To be discussed further to establish clinical performance requirements below Trust level, e.g., Locality HB etc. A request for change submitted to Terrafix to provide a facility to report at various levels.	
				8		Undertake a re-audit when TerraPACE user interface has matured and include a review of cases where justified exceptions have been documented correctly to ascertain if these have been shown as such in the raw data.	Kevin Webb	30/09/2023	Included on the Clinical Audit Plan 2023/24	
				9		Use this and the previous clinical quality assurance audits to inform an improvement plan for clinical indicators using ePCR data: • Improvements to the User Interface. • Improvement on both recording appropriately within ePCR and compliance to the individual criterion	Kevin Webb	31/12/2022	The Clinical Improvement Team have developed and are implementing an Improvement plan, initially linked to each of the audits for a condition specific focus each month.	
C	23/12/2022	CAED 20_001	Clinical audit and retrospective review of the use of Just in Case medication by Welsh Ambulance Services NHS Trust paramedics (2020/2021)	1		The results of this clinical audit to be shared with all staff via the WAST intranet.	Kevin Webb	28/02/2023	Posted on the Intranet 2nd February 2023	
				2		Suitable amendments are made to the clinical audit criteria for future audits • Advance or future care planning is not considered as a criterion of care within the inclusion criteria as it is not routinely recorded on the PCRs and currently not indicated as an EoLC prompt on ePCR. • The administration of medication via intravenous route is not included in the exclusion criteria.	Ed O'Brian & Kevin Webb	31/01/2023	These points will be taken into account for future JIC medicines audits	
				3		A single Paramedic only to complete any future clinical audits to mitigate the risk of information being interpreted inversely and to ensure consistency.	Ed O'Brian & Kevin Webb	31/03/2023	Where possible, this will be the method followed to ensure consistency of PCR reviews and data capture.	

				4		Just in case medications continue to be administered by WAST clinicians.	Ed O'Brian	28/02/2023	Approved at the Clinical Directorate meeting on 28th February 2023	
				5		Consider PGDs for just in case medications within WAST to replace the need for verbal order forms.	Chris Moore	31/12/2023	To be discussed further at the Ambulance Medicines Safety Officer Group and Ambulance Pharmacists Network who are doing a wider piece of work, which is feeding into NASMed/AACE. They are pulling together a framework/guidance on level of practitioners able to administer the JIC meds, so the work is ongoing, but it will inevitably lead to the use of PGDs for the JIC drugs.	
D	14/06/2023	CAED21_002	Safeguarding Adolescent Audit (2021)	1		The results of this safeguarding audit to be shared with all colleagues via WAST SharePoint as soon as possible.	Gwenan Jones-Parry	01/10/2023	Clinical audit posted on Intranet 5/7/23	
				2		Create a bespoke webinar to share the results of this audit. This webinar to be held at least twice before 1st October 2023.	Gwenan Jones-Parry	01/10/2023	NHS 111 Wales webinar recording is live and part of CPD training. EMS/CSD webinar recording is scheduled to be completed and released before 01/10/2023. Update 06.10.2023. The webinar has been recorded and is currently being tested / reviewed by HBCL's and Senior CSD clinicians before release.	
				3		Include the identified learning from this audit within the 2023/2024 safeguarding induction training delivered to new WAST colleagues.	Fiona Davies & Rhiannon Thomas	31/07/2023	The learning has been implemented into safeguarding induction training, with team members knowing to include the requirement for safeguarding reports in situations that meet the audit criteria.	
				4		Create a 7-minute briefing, published by the end of July 2023, which emphasises to WAST colleagues that child safeguarding includes all individuals under 18 years of age and there is a legislative duty to report safeguarding concerns directly with the Local Authority.	Gwenan Jones-Parry	31/07/2023	The 7-minute briefing has been created, shared and published on 17th July 2023	
				5		Within 4 months of publication, the relevant practice educators for Localities, CSD and NHS 111 Wales to ensure the results of this audit are disseminated within their respective teams.	Regional Clinical Leads CSD Practice Educators NHS 111 Wales Practice Coach Team	01/01/2024		
				6		Re-audit to be undertaken to ascertain if the above actions have resulted in improvements.	Fiona Davies & Rhiannon Thomas	31/03/2024	To be included on the 2024/25 Clinical Audit Plan	

INFORMATION SECURITY & GOVERNANCE KPI REPORTING

Reporting period:
September 2023

IG TOOLKIT & IMPROVEMENT

2023-24 IG Toolkit sees significant change from 2022-23 set. Evidence gathering in progress.

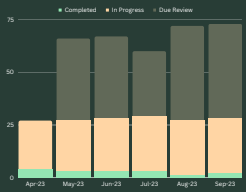
An **IG action plan** has been developed and progress is ongoing

Minimum expectations were NOT met across all categories in 2022-23 toolkit.

- Leadership & Oversight
- Policies & Procedures
- Training & Awareness
- Individual Rights
- Transparency
- Records of Processing Activity
- Contracts & Info Sharing
- Risks & DPIAs
- RM & Security
- Breach & Monitoring
- FOI & EIR
- Information Security
- Business Continuity

2023-24 categories will differ from this list, but our focus may remain.

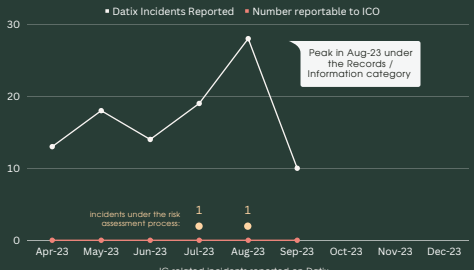
The **DPIA log** continues to be reviewed and updated weekly, including cloud security assessments.



DPIAs completed and in progress

Requests for review are sent regularly to project leads.

DATA PROTECTION BREACHES



Peak in Aug-23 under the Records / Information category

IG related incidents reported on Datix

INFO SECURITY

Reporting relates to cyber incidents, but recent threshold changes include confidentiality, integrity and availability of systems.

2 cyber incident reported to CRU under NIS regulations in 2023/24 to date

1) UK wide 999 outage (June 23)
2) 999 outage in SE (July 23)

>1000 weak user passwords across the Trust

Enforced reset in progress

RECORDS MANAGEMENT

Subject Access Requests

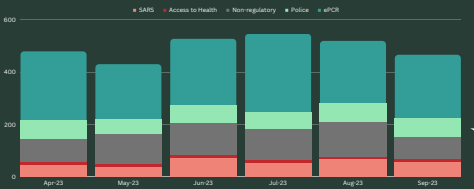
Must be responded to within 30 calendar days from receipt in line with GDPR.

Access to Health

Requests for personal information which fall under the Access to Health Records Act 1990 require response within 40 calendar days.

Other Requests

Requests which do not fall under either of the 2 other regulations must have a legal basis. These include requests from Police, Coroner etc.



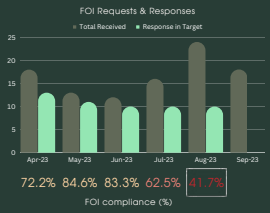
Sep-23 saw 26% growth compared to Sep-22 requests

Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	
95%	100%	100%	95%	90%	92%	Compliance (%)
2			3	7	5	Breaches (#)

DATA QUALITY

MEASURES OF DQ TO BE ESTABLISHED

FREEDOM OF INFORMATION

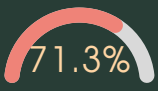


Freedom of Information

The FOI Act gives the public the right to access information held by public authorities. ICO target is for organisations to respond to **90%** within 20 working days.

Aug-Sept23 saw an increase in requests & their complexity compared to 22/23. Trust's FOI lead was on leave in August. Guidance being developed + plan for processes to be mapped, streamlined & automated.

AWARENESS & TRAINING



Mandatory ESR **Data Protection & IG training compliance** is below the 75% threshold



"Our people are our last line of defence."



Typical adoption rate of the 7 available cyber training packages on MetaLearn platform (increase on July)



Completion rate for targeted **Executive Training** (this is the highest uptake of all modules, increase from 22% in July)

Phishing campaign Oct 23



4867 users targeted by simulator Oct-23

39% (1909) deleted the email

14% (683) reported the email

June campaign saw only **5%** reported



June campaign saw **>22%** click the link

6% (276) clicked the links

2% (89) supplied credentials

26% of the 276 (47 who clicked + 22 who gave details) completed training

In June only **10%** completed training

AGENDA ITEM No	**17**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**4**

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

MEETING	Quality, Patient Experience & Safety Committee
DATE	31st October 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 Annex 2.

4. The principal risks were presented to the Trust Board on 28th September 2023 and are updated as at 1st September 2023. The high rated risks have been reviewed during this reporting period in line with the agreed schedule detailed at Annex 3.

5. Updates made in respect of actions, controls and assurances are highlighted in blue on the BAF. Whilst there has been no material change to the risk ratings, the Risk report submitted at the July 2023 Board meeting included a rationale for each of the risk ratings which is particularly important where ratings have remained static or increased. Notwithstanding, the detailed review, discussion and challenge that takes place with the Executive Leadership Team (ELT) and Assistant Director Leadership Team (ADLT) on these risks on a monthly basis.

6. As has been previously reported, all current mitigating actions within WAST's control have been completed or superseded in relation to Risk 223 and remain

on the BAF for review; that does not mean that the Trust is not continually seeking additional actions to mitigate this risk and most of these actions are articulated in the avoidable harm paper that the Board receive at each meeting.

7. The Executive Director of Quality & Nursing and Executive Director of Operations reported to Committees on the depth of review that is undertaken on both of these risks during the reporting cycle. Consideration has been given as to whether the scores and mitigations could be stratified by Health Board and the potential differentiation of risk across each of these areas as opposed to an all Wales Risk, and this continues.

8. Whilst both risks remain static at the highest score of 25, it is anticipated that this will be the case for the foreseeable future as long as the Trust is in a position where it is highly likely to have an incidence of premature death or avoidable harm as a result of being unable to respond in a way that it would wish to. The score is not based on the volume of cases of catastrophic harm, it is based on any one individual that experiences avoidable harm. The quality dimension of each of these risks will always be a challenging one to reduce whilst patients and the Trust are experiencing delays in the way in which they currently are.

9. The Chief Executive's report sets out participation in, and discussion at, regular stakeholder meetings with NHS Wales CEOs, the Director General of NHS Wales, Commissioners and EASC where stakeholder actions related to these risks.

RECOMMENDATION: Members are asked to consider the contents of the report.

KEY ISSUES/IMPLICATIONS
10. The key issues are set out in the Executive Summary above.
REPORT APPROVAL ROUTE
11. The BAF was considered by: • ADLT (14 August 2023) • ELT (30 August 2023) • Trust Board (28 September 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

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.	oderate 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.	cal media coverage - short-term reduction in public confidence/trust. ort-term negative social media. blic 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:	08/08/2023	TREND	25 (5x5)
		Date of Next Review:	08/09/2023	➡	

IF	THEN	RESULTING IN		Likelihood	Consequence	Score
significant internal and external system pressures continue	there is a risk of an inability and/or a delay in ambulances reaching patients in the community	patient harm and death	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 Q2 2023/24

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. **Of note, recent data analysis highlights the increased levels of red activity which has doubled since the pre covid period, plus an average increased on scene time of circa 10 minutes. Both measures are reflective of an increasingly challenged system with WAST crews fully exploring admission avoidance alternatives.**

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
	Internal **Management (1st Line of Assurance)**
1. Regional Escalation Protocol	1. Daily conference calls to agree RE levels in conjunction with Health Boards
2. Immediate release protocol	2. 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)
3. Resource Escalation Action Plan (REAP)	3. 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.
4. 24/7 Operational Delivery Unit (ODU)	4. 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.
5. Gold/Strategic, Silver/Tactical and Bronze/Operational 24 hour/ 7 day per week system to manage escalation plans	5. 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.
6. Limited Alternative Care Pathways in place	6. 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.
7. Consult and Close (previously Hear and Treat)	7. 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

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	08/08/2023	TREND	25 (5x5)
		Date of Next Review:	08/09/2023		

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

	Management Internal Audit report February 2022 (External Assurance). Consult and Close rate has increased from 12% to circa 15% March 2023.
8. Advanced Paramedic Practitioner (APP) deployment model / APP Navigation	8. 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. EMT have agreed to offer contracts to the 22 APPs who are about to complete their Masters programme. This will take our APP headcount to 88.7FTE. An investment proposal has been submitted to Welsh Government AHP in primary and community care pot. I think that there is low expectation that the bid will be successful. We are currently workforce planning to increase our APP headcount by 40 per year.
9. Clinical Safety Plan	9. Clinical agreement – agreeing escalation to higher levels, ODU dashboard, AACE paper through National Director of Operations group
10. Recruitment and deployment of CFRs	10. Volunteers are another resource for response, Volunteer
11. ETA scripting	11. 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
12. Clinical Contact Centre (CCC) emergency rule	12. CCC Emergency Rule is policy that has been signed off by Execs.
13. National Risk Huddle	13. 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.
14.	14.
15. Summer/Winter initiatives	15. Monitoring through SLT and STB
16. CHARU implementation	16. Monitored via the EMS project Board
17. National Transfer & Discharge Model	17.
18. Conveyance Reduction	18. This is part of the weekly performance review and aligned to Care Closer to Home Programme
19. Access to Same Day Emergency Care (SDEC) for paramedic referrals	19. 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.
20. Mental Health Practitioners in cars	20.
21. Roll out of ECNS	21. Reported through QuEST
22. Clinical Model and clinical review of code sets	22. Reported through QuEST
23. Remote Clinical Support Strategy	23. Strategic Transformation Board – IMTP deliverable
24. 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)	24. Formally documented action plan – actions captured are contained within and monitored via the Performance Improvement Plan (PIP)
25. Information sharing	25. Information Sharing: Patient Safety Reports, Chief Operating Officer (COO) Data Pack, Immediate Release Declined (IRD) Reports.
26. Completed EMS Roster Review	26. Helps to ensure that we have the maximum available capacity to respond to dispatch to 999 calls received in a timely manner
27. Work underway to reduce the number of multiple attendances dispatched to red calls	27. This will increase vehicle availability generally across the Trust

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	08/08/2023	TREND	25 (5x5)
		Date of Next Review:	08/09/2023	➡	

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

28. Transfer of Care	28. WAST has clearly articulated to the Health Board COOs the risk associated with delayed handovers. Consequently work has commenced to withdraw WAST staff from portering duties on hospital premises, cease the practice of ED swaps and cease the use of WAST equipment in EDs across Wales. Please refer to the following documents: i) Letter to COO Handover Delays 30.03.2023 ii) Letter to COO Handover Delays iii) WAST – Transfer of Care Brief
29. New 2023 EMS Demand and Capacity (roster) review	29. **To commence in order to ensure we continue to match capacity and demand to our best ability**
30. Connected Support Cymru – an innovative approach to supporting patients to remain at home with clinically appropriate support mechanisms, thus avoiding admission to hospital where appropriate.	30. **Multi phased approach commenced in Dec 2022 with St John Ambulance Cymru virtual ward responder, a digital and telehealth platform and a Community Welfare Responder model to enhance community resilience.**
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Acknowledgement and acceptance of risk by Health Boards and balancing the risks across the whole system	1. Improvement in handover delays across Cardiff and Vale and more latterly across AB have led to improved handovers at Eds. This has now been sustained for some months across C&V in a phased programme of improvement with no delays in excess of 2 hours. Programme of improvement underway in AB, commencing at 4hour tolerance with a plan to reduce over time. In other Health Boards, there remains little or no controls, with variation in both handovers and risk levels across Health Boards
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.	
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.	
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.	
12. Handover Improvement Plans agreed between WAST and Health Boards	12. Handover Improvement Plans have been replaced by Integrated Commissioning Action Plans (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. National Transfer & Discharge Model	18. National Transfer & Discharge model is yet to be determined. A task and finish has been established to progress this piece of work
21. Mental Health Practitioners	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:

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	08/08/2023	TREND	25 (5x5)
		Date of Next Review:	08/09/2023	➡	

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

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 People & Culture	**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	The temporary extension of the SJAC contract for overnight provision was evaluated, demonstrating on available evidence a positive performance impact over the period of operation (Jan-April 2023). The evaluation report was presented to EMT on 5 April 2023. The contract extension (as a temporary arrangement) ceased on 5 April 2023. Falls service enhanced day and night provision remains in place and utilisation of resources is 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:	03/08/2023	TREND	25 (5x5)
		Date of Next Review:	11/09/2023		

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 Q1 2023/24

The risk score remains constant at 25 for quarter 1 2023/24 (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 **1,440** +4 hour patient handover delays in **June 2023**; the target being 0 from September 2022 has now moved to the end of 2023/24. **In June 2023, over 18,000 hours were lost to hospital handover, equivalent to 21% of the Trust's conveying capacity.** 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 Trust received two Prevention of Future Death Reports (Regulation 28) from HM Coroner in North Wales in June 2023, both citing concerns regarding system delays and one case related specifically to the patient being significantly delayed outside of the hospital on arrival.**

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. WAST CEO and Directors have ensured that system safety and avoidable harm remain a live topic of discussion in all relevant forums and continue to seize opportunities as they emerge that can contribute to mitigating avoidable harm. The Joint Investigation Framework in place to review incidents across the system is now approved and included in the recently published National Policy on Patient Safety Incident Reporting & Management (May 2023). **The Trust adopted the National Patient Safety Policy and supporting appendices at the Clinical Quality Governance Group in June 2023.**

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) ***revised to March 2023/24.***
c) Alternative capacity equivalent to 1,000 beds project (LHB CEOs) **– 678 additional beds delivered, a significant achievement, but short of the target of 1,000.**
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 Executive Delivery Unit under the Joint Investigation Framework which **was formalised in the National Patient Safety Policy in May 2023**. 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 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 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.

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:	03/08/2023	TREND	25 (5x5)
		Date of Next Review:	11/09/2023	➡	

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

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.
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 **and Putting Things Right Quarterly Reports to Clinical Quality Governance Group and QuEST**
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. Monthly Integrated Quality and Performance Report (**June 2023 overall 77%** - Safeguarding and dementia over 90%.
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 July 2023 and Board sub-committee oversight and escalation through 'Alert, Advise and Assure' reports.

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:	03/08/2023	TREND	25 (5x5)
		Date of Next Review:	11/09/2023	➡	

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

16. Implementation of Duty of Quality, Duty of Candour and new Quality Standards requirements in April 2023.	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 July 2023 is 'Implementing and operationalising'. The Trust has representation on the All Wales Duty of Candour Implementation Group and is actively engaged in developing resources.
	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), the Emergency Ambulance Services Committee (EASC) including the Integrated Commissioning Action Plans (ICAPS) and Joint Executive Team (JET) meetings with 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. Lack of capacity in the Putting Things Right Team to deliver across the functions due to competing priorities resulting from sustained system pressures.	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 **25** overdue nationally reportable incident investigations. **Shared system learning from the Joint Investigation Framework is currently limited.**
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. In **June 2023**, **18,000** hours were lost with **1,440 +4 hour** delayed patient handovers.
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.	5.
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. New Quality Management System in development which will include monitoring of the new Quality Standards & Enablers and underpinning governance structure.
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

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Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Handover checklist implementation – Nationally WAST Quality Improvement (QI) Project	WAST QI Team (QSPE)	• TBC - Paused	• Timeframes awaited via Emergency Department Quality & Delivery Framework (EDQDF).
2. 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 and health board dashboards.
3. Continued Health Board interactions – my next patient (boarding), 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.
4. 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. However, Trust decision to proceed with 18 MSC places. • **RAG status reframed around the new timelines /programme.** • **22 trainee APPs expected to complete training in Jun-23.** • **EMT has agreed to offer places to these 22 trainee APPs funded from a reduction in technician posts 1/2s i.e. internal movement.** • **The Trust submitted a national bid to support APP expansion as part of the £5million additional Welsh Government funding for AHP expansion in Primary & Community Care.** • **In June-23 the Trust were informed that the bid was not successful. The funding had been allocated to health boards based on the initial funding allocation specified by Welsh Government. WAST is involved with two health board bids in BCU and C&V which require the Trust to support for delivery.**
5. Overnight falls service extension	Executive Director of Quality & Nursing	• **June 2023**	• Night Car Scheme extension agreed to 31 March **2024** (2 regional resources) • **Nighttime falls assistance 64% Utilisation (Apr 2023 -Jun 2023)** • **Day resources progress continuing toward 60% utilisation target. April – June responded to 1,845 incidents an 18% increase on same period 2022.** • **Falls level 1 and 2 impact evaluation report completed - and presented to Clinical Quality Governance Group (CQGG) Jan 2023.** • **Optima modelling underway to examine optimal resourcing level. The has been delayed due to prioritisation of Executive requests.**
6. Duty of Quality, Duty of Candour and new Quality Standards implementation from April 2023 with development of a Quality Monitoring System 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. • **RL Datix Dashboards and KPIs under development nationally.** • Key policies updated and approved. • **National Policy on Patient Safety Incident Reporting & Management adopted in June 2023.** • Participation in the All Wales Duty of Candour implementation group by Patient Safety Team – monthly. • Quality Management System workshop to be held 12 June 2023.
7. Virtual Ward now Connected Support Cymru	Executive Director of Quality & Nursing	• Q**3** 2023/24	• **Service live.** • **Currently identifying a 48% EA avoidance rate.** • **Staff absence and roster gaps in SJA (provider) an issue currently.** • **Funding also obtained to support the capacity to recruit volunteers (600 in total).**

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8. 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	• Q3 2023/24	• Informal consultation phase commenced May 2023.
9. Connect with All Wales Tissue Viability Network to explore strengthening the current investigations into harm from pressure damage across the whole patient pathway.	Assistant Director Quality & Nursing	• Q2 2023/24	• Meeting planned August 2023 with the Chair of the TVN Network.
10. Audit Wales 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?	CEO	• Q4 2023/24	• Conducted in three phases Audit Wales will independently investigate and report on patient flow out of hospital; access to unscheduled care services and national arrangements (structure, governance, and support) • WAST will proactively support this work and offer best practice examples from other jurisdictions that can support benchmarking and improvement activities. • Expected outcomes in 2023/24.
11. Internal Audit to undertake a review of Serious Adverse Incidents & Joint Investigation Framework	**Executive Director of Quality & Nursing**	• **Q3 2023/24**	• **Terms of reference drafted.**
Completed Actions	**Action Owner**	**When /Milestone**	**Progress Notes:**
1. HIW Improvement Plan / Workshop – WAST inputs / influencing improvements. 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.	Assistant Director of Quality & Nursing	Completed	
2. 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.
3. 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	Completed	• Revised joint investigation approach agreed and now formalised.
4. Recruit additional frontline capacity – additional £3m non recurrent 22/23 allocation	Director of People & Culture	Completed	• Strong focus from Executives with detailed updates to EMT every two weeks. • Year-end position is +85 FTEs, with a vacancy factor of just 1%, rather than the often used 5%, which would produce a figure of -88 FTEs rather than the estimated - 15 FTEs. • Further non recurrent funding has been secured for 2023/24
5. Transition Plan	Chief Executive Officer	Completed	• Action complete, but the Trust will continue to undertake strategic and technical workforce planning in support of the Trust's ambition e.g. inverting the triangle etc.
6. Consideration of additional WAST schemes to support overall risk mitigation through winter	Director of Operations	Completed	• Winter ended. Focus now on forecasting and modelling for the summer, but Trust not aiming to produce specific Summer Plan (the Trust did during the pandemic linked to travel restrictions). • The Trust needs to determine whether there is value in producing a specific winter plan, particularly, within the context of the financial constraints NHS Wales is not operating in.
7. National 111 awareness campaign	Director of Partnerships and Engagement Director of Digital	Completed	• The national awareness campaign was undertaken as planned and ended in March 2023. An evaluation will be provided to the 111 Board.

AGENDA ITEM No	**18.1**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**1**

Aseptic Non–Touch Technique (ANTT) Model policy changes 2023

MEETING	Quality, Patient Experience and Safety Committee
DATE	31/10/23
EXECUTIVE	Liam Williams
AUTHOR	L Neville/Louise Colson
CONTACT DETAILS	L Neville laurence.neville@wales.nhs.uk

EXECUTIVE SUMMARY

The 2019 all Wales Model Aseptic Non-Touch Technique (ANTT) Policy has been reviewed and updated. The revised policy was published in March 2023 this paper highlights those changes and any impacts for the Trust. The Committee is asked to approve the policy.

RECOMMENDATION: The Committee is asked to approve the policy.

CORPORATE OBJECTIVE	Strengthen the infrastructure required to support delivery.
CORPORATE RISK (Ref if appropriate)	
QUALITY THEME	Safe Care
HEALTH & CARE STANDARD	Infection Prevention and Control (IPC) and Decontamination

REPORT PURPOSE	**For approval**
CLOSED MATTER REASON	

REPORT APPROVAL ROUTE

WHERE	WHEN	WHY
Policy Group	**23/10/2023**	**Update approval**
Executive Leadership Team	**25/10/2023**	**For approval**

SITUATION

1. The 2019 all Wales Model Aseptic Non-Touch Technique (ANTT) Policy has been reviewed and updated. The revised policy was published in March 2023 this paper highlights those changes and any impacts for the Trust.

BACKGROUND

2. The current all Wales ANTT policy is published and managed by Public Health Wales. Members of the Trusts Infection Prevention and Control (IPC) team have been part of the task and finish group since 2017 to ensure that WAST practices and the working environment is accurately represented. This policy version FINAL Version 3 – March 2023 will replace the current FINAL Version 2 - July 2019.

ASSESSMENT

3. Changes from 2019 to the 2023 version:

Policy review from FINAL Version 2 - July 2019 and FINAL Version 3 – March 2023	
Reason	Version Update. Final Version 3 released March 2023.
Changes	
Sec 5.4	Links to ANTT Framework document.
Sec 9.4	Minor word changes
Sec 9.5	Examples of Aseptic items have been added
Sec 9.6	Wording changed; 'WAST have introduced colour coded labels' - replacing 'WAST intend to...'
Sec 12	Extra bullet point (4) document/policy review and bullet point 6 now includes Organisational/Workforce Dept.
Sec 13	Wording changes made to Policy Conformance
Sec 18	Updated references and Bibliography
App 8	Accreditation guide added
Summary	Nothing appears to have been taken away from the 2019 Policy and very minor points added. Roles and Responsibilities are the same, Training and Audit remain the same.

4. The changes made to the Final Version 3 document are minor changes to reflect updated research and references. There are no major changes to practice other than

the requirement for updating compliance with ANTT training which is planned for the Mandatory Inservice Training schedule for 2024/2025.

RECOMMENDED: That the Final version 3, March 2023, be approved by the Committee and replace the current Final Version 2 July 2019.3

Issues to be covered	Paragraph Number (s) or "Not Applicable"
Equality Impact Assessment	An Equality Impact Assessment has been undertaken at an all-Wales level on completion of version 1 (July 2017), Version 2 review (June 2019) and version 3 review (December 2022) with no change required. A Verification report has been completed for HARP, Public Health Wales to support version 3 (December 2022).
Environmental/Sustainability	Yes
Estate	N/A
Health Improvement	Yes
Health and Safety	Yes
Financial Implications	N/A
Legal Implications	Yes
Patient Safety/Safeguarding	Yes
Risks	Yes
Reputational	Yes
Staff Side Consultation	N/A

Model Policy
Aseptic Non-Touch Technique (ANTT®):
A national, standardised approach to aseptic technique

Date to be reviewed:	April 2026	**No of pages:**	30
Original Author job title(s):	Healthcare Associated Infection & Antimicrobial Resistance & Prescribing Programme (HARP), Public Health Wales (PHW) In Consultation with: • All Wales ANTT Steering Group • Higher Education Institute (HEI) sub-group • The Association for Safe Aseptic Practice • HCAI Delivery Board		
Responsible dept. / director:	HARP IP&C Team, Public Health Wales		
Approved by:	The all-Wales ANTT Steering Group & HEI sub-group The Association of Safe Practice (ASAP) HARP, Public Health Wales HCAI Delivery Board, Public Health Wales		
Original Date approved:	07 June 2019		
Original Effective Date (live):	04 July 2019		
Version:	FINAL Version 1 - 04 July 2019 FINAL Version 2 - July 2019 FINAL Version 3 – March 2023		
Date of Review	December 2022		
Date Verification form (1) completed:	24th March 2023		

Documents to be read alongside this model policy:	ANTT® Principles[1] NHS Scotland's National Infection Prevention and Control Model Policies NIPCM -on-line[2] Welsh Health Circular 2022/014 Amr-hcai-improvement-goals-for-2021-2023.(Welsh Government 01 March 2022)[3] Welsh Code of practice for the Prevention of Infection (Welsh Government, May 2014) Code-of-Practice [18] WHC 2015-26 ANTT Implementation (Welsh Government, 5thJune 2015)[19] WHC 2015-47 ANTT Follow up (Welsh Government, 9th Oct. 2015)[20] epic 3: National Evidence-Based Guidelines for the Prevention of Healthcare-Associated Infections in Hospitals in NHS Hospitals in England (Loveday et al, 2014)[9] The Royal Marsden Hospital Manual of Clinical Nursing Procedures 10th Edition (2020)[7] Procedures - Royal Marsden Manual (rmmonline.co.uk) National Institute of Clinical Excellence (NICE) Infection prevention and control of healthcare-associated infections in primary and community care (2017)[11] Healthcare-associated infections: prevention and control in primary and community care | Guidance | NICE

Executive Summary:
This model policy outlines the current national standardised approach for raising clinical standards of aseptic technique and achieving asepsis in non-invasive and invasive clinical procedures. The aim is to provide a standardised approach termed Aseptic Non-Touch Technique (ANTT®) and to reduce variation in aseptic technique and practice across Wales in the prevention of healthcare associated infections (HCAI). As agreed previously by Executive Nurse Directors, the intention is that this model policy is adopted as national policy by Health Boards and Trusts, including primary care and other health care organisation i.e., Care homes and independent hospitals within Wales. This policy requires relevant managers and leaders to organise and support its implementation and ongoing evaluation. This will ensure relevant clinical staff are appropriately trained and competency assessed in ANTT® so that it is embedded into everyday asepsis practice.
This ANTT Model policy was first published in July 2017, Emergency ANTT added in July 2019, version 3 /2023 all links refreshed, circulated for comment minor amendments and comments updating of appendices including ANTT Accreditation, terminology and updated framework information added into the appendix

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1. Introduction

Asepsis is generally considered to mean 'Freedom from pathogenic material in sufficient quantity to cause infection'.[14] During clinical procedures, the goal of asepsis is to prevent patient contamination by creating an environment that is low in microbe volume by using only sterile devices, materials and maintaining aseptic technique.

Aseptic technique is a core nursing and medical skill but is also used by other allied healthcare professionals (AHP) and healthcare support workers. The standard of aseptic technique practice can be inconsistent, and if not undertaken correctly may be instrumental in causing a healthcare-associated infection (HCAI) within primary, community, secondary and out of hospital care.

Historically, aseptic technique has been seen to be confusing and ambiguous with practice terms and principles having different meanings for different users. This has led to inconsistency and some substandard practices.

In the challenge to reduce HCAI, 'Aseptic Non-Touch Technique' (ANTT®) is used internationally as a safe and effective practice framework for aseptic technique for all aseptic clinical procedures.[19,20]

The Association of Safe Aseptic Practice (ASAP), in collaboration with Public Health Wales and supported by Welsh Government, have been providing ANTT® Resources practice and implementation support to all healthcare workers across Wales since June 2015.

Standardising aseptic technique with ANTT® across Wales will reduce variability in practice and further raise standards for the greater benefit of patients.

Welsh Government has directed all healthcare organisations to 'roll-out' ANTT® competency training to all relevant staff within their organisation.(WHC/2015/026) [19] The principles of ANTT® align with the principles of prudent healthcare[26] and a 'One Wales' agenda, Once For Wales approach. The need for asepsis, especially in the use of invasive procedures and wound management, is evidenced in the epic3 Guidelines.[9]

What is ANTT®?

The ANTT® Approach is an International Campaign designed to promote a clear understanding of asepsis and the essential elements of aseptic technique. This approach is a three-way 'partnership' between patients/service users, healthcare professionals and healthcare organisations, to actively promote the essential '6 Actions for Safe Aseptic Technique' (Appendix 4).

The ANTT® Practice Framework was originated by Stephen Rowley (2001),[15] and is defined as, *'A specific type of aseptic technique with a unique theoretical and clinical practice framework'.*[15]

The framework is applicable to all non-invasive and invasive clinical procedures including major surgery, the insertion and maintenance of indwelling medical devices, wound management and all primary, community and out of hospital-based care that requires aseptic practice.

ANTT® Practice Framework developments and dissemination are overseen by The Association for Safe Aseptic Practice (ASAP), a non-profit non-governmental organisation (NGO). The ASAP is working in partnership with NHS Wales and Public Health Wales to standardise aseptic technique across as a national standard and provides Welsh healthcare staff with updates to all ANTT® resources as they are reviewed and developed. The current resources and full ANTT® can be found following this link ANTT - Public Health Wales A summarised version is given in Rowley et al (2010).[16]

ASAP can be contacted for on-going support on practice and implementation issues via www.antt.org.

2. Purpose

The purpose of this national model policy is to support the implementation of the ANTT® practice framework to enable standardisation of technique and 'practice language' for all aseptic procedures. ANTT® must be embedded into every day clinical procedures as part of a robust commitment to reducing the risks of HCAI and need for antimicrobial prescribing to improve patient safety. Welsh Government set HCAI annual reduction expectations for *Clostridioides difficile*, *Staphylococcus aureus* bacteraemia and Gram-negative bacteraemia as well as expectations for antimicrobial prescribing. These expectations align to the ambitions outlined in the addendum to the 5 year UK National Action Plan (NAP) and the 20 year vision to achieve future reductions that include positively impacting on MRSA, MSSA Blood Stream Infections (BSI), Urinary Tract and Surgical Site Infection (SSI) rates. Compliance with ANTT® supports Health Boards/Trusts in reducing these and other HCAI's whilst improving patient experience and outcomes.

3. Aims and Objectives

This model policy provides a widely adopted evidence-based framework for establishing ANTT® as the safe and effective technique for all aseptic procedures in healthcare organisations across Wales.

Objectives are:

- To identify the role of ANTT® in the reduction of HCAI
- To identify key roles and responsibilities in ANTT® implementation

- To describe the implementation and uses of ANTT®
- To identify the principles of ANTT® and its application to practice
- To outline the requirements for learning and competency assessment for staff undertaking clinical aseptic procedures
- Provide resources and toolkit to support ANTT® in practice
- To be relevant in acute, community and primary care settings, including emergency out of hospital care

4. Scope of the Policy

This model policy is applicable in all settings that provide healthcare to patients and/or service users and to all healthcare workers (HCW) who perform a clinical procedure that requires an aseptic technique.

5. Roles and Responsibilities within Organisations

The Board and Chief Executive Officer (CEO) has ultimate responsibility for Infection Prevention and Control within Health Boards and NHS Trusts. This responsibility, together with responsibility for ANTT® is delegated to the Executive Team under the leadership of the Executive Director of Nursing.

5.1 The Executive Director of Nursing

- Has overall responsibility to ensure that ANTT® is fully implemented and effectively sustained within their organisation[19,20]
- Will ensure that this and local ANTT® policy/procedures are adhered to
- Will nominate an organisational lead for ANTT®
- Will review progress and report to the Board on ANTT® implementation and maintaining compliance in all groups of HCW's
- Will ensure there are adequate financial resource

The operational and professional responsibility lies with the individual performing the procedure.

5.2 Senior Clinical Leads, Departmental and Nurse Managers will

- Be responsible for the effective implementation and monitoring of compliance with ANTT®, ensuring appropriate action is taken when staff fail to comply with policy and required training
- Identify an ANTT® lead and key trainers and assessors for their area of responsibility
- Ensure additional resources and/or equipment is available to facilitate the HCW undertaking the theory and practice of ANTT®
- Facilitate completion of the All-Wales e-learning programme for ANTT® by all HCWs involved in aseptic procedures e.g., protected work time and access to a computer
- Facilitate completion of competency assessment for all HCWs undertaking any type of aseptic procedure
- Monitor and report on competency level of the team and report to the appropriate risk committee

- Support HCWs in achieving compliance with all statutory and mandatory training, including Standard Infection Prevention and Control Precaution (SICP) mandatory training
- Bring this model policy to the attention of all health professionals or workers involved in ANTT® including educational and specialist roles
- Embed ANTT® into routine aseptic practice and all teaching of clinical procedures that require asepsis

5.3 Healthcare Workers (HCWs) will

- Have a responsibility to be familiar with NIPCM policies[2] and adhere to this model policy and other relevant local IPC policies to reduce the risk of transmission of infection
- Always act in the patients' best interest
- Perform invasive and other procedures in accordance with the principles and process of ANTT® (appendices 2-5) and this policy.
- Take personal responsibility for attendance at mandatory training or completion of relevant e-learning and act in accordance with the Welsh Code of Practice for the Prevention and Control of Healthcare Associated Infections[18] in Wales
- Be accountable for their practice in accordance with their job description and professional codes of conduct, for example, NMC The Code - The Nursing and Midwifery Council[12] and GMC Good Medical Practice[8]
- Undertake the required ANTT® training and competency assessment if performing any aseptic clinical procedures
- Embed ANTT® into all aseptic practice

5.4 Primary and Community Care Healthcare Staff, including Welsh Ambulance NHS Trust (WAST)

In any out of hospital care settings (e.g., Community Nursing, Primary Care, Long Term Care Facilities, Welsh Ambulance Service) there may be challenges in the application of ANTT® principles relating to equipment and the environment. A local risk assessment (Appendix 7) should be undertaken to assess how the principles can be adopted and any adaption (if necessary) should be documented, minimising patient risk. Resources to assist with this risk assessment are available within the ANTT Framework on Public Health Wales website ANTT Framework.

Whilst recognising the application of ANTT® in challenging situations, it is still possible to aim to minimise patient risk by applying ANTT® '4 Actions for Safe Aseptic Technique' (Appendix 3). Tools and resources specific to community settings and ambulance staff can be accessed via this link Appendix 6 provides an example template for 'Ambulance Peripheral Cannulation Guideline'.
See also 8.6 – Emergency ANTT®

ANTT® principles will be applied and adapted to the management of chronic wounds. While it is recognised some chronic wound procedures e.g., leg

ulcer cleansing and dressing in a patients' own home, can be simplified, the aim is always asepsis, with the aim being not to introduce any further microorganisms into the wound. Guidance should be sought from the Tissue Viability Nurse on aspects that do require ANTT®.

5.5 Consultant Medical Staff will

- Undertake the required ANTT® training and competency assessment
- Be competent and keep your professional knowledge and skills up to date
- Comply with the Good Medical Practice Framework.[8] GMC Good medical practice
- Be responsible for ensuring their junior doctors and teams adhere to and embed the principles of ANTT® and undertake the required training and competency assessment

5.6 Infection Prevention and Control Team (IPCT), Tissue Viability Nurse (TVN), Continence Teams and Intravenous Access Teams

These specialist teams will participate in the National ANTT® Steering Group supporting ANTT® rollout across Wales. They have a pivotal role in assisting relevant organisational teams to coordinate ANTT® implementation, ensure training in their specialist fields conforms to ANTT principles as well as risk-management and evaluating effectiveness of its use.

The IPCT will:

- Provide expert advice in accordance with this policy
- Support managers and staff with the implementation of ANTT®
- Provide information, advice, and training to enable managers and users to undertake necessary risk assessment
- Support investigations in areas with specific risk to advise on safe practice
- Ensure local or adapted procedures/policy remains consistent with the evidence-base for safe practice and review/update local policy and procedures at least every 3 years
- Identify areas for improvement and report to Infection Prevention and Control Managers, local Infection Prevention and Control Committee, and local Clinical Risk or Patient Safety, Health and Safety and national groups
- Support education and training programme for ANTT® across primary and secondary care
- Report any impact of compliance identified during investigations related to an HCAI, in line with Duty of Quality and Duty of Candour. [29, 30] Assurance around shared learning from such investigation will be reported to the relevant governance, quality, and safety groups.

5.7 Nominated ANTT® Lead will

- Provide local leadership for the roll-out of ANTT®

- Participate in PHW-led all-Wales ANTT® Steering Group to enable sharing of best practice from and within their organisation
- Provide guidance to their organisation on future developments, e.g., primary care roll out, updated resources, standardised packs
- Ensure that all local training, policies, procedures, and guidelines are ANTT® compliant

5.8 Nominated Key-Trainers/Facilitators from each clinical area or professional group will:

- Facilitate completion of All Wales ANTT® e-learning training by all HCWs involved in aseptic processes
- Provide supplementary electronic/paper ANTT® training and competency assessment to relevant staff within their department
- Keep accurate records of staff trained
- Instil a culture for asepsis and of ANTT® practice across their clinical area/professional group
- Ensure compliance with ANTT® practice is achieved, challenging unsafe practice appropriately
- Maintain own compliance with ANTT® competence and practice
- Identify and support additional resources needed for compliance with ANTT® key principles
- Identify and address challenges and share areas of good practice via the Quality, Safety and Experience structures

5.9 Procurement Leads

Prior to purchase of any re-usable patient equipment, discussion must take place with manufacturers, local infection prevention and control leads, and local decontamination leads, where applicable, to ensure that such items can be safely decontaminated within the organisation. Equipment in use is required to facilitate ANTT® e.g., insertion packs, trays, trolleys. These should be made readily available and accessible across the organisation. There should be rationalisation and standardisation of equipment choices across Wales to help reduce practice variation in aseptic technique.

5.10 Higher Education Institutes (HEI):

Universities across Wales will work to standardise their curriculum regarding teaching and learning competencies in ANTT® for all healthcare professional students e.g., nursing, medical, podiatry, paramedics, and allied health in respect of ANTT®, at the point of registration.

6. Implementation of ANTT®

The implementation of ANTT® will require:

- Executive level commitment
- A robust ANTT® training and assessment programme
- Equipment and appropriate resources
- Raising ANTT® awareness across the whole organisation
- A locally agreed ANTT® audit programme

- External audit programme, as agreed with ASAP and HARP, PHW
- Robust monitoring and recording processes for compliance
- Key reporting mechanisms on impact or harm

6.1 ANTT® Accreditation for Healthcare Providers:

ANTT Accreditation Guide 2023 (PHW NHS. Wales) overseen freely by ASAP, provides healthcare organisations with a mechanism to demonstrate effective clinical governance for aseptic technique, and commitment to infection prevention and patient safety. This can be useful to demonstrate an organisations hard work in infection prevention to external regulators, patients/service users, and the public.
There are three levels of accreditation: Bronze, Silver, and Gold.

- ANTT Bronze Accreditation Workbook
- ANTT Silver Accreditation Workbook
- ANTT Gold Accreditation Workbook

Accreditation criteria is based upon the following pre-requisites for safe and best practice:

- ANTT® Policy
- ANTT® Education
- ANTT® Assessment
- ANTT® Monitoring

For support with ANTT® Accreditation please contact enquiries@antt.org

7. Training:

Wales commenced ANTT® programme roll out in June 2015(WHC/2015/026) [19] Substantial progress has been made across Wales despite limited resources to support this; however, all organisations are required to continue to aim for 100% compliance for those who will be performing procedures (regardless of job title) requiring the principles of aseptic technique.
As new employees join the organisation, compliance with ANTT® should be mandated as part of their induction programme.

Priority for training should be given to staff working within augmented care units, staff carrying out invasive procedures, and all new employees.

Professional registrants must recognise their accountability in accordance with their own code of conduct,[8,12] e.g. The Code (Nursing and Midwifery Council 2015)[12] states that nurses must have a good knowledge base before performing any clinical procedure, should be trained appropriately, and have achieved competency within their clinical area. The General Medical Council (Good medical practice-English 2014 (gmc-uk.org))[8] states that doctors must recognise and work within the limits of their competence, provide good standards of practice of care and keep professional knowledge and skills up to date.

- All HCWs across Wales who are involved in aseptic procedures will complete the nationally agreed ANTT® training in the principles and theory for ANTT® prior to competency assessment i.e., current e-learning module at learning@ NHS Wales: https://learning.wales.nhs.uk/
- ANTT® will also be taught locally within departments by means of trained key-trainers/facilitators/assessors, using ANTT® resources: ANTT resources (antt.org) within an implementation framework set out by the local organisation
- All taught procedures involving asepsis will be undertaken using ANTT®
- All HCWs performing ANTT® must be assessed as competent in the application of ANTT® utilising either the Standard ANTT® Competency Assessment tool (CAT) Standard CAT v1.5 or the Surgical Assessment tool Surgical CAT v2
- It is recommended that ANTT® competency assessment should be undertaken within 3 months of completing the ANTT® e-learning programme
- HCW's performing aseptic procedures must maintain their ANTT® competency with at least three-yearly practical competency assessment, monitored via local annual appraisal process and entered to ESR
- HCW's have an individual responsibility to ensure their competencies are maintained and must inform their line manager of any obstacles preventing them to achieve this, or lapse in competency
- Should a HCW change specialties or commence a new post within the HB/Trust requiring competence in different skill sets, the need for further ANTT® training/assessment must be risk assessed and agreed with their line manager. Advice can be sought from the local ANTT® Lead

For staff who are unable to access ANTT® eLearning programmes through either ESR or Learning@Wales, arrangements need to be made for electronic/paper educational resources, which must include the main principles of ANTT®.

It is acknowledged there remains a period of time when not all staff performing aseptic technique will have undergone the appropriate training and assessment in ANTT®. Therefore, existing aseptic practice skills, may be used to ensure service delivery is not affected, following individual local risk assessment with intention of becoming compliant as soon as practically possible.

8. Important basic infection prevention practice for aseptic technique:

This resource is not intended as a comprehensive educational tool, however, as well as providing an outline of the ANTT® Framework (see

appendix 9), some important general aspects of aseptic technique are outlined below.

8.1. Use of Standard Infection Prevention and Control Precautions (SIPCP) such as hand hygiene:

A pre-requisite to safe ANTT® is compliance with standard infection control precautions (SICP's):

SICPs should be performed in line with epic3 Guidelines[9] and the Scottish National Infection Prevention and Control Manual (NIPCM)[2] which is the resource adopted for use for healthcare in Wales. The 10 elements of SICP are:

- Patient Placement
- Hand Hygiene
- Respiratory cough and Hygiene
- Personal Protective Equipment
- Safe management of care equipment
- Safe management of care environment
- Safe management of linen
- Safe management of blood and body fluid spillages
- Safe disposal of waste
- Occupational safety: Prevention and Exposure management (e.g., sharps)

Key elements related to ANTT practice are hand hygiene, safe care of equipment and the environment, appropriate safe use of PPE and waste disposal.

8.2. Hand Hygiene

Hand hygiene is the single most effective way of preventing HCAI and cross infection from direct and indirect contact.[2,9,21] It is essential that hands are effectively decontaminated in accordance with the World Health Organisation (WHO) "MY five Moments of Hand Hygiene"[21] WHO SAVE LIVES Clean **YOUR** Hands. Technical Reference Manuel 2009 prior to, during (as required) and after all aseptic procedures are performed.

8.3. Use of personal protective equipment (PPE)

Gloves and other PPE provide a barrier between microorganisms on hands, clothing, and the susceptible sites but must be used in conjunction with good hand hygiene and donning and doffing technique.

Gloves use for ANTT:

- Must be donned and used as intended, changed at appropriate frequency and between procedures, and removed with care to prevent shedding or spreading of microorganisms
- Are **non-sterile** gloves for Standard-ANTT® procedures e.g., preparing and delivering **i**ntravenous medication, attaching

parenteral nutrition, venepuncture, and cannulation, as per local policies
- Are **Sterile** gloves for Surgical ANTT® procedures such as surgery, urinary catheterisation, or central venous catheter insertion

Aprons and Other PPE (aprons, gowns, masks, face protection) should be worn according to NIPCM and associated infection.

8.4. Environmental / Air contamination

Airborne particles in the clinical space will contain a range of microorganisms including those from the patient/service user, staff, and other sources. These have increasingly been shown to present a risk of transmission of a range of infections. Sensible precautions can be taken to reduce the risk of particle contamination of the aseptic site during ANTT procedures including:

- Preparation of drugs to be undertaken in an appropriate designated area away from the bedside and sink
- Where available, ANTT procedures i.e., changing of wound dressings, insertion of medical devices should be undertaken in a dedicated fit for purpose treatment/dressing/examination room away from the patients' bed area
- Do not undertake ANTT® when air particle movement levels are likely to be at their highest e.g., ward/department cleaning, adjacent to portable electric fans or close to open windows or building refurbishment
- Do not undertake ANTT® following recent bed making or patient undressing/dressing
- Advise patient of cough/sneeze etiquette e.g., use of tissues

8.5. Pre-requisite support of effective aseptic technique

The risk of microbiological contamination during ANTT® procedures can be reduced by important pre-requisite measures including:
- Effective environmental cleaning
- Safe storage of procedure equipment
- Compliance with decontamination procedures and policies
- Ergonomically designed clinical preparation areas
- Rationalisation and standardisation of procedure and equipment choices e.g., procedure packs, trays

8.6. Emergency ANTT

For WAST frontline emergency staff, including advanced paramedic practitioners, paramedics, advanced technicians, technicians, urgent care services staff, sub-contracted emergency staff, non-NHS organisations, Bank, and agency frontline staff.

The use of ANTT® is widespread within acute hospitals, yet ANTT's simple but robust practice principles are equally effective in the most challenging

and emergency situations and environments. Emergency life-saving time-critical procedures undertaken in the out of hospital environment justify reason for reduced compliance with all the principles of ANTT® and therefore Emergency ANTT® is the pragmatic approach to ANTT®, focusing specifically on:

- What is possible to deliver at that moment
- Prioritise the points at which 'Key-Parts' and 'Key-Sites' interact (the moments microbes can transfer)
- Dynamic risk assessment to determine preparation steps, and if they cannot be delivered, the most essential components of aseptic technique are prioritised first
- Recording the ANTT applied during the procedure e.g., Standard, emergency, surgical

The intention is not to dilute ANTT® or reduce standards, but to focus the practitioners' attention to the most important elements of safe practice first, in relation to time, setting and equipment permitting.

Emergency ANTT® should only be selected following risk assessment of the situation, for example: 'Do I have the time, the equipment, and the environment to apply Standard or Surgical ANTT?'
If the answer is 'yes' – use Standard or Surgical ANTT
If the answer is 'no' – use Emergency ANTT

It is important for the practitioner to document and handover when emergency ANTT is used and clarify if asepsis was maintained or compromised due to the 'emergency' situation. WAST have introduced the ANTT coded colour labels, which will be applied to any invasive procedures performed to alert receiving staff of ANTT procedures used (see Appendix 7).

9. ANTT Resources

9.1. ANTT® Procedure Guidelines

These simple picture-based procedure guidelines are a highly effective way for the organisation to make practice expectancy explicit, setting out procedure sequence and equipment. They should be displayed prominently in relevant clinical areas.

9.2. ANTT Approach Educational PowerPoint

'The ANTT-Approach' is an International Campaign designed to promote the essential elements of aseptic technique. This approach is a three-way 'partnership' between patients, HCWs and healthcare organisations to actively promote the essential '6 Actions for Safe Aseptic Technique' to be used every time.

Three posters simplify this framework:

- Patient poster – Appendix 3
- Clinical Staff Poster – Appendix 4
- ANTT® Clinical Practice Framework poster – *Appendix 5*

9.3. Steps for ANTT® procedure – see Appendix 2

10. Dissemination and Implementation

This revised and updated policy will be implemented via the following routes:

- Circulation to all Health Board/Trust Executive leads, IPCT leads, WAST leads, Primary & Community Care leads, HCAI DB
- Available via local Health Board/Trust Document library
- Available via PHW/HARP website
- Available to all HCWs via local Health Board/Trust intranet

Each Health Board/Trust is responsible for the full implementation of this revised policy and must ensure all relevant staff have access to the policy.

11. Audit and Monitoring of ANTT® Implementation

Monitoring will be undertaken through:

- The percentage of staff that have completed ANTT® theory and ANTT® Competency Assessments through ensuring records are updated centrally on ESR
- Audit observation of clinical practice and aseptic procedures
- Targeted patient feedback
- Documentation/policy review
- As part of the Improvement Cymru initiatives (Previously known as 1000 plus lives) e.g., bundle use and catheter-associated urinary tract infection (CAUTI) prevention, peripheral venous catheter (PVC) and central venous catheter (CVC) care, prevention of surgical site infection (SSI)
- Identifying impact and compliance levels of ANTT® on investigating HCAI, e.g., *Staphylococcus aureus* bacteraemia or surgical site infection (SSI), CAUTI through root cause analysis (RCA) and post-incident review (PIR)
- Annual IPC rolling programme of audit, including external audit by ASAP or ad hock audits by HARP team
- Target audit programmes, where deemed necessary following incident or outbreak
- Required changes in practice identified and actioned
- ANTT® accreditation

Any 'lessons learnt' should be shared locally and nationally across Wales to support and promote best practice.

12. Policy Conformance / Non-Compliance

If any Health Board employee fails to comply with this policy, the matter may be dealt with in accordance with their workforce and OD polices. The action taken will depend on the individual circumstances and will be in accordance with the appropriate disciplinary procedures. Under some circumstances, failure to follow this policy could be considered gross misconduct.

13. Distribution

The all-Wales policy will be available on the PHW/HARP internet site and via local Health Board/Trust Intranet site. Where staff do not have access to the intranet, their line manager must ensure that they have access to a current paper copy of this policy.

14. Review

This policy will be reviewed every 2 years or if guidance changes.

15. Legislation

The Control of Substances Hazardous to Health (COSHH) Regulations 2002 (as amended), Health and Safety Executive, L5 (6th edition) 2013. Welsh Government Health and Care Standards 201529. The 2023 Health and Social Care (Quality and Engagement) (Wales) Act 2020.[30]

16. Equality

An Equality Impact Assessment has been undertaken at an all-Wales level on completion of version 1 (July 2017), Version 2 review (June 2019) and version 3 review (December 2022) with no change required.

A Verification report has been completed for HARP, Public Health Wales to support version 3 (December 2022).

17. References and Bibliography

1. ANTT principles: www.antt.org

2. NHS Scotland's and Wales National Infection Prevention and Control Model Policies (NIPCM) on-line: NIPCM

3. Welsh Government: Welsh Health Circular (WHC/2022/14) Issue date:01/03/22: AMR improvement goals and HCAI reduction expectations by March 2023: Primary and secondary Care Antimicrobial Prescribing Goals; *C-difficile*, *S.Aureus*, Bacteraemia and Gram Negative Bacteraemia.

4. Implementing the Aseptic Non-Touch Technique (ANTT®) clinical practice framework for aseptic technique: a pragmatic evaluation using a mixed methods approach in two London hospitals. Volume 9, Issue 1. January 2018. Journal of Infection Prevention, SAGE Journals. https://journals.sagepub.com/doi/full/10.1177/1757177417720996

5. The Control of Substances Hazardous to Health (COSHH) Regulations 2002 (as amended). Health and safety Executive, L5 (6th edition) 2013: http://www.hse.gov.uk/pUbns/priced/l5.pdf

6. Department of Health (2009), the Health and Social Care Act (2008). Code of Practice for health and adult social care on the prevention and control of infections and related guidance. London.

7. Dougherty L. Lister S (2015) Aseptic Technique In: L Dougherty & S Lister (eds) The Royal Marsden Hospital Manual of Clinical Nursing Procedures 10. UK. Wiley-Blackwell 24th April 2020. Procedures - Royal Marsden Manual

8. General Medical Council (GMC) Good Medical Practice, Good medical practice - ethical guidance - GMC (gmc-uk.org) Good medical practice-English (gmc-uk.org)

9. Loveday H.P., Wilson J.A., Pratt R.J., Golsorkhi M., Tingle M., Bak A., Browne J., Prieto J., Wilcox M. (2014) epic 3: National Evidence - Based Guidance for Preventing Healthcare Associated Infections in NHS Hospitals in England. Journal of Hospital Infection. S1.

10. Overview | Healthcare-associated infections: prevention and control in primary and community care | Guidance | NICE , last update 11 April 2019.

11. NICE Infection prevention and control of healthcare-associated infections in primary and community care: Clinical guideline (CG139). Accessed October 2022.

12. NMC (2015) Code of Professional Practice. London. NMC. Last update: October 2022: The NMC Code:

13. Rowley, S. (2009) Improving standards of aseptic technique practice through an ANTT trust-wide implementation process: a matter of prioritisation and care. Journal of Infection Prevention, 10(1) JIP-2009 Improving standards

14. Rowley, S and Clare S (2011) ANTT: a standard approach to aseptic technique. Nursing Times; 107 :(36) Rowley, J. ANTT: 2011 a standard approach to aseptic technique | Nursing Times

15. Rowley, S (2001) Aseptic Non-Touch Technique Nursing Times. Infection Control Supplement Feb 15 97(7) p V1-V111. Aseptic non-touch technique |2001 Nursing Times

16. Rowley S, Clare S, Macqueen S, Molyneux, R (2010) ANTT v2: An updated practice framework for aseptic technique. British Journal of Nursing 2010: 19(5); S5-S11. ANTT v2: An updated practice framework for aseptic technique

17. Wales Governance e-Manual Standard 2.4 Infection Prevention and Control (IPC) and Decontamination - NHS Wales Shared Services Partnership

18. Welsh Government (May 2014). Code of Practice for the Prevention and Control of Healthcare Associated Infections Wales 2014 Code of Practice (Currently under review)

19. Code of practice for the prevention and control of healthcare associated infections (gov.wales)

20. Welsh Government: Welsh Health Circular (WHC/2015/026) 5 June 2015: Aseptic Non-Touch Technique (ANTT): Implementation of a National Standardised Approach (Welsh Government, June 2015).

21. Welsh Government: Welsh Health Circular (WHC/2015/047) 9 October 2015: Aseptic Non Touch Technique (ANTT): Implementation of a National Standardised approach- Follow-up (Welsh Government, October 2015).

22. World Health Organisation Save lives clean your hands "My Five moments" Technical reference manual ` WHO My Five moments

23. Welsh Government: WHC/2018/020: AMR Improvement Goals & HCAI Reduction Expectations by March 2019: Primary & Secondary Care Antimicrobial Prescribing Goals; *C.difficile*, *S.aureus* bacteraemia's and Gram-negative bacteraemia. Issue date: 04/05/2018.

24. Khurana, S., Saini, S.S., Sundaram, V., Dutta, S. and Kumar, P., 2018. Reducing Healthcare-associated Infections in Neonates by Standardizing and Improving Compliance to Aseptic Non-touch Techniques: A Quality Improvement Approach. *Indian paediatrics*, *55*(9), pp.748-752. Reducing Healthcare associated Infections in Neonates

25. Aziz, A.M., 2018. Winter and the key infection prevention and control practices. *British journal of community nursing*, *23*(11), pp.530-533. Winter and the key infection prevention and control practices - PubMed (nih.gov)

26. Haesler, E., Thomas, L., Morey, P. and Barker, J., 2016. A systematic review of the literature addressing asepsis in wound management. *Wound Practice & Research: Journal of the Australian Wound Management Association*, *24*(4), p.208. Systematic Review

27. Welsh Government/Prudent health care 2019: securing health and well being for future generations

28. UK Government Tackling antimicrobial resistance 2019 to 2024: the UK's 5-year National Action Plan. Tackling antimicrobial resistance 2019 to 2024: addendum to the UK's 5-year national action plan - GOV.UK (www.gov.uk)

29. UK Government How the UK will contribute to containing and controlling antimicrobial resistance (AMR) by 2040 UK 20-year vision for antimicrobial resistance - GOV.UK (www.gov.uk)

30. Welsh Government Heath Care standards 2015 Health standards framework English (gov.wales)

31. The Health and Social Care (Quality and Engagement) (Wales) Act 2020, The Duty of Quality Statutory Guidance 2023 and The consultation document on the duty of quality | GOV.WALES

18. APPENDICES

Appendix 1: Definitions / Glossary

Asepsis
Freedom from pathogenic material in sufficient dose to cause infection.

Aseptic field
A working area that has been rendered aseptic to reduce the risk of contamination of procedure equipment.

Aseptic Technique
A generic term and variable process for describing the precautions taken to reduce the risk of infection during invasive clinical procedures.

Aseptic Non-Touch Technique (ANTT®)
A specific type of aseptic technique with a unique theoretical and clinical practice framework (NICE 2012).

Decontamination
Removing, or killing pathogens on an item or surface to make it safe for handling, re-use or disposal by cleaning, disinfection and/or sterilisation.

Direct contact transmission
Spread of infectious agents from one person to another by direct skin-to-skin contact.

Disinfectant
A cleaning chemical used to remove infectious agents from objects and surfaces.

Disinfection
A process, for example using a chemical disinfectant, to reduce the number of infectious agents from an object or surface to a level that means they are not harmful to your health.

Hand Hygiene (HH)
HH is the single most important procedure for preventing the spread of HCAI. Effective HH is essential to ANTT® and must take place prior to and after all invasive techniques. HH applies to hand washing, antiseptic hand wash, antiseptic hand rub or surgical hand antisepsis.

Healthcare-associated Infection (HCAI)
Any infection acquired by a person as a consequence of healthcare interventions regardless of where care is delivered.

Indirect contact transmission – The spread of infectious agents from one person to another via a contaminated object.

Invasive device – A device which penetrates the body, either through a body cavity or through the surface of the body. Central Venous Catheters (central line), Peripheral/ Arterial Lines and Urinary Catheters are examples of invasive devices.

Invasive Procedures
A medical/nursing procedure that invades (enters) the body, usually by cutting or puncturing the skin or by inserting instruments into the body cavity.

Microorganism (microbe) – Any living thing (organism) that is too small to be seen by the naked eye. Bacteria, viruses, and some parasites are microorganisms.

Mode of transmission – The way that microorganisms spread from one person to another. The main modes or routes of transmission are airborne (aerosol) transmission, droplet transmission and contact transmission.

MRSA – Strains of the infectious agent (bacterium) *Staphylococcus aureus* that are resistant to many of the antibiotics commonly used to treat infections.

Personal Protective Equipment (PPE)
Equipment a person wears to protect themselves from risks to their health or safety, including exposure to infections e.g., disposable gloves and disposable aprons.

Spore
A form that some types of bacteria take under certain environmental conditions. Spores can survive for long periods of time and are very resistant to heat, drying and chemicals.

Sterile
Free from all live bacteria or other microorganisms.

Sterilisation
The procedure of making some object free of all germs, live bacteria, or other microorganisms (usually by heat or chemical means).

Appendix 2: Steps to an ANTT® procedure

Step 1.	ANTT® risk assessment: Does this procedure need the ANTT® principles applied? Is a Standard or Surgical-ANTT® required? Gain patient's consent and explain procedure Draw curtains around patient or take to appropriate room
Step 2	Decontaminate hands
Step 3	Clean trolley/tray with appropriate detergent wipe Gather equipment including alcohol hand rub
Step 4	Create suitable working environment. If procedure is performed at the bedside, ensure no cleaning or bed making are ongoing within the area for at least 30 minutes. Ensure windows are closed and no fans are on
Step 5	Decontaminate hands
Step 6	Apply single use disposable apron
Step 7	If required open dressing pack/sterile drape
Step 8	Open and prepare all equipment on the tray/trolley. Keep all equipment within their packaging. Identify Key-Parts
Step 9	Decontaminate hands
Step 10	Apply gloves if required
Step 11	Perform procedure using ANTT®
Step 12	Remove gloves and aprons and other PPE
Step 13	Dispose of waste
Step 14	Decontaminate hands
Step 15	Take patient back to the bedside if required and ensure patient is comfortable
Step 16	Clean trolley/tray/environment
Step 17	Decontaminate hands

Appendix 3: ANTT® Patient Poster



ASAP The Association for Safe Aseptic Practice

ANTT® Aseptic Non Touch Technique

MRSA Action UK

Appendix 4: ANTT® Clinical Staff Poster



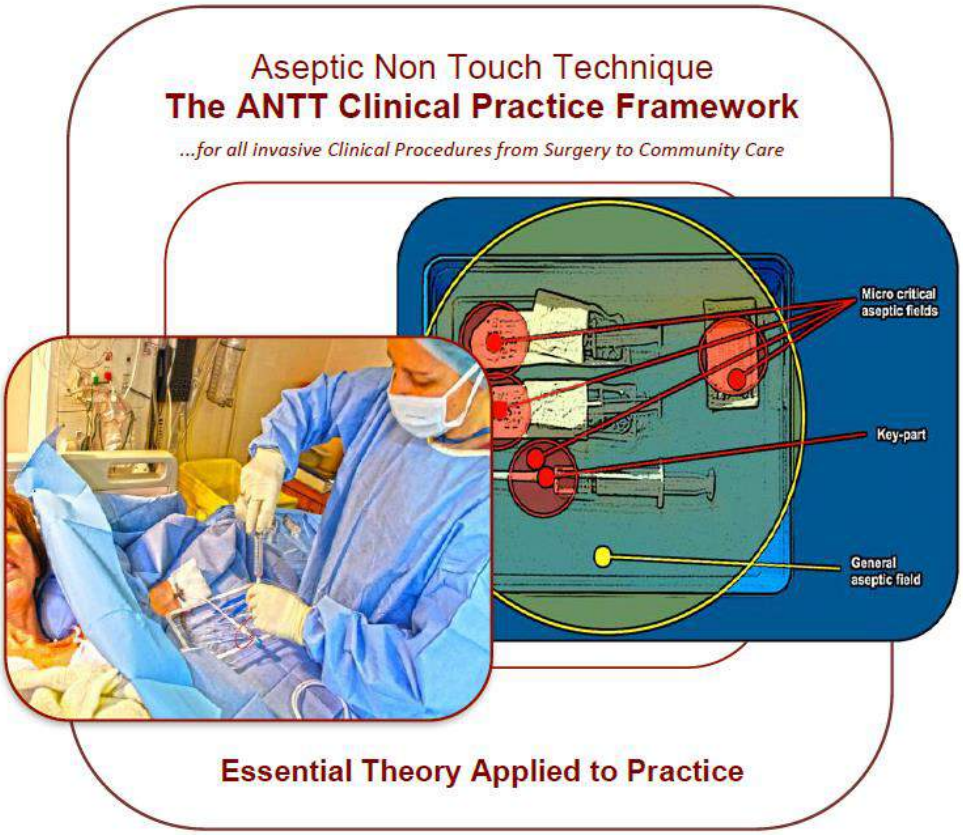
ASAP The Association for Safe Aseptic Practice

ANTT® Aseptic Non Touch Technique

MRSA Action UK

Appendix 5: ANTT® Clinical Practice Framework Poster:

ANTT®
Aseptic Non Touch Technique
www.antt.org



First, do no harm

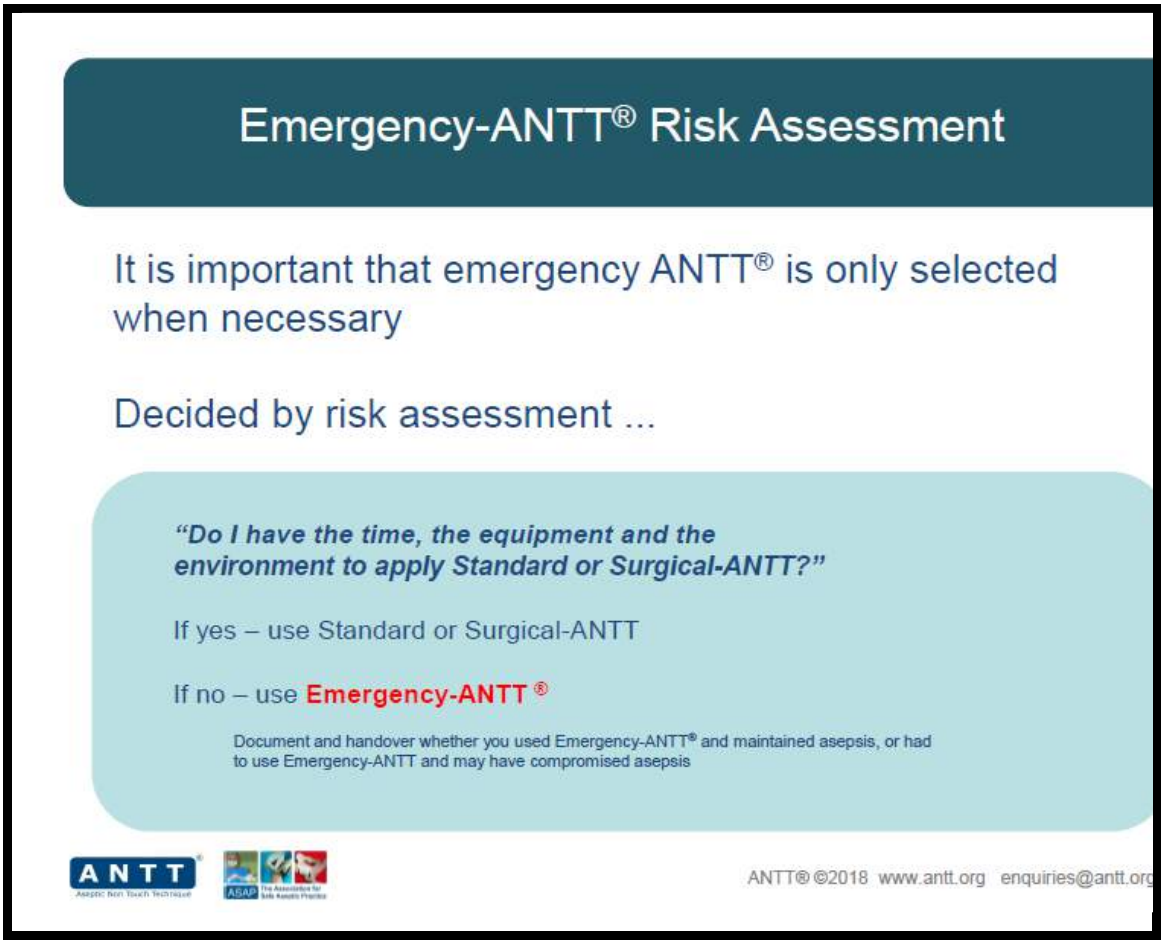


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Appendix 6: Example template for Ambulance Staff: Peripheral Cannulation Guideline (2017)

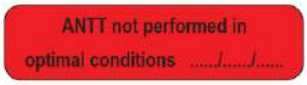


Appendix 7: Emergency ANTT Risk Assessment



Use of colour coded labels to alert receiving healthcare staff of ANTT procedure used:

Red Label applied to the procedure site. **ANTT not performed in optimal conditions. Date.**



Green Label applied to the procedure site. **ANTT performed in optimal conditions. Date.**



Appendix 8: Standard Terminology

Aseptic technique is historically confused with ambiguous terms used interchangeably. The ANTT® Practice Framework defines aseptic practice explicitly:

- ***Sterile Technique***

ANTT® does not use the word "sterile" for describing technique; due to the natural multitude of organisms in the atmosphere, it is not possible to achieve a true sterile technique in any setting. The term sterilized is used to identify products and equipment that have been sterilized. However, once opened to air equipment and products are said to be aseptic.

- ***Asepsis / Aseptic technique***

The term 'asepsis' means, '*Freedom from pathogenic material in sufficient quantity to cause infection'*. It is possible to achieve asepsis in health care delivery by taking steps to reduce patient contamination. Aseptic technique is a generic term for aseptic practice and has no explicitly defined practice framework.

- ***Aseptic Non-Touch Technique (ANTT®)***

ANTT® is a specific type of aseptic technique with a unique theoretical and clinical practice framework.[10,11,12] The ANTT® Practice Framework includes a set of Principles and Safeguards that, if followed, will ensure asepsis for all types of invasive procedures 'from the operating theatre to the community setting'. It is based on a novel concept termed 'Key-Part and Key-Site Protection'.

The 'ANTT-Approach' involves a combination of methods aimed at achieving and supporting best practice aseptic technique; including the ANTT® Practice Framework, a set of ANTT® Guidelines for the most common invasive procedures and a standard implementation process.

- ***Non-Touch Technique***

Non-touch technique is not a technique in itself. It is however an important component of ANTT®.

Appendix 9: ANTT® Practice Framework outline

This model policy is not intended as an educational tool for ANTT®. It is important that Practice Leads refer to the full ANTT® Practice Framework available on the www.antt.org or Public Health Wales on ANTT Framework
A snapshot of the framework is outlined below:

- The aim of ANTT® is always asepsis (see appendix 8)

- **Key-Parts** are the critical parts of any equipment that come into contact with Key-Sites; any liquid infusion; or with any other active Key-Parts connected to the patient via a medical device. If contaminated during a procedure, Key-Parts provide a route for the transmission of pathogens onto or into the patient and present a significant infection risk.

- **Key-Sites**: open wounds, including insertion and puncture sites for invasive medical devices.

- **There are two types of ANTT® (Surgical and Standard) determined by a simple ANTT® Risk Assessment:**

- **Standard-ANTT®** is used for procedures that are technically simple to achieve asepsis. Typically, such a procedure will be of short duration and involve few small Key-Parts and Key-Sites. In Standard-ANTT, primarily non-touch technique and individual Micro Critical Aseptic Fields protect Key-Parts.

- **Surgical-ANTT®** is required for procedures that are technically complex to achieve asepsis, are of longer duration, involve large open-sites and large or numerous Key-Parts. In contrast to Standard-ANTT, in Surgical-ANTT, Key-Parts are managed on one main Critical Aseptic Field (sterile drape) and sterile gloves are essential.

- **Aseptic Fields in ANTT®**: the type of aseptic field and how it is managed is dependent upon the type of ANTT® being utilized.

ANTT® uses three types of aseptic field:

- ✓ **Critical Aseptic Field:** a large sterile drape that is managed 'critically'
- ✓ **Micro Critical Aseptic field:** sterilized caps and covers etc. including the inside of some equipment packaging
- ✓ **General Aseptic Field**: A disinfected plastic tray, suitable sized single-use cardboard tray. NB: General Aseptic Fields are not relied upon to maintain asepsis. They are used to promote asepsis whilst Key-Parts within them are protected by Micro Critical Aseptic Fields. (See above).

A pre-requisite to safe ANTT® is compliance with standard infection prevention and control precautions:

AGENDA ITEM No	**18.2**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**1**

Medicines Management Policy (3.0)

MEETING	Quality, Patient Experience and Safety Committee
DATE	31st October 2023
EXECUTIVE	Brendan Lloyd, Executive Medical Director
AUTHOR	Head of Medicines Management
CONTACT	Dr Chris Moore chris.moore@wales.nhs.uk

EXECUTIVE SUMMARY

1. The Trust Medicines Management Policy (2.6), expired in February 2023. Whilst the policy review commenced in the summer of 2022, winter pressures and industrial action prevented timely completion of the policy review process.

2. The majority of updates to the policy reflect updated job roles/titles, (Clinical Team Leader – Duty Operations Manager), introduction of Cymru High Acuity Response Unit (CHARU) service and introduction of Methoxyflurane (Penthrox), across a range of clinical grades.

3. This policy has been through the relevant stages of the policy review process and agreed by the Policy Review Group, the Trade Union Group and the Executive Leadership Team.

RECOMMENDATION: The Committee is asked to approve the Policy.

REPORT PURPOSE	**For approval**
CLOSED MATTER REASON	

REPORT APPROVAL ROUTE

WHERE	WHEN	WHY
Policy Group	**23/10/2023**	**Update approval**
Executive Leadership Team	**25/10/2023**	**For approval**

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
NHS Trust

GIG CYMRU NHS WALES

Medicines Management Policy

Policy Number:	083	**Version No:**	3.0	**Supersedes:**	2.7
Date of Approval:		**Review Date:**	3 years from date of approval	**Impact Assessments Completed:**	Yes
Classification of Document:	Clinical	**Type of Document:**	Policy	**Approved by:**	
Brief Summary of Document:	To provide a set of guiding principles and procedures to ensure the safe and secure handling of medicines, within the Welsh Ambulance Services NHS Trust (the *Trust*). This policy will support compliance with current legislation, national guidance and best practice, whilst meeting the needs of the service.				
Scope:	This policy should be read and the guidance must be followed by all clinicians who are working for the *Trust* (on a paid or voluntary basis) and who administer/supply medicines to patients. This is inclusive of Welsh Ambulance Service Paramedics, Advanced Paramedic Practitioners and Emergency Medical Technicians. The policy relates to the operational management of all medicines used by the *Trust*.				
To be read in conjunction with:	WAST Controlled Drugs Policy (2021) HCPC Code of Conduct and Professional Behaviour RPS Safe and Secure Handling of Medicines: A Team Approach (2018) WAST ePCR TerraPace Training Modules WAST Employee Immunisation Policy (2015) WAST Omnicell SOP (V7) WAST Prescribing Policy V1.9				
Owning Committee	Clinical Quality Governance Group				
Policy Lead: **Trade Union Lead:**	Chris Moore Hugh Parry	**Job Title:**	Head of Medicines Management Trade Union Partner		
Executive Director:	Andy Swinburn	**Job Title:**	Director of Paramedicine		

Version Control Sheet

Version	Date	Author	Summary of Changes
	June 2022	C Moore	First draft review of existing MM policy
	Oct 2022	C Moore	Edits based on T&F group feedback
2.4	March 2023	C Moore	Paragraph on role of Pharmacist Advisor added, new section on preparation and administration of medicines added. Appendix 6 updated to reflect CFR/UCS meds
2.5	April 2023	C Moore	Minor amendments to paragraphs 6.5, 6.8 following Policy Group meeting 25.04.23
2.6	June 2023	C Moore	Prepare for consultation, reformat appendix 4
2.7	July 2023	C Moore	Minor amendments/additions from consultation feedback
3.0	August 2023	C Moore	Further minor amendments following Policy Group meeting 29.08.23
Keywords	Medicines, Management, Drugs, Policy		

Impact Assessment Reviews

Area	Date of Review	Name of Reviewer
Training	10.07.2023	M. Mulholland
Counter Fraud	10.07.2023	L. Haddow/Carl Window
Information Governance		
Records Management		
EqIA / Welsh Language	27.07.23/16.08.23	P. Spiteri / M Hughes
Estates	29.08.2023	N. Stephens
Environment	29.08.2023	N. Stephens
ESMCP	N/A	

Task and Finish Group Members

Name	Job Title
Chris Moore	Head of Medicines Management
Andy Swinburn	Director of Paramedicine
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Huw Parry	Trade Union Partner

Policy Approval Route

Where	When	Why
Policy Group	25/04/2023	Feedback on policy changes
Trade Union Partners e-mail review	26/04/2023	Feedback on policy changes

Disclaimer
If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or email AMB_Policies@wales.nhs.uk

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1. INTRODUCTION

1.1 The purpose of this policy is to provide a framework of guiding principles and procedures to ensure the safe and secure handling of medicines, within the Welsh Ambulance Services NHS Trust (the *Trust*). This policy will support compliance with current legislation, national guidance and best practice, whilst meeting the needs of the service.

1.2 This policy is not intended as a reference for the clinical indications or use of specific medicines.

2. POLICY STATEMENT

2.1 This Medicines Management Policy is intended as a working document for all individuals (clinicians and managers), dealing with medicines within the *Trust*. It offers a framework of processes for all aspects of medicines management including supply, administration, storage, disposal and adverse incident reporting. It is a multidisciplinary document that is intended to be as comprehensive and as inclusive as possible.

3. SCOPE

3.1 This Policy follows the legislative and best practice guidance offered but not restricted to, the following; *Prescriptions Only Medicines Act 1968, Human Medicines Regulations (2012), Misuse of Drugs Act 1971/1985, Patient Group Directions (NICE Guideline MPG2) (2017), To PGD or not to PGD Version 9.5 (SPS 2018), When to use a PGD (SPS 2022),* and the Royal Pharmaceutical Society's (RPS), Safe and Secure Handling of Medicines: A Team Approach (2018)

3.2 This policy should be read and the guidance followed by all clinicians who are working for the *Trust* (on a paid or voluntary basis) and who administer/supply medicines to patients. This is inclusive of all Welsh Ambulance Service Paramedic grades (APPs, SPs, etc.), Emergency Medical Technicians (EMTs), Nurses, Ambulance Care Assistants (ACAs) and Community First Responders (CFRs). This policy relates to the operational management of all medicines used by the *Trust*.

3.3 Any instances where there is a suspicion of unauthorised administration or supply of medicines to anyone other than a Trust patient, e.g. a member of Trust staff or other third party, must be referred in the first instance to the Trust Counter Fraud Service, who may wish to investigate or advise on whether the matter be referred to the Police.

3.4 Where staff have any suspicion that medicines are being taken or used by a member of staff or third party, they have a duty to report this to either their line manager, or in confidence to the Trust Local Counter Fraud Specialists. Further details of the Trust's Counter Fraud Policy, and how to report suspicions are available on the Trust intranet.

4. AIM

4.1 To ensure that all *Trust* healthcare professionals and clinicians are fully conversant with the standard procedures for the use and management of medicines. For guidance on

prescribing and management of prescription pads, please refer to the Trust Prescribing Policy.

5. OBJECTIVE

5.1 To set out safe systems for procuring, requisitioning, handling, storing, transporting, administering and disposing of all medicines used by *Trust* clinicians, whilst at the same time ensuring the protection of patients and staff by reducing risk and the potential for error.

6. RESPONSIBILITES AND ACCOUNTIBILITY

6.1 The **Chief Executive** has overall statutory responsibility for the safe and secure handling of medicines. Delegated responsibility for the day-to-day management of medicines lies with the **Executive Medical Director**.

6.2 The **Trust Board** play a key role in shaping the strategy, vision and purpose of an organisation. They are responsible for holding the organisation to account for the delivery of the strategy and to ensure value for money. They are also responsible for assuring that risks to the organisation and the public are managed and mitigated effectively.

6.3 The **Executive Medical Director** is the named *Trust* Controlled Drugs (CD) Accountable Officer (AO). Responsibilities of the AO include;

- To ensure the safe and effective management and use of CDs within the Trust
- To share information about concerns regarding CDs with other agencies through the Local Intelligence Networks (LIN).

6.4 The **Director of Paramedicine** is responsible for:

- The production of policies and procedures advising on the day to day safe and secure handling of medicines throughout the Trust.
- Ensuring that this policy is reviewed every 3 years to reflect and take account of changes in best practice guidance and/or legal framework relating to medicines management.
- Monitoring and review of the formulary of drugs available and used by *Trust* clinicians.
- Ensuring Patient Group Directions (PGDs) are in place and kept up to date.
- Ensure that the *Trust* Drug Formulary medicines are used according to best practice and current legislation.
- Ensuring that any identified medicines related risks are recorded on relevant Directorate and, if applicable, *Trust* Risk registers.

6.5 The Director of Paramedicine is also delegated with the day-to-day responsibilities of the AO and for ensuring that the Trust has the necessary policies and procedures in place for the safe and secure management of medicines.

6.6 The **Regional Clinical Leads** are responsible for maintaining oversight of safe Medicines Management practices and procedures within their geographical area of

responsibility. This includes ensuring that Health Board Clinical Leads are in a position to advise, or provide leadership on medicines related matters, particularly in relation to audits and attendance at CD Local Intelligence Networks.

6.6 The **Director of Quality & Nursing** is responsible for *Quality Improvement* practices which include but are not restricted to the corporate development, implementation and performance management of policies and procedures.

6.7 The *Trust* Head of **Medicines Management,** supported by the **Pharmacist Advisor**, is responsible for the development and implementation of safe and secure medicines management arrangements. This includes responsibility for the development and regular review of all medicines related policies & procedures, scheduling and facilitation of audits and dissemination of their findings. The **Head of Medicines Management** will support the development and review of new and existing PGDs, and maintain a register of Authorised practitioners. The Head of **Medicines Management** is also responsible for reviewing and collating all CD related adverse incidents and producing Quarterly Occurrence Reports on behalf of the Executive Medical Director. All MHRA Drug Alerts cascaded through the Welsh Government system will also be reviewed by the **Head of Medicines Management** and where necessary, disseminated to relevant clinical/operational teams.

6.8 The **Trust Pharmacist Advisor** will support the Trust **Head of Medicines Management** to deliver the safe and secure management of medicines, including the implementation and reporting of their use. They will take a lead role in the provision of safe systems of work aligned to the necessary regulation and mandatory compliance frameworks.

6.9 The **Head of Education** is responsible for ensuring that suitable and sufficient education and training is developed and delivered to support and maintain *Trust* clinician's knowledge and skills relating to medicines management procedures, including PGDs and any new medicines related developments.

6.10 **Heads of Service** and **Locality Managers** are responsible for:

- Supporting the operational implementation and performance management of medicines management policies and procedures.
- Ensuring **Duty Operations Managers (DOMs)/Senior Paramedics (SPs)** undertake regular medicines audits within their area of responsibility, using the *Trust* online medicines audit tool.
- Ensuring that any medicines related adverse incidents are robustly reported, recorded and investigated via the eDATIX system.
- That all CD related adverse incidents that involve the loss or suspected theft of ampoules/vials, are recorded on the EMS Occurrence Log and reported to the relevant Police Service via the 101 number.

6.11 **Advanced Practitioners (including trainees) and SPs,** are responsible for:

- Ensuring their use, administration and supply of medicines is consistent with their scope of practice and the auspices of the PGDs that support their advanced practice.
- Supporting all *Trust* clinicians who administer/supply medicines in their knowledge and clinical practice, to meet the standards identified in this policy.

- Supporting **Locality Managers** and **DOMs** in their role with regard to the management of medicines.
- Supporting monthly vehicle medicines audit checks of CDs and drug cases and Omnicell cycle counts (see section 16 of this document)
- Support the local implementation of PGDs by being responsible for ensuring staff are informed and supported at local level.

6.12 **Duty Operations Managers and SPs** are responsible for:

- Ensuring that any station-based medicines are securely stored and managed effectively, to minimise waste.
- Undertaking regular audits (see section 18), of vehicles and drug cases and equipment, to reduce unnecessary additional stocks or stockpiling of medicines occurring.
- Undertaking regular audit checks of vehicle CD safes and documentation to ensure compliance with record keeping.
- Supporting monthly Omnicell cycle counts

6.13 **Paramedics, EMTs, EMT3s, Nurses and peer vaccinators** are trained and educated in accordance with their profession, scope of practice and level of competency in good practice and legislative requirements in the administration, storage and disposal of medicines. It is their responsibility to remain up to date and to attend any training provided by the *Trust* maintaining full CPD records.

6.14 **All *Trust* personnel** that have a requirement to be involved in the receipt, storage, or use of Trust medicines, have a responsibility to:

- Be familiar with this policy, have a reasonable working knowledge of the guidance (within their scope of practice) and adhere to this at all times.
- To be personally responsible for the security, safe storage and management of all medicines for the duration of their period of duty.

6.15 The **Ambulance Practice Steering Group** is one of several clinically led Trust meeting groups that report into the **Clinical Quality Governance Group** (**CQGG**) to provide assurance and raise any matters for discussion to the Directors of Paramedicine and Nursing. Medicines related matters are routinely shared via 'triple A' (Alert/Advise/Assure) reports. Any significant matters raised at **CQGG** are taken forwards to **Executive Management Team** (**EMT**).

6.16 **QUEST** (Quality, Patient Experience and Safety Committee), has oversight of effective care, ensuring 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. In this respect, an annual report on medicines management, signed off by the Clinical Directorate business meeting will be submitted to **QUEST** during the first quarter of the financial year.

7. LOCATION OF MEDICINES ADMISTERED BY AMBULANCE CLINICIANS

7.1 All medicines for use by *Trust* clinicians are procured through NHS Wales District General Hospital Pharmacy Suppliers at NHS contract prices. The Trust uses a variety

of methods to procure and supply medicines for use by its clinicians which are outlined below.

7.2 **Omnicell Automated Medicines Cabinets**
The Trust operates a standardised approach for the supply of medicines to its frontline clinicians and vehicles. All EMS vehicles are equipped with a standard drug case, which contains a standard set of medicines (***appendix 1***).

7.3 WAST operates 20 identical Omnicell automated cabinets across Wales, for the sole use of WAST clinicians. Fifteen of the cabinets are installed at District General Hospitals (DGHs) in Wales and are located within, or in the immediate vicinity of the DGH Emergency Department (ED). The remaining 5 are installed at four Powys ambulance stations (Brecon, Llandrindod, Newtown and Welshpool) and one at Dobshill Make Ready Depot. The contents of the Omnicell cabinets are based on the WAST standard list of medicines (***appendix 1***). Levels within the cabinets are maintained by DGH Pharmacies, based on historical use. Trust clinicians can access the WAST Omnicell cabinets 24 hours a day, 7 days a week.

7.4 All WAST EMS clinicians are registered on the Omnicell system and access to the cabinets is via biometric (fingerprint) technology. Staff who do not wish to utilise the fingerprint access function, have the option to use their own unique username and password. Staff who wish to withdraw medicines are required to identify the vehicle they are operating on, so that the medicines can be identified as having been issued to that vehicle.

7.5 WAST Omnicells are equipped with a secure controlled drugs (CD) section, which is accessible to WAST Paramedic grades only. Schedule 4 CD benzodiazepine presentations may be withdrawn by paramedics without a witness fingerprint. Schedule 2 & 3 CD withdrawals (morphine sulphate and midazolam) require a witness fingerprint. This may be provided by an EMT or Paramedic grade member of EMS.

7.6 In most areas of Wales, the majority of Omnicell stock levels are maintained by DGH pharmacy staff, but where local arrangements do not support this, WAST DOMs undertake this function, on receipt of drug deliveries from the relevant pharmacy. Please refer to the WAST Omnicell SOP (V7) for additional detail on specific local arrangements.

7.7 Locality SPs and DOMs may share responsibility for undertaking monthly Omnicell cyclecounts, as a means of supporting quality assurance checks. This serves to ensure stock levels are monitored and if required, can be adjusted up or down on individual cabinets.

7.8 **Station Based Medicines**
In some geographically remote WAST locations it may be necessary to maintain a limited working stock of medicines. The main purpose of this is to reduce the need for vehicles to make excessive journeys to DGHs, to undertake restocks; e.g. post cardiac arrest resuscitation where adrenaline 1:10,000 stock is depleted. The decision to hold and maintain limited station stocks of medicines (resuscitation drugs only), is the responsibility of the Locality Manager.

7.9 It is the responsibility of the Locality Manager to ensure that any station stock held is managed consistently, to ensure excessive stocks of multiple presentations are avoided. Medicines should be stored securely, in a locked cupboard, in a locked room, and should not be accessible to unauthorised staff.

7.10 **Management of Ketamine and Midazolam**
To support the use of enhanced analgesia by Senior Paramedics and Cymru High Acuity Response (CHARU) paramedics, the Trust operates a 'hub and spoke' network of strategically located CD safes across Wales. Access to the safes is strictly controlled by requiring the necessary permissions written to individual Abloy CD keys. For further information, please refer to the Trust CD Policy

7.11 CD 'Hub' safes hold a stock of Ketamine, Midazolam and Flumazenil. These drugs are ordered by a limited number of authorised signatories and each presentation is recorded in the CD safe register. CD 'Spoke' safes have two enhanced analgesia packs assigned to them and these packs hold two ampoules/vials of each drug, which are also recorded in the analgesia pack register. Restocks of drugs into enhanced analgesia packs must be completed at the CD 'Hub' safes.

7.12 **Make-Ready Depot (MRD)**
The Trust operates a number of MRD facilities across Wales. MRD technicians have a responsibility to check the expiry dates of drugs stored in WAST drug cases and removing out of date drugs from the case. MRD technicians are responsible for identifying depleted drug stocks in the cases and are able to supplement depleted stocks from surplus items removed from overstocked cases, but this must not include decanting or splitting drug packs which could result in drugs with different expiry dates being held in the same pack. MRD technicians are not currently authorised to access Omnicell cabinets to make drug withdrawals. However, the feasibility of dedicated MRD based Omnicells is currently being explored (Cardiff MRD)

7.13 It is the responsibility of the Locality Manager to ensure that any surplus drug stocks held on station are managed consistently with the stock-keeping requirements described in section 6.1 of this policy. Medicines should be stored securely, in a locked cupboard, in a locked room, and not be accessible to unauthorised staff.

7.14 **Advanced Practitioner (AP) Medicines**
Introduction of the Omnicell system has provided the Trust the opportunity to standardise the supply of 'To Take Home' (TTH) medicines to its Advanced Practitioners (APs). TTH medicines to support the AP teams will be supplied from the relevant DGH pharmacy, and be available from the relevant Omnicell cabinets, as and when the teams establish in their Health Board areas. In some areas of Wales, ordering of some overlabelled or pack down presentations require a hard copy requisition direct to the relevant Pharmacy Production Unit. Where required, this will be facilitated through the Head of Medicines Management, or HBCLs locally, by completing a WAST Non-Stock Requisition.

7.15 Operational AP bags containing TTH medicines must be stored securely on ambulance stations when not in use, to prevent unauthorised access to their contents (e.g. antimicrobials etc,)

8. STORAGE AND SECURITY OF AMBULANCE MEDICINES

8.1 Ambulance medicines must only be stored in the original packaging in which they are supplied and must not be decanted or stored in any other container. Drug cases stored on Trust emergency ambulances must be secured in the designated cupboard space. This will ensure they are out of immediate sight of the public and reduce the potential for opportunistic theft, particularly in circumstances where the vehicle may be left unattended.

8.2 Drug cases stored on rapid response vehicles and in paramedic officer lease cars, must be stored in the rear hatch/boot compartment, out of immediate view. Unattended vehicles at the scene of incidents should wherever practicable be locked.

> **Good Practice**
> Medicines (excluding CDs), should only be stored within the vehicle drug case and primary response bag (see appendix 1). Additional stocks must not be decanted into defibrillator pouches, or personal kit bags.

8.3 There will be a limited requirement for fully equipped drug cases to be stored at ambulance stations or other locations. However, where this facility is required either temporarily or permanently, drug cases must be stored in a lockable cupboard, within the confines of a locked room.

8.4 To support operational clinical requirements, the following medicine presentations may be available from the secure ambulance station store:

- Sodium chloride 0.9% for IV injection/infusion (10ml flush and 500ml bags)
- Dextrose 10% WV for IV or IO infusion 500ml
- Tenecteplase injection – strategic WAST station locations including; Brecon, Llandrindod, Newtown, Welshpool Omnicells, and dedicated safes in Aberaeron and Dolgellau.

8.5 **Trust Issued DuoDote (Nerve Agent Antidote Kits)**
All Trust EMS vehicles are equipped with a special pouch for use in the event of a major incident. The pouches contains action cards, triage bands and 4 DuoDote (Nerve Agent Antidote Kits) these kits are in the form of an auto injector and contain:
2.1 mg of Atropine/600 mg Pralidoxime Chloride. The kits are stored in the door compartments of EAs, glove compartments of RRVs, responding officer vehicles and carried in large quantities on our resilience fleet.

9. PREPARATION AND ADMINISTRATION OF MEDICINES

9.1 When preparing medicines for administration, it is important to ensure appropriate measures are followed. To avoid the risk of medication errors, the Trust fully endorses the ‘6 Rights of Drug Administration

- Right person
- Right drug
- Right dose
- Right time

- Right route
- Right documentation

9.2 To minimise the risk of a medication error, parenteral (injectable) medicines should only be prepared by those qualified to administer them. Delegating responsibility for the preparation and administration of drugs to clinicians not qualified to administer them is not acceptable as it increases the risk of error and avoidable harm to patients.

9.3 Student paramedics are not permitted to prepare or administer any medicines, when on clinical placement. Delegation of these tasks even when supervised is not permitted.

10. RECORDING OF MEDICINES ADMINISTERED BY AMBULANCE CLINICIANS

10.1 All medicines administered by WAST ambulance clinicians, must be recorded in the Drugs section of the ePCR. The following information should be recorded:

- Time of administration (or supply - advanced practitioners)
- Name of drug/strength/presentation
- Dose(s) administered
- Unit
- Route
- Expiry date/batch number
- Staff ID (Name/PIN) of clinician who administered medicine

Exceptions to administration of an indicated medicine should be recorded in the narrative section of the ePCR

11. ACCIDENTAL MEDICINE ADMINISTRATION ERRORS

11.1 Any inadvertent or inappropriate medicine administration, either by dosage or medicine type, MUST be recorded on the ePCR and reported to the medical team at the receiving hospital during handover of care. The occurrence MUST also be reported immediately to the ambulance clinician's line manager and recorded on the Trust e-DATIX system, as soon as is practicable (prior to going off duty). The Patient Safety Team will forward all medicines related drug administration error reports to the *Trust* **Head of Medicines Management**, so that a record of errors can be monitored for trends and themes.

12. ADVERSE DRUG REACTIONS

12.1 Adverse reactions or incidents concerning any medicines administered by *Trust* clinicians, must be reported immediately to the receiving hospital clinical team. The incident must also be reported to the clinician's line manager and control, as soon as is practically possible. All adverse reactions must be reported via the *Trust* e-DATIX system, as soon as is practically possible, by the clinician involved.

12.2 The *Trust* Patient Safety Team review all medicines related incidents reported via the e-DATIX system and forward them to the *Trust* **Head of Medicines Management** for review and relevant action. Where necessary, consultation with the *Trust* Pharmacy Advisor will take place to confirm an agreed course of action. The recommendation from this consultation will be communicated to the *Trust* Executive Medical Director/Assistant

Medical Director/ Director of Paramedicine. The MHRA "Yellow Card" reporting system will be used to report appropriate incidents. If reported on Yellow Card, this needs to be reported on DATIX.

13. MEDICINES ALERTS, RECALLS AND SHORTAGES

13.1 Medicine hazard warnings and recalls can originate from a number of sources and include the Medicines and Healthcare products Regulatory Agency (MHRA), Committee on Safety of Medicines (CSM), DGH Pharmacies, the Welsh Government (WG), and the Department of Health (DH). Medicines shortages are most commonly reported through the Welsh Government Emergency Mailbox (HPGEmergencyMailbox@wales.nhs.uk)

13.2 Drug/medicines alerts are sent directly to the *Trust* **Executive Medical Director** and other Clinical Managers, via the offices of the Chief Medical Officer for Wales. The *Trust* **Head of Medicines Management** is responsible for reviewing all Drug Alerts, for relevance and impact to *Trust* clinicians. During periods of absence, this role is supported by the *Trust* Pharmacist Advisor. A record of all medicines related alerts received and reviewed, is maintained by the Clinical Administration Team.

13.3 All drug/medicines alerts identified as having direct relevance to *Trust* clinicians will be circulated to relevant staff groups (e.g. Advanced Practitioners), or, Heads of Service, Locality Managers, Regional Clinical Leads, Health Board Clinical Leads etc. Where appropriate, a *Trust* Clinical Notice will be issued via the JRCALC+ app. Copies are also available on the Trust intranet, via ***Clinical Services Directorate*** - ***Clinical Notices.*** An overview of the number and nature of drug/medicines alerts received each month is included in the monthly Medicines Management Assurance Report (MMAR).

13.4 Medicine shortages are routinely communicated through the Welsh Government Emergency Mailbox and *Trust* network of pharmacy suppliers. Where relevant, a Clinical Notice will be issued to inform staff and managers of the shortage and any interim arrangements put in place to mitigate the medicines shortage.

14. DISPOSAL OF UNUSED PREPARATIONS/EXPIRED MEDICINES – NON CDS

14.1 Where medications are prepared but not administered by Trust clinicians, this should be recorded in the WAST ePCR narrative section and the contents of the syringe disposed into the vehicle-based sharps bin containing an absorbent pad.

14.2 Unused prefilled syringes *(PFS);* should be removed from packaging and the liquid contents expelled into an appropriately sized sharps container with an absorbent pad. The empty syringe can then be disposed of into the same container. Uncontaminated PFS packaging (paper/plastic) can be disposed of as domestic waste.

14.3 Unused drug ampoules/vials; all packaging should be removed and the entire ampoule/vial disposed of into an appropriately sized sharps container. Uncontaminated packaging can be disposed of as non-clinical waste.

14.4 Expired drug presentations (as an entire product or pack) may be disposed of using the Pharmacy Return Bins, that are available at most WAST Omnicell sites. At sites where the return bins are not available, expired drug presentations can be disposed of in

vehicle sharps bins, or blue lidded medicines waste bins at ambulance station sites. All recyclable packaging must be removed, prior to disposal, as described in 14.2-14.3 (above).

Please refer to the Trust Management of Controlled Drugs Policy (section 16), for specific guidance on the disposal of morphine sulphate. which must be returned to the supplying pharmacy for destruction. A standard operating procedure (SOP) for the witnessed destruction of Ketamine and Midazolam has been developed. The witnessed disposal of these CDs will be limited to senior clinicians that have received appropriate training and are authorised to undertake this activity.

15. DEVELOPMENT OF PATIENT GROUP DIRECTIVES (PGD)

15.1 All master copies of Trust PGDs will be held by the Trust **Head of Medicines Management**. PGDs are required to be reviewed every three-years to ensure they remain up to date and fit for purpose. Reviews will be undertaken by the **Head of Medicines Management**, **Pharmacist Advisor** and at least one Advanced Practitioner. When a justifiable case is made by a practitioner for a specific medicine to enhance their practice, or a change is driven by national guidance, the practitioner will be provided the necessary support to develop a draft version of their PGD. The draft will then be refined by the **Head of Medicines Management,** before being shared with relevant professionals including the *Trust* **Pharmacy Advisor** and **Executive Medical Director**, before final sign-off.

15.2 PGDs will be distributed to the relevant Trust Registrants electronically. They will be required to read and confirm their competency to work within the scope of the PGD by completing an electronic authorisation (via MS Forms). A register of all authorised registrants and their PGD competencies will be maintained by the Clinical Administration Team. Individual PGD compliance is also recorded on the Electronic Staff Record (ESR) Authorised professionals are also required to retain hard copies of all PGDs for their own records to support their clinical practice.

16. MANAGEMENT OF ADVANCED PRACTITIONER MEDICINES.

16.1 *Trust* Advanced Practitioners (APs) and AP Trainees currently supply and/or administer a range of medicines under the auspices of PGDs. The full list of medicines and their presentations can be found in ***appendix 3*** of this document.

16.2 The administration and use of the AP medicines identified in ***appendix 3****,* is restricted to *Trust* APs and AP Trainees only.

16.3 TTH medicines to support local AP teams will be supplied from the relevant DGH pharmacy. The Trust Omnicell system has a dedicated AP drug section which will be made available as and when AP teams establish in Health Board areas. To minimise waste, APs are encouraged to monitor the stock levels held in the Omnicells, and if stock levels appear to be above (or below) those required to support clinical activity, to bring this to the attention of their Health Board Clinical Lead.

16.4 Operational AP bags containing TTH medicines must be stored securely on ambulance stations when not in use, to prevent unauthorised access to their contents (e.g. antimicrobials etc,)

16.5 **Antimicrobial Stewardship**
APs have a limited number of antimicrobials at their disposal. NICE Quality Standard (QS61) advocates that antimicrobials are prescribed (supplied), according to the principles of antimicrobial stewardship. The main principles are that antimicrobials are only supplied when they are needed and not supplied for self-limiting mild infections, such as coughs, colds, sinusitis or sore throats. The Trust antimicrobial PGDs are specific in their application and APs are individually and professionally responsible for ensuring their use of antimicrobials is consistent with the aforementioned principles.

16.6 To support the principles of antimicrobial stewardship, an annual audit of antimicrobial use by APs will be conducted and the findings reported to the Trust Ambulance Practice Steering Group, appropriate Trust Committees and where appropriate, National Antimicrobial Stewardship Forum.

16.7 **Storage of Temperature Sensitive Medicines**
For specific guidance relating to the management of vaccinations, please refer to the Trust Employee Immunisation Policy.

16.8 Trust clinicians responsible for administering vaccinations must ensure that temperature sensitive medicines and other medicinal products are stored in accordance with the patient information leaflet/summary of product characteristics (SPC), available within the packaging of all dispensed medicines in the UK. Electronic versions of these documents are also available via; http://www.medicines.org.uk/emc/

- Medicine fridges must be maintained between +2˚ and +8˚C. A mid-range of +5˚C is considered best practice. Use of an external digital thermometer is recommended.
- The fridge must be lockable OR kept in a locked room, away from unauthorised access.
- Used to store medicines or vaccines only. No foodstuffs.
- Wired into switchless sockets OR the electrical socket is clearly labelled to prevent accidental disconnection.
- Record weekly temperature readings, at the same time of day, using the *Drug Fridge Monitoring Form* (***appendix 5***), which should be affixed to the front of the fridge. Completed copies should be retained for a period of two years

17. MANAGEMENT OF THROMBOLYTIC AGENTS

17.1 The implementation of fast-track pathways for STEMI patients to receive Primary Percutaneous Coronary Intervention (PPCI), means that for a large population in Wales, the indications and use of prehospital lysis has reduced. In some areas of Southeast and West Wales, thrombolytics are no longer carried on ambulances, due to the relatively short transport times to definitive care. However, prehospital lysis may still be indicated for patients who cannot be transferred to definitive care within six-hours of their suspected STEMI onset.

17.2 In 2020, the Trust moved to a strategic model of thrombolytic deployment (Clinical Notice 35-2020) at eight sites across Wales. A single dose of Tenecteplase and pack of

Heparin, are stored at these agreed locations and may be used in consultation with the PPCI centre. Used doses will be replaced on a one for one basis.

17.3 It is the responsibility of the Locality Manager/DOM/SP team, or DGH by local agreement, to ensure that a suitable number of replacement packs of Tenecteplase are maintained or available at the relevant strategic sites.

17.4 If a thrombolytic pack has been prepared and not used or damaged, then this should be reported via the e-DATIX system and the Locality Manager notified.

18. AUDIT OF MEDICINES SUPPLY, STORAGE & ADMINISTRATION

18.1 Audit and record management will be implemented in accordance with the principles of the Royal Pharmaceutical Society's Safe and Secure Handling of Medicines: A Team Approach (2018).

18.2 The Trust Omnicell system provides the Trust the ability to monitor the volumes and frequency of drugs supplied to the organisation and those that are withdrawn for clinical use. Record keeping and invoicing associated with the pharmacy supply of medications to the ambulance service is the responsibility of the appropriate pharmacy. Wherever possible, supplying DGH pharmacies should provide a breakdown of the medicines they supply, which should accompany monthly invoices submitted to the Health Board Area Operations Managers for approval and sign-off. Wherever possible, this should include a breakdown of the volumes of medicines disposed of due to expiry.

18.3 Locality Managers are responsible for ensuring that regular EMS vehicle medicines management audits are undertaken. The *Trust* has developed an online audit tool to facilitate this, which is listed under Clinical Audit, accessed via the *Application Portal* on the *Trust* intranet. The Operations and Clinical Directorates have also produced a Vehicle Medicines Audits (VMA) process (see appendices 7 & 8), to promote regular monthly audits by localities.

18.4 Localities will be expected to undertake a minimum of one EMS vehicle medicines audit, per locality, per month. Compliance checks of these audits will be monitored and reported via monthly Medicines Management Assurance Reports to the APSG and on a quarterly basis to the Senior Operations Team. Annual summary reports will be presented to the Clinical Directorate business meeting and QUEST (see 6.16 above).

18.5 The *Trust* Health Informatics Department will provide reports on the most commonly used medicines used by WAST clinicians on a request basis.

19. MEDICINES RECONCILIATION (GREEN BAG SCHEME)

19.1 Hospitals in Wales have been operating 'Patient's Own Medications' schemes for some years as patients are expected to take their own medications into hospital with them for use during their stay.

19.2 Guidance issued by the National Institute for Health and Clinical Excellence (NICE) and National Patient Safety Agency further impresses the importance of ensuring patients are admitted with their own medications.

19.3 The Trust has supported the principles of medicines reconciliation for many years and GREEN BAGS, specifically designed to support this, are readily available for this purpose. The use of 'GREEN BAGS' ensures patients medications are easily identifiable on admission and is an accepted standard across Wales. This assists pharmacy professionals in being able to undertake essential medication reviews, which can have significant health benefits for patients.

19.4 Whilst it is important to ensure that wherever possible patients are admitted with their own medicines, for patients residing in nursing or care homes, this may not always be practicable. With the support and agreement of pharmacy professionals locally, some care providers operate a policy where the patients' medications are retained at the residence, but a copy of the Medication Administration Record (MAR) is provided to accompany the patient. To support best practice, the patients name should always be written on the GREEN BAG.

20. COMMUNITY FIRST RESPONDERS (CFRs)

20.1 The Trust trains and operates volunteers to work in the capacity of CFRs. Within the remit of this role, CFRs are permitted to administer oxygen to appropriate patient's oral paracetamol (tablets) and inhaled methoxyflurane for the initial management of pain in trauma. A dedicated team of WAST Officers are responsible for supporting CFRs at a local level and support them to replenish oxygen cylinders, paracetamol and disposable items. Replacement methoxyflurane inhalers will be available from the Trust Omnicell cabinets, via a dedicated (restricted access) drawer.

20.2 The CFR Officers are responsible for ensuring CFRs receive appropriate training and authorisation, and to ensure that their medical gases and medicines are stored safely and securely within Trust approved CFR response bags.

20.3 CFR volunteers are advised that depleted cylinders can be exchanged on a one-for-one basis with EMS operational crews attending the same incident, or, at a local ambulance station, subject to approval of the Locality Manager.

N.B. ***All ambulance clinicians have a professional responsibility to ensure that they are fully conversant with their legal and/or regulatory duties in relation to standards of clinical care and with regard to the supply, storage, and administration of medicines. Further information for paramedics can be found via the Health Professions Council (HCPC) website; www.hcpc-uk.org***

21. RECORDS MANAGEMENT

The Welsh Ambulance NHS Services Trust (WAST) recognises the importance of sound records management arrangements for both clinical and corporate records. The Trusts' records are its corporate memory, providing evidence of actions and decisions and representing a vital asset to support daily functions and operations. Records support policy formation and managerial decision-making, protect the interests of the Trust and the rights of patients, staff and members of the public.

22. EQUALITY

Equality Impact Assessment (EQIA) screening was undertaken and evidenced a neutral impact. The full EQIA document can be accessed by request to the **Head of Medicines Management**.

23. WELSH LANGUAGE IMPACT ASSESSMENT

The Welsh Language Measure (2011) established the principle that the Welsh and English language should be treated on a basis of equality. The duties deriving from the standards mean that the Trust will be required to assess what effect a policy decision would have on the opportunities for persons to use the Welsh language or treating the Welsh language no less favourably than the English language.

24. ANTI FRAUD AND CORRUPTION CONCERNS

The Welsh Ambulance Services NHS Trust is committed to taking all necessary steps to counter fraud, bribery and corruption within the Trust. Staff are encouraged to report suspected incidents of fraud and corruption to the Trust Local Counter Fraud Specialist, who will be happy to discuss any issues or concerns. Alternatively staff may contact the confidential NHS Fraud and Corruption Reporting Line 0800 028 40 60; or on-line reporting facility www.reportnhsfraud.nhs.uk

Where there is any suspicion or an allegation that a loss has been caused by means of deception (by staff or patient) this must be referred to the Trust's Local Counter Fraud Specialist for investigation. The results of any such investigation could lead to internal disciplinary and/or civil/criminal prosecution proceedings being instigated against the person/persons involved.

25. ENVIRONMENTAL STANDARDS AND IMPACT ASSESSMENT

This policy will put the relevant requirements in place (such as waste management plan, reduction of C02 emissions & reduction of carbon footprint) in order to ensure that the Welsh Ambulance Services NHS Trust ongoing commitment to reduce its impact on the environment is maintained and to become a more sustainable organisation in line with Trust policy and Environmental Governance System.

26. TRAINING AND IMPLEMENTATION

26.1 Managers and DOMs will be provided electronic copies of this updated Policy document following its approval and be advised to familiarise themselves with its content.

26.2 Newly Qualified Paramedics and newly transferred staff are provided oversight training of local medicines management arrangements and relevant policies and procedures on entry into the organisation as part of their Induction Training.

27. REFERENCES

- RPS Professional guidance on the safe and secure handling of medicines. Available from: Royal Pharmaceutical Society - safe and secure handling of medicines
- Health Act 2006. Available from: Health Act 2006

- Misuse of Drugs Act 1971. Available from: Misuse of Drugs Act 1971
- Records Management Code of Practice for Health and Social Care, Information Governance Alliance, 2016. Available from: Records Management Code of Practice - NHS Transformation Directorate
- HCPC Standards of Conduct, Performance and Ethics (2018): Standards of conduct, performance and ethics
- Professional Regulation Policy Paramedic Staff (2019) Professional Regulation Policy 100119.pdf
- Standards of Business Conduct Policy (2023) Standards of Business Conduct Policy Final v.3.0
- Disciplinary Policy and Procedure (2017) Disciplinary_Version_40_Mar 17.pdf
- WAST Controlled Drugs Policy (2021) WAST Management of CDs Policy (V5.5)
- WAST Employee Immunisation Policy (2015)
- WAST Vehicle Medicines Audit Tool - Medicines Audit Tool

28. APPENDICES

28.1 Appendix 1 – WAST Drug Case Contents Laminate

WAST DRUG CASE CONTENTS LAMINATE – WAS/MM01

N.B. this is a dynamic document, which will be updated to reflect changes in drugs used/carried. The most up-to-date version will be available on the WAST intranet site – Directorates-Clinical-Medicines Management

Note: All drugs must be stored in original packaging and within the packs listed below. Drugs must not be decanted into smaller units for storage in any other bags or containers.

PRIMARY RESPONSE BAG

Drug Name	Expiry date	Max No in Case	Min No in Case
Adrenaline 1:1,000	Please affix new expiry sticker here whenever drug is replenished	10 x 1mg	4 x 1mg
Aspirin 300mg	Please affix new expiry sticker here whenever drug is replenished	16 tablets	8 tablets
Glyceryl Trinitrate 400mcg S/L Spray	Please affix new expiry sticker here whenever drug is replenished	1 unit	1 unit
Ipratropium Bromide 250mcg/1ml	Please affix new expiry sticker here whenever drug is replenished	10 nebules	5 nebules
Naloxone 400mcg/1ml	Please affix new expiry sticker here whenever drug is replenished	10 x 400mcg	9 x 400mcg
Salbutamol 2.5mg/2.5ml	Please affix new expiry sticker here whenever drug is replenished	10 nebules	5 nebules
Salbutamol 5mg/2.5ml	Please affix new expiry sticker here whenever drug is replenished	10 nebules	5 nebules

CARDIAC ARREST POUCH

Drug Name	Expiry date	Max No in Case	Min No in Case
Adrenaline 1:10,000	Please affix new expiry sticker here whenever drug is replenished	8 x 1mg	4 x 1mg
Amiodarone 150mg/3ml OR 300mg/10ml	Please affix new expiry sticker here whenever drug is replenished	5 x 150mg OR 2 x 300mg	3 x 150mg OR 2 x 300mg

VEHICLE DRUG CASE

Drug Name	Expiry date	Max No in Case	Min No in Case
Atropine Sulphate 600mcg/1ml OR 1mg/10ml	Please affix new expiry sticker here whenever drug is replenished	10 x 600mcg OR 3 x 1mg	5 x 600mcg OR 3 x 1mg
Benzylpenicillin Pack	Please affix new expiry sticker here whenever drug is replenished	2 x 600mg 1 x Sterile Water 10ml	2 x 600mg 1 x Sterile Water 10ml
Chlorphenamine 4mg	Please affix new expiry sticker here whenever drug is replenished	28 tablets	8 tablets
Co-amoxiclav 1000mg/200mg injection	Please affix new expiry sticker here whenever drug is replenished	2 vials	1 vial
Dexamethasone 2mg Supplied as 3 tablet or 50 tablet pack	Please affix new expiry sticker here whenever drug is replenished	1 x pack	1 x pack
Diazepam solution 10mg/2ml	Please affix new expiry sticker here whenever drug is replenished	10 x 10mg	4 x 10mg
Diazepam Rectal 5mg	Please affix new expiry sticker here whenever drug is replenished	2 tubes	2 tubes
Diazepam Rectal 10mg	Please affix new expiry sticker here whenever drug is replenished	2 tubes	2 tubes
Furosemide 20mg/2ml OR Furosemide 50mg/5ml	Please affix new expiry sticker here whenever drug is replenished	10 x 50mg 10 x 20mg	5 x 50mg 5 x 20mg
Glucagon 1mg/1ml	Please affix new expiry sticker here whenever drug is replenished	2 x 1mg	1 x 1mg
Glucose 40% gel	Please affix new expiry sticker here whenever drug is replenished	3 x 25g tubes	3 x 25g tubes
Hydrocortisone sodium phosphate 100mg/1ml OR Hydrocortisone sodium succinate 100mg/1ml	Please affix new expiry sticker here whenever drug is replenished	5 x 100mg amps 2 x 100mg vials	4 x 100mg amps 2 x 100mg vials
Ibuprofen 200mg	Please affix new expiry sticker here whenever drug is replenished	24 x tablets	4 x tablets
Ipratropium Bromide 250mcg/1ml	Please affix new expiry sticker here whenever drug is replenished	10 x nebules	5 nebules
Magnesium Sulfate 20% solution 200mg/ml	Please affix new expiry sticker here whenever drug is replenished	10 amps	4 amps
Methoxyflurane Inhaler	Please affix new expiry sticker here whenever drug is replenished	2 Inhalers	1 Inhaler
Misoprostol 200mcg Supplied as 4 tablet or 56 tablet pack	Please affix new expiry sticker here whenever drug is replenished	1 x pack	1 x pack
Ondansetron 4mg/2ml	Please affix new expiry sticker here whenever drug is replenished	10 x 4mg	4 x 4mg
Paracetamol 500mg tablets	Please affix new expiry sticker here whenever drug is replenished	32 x 500mg	4 x 500mg

Paracetamol 120mg/5ml sachets	Please affix new expiry sticker here whenever drug is replenished	20 x 120mg/5ml	4 x 120mg/5ml
Paracetamol 1g/100ml Intravenous solution	Please affix new expiry sticker here whenever drug is replenished	**2 x 1g/100ml STORED IN IV DRAW**	**1 x 1g/100ml STORED IN IV DRAW**
Salbutamol 2.5mg/2.5ml	Please affix new expiry sticker here whenever drug is replenished	10 nebules	6 nebules
Salbutamol 5mg/2.5ml	Please affix new expiry sticker here whenever drug is replenished	10 nebules	6 nebules
Sodium Chloride 0.9%	Please affix new expiry sticker here whenever drug is replenished	10 x 10ml	5 x 10ml
Sterile Water for Injection 10ml	Please affix new expiry sticker here whenever drug is replenished	10 x 10ml	5 x 5ml
Tranexamic Acid 100mg/1ml	Please affix new expiry sticker here whenever drug is replenished	10 x 5ml	5 x 5ml

Note to paramedics and EMT's: Please ensure that the stock levels of the case are maintained at or above the minimum levels specified above. Each time a drug is replenished, peel off the old **ORANGE** expiry sticker on the relevant row and affix a new sticker, indicating the earliest expiry date of the replenished drug. Alternatively, a *Chinagraph* pencil or similar can be used.

'JUST IN CASE' DRUGS

Drug Name	Expiry date	Max No in Case	Min No in Case
Midazolam 10mg/2ml	Please affix new expiry sticker here whenever drug is replenished	10 amps	2 amps
Haloperidol 5mg/ml	Please affix new expiry sticker here whenever drug is replenished	10 amps	2 amps
Hyoscine Hydrobromide 400mcg/ml	Please affix new expiry sticker here whenever drug is replenished	10 amps	2 amps
Levomepromazine hydrochloride 25mg/ml	Please affix new expiry sticker here whenever drug is replenished	10 amps	2 amps

28.2 Appendix 2 – Omnicell Cabinet Manual Drugs Withdrawal Book

Welsh Ambulance Service NHS Trust

Omnicell Cabinet Manual Drugs Withdrawal Book

For the recording of all drug withdrawals from the Omnicell when manual emergency override procedures are required

Date	Name of POM	Number of Units Withdrawn	Destination (Vehicle Call Sign / Station)	Batch No.	Expiry Date	Withdrawn By	
						Signature	PIN

28.3 Appendix 3 – WAST Patient Group Direction Formulary

"Advanced Practice" PGDs (WAST Advanced Practitioners)

DRUG	PRESENTATION	CLINICAL SITUATION
Amoxicillin	500 mg capsules 250 mg capsules 250 mg/5ml suspension 125 mg/5ml suspension	Use in adults and children where anti-bacterial treatment is required for upper or lower respiratory tract infection.
Cetirizine	10 mg tablets 1 mg/ml solution	Treatment of seasonal allergic reactions
Co-amoxiclav	500/125 tablets	Infections caused by beta lactamase producing strains of bacteria, especially in human and animal bites, and cellulitis. Upper UTI
Codeine Phosphate	30mg tablets	Moderate pain
Clarithromycin	250 mg tablets 125 mg/5ml suspension	Use in adults and children over 1 year of age where anti-bacterial treatment is required for upper and lower respiratory tract infection and mild to moderate soft tissue infections, where Penicillin hypersensitivity is suspected or present.
Diazepam	2mg tablets	As an adjunctive treatment to Paracetamol, and/or non steroidal anti-inflammatory drugs (NSAID's) in the management of spasmodic, uncomplicated lower back pain (LBP).
Doxycycline	100 mg capsules	For the treatment of acute infective exacerbation of COPD, either as first line treatment or if allergic to penicillin based antimicrobials.
Flucloxacillin	500 mg capsules 250 mg capsules 250 mg/5ml suspension 125 mg/5ml suspension	Skin infections
Fluorescein	2% eye drops Fluorescein Sodium (Minims).	Detection of foreign bodies, corneal ulcers, abrasions and burns
Ibuprofen	200 mg coated tablet	In adults and children over 12 years to reduce pain and inflammation in a number of disorders.
Loperamide	2 mg capsules	Uncomplicated acute diarrhoea in adults and children over 12 years of age.
Nitrofurantoin	100 mg MR capsules or 50 mg capsules/tablets	For the treatment of acute lower urinary tract infection in adults over the age of 16 years.
Oral salts	6 gram sachet for reconstitution with 200 mL of water.	Oral fluid replacement in adults and children as a consequence of acute diarrhoea and/or vomiting.
Paracetamol	500 mg tablets 120 mg/5 ml suspension 250 mg/5 ml suspension	Mild to moderate pain and or for reduction of pyrexia in adults and children over 12 years.
Penicillin 'V'	250 mg tablets. 250 mg/5mL suspension 125 mg/5mL suspension	Use in adults and children in upper respiratory tract infection (URTI) where streptococcal tonsillitis/pharyngitis is suspected
Prednisolone	5 mg tablet	To reduce the inflammatory and allergic response in moderate and severe asthma attacks. It is given in combination with other initial treatment.
Prochlorperazine	3 mg buccal tablet	The symptomatic treatment of vertigo or severe nausea, vomiting and labyrinthine disorders in adults and children >12 years.

Sabutamol MDI	100 microgram metered dose inhaler (MDI)	The immediate treatment of acute asthma, COPD exacerbations, continuation of current asthma treatment
Tetracaine	Tetracaine (Amethocaine) Hydrochloride eye drops 0.5%.	Local anaesthesia for eye examinations, treatment, and foreign body removal.
Trimethoprim	100 mg tablet 50 mg/5 mL suspension.	Suspected lower urinary tract infection in adults and children

28.4 Appendix 4 – Additional Miscellaneous PGDs

'PARAMEDIC PGDs'

DRUG	PRESENTATION	CLINICAL SITUATION	STAFF GROUP
Co-amoxiclav injection	1000mg/200mg powder for solution for injection	Phrophylactic treatment of open fracture within 1-hour of injury	HCPC Registered WAST Paramedics
Diazepam injection	1mg/ml solution for injection	Management of convulsions, symptomatic cocaine toxicity	HCPC Registered WAST Paramedics
Tranexamic Acid	500 mg in 5 ml injection	Treatment of TIME CRITICAL traumatic haemorrhage	HCPC Registered WAST Paramedics

'SENIOR PARAMEDIC/CHARU PGDs'

DRUG	PRESENTATION	CLINICAL SITUATION	STAFF GROUP
Ketamine injection	Ketamine hydrochloride 10 mg/ml Supplied as 200 mg in 20 ml vial	Treatment of moderate to severe pain and to facilitate management and movement of patients.	Authorised HCPC Registered WAST Paramedics
Midazolam injection	Midazolam 1mg/ml, supplied as 5 ml ampoule (5 mg)	Management of agitation or emergence phenomenon related to ketamine administration.	Authorised HCPC Registered WAST Paramedics
Flumazenil injection	500 micrograms in 5 ml ampoules	For the complete or partial reversal of the central sedative effects of Midazolam, in order to restore spontaneous respiration	Authorised HCPC Registered WAST Paramedics

'OCCUPATIONAL HEALTH PGDs'

DRUG	PRESENTATION	CLINICAL SITUATION	STAFF GROUP
Inactivated Influenza Vaccine	0.5 ml suspension for intramuscular injection in a pre-filled syringe	Protection against seasonal influenza infection	Inactivated Influenza Vaccine (OH)
MMR Vaccine	Priorix: 0.5 ml MMRVaxPRO®: 0.5 ml	Adults (18 years of age and above), requiring immunisation against measles, mumps or rubella	Registered Healthcare Professionals
Hepatitis B Vaccine	Engerix B® (20 mcg/1ml) Fendrix®: (20 mcg/0.5ml)	Pre-exposure immunisation for Adult (18 years and above) individuals who are at increased risk of hepatitis B because of their occupation Immediate post-exposure immunisation to prevent infection, following significant exposure incidents	Registered Healthcare Professionals
Bacillus Calmette-Geurin (BCG) Vaccine (OH)	BCG vaccine AJV, Mycobacterium bovis BCG (Bacillus Calmette-Guérin),	Indicated for Welsh Ambulance Service NHS Trust and Public Health	Registered Healthcare Professionals

	to be diluted with one 1ml of diluted Sauton AJV.	Wales (PHW) staff at increased risk of exposure to tuberculosis (TB) infection and developing disease.	

28.5 Appendix 5 – Temperature Monitoring Form - Refrigerated Medicines

	1st	2nd	3rd	4th	5th	6th	7th	8th	9th	10th	11th	12th	13th	14th	15th	16th	17th	18th	19th	20th	21st	22nd	23rd	24th	25th	26th	27th	28th	29th	30th	31st
12˚																															
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3˚																															
2˚																															
1˚												**ACT QUICKLY!**																			
0˚																															
-1˚																															
-2˚																															
-3˚																															
Initials																															
T-stat setting																															

Observe the four Rs: **Read** **Record** **Reset** **React** MONTH:_____

Make sure the person making the recording:

- Does it the same day and time every week and signs the form
- ACTS if the temperature falls outside +2˚ to +8˚C
- Resets the thermometer after each reading.

Retain completed copies of this form for a period of two-years

28.6 Appendix 6 – WAST Medicines Summary Checklist Approved Clinicians

WAST Medicines Summary Checklist Approved Clinicians

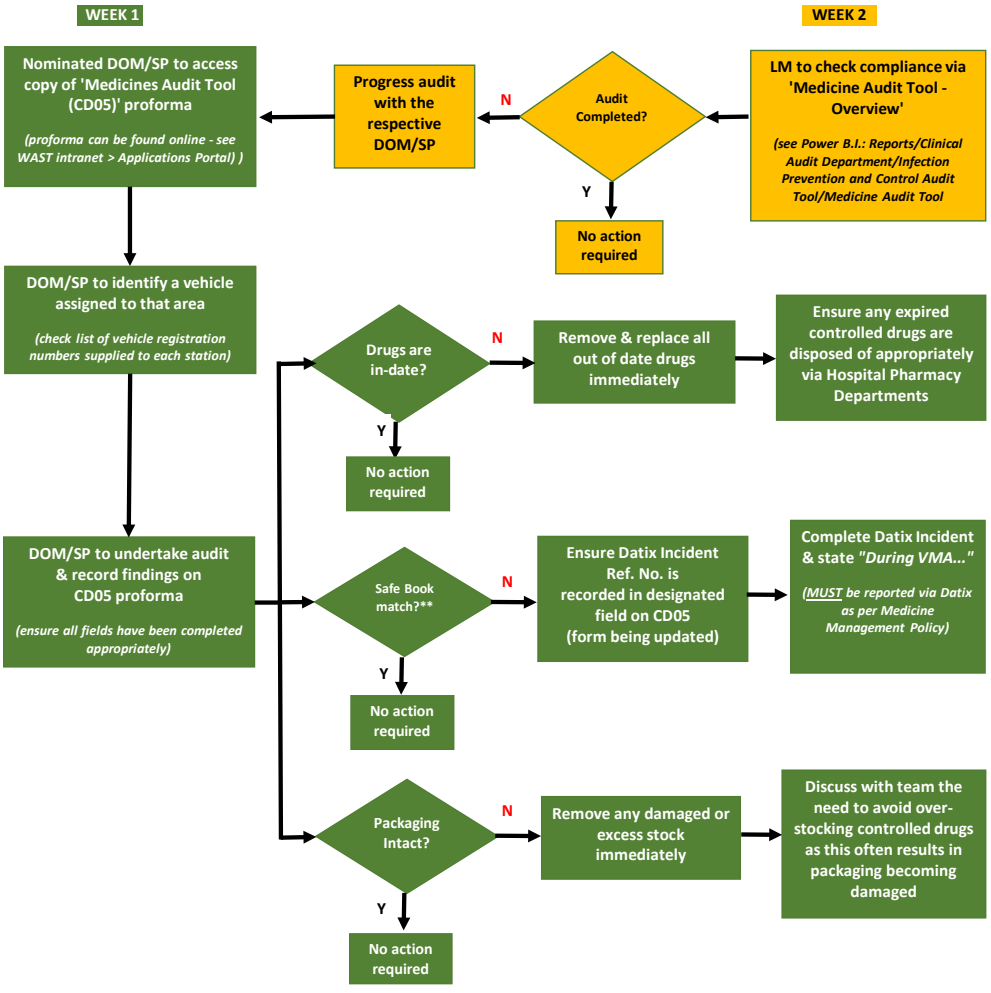
Medicine	UCS/CFRs	EMTs	Paramedics
Adrenaline 1:10,000			YES
Adrenaline 1:1,000		YES (for anaphylaxis only)	YES
Amiodarone 300mg/10ml OR 150mg/3ml			YES
Aspirin 300mg		YES	YES
Atropine Sulphate 600mcg/1ml OR 1mg/10ml			YES
Benzylpenicillin Pack			YES
Chlorphenamine 4mg			YES
Co-amoxiclav 1200mg			YES
Dexamethasone 2mg tablets		EMT3 only	YES
Diazepam 10mg/2ml			YES
Diazepam Rectal 5mg			YES
Diazepam Rectal 10mg			YES
Furosemide 50mg/5ml			YES
Glucagon 1mg/1ml		YES	YES
Glucose 10% infusion			YES
Glucose 40% gel		YES	YES
Glyceryl Trinitrate 400mcg S/L Spray		EMT3 only	YES
Heparin 5,000 units per ml			YES
Hydrocortisone 100mg/1ml		YES (all JRCALC indications)	YES
Ibuprofen 200mg tablets			YES
Ipratropium Bromide 250mcg/1ml		YES	YES

Medicine	UCS/CFRs	EMTs	Paramedics
Methoxyflurane Inhaler	YES	YES	YES
Misoprostol 200mcg tablets			YES
Morphine Sulfate			YES
Naloxone 400mcg/1ml		YES	YES
Nitrous Oxide (Entonox)		YES	YES
Ondansetron 4mg/2ml			YES
Oxygen	YES	YES	YES
Paracetamol 500mg tablets	YES	YES	YES
Paracetamol 120mg/5ml sachets		YES	YES
Paracetamol 1g/100ml IV solution			YES
Salbutamol 2.5mg/2.5ml		YES	YES
Salbutamol 5mg/2.5ml		YES	YES
Sodium Chloride 0.9%			YES
Tenecteplase 10,000 units or 8,000 units for reconstitution with WFI			YES
Tranexamic Acid 500mg in 5ml			YES

Appendix 7 – Vehicle Medicines Audit (VMA) LOCAL PROCESS

(MONTHLY) VEHICLE MEDICINE AUDIT - LOCAL PROCESS

Requirement: Audit of controlled drugs on x1 vehicle per locality area each month



*** Safe Book Details to be checked:**

- Vehicle Registration Number
- Locality
- No. of ampules in CD safe
- No. of ampules recorded in Safe Book (CD02)

NB: As outlined within the Medicine Management Policy, any drug discrepancy identified (whether via monthly audit or daily checks) MUST be reported as an incident via Datix

Escalation Timeframe:

Week 1 - Nominated DOM/SP to undertake audit or delegate within the team as appropriate

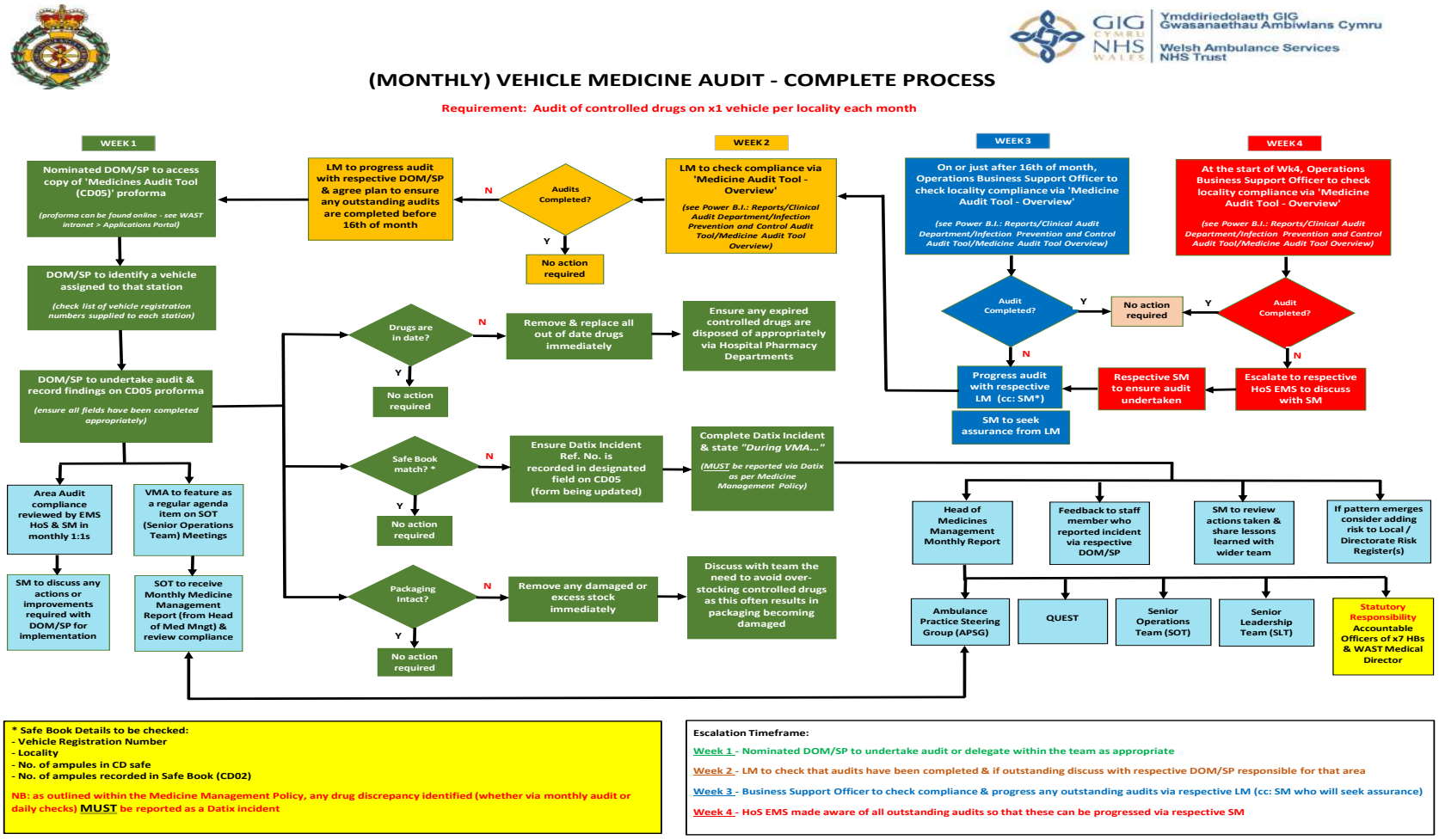
Week 2 - LM to check that audits have been completed & if outstanding discuss with respective DOM/SP responsible for that area

Week 3 - Business Support Officer to check compliance & progress any outstanding audits via respective LM (cc: SM who will seek assurance)

Week 4 - HoS EMS made aware of all outstanding audits so that these

Lisa Trounce (Business Manager) ~ VMA - Local Process V2.0 (Updated 07.09.2023)

Appendix 8 – Vehicle Medicines Audit (VMA) COMPLETE PROCESS



AGENDA ITEM No	**18.3**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**1**

Information Technology & Information Security Policy

MEETING	Quality, Patient Experience and Safety (Quest) Committee
DATE	31st October 2023
EXECUTIVE	Director of Digital Services
AUTHOR	Senior ICT Security Specialist
CONTACT	James Rowland, james.rowland@Wales.nhs.uk

EXECUTIVE SUMMARY

1. The report is being presented to QuEST to gain the formal approval for the review of the policy. The policy review deadline has lapsed by 18 months.

2. It was highlighted on the network and information systems regulation (NIS) assurance assessment completed by the Cyber Resilience Unit (CRU) on behalf of Welsh Government that the policy is to be reviewed and formally approved.

3. As an Operator of Essential Services (OES) the Trust is regulated by NIS and an up to date formally approved information security policy is a part of the regulation.

4. The policy went out for consultation between 09/07/23 to 04/08/23 and received 14 comments and 12 were incorporated 12 into the policy.

5. The policy was distributed to the ICT SMT and also the information governance steering group for peer review and feedback was incorporated into the policy.

6. The policy has been reviewed in conjunction with ISO 27001.

RECOMMENDATION: The Committee is asked to approve the Policy.

KEY ISSUES/IMPLICATIONS

NIS regulation requirement
Current policy is out of date
Identifies IT and information security standards within the Trust.

REPORT APPROVAL ROUTE
Policy Group - 23 October 2023 Executive Leadership Team – 25 October 2023

REPORT APPENDICES
N/A

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

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
NHS Trust

GIG CYMRU NHS WALES

IT & Information Security Policy

Policy Number:	056	**Version No:**	2.0	**Supersedes:**	1.5
Date of Approval:		**Review Date:**	3 years from date of approval	**Impact Assessments Completed:**	Yes
Classification of Document:	Corporate	**Type of Document:**	Policy	**Approved by:**	
Brief Summary of Document:	The purpose of this policy is to prevent unauthorised access to the Trust's information systems. The policy describes the rules and principles for information security for the Trust.				
Scope:	The Information Security Policy shall be adhered to by all Trust staff.				
To be read in conjunction with:	General Data Protection Regulation (GDPR) Access Control Policy Adverse Incident Investigation and Learning Policy Confidentiality Code of Conduct Data Protection Policy Freedom of Information Policy Information Governance Policy Records Management Policy. ISO 27001 (2013) Network and Information System Regulations (NIS) Cyber Essentials Guidelines NCSC Guidelines				
Owning Committee	Finance & Performance Committee				
Policy Lead: **Trade Union Lead:**	James Rowland Hugh Parry	**Job Title:**	Senior ICT Security Specialist Trade Union Partner		
Executive Director:	Leanne Smith	**Job Title:**	Interim Director of Digital Services		

Version Control Sheet

Version	Date	Author	Summary of Changes
0.1	10/04/18	Clare Elcock	Creation of Document
0.2	13/06/18	Craig Garner	Task and Finish group
0.3	03/07/18	Clare Elcock	Transferred to new policy template
0.4	09/08/18	James Rowland	Large re-write of Policy
0.5	17/09/18	James Rowland	Amendments
0.6	02/10/18	James Rowland	Task and Finish group amendments
0.7	10/10/18	James Rowland	Amendments following Bleddyn Roberts Comments
0.8	11/10/18	Julie Boalch	Changed front cover to reflect current template
0.9	23/10/18	James Rowland	Minor amendments following Policy Group
0.9.1	27/11/18	James Rowland	Comments from Policy Consultation
1.1	19/08/22	James Rowland	Review
1.2	08/03/23	James Rowland	Comments from ITSMT, Judith Birkett and Kelly Holding
1.3	01/06/23	Julie Boalch	Inclusion of Hugh Parry as TU Partner
1.4	15/08/23	James Rowland	Comments raised at policy group meeting and consultation period
1.5	18/08/23	Julie Boalch	Accepted tracked changes and finalise
2.0	23/10/23	Julie Boalch	Final Policy
Keywords	Information Security, Data Protection, Information Assets		

Impact Assessment Reviews

Area	**Date of Review**	**Name of Reviewer**
Training		
Counter Fraud	06/03/23	Carl Window
Information Governance	17/05/23	Kelly Holding
Records Management	06/03/23	Judith Birkett
EqIA / Welsh Language	07/06/23	James Rowlands
Trade Union Representative	17/05/23	Hugh Parry
ESMCP	28/11/18	Keith Williams

Task and Finish Group Members

Name	**Job Title**

Policy Approval Route

Where	When	Why
Meeting Title	Meeting Date	Purpose/Outcome

Disclaimer
If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Head of Risk/Deputy Board Secretary

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1. INTRODUCTION

1.1 The Welsh Ambulance Services NHS Trust (the Trust) recognises the importance of information, both in terms of healthcare management of individual patients and the efficient management of services and resources. This is because information is a vital asset that underpins the delivery of high-quality healthcare and many other key service deliverables.

1.2 The Trust also recognises the importance that all of its systems are protected to an adequate level from vulnerabilities. Such risks include accidental data change or release, malicious damage (internal or external), fraud, theft, failure and natural disaster.

1.3 It is important that a consistent approach is adopted to safeguard the Trust's information in the same way the other more tangible assets are secured, with due regard to the highly sensitive nature of some information held on both electronic and manual systems.

1.4 The Trust therefore has a responsibility to ensure that information is managed appropriately and in accordance with legal requirements, Health and Social Care (Quality and Engagement) Act, the Caldicott Principles into the Welsh Information Governance Toolkit and guidance provided by the Information Commissioner's Office (ICO), Cyber Essentials and ISO 27001 compliance.

1.5 In April 2021 the Network and Information Systems (NIS) Regulations has been made law in Wales with the Welsh Assembly Government (WAG) as the Competent Authority (CA). NIS aims to improve cyber and physical resilience of networks and systems that are critical to the provision of essential services. As the Trust provides essential services to the people of Wales we are bound by the law.

1.6 Information Governance (IG) is a framework for handling information confidentially, efficiently and securely, to appropriate legal, ethical and quality standards with the objective of delivering the best possible care and service.

1.7 The Trust regards all Person Identifiable Information (PII) and sensitive information as defined in this policy as confidential information.

2. POLICY STATEMENT

2.1 As well as a common law duty of care, the Trust has a legal obligation to maintain security and confidentiality for the data it holds, including but not limited to:

- Data Protection Act 2018;
- UK General Data Protection Regulations

- Freedom of Information Act 2000 (FOI);
- Network and Information Systems 2018
- Environmental Information Regulations 2004;
- Records Management Code of Practice for Health and Care 2022;
- Computer Misuse Act 1990;
- Common Law Duty of Confidentiality;
- Copyright, Designs and Patents 1988;
- Information Security Management ISO 27001.
- Control of Patient Information Regulations 2002
- Human Rights Act 1998

2.2 There are also regulatory requirements with which all NHS organisations must comply, including those set out in the Code of Connection and Health Standards to name a couple. It is the duty of the Trust and its staff members to meet these legislative and regulatory requirements in relation to Information Security.

2.3 This policy sets out the procedures to be followed by all Trust staff to ensure that the Trust's ICT assets (hardware, paper software and data) are protected and that the Trust's right to use the 'NHS network' is not compromised. It is aimed at ensuring:

Confidentiality	Data access is confined to those with specified authority to view the data.
Integrity	All systems are working as they were intended to work and all data protected from unauthorised change.
Availability	Data is available to the right person, when needed.

2.4 The need for an Information Security Policy

- Data stored in information systems represent an extremely valuable asset. The increasing reliance of the NHS on ICT for the delivery of health care makes it necessary to ensure these systems are developed, operated, used and maintained in a safe and secure fashion.

- The increasing need to transmit information across networks of computers renders data more vulnerable to accidental or deliberate unauthorised modification or disclosure. The use of computers to exchange data electronically offers advantages to service users if handled securely, but, could present serious hazards if security is inadequate.

3. SCOPE

3.1 The Information Security policy applies to all staff including students, temporary workers and partners, third party contractors and anyone undertaking work on behalf of The Trust.

3.2 The Trust has made a firm commitment to monitor and protect its confidential information. This may be personally identifiable information relating to patients or staff members or it may be documents of a commercially confidential or sensitive nature. It has, therefore, become a fundamental principle of the Trust to have effective and consistent Information Management Practices in place.

4. AIM

4.1 This policy is required to provide assurance to the organisation, its staff, partners and the public that information is handled appropriately and in accordance with statutory and legislative requirements.

4.2 This policy should also provide all administrators of the information systems with guidance on the principles to inform decisions and achieve positive outcomes for service users and the organisation.

5. OBJECTIVES

5.1 All individuals as referenced within the scope of this policy are aware of their obligations.

5.2 This policy must be read in conjunction with relevant organisational policies and procedures.

5.3 Information must only be shared where there is a defined purpose and appropriate legal basis for doing so.

5.4 Any information sharing which involves personal data or business sensitive information must be transferred securely

6. TERMINOLOGY

Term	Meaning/Application
SHALL	*This term is used to state a **Mandatory** requirement of this policy*
SHOULD	*This term is used to state a **Recommended** requirement of this policy*

MAY	*This term is used to state an **Optional** requirement*

7. INFORMATION SECURITY POLICY

7.1. Access Control

7.1.1 Please refer to the Trust's Access Control Policy

7.2. Backups

7.2.1 In order to ensure the confidentiality, integrity and availability of information, users **shall** ensure their information is saved in the appropriate location and subject to regular backup.

7.2.2 Where a user has network access, all information **shall** be saved to department network drive, which is automatically backed up by ICT.

7.2.3 It is strictly prohibited to save PII or and corporately sensitive data in your NHS Wales OneDrive, unless its data about yourself for example timesheets.

7.2.4 The local drive (your devices own hard drive) is not recommended for storing content as it is not backed up. If data is saved locally to the machine, then ICT **shall** not be held responsible if the data becomes corrupt or needs recovering in anyway.

7.2.5 Backups **shall** be conducted in accordance with the Trust's Backup Procedure(s).

7.3. Business Continuity

7.3.1 To ensure the continued confidentiality, integrity and availability of Trust assets, in the event of a major disruption to systems the Business Continuity Plan (BCP) may be invoked.

7.3.2 The ICT Business Continuity Plan (BCP) is owned and run by the ICT Disaster Management Team. An ICT Outage plan was created which will allow all directorates to use for their business continuity plans.

7.4. Clear Desk & Screen

7.4.1 We expect that all sensitive/confidential information is secure in your work area, this includes at the end of the day or when you are away for any period. The following rules are not exhaustive; as a result, all Trust employees shall exercise good care and

judgement. With the emphasis on working from home these rules also apply in your home and any place you are completing Trust work.

7.4.2 Computers

You **shall**

- Lock your device (Laptop, Desktop, Tablet, Mobile) when it is unoccupied.
  - Remember, when you leave your seat, control + alt + delete (and enter) or Windows Key + L. The latter is easier.
- Set your screen to time out after no longer than 15 minutes of inactivity.
- Shut your computer down completely at the end of the work day.
- Never write down usernames or passwords, also do not store them insecurely (Such as in word documents, excel spreadsheets, notepads, cello taped to laptop etc).
- Lock away portable computing devices such as laptops and tablets at the end of the day where possible.

7.4.3 Paperwork

You **shall**

- Dispose of paperwork in line with the disposal section of this policy.
- Lock away any paperwork when your desk is unoccupied or at the end of the day, especially if this contains sensitive information.

7.4.4 Printers

You **shall**

- Only print when absolutely necessary.
- Collect printouts from the printer as soon as possible, especially where it contains restricted or sensitive information.
- Consider conducting a test print to ensure you are using the correct printer when printing out restricted or sensitive information.
- Ensure that no documents are left on the printer overnight
- When printing restricted or sensitive information you should use a security passcode where possible.

7.4.5 Removable Media

You **shall**

- Treat mass storage devices such as CD's, USB Drives, External Hard Drives as sensitive and secure them in a locked drawer/cabinet.
- Remember, if left out, it's entirely possible for someone to make a copy of the data contained on removable media, or, introduce something to that removable media device (Such as malware and viruses).

7.4.6 Your Work Area

You **shall**

- Check around your area to make sure windows and doors are not left open and unlocked when leaving the office.
- Ensure whiteboards or any board containing Confidential or Sensitive information is erased when you're finished.
- Keep filing cabinets / storage cupboards containing Confidential or Sensitive information closed and locked when not in use or when not attended
- Not leave keys around the office if they are used to access Confidential or Sensitive information.
- Protect information deemed Confidential or Sensitive, be aware of your surroundings and mindful that other employees or external parties may be able to view the content. If you do not wish others to see, please move to a quiet location or ask for a screen privacy guard.
- Ensure that blinds and/or curtains are drawn at the end of the day.

7.5. ICT Asset Management and Disposal

7.5.1 ICT department will maintain an accurate record of all physical ICT assets owned by the Trust.

7.5.2 All ICT assets will be recorded on the Trusts asset register CMDB. In order for this to be successful all Trust employees **shall** adhere to the following

7.5.3 Trust employees **shall** not remove ICT assets from Trust premise without prior consent from the ICT department.

7.5.4 Users shall not transfer assets to another user without notifying the Service desk so our asset register can be updated

7.5.5 You **shall** ensure that all sensitive/confidential information is kept secure in your work area, this includes at the end of the day or when you are away for any period of time. The following rules are not exhaustive, as a result all Trust employees shall exercise good care and judgement.

7.5.6 Disposal of ICT assets **shall** be completed in accordance with the 'Waste Electrical and Electronic Equipment' (WEEE) Directive at all times.

7.5.7 For Further guidance see WEEE EPGN 005 (Estates Procedure guidance Note) on the Estates Portal.

7.5.8 Disposal of assets **shall** be conducted in line with internal ICT procedures and any storage of data will be destroyed in a secure manner.

7.5.9 To ensure that Trust assets are handled and disposed of in a consistent and secure manner, the following **shall** be adhered to;

Paper

- Where paper contains sensitive or confidential information, it must be shredded, if you are in any doubt, please shred regardless.

Laptops / Desktops / Mobile Phones / Tablets

- Devices must be stored in a secure location (Such as a locked office, cupboard etc) until they are collected by either ICT or Estates.

Removable Media (Such as USB Sticks, Hard Drives, CD's)

- Devices should be brought to regional ICT department for disposal.

Monitors and other ICT Equipment (including applications)

- Devices must be stored in a secure location (Such as a locked office, cupboard etc) until they are collected by either ICT or Estates
- Please ensure on all pool cars and Trust lease cars that data from the Satellite Navigation System is wiped when returned at the end of the lease period
- Please ensure any metadata is removed from files before being deleted

7.5.10 To arrange the disposal of the following assets, please contact The Trust's Service Desk.

- Laptops
- Desktops
- Mobile Phones
- Desk Phones
- Tablets
- Monitors
- Other ICT Equipment (Such as Keyboards, Mice, Printers & Scanners)

7.6. Encryption

7.6.1 Any device that can hold data is vulnerable to unauthorised access, to help protect our data devices may require encryption, further information can be found below.

7.6.2 The following encryption will be used on Trust assets.

Device Type	Operating System	Encryption
Laptops	Windows 10	BitLocker – XTS-AES-256
	Windows 11	BitLocker – XTS-AES-256

Desktops	Windows 10	XTS-AES-256.
Mobile Phones	Android	AES-256
	iOS	Data Protection
Tablets	Android	AES-256
iPad	iOS	Data Protection
Removable Media	For use with Windows 10	BitLocker to go – XTS-AES-256

7.7. Equipment

7.7.1 Users requiring equipment to carry out authorised tasks shall apply for equipment and funding through department heads. Purchase of this equipment will then be carried out centrally by ICT. This ensures that equipment purchased is compatible with existing systems and asset management.

7.8. Incidents and Reporting

7.8.1 All breaches of information security, actual or suspected, shall be recorded and reported to Information Security via the standard procedures for risk and incident reporting.

7.8.2 Please see the Incident Response Procedure for further information.

7.8.3 With NIS regulations now in place there are extra processes involved when dealing with a cyber incident. This is detailed in the Trust's cyber incident procedure.

7.9. Information Exchange

7.9.1 It is imperative that the utmost care is exercised when transferring information, especially information of a confidential nature (e.g. staff, patient or service user information). This includes transferring information by telephone (voice and text), email, fax, courier and public mail. If due care and attention isn't taken whilst exchanging information then severe financial penalties maybe incurred and also reputational damage against the Trust.

7.10. Internet and Email

7.10.1 Usage of Internet and Email are subject to both The Trust's and NHS acceptable use.

7.10.2 Internet usage refer to the NHS Wales Internet Use Policy

Commented [JR(ASNT0S1]: Need to get new url

7.10.3 Email usage refer to NHS Wales Email Use Policy

Commented [JR(ASNT0S2]: Need to get new url

7.11. Monitoring

7.11.1 Users accessing Trust systems will be subject to monitoring that includes;

- Failed attempts to access systems;
- Access patterns (log on log off);
- Allocation and activity of privileged accounts;
- Tracking of selected transactions;
- Use of sensitive resources;
- Inappropriate use of authorised software and IT equipment;
- Any use of un-authorised software and IT equipment.

7.11.2 An audit trail of system access and data use (where possible) by staff shall be maintained. This will be reviewed by information asset owners or their appointed information asset administrators and the Trust's ICT Security team in relation to any suspected security events, incidents or investigations. For national systems used across NHS Wales, the National Intelligent Integrated Audit Solution (NIIAS) audits system access to patient records for inappropriate use. More information about NIIAS can be found here.

7.11.3 In order to ensure compliance of policy and continued protection of our information, The Trust reserves the right to monitor activity and any systems where it suspects that there has been a breach of policy.

7.11.4 The Regulation of Investigatory Powers Act (2000) permits monitoring and recording of employees' electronic communications (including telephone communications) for the following reasons:

- Prevention or detection of crime.
- In the interests of national security.

7.11.5 Any monitoring will be undertaken in accordance with the Regulation of Investigatory Powers Act (2000) and the Human Rights Act. The Information Governance Team will compile monitoring reports and any unusual use of or suspected misuse of resources will be fully investigated. As part of the monitoring process, the Trust business critical systems will also be subject to regular audit by Information Security, who will provide reports on the state of the systems security to appropriate managers.

7.12. Passwords

7.12.1 All staff **shall** follow good security practices in the creation and use of passwords. The Trust recommends following the NCSC guidance of 3 random words NCSC lifts lid on three random words password logic - NCSC.GOV.UK

7.12.2 All Trust passwords **shall** be created using the following guidelines;

- Contain at least 11 characters.
- Contain at least 3 random words

7.12.3 Where a user account has a higher level of permissions or privileges (Administrative account) then the following password guidelines **shall** be followed;

- Contain at least 14 characters.
- Contain at least 3 random words

7.12.4 Summary of new password standards across NHS Wales domain are detailed below

- Passwords must be at least 11 characters long
- Your account will lock out after 10 incorrect (consecutive) password attempt.
- New passwords cannot be any of the last 24 previously used passwords.
- Passwords cannot be changed more than once a day.
- Weak passwords and passwords that have previously been compromised will be blocked.
- Passwords must only be known by the user associated with that password.
- You should not use the same password at home and at work

7.12.5 Where systems do not or cannot enforce the above password complexity, the guidelines contained here **shall** be adhered to.

7.12.6 Ensure you have setup Multi Factor Authentication up. Directions for this can be found here

7.12.7 Ensure you have setup the self-service password reset (SSPR). Instructions on setting this up can be found here

7.12.8 All users **shall** ensure they protect their user credentials and not share them with any other person. Users **shall** not make use of other users credentials.

7.12.9 When creating a password, you **shall** follow the guidelines below;

- Refrain from using common 'dictionary' words as these can easily be cracked.
- Not use names of family members, pets, friends or other personal information that you are likely to discuss with others.
- Not use phrases or words linked to The Trust (for example, ambulance, NHS, trust, healthcare).
- Not use number / letter patterns (for example, aaabbb, qwerty, 123456).
- Not be the same as your username or a variation of.
- Never use the word 'password' or any variation of it (for example, Pa$$w0rd).

- Never write the password down or store it in word documents or spreadsheets etc.

7.12.10 You **shall** change your password as soon as possible if you suspect it has been compromised, you must also report this to the Trusts service desk

7.13. Remote/Home Working

7.13.1 The physical security controls that are available within The Trust's offices may not be available within an employee's home or alternate working location. Therefore, the following measures shall be implemented to safeguard Trust and patient data and information assets.

7.13.2 When working away from the office (For example, at home, or in other office locations) you **shall** ensure the following are adhered to;

Equipment

- Trust equipment is to be used by Trust employees only.
- Equipment must be turned off when not in use or 'screen locked' when away from your machine (When you leave your seat, CTRL, ALT, DELETE and enter).
- Where possible, lock away your devices when they are not being used.
- If you have been permitted use of removable media devices, this should not be left in or connected to your computer and secured when not in use.

Documentation / Storing Files

- Trust records and paper documentation should only be taken from a Trust site where there is an agreement in place with Information Governance and/or line manager.
- Lock away paper documentation if it contains personal or sensitive data and corporate information.
- If you no longer require paper documentation, use a shredder to dispose of it. If one is not available, transport it safely into Trust offices and use the facilities provided.
- Where possible, reduce the use of paper-based information and access documentation via your Trust provided device (Such as a computer, laptop etc).

Polices

- Trust policies shall apply whilst working away from Trust premise.

7.13.3 When working in a public location (for example, a café) you **shall** ensure the following are adhered to;

Equipment

- Never leave Trust equipment unattended.
- Do not leave Trust equipment in plain sight when in vehicles.
- If you have been permitted use of removable media devices, this should not be left in or connected to your computer.

Check your surroundings

- Be mindful when working in public places of shoulder surfers, make sure others cannot see your work and do not work on sensitive material in these conditions.
- Be cautious when connecting to public Wi-Fi connections.

Documentation / Storing Files

- Where possible, avoid carrying paperwork and access documentation via your computer. If you need to carry documentation, take extra care to ensure it is protected and not easily lost/taken.

7.14. Removable Media

7.14.1 The use of personally owned removable storage devices such as memory sticks and external hard drives is strictly prohibited.

7.14.2 Removable Media orders need to be placed using the usual procurement method for ICT equipment.

7.14.3 The use of Removable Media should provide suitable protection for the Trust's data, options that are capable of providing encryption should be used (such as Hard Drives, USB Sticks etc). Where you are unable to use a device that provides encryption (such as a CD), you will need to seek approval from Information Security via amb_informationsecurity@wales.nhs.uk

7.14.4 To request access to use Removable Media, you will need to complete the Removable Media Request Form and submit this to the ICT Service Desk. Access will not be granted without completing this form. Temporary use of a device maybe given in certain circumstances but this will be decided by the Cyber Security Team.

7.15. Secure System Development and Deployment

The Trust **shall** ensure that security requirements are built into systems from the outset where possible. Suitable controls must be in place to manage the purchase or

development of new systems and the enhancement of existing systems, to ensure that information security is not compromised.

Security requirements of systems

7.15.1 Any individual responsible for implementing or modifying systems is responsible, in collaboration with IT for ensuring:

- That statements of business requirements for new systems, or enhancements to existing systems specify the security controls required for that system.
- That a Data Protection Impact Assessment (DPIA) is completed where applicable.
- Security assessment for new software or systems is completed
- A cloud security assessment is completed
- That all modifications to systems are logged and up to date documentation exists for their systems.
- That vendor supplied software used in systems, is maintained at a level supported by the supplier, if beneficial to the service. Any decision to upgrade must take into account the security of the release.
- That physical or logical access is only provided to suppliers for support purposes when necessary and must be with management and IT approval.
- That all supplier activity on the system is monitored.
- That copies of data must retain the same levels of security and access controls as the original data

7.15.2 A DPIA **shall** be completed, in liaison with the Information Governance Team to ensure all Information Governance & Security aspects of new and modified systems are considered.

7.15.3 It is mandatory that the purchase and renewal of any new contract for IT systems (on-premise or cloud based) is subject to a security assessment. The Welsh Health Circular Cyber Security and Information Governance WHC/2017/025 will be used to assess the relevant security maturity of the possible third party. Also for cloud systems a cloud security assessment will be completed which will use the NCSC cloud security principles https://www.ncsc.gov.uk/collection/cloud-security/implementing-the-cloud-security-principles . This will be done before any contact/orders are made for the system.

7.15.4 The Trust **shall** ensure demands on system capacity are monitored and projections of future capacity requirements are made to ensure that it has adequate processing and storage facilities available. The utilisation of key system resources, such as file servers, e-mail servers and business critical systems will be monitored so that additional capacity can be brought on-line when required or remedial actions put in place.

7.16. Unacceptable Use

7.16.1 In order to establish good Information Security Practises, usage of The Trust's assets) need to be controlled.

7.16.2 If you're in any doubt about what you should do, please contact the Information Security team for further information on amb_informationsecurity@wales.nhs.uk

7.16.3 The items identified here are not exhaustive and you are expected to exercise care and good judgement when using The Trust's assets.

7.16.4 This policy is subject to review and change as necessary, employees are reminded of their responsibility to check this document regularly.

Area	You Shall Not
Access	• Attempt to access The Trust's systems, services, applications, networks or servers that you are not authorised to. ○ Being granted access rights does not automatically mean you have authority to use them, this could have occurred accidentally or be performed by an unauthorised person. • Access The Trust's systems, services, applications, networks or servers for any reason other than to complete tasks assigned to you during your job role. • Connect to any Trust systems, services, applications, networks or servers out of hours unless you have been given permission to do so.
Account Management	• Allow any other person to use your username / password / remote access codes on any IT system. • Use shared user names / credentials (Where circumstances are identified that require the use of this, you will need to seek authorisation from the Information Security team). • Exhibit poor password practises (You should consult the Password section of this document for guidance on creating passwords).
Data Loss Prevention	• Transfer data out of The Trust unless you have been given authority to do so by the asset owner.

Area	You Shall Not
	• Attempt to store Trust data in cloud storage solutions such as Dropbox, Google Drive etc unless its been specifically approved within the Trust • Use unencrypted removable media to store or transfer Trust data. • Perform changes to Trust IT systems or information without prior authorisation from the asset owner. • Allow persons not employed by The Trust to view information or use any devices provided by The Trust without authorisation.
Devices	• Leave any device to which you are logged into unlocked when unattended. **For Example;** o Desktop / Laptop machines should have their screens locked and require a username / password to re-enter. o Mobile / Tablet devices should not be left on the home screen and should have their screens locked and require a username / password / pin to re-enter. • Connect unauthorised devices or devices not owned by the Trust to networks provided by the Trust unless prior authorisation has been provided from Information Security. • Modify Trust provided equipment, such modifications that are required to ensure the efficiency of the PC **shall** be provided and installed by IT staff (within budgetary constraints). • Authorise any maintenance to be carried out on Trust Assets by any other agency (The IT Department maintains IT hardware and software)
Internet & Email	• Visit any websites deemed to be illegal, offensive or sexually explicit. • Use internet services for any P2P (Peer to peer) downloads such as Bit Torrent. • Download any pirated software or data.

Area	You Shall Not
Malware	• Knowingly attempt to introduce any form of malware or virus to any Trust system, application, server, service or network. • Disable, tamper with or alter settings with Trust installed Anti-Malware software (Such as Sophos).
Security	• Ignore security flaws, faults, weaknesses or incidents you come across (This can include building, ICT or processes etc). o These **shall** be reported as soon as possible to the ICT Service Desk so they can be raised with the Information Security Team. o This **shall** also be raised on Datix too.
Software	• Install applications or software on any Trust device without first completing the Software Request form. • Install or use pirates, illegal or tampered with software / applications.

7.17. Contacting Information Security

7.17.1 Information Security are situated in Vantage Point, Cwmbran.

7.17.2 You can contact them via amb_informationsecurity@wales.nhs.uk

7.18. Can't Comply? Tell Us Why

7.18.1 It is important that all employees adhere to this and any other Information Security related policy. We understand there may be times you are unable to for genuine reasons, where this occurs you **shall** report this to Information Security on amb_informationsecurity@wales.nhs.uk using the 'Exception Form' that can be found on the Trust Intranet.

7.18.2 If staff fail to adhere to this policy then an investigation may take place which may lead to disciplinary action being taken

8. EQUALITY

8.1 The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on the grounds of any protected characteristic (Equality Act 2010).

9. TRAINING AND IMPLEMENTATION

9.1 Mandatory Information Governance training is provided to all staff on induction and as part of the Trust's ongoing training programme. Specific training should be arranged through the Information Asset Owners/Administrators where it is a pre-requisite before access is granted to the Information Asset.

9.2 Cyber security awareness training is provided on ESR and has been added to the mandatory information governance training.

9.3 Supplementary cyber awareness training will be given on a monthly basis from meta-learn which we encourage all staff to complete

10. AUDIT AND MONITORING

10.1 Systems will be audited and monitored in line with this policy and associated protocol.

10.2 Auditing and monitoring will only be carried out in agreement with the designated Information Asset Owner.

10.3 Policy compliance monitoring will be undertaken using the MetaPolicy system which will show policy compliance.

10.4 Counter Fraud, Bribery and Corruption Concerns

The Trust is committed to taking all necessary steps to counter fraud, bribery and corruption within the Trust. In conjunction with this policy, staff should report any suspected incidents of fraud and corruption to the Trust Local Counter Fraud Specialist, who will be happy to discuss any issues or concerns.

Alternatively staff may contact the confidential NHS Fraud and Corruption Reporting line 0800 028 40 60; or on-line reporting facility https://cfa.nhs.uk/reportfraud. Fraud investigations may lead to prosecution and civil recovery procedures, alongside internal disciplinary action.

11. RESPONSIBILITIES

11.1. Trust Board

The Trust Board is collectively responsible for ensuring that the information risk management processes are providing them with adequate and appropriate information and assurances relating to risks against the Trust's objectives. The Trust as a corporate body is the data controller.

11.2. QUEST

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.

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.

Receive assurance on, and review effectiveness of the Trust's information security protocols.

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.

11.3. Chief Executive

The Chief Executive is ultimately responsible for the confidentiality and security of patient, staff and corporate information. Implementation of, and compliance with the policy is delegated to the Caldicott Guardian for patient and staff information.

11.4. Director of Digital Services

The Director of Digital Services is the executive lead of this Policy and has overall responsibility for the development and regular review of policies within their areas of responsibility.

The Director of Digital Services is the Trust's Senior Information Risk Officer (SIRO) and has a responsibility to:

- Oversee the development of an Information Security Policy and its implementation;
- Take ownership of the risk assessment process for information risk;
- Review and agree action in respect of identified information risks alongside IAOs;
- Ensure that the Trust's approach to information risk is effective in terms of resource commitment and execution and that this is communicated to all staff;
- Provide a focal point for the resolution and/or discussion of information risk issues;

- Ensure the Board is adequately briefed on information risk issues;
- Successfully complete strategic information risk management training at least annually.

11.5. Executive Director of Quality & Nursing (Caldicott Guardian)

The Executive Director of Quality & Nursing is the Trust's Caldicott Guardian and has responsibility to:

- Promote clinical governance;
- Actively supporting work to enable information sharing where appropriate to share;
- Advising on options for lawful and ethical processing of information;
- Representing and championing confidentiality and information sharing requirements as well as issues at senior management level.

11.6. Information Governance Steering Group (IGSG)

IGSG has a responsibility to:

- Develop and maintain the IG agenda across the Trust;
- Monitor progress against the IG work plans and initiatives;
- Ensure policies and procedures are developed, implemented and reviewed appropriately;
- Review standards and guidance relevant to IG;
- Promote awareness of IG issues;
- Ensure IG risks and incidents are identified, logged, actioned and monitored routinely.

11.7. Board Secretary

The Board Secretary has a responsibility to:

- Ensure organisational procedures and processes are in place to comply with the FOI Act 2000;
- Report the Trust's compliance with the Freedom of Information Act and for reporting Freedom of Information issues to the Board (or equivalent);
- Work closely with the Board/Executive Team in the planning of Board and Committee meetings in which information governance arrangements are often discussed.

11.8. Data Protection Officer

The Head of Health Informatics is the Trust's Data Protection Officer and has responsibility to;

- Provide information and guidance to the Executive Team and SIRO on the processing of all personal data and any risks associated;

- Oversee the work plan relating to the IAO and Information Asset Register;
- Ensure there is a process to co-ordinate and report on any issues in relation to this policy to IGSG

11.9. ICT Security Specialist (Information Security)

The Information Security Specialist has responsibility to:

- Implement the IS agenda whilst coordinating the IS work programme;
- Develop and maintain IS policies and procedures to provide staff with direction and guidance on how to comply with IS requirements;
- Raise awareness and promote IS throughout the Trust.
- Work closely with the Data Protection Officer, Head of ICT, Senior Information Risk Owner (SIRO), Caldicott Guardian and IAOs to ensure information risks are managed effectively within the organisation.

11.10. Information Governance Manager

The Information Governance Manager has responsibility to:

- Implement the IG agenda whilst coordinating the IG work programme;
- Develop and maintain IG policies and procedures to provide staff with direction and guidance on how to comply with IG requirements;
- Raise awareness and promote IG throughout the Trust;
- Work closely with the Data Protection Officer, Records Services and Archives Manager, Senior Information Risk Owner (SIRO), Caldicott Guardian and Information Asset Owners (IAOs) to ensure information risk is managed effectively within the organisation.

11.11. Records Services and Archives Manager

The Records Services and Archives Manager has responsibility to;

- Establish a proactive and integrated approach to Records Management through creating, developing and maintaining robust and effective strategies, policies, systems and processes that ensure the function is embedded across the Trust;
- Provide specialist knowledge, advice and training around Records Management, including information rights, confidentiality and information security;
- Provide senior management support in the delivery of an effective Records Management Service across the whole Trust;
- Act as the Trust Lead with senior responsibility for raising awareness of Records Management and the associated training and awareness raising across the Trust. This will involve the development and deliverance of relevant training programmes

11.12. **Information Asset Owners (IAOs)**

IAOs have a responsibility to;

- Lead and foster an information security culture which values, protects and uses information for the success of the organisation and benefit of its patients;
- Know what information compromises or is associated with the asset, what enters and leaves it and why;
- Know and authorise who has access to the asset, whether system or information, why they need the access, and ensuring access is monitored;
- Understand and address risk to the asset, whether system or information, and why;
- Ensure the asset is used for the public good, including requests for access from others;
- Notify the IG Team of any changes to existing assets and ensuring that new information assets are added to the IAR and any redundant assets removed.

11.13. **Department Heads / Locality Manager**

Department Heads / Locality Manager have a responsibility to;

- Ensure all current, new and temporary staff are instructed of their IG responsibilities and made aware of this policy in addition to other IG related policies and procedures;
- Ensure staff receive IG training that is appropriate for their role;
- Ensure that Workforce and Operational Development are notified of new, moving and leaving employees to allow access rights to be appropriately established from the effective dates and leaving employees access to be revoked;
- Investigate and take relevant action on any potential breaches of this policy supported by IAO's and the IG Team in line with existing procedures.
- Ensure that exit interviews are conducted, and relevant accounts closed and equipment returned via HR and ICT Service Desk.
- Ensure all staff are made aware not to copy personal or sensitive data onto non-Trust owned computers, laptops or removable media.

11.14. **All Staff**

All staff have a responsibility to;

- Adhere to the Information Security Policy and all its contents;
- Adhere to all other Information Security / Information Governance related policies, procedures, including the Confidentiality Code of Conduct;
- Adhere to the relevant legislation in relation to information governance;
- Undertake IG / Info Sec training that is appropriate to their role;
- Maintain data confidentiality and integrity;

- Ensure the operational security of all systems they use and that there is no breach in information security as a result of their actions;
- Individual personal log in shall not be used by other users to access systems or applications;
- Raise any concerns in relation to Information Security with their line manager or the Information Security team.
- Report Information Security incidents immediately (Even if they are just suspected).

12. RECORDS MANAGEMENT

The Trust recognises the importance of sound records management arrangements for both clinical and corporate records. The Trust's' records are its corporate memory, providing evidence of actions and decisions and representing a vital asset to support daily functions and operations. Records support policy formation and managerial decision-making, protect the interests of the Trust and the rights of patients, staff and members of the public.

13. REFERENCES

- Information Commissioners Office www.ico.org.uk
- Information Governance Alliance (2016) Records Management Code of Practice for Health and Social Care 2016: NHS Digital
- Data Protection Act 2018;
- UK General Data Protection Regulations
- Freedom of Information Act 2000 (FOI);
- Environmental Information Regulations 2004;
- Equality Act 2010;
- Information Governance Alliance: Records Management Code of Practice for Health and Social Care 2016;
- Computer Misuse Act 1990;
- Common Law Duty of Confidentiality;
- Copyright, Designs and Patents Act 1988;
- Information Security Management ISO 27001.
- Network and Information Systems Directive 2018

14. APPENDIX 1 – GLOSSARY OF TERMS

Term	Description
Data Protection Impact Assessment (Privacy Impact Assessment)	Data Protection Impact Assessment (DPIA), or sometimes called a Privacy Impact Assessment (PIA), help organisations identify, assess and mitigate or minimise privacy risks with data processing. They are

	particularly relevant when a new data processing process, system or technology is being introduced. DPIAs also support the accountability principle, as they help organisations comply with the requirements of the General Data Protection Regulation (GDPR) and demonstrate the appropriate measures have been taken to ensure compliance. Failure to adequately conduct a DPIA where appropriate is a breach of the GDPR and Data Protection Act 2018 and could lead to fines of up to 2% of an organisation's annual turnover or €10 million – whichever is greater.
Encryption	The process of converting information into a form unintelligible to anyone except holders of a specific key or password.
External hard drive	Sits outside the main computer in its own enclosure. This portable encasement allows the user to store information on a hard drive that is not part of the computer, but is connected via a high-speed interface cable normally a USB or firewire.
Hardware	This is normally a physical device such as a VDU or printer.
Information Assets (IA)	Are identifiable and definable assets owned or contracted by an organisation which are valuable to the organisation. They will likely include the: • computer systems; • network hardware; • software; • supporting utilities, and • staff that are required to achieve processing of this data.
Information Asset Administrators (IAA)	Support the IAO to ensure that this procedure is followed, recognise actual and potential security incidents, and consult the appropriate IAO on incident management.
Information Asset Owners (IAO)	Are the senior individuals within the Trust. IAOs are accountable to the SIRO and will provide assurance that information risk is being managed effectively for their assigned assets.
Information Asset Register (IAR)	Is a register identifying the Trust's assets together with details of business criticality.

Patches	Are updates to computer programs, such as anti-virus, to keep the program up to date or fix a bug within a program.
PDA – Personal Digital Assistant	Refers to a handheld device that has several features including an address book, contacts list, calendar, memo and note pad e.g. Blackberry.
Personal data	Is data which relate to an individual who can be identified from those data or from those data and other information which is in possession of, or likely to come into the possession of a data controller, and includes any expression of opinion about the individual and any indication of the intentions of the data controller or any person in respect of the individual. Personal information includes names, address, date of birth, or any unique identifier such as NHS number, hospital number, national insurance number etc. It also includes information which, when presented in combination, may identify an individual, e.g. post code.
Removable media	Is a term used to describe any kind of portable data storage that can be connected to and removed from a computer e.g. CDs, DVDs, USB memory sticks or pens, PDAs.
Secure Sockets Layer (SSL)	Are encryption protocols that provide communications security over the Internet.
Sensitive personal data	This is defined as data regarding an individual's race or ethnic origin, political opinion, religious beliefs, trade union membership, physical or mental health, sex life, criminal proceedings or convictions. These data are subject to more stringent conditions on their processing when compared to personal information.
Software	Are programs that run on a computer e.g. word processing software, spreadsheets etc.
System or data	Used in the context of this policy refers to all information held in either electronic or paper format, also an "information asset" is a definable piece of information stored in a manner which is recognised as 'valuable' to the Trust.
USB – Universal Serial Bus	Or port connection that is universally compatible with many types of device such as wireless, printers, memory sticks etc.

USB memory sticks	Are devices with flash memory card formats. These devices come in many sizes and are generally used for the storage of data.

15. APPENDIX 2 – INFORMATION SECURITY DO'S AND DON'TS

INFORMATION AND IT SECURITY GUIDANCE FOR NHS STAFF

Do's		Don'ts
Saving and storage of Personal Identifiable Information (PII)		
• All electronic Personal Identifiable Information (PII) **must** be saved and stored on a network drive		• Never save PII on a C: drive of a desktop or laptop or on a data/memory stick which is not encrypted • Don't backup encrypted PII on a desktop or laptop • Don't save PII on any non-Trust computer laptop, memory stick or portable device • Don't temporarily save PII to a laptop/PC, unless a risk assessment has been agreed with the
Data/Memory Sticks and Cameras		
• PII can only be stored for transfer purposes on encrypted data/memory sticks and **must** be deleted from the device once the transfer has taken place • To take any images of individuals you must obtain their explicit consent and documentation of this must be kept in a traceable location • Images camera must be transferred to the network ASAP and deleted from the camera/SD card once		• Never transfer PII on a non-encrypted data/memory stick • Neither encrypted or unencrypted data/memory sticks should be used for long term storage of PII • Never store PII on cameras (including mobile phones) for long periods
Portable media devices. (PDAs / Mobile Phones)		
• Always maintain similar security as those mandated for laptops • Always encrypt portable media devices • Always use approved mechanisms and procedures to transfer information to and from portable media devices • Every device must be labelled specifying a return address if it is found • The Trust security application **must** be used on devices enabled for work purposes.		• Avoid storing PII data for any period of time on the devices local storage media • Never store sensitive or PII data unless the device is password or encryption protected
Laptop security		
• Laptops must only be used by staff to whom they were issued • Laptops must only be taken off site when absolutely necessary • Laptops must be securely stored (e.g. in locked draw) • When transporting laptops, keep out of sight in the boot of the car • Laptops must be backed up on the network regularly		• Never use laptops in a public place without completing an appropriate risk assessment • Never leave laptops unattended • Never use Trust laptops for unofficial business • Never use your laptop in clear public view

Sending information

• Consider using approved Trust Information Sharing systems – contact ICT Service Desk for info. • Only send the **minimum** PII in any transferable format • All electronic PII must be encrypted and any decryption key must be sent by a separate method • Use a trusted courier or send by special delivery		• Don't send PII in a standard envelope/jiffy bag by regular (1st/2nd class) post • Email should not be used to transmit sensitive or PII data unless it is sent to and from a 'wales.nhs.uk' domain in an encrypted format.

INFORMATION AND IT SECURITY GUIDANCE FOR NHS STAFF

Do's		Don'ts

Confidential information (non PII)

• Treat it according to its designation and sensitivity • Send by a secure means • Apply appropriate measures to secure storage and confidential destruction		• Don't open or read in a public place • Don't send unless encrypted or password protected • Never allow unauthorised personnel to view • Never dispose of using standard refuse bins or bags

Internet

• Be aware that the Trust has internet monitoring in place and therefore only use for the proper business of the Trust • Personal use is limited to 30 minutes internet access per day outside of working hours (e.g. Lunch breaks)		• Never share PII, pictures, or information that may cause offence to any member of NHS staff or bring the Trust into disrepute when using Social Networking Sites (Facebook, Twitter etc.) • Don't use Trust equipment to carry out personal financial transactions, or for financial gain • Don't use Trust equipment to carry out activities considered discriminatory, offensive, criminal, gambling, fraud, illegal weapons, hacking, dating, phishing, peer-to peer networking, and those of a pornographic nature • Never download games, proxy avoidance tools, or any other software that could cause damage or spy on others • Never transmit junk or chain emails • Never download streaming video or music

Passwords and PCs

• Always use passwords that cannot be guessed by others • Passwords should include letters (both upper and lower case) and numbers • Ensure you lock PC (ctrl-alt-del) when leaving it unattended even for the shortest length of time		• Never write down your password • Never share passwords with others • Don't use passwords that are easily guessed • Never leave PCs logged in overnight or when you leave the work station for a significant period of time • Never use another user's account to access information systems

Contributing to on-line databases for clinical purposes

- All PII remote access must be authorised by the IM&T Security Officer/Trust Manager - When contributing always ensure the browser has a (https://) address - Always ensure compliance with the Data Protection Act 8th Principle (patient consent required)		• Never send PII to http: websites • Never allow access to on-line databases to anyone who does not have a legitimate reason to access the information • Never leave web pages open while computer is unattended for others to see

Recipients external to the Trust – use of PII		
• Recipient must have a legitimate care or research relationship with any patient identified from the data • Sharing Agreements must be in place where there is a regular flow of PII between the Trust and another organisation. For more information on Sharing Agreements contact the Trust Caldicott Guardian Dr Brendan Lloyd • Always ensure a Duty of Confidentiality is fully understood by the recipient		• Never store/process PII where there is no legitimate reason to do so • Never forward PII to recipients in a manner not approved by the Trust (i.e. for a purpose the Trust is not aware of)

AGENDA ITEM No	**19**
OPEN or CLOSED	**OPEN**
No of ANNEXES	**2**

AUDIT TRACKER 2.0 – OCTOBER 2023

MEETING	QUEST Committee
DATE	31 October 2023
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Trish Mills, Board Secretary
CONTACT	trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. This paper provides the Committee with the current position with respect to management actions for audits within the purview of the Committee.

2. The Audit Tracker has been fully revised in Quarter 2 with excellent engagement with Directorates. C.30% of audit recommendations are presented as closed in quarter in this report and there are actions with a change in date proposed (marked in blue), many of which are due to be closed in Quarter 3.

3. Discussions have also taken place on historical actions and those where management actions may need to be amended in view of the current operating context.

4. With respect to the Committee's responsibility to scrutinise the impact of actions, members will recall that this was related to opportunities to strengthen challenge raised by Audit Wales in the 2022 Structured Assessment. It is proposed that the most effective way to do this is by identifying actions within audits as audit reports are reviewed by the Committee.

5. The current version of the tracker is now open for Directorate review for actions due in October, November and December. This will then be reported in the January and February Committee cycles.

RECOMMENDATION

6. The Committee is requested to:

(a) Monitor management actions to address recommendations in the Tracker, noting any revised dates for actions (in blue);
(b) Note the proposal for closer scrutiny of the impact of actions in response to audit recommendations; and
(c) Note that the Records Management and Senior Paramedic internal audits are nearing completion and will be presented to the next meeting.

KEY ISSUES/IMPLICATIONS
As set out above.
REPORT APPROVAL ROUTE
Tracker presented to ADLT 9th October 2023 Tracker circulated to ELT 13th October 2023

REPORT APPENDICIES
Annex 1 – Tracker 2.0 July-September 2023

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

SITUATION

1. This paper provides the Committee with the current position with respect to management actions for audits within the purview of the Committee.

BACKGROUND

2. In September 2023 the Audit Committee approved the Audit Process and Reporting Handbook. The Handbook has been further revised to include Audit Wales content.

3. The Handbook includes roles and responsibilities for the various stakeholders including:

    - The Assistant Directors Leadership Team (ADLT) as the forum to agree closure of actions, taking a check and challenge role on the Tracker.

    - Different reporting for the Audit Committee and Executive Leadership Team (ELT) to that provided to Committees, with the latter focused more on individual audits, progress and impact, and Audit Committee and ELT on the broader audit framework, progress and exposure. This will start when Tracker 3.0 is developed which will draw the agreed reporting from the tracker via Power BI.

    - The introduction of a point of contact in directorates for audits. This person(s) steers the audit with the Director and Assistant Directors/Deputies, ensuring internal audits feature on the directorate agenda monthly, they update the Tracker, and escalate issues as appropriate.

4. The Tracker has been fully revised in Quarter 2. Members will receive a copy of the Tracker by email and are invited to filter the excel sheet to their particular Committee to view the relevant audit actions. A copy of the Tracker is also reproduced at Annex 1.

ASSESSMENT

5. The Handbook notes that it is the responsibility of a Board Committee (other than Audit Committee) to:

    - Receive audits in their remit;
    - Monitor management actions to address recommendations; and
    - Scrutinise impact of actions in response to audit recommendations in terms of, for example, quality improvement, the provision of more efficient and effective patient care, improved governance, better use of resources etc.

6. There has been excellent engagement with Directorates on the revised Tracker 2.0, with the result that c.30% of audit recommendations are presented as closed in quarter in this report.

7. Some actions have had a change in date proposed (marked in blue), many of which are due to be closed in Quarter 3.

8. Discussions have also taken place on historical actions and those where management actions may need to be amended in view of the current operating context. There has been some traction with these and discussions will continue into Q3 with a view to closing down or revising as many as possible.

9. The Committee will note that the historical closed items which was a third and fourth tab on Annex 1 have been removed from Tracker 2.0. This is because there is a filter in place under the 'status' column to enable the viewer to see closed items. A copy of the historical closed tabs has been retained separately.

10. With respect to the Committee's responsibility to scrutinise the impact of actions, members will recall that this was related to opportunities to strengthen challenge raised by Audit Wales in the 2022 Structured Assessment. It is proposed that the most effective way to do this is by identifying actions within audits as the audit reports are reviewed by the Committee. For example, an internal audit or Audit Wales structured assessment/local review may include an action for roll out of training or for an evaluation. The Committee may wish to place closer attention to the impact of such actions by flagging them for follow-up on impact at a particular point in time.

11. The current version of the tracker is now open for Directorate review for actions due in October, November and December and will be reported in the January and February Committee cycles.

RECOMMENDATION

12. The Committee is requested to:

    (a) Monitor management actions to address recommendations in the Tracker, noting any revised dates for actions (in blue);
    (b) Note the proposal for closer scrutiny of the impact of actions in response to audit recommendations; and
    (c) Note that the Records Management and Senior Paramedic internal audits are nearing completion and will be presented to the next meeting.

Points of Contact, Directors and Owners of Audit Actions - Do Not Amend Any Column With a Red Header
When proposing a revised 1st, 2nd or 3rd date, include the rationale for the movement and any progress on the action to date
ALL FINAL INTERNAL AUDIT REPORTS CAN BE FOUND HERE [to be added in October]

Trust Ref. No.	Year/ Audit Plan	Committee assigned to	Report Title	Assurance Rating	Responsible Officer	Director	Priority Level	Rec. No.in Audit	Recommendation	Response No.in Audit	Management Response	Agreed Deadline in Report	Status - met or not met agreed deadline in report	1st revised date	2nd revised date	3rd revised date	Closure Status	Where a management action has not met the agreed or revised date, Director must inlcude here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. **Please add most recent update first**
462	21/22	Quest	Role of Advanced Paramedic Practitioner	Reasonable	Kerry Robertshaw, Jonathan Chippendale	Andy Swinburn	Medium		Formal structures should be established to ensure APPs are appropriately supported to deliver a high standard of practice. This could include a peer review network, where feedback and themes are reported to the Care Closer to Home Group.		Development of proposed standardised clinical appraisal and supervision model to ensure APPs remain up-to-date and competent within their clinical practice.	Mar-22	Not Met	Dec 22	Mar-24		Open	Last updated: 03.07.2023 APP leadership/clinical supervision rollout not supported at formal SOT in the current financial climate due to concerns around releasing APP leadership (8a) workforce from clinical duties to engage in leadership portfolio work streams. Decision to be revised in Q3. AHP funding bid against installing APP leadership infrastructure within the workforce appears unlikely to be successful. ePortfolio and curriculum development underpinned by clinical supervision framework, unable to progress until review in Q3
463	21/22	Quest	Role of Advanced Paramedic Practitioner	Reasonable	Kerry Robertshaw, Jonathan Chippendale	Andy Swinburn	Medium		The Trust should, through an effective appraisal process, appropriately monitor APPs development in order to achieve all four pillars of advanced practice.		The creation of a 'Principles of Advanced Practice' guidance document to be created which will detail the methodology, application and monitoring of how the four pillars of advanced practice are being addressed within APP practice. Following approval, reporting against this will take place on a 6-monthly basis.	Mar-22	Not Met	Dec 22	Mar-24		Open	Last updated: 03.07.2023 Principles of advanced practice document to be written over Q2 and steered through the Advanced practice Working group (new group created within LDP) and underpinned by the All Wales national advanced and enhanced advanced practice framework.
480	21/22	Quest	Information Management - Hear and Treat	Reasonable	Paula Jeffery	Liam Williams / Brendan Lloyd	Medium		1.1 We recommend that greater use is made of referral data in the incident records to inform further developments of current and future referral pathways, including; production of reports showing more detailed analysis by stop code.		1.1.1 A new report is available with data back to January 2021 which shows the referral pathway presented to the patient once the consultation with CSD is complete. This will be able to be broken down by health board area given the nature of the patient's location information. The Ops team is also reviewing in more detail the calls into CSD and their outcome. A review of this is likely late Q4 2022.	Mar-22	Not Met	Mar-24			Open	Last Updated: 061023: Capacity building in the CSD team will enable this action to be progressed. Currently in IMTP actions for this area for delivery Q3-4 pending team expansion. Recommended removal of example report in Recommendation related to 'detailed analysis by stop code' as this is not relevent. The information is not currently provided in a report as it is live data but a functionality request for referral data to be shown by Health Board on a Power BI dashboard will be raised with Health Informatics and should be achievable by end of Q4. Update 19/10/22 Q4 2022 Update (Q3 2022-23) - Data is now available in a report in Powr BI which shows the volume of telephone triaged calls which were referred to other services and can be broken down by Health Board area. Next steps this quarter is to work with Clinical Services to review the reports and analyse.
480	21/22	Quest	Information Management - Hear and Treat	Reasonable	Paula Jeffery	Liam Williams / Brendan Lloyd	Medium		1.2 Coordinated analysis, review and scrutiny of these internally to inform quality improvement.		1.1.2. The review can be shared to inform quality improvement.	Jun-22	Not Met	Sep-24			Open	Last Updated 061023: Further investigation to be undertaken on whether this data would benefit HB partners e.g. could report into SDEC meetings as it is currently unconfirmed whether there is a forum to enable this data to be shared. Management action relevent in 2018 before work undertaken to build on pathways. Info broken down for reporting currently not done by HB level in the usual process by CSD team (see 480 1.1 above). Team to look at possibility of incorporating this filter for reporting if it will be useful to the HBs or whether this is already reported on by Operations. Development of project work (480 1.2 above) may provide more information to accompany the data which HBs may find useful. Updated: 19/10/22 See above, subsequent action.
480	21/22	Quest	Information Management - Hear and Treat	Reasonable	Paula Jeffery	Liam Williams / Brendan Lloyd	Medium		1.3 Reporting referral volumes at health board level to assist with their service provision planning		1.1.3. The detail in the new stop codes will allow for the reporting referral volumes through Consult and Close in CSD.	Jun-22	Not Met	Nov 22	Mar-24		Open	Last Updated 061023: Further investigation to be undertaken on whether this data would benefit HB partners e.g. could report into SDEC meetings as it is currently unconfirmed whether there is a forum to enable this data to be shared. Management action relevent in 2018 before work undertaken to build on pathways. Info broken down for reporting currently not done by HB level in the usual process by CSD team (see 480 1.1 above). Team to look at possibility of incorporating this filter for reporting if it will be useful to the HBs or whether this is already reported on by Operations. Development of project work (480 1.2 above) may provide more information to accompany the data which HBs may find useful. Updated: 19/10/22 See above, subsequent action.
483	21/22	Quest	Information Management - Hear and Treat	Reasonable	Paula Jeffery	Liam Williams / Brendan Lloyd	Medium		We recommend that current analysis and sample examination of the 'Can't Send' call responses is extended to include other 'See and Treat' and 'Consult and Close' incident responses. This could be coordinated by theme and pathway type, to inform patient safety and quality improvement and should be routinely analysed and reported into the agenda of an appropriate group in the Trust's governance structure.		With the introduction of a dedicated training and audit team within the CSD more opportunity to analyse and sample Consult and close outcome will be possible. We will ensure it is part of normal audit of the activity in the CSD. Findings can be shared with other groups to ensure quality and enhanced clinical review similar to Can't Send outcomes.	Sep-22	Not Met	Dec 22			Closure Proposed (pending evidence)	Last Updated 061023: Achieved IAED/ACE accreditation in Sept 2023 and a prescribed percentage of audits for every clinician are undertaken every month and reported on compliance by PPeD. Management of staff who are not compliant with audits is stepped out within the quality assurance framework for ECNS. Consult and Close activity is reported on live in Power BI and includes several areas contribution to Consult and Close (CSD, APP NAV, PTAS, and 111 C&C) and is monitored through Operational performance meetings. The monthly audit reports are available and are reported to SLT. Updated: 19/10/22 Now that triage has moved to ENCS and reports and analysis of outcomes and audits are available this activity is more possible. The audit team are working on audit reviews and work closely with the Clinical Services team to produce this analysis. Exepcted Q3 2022-23)
524	21/22	Quest	Respiratory Protective Equipment	Reasonable	Louise Colson	Liam Williams	Medium		4.1 We recommend the Trust refreshes the above paper in light of the challenges in meeting the requirement to quality assure all Fit testers under its current model. [the paper referred to her was a paper that went to SPT in 2021 estimating the time in hours over a 3 year period that fit testing would be required to comply with HSE legislation]		4.1 A report will be provided to the Clinical & Quality Governance Group on the output of the Quality Assurance programme recently undertaken. Furthermore, it will outline proposal for the emerging risk of sustainable fit testing across the Trust. A crossdirectorate position on a sustainable Fit Testing model will be developed.	Sep-22	Not Met	Jun-23	Dec-23		Open	Update 28.9.23 : An updated Respiratory Protection paper was presented to SOT on 28.04.23 with a recommendation that a multi-disciplinary task and finish group was established to explore a sustainable option of providing respiratory protection for staff. The first meeting took place on 22.06.23 and an options appraisal paper has been submitted to CQGG and SOT on 25.09.23. Further update will be provided once both meetings have taken place. Update 30.06.23 Issue has been discussed in IPC Strategic Group, and escalted issue to CQGG. The matter has also being rasied within Operations Senior Leadership Team, with the management of Fit Testers and associated challenges to be managed through the Senior Operations Team; a T&F group has commence led by IPC to determine a sustainable approach which includes review of PPE/RPE provision. The action related to report generation is complete, and IPC Strategic Group will monitor ongoing performance.
525	21/22	Quest	Respiratory Protective Equipment	Reasonable	Jonathan Turnbull-Ross	Liam Williams	Medium		4.2 Recognising the challenges in delivery of the quality assurance programme due to operational pressures, we recommend that the programme be recommenced with progress updates provided to the Strategic IPC group on a regular basis.		4.2 A regular update on the quality assurance programme will be provided to IPC Strategic Group on a routine basis. This will commence from the next diarised Strategic Group meeting in October 2022.	Oct-22	Not Met	May-23			Closed in Quarter	Update 28.9.23: Proposed for closure. Programme is reported via IPC Group with regular reporting on fit testing via the IPC Management report. As per previous update reporting is completed quarterly. Highlight Report includes updated IPC Workplan; Updated report on FIT Testing; Education & Training via reporting from ESR to support the closure of this action (these element incoporate the quality assurance programme) Update 26.04.23: As above this paper will replace the Q4 Reporting. This action can now be closed as Fit Test reporting is being done quarterly.
506	22/23	Quest	Infection Prevention and Control	Reasonable	Louise Colson	Liam Williams	Medium		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.		1.1-1.3 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.	Mar-23	Not Met	Sep-23	Dec-23		Open	Update 27.09.23: Both the IPC and Premise and Vehicle cleaning policies are in the policy group process still. Several meetings have been cancelled due to competing priorities involving the public enquiry. Two policies are awating final approval, the next meeting is now the 10th October. I anticiapte approval at this meeting with final approval at QUEST at the December meeting. The 3P project initial outlay is complete and incorporated into annual plan of work and was presented at the IPC strategic meeting on the 26th September. 30.06.23 (as per previous) The IPC policy has now been to the Policy group 24.04.23, a longer delay than anticipated but this was due to circumstances outside of the control of the IPC team. This will now be available for consultation. This will be a new policy which combines the AACE national policy. In the meantime work has been undertaken within the 'IPC 3P' to map out other forms of Standard Operating Procedures and Guidance and where they are aligned to. The RACI framework is being used to aid with identifyng responsibilites, risks and monitoring responsibilities. This along with the audit tracker will be presented at the next IPC strategic meeting in Q2.
507	22/23	Quest	Infection Prevention and Control	Reasonable	Louise Colson	Liam Williams	Medium		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.		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.	Mar-23	Not Met	Sep-23	Feb-24		Open	Update 121023: this action will be closed once the IPC and the Premises and Vehicles Polices are approved at Committee . These Policies have been deferred to February Committee due to cancellation of Policy Group Meetings.Update 27.09.23 The Premise and Vehicle cleaning policy is awating approval vai the Policy Group pathway. There is a delay in its progress due to cancelled meetings. The nxt meeting is the 10th October and i anticiapate fianl approval at QUEST December 2023 The trust has a clear vehicle decontamination SOP. The vehilce audit tool has been redesigned, piloted and is good to go.
508	22/23	Quest	Infection Prevention and Control	Reasonable	Louise Colson	Liam Williams	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		1.1-1.3 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.	Mar-23	Not Met	Mar 24			Open	Update 27.09.23: The 3 P project continues, the content of which is now incorporated into the IPC annual plan. This was discussed and shared with the IPC Strategic meeting and is now at a stage for cross directorate working. All IPC related policies within the trust have been identified as the parent document, along with associated guidance, standards, SOPs, audit tools, risk assessments and training. Included is the RACI for each area of responsibility.This document has now started to identify the gaps and the work is at the stage to be shared as there are cross directorate responnsibilites. The progress has also been reported in the IPC Q1 highlight report Update 30.06.23 IPC 3P project to be reported to CQGG in Q2

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509	22/23	Quest	Infection Prevention and Control	Reasonable	Louise Colson	Liam Williams	Medium		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		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	Jun-23	Not Met	Jun 23	Sep-23		Closed in Quarter	Update 27.09.23: The IPP Safe Clean Care guidance based on the NIPCM has been published on the 25th August following approval at CQGG. Proposed for Closure The 3P Project details as above will be reported on Q2. Revised guidance dated 1 August 2023 provided and AAA to EMT from CQGG on 060923/ Updated 30.06.23 The IPC Safe Clean Care Guidance, replacement of the IPC Handbook, was present to IPC Strategic Group. Further review and amendment is required, and alignment to the 3P mapping exercise is necessary. The 3P project's output - a mapping of IPC governance/documents - will be presented to IPC Strategic Group and CQGG, with a view to the Safe Clean Care guidance supporting users in navigating IPC policy/SOPs.Project outlay complete will report in Q2 the next steps
517	22/23	Quest	Infection Prevention and Control	Reasonable	Louise Colson	Liam Williams	Low		The Trust should ensure online resources contain up to date links and guidance		We accept the recommendation, future workplans will detail requirements.	Jan-23	Not Met	Sep-23	Apr-24		Open	Update 27.09.23: Proposed revised date 31.03.24. The prehospital Care ESR taining resources has been updated. The ANTT Training package is in the process of being updated along with the All Wales ANTT policy. We have a plan with training school for ANTT training on the MIST training for 2024/25. This will commence April 2024. A discussion with the training school at the last IPC strategic meeting to transer some of the onclick training to the Learning Launchpad. The priority modules will be PPE, RED Level PPE training, Vehicle Cleaning and Waste management. The other modules via onlick can be incorporated into these modules as they are largely pandemic related training.. Updated 30.6.23 (as per previous 26.04.2023)
519	22/23	Quest	Infection Prevention and Control	Reasonable	Louise Colson	Liam Williams	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.		We accept the recommendation to standardise documentation formats. This action will be addressed through the IPC 3P Project (management response 1.1)	Jun-23	Not Met	Mar-24			Open	Update 27.09.23:The 3P project documentation was presented to the IPC strategic group n the September meeting, this will be reflected in the AAA report to CQGG and then in Q2 IPC Highlight report. Update 30.6.23: 3P project outputs to be presented to IPC Strategic Group and CQGG in Q2.
601	22/23	Quest	Pain Management	Limited	Chris Moore	Andy Swinburn	High	1.1	Whilst recognised not all PGD's are in relation to analgesia, the current data maintained for compliance for all, should be formally reported to an appropriate forum and action taken to address areas of non-compliance.	1.1	From the July reporting period, we will include compliance for 'Paramedic', 'Advanced Practice' and 'Enhanced Analgesia' PGDs in the monthly Medicines Management Assurance Report (MMAR). These reports are routinely shared with the Ambulance Practice Steering Group (APSG), Senior Operations Team (SOT) and highlights to CQGG via triple A (Advise/Assure/Alert) reports.	Jul-23	Met				Closed in Quarter	Last updated: 06.10.2023 - MMAR included APP and Enhanced analgesia PGD compliance from July. Assurance from Director on Evidence.
602	22/23	Quest	Pain Management	Limited	Chris Moore	Andy Swinburn	High	1.2	The Trust should ensure all PGDs follow the Medicines Management policy, with a review undertaken every three years as a minimum.	1.2 (a)	As an immediate action, with the support of our Pharmacist Advisor, we propose to 'extend' the current expiry dates of our out of date PGDs. This will be a limited time action to allow us time to catch-up with the backlog.	Sep-23	Met				Closed in Quarter	Last updated 06.10.2023 - All out of date PGDs were 'extended' from September (took a while to secure time with pharmacist advisor) to January. Assurance from Director on Evidence.
603	22/23	Quest	Pain Management	Limited	Chris Moore	Andy Swinburn	High	1.2	The Trust should ensure all PGDs follow the Medicines Management policy, with a review undertaken every three years as a minimum.	1.2 (b)	We will prepare and agree a prioritisation plan, to manage the expired status backlog which will be presented to APSG and through to CQGG.	Sep-23	Met				Closed in Quarter	Last updated: 06.10.2023 - Prioritisation plan has been agreed with pharmacist advisor and will begin review of expired PGDs from this month. Assurance from Director on Evidence.
604	22/23	Quest	Pain Management	Limited	Duncan Robertson	Andy Swinburn	High	1.2		1.2 (c)	The PGD development and review process is resource intensive, and pharmacist input is an essential requirement. Pharmacist Advisor availability is currently limited to 4-hours per month and does not currently meet the needs of the organisation, particularly given the uplift in advanced practitioners and extended skills (enhanced analgesia) of the paramedic workforce. We will develop an options appraisal to determine a costed and effective way forward to provide additional Pharmacist Advisor capacity	Mar-24	Not Yet Due				Open	
605	22/23	Quest	Pain Management	Limited	Duncan Robertson	Andy Swinburn	High	2.1	To gain assurances on the completeness of pain management recorded for patients, additional pathways within the ePCR system, should be established to extract the required data; and reported to an appropriate forum with any themes or trends highlighted within the report.	2.1	We propose to set up a task and finish group, to develop/design a pain management framework to support analysis and presentation of pain/analgesia related data. We anticipate this will enable a fuller picture of pain management, across a range of conditions, in addition to STEMI and Fractured Neck of Femur. The framework will be presented to the Clinical Intelligence and Assurance Group by the end of Q3 2023/24 and then through to CQGG and QUEST. There will be a co-dependency on some of the actions on the outcome of Matter Arising 3.	Dec-23	Not Yet Due				Open	Last updated: 13.04.2023 - ePCR Lessons learned event took place 15.03.2023. These have been recorded and will be added to the programme closure bundle. Recommend for closure.
606	22/23	Quest	Pain Management	Limited	Duncan Robertson	Andy Swinburn	Medium	3.1	The functionality of the ePCR system should be reviewed for the inclusion of a field to track the details of the member of staff who administered the analgesia to the patient.	3.1	The ePCR team will prepare a change request specification and work with our TerraPACE suppliers, to enable the identification of clinicians who have administered analgesia before the end of Q2. The change request will be submitted to the ePCR Clinical Reference Group who report to the CQGG. Note that delivering any change to the ePCR will have a cost associated with it, meaning that it may not be able to be delivered in practice until the funds have been identified.	Sep-23	Met				Closed in Quarter	Last updated: 06.10.2023 The change request has been written up but will not be progressed at this stage due to a lack of funding. Should funding become available, this change request will be considered as a ready to go business case and priority will be reviewed. Closed as to leave it open will mean it will remain open indefinately. Potential issues with funding were identified in the action.

Status:
Open - action not complete
Closed - action complete (normally filtered out)
Closure proposed - action complete and evidence reviewed/known
Closure proposed (pending evidence) - action complete and evidence awaited
Closed in Quarter - selected post ADLT when 'closure proposed' agreed. This pr

Internal Audit will review 'closed in quarter' as part of Committee papers

·ovides Committee with overview of actions closed in quarter.

Points of Contact, Directors and Owners of Audit Actions - Do Not Amend Any Column With a Red Header
When proposing a revised 1st, 2nd or 3rd date, include the rationale for the movement and any progress on the action to date

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106	Audit Wales	22/23	QUEST	Review of Quality Governance Arrangments	Jonathan Turnbull-Ross/ Wendy Herbert/ Hugh Bennett	Liam Williams		R8 We found that the QuESt Committee is well served with quality information, but there are opportunities for improvement. 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. ▪ enhance Covid-19 reporting in the integrated quality and performance report by including information about the harm caused to patients by ongoing service pressures caused by the virus. ▪ work with health bodies so that there are systems to determine the outcomes for patients who have received emergency ambulance services. This should particularly seek to understand the consequence and harm resulting from service failures such as long ambulance waits. ▪ develop patient outcome measures to support its existing quality measures.		a) The recommendation will be considered by the MIQPR Team, considering the accessibility and accuracy of this data noting the changes to apporach due to 'living with COVID' context.	Mar-23	Not Met	Update 121023 I. The Quality Management Group has been set up and is running on a weekly basis chaired by the Senior Quality Governance Lead. The structure of the meeting based around the four quadrants of the Quality Management System System (Quality Control, Quality Assurance, Quality Improvement and Quality Planning) is designed to triangulate information, highlighting areas for improvement, lessons learnt and risk. The structure allows for key stakeholders to attend a rolling programme outside of the core membership group including, EMSC, EMS Response, Integrated Care and Ambulance Care as well as wider corporate services. This is an emerging group that will develop over time to provide assurance to the Executive Team. II.There is also a quality Assurance template in development which will follow the QMS structure in its design in terms of the 4 key elements mentioned above. This will be singed off at Quality and Performance Steering Group in due course. The QA lead will then support EMSC,EMS field Ops, Integrated Care, Ambulance Care to undertake a self-review and collated a gap analysis with the Head of Quality Assurance. This process will act as an embedding tool of theory into practice of the QMS system. Further development will be required over time to embed the QMS into business as usual. III. There is a QMS dashboard is in development to support the group, this is emerging in 3 main parts and will develop over time. •Trust Strategic dashboard based on the MIQPR currently with Health Informatics for development. This will be brought to the QMS meeting for discussion. •Technical specification for all Trust Quality Metrics, this is in its final form. Once ready the HI team will develop into a dashboard for utilisation across business meetings and for the QMS team. •Datix dashboard development, training has been offered by the Once for Wales Team to provide operational leads with the skills and knowledge to search and run reports. In addition, Key leads from Digital, Patient Safety, Health & Safety will be provided training to design their own listing reports. This with enhance the overall management of incidents, mortality reviews, concerns etc. IV. The Quality Performance Management Framework (which is the overarching document to support the Quality Management Systemin WAST) is now being developed and overseen by a Steering Group with cross directorate representation from the Senior Leadership team. This organisational framework will be underpinned by local frameworks acknowledging the complexity and diversity of the organisation. The Terms of Reference for this group is now under review with the Board Secretary to bring it in line with the Duty of Quality requirements.	Closed	
106	Audit Wales	22/23	QUEST	Review of Quality Governance Arrangments	Jonathan Turnbull-Ross/ Wendy Herbert/ Hugh Bennett	Liam Williams		R8 We found that the QuESt Committee is well served with quality information, but there are opportunities for improvement. 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. ▪ enhance Covid-19 reporting in the integrated quality and performance report by including information about the harm caused to patients by ongoing service pressures caused by the virus. ▪ work with health bodies so that there are systems to determine the outcomes for patients who have received emergency ambulance services. This should particularly seek to understand the consequence and harm resulting from service failures such as long ambulance waits. ▪ develop patient outcome measures to support its existing quality measures.		b) The Trust, through the Quality Strategy, is seeking to develop a quality management system. This will improve triangulation of information, clarity of position, and impact of improvement effort.	Mar-23	Not Met	A "Harm Report" is produced for the Trust Board every two months. This includes a clear graphic on the estimated harm caused by system pressures, in particular, long waits. Recognising these long waits were there before the pandemic, so they are not attributable to the pandemic as such more a systematic failure to address handover over a sustained period.	Closed	
106	Audit Wales	22/23	QUEST	Review of Quality Governance Arrangments	Jonathan Turnbull-Ross/ Wendy Herbert/ Hugh Bennett			R8 We found that the QuESt Committee is well served with quality information, but there are opportunities for improvement. 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. ▪ enhance Covid-19 reporting in the integrated quality and performance report by including information about the harm caused to patients by ongoing service pressures caused by the virus. ▪ work with health bodies so that there are systems to determine the outcomes for patients who have received emergency ambulance services. This should particularly seek to understand the consequence and harm resulting from service failures such as long ambulance waits. ▪ develop patient outcome measures to support its existing quality measures.		c) The MIQPR has evolved in recent months and the quality metrics confirmed with Trust Board. Work is being undertaken to automate more of the reporting into Power BI dashboards with live feed where appropriate to inform of current state. The monthly MIQPR will continue to drive organisational discussion and governance reporting as the key analysis of quality of service delivery across the Trust.	Mar-23	Not Met	Update 121023 The MIQPR continues to be reported to commitees and Trust Board. TB recently approved a revised set of metrics. The Quality & Performance Management Steering Group has agreed that as a pragmatic first step to respond to the "Always On" requirement of the MIQPR will be converted to a live Power BI dashboard. The project group for this has just started, so timescales are to be confirmed dependent on the design brief.	Closed	

106	Audit Wales	22/23	QUEST	Review of Quality Governance Arrangments	Jonathan Turnbull-Ross/ Wendy Herbert/ Hugh Bennett	Liam Williams		R8 We found that the QuESt Committee is well served with quality information, but there are opportunities for improvement. 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. 🞎 enhance Covid-19 reporting in the integrated quality and performance report by including information about the harm caused to patients by ongoing service pressures caused by the virus. 🞎 work with health bodies so that there are systems to determine the outcomes for patients who have received emergency ambulance services. This should particularly seek to understand the consequence and harm resulting from service failures such as long ambulance waits. 🞎 develop patient outcome measures to support its existing quality measures.		d) The Trust will continue to share information and intelligence with partners that detail the consequences of system failures. Whilst particularly evident where experience or outcome is poor and results in complaint or adverse incident. The Trust will pursue patient outcome data through development of the ePCR over 2022/23. 🞎	Mar-23	Not Met	**REVISED DATE OF DECEMBER 2023** Update 121023: Work Ongoing and will take a period to complete. Conversations continue with DHCW and the Ambulance Data Set (ADS) lead in England to define the ePCR definitions. Work is also continuing with DHCW to establish data sharing to enable joining up of patient records to report on outcome data. no timeline as yet and meeting with DHCW continue to clarify some of the definitions following discussions with the lead for the ADS in England. Trust Information Governance colleagues are working with DHCW for this. Update 26.09.23: Duty of Quality Implementation plan includes the four quadrants of quality management system as set out in the 'road map'. Quality & Performance Management Steering Group continue to monitor and review the development of 'always on' reporting in line with the requirements of the act. Additional metrics have been approved by Trust Board for inclusion in the MIQPR including PREMS/PROMS, Duty of Candour metrics. New HI post now appointed to support MIQPR move to Power BI dashboard. Proposed Revised date 31.12.23 rationale for extension is to allow BI Dashboard work to commence to allow analysts to identify how best to report 'Patient Reported Experience' measures that add value to decision making. Historic Update: We continue to work with Welsh Government colleagues and NHS Executive in the development of the 'all-Wales' Quality Management System, including how the QMS will 'join up' and detail the impact of ambulance performance on HBs/patient care. The Trust PECI Team have also continued to develop the Civiva patient experience software, alongside HBs, to enable analysis of patient experiences of services.	Open	
106	Audit Wales	22/23	QUEST	Review of Quality Governance Arrangments	Jonathan Turnbull-Ross/ Wendy Herbert/ Hugh Bennett	Liam Williams		R8 We found that the QuESt Committee is well served with quality information, but there are opportunities for improvement. 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. 🞎 enhance Covid-19 reporting in the integrated quality and performance report by including information about the harm caused to patients by ongoing service pressures caused by the virus. 🞎 work with health bodies so that there are systems to determine the outcomes for patients who have received emergency ambulance services. This should particularly seek to understand the consequence and harm resulting from service failures such as long ambulance waits. 🞎 develop patient outcome measures to support its existing quality measures.		e) The Trust is often limited by data accessibility where the patient journey extends beyond the organisational boundary. The Trust will pursue patient outcome data through development of the ePCR over 2022/23, which will enable 'joining up' of patient records. Furthermore, the Trust will further consider accessibility and governance matters for wider adoption of Patient Reported Outcome Measures, and Patient Reported Experience Measures.	Mar-23	Not Met	**REVISED DATE OF MARCH 2024** Update 121023: PREMS live, but in development. PLICS is due to come on stream in Mar-24. PROMS is in development and dependent on DCHW. Business Care Process and Project Management Pathway are relevant considerations.	Open	
111	Audit Wales	22/23	QUEST	Structured Assessment 2022	Liam Williams	Liam Williams		R2 Improve quarterly patient experience reporting to QuESt by ensuring a balance of both positive and negative feedback and providing information on what is being done to address the negative themes arising in the report.		Agreed.	Sep-23	Met	Update 121023: Patient Experience & Community involvement reporting will include qualitiative and quantative data showing positive and negative feedback along with actions being undertaken. Compliments recorded in Datix will present the positive themes to balance the negative themes arising from Putting Things Right and poor experience reporting including patient stories and survey feedback recorded within Civica.	Closed	

AGENDA ITEM No	**20**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**2**

HEALTH INSPECTORATE WALES (HIW) EMSCCC PATIENT SAFETY REVIEW

MEETING	Quality Patient Experience & Safety Committee (QUEST)
DATE	31 October 2023
EXECUTIVE	Lee Brooks, Executive Director of Operations
AUTHOR	Alessandro Di Ronato
CONTACT	Alessandro.DiRonato2@wales.nhs.uk

EXECUTIVE SUMMARY

The purpose of this paper is to provide a summary and overview of the progress made on the actions agreed in response to HIW EMSCCC Patient Safety Review.

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

(1) **Note** the update provided for the status update of the actions detailed in this paper and in the appended tracker.
(2) Confirm its **assurance** that whilst actions 12.1 and 21.1 are overdue, progress is underway in structured workstreams.
(3) **Agree** that further update be provided to Committee either on completion, or if there are further impediments to completion.

KEY ISSUES/IMPLICATIONS

Two actions remain open however the delays are explainable, and progress is underway through workstreams that are incorporated in our IMTP. While there have been delays, the Committee can be assured that management remains focussed on full conclusion of all recommendations and continue to monitor progress.

REPORT APPROVAL ROUTE

Operations Senior Leadership Team – 17.10.2023
Executive Leadership Team – via AAA report
Quality, Patient Experience & Safety Committee – 31.10.2023

REPORT APPENDICES
ANNEX 1 – SBAR Providing background information. ANNEX 2 – HIW Action Plan Welsh Ambulance Service Trust - Local Review 2019-2020

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

ANNEX 1

SITUATION

1. Following concerns raised regarding the potential impacts of extended and deteriorating handover times at emergency departments across Wales, areview by Health Inspectorate Wales (HIW) was undertaken during Q3 & Q4 of 2019/20.

2. An action plan update was presented to Executive Management Team (EMT) onthe 03/08/22 and Quality Patient Experience and Safety Committee (QuEST) on 11/08/22.

3. The purpose of this paper is to provide a summary and overview of the progressmade against the action plan since the last update.

BACKGROUND

4. The principal objective of the review was to assess how patients are managedby EMS Coordination (EMSC) encompassing the period from the time the call is received through to an operational response arriving with the patient.

5. As a secondary objective the review considered how staff working in EMSC are resourced and supported.

6. HIW conducted the field work between November 2019 and January 2020 using a mixed methods approach including staff surveys, document reviews and semi-structure interviews.

7. The key findings of the review were:

    i. The review found a 'strong team ethos' through the EMSC despite oftenhaving to work in challenging circumstances relating to limited resources.

    ii. Pressures arising from lost hours at hospital because of delayed handovers of care at Emergency Departments was a consistentand 'significant' theme which was driving the negative staff and patient experiences.

    iii. Management, leadership, and accountability structures are clearhowever the review found that more could be done to increase the visibility of this leadership.

    iv. The review found that sound risk management processes were in place although opportunities for improvement were identified.

    v. Further organisational focus is required to ensure that EMSC have the correct resources, training, and development.

ASSESSMENT

8. The action plan contained 44 actions, 8 of which were deemed complete prior to the publication of the action plan based on developmental and improvement work already undertaken.

9. 18 have actions against them which are predominantly for EMSC but also include support/lead from other areas namely, Workforce and Organisation Development and Clinical Directorate.

10. An update was requested by HIW in Q2 2022 which involved submission of an updated response including the updated action plan.
11. The table below sets out the status of recommendations by quarter & financial year.

	Year (19/20)	Year (20/21)	Quarter 1 (21/22)	Quarter 2 (21/22)	Quarter 3 (21/22)	Quarter 4 (21/22)
Actions Due	7	30	4	1	0	2
Complete (Nov 21)	7	25	3	0	n/a	0
Complete (Jun 22)	7	27	3	0	n/a	1
% Complete (Aug 23)	100%	93%	100%	100%	n/a	50%
Outstanding	0	1	0	0	0	1

12. The remaining two outstanding actions continue to be reviewed and assessed. Outlined below are the two remaining actions:

13. The outstanding action from the 2020/21 is:

Action	Progress & Anticipated Completion
Action 21.1: Complete the North Wales EMS CCC estate strategy and identify opportunities for improvements.	Project board has now been set up with project support allocated. All interested parties including TU partners have been invited to inaugural meeting with a view to develop the OCP process for the process of relocation from Bryn Tirion to alternative site(s). The ambition is to have the majority of this in place by the end of this financial year

14. The outstanding action from the 2021/22 is:

Action	Progress & Anticipated Completion
Action 12.1 Continue with the work of theCAD Phase 3 project to realign workloads within the EMSCCC for more efficient operation.	As a result of securing updated data from ORH in relation to EMSC activity, it has been decided to reinvigorate and review the original EMT paper regarding resources and reconfiguration of work including boundaries and workloads. Initial conversations with TU partners have taken place at SLT TUP meeting and proposed structure will go through operational governance processes over the forthcoming months

15. Action 21.1 – An initial project board has been set up with the intention of scoping premises, the expected timelines to identify will be in October 2023.

16. Action 12.1 – The EMS Coordination Management team are exploring a revised structure taking cognizance of previous submissions to ELT. This is being done in consideration of the current financial climate within the trust and NHS Wales with the intention to deliver a revised structure within the current financial envelope.

17. On the 17th October 2023 the Senior Leadership Team endorsed the recommendations and approved the paper for onward submission.

RECOMMENDED: It is recommended that the Committee:

1. **Note** the update provided for the status update of the actions detailed in this paper and in the appended tracker.
2. Confirm its **assurance** that whilst actions 12.1 and 21.1 are overdue, progress is underway in structured workstreams.
3. **Agree** that a further update be provided to Committee either on completion, or if there are further impediments to completion.

Action Plan: Welsh Ambulance Service Trust - Local Review 2019-2020

Ref	Recommendation	Setting action	Timeframe	Responsible person	Action Status *(Complete/In Progress/Not Actioned)*
1	Consider how the service can maximise the opportunity to respond to patients who have specific therapeutic window timescales.	**Action 1.1: The trust will consider a review of response time standards and methodology for therapeutic conditions with commissioners** *Response time standards of this nature are subject to NHS Wales and commissioners' guidance as the trust is a commissioned service. The trust can consider timelines and response standards for various therapeutic windows which are outside the current response time standards in Wales with our Commissioner.*	Q3 20/21 **Completed: Q3 20/21**	Lee Brooks	Complete
2	Review and consider other viable options for managing patients on the call waiting queue in each of the three EMSCCCs.	**Action 2.1: In line with the Trusts Integrated Medium Term Plan (IMTP) deliver the recommendations in the Trust's Clinical Review.** *The Trust has undertaken a clinically led, operationally supported review of the clinical functions within the EMS Clinical Contact Centre. The review explores the utilisation of clinicians and how they can be used to best effect. The review makes a number of recommendations for change and development which will significantly contribute to the delivery of this recommendation including reviewing the other functions of the Clinical Support Desk (CSD) to ensure they are required and to assess if they could be delivered in a different way to support patient care.* *The Demand Management Plan (DMP) has been revised and re-published since the completion of the HIW review. This plan sets out additional measures that are to be taken for patients with long waits including clinical case reviews, enhanced cross-border resource utilisation and engagement with ambulance response leadership teams to consider alternative operational solutions. We believe this will provide clarity of actions*	Q2 20/21 **Completed: Q3 20/21**	Lee Brooks	Complete

		and realignment of roles to support increasing demand and patient safety management. ***Updated 24/10/22: DMP has been superseded by Clinical Safety Plan (CSP), which provides ongoing strategic oversight of demand and capacity. CSP continues to be reviewed with latest clinical and operational updates. The Trust is imminently publishing our most recent revision of the plan.***			
3	Review SICAT to determine the benefits in rolling this service out across Wales into all EMSCCCs.	**Action 3.1: Continue to engage with Health Board stakeholders regarding availability and expansion of (PTAS) opportunities.** **Action 3.2: Explore opportunities and funding for improved technical solutions to enable PTAS models to operate remote from the EMSCCC.** *The EMSCCC currently operates a small number of Physician Triage and Streaming (PTAS) models across Wales, one of which is the SICAT model in place in conjunction with Betsi Cadwallader University (BCU) Health Board.* *The Trust has worked alongside other Health Boards to explore the PTAS opportunities reflecting the patient and staff benefits derived from these schemes including Swansea Bay (SB) Health Board and Aneurin Bevan (AB) Health Board who have both trialled or put in place similar schemes.* *The CCC Clinical Review project has a work stream which is actively evaluating the current models and exploring additional opportunities with other Health Boards and this will continue as part of the review work.* *To overcome the challenges of co-locating the Trust is reviewing a version of the Computer Aided Dispatch system (CAD) which allows remote Health Board physicians to review the ongoing 999 calls to review opportunities for intervention to avoid the*	Q4 20/21 **Completed Q1 22/23**	Jonathan Edwards	Complete

		need for a patient to attend hospital. This will allow for more opportunities for PTAS across all Health Boards. ***Update 25/10/22: To date, three HB's are live with PTaS (HDUHB, BCUHB & ABUHB). Most HB's have had initial engagement, but some are awaiting documentation sign off by MoU and a Joint Commissioner Agreement. There is an ongoing review of the PTaS data and will undergo internal review before further engagement with HB leads.*** ***Further work is ongoing regarding the formal handover to the remaining HB's to be live with PTaS with continued engagement and reporting to NCCU. The most recent positions***			
4	Consider including more realistic expected waiting times to DMP scripts, to allow patients to make informed decisions about their wait.	**Action 4.1: Expected waiting times are currently included within the Demand Management Plan (DMP). These are provided in time bands which represent the time the caller can reasonably expect to wait for a response to arrive at their location, given the current volume of 999 and urgent responses being managed by the service.** **Action 4.2: In order to further improve patient experience and to enable patient's to make informed decisions regarding their care the Trust will review the existing approach with a view to providing more realistic waiting times.** *Consideration has been given to the presentation of actual or more precise expected waiting times but this is not possible due to the complexity and dynamic nature of the operational environment.* ***Update 24/10/22 – Since September / October 2021 an Estimate Time of Arrival (ETA) dashboard and Scripting has been fully functional across Wales that provides patients with a guide as to the likely waiting times for Ambulances in their area, based on the CSP level (demand & Capacity) in their area.***	Q4 19/20 **Completed Q4 19/20**	Lee Brooks	Complete

Action Plan: Welsh Ambulance Service Trust - Local Review 2019-2020

5	Undertake a review of the REAP and DMP escalation arrangements to ensure they are being applied consistently.	**Action 5.1: We will pursue with our Health Informatics (HI) colleagues an improved Ambulance Dispatch Operations Log (ADOL) report so that actions taken as a result of REAP and DMP levels are more visible and able to be reported on more easily.** **Action 5.2: The Trust will review the process of increasing DMP levels by the DCM to ensure the process is being followed and will review the findings to see if improvements can be made.** *The Resource Escalation and Action Plan (REAP) arrangements are reviewed annually by the Trust and will be reviewed again in August 2020. They are consistent with the Association of Ambulance Chief Executives (AACE) guidance and are especially geared towards activity in Wales.* *A REAP level assessment is undertaken at weekly performance meetings by the Director of Operations. Decision making is documented and held on record. This takes a current and future view of staffing levels, expected demand and other external factors such as events in the community or external pressures such as seasonal increases (winter) or pandemics. This process is consistent with other UK Ambulance Services.* *At the end of each session the REAP level is communicated to Trust staff through the usual communication routes and out to Health Boards through regular daily meetings. The REAP level is recorded in the Computer Aided Dispatch system to ensure that the level is known at all times.* *Each REAP level has certain actions associated with it and when these actions are carried out by commanders, managers and staff they are recorded in the Ambulance Dispatch Operations Log (ADOL) by the respective individuals. Reporting for this system is a manual process and quite complex and would benefit from improvement so that the entries in the log can more easily be reported to ensure compliance to the plans.*	Q3 20/21 **Completed Q3 21/22**	Lee Brooks	Complete

		Since the review took place the Demand Management Plan (DMP) has been updated and now includes more narrative and improved action cards for 999 Call Handlers, Dispatchers and Allocators and Clinicians working in the CSD. There are more distinct levels of DMP; DMP levels are managed through triggers by the Duty Control Manager (DCM) up to Level 3 and any level above by the Strategic Commander on duty. Higher levels require the information / approval of the Chief Executive Officer. Strategic Commanders, EMSCCC staff and CSD Clinicians were provided with familiarisation sessions on the new DMP. *Call Supervisors at each centre communicate the levels to the centre staff and to the other EMSCCCs and record the levels in the Ambulance Daily Occurrence Log (ADOL) for reference. The level is also recorded in a new web based system (this was not in place at the time of the review) so that it is available in real time for others to see the levels in each Centre (e.g. the Operational Delivery Unit) and so that it can be more easily reported and reviewed for past incidents.* *Similarly to REAP the DMP levels have actions associated with them and when these actions are carried out they should be recorded in the ADOL. Reporting for this system is a manual process and quite complex and would benefit from improvement so that the entries in the log can more easily be reported to ensure compliance to the plans.* ***Update 24/10/22 – REAP is subject to an annual review to ensure that it continues to meet the needs of the Trust and patient safety. REAP continues to be tested annually pre-winter. As noted above DMP has morphed into CSP and is subject to periodical reviews to ensure that it continues to meet the needs of patients. The CSP levels have been standardised across the UK.***			

Action Plan: Welsh Ambulance Service Trust - Local Review 2019-2020

6	Ensure Senior Management Staff routinely attend EMSCCCs as directed within the DMP escalation process where required.	**Action 6.1: We will review the current arrangements for managers attending the EMSCCC to ensure that this is taking place.** **Action 6.2: We will work with the ODU on support for EMSCCC and service delivery and review a need to adjust the requirement for operational managers to report to the EMSCCC.** *Occasionally the Locality Managers or on-call Tactical Commander (Silver) are requested to attend the EMSCCC to support the Duty Control Manager (DCM) in and out of hours. The EMSCCC Managers routinely attend the EMSCCC during significant escalation periods when they are on duty in hours. Out of hours the on call senior managers for EMSCCC and Ambulance Response are not mandated to attend the EMSCCC and remain on-call and available 24/7 for support and intervention where necessary.* *On the extremely rare occasions that any of these managers do not respond in or out of hours, there is a command structure available at all times within the Trust for escalation at the time to the next more senior commander. Any absence of a response is reported to the relevant member of the Senior Operations Team who will follow up with the individual involved.* *Since the review took place the pilot of the Operational Delivery Unit (ODU) commenced which provides extended hours of support for service delivery within the Trust and across the broader health system. It has been able to support the EMSCCC in some of the activities which previously needed a Tactical Commander to enable. This reduced the reliance on in and out of hour's commanders.* ***Updated 24/10/22: The ODU have operated on a 24/7 365 basis for the last 12 months and provides tactical coverage for the Trust across Wales supported where required***	Q3 20/21 **Completed 20/21**	Jonathan Edwards	Complete

		by tactical Commander for operational areas and supporting the 24/7 Strategic Commander. Commissioners have committed on permanent funding of the ODU.			
7	Continue discussions with Welsh Government to agree an appropriate Non-Send process, for low acuity patients during times of high demand on the service.	**Non-Send processes are now included with the DMP Action cards in place within WAST.** *Since the review took place, and as part of our preparations for the Covid-19 response, a revised Demand Management Plan (DMP) was introduced to include a non-send process. The plan has been extended from 4 to 8 levels with a scale of non-send commensurate with the demand and capacity presenting. It commences with a non-send process for the lowest of acuity, extending through to a process where ambulances might be reserved for only confirmed life threatening cases. Whilst a patient might not receive an ambulance response if non-send was invoked, we would signpost a caller according to their presentation. This was approved by Trust Board and was shared with Welsh Government.* *A key enabler for non-send are alternative patient focussed pathways. The Trust will continue to work with Health Boards to mobilise such pathways and pathway opportunities, for example through the recent release of the Consultant Connect technology.* ***Update 24/10/22: The CSP has changed the nomenclature from No Send to Can't Send reflecting that this is not a Trust decision not to send, but moreover reflective of the demand and capacity pressures, which means that difficult decisions have to be made around prioritisation based on the current system pressures.***	Q4 19/20 **Completed Q4 19/20**	Lee Brooks	Complete
8	Consider how it can engage further with the public to provide additional education and awareness on the	**Action 8.1: Further develop alongside Welsh government a national campaign to influence behaviour change.**	Q3 20/21 **Completed Q1 21/22**	Lee Brooks	Complete

	appropriate use of the emergency ambulance service.	**Action 8.2: Deliver further online events with the public which describe how we operate and appropriate use of the EMS service. Encouraging use of other services which can support people, including NHS 111 Wales, its website and online symptom checkers.** **Action 8.3: Launch a community participation network which will receive and disseminate information on key information and updates from the service. This network will receive and disseminate information on key information and updates from the service, as well as allowing members of the public to have their voices heard and be involved in shaping future service design and delivery.** **Action 8.4: Develop and disseminate an educational video aimed at a younger audience regarding the EMS service and appropriate use of it.** *Educating the public about the appropriate use of the ambulance service is a year-round objective for the Communications Team and Patient Experience and Community Involvement Team. A concerted effort to engage with the public on this subject is made over the busy winter months, and the Trust is working with Welsh Government to influence and develop a new, national campaign to effect behaviour change in this area.*			
9	Work with EMSCCC staff to explore well-being initiatives which could provide on duty support to staff and processes to improve attendance at work.	**Action 9.1: Wellbeing workshops are to be arranged for EMSCCC teams. These will focus on developing resilience in terms of sound foundations of good mental health.** **Action 9.2: The Health and Wellbeing Strategy is currently in consultation phase and a EMSCCC specific focus group will be convened to further develop the EMSCCC contribution to that strategy** **Action 9.3: Provide an awareness film for EMSCCC colleagues on muscular-skeletal injuries and how best to prevent them in the workplace.**	Q4 20/21 **Completed Q3 20/21**	Jonathan Edwards	Complete

Action Plan: Welsh Ambulance Service Trust - Local Review 2019-2020

		The Trust places a significant emphasis on the well-being of our colleagues. The following initiatives and actions are already in place and will continue: *• Provision of counselling during periods of high pressure.* *• Trauma Risk Incident Management (TRIM) referrals following complex and / or traumatic incidents.* *• Virtual and face-to-face drop in sessions to offer sign posting and awareness of the full organisational wellbeing offer. When and/ or if it becomes possible to conduct face to face drop in sessions then the plan is that this will be provided on site.* *• Mental health awareness training has been made available across the organisation and further training is planned in line with the strategy proposals and this will be included at induction for new members of staff following a review of the induction period.* *• In relation to physical wellbeing then health surveillance has commenced with skin surveillance and will expand to other areas including hearing checks in the near future.* *• The Trust have two physio providers and can fast track physiotherapy appointments and advice. Video guides for stretch and movement breaks to reduce MSK tensions and stresses are also available and wellbeing are able to signpost to these.* ***Updated 24.10.22: The Trust have commissioned a range of wellbeing activities to support staff, including the provision of 'Zen rooms' that provide a safe space for EMS CC staff to come out of the Operational environment and relax. This is just one of many initiatives the Trust have invested in recent years, alongside the Occupational Health Unit proactive activity.***			
10	Ensure robust workforce planning arrangements are in place which set out to mitigate against under resourced shifts, as well as	**Action 10.1: A CCC workforce plan is to be developed and maintained to align the needs and priorities of the organisation with those of our workforce to ensure we can meet service and production requirements and organisational objectives.**	Q3 20/21 **Completed Q3 20/21**	Jonathan Edwards	Complete

	to reduce the reliance on overtime.	**Action 10.2: We will ensure that there are sufficient plans in place for recruitment of staff to meet expected attrition and to ensure that the staffing levels do not drop to those which were being experienced during the review period.** *Since the review took place the Trust has completed a recruitment process which has provided sufficient staff to meet establishment levels. This has removed the vacancies which were impacting on the positions noted and reduced much of the reliance on overtime.* *As part of regular weekly operations the Area Manager, EMSCCC conduct twice weekly reviews of staffing levels in each of the EMSCCCs with the EMSCCC Centre Mangers in order to optimise staffing levels for each role and ensure as far as possible each position is covered by regular or relief staff.* *Since the Pandemic has required additional resource to meet the surge in demand a large number of bank staff are more readily available to meet any further temporary decreases in staffing levels for 999 Call Handlers and these can be called upon to fill gaps. The organisation's approach to covering vacant shifts however supports overtime being used before bank staff so this will not reduce the reliance on overtime*. ***Update 24.10.22: A formal establishment monthly review of recruitment is carried out by the Head of Service with the Assistant Director of Operations to review the workforce plan. This is also escalated on a monthly basis to the Executive Director of Operations. Any specific issues are fed through to Executive Management Team through the Senior Leadership Team meetings. This factors in internal and external attrition are assessed and People Services support with external recruitment campaigns***.			

Action Plan: Welsh Ambulance Service Trust - Local Review 2019-2020

11	Complete its review of the welfare call process and consider how funding can be made available to increase staffing to support this.	**Action 11.1: Work with Health Informatics (HI) colleagues to refresh analysis around welfare call demand based on new guidelines and utilise data to inform future workforce planning considerations.** *Since the review took place the requirement for welfare calls was reviewed by the Trust and updated to adjust the frequency of calls in line with the acuity of the patient. As such the requirement for the number of staff to complete welfare calls has reduced since it was earlier evaluated.* *Dispatchers and 999 Call Handlers (both staff are qualified as Emergency Medical Dispatchers, which is the qualification required to handle 999 calls and therefore carry out welfare checks) both perform welfare checks, though the Call Supervisors now monitor the waiting queue and allocate welfare calls to Call Handlers whenever available reducing the demand on Dispatchers to undertake this role.* *As part of the CAD Phase 3 project, which also supports the outcomes of the broader Emergency Medical Service Demand and Capacity Review, we are looking at the roles of all staff and we will calculate the amount of time required to perform welfare checks and at which times they are required (as they fluctuate increasing during period of longer patient waiting times) in order to be better prepared to request funding for the welfare check calls to be carried out in line with the recommendation.* ***Update 24.10.22: Welfare checks are part of the role of Dispatcher. Within the EMS Coordination Reconfiguration Project the need to maintain additional capacity to carry out tasks such as welfare calls to patients have been factored into the long term structures.***	Q3 20/21 **Completed Q3 20/21**	Lee Brooks	Complete
12	Review current duties of EMSCCC staff to determine where responsibilities can be streamlined.	**Action 12.1: Continue with the work of the CAD Phase 3 project to realign workloads within the EMSCCC for more efficient operation.**	Q4 20/21	Jonathan Edwards	**In Progress**

		CAD Phase 3 was renamed CCC Reconfiguration and recommenced following response to Wave 2 of the Covid 19 pandemic. The model agreed by SOT in December 2019 was progressed with Job Evaluation work completed in Qtr 1 21/22 and review of these evaluations following engagement with EMT in Qtr 2 21/22 was completed. EMT supported the proposal but a financial investment of circa £750k recurring was required to deliver. *As a result of a challenging financial position a funding stream for this investment has not yet been identified and this remains a cost pressure for the organisation. As a result CCC reconfiguration cannot be delivered in it's entirety and instead the Project Board are now reviewing the PID and TOR to review was modernisation actions can be achieved without a revised structure.* *This action is tracked through the EMS Transformational Change board. The Operational Delivery Unit (ODU) has commenced internal discussions on which responsibilities may move to the ODU remit and away from the EMSCCC, however its continuation is subject to business case approval and financial resources.* *A trial has been conducted of a fleet and logistics desk within the EMSCCC environment to manage vehicle movements, breakdowns and other general logistics which is currently being evaluated for its effectiveness.* ***Update 24.10.22:** As noted above, the EMS Coordination Reconfiguration project has restarted and in this financial year (2022/2023) focuses on three distinct areas; 1. Roster Review for EMDs, 2. Boundary Changes (for dispatch), 3. Better ways of working. In addition, we continue to pursue the changes identified above that require a £750k investment however funding support for this is contingent on external investment which in the current economic climate is difficult to secure.* ***Update 19.06.23: The EMS Configuration Programme recommenced in Q1 2023 following being paused due to Industrial Action and Operational Pressures. Roster***			

		Review of call takers is complete. The realignment of boundaries aspect of this work, which provides the necessary re-alignment of workloads has commenced and engagement with staff had taken place prior to the pause. This work has re-commenced and is currently waiting on a refresh of the data to finalise discussions with staff and Trade Union Partners.			
13	Explore other options available for a sustainable process for welfare check calls.	**A review of the triggers and actions associated with Welfare checks were undertaken with supported timescales agreed with CPAS** *As the welfare check call may require a re-triage of the patient, only qualified Emergency Medical Dispatchers (EMD) licensed to use the MPDS triage system can make the calls (999 Call Handlers and most Dispatchers are qualified). Call Handling Supervisors now monitor the waiting queue and allocate welfare calls to call handlers whenever available reducing the demand on Dispatchers to undertake this role.* *Reducing patient waiting times has the most significant impact on the requirement to make welfare calls and the Trust continues to work with Health Boards to examine ways in which delays handing over patients at hospital can be reduced which frees up resources to respond in a timely manner. See other action items.* ***Update 24.10.22: As noted above Dispatchers are carrying out the welfare callers, which is overseen by Call Taking Supervisors.***	Q4 19/20 **Completed Q4 19/20**	Lee Brooks	Complete
14	Review the process in place to allow staff to submit views and suggestions relating to the service. The process should consider and acknowledge suggestions received by providing feedback to staff.	**Action 14.1: The Trust has a mature and developed approach to enabling colleagues to share suggestions and views. Local measures in place include a dedicated email address for suggestions and quarterly open forums with senior managers.** *Additionally the EMSCCC actively utilises and supports the WAST Improvement and Innovation Network (WIIN). This is a cross-directorate network, with a Trust-wide membership supported by a steering group whose remit includes, but is not limited to, improvement and innovation, change management, service improvement and quality*	Q4 20/21 **Completed Q4 20/21**	Jonathan Edwards	Complete

		improvement. The purpose of the WIIN is to support colleagues with their ideas to make improvements and be innovative, offering guidance and support with Clinical Audit, Research, Quality Improvement and projects that require a more 'formal' approach which sit within the Project and Programme Management Framework. *The existing process will be reviewed on a cross-Directorate basis to ensure that that the arrangements give due consideration to all suggestions and provide staff feedback.*			
15	Ensure that staff are provided with the opportunity to contribute their opinions into the ongoing structure and resource review, and that these reviews are considered.	**Engagement and co-design was built into the CAD Phase 3 project and evidence of engagement sessions recorded** *The engagement and co-design phase of the structure and resource review (part of CAD Phase 3) concluded in December 2019. This phase of the project involved 9 virtual engagement sessions and 18 face-to-face roadshows and workshop sessions. This was supplemented by a dedicated Facebook group, letters to individual staff members, dedicated noticeboards and video messages.* *The dedicated email group and Facebook site continue to be available for staff to contribute views, opinions and ideas. This is of course supplemented by engagement and dialogue locally through management teams.* *The Organisational Change Policy shall be applied at the necessary times requiring consultation with staff about structural change.* ***Update 24.10.22: Staff are provided with an opportunity to engage with change processes and representatives from each centre sit on the EMS Coordination Reconfiguration Project Board as well as Trade Union Partners. For the Roster Review for example, Staff will be engaged with engagement events to ensure they understand the options being put forward and have a say in selecting (voting) for the roster they want to work on.***	Q3 19/20 **Completed Q3 19/20**	Lee Brooks	Complete

Action Plan: Welsh Ambulance Service Trust - Local Review 2019-2020

16	Consider a holistic review with stakeholder engagement, of the current handover arrangements in place, which should include current escalation arrangements during periods of high demand.	**Action 16.1: Continue to support local improvement initiatives such as the POD within Aneurin Bevan.** **Action 16.2: Continue to develop the Operational Delivery Unit business case to ensure support from the Commissioner and Welsh Government to address the flow concerns on a 24/7/365 basis.** **Action 16.3: Develop a communications plan to share with staff what actions are being undertaken to address the issue.** *The Trust continues to work with Health Boards and other stakeholders to address the concerning number of resource hours lost to delayed handovers at emergency departments in a collaborative fashion recognising this issue as a system wide concern.* *Specific actions include regular engagement at the most senior levels and the Emergency Ambulance Service Commissioner to discuss the impact of delays and a collaborative approach to their reduction.* *The Trust continues to work locally with Health Boards on unique approaches to resolve flow concerns at Emergency Departments (ED) for instance with Aneurin Bevan in staffing a patient care department (the POD) outside the ED.* *The Trust continues to pursue the funding for the Operational Delivery Unit (ODU), a hosted, all systems approach to ensuring flow of patients to and through emergency departments. In March 2020, WAST commenced a pilot of the Operational Delivery Unit (ODU) with two clear operating functions:* *• To provide senior leadership capacity to effectively manage and mitigate the pressure and risk across the Unscheduled Care System; and* *• To provide robust senior operational management support to mitigate on the day performance or service delivery challenges (including hospital handover issues).*	Q3 20/21 **Completed Q3 20/21**	Lee Brooks	Complete

		The pilot has been achieved through a hybrid of seconded and redeployed staff, neither of which is unfortunately sustainable beyond August 2020. A business case has been prepared to fund the ODU on a permanent basis. ***Update 24/10/22: The ODU has been successfully operating on a 24/7 365 basis for the last 12 months and provides that constant link between HB and hospital sites to ensure that patient flow and Ambulance demand is factored into the movement of patients. The POD at Aneurin Bevan is no longer provided. The Trust has instead deployed alternative cohorting models at The Grange Hospital and Morriston Hospital. Following evaluation this model was discontinued as it was not proven to be effective. The organisation continues to provide a monthly WAST Live. This allows any staff members to ask questions of the Executive Management Team and the session includes the opportunity for key messages to be shared with staff. The Trust has also just completed its third round of CEO Roadshows. This occur six monthly and are staff engagement sessions. The issue of hospital handover delays and the actions the Trust is taking are routinely covered, however additional information was shared in the October 2022 series of roadshows***.			
17	Implement a training strategy which ensures that staff are provided with the appropriate training and development, to enable them to undertake their relevant roles effectively. Progress against the strategy should also receive Trust Board oversight.	**Action 17.1: Continue to pursue the formalisation of the two EMSCCC training roles to further deliver the Dispatcher and Allocator role training courses.** **Action 17.2: Introduce dispatch training course for all new appointments into dispatch and allocation roles and schedule any update training for all dispatchers and allocators currently in post.** *Initial induction and training for entry into EMSCCC forms part of an existing and established scheme of work with signed off competencies and assessment in line with corporate induction, mandatory training and International Academy of Emergency Dispatch (IAED) requirements in 999 Call Handling.*	Q4 20/21 **Completed Q2 22/23**	Jonathan Edwards	Complete

		Prior to the HIW review being undertaken a member of the EMSCCC team was seconded into the role of Training Manager and over the subsequent months (finalised after the review) has created a formal Dispatcher and Allocator training programme with a record of competencies. The classroom based course has been created and piloted and includes live exposure with a mentor with sign off to agreed competencies and assessment. *Internal funding has been previously realigned to provide 2 FTE positions to deliver training courses, specifically dispatching and allocating. EMSCCC is progressing the job descriptions through internal evaluation and consistency checking processes and once complete intends to recruit into these positions to support the delivery of the standard dispatcher and allocator training course.* *Each of the Duty Control Managers (DCM) has been enrolled on an Institute of Leadership and Management (ILM) training course and we will continue to provide this opportunity to all future staff in this role.* *Finally across the CCC environment (EMS and 111), in conjunction with Health Education and Improvement Wales (HEIW), CCC has explored opportunities for education and accreditation against competencies, specifically focussed on remote clinical decision making and telephone triage for clinical and non-clinical roles.* **Action 17.3: Continue to engage with HEIW to develop an accredited programme of education focussed on clinical and non-clinical remote decision making.** *WAST continue to engage with HEIW around this programme which was paused during response to the Covid 19 Pandemic. Quest approved an extension until Qtr 2 21/22 however this work is now being tracked under the Gateway to Care programme. Given that the action was to engage the recommendation is to close this action and cross reference to the gateway to care programme for future monitoring.*			

		Update 24.10.22: As noted there has been significant progress on the first two actions with a Training Manager and 2 trainers appointed. Dispatch Training is now offered. 17.3 is now reinstated and will be owned by the 'Gateway to Care' programme.			
18	Ensure sufficient time is permitted to allow for appraisal discussions between managers and their staff to take place.	**Action 18.1: Work with DCMs to ensure existing time for protected appraisal discussions is utilised effectively and scheduled in advance or look for a more appropriate way that appraisals can be carried out.** *Existing time was already available within rostered training provision. There is ongoing work on an EMS-C roster review that could incorporate protected time to undertake PADR's. Due to the operational pressure and high level of escalation in operation between August 21 and Jun 22 this time was realigned to support operational service delivery. This has impacted on the capacity to undertake PADR. An action plan is now in place to ensure all EMS Coordination teams have received a quality PADR in the next 6 months. Administrative support teams are now tasked with scheduling these appointments to ensure timely PADR and 6 monthly reviews are completed. PADR compliance is currently 59.61% (excluding those with open sickness absence) having improved from 27.27% as of 1st April 2022 with a trajectory for completion by September 2022.*	Q3 20/21 **Completed Q3 22/23**	Jonathan Edwards	Complete
19	Ensure training is provided to relevant staff in regards to the annual appraisal process.	**Action 19.1: Develop and trial an EMSCCC specific appraisal process to ensure that staff receive the appropriate developmental discussion.** *Development of the EMSC trial has been completed with support from WOD and appropriate templates and training provided. Learning from this pilot is now informing a wider organisational review of PADR processes.*	Q4 20/21 **Completed Q2 22/23**	Jonathan Edwards	Complete

		Action 19.2: Workforce & Organisational Development team to assess the training needs of first line managers within EMSCCC to support their delivery of effective and meaningful PADRs. *A training needs assessment has been carried out through engagement with the Workforce and Organisational Development team, which resulted in a bespoke training package that has been developed and completed. Through this work in EMS-C wider change across the organisation has also taken place in terms of PADR delivery.*			
20	Consider benchmarking with the International Academy of Emergency Dispatch, to identify best practice for supporting and monitoring EMSCCC staff to explore options of improving the existing arrangements.	**WAST is an ACE accredited centre and regular benchmarking exercises are undertaken to support and maintain this position.** *In line with the IAED requirements to maintain Accredited Centre of Excellence (ACE) status in 999 call handling and triage, which the Trust holds nationally across all three EMS Clinical Contact Centres, a percentage of all 999 calls are audited routinely. To attain accreditation as an ACE centre the Trust must provide evidence of compliance scores monthly and provide 6 months of audits for quality assurance by the IAED to recertify every 2 years. Both the quantity and quality arrangements are set down by the IAED.* *In addition to the routine audits, additional calls associated with patient care concerns or areas of focused improvement for call handlers are also audited. All EMDs receive a minimum of 5 call audits a month and receive feedback on all those audits in various media with feedback documents being provided by email. Where evidence of required learning is identified feedback is provided face to face as are any audits related to concerns investigations. Our auditors undergo regular exercises supported by IAED to ensure consistency and best practice in audit.* *EMSCCC has an embedded and established process of recognition for high compliance to protocol standards as well as great customer service for 999 call handlers. In addition we monitor exemplary performance for nomination to national and*	Q4 20/21 **Completed Q4 19/20**	Lee Brooks	Complete

		international award ceremonies and have recognised several finalists for IAEDs 999 Ambulance Call Handler of the Year. ***Update 24.10.22: WAST continued to secure IAED accreditation and have a strong programme of audit in place to ensure that the quality and learning opportunities for EMDs are constantly available. The Audit and Training Units sit within the Service Manager Operations Quality portfolio that sits within the Resourcing and EMS Coordination Assistant Directorate Portfolio. There is daily interaction between the teams to ensure ongoing learning and support.***			
21	Consider how the EMSCCC working environments and IT equipment available can be improved to assist staff in carrying out their relevant roles as well as to improve staff well-being.	**Action 21.1: Complete the North Wales EMS CCC estate strategy and identify opportunities for improvements.** *Estates project reprioritised to focus on covid secure workplaces during Pandemic response. Whilst included within the Estates SOP this strategy work has not yet recommenced. This issue has been escalated and supported by the Operations Directorate Senior Leadership team and is currently supported by two corporate risks* ***Update 24.10.22:** A paper has progressed through Governance that sets out the Requirements for each of the EMS Coordination Centres. This now forms part of the Estates SOP. Progress has been made in Vantage Point House and Carmarthen to provide further space, which has proven effective. The North Centre remains at Bryntirion with options being explored across other parts of North Wales with the introduction of new ICT options that may provide a cost effective solution to moving staff from the existing site while retaining the network (Airwave) coverage. This is likely to be within the next 12-18 months.* ***Update 19.06.23: The Bryntirion site for EMSC in the North has been allocated some discretionary capital funding for this financial year to support some progress in this area. The project will likely span two years. In terms of the North Wales Estate (Bryntirion) initial work has started across departments to ensure that all elements of***	Q4 20/21	Jonathan Edwards	21.1 Not Actioned 21.2 Complete 21.3 Complete

		the work are mapped out and options are considered. There is a technological development (Airwave replacement) required to enable a full move out of Bryntirion. Early indication from the Ambulance Radio Programme (ARP) is that the roll-out of this technology is likely to be Q1 2024. In the interim senior managers are exploring the options to move those staff that can move out of Bryntirion. ***It should be noted that WAST have completed and rolled out the estates strategy in VPH with a view to progress plans with DPP for Llangunnor now to progress with the redevelopment of the ground floor. This is at design stage currently, but funding has been allocated from this year's discretionary capital budget to support this.*** **Action 21.2: Complete the return to the workplace review to ensure the maximum space is still provided in the medium term for clinicians to work remotely from the EMSCCC main spaces.** *A paper was approved through Senior Leadership Team and now forms part of the Estates Strategic Outline Plan. This focuses on increasing the capacity of all three sites to provide sufficient space to work from EMS Coordination Centres. Stephen Clinton as the ADO for Integrated Care is working with the Team to ensure that there is sufficient capacity for Clinicians to work at the three Centres. In addition, it is acknowledged that other facilities have also been created across the Estate to accommodate staff who want to work from WAST premises together with the capability of remote working that was expedited as part of the response to covid.* **Action 21.3: Undertake a review of opportunities to enhance the ICT equipment available to EMSCCC staff in order to assist colleagues to discharge their roles with greater efficacy and to enhance their wellbeing.** *The EMSCCC estate has seen some improvements since the review took pace including new staff rest and kitchen areas being provided in the North Wales EMSCCC. Additionally, motivated by the response to the pandemic the Trust has provided a*			

		significant number of laptops to enable CSD clinicians to work remotely including at home and in other areas of the Trust estate, including North Headquarters building. This has created space within all three EMSCCCs. *In response to the pandemic a new area in the Vantage Point House (VPH) building has been created for call taking capacity which allows all 999 and 111 Call Handlers to work away from the main joint CCC. This has created a significant amount of space in the main CCC. The team are currently reviewing the essential and non-essential activity that takes place in the main CCC to enable a more efficient layout which provides 2m distancing between each desk.* *Central and West EMSCCC has also acquired additional space in the building and desks have been removed from the main floor with 999 call handling staff working out of the room. This has created capacity and shortly the remaining desks will be moved to a new layout to facilitate 2m distancing. All changes to layout are intended to be permanent.* *In the longer term the Trust is reviewing an ongoing Estates Strategy which relates to the provision of a long term approach to housing current and future needs of the CCCs (EMS and 111).*			
22	Ensure that consideration is given to improving senior management availability and presence within the EMSCCC 24 hours a day.	**It is not possible to provide senior management availability across 3 sites within the existing management team but on call arrangements supported by development of the ODU provide escalation and support pathways for EMSCCC 24 hours a day.** *EMSCCC operate a CCC Tactical Advisor on-call to provide senior leadership support and guidance to EMSCCC remotely outside of normal operational hours. EMSCCC managers are situated on site during the in hours period.* *The Trust continues to pursue the funding for the Operational Delivery Unit, a hosted all systems approach to ensuring flow of patients to and through emergency*	Q4 19/20 **Completed Q4 19/20**	Jonathan Edwards	Complete

		departments with the ultimate aim of ensuring ambulance availability for calls in the community. (This action is included in another section of this response). ***Update 24/10/22: As noted above, the ODU has been successfully operating on a 24/7 365 basis for the last 12 months and provides that constant link between HB and hospital sites to ensure that patient flow and Ambulance demand is factored into the movement of patients***.			
23	Ensure adequate arrangements are in place to encourage staff where required to speak up regarding their personal concerns, particularly in relation to bullying, harassment or abuse.	**Action 23.1: Develop in collaboration with Board Secretary, Workforce and Organisational Development (WOD) and Trade Union Partners a poster campaign promoting the All Wales Raising a Concern policy to further reinforce the position.** *EMSCCC senior managers are committed to a programme of work to establish an open culture of dignity and respect within the CCC environment. Annual HSE stress risk assessments allow staff to identify any issues through anonymous surveys and access to senior managers. During 2019 a programme of engagement was completed with support from WOD experts and an external clinical psychologist to allow staff to identify issues around these factors and other stressors in the workplace environment.* *The Trust utilises the All Wales Raising a Concern Policy for reporting of issues of concerns including bullying and supports anonymous reporting 'whistleblowing' through this policy and this was recently promoted within the Trust. Staff have already been provided with a refreshed copy of the EMSCCC Code of Conduct including specific reference to Dignity at Work and descriptors of bullying and harassment as indicated in the All Wales policy.* **Update 24.10.22: the Trust carried out its Culture and Behaviours work over the last 12 months with Honne. A EMS Coordination Action plan has been constructed with buy in from managers across the centres to 'own' the plan and the actions therein.**	Q3 2020-21 **Completed Q3 20/21**	Lee Brooks	Complete

		Workshops have been carried out with Workforce and Organisational Development on a Pan Wales and Localised (Centre) basis to support the work.			
24	Ensure that engagement is improved between operational staff and the Trust senior management team working within the organisation.	**Action 24.1: Communicate schedule of engagement events for the coming year and review opportunities to engage through digital formats in the Covid environment.** *EMSCCC have an action plan of engagement with staff to improve visibility including a programme of workshops specifically designed to maximise exposure across the pan-Wales staff group with the senior management team. The first of these engagement sessions was completed in October 2019 and the second, which was due to take place in April 2020, was postponed due to the pandemic.* *The Area Manager for EMSCCC completes quarterly open forums for staff to engage directly about issues and concerns and to allow an opportunity to communicate current strategies for development within EMSCCC. The action plan also includes actions for the EMSCCC management team to schedule operational duties within EMSCCC to allow informal engagement and access to the management team. In addition the Trust operates a closed Facebook group where staff can share information with managers and raise questions and concerns, as well as opportunities to engage with the executive team via Facebook Live/Zoom engagement events chaired by the Chief Executive.*	Q2 2020-21 **Completed**	Jonathan Edwards	Complete
25	Reassess current risk assessment documentation in relation to EMSCCC staff training, to ensure sufficient actions and mitigations have been implemented.	**Action 25.1: A review of the risk relating to staff training (E-risk ID 119) will be undertaken to ensure the mitigating actions are sufficient and are progressed.** *EMSCCC utilises the Datix system in the Trust for reporting, reviewing and escalating risks at a departmental, directorate and organisational level. The EMSCCC leadership team undertake a review of any new or emerging risks as well as the highest rated risks during monthly business meetings and the senior leadership team undertake a*	Q3 2020-21 **Completed Q3 20/21**	Jonathan Edwards	Complete

		review with the Assistant Director of Operations (Resourcing and EMS Coordination) as part of regular business meetings. *The Assistant Director Leadership Team (ADLT) review organisational risks and recommend inclusion on the corporate risk register prior to approval by the Executive Management Team.* *The risk register in place contains a detailed description of the risks identified, an assessment of the risk and an initial risk rating as well as considering the level of assurance of internal controls related to the risk and monitoring arrangements. In order to provide a high level summary EMSCCC also have a dashboard to graphically represent the status of current risks and the register (corporate, directorate or local) in which they sit.*			
26	Ensure that clear guidance and training is provided to staff for reporting incidents.	**Action 26.1: Develop and issue guidance specifically focussed at EMSCCC staff about what, when and how to report an adverse incident including guidance for managers on ensuring feedback is completed.** *Staff within the EMSCCC compete Datix incident reports regularly on a wide variety of topics however there are some instances where it has been identified that there may not be enough clarity on when to submit a Datix report. We will review the process and documentation to ensure there is more clarity. In particular we will expand that guidance to the management team to ensure feedback is provided to individual staff members*	Q2 2020-21 **Completed Q2 20/21**	Jonathan Edwards	Complete
27	Ensure that there is a suitable process in place to enable consistent incident reporting which includes feedback to staff.	The existing Datix system provides a suitable reporting system which includes a feedback route for staff. *Staff within the EMSCCC compete Datix incident reports regularly on a wide variety of topics however there are some instances where it has been identified that there may not be enough clarity on when to submit a Datix report. We will review the process*	Q3 2019-20 **Completed Q3 19/20**	Lee Brooks	Complete

		and documentation to ensure there is more clarity. In particular we will expand that guidance to the management team to ensure feedback is provided to individual staff members			

AGENDA ITEM No	**21**
OPEN or CLOSED	**Open**
No of APPENDIX	**1**

Committee Priorities and Cycle Monitoring Report

MEETING	Quality, Patient Experience and Safety Committee
DATE	31 October 2023
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Trish Mills, Board Secretary
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. This report updates the Committee on progress against the priorities it set for 2023/24 and progress against the agreed Cycle of Business for the Committee.

2. Progress is steady across all priorities and there is nothing to escalate on the cycle of business progress.

RECOMMENDATION

3. The Committee is asked to note the update.

KEY ISSUES/IMPLICATIONS

No issues to raise.

REPORT APPROVAL ROUTE

Not applicable.

REPORT APPENDICES

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)	Yes	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

COMMITTEE PRIORITIES & CYCLE OF BUSINESS MONITORING REPORT

SITUATION

4. This report updates the Committee on progress against the priorities it set for 2023/24 and progress against the agreed Cycle of Business.

BACKGROUND

5. During the course of the effectiveness reviews, it was agreed that it is good practice for Committees to set priorities for the forthcoming year. The Committee's priorities, which are set out below, were agreed by the Trust Board in May 2023 and will be tracked quarterly.

6. The Committee's cycle of business was approved by the Committee in May 2023. The agenda is set with reference to that Cycle, together with the Forward Planner, action log and highest rated principal risks.

7. The monitoring report is at Annex 1. Items in green show they are cycled for a particular meeting. Items in beige indicate they are a prompt at agenda setting as they may be ad hoc items such as business cases or external reports. The blue indicates that the item is either on the agenda as scheduled or is an ad hoc item which was discussed in agenda setting.

ASSESSMENT

8. The Committee priorities, and progress against them is as follows:

Priority	Progress
a) Committee will monitor implementation of the Duty of Quality and Duty of Candour following the Health and Social Care (Quality and Engagement) (Wales) Act ('Act') coming in to force in the Spring of 2023; and	• A report was received at the Committee meeting in August. At this meeting the Committee noted that this business would be cycled as required. • An update report is scheduled for receipt and discussion at the October Committee meeting (and will be cycled into each meeting of the Committee as required). • The October update will provide the status of the Welsh Government (WG) gateway report and provide an indicator on the quality strategy implementation.

b) Implementation plan for the quality strategy.	• At the August Committee meeting it was noted that the Quality Strategy Implementation Strategy will be received in Q3 (the November 2023 Committee meeting). • The October Committee will receive an update on the Duty of Quality implementation and will receive an update on the status of the WG gateway report - which will provide an indicator on the quality strategy implementation.

9. The Committee is reminded that work is going to address potentially duplicative reporting in the monthly MIQPR and quarterly patient safety and quality assurance reports, and work is ongoing throughout 2023.

RECOMMENDATION

10. The Committee is asked to note the update.

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	
Putting Things Right 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	Included in DoQ/DoC report in November
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	Commissioned for 31.10, then agreed to defer to Feb 2024.
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	QIAs on NEPTS eligibility & Decommissioning of F&R service first responders Oct
External and/or peer reports	Various	Ad Hoc					Relevant Director	Assurance	Two HIW updates in August
Annual Mental Health Report	CQGG	Annually					EDQN	Assurance	Annual report in October meeting
Annual IPC report	CQGG	Annually	→				EDQN	Assurance	Deferred from May and presented in August
Annual safeguarding reports	CQGG	Annually	→				EDQN	Assurance	Deferred from May and presented in August
Referrals from PCC	PCC	Ad Hoc					Relevant Director	Discuss/Assure	
Clinical audit plan	CQGG	Annually					DP	Approval	Approved in May
Monitoring report on clinical audit	CQGG	Quarterly					DP	Assurance	
Spotlight On clinical indicators	CQGG	Quarterly					DP	Assurance	Started in August
Mortality Report	CQGG	Bi-annually					EDQN	Assurance	Reported in May as cycled
Meds management report	CQGG	Annually					DP	Assurance	
PECI report	TBC	Bi-annually					EDQN	Assurance	Reported in May as cycled
Patient story	N/A	Quarterly					EDQN	Assurance	
Patient story updates	N/A	Quarterly					EDQN	Assurance	
Information Governance Toolkit	IGSC	Annually	→				DD	Assurance	Reported in August
Information governance report	IGSG	Quarterly					DD	Assurance	Reporting started in August
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	Reported in August
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	Reported in May as cycled
Committee Cycle of Business monthly review	N/A	Quarterly					BS	Review	
Committee Review of Annual Priorities	N/A	Quarterly					BS	Review	Started in August as cycled
PROMPTS									
External Reports	N/A	Ad Hoc					Relevant Director	Varies	Ombudsman report in August
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

PATIENT STORY TRACKER
BETHAN HEWS

Bethan, an SPCT (WAST) Paramedic, working out of SBUHB responded to a patient in her early 60s diagnosed with metastatic bowel cancer. She had been referred to the SPCT for pain management. Her Advance Care Plan documented her preferred place of care and death was at home. As patient grew weaker, she was not able to swallow her painkillers consistently, she had been struggling to walk to the bathroom and had had a non-injury fall whilst trying to get to the toilet. She lived alone, and reluctantly, had agreed that it was time for her to go to hospital so that she could receive personal care from professionals, as well as better pain relief. WAST 999 called , whilst waiting for an ambulance call made to the CPCT Advice and Referral line to give an update on her situation. Bethan was available to make an immediate house call to assess the situation, her intervention meant that the patient received care in her own home, where she died with dignity and in comfort, surrounded by those most important to her, a couple of weeks later.

THEMES IDENTIFIED

- There would have been no clinical need for this patient to go to hospital, positive outcome with patient able to remain comfortable at home where she wanted to be at the end of her life.
- The value of the SPCT in reducing unnecessary admissions to hospital and freeing up ambulance resources.
- Value in seeing the patient as a whole , listening to their needs and providing patient centered care.

GOAL

- Patients seen by SPCT Paramedic remain in their own care setting avoiding 999 and hospital admission.
- Deliver a more responsive model, providing urgent assessment of patients, reducing the burden on other HCPs and admission avoidance.

PRIMARY DRIVERS

- Expand SPCT Paramedic team to facilitate an 8 - person rota with an additional Advanced Palliative Paramedic Practitioner.

SECONDARY DRIVERS

- Improve service efficiency

ACTIONS

- Capture experiences of palliative care/end-of-life patients. (EOLc)
- Continue, grow, expand and review collaboration with SBUHB on SPCT Paramedics.

RESPONSIBILITY FOR ACTIONS

- Clinical practice leads across WAST & SBUHB to review role of SPCT paramedics and identify opportunities for other areas of clinical practice that can have the same mutual benefits.
- PECI Team to work closely with EOLc Palliative Care Group on roll out of the national EOLc survey ensuring opportunities for WAST inclusion.

PROGRESS

- End of Life patients are being engaged to capture their experiences of palliative care/end-of-life teams.
- The EOLc experience survey is on civica and sits on NHS HBs & WAST platforms.

OUTCOME

- Phase 1 started, HBs identifying patients to participate. WAST likely take part in phase two when the survey is rolled out to include hospices/ care homes. Still need to resolve IG issues on surveying patients contacting 999.
- Patient's wishes can be met, and they can die with dignity and comfort in their own home.

Story action timeline



Updated 17 October 2023 v2