Bundle Quality, Patient Experience and Safety Committee 10 November 2022

Agenda attachments

ITEM 0 Open Quest Agenda - 10 November 2022.docx

0 09:30 - OPENING ITEMS

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

2 Minutes of last meeting

ITEM 2 QUEST OPEN MINUTES 11 August 2022 (002).doc

3 Action log and matters arising

ITEM 3 Action Log.docx

ITEM 3.1 Position statement Action F&P 121-22.docx

ITEM 3.2 Position statement 50-21a.docx

4 09:40 - Operations Directorate Quarterly Report Q2 2022/23

ITEM 4 Operations Quarterly Report for Committees 22-23 Q2 (Oct22) Reframed FINAL.docx.pdf

4.1 ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION

5 09:50 - Patient Experience

6 10:10 - Risk Management and Board Assurance Framework Report

ITEM 6 Executive Summary Risk Management Report QuEST 101122.docx

7 10:20 - Monthly Integrated Quality Performance Report

ITEM 7 MIQPR SBAR September 2022.docx to QUEST.docx

ITEM 7.1 Annex 1 MIQPR September 2022 .pptx to Quest.pdf

8 10:40 - Patient Safety Report Q2 2022/23

ITEM 8 Exec. Summary Patient Safety Report Quarter 2 (July - Sep 2022).docx

8.1 10:55 - COMFORT BREAK – 10 Mins

9 11:05 - Audit Wales - Review of Quality Governance Arrangements

ITEM 9 Executive Summary Audit Wales Quality Governance Review.docx

ITEM 9.1 Appendix 1 Audit Wales Report.pdf

10 11:25 - Health Inspectorate Wales Annual Report 2021-2022

ITEM 10 Executive Summary HIW Review.docx

ITEM 10.1 Appendix 1 HIW Annual Report 2021-2022.pdf

11 11:35 - Patient Experience and Community Involvement Quarterly Report.

ITEM 11 PECI Quarter 2 Report (July - September).docx

ITEM 11.1 Appendix 1 PECI Highlight Report July - Sept 22 (final).pdf

12 11:50 - Safeguarding Annual Report

ITEM 12 NHS Wales Safeguarding Network Annual Report 2021-22_ENG.pdf

13 12:00 - Dementia Update

ITEM 13 Executive Summary Dementia Update.docx

14 12:10 - Internal Audit Tracker Report

ITEM 14 Executive Summary QuEST - Internal Audit Report 101122.docx

15 12:20 - Joint Investigations Pilot

ITEM 15 Joint Investigations Pilot Process - FINAL.docx

ITEM 15.1 Joint Investigations letter.pdf

ITEM 15.2 Supporting Section X - joint investigations.docx

ITEM 15.3 DRAFT Joint Safety Incident Review Meeting - All Wales agenda template.docx

ITEM 15.4 Patient Safety Incident requiring joint review - form.docx

15.1 12:35 - 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.

16 Patient Story Driver Diagram

ITEM 16 Matt James Story_driver-diagram update September 2022.png

17 Committee Priorities Q3 2022/23

ITEM 17 Quest Committee Priorities November 22.docx

17.1 12:40 - CLOSING ITEMS

18 Key Messages for the Board

19 Any other business

16 November 2021

20 Date and time of next meeting: 9 February 2023 at 09:30

MEETING OF THE QUALITY, PATIENT AND SAFETY EXPERIENCE COMMITTEE

Held on 10 November 2022 from 09:30 to 12:45
Meeting held virtually via Microsoft Teams

AGENDA

No.	Agenda Item	Purpose	Lead	Format	Time
OPENING ITEMS					
1.	Chair's welcome, apologies, and confirmation of quorum	Information	Bethan Evans	Verbal	10 Mins
2.	Minutes of last meeting	Approval	Bethan Evans	Paper	
3.	Action log and matters arising	Review	Bethan Evans	Paper	
4.	Operations Directorate Quarterly Report Q2 2022/23	Discussion	Lee Brooks	Paper	10 Mins
ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION					
5.	Patient Experience	Information Discussion	Leanne Hawker	Verbal	20 Mins
6.	Risk Management and Board Assurance Framework Report	Assurance	Julie Boalch	Paper	10 Mins
7.	Monthly Integrated Quality Performance Report	Assurance	Rachel Marsh	Paper	20 Mins
8.	Patient Safety Report Q2 2022/23	Assurance	Wendy Herbert	Paper	15 Mins
COMFORT BREAK – 10 Mins					
9.	Audit Wales - Review of Quality Governance Arrangements	Assurance	Liam Williams	Paper	20 Mins
10.	Health Inspectorate Wales Annual Report 2021-2022	Assurance	Liam Williams	Paper	10 Mins
11.	Patient Experience and Community Involvement Quarterly Report.	Assurance	Leanne Hawker/ Liam Williams	Paper	15 Mins
12.	Safeguarding Annual Report	Assurance	Nikki Harvey	Paper	10 Mins
13.	Dementia Update	Assurance	Liam Williams	Paper	10 Mins
14.	Internal Audit Tracker Report	Assurance	Julie Boalch	Paper	10 Mins
15.	Joint Investigations Pilot	Assurance	Liam Williams	Paper	15 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.					
16.	Patient Story Driver Diagram	Information	Leanne Hawker	Paper	5 Mins
17.	Committee Priorities Q3 2022/23	Information	Trish Mills	Paper	
CLOSING ITEMS					
18.	Key messages for Board	Discussion	Bethan Evans	Verbal	5 Mins
19.	Any other business	Discussion	Bethan Evans	Verbal	
20.	Date and time of next meeting: 9 February 2023 at 09:30	Information	Bethan Evans	Verbal	

Lead Presenters

Name	Position
Julie Boalch	Head of Risk/Deputy Board Secretary
Lee Brooks	Executive Director of Operations
Bethan Evans	Non Executive Director
Nikki Harvey	Head of Safeguarding
Leanne Hawker	Head of Patient Experience & Community Involvement
Wendy Herbert	Assistant Director of Quality & Nursing,
Rachel Marsh	Director of Strategy, Planning and Performance
Trish Mills	Board Secretary
Leanne Smith	Interim Director of Digital Services
Andy Swinburn	Director of Paramedicine
Jonathan Turnbull-Ross	Assistant Director of Quality Governance
Liam Williams	Executive Director of Quality and Nursing

WELSH AMBULANCE SERVICES NHS TRUST

UNCONFIRMED MINUTES OF THE OPEN SESSION OF THE MEETING OF THE QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE HELD ON 11 August 2022 VIA TEAMS

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PRESENT:

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

IN ATTENDANCE:

Julie Boalch	Head of Risk and Deputy Board Secretary
Lee Brooks	Executive Director of Operations
Leanne Hawker	Head of Patient Experience and Community Involvement
Wendy Herbert	Interim Director of Quality and Nursing
Peter Hindley	Community Health Council
Carol Jones	Emergency Department Matron, Betsi Cadwaladr University Health Board
Sian Jones	Care Experience Manager, Betsi Cadwaladr University Health Board
Alison Kelly	Business and Quality Manager
Sue Last	Member of the public (Patient Experience)
Dr Brendan Lloyd	Executive Medical Director
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Trish Mills	Board Secretary
Steve Owen	Corporate Governance Officer
Hugh Parry	Trade Union Partner
Duncan Robertson	Assistant Director of Research, Audit and Service Improvement (North)
Chris Scott	Audit Manager
Leanne Smith	Executive Director of Digital Services
Andy Swinburn	Director of Paramedicine
Jonathan Turnbull-Ross	Assistant Director of Quality Governance
Liam Williams	Executive Director of Quality and Nursing

Apologies:

Angela Roberts	Trade Union Partner

31/22 PROCEDURAL MATTERS

The Chair extended a warm welcome to everyone. In particular, Liam Williams, the newly appointed Executive Director of Quality and Nursing, Carol Jones and Sian Jones from Betsi Cadwaladr University Health Board (BCUHB) and Peter Hindley from the Community Health Council and Sue Last who would be sharing her experience. Attendees were advised that the meeting was being audio recorded. Apologies were received from Angela Roberts, Trade Union Partner.

Minutes

The minutes of the meeting held on 12 May 2022 were confirmed as a correct record.

The action log was considered:

Action Number: 16/21 - To provide updates on the viability of CFR's to administer pain relief. Andy Swinburn advised there was no further update and agreed to provide an update at the meeting on 10 November 2022.

Action Number F&P 1/21-22 – Quest was to undertake a focused review of performance related to clinical outcome metrics at their 17 February 2022 meeting. Duncan Robertson reported that the Clinical Intelligence and Assurance Group were conducting deep dive quality assurance audits on each of the clinical indicators. Learning in terms of improvements of the data quality within Electronic Patient Care Record (EPCR) have been identified. He explained there was still further work to be undertaken to consider other elements of the EPCR.

Comments:

1. It was queried whether EPCR would give the ability to input the reasons why the correct pathway was not achieved as in the past achievement of this has been poor. For example, would EPCR provide information on a patient with a fractured neck of femur where pain relief was not required or necessary? Duncan Robertson explained there were justified exceptions for clinical indicators. There were occasions where part of the care bundle would normally be expected to deliver but there may be an approved reason why it wasn't. He added that clinicians will be directed to be able to populate the clinical indicators correctly, this was part of the learning phase going forward.

2. The Committee wondered whether this was still the right action or should it be reshaped and have a clearer deadline. Duncan Robertson advised that the final audit will be available in September. It was a continually rolling programme and more time would be required to consider other areas within the EPCR which would be monitored through the Clinical Intelligence and Assurance Group. In terms of the action this will be updated as and when further information was available. Andy Swinburn stated that, EPCR will be a game changer – it would be useful for the Committee to be advised of activity regarding the data quality ensuring that progress was continually reported through to the Committee. He further commented that the main focus was on quality as opposed to pace, and agreed to bring an update to the next meeting in November. The Committee discussed this action in further detail and it was recognised it would be part of the Quest Committee cycle of business going forward.

3. Action Number: 50/21a - To provide an update on the ongoing work to improve functionality on the Website of symptom checkers etc... Leanne Smith advised this was ongoing work and a further update would be provided at the November meeting.

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4. Action Number: 17/22 - To provide feedback on discussions at the older people's steering group and on the collaboration with health board colleagues to improve the falls processes and procedures; and also for the steering group to discuss the use of Mangar chairs in the Community. Jonathan Turnbull-Ross explained that a new group had been formed and an update will be provided at the next Quest meeting.

5. Action Number 23/22a - To consider the practical elements of promoting and integrating the Quality Strategy into everyone's role be a topic of discussion on a future Board development day. To also focus on the duties as part of the compliance element for development. This action was marked as closed as it is referenced later on in the Agenda under 41/22.

6. Action Number 23/22b - To provide feedback in terms of how to improve and influence the strategy going forward. To include how the Trust was embedding quality into the roles of others, i.e. what were the practical steps being taken to achieve this? This action was marked as closed as it is referenced later on in the Agenda under 41/22.

RESOLVED: That

(1) the Minutes of the Open meeting held on 12 May 2022 were confirmed as a correct record; and

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

32/22 PATIENT EXPERIENCE

1. The Committee welcomed Sue Last who is a wife/carer for her husband John who is living with dementia. Sue was attending the meeting virtually and the Committee thanked her for sharing her story. Wendy Herbert, on behalf of the Board extended sincere apologies to Sue for the experience she and her husband John encountered on the evening of 22 June 2022. In addition the Committee welcomed colleagues from BCUHB who would be able to share Sue's story as well. Prior to listening to Sue, Wendy Herbert explained that during the timeframe involved activity was really high and challenging due to the overall system pressures. On 23 June 281 hours were lost as a consequence of hospital handover delays and on 24 June 228 hours were lost.
2. Sue recognised that the problem was across the whole NHS system and pointed out that her story was not a complaint but more of what lessons can be learned from it.

3. Her husband fell on the evening of 22 June. Along with a friend Sue managed to pick him up and put him in bed. Sue rang the ambulance service around 1.30 am and was advised there would be between a 7 to 10 hour wait. At this point John was in a chair by the bed. Sue rang again around 9.30 am to check on progress and received a call around 10 am from the ambulance service and went through the triage questions. By midday Sue's son had arrived and managed to return John to bed. John was in a lot of pain and was bordering on delirium.

4. Around midday, Sue then rang the GP, the district nurses and the one stop shop and nobody could provide any help. On reflection Sue says she should have asked the GP to provide a strong analgesic due to John's pain; all Sue could administer was paracetamol and fluids.

5. At around 4.45pm a first responder arrived who was excellent and was worried about

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John, he called a clinician who agreed that the ambulance response should be escalated to Amber with blue lights. The ambulance did not arrive until about 8.30pm.

6. John was conveyed to the ED at Glan Clwyd and was taken in to the hospital within 30 minutes. Following x rays, ECG and a pain block he was returned to the ambulance, Sue was unsure how long he was in the ambulance for.

7. Following surgery on 24 June John's dementia has worsened. Sue now realises it is in John's best interest that he receives care on a 24 hours basis, which Sue is unable to provide. John is still in Denbigh Community hospital and has been there for the past 5 weeks. Sue is convinced that the wait combined with the surgery has had an impact on John's condition and understands it is very unlikely that John will be able to come home.

8. In terms of the questions Sue was asked during her call to the ambulance service she noted none of them related to dementia, especially regarding delirium and this should be considered going forward.

Comments

1. Wendy Herbert reiterated her huge thanks to Sue for sharing her story which had a great impact and will have an influence on the way the Trust delivers its services going forward.

2. Andy Swinburn expressed his sadness that the Trust had failed in its delivery care for John and articulated his apologies. The Trust was continually looking for alternative initiatives to keep ambulances away from the ED; this included increasing the skills of paramedics to treat more people in the community. In terms of pathways the Trust continued to work actively in collaboration with other health board colleagues to improve this area. The Trust was in the process of transformation to become a better community provider and not just a conveying organisation. In terms of analgesia in the ambulance service, the Trust was limited by various legislations and was in the process of identifying funds to allow first responders to better manage pain relief.

3. Lee Brooks explained that over the last 2 years the Trust had recruited 260 staff and was committed to keep this growth happening; despite all the challenges. The Trust was working on the review of rosters in order to service the demand in all areas as best it could; and this should occur in September. Staff attendance, clearly Covid has had a massive impact and has led to less ambulances on the road. The Trust continued to provide a high standard of wellbeing to its staff. The Clinical Support Desk (CSD) has seen an increase in staff by 50% over the last 6 months. The Trust works on seasonal impacts and each season tactics are developed to maximise capacity and reduce waiting times in the community as much as possible.

4. Wendy Herbert updated the Committee on the dementia work the Trust was conducting which was to ensure the workforce was suitably trained and educated to provide the appropriate and proper care for patients with dementia and also their carers. Wendy Herbert agreed to look at how to improve the experience of families when calling the CSD.

5. Sue realised that that the issues spanned across the whole NHS. There was limited assistance available for people in the community who had suffered a fall and needed picking up. Also, the questions being asked through triage did not cater for the issues she was faced with. Jonathan Turnbull-Ross reported that the Trust was working to improve its response to fallers in the community; this included collaboration with St

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John ambulance and health boards. He agreed to inform Sue with any progress in terms of the work and insight with regards to fallers specifically with BCUHB.

6. Sue was reassured by members of the Committee that the Trust Board had raised the concerns with the Health Minister and was doing everything in its power to improve the situation.

7. Was the Trust combining the information that were typically linked to having an ageing population and as inevitably more patients will present with dementia, were there any plans to accommodate this?

8. In terms of the questions from Clinical Service Desk staff, Sue was asked if there were any further questions that would have been useful. Sue said that once it was known the patient had dementia, there should be other specific and additional questions which could be posed on a case by case basis.

9. The Chair in summarising, reminded the Committee that the system pressures and the impact on patients and staff had been escalated to several forums. No one individual can make the change. It was important to continue to hear these stories which will incentivise the Trust to do the best it can and try and create some positive change in the system. This story will also help the Trust to develop its dementia plan and strategy going forward.

10. Carol Jones, on behalf of BCUHB offered their sincere apologies for the delays which were not acceptable. Sian Jones, ED Matron at BCUHB added that a great deal of work was underway in trying to manage and improve the ambulance handover delays.

RESOLVED: That the patient experience was noted.

33/22 OPERATIONS DIRECTORATE QUARTERLY REPORT – 2022 -23 Q1

Lee Brooks presented the report recognising that most colleagues had seen the report at other meetings, with that in mind he provided the following update:

1. During the first heatwave the Trust escalated to Resource Escalation Action Plan (REAP) level 4; the measures taken had been very effective. Currently the UK was experiencing another heatwave and although not as severe as the first one still presented its own challenges. Media engagement with the public in terms of providing advice under the current heatwave circumstances was not as extensive as the initial one.

2. The Trust was currently experiencing an outage in the computer system used to refer patients from NHS 111 Wales to out of hours GP providers and had declared a Business Continuity Incident. Committee members were assured actions to mitigate impact had been put in place and were being evaluated to consider those that might be incorporated into its business as usual approach. As a result of the outage there have been some incidents raised on the Trust's incident reporting system, Datix, but none had been raised indicating harm to patients.

Comments:

1. Why was the media campaign during this current heatwave not the same as the first heatwave? Lee Brooks explained that a media statement has been released but the Trust's engagement will not be as significant. He was confident that members of the

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public would have heeded the warning form the first media coverage.

2. The Committee discussed the merits of media coverage and the sustained coordinated campaign at an all Wales level which the Trust could benefit from; it should also help the public understand and recognise the role they can play in helping to minimise demand across the system.

3. The Chair referred to a recent visit she had made to the Hazardous Area Response Team and praised the positivity shown by them regardless of the demand and challenges they faced.

RESOLVED: That the update was received and discussed.

34/22 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK REPORT

Julie Boalch drew the Committee to the following highlights from the report:

1. The two highest risks, 223 (The Trust's inability to reach patients in the community causing patient harm and death) and 224 (Significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the Trust's ability to provide a safe and effective service), details of actions to mitigate these risks will be contained in the Board and Committee reports in September.

2. Risk 199 (Failure to embed an interdependent and mature health and safety culture which could cause harm and a breach in compliance with Health & Safety statutory legislation) has been transferred to the People & Culture Committee for oversight given that the Health & Safety function and programme of work were now included in the Terms of Reference and cycles of business for that Committee.

3. It was noted that the Assistant Directors Leadership Team had identified new risks that would be reported to a future Committee.

4. The Committee's attention was drawn to the new nationally agreed risk matrices and the risk reporting timetable.

5. The Committee noted the improved Board Assurance Framework which reflected the work undertaken to strengthen the articulation of risks and describes the controls and assurances and any mitigations against the risks.

Comments:

In respect of risk 223 it was suggested the Trust highlight ongoing discussions in respect of Section 28 Coroners Reports and how these were considered nationally.

RESOLVED: Members considered the contents of the report and:

(1) Noted that the 'avoidable harm' action plan would be incorporated into the BAF to support further mitigation of Risks 223 and 224;

(2) Noted the improved Board Assurance Framework;

(3) Noted the adoption of the new nationally agreed Risk Matrix including scoring levels, review schedules and risk descriptors;

(4) Noted the 2022/23 Risk reporting timetable; and

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(5) Noted the transfer of Risk 199 to the People & Culture Committee.

35/22 MONTHLY INTEGRATED QUALITY PERFORMANCE REPORT (INCLUDING REVISED KEY PERFORMANCE INDICATORS)

Prior to the update, Rachel Marsh pointed out an error in the report, the recommendation was for the Committee, and not the Board as stated.

In terms of highlights the following was brought to the Committee's attention:

1. 111 Clinical response –call answering performance and clinical ring back times remain below target. Recruitment and retention of call handlers and clinicians remain a priority and urgent discussions are ongoing to identify how the Trust can increase clinician numbers.

2. Response times – red and amber response times remained at unacceptable levels, in particular the amber tail; the amber 1 95th percentile was at 6 hours and 50 minutes. Actions continued to be undertaken to maximise the Trust's ability to respond and to mitigate risks to patients.

3. Ambulance Care, it was noted that there was relatively good performance. In particular the Trust was above the target for enhanced renal patient arrivals prior to appointment in July 2022 and has improved for patients requiring discharge; however. Overall demand for the service continued to increase although it has not yet recovered to pre CoVID-19 levels.

Comments:

1. Ambulance response, patients waiting in the amber category for over 12 hours, what was the Trust's advice/answer to these patients? Rachel Marsh explained that the total number of patients using other transport means such as taxis has significantly increased. Lee Brooks added that the Trust worked on the principle of enabling the caller/patient to make their own decision. An estimated time of arrival (ETA) within a certain time banding was being developed and would be offered to the caller/patient. The Trust was looking to reduce the time banding width and to increase the ETA accuracy. The caller/patient would be able make an informed decision on the response time and wait or whether to make other arrangements. Call handlers could face a predicament whereby they may be asked for advice on what to do, the Trust's position on this would be to offer the ETA and leave the ultimate decision to the caller/patient. In the background, the Clinical Support Desk (CSD) will monitor and if a need to travel has been identified, the CSD will manage the situation.

2. In terms of stroke patients and the length of waiting time, once the EPCR and health board data was matched and stroke was confirmed as the chief complaint; the Trust could begin to understand the clock time start on the treatment window. Going forward early identification of a stroke, establishment of the clock start time and treatment window and the priortisation of that patient moving through this time period should be explored. Dr Brendan Lloyd explained that this situation could become more complex, due to the clinical recommendations around the time window for a Thrombectomy (a type of surgery to remove a blood clot from inside an artery or vein) It was being proposed that this may be extended from five hours to ten hours which would mean a significant number of patients would fall outside of the therapeutic window currently being used, and would therefore be in the amber 2 category. Furthermore, in relation to this the Trust was also exploring a project looking at using direct video consultation for front line clinicians with specialists in the stroke unit.

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3. Wendy Herbert updated the Committee on the situation regarding the poor performance for the two day response target to concerns. This was due in part to staff resourcing which had now been addressed. In terms of compliance of the 30 day response, this had also deteriorated due to staff vacancies. There has also been a large increase in coroners' activity and Medical Examiners requests, both of which compromised the ability to respond to the 30 day target.

4. What was the difference in outcome in sending an ambulance after 12 hours or not sending one? And why was the Trust taking patients to hospital after several hours? Andy Swinburn explained if the patient has waited over 12 hours a positive outcome would be highly variable depending on the nature of the patient's complaint. In terms of advising people going to hospital, he used the following scenario as an explanation. There were 10 ambulances outside the Emergency Department all with patients with elderly fallers with hip injuries. A 35 year old person with chest pain then calls and is advised to make their own way to hospital. The patient then arrives in the Emergency Department and is immediately prioritised above those waiting in the ambulances. If the patient had been clinically triaged and taken through the Emergency Communication Nurse System (ECNS) the likelihood of it being a cardiac issue would probably have been doubtful. In this scenario the Trust may potentially have contributed to its own delays. Liam Williams pointed out it was also very important to consider the risks involved when advising callers either to wait or to self-transport.

5. The Committee expressed their concern that the Trust was consistently losing around 30% of its conveying resources and the increase of Appendix B referrals.

6. What was the reason for the number of clinical vacancies in 111? Rachel Marsh explained that the turnover rate was relatively high; the Trust was looking at initiatives to improve recruitment and retention which included maximising home working opportunities.

RESOLVED: That the Committee considered the June/July 2022 Integrated Quality and Performance Report and actions being taken and determined that it provided sufficient assurance.

36/22 QUALITY HIGHLIGHT REPORT QUARTER 1

Jonathan Turnbull-Ross presented the report and advised that it sought to provide assurance in line with Commissioning Core Standards, All Wales Health & Care Standards (2015) and the Health & Social Care (Quality & Engagement) (Wales) Act 2020, that promoted a Duty of Quality and Duty of Candour. He added that he report illustrated any governance concerns, issues, risks and area for improvement across the commissioned services.

In terms of key issues the Committee were updated on the following:

1. The once for Wales concerns management system; some of the older cases were being closed.

2. The new improvement group for older people and falls will be working on community resilience, volunteer strategy and patient experience and community involvement.

Comments:

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1. Could the report be more succinct for the Committee and explain what was meant by the Paramedic Pathfinder? In terms of the length of the report, Jonathan Turnbull-Ross explained the report had been refined and agreed to further review it. In terms of the Paramedic Pathfinder this was a tool used to establish the establish the relevant pathway for the patient, in a pre-hospital setting

2. Notification to handover lost hours, was there a way the Trust could evidence if the Trust was at the Commissioning intention target what the overall situation would look like? Rachel Marsh explained that Optima were conducting some modelling which will look at a 25% reduction but that would still be inadequate.

3. What were the governance arrangements for Allied Health Professionals (AHP)? Wendy Herbert advised that the Trust was discussing the role of AHP within the Trust with Welsh Government where clarity would be sought. She added that the Clinical Quality Governance Group within WAST were reviewing the role and function of the AHP. A discussion ensued whereby the Committee considered the merits, advantages and risks of AHP's from all types of background working within WAST.

4. Members were pleased to see how encouraging the Falls assistance service continued to be and felt it would be good to expand on this as it was having a positive impact on patients and reducing operational pressure for WAST .

5. In relation to older people Members asked why there wasn't more collaboration with the private sector and it was agreed that Wendy Herbert would investigate this further.

6. Going forward, the Committee requested to see more information relating to care home focused improvements work beyond the geographical area of Pembrokeshire.

RESOLVED: The Committee discussed and noted the report

37/22 PATIENT SAFETY REPORT Q1 2022/23

Wendy Herbert drew the Committee's attention following points to note:

1. Verified demands had decreased, however there had been an increase in red activity.

2. In terms of an amber response there had been a deterioration with this position and the impact to patient experience and outcomes will be noticeable. .

3. The Trust is currently not compliant with the two day and 30 day response targets due to the volume of complaints being received.

4. Appendix B activity had remained exceptionally high, 117 of the incidents were discussed Serious Case Incident Forums; 17 of these incidents met the National Reporting Incident Framework with 15 shared with the relevant health board. In addition to the Appendix B Report(s) being sent to the relevant Health Board's Patient Safety Team, the anonymised reports were now also sent to Health Care Inspectorate Wales (HIW).

5. There continued to be high levels of reporting for patient safety incidents which illustrated the excellent reporting culture.

6. During this quarter there were 1,807 immediate release requests, of which 43.7 % were declined. Work was ongoing with partners and July was showing signs of improvement.

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Comments:

1. Whilst there had been an improvement in the immediate release compliance, the Committee expressed concern that BCUHB declines exceeded 50%. Wendy Herbert explained this figure had recently improved following liaison with health board colleagues. She added there had been an improvement across Wales for red release but amber still remained a challenge to achieve.

2. Going forward it would be useful to see, as improvements were made, how that translates into the Trust's ability to respond and how that was evidenced. Lee Brooks explained that a weekly report was produced which showed the numbers of red and all immediate releases. The Trust received a narrative report on the declined red, with a dip sample on the ambers. Heath boards received a regular report on the learning from the immediate release reports.

RESOLVED: That the report was noted.

38/22 CORONER REGULATION 28 REPORTS RECEIVED

Wendy Herbert presented the report to the Committee noting that the long wait for an ambulance had clearly impacted on the patient's death.

Comments:

What could the Trust have done differently and was the coroner in communication with the health board. Wendy Herbert explained that the Trust's response to the coroner clearly articulated this. The health board was not issued with this Regulation 28 report.

RESOLVED: That the report was noted.

39/22 PATIENT EXPERIENCE AND COMMUNITY INVOLVEMENT (PECI) QUARTERLY REPORT

Leanne Hawker gave an overview of the report and drew the Committee's attention to the following:

1. The PECI tem continued to hear concerns regarding response times and delays in the back of ambulances.

2. The team were also identifying anticipatory anxiety across all communities.

3. Digital exclusion was an issue for some members of the community; this included internet coverage which in some areas in Wales was poor.

4. The team continued to advise staff in recognising the issues of people with learning disabilities and the need to make reasonable adjustments in terms of the response and care. Also to recognise when people with learning disabilities were in pain.

Comments:

1. The Committee acknowledged the issues around digital accessibility and also the issues with affordability for some people.

2. In terms of older people some were categorised as 50 plus, what was the age

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category in WAST. Leanne Hawker advised that WAST determined an older person to be 60 plus.

3. In terms of feedback from Community Health Councils (CHC) following the PECI team's engagement with them were there any themes and trends emerging? Leanne Hawker explained there was nothing particular but they very keen to understand how the Trust disseminated its messages to the public and how this was evidenced.

4. The Committee welcomed the report and acknowledged the excellent being undertaken by the PECI team.

RESOLVED: The Committee;

(1) Approved the highlight report for release to the NHS Wales Patient Experience Network, the WAST People and Community Network and external stakeholders; and

(2) Noted and supported the actions being taken.

40/22 HEALTH INSPECTORATE WALES (HIW) EMS CCC PATIENT SAFETY REVIEW

Lee Brooks explained this was the ongoing work in terms of the actions following the HIW review of the Clinical Contact Centre.

An update was given on the actions as follows:

1. The actions from the year 2019/20 had been completed.

2. There were 3 actions ongoing from year 2020/21 and 4 from year 2021/22.

3. The 3 actions from 2020/21 were now considered to be completed.

4. The 4 actions from 2021/22, 2 were completed and 2 were ongoing which were overdue and the Executive Management Team have concurred with the position in terms of the actions which have a timeline for closure.

Comments:

Following a query in terms of the action to ensure that protected time was given to staff for appraisal discussions, Lee Brooks advised that the action was on target and was being tracked.

RESOLVED: That the Committee

(1) Noted that Executive Management Team received and approved the progress again the HIW Action Plan; and

(2) Noted the contents of the report to secure the necessary assurance that progress was being made by the Trust against the HIW recommendations.

41/22 QUALITY STRATEGY HIGHLIGHT REPORT QUARTER 1

1. Jonathan Turnbull-Ross gave a verbal update commenting that progress during quarter 1 had been very challenging with some actions being delayed. There were

risks to delivering the strategy on time.

2. A workforce review has been undertaken and approval was expected to progress this into a formal consultation period with it becoming live in November. The Trust had originally requested funding for an additional four senior roles but had only received funding for two.

3. Jonathan Turnbull-Ross remained optimistic these posts would be recruited to by October.

Comments:

1. The Committee recognised that the Trust was operating in an increasingly tight financial environment and there were difficult choices to be made. There were other options the Trust could utilise, for example, local champions who would be critical to the delivery of the strategy.

2. Members acknowledged it was an ambitious strategy and would require collective cooperation from all involved to ensure its success, particularly at the grass root level.

3. The Chair made reference to the Committee action log discussed earlier at the meeting and those actions relating to the Quality Strategy; noting that the strategy should be integrated into everyone's role and what practical steps will be taken to develop this. Following on from this there will be broader discussion at Board Development and EMT after which more actions and clarity were likely to emerge.

RESOLVED: The update was noted.

42/22 INTERNAL AUDIT TRACKER REPORT

1. Julie Boalch explained that the purpose of the report was to provide the Committee with an update in relation to recommendations resulting from Internal Audit reviews and also give the Committee sight of the Internal Audit plan activity.

2. An internal audit review had been conducted on the Trust's Respiratory Protective Equipment which received a reasonable assurance rating.

3. There were currently three high priority recommendation shown as overdue and these related to the role of the Advance Paramedic Practitioner (APP) and the Respiratory Protective Equipment reports.

Comments

In terms of the Respiratory Protective Equipment, the Committee noted there was still further work for improvement, for example around fit testing. Jonathan Turnbull-Ross explained the Trust was more assured on current processes and that standards would need to be maintained. He added that the Trust had been approached by other organisations to provide them with fit testing which demonstrated some external validation.

RESOLVED: The Committee:

(1) Noted and considered the report;

(2) Considered the Internal Audit Plan activity;

DRAFT

(3) Received one current Internal Audit Report relevant to the Committee; and

(4) Considered the Trust's proposals to address each recommendation with the inclusion of revised completion dates, specifically those relevant to the Committee.

43/22 NHS WALES NATIONAL CLINICAL AUDIT AND OUTCOME REVIEW PLAN 2022/23

1. Duncan Robertson advised the Committee that the Clinical Directorate had received a request to review WAST's contribution to the NHS Wales National Clinical Audit and Outcome Review Plan - Annual Rolling Programme for 2022/23 and provide the organisation's position.

2. The criteria for clinical audits included in the National Clinical Audit and Outcome Annual Review Plan do not directly relate to the pre-hospital environment or necessitate the inclusion of WAST clinical data. The Trust, following a review by the clinical audit and effectiveness team determined that no contribution was required.

3. The Clinical Audit Programme for quarter 1 2022/23 was presented for the Committee's approval.

Comments:

Trish Mills confirmed that the Quest Committee approved the programme and provided assurance to the Audit Committee. She proposed to complete a brief highlight report on this topic to the Audit Committee.

RESOLVED: That the Committee;

(1) Noted the update for the NHS Wales National Clinical Audit and Outcome Review Plan;

(2) Approved the WAST Q1 Clinical Audit Programme; and

(3) Confirmed the submission route and frequency for approving the WAST Clinical Audit Programme

44/22 INFECTION PREVENTION CONTROL ANNUAL REPORT

1. Jonathan Turnbull-Ross informed the Committee that in the last 12 months, activity for the Infection Prevention & Control (IPC) Team has largely remained pandemic focused however, more recently, business as usual activity has merged with pandemic work.

2. There have been many improvements with IPC, all aimed at providing and continuing to maintain safe services for both patients and staff.

3. The overall governance structure has been revised and was more pragmatic to meet the needs of the Trust.

4. Going forward, the Trust should continue to learn from the fallout of Covid-19; and to consider the ongoing risks.

5. A key factor had been to understand the needs of staff and this had resulted in the improved development of training.

DRAFT

Comments:

1. The IPC policy was due to be reviewed in June and would it be presented at this Committee for approval? – Jonathan Turnbull-Ross explained it was currently being reviewed and continued to be updated to take into account the current situation and was likely to be presented at the next meeting.

2. What was the plan when Fit testing failed? Jonathan Turnbull-Ross advised that other suitable devices were offered should any of the Fit testing masks fail.

3. The Committee noted that a new risk had been added Risk ID 536 (the ability to sustain a comprehensive fit testing programme within the Trust). Jonathan Turnbull-Ross explained that the risk score of 12 was to be confirmed following further work by the IPC team.

RESOLVED: That the Committee noted the information within the paper 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.

45/22 PATIENT STORY DRIVER DIAGRAM

The report was for information purposes only.

RESOLVED: That the report was noted.

46/22 COMMITTEE PRIORITIES UPDATE

The report was for information purposes only.

RESOLVED: That the report was noted.

47/22 KEY MESSAGES FOR BOARD

The Chair advised that Trish Mills would provide a detailed report for the Board's attention.

48/22 ANY OTHER BUSINESS

The Committee thanked Wendy Herbert in her role as the Interim Director of Quality and Nursing for the contribution and support she had provided to the Committee.

Date of Next meeting: 10 November 2022

DRAFT

Minute Ref	Date	Agenda Item+C1:H13	Action Note	Responsible	Due Date	Progress/Comment	Status
16/21	7 May 2021	Patient experience	To provide updates on the viability of CFR's to administer pain relief	Andy Swinburn	10 November 2022	Update from 16th November meeting: Andy Swinburn updated the Committee explaining that 2 Business Cases were being developed; one from the development of the Omnicell cabinet perspective (readjust for penthrox inclusion) and one from the revenue perspective (purchasing of penthrox). Dr Brendan Lloyd explained the reasons for the delay in developing this and would continue to update the Committee. Update for 17th February meeting: The amendments to the safe have been agreed and purchase of the additional fittings for the cabinets has taken place. Work is still ongoing to identify the revenue funding for penthrox but new avenues are being explored, with the NCCU, to establish whether central funding, aligned to the decarbonisation agenda, may be applicable. Update for 12 May meeting: The introduction of Penthrox continues to be one of the items that is listed for consideration against this years list of items in which financial support is required. Further opportunities to support the introduction are being worked through with commissioners (as a potential carbon reduction measure). It was anticipated this action will be completed by 11 August 2022. There had been no further updates and it was agreed that an update would be provided on 10 November 2022. Improvements to the application were ongoing, Once the data was correct. Another few months until the data is ok, Update for 10 November Verbal update	Open

F&P 1/21-22	18 November 2021	Transferred from F and P Meeting on 18 November 2021	QuEST to undertake a focused review of performance related to clinical outcome metrics at their 17 February 2022 meeting	Andy Swinburn	10 November 2022	Update from 16th November meeting: QuEST requested for confirmation as to whether this will be a stand alone report or included in the performance report. Update for 17th February meeting: Andy Swinburn requests a revised date for this action due to ongoing pressures. Update for 12 May meeting: ePCR roll out has been completed last month and data collection validation is being worked through. In conjunction with this digipen decommissioning is a significant activity within the team. Once both these key elements have been settled attention will be turned to this focused review. It was anticipated this action will be completed by 11 August 2022. Update on 11 August **Duncan Robertson** reported that the Clinical Intelligence and Assurance Group were conducting deep dive quality assurance audits on each of the clinical indicators. Learning in terms of improvements of the data quality within Electronic Patient Care Record (EPCR) have been identified. He explained there was still further work to be undertaken to consider other elements of the EPCR. Update for 10 November **See attached position statement ITEM 3.1**	Open
50/21a	16 November 2021	PECI Highlight report	To provide an update on the ongoing work to improve functionality of symptom checkers etc.. of the Website	Leanne Smith	10 November 2022	Update for 17th February meeting: Andy Haywood seeks an extension for this item to May 2022. Update for 12 May meeting Work ongoing Deferred to 11 August meeting Work ongoing Deferred to 10 November meeting **See attached position statement ITEM 3.2**	Complete

17/22	12 May 2022	Staff Story	Falls. To provide feed back on discussions at the older people's steering group and on the collaboration with health board colleagues to improve the falls processes and procedures; and also for the steering group to discuss the use of Mangar chairs in the Community.	Jonathan Turnbull-Ross	10 November 2022	Update for 11 August Meeting Jonathan Turnbull-Ross explained that the new group will be meeting soon and by the next Quest this should be complete. An update will be provided at the next Quest meeting. Update for 10 November meeting The Falls Improvement Group have received the patient story and are undertaking a cross-directorate project of work ascertaining the possibility of placement of lifting aids within communities, for use by community members. In delivery of this work, external partnerships are being considered and developed for a sustainable solution to be implemented.	Complete
32/22a	11 August 2022	Patient Experience	Consider ways to improve the experience of families when calling the CSD, especially those with dementia	Wendy Herbert	10 November 2022	Update for 10 November 2022 Liaising with CSD Leads to review dementia learning needs, skills and knowledge of CSD clinicians whilst also considering the needs of all patient groups.	Complete
33/22b	11 August 2022	Patient Experience	To inform Sue Last with any progress in terms of the work and insight with regards to fallers specifically with BCUHB.	Jonathan Turnbull-Ross	10 November 2022	Update for 10 November meeting Sue Last's story has been shared with the Falls Improvement Lead. In regard to BCU provision, currently 2 units service BCUHB, one 'Level 2' (Paramedic and Therapist) resource, and one 'Level 1' Falls Response resource. Funding has been secured for 5 years via the Regional Integration Fund. Within the Health Board area, there are ambitions to expand the service to meet the demand, particularly noting the rural geographical. A Fall Evaluation Report is being produced (expected November 2022) to detail an analysis and evaluation of specialist Falls Resources across Wales. The Falls Improvement Lead will directly contact Sue Last following publication of the evaluation report.	Complete

35/22	11 August 2022	MIQPR	To strengthen the phrase 'sufficient assurance' as part of the following recommendation: That the Committee considered the June/July 2022 Integrated Quality and Performance Report and actions being taken and determined that it provided **sufficient assurance'.** It was agreed consideration would be taken to amend the wording for future recommendations	Rachel Marsh	10 November 2022	Update for 10 November meeting The recommendation wording was initially agreed by the Finance and Performance Committee when the MIQPR was being redesigned and as such is considered suitable at this time.	Open
36/22a	11 August 2022	Quality Highlight report	In relation to older people Members asked why there was not more collaboration with the private sector and it was agreed that Wendy Herbert would investigate this further.	Wendy Herbert	10 November 2022	Update for 10 November 2022 The Patient Experience & Community Involvement Team are reviewing contacts across the private sector to ensure they are included as key engagement stakeholders in community involvement work.	Complete
36/22b	11 August 2022	Quality Highlight report	Going forward, the Committee requested to see more information relating to care home focused improvements work beyond the geographical area of Pembrokeshire	Jonathan Turnbull-Ross	10 November 2022	Update for 10 November meeting A value based healthcare bid was developed and successful supported for further provision of Care Home training and support in Powys – approved funding for a Paramedic to provide training for a six-month period. Project management, administration and analysts support will be undertaken by the Health Board in assessing its effectiveness, to include benefits to WAST. The action is noted in detailing wider provision of activities in forthcoming reports.	Open

Position statement for:

F&P 1/21-22: Four of the five Clinical Indicators have received a deep dive audit (Fractured neck of femur, stroke, STEMI and hypoglycaemia). The ROSC at hospital CI is due to report the findings of the deep dive audit to the Clinical Intelligence and Assurance Group (CIAG) on the 11th November. This will complete this work with the current suite of recorded clinical indicators. The deep dive audits have prepared the ground for improvement work on each of the indicators and formed the basis for a series of 'top tips' posters to support Senior Paramedics and in the medium term, recommending changes to the ePCR user interface.

The Clinical Intelligence and Assurance Group have discussed the following Commissioning Intention: Outcome by response type. A meeting with commissioners taking place Friday 4th November will discuss the scope of this intention. This will lead to working up detailed specifications, running the data and reviewing results. This work will be run through the CIAG and is reflected in the Clinical Indicator Plan and Cycle. Results from CIAG will be reported to the Clinical Quality Governance Group. Planning is taking place in Q3 with data testing and reporting to be complete for the first phase by the end of Q4 2022/23.

Please note that currently WAST do not yet have a full year's worth of ePCR data covering the whole Trust, this will only occur at the end of March 2023 which reflects when the last health board area went live which may affect the outcome by response type if seasonal presentations come into play.

I would recommend that this action is closed and that once the commissioning intention has been realised, I can bring this back to QUEST once it has been to CQGG via CIAG.

- circ. 20 new webguides added to the website in the last year.
- Added a suite of ‘associated / useful links’ for each webguide directing users from disposition sections of webguides to other areas of 111.Wales (DoS / Live Well / Health A-Z) to promote better digital self-service.
- Various user interface improvements re the presentation of symptom checkers, optimising for both mobile and desktop.
- Introduced a local search engine into the “Check Your Symptoms” landing page, to allow users to search for symptom checkers (along with letter selection).
- Collated most used webguides into a “popular topics” section on the “Check Your Symptoms” page, for ease of access.
- Future focus to include: more digital content signposting; updating existing dispositions to be less risk-averse, and new webguides relating to child ailments.
- the Welsh Language Services Manager is reviewing the Welsh webguides and their associated interfaces.

Essentially, user experience work has progressed well this year, as has the foundational technical work, guiding users to the right advice. We are collaborating with clinical expertise to enhance the type and detail of the advice presented.

Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services NHS Trust

OPERATIONS DIRECTORATE
QUARTERLY REPORT FOR COMMITTEES
2022-23 Q2 (Jul-Sep22)

National Operations & Support

Challenges

Death of Her Majesty Queen Elizabeth II

Following the announcement of the death of Her Majesty Queen Elizabeth II, Operation Dragon (the Queen's funeral arrangements) and Operation Spring Tide (King Charles III succession to the throne) were set in motion. There was a significant directorate response to plan for these events. This included the provision of mutual aid to London in the form of Mobile Response Teams (MRTs) to support the state funeral held on 19th September, and joint working with partner agencies in preparation for the King's visit to Cardiff on 16th September 2022.

The Trust's Emergency Preparedness Resilience and Response (EPRR) Team, was already working closely with Welsh Government and partner agencies regarding the planning for the death of HM The Queen, subsequent Proclamations and The King's visit to Wales. However, when HM The Queen passed away urgent planning was still necessary. This resulted in pausing all other EPRR related work streams and assigning members of the team to specific tasks to ensure the Trust was ready in time.

The EPRR Team led the WAST planning team, brought together areas of the Trust to support the response and partners from St John Ambulance Cymru, and worked closely with multi-agency colleagues to ensure the Trust met its obligations within the specific response plans; This included working closely with Clarence House, the Royal Protection Team, medical leads, multi-agency partners within Wales and Welsh Government representatives.

Providing Mutual Aid to the Isle of Man Ambulance Service (IOMAS)

The IOMAS requested mutual aid to support them firstly with the TT race and then with the Manx GP. At the time the request was made the EPRR Team was not up to full capacity with a Locality Manager and Service Manager vacancies. This meant that members of the team were required to oversee the Trust civil contingencies responsibilities and as the events season has just started and there was a renewed interest in large events post the pandemic, this area of work was also very busy.

In order to meet the request an initial assessment was undertaken. It was ascertained that the original ask was for operational members of staff therefore the sourcing of staff to go to the IOM was passed to our Emergency Medical Service (EMS whilst the EPRR team coordinated the deployment of staff to the IOM.

The request was fulfilled and on both occasions the staff deployed were very happy with the arrangements in place and the IOMAS were very complimentary of both our staff and the organisation around their deployment.

Testing of the Trust Incident Response Plan (IRP)

The EPRR team recently reviewed and updated the Trust Incident Response Plan (IRP) which was subsequently approved by the Executive Management Team (this will be reported to our Finance and Performance Committee within the now established cycle of business). In preparation for its publication, the team engaged with all of Health Boards across Wales to develop and deliver two large multi-agency hybrid table top exercises, one in the North and one in the South, to test the Wales Mass Casualty Arrangements. These exercises would enable the Trust to test a large number of the elements of the IRP.

The EPRR Team is not afforded a training exercise budget, therefore it relies on partner agencies to support multi-agency exercising and fund the cost of planning and delivering exercises.

Planning was progressing well. However, due to increasing pressures within the hospitals, Health Boards made the decision to withdraw from the process, therefore the exercises will no longer be going ahead. Consequently the opportunity to test important elements of the Trust's IRP is no longer available.

In light of the very recent publication of the Manchester Arena Public Enquiry recommendations, the Trust is likely to need to take stock of our approach to exercising. The team shall be reviewing this report to determine what action must be considered by WAST.

IMTP

Staff & Volunteer Wellbeing

We continue to monitor and review the wellbeing of all staff and volunteers within the Operations Directorate, and identify opportunities where we can further support our staff and volunteers. A number of welfare related charitable funds bids were submitted by the directorate and approved by the Trust's Bids Panel in September 2022 and work is underway to bring these initiatives to fruition:

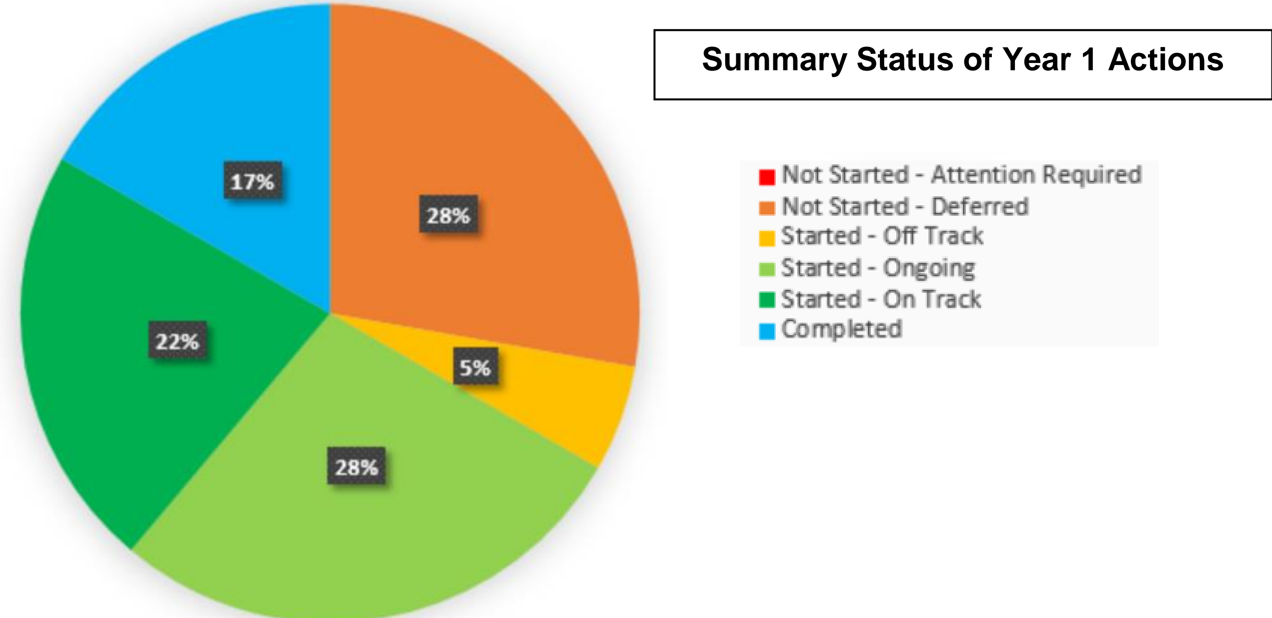
- Provision of Christmas Day Dinners and Christmas Hampers
- Development of a Hazardous Area Response Team (HART) Wellness Garden
- Zen Rooms for Contact Centres (EMS CCC & 111)
- Further supply of WAST Engraved Vacuum Flasks

A further extension of the hospital concession scheme up to the end of January 2023 has also been made.

WAST Strategy for Volunteering

The action plan accompanying the Volunteer Strategy continues to be progressed with a number of achievements realised during Q2. The pandemic and service pressures have impeded progress and outstanding year 1 actions are being considered against year 2 actions by the team:

- Establishment of the WAST **Volunteer Steering Group**
- Volunteer support at **events** supported by entire Trust (Royal Welsh Agricultural Show)
- Volunteer team structure increased to now include 2 additional CFR trainers, 2 additional Operational Assistants, 2 new Support Officer Posts (to support compliance & training co-ordination) within its funded establishment
- **Community resilience and service development** now has the dedicated focus of an Operations Manager, Community Support
- **Social media** coverage of volunteers and volunteering activities has increased
- Newly created **volunteer roles within CCC environment** received positive feedback
- Volunteer support provided to **111 Service** during recent business continuity incident
- **CFR champion roles** within stations have been developed and are proving successful



Response to & Recovery from the COVID-19 Pandemic

The majority of IMTP deliverables associated with the Trust's response to and recovery following the COVID-19 pandemic have been completed. The only action outstanding is that of lessons learnt during the last wave of the pandemic as the formal debrief has not yet completed. However, many of the systems and ways of working established during this period are continuing post pandemic.

Emergency Preparedness Resilience & Response (EPRR)

We are awaiting publication of a number of formal reports which will need to be reviewed to identify implications for the Trust and the potential impact of the recommendations made or any change in policy requirements:

Publication	Update
Consider the potential impacts on us from the review of the UK Civil Contingencies Act (CCA) 2004 and the likely legislative implications on our workforce.	Review ongoing by Westminster Government
Implementation of a Protect Duty (related to counter-terrorism preparedness) on all public bodies.	Publication anticipated circa March 2023
Receive and consider outcomes of the UK COVID-19 Inquiry and implementing lessons identified.	Inquiry has commenced and work is underway to provide information to the Wales Inquiry to apply for core participant status for module 3
Assess the outcome and recommendations from the Manchester Inquiry and prepare a report for consideration by WAST Executive	Publication due 02/11/22

General Update

Volunteer Steering Group

A WAST Volunteer Steering Group has been established to provide volunteers with a forum to be heard and identify opportunities for collaborative working within the Trust. Steering group membership consists of: representatives from Community First Responders, Volunteer Car Service, EMS Coordination, Chaplaincy Service, Volunteer Management Team and Operations Business Management. The Operational Delivery Unit (ODU) and PECI Team are also invited to attend. The group meets every 6 weeks and its' Chair and Deputy Chair are volunteers appointed by members. An open invitation is extended to Executives and Non-Executives to join any future meetings to support and engage with our volunteers.

EPRR and Specialist Operations

The Hazardous Area Response Team (HART) celebrated its' ten year anniversary in July 2022. The last ten years have seen a number of developments within the team including new vehicles, new technologies and advances in the team's capabilities. The team is proud of what they have achieved and continue to work hard to support the Trust and the communities they serve.

Resourcing & EMS Coordination

Challenges

EMD Recruitment and Retention

Emergency Medical Dispatcher (EMD) Recruitment and Retention has been an issue for some time, but has been acute over the last 6-12 months. The current rate of external attrition alone is circa 23% with yet more staff leaving to take up internal vacancies across the organisation. This has left the EMD establishment under significant pressure. Of the current establishment of 111.76 WTE in the EMD function we have experienced 56% turnover in the last 3 months along with 63 new EMDs taking up post since September. This has a profound impact on the performance across the unit as new EMDs try to acclimatise to the operational environment after training, but also seriously diminishes the availability of experienced colleagues to support their new colleagues.

The original challenge was to recruit and train sufficient staff to meet the vacancy levels within EMS Coordination and we have met that through working with People services to adapt out recruitment model to ensure that we can attract a broader spectrum of potential candidates and by providing assessments and interviews on weekends. A paper has also been prepare for EMT to consider ways of retaining staff.

Concerns

The number of Concerns flowing through from the ‘Putting Things Right’ Team continues to challenge staff across Operations Quality. The number of audits required as part of the investigation process remains high (circa n140) and well above the pre-winter numbers that we could have expected historically. The Operations Quality Team together with the ‘Putting Things Right’ team have worked collaboratively to deliver a ‘one team’ ethos working cross directorate to deliver a joint solution that meets the legislative requirements and patient safety needs, together with a proportionate investigative process. This arrangement provides the most timely solution so that we can continue to meet our expectations in terms of learning lessons and providing patients and families with the responses they need.

IMTP

Research & Innovation - Upgrade 999 Platform

An upgrade of the 999 platform is required to improve resilience, flexibility and interoperability for 999 call processing. The Assistant Director of Operations for Resourcing and EMS Coordination has been in discussion with the Head of ICT regarding the approach to funding. A response is awaited from Capital Programme Board and negotiations by ICT are ongoing.

General Update

IAED: 'ACE in Good Standing'

The international Academies of Emergency Dispatch (IAED) is the standing-setting organisation for emergency dispatch and response services worldwide, and is the leading body of emergency dispatch experts.

The IAED's various board and councils work on behalf of its members, and in co-ordination with other influential public safety organisations, to ensure that the comprehensive system of emergency dispatching is as safe, effective and up-to-date as possible. IAED is the only standard setting organisation to identify, research, maintain, produce and maintain standards of practice for emergency dispatch worldwide.

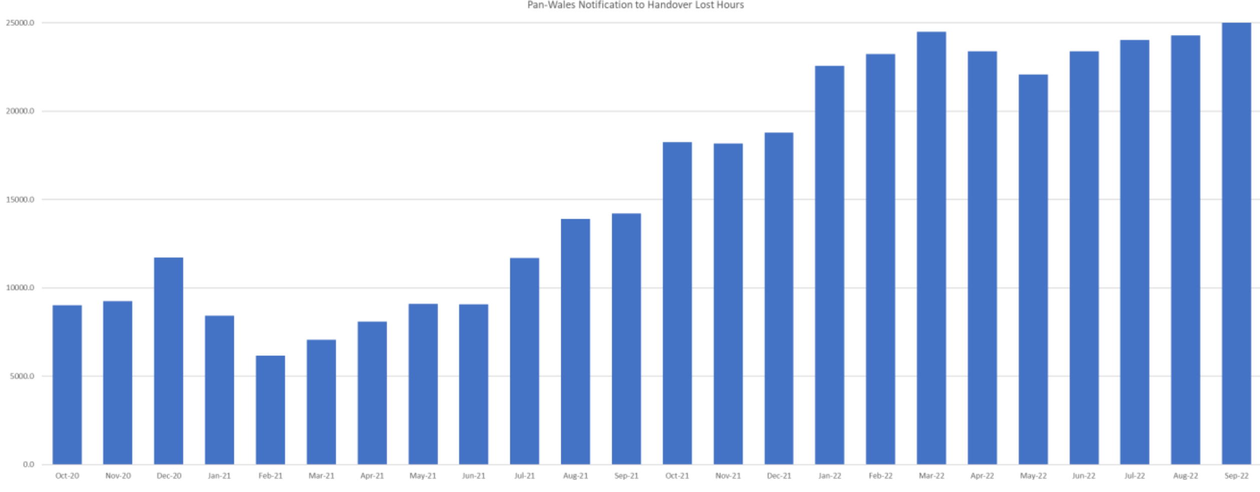
In July 2022, we submitted our ACE reports for the period April-June 2022. Following review of these ACE reports, the IAED determined that the Trust had met all requirements and achieved 'ACE in Good Standing' accreditation for Q2 2022. The Trust was congratulated on its commitment to excellence and thanked for its dedication to maintaining the high standards of accreditation. Additionally, recognition was also awarded for maintaining best practice during this especially challenging time of the Pandemic.

Emergency Medical Service

Challenges

Continued System Pressure

Delayed handover of care at Emergency Departments across Wales remains a significant challenge in being able to provide a safe level of emergency service. 25,167 hours were lost in September and on average we are losing 30% of our conveying capacity to delayed handover.



IMTP

EMS Roster Review

The introduction of the **Cymru High Acuity Response Unit (CHARU)** will be deployed to support patients with suspected critical illness or injury. The CHARU will replace the traditional RRV model and will include responding to an agreed dispatch criteria along with all red category calls.

The first of the new rosters are now live with 45% of Localities now operating under their new arrangements with the remaining on track to be operational before the end of November 2022.

CHARU resource type will be staffed by a paramedic who has successfully completed the training and education requirements. The three-day training course comprises of numerous assessments both written and practical on the latest evidence-based practice, adhering at all times to the policies and standards inherent within WAST. The course includes training and education in new medicines, additional equipment, technical and non-technical skills associated with clinical management of patients who have critical injuries or illnesses.

The project remains on track to be completed by the end of Q4 2023. See web link for latest update: Siren - News - 2022-043-CHARU

Improving Response Times in Rural Areas

EMT recruitment and recruitment to address the shortfalls in Powys is underway. Alongside this one workshop has already been held and another is scheduled for the end of October 2022. Following these workshops a paper will be crated outlining sustainable rural recruitment to support rural performance.

Develop Optimising Conveyance Improvement Plan

This IMTP deliverable is part of the Trust's activities contributing to 'Inverting the Triangle' and is being progressed as part of the Care Closer to Home Programme.

General Update

Christmas Planning

Christmas Planning has commenced within the Operations Directorate. Rosters for the festive period have been finalised and published. Charitable Funds have been awarded to provide Christmas Day dinners for those staff rostered to work on that day, and Christmas Hampers for stations/teams.

Ambulance Care

Challenges

Reduction of T1 Walkers Demand & Development of Eligibility Criteria

Work on this IMTP deliverable commenced in June 2022 but there is currently no agreement from Commissioners who have shared that Welsh Government do not wish to progress this. Following discussions with National Collaborative Commissioning Unit (NCCU) the Ambulance Care Management Team is creating a position paper to be presented to Welsh Government outlining the risks and mitigation. The matter of transporting ineligible patients may become more acute as the financial environment become more constrained.

Call Answer Performance

Increased call length due to additional scripting for Covid and eligibility combined with challenges with recruitment and retention had led to the performance of the non-emergency booking line being challenged for the first half of 2022.

A performance recovery plan was developed to provide focus on improving the service's call answer times and abandonment rates. As the impacts of the measures introduced start to have impact, we are beginning to see a steady improvement in core measures, however more work is required in this area.

The biggest challenge facing the function remains recruitment and retention of staff as the posts are band 2 and the recruitment market is currently very competitive for this level role. The service is working with the communications team and people services colleagues to implement actions that will hopefully ensure the position remains sustainable moving forward.

IMTP

Agree Roster Keys Pan-Wales

During the summer surgeries to review roster keys were slightly delayed therefore the date for completion was extended from Q2 to Q3. The need for urgency around this deliverable was conveyed at the last Programme Board. An evaluation was undertaken during September 2022 and the CLERIC system will be utilised to model keys during October 2022.

Review of Resource Unavailable Time

A multitude of work streams continue to be progressed within Ambulance Care. In September 2022, the action related to the review of unavailable time was completed. Reporting regarding resource downtime is now live and data included in the pack presented to the Operations Directorate Weekly Performance, demand and Capacity Meeting.

General Update

Capacity Management Plan

A Capacity Management Plan (CMP) has been deployed to guide the allocation of transport ensuring NEPTS remains within the budgeted resource provision. The result of the CMP has been a significant reduction in taxi expenditure. Further work is required to fully understand the impacts of using the Capacity Management Plan but financially this is aiding cost containment.

NEPTS Cleric Upgrade

Following completion of the new externally hosted environment for the upgraded NEPTS Computer Aided Dispatch (CAD), the new CLERIC Pink system is due to go live in December 2022.

Transfer of UCS from EMS to Ambulance Care

In July 2022, Trust staff who are in (Urgent Care Service (UCS) roles transferred from the Emergency Medical Service (EMS) to Ambulance Care. The transition is now complete and we have worked with People Services colleagues to develop an improved recruitment plan to address significant projected gaps of up to 50% in the services establishment. Delivery of the plan has gone well and we are on track to return to a full establishment by January 23.

Integrated Care

Challenges

Business Continuity Incident – 111

On 4th August 2022, the I.T. platform used in health boards to accept and manage referrals from 111 suffered an outage. That outage continues (at time of report 04/11/2022) and resulted in the Trust having to enact Business Continuity Incident (BCI) arrangements. New operational arrangements were designed and implemented to manage the impacts.

These arrangements included the deployment of GPs and Pharmacists into WAST, management of Priority 3 patients differently and other operational changes. Many of these arrangements have proved sufficiently successful that work is now underway to consider their place in the future 111 operational model.

The Business Continuity Incident was stood down on 15 September 2022, however work continues to prepare for reinstatement of systems.

IMTP

Implementation of 999 Triage System (ECNS)

The 999 Triage system (Emergency Communication Nurse System - ECNS) has been implemented successfully and further training provided in July 2022.

Testing of Booking Systems

Work is underway via the 111 Programme Team to identify pilot opportunities to test direct booking systems for 111 patients to Health Board services.

Deliver an Improved Directory of Services

A National Directory of Service Review led by NHS Improvement was undertaken and a number of change recommendations received. The findings of the review was presented to the Project Board and a task and finish group established. However, all of the recommendations made had significant funding implications therefore these have not yet been implemented due to financial constraints. A report was provided to the Six Goals Programme Board.

111 Press 2 (Mental Health)

111 Press 2 went live in Swansea Bay UHB on 2nd August 2022. The service, operated by the Health Board in collaboration with the Trust, connects callers requiring urgent mental health support to a specialist practitioner. Given the way this is hosted, we do not know the demand being managed by both Hywel Dda and Swansea Bay. We do however monitor the rates passed to 111 when these services are closed and these numbers so far are small.

111 Rostering

In July 2022 the trials of new shift lengths and shift start times in 111 commenced pan-Wales. Following engagement with staff and staff support, on the 12th September 2022 the service will commence a 13-week fixed rota trial. It is anticipated that the outcome will be an increase to the amount of fixed working rotas to enable a more comprehensive baseline cover. This work reflects extensive staff engagement with a view to improve attendance.

General Update

Integrated Care Estate

The Integrated Care teams moved into the new centre in Ty Elwy, North Wales, in August. The works at Vantage Point House continues and are expected to continue through the coming months. These fantastic new facilities provide modern, fit for purpose facilities for our people.

AGENDA ITEM No	6
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	2

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

MEETING	Quality, Patient Experience & Safety Committee
DATE	10th November 2022
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 3 risks that are relevant to Committee's remit.

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 2.

3. The BAF, in Annex 2, provides the Committee with an opportunity to review the controls in place against each principal risk and the assurance provided against those control where applicable. This will assist Members in evaluating current risk ratings.

4. The gaps in controls and assurance are set out on the BAF, as are the actions planned to address any gaps. This detail provides Members with an insight into the planned activity, as much as can be anticipated from time to time, to reduce the risk to a level of tolerance set by the target score. This format will continue to evolve as part of the risk transformation programme.

5. Risks are allocated to appropriate Directors to drive the reviews and actions to mitigate the risks. In addition to directorate reviews there are formal risk review discussions with the Assistant Directors Leadership Team (ADLT) and the Executive Management Team (EMT) in relation to risk escalation, changes in ratings, and any new risks for inclusion on the Corporate Risk Register.

RECOMMENDATION:

6. **Members are asked to consider the contents of the report and:**
    a. **Discuss the risks relevant to Committee.**
    b. **Note the closure of Risk 303 from the Corporate Risk Register.**
    c. **Review the Board Assurance Framework.**

KEY ISSUES/IMPLICATIONS
The key issues are set out in the Executive Summary above.

REPORT APPROVAL ROUTE
7. The report has been considered by: • ADLT – 16th October 2022 • ADLT – 31st October 2022 • EMT – 9th November 2022

REPORT ANNEXES
8. SBAR report. 9. Annex 1 - Summary table describing the Trust's Corporate Risks. 10. Annex 2 - 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

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

SITUATION

1. The purpose of this report is to provide an activity update in relation to the Trust's Corporate Risks, relevant to Committee.

2. A summary report describing the principal risks as of 31st October 2022 is detailed in Annex 1 as an extract from the Corporate Risk Register (CRR).

3. The risk owners have updated progress against the risks in accordance with the review schedule in place across the Trust, with the highest scoring risks reviewed monthly.

4. The Board Assurance Framework (BAF) report is included in Annex 2.

BACKGROUND

5. The Risk Management Transformation Programme was included in the IMTP (2022/2) with the immediate priority to undertake a detailed review of the Trust's 5 highest scoring risks initially with the remaining corporate risks to follow. The programme of work has been completed to strengthen the articulation of the corporate risks and any new risks including title, summary descriptions, controls, assurances and any gaps or additional actions required.

6. The Assistant Directors Leadership Team (ADLT) continue to review the risk assessments, which have been approved by the Risk Owner, on all new risks in addition to reviewing any changes to existing risks and mitigating actions, reporting activity to the Executive Management Team (EMT), Board Committees and Trust Board.

ASSESSMENT

7. There are currently 18 Corporate Risks on the register, 3 of which are assigned to QuEST for oversight, and these are described in the summary table in Annex 1. The table sets out the rearticulation of each of the Corporate Risks including titles and summary descriptions, utilising an '*if, then, resulting in*' approach, the Executive Owner of the Risk and the Risk score with any changes that have occurred during the period.

8. The EMT has approved the risks contained within this paper.

Corporate Risks

9. The full detail of each Corporate Risk, including controls, assurances, gaps and mitigating actions form part of the improved Board Assurance Framework (BAF) detailed in Annex 2.

10. In addition, Members are asked to note that the actions, which were contained in the July 2022 Board paper on avoidable harm and outlined at the last meeting, are included in the action section of the BAF for the Trust's highest

scoring risks 223 and 224 which are both rated 25. These actions seek to mitigate in real time, avoidable harm in the context of extreme and sustained pressure across the urgent and emergency care service.

Closure and De-Escalation of Risks

11. One risk, relevant to Committee, has been closed from the CRR and de-escalated to the Medical & Clinical Directorate Register since the last meeting.

12. **Risk 303** - *Delayed administration of chest compressions to patients as part of resuscitation*

    IF *there is no universal guidance issued in relation to the level of PPE required when administrating chest compressions and no reduction in infection rates of Covid-19*

    THEN *there is a risk of delayed administration of chest compressions to patients as part of resuscitation due to WAST ambulance crews continuing to wear level 3 PPE*

    RESULTING IN *potential patient harm and damage to the Trust's reputation*

13. The Risk Owner and ADLT recommended the risk be closed from the CRR as all actions have been completed and the score reduced to target. This was approved by the EMT in August 2022 and reported to Trust Board in September 2022.

Transfer of Risks

14. No risks have transferred during this reporting period.

Changes to Risk Scores

15. There have been no changes to the risk scores since the last meeting in September 2022.

Further Review of Risks

16. Work continues to consider and develop potential new Risks for inclusion on the CRR in the following areas:

    - *Patient Safety/Putting Things Right Team*
    - *NHS Decarbonisation*
    - *Supply Chain Issues – Digital Equipment*
    - *Securing Stakeholder Support to Deliver the Strategy and IMTP*
    - *Capacity to deliver change (IMTP)*
    - *Ongoing Impact of CoVID and Increasing Demand for Services (IMTP)*

Board Assurance Framework

17. The BAF is included at annex 2 which focusses the Board on the key risks that are mapped to the IMTP deliverables and that might compromise the achievement of the Trust's strategic objectives. Until such time as the more mature and strategic BAF is developed during 2023/24 as part of the risk transformational programme, these key risks are the corporate risks due to their relationship to the IMTP delivery and their risk ratings.

RECOMMENDED:

18. **Members are asked to consider and discuss the contents of the report and:**
    a. **Discuss the risks relevant to Committee.**
    b. **Note the closure of Risk 303 from the Corporate Risk Register.**
    c. **Review the Board Assurance Framework.**

Annex 1 – Corporate Risk Register Summary

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
223	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	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)** ➡
303 CLOSED	Delayed administration of chest compressions to patients as part of resuscitation	**IF** there is no universal guidance issued in relation to the level of PPE required when administrating chest compressions and no reduction in infection rates of Covid-19 **THEN** there is a risk of delayed administration of chest compressions to patients as part of resuscitation due to WAST ambulance crews continuing to wear level 3 PPE **RESULTING IN** potential patient harm and damage to the Trust's reputation	Director of Paramedicine	**10 (2x5)** ➡

Annex 2 – Board Assurance Framework

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death		Date of Review:	18/10/2022		TREND	25 (5x5)
			Date of Next Review:	18/11/2022		→	
IF significant internal and external system pressures continue	**THEN** there is a risk of an inability and/or a delay in ambulances reaching patients in the community	**RESULTING IN** patient harm and death		Likelihood	Consequence	Score	
			Inherent	4	5	20	
			Current	5	5	25	
			Target	2	5	10	

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

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

CONTROLS	**ASSURANCES**
	Internal **Management (1st Line of Assurance)**
1. Patient Flow Co-Ordination based in the Grange University Hospital	1. Patient Flow Coordinators (PFCs) are a commissioned service by the Health Board (x2 in ABUHB specifically for GUH) with a bespoke job description, these link directly with the National Delivery Managers in ODU
2. Regional Escalation Protocol	2. Daily conference calls to agree RE levels in conjunction with Health Boards
3. Immediate release protocol	3. The Immediate Release Protocol is a Nationally agreed NHS Wales protocol. Refusals by Health Boards are Datixed by WAST and compliance report shared weekly with the Health Board Chief Operating Officers (COOs)
4. Resource Escalation Action Plan (REAP)	4. Weekly review by Senior Operations team with assessment of action compliance. The Senior Leadership Team convenes every Tuesday as the Weekly Performance Meeting to review performance and demand data, and review/assign REAP Levels as appropriate. Dynamic escalation via Strategic Command structure.
5. 24/7 Operational Delivery Unit (ODU)	5. Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end. Provides operational oversight with dynamic CSP review and system escalation as required.
6. Gold/Strategic, Silver/Tactical and Bronze/Operational 24 hour/ 7 day per week system to manage escalation plans	6. Same as 5 - Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end. Provides operational oversight with dynamic CSP review and system escalation as required.
7. Limited Alternative Care Pathways in place	7. Limited Assurance - Health Informatics reports, APP dashboard monitors, reports on app use by Consultant Connect, APP development and expansion, and bids for additional prescribing APPs.
8. Consult and Close (previously Hear and Treat)	8. Monitoring CSD rates through AQIs. Consult and Close volumes form part of EMS CCC weekly reports to SLT. Regular reporting of incident volumes to Operational Review Groups. Summary level information about Consult and Close volumes, targets, trends and recontact rates reported to TB and sub-committees. Metrics relating to Ambulance Quality Indicators (AQI) published on a quarterly basis by EASC. Bi-monthly EASC Provider reports. Consult and Close performance reported in Joint Executive Team meeting every 6 months with Welsh Government. NWSSP Information Management Internal Audit report February 2022 (External Assurance)
9. Advanced Paramedic Practitioner (APP) deployment model	9. Qlik sense APP dashboard monitors performance and provides assurance that APPs are flowing patients into alternatives to emergency department. Qlik sense is a national report and can drill down into regional, local and individual performance as required
10. Clinical Safety Plan	10. Clinical agreement – agreeing escalation to higher levels, ODU dashboard, AACE paper through National Director of Operations group
11. Recruitment and deployment of CFRs	11. Volunteers are another resource for response, Volunteer
12. ETA scripting	12. The ETA Dashboard is a tactic that was signed off by EMT – there is a dashboard that supports scripting analysed by comparing with real time data
13. Clinical Contact Centre (CCC) emergency rule	13. CCC Emergency Rule is policy that has been signed off by Execs.
14. National Risk Huddle	14. This is a tactic contained in REAP ratified through SPT and EPT. Daily risk huddles are recorded, and documented actions are shared with stakeholders and progress monitored via the ODU.
15. Handover Improvement Plans agreed between Health Boards and WAST	15. Improvement plans are reviewed by EAST
16. Summer/Winter initiatives	16. Monitoring through SLT and STB
17. CHARU implementation	17. Monitored via the EMS project Board
18. National Transfer & Discharge Model	18. Task and Finish Group established

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	18/10/2022	TREND	25 (5x5)
		Date of Next Review:	18/11/2022	→	

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

19. Conveyance Reduction	19. This is part of the weekly performance review and aligned to Care Closer to Home Programme
20. Access to Same Day Emergency Care (SDEC) for paramedic referrals	20. This forms part of the handover improvement plans in place with Health Boards
21. Mental Health Practitioners in cars	21. Part of the Care Closer to Home workstream
22. Roll out of ECNS	22. Reported through QuEST
23. Clinical Model and clinical review of code sets	23. Reported through QuEST
24. Remote Clinical Support Strategy	24. Strategic Transformation Board – IMTP deliverable
25. Trust Board paper (28/07/22) detailing actions being taken to mitigate the risks (see actions section for details of specific work streams being progressed to mitigate this risk)	25. Formally documented action plan – actions captured are contained within and monitored via the Performance Improvement Plan (PIP)

GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Acknowledgement and acceptance of risk by Health Boards and balancing the risks across the whole system	None immediately identified but subject to continual review
2. Blockages in system e.g. internal capacity within Health Boards which affect patient flow	
3. Covid capacity streaming	
4. Transition Plan/Inverted Triangle – bid for transition plan has been put in and is now subject to funding	
5. Local delivery units mirroring WAST ODU	
6. Handover delays link to risk 224	
7. Tolerance in Health Boards has become the norm. As delays have increased, there appears to be no visible appetite to address these issues	
8. 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.	
9. 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	
Please note that the gaps listed are not WAST's and are therefore outside of the control of WAST	

Actions to reduce risk score or address gaps in controls and assurances	**Action Owner**	**By When/Milestone**	**Progress Notes:**
1. Exploring Rural model options (Paused during Pandemic Response) – subject to funding through IMTP. Now refreshed to wider rural model opportunities to include recruitment of CFRs. Additional funding has been sourced to increase posts within the volunteer function.	Assistant Director of Operations EMS / Assistant Director of Operations – National Operations & Support	31.12.22	Rural model options are being explored. Discussions have been opened up with one workshop held another scheduled for 28th October 2022 with the aim of producing a set of recommendations for consideration by SLT and EMT.
2. Leading Change Together (forum to progress workforce related work streams jointly with TUPs)	ADLT Sub-Group	30.09.22 - Paused	
3. EMS Demand & Capacity i.e. review and implementation of new EMS rosters	Assistant Director of Operations EMS	Extended from 30.09.22 to 31.12.22	On schedule to implement all EA and UCS rosters by the end of November 2022. CHARU rosters may drift into December 2022 due to recruitment and training.
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]	TBA	TBA	
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	31.12.22	Work undertaken to map influences and progress towards each. Trajectory cast until December 2022 - 15% to be achieved through efficiencies.

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death		Date of Review:	18/10/2022	TREND	25 (5x5)
			Date of Next Review:	18/11/2022	→	

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

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	Ongoing	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.
10. Transition Plan (I) [Source: Action Plan presented to Trust Board 28/07/22]			
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	TBA	Level 2 Falls Service implemented as a pilot. Awaiting evaluation of the pilot and assessment of outcomes and potential longevity of this initiative.
12. External Controls detailed within the Action Plan presented to Trust Board on 28/07/22: 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)			

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:	31/10/2022	TREND	25 (5x5)
		Date of Next Review:	30/11/2022	➡	

IF	THEN	RESULTING IN		Likelihood	Consequence	Score
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	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

CONTROLS	**ASSURANCES**
	Internal **Management (1st Line of Assurance)**
1. WAST Serious Clinical Incident Forum (SCIF) is in place to discuss patient safety incidents, learning and improvement actions to prevent future harm, working in collaboration with Health Boards / NHS Wales Delivery Unit under the *Framework for the Investigation of Patient Safety Serious Incidents (SIs)* V2.2, dated July 2019.	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 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 commended in August 2022.	2. Workshop with system partners in place with executive directors of nursing attendance – next meeting 08.09.2002 – plan to finalise revised approach to Appendix B process by November 2022.
3. WAST and system compliance with National Standards - 15-minute handover (NHS Wales Hospital Handover Guidance v2 (May 2016)	3. Monthly Integrated Quality and Performance Report, Health Informatics reports, APP dashboard monitors, reports on app use by Consultant Connect and shared at local and corporate meetings regarding patient safety and handover of care position across NHS Wales and NHS England.
4. WAST Clinical Notice in place - Escalating a clinical concern with a deteriorating patient outside the Emergency Department (11.02.2021). National Early Warning Score (NEWS) trigger of 5 or above for escalation to hospital clinicians. NEWS data available via EPCR (electronic patient care record).	4. NEWS data now available via ePCR and escalation system in place. Learning from incident reporting processes.
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. Patient Flow Coordinators (PFCs) are a commissioned service by the Health Board (x2 in ABUHB specifically for GUH) with a bespoke job description, these link directly with the National Delivery Managers in ODU.
7. Regional Escalation Protocol and Resource Escalation Action Plan (REAP).	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 via 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
9. 24/7 Operational Delivery Unit (ODU) escalating handover delays / patient condition to Health Board colleagues.	9. Shift reports from ODU & ODU Dashboard received by Exec, 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 Exec, 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, dementia awareness, mental health.	12. Integrated Quality and Performance Report (June 85% target met)
13. Clinical audit programme	13. Clinical audit programme with oversight from the Clinical Quality Governance Group.

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:	31/10/2022	TREND	25 (5x5)
		Date of Next Review:	30/11/2022	➡	

IF	THEN	RESULTING IN
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

Controls	Assurance
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.
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 and Board sub-committee oversight and escalation.
	External Sources of Assurance **Management (1st Line of Assurance)**
	1. Monitoring and oversight of the Ambulance Quality Indicators (AQIs) including handover of care timeliness and Commissioning Framework by the Chief Ambulance Services Commissioner (CASC) and Joint Executive Team meeting Welsh Government (I&E).
	2. Healthcare Inspectorate Wales (HIW) 'Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover' Report and system wide improvement plan with working group in place with WAST senior representation. Oversight by HIW and CASC

GAPS IN CONTROLS	GAPS IN ASSURANCE
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.	1. Strengthen and triangulate patient safety metrics and look back data at ED, service and corporate level for baseline data for improvement projects and WAST reports.
2. Inconsistent review of potentially serious / catastrophic patient safety incidents in line with the Framework for the Investigation of Patient Safety Serious Incidents (SIs) V2.2, dated July 2019 (frequently referenced as 'Appendix B' Reports) by Health Boards pan NHS Wales and lack of ownership of system risks. Lack of whole system approach to handling patient safety incidents resulting from system pressures*.	2. Implementation of revised process, engagement and outcome and improvement measures at system level – to be confirmed.
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 from c6000 hours per month at the end of 2018 to in excess of 22000 hours per month during Q4 21/22 and Q1 22/23. This scale of lost emergency ambulance capacity has peaked at 30% per month of the entire emergency ambulance fleet..
4. Variation in responsiveness at Emergency Departments to the escalating concerns regarding patients' NEWS*.	4. Strengthen patient safety reports and audit processes as system embeds.
5. (a) Variation in appetite across the Health Boards to implement Fit2Sit, citing overcrowded emergency department waiting rooms as the reason. Limited confidence in system engagement to address Goal 4 and achieve reduction in handover delays*. 5. (b) Protracted timescales in the Right care, right place, first time Six Goals for Urgent and Emergency Care - A policy handbook 2021–2026. Goal 4 'Improving ambulance patient handover, ensuring no one arriving by ambulance at an Emergency Department waits more than 60 minutes from arrival to handover to a clinician – by the end of April 2025. The number of people waiting over this period for ambulance patient handover will reduce on an annual basis until that point'. No detail on incremental improvements required at emergency department level or oversight mechanisms. EASC have stated that no delay should exceed 4 hours although WAST is yet to see any demonstrable plans to support this*.	5. 15-minute handover target is not being achieved pan-Wales consistently.
6. Variation pan Wales / England as position not implemented across all emergency departments*.	6.
7.	7.

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:**	**31/10/2022**	TREND	25 (5x5)
		Date of Next Review:	**30/11/2022**	→	

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

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

8. Variation pan Wales / England as position not implemented across all emergency departments*.	8. Health & Care Standards self – assessment in progress.
9. Variable response pan Wales / England. WAST have minimal control on this at patient level*.	9.
10.	10.
11. Variable response pan Wales / England. WAST have minimal control on this at patient level*.	11.
12.	12.
13. Transition to ePCR impacting on data temporarily	13.
14. National steer required to confirm the accountability arrangements regarding patients in ambulances outside of the emergency departments. The seven Local Health Boards (LHBs) in Wales are responsible for planning and securing delivery of primary, community, secondary care services, and also the specialist services for their areas*.	14. HIW approve and sign off WAST elements of recommendations.
15.	15.
	External Gaps in Assurance 1. Lack of escalation and response to AQIs by the wider urgent care system and regulators
	2. Lack of collective system response to HIW 'Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover' Report. Meetings cancelled x 2 in May 2022. WAST has representation on the working group*

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
Right care, right place, first time Six Goals for Urgent and Emergency Care A policy handbook 2021–2026 – Goal 4: Rapid response in physical or mental health crisis.	CEO	• WAST is represented on the Clinical Reference Group by the Director of Paramedicine	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
Handover checklist implementation – Nationally WAST Quality Improvement (QI) Project	WAST QI Team (QSPE)	• Checkpoint Q4 2022/23	Timeframes awaited via Emergency Department Quality & Delivery Framework (EDQDF)
Implement nationwide approach to emergency department 'Fit 2 Sit'	CMO/CNO	• Acceptance at meeting of Chairs and CEOs led by Director General for Health and Social Services and the NHS Wales Chief Executive on 08.06.2022 that a national approach to Fit 2 Sit should be adopted. Chief Medical Officer and Chief Nursing Officer to champion development through peer groups • Checkpoint Q4 2022/23	Emergency Department Quality & Delivery Framework final version drafted for consultation / approval.
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	• Checkpoint Q4 2022/23	Incremental improvements to quality and safety data and information to enable triangulation. Access to ePCR data (NEWS) now available.
Continued Health Board interactions – my next patient, patient safety team dialogue – proactive conversations with Health Board Directors of Quality & Nursing.	Executive Director of Quality & Nursing	• Monthly	Monthly meetings continue to be held and the content of the health board reports are currently under review
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	• August 2022 in progress • Checkpoint Q4 2022/23	
Participation in the CASC led workshop to reform *the Framework for the Investigation of Patient Safety Serious Incidents (SIs) V2.2, dated July 2019*.	Assistant Director of Quality & Nursing	• Checkpoint post pilot Q4 2022/23	Revised joint investigation approach agreed which is to be piloted from November 2022.
Recruit additional frontline capacity – additional £3m non recurrent 22/23 allocation	Director of Workforce & Organisational Development	• Recruitment decision made at EMT on 15.06.2022 for 100 WTE with offers already made to ACA2s and EMTs on hold list • Courses to commence in Q2 2022/23 with first new deployments in Q3 2022/23 • Offers also made to all 61 NQPs from "Big Bang" event	

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:	31/10/2022	TREND	25 (5x5)
		Date of Next Review:	30/11/2022	→	

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

		• Correspondence to CASC confirming action taken sent 21.06.2022 with request for recurrent funding source set out • End of Q3 and into Q4 2022/23	
Recruit and train more Advanced Paramedic Practitioners – Value Based Healthcare Fund bid for up to 50 WTE	Director of Paramedicine	• Bid to Value Based Healthcare Fund made for up to 50 WTE APPs to commence fulltime education for 12 months from January 2023 • Q4 2023/24	
Senior system influencing	Trust Chair Chief Executive Officer	• Ensure that system safety and avoidable harm remain a live topic of discussion in all relevant fora • Seize opportunities as they emerge that can contribute to mitigating avoidable harm • JESG forum used to raise awareness amongst Emergency Service Chief Officers who have written twice to NHS Wales Chief Executive to convey the impact of our inability to respond to incidents in the community on their core service provision	Ongoing
Emergency Department cohorting	Director of Operations	• Provide additional clinical staff and suitable space for patients arriving by ambulance to be held at the emergency department awaiting admission enabling the ambulance to be released • In place at Morriston and The Grange	Ongoing
Transition Plan	Chief Executive Officer	• Formally submitted to Commissioners in December 2021 and subsequently subject to a part year funding request of Welsh Government on 24 May 2022 this plan sought to grow our establishment to a further 294 WTE having forecast the challenges currently being seen • Around two thirds of the growth was to deploy additional response capacity (now provided in part by 4 above) whilst the system took action to reduce emergency department handover delays • Around one third of the growth was to accelerate the transition to a new model of service delivery (inverting the triangles) – also now subject to a separate bid as in 5 above	Transition now complete. **CLOSE**
Overnight falls service extension	Director of Quality & Nursing	• Review current extension to falls scheme that has temporarily been running on night duty • Benefit derived but further improvement in utilisation and overall volume of work undertake are necessary in the next 3 months • Scheme extension agreed to 31 March 2023	
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?	Chief Executive Officer	• Conducted in three phases over the next 6 to 9 months 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 • Q1 2023/2024	
Consideration of additional WAST schemes to support overall risk mitigation through winter	Director of Operations	• Summer performance forecast complete and winter underway imminently • Discussions underway during Q2 to create new/further schemes to support operational delivery through winter • Q3 2022/23	
National 111 awareness campaign	Director of Partnerships and Engagement Director of Digital	• National public awareness campaign funded by Welsh Government to promote appropriate use of services (111 as an alternative to 999/ED where appropriate)	

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:	31/10/2022	TREND	25 (5x5)
		Date of Next Review:	30/11/2022	➡	

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

		• Upgrade to 111 website and symptom checkers also underway • Q3 2022/23	

IMTP Deliverable Key

No.	IMTP Deliverable
1	We will recover our systems of working and implement new ways of working developed during the pandemic as we learn to live with COVID-19
2	We will engage with a range of stakeholders, developing genuine Pan-Wales representation on partnership structures and delivering strong political and media relationships across the spectrum
3	We will develop and deliver a collaborative programme of work to design and implement new models within EMS (Inverting the Triangles)
4	We will work with partners to promote and expand use of 111 across Wales
5	We will increase the capacity and capability of the clinical teams for 111 and 999 callers, increasing clinical information available to them and we will create one integrated national team
6	We will work with partners to increase the number of seamless 24/7 pathways from the 111 clinical team to appropriate face to face consultations
7	We will take steps to continuously improve the safety and quality of the service and provide an improved patient experience
8	We will increase accessibility, content and user experience of the 111 Digital front end, which can offer increasingly personalised advice
9	We will increase and balance response capacity and capability across urban and rural area of Wales
10	We will increase skill levels and resources (information, equipment and technology) available to clinicians on scene to allow them to most effectively assess and treat patients
11	We will work with partners to increase number of seamless 24/7 referral pathways as alternatives to ED conveyance and improve hospital handover
12	We will take steps to continuously improve the safety and quality of the service and provide an improved patient experience
13	We will develop and deliver an improvement plan for NEPTS and increase capacity where required to meet demand
14	We will develop and implement with partners an-All Wales transfer and discharge service
15	We will continue to deliver against our Transport Solutions Programme to embed as a business-as-usual approach to service delivery
16	We will take steps to continuously improve the safety and quality of the service and provide an improved patient experience
17	We will improve resource availability, tackling absence and recruitment challenges to deliver improved performance
18	We will effectively manage risk, governance and compliance to promote and protect colleague and patient safety, and ensure a safe, productive and fair work environment
19	We will purposefully shape our future People and Culture Strategy to equip our people to thrive in a changing environment
20	We will foster a culture of belonging and wellbeing where our people can engage, feel supported and represented
21	We will improve access to, and availability of services via the 111 Wales website and other digital channels (NHS Wales app)
22	Improved signposting to the most appropriate service
23	Improved digital tools and services to empower our teams to do their best
24	We will use modern technology to reduce repeat tasks and improve processes
25	Standardised information architecture and common approach to data and analytics across the organisation

26	We will deliver greater insights to WAST and NHS Wales, through improved data sharing, analytics and visualisation
27	Improved resilience, flexibility and interoperability for the 999-call platform
28	We will provide an improved financial plan to support our ambitions
29	Finalise our organisational position on achieving University Trust Status (UTS) in collaboration with WG, embracing a culture of learning, research and innovation
30	We will deliver the Estates Strategic Outline Plan
31	We will implement the Environmental and Sustainability Strategy
32	Deliver the Fleet SOP
33	We will secure and implement Quality Management and control systems
No.	**IMTP Deliverable**
34	We will transform the way we work and engage with people
35	We will revisit and implement the Public Health Plan
36	We will implement the Clinical Strategy to support developments across our service ambitions
37	We will deliver a values-based approach
38	We will deliver strong risk management processes and embed a Trust-wide risk culture that embeds the principles of good governance

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

MONTHLY INTEGRATED QUALITY & PERFORMANCE DASHBOARD – September 2022

MEETING	QUEST Committee
DATE	10th November 2022
EXECUTIVE	Rachel Marsh – Executive Director of Strategy, Planning and Performance
AUTHOR	Hugh Bennett – Assistant Director of Commissioning and Performance Nicola Quiller – Commissioning & Performance Officer
CONTACT	Hugh.bennett2@wales.nhs.uk Nicola.Quiller@wales.nhs.uk

EXECUTIVE SUMMARY

The purpose of this report is to provide senior decision makers in the Trust with an integrated dashboard (Our Patients, Our People, Value and Partnerships/System Contribution) focused on the “vital few” key metrics. This report is for **September 2022** (with the exception of Sickness where August 2022 is reported).

This Report contains information on 24 key indicators. The indicators used at this high-level show, in many areas, a continued poor picture in terms of the quality and safety of the service that the Trust can provide to patients. There are however some areas of improving performance within the Trust’s control, such as the decrease in levels of sickness absence in August and the improving levels of PADRs completed.

RECOMMENDATION

QUEST committee is asked to: -

- **Consider** the September 2022 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 **September 2022.**

BACKGROUND

2. This Integrated Quality & Performance Report contains information on 24 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 a 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 our plans (IMTP) and strategies. This annual review is complete and was endorsed at the July 2022 Finance & Performance Committee and Trust Board meetings; changes have been applied for the August 2022 report, with some final amendments required in the next iteration.

ASSESSMENT

Our Patients – Quality, Safety and Patient Experience

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

6. 999 answering times have been challenged through significant increases in demand. The median and 65th percentile performance remain good, the call answering tail decreased in August 2022 to 52 seconds, however, this remains higher than the Trust would want.

7. There is no additional funding secured into 2022/23 for 999 call handlers. Forecasting and modelling has been completed and fed into the EMS Co-ordination Reconfiguration project with a re-rostering project planned for completion by March 2023.

8. 111 call answering performance remains poorer than the Trust would want. Recent negotiations with commissioners suggest that the Trust has broadly the commissioned and funded number of call handlers in post, however, further work is required to reduce capacity lost through sickness absence, align capacity with

demand and improve efficiency of use of resource. A recent demand & capacity review of 111 by Operational Research in Health (ORH) was presented formally to EMT on 03 August 2022 and agreed.

9. **111 Clinical response:** whilst the Trust continues to see achievement of the clinical call back times for the highest priority 111 calls, we know that the waits for a clinical ring back for most patients are too long. Some improvements were recorded in August 2022. Recruitment and retention of clinicians remains a priority, with significant numbers of clinical vacancies currently. An urgent set of actions within a focused plan are now in place to increase clinician numbers. This includes introduction of a new base for staff within the Cardiff area, a more focussed recruitment campaign and consideration of expanded numbers of clinical professions.

10. **Ambulance Response** (safety / patient experience): Red response times declined into August 2022 despite a reduction in patient demand. In comparison Amber saw improvements in performance across the percentiles; however, the Amber 1 tail (95th percentile) remains at unacceptable levels, at five hours 56 minutes. These long response times have a direct impact on outcomes for many patients. This was the focus of the discussion during the last committee cycle where Non-Executive Directors expressed considerable concern at the levels of avoidable harm to patients and impact on staff well-being. Actions within the Trust's control include:

    Capacity:

    - Recruitment: the Trust has recently received an additional £3m in 2022/23 which will allow the Trust to recruit 100 FTEs over and above the existing establishment. There are clear plans to deliver this uplift by 23 January 2023. This increased establishment will leave a relief gap of 64 FTEs, against the FTE requirement for the re-rostered position, including full roll out of the Cymru High Acuity Response Units (CHARUs).

    - Winter modelling: the Trust has completed winter modelling (March 2023) based on the delivery of the 100 FTEs and the Ministerial direction for hospital handovers to have a four hour backstop and a 25% reduction in minutes per handover. Whilst indicating an improved position for performance/patient safety, Red 65% and Amber 1 30 minutes are not modelled as being achieved. The Trust has updated is rolling tactical seasonal plan (Performance Improvement Plan) with a range of additional actions to improve patient safety as the Trust starts to move into the winter period.

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

    - The Ambulance Response roster review is on target for go live between September 2022 and November 2022. This will have the equivalent performance impact of 72 FTEs.

    - A Managing Attendance Programme has been agreed with EMT, which includes seven work-streams. This is now live and being reported to EMT every two weeks. This is planned to reduce sickness absence in line with a trajectory included in the IMTP, and improvements have been seen in August.

- Further discussion continues constructively with trade union partners on a range of other potential workforce efficiencies and staff-well-being.

Demand Management

- The Trust has prioritised 41 additional clinicians into the Clinical Support Desk, with 36 Paramedic FTEs and five mental health practitioners successfully recruited and now in place. As well as improving the safety of the calls that are waiting, this investment will also mean an increase in consult and close rates, with the Trust now aiming to achieve a 15% rate by December 2022, an increase in the previous target of 10.2% which has been delivered.

11. One of the key factors in relation to response times is the capacity lost to handover outside Emergency Departments. 24,295 hours were lost in August which represents 30% of the total number of conveying resource hours produced for the month. The levels are so extreme that all the actions within the Trust's control cannot mitigate and offset this level of loss. Urgent and high level discussions have taken place between the Trust, Health Board CEOs and the CEO of NHS Wales. A number of mitigating actions have been agreed and a target of no >4 hour waits and a reduction of 25% in minutes per ambulance arrival (from Oct. 21 baseline). Whilst this is a target and trajectories are in place, improvements have not yet been seen with September seeing a further increase in handover lost hours to 25,167 hours or 2,188 shifts. Immediate Release figures for September were: Red 285 accepted and 31 declined; and Amber 1 251 accepted and 508 declined.

12. Ambulance Care (formally NEPTS) (Patient Experience): Performance was above target for enhanced renal patient arrivals prior to appointment in September 2022 and improved for patients requiring discharge; however, overall demand for the service continues to increase, although it has not yet recovered to pre CoVID-19 levels. EASC (10th May 2022) had a "focus on" development session on NEPTS, which included looking at the imbalance of demand and capacity and options for resolving this. The feedback from the "focus on" session with EASC indicated a need to look at NEPTS changing demand and the capacity to support this. In the short term a capacity management plan is in place whilst pre-work is being undertaken on a potential roster review next year. A more efficient management of demand is another line of enquiry.

13. National Reportable Incidents (NRIs) / Concerns Response: The Trust reported 7 NRIs to the Delivery Unit in September 2022, compared to ten in August 2022; and 15 serious patient safety incidents were referred to health boards in September 2022 under the "Appendix B" arrangement, compared to 10 in August 2022. In September 2022 complaint response times improved slightly to 28%, failing to meet the 75% target. In the main, many of these incidents will be because of continued longer response times and the actions outlined above therefore are key. The Trust is putting more capacity into the Putting Things Right team.

14. Clinical outcomes: The Trust is unable to fully report on the performance of all clinical indicators whilst work continues to link ePCR with the CAD and quality assure metrics. The percentage of suspected stroke patients who are documented as receiving an appropriate stroke care bundle was 79.10% in

September 2022, below the 95% performance target. The introduction of ePCR enables the collection and sharing of information and data in a more timely and accurate manner. This will enable the Trust to better showcase clinical care provided to patients. Work is ongoing on the new call to door time-based metrics for STEMI and Stroke using the following roll out plan:

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

Our People (workforce resourcing, experience and safety)

15. **Hours Produced**: 114,353 Ambulance Response ambulance unit hours were produced in September 2022. The emergency ambulance unit hours production (UHP) was 96% in September 2022 and RRV UHP was 76%. Key to the hours produced are roster abstractions which remain high.

16. **Response Abstractions:** abstraction levels remained at 40% in September 2022, but are significantly improved from the high in March 2022 of 49%, however, they remain much higher than the 30% benchmark. COVID-19 has had a significant impact on abstractions with sickness abstractions being 10% in September 2022 (benchmark 5.99%). The training abstraction is also high, driven by internal movements linked to recruitment.

17. **Trust Sickness absence:** the Trust's overall sickness percentage was 8.72% in August 2022 which represents an improvement. Actions within the IMTP concentrate on staff well-being with an aim to start to reduce this level. A specific Managing Attendance programme has been established, led by the Deputy Director of WOD, to identify and implement actions across a range of areas to improve sickness absence and alternative duties.

18. **Staff training and PADRs:** Stat / Mand training compliance rates have been improving again achieving the 85% target. PADR levels are also improving steadily although remain below target.

19. Equality, Diversity and Inclusion: work is ongoing to agree the indicators to be used at this level to demonstrate progress in this area.

Finance and Value

20. **Financial Balance**: the Trust has reported outturn performance for September 2022 with a surplus of £1,000, and a forecast to the year-end of breakeven. At present the Trust is forecasting achievement of both its External Financing Limit and its Capital Resource Limit for 2022/23.

21. **Post-production lost hours**: the efficient and effective use of the capacity that the Trust produces is a key indicator. This is measured within the EMS service by the calculation of post-production lost hours (PPLHs). The reasons for PPLHs are many and varied. The EMS Demand & Capacity Review identified that the Trust benchmarked favourably on all elements of PPLH other than return to base

meal breaks. The Trust and TU partners continue to work together on options for change.

Partnerships/ System Contribution

22. **Shift left**: much of Trust's work relates to working with health boards and other partners to provide the right care closer to home and reducing the number of patients who need to be conveyed to hospital. Good progress has been made through the year in increasing **consult and close** rates after 999 calls; and the Trust achieved 12.3% in September 2022, compared to the benchmark of 10.2%, which was exceeded during 2021/22.

23. The Trust has an ambition to shift more patient demand left, where it is clinically safe to do so through both consult and close and see & treat, a position consistent with the EMS commissioning framework. To this end the Trust has increased the establishment in the Clinical Support Desk by 41 FTEs, almost doubling the existing establishment, with 36 Paramedic FTEs and 5 FTE mental health professionals. The Trust is also implementing new clinical triage software (now live) and working with health boards on how they can support remote demand management. There is a revised ambition of 15% for consult and close into 2022/23 (for December 2022).

24. The Trust **conveyed** 33% of patients to emergency departments in September 2022, but this figure needs to be treated with significant caution as analysis shows that conveyance rates are linked to pressures within the system and the application of the Clinical Safety Plan (CSP), which will trigger the Trust being unable to send ambulances to lower acuity calls, with many patients cancelling the ambulance due to the long response times. In September, over 11,500 patients cancelled their ambulance and the Trust was unable to send an ambulance due to application of CSP levels to approximately 700 callers. In the longer term, as the Trust knows, the system needs to transform if it is to become more sustainable. A formal programme to take forward "inverting the triangle" has been established. A bid was submitted to Welsh Government to start to increase numbers of APPs being trained; this was not successful, but the Trust has decided to proceed with the option of an additional 10 MSC places from September 2022 and a further 8 later in the year.

25. **Handover lost hours**: 25,167 hours were lost in September 2022. These levels are unprecedented and extreme and whilst the Trust can seek to mitigate the impact of handover lost hours through various efficiencies, the Trust cannot offset this scale of lost hours. The Trust continues to raise this issue with EASC, Health Boards and Welsh Government. Fortnightly meetings have been established with each health board by the CASC, which WAST attends, which are designed to focus on action plans and trajectories for improvement. The 2022/23 EASC commissioning intentions for handover lost hours focuses on setting improvement trajectories per site; however, the pressure on the unscheduled care system as Wales emerges from the pandemic mean that the Trust can expect these extreme levels to continue into 2022. Ministerial direction indicates that the Immediate Release Directions should be accepted and an escalation procedure has been agreed nationally and implemented from the 25th July 2022; however, practice on the ground is at variance with the direction.

Summary

26. The indicators used at this high-level show, in many areas, a continued poor picture in terms of the quality and safety of the service that the Trust provides to patients. Patient demand across the 111 and EMS services decreased in September 2022, however, other factors such as the continuation of the CoVID-19 variants, levels of sickness (including CoVID-19 related absence) and extreme handover lost hours continue to impact on the Trust, in particular, the EMS. EASC, WG and the 111 Programme Board have been very supportive of the Trust through the pandemic, investing in a range of mitigations; however, funding for further initiatives is currently limited as the fiscal position becomes much tighter. For 111 and Ambulance Care (NEPTS) the Trust can look to take a range of actions to optimise the balance between patient demand and capacity; however, for EMS the Trust cannot take sufficient actions within its control to mitigate the impact of the extreme handover lost hours. As a result, all three committees have expressed serious concern about the impact of handover lost hours on patient safety and staff well-being. The Trust has received further funding (£3m) for +100 FTEs into EMS, which is welcome, but it remains critical to patient safety that handover lost hours are reduced in line with Ministerial expectation.

RECOMMENDATIONS

QUEST committee is asked to: -

- **Consider** the September 2022 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**
27 Oct-22	**CEO & Director of Strategy, Planning & Performance**
02 Nov-22	**Executive Management Board**
10 Nov-22	**Quality, Patient Experience and Safety Committee**

REPORT APPENDICES
Appendix 1 – Top Indicator Dashboard

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

Monthly Integrated Quality & Performance Report

September 2022

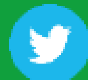
Annex 1 – Top Indicator Dashboard

Section 1: Monthly Indicators / Top Indicators Dashboard

Top Monthly Indicators	Target 2022/23	Baseline Position (2021/22)	Sep-22	2 Year Trend	RAG
Our Patients - Quality, Safety and Patient Experience					
NHS111 Abandoned Calls	< 5%	18.60%	10.6%		R
999 Call Answer Times 95th Percentile	95% in 00:00:05	00:52	00:52		R
999 Red Response within 8 minutes	65%	55.2%	50.0%		R
999 Amber 1 Median	00:18	01:10	01:30		R
Stroke Patients with Appropriate Care	95%	TBD	79.10%		R
Acute Coronary Syndrome Patients with Appropriate Care	95%	TBD	45.00%		R
Renal journeys arriving within 30 minutes of their appointment (NEPTS)	70%	79%	74%		G
Discharge & Transfer journeys collected less than 60 minutes after booked time (NEPTS)	90%	81.00%	88%		A
National Reportable Incidents reports (NRI)	Reduction Trend	5	7		R
Concerns Response within 30 Days	75%	61%	28%		R

Top Monthly Indicators	Target 2022/23	Baseline Position (2021/22)	Aug-22	Sep-22	2 Year Trend	RAG
Our People						
Capacity						
EMS Abstraction Rate	29.92%	42.00%	40%	41%		R
Hours Produced for Emergency Ambulances	95%	95.0%	95%	96%		G
Health and Wellbeing						
Sickness Absence *(all staff)*	5.99%	10.48%	8.72%	-		R
EMS Operations Sickness Rates	5.99%	7.76%	9.87%	9.26%		R
Staff Turnover Rate	TBD	8.71%	11.50%	11.35%		R
Statutory & Mandatory Training	>85%	82.3%	85.44%	85.60%		G
PADR/Medical Appraisal	>85%	60%	73.66%	78.75%		A
Value						
Financial balance - annual expenditure YTD as % of budget expenditure YTD	100%	100%	100.00%	100.00%		G
Post-Production Lost Hours (EA, RRV, UCS)	Reduction Trend	8,582	7175:52	8520:31		A
Partnerships / System Contribution						
NHS111 Consult and Close	Improve	7,843	14,729	15,342		G
Combined 999 & NHS111 Consult & Close	15.0%	10.4%	11.8%	12.3%		A
% Of Total Conveyances taken to a Service Other Than a Type One Emergency Department	Improvement Trend	TBD	11.99%	11.14%		TBD
Number of Handover Lost Hours	25% reduction from Oct-21 position	15,955	24,295	25,167		R

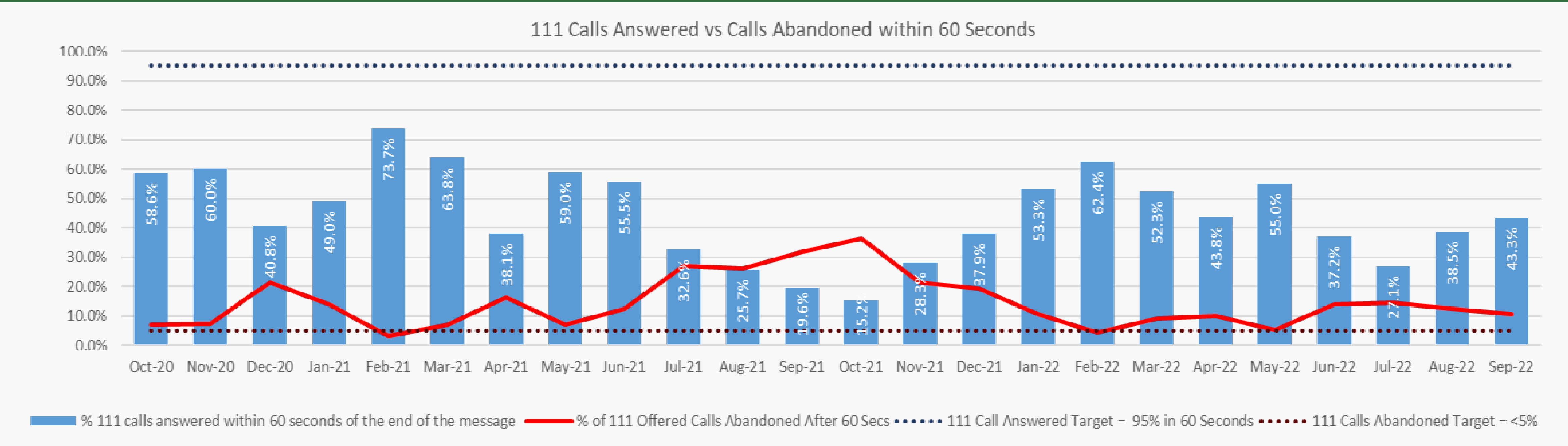
In-Month RAG Indicates =
Green: Performance is at or has exceeded the target *(Indicates no action is required)*
Red: Performance is less than 10% of target (Indicates close monitoring or significant action is required)
Amber: Performance is at or within 10% of target *(Indicates some issues/risks to performance (monitoring is required))*
TBD: Status cannot be calculated (To Be Determined)

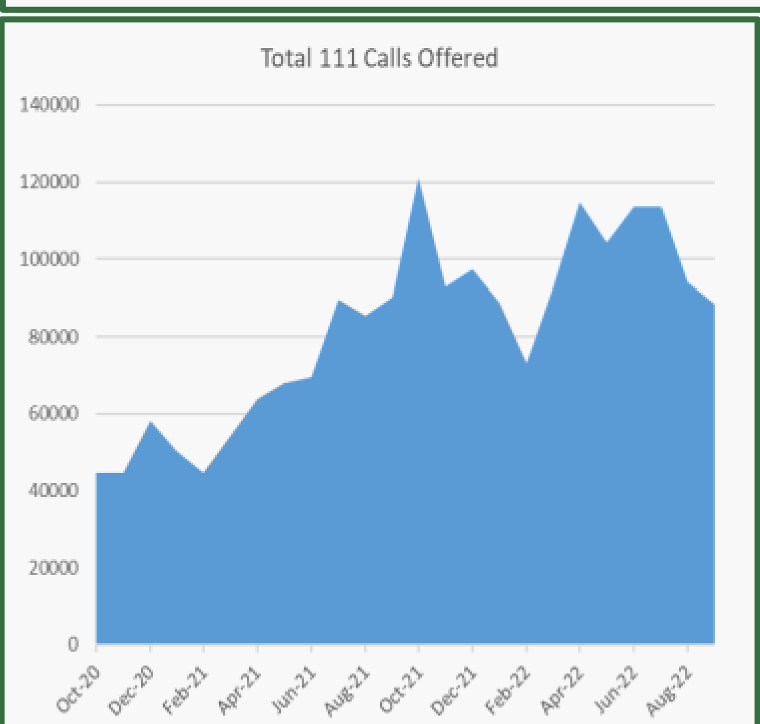


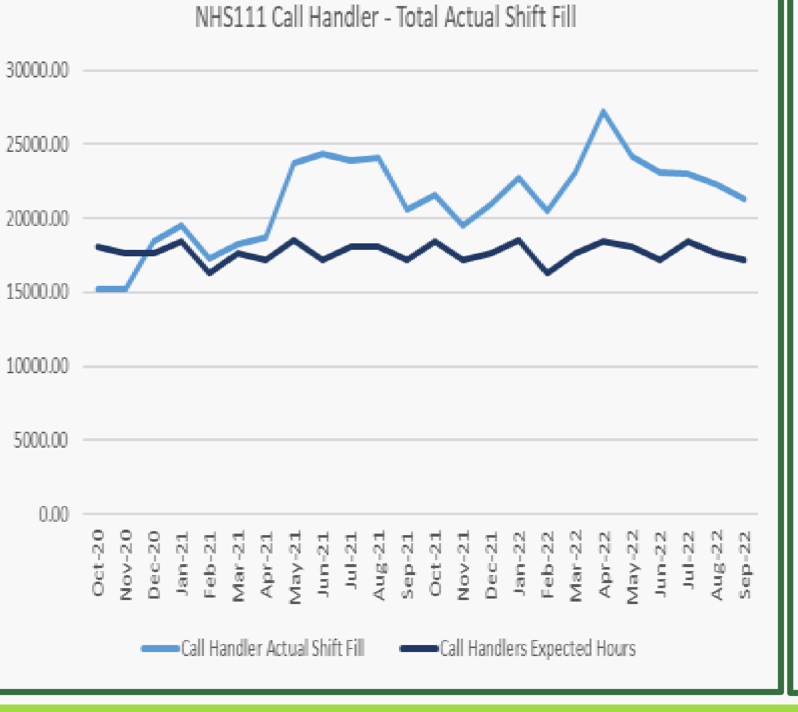
Our Patients: Quality, Patient Safety & Experience
111 Call Answering/Abandoned Performance Indicators

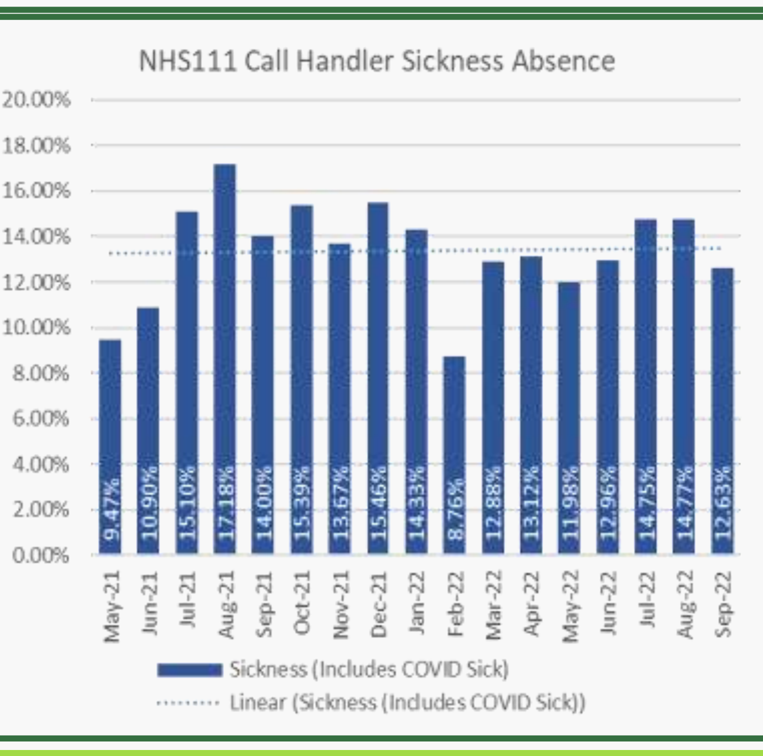
R

Influencing Factors – Demand and Call Handling Hours Produced









Analysis

111 call abandonment is a key patient safety indicator for the service. **September 2022** saw an abandonment rate of 10.6%, therefore failing to meet the 5% target.

The percentage of 111 calls answered within 60 seconds of the end of the message improved in September 2022 to 43.3%. Although 111 call demand decreased for the third consecutive month it still remains high, therefore a significant number of people continue to receive a poor patient experience.

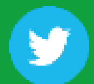
Capacity (staff hours) has generally been increasing in line with the roll-outs and as planned; however, this is impacted by sickness abstractions for Call Handlers (which includes COVID-19 Sickness) which although decreased in September 2022, remain high at 12.63%. Demand has fallen but so has capacity which is why performance has remained relatively stable this month. It is worth noting that in response to the ongoing Business Continuity incident as a result of the Adastra outage, additional Call Handlers have been necessary to support manual processes as the Trust is unable to pass calls to Health Boards electronically.

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 178 WTE call handlers will be funded this year. We are currently broadly at that number with no vacancies.
- Work continues on sickness absence in line with the Trust's managing absence work programme
- Work is underway to look at the rosters and ensure that capacity is aligned to demand, and to try and even out performance through the week
- Work also continues in reviewing the use of the Clinical Advice Line which is available to call handlers who want some clinical advice whilst on call with the patient. The call handler has to wait for a clinician to answer the call and therefore the time spent is related to clinician availability. At present there are high levels of vacancies

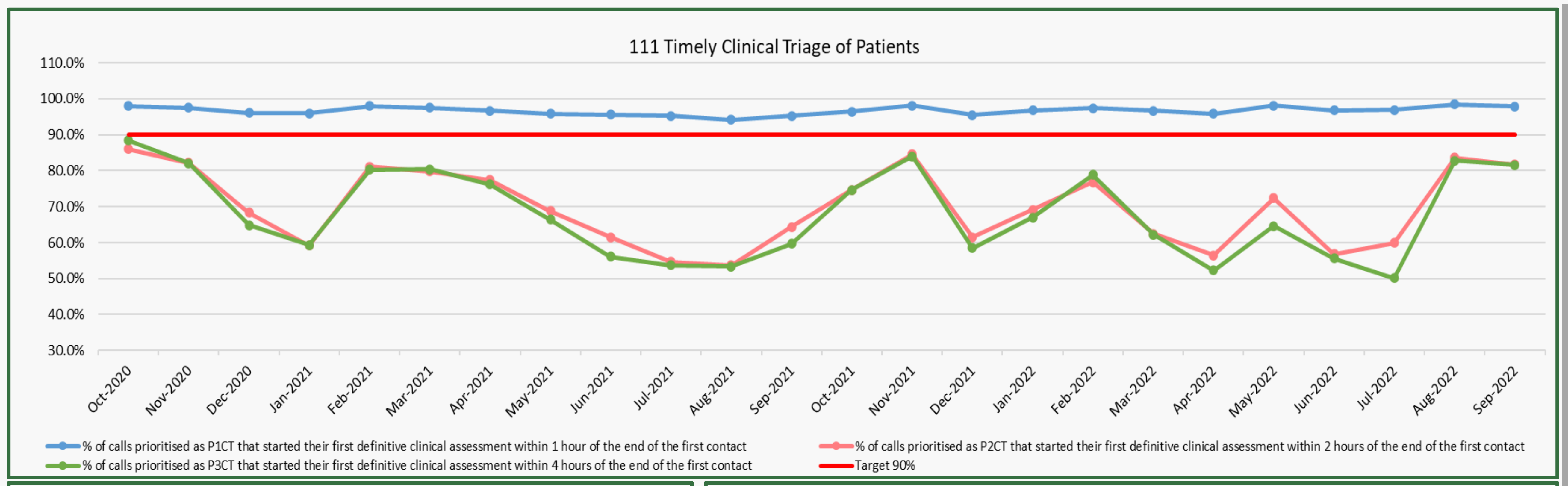
Expected Performance Trajectory

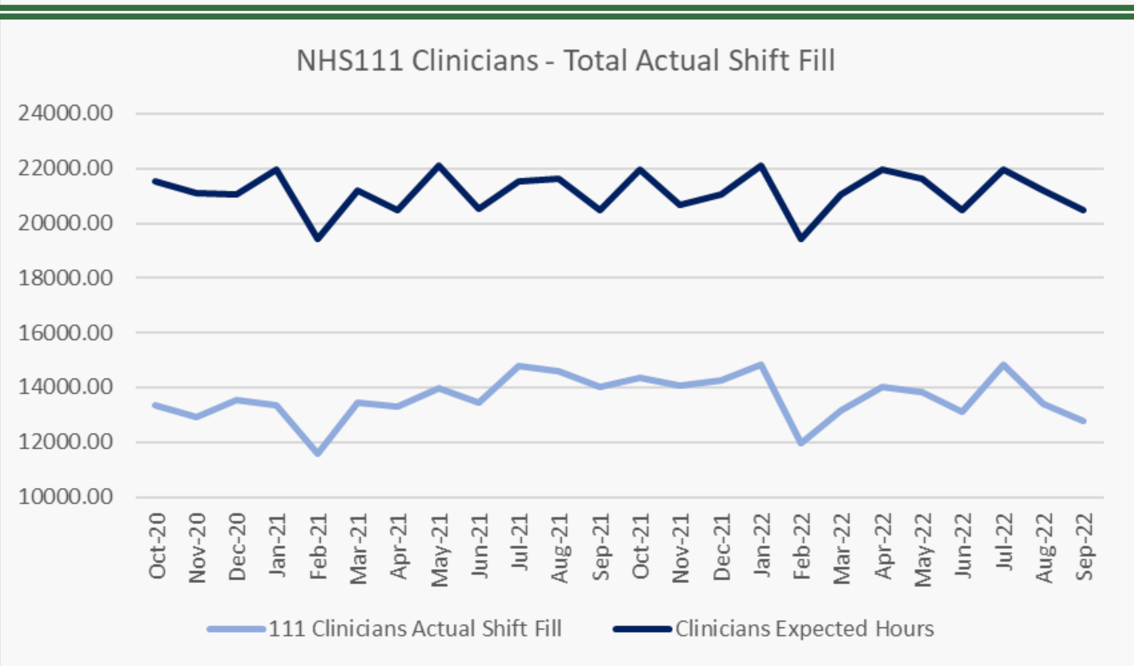
With call handler numbers broadly at commissioned levels, call answering times will only be improved through improved efficiency gains (reducing sickness absence, re-rostering, reducing time for CAL line).

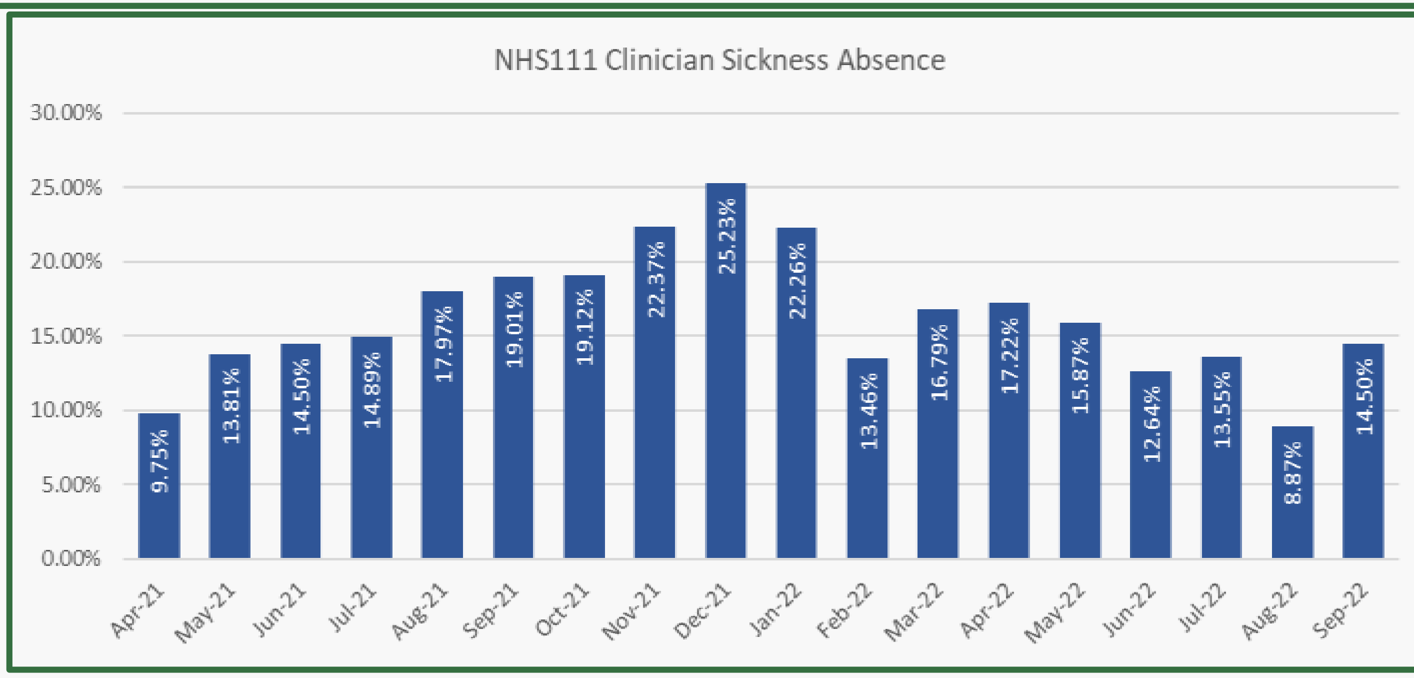


(Responsible Officer: Lee Brooks)

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







Analysis

The performance of **111 calls receiving a timely response to start their definitive clinical assessment has seen improvements across the priorities. The highest priority calls, P1CT, continue to receive a timely response** which has continuously achieved the 90% target over the last 2 years.

For lower category calls the Trust is not meeting the 90% target, but there has been a significant improvement in performance in recent months.

Demand for the service has grown significantly, although call volumes reduced again in September 2022, but call volumes remain high, which affects performance; in addition, recruitment and retention of clinical staff also remains problematic.

12,789 hours were filled by clinicians in September 2022 a reduction when compared to 13,415 in August 2022, and below the commissioned level of 20,201 hours. Clinician sickness absence was 14.50% in September 2022, which is a significant increase compared to 8.87% in August 2022. At present there are 100.1 (FTE) nurses and paramedics employed within NHS111 and 39.1 FTE Vacancies *(data correct as of 16/09/22 and therefore subject to change).*

Remedial Plans and Actions

The main driver of improved performance will be the correct number of clinicians in post to manage current and expected demand. At present there are significant numbers of clinical vacancies. Urgent actions are in place now to increase recruitment this winter, including:

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

NB: Future iterations of this report will include Clinician FTE numbers and vacancies.

Expected Performance Trajectory

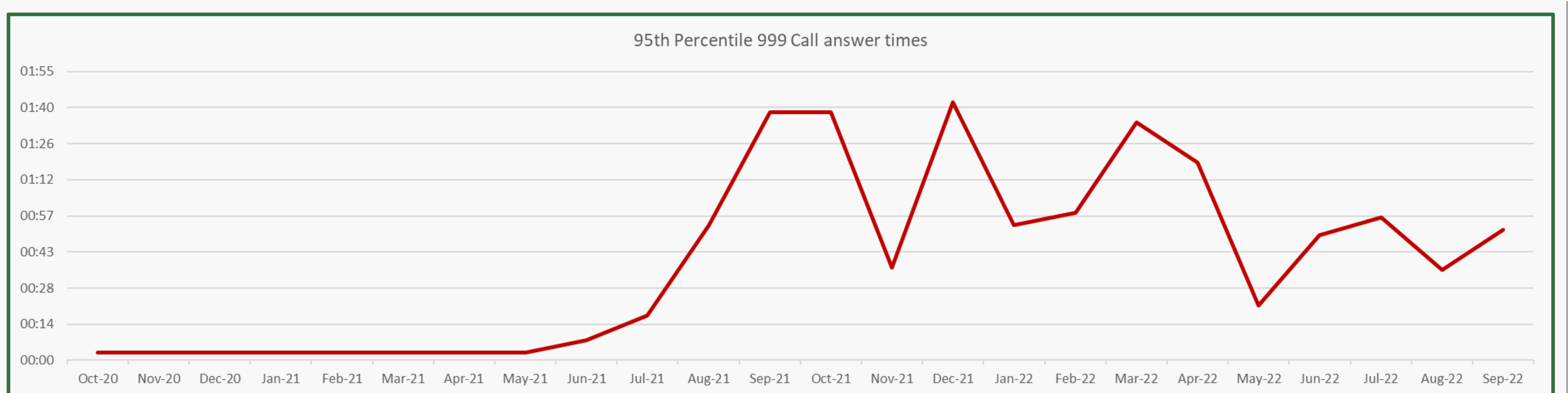
Risks have been highlighted in previous reports about the ability to recruit sufficient clinicians and this is now being seen. Although urgent actions are in play as set out above, performance is likely to be poorer than the Trust would want until these bear fruit into Q4.

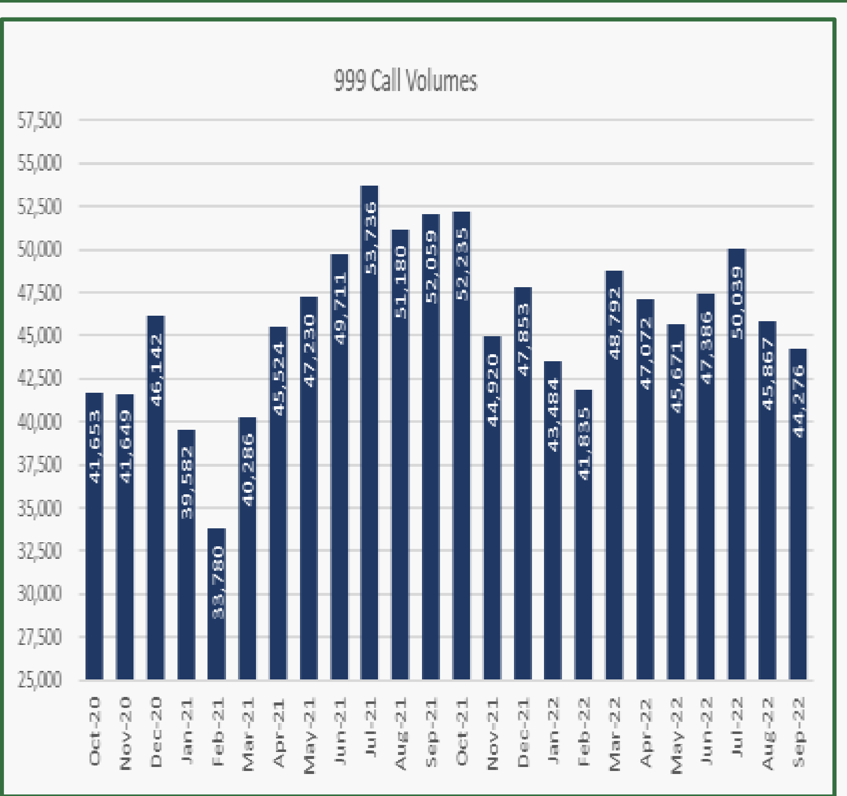
Our Patients: Quality, Safety & Patient Experience
999 Call Performance Indicators
Influencing Factors – Demand and Hours Produced

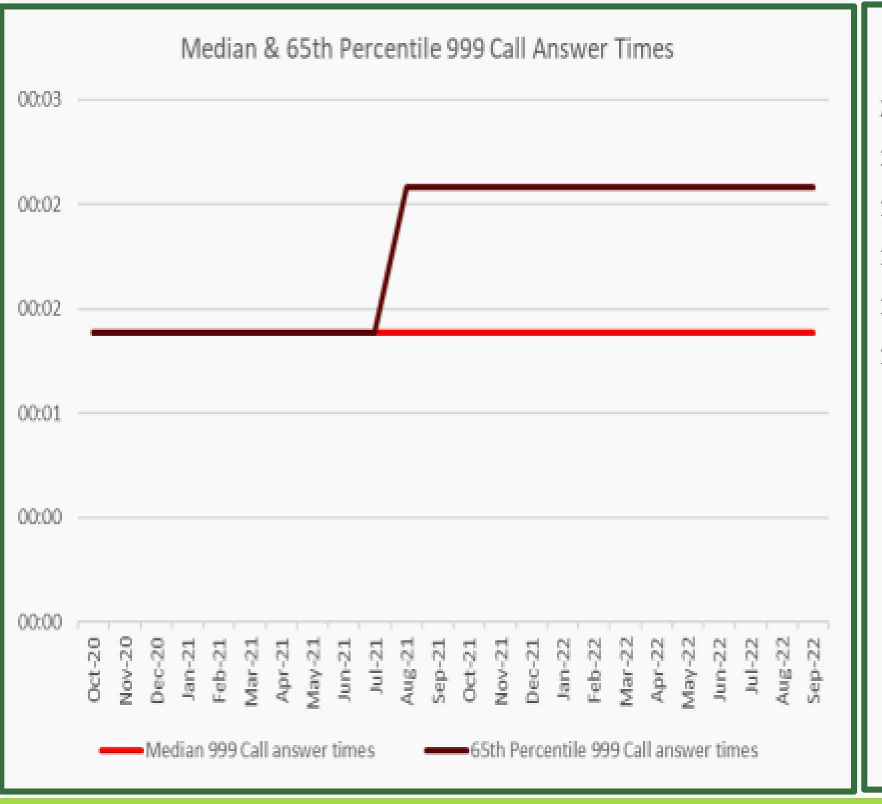
R

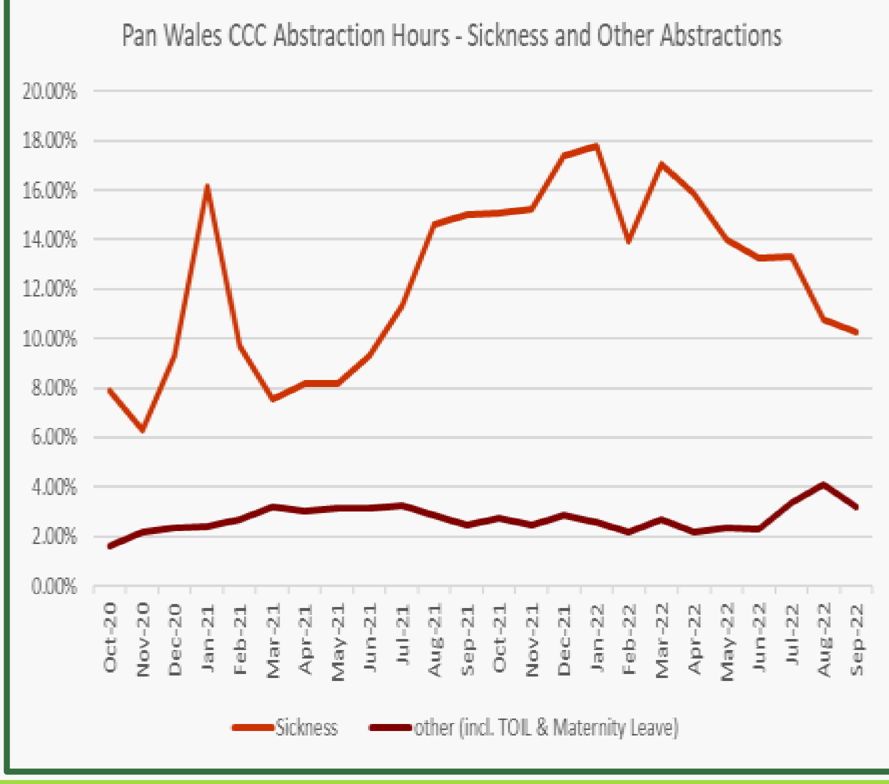
FPC

CI









Analysis

The 95th percentile 999 call answering performance declined in September 2022 to 52 seconds, compared to 36 seconds August 2022. Delays in call answering times are a significant concern in relation to patient safety. 88.3% of calls were answered within 6 seconds in September 2022.

The median call answer times for 999 services remains consistently at 2 seconds. In September 2022 65th percentile continued to average at 3 seconds.

The Trust received 44,276 emergency 999 calls in September 2022, a decrease compared to August 2022. September 2022 saw a reduction in sickness abstractions, in line with the planned trajectory.

A continuing higher level of call volumes could be as a result of repeat callers, as a direct result of long wait times, prompting people to call back or conditions to deteriorate.

Remedial Plans and Actions

- EMS CCC meet twice weekly to review demand profiles and align staffing levels appropriately. Resources teams are focussing on balancing capacity across the 7-day period, targeting overtime to weekends and Mondays where patterns of demand and reduced UHP are identified.
- Additional funding original approved has been withdrawn this fiscal year and as such EMD establishment will remain at baseline demand levels within the financial envelope for EMS Coordination.
- Increased pressure and sustained levels of 999 demand above baseline is impacting on staff attrition and wellbeing.
- There are currently 73 FTEs (94.81%) Clinical Support Desk staff in post of the overall 77 FTE establishment, 3 of these people are in training.

NB: FTE Data correct as of 21/07/2022

Expected Performance Trajectory

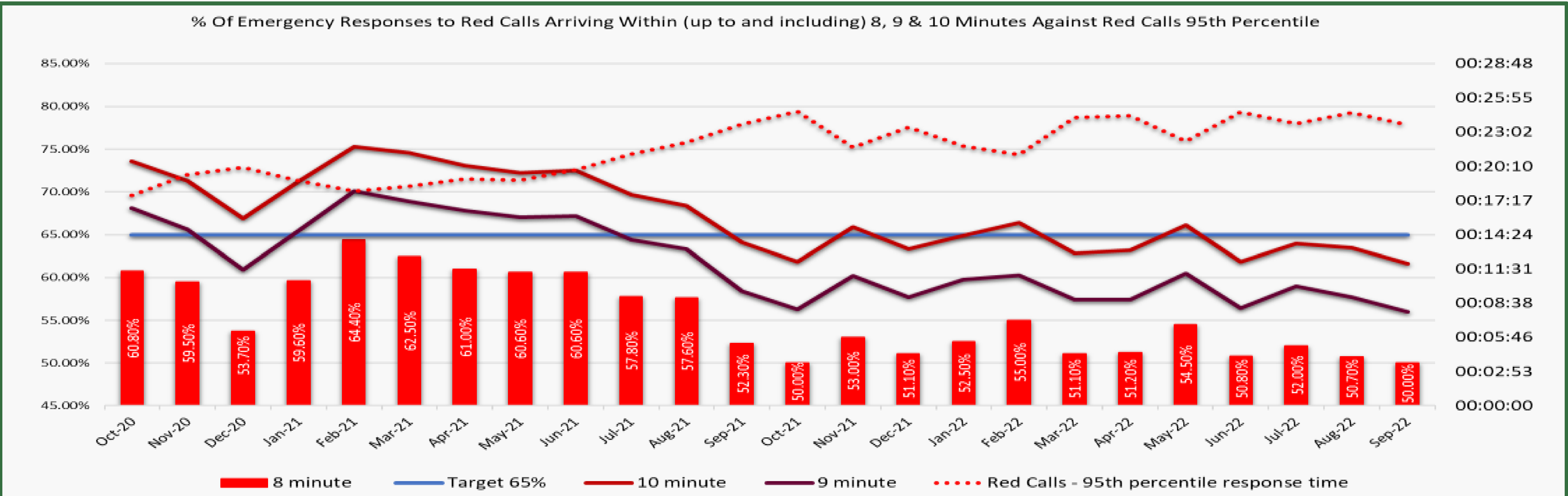
Performance is expected to continue to be difficult with call demand forecasted to increase throughout the fiscal year. EMS Coordination continue to focus on proactive recruitment to mitigate the impact of current attrition rates

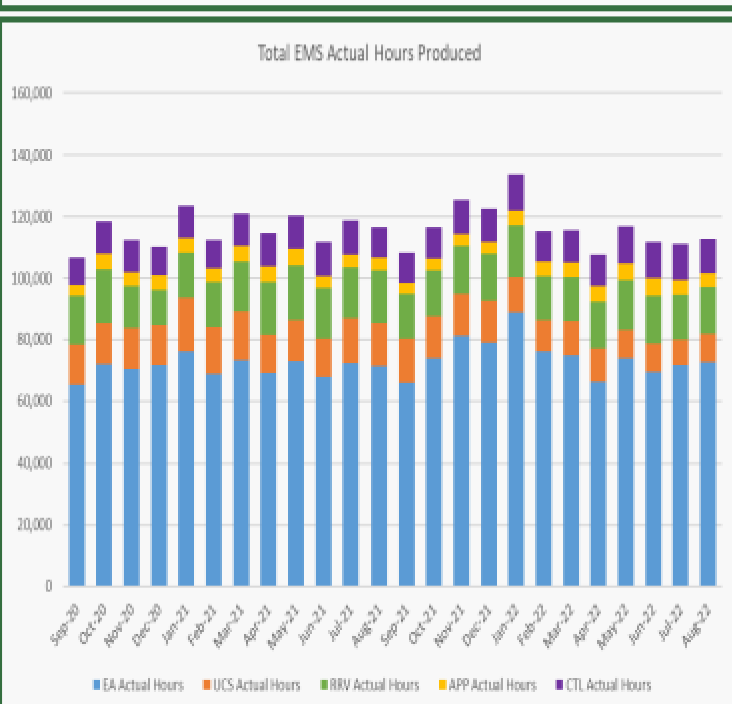
Our Patients: Quality, Safety & Patient Experience
Red Performance Indicators

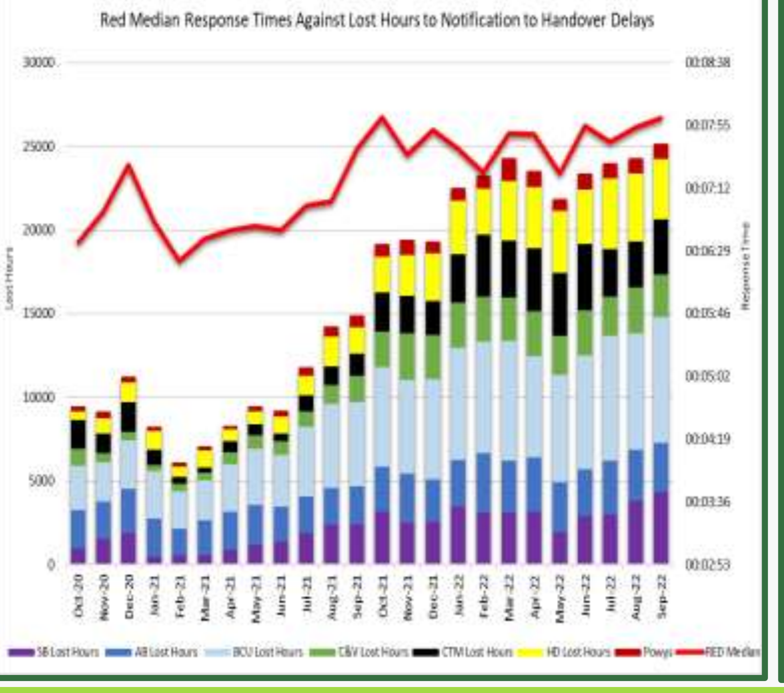
Influencing Factors – Demand, Hours Produced and Hours Lost

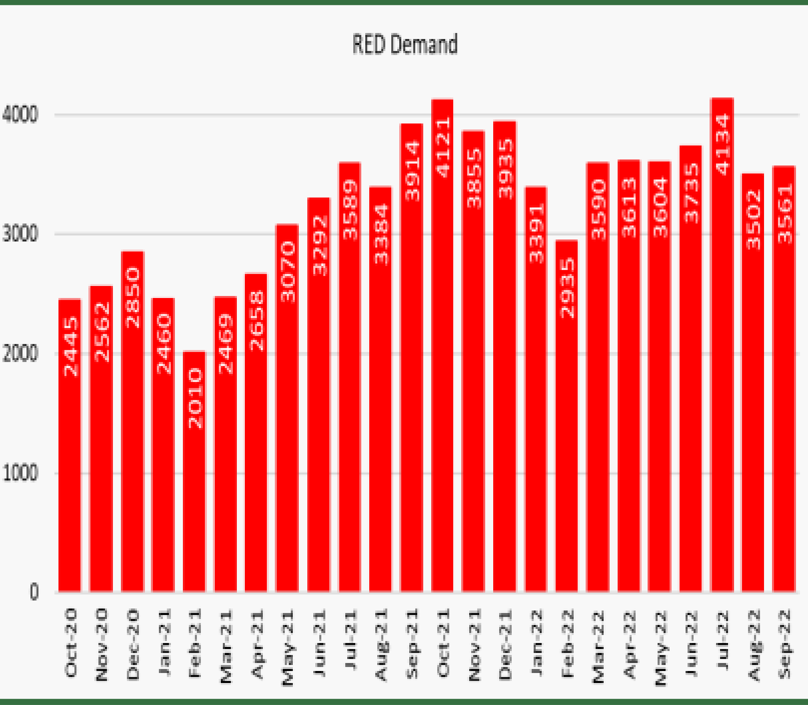
65%	95%
R	R

CI QUEST FPC









Analysis

Red performance declined in September 2022; remaining significantly lower than the 65% target; the target has not been achieved since July 2020. There was also significant health board level variation with none of the seven health board areas achieving the 65% target. A continuing level of poor performance was forecast in the spring plan based on predictions of demand, lost hours and hours produced. Red 10-minute performance was 61.6% in September 2022.

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

Red demand in the last 2 years has seen a particular increase, outside of normal expected variation which is impacting on response times. Demand is not expected to decrease, and the current levels have been built into forecasting and modelling work.

The lower centre graph demonstrates the correlation of performance with hospital handover lost hours, with extreme levels of losses continuing to be seen with 25,166 hours lost in September.

There are many other factors which affect Red, including additional time taken to don level 3 PPE to Red calls relating to some respiratory disease/issues (this requirement remains in place).

Remedial Plans and Actions

The main improvement actions are:

- Increase capacity where funded - recruitment of 100 FTEs, EMTs and ACA2s during 2022/23 (on target for all operational by end of Jan 2023)
- Reduce hours lost through sickness absence through managing attendance programme – trajectory for improvement in place as part of IMTP.
- Increasing capacity through modernisation of practices and supporting staff well-being. This is under discussion with TU partners currently.
- Working with partners to reduce hours lost at hospital. Handover reduction plans and trajectories are currently being developed by health boards facilitated by the NCCU. Agreement on immediate release and fit to sit, together with commitment to no >4 hour waits and a reduction in 25% overall.
- Improving efficiency – new rosters to be implemented September – November. Equivalent of 72 WTE additional staff. Plan on track
- A deep dive of Red performance by Health Informatics has concluded with further actions to investigate increased time spent on scene and consideration of dispatch volumes and locations.
- CSAM Optima have undertaken work to investigate Red variation summarising that Red variation on any given day can be difficult to impact due to the +20 factors that affect Red response times.

Expected Performance Trajectory

Winter modelling (March 2023) indicates that without reductions in handover in line with the Welsh Government directives, the Trust can expect to see Red 8 minute performance reduce to below 40% without the application of the Clinical Safety Plan to levels 3 and above and the recruitment of the +100.

(Responsible Officer: Lee Brooks)

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

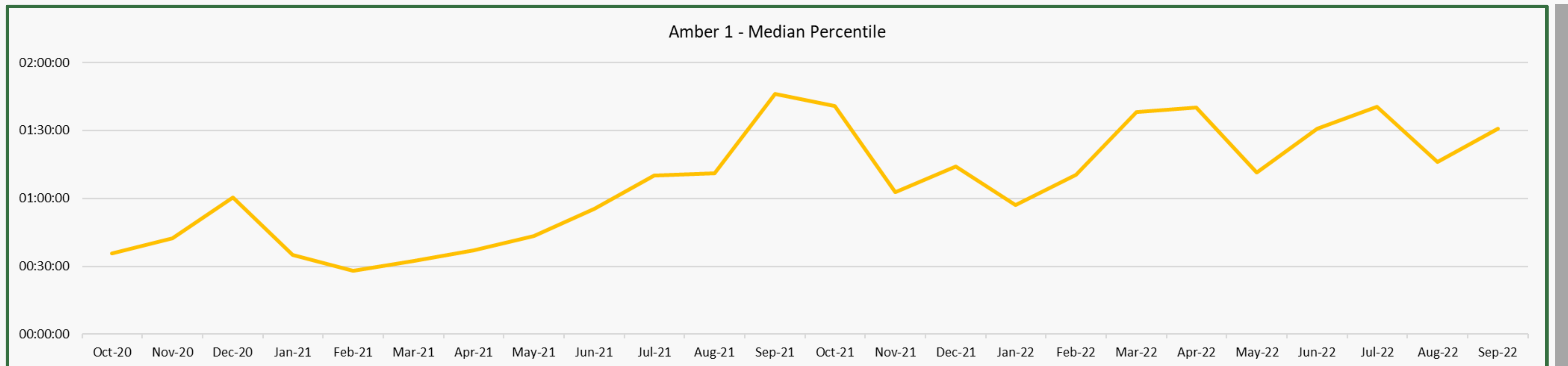
Influencing Factors – Demand, Hours Produced and Hours Lost

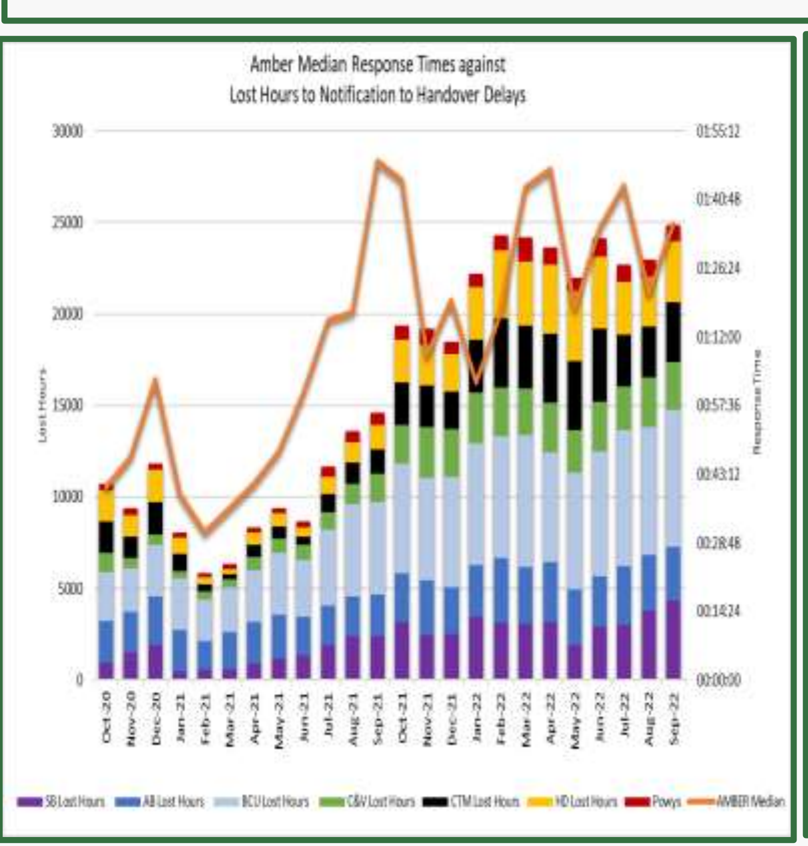
R

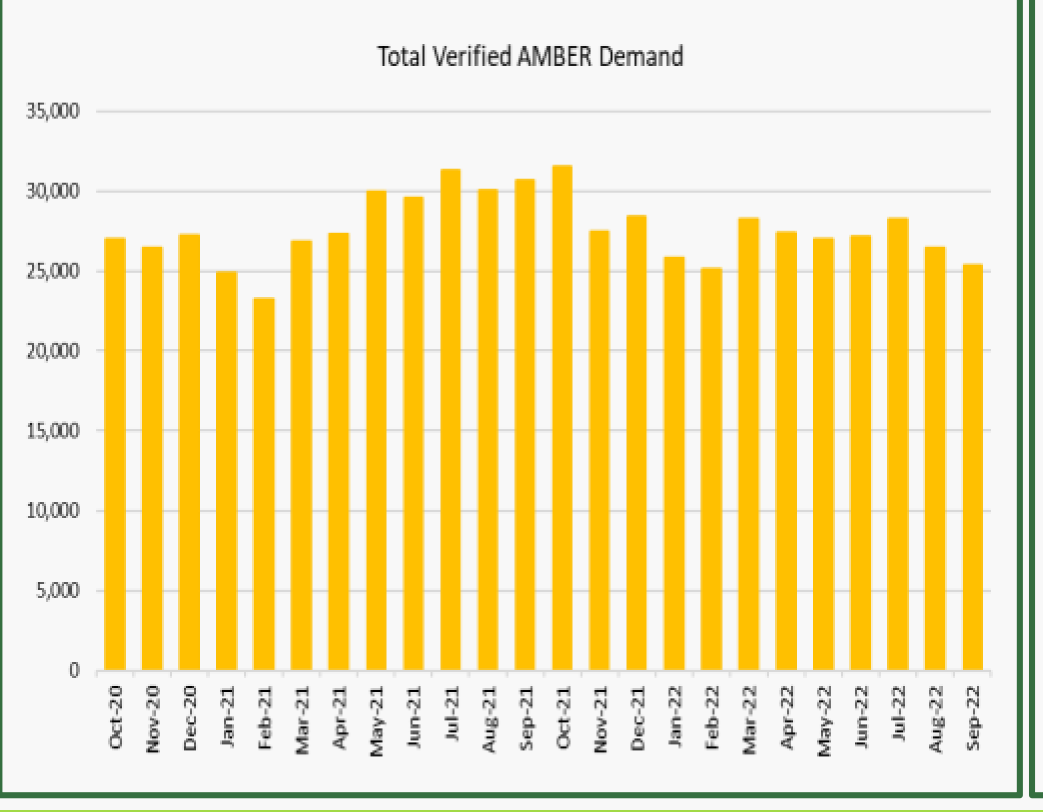
CI

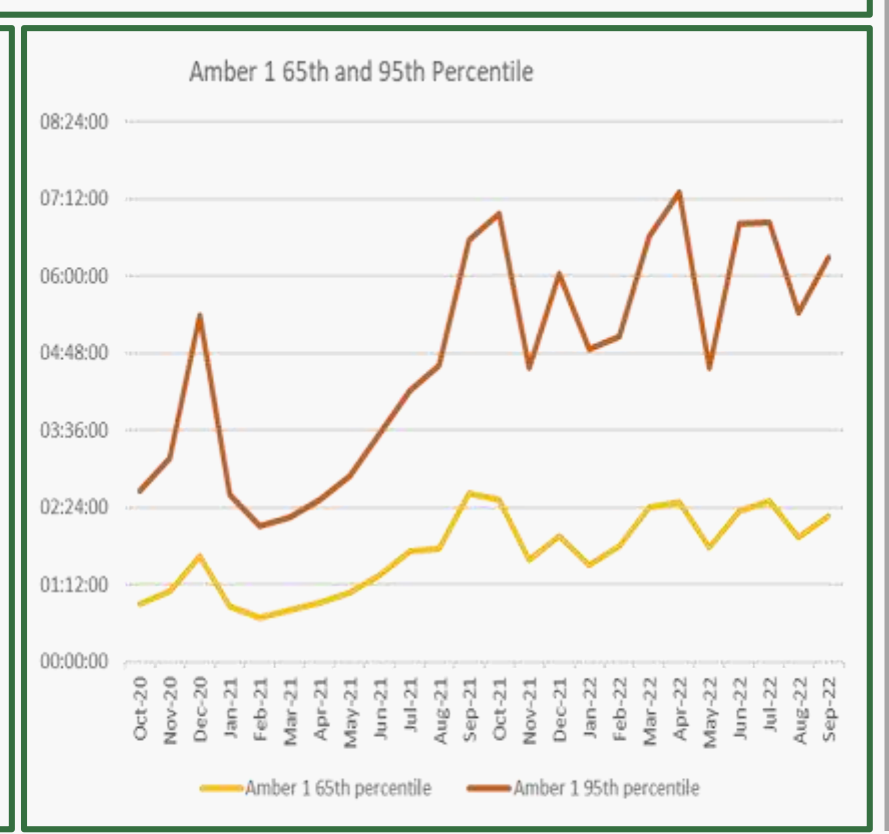
FPC

QUEST









Analysis

Amber response times declined across the percentiles in September 2022. In addition, there were some some very long patient waits (see below). The ideal Amber 1 median response time is 18 minutes, in September 2022 the Trust recorded median response times of 1 hour 30 minutes.

In September 2022, 892 patients (all categories, not just Amber) waited over 12 hours, an increase when compared to August 2022, continuing to represent a very poor quality and experience of service. 749 of these patients were in the Amber category.

Amber demand decreased again in September 2022 although has been broadly stable.

There is strong correlation between Amber performance and lost hours due to notification to handover delays. The number of hours lost to notification to handover delays in September 2022 increased to 25,166, higher than the worst recorded in March 2022 of 24,479, and higher than the Trust would like. Prior to August 2021 the worst handover levels recorded were in December 2019 (13,820).

Remedial Plans and Actions

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

Expected Performance Trajectory

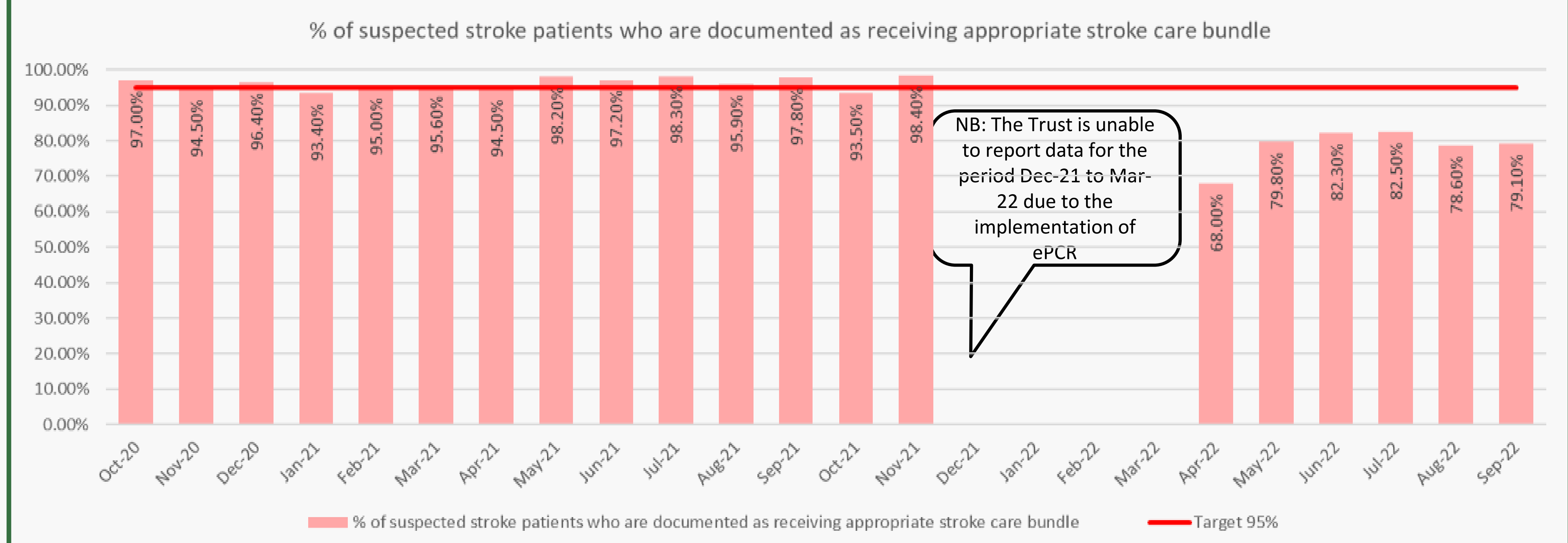
The EMS Operational Transformation Programme is the Trust's key strategic response to Amber. As per the commentary on Red performance delivering these benchmarks is dependent on a range of investments, efficiencies and system efficiencies, not all of which are within the Trust's control, and which are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

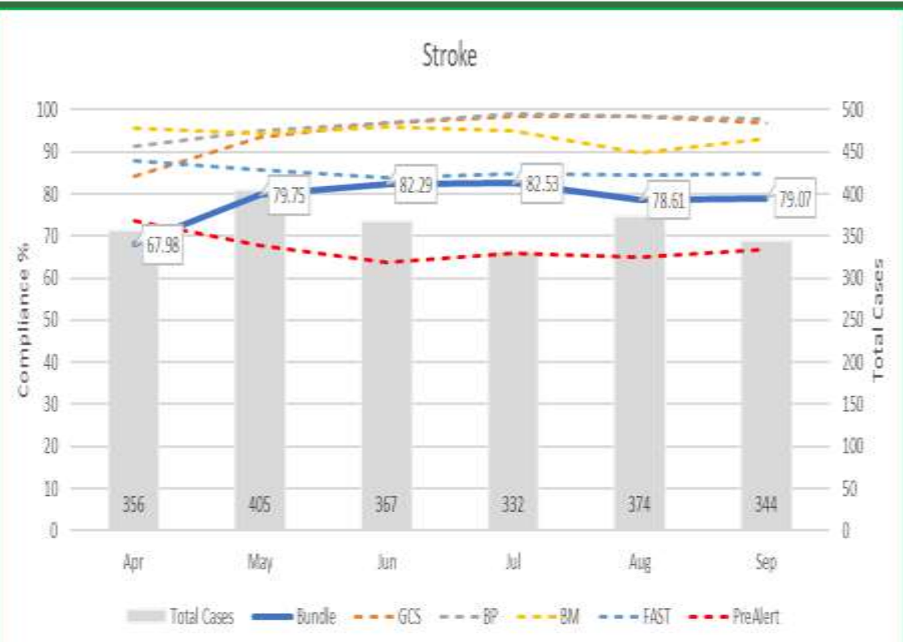
Our Patients: Quality, Safety & Patient Experience
Clinical Outcomes Indicators

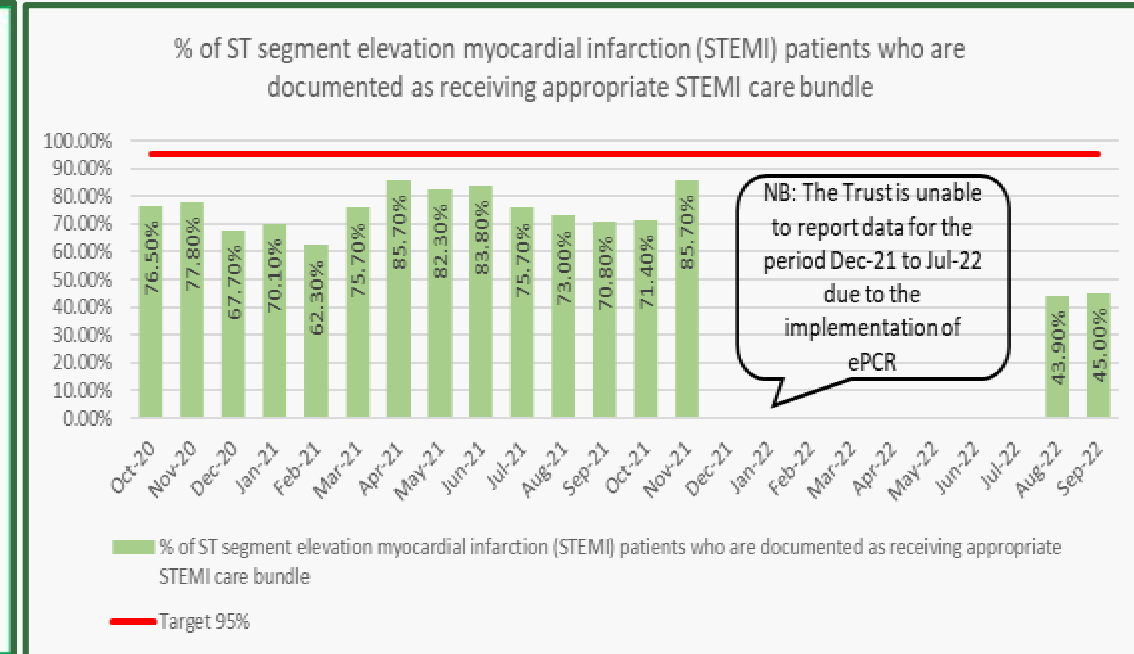
Self Assessment: Strength of Internal Control: Moderate

QUEST

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







Analysis

Clinical: the Trust is unable to fully report on the performance of all clinical indicators whilst work continues to link ePCR with CAD and quality assure metrics.

Clinical Indicator for Stroke has seen a 0.5% improvement in September 2022 following a 3.9% drop in care bundle compliance in July and August 2022. From the chart, the key factor for improving care bundle compliance is the recording of a pre-alert, or a justified exception. In addition, the number of recorded (or with a documented justified exception) blood glucose reading has also dropped, which has contributed to the overall score.

It is likely that as the system continues to embed within clinical practice, that users are still getting used to an adjusted workflow and data points might be missed. An improvement approach has been taken and a series of 'Top Tips' posters have been circulated and specifically shared with Senior Paramedics to support their conversations with WAST clinicians as part of the ride-out process. This is based on a deep dive audit conducted and reported through the Clinical Intelligence Assurance Group. In addition, the deep dive audit is contributing to recommending improvements that can be made to the ePCR user interface to enable better data capture in future versions of the application. Each Clinical Indicator is subject to a deep dive audit owing to the changes in how data flows to generate the CI report.

Mortality Review: *There remains a challenge in undertaking mortality reviews in a timely manner due to the inability to access Corpuls records to support individual cases.*

The Delivery Unit has issued guidance to all NHS bodies in Wales on how mortality reviews should be undertaken moving forward. This aligns mortality reviews with requests for information from the Medical Examiner, this should then link with organisation Putting Things

Remedial Plans and Actions

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

The new agreed indicator for this year (commissioning intention) is the call to door time for STEMI and Stroke. There is a lot of work required to agree and then report on this indicator, with he following roll out plan:

- ✓ Q3 (Oct – Dec 2022) – a decision will be made on the criteria to define 'call to door' and a reporting dashboard will be developed.
- ✓ Q4 (Jan – Mar 2023) – The data will be tested internally to include data from April 2022.
- ✓ April 2023 – Approve for ASI reporting

The Trust cannot currently report on ROSC rates, a deep dive audit into ROSC at hospital will be completed for November CIAG meeting when decisions whether to approve reporting via EASC to the suite of indicators will be made.
The Trust's introduction of the Cymru High Acuity Response Unit (CHARU) model, based on improved clinical leadership and enhanced training, will further improve outcomes for patients. This will commence in October 2022 in some areas.

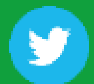
Mortality Review: The Trust has developed a 'Learning from Mortality Reviews Framework' which was approved at the Trust's Clinical Quality and Governance Group on 30 September 2022 and has been shared with the All-Wales Mortality Review Steering Group.

Expected Performance Trajectory

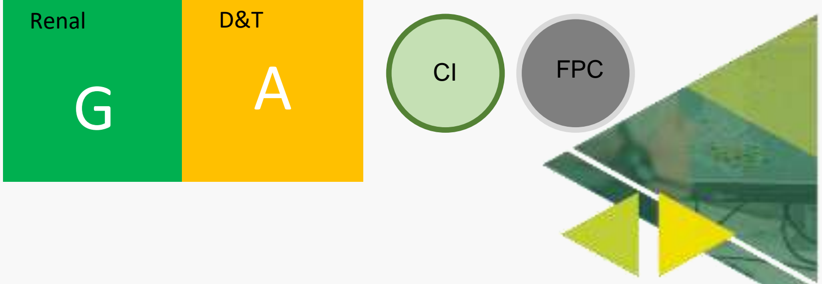
Clinical: As shown throughout the UK, the implementation of CHARUs will aide the Trust in successfully increasing ROSC rates. Once CHARU has been implemented it is anticipated that ROSC rates should increase.

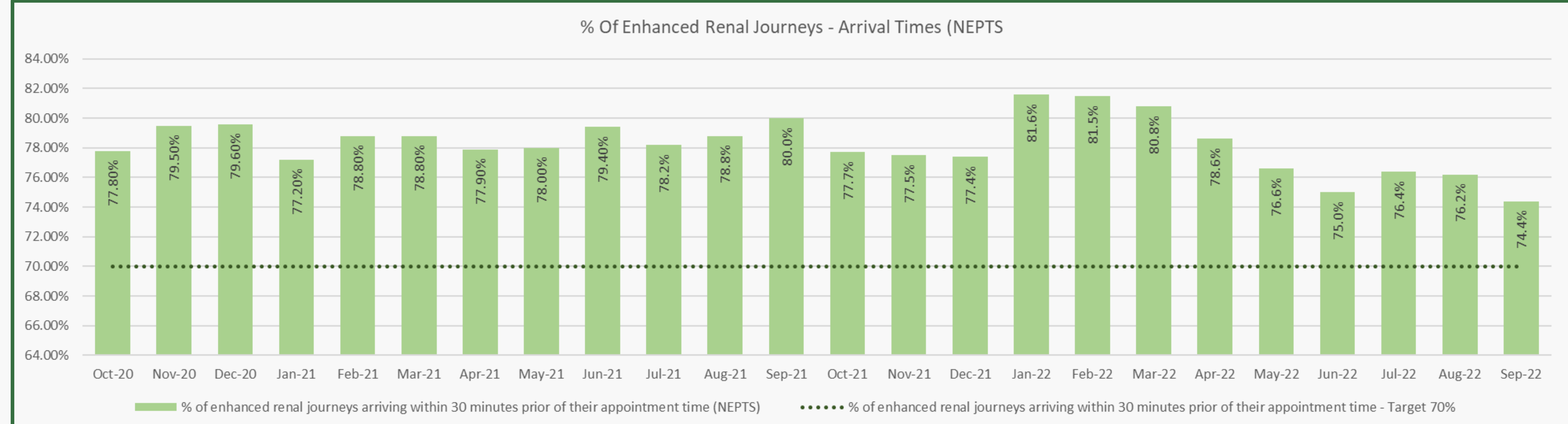
Mortality Review: The Trust is in the process of developing the internal mechanisms in order to facilitate Mortality Reviews. The Medical Examiners have currently been referring cases relating to 'in hospital deaths'. The next stage will be to refer cases relating to community deaths (date not yet confirmed by the Medical Examiners). There is currently a backlog of cases being reviewed by the Trust. Once the Medical Examiners start to refer community cases then the workload is likely to increase significantly.

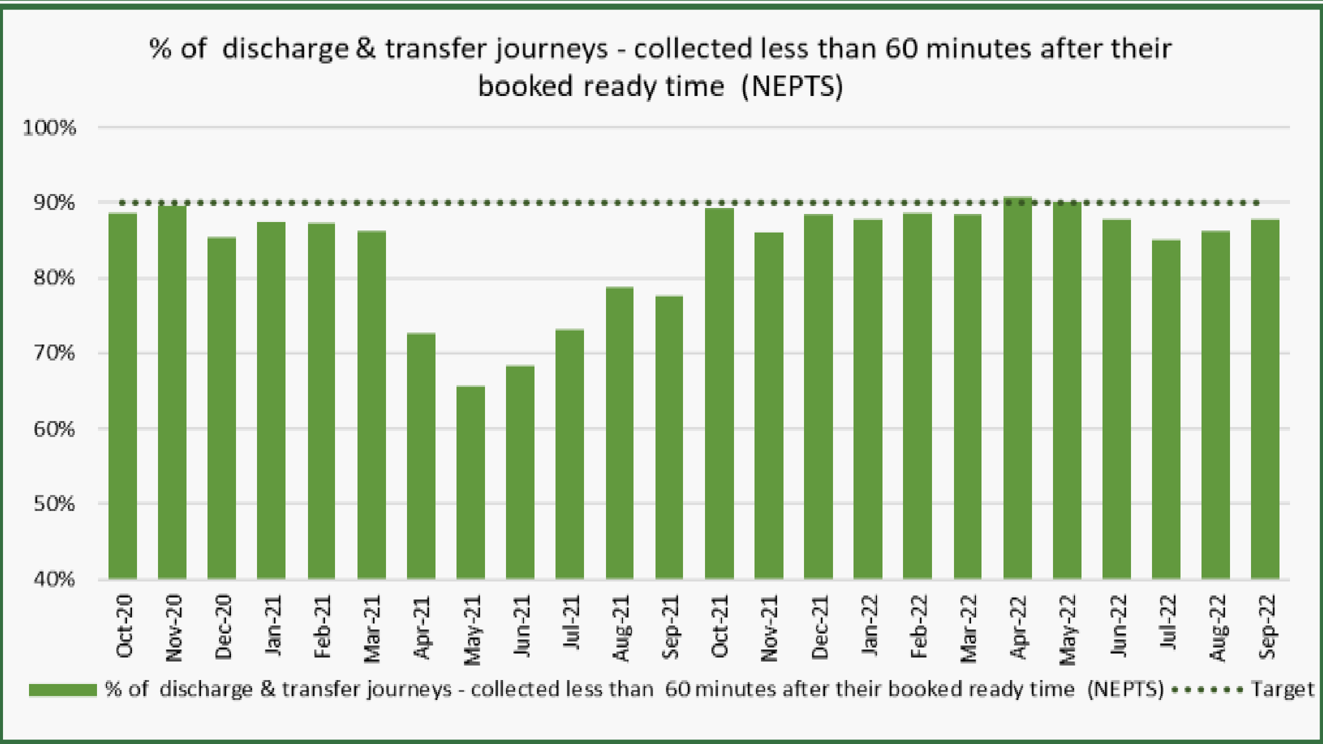
Mortality Reviews Data source: Internal Web Application

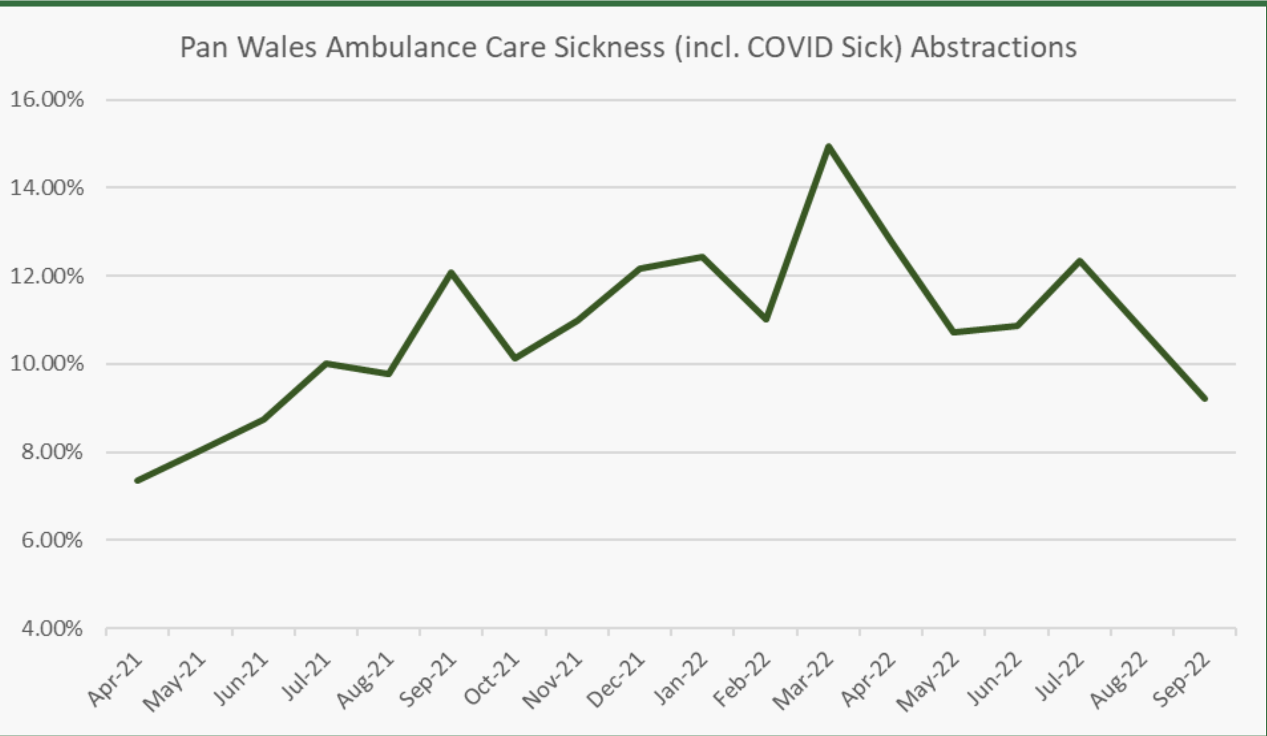


Our Patients: Quality, Safety & Patient Experience
Ambulance Care Indicators
Patient Experience









Analysis

Ambulance Care has seen a stabilisation of service delivery affecting patient experience. 74.4% of enhanced renal journeys arrived within 30 minutes prior to their appointment time, achieving the 70% target in September 2022.

87.7% of discharge & transfer journeys were collected within 60 minutes of their booked ready time, therefore not achieving the 90% target, but an improvement compared to August 2022 (86.2%).

Key factors affecting these indicators are demand and capacity:

- **Capacity** continues to be adversely affected by other factors such as sickness absence levels, although these improved in September 2022 9.21% along with Annual Leave returning to levels below the 20% cap at 17.08%.
- Overall demand has been increasing since the initial reduction at the beginning of the pandemic, but overall it is still not quite at pre-pandemic levels.
- As the Trust emerges out of pandemic response and the health system is "re-set" it is anticipated that further demand increases could be experienced at which point capacity may be an issue. This has been modelled and mitigations put in place.

Remedial Plans and Actions

- **Re-rostering NEPTS Transport**: Service mangers have attended meetings and an alternative to the ORH roster keys is being developed for testing v the ORH keys on Cleric Training Package. A business case/PID will be produced in Quarter 3. 2022/23
- **Demand:** Continue to work with health boards to understand and model the impact of their recovery plans;
- **Demand**: In the absence of additional funding, the service has implemented a capacity management plan to assist it in ensuring it remains within budget and prioritises resources for those most in need
- **Capacity**: discussions with EASC on options for balancing demand and capacity.

Expected Performance Trajectory

At present, the uncertainty around demand and future impacts of the pandemic and system recovery means that it is difficult to forecast performance; however, it is likely that the service will experience both positive and negative fluctuations of performance until activity normalises across the system.

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

SCIF. A

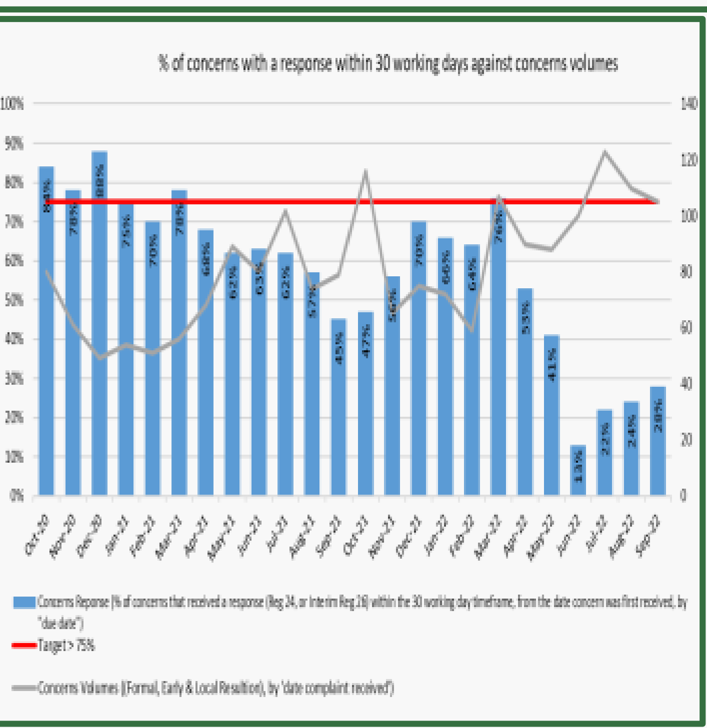
Self Assessment: Strength of Internal Control: Moderate

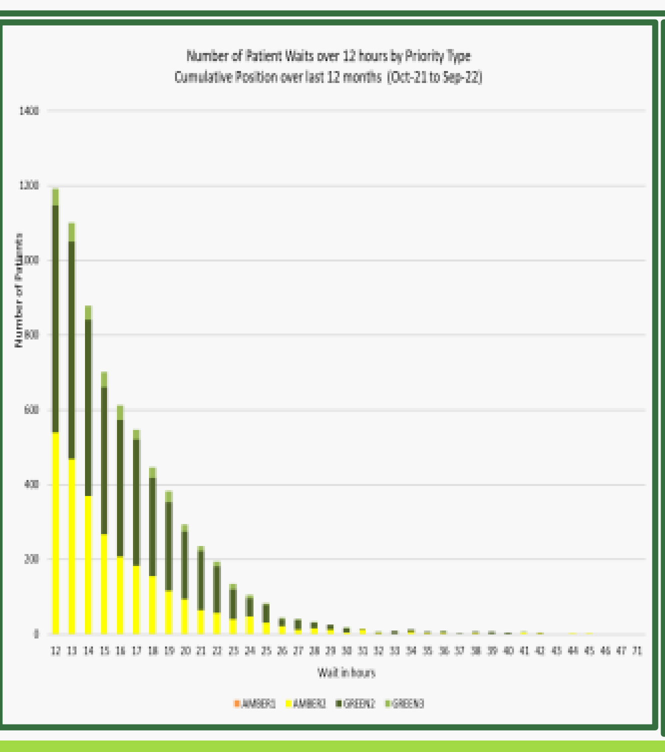
QUEST

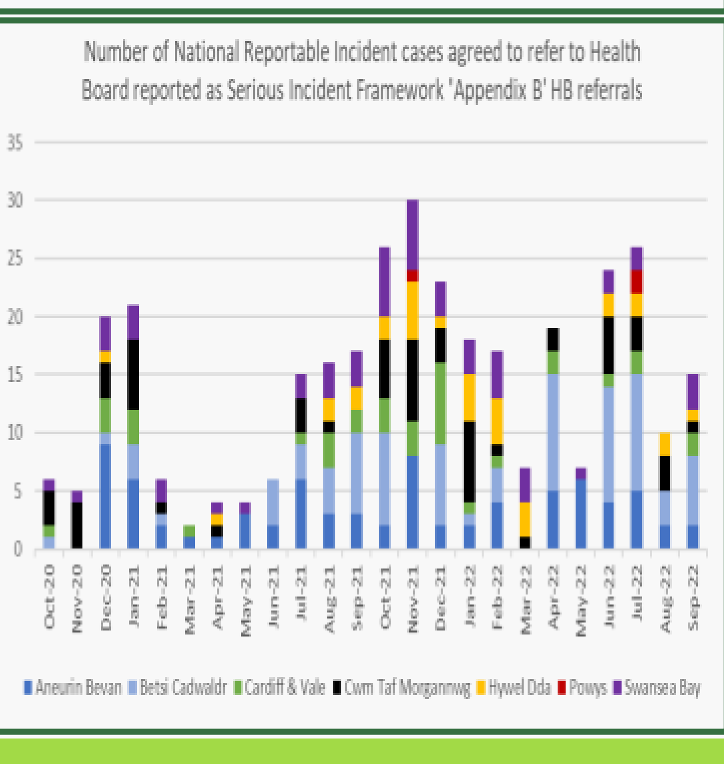
Health & Care Standard Health - Safe Care / Timely Care

Number of SCIF cases reported as National Reportable Incidents (NRI) By Date Reported to the Delivery Unit by WAST

Month	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
NRI	5	5	8	10	3	7	9	1	4	4	5	8	7	9	4	5	2	7	3	11	3	2	10	7







Analysis

The **percentage of responses to concerns improved marginally in September 2022 to 28%** against a 75% target. Several factors continue to affect the Trust's ability to respond to concerns, including, overall increased demand, a rise in the number of inquests, continuing volumes of NRI's and timely response to requests for information from key parties. The number of total concerns decreased in September 2022 (105) when compared to August 2022 (110).

There were 7 SCIF forums held in September 2022, during which 39 cases were discussed, 7 of these cases were reported to the Delivery Unit and 15 were passed to Health Boards as National Reportable Incident Framework 'Appendix B' incident referrals.

Themes relating to incidents reported to the NHS Wales Delivery Unit as Nationally Reportable Incidents (NRIs) include call categorisation (e.g., ineffective breathing), vehicle allocation (missed allocation) and clinical aspects of care including misdiagnosis and subsequent management. Year on year the overall volumes of NRIs remains static with the same volume recorded in 2021-22 as 2020-21 (Oct-Sept). In September 2022 there were 0 NRIs relating to Red calls, 4 relating to Amber calls, there were none in relation to Green calls. There were 2 NRIs as a result of calls prioritised Amber which should have been Red.

As reported earlier, in September 2022, 890 patients waited over 12 hours for an ambulance response, an increase month on month, also an increase when compared to 586 in September 2021 and 275 in September 2020.

37 Compliments were received from patients and/or their families in September 2022, a decrease compared to the previous month (41).

Remedial Plans and Actions

A range of actions are in place:-

- The general theme in relation to the Trust's concerns portfolio remains timeliness to respond. Additional resources for complaints handling administration has been agreed by the Executive Management Team .
- WAST is working closely with EASC, NHS Wales Delivery Unit and Health Boards to agree a new approach to joint investigations across the system ensuring a consistent approach. A number of workshops have been held, led by Nurse Directors and a revised joint investigation process has been proposed to be piloted initially.
- Immediate improvement actions following the SCIF include education and training for individual staff and circulation of bulletins to share learning and provide updates.
- Themes and trends from incidents are escalated to the relevant oversight group for review and action as necessary e.g. Clinical Prioritisation Assessment Software (CPAS) Group
- Health Board specific quality and safety reports are shared with each respective Health Board Directors of Nursing & Quality and regular meetings are held between the Trust and respective Health Boards on a monthly basis.
- The key strategic action is the EMS Operational Transformation Programme.

Expected Performance Trajectory

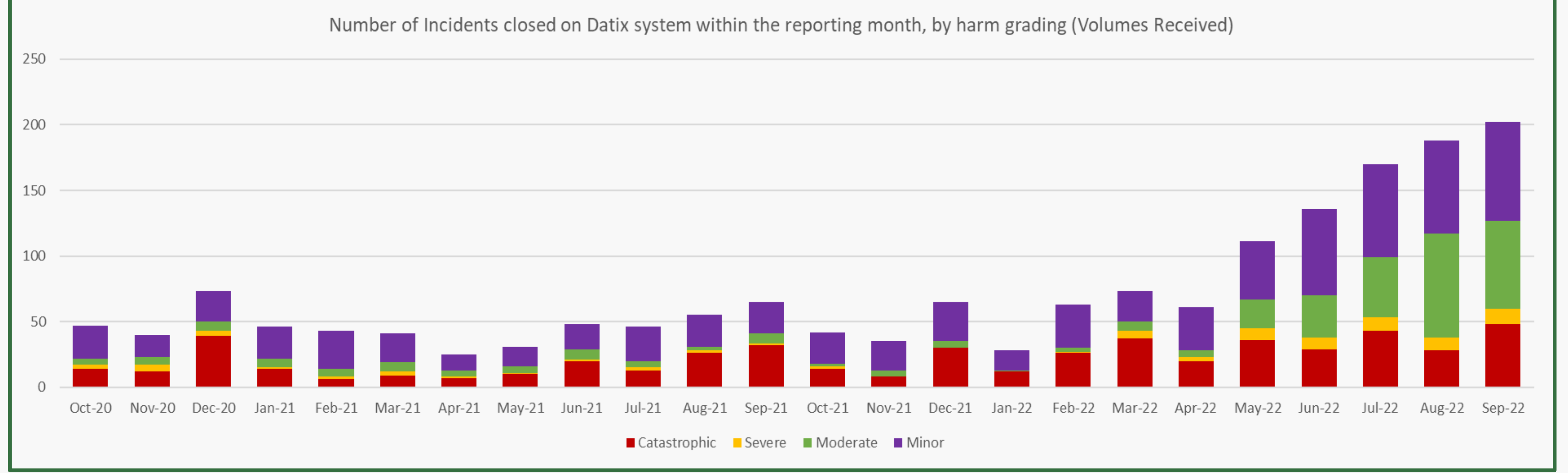
The Trust is expecting continuing challenges with performance especially as hospital delays remain a significant challenge impacting on the quality and safety of care to patients in the community and those delayed outside of hospitals awaiting transfer to definitive care.

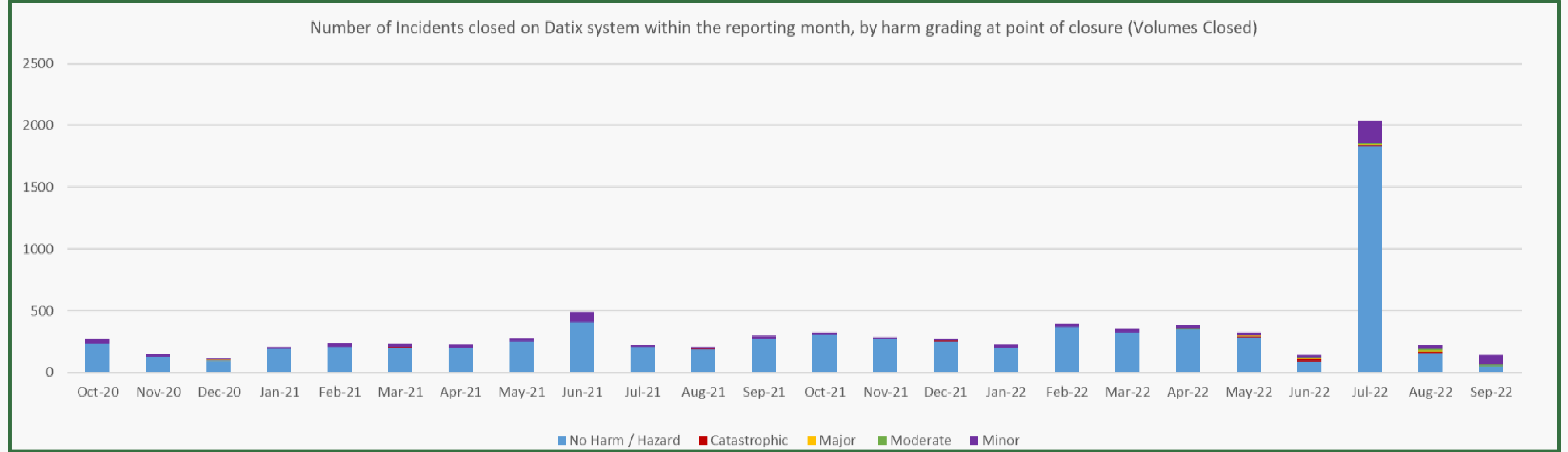
NB: September 2022 data is correct on the date and time it was extracted; therefore, these figures are subject to change. At present reporting accurate data is not possible due to implementation of the Once For Wales Datix RL system.
*****NB: Complex Cases will always report one month in arrears***

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

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

Health & Care Standard
Health – Safe Care





Analysis

Patient Safety: The number of patient safety adverse incidents volumes submitted on Datix Cymru via frontline crews, health boards, the Operational Delivery Unit (ODU) and CCC within September 2022 decreased to 303 when compared to 416 in August 2022. The 416 reports relate to incidents where the outcome for our patients was:

- No harm or hazard – 101
- Minor harm – 75
- Moderate harm - 67
- Severe Outcomes - 12
- Catastrophic - 48

Once cases are investigated by the Patient Safety or Clinical team, (or for instances where serious harm has occurred referred to SCIF for review) they are closed; 143 cases were closed in September 2022. Monthly volumes should be interpreted with caution as incidents can be duplicated on the system (for example; 2 crews submitting the same incident), however the increase in incident volumes is attributed to the current rise in hospital handovers.

The spike seen in the number of cases closed in July 2022 is as a result of significant work undertaken to manage processes for closure of all DATIX historical incidents (including COVID related incidents) and the transition to the new DATIX.

Remedial Plans and Actions

Patient Safety: Capacity issues have impacted the ability of some teams in their ability to support investigations due to ongoing operational pressures related to the continued pandemic.

Expected Performance Trajectory

The Trust will continue to ensure lessons are learnt from every case reviewed and best practice will be implemented to continue to ensure care is of the highest quality.

NB: September 2022 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 and Ombudsmen Indicators

Self Assessment: Strength of Internal Control: Strong

Health & Care Standard
Health – Safe Care

Number of Coroner Requests by Health Board

0, 10, 20, 30, 40, 50, 60, 70, 80, 90

Oct-20, Nov-20, Dec-20, Jan-21, Feb-21, Mar-21, Apr-21, May-21, Jun-21, Jul-21, Aug-21, Sep-21, Oct-21, Nov-21, Dec-21, Jan-22, Feb-22, Mar-22, Apr-22, May-22, Jun-22, Jul-22, Aug-22, Sep-22

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

Analysis

Coroners: In September 2022, the number of in month requests is higher than the same month in the previous years. The timeliness of our response and unexpected deaths continues to be the main themes. There continues to be a marked increase in the BCUHB area.

At the end of September 2022 there are 413 claims open; these relate to Personal Injury (75 Claims); Personal Injury - Road Traffic Accidents (47 Claims), Clinical negligence (105 claims); Road Traffic Accident (163 claims) and Damage to Property (23 claims).

Ombudsman: There are currently 17 open Ombudsman cases in September 2022. At present cases are not being investigated, which supports the Trusts actions.

Remedial Plans and Actions

Coroners: Cases continue to be registered and distributed in a timely manner. If there is likely to be a delay in responding the Trust ensures that the coroner is kept informed of the expected date of response. Inquests are being arranged for December and into 2023.

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

Expected Performance Trajectory

Coroners: The Trust continues to focus on the learning from our investigations and report these via the Patient Safety Highlight report, which is presented to the Executive Management Team and Trust Board.

In addition to this, learning from our investigations continues to be presented to the Patient Safety, Learning and Monitoring Group and our Scrutiny Panels.

Individual learning is also a huge focus across the organisation with significant attention on both clinical and CCC areas of business.

We also continue to engage with our Health Board colleagues where we have utilised the Joint Investigation Framework and/or where there is a focus on joint investigations and learning.

Ombudsmen: The Trust will continue to ensure lessons are learnt from every case reviewed and best practice will be implemented to continue to ensure care is of the highest quality.

Data source: Datix

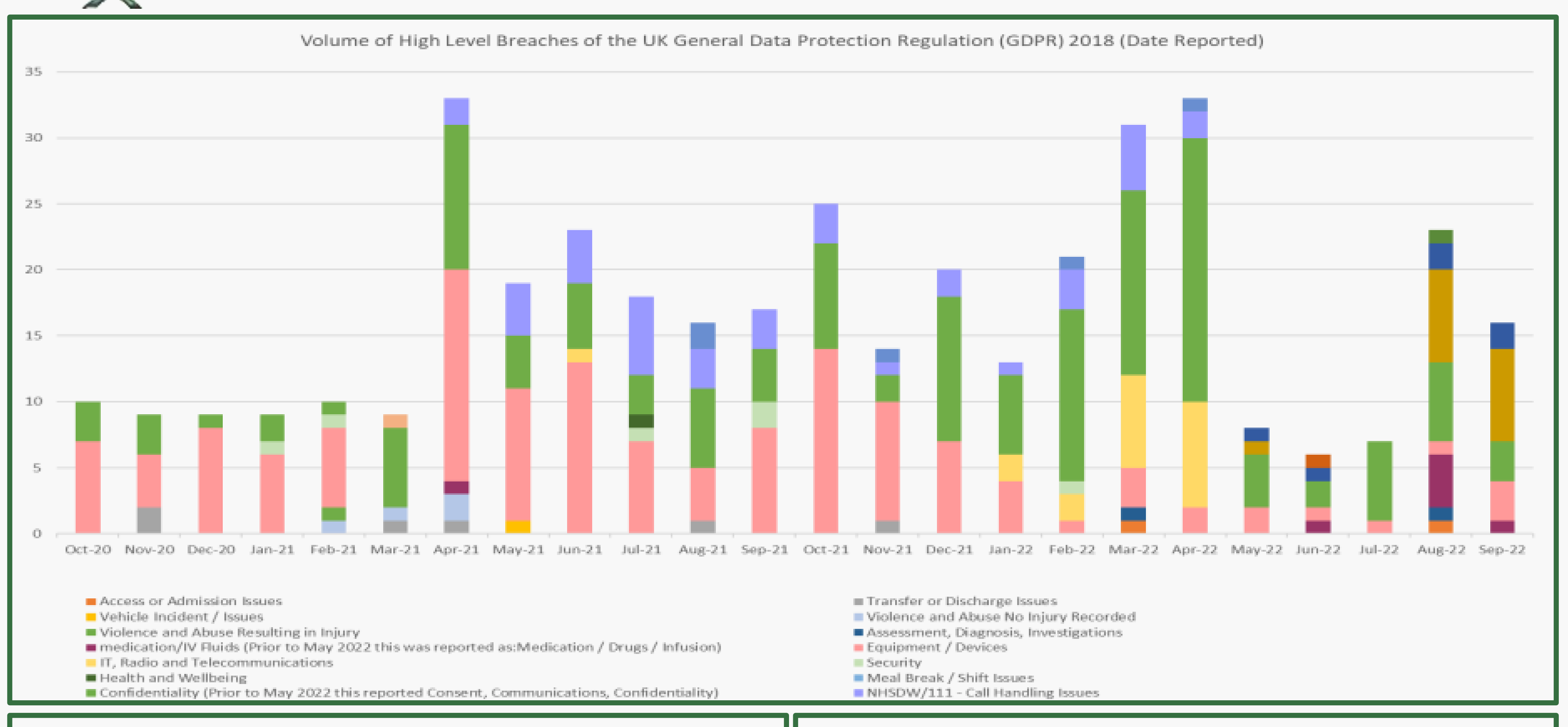
Our Patients: Quality, Safety & Patient Experience
Safeguarding, Data Governance & Public Engagement Indicators

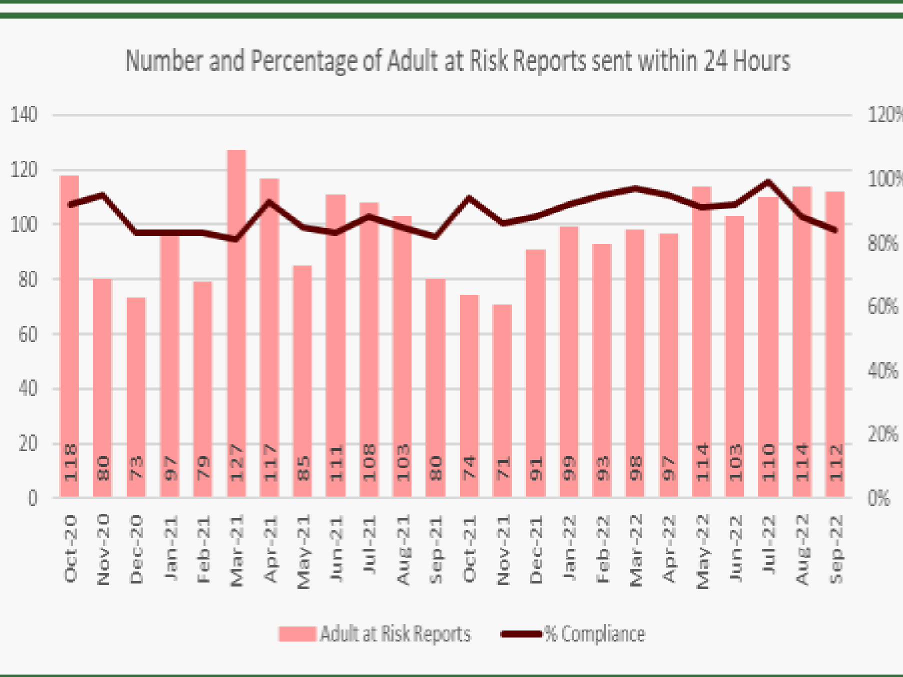
Health & Care Standard
Health – Safe Care

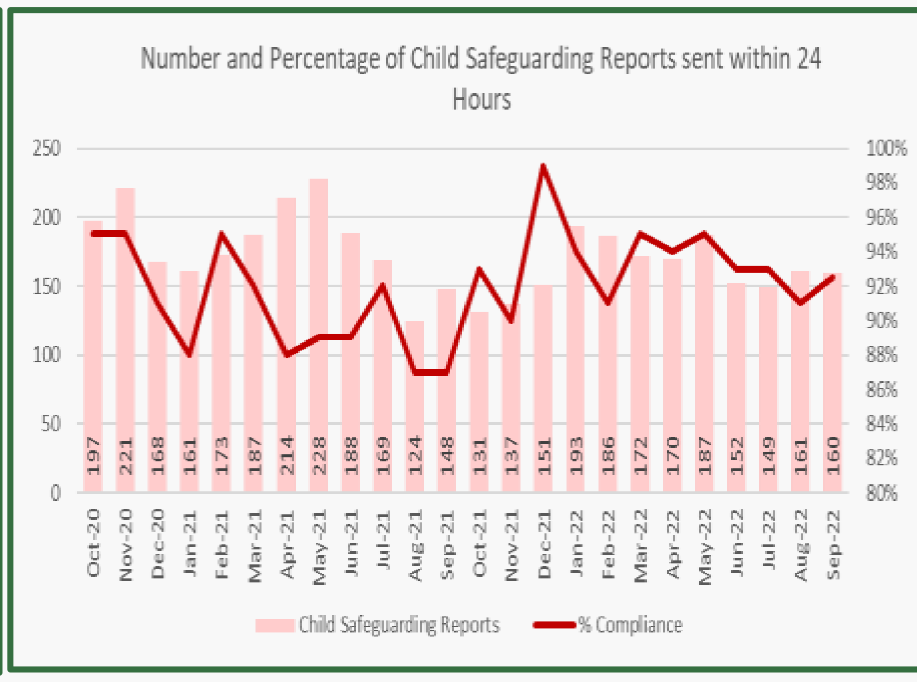
Self Assessment: Strength of Internal Control: Strong

QUEST

NB: Next Public Engagement update (Jul-Sep 2022) Due October 2022







Analysis

Safeguarding: In September 2022 staff completed a total of 112 Adult at Risk Reports, a decrease compared to August 2022 when 114 were reported. 84% of these were processed within 24 hours. Whilst the Trust does not report on Adult Social Need reports, 386 referrals were received during this reporting period.

There have been 160 Child Safeguarding Reports in September 2022, a decrease from August 2022 when 161 reports were made. In September 2022 93% were sent within 24 hours.

Data Governance: In September 2022 there were 22 information governance (IG) related incidents reported on Datix Cymru categorised as an Information Governance (IG) breach, a decrease when compared to August 2022 but an increase compared to July 2022. Of these 22 breaches, 7 related to Information technology, 6 records/information, 3 Confidentiality, 3 equipment / Devices, 2 communication and 1 medication/IV Fluids.

Public Engagement: For the first time since 2019 the PECI Team have re-started and proactively engage with people and communities in person, by attending community events, open days, school visits and other forums. This face-to-face engagement permits meaningful conversations with people about using the services we provide; helping communities feel listened to and empowered to drive change. There where 66 engagement events held in Quarter 1, allowing engagement with 2,472 people. 71 NHS 111 Wales website surveys were returned, 80 people completed a survey about their experience of calling NHS 111 Wales. We continue working with NEPTS colleagues to promote patient experience surveys for users, surveys are sent direct via post, text and online. 280 NEPTS surveys were completed in this quarter. In this quarter we made a 999-patient experience survey available for the first time, this was completed by 30 people who shared their views on recent experiences of calling 999. More work will be done to further promote these surveys and capture more patient feedback. 117 compliments were also logged and processed; these positive experiences are also celebrated every Thursday on our social media channels using the #ThankYouThursday hashtag.

Remedial Plans and Actions

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

Data Governance: During the reporting period, of the 22-information governance related incidents reported on Datix all incidents have been reviewed and investigated where necessary by the IG team and remedial actions taken where appropriate. 0 incidents were deemed to meet the risk threshold for reporting to the Information Commissioner's Office (ICO).

Public Engagement: Though we continued to engage with communities across Wales throughout the coronavirus pandemic, this was done in a much more digital way, holding online events and joining online forums and meetings. Whilst this online engagement was crucial and allowed us to maintain connections, it was widely acknowledged that for many, online engagement was a barrier, and some felt excluded from participating in online activities in general. A return to in person community engagement is very welcome and allows to re-start having rich conversations with people about their experiences and expectations. It is acknowledged that coronavirus cases in the community are rising again, the PECI Team will continue to take measures to ensure staff and communities safety during engagement events.

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 next Information Governance Steering Group is arranged for October 2022 and will review the general IG assurance items, including the Welsh NHS IG Toolkit status and updates. The DHCW Welsh IG Toolkit Team are currently considering question sets for consultation for the next submission period.

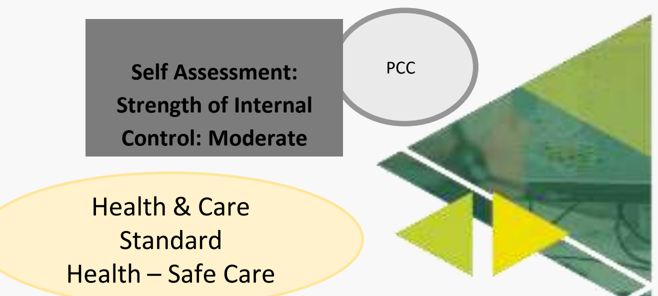
Public Engagement: Outcomes of our engagement with people and communities across Wales remain consistent to those previously reported. With people continuing to tell us that long waits and delays remain their primary concern; though the transport, care or treatment they ultimately receive is good. This theme is repeated across all services delivered by the Welsh Ambulance Service - 999 emergency care, Non-Emergency Patient Transport and NHS 111 Wales. The PECI Team will continue engaging with communities, proactively communicating with people and communities, sharing important information regarding Trust services and appropriate use of these during the current period of increased demand. Learning from our engagement will be shared with partners, stakeholders and colleagues and will be used to help influence quality improvement.

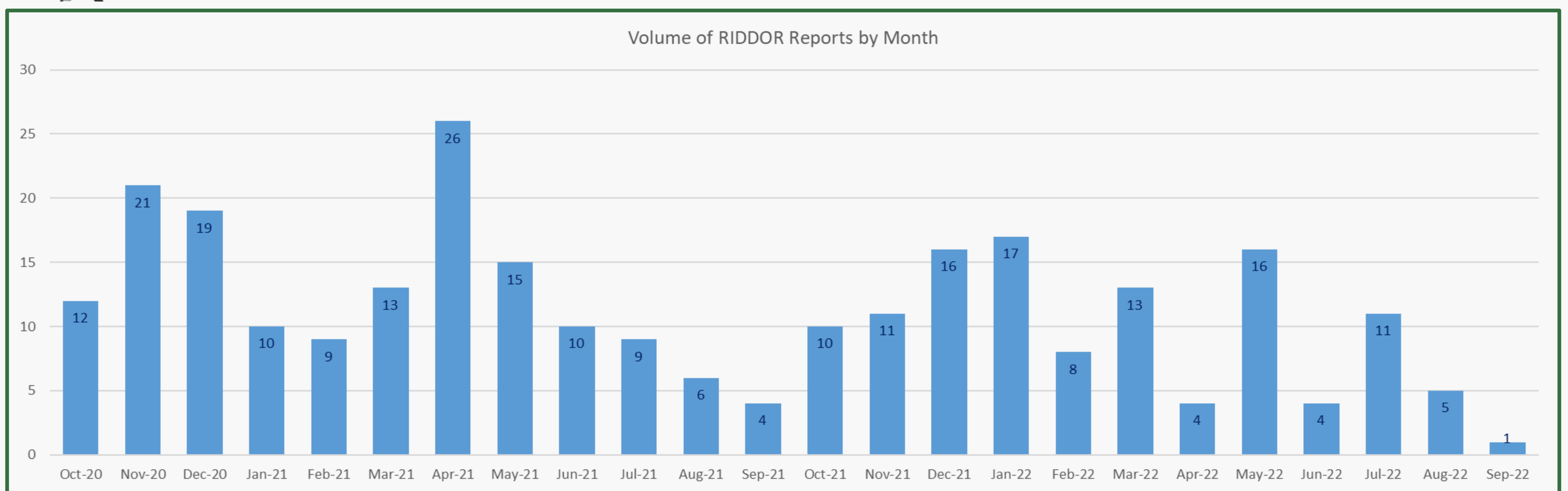
Safeguarding Data source: Doc Works

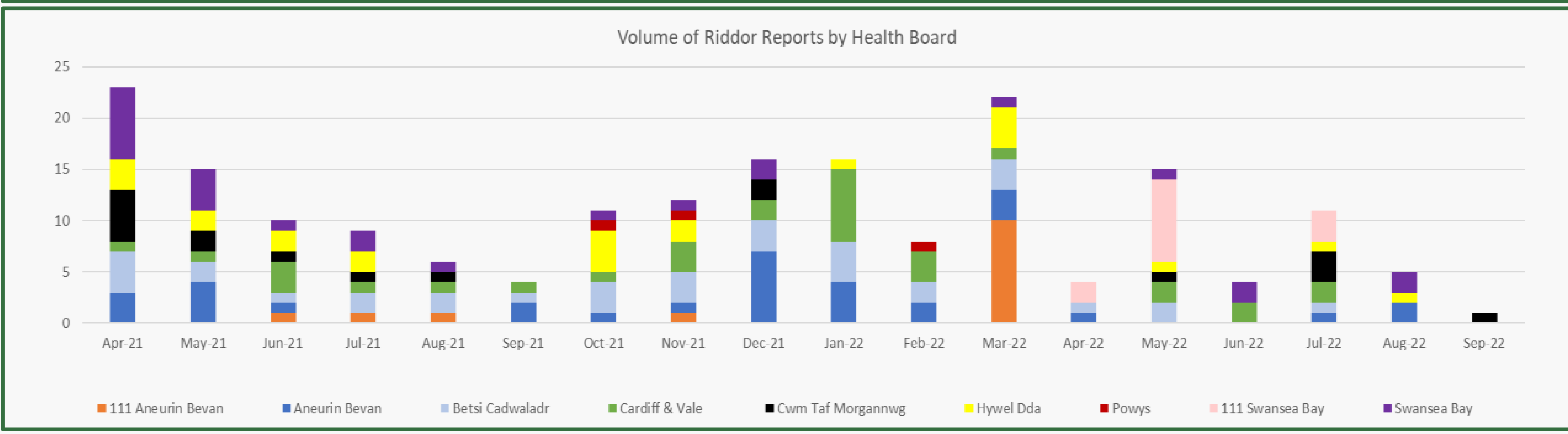
NB: Data Governance Incidents are based on 'Date Reported' rather than 'Incident Date' as the process is currently manual until a dashboard is implemented and is therefore subject to change

(Responsible Officer: Liam Williams)

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







Analysis
Whilst there is a strong level of internal control with respect to metrics provided to the Health & Safety Executive (HSE), there are moderate levels of internal control. Challenges around incident reporting times or handlers confirming staff sickness absence to the H&S function are impacting on the timeliness of Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDORS) to the Health and Safety Executive (HSE). In September 2022 there was 1 RIDDOR reported. As shown in the bottom graph this related to CTMUHB.

Risk 199 is currently rated as 15. This was reduced in Q2 as a result of work undertaken via the Working Safely Programme and funding secured for the Workforce review which commenced on 3rd October 2022.

Remedial Plans and Actions
DATIX incident review meetings are held on a weekly basis to review non patient safety incidents to check for potential RIDDORS. RIDDOR performance is to be presented at EMS business meetings commencing in Q3.

The Working Safely Programme (IMPT deliverable) 'Pump Prime' phase ceased on 31 September 2022. A closure report is to be presented to the Working Safely Strategic Board in Q3 2022.

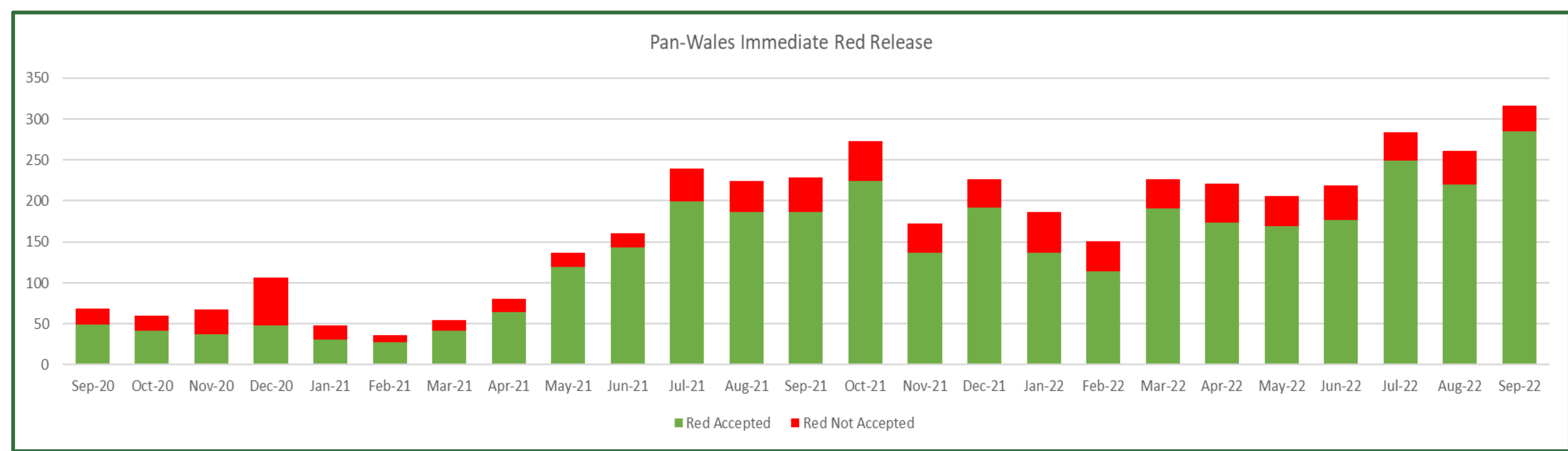
Expected Performance Trajectory
The funding allocated to increase the H&S function with the new structure came into force on 3rd October 2022. This will allow for the transition from the Working Safely Pump Prime phase to Working Safely Programme. Additionally, the embedding of expertise within the organisation and operational structures will influence performance positively.

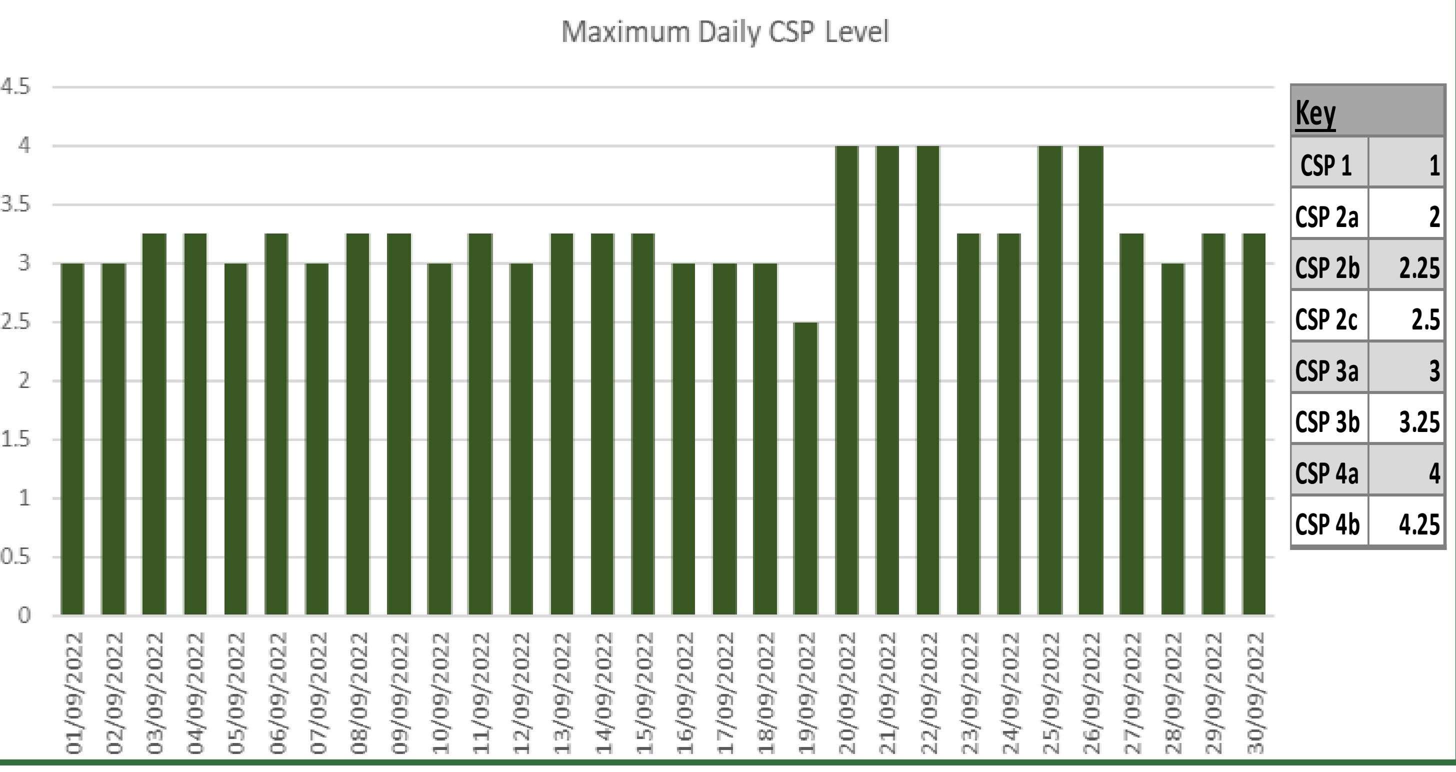
Increased focus by the Health and Safety Managers and presence of newly appointed Health and Safety should additionally improve the Trusts RIDDOR performance during Q3 2022.

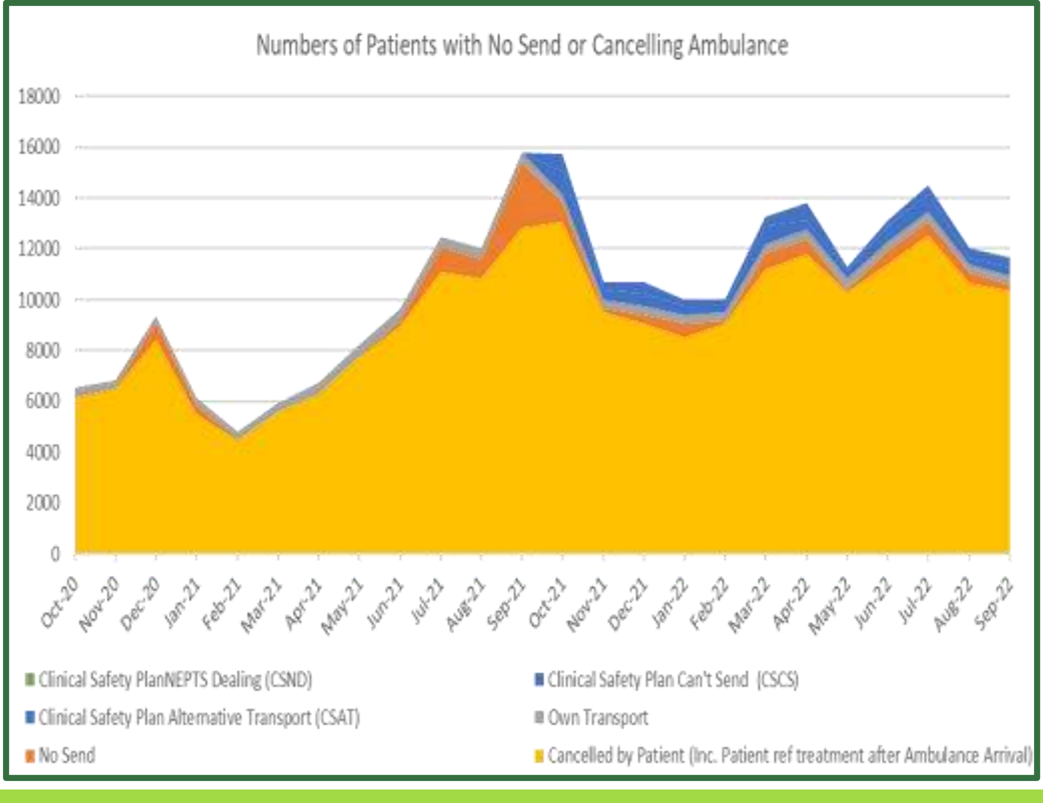
*****NB: September 2022 data is correct on the date and time it was extracted; therefore, these figures are subject to change***

Data source: Datix

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







Analysis

There were 1,075 request made to Health Board EDs for immediate release of Red or Amber 1 calls in September. Of these 285 were accepted and released in the Red category, 31 were not accepted. In conjunction to this, 251 ambulances were released to respond to Amber 1 calls, but 508 were not.

During September 2022, the Trust has not seen any days at CSP level 1, Business as Usual (BAU) or CSP 2a, 5 days were spent at Clinical Safety Plan (CSP) level 4a, resulting in clinical screening of Amber 1 calls and the Trust being unable to respond to calls in the Amber 2 and Green categories advising these patients to contact their GP, 111 Online or make their own way to a Minor Injury Unit (MIU), those callers within the HCP category are advised to make their own way to hospital. 14 days were spent at CSP level 3b, therefore seeing the Trust only being able to respond to Red and with some exceptions, Amber 1 calls, with Amber 2 calls being clinically screened and the Trust unable to respond to Green and HCP calls. 10 Days were spent at CSP level 3a again resulting in the Trust only responding to Red calls and with some exceptions Amber 1 and 2 calls. 1 day was spent at CSP 2c seeing the Trust respond to Red calls and only those calls with exception in the remaining categories.

In September 2022, 380 ambulances were stopped due to CSP alternative transport and 348 were as a result of CSP Can't send options. In addition, 10,325 ambulances were cancelled by patients (including patients refusing treatment at scene) and 321 patients made their way to hospital using their own transport.

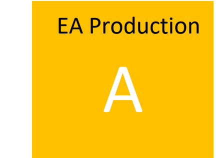
Remedial Plans and Actions

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.

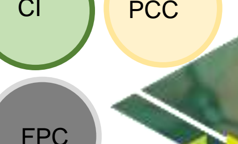
Expected Performance Trajectory

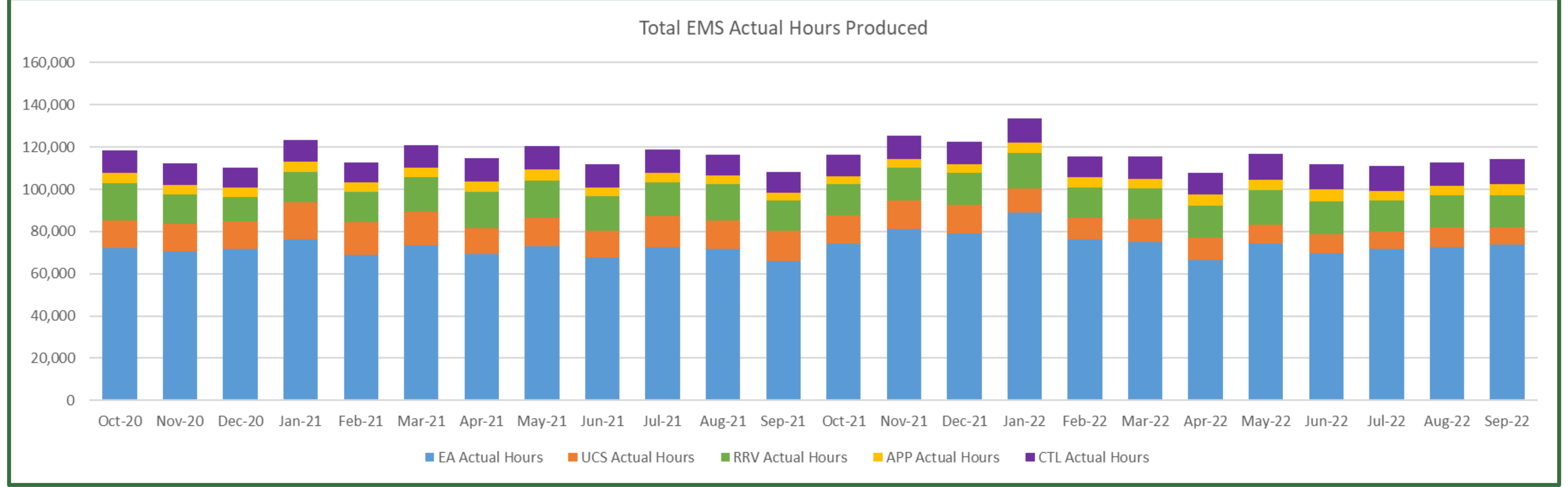
The Trust continues to monitor CSP levels both daily through the ODU and weekly through the Weekly Operations Performance Meeting and mitigations are actioned to reduce the impact on the Trusts ability to respond to demand. Winter pressures will impact the Trust and seasonal planning is being used to prepare for this.

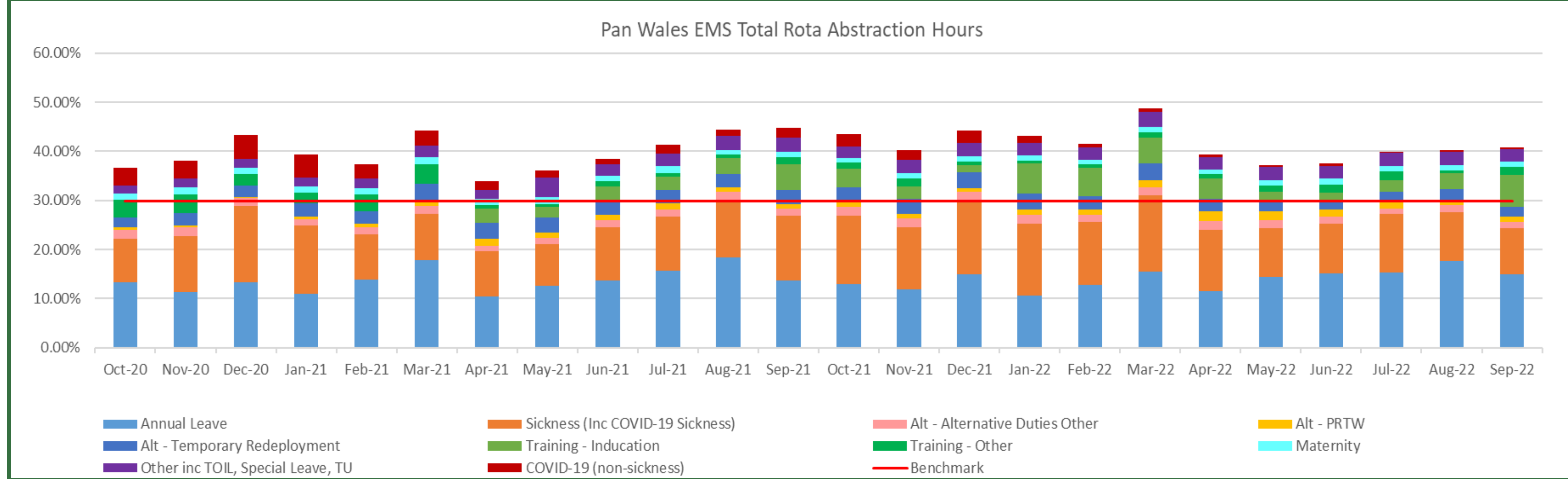
Our People
Capacity - Ambulance Abstractions and Production Indicators



Abstractions
R







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 2022, total abstractions stood at 40.81%. This compares to a benchmark set in the Demand & Capacity Review of 30% which the Trust was achieving pre-COVID-19. The highest proportion was Annual Leave at 15.05% and sickness at 9.26%. Sickness abstractions for September 2022 were lower when compared to the previous year (13.06%). COVID-19 (non-sickness) related abstractions increased in September 2022 when compared to the previous month but decreased when compared to the same period last year accounting for 0.28% of overall abstractions.

Emergency Ambulance Unit Hours Production (UHP) was 96% in September 2022 (73,700 Actual Hours), therefore achieving the 95% benchmark. In comparison, RRV UHP achieved 76% (15,095 Actual Hours) compared to 75% in August 2022. The total hours produced is a key metric for patient safety. The Trust produced 114,353 hours in September 2022, but the graph shows that even despite significant funding for increased substantive numbers of staff, total hours produced has not risen sustainably.

The Demand and Capacity Roster review for EMS has concluded and new rosters have began rolling out across the Trust, commencing with Ceredigion on 25th September 2022.

Remedial Plans and Actions

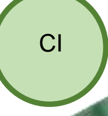
The EMS Demand & Capacity Review benchmark for GRS sickness absence abstractions is 5.99%. A new formal programme of work has commenced to review and take action to reduce sickness absence / alternative duties, which is reported into EMT every two weeks. In future months, we will include a graph in this pack of performance against the agreed trajectory.

The Trust has a budgeted establishment of 1,661 FTEs for 2022-23. The key actions to maximise production will continue to be the EMS Demand & Capacity Review with an additional 100 WTE to be recruited this year.

Following completion by localities of new roster rollout, the Trust will report 2 levels of UHP commissioned vs ORH demand key once all rosters are live; implementation of rosters commenced in September 2022

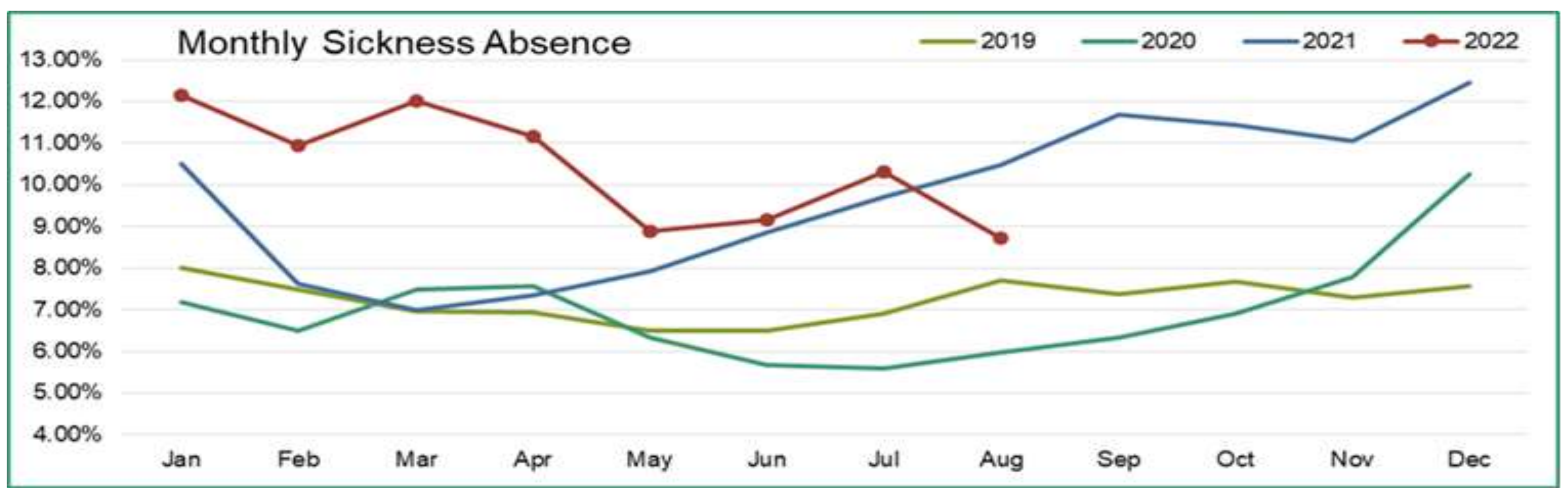
Expected Performance Trajectory

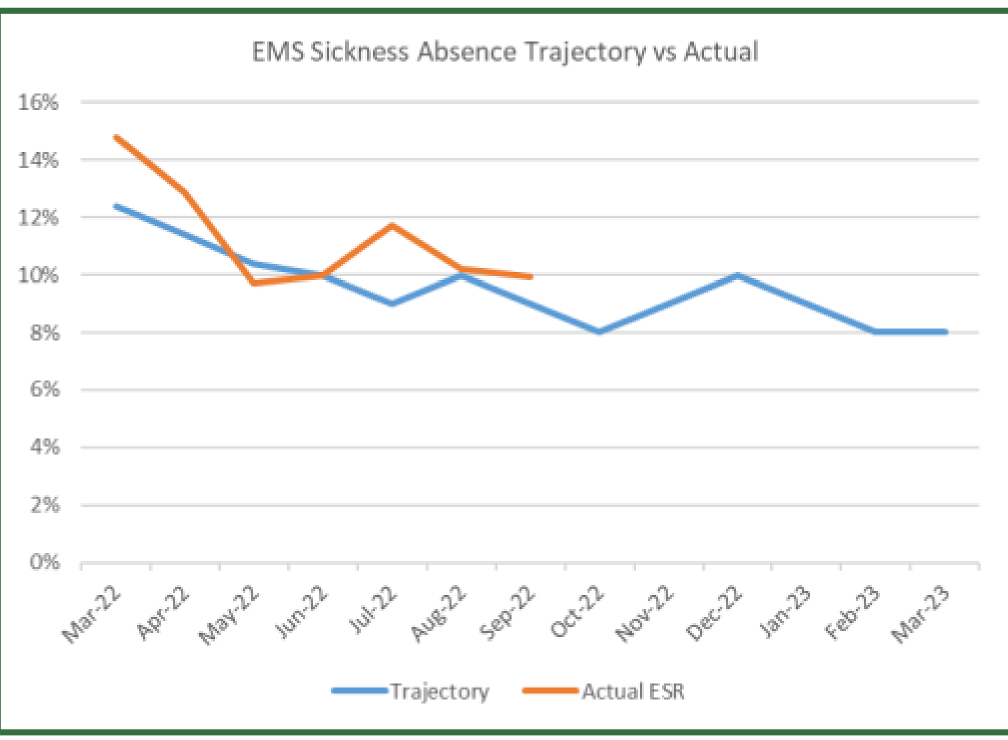
Subject to the longer-term impact of COVID-19 the benchmark is a UHP of 95% across the Trust's three main resource types and an abstraction rate of 30%.

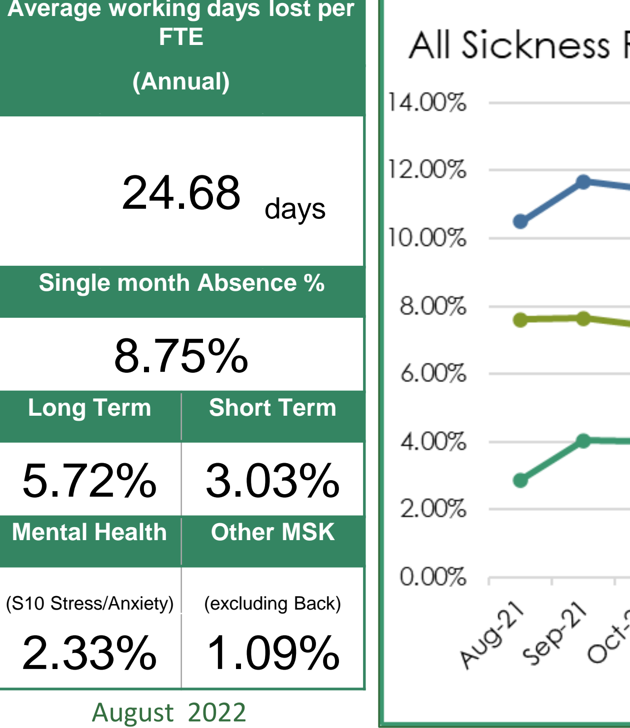


Our People
Health & Wellbeing - Sickness Absence Indicators

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

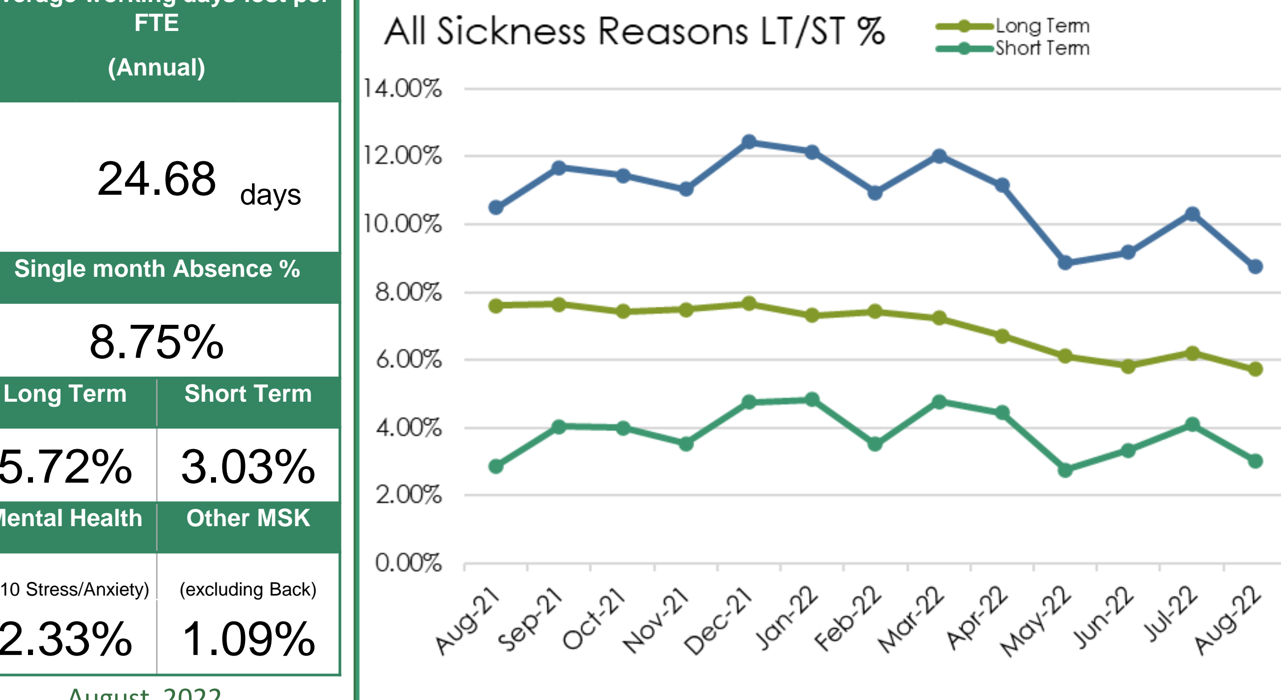






Average working days lost per FTE (Annual)	
24.68 days	
Single month Absence %	
8.75%	
Long Term	Short Term
5.72%	3.03%
Mental Health	Other MSK
(S10 Stress/Anxiety) 2.33%	(excluding Back) 1.09%

August 2022



Analysis

There has been a decrease in sickness absence in August, with a reduction in COVID absences to 1.04% FTE in August, down from 2.56% FTE in July.

- Based on current intelligence, we are expecting September to remain static.
- The number of long COVID cases continues to decline.
- Physiotherapy: 39 referrals were received in August 2022. This was a 100% increase on referral received in August 2021.
- Average Length of Time from Referral to Clinical Assessment: 2.38 days.
- Average age of those referred is 48 years, with back and shoulder issues being the main reason for referral.
- Health Assured- EAP: Call summary - In August 2022 = 57calls
- Thrive App August 2022 – Total of 647 staff signed onto App with 57 Active Users in the month

Remedial Plans and Actions

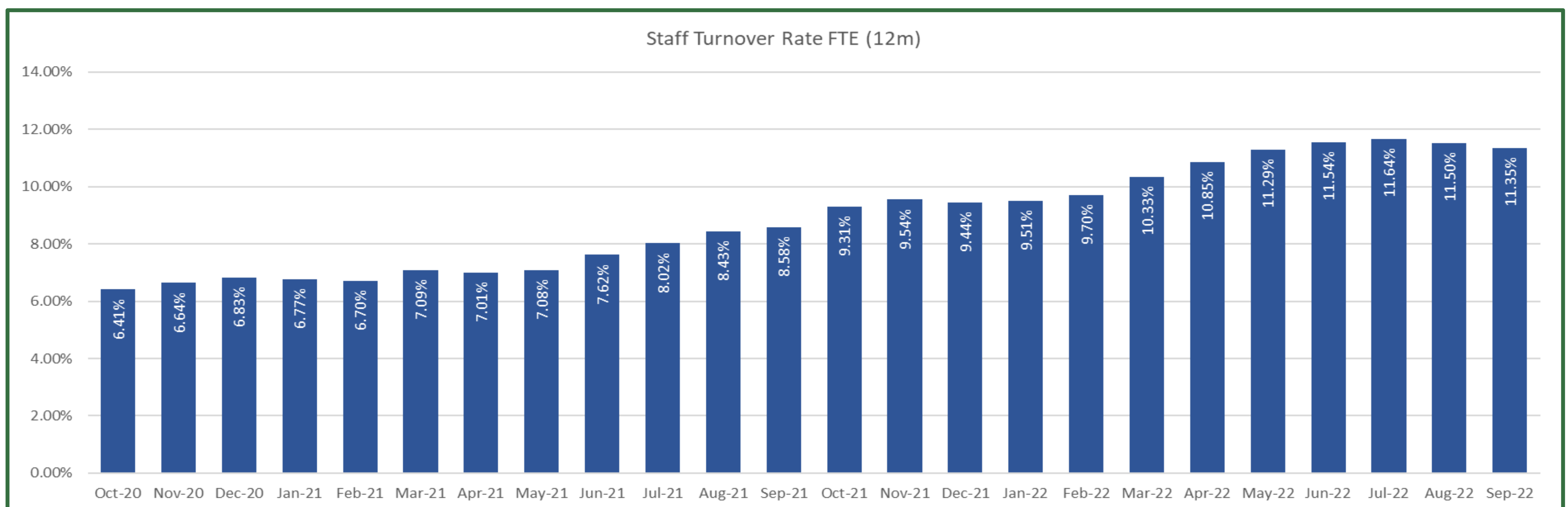
- Bitesize training is now live, with sessions planned throughout October 2022. Sessions are being well received, with attendance across all WAST directorates.
- The CCC sickness absence management programme has identified several training areas. Discussions are underway to support delivery for this.
- Focus remains on directing colleagues undertaking alternative roles as a direct result of sickness absence.
- STS audits have been completed in EMS – main themes identified show that RTWs are not being inputted into ESR; some reasons for absence are not being completed on ESR; no uniform means of identifying / recording which employees have prompted the MAAW policy and which stage of the policy an individual is on.
- Survey to managers re MAAW is drafted and due to go live in October 2022.
- Occupational Health continue to engage with Health Board colleagues to fast track appointments and treatment to reduce length of absences.
- Regular meetings continue to be held to discuss complex cases.
- Case reviews continue to be held to agree next steps for colleagues that are on LTS due to COVID so that comprehensive RTW plans are developed.

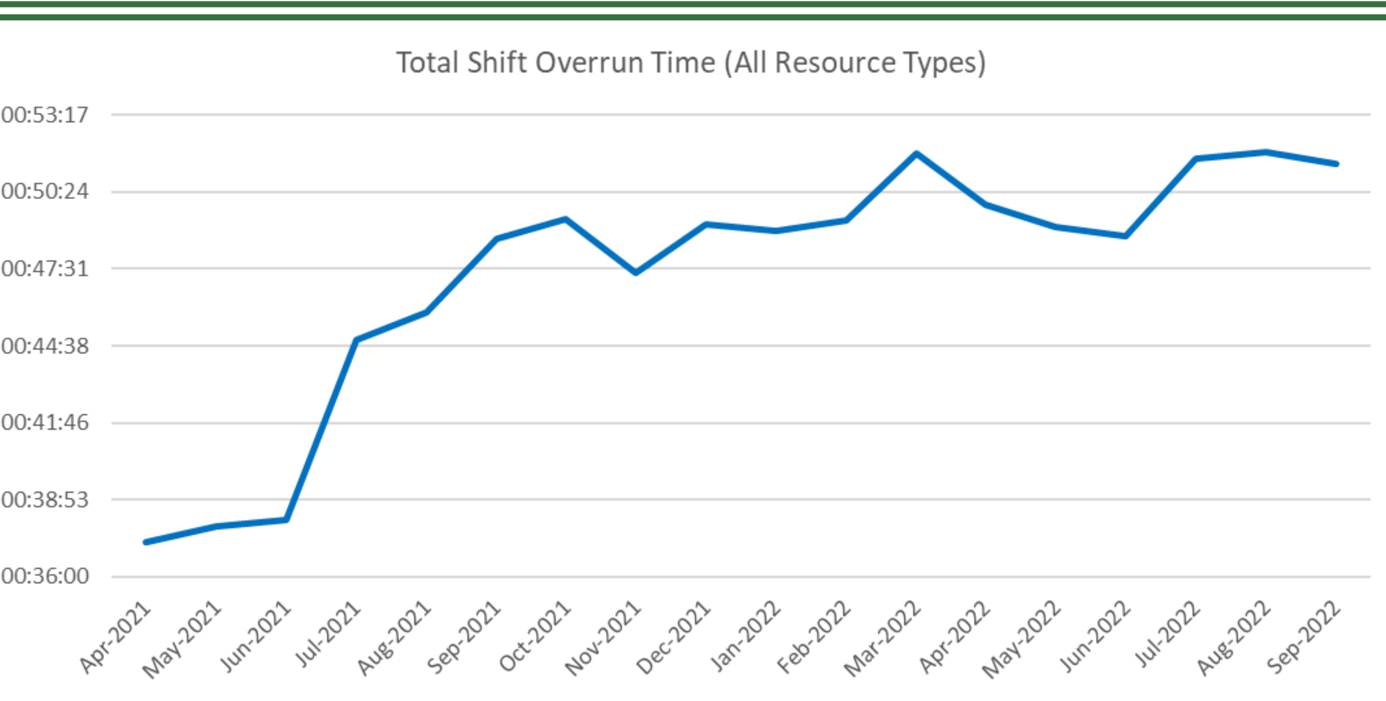
Expected Performance Trajectory

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

Our People
Health and Wellbeing – Turnover

A





	FTE by Month		
Org L4	2022 / 07	2022 / 08	2022 / 09
020 Ambulance Care L4 (NX10)	837.86	847.63	792.04
020 Emergency Medical Services L4 (DX04)	1,717.90	1,729.51	1,795.94
020 Integrated Care L4 (DX03)	438.72	437.38	436.81
020 National Operations & Support L4 (DX02)	162.89	157.77	157.77
020 Resourcing & EMS Coordination L4 (DX05)	342.01	346.19	333.08
Grand Total	**3,499.38**	**3,518.49**	**3,515.64**
Ambulance Response:			**1549.53**

Analysis

Staff turnover rates in September 2022 were 11.35%, decreasing month on month. In comparison staff turnover rates were 8.58% in September 2021. As highlighted in the Staff & Wellbeing deep Dive presented to People and Culture Committee on 06th September 2022 the number of staff leavers has increased over the last 3 years and were lower pre-pandemic; staff leave the Trust for a variety of reasons including promotions, relocations and due to pressures of NHS working.

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.

Wellbeing levels remain low for a range of reasons such as wider system challenges, COVID and population issues (cost of living crisis), the Trust continues to address these circulating communication for wellbeing opportunities and groups, such as women's health, menopause and pensions presentations and through training, including Carers Wales Workplace Champion training in October 2022.

Remedial Plans and Actions

Cost of living champions are being identified across the Trust to act as a support system over the winter months in relation to the cost of living crisis. This network will support colleagues in signposting to local services and events within their local areas

- A direct survey was undertaken with colleagues across the Trust in November 2020 which identified that colleagues would like to see improvements in:
- Improved training and development opportunities
- Managers who listen more
- More focus on staff wellbeing
- An end to bullying and harassment
- Increased professionalism and positive behaviours

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, financial advice and the Trust will work at a local level recruiting champions. The People and Culture Strategy will continue with its wellbeing focus.

Other key metrics will be determined for reporting in future iterations.

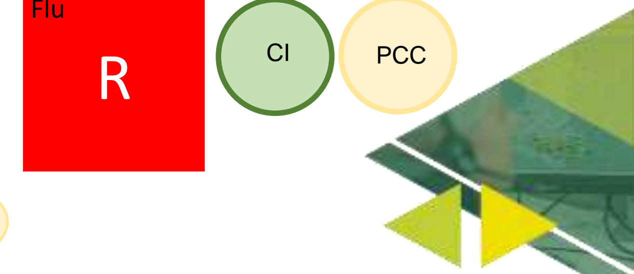
Our People
Staff Vaccination Indicators

Flu

R

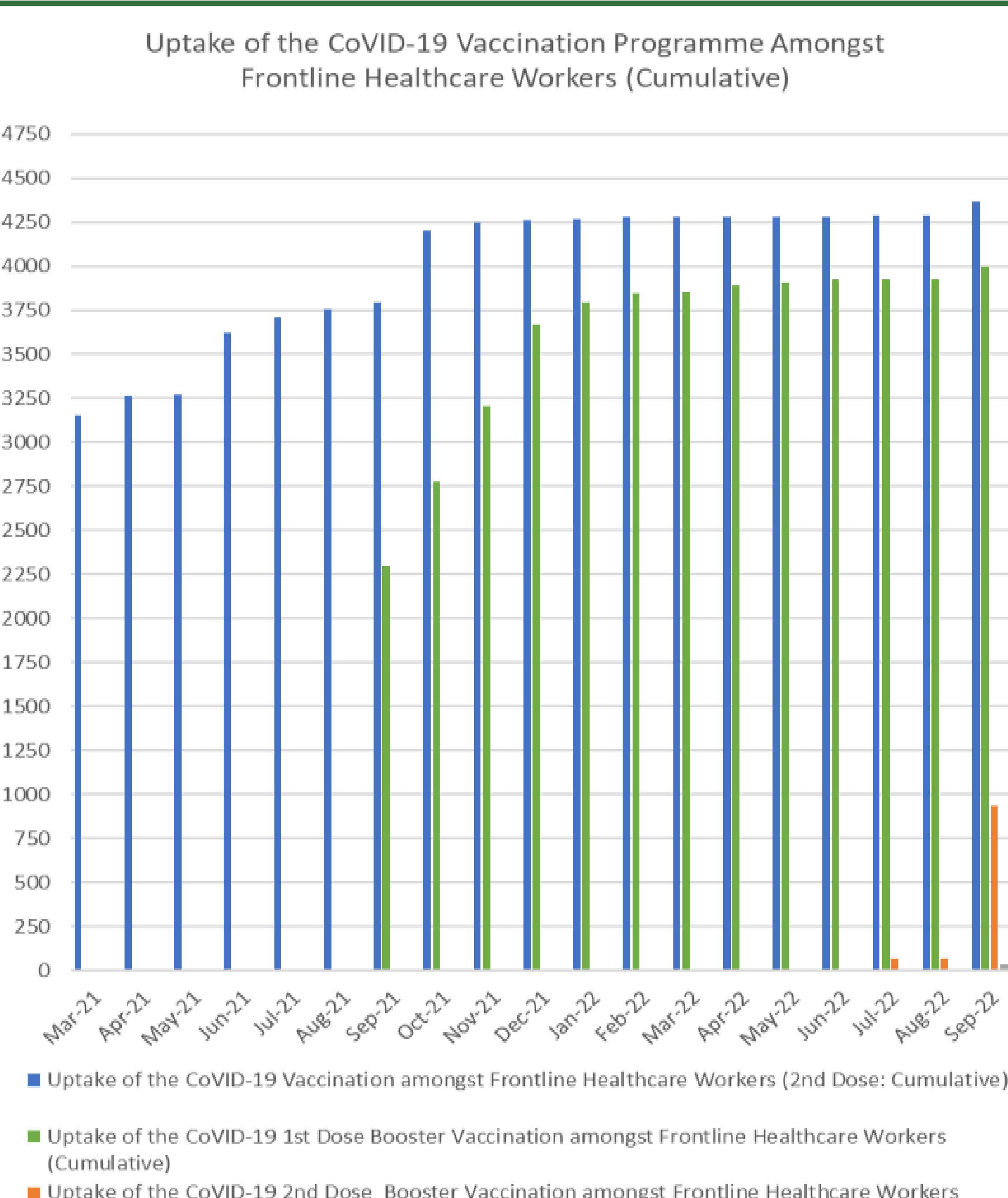
CI

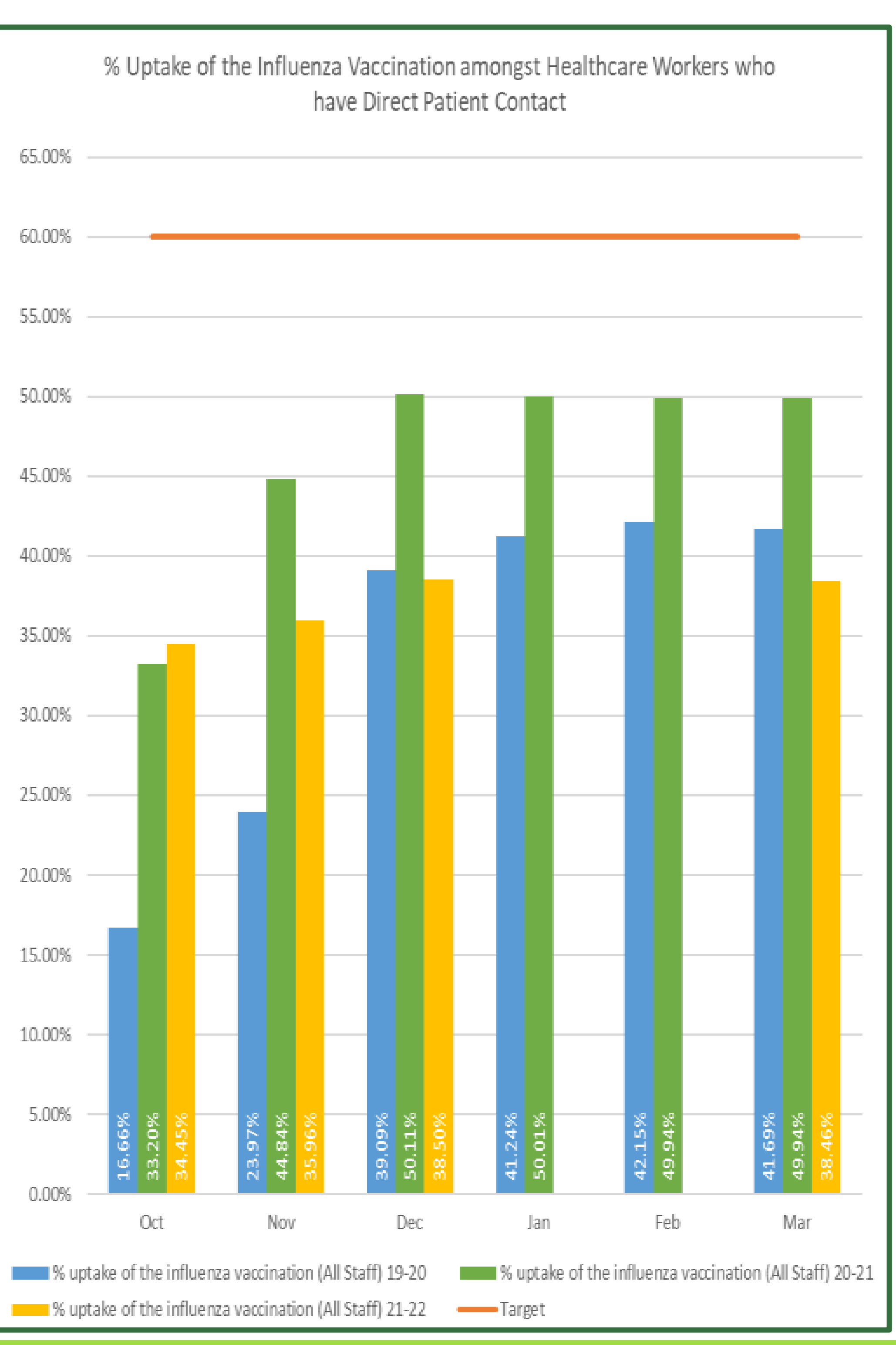
PCC



Health & Care Standard
- Health (PPI)

NB: Next Reporting Flu Campaign October 2022





Analysis

The 2022-23 flu campaign is now underway and will commence reporting from October 2022. Flu leads, and peer vaccinators have been identified. 2,000 vaccines have been received by the Trust.

In September 2022 an up-to-date staff list has been used to calculate , with extraction of 485 leavers and 619 new staff added, therefore there are 4,667 staff currently employed (All staff), 2,913 of these are front line. As of September 2022 front line (Patient Facing and Non-Patient Facing staff), 94% (4,391) of staff have received a first dose COVID-19 vaccination, 94% (4,366) have received a second dose and 17% (535 Staff) have received the SPIKEVAX booster vaccination

Remedial Plans and Actions

- Staff are required to complete mandatory training for flu through Flu One e-learning modules via ESR.
- Planning has commenced earlier than ever for the 2022/23 campaign, with 48 Flu Leads (across all EMS localities and all Directorates, unlike previous years) being appointed in July 2022.
- Monthly Flu Update meetings (with Flu Leads) commenced earlier than ever too, with the first taking place on Monday 12th September to ensure all are ready for the delivery of the flu vaccines
- Vaccines are being delivered from 16th – 21st September all in a bulk order to 4 delivery points (Matrix One, Ty Elwy, Hensol and Caernarfon), as opposed to being delivered over several months and therefore, preventing vaccine supply issues that have occurred in previous years
- The Flu Siren page has launched, with all details of clinics, Flu Leads, Peer Vaccinators.
- The Digital Directorate is currently creating an online booking page for staff to directly book flu vaccinations with the Occupational Health Department (this is a new idea, as previously if staff wish to have their flu vaccine with OH, they have had to phone a booking line)
- The Trust aim to have 146 signed off and competent Peer Vaccinators for the 2022/23 campaign as opposed to (Approx.) 50 in previous years
- The flu consent / opt-out form has been simplified with fewer questions in a bid to encourage the staff who do not wish to have the flu vaccine or have had the vaccine elsewhere to let us know, which will hopefully increase engagement across the Trust.

Expected Performance Trajectory

An evaluation of the 2021-22 flu campaign has concluded. Early indications from the southern hemisphere are that there has been more flu trough the winter of 2022. The Trust is currently developing forecasts for the winter period that build in CoVID-19 and flu.

NB: *Due to a technical error in the downloading of data for the Trust are unable to report monthly flu data for January & February 2022.*

NB: COVID Vaccinations are reported using the WAST definition of Frontline Pacing Facing employees and therefore includes those employed within Clinical Contact Centres.

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

Our People
Health and Wellbeing - PADR and Training Rates Indicators

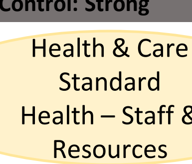
A

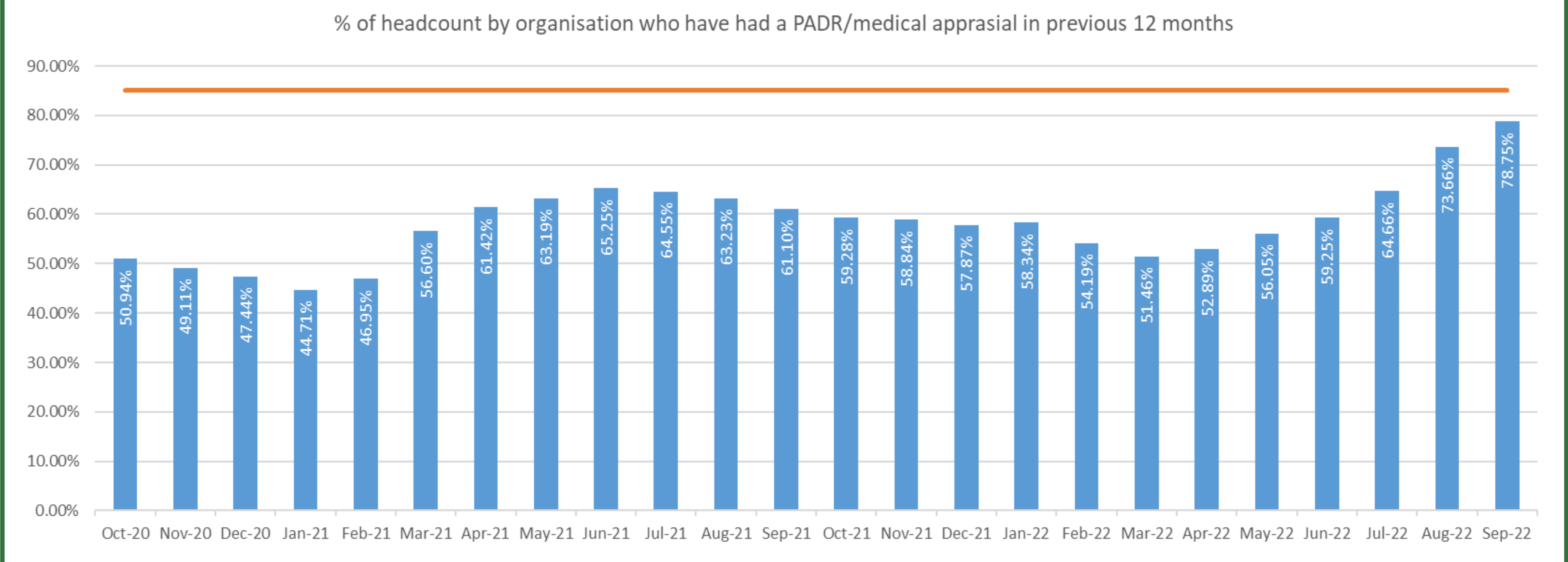
Self Assessment: Strength of Internal Control: Strong

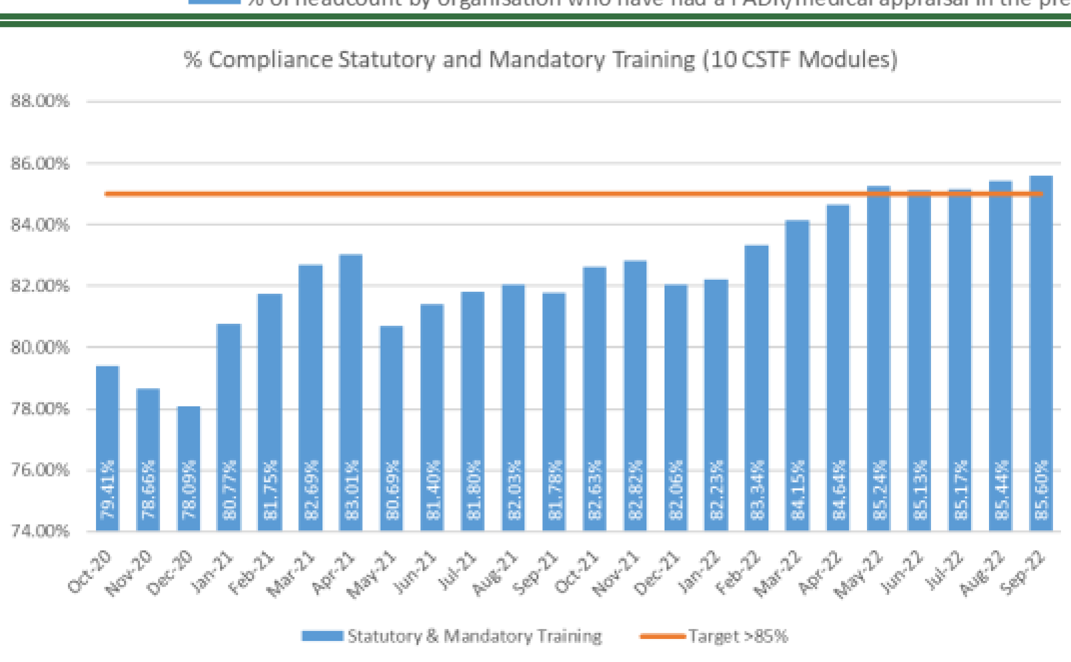
CI

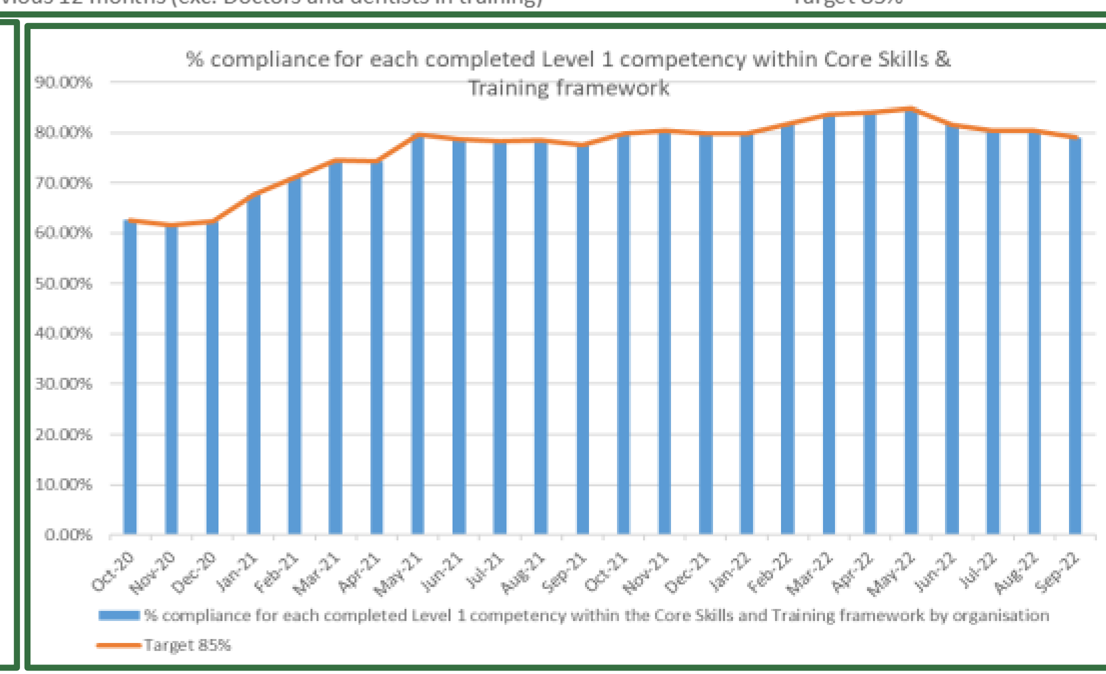
PCC

Health & Care Standard Health – Staff & Resources









Analysis

PADR rates for September 2022 improved for the seventh consecutive month to 78.75% and are on an upward trajectory, however they continue to remain below the 85% target.

September 2022 Statutory & Mandatory Training rates increased by 0.16% from the August 2022 figure, once again achieving the 85% target for the fifth consecutive month. Fire Safety (68.41%) and Equality & Diversity (76.28%) failed to achieve the 85% target; however, Moving & Handling (84.88%), Information Governance (85.22%) Dementia Awareness (88.41%) and Safeguarding Adults (89.10%) achieved the target in September 2022.

There are currently 2 (13 for Admin & Clerical Staff) Statutory and Mandatory courses that all NHS employees must complete in their employment. These Are listed in the table to the right.

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
Environment, Waste and Energy **(Admin & Clerical staff Only)**	Yearly

Remedial Plans and Actions

Since the onset of CoVID the Learning and Development team have moved the Trust towards a more blended model of education. All staff are actively encouraged to take ownership of their e-learning through self-identification of topics they are required to update. This is done through logging into ESR and reviewing individual compliance. Where e-learning is appropriate staff log in and complete this in a timely manner. This then negates the need for colleagues to attend classroom based CPD days where it is not necessary. CPD is supported by the ESR Team and user guides, and other supportive information is available through the WAST intranet and via Yammer.

A campaign is underway to 'mop up' last years non-compliance and is due for completion shortly. A presentation to SOT and SESG in July 2022 outlined proposals for 22-23 CPD topics and structure. In addition, meetings are ongoing with the Ambulance Response Team to highlight compliance rates for Frontline staff and continue to monitor.

A series of deep dives into PADR rates resulted in a refresh process, phase 1 of which is now complete. Phase 2 involves development and launch of a manager toolkit to support colleagues and managers through the PADR process and subsequently improve completion rates. Phase 3 will involve transfer of this form to ESR, enabling PADR data and information to be fully reportable to inform organisational training and intervention plans. It is envisaged that the ESR version of the form will be live by November 2022.

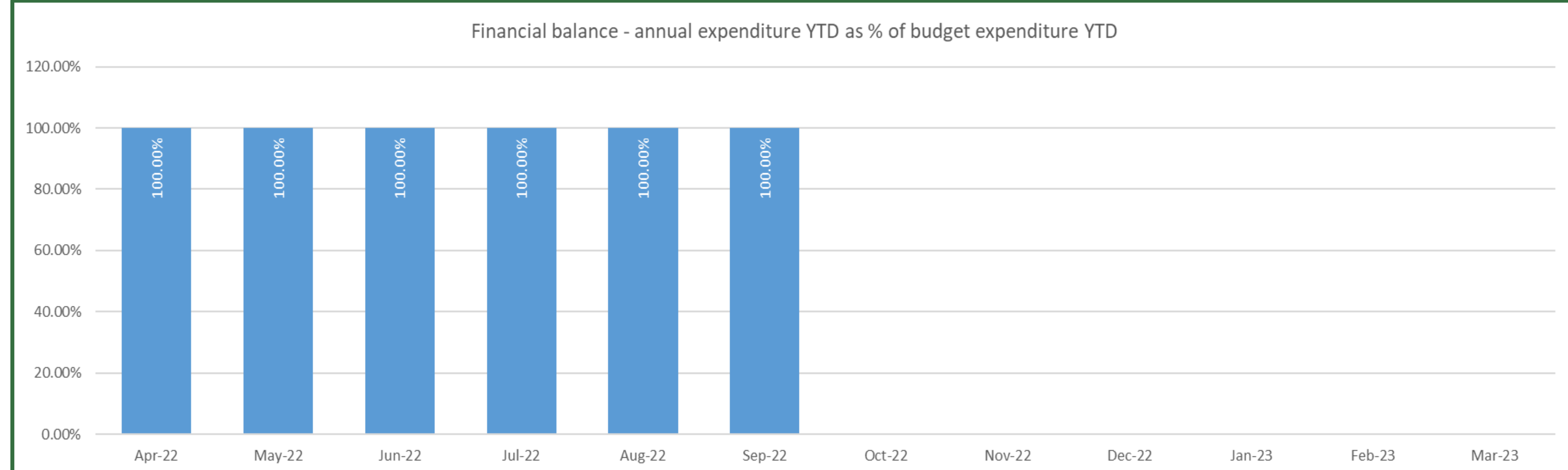
Expected Performance Trajectory

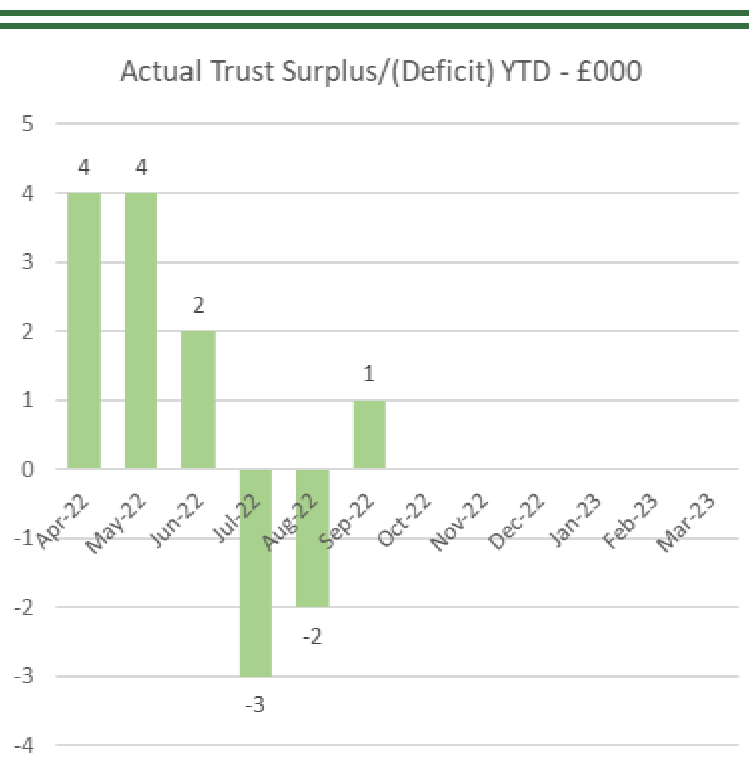
Uptake in the e-learning based topics continues to be very positive and staff of all grades have embraced the concept and are engaged with this new concept. Staff seem to have bought into the "new normal" and the Trust expects to continue to see improving compliance figures across the Trust.

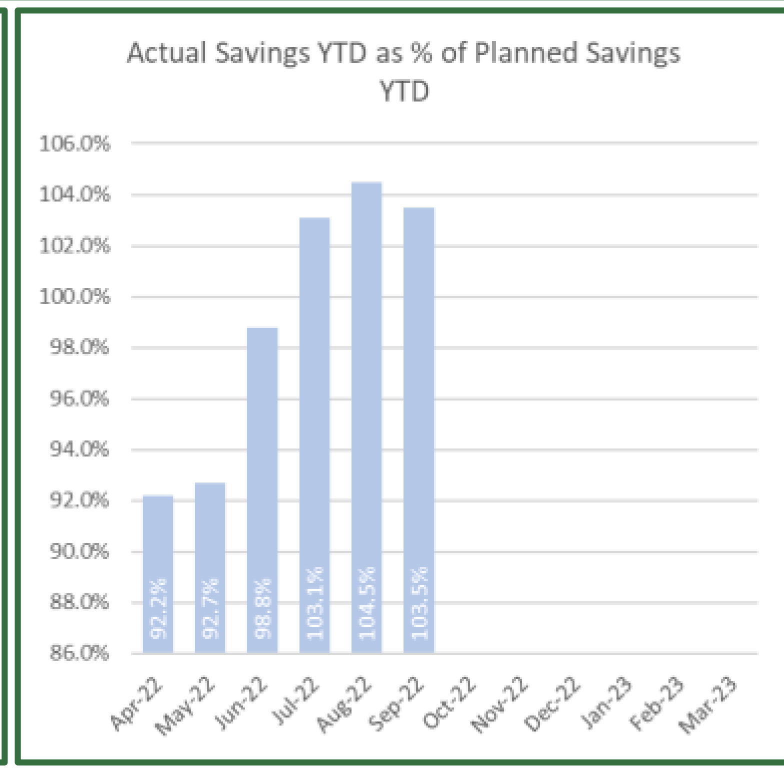
Data source: ESR

Finance, Resources and Value
Finance Indicators

G







Analysis

The reported outturn performance at month 6 is a surplus of £1,000, with a forecast to the yearend of breakeven.

For month 6 the Trust is reporting planned savings of £2.158m and actual savings of £2.233m, an achievement rate of 103.5%.

Cumulative performance against the Public Sector Purchase Programme (PSPP) as of September 2022 was 97.2% against a target of 95%.

As of September 2022, 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 2022-25 will build on the plans and financial performance of the last few financial years, in which the Trust has, year on year, achieved financial balance; the 2022-25 financial plan was submitted to WG following Board sign off on 31st March 2022.

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

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

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

Expected Performance Trajectory

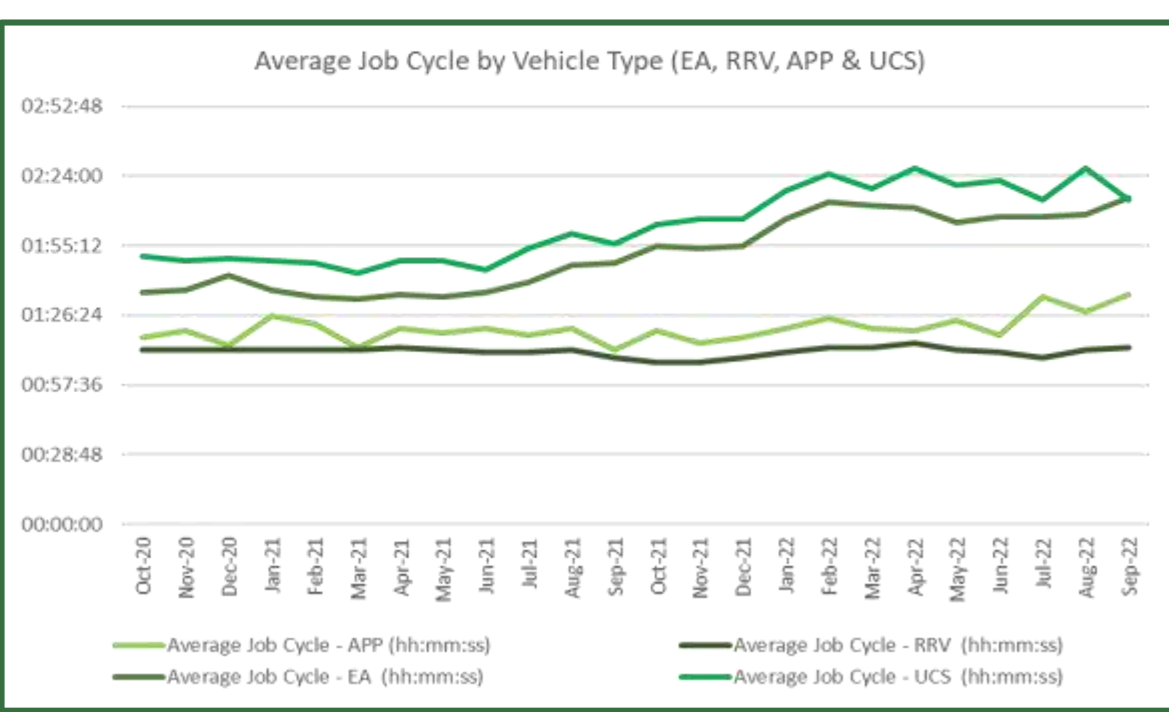
The expectation is that the Trust will continue to meet its statutory financial duties, as outlined in its IMTP; however, it is expected that the Trust will continue to operate in a challenging financial environment and will need to continue to deliver further planned savings into 2022/23.

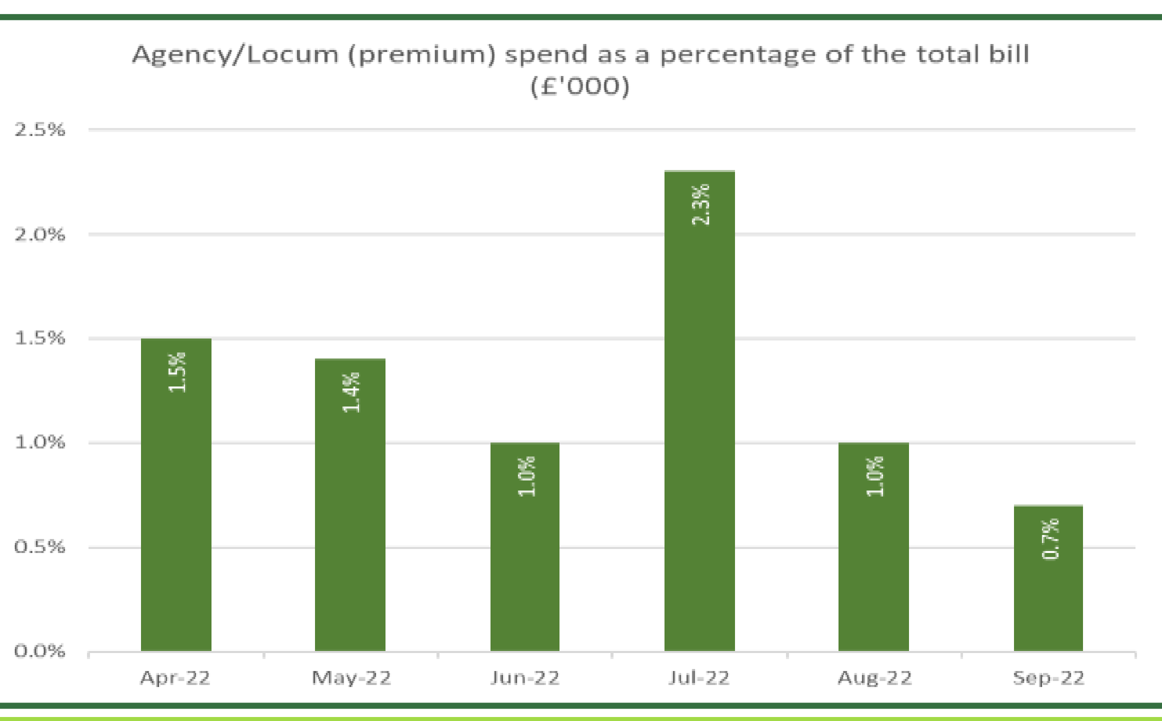
Finance, Resources and Value
Resource and Value Indicators

G

FPC

Slide under Development: Future iterations of the report will include emissions data





Analysis

The Trust has deployed 23 plug in hybrid Rapid Response Electric Vehicles (EV) across Wales as part of the 2022/23 fleet replacement programme in an ongoing commitment to decarbonisation and in line with actions identified in the Decarbonisation Action Plan.

As demonstrated in the bottom left graph, average job cycle decreased in August 2022 for UCS, but increased for Advanced Paramedic Practitioners (APP), UCS and EA calls. EA calls averaged 2 hours and 15 minutes in September 2022 and have been on an increasing trajectory.

There was a decrease seen in agency spend again in September 2022 from the August 2022 position.

Remedial Plans and Actions

In terms of physical infrastructure, WAST Information Communications Technology (ICT) is heavily involved in both the expansion of Fleet and Estates. All new buildings require fitting out with the latest ICT equipment, networking, and audio-visual equipment to enable hybrid working, whilst the Trust continues to modernise the digital offer within both EMS and NEPTS fleet to provide connected workspaces wherever our people need to be. In terms of digital infrastructure, there is also a constant requirement to ensure that our critical services are supported by modern, resilient, and secure technology.

Expected Performance Trajectory

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

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

Post Production Lost Hours - By Unavailability Reason (EA, RRV, UCS)

10800:00:00
9600:00:00
8400:00:00
7200:00:00
6000:00:00
4800:00:00
3600:00:00
2400:00:00
1200:00:00
00:00:00

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

- L3 PPE Cool Down
- U/A Equipment
- U/A HALO Duties
- U/A Leave- Not Available
- U/A Meeting
- U/A Patient Documentation
- U/A RTB Stand Down Mealbreak
- U/A Soiled Uniform
- U/A Staff Illness/Injury
- U/A Traumatic Incident Stand Down
- U/A Vehicle Cleaning
- U/A Vehicle Defect

Analysis

There were 8,520 postproduction lost hours (PPLH) across EA, RRV & UCS vehicles in September 2022; an increase when compared to August 2022 (7,175).

In September 2022 hours lost through PPLH can be down to numerous factors, including, but not limited to Return to Base, Meal Breaks (5,934 Hours), HALO duties (1,083 hours) and Vehicle Cleaning (505 Hours). It can also be as a result of different processes at hospital sites causing variation in process in flow throughout the system that contribute towards post- production lost hours.

Remedial Plans and Actions

This continues to be an area of focus via a series of workshops with TU Partners and is scrutinized weekly at Operation Performance Meetings.

Expected Performance Trajectory

The current data needs to be treated with a degree of caution, for example, there are good reasons for some post production lost hours, plus there are issues of data entry. The Trust has recently undertaken more benchmarking on PPLHs which suggests that it compares favorably with two other ambulance services, but less so with a third. Contact is being sought with this third service. A deep dive on was presented to May-22 F&P Committee.

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

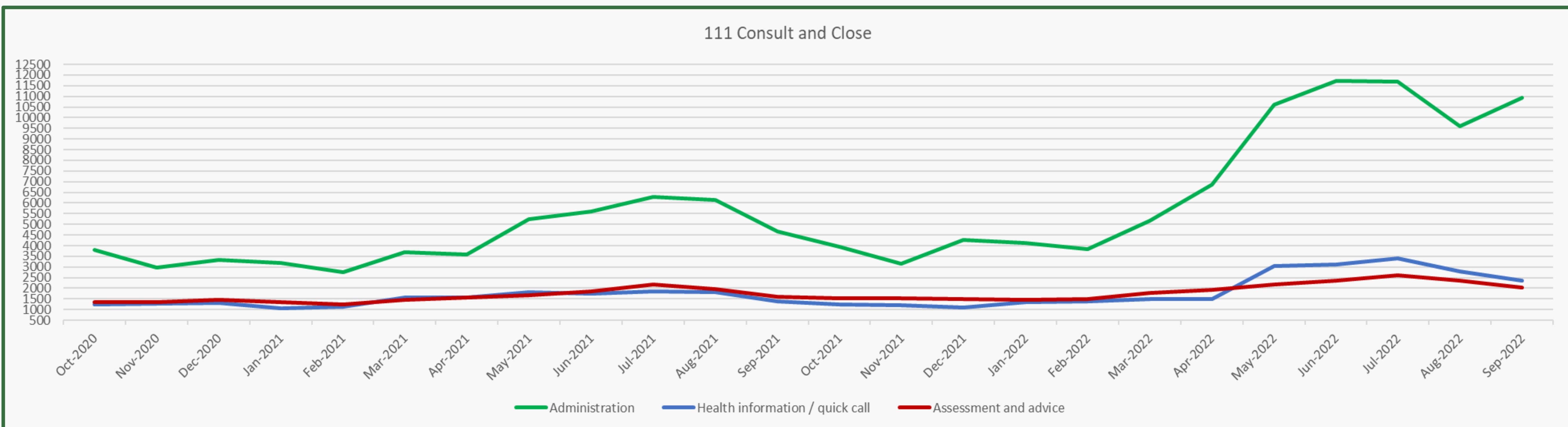
Partnerships / System Contribution

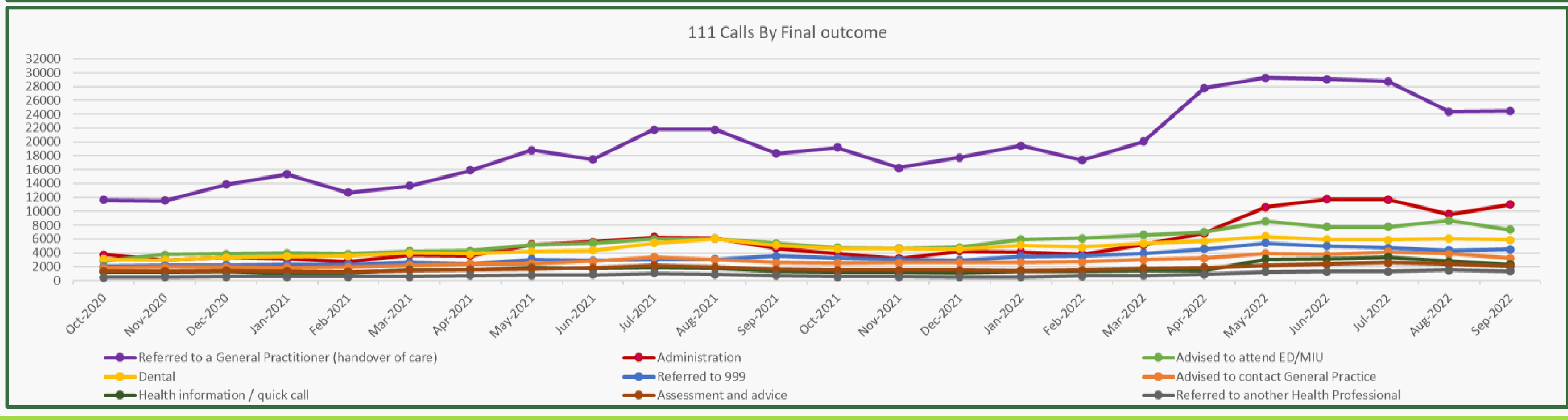
NHS111 Hand Off Metrics and NHS111 Consult & Close Indicators

Influencing Factors – Demand and Clinical Hours Produced

G

FPC





Analysis

The top graph depicts the outcomes for calls handled through NHS111 Consult and Close with administration calls (those calls resulting in no action) accounting for the highest volume (10,947 calls); callers requiring health information accounted for 2,347 calls and callers requiring assessment and advice accounted for 2,048 calls.

In September 2022 calls Referred to General Practitioner (handover of care) continued to be the top outcome for NHS111 accounting for 39% of calls.

In September 2022 62,208 calls were received in the 9 categories displayed in the bottom graph, a decrease when compared to 63,553 in August 2022; but a significant increase when compared to 26,778 in September 2020 and 43,350 in September 2021.

Remedial Plans and Actions

Work is underway to develop live informatics which provide real time information on clinician availability to allow improved understanding and management; this will enable the Trust to report more meaningful metrics and accurately monitor patient outcomes.

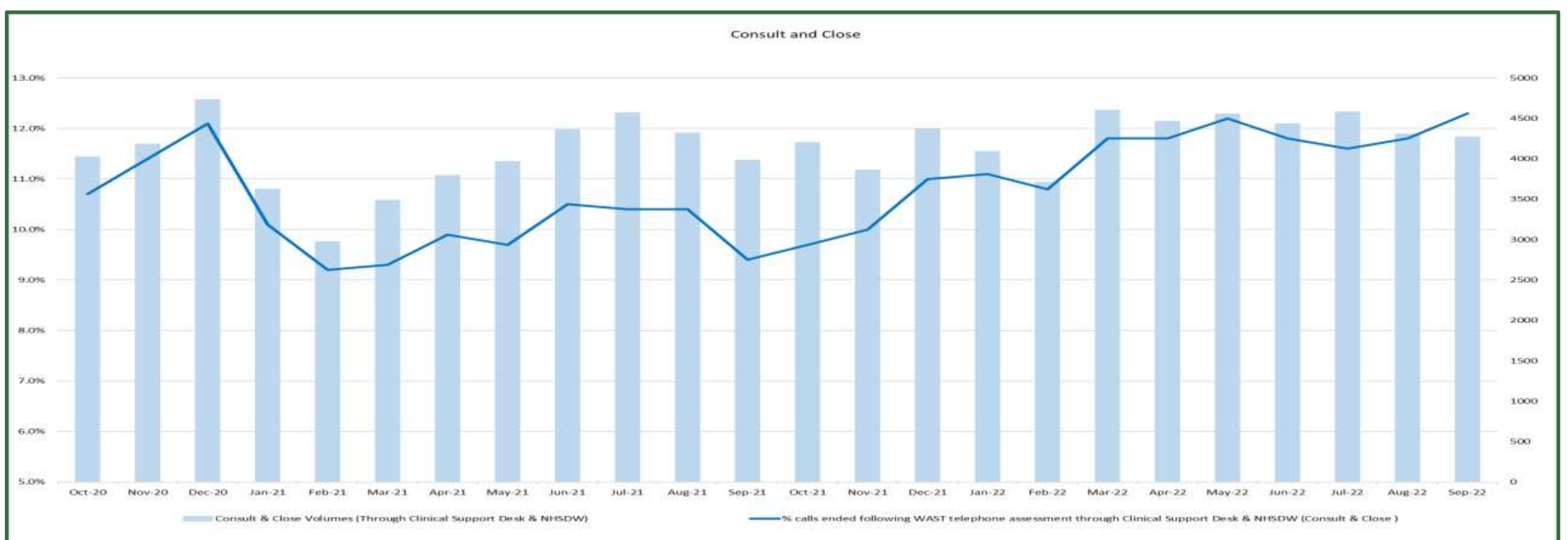
A new NHS111 Consult and Close dashboard is in development to report more accurate and specific data in relation to calls ending in alternative transport, referral and self care.

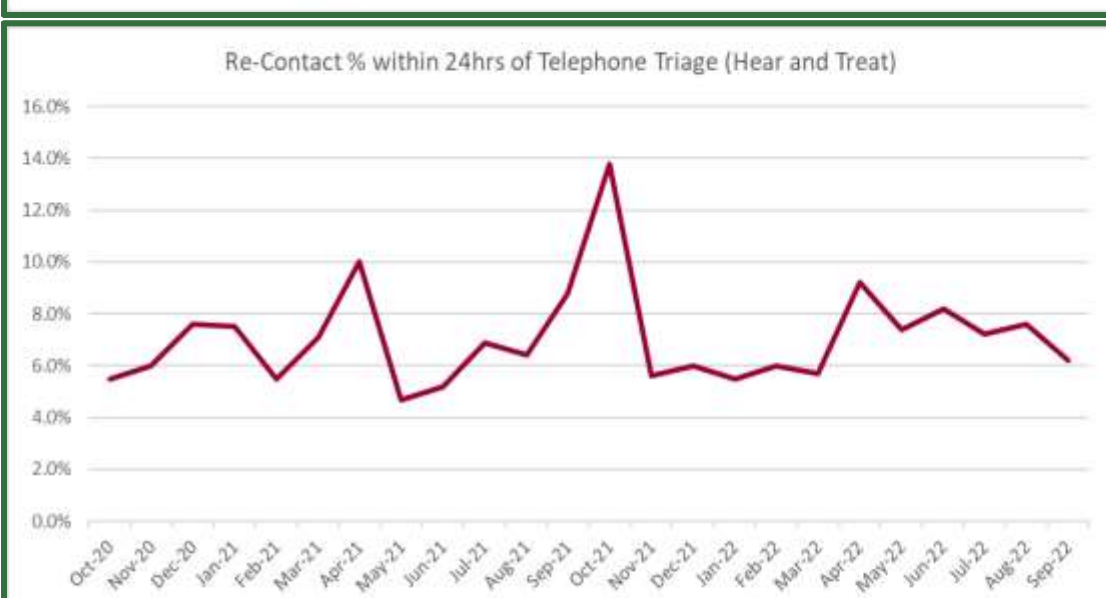
Expected Performance Trajectory

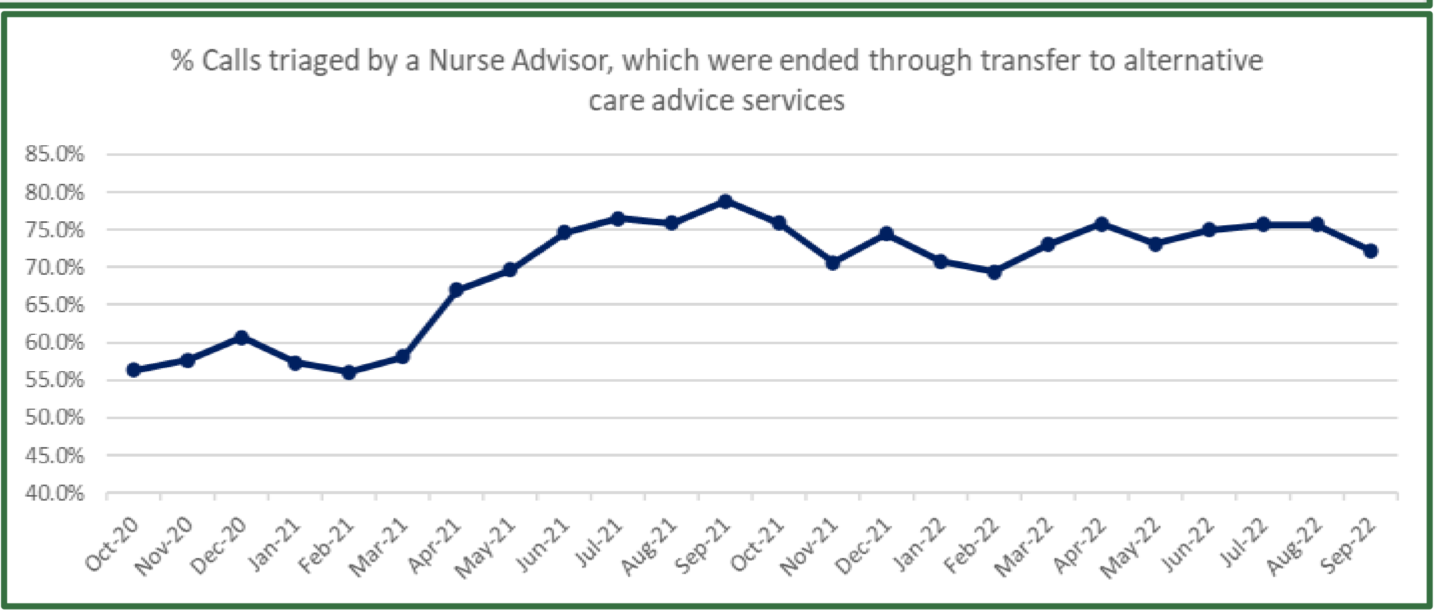
A Contract Analyst is currently undertaking work to improve 111 data metrics available; this will allow us to report more meaningful and relevant data in relation to whether patients are directed to the most appropriate and best outcomes.

Partnerships / System Contribution Consult & Close Indicators

A







Analysis

The **Clinical Service Desk (CSD) and NHS111 (Consult & Close)** achieved 12.3% performance in September 2022, therefore continuing to achieve the historical 10.2% benchmark and working towards the mew benchmark of 5%.

8.8% of consult & close volumes were achieved by the CSD in September 2022. In comparison, 3.5% of consult & close was by NHS111.

The percentage of re-contacts within 24 hours of telephone hear and treat has fluctuated over the last two years, peaking in Jun-20 to 15.7%.

Re-contact rates in September 2022 were 6.2% a decrease compared to 7.6% in August 2022, this is also a decrease compared to 8.8% in September 2021.

The percentage of calls triaged by nurse advisor ended through transfer of alternative care advice services increased month on month to 72.2% in September 2022; by comparison, this figure was higher in September 2021 at 78.8%.

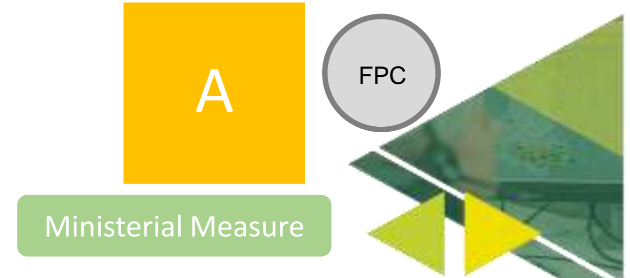
Remedial Plans and Actions

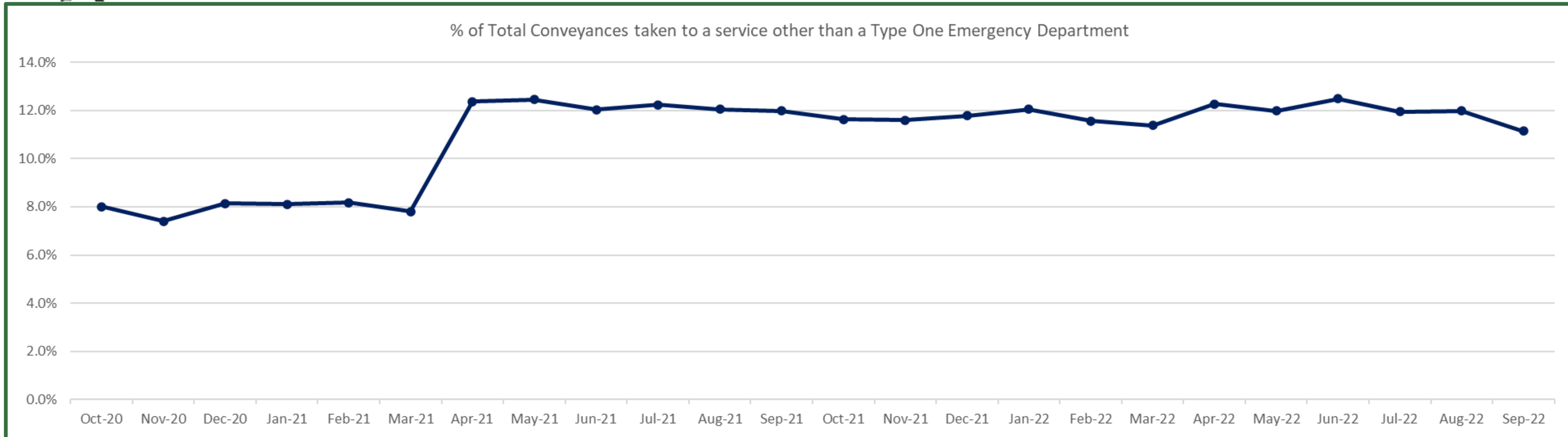
- Funding has been agreed to double the size of the CSD, including introduction of 5 mental health practitioners. These staff are now in place.
- The team are also undertaking detailed process maps of the work that they do in order to identify where improvements can be made
- The revised establishment is 96 FTEs with current in post 90 FTEs.

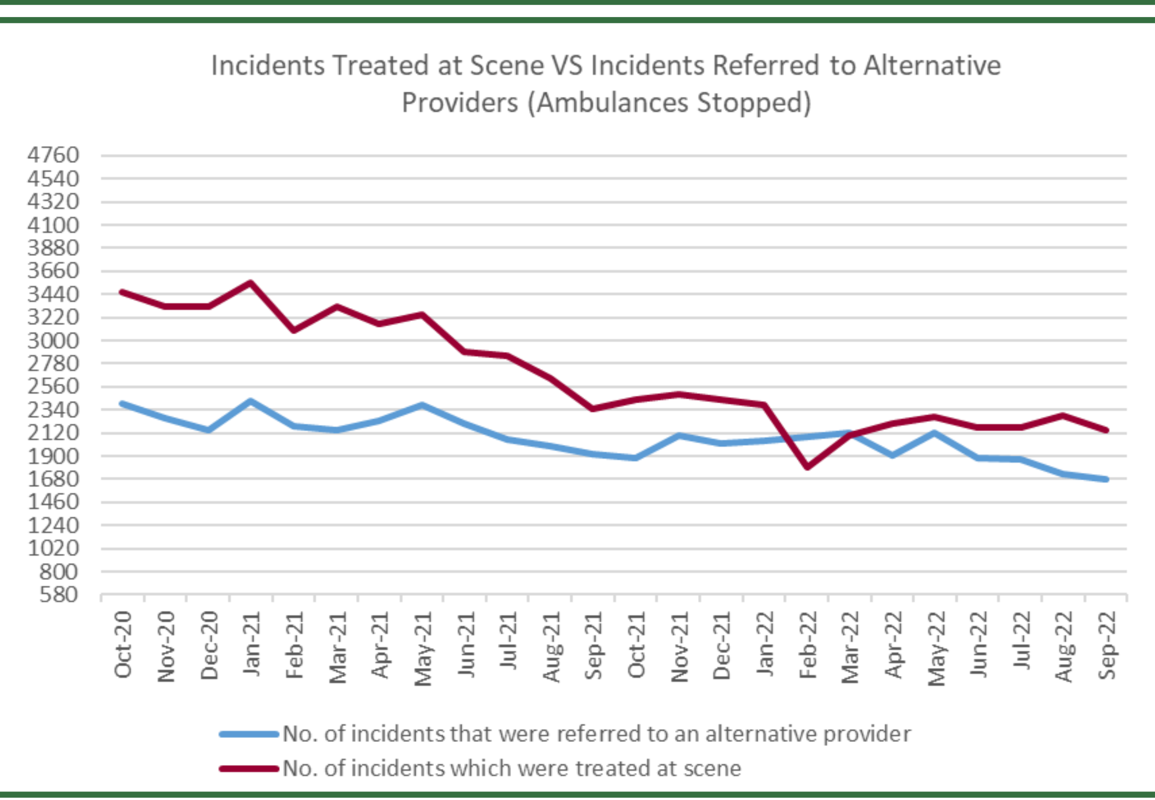
Expected Performance Trajectory

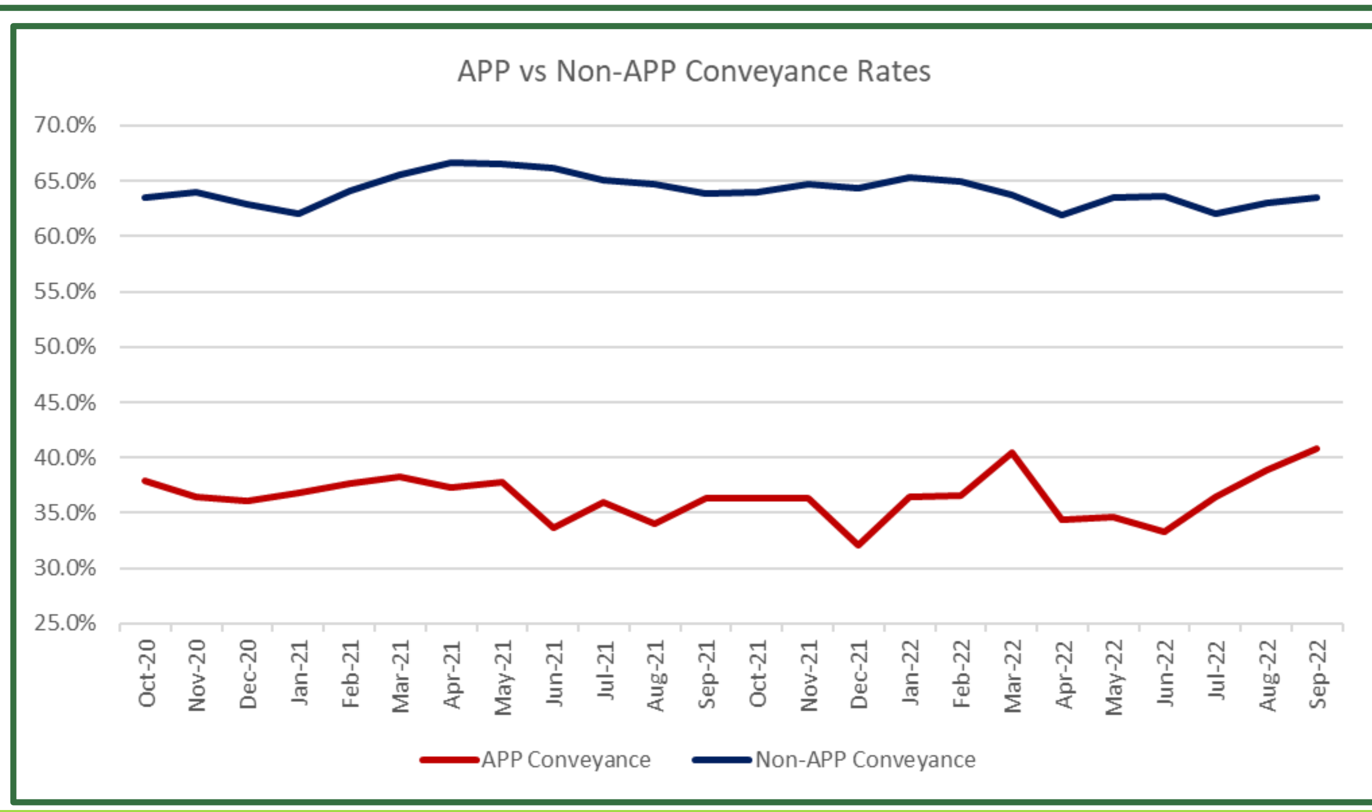
The current target for this year is 15% hear and treat rate for 2022/23 as part of the development of the 2022-25 IMTP and associated forecasting and modelling. We would hope to be achieving this in the second half of the year.

Partnerships / System Contribution
Conveyance to ED Indicators









Analysis

In September 2022 11.14% of patients (1,417) were conveyed to a service other than a Type One ED. Although not shown here, the percentage of patients conveyed to EDs increased (i.e. declined) compared to the same period last year. In September 2022 conveyance to EDs as a proportion of total verified incidents was 32.33% (compared to 29.80% in September 2021).

The combined number of incidents treated at scene and referred to alternate providers decreased for the fourth consecutive month in September 2022. 1,682 incidents were referred to alternative providers in September 2022 and 2,152 incidents were treated at scene; however, a review of other outcomes (see graph) shows that there are a number of incidents where there was a no send due to escalation of the Clinical Safety Plan (CSP).

Remedial Plans and Actions

The Head of Strategic Development has been appointed to lead on the "inverting the triangle" strategic transformation. Key actions include: formal consultation with stakeholders, a new strategic demand & capacity review, evaluating the results of various pilots e.g. Swansea Bay APP, prescribing etc.

One of the Trust's commissioning intentions is to develop an optimising conveyance strategy, which will bring forward clearer proposals linked to further work on the EMS Demand & Capacity Review.

Additional same day emergency care (SDEC) services are due to go live however inclusion/exclusion for SDEC may be limiting appropriate patients and opening hours vary amongst the units available. Work is underway to ensure appropriate use Of SDEC services by clinicians, missed opportunities and better use of ePCR.

Expected Performance Trajectory

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

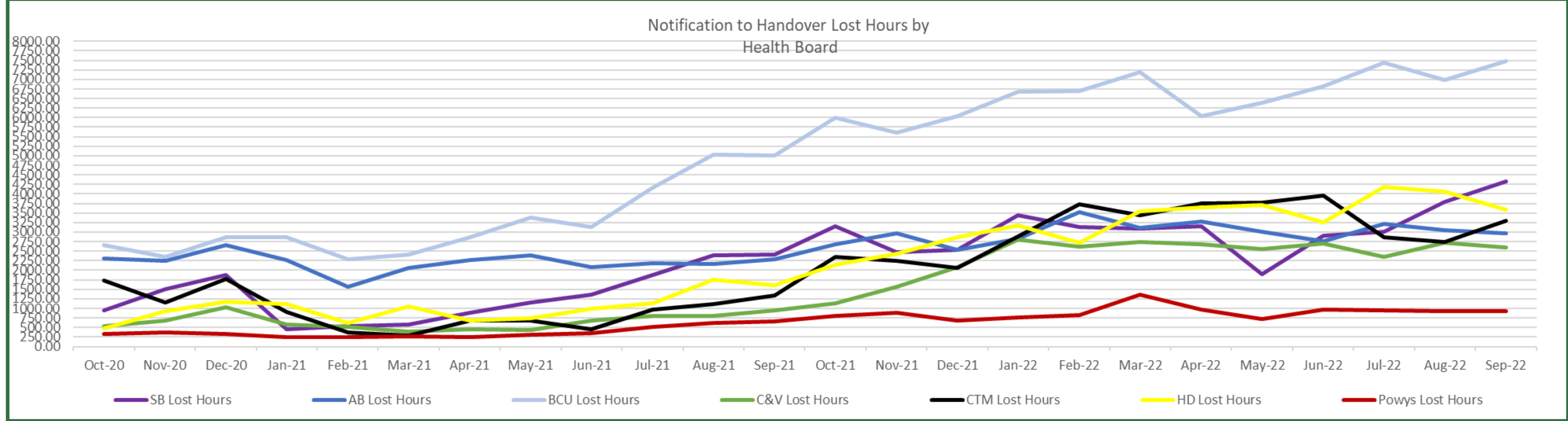
(Responsible Officer: Andy Swinburn)

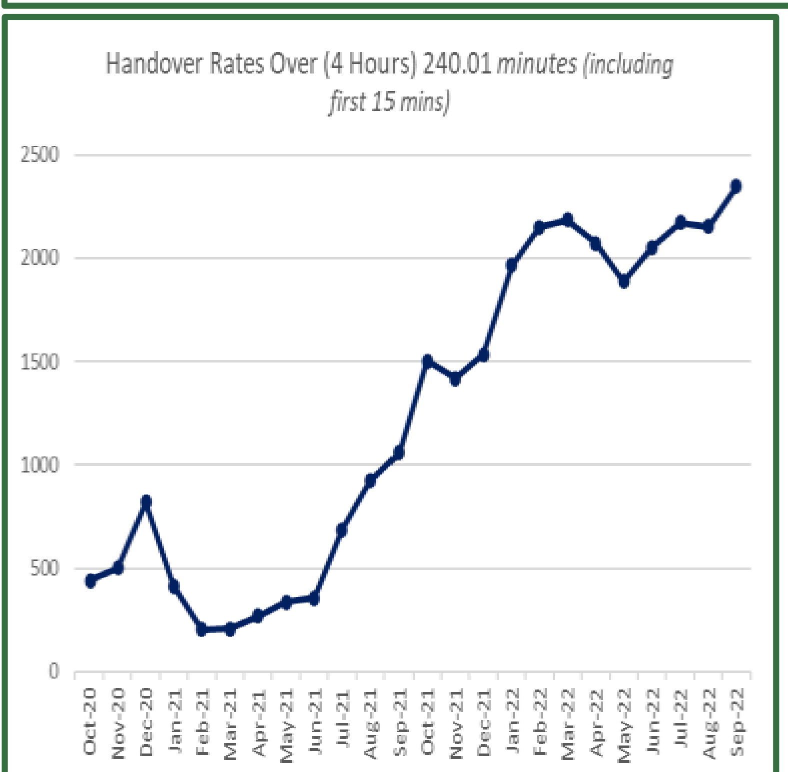
Partnerships / System Contribution
Handover Indicators

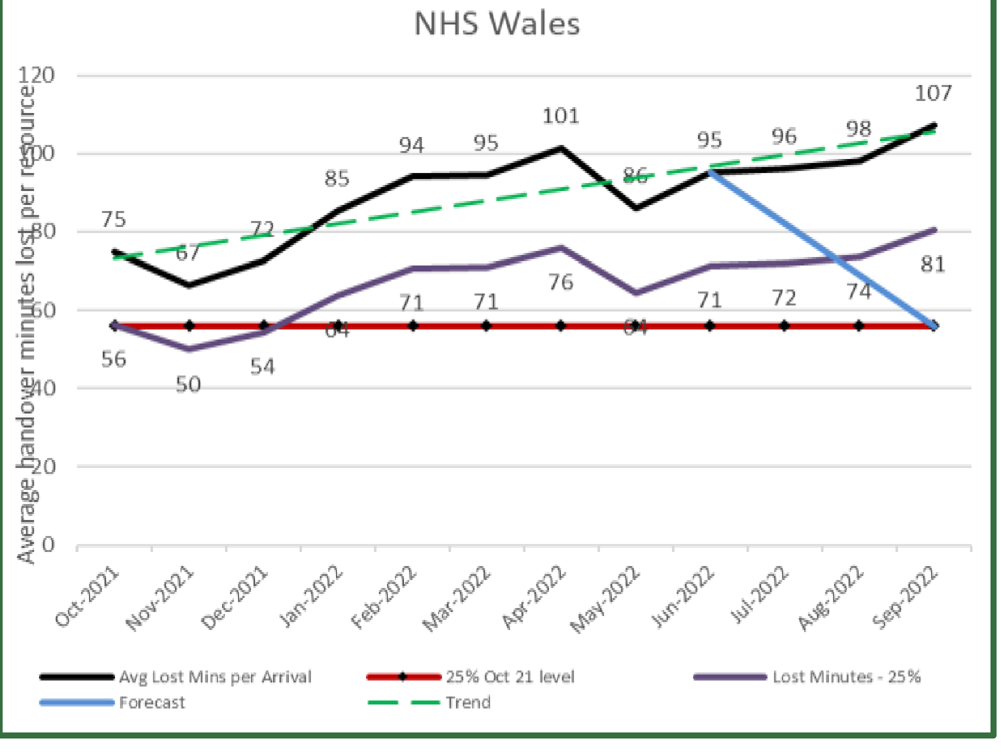
R

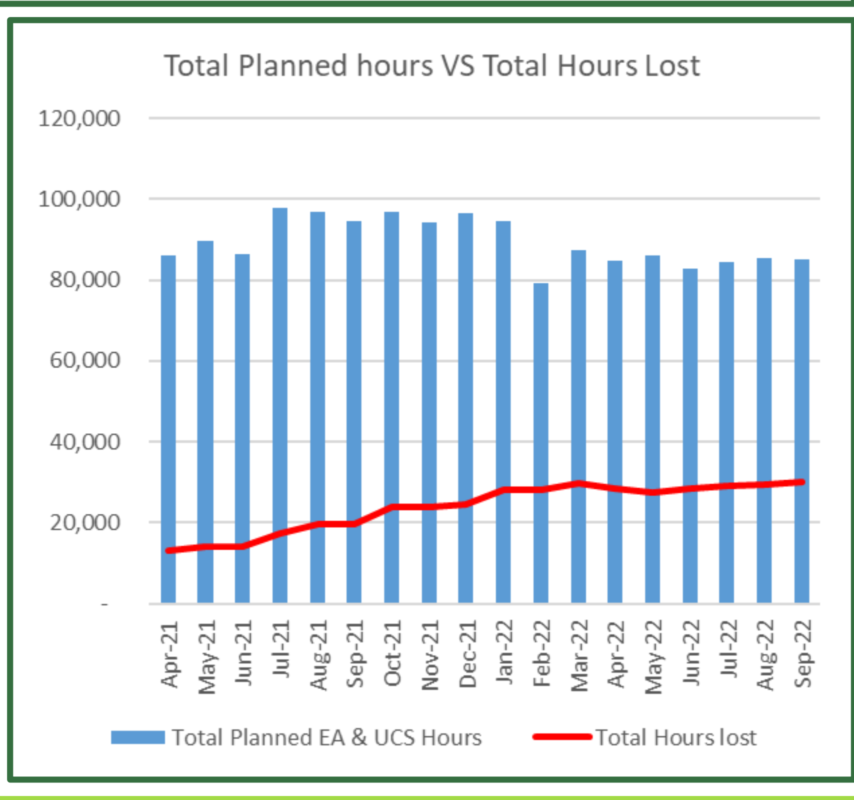
CI

QUEST









Analysis

267,766 hours were lost to Notification to Handover, i.e. hospital handover delays, over the last 12 months, compared to 117,600 in same period a year ago (October 2020 to September 2021). 25,167 hours were lost in September 2022, a 43% increase compared to 14,202 lost hours in September 2021. The hospitals with highest levels of handover delays during September 2022 were:

- Morriston Hospital (SBUHB) at 4,331 lost hours
- Glan Clwyd Hospital Bodelwyddan (BCUHB) at 3,496 lost hours
- The Grange University Hospital (ABUHB) at 2,664 lost hours
- University Hospital of Wales (CVUHB) at 2,570 lost hours.

Notification to handover lost hours averaged 838 hours a day in September 2022.

In September 2022 the Trust could have responded to approximately 7,939 more patients if handovers were reduced.

Remedial Plans and Actions

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

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

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

Expected Performance Trajectory

The direction is that handover lost hours should return to 25% of their Oct-21 levels, just under 14,000 hours, that there should be no waits over 4 hours and non-release for Immediate Release Requests should become a Never Event.

Definition of Indicators

Indicator	Definition	Indicator	Definition
111 Abandoned Calls	An offered call is one which has been through the Interactive Voice Response messages and has continued to speak to a Call Handler. There are several options for the caller to self serve from the options presented in the IVR and a proportion of callers choose these options. An example is to guide the caller to 119 if they wish to speak to someone about a Coronavirus test. Once the caller is placed in the queue for the Call Handler if they hang up they are counted as "abandoned" as we did not answer the call. The threshold starts at 60 seconds after being placed into the queue as this allows the callers to respond to the messages and options presented as it often takes a short while for the caller to react. Starting the count at 60 seconds provides a picture of abandonment where the caller has chosen not to wait, despite wanting to speak to a Call Handler	**Hours Produced for Emergency Ambulances**	Proportion of hours produced within the calendar month for Emergency Ambulance Vehicles (Target 95%).
111 Patients Called back within 1 hours (P1)	(Welsh Government performance target) which prescribes that 111 has up to 1 hour (longer for lower priory callers) for a 111 Clinician to call the patient to discuss their medical issue. These callers will already have been screened by Call Handlers and received an outcome which needs a conversation with a 111 Clinician. WAST operates a queue and call back method for all Clinical Calls.	**Sickness Absence (all staff)**	Staff sickness volumes as a percentage for all staff employed within the Welsh Ambulance Services NHS Trust.
999 Call Answer Times 95th Percentile	Time taken (in Minutes) to answer 999 emergency calls by call handlers. A percentile (or a centile) is a measure used in statistics indicating the value below which a given percentage of observations in a group of observations fall. For example, the 95th percentile is the value below which 95 percent of the observations may be found.	**Frontline COVID-19 Vaccination Rates**	Volume of frontline (patient facing and non-patient facing) who have received a second COVID-19 vaccination.
999 Red Response within 8 Minutes	Percentage of 999 incidents within the Red (immediately life-threatening) category which received an emergency response at scene within 8 minutes.	**Statutory and Mandatory Training**	Combined percentage of staff who are compliant with required statutory training undertaken by staff where a statutory body has dictated that an organisation must provide training based on legislation and mandatory training which relates to trade-specific training that the employer considers essential or compulsory for a specific job. (A detailed list of these can be found on slide 20).
Red 95th Percentile	Time taken (in minutes) for emergency response to arrive at scene for Red (immediately life-threatening) calls (NB: The 95th percentile is the value below which 95 percent of the observations may be found).	**PADR/Medical Appraisal**	Proportion of staff who have undertaken their annual Performance Appraisal & Development Review (PADR) or Medical Appraisal. This is a process of self-review supported by information gathered from an employees work to reflect on achievements and challenges and identify aspirations and learning needs. It is protected time once a year.
999 Amber 1 95th Percentile	Time taken (in minutes) for emergency response to arrive at scene for Amber 1 calls (other life-threatening emergencies – including cardiac chest pains or stroke). (NB: The 95th percentile is the value below which 95 percent of the observations may be found.	**Ambulance Response FTEs in Post**	Number of Emergency Medical Services, Full Time Equivalent (FTE) staff working for the Welsh Ambulance Services NHS Trust.
Return of Spontaneous Circulation (ROSC)	Percentage of patients for whom Return Of Spontaneous Circulation occurs. This refers to signs of restored circulation (more than occasional gasp, occasional fleeting pulse or arterial waveform) evidenced by breathing, a palpable pulse or a measurable blood pressure.	**Ambulance Care, Integrated Care, Resourcing & EMS Coordination FTEs in Post**	Number of Ambulance Care, Integrated Care, Resourcing & EMS Coordination Full Time Equivalent (FTE) staff working for the Welsh Ambulance Services NHS Trust.
Stroke Patients with Appropriate Care	Proportion of suspected stroke patients who are documented as receiving an appropriate stroke care bundle (a bundle is a group of between three and five specific interventions or processes of caret hat have a greater effect on patient outcomes if done together in a time-limited way ,rather than separately).	**Financial Balance – Annual Expenditure YTD as % of budget Expenditure**	Annual expenditure (Year to Date) as a proportion of budget expenditure.
Acute Coronary Syndrome Patients with Appropriate Care	Proportion of STEMI patients who receive appropriate care. ST segment elevation myocardial infarction - occurs when a coronary artery is totally occluded by a blood clot.	**Post Production Lost Hours**	Number of hours lost due to ambulance vehicles being unavailable due to a variety of reasons (A detailed list of these is show in the graph on slide 22).
Renal Journeys arriving within 30 minutes of their appointment (NEPTS)	Proportion of renal journeys which arrive at hospital appointments within 30 minutes (+/-) of their appointment time.	**111 Consult and Close**	Consult and Close refers to the response to 999 callers where an alternative to a scene response has been provided. A cohort of 999 calls are passed to 111 where they are low acuity and the Clinicians in 111 may be able to help the caller with self-care, referral, etc. This is similar to the work of the Clinical Support Desk but for a lower acuity of caller. Where the outcome from the 111 clinical consultation ends in a Consult and Close outcome (self-care, referral, alternative transport) this is captured and forms part of the Trust's Consult and Close reporting. Over 50% of calls passed to 111 in this way are successfully closed without an ambulance response.
Discharge & Transfer journeys collected less than 60 minutes after booked ready time (NEPTS)	Proportion of journeys being discharged from and/or transferred between hospitals which were collected within 60 minutes of the hospital booked ready time.	**999 / 111 Hear and Treat**	Proportion of 999/111 calls which are successfully completed (closed) without dispatching an ambulance vehicle response. This may include advice, self-care or referral to other urgent care services.
National reportable Incidents (NRI)	Volume of patient safety incidents reported in the month which caused or contributed to the unexpected or avoidable death, or severe harm, of one or more patients, staff or members of the public, during NHS funded healthcare.	**% Incidents Conveyed to Major EDs**	Proportion of patients transported to a hospital Emergency Department following initial assessment at scene by a Welsh Ambulance Services NHS Trust Clinician, as a proportion of total verified incidents. (NB: An ED provides a wide range of scute 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

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

AGENDA ITEM No	8
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	1

PATIENT SAFETY REPORT
QUARTER 2 (JULY - SEPTEMBER 2022)

MEETING	Quality, Patient Experience & Safety Committee
DATE	10 November 2022
EXECUTIVE	Executive Director of Quality & Nursing
AUTHOR	Wendy Herbert
CONTACT	Wendy.herbert3@wales.nhs.uk

EXECUTIVE SUMMARY

This Report will provide an update to The Quality, Patient Experience & Safety Committee on the key information in relation to Putting Things Right and Patient Safety.

In summary the report for this quarter identifies:

- A continued increase in the number of concerns being received;
- A continuing number of incidents being reviewed at the Serious Case Incident Forum (SCIF);
- A continuing number of Appendix B incidents passed to Health Boards;
- A continuing number of Nationally Reportable Incidents (NRIs) identified;
- A slight increase in Political complaints received;
- An increase in Coroner's requests for information;
- A decrease in the number of personal injury claims, albeit they are of a more complex nature;
- The Trust responded to the Regulation 28 (Prevention of Future Deaths) Report received in June;
- A detailed breakdown of Appendix B Reports and immediate release reports by Health Board;
- Additional funding has been received (£100k) to support and improve our compliance against our Putting Things Right and Patient Safety functions.

RECOMMENDED: That, the Committee,
(1) Receives the report for discussion.

KEY ISSUES/IMPLICATIONS

(i) There continues to be an increase in activity in the majority of areas across Putting Things Right (PTR).
(ii) There continues to be a high-level volume of concerns being received.
(iii) A significant improvement in our two-day acknowledgement of concerns, but a deterioration in our thirty-day compliance.

(iv)	There has been a decrease in the number of patient safety incidents received this quarter (1257 compared with 1379 the previous quarter). However, at the time of reporting we have seen a considerable increase in the patient safety incidents recorded to potentially be catastrophic or severe.

REPORT APPROVAL ROUTE
Quality, Patient Experience & Safety Committee - 10 November 2022

REPORT APPENDICES
Annex 1 – SBAR providing background information.

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

ANNEX 1

PUTTING THINGS RIGHT						
	Quarter 1, 22-23			Quarter 2, 22-23		
	April 2022	May 2022	June2 2022	July 2022	Aug 2022	Sep 2022
Patient Safety Incidents						
Catastrophic	20	36	29	43	28	48
Severe	3	9	9	10	10	12
Moderate	5	22	32	46	79	67
Low	33	44	66	71	71	75
None	474	285	301	368	228	101
Total	546	396	437	538	416	303
Concerns						
Total Received	90	88	100	123	110	105
Total Closed	73	92	58	70	86	99
2 Day Acknowledgment %	31%	12%	26%	62%	92%	92%
30 Day Response due %	53%	41%	13%	22%	24%	28%
Ombudsman						
Cases Received	7	5	3	1	4	1
Cases Closed	3	5	4	4	2	1
Reports Received	0	1	1	1	0	1
Coroners						
Information request	115	112	116	128	137	152
Identified as Interested Party	19	20	19	21	19	20
Staff attending	5	5	6	5	4	3
Regulation 28 issued	0	1	1	0	0	0
Response to Regulation 28 in 56 working days	0	0	1	0	1	0
Response to Regulation 28 outside 56 working days	0	0	0	0	0	0
Nationally Reportable Incidents (NRIs) to Delivery Unit (reporting date)						
Serious Case Incident Forums held	7	8	8	5	8	7
Serious Case Incident Forums Cases	26	44	47	34	38	39
WAST NRIs reportable to Delivery Unit	3	11	3	2	10	7
Incidents reviewed at SCIF and reported under the Joint Investigation Framework	19	7	24	26	10	15
NRI Closures Submitted – Total	5	8	7	26	1	2
NRI Closed by Delivery Unit – Total	0	11	0	0	18	0
Claims						
Personal Injury – Received	3	1	0	1	2	5
Personal Injury – Closed	3	0	1	1	0	2
Clinical Negligence – Received	4	1	2	0	3	0
Clinical Negligence – Closed	3	0	0	0	1	0
Road Traffic Collision & Damage to Property – Received	15	17	25	20	17	22
Road Traffic Collision & Damage to Property – Closed	6	19	10	17	10	15

SETTING THE CONTEXT FOR THIS PERIOD

1 During Quarter 2 (July - September 2022), the Trust's verified incidents were 110,970 compared to 128,413 for the same period last year. For the same periods, 111 call volumes were 295,840 and 265,050 respectively.

2 From the total of verified incidents above, the following can be extrapolated:

(i) Red - **11,197** compared to **10,887;**
(ii) Amber - **80,053** compared to **92,016;**
(iii) Green - **19,720** compared to **25,510.**

3 Overall total verified incident demand saw a **13%** decrease in Quarter 2 compared to the same period the previous year.

4 The Trust lost a total of **73,483** hours to notify to handover delays across this quarter, an increase when compared to the previous quarter (April - July 2022).

5 Red performance remains a challenge and the **65%** target has not been achieved for **26** months. In Quarter 2 the Trust achieved **52.0%** in July, **50.7%** in August and **50.0%** in September, therefore continuing to fall below the **65%** target. This performance percentage was lower than the same periods in 2021, **57.8%**, **57.6%** and **52.3%** respectively.

6 During this quarter, the number of patients attended in the Red category was **11,025** compared with **10,771** in 2021. July saw the largest variation with **4,071** Red responses in 2022 compared to **3,557** in 2021, which is an increase of **14%**.

7 Amber median performance during Quarter 2 was **1** hour **43** minutes (**1** hour **15** minutes), **1** hour **21** minutes (**1** hour **17** minutes) and **1** hour **35** (**1** hour **48** minutes) respectively. The figures in brackets are for the same period in 2021.

SITUATION

8 This Patient Safety Highlight Report covers the period of 1 July - 30 September 2022 and also provides a retrospective analysis of data for the same period last year in key areas.

9 This Report will specifically focus on key issues surrounding patient safety and concerns, providing assurance to the Board on monitoring arrangements and learning.

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

BACKGROUND

11 The purpose of this Patient Safety Highlight Report is to provide an update to Trust Board on the key information in relation to Putting Things Right (PTR) and Patient Safety. This report provides key information on:

(i) Patient Safety Incidents and Alerts/Notices;
(ii) Nationally Reportable Incidents (NRIs) (previously Serious Adverse Incidents);
(iii) Concerns (including political);
(iv) Redress;
(v) Ombudsman;
(vi) Coroners;
(vii) Claims;
(viii) Organisational Learning.

12 It also identifies themes and trends emerging from our concerns portfolio, providing assurance to Trust Board on the progress and implementation of corrective Action Plans against these.

13 The Trust's Quarterly Quality Assurance Report is presented to the Quality, Patient Experience and Safety Committee (QuESt) to monitor and measure the emergent trends from quality data and information in relation to the Health & Care Standards and Commissioning Core Requirements.

14 Following recruitment of 2 new Concerns Administrators the 2-day acknowledgement Key Performance Indicator (KPI) average for Quarter 2 was **82%** in comparison to **23%** for the previous quarter. This is expected to further improve over the course of the next quarter following a successful training period. A further Concerns Administrator has been recruited on a 6-month fixed term/secondment basis and is currently receiving training.

15 Our 30-day compliance average for this quarter was below what is expected, sitting at **25%**. This is due to multiple factors, including:

(i) The overall increase of complaints being received and the complexity of the concerns raised;
(ii) The increasing volume of potential catastrophic/severe patient safety incidents that require a full investigation to identify potential harm;
(iii) Impact of vacant posts within our Clinical Contact Centre;
(iv) Impact on pressures within the Emergency Operations Centre (EOC)
(v) Delay in audits (Medical Priority Dispatch System - MPDS, Clinical Support Desk - CSD) due to competing pressures.

16 To support and improve the above position, a business case was presented to the Executive Management Team. The purpose of the business case was to highlight the pressures and the lack of capacity within the Corporate PTR team/Legal Team and within the CCC PTR Team. As a result, additional funding (£100k) has been made available. The money will fund a number of key posts, which will ensure that there is additional resilience to be able to meet capacity and demand within this area particularly during the winter period.

17 The Legal Services Team has successfully recruited into the position of Claims Investigation Officer, pending the appropriate checks with Shared Services.

18 Following the transition from Datix Web to the Once for Wales (OfWs) RL Datix, the procedure for managing Redress cases on the system has improved, allowing better reporting metrics on complaints that are reviewed at Complex Case Panel (CCP) and the number which trigger Redress. It was expected that

reporting could commence from Quarter 2 but due to the volume of CCP cases still being managed on the historic Datix system this cannot commence at present.

19 The volume of incidents and concerns received during this quarter has remained at an escalated level. The SCIF Panel continues to meet twice weekly in order to accommodate the number of potentially serious incidents occurring pan NHS Wales.

20 In addition to the Appendix B Report(s) being sent to the relevant Health Board's Patient Safety Team.

21 Health Board Chief Executives (CEOs) also now receive a letter and summary of the Appendix B Reports from the Chief Executive's Office on a weekly basis.

ASSESSMENT

Patient Safety Incidents

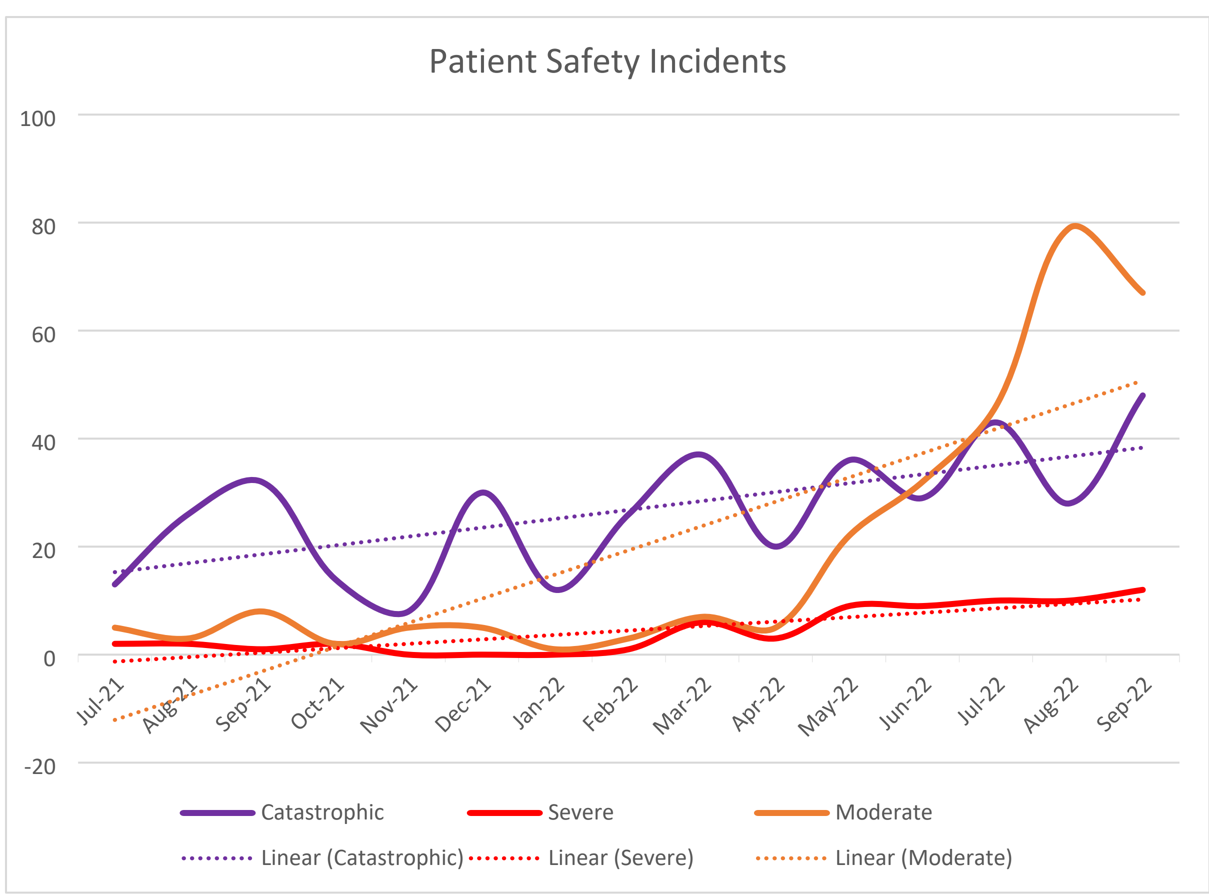
22 **Patient Safety Incidents (PSI) reported as catastrophic are usually related to patient outcome. In all cases an investigation is pending and it has not been established whether the outcome was due to any act or omission by The Welsh Ambulance Services NHS Trust (WAST) or whether it was due to the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

23 Organisations with higher rates of incident reporting are recognised as having a positive reporting and safety culture. The ambition should be to see an increase in reporting with a decrease in severity of harm.

24 During this period a total of **1,257** patient safety incidents were reported, **538** in July, **416** in August and **303** in September. This is a decrease in comparison to the previous quarter, but an increase in comparison to the same period last year where there were **1099** incidents reported. All incidents with an initial harm grading of moderate, severe or catastrophic are reviewed weekly by the Patient Safety Team and re-graded if required. **It must be noted that the harm grading may change subject to the conclusion or outcome of any investigation.**

25 The chart below illustrates the number of patient safety incidents reported on a rolling basis from April 2021, graded moderate, severe and catastrophic on initial reporting.

26 Future reports using RL Datix (Datix Cymru) will allow reporting of both initial and final grading of the incidents.



NHS Wales Patient Safety Alerts/Notices

27 Following a comprehensive risk assessment on *013 Ligature and ligature point risk assessment tools and policies* recommendations will be reported to the Clinical & Quality Governance Group and our compliance has been confirmed with Patient Safety Wales.

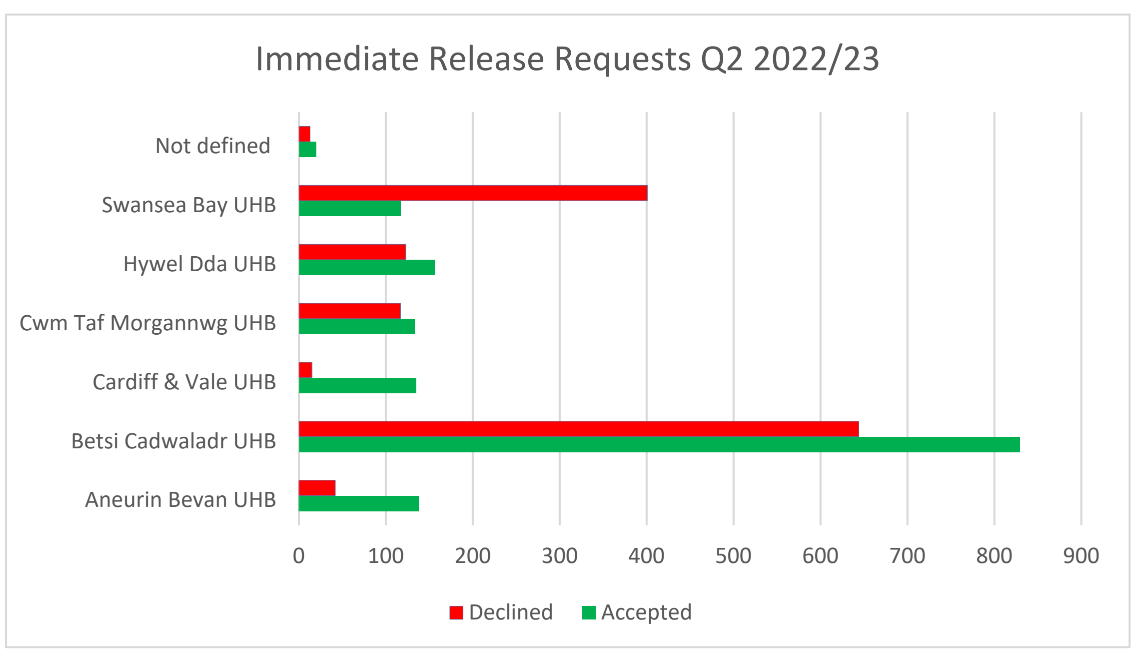
NHS Wales Immediate Release Requests

28 During the quarter there were a total of **2,883** Immediate Release Requests made to Health Boards. These requests are made to release an emergency ambulance to respond to a patient in the community who has potentially a life threating or serious condition. The Trust continues to work with Health Boards, Welsh Government and Commissioners to influence immediate release requests.

29 Of these, **1,528** were accepted (53%) and **1,355** were declined (47%). This is illustrated in the chart below:

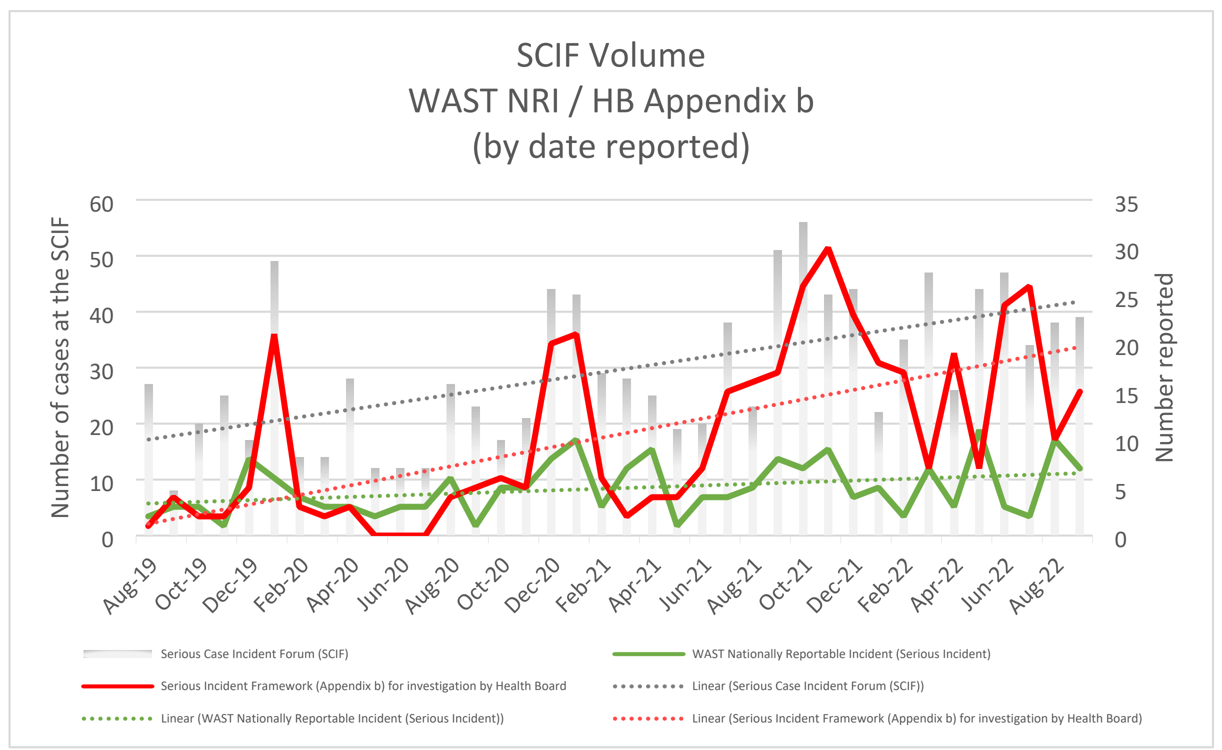
Health Board Quarter 1 2022/23	Number accepted	Number declined	% Declined
Aneurin Bevan University Health Board	138	42	23%
Betsi Cadwaladr University Health Board	829	644	44%
Cardiff & Vale University Health Board	135	15	10%
Cwm Taf Morgannwg University Health Board	133	117	47%
Hywel Dda University Health Board	156	123	44%
Swansea Bay University Health Board	117	401	77%
Not defined	20	13	39%
Total (n)	1,528	1,355	47%

Overall Total (n)	2,883		
Total (%)	53%	47%	

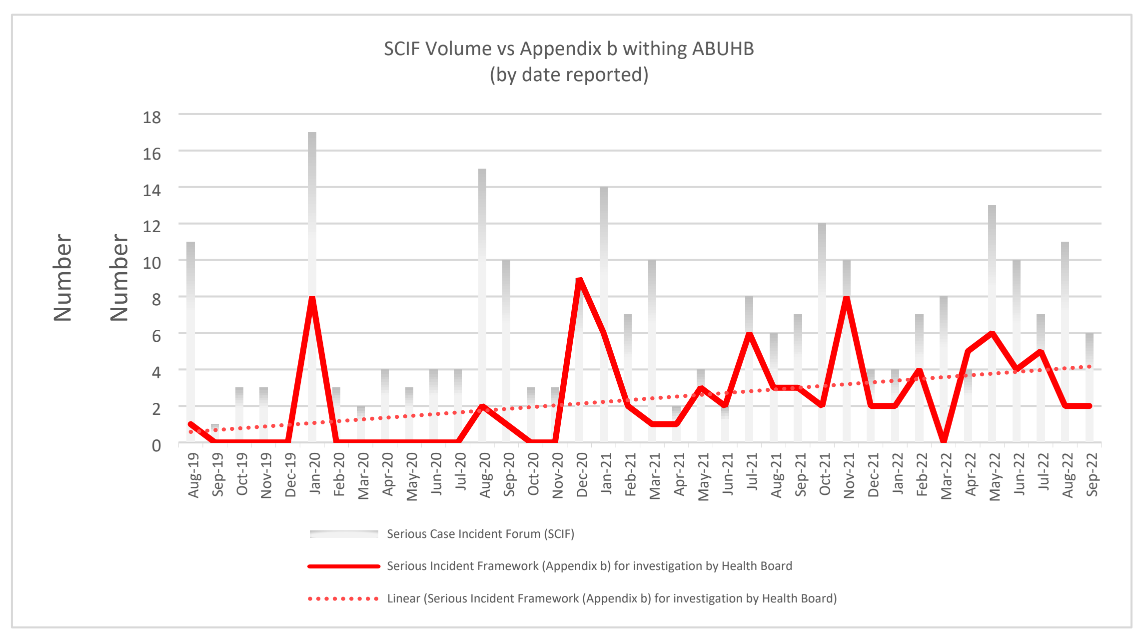


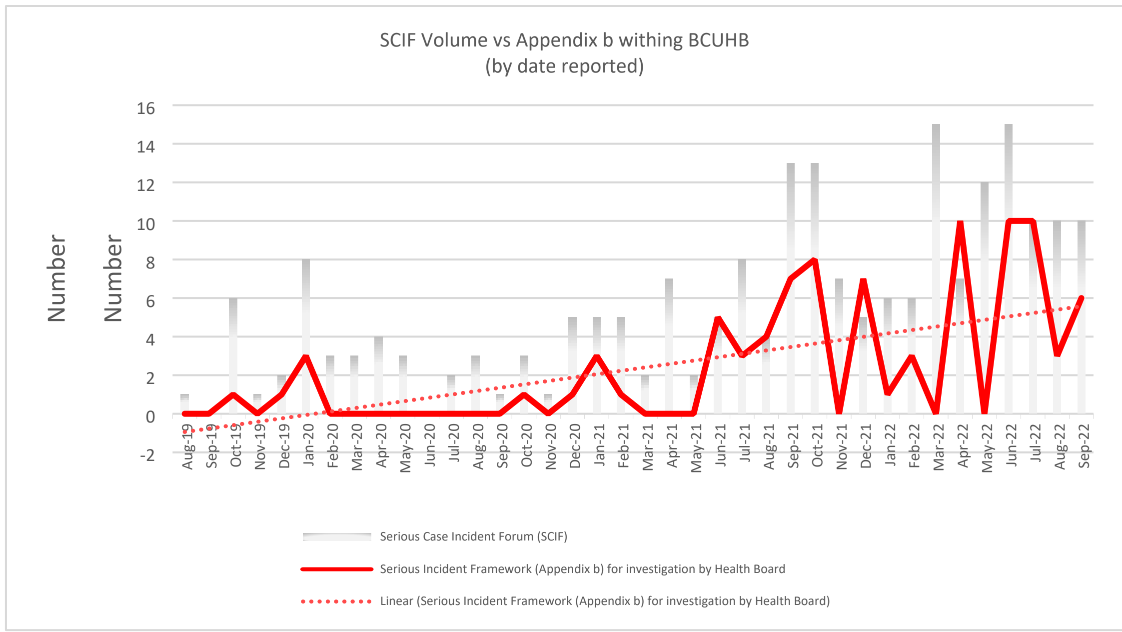
Serious Case Incident Forum (SCIF) and Nationally Reportable Incidents (NRIs)

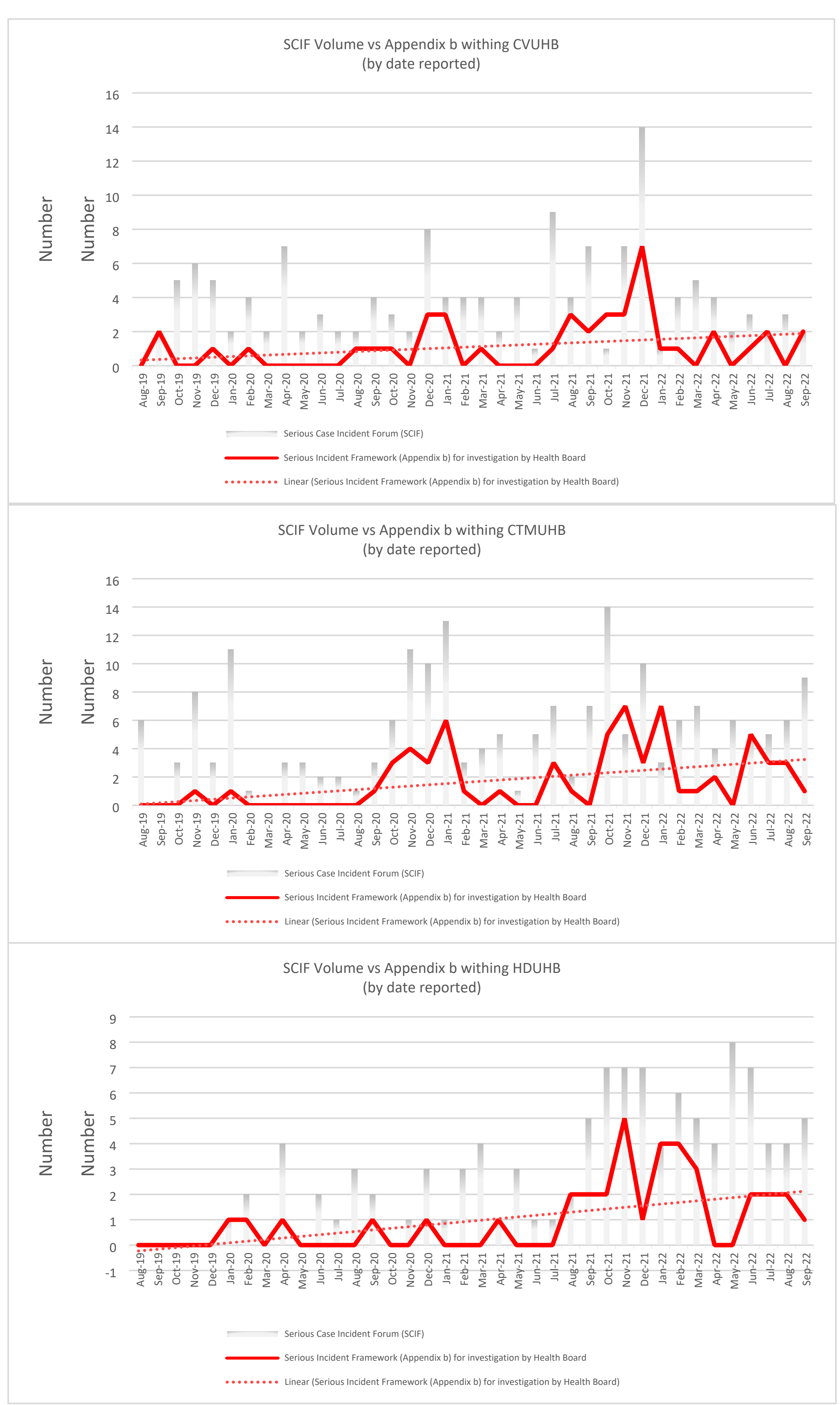
30 The chart below details the number of cases discussed at the SCIF and those reported either to the Health Boards for further investigation (Appendix B) and those reported and investigated internally. Incidents not reaching the threshold are managed as lower graded patient safety incidents (low or no harm):



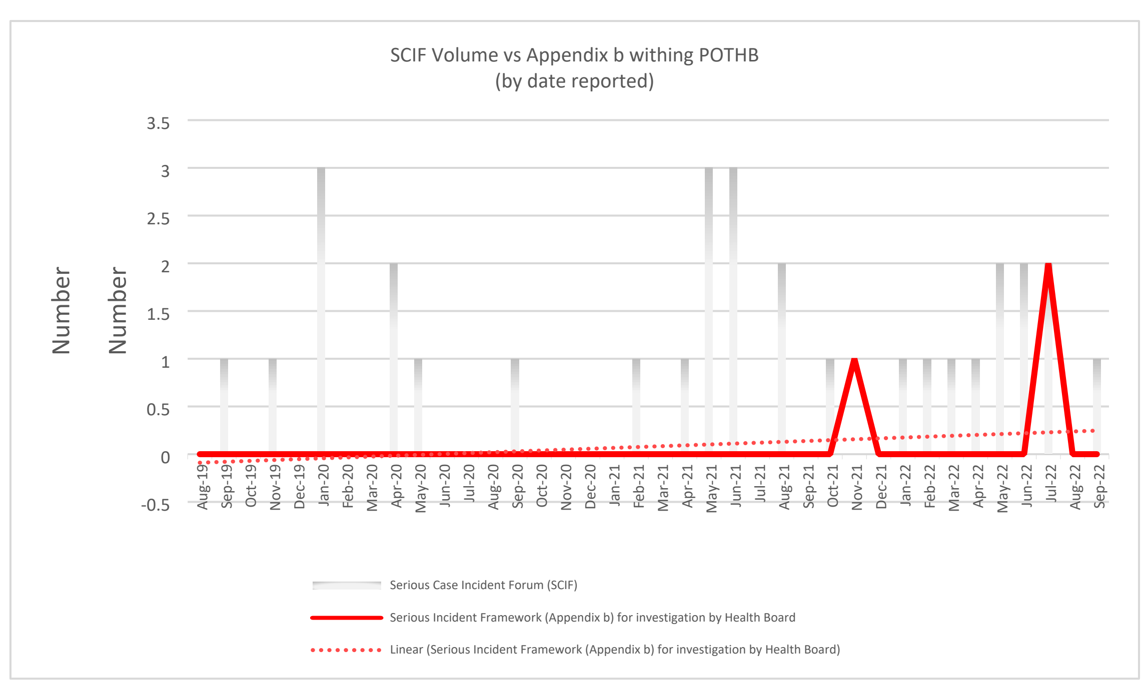
32 The following charts detail individually by Health Board, the number of cases discussed at the SCIF and passed to the Health Boards for further investigation (Appendix B):

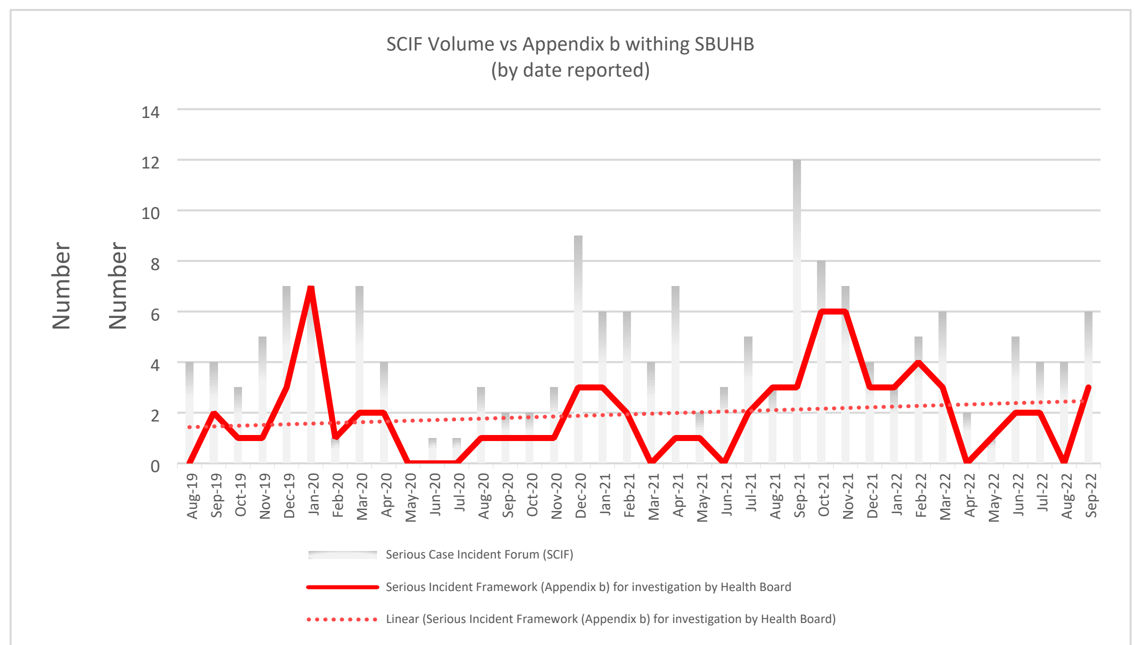






SCIF Volume vs Appendix b withing CVUHB
(by date reported)
Number
Serious Case Incident Forum (SCIF)
Serious Incident Framework (Appendix b) for investigation by Health Board
Linear (Serious Incident Framework (Appendix b) for investigation by Health Board)
SCIF Volume vs Appendix b withing CTMUHB
(by date reported)
Number
Serious Case Incident Forum (SCIF)
Serious Incident Framework (Appendix b) for investigation by Health Board
Linear (Serious Incident Framework (Appendix b) for investigation by Health Board)
SCIF Volume vs Appendix b withing HDUHB
(by date reported)
Number
Serious Case Incident Forum (SCIF)
Serious Incident Framework (Appendix b) for investigation by Health Board
Linear (Serious Incident Framework (Appendix b) for investigation by Health Board)





33 The Trust continues to hold frequent meetings with Health Board colleagues, Welsh Government, NHS Wales Delivery Unit and other system partners to address patient harm caused by system pressures.

34 Recent feedback from the NHS Wales Delivery Unit is ‘There has been visible improvement in the local assessment of the Appendix Bs referred to Health Boards/Trusts, with some of these being converted to NRIs. The conversion rate does however remain lower than we might expect, given the number of patient deaths occurring in the community associated with delayed response’.

35 The NHS Wales Delivery Unit assessment of this to date is that the focus of investigations is still around resource capacity both for WAST and for the relevant organisation(s), at the time of the incident, rather than the broader ‘patient story’ leading up to the need to request an ambulance, we are not capturing the broader

system contributory factors. This can be addressed during the National Task and Finish (T&F) Group work, which will look at reporting process as well as appropriate investigation scope.

36 A series of meetings have been held between the NHS Wales Delivery Unit, the Emergency Ambulance Services Committee (EASC) Health Boards and WAST, to progress the review and update the Joint Investigation Framework.

37 During this reporting period there were **20** SCIF meetings held, with **111** incidents discussed.

38 During the reporting period **19** incidents have been reported as NRIs to the Delivery Unit and **51** incidents were referred under the Joint Incident Framework (Appendix B) to the respective Health Board.

39 Following review of the **19** Incidents reported as NRIs to the Delivery Unit (DU) the overarching high-level themes and trends were identified:

(i) Call categorisation (**5**), (**4** of which were missed ineffective breathing);
(ii) Missed Allocation Opportunity (**1**);
(iii) Clinical assessment and/or treatment (**6**);
(iv) Other (**7**):
 1. Tourniquet advice not provided;
 2. Failed contact;
 3. CPR Instructions;
 4. Missed opportunity to safeguard patient;
 5. Call priority following successful ROSC within the community;
 6. Safeguarding;
 7. 111 clinical triage.

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

40 Key Definitions:

(i) *Early Resolution* - 2-day informal response;
(ii) *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 KPI is **75%**, which requires the closure of the response letter.

41 The Putting Things Right (PTR) Department continues to receive a steady number of concerns within this reporting period (**338**). This is an increase in comparison to the same reporting period last year where **255** concerns were received.

42 As of 10 October 2022, there were **278** open concerns with **180** in backlog (**155** of which are formal). This is an increase in the number of open concerns and an increase in the number in backlog.

43 As of 10 October 2022, there were **44** open Redress cases and **49** for review at the Clinical Complex Case Panel.

44 During this reporting period the 2-day acknowledgement performance was **62%**, **92%** and **92%** (**41%**, **45%** and **67%**) with the 30-day target achieving **22%**, **24%** and **28%** (**62%**, **57%** and **45%**) respectively.

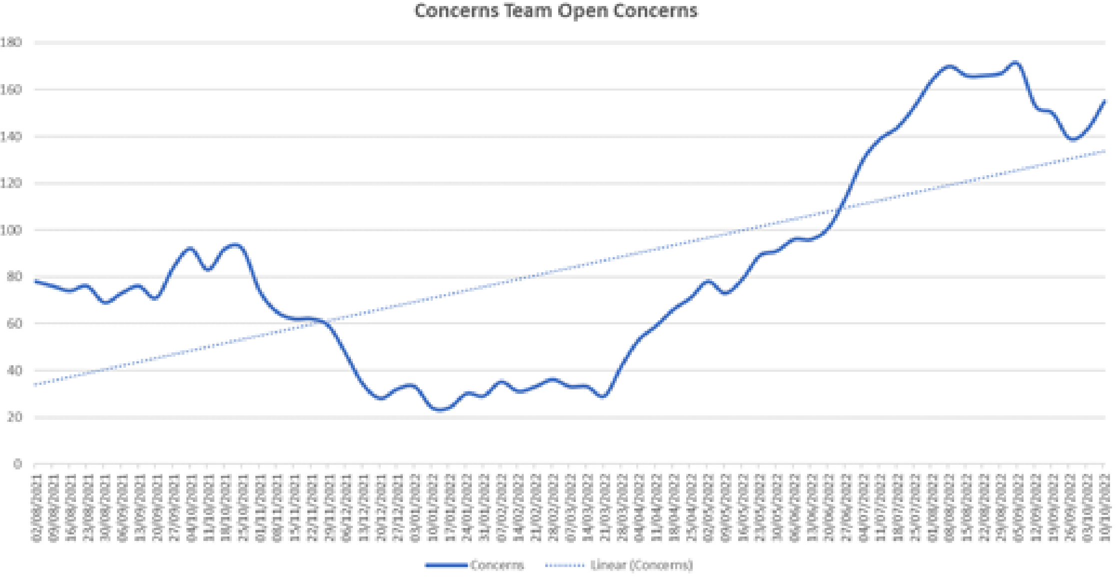
45 The average across this period is therefore **82%** (**38%**) for 2-day acknowledgement and **25%** (**55%**) for 30-day target. The figures in brackets are for the same reporting previous in 2020/21.

46 Following on from the unprecedented pressures of the last quarter, this reporting period has remained busy with the volume of concerns increasing.

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

EMS Co-ordination and Resourcing Centre Concerns Breakdown

48 The number of concerns coming into the EMS Co-ordination and Resourcing Centre continues to rise however, a new process to review and investigate grade 1 & 2 concerns enables a more timely response for the complainant focusing on their questions and concerns. The overall total of open concerns remains high:



Ombudsman and Political Investigations

49 There are currently **15** open Ombudsman cases. The Trust has submitted all documentation to the Public Service Ombudsman for Wales (PSOW) and is awaiting conclusion of the investigation.

50 During the reporting period there have been two final reports received. These reports contained recommendations that the Trust:

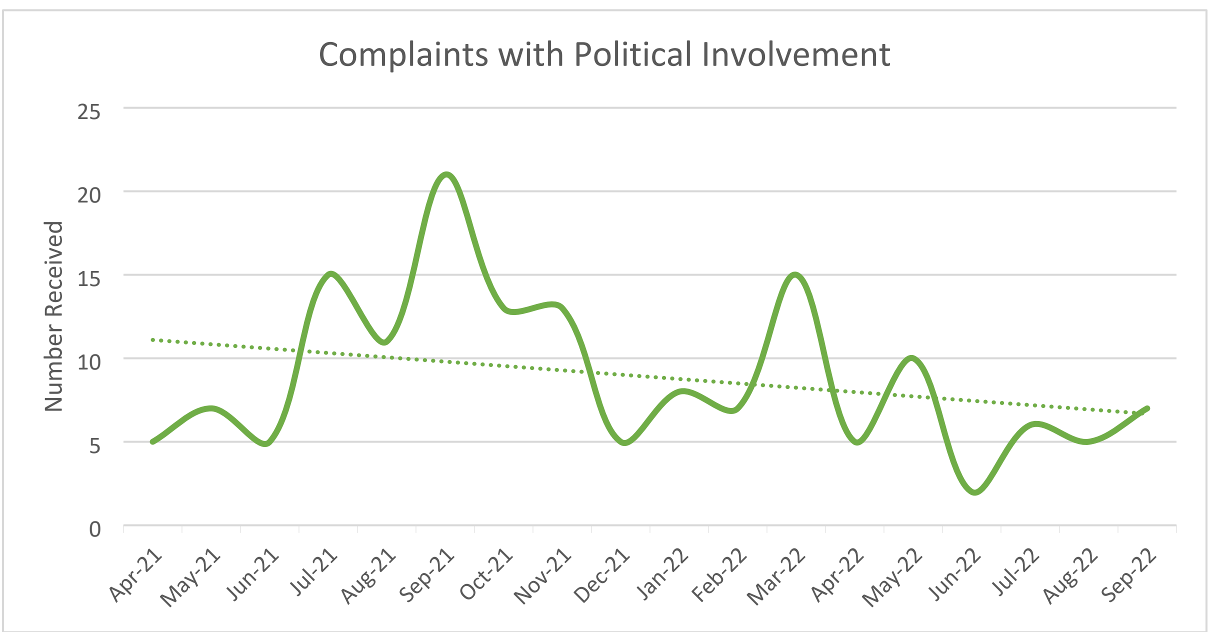
(i) Write a letter of apology to the complainant and a reminder to all staff about the need to be accurate during the writing of investigation reports and letters of response, after the Trust had incorrectly shared that the patient had signed a DNACPR;

(ii) Write a letter of apology and issue a compensation payment of £250.00 due to maladministration, where the Trust responded to a family referencing an injury to the wrong arm;
(iii) A reminder to all staff regarding the importance of completing all relevant fields on ePCRs.

51 This quarter has seen an increase in the number of political concerns being received (**18**). Whilst the majority of political concerns still relate to timeliness of EMS responses, we are witnessing a greater volume of concerns relating to other issues, including:

(i) Non-Emergency Patient Transport Services (NEPTS) – Booking issues / transport suitability;
(ii) 111 – access to service.

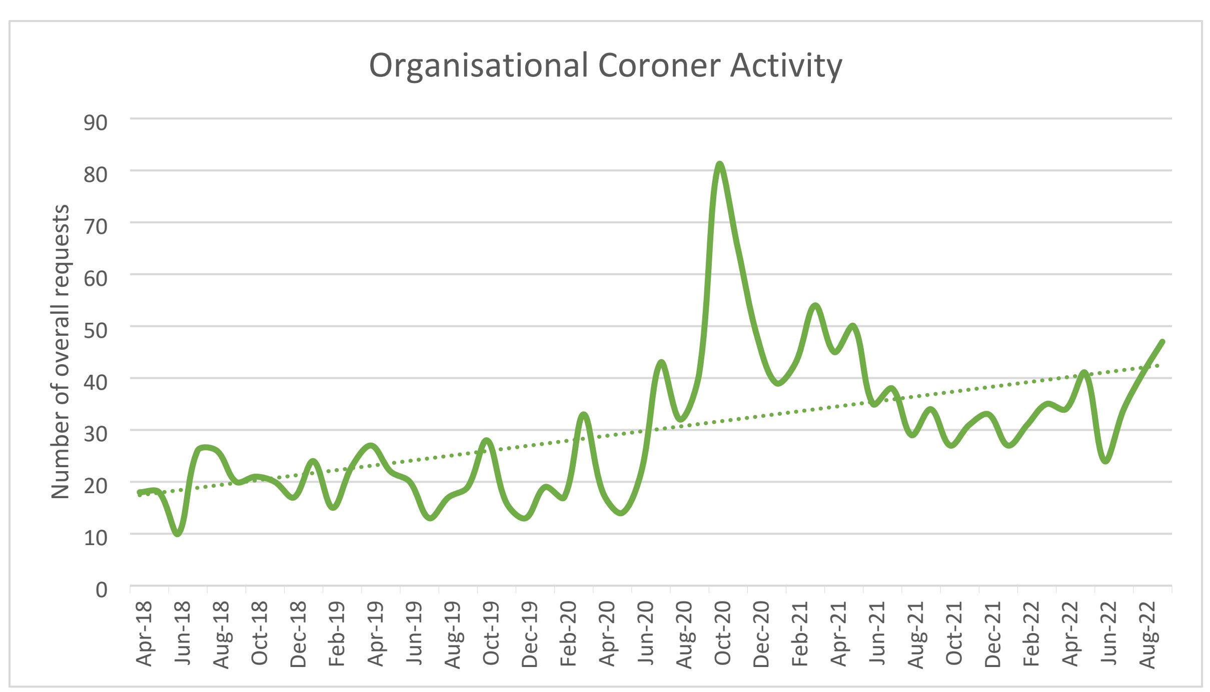
52 There are currently **16** open political concerns.



Organisational Coroner's Activity

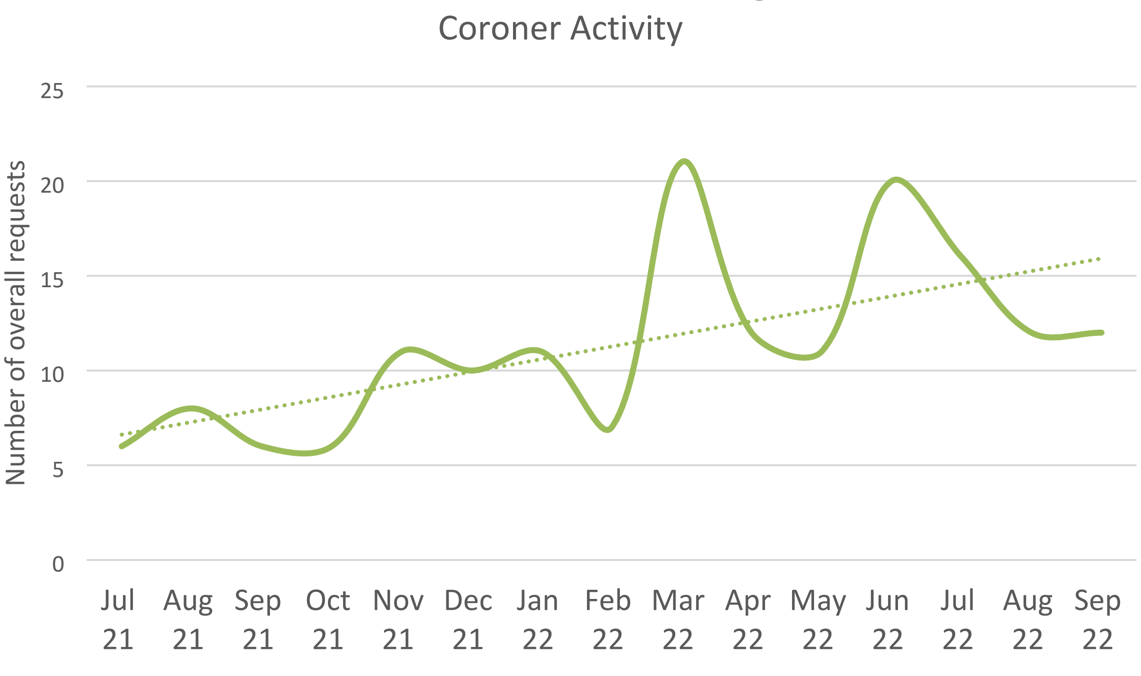
53 The number of approaches received from Coroners has increased during the reporting period. The complexity of the requests being received continues to be high, resulting in more statements per approach, together with increased legal complexity, requiring extensive disclosure, attendance at Pre-Inquest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

54 The month the Trust has completed and released on-click training, available to all staff. This training is aimed at improving the quality of statements being provided in corner and all other situations. Please refer to the chart below which illustrates the continuing pattern:



EMS Co-ordination and Resourcing Centre Coroner Activity

55 Coroner requests remain high for the EMS Co-ordination and Resourcing Centre with **27** open requests for statements:



Prevention of Future Death Reports (Regulation 28)

57 During the reporting period the Trust received no Regulation 28 (Prevention of Future Deaths) Reports and issued one response within the 56-day target.

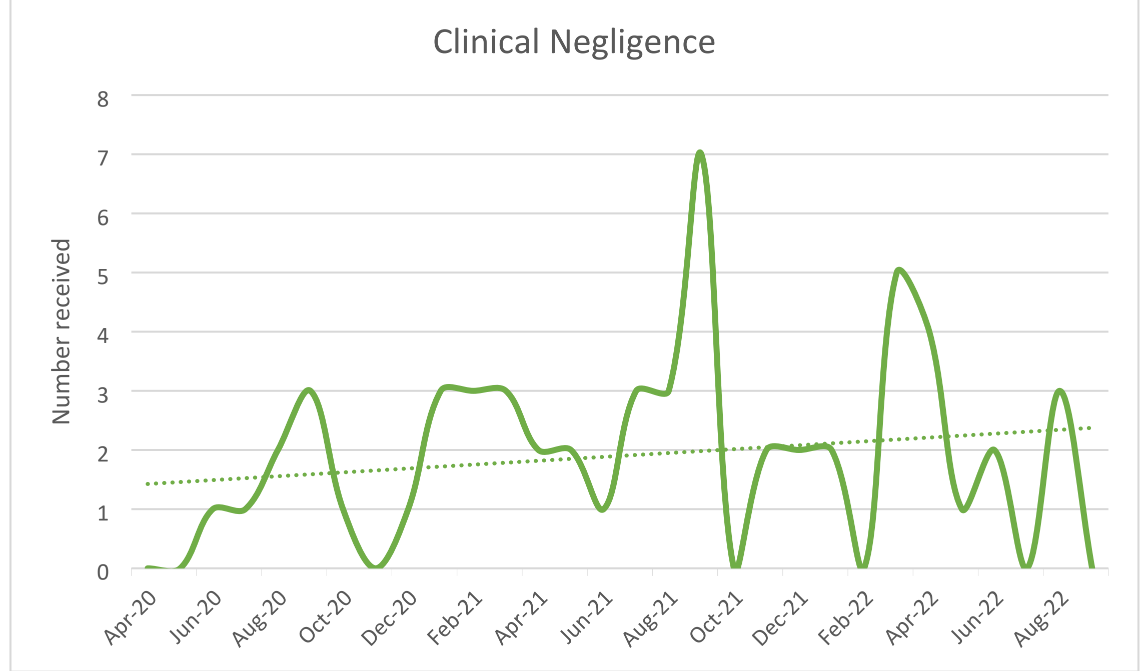
Regulation 28 Improvement Plan Update

58 Oversight of the Improvement Plan is via the Assistant Directors' Leadership Team (ADLT) meeting on a quarterly basis.

59 It has been agreed that relevant improvement actions will be mapped to current programmes of work contained in the Integrated Medium Term Plan (IMTP) as a number of the actions relate to wider system pressures.

Legal Claims

60 The receipt of clinical negligence claims in this reporting period has seen a decrease from the previous quarter, with **3** cases being received. Overall, there has been a significant ongoing increase in the number of clinical negligence claims being received by the Trust, many of which stem from delayed responses to patients at a time of escalation:



61 The number of open clinical claims being investigated and litigated is now standing at an unprecedented level in the Trust's history.

62 Whilst personal injury claims received have increased to **12**, from **6,** during this quarter. However, numbers alone do not capture the increased complicity and value in the legal claims received and the number being litigated following the issue of legal proceedings.

63 The Trust is now not only contesting liability in many cases and testing the strength of our evidence, but the extent of injuries and value of damages being claims. The staff claims relate primarily to issues with equipment. Recent cases have collapsed following the death of a key witness, where the Trust was testing the strict liability after the Enterprise Act 2013. These were tests surrounding defective equipment.

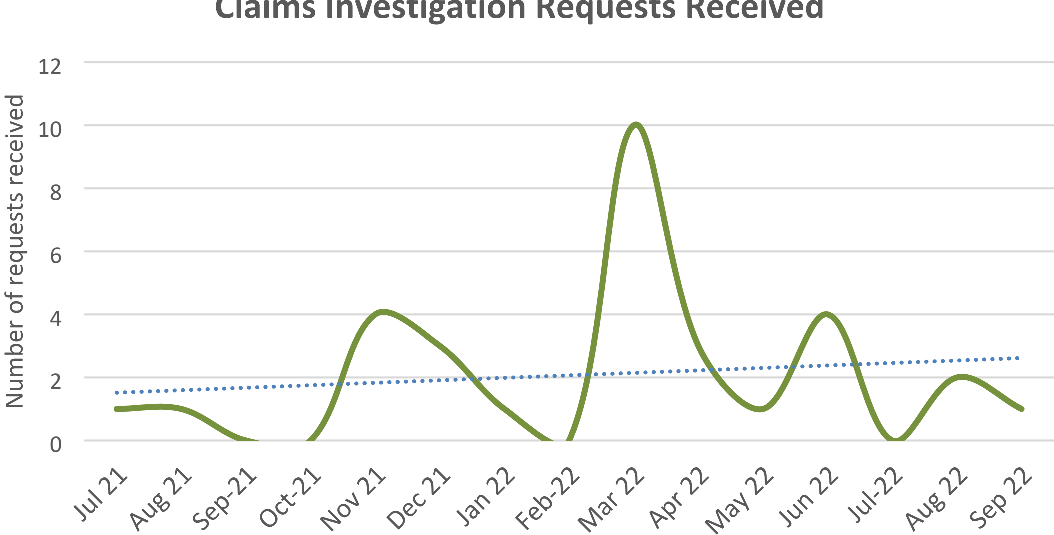
64 In addition, the Trust has received claims in relation to General Data Protection Regulation (GDPR) breaches and loud noises. There is no discernible trend with these new claims.

65 During the reporting period the number of road traffic accident and damage to property incidents have returned to the usual seasonal volume. However, these too have increased in complexity and value. Like other aspects of the current financial situation, the cost of repairs and hire charges have increased. We are starting to see more people entering credit hire, as they do not have funds to hire a vehicle without entering a credit agreement. Additionally, there have been nationwide issues with spare parts, causing major delays in repairs, with the associated knock-on effect of longer periods of car hire.

66 Additionally, there has been an increase in the number of cases where the Police are undertaking an investigation. This has increased from 1 to 3 cases (2 new cases in the reporting period) and we will monitor to see if this is a continuing trend.

EMS Co-ordination and Resourcing Centre Claims Investigation Requests

67 The graph below provides a breakdown of claims investigation requests for CCC. These investigations include the completion of Learning from Events Reports and collation of supporting evidence for Welsh Risk Pool ahead of any reimbursement:



Organisational Learning

68 Organisational learning occurs through several routes. Examples of learning and improvement actions are detailed throughout this section. The Patient Safety Team is currently looking to develop an Organisation Learning Bulletin which would include inputs from all services.

Clinical Notices issued July:

(i) 19/22 SDEC in Glangwili Hospital;
(ii) 20/22 Ambulance Service Indicators;
(iii) 21/22 Vascular Pathway;
(iv) 22/22 Escalating a deteriorating patient;
(v) 23/22 Heat Related Illness;
(vi) 24/22 SDEC in Prince Phillip Hospital;
(vii) 25/22 RSC Bronchiolitis Pathway.

Clinical Notices issued August:

(i) 26/22 SDUC in Cardigan Hospital;
(ii) 27/22 Previous ePCR Look Up;
(iii) 28/22 Ambulance Service Indicators;
(iv) 29/22 SDEC in Glan Clwyd Hospital;
(v) 30/22 Shortage of Tenecteplase 10000 units;
(vi) 31/22 Recognition of Life Extinct Form.

Clinical Notices issued September:

(i) 32/22 National Audit of Dementia;
(ii) 33/22 MPDS Categorisation Update.

Learning from Clinical Reviews by Health Board Area:

Clinical Reviews by Health Board July to September 22	Number	Brief Description of Review	Themes	Learning Opportunities and Improvements
Aneurin Bevan	5	• Paramedic crew failed in their duty of care and patient has come to harm	• Poor attitude and failure to recognise requirement of a health care professionals.	• Review ongoing
		• Patient in cardiac arrest and APP failed to recognise VF. DC shock delivered by back up crew and APP admitted they didn't recognise the rhythm.	• Failed to treat a patient in line with Clinical Practice Guidelines	• Improved clinical practice and decision making with focus on individual learning
		• 14 YOF in social care facility	• Failed to recognise a	

		called child line with intention to take own life. On arrival patient refused to engage with crew and advised police had been in attendance. Crew failed to report incident as a child in need. Safeguarding now involved following incident delay.	child's needs and ability to communicate when help was required	• Improved awareness of safeguarding guidance for children.
		• Following call for shortness of breath, complaint received about delayed response which was investigated. Failure to complete ePCR despite patient engagement as patient was verbally abusive to staff member. Learning that ePCR should have documented the events and DATIX considered.	• Lack of PCR completion	• Improved ePCR completion • Refer to V&A guidelines for delivering care to abusive patients.
		• Following RED call for COPD patient who was not conveyed through choice, patient outcomes were very poor. Lack of patient paper documentation from attending		• Informed patient decisions • ePCR completion

		individual to support ePCR documentation from back up crew.		
Betsi Cadwaladr	5	• Male child fall and attended by double EMT crew. Crew called paramedic to deliver analgesia, but family declined conveyance resulting in patient deterioration despite crew advising x ray and patient underwent surgery at children's hospital. • 37- Year-old female CVA with midline shift following 2 x contacts with WAST. The first attending crew referred patient to GPOOH services for symptom management medication. 2nd attending crew pre-alerted to resus and raised a DATIX. • Concern that a crew decided to stop and handover to the night crew with a patient that was later pre-alerted to resus.	• Safety netting for EMTs. • Epcr completion • Non-conveyance of minors due to parent refusal. • Poor documentation • Poor communication and development of management plan. • Poor documentation and handover. • Recognition of patient conditions.	• Use of ePCR to support clinical decisions. • Improved ePCR completion • Poor communication • Adherence to pre-alert guidance and recognising severity of patient condition. • Improved decision making • Improved documentation • Improvement and recognition of patients with neutropenic sepsis.

		• EMS crew raised concerns surrounding clinical treatment regime from an NQP towards a terminally ill patient. This was resolved with SP input • NQP lead clinician with three EMTs at Cardiac Arrest. Difficulty in clinical leadership and omitted drug therapy during arrest. NQP submitted Datix themselves. Clinical support and Action plan formulated by SP.	• Poor management of patient with neutropenic sepsis. • Lack of clinical leadership for NQPs. • Lack of clinical leadership for NQPs.	• NQP discharge protocol. • Allocation of ambulance resource to red calls.
Cardiff and Vale	2		• Multiple issues when dealing with a critically unwell patient (shocking a pulsed VT). • Poor documentation not representative of the management of patient the	• Appropriateness of assessment and poor management. • Improved PCR documentation. • Loss of data on ePCRs. • Management of staff outside DGHs.

			crew state they provided.	
Cwm Taf	1	• Elderly faller, with hip injury concerns regarding delay raised.	• Delayed response • Inadequate pain relief.	• Timeliness of observations • Appropriate pain relief
Hywel Dda	1	• Major haemorrhage patient was transported to rural trauma unit with no trauma desk contact, subsequently requiring an inter-hospital transfer for definitive care. Questionable haemorrhage control techniques utilised. No harm caused to patient	• Trauma desk use • Haemorrhage control	• Review and referral to haemorrhage control and major trauma guidance
Powys	0			
Swansea Bay	5	• Patient fallen down stair and did not attend A&E. Patient fell again 10 days later and was found to have sustained Thoracic Vertebra fracture. • Patient with facial laceration resulting from a fall attended to by APP who advised family take patient to A&E via own transport (with them following) due to back up delays. Pt deteriorated	• Incorrect use of JRCALC immobilisation algorithm and red flags not acted upon • Hospital Delays	• Ensuring navigator trial linked in with current guidance. • APP scope of practice Improved communication • Handover delays

		after waiting 4 hrs to be triaged in A&E		
		• Crew handed over paediatric patient to hospital staff and no POPS score given and limited observations	• POPS scoring • Timely observations	• Greater understanding of the application of POPS • Frequency of observations
		• Paramedic assessed a fallen patient and queried leg fracture. Arranged for patient to attend MIU via own transport. MIU submitted Datix as patient found to have a fractured NOF	• Appropriatene ss of Assessment • Transport decisions influenced by hospital delays	• Review ongoing
		• Patient who had fallen downstairs was not immobilised and no call made to Trauma desk (Silver Trauma)	• Incorrect use of JRCALC immobilisatio n algorithm and Silver Trauma criteria	• Use of Trauma Tool • Referral to spinal immobilisation guidance • Improved use of JRCALC

Welsh Risk Pool Learning from Events Reports

69 The following coaching bulletins have been issued for Call Handlers and Dispatchers:

Call Handlers	Dispatchers
Solo response	Applying a tourniquet process
Estimated time of Arrival	Passing information to the police
111 calls no address available	Falls responders
Care and nursing home	Allocating P2 back up
Tourniquet	Deployment of RRVs
	Immediate release protocol
	Mobilisation delay to red calls
	Welfare calls no capacity

70 A weekly question and answer inbox is set up for staff to question the MPDS Team about the correct approach for various situations including. Please see below:

Question	Answer
(SE) If the patient is bleeding from the penis, when on P21 & asks "What part of the body is bleeding from?" which is the appropriate selection.	Both external bleed from the penis and urinating (non-traumatic) are Not dangerous haemorrhage.
(SE) If someone has a defib fitted do we still read "Get a defibrillator" PDI's	Please contact MPDS to confirm if this a patient with an AICD fitted or who has already had an external defib applied.
(SE) If fitting due to an overdose P12 or P23?	Protocol 23 if known at the start, to cover scene safety and fitting PDI's can be given from the target tool. Protocol 12 only covers overdose when given in the secondary survey. If utilising Protocol 23, apply an urgent warning to notify dispatch that the patient is fitting.
(SE) If someone has fallen and injured their hip but not on the floor codes G3 Do we upgrade to G2? or is it only for 6 hrs?	Any upper leg, hip or pelvic injury that codes as Green 3 should be overridden to a Bravo response to ensure it is coded as a Green 2. Separate policy for non-recent injuries. Non-recent injuries on protocols 17 and 30 – if the caller reports that the patient has a traumatic injury or fallen **more than 6 hours ago** and has an injury to a **possibly dangerous body area**, EMD should override the code to a 30-B-0 or 17-B-0 using the override.
(SE) If someone is reported to have had a trauma but mentions obvious death descriptor – which protocol does this get handled on?	We can handle obvious death on protocols 14 (drowning), 27 (stab/gunshot/penetrating trauma). All other obvious death trauma can be handled on protocol 9. The Protocol will prompt you to shunt:

	:42 :25 30: Traumatic Injuries (Specific) Entry KQ PDI/CEI DL C20 - OBVIOUS DEATH AED: Ye Okay, **stay on the line** while we **make sure** of his situation. * Go to Protocol 9, click the <Delay Send> button if prompted to reconfi OBVIOUS DEATH, then verify "why" and "beyond resuscitation."
(N) If a patient had fallen down the stairs and was now fitting, would you go down P17 and just give fitting PDIs?	This should be carefully evaluated at ‘tell me exactly what happened’, to be able to choose the most appropriate chief complaint. If the patient is actively fitting following a trauma, then select the relevant trauma Protocol and provide fitting PDIs from the target tool.
(N) On a Green 2 Non-imminent labour, do we have to stay on the line?	Yes, select the relevant DLS link to F-2, which will prompt you to stay on the line and utilise the contractions timer. Urgent Disconnect can still be utilised.
(N) Can we stop giving ETA times on duplicate calls? - for example, we say to the caller 'amb could be 5 hours' and they answer back saying they've already been waiting for 8 hours. This always distresses the caller even more, and results in us saying 'we will be running off the previous call' - don't feel like it's working very well at the moment.	No, we can’t stop giving the ETA on duplicate calls as we have to give the current picture of demand. There may now be a way to take the patient to hospital by other means that was not available before.
(N) If a patient had a fit in the morning and given their rescue meds, then to help - are we able to override the call to red if the patient has had another fit later on in the day and they cannot be given anymore rescue meds as they've been given their allowance?	This situation should be clarified to understand what has happened, but if a patient has already had rescue meds and the caller feels they would require more but have had their daily allowance, it can be understood why an EMD would err on the side of caution and override this to a Red response.

71 This helps to demonstrate the wide variety of calls the Emergency Medical Dispatchers (EMDs) take and the amount of knowledge they need to have to take 999 calls safely.

72 Focused audits have been undertaken on the following topics:

a. Tourniquet use;
b. Ineffective breathing protocol 6.

Next steps

73 Developments/considerations for this report include:

- Further development of patient safety metrics;
- Information breakdown of data at service level i.e., Ambulance Care, Emergency Medical Services & 111 (appendices);
- Continue to identify themes and trends to improve organisational learning, patient safety and experience.

AGENDA ITEM No	9
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	1

Audit Wales – Review of Quality Governance Arrangements

MEETING	Quality, Patient Experience & Safety Committee (QuESt)
DATE	10 November 2022
EXECUTIVE	Executive Director of Quality & Nursing / Director of Paramedicine
AUTHOR	Asst. Director of Quality Governance
CONTACT	Jonathan.turnbull-ross@wales.nhs.uk

EXECUTIVE SUMMARY

In 2020, Audit Wales commenced a review of the Trust Quality Governance Arrangements seeking to provide external assurance on the infrastructure, information process flows and effectiveness of arrangements. The review was impacted by the COVID-19 pandemic, with the Trust utilising its pandemic management structure throughout the response and recovery phases of the health emergency. The Trust returned to business-as-usual state in 2022. The prolonged audit time further led to multiple auditors assigned to the work.

There report acknowledges the "extreme service pressures driven by whole system issues" that impact upon the Trust. Overall, the report demonstrates that many components of the Trust's quality governance arrangement are working effectively and made recommendations for improvement in a number of areas to ensure the Trust is more fully informed of safety and quality issues. Specific areas identified were Clinical Audit planning and information sharing, assurance and information arising from mortality reviews and, quality performance reporting & learning.

The report highlights the importance placed by Trust Board on the delivery of the Quality Strategy 2021-24, recognising the alignment with the Health and Social Care (Quality & Engagement) (Wales) Act 2020 due to be enforce from April 2023. The report notes the service delivery pressure, specifically REAP4 and COVID Response, and the withdrawal of human resource investment following removal of funding allocation from Trust commissioners.

The report has been presented to and received by Audit Committee and is presented to QUEST Committee for further consideration of the matters contained.

KEY ISSUES/IMPLICATIONS

1. Audit recommendations received, with management response and associated actions noted.
2. Reports highlights improvement opportunities to strengthen quality performance reporting to Committee/Board.

3.	Report highlights improvement opportunities regarding Board Member engagement/walkaround activities, following the removal of COVID-19 restrictions prohibiting such activities.

REPORT APPROVAL ROUTE
Quality, Patient Experience & Safety Committee – 10 November 2022

REPORT ANNEXES
Appendix 1 Audit Wales Review of Quality Governance Arrangements

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

Review of Quality Governance Arrangements – Welsh Ambulance Services NHS Trust

Audit year: 2019

Date issued: August 2022

Document reference: 3016A2022

This document has been prepared for the internal use of Welsh Ambulance Services Trust as part of work performed performed in accordance with statutory functions.

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Summary report

About this report

1. Quality should be at the 'heart' of all aspects of healthcare and putting quality and patient safety above all else is one of the core values underpinning the NHS in Wales. Poor quality care can also be costly in terms of harm, waste, and variation. NHS organisations and the individuals who work in them need to have a sound governance framework in place to help ensure the delivery of safe, effective, and high-quality healthcare. A key purpose of these 'quality governance' arrangements is to help organisations and their staff both monitor and where necessary improve standards of care.
2. The drive to improve quality has been reinforced in successive health and social care strategies and policies over the last two decades. In June 2020, the Health and Social Care (Quality and Engagement) (Wales) Act became law. The Act strengthens the duty to secure system-wide quality improvements, as well as placing a duty of candour on NHS bodies, requiring them to be open and honest when things go wrong to enable learning. The Act indicates that quality includes but is not limited to the effectiveness and safety of health services and the experience of service users.
3. Quality and safety must run through all aspects of service planning and provision and be explicit within NHS bodies integrated medium-term plans. NHS bodies are expected to monitor quality and safety at board level and throughout the entirety of services, partnerships, and care settings. In recent years, our annual Structured Assessment work across Wales has pointed to various challenges, including the need to improve the flows of assurance around quality and safety, the oversight of clinical audit, and the tracking of regulation and inspection findings and recommendations. There have also been high profile concerns around quality of care and associated governance mechanisms in individual NHS bodies.
4. Given this context, it is important that NHS boards, the public and key stakeholders are assured that quality governance arrangements are effective and that NHS bodies are maintaining an adequate focus on quality in responding to the Covid-19 pandemic. The current NHS Wales planning framework reflects the need to consider the direct and indirect harm associated with Covid-19. It is important that NHS bodies ensure their quality governance arrangements support good organisational oversight of these harms as part of their wider approach to ensuring safe and effective services.
5. Our audit examined whether the organisation's governance arrangements support delivery of high quality, safe and effective services. We focused on both the operational and corporate approach to quality governance, organisational culture and behaviours, strategy, structures and processes, information flows and reporting. This report summarises the findings from our work at the Welsh Ambulance Services NHS Trust (the Trust) carried out in 2021/22.

Key messages

6 The Trust continues to deal with extreme service pressures driven by whole system issues that are resulting in unprecedented ambulance handover delays, and associated difficulties in responding in a timely fashion to calls for an emergency ambulance. Staff are working under significant pressure and sickness absence levels are high. More than ever, therefore, the Trust needs to have robust governance arrangements that allow it to maintain the necessary oversight and scrutiny on the quality and safety of its services.

7 **In overall terms we found that whilst many facets of the Trust's quality governance arrangements are working well, improvements are required in a number of key areas to ensure the Trust is fully informed on issues relating to the quality and safety of its services. The Trust also needs to play its part in the improvements that are required to serious incident reporting across organisational boundaries.**

8 The Trust has renewed its Quality Strategy, is strengthening its risk management arrangements and has invested in quality improvement processes. Lines of accountability for quality governance are clear, and there are good arrangements to listen to and act upon the experiences of patients and staff.

9 The role of Quality Patient Experience and Safety (QuESt) Committee is clearly defined, and its work is supported by a good suite of performance information. The Trust has correctly identified opportunities to rationalise the working groups that support the Committee and must also deliver on commitments in its Quality Strategy to improve its quality management systems.

10 However, the necessary attention given to responding to Covid-19 and wider service pressures have caused delays in pursuing the Trust's quality agenda, constraining its ability to successfully deliver its renewed Quality Strategy. A key area for improvement is the need to address the significant backlog of mortality reviews, and to keep the QuESt Committee adequately sighted of progress in this area. There is also a need to better triangulate information from different sources to ensure there is a full understanding of patient outcomes and avoidable harms associated with long waits for an emergency ambulance.

11 Patient safety walkabouts by Board members need to be reinstated and undertaken on a more systematic basis across the Trust's operations and locations. Action is also needed to ensure clinical audit becomes a recognised and visible source of assurance within the Trust's quality governance framework, beginning with approval of a clinical audit plan for 2022-23.

12 The work that is being done on organisational culture and behaviours needs to understand and address concerns around incident reporting, appraisal rates and to ensure adequate responses to any incidents of bullying and harassment.

13 Whilst the Trust's internal system for managing concerns and serious incidents is sound, the joint escalation framework for managing serious incidents across

organisational boundaries is no longer effective, and the Trust must work with its commissioners and health board partners to improve this.

Recommendations

14 Recommendations arising from this audit are detailed in **Exhibit 1**. The Trust's management response to these recommendations is summarised in **Appendix 1**.

Exhibit 1: recommendations

Recommendations
Quality Strategy delivery R1 We found that delivery of the Trust's renewed Quality Strategy (2021-2024) has been severely hampered by resource pressures caused by the pandemic and a lack of funding to support four senior quality lead posts which are central to delivery. The Trust should update its implementation plan outlining how it will deliver its quality ambitions.
Clinical Audit Plan R2 We found that the clinical audit plan is not approved in a timely manner and the QuESt Committee does not have adequate oversight of progress and delivery. The Trust should ensure that: • the QuESt Committee scrutinises and approves a clinical audit plan ahead of each financial year. • the QuESt Committee receives quarterly updates on delivery of the approved clinical audit plan, assurance reports including learning and improvement actions resulting from this work.
Mortality reviews R3 The QuESt Committee does not receive adequate assurances on mortality reviews. The Trust should ensure the QuESt Committee receives quarterly update reports to include: • the number of reviews undertaken, and the numbers of reviews required but not yet complete. • any significant concerns, lessons learned and what changes have been made as a result. • updates on actions to address the mortality review backlog

Recommendations

- updates on progress implementing the all-Wales Learning from Mortality Reviews Framework

R4 The Trust has a significant backlog of mortality review. The Trust should develop an action plan to reduce the backlog, reporting progress at each QuESt Committee.

Personal Appraisal and Development Reviews (PADR)

R5 The Trust has low PADR compliance rates, for example in June 2022 the Trust's compliance was 59% against the 85% target. As part of embedding its new behaviours, the Trust should ensure that PADR rates are improved and set out the actions it will take to achieve this.

Board member walkabouts

R6 Prior to the pandemic, Board members regularly participated in ambulance ride-outs and station visits, but these were ad-hoc in nature and feedback was not collated in a structured way. Now that visits can restart the Trust should develop a standard operating procedure which clarifies the process, frequency of the visits and ensures coverage across the Trust’s operations and geographical areas. It should also include a standard template to capture feedback and learning.

Joint Escalation Framework

R7 The joint escalation framework in place with health bodies is no longer effective. The Emergency Services Ambulance Committee is coordinating action to strengthen those arrangements. The Trust must ensure that the recommendations made by the Delivery Unit are effectively responded to in a timely fashion and progress reported regularly to the Board and QuESt Committee.

Quality performance reporting and learning

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.

Recommendations

- 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.

Detailed report

Organisational strategy for quality and patient safety

15 Our work considered the extent to which there are clearly defined priorities for quality and patient safety and effective mitigation of the risks to achieving them.

16 We found that **while the Trust has a renewed Quality Strategy and is strengthening its risk management systems, resource constraints threaten the progress of its ambitions.**

Quality and patient safety priorities

17 **Resource issues caused by the Covid-19 pandemic and funding challenges poses a risk to the Trust successfully delivering its renewed Quality Strategy.**

18 The Board approved its 2021-24 Quality Strategy (the Strategy) in May 2021. The Trust had begun work to renew its quality strategy in 2019, which it paused in 2020 to enable it to respond to the Covid-19 pandemic and restarted in 2021. The strategy, developed through engagement with stakeholders including patients and staff, sets out six quality priorities based on the Health and Care Standards. These are:

- **Person-centred Care** – Our services will respond to people's needs and choices. We want people to have a positive experience and value the services and care we provide.
- **Timely Care** – People will have timely access and response to services based on clinical need and will be actively involved in decisions about their care.
- **Efficient Care** – We will ensure that we provide the best quality care through the most efficient use of the resources available.
- **Safe Care** – We will ensure that people using our service are protected from avoidable harm.
- **Effective Care** – The care and treatment we provide will achieve good outcomes and will be based on the best available evidence. We will embrace opportunities to learn, grow and improve.
- **Equitable Care** – We will ensure that the quality of service meets the needs of individuals, taking into account individual characteristics and circumstances.

19 The Strategy includes actions the Trust is taking to comply with the Health and Social Care (Quality and Engagement) (Wales) Act 2020. Specifically:

- developing a culture of candour;
- ensuring robust quality management systems; and
- listening and learning from patients and service users.

20 The Strategy is a high-level document which supports the Trust's long-term strategic framework, Delivering Excellence 2030. The long-term strategic framework states the Trust's aim to ensure 'quality is at the heart of everything we do'. The Trust's 2022-25 integrated medium-term plan is aligned to this and includes deliverables to help achieve its wider aim.

21 There was a long gap between Board approval of the strategy and the subsequent approval of the strategy implementation plan. In February 2022, the QuESt Committee received the Quality Strategy implementation plan, following endorsement by the Assistant Director Leadership Team. This is nearly a year after the Board approved the overarching Strategy. The Trust reported that service and resource pressures cause by Covid-19 and wider system pressures delayed the implementation plan. Many actions in the implementation plan are scheduled for 2022-23 but the compressed timetable introduces risks to delivery. Commencement dates for some actions are yet to be confirmed. These generally relate to workshops due to be delivered by Welsh Government on compliance with the Health and Social Care (Quality and Engagement) (Wales) Act 2020. Wider progress of strategy implementation in the Trust has also been delayed because of the pandemic.

22 The Trust's Resource Escalation and Action Plan (REAP) arrangements enable it to manage its resources at times of extreme pressure. When the Trust is at its highest level of escalation, REAP 4, all non-essential work is paused, and resources are diverted to aid frontline services. This was the case for most of quarters 3 and 4 of 2021-22. The consequence of this is that the implementation of the 2021 quality strategy has been slow to progress. Given the strategic priority the Board has given to quality, the Trust needs to find a way of delivering its important quality improvement actions alongside managing, what might be, sustained service pressures. To ensure the Strategy delivery progresses, the Trust has convened a cross-discipline Quality Strategy Implementation Working Group, this should help to strengthen the actions taken to deliver the Strategy. The group was established in late 2021, so it is too early to measure the groups impact. However, the Trust reported that operational and staffing pressures have had an impact on the group's effectiveness.

23 The QuESt Committee received regular updates as the Strategy developed, and more recently updates on delivery. The reports routinely highlight resource challenges posed by service pressures. But in May 2022 the update report also highlighted financial challenges. The Trust has plans to recruit four senior quality leads to help deliver the quality strategy. However, the update report stated that the Chief Ambulance Service Commissioner's (CASC) office informed the Trust that it will not fund these posts on a recurrent basis. If the Trust is to successfully deliver its strategy, it will need to revisit its strategy implementation plan (**Recommendation 1**).

Risk management

24 **The Trust is taking steps to strengthen its risk management systems and it clearly articulates quality and patient safety risks. But given the levels of risk the Trust faces and its improvement ambitions, resources for risk management are low.**

25 In December 2021, the Audit Committee endorsed the Trust's risk management and Board Assurance Framework (BAF) transformation programme. Its aims include improving risk management by better defining risks, implementing the once for Wales Datix module, developing risk appetite statements and training staff and board members.

26 While the Trust's risk management strategy and framework expired in 2021, it appropriately covers clinical and non-clinical risks and remains extant. The Trust has decided not to refresh the strategy, instead, it will develop a risk management framework and associated policies, procedures, and training as part of its transformation programme by December 2022.

27 The Trust does not have a dedicated risk management team. In 2020, responsibility for risk management transferred from the health and safety department to the corporate governance team, but resources did not transfer with the responsibility. The previous corporate governance manager, now Head of Risk / Deputy Board Secretary is responsible for risk management. At the time of our fieldwork, risk management capacity only equated to a 0.4 WTE employee. We are aware that the Trust is recruiting to two vacancies within the corporate governance team; a Band 6 Risk Officer and a Corporate Governance Manager, who is joining the Trust in October 2022. At operational levels, there are no risk managers, instead senior leaders are responsible for risk management. Risk registers are reviewed at fortnightly assistant directors' meetings and monthly at executive team meetings. Given the level of risk the Trust carries, along with its ambition to deliver its risk transformation programme, resources for risk management are limited.

28 We reviewed the Trust's updated corporate risk register, reported to the Audit Committee in June 2022, and four of the top risks clearly articulate quality and patient safety risks. The Trust uses a 'if', 'then', 'resulting in' model to describe each risk, this clearly shows the consequence of not taking any mitigating actions. For each risk, the register sets out the controls, assurances mechanisms and actions to reduce gaps in controls and the risk score. However, the risk scores for these risks remain high. The risks, which are assigned to the relevant committees for scrutiny are:

- the Trust's inability to reach patients in the community causing patient harm and death (risk score 25).
- 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 (risk score 25).

- high absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service (risk score 20).
- failure to embed an interdependent and mature health and safety culture which could cause harm and a breach in compliance with Health & Safety statutory legislation (risk score 20).

29 In May 2022, the Trust received a reasonable assurance internal audit report on risk management systems. The review made five recommendations, one high priority, two medium and two low. The high priority recommendation related to the operations directorate risk management and escalation arrangements. Internal audit found that whilst risk is a regular agenda item at the newly established Senior Operational Team meeting, this is limited to corporate and directorate level risks and does not include high scoring local risks. It also found unclear escalation processes and inconsistent monitoring and management of Operations Directorate risks. The Trust is responding to these recommendations as part of its risk transformation programme.

Organisational culture and quality improvement

30 NHS organisations should be focused on continually improving the quality of care and using finite resources to achieve better outcomes and experiences for patients and service users. Our work considered the extent to which the Trust is promoting a quality and patient-safety-focused culture, including improving compliance with statutory and mandatory training, participating in quality improvement processes that are integral with wider governance structures, listening and acting upon feedback from staff and patients, and learning lessons.

31 We found that **the Trust is investing in operational quality improvement, is taking steps to improve its organisational culture and the Board regularly hears from service users and staff. However, there is a worrying backlog of mortality reviews, which needs greater Board visibility as does delivery of the clinical audit; there is also a need to improve Board member walkabout arrangements.**

Quality improvement

32 **The Trust is investing in quality improvement, however, a recent funding challenge is hindering further investment. Clinical audit needs strengthening and the there is a need to address the substantial backlog of mortality reviews.**

Resources to support quality improvement

33 The Trust's Quality Improvement (QI) Team supports operational staff on quality improvement challenges, projects, and training. The Trust expanded the team of two to seven in 2019 after successfully securing funding through the Healthier

Wales and Regional Improvement and Innovation Coordination Hub funds. The Healthier Wales funding is recurring and specifically to implement a programme for improving the experience of care for older people. Welsh Government awarded Regional Improvement and Innovation Coordination Hub funding has been extended annually, on a fix-term basis, since 2020. The Trust is currently reviewing the QI Team. The Trust had also planned on further expanding quality improvement support by recruiting four senior quality leads by the start of 2022-23. These roles were central to delivering the Trusts quality strategy. However, as highlighted in **paragraph 23** the Trust was unable to secure recurrent funding for these posts, so will need to seek alternative funding and alternative delivery methods.

34 The Trust launched the WAST Improvement and Innovation Network (WIIN) in 2017 to drive consistent quality improvement across the organisation. The cross-directorate network, coordinated by the Quality Improvement Team, supports staff with quality improvement projects, training, and communications. The network is also a key link for improvement bodies and teams across other organisations and health bodies, aiding cross working. In March 2019, the Trust established an online portal for WIIN. Hosted on the Trust's intranet, the portal allows staff to submit suggestions and ideas for improvement proposals. Once ideas are submitted, the WIIN Business Group formally review the ideas using a scoring matrix and categorise into areas of research, audit or clinical improvement. Clinical improvement proposals are generally taken forward by the Clinical Improvement Team. The Trust reports the number of project ideas submitted in its integrated quality and performance report. In June 2022 there were 22 submissions. The Trust reported that the WIIN platform is currently focusing on improving patient handover delays at hospital and rolling out the Electronic Patient Care Record (see paragraph 75). During the height of the pandemic, the Trust redeployed members of the Quality Improvement Team to support core Trust services and paused much of the quality improvement activity, this is now slowly resuming.

35 Improvement in Practice is the national quality improvement training programme for NHS staff in Wales, it replaced Improving Quality Together (IQT) in January 2020. The goal of the programme is to develop quality improvement capability within NHS Wales using a common language for quality improvement. About a fifth of Trust staff (20.5%) completed the bronze IQT training and 1.1% completed silver training. The Trust reported that completion of silver IQT projects was impacted by the pandemic, accounting for the low compliance. As IQT was ending the Trust started offering training delivered by the Scottish Improvement Leader to broaden training opportunities for staff. The Trust has not set a target for staff completing this training, but it is working with Improvement Cymru to understand and maximise training opportunities.

Clinical audit

36 Clinical audit is an important way of providing assurance about the quality and safety of services. The Trust's Clinical Audit Team, employing 12.73 WTE staff, provides training and support to clinical team leaders such as senior paramedics. The type of support provided by the team includes developing audit proposals, preparing and collating data (for example patient clinical records) and writing audit reports. The Trust does not have a clinical audit policy but following an internal audit recommendation has developed a clinical audit guide and audit proposal template to support staff.

37 We found that Board level reporting on the Trust's clinical audit plan is sporadic and not timely. After pausing clinical audit work during the pandemic, the Trust reinstated it by mid-2021. During 2021-22, the QuESt Committee received brief updates on clinical audits through the quality assurance report. However, we have found no evidence of an approved 2021-22 clinical audit plan. Without an approved plan it is difficult to understand the extent of delivery and the level of assurance on the risks faced. A clinical audit plan has been produced for 2022-23 but the timeliness of its approval remains an issue. The Clinical Intelligence Assurance Group and Clinical Quality Governance Group have both reviewed the 2022-23 clinical audit plan in April 2022, but the QuESt Committee did not receive it for formal approval until August 2022.

38 Operational groups and forums consider progress of clinical audit activity, and the Trust provides updates on its intranet for staff to access. However, there is insufficient coverage of clinical audit progress and any risks the work highlights at the QuESt Committee (**Recommendation 2**).

Mortality reviews

39 Mortality review meetings provide a systematic approach for the peer review of patient deaths to reflect, learn and improve patient care. Mortality reviews are conducted when a patient dies whilst in the Trust's care, including whilst waiting for an ambulance to arrive. To aid learning the Trust also reviews cardiac arrests where patients have survived. A Serious Case Incident Forum scrutinises issues identified through mortality reviews.

40 The Trust aims to present mortality reviews and lessons learned to the QuESt Committee quarterly. But our review of QuESt Committee papers shows there is inadequate reporting on mortality reviews (**Recommendation 3**). Whilst mortality reviews feature regularly in QuESt Committee papers, through the quality assurance and, more recently, the integrated quality and performance reports, papers include no substantial detail. Officers periodically report on the backlog of cases, which in August 2022 stood at 800, but reporting does not include the number of reviews conducted or detail lessons learned. This means the committee is not receiving assurances that mortality reviews are taking place or how they are helping to improve quality and patient safety. The committee does, however,

receive details on coroner's activities through the patient safety highlight report. The report details case numbers, outline of hearings and lessons learned for cases where the Trust was an interested person.

41 Since May 2021, the Trust has highlighted challenges in undertaking timely mortality reviews. This is due to several issues, namely the volume of reviews, lack of clinical resources to conduct the reviews when the Trust is working at its highest escalation level (REAP 4), and issues downloading data from the Trust's patient monitoring system (Corpuls). Together these issues have caused a backlog of reviews. The Trust has not reported its mortality review backlog to the QuESt Committee since September 2021, at the time it had grown to 450 cases (**Recommendation 4]**. The Trust reported that it is working with the Corpuls support team and its internal IT team to resolve the data issues.

42 The Trust has recognised that its current mortality review process needs to improve. In March 2022, the Trust held a workshop to review the All-Wales Learning from Mortality Reviews Framework (the Framework) and consider how the Trust could implement it. The Framework recommends mortality reviews follow the Putting Things Right process. While adopting the Framework, the Trust would like to retain an element of their current system to review the care provided to patients who die in their care. Officers presented the outcome of this workshop to the QuESt Committee in August 2022.

Values and behaviour

43 **There are important cultural issues to address around incidents reporting, appraisal rates, and perceptions of bullying and harassment, which the Trust has the opportunity to address through embedding its refreshed organisational behaviours.**

44 Clearly articulated values and behaviours are central to ensuring strong quality and patient-safety-focused culture, promoting continuous improvement, openness, transparency and learning when things go wrong. In March 2021, the Trust commissioned external psychologists to review and refresh its organisational behaviours. The work, supported by a panel of representative staff, included extensive staff engagement through focus groups, interviews and surveys. In November 2021, the People and Culture Committee received the outcome of the review and an action plan for embedding the refreshed behaviours. Officially launched in March 2022, the refreshed behaviours focus on wellbeing, inclusion, belonging and leadership with compassionate conversations. Subsequent committee papers show that the Trust is starting to use the behaviours to improve organisational culture, for example recruitment practices and how it manages sickness management. Nevertheless, sickness absence has been and continues to be a long-standing challenge.

45 All staff have access to and are encouraged to use the Datix system to report incidents and near misses. The Trust's Concerns Team provide operational staff with regular and ad-hoc training on using the Datix system and a variety of other

concerns management skills (for example, undertaking root cause analysis, completing patient clinical records, and taking witness statements). Of the 30 staff who completed our survey[1], most (23 out of 30) agreed or strongly agreed that the organisation encourages staff to report errors, near misses or incidents. However, worryingly, less than half agreed or strongly agreed that staff involved in an error, near miss or incident are treated fairly by the organisation (14 out of 30), that the organisation acts to ensure that errors, near misses or incidents do not happen again (12 out of 30); and that the organisation gives staff feedback about changes made in response to reported errors, near misses and incidents (11 out of 30). This reveals a potentially concerning picture in relation to the culture around reporting errors, near misses or incidents and raising concerns.

46 It is worrying that Trust staff responding to the 2020 NHS Wales staff survey[2] reported high levels of bullying, harassment, or abuse by a member of the public (25.5%), a colleague (19.1%) or line manager (11.3%) over the past year. And fewer than half (46.2%) agreed or strongly agreed that the organisation takes effective action. The Trust recognises that bullying and harassment is an issue, and it is encouraging to see action taken through its work to embed its refreshed organisational behaviours. For example, the Trust's 'With Us, Not Against Us' campaign aims to tackle violence and aggression against staff and initiatives such as the 'Warm WAST Welcome' aim to engender a welcoming and open culture. In addition, the Trust has committed to a harassment and bullying review through its Behaviours Delivery Plan.

47 Statutory and mandatory training is important for ensuring staff and patient safety and wellbeing. In June 2022, the Trust met the 85% statutory and mandatory training compliance target. While the Trust is progressing with mandatory training, Personal Appraisal and Development Reviews (PADR) needs strengthening. PADR is a two-way discussion which helps staff understand what the Trust expects of them in their role and become more engaged and take responsibility of their own performance and development. The NHS target for PADR compliance is 85%, the Trust consistently falls below this target, compliance in June 2022 was 59%. Between July 2020 and June 2022, the highest compliance rate the Trust achieved was 65% and the lowest 45%. This target is generally unmet across health bodies. To improve compliance the Trust is encouraging staff to engage in their personal development through campaigns promoted on its intranet (#WASTMakeItHappen) and where appropriate increasing access to e-learning. However, given the low

[1] We invited staff working across operational services to take part in our online attitude survey about quality and patient safety arrangements. The Trust publicised the survey on our behalf. Although the findings are unlikely to be representative of the views of all staff across operational services, we have used them to illustrate particular issues.

[2] The NHS Wales staff survey ran for three weeks in November 2020 at the same time as the second surge in Covid-19 transmission and rising numbers of hospital admissions. The survey response rate was 39%.

compliance rates, the Trust should look at whether staff are given enough time for PADR activities and, through its refreshed behaviours, ensure leaders and managers encourage compliance (**Recommendation 5**).

Listening and learning from feedback

48 **The Trust has good arrangements for listening and learning from service users and staff, who the Board hear from regularly, but there is scope to improve Board member walkabouts.**

Patient experience

49 Patient experience is integrated into the Trust's existing strategies and plans. For example, one of the three quality drivers in the Trust's Quality Strategy is 'to ensure a positive patient outcome and experience', through 'embracing the contribution of patients and service users'. To support this approach the Trust uses a continuous engagement model to drive patient and service user engagement.

50 Each quarter, the QuESt Committee receives several reports which highlight aspects of patient experience. At each meeting, the committee receives:

- the patient experience and community involvement report, which highlights the work of the Patient Experience and Involvement Team;
- The patient safety highlight report which updates the committee on key information related to Putting Things Right and patient safety; and
- the integrated quality and performance report that includes some indicators related to patient experience.

51 While each of these reports individually highlights lessons learned, it would be beneficial to triangulate learning themes and improvement priorities across the reports (**recommendation 8a**).

52 The Trust's Patient Experience and Involvement team (11.8 WTE) use a range of techniques to seek patient and user feedback such as the 'have your say' facility on its website, feedback through social media channels, documenting patient stories, running engagement events and patient experience surveys for non-emergency patient transport service users. The Trust also has a People and Community Network, which is a service user panel made up of members of the public, service users, patient group representatives and other interested services and organisations. The network informs service improvement through activities such as commenting on the readability of leaflets, completing surveys, undertaking mystery shopping exercises and attending meetings. As at June 2022, the network had 95 members, which the Trust is continuing to grow.

Patient and staff stories

53 The Board, QuESt Committee, and more recently the People and Culture Committee, routinely receive patient and staff stories. The Trust actively seeks out patient stories, both from its emergency response and 111 services. The Patient Experience and Involvement Team actively contact service users that make a complaint to involve them in patient stories. In some cases, the complainant is offered the opportunity to record their experience for the Board. The Trust alternate patient and staff stories, so the Board and committees also regularly hear staff stories. Recently the Board has heard from a nurse working in the 111 service, a senior paramedic, 999 call-takers and the son of a frequent faller.

54 The Trust uses a driver diagram to ensure the learning and actions from patient stories are making a difference. In addition to summarising the story, the driver diagrams helpfully outline what the Trust aims to do, what this requires, ideas to make this happen, and action points. This is a good process to ensure learning from patient stories, although the Trust explained that some changes can take a long time to action because the issues are complex in nature.

Board member walkabouts

55 As with other health bodies, the Trust suspended its Board member patient safety walkabouts during the pandemic. Prior to this, Board members regularly participated in ambulance ride-outs and station visits. But these were ad-hoc in nature and the Trust did not collate structured feedback. However, the Trust reported that Board member engagement has enhanced since the pandemic. Where restrictions allow, Board members continue to engage with staff, for example through site visits, CEO roadshows and long service awards. Now that restrictions have eased the Trust will be restarting formal patient safety walkabouts. This is a good opportunity for the Trust to develop a standard operating procedure for walkabouts which clarifies the process, frequency of visits and ensures coverage across the Trust's operations and geographical areas. The standard operating procedure should also include a standard template to capture feedback and set out how it will be reported (**Recommendation 6**).

56 The Trust reported that it will adopt the all-Wales principle being drafted for Board level walkabouts and this should be included in the standard operating procedure.

Governance structures and processes

57 Our work considered the extent to which organisational structures and processes at and below board level support the delivery of high-quality, safe, and effective services.

58 We found that **the Trust has a clear quality governance structure, and it is taking steps to improve the QuESt Committee sub-structures. While the Trust's internal arrangements for managing concerns and serious incidents**

operates well, the interface with other bodies and handling of incidents through the joint escalation framework is not effective.

Organisational design to support effective governance

59 The Trust is commissioned by the Emergency Ambulance Services Committee (EASC). EASC is a joint committee of the seven health boards in Wales. Each health board chief executive is a member of EASC. Collectively, the committee commissions the Trust to deliver safe, quality driven services. Ultimately, EASC is responsible for overseeing the quality and improvement of the services it commissions. The committee has some quality assurance processes in place. For example, in 2016, it introduced ambulance quality indicators[3]. EASC review the quality indicators at each joint committee meeting alongside other performance reports. The committee also receives other ad-hoc quality and safety reports and routinely reviews the EASC risk register.

60 The Quality and Performance Framework states that overall accountability for quality and performance rests at Trust Board level, but everyone in the Trust has a responsibility for quality and performance. At a practical level, the Executive Director of Quality and Nursing is the executive lead for quality and patient safety, but the responsibility is shared with the Executive Medical Director who holds responsibility for clinical effectiveness. Assistant directors and heads of service support the Trust's executive team providing day to day leadership on a range of functions such as quality governance, quality improvement, patient experience, patient safety and concerns and clinical effectiveness.

61 Oversight and assurance on quality and safety matters within the Trust takes place through its QuESt Committee. The Trust is in the early stages of reviewing the number and make-up of the groups which inform the QuESt Committee with the intention of improving the connection to frontline operations, this is a commitment in the Trust's Quality Strategy. Currently, there are six groups which inform the QuESt Committee. These groups feed into the Clinical and Quality Governance Group, which reports up to the Executive Management Team. These groups are:

- Patient Safety Learning and Monitoring
- Serious Case Incident Forum
- Complex Case Management
- Scrutiny Panel
- Health and Safety Committee
- Infection Prevention and Control Steering Group

3 EASC and the Trust jointly developed the Ambulance Quality Indicators to monitor the quality of patient care as well as response times. Indicators are reported along the Five Step Ambulance Care Pathway; help me choose, answer my call, come to see me, give me treatment and take me to hospital.

62 Issues covered and escalated by the groups above inform update reports to the QuESt Committee and the Board. However, the current number and remits of these groups creates a risk of duplication and the current review creates an opportunity to rationalise the structure.

63 The Trust has a straightforward organisational structure. It has one Operations Directorate which houses the majority of clinical contact centre and response team staff. The other directorates perform enabler, support, and research functions, including the Quality, Safety & Patient Experience Directorate. Quality guidance, policy and information is cascaded operationally, however the geographical spread of operational staff and shift patterns can make this difficult.

Handling complaints and incidents

64 The Trust has sufficient capacity for managing complaints and concerns in accordance with the Putting Things Right process. There are 18.4 WTE staff in the Concerns Team, who manage complaints and provide concerns management training to operational staff. The team work closely with the patient safety team to help identify near-misses and adverse events, which feeds into organisation-wide learning. During the pandemic, the Trust deployed members of the Concerns Team to support the Trust's pandemic plan. During this time, the team's activity reduced because volumes of concerns received were lower and coroners' inquests were paused. Now that activity has resumed, the team's workload has increased, stretching its capacity. In June 2021, the Trust received a substantial assurance report from internal audit on its concerns and serious incident management systems.

65 In 2019, the Trust and all trusts and health boards agreed a joint investigation framework for serious patient safety incidents. The framework sets out the process for escalating serious incidents where the main cause is a factor outside of the Trust's control or because of health board hospital handover delays.

66 The Trust identifies cases for escalation through its Serious Case Incident Forum (SCIF). In these cases, the Trust completes an incident referral form (known as an Appendix B form) and sends it to the appropriate health body for investigation, copying in the Welsh Government's Delivery Unit. In May 2022, the Trust received a report from the Delivery Unit outlining findings from their analysis of 'Appendix B' reports. The review found that the framework is no longer effective, given that significant numbers of Appendix B referrals are not investigated properly or reported nationally because of a breakdown in communications between the Trust and health boards. The report made four recommendations:

- to establish a task and finish group to revisit the Framework to ensure the process is fit for purpose and is updated to reflect current national policy regarding patient safety incidents.
- the task and finish group should be coordinated by the EASC, as the body responsible for the delivery of WAST services, and the commissioning arrangements between WAST and health boards and trusts.

- WAST and EASC should update their relevant committee and the Board and consider sharing to nurse directors so they may assess their position.
- the revised policy is endorsed via Nurse and Medical directors and relaunched at the earliest opportunity.

67 The Emergency Services Ambulance Committee is now coordinating action to strengthen arrangements. The Trust must work with its commissioners and partner health bodies to respond to the Delivery Unit's recommendations (**Recommendation 7**). This should ensure strong and effective approaches for quality assurance, escalation, and immediate improvement actions, and wider learning where quality issues cross organisational boundaries.

Arrangements for monitoring and reporting

68 Our work considered whether arrangements for performance monitoring and reporting at both an operational and strategic level provide an adequate focus on quality and patient safety.

69 We found that **the Trust recognises the challenges posed by Covid-19 and is taking steps to improve quality monitoring by improving the data it collates and quality management systems.**

Information for scrutiny and assurance

70 **The Trust has good resources for data analytics and is taking steps to improve the quality, timeliness and integration of data to support quality improvement. However, more needs to be done to ensure that patient outcomes and extent of avoidable harm are fully understood, especially for patients experiencing long waits for ambulance services.**

71 The Trust is clearly committed to assessing how Covid-19 is continuing to affect the service it provides. The quarterly integrated quality and performance report, presented to the Board and its committees, includes a Covid-19 activity dashboard. The metrics included in the dashboard have evolved over the course of the pandemic, with more detail provided during significant waves. It includes information such as cases per 100k population, hospital and ventilated bed occupancy rates and service demand linked to Covid-19. Narrative in performance and assurance reports outline the impact of the pandemic on key performance measures and remedial actions.

72 Whilst there is sufficient information about the effect of Covid-19 on service delivery, there is less about the harm caused to patients by issues such as long ambulance waits or people avoiding accessing emergency services (**Recommendation 8b**). The Delivery Unit report (paragraph 65) highlighted that there is a lack of national data to capture and understand the harm caused by the Trust's inability to respond and treat seriously unwell patients in the community during periods of high handover delays. Much more needs to be done to ensure

quality systems join up, so that the patient outcomes are fully understood particularly when there are service failings such as extensive delays in access to ambulance services (**recommendation 8c**). Linked to this issue, the Trust will need to ensure that it complies with the new Duty of Candour, which requires clear quality standards, underpinned by quality data, that act as a trigger for the duty of candour when services fall short of expected levels.

73 The Trust has good data analytics support. The Health Informatic Team employs 22 WTE staff and supports the organisation by developing daily, weekly and monthly performance reports. The team coordinates live reports through information management systems such as Qliksense, Report Manager and Microsoft Power BI. The Team also supports service delivery and decision making through data analysis, modelling and forecasting.

74 In February 2022, the Trust received a reasonable assurance Internal Audit report on information management. The Internal Audit review focused on 999 calls, specifically information on patient discharges through 'Consult and Close', 'See and Treat' and 'Can't Send' treatment pathways and how this is analysed to inform patient safety and quality improvement. The Trust received two medium priority recommendations. These related to making greater use of referral data captured in incident records to improve referral pathways and to reduce the risk of patient harm, extend the sample review of ‘Can’t Send’ call response to include ‘See and Treat’ and ‘Consult and Close’ and ensure learning is routinely reported at an appropriate group.

75 The Trust is improving its system for collating clinical indicators. Until recently, the Trust was using Digi Pen, a semi electronic patient records system. One of the main issues with Digi Pen was limited integration with health board systems. This meant it was difficult to track a patients’ journey and outcome after they have been handed over to an emergency department. The Trust is in the process of rolling out the Electronic Patient Care Record. This new system, which will be fully implemented by March 2023, is fully electronic and integrated with NHS Wales systems such as health board emergency department systems and the Welsh Care Records Service. The Trust is also working with Digital Health and Care Wales on an interface with GP records. The Electronic Patient Care Record provides opportunities for better and more timely data and enables sharing of information between NHS bodies to improve the patient journey. The data from the new system will inform the clinical indicators as part of the ambulance quality indicators[4] and metrics within the Trust’s clinical strategy.

Coverage of quality and patient safety matters

76 **The QuESt Committee is well served with quality information but reporting on mortality reviews and clinical audit needs greater focus. There are**

opportunities to better triangulate data and learning presented in different quality assurance reports and to develop patient outcome measures.

77 The Trust's Integrated Quality and Performance report focuses on key national measures and is broadly aligned to the quadruple aims within A Healthier Wales. The Board and its committees, including QuESt, receive the report at each meeting. One of the four sections in the report called 'our patient' covers quality, safety, and patient experience. It includes measures such as 111 and 999 call handling, stroke, and acute coronary care, over 12 hour waits, nationally reportable incidents and concerns response in 30 days. The report has a clear format with written analysis against each measure, remedial actions and expected performance trajectory. A cover report highlights key issues. Whilst the report gives a good overview of quality and patient safety performance, there is scope to include patient outcome measures and to better triangulate data (**Recommendation 8b**). It is particularly important to understand the outcomes for patients who have waited excessively, outcomes for those who called for an ambulance but cancelled due to long waits, and how outcomes are affected positively or negatively by, for example, implementation of the new Clinical Safety Plan. This will require joining up of systems across organisational boundaries between the Trust and health boards.

78 Aside from the Integrated Quality and Performance report, the QuESt Committee regularly receives other quality and patient safety assurance reports. These include:

- Patient Safety Report
- Quality Highlight Report
- Patients Experience and Community Involvement Highlight Report
- Red review activity
- Operations directorate quarterly report
- Quality Strategy progress report

79 Until September 2021, the QuESt Committee received a Quarterly Quality Assurance report which reported in line with the health and care standards. Since then, as stated on paragraph 76, the integrated performance report has included a section for 'quality, safety and patient experience', whilst this provides a good high-level summary, some of the quality focus and detail in the original Quality Assurance report has been lost. Quality metrics are available separately in the reports listed above but there is merit in the committee receiving a quality assurance report which highlights and triangulates key themes, trends and learning points (**Recommendation 8a**). Also as highlighted in paragraphs 37 and 40, the committee should receive regular and detailed updates on the Trust's clinical audit plan (**Recommendation 2)** and mortality reviews (**Recommendation 3)**.

80 The Trust is in the process of improving its performance reports. Since March 2022, the QuESt Committee highlight report received by the Board uses an 'Alert, Advise and Assure format:

- Alert – alert the Board to areas of escalation.
- Advise – details any areas of on-going monitoring, approvals, or new developments.
- Assure – details any areas of assurance the Committee has received.

81 This format is an improvement on the previous highlight report as it aims to draw Board members to the committee's key concerns. The format is still new, so the Trust is keeping it under review with a view to strengthening it further.

Appendix 1

Management response to audit recommendations

Exhibit 2: management response

Recommendation	Management response	Completion date	Responsible officer
Quality Strategy delivery R1 We found that delivery of the Trust's renewed Quality Strategy (2021-2024) has been severely hampered by resource pressures caused by the pandemic and a lack of funding to support four senior quality lead posts which are central to delivery. The Trust should update its implementation plan outlining how it will deliver its quality ambitions.	Following discussion by the Trust's Quality Committee in August 2022, a revised implementation action plan will be developed.	November 2022	J Turnbull-Ross

Recommendation	Management response	Completion date	Responsible officer
Clinical Audit Plan R2 We found that the clinical audit plan is not approved in a timely manner and the QuESt Committee does not have adequate oversight of progress and delivery. The Trust should ensure that: • the QuESt Committee scrutinises and approves a clinical audit plan ahead of each financial year. • QuESt Committee receives quarterly updates on delivery of the approved clinical audit plan, assurance reports including learning and improvement actions resulting from this work.	The Annual Clinical Audit Programme will be incorporated into the Committee's cycle of business ensuring it is presented to QuESt for scrutiny and approval ahead of each financial year. The Clinical Audit Programme will then be monitored on a quarterly basis by the Clinical Intelligence Assurance Group and updates providing assurance on learning will be submitted to the Clinical and Quality Governance Group. This group will escalate matters for information, assurance, or alert/action to the QuESt Committee.	Q3 2022/23	D. Robertson

Recommendation	Management response	Completion date	Responsible officer
Mortality reviews R3 The QuESt Committee does not receive adequate assurances on mortality reviews. The Trust should ensure the QuESt Committee receives quarterly update reports to include: • the number of reviews undertaken and the numbers of reviews required but not yet complete. • any significant concerns, lessons learned and what changes have been made as a result. • updates on actions to address the mortality review backlog	Monthly oversight of the All Wales Mortality Review Framework now occurs at the Clinical Quality Governance Group (CQGG) via the Alert / Advise / Assure process (Executive led) with onward assurances / updates to QuESt through the CQGG reporting mechanisms. Detailed reporting including organisational and system learning will be included in the Quarterly Patient Safety Report (standing agenda item at QuESt) from Q2 2022/3.	CQGG oversight commenced Q1 2022/23. QuESt reporting from November 2022.	M Jenkins / J Palin

Recommendation	Management response	Completion date	Responsible officer
• updates on progress implementing the all-Wales Learning from Mortality Reviews Framework			
Mortality reviews R4 The Trust has a significant backlog of mortality review. The Trust should develop an action plan to reduce the backlog, reporting progress at each QuESt Committee.	Action will be taken to establish the challenges in this area and implement process improvement to resolve future backlogs. A report will be provided to CQGG on progress.	Q3 2022/23	M Jenkins / J Palin
Personal Appraisal and Development Reviews (PADR) R5 The Trust has low PADR compliance rates, for example in March 2022 the	The Trust acknowledges compliance is below the 85% target. The Trust is currently assessing the current PADR process, with a view to development. Performance is improving, with a positive trajectory.	Q4 2022/23	L Rogers

Recommendation	Management response	Completion date	Responsible officer
Trust's compliance was 51% against the 85% target. As part of embedding its new behaviours, The Trust should ensure that PADR rates are improved and set out the actions it will take to achieve this.	The People and Culture Committee will continue to receive progress reports on a quarterly basis.		
Board member walkabouts R6 Prior to the pandemic, Board members regularly participated in ambulance ride-outs and station visits, but these were ad-hoc in nature and feedback was not collated in a structured way. Now that visits can restart the Trust should develop a standard operating procedure which clarifies the process, frequency of the visits and ensures	The standard operating procedure (SOP) is in development and will include a formal feedback mechanism to facilitate any learning.	March 2023	T Mills

Recommendation	Management response	Completion date	Responsible officer
coverage across the Trust's operations and geographical areas. It should also include a standard template to capture feedback and learning.			
Joint Investigation Framework R7 The joint escalation framework in place with health bodies is no longer effective. The Trust must ensure that the recommendations made by the Delivery Unit are effectively responded to in a timely fashion and progress reported regularly to the Board and QuESt Committee.	The Trust is actively contributing to work with partners across Emergency Services Ambulance Committee regarding the Joint Escalation Framework. Recommendations and/or actions arising on this matter will be reported accordingly to the QuESt Committee.	Q4 2022/23	W Herbert

Recommendation	Management response	Completion date	Responsible officer
Quality performance reporting and learning R8 We found that the QuESt Committee is well served with quality information, but there are opportunities for improvement. The Trust should: • a) 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. • b) Enhance Covid-19 reporting in the integrated quality and performance report	• a) 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. • b) The recommendation will be considered by the MIQPR team, considering the accessibility and accuracy of this data noting the changes to approach due to 'living with covid' context. • c) 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. • d) The Trust is often limited by data accessibility where the patient journey extends beyond the organisational boundary. The Trust will pursue patient	Q4 2022/23	J Turnbull-Ross W Herbert H Bennett

Recommendation	Management response	Completion date	Responsible officer
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.	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.		

Appendix 2

Staff survey findings

Exhibit 3: staff survey findings

Attitude statements	Number of staff agreeing or disagreeing with statements						
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know	Total respondents
Delivering safe and effective care							
1. Care of patients is my organisation's top priority	11	11	3	4	1	0	30
2. I am satisfied with the quality of care I give to patients	0	12	1	7	7	3	30
3. There are enough staff within my work area/department to support the delivery of safe and effective care	1	1	5	14	8	1	30
4. My working environment supports safe and effective care	2	15	6	3	2	1	30

Attitude statements	Number of staff agreeing or disagreeing with statements						Total respondents
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know	
Delivering safe and effective care							
5. I receive regular updates on patient feedback for my work area / department	2	3	4	11	6	4	30
Managing patient and staff concerns							
6. My organisation acts on concerns raised by patients	5	21	1	1	0	2	30
7. My organisation acts on concerns raised by staff	2	10	6	9	1	2	30
8. My organisation encourages staff to report errors, near misses or incidents	3	20	2	3	1	1	30
9. Staff who are involved in an error, near miss or incident are treated fairly by the organisation	4	10	6	1	4	5	30

Attitude statements	Number of staff agreeing or disagreeing with statements						
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know	Total respondents
Managing patient and staff concerns							
10. When errors, near misses or patient safety incidents are reported, my organisation acts to ensure that they do not happen again	2	10	12	3	2	2	30
11. We are given feedback about changes made in response to reported errors, near misses and incidents	2	9	4	9	2	4	30
12. I would feel confident raising concerns about unsafe clinical practice	6	15	3	3	2	1	30
13. I am confident that my organisation acts on concerns about unsafe clinical practice	7	9	6	5	1	2	30

Attitude statements	Number of staff agreeing or disagreeing with statements						
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know	Total respondents
Working in my organisation							
14. Communication between senior management and staff is effective	2	7	6	7	8	0	30
15. My organisation encourages teamwork	2	13	6	7	1	1	30
16. I have enough time at work to complete any statutory and mandatory training	3	10	6	6	5	0	30
17. Induction arrangements for new and temporary staff (eg agency/locum/bank/re-deployed staff) in my work area/department support safe and effective care	1	11	6	3	4	5	30

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We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

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

Healthcare Inspectorate Wales – Annual Report 2021-2022

MEETING	Quality, Patient Experience & Safety Committee (QuESt)
DATE	10 November 2022
EXECUTIVE	Executive Director of Quality & Nursing / Director of Paramedicine
AUTHOR	Asst. Director of Quality Governance
CONTACT	Jonathan.turnbull-ross@wales.nhs.uk

EXECUTIVE SUMMARY

Healthcare Inspectorate Wales (HIW) Annual Review 2021-2022 is presented to QUEST Committee, outlining the inspectorate assessment of NHS Wales organisations. The Annual Report is to be presented to the November Trust Board by HIW.

The report acknowledges the significant pressure across NHS Wales, specifically noting the challenges for the Trust in staff abstractions impacted by COVID-19 related absence. The report details the work undertaken by HIW including seeking assurance on the safety and quality of care provided by the Trust. The HIW local review of patient experience whilst waiting in the ambulance for secondary care handover is discussed, detailing the extremely negative impact on patients and staff. The report explains the system-wide recommendations made by HIW for improvement on this issue, including a need for collaboration with Health Board across Wales.

Of the All-Wales total concerns received by HIW (n=514), five concerns apply to the Trust. Four whistleblowing concerns were raised to HIW related to the Trust.

Across Wales, the report noted common areas of concern through our work; in general, these were pressures associated with recovery of services, waiting times for treatment and significant issues with patient flow in hospitals and notable pressure and demand on children's services, mental health services and primary care.

The Committee is asked to receive the report, acknowledge the matters contained within, and advise Trust Board of key considerations for the Trust.

KEY ISSUES/IMPLICATIONS

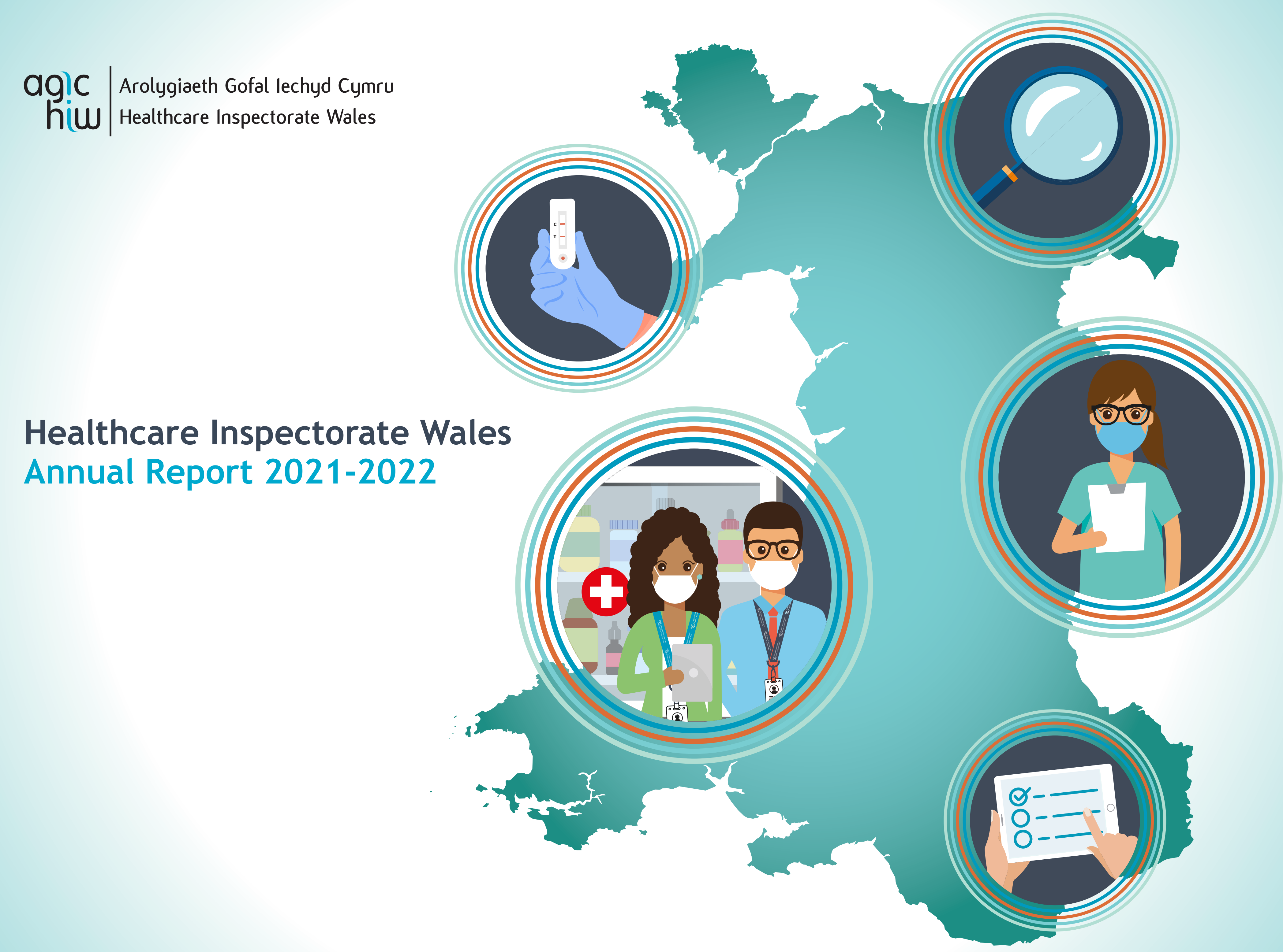
1. An increase of concerns reported to HIW across NHS Wales, increasing by 40% since 2019-2020.

2. NHS Wales safety and quality concerns relating to patient flow, supply-demand gaps regarding mental health services and primary care services – leading to demand impact for the Trust.

REPORT APPROVAL ROUTE
Quality, Patient Experience & Safety Committee – 10 November 2022

REPORT ANNEXES
Appendix 1 HIW Annual Review 2021-22

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



Healthcare Inspectorate Wales
Annual Report 2021-2022

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

Our purpose

To check that people in Wales receive good quality healthcare.

Our values

We place patients at the heart of what we do.

We are:

- **Independent**
- **Objective**
- **Caring**
- **Collaborative**
- **Authoritative**

Goal

To encourage improvement in healthcare by doing the right work at the right time in the right place; ensuring what we do is communicated well and makes a difference.

Through our work we aim to:

Provide assurance

Provide an independent view on the quality of care.

Promote improvement

Encourage improvement through reporting and sharing of good practice.

Influence policy and standards

Use what we find to influence policy, standards and practice.

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Foreword

Welcome to our Annual Report for 2021-2022, a year which continued to be unpredictable and with significant ongoing challenges in both healthcare, and daily life

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Priority 1

To maximise the impact of our work to support improvement in healthcare

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Priority 2

To take action when standards are not met

NHS Health Boards and NHS Trusts

Page 64-65

Priority 3

To be more visible

Collaboration and joint working with other organisations is an integral part of the way in which we work

Page 66

Priority 4

To develop our people and our organisation to do the best job possible

Although the last year has been one of significant change, we have continued to invest in the development HIW

Foreword

Alun Jones
Chief Executive

"I once again commend the strength and resilience shown by staff working at all levels within healthcare services, who continue to deliver care and treatment in the best way they can, despite the many challenges they face daily."

Welcome to our Annual Report for 2021-2022, a year which continued to be unpredictable and with significant ongoing challenges in both healthcare, and daily life.

Healthcare services continued to be under intense pressure from the impact of the COVID-19 pandemic and our role has been crucial in supporting the delivery of safe healthcare for the people of Wales. Our core purpose of checking the quality and safety of healthcare services did not change, and we continued to adapt our processes and approach to work in response to the ongoing unprecedented situation.

The report sets out our key findings from the regulation, inspection and review of healthcare services in Wales. It outlines how we carried out our functions and the number of inspections and quality checks we undertook across Wales.

Change and flexibility have been key features of life since March 2020 and as an organisation we have learned much about how and where our work can add value to the healthcare improvement agenda. Through this report we will offer an insight into our work over the 12-month period, outlining how we adapted and used our resources most effectively to deliver our work and support improvement. This involved continuing with quality checks which we introduced earlier in the pandemic and enabled us to gain assurance remotely. We worked collaboratively with others to harness insight and understanding, building on lessons learnt. We also used new styles of reporting which enabled us to share our findings quickly to enable healthcare services to take improvement action more quickly.

In a year which has seen healthcare services work hard on recovery from the early days of the pandemic, to restore services which had been paused, whilst continuing to deal with emerging variants, outbreaks and further peaks of COVID-19, we have seen significant turbulence. I once again commend the strength and resilience shown by staff working at all levels within healthcare services, who continue to deliver care and treatment in the best way they can, despite the many challenges they face daily.

Senior managers leading services have demonstrated tenacity and ability to continue innovating and supporting their organisations. Staff working on the front line have continued to demonstrate their compassion and resilience, as once again, patients have told us of their positive experiences of staff despite highly challenging circumstances.

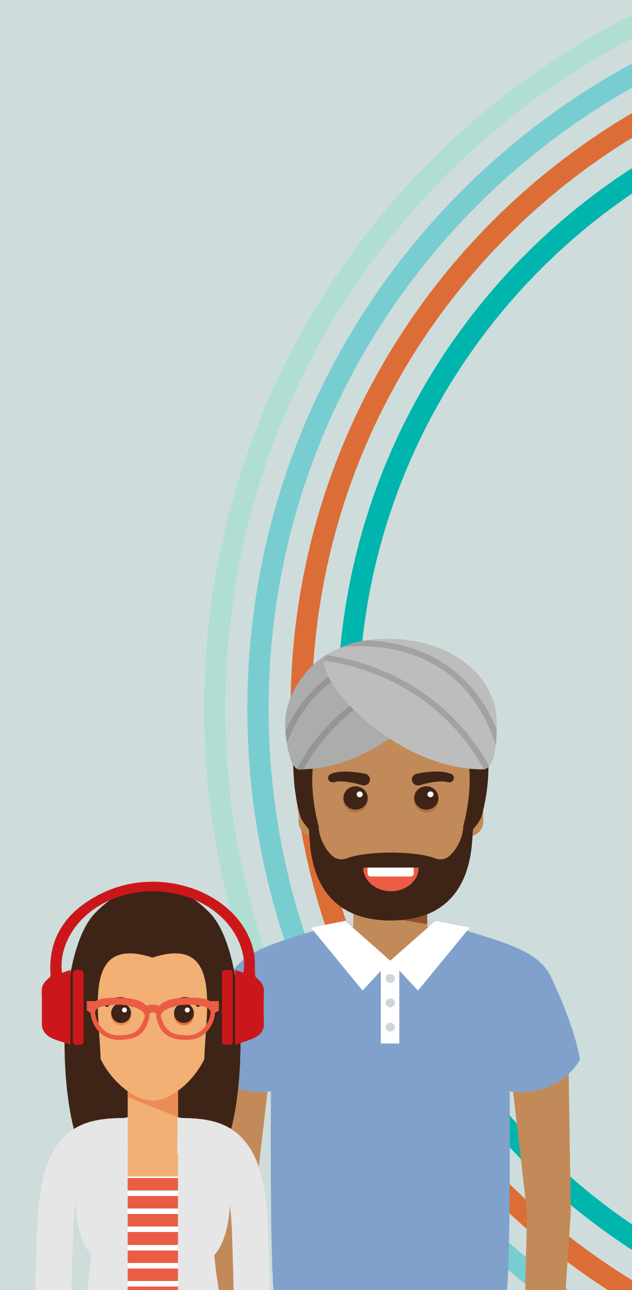
It is clear that there remain many challenges ahead, for services, for the staff who work within them and for the people of Wales whilst the gargantuan task of service recovery continues. For healthcare organisations, it will be staff who will be the key to the success of this recovery. Supporting staff wellbeing, continuing to invest in training and support services for them and continuing to innovate within existing service delivery will be key to the effective recovery of staff and services from the fatigue brought on by the pandemic.

The year in question reflects a time when we worked on the commitments we made in our one year Strategy and Operational plan. We made good progress in meeting the achievements we set out to deliver. I am proud to have continued leading the organisation through this time, working daily alongside a team of professional and committed staff who work hard to support the organisation as we deliver our vision of improving healthcare for the people of Wales.

In March 2022, we published our new and ambitious strategy, and we are fully committed over the next three years, to implementing and delivering our new priorities which further our aim to drive improvement in healthcare.
We will continue to use our role to encourage improvement in healthcare, building on the best of what we have done to date to deliver the greatest impact.

If you have any questions, comments, ideas or feedback on our work, please do get in touch with us – we would love to hear from you.

Alun Jones
Chief Executive, Healthcare Inspectorate Wales



Overview

For HIW, as for many healthcare services and organisations, it was a year of continued and significant change, where we had to adapt to ensure that we continued to check that people in Wales were receiving good quality healthcare. We introduced new ways of working to ensure we discharged our statutory functions, whilst being as flexible and adaptable as possible to ensure we did not add undue burden to a system already under significant pressure following the COVID-19 pandemic.

We continued with a full range of assurance and inspection activities, building on our enhanced ways of working, allowing us take action where standards were not met but to also support a broader recovery of healthcare services. During the year, we kept our activity under regular review to ensure that we targeted our resources most effectively. We operated responsively, with our work underpinned by our strategic priorities. This report describes our progress against these priorities as we aim to drive improvement and promote quality in healthcare services across Wales.

Our 2021-2022 Strategic Priorities:

1. To maximise the impact of our work to support improvement in healthcare
2. To take action when standards are not met
3. To be more visible
4. To develop our people and our organisation to do the best job possible

To maximise the impact of our work to support improvement in healthcare

HIW has an ongoing programme of national and local reviews which helps us to evaluate how healthcare services in Wales are delivered.

Local reviews are pieces of work which explore an aspect of one organisation or region, whilst **national reviews** explore healthcare services across Wales.

National and Local Reviews

COVID-19 National Review - How healthcare services across Wales met the needs of people and maintained their safety during the pandemic

The purpose of our COVID-19 review was to understand how healthcare services across Wales met the needs of people and maintained their safety during the pandemic. We also considered how services managed their environments of care, infection prevention and control measures, and how the physical and mental well-being of staff was supported.

A key theme to have emerged from our review was the need for healthcare services to further strengthen their infection prevention and control arrangements to mitigate the risk of cross infection or further outbreaks of COVID-19. In addition, the arrangements for supporting and maintaining the physical and mental well-being of staff required attention and focus as healthcare services continued through the recovery phase of the pandemic. However, in general, our review found the quality of care being provided across Wales was good and was delivered by hugely committed and dedicated groups of staff.

National Review of Mental Health Crisis Prevention in the Community

The focus of our review was to understand the adequacy of the measures in place across Wales, to help mental health crisis being prevented in the community, through timely and appropriate care. We considered the experiences of people who accessed care and treatment to support their mental health and prevent crisis. In addition, whether the services provided were safe and effective, and how healthcare teams worked collaboratively throughout the community to help prevent mental health crisis. Furthermore, we explored how third sector organisations support this.

Our review found challenges across Wales inhibiting the ability of people to access timely support for their mental health, which could increase the risk to their safety (or to others) and may result in hospital admission.

Key findings included inefficiencies in process, particularly for direct referrals where patients were caught in a cycle of continually accessing GP services to re-commence the referral process. This resulted in individuals experiencing lengthy waiting times and a lack of support for their mental health. HIW's review urged health boards to consider how they can address this gap in provision, strengthening the engagement between GPs and other primary and community care services and secondary mental health services. The review did find healthcare staff were committed and dedicated to providing support and care to people with mental health needs.

HIW noted several positive initiatives across Wales, including the implementation of a single point of access. Where this was in place, it ensured that specialist mental health professionals were available to provide clinical triage, onward referral, and effective signposting to individuals in crisis. HIW made a recommendation that health boards must ensure that single point of access services are implemented across Wales and are accessible to all those experiencing mental health crisis.

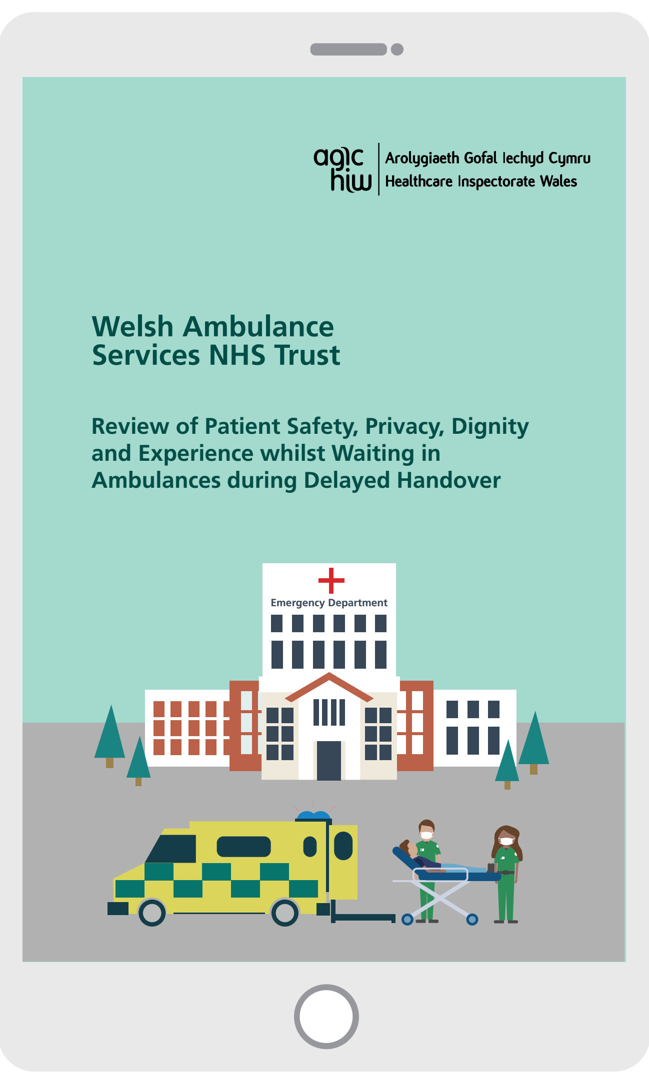
Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances During Delayed Handover

Our review found that the issue of prolonged handover delays is a regular occurrence with ambulance wait times outside Emergency Departments (EDs) across Wales. The delays and variations in process between and within health boards was having a detrimental impact upon the ability of the healthcare system to provide responsive, safe, and dignified care to patients.

Whilst there are expectations and guidance for NHS Wales to follow, and a clear will to meet these guidelines, there are substantial challenges to achieve timely patient handover across Wales which inhibit efforts to consistently achieve these. The challenges are indicative of the wider patient flow issues across all hospitals. Our review team found some inconsistencies and a lack of clarity between the Welsh Ambulance Services NHS Trust (WAST) and ED staff about responsibility for patient care, until transfer of care to health board teams. These types of inconsistencies were increasing risk and having a detrimental impact on patient care and safety.

Patients were generally positive about their experiences and provided good feedback about ambulance crews and ED staff, however, this should not detract from the issues associated with delayed handover.

A significant amount of work is already underway across NHS Wales to tackle these issues. Progress has been made in some areas, and improvement work is ongoing between WAST, health boards and Welsh Government to meet these challenges.

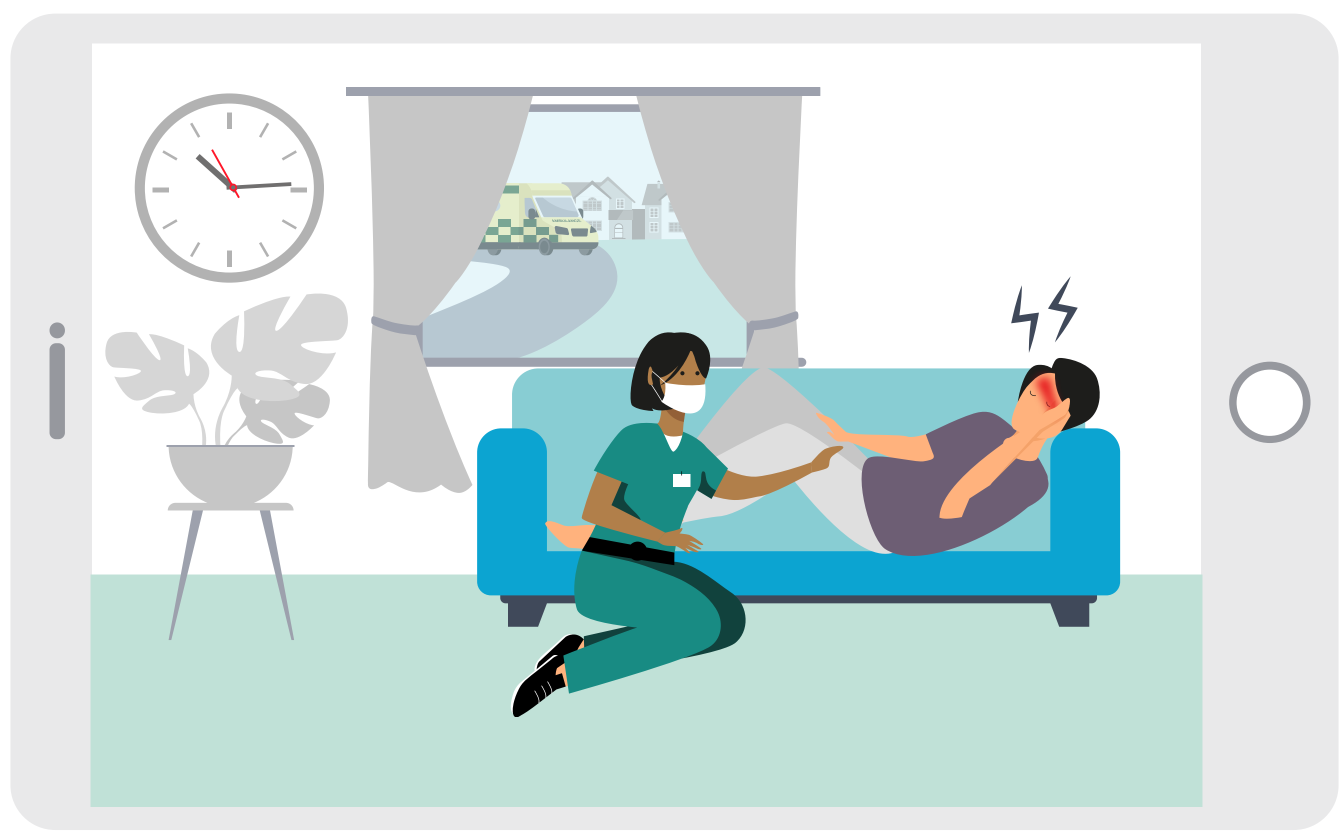


Current Ongoing Reviews

National Review of Patient Flow (Stroke Pathway)

Ineffective and inefficient patient flow can have a significant impact on the quality and safety of patient care. As a result, we decided to undertake a national review of Patient Flow. In order to assess the impact of patient flow challenges on the quality and safety of patients awaiting assessment and treatment, we elected to focus our review on the stroke pathway. We want to understand what is being done to mitigate any harm to those awaiting care, as well as understand how the quality and safety of care is being maintained throughout the stroke pathway.

The planning of the review commenced in autumn 2021, and the field work began in March 2022. Throughout our review we will consider how NHS Wales addresses peoples' access to acute care at the right time and if care is received in the right place, by people with the right skills, through to timely discharge from hospital services. We want to understand what is being done to mitigate any harm to those awaiting care, as well as understand how the quality and safety of care is being maintained throughout the stroke pathway. We aim to publish the review report during winter 2022-2023.



Review of Discharge Arrangements for Adult Patients from Inpatient Mental Health Services in Cwm Taf Morgannwg University Health Board

We made the decision to undertake this review following our assessment of a range of information sources which indicated significant concerns around mental health services within Cwm Taf Morgannwg University Health Board (CTMUHB). We commenced the review in January 2022 which will progress into late summer and the report will be published later in 2022. The focus of the review is to explore the quality and safety of discharge arrangements of adult patients from inpatient mental health units, back into the community.

Local Review of the Quality Governance Arrangements in Place within Swansea Bay University Health Board (SBUHB) for the delivery of Healthcare Services to Her Majesty's Prison (HMP) Swansea

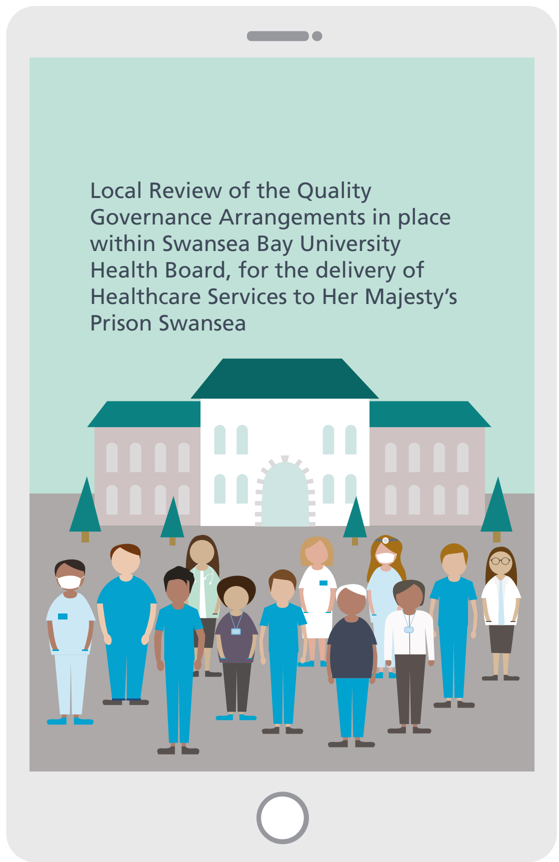
We decided to undertake a review of the effectiveness of Swansea Bay University Health Board's quality governance arrangements for the provision and oversight of healthcare services in HMP Swansea.

The review assessed the actions taken by the health board to address the issues highlighted following previous inspections by Her Majesty's Inspectorate of Prisons, which we contributed to, and how effective the health board's quality governance arrangements are regarding prison healthcare. Our review concluded that the health board's quality governance arrangements do not adequately support the delivery of good quality, safe and effective healthcare services to the population of HMP Swansea.

We identified a need to strengthen these arrangements and raise the profile of prison healthcare within the health board to ensure that the quality of prison healthcare is designed, delivered, and monitored effectively. The review report details our findings and recommendations for improvement within several areas of the health board and Prison Partnership Board.

HIW recommended that prison healthcare, including the quality of the service, needs to feature more prominently on the health board's quality agenda, so that safe, effective care can be provided to the prison residents.
HIW asked the health board and Prison Partnership Board to carefully consider the findings from this review and act upon the recommendations set out within the report.

HIW continue to work with the health board to ensure improvements are made in a timely manner and will monitor the progress made. The report was circulated to other health boards to share lessons learnt, and to consider the findings against their own quality governance arrangements.



Joint Inspection of Child Protection Arrangements (JICPA)

During 2021, we worked jointly with four other inspectorates on a second pilot review of child protection arrangements. The review was undertaken in the Neath Port Talbot local authority which is situated within Swansea Bay University Health Board. It was led by Care Inspectorate Wales (CIW), and included HIW, Estyn, Her Majesty's Inspectorate of Constabulary and Fire & Rescue Service and Her Majesty's Inspectorate of Probation.

The focus of the review was to explore the arrangements in place for the multi-agency response to children at risk of criminal and sexual exploitation. On completion of the review, we identified several key strengths across the multi-agency partnership in relation to processes, structures and relationships which helped to facilitate effective partnership working where a child was at risk of exploitation. We also identified areas for improvement throughout the review, which included the need to strengthen contextual safeguarding, and the need to reduce the waiting times for Children and Adolescent Mental Health Services (CAMHS) assessment following referral.

In the last quarter of 2021-2022, HIW, CIW and Estyn submitted a joint business case to Welsh Government to secure additional funding to continue the JICPA work, to enable us to review processes within a further four local authorities across Wales. As part of the plan, we would complete work in six further local authorities and evaluate all JICPA reviews undertaken to produce a national report, which would be published in summer 2024 once all work is complete. A provisional agreement is now in place for the funding early in quarter one of 2022-2023.

To take action when standards are not met

We are responsible for inspecting, reviewing, and investigating NHS services and independent healthcare services throughout Wales.
We inspect NHS services and regulate independent healthcare providers against a range of standards, policies, guidance and regulations to highlight areas requiring improvement. When through our work we find this is not the case, we will take action so that health boards and their services know where they need to make improvements.

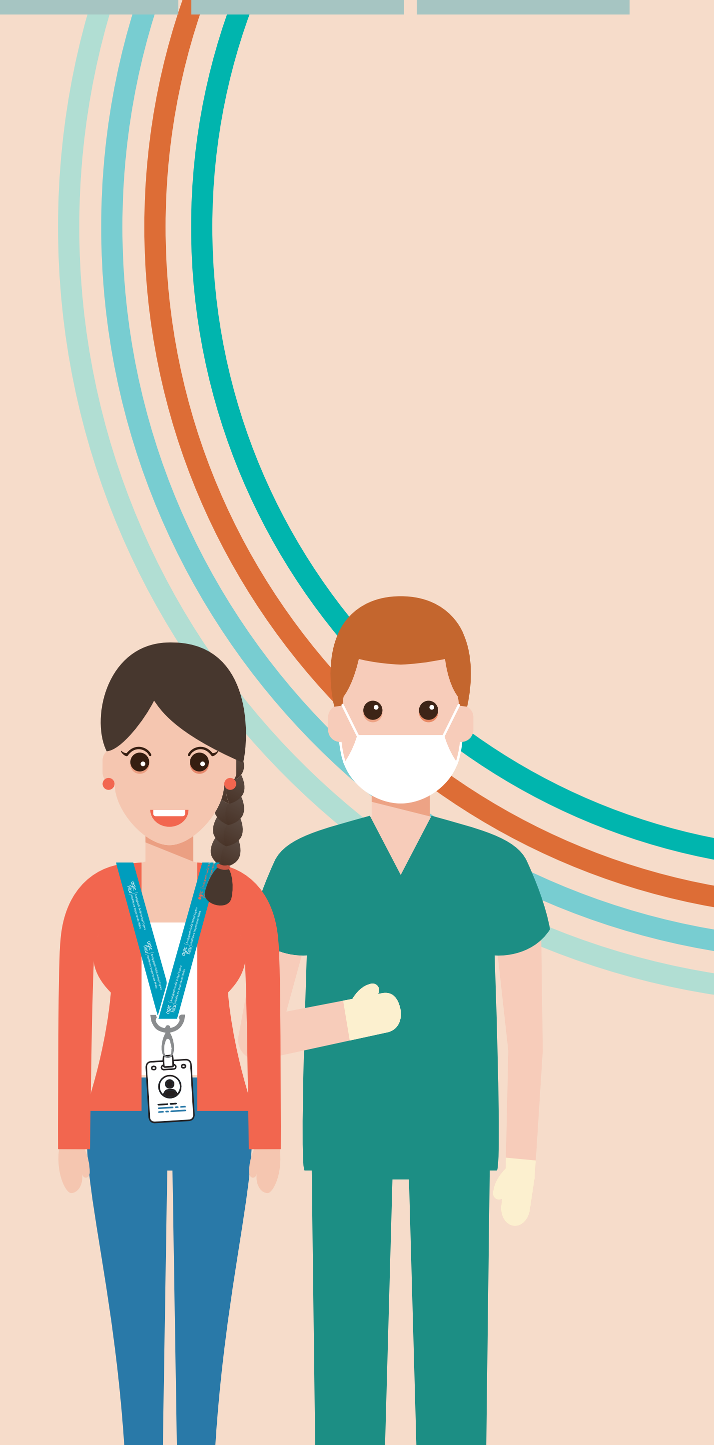
Service of Concern process introduced for NHS Bodies in Wales

One of the key priorities set out within our strategic plan was to take action when standards are not met. In line with this priority and wishing to increase transparency about how we discharge our role in providing assurance to the public regarding the quality and safety of healthcare services, we introduced a Service of Concern process for the NHS in November 2021.

This process is used when we identify significant service failures, or when there is an accumulation of concerns about a service or setting. The intention of the process is to support improvement and learning, both for the service in question, and across NHS services more broadly. Our escalation and enforcement process for independent healthcare currently utilises such a process.

The process may lead us to make a Service Requiring Significant Improvement designation. This enables us to plan and deliver future activities necessary to gain assurance about the quality and safety of care by a service. We then work with the health board and services to ensure improvements and effective actions are made in a timely manner. We will then consider and review whether the service can be de-escalated and removed from the process.

This process enables a range of stakeholders including health boards to take the rapid action necessary to ensure safe and effective care can be provided to people. The Service of Concern process has strengthened the action we take to drive improvement when services fall significantly short of the required standard. Examples of our use of this process are outlined later within this report.



Use of HIW's legal powers

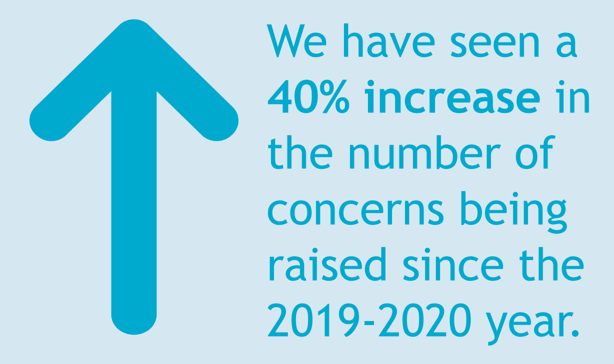
In February 2022 following a criminal investigation relating to an unregistered service, HIW issued a caution for a breach of section 11 of the Care Standards Act 2000.

As the regulator of independent healthcare services in Wales, HIW is committed to taking action when standards are not met. In order to ensure that patients receive safe effective care the use of legal powers on this occasion highlights how HIW will take action when a healthcare provider does not comply with the regulatory requirements.

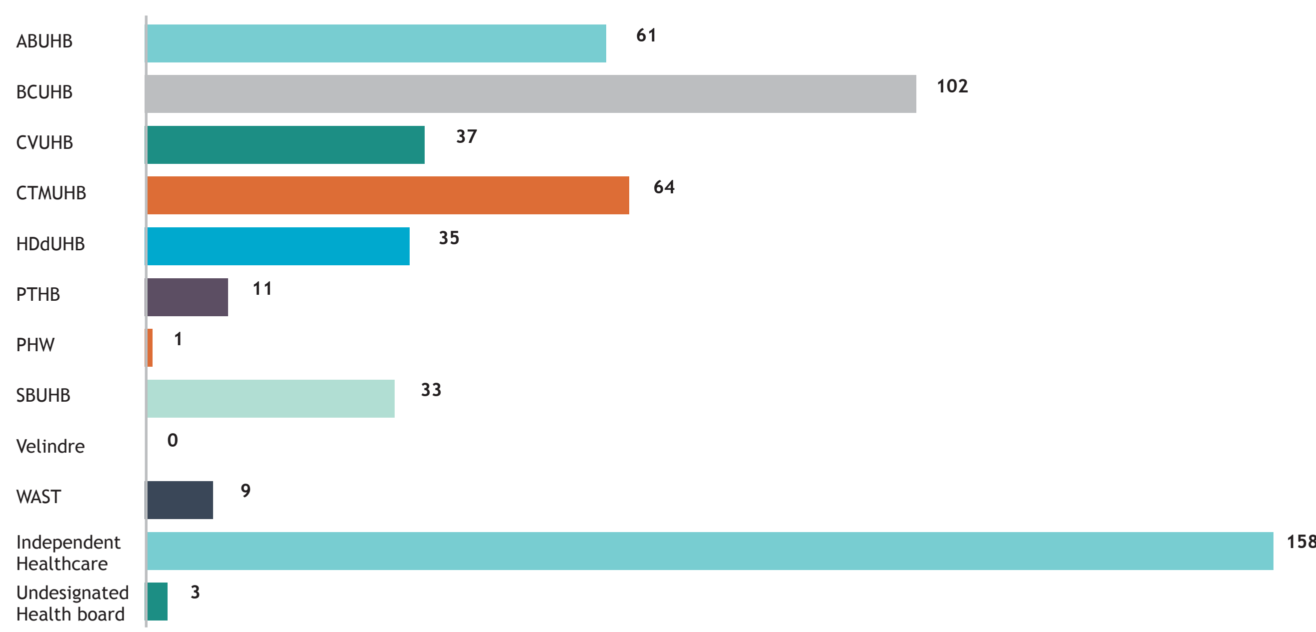
Concerns

The concerns we receive continue to be an invaluable source of intelligence to the organisation and their importance cannot be underestimated. Some of the onsite inspection work we undertook during 2021-2022 was as a direct result of concerns that had been raised with us. In addition to the evidence we have gathered directly from our inspection and Quality Check activity, we have also sought assurance from healthcare organisations in relation to concerns received.

In total, we received 514 concerns from April 2021 to March 2022. This represents an increase of eighty compared to the previous year. Of note, however, is that HIW is seeing a sustained increase in numbers of concerns being raised since the start of the COVID-19 pandemic.

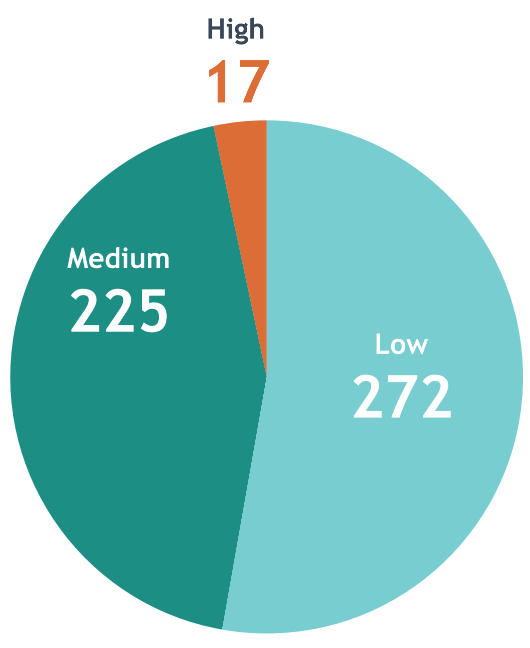


Location of concerns



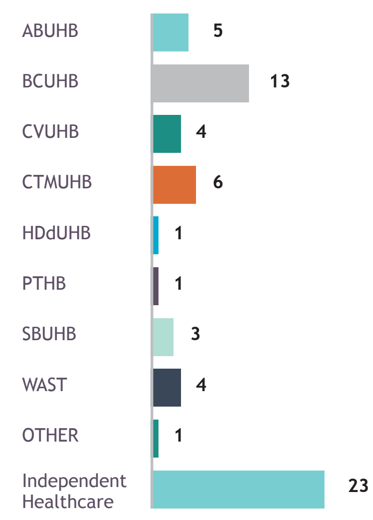
Concerns, Whistleblowing and Safeguarding

Risk levels of concerns received



- High-risk concerns require immediate action and response within 2 working days, either by HIW or other agency.
- Medium-risk concerns may require more direct HIW input, and responses should be actioned within 5 working days.
- Low-risk concerns are those concerns that are generally dealt with by way of signposting towards Putting Things Right or the respective local complaints process for independent health providers and responses should be actioned within 7 working days.

Whistleblowing Concerns



Whistleblowing Concerns

25 received for **2019-2020**

100 received for **2020-2021**

61 received for **2021-2022**

In total, we received 17 high risk concerns in 2021-2022. All high-risk concerns were evaluated, actioned and escalated and assurances requested from health boards / trusts or independent healthcare settings. Where appropriate we also contacted the local safeguarding team and shared any safeguarding concerns that we may have identified. At times we have also had to share information with the emergency services such as the police due to the nature of concerns raised or due to concerns over a person’s well-being.

Concerns were received from a range of individuals including, patients, their families, friends, staff, and allied health professionals. It is important to note that of 61 concerns received from whistle-blowers, 37 were in relation to NHS health boards / trusts and 24 were in relation to independent healthcare settings. Common themes identified from concerns received were mainly in relation to two key areas. The first group of concerns were in relation to clinical assessments and treatment. The second group of concerns related to infrastructure, staffing, and facilities.

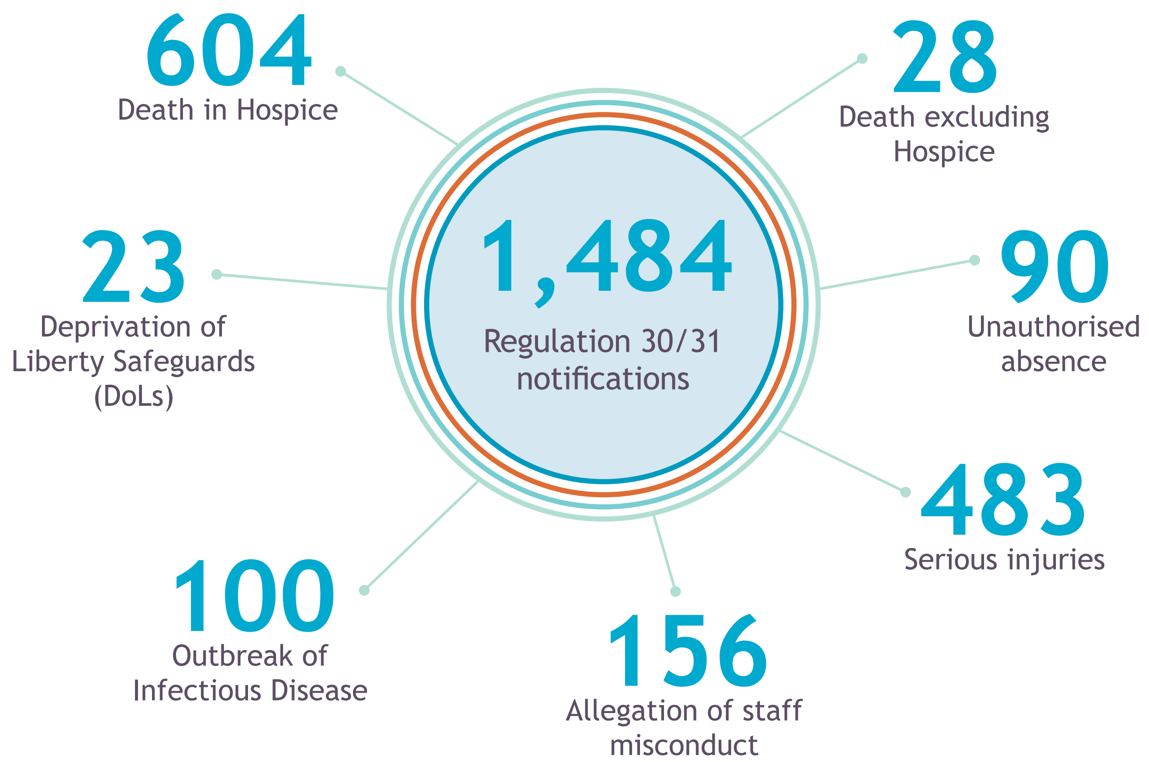
In total we received 404 safeguarding referrals from local authorities.

Local authorities and the police are the statutory lead for all safeguarding referrals and the final decision on action is made by them. HIW is invited to initial strategy meetings where we can have an input into any potential actions that are taken. We also review all referrals that are submitted, and the information is shared internally with relationship managers for intelligence. Relationship managers are the first point of contact for HIW staff and health boards/ trusts. They also take the lead in determining the inspection and assurance activity within each health board. If there is a need for further action, we write out to the health boards / trusts or independent healthcare setting and request assurance or a regulatory notification where applicable.

Regulatory Notifications

Independent healthcare providers are required to inform us of significant events and developments in their service submitting notifications against Regulation 30/31 of the Independent Healthcare (Wales) Regulations 2011.

In total we received 1,484 Regulation 30/31 notifications. A breakdown of the notifications is as follows:



This is a **36% increase** in the number of notifications we received, compared to 2020-2021. The number of serious injuries reported within independent healthcare services has increased significantly by **72%** over the last year.

During 2021-2022 we received 156 Regulation 25 notifications (The Private Dentistry (Wales) Regulations 2017).

They are as follows:

All notifications are reviewed by a case manager when they are submitted and then reviewed weekly by the Investigation team. For every notification submitted we request follow up information to provide reassurance that the incident has been handled appropriately and that the setting has attempted to mitigate the risk of similar incidents happening again. When similar themes are noted, we refer the information to the enforcement team and the escalation and enforcement pathway starts.

Death in Custody Reviews

It is the responsibility of the Prisons and Probation Ombudsman (PPO) to undertake an investigation of every death that occurs in a prison or approved premises in Wales. HIW supports these investigations by undertaking a clinical review of all deaths within a Welsh prison or approved premises. This collaboration has been formally outlined within a Memorandum of Understanding between the PPO and HIW. A link to the agreement can be found on our website.

The purpose of our clinical reviews is to critically examine and evaluate the quality of healthcare services provided to prisoners during their time within a prison or approved premises.

From 1 April 2021 to 31 March 2022, we were commissioned by the PPO to undertake 15 clinical reviews. This is one less compared to 2020-2021. These clinical reviews were conducted at four out of the six prisons located in Wales. No clinical reviews were undertaken in relation to HMP Prescoed or HMP Usk.

The table below identifies the number of reviews and their locations:

Location	Total
HMP Parc	7
HMP Berwyn	2
HMP Cardiff	5
HMP Swansea	1

Overall, our death in custody reviews highlighted that the care provided to prisoners in Wales was equitable with the expected level of care a person in the community would receive. Access to GPs, nursing staff and allied health professionals was deemed sufficient in the vast majority of our reviews.

In all of our clinical reviews we identified the need for improvement and highlighted good practice. There were two key areas highlighted for improvement, these were the need to ensure comprehensive and detailed documentation was completed for all patients and improvement in relation to the timely undertaking of investigations such as blood tests and x-rays.

Good record keeping is a fundamental part of delivering safe and effective patient care. An accurate documented record that details all aspects of the patient's care and treatment is fundamental as it contributes to the dissemination of information amongst different care practitioners involved in the patient's treatment or care. A specific area of documentation that was identified as needing improvement was the recording of physical observations as part of patient assessments. These observations provide a significant insight into a patient's state of health and can alert practitioners to the clinical deterioration of an individual.

It was acknowledged that on some occasions, delays were experienced by prisoners in obtaining blood tests and x-rays. Numerous factors were identified which can impact on the timeliness of these investigations being undertaken, such as transport and the availability of specific staff. In addition, vulnerabilities were identified in alerting healthcare staff when a prisoner had not attended an appointment. The importance of recognising these missed appointments need to be clearly embedded in policies and procedures and escalated accordingly to ensure individuals receive the required investigations.

Our clinical reviews highlighted that healthcare professionals working in prisons were motivated, dedicated and committed. Evidence showed that staff endeavoured to provide high levels of holistic care and treatment to their patients. HIW's findings following a review into the effectiveness of Swansea Bay University Health Board's quality governance arrangements for the provision and oversight of healthcare services in HMP Swansea did provide a differing perspective. Our review concluded that the health board's quality governance arrangements do not adequately support the delivery of good quality, safe and effective healthcare services to the prison population. We identified a need to raise the profile of prison healthcare within the health board to ensure that the quality healthcare is designed, delivered, and monitored effectively. HIW recommended that prison healthcare needs to feature more prominently on the health board's quality agenda, so that safe, effective care can be provided to the prison residents.

NHS Assurance and Inspection Findings

We continued to deliver a blended approach to assurance and inspection via onsite inspections and remote Quality Checks. There was ongoing work to develop and enhance current methodologies, which are the tools used to undertake inspection and assurance work. All methodologies continued to include a specific focus on COVID-19.

Hospitals

COVID-19 continued to impact the way in which we inspected and sought assurance of NHS hospitals throughout 2021-2022. During Winter 2021, rates of COVID-19 transmission continued to increase, including the emergence of the Omicron variant. It was important that we took a cautious approach to reduce burden on the services most affected. We therefore cancelled all routine NHS onsite inspection work throughout December and January. We still undertook onsite inspection work where we considered there to be a high risk to patient safety as a result of specific issues that we were aware of and was not possible to gain assurance remotely. All other work during this period we conducted remotely. In February 2022, we resumed all our routine NHS onsite inspections following the move to alert level 0 across Wales and the general decreasing trend in rates of COVID-19. We provided 24 hours' notice for inspections to elective, scheduled care areas where the flow of patients is planned, and COVID-19 precautions are structured around patients who are being admitted for planned surgery, or where there are patients with compromised immunity due to the treatment they are receiving and in maternity services. This allowed our inspection teams to communicate with NHS staff and for arrangements to be put in place so that the inspection could be undertaken safely. We continued to conduct unannounced inspections (no notice provided) of clinical areas within unscheduled care areas.

During this period, we undertook:

Of the eight onsite inspections we completed, two of those were categorised as a 'green' pathway[1].

Our onsite inspections and Quality Checks covered a variety of different types of hospital wards including emergency departments, maternity, oncology, cardiac, paediatric units, step down facilities and one minor injury unit.

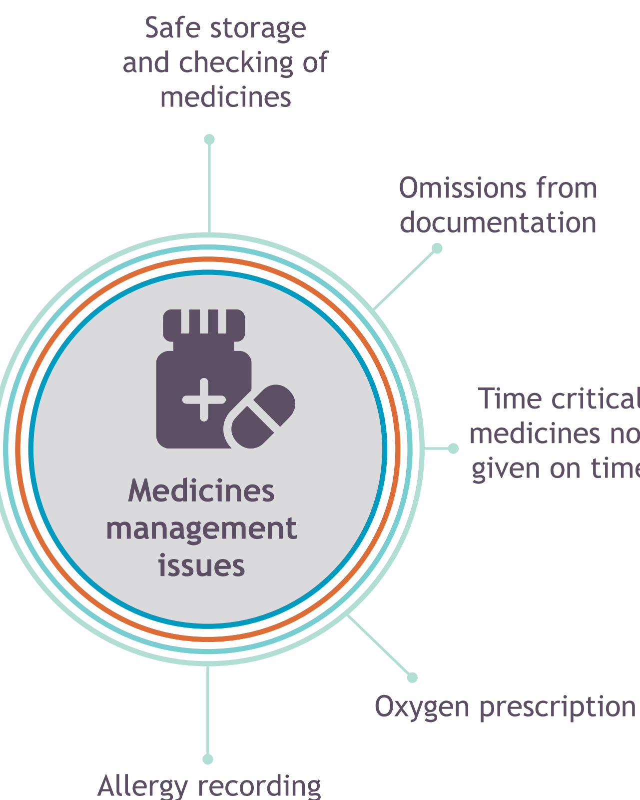
It was clear, from work carried out throughout the year, that there was significant and sustained pressure on the emergency care system, and that this directly impacted patient care. Through our inspection and assurance work we identified a clear difference between scheduled and unscheduled care. We identified many more areas requiring improvement within unscheduled care compared to scheduled care. In particular, scheduled care areas, such as oncology and cardiac wards, where the staff have more control over admission and can provide more patient centred care had fewer areas for improvement.

Although responses we received to our staff questionnaires indicated low staff morale, particularly related to challenges around staffing numbers and high demand for services, this did not generally seem to impact on the experience patients had of staff. Patients told us staff were kind and compassionate.

Our inspections continued to note low levels of compliance with mandatory training for staff. Mandatory training plays a key role in ensuring staff can provide safe and effective care to patients.

[1]The Green Pathway is the term given to COVID-free areas of a hospital. Within the pathway there are specific pathways such as surgical pathways. Measures taken can include patients being assessed as having no current risk of COVID and patients booked for surgery may be asked to self-isolate in their homes.

Medicines management continues to be a concern for HIW, as we identified issues across all of our hospital inspections in relation to:



Through our work we experience many clinical areas. We encounter patients who receive their care within and from services, and when visiting is possible, we also meet relatives, carers and others involved in their lives away from healthcare. We also encounter the staff working within services day to day; therapy staff whose work takes them to departments to support with specific issues, housekeeping staff whose input supports the smooth running of departments, and managers and senior leaders who provide the governance and leadership that is needed daily to ensure services achieve and maintain standards, and where necessary, improve. We have observed services at times of significant pressure, and the staff within them working relentlessly to deliver care. We have seen services at times when pressure is not significant, but staff still working hard to deliver care. We acknowledge the challenge and stress that sustained high pressure can cause. The case studies below demonstrate the way in which we continued to focus on patient safety in 2021-2022, challenging services and health boards to look for different ways of doing things when outcomes for patients could be improved.

Case Study – Inspection of the Emergency Department, Prince Charles Hospital, Cwm Taf Morgannwg University Health Board

In the following case study, we have focussed on the findings and outcome of an inspection we carried out of the Emergency Department (ED) in Prince Charles Hospital. This example of our work illustrates a department working under significant pressures leading to issues with patient safety. What happened next was an example of a health board working responsively and constructively to tackle the issues our work highlighted. By responding in this way, early progress was made in improving patient safety and outcomes for patients.

During our inspection in September 2021, we found that the ED, as the front door to a wider healthcare system, was experiencing a period of heightened pressure due to high demand on services. Patient flow throughout the hospital was clearly an issue.

We acknowledged that this was a very challenging and stressful environment for staff, who continued to work above and beyond in exceptional and challenging conditions.

The inspection revealed extensive issues in relation to patient safety, meaning that we could not be assured that patients in attendance at the ED were receiving safe care. These concerns related to inadequate infection prevention and control arrangements, ineffective arrangements for the segregation of COVID-19 patients, inappropriate or incorrect usage of Personal Protective Equipment, and numerous environmental factors impacting on the ability of staff to provide safe and dignified care. The department and GP assessment unit were significantly overcrowded to a level where this affected patients' dignity and safety. The paediatric area was not sufficiently staffed, and the environment was not conducive to safe and dignified care. Patients were not always monitored at a frequency which would identify deterioration and changes in their condition. Our discussions with staff also revealed concerns about their well-being, due to the environment that they were working within.

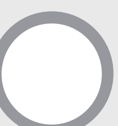
We used our Immediate Assurance process, where we formally write to a health board immediately after the inspection, to outline the urgent remedial actions that were needed to ensure patient safety. Our full inspection report identified the longer-term improvements that were required.

Key staff at the health board were positive in their response to our feedback, and in our subsequent engagement, with a clear commitment to addressing the issues highlighted. The health board's responses included a comprehensive set of actions, with much progress already made at the time our report was published.

Due to the significance of the issues found in the inspection, we undertook a follow-up inspection in January 2022.

At the time of the follow-up inspection, we found that the ED continued to experience a period of heightened pressure due to high demand on services. Once again, we acknowledged that this remained a very challenging and stressful environment for some staff, who continued to work above and beyond in exceptional and challenging conditions. Whilst some areas still needed attention, there were no urgent patient safety issues.

There was a clear commitment to addressing the issues highlighted in the initial inspection and we found that the health board had made significant progress in addressing most of the improvements raised in a sustainable way, rather than quick fixes to issues which cannot be maintained. The rapid and positive outcome achieved within this example is of note, with this being achieved through a constructive and supportive style adopted by senior leaders in supporting staff in the department. Staff felt there was a shared responsibility for improvement. Our work provided an insight into challenges at the department, and this will support the health board in continuing to improve delivery of care provided by the ED. The outcome of our work and the effort from the health board was improved patient safety in the department.



Case Study - Enhanced Quality Check Ysbyty Glan Clwyd, Betsi Cadwaladr University Heath Board

In May 2022, we identified the Emergency Department (ED) at Ysbyty Glan Clwyd, Betsi Cadwaladr University Health Board as a Service Requiring Significant Improvement.

This designation was based on an accumulation of evidence where HIW identified specific risks following a No Surprises Notification in January 2022, concerning potential unsafe discharge from the ED. A patient was unfortunately found deceased after discharge. Following insufficient assurances from the health board in response to HIW's initial correspondence, HIW undertook an in-depth review of the case notes of the patient involved. This review highlighted a number of concerns and significant patient safety concerns. This was fed back to the health board and assurance and actions were provided to HIW that safe care and treatment was being provided at this time.

HIW subsequently completed an enhanced Quality Check of the department in March 2022. Quality Checks are a snapshot of the standards of care within healthcare services. They are conducted entirely offsite and focus on three key areas: infection prevention and control, governance (specifically around staffing) and the environment of care.

Due to the issues noted in January 2022, we expanded our usual methodology to seek assurance on how the health board ensures patients are cared for, and discharged, safely.

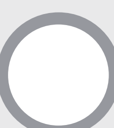
Our work identified numerous patient safety issues. We issued an Immediate Assurance letter, where we write to the health board immediately after the Quality Check, outlining urgent remedial actions to ensure patient safety.

Whilst the health board responded positively with a detailed action plan, the severity of the issues identified led HIW to remain concerned about wider patient safety at the department. Consequently, we undertook a full onsite inspection in May 2022 to inspect the full environment of care, and ensure the actions set out in the health board's response to the March Quality Check were completed and sustained.

Our onsite inspection identified further significant patient safety issues. We also identified areas where the health board's actions in response to the March Quality Check had been ineffective. We escalated our concerns to senior staff at the health board during the inspection, as well as at our standard feedback meeting at the end of the inspection. We received verbal assurances from the health board on actions that would ensure patient safety, and we issued a further Immediate Assurance letter on 9 May 2022.

Having considered the findings and evidence gathered since January 2022, HIW determined that the health board had not been able to demonstrate sufficient progress against several key areas of concern relating to patient safety and quality of care, with particular concern regarding the poor standard of nursing documentation. Our May 2022 onsite inspection highlighted that the health board had not demonstrated improvement to an acceptable standard in response to the Immediate Assurance issues identified during the March 2022 Quality Check. Furthermore, the May 2022 inspection identified several additional areas of concern relating to patient safety. As a result, we were concerned there was a risk to the safety of patients seeking care at the Emergency Department in Ysbyty Glan Clwyd.

The designation of Ysbyty Glan Clwyd Emergency Department as a Service Requiring Significant Improvement enabled HIW to plan and deliver any future activities necessary to gain assurance about the quality and safety of care in the service. This process considers the timing of any follow up activity, to enable HIW to decide whether the service can be de-escalated and removed from this process.



General Practice

We continued to use Quality Checks to seek assurance on the quality of care being provided by GP practices during 2021-2022. Our Quality Checks continued with a specific focus on COVID-19. During this period, we undertook 25 Quality Checks of GP practices across health boards in Wales.

It was positive to note from our assurance work that there was good evidence of GP practices using their membership of a cluster[2] to support the provision of patient care and sharing of ideas and good practice between GP practices. We noted that most GP practices had made significant changes to their practice environments to ensure that they were safe for patients and could be easily cleaned in response to the challenges of the COVID-19 pandemic.

However, it was disappointing to discover that at some GP practices there was a lack of cleaning policies and full cleaning schedules. We also noted a lack of completed risk assessments at some practices for home visits, practice staff and the environment. Policies and risk assessments are management tools which help to ensure that all staff are aware of what is expected of them, they can be used to help outline and ensure safe practice and they can help to maintain consistency in standards and support improvements in quality. Where these tools are absent or are not kept up to date it indicates a weakness in management practices, and this is of concern. GP practices and primary care leaders within health boards should ensure there are processes and systems in place to support effective management of these services.

We identified a theme through our activity and intelligence relating to the accessibility and availability of face-to-face appointments. This showed that although practices were doing their best to recover services affected by the pandemic, issues of access still persisted. People told us that they could not always get appointments when they needed them and found it difficult in some areas to access practices by phone. We also found that an element of digital exclusion has continued, with some people unable to access services in an equal way due to a focus on online and telephone consultations. We found that practices had continued to respond well to the challenges of the pandemic. This included releasing staff to provide vital support to vaccination programs and clinics. A number of areas had developed innovative approaches to manage consultations and meet the demands of their communities. As a result, we have redesigned our methodology for GP inspections and introduced new peer reviewers to this process. This will ensure that HIW keeps pace with the developments in this sector.

[2] A cluster is a group of GP surgeries working together to pool resources and share best practice in a bid to help patients remain fit and healthy, and to improve the way patients are cared for if they become unwell.

Mental Health

We look at how NHS mental health and independent mental health care services meet and comply with a range of professional standards and guidance, including the Mental Health Act 1983 and the Independent Healthcare (Wales) Regulations 2011.

The provision of mental health care during the pandemic has been challenging and complex for both the NHS and independent healthcare service providers. We continued to use a mix of remote Quality Checks and onsite inspections for our work to mental health care settings. This hybrid approach enabled us to seek assurance from services at a time when the risk threshold for conducting inspection visits was high and to conduct our work onsite when either the COVID-19 risk was lower, or where the risk to patient safety was of significant concern. Our Review Service for Mental Health (RSMH) continued during this time, as well as our concerns and notifications processes. We also continued to respond to patients in mental health settings who contacted us during this period.

Over the past 12 months, our assurance work evidenced several key themes across a range of settings in relation to mental health care. Mental health is challenging and complex and inspections highlighted staff were often required to intervene to manage patient behaviours and ensure their safety, rather than provide care and treatment bespoke to their needs.

During 2021-2022 we undertook:

Inspections also highlighted instances of:

- Mandatory training for staff not being completed or up to date
- Poor medication management including incomplete administration charts and medication being stored incorrectly
- Risks being identified and subsequently not addressed in a timely manner or not addressed at all
- An over reliance on agency staff and repeat periods of inadequate resourcing
- Care and treatment plans not being monitored and regularly updated
- A lack of governance oversight including collaborative working and sharing information for future improvement.

In most cases we found that staff working in services providing mental health care and treatment, treated patients with kindness and respect. We also saw that most services continued to work well to adapt to the changing needs presented by the pandemic. Patients were receiving compassionate care in most cases which promoted their independence and autonomy. We also saw that in some cases the recovery from the pandemic was going well, with improvements on previous inspections noted.

During 2021-2022 we inspected two out of the three children and adolescent mental health units in Wales, Tŷ Llidiard in Bridgend, and Hillview Hospital in Ebbw Vale.

Learning Disability

HIW undertook eight Quality Checks and five inspections of facilities providing learning disability services. In most cases, we found that patients accessing care in these facilities were receiving person centred and compassionate care and treatment. Tailored care plans were in place and allowed staff and patients to work towards common goals for the benefit of patients. We saw that staff interacted with patients in a kind and compassionate manner and worked hard to meet patient needs. However, we did find that staffing numbers were not always at a level which met patient needs. We also saw that the COVID-19 pandemic had negatively affected the promotion of independence in some of these settings. We saw in one case that there were significant issues relating to the environment, governance and safety of the unit. As a result, an Immediate Assurance letter was issued, and significant improvements were implemented by the Hywel Dda University Health Board.

The Second Opinion Appointed Doctor (SOAD) Service

HIW operates the SOAD service for Wales, and we appoint registered medical practitioners to approve some forms of treatment. The role of the SOADs is to safeguard the rights of patients who are detained under the Mental Health Act and either do not consent or are considered incapable of consenting to treatment (section 58 and 58A type treatments). Individual SOADs come to their own opinion about the degree and nature of an individual patient's mental disorder and whether the patient has capacity to consent.

They must be satisfied that the patient's views and rights have been taken into consideration. After careful consideration of the patient and approved clinician's views, a SOAD has the right to change the proposed treatment. For example, a SOAD may decide to authorise only part of the proposed treatment or limit the number of electroconvulsive therapies (ECTs) given.

The SOADs have a responsibility to ensure the proposed treatment is in the best interest of the patient. The appropriate approved clinician should make a referral to HIW for a SOAD opinion relating to:

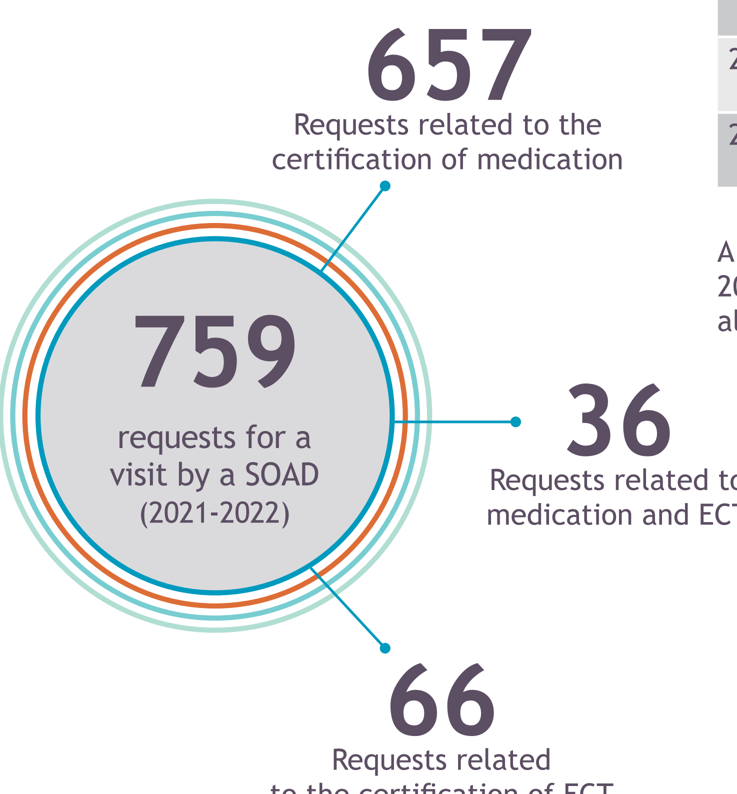
- liable to be detained patients on Community Treatment Orders (CTO) (Section 17A) who lack the capacity to proposed treatment or who do not consent for Part 4A patients
- serious and invasive treatments such as psychosurgery or surgical implements for the purpose of reducing male sex drive (Section 57)
- detained patients of any age who do not consent or lack the capacity to consent to Section 58 type treatments (section 58)
- patients under eighteen years of age, whether detained or informal, for whom Electroconvulsive Therapy (ECT) is proposed, when the patient is consenting having the competency to do so (Section 58A), and
- detained patients of any age who lack the capacity to consent to electroconvulsive therapy (ECT) (Section 58A).

Due to the ongoing COVID-19 pandemic and health and safety concerns regarding on site visits for the SOADs, in 2020-2021 we operated a temporary COVID-19 safe methodology for the SOAD service, wherein onsite hospital visits were temporarily suspended and replaced with teleconference or telephone call appointments. As we move to a post-pandemic operating model, the SOAD service now operates a hybrid methodology where onsite visits, where safe and practicable, are carried out, however, remote certification is still also utilised enabling the efficiencies gained from the remote methodology to continue, whilst ensuring patients safety and rights are prioritised.

We continue to work with Mental Health Act administrators in health boards and independent providers to ensure that patients get timely access to a SOAD and that the process is as smooth as possible to ensure that the rights of patients are protected. We attended the Mental Health Act Administrators annual forum and engaged with stakeholders directly to support understanding of our hybrid methodology.

In Wales during 2021-2022, there were 759 requests for a visit by a SOAD. This figure is a slight drop from the previous year, although it remains broadly consistent with figures from previous years.

These were:



The following table provides a breakdown of requests per year:

Requests for visits by a SOAD in 2021-2022

Year	Medication	ECT	Both	Total
2019-2020	**855**	**50**	**27**	**932**
2020-2021	**869**	**60**	**27**	**956**
2021-2022	**657**	**66**	**36**	**759**

A regular programme of training is provided to all SOADs to encourage best practice. In the year 2021-2022 training which focussed on depression treatment and medications was provided. SOADs also attended a session in winter 2022 focussing on Legal Updates to the Mental Health Act 1983.

Review of Treatment (Section 61)

Following the authorisation of a treatment plan by an authorised medical practitioner (SOAD) that has been appointed by HIW, a report on the treatment and the patient's condition must be provided by the responsible clinician in charge of the patient's treatment and given to HIW. The designated form is provided to the Mental Health Act Administrators office for all local health boards and independent settings for the Responsible Clinician to complete. For the sixth consecutive year HIW undertook an audit of these forms to ensure that adequate patient safeguards were in place. The treatments are reviewed by our lead SOAD for Wales on a monthly basis.

There remain very few instances where discrepancies are identified by the reviewer. Further improvements from our previous report continue in relation to the following areas:

- There continue to be minimal occasions where more medication is listed under the treatment description than is authorised on the CO3 form. In these instances, the reviewer highlights the need for a SOAD request to be submitted by the setting.

[3] The Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008 are the principle regulations dealing with the exercise of compulsory powers in respect of persons liable to be detained in hospital or under guardianship, together with community patients, under the Mental Health Act 1983.
The Regulations prescribe the forms that are to be used in the exercise of powers under the Act, and these are set out in Schedule 1 of the Regulations. These Regulations (and the prescribed forms) came into force on 3 November 2008 and include CO forms.

Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R)

HIW is responsible for monitoring compliance against the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R). The regulations are intended to protect people from hazards associated with ionising radiation. Our inspection approach checks that services are compliant with these (IR(ME)R) regulations and looks at whether care and treatment is being provided in line with the Welsh Government's Health and Care Standards.

During 2021-2022 HIW completed seven IR(ME)R inspections, covering the three modalities of medical exposures. Six of these inspections covered the NHS and one covered independent hospitals.

HIW was assisted in these inspections by a Senior Clinical Diagnostic Officer from the Medical Exposures Group (MEG) of the UK Health Security Agency (UKHSA), who acted in an advisory capacity. All the inspections were undertaken onsite. As part of the process, we asked providers to undertake a full self-assessment and then we held discussions with staff about the content of the self-assessments and the supplementary evidence provided to support the self-assessment. Whilst onsite we also reviewed clinical and other relevant records as well as observing the environment in which services were delivered. We also requested patient and staff feedback through online surveys. The QR code to access the survey was displayed on posters in the services we inspected, and we promoted the surveys through our social media channels. Paper copies of the patient survey are also provided in advance of the inspection to the setting to accommodate patients who are unable to access the online survey. HIW received 273 completed patient questionnaires and 214 staff questionnaires covering these seven inspections.

Feedback from patients was overwhelmingly positive with patients confirming that they had been treated with dignity and respect and had been helped to understand the risks and benefits of the procedure they were receiving. During our IR(ME)R assurance activity we continued to meet experienced and committed teams of professionals, with a good team working ethos. Overall, staff we spoke with demonstrated a good awareness of their responsibilities under IR(ME)R and we were assured that examinations at all sites inspected were undertaken safely.

Medical Physics Experts (MPEs) are qualified staff who are able to act or give advice on matters relating to radiation physics applied to medical exposure in diagnostic radiology, nuclear medicine, and radiotherapy. We noted that the relationships between the various IR(ME)R locations inspected and the MPEs was good, whether this was provided as part of a service level agreement with another health board or by staff employed directly by the health board.

Some common themes have emerged across our IR(ME)R inspections this year. They are summarised as follows:

Employer's Procedures - on several occasions we identified that these did not provide enough detail and did not reflect the actual agreed practices staff described to us. We also saw examples where procedures were not up to date and had not been reviewed. Therefore, whilst staff could describe safe practises to us, we could not be assured that the written procedures would provide new, locum or agency staff with the required level of information to guide them in performing their relevant roles. Examples of common areas where detail was lacking in Employer's Procedures included:

- The information supplied in the self-assessment form contained additional information which should be included in the employer's procedures to explain the process in more detail.
- Pregnancy employer's procedures and relevant documents did not always reflect the terminology used in IR(ME)R 2017. Also, pregnancy enquiry EPs were a common area where agreed practise described by staff was not reflected accurately in the employer's procedures itself.

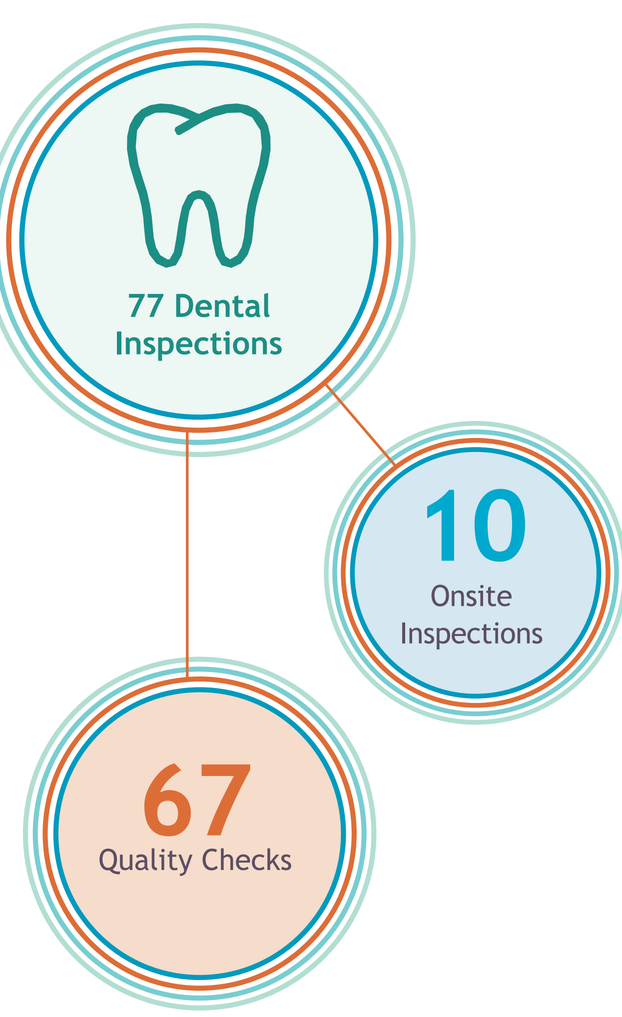
Entitlement - is the process of defining the roles and tasks that individuals, referred to as duty holders, are allowed to undertake. We identified that duty holders had not always been formally notified of their entitlement and scope of practice under IR(ME)R.

Clinical audit - is a key component of improving patient care through identifying areas for improvement and to promote effective use of resources and enhance clinical services. Audits should also highlight any discrepancies between actual practice and standards. Some instances were noted where the difference between IR(ME)R audit and clinical audits was not fully understood and as a result clinical audits had not been completed.

Staff Capacity - in most cases staff told us that they felt supported by senior management and the wider organisation. However, they did tell us that they struggled in terms of capacity to undertake all relevant tasks required as part of their duty holder roles. This may have been evident in the number of recommendations made in relation to mandatory training levels being low and appraisals not being completed in a timely manner.

We identified recommendations for improvement relating to collecting feedback from patients and informing staff of the results of this feedback. In most cases this was due to the COVID-19 pandemic which had reduced the collection of feedback. It is hoped that the process of collecting feedback would return to pre-pandemic levels in 2022-2023.

Dental Practices



Earlier in the pandemic, dental practices worked under a Red Alert which was issued by the Chief Dental Officer for Wales and which prevented them from undertaking any Aerosol Generating Procedures (AGPs). Enhanced cleaning and the requirement for time in between patients, led to a much more limited dental care provision than pre-pandemic. In summer of 2020 dental practices were able to increase the treatment they could provide and during 2021–2022 we saw them steadily increase service provision, working to recover back towards pre-pandemic levels.

During the year we undertook 77 pieces of assurance work across dental practices across Wales. Due to COVID-19 risk levels, we conducted most of this work remotely, and undertook ten onsite inspections where the level of risk to patient safety could not be explored remotely.

In three Quality Checks we had concerns which meant we needed to ask the practices to take immediate action to reduce risks to patient safety; we did this either via our Immediate Assurance process or issuing a Non-Compliance Notice, dependant on whether the practice provided NHS dental treatment, private dental treatment or a mixture of both. In one instance, a health and safety assessment had been correctly carried out by the practice, but the findings had not subsequently been acted on, leaving outstanding areas of health and safety concern. In the other two instances we found that there were inadequate seals to either flooring or to the flooring and worksurfaces in clinical decontamination rooms. Appropriately sealed floors and worksurfaces are necessary to reduce the risk of contamination and to support good standards of infection prevention and control.

Overall, we found evidence that dental practices had effective COVID-19 procedures in place to reduce the risk of virus transmission. This included social distancing, fallow time (settle time in between patients which is necessary for reducing levels of circulating air particles), and quick methods of communication with staff teams to ensure they received timely updates on COVID-19 procedures.

We also found evidence that many dental practices had considered the Welsh language needs of the patient population and were able to provide bilingual information to patients and a bilingual service where possible.

We were also pleased to note the efforts made by some practices to support and accommodate patients with additional needs to receive their treatment. One practice, 'MyDentist' in Wrexham told us that they held dedicated sessions, twice per year, for patients diagnosed with autism to receive treatment in a calming environment. Extra time was set aside for each appointment, lights are dimmed, and the radio volume lowered. We were also told that there were sensory toys, light blocking glasses and ear defenders available for patients to use.

Bryant Dental Practice also told us that during the pandemic, the practice utilised the 'Attend Anywhere' service and remote triage to reach patients who were too nervous to attend the practice due to COVID-19. We were also told that protected appointment slots are made available for vulnerable or at-risk patients at the start or end of each day.

We did find some common areas for improvement through our work. The majority of dental practices needed to improve their documentation recording staff training and ensure that all staff completed mandatory training sessions. We recognise that training has been challenging to source at times during the pandemic, but practices must continue to prioritise this as up to date training supports with quality and patient safety.

We found some areas of management and governance which needed strengthening:

- **A number of practices did not have a system which ensured all risk assessments were being kept up to date. We noted that some fire risk assessments were out of date. Risk assessments are an important management tool which helps to keep patients and staff safe and should be reviewed and updated regularly to reduce risks.**

- **Some dental practices did not have an up-to-date Infection Prevention and Control policy to work from. Whilst we acknowledge there have been some frequent updates to infection control advice over the course of the pandemic, correct IPC procedures (which should be governed through a policy) are crucial for maintaining patient safety.**

- **We also found numerous examples of practices not undertaking audits of their work. Audits offer an opportunity to review the consistency.**

Practices should ensure they take account of the above findings, considering whether they can apply any of this learning to their service to improve the quality and safety of care and treatment that is provided.

Independent Healthcare

Acute Hospitals

Due to the impact of NHS waiting times, independent healthcare is being utilised by patients now more than ever. After exclusively making use of remote Quality Checks throughout 2020-2021, it was important for our inspectors to return to onsite visits of independent hospitals to ensure patients received safe and effective care.

During 2021-2022 we completed four onsite inspections of Independent Hospitals.

Overall, our inspections found that safe and effective care is being provided to patients. Most patients who participated in the inspection expressed satisfaction with the care and treatment received.

Patients told us that staff were kind and caring and we observed good interactions between staff and patients, with staff supporting patients in a calm, dignified and respectful manner.

We found that the staff teams were committed to providing patients with safe and effective care and patients' care needs had been assessed by staff and monitored to promote patient well-being and safety.

The hospitals we inspected were clean and tidy and arrangements were in place to reduce cross infection. This is of high importance as during the time of our inspections, COVID-19 was still prevalent. However, even our most positive of inspections identified issues in medicines management procedures, for example, daily controlled drugs checklists not fully completed. We also noted issues with medications security, storage, and temperature checks.

We found good management and leadership in the hospitals with staff commenting positively on the support that they received from the management team. There was a clear multi-disciplinary approach to provisions of care across all three inspections.

Hospices

Hospices provide care to adults, young people and children who have a terminal illness or a long-term condition that cannot be cured. Due to the vulnerability of the patients, it is imperative that hospices have policies and procedures in place to protected patients from COVID-19.

During the year we completed:

Overall, our assurance and inspection work of hospices throughout the year was positive with evidence that services provided safe and effective care.

Adults

We noted the interaction between staff and patients was good and it was evidence that family members were engaged and involved in their relative's care. There were good examples of multi-disciplinary working to improve provisions of care.

Staff emphasised the importance of maintaining visiting as far as possible for the well-being of patients and their relatives, particularly for patients in their last days of life. Staff described how this was achieved in a timely and effective manner in line with public health guidance at that time. This included initially restricting visiting numbers and COVID-19 testing for relatives before visiting.

We did find some common areas for improvement through our work:

- Environmental risk assessments and action plans were not always complete.
- Low levels of completed mandatory training.

Young People and Children

During our inspection we observed staff being kind and respectful to children. We saw staff making efforts to protect children's privacy and dignity when providing assistance with personal care needs. We viewed staff communicating with children in a calm, friendly and cheerful manner. Staff were observed communicating with children in an encouraging and inclusive manner.

The multi-disciplinary team provided patients with individualised care according to their assessed needs. There were robust processes in place for referring changes in patients' needs to other professionals such as tissue viability nurses, speech and language therapists and dieticians.

Children who completed the online survey told us that they were involved in the planning and provision of their own care. Parents/guardians told us that they were being consulted and encouraged to ask questions and make decisions around care provision.

Treatment using a Class 3B/4 laser or Intense Pulsed Light (IPL)

The 2021-2022 year saw many registered lasers and IPL providers re-open their services to patients following a period of closure due to the COVID-19 pandemic.

Once these services reopened, we returned to seeking assurance that laser and IPL services were safe for patients through our Quality Checks.

During this period, we conducted 15 Quality Checks and one onsite inspection of laser and IPL registered providers across Wales.

The themes from our work during this time are set out below and providers should use these as learning points, considering whether they can make any improvements based on what we have found and recommended.

Registered laser and IPL services provided us with good evidence of COVID-19 procedures, such as social distancing arrangements for patients and staff in waiting areas. Many services also had comprehensive COVID-19 risk assessments in place. It was reassuring to find that many of the services had taken time during their period of closure to understand the COVID-19 regulations and put safe practices in place to reduce the transmission of COVID-19. We found that nearly all providers ensured that a face-to-face consultation was carried out on prospective patients prior to the start of any treatment. They also ensured consent was obtained from patients ahead of treatment taking place.

During our Quality Checks we discovered that not all providers had an up-to-date safeguarding policy. Safeguarding policies and procedures which are accurate and up to date are an important means of supporting safe practices. We also noted that not all providers had a valid set of local rules that refer to the current IPL device in place. Local rules are set by the Laser Protections Adviser (LPA) which outline the safe and correct use of the laser machine. Providers must have a contract in place with an LPA to be able to provide laser treatments safely and legally.

Many providers were required to update their Infection and Prevention Control Policy.
By ensuring the policy is up to date, providers can be assured that staff and patients are protected infectious diseases and infections.

Nearly half of the providers did not have a policy in place which outlined how the service would approach the need to communicate and provide information in Welsh should the patient request it. Standard 18 of the National Minimum Standards of Independent Health Care Services in Wales[4] states that services should comply with legislation and guidance to ensure effective, accessible, appropriate and timely communication and address all language and communication needs.

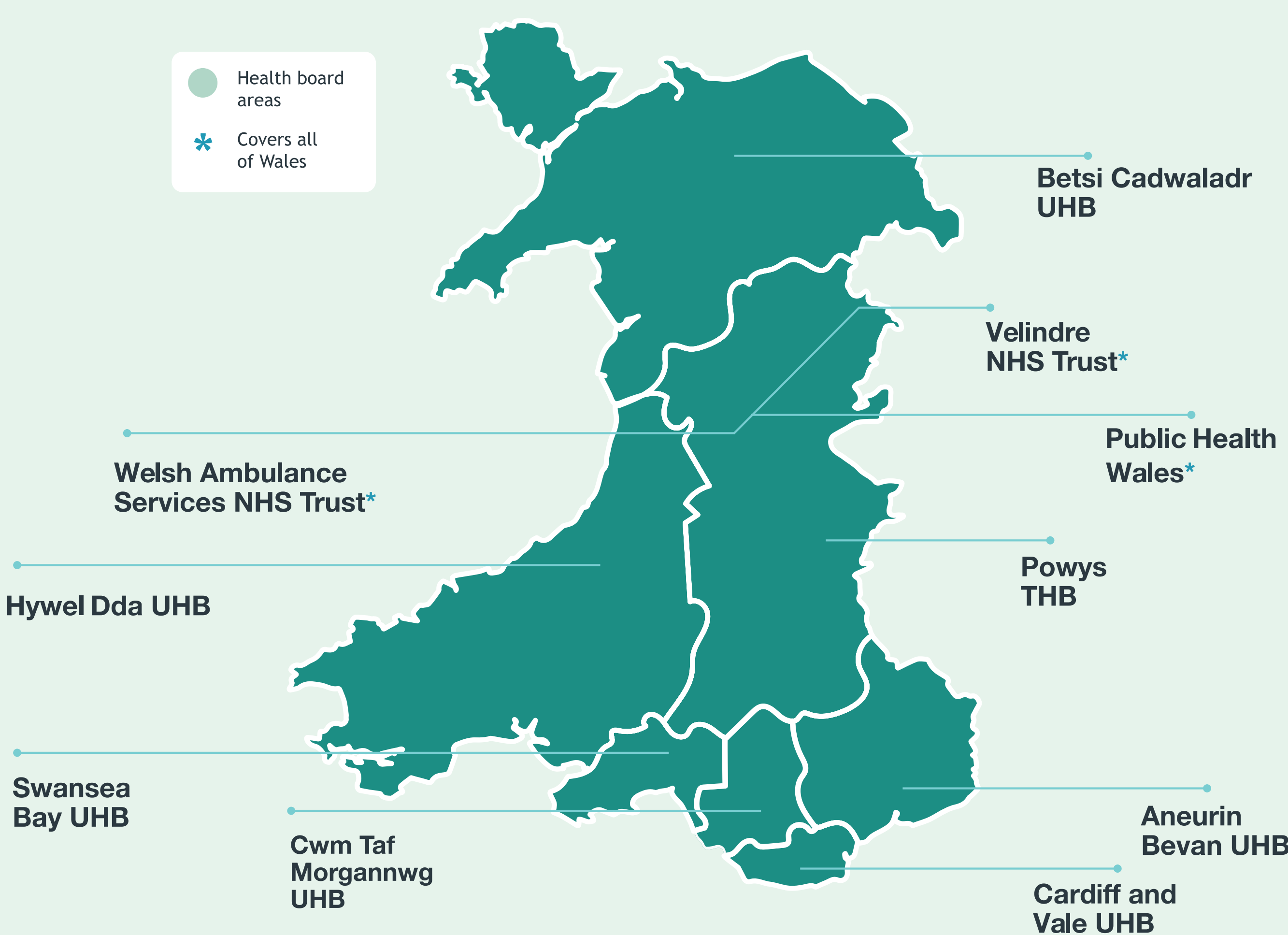
[4] https://gov.wales/sites/default/files/publications/2019-07/the-national-minimum-standards-for-independent-health-care-services-in-wales-2011-no-16.pdf

NHS Health Boards and NHS Trusts

The period covered by this report, 1 April 2021 - 31 March 2022, continued to present healthcare services, and health boards with unique pressures and challenges.

This year they have faced not just the challenge of dealing with COVID-19 itself, but the added challenge of recovering services, tackling long waiting lists and demand for services as a result of many being paused in the initial pandemic response.

Across Wales we noted some common areas of concern through our work; in general, these were pressures associated with recovery of services, waiting times for treatment and significant issues with patient flow in hospitals, and notable pressure and demand on children's services, mental health services and primary care.



Aneurin Bevan University Health Board

514
Total number of concerns (all-Wales)

5
Number of whistleblowing concerns for ABUHB

61
Number of concerns for ABUHB

Below is a breakdown of quality checks and onsite inspections that took place within the health board

Quality Checks	9
GP	5
Hospital	2
Learning Disability	1
Community Hospital	1

Onsite	3
Hospital	2
IRMER	1
Mental Health Hospital	1

Within Aneurin Bevan University Health Board, during the 2021–2022 period, our work to seek assurance on the safety and quality of care within the health board comprised of a mix of Quality Checks and onsite inspections, consideration of the themes and trends presented by concerns and whistleblowing reports received directly by us, and monitoring of data sets and intelligence shared with us from partner organisations who make up our National Healthcare Summit members [Healthcare Summit | Healthcare Inspectorate Wales (hiw.org.uk)]. The view of the health board developed over this time is a culmination of all the above sources of evidence.

During this period, we have seen evidence of Aneurin Bevan University Health Board working hard through difficult times to resolve the issues that have arisen from the pandemic and in specific service areas where there have been particular challenges.

Changes made to governance structures during the pandemic have been carried forward due to the beneficial impact the health board found these had. We noted that engagement with senior leaders continued to be positive and considered that communication between the health board and HIW had shown improvement.

The health board has been proactive in sharing the learning from our assurance and inspection work across its services and has also proactively worked to deliver and embed actions for improvement that we have recommended through our work. The health board has kept us up to date on its progress on a regular basis.

A challenge for the health board throughout this time has been the newly opened Grange hospital. We undertook an onsite inspection to the emergency department and found several issues, some of which required immediate attention to improve patient safety. Staff who responded to our questionnaire told us about feeling pressured and struggling to cope with high levels of demand. High levels of demand for emergency department treatment have been seen across Wales, but this coupled with a new department, new building and new team pose an additional challenge and we urged the health board to continue with the positive input to support the department as it matures as a service.

In many of our Quality Checks, our findings were positive, in particular around access to PPE, with minimal improvements required in any area. However, we were disappointed to note that compliance rates with mandatory training continued to need improvement.

During this period, we noted the health board working hard to maintain service delivery in the face of some substantial staffing challenges. At times, emergency actions have needed to be taken, such as temporarily pausing some services until staffing levels were safe again. Recruitment drives and promoting positive working cultures across services will need to be areas of focus for the health board as it continues to tackle this challenge.

The concerns we received the most for Aneurin Bevan UHB related to:

- **Clinical Assessment**
- **Infrastructure (Staff facilities and the environment)**
- **Treatment / Procedure**

Betsi Cadwaladr University Health Board

13 Number of whistle blowers for BCUHB

102 Number of concerns for BCUHB

Below is a breakdown of quality checks and onsite inspections that took place within the health board

Quality Checks	7
GP	3
Hospital	2
Learning Disability	2

Onsite	4
Mental Health Hospital	2
IRMER	1
Learning Disability	1

Within Betsi Cadwaladr University Health Board, during the 2021–2022 period, our work to seek assurance on the safety and quality of care within the health board comprised of a mix of Quality Checks and onsite inspections, consideration of the themes and trends presented by concerns and whistleblowing reports received directly by us, and monitoring of data sets and intelligence shared with us from partner organisations who make up our National Healthcare Summit members [Healthcare Summit | Healthcare Inspectorate Wales (hiw.org.uk)]. The view of the health board developed over this time is a culmination of all the above sources of evidence.
During the period in question, the health board had recently come under the leadership of a new Chief Executive, Jo Whitehead, who was appointed in January 2021. We noted positive evidence of change at this most senior level through open dialogue and a commitment to working together with us and other partners to help bring about change and improvement in services throughout the health board.

We noted that the culture in many areas across the health board still required work to ensure that staff feel empowered to challenge issues and raise concerns. It is critical that the health board continue to work on this area, empowering staff and developing a culture where staff feel confident to raise concerns and constructively challenge.

As a result of ongoing concern about standards of care in mental health inpatient services at the health board we conducted two onsite inspections to the Hergest unit. We were concerned to find issues relating to staffing levels and significant staff fatigue, and infection prevention and control during our inspection work to Hergest.

The health board responded constructively to the challenges we raised as a result of this work, but continued input from the health board will be necessary to bring about and sustain the level of improvement needed in this service. We will continue to monitor the progress made against the specific recommendations we made following our inspection to Hergest and will consider how the learning is shared to other services across the health board.

Poor record keeping was also an area of concern emerging through our ongoing work and monitoring of the health board. As a result of this emerging trend, we specifically focussed on record keeping in work within the health board during this year. We undertook an offsite Quality Check of the emergency department at Ysbyty Glan Clwyd in March 2022, with a significant focus on the evidence drawn from patient record keeping. We found a high level of risk to patient safety through this work and requested the health board take immediate action to reduce the risk. The outcome and findings of this work have contributed to the overall view of this specific service as an emergency department in Wales. We will continue to monitor the progress the health board makes in this specific department and how the learning is shared and used to shape improvement across their services.

The concerns we received the most for Betsi Cadwaladr UHB related to:

- **Infrastructure (Staff facilities and the environment)**
- **Whistleblowing**
- **Clinical Assessment**

Cardiff and Vale University Health Board

514 Total number of concerns (all-Wales)

4 Number of whistle blowers for CAVUHB

37 Number of concerns for CAVUHB

Below is a breakdown of quality checks and onsite inspections that took place within the health board

Quality Checks	6
GP	5
Hospital	1

Onsite	3
Hospital	1
IRMER	1

Within Cardiff and Vale University Health Board, during the 2021–2022 period, our work to seek assurance on the safety and quality of care provided by the health board comprised of a mix of Quality Checks and onsite inspections, consideration of the themes and trends presented by concerns and whistleblowing reports received directly by us, and monitoring of data sets and intelligence shared with us from partner organisations who make up our National Healthcare Summit members [Healthcare Summit | Healthcare Inspectorate Wales (hiw.org.uk)]. The view of the health board developed over this time is a culmination of all the above sources of evidence.

Through our assurance work, we did not identify any significant concerns during the year. However, we noted a significant increase in demand for services, as the health board began recovery form the pandemic. This was also evident within the University Hospital for Wales Emergency Unit, which saw a rapid rise in demand at a time where additional measures were required to help maintain adequate infection prevention and control. The health board is undertaking a significant amount of work to improve the infrastructure, environment, and processes to manage this. We also noted significant pressure within the health board's Mental Health services including Child and Adolescent Mental Health Services (CAMHS).

This includes the timely compliance with referral, assessments, and treatment times. However, the health board has made progress with some improvements already in these areas.

Bed availability within inpatient CAMHS units nationally, is at a premium. Challenges remain in the health board, with its ability access CAHMS inpatient services in other localities.

As a result, where children and adolescents require inpatient treatment, and beds are not available in a specialist unit, some patients require admission to general paediatric areas, with the support of registered mental health nurses, and at times, older adolescents have been admitted to the adult inpatient services located in Hafan Y Coed. The challenge for the health board will be to sustain and continue improvements in this area, particularly when the demand for CAMHS services remains high. We will continue to monitor our findings for the past year throughout the 2022–2023 inspection year. This will include undertaking planned and reactive inspection and assurance work as necessary, maintaining our relationship manager communication with the health board and partner organisations and through our engagement with service users and staff. This will enable us to check that healthcare services are provided in a way which maximises the health and well-being of people who use services within the health board's hospitals and its community services.

Throughout the year, we identified that the health board teams have continued to work tirelessly during several significant challenges which remain as a result of the pandemic. These challenges include an increase in staff absences and vacancies, stretched services and the resulting impact these challenges can have on staff well-being and patient safety. The health board has been proactive in supporting its staff, with a plan in place to support their health and well-being.

Our engagement with the executive team has continued to be positive and constructive, both to HIW and the health board. There has been number of changes within the executive team which included the appointment of a new Chief Executive, and the recruitment process in place to obtain additional key executives, which included the Executive Director of Nursing, Medical Director, and Chief Operating Officer. We endeavour to maintain our positive relationships with the executive team and other senior leaders.

The concerns we received the most for Cardiff and Vale UHB related to:

- **Infrastructure (Staff facilities and the environment)**
- **Mental Health Act**
- **Clinical Assessment**

Cwm Taf Morgannwg University Health Board

Below is a breakdown of quality checks and onsite inspections that took place within the health board

Quality Checks	9
GP	3
Mental Health Hospital	3
Learning Disability	2
Hospital	1

Onsite	5
Hospital	3
IRMER	1
Mental Health Hospital	1

Within Cwm Taf Morgannwg University Health Board, during the 2021–2022 period, our work to seek assurance on the safety and quality of care within the health board comprised of a mix of Quality Checks and onsite inspections, consideration of the themes and trends presented by concerns and whistleblowing reports received directly by us, and monitoring of data sets and intelligence shared with us from partner organisations who make up our National Healthcare Summit members [Healthcare Summit | Healthcare Inspectorate Wales (hiw.org.uk)]. The view of the health board developed over this time is a culmination of all the above sources of evidence.

Overall, we found that the health board was continuing to make progress against the joint Audit Wales and HIW review of governance conducted in 2019. Both organisations jointly followed this up during 2020, reporting in May 2021. We found that there was a greater strategic focus on quality, safety and risk than had been previously found. However, we noted that it was too early to fully assess the effectiveness of the improvements and consequently we will be undertaking a further follow-up review during 2022-2023.

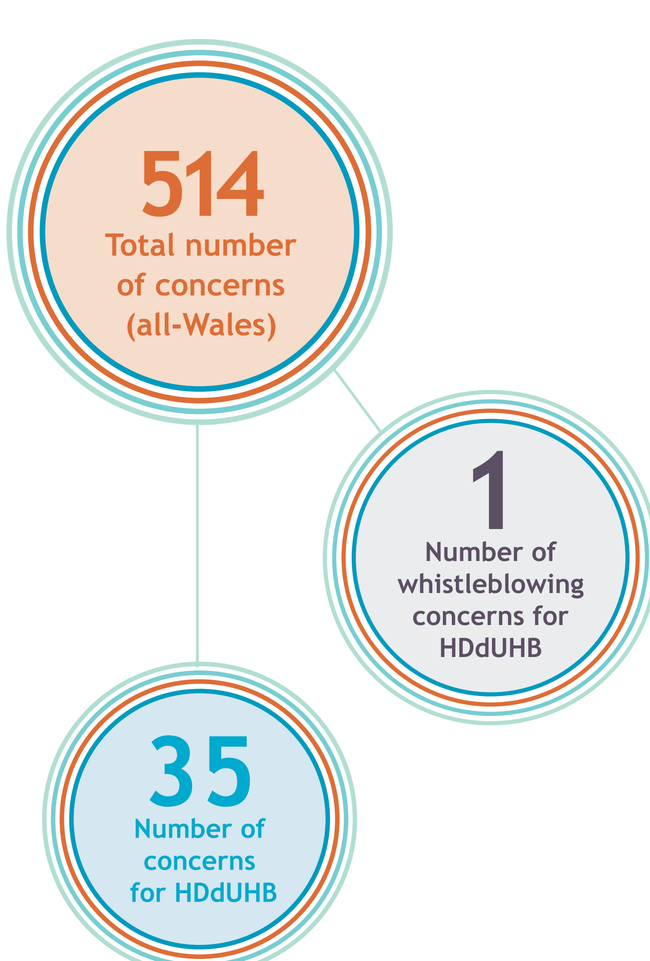
As a result of growing concern about the Emergency Department in Prince Charles Hospital, we carried out an unannounced inspection of the unit. We had significant concerns about patient safety and the potential high levels of risk to patients because of our findings. We were pleased that the health board responded very positively to our findings, noting their openness and willingness to work on tackling and addressing the issues we had highlighted through our work. We returned to the department unannounced four months later to consider their progress and could see several improvement initiatives in place which were already beginning to make a difference. We noted, however, that there were still areas which needed more work and urged the health board to maintain the momentum behind the improvement.

A challenge for Cwm Taf Morgannwg University Health Board will be around sustaining these improvements. Some of the issues we identified indicated that the culture at the department needed to be addressed. Where there are cultural issues, the challenge of maintaining the impetus and embedding changes may be greater. In a health board that has previously faced challenges with quality governance, it was positive to note the beginnings of change and the progress made by the health board to improve and sustain those improvements. The work done on improving the culture, values and behaviours across the organisation is a positive step for the whole health board but one that will need continued focus to make sustainable change.

The concerns we received the most for Cwm Taf Morgannwg UHB related to:

- **Infrastructure (Staff facilities and the environment)**
- **Treatment / Procedure**
- **Clinical Assessment**

Hywel Dda University Health Board



Below is a breakdown of quality checks and onsite inspections that took place within the health board

Quality Checks	8
GP	2
Mental Health Hospital	2
Learning Disability	2
Hospital	2

Onsite	3
Hospital	2
IRMER	1

Within Hywel Dda University Health Board, during the 2021–2022 period, our work to seek assurance on the safety and quality of care within the health board comprised of a mix of Quality Checks and onsite inspections, consideration of the themes and trends presented by concerns and whistleblowing reports received directly by us, and monitoring of data sets and intelligence shared with us from partner organisations who make up our National Healthcare Summit members [Healthcare Summit | Healthcare Inspectorate Wales (hiw.org.uk)]. The view of the health board developed over this time is a culmination of all the above sources of evidence.

During this period, we have seen evidence of Hywel Dda University Health Board working hard through difficult times to recover services following the early restrictions of the pandemic. Through our engagement with senior leaders in the health board and observing at quality and safety meetings, it has been evident that quality is clearly embedded in their approach to leading the health board, and we have seen a strong focus on a learning culture.

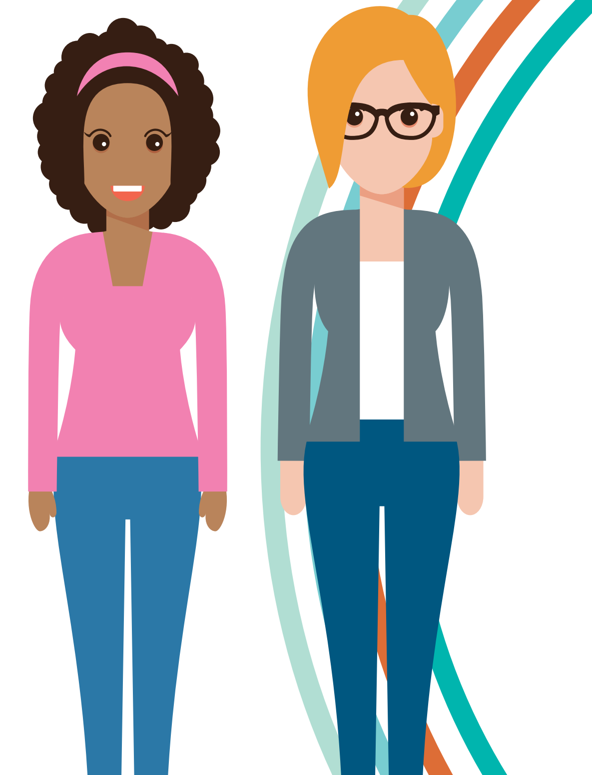
Difficulty in recruiting qualified staff continues to be a challenge for the health board, although there had been an increase in numbers of applicants for roles as healthcare support workers. The health board has continued

to tackle recruitment challenges through initiatives such as the use of an apprenticeship scheme, which enables people to work and gain healthcare qualifications. Resilience across their services has been fragile at times due to the staffing issues and compounded by the rurality and geographical spread of the health board and their hospitals. We note that senior leaders continue to plan and work proactively in an attempt to develop sustainable services for the future.

We carried out an offsite Quality Check of one of the health board's inpatient learning disability services and had significant concerns about the safety of the environment and the day-to-day management of risks in a service which was caring for vulnerable patients. The health board responded very quickly and constructively to the issues we identified and sped up their intention to discharge the patients to alternative placements. This action meant the service was empty and the health board did not admit any further patients for the remainder of the year while they worked to tackle the numerous service delivery issues that were present. We will continue to closely monitor the progress and re-opening of this service through our work and will consider further intervention and escalation if necessary. Through our partnership working with the Community Health Council (CHC), we were made aware of reports of poor patient experience within maternity services provided by the health board. The CHC ran a survey asking for experiences of maternity services within the health board. The results were mixed and saw several negative responses from patients. We engaged with the health board and have monitored their initial response to the issues; the challenge for them will be to fully embed the changes and maintain the momentum behind the improvements. We will continue to engage with the CHC to understand whether the patient experience within these services is improving and will consider future assurance work to check on the improvements in service delivery that have been made because of these interventions.

The concerns we received the most for Hywel Dda UHB related to:

- **Infrastructure (Staff facilities and the environment)**
- **Treatment / Procedure**
- **Self-harming behaviour**



Powys Teaching Health Board

514
Total number of concerns (all-Wales)

1
Number of whistleblowing concerns for PTHB

11
Number of concerns for PTHB

Below is a breakdown of quality checks and onsite inspections that took place within the health board

Quality Checks	2
GP	2

Onsite	3
Hospital	1
CMHT	1

Within Powys Teaching Health Board, during the 2021-2022 period, our work to seek assurance on the safety and quality of care within the health board comprised of a mix of Quality Checks and onsite inspections, consideration of the themes and trends presented by concerns and whistleblowing reports received directly by us, and monitoring of data sets and intelligence shared with us from partner organisations who make up our National Healthcare Summit members [Healthcare Summit | Healthcare Inspectorate Wales (hiw.org.uk)]. The view of the health board developed over this time is a culmination of all the above sources of evidence.

During this period there have been several changes to senior leadership and management within the health board. This includes staff leaving, retiring, and undertaking secondments elsewhere within the organisation. Due to the level of recruitment, this is an area which may take time to stabilise, but it has been positive to note that the executive team is focusing on supporting and embedding leadership changes as a priority in support of their workforce and the continued delivery of frontline patient care.

There has been continued positive engagement with the leadership team, including regular and ongoing meetings with the Director of Nursing and Medical Director throughout the year.

Powys Teaching Health Board commissions a significant proportion of its services from providers in both England and Wales. There are arrangements in place to monitor the performance of the providers used to deliver services to Powys patients via a Commissioning Assurance Framework. However, some of the performance data was paused earlier in the COVID-19 pandemic, therefore this monitoring arrangement has not been fully functional throughout the year. As some services are provided by other health boards and trusts, the restarting of services has been variable, leading to a potential inconsistency and impact on Powys residents.

The health board has been monitoring this closely, reporting issues openly at quality, safety, and performance forums. We will continue to engage with the health board on this to ensure we remain up to date on this complex situation, and we will consider future work to better understand commissioning arrangements.

We undertook an onsite inspection to the mental health ward at Bronllys Hospital and identified that there had been limited improvements to some of the recommendations we had made at an inspection we carried out there in 2019. The lack of progress seemed to be particularly around the buildings and maintenance issues that we had identified. We urged the health board to improve their oversight of this area and make progress on these actions. Since then, it has been pleasing to observe updates provided by the health board to their quality and safety committee regarding the overall progress made against HIW recommendations and their subsequent completion.

The concerns we received the most for Powys THB related to:

- **Infrastructure (Staff facilities and the environment)**
- **Treatment / Procedure**
- **Clinical Assessment**

Swansea Bay University Health Board

Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

3
Number of whistleblowing concerns for SBUHB

33
Number of concerns for SBUHB

Below is a breakdown of quality checks and onsite inspections that took place within the health board

Quality Checks	8
GP	5
Hospital	2
Learning Disability	1

Onsite	4
Learning Disability	1
Mental Health Hospital	1
IRMER	1
HMP	1

Within Swansea Bay University Health Board, during the 2021–2022 period, our work to seek assurance on the safety and quality of care within the health board comprised of a mix of Quality Checks and onsite inspections, consideration of the themes and trends presented by concerns and whistleblowing reports received directly by us, and monitoring of data sets and intelligence shared with us from partner organisations who make up our National Healthcare Summit members [Healthcare Summit | Healthcare Inspectorate Wales (hiw.org.uk)]. The view of the health board developed over this time is a culmination of all the above sources of evidence.

During this period, we have seen evidence of Swansea Bay University Health Board working hard through difficult times to resolve the issues that have arisen from the pandemic and also in specific service areas where there have been particular challenges.

There have been changes in the executive team over a number of years, however, the health board has made new executive appointments, including a new CEO and Executive Nurse Director. We also note the positive impact of stability in the executive team will require time to achieve and will continue to monitor progress through our work.

As a result of negative findings from a previous HIW inspection to Morriston Hospital Emergency Department in January 2020, we undertook an offsite Quality Check to check on progress and to consider how the department was responding to the ongoing challenges of the pandemic. We found that there had been improvements made but a significant demand for emergency care and lack of capacity elsewhere in the hospital due to the high number of inpatients was continuing to be a challenge. We were concerned to find that the training data being maintained by the department was not up to date so we could not be assured that there was an appropriate number of trained staff covering the area. The health board responded positively to this challenge and was able to assure us of sufficient numbers of trained staff by providing additional evidence. Whilst this is one specific example, we noted that demand and capacity challenges were present in other areas, these can present immediate challenges and divert the focus away from longer term improvement work.We were pleased to see that the health board was continuing to look for solutions to demand and capacity issues, such as dedicating the Neath Port Talbot site for planned and elective surgical procedures, supporting a better flow of patients at acute sites and to ensure continued attempts to reduce lengthy waiting lists. We recognise this is an ongoing challenge for the health board which will need to support and maintain the resilience of its workforce to meet continued high demand.

We also carried out a review of the governance arrangements in place by the health board in the provision of healthcare services to the prison population in HMP Swansea. This review was as a result of previous concerns raised by Her Majesty's Inspectorate of Prisons (HMIP) regarding the prison. The evidence we gathered pointed to gaps in oversight by the health board and processes that were not robust enough to ensure an effective service was being provided. The health board responded constructively and positively to our findings on this and will need to continue working on the recommended actions in order to create and sustain improvement.

The concerns we received the most for Swansea Bay UHB related to:

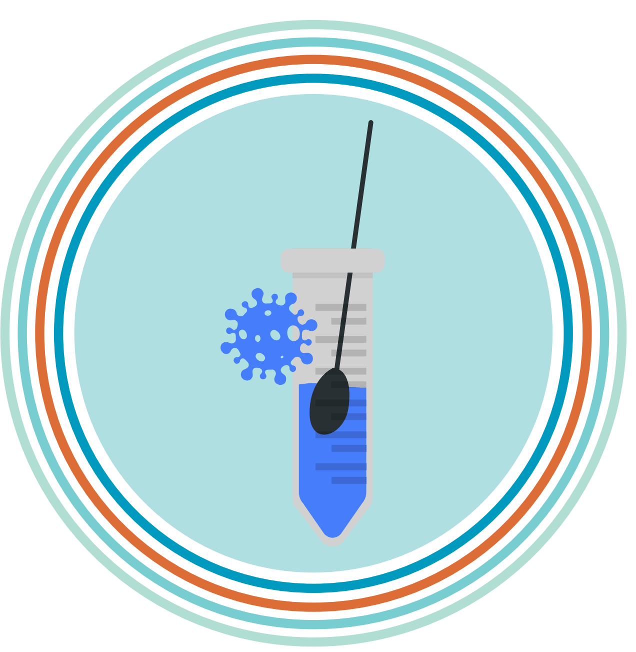
- **Infrastructure (Staff facilities and the environment)**
- **Safeguarding**
- **Clinical Assessment**

Public Health Wales

Within Public Health Wales, during the 2021-2022 period, our work to seek assurance on the safety and quality of care within the trust comprised of consideration of the themes and trends arising from concerns, attendance at quality and safety meetings, engagement with the senior executive team, monitoring of data sets and intelligence shared with us from partner organisations who make up our National Healthcare Summit members [Healthcare Summit | Healthcare Inspectorate Wales (hiw.org.uk)]. The view of the trust developed over this time is a culmination of all the above sources of evidence.

During this period, we observed Public Health Wales providing an important contribution to the ongoing surveillance of COVID-19 rates and communication of this to the public. Health Improvement programmes demonstrated innovation to delivering services remotely. Valued work was undertaken to support schools and businesses look after the emotional and mental well-being of pupils and staff as the nation came out of the pandemic. The delivery of vital public health screening services provided by the trust continued to be impacted by the COVID-19 pandemic. We saw evidence of services working to overcome these challenges in line with agreed recovery plans. Dedicated resource has been invested to tackle demand for each service and find solutions to the loss of community facilities which were used to host clinics pre-pandemic.

We recognised improvements with the recovery of services such as bowel and cervical screening and activities operating at pre-pandemic capacities for services such as breast screening and abdominal aortic aneurysm screening. We have noted the trust has an open and constructive culture amongst their staff and senior leaders which is positive as they continue working post-COVID-19. Through our work and engagement with the trust we will continue to monitor these areas which have been a particular challenge and will consider undertaking assurance work to further investigate issues as appropriate.



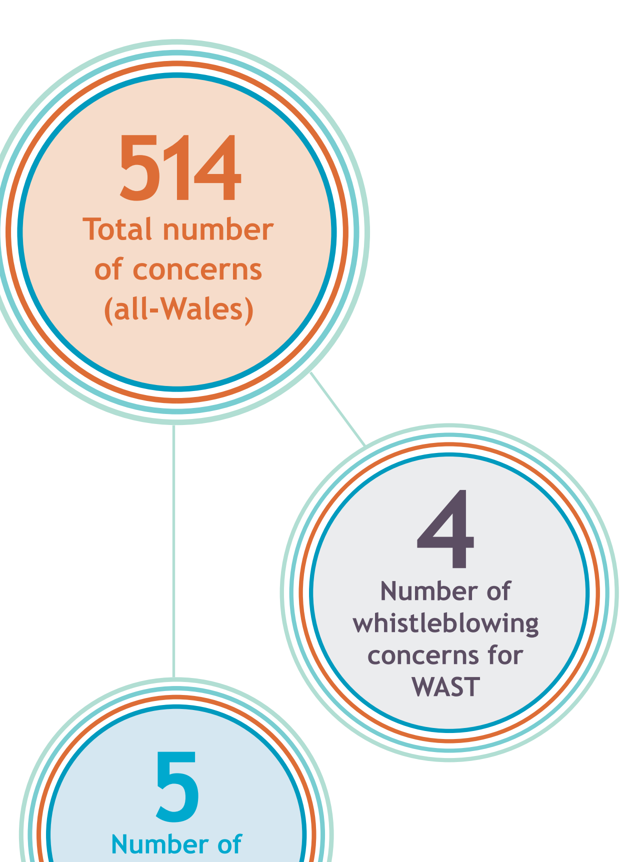
Velindre University NHS Trust

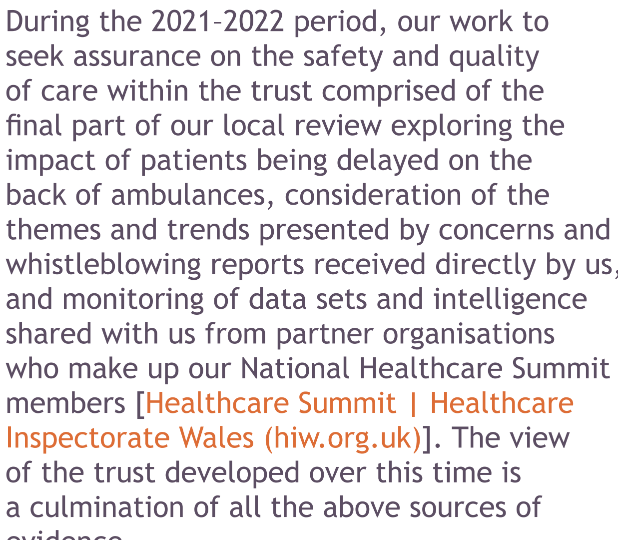
Our work to seek assurance on the safety and quality of care within Velindre University NHS Trust during the 2021-2022 period comprised of an offsite Quality Check of the inpatient service and monitoring of data sets and intelligence shared with us from partner organisations who make up our National Healthcare Summit members [Healthcare Summit | Healthcare Inspectorate Wales (hiw.org.uk)].The view of the trust developed over this time is a culmination of all the above sources of evidence.

We saw evidence of Velindre University NHS Trust working very hard to maintain the services they provide through specialist cancer inpatient and outpatient services, and also across Wales through the Welsh Blood Service. COVID-19 remained the biggest risk to service delivery with staff absences, capacity reductions and increasing patient numbers impacting on the trusts ability to reduce waiting times for treatment and services such as radiotherapy. Attempts to undertake HIW assurance work at the trust were hindered by an increase in infections in early 2022. This work will now take place in 2022-2023 and will provide us with a sense of how services are recovering from the pandemic.

We noted the efforts of the Welsh Blood Service to build and sustain blood stocks throughout the pandemic. We noted evidence of the organisation continuing to plan for future service requirements and monitored progress with the Transforming Cancer Service Programme. We have seen transparent and constructive challenge taking place by independent members on all aspects of the trust at committee meetings.
Engagement between HIW and the executive team for the trust remains positive and constructive, with a welcome for the scrutiny we are able to provide.

Welsh Ambulance Services NHS Trust





During the 2021–2022 period, our work to seek assurance on the safety and quality of care within the trust comprised of the final part of our local review exploring the impact of patients being delayed on the back of ambulances, consideration of the themes and trends presented by concerns and whistleblowing reports received directly by us, and monitoring of data sets and intelligence shared with us from partner organisations who make up our National Healthcare Summit members [Healthcare Summit | Healthcare Inspectorate Wales (hiw.org.uk)]. The view of the trust developed over this time is a culmination of all the above sources of evidence.

During this period, we noted the trust working through highly challenging times to provide their services and expertise across all parts of Wales.

Throughout the year the trust has been very open and honest with HIW, responding promptly to requests for information and data. We observed good levels of scrutiny and challenge at quality and safety meetings and have been assured that senior leaders seem to clearly recognise the issues they are facing and are committed to improvement. However, we also noted ongoing issues in service delivery despite this commitment to improvement.

Staffing has been a particular and significant challenge for the trust as it continues to see COVID-19 related absences impacting their workforce. Military personnel were brought in to support on community response vehicles and whilst this may have provided a temporary solution, once this resource is no longer available, the trust will need to continue to find solutions to their workforce challenge. We realise that this will not be simple to resolve and we will continue to monitor the trust’s approach to service design and workforce planning through our work.

Our local review of patient experience whilst waiting in the back of ambulances found a number of examples where delays in handover had impacted extremely negatively on patients, but also on the ambulance staff providing their care. Staff told us that they were frustrated to find themselves waiting for long periods of time, sometimes entire shifts, waiting outside a hospital to transfer a patient and felt demoralised at not being able to provide care to patients in need of their help within the community. Whilst patients reported being cared for well by the ambulance staff who looked after them, they did not report positively about the length of time spent in the ambulance environment.

We made several recommendations through our review which we recognised were a substantial challenge to the trust and wider NHS system, however, to improve patient safety and tackle the impact on staff well-being, these recommendations must be acted on. The challenge for the trust will be the need to collaborate with health boards across Wales, all of whom have their own unique features and challenges. Supporting the well-being of ambulance staff who provide direct patient care and have direct contact with patients as call handlers will need to be of the utmost priority to the trust as it continues working on the recommendations and through this challenging time.

To be more visible

Collaboration and Engagement

Collaboration and joint working with other organisations are an integral part of the way in which we work. This year we continued to build on the strong relationships we have in place with our partners, once again acknowledging the additional insight this provided and the positive impact on our work that this gave us.

Collaboration

We continued to work with partners to explore how we can share data and intelligence. This included hosting two Healthcare Summits, in May and November 2021.

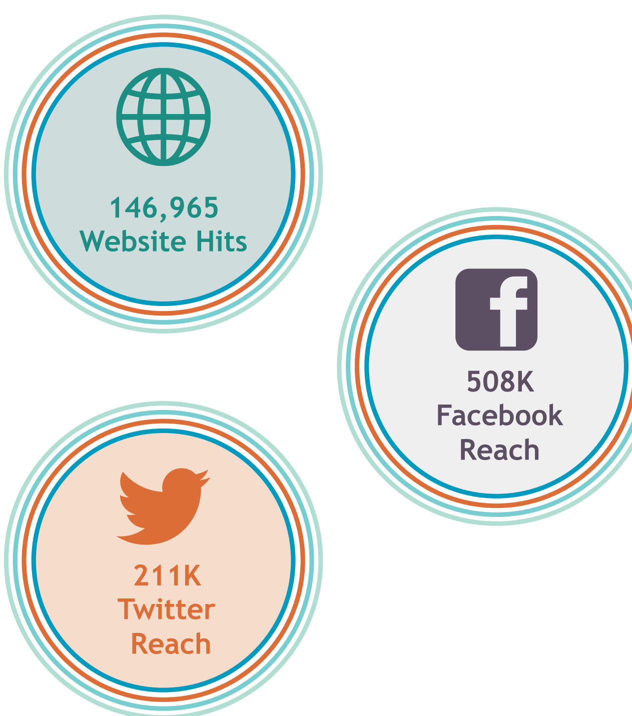
The summits were attended by the key regulatory and improvement bodies for healthcare in Wales. We agreed a collective view on the key national issues and risks across Wales, for example access to Child and Adolescent Mental Health Services (CAMHS). We shared these concerns, on behalf of all partners, with the NHS Wales Chief Executive. The purpose of this was to help us better understand what improvement action is underway at a national level. This forum continued to be a rich and valuable source of information and route for information sharing. We also started working with partners to develop a new mechanism, for members of the Healthcare Summit to share emerging serious patient safety risks and concerns across the sector. The work to develop this new mechanism will continue into 2022-2023.

During the year we continued to work closely with our partner, Care Inspectorate Wales (CIW).

In March 2022 we jointly published our report into the use of Deprivation of Liberty Safeguards (DoLS) in Wales. The safeguards apply to people over the age of 18 in hospitals or care homes, who cannot consent to treatment or care. We worked alongside CIW again, plus Her Majesty's Inspectorates of Probation (HMIP) and of Constabulary and Fire Services (HMICFRS), as well as Estyn, the education and training inspectorate for Wales to review the child protection arrangements in place in the Neath Port Talbot area.

We also work closely with Audit Wales, and in May 2021 we published a report providing detail on the progress made by Cwm Taf Morgannwg University Health Board in addressing the recommendations from our 2019 joint review into their governance arrangements. HIW's clinical team has been actively working in collaboration with training providers and professional organisations to support training delivered by the General Medical Council and to pre-registration nursing students. This supports greater awareness and understanding of the role of HIW in Wales. The clinical team has also been sharing good practice we have identified through our inspection work by signposting health board teams to the services they can approach to learn from.

Engagement



Speaking and listening to people who use healthcare services and who work within healthcare services is of the highest priority to us. By doing this, we can better understand what matters to people and can gain a greater understanding of the culture within a service and insight into the experience patients receive.

During our inspection and review work we ask patients to tell us about the care they receive by completing a short survey, and when we are able to speak to patients in person during onsite visits, we gather views directly. This year, for example, we used a short engaging video on social media to help explain our National Review of Patient Flow and to encourage people to tell us about their personal experience, or the experience of their loved ones if they have been treated for a stroke. In January 2022, we launched a refreshed area on our website, keeping all our surveys in one place and making it easier for people to find out what active work we have ongoing, and provide their comments. Work on our 2022-2025 strategy was a key focus during the year and as part of this we undertook two large scale online surveys open to stakeholders and the public. We used these surveys to help shape our future direction through the increased understanding the responses gave us about the impact of our work on people and services.

In February 2022, we increased our social media presence and launched on LinkedIn. We recognised this as an important additional avenue for engagement with healthcare professionals. We have continued to use Twitter and Facebook to engage widely with social media users about our work, encouraging people to click through to our website where they can find out more about our work and role in Wales. Across our digital platforms we have seen an increase in engagement with a higher number of impressions and a wider reach of our content.

We also developed a new methodology for onsite inspections of Mental Health Units. One important change in this area is the implementation of a process to use questionnaires for patients, staff, friends, and family members. This will increase our engagement with people who use mental health services and those who work within them.

In response to previous feedback from the public that our reports can be hard to understand, we concluded a project to implement a new reporting style for onsite inspections. This new approach was implemented in April 2022 and involves publishing a public summary and a full detailed report for the setting. We also reviewed how we report to remove unnecessary duplication and make the reports easier to read. The outcome of this will be reports that are easier to understand and engage with.

To develop our people and our organisation to do the best job possible

Internal Update

Although the last year has been one of significant change, we have continued to invest in the development of HIW and its people in order to ensure we monitor and check that people in Wales are receiving good quality healthcare. We introduced many new ways of working to continue to fulfil our organisational functions, whilst being flexible to any emerging risks. People are at the heart of what we do, and it is important we strive to share lessons learnt, reflect on what has worked well and take forward this learning to continuously improve.

We listened to and supported the well-being of our people to enable them and our organisation to do the best possible job and keep our communities safe and well. Our Corporate Service department developed a bespoke Learning and Development programme for our staff, tailoring unique opportunities to enable our workforce to build on vital skills. Following the launch and implementation of our internal Well-being Strategy our staff survey scores have shown clear signs of improvement across our key themes including inclusion, leadership and change.

We have also recruited to several new roles including Mental Health Act and peer reviewers to strengthen our access to clinical expertise alongside developing a professional pathway f or all our HIW inspectors. Over the past 12 months we have recruited a number of peer reviewers with experience in specialised nursing roles including stroke and child and adolescent mental health.

We implemented a new Customer Relationship Management system in March 2022. The new system replaced many of our existing spreadsheets and documentation. The system has been successfully rolled out and allows our staff to use data and information more effectively and efficiently to strengthen our ability to generate intelligence and insight. We have continued to work with partners to explore how we can share data and intelligence. This includes early collaborative work to develop a new process for healthcare organisations and partners in Wales to share serious patient safety risks and concerns across the sector.
We have held regular staff forums to discuss lessons learnt, areas of improvement and empower our workforce to have their say.
The forum and anonymous staff suggestion box are monitored and fed back to senior leadership, where ideas, concerns and proposals are reviewed and actioned.

Commitment Matrix

The following table is a list of the objectives HIW set itself for 2021-2022, together with details of how we met the objective.

What we said	Measured by	Outcome
Regulating independent healthcare		
Deliverable 1		
Process applications to register, or changes to registration, in a timely manner. Ensure all applicants can demonstrate they meet relevant regulation and minimum standards.	Registration applications determined within 12 weeks of full and complete submission.	The following registration work was completed during 2021-2022 **Independent Healthcare Services** • 44 New Registrations • 28 Changes of Registered Managers • 12 Changes of Responsible Individuals • 22 Variations of HIW Registration Conditions **Private Dental Practices** • 14 New Registrations • 37 Changes of Registered Managers • 12 Changes of Responsible Individuals • 1 Variation of HIW Registration Conditions

What we said	Measured by	Outcome
Regulating independent healthcare		
Deliverable 2		
Conduct a programme of visits to suspected unregistered providers as required. Deliver a programme of assurance and inspection work on independent settings in line with our frequency rules. Continue to plan and deliver the rest of our work programme in areas where we believe there is the highest level of risk to patient safety.	Number of visits undertaken. Number of Quality Checks undertaken. Number of reports published four weeks following Quality Check. Number of full inspections undertaken. Number of reports published three months following an inspection. Where urgent action is required, following assurance working the independent sector, the service will be issued with a Non-Compliance Notice within two days.	We carried out three visits to unregistered providers. We carried out 91 Quality Checks of independent services. We carried out 34 onsite inspections of independent services. We published 91 Quality Checks during 2021-2022. 75 of these were published within four weeks. We published 34 onsite inspections reports during 2021-2022. 28 of these were published within three months following the inspection. We issued 16 Non-Compliance Notices.

What we said	Measured by	Outcome
Regulating independent healthcare		
Deliverable 3		
Ensure that concerns and Regulation 30/31 notifications are dealt with in a timely and professional manner.	Number of concerns received. Number of Regulation 30/31 notifications received. Analysis of source and action taken.	During 2021-2022 we received 144 concerns from the public or staff. We also received 16 concerns in relation to unregistered providers or settings that do not require registration with HIW. All concerns are reviewed and evaluated on a weekly basis and inform decisions about our inspection activities and priorities. Independent healthcare providers are required to inform us of significant events and developments in their service. These Regulation 30/31 notifications continue to be managed in line with our process and dealt with effectively. In total we received 1,484 Regulation 30/31 notifications. A breakdown of the notifications are as follows: • Death in Hospice - 604 • Death excluding Hospice -28 • Unauthorised absence - 90 • Serious injuries - 483 • Allegation of staff misconduct - 156 • Outbreak of Infectious Disease - 100 • Deprivation of Liberty Safeguards (DoLs) - 23

What we said	Measured by	Outcome
Regulating independent healthcare		
Deliverable 3		
		In total we received 156 Regulation 25 (The Private Dentistry (Wales) Regulations 2017) notifications during 2021-2022. They are as follows: • Serious injuries – 8 • Outbreak of an Infectious Disease – 147 • Allegation of staff misconduct – 1 • Death of a patient – 0 All notifications were evaluated, and additional assurances were sought where necessary.

What we said	Measured by	Outcome
Inspecting the NHS		
Deliverable 4		
Deliver a programme of assurance and inspection work in the NHS across all settings informed by analysis of risk and how our resources are best deployed. Continue to plan and deliver the rest of our work programme in areas where we believe there is the highest level of risk to patient safety.	Number of Quality Checks undertaken. Number of reports published five weeks following Quality Check. Number of full inspections undertaken. Number of reports published three months following an inspection. Where immediate assurance is required following an NHS assurance process, letters will be issued to the Chief Executive of the organisation within two days.	We carried out the following Quality Checks and inspections: **Quality Checks** 25 GP 10 NHS Hospital 5 NHS Mental Health Hospitals 8 Learning Disability 1 Step Down Community Hospital **Onsite Inspections** 8 NHS Hospitals 7 NHS Mental Health Hospitals 5 Learning Disability 6 IR(ME)R We published 49 Quality Checks during 2021-2022. 26 of these were published within four weeks. We published 23 onsite inspection reports during 2021-2022. 17 of these were published within three months following the inspection. We issued 12 out of 14 Immediate Assurance letters within two days of inspection/Quality Check.

What we said	Measured by	Outcome
Inspecting the NHS		
Deliverable 5		
Continue our programme of reviews including: • Mental health crisis prevention in the community. • Medicines management review. • Focused local reviews; one of these will be a local review of WAST. That will consider thesafety, dignity, well-being and overall experience of patients whilst waiting in ambulances at hospital emergency departments. • COVID-19: Themes and learning from our work. Undertake follow-up work on previously published local or national reviews, including: • Phase one of our National Review of Maternity Services. • Review of Patient Discharge from hospital to GP Practices. • Review of Integrated Care: Focus on Falls. • Substance Misuse Services in Wales. • WAST – Assessment of Patient Management Arrangements within Emergency Medical Service Clinical Contact Centers. • PHW – Assessment of how the breast screening process is managed in a timely manner for women who have an abnormal screening mammogram.	Analysis, production and publication of the review. Publication of terms of reference for these reviews. Commence programme of follow up work.	During the year we published: • COVID-19 National Review • National Review of Mental Health Crisis Prevention in the Community • Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover We also completed our local review of Governance Arrangements at Swansea Bay University Health Board for the Provision of Healthcare services to Her Majesty's Prison Swansea. We started work on our National Review of Patient Flow (Stroke Pathway) and Local Review of Discharge Arrangements for Adult Patients from Inpatient Mental Health Services in Cwm Taf Morgannwg University Health Board.

What we said	Measured by	Outcome
Inspecting the NHS		
Deliverable 6		
Conduct a high-level review of each NHS body through: • Further development of the Relationship Management function. • Producing an annual statement for each health board and NHS trust.	Publication of health board and NHS trust annual statements.	As part of our 2021-2022 annual report, we have undertaken a high level review of each NHS health board and trust. We have produced a statement for each health board and trust, and these can be found in the *'To take action when standards are not met'* section of this report.

What we said	Measured by	Outcome
Our work in mental health		
Deliverable 7		
Undertake a programme of assurance and inspection work on NHS, independent mental health and learning disability settings. Continue to plan and deliver the rest of our work programme in areas where we believe there is the highest level of risk to patient safety. Undertake a minimum of one piece of Learning Disability assurance work in each Health Board area in this inspection year.	Number of assurance and inspection activities undertaken.	During 2021-2022, we undertook the following assurance and inspection work across NHS, independent mental health and learning disability settings: **Quality Checks** • 5 NHS Mental Health Hospitals • 8 Learning Disability **Inspections** • 14 Independent Mental Health Hospitals • 7 NHS Mental Health Hospitals • 5 Learning Disability

What we said	Measured by	Outcome
Our work in mental health		
Deliverable 8		
Provide a Second Opinion Appointed Doctor service for approximately 1000 SOAD requests.	Publication of Key Performance Indicators.	The SOAD services undertook 759 case reviews. These were: • 657 – Medication • 66 – ECT • 36 – Medication and ECT

What we said	Measured by	Outcome
Sharing what we find		
Deliverable 9		
Publish reports from all our assurance activity in accordance with our performance standards.	Publication of reports according to our Publication Schedule. Publication of HIW performance against targets. Publication of Annual Report for 2020-2021.	We published 140 Quality Checks during 2021-2022. 101 of these were published within four weeks. We published 57 inspection reports during 2021-2022. 45 of these were published within three months following the inspection.

What we said	Measured by	Outcome
Sharing what we find		
Deliverable 10		
To actively share our findings and recommendations with stakeholders, service providers and the public to influence and drive improvements in healthcare. In particular in relation to: • Hospital Assurance activity • GP Practices • Dental Practices • Mental Health Act Annual Monitoring Report • Deprivation of Liberty Safeguards (DOLS) • IR(ME)R • Lasers • HIW Annual Report	Publication and dissemination of our findings in a number of ways including: Learning bulletins distributed. Case studies of good practice distributed. Improved website content.	We held regular workshops with Community Health Councils and quarterly summits key stakeholders for the NHS and independent healthcare sector. We issued 19 newsletters throughout the year ranging from updates and guidance to dental practices, winter update to stakeholders, and monthly newsletters. We have supported improvements to our website in 2021-2022 including: • created a new surveys section on our website. • created a new social media feature on our website. • Made regular improvements to the functionality of the website to provide a better user experience including engaging features, streamlined navigation tools and the use of branded imagery.

What we said	Measured by	Outcome
Working with others		
Deliverable 11		
Continue our joint inspection work with UK agencies. Details to be agreed on a quarterly basis.	Number of inspections undertaken.	We carried out 15 death in custody investigations. We undertook two prison inspections with HMI Prisons and HMI Probation.

What we said	Measured by	Outcome
Working with others		
Deliverable 12		
Continue working with other agencies on inspections and influencing best practice. Our five planned reviews with other Inspection Wales and Her Majesty's Inspectorate services are: • Review of Health Board and Trust Quality Governance arrangements (Governance reviews with Audit Wales).	Participation in joint work. Consolidation of the key findings and emerging themes from our joint work, and consider how these can inform our future work programmes.	CIW had involvement in design of work through our stakeholder group for our Mental Health Crisis review. We continued to work with Audit Wales to review Health Board and Trust Quality Governance arrangements. We undertook a JICPA second pilot review with all relevant agencies of child protection arrangements.

What we said	Measured by	Outcome
Working with others		
Deliverable 12		
• CIW providing support to our Mental Health Crisis Prevention review. • Joint Inspectorate of Child Protection Arrangements (JICPA) review (with CIW, Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services, Her Majesty's Inspectorate of Probation (HMI Probation) and Estyn). • Supporting HMI Probation with their joint thematic inspection of community-based drug treatment and recovery work with probation service users (for intelligence to support our Mental Health Crisis Prevention review). • Supporting HMI Prisons with their inspections of prison services in Wales. • Work with the Welsh Government, Care Inspectorate Wales and other stakeholders to review the effectiveness of Regional Partnership Board joint working.		HIW, CIW and Estyn submitted a joint business case to Welsh Government to secure additional funding to continue our JICPA work, to enable us to review processes within a further four local authorities across Wales. Within the plan, we would conclude the work undertaken in six local authorities and will evaluate all JICPA reviews undertaken to produce a national picture within a report, which would be published in summer 2024 once all work is complete. A provisional agreement is now in place for the funding early in quarter one of 2022-2023. HIW continued to work closely with CIW and Welsh Government to undertake work with and assess the effectiveness of the regional partnership boards. Our newly appointed Director of Strategy and Engagement will be leading this work through work with the partnership boards and providing regular updates to our review steering board.

Our priorities for 2022-2025

Healthcare exists for people and communities, and the work we carry out looks at whether it meets the needs of a community and whether it is of a good quality. Where we find inequalities in healthcare provision, where a service is not designed for the needs of the community it serves, we will challenge this.

Equality and diversity is embedded in the work we do and we consider how healthcare services reach those who face the greatest barriers to accessing quality healthcare.

Our responsibilities in relation to mental health span both the NHS and the independent sector. HIW also works with other review and inspectorate bodies to consider the quality of healthcare delivered in non-healthcare settings such as prisons.

As we head into the next three years we will be working to our new strategy.

Our goal is:

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

These priorities will help us to consider whether healthcare meets the needs of a community and whether it is of a good quality. Equality and diversity will be core to the work we do and our strategy supports us to consider how healthcare services reach those who face the greatest barriers to access, and poorest outcomes in health.

Our Resources

For 2021-2022 we had a budget of approximately £4.3m. Although the pandemic impacted our ability to deliver a full programme of onsite activity, we continued to make use of our new method for gaining assurance offsite, known as a Quality Check, where appropriate. We strengthened this approach during 2021-2022 following an evaluation of its effectiveness and suitability for its use beyond the pandemic. However, we continued to respond to emerging in-year intelligence which gave us immediate cause for concern or where the risk to patient safety was such that onsite activity was the most appropriate method for gaining assurance.

We have posts equivalent to approximately 83 full-time equivalent staff. We currently have a panel of over 200 specialist peer reviewers with backgrounds including specialist and general nurses, GPs, dentists, anaesthetists, and GP practice managers. We also have specialists in Mental Health Act Administration and a panel of psychiatrists who provide our Second Opinion Appointed Doctor (SOAD) service. We have over 30 Patient Experience Reviewers and Experts by Experience.

The table shows the number of full or part time posts in each team within HIW during 2021-2022.

Team	Whole time posts
Senior Executive	3
Inspection, Regulation and Concerns	39
Partnerships, Intelligence, and Methodology	14
Strategy, Policy and Communication	5
Clinical advice (including SOAD service)	4
Corporate Services (including business support)	18
Total	83

Finance

The table shows how we used the financial resources available to us in the last financial year to deliver our 2021-2022 Operational Plan.

	£000's
HIW Total Budget	**£4,376,000**

Expenditure	£000's
Staff costs	**3,882,624**
Travel and Subsistence	**13,150**
Learning & Development	**18,883**
Non staff costs	**45,944**
Translation	**59,939**
Reviewer costs	**414,358**
ICT Change Program costs	**333,816**
ICT Non CRM costs	**15,102**
Depreciation of assets	**13,866**
Total expenditure (a) £	**4,797,682**

Income	£000's
Independent healthcare	**311,790**
Private dental registrations	**241,900**
Total income (b) £	**553,690**
Total Net Expenditure (a-b) £	**4,243,992**

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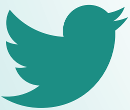
Find us on:



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

PATIENT EXPERIENCE & COMMUNITY INVOLVEMENT QUARTER 2 REPORT (JULY - SEPT 2022)

MEETING	Quality, Patient Experience & Safety Committee
DATE	10 November 2022
EXECUTIVE	Executive Director Quality & Nursing
AUTHOR	Head of Patient Experience & Community Involvement
CONTACT	Leanne Hawker Leanne.Hawker@wales.nhs.uk

EXECUTIVE SUMMARY

This report presents an overview on how the Trust has met its' mandatory responsibility to listen and learn from people's experiences and capture and report on experiences in line with the National Service User Framework (2014); the NHS Wales Planning Framework; NHS Delivery Framework (2018/19); Welsh Government's National Framework for Assuring Service User Experience (2015) and Health Care Standards for Wales (WG, 2015b).

This report covers the period July – September 2022. Throughout this period we have:

- Engaged and listened to people share their experiences and feelings;
- Shared peoples experiences across internal and external forums; and
- Reported back to communities to strengthen confidence that they are being listened too and the Trust is acting to improve services.

Our Continuous Engagement Model enables us to foster trust and stronger relationships across communities as we ensure a flow of information on Trust activities based on people's experiences and feedback. We continue also to provide information on how people can access a range of services, obtain general health information and the skills necessary in responding to an emergency.

The Committee is asked to note the findings of the report and for the report to be shared with external stakeholders for information.

RECOMMENDED: That the Committee approve the Highlight Report for release to the NHS Wales Patient Experience Network; WAST People & Community Network and external stakeholders; and note and support the actions being taken forward.

KEY ISSUES/IMPLICATIONS
The Patient Experience & Community Involvement Team remains committed to its programme of continuous engagement with people and communities, allowing us to provide information and supporting evidence to relevant forums about people's experiences and expectations of services delivered by the Trust. Through this engagement we have also been able to feedback to communities about how their experiences have been shared and what difference their voices have made. A key theme around 'long waits for an ambulance' continues to be a feature with respect to people reporting poor experiences. We are hearing more of people coming to harm either as a direct or indirect result of waiting on the floor and in particular the adverse impact on older people. Family/Carers are also reporting on the psychological impact on witnessing elderly/frail relatives in pain/distress waiting for an ambulance and where the patient has later died (not necessarily as a result of their wait) has left them with painful memories of not being able to 'do anything' in the patients final moments at home.

REPORT APPROVAL ROUTE
Quality, Patient Experience & Safety Committee – 10 November 2022

REPORT APPENDICES
An accompanying Patient Experience & Community Involvement Highlight Report on experience and engagement activities over the last quarter are attached.

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

Patient Experience & Community Involvement Highlight Report

July – September 2022

www.ambulance.wales.nhs.uk @WelshAmbPECI

This report provides information on the different ways we collect service user feedback and experience, what it means, and how we are using it to improve the service. Included within this report is evidence of community engagement work, social media activity and our involvement in public health.

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Overview

Within this reporting period, we have engaged with:

77 Engagement Opportunities Attended	5,960 People Engaged With

This engagement has included:

- Engagement with LGBTQ+ communities; attending Pride Cymru for the first time in three years due to the coronavirus pandemic and participating in a Welsh Government consultation on the LGBTQ+ Action Plan for Wales which will see actions to understand and improve experiences of using NHS service for LGBTQ+ people.

- Engagement with diverse and ethnic minority communities; attending Cardiff Mela. The largest single day multicultural event in Wales, providing opportunity to engage with people from many backgrounds and explore some of the experiences and healthcare issues this diverse community faces.

Patient Reported Experience Measures (PREMS)

- **Your experience of calling 999 – 78 surveys completed**
- **Your Non-Emergency Patient Transport experience - 307 surveys completed**
- **Your experience of calling NHS 111 Wales - 40 surveys completed**
- **Your experience of calling visiting NHS 111 Wales online - 59 surveys completed**

What was good?

The People & Community Network held it's first focus group in support of an NHS 111 Wales advertising campaign.

- *People & Community Network members were invited to participate in a focus group to review and give feedback on a range of creative ideas which had been put forward by an advertising company which could potentially be used to create a winter advertising campaign to raise awareness of NHS 111 Wales. Network members were able to offer feedback and insight into ideas about the campaign in line with their own personal experience, including concerns of digital access for Older People and a desire to see diversity represented in the final campaign.*

What could be improved?

Critical feedback was received from a Stroke Survivors Group

- *At a Stroke Survivors and Carers group in Swansea people were critical of how strokes are categorised within our current response model. People felt they should be given a higher priority when time critical treatment is so important. In general people at the group told us they hadn't had good experiences with the Welsh Ambulance Service.*

Positive Experiences

Compliments

The Trust received **114** compliments between July and September 2022.

From 1st September 2022 we switched to using the new Feedback Module in Datix Cymru to record all compliments received by the Trust. Because of this we are currently unable to provide a breakdown of compliments recorded by function or area.

The feedback module of Datix Cymru, where compliments are now recorded, is undergoing further development based on new user feedback. We are working with the Once For Wales Central Team and sit on both the Coding and Compliments workstreams which will see enhancements made to the system which will allow us to acutely record the number of compliments received and report in more detail which functions these compliments relate to.

I want to thank the 2 paramedics that attended to me yesterday. I may have recalled their names incorrectly but I think they were Sam and Bryn. These guys were absolutely first class. Right from the moment they arrived they were calming, caring, informative, personable, engaging and clearly very well trained. They explained every stage, what was happening, what they would do next and what options we had in relation to my situation. They even calmed my dog who barks at everyone! These guys were a credit to themselves and a credit to the ambulance service. Please pass on my sincere thanks, and whilst I hope in the most polite of ways that I never meet them again, I will sleep a little better at night knowing that those guys, and no doubt many more like them, are out there when we really need them!

Just want to give a huge thank you to both paramedic teams who attended after I had suffered a seizure last Thursday. I cannot thank both enough. It was my 9 year old son who called 999 and everyone from the Welsh Ambulance Service from the call handlers to the paramedics are to be highly commended. Thank you for all your help.

Thank you!!! Received the best care ever, for my son from paramedics. We went from our home address and were promptly transferred to Glangwilli, to get the vital intravenous antibiotics that my son required. Thank you, you were so kind and incredibly helpful and knowledgeable. I really hope you get to see this thank you message, after 5 days in hospital - we are now discharged and he's made a beautiful recovery - this is all thanks to you all, for being so fast at collecting us and helping get us to hospital safely! Thank you!!

The 114 compliments received during this quarter represent a 3% decrease on the 117 compliments received during the previous reporting period.

#ThankYouThursday - Celebrating Positive Experiences

Every month we receive many letters, cards and emails from patients, service users and their families who want to say thank you for the care, support and compassion that our staff and volunteers have shown them at their time of need.

These compliments are captured, staff involved are informed and the number of compliments received is formally reported, but we wanted to do something that celebrated these positive stories a little more. Using the hashtag #ThankYouThursday, we continue to highlight one compliment a week that we share across our social media platforms, and more widely with staff inside the organisation, to draw attention to the many words of gratitude that we receive.

#ThankYouThursday

I would like to thank you SO much for the service my mother received yesterday.

The call handler stayed on the phone to me while the ambulance was coming and was so reassuring. The ambulance arrived much more quickly than I was expecting and the ambulance crew were brilliant.

Because it was all so speedy, my mother had clot busting treatment in good time and is now recovering amazingly well.

I cannot thank you enough.

#ThankYouThursday

Just a quick thank you for a great service to and from hospital today.

My driver was attentive and anticipated my needs - getting in and out of the vehicle, sitting and standing also. I felt safe during both journeys. I couldn't really ask for more.

Well done all round, including the team member who booked the transport for me, who was both polite and efficient.

Thank you.

The Patient Story

Sue’s Story

At the last Quality, Safety and Patient Experience Committee in August we shared Sue’s story. Rather than present a recorded story this quarter, Sue attended Committee in person to share her experience with committee members. QuEST Committee welcomed Sue, the wife and carer for her husband John, who lives with dementia. Sue and John live in North Wales and attended the meeting virtually with colleagues from Betsi Cadwaladr University Health Board.

Sue told the committee about her experience of a long wait for help following a 999 call she made after her husband, who has dementia, fell at home. The experience can be summarised as:

19 hour wait for an ambulance after a fall – no updates on time of arrival

- Sue called for her husband John, who is 82 and has dementia and had fallen at home
- Called 999 at 1.45am 23 July - Thursday morning was told it would be 7 or 8 hours wait.
- Rang at 8am to try and get an update all they could do was take details again, and apologise
- At about 10.00am received call from ambulance triage, then another every 3 hours. Again, no information and just apologies
- About 3.45pm a first responder arrived and he was quite concerned about John's observations and spoke to a clinician who escalated the call to a higher priority. It still didn't arrive until about 8.30pm.
- During the day tried to get help from GP. District Nurses and Social Services, all to no avail
- Once the ambulance arrived everyone was great
- Taken to Ysbyty Glan Clwyd, had x-rays, pain blocker and observations taken and then put back into the ambulance to wait for a bed
- Rapid deterioration in his dementia and concerns raised by hospital staff about whether he would be able to come home at all as Sue would need so much support and rehab.

During the timeframe involved activity across the Welsh Ambulance Service was extremely high and overall system pressures were challenging. On 23 June 281 hours were lost as a consequence of hospital handover delays and on 24 June 228 hours were lost.

Sue recognised that the problem was across the whole NHS system and pointed out that her story was not a complaint but wanted lessons to be learned from it. Sue realised that the issues spanned across the whole NHS; there was limited assistance available for people in the community who had suffered a fall and needed picking up. Sue was reassured by members of the Committee that the Trust Board had raised the concerns with the Health Minister and was doing everything in its power to improve the situation.

It is important to continue to hear these stories which will incentivise the Trust to do the best it can and try and create positive change in the system. This story will also be used to help the Trust to develop its dementia plan and strategy and we plan to record a digital story with Sue to enable her experience to be shared more widely across the Trust.

Engaging with Communities

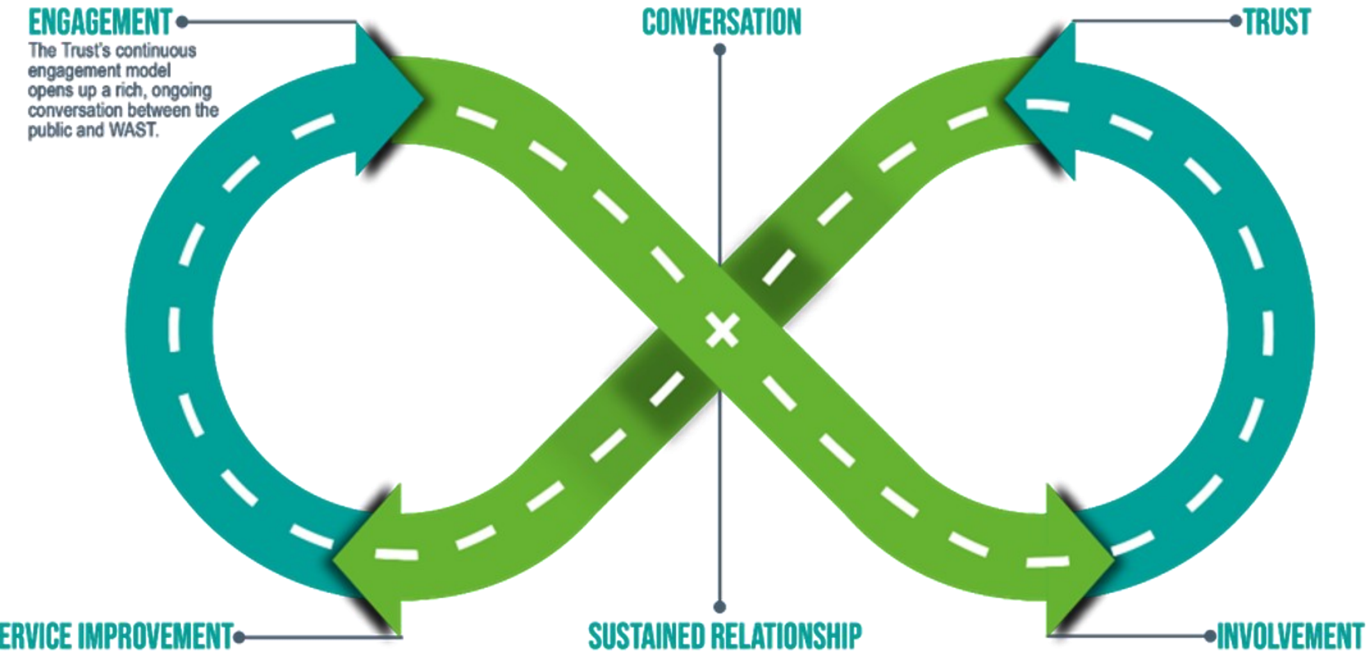
Proactively engaging with people and communities across Wales by attending community events, open days, visiting schools and other forums forms a central part of our continuous engagement model. This face-to-face engagement with people allows us to have meaningful conversations with people about using the services we provide; helping communities to feel listened to and empowered to drive change.

Over the past three months we have attended a range of different events and groups in the community where we've engaged with large numbers of people and have provided information about the Welsh Ambulance Service, we have gathered feedback, promoted volunteering and career opportunities and provided CPR and Defibrillator demonstrations. These have included engagements with:

- Older people's groups
- Ethnic minority communities
- LGBTQ+ groups
- Stroke survivors
- Children & Young People
- Learning Disability groups

Whilst it is difficult to demonstrate an immediate impact or outcomes to this engagement; it is through this ongoing engagement cycle that we are able to build trust and sustained relationships with people and communities.

The introduction of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 will also see new requirements placed on us to ensure we are listening to and acting upon citizen's voices. Our continuous engagement model and new People & Community Network will play an essential role in ensuring that the Trust is actively listening to people right across Wales who use and rely on the services we provide for them.



LGBTQ+ Community

In August we were extremely pleased to be able to return to participating in Pride Cymru celebrations. The annual Pride Cymru event in Cardiff is Wales' largest celebration of equality & diversity and offers a great opportunity for us to engage with the LGBTQ+ community whilst allowing our staff and volunteers a chance to celebrate their own diversity.

During the event the Welsh Ambulance Service together with over 400 colleagues from across NHS Wales led the pride parade through the streets of Cardiff. We also hosted a Welsh Ambulance Service information stall in the event's Marketplace area. We used the opportunity to ask the LGBTQ+ community about their experiences and expectations of using the Welsh Ambulance Service. Most people we spoke to had positive things to say, though some still felt anxious about how they'd be treated if they need to use NHS services:

"It's hard being a Trans person right now, there's so much judgement and misinformation out there. Getting ill and needing to access healthcare services as a Trans person is one of my biggest fears. I'm so scared the people who are supposed to be there to help me won't understand my situation or that they'll treat me differently because of their own views about Trans people"

During this quarter we also participated in a Welsh Government feedback session about the LGBTQ+ Action Plan for Wales which is currently being drafted. Of note for us was an aim within the plan to 'Understand and improve the experiences of LGBTQ+ people when accessing health and social care services'. Welsh Government colleagues are keen to engage with Patient Experience Teams at Trust's and Health Boards across Wales to ensure consistent reporting mechanisms are in place that will allow us to monitor experiences of LGBTQ+ people who use and access our services. We have incorporated this requirement into our current workplan and will work with colleagues across NHS Wales to consider how we ensure consistency.

Stroke Patients

We were invited to attend a Stroke survivors and carers group in Swansea during September. At the group we spoke about how the Welsh Ambulance Service wants to engage with communities and use their feedback to help improve the quality of services we deliver.

People at the group were very keen to share their experiences with us, with many telling us they didn't feel they had the best experience when accessing services delivered by the Welsh Ambulance Service:

"999 call handlers need to show a bit more empathy and care"

"Some staff are very patronising. Was asked 'how do you know this could be a potential stroke?' I am not stupid; I know about FAST"

"When you call 999 the words used need to be simpler"

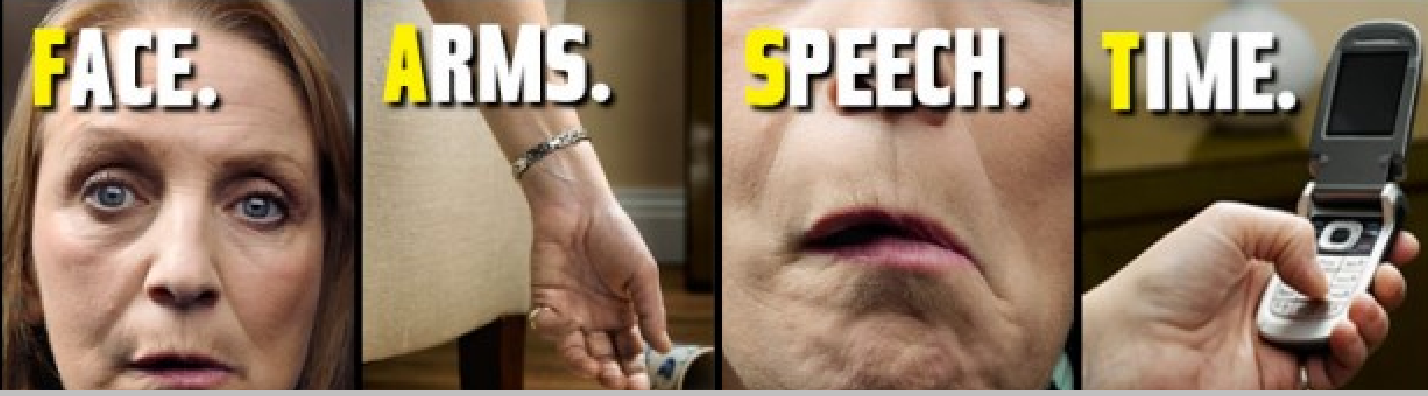
"I have never been able to get an ambulance"

"I would never phone 111 again. Phoned and was told that someone would phone me back within 4 hours. A GP phoned me back and said that I shouldn't have waited so long as I was urgent and needed to be seen immediately"

The categorisation of potential Stroke's into our Amber category was a real sticking point for all people at the group. They all believed this to be wrong and felt that stroke should be given a higher priority:

"Because of the way amber calls are prioritised, my husband didn't get an ambulance in time for him to be given clot busting treatment. He now has no speech and is in a wheelchair. We have 2 carers in four times a day. This is a drain on resources and is a situation that could have been avoided"

Additional feedback captured during this visit centered around information given about ambulance Estimated Time of Arrival (ETA). People at the group told us that in the last couple of months they had experiences of being told that "an ambulance would arrive shortly". People wanted to be given more accurate ideas of ETA so they could make informed decisions about whether to wait for an ambulance to arrive or to look for alternative ways of getting to hospital to receive time critical treatment.



Engaging with people affected by dementia across Powys

The Welsh Ambulance Service have been delighted to work with 'Dementia Matters in Powys', a charity that supports the health and wellbeing of people living with dementia and those who care for them. Together we have held engagement events in Ystradgynlais, Welshpool, Newtown, Llandrindod Wells and Brecon, enabling the Trust to deliver interactive experiences and other activities to people living with dementia, their carers and families.

This engagement work is vital for us to listen and learn from people affected by dementia when using our range of services. In particular we educate people about what to expect when accessing and using our services. Where possible, we bring vehicles out to groups so they can familiarise with our environments.

Wendy from Dementia Matters in Powys said:

"The Welsh Ambulance provides such a valuable service to our local communities. It was nice to be able to talk about the service without having to go through the trauma of an emergency! Thank you and we look forward to having you visit again in the future."

Alison Johnstone, Programme Manager for Dementia for the Trust, who led on this engagement, goes onto say:

"Feedback tells us that our environments can be distressing and difficult for people living with dementia. These opportunities to engage and educate are really important and are a key part of our dementia plan".

An ongoing programme of engagement with Dementia groups right across Wales is planned. You can also find out more about what the Trust is doing to improve services for Dementia patients by reading our Dementia Plan.

Ethnic Minority Communities

Over the last quarter we have continued our engagement with Black, Asian and Minority Ethnic communities. Cardiff was also host to a Multicultural Mela in September, a colourful and vibrant day celebrating the diversity in our communities. The largest single day multicultural event in Wales, it provided us with an opportunity to engage with people from many backgrounds and explore some of the experiences and healthcare issues this diverse community faces.

On the day we were joined by colleagues from the Equality, Diversity & Inclusion Team; Community First Responders from our Volunteer Team as well as by a Non-Executive Director from our Trust Board. We used the event as an opportunity to talk to attendees about working and volunteering for the Welsh Ambulance Service, as well as promoting what we re doing to make our services and information we provide more accessible to people who don't speak English as a first language. We were able to demonstrate the ReciteMe translation feature available on the NHS 111 Wales website, which was really well received. CPR and defibrillator demonstrations were also a huge attraction, with people really interested to learn more about what they could do to help someone in an emergency.

"I'm a GP in Cardiff and having access to the information on NHS 111 Wales in different languages would be very useful to patients in our surgery"

It was great to have a Non-Executive Director from the Trust Board attend with us as well and see firsthand the impact of community engagement, visibility and participation.

"I really enjoyed my time with the team on Sunday. Their passion and dedication is palpable, you could clearly see the positive impact on the public!"

Learning Disability Staff Training

The Patient Experience & Community Involvement Team were commissioned to produce a staff e-learning module, aiming to increase awareness and understanding amongst our staff and volunteers about providing good care to people with a learning disability.

The course, called 'Understanding Learning Disability' is now complete and available for staff to access through the Welsh Ambulance Service Learning Zone.

The e-learning module brings together all we have learnt from 13 years of engagement and learning with the learning disability community and covers the history and themes of the engagement and sets out the common health barriers and inequalities in the context of reasonable adjustments that staff and volunteers at the Welsh Ambulance Service can make when they respond to someone with a learning disability.

The launch of this training marks an exciting point in our engagement with the learning disability community, as we plan to expand our reach to further include people with a severe and profound learning disability. Much of our work to date has been focused on people with a mild to moderate learning disability, developing resources and capturing experiences from those who are able to communicate for themselves. We are currently working with colleagues who work in Local Authority learning disability services to host a series of events that will concentrate on the sensory experience of having basic observations taken and the equipment that our staff use when taking these.

The module has already sparked recognition for the need for supplementary learning opportunities around atypical presentations of pain in the learning disability community, a venture which will see collaborative working with partner organisations, including London Ambulance Service, who have a specialist lead for Learning Disability and Vulnerabilities.

Module 1: Introduction to Learning Disability

It is well documented that people with a learning disability (LD) have a poorer experience of accessing healthcare services than the general public.

WAST have engaged with people with a LD and developed a suite of resources to help the community understand the services we offer, as well as how and when to access them.

This course is a chance to learn about reasonable adjustments you can make to start positively affecting health experiences and outcomes for people with a LD when accessing WAST services.

Children & Young People

Food Fun Wales

Ever year during the summer holidays, the Patient Experience & Community Involvement Team participate in a school based programme called 'Food Fun Wales' which provides healthy meals, food and nutrition education, physical activity and enrichment sessions to primary school pupils in areas of social deprivation in Cardiff. This summer, we visited six schools meeting over 250 pupils to talk about appropriate use of 999 and how to check if someone is awake and breathing. For Key Stage 2 pupils, we also taught them how to do hands only CPR, using a defibrillator and what to do when someone is choking. The visits support the UN Rights of the Child and helps prepare young callers to become resilient members of the community by knowing what to do in an emergency while help is on its way.

7 Important Checks

We know from our engagement that a child's experience of the NHS in an emergency setting can be distressing, so familiarisation is key.

To help children learn about some of the equipment ambulance crews use during their observations, a pictorial information leaflet '7 Important Checks' is now available for distribution. This new resource aims to reduce any anxiety children may have and promote a positive experience.

Royal Welsh and Other Agricultural shows

In August we were pleased to collaborate with colleagues from across the Trust to spend four days at the Royal Welsh Show in Builth Wells. This year marked the Welsh Ambulance Service's biggest ever presence at the show, enabling the organisation to proudly exhibit some of our most modern fleet alongside one of the oldest ambulance vehicles the Trust owns, first used in the 1950's. Clearly demonstrating just how much our service and the care we provide has developed.

Collogues from Save a Live Cymru also attended the event and spent four successful days teaching hundreds of people how to perform effective bystander CPR, where to find a public access defibrillator and how to use one when someone is in cardiac arrest – all with the aim of helping to increase the number of people who survive a cardiac arrest in Wales.

The Trust's Patient Experience & Community Involvement Team used the opportunity to engage with people about their experiences of using our services, as well as providing information about our services and useful tools and resources such as 'The Blue Light Hub' app for children and young people and the What Three Words service which helps to provide a more accurate location when calling emergency services.

I was bailing and nearly had an accident. It's on the far field - I know it as Cae Melyn but the address is the house which is a mile away. You wouldn't know where to come but What Three Words would take you straight to me! I'm going to download it when I get home.

In addition to the Royal Welsh Show, during this quarter we also attended agricultural shows in Pembrokeshire and Monmouth. We know that people living in more rural areas of Wales face particular issues when accessing healthcare services, so ensuring we listen to their needs and concerns is vitally important.

Citizen Voice: People & Community Network

A screenshot of the Network's animated video

Refreshing the Network

- We have produced a multi-lingual animated video promoting the Network which will be shared with current members and colleagues across the Trust in the next few weeks, alongside a press release distributed across Wales, through the Trust's communication channels.
- We continue to work on accessibility of the Network, specifically for people with a learning disability or sensory loss, and for those new to Wales for who English or Welsh is not their first language.

Citizen Voice Body & The Network

- Work continues to reconnect and strengthen the Patient Experience & Community Involvement Teams working relationship with the 7 Community Health Councils (CHCs) across Wales, including the Board of CHCs.
- Over the past quarter we have met with many CHC colleagues and have delivered presentations about the Network and our continuous engagement model to at a range of CHC meetings, including: Aneurin Bevan CHC's Visiting & Participation Panel and South Glamorgan CHC's Continuous Engagement Group.

Focus Group for NHS 111 Wales Advertising Campaign

- People & Community Network members were invited to take part in a focus group hosted by Cowshed Communication, a Cardiff-based PR and Communication Agency, who are designing the current campaign to raise awareness of the NHS 111 Wales service.
- The productive meeting saw Network members sharing opinions and ideas about the campaign in line with their own personal experience, including: concerns of digital access for Older People and a desire to see a diverse range of people in the final advert.
- While the aim of the feedback was to guide Cowshed Communication in their adaptation of the campaign, it highlighted potential concerns that could be addressed at engagement events with the general public, including: clarification on when to call NHS 111 Wales, rather than 999 or a GP; what are the questions asked when someone calls NHS 111 Wales; and access to the NHS 111 Wales service for someone who has a disability, sensory loss, or English is a second language.

Patient Reported Experience Measures

Your Experience of Calling 999

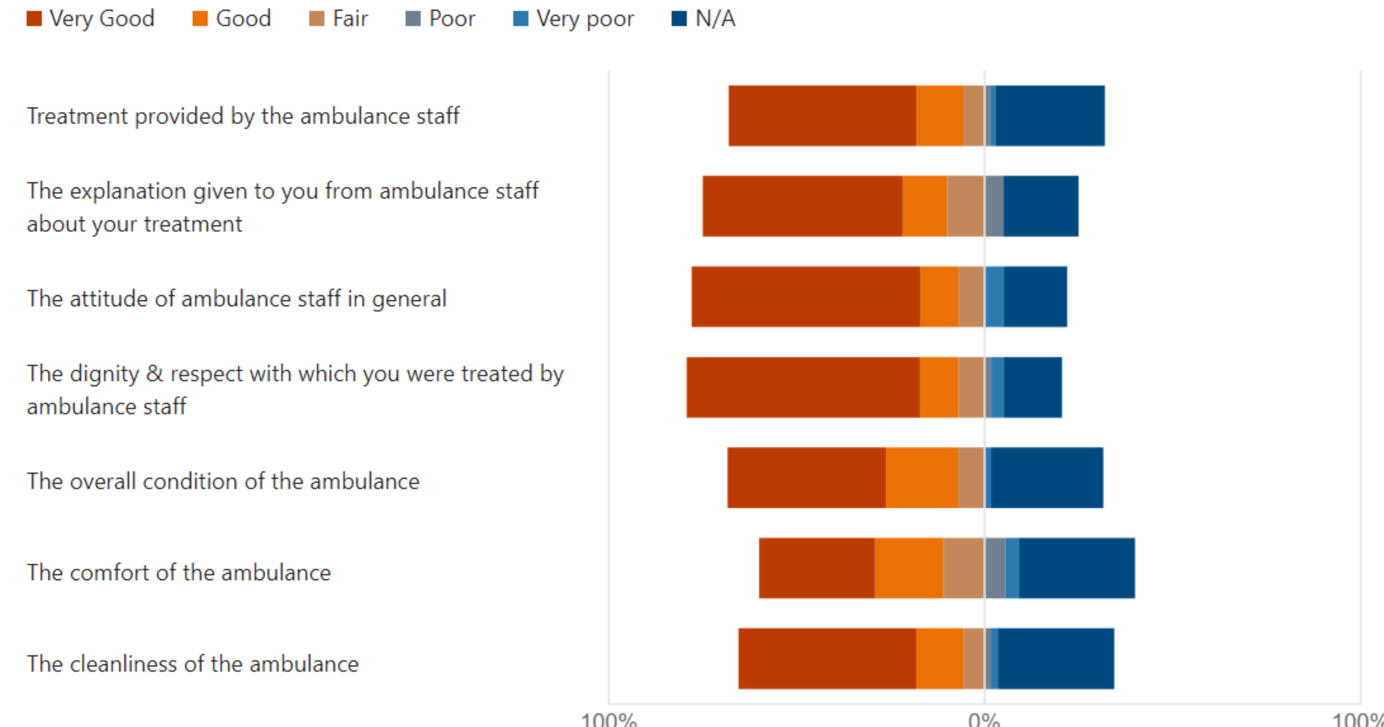
Over the last quarter we have continued to promote a new patient experience survey asking people to share their experiences of calling 999 for help in an emergency. This survey can be accessed online through the Welsh Ambulance Service website and has been promoted publicly across all of the Trust's social media platforms.

From July to September 78 people used the survey to provide feedback. We are still unable to directly contact 999 service users to ask for feedback. Instead, we rely on them seeking out opportunities to provide feedback independently.

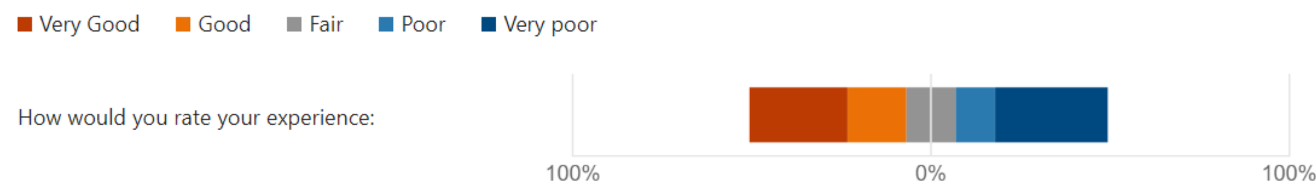
During this quarter, responses were received from all Health Board areas across Wales.

A majority (58%) told us that this was the first time they had needed to call 999 in the past 12 months, whilst 18% told us they had needed to call 999 at least 3 times in the past 12 months. .

- **69% of respondents said they felt confident in the ability of the person who answered their call to manage the call and provide appropriate advice.**
- **76% 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, 79% said they felt they were given enough advice about what to do next.**
- **Of those who said an ambulance arrived, 45 respondents (58%) said they waited over 1 hour for help to arrive. With 18 respondents telling us they decided to make their own way to hospital after being advised there would be long wait.**



How would you rate your overall experience?



Please tell us why you gave the ratings above:

"He died having waited for 3 and a half hours for an ambulance and stopped counting the amount of times he fitted at 13 - priority still wasn't given"

"Clear concise instructions given by call handler"

"Because of the professionalism and due care and attention they gave"

"The call was in relation to a child and the operator showed no empathy, informed us it would be over an hour wait and then wanted to get of the line. They then proceeded to wish us all the best"

"The call handler and the team that responded were really efficient and helpful"

"I had respiratory failure, couldn't breathe and couldn't get an ambulance"

"The trauma paramedic was there within 5 minutes and the ambulance in 15. They were all reassuring, sorted the problem out and made arrangements for hospital. Excellent"

"The response was horrific, and although the crew were incredible - it doesn't make up for the fact I nearly lost somebody". Of course, this isn't WAST's fault, rather the government given the lack of available crews"

"Prolonged wait for an ambulance, when finally arrived advised a paramedic ambulance was needed and not a non-emergency. A paramedic then turned up in a car ambulance, only to leave and be taken by the original non-emergency ambulance. Felt the staff didn't know what to do"

"My father was having a heart attack and had to wait over a hour for an ambulance. My father passed away"

"My father had chest pain and I was told an ambulance was not available and to take him to hospital myself"

"My 95 year old grandmother waited 15 hours on the floor with a broken hip. No pain relief & no fluids given. She passed away 2 days later, I'm not saying the wait made a difference to the outcome but that 15 hour wait was distressing for my grandmother, the family and the carers"

"3hrs for elderly relative was to long to wait for help!"

"Had I not been available to get to my mother, she wouldn't have survived the wait"

"Rang for an elderly person who was extremely ill but was told better off finding own way as ambulances too busy at least 6 hrs delay"

"Wait for Ambulance was far too long. We were asked for a Family member to take them instead. Difficulty in breathing already on oxygen, over 80. Not urgent enough! "

"Service provided by staff was good Just the staff been let down by the service "

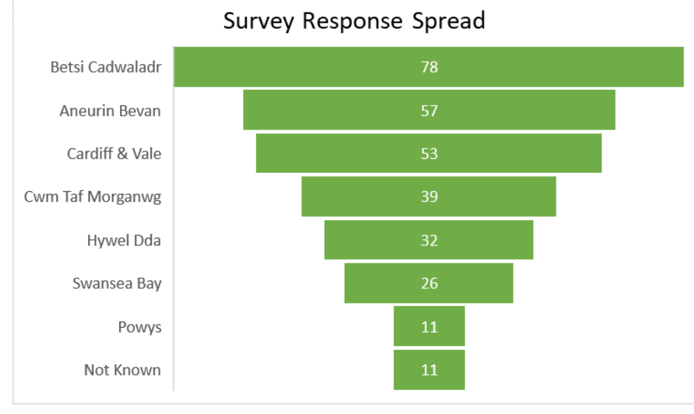
Overall, there was a fairly even split in responses received from people rating their experience as Good verses Poor. Of those saying their experience was poor, long waits in the community for help to arrive is a clear and consistent theme in these respondents' feedback and comments.

Non-Emergency Patient Transport Service

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 patient experiences, and identify areas of good practice and quality improvement opportunities.

Between July and September 2022, a total of 307 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.

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



These results showed us that:

- A majority of people (82%) 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 and waiting for transport to arrive.

What was Good:

"The ambulance people are always polite and helpful"

"Driver of hospital was approachable and made me safe and comfortable to the hospital and return"

"Everyone from the call handler to the 2 gentlemen who took me were amazing, helped me find the right department & then waited outside for me"

What was Bad:

"The seats were uncomfortable for me due to my health conditions"

"Ambulance arrived very late for my appointment, I had to make several call to chase the transport"

"Only the phone call waiting time to get through to book transport"

"Was asked to be ready for 8am for 10am appointment. Transport arrived at 10.15am! I arrived for appointment at 11.15am"

Patient Experience Surveys

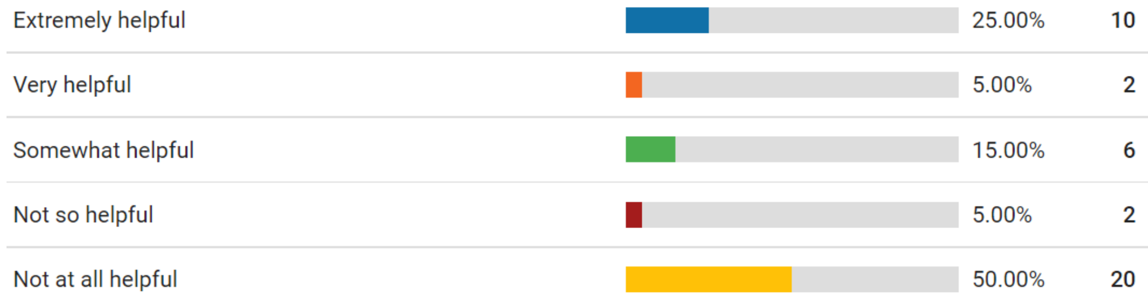
NHS 111 Wales Telephony Service

We have continued to promote a survey, encouraging people to share their experiences with us of calling the NHS 111 Wales service. **Between July and September 40 people completed the survey.** Responses were received from all Health Board areas, providing a mixed response about their experience of using the telephony service.

When asked if they had contacted another service before calling NHS 111 Wales, a majority of people said no, 111 had been their first port of call.

Of those who had contacted another service, people told us they had been advised to call 111 by their GP, pharmacist or Dentist, or

51% of respondents told us they were Dissatisfied or Very Dissatisfied with the length of time it took for their call to be answered (a slight decrease from 53% in the previous quarter). 50% of respondents told us they found their call ‘Not at all helpful’ with 25% saying their call was ‘Extremely helpful’. However, a majority (80%) said they did go onto follow the advice given to them.



50% of respondents said they needed to re-contact NHS 111 Wales at a later time or date for further information or advice about the same health problem.

“Call handled was very efficient no issues - call back was quick however advised that OOH GP would contact and this never happened”

“I rang and spoke to a call handler that was unhelpful. This was the first time I’d ever called. Massively disappointed. The time between my initial call and being able to see a doctor face to face was 13 hours”

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

Patient Experience Surveys

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.

In the last quarter 59 people completed a website experience survey

Just over half of respondents (58%) told us that they didn't find it easy to find the information they were looking for on the website. This is a slight increase on responses from previous reporting periods from people telling us they found it difficult to find the information they need.

In contrast, 34% of respondents said they found it either 'Extremely' or 'Very' easy to find the information they needed, with 30% of people rated their overall experience as Good to Excellent.

What did you like about the website?

"I've had to use it 3 consecutive days so I'm learning. Surely though it should be easy from the outset. I dislike the dependence on web technology. I liked nothing - it is a tool; I don't like the hammer I own"

"A-Z of conditions (when I eventually found it)"

"User friendly and helpful"

"Clear easy to navigate info to the point and easy to follow/understand"

"Photographs of rashes. The best of all the sites I visited . Thank you"

What didn't you like about the website?

"The fact that no one will answer the phone, except an endless recorded message which keeps telling me to use the website, which then still doesn't allow me to speak to anyone"

"Advice" is too general"

"It's archaic out of date and lacks information and resource, having to reuse and revisit is not a sign of a good website its a sign this is all that's available "

Average rating given was 2.56 (out of 5)

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

Social Media

Patient Experience & Community Engagement

Social Media allows us to engage and respond to the public & organisations in real time and keep appropriate use of 999 services and the NHS 111 Wales service at the forefront of people's minds. It's also a great way to capture feedback, share compliments, signpost visitors and demonstrate how users' feedback can influence service delivery.

Twitter Summary, July - September 2022	
	@WelshAmbPECI
Tweet impressions (how many people our tweets have reached)	41,862
New followers	17
Current Number of Followers	4,630

This period's most popular tweet from @WelshAmbPECI was made in September and celebrated the return of Shoctober, our annual schools campaign which aims to teach young people about to do in an emergency, how to perform effective CPR and how to find and use a public access defib. Because of the coronavirus pandemic the campaign has not been run for the past two years, but we look forward to making a return to visiting schools across Wales this October. The Tweet earned 1,900 impressions.

Its been on hold for 2 years, but now our volunteers are back, ready and waiting to launch **#Shoctober**😃 **#educationprogramme #lifesavingskills** Monday we'll be visiting primary schools **@AneurinBevanUHB @NewportCouncil @CwmTafMorgannwg @RCTCouncil @SwanseabayNHS @SwanseaCouncil** pic.twitter.com/G4nnkjs7ox

Social media continues to play a vital role in helping us to engage with people right across Wales. Sharing information about using our services responsibly and offering opportunities for people to interact with us, providing feedback, asking questions, sharing experiences and completing surveys.

NHS 111 Wales Overview

Compliments	Compliments Received
NHS 111 Wales	Because of implementation of the new Datix Cymru system in September, we are currently unable to report specific number of compliments received by NHS 111 Wales.

Huge thanks to NHS 111 Wales and NHS 111 England for dealing efficiently with a complicated call from me, in England, about my mum, in Wales. The conference call system is excellent and the transfer between the systems worked well. Thank you!

	Total Website visits (English)	Total Website visits (Welsh)	Top Page Viewed
July	354,728	730	homepage
August	371,106	556	homepage
September	348,944	653	homepage
Total	1,074,778	1,939	

During this reporting period, the most popular symptom checkers visited were:

- Abdominal Pain – 46,104 views
- Generally Unwell – 32,124 views
- Leg Pain – 28,637 views

Twitter Summary, @NHS111Wales July – September 2022	
Tweet impressions (how many people our tweets have reached)	89,700
New followers	57
Current Number of Followers	7,104

Facebook April – June 2022	
Facebook Reach (how many people our Facebook posts reached)	21,995

Looking Ahead…

Shoctober & Restart a Heart

Schools and volunteers across Wales are now being recruited to take part in this year's Shoctober and Restart a Heart campaigns; teaching children and young people vital life saving skills including effective CPR, how to locate and use a public access defibrillator and what to do when help is on the way.

Launch of New to Wales information pack

The eagerly awaited information pack for diverse communities across Wales is in its final stages, as we collaborate with partners to create suitable illustrations to be used within the information resource. Once launched, this will sit on the NHS 111 Wales website and utilise the ReciteMe tool's translation function.

Easy Read on NHS 111 Wales

Technical issues which had been holding this project up are now resolved and we look forward to launching this new centralised bilingual easy read information section on the NHS 111 Wales website. Working in partnership with a coalition of other organisations including Mencap Cymru, Down Syndrome UK and Learning Disability Wales, this resource will become a central point of access of all health related easy read information across Wales.

Learning Disability Events

Working in partnership with colleagues within Learning Disability Services at Ceredigion County Council, we will be holding a series of engagement events for people with a moderate to severe learning disability and their carers. Our past engagement with the learning disability community has focused on those with a more moderate learning disability, this new work will help broaden our scope of understanding.

Collaboration with Aneurin Bevan Health Board

Working with Aneurin Bevan Health Board and the Welsh Ambulance Service's Value Based Healthcare Project Team we are in the early stages of planning a patient experience survey to gather feedback on people's experiences of using the Hospital Transfer & Discharge Service currently in place at The Grange University Hospital.

NHS Wales Safeguarding Network

Annual Report 2021-22

Multi-Agency Working

All Wales Systems Leadership

Embedding Policy into Practice

Upskilling the Safeguarding Workforce | Regional Round Up | Improvement Tools

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NHS Wales Safeguarding Network
Author: Shamala Govindasamy
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June 2022

About the National Network

The NHS Wales Safeguarding Network (the Network) is a strategic NHS Wales group that meets quarterly and includes members from Trusts and Health Boards, the National Safeguarding Team, Welsh Government and other key stakeholders. In the past decade the Network has successfully linked local and national policy to develop a collaborative approach to safeguarding delivery across the NHS in Wales.

The Network provides; specialist safeguarding support, learning from incidents, shared good safeguarding practice and collects information from current national issues by engaging with existing groups. By ensuring that good practice and areas of development are shared with safeguarding leaders, children and adults at risk benefit from improved safeguarding provision.

Collaboration is embedded in the Network's leadership led by Dr Aideen Naughton from the National Safeguarding Team (NST) and co-chaired by Mandy Nichols-Davis from Hywel Dda Health Board, who both bring invaluable cooperative leadership and expertise.

About the National Safeguarding Team (NST)

The National Safeguarding Team (NST) comprises a team of specialist Doctors, Nurses, a Programme Manager and Business Support Team who work closely with Welsh Government, and the 7 Health Boards and 3 NHS Trusts, to improve safeguarding arrangements across NHS Wales.

The NST facilitates and co-chairs the Network to ensure that collaboration in safeguarding occurs between the Trust, Boards and key stakeholders.

The NST holds a unique position in the Network, providing a national lens to safeguarding activity occurring within the Trusts and Boards and externally across Wales.

Chair's Introduction

Dr Aideen Naughton

Welcome to the Annual Report of the NHS Wales Safeguarding Network. It is my pleasure as the Chair of the Network to demonstrate the valuable work that has been completed across Wales to keep children and vulnerable adults safe.

This report details our key achievements in 2021-2022, a year when the NHS Wales Safeguarding Network continues to be a crucial resource in yet another challenging year. Safeguarding within a global pandemic has changed and shaped NHS Wales in ways that could not have been predicted. As we emerge to living with COVID-19, safeguarding practitioners benefit from innovative practice developed during the pandemic whilst retaining an agile mindset for the challenges ahead as the world around us continues to present new pressures and demands.

A report published by Public Health Wales in October 2021 set out the cumulative impacts of Brexit, coronavirus and climate change together and their combined influences on health, wellbeing and inequalities in Wales. The range of factors that will be impacted by the three challenges, included health, economic, social and security, mental wellbeing, environment and access to, and quality of services. The report highlights how this 'triple challenge' will have direct and indirect impacts on the population providing insights we must be mindful of for future safeguarding practice. At the time of writing the War in Ukraine following the Russian invasion is in its third month. The resultant shockwaves reverberate across the world with escalating fuel prices and inflation pressures as well as the largest migration of refugees since the 1940s. This further compounds the impacts of the 'Triple Challenge'.

Our forward planning and horizon scanning sections demonstrate how the Network is preparing for emergent challenges; mindful that we will need to look forward whilst simultaneously building on the resilience and knowledge base from the last period.

By retaining this agile approach, the Network continues to be an advocate for vulnerable service users.

I hope you find this report informative and that you are able to share it throughout your organisation.

Dr Aideen Naughton
Chair of the NHS Wales Safeguarding Network

As we emerge to living with COVID-19, safeguarding practitioners benefit from innovative practice developed during the pandemic whilst retaining an agile mindset for the challenges ahead as the world around us continues to present new pressures and demands.

Leading and Communicating

Network Collaboration

The Network is a vital and vibrant resource in Wales, with cohort of experienced, credible and valued system leaders in safeguarding who embed the vision of *'A Wales where everyone is safe'*.

Aligning and sharing practice, translating policy and producing resources are a key part of Network business. Specialist sub-groups report into the Network including Looked After Children, the Safeguarding Maturity Matrix, Safeguarding Training and Violence against Women, Domestic Abuse and Sexual Violence provide a structure for more in-depth work using a planned approach.

Stakeholder Communication

- A Network Communications bulletin is widely cascaded to relevant stakeholders. The bulletin collates Network achievements, policy, events, learning opportunities and good practice examples relevant to safeguarding practice.
- Up to date information on the Network is embedded in the refreshed NST website which also stores key safeguarding tools and reports developed by the Network.
- The Network Annual Report is widely circulated to a range of multi-agency stakeholders.

Multi-Agency Working

Partnership Working Principles

The Network adheres to a system wide approach to ensure organisations have arrangements in place to protect and safeguard children and vulnerable adults who are at risk of abuse and neglect.

To this end Network partners outside of NHS Wales include Welsh Government, the Older Persons and Children's Commissioner Offices. Additionally, the Network provides representation at key multi-agency meetings to support the development of ongoing prevention work.

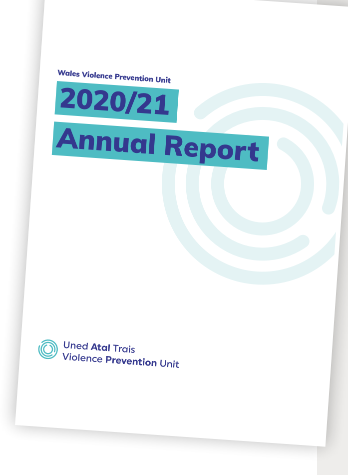
The partnership approach facilitates the sharing of good practice, key safeguarding information and national updates to promote effective specialist support across the organisations and agencies.

Regional Safeguarding Boards

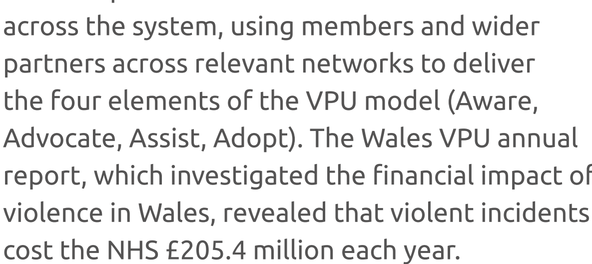
The 6 Regional Safeguarding Boards across Wales co-ordinate multi agency practice, ensuring effectiveness of local arrangements to safeguard and promote the wellbeing of adults at risk, children and young people.

Public Health Wales National Safeguarding Team are members of all Regional Safeguarding Boards providing independent expertise to the work of the Boards to support agencies across the region. As Network representatives they contribute to the ongoing development of the multiagency work and support innovative solutions to overcoming any barriers identified to successful multi-agency working.

Wales Violence Prevention Unit



The Wales VPU (VPU) aims to embed a public health approach to violence prevention across the system, using members and wider partners across relevant networks to deliver the four elements of the VPU model (Aware, Advocate, Assist, Adopt). The Wales VPU annual report, which investigated the financial impact of violence in Wales, revealed that violent incidents cost the NHS £205.4 million each year.



Through associate membership, the Network continues to support the Wales VPU to develop collaboration, community consensus, co production and long-term ambitions that violence prevention should be reflected in all national policy.

More specifically, the NST have collaborated with the VPU to improve the way in which NHS Female Genital Mutilation (FGM) statistics are stored and collated. The VPU have now taken responsibility for collecting the data with a view to formulating a regular reporting framework.

All Wales
Systems Leadership

Looked After Children

Context

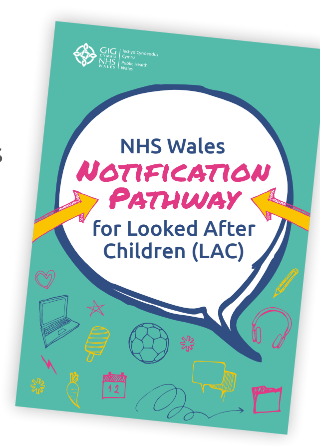
On 31st March 2021 a total of 7,625 children were looked after in Wales, an increase of 2% from the previous year representing 115.3 looked after children per 10,000 of the under 18 years population. Of these, 70% were living with foster carers, 16% were living with their parents (or another person with parental responsibility) 7% were in secure units, children's homes or hostels, 3% were adopted and 2% were in residential schools or living independently. 7% of these children and young people had experienced 3 or more placement moves during the year 2020-2021. 220 children left care via a special guardianship order (89% of which were granted to the child/young person's former foster carer) and 266 children were adopted.

7,625 children
were looked after in Wales, an **increase of 2%** from the previous year.

Network Leadership Activity

The Looked After Children Steering Group, managed by the Network, is the vector for providing leadership for health professionals working with looked after children and young people across Wales bridging vital strategic arrangements at local level and national policy developments. This is achieved via quarterly meetings led by the Designated Doctor for Looked After Children, adoption and fostering. →

Activity over the last period includes:



- Collation of reflections and lessons learned during the COVID 19 pandemic.
- Updating the All Wales Notification Pathway to include a more comprehensive risk assessment.

The group is also currently working on the development of a Client Satisfaction tool for use by Looked After Children and Young People following their statutory health assessment. The feedback will be used to improve services and therefore health outcomes for children looked after.

The Designated Doctor will continue to contribute expertise to the Foetal Alcohol Innovative Collaborative to develop appropriate services and diagnostic pathways in Wales for unborn children exposed to alcohol.

Future Activity

- Evaluation of the Looked After Children Health Assessment Framework to establish the impact of the tool on the quality of health assessment since its implementation and to identify further improvements.
- Reviewing health board services for Looked After Children and Young People to assess regulation compliance to identify strengths, weaknesses, delivery gaps as well as how the service has adapted during the pandemic to inform future practice.
- Working collaboratively with the Welsh Government and the National Adoption Service to create a standard operating procedure for use of NHS numbers following the granting of an adoption order.

Violence against Women, Domestic Abuse and Sexual Violence (VAWDASV)

Leadership Governance

The NHS Wales VAWDASV Steering Group works with the Trusts and Health Boards to ensure that governance processes are in place to collate, review and share good practice. Steering Group members collaborate to increase the knowledge relating to VAWDASV across NHS Wales whilst maintaining a health-based voice and influence across policy makers.

A series of speakers gave updates on the following topics: -

- Welsh Government - Evaluation of Welsh Government Wales Ask & Act Training
- Welsh Women's' Aid - the role health plays in relation to VAWDASV
- SARC (Sexual Assault Referral Centre Regionalisation Project - update on the Independent Sexual Violence Advocate (ISVA) provision.

Review of National Strategy

Network representatives attended Welsh Government consultation meetings to review the National VAWDASV Strategy, collating input from Health Boards and Trusts.

The revised strategy will include a blueprint plan to enable a multi-agency approach to tackling VAWDASV. The blueprint will a shared governance structure of both devolved and non-devolved bodies and will ensure partnership across public, private and specialist sectors, including representation from health via the Network representation. →

The impact and implications of the Covid pandemic have been discussed at the VAWDASV Steering Group meetings.

COVID-19 and VAWDASV

The impact and implications of the Covid pandemic have been discussed at the VAWDASV Steering Group meetings. This enabled members to discuss any challenges and share good practice. For example, in some areas, training compliance improved due to online training. Additionally, the promotion and inclusion of minority groups in relation to preventing, protecting and supporting survivors of VAWDASV became more prominent.

Planned Forward Activity

- To review how VAWDASV is identified and recorded within all NHS Wales Emergency Departments & Minor Injury Units.
- Seek assurance that Health Boards and Trusts have incorporated lessons learned from the impact and implications of COVID.
- Review of NHS Wales Ask & Act training Group 2 see **Upskilling Section**.

Single Unified Safeguarding Review

Context

The Welsh Government's Single Unified Safeguarding Review (SUSR) aims to create a single review process where a multi-agency approach is required. This approach will incorporate review processes such as Adult Practice Review; Child Practice Review; Domestic Homicide Review; Mental Health Homicide Review; Offensive Weapon Homicide Review. The learning from these reviews will be saved and coded, whereby a final report will be used to inform professional practice via the Wales Safeguarding Repository.

The approach fulfils a need for a more centralised, proactive, structured approach to facilitate learning from reviews of fatal incidents which, although focussed on Wales, will provide a platform to share practice across England and Wales.

Network Activity

The Network has contributed to the Training and Development Sub group which has created a training and development framework for Approved Chairs and Reviewers.

Work continues to develop the draft SUSR Training Resources in line with the Learning and Development Plan. Best Practice examples will be considered to enhance this work.

Expert Review

Suicide Rapid Review

Context

In November 2021 an increase in suspected possible or probable suicide deaths in children, occurring over a short time period was identified. Welsh Government commissioned the Child Death Review Programme (Public Health Wales) to undertake a review of the possible suicides in children and young people aged 8-17 years between 1st January and 30th November 2021.

Network Activity

Designated Doctors from the NST provided expertise to the Welsh Government group that considered the findings and next steps. This ensured that Regional Safeguarding Boards were recognised as key stakeholders for receipt of the learning.

Findings

Key themes from the review covered opportunities for preventative activity and consideration of more focussed support.

The vulnerabilities identified were:

- Looked After Children
- Children on the Child Protection Register
- A history of self-harm
- Family known to social services
- Previously bereaved or directly impacted by a suicide
- Living in more disadvantaged or under-served communities

Impact

In January 2022 a letter sharing the lessons was sent to mental health, substance misuse, education, and safeguarding and youth justice services. It reminded all of the importance of vigilance to provide additional support to these vulnerable children at risk of suicide and to ensure a consistent and sensitive multiagency response to unexpected deaths and included guidance on how to support children and young people.

Child Death Rapid Review

Context

In October 2021, the NST Designated Doctor was commissioned by Cwm Taf Morgannwg Safeguarding Board (CTMSB) to undertake an independent rapid review into the deaths of five children in Bridgend. The NST was chosen as an independent safeguarding specialist was required to assess the effectiveness of multi-agency decision making and evaluate the application of current thresholds for risk and harm in Bridgend in relation to child protection and safeguarding. The Safeguarding Board sought assurance that, in light of these 5 deaths, there were no immediate measures or actions required by the Board to safeguard children and young people within this area.

Review Delivery

The review took place over 6 weeks, using a project management approach, and involved reviewing records, minutes, documents and policies to benchmark against best practice and national standards.

A detailed report including 27 recommendations was presented to CTMSB in December 2021; subsequently a plan has been created to address all recommendations.

In addition, an event was organised to explore how well the multi-agency staff in Bridgend felt that they had been supported to date. This supplied valuable feedback for the multi-agency partners and enabled signposting to support resources as necessary.

Feedback

Stakeholder feedback from the review: -

> **"Undertaken within a short timescale and completed to a high professional standard, involving all the right people"**

> **"Thorough, methodical and detailed approach to the task"**

> **"Objectivity and Independence of the review was commendable"**

Improvement Tools

The Network continue to develop innovative methods and products to improve practice, facilitating an assured NHS Wales wide standard for safeguarding.

Safeguarding Maturity Matrix

Context

The Safeguarding Maturity Matrix (SMM) is a self-assessment tool that was launched in 2018 to replace the previous tool known as the Quality Outcome Framework (QOF). The SMM acts as an all-age self-assessment tool to support safeguarding quality improvement across NHS Wales.

The SMM is completed by the 7 health boards and 3 NHS trusts within Wales. The National Safeguarding Team receive the information and collate it to provide a national report of the NHS Wales safeguarding services across Wales.

Measuring the effectiveness and quality of safeguarding provision is an important part of the Networks role within NHS Wales. The ability for Health Boards and Trust to assess their strengths and gaps each year and to use the findings from the SMM tool to direct their own quality improvement plans and the Network Workplan is key.

As such, the SMM enables the NHS in Wales to review its effectiveness and to verify that fundamental safeguarding legislation such as the United Nations Convention on the Rights of the Child 1989, Human Rights Act 1998 and the Social Services and Well-being (Wales) Act 2014 underpins core safeguarding business.

SMM Standards and Self-Assessment

The SMM consists of a set of five standards that underpin the self assessment process: -

1 | Governance and a Rights Based Approaches

2 | Safe Care

3 | Adverse Childhood Experiences (ACE) Informed

4 | Learning Culture

5 | Multi Agency Partnership Working

Each standard includes several example indicators to assist organisations in establishing their self-assessment score. The scoring is out of 5 with 5 indicating a ‘mature’ organisation and 1 indicating ‘basic progress’ with improvements required.

The Trusts and Boards complete the SMM and the related Improvement Plans, including their self-assessment scores. These are then submitted to the NST to inform the national picture of safeguarding and are reported to Chief Nursing Officer in Welsh Government. →

A representative from each organisation was paired with another organisation together with an NST member to act as an independent facilitator.

Peer Review Process

In 2021 the NST coordinated the annual Peer Review process to identify and share examples of good practice and to collaborate for improvement involving 2021 representatives from all the Health Boards and Trusts took.

To adhere to Covid guidance, the process took a different format this year to operate within the Welsh Government Covid guidance at that time. A representative from each organisation was paired with another organisation together with an NST member to act as an independent facilitator. Virtual or in person meetings took place with information shared including annual reports, policies, standard operating procedures, and their safeguarding improvement plans from their latest SMM.

Peer review proformas contributed to an overarching report, and a virtual meeting was held for all small teams to share their learning. Both these activities have informed the forthcoming Network work plan.

CHALLENGES
Raising Awareness throughout NHS Wales
Embedding all related issues in Safeguarding training
Implementing Legislation and Guidance
Competing priorities within organisations
Identifying Individuals in vulnerable groups e.g. NHS workforce, LAC, asylum seekers

RECOMMENDATIONS AND ASPIRATIONS
Actively promote equality and diversity in the workforce reflecting the population that we serve
Encourage and increase awareness of equality and diversity to positively influence the inclusion of underrepresented groups promoting socio-economic developments
Robustly promote The Rights of the Child throughout organisation, for example, by establishing steering groups and promoting participation of children and young people
Consider the impact of COVID-19, including long term, on all underrepresented groups
Promote the use of multi-language and easy read versions of communications

Impact of COVID-19 on socio economic issues, such as BAME, Equality, Diversity and other Human Rights Concerns across NHS Wales

EXAMPLES OF GOOD PRACTICE
- 'Keep Wales Safe' Campaign
- 'Train, Work, Live' Campaign
- Welsh Language Lead
- Equality and Diversity Leads
- BAME Staff Networks (helpline, briefings)
- Patient Involvement and Community Involvement Team

WHAT DOES GOOD LOOK LIKE?
NHS Wales have implemented the COVID-19 Risk Assessment for staff on ESR
Organisational Strategic Policy Guidance acknowledges the Legislation and outlines the expectation of the organisation, Departments and the Staff
Arrangements are in place to acknowledge the needs of those with protected characteristics including age, disability, learning difficulties, race, children and young people, pregnancy, religious belief, language, sexual orientation and those living in poverty.
Where the need for improvements has been recognised a plan is in place to implement and monitor the identified changes. Proposals are included in the Organisational IMTP
Organisational Statutory and Mandatory Training includes BAME, Equality and Diversity and other Human Rights related issues.

LINKS TO OTHER ORGANISATIONS
Welsh Government
Health Education and Improvement Wales (HEIW)
Multi Agency Partnerships e.g. Regional Safeguarding Boards
Voluntary Agencies
Groups representing specific populations

LEGISLATION AND GUIDANCE
Coronavirus Act 2020 (Wales) Regulation
The Health Protection (Coronavirus) Regulations 2020
BAME COVID-19 Socio-economic Report 2020
Human Rights Act 1998
Alerts Levels and restrictions in Wales: Children's Rights 2020
Adoption and Fostering (Wales) Regulations 2020
COVID-19 Workforce Risk Assessment Tool - integrated impact assessment 2020
Assessment of additional measures to manage COVID-19 in Wales 2020
Strengthening and advancing Equality and Human Rights in Wales 2020
A More Equal Wales: The Socio-economic Duty 2020
United Nations Convention on the Rights of the Child 1990

10

11

Tool Revision

During the past year the SMM group (a sub-group of the Network) was re-established and with the support of the NST a review of the current SMM was undertaken. The findings from this review included: -

- A consensus that the SMM was a definite aid to the Health Boards and Trusts supporting them to identify their strengths and gaps and plan their quality improvements.
- The SMM complements other assurance reports, with examples of the SMM standards being used to structure other reports.
- The current standards were mainly considered as useful to structure evaluation.
- The peer review approach was viewed as helpful
- Scoring of quality was subjective and lacked meaning.
- Scoring examples/indicators only give qualitative examples which means that evidence provided in Improvement Plans are also qualitative and anecdotal.
- The standards are not reflected in the current legislation and policy that Health Boards and Trusts are required to meet.
- A lack of inclusion of specific adult safeguarding requirements, particularly with the Mental Capacity Amendment Act (2020) changes impending.
- In light of the NHS response to Covid, the need for a new standard that recognises that organisations are responsive, resilient and purposeful in the face of unforeseen events.

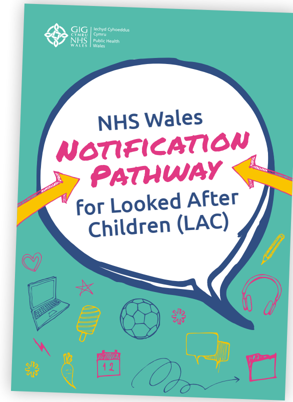
As a result of this review the SMM has been revised with a view to be piloted in 2022-2023. The NST will conduct an evaluation of the pilot and use the findings to inform a final version of a new SMM to launch in 2023.

LAC Notification Pathway Review

Context

Looked after children and young people represent one of the most vulnerable groups in modern society. As a result of their exposure to adverse childhood events most of these children and young people have a multitude of unmet health needs. Additionally, up to 10% of children looked after will experience 3 or more placement moves in any one year which may involve moving to different health boards in Wales or even to another home nation. This can sometimes mean that health needs are overlooked with health appointments being delayed, missed or cancelled. Slow or delayed transfer of health records can have an additional impact on this.

The Pathway



The All Wales LAC Notification Pathway was produced in collaboration with all Health Boards in Wales to facilitate a safe and effective notification process ensuring systems are in place to enable health information and health records to accompany each child. This notification pathway provides standards of good practice for health organisations who are working with children currently looked after by the local authority who have been provided with hard and digital copies of the pathway which has clear and concise minimum requirements for its use.

By utilising the notification pathway, LAC Health Services within NHS Wales are notified of all placements of children or young people who are looked after including pre-adoption placements, change of placements, have a change of legal status, have an adoption order granted or leave the care system. The child's health record and most recent health assessment should follow each child or young person to their area of residence whilst being looked after by the local authority. Through the Pathway's Healthcare Needs Notification Form, NHS Wales will share information relating to the child and young person's general practitioner, dentist and any other relevant health professionals to ensure continuity of care.

Review

Following its introduction in 2020 the Pathway has been used throughout Wales and has been well received both within Wales and beyond. In fact, other regions in England have adopted a similar policy and documentation within their own area having received notifications from Wales using this tool.

Whilst overall the review found the Pathway effective, it was noted that more attention was needed to highlight the general and specific risks of children moving out of area. Therefore, a section specific to risk assessment has been added to the Health Care Needs Notification Form and the refreshed version is due to be circulated and implemented throughout Wales.

Embedding Policy **into Practice**

Changes to Deprivation of Liberty due to the Mental Capacity Amendment Act

The Network tasked a sub-group to help prepare NHS Wales for the Mental Capacity (Amendment) Act (2019), incorporating the transition from Deprivation of Liberty Safeguards (DoLS) to Liberty Protection Safeguards (LPS).

Context

The Mental Capacity Act (MCA) 2005, covering England and Wales, provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to prepare for a time when they may lack capacity in the future.

In some cases people lack the capacity to consent to particular treatments or care that is recognised by others as being in their best interests or which will protect them from harm. Where this care might involve depriving people of their liberty, extra safeguards have been introduced in law to put the person's rights and wishes at the centre of all decision-making.

Currently the Deprivation of Liberty Safeguards (DoLS) are the model to safeguard and protect individuals. A Supreme Court ruling in March 2014 resulted in a very large increase in the number of applications for DoLS authorisations and all public bodies have since seen a constant increase in applications. The House of Lords published a scrutiny report (2014) of the MCA that concluded that DoLS were "not fit for purpose" and recommended they be replaced. In July 2018, the UK Government published a Mental Capacity (Amendment) Bill, that became law in May 2019.

The aim of LPS is to simplify the process so that it will be quicker and less bureaucratic than DoLS so people will have better quality care with minimum restrictions. Amongst other changes it will offer greater involvement for families and extend the scope to include sixteen to seventeen year olds and those residing in domestic settings.

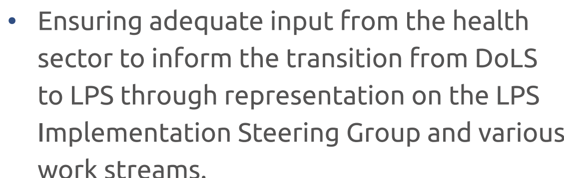
The date for the introduction of the LPS has not yet been decided. It will be finalised after the consultation on the proposed changes to regulations and the MCA Code of Practice.

Activity and Output

An expert group, comprised of representatives from all NHS Wales Health Boards and Trusts and the Office of the Older People's Commissioner (OPC), was convened to carry out this exercise. The group was chaired by the lead GP of the NHS Wales National Safeguarding Team.

Work included:

- Working with the Welsh Government LPS Implementation Steering Group and relevant work streams to co-ordinate the NHS Wales contribution. →



- Ensuring adequate input from the health sector to inform the transition from DoLS to LPS through representation on the LPS Implementation Steering Group and various work streams.
- Providing a consensus view to the LPS Implement Steering Group and work streams through collaborative working across NHS Wales organisations and the Older Persons Commissioners Office,
- Facilitating Health Boards and Trusts to share concerns, best practice and progress towards the transition from DoLS to LPS to enable consistent approaches across NHS Wales.
- Production of a collaborative Network response to the MCA Amendment Act Code of Practice consultation to feedback to the UK government.
- Production a collaborative Network response to the draft Welsh LPS regulations consultation to feed back to Welsh Government.

Forward Activity

The next steps for the Network subgroup are: -

- Finalising the combined NHS Wales response to the consultations on the Draft Regulations and the MCA code of practice.
- Continuing to ensure that the 'voice of health' is represented in the LPS Implementation Steering Groups and work streams.
- Providing a consensus view on a proposed Workforce and Training Framework for Wales.
- Considering the implications of the new regulations and code for the implementation of LPS in NHS Wales.
- Collaborating to ensure a consistent approach to the challenges of the transition to, and the implementation of the LPS in NHS Wales.

System Rheoli Pryderon Unwaith dros Gymru

Once for Wales Concerns Management System

Once for Wales

Overview

The Once for Wales Safeguarding Management System has been designed for health organisations to capture all safeguarding activity, to monitor and action safeguarding incidents, concerns and outcomes and identify key learning to drive forward local improvements and to share those insights across all health organisations across Wales. It is a component of the Once for Wales Concerns Management System (OfWCMS).

It will triangulate information relating to Patient Safety Incidents, including incidents relating to Deprivation of Liberty Safeguards and in the future Liberty Protection Safeguards. Through these actions the system will support organisational safeguarding assurance and facilitate quality improvements to safeguard every individual accessing health services in Wales.

Activity

Over the last period, the sub-group of the NHS Wales Safeguarding Network has led on developing the system to effectively capture safeguarding activity across health boards, incorporating alerts for managers to review organisational actions. Other improvements include the generation of graphical safeguarding reports to highlight risks, trends and themes to support wider organisational learning.

Legacy

An effective system that will capture all safeguarding activity and integrate organisational learning to reduce harm and improve patient safety and safeguards across NHS Wales.

Routine Enquiry into Domestic Abuse Audit

Context

Routine Enquiry into Domestic Abuse involves asking all pregnant women about abuse regardless of whether there are any indicators or suspicions of abuse. Research has shown domestic abuse often starts or is exacerbated in pregnancy.

In the last period the minimum standards of NHS Wales Routine Enquiry into Domestic Abuse for midwives and health visitors have been reviewed to ensure relevance with VAWDASV (Wales) Act 2015

Network Activity

- The revision of the Minimum Standards took place following a multi- agency approach which included collaboration with Welsh Women's' Aid and survivors of domestic abuse.
- All amendments have been incorporated into an agreed revised document which has been distributed to all Health Boards and Trusts to use for audit
- A universal information-sharing protocol has been devised and shared based on an existing process - Sharing Information in Pregnancy (SiP) which was already in use by some Health Boards.

Domestic Abuse Act

Context

The Domestic Abuse Bill for England & Wales was enacted on 29th April 2022. Although this Act includes Wales, the VAWDASV (Wales) Act 2015 remains statute.

The measures in the Act seek to: promote awareness - to put abuse at the top of everyone's agenda, including by legislating for the first time for a statutory definition of domestic abuse. protect and support victims, including by introducing a new Domestic Abuse Protection Notice and Order.

Network Activity

The Home Office are currently leading on a piece of work identifying how the Domestic Abuse Act will affect services and people in Wales in conjunction with the Welsh Government VAWDASV Team. A timeline of this Act has been shared with the Network VAWDASV Steering Group and all Health Boards and Trusts. The Steering Group are currently considering the implications of the Act for health services in Wales.

Ending Physical Punishment in Wales

Context

In January 2020 the Senedd passed the Children (Abolition of Defence of Reasonable Punishment) (Wales) Act which went live on 21 March 2022. The Act aims to protect children's rights and give all children the best start in life. Wales joined over 55 nations worldwide who have already outlawed physical punishment of children. The law removes a 160-year-old defence of reasonable punishment and gives children the same legal protection from assault as the law provides for adults.

Network Activity

Network members have worked with Welsh Government and key stakeholders to ensure that the ground-breaking law is implemented in the best way possible. Welsh Government led a Strategic Implementation Group that oversaw three task and finish groups to consider the requirements of both practitioners and society to implement the Act. Network chair Dr Aideen Naughton took part in a live Q&A panel during National Safeguarding Week November 2021 attended by over 800 participants from the wider public and third sector. Furthermore, Network expertise has shaped a Factsheet to help health professionals understand what they need to know about the change in the law.

Wales joined over 55 nations worldwide who have already outlawed physical punishment of children.

Upskilling the **Safeguarding Workforce**

Network Training Sub-Group

NHS Wales have a duty to provide their employees with access to child and adult safeguarding training to ensure they develop the knowledge and skills required to undertake their roles to competently safeguard children and adults at risk.

The Network has supported this aim through a Training Subgroup to coordinate contribution from all health boards and trusts in addition to input from Health Education and Improvement Wales (HEIW). The group share resources which can be used across NHS Wales and comment on and critique the content of training packages as necessary. Bi-monthly information briefings and safeguarding topics are now being developed to ensure timely accessible information is available to relevant staff within NHS Wales.

Key current work includes:

- NHS representation on the group developing Multi-Agency Safeguarding Standards (see below for further detail), ensuring that the standards are compatible with current health guidelines
- NHS representation on the group developing a Training Framework for multi-agency use.

Future work includes:

- Reviewing consultation outcomes of the Multi-Agency Safeguarding Standards.
- Agreeing the Training Framework for multi-agency use.
- Consideration of a Quality Assurance Framework for safeguarding training events to ensure both consistency and that meet the agreed standards.
- Consideration of a Multi-Agency Training Certification to promote portability of training within and between agencies.

Multi-Agency Safeguarding Standards

About the Standards

The purpose of the standards is to make sure that everyone in Wales receives consistent and good quality training relevant to their role and responsibilities, and that we, as practitioners, can safeguard people to the best of our ability.

Currently there are no multi-agency national standards for safeguarding training in Wales. This means that there is a lack of consistency in the design, content and provision of safeguarding training across organisations in Wales. In some there is also confusion around the appropriate levels of safeguarding training for the workforce.

The aims of the standards are:

- The creation of a set of safeguarding standards that underpin training, learning and development activity related to children and adults in Wales.
- A multi- agency set of standards for all levels of safeguarding, linked to the competencies and knowledge required.
- A way to map specialist topics or "other" safeguarding training outside of the core modules across to the set of standards
- An ability for these to be used across agencies, regions and differing needs within the public facing sectors.

Network Input

The Network are part of a multi-agency national group lead by Social Care Wales to develop Multi-Agency National Safeguarding Training Standards. Current work includes coordination of an NHS Wales response to the latest consultation to ensure the health aspect is understood and included.

Ask and Act Training

Context

Ask and Act training covers an organisational duty to encourage relevant professionals to "Ask" potential victims, in certain circumstances (targeted enquiry) and to "Act" to increase identification of those experiencing VAWDASV to offer referrals and interventions for those identified at the earliest opportunity.

The training upskills professionals to:

- recognise the signs that someone is being abused
- talk to that person sensitively (if appropriate)
- offer options and services to them quickly and efficiently

The Network adapted the existing Welsh Government Group 2 Ask and Act training package to ensure relevance within health settings, and that that service users affected by VAWDASV were appropriately supported.

Evaluation

- The VAWDASV Steering Group will undertake an evaluation of the Ask & Act training package.
- The evaluation will ensure training is up to date and consistent with any new evidence, national priorities and legislation changes, including the emerging Safeguarding National Training Framework.

Next Steps

VAWDASV Network Sub-group to review NHS Wales Ask and Act training to ensure it: -

- Sufficiently addresses the risk to older people in the context of domestic abuse
- Aligns with the emerging safeguarding training standards and framework

Safeguarding Children's Masterclass

Masterclass for Paediatricians

Due to the success of the 2020 event, an additional Masterclass for paediatricians via webinar took place in June 2021.

Sessions covered:-

- Perplexing Presentations (PP) or Fabricated or Induced Illness (FII) in children
- Supporting Sudden Death in Children and Young Adults
- Safeguarding and Dermatology
- A Year of Reflection: what changed for looked after children and adoption in 2020

Feedback

The event had over 80 attendees. A selection of attendee feedback from the event, as below: -

> **"Great line up of speakers and topics, with insights which were aspirational"**

> **"I will use the knowledge gained today in the appropriate clinical contexts to improve care for the children seen for safeguarding medicals"**

> **"The session reminded me to always see young people on their own as well and to consider sexual exploitation in re-attenders"**

Representing at Events

Family Justice Council Medical Event

A Designated Doctor and a member of the Network were appointed in a leadership role as Medical Co-Chair of the Wales Family Justice Council Medico legal committee which is a forum to improve relationships between health professionals and the judiciary with the aspiration of increasing the pool of expert witnesses within Wales.

They arranged the inaugural event for the Committee which was attended by 179 people from a wide variety of backgrounds across medicine, psychology, CAFCASS and law. The session focus was Giving Evidence in Perplexing Presentation and Fabricated Illness in Children Cases. It proved an opportunity to discuss the Royal College of Paediatrics and Child Health (RCPCH) guidelines. This included the different approaches suggested and how this may affect the way agencies manage these cases, and the consequences for the subsequent judicial process and how experts may give evidence.

British Paediatric Dentists Webinar

In October 2021 the British Paediatric Dentists society held its Biannual scientific webinar attended by over 600 participants from across the UK. The NST service lead Dr Aideen Naughton was invited to talk about the impact of childhood adversity on brain development and the lifelong consequences for society and citizens physical and mental health

Webinar on Impacts of COVID-19 on our Children and Young People

In September 2021 Network Designated Doctor Claire Thomas was invited to talk on a Public Health Network Cymru webinar focussing on The Wider Impacts of COVID-19 on our Children and Young People and families. The fully attended webinar noted that COVID-19 has been a devastating pandemic for all but especially for our children and young people and the effects of this on their health, education and wellbeing will continue for years to come. The webinar explored these impacts and some of the ways in which this is being addressed within Wales, culminating in a lively question and answer session.

Regional **Round Up**

In the spirit of collaboration and innovation, Network members regularly share effective safeguarding practice. This allows them to highlight what works in their area, build effective partnerships and expand their ideas of what good practice looks like, thereby improving the overall arrangements for safeguarding in NHS Wales.

Corporate safeguarding teams across NHS Wales maintained agility during another turbulent year, delivering innovative initiatives while returning to full service alongside the challenges of the ongoing pandemic.

Below are some examples of organisation-based practice and innovations over the last period: -

Cwm Taf Morgannwg University Health Board

Child Protection Safeguarding Hub

In the last period Cwm Taf Morgannwg University Health Board (CTMUHB) Corporate Safeguarding Team has concentrated on the development of a child protection safeguarding hub that places children at the centre of the safeguarding process. The Hub was developed in response to several issues and the recommendations of an external audit.

About the Hub

The Hub is a centre for the physical assessment of children aged 1 to 17 years who require an urgent child protection physical examination (Child Protection Medical) in the Board area. Staff include Consultant Paediatrician Clinical Nurse Specialist and administrative assistant who provide a single point of contact for colleagues, partner agencies and families, and ensure a quality, evidence-based approach to care is maintained.

Hub Benefits

- The legal responsibilities of the health board are met in an effective manner
- Effective time management for health board resources involved in the safeguarding process such as the expertise of paediatricians.
- A dedicated team to ensure that a child is seen at the 'right time by the right person'.
- Consistent management of referrals, providing quality and ensuring that information is shared in a timely manner.
- A dedicated child friendly environment, which is reportedly an improvement from the previous acute clinical environment.
- Improved ward resources through the reduced need for a bed in an acute ward.
- Ability to access medical illustrations, further clinical investigations and follow up services.
- Increased training opportunities for all health board staff to gain experience in safeguarding as well as students wishing to undertake bespoke placements.

Effectiveness and Feedback

The effectiveness of the Safeguarding Hub has been measured in a variety of ways to ensure it provides an exceptional care to children and families, meets the standards set out by the Royal College of Paediatrics and Child Health (RCPCH) and improves ward efficiency.

Feedback has been collated from parents and professionals, with the voice of the child established through child friendly forms.

Response themes include: -

- Helpful, supportive and friendly
- Professional and knowledgeable
- Child focused
- Good time management
- Excellent communication

By obtaining feedback from children, young people and families in a sensitive and compassionate manner the service aims to evolve and facilitate a good experience in the most challenging of circumstances.

Cardiff and Vale University Health Board

The Corporate Safeguarding Team at Cardiff and Vale University Health Board (CAVUHB) have been working on a variety of initiatives covering Sexual Abuse, pressure damage alongside upskilling and resourcing activities.

Routine Enquiry on Sexual Abuse

The Board has commenced a pilot within the Midwifery Service at University Hospital of Wales on Routine Enquiry (RE) around Childhood or Adult Sexual Abuse.

Designated areas within Midwifery are being used as a starting point, with RE questions being asked to those booking in with the Elan Team (for women who require additional social support) and the Pregnancy Advisory Service (PAS).

Early indications are that while there are no new cases indicated or onward referral to police or Sexual Assault Referral Centres (SARC) required, survivors noted that the case for them was addressed at the time. Whilst individuals have expressed that they were pleased that this process was being piloted, they would have liked the Enquiry to have been in place when they had been experiencing sexual abuse.

Additional training is being considered around difficult conversations with survivors, to upskill staff in feeling confident to open up discussions and offer support.

The pilot is ongoing and not evaluated yet. Meanwhile the Board are in discussion with the Centre of Excellence around how to progress the work further with a view to a wider roll out.

Pressure Damage Audit

CAVUHB are undertaking an internal audit to look at pressure damage that is not reportable to Local Authorities under the Social Services and Well-being (Wales) Act, as it is deemed to be unavoidable. The Board will examine internal processes to give robust assurance to Local Authorities that accurate reporting is in place.

Additional Activities

- Safeguarding training has resumed, with a refreshed focus on targeting difficult to reach groups such as District Nurses, by offering biannual bespoke training.
- Safeguarding group supervision for adult based Health Lead Practitioners has recommenced.
- Routine Enquiry in the Emergency Unit has commenced.
- Additional funding from the VAWDASV Board has facilitated additional Independent Domestic Violence Advisor (IDVA) capacity.
- Secondments into the safeguarding team commenced in January 2022, to support succession planning and sustainability.
- Also in January 2022, a Safeguarding Nurse advisor was seconded to the Local Authority Adult safeguarding team for upskilling and facilitation of better multi-agency working.

Welsh Ambulance Services NHS Trust

Welsh Ambulance Services NHS Trust (WAST) launched various innovative initiatives over the last period.

Joint initiative to safeguard vulnerable people at home

WAST partnered with fire and rescue services to launch a new initiative to better protect vulnerable people at risk of an accident in their home. The system allows ambulance crews to e-refer at-risk patients to their fire and rescue service counterparts across Wales for a 'Safe and Well' check.

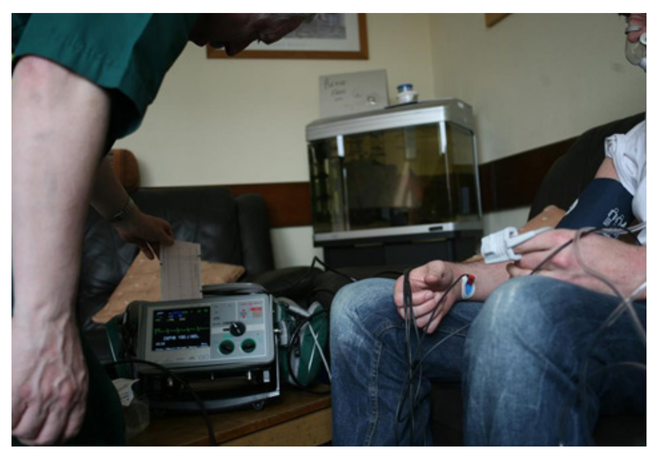
When visiting to deliver a medical intervention, Ambulance crews may notice red flags, for example that the patient has cigarette burns on their clothes or furniture, or that the patient's hoarding has blocked an escape route. By using an iPad referral form they can enlist a fire crew to visit the property to mitigate any risks.

Nikki Harvey, the Welsh Ambulance Service's Head of Safeguarding, said:

"Anything that we can do collectively to improve patient safety, mitigate the risk of accidents and prevent harm could reduce 999 calls in the future."

Tim Owen, Community Safety Manager at North Wales Fire and Rescue Service, noted:

"This agreement will enable us to extend this work, identifying those most at risk and vulnerable in our communities to make them safer."



Digitisation of the Live Fear Free Pathway

Since 2014, WAST have used a bespoke pathway where victims/survivors of VAWDASV can be signposted to the Live Fear Free helpline (a 24/7 service that provides support to victims of domestic abuse and sexual violence). WAST have now updated the Live Fear Free referral pathway by launching a digital referral form during National Safeguarding Week. It is important to note that this pathway supports both patients, service users and WAST employees.

Safeguarding Training Scenarios

Due to COVID, safeguarding CPD sessions have shifted to focus on the clinical aspects of different organisational roles, with mandatory and statutory CPD being completed virtually. This new approach will be rolled out during the 2022/2023 period.

To progress this work, the Safeguarding Team are collaborating with the National Ambulance Training College to develop safeguarding scenarios related to VAWDASV, self-neglect and child and adult at risk. These topics reflect relevant concerns and will therefore better equip practitioners to discharge their safeguarding duties.

Velindre University NHS Trust

The key achievements for the Velindre University NHS Trust (VUNHST) Corporate Safeguarding Team in the last period are as follows: -

- The scope of the role and function of the Trusts Safeguarding & Vulnerable Adults Group extended to include the Vulnerable Adults agenda including cognitive impairment, dementia, older persons and learning disability.
- Continued full compliance with its statutory responsibilities by reporting safeguarding concerns and working with multiagency partners.
- Safeguarding supervision and advice was accessed from both the Cancer Centre and Welsh Blood Service.
- Safeguarding training continued to be delivered virtually and via eLearning.
- Continued regional partnership training for domestic abuse.
- Continued supporting the national safeguarding work and regional board responsibilities.
- The divisions improved their processes for reporting safeguarding activity and assurances to the senior management teams.
- Safeguarding newsletters were developed and disseminated across the Trust with key messages. Screens in patient facing areas were utilised to communicate messages to service users and staff.
- Audits completed utilising the Welsh Nursing Care Record.

Hywel Dda University Health Board

Hywel Dda University Health Board (HDdUHB) has continued to prioritise safeguarding and respond to the challenges of the last period. They have sustained a single point of contact for all staff and external partners, while continuing to develop staff across the organisation.

Role Development

Appointment of a leadership post to facilitate delivery on the Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) agenda has improved engagement across Primary Care clusters and facilitated shared learning from domestic homicide reviews.

Learning Culture

- Safeguarding Level 3 training compliance has improved.
- Appointment of a Domestic Abuse Support Officer has improved capacity for Group 2 Ask and Act training.
- The Named Doctor and Lead Nurse Safeguarding Children have delivered multi-agency (Procedural Response to Unexpected Deaths in Childhood) PRUDiC training.
- The Lead Safeguarding Adults Practitioner and Lead VAWDASV and Safeguarding Practitioner have delivered bespoke safeguarding workshops on the STAR Leadership programme.
- They above named practitioners have also delivered sessions on Domestic Abuse and Older People to the wider organisation and specific teams.
- The adult safeguarding team have delivered bespoke sessions on self-neglect, discharge planning, professional concerns and the provision of information to the enquiry process.
- The Lead LAC Nurse has recorded a video to support the Health Board's professional curiosity training resources.

Improvement and Assurance

- The Lead Safeguarding Adult Practitioner worked with digital service to enhance the system for recording advice, support and strategy discussions.
- The Named Midwife worked with digital services to enhance the Sharing of Information in Pregnancy (SIP) database and plan to release a mobile app for community midwives.
- HDdUHB are leading the pilot of the safeguarding report form in Once for Wales Management System report form on behalf of NHS Wales.
- Multi-agency working includes:
  - Contributing to the High-Risk Behaviour Procedure (including Self Neglect and Hoarding)
  - The Lead Nurse Safeguarding Children led on the development of regional Guidance on Working with People who are Uncooperative in partnership with a Local Authority.
- The LAC team worked with the organisation's Enabling Quality Improvement in Practice (EQIiP) initiative to develop resources that support young people, carers and professionals with urinary/ faecal soiling which may risk placements.

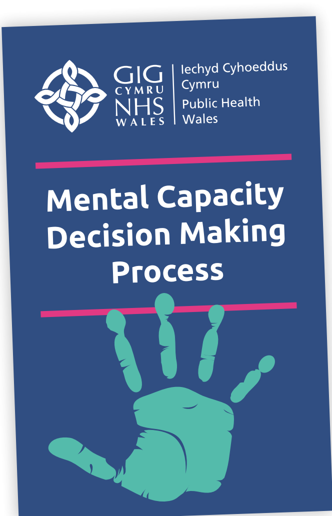
The Lead Safeguarding Adult Practitioner worked with digital service to enhance the system for recording advice, support and strategy discussions.

Public Health Wales

In 2021, the public health agency for Wales, Public Health Wales (PHW) saw a new appointment to the Named Safeguarding Lead role who has driven forward quality and improvement in Safeguarding across the organisation.

Best Interest Decisions in Screening

PHW have implemented an innovative way of gaining consent for members of the public attending screening who lack capacity. This novel approach has been developed in partnership with Welsh Risk Pool and Welsh Health Legal, specifically for non-registered health care workers as decision makers. Training has been delivered and the form has been successfully implemented in one screening programme using a quality improvement methodology.



PHW aims to implement the form throughout all screening programmes supported by the Safeguarding Lead. Additionally, information cards have been developed to support non-registered health care workers to better understand the decision-making process.

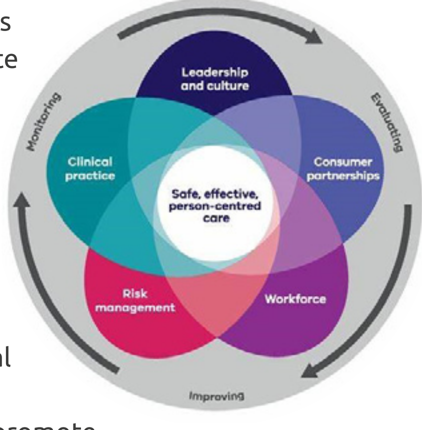
PHW have implemented an innovative way of gaining consent for members of the public attending screening who lack capacity.

A Children's Rights Approach

Work has been progressed with an organisational benchmarking exercise against the Children's Commissioner's "The Right Way Matrix" based on the 5 principles from "The Right Way" guide. Engagement throughout the organisation has been positive and findings are currently being collated and analysed. The resulting organisational position will be used to engage the Young Ambassadors in developing an approach that will ensure Childrens Rights are embedded within PHW and considered in decision making at every level and when working with children.

Clinical Governance

Public Health Wales has developed a Directorate Clinical Governance Group to identify how information available within the directorate including Safeguarding can be better utilised to identify areas of clinical and quality risk. The group will inform and promote continuous improvement of services, functions and programmes supporting effective clinical governance across the organisation. The group will also improve the understanding of how information can be better presented, flow and inform the wider organisational operating frameworks and complement the Safeguarding Maturity Matrix submission.



Swansea Bay University Health Board

Swansea Bay University Health Board (SBUHB) Corporate Safeguarding Team continue to progress with innovative work in the context of the competing priorities and the ongoing pressures of the pandemic.

Effective Information Sharing

The SBUHB Safeguarding SharePoint collates Safeguarding information, resources and policies, training dates and campaigns. The single point of access has increased the Corporate Safeguarding Team profile.

Rapid Response to Suicide of an Adult

SBUHB continue to engage with the regional Adult Rapid Response to Suicide Meetings and are working with partner agencies to amend the Terms of Reference to include the sudden death of a person under 21 years and significant suicide attempts.

Identification and Referral to Improve Safety (IRIS)

IRIS has been successful with a rise in first time referrals and a high percentage of referrals in the 60+ age group. A Health Data Scientist evaluation has established early indicators of health and economic benefits including financial benefits of £44k alongside an 8% increase in Quality Adjusted Life Years (QALY).

Violence Prevention Team and Health Independent Domestic Violence Advocate (IDVA)

The Violence Prevention Team at SBUHB is the second of its kind in Wales with a focus on support and advice for patients experiencing violence with injury, aiming to help break the cycle of violence. Complementing this funding was secured for a Health IDVA.

Training & Learning

- Together with their Nurse Education Team, SBUHB have embedded Safeguarding as part of Nurse Induction covering Level 3 Safeguarding People and "Ask and Act" Group 2 training.
- Lunch and Learn Safeguarding themed sessions have provided an opportunity for co-workers from different teams to share expertise.
- Safeguarding Supervision Training Days were delivered for staff from SBUHB, CTMUHB and C&VUHB with excellent feedback received and further dates planned.

Joint Inspectorate Review of Child Protection Arrangements (JICPA)

Together with respective partners SBUHB participated in a JICPA pilot inspection, contributing to the multi-agency response and Action Plan, monitored by the Health Board Safeguarding Committee.

Mother & Baby Unit ("Uned Gobaith/Unit of Hope")

SBUHB have set up a local Unit to help women who experience serious mental health problems during pregnancy and following birth. It is the only inpatient Unit of its kind in Wales offering multidisciplinary mental health care to women from 32 weeks of pregnancy until their baby's first birthday.

Aneurin Bevan University Health Board

Aneurin Bevan University Health Board (ABHUB) continued to develop its safeguarding hub, commented on the hidden costs of lockdown and hosted a child death review.

Early Intervention and Prevention Hub

ABUHB Corporate Safeguarding Team set up the Gwent Early Intervention and Prevention Hub in 2021, to address the increasing amount and complexity of the safeguarding concerns being seen within the Health Board.

The hub provides internal support to the Health Board, so that professionals could have a single point of contact to discuss safeguarding concerns in easy and timely ways. This has been hugely successful in raising the profile of safeguarding in the Health Board and providing support to frontline professionals when they require it.

The hub facilitates multi-agency working as it coordinates Duty to Reports to the Local Authority from the Health Board. Thereby the Health Board can better contribute to the identification, collation, and coordination of information to inform initial decision making for safeguarding cases. Additionally, Hub staff attend all strategy discussions for cases involving health to ensure information sharing is holistic and inclusive.

Child Sexual Exploitation (CSE) and Lockdown

A lead ABUHB nurse published an article in the British Journal of Nursing on Child Sexual Exploitation (CSE) in relation to the social isolation of COVID 19. The publication gave examples of the effects of social isolation on young people and the growing concerns around CSE and online grooming, noting poignantly that isolation should be considered an adverse childhood experience.

Child Death Review

Due to a significant number of child deaths related to asphyxiation, the Board worked with Welsh Government on a rapid review to ascertain themes of the cases along with several near misses. Findings revealed that most of the children were already know to children services and were or had been on the Child Protection register. There were also links within community and or school. This then led to the development of a strategic group within the Gwent Safeguarding Board, whose work is ongoing to look at prevention regarding suicide and self-harm for young people.

Independent Domestic Violence Advocate

The Health Board trialled an Independent Domestic Violence Advocate (IDVA) in the Mental Health. The successful pilot supported training and practice development for people impacted by domestic abuse and coercive control seeking mental health support. The IDVA will support the Emergency Department – an exciting development for 2022-23.

Betsi Cadwaladr University Health Board

The Corporate Safeguarding Team at Betsi Cadwaladr University Health Board (BCUHB) have carried out a wide range of innovative practice, collaborations and learning activities over the last period.

Focus on Falls

BCUHB have increased organisational awareness of the correlation between falls and adult at risk reporting through attendance and presenting at key Governance Groups and Adult Safeguarding Supervision. A Strategic Falls Group have created a Falls Policy and training in line with Wales Safeguarding Procedures to support all staff. A wide range of teams review all falls with harm within the District General Hospitals with the learning shared through daily Safety Briefings.

Co-Production for Safeguarding Week

Co-Production with people in their service is a passion at BCUHB. Within a community hospital, a dementia support worker facilitated patients to learn about modern day slavery upon their request. Patients shared information and created a collage poster raise awareness with other residents.

Coping with Crying Audit

Following a Child Practice Review, it was recommended that BCUHB audit compliance with the Coping with Crying Guideline. The audit included midwifery, neonates and health visiting practice, with findings expected to be published in Spring 2022.

Independent Domestic Violence Advisors

A pilot has commenced for two health Independent Domestic Violence Advisors (IDVAs) to be based within the Corporate Safeguarding Team. The roles are based in community and hospital settings and aim to empower survivors to increase their options, make positive choices/decisions, and increase their confidence, safety and recovery.

Identification and Referral to Improve Safety (IRIS)

A pilot has commenced in South Denbighshire of the IRIS Project which involves training and support for GPs to identify patients affected by domestic violence and abuse and refer them to specialist services.

Agencies Domestic Abuse Perpetrator Tasking (ADAPT)

Chaired by North Wales Police (NWP), ADAPT is a multi-agency approach to domestic abuse perpetrators with the aim to aim to introduce offenders to support programmes and reduce the risk they pose to their victims. Multi-agency meetings incorporate Health representatives including the substance misuse service, mental health division and corporate safeguarding.

Additional Activity

- 5-day bespoke placements for 2nd year Bangor University student nurses in the Safeguarding Team
- Children at Risk Level 3 training delivered to North Wales Police Custody Nurses
- Formation of a Strategic Steering Group to prepare for the Abolition of Reasonable Punishment Act (Wales) 2020, due for implementation on the 21st March 2022.

Powys Teaching Health Board

Communicating and sharing

The Powys Teaching Health Board (PTHB) Safeguarding Team developed resources to strengthen sharing of information across the Health Board.

Monthly newsletter topics have included: -

Virtual Safeguarding Hub

A Virtual Safeguarding Hub has been introduced to act as a single point of contact into the Safeguarding Team for all PTHB employees and partners

Functions include:

- Managing flows of information
- Managing and responding to requests for advice and support
- Attending adult and child strategy discussions, actioning daily domestic incidents and Once for Wales Incident Reports.

The Hub has improved time efficiency, established positive relationships with the Local Authority and provided consistent health input into adult and child strategy discussions.

Acting on Audits

Audits have resulted in the following actions: -

- A rewrite of the PTHB *Was Not Brought/No Access Visit Protocol*
- Introduction of a Significant Event Chronology function on the Welsh Community Care Information System (WCCIS)
- A Standard Operating Procedure for training to ensure that changes are cascaded effectively.

High Risk Behaviour Procedure

PTHB contributed to a Regional Task and Finish Group to develop a new document on behalf of Mid and West Wales Safeguarding Board - *High Risk Behaviour Procedure (Including Self Neglect and Hoarding)* - which is now being embedded in practice.

The document presents a multi-agency guide for practitioners working with individuals displaying high-risk behaviours, that emphasises the importance of multi-agency partnership working to build a fuller picture to better support people.

Health Assessment Choices for Looked After Children

Although Health Questionnaire for looked after children is already in place, in person assessments can be difficult to arrange and are occasionally refused by vulnerable children who dislike unfamiliar contact.

During the COVID 19 pandemic PTHB introduced virtual health assessments by necessity, however it became evident that delivery choice needed consideration. As a result, the Health Questionnaire was digitised and redesigned with input from the children and carers.

The new questionnaire went live in February 2022 with an improvement in returns alongside positive responses from the children and carers. Children now have a choice for their Health Assessments - face to face, virtual via Teams or via the Health Questionnaire. By valuing the children's needs and choices practitioners are less likely to encounter refusals and can provide the support they need.

Plans and **Preparedness**

Future Priorities

Looking to 2022/2023 it is imperative that the Network push forward with new areas of development whilst ensuring the work we have developed is maintained, updated and robustly evaluated.

Many of the areas of the current Work Plan will continue into the next period namely: SMM, VAWDASV, Mental Capacity Amendment Act, safeguarding upskilling, Violence Prevention and Looked After Children practice tools. Future annual reports will report on the progress of these longitudinal topics.

Additional work over the next period includes: -

- NHS Wales safeguarding staffing succession planning
- Planning for a Safeguarding Leadership Conference in March 2023 - celebrating 10 years of the Network
- Safeguarding actions relating to Restorative Supervision
- Upskilling events including: -
  - – Safeguarding Leadership Development
  - – Safeguarding using an ACEs and trauma informed approach
- Revision of the Procedural Response to Unexpected Deaths in Childhood (PRUDiC) for Welsh Government

Horizon Scanning

By taking a Horizon Scanning approach, the Network can consider predicted societal trends and shifts that threaten the safety of children and adults at risk. This context informs our short and long-term work planning, maximising our resource base through early stage upskilling.

Emerging issues currently on the Network's radar include: -

Gender Identity and Gender Dysphoria Advice

At present there is a lack of defined clinical pathways or agreed best practice for assessment and intervention. NHS staff would benefit from further advice and guidance from professional bodies who may need to provide care to patients with gender identity concerns while patients are waiting to access support from specialised gender dysphoria services.

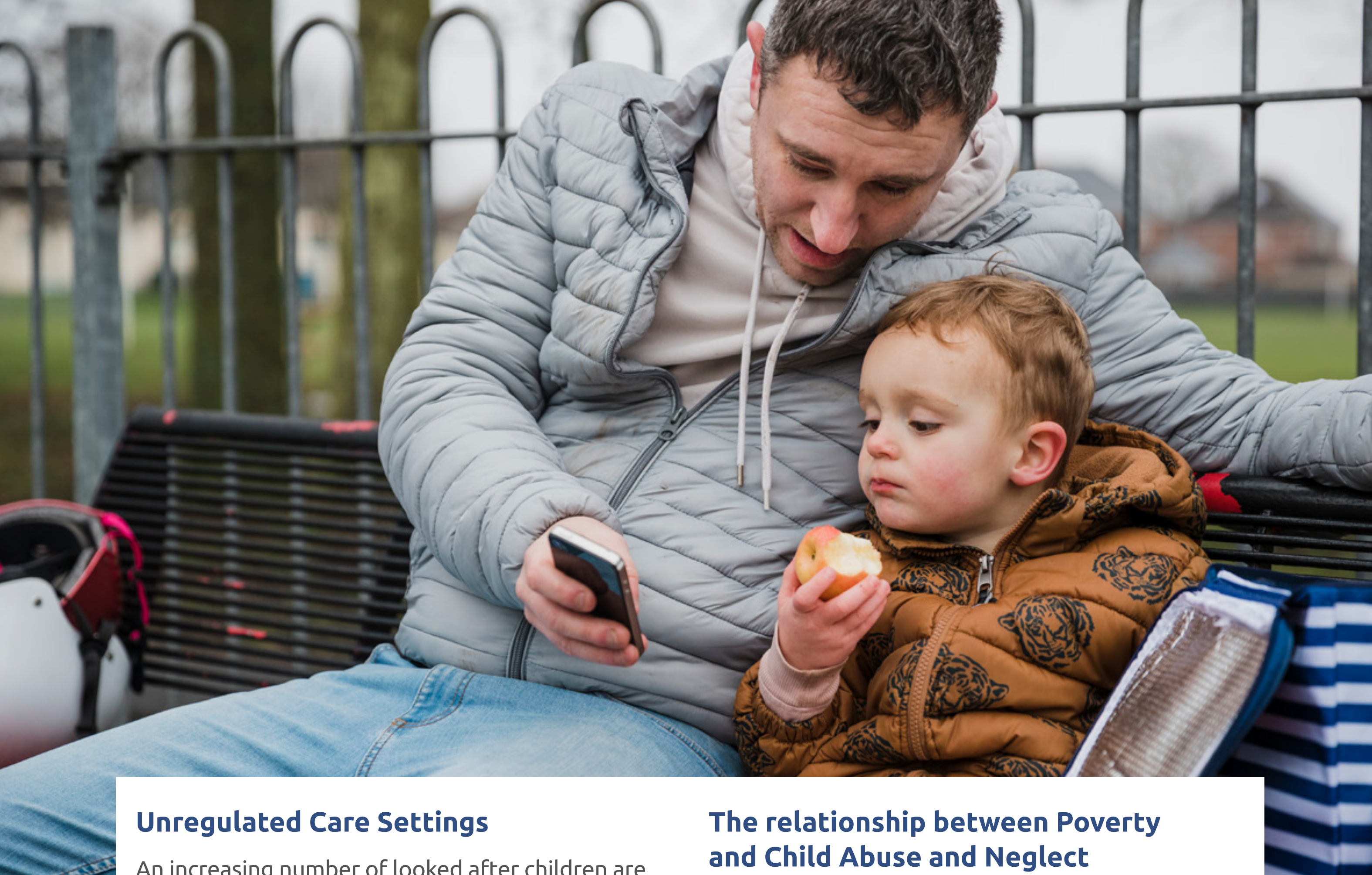
Forced Marriage of People with Learning Difficulties

Forced marriage of children and adults with learning disabilities is an issue that has been highlighted by many frontline professionals including teachers, social workers, health professionals and police officers. It is, as with many other types of abuse, a largely hidden issue and likely to be vastly underreported. The Forced Marriage Unit has noted that guidance provided to professionals required improving and locating within evidence-based practice.

Unaccompanied Asylum Seeking Children

Unaccompanied Asylum Seeking Children (UASC) are children and young people who are seeking asylum who have been separated from their parents or carers. Cardiff and Vale UHB and Aneurin Bevan UHB have been part of the pilot for the National Transfer Scheme which is now being rolled out across Wales. This means more health boards will be receiving UASC, despite no additional resources being allocated to meet this demand, which will have a direct impact on the children themselves.

Unaccompanied Asylum Seeking Children (UASC) are children and young people who are seeking asylum who have been separated from their parents or carers.



Unregulated Care Settings

An increasing number of looked after children are being placed in unregulated care settings where they live semi-independently with minimal support or assurance checks. The number of children entering care has been rising annually, alongside the increase in complexity of these children's needs. These factors have led to a lack of suitable placements; hence some vulnerable young people are being placed in unregulated accommodation where significant safeguarding concerns are emerging.

The impact of poverty and family adversity on adolescent health

An analysis using the UK Millennium Cohort Study assessed the clustering of trajectories of household poverty and family adversities and their impacts on adolescent health outcomes. Results showed that that persistent poverty and/or persistent poor parental mental health affects over four in ten children. The combination of both affects one in ten children and is strongly associated with adverse child outcomes, particularly poor child mental health.

The relationship between Poverty and Child Abuse and Neglect

It is now widely accepted that poverty and inequality are key drivers of harm to children although to date, changes in policy and practice responses have been limited.

New evidence from the University of Huddersfield has confirmed that poverty affects every aspect of family life. Poverty is inextricably implicated in other factors which increase the risk of harm: including domestic violence, poor mental health and substance use. Furthermore children's age and ethnicity interact with poverty in ways that increase inequalities.

Results showed that that persistent poverty and/or persistent poor parental mental health affects over four in ten children.

Practitioners also need to be able to enhance victim safety through trauma-informed advocacy services.

Strangulation and Suffocation Offence

A new specific offence of strangulation and suffocation will come into force in England and Wales in June 2022. Strangulation and suffocation are sadly widespread; being strangled not only leads to potential serious medical consequences that should be identified early on, it also raises by seven-fold the risk of becoming a future domestic homicide victim.

Upskilling is now required for health staff for them to identify the signs and symptoms of non-fatal strangulation and suffocation cases. Practitioners also need to be able to enhance victim safety through trauma-informed advocacy services.

Quality and Engagement Act

The Health and Social Care (Quality and Engagement) (Wales) Act 2020 received Royal Assent on 1 June 2020 and will be brought into force in spring 2023. The Act is part of the much broader agenda to improve the quality of care across NHS Wales organisations and social services.

The Act will:

- ensure that NHS bodies and ministers think about the quality of health services when making decisions
- ensure NHS bodies and primary care services are open and honest with patients, when something may have gone wrong with their care
- create a new Citizen Voice Body to represent the views of people across health and social care
- support the appointment of vice chairs for NHS trusts

NHS Wales will need to work together to prepare for these key legislative changes.

Piloting of Offensive Weapons Homicide Reviews

Commencing December 2022 Wales, along with London and the Midlands, will be one of the first regions to trial a collaborative new approach to prevent future deaths involving offensive weapons, such as knives and guns. These multi-agency reviews aim to provide a more holistic understanding of offensive weapons homicides to better inform preventative actions to save lives in the future. The Wales Violence Prevention Unit (VPU) has been closely involved in the development of this initiative by acting as a link with the Home Office who are funding the pilot.

Conclusion

Over the next period, the Network will continue working together to achieve 'A Wales where everyone is safe' highlighting the need for safeguarding to be recognised as an essential service throughout the NHS in Wales.

Thank you for your attention to the NHS Wales Safeguarding Network Annual Report 2021/2022; we look forward to reporting back on our delivery progress next year.

AGENDA ITEM No	13
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	1

Dementia Update

MEETING	Quality, Patient Experience & Safety Committee
DATE	10 November 2022
EXECUTIVE	Liam Williams, Executive Director of Quality & Nursing
AUTHOR	Alison Johnstone, Programme Manager for Dementia
CONTACT	Alison.Johnstone@wales.nhs.uk

EXECUTIVE SUMMARY

This report provides an update on the Trust's Dementia Programme and the current position regarding national programmes of work. The report also highlights current projects and progress against the WAST Mental Health & Dementia Plan.

Dementia update reports are required through QUEST Committee and Trust Board to demonstrate our progress against our funding allocation from Welsh Government.

It is recommended that the Quality, Patient Experience & Safety Committee,

(1) **Notes the work and progress against national dementia programme workstreams.**

(2) Discuss any areas of concern or work not covered or achieved.

KEY ISSUES/IMPLICATIONS

(1) An update on the Trust's Dementia Programme.

(2) Information on current dementia projects and relationships with key national dementia programme.

REPORT APPROVAL ROUTE

Executive Management Team –2 November 2022

Quality, Patient Experience & Safety Committee – 10 November 2022

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)	ALL	Financial Implications	ALL
Environmental/Sustainability	ALL	Legal Implications	ALL
Estate	ALL	Patient Safety/Safeguarding	ALL

Ethical Matters	ALL	Risks (Inc. Reputational)	ALL
Health Improvement	ALL	Socio Economic Duty	ALL
Health and Safety	ALL	TU Partner Consultation	ALL

ANNEX 1

SITUATION

1. The Mental Health & Dementia (MH&D) Team is providing an update to key committees on current dementia work and relationships with national programmes of work in Wales.

2. We have received annual funding from the Welsh Government since 2018 for our dementia programme through the Integrated Care Funds. This was recurring from 2018-2022 as per the lifespan of the National Dementia Plan 2018-2022. We now complete an annual request for funding for the Trusts Dementia programme from Welsh Government, ensuring our work programme aligns with national dementia priorities.

BACKGROUND

3. The current Trust's Mental Health & Dementia Plan 2021-2024 continues to drive dementia as a key policy area. This plan was signed off by Quest and Trust Board in 2021.

4. Population growth and improved longevity, combined with increases of certain dementia risk factors have led to a dramatic increase in the number of deaths caused by dementia. Dementia is one of the fastest growing causes of disability across the world and is recognised as a global public health priority (WHO, 2021).

ASSESSMENT

Update on new Dementia Standards

5. The All Wales Dementia Care Pathway of Standards was published by Improvement Cymru in 2021, following extensive engagement with individuals living with dementia, carers, voluntary organisations and health and care professionals. The co-produced pathway promotes a whole systems integrated care approach. The implementation of the standards is being supported nationally and regionally by the Dementia National Steering Group and by five work streams, which are: Community Engagement, Memory Assessment Services, Dementia Connector, Hospital Charter and Workforce / measurement.

6. WAST has representation at each of the workstreams and is contributing to specific standards relevant to WAST. Our dementia programme supports the Standards and contributes to integrated work to improve dementia care and services.

WAST Developments:

Training

7. We deliver a range of learning opportunities to our workforce with role specific content. This is in line with the Good Work Framework, a learning and development framework for people working in dementia care. Content for WAST covers basic dementia awareness, through to skills-based learning for different roles, and content for senior staff at influencer level.

8. These opportunities are on induction, continuing professional development and also includes 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. 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.

9. The team are working on a training dashboard which will determine number of staff trained through the different channels (e.g. role specific on induction or CPD, and e-learning). Our current compliance for the NHS Wales e-learning module is 88% which is regularly promoted to staff.

10. All learning opportunities are evaluated, and feedback is overwhelmingly positive. Having people affected by dementia involved in delivering stories and sharing their experiences through the learning is always rated as one of the most positive learning outcomes. The Dementia Team are developing a post-learning evaluation where staff can consider the impact of the learning on their practice.

11. Work is underway to develop specific learning for telephone-based staff, in particular 111 and CSD. Dementia training will be available for 111 staff on the 2023 CPD programme, and work is being planned on developing resources for staff in CSD to use with dementia patients and their carers/families which includes a reminiscence toolkit for them to use during calls.

12. Work continues with the family who provided the last patient story to August Quest. A visit is planned to record the story digitally with the family, for wider learning and sharing with staff and partners. A focus of this is how we support people living with dementia and their families during long waits.

Blue Light Partners – Emergency Service Commitments

13. WAST chairs the All-Wales Blue Light Dementia network, bringing together partners to focus on the UK Emergency Service Dementia Commitments. Much work has been achieved to connect the WAST dementia agenda with other services to improve personal, home and community safety; emergency response to dementia calls; joint learning and development opportunities and engagement across services.

14. The group has been offered an exciting opportunity to lead the refresh and relaunch of the UK Emergency Service Dementia Commitments, in partnership with the Policy Office of Alzheimer's Society UK. Task and Finish groups have been set up to write the new commitments.

Delivering person centred Reminiscence therapy to dementia patients

15. Working in partnership with My Improvement Network, we have secured 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 to blend entertainment with therapy and to assist patients (particularly with memory impairments) 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.

16. We hope this pilot will demonstrate how we can better support patients who may be distressed or agitated when in our care. Staff can utilise the tablets where to provide distraction and occupation for patients emotional and wellbeing needs during transport, or handover delays. The 1-year pilot commenced in June 2022 and will be evaluated Summer 2023.

17. Early feedback from RITA champions includes:

- "Used RITA for the first time with a lady with mixed dementia and a potential fractured neck of femur. Took a lot of Entonox to move her initially, but once on the ambulance I gave her the tablet with a 360° Coral reef, which distracted her wonderfully all the way to hospital - she was holding the gas nozzle but never used it. A really positive first experience with it. It was amazing to see the difference in her, I was really impressed"
- "Used the tablet with a patient who had not been diagnosed with dementia but was experiencing memory problems. Sat with patient for over 5 hours on the ambulance and he thoroughly enjoyed playing the games and listening to the music which brought back good memories and allowed him to sing along as he remembered most of the words. During these long handover delays we are encountering at A&E at the moment it really helped the patient and made the time pass quicker"
- "We were caring for a lady who had Alzheimer's, 91 years of age who was waiting outside hospital. She loved the tablet, listening to the music and humming along, she also enjoyed the movie clips. She was becoming restless whilst waiting but once we started using the tablet her mood settled"

Dementia and Sensory Friendly Environments

18. In our Mental Health and Dementia plan we have made a commitment to improving the environments of our ambulances for people with dementia, their carers, those with sensory loss and other cognitive impairments. There are many

strategic drivers which stress how important the environment is for people affected by dementia.

19. We receive concerns, feedback and patient stories on situations where our environments including vehicles, processes and staff interactions have had an impact on the experiences of people when in our care. People have told us that lighting, noises, lack of communication and reassurance, particularly in an emergency can be distressing and anxiety provoking. Analysis from our ongoing literature review has found that stress can be reduced when people living with dementia and sensory loss are given multiple, sensory cues that are helpful, and excess stimulation is removed.

20. We are working with a wide range of colleagues to explore solutions to noise reduction, lighting, enhancing skills and knowledge of our workforce and opportunities for digital technologies to support person centred care. Quality Improvement methodologies will be used to test these changes, working in partnership with a range of staff and experts. The Dementia and Sensory Friendly Ambulance Outcome and Recommendation paper will be available shortly, and presented to key committees for discussion.

National referral pathway for dementia support

21. We are working in partnership with Alzheimer's Society Cymru (ASC) on a referral process from any of our staff groups (111, NEPTS, EMS) into the All-Wales Dementia Connect team (run by Alzheimer's Society Cymru). This referral into ASC can be from anyone in our service who is concerned about someone's dementia, memory loss, confusion (they do not have to have a diagnosis), which can also be for carer/families. The Dementia Connect service is an all-Wales bilingual telephone service but also connects to local face to face services and support from Dementia Connect advisers, and Admiral Nurses where available. The referral pathway will be available on staff I-Pads and via a web form, and will be launched winter 2022.
22. This referral will support those with or without a diagnosis of dementia for additional care, support and services.

Preventable Emergency Admissions

23. Statistics by Alzheimer's Research UK looks at the impact of dementia on the hospital system:

- The number of people being admitted to hospital with dementia increased by 150% from 162,000 to 405,000;
- The number of hospital bed days for people living with dementia increased from 6.3m (2010/11) to 9.4m (2017/18);
- Stays in hospital due to dementia rose 180%, from 345,000 to 975,000;
- In 2017 people with dementia had a significantly higher proportion of emergency admissions (77%), compared to those without (34%);
- For patients with dementia, 90% of the total costs for the NHS are in emergency admissions, this is compared to 60% for patients without dementia;

- Underlying causes of admission for people with dementia included admissions for potentially preventable conditions such as pneumonia, sepsis, urinary system disorders, and leg fractures https://dementiastatistics.org/impactdashboard/

24. This data tells us that that we have a larger role to play in supporting more community-based care, alternative care pathways and more advanced clinical decision-making skills of our different staff groups. This connects to wider work around Inverting the Triangle and working with partners to provide more community based care and support. This conversation will be continued with the Care Closer to Home Group imminently.

Dementia Dashboard

25. A new Dementia Dashboard developed by Health Informatics has enabled us to gather valuable data on dementia information available on the e-PCR. A dementia button allows us to view the case mix of dementia related calls coming through EMS. However, further improvements are required to the e-PCR dementia button to allow for more meaningful data to be captured. This will enable us to analyse dementia data, audit our practice, and work with partners to identify alternative pathways and preventable hospital admissions.

26. Health Boards are now requesting for WAST dementia data to be released, so teams can analyse and initiate improvement work between partners.

27. The Health Foundation is leading a UK wide improvement project to install and evaluate dementia button on ambulance electronic patient record, HERE

AGENDA ITEM No	14
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	1

AUDIT REPORT

MEETING	Quality, Patient Experience and Safety Committee
DATE	10th November 2022
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Julie Boalch, Head of Risk and Corporate Governance
CONTACT	Julie.Boalch@wales.nhs.uk

EXECUTIVE SUMMARY

1. The purpose of the report is to provide an update in relation to recommendations resulting from Internal Audit reviews pertinent to the Committee.

2. In addition, the paper sets out the Internal Audit plan activity and includes copies of current and relevant Audit Reports that provide a fundamental line of assurance to the Committee.

RECOMMENDATION:

3. **The Quality, Patient Experience & Safety Committee is asked to:**
   a. **Note and consider the contents of the report.**
   b. **Consider the Internal Audit Plan activity.**
   c. **Consider the Trust's proposals to address each recommendation with the inclusion of revised completion dates, specifically those relevant to Committee.**
   d. **Agree any specific items that the Committee wishes to see raised to Senior Management and Audit Committee.**

KEY ISSUES/IMPLICATIONS

4. The internal audit recommendations continue to be reviewed by the Assistant Directors Leadership Team (ADLT) and the Executive Management Team (EMT) to ensure that any new completion dates are assigned with realistic timescales and a strong narrative and rationale to support any extension.

REPORT APPROVAL ROUTE
5. The report has been submitted to: • ADLT – 16th October 2022 • ADLT – 31st October 2022

REPORT APPENDICIES
6. The Audit Tracker has been circulated as a separate document – Appendix 1.

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

WELSH AMBULANCE SERVICES NHS TRUST
QUALITY, PATIENT EXPERIENCE & SAFETY COMMITTEE
INTERNAL AUDIT TRACKER

SITUATION

1. The purpose of this paper is to provide the Quality, Patient Experience & Safety Committee (QuEST) with an update in respect of recommendations resulting from internal audit reviews that are presented to the Committee for oversight.

2. In addition, the paper sets out the Internal Audit plan activity and includes copies of current and relevant Audit Reports that provide a fundamental line of assurance to the QuEST.

BACKGROUND

3. The audit recommendation tracker is in place for the purpose of tracking progress across the Trust to ensure that recommendations contained in internal and external audit review reports are actioned and in a timely manner.

4. This tracker provides Senior Managers with a workable tool that allows for closer scrutiny of audit recommendations and is designed to provide a more detailed focus as to the reasons why recommendations are overdue or have not progressed within the agreed timeframes. This will highlight areas that may require additional support and ensures there are clear mechanisms in place to escalate any issues.

5. The Internal Audit plans have been developed in partnership with the Executive Management Team to identify current and emerging areas of risk, as well as specific assurance needs within the Trust.

ASSESSMENT

Internal Audit Plan 2022/23

6. There are three internal audit reviews relevant to the QuEST which are included in the 2022/23 Internal Audit Plan as follows:

Internal Audit Report	Estimated Date of Audit	Date due at Audit Committee
Infection Prevention and Control	Q2	December 2022
Clinical Handover	Q3	March 2023
Pain Management	Q3	March 2023

Internal Audit Highlights

7. At the time of issuing the paper, there were a total of 98 current internal audit recommendations on the tracker. 33 recommendations were marked as complete at the September 2022 Audit Committee and removed from the tracker.

8. 21 recommendations were added to the tracker resulting from 2 Internal Audit Reports which were presented to the Audit Committee in September 2022. None of these recommendations were assigned to QuEST for oversight.

9. The status of each of the current internal audit recommendations is described in the table below.

Status	Total Number of Recommendations on the tracker	Those directly relevant to QuEST	High Priority QuEST	Medium Priority QuEST	Low Priority QuEST
Overdue	39	10	2	8	0
Not yet due*	29	1	0	1	0
Complete	30	3	0	3	0
Total	98	14	2	12	0

* accepting extensions have been applied in line with the agreed pandemic arrangements.

10. There are 2 high priority recommendation showing as overdue for QuEST to review. 1 of which is in relation to the Role of the Advanced Paramedic Practitioner Report and 1 which relates to the Respiratory Protective Equipment review.

11. The remaining 8 recommendations showing as overdue relate to the following Reasonable Assurance rated reports:

- 21/22 Role of Advanced Paramedic Practitioner
- 21/22 Information Management Hear and Treat
- 21/22 Respiratory Protective Equipment

12. The total number of recommendations, separated by financial year, and status this period is described below.

Financial Year	Total Number of Recommendations on the tracker	Those directly relevant to QuEST	Complete QuEST	Overdue QuEST	Not Yet Due QuEST
2019/20	3	0	0	0	0
2020/21	14	0	0	0	0
2021/22	60	14	3	10	1
2022/23	21	0	0	0	0
Total	98	14	3	10	1

13. The number of recommendations by assurance rating and level of priority are described below.

Assurance Ratings	Total No. of Recommendations on the tracker	Those directly relevant to QuEST	High Priority QuEST	Medium Priority QuEST	Low Priority QuEST
Limited	8	0	0	0	0
Reasonable	88	14	2	12	0
Substantial	0	0	0	0	0
Not Rated	2	0	0	0	0
Total	98	14	2	12	0

14. The Governance team continue to seek assurance from Senior Management relating specifically to each report that:

- Recommendations have been considered and completed within agreed timeframes and,
- All is being done to ensure that the follow up of recommendations will not result in further *Limited* or *No Assurance* rated reports.

RECOMMENDED:

15. The Quality, Patient Experience & Safety Committee is asked to:

a) Note and consider the contents of the report.

b) Consider the Internal Audit Plan activity.

c) Consider the Trust's proposals to address each recommendation with the inclusion of revised completion dates, specifically focussing on those relevant to QuEST, and

d) Agree any specific items that the Committee wishes to see raised to Senior Management and Audit Committee.

AGENDA ITEM No	15
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	4

Joint Investigations Pilot

MEETING	QUEST Committee
DATE	10 November 2022
EXECUTIVE	Executive Director of Quality & Nursing / Director of Paramedicine
AUTHOR	Executive Director of Quality & Nursing
CONTACT	liam.williams2@wales.nhs.uk

EXECUTIVE SUMMARY

1. Following a sustained period of operational pressures across Wales and increasing numbers of National Reportable Incidents relating to catastrophic or severe harm, the Appendix B process was implemented for WAST Serious Incidents. The process was approved by the WAST Board to report on the risks and harm arising from ambulance delays caused by extended transfers of care at emergency departments.

2. This process was requested to be reviewed by EASC and was led by the NHS Wales Delivery Unit. Significant discussion and work occurred over the summer to agree the Joint Investigations framework through a Task and Finish Group that has had membership from every Health Board, WAST and wider NHS Partners. A key outcome of the process is the requirement for a joint meeting to confirm a serious incident has occurred, confirm if a joint investigation is required and subsequently, which organisation will lead the investigation. It is expected by Health Boards that the joint investigation will secure a wider level of participation from health and care partners to reflect ongoing patient management in the community, and system pressures arising from delayed discharges.

3. Implementation of the Joint Investigations Process is due to take place through a Pilot that that will report to EASC and the NHS Wales Delivery Unit. Further work is required on the supporting performance metrics for the new process, and there is an urgent requirement for development time in the All-Wales web-based DATIX platform to enable efficient cross-organisational working.

4. It is not expected that this process will have a significant impact on WAST in reporting or investigating incidents, however, it is expected that there will be an impact for Health Boards seeking higher levels of engagement from General Practice and Social Care.

5. Approval for engagement in the Pilot is requested by the Executive Director of Quality and Nursing on the basis that EASC and the NHS Wales Delivery Unit progress:

   a. Monitoring and closure of outstanding incidents in the system
   b. Identification of performance metrics to be monitored and managed through EASC and the NHS Wales Delivery Unit
   c. Agreement to accelerate DATIX web developments that facilitate joint investigations and reporting
   d. Ongoing work by the Joint Investigations Task and Finish Group to agree an evaluation framework for the Pilot before approval is requested to make the change substantive.

RECOMMENDATION:

The Committee is requested to approve the revised Joint Investigation Pilot.

KEY ISSUES/IMPLICATIONS

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

REPORT APPROVAL ROUTE

QUEST – 10 November 2022

REPORT ANNEXES

1. Joint Investigation Letter
2. PILOT National Policy on Patient Safety Incident Reporting: Supporting Section X
3. DRAFT Joint Safety Incident Review Meeting – All Wales Agenda Template
4. Patient Safety Incident Requiring Joint Review - Form

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

Eich cyf/Your ref::
Ein cyf/Our Ref:
Ffôn/Tel:
Symudol/Mobile:
Ebost/Email: Ross.whitehead@wales.nhs.uk
Adran/Dept: EASC Team

Date: 12 October 2022

FAO Executive Directors of Nursing

Dear Colleagues,

Re: Appendix B Task and Finish Group for the Emergency Ambulance Services Committee Management Group

Following my email to you on the 4 August 2022 on the establishment of a Task and Finish Group to review the Appendix B Process, I wanted to take the opportunity to thank you for your and your representative's involvement in this work.

You will be aware that the group has met on 4 occasions since the 19 August and has made significant progress. I am pleased to attach to this letter a new, collaboratively developed approach for Joint Investigations and accompanying documentation to replace the Appendix B Process.

The group recommended that the revised process should be implemented immediately on a pilot basis prior to inclusion in forthcoming update to the National Patient Safety Incident Reporting Policy; work led by the NHS Wales Delivery Unit.

Please could you provide written confirmation on your acceptance of this recommendation to CTM_CASC_EASC@wales.nhs.uk by the 19 October 2022.

I am aiming to report back to the EASC Management Group and confirm that the work has been completed at the next meeting.

The group also recognised that it would be helpful to continue to meet in the short term in order to share learning and feedback on the pilot process, and we will bring forward a revised terms of reference for the group to enable this to take place.

Once again, I would like to thank both you and your teams for your valuable engagement with this work.

Please do not hesitate to contact me should you require any further information.

Yours sincerely.

Ross Whitehead

Dirprwy Prif Gomisiynydd y Gwasanaethau Ambiwlans	Deputy Chief Ambulance Services Commissioner

cc.
Stephen Harrhy, Chief Ambulance Services Commissioner
Sue Tranka, Chief Nursing Officer
Cathy Dowling, NHS Wales Delivery Unit
Members of the Appendix B Task and Finish Group

PILOT

National Policy on Patient Safety Incident Reporting

Supporting Section X: DRAFT joint investigation policy & process

This section of the Policy was developed collaboratively by NHS Wales Health Boards & Trusts via the National Task and Finish Group established to improve national processes for the joint investigation between WAST and other NHS Wales organisations of patient safety incidents.

The Task and Finish Group agreed to this draft policy & process at the meeting on 22 September 2022, with the intention of piloting it with immediate effect to enable testing to take place prior to incorporating into the policy update in late 2022.

While this process was established to support joint incident investigations between WAST and other NHS Wales organisations, the principles and processes can apply to any joint investigation process including those related to other types of Concerns under PTR.

Joint safety incident management meetings

Joint safety incident management meetings are considered to be an essential element of the early process of starting to investigate a patient safety incident, to facilitate discussion and joint decision making as soon as practicable after an incident has been identified.

The format and membership of this meeting must be considered and understood ahead of time to enable meetings to be quickly established as required.

The below principles may help Health Boards and Trusts in establishing joint safety incident management meetings:

Membership, including:

- Health Board/Trust representatives – while information from all relevant aspects of the patient's care should be captured (including emergency care, primary & community care, flow management etc.), this may not necessarily require multiple Health Board/Trust representatives at the meeting. Within the organisation there may need to be a process for information sharing and delegation to a single or small number of Health Board representatives in order to facilitate a timely meeting;
- Relevant social care/Local Authority engagement;
- Relevant independent/private providers;
- Other stakeholders engaged in commissioned services related to the incident.

Consideration should be given to:

- Whether meetings are established on a local or regional basis;
- The frequency of meetings, noting the expected timescales set out in the process below;
- Whether meetings are set up as routine (e.g. each fortnight) and/or in response to individual incidents.

Standard data set

As the purpose of the meeting is to have a rapid, informed discussion to support joint decision making, it is important that appropriate information is available to all members ahead of the meeting. This should include:

- a list of incidents requiring joint discussion, and
- for each incident under discussion, a standard set of data including, where applicable:
  - Patient notes from the relevant episode of care
  - Any relevant recent patient history including related to episodes of care, relevant discharges, outpatient appointments, primary and community care etc.
  - Operational position of relevant organisations
  - Any records of communication between relevant organisations
  - Records from relevant internal reviews e.g. Mortality Review
  - Medical Examiner records
  - Information on any other concerns linked to the same patient

Investigation methodology

Consideration should be given to the use of the appropriate investigation methodology/tools depending on the circumstances of the incident.

Although relevant for all incident investigations, the concept of systems thinking and taking systems-based approaches will be of particular importance to joint investigations, in order to study and understand the interfaces and interactions between different component parts of the healthcare system and community.

Regardless of the methodology used, it is mandated that the Yorkshire Contributory Factors Framework is utilised as part of the investigation analysis, to enable local, regional and national collation and analysis of data.

Overview of joint investigation process:

1. The organisation who identifies that an incident has occurred is responsible for reporting the incident on their local Datix Cymru system in line with local requirements. This should be within one working day of identification of the incident.
2. In line with the organisation's local processes, the incident will be reviewed in a timely manner to assess the circumstances and determine next steps. It is expected that this review will take place within two working days of the report being made. A routine part of this review will be to consider if a joint review is indicated.

   Where a joint review is indicated, the identifying organisation will initiate the joint review process with organisations relevant to the incident. This includes:

   - identifying potential stakeholder organisations required for joint discussion(s);
   - making stakeholder organisations aware of the circumstances of the incident, and of the indication for joint review and requesting relevant data to be collated ahead of the joint review meeting. Until an electronic solution is determined, information should be shared between organisations on the "Patient safety incident requiring joint review" form; and
   - ensuring that the incident is discussed at a joint review meeting in a timely manner. This is expected to take place as soon as possible and usually within two weeks of

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identification of the incident, recognising that there may be occasions where this timescale is exceeded due to complexity.

3. To support discussions in relation to the incident, the data described in the standard dataset should be made available, where possible, to all parties involved in the joint review meeting. However, not having all the data should not prevent the discussion taking place.

4. The incident should be discussed at the joint incident management meeting to make a joint decision on whether it requires a joint investigation. **It is essential that the review puts the patient at the centre of the discussion**.

    - If the decision is that the incident does not require a joint investigation, then the rationale for this decision should be documented as part of the minutes for the joint review meeting. Consideration must be given to whether an individual organisation should carry out an investigation under PTR.

    - If the decision is that the incident does require a joint investigation, then the following points should be discussed and agreed:

        - Clarity on what the incident is, as well as the outcome
        - Consideration of the level of harm arising from the incident (using the current knowledge available) as this will inform and influence actions under PTR
        - Scope and Terms of Reference for the joint investigation
        - Investigation methodology to be used and expected timescales for completion (30, 60, 90 or 120 days)
        - Roles and responsibilities of all organisations involved in joint investigation
        - Agreement of who will be lead organisation, with responsibility for acting as the Single Point of Contact for the patient/family
        - Decision on any national reporting requirement (NRI)
        - Plan to support staff who have been involved in the incident
        - Governance and sign off arrangements for the final investigation report
        - (if needed) plan for coordination with other concerns processes e.g. complaints, inquest
        - Safeguarding considerations
        - Media and communications considerations

5. Consideration of the lead organisation should be taken on a case by case basis, however over time discernible patterns may become clear around who the lead should be depending on the circumstances of the incident. When deciding the lead organisation, consideration should be given to factors such as:

    - the patient must be put at the centre of the investigation so the primary consideration needs to be, which organisation will be best placed *for the benefit of the patient and/or their family* to undertake the lead role which will include acting as the single point of contact for the patient/family;

    - what the actual incident is and where it occurred, which may be different to where harm and/or incident was identified.

6. All NHS Wales organisations involved in the joint investigation will raise an incident on their Datix Cymru system, clearly coding this as a joint investigation with the relevant reference

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details for the other organisations for cross-matching purposes. The process for this should be as set out in the current Datix Cymru user guide.

Non-NHS Wales organisations should give consideration to their own local recording requirements.

7. Should the incident meet the threshold for national safety incident reporting, the lead NHS Wales organisation will undertake any national reporting requirement.
8. The lead organisation will engage the patient and/or family in line with the requirements of PTR. For incidents where moderate harm or above has resulted, this will include proactively making contact with the patient/family at the earliest appropriate opportunity, and engaging them in the investigation process, including understanding events from their perspective and ensuring any of their questions are taken into consideration as part of the investigation. Involvement of the patient/family should be undertaken throughout the investigation process.
9. Following the joint decision to undertake a joint investigation, a proportionate investigation will be jointly undertaken by the relevant stakeholders utilising the chosen methodology and within the stipulated timescale. Regardless of the methodology chosen, the investigation must include analysis in line with the Yorkshire Contributory Factors Framework (YCFF).
10. The end product of the joint investigation will be one investigation report which covers all parts of the patient's journey relevant to the incident, incorporating the YCFF analysis, along with identified areas for improvement.
    - It is essential that action is taken to address the identified areas for improvement, consideration should be given to whether this is best addressed through a stand-alone action plan or via a thematic action plan.
11. The joint investigation report will be submitted through the governance and quality assurance mechanisms for sign off as agreed at the joint safety incident management meeting.
12. Once the joint investigation report has been finalised, each NHS Wales stakeholder organisation will:
    - update their Datix Cymru record with the investigation outcomes and contributory factor analysis; and
    - share the outcomes and learning from the investigation within their organisation.
13. In addition to the above, the lead organisation will:
    - If the incident was nationally reported, complete any outcome requirements associated with the notification, including sharing the contributory factor analysis at a national level; and
    - complete any relevant PTR requirements in line with the organisation's governance processes, including engaging with the patient/family about the final investigation report.
14. In order to support learning from these investigations, the following analyses will be required:
    - In line with each organisation's internal governance mechanisms, each NHS Wales organisation who has been party to one or more joint investigations will undertake

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regular analysis of the contributory factors associated with investigations. This analysis should be used to inform thinking around commonly occurring factors and how these could be improved. These analyses and any resulting actions for improvement should be regularly shared at a minimum with:

   i. relevant Committees within the organisation's quality and safety structures

   ii. the joint safety incident management meetings as appropriate.

- On a quarterly basis, the NHS Wales Delivery Unit will undertake an analysis of the contributory factors associated with all joint investigations which have been nationally reported. This analysis will be shared with all organisations who have been party to one or more joint investigations, as well as through relevant national fora.

Joint Safety Incident Management Meeting agenda

(Standard All Wales template)

Date & time:

Venue:

Chair:

Organisations represented:

1.	Welcome & introductions
2.	Incidents requiring joint discussion • • •
3.	*For each incident under discussion:* Does this incident require a joint investigation? If **yes**: • Clarify the incident to be investigated, as well as the outcome (as far as can be known) • Consideration of the level of harm arising from the incident (using the current knowledge available) • Agree scope and TOR of joint investigation • Agree investigation methodology to be used and expected timescales for completion (30, 60, 90 or 120 days) • Identify all organisations involved in the joint investigation and their roles and responsibilities • Agreement of who will be lead organisation, with responsibility for acting as the Single Point of Contact for the patient/family • Decision on any national / external reporting requirements including NRI • Plan to support staff involved in the incident • Governance and sign off arrangements for the final investigation report • Plan for coordination with other concerns processes e.g. complaints, inquest etc. • Safeguarding considerations • Media and communications considerations
4.	AOB & close

Patient Safety Incident requiring joint review

Organisation that identified the incident	
Organisation internal reference number	
Date incident occurred	
Date incident identified	
Details of person affected (to enable cross-referencing by other relevant organisations)	
Concise summary of incident	
Impact on patient (based on current information)	
Make safe actions taken: • In respect of the patient • In respect of the wider organisation to prevent recurrence	
Organisations to be included in the joint review process	
Relevant information to be shared as part of the joint review process	

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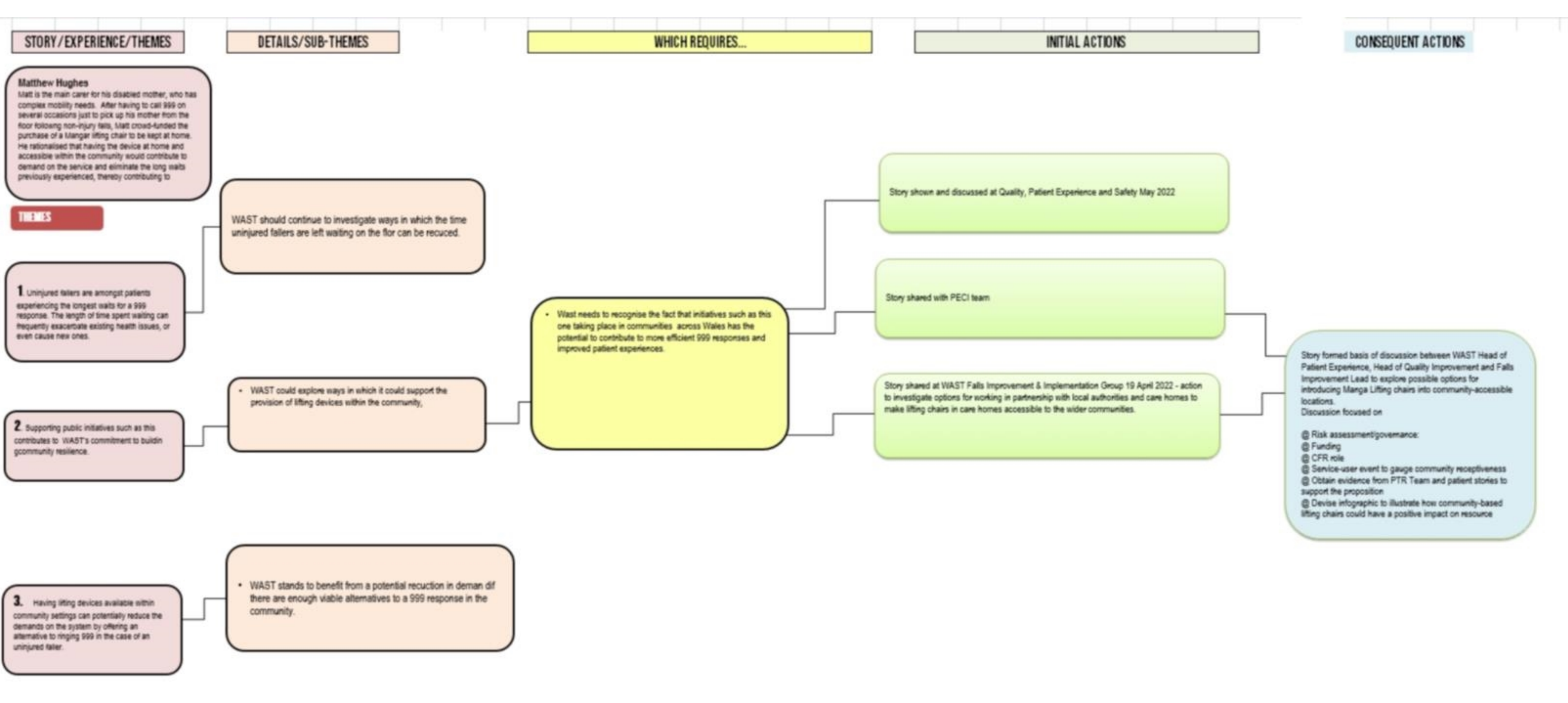

STORY/EXPERIENCE/THEMES
DETAILS/SUB-THEMES
WHICH REQUIRES...
INITIAL ACTIONS
CONSEQUENT ACTIONS
OUTCOMES
Matthew Hughes
Matt is the main carer for his disabled mother, who has complex mobility needs. After having to call 999 on several occasions just to pick up his mother from the floor following non-injury falls, Matt crowd-funded the purchase of a Mangar lifting chair to be kept at home. He rationalised that having the device at home and accessible within the community would contribute to demand on the service and eliminate the long waits previously experienced, thereby contributing to
THEMES
1. Uninjured fallers are amongst patients experiencing the longest waits for a 999 response. The length of time spent waiting can frequently exacerbate existing health issues, or even cause new ones.
2. Supporting public initiatives such as this contributes to WAST's commitment to buildin gcommunity resilience.
3. Having lifting devices available within community settings can potentially reduce the demands on the system by offering an alternative to ringing 999 in the case of an uninjured faller.
WAST should continue to investigate ways in which the time uninjured fallers are left waiting on the flor can be reduced.
WAST could explore ways in which it could support the provision of lifting devices within the community,
WAST stands to benefit from a potential recuction in deman dif there are enough viable alternatives to a 999 response in the community.
Wast needs to recognise the fact that initiatives such as this one taking place in communities across Wales has the potential to contribute to more efficient 999 responses and improved patient experiences.
Story shown and discussed at Quality, Patient Experience and Safety May 2022
Story shared with PECI team
Story shared at WAST Falls Improvement & Implementation Group 19 April 2022 - action to investigate options for working in partnership with local authorities and care homes to make lifting chairs in care homes accessible to the wider communities.
Story formed basis of discussion between WAST Head of Patient Experience, Head of Quality Improvement and Falls Improvement Lead to explore possible options for introducing Manga Lifting chairs into community-accessible locations.
Discussion focused on
@ Risk assessment/governance:
@ Funding
@ CFR role
@ Service-user event to gauge community receptiveness
@ Obtain evidence from PTR Team and patient stories to support the proposition
@ Devise infographic to illustrate how community-based lifting chairs could have a positive impact on resource

AGENDA ITEM No	17
OPEN or CLOSED	Open
No of APPENDIX ATTACHED	0

Committee Priorities 2022/23

MEETING	Quality, Patient Experience & Safety Committee
DATE	10 November 2022
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 2022/23.

2. Progress is steady across its priority focus with the January 2023 meeting focusing on implementation of the duty of quality and the duty of candour.

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 FOR 2022/23

SITUATION

4. This report updates the Committee on progress against the priorities it set for 2022/23.

BACKGROUND

5. During the course of the 2021/22 effectiveness reviews, it was agreed that it is good practice for Committees to set priorities for the forthcoming year.

6. The Committee's priority, which us set out below, was agreed by the Trust Board in May 2022 and will be tracked quarterly.

ASSESSMENT

7. The Committee priority, and progress against it is as follows:

Priority	Progress
Further embed oversight of patient safety, openness and transparency, the Committee will monitor the Trust's readiness for the introduction of the Duty of Quality and Duty of Candour when the Health and Social Care (Quality and Engagement) (Wales) Act ('Act') comes in to force in the Spring of 2023	• The quarterly Quality Highlight Report provides updates on preparations to implement the Act. • 12th May meeting: The Quality Strategy and its implementation will focus on embedding the Duty of Quality and the Duty of Candour. Further detail was sought on the practical steps being taken to integrate quality into other roles as part of the Quality Strategy. The Committee stressed the importance of this given the requirement to report against the Duty of Quality and Duty of Candour when the Act is implemented in April 2023. • 27th October: A Board development session was provided by the Quality Governance Team and Welsh Government on the requirements to implement the Duty of Quality and the Duty of Candour. • The January 2023 meeting of the Committee will focus on the Trust's preparedness for the introduction of the duty of quality and the duty of candour in April 2023.

RECOMMENDATION

8. The Committee is asked to note the update.