

Bundle Quality, Patient Experience and Safety Committee 11 August 2022

Agenda attachments

ITEM 0 Open Quest Agenda - 11 August 2022 (2).docx

- 0 09:30 - OPENING ITEMS
- 1 Chair's welcome, apologies, and confirmation of quorum
- 2 Declarations of interest
- 3 Minutes of last meeting
ITEM 3 QUEST OPEN MINUTES 12 May 2022 TM.doc
- 4 Action log and matters arising
ITEM 4 Action Log.docx
- 4.1 ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION
- 5 09:45 - Patient Experience
- 6 10:15 - Operations Directorate Quarterly Report – 2022 -23 Q1
ITEM 6 Ops Directorate Quarterly Report for Committees 22-23 Q1 (Jul22) FINAL.pdf
- 7 10:25 - Risk Management and Board Assurance Framework Report
ITEM 7 Executive Summary Risk Management Report QuEST 110822.docx
- 8 10:40 - Monthly Integrated Quality Performance report (including revised KPIs)
ITEM 8 MIQPR SBAR QuEST June July 2022.docx nqhb.docx
ITEM 8.1 Annex 1 MIQPR June July 2022.pdf
- 9 11:00 - Quality Highlight Report Quarter 1
ITEM 9 Quality Highlight Report, Quarter 1 (April - June 2022).docx
- 10 11:15 - Patient Safety Report Q1 2022/23
ITEM 10 Patient Safety Report Quarter 1 (April - June 2022).docx
ITEM 10.1 Patient Safety Report, Quarter 1 (April - June 2022) - Appendix 1.PDF
- 11 11:35 - Coroner Regulation 28 reports received
ITEM 11 Coroner Regulation 28 Reports Received.docx
ITEM 11.1 Coroner Regulation 28 Reports Received - Appendix 1.pdf
- 11.1 11:45 - COMFORT BREAK
- 12 11:55 - Patient Experience and Community Involvement Quarterly Report.
ITEM 12 PECEI Highlight Report - Quarter 1 (April - June).docx
ITEM 12.1 PECEI Highlihght Report - Quarter 1 (April - June) - Annex 1.pdf
- 13 12:10 - Health Inspectorate Wales (HIW) EMS CCC Patient Safety Review
ITEM 13 QuEST paper HIW Review - 110822.docx
ITEM 13.1 SBAR HIW Review - EMT paper 030822.docx
ITEM 13.2 HIW Audit Tracker 050822.xlsx
- 14 12:25 - Quality Strategy Highlight Report Quarter 1 - Verbal Update
- 15 12:35 - Internal Audit Tracker Report
Item 15.1 - Audit Tracker has been circulated by e mail
ITEM 15 Executive Summary QuEST - Internal Audit Report 110822.docx
ITEM 15.2 WAST_2122-21_RPE_Final Internal Audit Report_for Trust issue.pdf
- 16 12:45 - NHS Wales National Clinical Audit and Outcome Review Plan 2022/23
ITEM 16 SBAR - NHS Wales Audit and Outcomes 2022-23 - Final TM.docx
ITEM 16.1 Clinical Audit Programme 2022 -23 Q1.pdf
ITEM 16.2 NHS Wales National Clinical Audit and Outcome Review Plan - Annual R....pdf
- 17 12:55 - Infection Prevention Control Annual report
ITEM 17 Infection Prevention Control Annual Report (1.4.21 - 31.3.22).docx

ITEM 17.1 Infection Prevention Control Annual Report (1.4.21 - 31.3.22) - Appendix 1.docx

ITEM 17.2 TOR SBAR to HIW.docx

ITEM 17.3 Cleaning standards.pdf

- 17.1 13:05 - CONSENT ITEMS
- 18 Patient Story Driver Diagram
ITEM 18 Patient Story Driver Diagram.pdf
- 19 Committee Priorities Update
ITEM 19 Quest Committee Priorities August 22.docx
- 19.1 CLOSING ITEMS
- 20 Key messages for Board
- 21 Any other business
- 21 Date and time of next meeting: 10 November at 09:30



MEETING OF THE QUALITY, PATIENT AND SAFETY EXPERIENCE COMMITTEE

Held on 11 August 2022 from 09:30 to 13:10

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	15 Mins
2.	Declarations of interest	Information	Bethan Evans	Verbal	
3.	Minutes of last meeting	Approval	Bethan Evans	Paper	
4.	Action log and matters arising	Review	Bethan Evans	Paper	
ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION					
5.	Patient Experience	Information Discussion	Leanne Hawker	Verbal	30 Mins
6.	Operations Directorate Quarterly Report – 2022 -23 Q1	Discussion	Lee Brooks	Paper	10 Mins
7.	Risk Management and Board Assurance Framework Report	Assurance	Julie Boalch	Paper	15 Mins
8.	Monthly Integrated Quality Performance report (including revised KPIs)	Assurance	Rachel Marsh	Paper	20 Mins
9.	Quality Highlight Report Quarter 1	Assurance	Jonathan Turnbull Ross	Paper	15 Mins
10.	Patient Safety Report Q1 2022/23	Assurance	Wendy Herbert	Paper	20 Mins
11.	Coroner Regulation 28 reports received	Assurance	Wendy Herbert	Paper	10 Mins
COMFORT BREAK					
12.	Patient Experience and Community Involvement Quarterly Report.	Assurance	Leanne Hawker/ Wendy Herbert	Paper	15 Mins
13.	Health Inspectorate Wales (HIW) EMS CCC Patient Safety Review	Approval	Lee Brooks	Paper	15 Mins
14.	Quality Strategy Highlight Report Quarter 1	Assurance	Jonathan Turnbull Ross	Verbal	10 Mins
15.	Internal Audit Tracker Report	Assurance	Julie Boalch	Paper	10 Mins
16.	NHS Wales National Clinical Audit and Outcome Review Plan 2022/23	Approval	Duncan Robertson	Paper	10 Mins
17.	Infection Prevention Control Annual report	Assurance	Wendy Herbert	Paper	10 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.



18.	Patient Story Driver Diagram	Information	Leanne Hawker	Paper	
19.	Committee priorities update	Information	Trish Mills	Paper	
CLOSING ITEMS					
20.	Key messages for Board	Discussion	Bethan Evans	Verbal	5
21.	Any other business	Discussion	Bethan Evans	Verbal	
22.	Date and time of next meeting: 10 November at 09:30	Information	Bethan Evans	Verbal	

Lead Presenters

Name	Position
Bethan Evans	Non Executive Director
Lee Brooks	Executive Director of Operations
Jonathan Turnbull-Ross	Assistant Director of Quality Governance
Julie Boalch	Head of Risk/Deputy Board Secretary
Leanne Hawker	Head of Patient Experience & Community Involvement
Wendy Herbert	Interim Executive Director of Quality & Nursing,
Andy Swinburn	Director of Paramedicine
Leanne Smith	Interim Director of Digital Services

WELSH AMBULANCE SERVICES NHS TRUST

UNCONFIRMED MINUTES OF THE OPEN SESSION OF THE MEETING OF THE QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE HELD ON 12 May 2022 VIA TEAMS

PRESENT:

Bethan Evans	Non Executive Director and Chair
Paul Hollard	Non Executive Director
Ceri Jackson	Non Executive Director

IN ATTENDANCE:

Julie Boalch	Head of Risk and Deputy Board Secretary
Hugh Bennett	Assistant Director, Commissioning and Performance
Craig Brown	Trade Union Partner
Lee Brooks	Executive Director of Operations
Mark Cadman	Head of Patient Safety
Andrew Clement	Visual Design Specialist
Wendy Herbert	Interim Director of Quality and Nursing
Peter Hindley	Community Health Council
Fflur Jones	Audit Wales
Gerallt Jones	Health Inspectorate Wales
Lee Joseph	NHS Wales Delivery Unit
Alison Kelly	Business and Quality Manager
Trish Mills	Board Secretary
Steve Owen	Corporate Governance Officer
Jane Palin	Assistant Director of Quality and Nursing
Hugh Parry	Trade Union Partner
Angela Roberts	Trade Union Partner
Duncan Robertson	Assistant Director of Research, Audit and Service Improvement (North)
Chris Scott	Internal Audit
Andy Swinburn	Director of Paramedicine
Gareth Thomas	Patient Experience and Community Involvement Manager
Jonathan Turnbull-Ross	Assistant Director of Quality Governance

Apologies:

Professor Kevin Davies	Non Executive Director
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Hannah Rowan	Non Executive Director

16/22 PROCEDURAL MATTERS

The Chair extended a warm welcome to everyone. Attendees were advised that the

meeting was being audio recorded. The Chair referred the Committee to the standing declaration of interest of Ceri Jackson as a Trustee of the Stroke Association.

Minutes

The minutes of the meeting held on 17 February 2022 were confirmed as a correct record subject to amending the correct title of Leanne Hawker to read Head of Patient Experience and Community Involvement.

The action log was considered:

Action Number 16/21: Viability of Community First Responders to administer pain relief. Brief update was provided by Andy Swinburn. Further update to be provided at 11 August meeting.

Action Number F and P 1/21-22: Focused review of performance related to clinical outcome metrics. Andy Swinburn commented that the Commissioner has indicated there may be amendments to the quality indicators which required measuring going forward. Duncan Robertson added that further deep dives on several clinical indicators were being undertaken. More updates will be provided at the 11 August meeting.

Action Number 20/21a: Update on improving functionality of symptom checkers on the Website. Update deferred to 11 August meeting.

Action Number 09/22: Provide more clarity on the interpretation of Post Production Lost Hours. Detail was included in later Agenda item. Hugh Bennett added that a PPLH deep dive was being presented to the Finance and Performance Committee next week. It was agreed that the presentation would be circulated to Quest members following that meeting.

Action Number 12/22: Was there a capacity in the CSD to focus on the categorisation of ineffective breathing as a major issue? Lee Brooks advised that agenda Item 9 would provide further analysis. Action Closed

RESOLVED: That

- (1) the Minutes of the Open meeting held on 17 February 2022 were confirmed as a correct record subject to the minor amendment as described;**
- (2) the standing declarations of Ceri Jackson as a Trustee of the Stroke Association were noted; and**
- (3) consideration was given to the Action Log as described above.**

17/22 PATIENT EXPERIENCE

1. Gareth Thomas introduced the patient experience which was a video showing Mr Martin Hughes who had started a Go Fund Me page to raise money to buy a Mangar Elk lifting chair. Mr Hughes' mother suffered a series of falls where she was thankfully uninjured. On one occasion, after a six hour wait for the ambulance to arrive only to get his mother on her feet again after 10 minutes using the chair.
2. Following this episode he decided to purchase a chair for use in the community and to reduce the strain on the ambulance service in circumstances where someone who has had a fall was uninjured.
3. The chair was purchased with money raised and has been used three times since last

November. Mr Hughes added that should these chairs be in use in the community it would be of great benefit and free up more ambulance resources.

4. Andrew Clement added there was approximately 700 lifting chairs allocated to care homes across Wales. Wendy Herbert agreed to take forward an action to look into the availability of lifting chairs in care homes and the possibility of their use in the community via the Older Person's Steering Group.
5. Whilst it was recognised that these chairs should be used with caution, particularly where a patient may be injured, the Committee commended Mr Hughes for his actions and thanked him for sharing his story.
6. Bethan Evans thanked Mr Hughes for sharing his story with the Committee.

RESOLVED: That

- (1) the patent experience was noted; and**
- (2) it was agreed Wendy Herbert would update the Committee at its next meeting on the availability of lifting chairs in care homes.**

18/22 PATIENT EXPERIENCE AND COMMUNITY INVOLVEMENT HIGHLIGHT REPORT

1. Gareth Thomas updated the Committee on the contents Patient Experience and Community Involvement (PECI) quarterly report for January to March 2022. The Committee was assured that through the Continuous Engagement Model the Trust was appropriately engaging with patients and the community, capturing their experiences and reporting back to them to give them confidence they were being listened to. He drew the Committee's attention to the following highlights:
2. The Team had continued to receive many compliments on the care received; and also feedback was received for areas in which the Trust could improve.
3. The majority of Covid restrictions had ended which allowed the Team to restart several face to face engagements in the community; which included refugee groups and the development of 'A welcome to Wales' pack which had been translated into several languages.
4. The annual defibrillator campaign was again a great success which was partly online and in person. Going forward the Team was considering ways to implement training on defibrillators and CPR for the sight loss community
5. The blue light hub app continues to be really successful with a lot more people downloading and using it with their children; further development of the app continued to be explored with Cardiff University and primary schools in Cardiff.
6. Surveys on the experience of patients continued and in particular the feedback received from the Non-Emergency Patient Transport Service (NEPTS) survey scored 8 out of 10 or higher.

Comments:

1. Members thanked the Team for the very comprehensive report appreciating the work involved in producing it.
2. The Committee considered the overall approach to accessibility, commenting it would

be useful to explore the possibility of adding audio visual description to future communications.

3. Bethan Evans read out the comments from the report which related to a palliative care patient and the experience of the wish ambulance service. A note of thanks for the staff involved and their sterling work on the wish ambulance was recorded which was fully endorsed by all Members. Andy Swinburn commented that the staff conducted this work voluntarily and personally praised them for their efforts.

RESOLVED: That the Committee noted the findings and that the report would be shared with external stakeholders.

19/22 COMMITTEE PRIORITIES

1. Trish Mills explained that the Committee's priorities had been set earlier in the year which had been designed to embed the duty of quality and the duty of candour in all that it does.
2. In order to provide clarity, the Committee's priorities for 2022/23 were amended to read "to 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 comes in to force in the Spring of 2023". The Committee will review progress quarterly.
3. Bethan Evans added that the Committee should be transparent and following a discussion at the Chairs Working Group meeting agreed on the elongated version of the Committee's priorities which was felt would be more user friendly for members of the public and provide more clarity.

Comments:

The Committee supported this version of the Committee's priorities

RESOLVED: That the Committee agreed the revised wording as described.

20/22 OPERATIONS CURRENT/FORWARD LOOK

The Committee received the quarterly Operational Update from Lee Brooks as a standing agenda item. The following highlights were brought to the Committee's attention:

1. The number of staff sickness relating to Covid continued to decrease; as of today this was below 60.
2. The Resource Escalation Action Plan (REAP), whilst still at a high level had been reduced to 3 from 4.
3. It was anticipated that the Emergency Communication Nurse System (ECNS) would go live very soon.

Comments:

Following a query in terms of the benefits for the Reset, Lee Brooks apprised the Committee where extending schemes such as the pilot of the Advance Paramedic Practitioner navigator role had been beneficial.

The Committee noted the expansion of the Clinical Support Desk and the roll out of the 111 service across the whole of Wales.

The Mobile Testing Unit (MTU) was due to end by the end of June 2022; were there any risks in terms of the exit strategy? Lee Brooks advised the Committee of the potential opportunities for MTU staff within WAST and didn't anticipate any risks going forward.

RESOLVED: That the update was noted.

21/22 RED REVIEW ACTIVITY

1. Lee Brooks explained that the report considered in detail the drivers for increased red demand and the actions the Trust has undertaken to comprehend and respond to the situation.
2. The Committee were reminded of the change applied to the Medical Priority Despatch System (MPDS) (introduction of the code: unconscious patients with abnormal breathing) back in 2019, and since then audits had been undertaken to gain assurance on call handler compliance. Whilst there has been an increase in ineffective breathing, particularly in red calls, the audits have given assurance that the process has been applied as intended by the International Academy of Emergency Despatch.
3. An analysis was undertaken on the top 10 red priority protocols in terms of activity;
 - a. Breathing Problems (Protocol 6)
 - b. Cardiac/Respiratory Arrest (Protocol 9)
 - c. Unconscious/Fainting (Protocol 31)
 - d. Overdose/Poisoning (Protocol 23)
 - e. Pandemic Flu (Protocol 36)
 - f. Pregnancy/Childbirth/Miscarriage (Protocol 24)
 - g. Falls (Protocol 17)
 - h. Running Call (Override)
 - i. Convulsions Fitting (Protocol 12)
 - j. Allergies/Envenomation (Protocol 2)
4. In terms of breathing problems as a chief complaint, there had been an increase in the number of incidents referred to by other healthcare professionals. There would be further focused audits relating to unconscious/fainting and trauma; this work was underway. In respect of convulsions and fitting the Committee were advised that, should the patient be fitting for a period of more than 20 minutes, this would be upgraded to red.
5. Lee Brooks summarised it was unlikely that in the immediate term, red activity demand would decrease.

Comments:

1. Was there an update on the increase in demand correlating to other services? Lee Brooks that the same issues, themes and demands were being experienced across the UK.
2. Was there any further information in terms of allergic reactions? Lee Brooks explained that this was subject to a clinical review and the output of this was awaited.
3. How would the findings of the clinical audits be linked into Public Health Wales? Lee

Brooks advised that should these findings provide a positive change in population health, this would be considered.

RESOLVED: The Committee:

(1) Noted the outcome of the analysis of the red activity review, including some additional work including:

- a. **111/QSPE undertake further review of the origins and outcomes for 0-4yrs demand to understand any learning or systems changes that could better address this increasing Red emergency demand.**
- b. **A clinical review of Red demand was commissioned to understand increased incidents associated with allergic reaction and to identify any trends in allergy triggers or clinical outcomes.**
- c. **Emergency Medical Services Coordination continued to use focussed audit to explore areas identified for potential Emergency Medical Dispatch learning; and**

(2) Noted there was no indication as a result of this review, save for some seasonal shifts for breathing problems, that red activity was likely to reduce to levels seen pre-International Academy of Emergency Despatch process change in 2019.

22/22 QUALITY HIGHLIGHT REPORT QUARTER 4 (JANUARY –MARCH 2022) and MONTHLY INTEGRATED PERFORMANCE REPORT

Jonathan Turnbull-Ross gave an outline of the Quality Highlight Report for Quarter 4 report and drew the Committee's attention to the following areas:

1. 104 cases had been discussed at 18 Serious Case Information Forums (SCIF); 42 of these cases were referred to the respective Health Board.
2. 2 Coroners cases resulting in a Regulation 28 (Prevention of Future Deaths) had been received during the quarter.
3. Handover hours lost this quarter were approaching 25,000; the Trust continued to meet with other health board colleagues to seek improvements in this area.
4. In terms of the Clinical and Quality Governance Group activity, updates were given on the Physician response Unit and the process of the management of expected deaths.
5. In response to a query at the last meeting regarding Post Production Lost Hours (PPLH) to provide more analysis, Jonathan Turnbull-Ross described in detail how PPLH were accounted for and the reasons for the lost hours. 83% of PPLH were attributed to 3 main reasons; Return to Base Stand Down Meal Break, Hospital Ambulance Liaison Officer Duties and Operations Manager Duties. These 3 categories accounted for over 12,910 PPLH. Going forward further work was being undertaken to understand in more depth the expected number of hours lost.

Hugh Bennett updated the Committee on the details within the Monthly Integrated Quality Performance report and drew out the following points:

1. The demand on the 111 service was expected to stabilise as the pandemic eased.
2. Call answering performance remained an issue; the Trust was addressing this by way

of improving the technical side.

3. There had also been issues with the call answering in respect of the Non Emergency Transport Service and further recruitment as one of the solutions to address this was being considered. Having said this the call answering performance remained above the target.
4. In terms of EMS, the benchmark for hear and treat has been exceeded, the roster review was due to be implemented, staff absence and absences had remained high.
5. The Trust was not in receipt of the investment for the transition plan which would have offset the levels of handover delays. Hugh Bennet explained that the mitigations in place by the Trust to offset the levels of handover was not enough to reduce it.

Comments:

1. Lee Brooks gave an overview of the Trust's position in relation to its ability to respond; red performance continued to be unsatisfactory. The last two months, March and April had been extremely challenging for the Trust. It was noted that in some regions in Wales, a no send policy was used 60% of the time. Delays in response have resulted in some patients dying before an ambulance could reach them. This does not necessarily indicate that the delay in response was directly attributable as the primary cause of death but was obviously a massive worry for the Trust. Call handlers, as they were dealing at the front end of the calls, were finding the current situation extremely disconcerting. He further commented on other areas of concern for the Trust which included staff sickness and PPLH. The former was currently at around 11%, the target was around 6%. PPLH would never be zero and would normally be around 6-7% as there were always unavoidable factors affecting this figure.

Currently, due to handover delays, the Trust was experiencing a 30% loss in conveying capacity. He added that at this precise moment, 40% of the Trust's ambulances were outside an Emergency Department. For the Trust to respond to patients in the Community in a timely manner was therefore almost impossible. Unless there was seismic shift in improving the lost hours, the Trust will not be able to reach patients in time.

2. The impact on the Trust's ability to respond to patients in the Community due to the handover delays was of grave concern. There were areas where the Trust had implemented various initiatives to improve the situation but clearly this was not enough and urgent remedial action was required. The Committee recognised it was a system wide problem and that the Trust was part of the system.
3. Members were deeply concerned with the overwhelming lost hours due to handover delays which were not only having a profound impact on patient safety but also on all staff in terms of their wellbeing, stress and anxiety.
4. The Committee were assured that the Trust was doing everything possible to alleviate the situation but were still staggered by the incredible number of hours being lost due to hand over delays.
5. The Trade Union Partners recognised the work the Trust was undertaking to improve staff welfare and the support given to them and thanked the Committee for its help

and appreciation.

6. The Committee discussed the possibility of compiling a combined escalation report to the Board which would be generated from this Committee, the People and Culture Committee and the Finance and Performance Committee, given the continuing and increasing Patient Safety concerns. It was agreed to discuss this further on in the meeting.

RESOLVED: That the Committee considered, noted and discussed the contents of the reports

23/22 QUALITY STRATEGY PROGRESS REPORT

1. Jonathan Turnbull-Ross explained that the plan had been delayed due to the Trust's response to the pandemic, and whilst work has commenced, the Committee were apprised of resourcing issues for the planned senior quality leads' roles, which may delay progress.
2. The key intentions of the strategy was around responsiveness, making it more local and bringing expertise to the local leadership structures. Funding for the latter however will not be provided on a recurrent basis. Opportunities for internal funding were being explored and the Committee would review this in more detail at their next meeting.

Comments:

1. The Committee recognised that the lack of funding to recruit the senior lead quality posts would have an overall impact on the strategy and welcomed the work being undertaken to address this through other internal avenues.
2. It was agreed that the progress report at the next meeting would include further details on the delivery of the strategy.
3. Furthermore, the practical elements of promoting and integrating the Quality Strategy into everyone's role be a topic of discussion on future Board development day

RESOLVED: That the Committee noted the report, including the financial challenge that directly affected the delivery of the strategy.

24/22 DELIVERY UNIT, ANALYSIS OF THE JOINT INVESTIGATION FRAMEWORK (APPENDIX B)

1. Lee Joseph, the Quality and Safety Manager in the Delivery Unit presented the Delivery Unit's Analysis of Appendix B report which covered the period 14 June to 30 November 2021. He noted that the Delivery Unit and Welsh Government receive copies of the Appendix B referrals, but they did not form part of any assessment by the Delivery Unit, with only the numbers being tracked and with responsibility on the Health Boards to receive, analyze and assess if a patient incident occurred. However the Delivery Unit noted the lack of translations of these referrals to patient safety incidents and that is what triggered the audit.
2. The analysis had focused on identifying any trends and themes of potential patient harm caused by the Trust's inability to respond to calls due to NHS Wales's system pressures.
3. The Delivery Unit reviewed 85 Appendix B reports received in the timeframe and the

following findings were identified:

- a. Outcome was death: 71
 - b. Recognition of life extinct on arrival (ROLE): 61
 - c. Initial grading Red: 3
 - d. Initial grading Amber 1: 64
 - e. Total number upgraded following patient deterioration: 57
 - f. Number upgraded to red following patient deterioration: 46
 - g. WAST operational contributory factors identified: 0
4. At the time of the report none of the 85 referrals had been converted to National Reportable Incidents by Health Boards, and as at today's meeting that number is two. Lee Joseph indicated that following their own review it is possible that 16 of the 85 referrals could be classified as National Reportable Incidents.
 5. It was noted that the average response time for the patients in the Amber 1 category was 6 hours 29 minutes and the average response time once upgraded to red was 6.5 minutes.
 6. There was clear evidence that the majority of patients had been given the appropriate response of Amber 1; however there were cases where the target response time was not being met and patients were deteriorating in the community.
 7. Cross analysis of the Appendix B's, with nationally reported patient safety incidents, indicates the high likelihood that incidents of avoidable patient safety harm and death were not being adequately investigated and reported nationally.
 8. The Delivery Unit has formalised several recommendations which include the setting of a task and finish group by the Emergency Ambulance Services Committee (EASC) to revisit the Framework to ensure the reporting process was fit for purpose improved upon, and working with the Health Boards to ensure the Appendix B referrals are reviewed.
 9. WAST has a healthy and open reporting culture and when there are contributory factors from the Trust they are reported routinely and in a timely way. Lee Joseph indicated he has also attended the Serious Case Incident Forum (SCIF) meetings and has observed the ways in which incidents are discussed and reported.

Comments:

1. Lee Brooks sought, in the absence of some events not being reported, what was the understanding of system risk? Lee Joseph explained that since this report has been published, there has been a slight increase in Appendix B reports being submitted by the Health Boards as they consider their reporting arrangements. In terms of understanding the risk there was a need to clearly identify where the harm or avoidable harms were occurring and what the impact was i.e. rather than the issue being about Appendix B referrals, it is about the risk of patient safety incidents due to system pressures.
2. Following a query in terms of regulatory requirement, Lee Joseph explained that once the incident was reported it was at that point it became a regulatory requirement to follow a sequence of events where it was investigated appropriately. His opinion was currently, as the evidence may suggest, some Appendix B reports being sent were not being appropriately assessed to determine whether it was a patient safety incident. Health Boards are therefore not fulfilling their regulatory requirements to undertake

these investigations. At the moment the Joint Investigation Framework is not policy and is based on goodwill in terms of following it and is inherently a culture issue.

3. Will the recommendations in the report really deliver the change that will reduce the levels of patient harm and what were the timescales in achieving them? The report has identified the problem and has suggested the appropriate mechanism to reduce harm through those recommendations. A timeline was yet to be confirmed but there will be continued liaison with EASC to identify membership of the task and finish group.
4. Given the length of time since the report was delivered and the timespan of the audit, had the report being considered by Health Boards? Lee Joseph explained that the report had been shared with Nurse Directors and they were required to assure the Delivery Unit that they will submit a return having made their assessment and updated with their input. Once this was received the Delivery Unit would recommend it is shared with the Health Boards' quality committees, however he was unaware as to whether the relevant committee/Board had seen the report, but would seek that information from Health Boards. In the meantime, Lee Joseph confirmed that Welsh Government colleagues are aware of the contents of the report.
5. Serious concern was expressed by the Committee that health boards were not reviewing these reports and the clear consequences of patient safety as a result. The Delivery Unit had identified 16 out of 85 referrals under Appendix B as potentially being National Reportable Incidents, however as the referrals had increased from November 2021 to date, potentially there are a similar number not yet reported. It was agreed that the issue would be escalated to the Board as a matter of urgency.
6. Wendy Herbert explained that the Trust had, in collaboration with the Delivery Unit and Welsh Government developed the Joint investigation framework. Whilst the process can be changed, the problem was the impact on patients should an investigation not be carried out. She encouraged an urgent piece of work, across all health boards, be carried out to improve the current situation as at the moment patients were coming to harm.

RESOLVED: That the update was noted.

25/22 QUARTER 4 PATIENT SAFETY REPORT

Wendy Herbert updated the Committee and drew attention to the following points:

1. The number of patient safety incidents had increased significantly in those that had initially been categorised as catastrophic and continued to do so.
2. Timeliness to respond to concerns under Putting Things Right Regulations has increased in the quarter, ending with the target of 75% within 30 days being exceeded in March.
3. Coroners requests for further information has increased markedly, the Team were currently working on around 170 cases; the majority of these were in respect of timeliness to respond. In North Wales, the senior coroner has requested the Trust complete an individual organisational statement which may result in the Chief Executive being called to and inquest in the next few months.
4. A continued increase in levels of hospital handover delays has also seen an increasing number of nationally reportable adverse incidents with hospital handover delays being the root cause of not providing a timely response.
5. Patients were continuing to wait longer for an Amber response and this had an

impact on the Red categorisation.

6. During this quarter, a total of 1,346 patient safety incidents were reported, 407 in January, 440 in February and 499 in March. This was a significant increase in comparison to the same period last year where there were 750 incidents reported.
7. There were a total of 1,623 Immediate Release Requests made to Health Boards. Of these, 882 were accepted (54.3%) and 741 were declined (45.7%).
8. The Putting Things Right (PTR) Department continued to receive a steady number of concerns within this reporting period (238). This was an increase in comparison to the same reporting period last year where 163 concerns were received.
9. This quarter has seen a decrease in the number of political concerns being received. Of the 28 new concerns, 9 related to an issue other than the timeliness of EMS responses.
10. 14 incidents had been reported as National Reporting Incidents to the Delivery Unit; the main themes and trends were identified as call categorisation

Comments:

1. The Committee acknowledged with grave concern the stark situation against the backdrop of hospital handover delays and unrelenting red and amber pressure, with particular concern voiced over the approval rates for Immediate Release requests.
2. Following a query on the funding for Patient Safety Manager, Wendy Herbert confirmed that they had been recruited and also 2 Band 3 administrators had been appointed into the Team.
3. In response to a question regarding catastrophic incidents being very high and significantly above that of the previous quarter. Wendy Herbert explained that Patient safety incidents classed as 'catastrophic' have increased significantly in Quarter 4, totalling 75 compared to 52 in Quarter 3, and up by more than 50% on the same time last year when the number was 29. Whilst the Committee understood that the classification of 'catastrophic' given at the outset may change as a result of an investigation, this upward trajectory nevertheless highlighted an increase in patient safety incidents.

RESOLVED: That the report was received for assurance and discussion.

26/22 RESPONSE TO CORONER – REGULATION 28, PREVENTION OF FUTURE DEATHS

Wendy Herbert explained that the report informed the Committee that the Trust had received 2 Regulation 28 Prevention of Future Deaths Reports. These Reports were issued to the Trust alone and did not include the Health Boards. The Committee recorded its condolences to the families affected. The Trust has provided responses and Improvement Plans to the respective Coroners. The improvement plan was monitored through the Assistant Directors Leadership Team.

RESOLVED: That the report was received.

27/22 COMMITTEE ASSURANCE REPORT

Julie Boalch drew the following key highlights for the Committee's attention:

1. There were currently 4 of the 16 corporate risks assigned to the Quest Committee for

overview. Each of these risks had been rearticulated as part of the risk transformation programme.

2. No new risks had been escalated to the Corporate risk register; however one risk had been closed which was reported to Trust Board in March 2022 (ID 316 (Potential for a high volume of personal injury claims due to work acquired Covid infection))

Comments:

1. Should 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) be transferred to the People and Culture Committee for oversight, given that responsibility for Health and Safety had now moved to the People and Culture Committee. Yes, this would be transferred.
2. Trish Mills explained that work continued to rearticulate the risks particularly the higher scoring risks ensuring the appropriate governance procedures were carried out. Furthermore, the Trust will liaise with other health boards on a reciprocal basis to advise on how to mitigate risks going forward. Part of the risk management programme will increase risk maturity.
3. Does the Trust have sight of the top risks presented to Health Boards? It was agreed to share this, it had been presented recently to EMT

RESOLVED: The Committee received assurances on the report and specifically noted:

- a. The rearticulating of the 4 Corporate Risks assigned to the Committee for oversight as part of the risk transformation work programme.
- b. The closure of Risk 316, reported to Trust Board in March 2022.
- c. The pause of the Board Assurance Framework (BAF) for 3 months.

28/22 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. One high priority recommendation was overdue (Role of the Advanced Paramedic Practitioner) and one medium priority recommendation which was still outstanding from 2019/2020 which related to the Trust's risk appetite statement that formed part of the transformation programme which was currently underway.

RESOLVED: That the Committee:

- a. Noted and consider the contents of the report.
- b. Considered the Internal Audit Plan activity.
- c. Received one current Internal Audit Report relevant to the Committee.
- d. Considered the Trust's proposals to address each recommendation with the inclusion of revised completion dates.

29/22 PATIENT EXPERIENCE DRIVER DIAGRAM

Resolved: This Item was received for information.

30/22 PRACTICAL OBSTETRIC MULTI-PROFESSIONAL TRAINING (PROMPT)

Resolved: This Item was received for information.

31/22 KEY MESSAGES TO BOARD

The Chair and Trish Mills would review and finalise this after the meeting and gave a brief overview of the expected content. Clearly, the key message was the level of concerns voiced by this Committee around patient safety, patient harm and avoidable harm, as well as staff welfare.

RESOLVED: That the Committee noted the update.

30/22 ANY OTHER BUSINESS

1. The Committee held a discussion which focused on how to escalate the issues regarding the current service pressures discussed, to the Board. There needed to be wider group of people to discuss broader escalation.
2. It was suggested that a combined escalation report following this Committee's, the People and Culture Committee, and the Finance and Performance Committee discussions on the overall situation be articulated and submitted.
3. From a Trade Union perspective, the seriousness of the concerns reflected on patients and staff and that the Committees were taking the issue extremely seriously was welcomed. It was suggested that a message be circulated to staff to articulate the current situation and, whilst the Trust was unable to resolve it, it was trying its best to improve. It must be a collaborative response from the Committees. Trade Union Partners strongly supported this.
4. The issues presented around Appendix B reports and the non-compliance of the framework must be part of the escalation report going forward. Furthermore, what were the opportunities for deep dives and what was the evidence around immediate release. This should also link in with the other key messages for the Board
5. One of the key points to raise must be around how we can communicate and engage collaboratively with our colleagues in Health Boards, so that we can discuss and identify system wide solutions.
6. The comments, concerns and points raised throughout the meeting would be escalated to the Chair of the Trust Board and the Chief Executive in the first instance and feedback would be provided to the Committee in due course.

Date of Next meeting: 11 August 2022

Minute Ref	Date	Agenda Item+C1:H 13	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	11 August 2022	<p><u>Update from 16th November meeting:</u> Andy Swinburn updated the Committee explaining that 2 Business Cases were being developed; one from the development of the Omnicell cabinet perspective (readjust for pentrox inclusion) and one from the revenue perspective (purchasing of pentrox). Dr Brendan Lloyd explained the reasons for the delay in developing this and would continue to update the Committee.</p> <p><u>Update for 17th February meeting:</u> 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 pentrox but new avenues are being explored, with the NCCU, to establish whether central funding, aligned to the decarbonisation agenda, may be applicable.</p> <p><u>Update for 12 May meeting</u></p> <p>The introduction of Pentrox continues to be one of the items that is listed for consideration against this years list of items in which financial support is required.</p> <p>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.</p>	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	11 August 2022	<p><u>Update from 16th November meeting:</u> QuEST requested for confirmation as to whether this will be a stand alone report or included in the performance report.</p> <p><u>Update for 17th February meeting:</u> Andy Swinburn requests a revised date for this action due to ongoing pressures.</p> <p><u>Update for 12 May meeting:</u> 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. Duncan Robertson added that further deep dives were being undertaken on several clinical audits</p>	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	Andy Haywood	11 August 2022	<p><u>Update for 17th February meeting:</u> Andy Haywood seeks an extension for this item to May 2022.</p> <p><u>Update for 12 May meeting</u> <u>Deferred to 11 August meeting</u> <u>Deferred to 10 November meeting</u></p>	Open
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	Wendy Herbert	11 August 2022	<u>Update for 11 August Meeting</u>	Open

			group to discuss the use of Mangar chairs in the Community.				
23/22a	12 May 2022	Quality Strategy Progress report	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	Wendy Herbert	11 August 2022	<u>Update for 11 August Meeting</u> On Agenda	Open
23/22b	12 May 2022	Quality Strategy Progress report	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.	Jonathan Turnbull-Ross	11 August 2022	<u>Update for 11 August Meeting</u> On Agenda	Open



OPERATIONS DIRECTORATE QUARTERLY REPORT FOR COMMITTEES 2022-23 Q1 (Apr-Jun22)

❖ NATIONAL OPERATIONS AND SUPPORT

Mobile Testing Units (MTU) Programme

Following submission of the Trust's proposal for the retention of Mobile Testing Units, Welsh Government has confirmed an extension of the contract until 31st March 2023. This contract provides for three MTU teams (one in the North and two in South) working Monday-Friday with some weekend contingency factored in should this be required.

EPRR and Specialist Operations

Her Majesty the Queen's Platinum Jubilee celebrations took place in June with a four-day weekend where members of the public celebrated across the UK. The EPRR team was part of the multi-agency planning with partners from the Welsh Police forces and our Health Board colleagues, to ensure we worked together across communities. The Trust anticipated an increase in demand and put plans in place which included additional command arrangements, MRT teams, Cycle Response Units and Alcohol Treatment Centres.

In May, our EPRR specialist and non-specialist assets took part in Exercise Celtic Consolidation - a large multi-agency exercise testing our combined response to a Manchester Arena style attack at Cardiff City Stadium. The exercise involved twenty WAST staff (including HART and SORT) working with partners from EMRTS, St John Ambulance Cymru, South Wales Police and South Wales Fire and Rescue. Further multi-agency exercises have taken place to look at our combined response to a Chemical, Biological, Nuclear and Radiological Attack in the South of Wales with a similar exercise being planned to take place in the North of Wales in July 2022. Further exercising opportunities are also planned to look at our response to specific sites, such as the Severn Tunnel.

In June, six members of staff and a DOM travelled to the Isle of Man to support the Manx Ambulance Service during this year's TT race. Our staff worked alongside the Isle of Man ambulance service staff and colleagues from Gibraltar and Guernsey. The staff who deployed reported that the experiences they had were hugely beneficial to them clinically and personally, and we look forward to a continued relationship with colleagues in the Isle of Man.

Work on the Trust's business continuity plans remains ongoing. Exercise Joshua was very successful in testing our internal response to ICT failures. This has allowed the team to produce the Trust's Critical ICT Disruption Plan. This plan was further tested via exercise Joshua 2 which took place at the end of June 2022. An exercise report shall follow.

The WAST Hazardous Area Response Team (HART) celebrates its' 10-year anniversary in 2022 and events have been planned to mark this occasion. HART continues to provide the

Trust's specialist response to incidents involving chemicals, limited access and egress and incidents at height. Work is continuing to update the HART Incident Ground Technology and this work will continue over the coming months.

Prolonged Period in High Escalation (REAP levels)

The aim of the Resource Escalation Action Plan (REAP) is to describe the arrangements to be considered by the Trust in response to a strategic or dynamic assessment of pressures affecting or likely to affect service delivery. The categorisation is considered weekly at the Operations Weekly Demand, Capacity and Performance meeting which is attended by members of the Senior Leadership Team and others.

High levels of REAP were not really intended for prolonged periods of time, mainly because the actions within REAP are intended to help the Trust recover the situation. Throughout the period of the pandemic, and the current high pressures, the actions either within REAP, or other actions taken like cohorting areas, are not resulting in an ability to de-escalate.

An absolute application of the REAP actions for prolonged periods of time is highly likely to have medium to long term impacts on our capacity to transform, on regulatory requirements, and management and clinical supervision activity.

The Executive Management Team have therefore agreed that after a period of REAP 4 extending for two weeks, that the Strategic commander in consultation with the respective Director, balance the application of REAP 4 actions between the immediate needs of the presenting operational and clinical situation, versus the medium to long term impacts on transformation, regulatory requirements and management and clinical functions. At CSP 4a in REAP 4, it has also been agreed that all available clinical staff are expected to support patient facing duties.

Volunteering

In the first week of June, we celebrated our amazing workforce of volunteers during National Volunteer Week. Several coordinated media releases shone a light on the work of our volunteers who continue to provide a dedicated response as Volunteer Car Drivers, or Community First Responders.

❖ EMERGENCY MEDICAL SERVICE (EMS)

EMS Roster Review

The purpose of the EMS Roster Review project is to: deliver EMS Response rosters for Cymru High Acuity Response Unit (CHARU) replacing Rapid Response Vehicles (RRV), Emergency Ambulance (EA) and Urgent Care Service (UCS) aligned to patient demand; improve staff well-being and achieve an efficiency gain (not saving) of 72 FTEs, by December 2024.

Voting on the EMS Roster Review closed on Friday 20th May 2022. The project team have been working over the past few weeks to ratify the results, which is now complete. Whilst

the results of the vote have been shared with all staff an additional validation process is being confirmed with our trade unions. An implementation plan has been agreed at Project Board, which is scheduled to commence with Emergency Ambulance rosters in Hywel Dda from 5th September. A separate implementation plan for UCS and CHARU will be agreed in due course.

The project remains on track to be completed by the end of Q4 2023.

❖ RESOURCING & EMS COORDINATION

On 30th June 2022 the Senior Leadership Team approved the Standard Operating Procedure (SOP) for Remote Supervision. The purpose of the SOP is to allow remote supervision of Emergency Medical Dispatchers. Supervision is provided for EMDs in order to provide support for call handling performance, complex call management and clinical support for call escalation. This will also provide the opportunity for a remote call audit function, which will enhance our ability to carry out live call audit and will support the ongoing improvement in quality of the call handling service we offer communities across Wales. In addition, this facility will also support the ability for Clinicians through the Clinical Support Desk to directly listen in to calls, which will support the provision of timely clinical support when needed.

Following a period of stasis over the winter period, the EMS Coordination Reconfiguration Project Board resumed on 23rd May 2022. Project Board Members, which includes Trade Union Partners agreed to focus on the areas within the Project that can be progressed over the forthcoming months that will improve the delivery of services within the Centre and will focus on a review of the demand and capacity across the Centres, a roster review within the Department, the allocation of work across boundaries, and other opportunities for continuous improvement. This will report through the Operational Transformation Programme Board.

A Global Rostering System (GRS) Steering Group will shortly be set up to review the functionality available through the GRS Rostering System. Due to the onset of Covid many aspects of functionality available through the Rostering System were not implemented and additional functionality is now available to the Trust that would significantly improve the way we manage functions such as Continuous Professional Development, Timesheets and Annual leave. There are several system improvements that could prove incredibly useful to the organisation and staff alike and would help move us to a position where staff members are able to carry out a number of functions themselves. It is hoped that this Steering Group will help shape not only the current use of the GRS system but would also shape further development to the system to realise greater opportunities for working in a more efficient way.

❖ AMBULANCE CARE

Capacity Management Plan

Since the Capacity Management Plan has been deployed to try to control the Trust's spend on taxi usage, we have seen a reduction in 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 system is on schedule to go live in August 2022.

Transfer of UCS to Ambulance Care

The transfer of the urgent care service (UCS) to the Ambulance Care section took place on the 1st July. Early indications are that the transfer has occurred as expected, focus will now be placed upon integrating the service into the Ambulance Care function and refocusing the service towards delivering its' core purpose.

NEPTS Plurality Model Redesign

The first phase of the redesign of the NEPTS plurality model continues with tenders out for all externally commissioned work, this time using the new 3Q quality approach to measure both quality and value.

The new plurality model should improve value for money whilst also ensuring that we utilise providers of the highest quality. The new contracts will start to go live from the 1st October 2022.

❖ INTEGRATED CARE

111 Press 2

111 Press 2 went live in the Hywel Dda Health Board area on the 20th June. The service, operated by the Health Board in collaboration with WAST connects callers requiring urgent mental health support to a specialist practitioner. Further roll outs of the service are expected through the summer. We are closely monitoring any unanswered demand which returns to 111 core service. The early analysis indicates small numbers during the hours the service is non-operational.

111 Rostering

Following a significant staff engagement exercise the 111 Operations team have been working with Trade Unions, Resourcing and Staff to improve our approach to resourcing.

During July trials of new shift lengths and shift start times will commence pan-Wales. It's expected that these trials will improve our people's working lives and improve the alignment between 111 demand and capacity.

Further trials of fixed rosters are being developed to be in place later this summer.



AGENDA ITEM No	7
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	4

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

MEETING	Quality, Patient Experience & Safety Committee
DATE	11 th August 2022
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Julie Boalch, Head of Risk, Deputy Board Secretary
CONTACT	Julie.Boalch@wales.nhs.uk

EXECUTIVE SUMMARY
<p>1. The purpose of the report is to provide the Quality, Patient Experience & Safety Committee (QuEST) with an update in respect of Corporate Risks that are relevant to the Committee’s remit for review.</p> <p>2. In addition, it provides a progress update in respect of the Risk Transformation Programme which was supported as the direction of travel at the Audit Committee in December 2021 and has been included in the Integrated Medium Term Plan (IMTP) (2022/25).</p> <p>RECOMMENDATION:</p> <p>3. Members are asked to consider the contents of the report and:</p> <ul style="list-style-type: none"> a. Discuss the risks relevant to Committee. b. Note that the ‘avoidable harm’ action plan will be incorporated into the BAF to support further mitigation of Risks 223 and 224. c. Note the improved Board Assurance Framework. d. Note the adoption of the new nationally agreed Risk Matrix including scoring levels, review schedules and risk descriptors. e. Note the 2022/23 Risk reporting timetable. f. Note the transfer of Risk 199 to the People & Culture Committee.

KEY ISSUES/IMPLICATIONS
<p>4. Concerns were escalated to the Trust Board by the Chairs of Quality, Patient Experience and Safety Committee (QUEST), the People and Culture Committee (PCC), and the Finance and Performance Committee (FPC) in relation to the significant impact on staff and patients as a result of system pressures and particularly as a consequence of delays in handover at emergency departments.</p> <p>5. The Trust Board received a further paper on actions to mitigate real time avoidable patient harm in the context of extreme and sustained pressure across the urgent and emergency care system which has negatively impacted patient</p>

flow through all hospital sites and led to a substantial growth in emergency ambulance handover lost hours and a growing number of cases of avoidable harm or death to patients.

6. These actions, for the Welsh Ambulance Service and system stakeholders, will further mitigate the Trust's highest scoring risks 223 and 224 and will be reflected in the Board Assurance Framework during the September Board and Committee reports.
7. The Trust Board will be informed of the progress against these actions and the plan closely scrutinised by Committees.
8. Further, this paper sets out the outcome of the work that has been undertaken to date to strengthen and rearticulate the Trust's Corporate Risks, relevant to Committee, including new titles, summary descriptions and scores which Members are asked to note.
9. A review of each Corporate Risk score has been undertaken by mapping each control to related assurances and by identifying any gaps in these as well as any actions that can be taken to further mitigate the risk.
10. Members are asked to note the risk reporting timetable approved by Audit Committee.
11. The new nationally agreed Risk Matrix is included in this paper for information.
12. The Executive Management Team (EMT) received formal, monthly feedback from the Assistant Director Leadership Team (ADLT) on activity relating to the corporate risks for approval.

REPORT APPROVAL ROUTE

13. The report has been considered by:
 - ADLT – 21st March 2022
 - ADLT – 22nd April 2022
 - EMT – 11th May 2022
 - Audit Committee – 7th June 2022
 - Trust Board – 28th July 2022

REPORT ANNEXES

14. SBAR report.
15. Annex 1 - Summary table describing the Trust's Corporate Risks.
16. Annex 2 - Risk Matrix
17. Annex 3 – Risk Reporting Timetable
18. Annex 4 - Board Assurance Framework

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

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

SITUATION

1. The purpose of this report is to provide an update in relation to the Trust's Corporate Risks, relevant to Committee, with a particular focus on the work that has taken place to rearticulate and strengthen these.
2. The controls and assurances have been mapped in order to consider the robustness of a control, any gaps in controls and assurances and any further actions that have been identified to mitigate those gaps and the risks.
3. A summary report describing each of the corporate risks as of 12th May 2022 is detailed in Annex 1 as an extract from the Corporate Risk Register (CRR). The new timetable means that there is a lag which will resolve itself through the September reporting cycles; however, the risk owners update progress against the risks in accordance with the review schedule in place across the Trust, with the highest scoring risks reviewed on a monthly basis.
4. The approved National Risk Matrix is included in Annex 2 for Members information.
5. A Risk Reporting Schedule is included in Annex 3 for information.
6. The improved Board Assurance Framework (BAF) report is included in the paper in Annex 4.

BACKGROUND

7. The Risk Management and Board Assurance Framework Transformation Programme was supported as the direction of travel at the Audit Committee in December 2021 and has been included in the IMTP. A progress report was submitted to the Audit Committee meeting in June 2022.
8. The immediate priority was for a detailed review of the Trust's 5 highest scoring risks with the remaining corporate risks to follow. A programme of work has been undertaken 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.
9. 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

10. There are currently 16 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

new 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.

Highest Scoring Risks

11. The immediate priority of the transformation programme was to undertake a full review of the Trust's highest scoring risks: Risks 223, 224, 199, 316 and 160 which has been completed. New titles were determined, and the risks clearly articulated with new summary descriptions, controls and assurances which have been mapped and actions identified resulting from any gaps.
12. The same process has been applied to the remaining Corporate Risks on the CRR and these are described in the table in Annex 1 focussing on titles, summary descriptions and scores only. The full Risk detail, including controls, assurances, gaps and mitigating actions form part of the improved Board Assurance Framework (BAF) detailed in Annex 4; however, whilst significant progress has been made, this work is not fully complete with a number of risks still a work in progress.
13. The EMT has approved the rearticulation of each of the Corporate Risks, which are included in the summary table in Annex 1.
14. Members are asked to note that there were a number of actions outlined at the July 2022 Trust Board meeting which will mitigate real time, avoidable harm in the context of extreme and sustained pressure across the urgent and emergency care service. These actions will further mitigate the Trust's highest scoring risks 223 and 224 and will be incorporated into the Board Assurance Framework during the July/August review of these risks. Members will see these reflected in the reporting for the September Board and Committee meetings.

Closure and De-Escalation of Risks

15. No risks have been closed from the CRR or de-escalated to Directorate Registers since the last meeting in May 2022.

Transfer of Risks

16. Risk 199 has transferred to the People & Culture Committee for oversight given that the Health & Safety function and programme of work are now included in the Terms of Reference and cycles of business for that Committee.

Changes to Risk Scores

17. There have been no changes to the risk scores since the last meeting in May 2022.

Further Review of Risks

18. Work is ongoing to consider and develop potential new Risks for inclusion on the CRR and consideration will be given during the coming weeks to the following:
- *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)*
 - *Staff health and wellbeing in the face of continued pressure (IMTP)*

Board Assurance Framework

19. One element of the Risk Transformational Programme was to develop a transitional BAF that 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 transformational programme, these key risks are the corporate risks due to their relationship to the IMTP delivery and their risk ratings.
20. This BAF was presented to Audit Committee in June 2022 and will be presented to each of the Committees as a standing Agenda item throughout the reporting cycles.

National Approach and Risk Matrices

21. Members are asked to note the new, nationally agreed Risk Scoring Matrices (Annex 2). These have been developed in partnership across Health Boards and Trusts to align the approach to Risk Management across the NHS in Wales wherever possible.

Reporting Timetable




22. Members are asked to note the agreed risk reporting timetable described in annex 3.
23. Each of the red and high scoring risks will be reviewed monthly by the Risk Owners with the support of the Risk Team as part of the agreed review frequency matrices; however, these will be reported to Trust Board on a quarterly basis and any additional actions included where possible.

RECOMMENDED:

24. **Members are asked to consider and discuss the contents of the report and:**
- a) Receive the improved Board Assurance Framework.**
 - b) Note that there are further actions outlined in the Avoidable Harm**

- paper that will further mitigate Risk 223 and 224.
- c) Note the adoption of the new nationally agreed Risk Matrix including scoring levels, review schedules and risk descriptors.
 - d) Note the 2022/23 Risk reporting timetable.

Annex 1 – Corporate Risk Register Summary

CORPORATE RISK REGISTER				
RISK ID	NEW RISK TITLE	NEW SUMMARY DESCRIPTION	EXECUTIVE OWNER	RISK SCORE
223	<p>The Trust's inability to reach patients in the community causing patient harm and death</p> <p>Previous title: <i>Unable to attend patients in community who require See & Treat</i></p>	<p>IF significant internal and external system pressures continue</p> <p>THEN there is a risk of an inability and/or a delay in ambulances reaching patients in the community</p> <p>RESULTING IN patient harm and death</p>	Director of Operations	<p>25 (5x5)</p> 
224	<p>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</p> <p>Previous title: <i>Patients delayed on ambulances outside A&E Departments</i></p>	<p>IF patients are significantly delayed in ambulances outside A&E departments</p> <p>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</p> <p>RESULTING IN patients potentially coming to harm and a poor patient experience</p>	Director of Quality & Nursing	<p>25 (5x5)</p> 
303	<p>Delayed administration of chest compressions to patients as part of resuscitation</p> <p>Previous title: <i>Delayed administration of chest compressions to patients as part of resuscitation</i></p>	<p>IF there is no universal guidance issued in relation to the level of PPE required when administering chest compressions and no reduction in infection rates of Covid-19</p> <p>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</p> <p>RESULTING IN potential patient harm and damage to the Trust's reputation</p>	Director of Paramedicine	<p>10 (2x5)</p> 

Annex 2 – Proposed National Risk Matrix begins at the top of the next page (17)

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

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

Annex 3 - Risk Reporting Timetable

	ADLT	EMT	Deadline for Papers	Audit Committee	FPC	QuEST	PCC
1	5th May 2022	11th May 2022	31st May 2022	7th June 2022	18th July 2022	11th August 2022	6th September 2022
2	8th August 2022	24th August 2022	8th September 2022	15th September 2022	19th September 2022	10th November 2022	29th November 2022
3	31st October 2022	9th November 2022	24th November 2022	1st December 2022	16th January 2023	9th February 2023	21st February 2023
4	23rd January 2023	8th February 2023	23rd February 2023	2nd March 2023	20th March 2023		

Risk Register locked and no further changes will be made apart from any amendments agreed at EMT.

No risk report to FPC on 14th November 2022 (duplicate of 19th September 2022 report).

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death			Date of Review:	11/05/2022	TREND	25 (5x5)
				Date of Next Review:	09/06/2022	➔	
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			
<ul style="list-style-type: none"> a. Hospital Ambulance Liaison Officer (HALO) b. Regional Escalation Protocol c. Immediate release protocol d. Resource Escalation Action Plan (REAP) e. 24/7 Operational Delivery Unit (ODU) f. Incident Response Plan (IRP) g. Gold/Strategic, Silver/Tactical and Bronze/Operational 24 hour/ 7 day per week system to manage escalation plans h. Alternative care pathways in place i. Hear and Treat j. Consult and Close k. Advanced Paramedic Practitioner (APP) deployment model l. Clinical Safety Plan m. Volunteers getting to patients n. Extended cohorting arrangements at Morriston and Grange hospitals to end of July 2022 o. ETA scripting p. Clinical Contact Centre (CCC) emergency rule q. Protocol 36 (dealing with pandemic flu symptoms) r. BT duplicate call filter s. Escalation forums to discuss reducing and mitigating system pressures t. SCIF to discuss patient incidents that have triggered a certain risk level which have a potential of being reported to the Welsh Government 				<p>Internal Management (1st Line of Assurance)</p> <ul style="list-style-type: none"> a. 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 b. Daily conference calls to agree RE levels in conjunction with Health Boards c. 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) d. Weekly review by Senior Operations team. 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. e. Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end f. The Incident Report Plan has been ratified via EMT g. Same as e h. Health Informatics reports, APP dashboard monitors, reports on app use by Consultant Connect i. Monitoring CSD rates through AQIs j. Consult and Close volumes form part of EMS CCC weekly reports to SPT. 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) k. 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 l. Clinical agreement – agreeing escalation to higher levels, ODU dashboard, AACE paper through National Director of Operations group m. Volunteers are another resource for response, Volunteer n. Service level agreement in place o. 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 p. CCC Emergency Rule is policy that has been signed off by Execs. q. There is a regular review of levels through SPT ratified at EPT. r. This is a tactic contained in REAP ratified through SPT and EPT s. Daily risk huddles are recorded, and documented actions are shared with stakeholders and progress monitored via the ODU t. Occurs on a weekly basis and meetings are minuted 			

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death			Date of Review:	11/05/2022	TREND	25 (5x5)
				Date of Next Review:	09/06/2022	➔	
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	
GAPS IN CONTROLS			GAPS IN ASSURANCE				
<ul style="list-style-type: none"> Acknowledgement and acceptance of risk by Health Boards and balancing the risks across the whole system Blockages in system e.g internal capacity within Health Boards which affect patient flow Covid capacity streaming Transition Plan/Inverted Triangle – bid for transition plan has been put in and is now subject to funding Local delivery units mirroring WAST ODU Handover delays link to risk 224 Tolerance in Health Boards has become the norm. As delays have increased, there appears to be no visible appetite to address these issues 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. 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 <p><i>Please note that the gaps listed are not WAST's and are therefore outside of the control of WAST</i></p>			None immediately identified but subject to continual review				
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			Assistant Director of Operations EMS / Assistant Director of Operations – National Operations & Support	Subject to funding - no timeframe for this			
2. Leading Change Together (forum to progress workforce related work streams jointly with TUPs)			ADLT Sub-Group	30.09.22			
3. EMS Demand & Capacity i.e. review and implementation of new EMS rosters			Assistant Director of Operations EMS	30.09.22			
4. Transition arrangements post pandemic			Executive Pandemic Team	30.09.22			

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:	20/05/2022	TREND	25 (5x5)	
			Date of Next Review:	30/06/2022			
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			
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				
<p>a. 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 <i>Framework for the Investigation of Patient Safety Serious Incidents (SIs) V2.2</i>, dated July 2019.</p> <p>b. 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. To be chaired by the Deputy Chief Ambulance Commissioner.</p> <p>c. WAST and system compliance with National Standards - 15-minute handover (NHS Wales Hospital Handover Guidance v2 (May 2016))</p> <p>d. 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.</p> <p>e. Workstreams put in place to meet requirements of <i>Right care, right place, first time Six Goals for Urgent and Emergency Care A policy handbook 2021–2026</i>. Goal 4 incorporates the reduction of handover of care delays through collective system partnership. WAST membership on the workstream in place looking at handover of care delays which includes the implementation of Fit2Sit programme and handover of care checklist pan NHS Wales. Additionally, the Emergency Ambulance Services Committee (EASC) have stated that no delay should exceed 4 hours.</p> <p>f. Hospital Ambulance Liaison Officer (HALO) (Some health Boards).</p> <p>g. Regional Escalation Protocol and Resource Escalation Action Plan (REAP).</p> <p>h. Staff from WAST, Health Boards and third sector organisations assisting to meet patient's Fundamentals of Care as best they can in the circumstances.</p> <p>i. 24/7 Operational Delivery Unit (ODU) escalating handover delays / patient condition to Health Board colleagues.</p> <p>j. Gold/Strategic, Silver/Tactical and Bronze/Operational 24 hour/ 7 day per week system to manage escalation plans.</p> <p>k. Escalation forums to discuss reducing and mitigating system pressures.</p> <p>l. WAST Education and training programmes include deteriorating patient (NEWS), tissue viability, dementia awareness, mental health.</p> <p>m. Clinical audit programme</p> <p>n. Workshop set up by the Deputy Chief Ambulance Commissioner to respond to the findings in the Health Care Inspectorate Wales (HIW) Report <i>Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover</i> (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.</p>			<p>Internal Management (1st Line of Assurance)</p> <p>a. Patient safety reporting and escalation through the Serious Clinical Incident Panel (SCIP), Patient Safety Highlight Reports, Health Board specific reports in place with escalation through WAST governance framework</p> <p>e. Monitoring of Ambulance Quality Coordinators</p> <p>f. 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</p> <p>g. 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</p> <p>h. Confirmed through HIW workshops</p> <p>i. Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end</p> <p>j. Same as i</p> <p>k. Daily risk huddles are recorded, and documented actions are shared with stakeholders and progress monitored via the ODU</p> <p>l. Integrated Quality and Performance Report, Health Informatics reports, APP dashboard monitors, reports on app use by Consultant Connect (I) and shared at local and corporate meetings regarding patient safety and handover of care position across NHS Wales and NHS England</p> <p>m. <i>TBC via meeting with Assistant Director Research, Audit and Service Improvement</i></p> <p>n. HIW approve and sign off WAST elements of recommendations</p> <p>External Management (1st Line of Assurance)</p> <p>a. 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).</p> <p>b. 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</p>				
GAPS IN CONTROLS			GAPS IN ASSURANCE				
<ul style="list-style-type: none"> 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* (covering control a) Lack of pace in the formation of a working group (pan Wales) to address the findings of the NHS Wales Delivery Unit Report on the implementation of the Framework for the Investigation of Patient Safety Serious Incidents (SIs)* (covering control b) Lack of implementation and holding to account regarding the <i>NHS Wales of the Handover Guidance v2</i> and recognition of the patient safety risks pan NHS Wales* (covering control c) Variation in responsiveness at Emergency Departments to the escalating concerns regarding patients' NEWS* (covering control d) Internally WAST require rapid access to collective patient safety data including NEWS at Emergency Department level for local managers, the Operational Delivery Unit, senior managers, and patient safety / quality improvement teams to support quality and patient safety conversations and reporting (covering control d) 			<ul style="list-style-type: none"> Lack of live collective patient safety metrics and look back data at ED level for in baseline data for improvement projects and WAST reports (covering assurance a) Strengthen current quality, safety and patient experience reports to include collective data over time and use statistical process charts where appropriate (covering assurance b) 15-minute handover target is not being achieved pan-Wales * (covering assurance c) TBC via discussion with Assistant Director Research, Audit and Service Improvement (covering assurance d) Planning and performance teams are preparing workstreams. Lack of escalation and response to AQIs by the wider urgent care system and regulators * (covering assurance e) Lack of escalation and response to AQIs by the wider urgent care system and regulators* (covering assurance a) 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* (covering assurance b) <p>(*WAST can influence but the gap is out of WAST's control).</p>				

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:	20/05/2022	TREND	25 (5x5) ➔		
			Date of Next Review:	30/06/2022				
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			
<ul style="list-style-type: none"> Variation in appetite across the Health Boards to implement Fit2Sit, citing overcrowded emergency department waiting rooms as the reason. Quality Improvement approach required to engage and influence, led by WAST (WAST have some control on this). Limited confidence in system engagement to address Goal 4 (covering control e) Protracted timescales in the <i>Right care, right place, first time Six Goals for Urgent and Emergency Care - A policy handbook 2021–2026</i>. 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*. Position not implemented across all emergency departments* (covering control f) Variable depending on staff resources and facilities at each ED. WAST have minimal control on this at patient level* (covering control h) Mandatory training compliance lower than required. Recovery plan in place (covering control i) Lack of pace and engagement from system partners. Second meeting cancelled on two occasions in May 2022* (covering control n) 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* (covering control n) <p>(*WAST can influence but the gap is out of WAST's control).</p>								
Actions to reduce risk score or address gaps in controls and assurances			Action Owner	By When/Milestone	Progress Notes:			
1. 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.			TBC	Awaiting internal programme details				
2. Fit 2 Sit implementation – through the Emergency Department Quality Delivery Framework (EDQDF).			Head of Quality (QSPE)	Timeframes awaited via EDQDF				
3. Develop and implement patient safety dashboards at Emergency Department level (NHS Wales & NHS England). With a handful key quality metrics / KPIs which may include: <ul style="list-style-type: none"> NEWS Age Waiting times (Live) (Call to current time) Existing long-term condition Immediate release data (Links to 223) 3. Incrementally strengthen the look back collective intelligence data in the Patient Safety Highlight Report over the next six months to include as relevant: <ul style="list-style-type: none"> 'Call to definitive care' time 'Number of patients ROLED at scene – outside of response time' Safeguarding referrals Patient experience data Clinical audit data SCIF (NRIs) / Appendix Bs numbers Pressure damage – whole pathway (grade 3 /4 – ambulance transfers) Regulation 28 Prevention of Future Deaths Reports issued Concerns data Medical examiner / mortality review outcomes 			Head of Patient Safety	October 2022				
			Head of Patient Safety	Develop during Quarter 2 2022 data period				
4. HIW Improvement Workshop and Task & Finish Group (coordinated by CASC). WAST actions required and also influencing improvements across the system in response to the 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 Quality & Nursing	Quarterly updates on progress to QuEST commencing August 2022				
5. Participation in the CASC led workshop to reform <i>the Framework for the Investigation of Patient Safety Serious Incidents (SIs) V2.2, dated July 2019</i>			Assistant Director Quality & Nursing	Timeframes awaited from CASC / NHS Wales Delivery Unit				

Risk ID 303	Delayed administration of chest compressions to patients as part of resuscitation			Date of Review:	26/04/2022	TREND	10 (2x5)
				Date of Next Review:	05/07/2022	➔	
IF there is no universal guidance issued in relation to the level of PPE required when administering 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		Likelihood	Consequence	Score	
			Inherent	3	5	15	
			Current	2	5	10	
			Target	1	5	5	
IMTP Deliverable Numbers: 7,12,16, 36							
EXECUTIVE OWNER		Director of Paramedicine		ASSURANCE COMMITTEE		Quality, Safety and Patient Experience Committee	
CONTROLS				ASSURANCES			
<ul style="list-style-type: none"> a. PPE provision to frontline staff b. Mandatory PPE training for frontline staff c. Clear Trust guidelines for PPE to be used during resuscitation d. PPE guidance to staff on intranet – this clearly states what level 3 PPE consists of e. Communication to caller via CCC call handler regarding Basic Life Support (BLS) f. Guidance updates relating to IPC/PPE/Resuscitation guidelines provided to Clinical Advisory Cell g. Monitoring and reporting of patient safety incidents via Executive Pandemic Team/Senior Pandemic Team (SPT) h. Dissemination of process for rapidly donning PPE. This includes briefing of bank staff, volunteers and military for donning and doffing PPE i. PPE breach reporting process j. Covid 19 vaccination of staff members k. Monitoring return of spontaneous circulation rates l. Chest compression advice provided to callers by call handlers 				Internal Management (1st Line of Assurance): <ul style="list-style-type: none"> a. Staff have emergency PPE wallet if caught unawares. All PPE is ordered via logistics in local area. All staff are fit tested for FFP3 protection. Fit testing and Respiratory Protection Equipment (RPE) SOPs – these go through WAST governance structures. Training and videos available for staff on use of PPE which is captured on ESR b. Mandatory training is recorded on ESR c. Coronavirus update section which details Trust guidelines. Frontline EMS staff issued with iPads to be able to access the intranet d. PPE guidance available on the intranet and regularly reviewed and updated at the Clinical Advisory Cell and signed off at SPT as required e. CCC call handling protocol f. All meetings of the Clinical Advisory Cell are minuted and upwardly reported to SPT via a Common Recognised Information Picture (CRIP) g. Incidents recorded on Datix h. Coronavirus update section which details Trust guidelines. Frontline EMS staff issued with iPads to be able to access the intranet. Register for donning and doffing PPE training i. Breaches recorded on Datix j. Essential register reported to SPT k. Monthly clinical indicators l. Calls are subject to auditing External Not applicable			
GAPS IN CONTROLS				GAPS IN ASSURANCE			
<ul style="list-style-type: none"> • If the right level of PPE is not used, there is no way of knowing unless the team or part of the team report it. • Impact of new variants 				<ul style="list-style-type: none"> • Difficult to obtain a true picture, if incidents are not reported • Difficult to plan against future environmental factors which are outside WAST's control 			
Actions to reduce risk score or address gaps in controls and assurances				Action Owner	By When/Milestone	Progress Notes:	
1. Monitor vaccinations / booster rates of staff				Occupational Health team	31.03.23 – Checkpoint Date		
2. Monitor changes to changes to resuscitation guidelines				Cardiac Lead – Clinical Directorate	31.03.23 – Checkpoint Date		
3. Monitoring any move from pandemic to endemic				SPT / Business Continuity and Recovery Team	31.03.23 – Checkpoint Date		
4. Monitoring changes to the national guidance for PPE				IPC team who report to BCRT who report to EPT	31.05.22		

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



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Gwasanaethau Ambiwylans Cymru
Welsh Ambulance Services
NHS Trust

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

MONTHLY INTEGRATED QUALITY & PERFORMANCE DASHBOARD – June/July 2022
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MEETING	Quality, Patient Experience and Safety Committee
DATE	11 th August 2022
EXECUTIVE	Rachel Marsh – Director of Strategy, Planning and Performance
AUTHOR	Hugh Bennett – Assistant Director of Commissioning and Performance Nicola Quiller – Commissioning & Performance Officer
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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 **June 2022** (and where data is available July 2022).

RECOMMENDATION

Trust Board is asked to:-

- **Consider** the June/July 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.
- **Approve** the proposed new metrics for reporting from the next period

KEY ISSUES/IMPLICATIONS

Overview

This Integrated Quality & Performance Report contains information on 28 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.

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

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 Finance and Performance Committee and Trust Board meetings; changes will be applied for the August 2022 report.

Our Patients – Quality, Safety and Patient Experience

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

999 answering times have been challenged through significant increases in demand. The median and 65th percentile performance remain good, but the call answering tail increased in June 2022 to over 50 seconds, which is higher than the Trust would want.

There is no additional funding secured into 2022/23 for 999 call handlers. Forecasting and modelling is being undertaken on the future call taker requirement through to December 2024, which is currently with the AD EMS Co-ordination & Resource for consideration.

111 call answering performance saw an improvement in May 2022, but then a deterioration in June and July. Recent negotiations with commissioners suggest that the Trust has broadly the right number of call handlers in post, however, further work is required to reduce capacity lost through sickness absence, align capacity with demand through 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.

111 Clinical response: whilst the Trust continues to see achievement of the clinical call back times for the highest priority 111 calls, improvements were recorded in the answering of P1CT and P2CT, however P1/D1 (Dental) and P3CT calls saw a decline in performance in July 2022. The Trust knows that the waits for a clinical ring back are too long. Recruitment and retention of clinicians remains a priority, with significant numbers of clinical vacancies currently. Urgent discussions are underway to develop a more focused plan to increase clinician numbers.

Ambulance Response (safety / patient experience): Red and Amber response times declined into June 2022 and a marginal increase in patient demand was seen. The Amber 1 tail (95th percentile) remains at unacceptable levels, at six hours 50 minutes. These long response times have a direct impact on outcomes for many patients. This was the focus of the discussion at FPC who remained extremely concerned at the levels of avoidable harm to patients. Actions within the Trust's control include:

Capacity:

- Recruitment: the Trust has a revised relief gap of 148 FTEs for Ambulance Response which takes into account the uplift in FTEs required for the Cymru High Acuity Response Unit (CHARU), the decision not to reduce any emergency ambulance cover in Hywel Dda and prioritisation of CSD staffing increases. The Trust has recently received an additional £3m in 2022/23 which will allow the Trust to recruit 100 FTEs. Due to the length of training, the majority of these additional staff will become operational in Q4.
- Summer/winter modelling: the Trust has recently completed its summer modelling and is in the process of sharing the results with senior stakeholders across the system. The Trust will seek to bring forward potential tactical actions it can take through the summer and winter that put further capacity into the system (the winter modelling is expected to be completed no later than mid-August 2022). This demonstrates a continued level of very poor response times. In discussing this report, FPC noted their considerable concerns and it was agreed that the detailed modelling would be shared with the whole Board (complete).

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.
- 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 for the second half of 2022/23, an increase in the previous target of 10.2% which has been delivered. The Clinical Support Desk has made good progress and currently has a 6% vacancy level against the new establishment of 96 FTEs.

One of the key factors in relation to response times is the capacity lost to handover outside Emergency Departments. There were over 23,000 hours lost in July 2022, 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). Delivery against these commitments will be monitored through this performance report in future months.

Ambulance Care (formally NEPTS) (Patient Experience): performance was above 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 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.

National Reportable Incidents (NRIs) / Concerns Response: the Trust reported 3 NRIs to the Delivery Unit in June 2022, compared to 11 in May 2022; and 24 serious patient safety incidents were referred to health boards in June 2022 under the “Appendix B” arrangement, compared to 7 in May 2022. In July 2022 complaint response times improved to 22% therefore failing to meet the 75% target. In the main, many of these incidents will be as a result of continued longer response times and the actions outlined below therefore are key.

Our People (workforce resourcing, experience and safety)

Hours Produced: 117,865 Ambulance Response ambulance unit hours were produced in June 2022. The emergency ambulance unit hours production (UHP) was 93% in June 2022 and RRV UHP was 79%. Key to the hours produced is the abstractions which remain high.

Response Abstractions: abstraction levels increased in July 2022 to 40%, 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 12% in July 2022 (benchmark 5.99%). Workforce fatigue is also an issue.

Trust Sickness absence: The Trust’s overall sickness percentage was 8.85% in May 2022 which represents an improvement on April 2022. High sickness levels were seen across all areas of the Trust’s operations including Ambulance Response, EMS Co-ordination, 111 and Ambulance Care, affecting capacity in all areas. Actions within the IMTP concentrate on staff well-being with an aim to start to reduce this level. In addition, Employee Assistance Provider (EAP) data suggests that most requests for counselling are as a result of work related stress. 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.

Staff training and PADRs: Stat / Mand training compliance rates have been improving and hit the target of 85% for the first time in nearly 2 years. PADR levels remain low.

Finance and Value

Financial Balance: The Trust has reported outturn performance for June 2022 with a surplus of £2,000 and has 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.

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

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 11.5% in June 2022, compared to the benchmark of 10.2%, which was exceeded during 2021/22.

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 a 5 mental health professionals FTEs into the Clinical Support Desk (CSD). 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 the second half of the year).

The Trust **conveyed** 36% of patients to emergency departments in June 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 July, over 12,000 patients cancelled their ambulance and we were unable to send an ambulance due to application of CSP levels to nearly 1,000 callers. In the longer term, as we know, we are clear that 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 has been submitted to Welsh Government to start to increase numbers of APPs being trained.

Handover lost hours: 23,978 hours were lost in July 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 for implementation from the 25th July 2022.

There have been a recent high profile report which references handover, the Health & Social Care Committee report on Hospital Discharge and its Impact on Patient Flow through Hospitals ([Hospital discharge and its impact on patient flow through hospitals \(senedd.wales\)](https://www.senedd.wales)), and includes recommendation six:-

“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”.

Summary

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. Demand across the 111 and EMS services increased in June 2022, this coupled with other factors such as the continuation of the CoVID-19 variants, high 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 just received further funding (£3m) for +100 FTEs into Ambulance Response, which is welcome, but it remains critical to patient safety that handover lost hours are reduced in line with Ministerial expectation.

REPORT APPROVAL ROUTE

Date	Meeting
05 August 2022	Assistant Director of Commissioning & Performance
10 August 2022	Executive Management Team
11 August 2022	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



GIG
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Ymddiriedolaeth GIG
Gwasanaethau Ambiwylans Cymru

Welsh Ambulance Services
NHS Trust

Monthly Integrated Quality & Performance Report

June / July 2022

Annex 1 – Top Indicator Dashboard





Section 1: Monthly Indicators / Top Indicators Dashboard



Top Monthly Indicators	Target 2022/23	Baseline Position (2021/22)	Jun-22	Jul-22	2 Year Trend	RAG
Our Patients - Quality, Safety and Patient Experience						
111 Abandoned Calls	< 5%	18.60%	14.0%	14.6%		R
111 Patients called back within 1 hour (P1)	90%	94.00%	94.4%	94.5%		G
999 Call Answer Times 95th Percentile	95% in 00:00:05	00:52	00:50	-		R
999 Red Response within 8 minutes	65%	55.2%	50.8%	52.0%		R
999 Amber 1 Mean		01:39:58	2:13:57	2:19:23		TBD
Renal journeys arriving within 30 minutes of their appointment (NEPTS)	70%	79%	75%	77%		G
Discharge & Transfer journeys collected less than 60 minutes after booked time (NEPTS)	90%	81.00%	87%	85%		A
National Reportable Incidents reports (NRI)	Reduction Trend	5	3	-		A
Concerns Response within 30 Days	75%	61%	13%	22%		R
Immediate Release Request Volumes (Red/Amber 1)	TBD	682	623	769		TBD

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)

Top Monthly Indicators	Target 2022/23	Baseline Position (2021/22)	Jun-22	Jul-22	2 Year Trend	RAG
Our People						
Capacity						
EMS Abstraction Rate	29.92%	42.00%	37%	40%		R
Hours Produced for Emergency Ambulances	95%	95.0%	94%	94%		A
Health and Wellbeing						
Sickness Absence (all staff)	5.99%	10.48%	-	-		R
EMS Operations Sickness Rates	5.99%	7.76%	10.18%	11.95%		R
Staff Turnover Rate - Indicator Under Development	TBD	TBD				R
Frontline CoVID-19 Vaccination Rates	-	3913	4,283	-		-
Statutory & Mandatory Training	>85%	82.3%	85.13%	-		G
PADR/Medical Appraisal	>85%	60%	59.25%	-		R
Value						
Financial balance - annual expenditure YTD as % of budget expenditure YTD	100%	100%	100.00%	-		G
Post-Production Lost Hours (EA, RRV, UCS)	Reduction Trend	8,582	7678:44:36	7008:44:36		A
Partnerships / System Contribution						
111 Consult and Close	Improve	7,843	17,208	17,694		G
Combined 999 & 111 Hear & Treat	15.0%	10.4%	11.8%	-		G

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

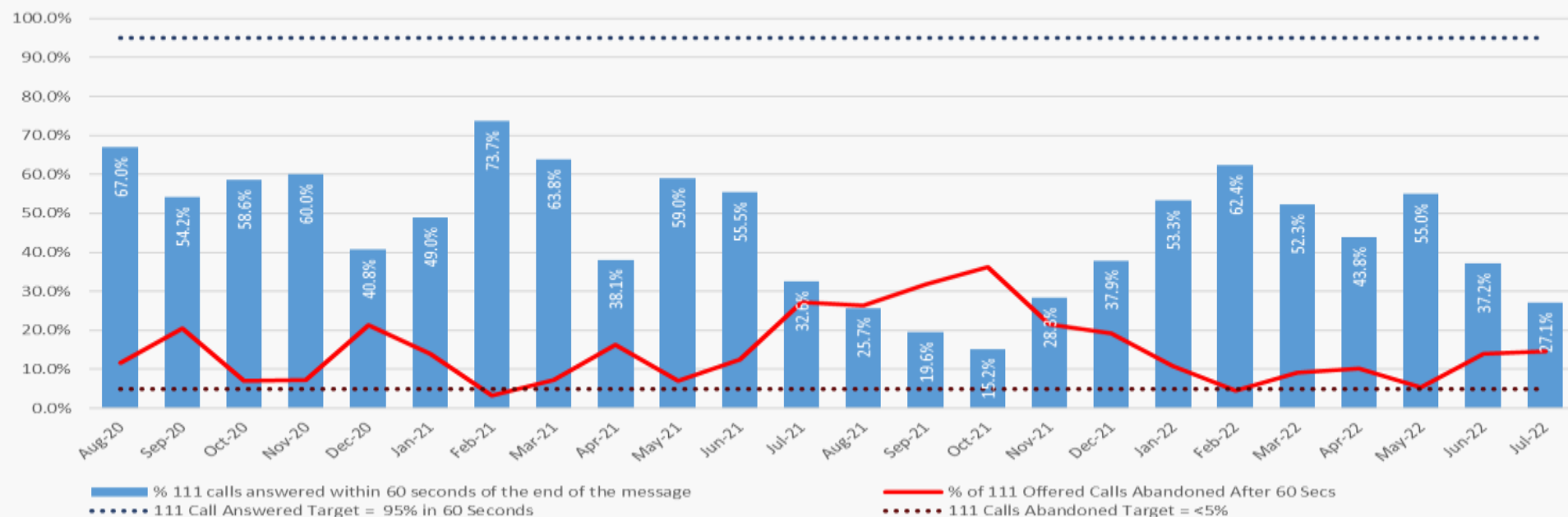
111 Call Answering/Abandoned Performance Indicators



Influencing Factors – Demand and Call Handling Hours Produced

**NB: July 2022 111 Shift fill data unavailable

111 Calls Answered vs Calls Abandoned within 60 Seconds



Analysis

111 call abandonment is a key patient safety indicator for the service. July 2022 saw a decline (worsening) in abandonment rates to 14.6%, therefore failing to meet the 5% target.

The percentage of 111 calls answered within 60 seconds of the end of the message improved in July 2022 to 27.1%. Given the continued high volumes of calls per month, this still represents a significant number of people who receive a patient experience which didn't meet the levels achieved in February 2022 (62.4%).

111 call demand increased marginally in July 2022 compared to the previous month.

The graph alongside also shows that capacity (staff hours) has been increasing in line with the roll-outs and as planned; however, despite recruiting significant numbers of additional staff as agreed with commissioners, although sickness absences (which includes COVID-19 Sickness) continue to reduce they remain high at 12.51% for NHS111 in June 2022. This means that demand is higher than forecast, capacity is lower than planned leading to the longer average call answer times as seen.

Communication regarding the use of 111 is regularly circulated to the public, which includes utilising online 111 Wales; in July 2022 there were 348,944 visits to the website. In July 2022 the top viewed pages were My Health Online with 20,885 visits, COVID which accounted for 17,192 followed by leg pain symptom checker which accounted for 14,553 hits.

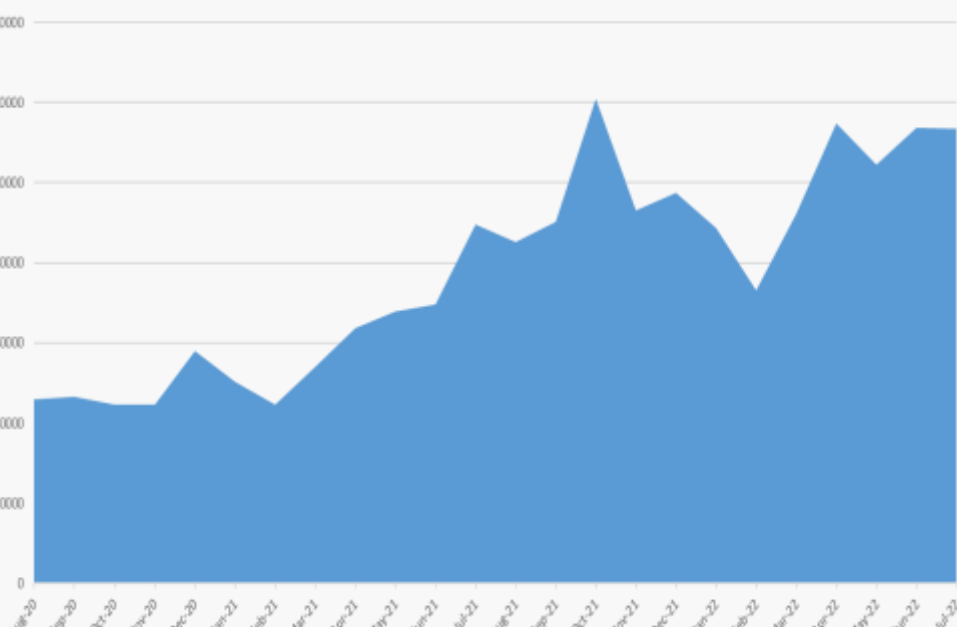
Remedial Plans and Actions

- 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. Discussions are ongoing with commissioners to confirm the commissioned WTE for call handlers, which we think will be around 178 WTE. 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

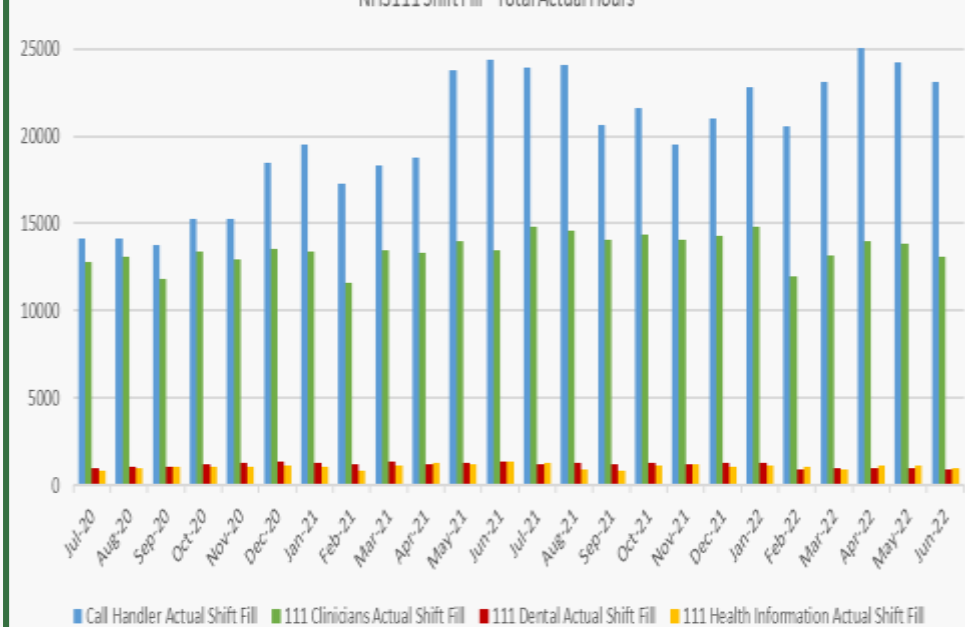
Expected Performance Trajectory

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)

Total 111 Calls Offered



NHS111 Shift Fill - Total Actual Hours

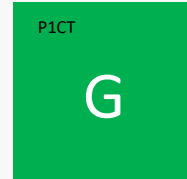




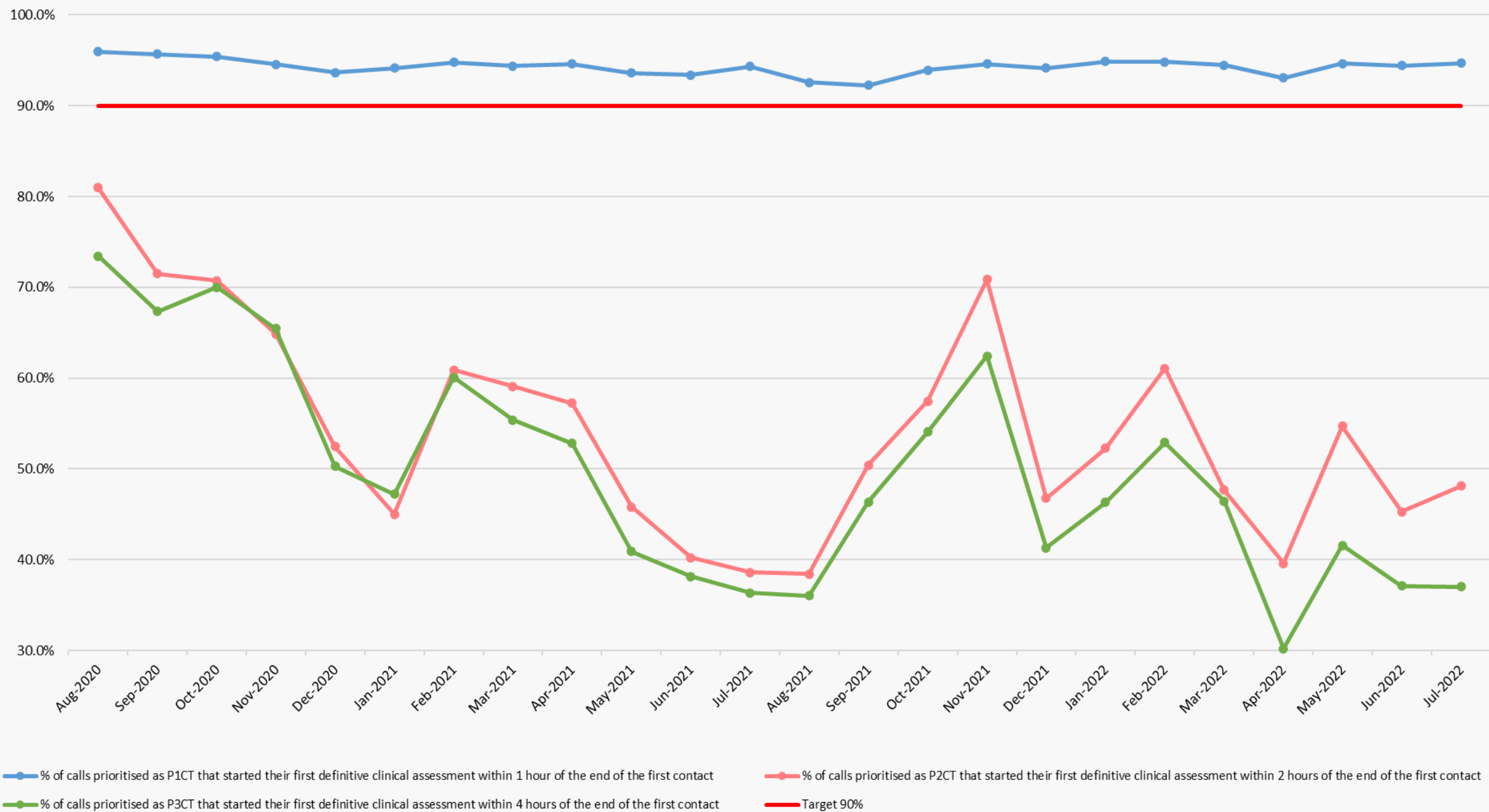
Our Patients: Quality, Safety & Patient Experience

111 Clinical Assessment Start Time Performance Indicators

Influencing Factors – Demand and Clinical Hours Produced



111 Timely Clinical Triage of Patients



Analysis

The performance of 111 calls receiving a timely response to start their definitive clinical assessment remains a challenge, with the continuing exception of the highest priority calls.

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 still not meeting the 90% target, and, in July 2022 a decline was seen in P1CT and P2CT, however P1/D1 and P1CT categories saw improvements.

Demand for the service continues to grow (see previous slide) which will affect performance, but in addition, recruitment and retention of clinical staff also remains problematic.

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 consideration is being given to an updated action plan which may include:

- Utilisation of other clinicians to fill vacancies
- Maximising opportunities through agile working
- Review of existing staff bases
- Review of service model
- Targeted recruitment drive

Expected Performance Trajectory

Risks have been highlighted in previous reports about the ability to recruit sufficient clinicians and this is now being seen. Urgent work is now underway to agree a series of actions that might help to increase recruitment, reduce turnover and reduce demand on clinicians, but performance is likely to be poorer than the Trust would want for some time to come.



(Responsible Officer: Lee Brooks)

Welsh Ambulance Services NHS Trust



Our Patients: Quality, Safety & Patient Experience

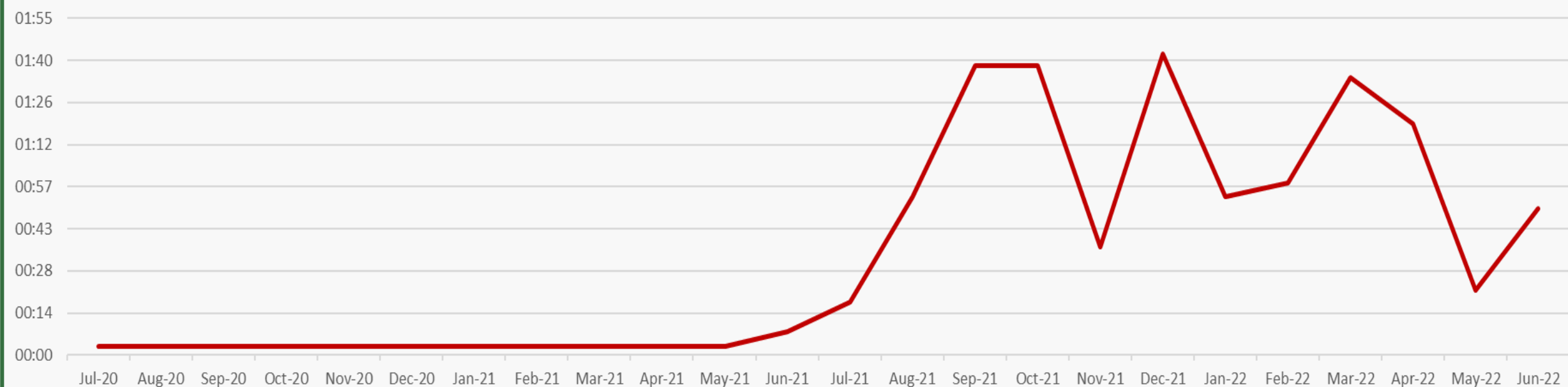
999 Call Performance Indicators

Influencing Factors – Demand and Clinical Hours Produced



NB: July 2022 data not yet available as AQIs not published

95th Percentile 999 Call answer times



Analysis

The 95th percentile 999 call answering performance declined in June 2022 to 50 seconds, compared to 22 seconds May 2022. Therefore, failing to meet the 6 second answer target for the eleventh consecutive month largely as a result of increased call demand, particularly at weekends. Increasing call answering times are a significant concern in relation to patient safety. Despite increasing call demand, the Trust continue to outperform other ambulance services, placing 10th out of 14 services (1 being worst and 14 being best performing) for call answering times. London Ambulance Service (LAS) recorded the highest volume of call answering delays, whereas West Midlands Ambulance Service (WMAS) are currently the best performing..

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

The Trust received 47,386 emergency 999 calls in June 2022, an increase compared to May 2022, higher than June 2020 but lower than June 2021. The continued high call volumes are likely to be a result of public activity returning to normal levels, along with the impact of the continuing pandemic. Although not shown here, June 2022 saw a reduced level of staff abstraction due to sickness and COVID (13.16%), however this continues to reduce capacity within the call centres.

Remedial Plans and Actions

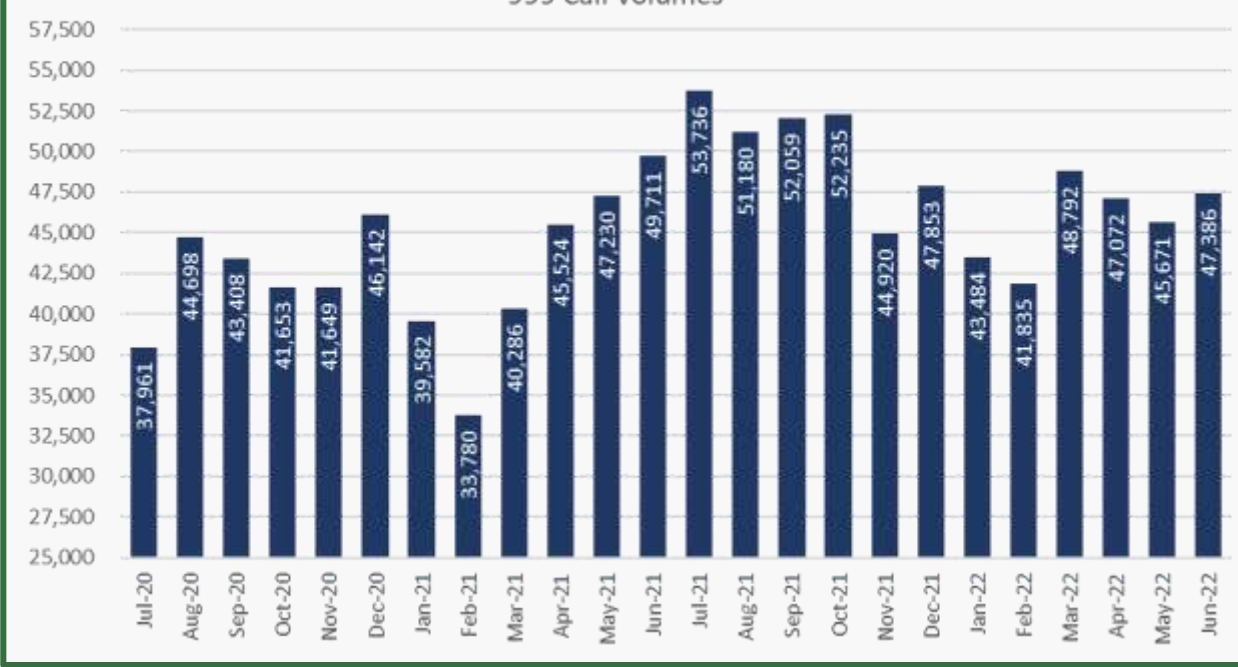
- EMS CCC meet twice weekly to review demand profiles and align staffing levels appropriately. Resources teams are focussing on balancing capacity across the 7-day period, targeting overtime to weekends and Mondays where patterns of demand and reduced UHP are identified.
- Additional funding original 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. Therefore, there are currently 4 FTE Vacancies.

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

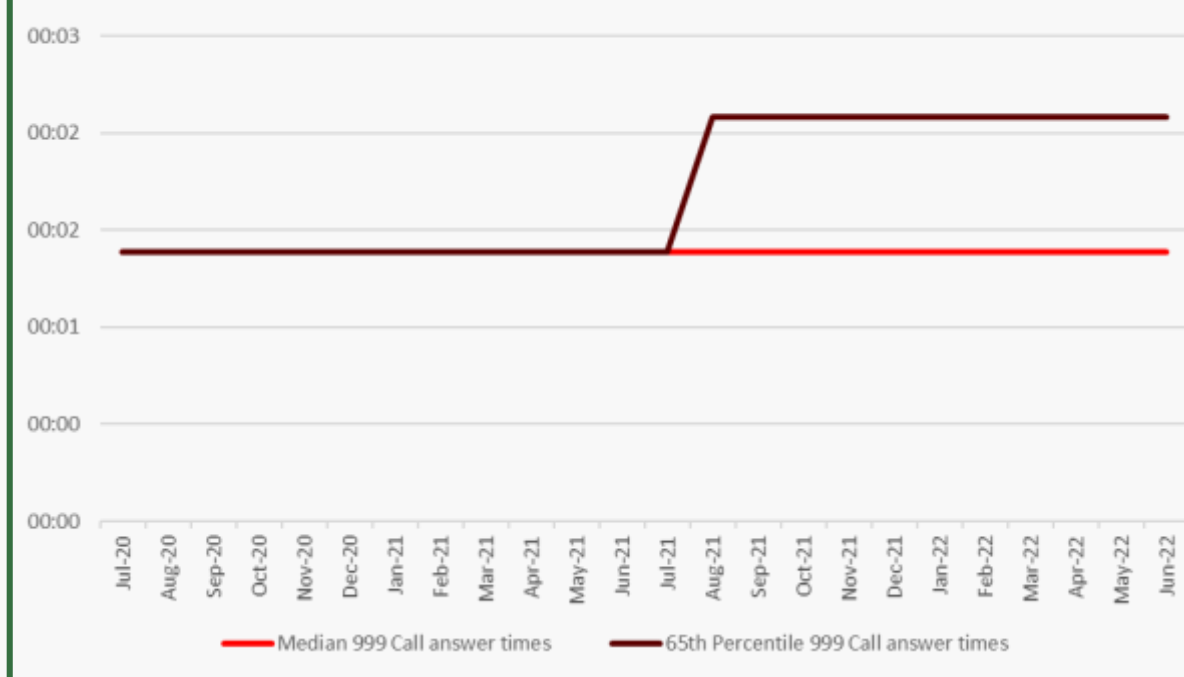
Expected Performance Trajectory

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

999 Call Volumes



Median & 65th Percentile 999 Call Answer Times



(Responsible Officer: Lee Brooks)

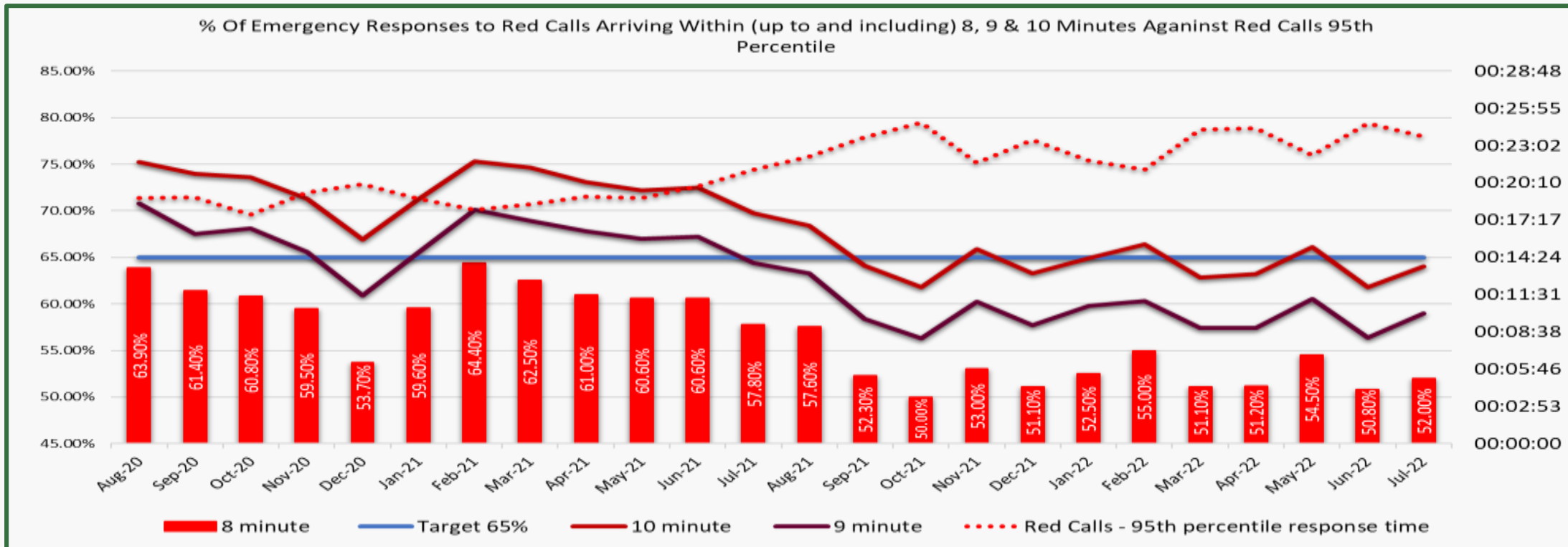
Welsh Ambulance Services NHS Trust



Our Patients: Quality, Safety & Patient Experience

Red Performance Indicators

Influencing Factors – Demand, Hours Produced and Hours Lost



Analysis

Red performance improved in July 2022; however, it remains significantly lower than the 65% target; the target has not been achieved since July 2020. There was also significant health board level variation with only one (C&V) 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 64% in July 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 23,978 hours lost in July.

The number of EA actual hours produced increased slightly, however RRV hours decreased in July 2022 compared to June and were lower than planned, with continuing high (though reduced) levels of abstraction due to sickness absence (c10%)

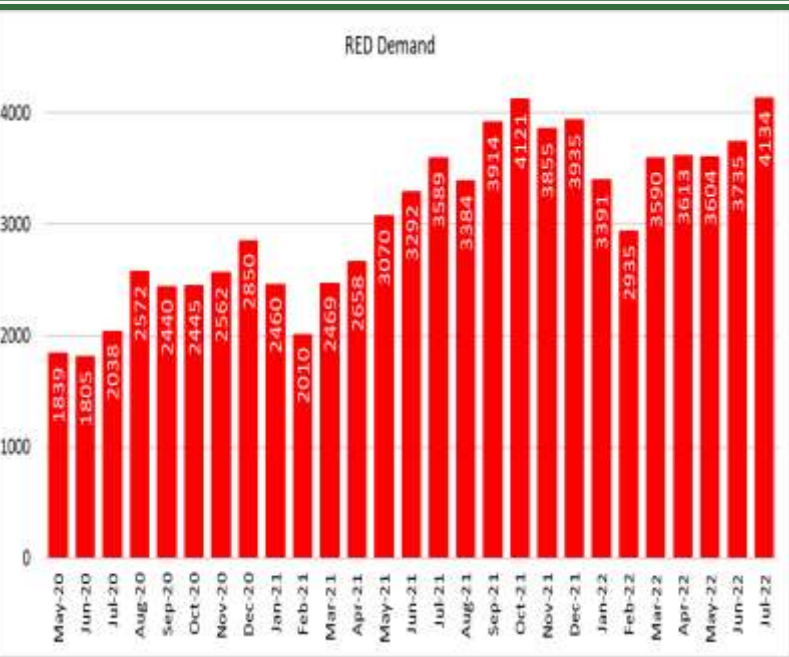
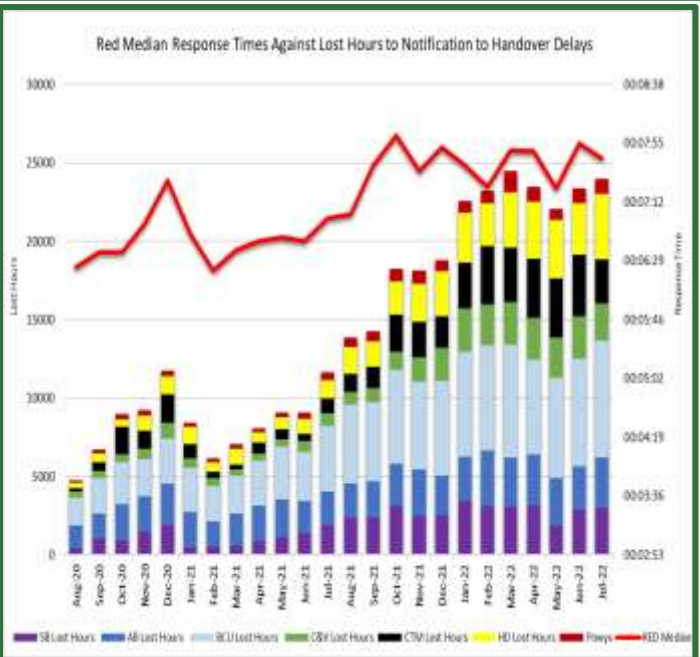
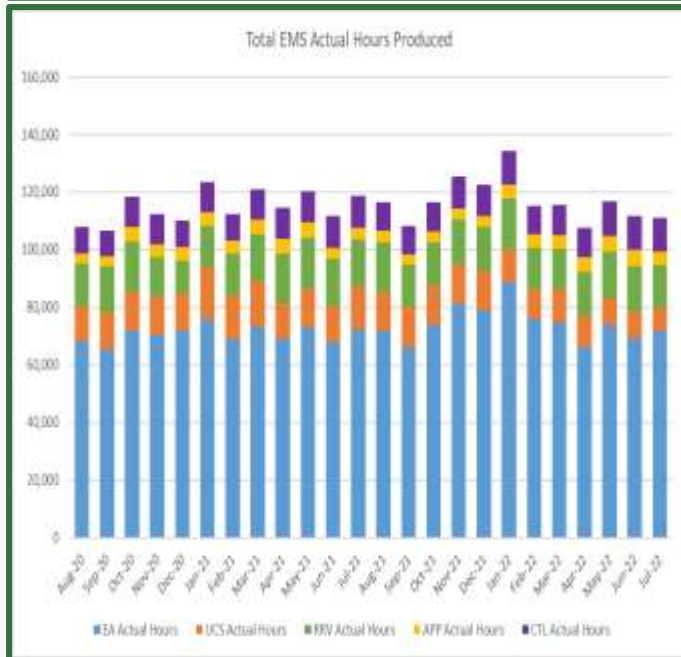
There are many other factors which affect red, including additional time taken to don level 3 PPE to Red calls relating to some respiratory disease/issues (this requirement remains in place).

Remedial Plans and Actions

- The main improvement actions are:
- Increase capacity where funded - recruitment of 100 FTEs, EMTs and ACA2s during 2022/23.
 - 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
 - Implementation of CHARU service as part of new rosters will positively impact on red performance in particular. It is only partially funded however.

Expected Performance Trajectory

Modelling through the summer forecasts continued poor red response times, if no reduction in hospital handover delays are seen in particular.



(Responsible Officer: Lee Brooks)

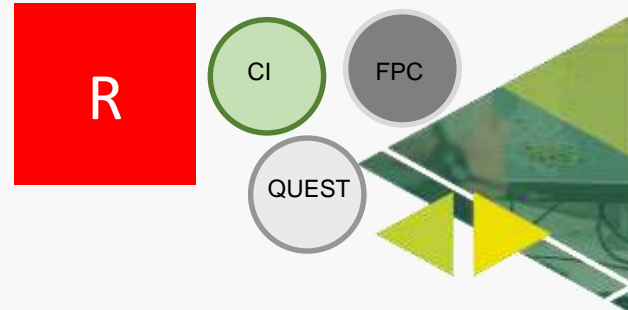
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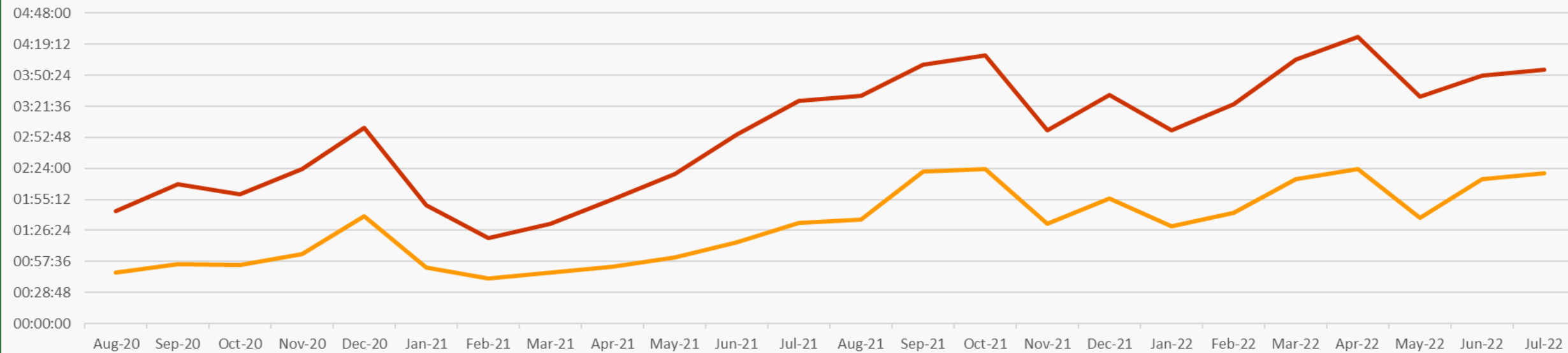
Our Patients: Quality, Safety & Patient Experience

Amber Performance Indicators

Influencing Factors – Demand, Hours Produced and Hours Lost



Amber 1 & 2 Mean Performance



Analysis

Amber performance saw declines in the percentiles in July 2022, with the exception of Amber 95th Amber 2 95th. In addition, there were still some very long patient waits. The ideal Amber 1 median response time is 18 minutes. Amber 1 and 2 mean performance also saw declining performance as indicated in the top graph.

In July 2022, 778 patients (all categories, not just Amber) waited over 12 hours, an increase when compared to June 2022, continuing to represent a very poor quality and experience of service. 659 of these patients were in the Amber category.

Amber demand increased in July 2022 and activity remains at a high level, additionally continuing high handover continue to affect performance.

There is strong correlation between Amber performance and lost hours due to notification to handover delays, as demonstrated in the graph on the bottom left of this page. The number of hours lost to notification to handover delays in July 2022 increased to 23,978, remaining higher than the worst recorded in December 2019 (13,820).

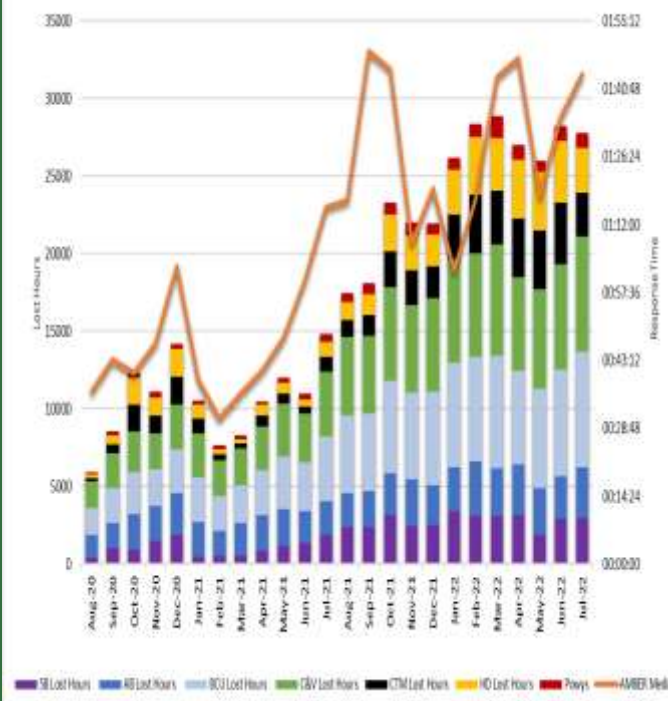
Remedial Plans and Actions

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.

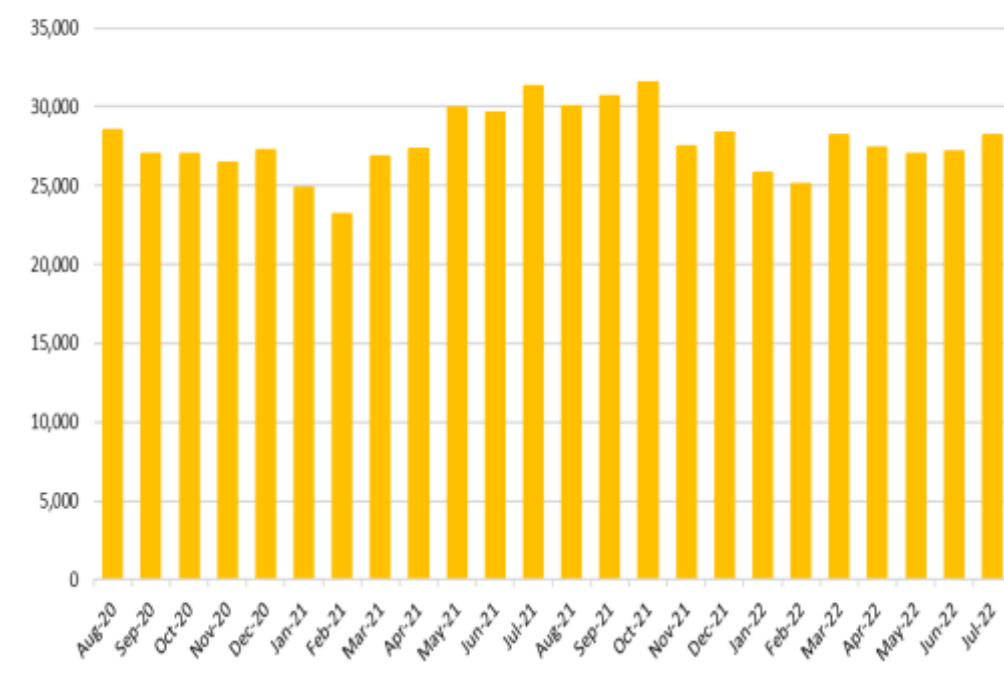
Expected Performance Trajectory

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.

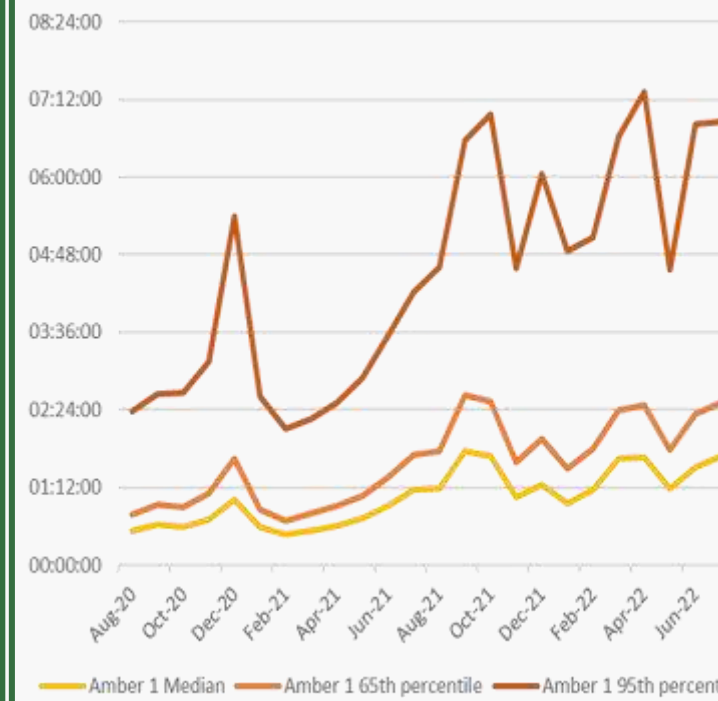
Amber Median Response Times against Lost Hours to Notification to Handover Delays



Total Verified AMBER Demand



Amber 1 Median, 65th and 95th Percentile



(Responsible Officer: Lee Brooks)

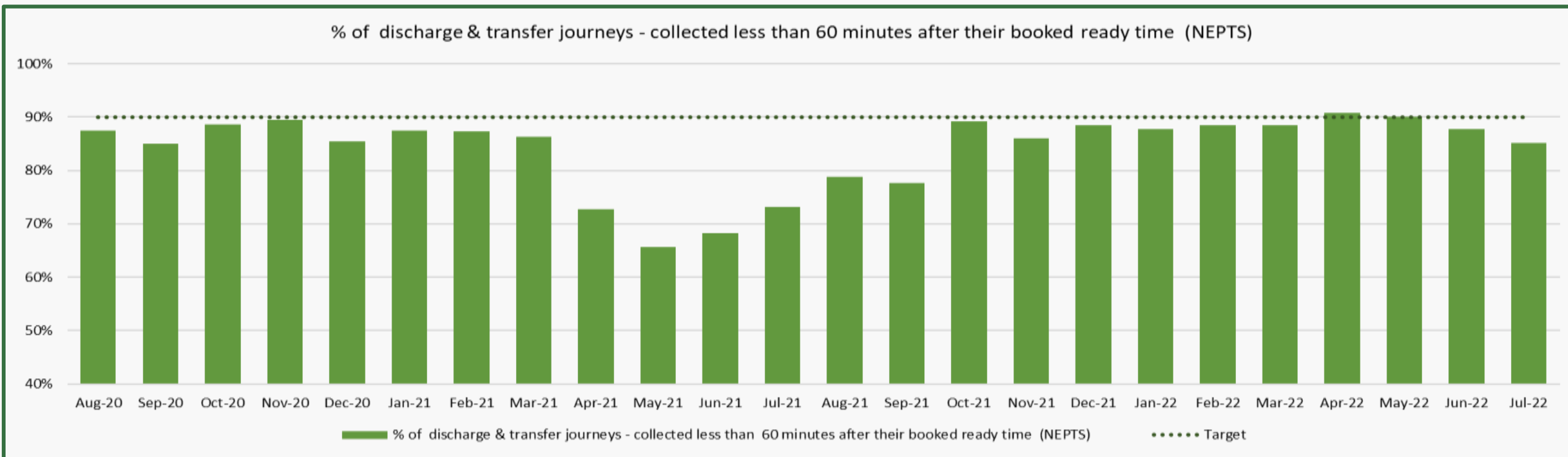
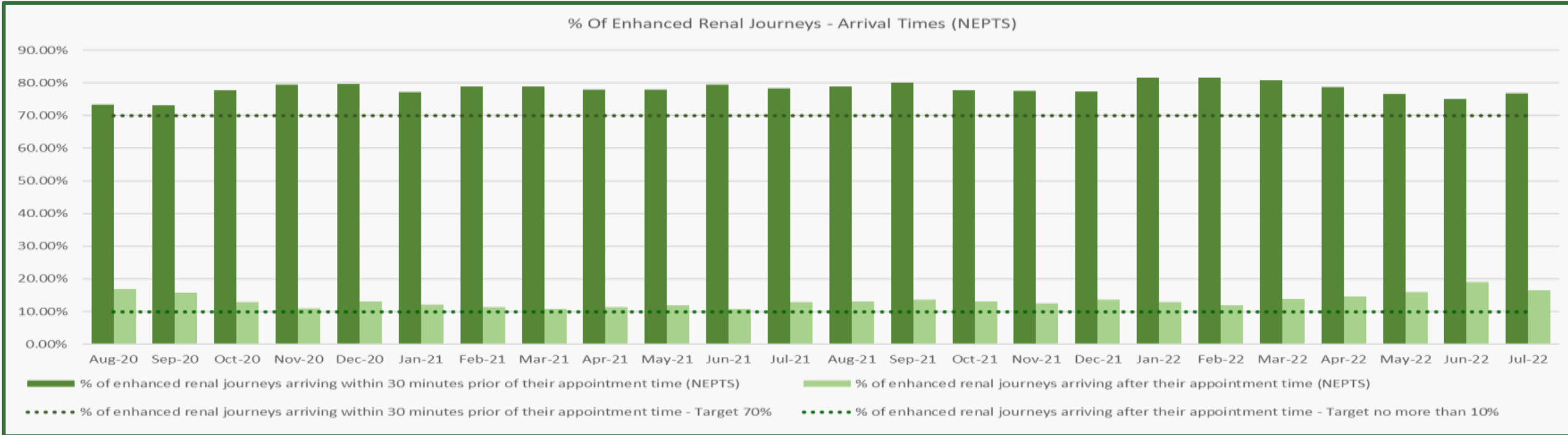
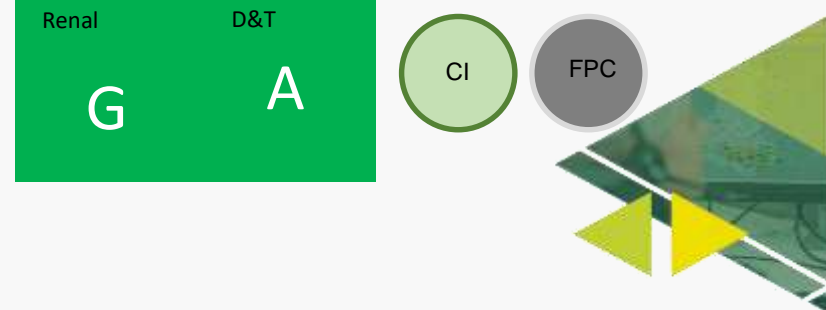
Welsh Ambulance Services NHS Trust



Our Patients: Quality, Safety & Patient Experience

Ambulance Care Indicators

Patient Experience



Analysis

Ambulance Care has seen a stabilisation of areas of service delivery affecting patient experience. In July 2022 85% of discharge & transfer journeys were collected within 60 minutes of their booked ready time, therefore not achieving the 90% target and a decline compared to June 2022 (88%). 76.7% of enhanced renal journeys arrived within 30 minutes prior to their appointment time, achieving the 70% target and 16.5% arrived after their booked appointment time, falling outside of the 10% target.

Key factors affecting these indicators are demand and capacity:

- **Social distancing on transports:** this ended in June 2022 so there is no reduction in capacity because of this.
- **Capacity** continues to be adversely affected by other factors such as sickness absence levels, although these are seeing improvements and reduced to 7.37% in June
- 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

- **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
- **Efficiencies:** Work is underway on actions to improve efficiency, including those actions identified through the D&C review, in particular, re-rostering.
- **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.



(Responsible Officer: Lee Brooks)

Welsh Ambulance Services NHS Trust



Our Patients: Quality, Safety & Patient Experience

Patient National Reportable Incidents & Patient Concerns Responses Indicators

SCIF. **A**

Self Assessment:
Strength of Internal Control: Moderate



Health & Care Standard
Health - Safe Care / Timely Care

NB: July 2022 SCIF, NRI & Appendix B data not available for reporting

Analysis

The percentage of responses to concerns improved in July 2022 to 22%, compared to 13% in June 2022, therefore not achieving the 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 NRIs and the availability of other departments to provide a timely response to requests for information. The number of total concerns increased in July 2022 (123) when compared to June 2022 (100).

There were 8 SCIF forums held in June 2022, during which 47 cases were discussed, 3 of these cases were reported to the Delivery Unit and 24 were passed to Health Boards as National Reportable Incident Framework 'Appendix B' incident referrals.

Year on year the overall volumes of NRIs is on an increasing trend. The sharp increase seen in September – November 2021 and again in March and May 2022 is concerning and has been linked to the significant delays across the system along with the continued levels of NRIs. In May 2022 there were 0 NRIs relating to Red calls, 6 relating to Amber calls and 0 relate to Green calls. There were 5 NRIs as a result of calls prioritised Amber which should have been Red.

At present it is not possible to report on the number of cases within the Complex Case Panel and Redress due to the implementation of the new Once for Wales Datix RL system.

As reported earlier, in July 2022 778 patients waited over 12 hours, an increase month on month, and when compared to 494 in July 2021 and 23 in July 2020.

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

Remedial Plans and Actions

A range of actions are in place:-

- The general theme in relation to the Trust's concerns portfolio is timeliness to respond.
- There is continued engagement with Health Boards in relation to Joint investigations where the primary causal factor is in relation to delayed handover.
- Concerns have been highlighted following a Delivery Unit report into the Health Boards handling of Appendix B cases, some of which should potentially have been reported as Nationally Reportable Incidents (NRI's) by the HBs.
- Health Board specific QSPE reports are being shared with each respective HB Directors of Nursing.
- The key strategic action is the EMS Operational Transformation Programme.

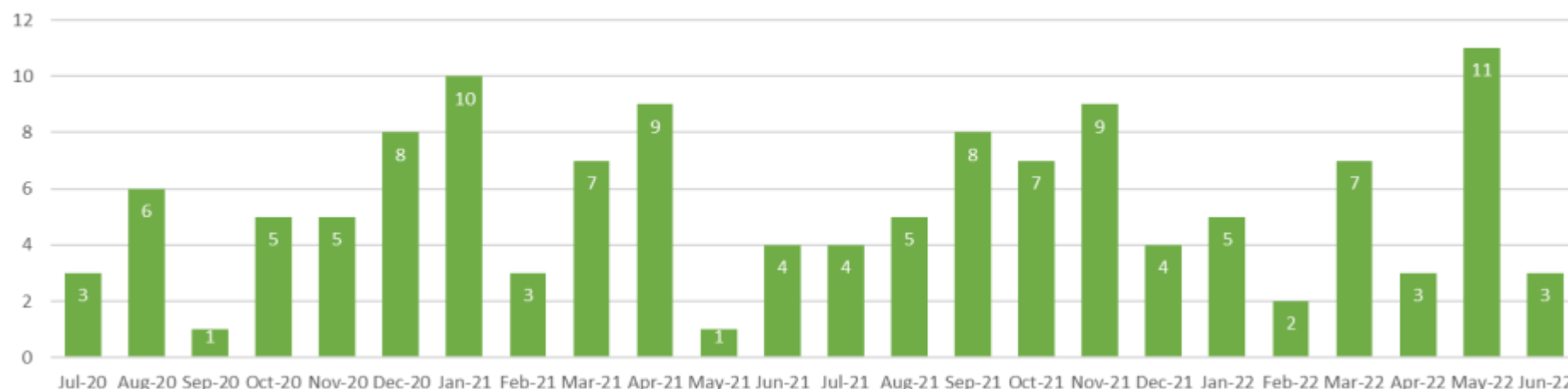
Expected Performance Trajectory

Following the end to Military assistance on 31 March 2022, the Trust is expecting continuing challenges with performance especially as hospital delays remain a significant challenge for the Trust.

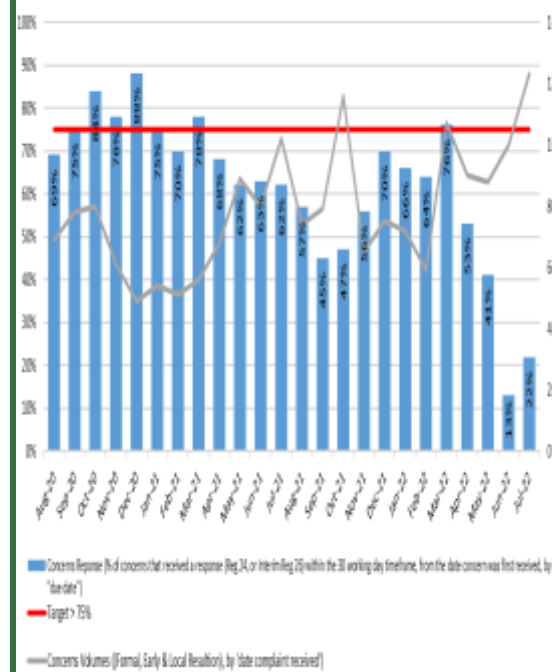
****NB: June/July 2022 data is correct on the date and time it was extracted; therefore, these figures are subject to change. At present reporting accurate data is not possible due to implementation of the Once For Wales Datix RL system.**

****NB: Complex Cases will always report one month in arrears**

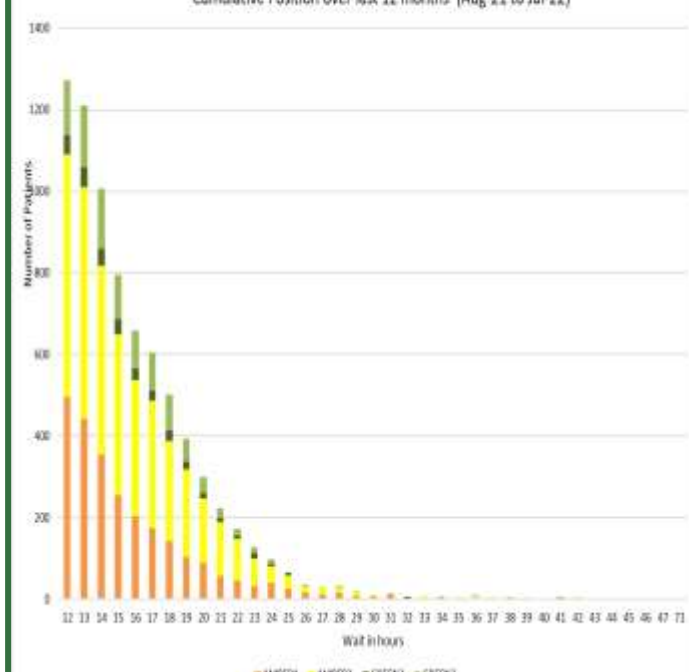
Number of SCIF cases reported as National Reportable Incidents (NRI) By Date Reported to the Delivery Unit by WAST



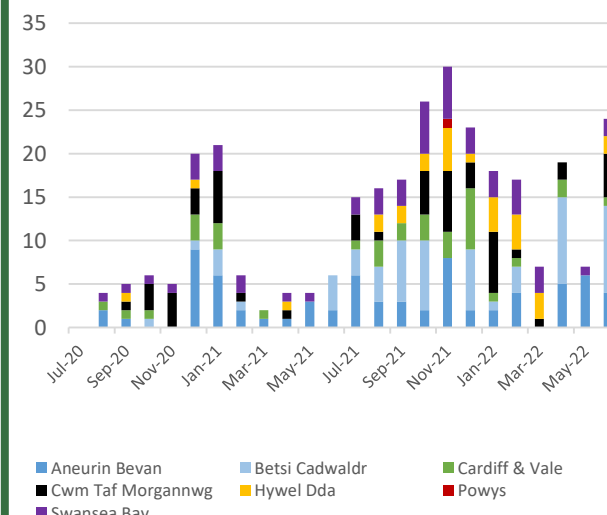
% of concerns with a response within 30 working days against concerns volumes



Number of Patient Waits over 12 hours by Priority Type Cumulative Position over last 12 months (Aug-21 to Jul-22)



Number of National Reportable Incident cases agreed to refer to Health Board reported as Serious Incident Framework 'Appendix B' HB referrals



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



(Responsible Officer: Wendy Herbert)

Welsh Ambulance Services NHS Trust



Our Patients: Quality, Safety & Patient Experience

Patient Safety Indicators

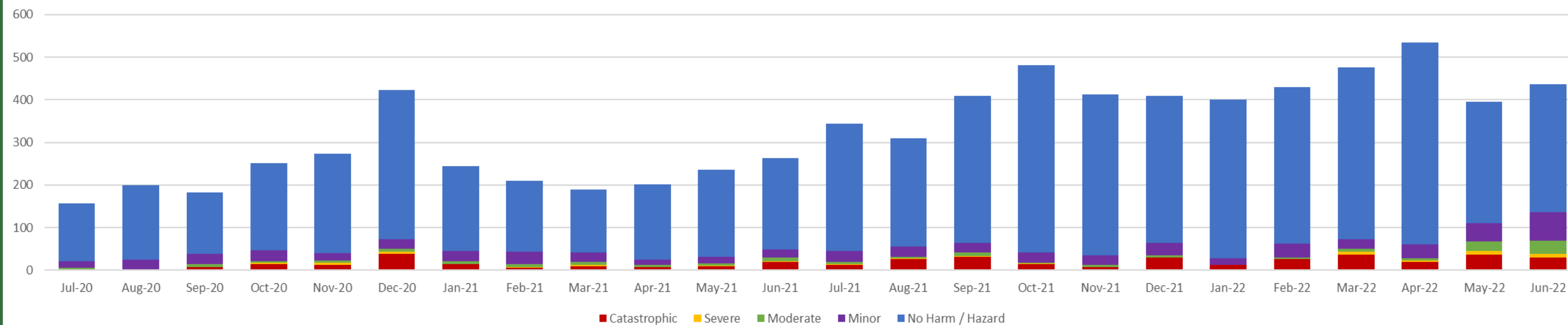
Self Assessment:
Strength of Internal
Control: Moderate

PCC

Health & Care
Standard
Health – Safe Care

NB: July 2022 data not available for reporting

Number of Incidents closed on Datix system within the reporting month, by harm grading (Volumes Received)



Analysis

Patient Safety: The number of patient safety adverse incidents submitted within June 2022 increased to 437; 301 of these were in relation to incidents where there was no harm or hazard, 66 were minor, 32 were moderate, 9 were severe and 29 incidents were catastrophic. 324 cases were closed in May 2022 in comparison to 389 in April 2022.

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

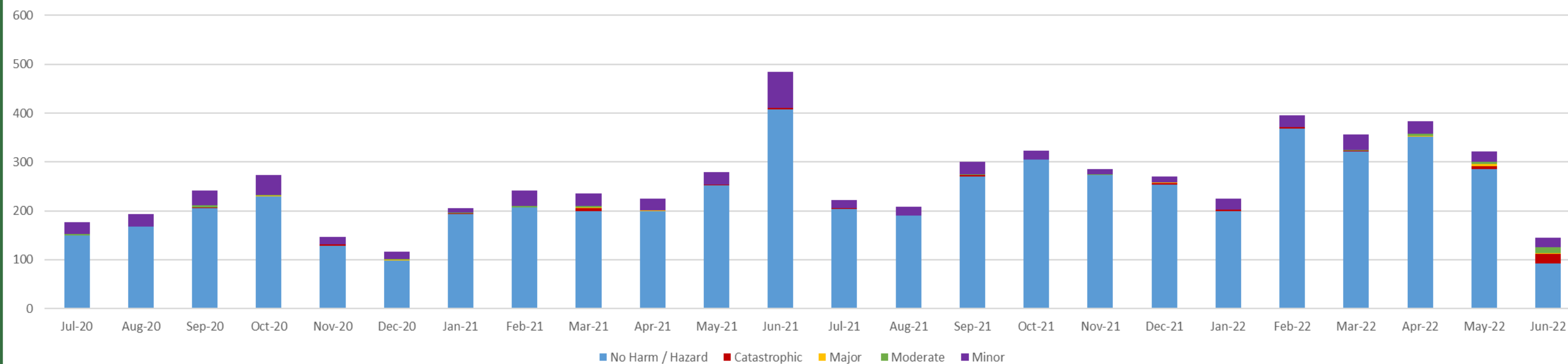
The Trust will continue to ensure lessons are learnt from every case reviewed and best practice will be implemented to continue to ensure care is of the highest quality.

****NB: April 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.

Data source: Datix

Number of Incidents closed on Datix system within the reporting month, by harm grading at point of closure (Volumes Closed)



(Responsible Officer: Wendy Herbert)

Welsh Ambulance Services NHS Trust



Our Patients: Quality, Safety & Patient Experience

Coroners and Ombudsmen Indicators

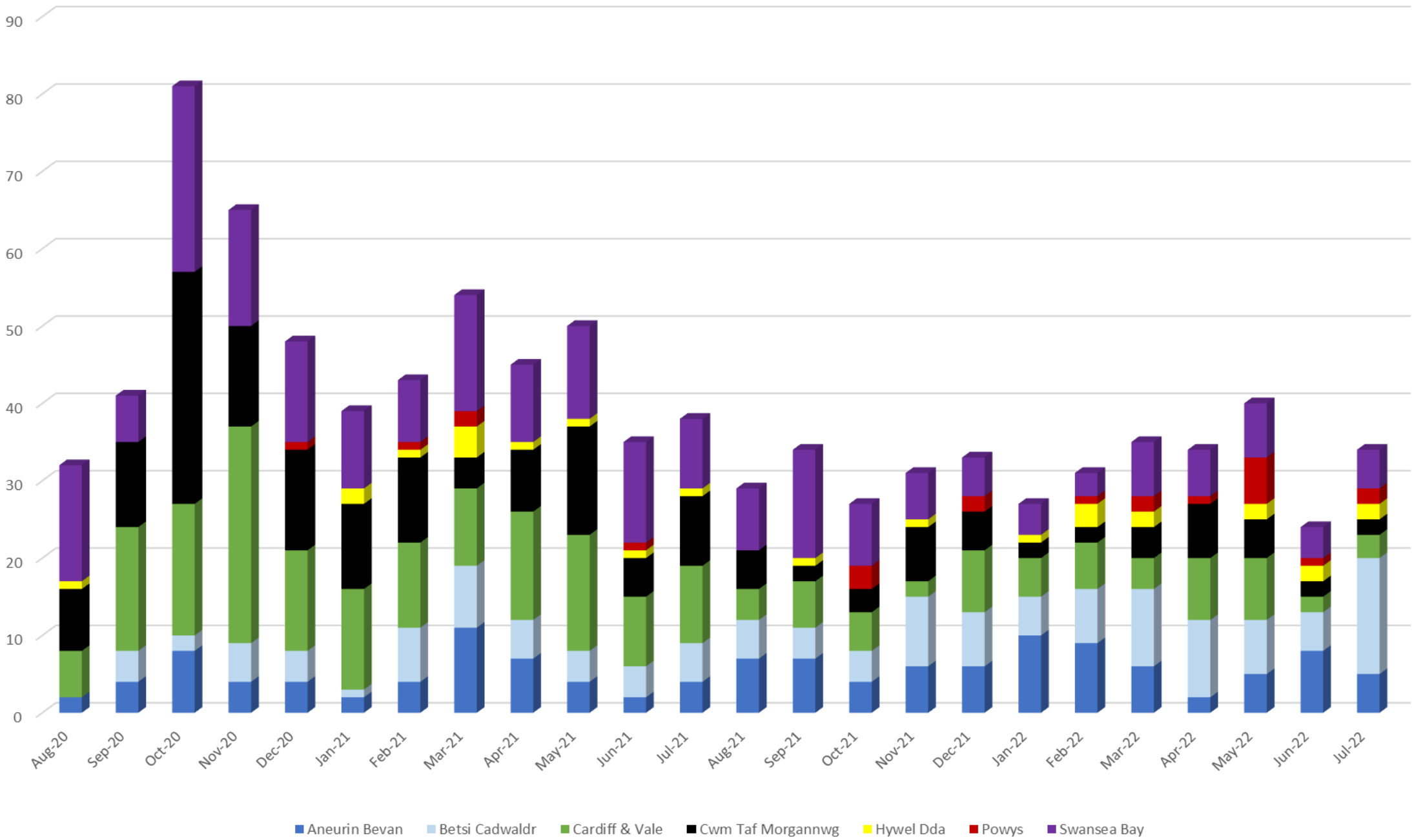
Self Assessment:
Strength of Internal
Control: Strong

QUEST

Health & Care
Standard
Health – Safe Care



Number of Coroner Requests by Health Board



Analysis

Coroners: In July 2022, The number of in month requests continue to be increased from pre-pandemic requests. The timeliness of the Trusts response and unexpected deaths continues to be the main themes. The Trust has noticed that there has been a marked increase in the BCUHB area.

At the end of July 2022 there are 387 claims open; these relate to Personal Injury (70 Claims); Personal Injury - Road Traffic Accidents (44 Claims), Clinical negligence (105 claims); Road Traffic Accident (147 claims) and Damage to Property (21 claims).

Ombudsman: There are currently 14 open Ombudsman cases in July 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 September - December at this time.

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 it 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



(Responsible Officer: Wendy Herbert)

Welsh Ambulance Services NHS Trust



Our Patients: Quality, Safety & Patient Experience

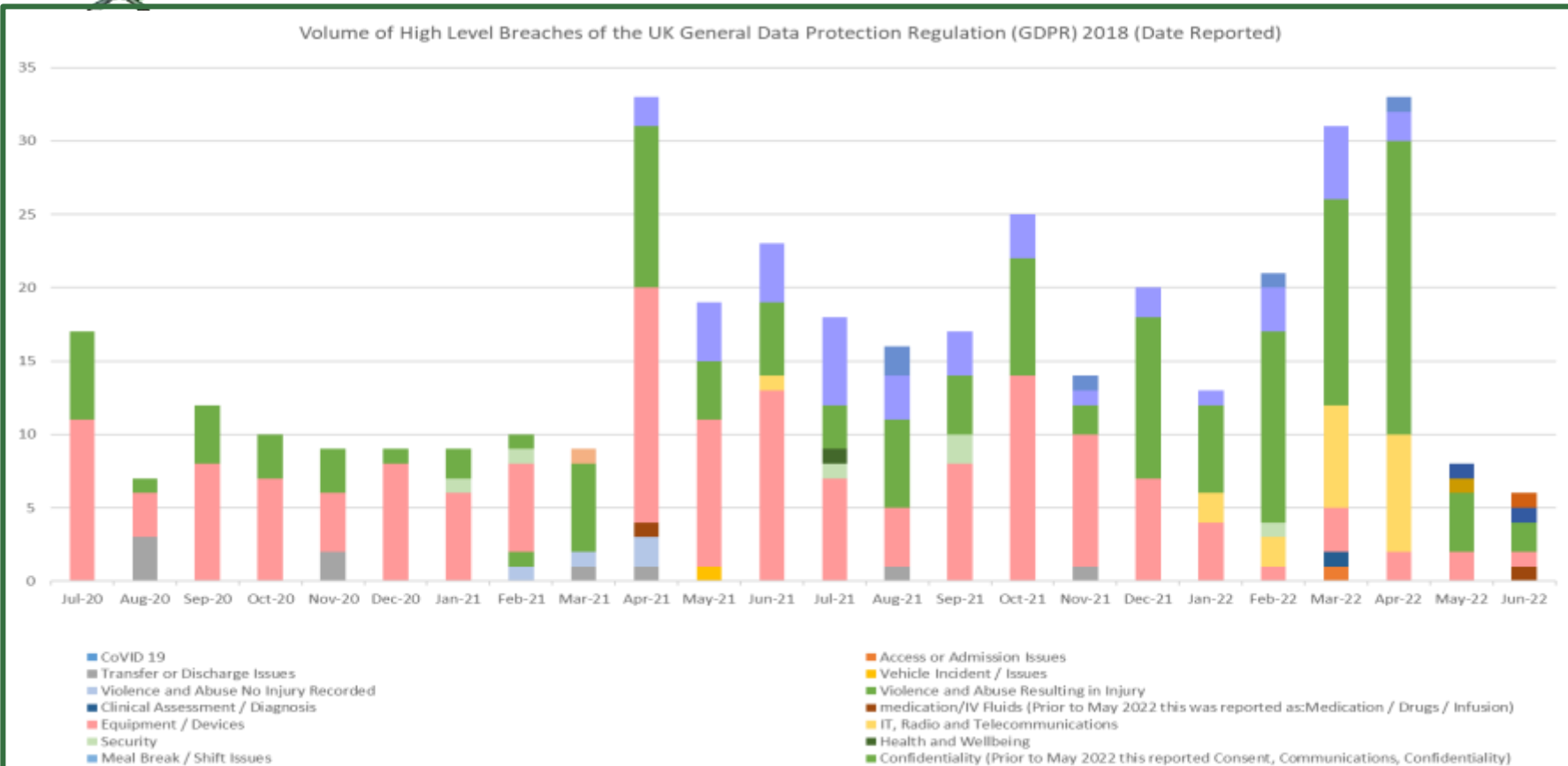
Safeguarding, Data Governance & Public Engagement Indicators

Health & Care Standard
Health – Safe Care

Self Assessment:
Strength of Internal Control: Strong



NB: July 2022 data not available for reporting



Analysis

Safeguarding: In June 2022 staff completed a total of 103 Adult at Risk Reports, a decrease compared to May 2022 when 114 were reported. 92% of these were processed within 24 hours.

There have been 152 Child Safeguarding Reports in June 2022, a decrease from May 2022 when 187 reports were made. In June 2022 92% were sent within 24 hours.

Data Governance: In June 2022 reporting for Data Governance transferred to the new Once For Wales Datix RL system; there were 21 information governance (IG) related incidents reported on Datix RL categorised as an Information Governance (IG) breaches, a decrease when compared to May 2022. 15 related to records/information, 2 were in relating to Confidentiality, 1 related equipment / devices, 1 related to medication/IV fluids, 1 related to communication and 1 related to aggression. All have been investigated by the IG team and received feedback on the IG Policy and practice elements, and where appropriate learning has been put in place.

Public Engagement: For the first time since 2019 the PECCI 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 were 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 21-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.

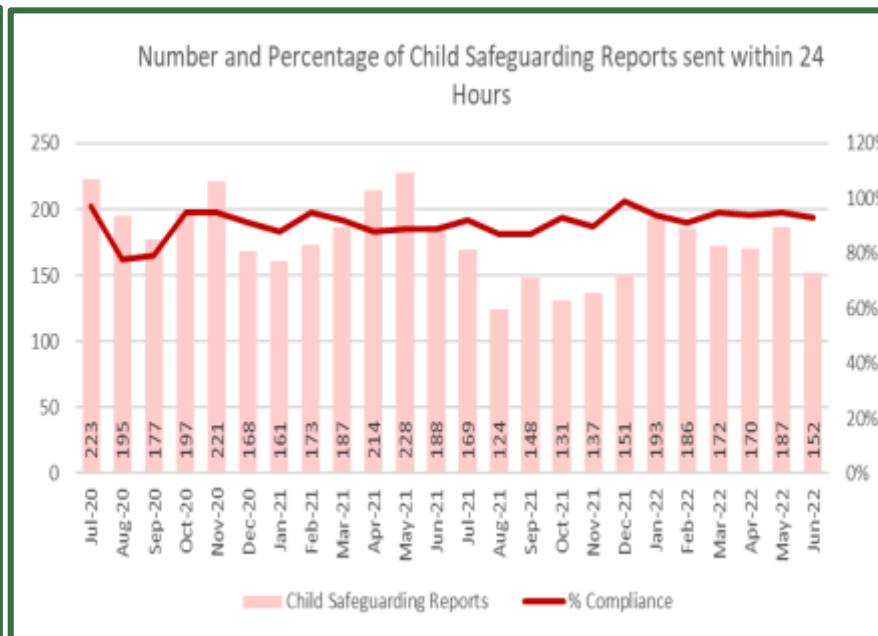
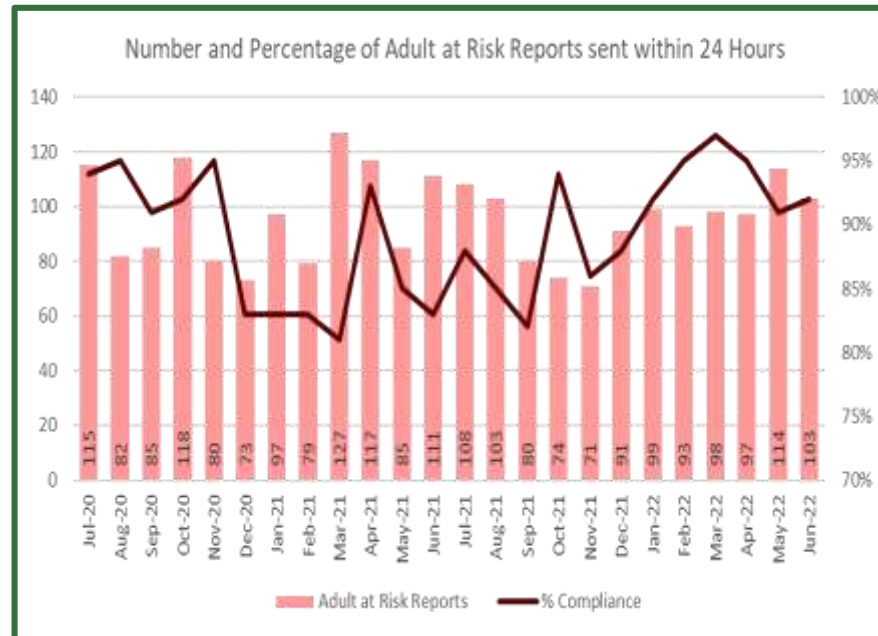
Public Engagement: Though we continued to engage with communities across Wales throughout the coronavirus pandemic, this was done in a much more digital way, holding online events and joining online forums and meetings. Whilst this online engagement was crucial and allowed us to maintain connections, 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 PECCI 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: An annual assessment of compliance using the Welsh NHS IG Toolkit; an individual evidence-based assessment consisting of 255 items will continue to be utilised to measure the Trust against National Information Governance and Security Standards, and the Trust's FY21-22 IG Toolkit responses have now been submitted.

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 PECCI 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' and the process is currently manual until a dashboard is implemented and is therefore subject to change



(Responsible Officer: Wendy Herbert)

Welsh Ambulance Services NHS Trust



Our Patients: Quality, Safety & Patient Experience

Health & Safety (RIDDORS) Indicators

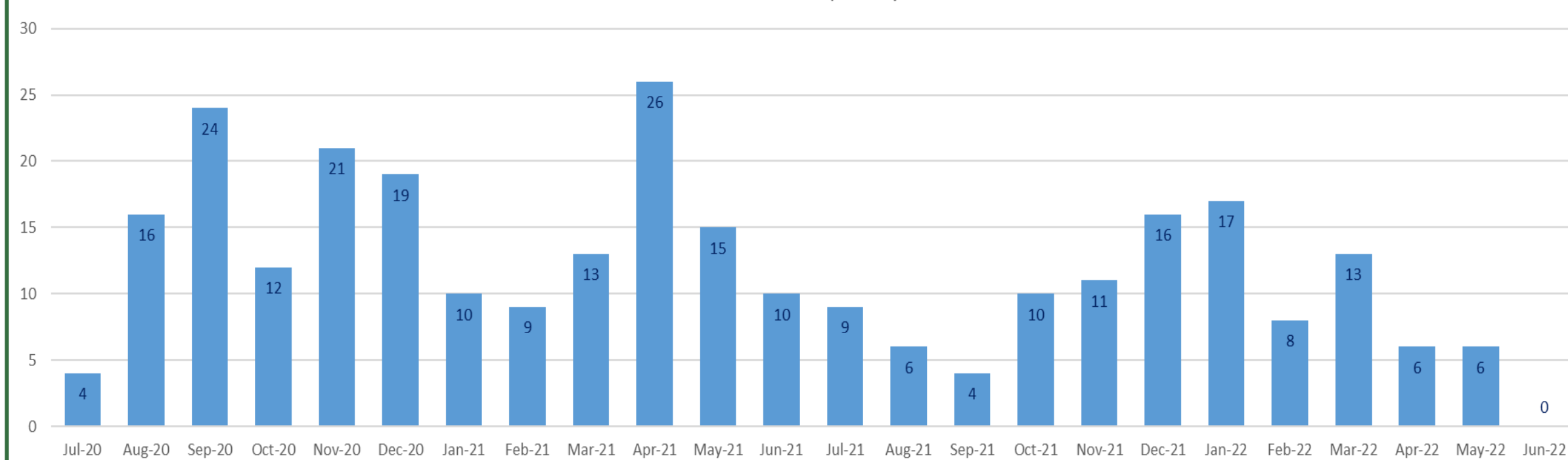
Self Assessment:
Strength of Internal
Control: Moderate

QUEST

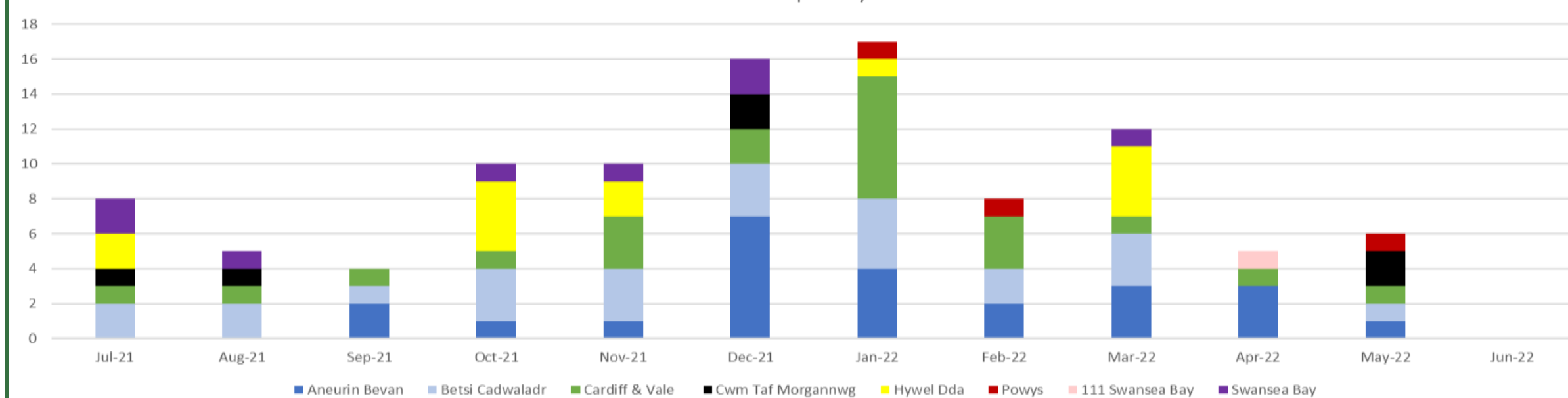
Health & Care
Standard
Health – Safe Care

NB: July 2022 data not available for reporting

Volume of RIDDOR Reports by Month



Volume of Riddor Reports by Health Board



Analysis

Whilst there is a strong level of internal control with respect to GL1 Metrics provided to the Health & Safety Executive (HSE), there are moderate levels of internal control. Challenges around obtaining staff details are impacting on timeliness of Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDORS) to the Health and Safety Executive (HSE). During Quarter 4 (January - March 2022) there were no fines, prosecutions, HSE improvement or Prohibition notices.

In June 2022 there were zero RIDDORS reported.

Remedial Plans and Actions

Some members of the Health & Safety Team have been granted authorisation to access details from the Electronic Staff Record (ESR) which will provide timely access to key details in relation to RIDDOR reporting. However, one key member responsible for reporting of RIDDORS left the organisation in November 2021. Additionally, the Regional H&S Manager also responsible for reporting is on long terms sickness absence.

The Trust's compliance with Health and Safety legislation requires further work to specify and detail areas to improve compliance. A draft transformation plan has been approved by EMT endorsing the commencement of this comprehensive holistic action plan, through a Working Safely Programme.

Expected Performance Trajectory

The Trust continues to work towards improving internal controls and the timeliness of reporting RIDDORS.

The Trust has recently agreed (and funded) a new structure for the Health & Safety Team, which is currently being recruited into, whilst a clear programme of work exists for reviewing and updating policies and procedures.

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

Data source: Datix



(Responsible Officer: Wendy Herbert)

Welsh Ambulance Services NHS Trust



Our Patients: Quality, Safety & Patient Experience

Corporate Risk Indicators

Self Assessment: Strength
of Internal Control:
Moderate - Strong

See
Table

Health & Care
Standard
- GLA3

Currently unable to report - Slide Under Review

NB: Next Update (April- June 2022) due July 2022

Data source: Electronic Risk Register



(Responsible Officer: Wendy Herbert)

Welsh Ambulance Services NHS Trust



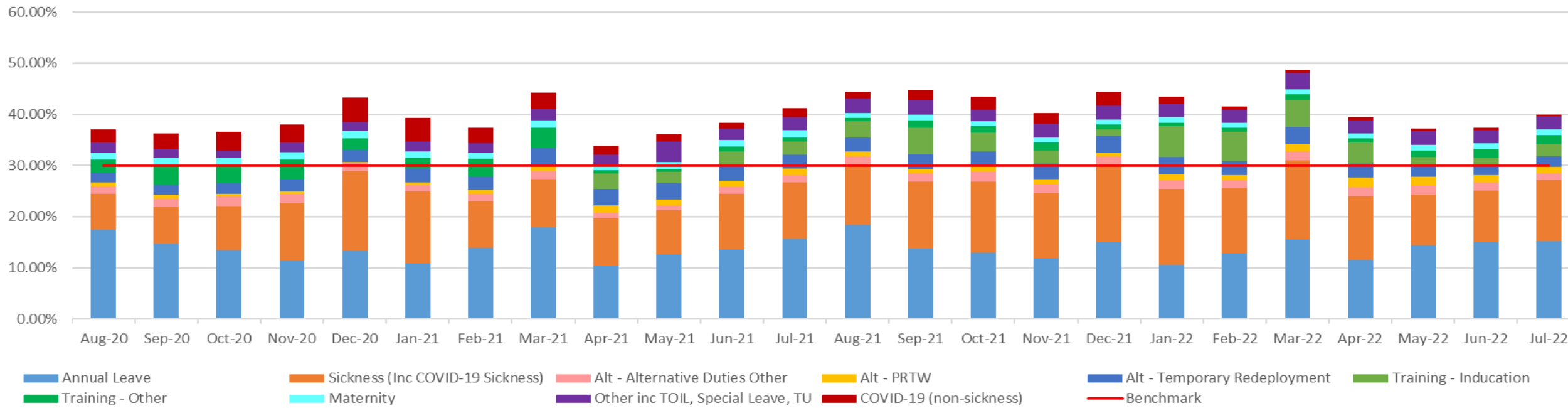
Our People

Ambulance Abstractions and Production Indicators

Abstractions **R** EA Production **A**

CI PCC
FPC

Pan Wales EMS Total Rota Abstraction Hours

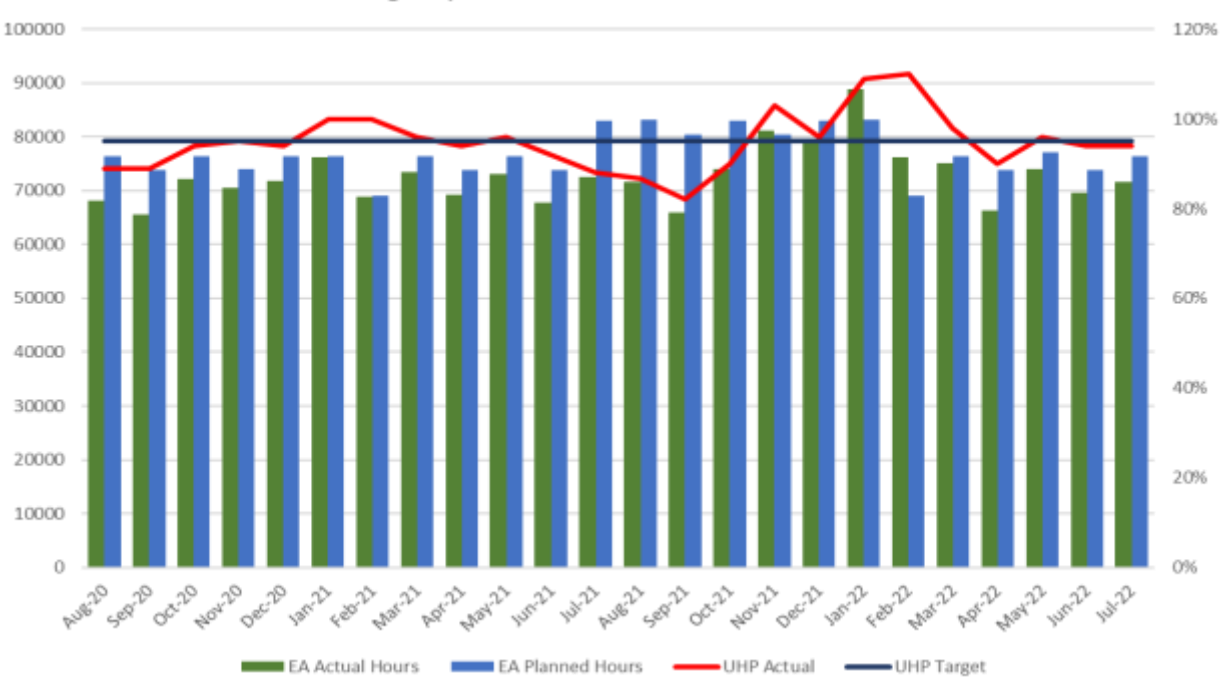


Analysis

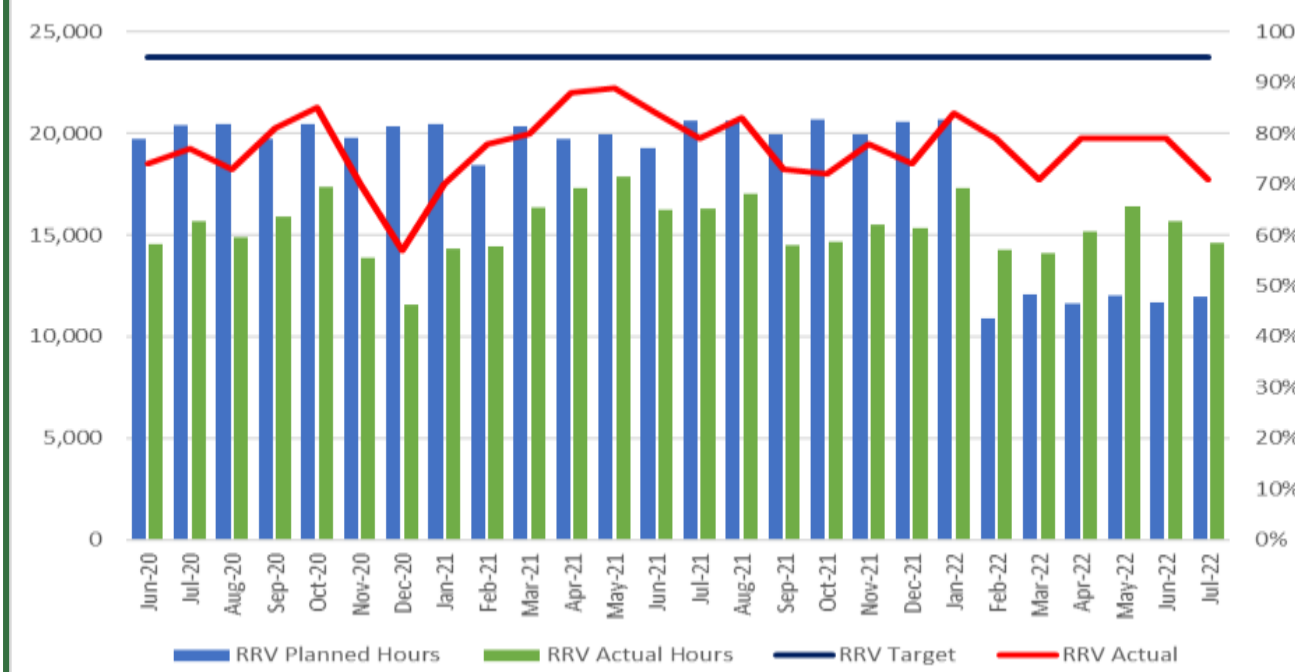
As shown in the top graph, monthly abstractions from the rosters are key to managing the number of hours the Trust has produced. In July 2022, total abstractions stood at 39.92%. This compares to a benchmark set in the Demand & Capacity Review of 30% which the Trust was achieving pre-COVID-19. The highest proportion was Annual Leave at 15.26% and sickness at 11.95%. Sickness abstractions for July 2022 were higher than the previous year (11.11%) however, COVID-19 (non-sickness) related abstractions decreased in July 2022 when compared to June 2021 accounting for 0.30% of overall abstractions.

Emergency Ambulance Unit Hours Production (UHP) was 94% in July 2022 (71,682 Actual Hours), falling short of the 95% benchmark. RRV UHP achieved 71% (14,583 Actual Hours) compared to 79% in June 2022. The total hours produced is a key metric for patient safety (included on slide 7 red performance). In July 2022 the Trust produced 111,168 hours, but the graph shows that even despite significant funding for increased substantive numbers of staff, total hours produced has not risen sustainably.

Emergency Ambulance Unit Hours Production



RRV Hours Planned vs Actual



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 key actions to maximise production will continue to be the EMS Demand & Capacity Review with an additional 100 WTE to be recruited this year.

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%. The Trust is proposed, as part of the Transition Plan, that a higher level of abstractions (and relief) is used.

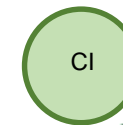


(Responsible Officer: Lee Brooks)

Welsh Ambulance Services NHS Trust



Our People Sickness Absence Indicators

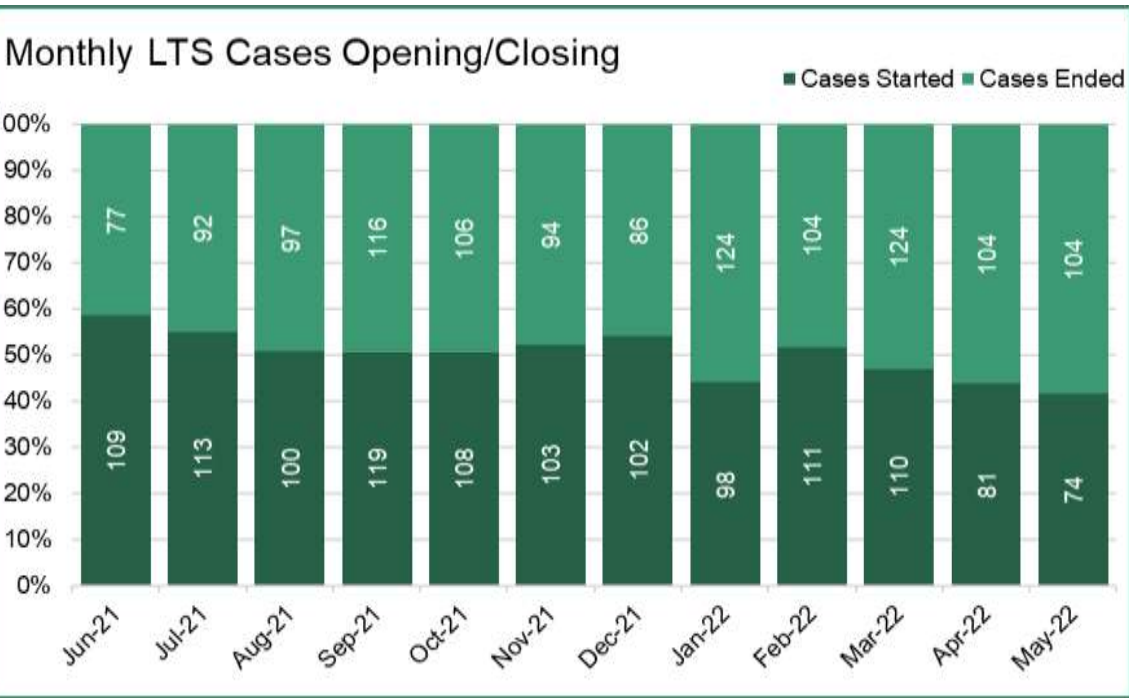
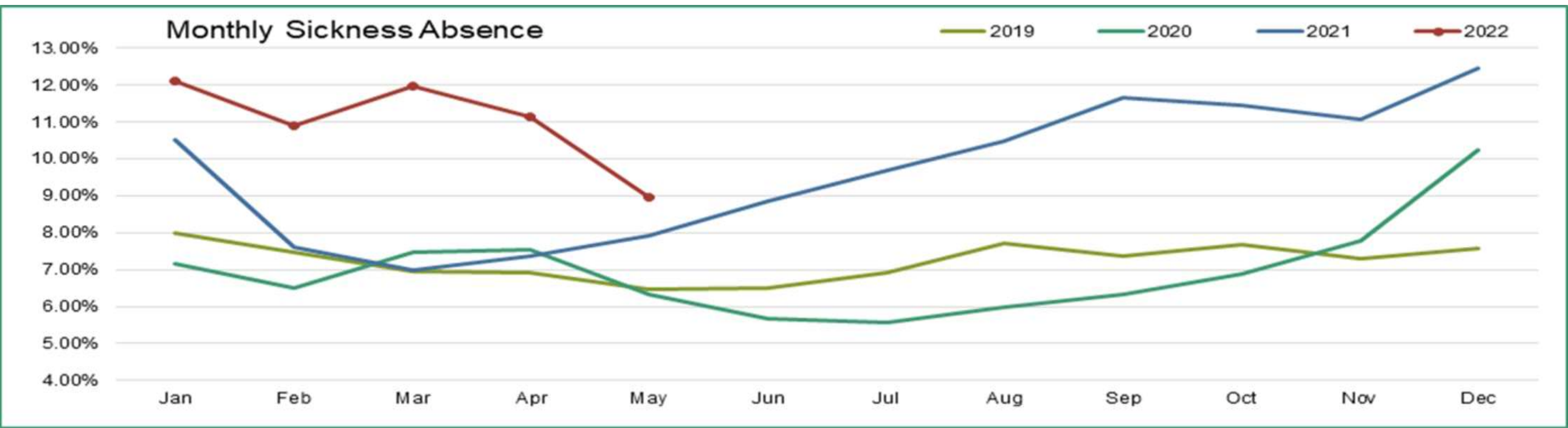


NB: May 2022 / June 2022 update not available

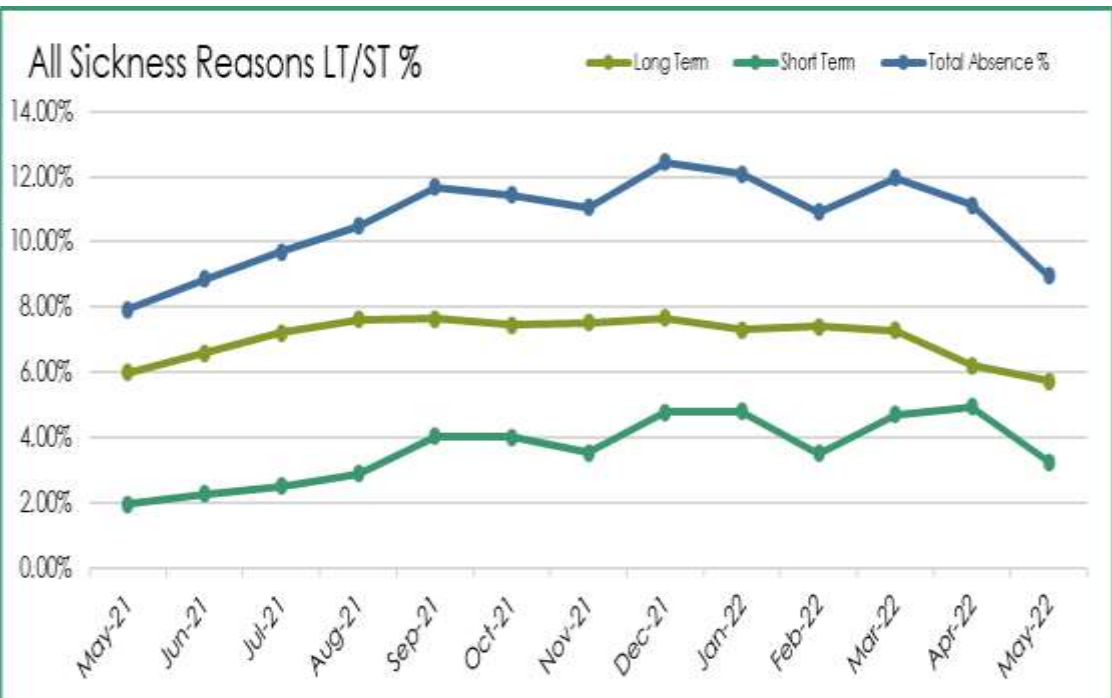
Analysis
The monthly sickness absence figure for May 2022 was 8.97%, a decrease of 2.16% from last month; however, sickness levels remain the highest recorded in a 5 year period with increases in both short term and long term absence.

Remedial Plans and Actions
Physiotherapy: 44 referrals were received in May 2022. This is the most referrals received by the provider in one month to-date.
Average Length of Time from Referral to First Contact: 1.7 days
Average Length of Time from Referral to Televid Clinical Assessment: 2.7 days
Health Assured- EAP: Call summary- In May 2022 69 calls (63 Counselling/6 Legal) (This increased from 36 calls in April 2022)

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.



Average working days lost per FTE (Annual)	
24.89 days	
Single month Absence %	
8.95%	
Long Term	Short Term
5.70%	3.25%
Mental Health	Other MSK
(S10 Stress/Anxiety) 2.29%	(excluding Back) 1.35%



(Responsible Officer: Catherine Goodwin)

Welsh Ambulance Services NHS Trust



Our People

Staff Vaccination Indicators

NB: April 2022 COVID-19 Vaccine Data not Available

Self Assessment:
Strength of Internal
Control: Moderate

Flu

R

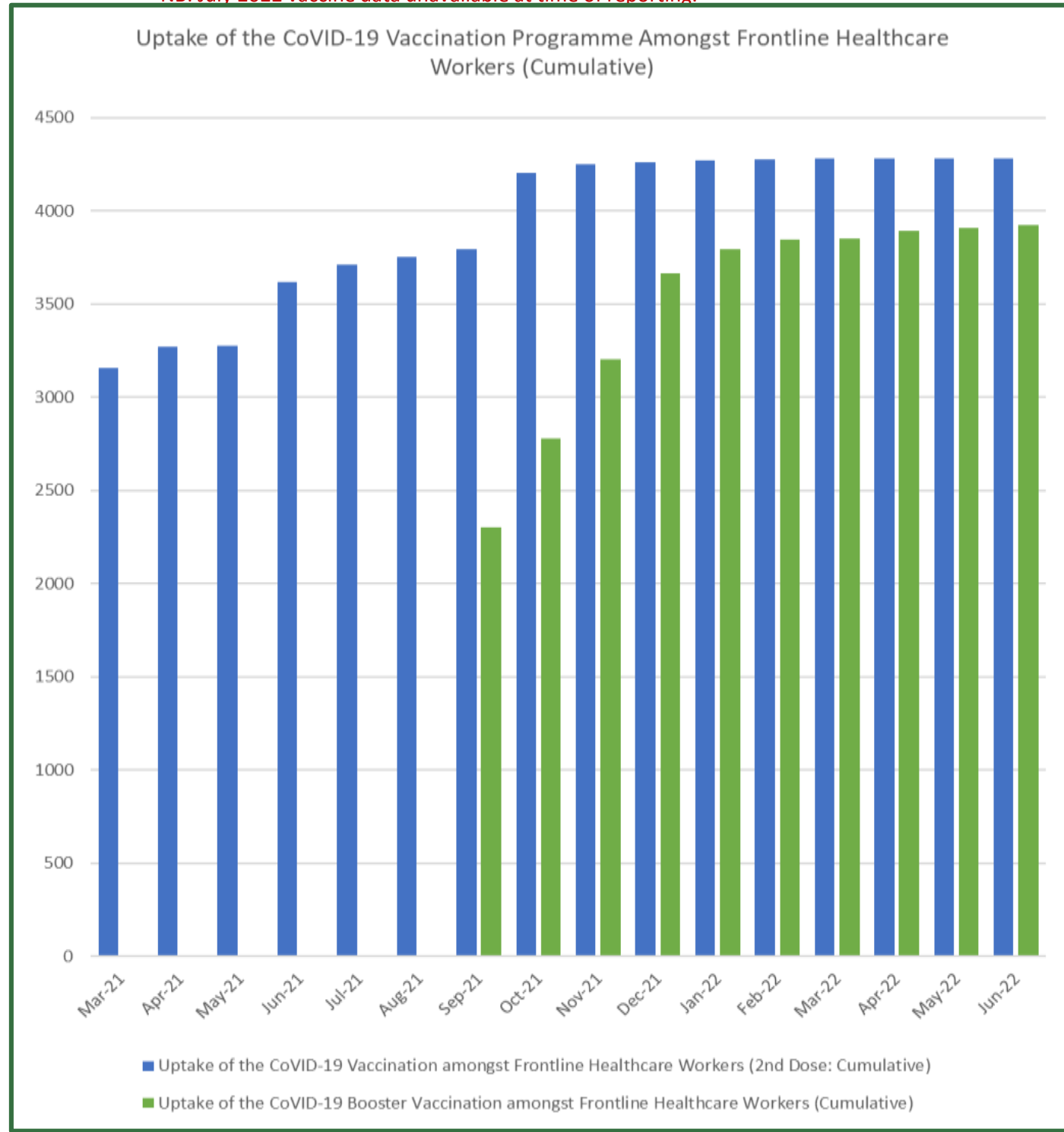
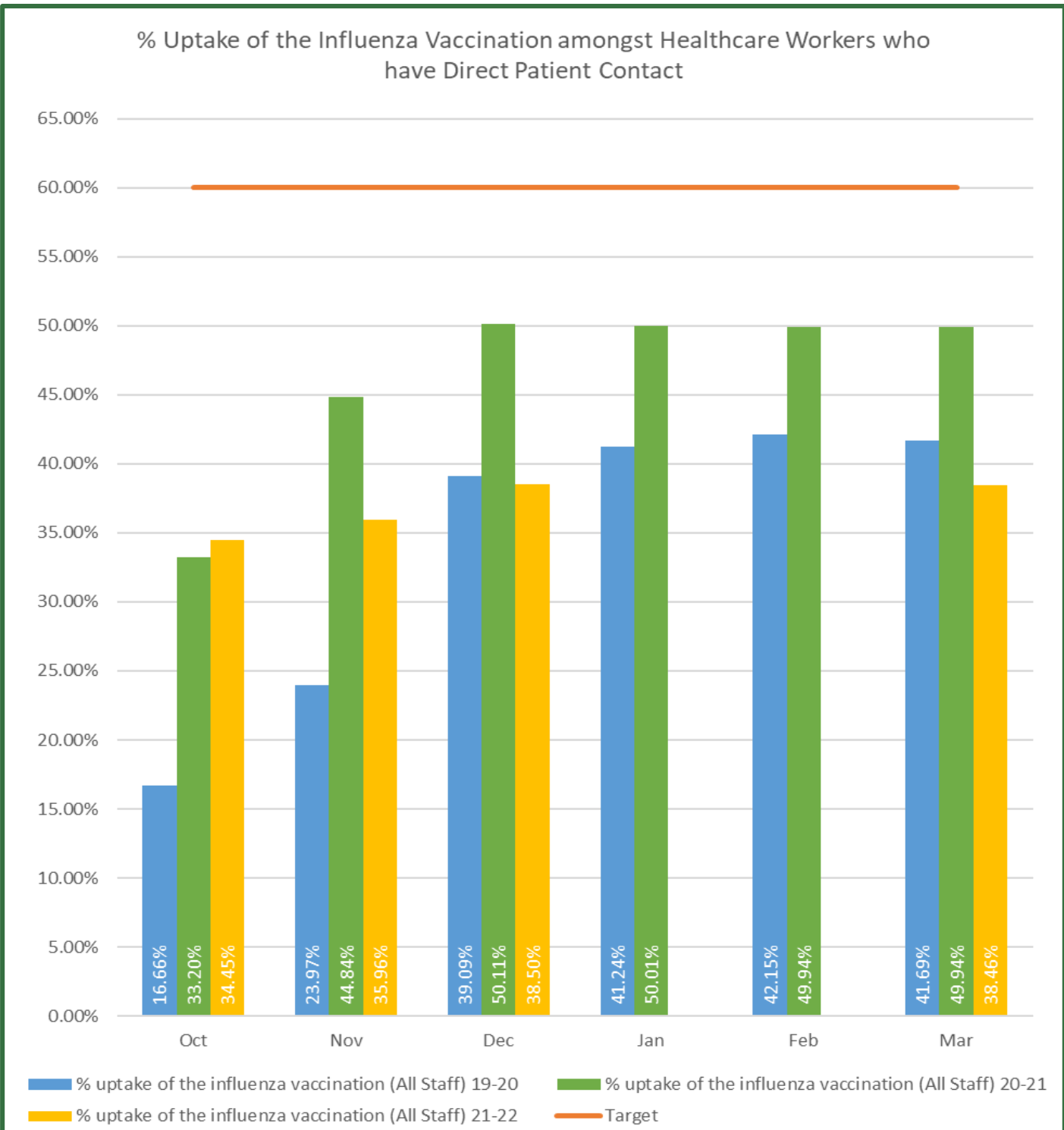
CI

PCC

NB: Next Reporting Flu Campaign October 2022

Health & Care
Standard
- Health (PPI)

NB: July 2022 vaccine data unavailable at time of reporting.



Analysis
The 2021-22 flu campaign got underway in Oct-21 and has now concluded; as indicated in the graph to the left 38.46% of EMS (response) and NEPTS staff received a vaccination, therefore not achieving the 60% target.

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

Of the 4,532 staff currently employed (All staff) front line (Patient Facing and Non-Patient Facing staff), 95% of staff have received a first dose COVID-19 vaccination, 95% (4,283) have received a second dose and 87% (3,925 Staff) have received a booster vaccination. In addition 94% of volunteers have received a first dose vaccination, 93% have received a 2nd dose and 88.5% have received a booster vaccination.

Remedial Plans and Actions
Staff data has been refreshed to accurately staff numbers employed by WAST.

Expected Performance Trajectory
An evaluation of the 2021-22 flu campaign is currently being completed. Early indications from the southern hemisphere are that there has been more flu in their winter. The Trust is currently developing forecasts for the winter period that build in CoVID-19 and flu..

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



(Responsible Officer: Catherine Goodwin)

Welsh Ambulance Services NHS Trust



Our People

PADR and Training Rates Indicators

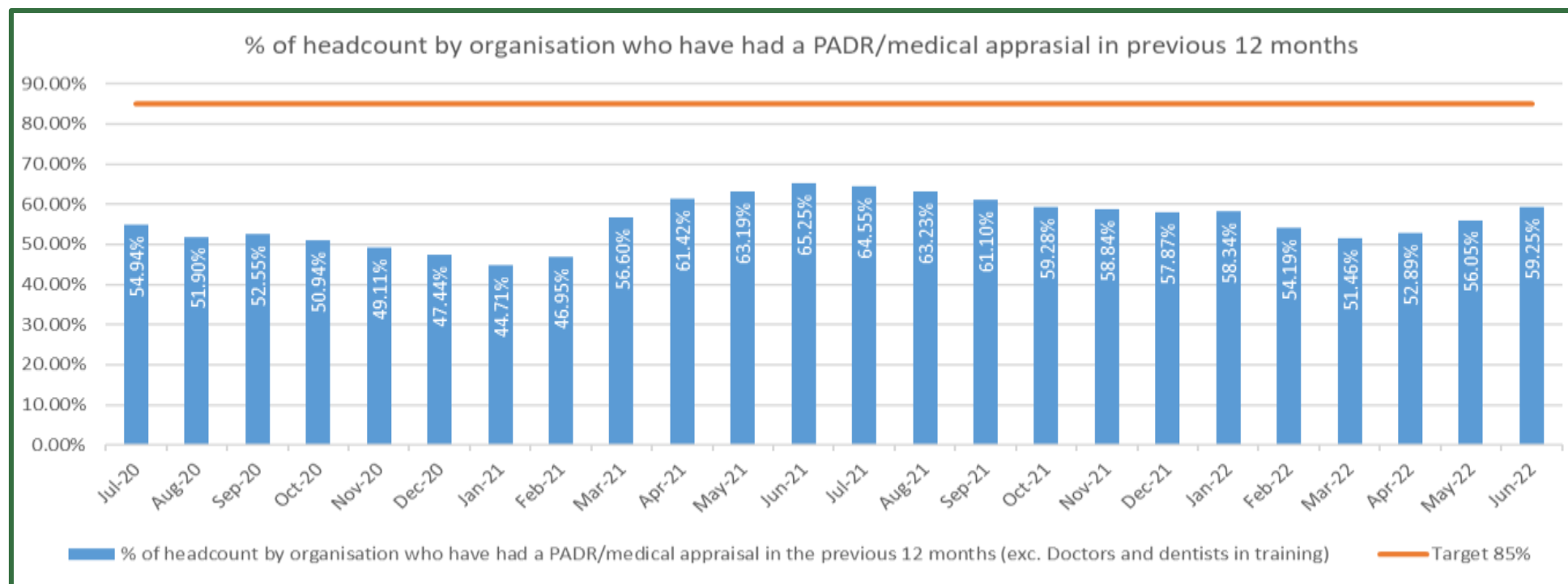
R

Self Assessment:
Strength of Internal
Control: Strong

CI

PCC

Health & Care
Standard
Health – Staff &
Resources



Analysis

PADR rates for June 2022 improved for the fourth consecutive month to 59.25% however they continue to remain well below the 85% target.

June 2022 Statutory & Mandatory Training rates decreased by 0.11% from the May 2022 figure, but still achieved the 85% target for the second time in 23 months. Fire Safety (67.68%) and Moving & Handling (84.06%) both failed to achieve the 85% target; however, Information Governance (85.56%) and Safeguarding Adults (88.31%) achieved the target in June 2022.

As of June 2022 92.7%, of staff have completed mandatory Equality and Human Rights 'Treat me Fairly' (TMF) Training. 100 colleagues have begun Allyship journeys, including Board members, and the programme continues to be well received; work is underway to ensure the programme is updated and bespoke wherever possible to ensure greater engagement.

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

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.

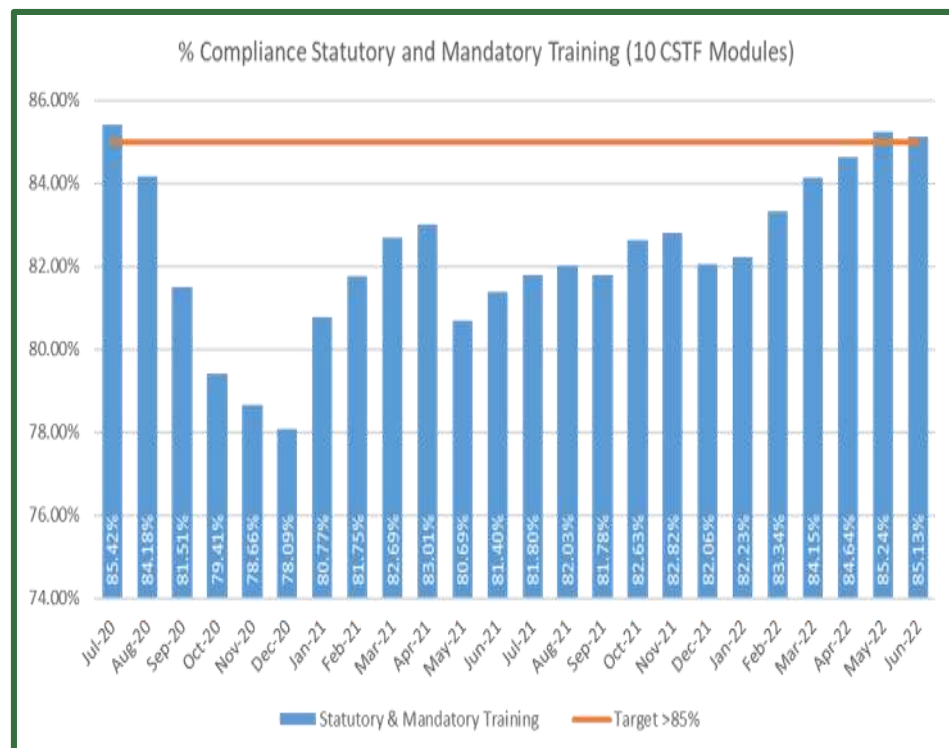
Remedial Plans and Actions

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 will outline 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.

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

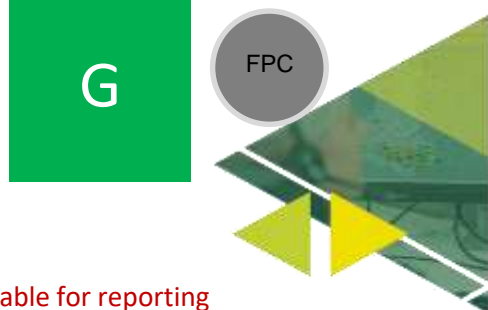


(Responsible Officer: Catherine Goodwin)

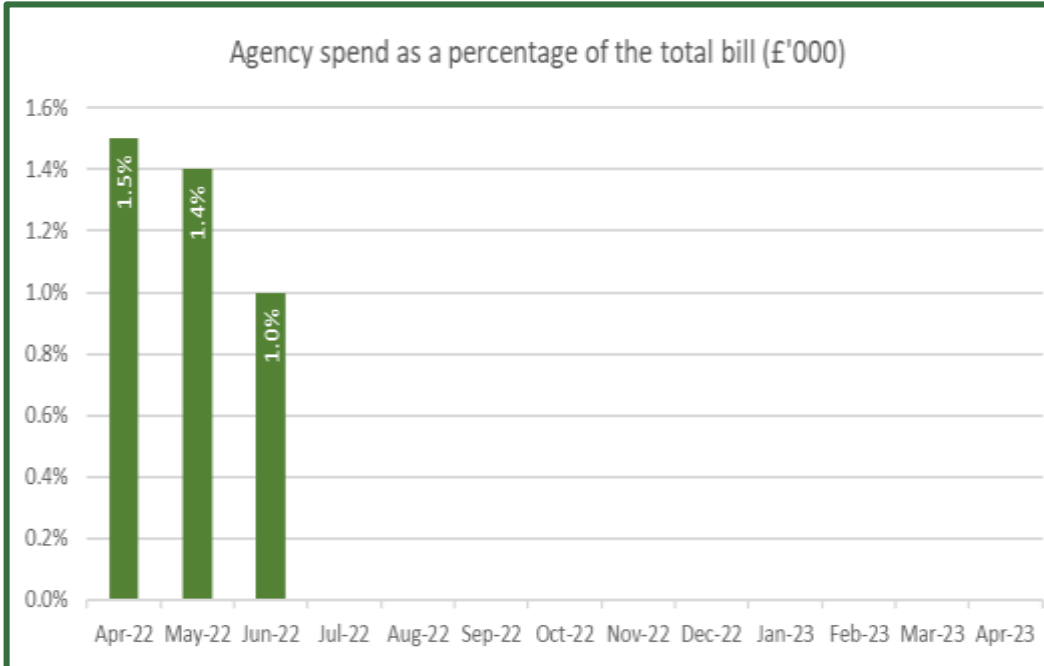
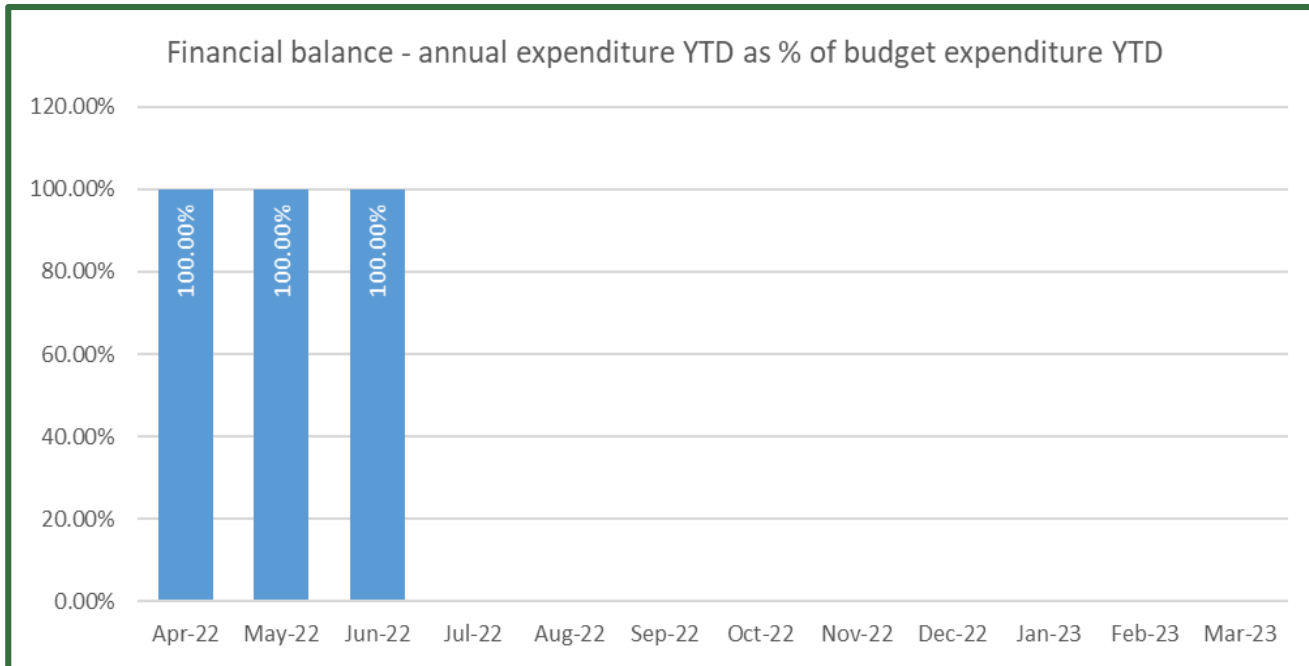
Welsh Ambulance Services NHS Trust



Finance and Value Finance Indicators



NB: July 2022 data not available for reporting



Analysis

The reported outturn performance at month 3 is a surplus of £2,000, with a forecast to the yearend of breakeven.

For month 3 the Trust is reporting planned savings of £1.043m and actual savings of £1.030m, an achievement rate of 98.8%.

Cumulative performance against the Public Sector Purchase Programme (PSP) as of June 2022 was 96.5% against a target of 95%.

As of June 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.

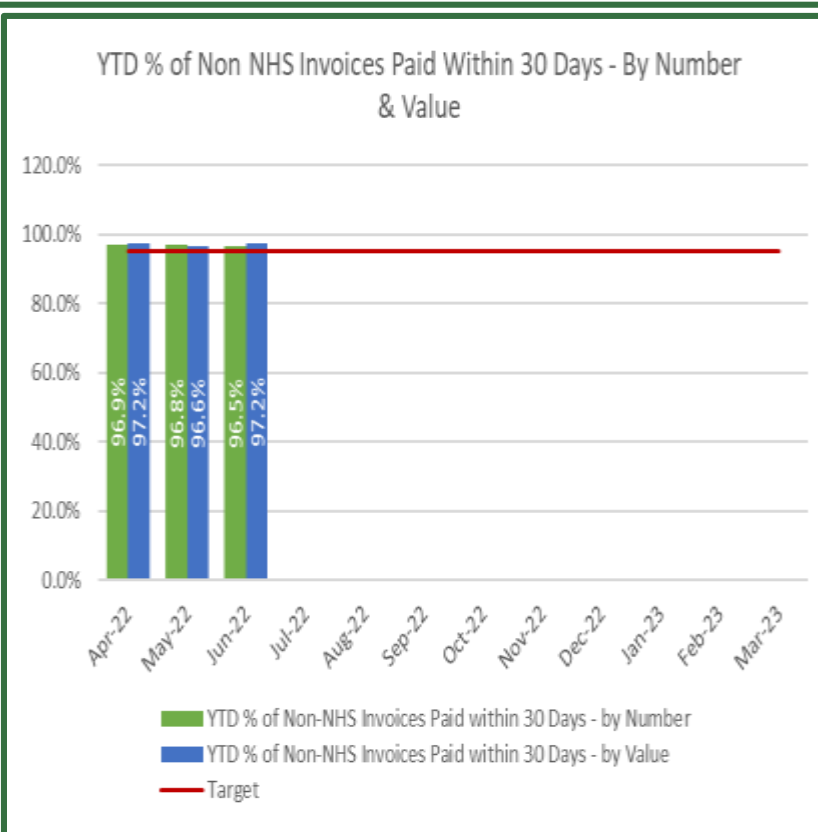
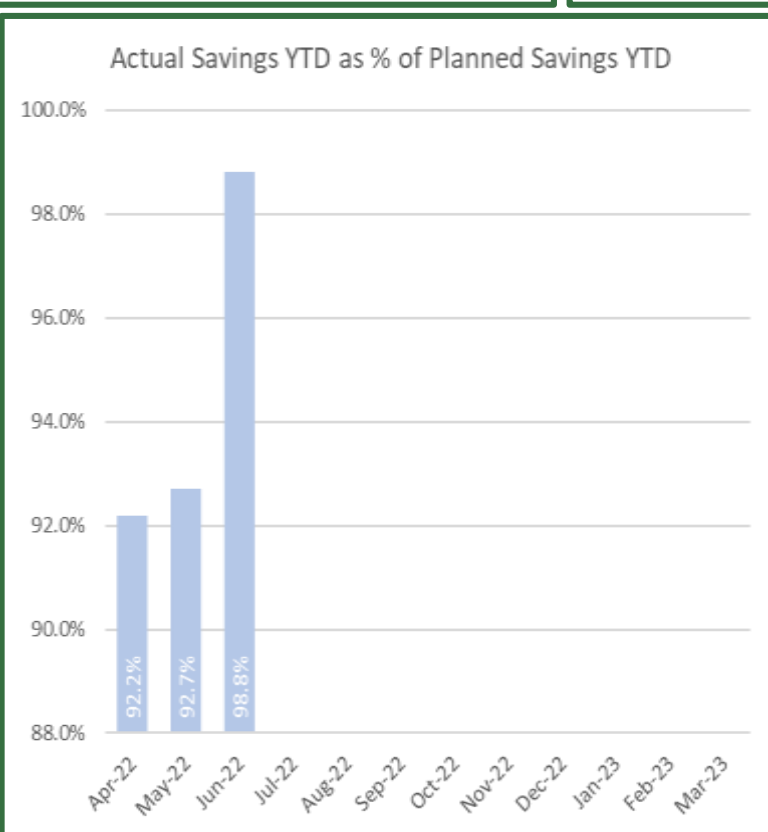
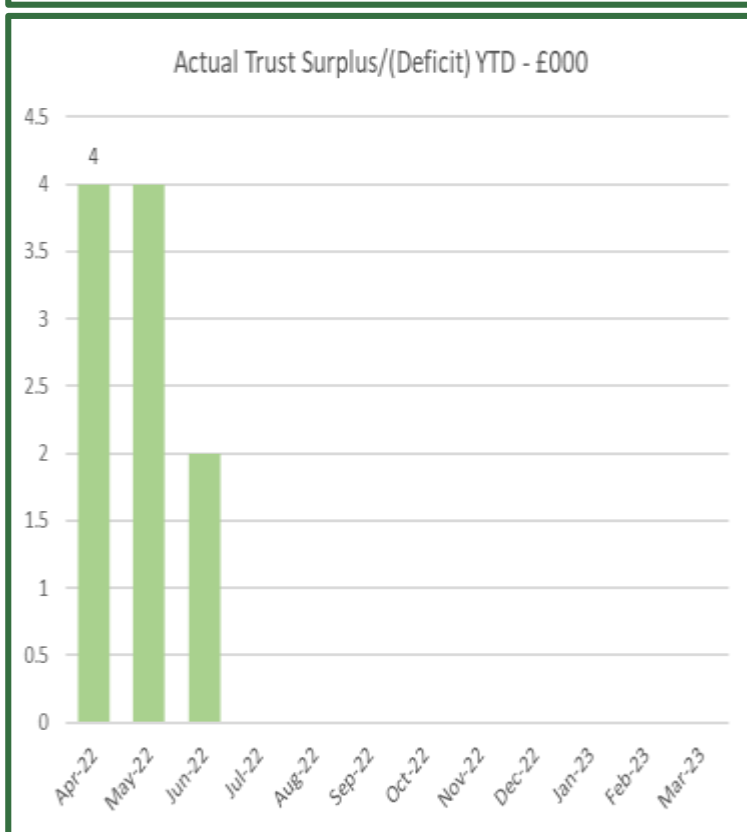
No financial plan is risk free. Financial risk management forms a key element of the project plans which underpin both the Trust's ambitions and savings targets. The Trust continues to seek to strengthen where it can its financial capacity and corporate focus on finance, and as an organisation have structures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



(Responsible Officer: Chris Turley)

Welsh Ambulance Services NHS Trust



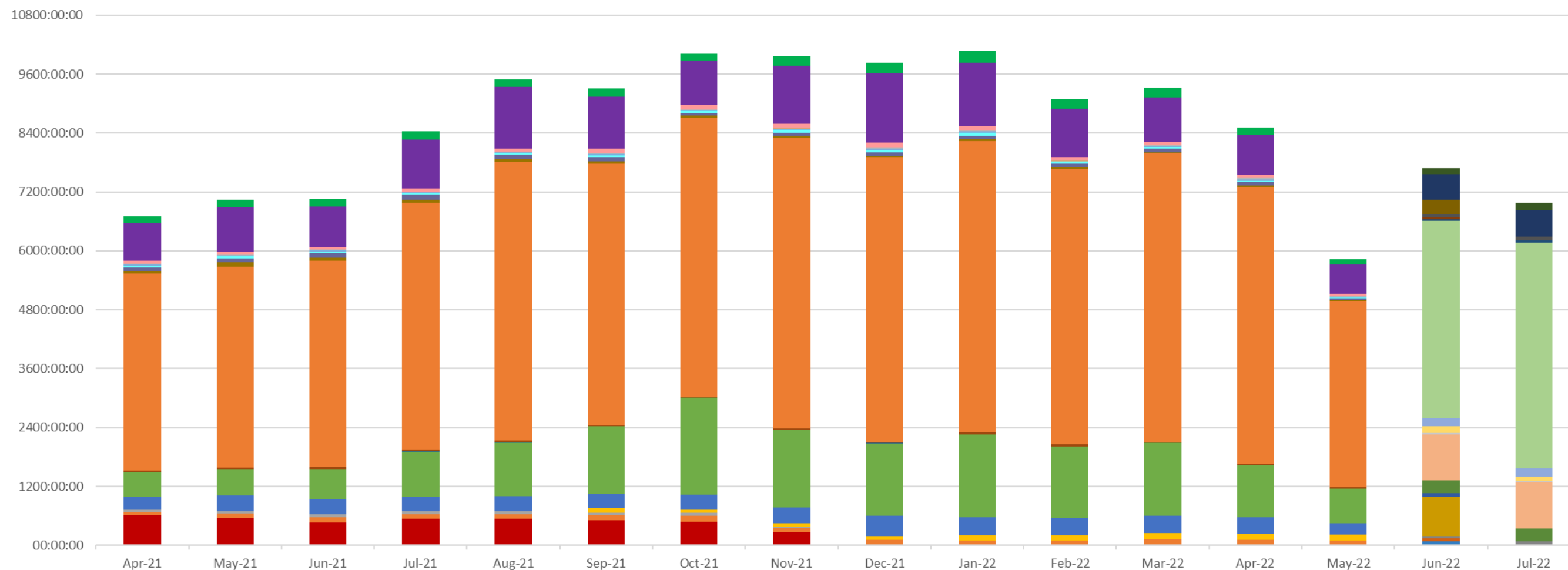
Value / Partnerships & System Contribution

EMS Utilisation & Post Production Lost Hours Indicators



NB: Revised data reported based on amendments in QlikSense and refinements applied to improve accuracy in reporting

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



- CLEANING – CoVID19
- HALO DUTIES
- SOILED UNIFORM - NOT AVAILABLE
- TRAUMATIC STAND DOWN - NOT AVAILABLE
- U/A Clinician Travelling
- U/A HALO Duties
- U/A Soiled Uniform
- U/A Vehicle Defect
- COMMUNICATIONS - NOT AVAILABLE
- L3 PPE Cool Down
- STAFF ILLNESS - NOT AVAILABLE
- VEHICLE CLEANING - NOT AVAILABLE
- U/A Crew Off Duty
- U/A Leave- Not Available
- U/A Staff Illness/ Injury
- CoVID 19 RTB/ Awaiting Decontamination Cleaning
- POLICE INTERVIEW - NOT AVAILABLE -
- STAFF INJURY - NOT AVAILABLE
- VEHICLE DEFECT - NOT AVAILABLE
- U/A DOM Duties
- U/A Meeting
- U/A Traumatic Incident Stand Down
- Crew Documentation
- RTB S/D MEALBREAK - NOT AVAILABLE
- Tactical Approach to Production Crew Concern
- End Shift
- U/A Equipment
- U/A Patient Documentation
- U/A Undisturbable Rest Break
- EQUIPMENT - NOT AVAILABLE
- SAFEGUARDING/POVA - NOT AVAILABLE
- TRAINING ON BASE - NOT AVAILABLE
- Paper Operations
- U/A Event Resource
- U/A RTB Stand Down Mealbreak
- U/A Vehicle Cleaning

Analysis

There were 7,008 post production lost hours (PPLH) across EA, RRV & UCS vehicles in July 2022; a decrease when compared to June 2022 (7,678).

In July 2022 hours lost through PPLH can be down to numerous factors, including, but not limited to Return to Base, Meal Breaks (4,597 Hours), HALO duties (948 hours) and Vehicle Cleaning (537 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 is currently an area of focus via a series of workshops with TU Partners.

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**



(Responsible Officer: Lee Brooks)

Welsh Ambulance Services NHS Trust



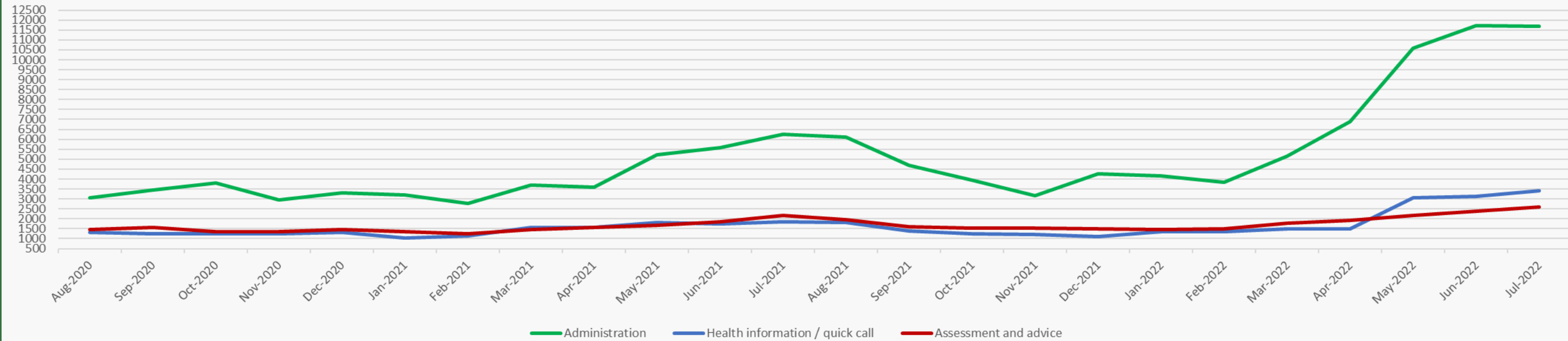
Our Patients: Quality, Safety & Patient Experience

111 Hand Off Metrics and 111 Consult & Close Indicators

Influencing Factors – Demand and Clinical Hours Produced



111 Consult and Close



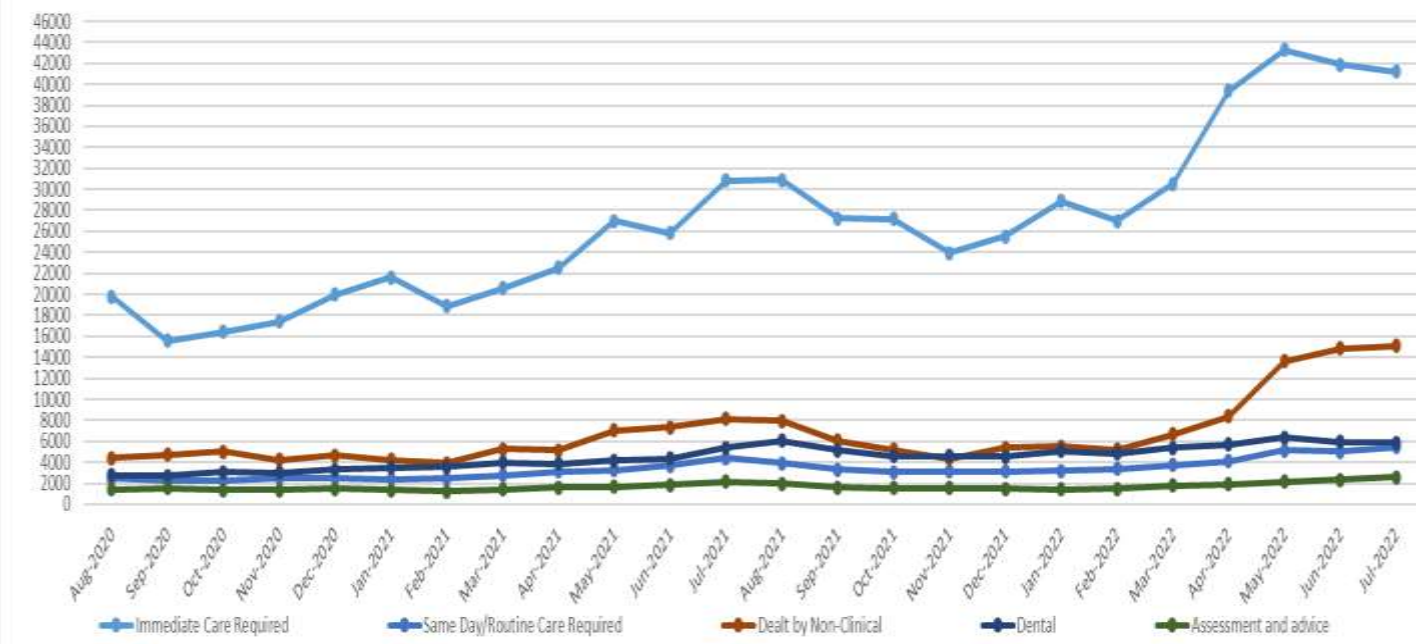
Analysis

In July 2022 calls Referred to General Practitioner (handover of care) continued to be the top outcome for NHS111 accounting for 41% of calls.

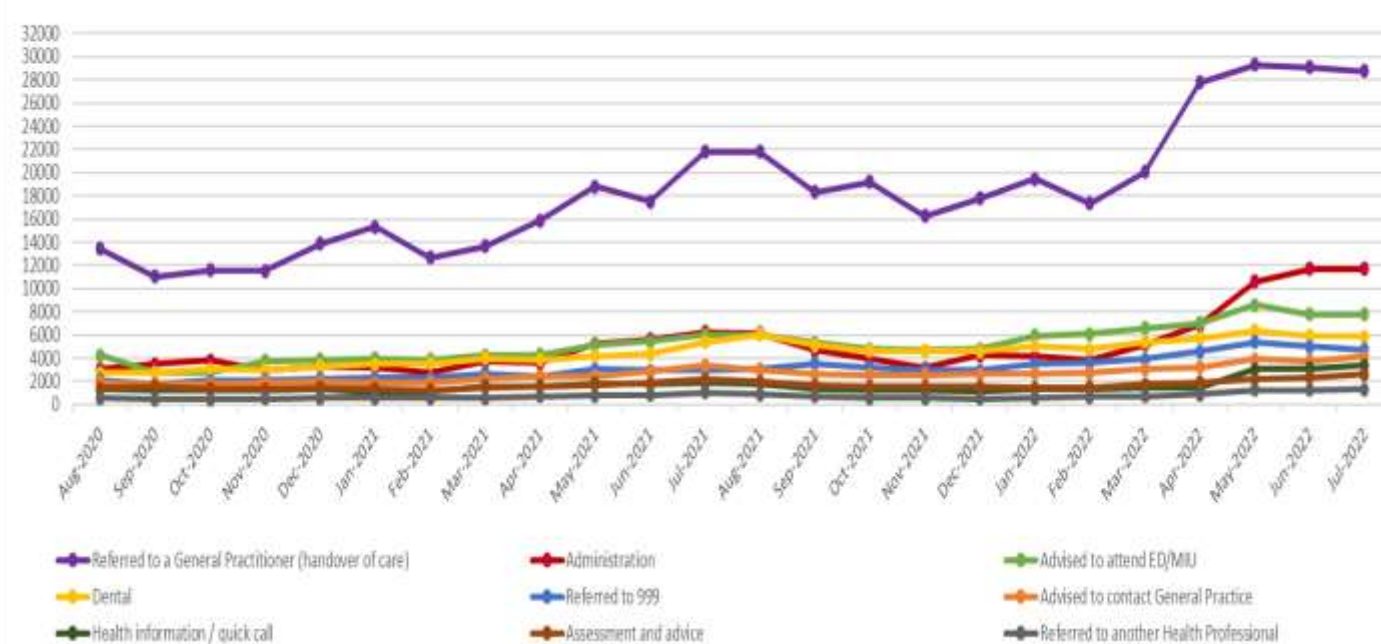
Calls falling in the Immediate Care Required category saw the highest volume; this includes calls referred to General Practitioner (28,752), and advised to attend ED/MIU (7,759) and calls referred to 999 (4,726).

In July 2022 70,265 calls were received in the 9 categories displayed in the bottom right graph, an increase when compared to 70,039 in June 2022; 26,511 in July 2020 and 50,955 in July 2021.

111 Calls by Final Outcome



111 Calls By Final outcome



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.

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.

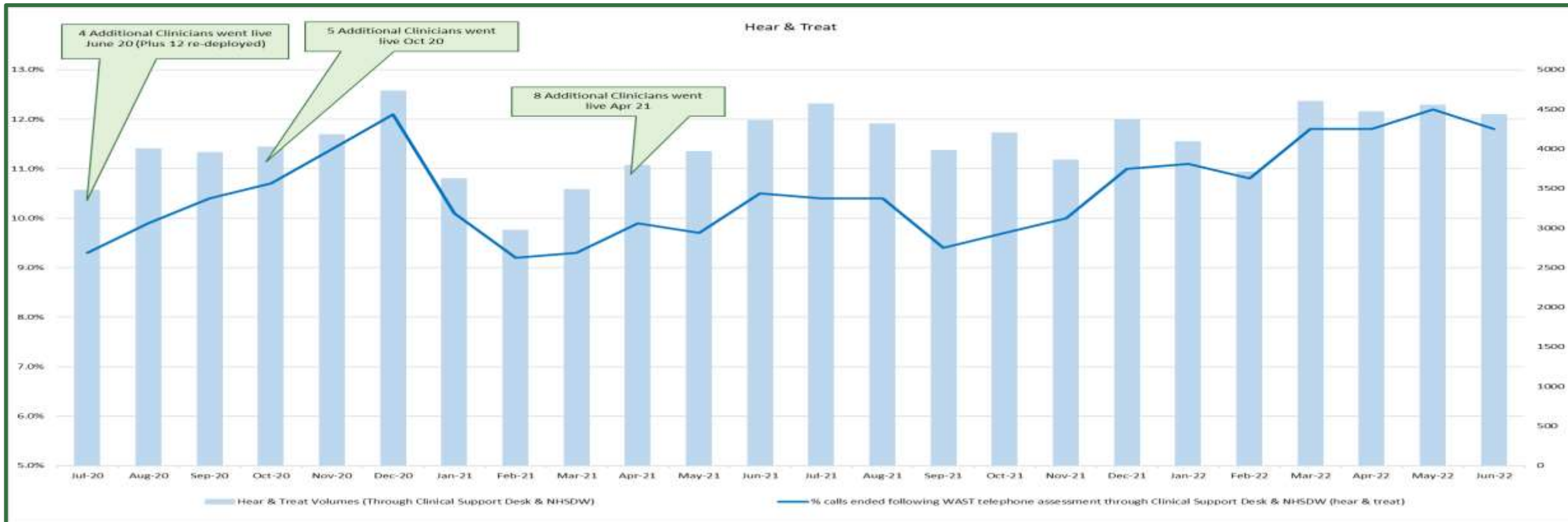




Partnerships / System Contribution Consult & Close Indicators



NB: July 2022 data unavailable at time of reporting.



Analysis

The **Clinical Service Desk (CSD)** and **NHSDW (Hear & Treat)** achieved 12.2% performance in May 2022, therefore continuing to achieve the 10.2% target for the seventh consecutive month.

9.1% of hear & treat volumes were achieved by the CSD in May 2022. In comparison, 3.1% of hear & treat 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 May 2022 were 7.4% a decrease compared to 9.2% in April 2022, however, this is an increase compared to 4.7% in May 2021.

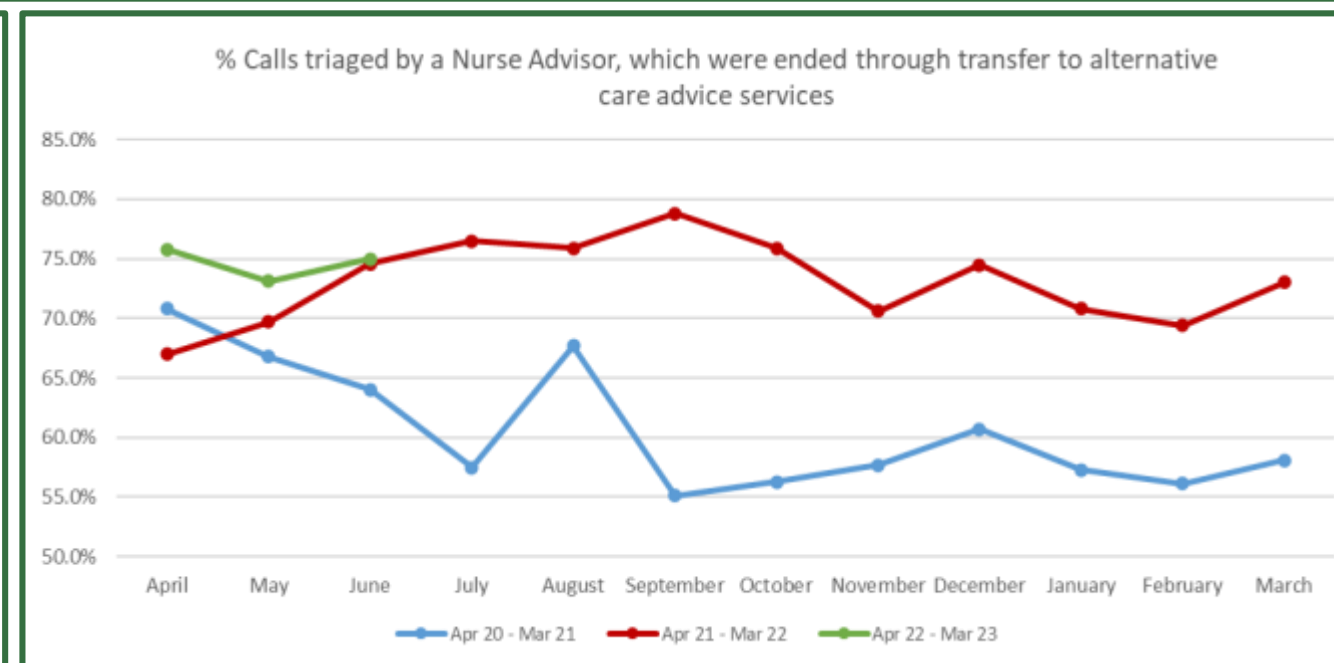
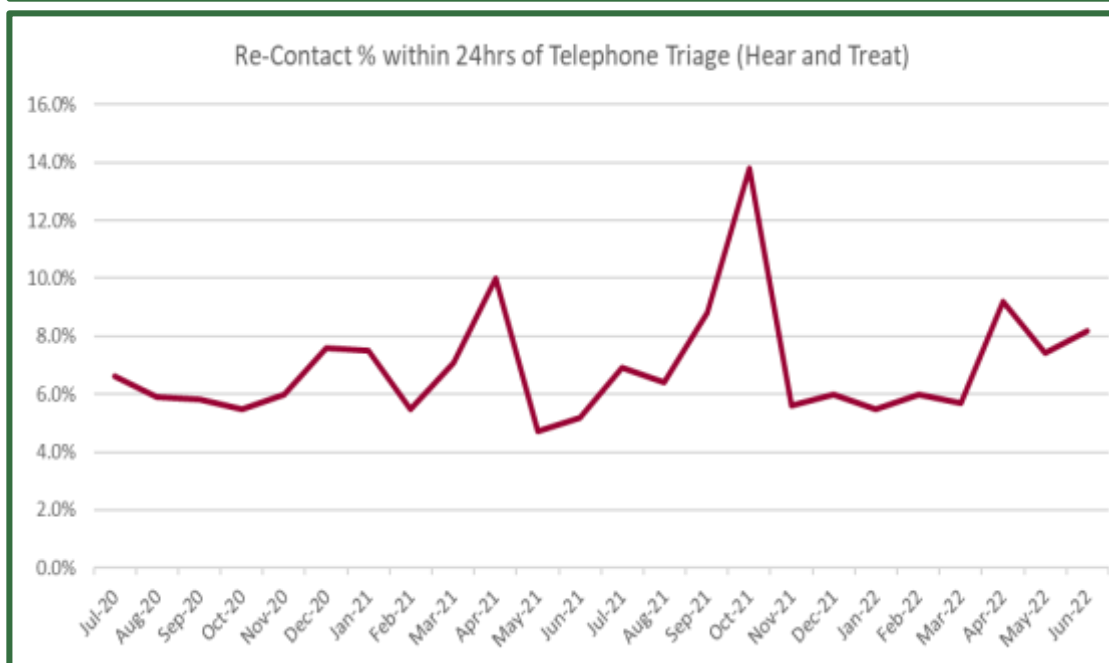
The percentage of calls triaged by nurse advisor ended through transfer of alternative care advice services increased month on month to 73.1% in May 2022; by comparison, this figure was 69.7% in May 2021.

Remedial Plans and Actions

- Funding has been agreed to double the size of the CSD, including introduction of 5 mental health practitioners. In the first few months of the year, the staff have been onboarded and have been training on the new ECNS system. It is likely therefore that we will start to see the full effect into Q2 / Q3
- 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



(Responsible Officer: Lee Brooks)

Welsh Ambulance Services NHS Trust

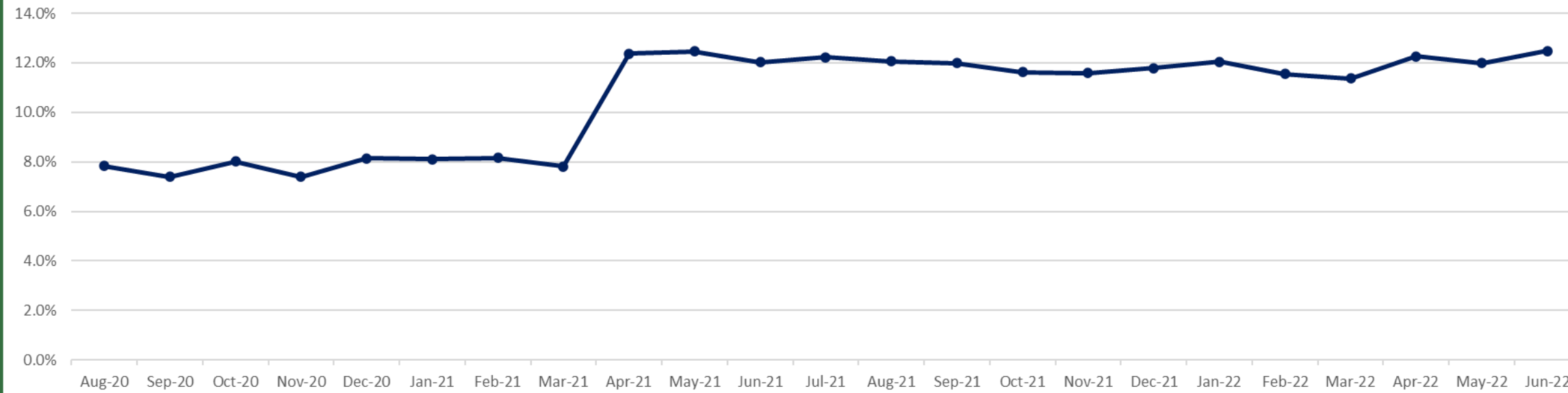


Partnerships / System Contribution Conveyance to ED Indicators



NB: July 2022 Conveyance data not available for reporting

% of Total Conveyances taken to a service other than a Type One Emergency Department



Analysis

The percentage of patients conveyed to EDs decreased (i.e. improved) compared to the same period last year. In June 2022 conveyance to EDs as a proportion of total verified incidents was 35.992% (compared to 39.76% in June 2021). In addition, 12.5% of patients (1,502) in June 2022 were conveyed to a service other than a Type One ED.

The combined number of incidents treated at scene and referred to alternate providers decreased in June 2022 when compared to May 2022. 1,883 incidents were referred to alternative providers in June 2022 and 2,173 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).

In July 2022 683 ambulances were stopped due to CSP alternative transport and 370 were as a result of CSP Can't send options. In addition, 12,512 ambulances were cancelled by patients (including patients refusing treatment at scene) and 405 patients made their way to hospital using their own transport.

Remedial Plans and Actions

This indicator captures the impact of all "shift left" activity, for example hear & treat, see & treat (APPs, Band 6 Paramedics), pathways and conveyance to other hospital locations e.g. minor injury units (MIUs), direct admissions etc. Years 3-5 of the EMS Operational Transformation Programme offer the potential to take a more transformative look at options for further reducing conveyance, where it is clinically safe and appropriate to do so. The initial results of this modelling are expected w/c 24 January 2022 (received).

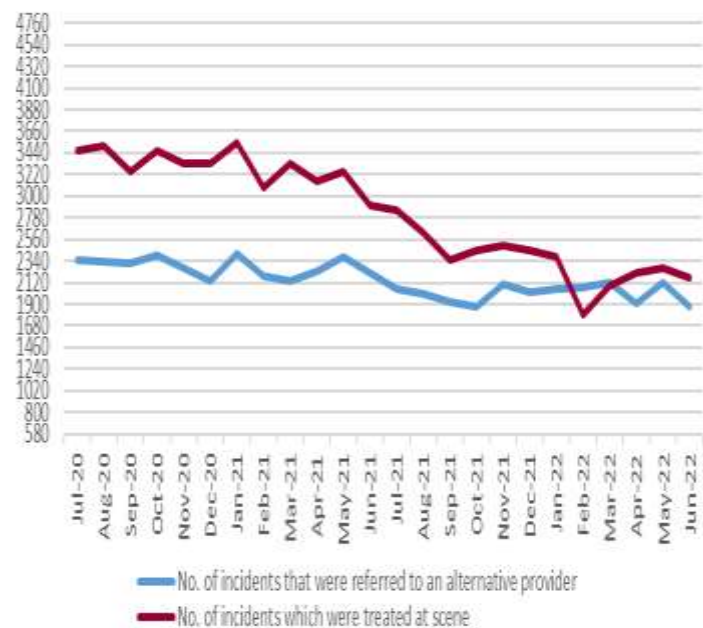
As part of the IMTP and working with partners across the health system. WAST has been asked to lead on the development of a National Respiratory work stream. A four phased proposal has been designed to deliver sustainable service level improvement for respiratory patients across Wales aligned to the national strategic direction and delivered in collaboration with Health Boards & key stakeholders: delivery will be dependent on cooperation with health boards who will need to provide a service to refer into; however, this has the opportunity to increase referrals to alternative providers.

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.

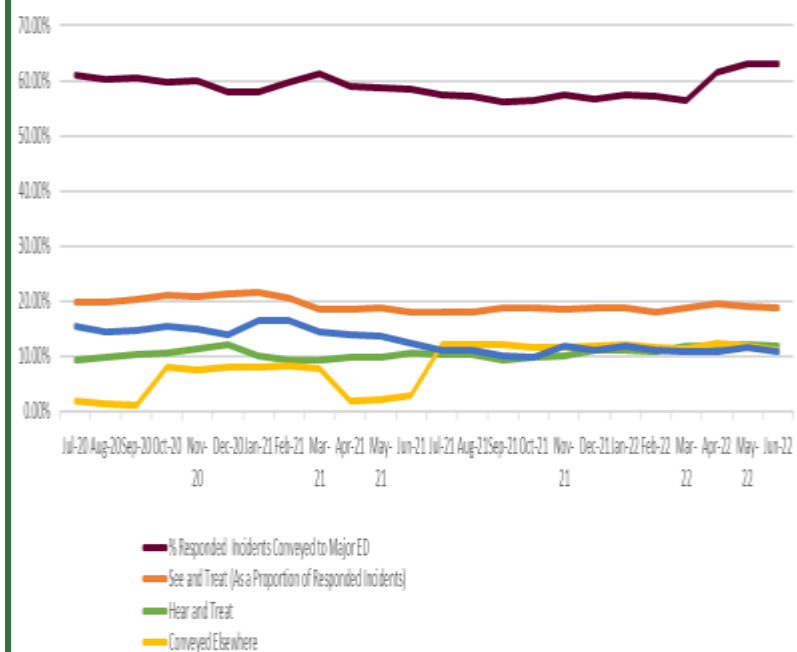
Expected Performance Trajectory

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.

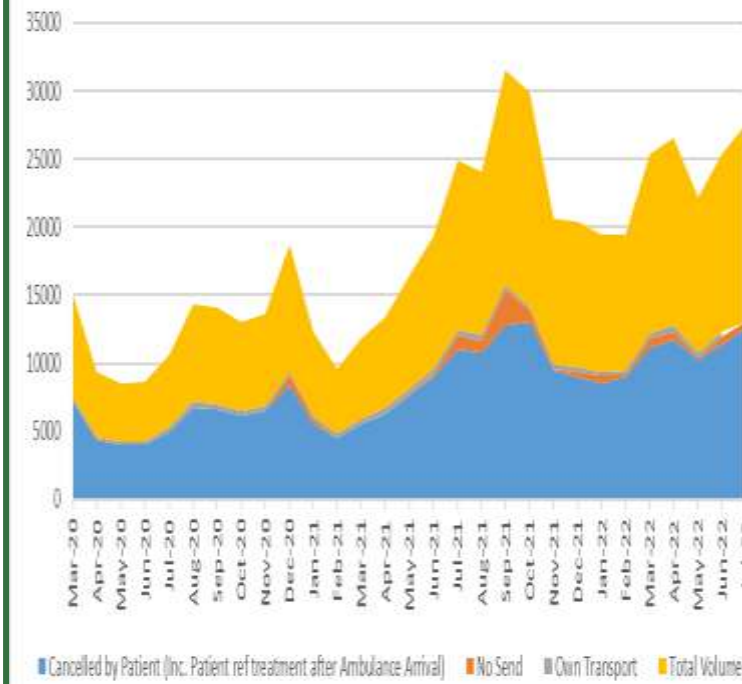
Incidents Treated at Scene VS Incidents Referred to Alternative Providers (Ambulances Stopped)



% of Patients Conveyed to Major ED, Triaged through Hear or See and Treat or Conveyed Elsewhere



Numbers of patients with no send or cancelling ambulance

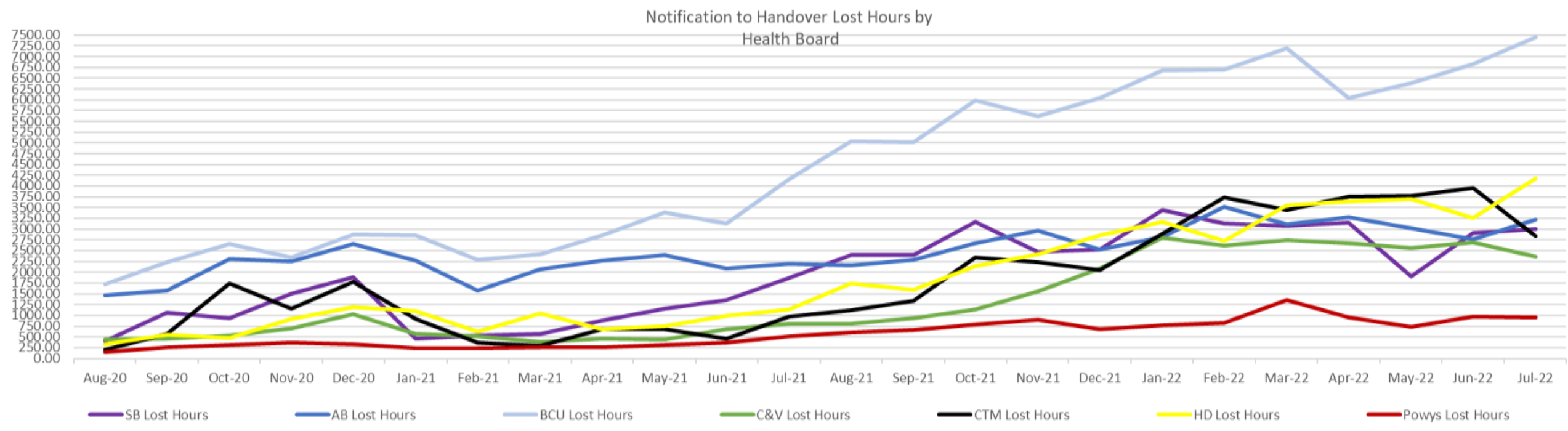
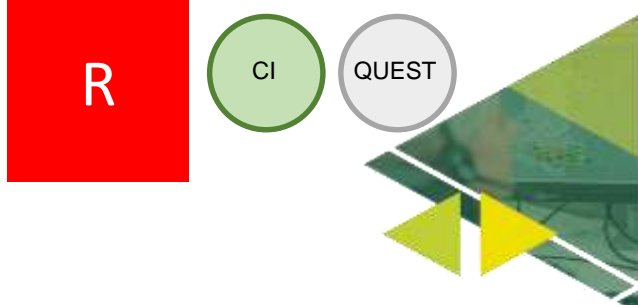


(Responsible Officer: Andy Swinburn)

Welsh Ambulance Services NHS Trust



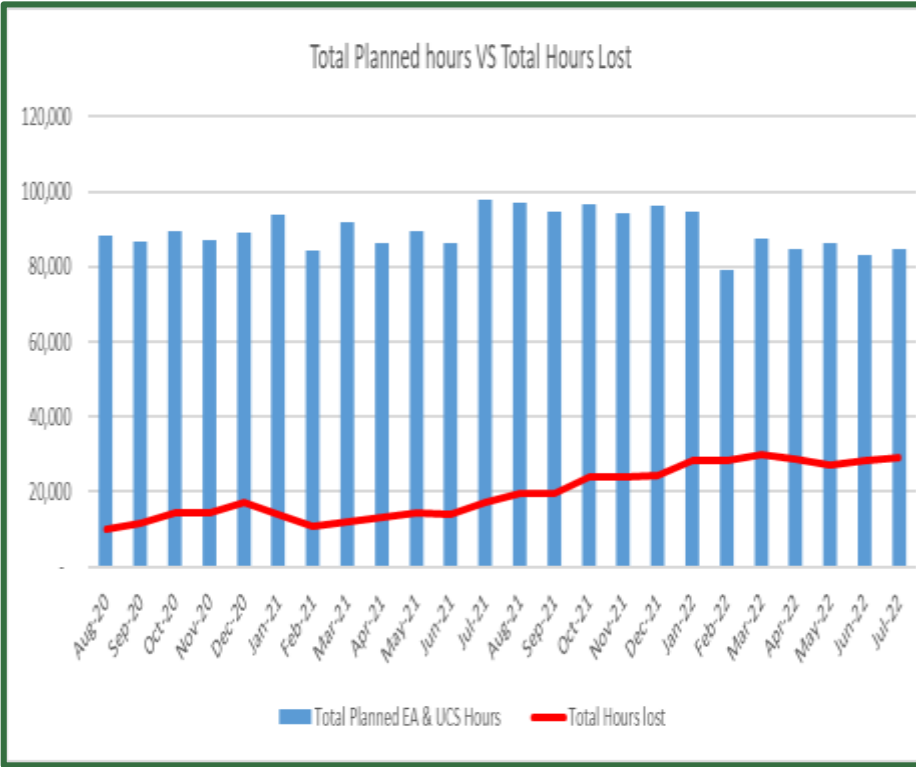
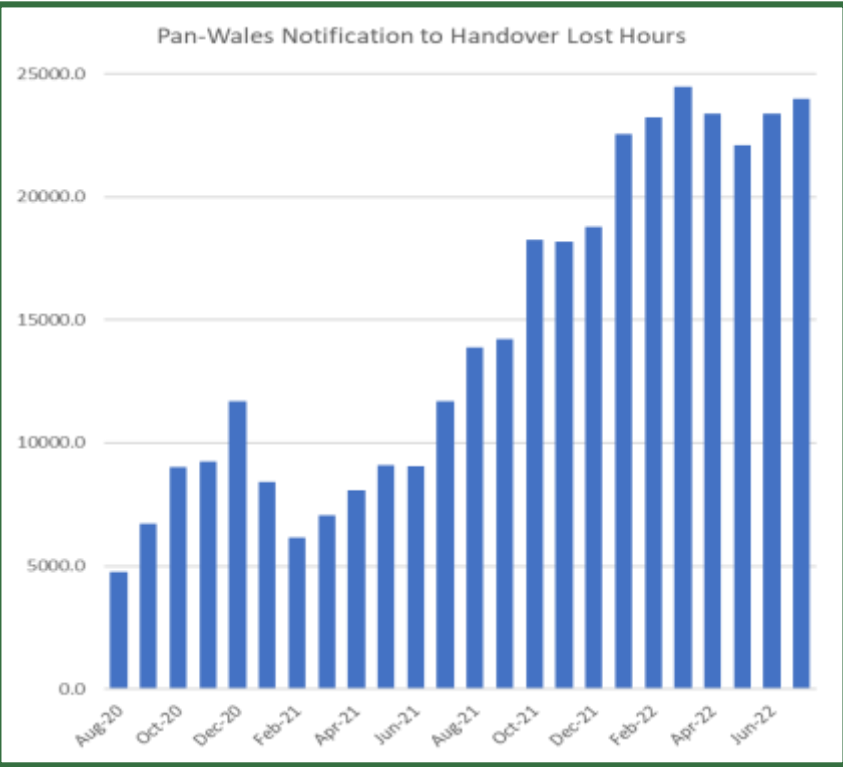
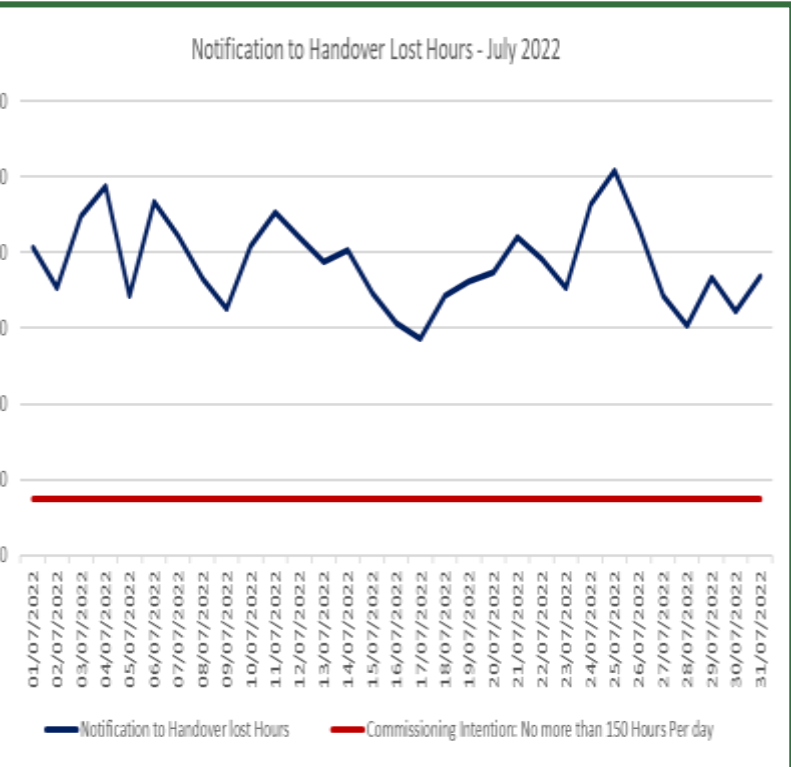
Partnerships / System Contribution Handover Indicators



Analysis
246,350 hours were lost to Notification to Handover, i.e. hospital handover delays, over the last 12 months, compared to 100,981 in same period a year ago (August 2020 to July 2021). 23,978 hours were lost in July 2022, a 51% increase compared to 11,685 lost hours in July 2021 and an increase when compared to 13,820 recorded in December 2019, the previously worst recorded month, prior to August 2021. The hospitals with highest levels of handover delays during July 2022 were Glan Clwyd Hospital Bodelwyddan (BCUHB) at 2,895 lost hours, the Grange University Hospital (ABUHB) at 2,788 lost hours, Morriston Hospital (SBUHB) at 2,779 lost hours and the University Hospital of Wales (CVUHB) at 2,233 lost hours.

Notification to handover lost hours averaged 773 hours a day in July 2022, 515% higher than the commissioning intention of no more than 150 hours per day.

In July 2022 the Trust could have responded to 7,564 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). 22 ideas have been received through the WIIN platform from staff in June 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 care that have a greater effect on patient outcomes if done together in a time-limited way, rather than separately).	Financial Balance – Annual Expenditure YTD as % of budget Expenditure	Annual expenditure (Year to Date) as a proportion of budget expenditure.
Acute Coronary Syndrome Patients with Appropriate Care	Proportion of STEMI patients who receive appropriate care. ST segment elevation myocardial infarction - occurs when a coronary artery is totally occluded by a blood clot.	Post Production Lost Hours	Number of hours lost due to ambulance vehicles being unavailable due to a variety of reasons (A detailed list of these is show in the graph on slide 22).
Renal Journeys arriving within 30 minutes of their appointment (NEPTS)	Proportion of renal journeys which arrive at hospital appointments within 30 minutes (+/-) of their appointment time.	111 Consult and Close	Consult and Close refers to the response to 999 callers where an alternative to a scene response has been provided. A cohort of 999 calls are passed to 111 where they are low acuity and the Clinicians in 111 may be able to help the caller with self-care, referral, etc. This is similar to the work of the Clinical Support Desk but for a lower acuity of caller. Where the outcome from the 111 clinical consultation ends in a Consult and Close outcome (self-care, referral, alternative transport) this is captured and forms part of the Trust’s Consult and Close reporting. Over 50% of calls passed to 111 in this way are successfully closed without an ambulance response.
Discharge & Transfer journeys collected less than 60 minutes after booked ready time (NEPTS)	Proportion of journeys being discharged from and/or transferred between hospitals which were collected within 60 minutes of the hospital booked ready time.	999 / 111 Hear and Treat	Proportion of 999/111 calls which are successfully completed (closed) without dispatching an ambulance vehicle response. This may include advice, self-care or referral to other urgent care services.
National reportable Incidents (NRI)	Volume of patient safety incidents reported in the month which caused or contributed to the unexpected or avoidable death, or severe harm, of one or more patients, staff or members of the public, during NHS funded healthcare.	% Incidents Conveyed to Major EDs	Proportion of patients transported to a hospital Emergency Department following initial assessment at scene by a Welsh Ambulance Services NHS Trust Clinician, as a proportion of total verified incidents. (NB: An ED provides a wide range of acute in-patient and out-patient specialist services together with the necessary support systems, which allow emergency admissions, and which usually has an Accident and Emergency Department).
Concerns Response within 30 Days	Proportion of concerns responded to by the complaints team within 30 working days of receiving the concern.	Number of Handover Lost hours	Number of hours lost due to turnaround times at EDs taking more than 15 minutes. Transferring the care of a patient from an ambulance to an ED is expected to take no longer than 15 minutes, with a further 15 minutes for ambulance crews to make their vehicle ready for the next call.
EMS Abstraction Rate	The percentage of Emergency Medical Services (EMS) staff unavailable for rostered duties due to reasons, such as: annual leave, sickness, alternative duties, training, other and COVID-19.		



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	9
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	1

QUALITY HIGHLIGHT REPORT QUARTER 1 APRIL - JUNE 2022

MEETING	Quality, Patient Experience & Safety Committee
DATE	11 August 2022
EXECUTIVE	Executive Director of Quality & Nursing
AUTHOR	Head of Quality Assurance
CONTACT	Caroline Miftari 07970406447 Caroline.miftari@wales.nhs.uk

EXECUTIVE SUMMARY

The report (**Annex 1**) seeks 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 promote a Duty of Quality and Duty of Candour. Highlighting any governance concerns, issues, risks and area for improvement across the commissioned services.

The report contains a summary of:

- (i) Quarterly Q-IPR dataset, drawing out the key areas of risk
- (ii) Key activities of the Clinical & Quality Governance Group
- (iii) Quality focus area (arising from the Quality, Patient Experience & Safety Committee).

The key challenge in writing the report for the Quality, Patient Experience & Safety Committee (QuEst) is the timing of the release of Ambulance Quality Indicators for the last month in the quarter required to write part A of the report. This results in a narrow window for the Head of Quality Assurance to compile the report with the third month's data and gain scrutiny from Governance Leads. Scrutiny is essential to ensure compliance against the All Wales Health & Care Standards and Core Commissioning requirements.

KEY ISSUES/IMPLICATIONS

The Key implications for the quarter are noted below:

- (i) Notification to handover lost hours averaged 712 hours a day in May 2022, 475% higher than the commissioning intention of no more than 150 hours per day.
- (ii) The Red performance indicators have been consistently below the 65% target, 50%, 54% for April and May respectfully, with some Health Board variation.

- (iii) In May 2022, 619 patients (all categories) waited over 12 hours, a decrease when compared to April 2022, continuing to represent a very poor quality and experience of service. 475 of these patients were in the Amber category.
- (iv) During the quarter there have been 17 Nationally Reportable Incidents (NRIs) reported to the Delivery Unit.

Health Inspectorate Wales inspect and regulate the Trust against a set of Standards, Policies, Guidance and Regulations to highlight areas of improvement. The All Wales Health and Care Standards are key to this inspection, and include:

- Governance, Leadership and Accountability
- Standard 1.1 Health Promotion, Protection and Improvement
- Standard 2.1 Managing Risk and Promoting Health and Safety
- Standard 3.1 Safe and Clinically Effective Care
- Standard 4.1 Dignified Care
- Standard 5.1 Timely Access
- Standard 6.1 Planning Care to Promote Independence
- Standard 7 Staff and Resources

Compliance against the All Wales Health and Care Standards are illustrated through a number of different reports that are reported to either QuEST or the People and Culture Committee. The reports include Q-IPR, Quality Report, Patient Experience and Community Involvement Highlight Report, Patient Safety Highlight Report.

The key issues currently affecting the Trust is timely access to care. This will have a negative impact on the delivery of safe and effective care and the Trusts ability to manage risk and promote health and safety.

RECOMMENDED: That the Committee discusses and notes the content of the report.

REPORT APPROVAL ROUTE	
Executive Management Team	3 August 2022
Quality, Patient Experience & Safety Committee	11 August 2022

REPORT APPENDICES
Annex 1 - SBAR providing background information relating to the Integrated Quality Performance Highlight Report Quarter 1, 2022-23

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

SITUATION

- 1 The report provides an overview of the quarterly Q-IPR Dataset, Clinical Quality Governance Group (CQGG) overview, and quality improvement focus area arising from QuEst.

BACKGROUND

- 2 The Trust's Quality Report seeks to provide assurance with respect to the Commissioning Core Standards, All Wales Health & Care Standards (2015) and the Health & Social Care (Quality & Engagement) (Wales) Act 2020 that promote a Duty of Quality and Duty of Candour. Highlighting any governance concerns, issues, risks, and area for improvement across the commissioned services.
- 3 The Health & Social Care (Quality & Engagement) (Wales) Act 2020 aims to unlock the potential of NHS bodies to demonstrate that quality is at the heart of all we do, taking forward the sound quality foundation already within the NHS in Wales to the next level, requiring a system-wide approach. The Act covers four principal areas: Duty of Quality; Duty of Candour; Establishment of a new Citizen Voice Body and Provision for NHS Trusts to introduce the role of Vice Chairs.
- 4 The Welsh Government has set up a series of work streams in line with the Duty of Quality and Duty of Candour with key representatives from each Health Board and Trust to establish guidelines to ensure full implementation of the Act.

ASSESSMENT

Part One: Q-IPR Data Set Overview for Quarter 1, 2022-23

- 5 The Q-IPR slide decks are published monthly by the Strategy, Planning and Performance Directorate, highlighting performance against a key set of defined quality and performance measures. The IPR metrics are aligned to the All Wales Health and Care Standards and the Core Commissioning requirements.
- 6 This report seeks to compliment the Q-IPR report, drawing out the key areas of risk relevant to service quality and safety.

Patients delayed on ambulances outside the Emergency Departments

- 7 Patients delayed on ambulances outside the Emergency Departments (Risk 224) is one of the highest risks within the Trust. Notification to handover lost hours averaged 712 hours a day in May 2022, 475% higher than the commissioning intention of no more than 150 hours per day.
- 8 Executives and Non-Executive colleagues have continued to highlight this serious patient safety issue to external stakeholders including Emergency Ambulance Services Committee (EASC), Health Boards, Health Inspectorate Wales, and Welsh Government. The Trust continue to seek resolution of the

system challenges and will continue to influence and system partners of the high risk and patient harm occurring in communities, as a result of prolonged ambulance handover delays.

- 9 Healthcare Inspectorate Wales (HIW) has undertaken a local review of the Trust to consider the impact of ambulance waits outside Emergency Departments, on patient dignity and overall experience during the COVID-19 pandemic. Over the quarter, EASC Management Group and HIW Task & Finish Group chaired by the National Collaborative Commissioning Group (NCCU) meet regularly to facilitate discussions between each Health Board and the Welsh Ambulance Services NHS Trust (WAST) on handover reduction plans and improvement trajectories. The Group last met in May 2022 where further actions were agreed.

Impact on community waiting times

- 10 Patients delayed on ambulances outside the Emergency Departments (Risk 224) has a subsequent impact on patients in the community receiving a timely response. The Trust's inability to reach patients in the community causing patient harm and death is also on the Corporate Risk Register (risk 223).
- 11 The severity of community delays effecting patients in the community is illustrated through performance in response time:
 - Red Performance Response to red 999 calls: The Trust has a target measure of achieving 65% for emergency vehicles to respond to red calls arriving within (up to and including) 8 minutes against the red calls 95th percentile. The Red Performance Indicators have been consistently below the 65% target, 50%, 54% for April and May respectfully, with some Health Board variation. Three of the main determinants of red performance are demand, unit hours produced, and handover lost hours. Hospital lost hours continue to rise and impact on service delivery.
 - Amber 1 & Amber 2 Performance: Amber performance improved in May 2022, however, there were still some very long patient waits. The ideal Amber 1 median response time is 18 minutes. In May 2022, 619 patients (all categories) waited over 12 hours, a decrease when compared to April 2022, continuing to represent a very poor quality and experience of service. 475 of these patients were in the Amber category.

There is strong correlation between Amber performance and lost hours due to notification to handover delays. The Trust carefully monitors long response times and their impact on patient safety and outcomes. The Trust supplies regular information to the Chief Ambulance Service Commissioner (CASC) and EASC; and produces monthly quality, safety & patient experience (QSPE) reports for each Health Board.

Patient Safety

- 12 Delays in responding to 999 calls can impact negatively on patient clinical outcomes, safety, and experience. To identify patient safety concerns, the Patient Safety Team produces an at a glance brief for the Chief Executive on a

weekly basis to provide an update of the previous week's patient safety landscape, demonstrating whether harm is occurring to patients in the community. The key areas focused upon are: Patient Safety Incidents (Internal); Patient Safety Incidents (External); Formal Concerns; Serious Case Incident Forum (SCIF) activity; NRIs reported by the Trust; Incidents considered at SCIF and passed to the respective Health Boards either as a Patient Safety Incident or under Appendix B through the Serious Incident Framework; and, adverse media attention

Serious Adverse Incidents

- 13 The number of NRIs that occur as a result of services undertaken by the Trust are a potential symptom of issues or risks within the system and highlight the need for lessons learnt and improvements. During the quarter there have been 17 NRIs reported to the Delivery Unit. It should be noted that, under the Joint Investigation Framework Appendix B, Patient Safety Incidents that have been identified as serious where the primary causal factor relates to, or as a consequence of, Health Board hospital handover delays following discussion at SCIF, are referred to the relevant Health Board for investigation. However, these are not included in the Trust NRI figures reported to the Delivery Unit.
- 14 During the quarter there were 23 SCIFs convened with 117 cases considered. 17 have been reported as NRIs to the Delivery Unit, with 50 cases being referred under Appendix B to the respective Health Board.
- 15 The Trust continues to focus on the learning from investigations and reports via the Patient Safety Highlight Report. In addition to this, learning from investigations continues to be presented to the Patient Safety, Learning and Monitoring Group and the Trust Scrutiny Panels. Individual learning is also a focus across the organisation with significant attention on both clinical and Clinical Contact Centre areas of service. The Trust also continues to engage with Health Board colleagues where the Trust has utilised the Joint Investigation Framework and/or where there is a focus on joint investigations and learning.

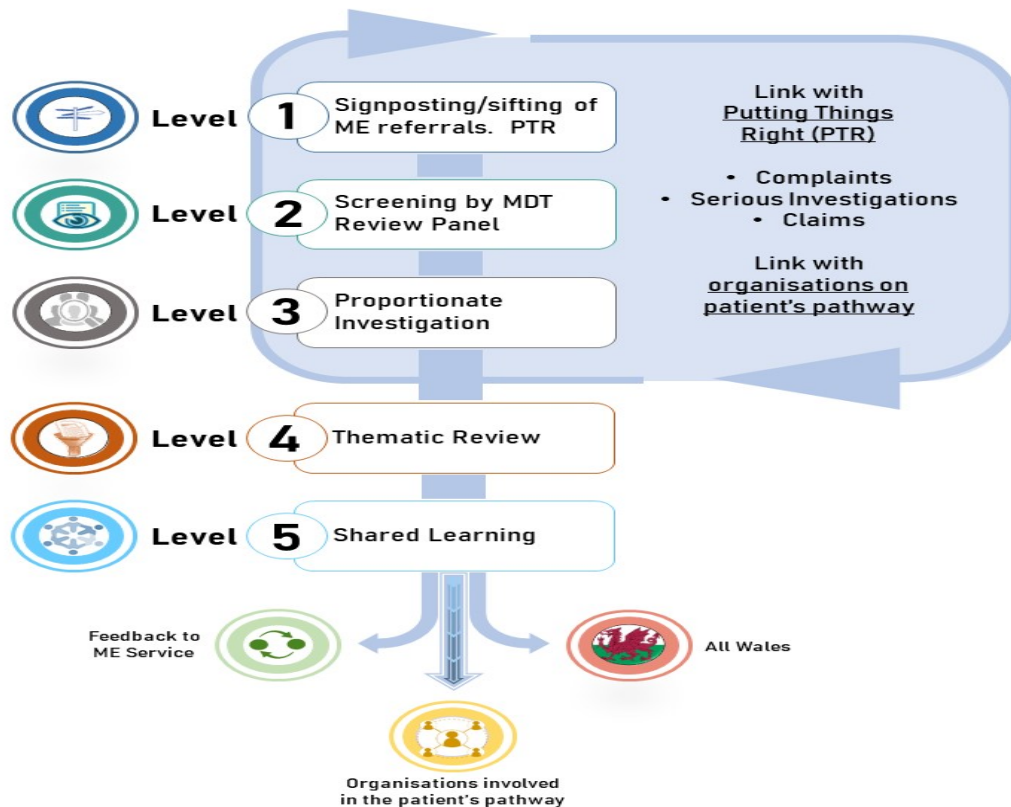
Part 2: Clinical and Quality Governance Group Overview

- 16 Over the quarter, the CQGG has met monthly. The purpose of the CQGG is to provide leadership and governance, overseeing on matters of a clinical and quality domain. The Group provides governance and assurance for Trust Mfunctions; providing a forum to direct improvement in response to organisational learning and to deliver excellence.
- 17 A variety of areas of concern and improvement initiatives have been discussed to provide assurance, enhance services and ensure patient safety and experience matters are considered.

All Wales Learning from Mortality Reviews

- 18 The Trust has undertaken Mortality Reviews since 2015, however in August 2021 the Delivery Unit issued the All Wales Learning from Mortality Review Framework. The Framework is a significant shift from the Trust previous method

of undertaking Mortality Reviews. The Framework document sets out that NHS organisations in Wales should undertake Mortality Reviews in relation to requests for information from the newly formed Medical Examiners (ME) in Wales.



19 The Clinical & Medical Services Directorate and Patient Safety Team have considered the new Framework, in particular in that Mortality Reviews are to follow the Putting Things Right Regulations with the Medical Director or equivalent who has the responsibility to:

- When a *Medical Examiner's Advice and Scrutiny Form* is received by an organisation, systems are in place to acknowledge receipt and monitor the case through to final closure and feedback to the ME
- The *Medical Examiner's Advice and Scrutiny Forms* are appropriately managed in line with the principles of *Putting Things Right* and this Framework
- Organisational structures and processes are established and are effective, where roles and responsibilities have been clearly defined, to achieve the key outcomes of a mortality review, which results in implemented improvements
- Organisational structures and processes are effective in supporting local and national learning; systems are in place to identify named individuals who will be trained in the MR and investigation process.

20 The CQGG have reviewed the Framework and considered the governance requirements to ensure compliance and assurance. The Regional Consultant Paramedic, Patient Safety Lead and the Datix Cymru Lead will further scope the alignment of the Mortality Module within Datix Cymru as a single route for Medical

Examiner requests to be received and reviewed in line with the All Wales Framework.

Paramedic Pathfinder

- 21 The future of the Trust using Paramedic Pathfinder has been discussed in view of the introduction of Emergency Communication Nurse System (ENCS). Three potential options have been considered at the Ambulance Practice Steering Group and subsequently at the CQGG, the options include:
- Full removal of Paramedic Pathfinder
 - Partial use of Paramedic Pathfinder
 - Full use of Paramedic Pathfinder across the emergency medical workforce
- 22 Option one is the favoured option as currently Paramedic Pathfinder is not consistently utilised across the Trust and has not been incorporated into the initial functional design specification for Electronic Patient Care Record (EPCR).
- 23 If the Trust do not continue to use Paramedic Pathfinder there is clinical mitigation in place which are embedded in EPCR. Pathfinder is not audited routinely but does form part of Clinical Reviews.
- 24 Further mitigation of clinical risk has been considered, as in recent years the Trust has invested in additional support for clinical decision-making. These include the Clinical Support Desk (CSD), provision of a Senior Clinician on call, the Newly Qualified Paramedic (NQP) Deviation Policy, developing the Non-Conveyance Policy, JRCALC plus App and the EPCR. In addition use of National Early Warning Score (NEWS) and Paediatric Observational Priority Score (POPS).
- 25 If the Trust choose to continue to use Paramedic Pathfinder there may be a future revenue cost associated that has not yet been established. It would also require future iterations of EPCR to incorporate Paramedic Pathfinder which would have a development cost. Further discussions and scoping will be undertaken and brought back to a subsequent Clinical Quality Governance Meeting for approval.

High Consequence Infectious Diseases

- 26 A High Consequence Infectious Disease (HCID) Standard Operating Procedure (SOP) has been developed for use in the Trust. Its design is specific to any disease pathogen identified as a HCID. The aim is to provide operational guidance to staff within the Trust in the event that any disease pathology presents as a HCID. The SOP has been approved by the CQGG.

Professional Accountability and Governance of Allied Health Care Professionals

- 27 The Trust has identified a gap within its governance structure to support Physiotherapists/Occupational Therapists and other Allied Health Care Professionals, other than those who are registered as Paramedics or Nursing members of staff, in terms of the professional accountability structures.

Individuals who work within these roles may need to work clinically to ensure they maintain clinical competence and confidence.

- 28 Discussions considered the requirements for a Director-level Lead for Allied Health Professionals (including but not limited to Physiotherapists, Occupational Therapists, and Social Workers) and the merit in the development of specific Job Descriptions to support Allied Professionals working and progressing within the Trust.
- 29 Therapists who are currently employed to work within the Level 2 Falls and Frailty Service do so by means of Honorary Contract across two Health Boards within Wales. Due to the Honorary Contract process, clinical accountability, clinical supervision and support has often remained outside of the Trust, within the individual's Health Board.
- 30 Further advice to be sought from Welsh Government and Directors of Nursing to agree an appropriate governance structure for the Trust outlining professional lines of accountability, support and process of maintaining clinical practice and continuous professional development.

Once For Wales Concerns Management System - Closure of Records Update

- 31 Phase one (2011-18) closure of incident records has been undertaken by the Patient Safety and Health and Safety Teams. The total number of incidents individually reviewed were 784.
- 32 The Patient Safety Team reviewed a total of 317 open incident records relating to 2011-2018. The Health and Safety Team reviewed a total of 467 open incidents relating to 2011-18. The review did not identify any areas of new concern, only issues that the Trust has previously identified through theme and trend analysis.
- 33 For Phase two the Trust is looking to batch close 5960 patient safety, no harm and minor harm incidents, centred on the learning from phase one. Of the remaining 391 that fall within the following categories, triggered for the SCIF, unconfirmed, major, moderate and catastrophic, the Patient Safety Team will individually review. Incidents that have not been investigated, will be investigated in line with the Adverse Incident Policy and Procedure.
- 34 The Trust is looking to batch close 7,387 health & safety, no harm and minor harm incidents, centred on learning from phase one. Of the remaining 978 health and safety incidents that fall within the following categories, unconfirmed, major, moderate and catastrophic, the Health and Safety Team will undertake an individual review of incidents referring to operations where appropriate.
- 35 The risk-assessed based approach has enabled the Trust to investigate incidents necessary, whilst ensuring proportionate resources are allocated to lower grade issues and incident reported. A full Learning Report will be provided to the Executive Team on completion of the activity; it is likely to include a

recommendation for policy review and process improvement to streamlined process for investigation completion and resolution of issues.

Part 3: Quality Improvement Focus area - Supporting our Communities

- 36 Following a request from QuEST the Quality Improvement Team have provided a focus around improvement opportunities focused on supporting our communities and developing community resilience.
- 37 The Kings Fund have previously acknowledged that “community capacity is a core part of resilient communities and a resilient health and care system. No public service should think it can be perfectly resilient by itself - there is an eco-system that extends well beyond the statutory sector. A resilient health and care system needs resilient community networks and support, facilitated by a strong voluntary and community sector. This has been crystal clear in the COVID-19 pandemic (Kings Fund, 2020). As system wide pressures increase and operating environments remain challenging, there is a fundamental need to assist communities to enhance their resilience. This is important for patients who access our services, those who are required to wait for ambulance response and those who are supported to remain at home and/or access alternative services within the community.

Falls Improvement: Improving our response during nights

- 38 The Improvement Team have recently completed an evaluation of the Falls Assistant Service (by night), which has operated within the South Central and South East Territory areas. The evaluation demonstrated an increase in the utilisation of resources by night, improved response time for falls incidents and a reduction in number of emergency ambulances required to attend falls specific incidents.
- 39 Following a presentation of the evaluation findings and discussion, the Executive Management Team approved the extension of the service up to and including the 31 March 2023.
- 40 In addition, the Improvement Lead for Falls has been working closely with Betsi Cadwaladr University Health Board (BCUHB) on the spread and scale of our Integrated Falls and Frailty Response Service (Level 2) provided by Paramedic and Therapist.
- 41 The pilot within BCUHB has demonstrated comparable utilisation and non-conveyance of fallers (85% non-conveyed), illustrating the benefit of this Service Model and the feasibility of spread and scale.
- 42 From January through to the end of June 2022, the Falls Assistants and Level 2 falls response vehicles have responded to 3,160 falls, which represents 20% of the total falls demand pan Wales.
- 43 The team have also been working closely with Health Boards on adoption of training and response to non -injury falls within nursing homes to reduce call outs to nursing homes where those patients are not conveyed, again supporting

release of Emergency Medical Service (EMS) capacity and improving patient experience and outcomes by reducing time on floor. Again, with successful evaluation of care home falls management, spread and scale is planned enabling care homes to manage non-injury falls without the need for WAST support.

- 44 The enhanced Falls Assistant and Falls, and Frailty Response Teams has provided additional resilience within communities, providing additional response capability, often where other emergency response capable vehicles are unavailable. Patients are actively supported to access community-based support services, via the Clinical Support Desk within the Clinical Contact Centre. Our work with partners including St John Ambulance Cymru and the Mid and West Wales Fire and Rescue Service is key to ensure the provision of an enhanced Falls Response Service.

Older Persons Improvement

- 45 The Improvement Lead's for Older People, Falls and Frailty and Dementia have developed a short film demonstrating the innovative work that the teams are leading on to assist in improving outcomes for older people, fallers and patients with dementia accessing services provided by the Trust. When launched this film will be shared with the public, partners and workforce and offers an insight into how through working together we can develop and improve. The Older Persons Framework is the key driver behind the development of this visual story and will aim to seek collaborative opportunities with partners.
- 46 The Improvement Lead for Older People has been working with partners across the wider NHS, Local Authority and third sector to collectively identify issues and examine opportunities for improvement. This includes but is not limited to:
- **National:** All Wales Optimised Patient Flow Feedback, National Falls Prevention Taskforce, National Inpatient Falls Group, St John Ambulance Cymru
 - **Central:** Pembrokeshire Care Homes focused improvement work, Hywel Dda Falls Prevention Group
 - **Powys:** Focused Quality Improvement work (Cwrt Enfys - Powys), Older Persons Forum,
 - **ABUHB:** Redesigning services for older people - Early intervention and hot clinic workstreams, Age Friendly Monmouthshire, Care home improvement - falls workstream

Research Innovation and Collaboration (RIC) Hub update

- 47 The RIC Lead and Older Persons Lead, has been working with the Welsh Hack Team, following a successful bid for funding to work with the Science and Engineering Applications Ltd Team (Scinap).
- 48 CHAI® (technology and IP owned by Scienap) was developed in partnership with Local Health Boards and naturally evolved into a community care platform in response to the COVID-19 pandemic. This digital platform harnesses community support networks, friends, family members, volunteers - able to sustainably assist vulnerable individuals and those with chronic conditions.

- 49 CHAI® 999, created for the Welsh Health Hack, could enable WAST Clinical Contact Centres to access Community Teams pan-Wales. Each 999 Call Handler will get urgent 'eyes on' their patient to ensure most appropriate response, including alternative pathways and safe patient dispositions.
- 50 Additional CHAI® services will soon afford WAST instant access to patient passports (rare/complex diseases and autistic patient), chronic condition records and smart fall devices.
- 51 The ability for us to also add training and urgent information short films and signposting materials will reinforce the community resilience ethos - WAST will have non-exclusive, royalty free licence to use and/or modify the videos in perpetuity. Scienap is also in the process of adding an Artificial Intelligence (AI) chatbot and AI signposting to CHAI® in partnership with the TriTech Institute.
- 52 The project will initially operate in the BCUHB area for the pilot duration.
- 53 CHAI® has the potential to enhance our Response Model for a large and growing cohort of service users, including: the very elderly and/or frail living at home; people with chronic conditions; people with rare or complex conditions (over 200,000 in Wales); and people with autism.
- 54 Current users of the CHAI® application are able register their Community Support Group (friends, family, carers). Each member of the Support Group will be invited to share their contact details with WAST, and we will be able to contact them quickly in the event of a 999/111 trigger.
- 55 CHAI® 999, a bespoke application tailored to the WAST environment, will enable WAST Clinical Contact Centres pan-Wales access to these Community Teams; enabling 999 and 111 Practitioners urgent 'eyes on' their patient to ensure most appropriate response, including alternative pathways
- 56 The Team are currently in the initiation stage of the project, with a Task and Finish Group scheduled for August. It is anticipated that the software and testing will commence in October 22.
- 57 Additionally, following a successful funding bid from the Bevan's Commission, the Team have been working with Aneurin Bevan University Health Board (ABUHB), FUJI and the Operations Team to develop a feasibility project for an 'Urgent Response X-ray Unit'. This Team will commence operating in October 2022 for a period of six months, followed by a period of evaluation.
- 58 The project will aim to:
- evaluate suitability of equipment and quality of x-ray films in the pre-hospital setting
 - determine risk and governance implications, from a medical physics perspective, that reflect safety and suitability of mobile x-ray imaging within Ambulance Service and community contexts.

- 59 Additionally, the project will look to develop a Portable X-ray Deployment Model that details: staff skills and competency requirement; booking system processes (WAST-ABUHB flow centre); ICT infrastructure (FUJI Cloud system) and integration with local (ABUHB) systems. This is a very innovative project, with significant interest from stakeholders across the UK.
- 60 Through early access to x-ray diagnostics and enhanced integrated care within the community, patients will be supported to remain at home where clinically appropriate, with appropriate community service involvement.
- 61 As an Ambulance Service, it is essential that we explore all opportunities to ensure we promote and enable community resilience. This needs to be embedded throughout all parts of our service delivery through supporting access, to supporting patients who are cared for at home. We often care for patients and rely on the support of the patient's networks (personal and professional) to ensure safe and effective care. Additionally, community resilience is essential to ensure patients feel supported and empowered to make the best decisions around accessing and determining care required. The Quality Improvement Team are continually working with partners within the Trust and across Health, Social Care, Local Authority, and the voluntary sector to identify opportunities resulting in improvement for our patients. There has been a key focus on falls, older peoples care and supporting the wider Community Teams to recognise and support patients within their own homes. This has been a key area of concern from patients and service providers across Wales. Looking to the future the development and expansion of volunteers and the links with the third sector will be crucial in supporting patients within their own home. We will need to explore opportunities for the use of technology and social connections, to support patients who are waiting or have received an ambulance response in the community. This will be key to ensure patients are not only supported during their individual episode of care but are supported to remain well and reduce the need for unscheduled access to the services.



AGENDA ITEM No	10
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	2

PATIENT SAFETY REPORT QUARTER 1 (APRIL - JUNE 2022)
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MEETING	Quality, Patient Experience & Safety Committee
DATE	11 August 2022
EXECUTIVE	Executive Director Quality & Nursing
AUTHOR	Assistant Director of Quality & Nursing (Interim)
CONTACT	Jane Palin jane.palin@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 continued increase in the number of incidents being reviewed at the Serious Case Incident Forum (SCIF).
- An increase in the number of Appendix B incidents passed to Health Boards.
- An increase in the number of Nationally Reportable Incidents (NRIs) identified.
- A decrease 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 has received 1 Regulation 28 (Prevention of Future Deaths) Report from Coroners in South Wales during this period relating to timelines.
- A detailed breakdown of Appendix B Reports and immediate release reports by Health Board.

RECOMMENDED: That the Committee receives the report for discussion.

KEY ISSUES/IMPLICATIONS

- (i) There continues to be an increase in activity in the majority of areas across Putting Things Right (PTR).
- (ii) There continues to be a high-level volume of concerns being received.
- (iii) A reduction in compliance with both the 2-day acknowledgment and 30-day formal response target across the quarter.
- (iv) A continued increase in the volume of patient safety incidents being reported.

REPORT APPROVAL ROUTE	
Executive Management Team	20 July 2022
Quality, Patient Experience & Safety Committee	11 August 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 4, 21-22			Quarter 1, 22-23		
	Jan 2022	Feb 2022	March 2022	April 2022	May 2022	June 2022
Patient Safety Incidents						
Catastrophic	12	26	37	20	36	29
Severe	0	1	6	3	9	9
Moderate	1	3	7	5	22	32
Low	15	33	23	33	44	66
None	372	367	403	474	285	301
Total	407	440	499	546	396	437
Concerns						
Total Received	72	59	107	90	88	100
Total Closed	72	108	73	73	92	58
2 Day Acknowledgment %	34%	22%	14%	31%	12%	26%
30 Day Response due %	66%	64%	76%	53%	41%	13%
Ombudsman						
Cases Received	2	4	4	7	5	3
Cases Closed	3	5	2	3	5	4
Reports Received	0	1	0	0	1	1
Coroners						
Information request	96	95	106	115	112	116
Identified as Interested Party	12	12	17	19	20	19
Staff attending	6	5	5	5	5	6
Regulation 28 issued	0	2	0	0	1	1
Response to Regulation 28 in 56 working days	0	0	2	0	0	1
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	5	6	7	7	8	8
Serious Case Incident Forums Cases	22	35	47	26	44	47
WAST NRIs reportable to Delivery Unit	5	2	7	3	11	3
Incidents reviewed at SCIF and reported under the Joint Investigation Framework	18	17	7	19	7	24
NRI Closures Submitted – Total	6	7	7	5	8	7
NRI Closed by Delivery Unit – Total	0	0	5	0	11	0
Claims						
Personal Injury – Received	0	4	3	3	1	0
Personal Injury – Closed	0	0	19	3	0	1
Clinical Negligence – Received	2	0	5	4	1	2
Clinical Negligence – Closed	0	0	0	3	0	0
Road Traffic Collision & Damage to Property – Received	30	31	26	15	17	25
Road Traffic Collision & Damage to Property – Closed	29	17	21	6	19	10

SETTING THE CONTEXT FOR THIS PERIOD

- 1 During Quarter 1 (April - June 2022), the Trust's verified incidents were **113,091** compared to **121,726** for the same period last year. For the same periods, 111 call volumes were **332,870** and **201,222** respectively.
- 2 From the total of verified incidents above, the following can be extrapolated:
 - (i) Red - **10,952** compared to **9,020**
 - (ii) Amber - **81,503** compared to **86,901**
 - (iii) Green - **20,636** compared to **25,805**
- 3 Overall total verified incident demand saw a **7%** decrease in Quarter 1 compared to the same period the previous year.
- 4 The Trust lost a total of **68,849** hours to notify to handover delays across this quarter, which is a slight decrease when compared to the previous quarter (January - March 2022).
- 5 Red performance remains a challenge and the **65%** target has not been achieved for **23** months. In Quarter 1 the Trust achieved **51.2%** in April, **54.5%** in May and **50.8%** in June, therefore continuing to fall below the **65%** target. This performance percentage was lower than the same periods in 2021, **61.0%**, **60.6%** and **57.8%** respectively.
- 6 During this quarter, the number of patients attended in the Red category was **10,952** compared with **9,020** in 2021. April saw the largest variation with **3,613** Red responses in 2022 compared to **2,658** in 2021, which is an increase of **26%**.
- 7 Amber median performance during Quarter 1 was **1 hour 40 minutes (41 minutes)**, **1 hour 11 minutes (47 minutes)** and **1 hour 30 (1 hour)** respectively. The figures in brackets are for the same period in 2021.

SITUATION

- 8 This Patient Safety Highlight Report covers the period of 1 April - 30 June 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

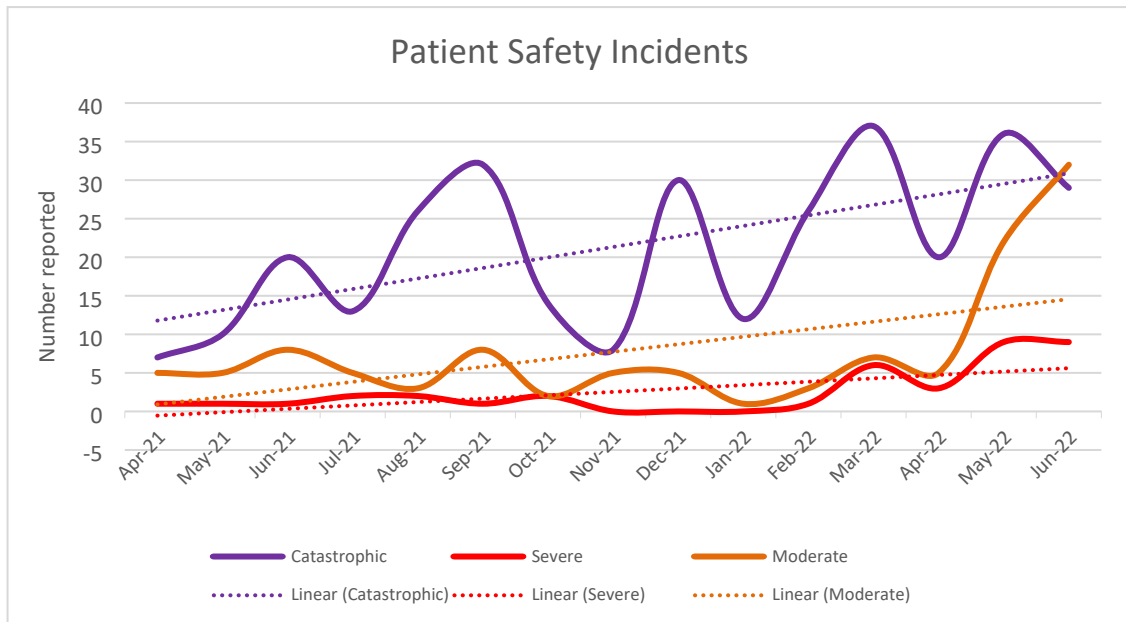
- 11 The purpose of this Patient Safety Highlight Report is to provide an update to Trust Board on the key information in relation to Putting Things Right (PTR) and Patient Safety. This report provides key information on:
 - (i) Patient Safety Incidents and Alerts/Notices
 - (ii) Nationally Reportable 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 The team has successfully recruited 2 new Concerns Administrators to backfill the vacant positions. Due to the increasing workload, we are currently recruiting for a further Concerns Administrator on a 6-month fixed term/secondment basis.
- 15 The benefit of having filled these vacant positions is already being witnessed with the number of complaints awaiting registration in the PTR inbox decreasing. This in turn will allow our 2-day acknowledgement Key Performance Indicator (KPI) to strengthen over the next quarter.
- 16 Our 30-day compliance average for this quarter was below what is expected, sitting at 36%. This is due to multiple factors, including:
 - (i) The overall increase of complaints being received
 - (ii) Impacts of vacant posts
 - (iii) Impact on pressures within the Emergency Operations Centre (EOC)
 - (iv) Delay in audits (Medical Priority Dispatch System - MPDS, Clinical Support Desk - CSD) due to competing pressures
- 17 The Legal Services Team is currently re-advertising the Claims Investigation Officer position. The previous successful applicant withdrew due to salary issues with NHS Agenda for Change.
- 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. This will be reported from Quarter 2 with a more accurate position being reported in Quarter 3 when the Datix Web system will no longer be in use.

- 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, the anonymised reports are now also sent to Health Care Inspectorate Wales (HIW) at the request of our HIW Relationship Manager. These reports will subsequently be discussed at the HIW and Health Board Quality Meetings.
- 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.
- 22 The Trust also had an opportunity to provide evidence to the Health and Social Care Committee: Hospital discharge and its impact on patient flow through hospitals and how this is of critical importance on handover delays and the impact of patients waiting for an emergency response in the community (**Appendix 1**).

ASSESSMENT

Patient Safety Incidents

- 23 **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.**
- 24 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.
- 25 During this period a total of **1,379** patient safety incidents were reported, **546** in April, **396** in May and **437** in June. This is a significant increase in comparison to the same period last year where there were **780** 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.**
- 26 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.
- 27 Future reports using RL Datix (Datix Cymru) will allow reporting of both initial and final grading of the incidents.



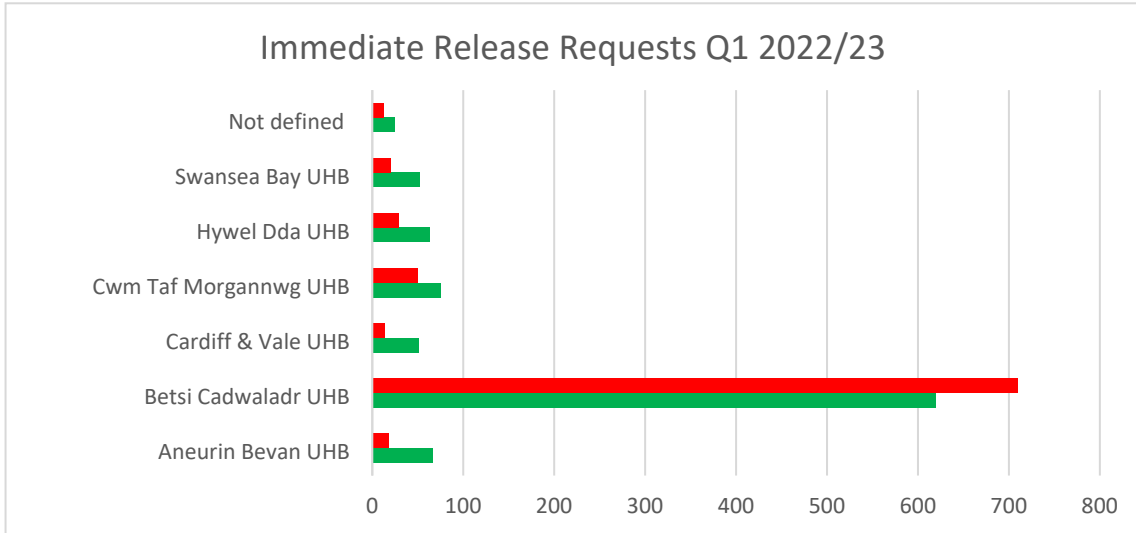
NHS Wales Patient Safety Alerts/Notices

- 28 One alert is currently open - *013 Ligature and ligature point risk assessment tools and policies*. Oversight of this alert is via the Clinical & Quality Governance Group which has requested the Vehicle Group to review and report back any actions at the end of July 2022. The Association of Ambulance Chief Executives (AACE) are also reviewing the alert to form a view on actions to be taken.

NHS Wales Immediate Release Requests

- 29 During the quarter there were a total of **1,807** 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 threatening or serious condition. The Trust continues to work with Health Boards, Welsh Government and Commissioners to influence immediate release requests.
- 30 Of these, **953** were accepted (52.7%) and **854** were declined (47.3%). This is illustrated in the chart below:

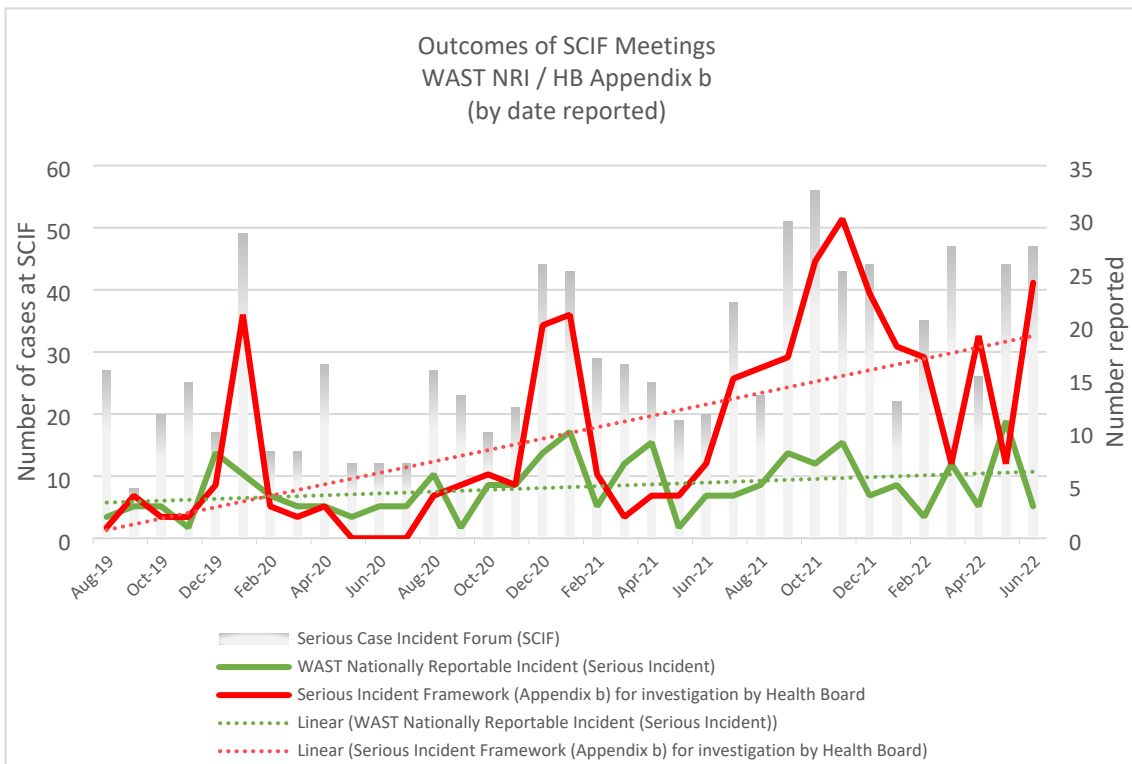
Health Board Quarter 1 2022/23	Number accepted	Number declined	% Declined
Aneurin Bevan University Health Board	67	18	21.2%
Betsi Cadwaladr University Health Board	620	710	53.4%
Cardiff & Vale University Health Board	51	14	21.5%
Cwm Taf Morgannwg University Health Board	75	50	40%
Hywel Dda University Health Board	63	29	31.5%
Swansea Bay University Health Board	52	20	27.8%
Not defined	25	13	34.2%
Total (n)	953	854	47.3%
Overall Total (n)	1,807		
Total (%)	52.7%	47.3%	



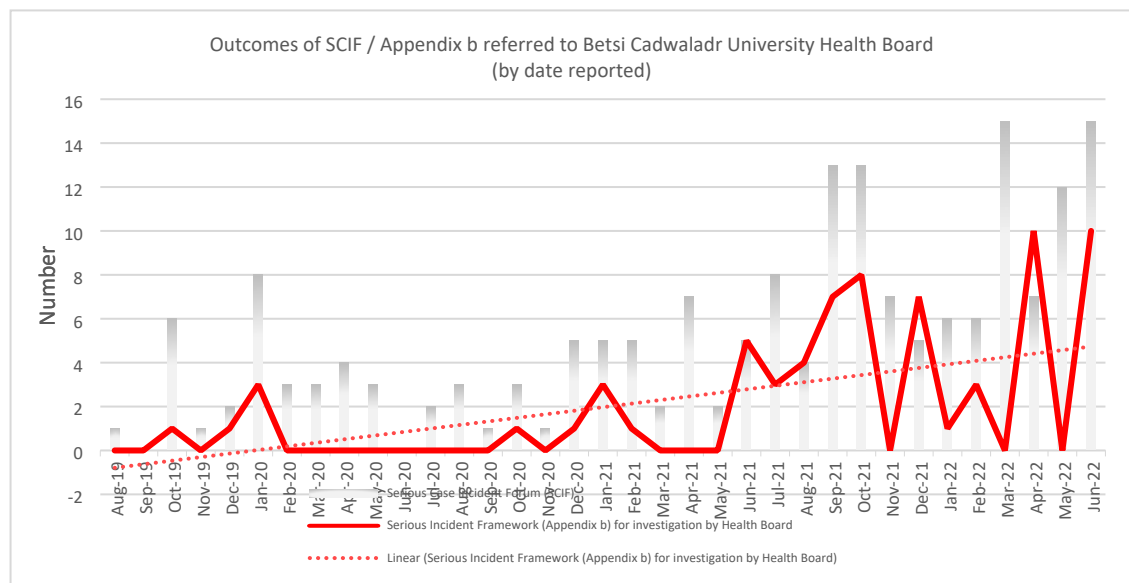
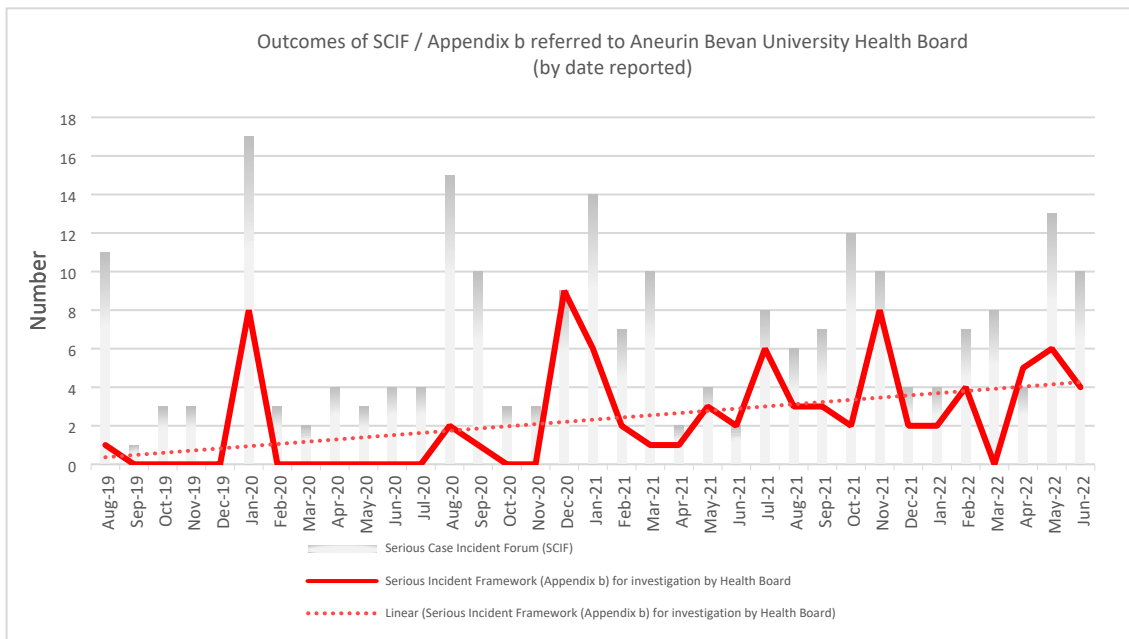
Key: Red - declined, Green - accepted.

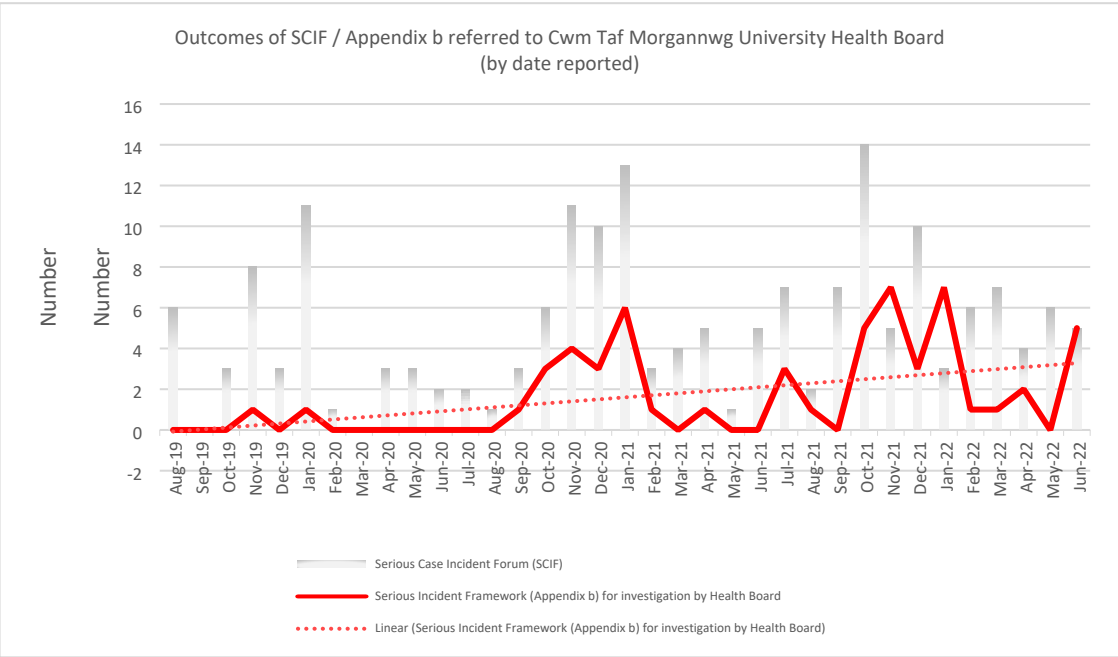
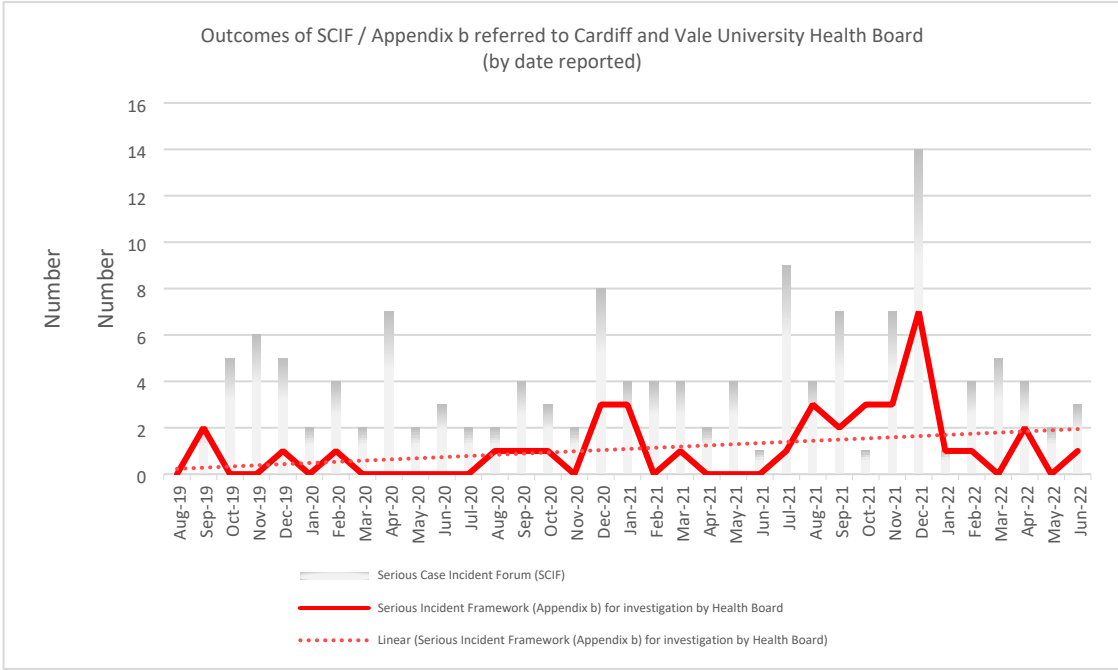
Serious Case Incident Forum (SCIF) and Nationally Reportable Incidents (NRIs)

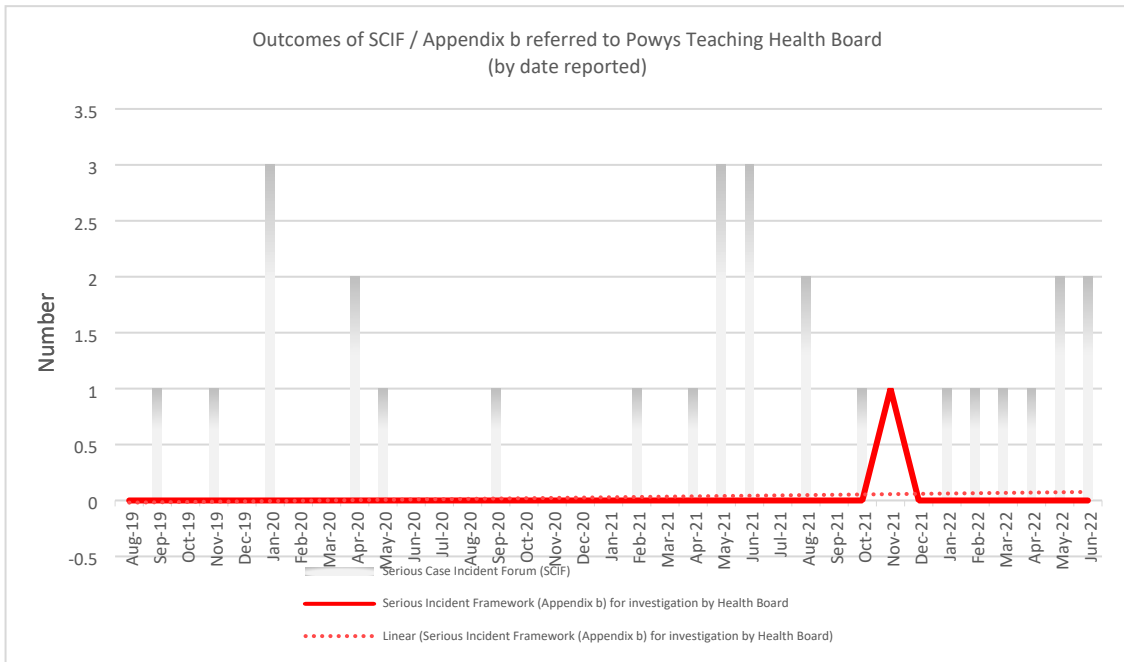
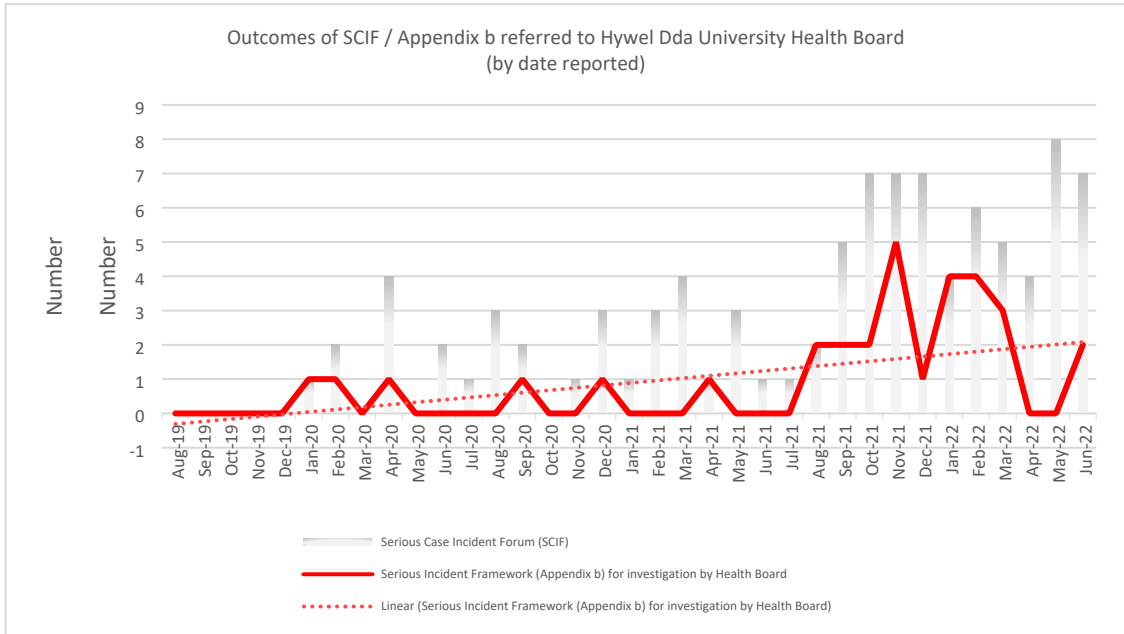
- 31 The chart below details the number of cases discussed at the SCIF and those reported either to the Health Boards for further investigation (Appendix B) and those reported and investigated internally. Incidents not reaching the threshold are managed as lower graded patient safety incidents (low or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

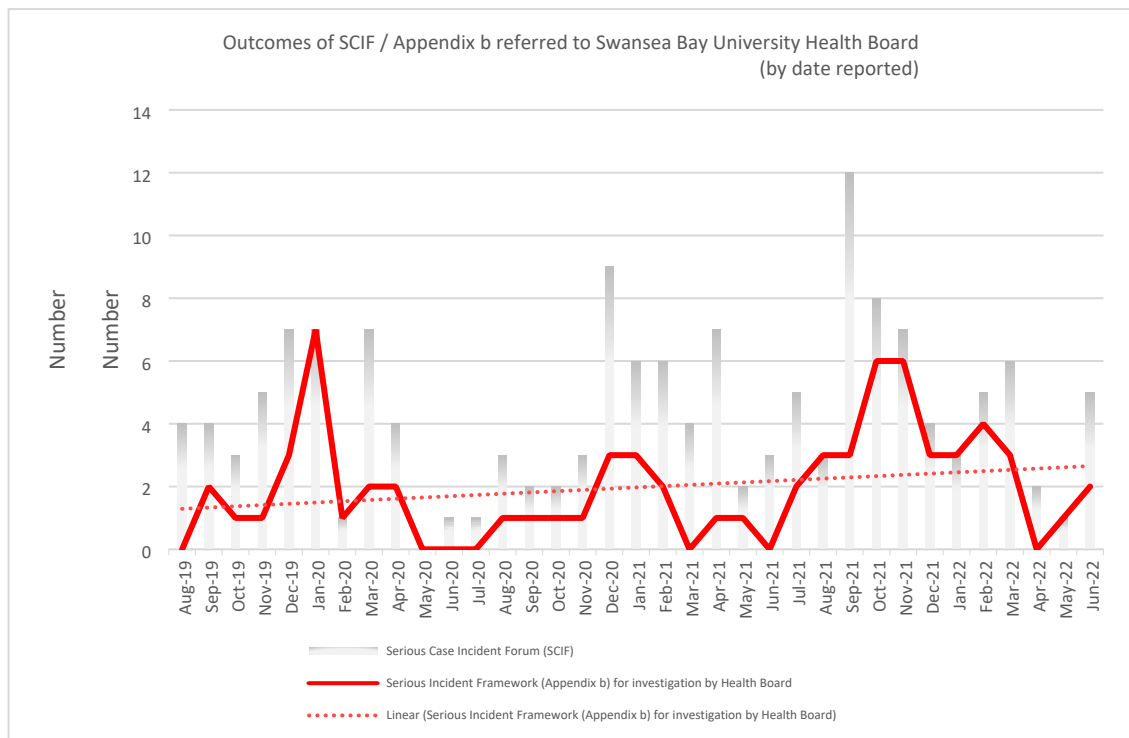


32 The following charts detail individually by Health Board, the number of cases discussed at the SCIF and passed to the Health Boards for further investigation (Appendix B):









- 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 further meeting is planned in July between the NHS Wales Delivery Unit and the Emergency Ambulance Services Committee (EASC) to progress arrangements for the T&F Group.
- 37 During this reporting period there were **23** SCIF meetings held, with **117** incidents discussed.
- 38 During the reporting period **17** incidents have been reported as NRIs to the Delivery Unit and **50** incidents were referred under the Joint Incident Framework (Appendix B) to the respective Health Board.

39 Following review of the **17** Incidents reported as NRIs to the Delivery Unit (DU) the overarching high-level themes and trends were identified:

- (i) Call categorisation (**8**), (**5** of which were missed ineffective breathing)
- (ii) Missed Allocation Opportunity (**4**)
- (iii) Clinical assessment and/or treatment (**3**)
- (iv) Resource/Operational Shortfall (**2**)

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 (**278**). This is an increase in comparison to the same reporting period last year where **234** concerns were received.

42 As of 12 July 2022, there were **215** open concerns with **85** in backlog, which is an increase on the number of open concerns and an increase in the number in backlog.

43 As of the end of June 2022, there were **38** open Redress cases.

44 During this reporting period the 2-day acknowledgement performance was **31%**, **12%** and **26%** (**49%**, **40%** and **27%**) with the 30-day target achieving **53%**, **41%** and **13%** (**68%**, **62%** and **63%**) respectively.

45 The average across this period is therefore **23%** for 2-day acknowledgement and **36%** for 30-day target. The figures in brackets are for the same reporting period in 2020/21.

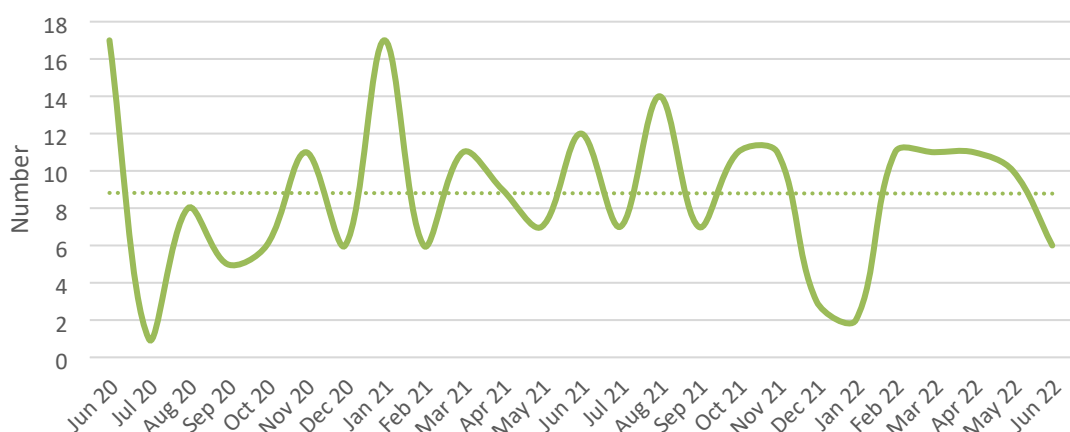
46 Following on from the unprecedented pressures of the last quarter, this reporting period has remained busy with the volume of concerns increasing.

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

Clinical Contact Centre (CCC) Concerns Breakdown

48 The CCC Concerns Team has continued to see an increase in their workload with open investigations starting to increase in most areas. The number of outstanding concerns investigations is now higher than it was at any point last winter. Unlike previous years we have not seen the numbers coming in decrease during the spring, early summer months, and this is a concern going into next winter.

CCC Coroner's Requests for Statements Received



Ombudsman and Political Investigations

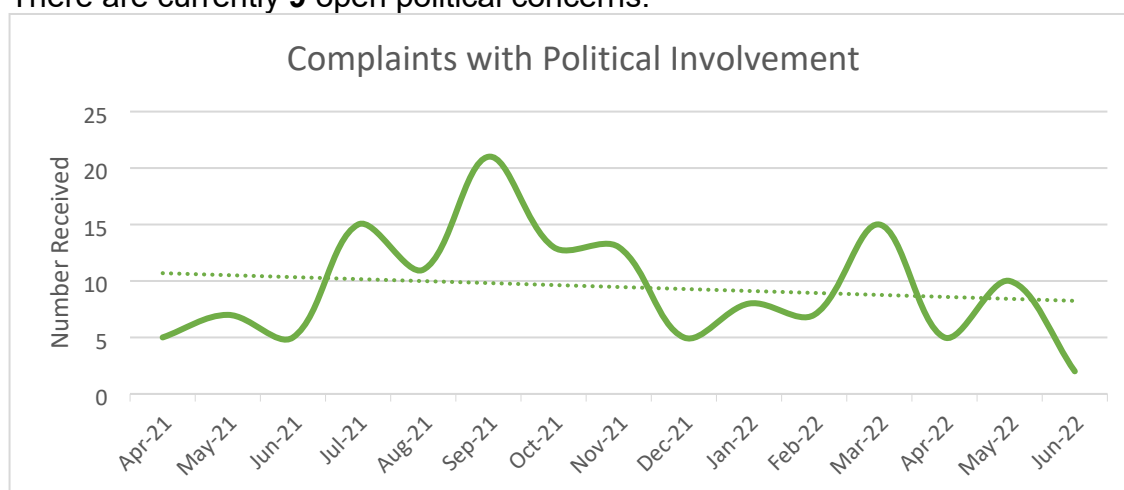
49 There are currently **16** open Ombudsman cases. The Trust has submitted all documentation to the Public Service Ombudsman for Wales (PSOW) and is awaiting conclusion of the investigation.

50 During the reporting period there have been no final reports received. Two draft reports have been received and the content accepted by the Trust. This included returning 1 case to the Redress process.

51 This quarter has seen a decrease in the number of political concerns being received. Of the **14** new concerns, **4** relate to an issue other than the timeliness of the Emergency Medical Service (EMS) responses. This reflects that, whilst the majority of political concerns still relate to timeliness of EMS responses, a larger percentage of the overall number of political concerns now relate to issues other than timeliness. This includes such matters as:

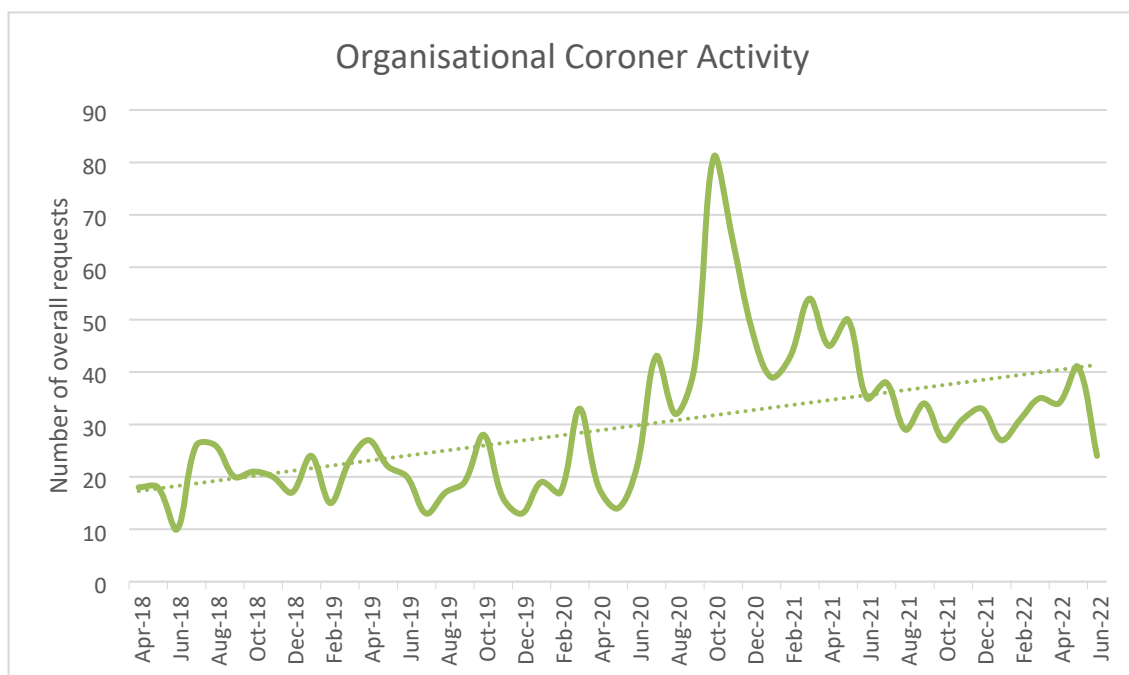
- (i) Advice given by Call Handlers
- (ii) Non-Emergency Patient Transport Services (NEPTS) eligibility
- (iii) Treatment provided by EMS

52 There are currently **9** open political concerns.



Organisational Coroner's Activity

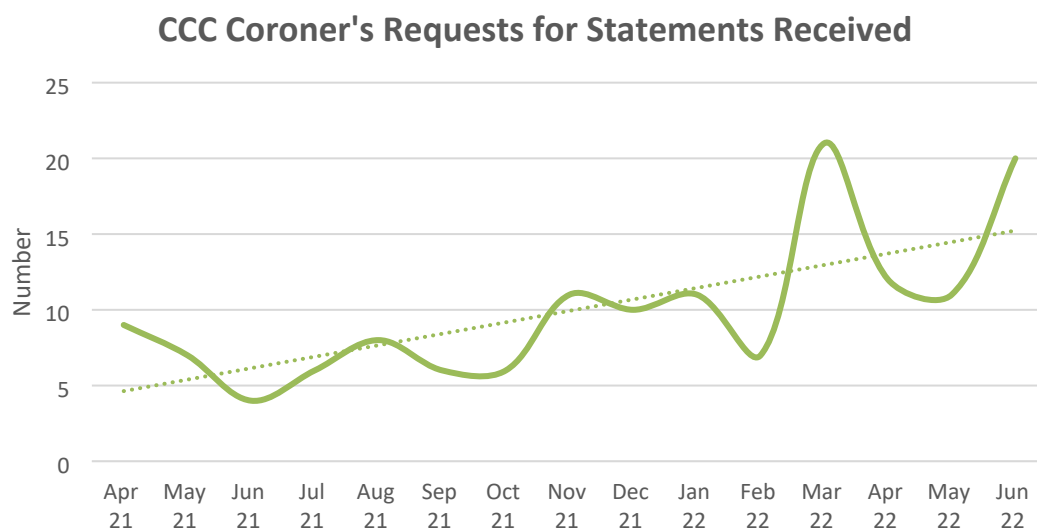
- 53 The number of approaches received from Coroners has decreased during the reporting period, especially when compared to the same period last year. Although there has been a decrease in the number of approaches, these have still not returned to a pre-COVID level.
- 54 The complexity of the requests 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, with increased numbers of inquests being RAG rated 'red'. Please refer to the chart below which illustrates the continuing pattern:



Clinical Contact Centre Coroner's Activity Breakdown

- 55 There are concerns regarding the number of Coroner's statements and attendances that are falling to the CCC Concerns Team and Managers. In previous months there were less than 10 statements a month for this small group of staff to complete, this is still more than most Management Teams have to complete. In May 2018 statements were completed and in June 2014 statements were completed. The only theme being identified through these statements are the delays in getting a response. Whilst it is recognised this is a huge concern for the public and Coroners, unfortunately this is not something the CCC has much control over. This also impacts on the operational running of the CCCs with Managers spending more time writing statements and attending Coroner's Courts.

56 The graph below shows the trends from last year to this year:



Prevention of Future Death Reports (Regulation 28)

57 During the reporting period the Trust received 2 Regulation 28 (Prevention of Future Deaths) Reports:

(i) RG - The Trust was an interested party to the Inquest. The incident occurred in October 2021. There was a response time of **14** hours and **58** minutes to an elderly male patient, who had suffered an unwitnessed fall at a Nursing Home. The Coroner asked the Trust to consider and address **4** issues:

- The first cause of the delay given was that all available resources were managing incidents of a higher acuity or same category but registered prior to this call.
- The second cause of the delay was a handover delay across all Betsi Cadwaladr University Health Board (BCUHB) sites. A total of **131.1** hours were lost in delay of handovers on 9 October 2021.
- Whilst on the evidence it was not found that the delay contributed to Mr G's death, there remains a significant risk that deaths will continue to occur or that future deaths will occur either with patients waiting to be transferred into hospital from the ambulance or by ambulances not being available to those in the community requiring Paramedic assistance and transfer to hospital.
- The matters of concern herein are longstanding and despite proposed future action the concerns remain.

(ii) SG - The Trust was not an interested party to the Inquest. The incident occurred in May 2021. There was a response time of **12** hours and **45** minutes to an elderly male patient, unwitnessed fall at home. On arrival at hospital the patient was delayed for **3** hours and **28** minutes outside of hospital. The Coroner asked the Trust to consider and address 2 issues:

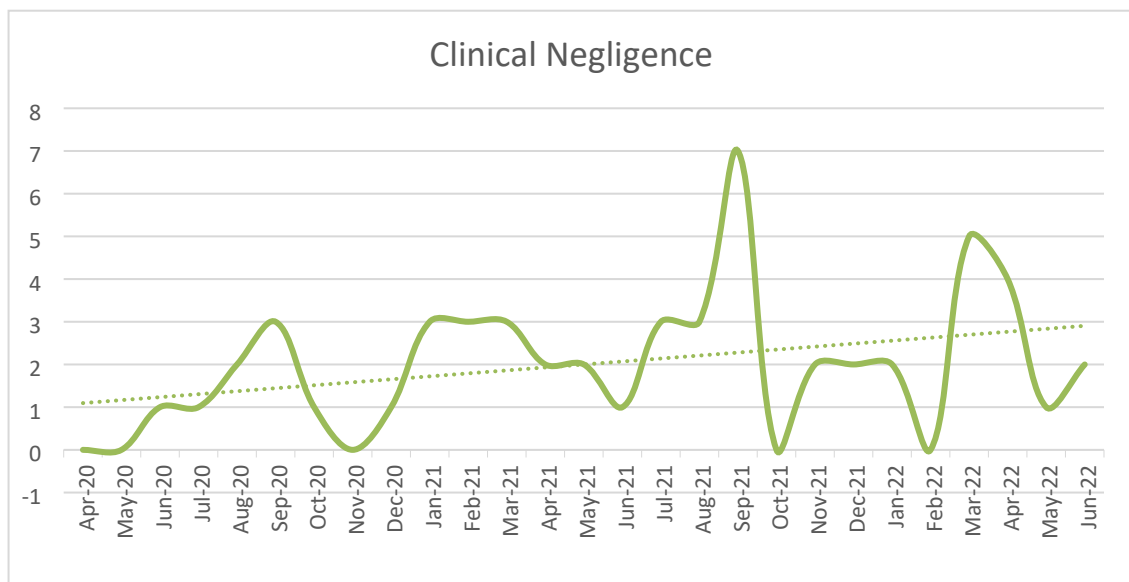
- Confirmation whether the effect of long lies in elderly patients is understood and taken into account during the categorisation process.
- Confirmation of the current average waiting times for Amber 1 and Amber 2 responses and any plans in place to improve responsiveness.

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. The Plan will be scrutinised at the ADLT Meeting on 8 August 2022.

Legal Claims

- 60 The receipt of clinical negligence claims in this reporting period has seen a decrease from the previous quarter, with **7** 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.

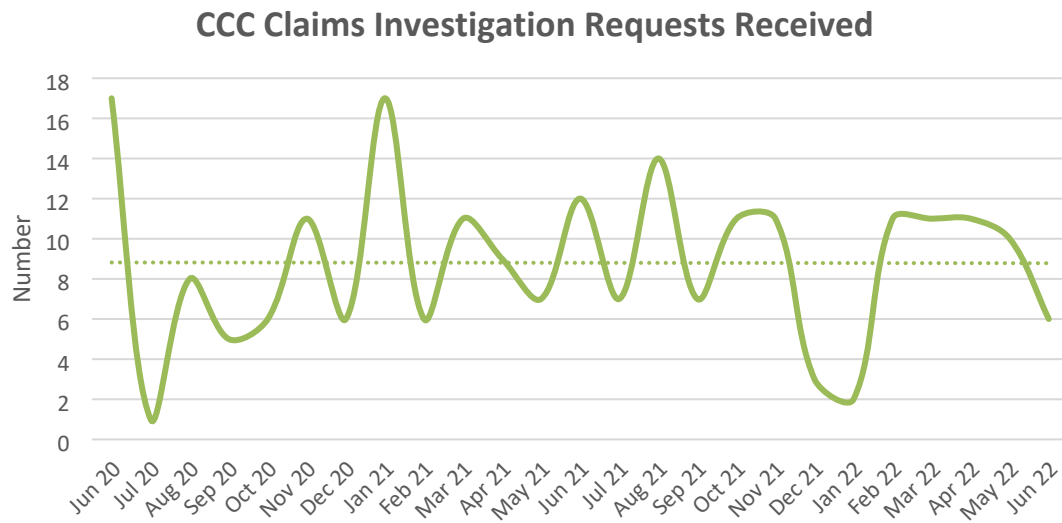


- 61 The number of open clinical claims being investigated and litigated is now standing at an unprecedented level in the Trust's history.
- 62 Whilst personal injury claims received have decreased from **9** to **6** during this quarter, this is reflective of normal seasonal intake. However, what is not reflective in the raw data is 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 claimed. The staff claims relate primarily to issues with equipment. In addition, the Trust has received claims in relation to General Data Protection Regulation (GDPR) breaches. There is no discernible trend with these new claims.
- 64 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, 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.

CCC Claims Investigation Requests

65 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

66 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 April:

- (i) 08/22 National Chronic Obstructive Pulmonary Disease (COPD) Referral Pathway - Access Change in Aneurin Bevan University Health Board
- (ii) 09/22 Urgent Primary Care Centre (UPCC) Referral Pathway available in Swansea Bay University Health Board
- (iii) 10/22 Repose Mattress

Clinical Notices issued May:

- (i) 11/22 Same Day Emergency Care Services Available in Withybush Hospital
- (ii) 12/22 Utilising Feature within TerraPACE Application
- (iii) 13/22 Clinical Equipment Updates
- (iv) 14/22 Standard Operating Procedure Non-Conveyance & Recognition of Life Extinct (ROLE) for ePCR users

- (v) 15/22 Standard Operating Procedure Conveyance to non ePCR enabled sites
- (vi) 16/22 Paediatric Observation Priority Score (POPS) Clinical Audit (Swansea Bay University Health Board - SBUHB)
- (vii) 17/22 Ambulance Service Indicators reported from WAST ePCR data (April)

Clinical Notices issued June:

- (i) 18/22 Withdrawal of Paramedic Pathfinder

Learning from Clinical Reviews by Health Board Area:

Clinical Reviews by Health Board April to June 2022	No	Themes	Learning Opportunities & Improvements
Aneurin Bevan	3	<ul style="list-style-type: none"> • Failure to examine injured patient adequately • Poor clinical practice and documentation • Pathway not followed 	<ul style="list-style-type: none"> • Improved clinical practice • Improved PCR compliance • Clinical findings • Improved decision making • Correct use of pathway
Betsi Cadwaladr	16	<ul style="list-style-type: none"> • Obstetric Emergency • NQP Scope of Practice • Inappropriate discharge of patient • Delayed response • PCR Completion • ePCR process • Delayed response • Assessment • Communication • Inappropriate discharge of care • Patient conveyance • Lack of BCUHB Intra hospital transfers provision • Handover delays • Poor ePCR completion 	<ul style="list-style-type: none"> • Improved identification of a patient's condition. • Management of patients outside ED. • Improved ePCR completion. • Capacity • Wider communication amongst agencies • Appropriateness of assessment • Appropriateness of discharge • Safety-netting • Service design for Intra hospital transfers
Cardiff and Vale	7	<ul style="list-style-type: none"> • Sub-optimal management of an unconscious patient • Long term management of a patient on vehicle • Sub-optimal patient management • Drug administration error x2 • EMT acting outside scope of practice • Patient ROLE outside of JRCALC 	<ul style="list-style-type: none"> • Referral to airway management procedures • Failure to notice a deteriorating patient • Incorrect medication administration • Improved communication x 2 • Clinical boundaries associated with clinician's scope of practice x 2
Cwm Taf	1	<ul style="list-style-type: none"> • Assessment and treatment of patient with dementia 	<ul style="list-style-type: none"> • Improved PCR documentation
Hywel Dda	1	<ul style="list-style-type: none"> • Suboptimal assessment of a trauma patient 	<ul style="list-style-type: none"> • Improved assessment and management of spinal trauma
Powys	1	<ul style="list-style-type: none"> • Failure to immobilise 	<ul style="list-style-type: none"> • Referral to spinal

		patient	immobilisation guidance
Swansea Bay	4	<ul style="list-style-type: none"> • Unrecorded observations during handover delay • Administration of drug to incorrect patient • Administration of incorrect drug dose to patient – EMT administered • Drug administration error 	<ul style="list-style-type: none"> • Frequency of observations • Improved understanding of Medicines Management • Poor attention to pre-arrival MDT information • Clinical boundaries associated with clinician's scope of practice • Improved communication

Welsh Risk Pool Learning from Events Reports

Case 4602 - January 2016

- 67 A decision was made not to transfer a patient to hospital on 24 January 2016. Medserve Project was a Welsh Government backed initiative designed to determine whether patients could be assessed and, if necessary, treated in the community in an attempt to avoid unnecessary admissions to hospital. The following day a further ambulance attended whereupon the patient was assessed and transferred to University Hospital of Wales (UHW), where a CT scan revealed a large haematoma left frontal extradural haematoma.
- 68 Expert independent opinion was supportive of the care provided. Counsel's advice was to make an offer to settle the claim on a risk basis.
- 69 Supporting evidence included current developments expansion of Advanced Paramedic Practitioners (APPs), Clinical Service Desk and Cymru High Acuity Response Unit (CHARU), updated guidance via Clinical Notices and learning through SCIF.
- 70 The following coaching bulletins have been issued for Call Handlers and Dispatchers:

Call Handlers	Dispatchers
Multi-vehicle response	Tourniquet safety netting
End of Protocol 36 reintroduction of Emergent Infectious Disease Symptoms	Passing update to police particularly around violent patients
Providing Estimated Time of Arrivals	Falls responders
Up grading hip pelvic upper leg injuries	Allocating to P2 back ups
New Clinical Support Desk Codes	
Protocol 26 - sick person	
Demographics	
Higher MPDS response in lower determinant levels	

Call Handlers	Dispatchers
Dispatch Life Support advice in 3 rd party calls	
Address searching	
Exposure to the elements	

71 A weekly question and answer inbox is set up for staff to question the MPDS Team about the correct approach for various situations including amongst others:

- (i) Time frame for severe pain
- (ii) Generalised fit
- (iii) Aspirin advice
- (iv) Assault with a corrosive substance which protocol
- (v) Unconscious overdose
- (vi) Motorbike versus motor
- (vii) Diving accidents
- (viii) Black stools and iron tablets
- (ix) Labour and Expected Time of Arrival (ETAs)

72 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.

73 The CCC has reintroduced the compliance recognition badges following the pandemic. This month (June 2022) **16** EMDs have received their bronze badges.

74 This means that they have met the criteria of **total compliance** for a random sample of call audits, with a minimum of **10** calls audited. This is a tremendous achievement and worthy of recognition.

Next steps

75 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)
- Modelling of patient harm data (handover of care impacts)

Health and Social Care Committee: Hospital discharge and its impact on patient flow through hospitals

Evidence from the Welsh Ambulance Services NHS Trust

1. The Welsh Ambulance Services NHS Trust welcomes the opportunity to provide evidence to the Health and Social Care Committee in its inquiry into hospital discharge and its impact on patient flow.
2. As an ambulance service, the issue of patient flow is one of critical importance given its impact on the front door of emergency units and, by extension, delays in handing over the care of patients from ambulance to hospital staff and thus the availability of ambulances to respond to emergencies in the community.
3. As a service, we recognise that the issues inherent in the flow of patients through hospitals are complex. The current pandemic has amplified and exacerbated the structural weaknesses already apparent in the health and care system prior to March 2020, which meant extended delays outside hospitals for ambulances were already a feature of the healthcare system, although not to the extent that they are currently.
4. These delays have an inevitable impact on the availability of ambulances in the community. During the first wave of the pandemic, there was considerable drop-off in what might be deemed “routine activity” which meant that ambulance availability was improved, as delays were far less prevalent.
5. As we have moved through the pandemic, and with the onset of elevated, rather than routine, levels of demand, the situation has deteriorated significantly across the health and care sector.
6. At the time of writing, the Omicron wave is moving towards its peak. The advent of Omicron has resulted in excessive strain placed upon the entire sector, with high levels of staff absences across the Welsh Ambulance Service, local health boards and in social care.
7. Couple this with high levels of demand and limited flow through hospitals, and this has seen ambulance performance levels continue to decay throughout the final weeks of 2021 and into 2022, resulting in extended waits for ambulances in the community, including for higher priority amber one calls, as well as, unfortunately, for life-threatening red calls, where performance continues to fall short of the 65% pan-Wales target.
8. The graphs in the data pack annexed to this document give an indication of the hours lost in recent months to handover delay. The stories data do not always tell are the incredibly poor experiences of patients waiting for hospital care and the frustration and moral injury to crews, many of whom regularly spend entire shifts caring for one patient outside hospitals, in the full knowledge that there are very many patients waiting in the community for whom no care is available and where risk is at its highest.

9. Similarly, the impact on performance and the concomitant impact on staff and patient experience is apparent.
10. Notwithstanding the emergence of the Omicron variant and its enhanced transmissibility, like the rest of the NHS in Wales, the Welsh Ambulance Service has extensive winter plans in place, as well as a long term plan for growth and the redefinition of the service, continuing its journey towards a service fundamentally rooted in clinical practice, rather than one providing a conveyance service.
11. The balance between managing the immediacy of the situation and planning for recovery and growth is a fine one, and one of which the Welsh Ambulance Service Board is acutely aware.
12. However, the current situation means that the WAST leadership team has expedited some longer term plans while exploring all possible means of support for the service now, including the third request for Military Aid to the Civilian Authorities (MACA), which will now run with increased number (251 frontline operatives) until the end of March 2022.
13. Much of this longer term investment and development is focused on treating as many patients at scene as possible, reducing unnecessary conveyance to hospital and thus reducing pressure on the wider health and care system through avoidable admission.
14. While there is a role for optimising advanced practice and more innovative ways of utilising clinical staff in achieving this, it is also fair to say that the success of this approach longer term will ultimately hinge on health boards, primary care and the social care sector working differently with the ambulance service, as one integrated system, to deliver care collaboratively for patients.
15. This means opening up existing or developing new pathways of care which are open to referral by ambulance service clinicians, as well as utilising clinical and social care staff differently and more appropriately to manage patients, as far and as safely as possible, in the community.
16. While acknowledging such changes often take time to effect, conversations are currently underway with a number of local authority partners to understand better how partnerships can be forged between WAST and social care to maintain more people at home.
17. Understanding the social care services that will add the most value to local people and working together, either to enable referral rights to them for ambulance staff, or developing them in partnership, possibly on a regional partnership board basis, is at the heart of these discussions.
18. Similarly, the options of digital and remote triage of calls will need to be developed much more extensively over the coming months and years to again reduce the need for the deployment of an ambulance, with the potential to refer patients to other elements of the health or social care system.

19. While work continues to properly articulate the steps and means by which this longer term ambition can be achieved, the Welsh Ambulance Service has been fortunate in receiving support from its commissioners, both to deal with the immediate pressures and to invest in the staff and models which will deliver that longer term ambition.
20. In real terms, this has included in recent months:
- (i) Employing a further 36 clinicians to work on our Clinical Support Desk, managing demand through clinical triage of lower acuity patients who can be provided with advice and guidance to avoid the deployment of an ambulance. CSD clinicians also provide support to crews on scenes with additional clinical opinion and advice, with a view to avoiding conveyance where clinically safe to do so.
 - (ii) Recruitment of an additional 32 FTE emergency medical dispatchers to help answer 999 calls
 - (iii) Establishing our “Winter Cell” to support coordination across the system during the season
 - (iv) Implementing our “Clinical Safety Plan” which allows us to target our resources in line with demand to safeguard the most clinically vulnerable
 - (v) Recruitment of additional 111 call handlers to manage elevated call volumes
 - (vi) Deployment of new menu options across 111 to flow callers more appropriately
 - (i) Working closely with health board partners to implement online physician triage and streaming
 - (ii) Recruitment of mental health clinicians to support our clinical support desk – deployment expected early in 2022
 - (iii) Corporate staff providing additional support to frontline colleagues
 - (iv) Additional capacity at Morriston and the Grange University Hospital to assist with handover
 - (v) St John Ambulance Cymru providing additional support
 - (vi) Additional NEPTS provision to increase capacity
 - (vii) Reinstating and re-profiling support from Mid and West Wales Fire and Rescue Service to include provision of a level one falls service. Training is underway and the service is expected to roll out from January
 - (viii) Enhancing a range of staff wellbeing initiatives, including hospital concessions, British Red Cross staff support, pool cars for end of shift, pet therapy etc.
21. In respect of discharge, the contribution of the ambulance service’s non-emergency patient transport service (NEPTS) should not be underestimated in facilitating the discharge of patients, either to their own place of residence or to “step-down” care facilities.
22. Earlier in 2021, NEPTS worked on modelling likely future demand for its discharge and transfer service over the winter months. That modelling was used to work with health boards and commissioners to identify additional funding for extra discharge and transfer resources to support additional flow in a timely manner. This capacity has been well used in recent months.

23. Whilst acknowledging the extensive work that is underway across the system, it is important that the many structural weaknesses across health and care services are addressed, rather than relying on reactive, short-term fixes to alleviate the pressures and improve the experience of patients, citizens and staff.
24. This must include creating an employment environment where there is parity of esteem and reward for social and healthcare staff, to facilitate improved recruitment to social care roles.
25. Similarly, while good work is underway across Regional Partnership Boards to consolidate and enhance relationships and services across the health and social care interface, there remains much to do in terms of overcoming professional and clinical barriers to provide meaningful services that genuinely address the needs of people in need.
26. None of these ambitions is simple to achieve. That said, our collective experiences of the pandemic hitherto suggests that we have the platform, the collective will and the ideas to move this agenda forward at pace, with the right level of support and focus, recognising the distraction which the latest Omicron phase of the pandemic has presented.

Ends/EVH/Jan22



AGENDA ITEM No	11
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	2

CORONERS REGULATION 28 REPORTS RECEIVED

MEETING	Quality, Patient Experience & Safety Committee
DATE	11 August 2022
EXECUTIVE	Executive Director Quality & Nursing
AUTHOR	Investigation Manager
CONTACT	Catharyne Punyer 07880 477388 Catharyne.Punyer@wales.nhs.uk

EXECUTIVE SUMMARY

This Report is to bring to the attention of the Quality, Patient Experience & Safety Committee, that the Trust has received a Regulation 28 (Prevention of Future Death) Report.

The Trust has until 9 August 2022 to supply a response to the Coroner.

The specific issues to be addressed have been shared with the appropriate Managers, with a timescale incorporated, to ensure that the Trust responds in a timely manner.

The Regulation 28 and the Trust's responses will be made public (although redacted).

RECOMMENDED: That the Committee notes this Report.

KEY ISSUES/IMPLICATIONS

- (i) The Trust has now received 4 Prevention of Future Death (PFD) Reports this year.
- (ii) Full and timely responses must be achieved.
- (iii) The cases have been allocated to the relevant personnel and response deadlines have been provided to ensure that the responses can be drafted and agreed by the Quality, Patient Experience & Safety Committee prior to submitting to the Coroners.
- (iv) Any actions agreed and shared with the Coroner will be approved via this group.
- (v) There are further cases, with similar circumstances, that are due to be considered by the same Coroners.
- (vi) Failure to demonstrate improvements following PFD Reports could result in corporate manslaughter and neglect prosecutions/findings.

REPORT APPROVAL ROUTE

Executive Management Team	20 July 2022
Quality, Patient Experience & Safety Committee	11 August 2022

REPORT APPENDICES

Annex 1 - SBAR providing background information.

Appendix 1 - Coroners Regulation 28 (GS)

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

SITUATION

- 1 This overview document provides details of the Regulation 28 (Prevention of Future Death) Report that was jointly issued to the Trust (**Appendix 1**).

BACKGROUND

- 2 PFD: SG

Dated: 17 June 2022
Coroner: Caroline Saunders
Response due: 9 August 2022

Summary

- 3 There was a response time of 12 hours and 45 minutes to an elderly male patient, who had suffered an unwitnessed fall at his home.
- 4 The Trust received a total of 5 emergency 999 calls and 2 welfare calls were made.
- 5 When the ambulance arrived at hospital, the patient was held outside of hospital for 3 hours and 28 minutes.
- 6 The Trust had reviewed the calls received and our response had been in line with the Clinical Response Model. There was no avoidable delay:

Medical cause of death:

- 1a) Chest infection
- 1b) Hip fracture (operated) and long lie
- 2 Chronic kidney disease, Frailty of old age, Ischaemic heart disease

PFD issues:

- 7 Confirmation whether the effect of long lies in elderly patients is understood and taken into account during the categorisation process.
- 8 Confirmation of the current average waiting times for Amber 1 and Amber 2 responses and any plans in place to improve responsiveness.

ASSESSMENT

- 9 There are several further Inquests that relate to delays in ambulances responding to patients. These Inquests are pan-Wales, however, there are further Inquests (with the same Coroner) relating to delays in ambulances arriving with patients, both in the community and inter-hospital transfers.

RECOMMENDED: That the Committee notes this Report.

29 JUN 2022

Caroline A. Saunders
Senior Coroner
For Gwent



Gwent Coroner Service
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Godfrey Road
Newport
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NP20 4UR

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Chief Executive
Welsh Ambulance Services NHS Trust Headquarters
Ty Elwy Unit 7
Richard Davies Road
St Asaph Business Park
St Asaph
Denbighshire
LL17 0LJ

17 June 2022

Dear Sir/Madam

Re: Gwynne Samuel
DOB: 19 January 1926
DOD: 20.May 2021

Following the Inquest, touching upon the death of Mr Gwynne Samuel.

Please find enclosed a Regulation 28 report, for your attention.

Yours faithfully

A handwritten signature in black ink, appearing to read 'Caroline Saunders'.

Caroline Saunders
Her Majesty's Senior Coroner for the area of Gwent


Enc

Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <ol style="list-style-type: none">1. The Chief Executive of Wales Ambulance Service NHS Trust
1	<p>CORONER</p> <p>I am Caroline Saunders, Senior Coroner for the Area of Gwent</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>I make this report under Paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013</p>
3	<p>INVESTIGATION AND INQUEST</p> <p>On 3/6/21 an investigation was opened into the death of Gwynne SAMUEL</p> <p>The investigation concluded at the end of the inquest on: 16/6/22</p> <p><u>The conclusion of the inquest was recorded as:</u></p> <p>Death by Accident .</p> <p><u>The medical cause of death was:</u></p> <p>1a) Chest infection 1b) Hip fracture (operated) and long lie 2 Chronic kidney disease , Frailty of old age, Ischaemic Heart Disease</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Gwynne Samuel (GS) was a 95-year-old gentleman who lived alone. On 10/5/2021 he suffered a fall at home. GS was experiencing pain, a swollen neck and was bleeding. His daughter discovered him and called for an ambulance at 19:53 on 10/5/21. An ambulance eventually arrived at 07:36 on 11/5/21.</p> <p>GS was admitted to the Grange University Hospital, Llanfrechfa, where he was diagnosed with a fractured neck of femur. GS was in a poor condition and the evidence heard at the inquest confirmed that he had suffered an acute kidney</p>

	<p>injury caused by rhabdomyolysis. Rhabdomyolysis is directly attributable to the long lie GS had experienced whilst waiting for an emergency ambulance.</p> <p>As a result, the necessary operation on his hip was delayed until 13/5/21, by which time he was developing a chest infection.</p> <p>Post-operatively GS went into a further decline and was overwhelmed by pneumonia. He died on 20/5/21.</p>
5	<p>CORONER'S CONCERNS</p> <p>During the course of the inquest, evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.</p> <p>The MATTERS OF CONCERN are as follows: -</p> <p>GS was an elderly gentleman who had suffered a significant fall. The time it took for an ambulance to arrive and convey him to hospital contributed to his death insofar that the development of an acute kidney injury, which compromised his treatment and general condition, was caused by a long lie.</p> <p>A report obtained from WAST indicated that GS had been categorised as an Amber 2, which I understand is an urgent clinical priority considered serious but not life threatening.</p> <p>Whilst I accept that there was no evidence that GS was in immediate peril, it would appear that the clinical ramifications of an elderly person lying for a long period of time are not taken into account during the categorisation process.</p> <p>Whilst I heard evidence, and understand, the pressures on the ambulance service during the pandemic and the inability to release emergency ambulances due to congestion in hospital emergency departments, the inability to provide an ambulance to a patient determined to be in a serious condition (Amber 2) for 12 hours, puts lives in danger and, as in this case, may contribute to their death.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p> <p><u>I should be grateful if the following information be provided to me:</u></p> <ol style="list-style-type: none"> 1. Confirmation whether the effect of long lies in elderly patients is understood and taken into account during the categorisation process. 2. Confirmation of the current average waiting times for Amber 1 and Amber 2 responses and any plans in place to improve responsiveness.

7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely 09 August 2022, I, the Coroner, may extend this period.</p> <p>Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is necessary</p>
8	<p>COPIES AND PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and the following Interested Person (s)</p> <p style="padding-left: 40px;">The family of Gwynne Samuel Health Inspectorate Wales. Minister of Health for Wales.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>The Chief coroner may publish either or both in a complete or redacted summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the Coroner, at the time of your response, about the release or the publication of your response by the Chief coroner.</p>
9	<p>DATE 17/6/22</p> <p>Signed</p> <p></p> <p>Caroline Saunders Her Majesty's Senior Coroner for the Area of Gwent.</p>



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

PATIENT EXPERIENCE & COMMUNITY INVOLVEMENT HIGHLIGHT REPORT, QUARTER 1 (APRIL - JUNE 2022)

MEETING	Quality, Patient Experience & Safety Committee
DATE	11 August 2022
EXECUTIVE	Executive Director Quality & Nursing
AUTHOR	Patient Experience & Community Involvement Manager
CONTACT	Gareth Thomas 07387 230789 Gareth.w.thomas@wales.nhs.uk

EXECUTIVE SUMMARY

This report presents how and with whom the Trust has been meeting 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 April - June 2022. Throughout this period we have:

- Engaged with people which has enabled us to capture experiences;
- Shared experiences/evidence captured which has led us to being able to share their voices in several forums; and
- Reported back to communities to strengthen confidence that they are being listened too and the Trust is acting.

Through our Continuous Engagement Model, we are improving peoples' knowledge and understanding of the Trust; providing them with information on how to access general health information and the skills necessary in responding to an emergency.

RECOMMENDED: That the Committee

- (1) approve the Highlight Report for release to the NHS Wales Patient Experience Network; Welsh Ambulance Services NHS Trust People & Community Network and external stakeholders; and**
- (2) 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.

Our continued engagement with the public is important to ensure ongoing conversations on what the Trust is doing and why, especially during this continued period of time when the Trust is experiencing increased demand and is at high levels of escalation.

With coronavirus restrictions now mostly lifted in the community, we have been able to resume a full programme of face-to-face engagement in the community. However, we continue to monitor and be aware of rising coronavirus levels and are continuing to apply a cautious approach to public engagement. We have quickly received many invitations to attend community events with people keen to engage with the Welsh Ambulance Service. Attending these events allows us to:

- Be visible in communities and build community trust.
- Support people to make informed decisions on access to health care services.
- Inform people about what we are doing to ensure they receive good/safe services.
- Gather feedback and experiences to influence service plans.

We now also have available a complete set of online Patient Experience Surveys, encompassing all services delivered by the Welsh Ambulance Service; adding an additional mechanism to our portfolio of options to capture patient experience.

REPORT APPROVAL ROUTE

Executive Management Team	20 July 2022
Quality, Patient Experience & Safety Committee	11 August 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
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GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Gwasanaethau Ambiwllans Cymru
Welsh Ambulance Services
NHS Trust

Patient Experience & Community Involvement Highlight Report

April – June 2022



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.

Contents	Page
Overview	3
Positive Experiences	4
#ThankYouThursday	5
Patient Story	6
Engaging with Communities	7 – 12
People & Community Network	13
Patient Experience Surveys	
• <i>999 Services</i>	14 - 15
• <i>Non-Emergency Patient Transport</i>	16
• <i>NHS 111 Wales</i>	17 - 18
Social media	19
NHS 111 Wales Overview	20
Looking Ahead	21

Overview

Within this reporting period, we have engaged with:

66 Engagement Opportunities Attended

2,472 People Engaged With

This engagement has included:

- [Engagement with minority and ethnically diverse communities, in partnership with colleagues from the Trust's Inclusion Team. Creating stronger links between our Teams, as recommended in a recent Welsh Government Audit of the Trust's strategic equality plan.](#)
- [Relationship building with Community Health Council's across Wales, as we move towards the development of the Citizen Voice Body, which will replace CHCs as set out under plans within the Health & Social Care Quality & Engagement Act.](#)

Outcomes of 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.

What was good?

- ✓ **We have been able to make an active return to engaging with people and communities in person.**
 - *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.*

What could be improved?

- ✗ **Concern about ambulance response times.**
 - *Across all our engagement this quarter we have heard people talking about concerns they have about potential ambulance delays. Sometimes, these concerns relate to an experience, while other people tell us about things they have heard through friends, family or the media. It was clear there was concern for community safety with people wondering 'Will there be an ambulance available for me if I need one?' These concerns are echoed in some of the feedback received through our new 999 Patient Experience Survey. Where these concerns are raised, we are able to explain how 999 calls are categorised, reassure that we are doing all we can to get help to the people who need it the most and provide information about other sources of help that might be more suitable than calling 999.*

Positive Experiences

Compliments

The Trust received **117** compliments between April and June. These can be broken down by function as below. Numbers below may not add up to 117 as some compliments received are about multiple functions, so are recorded twice:

Function	Compliments Received
EMS Ops	84
EMS Ctrl	7
NEPTS Ops	9
NEPTS Ctrl	0
CFRs	2
NHS 111 Wales	23

An amazing thank you to the paramedics involved in my grandmothers care yesterday after she fell in her garden at approximately 1530. After being told we could be waiting over 4hours for an ambulance the paramedics were on the scene incredibly fast within an hour. They were kind and kept my Nan and the rest of the family reassured. They were great and took phone numbers and kept us thoroughly updated whilst she stayed on the ambulance for at least 4hours after her arrival at A&E. Can't thank them enough for their quality care.

Would like to thank the crew from Pontardawe who were called to me on 4th June and transported me to Morriston hospital with chest pains. They were polite, reassuring and funny and made me feel completely at ease as well as being extremely efficient. If you could pass on my thanks that would be great. I was sent home that evening after being given the all clear-it was my lungs 'having a hissy fit' (doctors words not mine) not a cardiac incident. At this time when the service is so maligned and under so much pressure it is reassuring to know that the crews remain cheerful and positive and professional. Once again thank you.

My dad was in a serious road accident on Tuesday 14th June. He was riding a motorbike at the time and had experienced some real trauma due to the crash. His life was saved by members of the paramedic team & I would really like to find these people to thank them & allow them to have an update on how my dad is doing now. The work you are doing is truly remarkable. If you have any idea who these people are, please pass my details on and allow them to contact me.

The 117 compliments received during this quarter represent a 11% decrease on the 131 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

On 12th May, my 7-year-old son had a cardiac arrest at home and my wife called 999.

The person who took the call was absolutely brilliant: he managed to calm my wife, who was naturally in a panic, and gave instructions that allowed her to move a piece of toast from our son's neck, allowing him to breath.

The ambulance, police and air ambulance were called and the response was absolutely fantastic to help save my beloved son's life.



#ThankYouThursday

I had two great journeys with your service today.

Outgoing, I had a phone call to advise of expected pick up time and the journey was comfortable and safe. Your driver kindly escorted me to the location of my appointment in the hospital and her customer service skills were of the very highest standard. My return journey was a little delayed, but again the journey was excellent and throughout I felt safe and both driver and escort showed impressive customer service skills.

When you get it right, you really do get it close to perfect.

I feel privileged to be able to use your service.





The Patient Story

Matthew's Story...

At our Quality, Safety & Patient Experience Committee Meeting in May, we presented [Matthew's story](#). Matthew is a carer for his mum who has a rare neurological condition which significantly affects her mobility.

In his story, Matthew tells us that his mum's lack of mobility can make it difficult for her to transfer between her power wheelchair and bed or another surface. She has experienced many falls in the process. The falls tend not to cause injury; instead, she finds herself stuck on the floor unable to get back up again. Matthew is unable to lift her alone, so they end up calling 999 for ambulance assistance. Matthew tells us that he understands this may not be the best use of an ambulance crew, but he feels stuck and has no other option. When calling for an ambulance to help, Matthew and his mum have experienced long waits for help to arrive.

During one ambulance call out, the ambulance crew used a Manga lifting device to help his mum up from the floor. After this experience, Matthew investigated the commercial availability of these devices and went on to raise money, through crowdfunding, to buy a Manga device of his own. Since having the device he has used it several times to lift his Mum following a fall – each time avoiding what would have been a 999 call and potentially long wait for help to arrive.

Matthew feels that more should be done to make these devices available to people in the community, enabling people to take greater responsibility for helping themselves and people they care for; and in turn reducing reliance on ambulance services. He can see how this has already been effective with community access defibrillators and wonders if a similar thing could happen here.

Since sharing Matthew's story with the Committee, an action was taken by the Executive Director of Quality & Nursing to explore what Manga lifting devices are already available in the community, within nursing homes and other settings that could potentially be made more widely accessible.



Engaging with Communities

For the first time since 2019 we have been able to re-start and proactively engage with people and communities in person, by attending community events, open days, attending schools and other forums. 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.

LGBTQ+ Community - Swansea Pride

Swansea Pride, the annual South West Wales LGBTQ+ festival, took place on April 30th, 2022, at the National Waterfront Museum and Museum Green, Swansea. This was the first time the event has taken place since 2018 and it was great to be back, showcasing the Welsh Ambulance Service as a diverse and inclusive service provider.

Members of the Patient Experience & Community Involvement Team attended the event accompanied by Community First Responders (CFRs) from across south Wales.

Conversations were held with people attending about the pressures felt across the healthcare system and the impact this has on staff, patients and volunteers. The First Responders shared first-hand experience of what their role as a volunteer involved and used the event as an opportunity to recruit more people to become CFR's and Volunteer Car Service Drivers. The CFRs also provided an insight into the equipment they use as volunteer responders and demonstrated the use of both a Defibrillator and a Mangar lifting cushion.



Mental Health

Over the past quarter we have engaged with a number of mental health groups and forums across Wales, including: Wales Mental Health Forum, Cwm Taf Morgannwg Mental Health Forum, Powys Mental Health Network, Aneurin Bevan Suicide & Self-harm Prevention Steering Group, Adferiad Only Human Campaign for people recovering from substance misuse and attended a meeting to review the Cardiff & Vale Mental Health Charter.

The Cardiff & Vale Mental Health Charter was co-produced 11 years ago, designed for service users in Mental Health to be encouraged to take ownership of their care and treatment plans. In planning to update the Charter, it was recognised that much has now changed – including the role that the Welsh Ambulance Service plays in treating and responding to people in Mental Health need. A public consultation is now planned to gather feedback on what should be included in the new Charter, with the Welsh Ambulance Service playing an important role in ensuring the views of our service users are included.

Across all of these Mental Health forums and networks we heard feedback from people with lived experience of mental illness. There were common themes in the feedback about issues which contribute to mental illness, including rural isolation, loneliness and digital exclusion. People said they wanted to see better collaborative working between agencies and a more joined up approach to how people can access services near to where they live.

Feedback, and information from all Mental Health engagement we participate in, is reported back to the Welsh Ambulance Services' Mental Health & Dementia Team, helping to support progress of our own Mental Health plans.

Older People

We have also continued to engage with older people over the past quarter attending many Senior Citizen groups and Older People's social groups in person for the first time in over two years. At these groups we spoke to older people about what things had been like for them during the coronavirus pandemic, with many telling us that they had really struggled to stay connected and access health services. They told us that the push to access healthcare services online had been particularly difficult as they do not have access to the internet, nor would they understand how to use it. From all the older people we spoke to, only a handful told us they had attempted to use an online symptom checker via the NHS 111 Wales website, but would have much preferred to speak to a 'real person'.

Digital exclusion has been a recurring theme in much of the feedback we have heard over the past three months. Ensuring access to our services for older people and those digitally excluded for socio-economic or other reasons is something we must continue to be mindful of; making sure that other contact methods are available and well publicised.



Ethnic Minority Communities

Cardiff Ethnic Minority Health Fair

The Cardiff Minority Ethnic Community Health Fair resumed in Cardiff this year and PECCI were supported by colleagues from the Inclusion Team and local Community First Responders (CFRs) to host an information stall, engaging with attendees about their experiences of using Welsh Ambulance Services. Our CFR colleagues also gave demonstrations on CPR, defibrillators and invited people to learn these life saving skills by having a go themselves. Information was provided about volunteering opportunities at Welsh Ambulance Service, encouraging people to think about becoming a volunteer and supporting their local community.

We took the opportunity to talk with partner organisations attending the event about our forthcoming 'New to Wales' information pack, which nears the end stages of development. People were pleased to hear about this development and felt it would be a useful tool for many. It was clear to observe that many of the elders at the Health Fair relied on younger family/community members to translate for them. Engaging with older generations within minority ethnic communities, where English is not the first language or they are new to Wales, to introduce and encourage use of tools like ReciteMe will be important, but we may need intergenerational sessions to truly encourage the message. We will also need to be mindful of this community's confidence and comfort using English language.

Attendees at the event enquired about ambulance response times in the Cardiff and Vale area, compared to our targets and current national performance.

"I was out and a man collapse in a car park. He was holding his chest, we thought he might have had a heart attack. We phoned 999 and were told an ambulance would take 9 hours. Luckily someone knew there was a hospital nearby and took him. It's heart-breaking, he could have died. "

There was interest in Equality and Diversity matters within the trust, from recording numbers of patients from a minority ethnic background to diversity within the workforce, which our colleagues from the Inclusion Team were able to help answer.



Learning Disability Community

Staying Safe this Summer

In partnership with All Wales People First, we held our second, virtual event of 2022 for the learning disability community. The online event provided us with a chance to talk with this community about what they could do to stay safe and well during the summer months, including demonstrating the online symptom checkers available on the NHS 111 Wales website and explaining how these can signpost to the most appropriate help. The session also included a number of fun quizzes to reinforce the learning. Feedback was very positive, and we will continue to host events throughout the year.

The session was great, you kept the content really accessible for the audience. Maybe next time the session could be a little longer, as there was lots of debate still going on.

Learning Disability Awareness week

The theme of this year's awareness week was 'People with a learning disability reconnecting with friends and communities after Covid19'. The week also provided an opportunity to talk about the issues many people still face after the end of Covid restrictions, like still having to isolate or dealing with poor mental health and anxiety.

To support this theme, we attended 'Adfest' to reconnect face-to-face with the learning disability community and to enable them to share any experiences of using our services. We also used social media throughout the week to share information about the range of Easy Read resources available on the NHS 111 Wales website.

Adfest

All Wales People First is an Advocacy Service for people with a learning disability. AdFest is their annual event where people with a learning disability come together to socialise and learn about matters which affect them. For the Welsh Ambulance Service, attending Adfest was a great way of reconnecting with members of learning disability groups from across Wales.

At the event, the Patient Experience & Community Involvement Team were invited to host an information stand and facilitate a presentation about the new Easy Read section on the NHS 111 Wales website.

This one-stop-shop approach to Easy Read health information was welcomed and the layout and design were given the thumbs up. Everyone agreed that Easy Read benefits lots of people. Partner agencies and participants alike were pleased to hear that this new section of the website will also be used to host information about national campaigns such as Annual Health Checks and Health Profiles.



Children & Young People

Blue Light Hub App evaluation

Following the launch in July 2021, of our children & young people's 'Blue Light Hub' gaming app, we are eager to evaluate the effectiveness and understanding for children's learning and understand whether the App helps children feel more confident about engaging with emergency services. With support from Cardiff University and local Cardiff primary schools, we are in the process of gathering the data which will help shape future App developments and engagement work with children and young people. It will also provide a platform for future researchers to further investigate ways to reduce unnecessary 999 calls and therefore reduce strain on services.

Community engagement visits

Following the relaxation of coronavirus restrictions, we are delighted to get back on the road with staff and Community First Responders (CFRs) and meet children and young people across Wales.

We know from our continuous engagement that a child's experience of the NHS in an emergency setting can be distressing, so familiarisation is key. By allowing them to meet us, learn about the equipment we use, talk about when it's appropriate to call 999 and understand the questions we ask when calling 999, this will help prepare and reassure young people should they ever need our help. By teaching the next generation lifesaving skills, we are also supporting their rights as a child, as specified under Article 29: *"...help you to develop your skills and talents to the full"* and encourage them to become resilient members of the community.



Community Health Councils

Enhancing our relationship and working practice with Community Health Councils (CHC) across Wales is something we are keen to do, especially as we move towards the development of the Citizen Voice Body, which will replace CHCs, as set out under plans within the Health & Social Care (Quality & Engagement) (Wales) Act.

In the last quarter, we reached out to the 7 CHC bodies currently in place across Wales in effort to re-connect and strengthen our relationships. Follow-up meetings have been arranged with 3 of the 7 CHCs and are due to take place in the next quarter.

South Glamorgan CHC

During this time period, we began to attend the quarterly local committee meetings for South Glamorgan CHC, covering Cardiff & the Vale of Glamorgan respectively. At the last meetings for each area, we shared a presentation detailing current performance and patient experience feedback received within the Cardiff & Vale Health Board area.

During the meeting in April, a member of the public raised queries concerning: timely response to Red calls, the use of alternative vehicles to get to a patient quicker and engagement opportunities in the area. To answer his questions and explain how the Trust responds, a meeting was held with the Service Manager for the South East EMS and Locality Manager for Cardiff.

Swansea Bay CHC

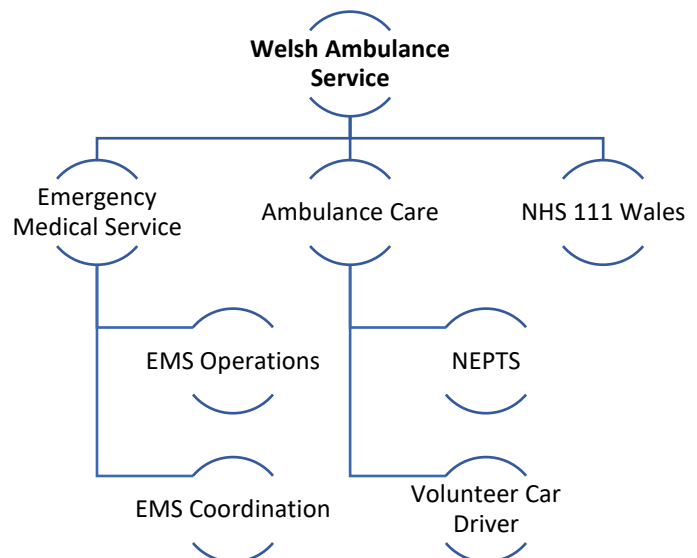
At a meeting with Swansea Bay CHC, we shared information about how we have been engaging with local communities, including older people, learning disability groups and young people. The Swansea Bay CHC's Engagement Officer is keen to work more closely with us and we have discussed possibilities of holding future meetings and information stands in partnership at local events.

Civica – Once for Wales Patient Experience Solution

Over the past quarter, we have begun to work with the Civica Team to develop the new Once for Wales Patient Experience Solution, tailoring it to meet our needs at the Welsh Ambulance Services NHS Trust.

We are currently developing the system's 'hierarchy' which will allow data captured to be accurately reported to the appropriate Department or Team.

Information about the Civica system has now been formally presented to the Trust's Executive Management Team, who saw great potential in the system for supporting future community engagement and consultation, especially around proposed service transformation.





The Citizen's Voice People & Community Network



Network Members:
95



Promoting the Network

- Contact has been made with all Voluntary Councils (19) across Wales to share Network information with Third Sector partners
- Contact has been made with all Community Health Councils (7) across Wales, including Board of CHCs to introduce the Network. We have also started to have follow up meetings with CHC colleagues to discuss closer working relationships.
- A new promotional leaflet and other resources are in the final stages of development and will be used to recruit more members to the Network.

Mystery Shopper Campaign

- A task & Finish Group has been established and meet regularly to finalise details for Phase 1 of NHS 111 Wales (Telephony) Mystery Shopper Campaign: testing the accessibility of IVR Messaging (up to the point of being placed in a queue).
- A Participant Brief and Reporting Form have been developed together with information for staff.

People & Community Group

- An internal group of Welsh Ambulance Service colleagues now meet quarterly to share updates, opinions, and ideas relevant to the People & Community Network, covering issues such as accessibility, inclusion and user experience.
- A Terms of Reference has been drafted for this group and is currently awaiting final approval.
- This group will eventually include public membership, made up of People & Community Network members.

Sharing Best Practice & Developing Governance

- We have held introductory meetings with colleagues at South Western Ambulance Service, who have recently established a Patient Participation Panel. They have shared with us their lessons learnt as well as examples of Terms of Reference and Code of Conduct which could help guide our own.
- We have held regularly meetings with the Patient Experience Manager at Cardiff & Vale Health Board, who are also developing a Patient/Public Network to share learning and develop processes.
- The Patient Experience & Community Involvement Team have been liaising with colleagues in the Information Governance Team to review necessity for a Data Processing Impact Assessment (DPIA) for the Network.

Patient Experience Surveys

Calling 999

Within the last quarter we have launched 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.

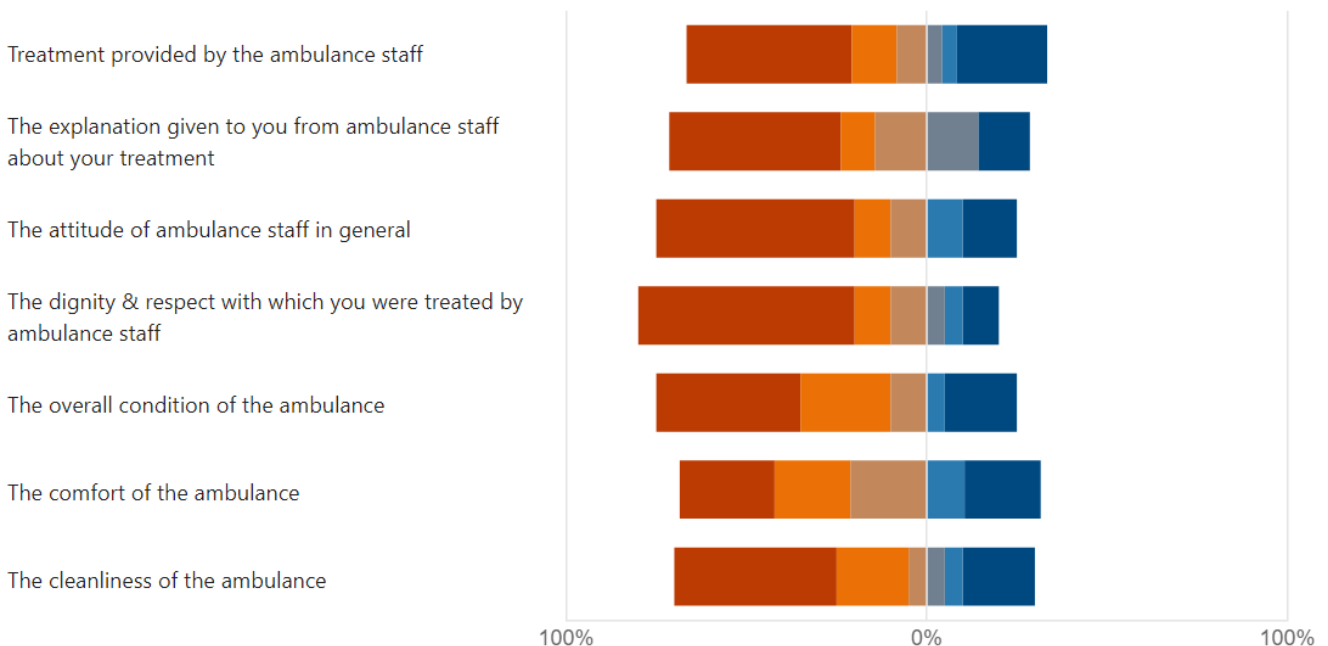
Up to the end of June 2022, 30 responses had been received for this new patient experience survey. Because of governance restrictions we are currently unable to directly contact 999 service users to ask for feedback. Instead, we rely on them seeking out opportunities to provide feedback independently. We plan to continue making this survey available to our 999 service users and are exploring options to help increase engagement with the survey and increase the amount of feedback we are able to capture.

From this initial group of respondents, responses were received from all Health Board areas across Wales. A majority (66%) told us that this was their first time calling 999, whilst one respondent said they had previously called 999 on more than 5 occasions.

- **59% of respondents said they felt confident in the ability of the person who answered their call to manage the call and provide appropriate advice.**
- **68% 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, 70% said they felt they were given enough advice about what to do next.**
- **Of those who said an ambulance was sent, 50% said they waited over an hour for help to arrive, with two people saying they waited over 7 hours and one saying they waited 23 hours.**

How would you rate your experience of the following aspects?

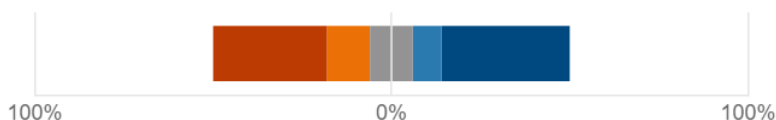
Very Good Good Fair Poor Very poor N/A



How would you rate your overall experience?

Very Good Good Fair Poor Very poor

How would you rate your experience:



Please tell us why you gave the ratings above:

“Very pleasant paramedic and young Marine who was driving the ambulance”

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

“He died having waited for 3 and a half hours for an ambulance”

“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”

“The call handler and the team that responded were really efficient and helpful”

“The first responder got to us within good time and the ambulance arrived shortly after”

“I had respiratory failure, couldn't breathe and couldn't get an ambulance”

“The trauma paramedic was there within 5 minutes and the 2 ambulance men 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”

“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 an 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”

“Nothing good. Diabolical service. 25 hours and still waiting for an ambulance . The service should be ashamed of itself. This is not difficult. Animals are treated better”

Overall, there was a fairly even split in responses received from people rating their experience as Good or Poor. This is further demonstrated in the comments above.

The feedback received through this survey will help us to build a better picture of what people say it feels like to us our emergency 999 service. We will share the feedback received with appropriate service managers and work with them to identify any potential opportunities for learning or service improvement.

Patient Experience Surveys

Non-Emergency Patient Transport Service

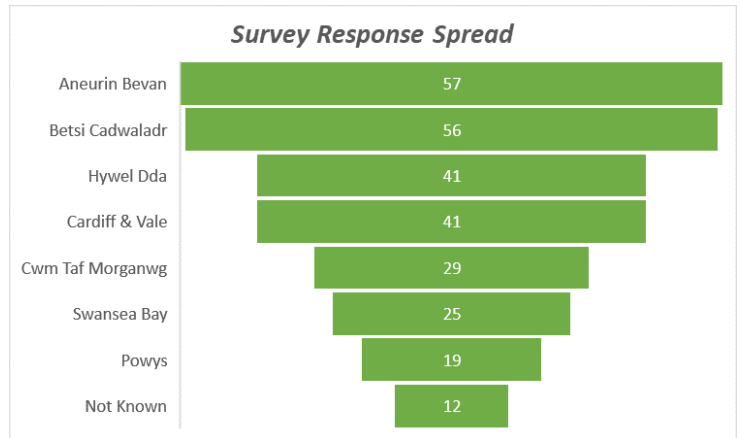
We have continued to work with colleagues in the Non-Emergency Patient Transport Service (NEPTS) to survey NEPTS users, helping us to build a better understanding of their patient experiences, and identify areas of good practice and quality improvement opportunities.

Between April and June 2022, a total of 280 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, though Aneurin Bevan continues to show the highest levels of engagement. In this quarter we see an improved response from users in Cardiff & Vale.

These results showed us that:

- A majority of people (87%) found the booking process easy. Those who answered negatively here said it was because of long delays for booking calls to be answered.
- 90% said they were happy with the transport they received.
- A majority of people (85%) 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.



When asking respondents ‘Was there anything particularly bad about your experience?’, from all responses received, the words ‘wait’ or ‘waiting’ appear most often.

“Long wait on phones and no other way for me to book”

“Had to wait 4 hours for pick up to go home”

“I was left waiting 3 hours for the transport to take me home”

Patient Experience Surveys

NHS 111 Wales Telephony Service

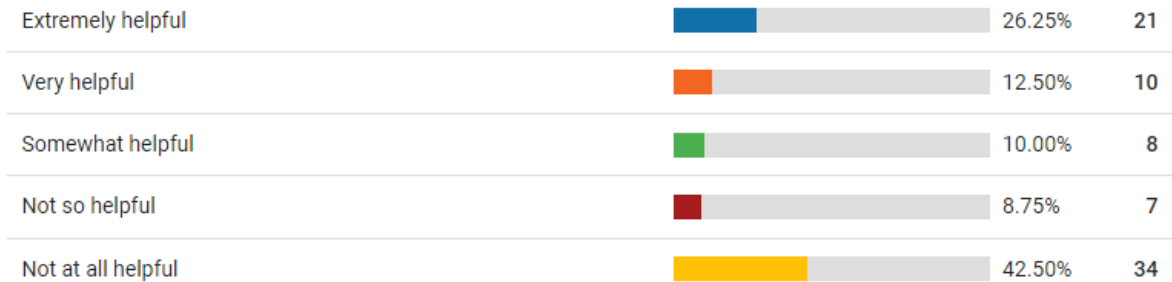
We have continued to promote a new survey, encouraging people to share their experiences with us of calling the NHS 111 Wales service. **Between April and June 80 people completed the survey.** Responses were received from all Health Board areas, providing a mixed response about their experience of using 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.

53% 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 increase from 50% in the previous quarter). 42.5% of respondents told us they found their call 'Not at all helpful' with 26% saying their call was 'Extremely helpful'. However, a majority of 72% said they did go onto follow the advice given to them.



28% 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.

“It was first time I’ve used the service and I thought it was extremely impressive. Very prompt and efficient service”

“Waited considerable amount of time to speak to initial adviser who not being medically qualified did not assist. Received call back from a nurse several hours later still no advice and out of hours Doctor did not call as promised. What a total waste of time”

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 71 people completed a website experience survey

Over the past quarter there has been a notable decrease in people searching for information about Coronavirus related issues and an increase in search terms related to more general health and well-being.

Just under half of respondents (45%) told us that they didn't find it easy to find the information they were looking for on the website. This remains consistent with responses from previous reporting periods.

In contrast, 41% of respondents said they found it either 'Extremely' or 'Very' easy to find the information they needed, and 48% of people rated their overall experience as Good to Excellent.

What did you like about the website?

"Factual advice"

"That it exists! I can not worry and not bother a GP or phone unnecessarily"

"User friendly and helpful"

"Answered all my concerns"

"I could get all the answers by just scrolling down and not having to keep going into separate pages"

What didn't you like about the website?

"More clinical advice needed! As quite often the information is presented as if everyone is a squid brain!"

"It might save resources if Wales and England link and create one site. I often look at 'NHS information' but didn't realise before I was on an exclusively English site"

"Info not detailed enough"



Average rating given was 2.81 (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, January - March 2021

	@WelshAmbPECI
Tweet impressions (how many people our tweets have reached)	60,100
New followers	47
Current Number of Followers	4,607

This period's most popular tweet from @WelshAmbPECI was made in June and celebrated the achievement of a member of the Patient Experience & Community Involvement Team, who ran the Swansea Half Marathon, raising money for TASC, the the Ambulance Staff charity which supports Ambulance Staff and their families to enhance their mental and physical well-being. The Tweet earned 3,957 impressions.

Congratulations to Matt (one of our own in the PEGI Team 😊) who ran the @SwanseaHalf today for @TASCharity, the Ambulance Staff charity which supports Ambulance Staff and their families to enhance their mental and physical well-being. Well done Matt we're proud of you 🙌
pic.twitter.com/rHgK7tTBJJ



↩ 5 ↻ 3 ❤ 38

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	23
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Due to my Dad's ongoing ill health, I called 111 at midnight last night. The call was answered swiftly and the call handler was excellent, unfortunately there was a delay in the call back from the clinician, but I understand it is very busy, a different call handler rang me back at 3am. This call handler was also excellent, but knowing we could call back at any time and seek advice, this is so reassuring.

	Total Website visits (English)	Total Website visits (Welsh)	Top Page Viewed
April	351,750	4,549	homepage
May	329,785	1,347	homepage
June	335,889	948	homepage
Total	1,017,424	6,844	

During this reporting period, the most popular symptom checkers visited were:

- Covid – 63,675 views
- Leg pain – 51,230 views
- Generally Unwell – 39,786 views

Twitter Summary, @NHS111Wales April – June 2022

Tweet impressions (how many people our tweets have reached)	96,600
New followers	54
Current Number of Followers	7,042

Facebook April – June 2022

Facebook Reach (how many people our Facebook posts reached)	19,725
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Looking Ahead...

Royal Welsh Show

Together with colleagues from across the Trust, we will be attending the 2022 Royal Welsh Show. The Royal Welsh Show plays a leading role in the development of agriculture and the rural economy. Our attendance will enable us to engage with the farming and rural communities, who we know experience increased incidence of poor mental health, digital exclusion and report difficulty accessing services because of rurality.

Launch of Learning Disability E-Learning

The commissioned Learning Disability e-learning module awaits final sign off and should be ready to promote to Welsh Ambulance Service staff in the next month. We also plan to hold additional training sessions that will enhance this online offering.

Easy Read on NHS 111 Wales

A consortium of Learning Disability services and organisations have all agreed to jointly promote the new easy read pages amid wider discussions that easy read is exactly that, easier to read, and therefore beneficial to other audiences including people living with dementia and people who are autistic. This potentially widens the consortium much further than originally planned.

Shoctober & Restart a Heart

Though not scheduled to happen until October, work has commenced to recruit volunteers from across the Trust and from external partners who can support delivery of the Shoctober and Restart a Heart schools engagement programmes.

Food Fun Wales

Over the summer holidays when schools are closed, in conjunction with Cardiff Council, we support a school-based education programme 'Food Fun Wales' that provides food and nutrition education, physical activity, enrichment sessions and healthy meals to children who otherwise wouldn't have access during the holidays. The enrichment sessions involve outside agencies, like the Trust, going in and talking to the pupils. During our sessions, we deliver content covering appropriateness of 999 and teach them life-saving skills they might be asked to do while 'help is on its way'.

Youth Ambassador for Welsh Ambulance Service

The Patient Experience & Community Involvement Team are working with the National Volunteer Manager and a 17-year-old, aspiring Emergency Department doctor, to develop a Youth Ambassador role for the Trust. After their 18th birthday, in August, they will begin training to become a Community First Responder and start attending the Volunteer Stakeholder Steering Group, playing a valuable role as Youth Representative.



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Gwasanaethau Ambiwllans Cymru
Welsh Ambulance Services
NHS Trust

AGENDA ITEM No	13
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	2

Health Inspectorate Wales (HIW) EMS CCC Patient Safety Review

MEETING	Quality Patient Experience and Safety Committee (QuEST)
DATE	11 th August 2022
EXECUTIVE	Lee Brooks, Executive Director of Operations
AUTHOR	Kate Blackmore, Head of Service EMS Coordination
CONTACT	Kate.blackmore@wales.nhs.uk

EXECUTIVE SUMMARY
<p>Following concerns raised regarding the potential impacts of extended and deteriorating handover times at emergency departments across Wales, a review by Health Inspectorate Wales (HIW) was undertaken during Q3 & Q4 of 2019/20.</p> <p>The principal objective of the review was to assess how patients are managed by EMS Coordination (EMSC) encompassing the period from the time the call is received through to an operational response arriving with the patient.</p> <p>The action plan contained 44 actions, 8 of which were deemed complete prior to the publication of the action plan based on developmental and improvement work already undertaken. An extension was requested for 6 recommendations following a review in January 2021 due to the impact of the Covid-19 Pandemic on the organisation's ability to deliver against agreed timescales.</p> <p>The current progress and position can be noted in the Key Issues / Implications below.</p> <p>RECOMMENDATIONS</p> <ol style="list-style-type: none"> 1. QuEST to note that Executive Management Team (EMT) received and approved the progress against the HIW Action Plan. 2. QuEST note the contents of this report to secure the necessary assurance that progress is being made by the Trust against the HIW recommendations.

KEY ISSUES/IMPLICATIONS
<p>Since the last update to QuEST in November 2021 a further 2 actions have been completed, namely, action 3.1 (Continue to engage with Health Board stakeholders regarding availability and expansion of (PTAS) opportunities & action 5.1 (We will pursue with our Health Informatics (HI) colleagues an improved Ambulance Dispatch Operations Log (ADOL) report so that actions taken as a result of REAP and DMP levels are more visible and able to be reported on more easily).</p> <p>The actions for the 2021/2022 financial year;</p>

- Given the training needs analysis is completed and reviewed regularly by the EMS-C management team actions 18.1 19.2 are recognised as completed.
- Similarly, EMS-C supports agile working for all roles that can be completed outside of the Clinical Contact centre environment and as such action 21.2 is recognised as completed.
- In terms of action 19.2 this is linked to action 19.1 and while there have been operational pressures affecting the full completion of the 'PADR lite' this is action is closed.

The actions which remain outstanding for 2021/22 are outlined below:

- Action 17.3 references engagement with HEIW to develop an education programme. WAST have been engaging with HEIW throughout the pandemic and this action is now embedded within the Gateway to Care programme this action be closed and delivery monitored through the Gateway to Care programme.
- Action 12.1 refers to the CAD Phase 3 (CCC Reconfiguration), which has been reinvigorated after a period of stasis, due to a number of issues including the demands of the Covid Pandemic. This is to be noted as an **overdue action** with a timeline for delivery by the end of Qtr 4 2022/2023.
- Action 21.1 is dependent upon the Estate SOP and a working group is scoping options. This should be noted as an **overdue action**. The timescale for this action will be updated once the Task and Finish Group have determined an achievable timeline.

REPORT APPENDICES

Appendix 1 – SBAR
Appendix 2 – Audit Tracker

REPORT CHECKLIST

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

SITUATION

1. Following concerns raised regarding the potential impacts of extended and deteriorating handover times at emergency departments across Wales, a review by Health Inspectorate Wales (HIW) was undertaken during Q3 & Q4 of 2019/20.
2. The final action plan was presented to Executive Management Team (EMT) on the 26th July and Quality Patient Experience and Safety Committee (QuEST) on 8th September 2020.
3. The purpose of this paper is to provide a summary and overview of the progress made against the action plan. It is provided to the committee for assurance purposes following the most recent approvals provided by the Executive Management Team.

BACKGROUND

4. The principal objective of the review was to assess how patients are managed by EMS Coordination (EMSC) encompassing the period from the time the call is received through to an operational response arriving with the patient.
5. As a secondary objective the review considered how staff working in EMSC are resourced and supported.
6. HIW conducted the field work between November 2019 and January 2020 using a mixed methods approach including staff surveys, document reviews and semi-structure interviews.
7. The key findings of the review were:
 - i. The review found a 'strong team ethos' through the EMSC despite often having to work in challenging circumstances relating to limited resources.
 - ii. Pressures arising from lost hours at hospital as a consequence of delayed handovers of care at Emergency Departments was a consistent and 'significant' theme which was driving the negative staff and patient experiences.
 - iii. Management, leadership and accountability structures are clear however the review found that more could be done to increase the visibility of this leadership.
 - iv. The review found that sound risk management processes were in place although opportunities for improvement were identified.
 - v. Further organisational focus is required to ensure that EMSC have the correct resources, training, and development.

ASSESSMENT

8. The action plan contained 44 actions, 8 of which were deemed complete prior to the publication of the action plan based on developmental and improvement work already undertaken.
9. 18 have actions against them which are predominantly for EMSC but also include support/lead from other areas namely, Workforce and Organisation Development and Clinical Directorate.
10. An update was requested by HIW in April 2021 which involved submission of an updated response including the updated action plan. A further update was completed in November 2021.
11. The table below sets out the status of recommendations by quarter & financial year. An extension was requested for 6 recommendations following a review in January 2021 due to the impact of the Covid-19 Pandemic on the organisation's ability to deliver against agreed timescales. The agreed timescales have now been realigned in the table below to meet the revised delivery dates.

	Year (19/20)	Year (20/21)	Quarter 1 (21/22)	Quarter 2 (21/22)	Quarter 3 (21/22)	Quarter 4 (21/22)
Actions Due	7	30	4	1	0	2
Complete (Nov 21)	7	25	3	0	n/a	0
Complete (Jun 22)	7	27	3	0	n/a	0
% Complete (Jun 22)	100%	90%	75%	0%	n/a	0%
Outstanding	0	3	1	1	0	2

12. Since the last update to QuEST a further 2 actions have been completed
 - a. Action 3.1 – Continue to engage with Health Board stakeholders regarding availability and expansion of (PTAS) opportunities.
 - b. Action 5.1 – We will pursue with our Health Informatics (HI) colleagues an improved Ambulance Dispatch Operations Log (ADOL) report so that actions taken as a result of REAP and DMP levels are more visible and able to be reported on more easily.
13. The 3 actions outstanding from the 2020/21 fiscal year are:

Action	Progress & Anticipated Completion
Action 18.1 Work with DCMs to ensure existing time for protected appraisal discussions is utilised effectively and scheduled in advance or look for a more appropriate way that appraisals can be carried out.	Existing time was already available within rostered training provision. There is ongoing work on a EMS-C roster review that could incorporate protected time to undertake PADR's. Due to the operational pressure and high level of escalation in operation between August 21 and Jun 22 this time was

	<p>realigned to support operational service delivery. This has impacted on the capacity to undertake PADR. An action plan is now in place to ensure all EMS Coordination teams have received a quality PADR in the next 6 months. Administrative support teams are now tasked with scheduling these appointments to ensure timely PADR and 6 monthly reviews are completed. PADR compliance is currently 59.61% (excluding those with open sickness absence) having improved from 27.27% as of 1st April 2022 with a trajectory for completion by September 2022.</p>
<p>Action 19.2 Workforce & Organisational Development team to assess the training needs of first line managers within EMSC to support their delivery of effective and meaningful PADR</p>	<p>A training needs assessment has been carried out through engagement with the Workforce and Organisational Development team, which resulted in a bespoke training package that has been developed and completed. Through this work in EMS-C wider change across the organisation has also taken place in terms of PADR delivery.</p>
<p>Action 21.2 Complete the return to the workplace review to ensure the maximum space is still provided in the medium term for clinicians to work remotely from the EMSCCC main spaces.</p>	<p>A paper was approved through Senior Leadership Team and now forms part of the Estates Strategic Outline Plan. This focuses on increasing the capacity of all three sites to provide sufficient space to work from EMS Coordination Centres. Stephen Clinton as the ADO for Integrated Care is working with the Team to ensure that there is sufficient capacity for Clinicians to work at the three Centres. In addition, it is acknowledged that other facilities have also been created across the Estate to accommodate staff who want to work from WAST premises together with the capability of remote working that was expedited as part of the response to covid.</p>

14. Given the training needs analysis is completed and reviewed regularly by the EMS-C management team **it is suggested that actions 18.1 19.2 are recognised as completed.** Prolonged operational pressure has meant that full PADR processes have been delayed and an action plan is now in place to deliver with administrative support.
15. Similarly, EMS-C supports agile working for all roles that can be completed outside of the Clinical Contact centre environment. Whilst a full return to the workplace strategy has not yet commenced as we move to living with Covid EMS-C and Integrated Care completed actions regarding agile working. In addition, EMS-C continue to progress Estate's strategy to address corporate risks 244 and 245 to ensure sufficient capacity for resilient operations where agile working would not be appropriate. **As such it is recommended that action 21.2 is recognised as completed.**

16. The 4 actions which remain outstanding for 2021/22 are:

Action	Progress & Anticipated Completion
<p>Action 12.1 Continue with the work of the CAD Phase 3 project to realign workloads within the EMSCCC for more efficient operation.</p>	<p>CAD Phase 3 was renamed CCC Reconfiguration and recommenced following response to Wave 2 of the Covid 19 pandemic. The model agreed by SOT in December 2019 was progressed with Job Evaluation work completed in Qtr 1 21/22 and review of these evaluations following engagement with EMT in Qtr 2 21/22 was completed. EMT supported the proposal but a financial investment of circa £750k recurring was required to deliver. As a result of a challenging financial position a funding stream for this investment has not yet been identified and this remains a cost pressure for the organisation. As a result CCC reconfiguration cannot be delivered in its entirety and instead the Project Board are now reviewing the PID and TOR to review what modernisation actions can be achieved without a revised structure. This action is tracked through the EMS Transformational Change board.</p>
<p>Action 17.3 continue to engage with HEIW to develop an accredited programme of education focussed on clinical and non-clinical remote decision making</p>	<p>WAST continue to engage with HEIW around this programme which was paused during response to the Covid 19 Pandemic. Quest approved an extension until Qtr 2 21/22 however this work is now being tracked under the Gateway to Care programme. Given that the action was to engage the recommendation is to close this action and cross reference to the gateway to care programme for future monitoring.</p>
<p>Action 19.1 Develop and trial an EMS CCC specific appraisal process to ensure that staff receive the appropriate developmental discussion</p>	<p>Development of the EMSC trial has been completed with support from WOD and appropriate templates and training provided. Learning from this pilot is now informing a wider organisational review of PADR processes.</p>
<p>Action 21.1 Complete the North Wales EMS CCC estate strategy and identify opportunities for improvements</p>	<p>Estates project reprioritised to focus on covid secure workplaces during Pandemic response. Whilst included within the Estates SOP this strategy work has not yet recommenced. This issue has been escalated and supported by the Operations Directorate Senior Leadership team and is currently supported by two corporate risks.</p>

17. Action 12.1 refers to the CAD Phase 3 (CCC Reconfiguration) , which has been reinvigorated after a period of stasis due to a number of issues including the



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Welsh Ambulance Services
NHS Trust

AGENDA ITEM No	
OPEN or CLOSED	
No of ANNEXES ATTACHED	

<p>Health Inspectorate Wales (HIW) EMS CCC Patient Safety Review</p>

MEETING	Executive Management Team (EMT)
DATE	3 rd August 2022
EXECUTIVE	Lee Brooks Executive Director of Operations.
AUTHOR	Kate Blackmore Head of Service EMS Coordination
CONTACT DETAILS	Kate.blackmore@wales.nhs.uk 01267 225772

CORPORATE OBJECTIVE	IMTP priority objective (s)
CORPORATE RISK (Ref if appropriate)	CRR1 - Operational Performance variance across HB areas (Datix ID: 220) CRR57 - Patients delayed on ambulances outside A&E Depts (Datix ID: 224) CRR3 - Escalation system in Trust in increased operational pressure (Datix ID: 221) CRR58 - Unable to attend patients in community who require See & Treat (Datix ID: 223)
QUALITY THEME	2. Safe Care 3. Dignified Care 4. Effective Care 5. Timely Care 6. Individual Care 7. Our Staff and Resources
HEALTH & CARE STANDARD	2.1 - Managing Risk and Promoting Health and Safety 3.1 - Safe and Clinically Effective Care 3.3 - Quality Improvement, Research and Innovation 3.4 - Information Governance and Communications Technology 4.1 - Dignified Care 5.1 - Timely Access (to care) 6.3 - Listening and Learning from Feedback 7.1 - Workforce

REPORT PURPOSE	To provide a summary and overview of the progress made on the actions agreed in response to HIW EMSCCC Patient Safety Review.
CLOSED MATTER REASON	None.

REPORT APPROVAL ROUTE

WHERE	WHEN	WHY
SLT	26/07/2022	Approval
EMT	03/08/2022	Approval
QuEst	11/08/2022	Assurance

SITUATION

1. Following concerns raised regarding the potential impacts of extended and deteriorating handover times at emergency departments across Wales, a review by Health Inspectorate Wales (HIW) was undertaken during Q3 & Q4 of 2019/20.
2. The final action plan was presented to Executive Management Team (EMT) on the 26th July and Quality Patient Experience and Safety Committee (QuEST) on 8th September 2020.
3. The purpose of this paper is to provide a summary and overview of the progress made against the action plan.

BACKGROUND

4. The principal objective of the review was to assess how patients are managed by EMS Coordination (EMSC) encompassing the period from the time the call is received through to an operational response arriving with the patient.
5. As a secondary objective the review considered how staff working in EMSC are resourced and supported.
6. HIW conducted the field work between November 2019 and January 2020 using a mixed methods approach including staff surveys, document reviews and semi-structure interviews.
7. The key findings of the review were:
 - i. The review found a 'strong team ethos' through the EMSC despite often having to work in challenging circumstances relating to limited resources.
 - ii. Pressures arising from lost hours at hospital as a consequence of delayed handovers of care at Emergency Departments was a consistent and 'significant' theme which was driving the negative staff and patient experiences.
 - iii. Management, leadership and accountability structures are clear however the review found that more could be done to increase the visibility of this leadership.
 - iv. The review found that sound risk management processes were in place although opportunities for improvement were identified.
 - v. Further organisational focus is required to ensure that EMSC have the correct resources, training, and development.

ASSESSMENT

8. The action plan contained 44 actions, 8 of which were deemed complete prior to the publication of the action plan based on developmental and improvement work already undertaken.
9. 18 have actions against them which are predominantly for EMSC but also include support/lead from other areas namely, Workforce and Organisation Development and Clinical Directorate.
10. An update was requested by HIW in April 2021 which involved submission of an updated response including the updated action plan. A further update was completed in November 2021.
11. The table below sets out the status of recommendations by quarter & financial year. An extension was requested for 6 recommendations following a review in January 2021 due to the impact of the Covid-19 Pandemic on the organisation's ability to deliver against agreed timescales. The agreed timescales have now been realigned in the table below to meet the revised delivery dates.

	Year (19/20)	Year (20/21)	Quarter 1 (21/22)	Quarter 2 (21/22)	Quarter 3 (21/22)	Quarter 4 (21/22)
Actions Due	7	30	4	1	0	2
Complete (Nov 21)	7	25	3	0	n/a	0
Complete (Jun 22)	7	27	3	0	n/a	0
% Complete (Jun 22)	100%	90%	75%	0%	n/a	0%
Outstanding	0	3	1	1	0	2

12. Since the last update to QuEST a further 2 actions have been completed
 - a. Action 3.1 – Continue to engage with Health Board stakeholders regarding availability and expansion of (PTAS) opportunities.
 - b. Action 5.1 – We will pursue with our Health Informatics (HI) colleagues an improved Ambulance Dispatch Operations Log (ADOL) report so that actions taken as a result of REAP and DMP levels are more visible and able to be reported on more easily.
13. The 3 actions outstanding from the 2020/21 fiscal year are:

Action	Progress & Anticipated Completion
Action 18.1 Work with DCMs to ensure existing time for protected appraisal discussions is utilised effectively and scheduled in advance or look for a more appropriate way that appraisals can be carried out.	Existing time was already available within rostered training provision. There is ongoing work on a EMS-C roster review that could incorporate protected time to undertake PADR's. Due to the operational pressure and high level of escalation in operation between August 21 and Jun 22 this time was

	<p>realigned to support operational service delivery. This has impacted on the capacity to undertake PADR. An action plan is now in place to ensure all EMS Coordination teams have received a quality PADR in the next 6 months. Administrative support teams are now tasked with scheduling these appointments to ensure timely PADR and 6 monthly reviews are completed. PADR compliance is currently 59.61% (excluding those with open sickness absence) having improved from 27.27% as of 1st April 2022 with a trajectory for completion by September 2022.</p>
<p>Action 19.2 Workforce & Organisational Development team to assess the training needs of first line managers within EMSC to support their delivery of effective and meaningful PADRs</p>	<p>A training needs assessment has been carried out through engagement with the Workforce and Organisational Development team, which resulted in a bespoke training package that has been developed and completed. Through this work in EMS-C wider change across the organisation has also taken place in terms of PADR delivery.</p>
<p>Action 21.2 Complete the return to the workplace review to ensure the maximum space is still provided in the medium term for clinicians to work remotely from the EMSCCC main spaces.</p>	<p>A paper was approved through Senior Leadership Team and now forms part of the Estates Strategic Outline Plan. This focuses on increasing the capacity of all three sites to provide sufficient space to work from EMS Coordination Centres. Stephen Clinton as the ADO for Integrated Care is working with the Team to ensure that there is sufficient capacity for Clinicians to work at the three Centres. In addition, it is acknowledged that other facilities have also been created across the Estate to accommodate staff who want to work from WAST premises together with the capability of remote working that was expedited as part of the response to covid.</p>

14. Given the training needs analysis is completed and reviewed regularly by the EMS-C management team **it is suggested that actions 18.1 19.2 are recognised as completed.** Prolonged operational pressure has meant that full PADR processes have been delayed and an action plan is now in place to deliver with administrative support.
15. Similarly, EMS-C supports agile working for all roles that can be completed outside of the Clinical Contact centre environment. Whilst a full return to the workplace strategy has not yet commenced as we move to living with Covid EMS-C and Integrated Care completed actions regarding agile working. In addition, EMS-C continue to progress Estate's strategy to address corporate risks 244 and 245 to ensure sufficient capacity for resilient operations where agile working would not be appropriate. **As such it is recommended that action 21.2 is recognised as completed.**

16. The 4 actions which remain outstanding for 2021/22 are:

Action	Progress & Anticipated Completion
<p>Action 12.1 Continue with the work of the CAD Phase 3 project to realign workloads within the EMSCCC for more efficient operation.</p>	<p>CAD Phase 3 was renamed CCC Reconfiguration and recommenced following response to Wave 2 of the Covid 19 pandemic. The model agreed by SOT in December 2019 was progressed with Job Evaluation work completed in Qtr 1 21/22 and review of these evaluations following engagement with EMT in Qtr 2 21/22 was completed. EMT supported the proposal but a financial investment of circa £750k recurring was required to deliver. As a result of a challenging financial position a funding stream for this investment has not yet been identified and this remains a cost pressure for the organisation. As a result CCC reconfiguration cannot be delivered in its entirety and instead the Project Board are now reviewing the PID and TOR to review what modernisation actions can be achieved without a revised structure. This action is tracked through the EMS Transformational Change board.</p>
<p>Action 17.3 continue to engage with HEIW to develop an accredited programme of education focussed on clinical and non-clinical remote decision making</p>	<p>WAST continue to engage with HEIW around this programme which was paused during response to the Covid 19 Pandemic. Quest approved an extension until Qtr 2 21/22 however this work is now being tracked under the Gateway to Care programme. Given that the action was to engage the recommendation is to close this action and cross reference to the gateway to care programme for future monitoring.</p>
<p>Action 19.1 Develop and trial an EMS CCC specific appraisal process to ensure that staff receive the appropriate developmental discussion</p>	<p>Development of the EMSC trial has been completed with support from WOD and appropriate templates and training provided. Learning from this pilot is now informing a wider organisational review of PADR processes.</p>
<p>Action 21.1 Complete the North Wales EMS CCC estate strategy and identify opportunities for improvements</p>	<p>Estates project reprioritised to focus on covid secure workplaces during Pandemic response. Whilst included within the Estates SOP this strategy work has not yet recommenced. This issue has been escalated and supported by the Operations Directorate Senior Leadership team and is currently supported by two corporate risks.</p>

17. Action 12.1 refers to the CAD Phase 3 (CCC Reconfiguration) , which has been reinvigorated after a period of stasis due to a number of issues including the demands of the Covid Pandemic. This said, as noted in the table above, the Project has been reinvigorated and has set out four work packages that can progressed in the absence of any further financial support. **This is to be noted as an overdue action with a timeline for delivery of the 4 work packages, which includes a roster review, by the end of Qtr 4 2022/2023.**
18. Action 17.3 references engagement with HEIW to develop an education programme. WAST have been engaging with HEIW throughout the pandemic and this action is now embedded within the Gateway to Care programme. **The recommendation of this paper is to close this action and continue to monitor delivery through the Gateway to Care programme.**
19. Protected time within EMSC is restricted to training days. All other rostered hours are focused on operational service delivery. In terms of action 19.2 this is linked to action 19.1 and while there have been operational pressures affecting the full completion of the 'PADR lite', it is suggested that this specific action is complete as the necessary appraisal process has been developed and trialled. As part of the Roster review process, it may also be possible to review the opportunity within the roster to provide protected time so that managers and staff can undertake these vital conversations outside of the operational pressures. **It is recommended that this action is closed.**
20. The ability to deliver action 21.1 is dependent upon the Estate SOP and as noted above this is currently with The Estate Sop working group to scope opportunities. **This should be noted as an overdue action. The timescale for this action will be updated once the Task and Finish Group have determined an achievable timeline.**

RECOMMENDED: That

1. EMT note the update provided and agree to the closure of the actions detailed in this paper.
2. EMT agree to the additional closure of action 18.1, 19.1, 19.2 & 21.2 given the evidence available to support this in the BAU environment.
3. EMT agree to the additional closure of action 17.3, which are now tracked through alternative work programmes.
4. EMT acknowledge actions 12.1 & 21.1 are now overdue.

Rec. No.	Year of Report	Committee assigned to	Report Title	Assurance Rating	Responsible Officer	Director	Recommendation	Action	Management Response	Agreed Deadline in Report	Status	Due	Proposed completion date or date completed	Reason overdue / Reason complete If closed and not complete, please provide justification	What are the barriers to implementing the recommendation including any interdependencies?	How is the risk identified being mitigated pending implementation of the recommendation?	If complete can evidence be provided upon request?	No. of months past agreed deadline in report	Is the risk identified included on a Risk Register? Yes/No	
12	20/21	QS&PE	Health Inspectorate Wales (HIW) - CCC Managing Patient Safety	Not Rated	Stephen Clinton	Lee Brooks	Review current duties of EMSCCC staff to determine where responsibilities can be streamlined.	Action 12.1 Continue with the work of the CAD Phase 3 project to realign workloads within the EMSCCC for more efficient operation.	In 2019 the Trust commenced a project called CAD Phase 3 to review the EMSCCC structure and operating model. Originally, this was to take advantage of the	Q4 2020-21	Partially complete	Overdue	31.03.22	Acknowledge action is now overdue	The CAD Phase 3 (CCC Reconfiguration) , which has been reinvigorated after a period of status due to a number of	Q4 		#VALUE!		
17	20/21	QS&PE	Health Inspectorate Wales (HIW) - CCC Managing Patient Safety	Not Rated	Brian Jarvis	Lee Brooks	Implement a training strategy which ensures that staff are provided with the appropriate training and development, to enable them to undertake their relevant roles	Action 17.3 Continue to engage with HEIW to develop an accredited programme of education focussed on clinical and non-clinical remote decision making.	Initial induction and training for entry into EMSCCC forms part of an existing and established scheme of work with signed off competencies and assessment in	Q4 2020-21	Complete	Complete	30.09.21	Recommend Closure		C:\Users\PE144611\Documents\QuEST HIW Update 181120.docx		Document		
18	20/21	QS&PE	Health Inspectorate Wales (HIW) - CCC Managing Patient Safety	Not Rated	Kate Blackmore	Lee Brooks	Ensure sufficient time is permitted to allow for appraisal discussions between managers and their staff to take place.	Action 18.1 Work with DCMs to ensure existing time for protected appraisal discussions is utilised effectively and scheduled in advance or look for a	Duty Control Managers (DCMs) and their teams share the same regular training day and on this day the appraisal discussions take place. There are sufficient days to	Q3 2020-21	Complete	Complete	31.12.20	Recommend Closure				#VALUE!		
19	20/21	QS&PE	Health Inspectorate Wales (HIW) - CCC Managing Patient Safety	Not Rated	Stephen Clinton / Helen Watkins	Lee Brooks / Claire Vaughan	Ensure training is provided to relevant staff in regards to the annual appraisal process.	Action 19.1 Develop and trial an EMSCCC specific appraisal process to ensure that staff receive the appropriate developmental discussion.	EMS CCC and WOD managers engaged on the agreed action and will collaborate on the development of this process	Q4 2020-21	Complete	Complete	30.06.21	Recommend Closure		Q1 21/22		#VALUE!		
19	20/21	QS&PE	Health Inspectorate Wales (HIW) - CCC Managing Patient Safety	Not Rated	Helen Watkins	Claire Vaughan	Ensure training is provided to relevant staff in regards to the annual appraisal process.	Action 19.2 Workforce & Organisational Development team to assess the training needs of first line managers within EMSCCC to support their	EMS CCC and WOD managers engaged on the agreed action and will collaborate on the development of this process	Q4 2020-21	Complete	Complete	31.03.21	Recommend Closure 				#VALUE!		
21	20/21	QS&PE	Health Inspectorate Wales (HIW) - CCC Managing Patient Safety	Not Rated	Richard Davies / Stephen Clinton	Chris Turley / Lee Brooks	Consider how the EMSCCC working environments and IT equipment available can be improved to assist staff in carrying out their relevant roles as well as to improve staff well-	Action 21.1 Complete the North Wales EMS CCC estate strategy and identify opportunities for improvements.	The EMSCCC estate has seen some improvements since the review took place including new staff rest and kitchen areas being provided in the North Wales EMSCCC.	Q4 2020-21	Partially complete	Overdue	31.03.22	Acknowledge action is now overdue	The ability to deliver action 21.1 is dependent upon the Estate SOP and is currently with The	Q4 21/22		#VALUE!		
21	20/21	QS&PE	Health Inspectorate Wales (HIW) - CCC Managing Patient Safety	Not Rated	Richard Davies / Stephen Clinton	Chris Turley / Lee Brooks	Consider how the EMSCCC working environments and IT equipment available can be improved to assist staff in carrying out their relevant roles as well as to improve staff well-	Action 21.2 Complete the return to the workplace review to ensure the maximum space is still provided in the medium term for clinicians to work remotely from	The EMSCCC estate has seen some improvements since the review took place including new staff rest and kitchen areas being provided in the North Wales EMSCCC.	Q2/3 2020-21	Complete	Complete	31.12.20	Recommend Closure				#VALUE!		

CCC - Development PADR Process - HIW Review Action.msg

Key
 Less than 3 months
 Between 3 and 6 months
 Between 6 and 12 months
 Over 12 months

	Due	At Publication	December 20 QuEST	Feb 21 QuEST
Action 1.1 The Trust will consider a review of response time standards and methodology for therapeutic conditions with commissioners.	Q3 2020-21			
Action 2.1 In line with the Trusts Integrated Medium Term Plan (IMTP) deliver the recommendations in the Trust's Clinical Review.	Q2 2020-21			
Action 3.1 Continue to engage with Health Board stakeholders regarding availability and expansion of (PTAS) opportunities.	Q4 2020-21			
Action 3.2 Explore opportunities and funding for improved technical solutions to enable PTAS models to operate remote from the EMSCCC.	Q3 2020-21			
Action 4.1 Expected waiting times are currently included within the Demand Management Plan (DMP). These are provided in time bands which represent the time the caller can reasonably expect to wait for a response to arrive at their location, given the current volume of 999 and urgent responses being managed by the service.	Q4 2019-20			
Action 4.2 In order to further improve patient experience and to enable patient's to make informed decisions regarding their care the Trust will review the existing approach with a view to providing more realistic waiting times.	Q1 2021-22			
Action 5.1 We will pursue with our Health Informatics (HI) colleagues an improved Ambulance Dispatch Operations Log (ADOL) report so that actions taken as a result of REAP and DMP levels are more visible and able to be reported on more easily.	Q3 2020-21			
Action 5.2 The Trust will review the process of increasing DMP levels by the DCM to ensure the process is being followed and will review the findings to see if improvements can be made.	Q3 2020-21			
Action 6.1 We will review the current arrangements for managers attending the EMSCCC to ensure that this is taking place.	Q3 2020-21			
Action 6.2 We will work with the ODU on support for EMSCCC and service delivery and review a need to adjust the requirement for operational managers to report to the EMSCCC.	Q3 2020-21			
Non-Send processes are now included with the DMP Action cards in place within WAST.	Q4 2019-20			
Action 8.1 Further develop alongside Welsh government a national campaign to influence behaviour change.	Q3 2020-21			
Action 8.2 Deliver further online events with the public which describe how we operate and appropriate use of the EMS service. Encouraging use of other services which can support people, including NHS 111 Wales, its website and online symptom checkers.	Q3 2020-21			
Action 8.3 Launch a community participation network which will receive and disseminate information on key information and updates from the service. This network will receive and disseminate information on key information and updates from the service, as well as allowing members of the public to have their voices heard and be involved in shaping future service design and delivery.	Q3 2020-21			
Action 8.4 Develop and disseminate an educational video aimed at a younger audience regarding the EMS service and appropriate use of it.	Q4 2020-21			
Action 9.1 Wellbeing workshops are to be arranged for EMSCCC teams. These will focus on developing resilience in terms of sound foundations of good mental health.	Q4 2020-21			
Action 9.2 The Health and Wellbeing Strategy is currently in consultation phase and a EMSCCC specific focus group will be convened to further develop the EMSCCC contribution to that strategy	Q3 2020-21			
Action 9.3 Provide an awareness film for EMSCCC colleagues on muscular-skeletal injuries and how best to prevent them in the workplace.	Q3 2020-21			
Action 10.1 A CCC workforce plan is to be developed and maintained to align the needs and priorities of the organisation with those of our workforce to ensure we can meet service and production requirements and organisational objectives.	Q3 2020-21			
Action 10.2 We will ensure that there are sufficient plans in place for recruitment of staff to meet expected attrition and to ensure that the staffing levels do not drop to those which were being experienced during the review period.	Q2 2020-21			
Action 11.1 Work with Health Informatics (HI) colleagues to refresh analysis around welfare call demand based on new guidelines and utilise data to inform future workforce planning considerations.	Q3 2020-21			
Action 12.1 Continue with the work of the CAD Phase 3 project to realign workloads within the EMSCCC for more efficient operation.	Q4 2020-21			
A review of the triggers and actions associated with Welfare checks were undertaken with supported timescales agreed with CPAS	Q4 2019-20			
Action 14.1 The Trust has a mature and developed approach to enabling colleagues to share suggestions and views. Local measures in place include a dedicated email address for suggestions and quarterly open forums with senior managers.	Q4 2020-21			
Engagement and co-design was built into the CAD Phase 3 project and evidence of engagement sessions recorded	Q3 2019-20			
Action 16.1 Continue to support local improvement initiatives such as the POD within Aneurin Bevan.	Q3 2020-21			
Action 16.2 Continue to develop the Operational Delivery Unit business case to ensure support from the Commissioner and Welsh Government to address the flow concerns on a 24/7/365 basis.	Q3 2020-21			
Action 16.3 Develop a communications plan to share with staff what actions are being undertaken to address the issue.	Q3 2020-21			
Action 17.1 Continue to pursue the formalisation of the two EMSCCC training roles to further deliver the Dispatcher and Allocator role training courses.	Q4 2020-21			

Action 17.2 Introduce dispatch training course for all new appointments into dispatch and allocation roles and schedule any update training for all dispatchers and allocators currently in post.	Q4 2020-21			
Action 17.3 Continue to engage with HEIW to develop an accredited programme of education focussed on clinical and non-clinical remote decision making.	Q4 2020-21			
Action 18.1 Work with DCMs to ensure existing time for protected appraisal discussions is utilised effectively and scheduled in advance or look for a more appropriate way that appraisals can be carried out.	Q3 2020-21			
Action 19.1 Develop and trial an EMSCCC specific appraisal process to ensure that staff receive the appropriate developmental discussion.	Q4 2020-21			
Action 19.2 Workforce & Organisational Development team to assess the training needs of first line managers within EMSCCC to support their delivery of effective and meaningful PADR's.	Q4 2020-21			
WAST is an ACE accredited centre and regular benchmarking exercises are undertaken to support and maintain this position.	Q4 2019-20			
Action 21.1 Complete the North Wales EMS CCC estate strategy and identify opportunities for improvements.	Q4 2020-21			
Action 21.2 Complete the return to the workplace review to ensure the maximum space is still provided in the medium term for clinicians to work remotely from the EMSCCC main spaces.	Q2/3 2020-21			
Action 21.3 Undertake a review of opportunities to enhance the ICT equipment available to EMSCCC staff in order to assist colleagues to discharge their roles with greater efficacy and to enhance their wellbeing.	Q4 2020-21			
It is not possible to provide senior management availability across 3 sites within the existing management team but on call arrangements supported by development of the ODU provide escalation and support pathways for EMSCCC 24 hours a day.	Q4 2019-20			
Action 23.1 Develop in collaboration with Board Secretary, Workforce and Organisational Development (WOD) and Trade Union Partners a poster campaign promoting the All Wales Raising a Concern policy to further reinforce the position.	Q3 2020-21			
Action 24.1 Communicate schedule of engagement events for the coming year and review opportunities to engage through digital formats in the Covid environment.	Q2 2020-21			
Action 25.1 A review of the risk relating to staff training (E-risk ID 119) will be undertaken to ensure the mitigating actions are sufficient and are progressed.	Q3 2020-21			
Action 26.1 Develop and issue guidance specifically focussed at EMSCCC staff about what, when and how to report an adverse incident including guidance for managers on ensuring feedback is completed.	Q2 2020-21			
The existing Datix system provides a suitable reporting system which includes a feedback route for staff.	Q3 2019-20			

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	Qtr Due	Due	Complete	Outstanding	% complete
Actions	Q1 2019/20	0			
	Q2 2019/20	0			
	Q3 2019/20	2	2	0	100.00%
	Q4 2019/20	5	5	0	100.00%
	Q1 2020/21	0	0	0	n/a
	Q2 2020/21	4	4	0	100.00%
	Q3 2020/21	20	14	6	70.00%
	Q4 2020/21	12	4	8	33.33%
	Q1 2021/22	1	0	1	0.00%
		44	29	15	65.91%



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Gwasanaethau Ambiwylans Cymru
Welsh Ambulance Services
NHS Trust

AGENDA ITEM No	15
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	2

AUDIT REPORT

MEETING	Quality, Patient Experience and Safety Committee
DATE	11 th August 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 the Quality, Patient Experience and Safety Committee (QuEST) with an update in relation to recommendations resulting from Internal Audit reviews.
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.

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. **Receive one current Internal Audit Report relevant to the Committee.**
 - d. **Consider the Trust's proposals to address each recommendation with the inclusion of revised completion dates, specifically those relevant to QuEST.**
 - e. **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 – 26th June 2022

REPORT APPENDICIES

6. The Audit Tracker has been circulated as a separate document – Appendix 1.

7. Respiratory Protective Equipment Internal Audit Report – Appendix 2.

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 2021/22

6. There is one current internal audit report relevant to the QuEST which form part of the 2021/22 Internal Audit Plan. This report is attached as Appendix 1 in relation to the following review:

Internal Audit Report	Assurance Rating	Date received at Audit Committee
Respiratory Protective Equipment Internal Audit Report	Reasonable	June 2022

Internal Audit Plan 2022/23

7. 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

8. At the time of issuing the paper, there were a total of 95 current internal audit recommendations on the tracker. 27 recommendations were marked as complete at the June 2022 Audit Committee and removed from the tracker.
9. 33 recommendations were added to the tracker resulting from 7 Internal Audit Reports which were presented to the Audit Committee in June 2022. 9 of these recommendations were assigned to QuEST for oversight and were from a Reasonable Assurance rated report.
10. 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	49	13	3	10	0
Not yet due*	37	7	0	7	0
Complete	9	0	0	0	0
Total	95	20	3	17	0

* accepting extensions have been applied in line with the agreed pandemic arrangements.

11. There are 3 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 2 related to the Respiratory Protective Equipment review.
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	15	0	0	0	0
2021/22	77	20	0	13	7
Total	95	20	0	13	7

13. The remaining 13 recommendations showing as overdue relate to the following reports:
 - 21/22 Role of Advanced Paramedic Practitioner
 - 21/22 Controlled Drugs
 - 21/22 Information Management Hear and Treat

- 21/22 Respiratory Protective Equipment

14. 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	12	0	0	0	0
Reasonable	77	20	3	17	0
Substantial	0	0	0	0	0
Not Rated	6	0	0	0	0
Total	95	20	3	17	0

15. 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:

16. **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) Receive one current Internal Audit Report relevant to the Committee.**
 - d) Consider the Trust's proposals to address each recommendation with the inclusion of revised completion dates, specifically focussing on those relevant to QuEST, and**
 - e) Agree any specific items that the Committee wishes to see raised to Senior Management and Audit Committee.**

Respiratory Protective Equipment Final Internal Audit Report

May 2022

Welsh Ambulance Services NHS Trust



Partneriaeth
Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services
Partnership
Audit and Assurance Services



Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
NHS Trust



Contents

Executive Summary	3
1. Introduction	4
2. Detailed Audit Findings	4
Appendix A: Management Action Plan	13
Appendix B: Assurance opinion and action plan risk rating	21

Review reference:	WAST-2122-021
Report status:	Final
Fieldwork commencement:	27 th January 2022
Fieldwork completion:	6 th April 2022
Draft report issued:	20 th April 2022
Debrief meeting:	4 th May 2022
Management response received:	3 rd May 2022/20 th May 2022
Final report issued:	23 rd May 2022
Auditors:	Simon Cookson, Director of Audit & Assurance Osian Lloyd, Deputy Head of Internal Audit Jonathan Jones, Audit Manager
Executive sign-off:	Wendy Herbert, Interim Director of Nursing & Quality
Distribution:	Jonathan Turnbull-Ross, Assistant Director of Quality Governance, Judith Bryce, Assistant Director of Operations (National Operations & Support) Louise Colson, Head of Infection Prevention & Control
Committee:	Audit Committee



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

Acknowledgement

NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - please note

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of NHS Wales Audit and Assurance Services, and addressed to Non-Executive Directors or officers including those designated as Accountable Officer. They are prepared for the sole use of Welsh Ambulance Services NHS Trust and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Executive Summary

Purpose

To review that there are adequate arrangements in place for the provision of Respiratory Protective Equipment (RPE).

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Gaps identified in local records for Fit test records and device maintenance logs.
- Consideration needed to development of a sustainable Fit testing model.
- Amendments to SOP to incorporate monitoring (RPE) and Continuous Personal Development (Fit testing) requirements.

Report Classification

Reasonable



Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Trend

N/a

Assurance summary¹

Assurance objectives	Assurance
1 Policies and procedures	Reasonable
2 Executive and operational responsibilities	Reasonable
3 Training and QA resourcing	Reasonable
4 Compliance with policies and procedures	Limited
5 Reporting arrangements	Limited

Key matters arising

	Assurance Objectives	Control Design or Operation	Recommendation Priority
1 RPE Monitoring arrangements	1	Design	Medium
2 Fit tester Continuous Personal Development	2	Design	Medium
3 Quality Assurance Outcomes	3	Operation	Medium
4 Resource to address Fit testing	3, 5	Design	Medium
5 RPE Maintenance Logs & Fit test Records	4	Design	High
6 RPE Reporting	5	Design	Medium

¹ The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

1. Introduction

- 1.1 The Health and Safety at Work Act 1974 requires employers to prevent or control the exposure of employees to hazardous substances at work. As a result of the Covid-19 pandemic demand for Respiratory Protective Equipment (RPE) and required training increased substantially.
- 1.2 RPE can come in many forms, including FFP3 disposable masks to powered full/half hoods. The effectiveness of face fitting masks is dependent on ensuring good contact between the wearer and the face seal of the equipment. There can also be variations in fit across the various manufactures and models available.
- 1.3 Health and Safety Executive (HSE) guidance *INDG479 Guidance on respiratory protective equipment fit testing* states that RPE should be subject to a Fit test and that this should be undertaken by a competent tester.
- 1.4 In July 2020 the Trust identified a risk (ID322) relating to a lack of compliance in terms of the provision of competent registered Fit testers within the Trust, noting weak management and governance in relation to RPE testing and training across the organisation.
- 1.5 A Programme of Improvement work was initiated under the Head of Infection Prevention and Control (IPC). This captured a number of actions including external British Safety Industry Federation accreditation for a small number of Fit testers within the IPC team.
- 1.6 The September 2021 meeting of the Trust's Quality, Patient Experience and Safety (QUEST) committee received an update indicating progress with the improvement plan and that further consideration of the longer-term strategic approach to Fit testing was underway.
- 1.7 The key risk considered in this review is a lack of compliance with statutory regulations leading to staff harm and associated financial and reputational implications.
- 1.8 The audit excluded review of RPE stock ordering or distribution processes.

2. Detailed Audit Findings

Audit objective 1: The Trust has approved policies and procedures related to Respiratory Protective Equipment and these are available to staff.

- 2.1 Fit testing within the Trust over the last twelve months has been required on an extensive basis due to the pandemic; this has been exacerbated by the frequent changes in RPE available through supply chains, resulting in provision of multiple models and new equipment requiring additional fit tests.
- 2.2 There are four key Trust documents which relate to Respiratory Protective Equipment. These include the *Infection Prevention & Control Policy: Elimination of Healthcare Associated Infections*, *Covid-19 Guidance – Infection Protection &*

Control (IPC) & Personal Protective Equipment (PPE) guidance document, Respiratory Protective Equipment Standard Operating Procedure, and Fit Testing Standard Operating Procedure.

- 2.3 The latest version of the Trust IPC policy is version 1.4 and was issued in September 2020. Within the policy, section 6.5 '*Personal Protective Equipment*' includes a number of headline instructions on the use of RPE, including that staff should only use masks for which they have been fit tested and should undertake a fit check ahead of each use. Further direction is noted through the listing of the RPE SOP under the heading '*To be read in conjunction with*' of related policies and procedures.
- 2.4 To support the overarching IPC Policy the Trust also has a specific *Covid-19 IPC/PPE Guidance* document which reflects nationally issued guidance. It contains IPC control measures for health and social care organisations based upon the current pandemic threat level and contains a hyperlink to the current RPE SOP.
- 2.5 Version 2.3 of the RPE SOP was approved by the Senior Pandemic Team (SPT) on 4th November 2021. The document seeks to provide clarity of terminology, risks and agreed principles when selecting appropriate RPE. The SOP states that '*All staff will be FFP3 Fit tested by competent fit testers following the standards as set out by the Health & Safety Executive (HSE),*' and the HSE definition of competency is also included as is reference to the Trust's Fit Testing SOP. Section 8 includes information related to each type of mask available/in use within the Trust, covering background and reference to the Trust PPE level, cleaning and decontamination/filter guidance where applicable, including links to training videos. The SOP includes 10 appendices which support these areas through inclusion of picture guides/instructions/charts, documentation to be retained to support use, and a list of high consequence infectious diseases where use of RPE would be appropriate.
- 2.6 Earlier versions of the RPE SOP had included within in it guidance on the Fit testing process. However, for practicality and ease of use, a dedicated Fit Testing SOP has been introduced. The current version 1.4 was approved by SPT on 26th April 2021. It contains further details on the HSE competent person definition, noting they should be appropriately trained, qualified and experienced in either quantitative (use of a portacount machine) or qualitative (subjective assessment of sweet/bitter aerosol). The SOP provides detailed guidance across the mask types available to staff within the Trust and direction to appendices which contain staff records and maintenance documentation alongside training materials.
- 2.7 HSE Operational Circular 282/28 '*Fit Testing of Respiratory Equipment Facepieces*' provides advice and guidance related to the suitability of Fit testing methods and results, including inspection. We compared this guidance against the Trust SOP and found the Trust has established documentation which is consistent with the guidance. We note the circular states that inspectors should check that the '*fit test is valid and does relate to the correct RPE and the wearer. Checks should be carried out to establish the authenticity of the fit test certificate*'. The Trust's RPE

SOP includes a section on monitoring arrangements, but these are limited to the overall number of staff tested/trained. **See MA1**

- 2.8 All guidance and SOP documents are available within the IPC section of the Trust's intranet site. However, the IPC Policy listed is the previous version (1.3), which does not contain a link to the RPE SOP. This is raised for management information.

Conclusion:

- 2.9 The Trust has established policies and procedures to support the selection, Fit testing and use of RPE. We have highlighted one area where additional clarity of future monitoring would be beneficial and assign this objective **Reasonable** assurance.

Audit objective 2: Executive and operational responsibilities are clearly defined ensuring accountability.

- 2.10 We note a high level of consistency of content across both documents in outlining Executive responsibilities. The Executive Director of Nursing & Quality has delegated responsibility for IPC, and as such the directorate is responsible for the provision and content of training. We note a small enhancement within the Fit Testing SOP that this training be provided by 'competent' trained staff.
- 2.11 Operational management has responsibility for identifying those staff who will need RPE, and for ensuring training records are retained and entered on ESR. We note that Fit test provision is not explicitly outlined, but is arranged by local management. Responsibility for selection or nomination of staff to undertake Fit testing is not outlined within the SOP, but we understand this is at local management discretion, we later discuss the model for delivery at 2.24-30.
- 2.12 Individual members of staff are responsible for undertaking training and, following issue of a device, to maintain, clean and store their equipment. Staff should also inform their manager of any facial changes which would require a re-test. The need to undertake a self-fit check and to check their device prior to use is also outlined.
- 2.13 Continued Personal Development (CPD) requirements are outlined within the RPE SOP. The Trust has adopted a three-year period for staff to be retested, which is to be managed by operational teams. We note that the Fit Testing SOP refers to re-testing every three years, but not to any specific competency related requirements for Fit testers, although discussion with the IPC team indicate an annual review will be undertaken. **See MA2**
- 2.14 We note that monitoring and reporting arrangements outlined within the SOPs are limited. Within the RPE SOP it includes reporting training compliance, through the Trust's Quarterly Assurance Report. There is no reference to ongoing performance or quality measurement. This is also the case for the Fit Testing SOP, which also does not set out any future CPD requirements for Fit testers. **See MA2**

- 2.15 Discussion with IPC team members indicated that updates to SOP and associated documentation/templates have been communicated through 'Siren' announcements; a review of the Trust intranet confirms this has been the case.

Conclusion:

- 2.16 Our review of the relevant SOP notes that there is an outline of responsibilities and accountabilities. However, we did identify a gap related to the review and CPD requirements of the Fit Testing SOP. Noting this we assign this objective **Reasonable** assurance.

Audit objective 3: Training requirements and quality assurance mechanisms are resourced appropriately.

- 2.17 Fit testing has historically been provided on a 'train the trainer' model within the Trust, and those providing Fit tests do so alongside their substantive duties or whilst on alternative duties for a relatively short period of up to 12-16 weeks. This provides a challenge in maintaining practice and standards and alone this would not meet the HSE definition of competent. There was also no follow up review of those who were providing tests and so little assurance that standards had been maintained.
- 2.18 Within the RPE SOP it is outlined that "*All staff will be FFP3 Fit tested by competent fit testers following the standards as set out by the Health & Safety Executive (HSE).*" HSE guidance notes that competence can be demonstrated through achieving accreditation under the Fit2Fit RPE scheme developed by the British Safety Industry Federation (BSIF). Two members of the IPC team have gained this accreditation and are responsible for ensuring that training material and processes within the Trust meet accredited standards.
- 2.19 The IPC team has produced training materials/action cards which address the three mask types currently in use (FFP3 Disposable, Corpro Half Mask, Versaflo Powered Hood), and the two Fit testing methods (qualitative and quantitative). These provide guidance across selection, donning, doffing, device maintenance/cleaning and documentary requirements. These are available through the Microsoft Teams channel established for Trust Fit testers, which also contains supporting record keeping forms.
- 2.20 The team has developed matching quality assurance (QA) action cards when reviewing the competence of Fit testers and there is evidence of refinement and enhancement in response to the identification of good practice. Timings for each competency have been shared but there are a number of factors which can impact the length of a review, particularly where refresher training is needed by the Fit tester.
- 2.21 Information was sourced from ESR in early 2021 to support the establishment of a quality assurance programme for review of active Fit testers. Discussion with the team outlined that there were difficulties encountered due to input errors where those Fit tested were entered as Fit testers. Additionally, ESR included

those who were Fit tested whilst on alternative duties but had now returned to substantive roles. Contact was also made with Locality Managers directly to confirm those undertaking Fit testing currently, although few direct responses were received.

- 2.22 The team now maintains an email distribution list of active Fit testers based upon the responses from Locality Managers and the those who have been initially trained by the team. A spreadsheet record of Fit testers who have received a quality assurance review has also been populated and maintained. An early opportunity to assess operational Fit testing had taken place in May 2021. However, the majority of assessments were undertaken during November and December 2021, following the team gaining its accreditation. At the time of our fieldwork, the team's spreadsheet held 52 Fit testers, of which 44 have been undertaken since accreditation.
- 2.23 We note that progress in the roll out of the programme was impacted by the need to support the Fit test of around 300 military staff deployed to support the Trust in January 2022. We were also informed that the release of operational staff during the recent REAP escalation had also been a challenge, alongside making arrangements to cover the organisation as the two accredited members are based in North Wales and Pembrokeshire. The complexities of the Fit testing process can also mean the team continues to support those who have been quality assured for some time, where further support has been requested by the Fit tester.
- 2.24 Discussion with the team also highlighted that they have modified initial practice from group QA to individual review, having noted group sessions negatively impacted response and practical assessment. The team also noted that where staff had not undertaken Fit testing for some time there was a deficiency of practice and, despite training materials being circulated ahead of assessment, gaps in knowledge.
- 2.25 The turnover of staff providing Fit testing provision is high as they usually no longer perform testing once they return to their normal duties; thus, their skills competency in fit testing diminishes. Discussion with the IPC team highlighted a number of instances of 'skillfade' where additional refresher training has been required to support a Fit Testers QA review. The team have also asked Fit testers to refrain from undertaking the role where concerns over practice and approach have been identified.
- 2.26 We sampled five records from the team's local spreadsheet and completed QA assessments could be provided for four. One assessment was record on a training action card as opposed to a QA form. All records were signed by a Fit tester and IPC team member. The forms contain prompts for the capture of the number of tests/retests and pass mark, but we note only an overall pass was captured. Forms did contain narrative outline of areas that require addressing, but we note the spreadsheet in use does not include this detail. **See MA3**
- 2.27 ESR now includes competencies for those Fit testers who have been assessed by the IPC team. Whilst not all of those within the team's spreadsheet have been

added, we note that review of the ESR report did not identify any entries not on the spreadsheet.

- 2.28 We were informed there will be a requirement for the team to provide an annual assessment of those Fit testers that have been reviewed previously. As there are still around 50+ Fit testers who are yet to be assessed, and the team continues to provide support for standard fit test training, it is unclear if there are adequate resources currently available to fulfil the SOP objective that all Fit testers meet the competency requirement. At the time of our fieldwork there was a focus on supporting the South East territory, but that requests received were for training fit testers in that region rather than for the QA of testers. **See MA4**
- 2.29 There have been discussions on future models for the provision of competent Fit testers within the Trust, necessary to provide safe respiratory protection for staff. An options paper developed for SPT recognised Fit testers need to be the experts within this field, having a broad and deep competence in terms of knowledge, skill and experience, through practice and education. It also highlighted the challenges to attain this with the Trust's current model which is not sustainable as it does not provide resilience in this provision.
- 2.30 The options paper estimated a requirement of 7,000 hours of fit testing across a 3-year schedule, on the basis that there are 3,000 patient facing staff within the Trust and 500 Community First Responders. We were informed that a decision had not been progressed and at the time of our fieldwork a further options paper was under consideration but that it was unlikely that additional funding would feature to support arrangements. **See MA4**

Conclusion:

- 2.31 Following IPC accreditation there has been development of training materials and a quality assurance programme to support the Trust approach to Fit Testing and the HSE competency definition. The current model makes the ongoing delivery of the programme difficult, but noting the progress in this area we assign the objective **reasonable assurance**.

Audit objective 4: Mechanisms are in place to capture compliance with Trust policies and procedures.

- 2.32 Objectives within the RPE SOP include clarity on terminology, the level of RPE that should be applied and provides guidance to staff for the decontamination and maintenance of reusable RPE. The SOP contains links to both manufacturer and Trust training videos on assembling and cleaning devices.
- 2.33 ESR reports are available to support the monitoring of Emergency Medical Services (EMS) and Non-Emergency Patient Transport Services (NEPTS) staff tested. Reports produced at the end of January 2022 indicated high levels of compliance across the Trust, with EMS reporting 94.65% and NEPTS 88.69%.
- 2.34 Whilst the QA programme provides a mechanism for the review of Fit testers, there is currently no routine check of standard Fit test documentation. Within

recent updates to the SOP there has been the inclusion of template maintenance logs to demonstrate devices are being used in accordance with manufacturers' guidance.

- 2.35 HSE guidance (Respiratory protective equipment at work – HSG53) notes that maintenance is a requirement for all reusable RPE and where use is occasional examination and testing of equipment should be carried out at least every three months. Additionally, the guidance includes a number of key points such as the need to follow manufacturers' instructions, keep records of examination and testing, and ensure maintenance intervals are appropriate.
- 2.36 Within recent updates to the RPE SOP there has been the inclusion of template maintenance logs to demonstrate devices are being used in accordance with manufacturers' guidance. We note use of Siren in April 2021 to issue a notice from the Director of Operations reminding staff of the need to check equipment prior to each use, follow the guidance within the RPE SOP and undertake and document maintenance checks on the provided templates.
- 2.37 Using ESR as a source record, we requested Fit test records and associated maintenance logs for five staff across four separate localities. Noting current operational pressures we undertook a limited sample.
- 2.38 We received 13 of the 20 requested records. Of those that were not provided:
- Three Fit tests not retained within locality records;
 - Two records not were available (but alternative dates/devices could be provided);
 - one was noted as no record of staff member within the locality records; and
 - one staff transfer with record outstanding at time of closing fieldwork.
- 2.39 Review of the Fit test records provided highlighted three did not contain details of the device (batch number) of the issued Corpro device (linkage between record and device is a HSE requirement), whilst another six contained gaps in completeness regarding any re-tests which were required. **See MA5**
- 2.40 Only four of the 20 maintenance logs requested were provided. Of these, one log was blank and the remaining three contained only one entry covering filter use. No entries were supplied to support monthly equipment checks, suggesting that use of the log may not be embedded in everyday practice. Responses received indicated that staff were not aware of the requirement to log usage. HSE guidance notes that records of equipment maintenance in line with manufacturer's instructions should be retained. **See MA5**
- 2.41 The IPC team presentation to the Strategic IPC group in January 2022 highlighted that there is awareness that maintenance logs are not being used consistently across the Trust. Discussion with the team outlined that electronic records and logs have been developed to support operational use, but these are still in development. **See MA5**

Conclusion:

- 2.42 The Trust has high overall compliance for staff Fit testing, and our request of records supports that there is some compliance with Fit test record keeping. However, maintenance logs for devices and filters were not available for 16/20 staff. The IPC team are developing electronic recording options to support this but these are not currently rolled out and so we assign this objective **limited** assurance.

Audit objective 5: The Board receives assurance on compliance, with appropriate escalation mechanisms in place.

- 2.43 Discussion with the Head of IPC indicated that the Strategic IPC Group would be the forum which received reporting related to RPE. The group had primarily been stood down as a result of the operational pressures brought on due to the Covid-19 pandemic but has met in May 2021 and January 2022. We note both these meetings received updates related to the Fit testing programme but did not provide information relating to overall compliance or performance. **See MA6**
- 2.44 The Strategic IPC group has revised terms of reference which include that highlight reports from the group would be provided to the Clinical Quality Governance Group, which in turn will report to the QUEST committee. At the time of fieldwork, no Clinical Quality Governance Group meetings had taken place, however we note an IPC Highlight report was provided to the Assistant Directors Leadership Group in February 2022. The report listed RPE under the alert/escalate category, noting the impact of supporting military personnel with Fit testing and general issues around access to operational Fit testers. As with the information to the Strategic IPC group, there was no detail on overall compliance/performance included. **See MA6**
- 2.45 The Head of IPC raised a risk due to the lack of compliance with Health and Safety regulations relating to competent Fit testers (ID322) in July 2020. The risk was initially rated at 15, but following the improvement programme including accreditation, review of documentation and the start of the QA programme the risk was closed due to meeting its target score in December 2021. Discussion with the Head of IPC indicated that there is consideration of including a new risk related to the long term provision and resourcing of Fit testing, but at the time of fieldwork this risk had not been added to Datix.
- 2.46 We note that longer term provision of Fit testing was outlined within an 'Options' paper provided to the Senior Pandemic Team and a number of models were outlined to support the longer term strategic approach to delivery. We have not identified any further progress in this area, and whilst we could confirm Fit testing has been included within the Trust's Working Safely Programme, no detail on next steps was available at the time of our fieldwork. **See MA4**
- 2.47 A report provided to QUEST Committee in September 2021 had included the risk assessment, alongside copies of the SOPs, training and documentary materials. The report was welcomed by the Committee, with members noting it demonstrated the Trust's emphasis on protecting both staff and the public.

Conclusion:

2.48 There have been updates provided to the Strategic IPC group and QUEST committee relating to the improvement programme, and there is a clear line of reporting available for escalation should it be required. However, we note that reporting has focused on programme improvements, but is yet to be followed by information related to ongoing performance. As such we assign this objective **limited** assurance.

Appendix A: Management Action Plan

Matter arising 1: RPE monitoring arrangements (Design)

Impact

The Health and Safety Executive has issued an operational circular to support the Fit testing of Respiratory Protective Equipment Facepieces (OC 282/28). We note paragraph 10 (3) outlines that HSE inspections would include checks to confirm that the Fit test certificate is valid, relates to the RPE issued, and that the device is clean and well maintained.

Potential risk of:

- Insufficient monitoring arrangements.

The Trust RPE SOP includes an outline of monitoring arrangements, which include the results of Fit testing being recorded via the Electronic Staff Record and compliance levels to be reported. However, it does not include requirements for checks to be undertaken following the Fit test or mechanisms for ongoing review of Fit test records or device maintenance.

Recommendations

Priority

- 1.1 Consideration should be given to establishing future monitoring arrangements related to RPE/Fit testing, to provide a mechanism for ongoing assurance on RPE issued and its maintenance.

Medium

Management response

Target Date

Responsible Officer

- 1.1 The RPE SOP (page 13) includes narrative on audit requirements of RPE. The RPE SOP will be reviewed to incorporate quality inspections to be undertaken by members of the IPC Team; this will be scheduled within the IPC Audit Work Programme.

June 2022

Louise Colson, Head of Infection Prevention & Control

Matter arising 2: Fit Testing CPD (Design)**Impact**

The RPE SOP includes that repeat Fit testing for staff is recommended on a 3 yearly basis, and this should be managed operationally through continued personal development. The Fit Testing SOP does not include an equivalent outline of how frequently Fit testers should receive a follow up review or assessment. Discussion with the IPC team indicated that this would likely be on an annual basis.

Potential risk of:

- CPD requirements not documented.

We also note that whilst there is an outline of summary monitoring and reporting routes within the RPE SOP, no performance or quality measurements for Fit testing, or further reporting is included within the SOP.

Recommendations**Priority**

- 2.1 Ongoing CPD requirements for Fit testers should be confirmed and reflected within the Fit Testing SOP.
- 2.2 Management should consider developing relevant performance or quality measurements related to the provision of Fit testing, and document appropriate reporting measures for these within the SOP.

Medium**Management response****Target Date****Responsible Officer**

- | | | | |
|-----|---|----------------|---|
| 2.1 | The Fit Testing SOP will be reviewed and amended to outline the refresher/update requirements of Fit Testers, including the frequency of such activities. | June 2022 | Louise Colson, Head of Infection Prevention & Control |
| 2.2 | As part of pandemic recovery, the IPC team will establish arrangements for business as usual performance measures. A Fit Testing/RPE quality performance framework will be developed; a reference will be incorporated into the Fit Testing SOP. Due to the nature of the proposed information system, the target date from completion is September 2022. | September 2022 | Louise Colson, Head of Infection Prevention & Control |

Matter arising 3: Quality Assurance outcomes (Operation)	Impact	
<p>We note that comprehensive quality assurance action cards have been created to support the review of Fit testers. The format of these include an outline of areas repeated or where improvement/retesting was required. Currently the spreadsheet in use to support the quality assurance process captures limited details on the assessment, such as date of review and a 'notes' column which has inconsistent usage. Modification to include outcomes could support future reporting across themes or areas of inconsistent practice.</p>	<p>Potential risk of:</p> <ul style="list-style-type: none"> Detail on outcomes and themes not captured formally. 	
Recommendations	Priority	
<p>3.1 The IPC team monitoring spreadsheet should be modified to capture outcomes and include any areas of repeat inconsistent practice.</p>	<p>Medium</p>	
Management response	Target Date	Responsible Officer
<p>3.1 The recommendation is accepted. The Quality Assurance Tool will be redesigned utilising a new information system, ensuring IPC staff undertaking inspection/checks enter required information. Additionally, this will improve consistency for report.</p>	<p>June 2022</p>	<p>Louise Colson, Head of Infection Prevention & Control</p>

Matter arising 4: Resource to address Fit Testing (Design)**Impact**

Challenges to the current and future delivery of quality assuring all Fit testers within the Trust are complicated by the current model, which can include staff on temporary alternative duties or is undertaken voluntarily which can result in the tester withdrawing from practice at any time. The quality assurance programme has reviewed around half of the testers, however progress in this area is impacted by the cycle of changes in Fit testers and the team providing operational support to train new testers.

Potential risk of:

- Detail on outcomes and themes not captured formally.

A paper prepared for the Senior Pandemic Team in 2021 estimated that over a three year period up to 7000 hours of Fit testing would be required to comply with HSE legislation. The paper outlined possible options including:

- Retain current model with risk that compliance would not be achieved
- Establish a dedicated Fit test team
- Incorporation of Fit testing into the Workforce and OD welfare team
- Incorporation into the Duty Office Manager portfolio
- Incorporation into the Resilience team as part of the Make Ready Establishment.

No update could be provided on the outcome from the above paper, and at the time of fieldwork arrangements were again subject to review.

Recommendations**Priority**

- 4.1 We recommend the Trust refreshes the above paper in light of the challenges in meeting the requirement to quality assure all Fit testers under its current model.
- 4.2 Recognising the challenges in delivery of the quality assurance programme due to operational pressures, we recommend that the programme be recommenced with progress updates provided to the Strategic IPC group on a regular basis.

Medium**Management response****Target Date****Responsible Officer**

- 4.1 A report will be provided to the Clinical & Quality Governance Group on the output of the Quality Assurance programme recently undertaken. Furthermore, it will outline proposal for the emerging risk of sustainable fit testing across the Trust. A cross-directorate position on a sustainable Fit Testing model will be developed.
- September 2022
- Louise Colson, Head of Infection Prevention & Control

4.2 A regular update on the quality assurance programme will be provided to IPC Strategic Group on a routine basis. This will commence from the next diarised Strategic Group meeting in October 2022.

October 2022

Jonathan Turnbull-Ross,
Assistant Director of Quality
Governance

Matter arising 5: RPE Maintenance Logs & Fit testing records (Design)**Impact**

HSE guidance requires that reusable RPE receive regular examination and testing, and that this should be recorded and undertaken at regular intervals. The RPE SOP includes a *decontamination, filter and maintenance log*. The document supports recording of:

- Filter usage and rest time.
- Monthly maintenance to filter, facepiece, straps and other equipment aspects.
- Decontamination and sanitising log.

As part of our fieldwork we requested the above documentation for 20 EMS staff based across four localities. Only four filter logs were provided, and of these one was blank and the remaining logs held only one entry each. No monthly maintenance record or decontamination log were supplied.

The IPC team are developing electronic resources to replace the paper documents to assist with ongoing recording, but these were still to be issued at time of fieldwork.

Additionally, we requested related Fit test records for the staff above, with only 13 records available to support entries made within ESR. Noting the Trust's current high compliance reported for EMS and NEPTS staff this could indicate wider noncompliance with Trust SOPs or gaps in record keeping.

Potential risk of:

- Noncompliance with recording of maintenance and decontamination logs
- Noncompliance with record keeping requirements/SOP

Recommendations**Priority**

- 5.1 The Trust should progress with the development of electronic resources to support the recording of RPE maintenance and decontamination and prioritise the distribution of these alongside guidance for use.
- 5.2 The Trust should consider mechanisms to monitor and provide assurance on compliance with the documentary requirements of the RPE and Fit Testing SOPs.

High**Management response****Target Date****Responsible Officer**

- 5.1 The Trust will finalise development of the digital maintenance log, and issue its release for use to the workforce. The distribution of information to the workforce will be undertaken through the Operations Directorate leadership structures.

May 2022

Louise Colson, Head of Infection Prevention & Control / Judith Bryce, Assistant Director of Operations National Operations & Support






5.2 The RPE SOP and Fit Testing SOP will be reviewed to incorporate arrangements for the formal monitoring of compliance. This will be considered by the Operations Directorate leadership structures, and through the Clinical & Quality Governance Group, which will sit in June 2022.	June 2022	Louise Colson, Head of Infection Prevention & Control / Judith Bryce, Assistant Director of Operations National Operations & Support
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Matter arising 6: RPE Reporting (Operation)	Impact	
<p>The Strategic IPC Group has been stood down as a result of the operational pressures of the Covid-19 pandemic, although two meetings have taken place in May 2021 and January 2022. Agendas confirm that meetings received updates against the Fit testing Programme, but we note these provided outlines of progress in action rather than metrics on performance.</p>	<p>Potential risk of:</p> <ul style="list-style-type: none"> Lack of scrutiny on delivery and progress 	
Recommendations	Priority	
<p>6.1 There is a need to further outline the performance or quality outcomes for RPE and Fit testing and we would note there is opportunity to establish areas for monitoring to allow for any necessary escalation through the Trust's structure as appropriate.</p>	<p>Medium</p>	
Management response	Target Date	Responsible Officer
<p>6.1 A routine agenda item on performance metrics will be added to the IPC Strategic Group Meeting agenda; from the next diarised meeting (October 2022). Management response action 2.2 and 5.2 will support delivery of data reporting.</p>	<p>October 2022</p>	<p>Jonathan Turnbull-Ross, Assistant Director of Quality Governance</p>

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	Substantial assurance	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable assurance	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited assurance	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	No assurance	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Assurance not applicable	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.



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GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Gwasanaethau Ambiwylans Cymru
Welsh Ambulance Services
NHS Trust

AGENDA ITEM No	16
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	2

NHS Wales National Clinical Audit and Outcome Review Plan 2022/23
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MEETING	Quality, Patient Experience and Safety Committee
DATE	11 th August 2022
EXECUTIVE	Director of Paramedicine
AUTHOR	Head of Clinical Audit & Effectiveness
CONTACT	Kevin Webb Kevin.webb@wales.nhs.uk

EXECUTIVE SUMMARY
<p>The Clinical Directorate has received a request to review our contribution to the NHS Wales National Clinical Audit and Outcome Review Plan - Annual Rolling Programme for 2022/23 and provide the organisation's position. This is required to provide assurance to the Trust Board.</p> <p>The National Clinical Audit and Outcome Annual Review Plan (Annex 1) is an annual rolling programme confirming those clinical audits which Health Boards and Trusts are expected to participate in (<i>where they provide the service</i>)</p> <p>RECOMMENDED: That the committee:</p> <ol style="list-style-type: none"> a. Note the update for the NHS Wales National Clinical Audit and Outcome Review Plan b. Approve the WAST Q1 Clinical Audit Programme c. Confirm the submission route and frequency for approving the WAST Clinical Audit Programme

KEY ISSUES/IMPLICATIONS
<p>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.</p> <p>However, as an example, WAST does contribute indirectly to the Myocardial Ischaemia National Audit Project (MINAP), the Sentinel Stroke National Audit Programme (SSNAP) and the Trauma Audit & Research Network (TARN) as data from Patient Clinical Records is used to inform these.</p> <p>WAST has an annual Clinical Audit Programme updated on a quarterly basis which is reviewed by the Clinical Intelligence Assurance Group (CIAG).</p> <p>The Terms of Reference for this Committee provides that it approves the annual clinical audit plan that meets the standards set for the NHS in Wales, reviews the</p>

outcomes of clinical audits in line with the clinical audit plan, and provides assurance to the Audit Committee in this respect.

REPORT APPROVAL ROUTE

Clinical Services Directorate Business Meeting 29th June 2022
Quality, Patient Experience and Safety Committee – 11th August 2022

REPORT APPENDICES

NHS Wales National Clinical Audit and Outcome Review Plan 2022/23
WAST Clinical Audit Programme Q1 2022/23

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

SITUATION

1. The Clinical Directorate has received a request to review our contribution to the NHS Wales National Clinical Audit and Outcome Review Plan - Annual Rolling Programme for 2022/23 and provide the organisation's position. This is required to provide assurance to the Trust Board.

BACKGROUND

2. The National Clinical Audit and Outcome Annual Review Plan (Annex 1) is an annual rolling programme confirming those clinical audits which Health Boards and Trusts are expected to participate in (***where they provide the service***)
3. The plan also confirms how the findings from audits and reviews will be used to measure and drive forward improvements in the quality and safety of healthcare services in Wales.

ASSESSMENT

4. 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. However, as an example, WAST does contribute indirectly to the Myocardial Ischaemia National Audit Project (MINAP), the Sentinel Stroke National Audit Programme (SSNAP) and the Trauma Audit & Research Network (TARN) as data from Patient Clinical Records is used to inform these.
5. There are occasionally condition specific audit titles included in the National Clinical Audit and Outcome Annual Review Plan that could suggest audit topics for WAST. As the criteria used for the National Clinical Audit and Outcome Annual Review Plan differs due to the type of care being delivered e.g., in-hospital, if these audit titles are considered by WAST then specific pre-hospital criteria is decided on.
6. The Terms of Reference for this Committee provides that it approves the annual clinical audit plan that meets the standards set for the NHS in Wales, reviews the outcomes of clinical audits in line with the clinical audit plan, and provides assurance to the Audit Committee in this respect.
7. WAST has an annual Clinical Audit Programme (Annex 2) which is a dynamic document, updated on a quarterly basis and reviewed by the Clinical Intelligence Assurance Group (CIAG). The CIAG also monitors the action plans monthly as a result of learning from each of the clinical audits. These are then shared with other groups and committees as required.
8. As ePCR becomes further embedded into clinical practice and the data is better understood, there may be opportunities for WAST to directly provide data for the national audit programme if required. Future bulletins from the

NHS Wales National Clinical Audit and Outcome review Plan will be similarly reviewed.

RECOMMENDED: That

The committee:

- a. Note the update for the NHS Wales National Clinical Audit and Outcome Review Plan
- b. Approve the WAST Q1 Clinical Audit Programme
- c. Confirm the submission route and frequency for approving the WAST Clinical Audit Programme

EQUALITY IMPACT ASSESSMENT

Not required

REPORT CHECKLIST

Issues to be covered	Paragraph Number (s) or “Not Applicable”
Equality Impact Assessment	Not applicable
Environmental/Sustainability	Not applicable
Estate	Not applicable
Health Improvement	Not applicable
Health and Safety	Not applicable
Financial Implications	Not applicable
Legal Implications	Not applicable
Patient Safety/Safeguarding	Not applicable
Risks	Not applicable
Reputational	Not applicable
Staff Side Consultation	Not applicable



Clinical Audit Programme

2022/2023

Quarter 1

(Last updated 6th July 2022)



The development of this annual programme takes into consideration a number of aspects including the resources available both in terms of funding and skills. As is often the case in healthcare there are substantially more requests for clinical audits than there are resources available to manage them. For this reason, it has been necessary to tailor the programme so that it is realistic, achievable and that expectations are not overreached.

The programme is developed in consultation with the Clinical Audit Team, and senior clinical, and non-clinical managers within the Trust. It is expected that managers will ensure there is an opportunity for staff at all levels to contribute to the development of the core programme and undertake clinical audits.

Following requests to undertake clinical audits, a proposal form will be provided allowing the aims, objectives, author and a sponsor to be identified, along with the necessary data and level of support required from the Clinical Audit Team.

The decision for clinical audit topics chosen for inclusion will be influenced by:

- ❖ Opportunities to improve clinical effectiveness and evidence-based practice (e.g., efficacy of treatment, new initiatives, pilot projects)
- ❖ Clinical risk management/patient safety (e.g., choosing topics in response to concerns highlighted by patient safety incidents);
- ❖ Local and Trust wide priorities
- ❖ Guidance documents (e.g., NICE and AACE / JRCALC)
- ❖ National Ambulance Service Clinical Quality Group
- ❖ Policy documents relating to health and healthcare
- ❖ Other benchmarking activities as appropriate

A number of new service delivery models are often required for a modern ambulance service. The robust evaluation of service development topics is essential and needs to be planned from their inception.

It is not always possible to predict at the start of a financial year all of the topics that will require evaluation and therefore flexibility in setting a clinical audit programme is required, resulting in the annual programme being a dynamic document.

The aim of this document is to detail the clinical audit topics that are either planned, currently underway or have been completed during the financial year.

It is expected that all the topics identified in the programme will be initiated during the course of a financial year. Those initiated during Q3 or Q4 may not be fully completed and will need to be considered in the subsequent year's programme.

The completed clinical audit reports are available on the Clinical Audit page of the Trust's Intranet website. (<https://nhs.wales365.sharepoint.com/sites/AMB-Intranet-Medical/SitePages/Clinical-Audit-Programme.aspx>)

Kevin Webb – Head of Clinical Audit and Effectiveness

Table 1 – Summary (Full information in Table 2)

*	N/A = Not due to start	Not started / not progressing as planned	**Progressing as planned	Completed
** A clinical audit is deemed as started once a clinical audit proposal and criterion table have been approved by the CA&ED and the PCRs and/or data supplied				
Clinical Audit Classification		Tier 1 = UK Ambulance Services or Trust wide		Tier 2 = Health Board / Locality / Team

Ref	Tier	Clinical Audit Title	Clinical Audit Author	Clinical Audit Sponsor (Directorate)	Actual Audit Start Date	Current Status (RAG)*				
						Q4 2021/ 2022	Q1	Q2	Q3	Q4
20_001	1	Clinical Audit on the use of Just in Case Medications	Edward O'Brian End of Life Care Lead <i>(Medical & Clinical)</i>	Greg Lloyd Head of Clinical Operations <i>(Medical & Clinical)</i>	September 2020					
21_002	1	Safeguarding Adolescent Audit	Gwenan Jones-Parry Safeguarding Specialist Paramedic <i>(QSPE)</i>	Rhiannon Thomas Senior Professional Safeguarding	July 2021					
21_003	1	Bronchiolitis Pathway Compliance to the All-Wales Guideline	Richard Teulon Clinical Audit Coordinator	Greg Lloyd Head of Clinical Operations <i>(Medical & Clinical)</i>	December 2021					
22_001	1	ePCR Clinical Data Assurance Fractured Neck of Femur Clinical Indicator	Clinical Audit & Effectiveness Team	Duncan Robertson Interim Assistant Director of RASI	March 2022					
22_002	1	ePCR Clinical Data Assurance Stroke Clinical Indicator	Clinical Audit & Effectiveness Team	Duncan Robertson Interim Assistant Director of RASI	March 2022					

22_003	1	ePCR Clinical Data Assurance STEMI Clinical Indicator	Clinical Audit & Effectiveness Team	Duncan Robertson Interim Assistant Director of RASI	June 2022	N/A				
TBC	1	ePCR Clinical Data Assurance Hypoglycaemia Clinical Indicator	Clinical Audit & Effectiveness Team	Duncan Robertson Interim Assistant Director of RASI		N/A	N/A			
TBC	1	Re-audit of compliance to a Pain Score on PCRs for patients ≥18 years.	Claire Muxworthy Clinical Audit Coordinator <i>(Clinical)</i>	Kevin Webb Head of Clinical Audit & Effectiveness <i>(Medical & Clinical)</i>	To commence when the actions from the previous audit have been completed	N/A	N/A	N/A	N/A	N/A
TBC	1	Re-audit of clinical photographs in aiding care delivery (Consultant Connect)	Ruth Saele Clinical Data Specialist <i>(Clinical)</i>	TBC	Following strengthened guidance being issued	N/A	N/A	N/A	N/A	N/A
TBC	1	Re-audit of assurance for the recording of a Clinical Frailty Score (CFS) in patients aged ≥ 65 years	TBC	TBC	Dependent on ePCR data once the system is rolled out across WAST and when sufficient ePCR data for frailty is available.	N/A	N/A	N/A	N/A	N/A
TBC	1	Re-audit of Bronchiolitis Pathway – Compliance to the All-Wales Guideline for Ambulance Service Management	TBC	TBC	Dependant on ePCR data in Winter 2022/23.					

Table 2 – Full Information

Ref	Clinical Audit Title	Rationale / Drivers	Clinical Audit Author	Clinical Audit Contact / Support	Actual Audit Start Date	Comments
20_001	Clinical Audit on the use of Just in Case Medications	To review the outcomes for patients administered JIC medications and compliance with the agreed SOP.	Edward O'Brian End of Life Care Lead	Claire Muxworthy Clinical Audit Coordinator	September 2020	<p>Progressing but at a slower pace as other work has been a priority.</p> <p>The author is now being assisted by two paramedics on alternative duties.</p> <p>Data capture and analysis complete. A draft report is being written.</p>
21_002	Safeguarding Adolescent Audit	It was agreed as part of the learning from a domestic homicide review and as part of the safeguarding team's future work plan that an audit would be completed to develop a mechanism to review this aspect of safeguarding practice.	Gwenan Jones-Parry Safeguarding Specialist Paramedic	Claire Muxworthy Clinical Audit Coordinator	July 2021	<p>There are 3 aspects to the data capture: PCR, MPDS & CAS.</p> <p>Spreadsheets developed for each of these so that data capture and analysis can progress.</p> <ol style="list-style-type: none"> 1. Data analysed, report to be written 2. Data collection commenced 3. Not yet commenced

Ref	Clinical Audit Title	Rationale / Drivers	Clinical Audit Author	Clinical Audit Contact / Support	Actual Audit Start Date	Comments
21_003	Bronchiolitis Pathway Compliance to the All-Wales Guideline	<p>The levels of Bronchiolitis in children (aged 2 and under) is increasing due to the impact of the Respiratory Syncytial Virus (RSV). This level is predicted to continue to rise by 20 – 50%.</p> <p>WAST have worked with a national task force to develop a bronchiolitis pathway which identifies mild, moderate and severe diseases, in addition to providing a lot of information on red flags and alternative diagnosis.</p>	Richard Teulon Clinical Audit Coordinator	Ruth Saele Clinical Data Specialist	December 2021	<p>An interim report was presented to the CIAG on 21/01/2022. Agreed to finalise this with October 2021 data.</p> <p>Final report approved at CIAG 19.5.2022.</p>
22_001	ePCR Clinical Data Assurance – Fractured Neck of Femur Clinical Indicator	To determine if the automated reporting from within the TerraPace application / ePCR provides an accurate picture of the care provided to patients who have sustained a #NOF.	Clinical Audit & Effectiveness Team	Kevin Webb Head of Clinical Audit & Effectiveness	March 2022	Audit approved at CIAG 19.5.2022
22_002	ePCR Clinical Data Assurance – Stroke Clinical Indicator	To determine if the automated reporting from within the TerraPace application / ePCR provides an accurate picture of the care provided to patients who have sustained a stroke.	Clinical Audit & Effectiveness Team	Kevin Webb Head of Clinical Audit & Effectiveness	March 2022	Audit approved at CIAG 15.6.2022
22_003	ePCR Clinical Data Assurance – STEMI Clinical Indicator	To determine if the automated reporting from within the TerraPace application / ePCR provides an accurate picture of the care provided to patients who have sustained a STEMI.	Clinical Audit & Effectiveness Team	Kevin Webb Head of Clinical Audit & Effectiveness	June 2022	Raw ePCR data received, auditing commenced.

Ref	Clinical Audit Title	Rationale / Drivers	Clinical Audit Author	Clinical Audit Contact / Support	Actual Audit Start Date	Comments
TBC	ePCR Clinical Data Assurance – Hypoglycaemia Clinical Indicator	To determine if the automated reporting from within the TerraPace application / ePCR provides an accurate picture of the care provided to patients who have sustained a hypoglycaemia.	Clinical Audit & Effectiveness Team	Kevin Webb Head of Clinical Audit & Effectiveness	TBC	Data not yet available
TBC	Re-audit of compliance to a Pain Score on PCRs for patients ≥18 years.	To ascertain if actions following the previous audit have led to an improvement.	Claire Muxworthy Clinical Auditor	Kath Charters Clinical Data Specialist	TBC	To commence when the actions from the previous audit have been completed
TBC	Re-audit of clinical photographs in aiding care delivery (Consultant Connect)	To ascertain if actions following the previous audit have led to an improvement.	Ruth Saele Clinical Data Specialist	Kevin Webb Head of Clinical Audit & Effectiveness	TBC	Following strengthened guidance being issued
TBC	Re-audit of assurance for the recording of a Clinical Frailty Score (CFS) in patients aged ≥ 65 years	To ascertain if actions following the previous audit have led to an improvement.			TBC	Dependent on ePCR data once the system is rolled out across WAST and when sufficient ePCR data for frailty is available.
TBC	Re-audit of Bronchiolitis Pathway –Compliance to the All-Wales Guideline for Ambulance Service Management	To ascertain if actions following the previous audit have led to an improvement.			TBC	Dependant on ePCR data in Winter 2022/23.

NHS Wales National Clinical Audit and Outcome Review Plan

Annual Rolling Programme from 2022/23

June 2022

The annual National Clinical Audit and Outcomes Review Plan confirms the list of National Clinical Audits and Outcome Reviews all health boards and trusts are expected to participate in 2022-23 (where they provide the service). The plan confirms how the findings from audits and reviews will be used to measure and drive forward improvements in the quality and safety of healthcare services in Wales.

Section 1 of the National Health Service (Wales) Act 2006 places a duty on the Welsh Ministers to continue the promotion of a comprehensive health service designed to secure improvement in the physical and mental health of the people of Wales. Section 2 of that Act empowers Welsh Ministers to do anything which is calculated to facilitate, or is conducive or incidental to, the discharge of that duty.

1. What do we want to achieve?

NHS Wales needs to be a learning organisation, which regularly seeks to measure the quality of its services against consistently improving standards and, in comparison with other healthcare systems across the UK, Europe and the World. This measurement should be used to set improvement priorities.

The Welsh Government and NHS Wales are committed to the principles of value-based healthcare to help meet the challenges of rising costs and increasing demand, while continuing to improve the quality of care.

Clinical audit is an integral component of the quality improvement process and is embedded within the Welsh healthcare standards.

2. The programme of audits

The agreed NHS Wales programme of audits includes the majority of audits currently supported by the National Clinical Audit and Patients Outcome Programme (NCAPOP) managed by the Healthcare Quality Improvement Partnership (HQIP), but can also include a number of other national or multi-organisational audits recognised as being essential.

The Clinical Outcome Review Programme (formerly Confidential Enquiries) is commissioned by HQIP on behalf of the Welsh Government, NHS England, NHSSPS Northern Ireland, ISD Scotland and the Channel Island and Isle of Man governments. The programme is designed to help assess the quality of healthcare and stimulate improvement in safety and effectiveness by

systematically enabling clinicians, managers and policy makers to learn from adverse events and other relevant data.

The final agreed list of audits and reviews is published annually. The programme for 2022-23 is attached at Annex A.

3. How will participation, learning and action on findings be encouraged throughout Wales?

Continued encouragement of audit:

- Feedback relating to the benchmarked performance of individual providers within clinical audits and reviews to organisations as appropriate for reflection and action.
- By raising the profile of clinical audit with boards, patient groups, clinicians and all staff working within the NHS. To include, organisational visits and liaison with professional bodies in Wales to encourage audit amongst their disciplines and specialism.
- Developing closer partnerships working with health boards/trusts clinical audit teams to improve knowledge and understanding of national and local audit/review activities.
- Working in partnership with other healthcare organisations e.g. Public Health Wales, Digital Health and Care Wales (DHCW) to promote and encourage a culture of participation in audit and action on findings.

Identifying areas needing a national approach to improvement:

- Reviewing common issues for all Welsh healthcare providers arising from audit and reviews and sharing solutions.
- By ensuring the findings and recommendations from audits are fully considered by the appropriate national advisory groups/networks.
- Working in partnership, via HQIP and with audit project teams to ensure the provision of Welsh-specific findings and potential solutions, and develop and organise workshops and events to disseminate them.

Addressing clinical services where performance may give cause for concern:

- Clearly identifying the comparative performance of individual provider organisations and understanding the reasons for any disparity.
- Ensuring issues are considered in regular performance review meetings between health boards/trusts and in Welsh Government Quality Delivery Board meetings.
- Protocol confirming the arrangements for the identification and handling of organisations identified in audits and reviews as being “Outliers” including such activity designed to improve and encourage quality improvement.

Greater transparency:

- By seeking to improve the way in which the findings, recommendations and improvement actions from audit and reviews are made available to patients, public and all staff working in the NHS.

4. What is the Role of Welsh Government?

In partnership with NHS England and HQIP, the Welsh Government supports and funds the cost of NHS Wales' participation in the National Clinical Audit and Clinical Outcome Review Programme. The Welsh Government along with DHCW will seek to encourage greater participation and learning from clinical audits and reviews leading to improved services, better patient outcomes and safer patient care.

The Welsh Government is a member of the NCAPOP Partners Group and provides the Welsh Government's position and context to ensure the audits align with the long-term plan in Wales.

5. What is the Role of Digital Health and Care Wales

DHCW has become the joint data controller with HQIP for the delivery of any audits commissioned by HQIP as part of NCAPOP.

As part of its Statutory functions as a Special Health Authority, Welsh Government has requested that DHCW identify data sharing opportunities to support clinicians and networks in Wales and provide advice and support to health boards.

6. What are the responsibilities of Welsh health boards and trusts?

Welsh health boards and trusts should provide the resources to enable their staff to participate in all audits, reviews and national registers included in the annual plan (where they provide the service). They should ensure the full audit cycle is completed and that findings and recommendations from audit link directly into the quality improvement programme and lead to improved patient care and outcomes.

To ensure the maximum benefit is derived from the clinical audit programme health boards and trusts should:

- Ensure the necessary resources, governance and organisational structures are in place to support complete engagement in audits, reviews and national registers included in the annual Plan.
- Appoint a clinical lead to act as a champion and point of contact for every National Clinical Audit and Outcome Review, which the health board is participating in. Health boards and trusts should also encourage and support clinical leads to take on the role of all-Wales representative on audit steering groups and networks where required.

- Ensure there is a formally recognised process for reviewing the organisations performance when reports are published. This review should include consideration of improvements (planned and delivered) and an escalation process to ensure the executive board is made aware when issues around participation, improvement and risk identification against recommendation are identified.
- Have clear lines of communication, which ensures full board engagement in the consideration of audit and review of findings and, where required, the change process to ensure improvements in the quality and safety of services take place.
- Work with DHCW to facilitate the wider use of data from audit and national registries to be used as supporting information for medical revalidation and peer review.
- Ensure learning from audit and review is shared across the organisation and communicated to staff and patients.
- Existing Data Sharing Agreements between the Health Boards and NHS Trusts shall be utilised for the information sharing event, and this should be documented on the National Information Flows Register as held by DHCW.
- DHCW, Local Health Boards and the Trusts shall produce such Data Privacy Impact Assessments (DPIAs) as may be necessary to comply with the GDPR where new identifiable data is to be shared or otherwise processed.

In previous years health boards were tasked with completing a proforma to provide to Welsh Government for each published audit report. As the audit process has matured, audit results feed into a range of networks and policy development and as such it has been determined these proformas are an additional layer, which are no longer required. From 2022/23 routine proformas to the Welsh Government for every audit will no longer be required. Welsh Government policy officials may ask for feedback when required.

7. How Will We Measure Success?

By year on year consideration of audit reports and in comparison with other UK, European and International healthcare systems to determine how compliance with best practice and achievement of healthcare outcomes compares to national and international benchmarks.

The following key criteria will also be used for judging success:

- 100% participation, appropriate levels of case ascertainment and submission of complete data sets by all health boards and trusts (where applicable) in the full programme of National Clinical Audits and Clinical Outcome Reviews.

- Less variation between local services and measurable year on year improvements in performance to achieve the highest standards. Organisations recognised as being above the audit “average” or within the top quartile for each audit and maintaining that level.
- Improvements in the quality and safety of patient outcomes and experience brought about by learning and action arising from the findings of National Clinical Audit and Clinical Outcome Review reports.

8. How Will We Maintain Success?

The audit and quality improvement approach has the advantage of engaging those placed to make change and those expected to deliver and maintain change on a daily basis. This approach has a demonstrated track record of delivering and maintaining service improvement for a range of issues in a range of settings. Where there are expectations of delivering and maintaining better quality care and outcomes, the audit and quality improvement should be the normally used first-line approach.

9. Conclusion

The findings and recommendations from national clinical audit, outcome reviews and all other forms of reviews and assessments will be one of the principal mechanisms for assessing the quality and effectiveness of healthcare services provided by health boards and trusts in Wales.

In line with our stated ambition to develop a healthcare service that is recognised as being one of the best in the world, and to drive forward improvement, the clinical audit process will also be used to assess Welsh healthcare services against similar services being provided in other countries across the UK, Europe and Internationally.

Annex A

Annual Programme for 2022 - 23 of National Clinical Audit and Outcome Reviews in which all Welsh health boards and trusts must participate (where services are provided)

Acute	Audit website homepage	Contact	Collecting data in 2022/23
National Joint Registry	www.njrcentre.org.uk	enquiries@njrcentre.org.uk	Yes (W, E & NI)
National Emergency Laparotomy Audit *	www.nela.org.uk	info@rcoa.ac.uk	Yes (W & E)
Case Mix Programme (CMP)	www.icnarc.org	cmp@icnarc.org	Yes (W, E & NI)
Major Trauma Audit Trauma Audit and Research Network #	https://www.tarn.ac.uk/	support@tarn.ac.uk	Yes (W, E & NI)

Long Term Conditions	Audit website homepage	Contact	Collecting data in 2022/23
National Diabetes Audit *	General: https://digital.nhs.uk		(W & E)
Note this covers the following areas : National Diabetes Foot Care Audit	Footcare: https://digital.nhs.uk/data-and-information/clinical-audits-and-registries/national-diabetes-foot-care-audit	ndfa@nhs.net	Yes
• National Diabetes Inpatient Safety Audit (NDISA)	NaDia: https://digital.nhs.uk/data-and-information/clinical-audits-and-registries/national-diabetes-inpatient-audit	nadia@nhs.net	Yes
• National Pregnancy in Diabetes Audit	Pregnancy: https://digital.nhs.uk/data-and-information/clinical-audits-and-registries/national-pregnancy-in-diabetes-audit	npid@nhs.net	Yes
• National Diabetes	Core: https://digital.nhs.uk/data-	diabetes@nhs.net	Yes

Core Audit	and-information/clinical-audits-and-registries/national-diabetes-audit		
National Paediatric Diabetes Audit (NPDA) * #	www.rcpch.ac.uk/npda	npda@rcpch.ac.uk	Yes (W & E)
National Asthma and COPD Audit Programme (NACAP)* # Note this covers the following areas :	https://www.rcplondon.ac.uk/projects/national-copd-audit-programme	copd@rcplondon.ac.uk	Yes (W & E)
<ul style="list-style-type: none"> • COPD Secondary Care • Adult Asthma • Paediatric Asthma Secondary Care • Pulmonary Rehabilitation 	https://www.rcplondon.ac.uk/projects/national-asthma-and-copd-audit-programme-nacap-secondary-care-workstream-copd https://www.rcplondon.ac.uk/projects/national-asthma-and-copd-audit-programme-nacap-secondary-care-workstream-adult-asthma https://www.rcplondon.ac.uk/projects/national-asthma-and-copd-audit-programme-nacap-secondary-care-workstream-children-and-young https://www.rcplondon.ac.uk/projects/national-asthma-and-copd-audit-programme-nacap-pulmonary-rehabilitation-workstream		
Renal Registry (Renal Replacement Therapy) #	https://ukkidney.org/about-us/who-we-are/uk-renal-registry	renalregistry@renalregistry.nhs.uk	Yes (W, E & NI)
National Early Inflammatory Arthritis Audit * #	https://www.rheumatology.org.uk/Practice-Quality/Audits/NEIA-Audit	bsr@rheumatology.org.uk	Yes (W & E)
All Wales Audiology Audit #			Yes (Wales only)

Older People	Audit website homepage	Contact	Collecting data in 2022/23
Sentinel Stroke National Audit Programme (SSNAP) *	www.strokeaudit.org	ssnap@rcplondon.ac.uk	Yes (W, E & NI))
Falls and Fragility Fracture Audit Programme Including: <ul style="list-style-type: none"> National Audit of Inpatient Falls National Hip Fracture Database Fracture Liaison Service Database *	https://www.rcplondon.ac.uk/projects/falls-and-fragility-fracture-audit-programme-ffap	FFFAP@rcplondon.ac.uk <u>Inpatient Falls</u> falls@rcplondon.ac.uk <u>Hip Fracture Database</u> nhfd@rcplondon.ac.uk Fracture Liaison Service Database FLSDB@rcplondon.ac.uk	Yes (W, E, NI))
National Audit of Dementia *	www.nationalauditofdementia.org.uk	nad@rcpsych.ac.uk	Yes (W & E)

End of Life	Audit website homepage	Contact	Collecting data in 2022/23
National Audit of Care at the End of Life (NACEL) *	https://www.nhsbenchmarking.nhs.uk/nacel	enquiries@nhsbenchmarking.nhs.uk	TBC (W & E)

Heart	Audit website homepage	Contact	Collecting data in 2022/23
National Cardiac Audit Programme (NCAP) <ul style="list-style-type: none"> National Heart Failure Audit * National Audit of Cardiac Rhythm Management * 	https://www.nicor.org.uk/ https://www.nicor.org.uk/national-cardiac-audit-programme/heart-failure-heart-failure-audit/ https://www.nicor.org.uk/national-cardiac-audit-programme/cardiac-rhythm-management-arrhythmia-audit/	nicor-auditenquiries@bartshealth.nhs.uk	(W & E) Yes Yes

<ul style="list-style-type: none"> National Adult Cardiac Surgery Audit* 	https://www.nicor.org.uk/national-cardiac-audit-programme/adult-cardiac-surgery-surgery-audit/		Yes
<ul style="list-style-type: none"> National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty) * 	https://www.nicor.org.uk/adult-percutaneous-coronary-interventions-angioplasty-audit/		Yes
<ul style="list-style-type: none"> National Congenital Heart Disease Audit * # 	https://www.nicor.org.uk/national-cardiac-audit-programme/congenital-heart-disease-in-children-and-adults-congenital-audit/		Yes
<ul style="list-style-type: none"> Myocardial Ischaemia National Audit Project (MINAP)* 	https://www.nicor.org.uk/national-cardiac-audit-programme/myocardial-ischaemia-minap-heart-attack-audit/		Yes
National Audit of Cardiac Rehabilitation	http://www.cardiacrehabilitation.org.uk/	corinna.petre@york.ac.uk	Yes (W, E & NI)
National Vascular Registry Audit *	www.vsqip.org.uk	nvr@rcseng.ac.uk	Yes

Cancer	Audit website homepage	Contact	Collecting data in 2022/23
National Lung Cancer Audit *	https://www.rcplondon.ac.uk/projects/national-lung-cancer-audit On 1 February 2022, the project transferred to the Royal College of Surgeons of England. It was previously run by the Royal College of Physicians.	nlca@rcplondon.ac.uk	Yes (W & E_)
National Prostate Cancer Audit *	www.npca.org.uk	npca@rcseng.ac.uk	Yes (W & E)
Gastrointestinal Cancer Audit Programme (GICAP) *			Yes (W & E)

<ul style="list-style-type: none"> National Bowel Cancer Audit 	www.nboca.org.uk	bowelcancer@nhs.net	
<ul style="list-style-type: none"> National Oesophago-gastic Cancer Audit 	https://www.nogca.org.uk/	og.cancer@nhs.net	
National Audit of Breast Cancer in Older People (NABCOP) *	https://www.nabcop.org.uk/	nabcop@rcseng.ac.uk	Yes (W&E)

Women's and Children's Health	Audit website homepage	Contact	Collecting data in 2022/23
Paediatric Intensive Care Audit (PICaNet) * #	www.picanet.org.uk	picanet@leeds.ac.uk	Yes (UK)
National Neonatal Audit Programme Audit * #	www.rcpch.ac.uk/nnap	enquiries@rcpch.ac.uk	Yes (W & E)
National Maternity and Perinatal Audit * #	http://www.maternityaudit.org.uk/pages/home	nmpa@rcog.org.uk	Yes (W, E & S)
National Perinatal Mortality Review Tool	https://www.npeu.ox.ac.uk/pmrt	general@npeu.ox.ac.uk	Yes (W, E & S)

Other	Audit website homepage	Contact	Collecting data in 2022/23
National Clinical Audit of Seizures and Epilepsies for Children and Young People (Epilepsy12) * #	https://www.rcpch.ac.uk/work-we-do/quality-improvement-patient-safety/epilepsy12-audit	enquiries@rcpch.ac.uk	TBC
National Clinical Audit of Psychosis *	https://www.rcpsych.ac.uk/improving-care/ccqi/national-clinical-audits/national-clinical-audit-of-psychosis	NCAP@rcpch.ac.uk	Yes (W & EW)

(* denotes NCAPOP Audits)

(# denotes reports likely to include information on children and / or maternity services)

Clinical Outcomes Review Programme

The **Clinical Outcome Review Programme** (CORP) is designed to help assess the quality of healthcare, and stimulate improvement in safety and effectiveness by enabling learning from adverse events and other relevant data. It aims to complement and contribute to the work of other agencies such as NICE, the Royal Colleges and academic research studies, which support changes to improve NHS healthcare.

Without high quality data, improvement in clinical care is unlikely to occur. National clinical audits and outcome reviews are focused on areas of healthcare considered to be important, where there are often issues of concern and where national results are considered essential to improve practice and standards.

With the ability to measure against recognised standards and compare services on a local, regional or national basis, clinical audit and outcome reviews are very powerful tools for assessing the quality of services being provided. When used as part of the wider quality improvement cycle, they provide a strong mechanism for driving service change and improving patient outcomes, but full participation and a determination to learn from the findings is essential.

Service provider contracts for these programmes have been awarded to the following suppliers (links are provided to website homepages):

Clinical Outcomes Review Programme	Programme website homepage	Contact	Collecting data in 2022/23
Medical and Surgical Clinical Outcome Review Programme *	http://www.ncepod.org.uk/ To include: - Community acquired pneumonia - Crohn's Disease - Endometriosis - End of life care	ncepod@nhs.net	(W, E) Yes Yes Yes Yes
Mental Health Clinical Outcome Review Programme *	http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci - National Confidential Inquiry into Suicide and Safety in Mental Health	ncish@manchester.ac.uk	(W, E) Yes

<p>Child Health Clinical Outcome Review Programme</p> <p>*#</p>	<p>http://www.ncepod.org.uk/</p> <p>- Transition from child to adult health services</p> <p>- Testicular torsion</p>	<p>ncepod@nhs.net</p>	<p>(W, E)</p> <p>Yes</p>
<p>Maternal, Newborn and Infant Clinical Outcome Review Programme</p> <p>*#</p>	<p>https://www.npeu.ox.ac.uk/mbrance-uk</p>	<p>general@npeu.ox.ac.uk</p>	<p>(UK)</p> <p>Yes</p>



AGENDA ITEM No	17
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	3

INFECTION PREVENTION AND CONTROL ANNUAL REPORT 1 APRIL 2021 - 31 MARCH 2022
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MEETING	Quality, Patient Experience & Safety Committee
DATE	11 August 2022
EXECUTIVE	Executive Director Quality & Nursing
AUTHOR	Head of Infection Prevention & Control
CONTACT	Louise Colson 07387249918 Louise.Colson@wales.nhs.uk

EXECUTIVE SUMMARY

In the last 12 months, activity for the Infection Prevention & Control (IPC) Team has largely remained pandemic focused however, as the world moves to a position of living with COVID-19 supported by an advanced Vaccination Programme, business as usual activity has merged with pandemic work.

The Welsh Ambulance Services NHS Trust (WAST) is committed to a zero tolerance of preventable healthcare associated infections (HCAIs). We are prioritising actions to reduce the risk transfer of community acquired infections in the pre-hospital care environment that could impact on the care provided to patients, carers and staff in secondary care and the wider community. The Trust is committed to working in partnership with all staff, service users and key stakeholders, to include Health Boards, Trusts, Public Health Wales, and Welsh Government.

It is the aim of IPC in WAST to:

- Develop a culture where preventable infections are not tolerated
- Ensure IPC leadership is present at all levels of the organisation and across all disciplines
- Improve quality and safety
- Measure success by monitoring practice, incidents, and indicators of good practice
- Work collaboratively with both internal and external stakeholders ensuring that WAST has appropriate representation and maintain confidence of the public, service users and staff
- Practice will be monitored through an internal Audit Programme so that we measure improvements, learn from staff and user experiences, and provide assurance to the Trust that the care we offer is safe and in line with National Guidelines
- Interrogate incident data submitted via Datix

The Trust IPC Audit Programme will include:

- A Programme of Infection Prevention and Decontamination Audits will be in place to assess the condition of the environment and equipment
- A Programme of Cleanliness Audits both in ambulance vehicles and stations
- A Programme of Respiratory Protective Equipment (RPE) Maintenance Logs following on from the Internal Audit performed by Shared Services
- A Programme of Audit for Hand Hygiene and Bare Below the Elbow
- A Programme of Peer Review undertaken with National IPC Teams within the Emergency Medical Services (EMS), supported by the Association of Ambulance Chief Executives (AACE)

Outcomes and keys areas for further improvement will be monitored via the Trust's IPC Strategic Group reporting quarterly to the Clinical & Quality Governance Group as the Pandemic Cell structure is slowly replaced by business-as-usual activity.

The IPC Team has increased its resilience within the Trust with two new substantive whole time equivalent posts. This was a competitive process of appointments, and 2 internal candidates were successful in their application. The Head of IPC is committed to supporting these staff with training and education to that of expert Practitioners. This is essential in ensuring succession planning and a sustainable dynamic IPC Team to lead the Trust now and in the future.

RECOMMENDED: That the Committee note the information within this paper and receive assurance that the Trust is actively driving towards a consistent IPC culture, one in which we maintain high standards of patient care and staff safety.

KEY ISSUES/IMPLICATIONS

- (i) The requirement for a comprehensive Audit Programme for 2022/23

REPORT APPROVAL ROUTE

Assistant Directors Leadership Team	16 May 2022
Clinical and Quality Governance Group	31 May 2022
Executive Management Team	20 July 2022
Quality, Patient Experience & Safety Committee	11 August 2022

REPORT APPENDICES

Annex 1 - SBAR providing background information.

Appendix 1 - Executive Summary regarding IPC Strategic Group Terms of Reference

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

SITUATION

- 1 This report provides an analysis of IPC performance throughout the organisation from 1 April 2021 - March 31 2022.
- 2 The WAST focuses on safe care and is continually looking for ways to improve. This report is presented to provide assurance to patients and service users and WAST Trust Board on how we are continuing to provide quality and safety in the care that we deliver.
- 3 The report is part of our governance arrangements, and we have full support from the Board for our position of zero tolerance of HCAs. The team embraces the Welsh Government Code of Practice on Prevention and Control of HCAs, this enhances and supports our working practices detailed in the Health and Care Standards.
- 4 Standard infection prevention and control precautions are the basic infection prevention practices that, when used consistently and diligently, reduce the transmission of potentially pathogenic organisms from both recognised and unrecognised sources, ultimately protecting patients, staff, and visitors. These include correct hand hygiene, safe cleaning and decontamination, safe handling and disposal of waste and linen, sharps safety, correct use of personal protective clothing, safe handling of blood and body fluids and respiratory hygiene.
- 5 IPC has taken centre stage over the last 2 years, as a result there have been numerous improvements and behaviours relating to IPC that the Trust should seek to retain. This will ensure that we maintain safe services for both patients and staff.
- 6 National agencies around the United Kingdom are now working towards sustainable guidance for the future which sees COVID-19 as part of seasonal respiratory illnesses.
- 7 COVID-19 will remain and become endemic, thus being able to predict more easily its increase in transmission, likely to be along the same patterns as other seasonal respiratory illnesses.
- 8 On 4 March 2022 Welsh Government released its paper on the transition of COVID-19 from pandemic to endemic [Together for a Safer Future](#).
- 9 Key messages:
 - The long-term transition from pandemic to endemic
 - Monitoring behaviours in the long term
 - Surveillance and responding to outbreaks of COVID-19
 - Vaccination
 - Test Trace and Protect
 - Adaptions of public services and businesses
 - International travel

- Equalities, communication and looking ahead
- 10 COVID-19 is still being transmitted within the community however, up to 60% of current cases have been diagnosed secondary to a primary illness and can be contributed to the continuation of proactive testing. Routine testing for COVID-19 will cease at the end of June and testing will only be provided for diagnostic purposes and subsequent treatment.
 - 11 The Scientific Advisory Group (SAGE) has highlighted that we are likely to see fluctuations in the global patterns of COVID-19 infections moving forward and that vaccinations will reduce the risk to people across the world.
 - 12 It is expected that COVID-19 will become one of many seasonal respiratory infections to manage in healthcare and that we are at a point in time now where the response to COVID-19 needs to form part of business-as-usual activities.
 - 13 For COVID-19 to fit the definition of endemic it needs to be more predictable, and this takes place over time, even years. COVID-19 remains a threat, there could be further variants that emerge and the ongoing immunity from vaccinations.
 - 14 It is now time to move out of a pandemic response and learn to live and work with COVID-19.

BACKGROUND

- 15 The IPC All Wales Code of Practice builds on the 2011 Welsh Government Commitment to Purpose, Eliminating Preventable HCAI. It sets out the minimum necessary IPC arrangements for NHS Healthcare providers in Wales. The code is based on nine standards of practice [Welsh Government IPC Codes of Practice](#).
- 16 The Health and Care Standards (WG 2015) provide an overall quality assurance system within the National Health Service (NHS) in Wales for all people that use the service. 2.4 of the Health and Care Standards under safe care pertains to IPC and decontamination [Health and Care Standards 2015](#):

SAFE CARE: The principle of safe care is to ensure that people in Wales are protected from harm and supported to protect themselves from known harm.

Effective infection prevention and control needs to be everybody's business and must be part of everyday healthcare practice and based on the best available evidence so that people are protected from preventable healthcare associated infections'

ASSESSMENT

- 17 Over the last 2 years the Trust has operated within its pandemic cell structure. IPC representation has operated within these structures from response to recovery. As we move to business as usual the governance structure for IPC will revert back to management via the IPC Strategic Group (IPCSG).
- 18 The Head of IPC currently has membership at the Business Continuity and Recovery Cell meeting once per week and the Quality, Safety and Well Being Advisory Cell, meeting once per two weeks.

IPC Governance

- 19 In preparation for business-as-usual activity the Terms of Reference and membership for the IPCSG were revised along with the governance reporting structure. All were approved via the Executive Management Team on the 31 March 2021 (**Appendix 1**). The first meeting of the revised membership took place on 21 May 2021. Subsequent meetings are quarterly and chaired by the Assistant Director of Quality Governance.
- 20 The functions of the IPCSG are to:
 - Receive a strategic overview of IPC activity
 - Monitor progress against the IPC Annual Plan
 - Monitor the performance against standards and key performance indicators
 - Seek and monitor assurance of compliance with the Health and Care Standards, IPC Guidance and the IPC Codes of Practice as set out by Welsh Government
 - Review and monitor IPC incidents and risks
 - Escalate issues to the Clinical Quality & Governance Group (CGQG), the Assistant Directors Leadership Team (ADLT) and the Executive Management Team (EMT) for any issues requiring an executive decision
 - Promote best practice by raising and discussing IPC issues as they arise, in operational detail
 - Share and give advice on research, innovation, and improvements
- 21 WAST is committed to providing outstanding care, positive clinical outcomes and high quality patient experience. HCAs are regarded as avoidable harm by the Department of Health (DH) and, as such, NHS providers have a duty of care to reduce the risk of HCAs to patients as far as possible.

IPC Team Establishment and functions

- 22 Pre-pandemic, the IPC Team consisted of two whole time equivalent staff. It became evident very early on in the pandemic that there was little resilience within the team. Eleven members of staff joined the team on a short-term secondment basis for the immediate requirements of the pandemic. Over a period of six months these team members reverted back to their substantive posts. Two further posts were created within the team with internal funding, following a competitive recruitment process two substantive internal appointments were made. The new IPC Team structure is detailed in **Figure 1**.

- 23 The role of the IPC Team is to support all staff and volunteers to deliver the best IPC practices they can. To achieve this objective the IPC Team is responsible for providing evidence-based advice and training materials, reviewing and updating IPC related Policies and Standard Operating Procedures and auditing practice at the front line (not an exhaustive list). In addition, the IPC Team has oversight on IPC related DATIX incidents in order to support local investigations.

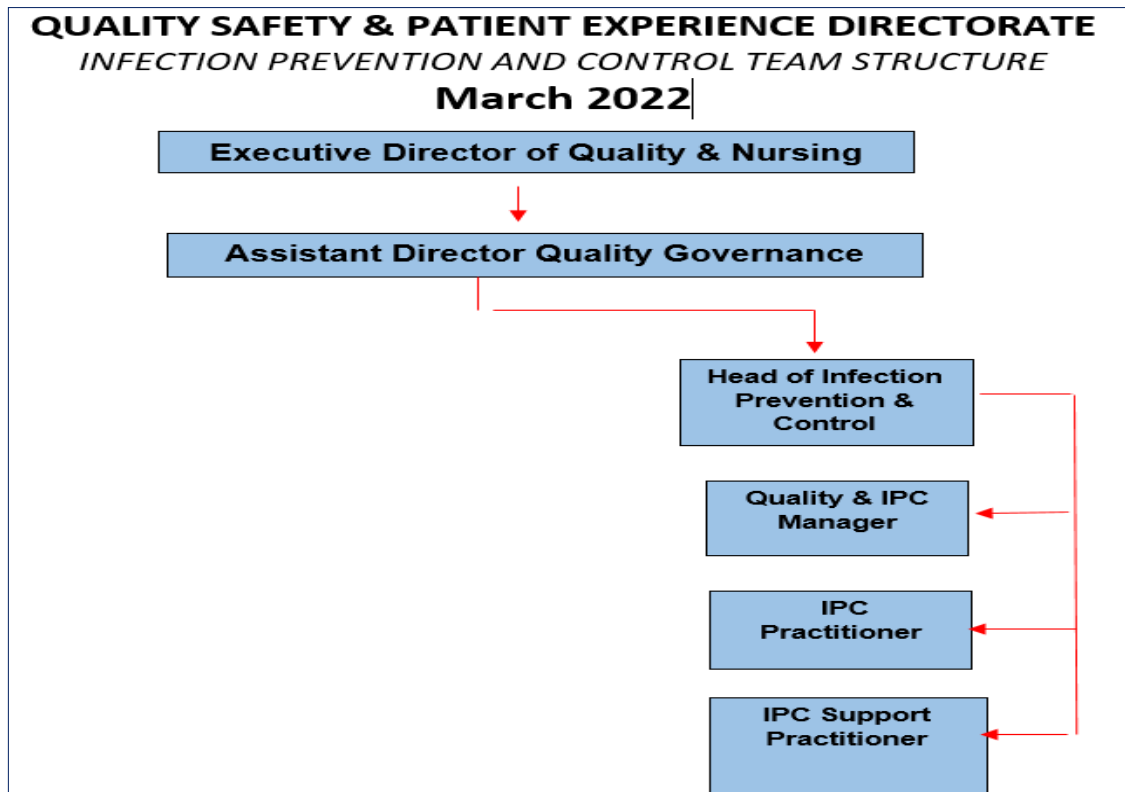


Figure 1: IPC Establishment at 31 March 2022

Infection Prevention and Control Priorities

Priority 1 - Policies Documents

- 24 The IPC Policy will be reviewed in June 2022. This has been delayed due to the COVID-19 pandemic. WASTs Policy Group is aware of the delay and a date has been set for June 2022 for the revised Policy to be assessed by the Policy Group. The new IPC Policy will be based on both the National IPC Policy as set out by the AACE, Public Health Wales (PHW) and Welsh Government Standards of Practice.
- 25 The Premise and Vehicle Cleanliness Policy has been reviewed and will be presented at the Policy Group on the 31 May 2022.
- 26 The All-Wales Aseptic Non-Touch Technique (ANTT) and Sharps Policy are within date and do not require updating.
- 27 There are 3 further policies that need to be developed and written utilising multidisciplinary Task and Finish Groups and approved via the Trusts Policy Group:
- Communicable Disease Policy

- Waste Management Policy
- Transfer Policy (there are discussions within PHW that there should be a National Patient Transfer Policy therefore this will be delayed until clarified)

Priority 2 - Standard Operating Procedures Documents (SOPs)

- 28 The above tabled SOPs have been developed during the pandemic period. Updates have been made when required to ensure that any relevant changes have been captured and documented. Version control of these documents have been maintained.
- 29 Further SOPs that were started prior to the pandemic and now which require completion are:
- The Trust's Antimicrobial Resistance Delivery Plan
 - Invasive Procedure Standard Operating Procedures
 - High Consequence Diseases Standard Operating Procedure
 - Decontamination of Medical Devices Standard Operating Procedures
 - Infectious Disease Outbreak Management (Non COVID -19) Standard Operating Procedures

Priority 3 - Guidance Documents

- 30 Guidance documents over the last year have changed frequently as new information and research has emerged regarding COVID-19 and its known variants. As we move to business as usual many practices will be maintained to provide safety to patients and staff.
- 31 The current IPC Personal Protective Equipment (PPE) Guidance Version 3 represents the transition guidance from COVID-19 to business-as-usual activity. Not all of the Emergency Services pre pandemic language and understanding has as yet changed back e.g., Level 2 and 3 PPE categories as opposed to previous Red, Amber and Green PPE categories. The IPC Team will continue to monitor guidance documents and advise the Trust accordingly of both National and Welsh changes and advice. All guidance documents have been version controlled with updates and changes clearly recorded.

Priority 4 - Standards

- 32 Standards of Practice that govern IPC in Wales are set by Welsh Government and PHW. The Health and Care Standards section 2.4 Safe Care and the IPC Standards of practice (links inserted at the start of the report).
- 33 Additional Standards that the IPC Team has developed:
- *Vehicle Cleaning Standards* - these Standards are soon to be accompanied by a *Vehicle Cleaning SOP* which is under development with the Operational Team supported by the IPC Team
 - *Welsh Ambulance Key Standards for Environment Cleanliness*, based upon National Cleaning Standards for the NHS.

34 Further Standards in development:

- Bare Below the Elbow and Hand Washing Standards of Practice
- Standard Infection Prevention and Control (SIPCS)
- Transmission Based Precautions (TBPs) Standards of Practice

35 These additional Standards have been added into the IPC Work Plan for the financial year 1 April 2022 - 31 March 2023 and are essential to complete in order for the IPC Team to complete audits of practice.

Priority 5 - Audits

36 No IPC Audits were performed in the period of April 2021 to March 2022. This was as a result of competing resources to manage the continuing pandemic and emerging variants of concern.

37 Two internal audits have been completed by Shared Services:

- *Face Fit Testing* - this received a reasonable assurance with recommended actions
- *Waste Management* - this received a limited assurance with recommended actions.

38 Recommendations were made for both Audits and actions are in the process of completion in response.

39 The IPC Team is committed to the following Audits for the financial year 1 April 2022 - 31 March 2023:

- Corpro mask use, filter and maintenance logs and ESR Records
- Versaflo usage, filter and maintenance logs
- Peripheral cannulation and ANTT compliance
- On Click and eLearning compliance
- Premise and vehicle cleaning
- Hand hygiene and bare below the elbow

40 The current premise and vehicle Audit Tool is now being reviewed and transferred to Microsoft forms. The previous tool required updating and is placed on a largely redundant platform.

Priority 6 - Risk Management

41 There were six identified risks during the period 1 April 2020 - 31 March 2021 that the IPC Team managed:

RISK ID	RISK DESCRIPTION	INITIAL RISK SCORE	CURRENT SCORE	RISK ACTION
344	Adenosine Triphosphate Project: Risk of failure due to lack of funds to purchase testing swabs	20	8	Closed 12/04/2021
302	Trust IPC Team structure	20	8	Closed

	insufficient to meet organisational IPC requirements			19/10/2021
351	Increased COVID-19 Transmission due to not wearing medical masks in trust vehicles	15	15	Closed 20/04/2021
322	Lack of compliance with Statutory Health and Safety Regulations relating to competent registered fit testers	15	15	Closed 22/12/2021
348	Solo Donning and Doffing Level 3 PPE	12	12	Closed 20/04/2021
349	Buddy Doffing of Level 3 PPE	8	8	Closed 19/10/2021
536	The ability to sustain a comprehensive fit testing Programme within the trust.	12 tbc		New Risk 11/05/2022

Priority 7 - Internal Risk Assessments

Completed	In development	Comments
Wearing Masks in Trust Vehicles	The use of Twiddle Mitts	Not endorsed nationally
Conveyance of Patients in RRV's	Revisit Pandemic Preparedness	
Donning Level 3 PPE	The ability to sustain a comprehensive fit testing programme within the trust.	Risk ID 536
Doffing Level 3 PPE	Needlestick injuries	AACE National Risk
Conveyance of COVID+ patients in AWLT vehicles (NEPTs)	Compliance to Hand Hygiene and Bare Below the Elbow	AACE National Risk
VCS Risk Assessment	Compliance with PPE procedures relevant to IPC	AACE National Risk
111 Training Rooms – COVID19 Specific	Contamination from blood and bodily fluids	AACE National Risk
HSE Non Compliance Competent Fit Testers	IPC Training and Education appropriate for all staff levels and grades	AACE National Risk
IPC team establishment	Compliance with Waste Management	AACE National Risk
ATP Project risks	Compliance with Vehicle Cleaning Standards	
PPE Breach Known and Unknown COVID status	Effective Premise Cleaning	
Carry Food in Trust Vehicles		

Firefighting

42 In addition to the planned IPC Work Plan, there are frequent occasions that support is required, often on a daily basis. These requests can either come to the individuals within the IPC Team, via the generic IPC inbox email address or as a result of queries from internal meetings and other Directorates. This can include:

- Daily helpdesk style assistance to the Trust
- IPC Notices construction and publishing
- Datix monitoring and supporting investigation where required
- Monitoring emerging trends and requests from peers for IPC support
- Support for projects submitted to the WAST Improvement & Innovation Network (WiiN) platform for improvements and innovations

Education and Training

43 As a result of COVID-19 and more broadly, the prevention and management of other HCAs, it was widely recognised that there was a need to improve existing IPC training and practice. The Welsh Government Nosocomial Transmission Group asked Health Education and Improvement Wales (HEIW) to lead work focusing on workforce development and education provision, to support the improvements required.

44 The following areas of workforce and education development were agreed:

- Identify minimum education and training standards for IPC practice
- Production of resources to reinforce best practice
- Review and refresh of NHS mandatory training
- Strategic work to ensure future sustainable specialist IPC workforce

45 The All-Wales Infection Prevention and Control Training, Learning and Development Framework for Health, Social Care, Early Years and Childcare was developed and published on the 14 April 2021 and issued to the service on 27 August 2021. It should be noted that Levels 0 to 4 outlined within the Framework are not academic levels.

[All Wales Infection Prevention and Control Training, Learning and Development Framework for Health, Social Care, Early Years and Childcare](#)

46 To support the standards within the Framework, an IPC Education and Training Content Development Group was established by HEIW with membership including PHW, Social Care Wales, and specialist IPC Advisors. WAST representation on this Group was the Head of IPC.

47 The work that was completed by the Content Development Group to support service education for IPC on a Once for Wales approach from Level 0 of the Framework includes animation resources [IPC Animation HEIW](#) changes to mandatory training [Infection Prevention and Control Training](#), Massive Open Online Course (MOOC) available via Bangor and Swansea University, an online

course with training targeted at Registered Practitioners/Senior level staff in supervisory roles with responsibility for ensuring compliance with good clinical practice. Information on how to access this course can be found on the IPC Intranet page in the Training Folder: [Infection Prevention and Control Training](#).

Specialist Workforce

- 48 This separate Programme of Work is progressing to develop an interactive IPC Multi-disciplinary Workforce Model and Career Pathway, aligned to which will be an Education, Learning and Development Framework. This strategic work, with a focus on ensuring a sustainable specialist workforce, commenced in May 2021 and will provide a report in the future.

Current training available for staff within the trust:	Training for the IPC team has been facilitated using a variety of methods
<ul style="list-style-type: none"> • WAST Learning Zone On click 6 modules available • Pre-Hospital Care Module via Electronic Staff Register (ESR) • Level 1 and 2 IPC training via ESR • Emergency ANTT Training 	<ul style="list-style-type: none"> • PADR • IPC specialist education/training • BSIF Accreditation • CPD Activity • Statutory and Mandatory Training • National IPC Group membership • National IPC Conference • Membership of the Infection Prevention Society

Internal Training Reports

EMS IPC Onclick Module Compliance - as of 11.05.2022			
Row Labels	No. of Completions	Headcount	Compliance
020 Ambulance Response - ABM L6 (DZ51)	253	310	81.61%
020 ABM Bridgend Locality L8 (DD30)	54	68	79.41%
020 ABM Neath Locality L8 (DD40)	88	103	85.44%
020 ABM Swansea Locality L8 (DD50)	111	139	79.86%
020 Ambulance Response - Aneurin Bevan L6 (DZ71)	234	310	75.48%
020 Area Management - Aneurin Bevan L8 (DE10)	0	1	0.00%
020 Caerphilly Locality Management (DE40)	45	65	69.23%
020 Gwent/Torfaen Locality Management (DE30)	86	130	66.15%
020 Newport/Monmouth Locality Management (DE20)	103	114	90.35%
020 Ambulance Response - BCU L6 (DZ61)	279	463	60.26%
020 Area Management - BCU L8 (DF10)	7	17	41.18%
020 BCU-E Conwy & Denbighshire Locality L8 (DF30)	108	138	78.26%
020 BCU-E Flintshire & Wrexham Locality L8 (DF40)	59	136	43.38%
020 BCU-W South Gwynedd Locality L8 (DF50)	45	66	68.18%
020 BCU-W Ynys Mon Locality L8 (DF60)	60	106	56.60%
020 Ambulance Response - C&V L6 (DZ72)	162	202	80.20%
020 C&V Cardiff Locality L8 (DG20)	102	123	82.93%
020 C&V Vale Locality L8 (DG30)	60	79	75.95%
020 Ambulance Response - Cwm Taf L6 (DZ73)	110	172	63.95%
020 Merthyr Locality L8 (DH40)	61	81	75.31%
020 RCT Locality L8 (DH30)	49	91	53.85%
020 Ambulance Response - Hywel Dda L6 (DZ52)	249	308	80.84%
020 Carmarthen Locality L8 (DJ20)	104	125	83.20%
020 Ceredigion Locality L8 (DJ30)	66	73	90.41%
020 Pembroke Locality L8 (DJ40)	79	110	71.82%
020 Ambulance Response - Powys L6 (DZ53)	91	139	65.47%
020 North Powys Locality L8 (DK20)	49	73	67.12%
020 South Powys Locality L8 (DK30)	42	66	63.64%
020 Operations Directorate - Resilience L6 (DZ03) (HART Only)	38	43	88.37%
020 Hazardous Area Response Team L8 (DA20)	38	43	88.37%
Grand Total	1416	1947	72.73%

EMS On-Click Module Compliance as 11 May 2022

NEPTS IPC Onclick Module Compliance - as of 11.05.2022

Row Labels	No. of Completions	Headcount	Compliance
020 NEPTS C&W ABM L6	87	89	97.75%
020 NEPTS C&W Hywel Dda Area L6	59	63	93.65%
020 NEPTS C&W Powys Area L6	40	40	100.00%
020 NEPTS NR BCU Area L6	92	127	72.44%
020 NEPTS SE Aneurin Bevan Area L6	116	180	64.44%
020 NEPTS SE C&V Area L6	56	65	86.15%
020 NEPTS SE Cwm Taf Area L6	45	61	73.77%
Grand Total	495	625	79.20%

NEPTS On-Click Module Compliance as 11 May 2022

Infection Control Level 1 Compliance - as of 10.05.2022

Assignment Count	Required	Achieve	Compliance	
4290	4290	3785	88.23%	
Org L4	Assignment	Require	Achieved	Compliance
020 Ambulance Care L4 (NX10)	791	791	743	93.93%
020 Board Secretary L4 (BX81)	5	5	0	0.00%
020 Capital & Estates L4 (HX15)	14	14	9	64.29%
020 Chief Executive Directorate L4 (BX11)	19	19	6	31.58%
020 Clinical Division L4 (UX14)	45	45	36	80.00%
020 Complaints Claims & Litigation L4 (UX12)	19	19	18	94.74%
020 Education & Development L4 (PX12)	30	30	27	90.00%
020 Emergency Medical Services L4 (DX04)	1929	1929	1765	91.50%
020 Finance Division L4 (FX11)	26	26	22	84.62%
020 Health & Safety L4 (PX13)	9	9	6	66.67%
020 Health Informatics L4 (HX13)	20	20	13	65.00%
020 ICT Division L4 (IX12)	37	37	30	81.08%
020 Integrated Care L4 (DX03)	556	556	491	88.31%
020 Medical Division L4 (UX13)	1	1	1	100.00%
020 National Fleet Services L4(DZ41)	46	46	44	95.65%
020 National Operations & Support L4 (DX02)	204	204	175	85.78%
020 Partnerships & Engagement L4 (CX11)	17	17	10	58.82%
020 Quality & Nursing L4 (JX11)	91	91	82	90.11%
020 Research & Development Division L4 (UX11)	6	6	5	83.33%
020 Resourcing & EMS Coordination L4 (DX05)	357	357	257	71.99%
020 Strategy, Planning & Performance L4 (HX17)	11	11	3	27.27%
020 Workforce & OD L4 (PX11)	57	57	42	73.68%

IPC Level 1 compliance as 10 May 2022

Infection Control Level 2 Compliance - as of 10.05.2022

Assignment Count	Required	Achieve	Compliance	
2115	2115	1026	48.51%	
Org L4	Assignment	Require	Achieved	Compliance
020 Ambulance Care L4 (NX10)	74	74	45	77.78%
020 Clinical Division L4 (UX14)	11	11	3	46.74%
020 Education & Development L4 (PX12)	18	18	14	100.00%
020 Emergency Medical Services L4 (DX04)	1872	1872	875	33.33%
020 Health & Safety L4 (PX13)	1	1	1	62.30%
020 Integrated Care L4 (DX03)	6	6	2	100.00%
020 National Operations & Support L4 (DX02)	122	122	76	90.00%
020 Quality & Nursing L4 (JX11)	1	1	1	100%
020 Workforce & OD L4 (PX11)	10	10	9	100%
Org L6	Assignment	Require	Achieved	Compliance
020 Ambulance Care C&W Hywel Dda Area L6	1	1	1	100.00%
020 Ambulance Care SE Aneurin Bevan Area L6	73	73	44	60.27%
020 Clinical Division L6 (U203)	11	11	3	27.27%
020 EMS - ABM L6 (D251)	306	306	133	43.46%
020 EMS - Aneurin Bevan L6 (D271)	303	303	147	48.51%
020 EMS - BCU L6 (D261)	454	454	195	42.95%
020 EMS - C&V L6 (D272)	193	193	119	59.80%
020 EMS - Cwm Taf L6 (D273)	170	170	103	60.59%
020 EMS - Hywel Dda L6 (D252)	304	304	116	38.16%
020 EMS - Powys L6 (D253)	136	136	62	45.59%
020 Education & Development L6 (P202)	18	18	14	77.78%
020 Health & Safety L6 (J203)	1	1	1	100.00%
020 Integrated Care L6 (D290)	6	6	2	33.33%
020 National Operations & Support - Volunteer Management L6 (D205)	4	4	3	75.00%
020 National Operations & Support L6 (D202)	73	73	62	84.93%
020 Quality & Nursing L6 (J201)	1	1	1	100.00%
020 Resilience/Business Continuity L6 (D203)	45	45	11	24.44%
020 Workforce & OD L6 (P201)	10	10	9	90.00%

IPC Level 2 compliance as 10 May 2022

- 49 Early discussions have taken place with the National Training College to review all of the available IPC training and to analyse how best to deliver this training in a sustainable and effective manner using the All-Wales IPC Training Framework.

Fit Testing Improvement Project

- 50 Fit Testing is currently provided by a cohort of internal operational staff. These staff have been trained by both external and internal providers and can now support both Qualitative (Bitrex) and Quantitative (Portacount) testing. Typically,

this has been conducted on an ad hoc basis and usually utilises staff that have been allocated alternative duties, often for a short period of time. This has been custom and practice over many years. The turnover of staff providing fit testing provision is high as they no longer perform any testing once they return to their normal duties; thus, their skills and competency in fit testing diminishes.

- 51 The Electronic Staff Register (ESR) is currently used to record those trained to fit test, outcomes of staff fit testing and a record of RPE and PPE requirements. It is an accessible platform to all staff and can be managed locally by admin staff, Locality Managers or Duty Operational Managers. It is easy to update, and guidance is readily available to support this. It also allows individual staff to have sight of their own requirements and to ensure it is accurate and up to date.
- 52 All fit testing in the Trust should be completed by staff identified as competent, as defined by the Health & Safety Executive Regulations, Health & Safety Guidance 53 (HSG53), HSE COSHH Regulation and Guidance on RPE FIT testing (HSE INDG 479).
- 53 During the year of 1 April 2021 - 31 March 2022 significant improvements were made in relation to the operational delivery of fit testers. Two members of the IPC Team achieved British Safety Industries Federation (BSIF) certification as competent fit testers. These two members of staff have over many months updated all of the training material to train internal staff. They are assessed both theoretically and practically and issued with a competency profile and a certificate of completion once the training is complete. All known existing fit testers within the Trust have been invited to take part in a quality assurance process to ensure they have the right skills and knowledge to be identified as competent to fit test, any gaps identified in this process staff were given further training.
- 54 The Health and Safety Executive does not state a specific timeframe for re-testing staff, their recommendation is the more frequent RPE is used the more frequent fit tests are performed. Largely, organisations themselves determine the timeframes for retesting staff based on the types of work activity they perform and the required RPE to support this activity. The IPC Team has consulted with health and safety colleagues and has determined that retesting should take place every three years within the Trust. A three-year period would be an adequate timeframe to capture any naturally occurring facial changes or any changes to RPE from procurement.
- 55 Some staff will require their three yearly refit test within 2022. The IPC Team is currently in discussions with the ESR Team to establish how best to alert Managers of this requirement.
- 56 It will be imperative that those staff that are identified as competent fit testers in the Trust are available for this Programme of Work when required.

Region	Registered fit testers on ESR	Trained and Quality Assured Fit Testers (the only fit testers who should be actively testing staff)
North	28	10
Central & West	57	35
South & East	54	22

PPE Mask Compliance - as of 10/05/2022

PPE Mask Compliance - as of 10/05/2022								
EMS	Locality	Headcount	Total no of staff fit tested (for ANY mask)	Compliance rate for fit testing	No. of staff awaiting fit testing	No of staff who've passed at least 1 form of mask	% of staff who have passed at least 1 fit test (as a % of the staff who	No. staff who've failed ALL fit tests taken
ABM	Bridgend	68	67	98.53%	1	67	100.00%	0
	Neath	102	94	92.16%	8	94	100.00%	0
	Swansea	139	132	94.96%	7	131	99.24%	1
	Area Management	1	1	100.00%	0	1	100.00%	0
	Caerphilly	66	64	96.97%	2	60	93.75%	4
	Gwent	123	121	98.37%	2	111	91.74%	10
	Newport/Monmouth	112	106	94.64%	6	98	92.45%	8
	Area Management	17	16	94.12%	1	16	100.00%	0
	Conwy/Denbighshi	134	125	93.28%	9	122	97.60%	3
	Flintshire/Wrexha	135	119	88.15%	16	112	94.12%	7
	South Gwynedd	65	63	95.45%	2	58	92.08%	5
	Ynys Mon	104	101	97.12%	3	93	92.08%	8
	Cardiff	121	115	95.04%	6	112	97.39%	3
	Yale	73	70	95.89%	3	66	94.23%	4
	Cwm Taf	Merthyr	89	70	87.50%	10	70	100.00%
RCT		91	82	90.11%	9	74	90.24%	8
Hywel Dda	Cardiff	124	119	95.97%	5	104	87.33%	15
	Ceredigion	72	67	93.06%	5	64	95.52%	3
	Pembroke	109	102	93.58%	7	91	89.22%	11
Powys	North Powys	70	62	88.57%	8	59	95.16%	3
	South Powys	66	64	96.97%	2	63	98.44%	1
HART	HART	43	40	93.02%	3	40	100.00%	0
Totals		1927	1800	93.41%	127	1706	94.78%	94
NEPTS								
Area	Headcount	Total no of staff fit tested	Compliance rate for fit testing	No. of staff awaiting fit testing	No of staff who've passed at least 1 form of mask	% of staff who have passed fit testing (as a % of the staff who have	No. staff failed ALL fit testing	
ABM	90	86	95.56%	1	85	98.84%	1	
Aneurin	177	131	74.01%	42	111	94.72%	20	
BCU	127	111	87.40%	16	99	93.18%	12	
C&V	65	62	95.38%	3	59	95.16%	3	
Cwm Taf	61	57	93.44%	3	57	100.00%	0	
Hywel Dda	57	57	100.00%	0	50	87.72%	7	
Powys	49	41	102.50%	1	37	90.24%	4	
Totals		617	545	88.33%	72	498	91.98%	47

Fit Testing Compliance Report to 10 May 2022

WAST IPC Team Representation

57 It is encouraging to note below the meetings, working and Advisory Groups that members of the IPC have working relationships with and are able to represent the service, ensuring that the service and the out of hospital environment for IPC considerations and communication. It is essential that these relationships are strengthened, and IPC remains a focus for good standards and practices:

Internal	External
<ul style="list-style-type: none"> • Environmental Working Group • Decontamination of medical devices • Estates Working Group • Fleet Working Group • Working Safely Dynamic Delivery Group • Clinical Waste Working Group • IPC Team Meetings • Quality Live • Outbreak Management Teams • High Consequence Disease Task and Finish Group • Senior Pandemic Team • Quality Safety, Wellbeing Advisory Cell • Business Continuity and Recovery Cell • National Health & Safety Committee • Pandemic Governance Group 	<ul style="list-style-type: none"> • National Ambulance IPC Group. • Public Health Wales Working and Advisory Groups. (e.g., HCAs and IPC Working Group) • Infection Prevention Society Working Groups and Branch Meetings. • National Infection and Prevention for Ambulance Service • All Wales IPC Education Working Group • National Framework Operational Delivery Group for the investigations of COVID related HCAs • Small Business Research Innovation Network

- | | |
|--|--|
| <ul style="list-style-type: none">• Aneurin Bevan (AB) and Cardiff & Vale monthly Business Meeting• IPC Strategic Group | |
|--|--|

Future and Planned Work for 2022

- 58 A significant lesson learnt for the IPC Team over the last year has been the importance of detecting early signs of potentially important developments in relation to infectious diseases. This is done by systematically examining potential threats worldwide in terms of both notifiable and high consequence infections. As COVID-19 demonstrated, it crossed both land and sea and this can be the same for any serious communicable disease.
- 59 Dedicated time within the IPC Team is allocated to horizon scanning weekly. Key information is accessed and examined. It is a statutory duty to notify local authority or local Health Protection Team of suspected cases of certain infectious diseases.

Notifications of Infectious Diseases (NOIDS)

- 60 NOIDS is the term used to refer to the statutory duties for reporting notifiable diseases in the Public Health (Control of Disease) Act 1984 and the Health Protection (Notification) Regulations 2010 [Notifiable diseases: weekly reports for 2021 - GOV.UK \(www.gov.uk\)](http://www.gov.uk)

High Consequence Infectious Disease (HCIDs)

- 61 This term is used to refer to infections which are acute, have a high case-fatality rate and may not have effective prophylaxis or treatment. They are often difficult to recognize and detect rapidly and are able to spread in the community and within healthcare settings. Management requires an enhanced individual, population and system response to ensure it is managed effectively, efficiently and safely.

Global Hazards

- 62 HCIDs including Viral Haemorrhagic Fevers (VHFs), are rare in the UK. When cases do occur, they tend to be sporadic and are typically associated with recent travel to an area where the infection is known to be endemic or where an outbreak is occurring. None of the HCIDs listed are endemic in the UK, and the known animal reservoirs are not found in the UK [High consequence infectious disease: country specific risk - GOV.UK \(www.gov.uk\)](http://www.gov.uk)
- 63 It is the intention of the IPC Team to monitor and horizon scan activity and to ensure that this information is disseminated to all relevant parties and to reinforce continued pandemic preparedness.

Datix Reports

- 64 The Datix Reports below represent incidents for the time period 1 April 2021 - 31 March 2022

- 65 The highest consistently reported is that of contaminated needlestick injuries largely seen in Emergency Medical Services (EMS) within the Swansea Bay locality.
- 66 Accidental breakages, exposure to blood or bodily fluids, IPC Procedure/Policy issues and failure to decontaminate vehicle completes the top five reported Datix for IPC.
- 67 In addition, 23 Datix Reports have been submitted for the Corpro 1400 Half Mask. The themes of incidents have been attributed to either being damaged, or generally broken. One appeared to be poorly fitted and one went missing. Many of the issues that have been reported could have been picked up with regular completion of the RPE Maintenance Logs. Recognising that paper copies are difficult to manage with such a mobile workforce it has now been transferred to an electronic format which can be accessed via trust IPads.
- 68 Compliance with Maintenance Log completion will form part of the IPC Audit Plan for 2022/23.
- 69 Please see tables below for a greater breakdown of IPC related Datix submissions:

IPC Incidents by Sub Category_from Financial Year 2012/13										
	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Accidental Breakages	23	33	29	33	27	14	17	20	27	23
Appropriate personal protective equipment not available	1	0	6	2	1	1	0	1	1	0
Exposure to blood/body fluids	17	21	22	45	35	35	35	44	11	15
Failure to decontaminate equipment	2	4	2	0	2	2	0	1	3	3
Failure to decontaminate vehicle	3	6	3	0	1	0	3	4	3	10
Failure to take universal precautions	6	6	7	0	0	1	1	4	3	3
Infection Control procedure/policy issues	8	7	13	19	9	9	7	12	14	14
Needlestick injury - clean	4	3	2	8	4	0	3	4	4	1
Needlestick injury - contaminated	26	15	25	24	25	27	22	30	30	36
Patient diagnosed infectious after staff contact	0	0	0	0	0	0	0	2	0	0
Razor cut	8	0	3	7	8	10	1	6	2	0
Staff did not have appropriate immunisation	0	0	0	1	1	0	0	0	0	0
Staff not aware site or scene was contaminated	2	3	3	1	6	7	4	2	0	0
Staff not aware/informed patient was infectious	20	27	15	14	14	20	12	18	4	6
Staff not informed by control pt was infectious	0	0	0	0	0	0	1	2	3	0
No value	2	0	0	0	0	0	0	0	0	0
Total	122	125	130	154	133	126	106	150	105	111

PPE/Uniform Incidents since April 2012											
	2012	2013	2014	2015	2016	2017	2018	2019	2020	No value	Total
Uniform contaminated - replacement unavailable	0	0	2	0	0	0	0	1	0	0	3
No/Lack of PPE issue	2	0	4	1	0	0	0	0	3	0	10
No value	0	0	0	0	0	0	0	0	0	0	0
Total	2	0	6	1	0	0	0	1	3	0	13

IPC Incidents by Sub Category in the Last Financial Year													
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Accidental Breakages	2	4	0	4	1	4	4	0	1	0	2	1	23
Exposure to blood/body fluids	0	3	4	0	1	2	0	1	1	0	0	3	15
Failure to decontaminate equipment	0	0	0	0	0	1	0	1	0	0	1	0	3
Failure to decontaminate vehicle	1	1	0	2	0	1	1	0	1	2	1	0	10
Failure to take universal precautions	1	0	0	0	1	0	0	0	1	0	0	0	3
Infection Control procedure/policy issues	0	1	1	4	1	2	2	1	0	0	0	2	14
Needlestick injury - clean	0	0	0	0	0	0	0	0	0	0	1	0	1
Needlestick injury - contaminated	4	4	3	4	3	1	3	3	3	5	2	1	36
Staff not aware/informed patient was infectious	0	0	0	2	0	1	0	0	1	0	2	0	6
Total	8	13	8	16	7	12	10	6	8	7	9	7	111

IPC Incidents by Function in the Last Financial Year					
	21/22 Q1	21/22 Q2	21/22 Q3	21/22 Q4	Total
111 Service	0	1	0	0	1
EMS Emergency Medical Service	22	26	20	16	84
EMS RRV	2	1	0	2	5
EMS Urgent Care Service	1	1	1	3	6
EMS HART	2	1	1	0	4
NEPTS Operations	2	3	1	1	7
NEPTS Control Centre	0	1	0	0	1
Fleet Services	0	1	1	1	3
Total	29	35	24	23	111

IPC Incidents by Sub Category and Health Board in the Last Financial Year									
	Aneurin Bevan	Betsi Cadwaladr	Cardiff & Vale	Cwm Taf Morgannwg	Hywel Dda	Powys	Swansea Bay	111 Aneurin Bevan	Total
Accidental Breakages	6	1	2	0	5	3	6	0	23
Exposure to blood/body fluids	2	5	2	1	0	1	4	0	15
Failure to decontaminate equipment	0	2	0	1	0	0	0	0	3
Failure to decontaminate vehicle	1	4	2	0	0	2	1	0	10
Failure to take universal precautions	1	1	0	0	0	0	1	0	3
Infection Control procedure/policy issues	2	4	0	0	5	1	1	1	14
Needlestick injury - clean	0	0	0	0	0	0	1	0	1
Needlestick injury - contaminated	6	1	6	5	2	3	13	0	36
Staff not aware/informed patient was infectious	1	1	1	1	1	0	1	0	6
Total	19	19	13	8	13	10	28	1	111

IPC Open Incidents by HB and Financial Quarter					
	20/21 Q1	20/21 Q2	20/21 Q3	20/21 Q4	Total
Aneurin Bevan	0	0	1	0	1
Betsi Cadwaladr	2	1	1	2	6
Cardiff & Vale	0	0	0	0	0
Cwm Taf Morgannwg	0	0	0	0	0
Hywel Dda	0	0	0	0	0
Powys	0	0	0	1	1
Swansea Bay	1	1	1	0	3
Total	3	2	3	3	11

Corpro Mask Datix from 1 April 2021 - 31 March 2022



Corpro Mask Datix
Apr21-Mar22.xlsx

Peer Reviews

- 70 There is the increasing need to provide assurance to Trust Boards and external bodies that IPC Standards, Policies and Procedures are in place and areas of good practice and learning is highlighted. In previous years, prior to the pandemic, the National Ambulance Society Infection Prevention Control Group (NASIPCG) and other sub-groups of AACE have undertaken peer reviews across the UK with neighbouring Trusts to provide a critical friend and provide the support that other Trust Leads may find useful and beneficial.
- 71 During the pandemic this has not been possible however, this is one area of work that the Quality Improvement Governance & Risk Directors (QIGARD) via the NASIPCG is keen to take forward during 2022/23 (no exact date has been confirmed at the time of writing this report). Over the last two years, having support from other services has been invaluable and sharing of practice has become intrinsically instinctive and normal practice for the IPC Leads demonstrating that we all work better together.
- 72 The Peer Review Programme will be based on identified individuals from each Trust visiting a peer service. The aim of the visit will be to undertake a peer review/assessment/support visit against some set criteria or areas identified in order to assess the IPC Standards within the host Trust. Good practice will be shared and identify areas of best practice that can be shared across other Trusts. In addition, support can be given for any identified gaps or areas of learning.
- 73 The assessment aspect of this review is still currently under development and WAST is keen to participate in this activity. No formal dates have been set but it is anticipated the first will begin at the end of July 2022. The table below represents which Trust will peer review and which Trust will be reviewed:

Trust	Date	Reviewer Trust (names tbc)	Supporting Trust/Reviewer (names tbc)
Scotland Ambulance Service	TBA	North West Ambulance Service	North East Ambulance Service
North West Ambulance Service	TBA	Yorkshire Ambulance Service	Scotland Ambulance Service

North East Ambulance Service	TBA	Scotland Ambulance Service	North West Ambulance Service
Yorkshire Ambulance Service	TBA	North East Ambulance Service	East Midlands Ambulance Service
West Midlands Ambulance Service	TBA	East Midlands Ambulance Service	Yorkshire Ambulance Service
East Midlands Ambulance Service	TBA	East of England Ambulance Service	South East Coast Ambulance Service
East of England Ambulance Service	TBA	London Ambulance Service	South Central Ambulance Service
Welsh Ambulance Services NHS Trust	TBA	South Central Ambulance Service	South West Ambulance Service Trust
South West Ambulance Service Trust	TBA	West Midlands Ambulance Service	Welsh Ambulance Services NHS Trust
London Ambulance Service	TBA	South East Coast Ambulance Service	Northern Ireland Ambulance Service
South Central Ambulance Service	TBA	Welsh Ambulance Services NHS Trust	London Ambulance Service
South East Coast Ambulance Service	TBA	South West Ambulance Service Trust	East of England Ambulance Service
Northern Ireland Ambulance Service	16/17.8.22	AACE D Bullock	Welsh Ambulance Services NHS Trust
Isle of White (?)	TBA	TBA	TBA

Forward Plan

Adenosine Triphosphate (ATP) Testing

- 74 ATP testing continues to be used within the Trust, largely for quality assurance of the cleanliness of vehicles cleaned within the Make Ready Depots (MRD). This process has been successful in highlighting high touch areas within vehicles and has since been included within training materials for vehicle cleaning.
- 75 There is intention to use ATP swabbing as part of the Premise Cleanliness Audits (in the first instance) with the aim to support visual inspections.

Safe Clean Care Campaign (SCCC)

- 76 The aim of the SCCC is to:
- Embed the importance of IPC in everyday practice
 - Reduce variation in IPC practice and standardise care processes
 - Improve the application of knowledge and skills in IPC
 - Help reduce the risk of HCAs, particularly cross infection/contamination
 - Help reduce unnecessary use of antibiotics
- 77 There are six key components to reduce the incidences of HCAs:
- Hand Hygiene
 - Environmental Hygiene
 - The principle of consistently utilising basic IPC precautions
 - Transmission Guidance and the reduction in the use of antibiotics
 - The principles of controlled and uncontrolled ANTT
 - Immunisation and personal health of staff

- 78 The initial work to start this Campaign was done in 2019 however, the emerging and subsequent COVID-19 pandemic put this on hold. It is the intention of the IPC Team to reignite this Campaign and build on the good practice and changed adopted during the pandemic.
- 79 Other areas of work that will likely run into 2023:
- Transfer best practice from the COVID-19 documents into business as usual e.g., Outbreak Management SOP
 - High Consequence Infectious Diseases (HCIDs) SOP
 - ANTT update training
 - Invasive Procedures SOP
 - Reintroduce the All-Things IPC Handbook now that it is aligned to the UK IPC Manual (this will likely replace the current IPC PPE Guidance document)
 - Review all current IPC training materials and develop to fill a number of gaps that have become apparent
 - Review all on-line training packages Level 1 and Level 2 and incorporate Emergency ANTT into ANTT ESR Framework and ON Click
 - Develop a formal IPC response to Datix reporting
 - Development of a suite of IPC related Risk Assessments
 - Develop Hand Hygiene and Bare Below the Elbow SOP
 - Management of Linen SOP
- 80 All documents that have been referenced in this report can be accessed either via the IPC Team, SharePoint or the IPC Intranet Page.
- 81 Whilst this report provides the IPC performance within the last twelve months, many business-as-usual activities have been put on hold. It is now imperative that this work progresses throughout the year and the team must remain focused on key areas for 2022. It is important that this year the team is able to perform audits and reignite and progress some areas of work outstanding as a result of the pandemic. We must now live with COVID-19, but we must also remain vigilant to any other emerging threats and maintain preparedness for any future infectious incidents.



AGENDA ITEM No	17.1
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	2

INFECTION, PREVENTION & CONTROL STRATEGIC GROUP - TERMS OF REFERENCE

MEETING	Executive Management Team
DATE	31 March 2021
EXECUTIVE	Executive Director of Quality & Nursing
AUTHOR	Head of Infection Prevention & Control
CONTACT	Louise Colson 07387 249918 Louise.Colson@wales.nhs.uk

EXECUTIVE SUMMARY

This Report will provide an update to the Executive Management Team on the key information in relation to the Welsh Ambulance Services NHS Trust (WAST) Infection, Prevention & Control Strategic Group Terms of Reference.

KEY ISSUES/IMPLICATIONS

- (i) Discusses, approves and commits resources to the membership of the Group
- (ii) Approves the Terms of Reference

RECOMMENDED: That the Executive Management Team receives this report and actions the above.

REPORT APPROVAL ROUTE

Assistant Directors Leadership Team	29 March 2021
Executive Management Team	31 March 2021

REPORT APPENDICES

Annex 1 - Infection, Prevention & Control Terms of Reference.

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)	ALL
Health Improvement	N/A	Socio Economic Duty	N/A

Health and Safety	N/A	TU Partner Consultation	N/A
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SITUATION

- 1 This SBAR seeks approval of proposed revision to the Infection Prevention and Control (IPC) Strategic Group Terms of Reference (ToR) (**Appendix 1**).
- 2 Over the past 12 months, the Trust has operated within the Pandemic Cell structure where IPC matters have had a clear governance structure to conduct business.
- 3 As the Trust has moved into 'monitor' and further considers movement towards 'recovery', revision to the governance structure and system is required.
- 4 In February 2020, at the outset of the pandemic, an Internal Audit assessed the Trust's Cleaning Standards as having limited assurance. Within the Audit, 'governance arrangements and lines of accountability' were found to have only achieved limited assurance status; specifically detailing:

"...the Infection Prevention Control (IPC) Strategic Group is not operating effectively and is therefore not fulfilling its role"
- 5 This paper provides an overview and rationale of the proposed ToR to strengthen the performance of the IPC Strategic Group. This requires Executive Management Team approval to satisfy the management response action (recommendation 4) of the Cleaning Standards Internal Audit (**Appendix 2**).

BACKGROUND

Internal Audit

- 6 On 28 February 2020, NHS Wales Shared Services Partnership Audit and Assurance Services issued the Trust with *WAST Cleaning Standards Internal Audit Report 19/20* (**Appendix 2**).
- 7 The Trust was assessed overall to have limited assurance.
- 8 Whilst the report found evidence of monitoring and accountability of cleaning standards, it was assessed that whilst IPC statutory and mandatory training compliance, datix incidents and cleanliness audits are included in the Quarterly Quality Assurance Reports which were presented at the Quality Steering Group (QSG) and Quality, Patient Experience & Safety (QuEst) Committee. The Audit identified opportunities to improve reporting and monitoring arrangements, particularly at the IPC Strategic Group.
- 9 Whilst actions arising from the Internal Audit were intended to be delivered by 2019/20 Quarter 4 and 2020/21 Quarter 1, the COVID-19 pandemic over the last 12 months has put many business-as-usual activities on hold whilst managing the pandemic as a strategic priority.

COVID-19 Pandemic

- 10 Over the pandemic period, matters relating to IPC have been governed and managed through the pandemic structure. Several core meetings within the Trust were paused. This included the Infection Prevention and Control Strategic Group Meetings.
- 11 The introduction of the cell structure during the pandemic improved many areas of IPC performance and improvement. Effective engagement across the organisation, significant attention and leadership on matters of IPC were fundamental to achieving this.
- 12 It is now widely recognised that a level of COVID-19 will remain within the community for an extended time; there is potential for further waves of COVID-19 activity.
- 13 Nevertheless, it is important to remain vigilant to other forms of transmissible infection and transmission. There are growing IPC work priorities, of which scope is beyond sole pandemic activity or have been identified through the pandemic and are necessary to ensure our people work safely, the Trust maximises the protection of patients and ensures organisational compliance.

IPC Strategic Group

- 14 Formerly, the Group supported the IPC agenda and the monitoring of the IPC Improvement Plan.
- 15 This formal Group reported to Quality Steering Group, with a Terms of Reference and membership.
- 16 Meetings were diarised for the year; however, attendance was consistently low and on occasions the Group was not quorate. It is understood that attendance was challenging to manage & enforce and delayed many areas of work that were dependent on cross-Directorate working and decision making.
- 17 It is the ambition of the IPC Team that the ability for collaborative working across Directorates continues, as has been experienced throughout the pandemic and that IPC continues to be considered a priority within the Trust.
- 18 The confirmation and commitment of members to the IPC Strategic Group is essential to ensure effective decision making and performance of the Group. The pandemic has provided clear evidence that such a function is critical and must be effective in performing its role, including medium and long-term scenario planning.

ASSESSMENT

- 19 The Internal Audit Team reviewed minutes, papers and action logs for the above forums, along with the Strategic Transformation Board (STB), Assistant Directors Leadership Team (ADLT) and the Board and noted the following regarding the IPC Strategic Group:

- (i) the group has been meeting every 8 weeks, rather than monthly as per the ToR
 - (ii) there has been limited attendance from Fleet, Estates and Operational representatives which has impacted the wider communication of key messages
 - (iii) implementation of the Trust's cleaning Policies and Standards is not a regular agenda item
 - (iv) Action Logs appear incomplete/in draft and have items dating as far back as February 2019
- 20 Within the recommendation offered (recommendation 4), the Internal Audit Team advises:
- (i) Cleaning Standards should be discussed and monitored at the IPC Strategic Group and escalated through the Trust's governance structures appropriately. Minutes and Action Logs should clearly evidence the discussions and scrutiny that take place at the meetings
 - (ii) The Trust should **review and finalise the Terms of Reference** for the IPC Strategic Group and **ensure there is appropriate attendance, engagement and participation from all parties** that have a role in delivering the IPC Improvement Plan
- 21 Recommendation 4 was accepted by the Trust, with the management response provided that 'the Terms of Reference for the IPC Steering Group (including membership) will be reviewed and shared with all Directors.'
- 22 The IPC Strategic Group ToR have been revised. It is important that, whilst progress has been made against the other Internal Audit recommendations, the IPC Strategic Group ensures and assures the Trust on the cleaning provisions, along with other IPC matters formed with the recommendations.
- 23 Whilst the revision of the ToR will provide greater clarity of purpose, scope and role, its success will be determined by the commitment and engagement of Trust leaders in attendance.
- 24 The ToR membership has been revised to include senior leadership required to enable decision making and accountability. It is essential these colleagues are supported to attend the Group.
- 25 The frequency of meetings has been changed to quarterly; this is a reduction from the previous ToR which intended to meet monthly. The intent of this proposal is reflective of the strategic level of the Group. The Strategic Group, through the support of the IPC Team, will be empowered to oversee the delivery of objectives which includes the use of cross-Directorate Delivery/Action Implementation Groups. It is envisaged this will further support the function to achieve the agility and pace desired, as experienced through the pandemic structure.
- 26 The key success to this Delivery Group will be the continued attendance of all the membership staff. Those not able to attend must send an appropriate deputy.

RECOMMENDED: That the Executive Management Team:

- (i) Discusses, approves and commits resources to the membership of the Group.**
- (ii) Approves the Terms of Reference**

APPENDIX 1

WAST Infection Prevention and Control Strategic Group ToR

APPENDIX 2

Cleaning Standards Internal Audit Report



Welsh Ambulance Services NHS Trust

Infection Prevention & Control (IPC) Strategic Group

TERMS OF REFERENCE

1. INTRODUCTION

- 1.1. The Welsh Ambulance Services NHS Trust (WAST) is committed to a zero tolerance of preventable Health Care Associated Infections (HCAIs).
- 1.2. The Trust seeks to develop the strategic intent, and hold oversight of the delivery of actions to reduce the risk of transfer of infections in the pre-hospital care environment that could impact on the care provided to patients, carers and staff.
- 1.3. The Trust prioritises the health, safety and wellbeing of our people; the IPC Strategic Group will provide leadership and support for all issues relating to safe Infection Prevention and Control (IPC) practices, which maximises working safely.
- 1.4. Through the IPC Strategic Group, the Trust is committed to working in partnership with all staff, service users and key internal and external stakeholders influential in the infection prevention and control, and health and care delivery. This includes; Health Boards, Trusts, Public Health Wales, academic institutions, and industry.
- 1.5. The Trust works in line within the *All Wales IPC Code of Practice 2014*, *UK Five-Year Antimicrobial Resistance Strategy 2019*, *Welsh Government Antimicrobial Resistance (AMR) delivery Action Plan 2019*, *Health and Social Care (Quality & Engagement) (Wales) Act 2020*, and the *Health and Care Standards 2015*.

2. PURPOSE & AIM

- 2.1. The purpose of the IPC Strategic Group is to provide strategic expertise, assurance on performance, and implementation of work programmes within the organisation of matters relating to IPC.
- 2.2. The Group will provide oversight of the development of Trust policies, plans and procedures.
- 2.3. The Group will provide a senior cross-directorate forum, in which IPC matters will be considered to ensure successful operationalisation and positive implementation into Trust policies, procedures and practices.

2.4. The IPC Strategic Group aim to:

- 2.4.1. Develop and maintain a culture within the Trust where preventable infections are not tolerated;
- 2.4.2. Ensure IPC leadership is visible at all levels of the organisation and across all service areas and functions;
- 2.4.3. Improve the quality and safety of IPC within the Trust, improving and embedding core practices, developing processes & systems, and leading on research and innovation;
- 2.4.4. Receive and disseminate information pertinent to IPC, monitoring and measuring performance at local, regional and Trust-wide levels;
- 2.4.5. Develop, coordinate and deliver actions that contribute to enabling the Trust staff to work safely, through the implementation of the IPC action plans, management of a *Safe Clean Care* campaign, and influencing action on lessons learnt from the COVID-19 Pandemic;
- 2.4.6. Contribute to and influence prudent antimicrobial prescribing into routine practice.

3. ROLE OF THE IPC STRATEGIC GROUP

- 3.1. As a cross-directorate forum, the Group will lead, coordinate and advise on the strategic intent for the Trust on all matters relating to Infection Prevention and Control. This includes medium- and long-term strategic consideration and planning.
- 3.2. To develop, implement and nurture a Group sub-structure across the organisations service areas that ensures 'bottom-up' intelligence and engagement is achieved.
- 3.3. To receive quality management reports relating to IPC performance and derived appropriate action to ensure the Trust remains compliant, manages risks and issues arising, and ensure safety of staff and patients.
- 3.4. Provide assurance to the Clinical and Quality Governance Group; in turn providing assurance to the Quality Safety and Patient Experience Committee (QuEST).
- 3.5. Seek and develop opportunities to work in partnership with key external & internal key stakeholders that align to the strategic ambitions of the Trust and those of the IPC Transformation plan.
- 3.6. Advise on the requirement for resources, equipment, products to maximise the reduction of Healthcare Associated Infections and/or improve health and safety of Trust staff.

3.7. Coordinate and action work programmes authorised through the Clinical and Quality Governance Group.

4. MEMBERSHIP & GOVERNANCE

4.1. The proposed core membership of the WAST IPC Strategic Group is:

	Title	Name
Quality	Assistant Director of Quality Governance (Chair)	Jonathan Turnbull-Ross
Quality	Head of IPC (Vice Chair)	Louise Colson
Quality	Head of Health & Safety	Nicola White
Clinical	Associate Director of Paramedicine	Andy Swinburn
Operations	Assistant Director of Operations – Resilience	<i>TBC post SOT. Subject to review (pending OCP)</i>
Operations	Assistant Director of Operations - EMS	<i>TBC post SOT. Subject to review (pending OCP)</i>
Operations	Assistant Director of Operations - NEPTS	<i>TBC post SOT. Subject to review (pending OCP)</i>
Operations	National Make Ready Lead	Tony Crandon
NATC	Assistant Director, Professional Education & Training	Andrew Challenger
Clinical	Head of Nursing Education Professional and Clinical Practice	Deb Armstrong
Occupational Health & Wellbeing	Head of Occupational Health/Wellbeing	Ceri Bryant
Estates	Head of Estates	Derek John
Fleet	Head of Fleet	David Holmes
Trade Union Partner	Trade Union Partner	<i>TBC post ToR confirmation</i>
Public Health Wales	Public Health / IPC Consultant Nurse	External

4.2. A secretariat will be provided by the Chair.

- 4.3. Core members must nominate a deputy representative to attend in their absence.
- 4.4. The Group will reserve the right to co-opt / invite other relevant attendees, as and when required.
- 4.5. In the absence of the Chair, leadership will be devolved to the Vice Chair.
- 4.6. The quorum for meetings is based upon a minimum of five members attending. Of this minimum number of members, either the Chair or Vice Chair must be in attendance for a meeting to take place.

5. FREQUENCY OF MEETINGS

- 5.1. Meetings will take place quarterly.
- 5.2. An extra-ordinary meeting can be called by approval of the Chair.
- 5.3. Agenda items must be provided to the administrative support seven working days before the meeting takes place.
- 5.4. The agenda will be distributed seven days prior to the meetings taking place.

6. ACCOUNTABILITY

- 6.1. The IPC Strategic Group will report to the Clinical & Quality Governance Group.
- 6.2. A highlight report will be provided to the Clinical & Quality Governance Group on a quarterly basis.
- 6.3. An exception report will be provided on request, or where significant matters arise.
- 6.4. An annual review of the Group Terms of Reference and high-level work plan will be conducted and be approved by the Clinical & Quality Governance Group.



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Welsh Ambulance Services
NHS Trust

Cleaning Standards

Internal Audit Report

2019/20

Welsh Ambulance Services NHS Trust

NHS Wales Shared Services Partnership

Audit and Assurance Services



CONTENTS	Page
1. Introduction and Background	4
2. Scope and Objectives	4
3. Associated Risks	5
<u>Opinion and key findings</u>	
4. Overall Assurance Opinion	5
5. Assurance Summary	5
6. Summary of Audit Findings	6
7. Detailed Audit Findings	7
8. Summary of Recommendations	10

Appendix A	Management Action Plan
Appendix B	Assurance Opinion and Action Plan Risk Rating
Appendix C	Responsibility Statement

Review reference:	WAST-1920-16
Report status:	Final
Fieldwork commencement:	14 November 2019
Fieldwork completion:	05 February 2020
Draft report clearance meeting:	04 February 2020
Draft report issued:	21 February 2020
Management response received:	27 February 2020
Final report issued:	28 February 2020

Auditors	Helen Higgs, Head of Internal Audit Osian Lloyd, Deputy Head of Internal Audit Rhian Gard, Principal Auditor
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Executive sign off	Claire Roche, Director of Quality and Nursing Lee Brooks, Director of Operations Chris Turley, Director of Finance & Corporate Services
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Distribution	Jonathan Turnbull- Ross, Assistant Director of Quality Governance Louise Platt, Assistant Director of Operations
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Richard Davies, Assistant Director
of Capital & Estates

Louise Colson, Head of Quality
Assurance & Infection Prevention
Control

Laurence Neville, Quality &
Infection Control Manager

Tony Crandon, Make Ready Lead

Judith Bryce, Head of Operational
Support

Derek Johns, National Estates
Manager

David Holmes, Fleet Manager

Committee

Audit Committee
Quality, Patient Experience & Safety
(QuEST) Committee



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

ACKNOWLEDGEMENT

NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Non-Executive Directors or officers including those designated as Accountable Officer. They are prepared for the sole use of Welsh Ambulance Service Trust and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction and Background

The Welsh Ambulance NHS Trust (the 'Trust') is committed to a zero tolerance of preventable healthcare associated infections (HCAI's). The Trust prioritises action to reduce the risk of transfer of community acquired infections in the pre-hospital care environment that could impact on the care provided to patients, carers and staff in secondary care and the wider community.

The Infection Prevention & Control Policy: Elimination of Healthcare Associated Infections (HCAI's) and the implementation of the nine standards of the All Wales Code of Practice 2014 through the implementation of an IPC improvement Plan 2017 - 19, promotes the importance of cleaning Trust vehicles, medical equipment and premises. Cleaning is paramount to the effective delivery of patient care in all healthcare environments.

2. Scope and Objectives

The overall objective of the review was to provide assurance that vehicles and stations are being cleaned to the expected standards. An assessment of the impact of 'make ready depots' (MRD's) was included. In addition, we sought to provide an assurance that the data from the Adenosine Triphosphate (ATP) swab testing at MRD's is informing effective decision making in terms of cleanliness.

The areas the review sought to provide assurance on are:

- clear governance arrangements and lines of accountability, including Executive responsibility and a multi-disciplinary scrutiny/review forum;
- operational policies / procedures are in place and set out cleaning requirements;
- there is staff awareness and promotion of the cleaning standards and staff have undertaken appropriate levels of training;
- vehicles and stations are cleaned in accordance with Trust cleaning schedules;
- regular cleanliness audits are undertaken across Trust premises and ambulances, including 'make ready depots'; and
- compliance is regularly monitored and reported within the Trust.

Limitations of scope

This audit did not review staff vaccinations, including the influenza jab, and the transmission of infectious diseases and the cleaning of ambulances between patients.

3. Associated Risks

The overarching risk associated with this review was as follows:


- Trust vehicles and premises are not appropriately cleaned or maintained leading to staff or patient harm and associated financial and reputational implications.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.





The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Cleaning Standards is **Limited** assurance.





RATING	INDICATOR	DEFINITION
Limited Assurance		The Board can take limited assurance that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with moderate impact on residual risk exposure until resolved.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the tables below:

					
1	Governance arrangements and lines of accountability		✓		

					
2	Operational policies and procedures			✓	
3	Staff awareness and training			✓	
4	Vehicles and stations cleaning schedules		✓		
5	Cleanliness audits		✓		
6	Compliance monitoring and reporting			✓	

* The above ratings are not necessarily given equal weighting when generating the audit opinion.

Design of Systems/Controls

The findings from the review have highlighted two issues that are classified as weaknesses in the system control/design for Cleaning Standards.

Operation of System/Controls

The findings from the review highlighted two issues that are classified as weaknesses in the operation of the designed system/control for Cleaning Standards.

6. Summary of Audit Findings

There are over 700 vehicles and 90 ambulance stations / premises across the Trust, which includes three MRD's that are staffed with a dedicated team responsible for routine and deep cleaning of ambulances. A clean healthcare environment is essential to patients and staff and these must be well maintained in line with the *National Specifications for Cleanliness in the NHS 2007*.

The audit identified a number of policy documents that provide staff with clear guidance on the standard of cleaning expected in relation to Ambulance vehicles in order to reduce Healthcare associated infections, thus protecting staff and patients. Interviews with a sample of staff during the audit confirmed awareness of the cleaning policies and standards and that the Trust is reporting high compliance rates with infection prevention and control training. In addition, the cleaning standards for premises

document is currently being drafted. It is recognised that whilst these policies and the accompanying standards are essential for the organisation, the Trust is not in a position to comply as the resources are not in place to do so.

We identified clear governance arrangements and lines of accountability, however the Infection Prevention Control (IPC) Strategic group is not operating effectively and is therefore not fulfilling its role. Whilst vehicle and station cleanliness audits are undertaken every 6 months, these provide only limited assurance as they are high level and subjective visual inspections. Further, we did not see evidence of follow up action being taken to address exceptions highlighted.

It is important to consider these findings in the context of the number of Infection Prevention Control datix incidents reported that are relevant to the cleaning of vehicles and premises: four incidents of '*Infection Control procedure / policy issues*' and one incident of '*failure of decontaminate vehicle*' have been reported since July 19. Whilst these figures are low there is still work to do to provide assurance that cleaning standards are being adhered to across the Trust.

7. Detailed Audit Findings

Objective 1: clear governance arrangements and lines of accountability, including Executive responsibility and a multi-disciplinary scrutiny/review forum

The IPC Strategic Group leads, coordinates and advises on all matters relating to Infection Prevention and Control within the context of the IPC Improvement Plan 2017-19, providing feedback to the Quality Steering Group (QSG) and then Quality, Patient Experience & Safety Committee (QuEST). The Director of Quality and Nursing is the Executive Sponsor of the IPC Strategic Group. The Group drives the development of cleaning policies and standards to be applied across the Trust, although we note focus has been on vehicles to date. The cleanliness of premises and the quality assurance mechanisms (including ATP testing and cleanliness audits) to monitor effectiveness has yet to be addressed.

Our review of meeting minutes and action logs highlighted that the Group is not operating effectively and is therefore not fulfilling its role. Although IPC statutory and mandatory training compliance, datix incidents and the 6 monthly cleanliness audits are detailed in the Quarterly Quality Assurance Reports presented at QSG and QuEST Committee, the findings raised in this report have identified opportunities to improve reporting and monitoring arrangements.

See Finding 4 in Appendix A.

Objective 2: operational policies / procedures are in place and set out cleaning requirements

The following policies and procedures refer to Cleaning Standards; the overarching *Infection Prevention Control Policy: Elimination of Healthcare Associated Infections (HCAI's)* which is underpinned and supported by the *All things Infection Prevention & Control guidance*, the *Premises and Vehicle Cleanliness Policy* and the *Ambulance Vehicles Cleaning Standards*. These documents provide staff with clear guidance on the level of quality expected within the context of Ambulance vehicles to reduce HCAI's protecting staff and patients. The cleaning standards for premises document is currently being drafted (refer to finding 1).

Objective 3: there is staff awareness and promotion of the cleaning standards and staff have undertaken appropriate levels of training

Interviews with a sample of staff during the audit confirmed awareness of the cleaning policies and standards. This has been achieved through promotion via the 'Siren' staff communications and resources being made available on the Infection Prevention and Control section on the Trust intranet site.

Depending on their role, Trust staff are required to complete level 1 and 2 IPC training. The Quarterly Quality Assurance Report for Quarter 2 2019/20, reported compliance rate for Emergency Medical Services (EMS) and Non-Emergency Patient Transport Services (NEPTS) patient facing staff of 99.5% and 79% for level 1 and 2 training respectively. In addition, 95% of patient facing staff that perform invasive clinical procedures on patients, have received Aseptic Non Touch Technique (ANTT) Training.

IPC training is offered to staff as part of the two day statutory and mandatory Continuous Professional Development (CPD) training programme directed by the Trust. The IPC CPD sessions for 19/20 covered topics relating to personal protective equipment, hand hygiene as well as vehicle cleaning and basic IPC precautions.

Objective 4: vehicles and stations are cleaned in accordance with Trust cleaning schedules

Cleaning of ambulances and stations at non-make ready depots is the responsibility of the ambulance crews. Consistent with the recent internal audit review of Appropriately Equipped Paramedics, all paramedics spoken with during our station visits reported that due to the service demand there is insufficient time to complete the required cleaning. We were advised that vehicle cleaning essentially consists of a wipe down with Clinell wipes as and when the opportunity or need arises. Furthermore, no cleaning records

are maintained to demonstrate that the cleaning standards are being adhered to.

Cleaning of Stations

The above is recognised in the draft '*Options Appraisal for the provision of Premises Cleaning Services*', and estimates that between 50,000 and 70,000 cleaning hours are required per year in order to attain the premises cleaning standard required by NHS National Cleaning Standards. The paper highlights that there is currently a variety of cleaning providers being contracted and notes a disparity in approach across the Trust.

The cleaning standards for premises document is currently being drafted. However, whilst these are essential for the organisation, the Trust is not in a position to comply as the resources are not in place to do so.

See Finding 1 in Appendix A

Cleaning of Vehicles

As noted under objective 2 above, there is clear guidance for staff on the level of cleaning expected within the context of ambulance vehicles.

The draft options appraisal states that the vehicle cleaning standards are effective and achievable for those vehicles that pass through the MRD's where there are three levels of vehicle cleanliness. However, whilst a cleaning record sheet is completed and retained for each vehicle cleaned within a MRD and these are reported on a monthly basis to the Operations Directorate, a check is not undertaken to ensure all vehicles within the Trust have been cleaned.

The MRD's can verify the effectiveness of the cleaning methods and compliance against those cleaning standards through ATP swabbing. Analysis from Phase 1 of the ATP proof of concept study highlighted the most common areas of contamination and thus, further work is planned to assess the long-term use of ATP testing as a form of effectively measuring cleaning standards both for vehicles (including NEPTS) and premises.

See Finding 2 in Appendix A

Objective 5: regular cleanliness audits are undertaken across Trust premises and ambulances, including 'make ready depots'

The Ambulance Vehicle Cleaning Standard includes a requirement for each health board area to audit compliance. Vehicle and station audits are undertaken every 6 months and should be presented to the IPC Group

(refer to objective 1 above and finding 4) with an overview report presented to QSG and QuEST Committee quarterly.

Whilst analysis from the most recent cleanliness audits (July – December 19) suggest high compliance, it is recognised that these provide only limited assurance as they involve high level and subjective visual inspections. As a result, alternative methods of audit are currently being considered. Where the reports did highlight some non-compliance, we did not see evidence of follow up action being taken to address and resolve the issues.

See Finding 3 in Appendix A

Objective 6: compliance is regularly monitored and reported within the Trust

As discussed under objective 1 and 5 above, whilst IPC statutory and mandatory training compliance, datix incidents and cleanliness audits are included in the Quarterly Quality Assurance Reports presented at the QSG and QuEST Committee, the findings raised in our report has identified opportunities to improve reporting and monitoring arrangements, particularly at the IPC Strategic Group.

See Findings 3 and 4 in Appendix A

8. Summary of Recommendations

The audit findings, recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined in the table below.

Priority	H	M	L	Total
Number of recommendations	3	1	0	4

Action Plan

Finding 1 Cleaning of Stations (Design)	Risk
<p>Cleaning of vehicles at non-make ready depots is the responsibility of the ambulance crews. Consistent with the recent internal audit review of Appropriately Equipped Paramedics, all paramedics spoken with during our station visits reported that there is insufficient time to complete the required cleaning. We were advised that vehicle cleaning essentially consists of a wipe down with Clinell wipes as and when the opportunity or need arises. Furthermore, no cleaning records are maintained to demonstrate that the cleaning standards are being adhered to.</p> <p>The above is recognised in the draft '<i>Options Appraisal for the provision of Premises Cleaning Services</i>', and estimates that between 50,000 and 70,000 cleaning hours are required per year in order to attain the premises cleaning standard required by NHS National Cleaning Standards. The paper highlights that there is currently a variety of cleaning providers being contracted and notes a '<i>disparity across the trust in the provision of cleaning services with the majority of station locations having no cleaners at all, relying on the goodwill of staff based there to deliver minimal station cleaning whilst not compromising operational delivery.</i>'</p> <p>The cleaning standards for premises document is currently being drafted. However, whilst these are essential for the organisation, the Trust is not in a position to comply as the resources are not in place to do so.</p>	<p>Stations not being cleaned, leading to staff and patient harm.</p>
Recommendation 1	Priority level
<p>We concur with management's intention to finalise, publish and implement the Cleaning Standards for Premises.</p> <p>The Trust should also review the arrangements and resources in place to demonstrate and ensure adherence to its cleaning standards for premises.</p>	<p style="text-align: center;">High</p>

Action Plan

Management Response 1	Responsible Officer/ Deadline
<p>Recommendation accepted.</p> <p>We will finalise and publish our Cleaning standards for stations.</p> <p>We will develop an implementation plan for the standards.</p> <p>We will review the arrangements in place to ensure adherence to the cleaning standards for premises.</p> <p>We will review the resources required to ensure adherence to the cleaning standards for premises.</p>	<p><i>Executive Lead: Director of Quality and Nursing / Director of Finance & Corporate Resources</i></p> <p>Assistant Director Quality Governance / 31st May 2020</p> <p>Assistant Director Capital and Estates / 30 June 2020</p>

Finding 2 Cleaning of Vehicles (Operation)	Risk
<p>As noted under finding 1 above, cleaning of vehicles at non-make ready depots is the responsibility of the ambulance crews, although paramedics spoken to during the audit highlighted that there is insufficient time to do so. The Ambulance Vehicle Cleaning Standards (2017) provides staff with clear guidance on the level of quality expected within the context of Ambulance vehicles to reduce Healthcare associated infections protecting staff and patients. In addition, there is a vehicle cleaning schedule included in an appendix in the All things Infection Prevention & Control guidance document along with a compendium (A-Z) of common diseases and guidance on equipment and cleaning required of vehicles post exposure / contamination.</p> <p>The draft <i>'Options Appraisal for the provision of Premises Cleaning Services'</i> discussed above also states that the vehicle cleaning standards are effective and achievable for those vehicles that pass through the MRD's where there are three levels of vehicle cleanliness (defined in the <i>'Make Ready Standard Operating Procedures (SOPs)'</i>):</p> <ul style="list-style-type: none"> • <i>'Level 1 – hard surface clean every 24 operational hours (which equates to every 2-3 days). This includes equipment stored on the vehicle interior (i.e. defibrillator, suction unit, and stretcher) and takes three and a half to four hours.</i> • <i>Level 2 – deep clean every six weeks. This includes cleaning equipment stored within cupboard and takes five to six hours.</i> • <i>Level 3 – ad hoc clean when a vehicle has been contaminated.'</i> <p>Whilst a cleaning record sheet is completed and retained for each vehicle cleaned within a MRD and the vehicles cleaned are reported on a monthly basis to the Operations Directorate, a check is not undertaken to ensure all vehicles within the Trust have been cleaned.</p> <p>The MRD's can verify the effectiveness of the cleaning methods and compliance against those cleaning standards through ATP swabbing. Phase 1 of the ATP proof of concept study</p>	<p>Vehicles are not being cleaned, leading to staff and patient harm.</p>

Action Plan

<p>commenced on the 5th April 2019 over a 12 week period, based on vehicles scheduled every six weeks for level two cleaning, this matched the six week vehicle servicing schedule. Analysis from this study highlighted the most common areas of contamination are the steering wheel, gear stick, door handle on passenger side of the cab, defibrillator handles and the MDT Screen. Further work is planned to assess the long-term use of ATP testing as a form of effectively measuring cleaning standards for vehicles (including NEPTS).</p>	
<p>Recommendation 2</p>	<p>Priority level</p>
<p>The Trust should review the arrangements and resources in place to demonstrate and ensure adherence to its cleaning standards for all vehicles across the organisation.</p> <p>We concur with management’s proposal to continue to assess the long-term use of ATP testing as a form of effectively measuring cleaning standards for vehicles (including NEPTS).</p>	<p>High</p>
<p>Management Response 2</p>	<p>Responsible Officer/ Deadline</p>
<p>We will assess the long term use of ATP testing to quality assure cleaning standards for vehicles.</p> <p>We will review the arrangements and resources in place to demonstrate and ensure adherence to its cleaning standards for all vehicles across the organisation.</p>	<p><i>Executive Lead: Director of Quality and Nursing / Director of Operations</i></p> <p>Assistant Director Quality Governance / 31.05.2020</p> <p>Assistant Director Operations / 31.05.2020</p>

Finding 3 Cleanliness Audits (Design)								Risk
<p>The Ambulance Vehicle Cleaning Standard includes a requirement for each health board area to audit compliance with the requirements, using an audit tool that has been designed in line with the standards. The results of the audits should be presented to the IPC Strategic Group by representatives from the Operations Directorate, <i>'identifying overall performance, key challenges and an improvement plan'</i>. An overview report is then presented to both the QSG and QuEST Committee quarterly.</p> <p>The vehicle and station cleaning audits are currently undertaken every 6 months. The tables below provided analysis from the cleanliness audits from January – June 2019 and were included in the quarter 1 2019/20 Quarterly Quality Assurance Report:</p>								<p>Inappropriate monitoring arrangements leading to vehicles and stations not being cleaned, resulting in staff or patient harm.</p>
<u>Vehicles</u>	<u>ABUHB</u>	<u>ABMU</u>	<u>BCHB</u>	<u>C&V</u>	<u>CT</u>	<u>HDda</u>	<u>PT</u>	
EA	91%	97%	98%	Not provided	97%	97%	100%	
RRV	97%	99%	99%	Not provided	98%	97%	100%	
NEPTs	95%	99%	95%	92%	91%	97%	97%	
HART	-	100%	-	-	-	-	-	
<u>Ambulance Stations</u>	<u>ABUHB</u>	<u>ABMU</u>	<u>BCHB</u>	<u>C&V</u>	<u>CT</u>	<u>HDda</u>	<u>PT</u>	
	77%	97%	94%	77%	97%	88%	98%	
<p>The figures suggest that compliance against the criteria is high, however the audits mainly involve high level visual inspections which are subjective and therefore provide only limited</p>								

Action Plan

<p>assurance. With the emerging MRD's and Mobile Cleaning proposals, vehicle cleaning audits will require a thorough review. As a result, alternative methods of audit are currently being considered.</p> <p>We obtained the equivalent audit data from the most recent 6 monthly audits (01.07.2019 - 31.12.2019). This highlighted the following exceptions which, despite being highlighted in performance reports, we did not see evidence of follow up action being taken to address and resolve:</p> <ul style="list-style-type: none"> • total vehicles audited = 288 out of a total of over 700; • total stations audited = 42 out of a total of 85 facilities (not including CCC's and main office buildings); and • nil submissions from Aneurin Bevan NEPTS vehicles, Cwm Taf Morgannwg NEPTS vehicles and stations and Cardiff and Vale stations. 	
<p>Recommendation 3</p>	<p>Priority level</p>
<p>We concur with the Trust that alternative audit methods should be considered to ensure more effective compliance monitoring.</p> <p>Follow up action should be undertaken to address and resolve compliance issues and exceptions identified.</p>	<p>High</p>
<p>Management Response 3</p>	<p>Responsible Officer/ Deadline</p>
<p>Alternative Audit methods will be considered via the IPC Steering group</p>	<p><i>Executive Lead: Director of Quality and Nursing / Director of Operations</i></p> <p>Assistant Director Quality Governance / 31.05.2020</p>

Action Plan

The practicalities of undertaking the Audits, action for non-compliance and action to be taken as a result of the findings of the audits will be addressed at the Senior Operational Team meeting

Assistant Director
Operations / 31.05.2020

<p>Finding 4 Infection Prevention Control Strategic Group (Operation)</p>	<p>Risk</p>
<p>The IPC Strategic Group leads, coordinates and advises on all matters relating to Infection Prevention and Control within the context of the IPC Improvement Plan 2017-19, providing feedback to the QSG and then QuEST Committee. The IPC Strategic Group drives the development of cleaning policies and standards to be applied across the Trust, although we note focus has been on vehicles to date. The cleanliness of premises and the quality assurance mechanisms (including ATP testing and cleanliness audits) to monitor effectiveness has yet to be addressed.</p> <p>We reviewed minutes, papers and action logs for the above forums, along with the Strategic Transformation Board (STB), Assistant Directors Leadership Team (ADLT) and the Board, and noted the following:</p> <p>IPC Strategic Group:</p> <ul style="list-style-type: none"> • the group has been meeting every 8 weeks rather than monthly per the Terms of Reference; • there has been limited attendance from Fleet, Estates and Operational representatives which has impacted the wider communication of key messages; • implementation of the Trust’s cleaning polices and standards is not a regular agenda item; and • action logs appear incomplete / in draft and have items dating as far back as February 2019. <p>Although IPC statutory and mandatory training compliance rates, datix incidents and the 6 monthly cleanliness audits are reported within the Quality Metrics section in the Quarterly Quality Assurance Report presented at QSG and QuEST Committee, the findings raised in this report have identified opportunities to improve reporting and monitoring arrangements. This is supported by the status of the Estates led IMTP deliverable: <i>‘review of approach to station cleaning’</i>, monitored at the STB, being recorded as <i>‘in progress, off</i></p>	<p>A lack of scrutiny on the appropriateness and delivery of the cleaning standards leading to staff or patient harm and associated financial and reputational implications.</p>

Action Plan

<p><i>target'</i> since July 2019. An options appraisal, which was due to be presented to the Executive Management Team, is still under development.</p>	
<p>Recommendation 4</p>	<p>Priority level</p>
<p>Cleaning standards should be discussed and monitored at the IPC Strategic Group and escalated through the Trust's governance structures appropriately. Minutes and action logs should clearly evidence the discussions and scrutiny that take place at the meetings.</p> <p>The Trust should review and finalise the terms of reference for the IPC Strategic Group and ensure there is appropriate attendance, engagement and participation from all parties that have a role in delivering the IPC Improvement Plan.</p>	<p>Medium</p>
<p>Management Response 4</p>	<p>Responsible Officer/ Deadline</p>
<p>The Terms of Reference for the IPC Steering group (including membership) will be reviewed and shared with all Directors.</p>	<p><i>Executive Lead: Director of Quality and Nursing</i></p> <p>Assistant Director Quality Governance / 31.03.2020</p>

Audit Assurance Ratings



Substantial Assurance - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.



Reasonable Assurance - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.



Limited Assurance - The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.



No Assurance - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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Audit

The audit was undertaken using a risk-based auditing methodology. An evaluation was undertaken in relation to priority areas established after discussion and agreement with WAST. Following interviews with relevant personnel and a review of key documents, files and computer data, an evaluation was made against applicable policies procedures and regulatory requirements and guidance as appropriate.

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Where a control objective has not been achieved, or where it is viewed that improvements to the current internal control systems can be attained, recommendations have been made that if implemented, should ensure that the control objectives are realised/ strengthened in future.

A basic aim is to provide proactive advice, identifying good practice and any systems weaknesses for management consideration.

Responsibilities

Responsibilities of management and internal auditors:

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

We plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we may carry out additional work directed towards identification of fraud or other irregularities. However, internal audit procedures alone, even when carried out with due professional care, cannot ensure fraud will be detected. The organisation's Local Counter Fraud Officer should provide support for these processes.

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GIG
CYMRU
NHS
WALES

Partneriaeth
Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services
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Audit and Assurance Services

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STORY/EXPERIENCE/THEMES

DETAILS/SUB-THEMES

WHICH REQUIRES...

INITIAL ACTIONS

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 development of community resilience.

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 floor 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 reduction in demand if 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 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.



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Welsh Ambulance Services
NHS Trust

AGENDA ITEM No	19
OPEN or CLOSED	Open
No of APPENDIX ATTACHED	0

Committee Priorities 2022/23

MEETING	Quality, Patient Experience & Safety Committee
DATE	11 August 2022
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Trish Mills, Board Secretary
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. During the course of the 2021/22 effectiveness reviews the Committee set a priority focus area for 2022/23. That priority was 'to 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'.
2. This report updates the Committee on progress against the priority as follows:
 - (a) The Quality Strategy and its implementation will focus on embedding the Duty of Quality and the Duty of Candour. At the Committee's meeting on 12 May 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. The agenda item for this 11 August 2022 meeting on the Quality Strategy will provide that further detail.
 - (b) A Board development session is being developed for all NHS Wales health bodies by the Welsh Government Steering Group for the Duty of Quality and the Duty of Candour. This is being earmarked in the calendar for October.
 - (c) The Steering Group will be seeking a nominated lead from each health body who will be responsible for the implementation of the Act and who will be asked to sit on the Steering Group in the months leading up to the introduction of the Act.

KEY ISSUES/IMPLICATIONS
Set out above

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)	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