# Bundle Quality, Patient Experience and Safety Committee 12 May 2022

Agenda attachments

ITEM 0 Open Quest Agenda - 12 May 2022 TM.docx

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|---|---|
| 0 | OPENING ITEMS |
| 1 | 09:30 - Chair's welcome, apologies, and confirmation of quorum |
| 2 | 09:32 - Declarations of interest<br>*Members are reminded that they should declare any personal or business interests which they have in any matter or item to be considered at the meeting which may influence, or may be perceived to influence their judgement, including interests relating to the receipt of any gifts or hospitality received. Declarations should include as a minimum, personal direct and indirect financial interests, and normally also include such interests in the case of close family members. Any declaration must be made before the matter is considered or as soon as the Member becomes aware that a declaration is required.*<br>*The board noted the standing declarations of interest in respect of: (If in attendance)*<br>*Professor Kevin Davies, Trustee of St John Cymru*<br>*Ceri Jackson, Trustee of the Stroke Association* |
| 3 | 09:34 - Minutes of last meeting<br>ITEM 3 QUEST OPEN MINUTES 17 February 2022 TM and WH.DOC |
| 4 | 09:37 - Action log and matters arising<br>ITEM 4 CURRENT Quest Action and Decisions Log TM.pdf |
| 4.1 | ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION |
| 5 | 09:40 - Staff Experience |
| 6 | 10:10 - Patient Experience and Community Involvement Quarterly Report. January – March 2022<br>ITEM 6 PECI Quarterly Report (January - March).docx<br>ITEM 6.1 PECI Quarterly Report (January - March) - Annex 1.pdf |
| 7 | 10:25 - Committee Priorities 2022/23<br>ITEM 7 QUEST SBAR on Committee Priorities.docx |
| 8 | 10:40 - Operations Directorate Quarterly Report – 2021-22 Q4<br>ITEM 8 Ops Directorate Quarterly Report for Committees 21-22 Q4 FINAL.pdf |
| 9 | 10:50 - Red Review Activity<br>ITEM 9 SBAR - Red Activity Review - FINAL.docx |
| 10 | 11:10 - Quality Highlight Report Quarter 4, January - March 2022<br>ITEM 10 Quality Highlight Report, Quarter 4, January - March 2022.docx |
| 10.1 | Monthly Integrated Quality & Performance Dashboard – March 2022<br>ITEM 10.1 MIQPR SBAR March 2022.docx<br>ITEM 10.2 Annex 1 MIQPR March 2022.pdf |
| 11 | 11:25 - Quality Strategy Highlight Report Quarter 4, 2021/22<br>ITEM 11 Quality Strategy Highlight Report, Quarter 4, 2021-22.docx<br>ITEM 11.1 Quality Strategy Highlight Report, Quarter 4, 2021-22 - Annex 2.xlsx |
| 11.2 | 11:35 - COMFORT BREAK |
| 12 | 11:45 - Analysis of 'Appendix B' Reports, submitted by WAST<br>ITEM 12 Analysis of Appendix B reports submitted by the Welsh Ambulance Service Trust (WAST) v1.1.docx |
| 13 | 12:15 - Executive Director of Quality and Nursing, Patient Safety Highlight Report<br>ITEM 13 Executive Director of Quality & Nursing Patient Safety Highlight Report - Quarter 4 2021-22.docx |
| 14 | 12:35 - Coroner Regulation 28 prevention of future deaths reports<br>ITEM 14 Coroner Regulation 28 Prevention of Future Deaths Report.docx<br>ITEM 14.1 Coroner Regulation 28 Prevention of Future Deaths Report - Appendix 1.pdf<br>ITEM 14.2 Coroner Regulation 28 Prevention of Future Deaths Report - Appendix 2.doc<br>ITEM 14.3 Coroner Regulation 28 Prevention of Future Deaths Report - Appendix 3.doc |

ITEM 14.4 Coroner Regulation 28 Prevention of Future Deaths Report - Appendix 4.pdf

ITEM 14.5 Coroner Regulation 28 Prevention of Future Deaths Report - Appendix 5.pdf

ITEM 14.6 Coroner Regulation 28 Prevention of Future Deaths Report - Appendix 6.pdf

ITEM 14.7 Coroner Regulation 28 Prevention of Future Deaths Report - Appendix 7.pdf

15 12:45 - Risk Management and Board Assurance Framework Report

ITEM 15 Executive Summary Risk Management Report QuEST 120522.docx

16 12:55 - Internal Audit Tracker Report

*Audit Tracker ITEM 16.1 - circulated separately by e mail.*

ITEM 16 Executive Summary QuEST - Internal Audit Report 120522.docx

ITEM 16.2 WAST_2122-011_Information Management_final Internal Audit Report client issue.pdf

16.1 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*

17 Patient Story Driver Diagram

ITEM 17 Patient Story Driver Diagram.pdf

18 Practical Obstetric Multi-Professional Training (PROMPT)

ITEM 18 PROMPT Course paper.docx

18.1 CLOSING ITEMS

19 13:05 - Key messages for Board

20 13:08 - Any other business

21 Date and time of next meeting:

*11 August 2022 at 09:30*

## MEETING OF THE QUALITY, PATIENT AND SAFETY EXPERIENCE COMMITTEE

Held on 12 May 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 | 10 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. | Staff Experience | Information Discussion | Gareth Thomas | Video | 30 Mins |
| 6. | Patient Experience and Community Involvement Quarterly Report. January – March 2022 | Assurance | Gareth Thomas/ Wendy Herbert | Paper | 15 Mins |
| 7. | Committee Priorities 2022/23 | Assurance | Bethan Evans | Paper | 15 Mins |
| 8. | Operations Directorate Quarterly Report – 2021-22 Q4 | Discussion | Lee Brooks | Paper | 10 Mins |
| 9. | Red Review Activity | Assurance | Lee Brooks | Paper | 20 Mins |
| 10. | Quality Highlight Report Quarter 4, January - March 2022<br><br>10.1 Monthly Integrated Quality Performance report | Assurance | Jonathan Turnbull Ross | Paper | 15 Mins |
| 11. | Quality Strategy Highlight Report Quarter 4, 2021/22 | Assurance | Jonathan Turnbull Ross | Paper | 10 Mins |
| | **COMFORT BREAK 11:35 TO 11:45** | | | | |
| 12. | Analysis of 'Appendix B' Reports, submitted by WAST | Assurance | Lee Joseph | Paper | 30 Mins |
| 13. | Executive Director of Quality and Nursing, Patient Safety Highlight Report | Assurance | Wendy Herbert | Paper | 20 Mins |
| 14. | Coroner Regulation 28 prevention of future deaths reports | Assurance | Wendy Herbert | Paper | 10 Mins |
| 15. | Risk Management and Board Assurance Framework Report | Assurance | Julie Boalch | Paper | 10 Mins |
| 16. | Internal Audit Tracker Report | Assurance | Julie Boalch | Paper | 10 Mins |
| **CONSENT ITEMS**<br>**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.** | | | | | |

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|---|---|---|---|---|---|
| 17. | Patient Story Driver Diagram | Information | Gareth Thomas | Paper | |
| 18. | Practical Obstetric Multi-Professional Training (PROMPT) | Information | Andy Swinburn | Paper | |
| **CLOSING ITEMS** | | | | | |
| 19. | Key messages for Board | Discussion | Bethan Evans | Verbal | 5 |
| 20. | Any other business | Discussion | Bethan Evans | Verbal | |
| 21. | Date and time of next meeting: 11 August 2022 at 09:30 | Information | Bethan Evans | Verbal | |

## Lead Presenters

| Name | Position |
|---|---|
| Bethan Evans | Non Executive Director |
| Lee Brooks | Director of Operations |
| Jonathan Turnbull-Ross | Assistant Director of Quality Governance |
| Julie Boalch | Head of Risk and Deputy Board Secretary |
| Wendy Herbert | Interim Director of Quality & Nursing, |
| Gareth Thomas | Patient Experience & Community Involvement Manager, |
| Andy Swinburn | Director of Paramedicine |
| Andy Haywood | Director of Digital Services |
| Lee Joseph | Quality and Safety Manager, Delivery Unit NHS Wales |

# WELSH AMBULANCE SERVICES NHS TRUST

## UNCONFIRMED MINUTES OF THE OPEN SESSION OF THE MEETING OF THE QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE HELD ON 17 February 2022 VIA TEAMS

**PRESENT:**

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

**IN ATTENDANCE:**

| | |
|---|---|
| Julie Boalch | Head of Risk and Corporate Governance |
| Hugh Bennett | Assistant Director, Commissioning and Performance |
| Jonathan Edwards | Assistant Director of Operations |
| Wendy Herbert | Assistant Director of Quality and Nursing |
| Peter Hindley | Community Health Council |
| Lucie Jones | Patient Safety Manager |
| Gerallt Jones | Health Inspectorate Wales |
| Alison Kelly | Business and Quality Manager |
| Trish Mills | Board Secretary |
| Steve Owen | Corporate Governance Officer |
| Hugh Parry | Trade Union Partner |
| Duncan Robertson | Assistant Director of Research, Audit and Service Improvement (North) |
| Claire Roche | Executive Director of Quality and Nursing |
| Chris Scott | Internal Audit |
| Gareth Thomas | Patient Experience and Community Involvement Manager |
| Jonathan Turnbull-Ross | Assistant Director of Quality Governance |

Apologies:

| | |
|---|---|
| Craig Brown | Trade Union Partner |
| Leanne Hawker | Partners in Health Lead |
| Brendan Lloyd | Medical Director |
| Lee Brooks | Director of Operations |
| Andy Swinburn | Director of Paramedicine |

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## 01/22 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 Emrys Davies' declaration of interest as a retired member of UNITE, Professor Kevin Davies as a Trustee of St John Wales and Ceri Jackson as a Trustee of the Stroke Association.

**Minutes**

The minutes of the meeting held on 16 November 2021 were confirmed as a correct record.

The action log was considered:

Action 16/21: Viability of Community First Responders to administer pain relief. Further update to be provided at 12 May meeting. Action to remain open.

Action 30/21: Patient Experience Diagram to be updated to relating to Andrea's Story. Completed. Action closed.

Action F and P 1/21: QuEST to undertake a focused review of performance related to clinical outcome metrics at their 17 February 2022 meeting. Due to ongoing pressures it was agreed that a revised completion date of 12 May 2022 be given. Action to remain open.

Action 48/21: Update on the Quality Strategy Implementation Action Plan. Item on agenda, action closed.

Action 50/21a: Functionality of symptom checkers on the website: Extension was requested for this action until 12 May 2022. Action to remain open.

Action 50/21b: PECI Highlight report. Further information was contained within the action log regarding the poor response to NEPTS patient experience survey in Cwm Taf. Action closed.

Action 57/21: Quarterly Integrated Performance Report to incorporate a 'deep dive' analysis. On agenda, action closed.

**RESOLVED: That**

**(1) the Minutes of the Open meeting held on 9 September 2021 were confirmed as a correct record;**

**(2) the standing declarations of Mr Emrys Davies as a retired member of UNITE, Professor Kevin Davies as a Trustee of St John Wales and Ceri Jackson as a Trustee of the Stroke Association were noted; and**

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

## 02/22 PATIENT EXPERIENCE

Gareth Thomas introduced the patient experience which was a video showing Hannah who expressed the anger and distress her and her family endured having heard they would have to wait at least two hours for an ambulance to reach her mother who had suffered a stroke.

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On hearing the news that the ambulance would not arrive until at least two hours, members of Hannah's family decided to take her mother to the hospital. At the hospital Hannah's mother was diagnosed with a Transient ischaemic attack, a 'mini stroke'

Fortunately, Hannah's mother was doing well and Hannah added that she would have liked the ambulance to be able to arrive quicker in cases like this.

Gareth Thomas added that the public expectation was that for stroke symptoms an ambulance would arrive quickly. This was a surprise to Hannah when she was told the ambulance would take two hours. At the time of Hannah's call the Trust was experiencing severe delays at the closest Emergency Departments.

Comments:

1. What would happen should a patient not have any other means to take them to hospital? Claire Roche explained that in times of extreme system pressures, when there are no immediate resources available, then a taxi could be arranged to take the patient to the emergency department as it is important for patients to have timely access to treatment. Duncan Robertson added that cases of stroke were in the amber 1 category and gave an overview of the findings from research undertaken by the clinical audit team to improve on scene time. Under normal circumstances the Trust would aim to reach the patient within 20 minutes; however long hospital handover delays have severely jeopardised this.

2. Members expressed concern that the same issues through these stories were being demonstrated with hitherto no improvement to the hospital handover delays. It was a system wide issue and Claire Roche assured the Committee that work was continuing to improve the situation.

3. Wendy Herbert reiterated that the current system wide issue was unprecedented adding that a joint investigation framework had been established with the health boards. It was hoped that working together more effectively would reduce avoidable harm in the community.

4. The Committee recognised that the current system wide pressures and the issues it entailed had been escalated on numerous occasions seemingly to no or little avail. This was of a serious concern to Members.

5. Members thanked Hannah for sharing her experience with the Committee and recognised there were several lessons to be learned going forward from the strong and sobering messages she depicted

**RESOLVED: That the patent experience was noted.**

**03/22 COMMITTEE EFFECTIVENESS REVIEW**

1. Prior to the update the Chair gave an overview of the process involved in how the Committee evaluated its effectiveness. The 2020/21 effectiveness review for the Committee included a review of the terms of reference and general operating arrangements, as well as a questionnaire completed by members and core attendees. Any amendments to Terms of Reference as a result of this process would thereafter be recommended to the Trust Board for approval.

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2. Trish Mills further explained that as part of the evaluation process ten questionnaires had been sent out to Members and core attendees of the Quest Committee. Six responses were received and from that, a set of actions and proposed changes were drawn up. Full details of the issues raised and the proposed actions were contained in the report; the questionnaire asked for the responses to include information on what the Committee did well, what it needed to do more of and what it should do less of.

3. The Terms of Reference were reviewed to ensure all matters within the remit of the Committee were clear and that these were articulated with the strategic, oversight and scrutiny role of the Committee in mind. The Committee's attention was drawn to the key issues which were illustrated comprehensively within the report and outlined below:

4. Language had been altered to provide clarity on the Committee's strategic, scrutiny, and oversight role and the purpose has aligned to the delegated powers.

5. The purpose has been revised to summaries the main delegated powers and to reflect the emphasis that will be placed on the Duty of Quality and the Duty of Candour as its implementation in 2023 was being prepared for.

6. Delegated Powers and Authority: This section had been revised to follow the primary areas of responsibility of the committee

7. Membership :Following the Medical Director moving to a part time role from 1 January 2022, the Director of Paramedicine will attend in his place, and a new addition to the attendees was the Director of Digital Services, who was also the Senior Information Risk Officer. The chairs of Sub-committees established by the Committee will also be in attendance.

The Committee noted the priorities going forward for the year 2022/23 which included the remit of the Committee, Membership and attendance, preparing a cycle of business and the setting up of sub-committees to assist the Committee in its discharge of responsibilities.

**RESOLVED: That the Committee:**

**(1) Reviewed and approved changes to Terms of Reference;**

**(2) Confirmed the proposed actions for issues raised in questionnaire; and**

**(3) Set priorities for the Committee for 2022/23.**

## 04/22 OPERATIONS CURRENT/FORWARD LOOK

Jonathan Edwards presented the report and drew attention to the following highlights:

1. Pandemic response – the Trust had returned to its response position phase of its pandemic plan. The extension of military support to 31 March 2022 had been approved. Staff abstractions had increased during this reporting period which was partly attributed to the new Omicron variant.

2. Emergency Rule, in response to the increased and sustained pressure on the 999 call handling demand; and following a review of call handling escalation/business continuity plans from other UK ambulance services a proposal was submitted to the Executive Management Team (EMT) to enhance the Trust's Emergency Rule guidance. The International Academy of Emergency Dispatch (IAED) who provided the governance structure for the Medical Priority Despatch System define the



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emergency rule as 'designed to be used when a service's call volume suddenly and unexpectedly exceeds the services ability to handle their call volume'. In WAST this guidance meant that when implemented all advice including CPR instructions would be removed from the call handling process, due to the significance of this approach the Emergency Rule had not been implemented, even at times of significant pressures. Following EMT approval on 5 January 2022 a revised approach to Emergency Rule implementation had been agreed which applies the guidance in a phased approach and also reduces the questioning process to the minimum required to achieve a code. This has helped to manage the demand on the 999 system.

3. Emergency Medical Service (EMS), one of the efficiencies and recommendations identified in the 2019 Operational Research in Health report was to review all operational rosters within the EMS function by December 2021. This was designed to improve the safety of patients and the wellbeing of staff and in particular aligning peak production more closely to the daily patient demand pattern. This was supported by a recommendation to increase EMS staffing by 263 Full Time Equivalents to assist with closing the gap that was identified in relation to the capacity for relief working.

4. Ambulance Care (Non-Emergency Patient Transport Service - NEPTS), in September the Trust was awarded additional funding until 31st March 2022 to help continue to support Health Boards as they endeavoured to reduce the backlog of planned care.

5. Integrated Care, recruitment continues to satisfy the demand from the Pandemic and the final roll out of Cardiff and Vale to the NHS 111 Wales programme. A new Interactive Voice Recording system was introduced to the 111 telephone number which was helping to signpost callers to the right destination earlier in their call, prior to speaking to a call handler. In early results, 15% of callers were not remaining on the line to speak with the initial call handler.

Volunteering, following successful recruitment an appointment has been made to the Trust's inaugural National Volunteer Manager position. The new post holder brings with them a wealth of experience from the voluntary sector. Comments:

Clarification was sought on the Emergency Rule process, Jonathan Edwards advised that when the initial call was taken through the MDPS system a number of scripts were followed to arrive at the chief complaint. The average handling time was around 5 – 6 minutes. At times of extreme demand under the ER there was a graduated approach which gave the ability for the call script to be reduced; therefore reducing the average handling time, allowing call handlers to answer more calls.

In respect of calls where a stroke had been categorised, Jonathan Edwards clarified that should there be no other response available, the preference would be to send an Emergency Ambulance, failing that a single Rapid Response Vehicle would be despatched.

**RESOLVED: That the update was considered and noted.**

**05/22 QUALITY STRATEGY PROGRESS REPORT**

1. Jonathan Turnbull-Ross presented the report which provided an overview of the progress thus far in the implementation of the Quality Strategy.

2. The Committee's attention was drawn to the following two key actions; the recruitment of the senior quality lead role and the plans in place for that role once filled.



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3. In terms of the wider issues concerning implementation of the strategy, workshops with Welsh Government were being held to finalise details and specifics.

4. In addition to the Trust's internal ambitions, the Strategy has been driven by new legislative requirements for health and care organisations in Wales: The Health and Social Care (Quality and Engagement) (Wales) Act 2020. This places legal duties upon the Trust including, the Duty of Quality, the Duty of Candour, and engagement requirements with Wales' Citizen Voice Body.

5. It was anticipated by the spring time that a clearer indication of what the Trust was expected to do to progress the strategy would be clarified; therefore allowing sufficient time for any specific testing of its robustness.

6. In respect of the senior quality lead position, it was the intention that they would link in with clinical quality and local management leads

Comments:

In terms of the quality culture and the quality management systems it was not explicitly documented that there would be continuous service improvement; would it be helpful to more explicit? Jonathan Turnbull-Ross agreed that this should be drawn out more going forward. He added that the quality performance management steering group would discuss and consider areas of continuous improvement as part of their focus going forward.

**Quality Performance Management Framework**

1. Hugh Bennett reminded the Committee that the Quality & Performance Management Framework laid out an integrated approach to helping the Trust improve the quality of its services and outcomes for patients and achieve its ambitions and objectives by monitoring and improving the performance of people, teams, and the organisation.

2. He explained there were five building blocks which were key to the success of the framework; these were outlined as follows: Setting aspirational objectives, developing a coherent set of performance measures and targets, implementing rigorous assurance, enabling positive ownership and accountability and providing resources and the tools to support individual and team achievement. Hugh Bennett provided a further explanation on each of the building blocks.

3. Members noted that a shadow quality and performance management steering group had been established; at this forum, the local frameworks and strategic partnerships will be discussed.

Comments:

1. Clarity was sought in terms of the metrics and what was to be drawn from them. Hugh Bennett referred to the Monthly Integrated Quality Performance report in which the vital metrics relevant to the Trust were illustrated and contained sufficient indicators for members to receive the appropriate assurance.

2. Members observed that the outcomes and experiences of patients within the measures was an aspiration of Welsh Government as part of the Outcome and Engagement Act; noting it would be important to capture this detail within the framework. Hugh Bennett explained the reasoning of balanced measures whereby

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the focus was not primarily on the statistics but would also look at the patient outcomes. Claire Roche added that it was key to capture details of patient outcomes at a local level.

**RESOLVED: That the reports were received and considered.**

## 06/22 PATIENT EXPERIENCE AND COMMUNITY INVOLVEMENT (PECI) HIGHLIGHT REPORT

The report was presented by Gareth Thomas; the following areas were brought to the Committee's attention

1. The majority of the engagement was conducted online, Shoctober start a heart and also building on community resilience. There was also target engagement working with dementia groups.

2. A lot of engagement with sensory loss groups focusing on sight loss groups and listened to the feedback and this was shared with the Non Emergency Transport Services Team. Going forward it was proposed to conduct an accessibility audit of NEPTS.

3. A recent patient survey had been carried out and the one that provided the most feedback was from NEPTS users. It was concluded that the service provided was generally good.

4. Work was underway with Civica who had been awarded the once for Wales contract for the patient experience and recording system. This will enable the Trust to capture quantitative data more effectively

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5. The Trust continues to encourage and actively promote people to join the Community network and become advocates for the service within their community network. Following on from this the Trust sough feedback through this mechanism on the 111 website. It transpired that the response was poor and lessons have been learned to improve this.

6. Work was ongoing using the network team to provide them with the opportunity to comment, influence and shape the Trust's IMTP in certain areas going forward.

Comments:

1. Engagement on the IMTP, was there an opportunity for Non Executive Directors (NEDs) to attend any of these network sessions. Gareth added that the team was looking into this process and would look to engage the NEDs.

2. Children and young people was themed throughout the report and the Committee saw this was useful as a messaging tool.

3. Wendy Herbert assured the Committee that following feedback from the public, work was continuing to improve the website experience ensuring it was fit for purpose and more user friendly.

4. It was encouraging to see the feedback from the mental health and ethnic minority groups.

5. The Chair drew attention to a minor amendment on page 12 of the report which had

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been rectified by Gareth prior to sharing with stakeholders

**RESOLVED: That the Committee noted the findings of the report and agreed for the report to be shared with external stakeholders.**

## 07/22 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK REPORT

Julie Boalch presented the report and provided the highlights from it as follows:

1. Phase one of the risk transformation programme was continuing at pace; the additional assistance of two risk officers in aiding this task would continue until 31 March 2022. Furthermore their work would include a detailed review of the corporate risks focussing on in particular, risks 223, 224, 199, 316 and 160. This would involve as a minimum strengthening the overall articulation, narrative and description of the risks.

2. Work continued on all the risks relevant to the Quest Committee, the detail of which will be reported to the Trust Board at its next meeting.

Comments:

1. Risk 199 – (Compliance with Health and Safety legislation), it was confirmed this would be transferred to the People and Culture Committee.

2. Risk 303 – (Delayed initiation of chest compressions (resuscitation)), clarification was sought on when this risk was last reviewed. Julie Boalch explained that the current datix system does not always automatically update and refresh data; the Committee were assured that this particular risk had recently been reviewed. The Committee also noted that when the new datix system was installed it would automatically update the system on a regular basis.

**RESOLVED: That the Committee noted and discussed the contents of the report.**

## 08/22 INTERNAL AUDIT TRACKER REPORT

Julie Boalch took the report as read and explained that the purpose of the report was to provide the Committee with an up to date position in relation to recommendations resulting from Internal and external audit reviews. The Committee's attention was drawn to the following key points:

1. Of the 17 recommendations, 5 have been completed during the reporting period, 7 were not yet due and 5 were overdue. Of the 5 that were overdue, none were rated as a high priority.

2. In respect of the 2 overdue recommendations from the 2019/20 financial year, one related to the Raising Concerns Report, whilst significant progress has been made on the Once for Wales Datix system, it was likely this could be further delayed due to an external issue outside of the Trust's gift.

3. The other overdue recommendation related to the Risk Management report; specifically the Trust's Risk appetite statement, in all likelihood this would require 12 months for it to be completed.

4. In terms of the remaining 3 recommendations shown as overdue from the 20/21 Concerns and Serious Incidents Management and the 21/22 Controlled Drugs review, these were on track to be completed by 31 March 2022.



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**RESOLVED: That**

**(1) the Committee noted and considered the contents of the report; and**

**(2) considered the Trust's proposals to address each recommendation with the inclusion of revised completion dates, specifically focussing on those relevant to Quest.**

**09/22 QUARTERLY INTEGRATED QUALITY & PERFORMANCE REPORT and the MONTHLY INTEGRATED QUALITY PERFORMANCE REPORT (MIQPR)**

1. Jonathan Turnbull-Ross informed the Committee that the report provided assurance in line with the specific regulations and standards that aimed to promote a duty of quality and candour across the Trust.

2. He drew attention to the key challenges that the Trust had been focussing on during the last quarter notwithstanding the effects on the service following the emergence of a new variant of Covid-19.

3. Members were updated on the quality improvement focus area noting that a significant amount of strategic planning had been undertaken in order improve overall quality of patient care.

Comments:

1. In respect of the large amount of historic incident records, was there a process to close them off? Jonathan Turnbull-Ross explained that this issue will be considered at Executive Management Team level and a sensible and pragmatic view will be taken to establish a process. In the meantime the records will still be held on the system.

2. The Committee recognised and expressed their concern with the significant amount of Post Production Lost Hours (PPLH) that were not included in the handover delay hours; notwithstanding the ongoing work to resolve the issue. The Chair added that this would be escalated to the Board as part of the Committee's highlight report. Hugh Bennett added that a note of caution should be applied in respect of interpretation of the data as there were other factors affecting PPLH, albeit it was still a very high figure. The Committee held a detailed discussion with regards to understanding PPLH and how this figure would be perceived by the public. Members further expressed their serious concern with the number of potential catastrophic incidents and extreme levels of hand over delays; noting it was system wide issue. It was agreed going forward that the report should provide more clarity in terms of how PPLH was recorded.

**MIQPR**

1. Hugh Bennett explained that the report contained details for December 2021 and some aspects from January 2022.

2. It was recognised that with military support stopping at the end of March 2022 and with handover levels likely to remain very high, April was going be a challenging month. The underlying message was that the Trust would not be able to offset the level of handover delays.

3. Shift left: The Trust continued to work tirelessly with health boards and other partners to provide the right care closer to home and reduce the number of patients who need to be conveyed to hospital. Good progress has been made through the year in increasing



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hear and treat rates after 999 calls; and the Trust achieved 11.3% in Jan-22, compared to the benchmark of 10.2%.

4. Abstraction levels had decreased in Jan-22, however, they remained very high at 41% (benchmark 30%). CoVID-19 has had a significant impact on abstractions with sickness abstractions being 15% in Jan-22 (benchmark 5.99%). Workforce fatigue was also an issue.
5. Ambulance Care (formally NEPTS) (Patient Experience): performance was above target for enhanced renal patient arrivals prior to appointment in Jan-22 and has improved for patients requiring discharge; however, Ambulance Care core (outpatient) demand has not yet recovered to pre CoVID-19 levels.
6. 111 Clinical response: Whilst the Trust continued to see achievement of the clinical call back times for the highest priority 111 calls, a decline in performance was seen in Dec-21 in the lower priority calls, but an improvement in Jan-22.

Comments:

1. Sickness and absence has always been an issue, and it was good to see it was being addressed; noting the pandemic had attributed to the increase.
2. It was suggested that Personal Appraisal Development Reviews should be targeted at 100%, with exceptions where applicable taking into account the disappointing rates of completion.
3. In respect of the Electronic Staff Record (ESR) online learning system, the Committee felt that the system could be improved and be more user friendly.
4. Once the military leave, any comments in terms of the impact? Jonathan Edwards gave an overview in terms of how the military assistance would taper off commenting there would be a transitional period starting from 21 March. The Operations team would factor this in when forecasting the Unit Hours Production in order to maximise productivity over that period.
5. As April was expected to be a very difficult month was there anything NED’s could do to support the Trust? The Chair advised this would be escalated to the Trust Chair
6. Was it possible to set a timeline in respect of expected performance trajectory and have a more detailed report on Post Production Lost Hours? Hugh Bennett agreed to consider this for the next report.

**RESOLVED: That the Committee noted and discussed the content of the reports.**

**10/22 QUARTER 3 PATIENT SAFETY REPORT**

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

1. The volume of 111 calls had increased significantly from the same period last year; in the region of 100,000 more.
2. There had been an increase of calls categorised as red, 11,911 as compared to 7,857 from the last year
3. Concerns and Serious Adverse Incidents (SAI) remained at a high level, particular SAIs.
4. Due to the continued increased demand on the Trust, the capacity of Clinical Contact

Centre staff and 111 staff to carry out welfare checks for extended wait patients remains an ongoing issue. A review of the Welfare Standing Operating Procedure has been undertaken within CCC in order to provide clarity to staff on the process expected of them.

5. The joint working with Clinical Contact Centre and the Quality Directorate, particularly regarding Careline was very positive

6. The 2 day acknowledgement to reply to concerns had significantly dipped; this was due to staff resource

7. In terms of the performance target for a 2 day acknowledgement for formal complaints, this had increased to 70%.

8. Coroner's activity, the number of approaches from Coroners was slightly lower from the same time last year. It was noted however there had been 110 requests received in December

9. 143 incidents had been considered during the reporting period whereby patients had been harmed or it was a catastrophic outcome. 20 of these had been reported under the national incident reporting framework. 79 of the 143 had been passed on to Health Boards as Appendix B cases, all were in relation to timeliness. Of these 61 were in the amber 1 category and patients had waited over 6 hours for a response/care and treatment.

10. The learning from Patient safety incidents continued; a number of clinical alerts had been issued as a result.

Comments:

1. This report illustrated the system wide pressures and in particular the impact on patient safety.

2. The Committee expressed their serious concern with the significant negative figures and agreed that this should be escalated to the Board.

3. Claire Roche advised the Committee of the tripartite meetings with Health Boards occurring on a quarterly basis that ensured they were fully sighted on the issues concerning and impacting on patients. These meetings were extremely helpful and gave the Trust an opportunity to address any issues with alacrity.

4. Following a query in respect of the 79 incidents reported to Health Boards. Members were advised that the information which illustrated a breakdown of incidents by Health Board area was already contained within a graph contained in the report. Claire Roche assured the Committee that the Commissioner received this detail on a regular basis.

5. Further concern was expressed in relation to Immediate Release Requests, noting there were still varying levels of response across different health boards. Could the Trust challenge this at individual Health Boards going forward? Wendy Herbert explained that the Health Board reports contained details of immediate release or decline on an individual health board basis. Jonathan Edwards updated the Committee on the procedure concerning immediate release. The decision to release ambulances at the hospitals was made by the nurses in charge at the time with the rationale for the decision included in the information relayed to each of the Chief Operating Officers for each Health Board area.

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

## 11/22 DEEP DIVE: LOSSES AND SPECIAL PAYMENTS, PERSONAL INJURY

Wendy Herbert gave the Committee an overview of the report and highlighted areas for their attention as follows:

1. The report included details of all personal injury claims, received during 2020 and 2021. This was a total of 38 registered cases. Members should be mindful that some of these cases can take several years to resolve.

2. In terms of themes and trends, needle stick injuries and slips, trips and falls remained the highest number in relation to staff.

3. In 2020 there were 2 patient claims and 21 staff claims and in 2021 there were 3 patient claims and 12 staff claims.

4. The 3 patient injuries claims from 2021 were in relation to NEPTS; this involved the moving of patients to/from the ambulance

Comments:

Jonathan Turnbull-Ross assured the Committee that ongoing work and discussions on specific issues in relation to accidents at work with Trade Union partners continued.

**RESOLVED: That the Committee considered the contents of the report.**

## 12/22 EVALUATION OF THE LIVE REVIEW OF RED 999 CALLS BY CLINICAL SUPPORT DESK CLINICIANS

1. Jonathan Edwards explained that the report looked at how the Trust can ensure calls were being accurately prioritised by Clinical Support Desk (CSD) Clinicians by determining if the red priority was appropriate.

2. Between 20 August and 1 November 2021 11,535 Red incidents were recorded. CSD red Review was in operation on 27 days during this period (at various time points) and Clinicians recorded reviews of 471 incidents. The vast majority were appropriately coded. There were 78 calls downgraded to amber 1 and a further 11 were downgraded to amber 2 or green.

3. The chief nature of the complaint of the cases reviewed were in the main related to breathing problems.

4. This review has shown that going forward the CSD will continue to:

    a. Use the red review process and continue to allocate Clinicians to the role during system pressure
    b. Commission Health Information to produce a dedicated downgrade report to evaluate downgraded calls more easily / accurately
    c. Look at EMS Coordination and Response noting they will undertake a focused MPDS audit of Red calls which were downgraded to further inform and alleviate sensitivities in the use of MPDS in the Trust
    d. Review Red activity with the additional information and periodically report on activity and outcomes
    e. And the Senior Operations Team will investigate the option to evaluate the impact that red review has on the Amber and Green pool of calls

DRAFT

Comments:

Had the Trust thought about focusing on the categorisation of ineffective breathing as a major issue? Jonathan Edwards advised that it had been a capacity issue with the CSD to focus on this particular area. As there was now additional resources at the CSD this could be considered and he agreed to arrange for this to be considered further.

**RESOLVED: That the report was noted.**

**13/22 PATIENT EXPERIENCE DRIVER DIAGRAM**

**RESOLVED: That the diagram was noted.**

**14/22 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.

1. Red performance
2. Patient safety impacts
3. Patient experience
4. New Terms of Reference had been agreed as part of the Committee effectiveness review.
5. Noting the progress of the Quality strategy
6. Managing the risk from April onwards with the removal of military assistance

**RESOLVED: That the Committee noted the update.**

**15/22 ANY OTHER BUSINESS**

As this was the last meeting for Emrys Davies and Claire Roche, they asked for a note of thanks be recorded for all the support received adding it had been a privilege to be part of the Trust's journey.

The Chair thanked both Emrys Davies and Claire Roche for all their contributions and wished them well for the future

**Date of Next meeting: 12 May 2022**

DRAFT

**ACTION LOG - FROM NOVEMBER 2021**
**QUEST COMMITTEE**

| Minute Ref | Date | Agenda Item+C1:H13 | Action Note | Responsible | Due Date | Progress/Comment | Status |
|---|---|---|---|---|---|---|---|
| 16/21 | 7 May 2021 | Patient experience | To provide updates on the viability of CFR's to administer pain relief | Andy Swinburn | 12 May 2022 | Update from 16th November meeting: Andy Swinburn updated the Committee explaining that 2 Business Cases were being developed; one from the development of the Omnicell cabinet perspective (readjust for penthrox inclusion) and one from the revenue perspective (purchasing of penthrox). Dr Brendan Lloyd explained the reasons for the delay in developing this and would continue to update the Committee.<br>Update for 17th February meeting: The amendments to the safe have been agreed and purchase of the additional fittings for the cabinets has taken place. Work is still ongoing to identify the revenue funding for penthrox but new avenues are being explored, with the NCCU, to establish whether central funding, aligned to the decarbonisation agenda, may be applicable.<br>Update for 12 May meeting<br>The introduction of Penthrox continues to be one of the items that is listed for consideration against this years list of items in which financial support is required. Further opportunities to support the introduction are being worked through with commissioners (as a potential carbon reduction measure). It was anticipated this action will be completed by 11 August 2022. | 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 | 12 May 2022 | Update from 16th November meeting: QuEST requested for confirmation as to whether this will be a stand alone report or included in the performance report.<br>Update for 17th February meeting: Andy Swinburn requests a revised date for this action due to ongoing pressures.<br>Update for 12 May meeting:<br>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. | 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 | Update for 17th February meeting: Andy Haywood seeks an extension for this item to May 2022.<br>Update for 12 May meeting<br>Deferred to 11 August meeting | Not due |
| 09/22 | 17 February 2022 | Quarterly Integrated Performance report | To provide more clarity within the report on the interpretation of Post Production Lost Hours | Jonathan Turnbull-Ross and Hugh Bennett | 12 May 2022 | Update for 12 May meeting Resulting from Committee discussion, a QI focus Post Production Lost Hours will be provided within the Quality Report to be received by the Committee. | Open |
| 12/22 | 17 February 2022 | Evaluation of the live review of red 999 calls by Clinical Support Desk Clinicians | Was there a capacity in the CSD to focus on the categorisation of ineffective breathing as a major issue? It was agreed that Jonathan Edwards would escalate this to Stephen Clinton | Jonathan Edwards | 12 May 2022 | Update for 12 May meeting<br>There are on average around 3,800 calls per month for breathing difficulties with approximately 1,200 prioritised as RED. Bringing these calls into the CSD will require considerably more clinicians, approaching a further 50 FTE. Around 72% of the remaining RED breathing difficulty calls attend hospital therefore the consult and close possibility is small for this group of callers. Red reviews were attempted on around half the red breathing difficulties calls this quarter. It is not always possible to dedicate a RED review clinician especially when in high levels of escalation when clinical screening of Amber 1 and 2 calls is a high priority as well as increasing consult and close as much as possible to reduce the overall number of ambulance responses. Ways to increase the focus on RED review is underway in the CSD. | Open |

| AGENDA ITEM No | 6 |
|---|---|
| OPEN or CLOSED | OPEN |
| No of ANNEXES ATTACHED | 1 |

# PATIENT EXPERIENCE & COMMUNITY INVOLVEMENT QUARTERLY REPORT JANUARY - MARCH 2022

| MEETING | Quality, Patient Experience & Safety Committee |
|---|---|
| DATE | 12 May 2022 |
| EXECUTIVE | Executive Director Quality & Nursing |
| AUTHOR | Patient Experience & Community Involvement Manager |
| CONTACT | Gareth Thomas<br>07387 230789<br>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 January - March 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
- 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: The Committee is asked to note the findings of the report and for the report to be shared with external stakeholders.**

## KEY ISSUES/IMPLICATIONS

The Patient Experience & Community Involvement (PECI) 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

Could not include document ITEM 6.1 PECI Quarterly Report (January - March) - Annex 1.pdf in the bundle

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.

As coronavirus restrictions have begun to ease, we have been able to resume some face-to-face engagement in the community, though a blended approach which incorporates some online engagement sessions to promote key messages is how we foresee ourselves working for the near future. This blended approach will ensure we:

- Continue to remain visible in communities and build community trust
- Support people to make informed decisions on access to health care services
- Inform people on what we are doing to ensure they receive good/safe services
- Build a repository of feedback and experiences to influence service plans

| REPORT APPROVAL ROUTE | |
|---|---|
| Executive Management Team | 27 April 2022 |
| Quality, Patient Experience & Safety Committee | 12 May 2022 |

| REPORT APPENDICES |
|---|
| **Annex 1** - An accompanying PECI Highlight Report on experience and engagement activities over the last quarter is 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 |

| AGENDA ITEM No | 7 |
|---|---|
| OPEN or CLOSED | OPEN |
| No of ANNEXES ATTACHED | |

# COMMITTEE PRIORITIES 2022/23

| MEETING | Quality, Patient Experience and Safety Committee |
|---|---|
| DATE | 12th May 2022 |
| EXECUTIVE | Trish Mills, Board Secretary |
| AUTHOR | Trish Mills, Board Secretary |
| CONTACT | Trish.mills@wales.nhs.uk |

## EXECUTIVE SUMMARY

1. The Committee agreed its priorities for 2022/23 when it completed its effectiveness review on 17th February 2022.

2. The Committee's priority was agreed as 'The organisation's journey towards further embedding the Duty of Quality and Duty of Candour in everything we do'.

3. The Committee is requested to agree to the wording of the revised priority to ensure it resonates with stakeholders as aligning with patient safety, openness and transparency.

4. Quarterly updates on progress will be provided to the Committee in August 2022, November 2022 and February 2023.

## REPORT APPROVAL ROUTE

N/A

## REPORT APPENDICES

1. SBAR

## REPORT CHECKLIST

| Confirm that the issues below have been considered and addressed | | Confirm that the issues below have been considered and addressed | |
|---|---|---|---|
| EQIA (Inc. Welsh language) | N/A | Financial Implications | N/A |
| Environmental/Sustainability | N/A | Legal Implications | N/A |
| Estate | N/A | Patient Safety/Safeguarding | Yes |

| Ethical Matters | N/A | Risks (Inc. Reputational) | N/A |
|---|---|---|---|
| Health Improvement | N/A | Socio Economic Duty | N/A |
| Health and Safety | N/A | TU Partner Consultation | N/A |

**ANNEX 1**

## SITUATION

1. The Chairs Working Group (CWG) has requested that the Committee review its priority for 2022/23 to ensure it resonates with stakeholders as aligning to patient safety, openness and transparency.

## BACKGROUND

2. On 17th February 2022 the 2022/23 priority for the Committee was agreed as '*the organisation's journey towards further embedding the Duty of Quality and Duty of Candour into everything we do*'.

## ASSESSMENT

3. The Duty of Quality and Duty of Candour are set out in the Health and Social Care (Quality and Engagement) (Wales) Act (the Act) which became law in 2020 and will be brought into force in the Spring of 2023.

4. The Duty of Quality is a system-wide way of working to provide safe, effective, person-centred, timely, efficient and equitable health care in the context of a learning culture, whilst the Duty of Candour ensures there is culture of openness and transparency when a patient suffers an adverse outcome.

5. The Committee's priority for 2022/23 was agreed to provide oversight as the Duty of Quality and Duty of Candour were embedded in the lead up to the Act coming into force in 2023.

6. Taking the above into account, it is proposed that the wording of the priority is amended to '*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'*.

7. The Committee will receive updates on the progress against this priority throughout the year.

## RECOMMENDATION

8. **The Committee is requested to consider the revised priority for 2022/23.**

# OPERATIONS DIRECTORATE
# QUARTERLY REPORT FOR COMMITTEES
# 2021-22 Q4

## ❖ PANDEMIC RESPONSE

Case rates of Covid 19 have continue to decline across Wales and Public Health Wales and Welsh Government have arguably commenced a transition from pandemic to endemic. Now that community transmission has declined and generally at steady and sustained pace, we have reviewed the use of the pandemic call handling protocol.

Protocol 36 was first de-escalated to the surveillance level on 24/02/22, with a subsequent removal of the protocol in its entirety and a move to EIDS (Emerging Infectious Diseases Surveillance) tool on 10th March 2022.

On 17th March 2022 the Senior Pandemic Team took forward a recommendation for the organisation to alter its position according to our Pandemic Plan. As a result, on 21st March 2022 the organisation transitioned from the Response Phase Monitor Position to the Recovery Phase of the Pandemic Plan. This coincided with a phased withdrawal of the military as part of military aid to civil agency arrangements with a full withdrawal of military colleagues that was effected by 31st March.

We place on record our full and unreserved thanks to our military partners for the support they have afforded the Trust since October 2021. Our Business Continuity and Recovery Team (BCRT) now has primacy for the organisation's recovery efforts.

The BA2 Omicron variant took hold as we moved toward the end of March, increasing staff absence to Covid in the region of 220. This occurred as military support wound down.

## ❖ EMERGENCY MEDICAL SERVICE (EMS)

### EMS Roster Review

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

A series of 'Working Parties 2' commenced on 17th January 2022. These were well attended by all staff groups. Feedback to the Project Board was that the sessions were positive and engaging with a number of questions posed from the attending representatives.

Working Parties are supported by Working Time Solutions Consultants (WTS) who assist the Operational Lead chairing the meeting, staff and TU colleagues engaged in the process. 'Working Parties 3' commenced on 28th February 2022. These further sessions provide an opportunity for staff to feedback on iterations of roster options with final amendments expected.

### Cymru High Acuity Response Unit (CHARU)

A series of CHARU drop-in roadshows were held on 24th and 25th February 2022. The purpose of the roadshows was to share further information for staff affected by the change. The CHARU resource type will be staffed by a paramedic who has successfully completed the training and education requirements.

The three-day training course will comprise of numerous assessments both written and practical on the latest evidence-based practice, adhering at all times to the policies and standards inherent within WAST. The course includes training and education in new medicines, additional equipment, technical and non-technical skills associated with clinical management of patients who have critical injuries or illnesses.

## ❖ RESOURCING & EMS COORDINATION

Following the move from Response Phase Monitor position to the Recovery Phase of the Pandemic Plan, Contact Centres across WAST have eased lockdown restrictions to enable key educational, leadership, wellbeing and partnership working visits. Infection Prevention Control measures remain in place but this is a first step towards living with Covid.

EMS Coordination have been recruiting new Emergency Medical Dispatchers (EMDs) across all three Emergency Clinical Contact Centres, four cohorts of staff are nearing completion of their training in Carmarthen and Llanfairfechan with two further cohorts scheduled for later in March and early April for Vantage Point house.

As part of the Emergency Services Mobile Communication Programme (ESMCP) EMS Coordination teams have been supporting the project to implement a new control room solution for Integrated Communication Control Systems (ICCS). As we move to a planned transition in July 2022 the EMS Coordination team have taken the first steps by training 12 members of the team as instructors in the new LifeX software solution. As we move towards Q1 of 2022/23 these new instructors will be rolling out training across EMS Coordination, NEPTS and EMRTS and supporting key critical systems testing in readiness for the next stages towards transition.

## ❖ INTEGRATED CARE

### 111 and 111 First Service

Cardiff and Vale core 111 and '111 First' service went live on 16th March 2022. This marks the culmination of a six-year programme of roll out, as a result 111 is now live across Wales. This national platform provides the basis for 111 to continue towards the organisational ambition of 111 representing the 'Gateway to Care' in Wales.

### EMS Physician Triage and Streaming (PTaS),

Building on the success of the EMS Physician Triage and Streaming (PTaS), two trials using two different models have commenced in the 111 environment. One with the South West Clinical Support Hub and the second with Aneurin Bevan Health Board. Evaluation of both models is taking place to inform a wider 111 PTaS approach.

### Clinical Support Desk (CSD)

The expansion of the Clinical Support Desk (CSD) continues apace with 35.2FTEs of the additional 36FTEs recruited, 20FTEs of which are now trained and operating on the CSD with the rest expected by early April. Early indications are positive as this growth, combined with the 111 contribution, is showing increased consult and close outcomes. In March some daily levels have been as high as 14%. As the remaining 16FTEs become operational we expect this contribution to grow in volume.

### Emergency Communication Nurse System (ECNS)

Training of CSD staff in the new Emergency Communication Nurse System (ECNS) has commenced alongside other areas of the project. A go live date is being honed by the Project Board with a view to during May.

## ❖ NATIONAL OPERATIONS AND SUPPORT

### NHS Wales System Reset – WAST Coordination Group

In response to broader health and social system pressures, a period of reset took place from 3rd March for two weeks. To coordinate the WAST response in support of the reset a coordination group was established. The WAST Coordination Group implemented a range of actions with our partners across the system to contribute to delivering the ambitions of the reset with particular focus on clinically safe admission avoidance. An internal debrief is scheduled to capture the learning from our approach with an emphasis on identifying the WAST activity that has been of most benefit, with a view to then considering the sustainability and appetite for continuation of support for these most beneficial activities.

### Mobile Testing Unit Programme (MTU)

The Mobile Testing Unit (MTU) Programme has been extended by Welsh Government until the end of June 2022. Welsh Government continues to determine testing needs for Wales, however in anticipation of the contract end we are now starting to consider our exit strategy and explore potential opportunities that may exist within the organisation for MTU staff who were employed on fixed term arrangements.

### Volunteering

Our very first National Volunteer Manager has been appointed – Jenny Wilson joined the Trust on 24th January 2022 and brings with her a wealth of knowledge and an extensive background in volunteering. Jenny is reviewing progress against the year one deliverables set out in the action plan which accompanied our Volunteer Strategy.

### Business Continuity

This year we are due a revision of our business continuity arrangements. Ahead of this revision, a lot of work has already been done, however, whilst there is not any specific threat we have brought forward some planing activity given events occuring with Europe at the moment. A tabletop exercise has been undertaken and in response, some further work is being completed to review plans, determine and agree critical systems and exercise these plans once again.

| AGENDA ITEM No | 9 |
|---|---|
| OPEN or CLOSED | OPEN |
| No of ANNEXES ATTACHED | |

# Red Activity Review

| MEETING | Quest Committee |
|---|---|
| DATE | 12 May 2022 |
| EXECUTIVE | Lee Brooks, Director of Operations |
| AUTHOR | Head of Service EMS Coordination |
| CONTACT | **Kate Blackmore**<br>Kate.blackmore@wales.nhs.uk<br>01267 225772 |

## EXECUTIVE SUMMARY

This report reviews the drivers for increased Red demand and the actions taken within EMS Coordination to understand and respond to this position.

## KEY ISSUES/IMPLICATIONS

1. Red acuity incidents have increased in proportion to total verified incidents from 5% to 10% since November 2017.

2. A change of guidance from the International Academy of Emergency Dispatch (IAED) led to a 1% increase from June 2019 associated with ineffective breathing.

3. Actions taken as a result of this increase and further learning from a focussed audit in October 2020 gives confidence that Red demand associated with ineffective breathing is correctly prioritised.

4. Increased demand associated with respiratory illness is aligned to winter respiratory virus' and waves of Pandemic infection particularly driven by those patients aged 0-4 years.

5. Red demand has increased associated with unconscious patients with abnormal breathing following the introduction of this code in October 2019 as part of the MPDS version 13.2 upgrade. WAST are required to maintain version upgrades as part of our ACE accreditation.

6. A review of Red demand drivers has identified a pattern associated with patients who have fallen resulting in either a report of unconsciousness or as a result of ineffective breathing and/or cardiac/respiratory arrest.

7. The reduction in the number of incidents identified as a running call can have a perverse impact on Red performance as these incidents are identified as an immediate hit due to the resource being at scene at the time of the call.

8. Red demand associated with prolonged fitting has increased by up to 221% between November 2019 and November 2021. Increased levels of lost hours associated with handover to hospital and subsequent impact on increased amber incidents response times is resulting in increased Red demand for these patients.

9. Patients reported as not alert as a result of allergic reactions have resulted in increased Red demand associated with Protocol 2. Further clinical review is required to identify any themes and trends associated with these patients.

**Actions ongoing:**

1. Focused audit scheduled for all trauma protocols to explore incidents that result in an arrest determinant, to assess departmental learning that can be applied to EMD practice.

2. Focused audit scheduled to explore incidents that result in code 31D02 Abnormal breathing, to assess departmental learning that can be applied to EMD practice.

**It is recommended that** the Quest Committee:

1. **NOTE** 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 is commissioned to understand increased incidents associated with allergic reaction and to identify any trends in allergy triggers or clinical outcomes.
    c. EMS Coordination continue to use focussed audit to explore areas identified for potential EMD learning.

2. **NOTE** there is no indication as a result of this review, save for some seasonal shifts for breathing problems, that red activity is likely to reduce to levels seen pre-IAED process change in 2019.

| REPORT APPROVAL ROUTE |
| --- |
| **Operations Senior Leadership Team – 8th February 2022.**<br>**Executive Management Team – 9th March 2022.** |

| REPORT APPENDICES |
| --- |
| Annex 1 – SBAR providing supporting background information and assessment |

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

| | |
|---|---|
| **CORPORATE OBJECTIVE** | **6. Develop a robust Performance Management Framework** |
| **CORPORATE RISK (Ref if appropriate)** | **CRR 223 Ability to respond to patients** |
| **QUALITY THEME** | **2. Safe Care**<br>**3. Effective Care**<br>**5. Timely Care** |
| **HEALTH & CARE STANDARD** | **2.1 Managing Risk and Promoting Health & Safety**<br>**3.3 Quality Improvement, Research & Innovation**<br>**5.1 Timely Access** |

| | |
|---|---|
| **REPORT PURPOSE** | **To provide assessment of the increased levels of Red demand and driving factors with consideration of the actions taken by EMS Coordination.** |
| **CLOSED MATTER REASON** | |

**SITUATION**

In November 2017, at the time the C3 Computer Aided Dispatch (CAD) system was implemented, Red priority incidents within Welsh Ambulance Services NHS Trust (WAST) accounted for 5% of our verified incident demand. By December 2021, Red priority incidents accounted for 10% of our verified incident demand.

Incidents prioritised as Red (immediately life threatening) have shown a steady increase in demand since February 2019. Despite some periods of lower demand in Spring 2020 (Apr/May/Jun) and January 2021 likely attributed to periods of lockdown connected to the pandemic, this increase has been sustained to a peak of 4,121 verified incidents in October 2021.

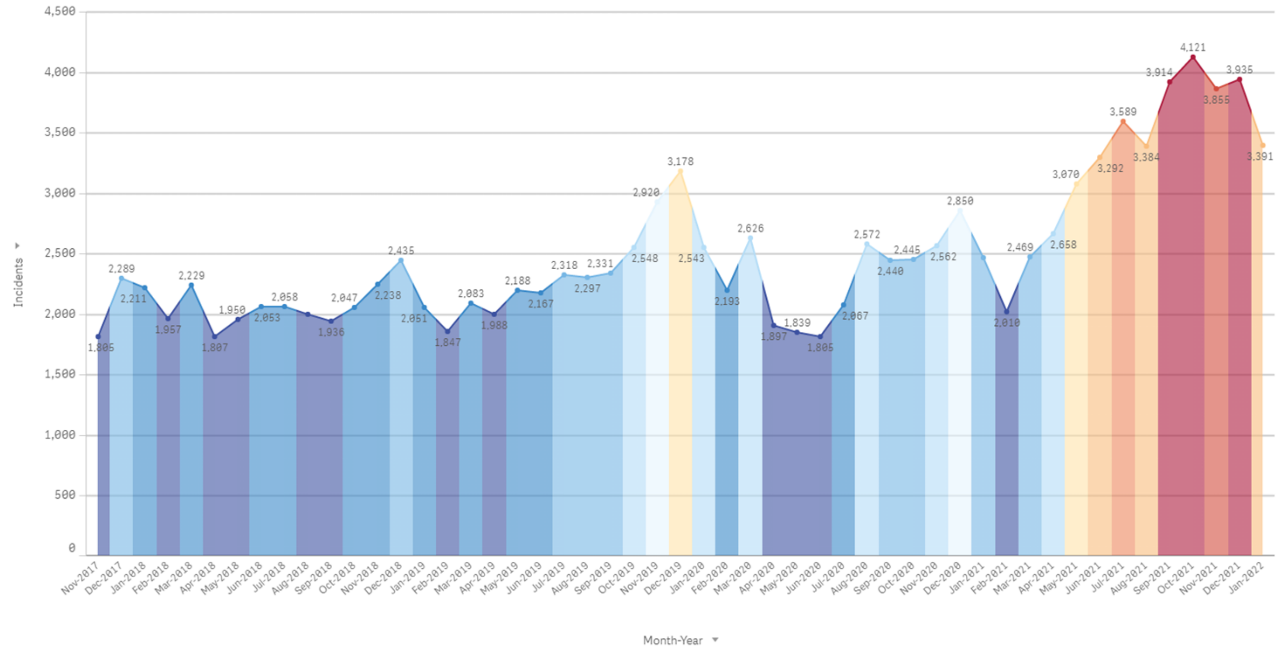



*Figure 1 - Verified Incidents (Red) by month*

Over the same period WASTs response to Red incidents within 8 minutes has deteriorated to a low of 50% in October 2021.

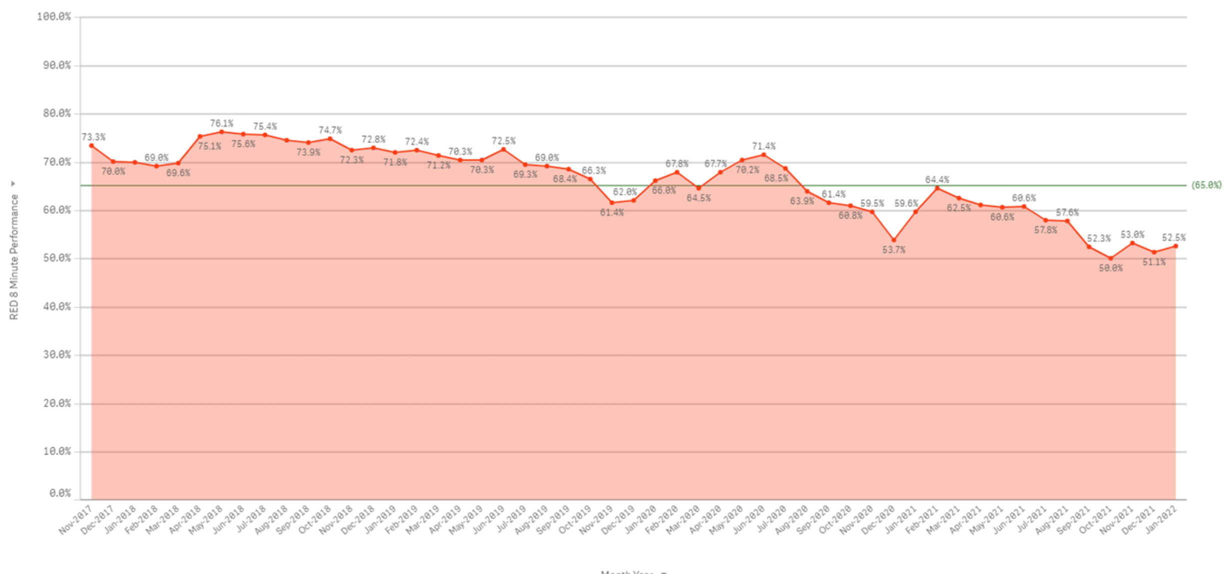



*Figure 2 - Red 8 Performance by month*

This paper explores reasons for the increase in Red demand and actions taken within EMS Coordination to understand and respond to this position.

**BACKGROUND**

**Ineffective Breathing**

In May 2019, following a levelling exercise with the International Academy of Emergency Dispatch (IAED), the process of generating an Echo determinant for patients identified as breathing ineffectively at any time within a call was agreed (Appendix 1).

Following implementation an increase in Red demand associated with breathing problems was identified. WAST engaged with the IAED and other UK ambulance services to identify areas of learning and best practice. As a result of this evaluation process, a programme of Continued Dispatch Education (CDE) was recommended for both EMDs and auditors.

In October 2020 a focussed audit of code 06E01 (Breathing Problems/Ineffective Breathing) was completed for 92 calls and the results reviewed, of these calls 11 were found to be over-coded. From this study it was identified that problem areas arose within the call process regarding asking the question "is the patient breathing?". The calls in which this was recognised as a problem identified a variety of reasons for errors, either not acting on updated information or incorrectly returning to case entry to alter the answer to this question instead of answering a key question. There were also examples of EMDs asking freelance questions.

As a result of identifying difficulty, in managing the 'is the patient breathing' question, individual feedback has been provided and tips have been included in the monthly coaching bulletin around chief complaint selection and freelancing. EMDs have been provided with online training 'Identifying Ineffective Breathing in the Telephony Environment' which is notoriously difficult.

A further focused audit on 06E01 and 36D01 was undertaken in November 2021 with 87 calls audited and reviewed. 36D01 is the pandemic protocol code for ineffective breathing and also achieves a Red categorisation.

As a result of this repeated audit it was identified that 20% of calls were non-compliant, this was mainly due to the EMDs selecting Protocol 6 (breathing problems) when they should have selected Protocol 36 (pandemic flu). Despite this non-compliance the incident priority was correct as the patients were identified as having ineffective breathing and if they had been on the correct protocol the ineffective breathing descriptor should still have been selected. The other high deviation detected was on some calls failing to ask the caller to fetch a defibrillator in case it was needed later, again this would not have affected the incident priority.

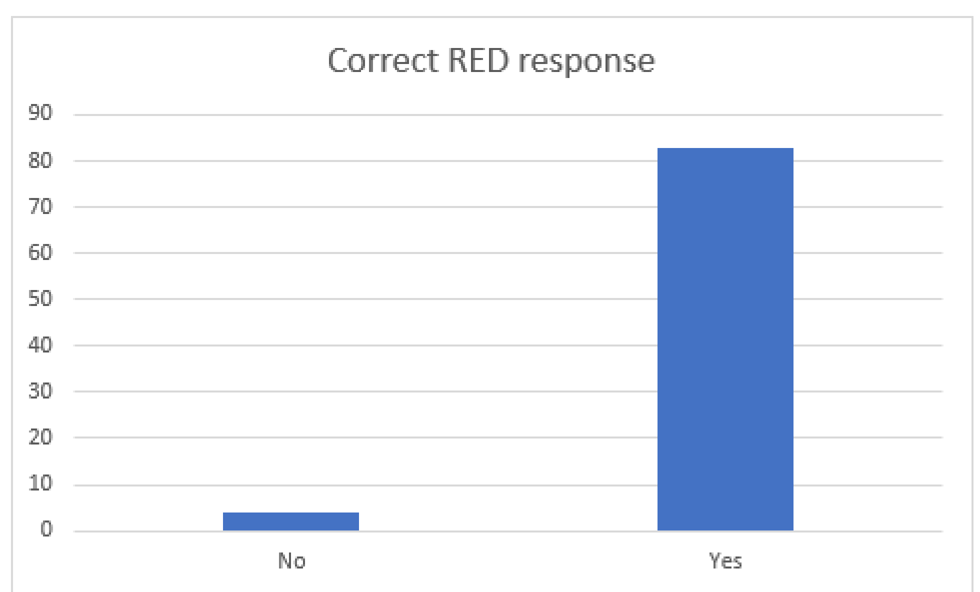



*Figure 3 - Focussed audit prioritisation compliance*

The November 2021 review identified that 4.5% of calls (4 out of 87 calls) were over coded as Red when they should have been Amber, this compares to 11.9% of calls (11 out of 92 calls) in the October 2020 study. This study would appear to identify that the supposition that the increase in red call categorisation due to inappropriate over coding of 06E01 is not supported as the proportion of calls over-coded has 06E01 has declined from 11.9% to 4.5%.

**ASSESSMENT**

Whilst the number of incidents prioritised as Red has been showing an increase since February 2019, the ratio of total verified incidents prioritised Red has fluctuated. Some level of increased Red demand would be expected in line with the rate of growth in all activity however the proportion of verified incidents now prioritised as Red has increased from 5% to 10% .

In June 2019 the ratio increased to 6%, the change to ineffective breathing management is likely to have contributed to this, with a further 1% increase experienced in November/December 2019 which is consistent with the equivalent period in 2018.

A further 1% increase was demonstrated in March 2020, as the organisation moved towards Pandemic response as a result of the Covid-19 emergence. During the following months the Red demand ratio reduced and consideration is given to the impact of Pandemic restrictions on emergency demand.

Following the easing of restrictions in July 2020 the Red demand ratio returned to the 6% baseline seen since June 2019. In November/December 2020 we saw the trend of a 1% increase demonstrated in previous years, however unlike previous years the demand did not recover and instead has shown a consistent increase reaching a peak of 10% in November/December 2021.

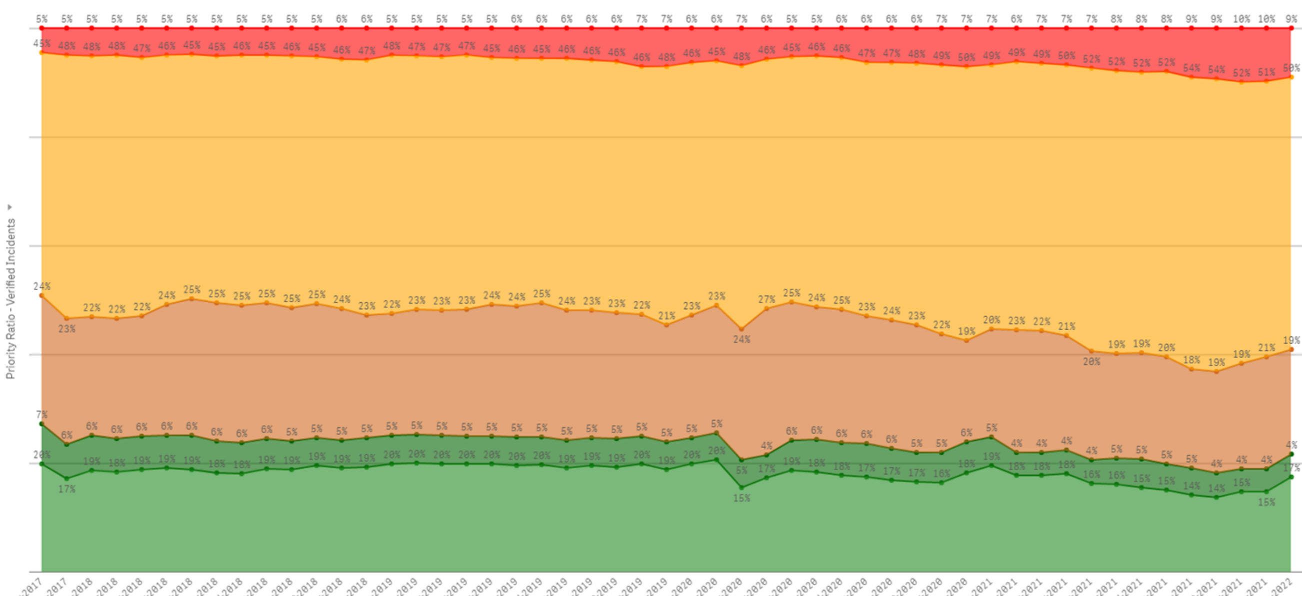



*Figure 4 - Acuity Trend by month*

The Top 10 Red priority protocols (since November 2017) are:

1. Breathing Problems (Protocol 6)
2. Cardiac/Respiratory Arrest (Protocol 9)
3. Unconscious/Fainting (Protocol 31)
4. Overdose/Poisoning (Protocol 23)
5. Pandemic Flu (Protocol 36)
6. Pregnancy/Childbirth/Miscarriage (Protocol 24)
7. Falls (Protocol 17)
8. Running Call (Override)
9. Convulsions Fitting (Protocol 12)
10. Allergies/Envenomation (Protocol 2)

It must be noted that the Pandemic Flu (Protocol 36) has not been available and in use across the entire period, and when this protocol is made available, results in a reduction of incidents in Breathing Problems (Protocol 6), Chest Pain (Protocol 10) and Sick Person (Protocol 26).

**Pandemic Flu**

When considering the impact of the Covid-19 Pandemic and the use of Protocol 36, there is only one Red priority outcome which happens to be associated with ineffective breathing. When reviewed in isolation the Protocol 36 clearly shows an increase in demand in winter 2020/21 during the 2$^{nd}$ wave of infections, a further peak during spring 2021 followed by a sharp increase in September 2021 associated with the Omicron wave.  The period of low activity is related to the removal of Protocol 36 whilst the prevalence of infection in the community remained low.

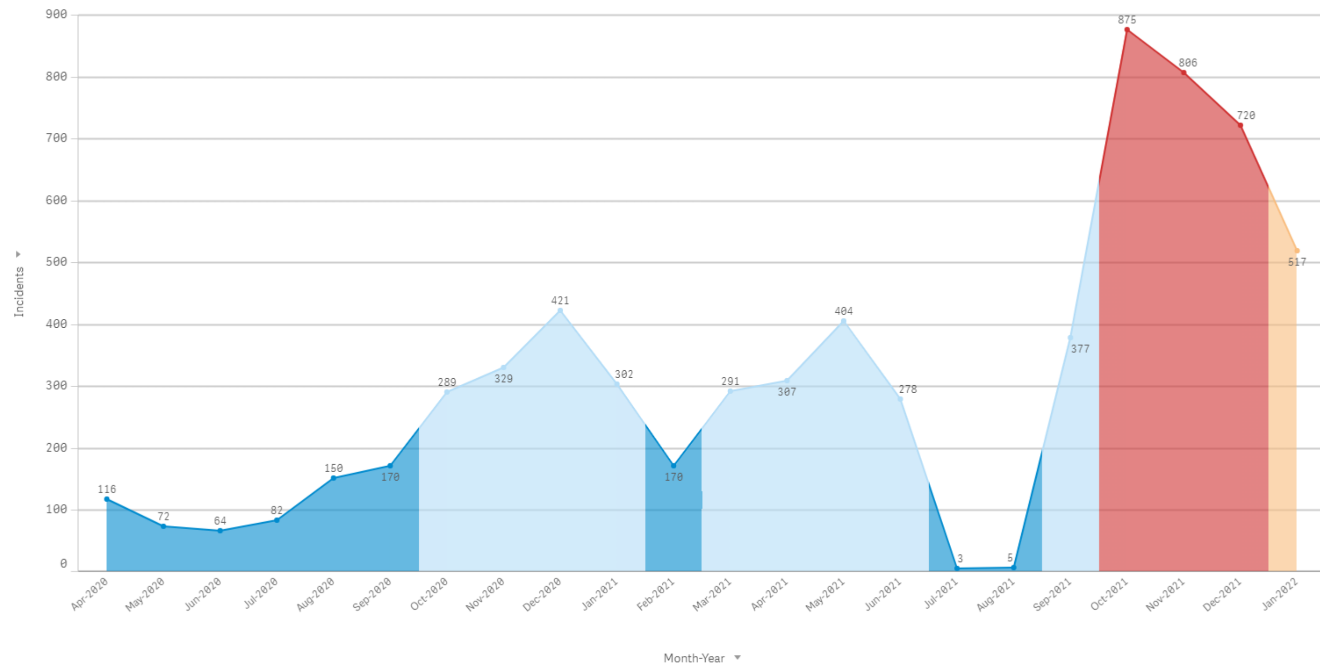



*Figure 5 - Protocol 36 Red Demand all demographics*

## Breathing Problems

A review of the data for Breathing Problems (Protocol 6) combined with ineffective breathing associated with pandemic flu (Protocol 36 Red incidents) identifies a pattern of increased activity associated with winter respiratory virus (such as flu) with the increased pressure associated with the Covid-19 Pandemic.

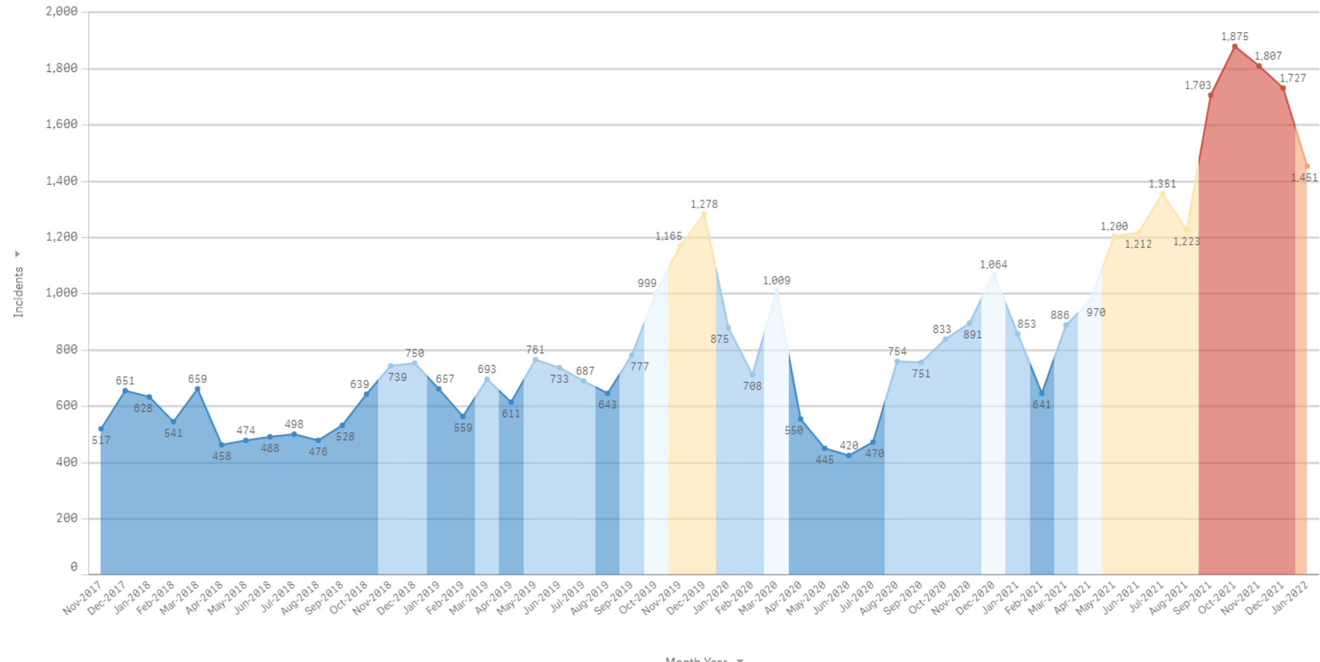



*Figure 6 - Protocol 6/36 Red demand all demographics*

The November 2021 focussed audit of ineffective breathing has identified that the red priority associated with these incidents are largely correct, with over coding having reduced significantly as a result of the learning implemented following the October 2020 audit.

When reviewing the age demographic of those coded as ineffective breathing (protocol 6 and protocol 36), increased numbers of patients aged 0-4 (pale pink bar) can be seen at times when Red ratio has increased (Nov/Dec 2017/18/19). Following the easing of restrictions in July 2020 we see a similar pattern through the summer and into winter before restrictions are reintroduced in December 2020. Again this pattern of increased demand is then demonstrated from March 2021 onwards reaching a peak in October 2021. Recent demand growth through the summer and leading to this peak in October 2021 in this age group could be associated with the Respiratory Syncytial Virus (RSV) that circulated out of season, peaking ahead of the winter period.

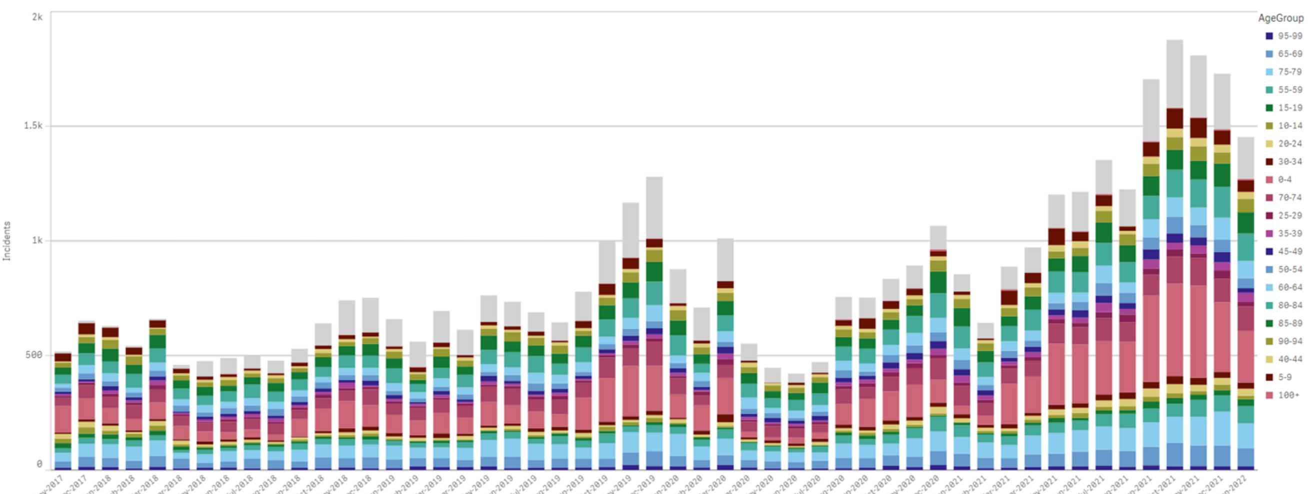



*Figure 7 - P6/36 Red demand by age demographic*

The focussed audit of ineffective breathing in November 2021 identified a pattern of demand originating from health care professionals. Consideration was given to the method of call for this Red demand and identified a possibly disproportionate increase in calls originating from Health Care Professionals. However, when reviewing the outcome for these patients, 79% of those who received a face-to-face response, were conveyed to hospital.

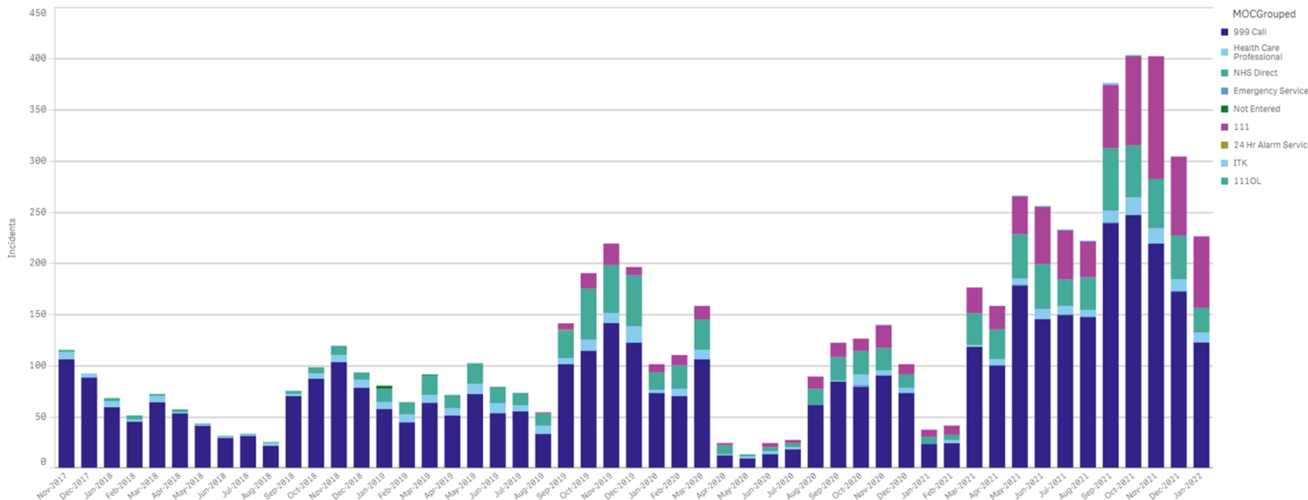



*Figure 8 - P6/36 demand for 0-4 yr olds by Method of Call*

**<u>Cardiac/Respiratory Arrest</u>**

A review of the Cardiac/Respiratory arrest (Protocol 9) demand by month and year suggests a fairly static pattern of demand with increases primarily associated with winter pressures.

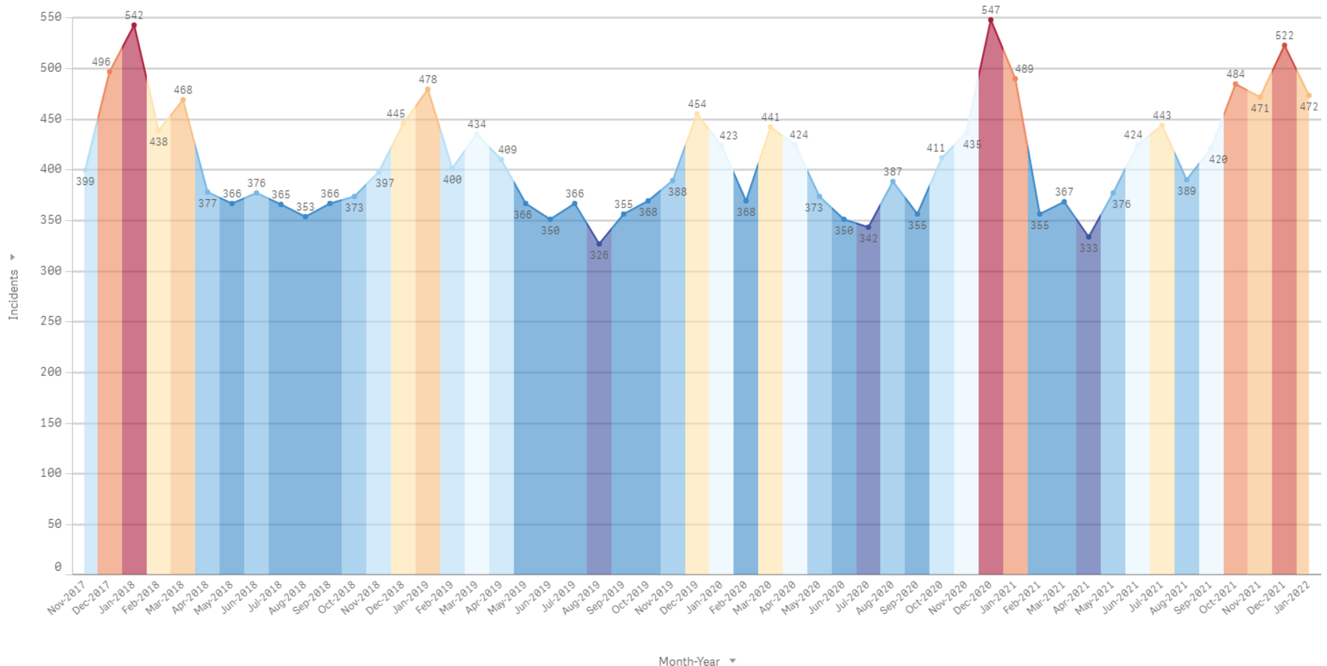



*Figure 9 - Protocol 9 demand by month/year*

## Unconscious/Fainting

A review of patients reported as unconscious and therefore generating a Red response under Protocol 31 shows a disproportionate increase in demand from November 2019 with a further step change in June 2021.

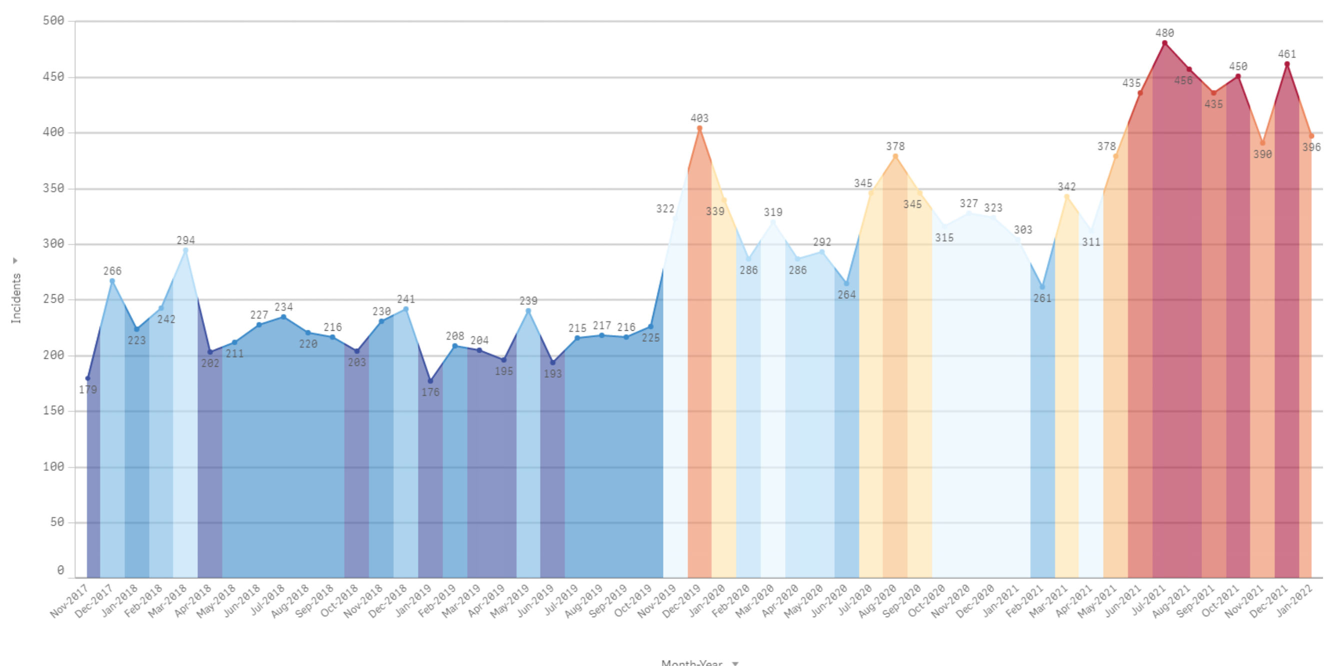



*Figure 10 - Protocol 31 demand by month/year*

As part of the Version 13.2 MPDS upgrade in October 2019 an additional code 31D02 with descriptor "unconscious patient with abnormal breathing" was introduced. This code is aligned to a Red response. MPDS recycle codes, the previous iteration of 31D02 (unconscious with effective breathing) produced low levels of Amber 1 demand, however the demand associated with the

version change showed a significant increase.  This is not as a result of the change to ineffective breathing which has a unique code of 31D01.

*Figure 11 - 31D02 Abnormal Breathing*

A review of the method of call, age demographics and location do not show any particular trend in relation to this code.  As a result, a focused audit will be scheduled to identify evidence of appropriate use.

> A focused audit is to be scheduled to explore incidents that result in code 31D02 Abnormal Breathing, to assess if there is any learning that can be applied to EMD practice.
>
> Focused audit is possible with the consent of the IAED that permits WAST to allocate a proportion of our audits to an area of our own choosing. Our track record and previous pilot engagement has grown IAED confidence in our application of focused audit.

## Overdose/Poisoning

Red demand associated with overdose has shown a steady increase since November 2017.  The normal pattern of demand seems to indicate increased demand during the summer period reducing in the winter months. A review of health board areas and method of call did not identify any unusual data trends.

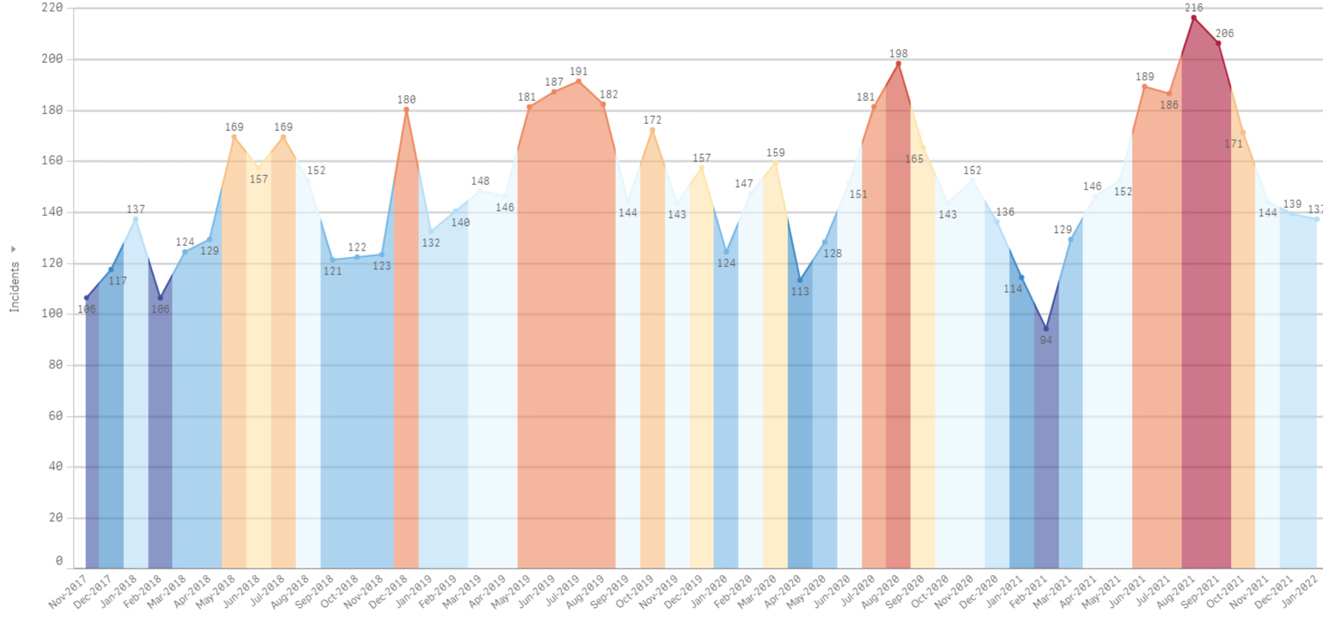



*Figure 12 - P23 Red Demand by month/year*

**Pregnancy/Childbirth**

Red demand associated with protocol 24 has remained fairly static. The demand does vary month on month with a peak in demand in September 2021 but this has returned to normal levels in the subsequent months. Consideration may be given to the capacity in labour wards impacting on our Red demand but this is not seen as a significant driver in our move from 5% red demand to 10% red demand.

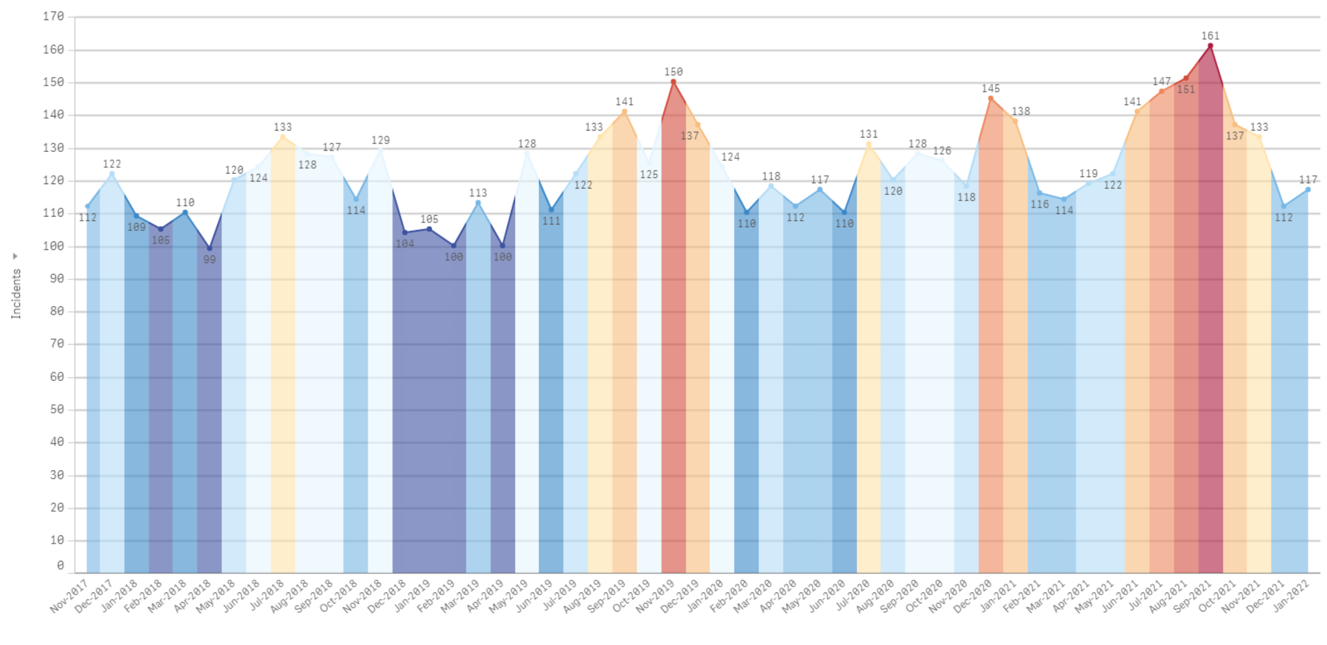



*Figure 13 - Protocol 24 red demand by month/year*

**Falls**

In January 2018 the MPDS team identified an issue with the coding of Ineffective Breathing in trauma protocols including fall. As a result, any patient who has fallen and is subsequently identified to have ineffective breathing is coded as an Arrest determinant and allocated a Red response even when the patient is conscious.

This issue was escalated to the national MPDS clinical focus group for resolution as an inappropriate coding. IAED asked UK services for examples however it would appear from the meeting notes that this wasn't explored further in later clinical focus group meetings.

Red demand associated with falls has experienced a step change in April 2021. A review of demand in Health Board areas seems to indicate the same or similar pattern of demand across all areas.

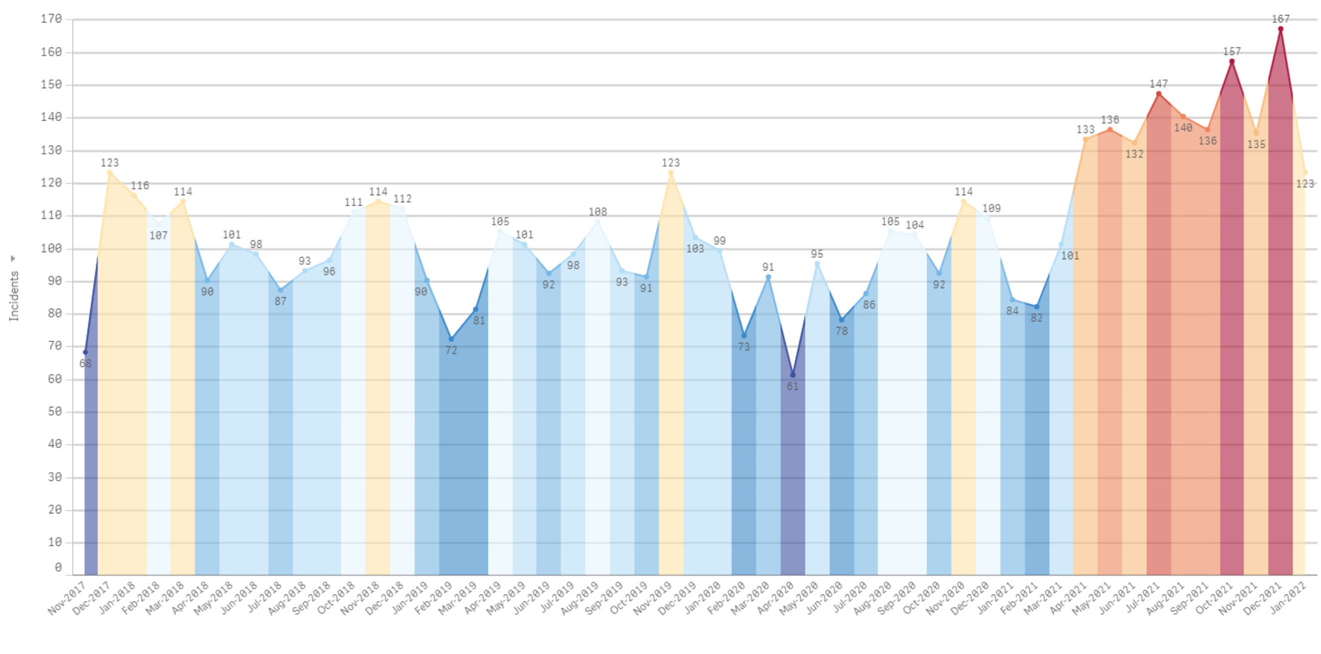



*Figure 14 - P17 Red demand by month/year*

The largest demand for Red falls is associated with unconscious patients (17D03) with the next largest demand relating to cardiac arrest (17D02). When we consider the ongoing identified issue of ineffective breathing in trauma protocols it is likely that this demand is not correctly reflecting the patient condition.

Within Protocol 17 there is a difficulty breathing descriptor for patients who have sustained a chest or neck injury, this code 17D05 is aligned with an Amber 1 priority.

Given that ineffective breathing is considered a Red priority in all other protocols it is possible that any change will result in a Red priority being assigned however we have requested a further escalation to the MPDS clinical focus group as this will impact on all trauma protocols.

When reviewing the response 65% of patients are conveyed to hospital, of those not conveyed the majority (75%) are recognised as deceased at the scene of the incident. This leaves a very small proportion of incidents that are resolved in another manner indicating an over prioritised incident. A focussed audit is being completed for all trauma protocols with an arrest determinant to understand the scale of the issue.

Reviews of the method of call and age demographic for this area shows nothing remarkable and a further investigation is required to understand the driver for the change in demand.

| A focused audit is being completed for all trauma protocols to explore incidents that result in an arrest determinant, to assess if there is any learning that can be applied to EMD practice.<br><br>Focused audit is possible with the consent of the IAED that permits WAST to allocate a proportion of our audits to an area of our own choosing. Our track record and previous pilot engagement has grown IAED confidence in our application of focused audit. |
|---|

**Running Calls**

Demand associated with running calls does fluctuate marginally. The reduction in running calls has been well documented before and shared with our commissioner. There remains continued focus on the number of incidents identified as Red as a result of a running call. There are clear

guidelines in place regarding the generation of a running call and these are reviewed regularly by the EMS Coordination management team. As a running call is an immediate hit for performance purposes (as the resource is at the scene), a reduction of these incidents can have a perverse impact on our performance.

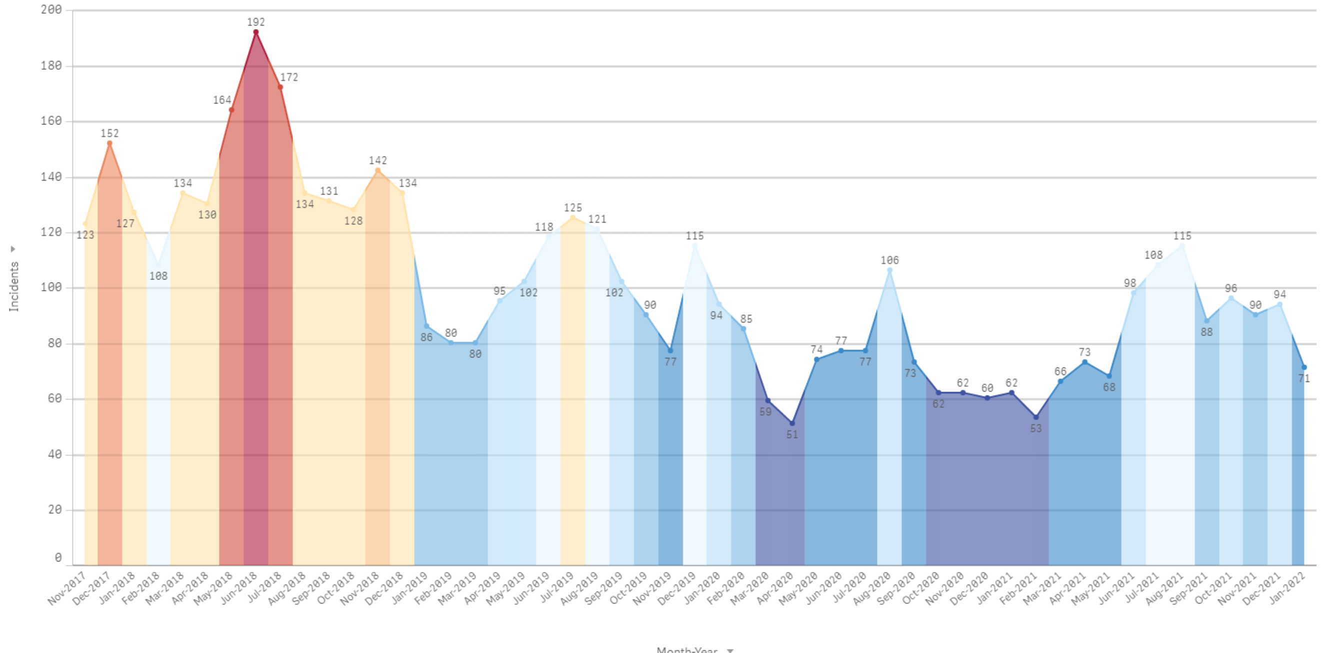



*Figure 15 – Running Call by month/year*

## **Convulsions/Fitting**

A review of calls associated with Convulsions and Fitting included Protocol 12 as well as the Nature of Call code for Prolonged fitting. In order to correctly clinically prioritise patients who are continuously fitting for a period of more than 20 minutes, EMDs are trained to escalate incidents of this type to a Red priority from an original Amber 1 priority. If we do not have resource capacity to provide a timely response to the original Amber coded incident the red volume increases.

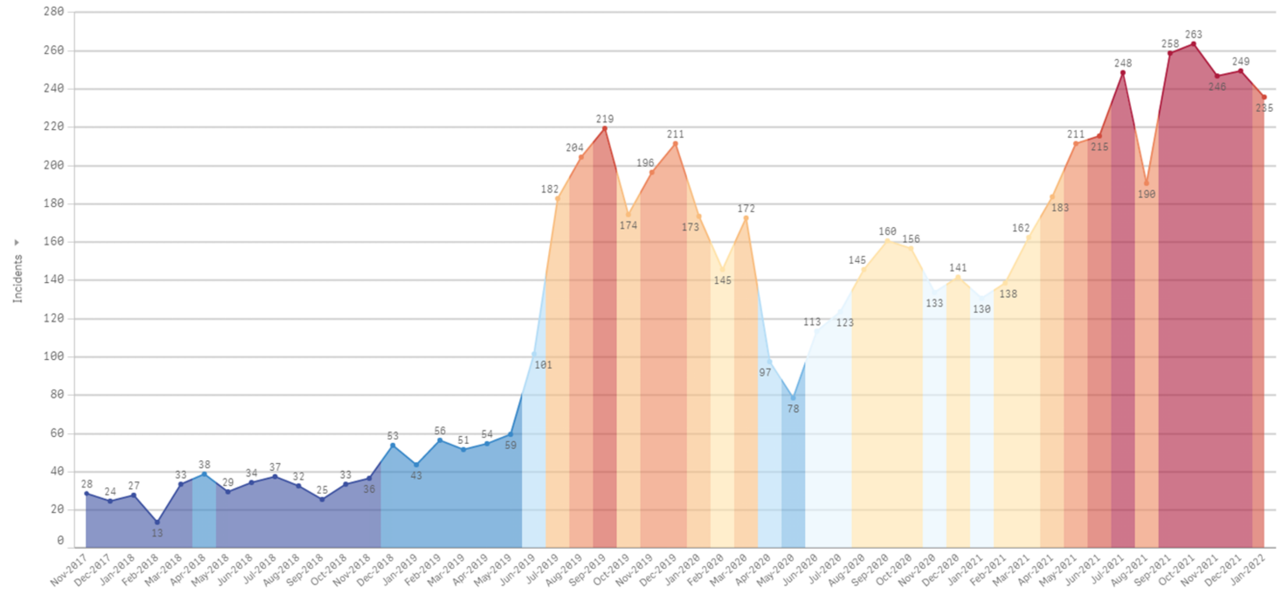
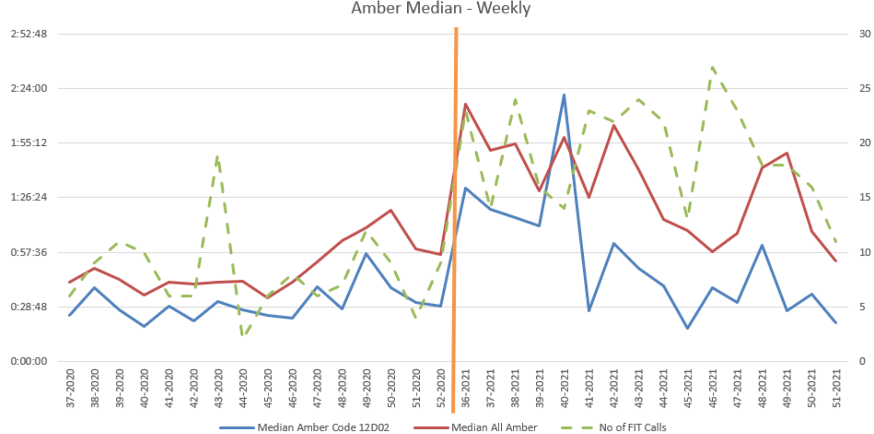



*Figure 15 - Protocol 12 and Prolonged Fit by month/year*

Red demand associated with fitting and prolonged fitting experienced a step change in demand in June 2019 as a result of the change in guidance regarding ineffective breathing. Protocol 12 includes an ineffective breathing determinant code (12D03).

| | 2019 | 2020 | 2021 | % Increase 2021 v 2020 |
|---|---|---|---|---|
| **Sep** | 61 | 40 | 77 | 92.5% |
| **Oct** | 39 | 40 | 92 | 130.0% |
| **Nov** | 50 | 28 | 90 | 221.4% |
| **Dec** | 52 | 38 | 68 | 78.9% |

A further increase in Red demand has been demonstrated from March 2021 with demand increasing by 221% by November 2021. This increase is as a combined result of delayed response to patients continually fitting (and therefore being escalated) as well as ineffective breathing reported in fitting patients.




Other determinants result in a red response but have low levels of demand that is not likely to contribute significantly.

## Allergies

Increases in Red demand associated with allergic reactions have demonstrated an increased trend since the beginning of the Covid-19 Pandemic.

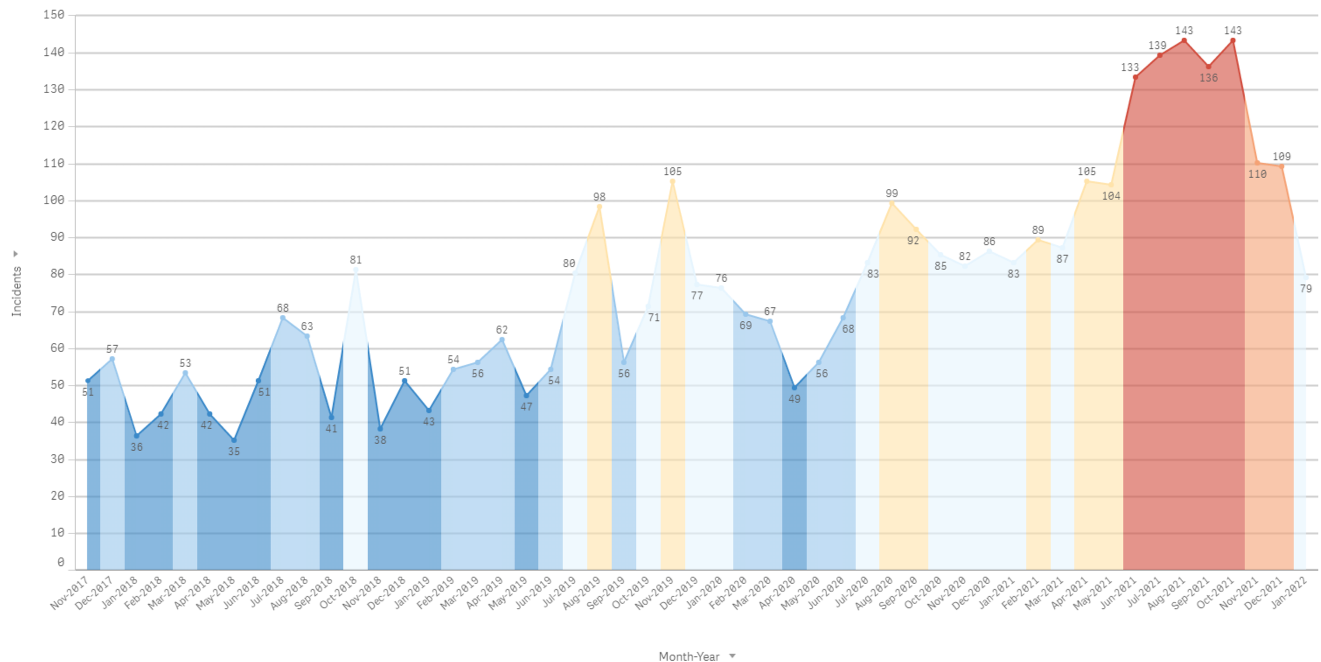



*Figure 16 - Protocol 2 Red demand by month/year*

When reviewing the method of call and patient demographic no significant themes could be easily identified.

The largest red code set in this protocol is identifying patients with difficulty speaking between breaths as a result of an allergic reaction (02D02). In addition Protocol 2 has an ineffective breathing descriptor which will have been effected by the process change in 2019.

However the most significant change in demand is not related to breathing difficulties but relates to patients who are not alert following an allergic reaction (02D01).

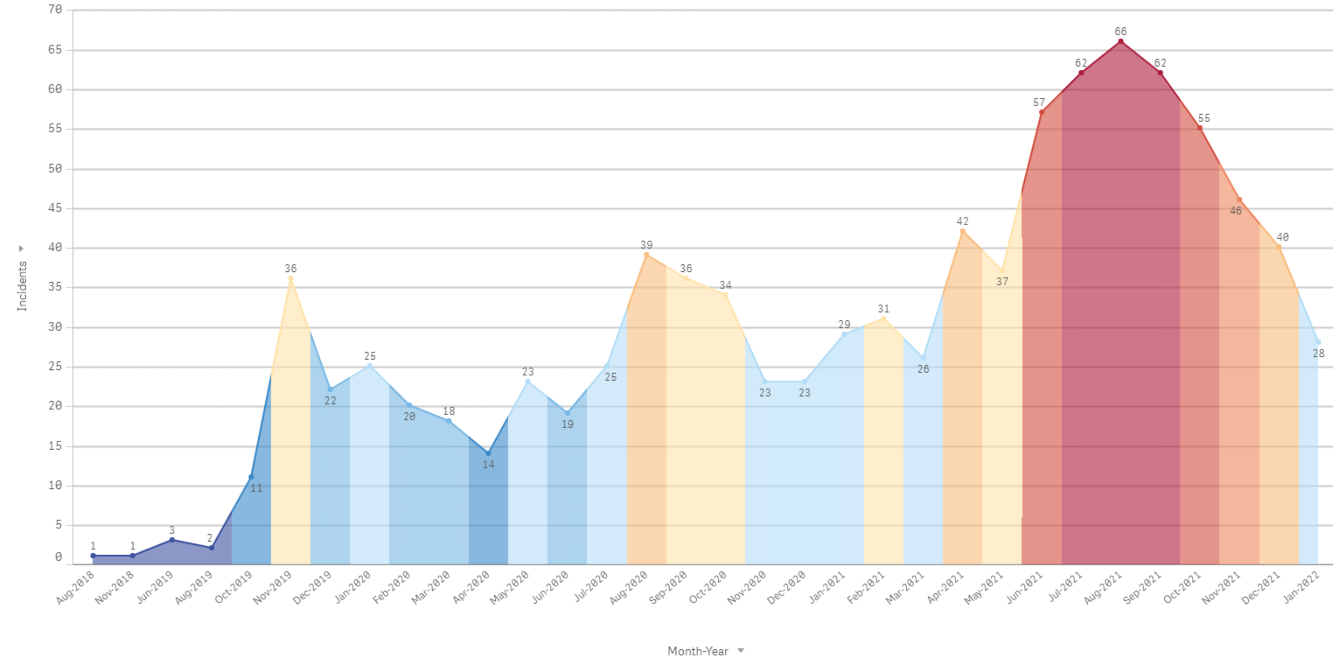



*Figure 17 - Protocol 2 Not Alert by month/year*

This increase seems to have impacted some health boards more than others with Betsi Cadwaladr, Aneurin Bevan and Cardiff & Vale seeing the greatest impact.

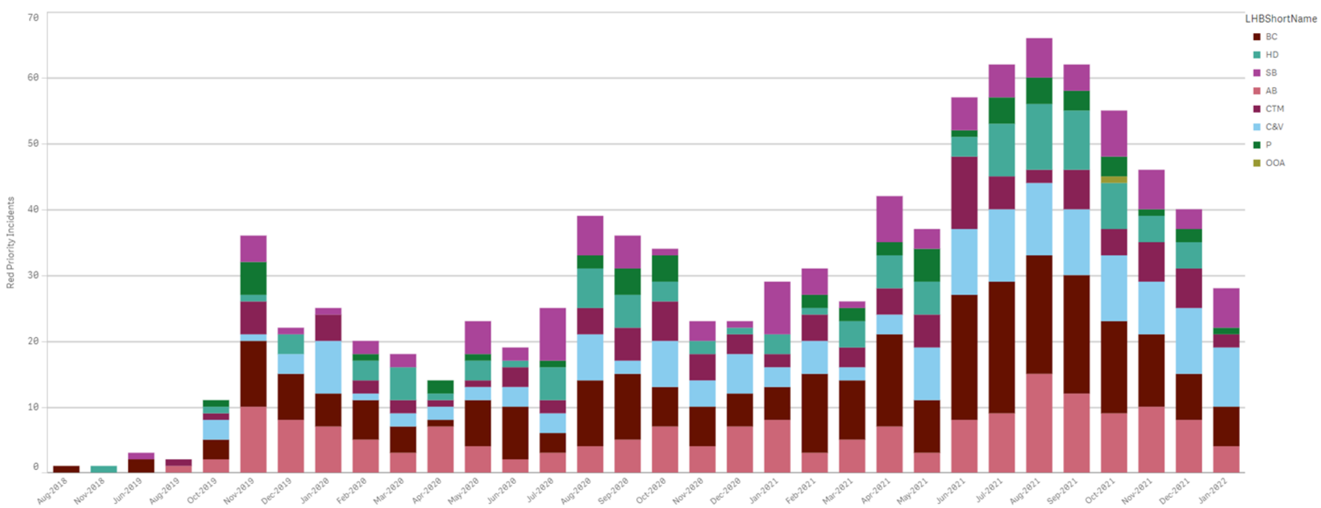



*Figure 18 - 02D01 by Health Board*

## Conclusion

Red demand levels have been significantly impacted by the Covid-19 pandemic with respiratory problems having the greatest impact. Focussed audits of the 999 calls received provide confidence that the priority of these incidents is accurate with over coding reduced as a result of the additional training and guidance issued to EMDs. We can therefore take some assurance from our previous response to outcomes of focused audit.

When reviewing the driver for increased demand for respiratory problems, paediatric demand in the 0-4 age range is the most significant factor. This was supported by the RSV demand data shared by Public Health Wales, however as RSV has reduced in prevalence the demand originating from paediatric patients remains high with the Omicron variant now having a greater impact on paediatric patients than other Covid-19 variants.

The increasing demand associated with allergic reactions needs further analysis to understand if restrictions in place to control the spread of Covid-19 is having an impact on those patients most susceptible to allergic reactions.

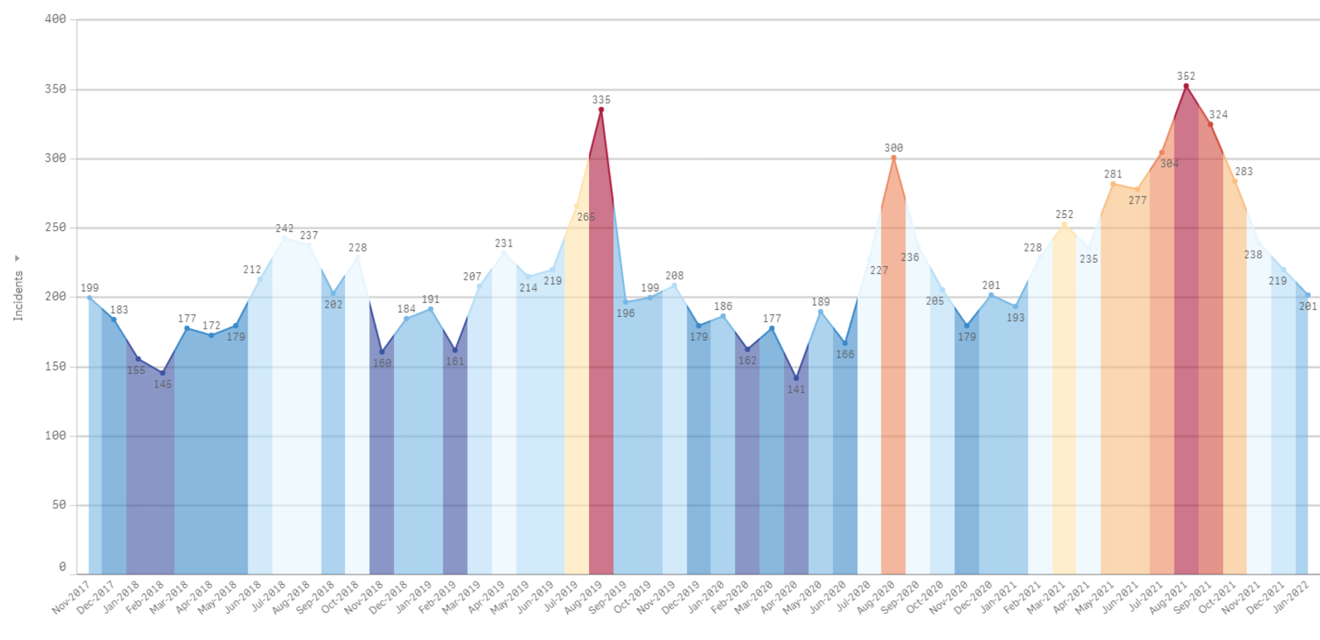



*Figure 20 - Demand associate with Allergic Reaction all priorities*

Consideration should also be given to any data available with the vaccination programme and whether the increase in demand associated with allergic reactions is directly related to this medication.

| Recommendation for a further clinical review of Red demand associated with allergic reaction to identify any trends in allergy triggers or clinical outcomes. |
|---|

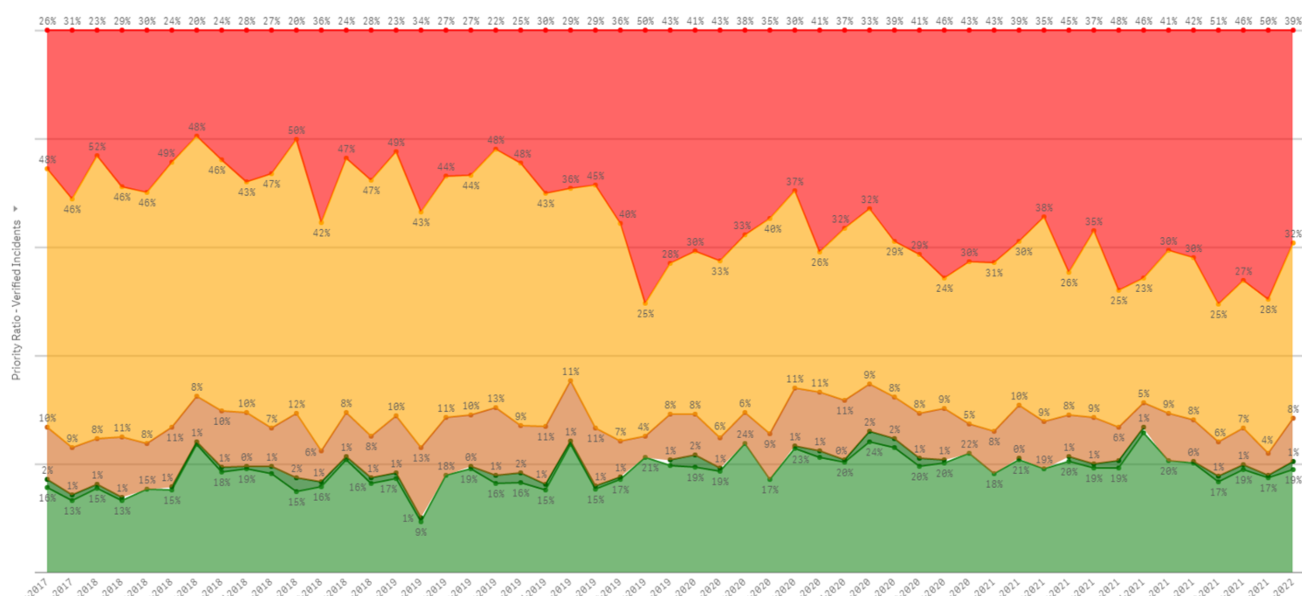



*Figure 19 - Protocol 2 acuity trend*

Increasing demand associated with prolonged fits can be directly associated with increasing response times to amber priority incidents. A continuing deterioration in lost hours at hospital will further impact our ability to respond to amber priority patients, which will have a continued impact on this type of red demand.

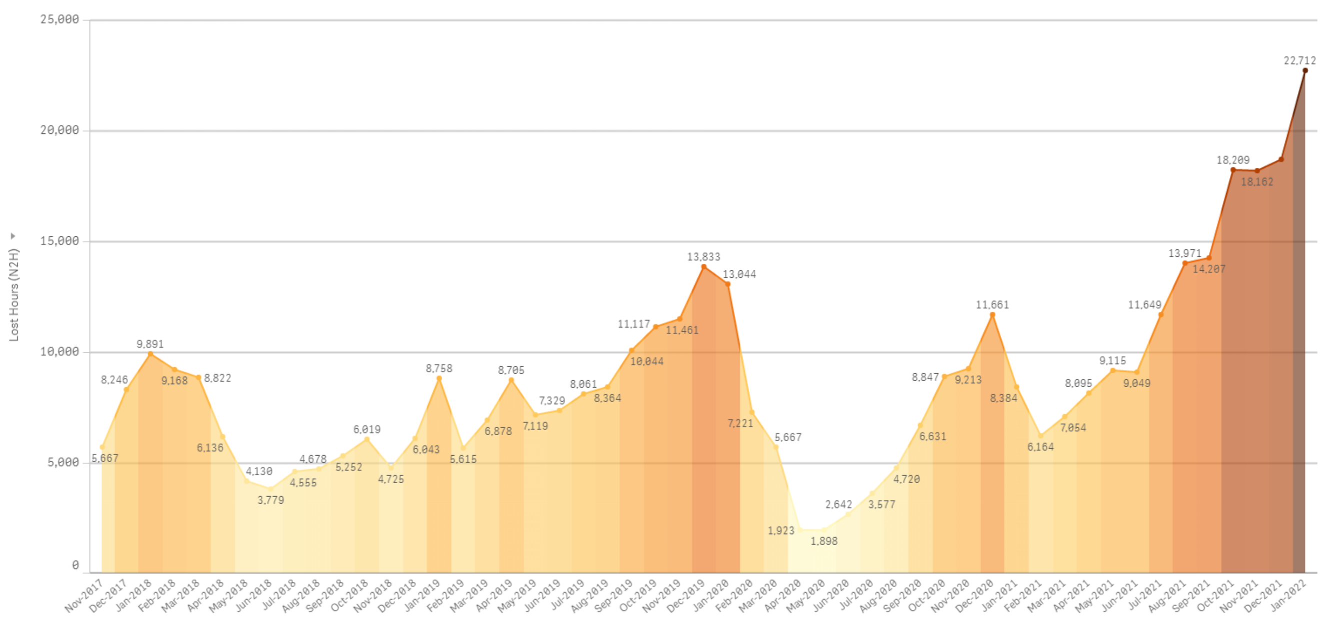



*Figure 20 - Lost hours at hospital by month/year*

Also for consideration is the change in how patients are accessing our services with increased levels of Red priority incidents being received from health care professionals including 111. Of particular note is the age demographic of patients accessing services in this way. A large proportion of the Red demand received from health care professionals is aligned to the increasing demand for 0-4 year olds.

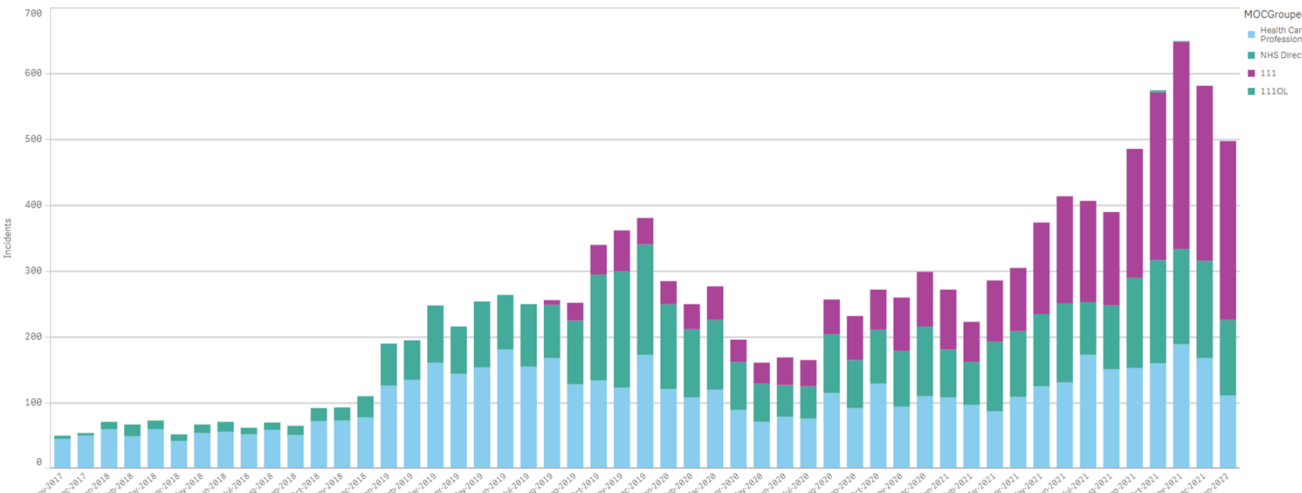



*Figure 21 - Red demand originating from health care professionals inc 111*

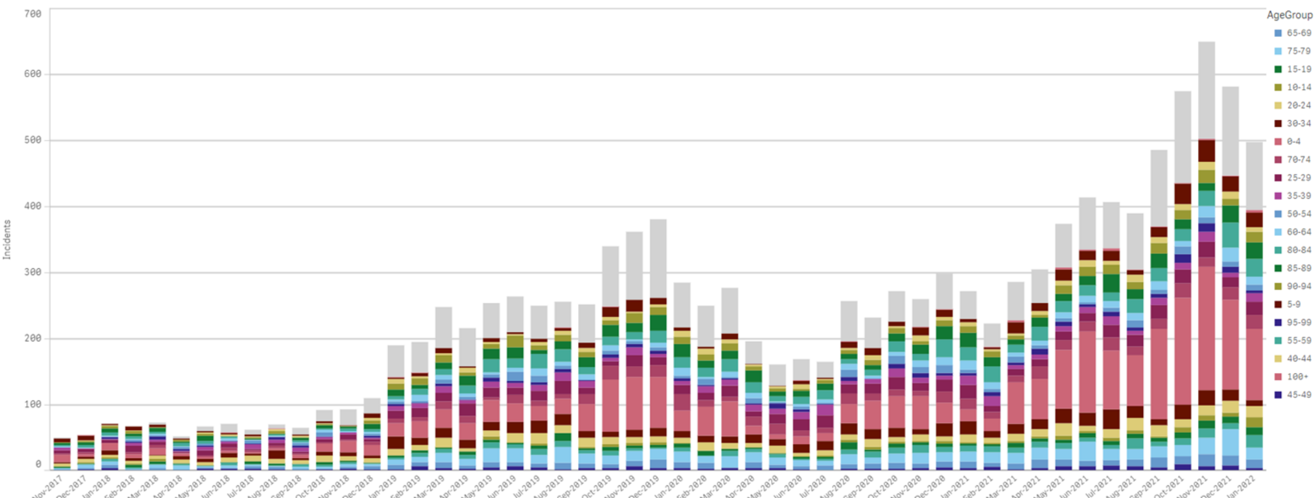



*Figure 22 - Patient demographic of HCP Red demand*

| 111/QSPE will undertake further review of the origins and outcomes for 0-4 yrs demand to understand any learning or systems changes that could better address this increasing Red emergency demand |
|---|

**It is recommended that** the Finance & Performance Committee:

1. **NOTE** 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 is commissioned to understand increased incidents associated with allergic reaction and to identify any trends in allergy triggers or clinical outcomes.
    c. EMS Coordination continue to use focussed audit to explore areas identified for potential EMD learning.

2. **NOTE** there is no indication as a result of this review, save for some seasonal shifts for breathing problems, that red activity is likely to reduce to levels seen pre-IAED process change in 2019.

**Appendices**

**Appendix 1 – Coaching Tip Echo at anytime**

10) Echo.pdf

**REPORT CHECKLIST**

| **Issues to be covered** | **Paragraph Number (s) or "Not Applicable"** |
|---|---|
| Equality Impact Assessment | n/a |
| Environmental/Sustainability | n/a |
| Estate | n/a |
| Health Improvement | n/a |
| Health and Safety | n/a |
| Financial Implications | n/a |
| Legal Implications | n/a |
| Patient Safety/Safeguarding | This paper provides an assessment of the increased levels of Red demand and driving factors with consideration of the actions taken by EMS Coordination.<br><br>Incidents prioritised as Red (immediately life threatening) have shown a steady increase in demand since February 2019. Over the same period WASTs response to Red incidents within 8 minutes has deteriorated. |
| Risks | CRR 223 Ability to respond to patients |
| Reputational | Analysis support the connectivity between activity and performance associated with Red demand. Failure to meet performance targets reflects a reputation risk to stakeholders and patients/service users. |
| Staff Side Consultation | Will be received through Trade Union Partners by virtue of attendance at finance and performance committee |

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

# QUALITY HIGHLIGHT REPORT QUARTER 4 JANUARY - MARCH 2022

| MEETING | Quality, Patient Experience & Safety Committee |
|---|---|
| DATE | 12 May 2022 |
| EXECUTIVE | Executive Director of Quality & Nursing (Interim) |
| AUTHOR | Head of Quality Assurance |
| CONTACT | Caroline Miftari<br>07970406447<br>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:

1. Quarterly Q-IPR datasets.
2. A summary of activities of the Clinical & Quality Governance Group.
3. A Quality Focus Area (arising from the Quality, Patient experience & Safety Committee) regarding post-production lost hours.

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.

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

## KEY ISSUES/IMPLICATIONS

The key challenges are:
1. Handover delays continue to impact negatively on service performance, noting an increase in hours lost this quarter.
2. Fourteen Nationally Reportable Incidents (NRI) sent to the Delivery Unit, this excludes any Appendix Bs sent to the Health Board.
3. Two Regulation 28 (Prevention of Future Deaths) received from the Coroner.

4. Clinical Outcome Indicators have not been reported this quarter due to decommissioning of Digi Pen and implementation of EPCR. This is discussed in more depth within part 2 of the report.
5. Continued challenges responding to Red calls within 8 minutes.

| REPORT APPROVAL ROUTE | |
|---|---|
| Integrated Governance Group (informal) | 3 May 2022 |
| Quality, Patient Experience & Safety Committee | 12 May 2022 |

| REPORT APPENDICES |
|---|
| **Annex 1** - SBAR providing background information relating to the Integrated Quality Performance Highlight Report Quarter 4, 2021-22 |

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

**ANNEX 1**

## SITUATION

1 The report provides an overview of the quarterly Q-IPR Dataset, Clinical Quality Governance Group (CQGG) overview, and quality improvement focus area arising from Quality, Patient Experience & Safety Committee (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 4, 2021-22**:

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. This report seeks to compliment the Performance Highlight Report with a focus on the quality.

### OUR PATIENTS

**Serious Adverse Incidents:**

6 The number of nationally reported incidents (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 14 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 Serious Case Incident Forum (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.

7 During the quarter there were 18 SCIFs convened with 104 cases discussed, 14 have been reported as NRIs to the Delivery Unit, with 42 cases being referred under Appendix B to the respective Health Board.

**Patient Safety Incidents reported through Concerns**:

8 Under Putting Things Right Regulations, the Trust is required to respond to concerns from the public within 30 days. During the quarter, the monthly response rate to concerns has been 66%, 64% and 78% respectfully, with a target of 75%. Several factors influence whether the Trust is able to reach its target, including increased demand, a rise in the number of inquests, increased volumes of NRIs and the availability of other Departments to provide a timely response to requests for information. Ultimately this may impact on the timeliness to establish patient safety risks/issues and implement learning across the business preventing further similar incidents.

**Patient Safety incidents reported by Staff via Datix**:

9 As a result of the ongoing preparation for the implementation of the All-Wales RL Datix software system due to go live in April 2022, it has been identified that there are a large number of open incident records that require closure. The Trust must close as many open historic records within the current Datix system in order to enable a smooth transition/migration of data of open cases requiring ongoing management onto the new RL Datix system. Closure of historic incident records should also be undertaken to comply with the Adverse Incident Policy. The closure of these records has been discussed through the Clinical Quality Governance Group and Executive Management Team. This has resulted in support for a risk-based approach to closure of records, similar to approaches being undertaken across Health Boards. Workshops led by Health & Safety, Patient Safety and Operations are planned to ensure a multi-disciplinary approach to closure. A review will be undertaken to provide further assurance on the accuracy and appropriateness for closure of incidents.

**RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) Reportable Incidents**:

10 The monthly number of RIDDOR reportable incidents this quarter are, 17, 8, and 8 respectively. It has been identified through Health & Safety Management Reports that compliance with timeliness requirements for RIDDOR submission to the Health and Safety Executive (HSE) as not consistently being achieved. The Health and Safety Team, in partnership with the Senior Operations Team, is developing proposals for improvement of this metric.

**Coroners and Ombudsman**:

11 There have been 2 Coroners' cases that have resulted in a Regulation 28 (Prevention of Future Deaths) this quarter. The first Regulation 28 received related to a 3-hour response time to an elderly faller, the second Regulation 28 related to vehicle allocation resulting in subsequent delay of ambulance arrival.

12 The number of in-month requests for information from the Coroner continues to be increased from pre-pandemic request. The complexity of the requests being received continues to be high.

13 There are currently 16 open Ombudsman cases as of the end of the quarter.

14 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.

15 The Trust continues to produce quarterly Patient Safety Health Board Reports that specifically focus on hospital handover delays and the impact on community waiting times and patient safety concerns. Risk 223 '*unable to attend patients in the community who require see and treat*' is classed as one of the Trust's highest risks. This is captured on the Corporate Risk Register at a risk score of 25.

**Data Governance Breaches**:

16 During the reporting period, 62 information governance related incidents have been reported on Datix, the highest being in March at 31. These have been attributed to consent, communications, confidentiality, IT, clinical assessment, equipment and medical devices. All incidents have been reviewed and investigated by the Information Governance (IG) Team and remedial actions taken where appropriate. There have not been any incidents that were deemed to meet the risk threshold for reporting to the Information Commissioner's Office. All have been investigated by the IG Team and colleagues received feedback on the IG Policy and practice elements and, where appropriate, learning has been put in place.

17 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. The next submission date for the IG Toolkit is due 31 March 2022.

**Clinical Outcomes**:

18 Clinical indicators have not been reported this quarter due to decommissioning of Digi Pen and implementation of EPCR. This is discussed in more depth within part 2 of the report.

## 111 SERVICE

**111 - Call Answering/Abandoned Performance**:

19 Calls abandoned within 60 seconds have been consistently below the target of 5%, ranging from 10.8%, 4.6% and 9.2% this quarter. Calls answered within 60 seconds of the end of the message have been consistently below target of 95%, ranging between 53.3%, 62.4% and 52.3%. However, this is an improvement on the last quarter.

20 The following are anticipated to improve service delivery:

- Following a successful launch in Cardiff & Vale Health Board (C&VUHB) on 16 March 2022 the 111 service is now live across Wales. Bringing an end to the NHS Direct Wales Service.
- To enable the launch of 111 service in C&VUHB strong progress has been made in Quarter 3 & Quarter 4 to deliver the accelerated 111 recruitment and training plan to increase the Call Handler & Clinical Advisor workforce.
- The increased estates and training capacity enabled the training cycle in January to deliver 24 WTE Call Handlers & 11 WTE Clinicians, with a further 50 WTE Call Handlers and 11.6 WTE Clinical Advisors on the February cycle.
- The additional workforce numbers meet the Call Handler requirements for the C&VUHB core 111 roll out and the projected expansion for the 111 First Service.
- The Clinical Advisor numbers meet the requirements for C&VUHB core 111 roll out however, further recruitment would be required to meet the 111 First service needs Pan Wales (if funded).
- A number of service improvement initiatives including the introduction of new messaging, review of the Clinical Advice Line (CAL) and the ongoing recruitment positions have had a positive impact to help stabilise the 111 call abandonment rate and improve call to answer times.

**111 Clinical Assessment Start Time Performance**:

21 Clinical telephone triage assessment standards require a clinical assessment to commence within 1 hour of the end of first contact for priority 1 calls, within 2 hours for priority 2 calls and 4 hours for priority 3 calls, with a target of 90%. During the quarter, priority 1 calls have met the target however, priority 2 and 3 calls have not met the 90% target.

22 The main driver to improve performance will be the correct number of Clinicians in post to manage current and expected demand. Urgent work is now underway through the Gateway to Care Transformation Board to consider:

- Opportunities to widen the scope of Clinicians who can apply, for example, through offering remote working, exploring use of different Clinicians or considering call centres in other areas.
- Opportunities to understand better and potentially reduce the number of tasks that Clinicians have to undertake so that the Trust needs fewer in the future, in particular, work is focusing on the use of the Clinical Advice Line.

## EMERGENCY MEDICAL SERVICES

**999 Call Performance (demand and clinical hours produced)**:

23 The Trust has a target of answering 999 calls within 5 seconds. This quarter over the month of January, February and March the average performance has ranged from 54 seconds, 59 seconds and 1.35 seconds, this is likely to impact negatively on patient experience and potentially patient outcome.

24 The Trust received 48,792 emergency 999 calls in March 2022, an increase compared to February 2022 and significantly higher than both March 2020 and March 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. Over the quarter there have been increased levels of staff abstraction due to sickness and COVID-19 abstractions in the call centres which is reducing capacity.

**Red Performance Response to red 999 calls**:

25 The Trust has a target measure of 65% for emergency vehicles to respond to red calls arriving within (up to and including) 8 minutes against the red calls 95$^{th}$ percentile. The Red performance indicators have been consistently below the 65% target, this quarter 52.5%, 55% and 51.1% respectfully, with some Health Board variation. 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, with continued increases outside of normal expected variation which is impacting on response times. Hospital lost hours continue to rise and impact on service delivery.

26 Delays in responding to 999 calls can potentially 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; Nationally Reportable Incidents (NRIs) reported by the Welsh Ambulance Services NHS Trust (WAST); 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.

**Amber 1 & Amber 2 Performance**:

27 Amber 1 performance has been challenging over the quarter. Amber 1, 95$^{th}$ percentile, has been 04.51 (hh.mm), 05.03 and 06.37 respectfully. There is strong correlation between amber performance and lost hours due to handover delays which are increasing. The Trust carefully monitors long response times and their impact on patient safety and outcomes and supplies regular information to the Chief Ambulance Services Commissioner (CASC), Emergency Ambulance Services Committee (EASC) and each Health Board in respect to handover

delays and the impact on patient safety. The EMS Operational Transformation Programme is the Trust's key strategic response to Amber.

**Ambulance Abstractions and Production**:

28 Unit Hour Production (UHP) is a key indicator to identify whether the Trust has sufficient resources to provide a clinical service utilising all Trust Fleet and Human Resources. The hours produced target is 95%, over the quarter hours produced have been 109%, 110% and 98% respectfully. Key to providing the required hours of production is the Trust abstraction rate. This quarter the abstraction rate has been 42%, 41% and 48% respectfully. Additionally, the higher production of hours has been aided through the support of military assistance, which will not continue into the next quarter.

**NON-URGENT PATIENT CARE TRANSPORT (NEPTs)**

**NEPTs Discharge and Transfer Journeys and Renal Journeys**:

29 Renal journeys arriving within 30 minutes of their appointment are above the 70% target this quarter. Patients collected within 60 minutes of their booking time has been within the target of 70%. Key factors affecting these indicators are demand and capacity:

- The service is still impacted by the effects of physical distancing, although in April 2022 steps have been taken to begin a move towards a new Living with COVID-19 position by increasing maximum patient loading by 1 per vehicle.
- Capacity has also been adversely affected by other COVID-19 factors including journeys taking longer due to Personal Protective Equipment (PPE), staff sickness, staff shielding, staff training and testing, infection prevention and control arrangements.
- The service continues to increase across all areas and in March 2022, overall demand was at 90% of the equivalent month in 2019 and was 10% busier than any month since February 2020. Only outpatient activity remains supressed with all other areas at or in excess of pre-pandemic activity levels.

**VALUE**

**Post-Production Lost Hours (PPLH)**:

30 Minimising PPLH across Emergency Ambulances, Urgent Care Vehicles, Rapid Response Vehicles and Advanced Paramedic Practitioners is critical to providing a safe and effective service. Over the quarter, 15,153, 11,010 and 11,452 post production hours have been lost in respective months.

31 Hours lost through post production can be down to numerous factors, including but not limited to meal breaks, vehicle cleaning and operational duty. It can also be as a result of different processes at hospital sites causing variation in process in flow throughout the system that contributes towards post-production lost hours. Lost post production hours do not include lost hours due to handover delays; this is reported independently.

32 Further analysis of post-production lost hours is contained within part 3 of this report.

**PARTNERSHIP/SYSTEM CONTRIBUTION**

**999 Hear & Treat / % incidents conveyed to Major Emergency Department (ED)**:

33 999 Hear and Treat calls this quarter have been within target, 11.1%, 10.8% and 11.8% respectfully. The percentage of incidents conveyed to Major Emergency Departments has also been within target this quarter.

**Number of handover lost hours**:

34 The number of handover hours lost this quarter are 23,214, 23,232 and 24,479 respectfully. The Executive Director of Quality and Nursing, Medical Director and the Director of Operations continue to meet with their counterparts within the Health Boards to drive through improvements in relation to number of hours lost to handovers and the subsequent impact on community waiting times. These meetings are supported by individual Health Board Reports outlining the impact on patient safety and experience. Patients delayed on ambulances outside the Emergency Departments (Risk 224) is also the highest risk within the Trust and recorded on the Corporate Risk Register.

**Part 2: Clinical and Quality Governance Group Overview**:

35 Over the Quarter the Clinical Quality Governance Group (CQGG) has met twice, in January and March 2022. The purpose of the CQGG is to provide leadership and governance, overseeing on matters of a clinical and quality domain. The Group provides strong governance and assurance for Trust functions; providing a forum to direct improvement in response to organisational learning and to deliver excellence.

36 The sub-groups reporting to the CQGG will be review into the next quarter to ensure good governance due to the learning identified throughout the Pandemic period and the subsequent impacts of the Pandemic response upon several of the sub-group's operations.

37 Over the quarter 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.

**Red Activity Review**:

38 A Red Activity Review has been undertaken to establish the drivers for increased Red demand. This has been discussed at the Operations Senior Leadership Team, Executive Management Team and CQGG to understand factors that are cited as reasons for the increase, current and future trends and any learning or systems changes that could better address increasing Red emergency demand.

39 The outcome of the analysis of the Red Activity Review, save for some seasonal shifts for breathing problems, identifies that Red activity is unlikely to reduce to levels seen pre International Academies of Emergency Dispatch (IAED) process change in 2019.

40 The analysis key factors:

- A change of guidance from the International Academy of Emergency Dispatch (IAED) led to a 1% increase from June 2019 associated with ineffective breathing.
- Increased demand associated with respiratory illness is aligned to winter respiratory viruses and waves of Pandemic infection particularly driven by those patients aged 0-4 years.
- Red activity associated with unconscious patients with abnormal breathing was noted following the introduction in October 2019 of the MPDS version 13.2 upgrade.
- A pattern associated with patients who have fallen resulting in either a report of unconsciousness or as a result of ineffective breathing and/or cardiac/respiratory arrest.
- The reduction in the number of incidents identified as a running call can have a perverse impact on Red performance as these incidents are identified as an immediate hit due to the resource being at scene at the time of the call.
- Red demand associated with prolonged fitting has increased by up to 221% between November 2019 and November 2021.
- Increased levels of lost hours associated with handover to hospital and subsequent impact on increased amber incidents response times is resulting in increased Red demand for these patients.
- Patients reported as not alert as a result of allergic reactions have resulted in increased Red demand. Further clinical review is required to identify any themes and trends associated with these patients.

**Ambulance Quality Indicators Transition to Electronic Staff Record**:

41 The Trust monitors and reports on Clinical Indicators as part of the Ambulance Quality Indicators (AQIs) using Digi pen data to ensure clinical compliance to specific conditions and facilitate opportunities for improvement. Clinical Indicators include, Return of Spontaneous Circulation, Stroke Care Bundle and Acute Coronary Syndrome patients with appropriate care. However, reporting for Clinical Indicators has been deferred until May 2022, all other AQIs will be published with the exception of these.

42 The rationale for this is the decommissioning of the Digi pen that commenced in November 2021 and is being replaced by the Electronic Patient Care Record, leading to challenges in collecting data during the switch over. The Emergency Ambulance Services Committee have agreed the reporting pause.

**Controlled Drugs (CD) Internal Audit Report**:

43 Internal Audit undertook a Controlled Drugs Audit, publishing the report in November 2021. Substantial Assurance was given for the Medicines Management Policy and Reasonable Assurance was given for Medicines

Managements. Further work has been requested regarding Controlled Drug Safes and Abloy key checks to ensure overall accuracy. In addition, the requirement to undertake further analysis of medicines audits undertaken, providing themes and trends regarding compliance issues to demonstrate learning and improvement.

**Management of an Adult Expected Death**:

44 The Management of Expected Deaths was previously discussed at the CQGG last quarter however, further clarity was sought regarding support and guidance of the GP Out of Hours and General Medical Council (GMC) for any changes to current practice.

45 Current practice sees ambulance Clinicians attempt to refer these calls to primary care following verification of death. If primary care decline to accept this referral, specifically in the out of hours period signposting to the police usually occurs. Requesting police attendance is not always appropriate for the family, as well as impacting negatively on police service time. The Police Service may also decline to attend, creating distress for family members due to uncertainty on next steps. Delays resulting from this also prevent ambulance staff from being able to respond to other emergencies in the community.

46 Further discussions with General Practitioners (GPs) have resulted in the following Management Process moving forward; WAST clinicians on scene would advise the family/carer to make contact with the patient's GP on the next working day to notify them of the death.

**Physician Response Model (PRU)**:

47 The CQGG was asked to approve the PRU Standard Operating Procedure developed to provide clarity and guidance for the extension of the trial, which has been extended for a further 6-month from November 2021.

48 The purpose of the PRU is to provide out of hospital assessment and support the Care Closer to Home agenda. Advice and guidance can also be provided to Trust Clinicians who may be on-scene with patients where alternative disposition may be available through Health Board pathways, currently not available to WAST Clinicians.

49 The PRU Model is becoming widespread across the UK with joint working between Emergency Departments and Ambulance Service Trusts. There have been several schemes to test this concept in both Aneurin Bevan University Health Board (ABUHB) (since 2015) and CVUHB (since 2020) which have proved productive. Those pilots have been extended for a further 6-month period to establish the benefits to patients and demand levels witnessed by WAST and Health Board partners.

**Part 3: Quality Improvement Focus area - Postproduction Lost Hours**:

50 In response to a Committee request in the previous quarter, further clarity was requested in relation to Postproduction Lost Hours. A detailed analysis has been

undertaken by the Quality Improvement Team to provide a visual breakdown of 'lost hours' and describe how the Trust may ascertain appropriate levels of 'lost hours' for task and activities that are essential for operational context.

51 During March 2022, there were 15,920 postproduction lost hours (PPLH) recorded. A pareto chart was completed (**Figure 1**) and identified that 47% of PPLH was as a result of 'Return to Base (RTB) for Stand Down (SD) Rest Break Not Available' (RTB S/D meal break). This equated to 7,343 hours during the month of March 2022.

52 In total 83% of all lost hours were due to 3 reasons, which included RTB SD Meal Break, HALO duties and Duty Operations Manager Duties. The 3 categories contributed to over 12,910 PPLHs.

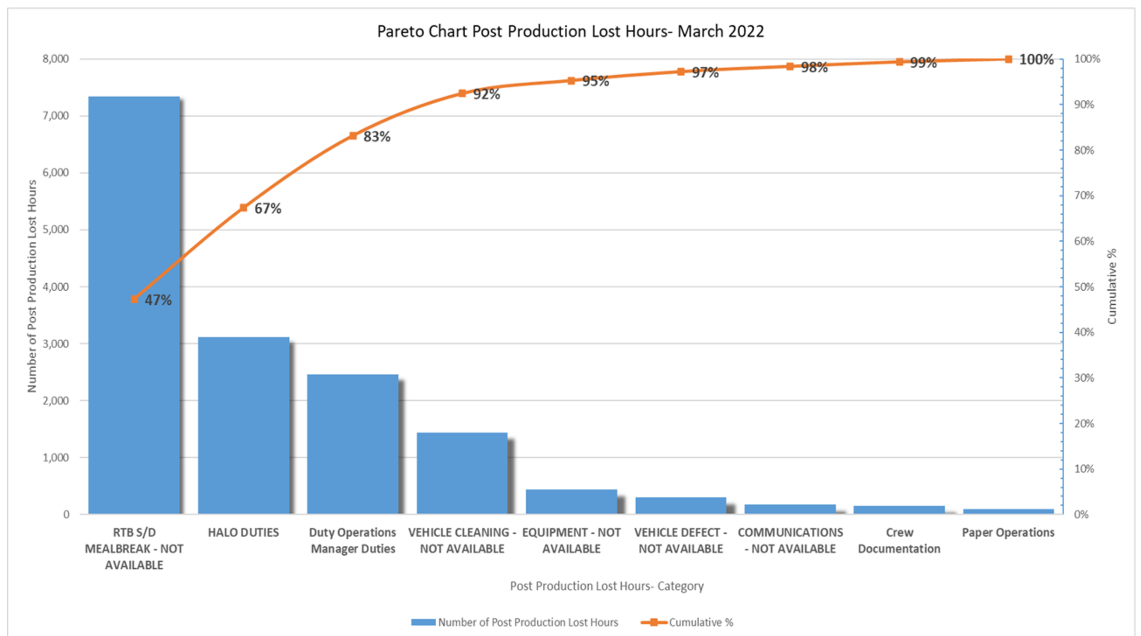


*Figure 1: Pareto Chart-Postproduction Lost Hours - March 2022 - Qlik Sense*

53 An analysis was undertaken of the category RTB/SD Meal Break for the month of March. As demonstrated in **Figure 2**, there were 15,356 individual events recorded. Common cause variation can be seen within the data for the month period.

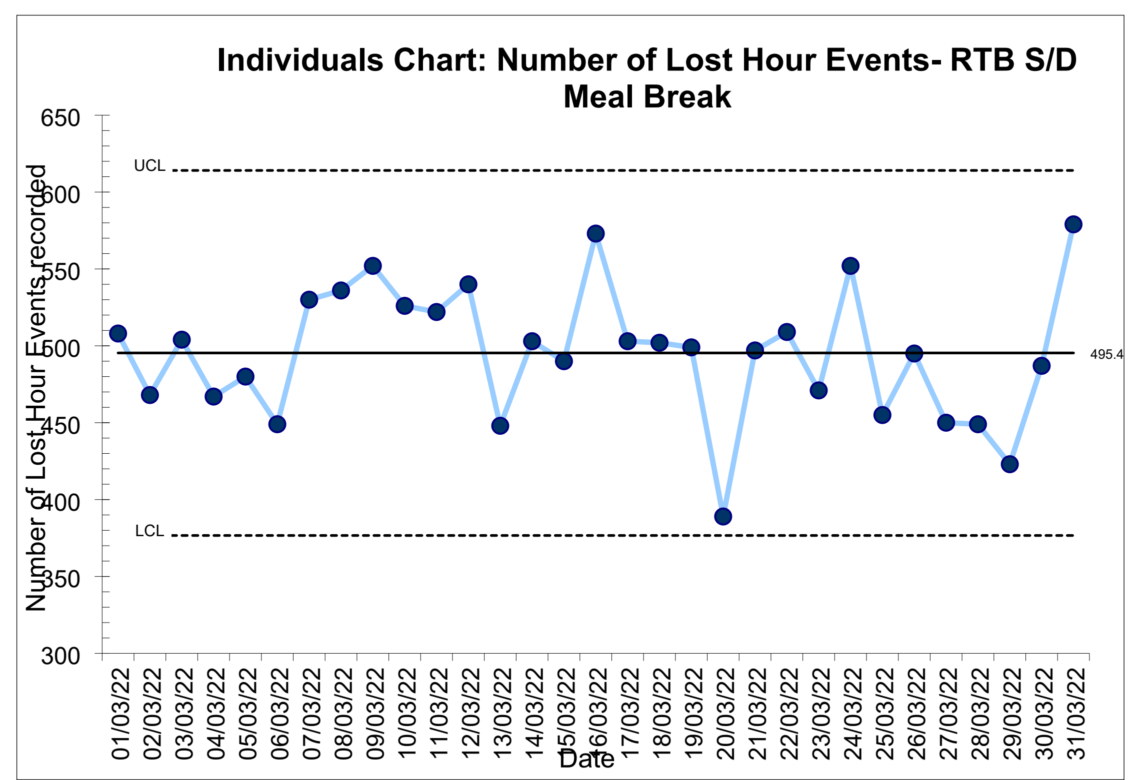



*Figure 2: Individuals Chart: Number of Lost Hour Events- RTB S/D Meal Break- Qlik Sense*

54 In total there were 7,343 hours lost due to RTB SD Meal Break as shown in **Figure 3**.

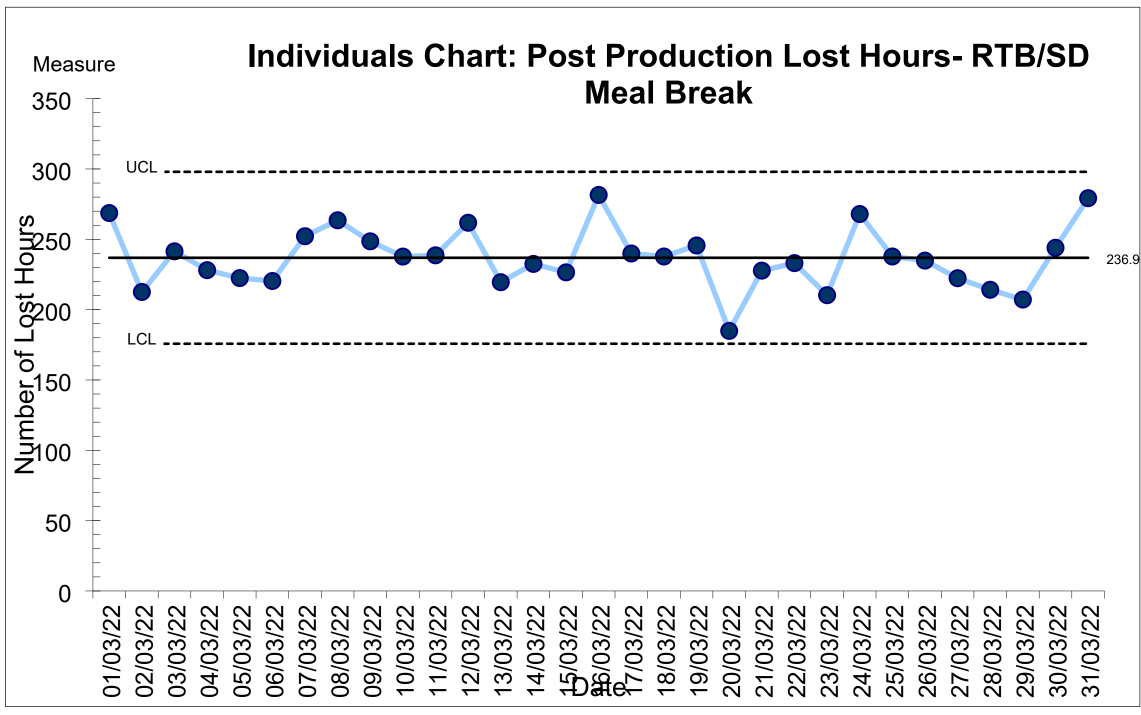



*Figure 3: Individuals Chart: Postproduction Lost Hours- RTB/SD Meal Break- Qlik Sense.*

55 As part of the analysis, the top 20 documented entries (highest) PPLH for RTB/Meal Break were examined. The lost hours documented within the top 20 for RTB/Meal Break was 163.68 hours. A manual 'by hand' assessment was undertaken by looking at the following:

- Actual recorded start of PPLH period (derived from the Trust's C3 radius/resource log) for each individual call sign.
- Actual recorded start time of break for each individual call sign.
- Time of allocation to 1st incident following rest break (to determine availability post break).

56 Following an analysis of the data, the findings are highlighted in **Figure 4**:

| Hours Recorded (1) | Actual Hours Lost (2) | Hours Discrepancy within Top 20 entries | % Difference | % Change to total lost hours RTB Stand-down |
|---|---|---|---|---|
| 163.68 | 18.25 | 145.43 | 156% | 2% |

*Figure 4: Hours recorded vs Actual Lost Hours. (1) - Demonstrates Hours recorded on the current system and (2) demonstrates actual lost hours as per resource logs of individual call signs based on manual assessment.*

57 Within the highest lost hours (top 20 entries), there was an over-reporting of 145 hours. Actual hours were 18 hours as opposed to the captured data of 145 hours. This demonstrated an over reporting in the highest post-production lost hours (top 20).

58 The analysis of the highest top 20 entries accounted for 163.68 hours out of the total recorded hours off 7,343 hours (2.2% of all captured lost hours). However, following analysis, if the true figure of 18.25 was utilised for lost hours, this would have equated to a 2% reduction in the total lost hours for RTB SD Meal Break.

59 Whilst small in the scale of data, it is important to recognise that data accuracy can be further improvement. For context, the Clinical Contact Centre (CCC) environment is pressured and manual tasks and manual checks will lead to human errors in data capture.

60 The Health Informatics Team have confirmed that a Computer Aided Dispatch (CAD) update, was completed on the 14 April in order to mitigate this issue. It is anticipated that this will result in an improved process to capture PPLH and will ultimately lead to improved accuracy of data.

61 On 5 April 2022, a Standard Operating Procedure (SOP) was approved by the Senior Operations Team (SOT), titled 'Unavailable and Non-Planned Reasons SOP'. This SOP will aim to ensure a standardised approach to the identification and collection of PPLH information, increase consistency and improve internal reporting.

62 Following this process change and subsequent assurance of data, the Trust will be able to determine the most optimal level of PPLH, which will provide further clarity on the lost hours due to necessity and 'lost' unproductive time.

| AGENDA ITEM No | 10.1 |
|---|---|
| OPEN or CLOSED | OPEN |
| No of ANNEXES ATTACHED | 1 |

# MONTHLY INTEGRATED QUALITY & PERFORMANCE DASHBOARD – March 2022

| | |
|---|---|
| **MEETING** | Quest Committee |
| **DATE** | 12 May-22 |
| **EXECUTIVE** | Rachel Marsh – Director of Strategy, Planning and Performance |
| **AUTHOR** | Hugh Bennett – Assistant Director of Commissioning and Performance<br>Kerri Hitchings – Commissioning & Performance Manager<br>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 M**ar-22** and (with the exception of Sickness).

**RECOMMENDATION**

The Committee is asked to:-

- **Consider** the Mar-22 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.

| KEY ISSUES/IMPLICATIONS |
| --- |

## Overview

Mar-21 Trust Board & QUEST received a revised Integrated Quality & Performance Report which contained 28 key indicators at a highly summarised level and demonstrated 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*'.

The Strategy, Planning & Performance Directorate has continued the formal update of the report, based on feedback from Board, committees and individual responses from non-executive directors and executives. The report will continue to be reviewed on an iterative basis, likely to be on an annual basis in line with the IMTP.

The review of the Quality & Performance Management Framework has concluded with the Framework approved by Mar-22 Trust Board. The focus is now on a work programme of deliverables for identified areas of improvement e.g. local frameworks.

## 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 remains at just under one minute. 111 call answering performance (answered within 60 seconds/abandoned after 60 seconds), saw a decline in Mar-22 linked to increasing demand, call abandonment rates increased (therefore, worsening) and did not meet the 5% target.

Actions to improve both of these areas involve the recruitment of additional call handlers. For the 999 calls, additional recruitment was being undertaken to uplfit the call taker establishment by 32 FTEs in 2021/22; however, recurent funding has not been secured into 2022/23. Forecasting and modelling is being undertaken on the future call taker requirement through to Dec-24, but as above funding is not available at this time. The CCC Reconfiguration Project deliverables for 2022/23 are currently being revisited in the light of the 2022/23 budget settlement.

Similarly 111 had successfully delivered two cycles of additional Call Handler and Clinical Advisor recruitment in January & February 2022; however, the 111 establishment and future transformational actions are now being reviewed as the service stabilises post pandemic and after a recent demand & capacity review of 111 by Operational Research in Health (ORH) with a report to EMT in May-22. Also, discussions are continuing with stakeholders on how to manage the over-established position for 111 Call Handlers following the decision by Welsh government not to continue to fund the 111 First programme.

Within the 111 service, a recently implemented telephony system for interactive voice response provides callers with expected answer times and sets out alternative options as the caller waits (for example, informing callers that they may find answers on the 111 website). In due course, there will also be an option for the caller to be called back rather than hold on. This will improve the patient experience, reduce numbers of calls that end up with the call handler and reduce abandonment rates.

**111 Clinical response:** whilst the Trust continues to see achievement of the clinical call back times for the highest priority 111 calls, a decline in performance across all the priorities was seen in Mar-22. The Trust knows that the waits for a clinical ring back are too long.

**Ambulance Response** (safety / patient experience): Red and Amber response times declined into Mar-22 supported by an increase in patient demand; in addition, the number of hours lost at hospitals remains extreme and cannot be offset by increased ambulance production. Response times continue to be much longer than the Trust would want. Actions within the Trust's control include:

Capacity:

- Recruitment of an agreed funded additional 127 FTE front line staff as part of the Year 2 EMS Operational Transformation Programme. The Trust was on course to close the relief gap early in 2022/23; however, in order to fund the uplift of 36 Paramedic FTEs into the Clinical Support Desk (CSD) the Trust will now have to hold open 46 ACA2 vacancies in 2022/23 i.e. recurrent funding has not been made available by EASC. On this basis the Trust will deliver an uplift of 217 FTEs for the relief gap (263 FTEs), 36 Paramedic FTEs for the CSD and a further five mental health practitioners, in total an uplift of 258 FTEs which clearly demonstrates that the Trust can recruit and support the wider unscheduled care system if funded to do so. No funding is available at this time for the Transition Plan which offered the system a further uplift of 294 FTEs including 95 FTEs to fill the Cymru High Acuity Response Unit (CHARU) roster keys.
- Securing of additional temporary capacity from alternative sources, including St John Cymru, Fire & Rescue Services and the military. A significant number of additional hours have been provided through the winter period as a result of support from the Trust's partners with emergency ambulance unit hour's production (UHP) at 98% in Mar-22 i.e. above the benchmark of 95%; however, military aid stopped on 31 Mar-22 and the Trust has received some limited support to continue to fund St John Cymru ambulance resources into the first four months of 2022/23. The level of hours that the Trust can provide, even with all efficiencies delivered, cannot off set the level of handover lost hours.

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

- The Ambulance Response roster review is on target for go live between Sep-22 and Nov-22. There is an increasing amount of stakeholder interest which is being fielded by senior officers of the Trust;
- 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.

- Work around workforce modernisation proposals, including post production lost hours (PPLH) is currently paused pending further dialogue with trade union partners.

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, with on-boarding and full go live occurring through Feb-22 and Mar-22 (on-target/recruited). As well as improving the safety of the calls that are waiting, this investment will also mean an increase in hear and treat rates.

The Trust has combined various tactical plans into a single Performance Improvement Plan (PIP) which is being reported to the Executive Management Team every two weeks (and onto the CASC). Actions are set out under four main headings with actions including:

- Better management of demand;
- Increasing capacity;
- Increasing effectiveness and efficiency of resources; and
- Supporting staff well-being.

Good progress has been made on the PIP. The PIP is supported by tactical forecasting and modelling, with the results for spring provide to senior decision makers. The focus is now on forecasting, modelling and planning for summer.

The modelling results are very concerning due to the end of military support and the extreme levels of handover. The Transition Plan could mitigate some of the patient safety concerns, but is not funded at this time.

**Ambulance Care (formally NEPTS) (Patient Experience)**: performance was above target for enhanced renal patient arrivals prior to appointment in Mar-22 and has improved for patients requiring discharge; however, overall demand for the service continues to increase and in Mar-22, overall demand was at 90% of the equivalent month in 2019 and was 10% busier than any month since Feb-2020, however, Ambulance Care core (outpatient demand) has not yet recovered to pre CoVID-19 levels. EASC (10 May-22) has a “focus on” development session on NEPTS, which will include looking at the in-balance of demand and capacity and options for resolving this. Other areas of focus include call answering performance, which is currently being addressed through a range of actions and oncology. Oncology may require a change in performance standard at the NEPTS Demand & Capacity Review identified that achieving the current standard through increasing FTEs would be prohibitively expensive.

**National Reportable Incidents (NRIs) / Concerns Response**: The Trust reported 7 NRIs to the Delivery Unit in Mar-22, compared to 2 in Feb-22; and 7 patient safety incidents were referred to health boards under the “Appendix B” arrangement, compared to 17 in Feb-22. Complaint response times improved to 76% meeting the 75% target for the first time in 12 months. 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**: 118,840 EMS ambulance unit hours were produced in Mar-22. The emergency ambulance UHP was 98% in Mar-22 and RRV UHP was 73%. The emergency ambulance UHP is supported by the Armed Forces, Fire & Rescue Services support and St John Ambulance Cymru capacity; however, the level of abstractions means that the capacity gain from this recruitment is less than the Trust would expect under more normal operating conditions.

**Response Abstractions:** Abstraction levels decreased in Mar-22, however, remain very high at 48% (benchmark 30%). CoVID-19 has had a significant impact on abstractions with sickness abstractions being 14% in Mar-22 (benchmark 5.99%). Workforce fatigue is also an issue.

**Trust Sickness absence:** The Trust's overall sickness percentage (Feb-22) was 10.93% and high sickness levels were seen across all areas of the Trust's operations including Ambulance Response, CCC, 111 and NEPTS, affecting capacity in all areas. Actions within the IMTP concentrate on staff well-being with an aim to start to reduce this level, although it is difficult to forecast the ongoing impact that CoVID-19 will have on staff and volunteers. In addition, Employee Assistance Provider (EAP) data suggests that most requests for counselling are as a result of work related stress. As outlined above, the PIP contains additional actions being taken in relation to staff well-being. 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:** PADR compliance and Stat / Mand training compliance are below target. This has been impacted on by the pandemic. The Learning and Development Team will continue to utilise Siren using the #WASTMakeItHappen tagline to reinvigorate My Learning on ESR to improve compliance rates for corporate staff.

## Finance and Value

**Financial Balance**: The Trust achieved financial balance in 2021/22, with a small revenue surplus of £0.075m and met its statutory duty to breakeven during this financial year.

**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). EMS Response lost over 11,000 PPLHs in Mar-22, compared to the 118,000 hours produced. The reasons for PPLHs are many and varied, with around 51% in March being attributed to return to base for meal break. The EMS Demand & Capacity Review identified that the Trust benchmarked favourably on all elements of PPLH other than return to base. The Trust and TU partners are currently collaborating on PPLHs through the Leading Service Change Together workshops which started in Sep-21. At this moment in time there is no agreed benchmark for PPLHs. Further benchmarking work with Operational Research in Health (with three other ambulance services) indicated that the Trust benchmarked favourably with two of the three. Initial contact has been made with the third ambulance service to compare practices around PPLH.

## Partnerships/ System Contribution

**Shift left**: much of our work as a Trust 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 **hear and treat** rates after 999 calls; and the Trust achieved 11.8% in Mar-22, compared to the benchmark of 10.2%.

The Trust has an ambition to shift more patient demand left, where it is clinically safe to do so through both hear & treat and see & treat (Finance & Performance Committee received a separate Deep Dive report on their agenda, which is available to all Trust Board members), 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). Recruitment is complete with staff on-boarding and going live in quarter four. The Trust is also implementing new clinical triage software and working with health boards on how they can support remote demand management. There will be a revised benchmark of 15% for hear & treat into 2022/23.

The Trust **conveyed** 32% of patients to emergency departments in Mar-22, a decrease compared to 35% in Feb-22; analysis shows that this may be 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. Further strategic modelling work has recently been completed on “inverting the triangle”.

**Handover lost hours**: The 2021/22 EASC commissioning intentions include an intention that handover lost hours should not exceed 150 hours a day for 95% of the year, which would mean a monthly loss of approximately 5,000 hours. 24,479 hours were lost in Mar-22. These levels are unprecedented and extreme and whilst the Trust can seek to mitigate the impact of handover lost hours, the Trust cannot offset this scale of lost hours. The Trust continues to raise this issue with EASC, Health Boards and Welsh Government and will continue to support any improvement programmes such as the EDQDF. 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.

### 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 all areas of the service increased in Mar-22, this coupled with other factors such as the continuation of the Omicron and Deltacron CoVID-19 variants, high levels of sickness (including CoVID-19 related absence) and extreme handover lost hours continue to impact on the Trust. EASC, WG and the 111 Programme Board have been very supportive of the Trust through the pandemic, supporting a range of mitigations; however, whilst the patient safety concerns are set to increase in 2022/23 as system pressure remains high, most short term in year non-recurrent mitigations are due to end on 31 Mar-22 e.g. military. Recurrent and increased funding for more permanent patient safety initiatives into 2022/23 looks unlikely at this point in time.

| REPORT APPROVAL ROUTE | |
|---|---|
| **Date** | **Meeting** |
| **27 Apr-22** | **Commissioning & Performance Manager**<br>**Assistant Director of Commissioning & Performance**<br>**Director of Strategy Planning & Performance** |
| **10 May-22** | **People & Culture Committee** |
| **12 May-22** | **Quality, Patient Experience & Safety Committee** |

| REPORT APPENDICES |
|---|
| **Appendix 1 – Top Indicator Dashboard** |

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

# Monthly Integrated Quality & Performance Report

## March 2022

## Annex 1 – Top Indicator Dashboard

# Section 1: Monthly Indicators / Top Indicators Dashboard

| Top Monthly Indicators | Target 2021/22 | Baseline Position (2020/21) | Mar-22 | 2 Year Trend | RAG |
|---|---|---|---|---|---|
| **Our Patients - Quality, Safety and Patient Experience** | | | | | |
| 111 Abandoned Calls | < 5% | 11.00% | 9.2% | | A |
| 111 Patients called back within 1 hour (P1) | 90% | 95.30% | 94.5% | | G |
| 999 Call Answer Times 95th Percentile | 95% in 00:00:05 | 00:03 | 01:35 | | R |
| 999 Red Response within 8 minutes | 65% | 63.6% | 51.1% | | R |
| Red 95th percentile | 00:14:00 | 00:17:59 | 00:24:17 | | R |
| 999 Amber 1 95th percentile | 01:18:00 | 02:24:10 | 06:37:49 | | R |
| Return of Spontaneous Circulation (ROSC) | Improve | 9.97% | - | | G |
| Stroke Patients with Appropriate Care | 95% | 95.83% | - | | G |
| Acute Coronary Syndrome Patients with Appropriate Care | 95% | 73.50% | - | | R |
| Renal journeys arriving within 30 minutes of their appointment (NEPTS) | 70% | 74% | 81% | | G |
| Discharge & Transfer journeys collected less than 60 minutes after booked time (NEPTS) | 90% | 88.00% | 88% | | A |
| National Reportable Incidents reports (NRI) | - | 4 | 7 | | R |
| Concerns Response within 30 Days | 75% | 75% | 76% | | G |

| Top Monthly Indicators | Target 2021/22 | Baseline Position (2020/21) | Feb-22 | Mar-22 | 2 Year Trend | RAG |
|---|---|---|---|---|---|---|
| **Our People** | | | | | | |
| EMS Abstraction Rate | 29.92% | 37.00% | 41% | 48% | | R |
| Hours Produced for Emergency Ambulances | 95% | 96.0% | 110% | 98% | | G |
| Sickness Absence *(all staff)* | 5.99% | 7.30% | 10.91% | 11.88% | | R |
| Frontline CoVID-19 Vaccination Rates | - | - | 4,278 | 4,279 | | - |
| Statutory & Mandatory Training | >85% | 83.1% | 83.34% | 84.15% | | A |
| PADR/Medical Appraisal | >85% | 52% | 54.19% | 51.46% | | R |
| Ambulance Response FTEs in Post | 1700 | 1702 | 1639 | - | | A |
| Ambulance Care, Integrated Care, Resourcing & EMS Coordination FTEs in Post | - | 1117 | 1763 | 1754 | | - |
| **Value** | | | | | | |
| Financial balance - annual expenditure YTD as % of budget expenditure YTD | 100% | 100% | 100.00% | 100.00% | | G |
| EMS Utilisation metric | 57% | - | | | | - |
| Post-Production Lost Hours (All Vechicle Types) | Reduction Trend | 11,053 | 11,010 | 11,452 | | R |
| **Partnerships / System Contribution** | | | | | | |
| 111 Consult and Close | Improve | 5,612 | 6,699 | 8,432 | | G |
| 999 Hear & Treat | 10.2% | 9.9% | 10.8% | 11.8% | | G |
| % Incidents Conveyed to Major EDs | <48.6% | 44.58% | 35.34% | 32.21% | | G |
| Number of Handover Lost Hours | < 150 hrs per day | 6,093 | 23,232 | 24,479 | | R |

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

# CoVID-19 Virus Monitoring

FPC QUEST

*Source: Welsh Government*
*Waste Water Monitoring Report extracted 12/04/2022*

## Wales Situation Report

**Since last week, SARS-CoV-2 viral load has decreased across the country. However, the signal continues to increase in Clwyd, Wye and Ynys Môn.**

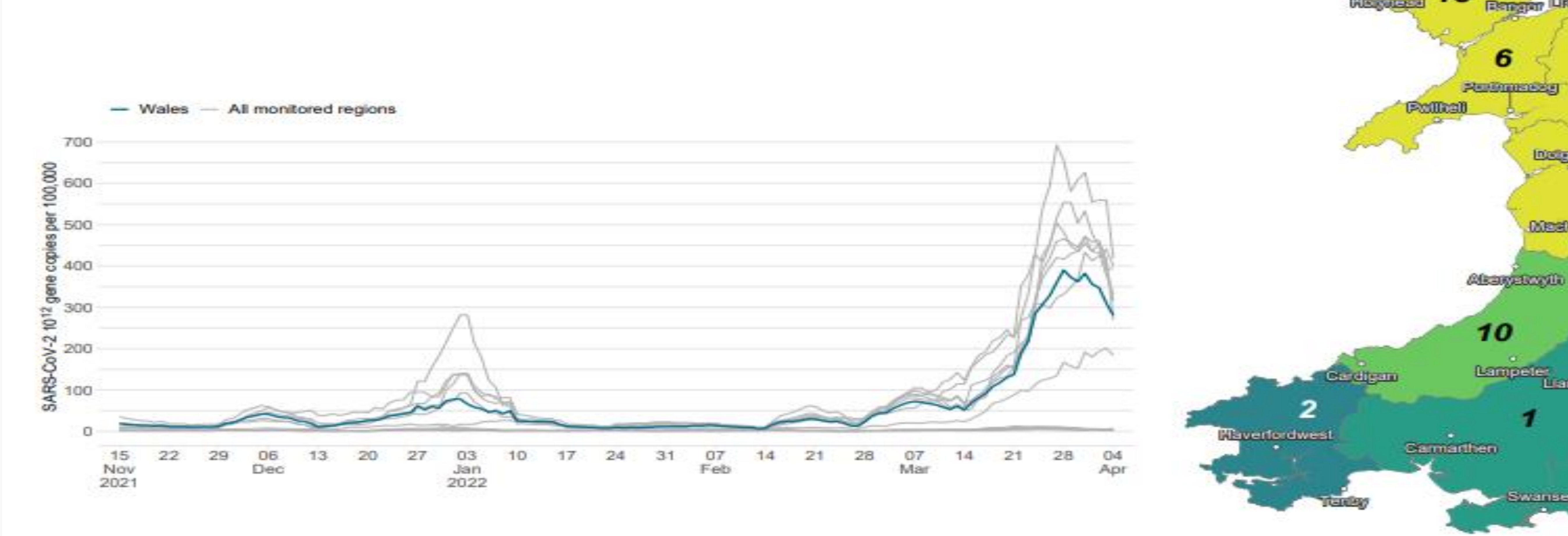
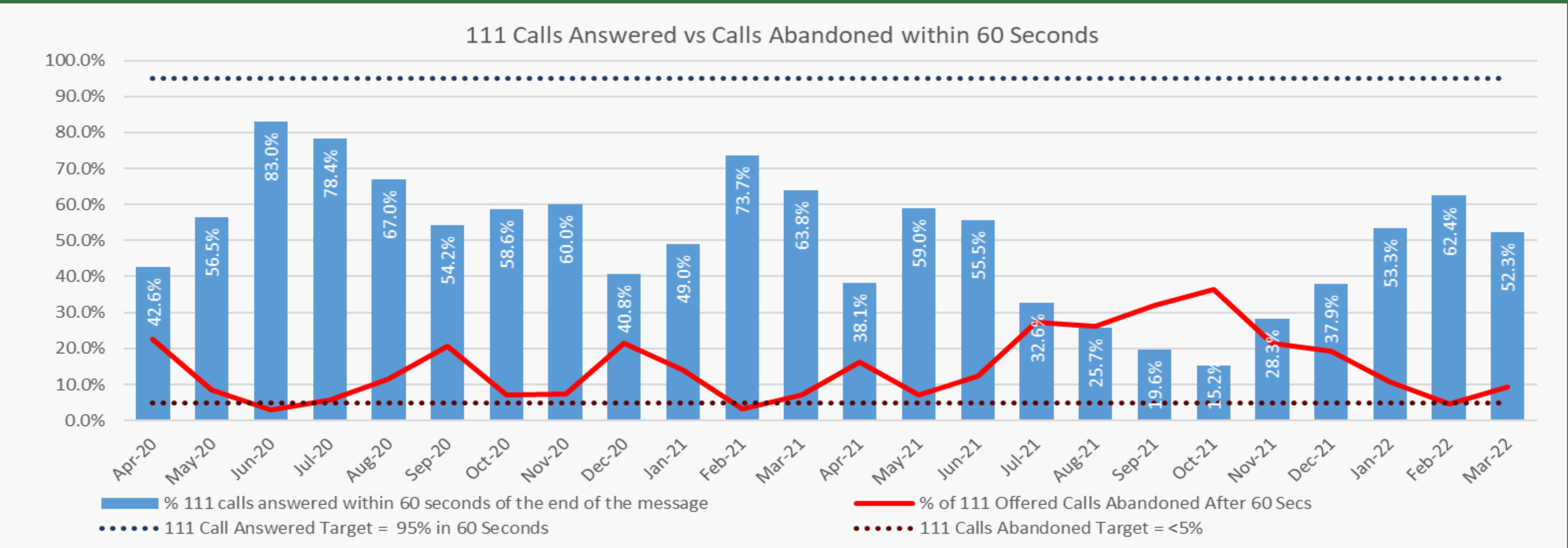


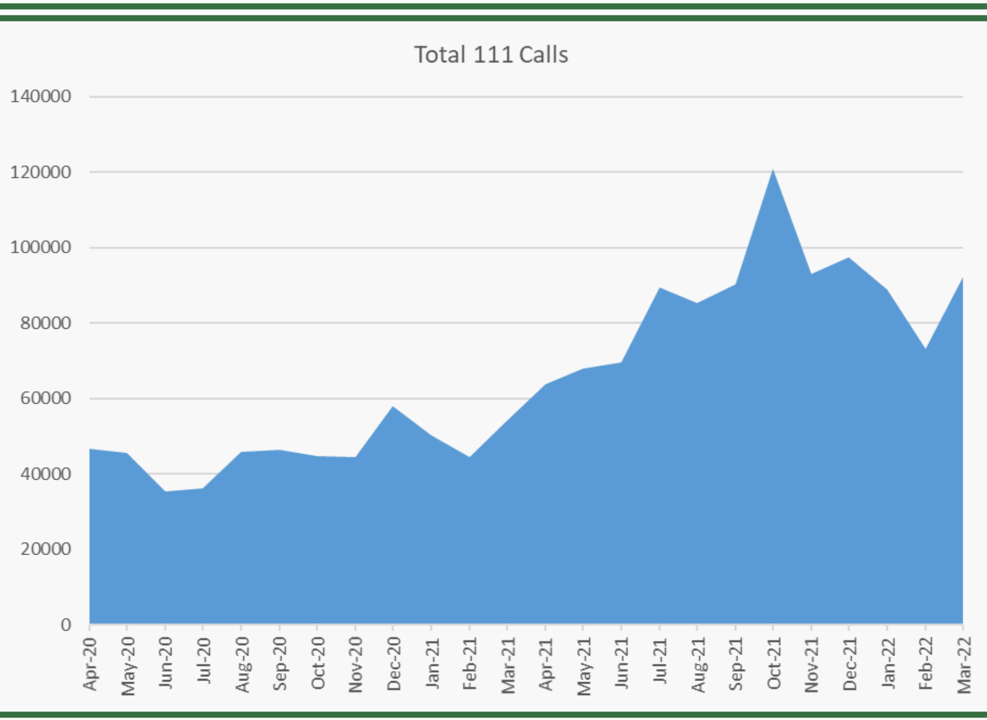

Figure 2 - National (blue lines) and Regions (grey lines) Rolling Mean SARS-CoV-2 gc/day per 100k

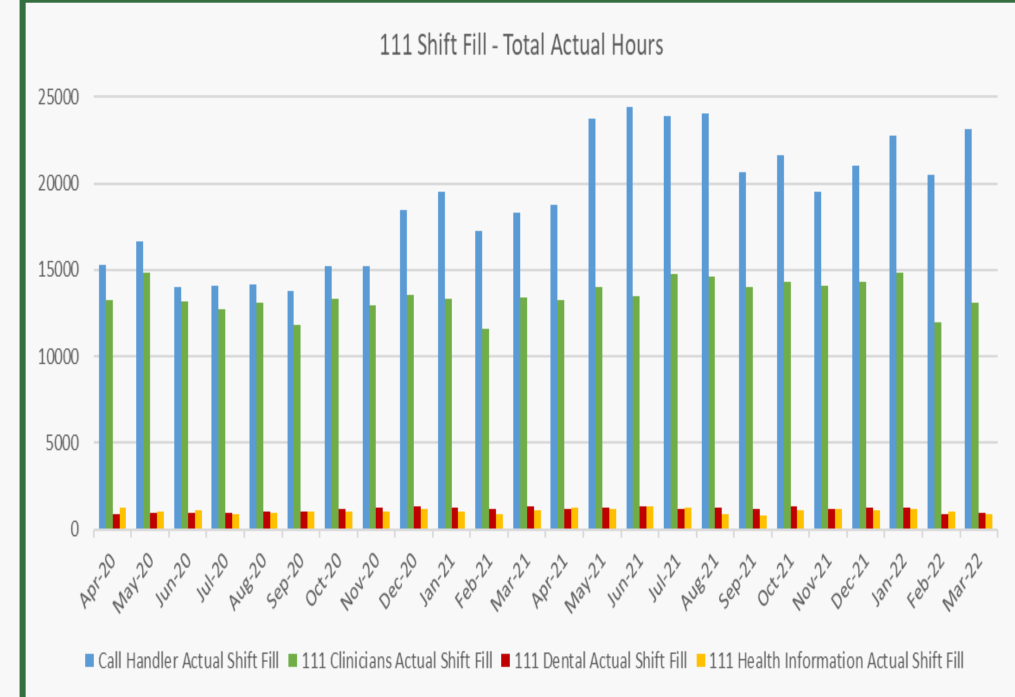
Figure 3 - National Heat Map showing Regional Mean SARS-CoV-2 gc/day per 100k

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

## Influencing Factors – Demand and Call Handling Hours Produced




**Analysis**

**111 call abandonment is a key patient safety indicato**r for the service**. Mar-22** saw a decline in **abandonment rates** to 9.2%, falling outside the 5%.

**The percentage of 111 calls answered within 60 seconds of the end of the message also declined in Mar-22 to 52.3%.** 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 during Feb 22 however the delivery in March continues to represent a significant improvement trajectory.

**111 call demand increased** in Mar-22 compared to the previous month, as seen in the graph. This is principally due to 111 becoming available in Cardiff and Vale UHB.

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, there are high sickness abstractions (which includes CoVID-19 Sickness), which sat at 14.08% for NHS111 in Mar-22. 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 Mar-22 there were 382,915 visits to the website In Mar-22 the stomach pain symptom checker accounted for 10,422 hits followed by searches for Quinsy which recorded 9,828 hits and rash which saw 6,835 searches.

**Remedial Plans and Actions**

- Following a successful launch in Cardiff & Vale Health Board (C&VUHB) on the 16th March the 111 service is now live across Wales. Bringing an end to the NHS Direct Wales Service. Additionally the this also saw CaV24/7 being replaced by the 111 First service.
- To enable the launch of 111 service in C&VUHB strong progress has been made in Q3 & Q4 to deliver the accelerated 111 Recruitment & training plan to increase the Call Handler & Clinical Advisor workforce.
- The increased estates and training capacity enabled the January training cycle to deliver 24 X FTE Call Handlers & 11 FTE Clinicians, with a further 50 WTE Call Handlers and 11.6 WTE Clinical Advisors on the February cycle.
- The additional w/f numbers meet the Call handler requirements for the C&V core 111 roll out and the projected expansion for the 111 First Service. The Clinical Advisor numbers meet the requirements for C&V core 111 roll out, however further recruitment would be required to meet the 111 First service needs Pan Wales (if funded).
- Welsh Government have indicated that there is unlikely to be recurrent funding to continue the implementation of the 111 First Service across Wales. Discussions are continuing with WG and plans are being considered to manage the impact of this decision.
- A number of service improvement initiatives including the introduction of new IVR messaging, review of the Clinical Advice Line (CAL) and the ongoing recruitment positions have had a positive impact to help stabilise the 111 call abandonment rate and improve call to answer times.

The workforce FTE table has been removed in this iteration as the numbers are linked to the budget deliberations, in particular, 111 First; consequently it is difficult to provide numbers with any degree of certainty at this point in time

**Expected Performance Trajectory**

The new IVR system will improve patient experience and is likely to reduce abandonment rates (people take up option of call back); however, call answering times will only be improved through additional capacity and this relies on our continued recruitment into funded posts and improved efficiency gains, with work ongoing to develop innovative solutions

# 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

100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%

Apr-2020, May-2020, Jun-2020, Jul-2020, Aug-2020, Sep-2020, Oct-2020, Nov-2020, Dec-2020, Jan-2021, Feb-2021, Mar-2021, Apr-2021, May-2021, Jun-2021, Jul-2021, Aug-2021, Sep-2021, Oct-2021, Nov-2021, Dec-2021, Jan-2022, Feb-2022, Mar-2022

- % of calls prioritised as P1CT that started their first definitive clinical assessment within 1 hour of the end of the first contact
- % of calls prioritised as P2CT that started their first definitive clinical assessment within 2 hours of the end of the first contact
- % of calls prioritised as P3CT that started their first definitive clinical assessment within 4 hours of the end of the first contact
- Target 90%

**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, with the exception of Mar-20, has continuously achieved the 90% target.

For lower category calls, we are not meeting the 90% target, in Mar-22 a decline was seen in all categories with the exception of P1CT.

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**

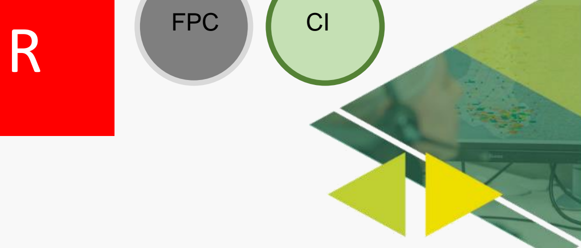
The main driver of improved performance will be the correct number of clinicians in post to manage current and expected demand. Urgent work is now underway through the Gateway to Care Transformation Board to consider:

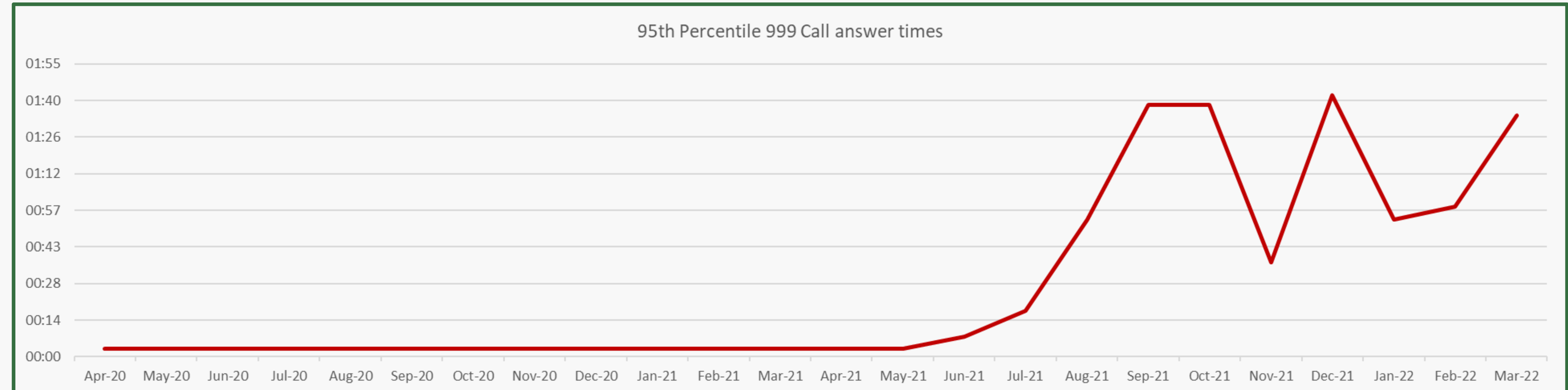
- Opportunities to widen the scope of clinicians who can apply, for example through offering remote working, exploring use of different clinicians or considering call centres in other areas.
- Opportunities to understand better and potentially reduce the number of tasks that clinicians have to undertake so that the Trust needs fewer in the future, in particular, work is focusing on the use of the Clinical Advice Line.

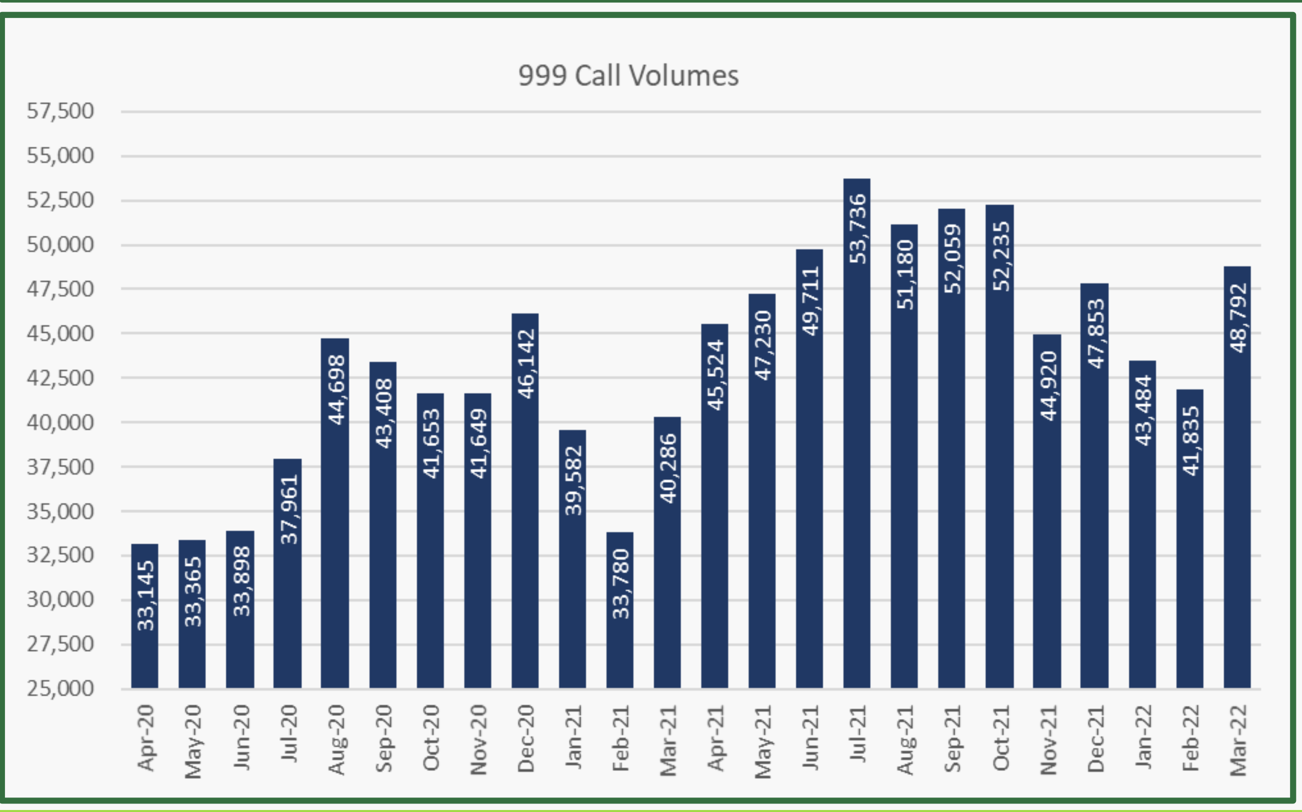
**Expected Performance Trajectory**

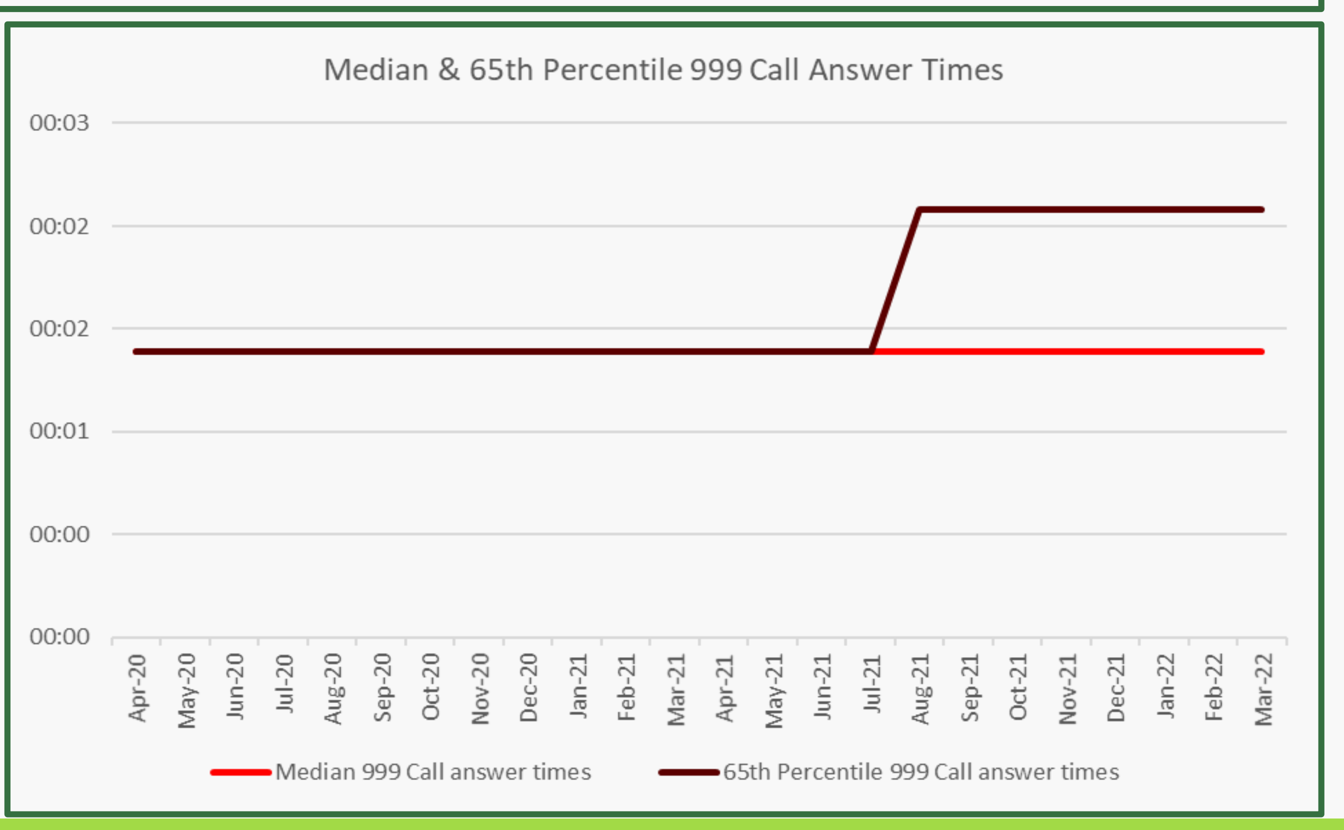
Risks have been highlighted in previous reports about the ability to recruit sufficient clinicians and this is now being seen. Urgent work is now underway to agree a series of actions that might help to increase recruitment, reduce turnover and reduce demand on clinicians, but performance is likely to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

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




**Analysis**

**The 95th percentile 999 call answering performance saw a further decline in Mar-22 to 1 minute 35 seconds**, compared to 59 seconds Feb-22, failing to meet the 6 second answer target for the ninth 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.

The median call answer times for 999 services remains consistently at 2 seconds. In Mar-22 65th percentile continued to average at 3 seconds.

**The Trust received 48,792 emergency 999 calls in Mar-22, an increase compared to Feb-22, and** significantly higher than both Mar-20 and Mar-21. 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, there are increasing levels of staff abstraction due to sickness and COVID (17%) in the call centres which is reducing capacity.

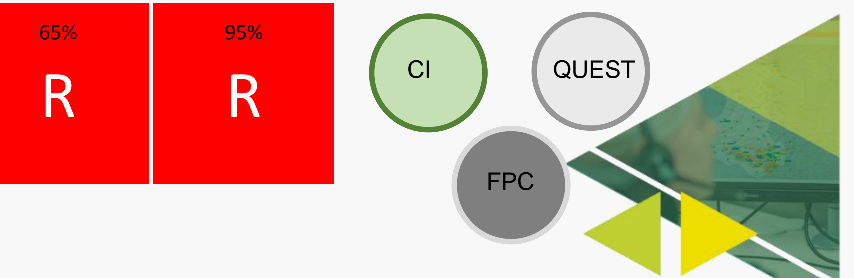
**Remedial Plans and Actions**

- 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.

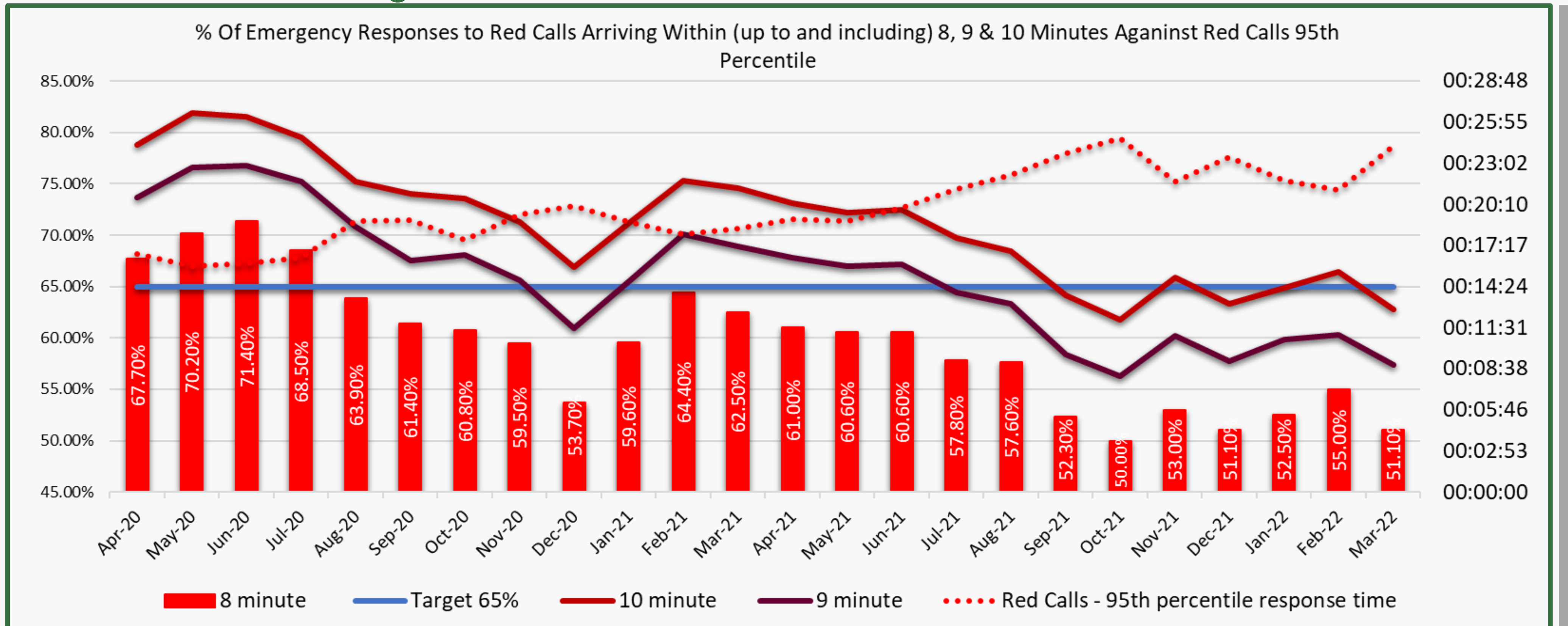
**Expected Performance Trajectory**

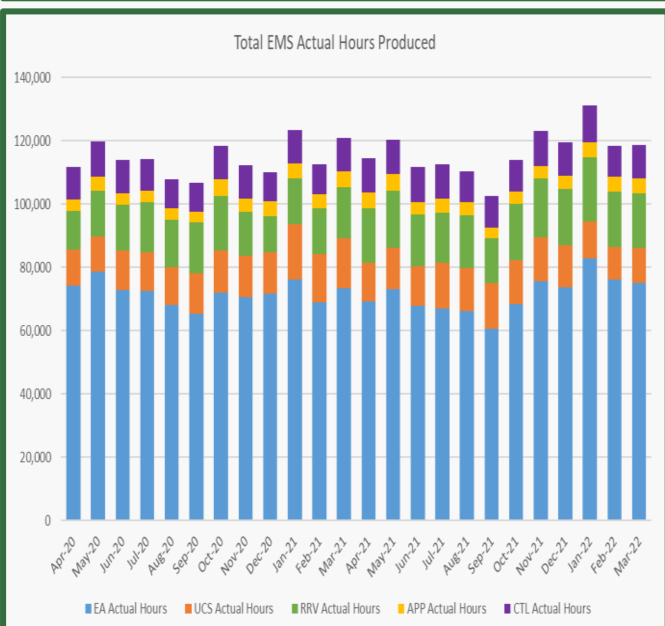
Performance is expected to continue to be difficult with demand forecasted to increase throughout the fiscal year. EMS Coordination continue to focus on proactive recruitment to mitigate the impact of current attrition rates

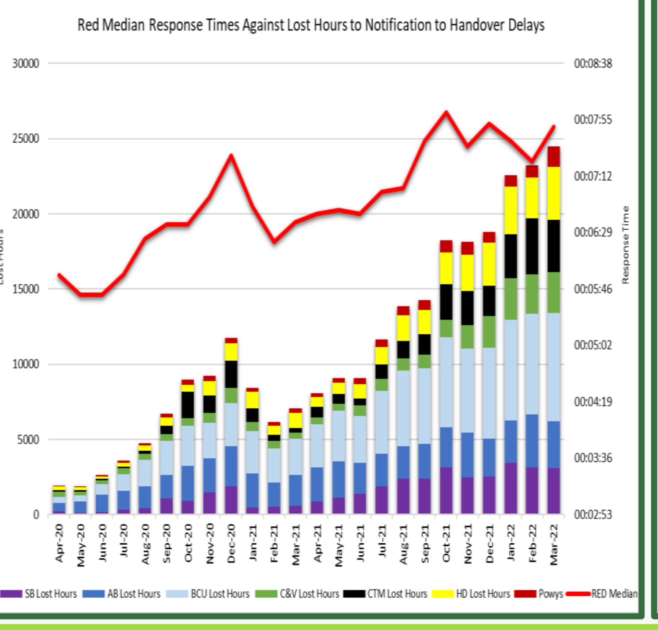
# Our Patients: Quality, Safety & Patient Experience
# Red Performance Indicators

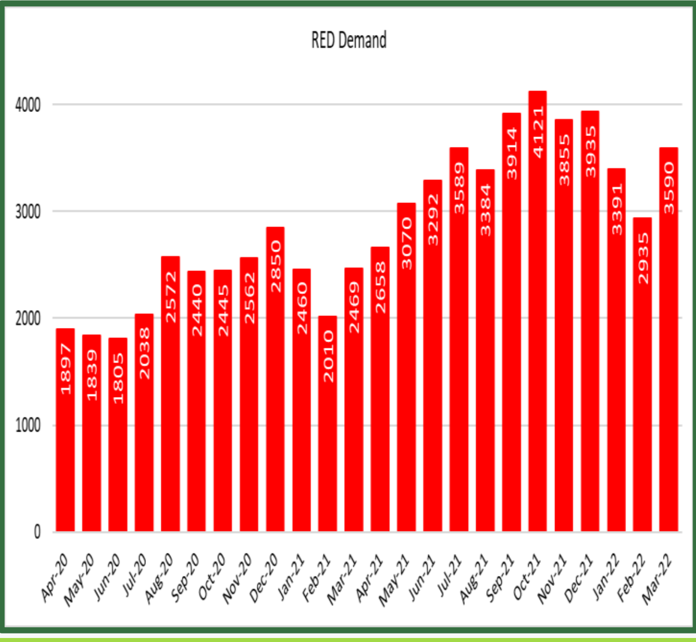



## Influencing Factors – Demand, Hours Produced and Hours Lost




**Analysis**

**Although some improvements have been seen, red performance did not achieve the 65% target** in Mar-22 and the target has not been achieved since Jul-20. There was also significant health board level variation but none of the seven health board areas achieved 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. Ongoing poor performance also continues to affect Red 9 minute responses, which achieved 57.4% and Red 10 minute performance, achieving 62.8% in Feb-22.

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.

The lower centre graph demonstrates the correlation of performance with hospital handover lost hours with Mar-22 having the highest ever recorded. In addition, the number of EA hours produced remains fairly stable despite support from the military having now ceased, RRV hours again saw less actual hours for Mar-22 than planned.

Other factors continue to affect performance including prioritising EA hours over RRV, and the additional time taken to don level 3 PPE to Red calls relating to respiratory disease/issues. The latter in particular was shown to add several minutes to a response, and this requirement remains in place.

**Remedial Plans and Actions**

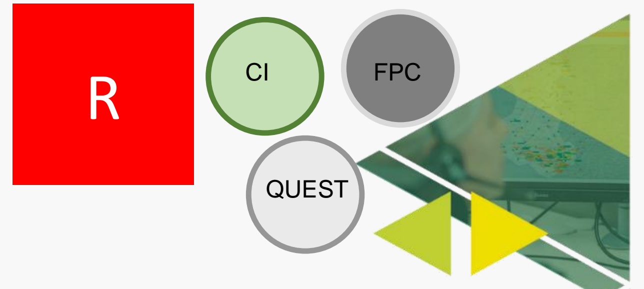
The main improvement actions are:

- Increase capacity – 136 WTE were recruited by end of Mar-21. This will be complemented by a further 81 FTEs early 22/23. This is revised down from 127 FTEs due to lack of recurrent funding to fill 46 ACA2s as the last part of the backfill on the 36 FTE Paramedic FTEs into the CSD.
- Reduce hours lost through modernisation of practices and supporting staff well-being. This is temporarily paused.
- 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.
- A very detailed set of strategic and more tactical actions have been pulled together into a performance improvement plan, many of which are also included in an action plan for the Ministerial oversight through the commissioning process. This is monitored every 2 weeks at EMT.

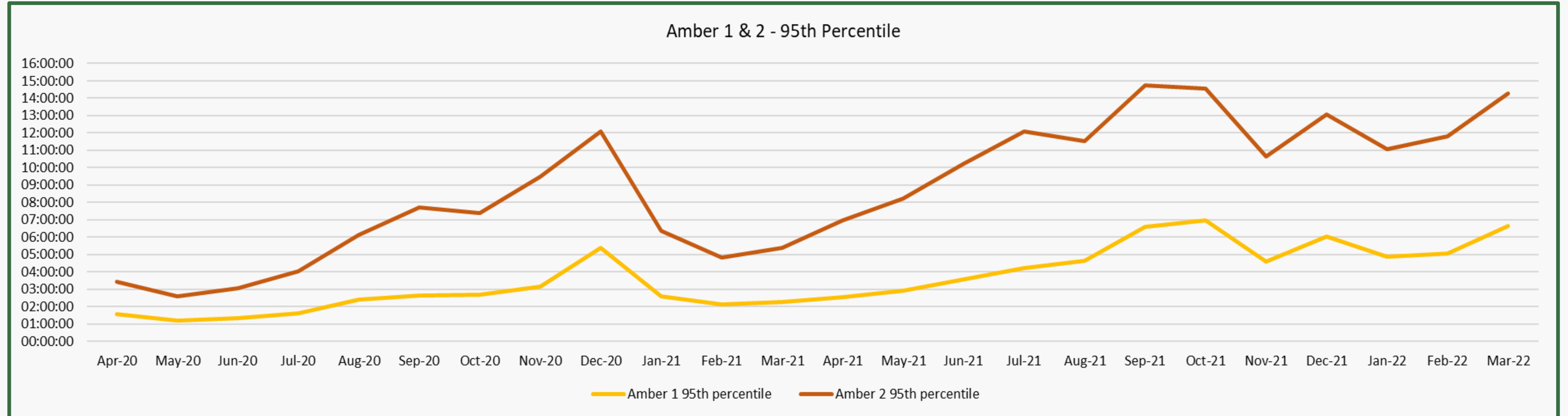
**Expected Performance Trajectory**

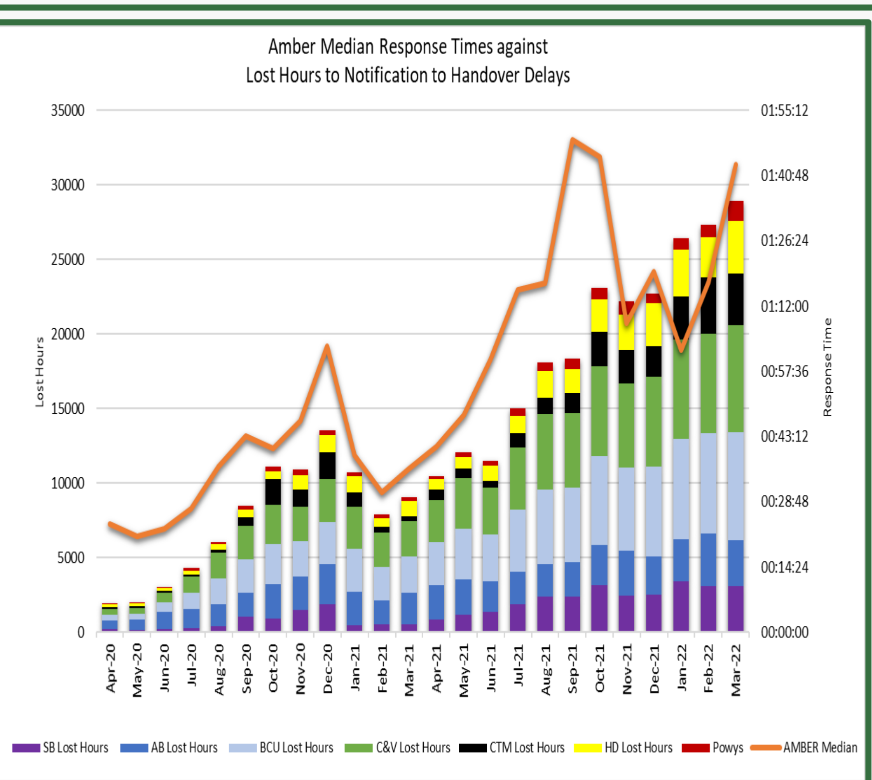
Unless Red demand reduces or the Trust is able to boost its RRV production Red performance is unlikely to achieve the 65% target; however, the Trust is building the CHARU keys into the re-rostering project, which along with other aspects of the Transition Plan (if funded) could stabilise performance. Funding is not currently expected. Looking ahead, it is expected that April will be a difficult month without support of military.

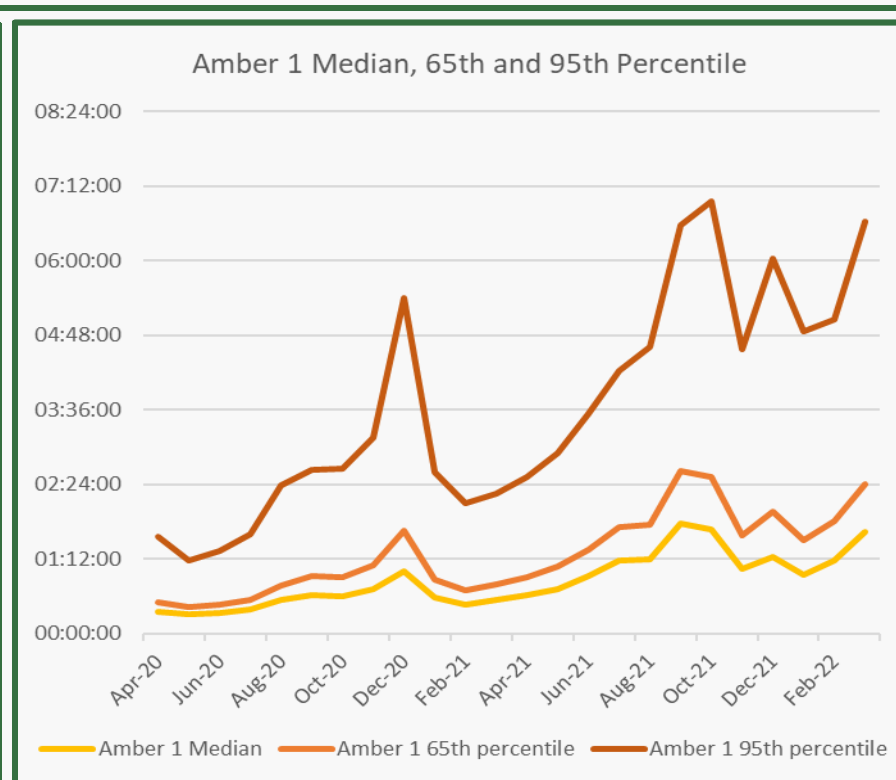
# Our Patients: Quality, Safety & Patient Experience
# Amber Performance Indicators




## Influencing Factors – Demand, Hours Produced and Hours Lost






**Analysis**

Amber performance declined across the percentiles in Mar-22; with some very long patient waits. The ideal Amber 1 median response time is 18 minutes.

In Mar-22, 802 patients (all categories, not just Amber) waited over 12 hours, an increase when compared to Feb-22, continuing to represent a very poor quality and experience of service. 671 of these patients were in the Amber category.

Amber demand increased in Mar-22, activity remains at a high level and handover times continued to worsen.

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 Mar-22 increased to 24,479. This remains higher than the worst recorded in Dec-19 (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 Nov-20 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. The programme models an Amber 1 median of 35 minutes and 90th percentile of 78 minutes in Dec-21 These are key benchmarks for the Trust. As per the commentary on Red performance delivering these benchmarks is dependent on a range of investments, efficiencies and system efficiencies, not all of which are within the Trust's control, and which are unlikely to show improvement in the coming months.

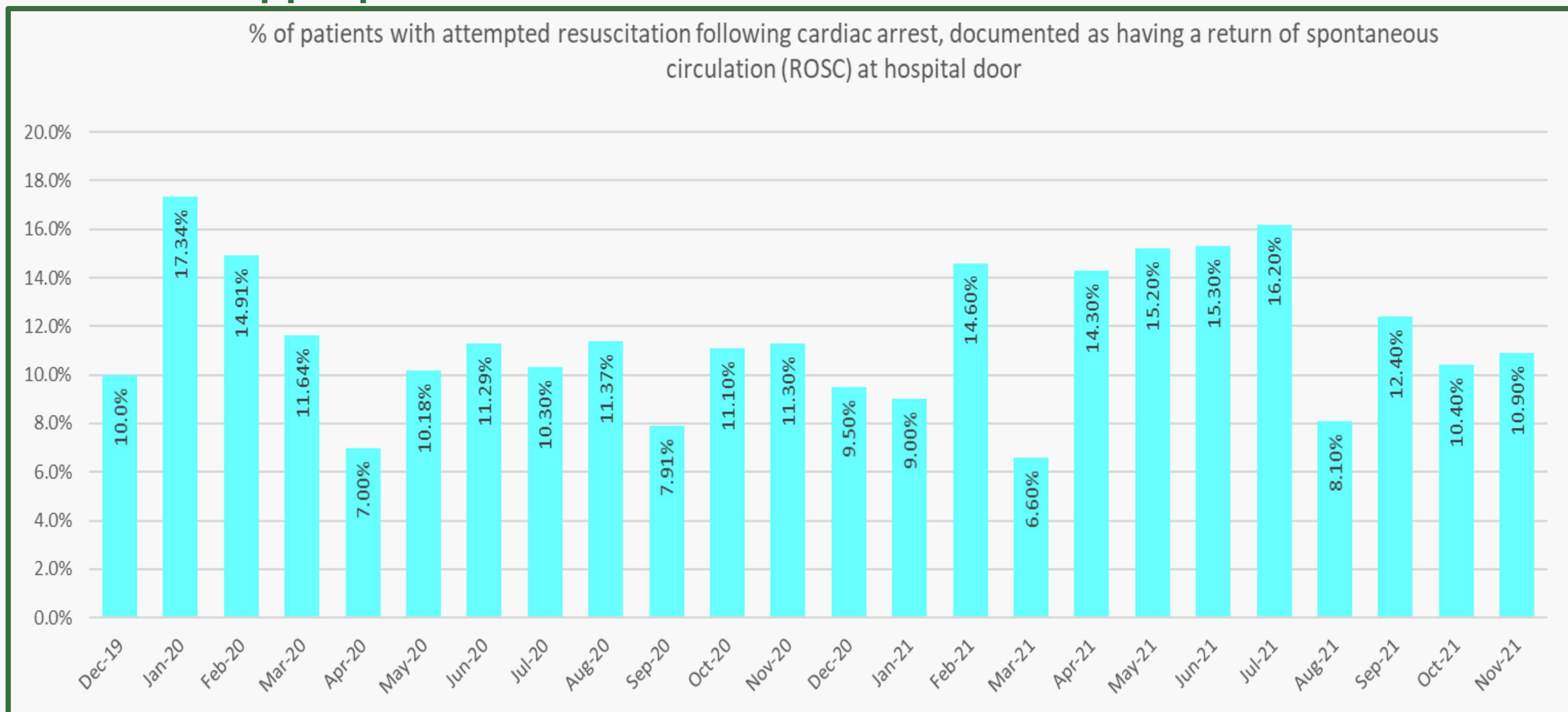
# Our Patients: Quality, Safety & Patient Experience
# Clinical Outcomes Indicators

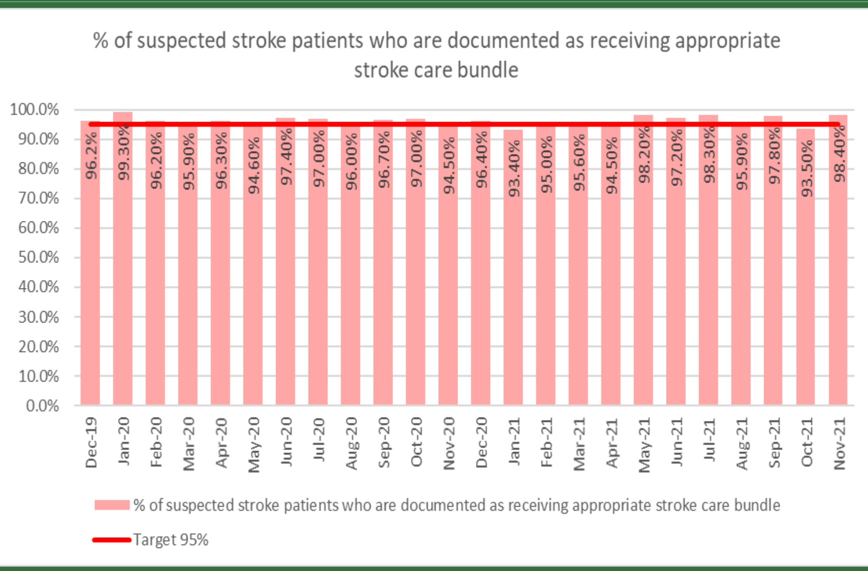
QUEST

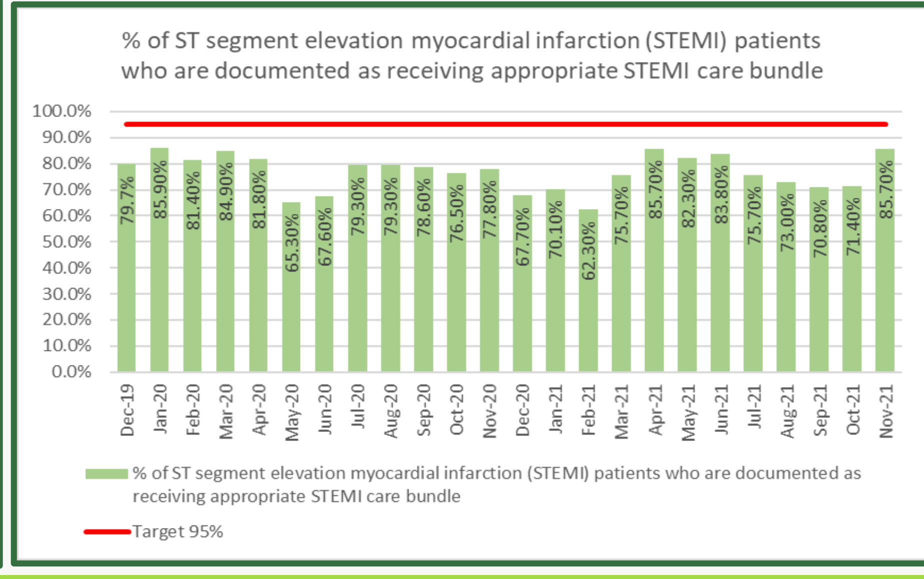
Self Assessment: Strength of Internal Control: Moderate

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

NB: Currently unable to report Clinical Indicators due to implementation of ePCR / Next reporting cycle Apr-Jun-22 due Jul-22




### Analysis

***Clinical Outcomes:*** The % of patients resuscitated following cardiac arrest, documented as having ROSC at hospital door was 10.9% in Nov-21. Rates of ROSC are complex and determined by numerous factors which contribute to the speed of response and the application of early defibrillation and chest compressions. These factors can include location of the incident, resource availability, public access defibrillation, willingness of bystanders to engage in resuscitation

Overall, performance remains a changeable picture for all clinical indicators. **The % of suspected stroke patients who are documented as receiving an appropriate stroke care bundle was 98.4% in Nov-21** a continued increase which saw it achieve the 95% target for the 6 of the last 7 months.

**The ST segment elevation myocardial infarction (STEMI) indicator** was previously an area of concern but has recovered in recent months, reporting 85.7% in Dec-21. The Clinical Audit and Effectiveness Department (CA&ED) undertook a deep dive of the STEMI compliance, and an improvement plan was agreed and is being progressed. These percentages refer to the application of a whole bundle of care.

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

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

### Remedial Plans and Actions

***Clinical Outcomes:*** A new chronic obstructive pulmonary disease (COPD) clinical indicator has been developed to support the Band 6 Paramedic project. The onward referral aspect of this indicator is work in progress and forms part of the national COPD pathway development. The Clinical Audit & Effectiveness Department have undertaken a benchmarking exercise to test the COPD Clinical Indicator which has been presented to the Clinical Intelligence Assurance Group. The testing highlighted the requirement for manual scrutiny of all COPD Patient Clinical Records and the need to refine the criteria to automatically capture more of the data. Feedback from the group will Finalise the required criteria, Health Informatics can then develop the reporting dashboard.

In relation to ROSC rates, whilst there are many system-wide factors affecting performance, within WAST's control it is felt that the introduction of a Cymru High Acuity Response Unit (CHARU) model, based on improved clinical leadership and enhanced training, will further improve outcomes for patients. This will be developed and implemented through 2022/23, subject of course to funding being agreed.

It is anticipated that the ePCR will be implemented by the end of 2021 and once accomplished it will allow the Clinical Audit Team to quality assure data and provide better information on which to target improvement work.

***Mortality Review:*** The Trust is currently looking to change the way it undertakes Mortality Reviews; this will follow guidance offered by the Delivery Unit to align mortality reviews with requests for information received by the Medical Examiner. This same guidance highlights that mortality reviews should link with the Trust Putting things Right (PTR) processes. Work is progressing with the PTR team, and a paper will be presented to the Clinical Quality Governance Group on 29-Apr 2022.

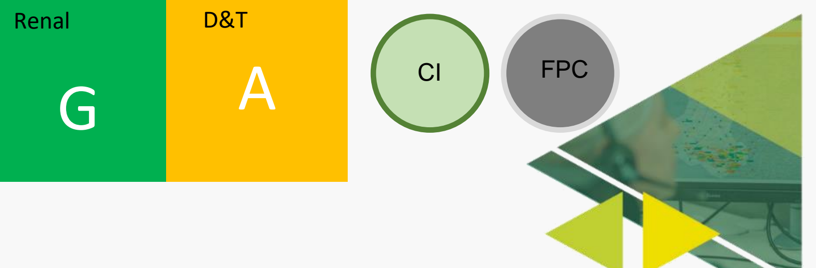
### Expected Performance Trajectory

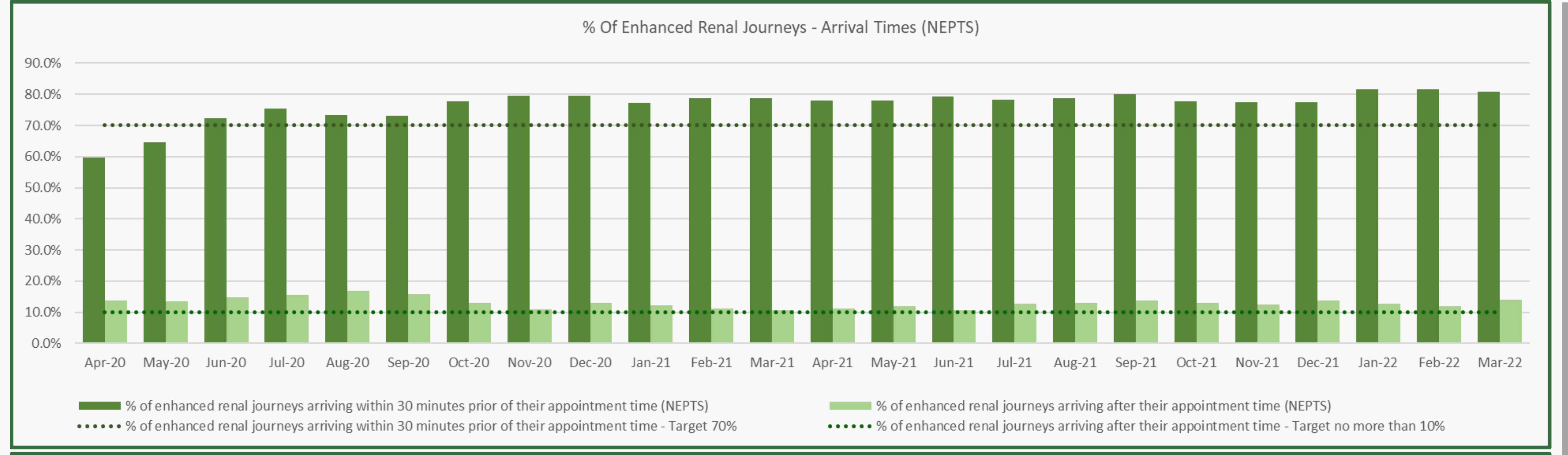
***Clinical Outcomes:*** As part of its plans for 2021/22, the Trust is developing the concept of CHARU for implementation. This concept is in place in several areas across the UK and has been very successful in increasing ROSC rates. Once CHARU has been implemented it is anticipated that ROSC rates should increase.

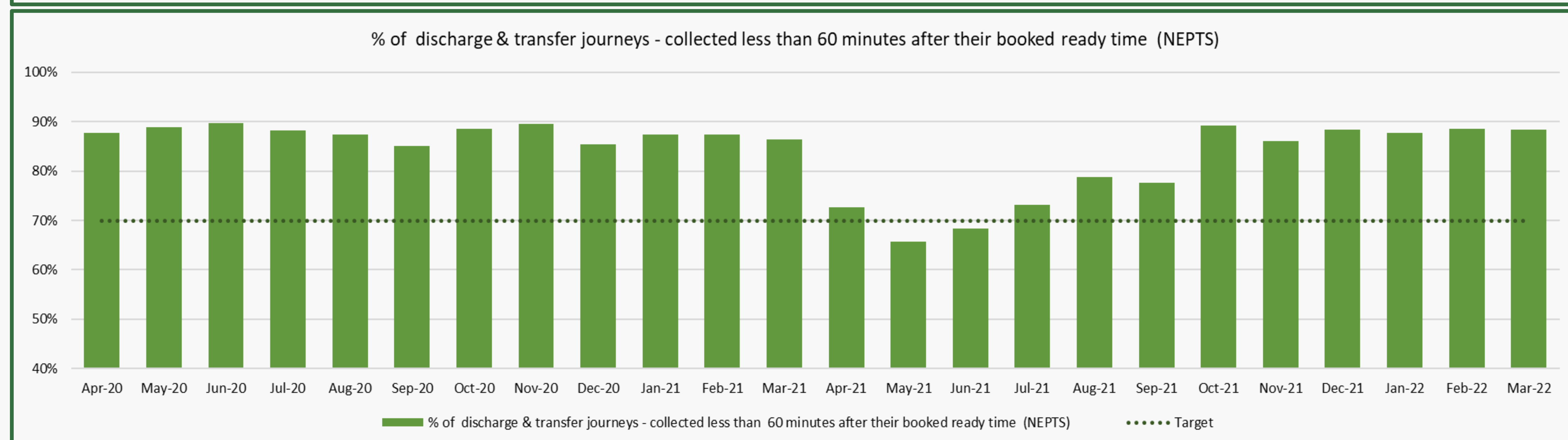
***Mortality Review:*** Changes to reporting systems will allow for more accurate and timely mortality reviews in line with Putting Things Right processes.

*Mortality Reviews Data source: Internal Web Application*

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




**Analysis**

**Ambulance Care has seen a continued improvement in key areas of service delivery affecting patient experience.** In Mar-22 88% of discharge & transfer journeys were collected within 60 minutes of their booked ready time, a marginal decline compared to Feb-22 (89%). 81% of enhanced renal journeys arrived within 30 minutes prior to their appointment time, achieving the 70% target and 14% arrived after their booked appointment time, falling just outside of the 10% target.

Key factors affecting these indicators are demand and capacity:

- The service is still impacted by the effects of physical distancing, although in Apr-22 steps have been taken to begin a move towards a new Living with Covid position by increasing maximum patient loading by 1 per vehicle.
- **Capacity** has also been adversely affected by other CoVID-19 factors: journeys taking longer due to PPE, staff sickness, staff shielding, staff training and testing, infection prevention and control arrangements and so on;
- Overall demand for the service continues to increase across all areas and in Mar-22, overall demand was at 90% of the equivalent month in 2019 and was 10% busier than any month since Feb-2020. Only outpatient activity remains supressed with all other areas at or in excess of pre-pandemic activity levels
- As we emerge out of pandemic response and the health system is “re-set” we are anticipating further demand increases 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.
- **Capacity**: discussions with EASC on options for balancing demand and capacity.

**Expected Performance Trajectory**

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

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

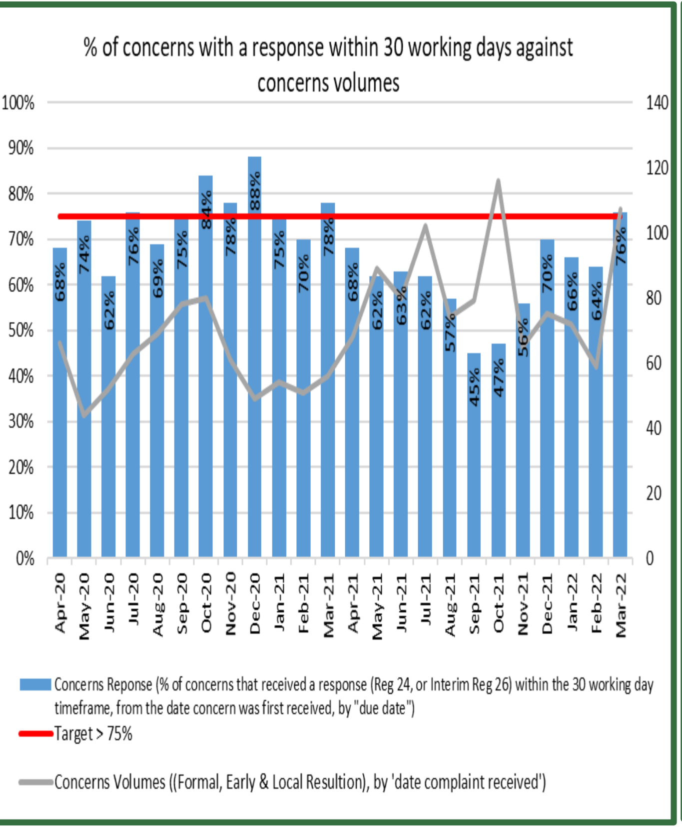
SCIF. A

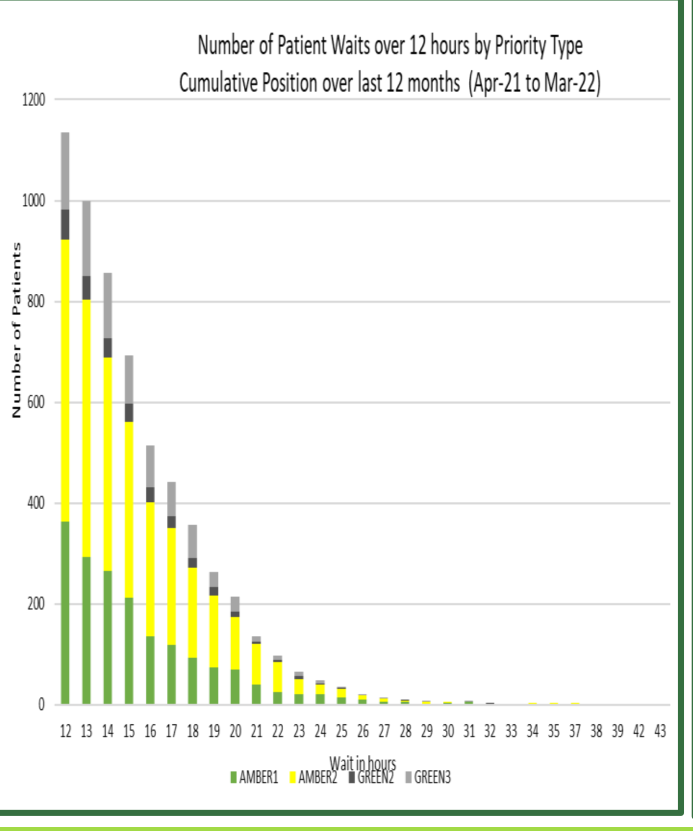
Self Assessment: Strength of Internal Control: Moderate

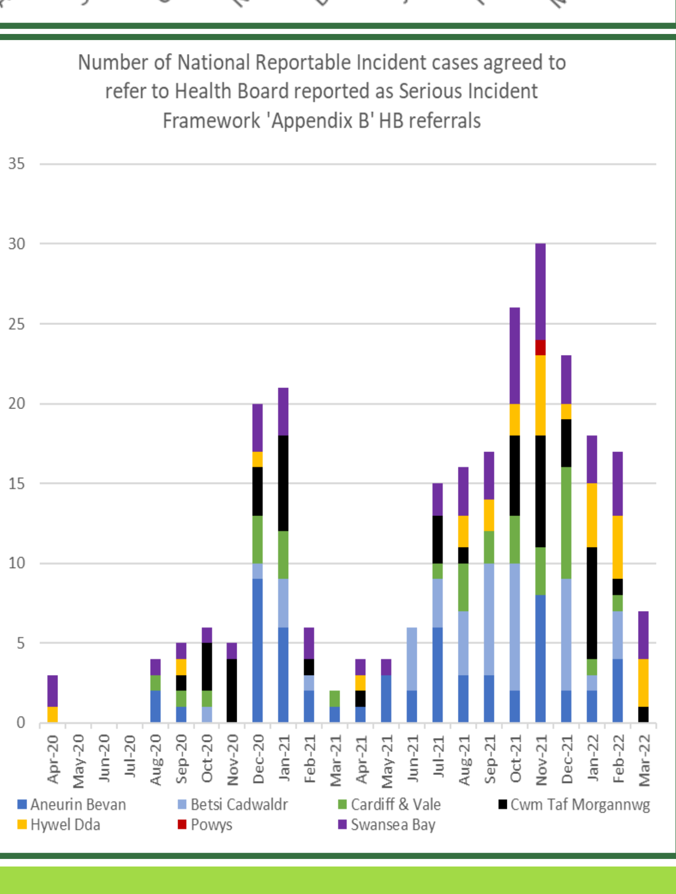
Health & Care Standard
Health - Safe Care / Timely Care

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

| Month | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Cases | 3 | 2 | 3 | 3 | 6 | 1 | 5 | 5 | 8 | 10 | 3 | 7 | 9 | 1 | 4 | 4 | 5 | 8 | 7 | 9 | 4 | 5 | 2 | 7 |




## Analysis

The **percentage of responses to concerns increased** in Mar-22 to 76%, compared to 64% in in Feb-22, therefore achieving the 75% target for the first time in 12 months. Several factors continue to affect the Trust's ability to respond to concerns, including, overall increased demand, a rise in the number of inquests, continuing volumes of NRI's and the availability of other departments to provide a timely response to requests for information. The number of total concerns increased in Mar-22 (107) when compared to Feb-22 (59).

**There were 7 SCIF forums held in Mar-22, during which 47 cases were discussed, 7 of these cases were reported to the Delivery Unit and 7 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 Sep-Nov-21 and again in Mar-22 is concerning and has been linked to the significant delays across the system along with the continued levels of NRIs. In Mar-22 there were 0 NRIs relating to Red calls, 6 relating to Amber calls and 1 relating to Green calls. There were 0 NRIs as a result of calls prioritised Amber which should have been Red.

The cases within the Complex Case Panel and Redress figures, indicate the number of cases within the reporting period, where the Trust has potentially breached its duty of care to the patient. In Feb-22 there were 2 complex cases, however at the date of reporting neither if these have been referred to the redress panel.

In Mar-22 802 patients waited over 12 hours a continued increase month on month and when compared to 86 in Feb-21 and 227 in Feb-19.

41 Compliments were received from patients and/or their families in Mar-22, an increase compared to the previous month.

## 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: Mar-22 data is correct on the date and time it was extracted; therefore, these figures are subject to change**
***NB: Complex Cases will always report one month in arrears**

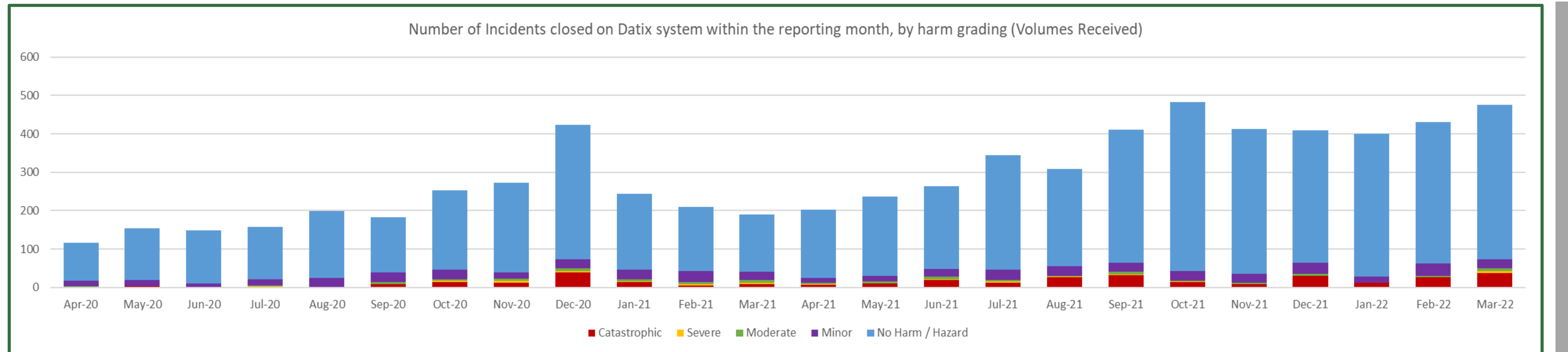
*NRI & Concerns Data source: Datix / Longest Waits Data Source: Report Manager*

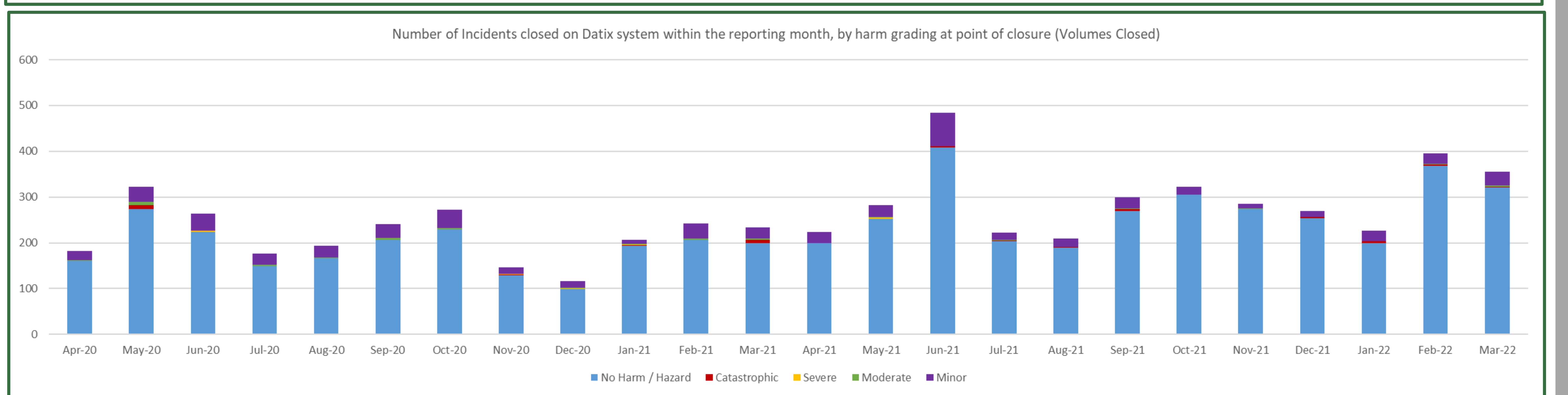
(Responsible Officer: Wendy Herbert)

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

Self Assessment: Strength of Internal Control: Moderate

Health & Care Standard
Health – Safe Care




**Analysis**

**Patient Safety:** The number of patient safety adverse incidents submitted within Mar-22 increased to 476; 403 of these were in relation to incidents where there was no harm or hazard, 23 were minor, 7 was moderate, 6 were severe and 37 incidents were catastrophic. 363 cases were closed in Mar-22 in comparison to 402 in Feb-22.

**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**

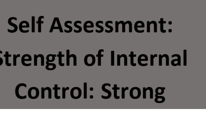
The Trust will continue to ensure lessons are learnt from every case reviewed and best practice will be implemented to continue to ensure care is of the highest quality.

***NB: Mar-22 data is correct on the date and time it was extracted; therefore, these figures are subject to change***

*Data source: Datix*

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

Self Assessment: Strength of Internal Control: Strong




Health & Care Standard
Health – Safe Care

Number of Coroner Requests by Health Board

(Stacked bar chart, Apr-20 to Mar-22; y-axis 0–90; series: Aneurin Bevan, Betsi Cadwaldr, Cardiff & Vale, Cwm Taf Morgannwg, Hywel Dda, Powys, Swansea Bay)

### Analysis

***Coroners:*** The Trust has responded to the 2 Reg 28 reports within the 56-day target. The actions from the associated plans will be monitored. This month has seen those cases identified as having the potential for the Trust to be an interested party, move into cases where it is confirmed that we are an interested party in the inquests. The number of in month requests continue to be increased from pre-pandemic request. The timeliness of our response and unexpected deaths continues to be the main themes. The complexity of the requests being received continues to be high, with multiple statements and additional information being requested, sometimes at very short notice.

***Ombudsman:*** There are currently 16 open Ombudsman cases in Mar-22. At present cases are not being investigated, which supports the Trusts actions.

### Remedial Plans and Actions

***Coroners:*** The Team is recovering from the unprecedented number of requests for information from Coroner's courts, that have been received from July 2020. There has been an increase in the number of cases in which staff attend to provide continuity evidence. The complexity of the requests continue to be high , with multiple statements being requested for each inquest. The pandemic has brought many challenges in relation to these requests , however inquests, where possible, continue to be heard remotely or hybrid (mixture of video, telephone, in person).

***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.

The Trust also continues to engage with our Health Board colleagues where the Trust has utilised the Joint Investigation Framework and/or where there is a focus on joint investigations and learning.

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

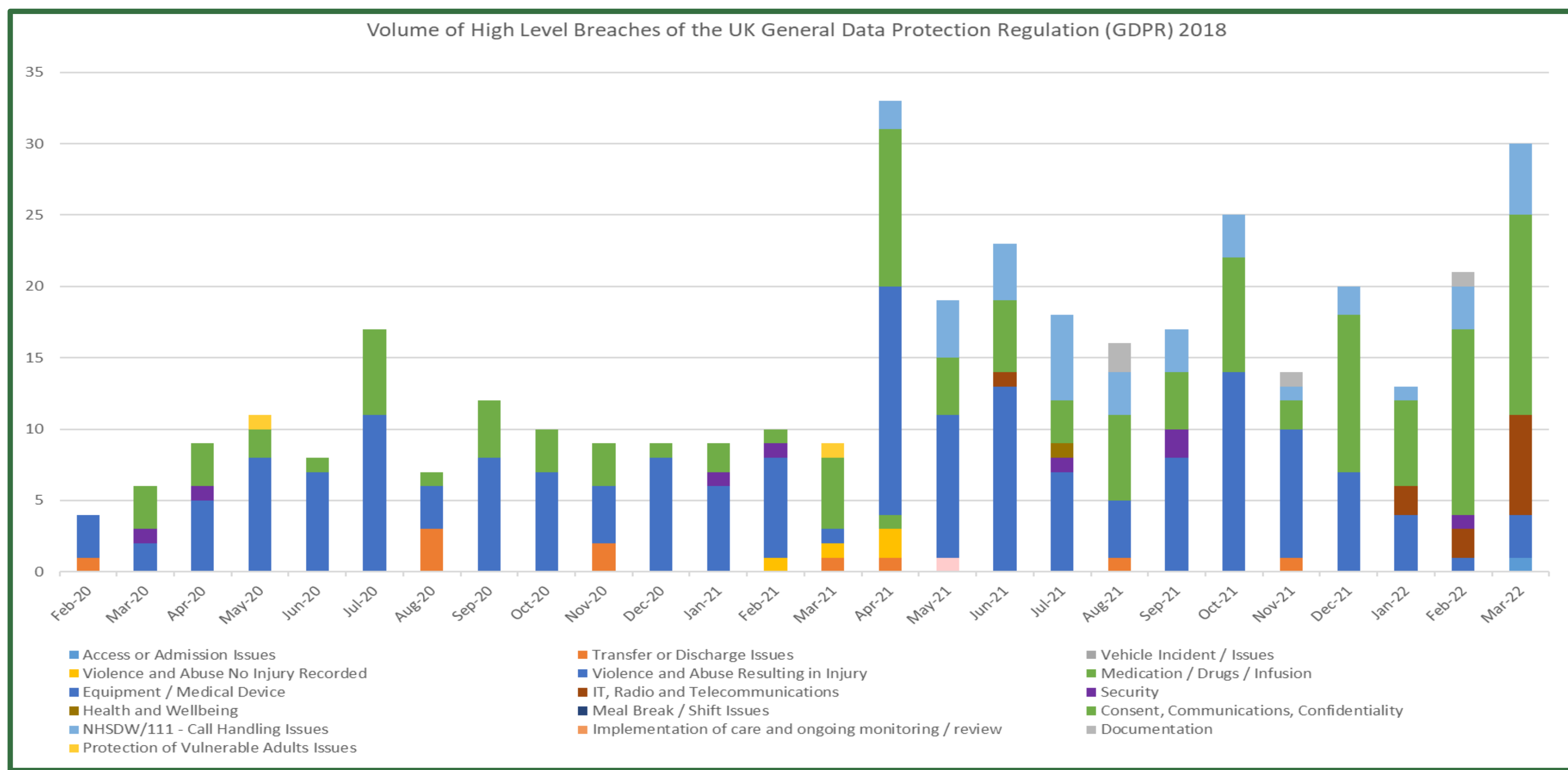
*Data source: Datix*

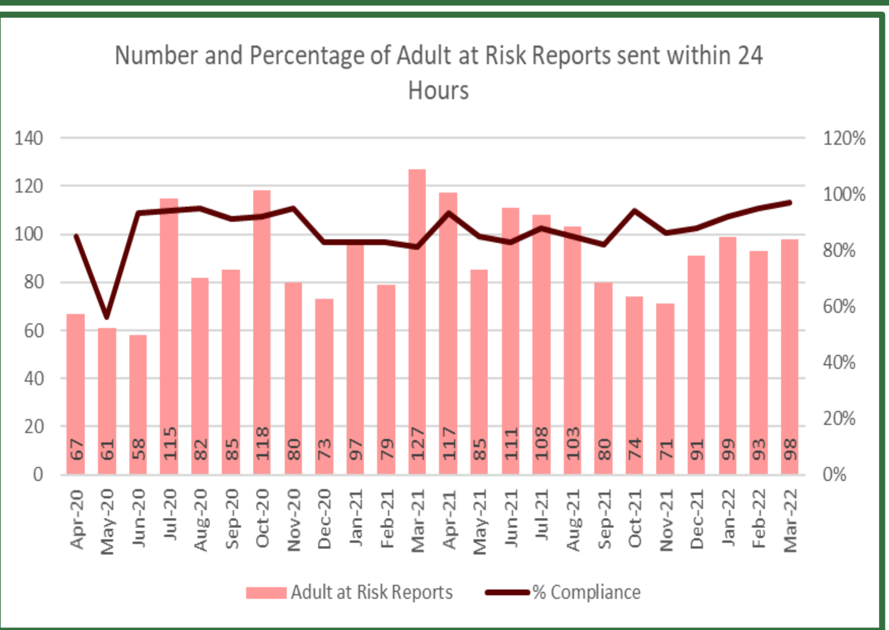
# Our Patients: Quality, Safety & Patient Experience
# Safeguarding, Data Governance & Public Engagement Indicators

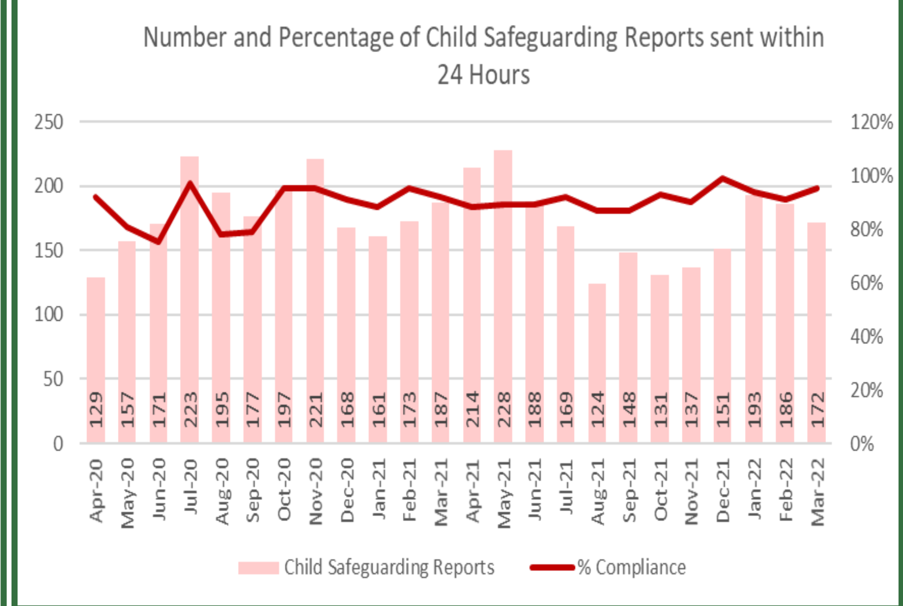
Health & Care Standard
Health – Safe Care

Self Assessment:
Strength of Internal Control: Strong

NB: Public Engagement next update (Apr-Jun 22) due Jul-22




### Analysis

***Safeguarding:*** In Mar-22 staff completed a total of 98 Adult at Risk Reports, a decrease compared to Feb-22 when 93 were reported. 95% of these were processed within 24 hours during Mar-22.

There have been 172 Child Safeguarding Reports in Mar-22, a decrease from Feb-22 when 186 reports were made. In Mar-22 95% were sent within 24 hours.

***Data Governance:*** In Mar-22 there were 31 information governance (IG) related incidents reported on Datix categorised as an Information Governance (IG) breaches, an increase when compared to Feb-22. 14 related to Consent, Communications or Confidentiality; 7 related to IT, Radio and Telecommunications, 5 related to 111 Call Handling issues, 3 related to equipment / medical devices, 1 related to clinical assessment, and 1 related to Access or Admission issues. 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:*** There where 77 engagement events held in Quarter 4, allowing engagement with 1,450 people. Easing of CoVID-19 restrictions has allowed the Trust to make a cautious return to face-to-face engagements within the community, along with a continuation of some online virtual engagement sessions. 68 NHS 111 Wales website surveys were returned, 28 people completed a new 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. 131 compliments were also logged and processed and 104 people left comments, suggestions and messages through our 'Have Your Say' function on the Welsh Ambulance Service Website. Engaging with people and communities continues to be a priority for the PECI Team, this engagement allows us to share important information about WAST services with communities and enables the collection of feedback and experiences which help us understand if services are meeting patient needs and expectations.

### 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 31 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:*** Within this reporting period remaining CoVID-19 restrictions ended, and the Trust made a cautious return to engaging with people and communities in person again. The PECI Team are extremely happy to be engaging with people in person again and look forward to re-building relationships with groups and communities whom we have not been able to meet due to the pandemic. To ensure the safety of our Team members and communities whilst we do this, we have reviewed and updated our existing processes and risk assessments to incorporate some additional CoVID-19 safety elements. Recognising that not all people feel ready to return to engaging with us in the way they would have before the pandemic, we continue to offer opportunities to engage using online platforms that have become so familiar.

### Expected Performance Trajectory

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

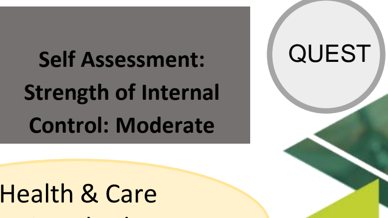
***Data Governance:*** An annual assessment of compliance using the Welsh NHS IG Toolkit; an individual evidence-based assessment consisting of 255 items will continue to be utilised to measure the Trust against National Information Governance and Security Standards, and the Trust's FY21-22 IG Toolkit responses have now been submitted.

***Public Engagement:*** The PECI Team will continue to share good practice and learning from our engagement with partners, stakeholders and colleagues at Ambulance Services across the UK. We will continue to proactively communicate with people and communities, sharing important information regarding Trust services, appropriate use of these during the current period of increased demand. With most coronavirus restrictions now lifted in Wales, the team are receiving invitations to engage with people and communities, and we look forward to attending these over the coming months.

*Safeguarding Data source: Doc Works*

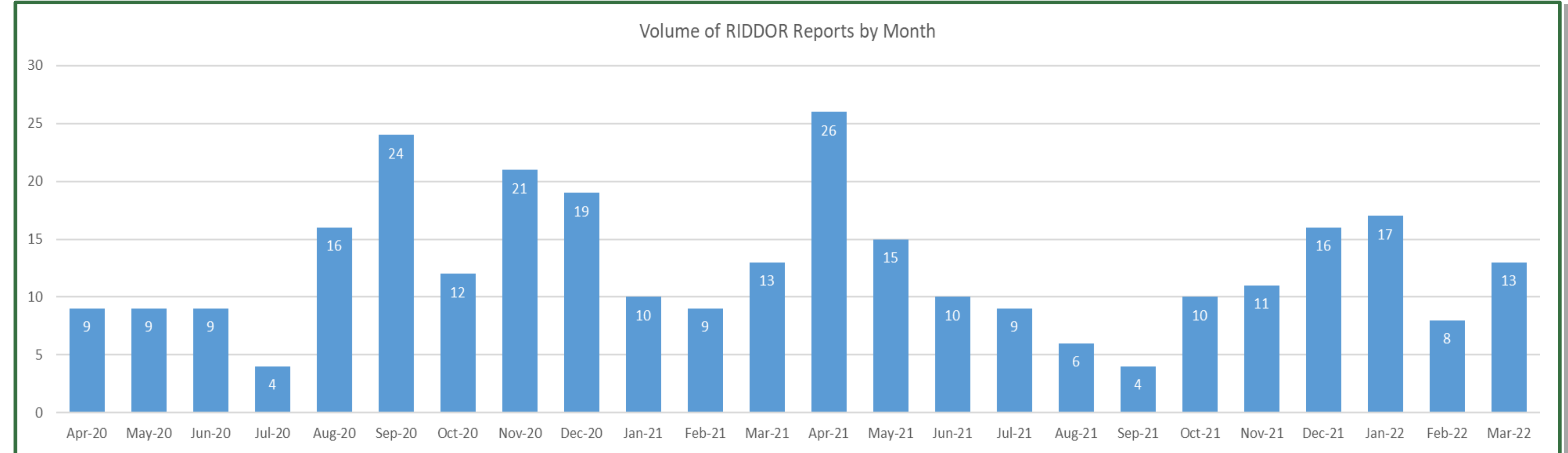
(Responsible Officer: Wendy Herbert)

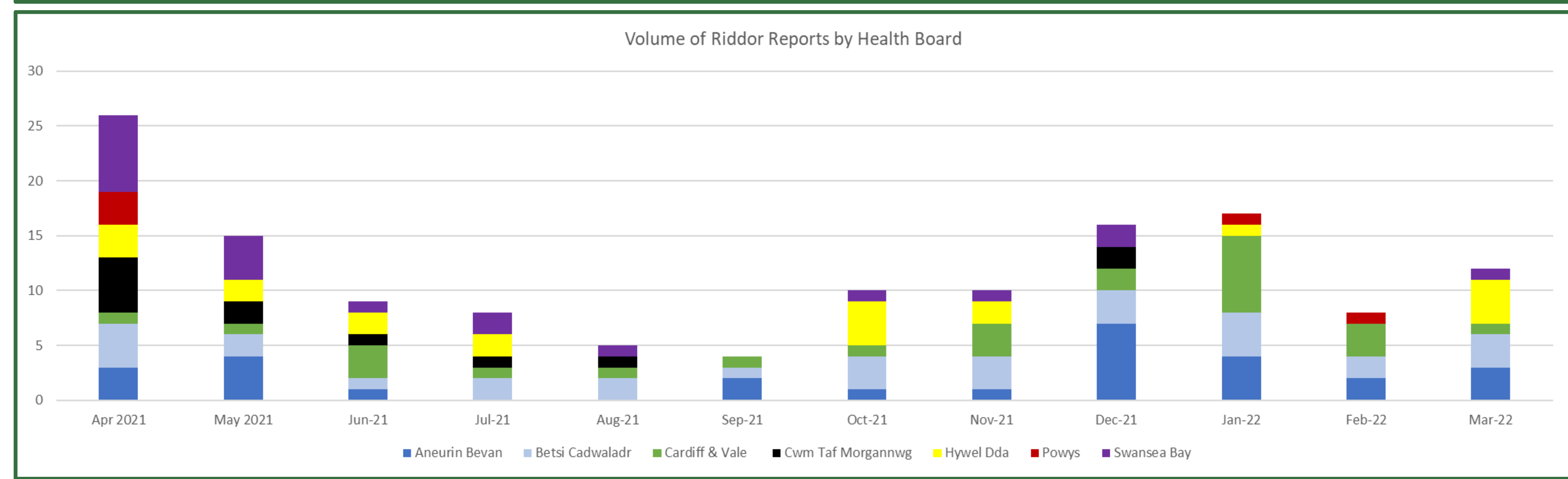
# Our Patients: Quality, Safety & Patient Experience
# Health & Safety (RIDDORS) Indicators




Self Assessment: Strength of Internal Control: Moderate

Health & Care Standard
Health – Safe Care




**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 (Jan-Mar-22) there were no fines, prosecutions, HSE improvement or Prohibition notices.

In Mar-22 RIDDORS reported were for 111 (1), ABUHB (3), BCUHB (3), CVUHB (1) and HDUHB (4).

**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 Nov-21. 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.

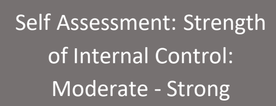
The Trust has recently reviewed its reporting process and has developed new arrangements for reporting RIDDOR reportable incidents. This change will be reflected in the Trust's Health and Safety Policy and the Adverse Incident Reporting Policy. Both polices will be going through the Trust's policy approval process within the next couple of months

***NB: Mar-22 data is correct on the date and time it was extracted; therefore, these figures are subject to change**

*Data source: Datix*

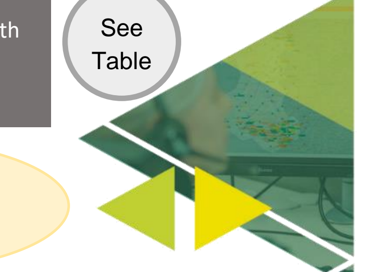
(Responsible Officer: Wendy Herbert)

# Our Patients: Quality, Safety & Patient Experience Corporate Risk Indicators




See Table

Health & Care Standard - GLA3



| RISK ID | NEW RISK TITLE | NEW SUMMARY DESCRIPTION | EXECUTIVE OWNER | RISK SCORE |
|---|---|---|---|---|
| 223 | The Trust's inability to reach patients in the community causing patient harm and death<br><br>Previous title:<br>*Unable to attend patients in community who require See & Treat* | **IF** significant internal and external system pressures and abstractions continue<br><br>**THEN** there is a risk of an inability and/or a delay in ambulances reaching patients in the community<br><br>**RESULTING IN** patient harm and death | Director of Operations | 25 (5x5) → |
| 224 | Significant handover delays outside A&E impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service<br><br>Previous title:<br>*Patients delayed on ambulances outside A&E Departments* | **IF** patients are significantly delayed in ambulances outside A&E departments<br><br>**THEN** access to definitive care is delayed and standards of patient care are compromised, and the environment of care will deteriorate<br><br>**RESULTING IN** patients potentially coming to harm | Director of Operations<br><br>Transferred to:<br>Director of Quality & Nursing | 25 (5x5) → |
| 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<br><br>Previous title:<br>*Compliance with Health and Safety legislation* | **IF** there is a failure to embed an interdependent and mature health and safety culture, effective arrangements and associated governance<br><br>**THEN** there is a risk of a potential breach in compliance with the requirements of the Health & Safety at Work etc. Act 1974 and associated regulations and other statutory instruments<br><br>**RESULTING IN** death or serious injury, and punitive actions from multiple enforcement agencies including penalties and adverse publicity leading to damage to reputation | Director of Quality & Nursing | 20 (4x5) → |
| 160 | High sickness absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service<br><br>Previous title:<br>*High Sickness Absence Rates* | **IF** there are high levels of sickness absence rates<br><br>**THEN** there is a risk of a reduced resource capacity<br><br>**RESULTING IN** an inability to deliver services which adversely impacts on quality, safety and patient/staff experience | Director of Workforce & Organisational Development | 16 (4x4) ↑<br>New score 20 (5x4) |
| 316 | Potential for a high volume of personal injury claims due to work acquired covid infection<br><br>Previous title:<br>*Increased risk of personal injury claims citing COVID exposure* | **IF** we are unable to determine the point of Covid infection due to a lack of documented evidence that proves the point of exposure<br><br>**THEN** there is a risk of a high increase in personal injury claims being awarded against WAST citing work acquired Covid infection<br><br>**RESULTING IN** potential, significant financial loss and adverse media coverage and reputational damage | Director of Quality & Nursing | 16 (4x4) ↓<br>New Score 12 (3x4) |

**Analysis**

There are currently 16 Corporate Risks on the register, with the 5 highest scoring detailed in the table. Sessions have taken place in Feb and Mar-2022 to review the highest scoring risks and determine new titles, clearly articulate the risks, descriptions and map controls and assurances.

The Assistant Directors Leadership Team (ADLT) reviewed the existing and proposed new corporate risks during the last quarter. The full Corporate Risk Register was presented to Trust Board on 24th March 2022.

EMT have approved the rearticulation of the highest scoring risks: Risks 223, 224, 199, 316 and 160 and identified gaps and articulate further actions to mitigate the risks in addition to reviewing scores and controls rating assurances.

Risk ID 223 and Risk ID 224 remain the highest scoring risks at scores of 25, this is due to pressure in the unscheduled care system and emergence of long handover delays at Hospital Emergency Departments. Risk ID 160 has been revaluated and scored at 20 due to ongoing high sickness levels and the risk to the inability of the Trust to deliver services.

**Remedial Plans and Actions**

Principal risks assigned to Committees detailed in the table and are considered for scrutiny and strategic oversight. The committees convened on the following dates:

a) **Quality, Safety & Patient Experience** (17th February 2022)
b) **People & Culture Committee** (22nd February 2022)
c) **Finance & Performance Committee** (17th March 2022)

d) Controls, assurances and any mitigating actions will be presented to the Board at the next meeting in May-2022

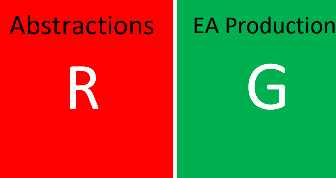
**Expected Performance Trajectory**

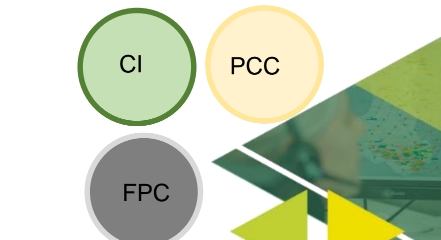
The Governance team are developing a transitional Board Assurance Framework which will be presented to Audit Committee in Jun-22 and Trust Board in Jul-22.

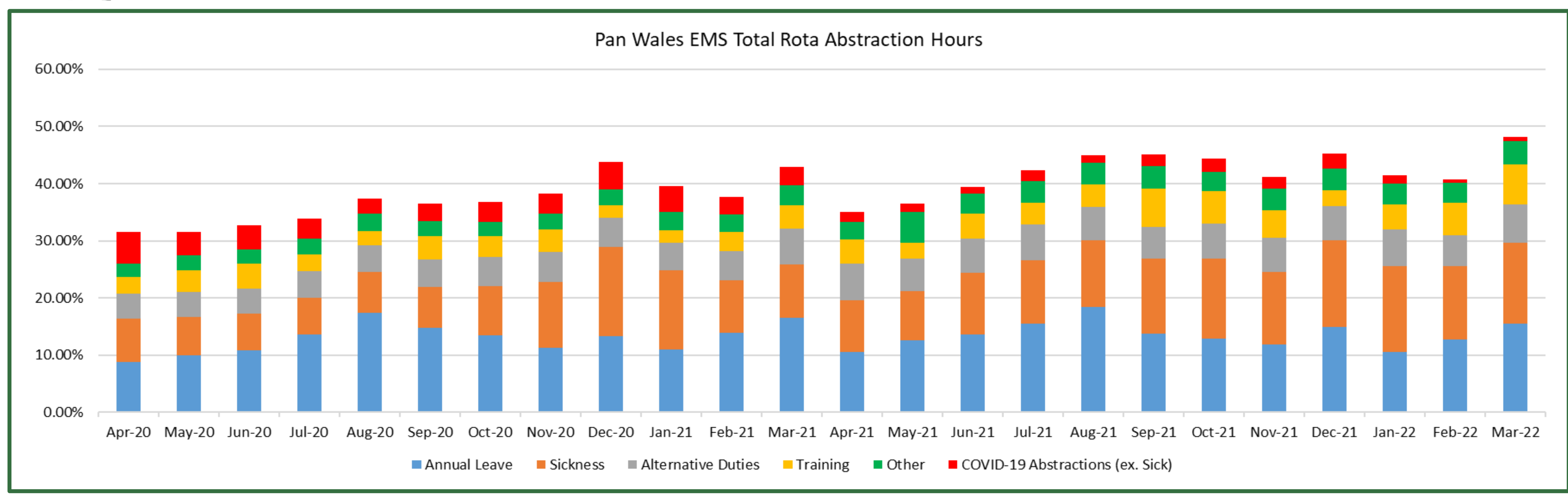
***NB: Next Update (Apr- Jun-22) due Jul-22***

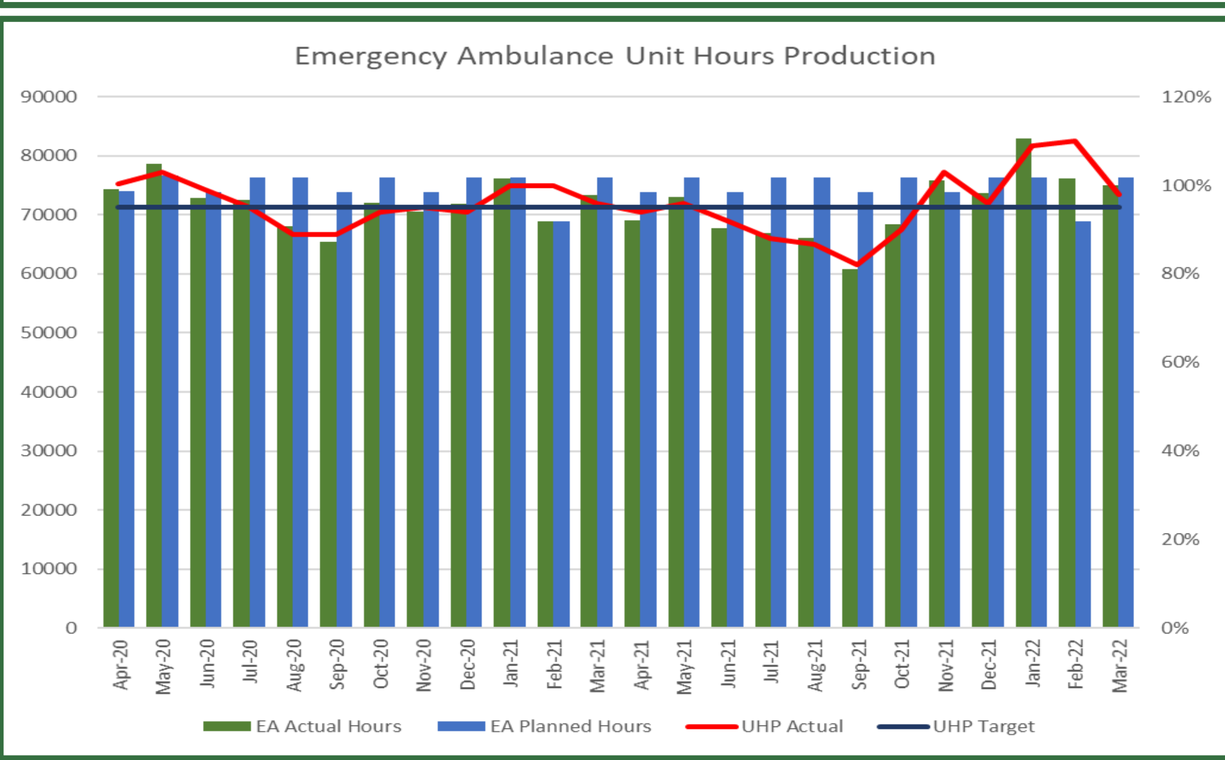
*Data source: Electronic Risk Register*

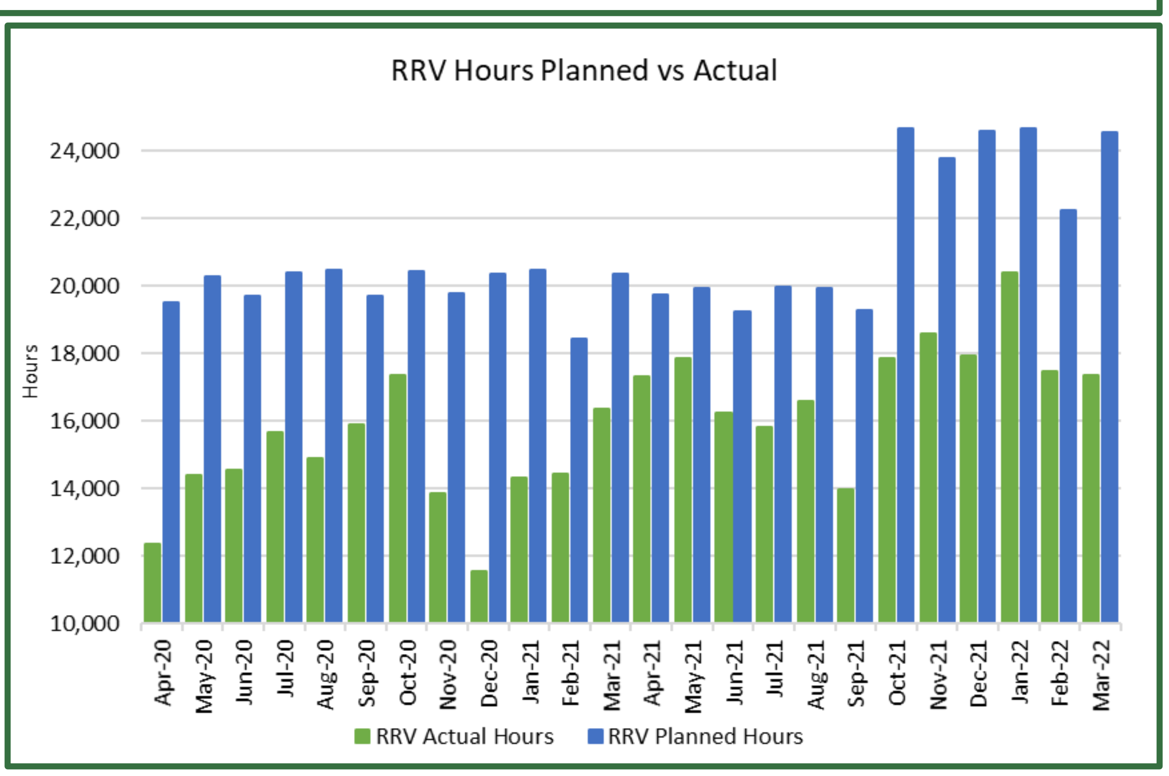
# Our People
# Ambulance Abstractions and Production Indicators




**Analysis**

As shown in the top graph, monthly abstractions from the rosters are key to managing the number of hours we produce. In Mar-22, total abstractions stood at 48.13%. 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 15.46% and sickness at 14.22%. Sickness abstractions for Mar-22 were higher than the previous year (9.40%); however, CoVID-19 related abstractions increased in Mar-22 when compared to Mar-21 accounting for 0.71% of overall abstractions.

**Emergency Ambulance Unit Hours Production (UHP) was 98% in Mar-22** (75,017 Actual Hours), achieving the 95% benchmark. RRV UHP achieved 94% (17,369 Actual Hours) compared to 120% in Feb-22. The total hours produced is a key metric for patient safety (included on slide 7 red performance). In Mar-22 the Trust produced 118,840 hours, but the graph shows that even despite significant funding for increased substantive numbers of staff, total hour produced has not risen sustainably. During Mar-22 support received from military personnel was phased out through a transition plan in preparation, this support ceased on 31 Mar-22.

Following a short period in REAP 3, the Trust escalated to REAP 4 on 18 Mar-22 and is now operating under the Pandemic Monitor Mode which was introduced on 21 Mar-22. The Trust continues to maintain a Performance Improvement Plan bringing together all tactical and transformative actions across the three services. Additional capacity have been actioned to help offset the level of abstractions.

**Remedial Plans and Actions**

The EMS Demand & Capacity Review benchmark for GRS sickness absence abstractions is 5.99%. A new programme of work is being commenced to review and take action to reduce sickness absence / alternative duties. The key actions to maximise production will continue to be the EMS Demand & Capacity Review with an additional 81 WTE to be recruited this year; however, the current impact of CoVID-19 means that the Performance Improvement Plan contains a range of tactical responses to increasing capacity in the short term e.g. military aid.

**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)

# Our People
# Sickness Absence Indicators

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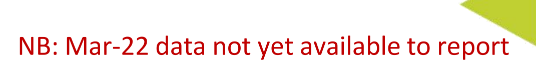
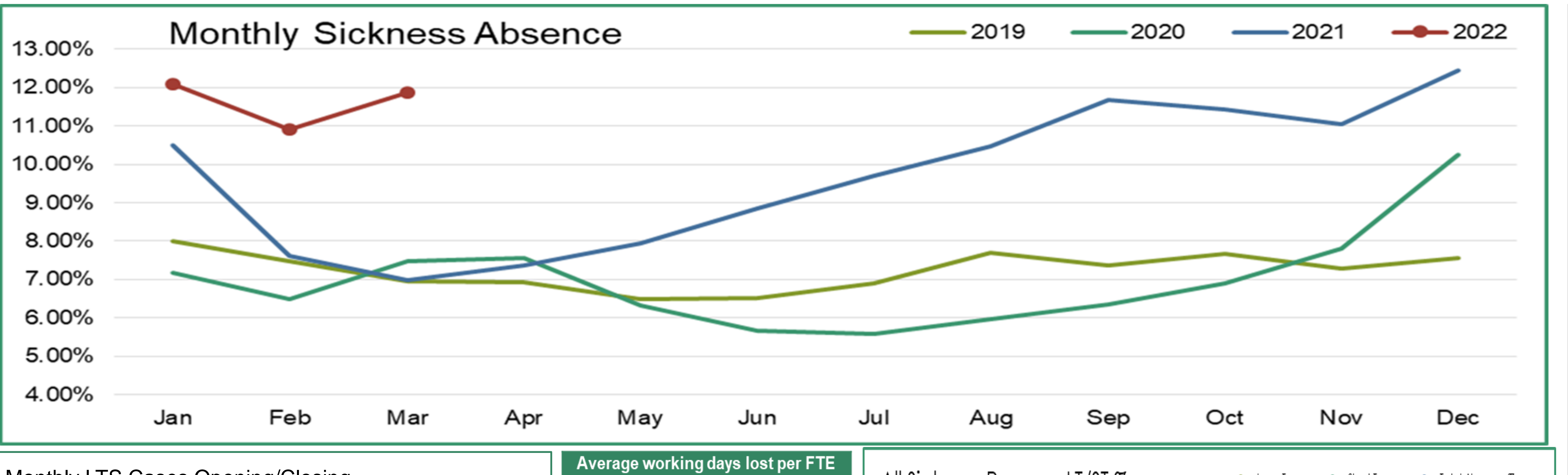
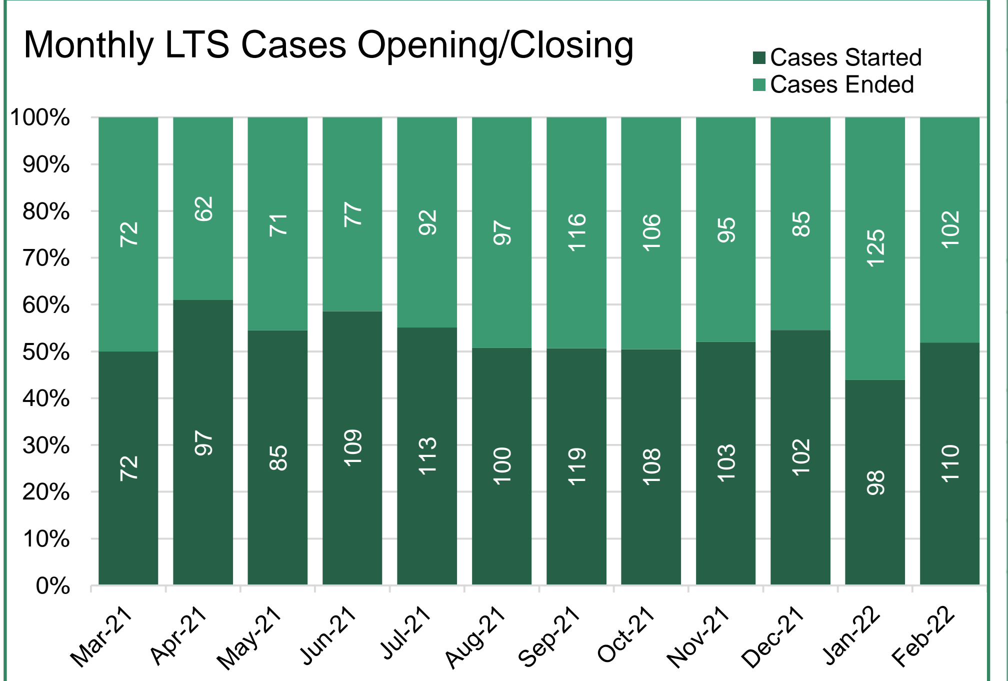
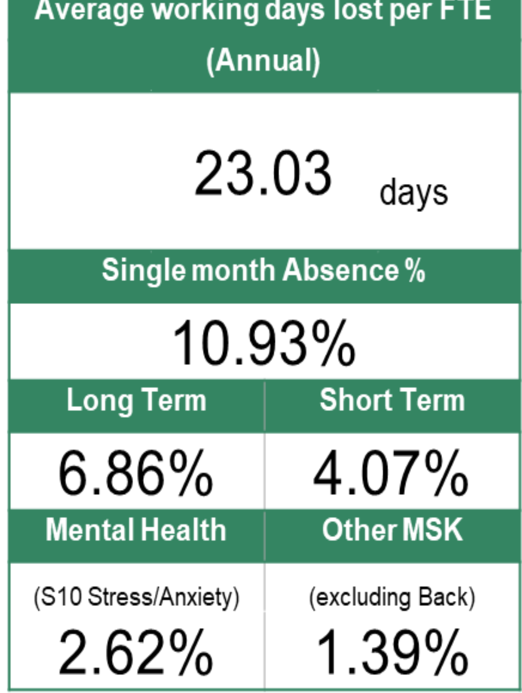
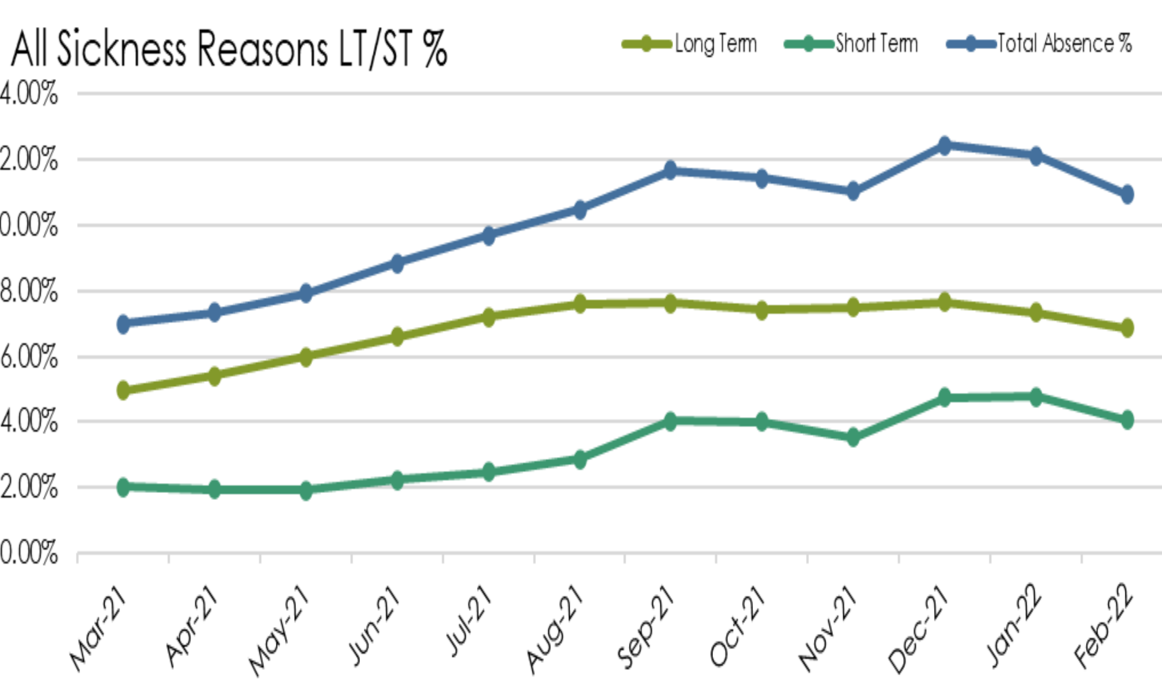


NB: Mar-22 data not yet available to report
*with the exception of Monthly Sickness graph




**Analysis**

The monthly sickness absence figure for Mar-22 was 11.88%, a decrease of 0.97% 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.

- Further decrease in Covid sickness absence and self-isolation during the Omicron wave
- Lowest rate of absence since Sept-2021
- Stress & Anxiety has returned to the top reason for absence
- Reduction in both LTS and STS for Feb-2022

**Remedial Plans and Actions**

- Physiotherapy referrals increased to 30 referrals for this month, with 63% off work at time of referral (26% increase compared to December). Majority of referrals were for back symptoms, closely followed by shoulder issues. Referrals to our EAP were reduced against December slightly to 53 calls, top call reasons for Mental Health, Relationships and Work

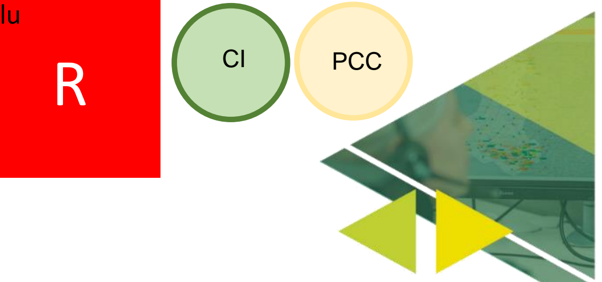
**Expected Performance Trajectory**

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

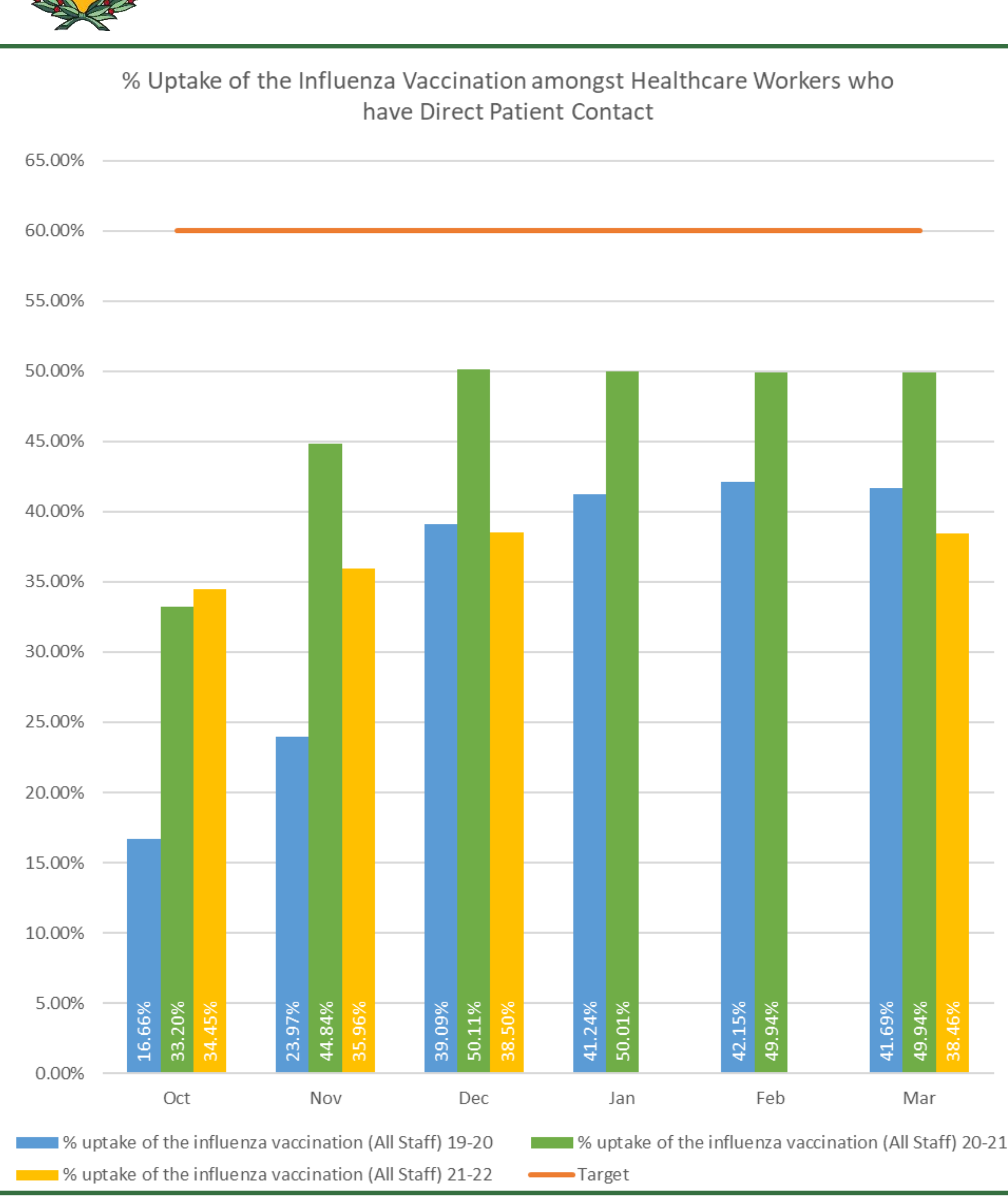
# Our People
# Staff Vaccination Indicators

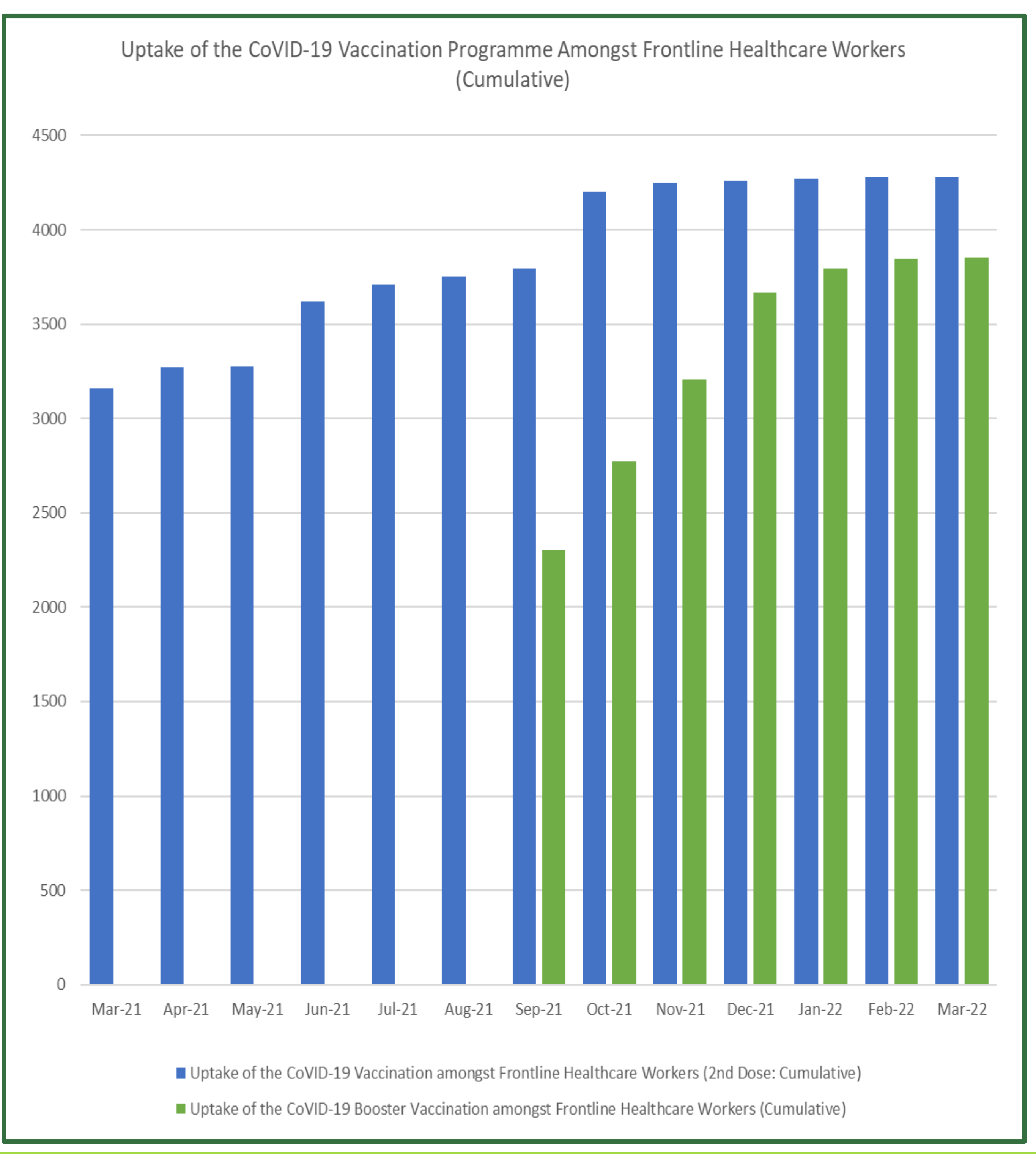
Self Assessment: Strength of Internal Control: Moderate

Health & Care Standard - Health (PPI)




*NB: Next Reporting Flu Campaign Oct-22*




**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 we are unable to report monthly data for Jan & Feb-22.*

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, 94% (4,279) have received a second dose and 85% (3,853 Staff) have received a booster vaccination. In addition 94% of volunteers have received a first dose vaccination, 93% have received a 2nd dose and 2.1% have received a booster vaccination.

**Remedial Plans and Actions**

Staff data has been refreshed to accurately staff numbers employed by WAST.

**Expected Performance Trajectory**

Due to the escalation to Alert Level 2 in Wales and a reduction in public mixing over the festive period, to date the expected surge in flu rates have not been seen in the 2021/22 winter period. This, combined with an uptake in vaccination across priority groups in Wales has meant that more people than ever before received an influenza vaccination and for the first time ever, over one million vaccinations were given in Wales. The Trust is still cautious that an easing of restrictions could see cases increase and winter planning has been key in preparing for this scenario.

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

# Our People
# PADR and Training Rates Indicators

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Self Assessment: Strength of Internal Control: Strong

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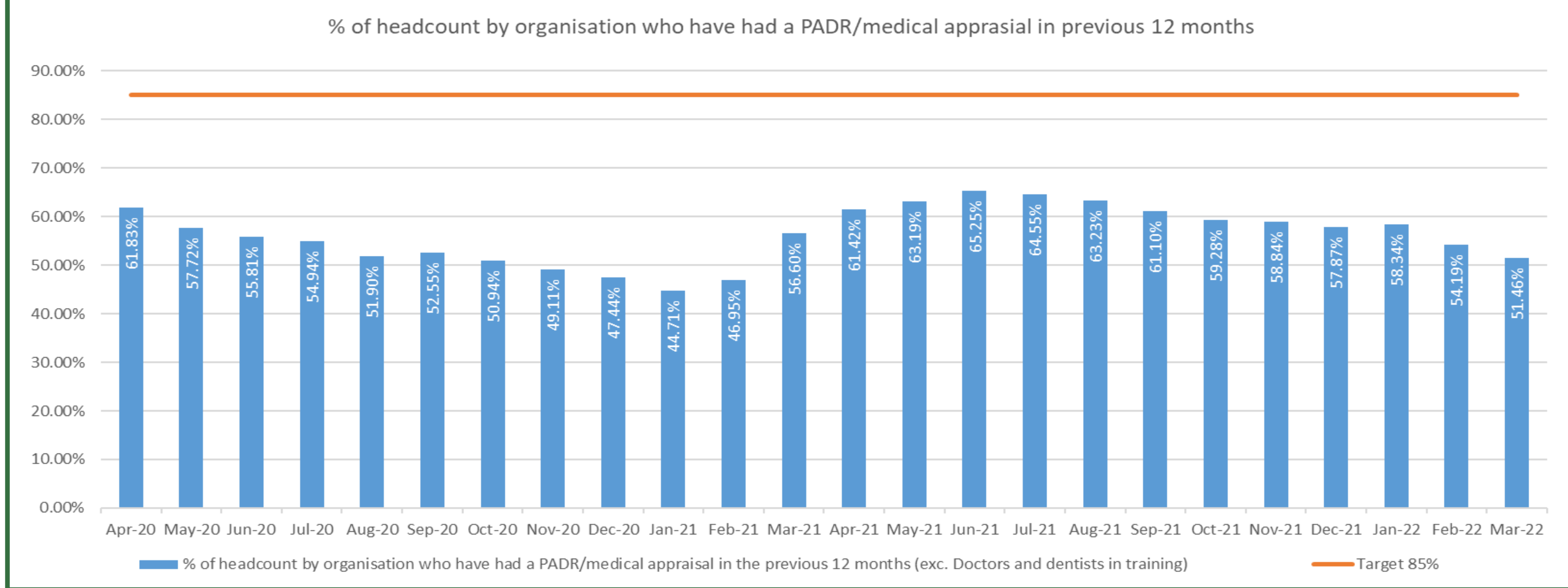
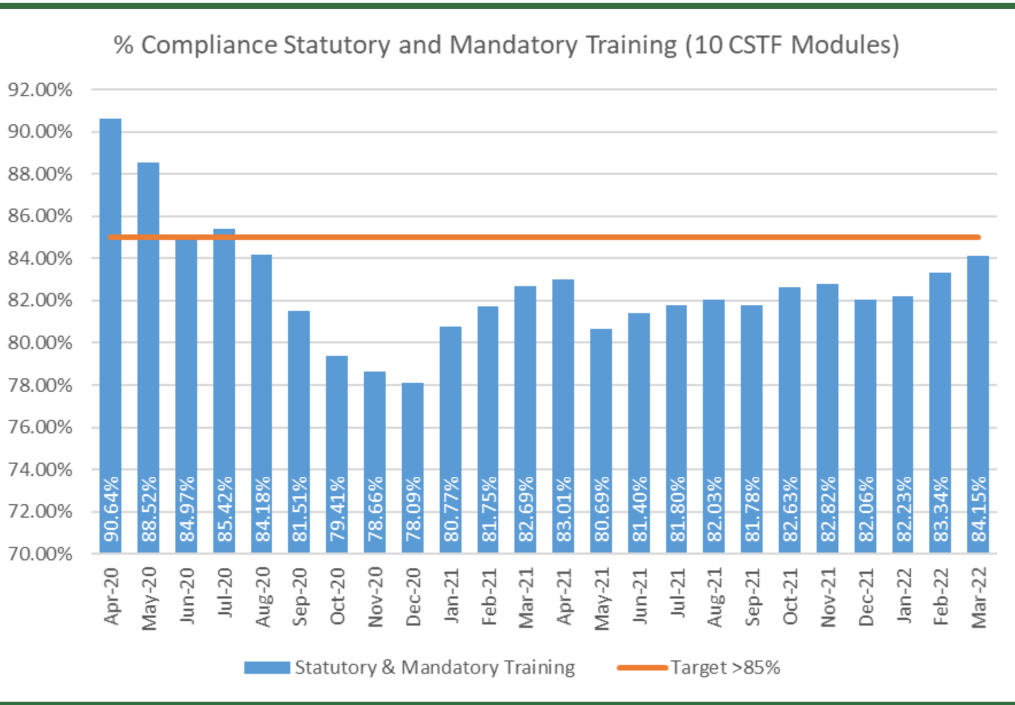
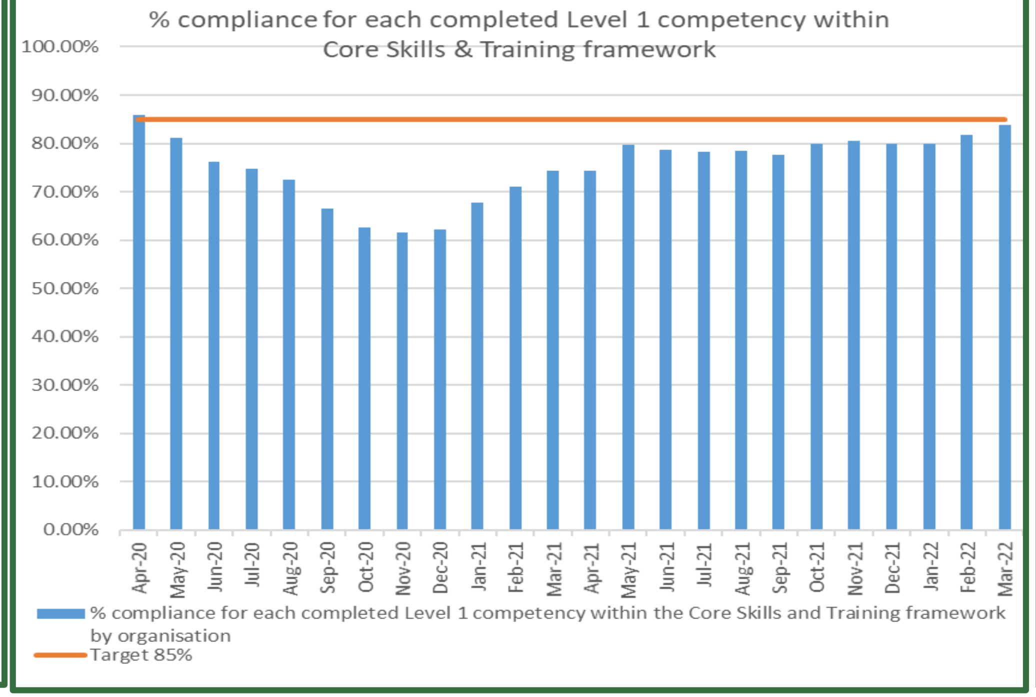
Health & Care Standard Health – Staff & Resources




## Analysis

PADR rates for Mar-22 declined to 51.46% continuing to remain well below the 85% target.

Mar-22 Statutory & Mandatory Training rates increased by 1.94% from the Feb-22 figure remaining just under the 85% target. Fire Safety (66.10%), Information Governance (84.80%) and Moving & Handling (82.57%) all failed to achieve the 85% target; however Safeguarding Adults (87.38%) achieved the target again in Mar-22.

In Mar-22 Band 6 Paramedic Competency rates (All Staff) are 83.71% for year 1, 78.44% for year 2 and 72.93% for year 3. These figures exclude newly qualified Paramedics and staff on Long-Term Sickness and Maternity. Of the original Band 6 paramedic cohort, the rates are 100% for year 1, 99.86% for Year 2 and 97.18% for year 3.

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

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

### Remedial Plans and Actions

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

Targeted communication via Siren and Yammer will continue using the #WASTMakeItHappen tagline to reinvigorate My Learning on ESR for Corporate Compliance will continue. . 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 we expect to continue to see improving compliance figures across the Trust.

*Data source: ESR*

# Finance and Value
# Finance Indicators

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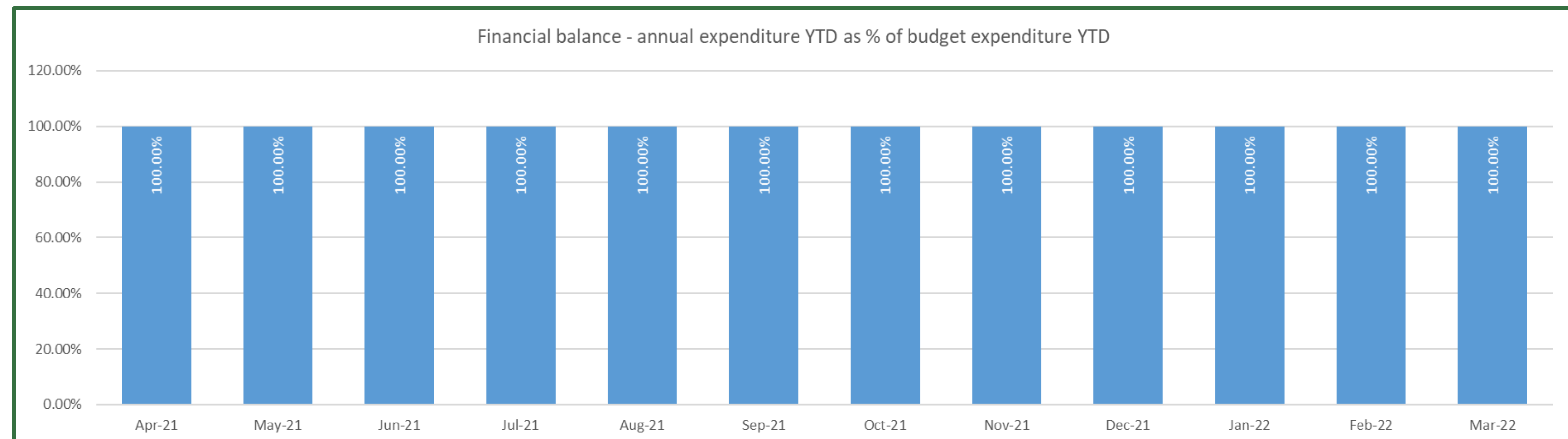


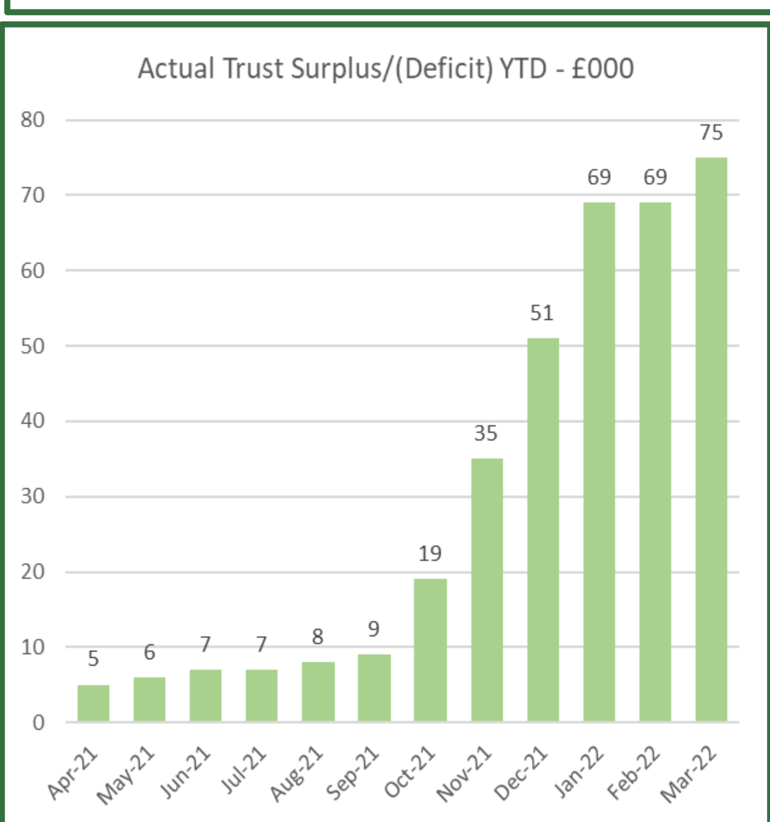

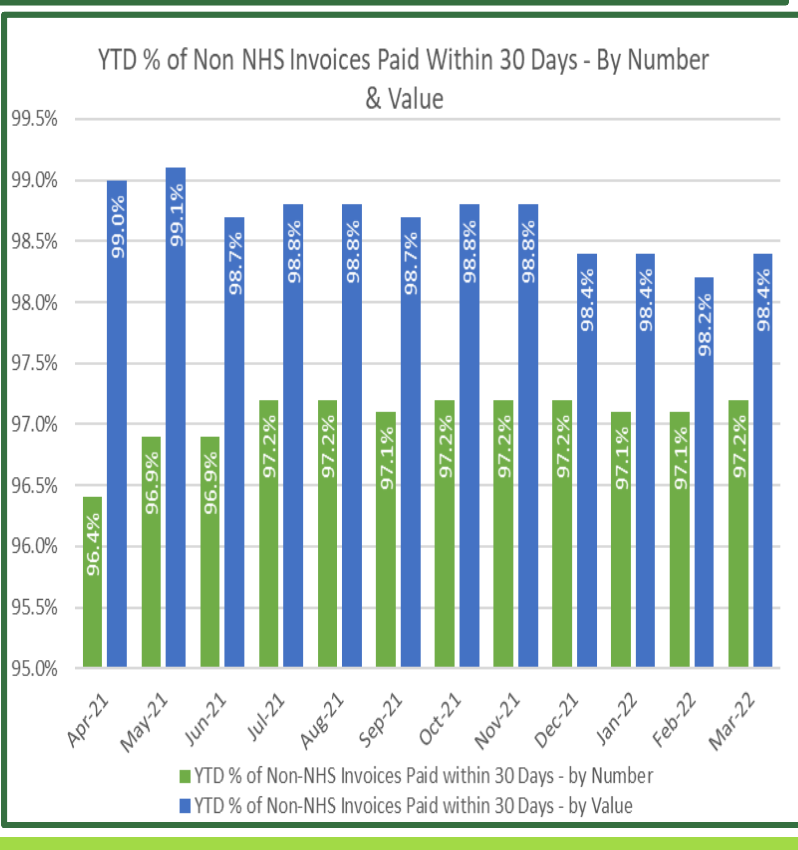


**Analysis**

At the end of the 2021-22 financial year, the reported outturn performance at month 12 is a surplus of £75k.

For month 12 the Trust is reporting planned savings of £2.800m and actual savings of £2.861m, an achievement rate of 102.2%.

Cumulative performance against the Public Sector Purchase Programme (PSPP) as of Mar-22 was 97.2% against a target of 95%.

As of Mar-22 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.

# Value / Partnerships & System Contribution
# EMS Utilisation & Post Production Lost Hours Indicators

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

Post Production Lost Hours - By Unavailability Reason

14000
12000
10000
8000
6000
4000
2000
0

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

- CLEANING – CoVID19
- COMMUNICATIONS - NOT AVAILABLE
- CoVID 19 RTB/ Awaiting Decontamination Cleaning
- Crew Documentation
- Duty Operations Manager Duties
- EQUIPMENT - NOT AVAILABLE
- HALO DUTIES
- L3 PPE Cool Down
- LEAVE - NOT AVAILABLE
- Paper Operations
- POLICE INTERVIEW - NOT AVAILABLE -
- RTB S/D MEALBREAK - NOT AVAILABLE
- SAFEGUARDING/POVA - NOT AVAILABLE
- SOILED UNIFORM - NOT AVAILABLE
- STAFF ILLNESS - NOT AVAILABLE
- STAFF INJURY - NOT AVAILABLE
- TRAINING ON BASE - NOT AVAILABLE
- TRAINING VEHICLE
- TRAUMATIC STAND DOWN - NOT AVAILABLE
- VEHICLE CLEANING - NOT AVAILABLE
- VEHICLE DEFECT - NOT AVAILABLE
- VEHICLE DEFECT NOT AT W/SHOPS
- Tactical Approach to Production Crew Concren
- SINGLE CREW

**Analysis**

**There were 11,452 post production lost hours (PPLH) in Mar-22;** which continues to show high levels compared to Feb-22 (11,010).

In Mar-22 hours lost through PPLH can be down to numerous factors, including, but not limited to Return to Base, Meal Breaks (5,935 Hours), HALO duties (1,752 hours), Duty Operations Manager duties (1,243 Hours) and Vehicle cleaning (936 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, which commenced in Sep-21. The current focus continues to be on data accuracy, modelling of options and potential tests of change.

**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 PPLH is going to May-22 F&P Committee.

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

# Value & Partnership Contribution Utilisation Indicators

Slide Under Development to provide Net Utilisation – there is an issue with PPLH data that is preventing this indicator being further developed at this point of time. Optima liaising with new AD Data & Analytics

EA Historical Gross Utilisation October 2021 (Busy Hours / Actual Hours)

80%
75%
70%
65%
60%
55%
50%
45%
40%
35%
30%
25%
20%

Mon 0 | Mon 6 | Mon 12 | Mon 18 | Tue 0 | Tue 6 | Tue 12 | Tue 18 | Wed 0 | Wed 6 | Wed 12 | Wed 18 | Thu 0 | Thu 6 | Thu 12 | Thu 18 | Fri 0 | Fri 6 | Fri 12 | Fri 18 | Sat 0 | Sat 6 | Sat 12 | Sat 18 | Sun 0 | Sun 6 | Sun 12 | Sun 18

Ideal EA utilisation | 1-3 Oct | 4-10 Oct | 11-17 Oct | 18-24 Oct | 25-31 Oct | Average (1-31 Oct)

**Analysis**

The chart outlines the gross utilisation for WAST; the ideal gross utilisation has been set as 57% after an extensive data analysis (the split between green and pink area in the chart). Achieving this level of utilisation enables the Trust to exactly deliver a 30 minute Amber 1 response time.

In addition each health board area has their own ideal EA utilisation. Analysis has indicated that this is higher for urban areas and lower for rural areas. A high degree of rurality means that more resources need to remain available more often to achieve the 30 minute Amber 1 response times.

The chart shows that's the EA utilisation has consistently been much higher than we would like in Oct-21; this extensive utilisation also explains why response times have been much slower than desired.

The dip seen during the early hours on a Monday is as a result of the data being available in weekly blocks which causes some of the workload within the first few hours of the dataset to be invisible. The 'tuning' of the ideal utilisation is revised periodically on larger datasets that do not contain these dips.

*NB: The thick black line identify the average hour-of-week EA utilisation for WAST, the thin lines indicate the values for every week within October.*
*The green and pink indicate the split below and above ideal utilisation*

**Remedial Plans and Actions**

The Trust is currently receiving support through additional hours obtained from the Military Aid to the Civil Aid (MACA) and Fire Service.

The Trust has combined various tactical plans into a single Performance Improvement Plan (PIP) which is being reported into Executive Management Team every 2 weeks set out under four main headings with actions including:

- Better management of demand;
- Increasing capacity;
- Increasing effectiveness and efficiency of resources; and
- Supporting staff well-being.

Application of the clinical Safety Plan is being utilised to ease pressures on the Trust during periods of excessive demand.

**Expected Performance Trajectory**

Further work is required on the measure, in particular, data issues around PPLH.

(Responsible Officer: Lee Brooks)

# Our Patients: Quality, Safety & Patient Experience
# 111 Hand Off Metrics and 111 Consult & Close Indicators
## Influencing Factors – Demand and Clinical Hours Produced

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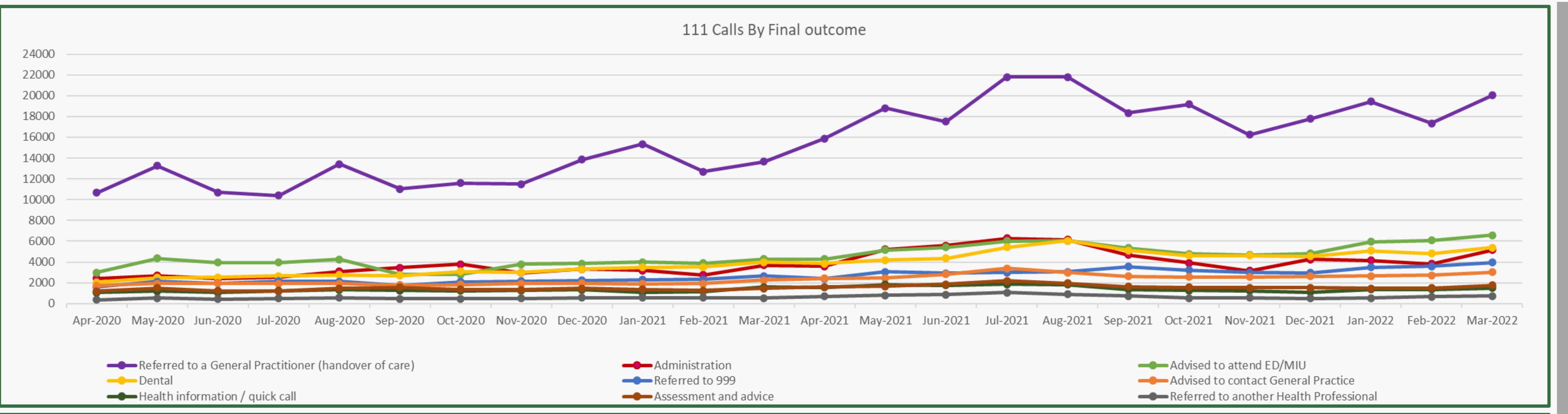


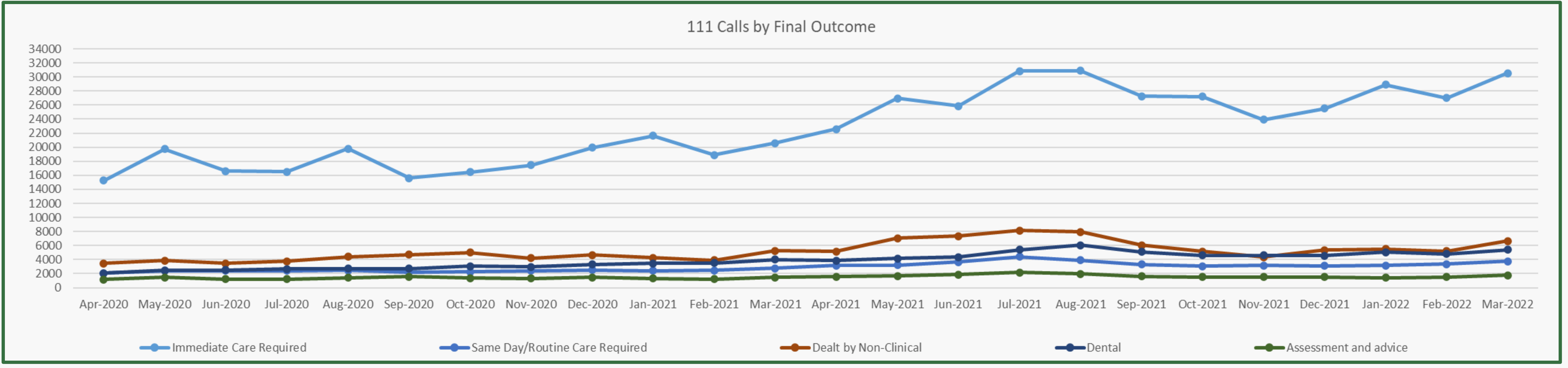


**Analysis**

**In Mar-22 calls Referred to General Practitioner (handover of care) continued to be the top outcome for NHS111 accounting for 42% of calls.**

Calls falling in the Immediate Care Required category saw the highest volume; this includes calls referred to General Practitioner (20,033), advised to attend ED/MIU (6,576) and Dental calls (5,389).

In Mar-22 48,120 calls were received in the 9 categories displayed in the top graph, an increase when compared to 41,927 in Feb-22; 26,542 in Mar-20 and 34,084 in Mar-21.

**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
# Hear & Treat Indicators

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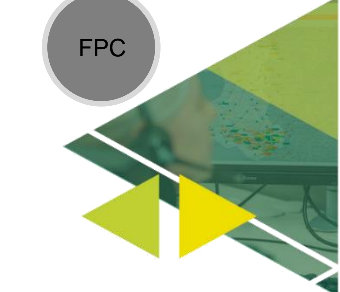


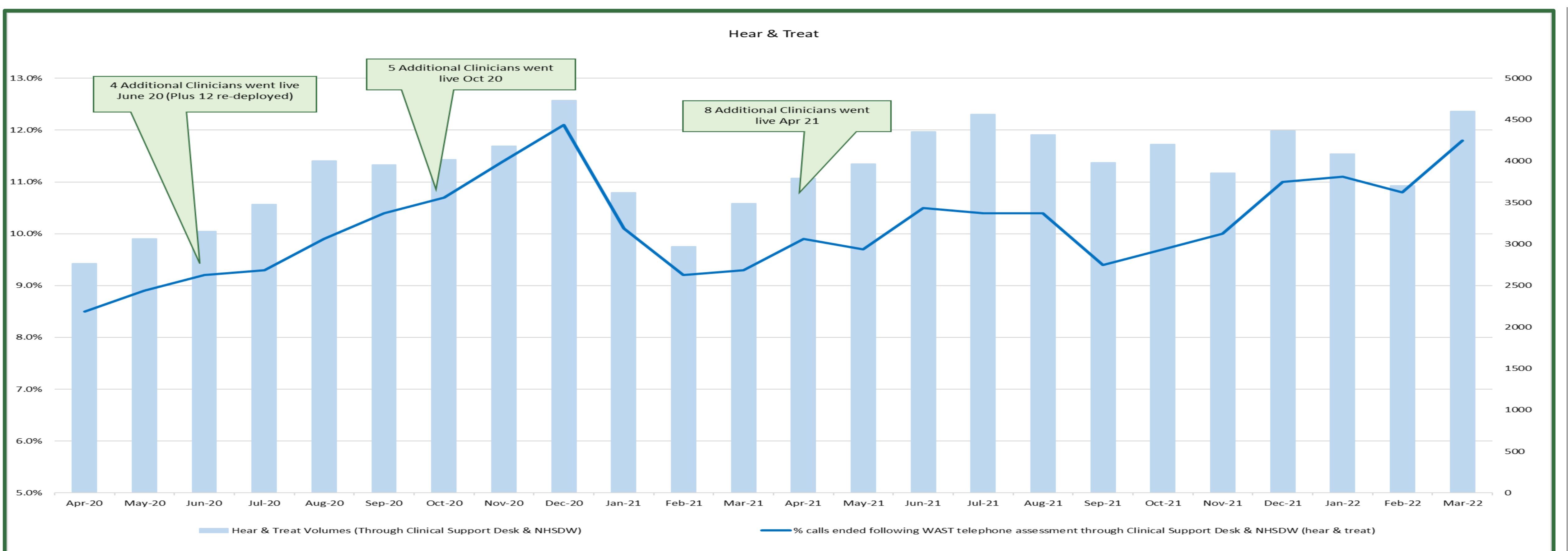


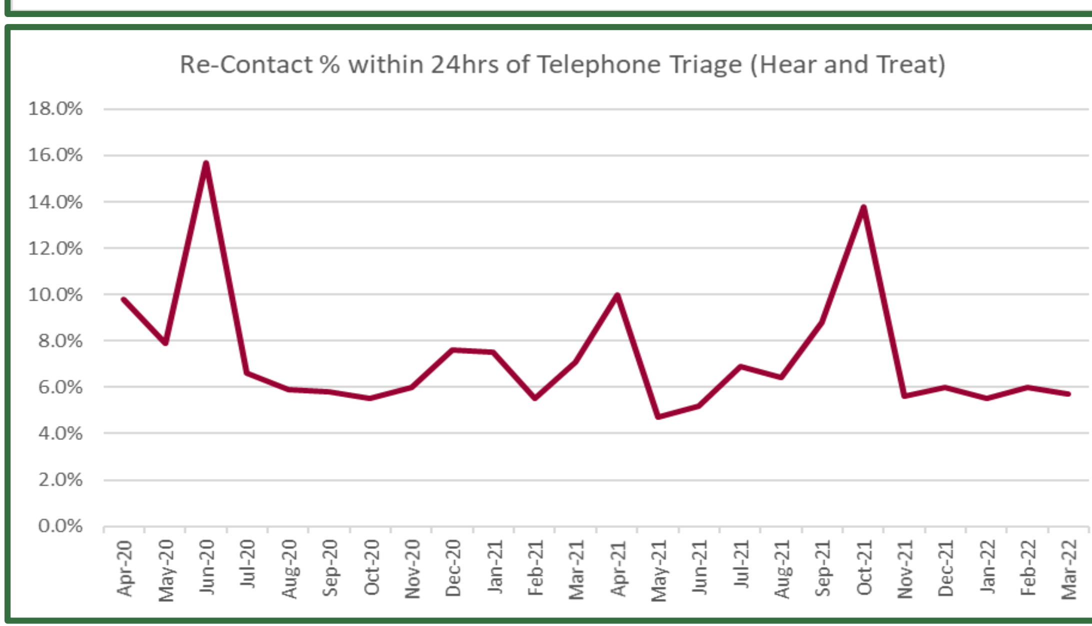


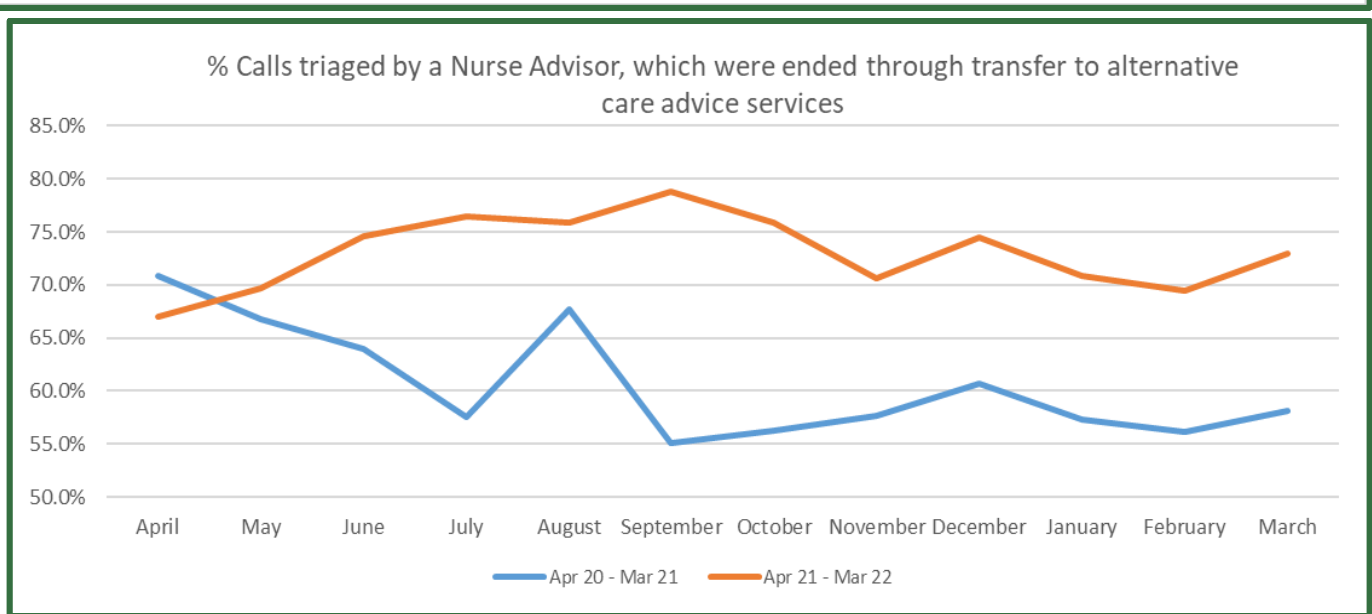


**Analysis**

The **Clinical Service Desk (CSD) and NHSDW (Hear & Treat)** achieved 11.8% performance in Mar-22, therefore continuing to achieve the 10.2% target for the fifth consecutive month.

8.4% of hear & treat volumes were achieved by the CSD in Mar-22. In comparison, 3.4% of hear & treat was by NHSDW/111.

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 Mar-22 were 5.7%** a decrease compared to 6% in Feb-22, this is also a decrease compared to 7.1% in Mar-21.

The percentage of calls triaged by nurse advisor ended through transfer of alternative care advice services decreased month on month to 73% in Mar-22; by comparison, this figure was 58.1% in Mar-21.

**Remedial Plans and Actions**

- The work to implement the findings of the CCC Clinical Review will be the main driver of change and improvement. The predicted impact on hear and treat rates is currently being considered.
- Commissioners have agreed funding for 4 FTE mental health practitioners into the 999 clinical teams which would increase hear and treat rates significantly based on findings of a pilot during the pandemic. Recruitment complete, onboarding in Feb-22.
- Commissioners have also agreed to fund an additional 36 paramedics (achieved) into the clinical service desk, to be backfilled through recruitment of additional EMTs and ACA2s respectively. Work is ongoing to develop the service model in a department that will therefore almost double in size.

**Expected Performance Trajectory**

The current benchmark is 10.2% hear and treat rate. The Trust is developing a trajectory of 15% for 2022/23 as part of the development of the 2022-25 IMTP and associated forecasting and modelling.

# Partnerships / System Contribution
# Conveyance to ED Indicators

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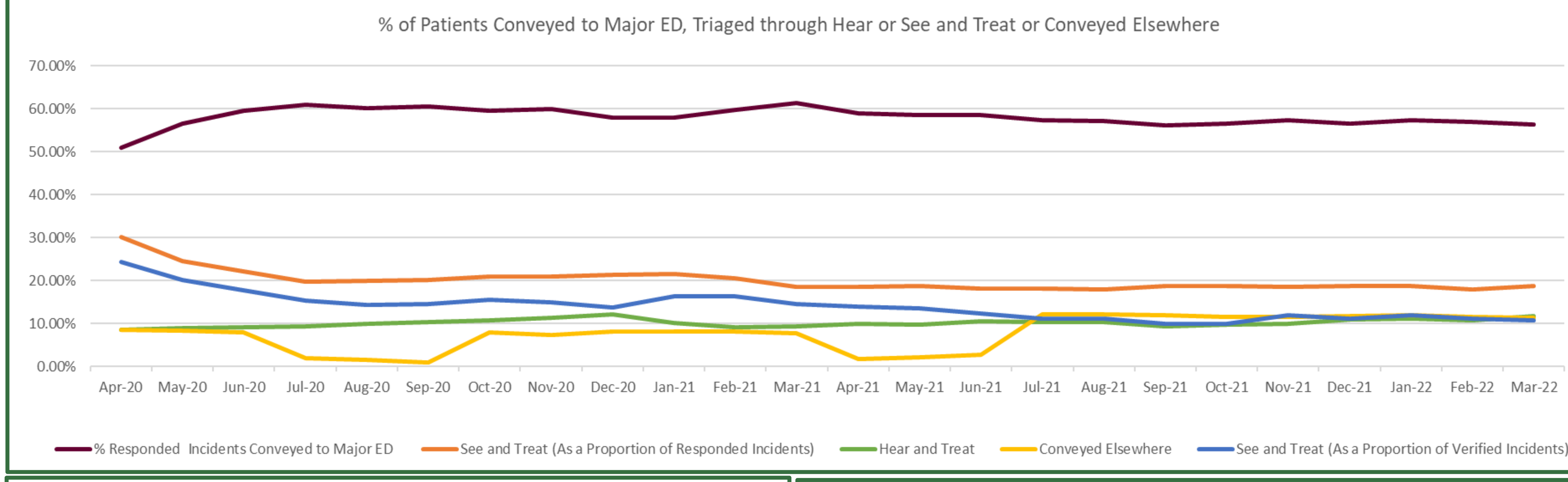
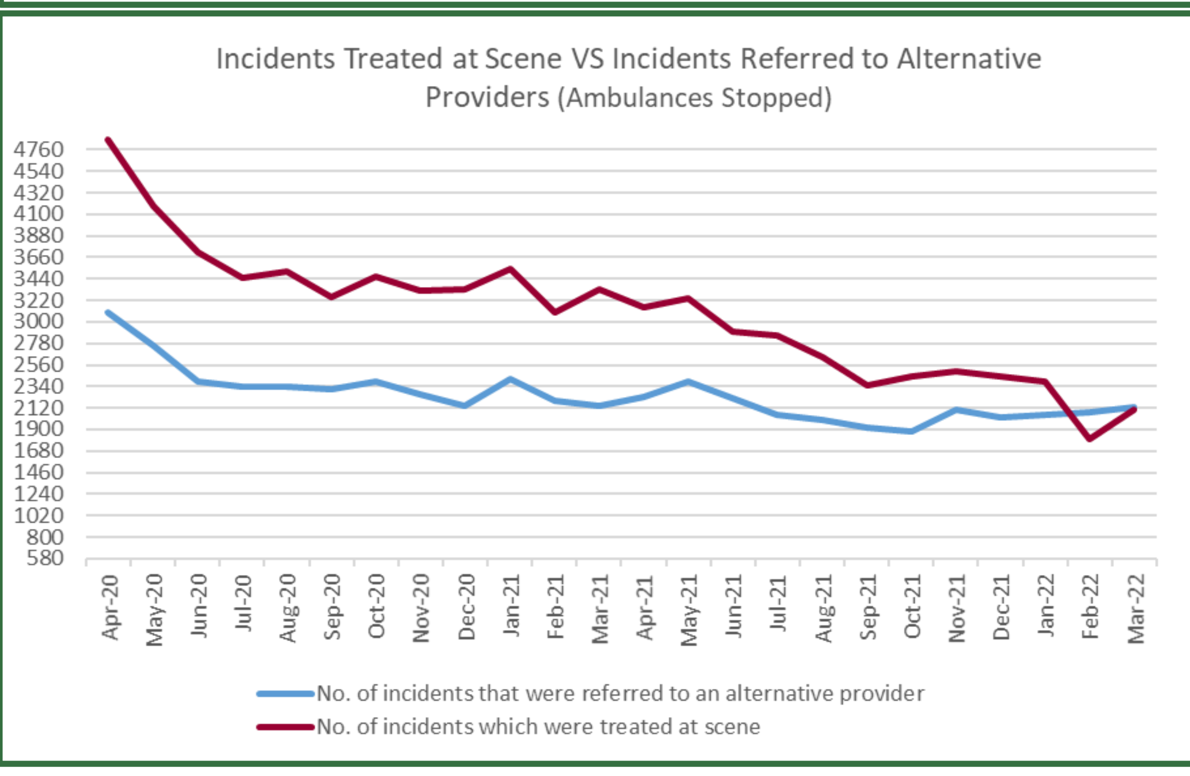
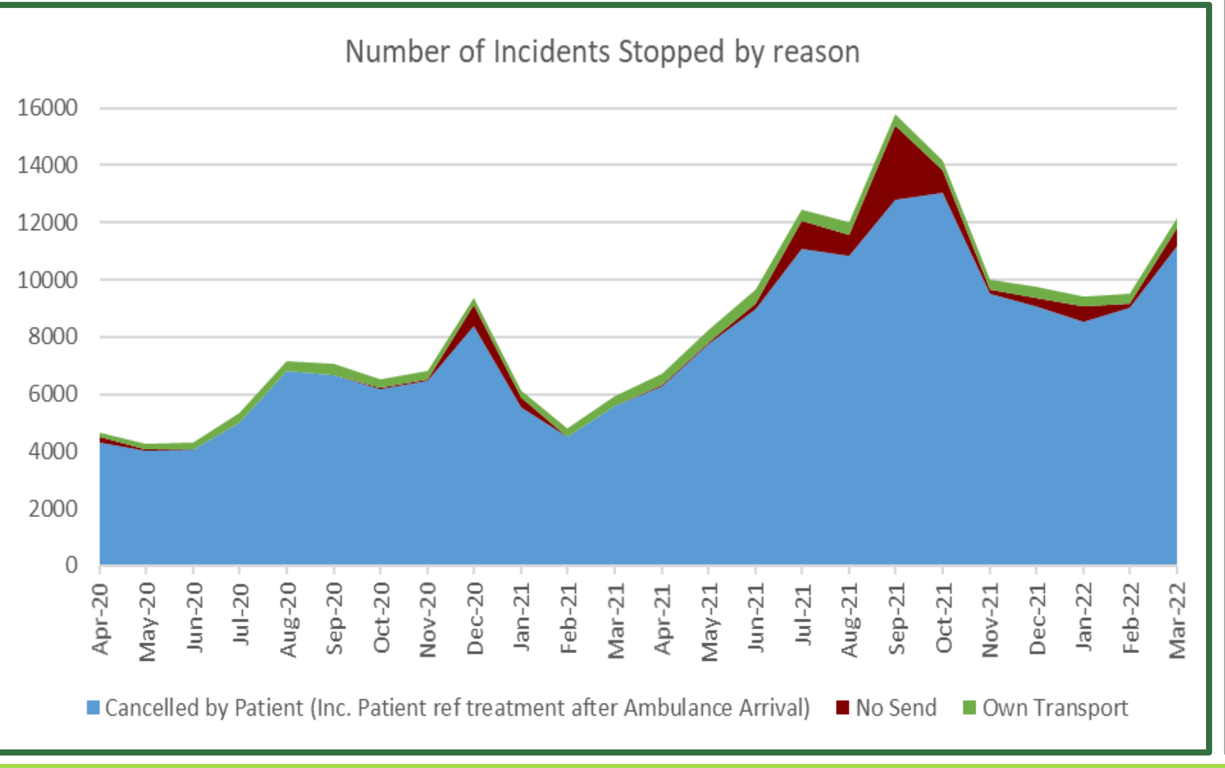



**Analysis**

**The percentage of patients conveyed to EDs decreased (i.e. improved) compared to the same period last year**. In Mar-22 conveyance to EDs as a proportion of total verified incidents was 32.21% (compared to 48.02% in Mar-21).

The combined number of incidents treated at scene and referred to alternate providers increased in Mar-22 when compared to Feb-22. 2,128 incidents were referred to alternative providers in Mar-22 and 2,096 incidents were treated at scene; however, a review of other outcomes (see graph) shows that the number of incidents where there was a no send, patient cancelled or went via their own transport remains an indicator which may mean patients reach hospital via another route. In Mar-22 12,160 ambulances were cancelled by patients, 646 fell in the unable to send category due to the escalation of the Clinical Safety Plan (CSP) and 341 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 Jan-22 (received.

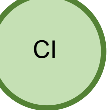
As part of the IMTP and working with partners across the health system. WAST has been asked to lead on the development of a National Respiratory work stream. A four phased proposal has been designed to deliver sustainable service level improvement for respiratory patients across Wales aligned to the 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.

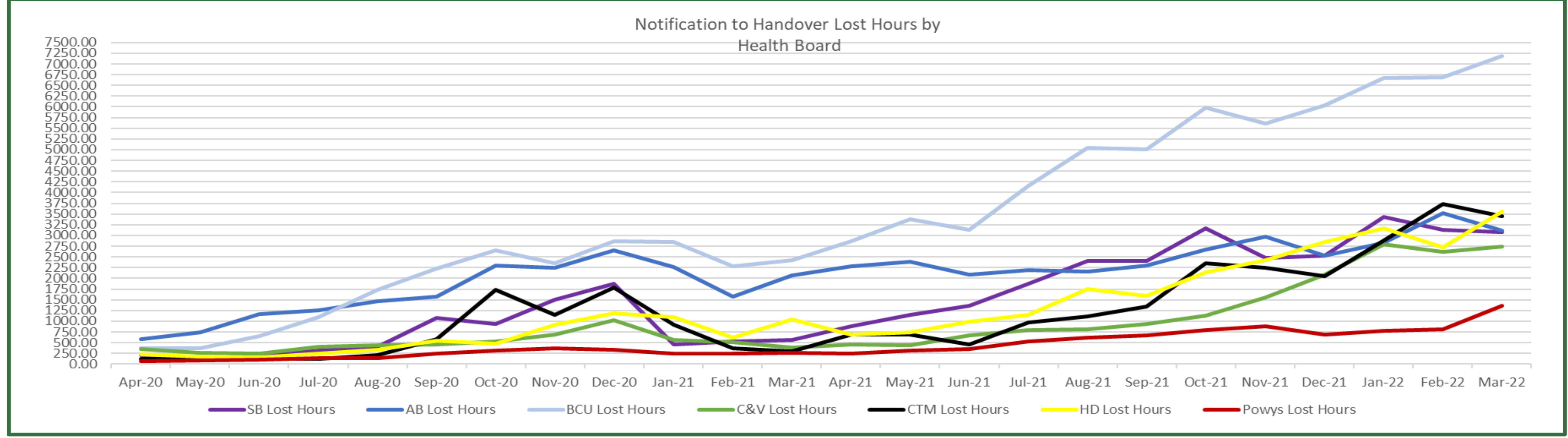
One of our commissioning intentions is to develop an optimising conveyance strategy, which will bring forward clearer proposals linked to further work on the EMS Demand & Capacity Review.

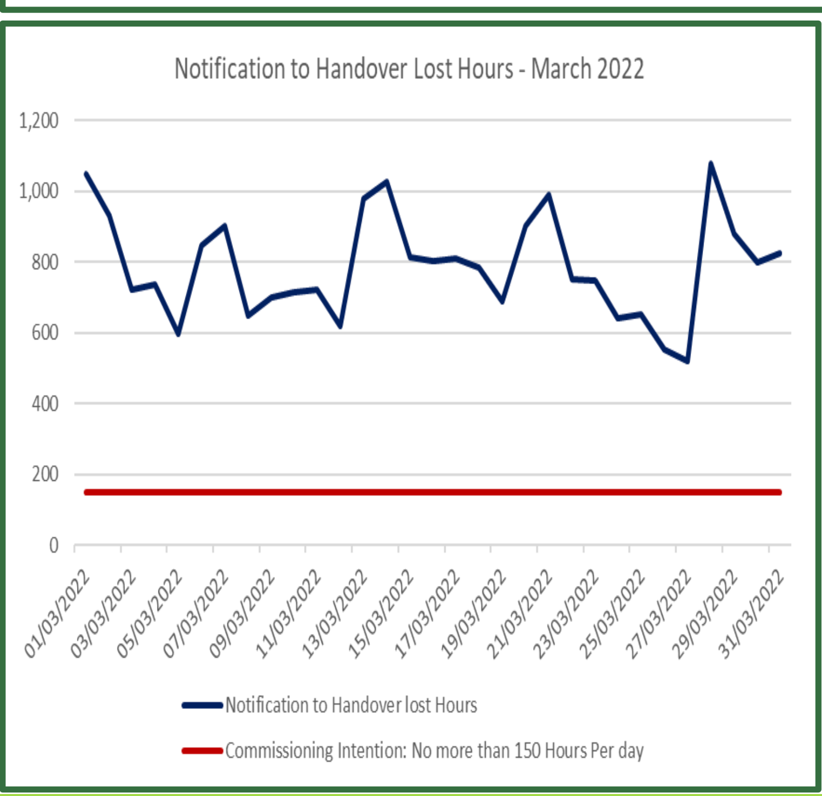
**Expected Performance Trajectory**

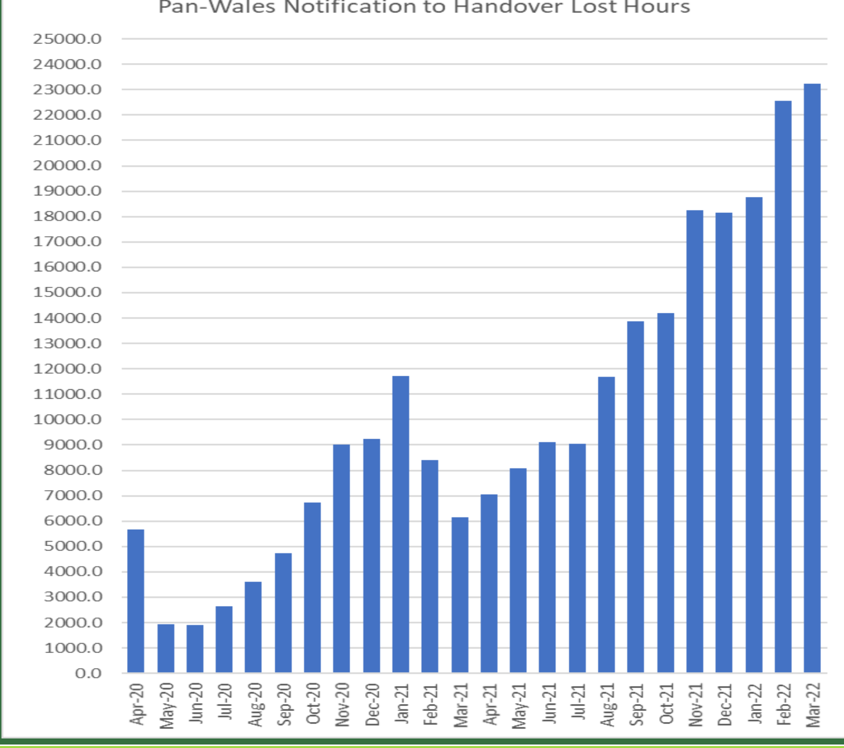
The Trust has completed modelling on a full strategic shift left, which identifies that the Trust could reduce handover levels by c.7,000 hours per month, with investment in APPs and the CSD; however, the modelling indicates that handover would still be at 10,000 hours per month. Health Board changes are required as well..

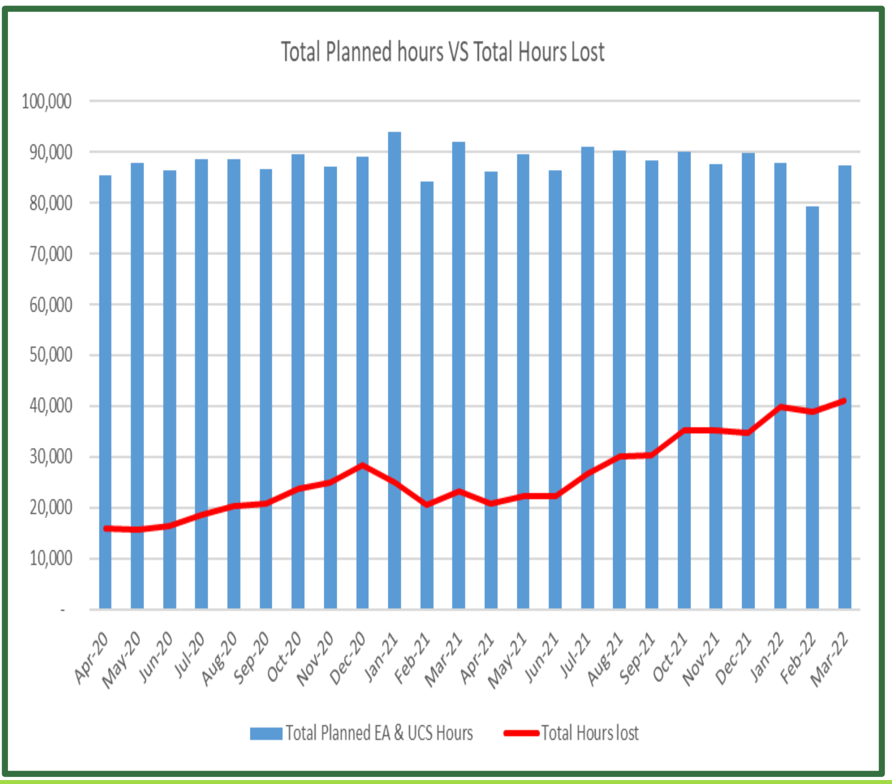
# Partnerships / System Contribution
# Handover Indicators






**Analysis**

**191,461 hours were lost to Notification to Handover, i.e. hospital handover delays, over the last 12 months, compared to 73,123 in same period a year ago (Apr-20 to Mar-21).** 24,479 hours were lost in Mar-22, a 71% increase compared to 7,052 lost hours in Mar-21 and also an increase when compared to 13,820 recorded in Dec-19, the previously worst recorded month, prior to Aug-21. The hospitals with highest levels of handover delays during Mar-22 were Glan Clwyd Hospital Bodelwyddan (BCUHB) at 3,055 lost hours, Morriston Hospital (SBUHB) at 2,745 lost hours, University Hospital of Wales (CVUHB) at 2,557 lost hours and Grange University Hospital (ABUHB) at 2,551 lost hours.

Notification to handover lost hours averaged 788 hours a day in Mar-22, 525% higher than the commissioning intention of no more than 150 hours per day.

**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). 31 ideas have been received through the WIIN platform from staff in Mar-22

**Expected Performance Trajectory**

The NCCU is currently facilitating discussions between each health board and WAST on handover reduction plans and improvement trajectories..

# 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).<br>(NB: The 95th percentile is the value below which 95 percent of the observations may be found. | **Ambulance Response FTEs in Post** | Number of Emergency Medical Services, Full Time Equivalent (FTE) staff working for the Welsh Ambulance Services NHS Trust. |
| **Return of Spontaneous Circulation (ROSC)** | Percentage of patients for whom Return Of Spontaneous Circulation occurs. This refers to signs of restored circulation (more than occasional gasp, occasional fleeting pulse or arterial waveform) evidenced by breathing, a palpable pulse or a measurable blood pressure. | **Ambulance Care, Integrated Care, Resourcing & EMS Coordination FTEs in Post** | Number of Ambulance Care, Integrated Care, Resourcing & EMS Coordination Full Time Equivalent (FTE) staff working for the Welsh Ambulance Services NHS Trust. |
| **Stroke Patients with Appropriate Care** | Proportion of suspected stroke patients who are documented as receiving an appropriate stroke care bundle (a bundle is a group of between three and five specific interventions or processes of caret hat have a greater effect on patient outcomes if done together in a time-limited way ,rather than separately). | **Financial Balance – Annual Expenditure YTD as % of budget Expenditure** | Annual expenditure (Year to Date) as a proportion of budget expenditure. |
| **Acute Coronary Syndrome Patients with Appropriate Care** | Proportion of STEMI patients who receive appropriate care.<br>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 Hear and Treat** | Proportion of 999 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.<br>(NB: An ED provides a wide range of scute in-patient and out-patient specialist services together with the necessary support systems, which allow emergency admissions, and which usually has an Accident and Emergency Department). |
| **Concerns Response within 30 Days** | Proportion of concerns responded to by the complaints team within 30 working days of receiving the concern. | **Number of Handover Lost hours** | Number of hours lost due to turnaround times at EDs taking more than 15 minutes. Transferring the care of a patient from an ambulance to an ED is expected to take no longer than 15 minutes, with a further 15 minutes for ambulance crews to make their vehicle ready for the next call. |
| **EMS Abstraction Rate** | The percentage of Emergency Medical Services (EMS) staff unavailable for rostered duties due to reasons, such as: annual leave, sickness, alternative duties, training, other and CoVID-19. | | |

| Term | Definition | Term | Definition | Term | Definition | Term | Definition | Term | Definition |
|---|---|---|---|---|---|---|---|---|---|
| AB / ABHB | Aneurin Bevan / Aneurin Bevan Health Board | C&V / C&VHB | Cardiff & Vale / Cardiff & Vale Health Board | HIW | Health Inspectorate Wales | NHSDW | National Health Service Direct Wales | RRV | Rapid Response Vehicle |
| AOM | Area Operations Manager | D&T | Discharge & Transfer | HI | Health Informatics | NPUC | National Programme for Unscheduled Care | SB / SBUHB | Swansea Bay / Swansea Bay Health Board |
| APP | Advanced Paramedic Practitioner | 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 | | |
| CTM / CTMHB | Cwm Taf Morgannwg Health Board | HD / HDHB | Hywel Dda / Hywel Dda Health Board | NHS | National Health Service | ROSC | Return Of Spontaneous Circulation | | |

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

# QUALITY STRATEGY HIGHLIGHT REPORT
# QUARTER 4, 2021/22

| **MEETING** | Quality, Patient Experience & Safety Committee |
|---|---|
| **DATE** | 12 May 2022 |
| **EXECUTIVE** | Executive Director of Quality & Nursing (Interim) |
| **AUTHOR** | Assistant Director of Quality & Nursing |
| **CONTACT** | Jonathan Turnbull-Ross<br>07870 382 778<br>Jonathan.turnbull-ross@wales.nhs.uk |

## EXECUTIVE SUMMARY

The report provides a progress update on the implementation of the Trust's Quality Strategy 2021-24.

Over 2021/22, the Trust launched the Quality Strategy and commenced foundational work to enable delivery. This included the conceptual development of a Framework to support the quality management system, recruitment to the People and Community Network and development of a quality leadership structure to embed within service areas. Over Quarter 4, the remaining components of this foundational work has been completed, with the approval of the Quality & Performance Management Framework and the approval of the Senior Quality Lead role job description. Is it expected a majority of the Quality Strategy Implementation Action Plan activities will commence from April 2022.

The report details several challenges to this work, particularly the response to the Omicron and Deltacron wave of the COVID-19 pandemic. Additionally, the report identifies that an emerging risk to delivery of the Strategy is unsecured funding for 4 whole-time equivalent, Band 8A Senior Quality Lead roles - central to plans for achieving the Strategy. Funding for this human resource had been attained through the Chief Ambulance Service Commissioner 'corporate funding'; regrettably, in late 2021/22 the Commissioner announced that this funding would not be provisioned on a recurring basis. The report outlines that whilst opportunities for further funding will be explored, the financial outlook is poor; therefore, posing risk to delivery of the intended Strategy.

**RECOMMENDED: That the Committee notes this report, including the financial challenge that will directly impact strategic delivery.**

## KEY ISSUES/IMPLICATIONS

(i) Unsecured funding from CASC, relating to Senior Quality Lead roles.
(ii) Emerging risk to strategic delivery, due to resource constraints.

| REPORT APPROVAL ROUTE | |
|---|---|
| Executive Management Team | 27 April 2022 |
| Quality, Patient Experience & Safety Committee | 12 May 2022 |

| REPORT APPENDICES | |
|---|---|
| **Annex 1** | SBAR Providing background information. |
| **Appendix 1** | Strategy Implementation Plan |

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

**ANNEX 1**

## SITUATION

1 The report provides a progress update on the implementation of the Trust Quality Strategy 2021-24. The report highlights the continuation of challenges experienced over 2021/22, as a result of the COVID-19 pandemic and highlights risks to the successful implementation of the Strategy as a result of financial implications for the financial year 2022/23.

## BACKGROUND

2 The Trust Quality Strategy 2021-24 launched in May 2021, following a period of development and engagement across stakeholders.

3 The Quality Strategy 2021-24 is aligned to the Trust's Delivering Excellence 2030 vision and complements the organisation's wider strategic plans and priorities. It is recognised that 'quality' is multifaceted and must embed throughout the organisation - it is not a Department or Directorate.

4 In addition to internal ambitions, the Strategy has been driven by legislative requirements for health and care organisations in Wales: The Health and Social Care (Quality and Engagement) (Wales) Act 2020. This places legal duties upon the Trust including, the Duty of Quality, the Duty of Candour and engagement requirements with Wales' Citizen Voice Body.

5 The Strategy provides high-level strategic direction on how the requirements will be achieved through 3 broad underpinning strategic themes that will shape delivery activities supporting progress.

## ASSESSMENT

### Progress

6 At the commencement of the quarter, the Assistant Directors Leadership Team discussed and endorsed the Quality Strategy Implementation Plan. It was also agreed that bespoke actions would be developed and incorporated into the Integrated Medium Term Plan (IMTP) aiding compliance. The finalised IMPT 2022/23 includes foundational actions that will enable progress against the Strategy. Specifically, the Quality & Performance Management Framework, which is essential for strong quality management system.

7 Whilst the Quality Strategy Implementation Working Group was initiated during Quarter 3, operational and staffing pressures have prohibited this forum from operating effectively over Quarter 4.

8 Job descriptions for the Senior Quality Lead role have completed the Workforce Job Evaluation process (14 January - 29 March 2022). It was expected that recruitment would be undertaken from April 2022 however, a significant financial challenge threatens implementation of this role.

## CHALLENGES

**Continued Pandemic Response (Covid-19: Omicron and Deltacron variants):**

9 During the Quarter the Trust continued to manage the demands of the Pandemic through the response phase. This has impacted on the progress of the Quality Strategy delivery in terms of the ability of key stakeholders to engage across the Directorates.

10 The continued pandemic pressures have significantly impacted on progress of the strategic work. On Monday 21 March 2022, the Trust formerly moved into 'recovery' phase of the Pandemic Management Plan. This is a positive development, however, it should be noted continued senior staff engagement with the Business Continuity & Recovery Team (BCRT) (within the pandemic management structure) will be required.

11 The recovery status will continue to impact staff availability for strategic work but will present opportunities to action efforts towards the Strategy deliverables, within the recovery context.

**REAP Level 4**

12 The Trust has escalated to REAP Level 4 within this quarter where non urgent meetings/activities are cancelled, and clinical staff asked to respond on the front line. Essential meetings, those directly contributing towards operational performance improvement, are limited to 60 minutes.

13 The heightened escalation status will impact of staff availability, requiring strategic work to be delivered in an alternative manner, or paused.

**Senior Quality Leads - Funding unsecured**

14 Central to the Quality Strategy ambitions is the embedding of quality leadership, to form a triumvirate *clinical - quality - operational leadership* structure across services and geographical territories. This expert leadership would play a pivotal role in embedding a quality culture and ethos for improvement, act as a guardian for effective Board-to-Floor governance and provide advanced quality management expertise and guidance.

15 This leadership position, termed *Senior Quality Lead*, will ensure responsiveness in dealing with quality, safety and patient experience related issues, enable pro-active and intuitive approach to improvement and further enhance citizen voice partnership within our local services.

16 The Chief Ambulance Service Commissioner (CASC) office advised the Trust that funding for 'corporate' posts would be made available and indeed provisioned in the financial year 2021/22. The Trust provisioned 4 Full-Time, Band 8A posts for this role. Regrettably, CASC has further advised the Trust that funding will not be provided on a recurring basis; subsequently, there is no financial provision for the *Senior Quality Lead* roles through this route.

17 Whilst identification for potential internal funding will be explored, in the context of a significant savings requirement for the financial year 2022/23 (and indication of future financially challenging years ahead) it is unlikely that internal funding will arise within the financial year, nor without wider opportunity cost.

18 This challenge will impact on delivery of the several activities detailed within the Implementation Plan (**Appendix 1**); particularly 7, direct action of which the roles where assigned to lead on. On a more general basis, the roles are an important lever to enable cultural maturation and effective resource expertise and leadership on a local level.

19 The Committee should take assurance that the Quality Strategy is being pursued with all available resources and that the aims of the Strategy remains of priority in attaining compliance with the Act. Noteworthy, is the progress against the Strategy is due for wider commencement from 2022/23, being supported by the foundational work established in 2021/22. Going forward, a significant resource challenge will be experienced, as key roles will not be financially support through commissioned funds. There is a risk that deliverables will not be fully resourced, nor achieve the spread and 'localness' as desired by the intended Strategy.

| Strategic Quality Aims | Strategic Outcome | Strategic Output/Intent | Action | Milestone / Measure | Lead | Complementary Activities | Commencement Date | RAG Status | Progress Update: 2021-22 Q4 |
|---|---|---|---|---|---|---|---|---|---|
| Quality Culture / Duty of Candour | Support a Learning Environment | Psychological Safety | Establish a psychological safety, through the Trust Health & Wellbeing Steering Group | Organisational learning processes, across the organisation (reaching local level) | Joint QSPE/WOD | Leadership and Culture Strategy | 2022/23 Q1 | | |
| | | Appreciation of Complex Clinical Judgements (Person Centred Care) | Embed learning & feedback from incidents and events – establishing processes for shared learning across workforce/organisation (organisational learning) | | | Speak Up Safely' | | | |
| | | Openness to new approaches | | | | | | | N/A |
| | | Resources to support reflection and learning | Suite of support tools and resources supporting reflective practice, and continuous development | Engaging and interactive information and educational content. | Senior Quality Lead Team | - | 2022/23 Q3 | | N/A |
| | Enhancing Knowledge, Skills and Professionalism (Duty of Candour) | Education and Training (Duty of Candour) | **Training package** – Duty of Candour | Development and delivery of training package. | H/o Quality Assurance | Welsh Government Q&S Act Workshops | TBC | | |
| | | | | Proportion of staff participating in training package. | | | | | |
| | | | | Positive review and satisfaction from staff participants. | | | | | N/A |
| | | Day-to-day 'Duty of Candour' implementation | *Process to capture DoC (low, medium and high level activity)* | *TBC* | Senior Quality Lead Team | WG / NHS Wales Delivery Unit – guidance on implementation | TBC | | N/A |
| | Delivering Learning & Improvements | Process and principles in which open, honest and transparent learning is undertaken | Embed enhanced learning, improvement and monitoring within quality management systems | Open, honest & transparent with service users when we have not met expectations | Senior Quality Lead Team | Quality & Performance Management Framework | 2022/23 Q1 | | |
| | | | Development of supporting processes and systems of work that focus improvement towards challenges | | | | | | N/A |
| Qulaity Management System | Quality Driven | Quality is everyone's responsibility | **Training package** – Duty of Quality | Development and delivery of training package. | H/o Quality Assurance | Welsh Government Q&S Act Workshops | TBC | | |
| | | | | Proportion of staff participating in training package. | | | | | |
| | | | | Positive review and satisfaction from staff participants. | | | | | N/A |
| | | | Statement/principle campaign | Formal statement/principle developed | Senior Quality Lead Team | Behaviour and cultural refresh (WOD); Welsh Government Q&S Act Workshops | TBC | | |
| | | | | Aligned to Trust behaviours and cultural refresh | | | | | N/A |
| | | | Celebrating success and exemplars | Continued engagement and communications | Senior Quality Lead Team | - | 2022/23 Q4 | | N/A |
| | | Empower local leaders | Quality Management training/education | Development of training, and information resources | Senior Quality Lead Team; Improvement Advisors | WAST Improvement & Innovation Network (WIIN); Research, Innovation & Improvement Coordination (RIIC) Hub | 2022/23 Q3 | | N/A |
| | | | Establish 'working together' with Senior Quality Leads | Development & introduction of Local Quality Lead role | H/o Quality Improvement | - | 2022/23 Q1 | | |
| | | | | Establish matrix-style Quality expertise for local operational leaders and Regional clinical leaders | | | | | N/A |
| | Integrating Quality Management | Systems that integrate and triangulate data | Establishment of a Quality & Performance Management Steering Group; Establishment of integrated 'governance' forums. | *TBC: Establishment of group, and effectiveness of work programme* | Quaility & Performance Management Frameowrk Steering Group | Quality & Performance Management Framework | 2021/22 Q4 | | |
| | | Collaborative forums for patient and service users | | | | | | | |
| | Strong Governance & Quality Management Structures | Integrating communication | | | | | | | |
| | | Integrating reporting lines | | | | | | | N/A |
| | | Integrated Governance Group | Establish and introduce an integrated, Clinical and Quality Governance Group (CQGG) | Establishment of group; review and evolution of sub-group reporting channels | Assistant Director of Quality Gov. | | 2021/22 Q3 | | |
| | | | Develop reporting and governance channels to local level | | | | | | N/A |
| | | Board to Floor | Development of sub-structure groups to CQGG. | Revised ToR; evolution of sub-groups to inform implemented structures and processes | Assistant Director of Quality Gov. | | 2022/23 Q1 | | |
| | | | Establishment and introduction of a integrated 'governance' forum | Pilot, test and evalutate integrated 'governance' forum; establishment of group (pending evaluation) | | | | | N/A |
| | Accelerating Quality Responsiveness | Reduce turn-around times on quality issues | Establishment of local Senior Quality Leads and local leadership 'ownership' of quality. | Cycle time in management of quality issues | Senior Quality Lead Team | - | 2022/23 Q1 | | N/A |
| | | Issues locally owned and managed | | Count of issues (by complexity) managed within local leadership structures (via Senior Quality Lead Team) | | - | 2022/23 Q2 | | N/A |
| Integrating the Citizen Voice | People & Community Network | Inclusivity | Establish a network representational of the Citizens of Wales, inclusive to all who seeking to be involved | Membership demographic measures | H/o Patient Experience and Community Involvement; Senior Quality Team; Partnership & Engagement; SP&P | - | On-going | | Engagement with communities has continued, with recrutiment of citiziens into the Trust People and Community Network. |
| | | Innovation | Establish and embed work processes to enable Citizens to be contributing and co-producting Trust service development and transformation | *Development of metrics to ensure Citizen voice is integrated within Quality & Performance Management Framework, and Senior Quality Lead Team performance metrics.* | | - | 2022/23 Q1 | | |
| | | Influencing | Embed the Citizen voice as an influencer in Trust decision making and planning | | | | 2022/23 Q1 | | |
| | | Involvement | Provide opportunities for meaningful engagement and involvement in Trust service developments | | | | 2022/23 Q1 | | |
| | Integration of Citizen Voice within Quality cycle (planning) | Effective Citizen participation in service change and delivery | Defined systems and processes that enable measureable/demonstratable integration of the Citizen's voice within Trust service developments, improvements and transformation in the pursuit of enhanced quality of care & experience. | | | | TBC | | |

**Analysis of 'Appendix B' reports, submitted by the Welsh Ambulance Service Trust (WAST)**

**Sponsored by** Cathy Dowling, Assistant Director Quality and Safety, NHS Wales Delivery Unit

**Prepared by** Lee Joseph, Quality and Safety Manager, NHS Wales Delivery Unit

## Purpose of paper

To summarise an analysis of 'Appendix B' reports, submitted by the Welsh Ambulance Service Trust (WAST) to the Health Boards and subsequently the NHS Delivery Unit Quality and Safety Team. The time period in scope is 14 June to 31 November 2021. The analysis focused on identifying any trends or themes of potential patient harm caused by WAST's inability to respond to calls due to NHS Wales system pressures.

## Situation

The current system pressures within NHS Wales continue to impact on WAST's ability to respond to calls in keeping with the prioritisation level, set by WAST dependent on clinical need. Whilst the impact is predominantly seen in WAST's ability to respond to calls within the community setting, it also applies to other WAST routine work such as urgent patient hospital transfers.

'Appendix B' reports are routinely copied to the Delivery Unit (DU) when submitted to the relevant HB/Trust in keeping with the current Framework arrangements. However, analysis by the DU has shown there is currently no correlation between the potential incidents of patient harm outlined within the Appendix B's, and national patient safety incident reporting. This suggests there is a breakdown somewhere in the process of local investigation and national patient safety incident reporting, after Appendix B's have been generated. Whilst not all incidents where an Appendix B has been generated will reach threshold for national reporting, in accordance with the Welsh Government (WG) National Patient Safety Incident Policy, i.e. severe harm or death, assessment of the information contained within the Appendix B's does make it highly likely that preventable harm, including severe harm and/or death is occurring, but not being reported nationally, and or potentially investigated appropriately in accordance with national regulations and policy.

## Background

In 2019, a joint investigation framework was jointly developed between all Health Boards, Trusts and WAST, to provide a clear and consistent approach to the identification, reporting, investigation and closure of incidents meeting criteria, as set out by Welsh Government in relation to what was then classified as 'serious incidents' (*Framework for the investigation of Patient Safety Serious Incidents (SIs), July 2019, V2.2*). The Framework was developed to consider all potential serious incidents (SIs) reported by the Welsh Ambulance Services NHS Trust (WAST) via their internal Serious Case Incident Forum (SCIF).

Once developed, the framework (**See in attachments**) was presented and approved for use through the following forums:

- All Wales Task and Finish Group (Assistant Director level)
- Head of Patient Experience Network;
- WAST – Quality Steering Group;
- Directors of Nursing forum NHS Wales; and,

- WAST Quality, Patient Experience & Safety Committee

The key purpose of the Framework, which remains in operation, is to "define the investigation Framework in the event of a Patient Safety SI related to handover delays at Health Board sites, which affects one or more health body in Wales". The Framework describes how the NHS in Wales will respond to patient safety SIs relating to extended delays in patient handovers and, where extended delays adversely impact patients within the community awaiting a response. The Framework sets out the mechanism by:

- Which organisation will take primacy for Advising Welsh Government (WG) of the SI;
- Which organisation will undertake the lead for the investigation and subsequent actions in
- accordance with the above mentioned Regulations and identify system wide learning; and,
- Which organisations will be required to support and contribute to the investigation
- This document is aligned with and supported by existing Health Boards and the WAST processes for investigating SIs.

The scope of the Framework relates to patient safety SIs arising from:

- Delayed patient handover at Health Board sites; and,
- Patients within the community awaiting a response due to delayed handovers.

From a WAST incident management perspective, the Framework states; "If the root cause of the suspected SI is primarily the result of, or attributed due to the delay in patient handover at hospital sites, the incident will be transferred to the relevant HB/Trust for investigation, and where appropriate, closed on Datix, and, the details of the incident will be passed to the appropriate lead HB/Trust, and the relevant documentation for this is set out in Appendix B: Incident Referral Form", hence the 'Appendix B' reporting process. The DU (and formally WG) are automatically sent a copy of all Appendix B's sent to HB/Trusts by WAST for information purposes.

## Assessment

To inform this assessment, the DU reviewed 85 Appendix B incident's, copied to the DU as part of process, between June and November 2021. The findings are set out in table 1 below:

**Table 1**

| Information | Total Number N=85 | Percentage |
|---|---|---|
| Outcome is death | 71 | 84% |
| Recognition of life extinct on arrival (ROLE) | 61 | 72% |
| Initial grading Red | 3 | |
| Initial grading Amber 1 | 64 | 75% |
| Total number upgraded following patient deterioration | 57 | 67% |
| Number upgraded to red following patient deterioration | 46 | 54% |
| WAST operational contributory factors identified | 0 | 0% |

| Number converted to National Reportable Incidents | 0 | 0% |
|---|---|---|
| **Response Times N=15** | | |
| Average response time for Amber 1 | 6 hours 29 minutes | |
| Average response time once upgraded to red | 6.5 minutes | |

Given that in 71 (84%) of cases the outcome has been death, with the vast majority of these deaths occurring prior to WAST arrival, the data indicates that the window of opportunity to provide medical assistance to seriously unwell patients in the community, classed as Amber 1 calls, is being routinely missed, and likely on the balance of probability to be a causative factor in the timing of patients death, given they were alive at the initial call but deceased upon arrival 6.5 hours later (on average).

There is clear evidence in the Appendix B's which show how patients are deteriorating over time resulting in several additional calls for assistance, eventually with symptoms resulting in a life threating condition. Even in cases where death would have occurred in any event regardless of response time, the Appendix B's illustrate a significant patient experience shortfall, particularly in regard to symptom control and management for these patients suffering a natural end of life acute medical event.

Detail within some of the Appendix B's, such as patient profile and presenting medical complaint, does however indicate that cases of severe avoidable or/and or unexpected harm, which has been caused or contributed to by action or inaction of NHS funded care, in keeping with national patient safety incident policy, is likely to have occurred on a number of occasions. However, analysis of nationally reported incidents since the 14 June 2021 finds no correlation between the Appendix B's submitted by WAST to HB/Trusts, and nationally reported patient safety incidents. This confirms that the management of such incidents is not in keeping with WG national policy.

The most common contributory factor detailed in the Appendix B is handover delays, where WAST resources are delayed in handing over patients upon at hospital sites in keeping with nationally agreed handover timescales. No WAST organisational or operational contributory factors were identified in any of the N=85 cases reviewed. This finding is however not unexpected given the purpose of the Appendix B referral process (incidents relating to extended delays in patient handovers and, where extended delays adversely impact patients within the community awaiting a response). Analysis of national patient safety incidents reported since 14 June 2021 confirms that WAST actively report other patient safety incidents nationally where handover delays have impacted upon response times, but also where they have identified internal causative factors such as control room errors, and other lost unit hour production (UHP), such as meal breaks and staffing resource availability amongst others.

Intelligence gathered from conversations with all organisations including WAST indicates that whilst organisations remain committed to the principles of the Framework, operational and cultural influences such as 'blame' and responsibility for patients waiting in the community for care, are barriers to affective investigations and reporting. There is also evidence of learned helplessness that the system pressures make investigations less valuable because the same causative effects exist. However, without a proportionate and questioning investigation approach, it is likely learning opportunities are being missed, notwithstanding a substandard response to patients, families and staff who will be impacted.

Whilst the Framework, commonly referred to as the Joint Investigation Protocol (JIP) remains operational, there have been national policy changes with regards to 'Serious Incident' management, which have occurred since the Framework was developed. The Framework, which was scheduled for review in September 2020, still refers to the reporting and management of SIs in keeping with the National Health Service (NHS) (Concerns, Complaints and

Redress Arrangements) (Wales) Regulations (referred to as the Regulations), and the Putting Things Right (PTR) supporting guidance on dealing with concerns about the NHS (version 3). However, changes to the management and reporting of patient safety incidents occurred on the 14 June 2021 with the introduction of a new WG National Patient Safety Incident policy, which dropped the use of Serious Incident (SI) terminology, instead referring to such incidents as 'Nationally Reportable Patient Safety Incidents'. The Framework is no longer consistent with national policy and arrangements.

**In summary**

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 are not being adequately investigated and reported nationally, and in keeping with either the previous WG national policy and guidance regarding patient safety incidents, or the updated policy since 14 June 2021. The Framework is no longer in keeping with national policy requirements.

A breakdown in communication, and the intended collaboration between WAST as the identifying organisation, and HB/Trusts as the commissioning organisations, is resulting in Appendix B's not being adequately investigated and reported nationally where applicable. National data on the harm being caused by system pressures, impacting on WASTs ability to respond and treat seriously unwell patients in the community, is not being captured. Therefore, learning opportunities to improve patient safety, and reduce adverse harm, notwithstanding the system pressures, is being lost.

## Recommendations

- A task and finish group is established to revisit the Framework to ensure the process is fit for purpose, and consider how best to reflect current national policy regarding patient safety incidents. This should include how incidents are reported in keeping with national reporting policy and responsibilities, and what minimum information sharing standards will be set, as to ensure comprehensive investigation are conducted.
- The task and finish group should be coordinated by the Emergency Ambulance Services Committee (EASC), as the body responsible for the delivery of WAST services, and the commissioning arrangements between WAST and HB/Trusts. The DU will support the process to ensure alignment with national policy requirements
- Internal governance – WAST and EASC will update their relevant Committee/Board
- The NHS Delivery Unit Quality and Safety Team will seek assurances from Nurse Directors/HB that they have assessed all their Appendix B since June 2021 to determine if they meet national reporting patient safety threshold

**Attachments**

191023 - Framework for the investigation o

| AGENDA ITEM No | 13 |
|---|---|
| OPEN or CLOSED | OPEN |
| No of ANNEXES ATTACHED | 1 |

# EXECUTIVE DIRECTOR OF QUALITY AND NURSING PATIENT SAFETY HIGHLIGHT REPORT

| MEETING | Quality, Patient Experience and Safety Committee |
|---|---|
| DATE | 12 May 2022 |
| EXECUTIVE | Executive Director of Quality & Nursing (Interim) |
| AUTHOR | Head of Patient Safety, Concerns and Learning (Interim) |
| CONTACT | Stephen Johnson<br>07545507755<br>stephen.johnson2@wales.nhs.uk |

## EXECUTIVE SUMMARY

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

In summary the report for this quarter identifies:

- A continued increase in verified calls into the Trust during this reporting period, particularly in 111.
- 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.
- A reduction in Red performance.
- Increase in cases taken to Serious Case Incident Forum (SCIF) which has resulted in a large proportion of incidents being shared with Health Boards under the Joint Investigation Framework.
- An increase in clinical negligence cases with an unprecedented number currently open.
- A decrease in the number of personal injury claims received but they are of a more complex nature.
- A decrease in Coroners enquiries this quarter, however the overall volume remains high in comparison to pre Covid volume.
- The Trust has received and responded to 2 Regulation 28 (Prevention of Future Deaths) reports from Coroners in South Wales.
- The additional finance received to support the PTR Team for the winter period ended on 31 March 2022.

**RECOMMENDED: That the Quality, Patient Experience & Safety Committee receives this report for assurance and discussion.**

| KEY ISSUES/IMPLICATIONS |
|---|
| • There continues to be an increase in the majority of areas in PTR.<br>• There continues to be a steady volume of concerns being received.<br>• Compliance with the 30-day formal response target across the quarter has improved slightly but the 2-day acknowledgment achieved target remains low due to vacancies. This should improve once the positions are backfilled.<br>• A continued increase in the volume of concerning patient safety incidents being reported. |

| REPORT APPROVAL ROUTE | |
|---|---|
| Executive Management Team | 27 April 2022 |
| Quality, Patient Experience & Safety Committee | 12 May 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 | 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 |

**ANNEX 1**

| PUTTING THINGS RIGHT | | | | | | |
|---|---|---|---|---|---|---|
| | Quarter 3, 21-22 | | | Quarter 4, 21-22 | | |
| | Oct 2021 | Nov 2021 | Dec 2021 | Jan 2022 | Feb 2022 | Mar 2022 |
| **Patient Safety Incidents** | | | | | | |
| Catastrophic | 14 | 8 | 30 | 12 | 26 | 37 |
| Major | 2 | 0 | 0 | 0 | 1 | 6 |
| Moderate | 2 | 5 | 5 | 1 | 3 | 7 |
| Minor | 24 | 22 | 30 | 15 | 33 | 23 |
| No Harm/Hazard | 440 | 377 | 344 | 372 | 367 | 403 |
| Total | 497 | 415 | 421 | 407 | 440 | 499 |
| **Concerns** | | | | | | |
| Total Received | 116 | 65 | 75 | 72 | 59 | 107 |
| Total Closed | 127 | 118 | 108 | 72 | 108 | 73 |
| 2 Day Acknowledgment % | 43% | 23% | 29% | 34% | 22% | 14% |
| 30 Day Response due % | 47% | 56% | 70% | 66% | 64% | 76% |
| **Ombudsman** | | | | | | |
| Cases Received | 4 | 2 | 5 | 2 | 4 | 4 |
| Cases Closed | 5 | 1 | 1 | 3 | 5 | 2 |
| Reports Received | 0 | 0 | 0 | 0 | 1 | 0 |
| **Coroners** | | | | | | |
| Information request | 76 | 90 | 110 | 96 | 95 | 106 |
| Identified as Interested Party | 11 | 10 | 11 | 12 | 12 | 17 |
| Staff attending | 7 | 5 | 5 | 6 | 5 | 5 |
| Regulation 28 issued | 0 | 0 | 0 | 0 | 2 | 0 |
| Response to Regulation 28 in 56 working days | 0 | 0 | 0 | 0 | 0 | 2 |
| Response to Regulation 28 outside 56 working days | 0 | 0 | 0 | 0 | 0 | 0 |
| **Nationally Reportable Incidents (NRIs) to Delivery Unit (reporting date)** | | | | | | |
| Serious Case Incident Forums held | 7 | 7 | 6 | 5 | 6 | 7 |
| Serious Case Incident Forums Cases | 56 | 43 | 44 | 22 | 35 | 47 |
| WAST NRIs reportable to Delivery Unit | 7 | 9 | 4 | 5 | 2 | 7 |
| Incidents reviewed at SCIF and reported under the Joint Investigation Framework | 26 | 30 | 23 | 18 | 17 | 7 |
| NRI Closures Submitted - Total | 0 | 0 | 5 | 6 | 7 | 7 |
| NRI Closed by DU - Total | 0 | 1 | 0 | 0 | 0 | 5 |
| **Claims** | | | | | | |
| Personal Injury - Received | 3 | 0 | 1 | 0 | 4 | 3 |
| Personal Injury - Closed | 0 | 0 | 0 | 0 | 0 | 19 |
| Clinical Negligence - Received | 0 | 2 | 2 | 2 | 0 | 5 |
| Clinical Negligence - Closed | 0 | 1 | 1 | 0 | 0 | 0 |
| Road Traffic Collision & Damage to Property – Received | 12 | 20 | 25 | 30 | 31 | 26 |
| Road Traffic Collision & Damage to Property – Closed | 16 | 18 | 23 | 29 | 17 | 21 |

## SETTING THE CONTEXT FOR THIS PERIOD

1 During Quarter 4 (January - March 2022), the Trust's verified incidents were 111,076 compared to 106,177 for the same period last year. For the same periods, 111 call volumes were 254,093 and 148,962 respectively.

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

(i) Red - 9,916 compared to 6,939
(ii) Amber - 79,129 compared to 74,952
(iii) Green - 22,031 compared to 24,286

3 Overall total verified incident demand saw a 4.4% increase in Quarter 4 compared to the same period the previous year.

4 The Trust lost a total of 70,027 hours to notify to handover delays across this quarter, which is a significant increase when compared to the previous quarter (October - December 2021). Red performance remains a challenge and the 65% target has not been achieved for 20 months. In Quarter 4 the Trust achieved 52.5% in January, 55.0% in February and 51.1% in March, therefore continuing to fall below the 65% target. This performance percentage was lower than the same periods in 2021, 59.6%, 64.4% and 62.5% respectively.

5 During this quarter, the number of patients attended in the Red category was 9,804 compared with 6,901 in 2021. March saw the largest variation with 3,552 Red responses in 2022 compared to 2,450 in 2021, which is an increase of 31%.

6 Amber median performance during Quarter 4 was 1 hour 2 minutes (39 minutes), 1 hour 17 minutes (30 minutes) and 1 hour 43 (36 minutes) respectively. The figures in brackets are for the same period in 2021.

## SITUATION

7 This Patient Safety Highlight Report covers the period of 1 January - 31 March 2022 and also provides a retrospective analysis of data for the same period last year in key areas.

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

9 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

10 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
(ii) Concerns (including political)
(iii) Ombudsman
(iv) Coroners
(v) Nationally Reportable Incidents (previously Serious Adverse Incidents - SAIs)
(vi) Claims
(vii) Key achievements and Learning

11 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.

12 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.

13 In line with the new reporting changes the work to integrate the Integrated Performance Report (IPR) and the Quality Assurance Report continues.

14 Following the agreement in September 2021 for additional funding to bolster the PTR administrative and patient safety functions, the team recruited a Patient Safety Manager which ended on 31 March 2022. The overtime granted to the team to assist with the registration of concerns and other PTR functions also ended on 31 March 2022.

15 In addition to the above we have backfilled the vacant Patient Safety Manager position in North Wales and recruited an additional substantive Patient Safety Manager and an Investigation Supervising Officer for 111. Further to this we have recruited a Patient Safety Manager until 31 May 2022 to backfill the Patient Safety Manager who is acting up as Interim Head of Patient Safety, Concerns and Learning.

16 The Legal Services Team has identified a suitable applicant for the vacant Claims Investigation Officer position, and they have been offered a substantive position. In addition to this, it has been agreed the secondment for the Claims Investigations Coordinator is to be extended until 31 December 2022.

17 The volume of incidents and concerns received during this quarter have remained at an escalated level. The Serious Case Incident Forum (SCIF) Panel continues to meet twice weekly in order to accommodate the number of potentially serious incidents/Appendix B being received.

18 The number of Declined Immediate Release Requests remains an ongoing concern as previously reported, with varying levels of response across Health Boards.

19 Due to the continued increased demand on the Trust, the capacity of Clinical Contact Centre and 111 staff to carry out welfare checks for extended wait patients remains an ongoing issue. A review of the Welfare Standard Operating Procedure (SOP) has been undertaken within the Clinical Contact Centre (CCC) in order to provide clarity to staff on the process expected of them.

20 The Service Manager within CCC has raised concerns over the number of additional rules Emergency Medical Dispatchers (EMDs) are required to remember within Medical Priority Dispatch System (MPDS), which are not completed within the scripting process. This is a potential risk when prioritising patients who call the service.

21 There are still concerns regarding the high number of potentially catastrophic incidents the Patient Safety Team are reviewing and the number of incidents requiring presentation at the SCIF. The majority of these incidents relate to hospital handover delays.

22 The SCIF Panel has reviewed a number of incidents where patients and their families have elected to travel to hospital in their own transport when faced with long delays, and subsequently the patient has passed away following arrival at hospital. This highlights the ongoing significant risk to patients in the community due to delays and the Trust's ability to respond in a timely manner.

23 During this quarter we were, at times, in receipt of +250 Military Personnel.

24 The Trust averaged an abstraction rate of 44% compared to the target of 30% driven by COVID-19 with sickness absence at 14% compared to the target of 5.99%.

25 Under normal circumstances this would have led to a significant failure to produce Emergency Ambulance (EA) unit hours production (target 95%) so we may have seen a drop below 80%. Instead, we achieved an average of 106% for the quarter due to the support received from the Military.

26 Despite the very high level of ambulance production, the level of handover lost hours has been so extreme it has offset any gains. In March 2022 the handover lost hours were 400% above the modelled position in the Emergency Medical Service (EMS) Demand & Capacity Review. The Trust lost 29% of its conveying capacity to hospital handover delays in March 2022.

## ASSESSMENT

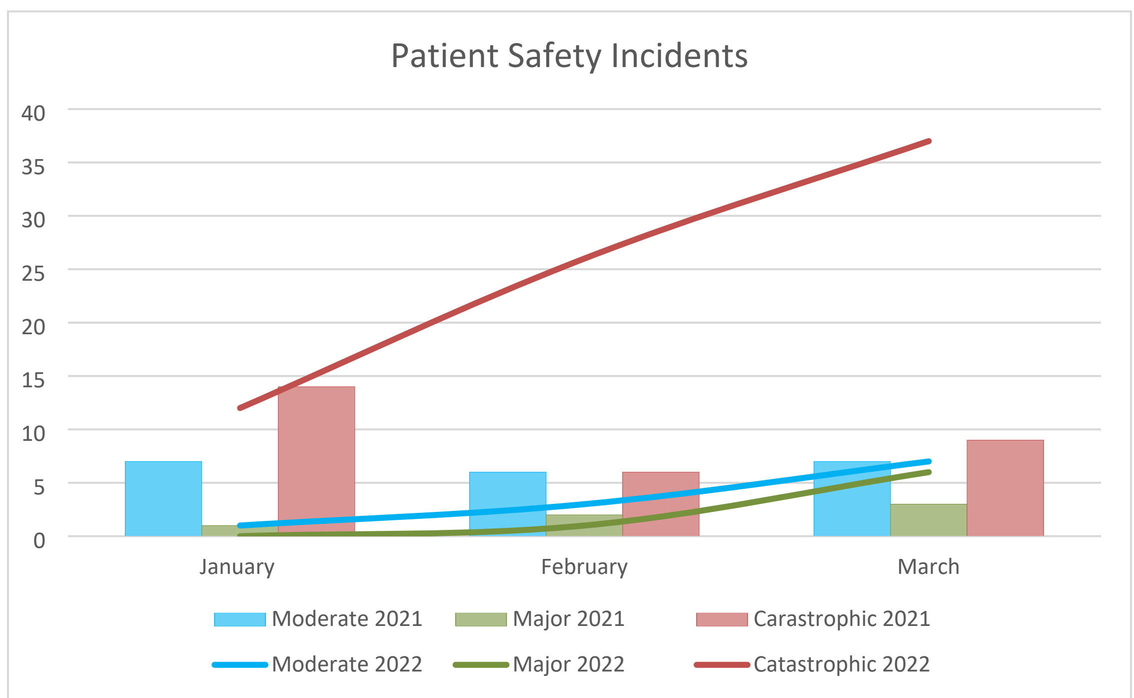
### Patient Safety Incidents

27 **Adverse Incidents 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 Welsh Ambulance Services NHS Trust (WAST) or whether it was due to the patient's underlying medical condition.**

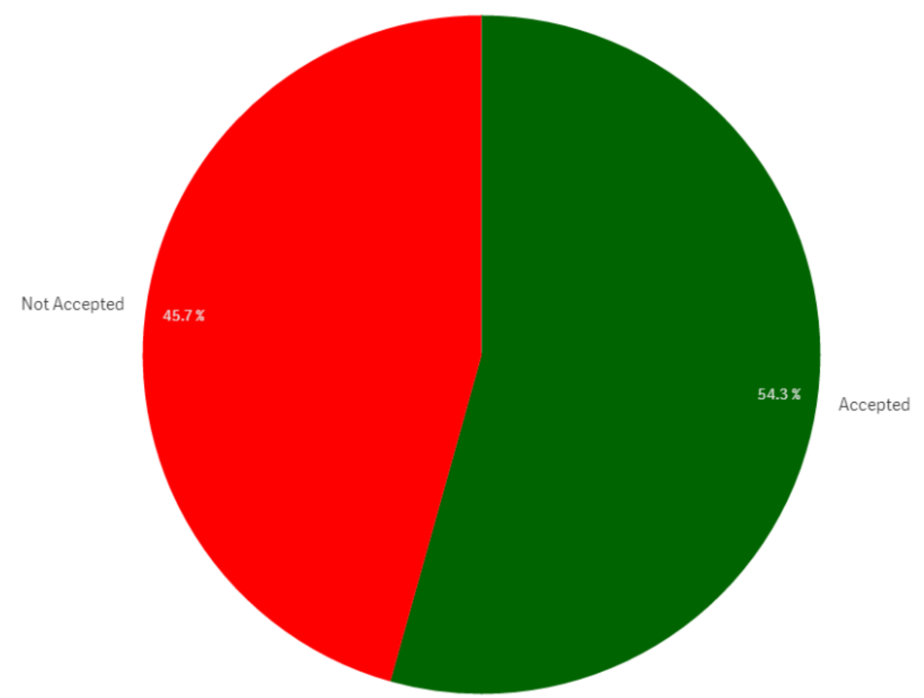
28 Safe organisations are organisations that promote adverse incident reporting especially when there is possibility of harm. This provides the Trust with an opportunity to learn from such events in order to prevent a re-occurrence.

29 During this period a total of 1,346 patient safety incidents were reported, 407 in January, 440 in February and 499 in March. This is a significant increase in comparison to the same period last year where there were 750 incidents reported. All incidents with an initial harm grading of moderate, severe or catastrophic are reviewed weekly by the Patient Safety Team prior to final upload to the National Reporting and Learning System (NRLS). **It must be noted that the harm grading may change subject to the conclusion or outcome of any investigation.**

30 The chart below illustrates a comparison between January - March 2020/21 and 2021/22, following the submission of the Datix by the reporter:



31 During the quarter 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%). This is illustrated in the chart below:




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

Key Definitions:

- Early Resolution - 2-day Key Performance Indicator (KPI) (previously an on the spot concern).
- Local Resolution - Although dealt with under the Regulations they do not require a formal Regulation 24 letter of response. Local resolution can be achieved by telephone, email or a face to face meeting. The spirit of the Regulations must be followed and the complainant must be satisfied with the response.
- Formal - This requires a formal letter of response, as required under the Regulations. These are currently signed off by the Chief Executive Officer, following quality assurance of the investigation and letter. The Key Performance Indicator (KPI) is 75%, which requires the closure of the response letter.

32 The Putting Things Right (PTR) Department continues to receive a steady number of concerns within this reporting period (238). This is an increase in comparison to the same reporting period last year where 163 concerns were received.

33 As of 6 April 2022, there were 125 open concerns (excluding Complex Case Panel) with 27 in backlog, which is an increase on the number of open concerns but a decrease on the number in backlog.

34 During this reporting period the 2-day acknowledgement performance was 34%, 22% and 14% (97%, 100% and 100%) with the 30-day target achieving 66%, 64% and 76% (75%, 70% and 78%) respectively.

35 The average across this period is therefore 23% for 2-day acknowledgement and 69% for 30-day target. The figures in brackets are for the same reporting previous in 2020/21.

36 Following on from the unprecedented pressures of the last quarter, this reporting period has remained busy with the volume of concerns remaining steady. Together with the staff vacancies it has meant that registering concerns in a timely manner has been a challenge. The 2 vacant Concerns Administrator posts for PTR are now out to advert closing on 18 April 2022, this will provide more resilience in registering concerns within the 2-day target deadline.

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

**Ombudsman and Political Investigations**

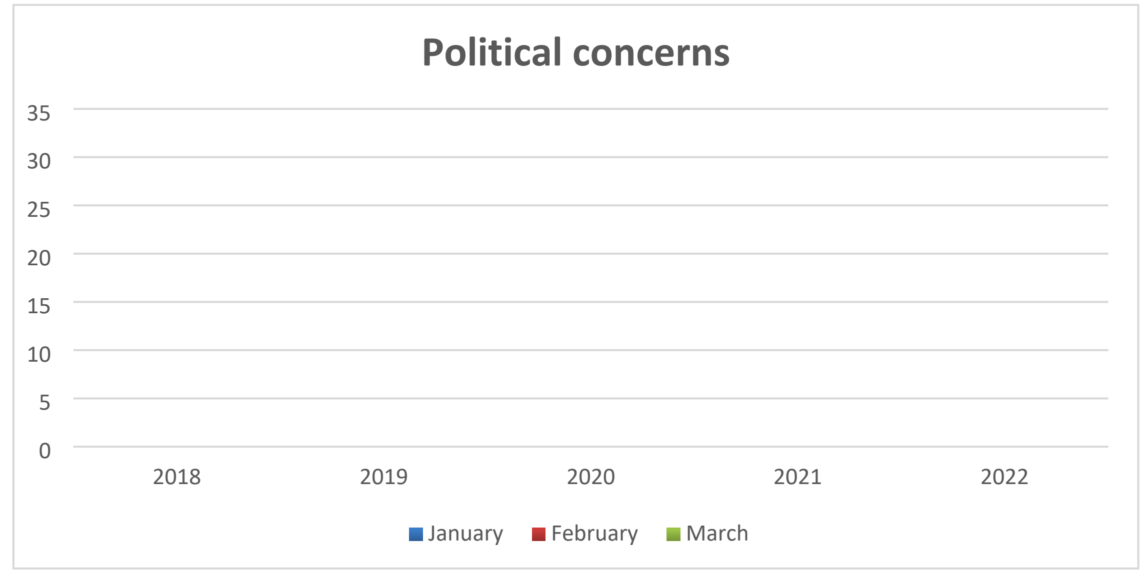
38 There are currently 16 open Ombudsman cases. There remain 2 cases where the Trust is preparing the documentation to share with the Public Service Ombudsman for Wales (PSOW) at the start of the investigation.

39 There remain several cases where the Trust has supplied evidence to the PSOW and is awaiting receipt of a draft report.

40 There have been 2 approaches to the Trust to supply documentation, where there are no concerns regarding the Trust. These requests have been around patient care and have been cases where we have seen delays in responding and patient's being delayed outside of hospital.

41 During the reporting period we have only received 1 final report that did not uphold the complaint against the Trust.

42 The table below illustrates the volume of political concerns received comparing the same periods over the past 5 years:



43 This quarter has seen a decrease in the number of political concerns being received. Of the 28 new concerns, 9 relate to an issue other than the timeliness of EMS responses *(figure correct at the time of reporting)*. 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:

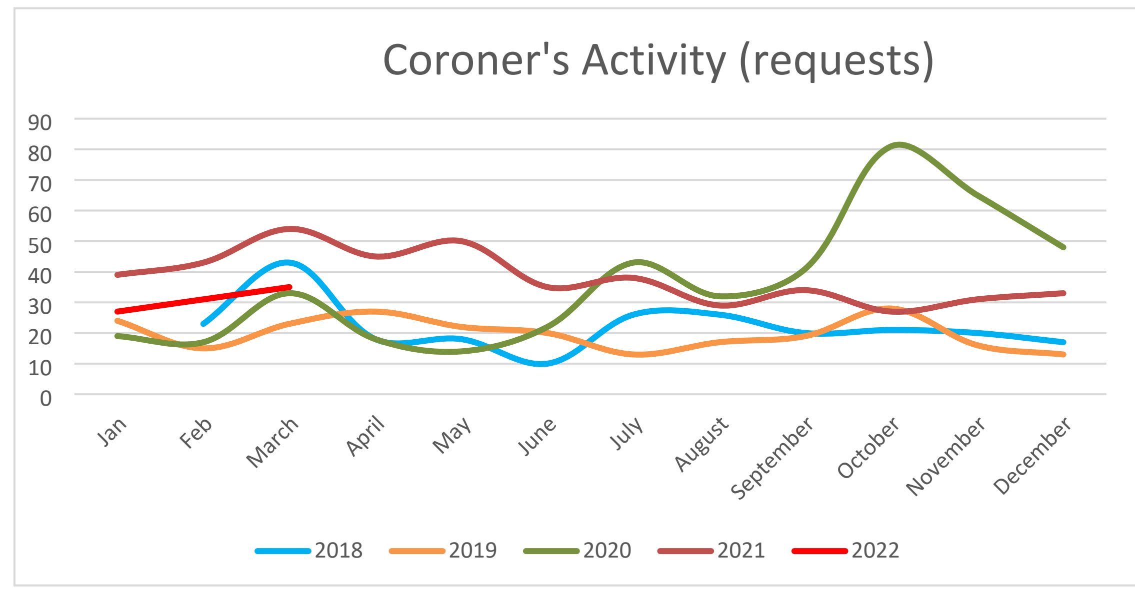
- Rapid Response Vehicle (RRV) cover within an area.
- Non-Emergency Patient Transport Services (NEPTS) bookings.
- 111 services.

44 There are currently 20 open political concerns.

**Coroner's activity**

45 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.

46 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 witness, 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:




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

(i) **BY** - The Trust was not a party to the Inquest. The incident occurred in July 2021. There was a 3-hour response time to an elderly patient who had fallen down the stairs. The Coroner requested that the Trust considered 2 issues:

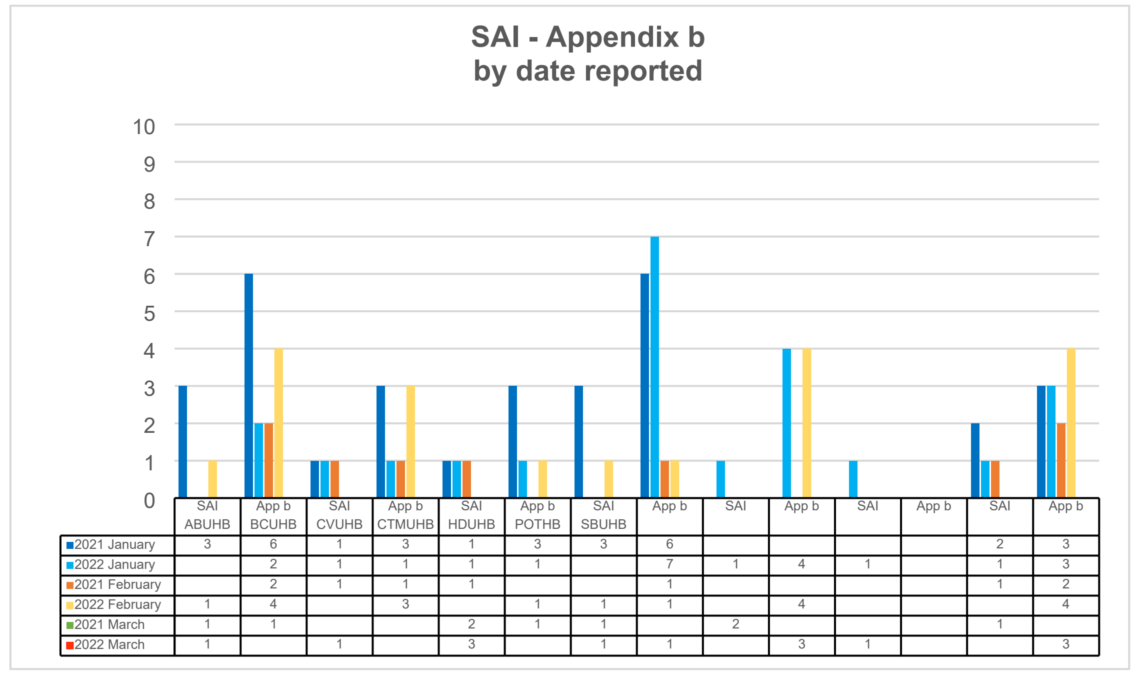
- Confirm the action that will be taken to improve the response times of emergency ambulances.
- Confirm whether there are any plans to review the categorisation of elderly patients who suffer falls and are more likely to be affected by the risks associated with lengthy periods of immobility.

(ii) **SGJ** - The Trust was a party to the Inquest. The incident occurred in October 2020. The patient had taken an overdose of a beta-blocker, concurrently with a large quantity of alcohol. The Trust had established an issue in relation to vehicle allocation resulted in a 43-minute delay in an ambulance arriving with the patient. The Coroner requested that the Trust considered three issues:

- “The concern here is that treatment for a massive propranolol overdose is *time critical* & the processing of the call did not appear to accurately reflect the peril the deceased was then in, nor the importance of providing an acute emergency response”.
- “The clinical floor walker would have had access to TOXBASE via the Clinical Support Desk at that time and had that been accessed and information promptly secured regarding the treatment indicated, this would have alerted the clinician to the need for an acute emergency response”.
- “A review of categorisations, coding’s and actions in the setting of a patient demonstrating the symptoms as per the deceased on 28/29 October 2020 to achieve clarity/consistency is invited”.

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

48 The chart below provides a comparison between the volume of NRIs and Appendix B Referrals within the same reporting period of the previous year (2021/22 versus 2020/21):




| | SAI ABUHB | App b BCUHB | SAI CVUHB | App b CTMUHB | SAI HDUHB | App b POTHB | SAI SBUHB | App b | SAI | App b | SAI | App b | SAI | App b |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2021 January | 3 | 6 | 1 | 3 | 1 | 3 | 3 | 6 | | | | | 2 | 3 |
| 2022 January | | 2 | 1 | 1 | 1 | 1 | | 7 | 1 | 4 | 1 | | 1 | 3 |
| 2021 February | | 2 | 1 | 1 | 1 | | | 1 | | | | | 1 | 2 |
| 2022 February | 1 | 4 | | 3 | | 1 | 1 | 1 | | 4 | | | | 4 |
| 2021 March | 1 | 1 | | | 2 | 1 | 1 | | 2 | | | | 1 | |
| 2022 March | 1 | | 1 | | 3 | | 1 | 1 | | 3 | 1 | | | 3 |

49 During this reporting period there were 18 SCIF Meetings held, with 104 incidents discussed.

50 During the reporting period 14 incidents have been reported as NRIs to the Delivery Unit and 42 incidents were referred under the Joint Incident Framework (Appendix B) to the respective Health Board.

51 Following review of the 14 Incidents reported as NRIs to the Delivery Unit (DU) the overarching high-level themes and trends were identified:

- Delayed response in attending (1)
- Call categorisation (7), (2 of which were missed ineffective breathing)
- Dispatch issue/Protocol (1)
- Clinical assessment and/or treatment (2)
- Welfare check issue (2)
- Other - Delayed CPR instructions (1)

**Legal Claims**

52 The receipt of clinical negligence claims in this reporting period has seen an increase from the previous quarter, with 7 cases being received. 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.

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

54 Whilst personal injury claims received have decreased from 12 to 9 during this quarter, this is reflective of normal seasonal intake. However, what is not reflective in the raw data is the increased complicity in the legal claims received and the number being litigated following the issue of legal proceedings. 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.

55 During the reporting period the number of road traffic accident and damage to property incidents have returned to the usual seasonal volume.

**KEY ACHIEVEMENTS, LEARNING AND IMPROVEMENTS**

Medical and Clinical Directorate

**Clinical Notices issued January:**

(i) 01/22 Patient Safety Notice - PSN064
(ii) 02/22 Airway Policy

**Clinical Notices issued February:**

There were no new clinical notices issued during February.

**Clinical Notices issued March:**

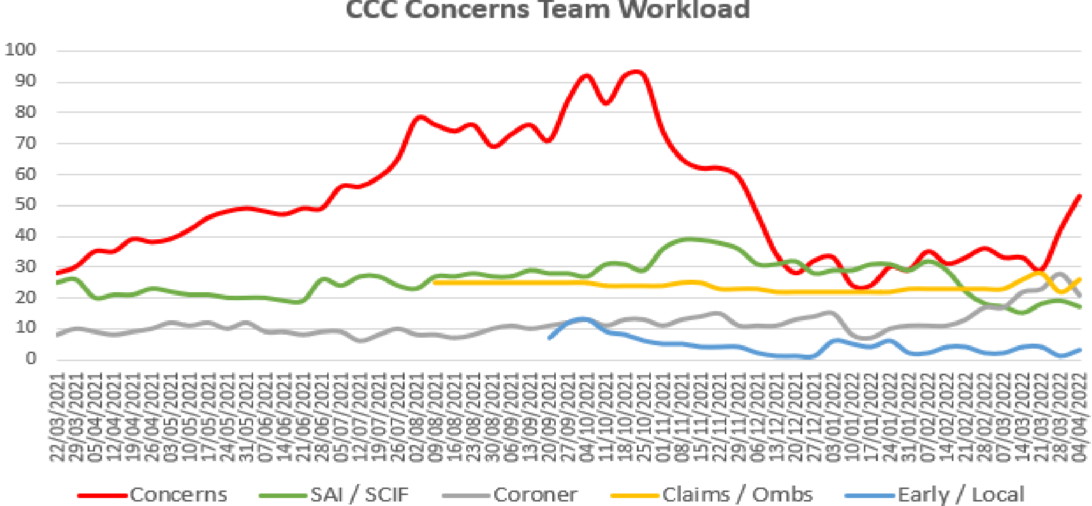
(i) 03/22 Airway Policy Podcast
(ii) 04/22 Standard Operating Procedure, Non-conveyance & Role for ePCR Users
(iii) 05/22 Patient Safety Notice - PSN058
(iv) 06/22 Taking and viewing images with ePCR and the Consultant Connect Application
(v) 07/22 Interim Standard Operating Procedure, ePCR handover at Aneurin Bevan sites.

| Clinical Reviews by Health Board January to March 2022 | No | Themes | Learning Opportunities |
|---|---|---|---|
| Aneurin Bevan | 4 | • Deterioration outside ED leading to Cardiac Arrest<br>• MH Pathway access<br>• Red maternity call, lack of information passed to receiving unit.<br>• EMT discharged patient at scene | • Improved communication at ED<br>• Mental Health pathway discussions with HBs<br>• Improved PCR documentation<br>• Informed Decision Making<br>• Clinical boundaries associated with clinician's scope of practice |
| **Clinical Reviews by Health Board January to March 2022** | **No** | **Themes** | **Learning Opportunities & Improvements** |
| Betsi Cadwaladr | 11 | • PCR completion<br>• Communication<br>• CD Meds<br>• Assessment<br>• Handover delays<br>• Pandemic Regulations<br>• Assessment<br>• In-Hospital Assessment | • Improved communication with military<br>• Improved Understanding of Meds Management<br>• Improved PCR completion<br>• Covid-19 Measures for patients<br>• Appropriateness and timeliness of assessment.<br>• Management of Patients outside ED |
| Cardiff and Vale | 9 | • Sub-optimal management of a paediatric patient<br>• Inappropriate discharge of a patient | • Appropriateness of assessment<br>• Improve conveyance communication around pre-alert.<br>• Clinical boundaries associated with |

| | | | |
|---|---|---|---|
| | | • Failure to identify a deteriorating patient outside ED<br>• Inappropriate ROLE performed by an EMT<br>• Lack of observations, poor documentation whilst outside ED<br>• Sub-optimal management of an unconscious patient | clinician's scope of practice<br>• Improvements in the management of patients.<br>• Improved identification of a patient's condition<br>• Recognition of ROLE<br>• Improved PCR/ePCR completion |
| Cwm Taf | 5 | Reviews pending approval | Reviews pending approval |
| Hywel Dda | 1 | • Sub-optimal management of a cardiac arrest | • Cardiac Arrest Management<br>• Improved PCR documentation |
| Powys | 1 | • Sub-optimal management of a patient requiring an ECG | • Improved identification of a patient's condition. |
| Swansea Bay | 3 | • Wrong drug administered<br>• Poor paediatric patient assessment<br>• Patient welfare and handover delays at ED | • Improved understanding of Medicines Management<br>• Improved identification of patient's condition<br>• Greater understanding of the application of POPS<br>• Better attention to fundamentals of care |

**Clinical Contact Centre**

56 The CCC Concerns Team is seeing an increase in their workload with open investigations starting to increase in most areas. The team has recently had 2 secondments of Investigating Supervisor officers come to an end:



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

| Call Handlers | Dispatchers |
|---|---|
| Chest pain - protocol 36 | Documentation |
| Aspirin and not alert patients | Fluctuating call priorities |
| Protocol 36 High risk patients | Delayed response guidance |
| Protocol 30 high velocity impact | Labour calls - 'call the midwife!' |
| Sepsis - under 16 years | Utilisation of RRVs or solo responders |
| CSP script | Delayed response documentation |
| Relationship to patient | Managing delayed response SOP feedback |
| Demand script exceptions | |
| Atypical fits | |
| Duplicate call process | |

58 A separate reminder was sent out to remind EMDs what to do when a Health Care Professional (HCP) raises concerns about the categorisation for a call.

59 Overdose/Poisoning was sent out as the 'Topic of the month' in March.

60 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:

- Abnormal but not noisy breathing and Road Traffic Collision patients
- Tourniquet use
- Recording changing colour
- Clinicians downgrading calls when EMD still on the line
- Falls and breathing difficulties - which protocol?
- Giving Narcan - will it do any harm if drug not known?
- Head stuck in bannisters following a fall

**LEARNING FROM EVENTS REPORTS**

61 The Welsh Risk Pool Learning from Events Report is used by Health Bodies in NHS Wales to report the issues that have been identified following a clinical claim or redress investigation. The Report also outlines how the identified issues have been addressed to reduce the risk of reoccurrence or reduce the impact of a future event. There are 2 Processes/Reports in place, 1 for clinical cases and 1 for non-clinical legal cases, including personal injury or violence & aggression matters.

62 Improvement to quality and safety in healthcare is aligned to learning which flows from case investigations and the Learning from Events Report provides a Framework for regulators and inspection bodies to gather assurance that appropriate improvement has been implemented. Reimbursement to Health Bodies for claims and redress cases is based upon these assurances that learning has taken place.

63 The following key actions, learning and improvements were identified in a recent review of a redress case (Ref: 18260):

(i) A Clinical Case Review was undertaken with the Trust's Health Board Clinical Lead to discuss the learning from the incident which included:

- Safe discharge
- Discussion Cauda Equina Syndrome (CES)
- Importance of pain management and documentation of pain score
- Documentation
- Adherence to local and National guidance

| AGENDA ITEM No | 14 |
|---|---|
| OPEN or CLOSED | OPEN |
| No of ANNEXES ATTACHED | 7 |

# CORONER REGULATION 28
# PREVENTION OF FUTURE DEATHS REPORTS

| | |
|---|---|
| **MEETING** | Quality, Patient Experience & Safety Committee |
| **DATE** | 12 May 2022 |
| **EXECUTIVE** | Executive Director Quality & Nursing |
| **AUTHOR** | Complaints Investigations Manager |
| **CONTACT** | Catharyne Punyer<br>07880 477388<br>Catharyne.Punyer@wales.nhs.uk |

## EXECUTIVE SUMMARY

This report is to bring to the attention of the Quality, Patient Experience & Safety Committee (QuESt) that the Trust has 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 Trust has provided responses and Improvement Plans to the respective Coroners.

The Reports and the Trust's responses will be available in the public domain.

The Trust has been notified of the potential that the Chief Executive Officers for the Welsh Ambulance Services NHS Trust (WAST) and Betsi Cadwaladr University Health Board (BCUHB) may be called to attend a Prevention of Future Deaths Hearing.

**RECOMMENDED: That the Quality, Patient Experience & Safety Committee receives this Report for assurance and discussion.**

## KEY ISSUES/IMPLICATIONS

- The Trust has not received a Regulation 28 since May 2021.
- Full and timely responses have been submitted.
- There are further cases, with similar circumstances, that are due to be considered by the same Coroners.
- Failure to demonstrate improvements following Prevention of Future Deaths Reports could result in corporate manslaughter and neglect prosecutions/findings

## REPORT APPROVAL ROUTE

| | |
|---|---|
| Executive Management Team | 27 April 2022 |
| Quality, Patient Experience & Safety Committee | 12 May 2022 |

| REPORT APPENDICES | |
|---|---|
| **Annex 1** | SBAR Providing background information. |
| **Appendix 1** | Regulation 28 Prevention of Future Deaths (BY) |
| **Appendix 2** | Regulation 28 Prevention of Future Deaths (SMG-J) |
| **Appendix 3** | Coroners letter to Joint Royal Colleges Ambulance Liaison Committee |
| **Appendix 4** | Letter to Coroner (BY) |
| **Appendix 5** | Improvement Plan (BY) |
| **Appendix 6** | Letter to Coroner (SMG-J) |
| **Appendix 7** | Improvement Plan (SMG-J) |

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

**ANNEX 1**

## SITUATION

1 This overview report provides details of the two Regulation 28 Prevention of Future Deaths (PFD) Reports, which have been received by the Trust during January and February of this year.

## BACKGROUND

2 **PFD 1: BY**

(i) Dated: 28 January 2022
(ii) Coroner: Caroline Saunders
(iii) Response due: 28 March 2022

**Summary**

- There was a 3-hour response time to an elderly patient who had fallen down the stairs.
- The Trust had not been aware of the issue prior to receipt of the PFD Report (be it an incident, complaint or coroner engagement).

**Medical cause of death**

(i) Bronchopneumonia
(ii) Multiple Rib and Spinal Fractures
(iii) Fall down stairs
(iv) Head Injury

**PFD issues**

- Confirm the action that will be taken to improve the response times of emergency ambulances
- Confirm whether there are any plans to review the categorisation of elderly patients who suffer falls and are more likely to be affected by the risks associated with lengthy periods of immobility

3 **PFD 2: SG-J**

(i) Dated: 4 February 2022
(ii) Coroner: Graeme Hughes
(iii) Response due: 1 April 2022

**Summary**

- Since 2019 the patient had experienced fluctuating and worsening mental health. On the evening of 28 October 2020, she had taken a significant overdose, concurrently with a large quantity of alcohol. The Trust had established an issue in relation to vehicle allocation resulted in a 43-minute delay in an ambulance arriving with her.

- The Coroner concluded that the delay in the arrival of the Emergency Services compromised an opportunity for earlier life-saving treatment. She died in the early hours of 29 October 2020 at the Royal Glamorgan Hospital. The cause of her death due directly to the toxic effects of the overdose.

**Medical cause of death**

(i) Propranolol Toxicity.

**PFD issues**

- When the initial 999 call was placed by the deceased's father at 22:05 on 28 October 2020, it was accepted that he explicitly indicated to the Call Handler that the deceased had taken an overdose of, inter alia, 70 x 40mg of Propranolol tablets. Based upon that and answers to other questions posed by the Call Handler, the Call Handler selected a protocol which did not appear to require this crucial piece of information to be either recorded within it, or to form part of the material which led to the categorisation of the call for the purposes of determining the appropriate response. In short, it led to a categorisation which could only loosely provide a response (based upon the level of demand that evening) estimate of around 3 hours. **The concern here is that treatment for a massive propranolol overdose is *time critical* and the processing of the call did not appear to accurately reflect the peril the deceased was then in, nor the importance of providing an acute emergency response**.
- There appeared to be an opportunity shortly following the initial categorisation of the response, by a clinical floor walker, to upgrade to a code/categorisation which would likely have led to a swifter response, but an under-appreciation, or otherwise, of the then time critical treatment window open to the deceased. I was informed in evidence **that the clinical floor walker would have had access to TOXBASE via the Clinical Support Desk at that time and had that been accessed and information promptly secured regarding the treatment indicated, this would have alerted the clinician to the need for an acute emergency response.** This was subsequently undertaken by the attending Paramedic (albeit not via TOXBASE) some hours later and who, immediately after having accessed the treatments for massive Propranolol overdose, appreciated that the deceased was a time sensitive patient and to convey to the Emergency Department with all haste.
- Following the second call to Clinical Contact Centre at 23:48 on 28 October 2020, there were somewhat bewilderingly complex and inconsistent categorisations of the code for response which appeared to lead to response vehicles being despatched or stood down, whilst the patient remained in need of time sensitive treatment by way of transfer to an Accident & Emergency Unit. **Whilst I was assured that this had been addressed by learning & guidance to Call Handlers, a review of categorisations, codings and actions in the setting of a patient demonstrating the symptoms as per the deceased on 28/29 October 2020 to achieve clarity/consistency is invited.**

**ASSESSMENT**

4 **PDF1** - There are several further inquests that relate to delays in ambulances responding to patients. These inquests are pan-Wales. However, there is 1

further inquest (with the same Coroner) relating to an elderly patient who had fallen downstairs and had to wait 12 hours for an ambulance.

5 **PDF2** - The Coroner also wrote to Association of Ambulance Chief Executives (AACE), to raise with JRCALAC, as to whether ambulances should carry medication to treat significant/massive propranolol overdoses.

6 CEO responses and Improvement Plans have been developed and forwarded to the respective Coroners within the required timeframes (**Appendixes 4 - 7**).

7 Oversight of the Improvement Plans will occur via the Assistant Directors Leadership Team Meeting, with escalation to the Executive Management Team if required.

**Caroline A. Saunders**
**Senior Coroner**
**For Gwent**

**Tel: 01633 414600**
**Email: gwent.coroner@newport.gov.uk**

Gwent Coroner Service
The Civic Centre
Godfrey Road
Newport
South Wales
NP20 4UR

Chief Executive
Welsh Ambulance Service NHS Trust
Headquarters
St Asaph Business Park
St Asaph
LL17 0LJ

- 3 FEB 2022

28 January 2022

Dear Sir/ Madam

**Re: Barbara Young**

Following the conclusion of the Inquest into Mrs Young's death.

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

Yours faithfully

pp

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

Enc.

- 3 FEB 2022

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

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

| | REGULATION 28 REPORT TO PREVENT FUTURE DEATHS<br><br>THIS REPORT IS BEING SENT TO:<br><br>1. Wales Ambulance Service NHS Trust |
|---|---|
| 1 | **CORONER**<br><br>I am **Caroline Saunders,** Senior Coroner for the Area of Gwent |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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 |
| 3 | **INVESTIGATION AND INQUEST**<br><br>On **3/8/21** an investigation was opened into the death of **Barbara YOUNG**<br><br>The investigation concluded at the end of the inquest on: **25/1/22**<br><br>The conclusion of the inquest was recorded as:<br><br>**Death by Accident**<br><br>The medical cause of death was:<br><br>**1a Bronchopneumonia**<br>**1b Multiple Rib and Spinal Fractures**<br>**1c Fall down stairs**<br><br>**2 Head Injury** |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Barbara Young fell downstairs at her home address on 15th July 2021. She sustained multiple injuries including fractures of her ribs, spine and skull. Barbara was taken to hospital where, due to her reduced mobility, she developed pneumonia. The combined effects of trauma and pneumonia proved overwhelming, and Barbara died at the University Hospital of Wales, Cardiff, on 23rd July 2021. |

| | |
|---|---|
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows: -<br><br>Barbara Young fell at home on 15/7/21 at approximately 11:30hours. Her family immediately called the emergency services and informed the ambulance call handlers that she had fallen downstairs, was not fully conscious and had sustained an apparently severe head injury.<br><br>An ambulance arrived at 14:26 hours. Mrs Young was taken to hospital where she was diagnosed with multiple injuries including an intracranial bleed, rib fractures, a pneumothorax and a fractured clavicle.<br><br>Given the nature of Mrs Young's injuries, her frailty and trauma- induced immobility, she developed pneumonia which was ultimately the cause of death.<br><br>I am informed that the risk of mortality in the elderly who have suffered significant trauma is high, because they are at greater risk of developing pneumonia. It is therefore essential that they receive emergency medical care as soon as possible. In this case it took 3 hours for an ambulance to arrive and whilst I have no evidence that this delay contributed to Mrs Young's death similarly I cannot confirm it did not, and that future lives could be at risk due to the delays in providing a timely emergency response.<br><br>I acknowledge the problems faced by the ambulance service over the last 2 years, problems that have been compounded by the effects of the pandemic and delays in transferring patients into hospital emergency departments. I have also been informed that there have been plans in place to improve the responsiveness of the service however from the evidence provided at this inquest it appears that problems still exist. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.<br><br>I should be grateful if the following information be provided to me:<br><br>1. Confirm the action that will be taken to improve the response times of emergency ambulances.<br>2. Confirm whether there are any plans to review the categorisation of elderly patients who suffer falls and are more likely to be affected by the risks associated with lengthy periods of immobility. |

| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely 25/03/22, I, the Coroner, may extend this period.<br><br>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 |
|---|---|
| 8 | **COPIES AND PUBLICATION**<br><br>I have sent a copy of my report to the Chief Coroner and the following Interested Person (s)<br><br>The family of Barbara Young<br>Health Inspectorate Wales.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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. |
| 9 | **DATE 28/01/22**<br><br>Signed<br><br>[signature]<br><br>Caroline Saunders<br><br>**Her Majesty's Senior Coroner for the Area of Gwent.** |

**ANNEX A**

**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)**

*NOTE: This form is to be used **after** an inquest.*

| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**Jason Killens at Welsh Ambulance NHS Trust** |
|---|---|
| 1 | **CORONER**<br><br>I am Graeme Hughes, H M Senior Coroner, for the coroner area of South Wales Central. |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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. |
| 3 | **INVESTIGATION and INQUEST**<br><br>On 3.11.20, I commenced an investigation into the death of Sarah Marie GILBERT-JONES.<br><br>The investigation concluded at the end of an inquest on 3rd February 2022. The conclusion of the inquest was:-<br><br>The deceased died due to the direct effects of a significant and deliberate overdose of her prescription medication. It is unlikely that she intended the consequences of that overdose to be her own death. It is likely that the timing of her death was contributed to by her sub-optimal transfer to hospital, narrowing the opportunity for administering effective life-saving medication and treatment.<br><br>The cause of death being: 1a: Propranolol Toxicity |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>These were recorded as :-<br><br>Since 2019, Sarah Marie GILBERT-JONES, had experienced fluctuating and worsening mental health. This had manifested itself in episodes of self-harm, and from the summer of 2020 overdoses of her prescription medication. On the evening of 28.10.20 she has taken a significant overdose, concurrently with a large quantity of alcohol. A delay in the arrival of the emergency services compromised an opportunity for earlier life-saving treatment. She died in the early hours of 2910.20 at the Royal Glamorgan Hospital. The cause of her death due directly to the toxic effects of the overdose.<br><br>The Inquest broadly focused upon:-<br><br>a. The emergency response following notification of the overdose & request for ambulance assistance. In particular, the *grading* of calls to the Clinical Contact Centre & the actions initiated following the same<br><br>b. Whether a delay(s) in ambulance service attendance (upon the deceased) & |

| | |
|---|---|
| 6 | conveyance to an Accident & Emergency Department, contributed to her death<br><br>c. The contribution, if any, of sub-optimal Mental Health Services provision upon her death |
| 5 | **CORONER'S CONCERNS**<br><br>During the course of the inquest the evidence revealed matters giving rise to concern.<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>(1) When the initial 999 call was placed by the deceased's father at 22.05 on 28.10.20, it was accepted that he explicitly indicated to the Call Handler that the deceased had taken an overdose of, inter alia, 70 x 40mg of Propranolol tablets. Based upon that, & answers to other questions posed by the call handler, the call handler selected a protocol which did not appear to require this crucial piece of information to be either recorded within it, or to form part of the material which led to the categorisation of the call for the purposes of determing the appropriate response. In short, it led to a categorisation which could only loosely provide a response (based upon the level of demand that evening) estimate of around 3 hours. The concern here is that treatment for a massive propranolol overdose is *time critical,* & the processing of the call did not appear to accurately reflect the peril the deceased was then in, nor the importance of providing an acute emergency response.<br><br>(2) There appeared to be an opportunity shortly following the initial categorisation of the response, by a clinical floor walker, to upgrade to a code/categorisation which would likely have led to a swifter response, but an under-appreciation, or otherwise, of the then time critical treatment window open to the deceased. I was informed in evidence that the clinical floor walker would have had access to TOXBASE via the Clinical Support Desk at that time, & had that been accessed & information promptly secured regarding the treatment indicated, this would have alerted the clinician to the need for an acute emergency response. This was subsequently undertaken by the attending paramedic (albeit not via TOXBASE) some hours later, & who immediately after having accessed the treatments for massive propranolol overdose, appreciated that the deceased was a time sensitive patient & to convey to the emergency department with all haste.<br><br>(3) Following the second call to Clinical Contact Centre at 23.48 on 28.10.20, there were somewhat bewilderingly complex, & inconsistent categorisations of the code for response which appeared to lead to response vehicles being despatched or stood down, whilst the patient remained in need of time sensitive treatment by way of transfer to an Accident & Emergency Unit. Whilst I was assured that this had been addressed by learning & guidance to call handlers, a review of categorisations, coding's & actions in the setting of a patient demonstrating the symptoms as per the deceased on 28/29 October 2020 to achieve clarity/consistency is invited. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you and your |

|  |  |
|---|---|
|  | organisation have the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 1st April 2022.<br><br>Only, I, the Coroner, may extend the period.<br><br>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 proposed. |
| 8 | **COPIES and PUBLICATION**<br><br>I have sent a copy of my report to the deceased's family and the Health Inspectorate Wales, Cwm Taf Health Board who may find it useful or of interest.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>The Chief Coroner may publish either or both in a complete or redacted or 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. |
| 9 | 4th February 2022<br><br>**SIGNED:**<br><br>Graeme Hughes, H M Senior Coroner for **South Wales Central** |

**GRAEME D HUGHES**

**HER MAJESTY'S SENIOR CORONER**

**SOUTH WALES CENTRAL CORONER AREA**

**CORONER'S OFFICE**
**THE OLD COURTHOUSE**
**COURTHOUSE STREET**
**PONTYPRIDD**
**CF37 1JW**

**Telephone: 01443 281100**
**Facsimile: 01443 485862**
**Email: Coroneradmin@rctcbc.gov.uk**
**www.southwalescentralcoroner.co.uk**

Mr Steve Irving
Executive Officer
The Association of Ambulance Chief Executives (AACE)
25 Farringdon Street
London
EC4 4AB

Our Ref: 22288

7th February 2022

Dear Mr Irving,

**Re: Sarah Marie GILBERT-JONES (deceased)**

**DOD: 29/10/2020 - Inquest concluded: 03/02/2022**

I understand that you are the administrative support/contact for the Joint Royal Colleges Ambulance Liaison Committee.

I attach for your attention: –

a. A copy of the record of inquest relation to the above

b. A copy of my regulation 28 report to the Welsh ambulance service following the inquest.

c. Pre- Inquest Statements of the witnesses, Dr Jonathan Whelan, Dr Asim Bilal, Paramedic David Moodley, and Miss Kate Blackmore

In so far as the above are concerned, I should mention that each of these witnesses (and indeed Dr Lawson) gave oral evidence at the inquest and so the statements are only provided to provide a *flavour* of the issues that were investigated during the inquest.

Should you require a recording of the inquest (which actually took place over three days) then I can make this available to you?

d. Post-mortem report of Dr Jason Shannon and toxicological report from Dr Alex Lawson.

I invite you to bring to the attention of the Committee a particular matter that arose during the course of the inquest which, whilst I did not consider engaged my formal regulation 28 duty, might be something that the committee would wish to consider, and subsequently determine be reflected in paramedic practice (or otherwise).

In short, Dr Bilal, in his role as an accident and emergency consultant, gave evidence to the effect that he believed it efficacious for paramedics to not only be equipped with (sufficient quantities of) glucagon and sodium bicarbonate, but also have it within their *standard operating instructions and authority,* the ability to administer these medications to patients in the out of hospital environment, believed to have taken a significant/massive propranolol overdose.

I received evidence from both paramedic Moodley and Dr Whelan that in 2020 and continuing, paramedics were neither equipped with these medications, nor authorised by their professional body, to administer the same in such circumstances.

I should emphasise, that I did not find this contributory to, nor causative of, Mrs Gilbert-Jones's death.

Hence, I shall be grateful if you would kindly in the first instance acknowledge receipt of this letter and the attachments and thereafter, and in due course, revert to me with either an indication that the matters raised will not be considered by the committee, or if they are, when that is likely to happen?

I have sent a copy of this letter (but not the attachments) to all interested persons in Mrs Gilbert-Jones's inquest – her family, the Welsh Ambulance Services Trust and Cwm Taff Morgannwg University Health Board.

I will forward any response from you, or the committee to those interested persons.

I am grateful to you, and the committee for your assistance and involvement.

Yours sincerely

Mr G D Hughes

H M Senior Coroner

South Wales Central Area

GIG CYMRU NHS WALES | Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services NHS Trust

Cadeirydd
Chair: Martin Woodford

Prif Weithredwr
Chief Executive: Jason Killens

Swyddfa'r Prif Weithredwr a'r Cadeirydd

Chair and Chief Executive's Office

Our Ref: CDP/ID 7972

24 March 2022

**PRIVATE & CONFIDENTIAL**
Ms Caroline Saunders
Senior Coroner for Gwent
**(Sent by email: gwent.coroner@newport.gov.uk)**

Dear Ms Saunders

**Re: Barbara Young**

I am writing in response to the Regulation 28 Report that you issued to this Trust, dated 28 January 2022, following the sad death of the late Mrs Barbara Young.

In the Regulation 28 Report you raised your concerns in relation to two matters, which I will respond to below:-

1. **Confirm the action that will be taken to improve the response times of emergency ambulances.**

To put this response in some context, you may be aware that during the first wave of the pandemic, we saw a reduction in our normal demand, in addition there were fewer delays in handing over patients at hospital.

However, subsequently during 2021 and 2022, activity returned not just too forecasted levels, but above predicted levels. This is further exacerbated by an increase in the acuity of our patients. As a result of this, the Welsh Ambulance Services NHS Trust (The Trust) continues to experience excessive delays in trying to respond to patients in our communities and handing patients over at hospitals for assessment, care and treatment. There have also been other contributory factors why there have been delays in providing a timely response which include, sickness absence, infection prevention and control measures and also delayed transfers of care out of hospital because of a lack of social care packages. This will mean that patients are

occupying acute hospital beds as it would be unsafe to discharge home without adequate social care in place.

I can confirm, as with all NHS Organisations, staffing has been significantly affected during the pandemic, with as many as 15% of staff away from work at any one time as a result of sickness absence, a significant proportion linked to Covid-19, whether that be the result of contracting the infection themselves, self-isolation or indeed, during the initial waves, shielding. This inevitably had a bearing, and continues to do so, on our ability to optimise the number of ambulances available to respond.

In addition, for Red calls, crews are required to wear additional personal protective equipment (PPE) which can add crucial minutes to put on, when crews arrive at scene. We recognise this is difficult, but we have a responsibility to safeguard our own crews where there is a risk to them and we follow national guidance on this matter.

During February 2022, the Welsh Government (WG) called a Risk Summit with all NHS providers and Local Authorities to review patient risks in the community and to identify what improvements could and should be made to improve system pressures. This meeting resulted in a mandate from WG for all Health Boards and Local Authority partners to work collaboratively to introduce a system reset during March 2022. In addition, Chief Executives of Health Boards have been asked to urgently provide their plans for how they will reduce hospital handover delays over the coming weeks.

I am able to provide you with absolute assurance that the negative and sometimes catastrophic impact the systems pressures are having on patients in our communities is constantly being reviewed and escalated at the highest level. I can also assure you, that the Trust has already taken many actions to try and mitigate the effects of ambulances being delayed at hospital, which then effects our ability to respond to people in the community. As I am sure you will appreciate, none of these matters sit in isolation but are interlinked. I wish to assure you that the Trust has made several changes and taken actions, over and above those I have listed here. However, I have selected the issues and actions that I hope best demonstrates that the Trust has considered every possible way in which we can react to and mitigate the impact of these pressures, which are fundamentally outside of our control. These include:

**Consult and Close**

There has been significant investment into the Clinical Contact Centre (CCC), where by the end of the month we have doubled our clinical workforce in this area (Nurses/Paramedics/Mental Health Practitioners), which is already showing some improvement in unnecessary dispatch and conveyance into hospital, where appropriate. The additional clinicians in the CCC are offering patients appropriate alternatives such as for example, signposting to pharmacist, having an up to date Directory of Service to local pathways, and, or giving self-care advice and support. This will release vital resources to respond to patients who need a face to face assessment in the community. We anticipate with this investment that we will be able to consult with our patients and close up to 15% of the calls we receive.

**Handover Delays**

Unfortunately the Trust continues to see a substantial number of hours lost to hospital handover delays, across NHS Wales, with more than 25,000 hours lost (25% of our on duty fleet) in February 2022. This has a significant impact on our ability to provide timely care and treatment to those in need an emergency community response. The Trust, continues to work closely with our Health Board colleagues across Wales to minimise delays by providing on-site support and,

with assistance from nursing and medical staff, prioritising those patients with the greatest clinical need. As an example, a number of Patient Flow Coordinators have been recruited to support the wider system flow pressures at the Grange Hospital, Cwmbran. In addition, we secured support from Private Ambulance Service clinicians over the winter months. The purpose of the approach is to facilitate safe timely transfers for a cohort of patients from the Trust ambulances when there is no capacity within the Emergency Department (ED) or elsewhere in the hospital to facilitate timely off-load. That said, delayed transfer of care remains a significant barrier our ability to respond to calls in the community in a timely fashion with 25% of our on duty fleet capacity lost in this way in February.

**Discharge and Transfer**

We also support the discharge and transfer of patients out of hours in order to release beds in hospitals, which in turn supports the improvement of patient flow in the emergency departments.

**Reducing Conveyance to ED Departments**

Where safe to do so, and where Health Boards have suitable alternative clinical pathways, the Trust aims to support people in the community and to reduce the number of unnecessary admissions to Emergency Departments. We continue to recruit and train Advanced Paramedic Practitioners who have a higher skill level and are trained to treat patients in their own homes, where possible.

**Additional Capacity from Military**

You may be aware that we have had support from the military on three separate occasions, the latest deployment being scheduled to finish at the end of March 2022. We have asked for military support to help us put out as many ambulances as possible, as well as securing additional support from St John Cymru Wales, other providers and utilising our own staff differently.

**Clinical Safety Plan (CSP)**

To support the Trust to be able to manage and respond to those patients in greatest need, the Trust has reviewed and enhance the process around the Clinical Safety Plan (CSP). This allows the Trust to manage the demands on the service differently during times of extreme pressure. The introduction of the CSP ensures that patients are advised of the current timeline of delay, and would be encouraged to contact family members, neighbours or friends to help assist with transport to hospital, should this be an option. This provides a framework for Trust Emergency Operations teams to respond dynamically to situations through a set of tactical options that are flexible, immediate and specific to each Health Board area. This ensures that patients with immediately life-threatening conditions such as cardiac arrest and catastrophic hemorrhage, continue to receive services as quickly as possible. The CSP has been approved by Trust executives and the senior management team, and it is accepted that in times of extraordinary pressure, the Trust will be unable to provide the level of response that would be desired. It is therefore appropriate to inform some callers of likely delays and advise them to seek alternative arrangements to ensure that the patient is taken to a facility that can provide appropriate, definitive care.

**Demand & Capacity**

To ensure that the Trust has the correct number of resources available to respond to the expected demand and maximise the number of resources available to respond to patients, the Trust undertook a Demand and Capacity Review. This review identified a range of efficiencies

for the Trust to achieve. This includes a full roster review and some focused improvement work on the management of sickness and absence.

Accordingly, the Trust has increased its workforce by 236 Full Time Equivalent staff, pan-Wales. The staff have been recruited and trained as part of our established Emergency Medical Services Operational Ambulance Programme. Additionally, we will reroster all staff during Q3 22/23 to ensure staff are on duty at the time and in the place that best match patient demand. This will release an internal efficiency equivalent to 72 FTE.

All of the actions above assist by reducing the pressure on busy hospital departments, improve patient flow within the wider NHS system and maximise the availability of our emergency resources for our most critical patients.

**2. Confirm whether there are any plans to review the categorisation of elderly patients who suffer falls and are more likely to be affected by the risks associated with lengthy periods of immobility.**

Each ambulance service has a response model that supports the categorisation given to each call (irrespective of which prioritisation system is used). That response model and the decisions made will reflect the demographics of the population and the geography being served by that individual ambulance service. In 2015 the Welsh Ambulance Services NHS Trust introduced its current Clinical Response Model (the Model), which removed timed targets for all but those patients with immediately life-threatening illnesses or injuries. The Model underwent a trial period before being approved by the Welsh Government and fully implemented by the Trust.

The appropriateness of the priority given to each category of call is reviewed and changes are considered by the Trust's Clinical Priority Software Advisory Group (CPAS). In all cases the group will consider the impact any change would have on the volume of each priority of calls received, for example the effect of increasing the number of Red calls would have an impact on all other codes. The CPAS group also sets an "ideal" response for each type of call, in an attempt to maximise efficient use of resources by avoiding "double dispatch" on calls.

The Medical Prioritisation Dispatch System (MPDS) does not provide a determinant code based on age within Protocol 17 (falls) which would prevent a specific prioritisation change for elderly patients. The principal role of the Clinical Support Desk (CSD) Clinician is to provide additional clinical triage, advice and support to patients to ensure that they can access the most clinically appropriate care for their urgent and emergency healthcare needs, commonly known as Hear and Treat (H&T). In addition to this principal role, the CSD also undertake a range of other clinical functions in pursuance of maximising patient safety for those awaiting an emergency ambulance. This includes reviewing long waiting patients to maintain patient safety. CSD clinicians have the ability to change the responding priority of an incident based on a secondary clinical assessment, this includes increasing the priority where the patient's clinical acuity indicates this is appropriate. Dispatch guidelines regarding falls and frailty responders are continually reviewed and updated to ensure maximum utilisation of this valuable resource, part of the CSD role is to provide support to falls assistants following an initial assessment to ensure the correct outcome is reached.

The categorisation of elderly patients who suffer falls and are more likely to be affected by the risks associated with lengthy periods of immobility, will be referred to the Trust's Clinical Priority Software Advisory Group.

Additionally, in 2018, Working in partnership with St John Cymru Wales, the Trust introduced the role of the Falls Assistants (FA). The FA predominately provide a response to patients who have no injuries or where there is a concern for welfare. However, they are able to respond to patients with other medical/frailty presentations, or if there is an injury. This decision will often be supported by a clinical triage and assessment by a clinician, over the phone, prior to allocation. The aim of this new level of response was to ensure those patients often presenting with lower clinical acuity, were provided with a timely response to reduce the risk of further harm.

Within 2021, the Trust successfully awarded a contract to provide a National Falls Assistant Service with one Falls Assistant (for 12 hours per day) in each Health Board area, to St John Cymru Wales. From December 2021 through to January 2022, the Quality Improvement Team are currently working with various stakeholders both internally and externally to further enhance the Falls Assistant provision. This includes the Operations and Clinical/Medical Directorate, along with Health Board Partners. We have introduced a further two vehicles by night (funded by the Trust) which is currently funded up to and including 31st March 2022.

Outside of our contract with St John, one vehicle has been funded by the Cardiff and the Vale Health Board (operational from 19.30-07.30), which is currently funded up to and including 31st March 2022. Additionally, Aneurin Bevan University Health Board continues to fund a Falls Response Service (Paramedic and Therapist) vehicle which operates daily (08.00-20.00hrs) and Betsi Cadwaladr University Health Board are currently funding a trial for a Falls Response Service model which operates 4 days per week. Swansea Bay University Health Board have agreed to fund a Falls Response Service provision for 1 day per week over the winter period, providing ad-hoc cover. In addition to the specialist falls response, the Trust are working with volunteers (community first responders) and Fire and Rescue Services to provide a designated response to patients who have fallen to ensure periods of immobility are reduced. Enhanced Clinical Desk capacity has been introduced with the Clinical Contact Centre, which ensures patients receive targeted advice when waiting for a response including advice in relation to pressure ulcers and reducing the period of immobility. This is provided as part of the telephone triage and assessment.

The Trust continues to work with partners to further expand the model, to ensure patients are able to receive a timely response. In December the Trust undertook a review of the Medical Priority Dispatch System (MPDS) codes for Falls to determine if there were opportunities to improve the timeliness of response. Following a review, four codes were identified as suitable for Falls Assistants (non-registered, in some areas St John Service) to attend without the need for Clinical Triage, thus reducing the requirement to send an Emergency Ambulance. Furthermore, improvements are actively being considered to improve utilisation of resources and support patients who are waiting for a response. A Quality Improvement Workshop has been prioritised for April, with representatives from across the organisation to identify tests of change and prioritise improvements. This includes a review of the advice provided via 999 and a review of the response availability and capacity. The Falls Improvement and Implementation Group (FIIG) will conduct a review of the guidance provided to patients following a fall, consider the risks associated immobility and will suggest possible improvements.

To conclude, and to provide you with absolute assurance, the Trust is aware of the risks and the impact that delays in care and treatment can have on patient outcomes. This is not the level of service that we want to provide for the people in Wales. I hope that this response as provided you with a level of assurance that we, as an organisation, are doing everything in our control to reduce the level of risk, harm and the impact that the system pressures is having on patients in our communities.

Whilst writing I would like to extend my sincere condolences to Mrs Young's family on their sad loss. I would also like to extend the offer to meet with you to discuss our response in more detail and to provide you with any further assurances you may require regarding our commitment to continuance improvement to support the prevention of future deaths.

Yours sincerely

**Jason Killens**
**Chief Executive**

**Enc: Action Plan**

**Welsh Ambulance Services NHS Trust Action Plan**

**Response following the inquest of Barbara Young**
**March 2022**

This plan represents the strategic projects and actions being taken by the Welsh Ambulance Services NHS Trust (the Trust) to address the concerns raised by the Coroner. Monitoring and evaluation of this plan is undertaken by the Executive Management Team and Quality, Patient Experience and Safety Committee of the Trust Board with more detailed delivery actions designed to give effect to the improvement required.

| Ref | Action | Impact/Outcome | Owner | Delivery date |
|---|---|---|---|---|
| 1 | Consideration at Clinical Priority Software Advisory Group(CPAS) | Point 2 *"Confirm whether there are any plans to review the categorisation of elderly patients who suffer falls and are more likely to be affected by the risks associated with lengthy periods of immobility."*- to be taken to the Trust's Clinical Priority Software Advisory Group to consider.<br><br>In all cases the group will consider the impact any change would have on the volume of each priority allocated to calls received, the effect of increasing the priority to a specific code and the impact that would have on all other codes. | CPAS | Q1 – 2022/23 |
| 2 | Alternative Patient Pathways | We are working in collaboration with the Health Board to develop out of hospital pathways to reduce the need to convey patients to hospital. | Care Closer to Home Group | Q1 – 2022/23 |
| 3 | Clinical Support Desk (CSD) | We have and will continue to expand our clinicians on the clinical desk in our 999 control room to support timely clinical assessment and to ensure we are sending the appropriate resource to the individual patient. | Assistant Director of Integrated Care | Q2/3 2022/23 |

| 4 | Mental Health Practitioners – Clinical Support Desk | We have recruited Mental Health Practitioners into the CSD to build clinical leadership, resilience and support to offer the best possible advice and support for people experiencing mental health distress or crisis. | Consultant Nurse Mental Health | Q1/2 2022/23 |
|---|---|---|---|---|
| 5 | CHARU | The Trust are introducing a new vehicle type called the Cymru High Acuity Response Unit (CHARU) which will be deployed to support patients with suspected critical illness or injury. The dispatch criteria has been approved and will include all red category calls, it also includes incidents such as falls from height, serious road traffic incidents, obstetric emergencies and serious assaults. The frequency of attendance and clinical management of these incidents by individual clinicians is comparatively rare against other presenting conditions. As a paramedic on CHARU there will be an increase in the frequency of attending these incidents across a wider footprint area. The CHARU resource type will be staffed by paramedics who have successfully completed the training and education requirements. The three-day training course will comprise of numerous assessments both written and practical on the latest evidence-based practice, adhering at all times to the policies and standards inherent within the Trust. This service is planned to go live in line with the new operational rosters late 2022. | Director of Paramedicine Assistant Director of EMS | Q2/Q3 2022/23 |
| 6 | Demand and Capacity Roster Review | The Trust is also undertaking a review of all operational rosters which aims to improve colleague experience and wellbeing, and of course, to further improve patient safety and clinical outcomes by aligning demand to our capacity. The review is due to be realised and implemented by the end of November 2022. | Assistant Director of EMS | Q3/4 2022/23 |
| 7 | Strategic Transformation Board | At present the Trust's 999 demand is managed in three ways: ambulance response (80%), See and Treat (10%) and patient pathways (10%). In order to manage this demand more effectively to ensure patients receive the right care, at the right time and in the right place, the Trust is proposing to flip this model with an ambition have | Executive Management Team | Long term plan and Dependant on funding |

| | | significantly more patients being offered community pathways and or self-care advice, and a reduction in hospital conveyance, with those patients requiring a face to face assessment being assessed and managed at home and where needed community support.<br>However, this service improvement is dependent upon funding. | Emergency Ambulance Service Committee (EASC) | |
|---|---|---|---|---|

Progress and delivery key

| **RAG rating colour** | **Progress description** |
|---|---|
| Red | Off track and not likely to deliver as planned, remedial action required |
| Amber | Currently off track and likely to deliver as planned with recovery action being taken |
| Green | On track for delivery as planned |
| Blue | Action complete |

GIG CYMRU NHS WALES | Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services NHS Trust

Cadeirydd
Chair: Martin Woodford

Prif Weithredwr
Chief Executive: Jason Killens

Swyddfa'r Prif Weithredwr a'r Cadeirydd

Chair and Chief Executive's Office

Our Ref: CDP/ID 6938

31 March 2022

**PRIVATE & CONFIDENTIAL**
Mr Graham Hughes
HM Senior Coroner at South Wales Central
**(Sent by email: clare.everett@rctcbc.gov.uk)**

Dear Mr Hughes

**Sarah Marie Gilbert-Jones**

I write in response to the Prevention of Future Deaths Report issued to this Trust on the 4 February 2022, following the inquest in relation to Sarah Marie Gilbert-Jones.

I understand that, whilst giving evidence, my staff provided you with details of changes that the Trust has already made (since this incident), that would have affected how we respond to such a call received today. I will not repeat that information here, but rather build on those changes.

The issue of Propranolol overdose has already been discussed at the International Academies Of Emergency Dispatch (IAED) Clinical Focus Group, initially raised by another ambulance service. This is not an issue being faced here in Wales alone. One consideration has been as to whether there is a specific question set, with associated code group and priorities, which will identify the case as a propranolol overdose. The Medical Priority Dispatch System (MPDS) already has a question set that relates to Fentanyl which was an issue in some countries.

The issues of instigating different actions for different drug types are twofold. There is the fact that the individual drugs that can be involved in overdose cases are many and varied. Additionally, this moves away from the basis of the Trust's Clinical Response Model, where the sickest patients are identified and attended first. This Model is based on the patient's condition at the time and is not based on potential future changes to their conditions.

During the incident that was subject of the inquest, the floorwalker did upgrade the call to elicit a faster response, from an Amber 2 to an Amber 1. I wish to assure you that within the Standard Operating Procedure for the Clinical Support Desk, which allows clinicians to place a “flag” on an incident.

That flag identifies the case as an overdose of such things as Propranolol, and is visible for the staff responsible for dispatching vehicles. This flag indicates to the Allocator that a vehicle should be sent as soon as possible and that allows the dispatch teams to consider allocating available resources out of time order (as resources are normally dispatched to the highest priority/oldest call first).

I attach for your reference a plan that lists the actions the Trust is proposing to consider in order to address the issues highlighted within your Regulation 28 report. Any changes made will be included within the Trust’s Standard Operating Procedures (Clinical Contact Centre and Clinical Support Desk).

Whilst writing I would like to extend my sincere condolences to Miss Gilbert-Jones family on their sad loss. I am pleased to hear that they have accepted the Trust’s offer to reconsider this matter under the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.

I would also like to extend the offer to meet with you to discuss our response in more detail and to provide you with any further assurances you may require regarding our commitment to continuance improvement to support the prevention of future deaths.

Yours sincerely

**Jason Killens**
**Chief Executive**

**Enc: Action Plan**

**Welsh Ambulance Services NHS Trust Action Plan**

**Response following the inquest of Sarah Marie Gilbert Jones**

This plan represents the strategic projects and actions being taken by the Welsh Ambulance Services NHS Trust (WAST) to address the concerns raised by the Coroner. Monitoring and evaluation of this plan is undertaken by the Executive Management Team and Quality, Patient Experience and Safety Committee of the Trust Board with more detailed delivery actions designed to give effect to the improvement required.

| Ref | Action | Impact/Outcome | Owner | Delivery date |
|---|---|---|---|---|
| 1 | The Trust's Clinical Priority Software Advisory Group (CPAS) to consider whether (temporarily) Propranolol overdose could be managed under another medication, such as the narcotic Fentanyl code group | If approved this would increase the priority of any Propranolol overdose regardless of quantity. This would be a temporary action to highlight this particular drug, whilst the Trust considers more permanent changes and undertakes the necessary actions. | Clinical Priority Software Advisory Group | Q1 2022/23 |
| 2. | The International Academies of Emergency Dispatch (IAED) Clinical Focus Group has been asked to consider what changes may be required and/or possible in relation to Propranolol overdoses. | It may be possible for Propranolol to have its own determinant, with associated priorities. The identification of the cases would need to take place during the initial question set. | IAED Clinical Focus Group | Q2 2022/23 |
| 3 | CPAS to review the priority associated with overdose determinants under the seizure/fitting protocol. | CPAS to consider whether the existing codes are appropriately prioritised, given that it does not specifically relate to Propranolol or identify the quantity of any specific drug taken. Any review of determinant codes within the dispatch cross reference table (DCR) has the ability to increase, maintain or reduce the response priority | Clinical Priority Software Advisory Group. | Q1 2022/23 |

| 4 | Consider the role of the clinical floorwalker within the Clinical Safety Plan. | The Trust to consider how best can the role of Floorwalker offer support? Should the role change to allow constant access to all systems, such as TOXBASE. Moving the floorwalker from mobile support giving verbal advice, to a specific point for triage, where advice can be recorded on the record by the clinician. | Director of Operations | Q4 2022/23 |
|---|---|---|---|---|
| 5 | Association of Ambulance Chief Executives (AACE) recommendations to be considered by the Trust | AACE recommendations include that overdose cases, including Propranolol, should be sent to a clinician to review the effects of the specific drug (using TOXBASE). This will happen whilst the incident remains visible for the dispatch team to see and allocate resources to, as and when a vehicle becomes available. System updates are required to implement these recommendations. | Director of Operations | Q4 2022/23 |
| 6 | Embed with staff the implications and management of incidents with fluctuating priorities. | A coaching tip has been sent to Clinical Contact Staff reinforcing and embedding the need for certain calls to remain Red, when there is a fluctuation in the patient's condition. This is regardless of whether the fluctuation is between Amber 2 and Red, or Amber 1 and Red. | Director of Operations | Q4 2021/22 |

Progress and delivery key

| RAG rating colour | Progress description |
|---|---|
| Red | Off track and not likely to deliver as planned, remedial action required |
| Amber | Currently off track and likely to deliver as planned with recovery action being taken |
| Green | On track for delivery as planned |
| Blue | Action complete |

| AGENDA ITEM No | 15 |
|---|---|
| OPEN or CLOSED | Open |
| No of ANNEXES ATTACHED | 0 |

# RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

| MEETING | Quality, Patient Experience & Safety Committee |
|---|---|
| DATE | 12th May 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 & Safety Committee (QuEST) with an update in respect of Corporate Risks that are relevant to the Committee's remit for review.

**RECOMMENDATION:**

2. **The Quality, Patient Experience & Safety Committee is asked to receive assurances on the report and specifically note:**
    a. **The rearticulation 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 suspension of the Board Assurance Framework (BAF) for 3 months.**

## KEY ISSUES/IMPLICATIONS

3. The Risk Management and Board Assurance Framework improvement programme was supported as the direction of travel at the Audit Committee in December 2021 and a progress report will be submitted for consideration at the meeting in June 2022.

4. The immediate priority was a detailed review of each of the Corporate Risks and the development, testing and implementation of the Once for Wales Risk Datix Module.

5. The Audit Committee approved a request to pause reporting of the BAF for a period of 3 months to enable the Governance team time to develop a transitional BAF that will be presented at the Audit Committee in June 2022 and the Trust Board in July 2022.

6. A programme of work has commenced to strengthen the articulation of the Trust's existing and any new Corporate Risks including title and descriptions, the controls, assurances and any additional actions required.

7. A temporary Risk Officer was appointed until the 31st May 2022 to support the Corporate Governance team with these priorities. The substantive post will be advertised for appointment to commence in July 2022.

8. The Executive Management Team (EMT) received formal, monthly feedback from Assistant Director Leadership Team (ADLT) on activity relating to the corporate risks for approval.

**REPORT APPROVAL ROUTE**

9. The report has been considered by:
   - ADLT – 21st March 2022
   - ADLT – 22nd April 2022
   - EMT – 11th May 2022

**REPORT ANNEXES**

10. An SBAR report is attached to this Executive Summary.

**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 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.

### BACKGROUND

2 The Risk Management and Board Assurance Framework Transformation Programme was presented to the Audit Committee in December 2021 and was supported. A progress report will be presented to the June 2022 Audit Committee as agreed.

3 The immediate priority was for a detailed review of the Trust's 5 highest scoring risks with the remaining corporate risks to follow and a programme of work has commenced 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.

4 The Assistant Directors Leadership Team (ADLT) continue to review the risk assessments 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

5 There are 4 Corporate Risks currently assigned to QuEST for overview which are described in the summary table below.

6 Each of these 4 risks have been reviewed as part of the transformation programme of work and have been rearticulated and approved by EMT.

7 Any changes to the risk score as a result of these reviews is articulated in the risk score column.

| CORPORATE RISK REGISTER: Extract | | | | |
|---|---|---|---|---|
| **RISK ID** | **NEW RISK TITLE** | **NEW SUMMARY DESCRIPTION** | **EXECUTIVE OWNER** | **RISK SCORE** |
| 223 | The Trust's inability to reach patients in the community causing patient harm and death<br><br>Previous title:<br>*Unable to attend patients in community who require See & Treat* | **IF** significant internal and external system pressures and abstractions continue<br><br>**THEN** there is a risk of an inability and/or a delay in ambulances reaching patients in the community<br><br>**RESULTING IN** patient harm and death | Director of Operations | **25 (5x5)** ➡ |

| CORPORATE RISK REGISTER: Extract | | | | |
|---|---|---|---|---|
| 224 | Significant handover delays outside A&E impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service<br><br>Previous title:<br>*Patients delayed on ambulances outside A&E Departments* | **IF** patients are significantly delayed in ambulances outside A&E departments<br><br>**THEN** access to definitive care is delayed and standards of patient care are compromised, and the environment of care will deteriorate<br><br>**RESULTING IN** patients potentially coming to harm | Director of Operations<br><br>Transferred to:<br>Director of Quality & Nursing | **25 (5x5)** ➡ |
| 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<br><br>Previous title:<br>*Compliance with Health and Safety legislation* | **IF** there is a failure to embed an interdependent and mature health and safety culture, effective arrangements and associated governance<br><br>**THEN** there is a risk of a potential breach in compliance with the requirements of the Health & Safety at Work etc. Act 1974 and associated regulations and other statutory instruments<br><br>**RESULTING IN** death or serious injury, and punitive actions from multiple enforcement agencies including penalties and adverse publicity leading to damage to reputation | Director of Quality & Nursing | **20 (4x5)** ➡ |
| 303 | Delayed administration of chest compressions to patients as part of resuscitation<br>Previous title:<br><br>*Delayed administration of chest compressions to patients as part of resuscitation* | **IF** there is no universal guidance issued in relation to the level of PPE required when administrating chest compressions and no reduction in infection rates of Covid-19<br><br>**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<br><br>**RESULTING IN** potential patient harm and damage to the Trust's reputation | | **10 (2x5)** ➡ |

Escalation of Risks

8 No new risks relevant to QuEST have been assessed or approved for inclusion on the Corporate Risk Register during this period.

Closure and De-Escalation of Risks

9 Risk 316 - *Potential for a high volume of personal injury claims due to work acquired covid infection* was approved for closure by the EMT as, following a detailed review of the controls and assurances, the score reduced from 16 (4x4) to 12 (3x4) and it was noted that the mechanisms are in place to undertake claims and that the long term impact is being managed.

10 No risks relevant to the PCC have been de-escalated to Directorate Registers during this period.

Board Assurance Framework

11 The Audit Committee approved a request to suspend reporting of the BAF for a period of 3 months to enable the Governance team to develop a transitional BAF that will be presented at the Audit Committee in June 2022 and the Trust Board in July 2022.

12 This will provide the Governance Team time to invest in developing a transitional BAF which clearly sets out the work that is currently underway to rearticulate the corporate risks as well as the relevant and current controls, assurances and actions that will mitigate the risks to their target.

13 By way of assurance, a high level report will be provided to the Trust Board and each scrutiny Committee during May 2022 on each of the corporate risks with a particular focus on the developing controls and assurances of the Trust's 5 highest scoring risks.

**RECOMMENDED:**

**14. The Quality, Patient Experience & Safety Committee is asked to receive assurances on the report and specifically note:**

**a. The rearticulation 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 suspension of the Board Assurance Framework (BAF) for 3 months.**

| AGENDA ITEM No | 16 |
|---|---|
| OPEN or CLOSED | Open |
| No of ANNEXES ATTACHED | 1 |

# AUDIT REPORT

| MEETING | Quality, Patient Experience and Safety Committee |
|---|---|
| DATE | 12th May 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.**
   e. **Agree any specific items that the Committee wishes to see raised to Senior Management and Audit Committee.**

## KEY ISSUES/IMPLICATIONS

4. Each of the 89 internal audit recommendations have been reviewed by the Assistant Directors Leadership Team (ADLT) and the Executive Management Team (EMT) since the last Audit Committee 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:<br>• ADLT – 22nd April 2022 |

| REPORT APPENDICIES |
|---|
| 6. The Audit Tracker has been circulated as a separate appendix.<br><br>7. Information Management – Hear and Treat and See and Treat Internal Audit Report |

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

**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 |
|---|---|---|
| Information Management – Hear and Treat and See and Treat Internal Audit Report | Reasonable | March 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. The Trust continued to face significant operational pressures resulting from the pandemic and REAP level 4 and as such expects to be carrying a higher number of overdue recommendations during this period.

9. At the time of issuing the paper, there were a total of 89 current internal audit recommendations on the tracker. 21 recommendations were marked as complete at the March 2022 Audit Committee and removed from the tracker.

10. 27 recommendations were added to the tracker resulting from 5 Internal Audit Reports which were presented to the Audit Committee in March 2022. 4 of these recommendations were assigned to QuEST for oversight and were from a Reasonable Assurance rated report.

11. 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 | 51 | 8 | 1 | 7 | 0 |
| Not yet due* | 26 | 6 | 0 | 6 | 0 |
| Complete | 12 | 2 | 0 | 1 | 1 |
| Total | 89 | 16 | 1 | 14 | 1 |

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

12. There is 1 high priority recommendation showing as overdue for QuEST to review which is in relation to the Role of the Advanced Paramedic Practitioner Report.

13. 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 | 4 | 2 | 1 | 1 | 0 |
| 2020/21 | 29 | 1 | 1 | 0 | 0 |
| 2021/22 | 56 | 13 | 0 | 7 | 6 |
| Total | 89 | 16 | 2 | 8 | 6 |

14. There is 1 recommendation showing as overdue from 19/20 reports which is of medium priority. This relates to the Trust's Risk Appetite Statement from the Risk

Management and Assurance review which forms part of the improvement programme currently underway.

15. The remaining 7 recommendations showing as overdue relate to the following reports:
- 20/21 Concerns and Serious Adverse Incidents Management
- 21/22 Role of Advanced Paramedic Practitioner
- 21/22 Controlled Drugs
- 21/22 Information Management Hear and Treat

16. 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 | 6 | 0 | 0 | 0 | 0 |
| Reasonable | 72 | 15 | 1 | 14 | 0 |
| Substantial | 1 | 1 | 0 | 0 | 1 |
| Not Rated | 10 | 0 | 0 | 0 | 0 |
| Total | 89 | 16 | 1 | 14 | 1 |

17. In terms of the 1 high priority recommendation, this relates to the Role of Advance Paramedic Practitioner review.

18. 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:**

**19. 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.**

# Information Management Internal Audit Report

February 2022

Welsh Ambulance Services NHS Trust

NWSSP Audit and Assurance

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| | |
|---|---|
| Review reference: | WAST-2122-011 |
| Report status: | Final |
| Fieldwork commencement: | 9th November 2021 |
| Fieldwork completion: | 12th January 2022 |
| Draft report issued: | 14th January 2022 |
| Debrief meeting: | 17th January 2022 and 4th February 2022 |
| Management response received: | 26th January 2022 and 4th February 2022 |
| Final report issued: | 15th February 2022 |
| Auditors: | Simon Cookson, Director of Audit & Assurance<br>Osian Lloyd, Deputy Head of Internal Audit<br>Chris Scott, Audit Manager |
| Executive sign-off: | Claire Roche, Executive Director of Quality & Nursing<br>Dr Brendan Lloyd, Executive Medical Director |
| Distribution: | Lee Brooks, Director of Operations<br>Jonathan Edwards, Assistant Director of Operations, Resourcing & EMS Coordination<br>Jonathan Turnbull Ross, Assistant Director of Quality Governance<br>Stephen Clinton, Assistant Director of Operations, Integrated Care |
| 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 Service Strategy and Terms of Reference, approved by the Audit Committee.

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# Executive Summary

**Purpose**

To assess, in respect of 999 calls, the availability of information on patient discharges through 'Consult and Close' ('Hear and Treat'), 'See and Treat' and 'Can't Send' emergency responses and how this is analysed to inform patient safety and quality improvement.

**Overview of findings**

Key matters arising concerned:

- Low level of incident 'See and Treat' and 'Consult and Close' pathway referral reporting.
- Low level of scrutiny of 'See and Treat' and 'Consult and Close' incident cases.

## Report Classification

| | | Trend |
|---|---|---|
| Reasonable | Some matters require management attention in control design or compliance.<br>**Low to moderate impact** on residual risk exposure until resolved. | Not previously audited |

## Assurance summary[1]

| | Assurance objectives | Assurance |
|---|---|---|
| 1 | Information capture | Reasonable |
| 2 | Communication of incident response models | Reasonable |
| 3 | Information analysis and solution evaluation | Limited |
| 4 | Management oversight | Reasonable |

## Matters arising

| | | Assurance Objective | Control Design or Operation | Recommendation Priority |
|---|---|---|---|---|
| 1 | Analysis, review and oversight of 'See and Treat, 'Consult and Close' and 'Can't Send' incident stop codes | 3 | Design | Medium |
| 2 | Management review of incident responses and patient outcomes | 3 | 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 Welsh Ambulance Services NHS Trust ('the Trust') operates Clinical Contact Centre call handling and clinical triage/assessment services nationally for both 111 and 999. Patients ringing 999 either receive advice over the phone ('Consult and Close', formerly known as 'Hear and Treat') or a response to scene from the Emergency Medical Service (EMS) ('See and Treat', 'See and Refer', 'See and Transport', collectively termed, and referred to in this report as 'See and Treat'). In periods of extreme demand, patients may be told an ambulance is not available ('Can't Send') and advised to contact their GP or the 111 service.

1.2 'Hear and Treat' and 'See and Treat' was a feature of Welsh Government's New Clinical Response Model which was piloted in 2016 and fully implemented in February 2017.

1.3 Enhancing the clinical response model for ambulance services to 'Consult and Close' people by providing clinically safe alternatives to transport to Emergency Departments and enable better management of people's health needs in the community has been an objective of Welsh Government for some years and appear in the healthcare plan 'A Healthier Wales: Plan for Health and Social Care' launched in 2018.

1.4 The terms 'Hear and Treat' (now referred to as 'Consult and Close') and 'See and Treat' were first introduced by the Trust in their Integrated Medium Term Plan (IMTP) 2017/18. Since then the 'See and Treat' and 'Consult and Close' patient treatment models have been introduced to their operation.

1.5 These models, which incorporate a series of clinical assessment steps that are used by call handlers to identify cases where they can be used, provide alternative emergency call responses to the despatch of an ambulance and subsequent conveyance to ED and through this reduce the number of these conveyances.

1.6 Volumes of patients using these pathways and their outcomes are monitored and reported internally and externally.

1.7 The Trust's Demand Management Plan has for many years provided a framework of tactical options to support them in responding to situations where the demand for services are greater than capacity. In 2020, the Demand Management Plan was expanded with the introduction of 'No Send' (also termed 'Can't Send') outcomes for callers at the point of contact. It has more recently been revised to be consistent with agreed UK naming and is now known as the Trust Clinical Safety Plan (CSP). This was approved by the Executive Management Team in September 2021.

1.8 The CSP provides a revised response matrix covering higher levels of excess demand, so that the Trust can dynamically react to situations to ensure those patients with the most serious conditions or in greatest need according to their presentation remain prioritised to receive services.

1.9 The overall objective of the audit was to assess, in respect of 999 calls, the availability of information on patient discharges through 'Consult and Close', 'See and Treat' and 'Can't Send' treatment pathways and how this is analysed to inform patient safety and quality improvement. This included an assessment of the effectiveness of patient communication, clinical handover and follow up arrangements.

1.10 The key risk considered in this review was that patient outcomes are adversely impacted through inappropriate or delayed clinical response.

1.11 The audit included in its scope only the calls that are received and processed by the 999 clinical support desk.

# 2. Detailed Audit Findings

### Objective 1: patient volumes that use the 'Consult and Close', 'See and Treat' and 'Can't Send' treatment pathways are accurately captured

2.1 We examined the processes involved in 999 call handling and either the despatch of an EMS responder or referral to other services, with an emphasis under this objective on the means by which incident responses are captured by systems for subsequent oversight reporting. We sought to establish whether data is generated to distinguish between the different types of incident response and whether systems are reliable and consistent in the capture of this.

2.2 All 999 calls are received in one of the three Wales Emergency Medical Services Clinical Contact Centres (EMS CCC). Within each EMS CCC, there is a team of operational staff who are responsible for triaging calls received and coordinating the appropriate response. A triage process is undertaken for each call and is completed through the Medical Priority Dispatch System (MPDS).

2.3 The MPDS is used internationally, including by half of the UK ambulance Trusts, to triage emergency calls. The responses provided by the caller to the call handlers questions allow the MPDS system to generate a number-letter-number format code to each type of incident. The Dispatch Cross Reference (DCR) table allocates MPDS codes to one of the Red, Amber 1, Amber 2, Green 2 and Green 3 priority classifications, in order to determine the response required.

2.4 According to the Trust escalation level and the CSP response matrix, higher priority calls receive an ambulance despatch. Calls requiring secondary triage are passed to the 111 service (not in the scope of this audit) and all other calls go to the Computer Aided Despatch (CAD) ambulance despatch system's call queue or 'stack'. Those that may be dealt with by telephone ('Consult and Close') are then picked up by the clinical staff of the Clinical Support Desk (CSD) and addressed according to the incident type.

2.5 The CSD is a virtual function spread across three CCCs and comprises of nurses and paramedics, who undertake secondary telephone assessment of patients calling or being referred to 999.

2.6 Nurses and paramedics triage patients remotely using Computer Decision Support Software (CDSS) to achieve the best outcome for them, within the general principles of providing *the Right Care, at the Right Time, in the Right Place*.

2.7 The CSD clinician picking up a call may conduct further assessment with the caller using the Manchester Triage System (to be replaced by the Emergency Communication Nurse System (ECNS) in March 2022), which could result in the case priority code being amended up or down (e.g. an Amber 1 may be raised to a Red or vice versa).

2.8 Calls which have undergone secondary triage by the 111 service are generally automatically closed in the CSD system but can be passed back in the event that an ambulance despatch is necessary.

2.9 Systems used in the CCC typically operate with a combination of defined entry and free form fields. The following data protection measures operate within the systems:

- user entry fields are controlled through the use of drop-down value lists.
- date and timestamps are automatically applied and can only exceptionally be overwritten / amended.
- other fields are auto populated - e.g. caller phone number, caller address.
- triage tools run on predefined workflows constructed around key questions that callers are asked in order to determine the nature of the incident. Caller responses determine the workflow pathways taken which direct call handlers with appropriate prompts.
- call designation codes, which are the output of the workflow, cannot be amended by the operator (but note that clinicians on the CSD picking up these calls can re-assess and amend the incident code and / or priority).
- audit logs operate within the systems to capture and report changes that are made to values e.g. time or date stamps.

2.10 The 'See and Treat' model is one which provides focused clinical assessment at the patient's location, followed by appropriate immediate treatment, discharge and / or referral. 'Consult and Close' describes the scenario where 999 calls are successfully completed ('stopped') without despatching an ambulance vehicle response. This may include advice, self-care or a referral to other urgent care services. In periods of high escalation, and in line with the Trust's CSP, lower priority calls will be 'stopped' after the caller is told the Trust cannot send an ambulance ('Can't Send'). In all three scenarios calls are assigned a 'stop' code which denote the call outcome.

2.11 A data warehouse combines the data collected in several related systems from which analysis and reporting is available, although we have not examined the parameters used to generate the reports.

2.12 'See and Treat' and 'Consult and Close' 999 caller outcome volumes are regularly reported internally and externally based on flags assigned to incident records in the database and volumes of incidents with a 'Can't Send' response 'stop' code are monitored by operational teams (these areas are examined further under Objective 3 and are the subject of **Matters Arising 1**).

2.13 We noted too there is a dedicated audit team within the EMS CCC who are responsible for auditing calls and providing feedback and support to call handlers. Quality Assurance reports are produced monthly which outline compliance against the Academy of Emergency Dispatch performance standards, including data on whether responses were ideal or if there was an over or under response.

2.14 It was noted within the Executive Director of Quality and Nursing Patient Safety Highlight Report presented to the Trust's Quality, Patient Experience and Safety Committee (QuEST) at its September 2021 meeting that between January 2021 - June 2021, 2,328 calls were randomly audited. Of these 155 were non-compliant. Further review identified that 72 of the non-compliance achieved the incorrect MPDS categorisation; 15 were over-coded, 32 were under-coded and for the remainder there was not enough information to determine

what the final code should have been. In a worst-case scenario assuming all the remainder of the calls were under-coded, this would mean 2% were under-coded against MPDS hierarchy.

2.15 Issues that emerge from this audit cycle that impact patient safety are also captured as Datix incidents and managed through the regular Datix review processes. Each CCC has individually been re-accredited by the International Academy of Emergency Dispatch as a Centre of Excellence (ACE).

Conclusion:

2.16 The Trust's triage systems automatically generate the priority codes for incidents and further assessments are made during the triage process by clinicians at the clinical service desk. Incidents are designated 'See and Treat', 'Consult and Close' or 'Can't Send' for monitoring and evaluation purposes. We have raised no findings in this section of the audit and consequently have provided **Reasonable** assurance for this objective.

### Objective 2: the alternative response pathways are communicated and explained to users of the emergency medical system, including patients and clinicians

2.17 The Trust communicates with service users and liaises and shares with health care partners through a variety of different channels. We sought to establish whether the Trust communicates the different incident responses with patients and partners to assist delivery and flow.

2.18 Callers to the 999 number are taken through a series of questions by call handlers to determine the severity of the incident. The Ambulance Service' response is determined by a combination of the incident severity and the Trust's level of escalation as set out in a response matrix in the Trust's CSP.

2.19 For consistency, call handlers use a series of scripts to advise callers how they will respond and to provide other key information, for example, where an ambulance is being despatched, it's estimated time of arrival.

2.20 In periods of higher escalation, scripts are also used to advise callers that an ambulance is not available and what action they should take. Callers with incidents which in the models are designated for 'Consult and Close' response will be advised they'll receive a call back from a clinician.

2.21 The CCC call handling supervisor monitors the waiting patients in the call 'stack' and directs welfare telephone calls to patients accordingly. Vulnerable patients who are waiting may receive these calls to ensure they remain stable and are aware of the delay to receiving assistance.

2.22 Patients who receive an ambulance response but are then assessed at scene for referral to other services are advised accordingly by the attending paramedic.

2.23 Regarding liaising with health care partners, the Trust chair the National Risk Huddles which take place daily, during which the Trust's CSP escalation level is shared. The National Risk Huddles are attended by the Strategic leads of all Health Boards and Welsh Government (these are the nominated System Leads responsible for service delivery in their respective

areas). If there is significant pressure in the system, additional ad hoc National Risk Huddles are also scheduled. The Trust's community demand and CSP level are discussed routinely during these huddles.

2.24 As well as the National Risk Huddles, local site huddles take place daily and these are attended by the Trust's Operational Delivery Unit National Delivery Managers or local Operations Managers. Again, the Trust's community demand and CSP level are routinely discussed during these local huddles to inform local planning assumptions, although we recommend later under objective 3 that the Trust provide health boards with more detailed incident response data to assist them with their service provision planning (see **Matters Arising 1**).

2.25 The Trust's unscheduled care partners across the system also have access to a live Power BI dashboard through which they can monitor the live CSP position (but not incident response data). The Trust is also in the process of providing Primary Care colleagues with access to the Power BI dashboard and it is anticipated that this will be in place by March 2022.

2.26 As the Trust escalate and de-escalate through the CSP levels, its Operational Delivery Unit make a number of recommendations cascaded to the relevant Strategic leads informing them of the escalation and potential impacts to service delivery in their respective areas. The Strategic leads are then responsible for cascading further the message within their own organisations. Again, we recommend under objective 3 that the Trust provide health boards with more detailed data to assist them with their service provision planning (see **Matters Arising 1**).

2.27 In terms of a more general approach to raising awareness as to purpose, scope and associated impacts of the CSP on the wider system, we were advised that representatives from the Trust have supported a number of meetings with relevant stakeholders across the system. This includes information sharing with health boards at regular peer to peer collaborative meetings.

2.28 The Trust use multiple channels to capture feedback from service users with all engagement and experience data being brought together and presented quarterly at the Trust's QuEST Committee in the Patient Experience Community Involvement (PECI) highlight report.

Conclusion:

2.29 We noted a detailed level of communication planning with both 999 callers in respect of individual incidents and health care partners regarding the fluctuating demand and response for emergency services and the changing response models being deployed by the Trust. We have raised no findings in this section of the audit (although Matters Arising 1 under objective 3 considers the provision of further information to health boards) and consequently have provided Reasonable assurance for this objective.

## Objective 3: assessments are made of the impact and effectiveness of the pathways on patient outcomes to inform patient safety and quality improvement

2.30 The Trust has a role as part of the broader urgent and emergency care system to develop services to influence a shift of patient demand towards scheduled care as far as possible.

2.31 The Trust has undertaken a clinical review of the CCC and, with funding agreed to recruit paramedics into the clinical service desk to further develop the service model, is currently implementing its findings.

2.32 To further the service's ambition to 'shift left' in the patient pathway, a range of initiatives are in progress to increase the volumes of incidents that are dealt with by either referral to alternative services through the CSD ('Consult and Close'), or at the scene ('See and Treat').

**Active monitoring of alternative pathways**

2.33 We sought to establish whether there is active monitoring of these volumes using the data captured which is then used to inform changes to the models for further improvement.

2.34 Analysis of the incident volumes that are dealt with via these routes are reported at a summary level to a number of operational review groups.

2.35 EMS CCC reports are seen by the weekly Senior Operations Team (although this group still meets as the Senior Pandemic Team (SPT) during the continuing pandemic response). We note the 'Consult and Close' volumes ('See and Treat' not reported to this group) are only one item in a very extensive performance report deck and are largely for information only, as the SPT have a broader responsibility to prioritise personnel resources and services to protect core activities. Incident outcomes and conveyance rates are also reported in the daily operational report of CCC activity. This records at summary level incident volumes dealt with through 'See and Treat' and 'Consult and Close' which inform and may contribute to operational decision making.

2.36 We noted that the Trust does not report on referrals activity by type. Although 'stop' codes, which include the suite of referral pathways, are assigned all incidents where there is no conveyance to an emergency department (ED), we did not encounter any regular incident reporting at this more detailed level (**see Matters Arising 1**). We note a link here to the Emergency Ambulance Services Committee (EASC) commissioning intentions 2022-23 (CI1) that call for the development of this area.

2.37 Other groups receive reports of activity volumes of the 'See and Treat' and 'Consult and Close' pathways to assess the impact on 999 verified incidents as initiatives launch and develop to increase their use and where uptake of these pathways is a project objective. For example, service development initiatives of the Care Closer to Home group (CCHG) linked to the EMS Demand & Capacity Review are aimed at providing safe alternatives at scene ('See and Treat') to Emergency Department (ED) conveyance and these include:

- developing a range of dedicated pathways that can be delivered by EMS responders e.g. COPD pathway.
- increasing the number and range of incident types that can be dealt with at scene by Advanced Paramedic Practitioners (APP).
- increasing the numbers of prescribing paramedics.

2.38 We noted the CCHG report the impact of these initiatives to the Clinical Transformation Board (CTB) and saw material illustrating the reduction in ED conveyances being achieved through the increasing number of APP attendances at 999 incidents.

**Monitoring and maintaining the Trust's incident response model**

2.39 We sought to establish whether there is active monitoring of the suitability of the Trust's current incident response model and to identify further opportunities where 'See and Treat' and 'Consult and Close' pathways can be expanded.

2.40 We note the role of the Clinical Prioritisation Assessment Software (CPAS) Group in managing the Trust's Despatch Cross Reference (DCR) table. This allocates the Medical Priority Despatch System (MPDS) incident codes to one of the Red, Amber 1, Amber 2, Green 2 and Green 3 priority classifications and gives the clinical contact centre advice on the ideal ambulance asset to send, including crew composition and vehicle type.

2.41 The DCR table, which is common to all 3 CCCs, is a critical look-up resource which is embedded in the Despatcher's workflow and is referenced to direct the call-handlers response to the 999 call.

2.42 CPAS meet quarterly to consider opportunities for changes to the DCR table arising from their own review work, as well as requests for change from the EMS CCC.

2.43 Requests for change which we saw to have emerged from recent review initiatives were:

- Shift left proposals from 'stop' code studies e.g. the MPDS protocol (code) 17 Falls case study (linking to the development of the Falls framework).
- Requests for incident code re-designation to 'Consult and Close' response where there has been a recent pattern of good outcomes with that approach. (e.g. some 021 MPDS incident codes relating to Haemorrhage / Lacerations).
- Focussed reviews on individual MPDS protocol usage e.g. Protocol 36, Pandemic response.
- Benchmarking exercises with other Ambulance Services (England, Scotland) who have had success with 'Consult and Close' and 'See and Treat' response to other incident types and where that response might prove effective for the Trust.

2.44 Changes to the individual incident response codes in the DCR table are made only after careful consideration and modelling to assess the impact on the service areas that would receive higher volumes of incidents to ensure patient safety would not be impacted.

2.45 We noted a total of 10 DCR table Request for Change (RFC) papers had been submitted to CPAS in 2021/22, although not all of these were 'Consult and Close' and/or 'See and Treat' related.

**Monitoring patient safety impacts of non-conveyance**

2.46 Regarding patient safety we sought to establish whether information is available and used to ensure that patients are not put at increased risk by increasing non-conveyance to an ED.

2.47 We found that monitoring of patient re-contact rates takes place to ensure that patients are not calling 999 soon after a 'Consult and Close' discharge because they still require emergency services.

2.48 The percentage of re-contacts within 24 hours of telephone 'Consult and Close' has fluctuated over the last two years, peaking in June 2020 at 15.7%. Re-contact rates in October 2021 were 13.8%, an increase compared to 8.8% in September 2021 and when compared to 5.5% in October 2020.

2.49 Re-contact rates are not monitored to the same extent for patients who are treated at scene ('See and Treat') but we note that these did not exceed 1.2% in January to July 2021 (more recent analysis packs do not record re-contact rates for 'See and Treat' incidents).

2.50 The Datix reporting system will capture any reports of concern relating to 'See and Treat', 'Consult and Close' and 'Can't Send' incident responses, which are subsequently reported to the quarterly QuEST sub-committee in the PECI Patient Safety Highlight report.

2.51 Any cases that are considered as potentially causing significant harm are identified and examined by the Trust Serious Case Incident Forum (SCIF) which meets twice a week. The cases are discussed and if necessary, reported as Nationally Reportable Incidents (NRI's) to the Delivery Unit and investigated accordingly, or for cases where the root cause of a potential NRI is hospital handover delays, shared with the relevant health board. These cases are reported in a regular Patient Safety report to the CEO and in a CEO brief presented to EMT monthly.

2.52 We were unable to confirm with analysis but were advised that there is no observed increase in cases attributed to the rise in 999 incident numbers being handled through the 'See and Treat' and 'Consult and Close' responses. Review of summary level reporting by the Patient Safety function confirmed no correlation is currently being reported or inferred between patient incidents and 'See and Treat', 'Consult and Close' and 'Can't Send' case volumes.

2.53 The revised response matrix of the recently adopted Clinical Safety Plan, which replaced the earlier Demand Management Plan, has led to a greater incidence of 'Can't Send' EMS CCC responses to 999 incidents.

2.54 We were advised that during periods of escalation when the Trust are not sending ambulances to Amber 1 priority incidents, analysis work is carried out of 'Can't Send' incident responses by the CCC to provide assurance that no obvious risks are being identified. Whilst we understand the results of this, and more detailed audits of a sample of these incidents, are shared with operational review teams, we were not able to confirm this information was regularly reported to the QuEST committee or other oversight body. We also noted the review work that is being done is limited currently to the 'Can't Send' cases and that there could be benefit in extending this to cover other 'See and Treat' and 'Consult and Close' incident responses (see **Matters Arising 2**).

**Monitoring alternative pathway incident response against targets**

2.55 We sought to establish whether information is available and used to assess the effectiveness of the incident response model against incident volume targets.

2.56 We noted that a quantitative target is set for 'Consult and Close' responses but not for 'See and Treat' volumes where, for the latter, the Trust's ambition, by design, is described in broader terms reflecting the commissioning intention of 'optimising conveyance'.

2.57 For the former, 'Consult and Close' volumes are recorded in the monthly reports as a percentage of verified incidents against a target of 10.2%. Latest reported data (October 2021) at the time of the audit indicated the service achieved a combined 9.7% performance

(CSD 5.8%, NHSDW/111 3.9%). Target volumes are not set for 'See and Treat' incident responses.

**Alternative pathways and patient outcome**

2.58 We sought to establish whether information is available and used to establish the effectiveness of the incident response in terms of patient outcomes.

2.59 Clinical guidelines for pre-hospital care are provided by the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) and Paramedics are able to access these and the available referral pathways at scene using tablet or other electronic devices. We understand that referral to a pathway involves contacting the referee, making arrangements for follow-up, e.g. speaking to a clinician through the 'Consultant Connect' technology, arranging a patient appointment with the patient's GP, and advising the patient accordingly. The most common instance of 'See and Treat' referral is to the patient's GP in which case the paramedic will make contact with the practice and make arrangements for the patient to be seen, although we were not able to establish what arrangements are made out of hours or with other referrals pathways e.g. palliative care, midwife, diabetic, falls, cardiac care etc. Notes are made on the incident record of what's been arranged and patients are advised accordingly.

2.60 Clinicians on the CSD taking calls from the 'stack' suitable for 'Consult and Close' use a Directory of Services (DoS) to determine what referral pathways are available in the area of the incident in question. The DoS is maintained by an internal team but is reliant on the information coming from the wider NHS Wales. We were advised that CSD clinicians make contact with pathway providers e.g., through the 'Consultant Connect' technology, and arrange for follow-up of these cases, although we didn't conduct any testing to verify this.

2.61 We were advised that there is no practical method at present to enable the Trust to trace 999 callers they've referred to other services to establish the effectiveness of this referral process. We note a lack of integration of Trust and health board systems prevents the Trust from understanding individual patient journey and outcomes. However, we were advised that the recent launch of the Electronic Patient Care Record (ePCR) solution will bring improved capability to achieve better data and better access to information to improve patient care, including enabling secure sharing of information with other NHS Wales bodies to improve learning and continuity of an individual's patient care.

2.62 We were advised that the linking of the health board Emergency Department Data Set (EDDS) and other partner systems to the Trust's data warehouse is currently being developed and will increase opportunities for further analysis of the broader patient journey in the near future.

Conclusion:

2.63 We noted incident volumes that are dealt with by 'See and Treat' and 'Consult and Close' responses are regularly reported to a number of operational review groups which monitor these against expectations and targets but that this is limited at summary level. Measurement of caller re-contact rates are analysed to gauge impact on Patient safety of increasing 'See and Treat' and 'Consult and Close' responses and decision makers observe levels of reported patient incidents to ensure these are not being impacted by rising levels of non-conveyance to ED. We have raised a number of findings in this section and have therefore provided **Limited** assurance for this objective.

## Objective 4: appropriate oversight arrangements are in place within the Trust to manage and monitor the delivery of the 'Consult and Close', 'See and Treat' and 'Can't Send' treatment pathways

2.64 We record in the previous section of this report the operational monitoring that takes place over 999 incident response within the CCC to assure process efficiency, effectiveness and the preservation of patient safety. This is as increasing numbers of cases are dealt with through telephone advice ('Consult and Close') and at scene by an EMS responder without ED conveyance ('See and Treat'). This section considers broader Trust management, commissioner and other stakeholder oversight.

2.65 We sought to establish whether information is available to senior decision makers in the Trust to assess the efficiency, effectiveness and safety of current response models and if so, whether this is used to inform future pathway developments.

2.66 We noted Trust Board and sub-committees receive only summary level information about 'See and Treat' and 'Consult and Close' volumes, targets, trends, re-contact rates etc. through the monthly integrated performance reports (MIQPR), indicators 22 ('Hear and Treat') and 23 (Conveyance to ED) which present the information in a graphical form. These mirror similar graphics as those provided to the operational teams, outlined under Objective 3 above and referred to in **Matters Arising 1**.

2.67 Information is provided to senior planning teams and Executives on the progress and success of service development initiatives on which decisions are then made for their future direction. Reports of the progress of 'shift left' service development initiatives linked to the EMS Demand & Capacity Review (examples of these were given under objective 3 above) are provided via the Strategic Transformation Board, to which programme boards managing these provide regular updates.

2.68 Future plans are formed drawing on the experience of earlier initiatives, and in the EMS context, from the impacts seen on the reduction in ED conveyances through the successful use of 'See and Treat' and 'Consult and Close' alternative incident responses.

2.69 Examples of this are the second phases now launching of the falls response team (development of Level 2 following the success of Level 1) and recruitment of CSD Mental Health practitioners to provide the resources to extend the Mental Health referral pathway 'See and Treat' offer.

2.70 Also monitored is the patient safety aspect, through the continuous incident capture in Datix and regular analysis, investigation and reporting of these to the Patient Safety groups and the Quality and Patient Safety & Experience sub-committee.

2.71 We looked at what the Trust are doing to share their EMS response information with commissioners and other stakeholders.

2.72 We note that the Ambulance Quality Indicators (AQIs) published by EASC quarterly include metrics relating to 'See and Treat' and 'Consult and Close', but at present none relating to the 'Can't Send' incident response which is applied when the Trust is at levels of high escalation.

2.73 We are advised that commissioners also have access to the Trust's data warehouse and through this, material is available to the National Collaborative Commissioning Unit (NCCU) at any time through the self-service Qliksense dashboards where users can configure their own enquiries.

2.74 The Trust reports bi-monthly to EASC in the EASC Provider Report, covering key issues affecting quality and performance for EMS and NEPTS and providing an update on commissioning and planning. The latest report of November 2021 refers to the award of new resources for the CSD and the further modelling work currently being undertaken on shift left options ('See and Treat', 'Consult and Close'), following the re-opening of the EMS Demand and Capacity Review.

2.75 We saw materials in which performance against a broad variety of different targets including 'See and Treat' and 'Consult and Close' are reported in the regular Joint Executive Team (JET) meeting held every six months with Welsh Government.

Conclusion:

2.76 The Trust uses incident response information available from its systems to assess the models being used and to further its ambition to shift more patient demand left, where it is clinically safe to do so (although we recommend in **Matters Arising 1** under objective 3 that the analysis is extended to further inform incident response model development). We have raised no findings in this section of the audit and consequently have provided **Reasonable** assurance for this objective.

# Appendix A: Management Action Plan

| Matters arising 1: Analysis, review and oversight of 'See and Treat, 'Consult and Close' and 'Can't Send' incident stop codes (Design) | Impact |
|---|---|
| We noted that the Trust do not routinely analyse and report the detail of 999 incident volumes by stop codes, including those dealt with by referral to the different health care partners and pathways, and as a result may miss opportunities to optimise case handling in using the 'See and Treat' and 'Consult and Close' options. Data is captured from a long list of values of different referral pathway types including palliative care, midwife, diabetic, falls and cardiac care, but we did not encounter any analysis of case volumes of these so were unable to determine how usage of the respective pathways is being monitored and interpreted (although project groups who own the service development initiatives will be conducting monitoring and data may be available through the Power BI reporting tools).<br><br>There have been examples of development in some of these pathways, e.g. falls framework and mental health pathway, but more coordinated analysis and scrutiny of all referral pathways usage could identify further improvement opportunities. This information could be used internally by the Trust to inform incident response development as well as being shared with health boards (who currently receive only records of incidents where the outcome was a conveyance to a hospital in their area) to assist in their service provision planning, and to do so would deliver against one of the current commissioning intentions. | Potential risk that opportunities for further 'See and Treat' and 'Consult and Close' incident responses are missed. |

| Recommendations | Priority |
|---|---|
| 1.1 We recommend that greater use is made of referral data in the incident records to inform further developments of current and future referral pathways, including;<br>1) production of reports showing more detailed analysis by stop code.<br>2) coordinated analysis, review and scrutiny of these internally to inform quality improvement.<br>3) reporting referral volumes at health board level to assist with their service provision planning. | Medium |

| Management response | | Target Date | Responsible Officer |
|---|---|---|---|
| 1.1 | 1.1.1 A new report is available with data back to January 2021 which shows the referral pathway presented to the patient once the consultation with CSD is complete. This will be able to be broken down by health board area given the nature of the patient's location information. The Ops team is also reviewing in more detail the calls into CSD and their outcome. A review of this is likely late Q4 2022. | Q4 2021-22 | Assistant Director of Operations (Integrated Care) S Clinton |
| | 1.1.2. The review can be shared to inform quality improvement. | Q1 2022-23 | Assistant Director of Operations (Integrated Care) S Clinton |
| | 1.1.3. The detail in the new stop codes will allow for the reporting referral volumes through Consult and Close in CSD. | Q1 2022-23 | Assistant Director of Operations (Integrated Care) S Clinton |

| Matters arising 2: Management review of incident responses and patient outcomes (Design) | Impact |
|---|---|
| We noted that, because of the heightened harm risk where ambulances are not sent to callers, the CCC are monitoring volumes of 'Can't Send' responses and examining sample cases to ensure there has been no patient harm resulting, but that this information is not routinely reported to an oversight group within the Trust's governance structure.<br><br>Other 'See and Treat' and 'Consult and Close' incident responses are not currently being similarly examined. As the Trust is expected to increase 'Consult and Close' and 'See and Treat' activity going forward, to shift left along the five-step clinical response model, this should present opportunities to expand this review process to assess these stop codes.<br><br>We note a lack of integration of Trust and health board systems prevents the Trust from understanding individual patient journey and outcomes. However, we were advised that the recent launch of the Electronic Patient Care Record solution will bring improved capability to achieve better data and better access to information to improve patient care. | Potential risk of patient harm |

| Recommendations | | Priority |
|---|---|---|
| 2.1 | We recommend that current analysis and sample examination of the 'Can't Send' call responses is extended to include other 'See and Treat' and 'Consult and Close' incident responses. This could be coordinated by theme and pathway type, to inform patient safety and quality improvement and should be routinely analysed and reported into the agenda of an appropriate group in the Trust's governance structure. | Medium |

| Management response | | Target Date | Responsible Officer |
|---|---|---|---|
| 2.1 | With the introduction of a dedicated training and audit team within the CSD more opportunity to analyse and sample Consult and close outcome will be possible. We will ensure it is part of normal audit of the activity in the CSD. Findings can be shared with other groups to ensure quality and enhanced clinical review similar to Can't Send outcomes. | Q2 2022-23 | Assistant Director of Operations (Integrated Care) S Clinton |

# Appendix B: Assurance opinion and action plan risk rating

## Audit Assurance Ratings

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

| Rating | Description |
|---|---|
| **Substantial assurance** | Few matters require attention and are compliance or advisory in nature.<br>**Low impact** on residual risk exposure. |
| **Reasonable assurance** | Some matters require management attention in control design or compliance.<br>**Low to moderate impact** on residual risk exposure until resolved. |
| **Limited assurance** | More significant matters require management attention.<br>**Moderate impact** on residual risk exposure until resolved. |
| **No assurance** | Action is required to address the whole control framework in this area.<br>**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.<br>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.<br>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.<br>Some risk to achievement of a system objective. | Within one month* |
| Low | Potential to enhance system design to improve efficiency or effectiveness of controls.<br>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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STORY/EXPERIENCE/THEMES

DETAILS/SUB-THEMES

WHICH REQUIRES...

INITIAL ACTIONS

CONSEQUENT ACTIONS

OUTCOMES

**Hannah Thomas**
Hannah lives with a learning disability and is a member of Caerphilly People First self-advocacy group. She was aware of her mother's hypertension and recognised the signs of a stroke when her mother collapsed at home. Her dad rang 999 for an ambulnce and on being given a 2 hour ETA Hannah was particularly concerned because she was familiar with the FAST campaign which emphasised the importance of urgent treatment Hannah was angry and really scared because she felt the 2 hour response would be harmful to her mum.

**THEMES**

**1.**

- Delayed response to a possible stroke which would have warranted an Amber 1 response, to which a 2 hour ETA might seem unaaceptable. (although guidelines recommend a maximum of 4 hours, NHS England works towards a 3 hour minute target response time from 999 call to thrombolysis.
- WAST has no specific time target for Amber calls. HIW WAST Local Review 2021 recommends that WAST "Consider how the service can maximise the opportunity to respond to patients who have specific therapeutic window timescales."

- Delayed response to a possible stroke which would have warranted an Amber 1 response, to which a 2 hour ETA might seem unaaceptable. (although guidelines recommend a maximum of 4 hours, NHS England works towards a 3 hour minute target response time from 999 call to thrombolysis.
- WAST has no specific time target for Amber calls. HIW WAST Local Review 2021 recommends that WAST "Consider how the service can maximise the opportunity to respond to patients who have specific therapeutic window timescales."

**2.** FAST message designed to raise awareness of stroke symptoms and encourage an urgent response has the potential to create false expectations for callers.

The much-publicised FAST message designed to raise awareness of stroke symptoms and encourage an urgent response has the potential to create false expectations for callers as it gives the impression that urgent, timely action is the most crucial factor, although a 4 hour window is actually deemed acceptable.

The reality is therefore slightly at odds with the message and can cause worry and distress for patients and relatives when, as in Hannah's case, they believed that a 2 hour wait for an ambulance would be dangerous.

**3.** Family advised to take the patient to hospital themselves.

Was it appropriate to advise the family to make their own arrangements to convey the patient themselves instead of waiting for the ambulance to arrive?

Would this have even been an option for them without someone being available to stay with Hannah while they were gone?

- Hannah's story shown at QUEST Committee 17/2/2022
- It was felt that the story needed to be shared more widely and agreed to take to the next Trust Board
- Chair of QuEST Committe wrote to Hannah thanking her for sharing her experience and raisning these issues.
- Mixed-messaging in relation to FAST action was acknowledged

- Story presented to Board on 24/03/2022
- Board acknowledged the power of the story
- Director of Quality and Nursing assured Board that she works with health board counterparts to ensure joined-up working takes place to explore ways of improving the situation in respect of hospital handover delays and the knock-on effect on WAST's ability to provide a timely response.

| AGENDA ITEM No | 18 |
|---|---|
| OPEN or CLOSED | OPEN |
| No of ANNEXES ATTACHED | |

# Practical Obstetric Multi-Professional Training (PROMPT)

| MEETING | Quest Committee |
|---|---|
| DATE | 12 May 2022 |
| EXECUTIVE | Director of Paramedicine |
| AUTHOR | Regional Clinical Lead- Consultant Paramedic |
| CONTACT DETAILS | Mike Jenkins 07738029348 |

| CORPORATE OBJECTIVE | |
|---|---|
| CORPORATE RISK (Ref if appropriate) | |
| QUALITY THEME | |
| HEALTH & CARE STANDARD | |

| REPORT PURPOSE | Information and support |
|---|---|

## REPORT APPROVAL ROUTE

| WHERE | WHEN | WHY |
|---|---|---|
| Ambulance Practice Steering Group | 14 February 2022 | Noting |
| Clinical Quality Governance Group | 31 March 2022 | Support |
| Quest Committee | 12 May 2022 | Information |
| | | |

## SITUATION

1. Paramedics are provided education in relation to obstetric emergencies such as:

   - Shoulder dystocia
   - Prolapsed Cord
   - Breach delivery
   - Post-Partum haemorrhage
   - Ante-partum haemorrhage
   - Eclampsia
   - Uterine inversion
   - Maternal sepsis
   - Neonatal resuscitation
   - Maternal resuscitation

2. In stating this, exposure to these conditions are extremely rare, and in some case a once in a career event. Additionally, when confronted with these conditions the Paramedic will on occasions be supported by a midwife, however often there is a lack of clarity upon the competencies of each professions scope of professional practice when confronted with an obstetric emergency. This has on occasions resulted in confusions and opportunities for learning post incident.

## BACKGROUND

3. PROMPT is a maternity safety programme that is funded by the Welsh Risk Pool and supported by the PROMPT Maternity Foundation. PROMPT Wales' courses consist of a full day of training either within the maternity unit or community setting. Courses are attended by all members of the maternity team annually. The day includes lectures, workstations and scenarios based around obstetric emergencies with a focus on team working, communication and situational awareness.

4. The Health Board Clinical Lead for Cardiff (HBCL) and Vale University Health Board has been in discussion with the national course leads for PROMPT. He has attended and has completed the necessary train the trainer course and now sits on the trainer's faculty.

5. It has been agreed that all Senior Paramedics (SP) across Wales can access the course, with a further train the trainer's course planned for all HBCLs and some SPs in the latter part of March. To date a significant number of SPs and HBCL have completed the course. Feedback from PROMPT leads has been extremely positive in relation to the attendance of Paramedics on this course, as it brings a greater awareness of the role and capability of Paramedics in these highly emotive and challenging situations.

6. Currently the Trust is developing a new tier of service, the Cymru High acuity Response Unit (CHARU), Paramedics staffing the CHARU will be targeted to all Red calls, and a small sub group of Amber calls. As such CHARU Paramedics

could potentially attend incidents where all of the above mentioned conditions are presented either to support Emergency Ambulance Staff already on scene, community midwife or as the first person on scene.

**ASSESSMENT**

7. It would be considered impractical/unachievable to attempt to support all Paramedics attending a PROMPT course. However the Regional Clinical Lead-Consultant Paramedic (SE) and HBCL for CVUHB attended a meeting with the PROMPT course national leads on the 1 February 2022 where the feasibility of placing all Paramedics who will staff the CHARU onto one of these Multi-Professional courses to support them for when attending an obstetric emergency, either to support the Trusts own staff or indeed a community midwife. The National PROMPT leads have agreed to accept Paramedics staffing CHARU onto the course. It is accepted that due to numbers it would take one to one and half years to get every Paramedic staffing CHARU onto the course. To assist, it was requested that WAST identify points of contacts within each Health Board. This point of contact will co-ordinate with local Health Board PROMPT faculties in identifying the names of Paramedics staffing CHARU for each planned course.

8. The RCL (SE) has suggested that this point of contact should be the relevant HBCL for each of the seven Health Boards in Wales. For noting, BCU has three faculties, West, Mid and Eastern areas.

9. The cost of this course is covered by the Welsh Risk Pool, only costs attributed to WAST would be for the CPD hours to attend this one day course and traveling costs.

10. This paper was submitted to the Ambulance Practice Steering Group on the 14th February 2022, questions which arose from this group included:

    - Can the course be delivered 'in house' by WAST?
      *No, this course is underpinned by the PROMPT Maternity Foundation and is aimed at being delivered to multi-disciplinary teams by experts in the field of obstetric emergencies.*
    - How often would paramedics have to refresh.
      *It is mandated that midwifes have to complete the course annually, it was agreed by the PROMPT Wales leads that Paramedics would be required to refresh every 3 years.*
    - Could members of the education team attend the course?
      *WAST Paramedic Educators are now being placed on PROMPT course across Wales.*

**RECOMMENDED: That the Committee,**

**(1) Notes and supports the content of this paper, and supports the concept that all Paramedics staffing CHARU undertaking the PROMPT course.**