

Bundle Quality, Patient Experience and Safety Committee 17 February 2022

Agenda attachments

ITEM 0 Open Quest Agenda - 17 February 2022 (002).docx

- 0 OPENING ITEMS
- 1 13:00 - Welcome and Apologies For Absence
- 2 13:01 - Declarations of Interest
- 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. (If in attendance)*
- Mr Emrys Davies, Retired Member of UNITE*
Professor Kevin Davies, Trustee of St John Cymru
Mrs Ceri Jackson, Trustee of the stroke association
- 3 13:02 - Minutes of last meeting
ITEM 3 QUEST OPEN MINUTES 16 November 2021 TM.doc
- 4 13:05 - Action Log and Matters Arising
ITEM 4 Quest Action Log.docx
- 4.1 ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION
- 5 13:10 - Patient Experience
- 6 13:40 - Committee Effectiveness Review
- To consider any other business to the agenda items listed above.*
- ITEM 6 QUEST SBAR on Committee Effectiveness.docx
ITEM 6a - Quest Terms of Reference 2022 - v.2 Marked Up.docx
ITEM 6b - Quest Terms of Reference 2022 - v.2 Clean.docx
ITEM 6c - Quest Effectiveness Review Survey Results.docx
- 7 13:55 - Operations current/forward look
ITEM 7 Ops Directorate Quarterly Report for Committees 21-22 Q3 (Jan22) FINAL.docx.pdf
- 8 14:05 - Quality Strategy Progress Report
ITEM 8 Quality Strategy Highlight Report Quarter 3 2021-22.docx
ITEM 8a Quality Strategy Highlight Report Quarter 3 2021-22 - Annex 2.xlsx
ITEM 8b QPMF SBAR Quest hb20220202_rm.docx
ITEM 8c WASTQualityPerformanceFramework rm FEB.docx
- 9 14:15 - Patient Experience and Community Involvement Highlight Report
ITEM 9 Executive Summary PECl Highlight Report (October - December).docx
ITEM 9a Executive Summary PECl Highlight Report (October - December) - Annex 1.pdf
- 9.1 14:35 - COMFORT BREAK 14.35 – 14.45
- 10 14:45 - Committee Assurance Report
ITEM 10 Executive Summary Risk Management Report QuEST 170222.docx
- 11 14:55 - Internal Audit Tracker Report
Audit Tracker circulated separately by e mail
ITEM 11 Executive Summary QuEST - Internal Audit Report 170222.docx
- 12 15:05 - Quarterly Integrated Quality & Performance Report
ITEM 12 Quality Highlight Report Quarter 3.docx
ITEM 12a MIQPR SBAR January 2022 QuEST.docx
ITEM 12b Annex 1 MIQPR January 2022 QuEST.pdf
ITEM 12c Top indicators MIQPR Dashboard January 2022 QuEST.xlsx
- 13 15:25 - Quarter 3 Patient Safety Report

ITEM 13 Patient Safety Highlight Report.docx

14 15:45 - Deep Dive: Losses and Special Payments, Personal Injury to Staff

ITEM 14 Losses and Special Payments Deep Dive.docx

15 16:00 - Review of Red 999 Calls by Clinical Support Desk Clinicians

ITEM 15 SBAR Quest - Red Review Evaluation Feb 2022.docx

15.1 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.

16 16:15 - Patient Experience Driver Diagram

ITEM 16 Patient_story_Andrea_T_Jan_2022_update.pdf

16.1 CLOSING ITEMS

17 16:20 - Key messages for Board

18 Any other business

19 Date and time of next meeting: 12 May 2022 at 09:30



MEETING OF THE QUALITY, PATIENT AND SAFETY EXPERIENCE COMMITTEE

Held on 17 February from 13.00 to 16:25
Meeting held virtually via Microsoft Teams

AGENDA

No.	Agenda Item	Purpose	Lead	Format	Time
OPENING ITEMS					
1.	Chair's welcome, apologies, and confirmation of quorum	Information	Bethan Evans	Verbal	10 Mins
2.	Declarations of interest	Information	Bethan Evans	Verbal	
3.	Minutes of last meeting	Approval	Bethan Evans	Paper	
4.	Action log and matters arising	Review	Bethan Evans	Paper	
ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION					
5.	Patient Experience	Information Discussion	Gareth Thomas	Video	30 Mins
6.	Committee Effectiveness Review	Approval	Bethan Evans	Paper	15 Mins
7.	Operations current/forward look	Discussion	Lee Brooks	Paper	10 Mins
8.	Quality Strategy Progress Report	Assurance	Jonathan Turnbull Ross	Paper	10 Mins
9.	Patient Experience and Community Involvement Highlight Report	Assurance	Gareth Thomas/ Wendy Herbert	Paper	20 Mins
COMFORT BREAK 14.35 – 14.45					
10.	Committee Assurance Report	Assurance	Julie Boalch	Paper	10 Mins
11.	Internal Audit Tracker Report	Assurance	Julie Boalch	Paper	10 Mins
12.	Quarterly Integrated Quality & Performance Report	Assurance	Jonathan Turnbull Ross	Paper	20 Mins
13.	Quarter 3 Patient Safety Report	Assurance	Wendy Herbert	Paper	20 Mins
14.	Deep Dive: Losses and Special Payments, Personal Injury to Staff	Assurance	Cate Punyer	Paper	15 Mins
15.	Review of Red 999 Calls by Clinical Support Desk Clinicians	Discussion	Lee Brooks	Paper	15 Mins
CONSENT ITEMS					
The items that follow are for information only. Should a member wish to discuss any of these items they are requested to notify the Chair so that time may be allocated to do so.					
16.	Patient Experience Driver Diagram	Information	Gareth Thomas	Paper	5
CLOSING ITEMS					
17.	Key messages for Board	Discussion		Verbal	5
18.	Any other business	Discussion		Verbal	
19.	Date and time of next meeting: 12 May 2022 at 09:30	Information		Verbal	



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Welsh Ambulance Services
NHS Trust

Lead Presenters

Name	Position
Bethan Evans	Non Executive Director
Claire Roche	Executive Director of Quality and Nursing
Lee Brooks	Director of Operations
Leanne Hawker	Partners in Healthcare Lead
Jonathan Turnbull-Ross	Assistant Director of Quality Governance
Julie Boalch	Head of Risk and Corporate Governance
Wendy Herbert	Assistant Director of Quality & Nursing,
Gareth Thomas	Patient Experience & Community Involvement Manager,

WELSH AMBULANCE SERVICES NHS TRUST

UNCONFIRMED MINUTES OF THE OPEN SESSION OF THE MEETING OF THE QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE HELD ON 16 November 2021 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 (joined for Items 10 and 11 only)
Lee Brooks	Director of Operations
Craig Brown	TU Partner
James Gough	Head of Quality Improvement
Nikki Harvey	Head of Safeguarding
Leanne Hawker	Head of Patient Experience and Community Involvement
Andy Haywood	Director of Digital
Wendy Herbert	Assistant Director of Quality and Nursing and Patient Experience
Stephen Johnson	Patient Safety/Clinical Risk Manager
Alison Kelly	Business and Quality Manager
Joseph Lewis	Service Manager, Non Emergency Patient Transfer Service North Wales
Dr Brendan Lloyd	Executive Medical Director (Left meeting after item 16)
Rachel Marsh	Director of Strategy and Planning
Trish Mills	Board Secretary
Steve Owen	Corporate Governance Officer
Hugh Parry	TU Partner
Angela Roberts	TU Partner
Claire Roche	Executive Director of Quality and Nursing
Andy Swinburn	Associate Director of Paramedicine
Gareth Thomas	Patient Experience and Community Involvement Manager
Duncan Robertson	Assistant Director of Research, Audit and Service Improvement (North)
Rachel Wright	Patient Carer Experience Lead (Betsi Cadwaladr University Health Board (Left meeting after Patient Experience)

45/21 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 9 September 2021 were confirmed as a correct record.

The action log was considered:

Reference: 16/21 - To provide an update on the viability of Community First Responders to administer pain relief. An update was received from Andy Swinburn: Confirmation from the Chief Pharmaceutical Officer had been received for Community First Responders to administer pentrox. Two Business cases were being developed; one was to reconfigure the Omnicell cabinets (readjust for pentrox inclusion) and one from the revenue perspective (purchasing of pentrox). The latter business case would be funded internally. To remain on the Action log.

Reference: 33/21 - Quarterly Quality Assurance Report (QAR), further information be included to reflect patient outcomes in more detail: The QAR and Monthly Integrated Performance Report (IPR) have transitioned into a single Committee Item. The Quarter Quality Report details patient waits, to complement the monthly dataset provided. Further analysis of longest waits will be detailed within the revised Quarterly Quality report. Action Closed.

Reference 37/21 - Risk Management and Board Assurance Framework, have additional risks from ID 223 and ID 224 such as staff sickness been evaluated. Trish Mills advised a deep dive on this subject would be conducted at the People and Culture Committee, adding that a report would be presented to the Audit Committee in relation to the risk improvement programme. Action Closed.

Reference 40/21 – Health and Safety Quarterly updates to include fire safety information: Jonathan Turnbull-Ross advised that the Estates Department had confirmed that fire non-conformance/performance information would be provided to the Health & Safety Committee on a quarterly basis; activities of the Committee will be reported through a Health and Safety Quarterly report to Committee. Additionally, the Executive Management Team will discuss alignment and reporting of wider Estates department responsibilities (gas, electric, asbestos, water management) to ensure assurance to the Board. 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.**

46/21 OPERATIONS UPDATE

Lee Brooks in presenting the report drew attention to the following areas:

1. Pandemic response, Senior Pandemic Team meetings had been restored
2. Military support; the Military Aid to Civil Authorities (MACA) would remain active until 30 November. This support contributed to around 10 -12% of the Emergency Ambulance production. This was clearly having a tangible and positive effect. An extension for MACA beyond November 30 had been submitted and was a repeat of the original request; 251 soldiers. A decision was still awaited.
3. In terms of red performance, there were signs of improvement. Amber performance, on average patients were now waiting less time and for green, the wait was slightly longer
4. The Trust had today deescalated from Resource Escalation Action Plan (REAP) 4 to REAP 3. The main reason for this was the additional capacity being provided by the military.
5. With regards to the 36 paramedics for the Clinical Support Desk, 50% had been achieved thus far.
6. The additional capacity for 999 call handlers should be realised in January 2022
7. In terms of Non Emergency Patient Transfer Service (NEPTS) activity, work was being developed to further enhance the overall quality of the service.
8. Organisational change within the Operations Directorate was now almost complete with many of the senior posts appointed.
9. In readiness for Winter the seasonal exercise had been completed and this included better management of duplicate calls

Comments:

1. When was the Trust expecting an answer regarding Military support? Lee Brooks explained at this stage it was not yet known.
2. If military support was not approved what impact would that have on the Trust? Lee Brooks explained that should this not been approved, inevitably patients will wait longer, the degree of the delay will be dictated by the activity.

47/21 STAFF EXPERIENCE

Prior to hearing the story, Leanne Hawker introduced Rachel Wright the Patient and Carer Experience Lead in Betsi Cadwaladr University Health Board and Joseph Lewis, the Service Manager for Non Emergency Patient Transfer Service (NEPTS) in North Wales.

Rachel Wright explained that this story expressed the personal view of NEPTS from Mr Parry's perspective, a dialysis patient who frequently used the service. Rachel stressed that Mr Parry had not made a complaint and had contacted the Patient Advise and Liaison Service at BCUHB to see if there was any flexibility in changing the dates and times he attended for dialysis

In the video, Mr Parry and his wife conveyed their thanks to the dialysis team for their continued work and making his life much easier. He explained that currently he attended dialysis in Glan Clwyd hospital three times a week in the morning and wanted to change this to afternoons, especially in the Winter. Mr Parry added that he lived on high ground and access to his house was via narrow and hilly roads and on winter mornings these roads became treacherous at times

Also in the video, Liz Cariello, the Dialysis Unit Manager at Glan Clwyd gave an overview of the dialysis shifts which ran from Mondays to Saturdays at various times. There were several challenges in coordinating the patients' needs and attributing the most suitable transport to meet those needs. For patients who required a dedicated crew, transport was only available on the afternoons of Monday, Wednesday and Friday. Whilst every effort was made to ensure the patient's and their family's needs were met, this was not currently possible as the six day service did not exist. Liz added that the lack of the six day service impacted on staff at the unit placing additional work on them. Liz referred to initiatives such as the home therapies team and self-care at Glan Clwyd hospital both of which gave the patients more independence. She reinforced the benefits of having a six day service which would enhance patient satisfaction and safety

Joseph Lewis informed the Committee on the work undertaken in partnership with the renal network and the local dialysis unit in BCUHB. In terms of the six day service this would require additional funding and this was being considered going forward.

Leanne added that this particular story demonstrated an excellent example in terms of having a once for Wales approach in experience and story-telling. Going forward, a once for Wales platform was being developed to illustrate stories like this on a collaborative basis

Claire Roche stressed the importance of sharing stories between organisations adding it had been a catalyst for change

Comments:

Was the Trust and BCUHB working together on value based healthcare? Rachel Wright advised that collaborative and value based work was welcomed and would liaise with Leanne to develop this going forward.

The Committee welcomed the positive story and suggested that the Trust should continue to pursue the possibility of providing six day cover in respect of dialysis patients

RESOLVED: That the patient experience was noted.

48/21 QUALITY STRATEGY PROGRESS REPORT – QUARTER TWO, 2021/2022

Jonathan Turnbull-Ross presented the report as read and drew attention to the following highlights:

1. There have been several Welsh Government workshops around the Duty of Quality and Candour.
2. The Patient Experience and Community Involvement (PECI) Team continue to champion the integration of the citizens voice.
3. The challenges of the Covid-19 continue to have an impact on the Trust in terms of capacity and demand issues and high staff sickness levels.

4. A draft quality strategy action plan was in development but still required further engagement.

Comments:

1. Following a query in terms of external partnership, Claire Roche added that developing external partnerships was part of the of the Trust's strategic ambition going forward. Rachel Marsh added that the work on the Board strategy group would focus on engaging with external partners.
2. Jonathan gave further details on the internal aspects including the quality performance management framework which would be key in developing the quality strategy going forward.

RESOLVED: That the

- (1) Committee received the report and noted the progress being made with the implementation of the Quality Strategy; and**
- (2) It was agreed that Jonathan Turnbull-Ross would provide an update on the feedback from internal engagements at the next meeting**

49/21 SAFEGUARDING ANNUAL REPORT – 2020-2021

Nikki Harvey explained that the Safeguarding Annual Report provided evidence on how the Trust had performed during the 2020-2021 period in relation to safeguarding people in its care.

The following headlines were drawn out for the Committee's attention:

1. Covid-19. This had a huge impact and there had been increased vulnerability for children and adults at risk of abuse.
2. A new system had been developed allowing staff to refer direct to the relevant local authority.
3. The introduction of the Coronavirus Act 2020 had relaxed certain obligations and enhanced multi agency working.
4. It was noted that safeguarding concerns had increased during periods of lockdown.
5. Safeguarding training for staff had achieved very high compliance

Comments:

1. Members acknowledged the well written report and noted the improvement in developing safeguarding. The Committee noted the work of staff during the pandemic and also the positive impact that the use of iPads had in reporting safeguarding incidents.
2. In terms of the breakdown of cases by age profile was there a correlation with that and the population percentage of those age groups? It was agreed that Nikki would highlight this demographic in next years' report.

3. Why was the report in November? Nikki Harvey advised of the significant delay, which was purely due to the pandemic. Going forward the reporting dates will be considered for next year.
4. Members welcomed the positive staff compliance rates in respect of training.
5. In terms of health board areas, was there a consistent level of understating from staff, in particular in the Cwm Taf area? Nikki explained that work was ongoing to address this.

RESOLVED: That the Committee approved the report.

50/21 PATIENT EXPERIENCE AND COMMUNITY INVOLVEMENT (PECI) HIGHLIGHT REPORT

Leanne Hawker presented the report as read and highlighted the following points:

1. One of the main themes of the feedback from patients was the long wait for ambulances.
2. Other themes included the frustration in accessing other services, particularly in primary care.
3. Patients were also confused as to which service to call; noting in some cases they were being signposted to 999 but did not feel this was appropriate.
4. My Health Online was now and had been for some time, in the top search terms on the NHS Website.
5. A series of online sessions were scheduled to showcase different elements of the NHS 111 website, information for carers and guidance for mental health and wellbeing support

Comments:

1. In terms of the challenges faced by some older people in accessing digital platforms, how was the Trust addressing the issue? Leanne explained that the Trust was working with other colleagues across Wales to reach out those not on line.
2. Andy Haywood updated the Committee on the new functionality with the Trust's website; which included making the symptom checker more accessible. Andy Haywood agreed to provide an update at the next meeting.
3. In respect of the responses to the NEPTS patient experience survey, the Committee queried the low response from Cwm Taf Health Board. Leanne Hawker agreed to liaise with NEPTS colleagues for more information

RESOLVED: That the report was approved for release to the NHS Wales Patient Experience Network; WAST People & Community Network and external stakeholders; and noted and supported the actions being taken forward.

51/21 COMMITTEE ASSURANCE REPORT

Julie Boalch presented the report as read. In respect of detail from the report the Committee were apprised of the following:

1. There had been no significant activity on the five risks assigned to the Committee for oversight. The risks had been reviewed by the Executive Management Team and the Assistant Directors Leadership Team.
2. Members were given assurance that each of the corporate risks were undergoing a full review; with priority on the highest scoring risks. Prior to the next meeting the highest rating risks would receive further attention, particularly on the articulation of the risk.
3. A proposal paper was being submitted to the Audit Committee highlighting the need to recruit a risk officer.

Comments:

There was a query on risk 224 in that it appeared it had not been reviewed for some time. Julie Boalch gave assurance this had been reviewed recently and would update the report accordingly.

RESOLVED: That the Committee noted, discussed and highlighted any concerns.

52/21 INTERNAL AUDIT TRACKER REPORT

Julie Boalch took the report as read and drew attention to the following key points:

1. There were currently 22 recommendations assigned to the Committee for oversight.
2. Five of these were high priority and none of these were overdue at this time.
3. There was one longstanding overdue recommendations from 2019/20 which was in relation to the once for Wales concerns system; this system had been postponed until April 2022.
4. The report highlighted there were three recommendations overdue, however one has since been marked as complete.
5. Each recommendation continues to be reviewed in detail.

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.**

53/21 OLDER PERSONS FRAMEWORK

James Gough provided the Committee with a PowerPoint presentation which outlined details of the Older Persons Framework.

1. The Older Persons Framework would ensure that the Trust was able to remain responsive to the changing needs of older people.
2. The Framework recognised there were five key elements which included
 - a. Access, this would focus on how the Trust could improve how older people access its services
 - b. Assessment and Action, how the Trust will improve its assessment and outcomes
 - c. Working Together, this involved how to identify opportunities in collaborative work to improve overall outcomes for older people
 - d. Ageing Well, This would focus on the development and the delivery of services helping Wales in its ambition to be the best place to grow older
 - e. Workforce, the ambition here was to strive for the Trust to be an exemplar employer for older people.

Comments

1. The Committee recognised this was an important and ambitious framework and looked forward to seeing it mature going forward and thanked the team involved for their efforts.
2. Going forward it may be prudent to differentiate between the older groups.
3. Wendy Herbert gave an overview of recent work which had looked into the learning from patient experience and potential patient harm and how to do things differently going forward. An example being the work surrounding the 'Care Line' service.
4. Claire Roche added that progress on the implementation plan would be reported on in future Committees.

RESOLVED: That the Committee received, noted and approved the framework.

54/21 HEALTHCARE INSPECTORATE WALES (HIW) REVIEW OF PATIENT EXPERIENCE AND HANDOVER DELAYS AND TRUST RESPONSE

1. Claire Roche made reference to the HIW report that had been published in October and which was on the agenda for the meeting.
2. A number of recommendations had been received and HIW specifically requested a coordinated system wide response from all Trust's. As yet HIW had not received the coordinated response from the Commissioner.
3. The Trust currently had an action plan in place and was waiting for the system wide response. Periodically, updates would be provided to the Committee in terms of the action plan.

Comments:

Members suggested it would be prudent that the Trust either had sight of the complete report or confirmation that the Trust's responses to the recommendations were unchanged. Claire Roche added that HIW had seen all the responses that have been sent to the

Commissioner

RESOLVED: That the Committee noted publication of the report and the current arrangements in place to respond to its recommendations.

55/21 CLINICAL CONTACT CENTRE: HEALTHCARE INSPECTORATE WALES REVIEW

Lee Brooks advised the Committee on progress with the action plan

1. Two actions required extensions, one required some Health Informatics and the other related to CAD realignment. The latter had been subject to EMT discussions.

Comments:

The Committee acknowledged there had been several challenges in respect of the organisational structure which impacted on the Clinical Contact Centre

RESOLVED: That the Committee:

- (1) noted the update provided and agreed to the closure of the actions detailed in the paper and in the appended tracker.
- (2) agreed to the additional closure of actions 3.1 and 18.1 given the evidence available to support this.
- (3) supported an extension for:
 - a. Action 5.1 until end of Quarter 3 2021/22 in order for Health Informatics colleagues to align capacity to achieve.
 - b. Action 17.3 until end of Quarter 2 2022/23
 - c. Action 21.2 until end of Quarter 1 2022/23 in order for WAST to fully explore the potential for a return to the workplace strategy.

56/21 AIRWAY POLICY

Andy Swinburn gave an outline in terms of the contents of the policy.

This Policy identified individual clinician's responsibilities when managing a patient's airway. It also supported the clinician in providing the necessary evidence to demonstrate competency.

Comments:

1. Members recognised it had been comprehensively reviewed by specialists.
2. Following a query in terms of intubation as described in the policy, Andy advised that it was only clinicians that intubated.
3. In terms of the FAQ, the Committee asked for the answer to the first question to be re-worded.

RESOLVED: That the policy was approved and adopted subject to re-wording of the first answer in the FAQ section.

57/21 QUARTERLY INTEGRATED QUALITY & PERFORMANCE REPORT

1. Jonathan Turnbull-Ross explained this was the first integrated report and gave a brief overview of the contents. The report highlighted several areas of performance that had given rise to challenges and also illustrated the actions being taken to overcome these.
2. He gave further information in terms of how the data within the reports would be collected; for example, the Integrated Performance Report element, which was essentially via the strategic directorate. It was planned to involve and integrate with several other directorates in order to discuss, monitor and learn from the key features emerging from the data sets.
3. The Committee recognised that the team was working through the expectations from the delivery unit and Welsh Government as expressed via the quality bill; in essence these were robust governance and quality arrangements.
4. Some of the key challenges being faced by the Trust which included significant waits for ambulances in the community had been drawn out within the report.

Comments:

1. Rachel Marsh advised there was still further work in order to ensure that any future reports were not duplicated.
2. The Committee welcomed the initial revised integrated report and noted the significant challenges with performance which were illustrated in the report.
3. Members discussed whether it would be useful, for the next report, to look in more detail at a particular theme/area and considered these further as follows; difficulty in engaging with primary care, and further detail around call answering by and after 60 seconds.
2. Jonathan Turnbull-Ross agreed to look at one of the areas of concern as discussed and incorporate a 'deep dive' analysis within the Quality Report as determined following liaison with Claire Roche and Rachel Marsh.

RESOLVED: That

- (1) the report was noted and discussed; and**
- (2) It was agreed that Jonathan Turnbull- Ross would consider, in liaison with Rachel Marsh and Claire Roche, and identify a key theme as discussed above for a deep dive analysis in the next report.**

58/21 QUARTER 2 PATIENT SAFETY REPORT

Wendy Herbert presented the report and drew the Committee's attention to the following points:

1. Volume of red and amber calls had increased significantly.
2. Hospital handover delays continued to have a dramatic impact on performance. A total of 39,774 hours had been lost.
3. Additional staff were being appointed to manage the increase in concerns activity.

4. The number of Serious Case Incident Forums have increased and continue to do so month on month.
5. A total of 1099 patient safety incidents had been reported during this quarter.
6. There remained 165 concerns open with a backlog of 64.
7. There was continued pressure on the staff involved in dealing with concerns.
8. There had been an increase in the number of political concerns received.
9. Coroners activity continued to increase with unprecedented levels.
10. Key achievements and learning had continued throughout the reporting quarter.

Comments:

1. Members noted that the report was indicative of the ongoing demand and service pressures.
2. The Committee recognised, following an update from Emrys Davies who had attended a recent scrutiny panel, that lessons continued to be learned in the CCC and that a programme had been implemented to provide support.

RESOLVED: That the Committee received the report for information and discussion.

59/21 EARLY IMPACT OF SENIOR PARAMEDIC ROLE

Andy Swinburn gave a PowerPoint presentation which outlined the early impact of Senior Paramedics (SP) attending cardiac arrests.

Members acknowledged there had been a positive impact specifically around the potential increase in Return of Spontaneous Circulation performance. Also the SP's had contributed to bringing a more focused lead role on CPR and not starting inappropriate CPR

The feedback from staff in terms of the SP being on operational ride outs had been overwhelmingly positive

Comments:

1. This was an excellent opportunity to bolster 2 way learning and continuous improvement.
2. How would these positive messages be shared with staff? Andy advised that in the main this would be by word of mouth and updates would be provided at the People and Culture Committee.

RESOLVED: That the update was noted

60/21 INFORMATION GOVERNANCE ANNUAL REPORT

Andy Haywood explained that the report provided assurance that the Trust was discharging its duty correctly in respect of data protection and governance.

The Committee noted that two potential data breaches had been reported to the

Information Commissioners Office; both of which have since been resolved without any further action required.

Members also noted that the Information Governance Steering Committee was due to be remodelled to reflect more pointed membership.

RESOLVED: That the report was accepted and a note of thanks was recorded for the Team involved in producing the report.

61/21 PATIENT EXPERIENCE DRIVER DIAGRAM

Gareth Thomas provided an update for the Committee relating to Tony's story.

RESOLVED: That the update was noted.

62/21 KEY MESSAGES FOR BOARD

The Chair and Claire Roche would review and finalise this after the meeting and gave a brief overview of the expected content.

63/21 HEALTHCARE INSPECTORATE WALES ANNUAL REPORT

Claire Roche explained that the report was for information and referred Members to a previous meeting whereby HIW had given an overview.

Date of Next meeting: 17 February 2022

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	17 February 2022	<p><u>Update from 16th November meeting:</u> Andy Swinburn updated the Committee explaining that 2 Business Cases were being developed; one from the development of the Omnicell cabinet perspective (readjust for pentrox inclusion) and one from the revenue perspective (purchasing of pentrox). Dr Brendan Lloyd explained the reasons for the delay in developing this and would continue to update the Committee.</p> <p><u>Update for 17th February meeting:</u> The amendments to the safe have been agreed and purchase of the additional fittings for the cabinets has taken place. Work is still ongoing to identify the revenue funding for pentrox but new avenues are being explored, with the NCCU, to establish whether central funding, aligned to the decarbonisation agenda, may be applicable.</p>	Open
30/21	9 September 2021	Patient Experience Driver Diagram	Patient outcomes to be included in the diagram	Leanne Hawker	17 February 2022	<p><u>Update for 17th February meeting:</u> An updated patient experience driver diagram is on the agenda at Item 16 which relates to Andrea's story, presented to QuEST in September 2021.</p>	Complete
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	17 February 2022	<p><u>Update from 16th November meeting:</u> QuEST requested for confirmation as to whether this will be a stand alone report or included in the performance report.</p> <p><u>Update for 17th February meeting:</u> Andy Swinburn requests a revised date for this action due to ongoing pressures.</p>	Open
48/21	16 November 2021	Quality Strategy Progress report	To provide an update on the Quality Strategy Implementation Action Plan in relation to feedback from internal engagement within the Trust - ADLT	Jonathan Turnbull-Ross	17 February 2022	<p><u>Update for 17th February meeting:</u> Discussion on the Quality Strategy Implementation Plan was held at ADLT on 10/01/2021; support for the plan was received with wider discussion on integration of actions/priorities within the Trust IMPT. Further detail is contained within the Quality Strategy Progress report.</p>	Open

50/21a	16 November 2021	PECI Highlight report	To provide an update on the ongoing work to improve functionality of symptom checkers etc.. of the Website	Andy Haywood	17 February 2022	Update for 17th February meeting: Andy Haywood seeks an extension for this item to May 2023.	Open
50/21b	16 November 2021	PECI Highlight report	Further information to be provided regarding poor response to NEPTS patient experience survey in Cwm Taf	Leanne Hawker	17 February 2022	Update for 17th February meeting: An invitation to participate in a NEPTS patient experience Survey is currently sent by SMS text message to service users who have agreed to participate in the survey programme. The survey is also available to any NEPTS user through the Welsh Ambulance Service website. Whilst the response rate for the reporting period concerned was low in Cwm Taf, we don't feel this warrants concerns at present as it is normal to see response rates to the survey fluctuate across Health Board regions each reporting quarter. For the upcoming reporting period (October – December), response rates to the survey were improved in Cwm Taf and instead we see a low uptake in Powys. From February, a postal NEPTS patient experience survey will also be initiated which will complement the SMS text surveys and will further increase the amount of patient experience feedback data we are able to collect from NEPTS users, helping us to build a better picture of what NEPTS users think about the service and identify potential learning and improvement opportunities.	Complete
57/21	16 November 2021	Quarterly Integrated Performance report	To incorporate a 'deep dive' analysis within the Quality Report as determined by EMT	EMT/ Jonathan Turnbull-Ross	17 February 2022	Update for 17th February meeting: Arrangements for the inclusion of a 'deep dive' section within the revised Quality Report have been discussed and agreed. This is further detailed within the Quality Report.	Complete



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Gwasanaethau Ambiwylans Cymru
Welsh Ambulance Services
NHS Trust

AGENDA ITEM No	6
OPEN or CLOSED	N/A
No of ANNEXES ATTACHED	4

COMMITTEE EFFECTIVENESS REVIEW 2021/22

MEETING	Quality, Patient Experience and Safety Committee
DATE	17 th February 2022
EXECUTIVE	Bethan Evans, Chair
AUTHOR	Trish Mills, Board Secretary
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. The Trust's Standing Orders and Committee Terms of Reference require that Board Committees evaluate their effectiveness annually and prepare an annual report to the Trust Board.
2. The 2021/22 Committee effectiveness reviews provides for a number of stages before the Committee's annual report is presented to the Trust Board. The first two stages of evaluation design and process are complete, and the Committee will now review proposed amendments to the terms of reference and consider the responses to the evaluation questionnaire.
3. Amendments have been proposed to the terms of reference for the Committee's consideration, as well as changes to operating arrangements as a result of the review and the responses to the questionnaire sent to members and core attendees.

RECOMMENDATION: The Committee is requested to:

- (a) Review and approve changes to terms of reference
- (b) Confirm the proposed actions for issues raised in questionnaire
- (c) Set priorities for the Committee for 2022/23

REPORT APPROVAL ROUTE

Executive Management Team – 9th February 2022 (by circulation)

REPORT APPENDICES

1. Annex 1 – SBAR
2. Annex 2 – Proposed changes to terms of reference (clean)
3. Annex 3 – Proposed changes to terms of reference (marked up)
4. Annex 4 – Committee questionnaire responses

REPORT CHECKLIST

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

COMMITTEE EFFECTIVENESS REVIEW 2021/22

SITUATION

1. The 2021/22 Committee effectiveness reviews provides for a number of stages before the Committee's annual report is presented to the Trust Board. The first two stages of evaluation design and process are complete, and the Committee will now review proposed amendments to the terms of reference and consider the responses to the evaluation questionnaire.

BACKGROUND

2. As the factors underpinning effective governance can change, for example as people leave, organisations restructure, or strategy shifts, regular reviews of Board Committees ensure governance remains fit for purpose.
3. Standing Orders, Committee Terms of Reference, and the Code of Governance provide that Boards should routinely assess the effectiveness of their governance arrangements, of which the Board's Committees form an integral part. Each Committee must submit an annual report to the Board through the Chair setting out its activities during the year and including the review of its performance.
4. The 2020/21 effectiveness review for the Committee includes 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 is thereafter recommended to the Trust Board for approval.

ASSESSMENT

5. Committees play an important role in supporting the Board fulfilling its responsibilities by:
 - Providing advice on strategic development and specific aspects of business
 - Gaining assurance on key aspects of activity in organisational performance, supporting achievement of the Trust's strategic goals
 - Carrying out specific responsibilities on the Board's behalf
6. Effective Committees provide a forum where ideas can be explored in greater detail than Board meetings are able to allow, providing time and space to consider issues to a greater depth.

7. To ensure that Committees are in the best position possible to provide this support in a streamlined and integrated way, the approach for review of a Committee’s operating arrangements is carried out annually in the following stages:

Stage	Process
Stage 1: Evaluation Design	<ul style="list-style-type: none"> Questionnaires for the Board Committees are developed by the Board Secretary in consultation with the Committee Chairs and Executive Leads.
Stage 2: Evaluation Process	<ul style="list-style-type: none"> Questionnaires are issued to Committee members and core attendees as set out in the Terms of Reference. Committee Chair, Executive Lead, Governance Officer and Board Secretary review questionnaires, review Terms of Reference and propose initial amendments. Responses are collated and this report summarises the findings and includes proposed recommendations to address issues raised.
Stage 3: Discussion and actions	<ul style="list-style-type: none"> The proposed amendments to the Terms of Reference and the responses to the questionnaires are discussed by the Committee.
Stage 4: Presentation to Trust Board	<ul style="list-style-type: none"> Any changes to the Terms of Reference and operating arrangements are recommended to the Trust Board together with the Committee’s annual report.

8. The Committee Chair, Executive Lead, Governance Officer and Board Secretary met for stage 2 on 25th January and 1st February 2022. 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. This was also an opportunity to begin building the cycles of business of the Committee aligned to the specific areas of delegated powers. The proposed amendments to the Terms of Reference are attached at Annex 2 in a tracked changes version, and Annex 3 as a clean version.

9. Key changes include:

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

9.2. Sections have been moved for better flow (not marked up).

9.3. 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 we prepare for its implementation in 2023.

9.4. Delegated Powers and Authority:

- (a) This section has been revised to follow the primary areas of responsibility of the committee i.e. strategy; safe care; effective care; citizen voice and patient experience; information governance and information security; and governance.

- (b) A transfer of responsibility with respect to health and safety, and selection, training, registration and revalidation of staff has been made to the People and Culture Committee. This enables the Committee to focus on safe, effective, patient centred care, whilst ensuring that the importance of quality reverberates through all Committees.
- (c) There is an emphasis on continuous improvement and evaluating the impact on patients, of good and poor performance.
- (d) The Committee's responsibilities with respect to information governance and information security have been strengthened and this will be reflected in the cycle of business and more regularity of reporting on this area.

9.5. Membership:

- (a) Following the Medical Director moving to a part time role from 1 January 2022, the Director of Paramedicine will attend in his stead, and a new addition to the attendees is the Director of Digital Services, who is also the Senior Information Risk Officer.
- (b) The chairs of Sub-committees established by the Committee will be in attendance. This aids purpose and communication.

10. The responses to the questionnaires were also reviewed at the above meeting, and they are attached at Annex 4. Ten questionnaires were distributed to the members and core attendees of the Committee, and 6 responses were received, 5 from members and 1 from attendees, however one respondent was unable to answer any of questions as they were new to the Committee. Key issues are set out below together with proposed actions where appropriate:

Issues raised	Commentary and proposed actions
What does this Committee do well?	<ul style="list-style-type: none"> • Effective scrutiny of quality matters, highlighting challenging issues and influencing the Trust's continuous improvement actions • Deep dives into serious adverse incidents and patient complaints for clarity on issues and drives for improvement • Collegiate, collaborative, supportive • Explores issues from a number of perspectives • Methodical in its approach to the quality agenda; robust planning ahead of meetings • Well chaired and all given opportunity to contribute; good discussion, particularly of highly emotive issues; good balance of empathy and scrutiny • Good attendance and mix of skills, knowledge and interest; good partnership working between members and attendees • Clearly written reports • Person centred in its focus
What does this Committee need to do more of?	<ul style="list-style-type: none"> • Deep dive into performance and the focus on our service as the metrics develop; hold to account where performance is challenging; explore the human impacts of service provision • Focus on the risk register, particularly where there are limited or no actions to address gaps

Issues raised	Commentary and proposed actions
	<ul style="list-style-type: none"> • Ensure a focused quality agenda and transfer some areas to other committees; streamline agenda to allow more time for large/strategic items to be discussed • Targeted presentations, allowing more time for discussion/debate <p>Actions:</p> <ul style="list-style-type: none"> (a) The risk registers are being improved to provide clarity on the risks, controls, assurance and actions to further mitigate. The BAF for the Committee can then be used to drive the agenda, ensuring areas where there is limited assurance are prioritised in the meeting. (b) Support of the committee will continue as the metrics further develop; targeted focus where areas of concern are identified will continue. (c) Clear instructions on limiting introduction and presentation of papers which have been read to allow more time for discussion and debate and focus on improvements and assurance.
<p>What should this Committee do less of?</p>	<ul style="list-style-type: none"> • Lengthy agenda and meetings. • Spend less time on issues that are of less priority for the Committee. • Less presenting and more scrutiny of effectiveness of actions in progress/completed. <p>Actions:</p> <ul style="list-style-type: none"> (a) Clear instructions on limiting introduction and presentation of papers which have been read to allow more time for discussion and debate and focus on improvements and assurance. (b) The development of a cycle of business for the Committee which will focus the agenda and provide clarity of the assurance items

11. It is good practice for Committees to set priorities for the forthcoming year when they review their effectiveness. Such priorities may include a particular focus throughout the year, or in particular quarters. For example, the Committee may wish to prioritise more agenda time to new issues it is adopting in its Terms of Reference; focus on areas it may not have addressed recently due to the pandemic; or review of the Committee’s risks, both operational and strategic. It is recommended that such priorities are limited to two or three, and that they are tracked quarterly through a Chair’s report to ensure they are on track.

12. The Committee may wish to consider having as its priority for 2022/23 the organisation’s journey towards further embedding the Duty of Quality and Duty of Candour into everything we do.

RECOMMENDATION

13. The Committee is requested to:

- (a) **Review and approve changes to Terms of Reference;**
- (b) **Confirm the proposed actions for issues raised in questionnaire; and**
- (c) **Set priorities for the Committee for 2022/23.**

NEXT STEPS

14. Next steps includes the following:

14.1. A Committee Annual Report will be prepared for the July Trust Board setting out:

- (a) Remit of the Committee
- (b) Membership and attendance
- (c) Effectiveness of the Committee (as a result of discussions from today's meeting)
- (d) Proposed changes to the terms of reference and operating arrangements
- (e) Priorities identified for the Committee for 2022/23

This report will be presented for approval at the 12th May 2022 meeting of the Committee and will also be considered in the round with all other Committee Annual Reports by the Chairs Working Group in May.

14.2. A key output of the discussions with the Chair, Executive Lead, Committee members and attendees, and the self-assessment questionnaire, is a cycle of committee business/programme of work for the Committee. This cycle of business will provide certainty on papers to be developed for upcoming Committees but will also clarify the assurance requirements aligned to the responsibilities of the Committee. The cycle of business will also provide a line of sight for the assurance journey of papers prior to their presentation at committees and will support the development of a legislative and regulatory framework where that is appropriate and applicable.

14.3. The Committee has authority to establish Sub-Committees to assist it in discharging its responsibilities. A review of the Sub-Committees reporting to this Committee, or any that should be established as a result of the effectiveness review, will be conducted in 2022/23.



QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE TERMS OF REFERENCE AND OPERATING ARRANGEMENTS

1. INTRODUCTION

- 1.1. The Trust's Standing Orders provide that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*".
- 1.2. In line with Standing Orders and the Trust's Scheme of Delegation, the Board shall nominate annually a committee to be known as the **Quality, Patient Experience and Safety Committee**. This Committee has a key assurance role on behalf of the Board in relation to the Trust compliance with the Commissioning Core Quality Requirements, the NHS Wales Health & Care Standards 2015 and the Health and Social Care (Quality and Engagement) (Wales) Act 2020 ~~working towards the required compliance of the Welsh Government Quality and Governance Bill.~~ The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set out below.

2. PURPOSE

- 2.1. The Committee is responsible for overseeing scrutinising the improvements in and outcomes in quality, patient experience, effectiveness and safety, and will oversee the development and -and-delivering of the Quality Sstrategies to achieve this.
- 2.2. During the 2022/23 financial year the Committee will oversee the systems and process being developed to ensure compliance with the Duty of Quality and the Duty of Candour as set out in the Health and Social Care (Quality and Engagement) (Wales) Act 2020 when it is implemented in 2023, and thereafter ensure compliance with the Act to improve the quality of healthcare provided by the Trust.
- 2.3. The Committee will provide oversight of, and seek assurance on, statutory and regulatory compliance.
- 2.4. Oversee the quality and integrity, safety and security, and appropriate access and use of information (including patient and personal information) to support the provision of high quality healthcare.
- ~~2.2. Its specific responsibilities are to provide:~~
- ~~2.3.~~

- ~~2.4. Evidence based and timely **advice** to the Board to assist it in discharging its functions and meeting its responsibilities with regard to governance, quality and safety of healthcare;~~
- ~~2.5. **Assurance** to the Board in relation to the Trust's arrangements for safeguarding and improving the quality and safety of patient centred healthcare in accordance with its stated objectives and the requirements and standards determined for the NHS in Wales.~~
- ~~2.6. The Audit Committee will need to have an effective relationship with this Committee to understand the processes in operation. The primary focus of this Committee in relation to risk is to:~~
- ~~• propose new policy when needed;~~
 - ~~• monitor the effectiveness of risk management processes, both clinical and non-clinical; and~~
 - ~~• intervene in the event of any risks arising which cannot be resolved by an alternative group or body of the Trust.~~

3. DELEGATED POWERS AND AUTHORITY

The Committee will ~~provide advice and assurance to the Board on the following:~~

- 3.1. ~~Ensure the organisation, at all levels (directorate/team/region/locality) has the right systems and processes in place to deliver, from a patients perspective – person centred, efficient, effective, timely and safe services; services consistent with the six domains of quality (patient centred; safe; equitable; timely; effective; and efficient)~~
- 3.2. ~~Advise the Board on a set of key indicators for quality, patient experience and clinical safety, and monitor performance against those indicators for clinical performance and clinical safety and assess the effectiveness of the relevant indicators~~
- 3.3. **Strategy**
- (a) oversee ~~and contribute to the development of~~ the Trust's strategies and plans for the delivery of high quality and safe services, consistent with the Board's overall strategic direction and any requirements and standards set for NHS bodies in Wales;
 - (b) monitor the implementation of strategies and plans within the remit of the Committee.
 - (c) there is clear, consistent strategic direction, strong leadership, transparent lines of accountability.

3.4. Safe Care

- ~~(a)~~ Ensure that the Health and Care Standards, Commissioning Quality Core Requirements are embedded Trust wide with actions taken in relation to any identified non-compliance.
- ~~(b)~~ (a) Ensure there is a process in place for quality impact assessments, and consider the implications for quality and safety and equitable care arising from the development of the Trust's corporate strategies and plans, or those of its stakeholders and partners, including those arising from any Joint (sub) Committees of the Board; and
- ~~(c)~~ (b) Consider the implications for the Trust's quality and safety arrangements from review/investigation reports, external guidance and national reports and actions arising from the work of external regulators.
- (c) Monitor Trust compliance with the Mental Health Act 1983, and Code of Practice, and the Mental Capacity Act 2005.
- ~~(d)~~ Review the annual infection prevention and control plan and monitor its implementation the outcomes of infection control audits and obtain assurance on the effectiveness of management actions relating to infection prevention and control
- ~~(e)~~ on the Trust's safeguarding matters and where appropriate make recommendations for change Ensure the Trust is meeting its obligations with respect to safeguarding of children and vulnerable adults
- ~~(f)~~ that the workforce is appropriately selected, trained, supported and responsive to the needs of the service, and that professional standards and registration/revalidation requirements are maintained Review the impact of professional standards and staffing issues on patient care, noting the People and Culture Committee has oversight of the selection, training, registration and revalidation for staff.
- ~~(g)~~ on the arrangements for the management of health, safety and security and compliance with relevant legislation
- (g) Ensure the Trust has systems and processes in place to support the delivery of an open and honest reporting and continuous learning culture in line with the Duty of Candour.
- (h) Oversee improvements and changes applied as a result of reviews of mortality, clinical incidents, complaints, litigation, external regulator reports etc., and their impact on minimising patient harm and maximising patient experience.

3.5. Effective Care

- (a) Ensure the care planned, ~~and~~ provided, across the breadth of the

organisation's functions ~~(including directorate/team/region/locality and those provided by the independent or third sector)~~ is clinically effective and quality driven consistently applied, based on sound evidence, is clinically effective and consistent with agreed standards e.g. NICE, JRCALC etc; and where this falls beneath expected standards, the impact is reviewed to support continuous improvement.

(b) ~~sApprove the annual there is an effective~~ clinical audit plan and quality improvement plan and function that meets the standards set for the NHS in Wales; review the outcomes of clinical audits in line with the ~~C~~Clinical Audit and Effectiveness Pplan and provide assurance to the Audit Committee in this respect;

(c) There is an ethos of continual quality improvement and regular methods of updating the workforce in the skills needed to demonstrate quality improvement throughout the organisation

3.6. Citizen Voice and Patient Experience

(a) Approve the patient experience/engagement plan and monitor its implementation.

~~(a)~~(b) Ensure the organisation, ~~at all levels (directorate/team/region/locality)~~ has a citizen centred approach, putting patients, patient safety, quality of care and safeguarding above all other considerations.

~~(b)~~(c) that Ensure the ~~work of the~~ Patient Experience & Community Involvement (PECI) continuous engagement model arrangements and associated service user experience feedback is taken into account in the design and delivery of services, ensuring the full implementation of lessons learnt;.

(d) Seek assurance that lessons are learned from patient experience information and patient safety and workforce related incidents, complaints and claims, and that learning from reports and incidents is embedded in the Trust's practices, policies and procedures

~~(e)~~(e) Ensure there is good collaborative team and partnership working to provide the best possible outcomes for its citizens

~~(d)~~(f) that aEnsure any matters raised by the Medical Director, Director of Quality & Nursing or other Directors in relation to patient safety and clinical risk are considered and addressed promptly and fully

3.7. Information Governance and Information Security

(a) Receive assurance the information governance and information security

arrangements are appropriately designed and operating effectively to ensure the on-the-reliability, integrity, safety and security of the-information to support the delivery of high quality, safe healthcare across the collected and used by the organisation.

- (b) Review progress of measures to improve data-information security and adherence to Caldicott performance-principles against the Information Governance Toolkit, Network and Information Systems (NIS) Directive (2018), Data Protection Act (2018), and receive assurance on compliance with relevant standards, legislation and regulations;
- (c) Receive assurance on, and review effectiveness of the Trust's information security protocols.
- (a)(d) Review performance of the Trust in relation to statutory and mandatory information requests and reporting requirements including but not limited to freedom of information requests, data breaches, police requests and subject access requests.

3.7.3.8. Governance

- (a) The Committee will, in respect of its assurance role, sSeek assurances that governance (including risk management, management of health and safety and security) arrangements are appropriately designed and operating effectively to ensure the provision of high quality, safe healthcare and services across the whole of the Trust's activities, and that these are compliant with relevant legislation. Additionally, the Committee will provide advice and assurance on the reliability, integrity, safety and security of the information collected and used by the organisation.
- (b) Approve the research governance framework and oversee its implementation in accordance with the Welsh Government Research Governance Framework for Health and Social Care.
- (a)(c) that rRecommendations made by internal audit and external reviewers are considered and acted upon on a timely basis;
- (d) Review and recommend to the Board the Trust's annual quality statement (as relevant) and quality improvement priorities for the coming year, monitoring progress against these priorities and their impact on patient safety.
- (e) Review policies in its remit and endorse policies for Board approval that relate to complaints and incidents in line with Putting Things Right.

The Committee will be responsible for monitoring the Trust compliance with the Mental Health Act and Code of Practice through the work of the

~~Trust Mental Health Steering Group.~~

~~3.8. The Committee's programme of work will be designed to ensure that, in relation to all aspects of quality and safety:~~

~~3.9. Annex A sets out the main functions of the Quality, Patient Experience and Safety Committee~~

Corporate Risks and Audit Recommendation Tracker

~~3.10.~~3.9. The Audit Committee has overall **responsibility** for ensuring that corporate risks are identified and are being properly managed within the Trust. The Audit Committee also has responsibility for ensuring that there are processes in place to address and take forward audit recommendations. Nevertheless, each risk from the corporate risk register and Board Assurance Framework, and each recommendation from the audit tracker, will be allocated to an appropriate Board Committee who will be responsible for ensuring that the Trust is managing and progressing each item as planned. Regular reports will be provided to individual Committees on those items for which they have responsibility and overall Trust-wide progress reports will be presented to each Audit Committee. The Committee will consider the control and mitigation of risks within their remit and provide assurance to the Board that such risks are being effectively controlled and managed.

Authority

~~3.11.~~3.10. The Committee is authorised by the Trust Board to investigate, or have investigated, any activity within its terms of reference. In doing so, it will have the right to seek any information it requires from any employee or inspect any books, records or documents relevant to its remit, ensuring patient/client and staff confidentiality as appropriate. All employees are directed to cooperate with any reasonable request made by the Committee.

~~3.12.~~3.11. The Committee is authorised by the Board to obtain outside legal advice or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Trust's procurement, budgetary and other requirements.

~~3.13.~~3.12. The Committee is authorised to approve Trust wide policies in accordance with the policy for the Review, Development and Approval of Policies.

Sub-Committees

~~3.14.~~3.13. The Committee may establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee business. Formal sub-committees may only be established with the agreement of the

Board.

4. MEMBERSHIP

Members

4.1. The membership of the Committee should include at least one member of the Trust's Audit Committee and will comprise:

Chair Non Executive Director

Members Three further Non Executive Directors of the Board.

Attendees

4.2. The core membership will be supported routinely by the attendance of the following:

- ~~Medical Director~~Director of Paramedicine
- Director of Operations
- Executive Director of Quality and Nursing (Lead Executive for Committee)
- Director of Digital Services (SIRO)
- Trade Union Partners (x 2)
- Chairs of Sub-committees

4.3. The Committee Chair may extend invitations to attend committee meetings to other Directors and/or Senior Managers, and to officials from within or outside the organisation to attend all or part of the meeting to assist with its discussions on any particular matter.

4.4. Members may send deputies in their absence who will act with their full authority. To instigate a substitution arrangement, the member of the Committee must notify the Board Secretary before the day of the meeting that he/she is unable to attend and the name of the member who will attend as the substitute.

Member Appointments

4.5. The membership of the Committee shall be determined by the Board, based on the recommendation of the Trust Chair, taking account of the balance of skills and expertise necessary to deliver the committee's remit, and, subject to any specific requirements or directions made by the Welsh Government.

4.6. Non Executive Members shall be appointed to hold office for a period of one year at a time, (Membership being reviewed by the Chairman of the Board on an annual basis) up to a maximum of their term of office. During this time a member may resign or be removed by the Board.

- 4.7. Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the Trust Chair and, where appropriate, on the basis of advice from the Trust's Remuneration Committee.

Secretariat and Support to Committee Members

- 4.8. The Board Secretary, on behalf of the Committee Chair, shall:
- arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and
 - ensure the provision of a programme of organisational development for committee members, as part of the Trust's overall board development programme developed by the Director of Workforce & Organisational Development.

5. COMMITTEE MEETINGS

Quorum

- 5.1. At least two members must be present to ensure the quorum of the Committee. In the absence of the Committee Chair, one of those in attendance must be designated as Chair of the meeting.

Frequency of Meetings

- 5.2. Meetings shall be held no less than quarterly or otherwise as the Chair of the Committee deems necessary, consistent with the Trust's annual plan of Board Business. Meeting agendas, papers and minutes shall be circulated no less seven days prior to each meeting.

Withdrawal of individuals in attendance

- 5.3. The Committee may ask any member or individual who is normally in attendance but who is not a member to withdraw to facilitate open and frank discussion of any particular matter.

6. RELATIONSHIPS & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/ GROUPS

- 6.1. The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.2. The Committee, through its Chair and members, shall work closely with the Board's other committees and groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business; and
- sharing of appropriate information;

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall assurance framework.

6.3. The Committee will consider the assurance provided through the work of the Board's other committees and sub groups to meet its responsibilities for advising the Board on the adequacy of the Trust's overall framework of assurance.

6.4. The Committee shall embed the Trust's corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1. The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board and the Chief Executive (Accountable Officer) on the Committee's activities. This includes verbal updates on activity, the submission of Committee minutes and written reports where appropriate throughout the year;
- bring to the Board and the Chief Executive (Accountable Officer's) specific attention any significant matter under consideration by the Committee; and
- ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Trust.

7.2. The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any sub committees established. In so doing, account will be taken of the requirements set out in the NHS Wales Quality & Safety Committee Handbook and national guidance.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1. The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum (as set out in section 5)

9. REVIEW

9.1. These terms of reference and operating arrangements shall be reviewed at least annually but more frequently if required.

The main functions of the Quality, Patient Experience and Safety Committee are to:

TO OBTAIN ASSURANCE:

- that the Health and Care Standards and Commissioning Quality Core Requirement are embedded Trust wide with actions taken in relation to any identified non-compliance;
- to provide assurance that the Trust is in compliance with the Mental Health Act and the Trust's Mental Health Improvement Plan;
- review the outcomes of clinical audits in line with the Trust's Clinical Audit and Effectiveness Plan;
- obtain assurance that the risks aligned to this Committee are supported with evidence of mitigation and controls assurance;
- assurance will be provided to the Committee by the Research and Development Forum with regards to the Trust's obligations for research and governance, as set out in the Welsh Government Research Governance Framework for Health and Social Care;
- review the outcomes of infection control audits and obtain assurance on the effectiveness of management actions relating to infection prevention and control;
- that recommendations made by internal and external reviewers are considered and acted upon on a timely basis;
- that lessons are learned from patient experience information and patient safety and workforce related incidents, complaints and claims;
- on the Trust's safeguarding matters and where appropriate make recommendations for change;
- that the work of the Patient Experience & Community Involvement (PECI) arrangements and associated service user experience feedback is taken into account in the design and delivery of services, ensuring the full implementation of lessons learnt;
- on the arrangements for the management of health, safety and security and compliance with relevant legislation;
- that the workforce is appropriately selected, trained, supported and responsive to the needs of the service, and that professional standards and registration/revalidation requirements are maintained;
- progress of measures to improve data security and Caldicott performance against the Information Governance Toolkit; performance against indicators for clinical performance and clinical safety and assess the effectiveness of the relevant indicators



QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE TERMS OF REFERENCE AND OPERATING ARRANGEMENTS

1. INTRODUCTION

- 1.1. The Trust's Standing Orders provide that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*".
- 1.2. In line with Standing Orders and the Trust's Scheme of Delegation, the Board shall nominate annually a committee to be known as the **Quality, Patient Experience and Safety Committee**. This Committee has a key assurance role on behalf of the Board in relation to the Trust compliance with the Commissioning Core Quality Requirements, the NHS Wales Health & Care Standards 2015 and the Health and Social Care (Quality and Engagement) (Wales) Act 2020. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set out below.

2. PURPOSE

- 2.1. The Committee is responsible for scrutinising improvements in outcomes in quality, patient experience, effectiveness and safety, and will oversee the development and delivery of strategies to achieve this.
- 2.2. During the 2022/23 financial year the Committee will oversee the systems and process being developed to ensure compliance with the Duty of Quality and the Duty of Candour as set out in the Health and Social Care (Quality and Engagement) (Wales) Act 2020 when it is implemented in 2023, and thereafter ensure compliance with the Act to improve the quality of healthcare provided by the Trust.
- 2.3. The Committee will provide oversight of, and seek assurance on statutory and regulatory compliance.
- 2.4. Oversee the quality and integrity, safety and security, and appropriate access and use of information (including patient and personal information) to support the provision of high quality healthcare.

3. DELEGATED POWERS AND AUTHORITY

The Committee will:

- 3.1. Ensure the organisation has the right systems and processes in place to deliver services consistent with the six domains of quality (patient centred; safe; equitable; timely; effective; and efficient).
- 3.2. Advise the Board on a set of key indicators for quality, patient experience and clinical safety, and monitor performance against those indicators .
- 3.3. **Strategy**
 - (a) Oversee and contribute to the development of the Trust's strategies and plans for the delivery of high quality and safe services, consistent with the Board's overall strategic direction and any requirements and standards set for NHS bodies in Wales.
 - (b) Monitor the implementation of strategies and plans within the remit of the Committee.
 - (c) Ensure there is clear, consistent strategic direction, strong leadership, transparent lines of accountability.
- 3.4. **Safe Care**
 - (a) Ensure the Health and Care Standards, Commissioning Quality Core Requirements are embedded Trust wide with actions taken in relation to any identified non-compliance.
 - (b) Ensure there is a process in place for quality impact assessments, and consider the implications for quality and safety and equitable care arising from the development of the Trust's corporate strategies and plans, or those of its stakeholders and partners, including those arising from any Committees of the Board.
 - (c) Consider the implications for the Trust's quality and safety arrangements from review/investigation reports, external guidance and national reports and actions arising from the work of external regulators.
 - (d) Monitor Trust compliance with the Mental Health Act 1983, Code of Practice, and the Mental Capacity Act 2005.
 - (e) Review the annual infection prevention and control plan and monitor its implementation
 - (f) Ensure the Trust is meeting its obligations with respect to safeguarding of children and vulnerable adults
 - (g) Review the impact of professional standards and staffing issues on patient care, noting the People and Culture Committee has oversight of the

selection, training, registration and revalidation for staff.

- (h) Ensure the Trust has systems and process in place to support the delivery of an open and honest reporting and continuous learning culture in line with the Duty of Candour.
- (i) Oversee improvements and changes applied as a result of reviews of mortality, clinical incidents, complaints, litigation, external regulator reports etc., and their impact on minimising patient harm and maximising patient experience.

3.5. Effective Care

- (a) Ensure the care planned and provided across the breadth of the organisation's functions is clinically effective and quality driven, and where this falls beneath expected standards, the impact is reviewed to support continuous improvement.
- (b) Approve the annual clinical audit plan that meets the standards set for the NHS in Wales; review the outcomes of clinical audits in line with the clinical audit plan and provide assurance to the Audit Committee in this respect;
- (c) Ensure there is an ethos of continual quality improvement and regular methods of updating the workforce in the skills needed to demonstrate quality improvement throughout the organisation

3.6. Citizen Voice and Patient Experience

- (a) Approve the patient experience/engagement plan and monitor its implementation.
- (b) Ensure the organisation has a citizen centred approach, putting patients, patient safety, quality of care and safeguarding above all other considerations.
- (c) Ensure the Patient Experience & Community Involvement (PECI) continuous engagement model is taken into account in the design and delivery of services, ensuring the full implementation of lessons learnt.
- (d) Seek assurance that lessons are learned from patient experience information and patient safety and workforce related incidents, complaints and claims, and that learning from reports and incidents is embedded in the Trust's practices, policies and procedures.
- (e) Ensure there is good collaborative team and partnership working to provide the best possible outcomes for its citizens.
- (f) Ensure any matters raised by the Medical Director, Director of Quality & Nursing or other Directors in relation to patient safety and clinical risk are considered and addressed promptly and fully.

3.7. Information Governance and Information Security

- (a) Receive assurance the information governance and information security arrangements are appropriately designed and operating effectively to ensure the reliability, integrity, safety and security of information to support the delivery of high quality, safe healthcare across the organisation.
- (b) Review progress of measures to improve information security and adherence to Caldicott principles against the Information Governance Toolkit, Network and Information Systems (NIS) Directive (2018), Data Protection Act (2018), and receive assurance on compliance with relevant standards, legislation and regulations.
- (c) Receive assurance on, and review effectiveness of the Trust's information security protocols.
- (d) Review performance of the Trust in relation to statutory and mandatory information requests and reporting requirements including but not limited to freedom of information requests, data breaches, police requests and subject access requests.

3.8. Governance

- (a) Seek assurance that governance arrangements are appropriately designed and operating effectively to ensure the provision of high quality, safe healthcare and services across the whole of the Trust's activities, and that these are compliant with relevant legislation..
- (b) Approve the research governance framework and oversee its implementation in accordance with the Welsh Government Research Governance Framework for Health and Social Care.
- (c) Recommendations made by internal audit and external reviewers are considered and acted upon on a timely basis;
- (d) Review and recommend to the Board the Trust's annual quality statement (as relevant) and quality improvement priorities for the coming year, monitoring progress against these priorities and their impact on patient safety.
- (e) Review policies in its remit and endorse policies for Board approval that relate to complaints and incidents in line with Putting Things Right.

Corporate Risks and Audit Recommendation Tracker

3.9. The Audit Committee has overall **responsibility** for ensuring that corporate risks are identified and are being properly managed within the Trust. The

Page 4 of 8

Model Standing Orders – Schedule 3.6: Quality, Patient Experience and Safety Committee TORs

Last Approved [insert]

Audit Committee also has responsibility for ensuring that there are processes in place to address and take forward audit recommendations. Nevertheless, each risk from the corporate risk register and Board Assurance Framework, and each recommendation from the audit tracker, will be allocated to an appropriate Board Committee who will be responsible for ensuring that the Trust is managing and progressing each item as planned. Regular reports will be provided to individual Committees on those items for which they have responsibility and overall Trust-wide progress reports will be presented to each Audit Committee. The Committee will consider the control and mitigation of risks within their remit and provide assurance to the Board that such risks are being effectively controlled and managed.

Authority

- 3.10. The Committee is authorised by the Trust Board to investigate, or have investigated, any activity within its terms of reference. In doing so, it will have the right to seek any information it requires from any employee or inspect any books, records or documents relevant to its remit, ensuring patient/client and staff confidentiality as appropriate. All employees are directed to cooperate with any reasonable request made by the Committee.
- 3.11. The Committee is authorised by the Board to obtain outside legal advice or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Trust's procurement, budgetary and other requirements.
- 3.12. The Committee is authorised to approve Trust wide policies in accordance with the policy for the Review, Development and Approval of Policies.

Sub-Committees

- 3.13. The Committee may establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee business. Formal sub-committees may only be established with the agreement of the Board.

4. MEMBERSHIP

Members

- 4.1. The membership of the Committee should include at least one member of the Trust's Audit Committee and will comprise:

Chair Non Executive Director

Members Three further Non Executive Directors of the Board.

Attendees

- 4.2. The core membership will be supported routinely by the attendance of the following:
- Executive Director of Quality and Nursing (Lead Executive for Committee)
 - Director of Paramedicine
 - Director of Operations
 - Director of Digital Services (SIRO)
 - Trade Union Partners (x 2)
 - Chairs of Sub-committees
- 4.3. The Committee Chair may extend invitations to attend committee meetings to other Directors and/or Senior Managers, and to officials from within or outside the organisation to attend all or part of the meeting to assist with its discussions on any particular matter.
- 4.4. Members may send deputies in their absence who will act with their full authority. To instigate a substitution arrangement, the member of the Committee must notify the Board Secretary before the day of the meeting that he/she is unable to attend and the name of the member who will attend as the substitute.

Member Appointments

- 4.5. The membership of the Committee shall be determined by the Board, based on the recommendation of the Trust Chair, taking account of the balance of skills and expertise necessary to deliver the committee's remit, and, subject to any specific requirements or directions made by the Welsh Government.
- 4.6. Non Executive Members shall be appointed to hold office for a period of one year at a time, (Membership being reviewed by the Chairman of the Board on an annual basis) up to a maximum of their term of office. During this time a member may resign or be removed by the Board.
- 4.7. Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the Trust Chair and, where appropriate, on the basis of advice from the Trust's Remuneration Committee.

Secretariat and Support to Committee Members

- 4.8. The Board Secretary, on behalf of the Committee Chair, shall:
- arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and

- ensure the provision of a programme of organisational development for committee members, as part of the Trust's overall board development programme developed by the Director of Workforce & Organisational Development.

5. COMMITTEE MEETINGS

Quorum

- 5.1. At least two members must be present to ensure the quorum of the Committee. In the absence of the Committee Chair, one of those in attendance must be designated as Chair of the meeting.

Frequency of Meetings

- 5.2. Meetings shall be held no less than quarterly or otherwise as the Chair of the Committee deems necessary, consistent with the Trust's annual plan of Board Business. Meeting agendas, papers and minutes shall be circulated no less seven days prior to each meeting.

Withdrawal of individuals in attendance

- 5.3. The Committee may ask any member or individual who is normally in attendance but who is not a member to withdraw to facilitate open and frank discussion of any particular matter.

6. RELATIONSHIPS & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/ GROUPS

- 6.1. The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.
- 6.2. The Committee, through its Chair and members, shall work closely with the Board's other committees and groups to provide advice and assurance to the Board through the:
- joint planning and co-ordination of Board and Committee business; and
 - sharing of appropriate information;

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall assurance framework.

- 6.3. The Committee will consider the assurance provided through the work of the Board's other committees and sub groups to meet its responsibilities for

advising the Board on the adequacy of the Trust's overall framework of assurance.

- 6.4. The Committee shall embed the Trust's corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1. The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board and the Chief Executive (Accountable Officer) on the Committee's activities. This includes verbal updates on activity, the submission of Committee minutes and written reports where appropriate throughout the year;
- bring to the Board and the Chief Executive (Accountable Officer's) specific attention any significant matter under consideration by the Committee; and
- ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Trust.

7.2. The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any sub committees established. In so doing, account will be taken of the requirements set out in the NHS Wales Quality & Safety Committee Handbook and national guidance.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1. The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum (as set out in section 5)

9. REVIEW

9.1. These terms of reference and operating arrangements shall be reviewed at least annually but more frequently if required.

QUEST EFFECTIVENESS REVIEW RESULTS

What does this committee do well?

ID	Name	Responses
1	anonymous	The committee is effective in scrutinising quality matters, highlighting challenging issues and influencing the Trust in its continuous improvement actions. The committee conducts deep dives into SAI's and patient complaints and ensures that the organisation and Board are aware of issue and drives for improvement.
2	anonymous	Collegiate, collaborative, supportive. Gets to the heart of the subject matter. Explores the issues from a number of perspectives.
3	anonymous	The committee addresses a broad agenda in a methodical way to enable all aspects of the committee work to be considered appropriately. The committee is chaired well and all members and attendees are given opportunity to question and raise issues.
4	anonymous	I am recently new to the meeting so am unable to answer
5	anonymous	- good attendance from Members and Attendees - providing a good mix of skill, knowledge and interest - good reports - written clearly with a good balance of detail - good discussions - often when handling highly emotive issues - a good balance between empathy and scrutiny - a clear desire to make continuous improvement in terms of performance, so that we maximise quality of service delivery for Patients - breadth of reports - different topics covered - very person centred in its focus - i.e. Patients - good partnership working between Members and Attendees - robust pre-Committee meetings - to plan and agree agenda, attendance and focus
6	anonymous	The members and core attendees are well engaged and supportive of the quality agenda.

What does this committee need to do more on?

ID	Name	Responses
1	anonymous	As the metrics develop the committee has the opportunity to deep dive on performance and challenge the organisation to focus on our service to patients. Continue to focus on our risk register to provide the right service and response in line with the 5 step model for patient care.
2	anonymous	Hold to account on areas where performance is challenging. Explore the human impacts of service provision.
3	anonymous	The committee needs to divert some aspects of its work/findings to other committees to consider and take responsibility for scrutiny rather than attempt to cover all areas in depth. The committee needs to consider how it relates to the other committees and how the workload can be better spread
4	anonymous	I am recently new to the meeting so am unable to answer
5	anonymous	- more focus on targeted presentations/introductions of Reports could benefit, thus allowing more time for discussion/debate - streamline/prioritise Agendas, so that they become more manageable (sometimes, they are overly long, which can limit the quality of discussions - by better prioritisation of Agendas, allow more time for 'large/strategic' items for discussion
6	anonymous	The Committee should review its risks in more detail, specifically those where there are limited or no actions to address the gaps in controls and assurance. This is particularly important as the high rated risks are under the remit of this Committee.

What should this committee do less of?

ID	Name	Responses
1	anonymous	Good progress made on committee papers and presentations. Work need to continue on the area to provide more scrutiny and gain more assurance on improvement actions.
2	anonymous	The agenda needs to be scrutinised in detail. What could reasonably be done elsewhere. Essentially the agenda is far to long.
3	anonymous	Less presenting and more scrutiny of effectiveness of actions that are in progress/completed
4	anonymous	I am recently new to the meeting so am unable to answer

ID	Name	Responses
5	anonymous	- spend less time on issues that are of less priority for this Committee; i.e. prioritise
6	anonymous	The agenda is very long. A review of ToRs and the development of a cycle of business, clear on assurance elements, will help with this. However as the Committee meets quarterly it is difficult to cut the agenda down without this cycle to indicate the core items which it must have oversight of.

Please select one of the options below

Member 5

Attendee 1



OPERATIONS DIRECTORATE QUARTERLY REPORT FOR COMMITTEES 2021-22 Q3 (January 2022)

❖ PANDEMIC RESPONSE

The Trust returned to the Response Position within the Response Phase of our Pandemic Plan. The Senior Pandemic Team (SPT) has been stepped back up and is currently meeting twice weekly, with a remit which incorporates both seasonal pressures we anticipate over the winter period, alongside the challenges which remain associated with the pandemic.

An extension of military support beyond the end of November 2021 to 31st March 2022 was submitted and approved and the numbers of personnel increased from 110 to 251. From week commencing 17 January this higher number shall be on task and deployed across WAST.

Between October and early November 2021, staffing abstractions in the directorate (reported from GRS) as a result of Covid remained stable at around 4-5%. Towards the end of December 2021 this began to increase reaching a peak on New Year's Eve (10-11%). This increase is attributed to the new Omicron variant which has an extremely high transmission rate. Since this peak we have experienced gradual reduction in Covid related abstractions however only time shall inform whether this is to be sustained.

Throughout Quarter 3 the focus of the Operations Directorate has been firmly on the pandemic response and winter pressures.

In addition to the SPT Tactical Plan and staff welfare measures outlined previously, additional tactical actions have been progressed to mitigate the increased risks posed by the Omicron variant:

- Review of premises Covid risk assessments including those of corporate buildings to ensure sufficient physical workplace distancing
- Increased home working across all critical functions to limit face-to-face contact and reduce onsite presence
- Our corporate staff volunteering to be reassigned temporarily to support critical functions
- Available clinicians moved into NHS 111 to support rosters
- Encourage staff to receive the Covid vaccinations/booster and enable military personnel to access vaccinations and boosters locally
- Extension of the strategic winter cell until the end of January 2022
- Deep cleaning and swabbing undertaken in all Trust contact centres

❖ RESOURCING & EMS COORDINATION

Emergency Rule

In response to increased and sustained pressure on the 999 call handling demand the EMS Coordination team reviewed tactics that could reduce average handling time and therefore increase the capacity of our Emergency Medical Dispatchers to handle 999 calls. The current process consists of 8 elements including recording key incident information, prioritisation processes, recording patient demographics as well as providing advice and additional scripting associated with Covid screening, Clinical safety plans and ETAs.

Following a review of call handling escalation/business continuity plans from other UK ambulance services a proposal was submitted to the Executive Management Team to enhance our Emergency Rule guidance. The International Academy of Emergency Dispatch (IAED) who provide the governance structure for MPDS define the 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 has not been implemented even at times of significant pressures.

Following EMT approval on 5th January 2022 a revised approach to Emergency Rule implementation has 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 phased approach would allow EMS Co-ordination to protect the most vulnerable patients for as long as possible even in times of extremis. A four stage approach has now been incorporated into the Clinical Safety Plan including required approvals to initiate each of those levels.

❖ **EMERGENCY MEDICAL SERVICE (EMS)**

One of the efficiencies and recommendations identified in the 2019 ORH report was to review all operational rosters within the EMS function by December 2021 to improve the safety of patients and the wellbeing of staff and in particular aligning our peak production more closely to the daily patient demand pattern. This was supported by a recommendation to increase EMS staffing by 263 FTE to assist with closing the gap that was identified in relation to the capacity for relief working.

In response to the Review WAST has established the EMS Operational Transformation Programme, of which the EMS Roster Review Project is one of ten partnership projects. The objectives as set out in the terms of reference is twofold; 1) improving patient safety by delivering rosters aligned to patient demand 2) improving staff well-being by delivering good workable shift patterns.

To date the following steps have been established:

Step One - Core Principles – the negotiation and agreement between management and trade union colleagues of the principles around which the rosters will be designed, which concluded in July 2021.

Step Two - Working Parties – 15 local groups working across Wales, in partnership between managers and local trade union representatives, on the detailed design of station rosters, circa 85 across Wales that require a full review. Due to the complexity of this work, timelines for this step were initially set to take place from September to December 2021. Working Parties 1 was completed, on schedule, in September 2021.

We recently "paused" the project to take the opportunity to review more recent data on the unscheduled care system and consider stakeholder feedback. This has now been completed and following due consideration of the current COVID19 response balanced against the importance of achieving agreed revised roster patterns before Winter 2022, Working Parties 2 will recommence from January 17th 2022.

Included in the new modelling is the intention to introduce the concept of CHARU (Cymru High Acuity Response Unit), which will be deployed to support patients with suspected critical illness or injury. The CHARU will replace the traditional RRV model. The dispatch criteria is currently being finalised but will include all red category calls but will also include examples such as falls from height, serious road traffic incidents and serious assaults.

❖ **AMBULANCE CARE (Non-Emergency Patient Transport Service - NEPTS)**

Covid Response & Recovery - Additional Capacity

In September we were awarded additional funding for the period until 31st March 2022 to help continue to support Health Boards as they endeavour to reduce the backlog of planned care.

We created a temporary new post of Ambulance Car Driver and the 30 successful candidates were recruited have commenced conveying T1 patients, enhancing our Volunteer Car Service and reducing our use of private taxi hire.

Quality Dashboard

Since first approval in February 2021, several operational performance measures have been added to our dashboard to create a balanced scorecard for NEPTS.

The quality dashboard is entering its twelfth month of reporting and as so, an additional section will be included within February's report sharing what actions have been taken to improve the measures within the dashboard and provide a deep dive into certain measures. The patient survey element continues and we have started to consider how we can share the outcomes with our staff.

Update re: 3Q's

The NEPTS Quality Management Framework has now been approved by EMT and work is now underway to successfully deliver the aims during 2022.

As part of the framework a Quality Framework a Quality Assurance, Quality Control & Award system, has been developed, the system will be called the '3Q's' Quality, Quality, Quality.

The 3Q's will allow the monitoring and measurement of quality against a set of standards. Providers will then be allocated the appropriate number of Q's based on their performance as measured against those standards.

The Q's will be awarded on the following basis:

- 2 Q's from the Quality Assurance Exemplar. (The Document that lays out and assesses what excellent looks like)
- 1 Q based upon performance against the QA Performance Matrix. (6 Performance related prerequisites that can be measured to show excellent performance)

It is the intention that these standards will also be used to assess WAST's ability to deliver on Quality and so we will also shine a light on ourselves to ensure we practice what we preach.

Colleagues from the NCCU have been engaged with this process and there has been overwhelming support and praise for this work.

Following approval, the team are currently undertaking virtual engagement sessions with external providers to discuss the awards in readiness for the implementation on the 1st of April 2022. Initial feedback from providers is very positive and we have had good engagement, all have commented how refreshing it is to be fully engaged with and having the opportunity to shape the future of NEPTS in Wales with WAST. We shall provide an update on this progress to QuEST.

❖ INTEGRATED CARE

111 Operations

Recruitment continues to satisfy the demand from the Pandemic and the final roll out of Cardiff and Vale to the NHS 111 Wales programme with an enhanced estates provision within the Trust's own premises enabling an increased hiring to meet the demand.

A new Interactive Voice Recording system was introduced to the 111 telephone number which is 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 are not remaining on the line to speak with the initial call handler.

Additionally, an informative Estimated Wait Time is now presented to the 111 caller to help manage expectation, especially during busy times. The old chargeable 0845 number for contacting NHS 111 Wales has been retired and all callers are now directed to 111. In a low-key switchover, the Trust is now able to pinpoint the dialling location of the caller and there will be no further caller charges for contacting the service.

Preparations continue for the delayed roll out of Cardiff and Vale with an expected go live data in the first week of March 2022.

CSD Operations

36 WTE paramedics have now been recruited to the Clinical Support Desk and through a staggered programme of training and mentoring will all be on line before the end of March 2022. Over half are on line already. Work is underway to enable the first Integrated Care Advanced Practitioners to provide senior clinical support to CSD operations, starting January 2022.

111 Christmas Bank Holiday Weekend

111 Operations saw its highest ever volume of presented calls during the Christmas Bank Holiday weekend with almost 6,000 callers presenting to the 111-call queue on Tuesday 28th December. Plans were already in place to bring in additional staff and to move staff from traditionally quieter days. While the abandoned calls were similar to a regular weekend the service also set a new record of calls to 111 answered in a single day at 3,180. Across the weekend the telephony platform was tested and it was gleaned that additional capacity was needed to enable the volumes trying to access the service could connect. A root cause analysis is underway and shall be considered by the EMT when complete, and in the interim additional capacity has been provided.

❖ NATIONAL OPERATIONS AND SUPPORT

Preparedness & Seasonal Planning Exercises

The EPRR and Specialist Ops team supported a table top exercise run by the Prepare Delivery Group called Celtic Consolidation. This was held on 25th November based on a terrorist CBRN attack and focussed on Control Room management; Tactical management; Strategic Management; Mass Fatalities processes; Mass casualties and health; Warning and Informing and Governance and Humanitarian issues. The afternoon session was a reflection on early themes gleaned from the ongoing Manchester Arena Inquiry.

The EPRR team ran the annual Seasonal Planning exercise over Teams on 13th October and used the opportunity to refresh commander's knowledge of the various plans and procedures we have in place to support decision making over the winter period. We shall be collating recent process developments relating to incident preparedness and shall present these to the relevant Committee for assurance.

Specialist Operations Response Team (SORT) Business Case

A business case for enhancing the Specialist Operations Response Team (SORT) was approved at EMT and has been submitted to Welsh Government for their consideration. This enhancement is based on a similar process already undertaken in England to strengthen the Trust's response to Marauding Terrorist and CBRN attacks and if approved will support an increase in SORT volunteer numbers, dedicated trainer, Senior Paramedic role and additional funding to support provision of training and PPE across Wales. Papers shall be prepared and progressed for any spending approval at the appropriate time.

Winter Ops Order

As part of setting up the Winter Cell the EPRR team drafted an Winter Cell Operations order which outlined all of the processes and capabilities that had been put in place to manage the additional demand, this also included a separate New Year's Eve annexe that was routinely updated to ensure the latest information was available.

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. It is anticipated that they will take up post towards the end of January 2022.



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Gwasanaethau Ambiwylans Cymru
Welsh Ambulance Services
NHS Trust

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

QUALITY STRATEGY HIGHLIGHT REPORT QUARTER 3, 2021/22

MEETING	Quality, Patient Experience & Safety Committee
DATE	17 February 2022
EXECUTIVE	Director of Quality & Nursing
AUTHOR	Head of Quality Assurance
CONTACT	Caroline Miftari Caroline.miftari@wales.nhs.uk

EXECUTIVE SUMMARY
<p>The Report will provide an update to the Quality, Patient Experience & Safety Committee on the Quality Strategy Progress over Quarter 3.</p> <p>The report highlights good progress made in discussing and approving the Quality Strategy Implementation Plan via the Assistant Directors Leadership Group (ADLT).</p> <p>Progress against the Strategy has been made, however the organisational challenges arising from the COVID-19 pandemic, and demand pressures have significantly impacted progress.</p> <p>RECOMMENDED: That the Committee receive this report.</p>

KEY ISSUES/IMPLICATIONS
<p>(i) Progress against the Strategy has been achieved, however challenges upon the organisation are significantly impacting resources towards delivery of the Strategy.</p>

REPORT APPROVAL ROUTE				
<table> <tr> <td>Executive Management Team</td> <td>2 February 2022</td> </tr> <tr> <td>Quality, Patient Experience & Safety Committee</td> <td>17 February 2022</td> </tr> </table>	Executive Management Team	2 February 2022	Quality, Patient Experience & Safety Committee	17 February 2022
Executive Management Team	2 February 2022			
Quality, Patient Experience & Safety Committee	17 February 2022			

REPORT APPENDICES
<p>Annex 1 - SBAR Annex 2 - Strategy Implementation Plan</p>

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

SITUATION

- 1 The Report provides a progress update on the implementation of Trust Quality Strategy.

BACKGROUND

- 2 The Trust Quality Strategy 2021-24 launched in May 2021.
- 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 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 The Strategy provides high-level strategic direction on how the requirements will be achieved through three broad underpinning strategic themes that will shape delivery activities and frameworks supporting progress.

ASSESSMENT

- 6 During the quarter the Assistant Directors Leadership Team have 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 aiding compliance.
- 7 Members of the Assistant Directors Leadership Team have subsequently meet to refine the implementation Action Plan (**Annex 2**). Significant efforts have been applied to ensure the implementation is 'conceptually right' and complementary to wider organisational efforts.
- 8 A Quality Strategy Implementation Working Group has been initiated with membership across disciplines to ensure the Quality Strategy maintains progress.
- 9 Job descriptions for the Senior Quality Leads have been developed and await Human Resource Job Evaluation process to complete. Colleagues are likely to commence in post during Quarter 1 of 2022/23. They will further assist in the integration and development of the Quality Strategy.
- 10 Development of the Quality and Performance Management Framework continues, the framework will become the basis of the Trust Quality Management System.

Challenges

(i) Pandemic Response (COVID-19)

During the quarter the Trust continue 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.

(ii) REAP Level 4

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.

(iii) Pace of Delivery - Welsh Government Workshops

The pace of delivery of the Duty of Quality and Duty of Candour Workshops will influence the pace at which the Trust will be able to implement the required Governance Framework and educational requirements and across the Trust. Currently the Workshops are at an early stage, engaging with all sectors of health and social care, and not due to complete until 2022/3.

Strategic Quality Aims	Strategic Outcome	Output Required	Proposed Action	Milestone / Measure	Lead	Complementary Activities	Commencement Date	
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)					
		Openness to new approaches						
		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
	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.				
		Day-to-day 'Duty of Candour' implementation	<i>Process to capture DoC (low, medium and high level activity)</i>	TBC	Senior Quality Lead Team	WG / NHS Wales Delivery Unit – guidance on implementation	TBC	
	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	Development of supporting processes and systems of work that focus improvement towards challenges	Open, honest & transparent with service users when we have not met expectations	Senior Quality Lead Team	Quality & Performance Management Framework	2022/23 Q1
Quality 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.				
			Statement/principle campaign	Formal statement/principle developed	Senior Quality Lead Team	Behaviour and cultural refresh (WOD); Welsh Government Q&S Act Workshops	TBC	
		Celebrating success and exemplars	Aligned to Trust behaviours and cultural refresh					
	Empower local leaders	Quality Management training/education	Development of training, and information resources	Senior Quality Lead Team	-	2022/23 Q4		
				Senior Quality Lead Team	WAST Improvement & Innovation Network (WIIN); Research, Innovation & Improvement Coordination (RIIC) Hub	2022/23 Q3		
			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					
	Integrating Quality Management	Systems that integrate and triangulate data Collaborative forums for patient and service users Integrating communication Integrating reporting lines	Establishment of a Quality & Performance Management Steering Group; Establishment of integrated 'governance' forums.	TBC: Establishment of group, and effectiveness of work programme	Quality & Performance Management Framework Steering Group	-	2021/22 Q4	
	Strong Governance & Quality Management Structures	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.	Quality & Performance Management Framework	2021/22 Q3	
			Develop reporting and governance channels to local level				2022/23 Q1	
		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.			
	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	
Issues locally owned and managed			Count of issues (by complexity) managed within local leadership structures (via Senior Quality Lead Team)	-		2022/23 Q2		
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	
		Innovation	Establish and embed work processes to enable Citizens to be contributing and co-producing 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			TBC		



GIG
CYMRU
NHS
WALES | Ymddiriedolaeth GIG
Gwasanaethau Ambiwylans Cymru
Welsh Ambulance Services
NHS Trust

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

QUALITY & PERFORMANCE MANAGEMENT FRAMEWORK 2022-2025

MEETING	QUEST
DATE	17 February-22
EXECUTIVE	Rachel Marsh – Director of Strategy, Planning and Performance Claire Roche – Executive Director of Quality & Nursing Trish Mills – Corporate Secretary
AUTHOR	Hugh Bennett – Assistant Director of Commissioning and Performance
CONTACT	Hugh.bennett2@wales.nhs.uk

EXECUTIVE SUMMARY

QUEST is asked to consider the draft Quality & Performance Management Framework.

Trust Board approved a Planning & Performance Management Framework in 2016. This is now out of date and does not reflect the significant improvement in practices since 2016 or future plans. The update has been delayed as a result of the pandemic response.

The purpose of the Framework is to deliver appropriate (prudent) patient care and staff well-being across the Trust's responsibilities, through the application of quality and performance management practice.

The Framework provides a formal document to give assurance to Trust Board that the Trust has a clearly defined approach for the delivery of quality and performance at all levels of the Trust.

The Framework is designed to be integrated and combines quality and performance; and reflects the statutory duty of quality as per the Health & Social Care (Quality & Engagement Act).

RECOMMENDATION

QUEST is asked to:-

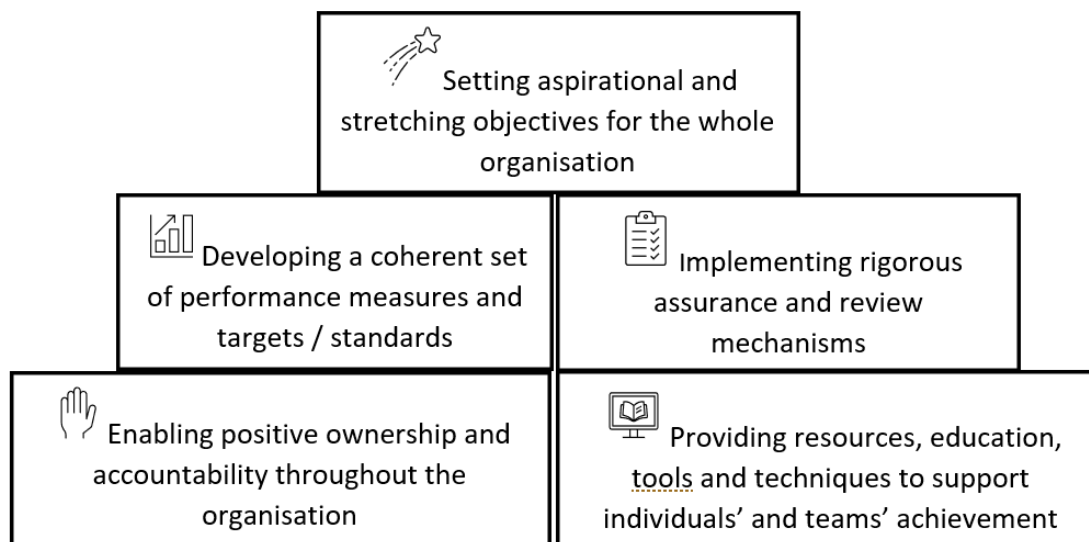
- **Consider** the draft Quality & Performance Management Framework 2022-2025.

KEY ISSUES/IMPLICATIONS

The draft Framework and its supporting appendices are attached at Appendix 1.

Five Building Blocks

The Framework has five component parts or building blocks.



Organisational Requirements

Each component has “Organisational Requirements”. These are the principles or the rules that define how the Trust will discharge quality and performance at every level in the Trust. There are 23 proposed Organisational Requirements.

Dynamic

The Framework is designed to be dynamic and reflect the fact that quality and performance management practice is being continuously improved. The Framework proposes the formal establishment of a Quality & Performance Management Steering Group to oversee the on-going development of the Framework before its next formal update to Trust Board in Mar-25

Priorities for Improvement

The Framework maps elements of the “as is” quality & performance management arrangements of the Trust at a Trust wide level, in particular, a quality and Performance Management Cycle that feeds through the meetings detailed in the Assurance & Review Governance Map.

The Trust’s current arrangements are considered good, but the ambition is excellence. Priority areas for improvement include:

- Local-frameworks: the development of documents in each area of the Trust which set out how the Framework will be enacted in that area. This will include an assessment of current practice v the Organisational Requirements as a guide to future improvement activity;
- Strategic partner or expert reference group: which enables the Trust to lever in excellent practice, looking to health economies across the world and different sectors as well as the NHS family;
- A formal dynamic and prioritised work programme for the Steering Group.

REPORT APPROVAL ROUTE

Date	Meeting
09 Feb-22	EMT
17 Feb-22	QUEST
22 Feb-22	People & Culture Committee
09 Mar-22	EMT
17 Mar-22	Finance & Performance Committee
27 Mar-22	Trust Board

REPORT APPENDICES

Appendix 1 – Draft Quality & Performance Management Framework

REPORT CHECKLIST

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



WAST QUALITY & PERFORMANCE MANAGEMENT FRAMEWORK

VERSION: (11)

02 Feb-22

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Appendices

1.	WAST Assurance & Review Governance Map	
2.	Quality & Performance Improvement Techniques	
3.	Quality & Performance Management Steering Group Terms of Reference	
4.	Quality & Performance Management Cycle	

1. Purpose

This Quality & Performance Management Framework sets out an integrated approach to helping the Trust **improve the quality of its services and outcomes for patients and achieve its ambitions and objectives** by monitoring and improving the performance of people, teams, and the organisation.

It establishes a framework for developing a **shared understanding** about what is to be achieved and an approach to leading and developing people which will ensure that it is achieved. It should **empower** colleagues at every level in the organisation to do their jobs more effectively and help remove barriers that are preventing them from giving their best.

The Framework also provides a formal document to give assurance to Trust Board that the Trust has a clearly defined approach for delivering quality and performance at all levels of the organisation.

Quality is defined within the Health and Social Care (Quality & Engagement) (Wales) Act 2020 as:

- the effectiveness of health services;
- the safety of health services; and
- the positive experience of individuals to whom health services are provided.

Performance Management is the process of actively managing delivery of a plan, in particular, regular review and corrective action to remain on target to deliver a plan and the process of making change to a process or system that is key to delivering improved performance, normally involving a service redesign technique.

2. Background

The Framework builds on the Trust Board **approved 2016 Planning & Performance Framework**. Whilst the Trust has not formally updated the Framework since that time, significant strides have been made in quality and performance management over the last 5 years.

Both the Trust's **Structured Assessment** and a recent internal audit of Clinical Contact Centre (CCC) performance management identified the need to formally update the Framework.

In developing this updated Framework, consideration has been given to similar frameworks in other public sector organisations, literature on quality and performance, external stakeholder requirements and feedback from internal stakeholders.

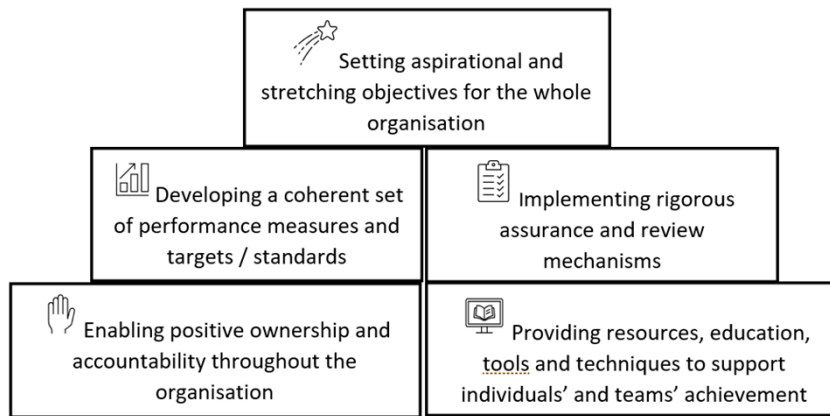
Importantly, this Framework is also a key facet of the Trust's action plan in relation to its **Quality Strategy**. The Quality Strategy 2021-24 is aligned to the Trust's *Delivering Excellence 2030* vision and complements the organisation's wider strategic plans and priorities. The strategy has been 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*. One of the key components of the Quality Strategy is to develop and embed **Quality Management Systems**, and this Framework should be read as the organisation's response to this element.

The Quality & Performance Management Framework also forms part of the wider assurance arrangements within the organisation. The **Risk Management Framework** is an integral part of our governance arrangements and is central to the management of the Trust's objectives. It includes the components that enable the Trust to effectively manage risk supporting the delivery of continuous quality improvement, safer patient care and the safety of our staff and visitors. This is strengthened by embedding a positive risk management culture and the principles of good governance throughout the organisation.

The **Board Assurance Framework** sets out WAST's overall arrangements for providing assurance to the Board by aligning these closely to the Board's strategic goals and objectives as described within its 3 year Integrated Medium Term Plan. In addition, the framework informs the Board on the principal risks that threaten the delivery of those objectives.

3. Framework Overview

The Trust's Quality & Performance Management Framework is a broad organisational framework made up of **5 key building blocks**, set out in the visual below. These set out both the **processes** that need to be in place across the organisation, but also importantly also touch on the **values and culture** of the organisation that will need to be embedded around **supporting people and teams** to take positive ownership and accountability for improvement.



The Trust is a complex and diverse organisation, and there will need to be some flexibility in terms of how this Framework is implemented. However, the Framework sets out some core principles or **organisational requirements** for each of these building blocks, which are set out in more detail in the following sections.

In each part of the organisation, whether that be in corporate or operational Directorates and teams, managers will be required to assess their own systems and processes against the requirements in this Framework, and where necessary, implement changes and improvements. The arrangements for quality and performance management, aligned to this Framework, for a particular part of the Trust, will be documented in a series of **local Frameworks**.

The Framework is designed to be a dynamic document, reflecting the fact that quality and performance management practices are being amended and improved on a weekly basis to reflect the fast moving and changing nature of the Trust's work, and later on the document, how this will happen will be described.

A **work programme** will be developed by the newly formulated Quality and Performance Framework Steering Group to take forward the development and implementation of this Framework across the organisation, reporting in to EMT and to the Finance and Performance Committee,

4. Setting Aspirational and Stretching Objectives

OR1	The Trust will clearly set out its long-term ambitions in a Board approved strategy or strategies . It will be easily accessible and understood by staff across the organisation and by stakeholders.
OR2	The Trust will operationalise these long-term ambitions through a Trust wide, rolling, three year Integrated Medium Term Plan (IMTP) .
OR3	More detailed Delivery Plans will be developed as required at Directorate, Team or Programme level, setting out how they will contribute to achievement of the Trust's Strategy and IMTP.
OR4	All staff will have a Performance Appraisal Development Review (PADR) with an individual plan for the year, connecting the individual's contribution to Trust ambitions and plans.
OR5	All plans at every level will be balanced , taking into account quality, our people, resources & value, and how the plan contributes to the wider system. The plans will also consider risks and how they might be mitigated.
OR6	The Trust will give due regard to Welsh Government, Commissioner and other strategies and statutory requirements when developing its plans and planning arrangements.
OR7	All plans should include objectives that are FAST : frequently discussed, ambitious, specific and transparent.
OR8	All plans should be dynamic and responsive to changing circumstances, with supplementary plans being produced (as agreed) where required

The Trust is committed to developing, evolving and clearly articulating its longer-term strategy and ambitions, taking into account the wider context in which it operates, and working in collaboration with internal and external stakeholders. The process of **production of plans** that then turns these longer-term ambitions into specific aims and objectives that are stretching and focused is a key component of the Framework.

The Trust has a **statutory requirement** to think and plan in a generational way (the Well-Being of Future Generations (Wales) Act 2015), plan in a way that is consistent with the NHS Wales Planning Framework, Commissioning requirements, Welsh Government strategy (currently A Healthier Wales) and a statutory requirement to think of quality and engagement through the Trust’s work – the Health & Social Care (Quality & Engagement) (Wales) Act 2020. But plans

The Trust will develop plans at every level of the organisation - **strategic, tactical and operational**. This will produce a **hierarchy of plans** that link together, aligning the Trust and all its people towards achieving its agreed, overall vision.

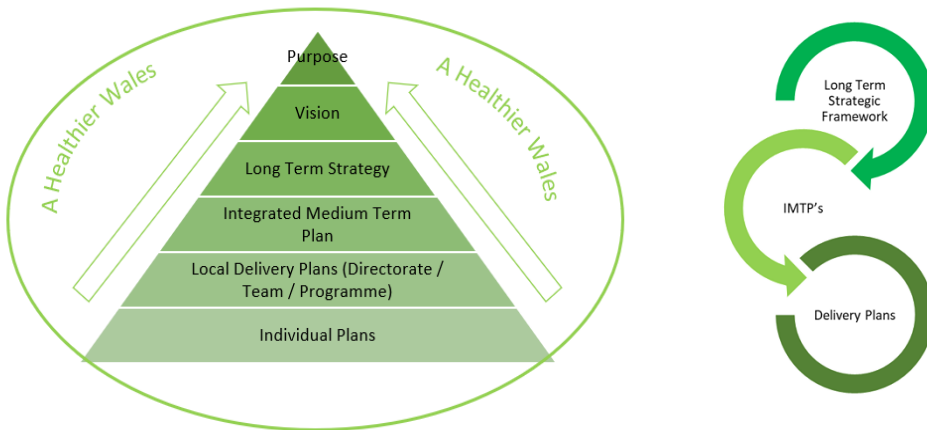
At an organisational level, **the Integrated Medium Term Plan** will set out, on a three-year rolling basis, the prioritised actions that the organisation will take to move it towards its strategic ambitions. The IMTP will take into account the national planning guidance issued by Welsh Government annually, the external environment in which we operate including statutory requirements and commissioning intentions, as well as intelligence gathered from patients and staff.

Underneath the IMTP, a range of more detailed **delivery plans** will be developed. These may be at a programme level, a Directorate level, or a sub-Directorate level. These are important mechanisms which set out the actions that individuals and teams need to take at all levels of the organisation, linked back to the IMTP.

Lastly, these plans will all be linked back to individuals through their **PADRs**, which will allow each member of staff to understand how they contribute to the organisations aims and objectives.

In addition, emergency and business continuity plans should be produced to deal with unplanned situations that interrupt the planned delivery of strategic ambitions and impact on the quality and performance delivery.

All plans will set out clear objectives which should be FAST (frequently discussed, ambitious, specific and transparent). Actions should have clear milestones for delivery.



5. Balanced & Coherent Measures and Targets

OR9	The Trust will develop appropriate measures at every level of the organisation, aligned to plans, that demonstrate progress in achieving long term ambitions and objectives.
OR10	The measures will be proportionate and balanced reflecting the quality of services to our patients, our people, finance & value and partnership & system contribution.
OR11	In reviewing progress against quantitative measures, consideration will be given to progress over time , and information will be simply presented to ensure that it is clearly understood.
OR12	Everyone in the Trust should have easy access to information on the measures relevant to their role, empowering quality and performance management in their job.
OR13	Everyone in the Trust should have access to and be aware of the corporate level measures and metrics to understand the progress that is being made.
OR14	All reports setting out progress against these measures will be quality assured in terms of the data, with clarity provided on data definitions.

Quantification of Aims & Objectives

The development and monitoring of measures is the mechanism by which the organisation can assess whether its strategy, aims and objectives are being achieved. If an aim or objective does not have an agreed quantifiable measure, then assessing progress becomes subjective and difficult. Aims and objectives, normally contained in plans, projects or programmes should be supported by measures. These measures should be FAST.

Balanced, Logical & Coherent Metrics

There is plenty of quality and performance literature that identifies that setting the wrong measures can cause perverse incentives or sub-optimize performance i.e. an over focus on one measure to the detriment of another. The origins of the **balanced scorecard** approach to measures came from a number of high-profile organisational failures, where there was an over focus on profit at the expense of wider considerations like safety. The Welsh Government paper "A Healthier Wales", set out the Quadruple Aims, which is based on this approach.

Welsh Government Quadruple Aim



The Trust agrees with this balanced approach and has interpreted it into the Trust setting with the following 4 areas of focus.

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

The metrics chosen should be logical (based on evidence) and **connected to one another** so that they provide a coherent picture of the interaction between variables that affect quality and performance.

A coherent set of metrics will usually look at the links between **inputs, processes and outputs and outcomes**, for example, ambulance hours produced, speed of mobilisation, Red 8 minute performance and lives saved, which helps determine value achieved from the initial investment of taxpayers' money.

The Institute of Health Improvement (IHI) similarly advise that metrics should be **proportionate**, focusing on the "the vital few" i.e. the key metrics that need to be affected in order to improve quality and performance.

Vanguard Systems Thinking also recommends the avoidance of hit/miss targets to help manage quality, safety and patient experience, so the use of **distribution curves** (median, 65th and 95th percentiles). This is not to say that hit/miss targets cannot be used, but that they should be supported by distribution measures e.g. Red A&E hit/miss, but also Red 95th percentile. The Trust has also learnt that a focus on what is happening in the last five percentile points is also an important aspect to patient safety.

Both IHI and Vanguard recommend the use of **time series analysis** graphs. Time series analysis enables colleagues to identify trends, variations, and changes in the metrics over time which may be driven by service change or presenting demand (user or patient). Time series analysis can be further supported using supporting techniques like statistical process control (SPC) and pathway/system mapping of flow (work, users and patients).

Metrics should be presented in a way that are **easy to read** and use, with an emphasis on graphical presentation that provides the reader with a coherent narrative of what is happening and why.

There will need to be an appropriate level work undertaken within the organisation to ensure that data is of sufficient **quality** to be used in reporting of these measures, and an appropriate clear definition of each measure.

And finally, **predictive techniques** are encouraged, for example forecasting patient demand and simulation modelling, which enable decision makers to get upstream and have sufficient time to take balanced, coherent and FAST actions to mitigate potential identified quality and performance issues.

Clearly, not all quality and performance reports need to be balanced and coherent, they may rightly have a specific focus, but **decision-makers should be receiving either balanced and coherent quality and performance reports or a suite of reports that together provide this balance and coherence.**

Drill Down

Most performance literature agrees that for senior decision makers quality and performance reports need to focus on the “vital few” metrics; however, it is also possible to “drill down” from key high level metrics and obtain more detailed information. This may be by geography (health board, locality, station) or by time (month, day, hour) or both. This ability to drill down enables colleagues to identify the geographic area or time period that is most important to improving quality and performance.

Alignment

The Trust operates in a data rich environment. Whilst this is a good thing, an issue can be that colleagues cannot always easily understand how the metrics they are working on align to what the Trust is trying to achieve overall. Most quality and performance literature agree that organisations are more effective if employees at every level in an organisation understand how their work and the metrics they are working on fit into the “**big picture**”. The most famous example of this is the NASA janitor who was helping to put a man on the moon.

This alignment has traditionally been done through PADRs. The Trust is currently developing IMTP posts that will provide colleagues with an overview of the Trust’s aims and objectives linked to key metrics. The Trust knows that this is an area, particularly with the growth of ICT, where there are opportunities for further development over the three years of this Framework.

6. Ownership & Accountability

The requirements for Ownership & Accountability are:-

OR15	Everyone in the Trust has a level of ownership and accountability for quality and performance management and improvement, commensurate with their job description.
OR16	The plans at every level of the organisation will clearly set out the owners of each action and deliverable, although matrix working is a key part of the way in which owners can ensure actions are delivered
OR17	The individual owner is accountable for the action, deliverable and outcome achieved, and is provided with the support to deliver.

Overall accountability for quality and performance rests at Trust Board level, but **everyone** in the Trust has a responsibility for quality and performance. Accountability and responsibility are detailed through a variety of management mechanisms, for example, formal schemes of delegation, job descriptions, scope of practice, plans and PADR's.

However, quality and performance management theory points to **one person** needing to be identified as **owning an aim, objective or measure**, to avoid confusion, create clarity and ensure ownership and accountability. The Trust makes extensive use of action logs, risk registers, project plans, programme plans, tactical plans as well as the Board level IMTP and Monthly Quality & Performance Report. It is established practice in the Trust that these management mechanisms include a column which identifies the Lead so that ownership and accountability are clear.

The identified lead is the person who is deemed to be **accountable** for a particular aim, objective or measure. The level of accountability should be appropriate to their job description with increasing breadth of responsibility and delegation to deliver the aim, objective or measure.

Accountability means that the lead will be **held to account**. This will normally be in a quality and performance forum (see next chapter) and will involve challenge and scrutiny if an aim, objective or measure is not being delivered. This process should lead to the identification of corrective actions to aid the delivery of the aim, objective or measure, which should be recorded.

Whilst it is right and proper that colleagues are held to account it is equally important that colleagues have the tools, techniques and capacity to deliver on what they are accountable for i.e. we set up to succeed.

7. Assurance & Review Mechanisms

OR18	There will be regular meetings at every level across the Trust (Trust wide, Directorate, team, individual) where quality and performance delivery is reviewed and assured, linked to the relevant plans.
OR19	These meetings will form part of a quality and performance management cycle (Trust, departmental or functional)
OR20	Where assurance is not achieved, corrective action will be agreed with a supporting improvement tool or the issue will be escalated.
OR21	The Trust will comply with and support all external quality and performance management assurance requirements (JET / EASC / 111 Programme Board)

Assurance is positive declaration intended to give confidence that a key deliverable/action and the associated measures are being delivered. **Assurance is achieved through review.** Review invariably requires formal organisational mechanisms. A lack of assurance should lead to corrective action in order to achieve assurance.

Assurance & Review Governance Map

Appendix 1 contains the Framework's Assurance & Review Governance Map i.e. the current standing meetings at a Trust wide level that focus on quality and performance management at a corporate level. This map itself will need to be reviewed against the requirements in this Framework.

Performance management theory and practice identifies that **regular meetings** provide a clear process for reviewing quality and performance, an organisational rhythm and through repetition the development of knowledge and insight.

For the Trust wide level meetings identified in *Appendix 1* the expectation is that:-

- They are formal meetings, with clear terms of reference;
- Receive a regular supply of timely quality and performance information;
- Quality and performance information is historic, but also predictive;
- There is a supporting action log and maybe also an action plan (optional);
- The meetings are undertaken in collaboration, in a matrix style.

Corrective Action

The acid test of quality and performance meetings is whether quality and performance improves or the impact of system pressures is mitigated. In more formal meetings there should be a clear action log with a focus on corrective/remedial actions allocated to attendees. In less formal meetings email notes or hand written notes in a daily log book may suffice. The actions/notes should be returned to in the next meeting.

8. Support to Individuals and Teams

OR22	The Trust will ensure that colleagues at every level in the Trust have access to the resources, education, training & development and tools and techniques to enable them to deliver and improve quality and performance.
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OR23	Appropriate quality and performance management training will be available for colleagues at all levels in the Trust, including training in data, analytics and behaviours.
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Access to Improvement Tools and Techniques

The Trust will ensure that colleagues at every level in the Trust are supported to deliver and improve quality and performance through the **availability of good improvement tools and techniques**.

The Trust acknowledges that the current range of improvement tools and techniques have emerged over time and not been subject to a more formal analysis of what each type of role in the Trust requires. This will be an area of development for the Framework over the next three years.

Nevertheless the Trust does have access to an extensive range of good improvement tools and techniques (see *Appendix 2*).

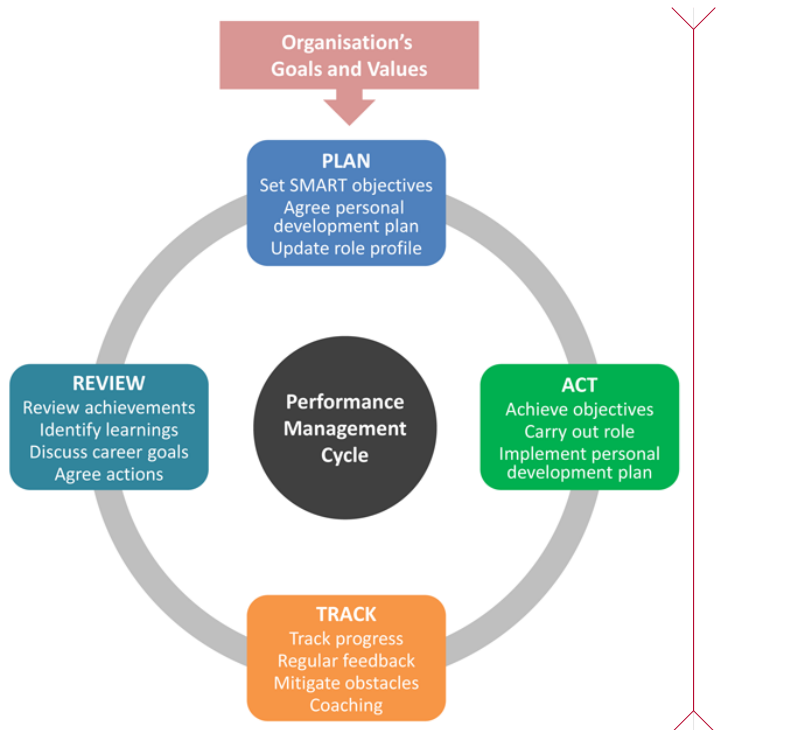
Quality & Performance Management Training

Similarly training on improvement tools and techniques is largely the responsibility of individual managers and staff via the PADR process; there is no real corporate overview (horizon scanning or needs analysis) of the Trust's quality, performance management and improvement tools & techniques. The proposed Quality & Performance Management Framework Steering Group will collaborate with the Workforce & OD Directorate to ensure appropriate quality and performance management training for colleagues at all levels in the Trust.

9. Quality & Performance Management Cycle

The process of developing a stretching aims and objectives in plans, the development of balanced, coherent and FAST measures and delivering these through ownership, accountability, assurance, review and improvement can be brought together and articulated into a formal quality & performance cycle.

Quality & Performance Management Cycle



Commented [RM(ASNT1): Look for organisational cycle

Quality & Performance Management Cycle (possible add of QMS diagram)

In Chapter 7 the Framework identified an Assurance & Review Governance Map (*Appendix 1*) i.e. the series of meetings that make up the Trust wide approach to quality and performance. In order for these meetings to be fully effective they need to fit together around a cycle that has the following characteristics:-

- i. sufficiently upstream to enable good planning for quality and performance;
- ii. integrated to ensure that plans are aligned to each other, what has been referred to as “planning advantage” (rather than competitive advantage);

- iii. Delivery focused, in particular, sufficient mechanisms are in place in year to ensure that a plan is supported and delivered; and
- iv. Evaluates, that the cycle asks “have we delivered what we set out to deliver?” and has “what we planned delivered the intended benefits and outcomes?”

Appendix 4 sets out the Trust’s Quality & Performance Cycle.

10. Roles & Responsibilities

Every colleague in the Trust has a role and responsibility for quality and performance management. There are also specific roles within the Framework.

The **Chair** has oversight and ultimate Board level accountability and responsibility for the Trust's quality and performance. In discharging this responsibility the Chair is supported by the Board made up of Non-Executive Directors and directors. The Quality & Performance Management Framework provides a key assurance mechanism for the Chair and Board to discharge their overall responsibility for quality and performance. The Chair has a specific role within this Framework to undertake a PADR with the CEO and monthly one to ones.

Non-Executive Directors support the Chair in discharging Board level accountability and responsibility for the Trust's quality and performance, in particular, act as Chairs and Vice Chairs of sub-committees to the Board with a specific focus as per the committee's terms of reference.

The **Chief Executive Officer** has ultimate officer accountability and responsibility for the Trust's quality and performance. The Chief Executive Officer will primarily discharge these responsibilities, in line with this Framework, through the Strategic Transformation Board, weekly Executive Management Team (EMT), monthly one to one meetings with Directors and PADRs.

The **Director of Operations** has lead officer responsibility for Operations quality and performance across the Trust's three patient pathways: 111, EMS and Ambulance Care; a specific lead responsibility for an Operation's Quality & Performance Management Sub-Framework.

The **Executive Director of Finance & Resource** has lead responsibility for the Trust's financial & resource planning, financial & resource monitoring and delivery and financial & resource benefits and outcomes, including financial balance. The Executive Director of Finance & Resource also has specific responsibilities for quality and performance management as per the Support Services Quality & Performance Management sub-framework.

The **Clinical & Medical Director** has lead officer responsibility for the Trust's overall Clinical Strategy, clinical practices and a specific lead responsibility for the Clinical & Medical Quality & Performance Management Sub-Framework.

The **Director of Paramedicine** has lead officer responsibility for the Trust's paramedicine and quality and performance management practices within this context. The Director of Paramedicine also has a director level responsibility for the paramedicine aspects of the Clinical & Medical Quality & Performance Management Sub-Framework.

The **Executive Director of Quality & Nursing** has lead responsibility for the regulation of registered nurses and professional standards in the Trust and the Trust's Quality Strategy. The Executive Director of Quality & Nursing has a specific lead responsibility for the QSPE Quality & Performance Management Sub-Framework. The Executive Director of Quality & Nursing is a member of the Quality & Performance Management Steering Group.

The **Executive Director of Workforce & OD** has lead responsibility for the Trust's People Strategy including workforce & OD aspects of the Quality & Performance Management Framework e.g. training, PADRs etc. The Executive Director of Workforce & OD also has specific responsibilities for quality and performance management as per the Support Services Quality & Performance Management sub-framework.

The **Director of Partnerships and Engagement** has lead responsibility for communications, engagement and partnership aspects of the Quality & Performance Management Framework e.g. communication

metrics etc. The Director of Partnerships and Engagement has a specific responsibility for the Trust's Annual Report and specific responsibilities for quality and performance management as per the Support Services Quality & Performance Management sub-framework.

The **Board Secretary** has lead responsibility for the Trust's Board Assurance Framework and overall governance of the Trust. The Quality & Performance Management Framework is a key part of the Trust's Board Assurance Framework. The Board Secretary has lead responsibility for managing the flow of reports to the Board and its sub-committees including quality and performance management reports. The Board Secretary has a specific responsibility for overseeing the management of the Trust's integrated year end reporting and specific responsibilities for quality and performance management as per the Support Services Quality & Performance Management sub-framework.

The **Director of Strategy, Planning and Performance** has lead responsibility for the Trust's planning and performance management processes, including the commissioning of the Trust's services by its funders. The Director of Strategy, Planning & Performance has lead responsibility for the Quality & Performance Management Framework and chairs the Quality & Performance Management Steering Group. The Director of Strategy, Planning & Performance also has specific responsibilities for quality and performance management as per the Support Services Quality & Performance Management sub-framework.

All **senior managers** have a responsibility to contribute to the on-going development of the Framework, in particular, its content and then application of the Organisational Requirements at every level of the Trust.

The following members of the Assistant Directors Leadership Team (ADLT) have AD lead responsibility for the Quality & Performance Management Framework and are members of the Quality & Performance Management Steering Group:-

- Assistant Director Strategy, Planning & Performance;
- Assistant Director Commissioning & Performance;
- Assistant Director Quality Governance;
- Assistant Director of Data & Analytics; and
- Head of Risk & Corporate Governance

Every member of staff has a responsibility to contribute to the on-going development of the Framework, in particular, its content and then application of the Organisational Requirements at every level of the Trust, in a way that is consistent with the Trust's behaviours.

11. Developing the Framework

The Framework will be formally reviewed (and Trust Board approved) every three years., but will also be dynamic and updated in the intervening three years if required. The Executive accountability for dynamically updating the Framework resides with the Director of Strategy, Planning & Performance, working in collaboration with the Executive Director of Quality & Nursing and engaging with the wider Executive team.

Responsibility for the ongoing development and implementation of this Framework will be discharged through a formal **Quality & Performance Management Framework Steering Group**, which will meet quarterly and ensure the Framework is dynamic, live and reflecting changes in theory, practice and the health care system. The terms of reference for the Quality & Performance Management Steering Group is attached at *Appendix 3*.

12. Further Advice & Guidance

Please contact:-

Hugh Bennett, Assistant Director Commissioning & Performance

Hugh.bennett2@wales.nhs.uk

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Alex Crawford, Interim Assistant Director of Planning & Transformation

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Julie Boalch, Head of Risk & Corporate Governance

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NHS Trust

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

PATIENT EXPERIENCE & COMMUNITY INVOLVEMENT QUARTERLY REPORT (OCTOBER - DECEMBER 2021)

MEETING	Quality, Patient Experience & Safety Committee
DATE	17 February 2022
EXECUTIVE	Director Quality & Nursing
AUTHOR	Patient Experience & Community Involvement Manager
CONTACT	Gareth Thomas Gareth.w.thomas@wales.nhs.uk 07387 230789

EXECUTIVE SUMMARY

This report presents how and with whom the Trust has been meeting it's 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 October - December 2021. 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 a number of forums
- Reported back to communities to strengthen confidence that they are being listened too and the Trust is taking action.

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 are 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 Team remains committed to its programme of continuous engagement with people and communities, allowing us to provide information and supporting evidence to relevant forums about people's experiences and expectations of services delivered by the Trust. Through this engagement we have also been able to feedback to communities about how their experiences have been shared and what difference their voices have made.

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

We will be focusing our attention on delivering online engagement sessions to promote key messages. This is vital to ensure we:

- Continue to 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

The Team are keen to make a return to face to face engagement in the community and will continue to assess possibilities of how and when this can happen safely.

REPORT APPROVAL ROUTE

Executive Management Team	2 February 2022
Quality, Patient Experience & Safety Committee	17 February 2022

REPORT APPENDICES

ANNEX 1 - Patient Experience & Community Involvement (PECI) Highlight Report

REPORT CHECKLIST

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



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Welsh Ambulance Services
NHS Trust

Patient Experience & Community Involvement Highlight Report

October – December 2021



This report provides information on the different ways we collect service user feedback and experience, what it means, and how we are using it to improve the service. Included within this report is evidence of community engagement work, social media activity and our involvement in public health.

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Patient Story	5
Have Your Say	6
Community Engagement & Partnerships	7 – 16
Social media	17
NHS 111 Wales	18 – 20
Outcomes and Moving forward	21

Overview

Within this reporting period, we have engaged with:

41 Engagement Opportunities Attended

1,119 People Engaged With

This engagement has included:

- Online engagement sessions with people about mental health & well-being, about forward planning for carers and NHS 111 Wales website awareness. Feedback from these sessions has been shared with the Mental Health & Dementia Team to help monitor implementation of their strategy and will also influence the content of training modules being developed for people with learning disabilities and mental health conditions.
- Conversations with blind and sight loss groups about their experiences of accessing and using our services, which reinforce our commitment to implementing the All Wales Standards for Accessible Communication and Information for People with Sensory Loss
- Engagement with Children & Young People, including those with complex needs and those in mainstream education. Strengthening our partnership with the Children's Commissioner for Wales and further embedding a 'Children's Rights' into our work.

The Patient Experience & Community Involvement Team remains committed to its programme of continuous engagement with people and communities, allowing us to provide information and supporting evidence to relevant forums about people's experiences and expectations of services delivered by the Trust. We have been able to feedback to communities how their experiences have been shared and what difference their voices have made. For example, at a previous Quality Committee we shared Tony's story. As a result of this, proposals have been made which would allow First Responders to administer basic pain relief. We have been able to feed this back to Tony and explain how his feedback has influenced this important change.

What was good?

- ✓ **Responses to the Non-Emergency Patient Transport Service Patient Experience Survey are overwhelmingly positive.**
 - *The survey results have been consistently positive for the past year and should provide high levels of assurance that people are generally very satisfied with the overall service they are receiving. We will continue to work with colleagues in the Non-Emergency Patient Transport Service Team to collate this information and further expand our survey programme to ensure all service users are given an opportunity to provide feedback.*

What could be improved?

- ✗ **Engagement with the People & Community Network by the wider Trust to facilitate feedback from service users on proposals or projects can be enhanced.**
 - *To date, the Network has been used to facilitate a mystery shopper exercise into usability of the NHS 111 Wales website and to prepare for consultation on the IMTP.*

Positive Experiences

Compliments

The Trust received **147** compliments between October and December. These can be broken down by function as below. Numbers below do not add up to 147 as some compliments received are about multiple functions, so are recorded twice:

Function	Compliments Received
EMS Ops	106
EMS Ctrl	11
NEPTS Ops	7
NEPTS Ctrl	2
CFRs	1
111/NHSDW	35

I just wanted to provide feedback of my experience with yourselves this morning as I think people are quick to critique a service but not to give credit where it's due. I called 999 this morning as my mum was having breathing difficulties and the service I received was excellent from start to finish. Your call handler was very clear, calm and really understanding, picking up on the smallest of details during the call which I really appreciated as I was stressed at the time. He stayed on the phone whilst we were waiting for help to arrive - which was no time at all. The ambulance crew arrived within minutes and they were fab too. They were really supportive with my mum and clear about what they were doing and why, which helped to put her mind at ease. I'm truly grateful for the amazing service we received this morning, despite you being under immense pressure at the moment, and we are very lucky to have the NHS - you are nothing short of amazing. Merry Christmas to all at WAST and a happy and healthy New Year, too. Sorry for the essay but a simple thank you wouldn't have sufficed.

After my Grandfather fell down the stairs and landed badly on his hip we rang 999. He was unable to move or weight bare on his left leg and we couldn't get him to the car. The EMT and paramedic were so friendly and professional. We were so relieved to see them and he couldn't have been in better hands. We understand the service is under so much pressure at the moment but we are so grateful for the paramedic team that came to our aid.

The 147 compliments received during this quarter represent a 6% decrease on the 157 compliments received during the previous reporting period.



The Patient Story

Mr. Parry's Story...

At our Quality, Safety & Patient Experience Committee Meeting in November, we presented Mr. Parry's story, in partnership with Betsi Cadwaladr University Health Board. Mr. Parry is a dialysis patient and uses the Welsh Ambulance Service's Non-Emergency Patient Transport Service to attend his dialysis appointments.

Mr. Parry wanted to change his dialysis shifts to participate in ploughing matches at the weekends and to be able to attend family events. In the story Mr. Parry explains that he feels issues with flexibility relate to the absence of a 6-day transport service from Welsh Ambulance Service. In the story the Dialysis Unit Manager at Betsi Cadwaladr University Health Board also explains how the provision of 6-day transport, to include Saturdays, would give all patients greater flexibility in shift patterns and would also ease pressures of staff.

Since presenting this story the Welsh Ambulance Service has submitted a request for funding to Welsh Government to offer a 6-day transport service, giving patients more choice in their care. The outcome of this bid is still awaited. However, the Health Board Renal Service have been able to increase patient flexibility in dialysis shifts and Mr. Parry has been offered the dialysis shift pattern he requested.

This was an excellent example of collaborative patient led improvements working with our Health Board colleagues. The story was a great opportunity for us to work together and acted as a catalyst for change. The Patient Experience Teams at both Betsi Cadwaladr and Welsh Ambulance Service have since continued to work closely to share best practice, building relationships and working towards positive outcomes for patients.





The Welsh Ambulance Service website, www.ambulance.wales.nhs.uk, features a feedback facility called 'Have Your Say'. This feature allows members of the public to leave us their feedback and comments about accessing and using any of the services we provide.

Between October – December 2021, 143 people used this facility to contact us with comments or questions about using services delivered by the Welsh Ambulance Service.

During this reporting period, most of the feedback received through the Have Your Say facility was positive and complimented our staff on the care they provided. Though we also received feedback and comments from members of the public about a diverse range of other issues, including concerns about poor experiences, people reporting poor driving by our staff our damage caused to private property, as well as people enquiring about career and job opportunities and people seeking information about community access defibrillators.

Members of the Patient Experience & community Involvement Team are able to ensure that staff compliments received in this way are processed and staff acknowledged. Whilst more general comments and questions are responded to in a timely way, with members of the public being provided with or signposted to appropriate information.

“Today I was transported from home to Singleton Hospital and back again. For the outgoing journey I received a phone call from the driver advising me that she would be with me within 30 minutes, When she arrived she was driving a new 'ambulance' car. What a brilliant idea. The journey was excellent, the driver helped me find where I needed to go and kindly escorted me to reception to get signed in. Big thumbs up from start to finish.

I waited for 90 minutes for transport home. I was kept updated by the ward staff and I did not feel the wait was excessive. The vehicle was double crewed and the attendant (not sure what we are meant to call them) collected me from the ward taking me to the vehicle, holding doors open and making sure I was safely able to get in the ambulance using the steps. The journey home was excellent and safe. All three staff should be commended for their professionalism, kindness, excellent communication skills and for providing a great service. The ambulance car service strikes me as an excellent expansion of the Non-Emergency Patient Transport Service. I think the Non-Emergency Patient Transport service is an amazing resource and your staff are generally excellent. I feel all three staff today excelled hence my message”.

This compliment was received from a patient who was extremely happy with their experience of using Non-Emergency Patient Transport. The compliment was passed onto staff involved as well as to relevant service managers.

A Return to Online Engagement

Over recent months we had begun to see an easing of coronavirus restrictions in the community and had started to make plans to safely begin to attend face to face engagement opportunities again. However, the emergence of the Omicron variant and the re-introduction of restrictions meant these plans were paused again and instead we returned to engaging with people & communities online.

Over the past quarter we have worked with colleagues and Teams across the Trust to plan and deliver several online engagement sessions, targeted at specific groups within the community, who we know from past engagement and feedback, have said they would find it beneficial to learn more about services and how to access appropriate help and support for their needs.

These online engagement events have included:

Mental Health & Well-Being Support

Our engagement in the community had shown that many people were unsure of where to go for appropriate information and advice about how to support their mental health and well-being. In response to this, working in collaboration with our colleagues in the Welsh Ambulance Service's Mental Health Team, we facilitated an online engagement session focused on mental health and well-being support. The session was very well attended by a mixed audience of service users, advocates and other service providers.

During the session information was provided about how to recognise signs of poor mental health, advice was given about how to stay well and look after your mental health & wellbeing and information was shared signposting people to appropriate support services already available in the community.

Cymorth Iechyd Meddwl a Lles
Ble i gael y gefnogaeth gywir i chi, eich anwyliaid, eich cymdogion neu'r bobl rydych yn gofalu amdanynt wrth i'r gaeaf nesáu...

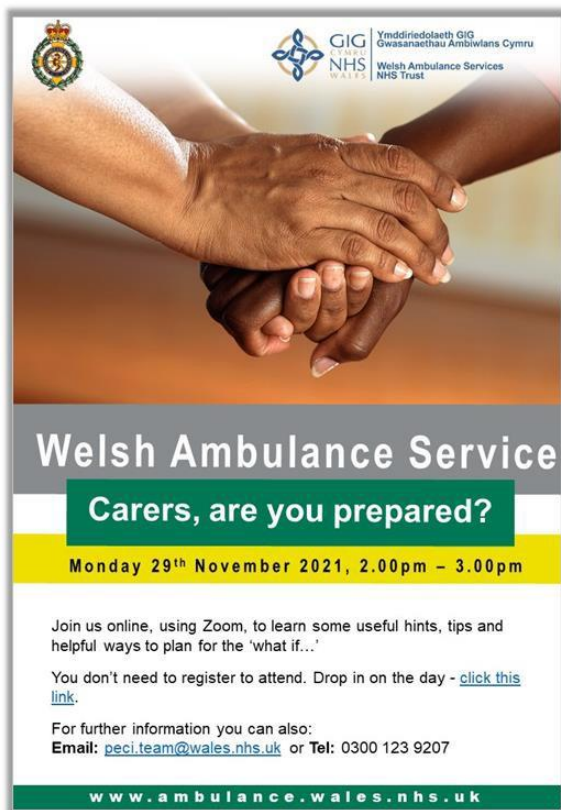
Mental Health & Wellbeing Support
Where to get the right support for you, your loved ones, your neighbours or the people you care for as winter approaches...

Tîm Profiadau Cleifion a Chynnwys y Gymuned
Ymddiriedolaeth GIG Gwasanaethau Ambiwians Cymru

Patient Experience & Community Involvement Team
Welsh Ambulance Services NHS Trust

“This was a great session, thank you! I work with people from ethnic minority backgrounds where talking about mental health is still stigmatised. The information you’ve provided has been really helpful and will really benefit the communities I work with. I’d love to work with you to ensure your services are culturally inclusive for people from ethnic minority backgrounds and for you to visit some of our groups in the community when you’re able to”.

Carers, Are you Prepared?



The poster features a central image of two hands clasped together, symbolizing support. At the top left is the Royal Coat of Arms, and at the top right are the logos for GIG Cymru, NHS Wales, and the Welsh Ambulance Services NHS Trust. The text is as follows:

Welsh Ambulance Service
Carers, are you prepared?
Monday 29th November 2021, 2.00pm – 3.00pm

Join us online, using Zoom, to learn some useful hints, tips and helpful ways to plan for the 'what if...'

You don't need to register to attend. Drop in on the day - [click this link](#).

For further information you can also:
Email: peci.team@wales.nhs.uk or Tel: 0300 123 9207

www.ambulance.wales.nhs.uk

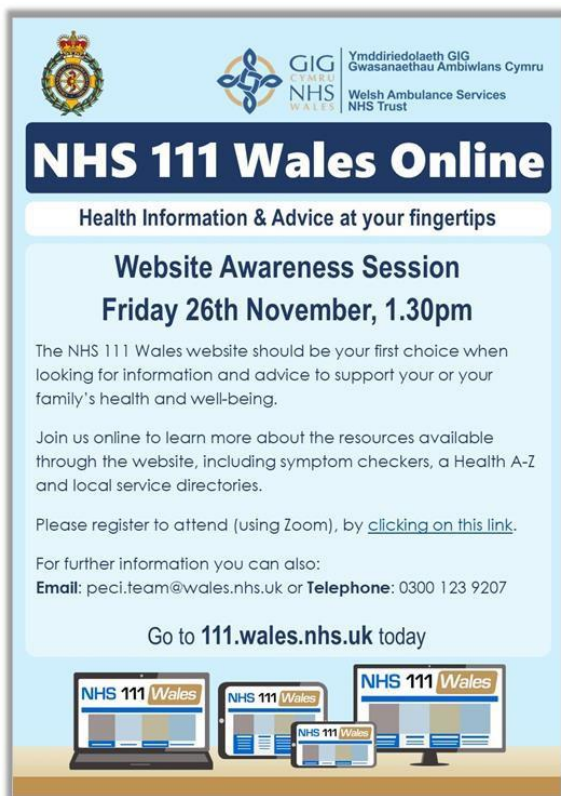
Again, working collaboratively with colleagues from the Mental Health and Dementia Team and the Older People's Improvement Lead at the Welsh Ambulance Service we facilitated an online engagement session for unpaid carers.

This session focussed on providing information about services delivered by the Welsh Ambulance Service and NHS 111 Wales and how these can support someone who has additional caring responsibilities.

During the session, practical advice was also offered about what carers can do to make sure they are prepared for the 'What if...', helping them to think ahead and make plans for all potential situations.

Advice was also offered to those attending about how to look after their own mental and physical health and how to access appropriate help and support.

NHS 111 Wales Website Awareness



The poster features the Royal Coat of Arms and logos for GIG Cymru, NHS Wales, and the Welsh Ambulance Services NHS Trust. The text is as follows:

NHS 111 Wales Online
Health Information & Advice at your fingertips

Website Awareness Session
Friday 26th November, 1.30pm

The NHS 111 Wales website should be your first choice when looking for information and advice to support your or your family's health and well-being.

Join us online to learn more about the resources available through the website, including symptom checkers, a Health A-Z and local service directories.

Please register to attend (using Zoom), by [clicking on this link](#).

For further information you can also:
Email: peci.team@wales.nhs.uk or Telephone: 0300 123 9207

Go to 111.wales.nhs.uk today

The bottom of the poster shows illustrations of the NHS 111 Wales website interface on a laptop, tablet, and smartphone.

With the continuous development of the NHS 111 Wales website and ever increasing focus on 'digital first', we facilitated this online information session to help explain the features and tools accessible via the NHS 111 Wales website for those who may be less familiar with them or those who are new to accessing health information and advice online.

During the session attendees were shown how to get the most out of some key features of the website, including the online symptom checkers, Health A-Z and local service directory.

We know from feedback collected from the NHS 111 Wales website experience survey, that some people find navigating the website difficult. This session intended to help answer some of the concerns we see repeatedly in those survey results and ongoing engagement and education sessions about the website will continue to be facilitated as necessary.

Learning Disability Community

Keeping You Safe Online Engagement Event

The Patient Experience & Community Involvement Team hosted a further two online 'Keeping You Safe' engagement events for people with a learning disability. As with past events, these focused on helping those with a learning disability understand why our staff need to wear additional Personal Protective Equipment (PPE), which many within the learning disability community tell us they find scary. The events also provided an overview of what you'll find in the back of an ambulance and explained some of the most common examinations our staff will carry out if an ambulance is sent to help them.

"It was really good and interesting and I learnt loads"

Learning Disability Staff Training

Our extensive back catalogue of engagement activity with people with a learning disability has led to an in-depth program of education and resource development for the community. An opportunity has arisen to deliver that learning to operational staff in the form of an e-learning module. Working in collaboration with the Mental Health Team, the module will consolidate learning across all key areas of the Welsh Ambulance Service and will accommodate separate modules for different staff groups where different teams require specialist insight.

Collaborating with Others

The E-learning module has also led to links being made with other ambulance services. London Ambulance Service's NHS Trust (LAS) has recently appointed a learning disability and vulnerable person lead and we have been liaising with LAS to share our journey, our engagement findings and to discuss the content of the above e-learning module.

Easy Read Information for Frequent Callers

People who call the 999 service frequently need information on appropriate use of services in a format that is suited to their level of needs. For those frequent callers with a learning disability, an Easy Read letter has been created in collaboration with the Community Learning Disability Team. It is hoped that this resource will prove useful in helping reduce the number of inappropriate calls to 999 and an uptake of more appropriate services.



Sensory Loss

Engaging with Blind and Sight Loss Groups

Over the past quarter we were invited to attend a number of engagement opportunities with sight loss groups. Because of coronavirus restrictions we have attended these groups virtually using Teams or telephone conference which is more accessible for people with sight loss.

Whilst attending these groups we have spoken to their members about services delivered by the Welsh Ambulance Service and NHS 111 Wales and have provided information about accessibility options for people with sight loss when using our services.

A common trend in feedback from these groups began to emerge around accessing and using the Non-Emergency Patient Transport Service (NEPTS). In response to this a member of staff from NEPTS was able to attend an engagement session with us and could provide further information about how the service works.

Experiences discussed at these groups has included people's frustrations about escorts being unable to travel with the patient, how changes to services were communicated to the general public (being inclusive of people with sight loss) and perceived inflexibility in rules.

"The last time I used the service everything started off ok, I was picked up from home and the staff were lovely and made sure I got onto the vehicle and was safely strapped into my seat. The problem happened when I got to the clinic. It was a new clinic, so I hadn't been there before and didn't know where I was going. When we arrived the staff got me off the vehicle and that was it, I was told you need to join the queue at reception. I'm registered blind so I didn't know where the door into the building was let alone where the end of the queue was. The service broke down just for those few minutes and I felt really vulnerable".

As a result of this and other patient experience feedback, the NEPTS Team have proposed an accessibility 'audit' of the service which we will work in partnership with them to plan and deliver.



Children & Young People

World Children's Day

As part of their community heroes project and in support of World Children's Day, the Patient Experience & Community Involvement Team were invited to visit Ysgol Maes y Coed in Neath, a school for young people with a variety of complex learning difficulties from the ages of 2 to 19.

We visited the school (at a time when coronavirus restrictions allowed us to) together with colleagues from South Wales Police, South Wales Fire & Rescue Service and Swansea Bay University Health Board.

Our visit to the school helped allow the young people to become familiar with emergency services and uniforms worn by healthcare staff. The young people also gave the visiting services some useful advice about communicating with people with additional needs, including teaching some key phrases in BSL which they felt would frontline staff should know. These key phrases can be used to communicate and reassure children with disabilities when they need help from any of the emergency or frontline services.



Since this visit, the Youth Engagement & Participation Service at Neath Port Talbot County Council have been awarded funding to develop information resources to help facilitate better communication with children & young people with additional and complex needs. These new resources will help spread this message beyond Ysgol Maes y Coed and right across the local authority area.



Shoctober

Due to ongoing coronavirus restrictions and face to face engagement events cancelled, we were unable to visit schools and provide CPR training and Defib awareness sessions in our usual way. Instead, throughout October we promoted our Shoctober animation featuring Cartin & Abi. The animation features our big/little accident quiz and is available in English, Welsh and BSL. To help ensure a wide reach within the community, the information was shared with all primary schools, home educated groups, St John Ambulance Cymru, Children's Commissioner for Wales and other key stakeholders. The animations are also hosted on the Welsh Governments educational online platform the 'Hwb' which all learners across Wales have access to.

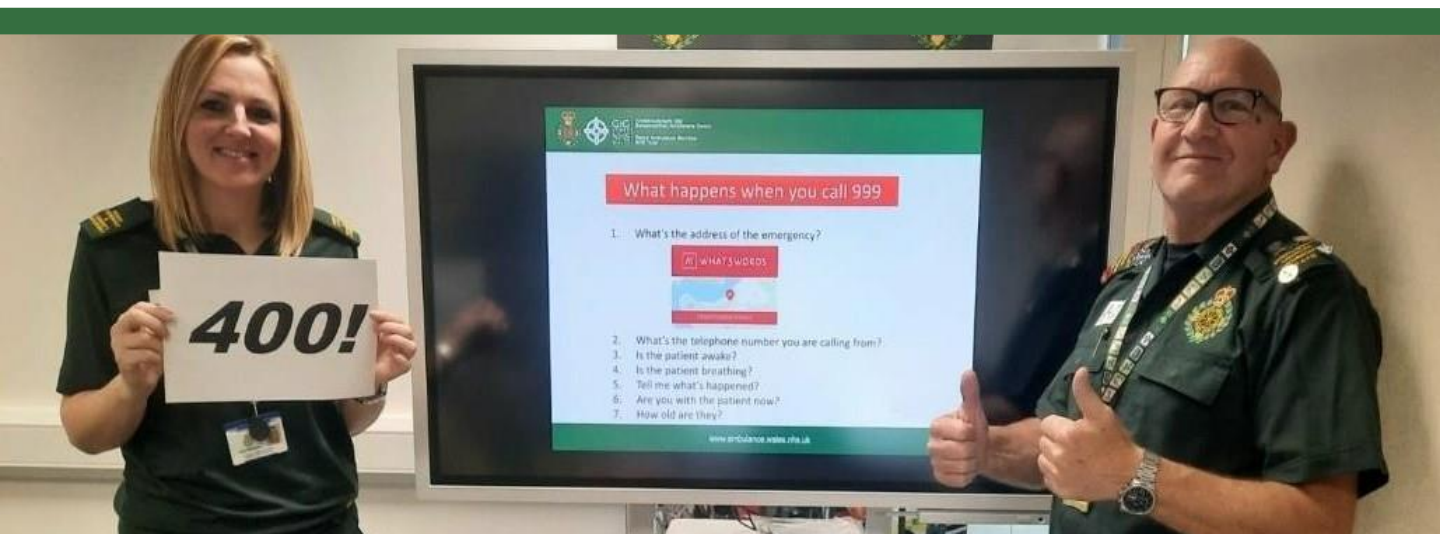


Restart a Heart

On 16th October we supported the annual Restart a Heart campaign via social media sharing key messages and promoting the Resus Council UK animation to on how to do CPR.

Throughout the same week, with the support of Operational colleagues, currently on alternative duties, we delivered virtual training sessions to over 400 college students about calling 999, the What3words app and demonstrating life-saving skills including CPR and how to use a defibrillator.

As well as teaching potentially life saving skills, these sessions support college student's Personal Safety module of the Healthy Colleges framework.



Cardiff Ambulance Station Development

Towards the end of 2020 we were approached by our colleagues in the Estates & Capital Department to help facilitate an engagement project with primary schools across Cardiff. The project would contribute towards the development of a new ambulance station for Cardiff, replacing the Trust's current Cardiff premises at Blackweir.

Staff working in Cardiff were keen to ensure that the local community were represented in some way within the new station, so primary school pupils across Cardiff were asked to Draw, paint or colour a picture that could be displayed on the wall of the new station that shows what they know about: 'Using the Welsh Ambulance Service Appropriately'.

From all entries received a winner would be chosen and would receive a lifesaving Defibrillator and cabinet for their school and the community they serve, kindly donated by Lawray Architects, one of the development construction partners.

From the 127 entries received, the winning entry (below) was drawn by 7-year-old Ludan who is a pupil at Radnor Primary School in Cardiff. His picture and a selection of other entries will now be professionally printed and turned into art works that can be displayed around the new Cardiff Ambulance Station. Ludan and his classmates will also be invited to attend the opening ceremony of the station and will have an opportunity to look around, learning more about how our services work, what our staff do, what our vehicles look like and the equipment we use. Maybe they'll be inspired to want to work for us one day!

Pupils at the school will now be asked to help promote our annual #Defibuary campaign supporting us to further raise awareness of the importance of community access defibrillators. Teachers and other staff at the school will also be offered an opportunity to learn more about how to use the Defibrillator won by the school.



Non-Emergency Patient Transport Service Patient Experience Surveys

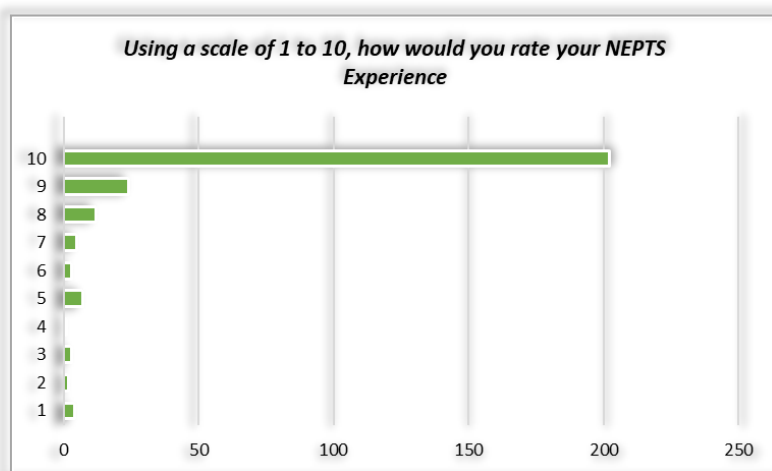
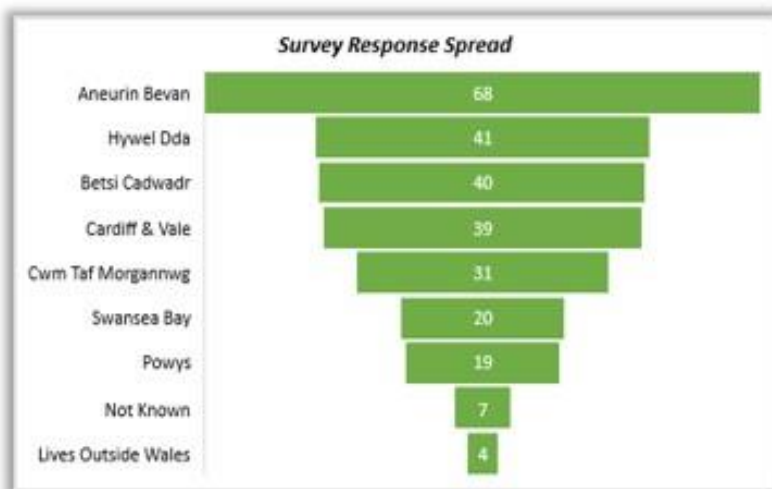
We have continued to work with colleagues in the Non-Emergency Patient Transport Service (NEPTS), to survey NEPTS users, helping us to build a better understanding of their patient experiences to identify areas of good practice and quality improvement opportunities.

Between October and December 2021, a total of 269 NEPTS patient experience surveys were completed. These responses were received from NEPTS users who had either been sent a text message asking them to complete a survey, or NEPTS users who had visited the Welsh Ambulance Service website to complete a survey online.

Responses were received from all Health Board areas, though significantly more people from Aneurin Bevan engaged with the survey. This remains consistent with results reported in the last quarter, though we now see an improved response from users in Cwm Taf Morgannwg which was noted as being low in the previous reporting period.

These results showed us that:

- A majority of people (92%) found the booking process easy.
- 96% said the call taker was polite when booking their transport.
- 93% said they were happy with the transport they received and 81% said the crew offered appropriate help and support if they needed it or asked for it.
- A majority of people (92%) scored their NEPTS experience 8 out of 10 or higher.



Overall, the survey results continue to be positive and offer reassurance that most NEPTS users are satisfied with the service. Less positive responses continue to follow historical trends and focus on wait time for booking calls to be answered, comfort and timeliness of transport. These themes are continually monitored by the NEPTS management Teams.

“The transport didn’t turn up and I missed an important appointment – awful service!”

In early 2022 we will add monthly postal surveys to our schedule of NEPTS patient experience surveying. This will increase the amount of data collected and will also allow patients who do not have access to the internet or mobile phones to participate and provide feedback.



**Be part of the
change you
want to see!**



The Citizen's Voice - People & Community Network

Network Members: 82

We continue to promote and encourage members of the public right across Wales to sign up to become members of the Trust's new People & Community Network. A key component of the Trust's Quality Strategy, the Network will enable people and communities to become more involved in the work of the Welsh Ambulance Service, amplifying the citizen's voice, ensuring it is heard in every corner of our organisation.

Mystery Shopper Campaign

In December Network members were invited to take part in a Mystery Shopper Campaign to review our NHS 111 Wales website. They were asked to find and access key sources of information and advice based on a range of pre-determined clinical scenarios. Unfortunately, we did not receive a great response to this exercise, with only a small number of people submitting any feedback. However, we plan to use this initial exercise as a learning opportunity and will review our processes to understand how response rates can be improved.

A second mystery shopper exercise is planned for the NHS 111 Wales telephony service to test accessibility of the Interactive Voice Recording (IVR) messaging. This will commence in Spring 2022.

Promoting the Network

The Patient Experience & Community Involvement Team are in the process of producing marketing materials for the Network, to include an information leaflet and promotional videos in English, Welsh and BSL. A Communication and Engagement Plan is also in development. The Plan will include a review of Network communications to date and an implementation plan for appropriate future communications.

Recent Communications

Integrated Medium-Term Plan (IMTP) 2022-2025: Network members have been invited to help influence the Trust's IMTP for 2022 – 2025. The poster overleaf was created by the Team to explain the IMTP, its purpose and value, and was circulated to all members. Several Network members have expressed an interest in participating in this process and will be invited to share their views with the Trust.

Citizen Voice Body for Health & Social Care: Network members were made aware of the recruitment process underway for the Welsh Government's Citizen Voice Body for Health & Social Care and were actively encouraged to consider applying for the posts available.



IMTP 2022-2025

INTEGRATED | MEDIUM | RISK | PLAN

WHAT IS THE IMTP? It helps us to:

- Set out our plans for over the next three years and how we will achieve these.

2022-2025



- Look at whether there are any risks involved in carrying out these improvements and tell if there are any current risks involved in the way we work.

WHY DO WE HAVE THE IMTP?

Top priorities around what's important to our patients, and staff.



- See how well we have done over the last year.



- 9 Because we must be ready to prepare a plan for the Welsh Government.



WHY IS THE IMTP VALUABLE?

- It reflects what our commissioners, patients and staff need from us.



- It enables us to make improvements for our patients and staff alongside the rest of the NHS across Wales.



Social Media

Patient Experience & Community Engagement



Social media allows us to engage and respond to the public & organisations in real time and keep appropriate use of 999 services and the NHS Direct Wales service at the forefront of people's minds. It's also a great way to capture feedback, share compliments, signpost visitors and demonstrate how users' feedback can influence service delivery.

Twitter Summary, October - December 2021

	@WelshAmbPECI
Tweet impressions (how many people our tweets have reached)	57,564
New followers	46
Current Number of Followers	4,545

This month's most popular Tweet from @WelshAmbPECI in this period was made in October, during our annual #ShoOctober campaign, the Tweet promoted our children's and young people information video about effective CPR. The Tweet gained 6,454 impressions.

A cardiac arrest can happen to anyone, at any age. Around 80% will occur at home. Our 999 call takers will stay on the line and explain what to do however it's important from a young age how to do **#CPR**. Our **#ShoOctober** children's animation explains how. bit.ly/3F944GW
pic.twitter.com/OaK5kdp3B3



Throughout the coronavirus pandemic our use of social media to share important messages has increased. Social media has proven to be a vital tool in allowing us to continue to engage with people and communities, sharing important information and messages and allowing the continuation of awareness campaigns such as #ShoOctober when face to face engagement hasn't been an option.

NHS 111 Wales Website

In the last quarter, we reported that work was underway by the NHS 111 Wales website Project Team to redevelop the NHS 111 Wales website to improve the look, feel and usability of the site. The Patient Experience & Community Involvement team continue to support the project team with this work by regularly sharing users' views and feedback about the website, captured through community engagement and via the online patient experience survey. We also monitor popular search terms used and most visited pages of the website to help shape the redevelopment.

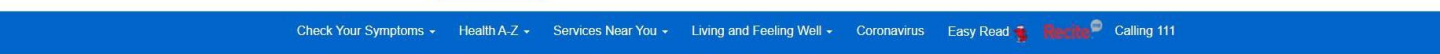
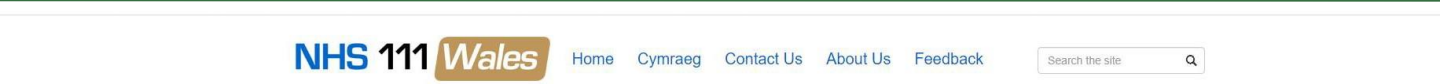
Service user feedback has recently helped shape changes to the Directory of Services (DOS), and a redesign of the homepage, Health A-Z and Easy Read sections are planned for the coming months and will take into account feedback received by website users.

The team continue to work closely with our clinical colleagues to support the public in managing their health. Based on feedback and 111 telephony enquiries, 16 new bilingual checkers have been developed since October covering a range of topics including anxiety, depression, suicidal thoughts, penile problems and burns.

	Total number of website visits (English)	Total number of website visits (Welsh)	Top Page Viewed
October	426,608	3,139	My Health Online
November	395,060	1,673	My Health Online
December	399,826	1,731	Covid symptom checker
Total	1,221,494	6,543	

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

1. COVID
2. Generally Unwell
3. Stomach pain



If you have symptoms of Covid-19 please visit our ['Coronavirus symptom checker'](#). For 'long covid' or ongoing symptoms, visit the [COVID Recovery App](#) and [Health A-Z](#). For information about the vaccine visit the ['Welsh Government'](#) and [Public Health Wales](#) websites. If you are pregnant and have questions about the vaccine, please visit the [Royal College of Midwives](#) website for further advice.



NHS 111 Wales Patient Experience Surveys

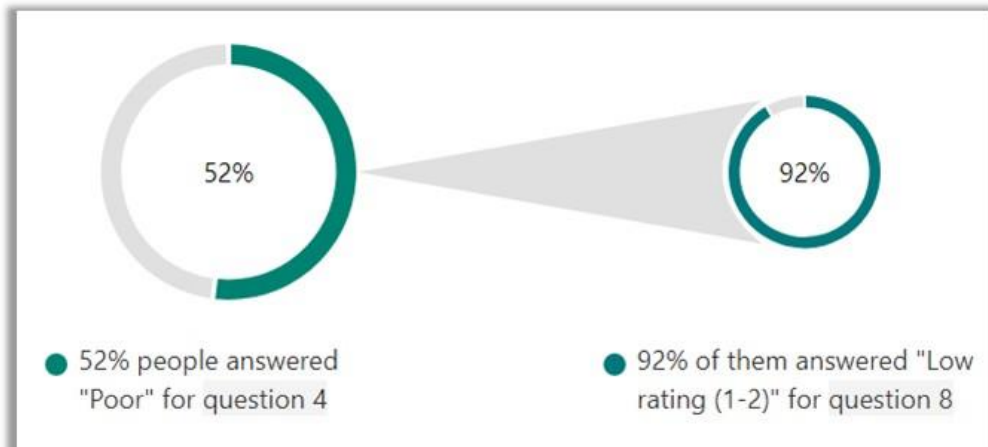
Throughout this reporting period we have continued to make available a patient experience survey asking people to share their views with us about accessing health information and advice through the NHS 111 Wales website.

In the last quarter 122 people completed a website experience survey

People told us they were using the website to find information about a variety of things, but Covid and Covid related issues was a central theme in the survey results.



Unfortunately, just over half of respondents (52%) told us their overall experience of using the website was poor. Moving through the survey, most people (92%) who rated their experience as 'poor' go on to give the website a low rating (1 or 2) out of five.



We continue to see some confusion amongst survey respondents, who use the survey to provide feedback about issues within the wider NHS, which are outside the control of NHS 111 Wales.

"Certain aspects are not clear and there is no online chat service, for example, where I can deal with all of this online. I don't want to sit on the phone for 45 minutes. People need Covid notes and people need Covid passes - they are not well signposted"

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

NHS 111 Wales Social Media

Twitter Summary, October – December 2021	
	@NHS111Wales
Tweet impressions (how many people our tweets have reached)	100,010
New followers	99
Current Number of Followers	6,909
Facebook October – December 2021	
Facebook Reach	17,624

The top social media post from NHS 111 Wales this quarter came from Twitter. It reminded people that if they need help in an urgent but not life threatening situation the NHS 111 Wales website should be their first port of call for help and information.

The Tweet earned 6,317 impressions.



Compliments

Compliments Received

NHS 111 Wales / NHSDW	35
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Thank you so much to @NHS111Wales the call handlers were so understanding and sympathetic. Referred me to out of hours and just had the doctor call out with pain injections and meds. I'd have been in agony all night without this service. Thank you so much

Outcomes of Engagement...

The feedback we have received during this quarter has clearly shown that :

- People are keen to engage with us and share their views about using our services.
- Our engagement has increased people's knowledge and awareness about services we deliver.
- Our engagement has provided opportunities for people to share both positive and negative experiences with us, which are shared internally with appropriate Teams and colleagues.
- People want to help influence our future plans and be involved in shaping IMTP priorities.

Looking Ahead...

#Defibuary

Throughout February, we will be promoting our annual #Defibuary campaign. Following feedback from last year's campaign, this year will see key information being shared with the public to give them confidence in recognising the signs and symptoms of a heart attack and a cardiac arrest, and what to do while help is on its way. A video will also be available demonstrating how to do CPR and use a defibrillator. Communities will also be encouraged to register defibrillators in their area on the BHF database 'The Circuit' and ensure they are 'rescue ready'.

Virtual Video Booth

In the coming months we will launch the 'Virtual Video Booth'. This facility will be available through the Welsh Ambulance Service website and will allow people to record and submit their patient experience story from the comfort of their own home. We hope that this facility will significantly increase the number of patient story's we are able to collect and a communications plan is being developed to promote this new facility to the public.

NHS 111 Wales Website Awareness for Learning Disability Groups

In February we will be holding an awareness session about accessibility of the NHS 111 Wales website, specifically tailored to the needs of people with a learning disability. During the session we will demonstrate how easy it is to access information though the website as well as highlighting learning disability specific elements of the website such as the Easy Read Health A – Z.

NHS 111 Wales Telephone Messaging Accessibility

Following a challenge regarding assessment about the accessibility and usability of the revised Interactive Voice Recording (IVR) messaging played to NHS 111 Wales callers, we will be facilitating an exercise with People & Community Network members to understand and consider the experience.

Engagement with the Bevan Commission

We are awaiting publication of a report by the Bevan Commission who are working with AW Communications to explore patient and public engagement in health and care across Wales. The report will explore what currently happens in the engagement/co-production space, what the challenges are, what could be improved, what could be shared in terms of best practice and honest experiences and how the Commission could help. The findings along with research and other meetings/workshops will inform a new paper and recommendations from the Commission to the Health Minister and NHS Wales Chief Executive. We are engaged in this process and have begun to share information about how patient experience and engagement happens at the Welsh Ambulance Service.



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

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

MEETING	Quality, Patient Experience & Safety Committee
DATE	17 th February 2022
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Julie Boalch, Head of Risk and Corporate Governance
CONTACT	Julie.Boalch@wales.nhs.uk

EXECUTIVE SUMMARY
<p>1. The purpose of the report is to provide the Quality, Patient Experience & Safety Committee (QuEST) with an update in respect of Corporate Risks that are relevant to the Committee’s remit for review.</p> <p>RECOMMENDATION:</p> <p>2. Members are asked to:</p> <p style="padding-left: 20px;">a) Note and discuss the contents of the report.</p> <p style="padding-left: 20px;">b) Highlight any specific aspects or concerns that need to be raised to Senior Management and/or Audit Committee.</p>

KEY ISSUES/IMPLICATIONS
<p>1. 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.</p> <p>2. The immediate priority is a detailed review of each of the Corporate Risks and the development, testing and implementation of the Once for Wales Risk Datix Module.</p> <p>3. 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 with the priority focus being on the Trust’s highest scoring risks.</p> <p>4. Two temporary Risk Officers have been appointed until the 31st March 2022 to support the Corporate Governance team with these priorities. The substantive post will be advertised for appointment to commence 1st April 2022.</p>

5. The ADLT reviewed the existing and proposed new corporate risks at regular intervals during the period the EMT received feedback from ADLT in January 2022 on activity relating to the Corporate Risks.

REPORT APPROVAL ROUTE

3. The report has been considered by:
- ADLT – 7th February 2022

REPORT ANNEXES

4. An SBAR report is attached to this Executive Summary.
5. A short summary table describing each of the 5 Corporate Risks assigned to QuEST for review is contained in Annex 1.
6. The extract from the BAF Report is detailed in Annex 2.

REPORT CHECKLIST

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

**RISK MANAGEMENT & BOARD ASSURANCE
FRAMEWORK REPORT
QUALITY, PATIENT EXPERIENCE & SAFETY COMMITTEE**

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.
- 2 An extract from the Corporate Risk Register (CRR) is detailed in Annex 1 as a short summary report.
- 3 A further extract from the Board Assurance Framework (BAF) report is included in the paper in Annex 2 for review by Members; the full report was presented to the Trust Board on the 27th January 2022.

BACKGROUND

- 4 The Risk Management and Board Assurance Framework improvement 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.
- 5 The immediate priority is a detailed review of each of the Corporate Risks and the development, testing and implementation of the Once for Wales Risk Datix Module.
- 6 A programme of work has commenced to strengthen the articulation of the Corporate Risks including title and descriptions, the controls, assurances and any additional actions required with the priority focus being on the Trust's highest scoring risks and all new risks.
- 7 Work continues with the Assistant Directors Leadership Team (ADLT) to review and report Corporate Risk activity to the Executive Management Team (EMT), each of the Committees and Trust Board.
- 8 The ADLT continue to undertake risk assessments on all new risks in addition to reviewing changes to existing risks and mitigating actions.

ASSESSMENT

Corporate Risks

- 9 There are 5 Corporate Risks currently assigned to QuEST which are described in the summary table in Annex 1 as at 18th January 2022; these have been extracted from the Datix E-Risk module.
- 10 An extract from the BAF is included in Annex 2.
- 11 Risk ID 223 and Risk ID 224 remain the highest scoring risks at scores of 25,

this is primarily due to the pressure in the unscheduled care system and long handover delays at Hospital Emergency Departments.

- 12 Further sessions are planned during February 2022, including key individuals, to continue the work to reassess these two risks in their entirety. Firstly, to determine new titles and secondly to clearly articulate the risk and description. A set of proposals will be submitted to the Executive Management Team for discussion ahead of presentation to the Trust Board in March 2022.
- 13 A similar exercise is underway to review Risk ID 199, 316 and 160 as a priority with the remaining Corporate Risks to follow suit.
- 14 The reporting timetable for the review of the work undertaken to rearticulate Risk ID 223, 224, 199, 316 and 160 and the strengthening of controls and assurances is as follows:
 - ADLT – 21st February 2022
 - EMT – 9th March 2022
 - Trust Board – 24th March 2022
- 15 No new risks relevant to QuEST have been assessed or approved for inclusion on the Corporate Risk Register during this period or de-escalated to Directorate Registers or escalated to the Corporate Register and there have been no changes to the scores since the last meeting in November 2021.

RECOMMENDED:

14. **The Quality, Patient Experience & Safety Committee is asked to:**
 - a) **Note and discuss the contents of the report.**
 - b) **Highlight any specific aspects or concerns that need to be raised to**
Senior Management and/or Audit Committee.

Annex 1 – Corporate Risk Register Summary

CORPORATE RISK REGISTER: Summary					
RISK ID	RISK	RISK CATEGORY	DIRECTORATE	CURRENT RISK SCORE	COMMITTEE
223	Unable to attend patients in community who require See & Treat	Service Delivery	Operations Directorate	25 (5x5)	Quality, Patient Experience and Safety Committee
224	Patients delayed on ambulances outside A&E Departments	Quality & Safety	Operations Directorate	25 (5x5)	Quality, Patient Experience and Safety Committee
199	Compliance with Health and Safety legislation	Statutory Duties	Quality, Safety & Patient Experience	20 (4x5)	Audit Committee; Quality, Patient Experience and Safety Committee
316	Increased risk of personal injury claims citing COVID exposure	Statutory Duties	Quality, Safety & Patient Experience	20 (5x4)	Quality, Patient Experience and Safety Committee
303	Delayed initiation of chest compressions (resuscitation)	Quality and Safety	Medical & Clinical	10 (2x5)	Quality, Patient Experience and Safety Committee

Annex 2 – Board Assurance Framework

Begins at the top of the next page

Risk ID	Risk Details	Risk Score			Existing Controls	Assurances	Actions
		Likelihood v consequence			<i>What measures are already in place to mitigate the risk?</i>	<i>What evidence is available to show that the controls are effective?</i>	<i>What additional actions need to be or can be taken to mitigate this risk</i>
	Title and Description	Initial	Current	Target			
223	Unable to attend patients in community who require See & Treat ASSIGNED TO: EXECUTIVE OWNER: LEE BROOKS COMMITTEE: QUEST DIRECTORATE: OPERATIONS	20 4x5 QTR 2 19/20	25 5x5 ↔ QTR 4 21/22	10 2x5 QTR 2 21/22	<p>Last reviewed on Datix: 07/01/22</p> <ol style="list-style-type: none"> 1. Welsh Government have set a target that ambulance handovers at ED will be no longer than 15 minutes. 2. Commissioning intention to reduce total lost hours at Welsh Hospitals do not exceed 150 hours per day. 	<ul style="list-style-type: none"> • 2016 Welsh Health Circular • 2021/22 Commissioning Intentions • Deep Dive x2 Risks - QUEST Presentation. ADLT and EMT review. • Ambulance Taskforce • Red immediate release request refusals now being recorded on Datix. • Datix recording all handover delays over 6 hours. • Weekly review of the impact of hospital waits data shared with the Chief Operating Officers group. • Weekly report to CEO and EMT and ADLT. • Return to response – monitor phase of Pandemic Plan • Re-establishment of the Pandemic Structures • Health Board to Health Board Executive reports. • Directors Peer Group meetings 	<ul style="list-style-type: none"> • Continue to engage in improvement work at Health Board level and as part of the EDQDF. • Leading Service Change Together programme of work is being developed in partnership. No outputs as yet as the programme is underway but the expectation is that modernisation proposals will be agreed to achieve internal, improved staff wellbeing and welfare, patient safety and organisational improvements by Q3 of 2022. • Schedule of workshops to be agreed by the working group. • ADLT to report outcome of the programme to Executive Management Team in Q1 of 2022.
					<ol style="list-style-type: none"> 3. Regional Escalation Protocol agreed between each Health Board and utilised by ODU to dynamically divert between Health Boards and manage system flow. The implementation of a risk based RES to incorporate an ambulance distribution framework that is intelligence led to help to improve the safe delivery of services to all patients requiring unscheduled care. 	<ul style="list-style-type: none"> • Daily 11am conference calls to agree RES levels in conjunction with HBs which is published in the On-call structure daily. It is used to determine delays in the system. 	<ul style="list-style-type: none"> • Development and pilot of a Rural Model (p18 of IMTP) Paper has been submitted to Commissioner on pilot for consideration by Director of Planning & Performance. The pilot is managed by Ben Collins, Interim Ambulance Operations Manager for Powys.
					<ol style="list-style-type: none"> 4. REAP (Resource Escalation Action Plan – hyperlink the document?) 	<ul style="list-style-type: none"> • REAP level is reviewed on a weekly basis by Senior Operations Team and can be dynamically reviewed by the Strategic Commander at any point. 	<ul style="list-style-type: none"> • Exercise scheduled for 13/10/21 to test REAP as part of winter planning exercise linked to demand forecasts. • The plan is subject to annual review and the current review commencing September 2021.
					<ol style="list-style-type: none"> 5. The Operational Delivery Unit is the first point of contact for all escalation issues and work is underway in October 2021 to become a 24/7 service. Escalation by the on-call system as and when required. Gold/Strategic, Silver/Tactical and Bronze/Operational 24 hour/ 7 day per week system to manage escalation plans. 	<ul style="list-style-type: none"> • The On Call OOH rota is bolstered by clinical and some corporate services. Duty Operations Manager appointed. • Shift reports received by Exec, SOT and On-Call team from ODU at start/end as well as ODU Dashboard. 	

Risk ID	Risk Details	Risk Score			Existing Controls	Assurances	Actions
		Likelihood v consequence			<i>What measures are already in place to mitigate the risk?</i>	<i>What evidence is available to show that the controls are effective?</i>	<i>What additional actions need to be or can be taken to mitigate this risk</i>
	Title and Description	Initial	Current	Target			
					<p>6. Alternative care pathways in place to provide safe clinical admission avoidance and available through the Consultant Connect App. This in addition to the Clinical Support Desk and Operational Advanced Paramedic Practitioners.</p>	<ul style="list-style-type: none"> • Reports from Health Informatics on use of national pathways. • Care Closer to Home Group developed and implemented alternative pathways providing consistency across the organisation. • Monitored through programme of work and conveyance • APP dashboard monitors collective and individual patient disposition. • Senior Paramedics in place and conducting operational contact shifts with their teams and encouraging use of alternative care pathways. • Consultant Connect provide regular reports on the use of the app. 	
					<p>7. Maximising the services across the 5 Step model: Hear and Treat Services (CCC, NHSDW and 111). Enhanced the 111 services through the 111 initiative.</p>	<ul style="list-style-type: none"> • CSD rates monitored through AQIs and number unique visits to the 111 Wales website as described in the performance report. The EASC AQI report is an output. 	<ul style="list-style-type: none"> • 111 element to be reflected in the performance report.
					<p>8. Developing community resilience in line with the 5 year Volunteering Strategy to reach patients sooner who require help when we can't get a resource to them.</p>	<ul style="list-style-type: none"> • Operations Manager Community Support – CFRs and Operations Manager Community Support – Alternative Responders. Volunteering Team is focussed on community resilience. MOU with St John Ambulance and Fire Services. Volunteer Strategy signed off. 	<ul style="list-style-type: none"> • The action plan to support implementation of the volunteer Strategy is awaiting sign off by Trust Board on 30th October 2021 and will be monitored by People & Culture Committee.
					<p>9. Clinical Safety Plan replaces the Demand Management Plan bringing WAST in line with other UK Ambulance Trusts. Introduction of ETA scripting enables patients to make an informed choice.</p>	<ul style="list-style-type: none"> • Optima modelling. Clinical agreement to escalate into higher levels. Live reporting through the ODU dashboard. Calls received Vs attended calls attributed to alternatives to dispositions and DMP. AACE paper through National Director of Operations group. 	

Risk ID	Risk Details	Risk Score			Existing Controls	Assurances	Actions
		Likelihood v consequence			<i>What measures are already in place to mitigate the risk?</i>	<i>What evidence is available to show that the controls are effective?</i>	<i>What additional actions need to be or can be taken to mitigate this risk</i>
	Title and Description	Initial	Current	Target			
					<p>10. Increasing capacity in our EMS Service through internal reconfiguration and recruitment (p18 of IMTP). Work with external partners and agencies.</p>	<ul style="list-style-type: none"> Monitored through the EMS Transformation Board. Seasonal planning approach incorporated into Senior Pandemic Team. Tactical Approach to Production. Winter modelling and forecasting through Optima. Performance Improvement Plan. 	<ul style="list-style-type: none"> Considering additional actions through the Trust's Tactical plan and the Performance Improvement Plan which are both reported and considered by the Senior Pandemic Team and reported to the Executive Pandemic Team. Monitoring those plans on a weekly basis. Expansion of numbers of clinicians (paramedics) into CSD to increase ability to triage greater number of calls having benefits for patients Additional Military Support request made for 250 personnel.
					<p>11. Bi-Weekly SCIF meetings</p>	<ul style="list-style-type: none"> Outcomes reported to the Patient Safety Learning and Monitoring Group and then to the Clinical Quality Governance Group. Quarterly Scrutiny Panels are held led by NEDs. Patient Safety Highlight report for Trust Board and Committee and Chief Executive Report to EMT. By Claire Roche weekly. Monthly meeting to discuss the information shared through SCIFs at the WAST and Health Board Patient Safety Meetings. Identified Learning is cascaded to the appropriate department or Directorate. 	
224	<p>Patients delayed on ambulances outside A&E Depts (CRR57)</p> <p>ASSIGNED TO: EXECUTIVE OWNER: LEE BROOKS COMMITTEE: QUEST DIRECTORATE: OPERATIONS</p>	<p>20 4x5</p> <p>QTR 2 19/20</p>	<p>25 5x5</p> <p>QTR 4 21/22</p>	<p>10 2x5</p> <p>QTR 4 20/21</p>	<p>Last reviewed on Datix: 07/01/22</p> <ol style="list-style-type: none"> Welsh Government target that ambulance handover at ED will be no longer than 15 minutes Piloted a HALO (hospital ambulance liaison officer) at major Emergency Departments REAP (Resource Escalation Action Plan) and Demand Management Plan in place Gold/Strategic, Silver/tactical and Bronze/Operational 24 hour/ 7 day per week system to manage escalation plans Alternative pathways in place Maximising the services across the 5 Step model: Hear and Treat Services (CCC, NHSDW and 111) Working to the Well-being and Future Generations Act in co-production with various 	<ol style="list-style-type: none"> CEO letters to Health Boards. CEO to CEO meetings. Ambulance Task Force. Medical Director/ COO/Nurse Directors meetings. Visits to HB Quality Committees. Joint Investigation Framework. Deep Dive x2 Risks - QUEST Presentation (Feb20). Regional Escalation Protocols - Establishment of Operational Delivery Unit (ODU) in WAST. Demand Management Plan (DMP) and clinical review of no sends (DMP 4 and above) Significant incident declared on 03/12/20 as a result of whole system pressure and escalation to REAP 4 for a sustained period throughout Dec20 into mid Jan21. 	<ol style="list-style-type: none"> WAST exploring the possibility of cohorting patients delayed outside EDs on agency vehicles managed by agency paramedics Transforming and modernising our service offer, including Mobile Urgent Care (p19-20 IMTP) Working with the system to consider how we can support the Welsh Access Model and implementation of Contact First across Wales (p16 & 18 IMTP)

Risk ID	Risk Details	Risk Score			Existing Controls	Assurances	Actions
		Likelihood v consequence			<i>What measures are already in place to mitigate the risk?</i>	<i>What evidence is available to show that the controls are effective?</i>	<i>What additional actions need to be or can be taken to mitigate this risk</i>
	Title and Description	Initial	Current	Target			
					partners and volunteers to build community resilience (Prudent care principles) 8. SAIs identified as being directly due to hospital handover delays are reassigned (in the form of an Appendix B) to the respective Health Board to investigate 9. SOP for managing patients on the back of ambulances 10. Lost hours due to Hospital Handover Delays are reviewed routinely by senior operational management team 11. Operational Delivery Unit (ODU) having oversight of the Regional and National positions, enabling live review of demands and delays, and arranging redirection of crews and resources as appropriate	11. Extended hours of opening in ODU and recruitment to commence imminently. 12. Tactical Approach to Production (TAP) 13. One additional UCS capacity in place by SJC through existing MOU agreed by EMT for 6mths Apr-Sept21. 14. Duty Operations Managers (DOMs) appointed and induction commencing May 2021. Senior Paramedics recruitment & induction also underway. 15. Weekly review of the impact of hospital waits data shared with COO group 16. Red immediate release request refusals now being recorded on Datix 17. Datix of all handover delays over 6hrs 18. HIW undertaking a review of patient experience as a result of handover delays 19. The role of the Operational Delivery Unit 20. Transforming and modernising our service offer, including Mobile Urgent Care 21. Working with the system to consider how we can support the Welsh Access Model and implementation of Contact First across Wales	

Risk ID	Risk Details	Risk Score			Existing Controls	Assurances	Actions
		Likelihood v consequence			What measures are already in place to mitigate the risk?	What evidence is available to show that the controls are effective?	What additional actions need to be or can be taken to mitigate this risk
	Title and Description	Initial	Current	Target			
199	<p>Compliance with Health & Safety legislation</p> <p>ASSIGNED TO: EXECUTIVE OWNER: CLAIRE ROCHE COMMITTEE: QUEST DIRECTORATE: QUALITY, SAFETY & PATIENT EXPERIENCE</p>	20 4x5	20 4x5 ↔	10 2x5	<p>Last reviewed on Datix: 23/12/21</p> <ol style="list-style-type: none"> Leadership and direction set by Executive Management Team and Head of risk and H&S. Health and Safety Governance structure (National Health and Safety Committee Meeting and Regional Meeting held in Q3& Q4 2020/2021. Structure and arrangements reviewed with view of implementation Q2 2021/22. Health and safety Policy and topic specific policies and procedures. Health and Safety mandatory training IOSH health and Safety training for Managers and Leaders. IOSH Managing Safely re-established March 2021. Programme for IOSH Leading Safely training for SMT and Execs under development view of implementation Q1 2021/22. Local H&S Inspections (COVID secure inspections undertaken) Rolling programme of H&S Review visits -(temp suspended to COVID). Rolling programme of inspections to be developed for 2021/22. Health and Safety improvement plan actions incorporated into draft H&S Transformation Plan. Plan presented at TU Cell, National HS Committee, Local risk assessments (COVID) Workplace Risk assessments prioritised rolling programme in place, monitored at SPT meetings. RA facilitation workshops held in May & June to assess scope of Ra/SOPS required for EMS and NEPTS activities. Two H&S Coordinators fixed term contracts cease on 31 August 2021. Serious incident investigation template developed. Working Safely paper presented at EMT on 16.06.21 Head of H&S appointed 18.06.21 Funding agreed to resource Working Safely 	<ol style="list-style-type: none"> Internal Audit Reports – <i>dates to be included</i> External Audit Reports HSE Visits / Inspections Local Authority Inspections HSE Covid Learnings Report / Trust Position Report Working Safely Report presented to EMT on 16/06/21 Local H&S Inspections – scope of inspections strengthened Rolling programme of H&S Review visits Health and Safety improvement plan Monitored through Health & Safety Committee, QuEST, EMT and ADLT. Health & Safety Committee received a draft review of the Health & Safety Improvement Plan for initial approval. Due to be presented to EMT for final approval. HSE CoVID Learning Report / Trust position report. Local Risk Assessments Health & Safety mandatory training IOSH Health & Safety Training for managers and Leaders Draft transformation plan Working safely action group established Local Risk Assessments <p>Health & Safety Governance Structure reviewed to strengthen existing arrangements for implementation Q2 21/22</p>	

Risk ID	Risk Details	Risk Score			Existing Controls	Assurances	Actions
		Likelihood v consequence			<i>What measures are already in place to mitigate the risk?</i>	<i>What evidence is available to show that the controls are effective?</i>	<i>What additional actions need to be or can be taken to mitigate this risk</i>
	Title and Description	Initial	Current	Target			
					Programme 02.08.21 21. Working Safely Programme board established 03.08.21 22. Working Safely Dynamic Delivery Action Group established 10.08.21 23. Working Safely Programme Manager Appointed 17.08.21. 24. IOSH Leading Safely Training piloted 13.08.21 25. WAST Leading Safely Behavioural audits training piloted 13.08.21		
316	Increased risk of personal injury claims citing COVID exposure ASSIGNED TO: EXECUTIVE OWNER: CLAIRE ROCHE COMMITTEE: QUEST DIRECTORATE: QUALITY, SAFETY & PATIENT EXPERIENCE	20 5x4 QTR 2 20/21	20 5x4 ↔ QTR 4 21/22	12 3x4 QTR 4 20/21	Last reviewed on Datix: 24/12/21 1. RIDDOR Investigation Tool trailed with developments undertaken to undertake amendments to accommodate 111 and strengthen Corporate investigation criteria. 2. Amendments made to tool January 2021 to incorporate MRD, MTU and include vaccination information. 3. Group established to investigate backlog of cases. 4. Central coordinator assigned to manage retrospective cases. 5. Operational staff members appointed to assist with completion of COVID Investigation tools. 6. Shielded staff member appointed and trained to review COVID investigations 7. Volume of cases challenging for staff to undertake a thorough investigation during periods of high operational demands. 8. Operational central coordinator appointed in Jan 2021 to coordinate backlog of retrospective cases. 9. Several changes in designated coordinators and support teams throughout Q4 20.21 - Q2 2021/22	1. Outbreak Management SOP 2. SBAR Trust Cleaning Provision Options V5 Oct 30 19 3. IPC Policy reviewed and updated 4. Competencies for Fit Testing on ESR 5. IPC Group feeds into QUEST 6. IPC Improvement Plan and monitoring 7. Pandemic Plan 8. HSE - RIDDOR Regulations 2013. 9. Local Authority local inspections 10. Regional Groups previously established to review and RA suitability and integrity of donated PPE. 11. Pan Wales group established to discuss RA's and information share	

Risk ID	Risk Details	Risk Score			Existing Controls	Assurances	Actions
		Likelihood v consequence			What measures are already in place to mitigate the risk?	What evidence is available to show that the controls are effective?	What additional actions need to be or can be taken to mitigate this risk
	Title and Description	Initial	Current	Target			
303	Delayed initiation of chest compressions (resuscitation) ASSIGNED TO: EXECUTIVE OWNER: ANDY SWINBURN COMMITTEE: QUEST DIRECTORATE: MEDICAL & CLINICAL	15 3x5 QTR 1 20/21	10 2x5 QTR 4 21/22	10 2X5 QTR 3 21/22	Last reviewed on Datix: 25/10/21 1. Ready available PPE: ease of access. 2. Repeated and regular communication to staff via written and broadcasts/ videos/ podcasts. 3. Clarity of guidance to staff (infographic). 4. Communication to caller via CCC call handler regarding BLS. 5. Clinical Cell will review frequently and amend guidance if required. 6. Patient safety incidents will be monitored and reported via EPT/TPT. 7. Dissemination of a process for rapidly donning PPE disseminated.	1. Operational performance appears to be improving in recent weeks, mitigating the impact of donning PPE. 2. Switching back on of GoodSam App which will increase the number of provider available to respond in a timely manner (albeit L3 PPE still required) 3. Existing guidance from RCUK still current and not been amended. 4. Now rapid donning process has been disseminated this now has the potential to improve the speed at which PPE can be donned. 5. The evidence of performance is reported through to Senior Pandemic Team.	

Strategic Aim Key

1	Help Patients and Staff to Stay Healthy
2	Help Patients More Easily Access our Services at the Right Time
3	Provide the Right Care in the Right Place, Wherever and Whenever it is Needed
4	Continue to Provide the Best Possible Care, Outcomes and Experience to Our Patients
5	Enable Our People to Be the Best They Can Be
6	Whole System Partnership and Engagement
7	Ensure the Design and Infrastructure of the Organisation are at the Forefront of Innovation and Technology
8	Quality at the Heart of Everything We Do
9	Value and Efficiency in Everything We Do



GIG
CYMRU
NHS
WALES
Ymddiriedolaeth GIG
Gwasanaethau Ambiwylans Cymru
Welsh Ambulance Services
NHS Trust

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

AUDIT REPORT

MEETING	Quality, Patient Experience and Safety Committee
DATE	17 th February 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 up to date position in relation to recommendations resulting from Internal Audit and external reviews.
2. **The Quality, Patient Experience & Safety Committee is asked to:**
 - a. **Note and consider the contents of the report,**
 - b. **Consider the Trust's proposals to address each recommendation with the inclusion of revised completion dates, specifically focussing on those relevant to QuEST, and**
 - c. **Agree any specific items that the Committee wishes to see raised to Senior Management and Audit Committee.**

KEY ISSUES/IMPLICATIONS

3. Each of the 83 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

4. The report has been submitted to:
 - ADLT – 7th February 2022

REPORT APPENDICIES

5. The Audit Tracker has been circulated as a separate appendix.

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 a position statement in respect of recommendations resulting from internal audit reviews that are assigned to the Committee for oversight.

BACKGROUND

2. The organisation was carrying a slightly higher number of recommendations as a direct consequence of key staff being redeployed due to the CoVID-19 pandemic when there was no real activity in respect of the audit recommendation tracker during the period 5th March 2020 to 30th June 2020.
3. However, the numbers are beginning to return to pre-pandemic levels with high level focus on completing recommendations within agreed timeframes and continued efforts to bring any overdue recommendations up to date.
4. The Executive Management Team (EMT) agreed a pragmatic approach to allow the organisation time to address all recommendations by extending the agreed deadlines by 6 months which was applied to all current recommendations up to and including recommendation number 333 19/20, being the last recommendation added to the tracker following the Audit Committee in March 2020.

ASSESSMENT

Internal Audit Highlights

5. 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.
6. At the time of issuing the paper, there were a total of 83 current internal audit recommendations on the tracker. 32 recommendations were marked as complete at the December 2021 Audit Committee and removed from the tracker.
7. 15 recommendations were added to the tracker resulting from 3 Internal Audit Reports which were presented to the Audit Committee in December 2021. 7 of these recommendations were assigned to QuEST for oversight and were from a Reasonable Assurance rated report.
8. The status of each of the current internal audit recommendations is described in the table below.

Status	Total Number of Recommendations	Those directly relevant to	High Priority	Medium Priority	Low Priority
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	on the tracker	QuEST	QuEST	QuEST	QuEST
Overdue	36	5	0	4	1
Not yet due*	33	7	1	6	0
Complete	14	5	2	2	1
Total	83	17	3	12	2

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

9. There are no high priority recommendations showing as overdue for QuEST to review.
10. 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
2018/19	4	0	0	0	0
2019/20	4	2	0	2	0
2020/21	32	1	0	1	0
2021/22	43	14	5	2	7
Total	83	17	5	5	7

6. There are 2 recommendations showing as overdue from 19/20 reports and are of medium priority. One relates to the Raising Concerns Report and changes to the new Once for Wales Datix system. Whilst significant progress has been made, the decision has been taken to postpone the implementation of this system and the completion date has therefore been amended to April 2022. The other recommendation relates to the Trust's Risk Appetite Statement from the Risk Management and Assurance review which forms part of the improvement programme currently underway.
7. The remaining 3 recommendations showing as overdue relate to the following reports:
- 20/21 Concerns and Serious Adverse Incidents Management
 - 21/22 Controlled Drugs
11. 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	10	2	1	0	1
Reasonable	60	14	2	12	0
Substantial	1	1	0	0	1
Not Rated	12	0	0	0	0
Total	83	17	3	12	2

12. In terms of the 3 high priority recommendations, two of these have been completed during the period and 1 is not yet due. These relate to the Fire Safety and the Role of Advance Paramedic Practitioner reviews.
13. Each of the 83 recommendations have been reviewed by the Assistant Directors Leadership Team since the last Audit Committee in December 2021 to ensure that realistic timescales have been proposed where necessary and any new completion dates assigned with a strong narrative and rationale to support this.
14. The EMT focussed particularly on the overdue recommendations and where a revised completion date had been proposed.
15. The Governance team continue to seek assurance from Senior Management to ensure 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:

8. **The Quality, Patient Experience & Safety Committee is asked to:**
 - a. **Note and consider the contents of the report,**
 - b. **Consider the Trust's proposals to address each recommendation with the inclusion of revised completion dates, specifically focussing on those relevant to QuEST, and**
 - c. **Agree any specific items that the Committee wishes to see raised to Senior Management and Audit Committee.**



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

QUALITY HIGHLIGHT REPORT QUARTER 3 OCTOBER - DECEMBER 2021

MEETING	Quality, Patient Experience & Safety Committee
DATE	17 February 2022
EXECUTIVE	Executive Director of Quality & Nursing
AUTHOR	Head of Quality Assurance
CONTACT	Caroline Miftari Caroline.miftari@wales.nhs.uk

EXECUTIVE SUMMARY
<p>The report (Annex1) 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 promotes a Duty of Quality and Duty of Candour. Highlighting any governance concerns, issues, risks and area for improvement across the commissioned services.</p> <p>The report contains a summary of:</p> <ol style="list-style-type: none"> 1. Quarterly Q-IPR Dataset 2. Clinical & Quality Governance Group Overview. 3. Quality Focus Area (arising from Quality, Patient Experience & Safety Committee). <p>This quarter the Trust are piloting a new process to review the report from an integrated perspective, including key governance, quality improvement and the citizen voice stakeholders.</p>

KEY ISSUES/IMPLICATIONS
<p>The key challenges are:</p> <ol style="list-style-type: none"> 1. During the quarter there have been 20 Nationally Reportable Incidents reported to the Delivery Unit. It should be noted that, under the Joint Investigation Framework Appendix B, this does not include the 79 cases referred to Health Boards. 2. As a result of the ongoing RL Datix Work Programme due to go live in April, it has been identified that there are a large number of open incident records. 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 and comply with the Adverse Incident Management Policy. 3. 111 calls abandoned within 60 seconds have been consistently below the target of 5%, ranging from 30.1%, 17.8% and 16.2% this quarter. 111 Calls answered

within 60 seconds of the end of the message has been consistently below target of 95%, ranging between 15.2%, 28% and 37.9%.

4. 111 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, however priority 2 and 3 calls have not met the 90% target, and a further decline noted in December 2021.
5. 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 95th percentile. The red performance indicators have been consistently below the 65% target, this quarter, 50%, 53% and 51% respectfully, with some Health Board variation.
6. The number of handover hours lost this quarter are 17,180, 18,160 and 18,860 respectfully.

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

REPORT APPROVAL ROUTE

Pilot Integrated Governance Group (informal initiative)	28 January 2022
Executive Management Team	2 February 2022
Quality, Patient Experience & Safety Committee	17 February 2022

REPORT APPENDICES

Annex 1 - SBAR Integrated Quality and Performance Highlight Report Quarter 3, 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

SITUATION

- 1 The report provides an overview of the quarterly Q-IPR Dataset, Clinical & Quality Governance Group overview, and Quality Improvement focus area arising from Quality, Patient Experience & Safety (QuEst).
- 2 The Trust are trialling a pilot group to review the report from corporate, clinical, and quality governance, citizens voice and quality improvement perspective highlighting key challenges and potential focus areas.
- 3 The citizens voice perspective will be woven throughout future reports, highlighting where initiatives have been undertaken reflective of concerns, issues or risks highlighted within the report. However, patient experience data is not binary, and it isn't as simple as reporting yes or no, good or bad. When citizens share their voices, their feedback, stories, and experiences will be nuanced, emotional and personal. How we report in an effective and meaningful way needs to be considered.
- 4 Future reports will reference relevant strategic objectives and corporate risks.

BACKGROUND

- 5 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 promotes a Duty of Quality and Duty of Candour. Highlighting any governance concerns, issues, risks, and area for improvement across the commissioned services.
- 6 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 foundation of quality 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.
- 7 The Welsh Government have 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.
- 8 The report has been divided into three key areas: Q-IPR data set, Clinical and Quality Governance Group Matters and a Quality Improvement Focus area.

ASSESSMENT

Part One: Q-IPR Data Set Overview for Quarter 3, 2021-22

- 9 The Q-IPR slide decks are published monthly by the Planning and Performance Directorate, highlighting the performance against a key set of defined quality

and performance measures. This report seeks to compliment the Performance Highlight Report, focusing on the quality aspect.

Our Patients

(i) Serious Adverse Incidents:

- The number of nationally reported incidents (NRI) 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 20 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, are referred to the relevant Health Board for investigation. However, these are not included in the Trust SAI (NRI) figures reported to the Delivery Unit. During this reporting period there were 20 Serious Case Incident Forums (SCIFs) convened with 143 cases discussed, 20 have been reported as NRI to the Delivery Unit, with 79 cases being referred under Appendix B to the respective Health Board.

(ii) Patient Safety Incidents reported through Concerns:

- Under Putting Things Right Regulations, the Trust are required to respond to concerns from the public within 30 days. During the quarter, the response rates to concerns has been 47%, 56% and 70% respectfully, with a target of 70%. This may impact on the timeliness to establish patient safety risks/issues and implement learning across the business preventing further similar incidents. The Assistant Director of Quality and Nursing has sought additional support mechanisms, including investing additional resource capacity, to support the Putting Things Right Team through the winter period and improve performance.

(iii) Patient Safety incidents reported by staff via Datix:

- As a result of the ongoing RL Datix Software System Work Programme due to go live in April, it has been identified that there are a large number of open incident records. 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. Currently there are 4,252 open incidents within the Datix system, 2,407 incidents have been open for over 5 months, 472 dating back to 2011- 2018. Of the 4,252, 1,967 are under review, 1,101 incidents have not yet been reviewed, 727 are awaiting final sign off by the Line Manager; 458 are awaiting final approval. Of the 4,252 open incident records 2,254 incidents are staff related, 1,998 incidents are patient safety related.
- The closure of historic records is due for discussion and approval of a Risk Assessment at the Clinical Quality Governance Group and discussion at the Executive Management Team.

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

- The number of RIDDOR reportable incidents this quarter are, 10, 9, and 7 respectively. The Health & Safety Team has recently 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. 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 presented to Trust Forums and the Assistant Directors Leadership Team (ADLT) endorsing the commencement of this action, through a Working Safely Programme.

(v) Coroners and Ombudsman:

- There have not been any Coroners cases which resulted in ongoing Regulation 28 cases this quarter. The Team has received unprecedented number of requests for information from Coroner's Courts, in addition there has been an increase in the number of cases in which staff attend to provide continuity evidence. The complexity of the requests remains 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).
- The Trust continues to focus on the learning from 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 investigations continues to be presented to the Patient Safety, Learning and Monitoring Group and the Trust Scrutiny Panels. Individual learning is also a huge focus across the organisation with significant attention on both clinical and Clinical Contact Centre areas of business. 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.
- There are currently 15 open Ombudsman cases in December 2021, with all information having been shared with the Ombudsman's office. Over recent years most approaches from the Ombudsman's office have related to the handling and response to calls, specifically surrounding delays. During the quarter there has been a marked change in focus; the Trust has been approached in relation to cases that relate to the clinical care provided. 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.

(vi) Community Waiting Times:

- The number of patient waits over 12 hours by priority type cumulative position over the last 12 months is illustrated within the report dashboard. Long community waits can negatively impact on patient safety incidents. However, to establish the full impact on patient safety the Trust should consider next

quarter monthly reporting for the number of Amber 1 & 2 patients waiting in the community greater than 1 hour and the number of Green 2 & 3 calls waiting in the community greater than 4 hours to establish a clearer picture of the potential impact on patient safety. 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.

(vii) Data Governance Breaches:

- During the reporting period 19 information governance related incidents have been reported on Datix. These have been attributed to consent, communications, confidentiality, equipment, and medical devices. All incidents have been reviewed and investigated by the Information Governance 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.

(viii) Clinical Outcomes:

- Overall, performance remains a changeable picture for all clinical indicators this quarter. The percentage of suspected stroke patients who are documented as receiving an appropriate stroke care bundle was 98.4% in November 2021, 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 December 2021. 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.
- The percentage of patients resuscitated following cardiac arrest, documented as having return of spontaneous circulation (ROSC) at hospital door was 10.9% in November 2021. 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. In relation to ROSC rates, whilst there are many system-wide factors affecting performance, within WASTs 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 2021/22, subject of course to funding being agreed.
- Patients with Acute Coronary Syndrome Patients with appropriate care has improved this quarter at 85.7% but still below the 95% target.
- 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 Clinic Records and the need to refine the criteria to automatically capture more of the data. Feedback from the group will finalize the required criteria, Health Informatics can then develop the reporting dashboard.

- It is anticipated that the Electronic Staff Record (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

111 Service

(i) 111 - Call Answering/Abandoned Performance

- Calls abandoned within 60 seconds have been consistently below the target of 5%, ranging from 30.1%, 17.8% and 16.2% this quarter. Calls answered within 60 seconds of the end of the message has been consistently below target of 95%, ranging between 15.2%, 28% and 37.9%, this will culminate in a poor experience for members of the public trying to access the 111 service.
- The rationale for the below target performance is a mismatch of demand and capacity. Demand for the service is higher than had been forecast and likely due to the COVID-19 Omicron variant and high positivity rates in Wales, along with the number of Public Holidays in December 2021.
- Capacity (staff hours) has been increasing in line with the rollouts for each Health Board area as planned; however, despite recruiting significant numbers of additional staff as agreed with Commissioners, there are very high sickness absences (which includes COVID-19 Sickness), which sat at 15.96% for NHS111 in December 2021. This means that demand is higher than forecast, capacity is lower than planned leading to the longer response times as seen.
- Communication to 'Think 111 First' is regularly circulated to the public, which includes utilising online 111 Wales, in December 2021 there were 426,608 visits to the website, the highest volume since April 2020. Searches for COVID remain the top reason for visits, accounting for 49,993 hits. 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.

(ii) 111 Clinical Assessment Start Time Performance:

- 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, and a further decline noted in December 2021.

- Demand for the service continues to grow in addition, recruitment and retention of clinical staff also remains problematic. The main driver of improved performance will be the correct number of Clinicians in post to manage current and expected demand. Urgent work is underway.

Emergency Medical Services

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

- The Trust has a target of answering 999 calls within 5 seconds. The quarter, performance has ranged between 1.39 seconds, 0.37 seconds, and 1.45 seconds, this is likely to impact negatively on patient experience and potentially patient outcome. The Trust received 47,853 emergency 999 calls in December 2021, an increase compared to November 2021. The continued high call volumes are likely to be a result of the impact of the continuing pandemic.
- There are also increasing levels of staff abstraction due to sickness and COVID (18%) in the call centres which is reducing capacity. Emergency Medical Services (EMS) Clinical Contact Centre (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 unit hours of production (UHP) are identified.

(ii) Red Performance Response to red 999 calls:

- 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 95th percentile. The red performance indicators have been consistently below the 65% target, this quarter, 50%, 53% and 51% 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, with December 2021 having the highest ever recorded.
- 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 (NRI) 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; Potential adverse media attention.

(iii) Amber 1 & Amber 2 Performance:

- Amber 1 and 2 performance has been challenging over the quarter. Amber 1 95th percentile has been, 06:58, 04:34 and 06:02 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. The Programme Models an Amber 1 median of 35 minutes and 90th percentile of 78 minutes in December 2021 these are key benchmarks for the Trust.

(iv) Ambulance Abstractions and Production:

- The unit hour's production 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 hour's produced target is 95%, over the quarter hours produced have been 90%, 103% and 96% respectfully. Key to providing the required hours of production is the Trust abstraction rate, this quarter the abstraction rate has been 44%, 41% and 45% respectfully. The Trust is proposing, as part of the Transition Plan, that a higher level of abstractions (and relief) is used.

Non-Urgent Patient Care Transport (NEPTs)

(i) NEPTs Discharge and Transfer Journeys and Renal Journeys:

- 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%.

(ii) Staff Vaccinations:

- The Trust continues to monitor the uptake of COVID-19 vaccinations for front line workers, which remains positive. Of the 4,532 staff currently employed (All staff), 95% of frontline (Patient Facing), 95% frontline (Not Patient Facing) staff have received a first dose vaccination and 3,665 of all staff employed have received a booster dose of the CoVID-19 vaccination, accounting for 82% of frontline.
- The 2021-22 Flu Campaign has commenced this quarter with 35.96% of EMS (response) and NEPTS staff have already received the vaccine.
- Consideration for future reporting should be given to the Hepatitis B, Measles, Mumps and Rubella (MMR) and Tuberculous (TB) status of the workforce ensuring the prevention of healthcare associated infections.

Value

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

- 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 17,180, 15,979 and 16,063 postproduction hours have been lost in respective months, the target for post-production hours lost is a reducing trend.
- Hours lost through postproduction can be down to numerous factors, including but not limited to meal breaks, vehicle cleaning, Hospital Ambulance Liaison Officer (HALO) duties, duty operations. 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. Moving forward the tracking and monitoring of post-production lost hours is undertaken through a data visualisation dashboard, Qlik Sense. Post-production lost hours is currently an area of focus via a series of workshops with Trade Union Partners, to establish a way forward. Improvements planned for next quarter include providing relief pool cars to make breaks and overruns more efficient, an initiative to increase crews having their break at hospital sites to reduce return to base.

Partnership/System Contribution

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

- 999 hear and treat calls this quarter have been within target, 9.7%, 10.0% and 11% respectfully. The percentage of incidents conveyed to Major Emergency Departments has also been within target this quarter.

(ii) Number of handover lost hours:

- The number of handover hours lost this quarter are 17,180, 18,160 and 18,860 respectfully. The 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 Two: Clinical and Quality Governance Group Overview

- 10 Over the quarter the Clinical and Quality Governance Group (CQGG) have met twice, in October and December 2021. 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.

- 11 The CQGG operates within the context of the Trust Strategic Aims, and support progress of the Trust Integrated Medium Term Plan (IMPT), Clinical Strategy, and Quality Strategy and is a sub-group of the Quality, Patient Experience and Safety Committee (QuESt). It is responsible for providing assurance on compliance with the NHS Wales Health & Care Standards and Commissioning Quality Core Requirements.
- 12 Over the quarter a variety of areas of concern or improvement initiatives have been discussed to provide assurance, ensure patient safety and address lessons learnt. A snapshot of discussions are outlined below.

Safe discharge of patients within the Discharge Lounge at the Grange Hospital, Aneurin Bevan.

- 13 Significant concerns relating to patient safety have been raised in relation to the safe discharge of patients within the discharge lounge. The discharge lounge is utilised to assist with hospital discharges and free up beds within the hospital, it is acknowledged that patients using the lounge are usually frail, elderly and vulnerable and usually have dementia. The Trust provide a transport service from the discharge lounge and have a dedicated non-clinical staff member situated in the lounge overseeing the transfers. The Trust Executive Medical Director, Executive Director of Quality and Nursing, Assistant Director of Quality and Nursing and the Head of Safeguarding have met with counterparts within the Health Board to discuss the Standard Operating Procedure, resolve concerns and identify next steps to ensure safe discharge for patients. The Head of Safeguarding has also met with Safeguarding Boards and all Heads of Local Authorities relating to Duty to Reports and way forward. A further update on resolution will be reported through the CQGG.

Bespoke Patient Experience Foundation Training Programme.

- 14 Improving experiences has important value not just to people/patients and families, it is recognised that good patient experience is associated with improved clinical processes and outcomes. Patients with better experiences often have better health outcomes. However, there is currently no formal qualification for roles in patient experience and no formal curriculum accepted as standard for development and training. The Head of Patient Experience has been exploring a bespoke Patient Experience Foundation Programme with the 'Point of Care Foundation' to support the 'Citizen's Voice' element of the Trust's Quality Plan.
- 15 Point of Care Foundation are an independent charity with a mission to humanise healthcare. Their work developed from the Point of Care Programme at The King's Fund (2007-2013). The Trust seek to develop 'patient experience professionals' and strengthen the understanding, value and work of patient experience across the Trust. The aim is to have approximately 30 people trained who will have the recognised qualification. The anticipated cost is approximate £20,000. Virtual training is being considered, nominations from

each Directorate are recommended in particular those who undertake patient engagement or patient experience work. Undertaking of the training is expected within the 2022-23 financial year. The Head of Patient Experience will continue engagement, seek views of colleagues and bring update back to future CQGG meetings.

Consultant Connect - Smartphone

- 16 The Consultant Connect Application is used for patient-specific advice and referrals. Phone lines are loaded onto the application which the user can select from a drop-down menu and connect to through the app. It also provides a facility to take and transmit photographs. Data Protection Impact Assessments (DPIA) have been completed, which assessed the privacy risks to individuals regarding the collection, use and disclosure of personal information or images. The DPIAs were based upon the application being accessed by Trust personnel from non-shared devices with individual user accounts. All activity including the calls made and taking of and access to call recordings and images by each individual user is logged. As the smartphones will be shared devices, the context of the information governance controls, and associated risks will differ. To balance functionality versus governance controls it has been agreed to disable the camera functionality on the smartphones only, effectively disabling the Consultant Connects photo function on the smartphones, but still allowing the ability to make calls using the app. Users will still be able to use the app for both calls and photos on their own personal devices if they choose. Users will also be advised to download the app to their WAST iPads and use the apps photo function on their iPads as the preferred way of taking clinical photographs and will be provided with guidance to log on and off the smartphone app at the start and end of each shift.

STEMI Care Bundle Improvement Plan

- 17 A reduction in performance was identified in April 2021 in the STEMI care bundle compliance. Patient Care Records (PCRs) for the 63 non-compliant cases during January, February and March 2021 were scrutinised to identify specific criteria of non-compliance to the STEMI care bundle and inform an Improvement Plan. An approved Improvement Plan was implemented and supported by Clinical Leads and Senior Paramedics. Further analysis of clinical indicator data since implementing the Improvement Plan shows an improving trend in care bundle compliance and especially in the documentation of analgesia which was the main area of concern in the initial review.

Findings from the Independent Maternity Services Oversight Panel Review of Maternal Mortality and Morbidity and Stillbirth Cases at Cwm Taf Morgannwg UHB

- 18 The Trust has reviewed the findings relating to the Trust, shared by the Oversight Panel. Consideration has been given to the two areas of learning identified for the Trust, to date.
- (i) Resuscitation skills of ambulance crew unknown. Query level of neonatal resuscitation training and frequency of skills drills update for ambulance crew unknown.

- (ii) No intravenous (IV) cannula sited by ambulance crew - she was hypotensive and tachycardia.
- 19 In response to these 2 areas of learning the Trust position has been outlined below:
- (i) The Trust clinicians are educated to provide neonatal resuscitation as part of their core training, this education is underpinned by the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) Clinical Practice Guidelines^{i,ii,iii}, and mirror the relevant UK Resuscitation guidelines (2015 & 2021). The latter version of JRCALC are available electronically to all WAST clinicians on their personally issued I-Pads, these are updated periodically to reflect any changes in current guidance.
- (ii) All Trust Clinicians are required to undertake annual statutory and mandatory education, this includes revisiting basic and advanced life support for neonatal resuscitation.
- 20 In 2015 a review of the equipment carried on all emergency ambulances and rapid response vehicles was undertaken, this was supported by the National Neonatal Group and Consultant Midwifery Group. As a result, between 2015 and 2019 the Trust introduced additional equipment to support staff in undertaking appropriate level of care for all term and preterm deliveries. This includes:
- Hats
 - Paediatric blizzard blankets
 - Warming cocoon
 - Full range of face masks starting at 35mm
 - I-gel airways to include size 1, 1.5, 2, 2.5
 - Neonatal SPO₂
 - Neonatal NIBP monitoring
- 21 To support the introduction of this equipment, an online training film was developed by the Trust and the National Neonatal Group that is available for all Trust Clinicians to watch. It is also recognised by the Trust that exposure to neonates who require resuscitation is an extremely rare event for its clinicians, often a once in a career event. In recognising this the Trust, in partnership with the National Midwifery Group, has developed a set of action cards that are within the maternity bags located on every emergency ambulance and rapid response vehicle. These action cards include a step wise approach to managing a number of obstetric emergencies, these include resuscitation of neonatal and term babies.
- 22 On occasions Trust Clinicians are called to still births where due to gestation period resuscitation would be inappropriate. Historically, due to the lack of appropriate equipment, still births have been placed in 'kidney bowls' or in waste disposal bags. It is accepted that this demonstrates a lack of empathy for grieving parents. In 2021 the Trust has liaised with the non-profit organisation 'Needles & Hooks and Premies (NHAP). This organisation, through its network of volunteers, has supplied the Trust with bespoke knitted

pockets that are designed to carry babies of less than 24 weeks, who are placed inside with ribbons to tie together. Parents are then encouraged to hold their baby during the journey to hospital. These have received positive feedback from WAST Clinicians and the National Maternity Group.

- 23 In relation to the second point of learning for the Trust, from its description it is assumed this relates to a single episode of care. Based on the available information we are unable to comment on this case. However, as stated above, Trust Clinicians follow guidance offered by JRCALC. In relation to women who are bleeding during pregnancy or post-partum, these guidelines identify the necessity to assess blood loss and to site a large bore cannula and manage time critical symptoms accordingly.
- 24 In relation to post-partum haemorrhage, as per neonatal resuscitation all emergency ambulances and rapid response vehicles have an action card that is intended to support the attending Clinician in managing a condition that is rarely seen by ambulance Clinicians.
- 25 In the event concerns arise around individual episodes of care, we openly invite patients or Health Boards to make us aware to enable us to investigate and where necessary evidence the necessary learning.
- 26 There are no outstanding risks or issues for the Trust to consider at this time as learning has been demonstrated within the assessment of the report.

Management of an Adult Expected Death

- 27 Approval was sought by the CQGG for the release of new guidance on the management of an expected death by Paramedics, Emergency Medical Technicians and Nurses to bring the Trust into line with other Ambulance Services. Requests for the Ambulance Service to manage an expected death are not uncommon. 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 appropriate for the family, as well as impacting negatively on police service time. Police forces may 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. Changes to the guidelines pend further discussion with 111 Service, GP Out of Hours Leads Group & General Practice Council (GPC) Wales. Linking with EPCR, feedback from meeting with General Practitioners are scheduled for early 2022.

Notification Procedure:

- 28 The Trust developed a Notification Procedure, approved at Executive Management Team in September 2019. The principle objectives of this procedure was to ensure a safe and consistent approach for documenting the receipt of notifications into the Trust, ensure all notifications are reviewed as to their relevance to core business, ensure a safe and consistent approach to the dissemination of relevant notifications to appropriate staff, outline roles and

responsibilities, monitor the effectiveness of the process and provide assurance to Trust Board that notifications are being handled correctly and in a timely manner.

- 29 Following evaluation of the Notification Procedure, it was identified that in order to provide assurance and improve compliance, the current process would benefit from a digital solution to provide a robust, auditable process of ensuring all notifications received are catalogued, reviewed and disseminated within agreed timeframes to the appropriate staff. This will ensure information containing legislative and NHS requirements such as Health & Safety Legislation, European Legislation and Health & Care Standards is disseminated appropriately across the Trust in a consistent and timely manner.
- 30 A presentation from the Director of Digital was organised with Digital Health Care in Wales in December 2021 regarding potential software to be used to manage all Notifications received by the Trust. Digital Health Care in Wales have offered a software template to the Trust ICT Team. Pending the SharePoint migration, the template will be explored to ensure fit for purpose for the management of Notifications by the Trust.

Part Three: Quality Improvement Focus area

- 31 Within Quarter 3, a significant amount of strategic planning has been undertaken between the quality improvement, assurance, and wider Quality Directorate to consider the development of a Total Quality Management System. This exciting opportunity will ensure quality planning, quality assurance, quality control and quality improvement will be inextricably linked.
- 32 Operating within a highly complex Health and Social Care System, the Trust continues to experience significant system wide pressures, which inevitably impacts upon its ability to provide a quality service. However, significant opportunities exist both internally and externally to jointly understand the issues, develop improvements and ensure a continuous focus on quality.
- 33 A new role of a 'Senior Quality Lead' has been developed, and their role will be key in providing and embedding 'Quality' across the entire organisation. They will be a key guardian and advocate of Board to floor governance, ensuring candour and transparency on the key challenges and the effectiveness of improvement efforts undertaken.
- 34 The Senior Quality Lead will provide credible and visible leadership in relation to quality, safety, and patient experience, across the organisation. They will proactively contribute to local triumvirate (quality, operational and clinical) leadership, providing expert senior support and guidance on quality matters, in an expert/professional advisor capacity. The Senior Quality Leads will ensure information and intelligence is gathered from across the organisation, to determine key areas of focus for targeted improvement. Through regular weekly/monthly meetings, the team will utilise improvement project data and local intelligence to determine key areas of focus or concern. Risks will be clearly identified, which will focus on potential impact of issues raised at a local level. The meetings will offer an opportunity to develop a working Strategy that

will determine improvement actions, develop organisational learning which will lead to significant and impactful change.

- 35 Key areas of focus and opportunities will be shared via the Clinical Quality Governance Group and the Quality, Safety and Patient Experience Committee. This will assist in the consideration and implementation of local, meso or system wide improvements. The introduction of these key roles and the integration of a quality improvement/assurance function will enable us to develop a robust process ranging from identification of issues through to development of improvements and recognition of learning. Through regular reporting, the Senior Quality Leads will be able to provide a high level of assurance to QuEST and the wider organisation, through the utilisation of quality, verified intelligence from a local level. The Leads will be responsible for ensuring all improvement efforts at a local level provide a high level of value-based healthcare. Where necessary Leads will be able to advise and take action to ensure projects or initiatives, deliver high quality outcomes for patients and service users.

ⁱ Joint Royal Colleges Ambulance Liaison Committee (2013) UK Ambulance Services Clinical Practice Guidelines. Class Professional Publishers, Bridgwater.

ⁱⁱ Joint Royal Colleges Ambulance Liaison Committee (2016) UK Ambulance Services Clinical Practice Guidelines. Class Professional Publishers, Bridgwater.

ⁱⁱⁱ Joint Royal Colleges Ambulance Liaison Committee (2019) Clinical Practice Guidelines. Class Professional Publishers, Bridgwater



GIG
CYMRU
NHS
WALES
Ymddiriedolaeth GIG
Gwasanaethau Ambiwylans Cymru
Welsh Ambulance Services
NHS Trust

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

MONTHLY INTEGRATED QUALITY & PERFORMANCE DASHBOARD – December 2021

MEETING	Quality, Patient Experience and Safety Committee
DATE	17 February-22
EXECUTIVE	Rachel Marsh – Director of Strategy, Planning and Performance
AUTHOR	Hugh Bennett – Assistant Director of Commissioning and Performance Kerri Hitchings – Commissioning & Performance Manager 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 **Dec-21** (and where available Jan-22).

RECOMMENDATION

Trust Board is asked to note that this report has been considered by the Finance and Performance Committee, and to:-

- **Consider** the Dec-21 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 stopped and started, due to the on-going pandemic response; however, it is now almost finalised and on-target for the Mar-22 committee cycle and Board. This Framework has several components, one of which will relate to the use of metrics and indicators across all areas and levels of the Trust to demonstrate progress towards the Trust's strategic objectives and goals as well as to point to areas where improvement is required. The Framework will therefore set out how metrics and indicators will be used at Board level, at Executive level, at Directorate level and at locality level.

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 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 over one minute. 111 call answering performance (answered within 60 seconds/abandoned after 60 seconds), remain off target, but did see a significant improvement in Jan-22 linked to the increasing capacity.

Actions to improve both of these areas involve the recruitment of additional call handlers. For the 999 calls, additional staff recruitment has been agreed by EMT in this financial year, with the recruitment and training of up to 32 WTE due to have been completed by mid February 2022; however, increased attrition means this target date has been revised to the financial year end. It is important to note however that funding is not yet secure to continue this level of additional capacity into next financial year, and is being worked through with commissioners.

Similarly, within the 111 service, recruitment continues with a further 30 WTE funded by the 111 Programme Board. The teams have, at pace, increased the capacity (including physical capacity) in the training cohorts planned from January onwards in order to achieve this uplift in Q4.

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 was seen in Dec-21 in the lower priority calls, but an improvement in Jan-22. The Trust knows that the waits for a clinical ring back are too long. Clinical Advisor recruitment continues with a training course starting on 10 Jan-22 with a further cycle planned to commence mid-Feb-22 (across the 3 sites for up to 29 staff; subject to workforce supply and ability to recruit). As with the call handler recruitment, the Trust is also urgently looking to secure additional numbers into each of the cohorts. A demand and capacity review is currently being undertaken by ORH with a view to providing a better indication of the staff required to meet performance standards.

Ambulance response (safety / patient experience): Red and Amber response times have improved into Jan-22 supported by a decrease in patient demand; however, 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 is on course to have exceeded this target when the uplift of Paramedics into the Clinical Support Desk is included. This will close the relief gap and allow the Trust to deliver 95% of UHP more consistently (subject to abstraction rates, in particular, sickness absence);
- 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 now started to be added as part of this capacity with emergency ambulance unit hours production (UHP) at 106% in Jan-22 i.e. above the benchmark of 95%. This will increase further in Q4.

Efficiency:

- Work is ongoing on a range of workforce modernisation proposals in partnership with trade union partners, aimed at increasing capacity and efficiency. This programme of work commenced in the Autumn and has included 3 to 4 months of negotiations and performance study before there is agreement and subsequent implementation. The response to Omicron has cut into the time for this work, but an initial report is expected into EMT for the end of Feb-22.
- The roster review programme, designed to optimise the alignment of planned hours with patient demand patterns across Wales, has re-commenced; significant elements of the project had already been completed. The project was paused whilst consideration was given to Red performance and further modelling on patient safety. The revised implementation timeframe is Sep-Nov 22 i.e. in time for winter 2022, with some rosters going live before this implementation timeframe where a station wants to go live early.

Demand Management

- The Chief Ambulance Services Commissioner (CASC) has funded 40 additional clinicians into the Clinical Support Desk, with recruitment now underway and on-target with 36 Paramedic FTEs recruited and mental health professionals also recruited, with on-boarding and full go live occurring through Feb-22 and Mar-22. 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.

The PIP is being supported by a range of sub-structures, for example, the re-establishment of the Senior Pandemic Team as part of moving back into “response” mode for the pandemic and its impact. Forecasting and modelling was completed for the winter period, which was fed into the PIP. Good progress has been made on the PIP.

The current concern is quarter one 2022/23, in particular, Apr-22 when we will see the end of military support, the transition plan (if funded) will not have taken effect and likely continued high handover levels. Forecasting and modelling on this has just been completed and made available to Executives, including mitigation options, which would require funding.

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. As the system “re-sets” the Trust anticipates a situation where Ambulance Care demand returns or surpasses previous levels; this coupled with reduced capacity caused by social distancing could mean that Ambulance Care will have insufficient capacity to service patient demand. The Trust has received external funding to increase its Ambulance Care capacity through the procurement of third party providers which is now live, but further discussions are now taking place on what happens beyond 31 Mar-22 as part of the 2022-25 Integrated Medium Term Plan (IMTP) process.

National Reportable Incidents (NRIs) / Concerns Response: The Trust reported 5 NRIs to the Delivery Unit in Jan-22, compared to 4 in Dec-21; and 18 patient safety incidents were referred to health boards under the “Appendix B” arrangement, compared to 23 in Dec-21. Complaint response times declined to 66%, which, given the continued high volumes is good (target 75%). 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: Nearly 128,000 EMS ambulance unit hours were produced in Jan-22, which was the highest ever level. The emergency ambulance UHP was 106% in Jan-22, however, RRV UHP, although improved, was 84%. The emergency ambulance UHP has improved as a result of military aid, Fire & Rescue Services support and St John Ambulance capacity. The Trust continues to recruit additional staff in line with the EMS Operational Transformation Programme so that numbers of substantive staff in post increase as well; however, the level of abstractions means that capacity gain from this recruitment is less than the Trust would expect under more normal operating conditions.

Response Abstractions: Abstraction levels decreased in Jan-22, however, remain 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 is also an issue.

Trust Sickness absence: The Trust's overall sickness percentage (Dec-21) was 12.45% 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 programme of work is being 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 #WASTMakeltHappen tagline to reinvigorate My Learning on ESR to improve compliance rates for corporate staff.

Finance and Value

Financial Balance: The Trust's year to date (YTD) expenditure to budget position is 100% i.e. balance.

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 14,000 PPLHs in Jan-22, compared to the 128,000 hours produced. The reasons for PPLHs are many and varied, with around 49% in January being attributed to return to base for meal break. The PPLH figure needs to be treated with a degree of caution, with further work currently being undertaken on data input accuracy. 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 11.3% in Jan-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, a position consistent with the EMS commissioning framework. To this end EASC has recently supported an increase of 36 Paramedic FTEs and a cohort of mental health professionals FTEs into the Clinical Support Desk (CSD). Recruitment is complete with staff on-boarding and going live in quarter four. This increase will represent an almost doubling of the size of the CSD, and alongside recruitment, work is ongoing to develop the new service and workforce model. The Trust is also implementing new clinical triage software and working with health boards on how they can support remote demand management. Further work is currently underway to identify a revised benchmark for hear & treat into 2022/23.

The Trust **conveyed** 34% of patients to emergency departments in Dec-21, a decrease compared to 37% in Nov-21; however, 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 is currently being undertaken on “optimising conveyance” with the initial results being reported in w/c 24 Jan-22.

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. 22,701 hours were lost in Jan-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. This is despite demand across all areas of the service in Jan-22 declining, other factors such as the continuation of the Omicron CoVID-19 variant, coupled with increasing levels of sickness and CoVID-19 related absence continue to impact the Trust. Pressures within the rest of the urgent and emergency care system are played out in the very high levels of lost hours at hospital. Commissioners of both the EMS, NEPTS and 111 services have been very supportive of proposals put forward to increase resources across a number of schemes, and staff across the Trust are focusing all efforts on a range of strategic and operational actions that will reduce demand, increase capacity or improve our efficiency and effectiveness. The Trust has undertaken a prioritisation exercise with the result that some IMTP actions have

been paused or slowed down to allow the Trust to concentrate on those programmes which will have the highest impact on patient safety and staff well-being. A key area of focus now is quarter 1 i.e. post military aid and whether the system decides to commission the Transition Plan.

REPORT APPROVAL ROUTE

Date	Meeting
14 Feb-22	Commissioning & Performance Manager Assistant Director of Commissioning & Performance Director of Strategy Planning & Performance
16 Feb-22	Executive Management Team
27 Feb-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



GIG
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Welsh Ambulance Services
NHS Trust

Monthly Integrated Quality & Performance Report

December 2021

Annex 1 – Top Indicator Dashboard





Section 1: Monthly Indicators / Top Indicators Dashboard



Top Monthly Indicators	Target 2021/22	Baseline Position (2020/21)	Nov-21	Dec-21	Jan-22	2 Year Trend	RAG	Top Monthly Indicators	Target 2021/22	Baseline Position (2020/21)	Nov-21	Dec-21	Jan-22	2 Year Trend	RAG
Our Patients - Quality, Safety and Patient Experience								Our People							
111 Abandoned Calls	< 5%	11.00%	21.5%	19.3%	10.8%		R	EMS Abstraction Rate	29.92%	37.00%	41%	45%	41%		R
111 Patients called back within 1 hour (P1)	90%	95.30%	94.8%	94.4%	94.9%		G	Hours Produced for Emergency Ambulances	95%	96.0%	103%	96%	106%		G
999 Call Answer Times 95th Percentile	95% in 00:00:05	00:03	00:37	01:43	-		R	Sickness Absence (all staff)	5.99%	7.30%	11.08%	12.45%	-		R
999 Red Response within 8 minutes	65%	63.6%	53.0%	51.1%	52.5%		R	Frontline CoVID-19 Vaccination Rates	-	-	4,248	4,258	4,270		-
Red 95th percentile	00:14:00	00:17:59	00:21:44	00:23:27	00:21:54		R	Statutory & Mandatory Training	>85%	83.1%	82.82%	82.06%	82.23%		A
999 Amber 1 95th percentile	01:18:00	02:24:10	04:34:47	06:02:36	04:51:35		R	PADR/Medical Appraisal	>85%	52%	58.84%	57.87%	58.34%		R
Return of Spontaneous Circulation (ROSC)	Improve	9.97%	10.90%	-	-		G	Ambulance Response FTEs in Post	1700	1702	1637	1639	-		A
Stroke Patients with Appropriate Care	95%	95.83%	98.40%	-	-		G	Ambulance Care, Integrated Care, Resourcing & EMS Coordination FTEs in Post	-	1117	1710	1681	1703		-
Acute Coronary Syndrome Patients with Appropriate Care	95%	73.50%	85.70%	-	-		R	Value							
Renal journeys arriving within 30 minutes of their appointment (NEPTS)	70%	74%	77%	77%	82%		G	Financial balance - annual expenditure YTD as % of budget expenditure YTD	100%	100%	100.00%	100.00%	100.00%		G
Discharge & Transfer journeys collected less than 60 minutes after booked time (NEPTS)	90%	88.00%	86%	88%	87%		A	EMS Utilisation metric	57%	-	-	-	-		-
National Reportable Incidents reports (NRI)	-	4	9	4	5		R	Post-Production Lost Hours (All Vehicles)	Reduction Trend	11,053	15,979	16,063	17,106		R
Concerns Response within 30 Days	75%	75%	56%	70%	66%		R	Partnerships / System Contribution							
								111 Consult and Close	Improve	5,612	5,915	6,875	6,943		G
								999 Hear & Treat	10.2%	9.9%	10.0%	11.0%	-		G
								% Incidents Conveyed to Major EDs	<48.6%	44.58%	36.57%	33.92%	-		G
								Number of Handover Lost Hours	< 150 hrs per day	6,093	18,160	18,773	22,701		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 Circuit Breaker Dashboard



Headline Indicators



Figure 1



Figure 2

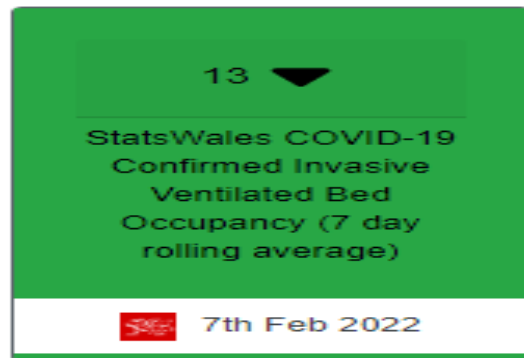


Figure 3

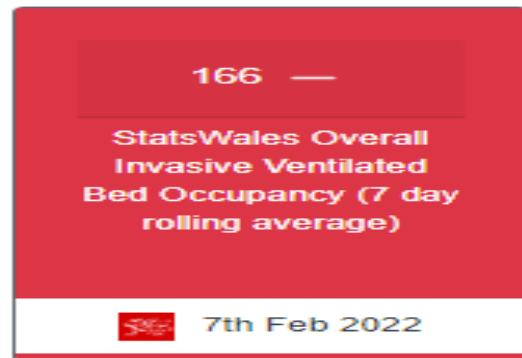


Figure 4

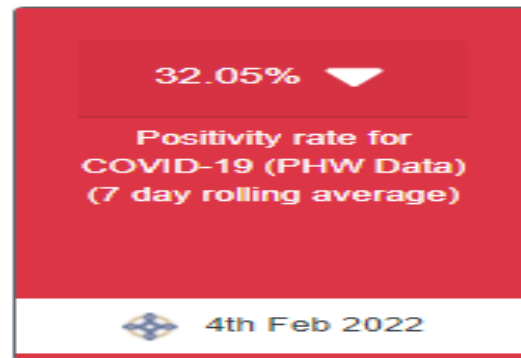


Figure 5

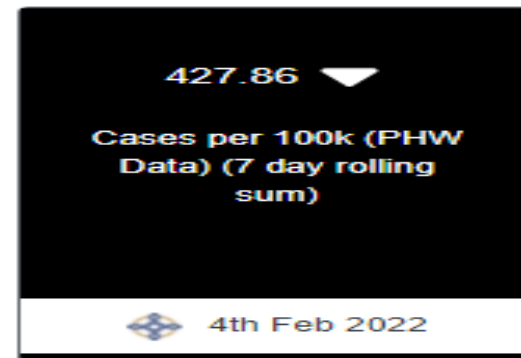


Figure 6

Transmission, Incidence and/or prevalence of the virus

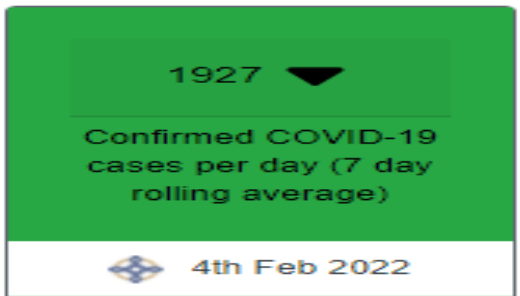


Figure 14

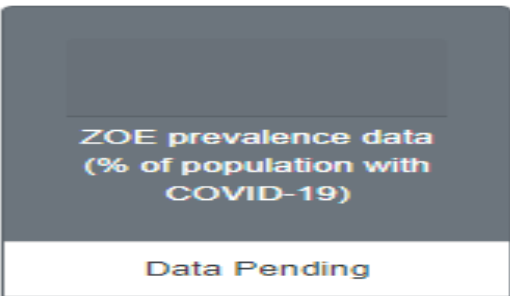


Figure 15



Figure 16



Figure 17

Cases in last 7 days per 100k population by local authority

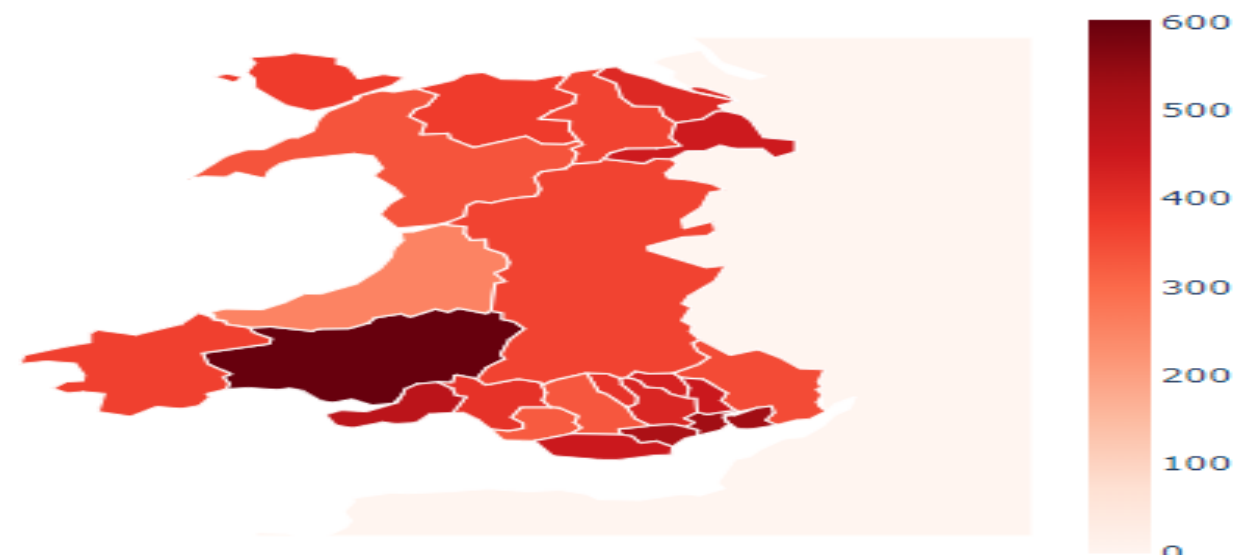


Figure 22 - 8th Feb 2022

Data Source: Welsh Government CoVID-19 Dashboard - Updated: 08/02/21



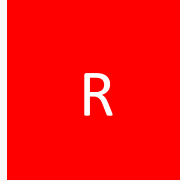
(Responsible Officer: Rachel Marsh)

Welsh Ambulance Services NHS Trust



Our Patients: Quality, Patient Safety & Experience

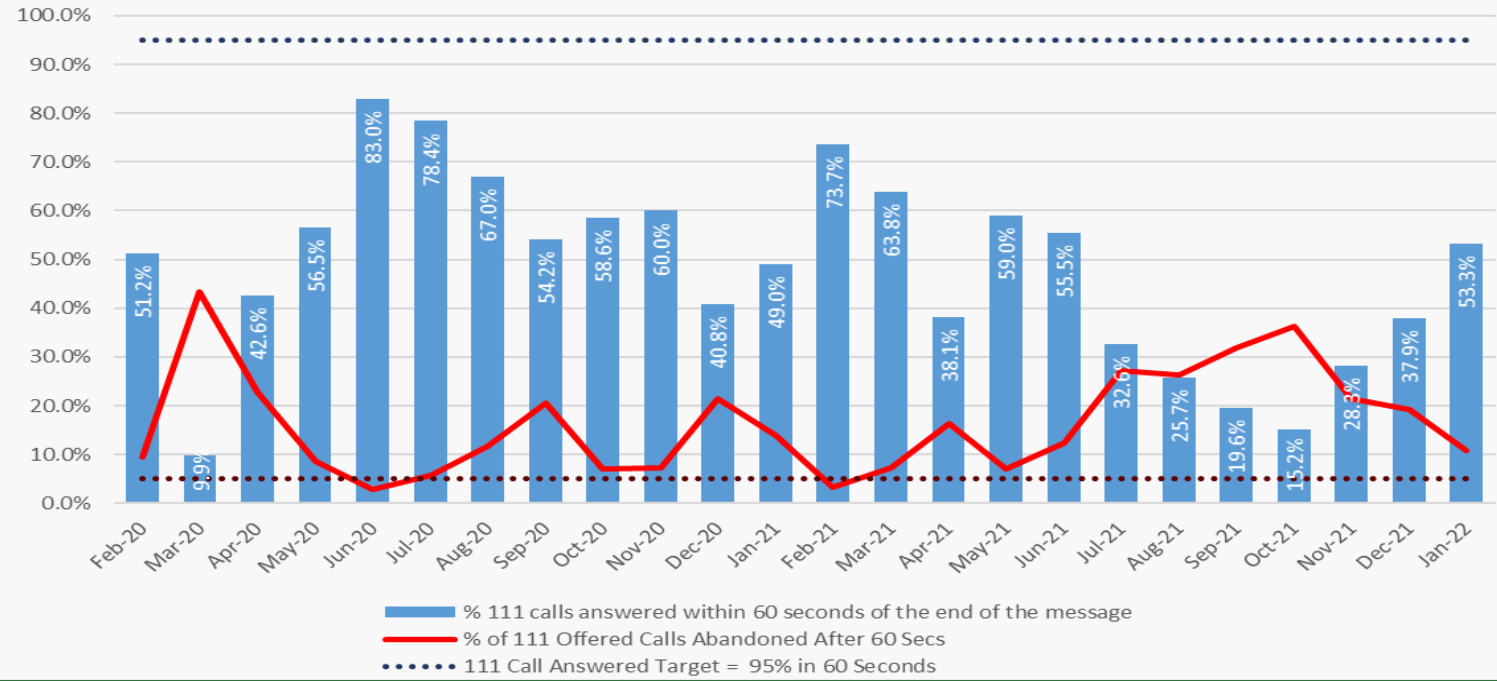
111 Call Answering/Abandoned Performance Indicators



NB: 111 Roles data correct at 12/01/22

Influencing Factors – Demand and Call Handling Hours Produced

111 Calls Answered vs Calls Abandoned within 60 Seconds



Analysis

111 call abandonment is a key patient safety indicator for the service. Jan-22 saw an abandonment rate of 10.8%, an improvement compared to previous months and the lowest since May-21.

The percentage of 111 calls answered within 60 seconds of the end of the message improved in Jan-22 to 53.3%. Given the continued high volumes of calls per month, this still represents a significant number of people who receive a poor patient experience.

The main reasons for high abandonment rate / long answer times is a mismatch of demand and capacity.

111 call demand decreased in Jan-22 compared to the previous month, as seen in the graph. Demand for the service is higher than had been forecast following the BCU roll-out in June 2021.

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 very high sickness absences (which includes CoVID-19 Sickness), which sat at 15.96% for NHS111 in Dec-21. This means that demand is higher than forecast, capacity is lower than planned leading to the longer response times as seen.

Communication to 'Think 111 First' is regularly circulated to the public, which includes utilising online 111 Wales; in Dec-21 there were 426,608 visits to the website, the highest volume since Apr-20. Searches for CoVID remain the top reason for visits, accounting for 49,993 hits.

Remedial Plans and Actions

- Increasing the 111 workforce profile for both Call Handling & Clinical Advisors continues to be a key area of focus for the 111 service, and an additional 30 WTE Call Handlers have been funded by commissioners to support this (complete).
- As part of an enhanced recruitment drive, specialist recruitment agencies have been successful alongside traditional recruitment processes, to increase the number of job applications for both Call Handler and Clinical Advisor posts.
- Additional training cycles have been planned for both Call Handlers & Clinicians, with the next cycle of training commencing on the 10th Jan-21 with a further cycle planned to commence in mid-Feb.
- The additional training cycles have been complimented by a successful expansion of the 111 training estate capacity across four sites including VPH, Matrix One, Ty Elwy & Thanet House. This has been a positive development increasing the number of available 111 training estate to deliver more training in the January & February cycles.
- A number of service improvement plans have been delivered to increase the productivity and increase capacity within the service to manage current demand pressures. This has included implementation of new IVR messaging and review of the Clinical Advice Line (CAL). These changes along with the continuing recruitment drive are demonstrating a positive impact on reducing the 111 call abandonment levels and providing a more responsive and timely service to patients.
- A D&C review is currently being undertaken by ORH to determine the appropriate levels of call handling and clinical capacity required to meet response times targets. This is expected to conclude in Feb / March 2022 (reported to EMT).

111 First	FTE Budgeted	FTE Actual	FTE Variance
Call Handler (Band 3, incl. HI advisor)	156.42	171.33	14.91
HI Advisor	9.95	9.7	-.024
Clinical Advisor - Paramedic	4.00	4.2	0.2
Nurse Advisor/ Clinical Advisor - Nurse	121.48	109.44	-12.03
Dental Health Advisor	8.52	7.1	-1.41
Senior Clinical Advisor - Nurse	13.20	16.4	3.2
Total	313.57	318.17	4.85

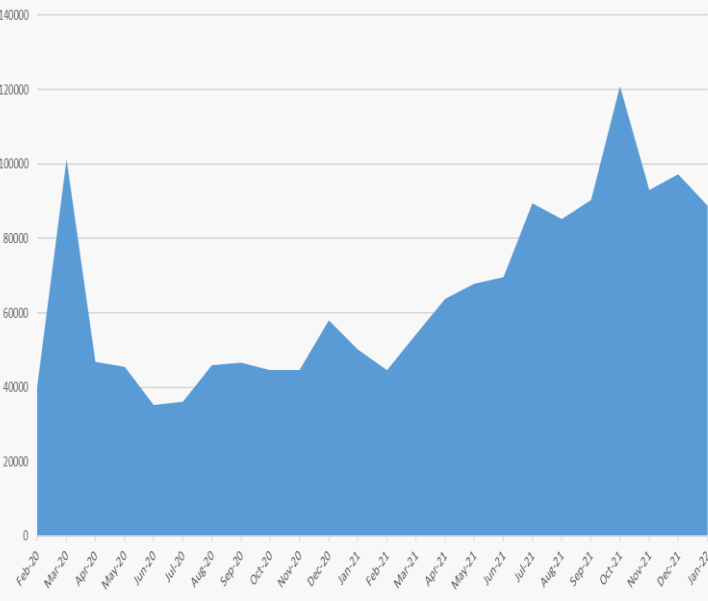
A 111 UHP Dashboard has been developed and is now live to track actual hours for call handlers and clinicians.

Discussions continue with commissioners to review numbers of call handlers to determine whether there is approval / funding to increase further.

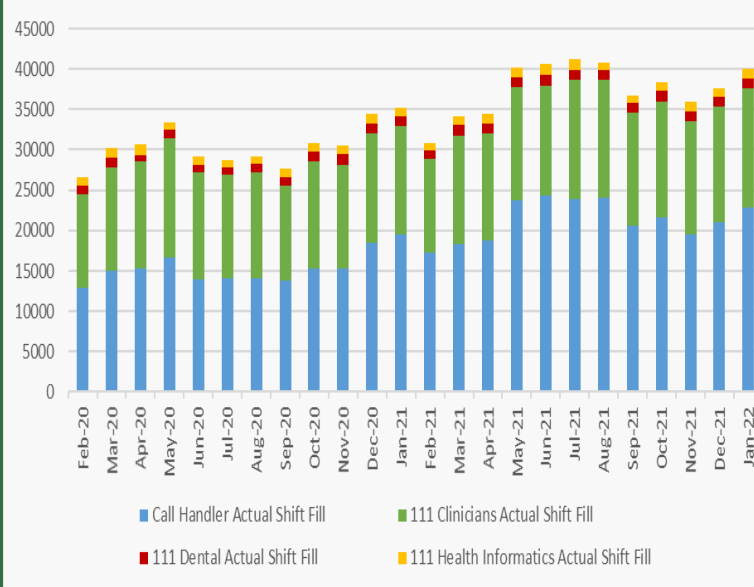
Expected Performance Trajectory

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

Total 111 Calls



111 Shift Fill - Total Actual Hours



(Responsible Officer: Lee Brooks)

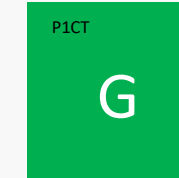
Welsh Ambulance Services NHS Trust



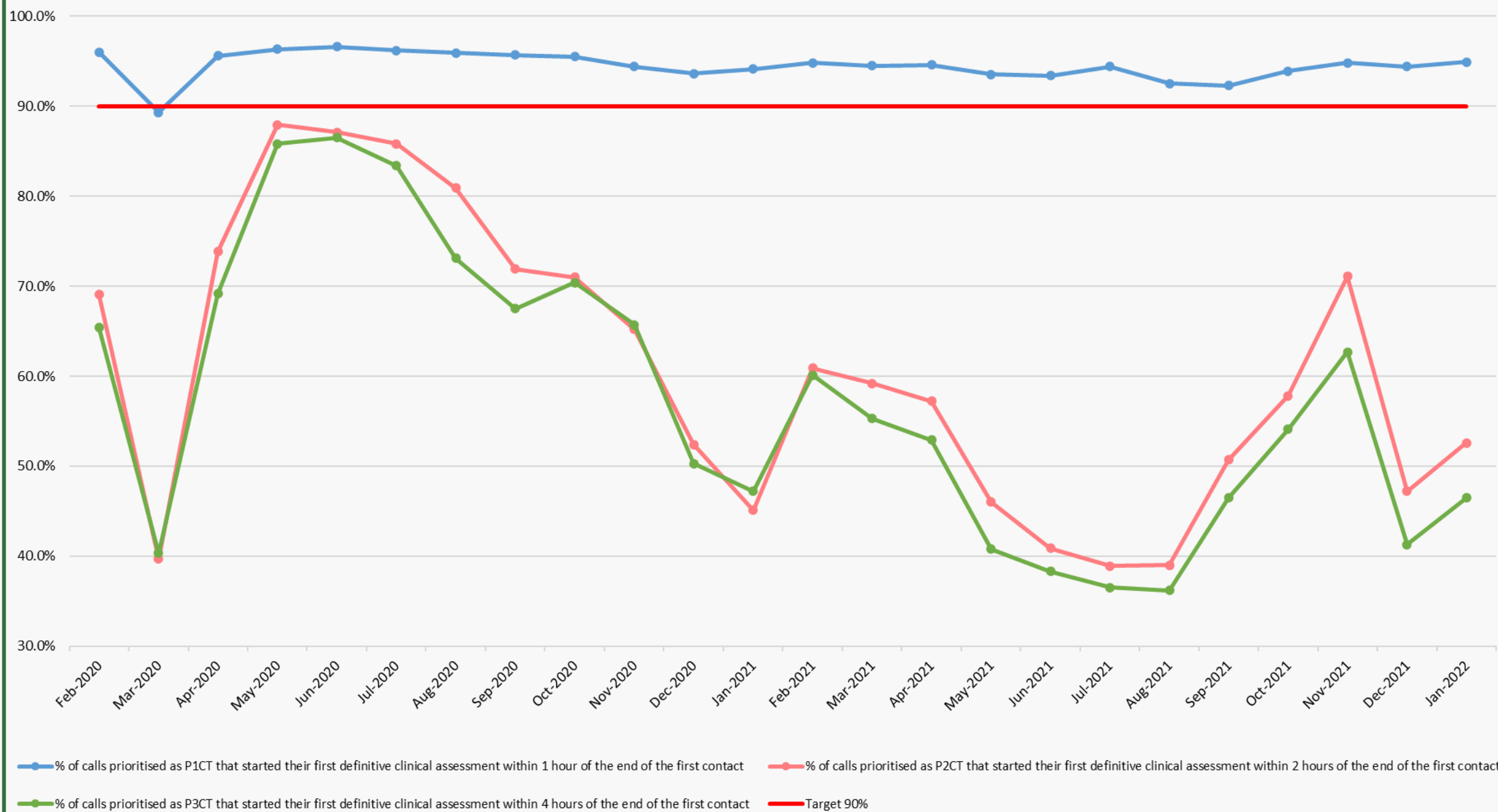
Our Patients: Quality, Safety & Patient Experience

111 Clinical Assessment Start Time Performance Indicators

Influencing Factors – Demand and Clinical Hours Produced



111 Timely Clinical Triage of Patients



Analysis

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

The highest priority calls, P1CT, continue to receive a timely response which, with the exception of Mar-20, has continuously achieved the 90% target.

For lower category calls, we are not meeting the 90% target, however an improvement was seen in all categories in Jan-22.

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, (see previous slide, now at 109.44 WTE for clinical Advisors (Nurse) against an FTE budgeted of 121.48), these are insufficient to meet demand.

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.



(Responsible Officer: Lee Brooks)

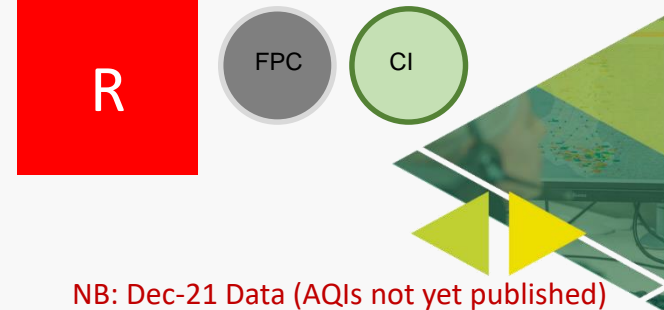
Welsh Ambulance Services NHS Trust



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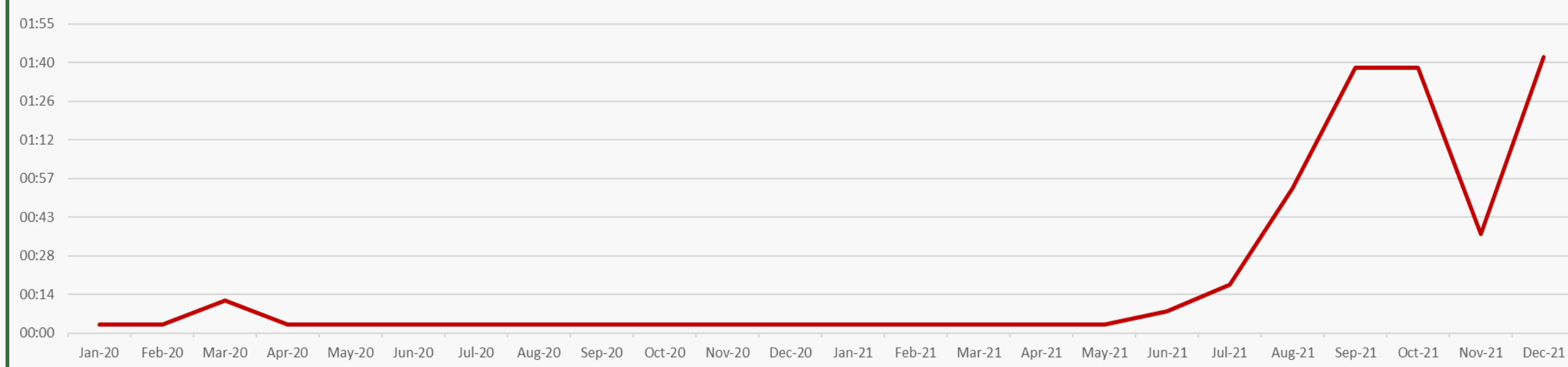
999 Call Performance Indicators

Influencing Factors – Demand and Clinical Hours Produced



NB: Dec-21 Data (AQIs not yet published)

95th Percentile 999 Call answer times



Analysis

The 95th percentile 999 call answering performance saw a decline in Dec-21 to one minute 43 seconds 37 seconds, compared to 37 seconds Nov-21, failing to meet the 6 second answer target for the seventh 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 Dec-21 65th percentile continued to average at 3 seconds.

The Trust received 47,853 emergency 999 calls in Dec-21, an increase compared to Nov-21, however this is higher than both Dec-19 and Dec-20. 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 (18%) 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.

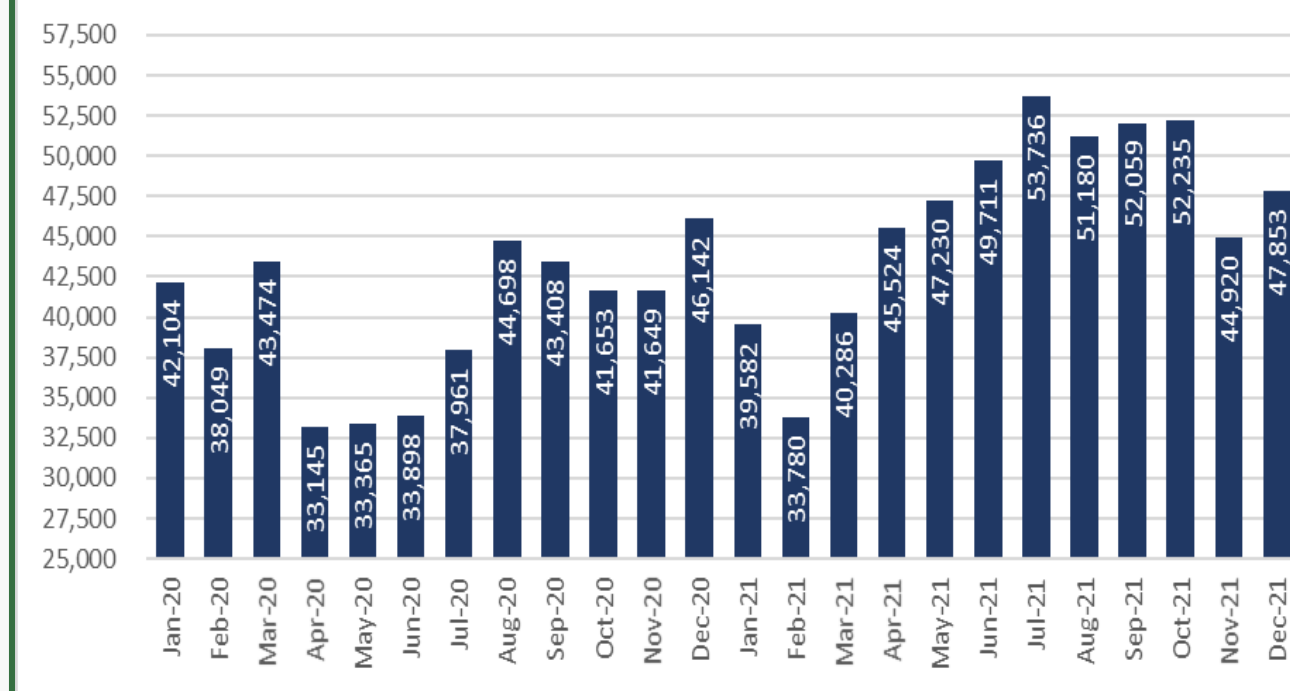
EMT has approved additional funding into EMS CCC in this financial year to allow recruitment of EMDs to match the new baseline demand level being experienced, this funding includes additional relief capacity that will mitigate abstraction levels. Increased EMD capacity will allow more opportunity for current EMDs to reset and recover during shifts.

- The Trust had targeted Feb-22 as the point in time when the full impact of the uplift of 32.25 FTE EMDs would be felt in CCC; however, rates of attrition have increased and this will no not be achieved (31 Mar-22 revised target date).
- The Omicron Tactical Action Plan includes additional Workforce & OD support to CCC to aid the recruitment process. This has been actioned.

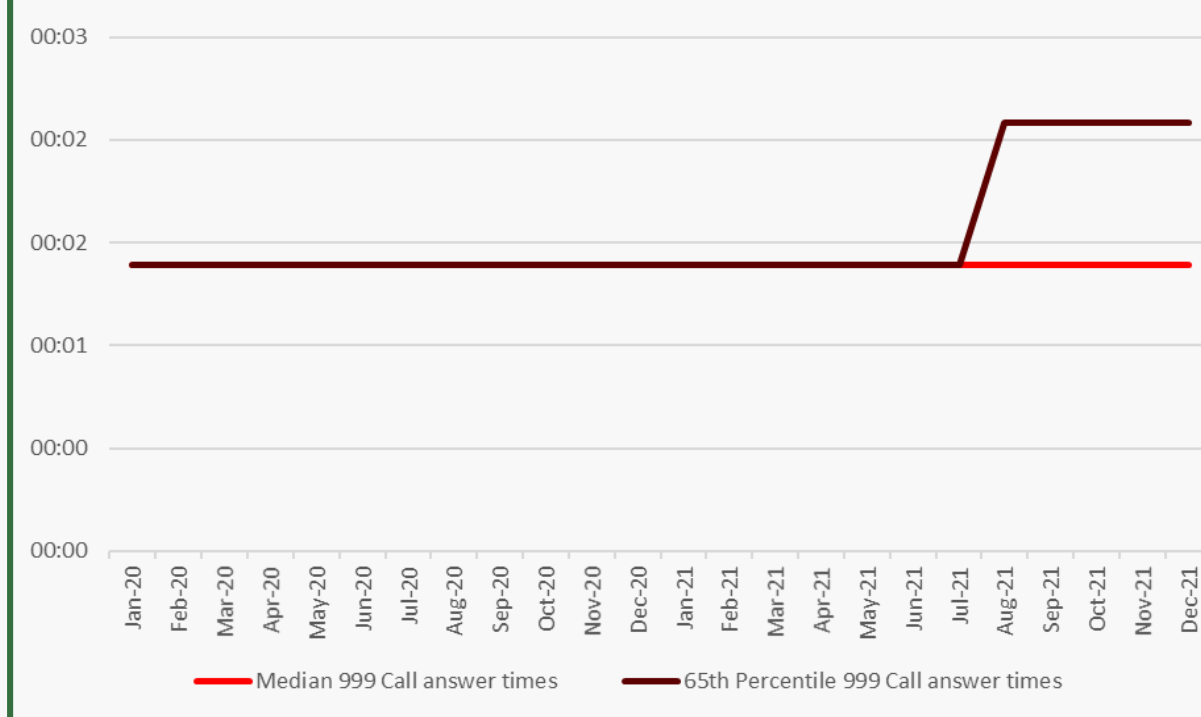
Expected Performance Trajectory

Performance is expected to continue to be difficult until additional staff are recruited. It is difficult to set a trajectory because of attrition, but 29 of the 32.25 FTEs have been recruited with an advert for another 10 (to offset the attrition) going out imminently.

999 Call Volumes



Median & 65th Percentile 999 Call Answer Times



(Responsible Officer: Rachel Marsh)

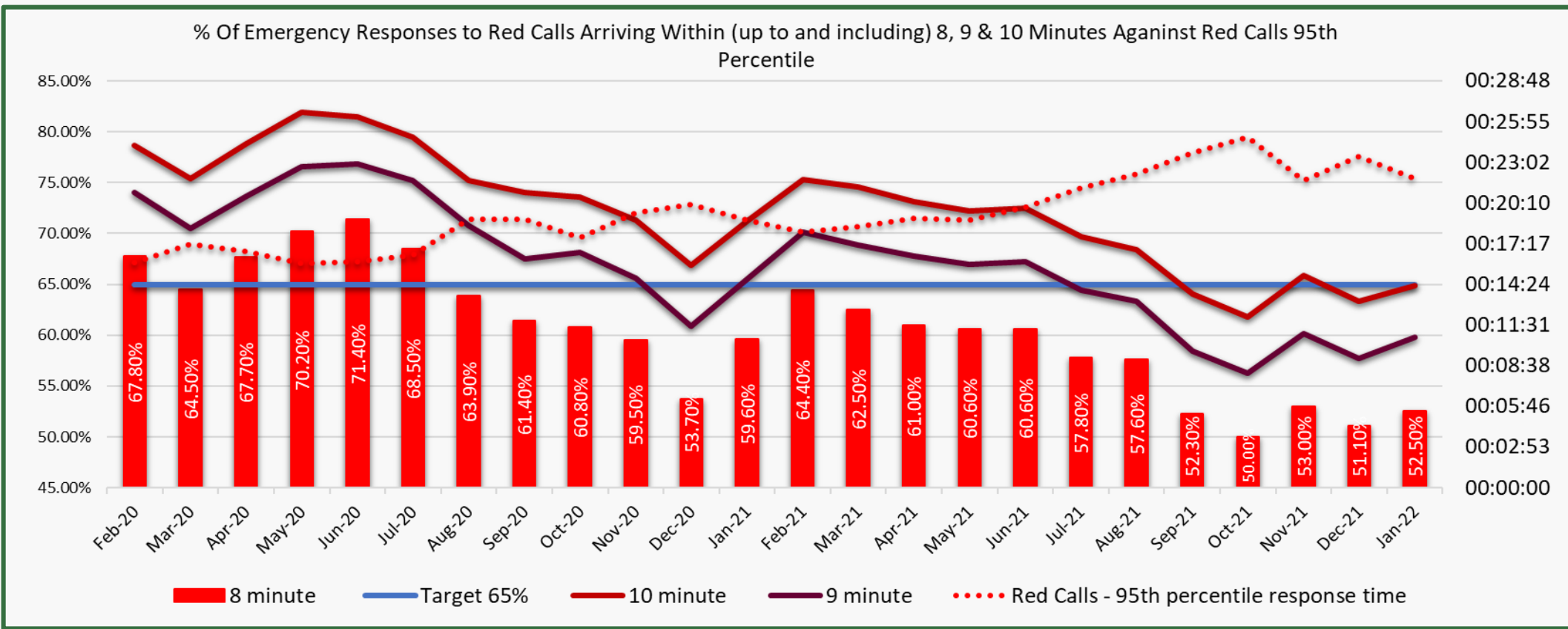
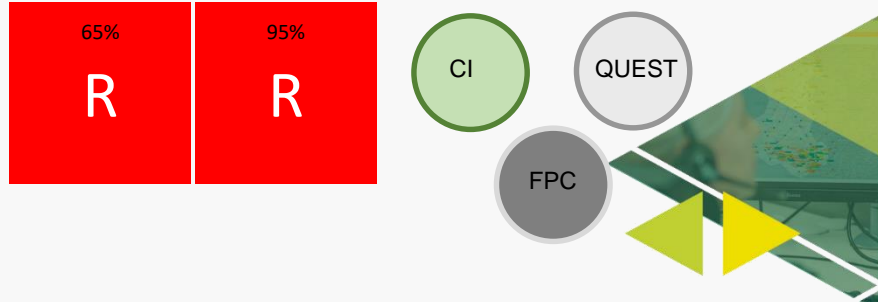
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Red Performance Indicators

Influencing Factors – Demand, Hours Produced and Hours Lost



Analysis

Red performance did not achieve the 65% target in Jan-22 and the target has not been achieved since Jul-20. There was also significant health board level variation and only one (Cardiff & Vale (68.1%)) of the seven health board areas achieved the 65% target. This level of performance was forecast in the winter plan based on predictions of demand, lost hours and hours produced. Ongoing poor performance is continuing to affect Red 9 minute responses, which achieved 59.8% and Red 10 minute performance, achieving 64.9% in Jan-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.

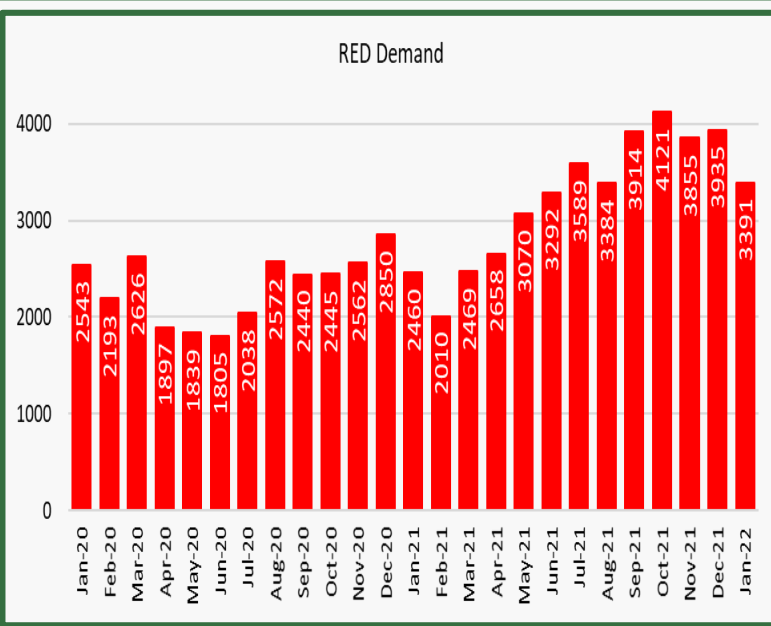
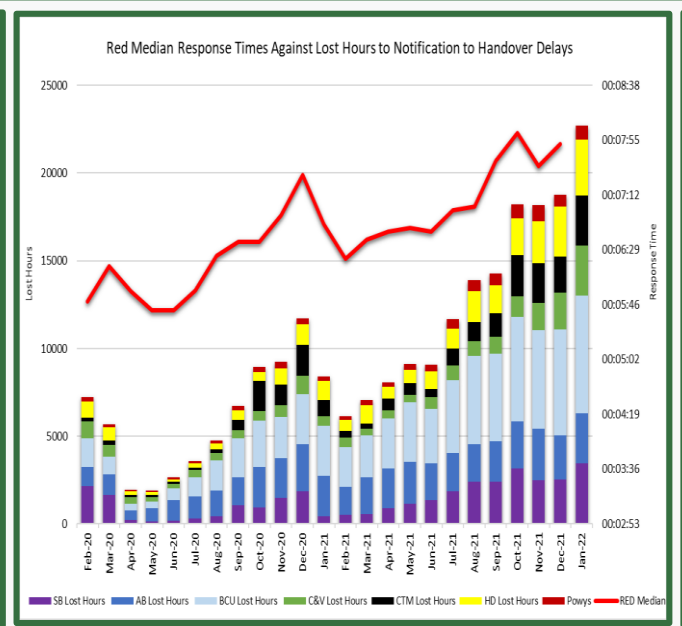
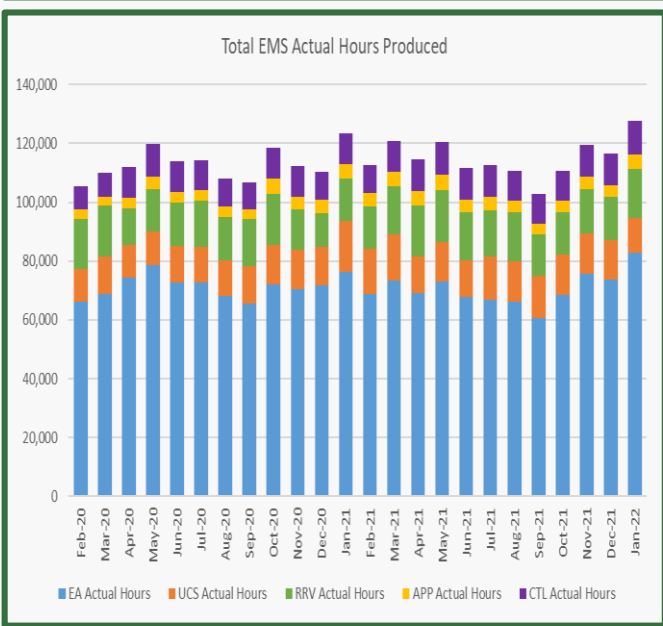
The lower centre graph demonstrates the correlation of performance with hospital handover lost hours with Jan-22 having the highest ever recorded. However, the number of hours produced was also higher than it has ever been, as a result of the military personnel in place (251).

During the pandemic there have been other factors that have also affected performance including prioritising EA hours over RRV, and the additional time taken to don level 3 PPE to all Red calls. 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 127 by the end of Mar-22. This will close the relief gap and, other factors aside, would allow UHP / hours produced closer to 95%. Additional capacity is also being utilised non-recurrently through St John Ambulance, Fire & Rescue Services and the military. This has allowed the total hours to rise. Discussions are ongoing with commissioners about increased capacity for next year (transition plan)
- Reduce hours lost through modernisation of practices and supporting staff well-being. This work is being led through the Leading Service Change together programme in partnership with TU partners.
- Working with partners to reduce hours lost at hospital (to a maximum 150 lost hours per day, 95% of the year) . This is not within the gift of the Trust to achieve, although it continues to take all actions possible to influence this agenda.
- 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

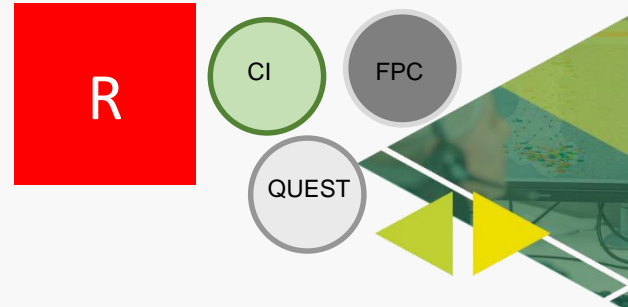
Unless Red demand reduces or the Trust is able to boost its RRV production Red performance is unlikely to achieve the 65% target; however, the Trust is building the CHARU keys into the re-rostering project, which along with other aspects of the Transition Plan (if funded) should stabilise performance. Looking ahead, it is expected that April will be a difficult month, as the military personnel leave.



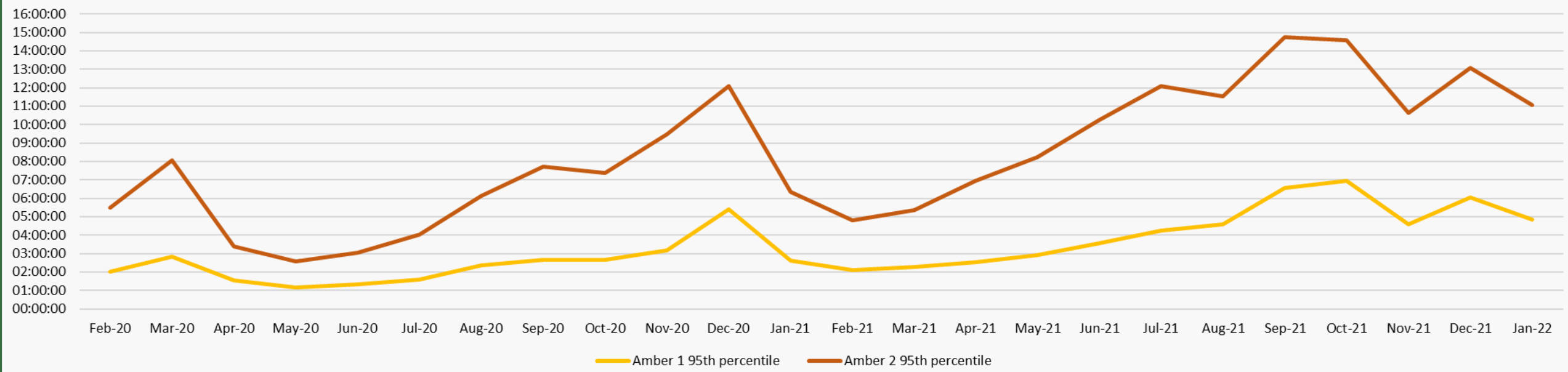
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Amber Performance Indicators

Influencing Factors – Demand, Hours Produced and Hours Lost



Amber 1 & 2 - 95th Percentile



Analysis

Amber performance improved across the percentiles in Jan-22; however, there were still some very long patient waits. The ideal Amber 1 median response time is 18 minutes.

In Jan-22, 503 patients (all categories, not just Amber) waited over 12 hours, a decrease when compared to Dec-21, continuing to represent a very poor quality and experience of service. 393 of these patients were in the Amber category.

Amber demand decreased in Jan-22 although 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 Jan-22 increased to 22,701. This is now higher than the worst recorded in Dec-19 (13,820).

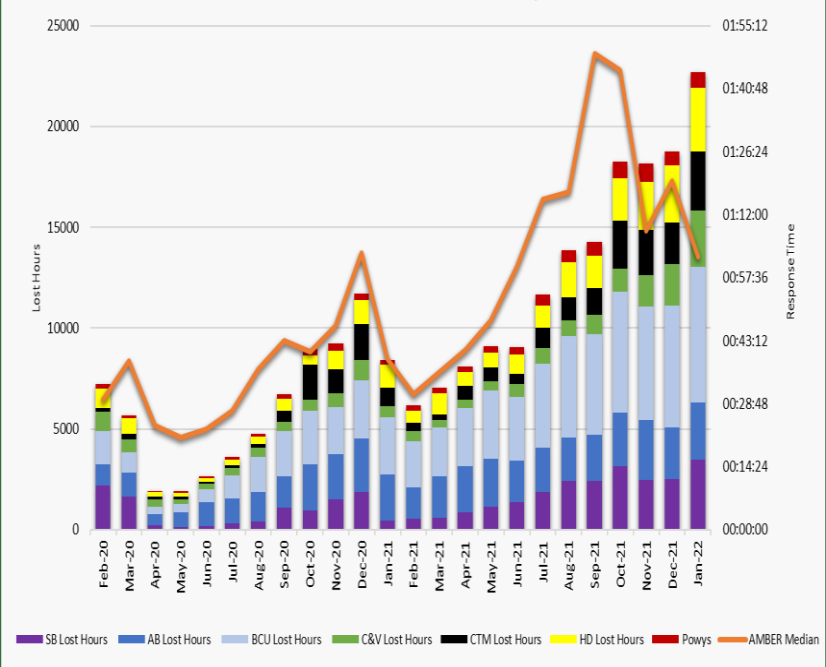
Remedial Plans and Actions

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.

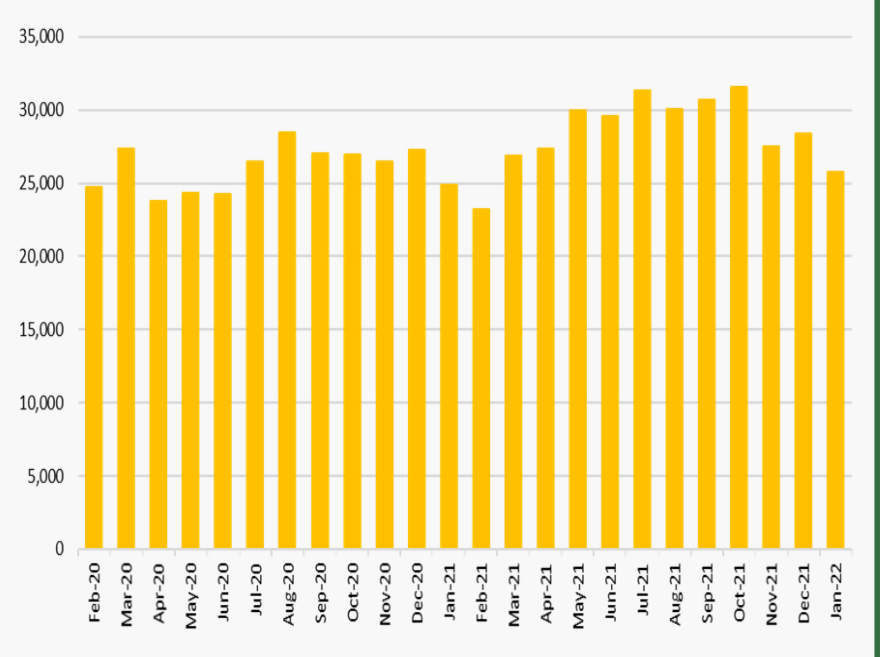
Expected Performance Trajectory

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.

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



Total Verified AMBER Demand



Amber 1 - Median and 65th Percentile



(Responsible Officer: Lee Brooks)

Welsh Ambulance Services NHS Trust



Our Patients: Quality, Safety & Patient Experience

Clinical Outcomes Indicators

Stroke/ROSC/
Sepsis &
Febrile Con.
G

Hypoglycaemic, (STEMI)
Acute Coronary & Hip
fracture
A

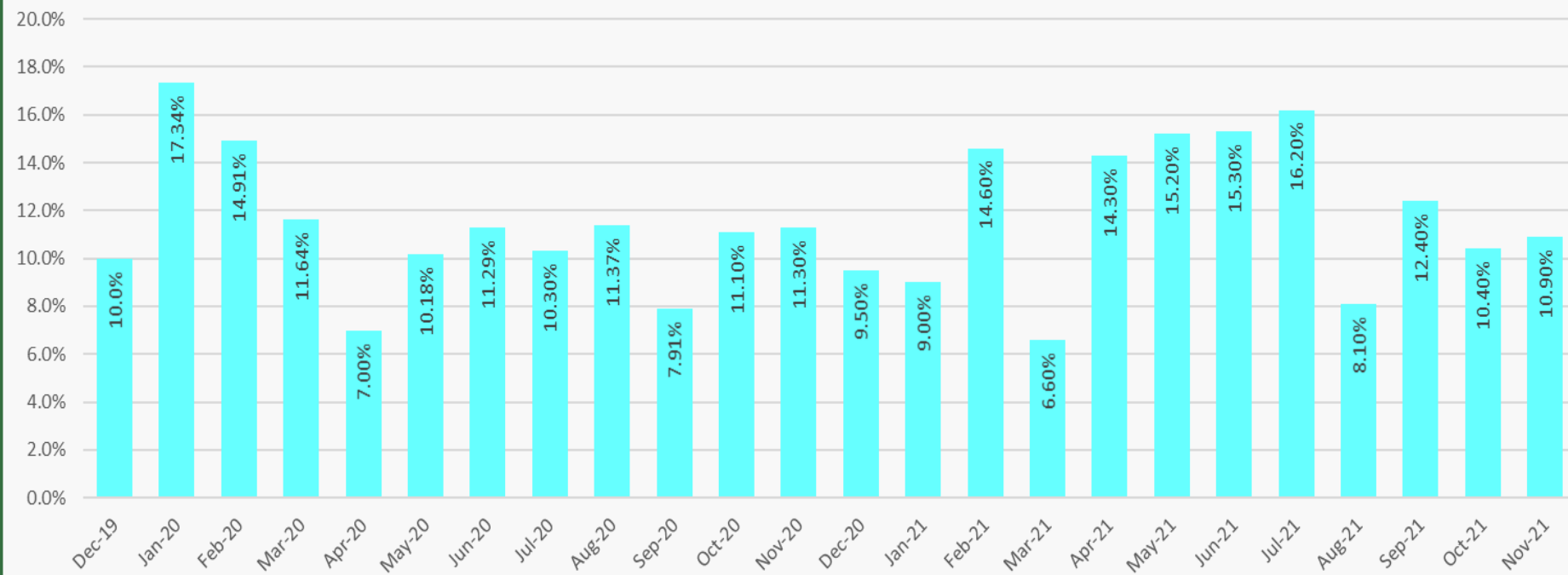
QUEST

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: Unable to report Dec-21 Clinical Indicators due to implementation of ePCR / Next reporting cycle Jan-Mar-22 due Apr-22

% of patients with attempted resuscitation following cardiac arrest, documented as having a return of spontaneous circulation (ROSC) at hospital door



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.

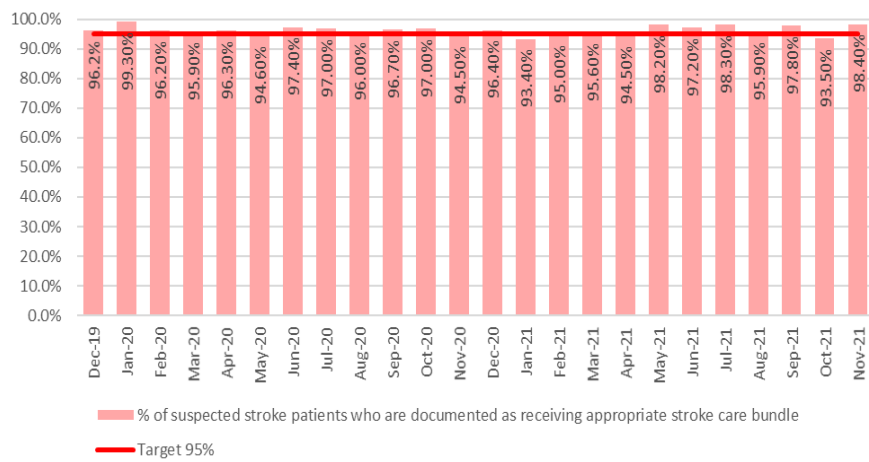
Mortality Review: There has been a workshop planned to review DU Guidance and consider how this would work within WAST and how it would influence the Trust's current method of undertaking Mortality Reviews. Outcomes from this workshop will be presented in the next update.

Expected Performance Trajectory

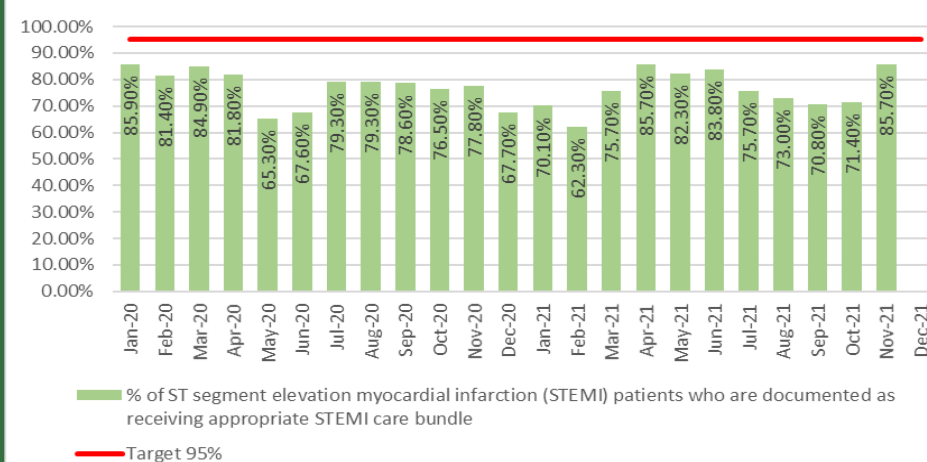
Clinical Outcomes: As part of its plans for 2021/22, the Trust is developing the concept of CHARU for implementation. This concept is in place in several areas across the UK and has been very successful in increasing ROSC rates. Once CHARU has been implemented it is anticipated that ROSC rates should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

Mortality Review: The Senior Paramedic Role has now been fully implemented across the Trust, early evidence demonstrates the ability to implement learning from Mortality Reviews promptly supporting individual and organisational learning.

% of suspected stroke patients who are documented as receiving appropriate stroke care bundle



% of ST segment elevation myocardial infarction (STEMI) patients who are documented as receiving appropriate STEMI care bundle



Mortality Reviews Data source: Internal Web Application



(Responsible Officer: Andy Swinburn)

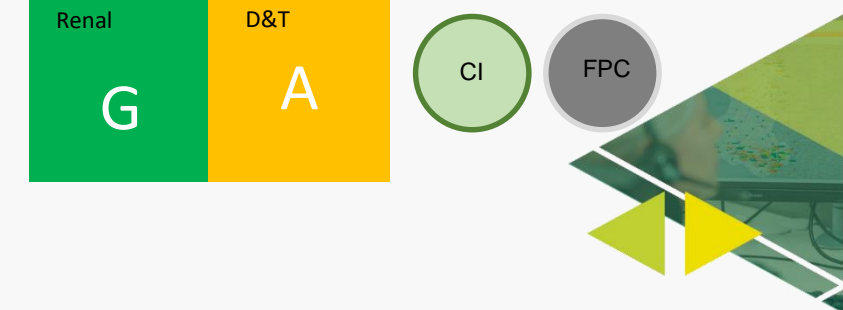
Welsh Ambulance Services NHS Trust



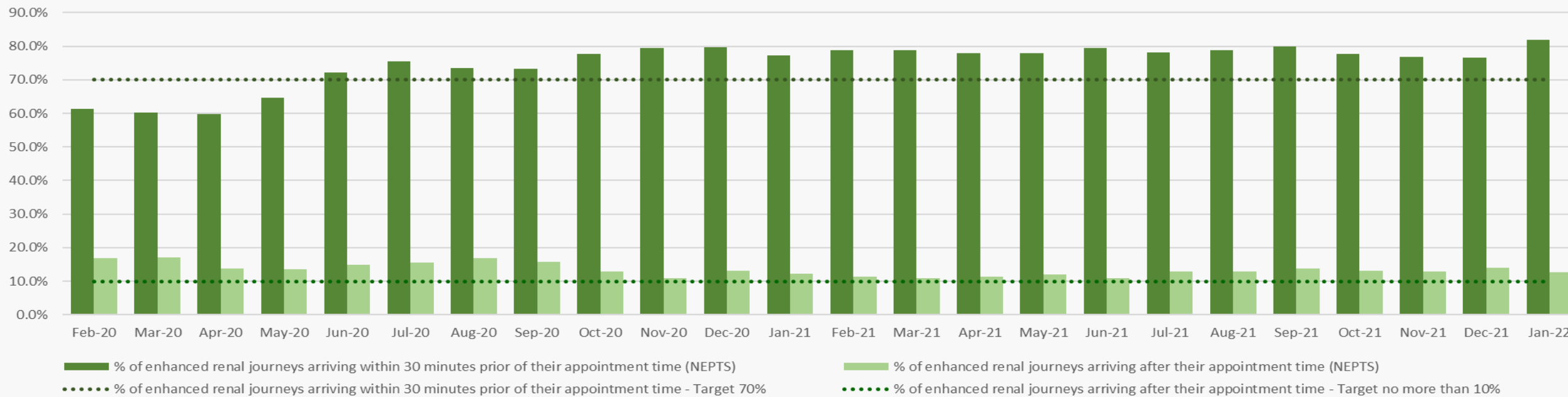
Our Patients: Quality, Safety & Patient Experience

Ambulance Care Indicators

Patient Experience



% Of Enhanced Renal Journeys - Arrival Times (NEPTS)



Analysis

Ambulance Care has seen a continued improvement in key areas of service delivery affecting patient experience. In Jan-22 87% of discharge & transfer journeys were collected within 60 minutes of their booked ready time, a slight decline compared to Dec-21. 82% of enhanced renal journeys arrived within 30 minutes prior to their appointment time, achieving the 70% target and 12.7% arrived after their booked appointment time, falling just outside of the 10% target.

Key factors affecting these indicators are demand and capacity:

- Social distancing means that the number of patients than can be transported per journey has reduced, which has reduced **capacity**;
- **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;
- However, there has been a significant reduction in **demand** as a result of planned activity reductions in health boards. The reductions in demand have helped offset reductions in capacity.
- As we emerge out of pandemic response in 2021/22 and the health system is "re-set" we are seeing demand increase again for NEPTS at which point capacity may be an issue. This has been modelled and mitigations put in place.

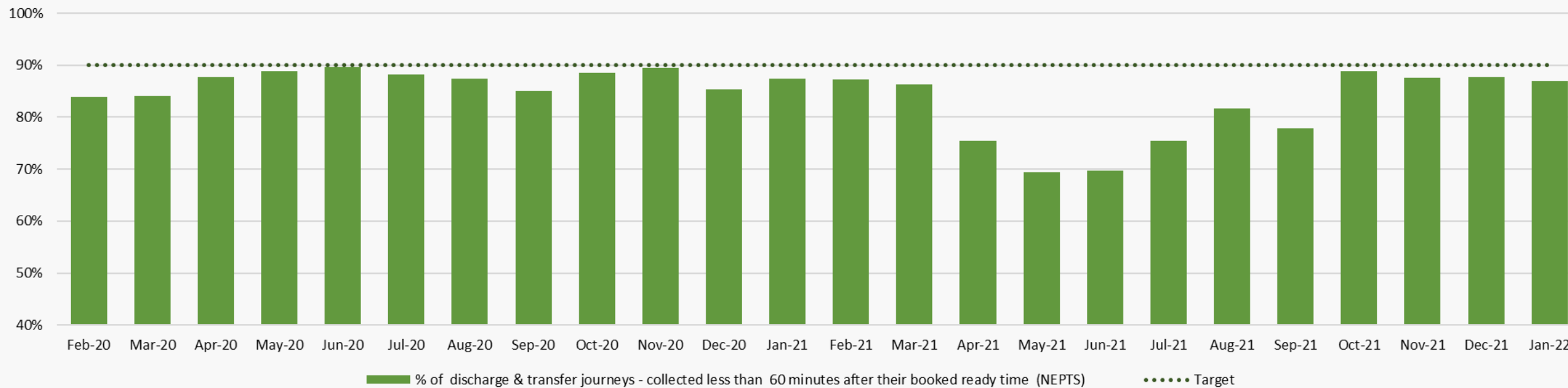
Remedial Plans and Actions

- **Demand:** Continue to work with health boards to understand and model the impact of their recovery plans;
- **Demand:** As part of the Transport Solutions programme, work towards finding alternative transport solutions for non-eligible patients (to reduce demand);
- The NEPTS Demand & Capacity Review is completed and has been shared and discussed with commissioners during Q1, and action plans will be developed. The Review includes a range of benchmarks particularly around efficiency of our service, which will help to increase **capacity**;
- A recruitment campaign recently concluded to increase call taker numbers and work is ongoing regarding Patient Needs Assessment to reduce call times.
- Additional resources have now also been agreed with commissioners to secure additional capacity through the 365 framework (private providers) and this is being taken forward at pace (now live).
- Resource team are now at an advanced stage in reviewing UHP measurements to reflect current rosters and the plurality model.

Expected Performance Trajectory

At present, the uncertainty around demand means that it is difficult to forecast performance. The Trust is in dialogue with the CASC about short term funding beyond 31 Mar-22. The Trust, in agreement with the CASC, has agreed to further work in 22/23 on proposed roster keys with go live likely to be in Q1 23/24

% of discharge & transfer journeys - collected less than 60 minutes after their booked ready time (NEPTS)



(Responsible Officer: Lee Brooks)

Welsh Ambulance Services NHS Trust



Our Patients: Quality, Safety & Patient Experience

Patient National Reportable Incidents & Patient Concerns Responses Indicators

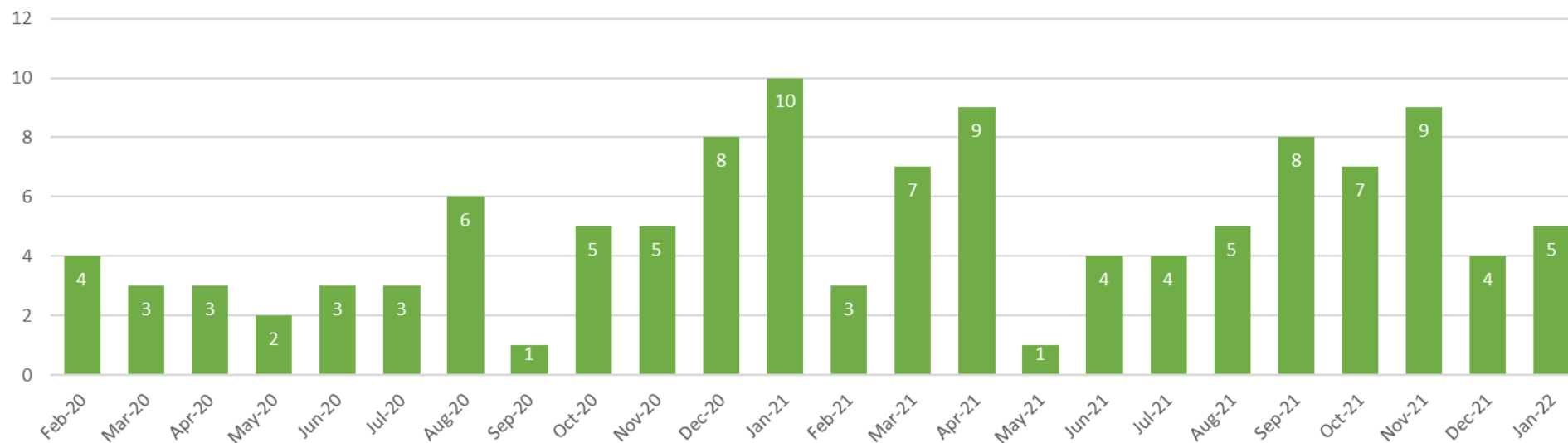


Self Assessment:
Strength of Internal
Control: Moderate

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Timely Care

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



Analysis

The percentage of responses to concerns declined in Jan-22 to 66%, compared to 70% in Dec-21, this continues to be lower than the Trust would like, this is the result of several factors, 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 decreased in Jan-22 (72) when compared to Dec-21 (75).

There were 5 SCIF forums held in Jan-22, during which 22 cases were discussed, 5 of these cases were reported to the Delivery Unit and 18 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 Mar-Apr-21 and through Sep-Nov-21 is concerning and has been linked to the significant delays across the system along with the continued levels of NRIs. In Jan-22 there was 2 NRIs relating to Red calls, 1 in relation to Amber calls and 2 NRIs prioritised Amber that 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 Jan-22 there was 1 complex case, however at the date of reporting this has not been referred to redress panel.

In Jan-22 503 patients waited over 12 hours an increase compared to 295 in Jan-20 and 183 in Jan-19.

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

Remedial Plans and Actions

A range of actions are in place:-

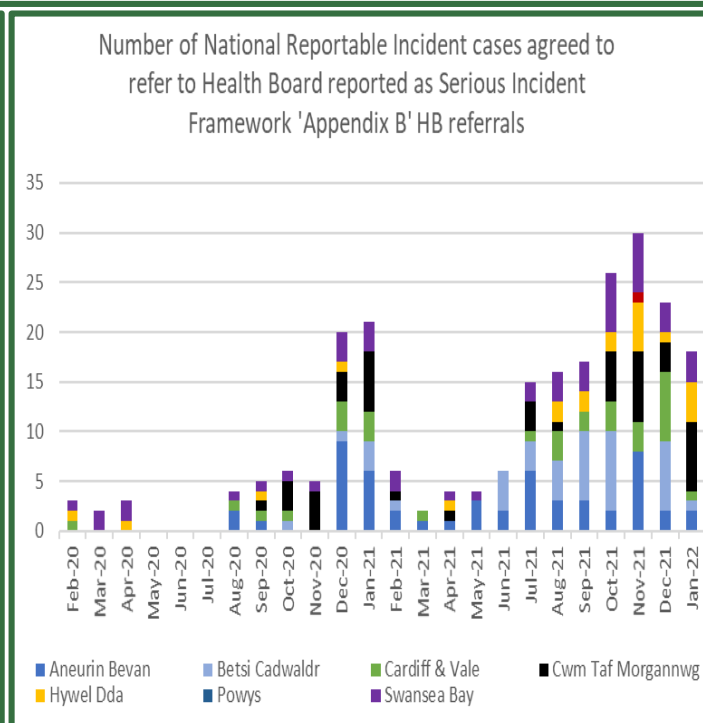
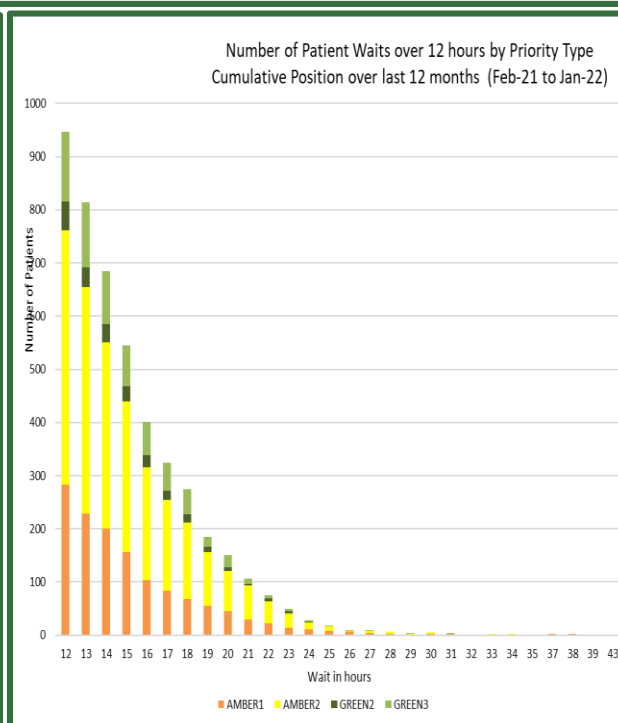
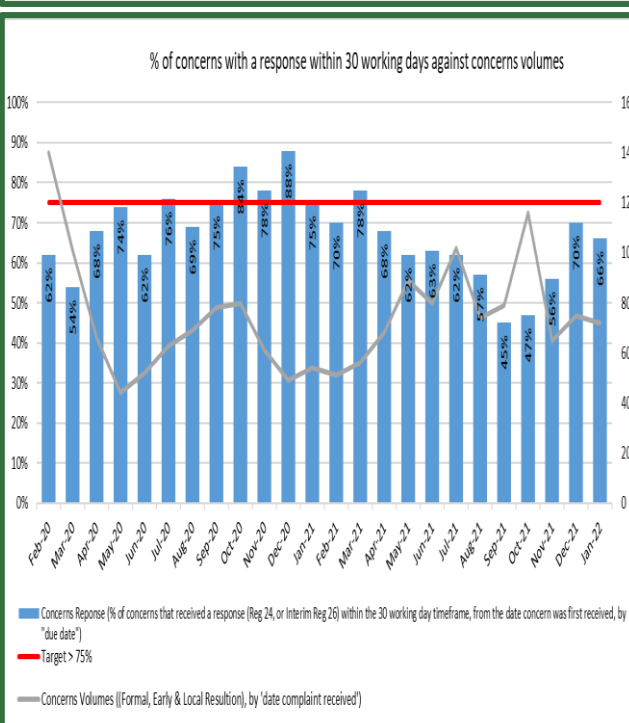
- The general theme in relation to the Trust's concerns portfolio is timeliness to respond.
- There is continued engagement with Health Boards in relation to Joint SI investigations where the primary causal factor is in relation to delayed handover.
- The Trust continues to draw the learning from our most serious incidents, in particular the issue surrounding 'ineffective breathing' descriptor.
- A 'deep dive' was undertaken in relation to the utilisation of Protocol 36 and following this no National Reportable Incidents had been raised or cases being discussed at SCIF.
- 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.

An action is underway to enable future reports to present current months redress and complex case panel figures.

Expected Performance Trajectory

The Trust expects that the upward (worsening) trajectory will continue as we move through the winter period; however, the support from the FRS and military may mitigate this.

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



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



(Responsible Officer: Wendy Herbert)

Welsh Ambulance Services NHS Trust



Our Patients: Quality, Safety & Patient Experience

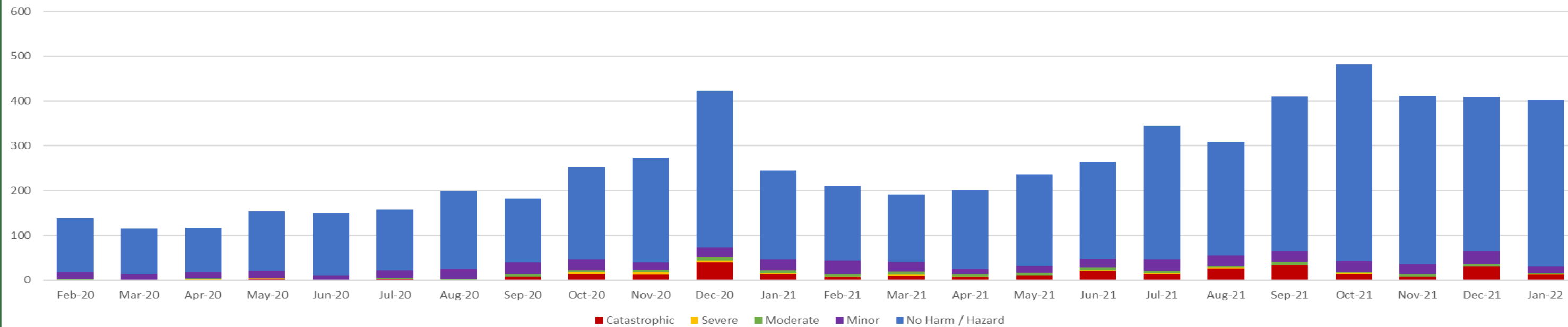
Patient Safety Indicators

Self Assessment:
Strength of Internal
Control: Moderate

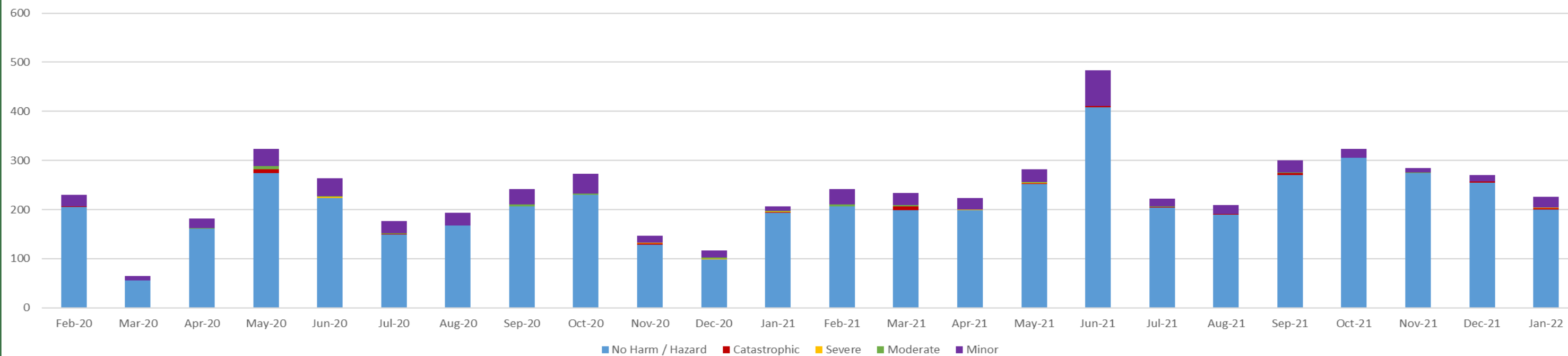
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Number of Incidents closed on Datix system within the reporting month, by harm grading (Volumes Received)



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



Analysis

Patient Safety: The number of patient safety adverse incidents submitted within Jan-22 decreased to 402,372 of these were in relation to incidents where there was no harm or hazard, 15 were minor, 1 was moderate, 2 were severe and 12 incidents were catastrophic. 227 cases were closed in Jan-22 in comparison to 275 in Dec-21.

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 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.

Performance

****NB: Jan-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)

Welsh Ambulance Services NHS Trust



Our Patients: Quality, Safety & Patient Experience

Coroners and Ombudsmen Indicators

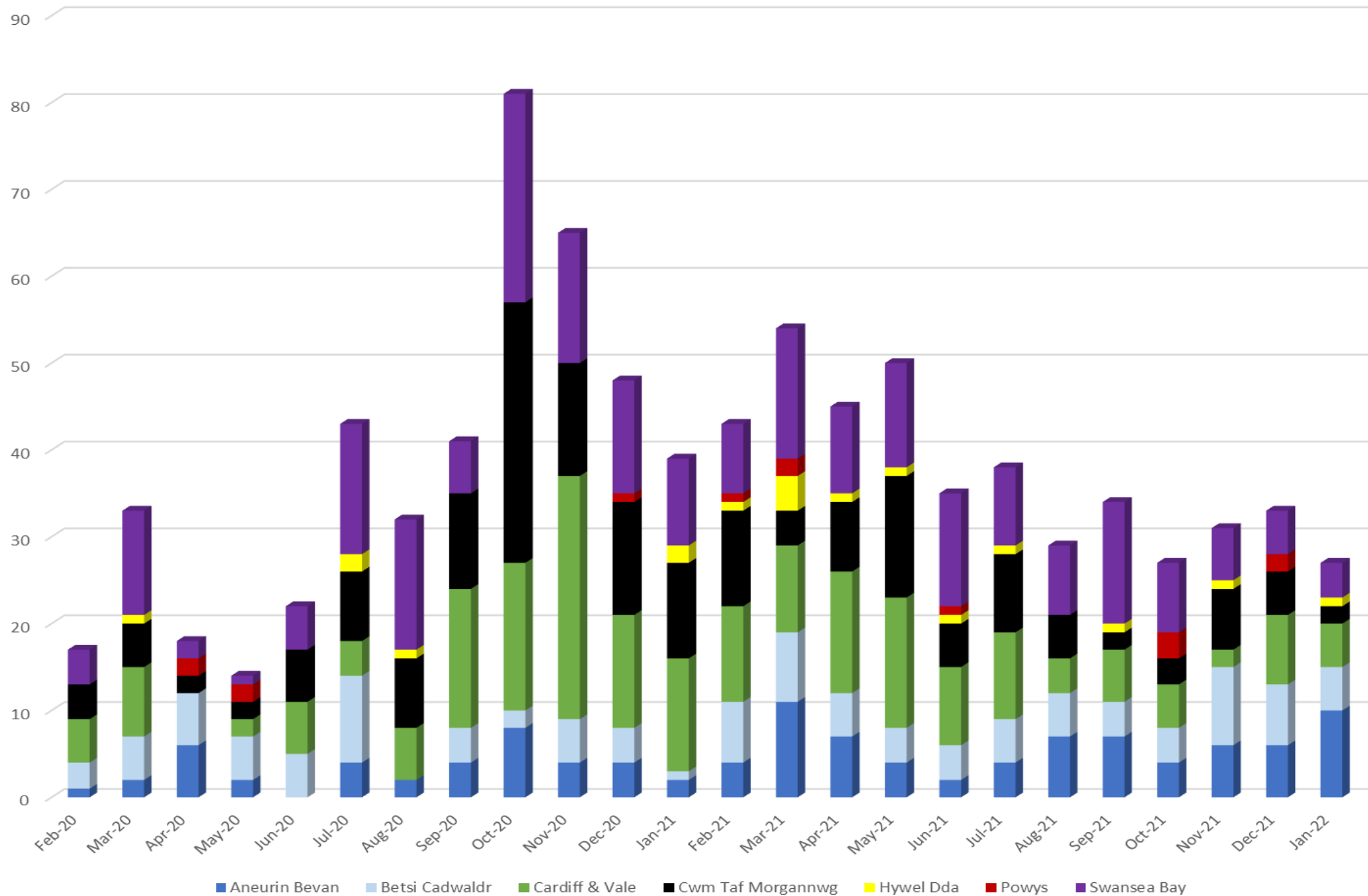
Self Assessment:
Strength of Internal
Control: Strong

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Number of Coroner Requests by Health Board



Analysis

Coroners: In Jan-22 there continues to be no Coroners Cases which resulted in ongoing Regulation 28 cases. The number of in month requests, although reduced from 2020, continue to be in excess of the 2019 December figures. The timeliness of our response and unexpected deaths continues to be the main themes. This month has seen a reduction in work on hand.

Ombudsman: There are currently 14 open Ombudsman cases in Jan-21. 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 remains 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



(Responsible Officer: Wendy Herbert)

Welsh Ambulance Services NHS Trust



Our Patients: Quality, Safety & Patient Experience

Safeguarding, Data Governance & Public Engagement Indicators

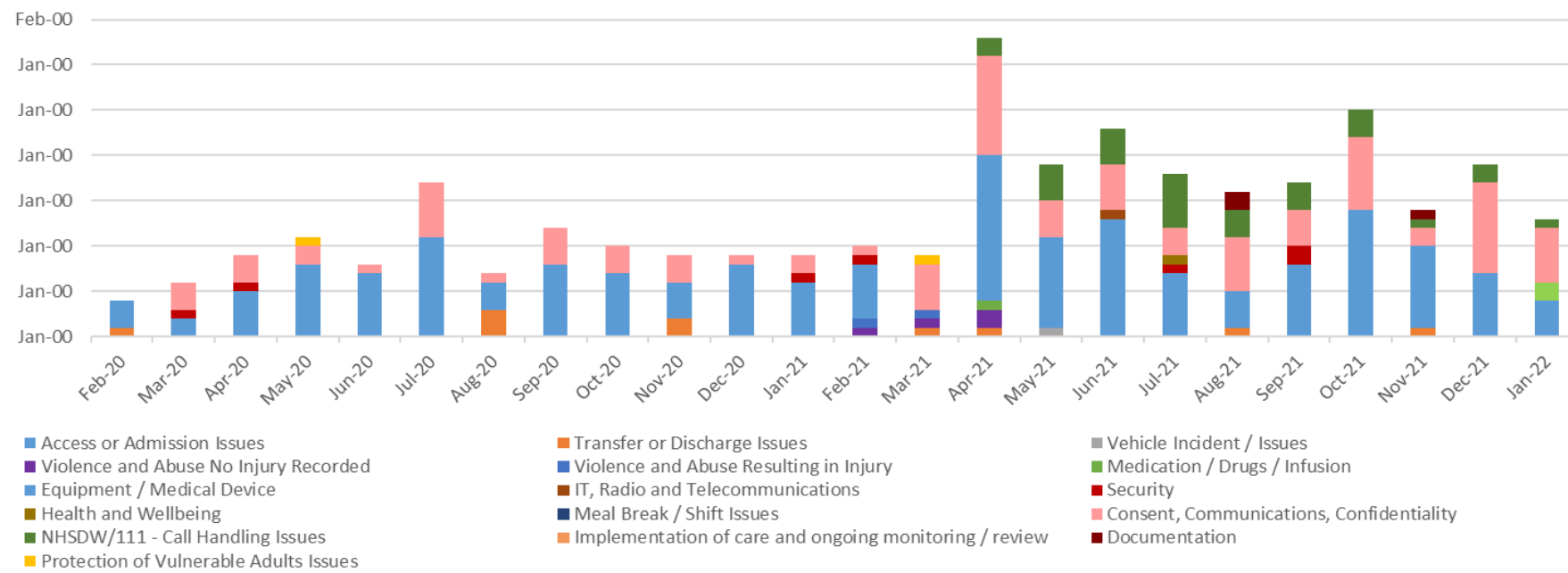
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Self Assessment:
Strength of Internal Control: Strong

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NB: Public Engagement next update (Jan-Mar-22) due Apr-22

Volume of High Level Breaches of the UK General Data Protection Regulation (GDPR) 2018



Analysis

Safeguarding: In Jan-22 staff completed a total of 99 Adult at Risk Reports, an increase compared to Dec-21 when 91 were reported. 92% of these were processed within 24 hours during Jan-22.

There have been 193 Child Safeguarding Reports in Jan-22, an increase from Dec-21 when 151 reports were made. In Jan-22 94% were sent within 24 hours.

Data Governance: In Jan-22 there were 13 information governance (IG) related incidents reported on Datix categorised as an Information Governance (IG) breaches, a decrease when compared to Dec-21. 6 related to Consent, Communications or Confidentiality; 4 related to Medical Devices or Equipment, 2 related to IT, Radio and telecommunications and 1 related to 111 Call Handling 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 were 41 engagement events held this quarter (October – December 21), allowing engagement with 1,119 people. Due to the return of many coronavirus restrictions, a majority of these events were held virtually, though some were attended in person before restrictions were re-introduced. 122 surveys relating to the NHS 111 Wales website were returned. Working with colleagues in the NEPTS Team 264 NEPTS patient experience surveys were returned. 158 compliments were also logged and processed. Engaging with people and communities has continued to be a priority for the PECEI Team, this engagement allows us to share important information about Welsh Ambulance services with communities and allows us to collect feedback and experiences from people which help us to understand if our services are meeting their needs and expectations.

Remedial Plans and Actions

Safeguarding: The Trust now primarily manages reports digitally via Docworks and since this move the majority of delays have been as a result of staff being unavailable during weekends and Bank holidays to forward the reports to local authorities. Commencing 08th Nov-21 any paper reports will be sent directly to the Safeguarding Team via email. With the launch of direct transfer the Trust expects to see an improvement.

Data Governance: During the reporting period of the 13 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 we began to see an easing of coronavirus restrictions which allowed us to start and make a return to face to face engagement; however, the emergence of the Omicron variant saw many restrictions re-introduced. To ensure the safety of our Team members and communities this means a majority of our engagement work will return to happening virtually using online and digital platforms. We have previously reviewed and updated our existing processes and risk assessments to incorporate coronavirus safety elements. We will continue to monitor the current coronavirus situation and will only attend engagement events in the community if we feel it is safe and appropriate to do so.

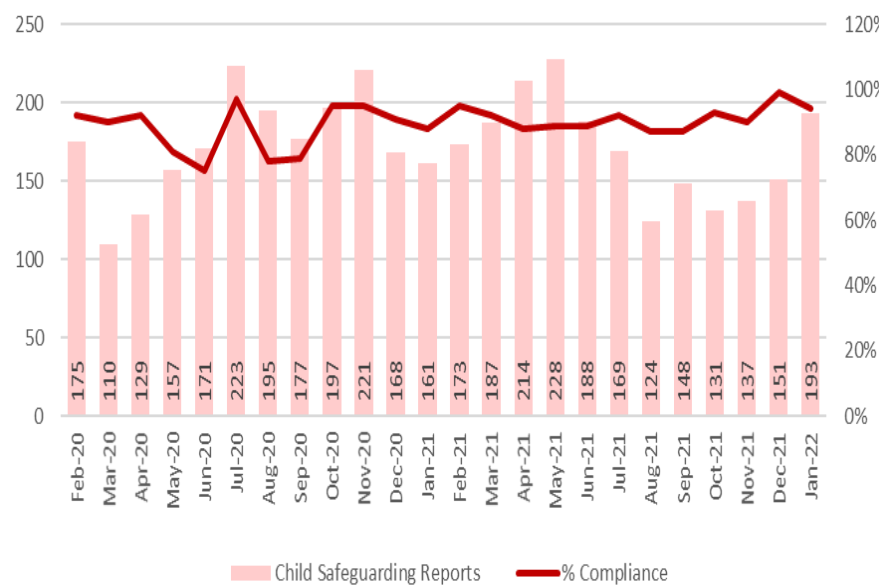
Expected Performance Trajectory

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

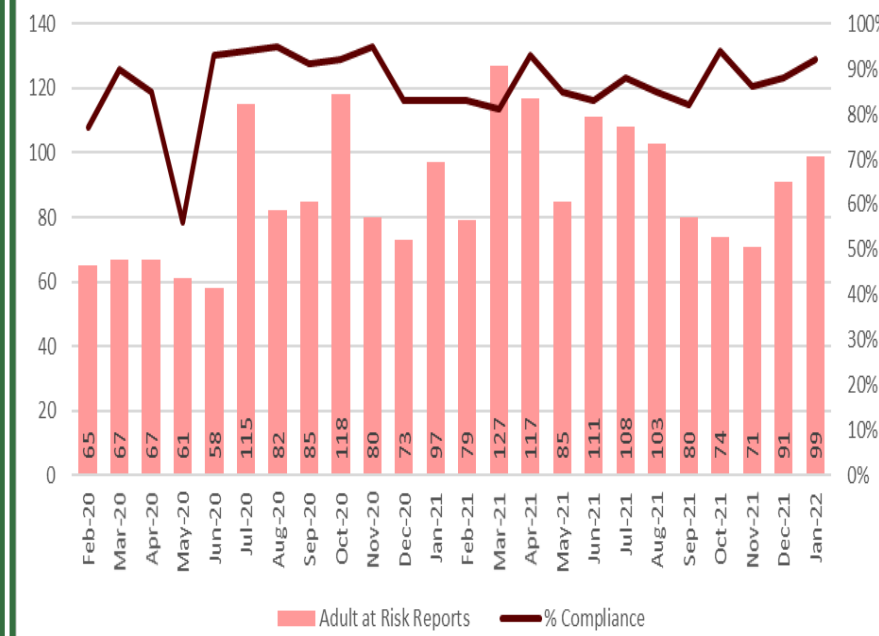
Data Governance: An annual assessment of compliance using the Welsh NHS IG Toolkit; an individual evidence based assessment consisting of 255 items will continue to be utilised to measure the Trust against National Information Governance and Security Standards. The next submission date for the IG Toolkit is due 31 Mar-21.

Public Engagement: The PECEI Team will continue to share good practice with health boards, other stakeholders and colleagues at Ambulance Services across the UK. We will continue to proactively communicate with people and communities, sharing important information about Trust services and using them appropriately during the current period of increased demand. With the Trust currently being at its highest escalation levels, all non-essential work will be being paused and some PECEI Team members will be offering support to the Operations Directorate.

Number and Percentage of Child Safeguarding Reports sent within 24 Hours



Number and Percentage of Adult at Risk Reports sent within 24 Hours



Safeguarding Data source: Doc Works



(Responsible Officer: Wendy Herbert)

Welsh Ambulance Services NHS Trust



Our Patients: Quality, Safety & Patient Experience

Health & Safety (RIDDORS) Indicators

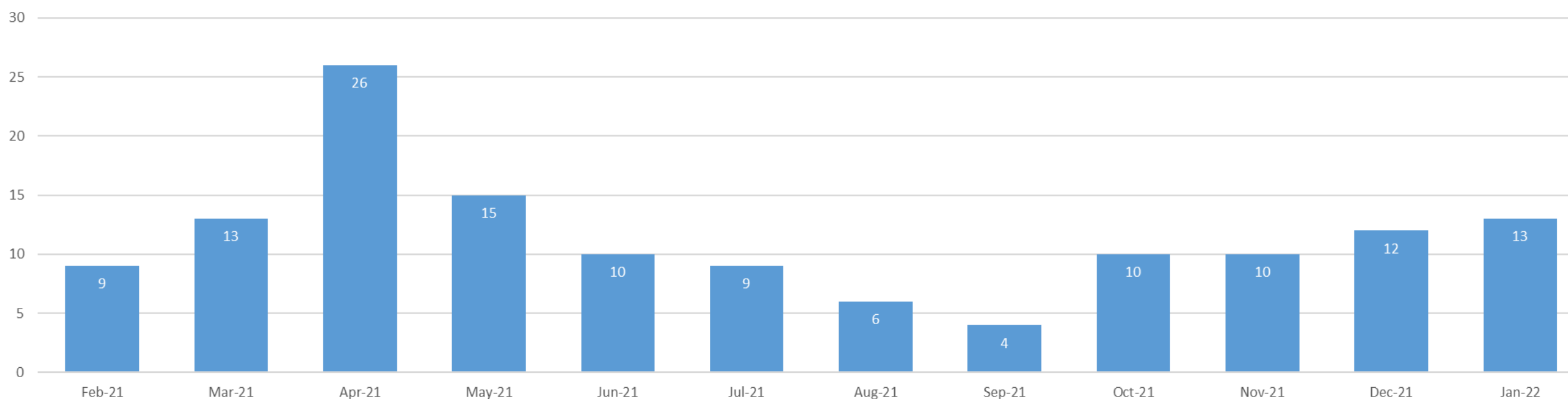
Self Assessment:
Strength of Internal
Control: Moderate

QUEST

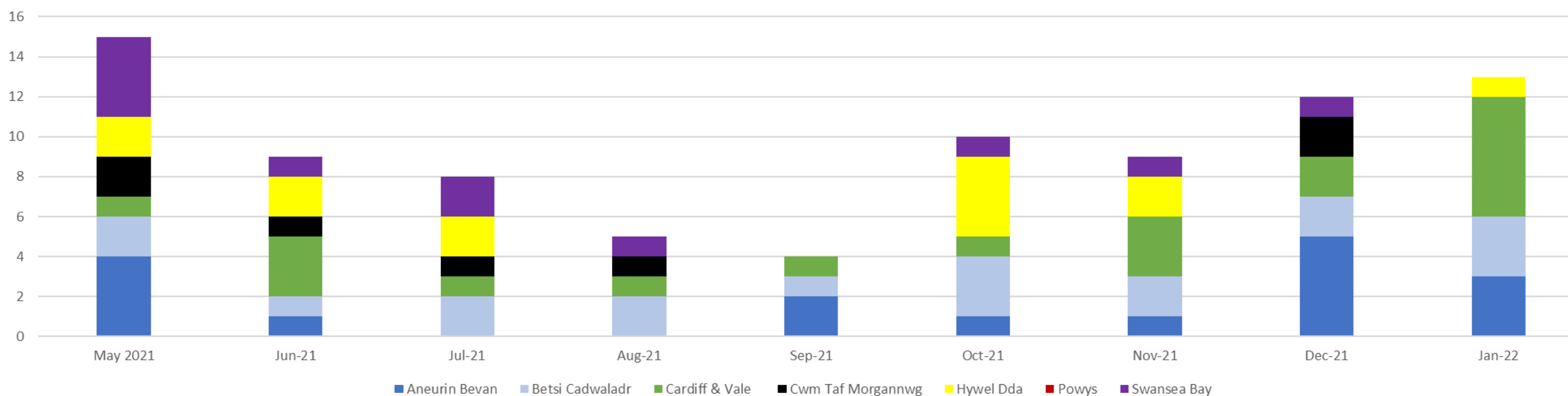
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Volume of RIDDOR Reports by Month



Volume of Riddor Reports by Health Board



Analysis

Whilst there is a strong level of internal control with respect to GL1 Metrics provided to the Health & Safety Executive (HSE), there are moderate levels of internal control. Challenges around obtaining staff details are impacting on timeliness of Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDORS) to the Health and Safety Executive (HSE). During Quarter 3 (Oct-Dec-21) there were no fines, prosecutions, HSE improvement or Prohibition notices.

In Jan-22 RIDDORS reported were for ABUHB (3), BCUHB (3), CVUHB (6) and HDUHB (1).

Remedial Plans and Actions

The Health & Safety Team has recently 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.

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 presented to Trust forums and ADLT endorsing the commencement of this action, 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 policies will be going through the Trust's policy approval process within the next couple of months

****NB: Jan-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)

Welsh Ambulance Services NHS Trust



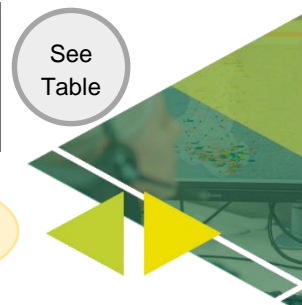
Our Patients: Quality, Safety & Patient Experience

Corporate Risk Indicators

Self Assessment: Strength
of Internal Control:
Moderate - Strong

See
Table

Health & Care
Standard
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CORPORATE RISK REGISTER: Summary

RISK ID	RISK	RISK CATEGORY	DIRECTORATE	CURRENT RISK SCORE	COMMITTEE
223	Unable to attend patients in community who require See & Treat (CRR58)	Service Delivery	Operations Directorate	25 (5x5)	Quality, Patient Experience and Safety Committee
224	Patients delayed on ambulances outside A&E Departments (CRR57)	Quality & Safety	Operations Directorate	25 (5x5)	Quality, Patient Experience and Safety Committee
199	Compliance with Health and Safety legislation	Statutory Duties	Quality, Safety & Patient Experience	20 (4x5)	Audit Committee; Quality, Patient Experience and Safety Committee
244	Impact on EMS CCC service delivery due to estates constraints	Service Delivery	Operations Directorate	20 (5x4)	Finance and Performance Committee
316	Increased risk of personal injury claims citing COVID exposure	Statutory Duties	Quality, Safety & Patient Experience	20 (5x4)	Quality, Patient Experience and Safety Committee

Analysis

The Assistant Directors Leadership Team (ADLT) reviewed the existing and proposed new corporate risks during the last quarter. The full Corporate Risk Register will be presented to Trust Board on 27th January 2022.

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.

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:

- QuEST Committee: 16th November 2021
- Finance and Performance Committee: 18th November 2021
- People & Culture Committee: 30th November 2021
- Audit Committee: 2nd December 2021

A full review of the data stored within the Corporate Risk register is currently undergoing a full review.

NB: Next Update (Jan- Mar-22) due Apr-22

Data source: Electronic Risk Register



(Responsible Officer: Wendy Herbert)

Welsh Ambulance Services NHS Trust



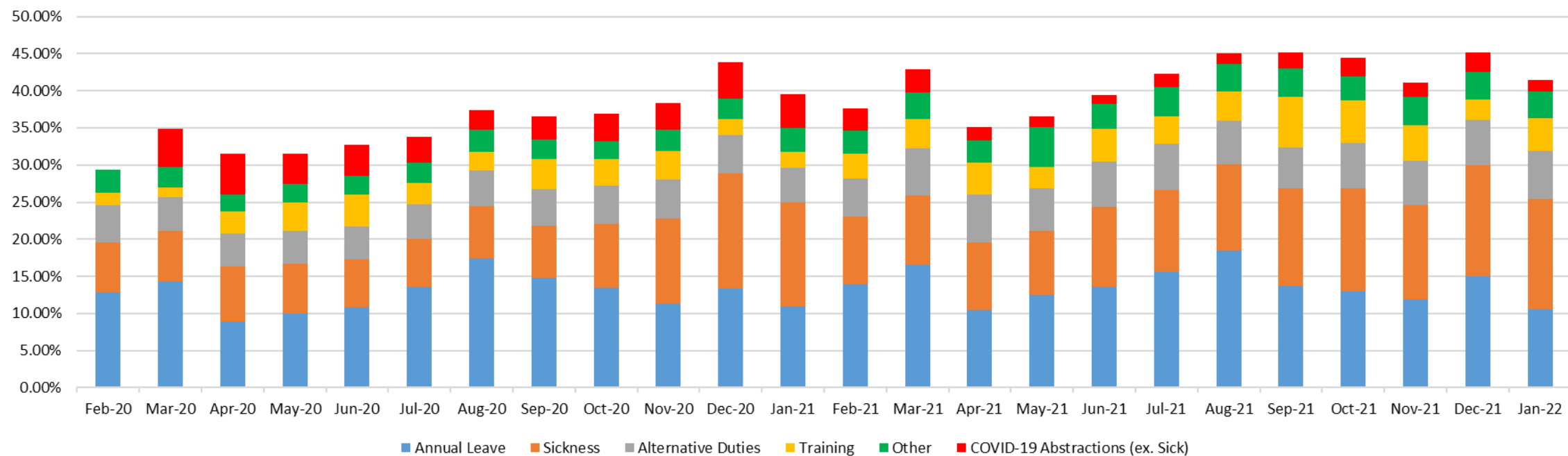
Our People

Ambulance Abstractions and Production Indicators

Abstractions **R** EA Production **G**

CI PCC
FPC

Pan Wales EMS Total Rota Abstraction Hours



Analysis

As shown in the top graph, monthly abstractions from the rosters are key to managing the number of hours we produce. In Jan-22, total abstractions stood at 41.44%. 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 sickness at 14.88% and Annual Leave at 10.59%. Sickness abstractions for Jan-22 were higher than the previous year (13.97%); however, CoVID-19 related abstractions decreased in Jan-22 when compared to Jan-21 accounting for 1.52% of overall abstractions.

Emergency Ambulance Unit Hours Production (UHP) was 106% in Jan-22 (82,936 Actual Hours), achieving the 95% benchmark. RRV UHP achieved 84% (16,821 Actual Hours) compared to 74% in Dec-21. The total hours produced is a key metric for patient safety (included on slide 7 red performance). In Jan-22 the Trust produced 127,780 hours, but the graph shows that even despite significant funding for increased substantive numbers of staff, total hour produced has not risen sustainably. From mid-Oct-21 Military support was re-introduced, and currently (from 05-Jan 22) 251 military personnel are providing support, this will now be phased out through a transition plan in preparation for it ceasing on 31 Mar-22.

The Trust de-escalated to REAP 3 on 18 Jan-22, however the Pandemic Plan Response Posture introduced on 20 Dec-21 remains in place. The Trust has introduced 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.

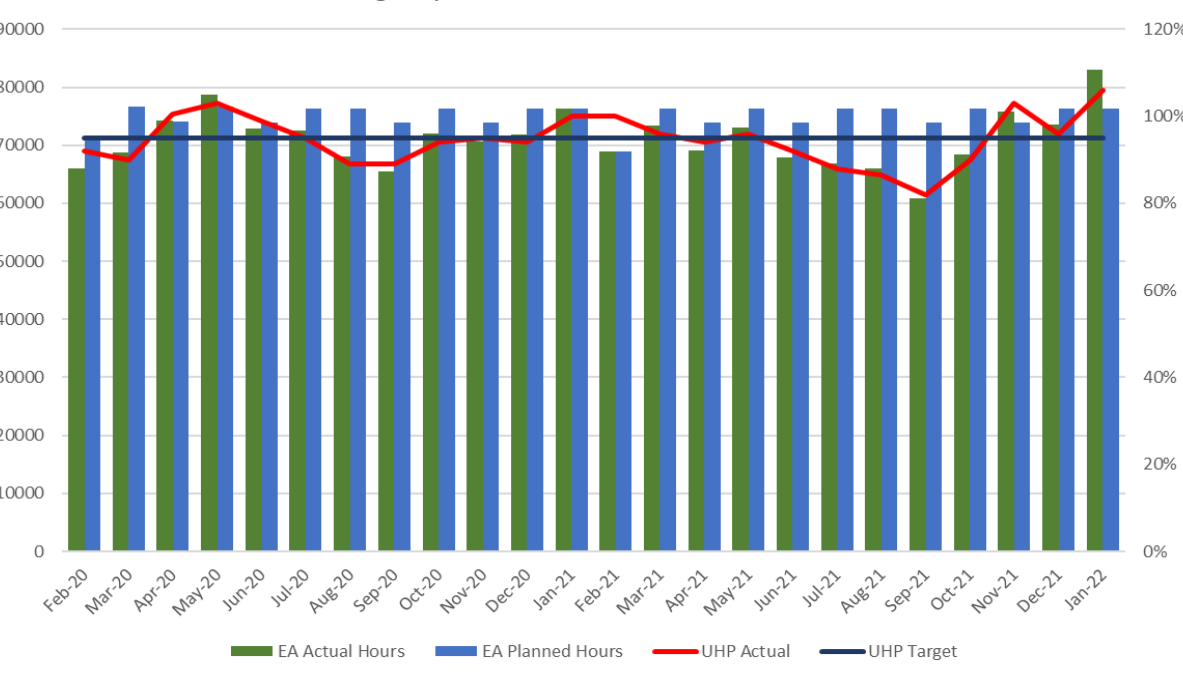
Remedial Plans and Actions

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 127 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.

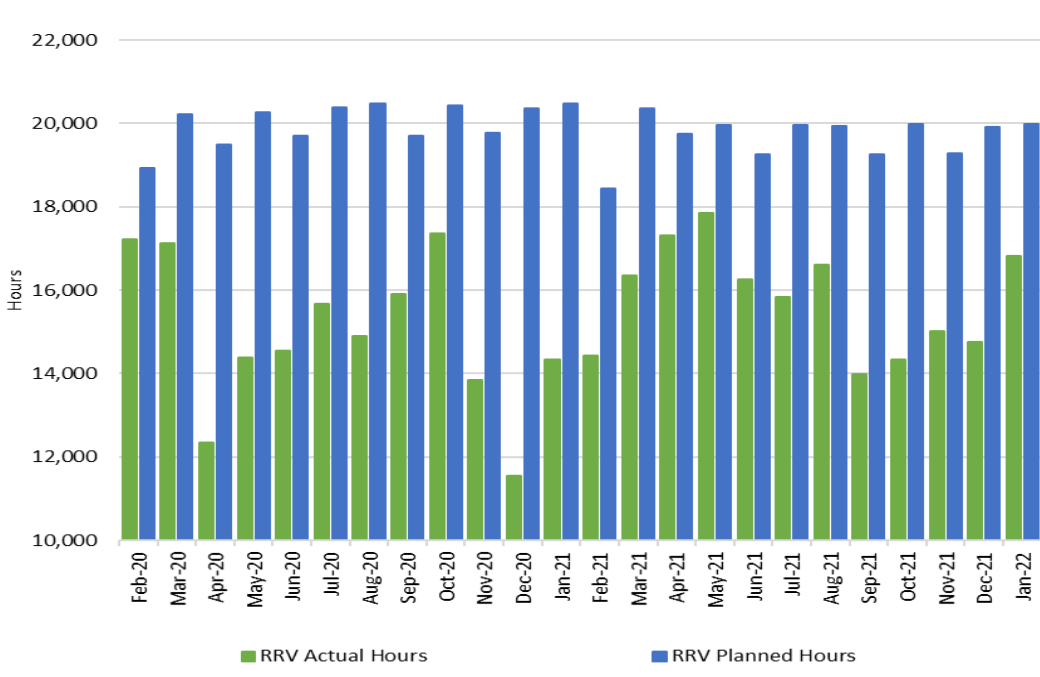
Expected Performance Trajectory

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 proposing, as part of the Transition Plan, that a higher level of abstractions (and relief) is used.

Emergency Ambulance Unit Hours Production



RRV Hours Planned vs Actual



(Responsible Officer: Lee Brooks)

Welsh Ambulance Services NHS Trust



Our People Sickness Absence Indicators



NB: Jan-22 data not yet available to report

Analysis

The monthly sickness absence figure for Dec-21 was 12.45%, an increase of 1.37% from last month; however, sickness levels are the highest recorded in a 5 year period with increases in both short term and long term absence.

- Considerable increase in Covid absence during the Omicron wave
- Chest & respiratory problems highest reason for absence in December
- Stress and Anxiety rates have lowered compared to November
- 40 cases of Long Covid

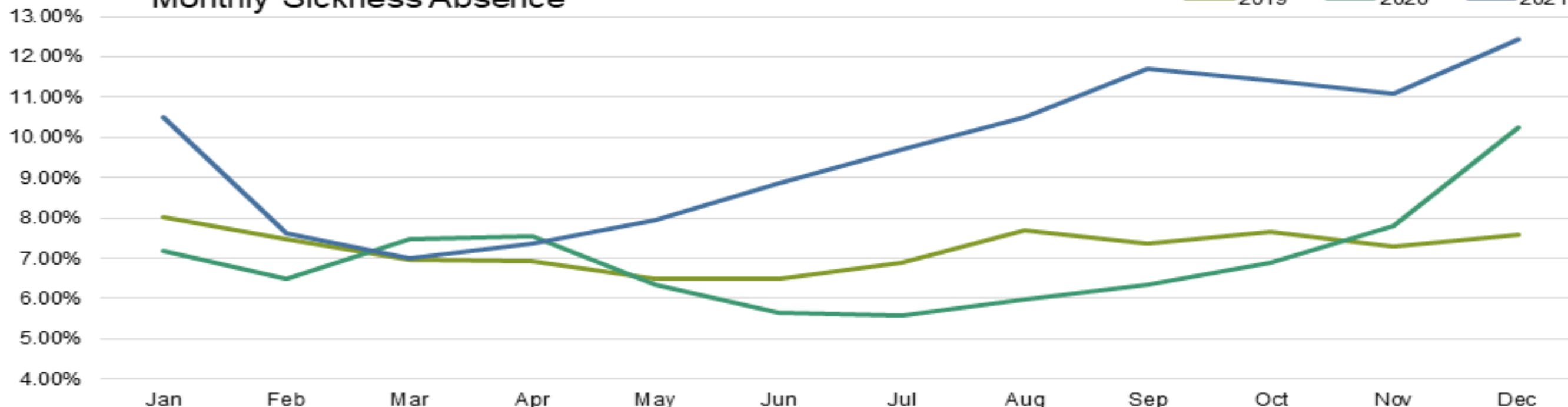
Remedial Plans and Actions

- The restructuring of the Operations Directorate on ESR has seen Integrated Care (NHSD111) and EMS Co-ordination (CCC) rise above EMS i.e. the sickness rate when combined.
- Physiotherapy referrals remain stable at 27 referrals for this month, with 37% off work at time of referral. Majority of referrals were for back symptoms. Referrals to our EAP were reduced against November, to 54 calls, however the need for counselling sessions rose by 9%

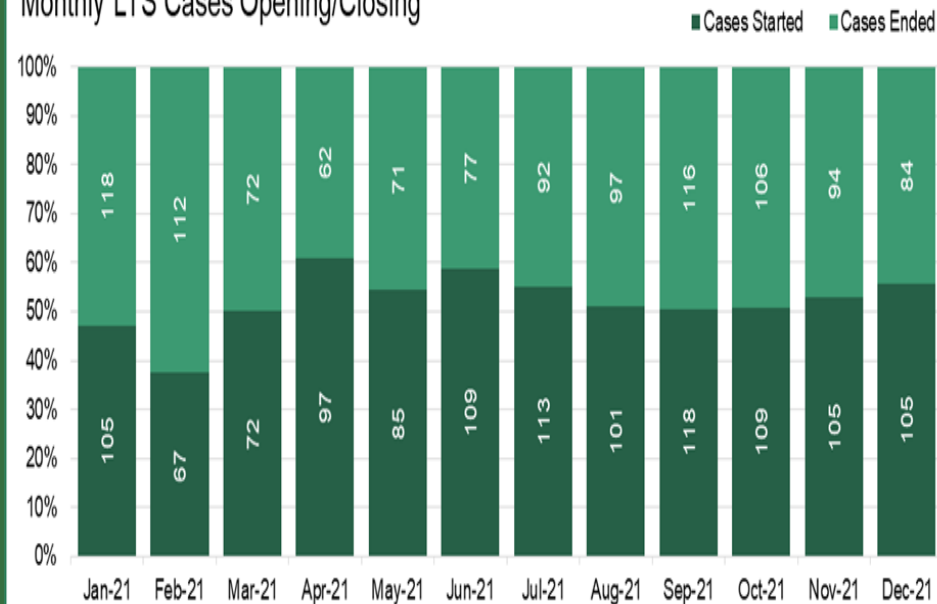
Expected Performance Trajectory

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.

Monthly Sickness Absence



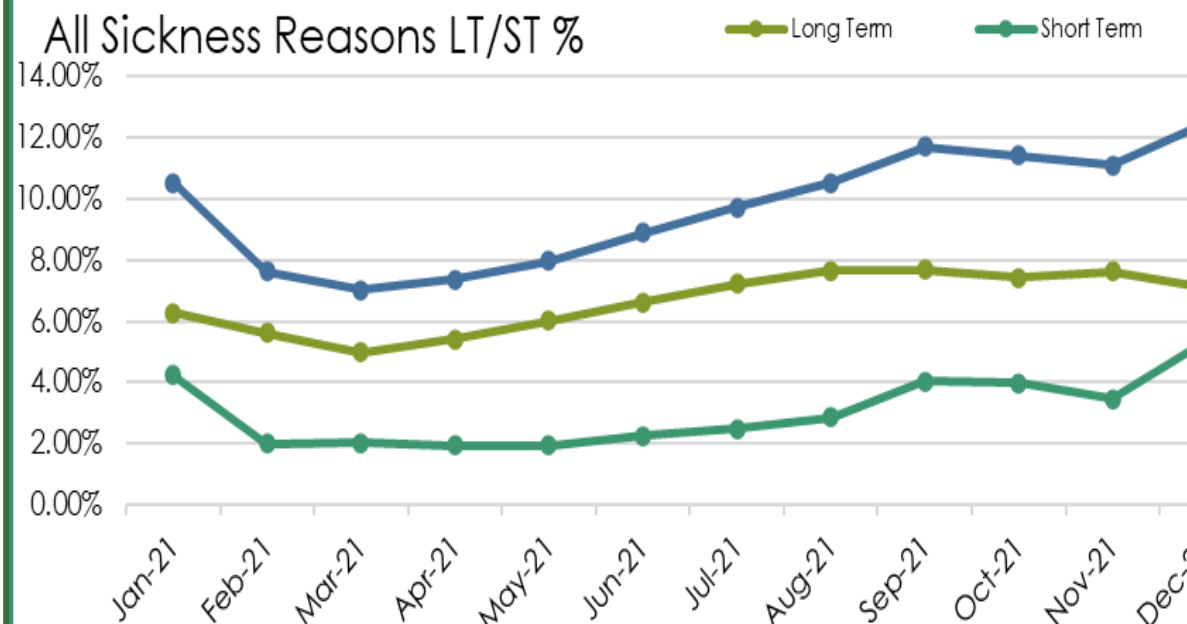
Monthly LTS Cases Opening/Closing



Average working days lost per FTE

Annual	
22.16 days	
Single month Absence %	
12.45%	
Long Term	Short Term
7.06%	5.39%
Mental Health	Other MSK
(S10 Stress/Anxiety)	(excluding Back)
2.61%	1.58%

All Sickness Reasons LT/ST %



(Responsible Officer: Claire Vaughan)

Welsh Ambulance Services NHS Trust



Our People Staff Vaccination Indicators

Self Assessment:
Strength of Internal
Control: Moderate

Flu
R

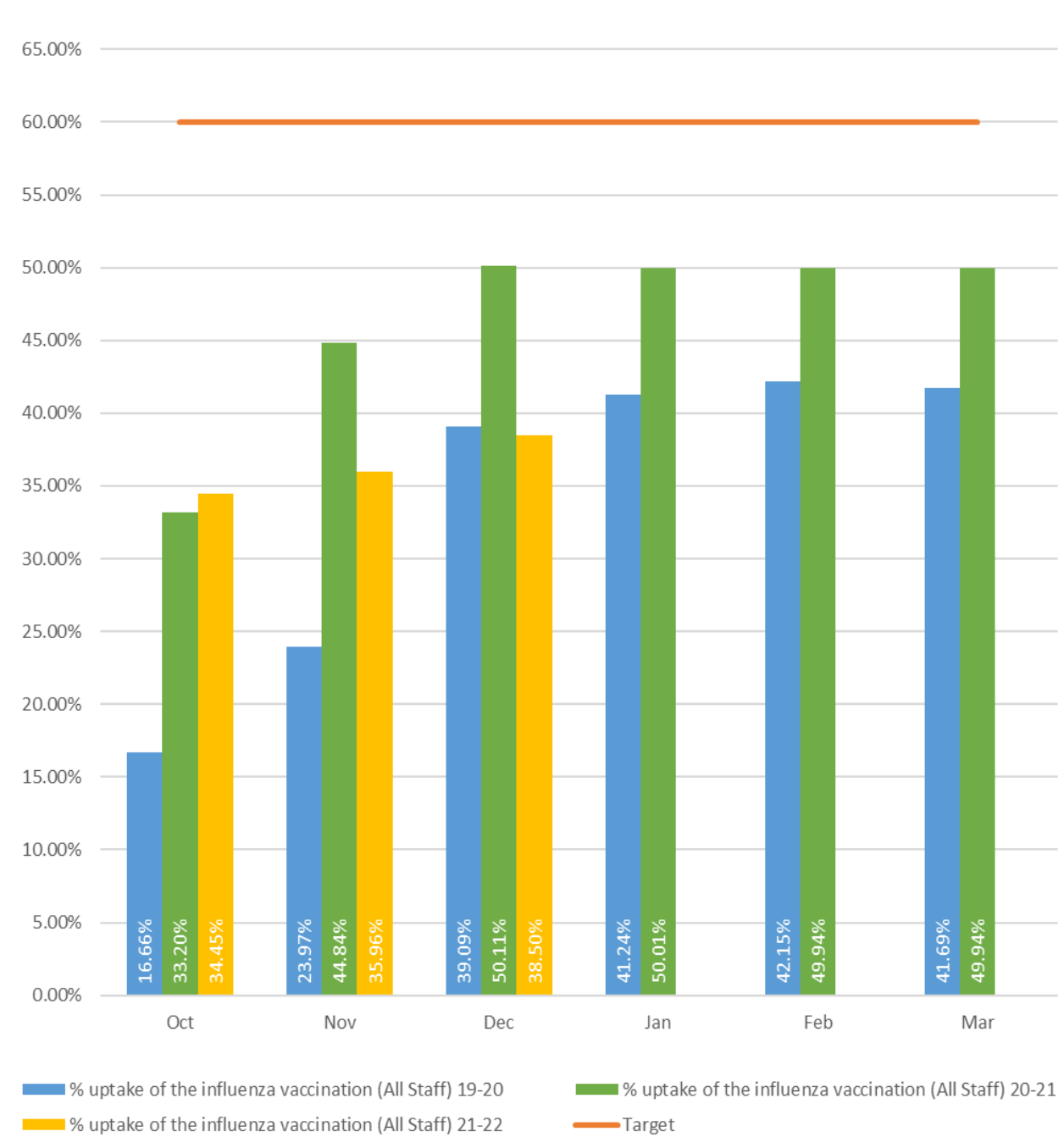
CI

PCC

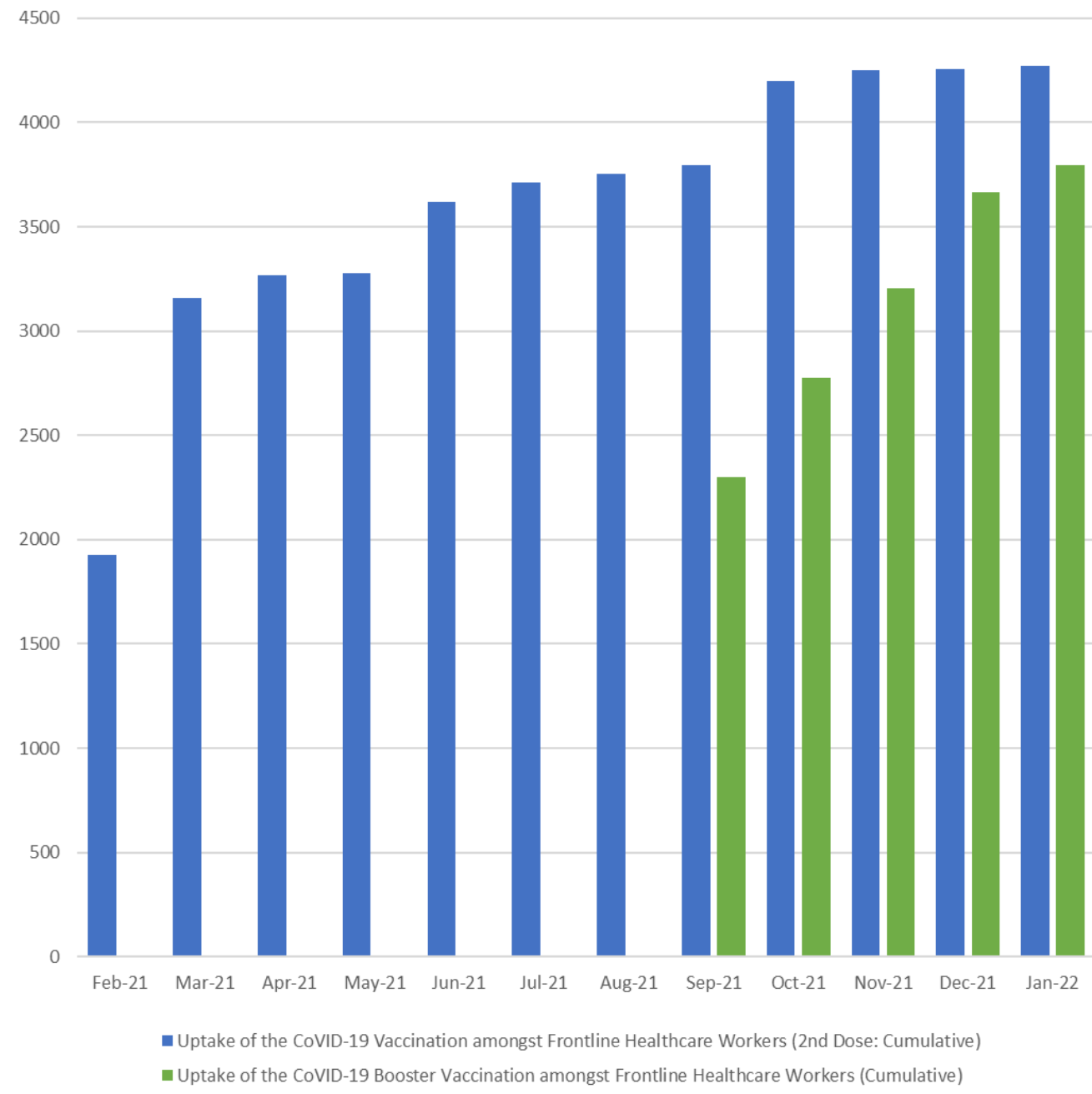
Health & Care
Standard
- Health (PPI)



% Uptake of the Influenza Vaccination amongst Healthcare Workers who have Direct Patient Contact



Uptake of the CoVID-19 Vaccination Programme Amongst Frontline Healthcare Workers (Cumulative)



Analysis

The 2021-22 flu campaign got underway in Oct-21 and as indicated in the graph to the left 38.50% of EMS (response) and NEPTS staff. received a vaccination.

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% (4,270) have received a second dose and 94% (3,795 Staff) have received a booster vaccination. In addition 94% of volunteers have received a first dose vaccination, 93% have received a 2nd dose and 1.4% 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.

NB: Flu Vaccines reports 1 month in areas therefore Dec-21 data provided

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



(Responsible Officer: Claire Vaughan)

Welsh Ambulance Services NHS Trust



Our People

PADR and Training Rates Indicators

R

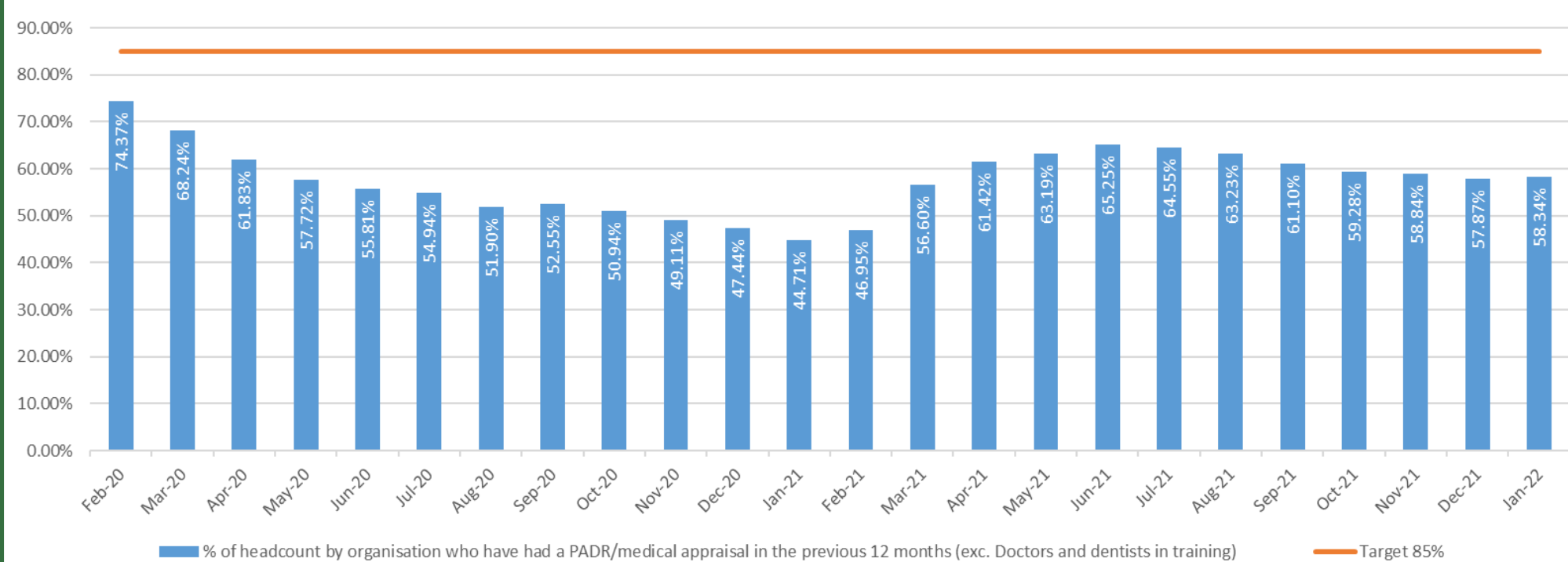
Self Assessment:
Strength of Internal
Control: Strong

CI

PCC

Health & Care
Standard
Health – Staff &
Resources

% of headcount by organisation who have had a PADR/medical appraisal in previous 12 months



Analysis

PADR rates for Jan-22 remained largely static at 58.84% but continue to remain below the 85% target. Jan-22 Statutory & Mandatory Training rates increased by 0.08% from the Dec-21 figure but still remains under the 85% target. Fire Safety (60.60%), Information Governance (82.64%) and Moving & Handling (71.91%) all failed to achieve the 85% target; however Safeguarding Adults (85.92%) achieve the target again in Jan-22.

In Dec-21 Band 6 Paramedic Competency rates are 83.92% for year 1, 78.41% for year 2 and 62.12% for year 3. These figures exclude newly qualified Paramedics and staff on Long-Term Sickness and Maternity. (No Jan-22 update available)

There are currently 2 (13 for Admin & Clerical Staff) Statutory and Mandatory courses that all NHS employees must complete in their employment. These include:

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

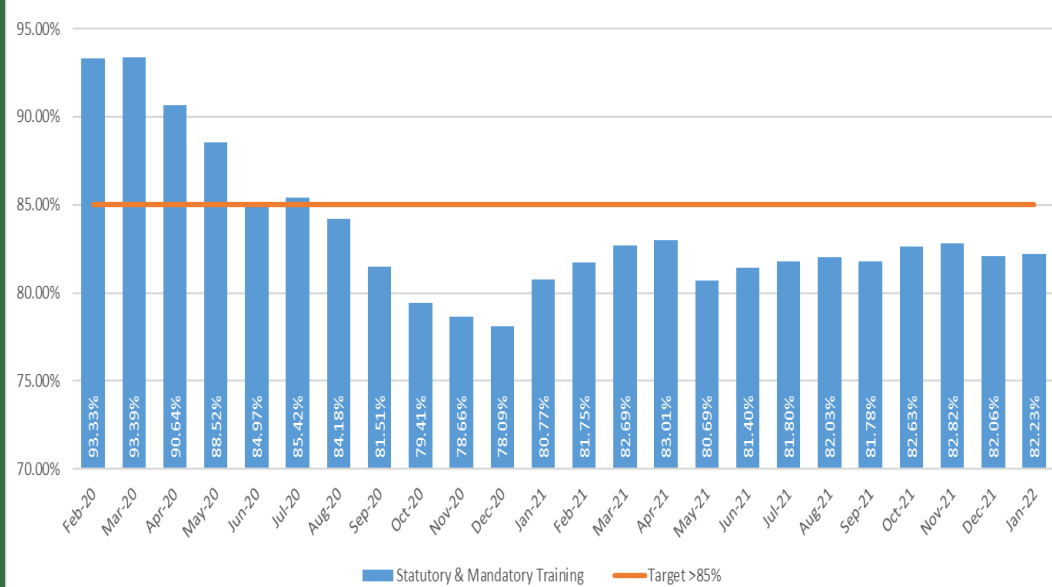
Remedial Plans and Actions

The Learning and Development team will continue to utilise targeted communication via Siren and Yammer using the #WASTMakItHappen tagline to reinvigorate My Learning on ESR for Corporate Compliance. In addition, meetings are ongoing with the Ambulance Response Team to highlight compliance rates for Frontline staff and continue to monitor. CPD is supported by the ESR Team and user guides, and other supportive information is available through the WAST intranet and via the WAST Facebook page.

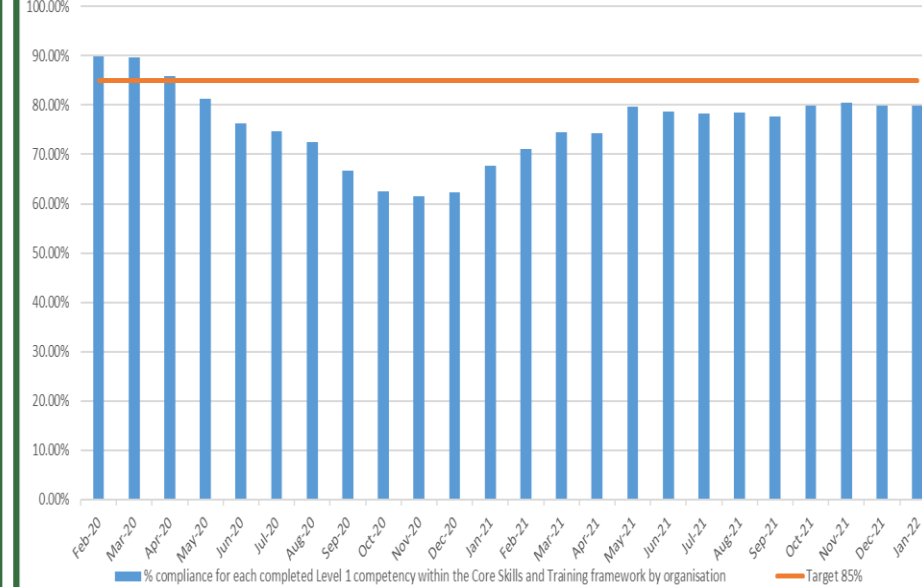
Expected Performance Trajectory

The outlook for 2021 is unclear, a third wave of the CoVid-19 pandemic has resulted in the Trust again moving out of the Monitor Phase and again into a Response Phase resulting in increased pressures in the work environment and less opportunity for training and development.

% Compliance Statutory and Mandatory Training (10 CSTF Modules)



% compliance for each completed Level 1 competency within Core Skills & Training framework



Data source: ESR



(Responsible Officer: Claire Vaughan)

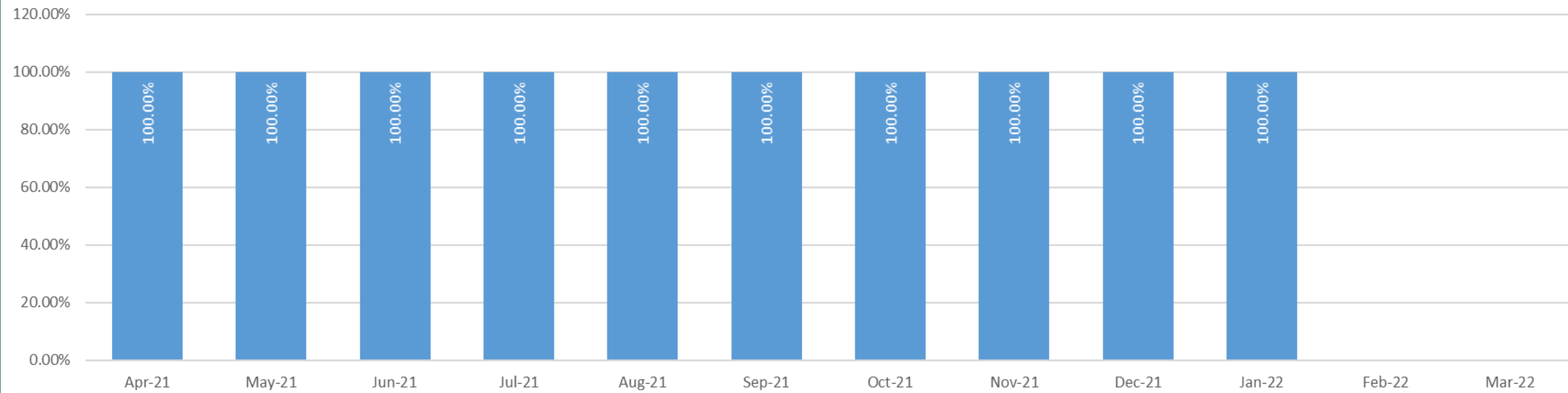
Welsh Ambulance Services NHS Trust



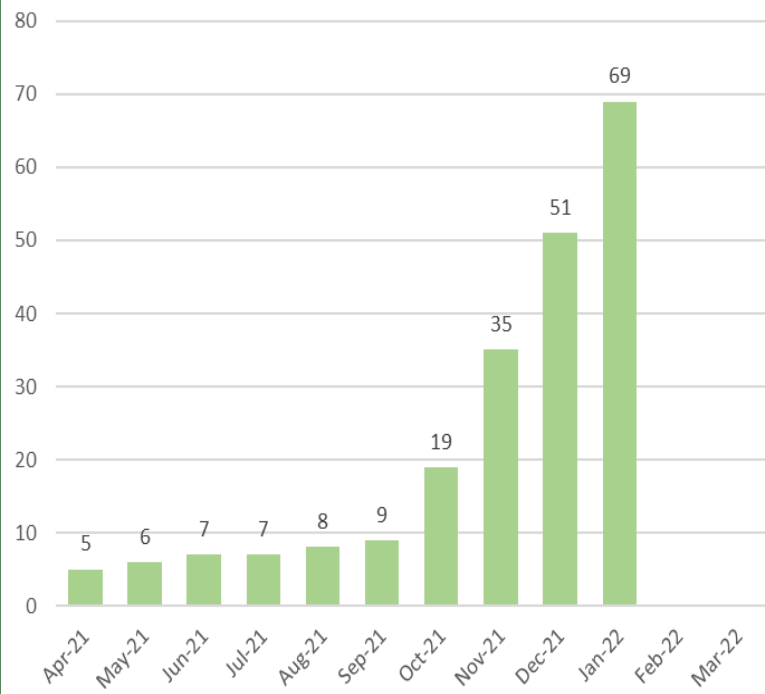
Finance and Value Finance Indicators



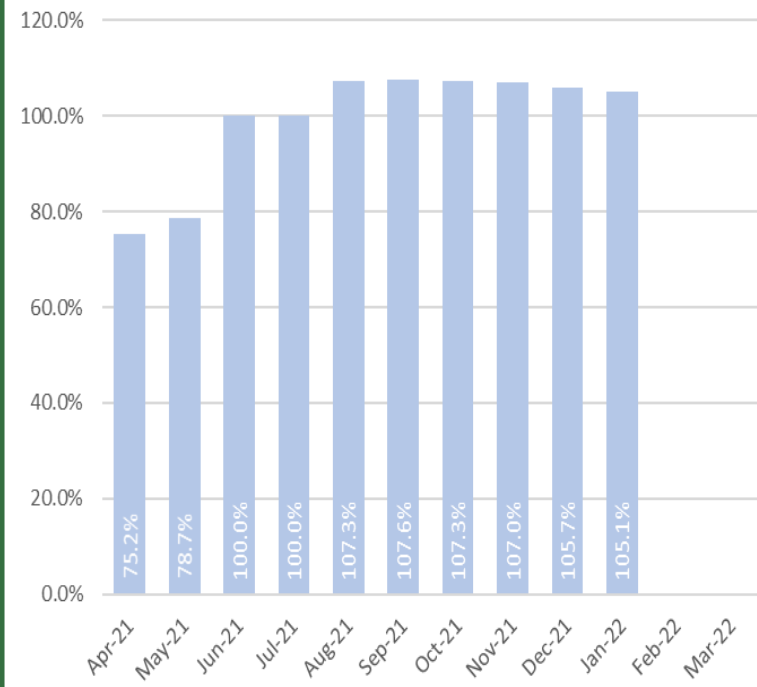
Financial balance - annual expenditure YTD as % of budget expenditure YTD



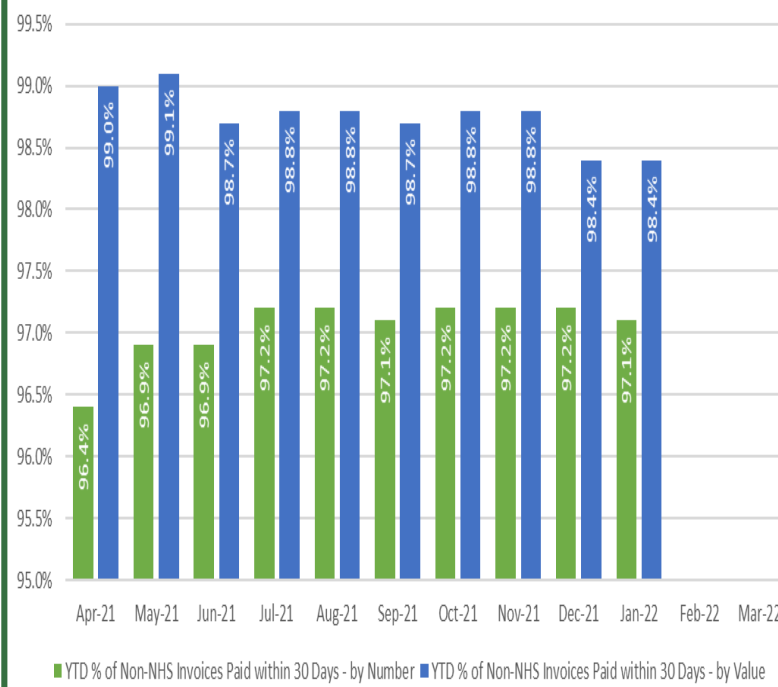
Actual Trust Surplus/(Deficit) YTD - £000



Actual Savings YTD as % of Planned Savings YTD



YTD % of Non NHS Invoices Paid Within 30 Days - By Number & Value



Analysis

As of Jan-22 the reported outturn performance at month 10 is a surplus of £69k.

For month 10 the Trust is reporting planned savings of £2.506m and actual savings of £2.634m, an achievement rate of 105.1%.

Cumulative performance against the Public Sector Purchase Programme (PSPP) as of Jan-22 was 97.1% against a target of 95%.

As of Jan-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 2021-24 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 current 2021-24 plan is in development.

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 2021/22 financial plan include:

- Continuing financial support from Welsh Government in relation to Covid pandemic costs which may persist at a significantly material level into the winter period and beyond;
- 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 2021/22.



(Responsible Officer: Chris Turley)

Welsh Ambulance Services NHS Trust

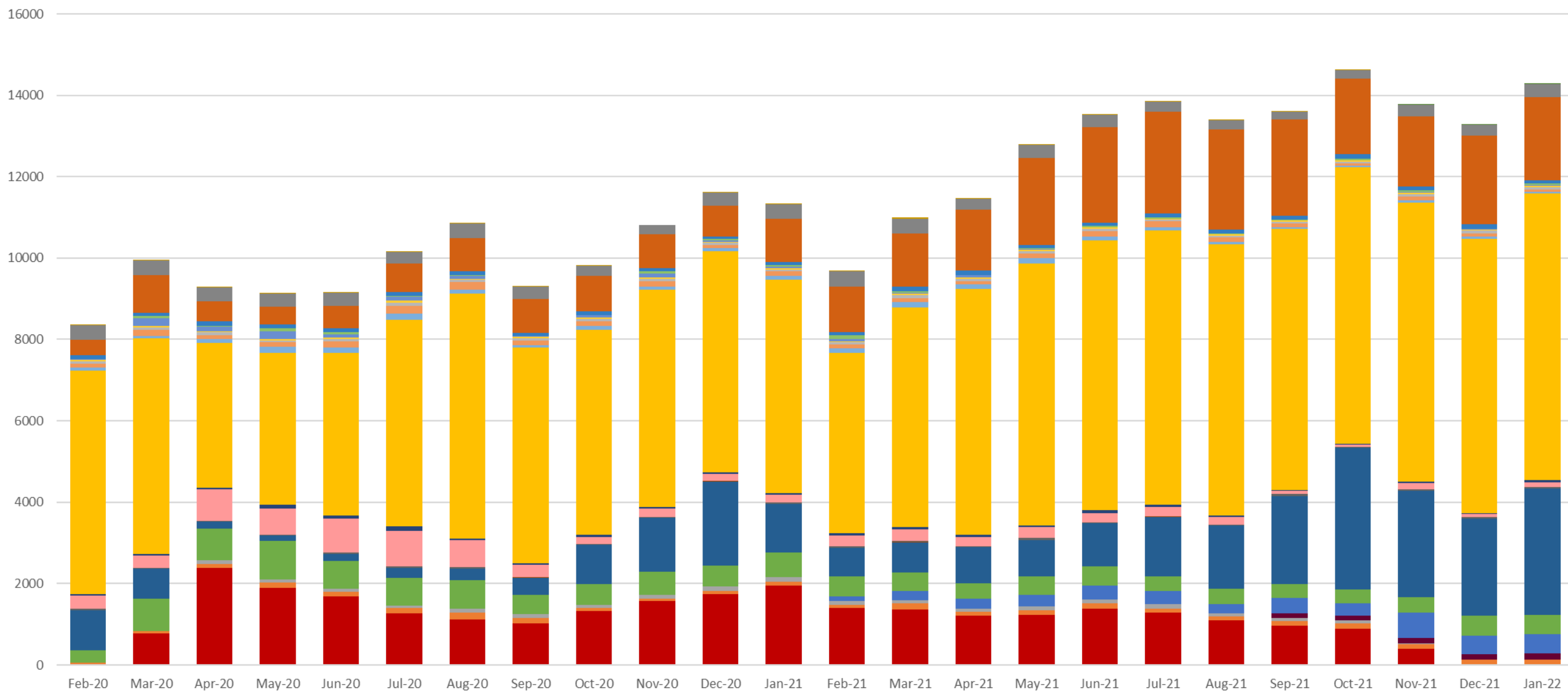


Value / Partnerships & System Contribution

EMS Utilisation & Post Production Lost Hours Indicators



Post Production Lost Hours - By Unavailability Reason



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

Analysis
 There were 17,106 hours lost in Jan-22; of this 14,279 were to APP, EA, RRV and UCS vehicles which continues to show high levels compared to previous months (PPLH). The highest number of hours were lost to EA vehicles, accounting for 10,969 in Jan-22.

In Jan-22 hours lost through PPLH can be down to numerous factors, including, but not limited to Return to Base, Meal Breaks (7,043 Hours), HALO duties (3,109 hours) and Vehicle cleaning (2,033 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.

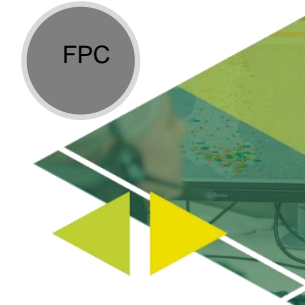
Remedial Plans and Actions
 This is currently an area of focus via a series of workshops with TU Partners, which commenced in Sep-21. The current focus continues to be on data accuracy, modelling of options and potential tests of change.

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.

****NB: PPLH Data correct at time of extract 10/02/22**

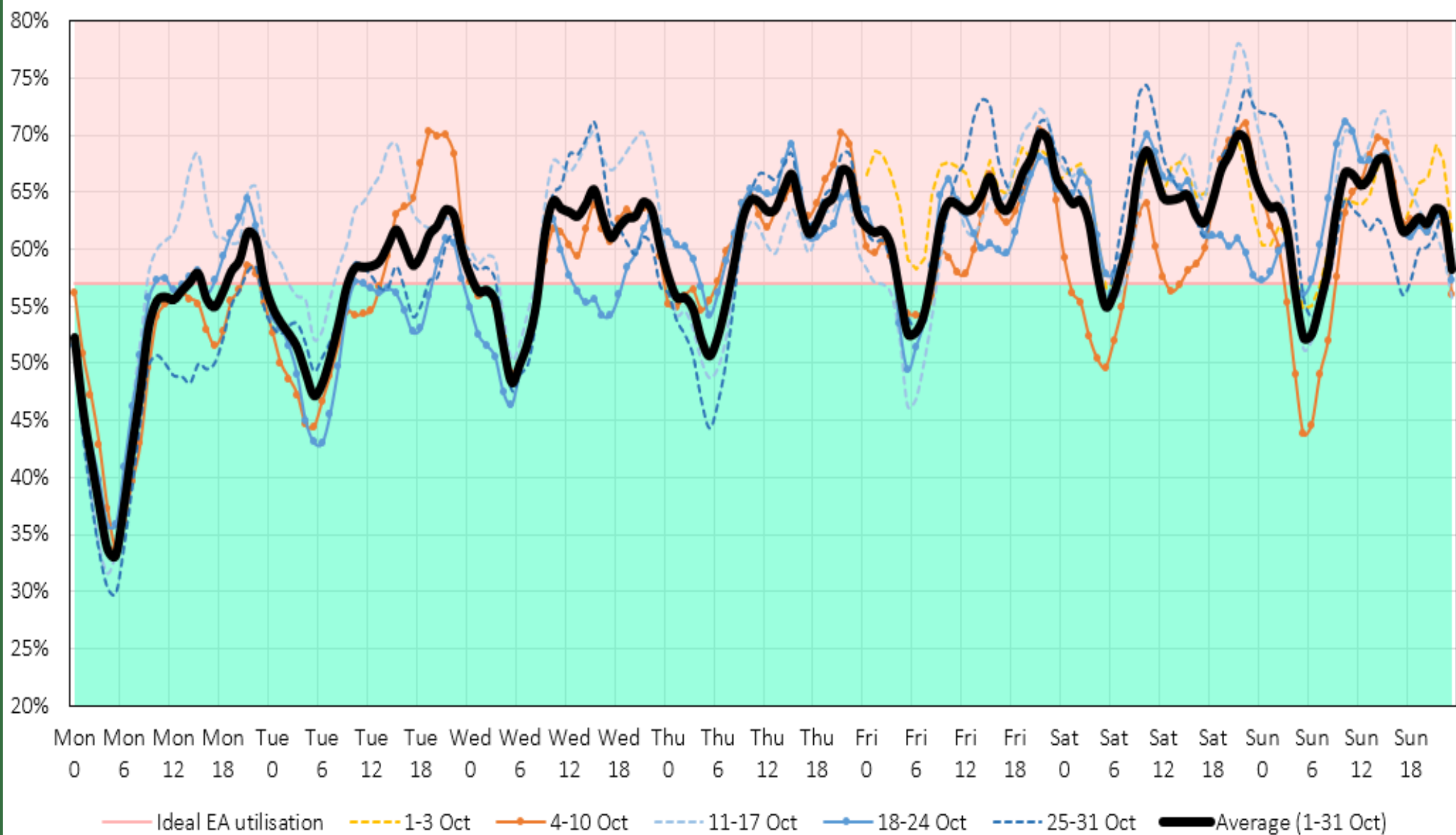


Value & Partnership Contribution Utilisation Indicators



Slide Under Development to provide Net Utilisation – No Update available

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



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

The Trust expects utilisation to improve as more hours are put into the system, however this is being offset by current handover levels.



(Responsible Officer: Lee Brooks)

Welsh Ambulance Services NHS Trust



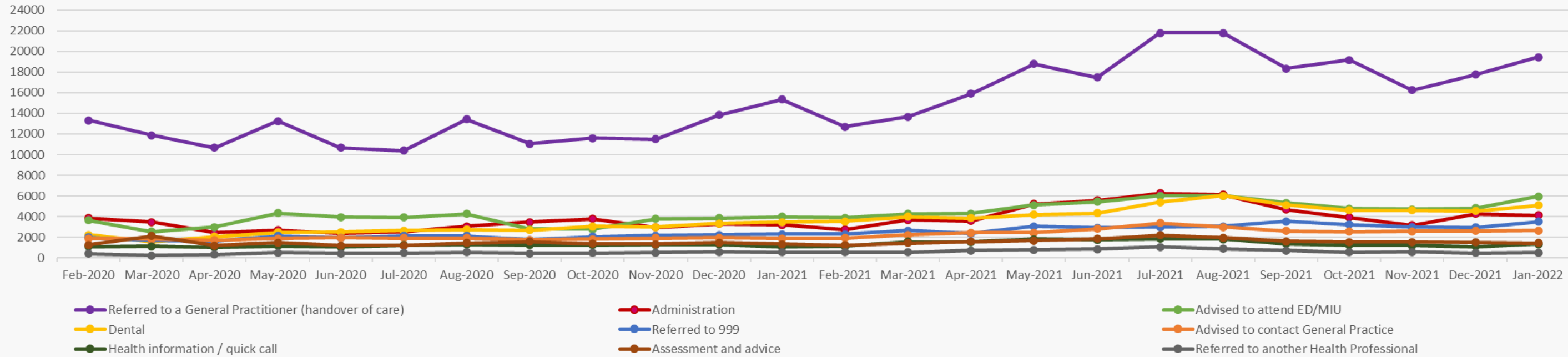
Our Patients: Quality, Safety & Patient Experience

111 Hand Off Metrics and 111 Consult & Close Indicators

Influencing Factors – Demand and Clinical Hours Produced



111 Calls By Final outcome



Analysis

In Jan-22 calls Referred to General Practitioner (handover of care) continued to be the top outcome for NHS111 accounting for 44% of calls.

Calls falling in the Immediate Care Required category saw the highest volume; this includes calls referred to General Practitioner (19,437), advised to attend ED/MIU (5,960) and Dental calls (5,078).

In Jan-22 44,102 calls were received in the 9 categories displayed in the top graph, an increase when compared to 40,077 in Dec-21, 32,243 in Jan-20 and 33,137 in Jan-21.

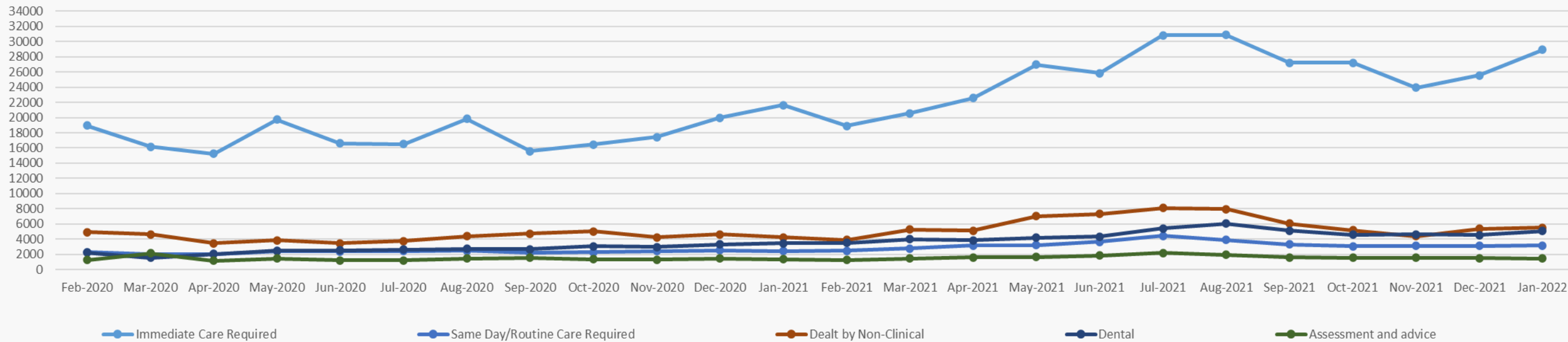
Remedial Plans and Actions

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.

111 Calls by Final Outcome



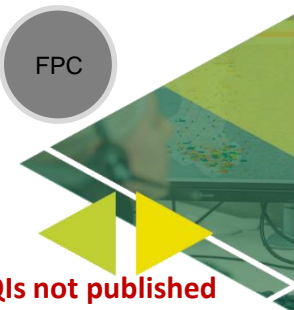
(Responsible Officer: Lee Brooks)

Welsh Ambulance Services NHS Trust

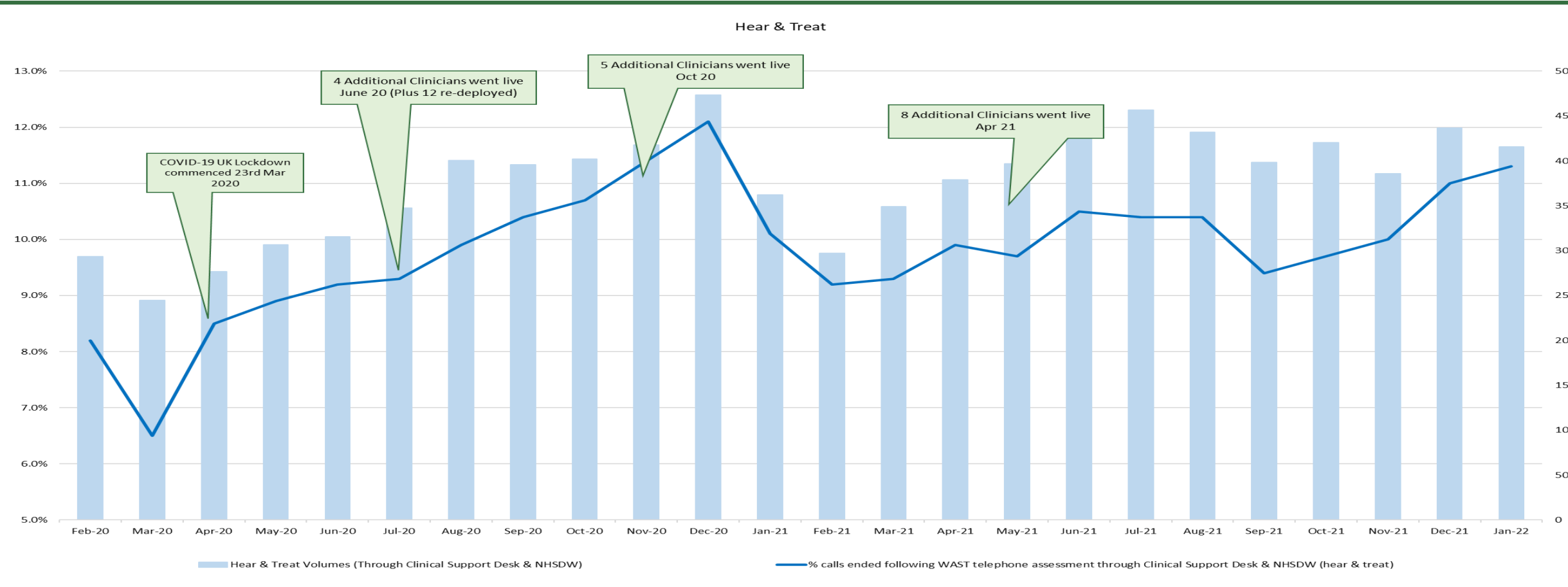


Partnerships / System Contribution

Hear & Treat Indicators



NB: Jan-22 Re-Contact & Alternative Care Services data not available as AQIs not published



Analysis

The **Clinical Service Desk (CSD)** and **NHSDW (Hear & Treat)** achieved 11.3% performance in Jan-22, therefore continuing to achieve the 10.2% target for the third consecutive month.

7.6% of hear & treat volumes were achieved by the CSD in Jan-22. In comparison, 3.6% 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 Dec-21 were 6.0% an increase compared to 5.6% in Nov-21, but a decrease compared to 7.6% in Dec-20.

The percentage of calls triaged by nurse advisor ended through transfer of alternative care advice services increased month on month to 74.5% in Dec-21; by comparison, this figure was 60.7% in Dec-20.

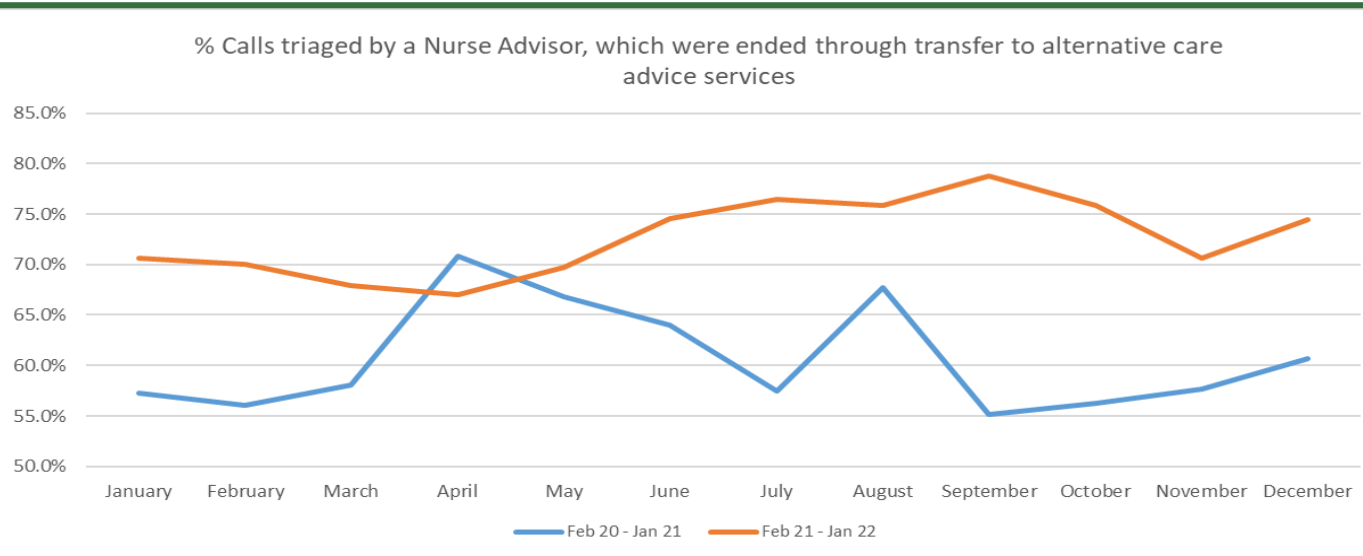
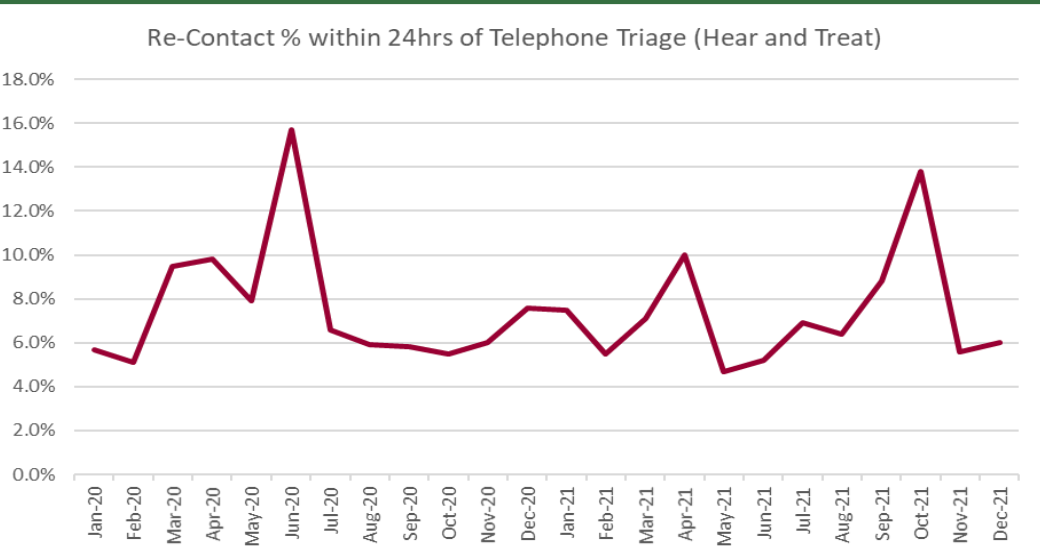
Remedial Plans and Actions

- 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. This benchmark is currently under review and expected to increase as part of the development of the 2022-25 IMTP and associated forecasting and modelling.

****NB: H&T Data correct at time of extract 10/02/22**



(Responsible Officer: Lee Brooks)

Welsh Ambulance Services NHS Trust

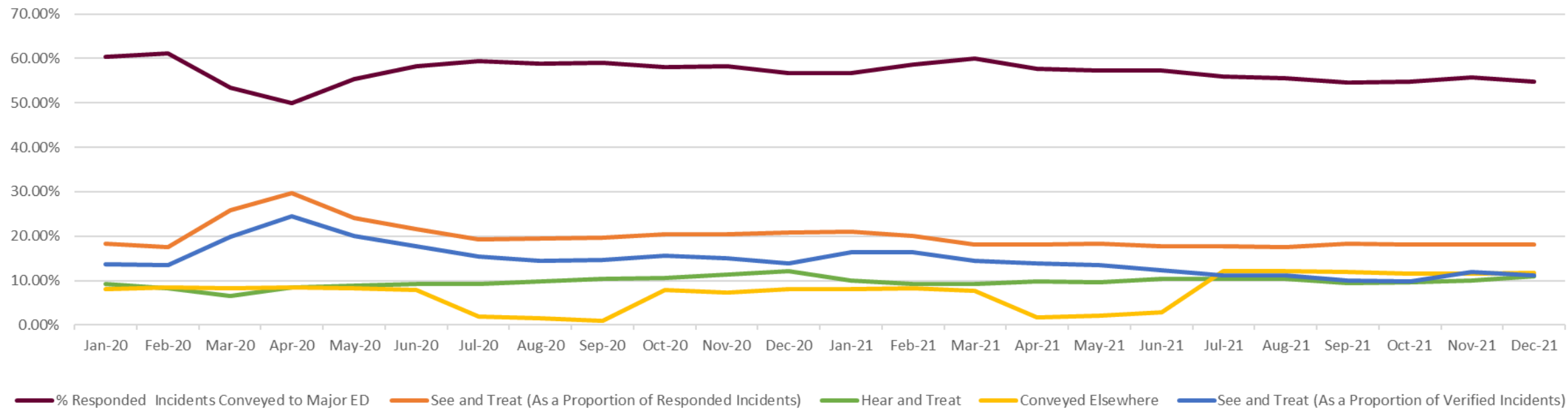


Partnerships / System Contribution Conveyance to ED Indicators



NB: Jan-22 Conveyance & Incidents data not available as AQIs not published

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



Analysis

The percentage of patients conveyed to EDs decreased (i.e. improved) compared to the same period last year. In Dec-21 conveyance to EDs as a proportion of total verified incidents was 33.92% (compared to 37.72% in Dec-20).

The combined number of incidents treated at scene and referred to alternate providers decreased in Dec-21 when compared to Nov-21. 2,024 incidents were referred to alternative providers in Dec-21 and 2,440 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 Jan-22 8,520 ambulances were cancelled by patients, 564 fell in the unable to send category due to the escalation of the Clinical Safety Plan (CSP) and 331 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).

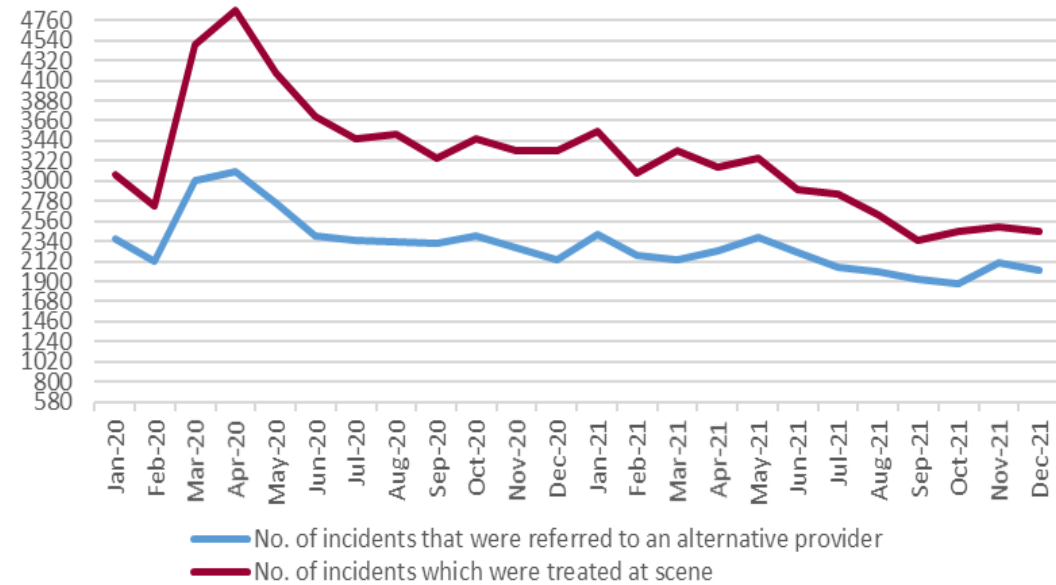
As part of the IMTP and working with partners across the health system. WAST has been asked to lead on the development of a National Respiratory work stream. A four phased proposal has been designed to deliver sustainable service level improvement for respiratory patients across Wales aligned to the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

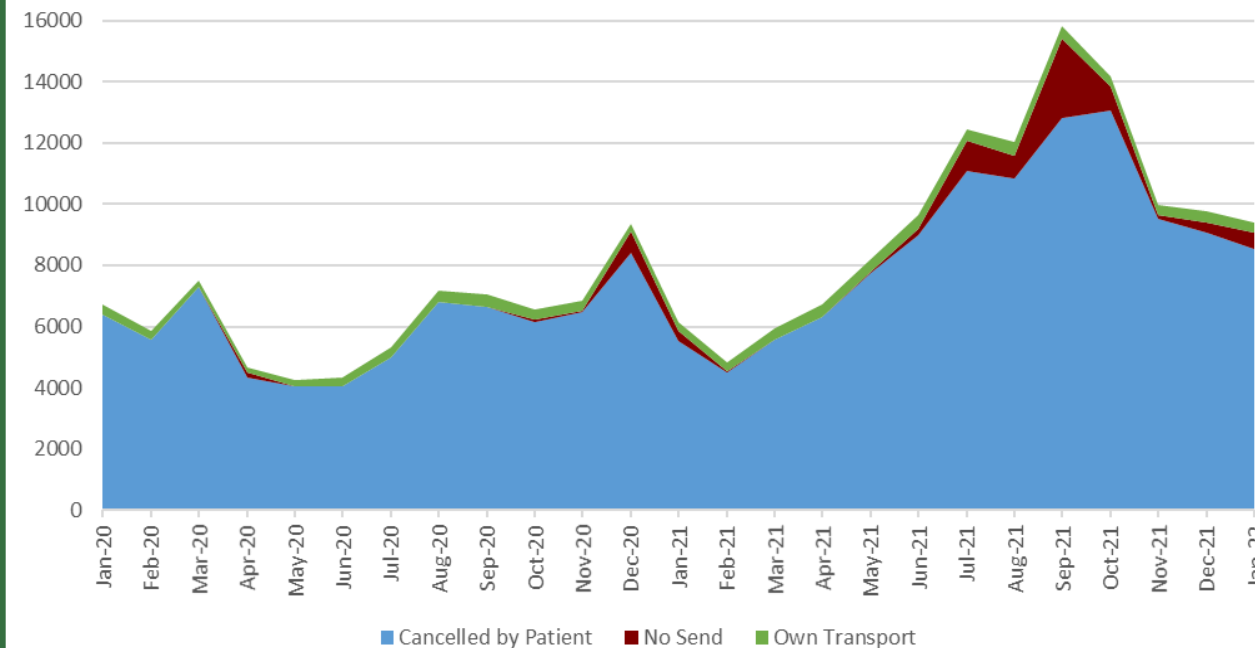
Expected Performance Trajectory

The initial modelling results due w/c 24 Jan-22 should give the Trust a first indication of what an optimised shift left benchmark may be. Further work will probably be required on confirming that figure. The Trust can then start to plot actions and a trajectory towards that benchmark.

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



Number of Incidents Stopped by reason

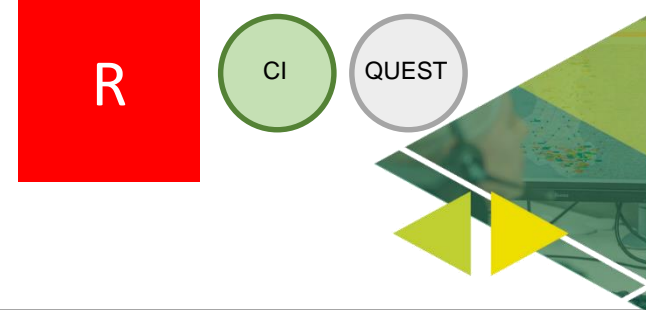


(Responsible Officer: Andy Swinburn)

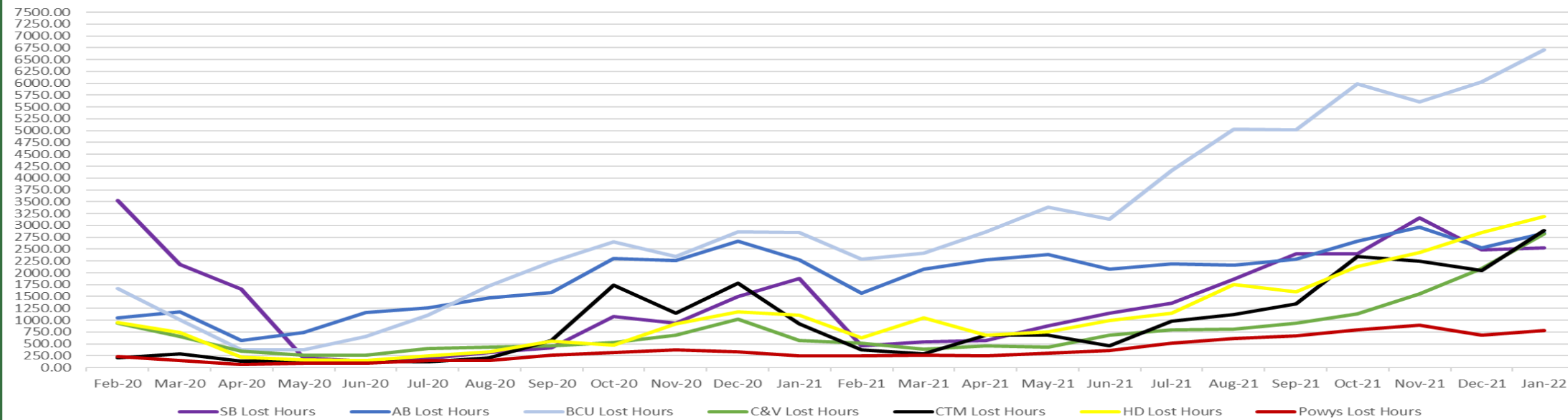
Welsh Ambulance Services NHS Trust



Partnerships / System Contribution Handover Indicators



Notification to Handover Lost Hours by Health Board



Analysis

157,097 hours were lost to Notification to Handover, i.e. hospital handover delays, over the last 12 months, compared to 72,816 in same period a year ago (Feb-20 to Jan-21). 22,701 hours were lost in Jan-22, a 63% increase compared to 8,416 lost hours in Jan-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 Jan-22 were Morryston Hospital (SBUHB) at 3,390 lost hours, Glan Clwyd Hospital Bodelwyddan (BCUHB) at 2,591 lost hours, Grange University Hospital (ABUHB) at 2,544 lost hours and Maelor General Hospital (BCUHB) at 2,249 lost hours.

Notification to handover lost hours averaged 712 hours a day in Jan-22, 474% higher than the commissioning intention of no more than 150 hours per day.

Lost hours remain a challenge for the Trust, in Jan-22 41,379 combined hours were lost to UHP shortfalls (under 95% UHP), handover, post production lost hours and hospital to clear lost hours.

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.

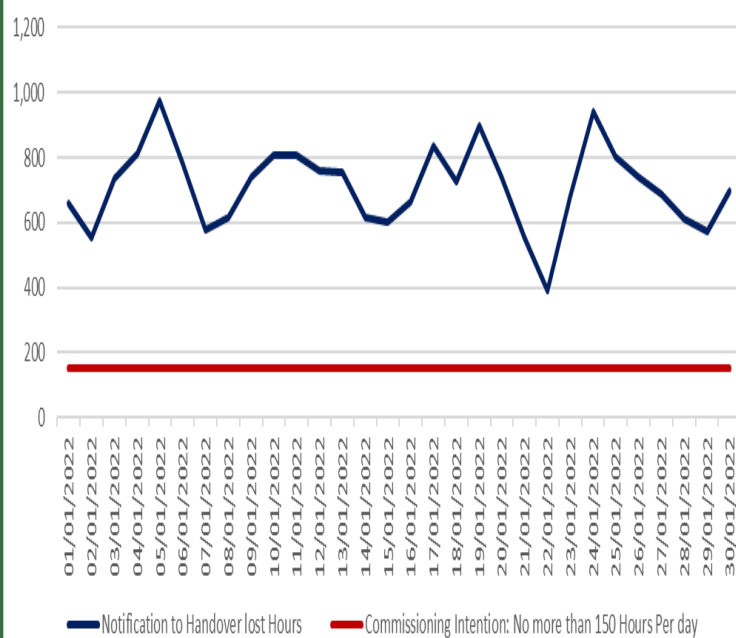
The WIIN platform continues to focus on patient handover delays at hospital and Electronic Patient Care Record (ePCR). 23 ideas have been received through the WIIN platform from staff in Dec-21

Expected Performance Trajectory

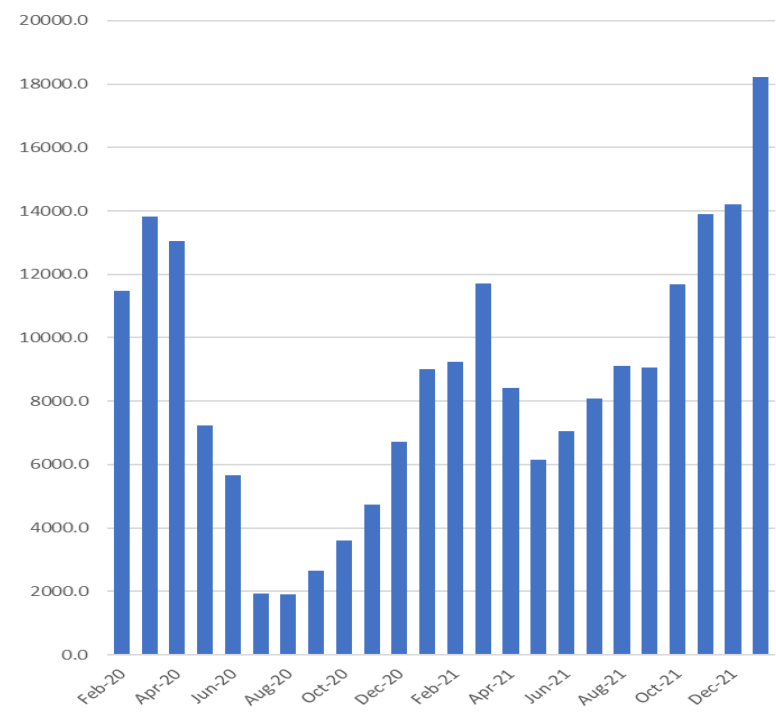
There is a 2021/22 EASC commissioning intention for handover, but this is clearly not going to be met. There is a recognition that handover must be reduced, but also that health boards ability to make a significant reduction before 2025 is unlikely; consequently current discussions in EASC are focused on clinical safety plans for health boards that are aligned and align to the Trust's; that these plans must include average handover patient waits as part of the escalation triggers with a probable red line/backstop of a maximum wait. It is not possible to provide a trajectory at this time.

****NB: Data extracted from QilkSense and subject to amendment upon publication of the AQIs**

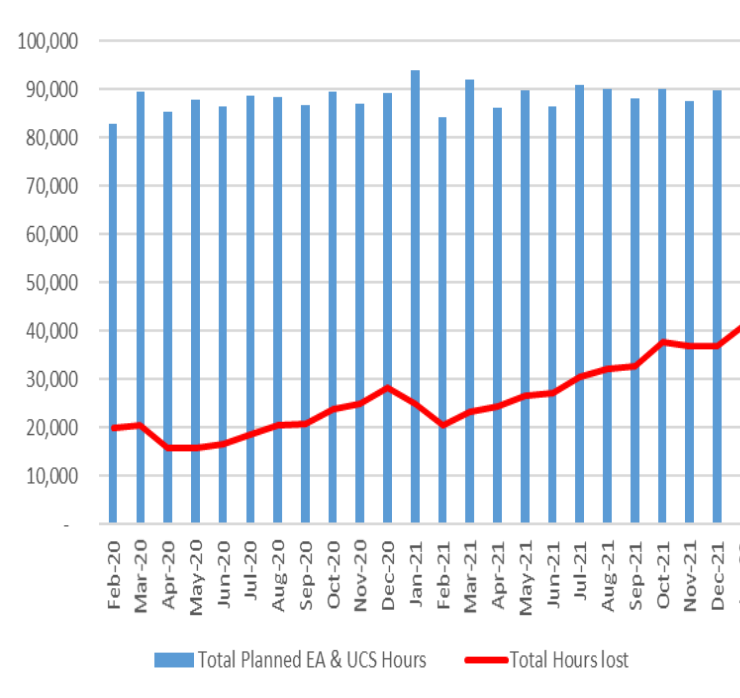
Notification to Handover Lost Hours - January 2022



Pan-Wales Notification to Handover Lost Hours



Total Planned hours VS Total Hours Lost

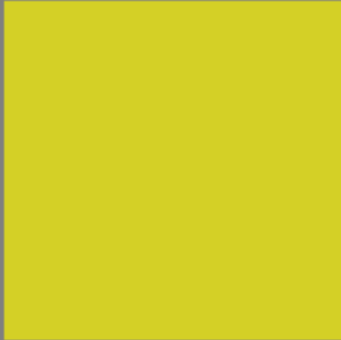
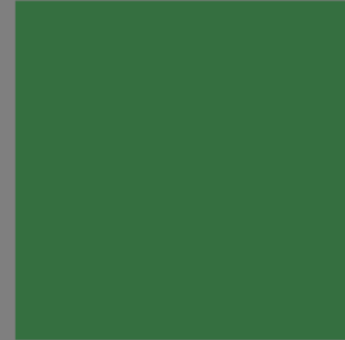
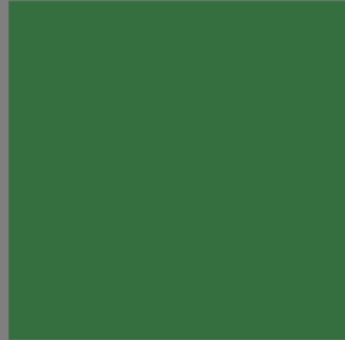


Term	Definition	Term	Definition	Term	Definition	Term	Definition	Term	Definition
AB / ABHB	Aneurin Bevan / Aneurin Bevan Health Board	C&V / C&VHB	Cardiff & Vale / Cardiff & Vale Health Board	HIW	Health Inspectorate Wales	NHSDW	National Health Service Direct Wales	RRV	Rapid Response Vehicle
AOM	Area Operations 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		





Ymddiriedolaeth GIG
Gwasanaethau Ambiwylans Cymru
Welsh Ambulance Services
NHS Trust



Welsh Ambulance Services NHS Trust
Integrated Performance Report
2020/21

Top Monthly Indicators	Target 2021/22	Baseline Position (2020/21)	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	2 Year Trend	RAG
Our Patients - Quality, Safety and Patient Experience																
111 Abandoned Calls	< 5%	11.00%	3.2%	7.2%	16.3%	7.0%	12.4%	27.2%	26.3%	31.9%	36.3%	21.5%	19.3%	10.8%		R
111 Patients called back within 1 hour (P1)	90%	95.30%	94.8%	94.5%	94.6%	93.5%	93.4%	94.4%	92.5%	92.3%	93.9%	94.8%	94.4%	94.9%		G
999 Call Answer Times 95th Percentile	95% in 00:00:05	0:03	0:03	0:03	0:03	0:03	0:08	0:18	0:54	1:39	1:39	0:37	1:43	-		R
999 Red Response within 8 minutes	65%	63.6%	64.4%	62.5%	61.0%	60.6%	60.6%	57.8%	57.6%	52.3%	50.0%	53.0%	51.1%	52.5%		R
Red 95th percentile	00:14:00	00:17:59	00:18:04	00:18:29	00:19:06	00:18:58	00:19:53	00:21:12	00:22:11	00:23:42	00:24:48	00:21:44	00:23:27	00:21:54		R
999 Amber 1 95th percentile	01:18:00	02:24:10	02:06:03	02:15:15	02:31:11	02:53:55	03:32:46	04:13:36	04:36:38	06:34:08	06:58:00	04:34:47	06:02:36	04:51:35		R
Return of Spontaneous Circulation (ROSC)	Improve	9.97%	14.60%	6.60%	14.30%	15.20%	15.30%	16.20%	8.10%	12.40%	10.40%	10.90%	-	-		G
Stroke Patients with Appropriate Care	95%	95.83%	95.00%	95.60%	94.50%	98.20%	97.20%	98.30%	95.90%	97.80%	93.50%	98.40%	-	-		G
Acute Coronary Syndrome Patients with Appropriate Care	95%	73.50%	62.30%	75.70%	85.70%	82.30%	83.80%	75.70%	73.00%	70.80%	71.40%	85.70%	-	-		R
Renal journeys arriving within 30 minutes of their appointment (NEPTS)	70%	74%	79%	79%	78%	78%	79%	78%	79%	80%	78%	77%	77%	82%		G
Discharge & Transfer journeys collected less than 60 minutes after booked time (NEPTS)	90%	88.00%	87%	86%	75%	69%	68%	73%	79%	78%	89%	86%	88%	87%		A
National Reportable Incidents reports (NRI)	-	4	3	7	9	1	4	4	5	8	7	9	4	5		R
Concerns Response within 30 Days	75%	75%	70%	78%	68%	62%	63%	62%	57%	45%	47%	56%	70%	66%		R
Our People																
EMS Abstraction Rate	29.92%	37.00%	38%	44%	35%	36%	40%	42%	45%	45%	44%	41%	45%	41%		R
Hours Produced for Emergency Ambulances	95%	96.0%	100%	96%	94%	96%	92%	88%	87%	82%	90%	103%	96%	106%		G
Sickness Absence (all staff)	5.99%	7.30%	7.63%	7.02%	7.38%	7.95%	8.87%	9.72%	10.50%	11.69%	11.41%	11.08%	12.45%	-		R
Frontline CoVID-19 Vaccination Rates	-	-	1,927	3,157	3,268	3,275	3,620	3,710	3,751	3,796	4,197	4,248	4,258	4,270		-
Statutory & Mandatory Training	>85%	83.1%	81.75%	82.69%	83.01%	80.69%	81.40%	81.80%	82.03%	81.78%	82.63%	82.82%	82.06%	82.23%		A
PADR/Medical Appraisal	>85%	52%	46.95%	56.60%	61.42%	63.19%	65.27%	64.55%	63.23%	61.10%	59.28%	58.84%	57.87%	58.34%		R
Ambulance Response FTEs in Post	1700	1702	1777	1767	1602	1585	1587	1584	1585	1587	1585	1637	1639	-		A
Ambulance Care, Integrated Care, Resourcing & EMS Coordination FTEs in Post	-	1117	1163	1176	1226	1487	1468	1468	1461	1447	1643	1710	1681	1703		-

Value																
Financial balance - annual expenditure YTD as % of budget expenditure YTD	100%	100%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%		G
EMS Utilisation metric	57%	-														-
Post-Production Lost Hours (All Vehicles)	Reduction Trend	11,053	10,676	12,461	13,067	14,673	15,412	16,138	15,837	15,747	17,180	15,979	16,063	17,106		R
Partnerships / System Contribution																
111 Consult and Close	Improve	5,612	5,162	6,731	6,732	8,728	9,197	10,310	9,896	7,670	6,722	5,915	6,875	6,943		G
999 Hear & Treat	10.2%	9.9%	9.2%	9.3%	9.9%	9.6%	10.5%	10.4%	10.4%	9.4%	9.7%	10.0%	11.0%	-		G
% Incidents Conveyed to Major EDs	<48.6%	44.58%	47.78%	48.02%	44.49%	42.54%	39.76%	35.41%	35.14%	29.80%	30.00%	36.57%	33.92%	-		G
Number of Handover Lost Hours	< 150 hrs per day	6,093	6,157	7,045	8,088	9,099	9,059	11,685	13,887	14,202	18,234	18,160	18,773	22,701		R



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 & Safety Committee
DATE	17 February 2022
EXECUTIVE	Director of Quality & Nursing
AUTHOR	Head of Patient Safety, Concerns and Learning (Interim)
CONTACT	Stephen Johnson stephen.johnson2@wales.nhs.uk 07545 507755

EXECUTIVE SUMMARY

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

In summary the report for this quarter identifies:

- A significant increase in verified calls into the Trust during this reporting period, particularly in 111
- Increased levels of hospital handover delays has also seen an increasing number of serious 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
- A decrease in clinical negligence cases
- An increase in personal injury claims
- There has been a slight reduction in coroner's activity, however the complexity of the cases requires additional staff statements and longer inquests
- Additional resilience has been approved to support the PTR activity

RECOMMENDED: That the Committee receives this report for assurance and discussion.

KEY ISSUES/IMPLICATIONS

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

REPORT APPROVAL ROUTE	
Executive Management Team	2 February 2022
Quality, Patient Experience & Safety Committee	17 February 2022

REPORT APPENDICES
Not applicable

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

PUTTING THINGS RIGHT			
	October 2022	November 2022	December 2022
Patient Safety Incidents			
Catastrophic	14	8	30
Major	2	0	0
Moderate	2	5	5
Minor	24	22	30
No Harm/Hazard	440	377	344
Total	497	415	421
Concerns			
Total Received	116	65	75
Total Closed	127	118	108
2 Day Acknowledgment %	43%	23%	29%
30 Day Response due %	47%	56%	70%
Ombudsman			
Cases Received	4	2	5
Cases Closed	5	1	1
Reports Received	0	0	0
Coroners			
Information request	76	90	110
Identified as Interested Party	11	10	11
Staff attending	7	5	5
Regulation 28 issued	0	0	0
Response to Regulation 28 in 56 working days	0	0	0
Response to Regulation 28 outside 56 working days	0	0	0
Nationally Reportable Incidents (NRIs) to Delivery Unit (reporting date)			
Serious Case Incident Forums held	7	7	6
Serious Case Incident Forums Cases	56	43	44
WAST NRIs reportable to Delivery Unit	7	9	4
Incidents reviewed at SCIF and reported under the Joint Investigation Framework	26	30	23
NRI Closures Submitted – Total	0	0	5
NRI Closed by DU – Total	0	1	0
Claims			
Personal Injury – Received	3	0	1
Personal Injury – Closed	0	0	0
Clinical Negligence – Received	0	2	2
Clinical Negligence – Closed	0	1	1
Road Traffic Collision & Damage to Property – Received	12	20	25
Road Traffic Collision & Damage to Property – Closed	16	18	23

SETTING THE CONTEXT FOR THIS PERIOD

- 1 During Quarter 3 (October - December 2021), the Trust's verified incidents were 122,083 compared to 114,336 for the same period last year. For the same periods, 111 call volumes were 253,143 and 147,206 respectively.
- 2 From the total of verified incidents above, the following can be extrapolated:

Red	11,911 compared to 7,857
Amber	87,453 compared to 80,675
Green	22,719 compared to 25,804
- 3 Overall total verified incident demand saw a 6.3% increase in Quarter 3 compared to the same period the previous year.
- 4 The Trust lost a total of 55,254 hours to notify to handover delays across this quarter, which is a significant increase when compared to the previous quarter (July - September 2021).
- 5 Red performance remains a challenge and the 65% target has not been achieved for 17 months. In Quarter 3 the Trust achieved 50.0% in October, 53.0% in November and 51.1% in December, therefore continuing to fall below the 65% target. This performance percentage was lower than the same periods in 2020 - 60.8%, 59.5% and 53.7% respectively.
- 6 During this quarter, the number of patients attended in the Red category was 11,777 compared with 7,810 in 2020. October saw the largest variation with 4,064 Red responses in 2021 compared to 2,428 in 2020, which is an increase of 40.3%.
- 7 Amber median performance during Quarter 3 was 1 hour 44 minutes (40 minutes), 1 hour 08 minutes (46 minutes) and 1 hour 19 (1 hour 3 minutes) respectively. The figures in brackets are for the same period in 2020.

SITUATION

- 8 This Patient Safety Highlight Report covers the period of 1 October - 31 December 2021, and also provides a retrospective analysis of data for the same period last year in key areas.
- 9 This Report will specifically focus on key issues surrounding patient safety and concerns, providing assurance to the Board on monitoring arrangements and learning.
- 10 Please note that the data contained within this Report is accurate at the time of reporting. **Data may be subject to change as incident case types may be regraded during the investigation process.**

BACKGROUND

- 11 The purpose of this Patient Safety Highlight Report is to provide an update to Trust Board on the key information in relation to PTR and Patient Safety. This report provides key information on:
- Patient Safety Incidents
 - Concerns (including political)
 - Ombudsman
 - Coroners
 - Nationally Reportable Incidents (previously Serious Adverse Incidents) (SAIs)
 - Claims
 - Key achievements and Learning
- 12 It also identifies themes and trends emerging from our concerns portfolio, providing assurance to Trust Board on the progress and implementation of corrective Action Plans against these.
- 13 The Trust's Quarterly Quality Assurance Report is presented to the Quality, Patient Experience and Safety Committee (QuEST) to monitor and measure the emergent trends from quality data and information in relation to the Health & Care Standards and Commissioning Core Requirements.
- 14 In line with the new reporting changes the work to integrate the IPR Report and the Quality Assurance Report continues.
- 15 Following the agreement in September for additional staff to bolster the PTR administrative and patient safety functions, the team have recruited a Patient Safety Manager until 31 March 2022. Unsuccessful attempts were made to recruit Administrators via Acorn agency and so overtime has been offered to the team to assist with the registration of concerns. Interviews are being held for a Legal Services Administrator to assist the Legal Services Team until 31 March 2022.
- 16 In addition to the above we have backfilled the vacant Patient Safety Manager position in North Wales, and we have recruited an additional substantive Patient Safety Manager for 111. A substantive Investigation Supervising Officer position for 111 is currently in the approval stage on TRAC in readiness for advertising. We also have a Patient Safety Manager secondment in the approval stage on TRAC to backfill the vacant Patient Safety Manager who is currently acting up as Interim Head of Patient Safety, Concerns and Learning.
- 17 In December the Claims Investigation Officer retired from post and this position is currently in the approvals stage on TRAC. In addition to this, it has been agreed the secondment for the Claims Investigations Coordinator is to be extended until 31 December 2022.
- 18 The volume of incidents/concerns received during this quarter have remained at an escalated level, and the SCIF Panel continue to meet twice weekly in order to accommodate the number of potentially serious incidents/Appendix b being received. Hospital handover delays continue to be the root cause in the

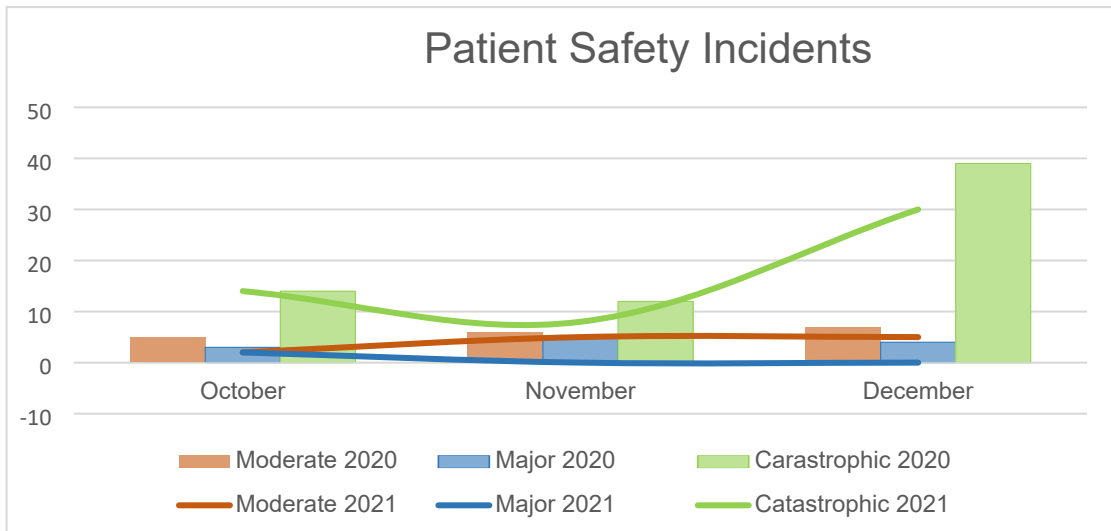
majority of cases reviewed at the SCIF, although call prioritisation issues remain a consistently high theme, especially 'missed ineffective breathing' during this quarter, which accounted for 5 of the 20 incidents reported to the Delivery Unit as Nationally Reportable Incidents (NRI's).

- 19 Concerns remain regarding Immediate Release Requests. As previously reported, there are varying levels of response across Health Boards. In some circumstances there are delays in reaching the right staff member resulting in a long delay in the request being addressed.
- 20 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 SOP has been undertaken within the Clinical contact Centre (CCC) in order to provide clarity to staff on the process expected of them.
- 21 The Older People's Improvement Lead and the Quality Assurance Manager's within the CCC have collaborated to improve the systems in place for re-contacting callers who have contacted 999 via Careline.

ASSESSMENT

Patient Safety Incidents

- 22 Adverse Incidents reported as catastrophic are usually related to patient outcome. On all cases an investigation is pending and it has not been established whether the outcome was due to any act or omission by the Welsh Ambulance Services NHS Trust (WAST) or whether it was due to the patient's underlying medical condition.
- 23 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.
- 24 During this period a total of 1,333 patient safety incidents were reported, 497 in October, 415 in November and 421 in December. 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.**
- 25 The chart below illustrates a comparison between October - December 2019/20 and 2020/21, following the submission of the Datix by the reporter.



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

26 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 KPI is 75%, which requires the closure of the response letter.

27 The PTR Department has witnessed a slight decrease in the number of concerns received for this reporting period (248), compared with the previous quarter (255). Although the final volume during this quarter is likely to be greater as there are still a number of concerns received during December that are yet to be registered. This is an increase in the same reporting period last year where 190 concerns were received.

28 As of 5 January 2022 there were 90 open concerns (excluding Complex Case Panel) with 34 in backlog.

29 During this reporting period the 2 day acknowledgement performance was 43%, 23% and 29% (90%, 96% and 100%) with the 30 day target achieving 47%, 56% and 70% (84%, 78% and 88%) respectively.

30 The average across this period is therefore, 32% for 2 day acknowledgement and 58% for 30 day target. The figures in brackets are for the same reporting period previous in 2020/21.

31 As anticipated, following on from the unprecedented pressures of the last quarter, this reporting period has been extremely busy with the volume of concerns remaining high. Together with the staff vacancies it has meant that

registering concerns in a timely manner has been challenging. The vacant administration post has been approved and will be advertised in the next quarter.

32 The overwhelming theme and trend through the vast majority of concerns is in relation to timeliness to responding to calls.

Ombudsman and Political Investigations

33 There are currently 15 open Ombudsman cases. There remains 3 cases where the Trust is preparing the documentation to share with the Public Service Ombudsman for Wales (PSOW) at the start of the investigation.

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

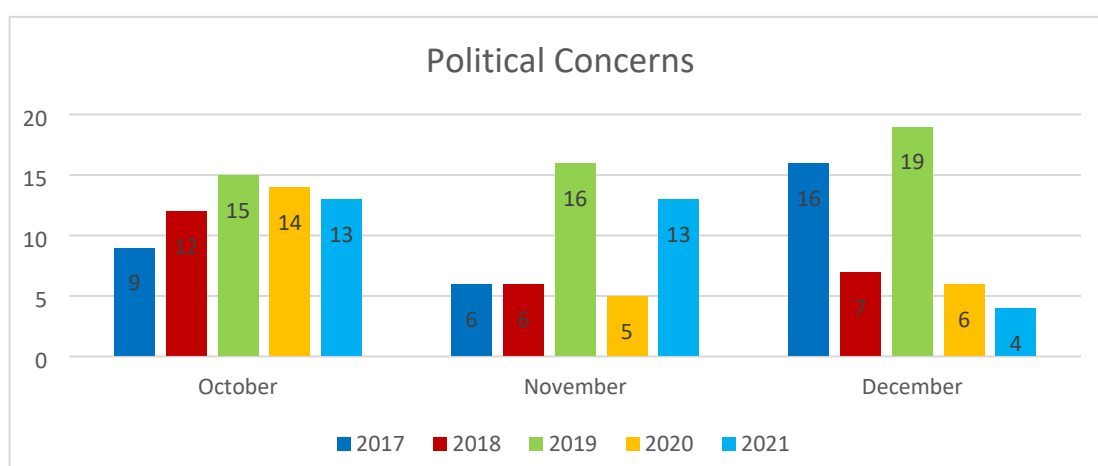
35 During the last few years the cases being considered by the Ombudsman's office have been primarily in relation to the timeliness of the Trust's response to patients and or the call prioritisation and the allocation of resources.

36 During the reporting period, the approaches being received have been in relation to the clinical care being provided by Trust staff. These include:

- The clinical decisions made when attending a patient experiencing seizures, who had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place
- The actions of the non-emergency staff when transferring the patient home
- The appropriateness of leaving a patient at home and the effect that decision had on the investigation for a suspected stroke
- The accuracy of advice provided by paramedics when they attended a patient and did not transport that patient to hospital

37 The outcome of these investigations will be shared when the final reports are received.

38 The table below illustrates the volume of political concerns received comparing the same periods over the past five (5) years:



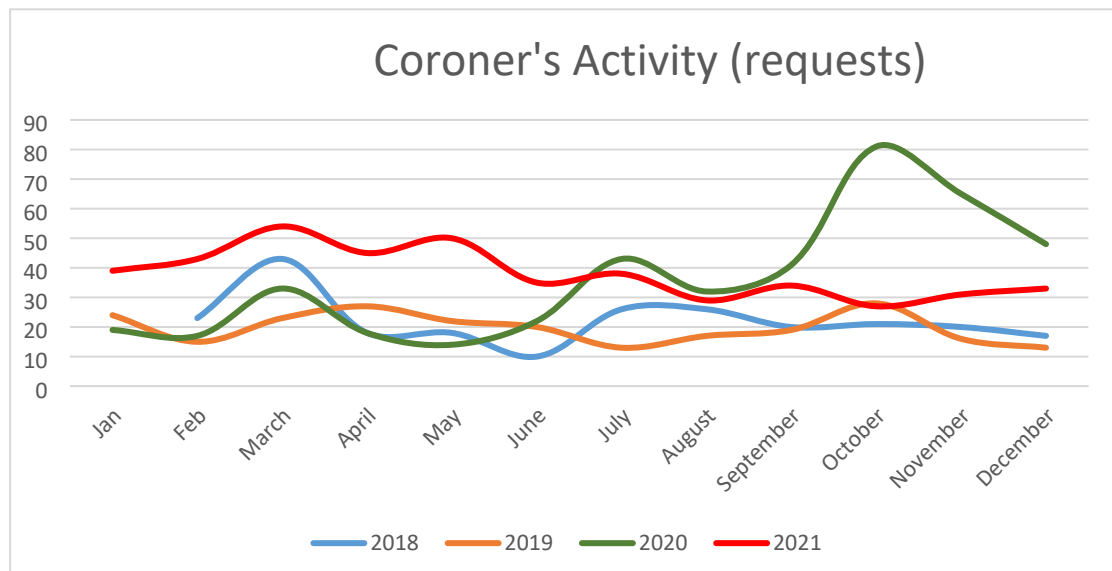
39 This quarter has seen a decrease in the number of political concerns being received. Of the 30 new concerns, only 4 relate to an issue other than the timeliness of Emergency Medical Services (EMS) responses.

40 There are currently 21 open political concerns. Of these 5 have had Redress offered by way of resolution. A further 5 have had the investigation concluded, with 19 still under investigation.

Coroner's activity

41 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.

42 The complexity of the requests being received have increased, resulting in more statements per approach. Please refer to the chart below which illustrates the continuing pattern:



43 The concern for future months continues to be that these initial requests for statements could translate into an increase in cases where the Trust is considered an Interested Person (IP) or requests for staff to attend hearings. Potentially causing an increase in staff abstractions.

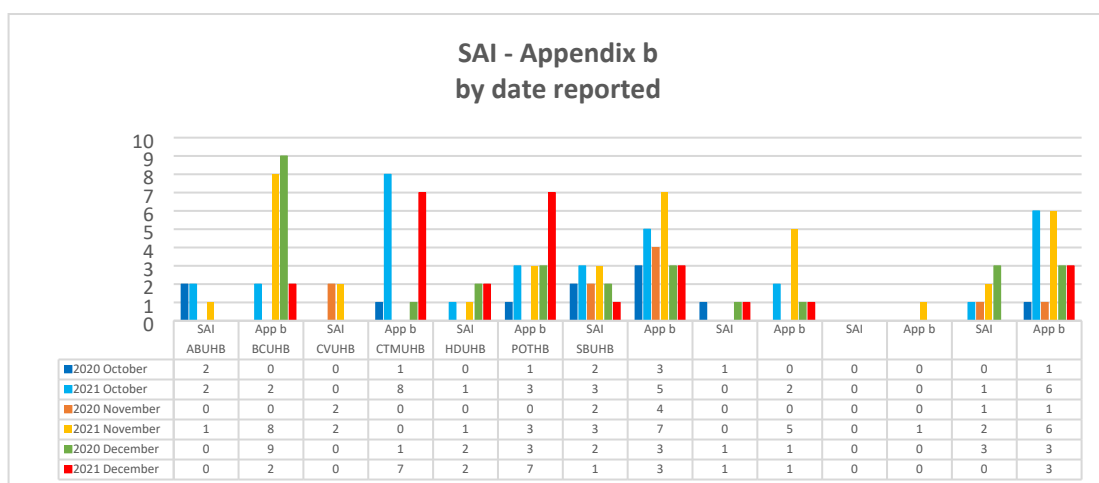
44 One inquest where the Trust is an IP relates to the death of a Trust member of staff. The Coroner wishes to examine whether the death was due to contracting COVID whilst on duty, although the corresponding RIDDOR Report from the health and Safety Executive (HSE) concluded that it was contracted whilst on duty. The Pre Action Review Hearing in November established that the Coroner will be considering Personal Protective Equipment (PPE) and Trust procedures. Apart from this, there were eleven pre-existing IP inquests ongoing.

45 During this reporting period there were 2 inquest hearings in respect of which the Trust was an IP, important to note that there were no Regulation 28 - Prevention of Future Deaths issued to the Trust:

- (i) RE - The Trust responded to a call received in respect of a prisoner. This incident occurred in October 2016. The Trust responded to the information received during the call. The Coroner's conclusion was that RE died by hanging in circumstances where his intention could not be ascertained. Whilst no Regulation 28 (Prevention of Future Death or PFD) Report was issued to the Trust, one was issued to the Prison Service.
- (ii) KH - The Trust responded to a call in relation to a patient who had taken an overdose/poisoning. This incident occurred in January 2021. The calls were correctly handled and the Trust responded with the nearest available vehicle, as soon as possible. The inquest concluded that KH had committed suicide and no PFD letter was issued.

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

- 46 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).



- 47 During this reporting period there were 20 SCIF meetings held, with 143 incidents discussed.
- 48 During the reporting period 20 incidents have been reported as NRIs to the Delivery Unit (DU), and 79 incidents were referred under the Joint Incident Framework (Appendix b) to the respective Health Board.
- 49 Each of the 20 Incidents reported by the Trust as NRIs to the DU within this period were reviewed to identify the overarching high-level themes, which were:
- (i) Missed Allocation (1)
 - (ii) Call categorisation, (11) (5 of which were missed ineffective breathing)
 - (iii) Pre arrival instructions not provided (1)
 - (iv) Clinical assessment and/or treatment, including 1 Never Event (6)
 - (v) Resource/Operational shortfall (1)

Legal Claims

- 50 The receipt of Clinical Negligence claims in this reporting period has decreased from 13 in the previous quarter to 4 in this quarter. It is positive that the increase experienced in the previous quarter this far does not seem to represent a permanent trend.
- 51 Personal Injury claims received have increased from 5 and 12 between the previous quarter and this one being reported. The increase relates to an increase in personal injury claims emanating from road traffic incidents. This represents a significant increase and will need to be monitored, especially in the traditionally busy winter months. The staff claims relate primarily to issues with equipment. In addition, the Trust has seen an increase in claims becoming litigated, with 4 sets of personal injury legal proceedings being served. There is no discernible trend with these claims.
- 52 During the reporting period there has been a decrease in the number of Road Traffic Collision and Damage to Property claims received, when compared to the same period during previous years. The weather has been mild, with little by way of seasonal snow and frosts, resulting in better driving conditions.

KEY ACHIVEMENTS AND LEARNING

(i) Medical and Clinical Directorate

Clinical Notices issued October:

22/21	Updates to TXA and Co-amoxiclav PGD's
23/21	All Wales Care Decisions Guidance for the Last Days of Life
24/21	Procedure for administration of Rectal Diazepam in patients aged less than 6 months

Clinical Notices issued November:

There were no new clinical notices issued during November.

Clinical Notices issued December:

25/21	3/12 Lead ECG Acquisition for Monitored Arrhythmia's
26/21	Implantable Cardioverter Defibrillator (ICD)
27/21	Infant Warming Mattress/Cocoon
28/21	WAST Standard Operating Procedure (Clinical) for all Epcr users

The Clinical Reviews undertaken are illustrated on the table below by Health Board Area:

Clinical Reviews by Health Board October to December 2021	Number	Themes	Learning opportunities
Aneurin Bevan	1	<ul style="list-style-type: none"> • Delayed patient treatment and remaining on scene with time critical presentation 	<ul style="list-style-type: none"> • Informed decision making • Importance of communication • Familiarisation with clinical guidelines
Betsi Cadwaladr	12	<ul style="list-style-type: none"> • Ketones monitoring - diabetic patient. • Double EMT crew on scene disposition. • Handover delay resulting in deterioration of patient • Non-conveyance. • Transport • POM left at scene (O2 bottle) • Family instructed by WAST to administer Just in Case Medication • Formal concern raised by family • CCC Allocation • PGD dispensing • Access/admissions • P3/P4 back up request as per CRM 	<ul style="list-style-type: none"> • Conveyance and non-conveyance decision making • Management of patients outside ED (Reg 28) • Familiarisation with clinical guidelines. • Improved Understanding of Medicines Management • Improvements in the management of EoLC patients and use of anticipatory meds - appropriateness of assessment • Appropriate use of SPs • Timely deployment of support resources
Cardiff and Vale	8	<ul style="list-style-type: none"> • Rushed management of a patient on scene. • Sub-optimal management of a cardiac arrest. • Sub-optimal management of a paediatric patient. • Inappropriate management and discharge of a diabetic patient. • Management and treatment of a septic patient. • Mis-diagnosis of a Myocardial infarction. • Failure to identify a clinical presentation. • Incorrect discharge of a patient 	<ul style="list-style-type: none"> • Improvements in the management of patients • Informed decision making • Familiarisation with clinical guidance • Improved PCR documentation • Conveyance decisions • Appropriateness of patient discharge • Timely deployment of support resources • Improved identification of patient's condition • Appropriateness of assessment • Clinical boundaries associated with clinicians' scope of practice

Cwm Taf	4	<ul style="list-style-type: none"> • Controversial lifting technique. • Advice provided by crew. • Fall, downstairs spinal immobilisation. • Fall, controversial lifting technique. 	<ul style="list-style-type: none"> • Correct choices in immobilisation decisions • Correct choices in moving and handling • Importance of communication
Hywel Dda	1	<ul style="list-style-type: none"> • Spinal immobilisation 	<ul style="list-style-type: none"> • Correct choices in immobilisation decisions
Powys	2	<ul style="list-style-type: none"> • Delay in treatment of Red Flag Sepsis. • ECG Recognition 	<ul style="list-style-type: none"> • Appropriateness and timeliness of assessment and treatment • Importance of adequate history • Improved ECG recognition
Swansea Bay	7	<ul style="list-style-type: none"> • Non-Immobilization concerns. • Possible non-recognition of deteriorating patient. • EtCO2 use and non-recognition of possible oesophageal intubation. • Incorrect drug administered. • Possible non-recognition of deteriorating patient. • Sub-optimal patient assessment. • Possible non-recognition of deteriorating patient. • Inappropriate use of card 35 	<ul style="list-style-type: none"> • Correct choices in immobilisation decisions. • Better utilisation of senior clinical on call function • Improved ECG recognition and interpretation • Familiarisation with Airway Management. • Management of patients outside ED • Greater understanding of the application of POPS • Understanding of escalation of concerns • Improved identification of patient's condition • Appropriateness of assessment • Development of future care plans

(ii) **Clinical Contact Centre**

The following Coaching bulletins have been issued for Call Handlers and Dispatchers.

Call Handlers	Dispatchers
Target tool quick access to early critical care instructions	Documentation
Protocol 23 what drugs are narcotics	Failed contact process
3 rd / 4 th party callers	Post production lost hours
Obvious death indicators	Hourly entries into ADOL
HCP calls not asking 'duty of care'	
Suspending interrogation to give immediate instructions	
Exit card instructions	
Exposure to the elements	

A separate Medical Priority Dispatch System (MPDS) coaching bulletin was issued regarding dealing with hangings.

A bulletin was issued removing over 65 year olds from the high risk category on protocol 36.

The MPDS Audit Team have introduced 'weekly questions'. This can be around any aspect of call handling. Emergency Medical Dispatchers (EMD) can submit their questions and the MPDS Team will jointly agree the response. Questions have been received on Road Traffic Collisions, DNACPRs, Seizures and advising naloxone.

A bulleting has been issued advising staff that, during Clinical Safety Plan escalation and following the delivery of the following script:

'Our advice is to ring your GP or go to 111 online. You could also make your own way to a minor injury unit or an emergency department at the hospital. If you choose to do this please follow any directions displayed on your arrival'

In respect of children, if the caller asks where to take them, the EMDs are to advise a Major Emergency Department.

The CCC Concerns Team are working with the older persons and frailty team to try and improve patient experience.



AGENDA ITEM No	14
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	1

LOSSES AND SPECIAL PAYMENTS DEEP DIVE INTO PERSONAL INJURY CLAIMS

MEETING	Quality, Patient Experience & Safety Committee
DATE	17 February 2022
EXECUTIVE	Director of Quality & Nursing
AUTHOR	Assistant Director of Quality & Nursing
CONTACT	Wendy Herbert Wendy.herbert@wales.nhs.uk 01792 315886

EXECUTIVE SUMMARY

Quarterly, the Audit Committee receive a Losses Payments paper in relation to the financial payments that are made by the Trust. This includes the payments made in relation to claims.

It was felt that the paper should be enhanced to include details surrounding themes and trends, and where appropriate lessons learned. Whilst the Legal Services Team (the Team) can identify themes and trends, as well as learn lessons in relation to the handling of the cases, the wider learning for the Trust is completed by individual Line Manager, the National Training College and Health & Safety Committee. The sharing with the National Training College and Health & Safety Committee will be via this report. In addition, all Welsh Risk Pool Services (WRPS) Learning from Events Reports are presented to the Health & Safety Committee to review learning.

The Trust has adopted a policy of in-house management of personal injury claims since 2008.

RECOMMENDED: That the Committee considers the content of this report

KEY ISSUES/IMPLICATIONS

For assurance only

REPORT APPROVAL ROUTE

Executive Management Team	2 February 2022
Quality, Patient Experience & Safety Committee	17 February 2022

REPORT APPENDICES

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

SITUATION

- 1 This report includes details of all personal injury claims, received during 2020 and 2021. This is a total of 38 registered cases.

BACKGROUND

- 2 Whilst the losses payments paper reports on payments that have been made in the preceding 3 months, those payments will relate to a variety of ongoing cases.
- 3 Often, by the time that the payments are made, the incident or event, will have occurred many years previously. Therefore, the payments may not relate to current themes and trends but rather be reflective of historic issues.
- 4 Additionally, the majority of claims will have multiple payments, in complex cases being paid over a number of years.
- 5 Again, should the themes and trends be drawn from the cases on which payments have been made in the preceding quarter, many cases would be considered multiple times. This in itself would skew the true themes and trends relating to our claims.
- 6 Therefore, this report is prepared to append to the losses payments paper. This paper focuses on one area of the claims received by the Trust. Looking at themes and trends, in relation to the claims being received, as well as learning in relation to the handling of the claims, with a view to minimising losses.

ASSESSMENT

- 7 For the purposes of current themes and trends this report includes details of all personal injury claims, received during the last 2 full calendar years (2020 & 2021).
- 8 For the purpose of the damages paid and learning this report includes details of all personal injury claims closed during the last 2 full calendar years (2020 & 2021).
- 9 Initially the personal injury data was going to be reported over two papers, one in relation to injuries to staff and one in relation to injuries to patients. However, given the low numbers involved, all personal injury claims have been included in this report.
- 10 The significant majority of the Trust's personal injury cases are managed by the Trust's own Legal Services Team. This includes the gathering of information and responding to allegations made against the Trust, the provision of pre-action disclosure of evidence and where legal proceedings are issued the legal case management of such cases.

- 11 As with clinical negligence claims (last report) in the majority of cases a claimant has 3 years from the date of the incident (or the date they became aware of the harm) to raise a claim. This period of time is referred to as limitation. Limitation is suspended whilst any investigation is being undertaken under the Putting Things Right scheme.
- 12 That being said limitation is a complex matter and the details above are simplistic and apply in the majority of case. There are cases that fall outside of these simple rules.
- 13 The Legal Services Team uses the Datix computerised system to register claims, and links them to any concerns (complaints or incidents) that have been received. That being said, the Datix system is not a case management system, but rather a reporting system, and as such the Trust currently manages its claims on paper files. The Trust is anticipating the introduction of a legal case management system aligned to that being introduced by Legal & Risk Services (L&RS). L&RS have agreed to create a dedicated Module specifically for the Trust within their new system, with appropriate data privacy and access restrictions. It is hopeful that this will be introduced within 2022-2023.
- 14 High value and complex cases are reported via different routes and this report is not looking to repeat the content of those papers.
- 15 The key points that have been considered are:

Current Themes and Trends

- 16 The table below illustrates the number of cases received.

	2020	2021
Total	23	15
Patient	2	3
Staff	21	12

- 17 From the table above it is possible to see that there has been a marked decrease in claims being received during 2021. By looking further back, the total cases in 2017 was 36, in 2018 was 24 and in 2019 was 31.
- 18 The 38 cases considered have incident dates ranging from December 2017 until November 2021. Increasingly accumulated effects are being reported, especially in terms of work related stress.
- 19 This in itself demonstrates the need for the Trust to maintain access to the incidents reported by staff on the existing incident reporting system, when the NHS in Wales moves to the newly introduced RL Datix system. For this reason the Legal Services Team ensure they take an active role in the introduction of the new system and has input in relation to the data retention needs of the old system.

- 20 All claims made to the Trust by patients relate to non-emergency patients. No personal injury claims have been received from the table below provides details of the allegations received.

	2020	2021
Issues when manoeuvring a patient in a wheelchair	1	1
Securing the patient in the vehicle		1
Injured entering or taking a seat in the ambulance (walking patients)	1	1

- 21 The number of cases involving staff are higher. The table below illustrates the functions within the Trust.

	2020	2021
Total	21	12
NHS Direct/111	2	1
Emergency Medical Services	12	9
Urgent Care Service	1	0
Non-Emergency Patient Transport Service	6	2

- 22 From the above table it is possible to see that the decrease in personal injury claims being received is in relation to staff claims. It is also possible to see that more claims are received from emergency staff rather than non-emergency staff. This is probably reflective of the fact that pre-travel risk assessments can be undertaken with non-emergency patients.
- 23 **Appendix 1** at the foot of this report details the allegations/causes of the claims being raised. Whilst some wider themes can be identified, such as slips/trips and manual handling, the details show that these are often isolated events.
- 24 Previously there had been multiple claims in relation to trips on charging cables, however there has only been one over the last two years. This is following learning and improvement plans being implemented.
- 25 The table does indicate that there continues to be multiple needle stick issues. There are also multiple claims in relation to COVID, Stress and assaults.

Closures and Learning

- 26 During the same period of the calendar years of 2020 and 2021, the Trust closed 31 claims.

Claimant	Damages Paid	No Damages Paid	Percentage Paid	Percentage no payments
Totals	10	21	32	68
Patient	0	3	0	100
Third party*	2	1	66	33
PCS Staff	0	3	0	100
EMS Staff	8	14	36	64
*People who are not patients or staff (family travelling with patients)				

- 27 The above table indicates that the Trust pays damages in 32 percentage of cases which correlates to a high defend rate. In all cases the Legal Services Team gather all information, investigate the allegations made against the Trust and where necessary instruct an independent expert.
- 28 The claims are managed in line with the courts Civil Procedure Rules and the Trust utilises Part 36 of those rules, which encourages parties to settle disputes without going to Trial, thus minimising legal costs to the Trust. Part 36 allows the Trust to make a 'without prejudice' offer to settle a matter with no admission of liability, when our investigation identifies weaknesses and/or fault.
- 29 In the cases where the Trust paid compensation, the table below details the basic reason for the claim and the amount of damages paid.

Type	Details	Amount
3 rd party	Stretcher came loss in rear of vehicle	1400.00
	Accumulated traumatic incidents/stress	50000.00
Employee	Needle stick	725.00
	Needle stick	1250.00
	Needle stick	2500.00
	On station - Trip/slip from vehicle	2735.00
	On station - Trip on charging cable	4000.00
	On station - Pothole	3000.00
	Manual handling - Bariatric patient	8000.00
	Whiplash*	4000.00
*This case has been wrongly coded and is a PIRTC		

- 30 The figures above illustrate that each case is considered on its own merit. The range in the awards in relation to needle stick illustrate the individual level of contamination and the effects on the individual staff member.
- 31 In each case that the Trust accepts liability and pays damages, the Trust completes a Learning from Events Report for the Welsh Risk Pool. This documents both individual learning and organisational learning on each case.

- 32 Examples of the learning in relation to the payments made above includes:
- Individual learning in relation to the use of equipment
 - Reminder in 2019/20 update training surrounding sharps, Personal Protective Equipment (PPE) and avoiding sharps injuries
 - Podcast from Assistant Medical Director covering certain procedures that incur risk of needle stick
 - The introduction of quarterly station inspections, with checklist completion
 - The introduction of Trauma Risk Management (TRIM), Silvercloud for CBT, Occupational assistance and 24 hour access to assistance (including Face to Face counselling).

Ongoing cases and significant cases the Trust is currently handling

- 33 The Trust currently has 82 open cases. Of these, 75 relates to staff, 5 relate to patients and 2 to third party claimants.
- 34 Of the cases 2/3rds relate to Emergency Services, with the majority of the remaining third relating to Non-Emergency Services.
- 35 This SBAR brings these cases to the attention of the reader. These cases are considered significant because of the quantum involved in each case is potentially £100,000.00, or above.
- (i) 5294 - This is a manual handling issue, in that the member of staff fell from the rear of a vehicle and sustained an injury.
 - (ii) 5318 - This was an incident on station when a member of staff slipped in the rear of an ambulance.
 - (iii) 5037 - This is a case involving work related stress
 - (iv) 5219 - This is a claim in relation to Post Traumatic Stress Disorder
 - (v) 5184 - This is a case involving work related stress

Future

- 36 Whilst the number of claims being received have reduced what cannot be extrapolated from the current Datix system and these figures are the number of cases which become ligated and the impact of this in both time and costs savings.
- 37 All cases are investigated and a detailed response and disclosure is provided under the relevant Pre-Action Protocol.
- 38 However an increasing number of those cases are later the subject of formal legal proceedings.
- 39 These cases can be litigated on one of three tracks - Small Claims, Fast Track and Multi-track dependent on value and legal complexity. The track determines the extent of legal input required on each case.

- 40 Of the 82 open cases, 23 are currently on a defended tracks with 6 running on the most complex Multi-track and the remainder on the Fast track or awaiting allocation by the Court.
- 41 To contextualise this in terms of legal expenses, the average external legal costs paid to external solicitor to defend a Multi-track case was previously @ £45,000 - £50,000 and the Trust's budgeted costs on each of the current defended in-house Multi-track cases are between £50,000 - £60,000. Whilst these Multi-track cases are being managed in-house and this creates a demand on time and resources, it does however create a potential financial saving of £300,000 - £360,000 on 6 cases alone as no external solicitors costs are actually incurred (albeit they are budgeted for by the Court).
- 42 This indicates that the Trust's model of in-house management of personal injury claims (where possible) does have significant costs savings benefits.

APPENDIX 1

Function	Themes	Detail	2020	2021
NHS Direct/111	Equipment (2)	Eye/sight injury (IT use)		1
		Chair arm snapped	1	
		Covid	1	

PCS	Equipment	Vehicle door slammed on limb	1	
	Manual handling (6)	Seating a patient	1	1
		Bariatric patient on a stretcher	1	
		Wheelchair on the ramp		1
		Moving a patient/4 man lift	1	
		Assault	1	
	Stress	1		

UCS	Manual Handling	Bariatric patient	1	
EMS	(4)	Needle stick	3	1
	On station/Slips and trips (8)	Slipped on step		1
		Slipped on ice		1
		Trip due to lack of light	1	
		Trip on hose pipe	1	
		Slipped on wet floor	1	
		Tripped on cable	1	
		Tripped on PPE		1
		Tripped leaving vehicle on restocking		1
	At patient location (5)	Equipment handle on carry chair broke	1	
		Caught response bag in house	1	
		Struggled with weight of response bag outside of house	1	
		Slipped leaving the vehicle on patient drive		1
		Grabbed by patient on Manga elk	1	
		On knees too long		1
	Assault		1	
	Stress	1		
	COVID		1	



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Gwasanaethau Ambiwllans Cymru
Welsh Ambulance Services
NHS Trust

AGENDA ITEM No	15
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	0

Evaluation of the Live Review of RED Calls in CSD

MEETING	Quest
DATE	17 February 2022
EXECUTIVE	Lee Brooks, Director of Operations
AUTHOR	Stephen Clinton, ADO Integrated Care & Mike Brady, CSD Manager
CONTACT	Stephen Clinton, ADO Integrated Care

EXECUTIVE SUMMARY

To ensure calls are being accurately prioritised the Clinical Support Desk (CSD) Clinicians can carry out a rapid review of any ongoing RED call to determine if the RED priority is appropriate. MPDS is a non-clinical prioritisation tool and clinical review of the presentation may yield a different priority.

During a trial period of increased RED Review activity CSD safely achieved a 20% downgrade rate for reviewed RED calls. By far the largest category of calls downgraded were (6) Breathing Problems.

The trial was successful but further study would benefit from improved data capture and reporting. It has been agreed to continue the RED Review process where staffing and demand allow and to further the trial period to review the efficacy.

This paper is for Quest to note.

KEY ISSUES/IMPLICATIONS

It may be possible to review RED calls routinely to ensure the call is confirmed as RED, clinically.

An impact of clinically reviewing the RED calls is undermining confidence in the non-clinical MPDS triage system, however communication, understanding of the two processes and providing feedback into MPDS audits will address this.

Downgrading RED calls to AMBER or even GREEN has an impact on this pool of resource, expanding them to higher levels. Although the volume of calls is low the impact of this in periods of high escalation is also under review.

REPORT APPROVAL ROUTE

At Senior Operations Team (now Operations Senior Leadership Team) on 14 December 2021 the recommendations that SOT note the paper and approve the recommendations were both agreed.

REPORT APPENDICES

No appendices

REPORT CHECKLIST

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

SITUATION

1. When the EMS system is operating in significant system pressure, with high demand and limited resources to respond, the Trust employs methods to deal with demand in a clinically safe way.
2. In August 2021, the CSD Clinicians began to increase the number of RED Reviews to ensure the limited resources were sent to the highest acuity patients.
3. This paper builds on a previous review to provide a deeper analysis of the process and outcomes while noting further analysis is required.

BACKGROUND

4. In normal operating models the Trust will focus responding resources on the highest acuity patients first. RED is a response priority established using non-clinical 999 call handling with the MPDS prioritisation tool and is a part of the Trust's Clinical Response Model (CRM). RED patients are immediately life threatened and the most rapid of responses is needed.
5. To ensure calls are being accurately prioritised the Clinical Support Desk (CSD) Clinicians can carry out a rapid review of any ongoing RED call to determine if the RED priority is appropriate. MPDS is a non-clinical prioritisation tool and clinical review of the presentation may yield a different priority.
6. The CSD Clinician will review the call visually in the Computer Aided Dispatch (CAD) system and can listen to the call while it is ongoing. At any time the Clinician may agree that this is a confirmed RED in which case the call is left to complete.
7. Once the MPDS assessment is complete, if the Clinician wants to review the call further, the EMD will transfer the caller across, and the Clinician will perform a clinical triage. At this stage the call is downgraded to AMBER 1 and resources managed appropriately.
8. The CSD Clinicians undertake a wealth of Consult and Close and Patient Safety activities including Clinical Floor Walking for the Clinical Safety Plan and Stack Safety, contacting waiting callers. Along with RED Reviews all of these are undertaken in periods of high escalation.
9. The broader impact of the movement of RED calls to the AMBER stack has not been contemplated in this report given the complexities of observing the impact in periods of high demand, high REAP levels and measures taken through CSP.

ASSESSMENT

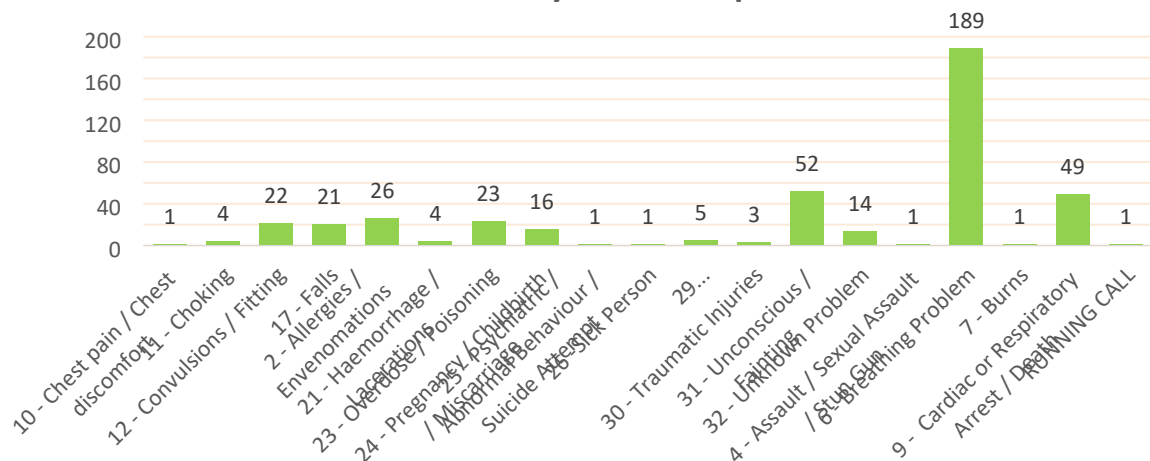
10. Between 20th August and 1st November 2021 11,535 RED incidents were recorded. CSD RED Review was in operation on 27 days during this period (at various time points) and Clinicians recorded reviews of 471 incidents.
11. There have been 471 RED reviews since the monitoring period began. Table 1 shows the outcome of these reviews.

Outcome	Count
---------	-------

01-RA - Current Response Appropriate	368
04-DA1 - Downgrade to Amber 1	78
06-DA2 - Downgrade to Amber 2	3
08-DG2 - Downgrade to Green 2	5
09-DG3 - Downgrade to Green 3	3
11-TAXI - Taxi Suitable	1
12-ALTRA - Alternative Transport	8
Remained Amber 1 as sent APP ETA < 10minutes	1
Remained RED as resource 1 minute ETA	1
Stayed RED - no time to assess to downgrade	1
Unable to downgrade as resource arrived was ETA 2 mins	1
Unable to downgrade due to DEFIB marked as at scene	1
Grand Total	471

- 98 of the 471 cases were downgraded from RED which represents 20% of those reviewed. No adverse incidents have been reported from the RED Review process since it started. Safely achieving a downgrade rate of 20% will have a significant impact on patient response and should continue.
- A comparison of RED Review against other aspects of CSD such as Consult and Close, Stack Safety and Clinical Floor Walking would benefit the Trust when dealing with increased demand for Clinicians. This will enable intelligent decision-making during escalation.
- Table 3 shows the Chief Complaint of the cases being reviewed by CSD. These are largely breathing problems, Cardiac Arrest, and Unconscious patients.

Red Review by Chief Complaint



- MPDS is not a triage tool, but rather a prioritisation tool. A case being downgraded does not mean the MPDS code was wrong, or a mistake has been made, rather a clinical triage process has taken place and yielded a different result.
- MPDS is purposefully sensitive to cases where deterioration may occur and is very good at finding the most serious cases amongst all callers. This approach will naturally leave some cases which are prioritised higher than a clinical triage would place them.

17. A rapid dip test review was undertaken of the downgraded cases in table 1. 10% of the downgraded cases were randomly selected, and a senior MPDS auditor rapidly reviewed the case for any errors.
18. Of the 10% rapidly reviewed, the following themes were identified that may have contributed to over triage. Though largely, most cases were correctly coded,
 - Incorrect shunt to higher determinate protocol
 - Incorrect chief complaint selected
 - Obvious death descriptor / Expected death process not followed
 - Ineffective breathing was initially selected but later downgraded after the diagnostic tool.
19. Given the themes identified, there is merit in exploring a focused MPDS audit on red cases for a short period, possibly a month. This may identify further themes and trends and allow internal training to focus on the needs identified. This seems to be especially prevalent for breathing difficulties which was the most recent significant change which led to an increase in RED calls some months ago.
20. There is not a robust method of reporting downgraded RED cases in the CSD. Much of this paper is built from different sources of information, and a single reporting source would benefit this process moving forward. This may better collate and display the re-triage process to external stakeholders also, being transparent in our downgrade process.
21. A further issue worthy of study is the impact of the downgraded RED calls being placed in a lower priority and what the outcome was for those patients compared to what it would have been had they remained RED. This is very challenging to fathom given the system pressures being experienced currently.
22. Further to this assessment it is proposed that
 - a. CSD continue the use of the RED Review process and continue to allocate Clinicians to the role during system pressure
 - b. Health Information be commissioned to produce a dedicated downgrade report to evaluate downgraded calls more easily / accurately
 - c. EMS Coordination and Response 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. CSD continues to review RED Review activity with the additional information and periodically report on activity and outcomes.
 - e. SOT investigate the option to evaluate the impact that RED Review has on the AMBER and GREEN pool of calls.

RECOMMENDATIONS

23. That Quest **notes** the content of the paper

