Bundle Quality, Patient Experience and Safety Committee 4 February 2025

Agenda attachments

ITEM 00 Agenda QuEST Committee 04022025

0 09:30 - OPENING ITEMS

1 Chair's Welcome, Apols and Quorum

2 Declarations of Interest

ITEM 02 Board Member register of Interests 8 January 2025

3 Minutes

3.1 Minutes 5 November 2024

3.2 Ratification of Chair's action (request for approval of the updated attached High Intensity User Policy v1.13)

ITEM 03 2024-11-05 Draft QUEST OPEN MINUTES

ITEM 03.2 Ratification of Quest Committee Chairs Actions from November 2024

4 Action Log & Matters Arising

4.1 Committee Highlight report

ITEM 04 Action Log

ITEM 04.1 Quest Committee Highlight Report November 2024

5 09:40 - Ops Report Q3 24/25

ITEM 05 Operations Quarterly Report for Committee 24-25 Q3 FINAL

6 09:50 - Committee Effectiveness Review

6. Committee Effectiveness Review

6.1 WAST Board Committee Remits

6.2 Terms of Reference

6.3 Cycle of Business

6.4 Draft Annual Report

ITEM 06 Effectiveness Review 2024-25 SBAR - QuEST

ITEM 06.1 Annex 1 - Committee remits delegated by Board 24-25

ITEM 06.2 Annex 2 - QUEST Committee Terms of Reference 2024-25 - Approved by Trust Board 30052024 - Updated 180924 re HCS Reference

ITEM 06.3 Cycle of Business

ITEM 06.4 Annex 4 - QUEST Draft Annual Report 2024-25

7 10:20 - Patient Story

The PTR Team has recently recorded a Deaf patient/complainant and the PTR staff who deal with her. They all express the challenges in responding to a Deaf complainant etc. With the likelihood of BSL becoming the third mandated language in Wales in the not too distance future along with the old Sensory Loss Standards becoming the newly revised 'Accessible and Communication Standards'

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8.1 10:50 - COMFORT BREAK

9 11:05 - Audit Wales Quality Governance Follow Up Review 2024 (Audit Wales Report)

ITEM 09 Audit Wales Quality Governance Follow Up Review 2024

ITEM 09.1 Quality Governance Follow Up Report FINAL

10 11:20 - The Duty of Quality Implementation Plan - Update

Verbal Update

11 11:30 - Health and Care Quality Standards Self Assessment

ITEM 11 Health Care Standards Self Assessment

ITEM 11.1 Health & Care Standards Self Assessment - Annex

ITEM 11.1a Quality Standards

12 11:40 - Datix Recovery and Improvement Plan

ITEM 12 Datix Recovery & Improvement Plan

ITEM 12.1 Datix Recovery & Improvement Plan - Annex 2

ITEM 12.2 Datix Recovery & Improvement Plan - Annex 3

13 11:55 - Putting Things Right Report

ITEM 13 Putting Things Right Report, Quarter 3 2024-2025 (October - December) (2)

ITEM 13.1 Putting Things Right Report, Quarter 3 2024-2025 (October - December) - Annex 2 (1)

14 12:15 - Monthly Integrated Quality Performance Report

ITEM 14 MIQPR SBAR QUEST Nov Dec 24
ITEM 14.1 MIQPR Oct Nov 24

15 12:25 - Focus on Clinical Indicator - Stroke
ITEM 15 SBAR - Stroke update
ITEM 15.1 Focus on CIs - Stroke

16 12:35 - Risk Management and Board Assurance Framework
ITEM 16 Executive Summary Risk Management Report QuEST 040225

16.1 12:45 - LUNCH

17 13:25 - Cancelled Calls Potential Impact Analysis
ITEM 17 Exec Summary Cancelled Calls Potential Impact Analysis

18 13:35 - Clinical Audit Plan 2025/26
18.1 Clinical Audit Plan 2025/26 - Approval
18.2 Action Tracker - Q3 (update) - Assurance
18.3 Clinical Audit Plan Q3 2024/25
ITEM 18 SBAR - Clinical Audit Plan 2025 - 26
ITEM 18.1 Clinical Audit Plan 2025 - 26
ITEM 18.2 SBAR - Clinical Audit Plan & Action Tracker Q3 2024-25 update
ITEM 18.3 Clinical Audit Plan Q3 2024 - 25

19 13:50 - Infection Prevention and Control Service Report
ITEM 19 Infection Prevention and Control Service Report
ITEM 19.1 Infection Prevention and Control Service Report - Annex

20 14:00 - Internal Audit Report: Patient Experience Community Involvement
ITEM 20 Patient Experience and Community Involvement Internal Audit Report
ITEM 20.1 Patient Experience and Community Involvement Internal Audit Report - Annex 1

21 14:10 - Audit Tracker (Q3 24/25)
ITEM 21 SBAR Audit Tracker to Committees - Q3 Reporting - October-December 2024 - QuEST Committee
ITEM 21.1 Internal Audit Tracker Actions
ITEM 21.2 External Audit Actions

22 14:20 - Policies for approval/Adoption
ITEM 22 Policies for Committee Approval - QuEST 040225
ITEM 22.1 Safeguarding Children and Adults at Risk of Harm Policy v3.9 (240125)
ITEM 22.2 Violence Against Women, Domestic Abuse & Sexual Violence 'Ask & Act' Policy v1.19 240125

22.1 CONSENT ITEMS

23 Committee Cycle of Business (CoB) and Priorities Update:4
ITEM 23 QuEST Committee Cycle of Business Monitoring Report and Committee Priorities Q4
ITEM 23.1 Monitoring Report
ITEM 23.1a Cycle notes

23.1 14:25 - CLOSING ITEMS

24 Key Messages for the Board

25 Reflections and Summary of Decisions/Actions

26 Any Other Business

27 Date & Time of the Next Meeting: 9 May 2025

Length of Meeting: 05:20		Agenda	[OPEN] QUEST COMMITTEE - 4 February 2025					Deadline for Papers:
Time	**Mins allotted**	**Agendum**	**Title**	**Format**	**Item for**	**Item requested by**	**Paper prepared by**	**Item presented by**
			OPENING ITEMS					
09:30	00:10	1	Chair's Welcome, Apols and Quorum	Verbal	Information	Standing	n/a	Chair
		2	Declarations of Interest	Verbal	To State Conflicts	Standing	n/a	Chair
		3	3.1 Minutes of the Last Meeting: 05 November 2024 3.2 Ratification of Chair's action	Paper	Approval	Standing	n/a	Chair
		4	Action Log & Matters Arising *Action: Impact of Changes to Stroke Categorisation: The Committee noted that updates on the location of stroke units will be provided in due course. Although the timeline was uncertain, Andy Swinburn agreed to keep the Committee updated. Item 4.1 AAA Report from 05 November 2024	Paper	Discussion	Standing	n/a	Chair
09:40	00:10	5	Ops Report Q3 24/25	Paper	Information	CoB	Operations	Lee Brooks
09:50	00:30	6	6. Committee Effectiveness Review 6.1 WAST Board Committee Remits 6.2 Terms of Reference 6.3 Cycle of Business 6.4 Draft Annual Report	Paper	Assurance	CoB	Gov	Trish Mills
			FOR APPROVAL, ASSURANCE AND DISCUSSION					
10:20	00:30	7	Patient Story The PTR Team has recently recorded a Deaf patient/complainant and the PTR staff who deal with her. They all express the challenges in responding to a Deaf complainant etc. With the likelihood of BSL becoming the third mandated language in Wales in the not too distance future along with the old Sensory Loss Standards becoming the newly revised 'Accessible and Communication Standards' it would be very timely and it would cover not just patient experience and PTR but equality also. Update on previous Staff Story (Sian Davies-Kumar, Palliative Care Paramedic) *Follow up staff story to be taken as read.*	Video	Discussion	CoB	Quality	Liam Williams
10:50	00:15	8	INTENTIONALLY LEFT BLANK					
11:05	00:15		COMFORT BREAK					
11:20	00:15	9	Audit Wales Quality Governance Follow Up Review 2024 (Audit Wales Report)	Paper	Assurance	CoB	Quality	Liam Williams
11:35	00:10	10	The Duty of Quality Implementation Plan - Update	Verbal	Assurance	Forward Planner	Quality	Liam Williams
11:45	00:10	11	Health and Care Quality Standards (update on the self-assessments)	Paper	Assurance	Ad Hoc	Quality	Liam Williams
11:55	00:15	12	Datix Recovery and Improvement Plan	Paper	Assurance	Ad Hoc	Quality	Liam Williams
12:10	00:20	13	Putting Things Right Report *Action: The Committee asked that relevant colleagues consider the structure of the Putting Things Right Report and what the Committee needs to focus on. This should be considered for the next report.(Liam Williams, Wendy Herbert and Claire Appleton)	Paper	Assurance	CoB	Quality	Liam Williams
12:30	00:10	14	Monthly Integrated Quality Performance Report	Paper	Assurance	CoB	SPP	Rachel Marsh
12:40	00:10	15	Focus on Clinical Indicator - Stroke	Presentation	Assurance	CoB	Clinical	Jonathan Chippendale
12:50	00:10	16	Risk Management and Board Assurance Framework	Paper	Assurance	CoB	Gov	Julie Boalch
13:00	00:40		LUNCH					
13:40	00:10	17	Cancelled Calls Potential Impact Analysis	Presentation	Discussion	Forward Planner	Clinical	Jonathan Chippendale

13:50	00:15	18	18.1 Clinical Audit Plan 2025/26 18.2 Action Tracker - Q3 (update) - Assurance 18.3 Clinical Audit Plan Q3 2024/25 The Audit Wales Follow up audit has specific recommendations relating to the Clinical Audit Plan - these were to be referenced in the update	Paper	Approval	CoB	Clinical	Jonathan Chippendale
14:05	00:10	19	Infection Prevention and Control Service Annual Report	Paper	Assurance	CoB	Quality	Liam Williams
14:15	00:10	20	Internal Audit Report: Patient Experience Community Involvement (Liam Williams)	Paper	Assurance	CoB	Gov	Trish Mills
14:25	00:10	21	Audit Tracker (Q3 24/25)	Paper	Assurance	CoB	Gov	Trish Mills
14:35	00:05	22	Policies for Approval/Noting					
			22.1 Safeguarding Children and Adults at Risk of Harm Policy 22.2 Violence Against Women, Domestic Abuse and Sexual Violence Policy	Paper	Approval	CoB	Gov	Trish Mills
			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.					
14:40	00:00	23	Committee Cycle of Business (CoB) and Priorities Update:	Paper	Information	CoB	Gov	Trish Mills
			CLOSING ITEMS					
14:40	00:10	24	Key Messages for the Board	Verbal	Discussion	Standing	n/a	Chair
		25	Reflections and Summary of Decisions/Actions	Verbal	Discussion	Standing	n/a	Chair
		26	Any Other Business	Verbal	Discussion	Standing	n/a	Chair
		27	Date & Time of the Next Meeting: 9 May 2025	Verbal	Information	Standing	n/a	Chair
14:50	**05:20**		**CLOSE**					

LEAD PRESENTERS

Name	Position
Julie Boalch	Assistant Director of Corporate Governance and Risk
Lee Brooks	Executive Director of Operations
Jonathan Chippendale	Consultant Paramedic - Urgent Care
Bethan Evans	Chair and Non-Executive Director
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Trish Mills	Director of Corporate Governance/Board Secretary
Andy Swinburn	Executive Director of Paramedicine
Liam Williams	Executive Director of Quality and Nursing

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Left Trust
BEAUMONT-WOOD, Rhiannon	**Non-Executive Director** * Member of the Remuneration Committee * Member of the the Audit, Risk and Assurance Committee * Member of the Quality, Patient Experience and Safety Committee	Dorset Integrated Care Board (NHS Dorset), Non-Executive Director	Financial Interest	May 2023		
		Nursing and Midwifery Council (NMC), Designated Council Member for Wales	Financial Interest	June 2024		
		RBW Executive and Professional Coaching Ltd, Company Director (Company No 14938585) and Shareholder	Financial Interest	June 2023		
		Currently on coaching framework with Health Education and Improvement Wales	Financial Interest	June 2024		
		Registered Nurse (NMC)	Non-Financial Professional	January 1995		
		Registered Specialist Community Public Health Nurse	Non-Financial Professional	September 1996		
		Member of the Royal College of Nursing	Non-Financial Professional	2007		
BEESLEE, Jayne	**Non-Executive Director** * Chair of the Finance and Performance Committee * Member of the Remuneration Committee * Member of the Academic Partnership Committee	Employment for interim assignments via Public Sector Resourcing (an agency) regarding the review of major UK government programmes (remunerated net of tax via an Umbrella Company – Danbro Employment Umbrella Ltd)	Financial Interest	01 October 2023		
		Member Representative on the UK Civil Service Pension Board	Non-Financial Personal	01 October 2019		
		Governor on the Finance & General Purposes Committee of Cardiff and Vale Further Education College	Non-Financial Personal	01 February 2024		
		Fellow Chartered Institute of Personnel & Development	Non-Financial Personal	01 April 2006		
BROOKS, Lee	**Executive Director of Operations**	Partner employed by Welsh Ambulance Services NHS Trust	Any Other Interest	July 2019		
		Member of the Order of St John	Any Other Interest	01 March 2023		
		Volunteer – St John's Ambulance Cymru	Any Other Interest	06 April 2023		
		Council Member – St John's Ambulance Cymru Gwent Council	Any Other Interest	06 April 2023		
CURRAN, Peter	**Non-Executive Director** * Chair of the Audit, Risk and Assurance Committee * Chair of the Charity Committee * Member of the Finance and Performance Committee * Member of the Remuneration Committee	Trustee of Action for Children [1097940]	Position in Charity or Voluntary Organisation	01 February 2021		
		Company Director – Action for Children [04764232]	Directorships	01 February 2021		
		Company Director – Action for Children (Wales) Ltd [10011497]	Directorships	05 April 2022		
		Trustee of National Youth Arts Wales [1170643]	Position in Charity or Voluntary Organisation	06 May 2021		
		Company Director – National Youth Arts Wales [10449512]	Directorships	06 May 2021		
		Non-Executive Director for Taff Housing	Position in Charity or Voluntary Organisation	01 May 2022		
		Company Director – Team Police Ltd [12518812]	Directorships	01 January 2022	31 October 2024	
		Independent Board Member of the Project Board – National Contemporary Art Gallery for Wales	Any Other Interest	01 January 2024		
		Interim Finance Director for Torfaen Leisure Trust	Directorships	01 September 2023	29 February 2024	
		Interim Independent Member – Kaplan International Colleges UK Ltd [05268303	Directorships	01 March 2024		
		Independent Member – Kaplan Open Learning (inc member of the Audit & Risk Committee)	Directorships	21 March 2024		
DENNIS, Colin	**Chair of Trust Board and Non-Executive Director** * Chair of Remuneration Committee	Chair – Citizen Housing [Charity] (previously WM Housing Group)	Position in Charity or Voluntary Organisation	01 January 2015		
		Company Director – Citizen Treasury PLC (previously WM Housing Treasury Ltd)	Directorships	29 August 2017		
		Company Director – Citizen Treasury Vehicle Ltd	Directorships	04 September 2017		
		Chair – North Devon Homes	Position in Charity or Voluntary Organisation	01 October 2021		
		Company Director – North Devon Homes	Directorships	01 April 2022		
		Chair – Green Square Accord (Housing Association)	Position in Charity or Voluntary Organisation	26 March 2024		
		Company Director – LowCarbonLiving Homes Ltd [04207671]	Directorships	26 March 2024		
		Company Director – Green Square Estates Ltd [8719365]	Directorships	26 March 2024		
EVANS, Bethan	**Non-Executive Director** * Chair of Quality, Patient Experience & Safety Committee * Member of Finance & Performance Committee * Member of People & Culture Committee * Member of Remuneration Committee	Managing Director (Employed) at My Choice Healthcare Limited.	Any Other Interest	01 June 2019		
		Non-Executive Board Member at RHA (Social Housing Organisation – Community Benefit Society)	Position in Charity or Voluntary Organisation	01 November 2019		
		Company Director – My Choice Healthcare South Wales Limited	Directorships	11 March 2020		
		Company Director – Moorlands Rehabilitation (Staffordshire) Limited.	Directorships	20 December 2019		
		Company Director – Springfield (Barqoed) Limited.	Directorships	12 March 2020		
		Company Director – Homes of Excellence Limited	Directorships	19 March 2021		
		Company Director – Victoria House Care Property Limited	Directorships	05 March 2020		
		Company Director – My Choice Healthcare (Four) Limited	Directorships	27 April 2022		
		Company Director – Luk Ros Property Limited	Directorships	12 March 2020		
		[Previously called Homes of Excellence Healthcare Limited, Company name changed 12.08.2022 - #12513139]	*Directorships*	*12 March 2020*		
		Company Director – Hawthorn Court Property Limited	Directorships	27 April 2022		
		[Previously called My Choice Healthcare (Three) Limited, Company name changed 12.08.2022 - #13371375]	*Directorships*	*27 April 2022*		
		Company Director – Ocean Living Property Limited	Directorships	22 July 2022		
		Company Director – Hawthorn Court Care Limited	Directorships	22 July 2022		
		Company Director – Glyncornel Property Limited	Directorships	01 July 2022		
		Company Director – My Choice Healthcare (Two) Limited	Directorships	01 July 2022		
		Company Director – Carmarthen Care Limited	Directorships	02 January 2024		
		Company Director – Towy Castle Property Limited	Directorships	01 September 2023		
HUTCHINGS, Hayley	**Non-Executive Director** * Member of the Remuneration Committee * Member of the Academic Partnership Committee * Member of the People and Culture Committee	Employed at Swansea University, Professor of Health Services Research	Financial Interest	17 June 1995		
HITCHON, Estelle	**Director of Partnerships and Engagement**	Member of Academi Wales Expert Panel	Position in Charity or Voluntary Organisation	15 July 2024		

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Left Trust
JACKSON, Ceri	**Non-Executive Director & Vice Chair of the Trust Board** * Chair of the People and Culture Committee * Member of the Charity Committee * Member of Audit Committee * Member of Quality, Patient Experience & Safety Committee * Member of Remuneration Committee	Management Consultant primarily working in third sector	Interest in Companies and Securities	01 May 2019		
		Associate Director of SamKat Consulting Ltd in my capacity as self-employed management consultant	Directorships	01 June 2021		
		Charity Trustee - Stroke Association Trustee, Chair Wales Advisory Group.	Position in Charity or Voluntary Organisation	08 October 2020		
		Charitable Company - Stroke Association - Company Director	Directorships	08 October 2020		
KILLENS, Jason	**Chief Executive**	Honorary Professor - Swansea University	Personal or Departmental Sponsorship	2019		
		Chairperson – Association of Ambulance Chief Executives (AACE)	Non-Financial Professional	September 2024		
		Company Director of the Association of Ambulance Chief Executives (AACE), Co No. (07761209)	Directorships	September 2024		
		Officer of the Order of St John	Any Other Interest	January 2024		
		Member of the Order of St John	Any Other Interest	2009	2024	
KNEESHAW, Carl	**Director of People**	Chartered Fellow of Chartered Institute of Personnel and Development	Personal or Departmental Sponsorship	April 2020		
		Fellow of Institute of Leadership	Personal or Departmental Sponsorship	October 2020		
		Safeguarding Lead for local outreach charity, Brunstad Christian Church – Huntworth, Bridgwater, Somerset	Position in Charity or Voluntary Organisation	September 2018		
LEWIS, Angela	**Director of Culture Change**	Nil Declaration				
MARSH, Rachel	**Executive Director of Strategy, Planning and Performance**	Nil Declaration				
MILLS, Patricia (Trish)	**Director of Corporate Governance/ Board Secretary**	Nil Declaration				
PARRY, Hugh	**Trade Union Partner**	Nil Declaration				
ROWAN, Hannah	**Non-Executive Director** * Chair of Academic Partnership Committee * Member of Charity Committee * Member of People & Culture Committee * Member of Remuneration Committee	Director, St Martin's Associates (Business consulting and coaching)	Directorships	04 April 2022		
		Non -Executive Director Qualifications Wales (regulator for all non degree qualifications in Wales)	Any Other Interest	01 April 2021		
		Trustee MAE Cymru (Christian charity which champions gender equality in church of Wales)	Position in Charity or Voluntary Organisation	13 November 2021	November 2023	
		Elected member, The governing body of the church in Wales (Parliament of church in Wales - voting member)	Any Other Interest	01 April 2021		
		Relative (Parent) is a Non-Executive Director for Social Care Wales	Any Other Interest	01 April 2017		
SAMMUT, Jonathan (Jonny)	**Director of Digital Services [appointed 26.09.2023]**	Fellow of the British Computer Society – FBCS	Any Other Interest	04 March 2024		
		Panel Member of the UK CIO Advisory Panel – Digital Health	Any Other Interest	05 July 2023		
		Federation of Informatics Professionals - Leading Practitioner	Any Other Interest	25 April 2024		
SWINBURN, Andrew (Andy)	**Executive Director of Paramedicine**	Strategic Advisor to College of Paramedics	Any Other Interest	01 January 2020		
TURLEY, Christopher	**Executive Director of Finance and Corporate Resources**	Treasurer of Royal Gwent Hospital League of Friends.	Position in Charity or Voluntary Organisation	01 February 2022	05 November 2024	
TURNER, Damon	**Trade Union Partner**	Nil Declaration				
WILLIAMS, Liam	**Executive Director of Quality and Nursing [from 01 August 2022]**	Chair/Director - Thornbury Carnival Community Interest Company Voluntary	Position in Charity or Voluntary Organisation	01 August 2019		
		Member Royal College Nursing	Any Other Interest	01 August 2022		
		Committee member Royal College Nursing, Nurses in Management and Leadership Forum Steering Committee	Position in Charity or Voluntary Organisation	01 August 2022		

WELSH AMBULANCE SERVICES NHS TRUST

MINUTES OF THE OPEN SESSION OF THE MEETING OF THE QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE HELD ON 5 NOVEMBER 2024 VIA TEAMS

Meeting started at 09:30

PRESENT:

Bethan Evans	Non-Executive Director
Ceri Jackson	Non-Executive Director and Vice Chair of the Board

IN ATTENDANCE:

Claire Appleton	Assistant Director of Putting Things Right
Hugh Bennett	Assistant Director, Commissioning and Performance (Left during Item 76/24)
Julie Boalch	Assistant Director of Corporate Governance and Risk
Lee Brooks	Executive Director of Operations (Joined at Item 63/24)
Jonathan Chippendale	Consultant Paramedic (Joined at Item 75/24)
Leanne Hawker	Head of Patient Experience & Community Involvement
Wendy Herbert	Deputy Director of Quality and Nursing
Bethan Jones	Local Safety Champion (Item 75/24 only)
Alison Kelly	Business and Quality Manager
Greg Lloyd	Assistant Director of Clinical Delivery (Joined at Item 63/24)
Osian Lloyd	Head of Internal Audit, NWSSP
Trish Mills	Director of Corporate Governance/ Board Secretary
Edward O'Brian	Clinical Lead, Palliative Care (Attended for Item 62/24 only)
Steve Owen	Corporate Governance Officer
Hugh Parry	Trade Union Partner
Alex Payne	Corporate Governance Manager
Jonny Sammut	Director of Digital Services
Andy Swinburn	Executive Director of Paramedicine
Jonathan Turnbull-Ross	Assistant Director of Quality Governance
Liam Williams	Executive Director of Quality and Nursing (Joined at Item 66/24)

OBSERVERS:

Angela Mutlow	Director of Operations Llais
Lisa Trounce	Head of Compliance and Assurance

APOLOGIES:

Henry Garrard	Trade Union Partner
Mark Marsden	Trade Union Partner
Rachel Marsh	Executive Director of Strategy, Planning and Performance

61/24 PROCEDURAL MATTERS

The Chair extended a warm welcome to everyone advising that the meeting was being recorded. Apologies were noted from Henry Garrard, Rachel Marsh, and Mark Marsden.

Declarations of Interest
There were no further declarations of interest to those already listed in the Register.

Minutes
The Minutes of the meeting held on 13 August 2024 were confirmed as a correct record, save for the correction of Leanne Hawker's job title.

Matters Arising
The Committee received an update following the patient story from Linda Erro Castillo at the last meeting and noted progress against actions identified, including the ability to record learning difficulties/autism/neurodiversity and to prompt/record reasonable adjustments will go live on the electronic Patient Care Record (ePCR) in October 2024.

Action Log
The action log and the Committee Highlight AAA report from the last Quality, Patient Safety and Experience Committee (QuEST) meeting were considered:

Minute 41/24: Operations Update: *Review of terminology used, a recent questionnaire from Public Health Wales still referred to "NEPTS" (Non-Emergency Patient Transport Services). Since the name has been updated to "Ambulance Care," this outdated terminology could potentially cause confusion among the public. Peter Brown agreed to action.* Operations Colleagues will review, and update language as required on an ongoing basis. It was agreed to close this action.

Minute 51/24: Impact of the changes to the Stroke categorisation: *The Committee noted that updates on the location of stroke units will be provided in due course. Although the timeline was uncertain, Andy Swinburn agreed to keep the Committee updated.* It was confirmed by Andy Swinburn there were no updates for this meeting. It was agreed appropriate for this action to remain open.

Transfer from QuEST to the People and Culture Committee (PCC) In respect of the relief gap in Powys, update to PCC on the recruitment and management of abstractions. This matter was discussed at PCC, and it was resolved that the projected improvement across all gaps except for EMT1-2 (remains static) by Feb 25. By Feb 25, 4 of the 6 staff groups will be at full establishment, as opposed to only 2 groups at present. NB: this is the confirmed position passed on acceptances of positions already received (but not yet started). If QuEST content with remarks from PCC, then propose for closure. The PCC have closed this action. It was agreed to close this action.

Committee AAA report dated 13 August 2024

The Chair drew the Committee's attention to the contents of the AAA report for their information; this highlighted the key points from the Committee's last meeting on 13 August 2024.

RESOLVED: That

(1) Apologies were recorded for Henry Garrard, Mark Marsden and Rachel Marsh.

(2) The Minutes of the Open meeting held on 13 August 2024 were confirmed as a correct record, save for the correction of Leanne Hawker's job title.

(3) An update on the previous patient story was given which concerned Linda Erro Castillo and progress against actions identified was noted.

(4) Consideration was given to the Action Log and the AAA report as described above.

62/24 STAFF STORY – SIAN DAVIES-KUMAR, PALLIATIVE CARE PARAMEDIC (VIDEO)

Note: This item was received prior to the Operations update.

Leanne Hawker introduced Sian's experience which highlighted a crucial aspect of end-of-life care: the need to respect and fulfil the family's wishes while ensuring the patient's comfort.

The Committee were shown a video in which Sian Davies-Kumar shared her experience as a Palliative Care Paramedic. She described a specific case where she attended to a young gentleman with metastatic brain cancer. The family had called 999, and Sian was able to manage the patient's symptoms effectively, ensuring he could stay at home as per his and his family's wishes. She coordinated with the palliative care team, GP, and district nurses to set up the necessary syringe drivers for pain management. Sian emphasised the importance of communication with the family and ensuring the patient's comfort, which facilitated a good death, surrounded by loved ones.

Leanne Hawker added that Sian's story was a powerful testament to the importance of addressing both the emotional and physical needs of patients and their families. By ensuring that the young gentleman could stay at home and be comfortable, she not only managed his symptoms but also provided immense emotional support to his family. This holistic approach will leave a lasting, positive legacy and a meaningful experience for everyone involved.

Liam Williams highlighted that Sian's presentation exemplifies the ideal scenario many healthcare professionals strive for: providing the best possible death in the preferred place, with comprehensive support for both the patient and their family.

Wendy Herbert commented that the contrast between the ideal scenario Sian shared and the reality many families experience highlighted the gaps in our current system. The lack of preparation and support for end-of-life care can lead to distressing situations for both patients and their families.

Hugh Parry raised the point concerning the timely access to syringe drivers and the scaling up of Palliative Care Paramedics. Andy Swinburn explained that while buying syringe drivers could address the immediate issue, it was crucial to ensure that existing community services were used and supported to deliver the care they were commissioned for. Sian's expertise was a result of her extensive experience in palliative care, which was difficult to replicate through training alone. Ultimately, while ambulance services can fill gaps in palliative care, the goal should be to strengthen the existing community services to provide comprehensive end-of-life care.

Liam Wiliams expressed his concern at the lack of a robust electronic record system for end-of-life care in Wales. He added it was frustrating to see that while other regions have evolved their systems, the current reliance on outdated special notes can hinder the quality of care and support for families.

The Committee recognised the significant challenges going forward and expressed their concerns about the lack of immediate solutions and the increasing pressure on resources. Furthermore, the competition for funding in the charity sector and the shortage of district nurses and GPs were critical issues that need addressing.

Ed O'Brian commented that the role of Palliative Care Paramedics in preventing 999 calls was significant. By intervening early and providing specialised care, they can prevent unnecessary emergency responses and ensure that patients receive the appropriate care in a timely manner. This not only benefits the patients and their families but also helps to optimise the use of emergency services.

He added that many deteriorations and end-of-life situations were not recognised until a 999 call was made. Families often panic because they have not been prepared or informed about what to expect, leading to emergency calls that could have been managed differently with better planning and support.

The Chair, on behalf of the Committee, expressed appreciation for the work that Leanne, Sian, and the entire team were doing. Their dedication and compassion made a significant difference in the lives of patients and their families. Stories like Sian's not only highlighted the challenges, but also the incredible impact that committed healthcare professionals can have, even under pressure.

RESOLVED: The Committee received the staff story.

63/24 OPERATIONS DIRECTORATE QUARTERLY REPORT – 2024/25 Q2

Lee Brooks presented the report and drew the Committee's attention to the following: -

1. Volunteer Care Driver Oncology Pilot: This was progressing well with encouraging feedback being received, particularly from the drivers. The Trust has moved onto the second phase of the pilot which was ensuring that our oncology patients were paired up with the same volunteer driver for the entirety of their treatment.

2. Manchester Arena Inquiry: The completion of the actions was progressing well with most actions in a healthy place. The outstanding 20 actions were currently being reviewed by Commissioners.

3. Grenfell Inquiry Reports: The review did not bring additional work for the Trust.

4. Major Incident Declarations: There had been some positive early feedback from the debrief processes involving the incidents in Cardiff, which related to a call in which it was reported difficulty in breathing with reports suggesting that this incident was of a potential gas/carbon monoxide origin with several symptomatic patients; and Powys, in relation to a train accident.

5. The Medical Emergency Response Incident Team (MERIT) and the decision to not continue training MERIT nurses unless commissioned was noted by the Committee.

6. EMS Coordination: As part of the non-pay annex aspect of the 2023 pay and conditions work, the Trust agreed to focus on the culture of EMS Coordination. An action plan has been created in partnership with Trade Union colleagues and more recently the Director of People and Culture conducted a series of visits across the three centres to listen to staff and their experiences.

7. EMS Establishment: The under-establishment was largely due to the existing dispatch function, which was under-established due to changes required as part of the Organisational Change Policy (OCP) process.

8. Estates and Infrastructure: EMS Coordination has benefited from significant investment to improve the working environment for our centres in both Llangunnor and the relocation of staff from the existing Bryn Tirion site in North Wales.

9. Medical Transfer Protocol Suite (MTPS): MTPS went live on 30 July 2024 and external stakeholders were informed of the changes to inter-facility call processing. Up to the end of August 2024, 820 incidents were processed on these new protocols.

10. EMS Performance: The increase in red activity and concerns about amber patients waiting longer were brought to the Committee's attention.

11. Quality and Support Days: The quality and support days continued to be undertaken across all areas of the operations team, however, to further support operational staff these days will be subject themed moving forward.

12. Unscheduled Care Service (UCS) Transition: The UCS transition has remained challenging due to several factors that also affect the UCS team. While the modified code set which includes suitable calls has been agreed, the implementation will need to be timed to coincide with the new recruited EMS workforce that are operational from Mid-September.

13. End of Shift Overruns; While it is noted that the level of investigation of over 2-hour end of shift overruns has continued to improve, along with the uptake of utilising the options available to reduce the end of shift overrun, it was now evident that a number of these overruns were down to staff not correctly booking off duty.

14. The Clinical Model Transformation programme has been a significant focus for the Integrated Care team. Work is underway to align 111 and CSD, develop the Remote Integrated Care Service (RICS) model, develop new pathways and test the 111-call handling software in the wider operational environment.

Ceri Jackson asked about the direct recruitment for the Cymru High Acuity Response Unit (CHARU) rollout, expressing concerns about rurality and inequity. She wished to understand more about how the direct recruitment will be facilitated and when it will be in place. Lee Brooks advised that considerable effort into addressing the recruitment challenges for CHARU has been undertaken, especially in rural areas. However, despite making adjustments and trying to recruit internally, it was clear that external direct recruitment was now necessary to fill the remaining vacancies. Hugh Bennett added that the benchmark was to achieve 95% and the first round of internal recruitment was due to finish in November 2024.

Hugh Parry noted the improvement in end-of-shift overruns, noting a decrease in two-hour overruns, and queried if there was an appetite to start looking at reducing overruns to one hour or even less. Lee Brooks commented that progress in reducing end-of-shift overruns to 90 minutes for UCS investigations has already been made and there was a strong appetite to improve this further.

Hugh Parry acknowledged that MERIT training has been valuable over the years, especially in terms of the contributions from nurses and clinicians during major incidents and expressed concern about losing the benefits of networking and team involvement as it was not commissioned. Lee Brooks explained that the Trust had reviewed the MERIT training and found that current paramedic skills were sufficient for major incident responses.

The Chair sought an update on the recruitment of Advanced Paramedic Practitioners (APP) noting that the previous recruitment process did not meet the expected numbers. Andy Swinburn elaborated on the recent recruitment process for APP. He noted that there was significant interest from experienced APP, including those from outside the organisation and former staff. However, the recruitment process faced a challenge because the interested candidates were on higher pay bands than what was originally offered. It was a requirement for these candidates to start at the bottom of the offered pay band, which led to a substantial pay cut for them. This was a deterrent for many potential recruits. He acknowledged this as a misstep and expressed hope that the issue would be resolved in the next recruitment round.

RESOLVED: That the report was received.

64/24 CLINICAL TRANSFORMATION PROGRAMME CLINICAL GOVERNANCE AND CLINICAL ADVISORY GROUP TERMS OF REFERENCE

Liam Williams explained that the clinical governance model for the Clinical Transformation Programme will follow the existing architecture of the Clinical Quality Governance Group (CQGG). However, it should be noted that the complexity and pace of the programme required senior clinical colleagues from across the Trust to review and consider proposals / developments and ensure that they were securing a safer operating environment for our patients and our people.

To support this approach, a Clinical Advisory Group (CAG) has been formed. The CAG has been formed to provide critical clinical oversight and strategic support to the Clinical Model Transformation (CMT), strengthening the Trust's commitment to safe, high-quality healthcare through well-informed, clinically led decisions. Reporting to the Clinical and Quality Governance Group (CQGG) and the CMT Programme Board, the CAG will act as a core advisory body, ensuring clinical perspectives shape and guide the transformation process in real-time.

The CAG's remit will focus on providing Senior and Consultant-Practitioner level advice on clinical matters, supporting decision-making, and overseeing clinical safety of the CMT Programme. Liam emphasised the need for good clinical governance and decision-making, noting that the CAG will support this by providing critical appraisal, confirm and challenge, and expertise. This group will ensure consistency, identify gaps or overlaps, and advise on challenges. The goal is to maintain rigorous governance while implementing the new clinical model.

Terms of Reference for the Clinical Advisory Group

The Terms of Reference for the Clinical Advisory Group (CAG) were appended to the report and received by the Committee for noting. Jonny Sammut asked for clarity regarding the ethical considerations around the CAG. Specifically, he inquired whether the Artificial Intelligence (AI) ethics piece would be treated separately or if it would be included within the CAG ethics panel.

Liam Williams responded that the CAG was specifically related to the clinical model, with Dr. Penelope Cresswell Jones from Public Health Wales included to help address ethical considerations. He clarified that the AI ethics work would reside in a separate ethics group for the Trust, which was in the process of being established.

RESOLVED: The Committee took assurance from the planned continuation of the existing clinical governance arrangements and the implementation of a Clinical Advisory Group in supporting the Clinical Model Transformation within the Trust and Noted the Clinical Advisory Group Terms of Reference.

65/24 RAPID CLINICAL SCREENING

Greg Lloyd provided an overview of the rapid clinical screening process. He explained that this process takes place after the final Medical Priority Dispatch System (MPDS) code was generated. Suitable calls then flow into a screening queue visible only to the Clinical Navigators, a senior clinical role that sits within the EMSC. Clinical Navigators will perform high acuity live reviews, provide remote clinical support, and oversee the EMSC response queue. They will also make decisions on dispatch out of time order based on clinical need and move calls back to integrated care if the patient's condition changes. They determine if a face-to-face response was required immediately or if the patient would benefit from further assessment. This process aims to involve clinicians early in decision-making to improve patient outcomes.

He also mentioned that calls with immediate threats to life were dispatched immediately, while others were screened for further assessment. having a clinician make early, informed decisions on suitable 999 calls was a game-changer. By increasing the number of patients undergoing remote assessment, the Trust can significantly enhance the chances of directing them to the right care from the outset.

Andy Swinburn explained that the approach for the rapid clinical screening set the Trust apart by innovating how emergency services were managed. Involving clinicians at the front end, the initiative aims to make more informed decisions about which patients need immediate ambulance services, thereby optimising resource use and reducing wait times.

Ceri Jackson expressed support for the rapid clinical screening model but also shared some concerns. She sought assurance on how the system would handle periods of high demand and asked for real-time visibility into the process, possibly through visits, to ensure the system's effectiveness during busy times.

Andy Swinburn acknowledged Ceri Jackson's concerns and agreed that it was important to be cautious. He stated that the current system was already failing to deliver optimal results, and the new model aims to add value and improve the situation. He highlighted that the rapid clinical screening would help identify which patients need immediate ambulance services and which can wait or receive alternative care. He also invited Ceri to visit and observe the process once the team has settled in, to provide assurance and see the system in action.

Lee Brooks noted that he is the Senior Responsible Officer (SRO) for this workstream. He added that his Team actively considered how to manage the system during busy periods, especially with the rapid clinical screening work stream. The phased recruitment approach, with some staff joining by December and the rest in January, presented a challenge but also an opportunity to gradually transition to the new mode of operations.

The Chair expressed enthusiasm about the rapid clinical screening initiative, acknowledging the level of unknowns but emphasising the potential for significant positive impact. She noted the importance of monitoring the impact closely and comparing it with expectations. She also highlighted the need for the team to have time to embed the new approach, especially during the high-pressure Winter period.

Hugh Parry added it was natural to have initial concerns about potential risks, especially with such significant changes. However, as the project progressed, he became more confident that it would reduce patient harm. He also noted the excellent pace of the project's rollout and expressed hope that the wider transformation would improve conditions for both patients and staff.

RESOLVED: The Committee Noted the PowerPoint update for the introduction of Rapid Clinical Screening and took assurance from the position given, and the future approach for its implementation.

66/24 MONTHLY INTEGRATED QUALITY PERFORMANCE REPORT – SEPTEMBER 2024

Hugh Bennett highlighted the following points for the Committee's attention:

1. Immediate release requests by Health Board were reviewed, and the Committee noted that the two with the highest percentage of immediate release, for both Red and Amber 1, Cardiff and the Vale University Health Board (97.1%) and Cwm Taf Morgannwg University Health Board (86.5%), both have the lowest numbers of lost hours by health board over the quarter.

2. There was a continuing number of serious incidents shared with Health Board colleagues to investigate under the Joint Investigation Framework. For the second period in a row, none were directly related to immediate release requests.

3. The number of patient safety incidents received on Datix has reduced compared to the same time last year.

4. There was a sustained increase in the number of concerns received compared to the same period in 2023.

5. National Reportable Incidents had increased in the quarter.

6. A return to usual activity levels in respect of Coroner's requests for information was noted, however the ongoing impact of increased requests from last quarter was acknowledged.

7. The five-day complaint acknowledgement compliance met the 100% Welsh Government target in the quarter.

8. The 30-day response saw dips in the quarter from 70% (July), to 40% (August) and 46% (September). The drop in performance was because of the PTR and Legal Services Recovery Plan to reduce open complaints, which decreased from 197 in July to 106 in September. This approach aims to reduce overdue responses and set up consistent future performance, with rapid improvement expected now that complaint volumes are more manageable. Most complaints continued to relate to delayed response in the community following calls made to 999.

9. Organisational learning, particularly from nationally reportable incidents reviews, was reviewed, with clinical notices issued as a result on maternity action cards, Terrapace updates and ePCR nudge tool, and procedural changes for reviewing ECGs.

10. The experience for oncology and renal patients of the non-emergency patient care service remained above target which was positive, with advanced discharge and transfer performance improving, but remaining below target.

11. 111 NHS Wales call answering performance improved over recent weeks, with the call abandonment performance improving to 7% (was 11.9% in June) against a target of 5%. It is expected to improve further in October.

12. Return of Spontaneous Circulation (ROSC) rates deteriorated slightly in September to 19.4% (comparted to 22.7% in June) due to, however members noted that other clinical indicators are improving because of the clinical indicator improvement plans.

Jonny Sammut mentioned that the Digital Directorate was actively resolving data quality issues at the source. Additionally, there was ongoing recruitment for additional data quality resources, with the aim of bolstering the team with two additional Full Time Equivalents (FTE).

Andy Swinburn commented on the significant improvements in clinical indicators and the progress being made across various areas. The Stroke Bundle Compliance in reaching nearly 90% compliance in stroke bundle protocols was a significant achievement.

Ceri Jackson inquired whether the data quality issues undermined the integrity of the data that has been published for some time, and if any actions were needed to address this. Liam Williams explained there was a need to revisit the reporting of moderate harm numbers for the current financial year, explaining that there was a defined metric in the PTR report, which will be carried forward into the MIQPR.

The Committee inquired about the focus on immediate release, noting the high number of declined immediate releases for red and amber calls, and whether the new Cabinet Secretary's focus on handover delays included immediate release. Liam Williams referred

to a letter published by NHS Wales Executive on handover delays and was made available for Committee Members to read.

Following a concern about the impact on Health Boards that were improving their handover delays but seeing their resources diverted to neighbouring Health Boards, and whether there was an overview of this impact from a commissioning perspective. Lee Brooks acknowledged that this posed challenges for commissioning, as Health Boards were concerned with activity within their geography, but the reality of resource flow and hospital locations meant that resources often crossed boundaries.

Following further conversation, it was mentioned by Jonathan Chippendale that there was a paper produced from some analysis completed several months ago that might be helpful. He offered to present this analysis, which talked about the flows and issues around patient cancellations at a future meeting. It was agreed that Jonathan Chippendale would provide an update at a future Committee meeting.

The Chair commented that the report demonstrated ongoing system pressures significantly impacting patients and the ability to reach them in a timely manner, leading to avoidable harm. She noted the ongoing actions to improve data integrity and noted a recruitment gap which was being mitigated. The Chair highlighted that while actions were being taken, the level of handover delays remained a significant challenge.

The Committee noted that a report on the Datix system and its use was due to be on the agenda but was delayed. This report will likely come to the January meeting, reflecting ongoing work to improve data quality and system use.

RESOLVED: The Committee received the Monthly Integrated Quality and Performance report for September 2024 and actions being taken and determined that the report provided sufficient assurance.

67/24 MENTAL HEALTH AND DEMENTIA ANNUAL REPORT 2023/24

Liam Wiliams presented the report drawing attention to the following areas:

He highlighted the international recognition received for the work done in support of people living with dementia, particularly in Reminiscence Interactive Therapy Activities (RITA) and the design of ambulance care vehicles.

The Team was commended for the partnerships they have fostered with organisations like Alzheimer's Society Cymru and received the Dementia Hero Award for Professional Excellence in 2023. The report also highlighted the challenges faced, such as under-resourcing and the need for greater strategic alignment and sets the strategic outlook for 2024/25.

Mental Health Response Vehicle (MHRV): This was having a positive impact with the imminent go-live of the MHRV covering the southeast of Wales, with plans to expand the service further.

Jonathan Turnbull-Ross added the following points: He emphasised the need for more integration, partnership, and clinical practice development in the upcoming year. He highlighted the importance of moving towards a 24/7 mental health practitioner model and the significance of the MHRV. Furthermore, he noted the potential changes in Welsh Government funding and the need to work with Commissioners to understand the importance of investing in mental health practitioners.

The Chair expressed her concern that about the availability of resources to continue and expand the work, including the need for funding to support initiatives like the RITA specialist roles. Liam Williams gave assurance that many iPads were due for renewal, and as frontline devices were refreshed, older devices would be repurposed for use in RITA settings. There was support in principle from the Welsh Government's mental health team, and this will be further developed with the Joint Commissioning Committee (JCC).

Ceri Jackson advised the Committee of the strong collaborations with charities like Mind and the opportunity to Increase visibility and policy focus on these collaborations, especially in the context of dementia and mental health. She added that Vice Chairs of the Health Boards have a mandatory remit on mental health and primary care. She added that she will be facilitating a presentation from the Wales Council for Voluntary Action (WCVA) to mental health charities on the role of the third sector in mental health and suggested that colleagues from the Trust may want to link up with her and discuss offline to explore useful lessons and projects from the WCVA.

RESOLVED: The Committee endorsed the 2023/24 Mental Health and Dementia Annual Report and noted that it would be presented to the Trust Board for their information at its upcoming meeting in November.

68/24 PUTTING THINGS RIGHT REPORT QUARTER 2, JULY - SEPTEMBER 2024

Claire Appleton drew the Committee's attention to the following areas:

1. The ongoing continued high level of risk of harm caused by system pressures and hospital handover delays continued to be a familiar theme.

2. The implementation of options through Datix Cymru to enhance joint information sharing and building a learning repository for joint investigations was progressing.

3. There was a reduction in coroner approaches after a spike in July but highlighted that the impacts would continue as dates for statements and inquest attendances were set.

4. The five-day complaint acknowledgement was consistently achieving the 100% target.

5. The 30-Day Compliance had seen a drop in performance, however the overall number of open cases had reduced by 50%.

6. It was noted there had been no Prevention of Future Death Reports for this quarter.

The Committee acknowledged the work and effort the Team had undertaken to improve the PTR process, and it was agreed, and following further discussion requested that a more streamlined report be presented at future meetings. Wendy Herbert added there was a meeting scheduled with Lee Brooks and Claire Appleton to review the PTR report. The goal was to ensure the report captured the key and salient points, as it had the potential to grow too detailed and lose focus on what was important.

RESOLVED: The Committee received the Putting Things Right (PTR) report for discussion and were satisfied with the assurance given regarding the Trust's PTR function.

69/24 DATIX RECOVERY AND IMPROVEMENT PLAN – ITEM DEFERRED

Liam Wiliams advised that this report was not able to go through the internal governance process and will be presented at the February meeting. Trish Mills confirmed that an offline discussion would be undertaken with Liam Williams to ascertain whether this report should be presented firstly to the Finance and Performance Committee (FPC) and then to QuEST, or whether taking it straight to QuEST was appropriate.

RESOLVED: The Committee noted that the Datix Recovery and Improvement Plan was deferred to the next meeting and that it would be ascertained whether the report should be presented in the first instance through FPC.

70/24 FOCUS ON CLINICAL INDICATORS - ST SEGMENT ELEVATION MYOCARDIAL INFARCTION (STEMI)

1. Jonathan Chippendale presented the Committee with a PowerPoint slide show which focused on the clinical indicator for STEMI (ST-Elevation Myocardial Infarction).
2. Measurement Criteria: The key elements measured included the administration of aspirin, GTN (glyceryl trinitrate), recording of at least two pain scores, and the administration of analgesia if indicated.
3. Data Quality: The data was drawn from the electronic patient care record (EPCR), and there was a noted variation between automated and manually audited data, indicating that care might be delivered but not always recorded accurately.
4. Several improvements had been made which included deep dives into data, user interface changes, collaborative work with EPCR users, and promotional activities like CEO roadshows.
5. The performance data showed an improvement from April 2023 onwards, with a step change in performance and an upward trajectory.

6. Further user interface changes were scheduled for November, including nudge tools to improve data recording and compliance.

The Committee found these updates valuable a In providing a deep dive and assurance on the quality of care. The extensive work ongoing in the Trust was noted, as was the positive impact on the culture around duty of quality, quality of care, ownership, and accountability.

RESOLVED: The Committee noted the update

71/24 CLINICAL AUDIT PLAN & ACTION TRACKER - Q2 (UPDATE) 2024/25

Jonathan Chippendale presented the update and drew the following points to the Committee's attention:

The Q2 2024-25 Clinical Audit Plan contained 13 audits covering a range of topics including clinical conditions, medicines, and compliance to documentation. This was a dynamic plan and since the Q1 update, the 'Newborn Normothermia' audit has been added. Of those indicated on the plan:

- 2 have been completed and approved at the Clinical Intelligence & Assurance Group (CIAG)
- 3 were progressing as planned.
- 2 were not progressing as planned as they were reliant on ePCR User Interface changes being implemented*. In addition, the Clinical Indicator Recovery Plan was currently a higher priority.
- 6 were yet to start, some were reliant on ePCR User Interface changes being implemented, some were not due to start until Q3/Q4.

Delays in implementing the required ePCR User Interface (UI) changes has impacted on the timely completion of actions. The Clinical Indicator Recovery Plan was a high priority and the timeframe for some of the clinical audits on the plan will need to be adjusted due to the required resources.

The Chair queried if the delay in ePCR UI changes would cause any detriment to the management of the clinical audit work and inquired about the expected duration of the delay. Andy Swinburn explained there has been some slippage in the current quarter, but ongoing discussions were taking place to address this. He expressed confidence that the necessary changes will be implemented, as they have been able to secure funding from other areas where there has been underspend.

RESOLVED: The Committee noted the Q2 2024-25 Clinical Audit Plan and Action Tracker update.

72/24 PATIENT EXPERIENCE AND COMMUNITY INVOLVEMENT BIANNUAL REPORT APRIL – SEPTEMBER

Leanne Hawker presented the Patient Experience and Community Involvement (PECI) biannual report. The report set out the team's focus on gathering feedback from the public and patients to improve the quality and experience of services She emphasised that the data demonstrated the emotional experiences of people using their services, identifying both positive and negative feelings. Leanne also noted the importance of acknowledging and responding to these emotions, and she pointed out specific information that highlighted feedback from frontline staff.

Key themes from feedback included response times for emergency services and access to care and outlined plans for improving data collection methods and reviewing survey questions to ensure they adequately addressed the experiences of patients. Overcoming the challenges related to fully utilising the Civica system for patient experience feedback was key, including information governance concerns and the need to comply with the Information Commissioner Officer (ICO) requirements.

Liam Williams highlighted key points about the team's efforts and the importance of their work in evolving the clinical model to better understand and improve patient experiences.

Ceri Jackson commented that focusing on older people and their specific needs, especially considering protected characteristics, was very important. She asked how the Team could best gather and use this feedback to improve services for older people. Furthermore, the People's Experience Framework was a promising initiative as it aimed to gather comprehensive feedback from across the system, which can significantly enhance understanding of patient experiences. Ceri Jackson asked how optimistic was the Trust in the people's experience framework to enable the Committee to hear about experiences across the system in the not too distant future. Leanne Hawker explained that the Team was collaborating closely with colleagues on the new framework and were optimistic about its potential. However, she noted that its effectiveness will depend on fully using all elements of the Civica system.

The Chair informed the Committee she had attended a learning disability conference facilitated by the PECI Team. She commented on the importance of broadening the engagement with individuals beyond the current groups, particularly those with more complex and profound learning disabilities and their families. She emphasised the need to engage with a broader representation to gather richer data and insights. Additionally, she mentioned the importance of understanding the impact of presenting to the Learning Disability Ministerial Advisory Group and suggested including the outcomes or changes resulting from such presentations in future reports.

RESOLVED: The Committee:

(1) Received the report and accepted the assurances that the Trust was meeting its statutory duties/responsibilities to consult' engage and involve the public/patients in its work; and

(2) Noted the activities to date and acknowledged that Patient Experience & Community Involvement Reports would be shared publicly through the Trust's People & Community Network.

73/24 LEARNING FROM DEATHS (MORTALITY REVIEWS) REPORT (Q1 - Q2)

Wendy Herbert provided an update on the learning from deaths report, highlighting the establishment of a new group to ensure the Trust captured learning from deaths, both internally and from external reviews.

She mentioned the significance of the Medical Examiner Service (MES), which was now fully functioning and included all community deaths. It was noted that 238 referrals have been received by the Trust from the MES in the first two quarters of 2024/25 with 44 cases requiring further review, either through the Serious Case Incident Forum (SCIF) process or additional investigation.

Members noted that themes and trends largely related to delays attending in the community and it was recognised that there was more to do to understand the differential impact of skill mix on patient outcomes.

Liam Williams added that the Trust was exploring new areas of learning from deaths including the use electronic patient records to identify patterns and conduct thematic analysis. The Trust was also learning from the Northwest Ambulance's data practices to help replicate successful strategies and improve overall data management.

Claire Appleton explained that the Trust was dealing with a significant volume of feedback and learning from the Medical Examiner Service, especially with the differences between how the service operated in Wales compared to England. The higher referral rate in Wales, with about 40% of cases being reviewed, compared to 10% in England. Receiving feedback on all cases, including those with compliments was valuable, however, managing this large volume of information and distinguishing between what was new learning and what was already understood was challenging.

RESOLVED: The Committee received the report for discussion.

74/24 IPC PREPAREDNESS & EMERGING HEALTH RISKS ASSOCIATED WITH MPOX AND OTHER HIGH CONSEQUENCE INFECTIOUS DISEASES

Members received assurance by Liam Williams on the work undertaken relating to Infection Prevention and Control (IPC) Preparedness and Emerging Health Risks with MPOX and the Trust's preparedness for an outbreak of a Highly Contagious Infectious

Disease (HCID) as set out by NHS Wales Executive.

The Committee were asked to note the focus on efforts to respond effectively and that the Trust was actively enhancing its IPC Guidance, with a key focus on the rollout of Powered Air Purifying Respirators (PAPRs) to frontline staff. This initiative was aimed at strengthening protection against airborne pathogens, particularly during aerosol-generating procedures (AGPs).

Alongside this, the Trust was preparing for increasing seasonal pressures due to Winter respiratory infections (e.g. flu and RSV), while also remaining vigilant about emerging High Consequence Infectious Diseases (HCIDs) like Mpox, Marburg virus and Middle East Respiratory Syndrome (MERS-CoV). Furthermore, a member of the Resilience Team will be attending a WG meeting to provide additional assurance regarding the organisation's readiness for any outbreak.

RESOLVED: The Committee noted the update and confirmed their assurance that the Trust was taking all appropriate measures to prepare for a case of Mpox or other High Consequence Infectious Diseases.

75/24 MATERNITY AND NEONATAL SAFETY SUPPORT PROGRAMME UPDATE

Liam Williams presented the report which was a culmination of the work conducted by Bethan Jones (Local Safety Champion – Midwife) and Steve Magee (Regional Clinical Lead) in the Maternity and Neonatal Safety Programme. Key points of note for the Committee included:

1. The report highlighted significant improvements, including work on Neonatal thermoregulation, increasing normothermic admissions from 4% to 75%, and the adoption of the maternity early warning score (MEWS) consistent with England and Scotland.

2. The Team has been recognised for their contributions, for winning an award at the NHS Wales Awards recently for the Maternity and Neonatal Safety Support Programme.

3. A proposal for a national maternity advice line was being developed, expected to be commissioned through Welsh Government and NHS Wales executive, leveraging the 111 capability and collaborating with Health Board colleagues.

Bethan Jones joined the meeting and expressed gratitude for the support and noted the positive impact and influence of the programme across Wales.

RESOLVED: The Committee received the report and accepted the assurances that the Trust was meeting its statutory duties/responsibilities to consult; engage and involve the public/patients in its work.

76/24 NEAR MISS REPORTING AND LOW HARM INTELLIGENCE REPORT

Claire Appleton presented the report which updated the Committee on organisational low harm and near miss Concerns (Incidents, Complaints and Claims). Intelligence on near miss and low harm reporting was illustrated from the Datix Cymru Electronic Risk Management System covering the period September 2022 - September 2024.

This Report has addressed recommendations from the Audit Wales Quality Governance Review 2022 to ensure that intelligence from 'near misses' or minimal harm events was appropriately reported on and analysed.

The Health and Safety Executive defines a near miss as 'an event that, while not causing harm, has the potential to cause injury or ill health'. A hazard is defined as an unsafe situation or set of circumstances with 'the potential to cause harm'. For the purposes of this update, no distinction has been applied between hazards and near misses, as both represent valuable learning opportunities.

The Trust receives a large volume of No and Low Harm Incidents and Grade 1 and 2 Complaints, which after investigation, were assessed as not having resulted in harm and were near miss opportunities for learning. The report assures consistency in the assessment of harm and highlights those themes in lower harm incidents often reflected those in high harm incidents, particularly around delays and their impacts.

Deeper analysis was limited currently because of the classification system of reported incidents which catered largely to secondary care services. There was scope to improve the relevance and application of the code sets to Ambulance Services through the Trust's representation at national workstreams.

In terms of the additional waits from a patient safety perspective in relation to the consequences of delayed transfers into other facility transfers it would be useful to see that data and it was agreed this would be e mailed to Lee Brooks for his Team to analyse.

Following a discussion on future reporting it was the general consensus that going forward, the reporting and analysis of near misses and low harm would be helpful if included within the Putting Things Right report.

RESOLVED:

(1) Approved the future reporting of near misses being included in the quarterly Putting Things Right Report to Committee; and

(2) The Chair of Committee will provide assurance to the Audit, Risk and Assurance Committee on the future approach.

77/24 AUDIT TRACKER

An update was provided on the Audit Tracker by Trish Mills:

It was noted that 23% (39% last quarter) of Committee related internal audit actions (due in quarter) had been closed in quarter; with no (62% last quarter) external audit actions closed this period.

Trish Mills also noted that the external audits tab was not uploaded to the pack of papers but advised Members there were three external audits, including two from the 2022 quality governance recommendations around patient outcomes. The information would be circulated to Members after the meeting.

The Committee noted that there were two open actions from the previous Audit Wales Review of Quality Governance audit from 2022-23 which will be revisited in response to the recently completed Follow Up Review of Quality Governance audit, and new management actions will be developed for these outstanding actions.

The current version of the Tracker was now open for Directorate review for actions due in October, November, and December 2024. These updates will then be reported to the Committee at its meeting in February 2025. The Committee took assurance from the position given and did not have any concerns.

RESOLVED: The Committee:

(1) Received and reviewed any Internal Audits and Audit Wales reviews within their remit where relevant. There were none required for review at this meeting;

(2) Monitored management actions to address recommendations in the Tracker, noting any revised dates for actions (in blue).

78/24 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK

Julie Boalch provided an overview of the two highest scoring risks 223 (*the Trust's inability to reach patients in the community causing patient harm and death*) and Risk 224 (*Significant handover of care delays outside accident and emergency departments impacts on access to definitive care being delayed and affects the Trust's ability to provide a safe & effective service for patients*) with the scoring of 25 remaining unchanged.

The Committee noted that the data presented was the same as that presented to the Audit Risk Assurance Committee and Trust Board in September 2024. Julie Boalch noted that the risks were being reviewed in line with their frequency review and will be presented to the Trust Board in November.

Additionally, she highlighted that workshops have been set up in December with key members of Lee Brooks and Liam Wiliam's teams, to finalise the work on reframing the controls for risks 223 and 224, with the results to be presented to the Board and Committees in early 2025.

RESOLVED: The Committee noted the contents of the report.

79/24 POLICIES FOR APPROVAL/NOTING

The following policies were presented the Committee:

Airway Policy, Liam Williams emphasised that the airway policy underscored its critical role in the Trust, and it was clear that a lot of effort has gone into developing this policy to ensure it met the needs of patients in cardiac and respiratory arrest situations. The policy was approved subject to a final read and final checks by Andy Swinburn in respect of correctness and consistency in terminology.

Management of Controlled Drugs Policy, Medicines Management policy and the Infection Prevention and Control - Sharps policy – All For noting

It was noted that the High Intensity Policy was not received and would be deferred to the next meeting.

RESOLVED: The Committee: Approved the Airway Policy subject to final checking, noted the Management of Controlled Drugs Policy, the Medicines Management Policy and the Infection Prevention Control – Sharps Policy. It was also noted that the High Intensity Policy was deferred.

80/24 COMMITTEE PRIORITIES AND CYCLE OF BUSINESS MONITORING REPORT

The Committee Priorities and Cycle of Business Monitoring Report was received.

RESOLVED: The Committee noted the update.

81/24 KEY MESSAGES FOR THE BOARD

These would be articulated on the Committee's Highlight report.

82/24 REFLECTIONS AND SUMMARY OF DECISIONS/ACTIONS

Ceri Jackson: Emphasised the balance between focusing on high-risk areas and celebrating successes. Appreciated the quality of presentations and acknowledged the extensive transformation and change within the Trust. Mentioned the challenge of lengthy papers and the need to keep this in mind.

Lee Brooks: Praised the chairing of the meeting for allowing sufficient airtime for important topics, even though it pushed the timeline. He appreciated the right level of challenge from Non-Executive colleagues, which added value to take back to their teams.

Trish Mills: Highlighted the challenge of having only two Non-Executive Directors for a lengthy and important meeting. Suggested focusing on what needs to come forward in meetings to help streamline the process and reduce the length of papers.

Liam Williams: Noted the need to balance giving assurance and having an audit trail for that assurance, ensuring good processes for internal and external requirements.

The Chair reflected on the importance of taking the necessary time for detailed reports, especially when they aligned with the Committee's terms of reference. She acknowledged the challenge of balancing detailed information with the need for concise reporting. The Chair also emphasised the significance of celebrating successes alongside addressing areas for improvement, highlighting the good work happening across the Trust.

83/24 ANY OTHER BUSINESS

None

Date of Next meeting: 4 February 2025

Meeting concluded at 14: 50.

Ymddiriedolaeth Brifysgol GIG Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services University NHS Trust

AGENDA ITEM No	**3.2**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**0**

QuEST Committee: Ratification of Chair's Action

MEETING	QuEST Committee
DATE	4 February 2025
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Trish Mills, Director of Corporate Governance/Board Secretary Steve Owen, Corporate Governance Officer
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. There was one matter of business which required a decision by the Committee that was dealt with via Chair's Action in December 2024, due to the need to transact the business as soon as possible. This decision was approved by Chair's Action on 18 December 2024.

1.1 QuEST Committee approval of the High Intensity User Policy (by 18 December 2024); The request was for the approval of the updated High Intensity User Policy v1.13. This request was made in the interests of time and with a desire to seek approval for implementation as soon as possible (prior to the next meeting of the Committee in early February 2025).

RECOMMENDATION:

2. **The Committee is asked to RATIFY this decision made by Chair's Action. The item of business was issued via email on 12 December 2024 and approved as requested. The confirmation of the decision was confirmed via email on 18 December 2024.**

KEY ISSUES/IMPLICATIONS

Not applicable.

REPORT APPROVAL ROUTE

Not applicable.

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)	NA	Financial Implications	NA
Environmental/Sustainability	NA	Legal Implications	Y
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

ACTION LOG - UPDATE
QUEST COMMITTEE

Minute Ref	Date	Agenda Item	Action Note	Responsible	Due Date	Progress/Comment	Status
51/24	13 August 2024	Impact of the Changes to Stroke Categorisation	**Impact of Changes to Stroke Categorisation:** The Committee noted that updates on the location of stroke units will be provided in due course. Although the timeline was uncertain, Andy Swinburn agreed to keep the Committee updated.	Andy Swinburn	4 February 2025	Update for 5 November 2024 Andy Swinburn has confirmed that there is no further update available for this meeting. Update for 4 February 2025 Suggest that this action is closed and update brought back at a future date. It is clear that no progress has been made, and a definitive decision is unlikley to be provided imminently. (AS)	Open
68/24	5 November 2024	Putting Things Right Report Quarter 2, July - September 2024	The Committee asked that relevant colleagues consider the structure of the Putting Things Right Report and what the Committee needs to focus on. This should be considered for the next report.	Liam Williams Wendy Herbert Claire Appleton	4 February 2025	Update for 4 February 2025 Verbal Update	Open

Ymddiriedolaeth Brifysgol GIG Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services University NHS Trust

QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE
HIGHLIGHT REPORT TO BOARD

This report provides the Board with key escalation and discussion points at the last Committee meeting. A full list of items discussed appears at the end of the report to enable members to raise any questions to the Chair which have not been drawn out in the report.

Trust Board Meeting Date	29 November 2024
Committee Meeting Date	5 November 2024
Chair	Bethan Evans

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. Lost hours due to handover delays remained significant in September (20,693 – which is higher that September 2023). **Handover delays continue to present patient safety risks and extended waits in the community** with a deteriorating Red performance being outside of what is acceptable to deliver a safe emergency service. Delays are also presenting as a theme in the Medical Examiner Service referrals for the first two quarters of 2024/25.

2. The Trust continues to work across the system with partners to influence system change. The Trust's focus is to implement a change in how it responds to patient demand through the **Clinical Transformation Programme.** Assurance was provided to the Committee on the progress and governance for that programme at this meeting.

ADVISE

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

3. **Sian Davies-Kumar, Palliative Care Paramedic** shared her experience as a palliative care paramedic. She described a specific case where she attended to a young gentleman with metastatic brain cancer. The family had called 999, and Sian was able to manage the patient's symptoms effectively, ensuring he could stay at home as per his and his family's wishes. She coordinated with the palliative care team, GP, and district nurses to set up the necessary syringe drivers for pain management. Sian emphasised the importance of communication with the family and ensuring the patient's comfort, which facilitated a good death surrounded by loved ones. Sian's story exemplifies the aspiration to provide the best possible death in the place of choice, with adequate support for the family, with the committee noting the need for more consistent and comprehensive end-of-life care for more patients from the wider NHS system. Investment through the six goals programme aims to improve community services, including a 2-hour community response and a renegotiation of the GP contract, however the current gap in commissioned community and primary care services for end-of-life care was emphasised.

Members expressed thanks to Sian for sharing her experiences and for the important work done by the palliative care team. The future WAST clinical model aims to involve enhanced support from APPs and the remote integrated care service to assist frontline clinicians and ensure appropriate escalation when needed.

4. The Committee received **an update following the patient story from Linda Erro Castillo** at the last meeting and noted progress against actions identified, including the ability to record learning difficulties/autism/neurodiversity and to prompt/record reasonable adjustments that went live on ePCR in October 2024.

5. The various initiatives in **maternity and neonatal care** were highlighted to the committee including:

   - Neonatal thermoregulation improvements significantly increasing normothermic admissions from 4% to 75%.
   - The maternity red phone service which offers a single point of access from WAST to Maternity Units and has been implemented across four Health Boards.
   - An OBC is being developed for a national maternity and labour advice line is being prepared at the request of Welsh Government.
   - Congratulations to the team for winning an award at the NHS Wales Awards recently for the Maternity and Neonatal Safety Support Programme.

6. The Committee received the **Operational Update for Q2 2024/25**. The Medical Emergency Response Incident Team (MERIT) training was discussed, with members noting that due to training not being commissioned, Trust has been unable to continue this. The ongoing challenge to recruit 111Wales call handlers was noted as was the plan to achieve this for winter. The committee was pleased to note that the trial to offer Welsh call answering skill has been extended. Trade Union partner representative commented on the positive tone of the report, which much going on across the directorate.

7. The **Airway Policy was approved**, with the committee noting that an EQIA had been done with no issues to escalate.

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

   - Members acknowledged the challenge of balancing detailed information with the need for concise reporting, as well as the value in celebrating successes alongside addressing areas for improvement;
   - Members thanked colleagues for the quality of the presentations and reports given and acknowledged the extensive transformation and change within the organisation which is being reported on by colleagues. The level of challenge from members was considered to be robust;
   - Members reflected on the length of papers and the need to consider how to focus on what business and content should be brought to the meeting to reduce the length of papers, where appropriate.

ASSURE

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

9. **Clinical Model Transformation (CMT)**
Assurance on quality and patient safety of the CMT was provided to the committee with respect to the clinical navigator model and internal clinical governance. The Committee noted:

9.1. The introduction of a new **Clinical Navigator** role as part of the CMT will focus on clinicians using their expertise to quickly assess patients and determine whether they require immediate emergency ambulance dispatch or are suitable for remote clinical management. Clinical Navigators will also perform high acuity live reviews, provide remote clinical support, and oversee the EMSC response queue. A successful recruitment campaign has attracted 30 staff, with 19 starting their induction training this week.

9.2. Non-Executive Directors commended the approach whilst seeking to emphasise the need to monitor resources and implementation of this and the model more broadly. The challenge of successful implementation during a very busy period for the Trust was recognised, as was the novel nature of the CMT and the need to learn quickly from any issues that arise. The levels of harm occurring in the community currently because of our inability to reach patients is well rehearsed in this committee and reflected in risks 223 and 224 and is the driver for this evolved model. The initiative aims to move towards safer care, acknowledging that while it may not eliminate all harm, it is expected to reduce the level of harm in the system and has the potential to add significant value, particularly to the patients currently coded in the Amber categories.

9.3. Members were reminded that Clinical Navigators are part of a broader clinical model that includes new clinical systems supporting 111 Wales and the Remote Integrated Care Service, which will enhance patient care planning and resource utilisation. The positive impact on patients and staff of the CMT was raised by Trade Union representation at the meeting.

9.4. The **Clinical Advisory Group** (CAG) has been established to provide crucial clinical oversight and strategic support to the Clinical Model Transformation (CMT) Programme. The CAG reports to the established Clinical and Quality Governance Group and the CMT Programme Board. This aims to reinforce clinical safety and make well-informed decisions through the guidance of senior clinical leaders. The CAG will provide senior clinical leaders in the Trust the opportunity to explore complex issues, offer diverse clinical insights across the CMT programmes, review safety data to mitigate risks, ensure ethical considerations, and maintain transparency and accountability. The CAG has delegated authority aligned to individual members to ensure effective and timely decision making as part of the CMT programme when required. Planning is underway for patient representation on the CAG in due course.

9.5. The **Quality Impact Assessment** for the CMT was reviewed in private session given that there are still issues under consideration with Welsh Government. Members received assurances on process and quality.

10. **Monthly Integrated Performance Report (MIQPR) and Putting Things Right (PTR) Report**

10.1. The Committee received assurance by way of the MIQPR for September 2024 along with the Q2 2024-25 PTR Report. The board receives the MIQPR at its meetings, however the bullet points below reflect discussion on key elements, with further detail on the PTR report drawn out for the board's assurance and awareness.

10.2. The MIQPR noted an absence of data for some of the committee-specific KPIs, however, that has now been resolved, with the PTR report setting out the correct data which will flow into the next iteration of the MIQPR. Work is underway to resolve other areas of data quality at source and aligning various types of information. The Finance and Performance Committee will review any data quality issues and improvement plans at their next meeting.

10.3. The Committee draws out the following areas of assurance for the Board:

- Immediate release requests by Health Board were reviewed, with the committee noting that the two with the highest percentage of immediate release, for both Red and Amber 1, Cardiff and the Vale University Health Board (97.1%) and Cwm Taf Morgannwg University Health Board (86.5%), both have the lowest numbers of lost hours by health board over the quarter.
- There is a continuing number of serious incidents shared with Health Board colleagues to investigate under the Joint Investigation Framework. For the second period in a row, none were directly related to immediate release requests.
- The number of patient safety incidents received on Datix has reduced compared to the same time last year.
- There is a sustained increase in the number of concerns received compared to the same period in 2023.
- National Reportable Incidents increased in the quarter.
- A return to usual activity levels in respect of Coroner's requests for information was noted, however the ongoing impact of increased requests from last quarter was acknowledged.
- The five-day complaint acknowledgement compliance met the 100% Welsh Government target in the quarter.
- The 30-day response saw dips in the quarter from 70% (July), to 40% (August) and 46% (September). The drop in performance was because of the PTR and Legal Services Recovery Plan to reduce open complaints, which decreased from 197 in July to 106 in September. This approach aims to reduce overdue responses and set up consistent future performance, with rapid improvement expected now that complaint volumes are more manageable. Most complaints continue to relate to delayed response in the community following calls made to 999.
- Organisational learning, particularly from nationally reportable incidents reviews, was reviewed, with clinical notices issued as a result on maternity action cards, Terrapace updates and ePCR nudge tool, and procedural changes for reviewing ECGs.
- The experience for oncology and renal patients of the non-emergency patient care service remain above target which was positive, with advanced discharge and transfer performance improving, but remaining below target.

- 111 NHS Wales call answering performance improved over recent weeks, with the call abandonment performance improving to 7% (was 11.9% in June) against a target of 5%. It is expected to improve further in October.
- ROSC rates deteriorated slightly in September to 19.4% (compared to 22.7% in June), however, members noted that other clinical indicators are improving because of the clinical indicator improvement plans. Due to the nature of this metric, common cause variation occurs which can result in a marked reduction in performance from small numbers of unsuccessful resuscitations attempts. The factors that influence this are multifactorial and as such it is not possible to identify the specific element.

11. The first **no and low harm incident** report was received by the committee. Members noted the large volume grade 1 and 2 complaints (none or low harm categories), which after investigation, are assessed as not having resulted in harm and are near miss opportunities for learning. Deeper analysis is limited currently because of the classification system of reported incidents which caters largely to secondary care services. There is scope to improve the relevance and application of the code sets to Ambulance Services through our representation at national workstreams. Future reporting and analysis of near misses and low harm will be included within the PTR Report.

12. The Committee focused on the **clinical indicators related to ST segment elevation myocardial infarction (STEMI) (heart attack)** including a presentation on criteria measurement, data quality, reporting, improvements, and next steps. A Clinical Indicator Recovery Plan, which aims to address identified risks and improve the accuracy of data recording and reporting, has been implemented, featuring workshops, ePCR user engagement and 'scripting' reviews. Manual audits show higher compliance than automated ones with 'raw' data suggesting that care is being delivered but not always recorded in the Electronic Patient Care Record (ePCR) where data is automatically sourced. Key issues include the user interface changes in the ePCR system and the development of a 'Tenant Structure' that would allow clinicians to own their own Clinical Indicator performance. Other key enablers included changes to scripting in automated audits, and additional 'nudge' tools. Committee were assured that the ongoing work is benefiting our patients.

13. The biannual **Patient Experience and Community Involvement (PECI) Report** for April to September 2024 sets out the team's focus on gathering feedback from the public and patients to improve the quality and experience of services. Key themes from feedback include response times for emergency services and access to care, and outlines plans for improving data collection methods and reviewing survey questions to ensure they adequately address the experiences of patients. Overcoming the challenges related to fully utilising the Civica system for patient experience feedback is key, including information governance concerns and the need to comply with ICO requirements. The Chair attended the recent learning disability conference facilitated by the PECI team, which was excellent, and fed back that broader engagement with a wider demographic with more complex issues would be beneficial.

14. The **Learning From Deaths (Mortality Reviews) Report** was received. 238 referrals have been received by the Trust from the Medical Examiner Service in the first two quarters of 2024/25 with 44 cases requiring further review under the Putting Things Right guidance. This workload is in excess of that expected and is placing pressures on several teams across the Trust to respond. The report highlighted themes and trends that largely relate to delays attending in the community. It was recognised that there is more to do to understand the differential impact of skill mix on patient

outcomes and use ePCR records to identify patterns in death related to or following care.

15. The **Mental Health and Dementia Annual Report 2023/24** was presented and is attached at **Annex 1**. Key accomplishments include the Mental Health Response Vehicle initiative, the ongoing use of RITA tablets for dementia care, and training programs for staff. The team was commended for the partnerships they have fostered with organisations like Alzheimer's Society Cymru and received the Dementia Hero Award for Professional Excellence in 2023. The report also highlights the challenges faced and sets the strategic outlook for 2024/25.

16. The **Clinical Audit Plan and Action Tracker update for Q2 2024/25** was received. 13 audits are included in the plan for 2024/25 and those completed during the period covering a range of topics including clinical conditions, medicines, and compliance to documentation, with the newborn normothermia audit added in Q2. Some audits are delayed due to ePCR user interface changes which are under review through the organisational clinical governance routes.

17. Members received assurance on the work undertaken relating to **IPC Preparedness and Emerging Health Risks with MPOX** and the Trust's preparedness for an outbreak of a highly contagious infectious disease (HCID) as set out by NHS Wales Executive. Committee noted the focus on efforts to respond effectively and that the Trust has stratified the national release of PAPR as a new universal EMS respiratory protective measure, prioritising those furthest away from the HART and M4 corridor for access to a specialist response. A member of the Resilience Team will be attending a Welsh Government meeting to provide additional assurance regarding the organisation's readiness for any outbreak.

18. An update was received on the **Audit tracker** with 23% (39% last quarter) of committee related internal audit actions (due in quarter) closed in quarter, with no (62% last quarter) external audit actions closed this period. The Committee noted that there are two open actions from the previous Audit Wales Review of Quality Governance audit from 2022-23 which will be revisited in response to the recently completed Follow Up Review of Quality Governance audit, and new management actions will be developed for these outstanding actions.

19. Members received the Committee **Cycle of Business Monitoring Report** and progress against the **Committee's priorities** for 2024/25.

20. The Quality Impact Assessment (QIA) for the **Manchester Arena Inquiry Project** was received in closed session due to the sensitive information it contained regarding the Trust's response capabilities and financial position. Members were assured and approved the QIA.

RISKS

Risks Discussed: The Trust's two highest scoring **risks 223:** the Trust's inability to reach patients in the community causing patient harm and death and **risk 224:** significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service remain unchanged at a score of 25.

Committee received assurance that the risks continue to be monitored closely in the relevant governance forums noting discussions on the mitigating actions, controls and assurances and mitigating actions are reviewed regularly.

New Risks Identified: No new risks were identified.

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

COMMITTEE AGENDA FOR MEETING		
Operations Directorate Quarterly Report for Q1 2024/25	Staff story – Sian Davies-Kumar, Palliative Care Paramedic	Clinical Transformation Programme – Clinical Governance
Rapid Clinical Screening	Monthly Integrated Quality and Performance Report	Mental Health and Dementia Annual Report 2023/24
Putting Things Right Report Q2 2024/25	Datix Recovery and Improvement Plan	Focus on Clinical Indicators – STEMI
Clinical audit plan and action tracker Q2 2024/25	Patient Experience and Community Involvement Biannual Report April to September 2024	Learning from Deaths (Mortality Reviews) Report April to September 2024
IPC Preparedness and Emerging Health Risks with MPOX and other high consequence infectious diseases	Maternity and Neonatal Safety Support Programme Update	Near Miss and Low Harm Intelligence Report
Audit Tracker	Risk Management and Board Assurance Framework	Policies for approval
Committee cycle of business monitoring report and committee priorities 2024/25		

COMMITTEE ATTENDANCE				
NAME	**07 MAY 2024**	**13 AUGUST 2024**	**05 NOVEMBER 2024**	**04 FEBRUARY 2024**
Bethan Evans (Chair)				
Kevin Davies				
Ceri Jackson	Chair			
Liam Williams				
Andy Swinburn		From 1100[1]		
Lee Brooks	Jonathan Edwards	Pete Brown (open)		
Rachel Marsh	Hugh Bennett	From 1120[2]	Hugh Bennett until 2pm	
Jonny Sammut				
Trish Mills	Julie Boalch			
Mark Marsden				
Hugh Parry				
Henry Garrard				

	Attended
	Deputy attended
	Apologies received
	No longer member

[1] Duncan Robertson in attendance from 0930
[2] Alex Crawford in attendance from 0930

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OPERATIONS DIRECTORATE
QUARTERLY REPORT FOR COMMITTEES
2024-25 Q3 (October – December 2024)

National Operations & Support

General Update

Specialist Operations Response Team (SORT) Enhancement

Following the successful award of funding from Welsh Government earlier this year on the SORT enhancement business case, work is progressing well to roll out the enhancement across Wales. A Senior Paramedic has been recruited who will join the team shortly, making a welcome addition to the HART and SORT clinical capabilities. A SORT Operations Manager has also been recruited and is due to take up post in January. SORT awareness sessions have taken place across North and South Wales and the equipment funded as part of the business case has been procured and is therefore complete. Vehicles however could not be secured in year with the time available since the award was confirmed, and colleagues are actively engaged on rolling capital budget forward.

Volunteering

The Volunteer team has successfully completed an Organisational Change Process (OCP) and is now operating in the new Function Based Model. This will bring efficiency across the team and streamline recruitment and onboarding as the new model of working takes effect. Additionally, our new Volunteer Management System "GO Assemble" has now been configured and is live across the volunteer team, with a phased launch to volunteers scheduled to roll out from January.

In October we held our Volunteer Conference in a new and successful hub and spoke format, with the conference held in Llandudno and streamed to Swansea with over 100 volunteers attending both events.

Grenfell Fire Inquiry Report

The EPRR team have undertaken a review of the two published Grenfell Inquiry reports. The fire at Grenfell Tower in West London in the early hours of 14 June 2017 spread rapidly, tragically causing the death of seventy-two people. Our assessment of the recommendations from the two Inquiry reports have been presented and compared with the recommendations from the Manchester Arena Inquiry (MAI). Our review found no additional actions that the Trust need consider, with the Grenfell recommendations mirroring the recommendations from MAI. This output however has been considered by the Executive Leadership Team and subsequently submitted as supplementary evidence to the MAI submission to commissioners.

Manchester Arena Inquiry (MAI)

Progress against the 68 recommendations, directly or through partnership working, that relate to the Trust, continues. We expect to complete all recommendations that do not rely on financial investment by the end of this financial year. To ensure the continued progression and completion of the recommendations with financial dependency (18 recommendations), a corporate risk has been developed for inclusion in the Trust's Corporate Risk Register and Board Assurance Framework. As the risk progresses through the internal governance route, culminating in final approval at Trust Board in January, there is an alignment of the outstanding MAI recommendations with a clearly defined business-as-usual framework, which will support the governance of capability gaps whilst awaiting financial decisions from commissioners and the implementation of necessary changes.

Resourcing, EMS Coordination and Quality

Challenges

HM Coroners (HMC)

The Operations Quality team continues to receive coroner requests meaning that the backlog of statements remains present. Capacity within Operations Quality (OQ) continues to be realigned where possible to support with the construction of statements and a robust quality assurance process is in place to ensure that accurate statements can be reviewed and signed by the Locality/Service Managers in EMS Coordination for serving to HMC. Any requests from HMC to prioritise or final deadlines are prioritised dynamically. Following the EMS Coordination (EMSC) reconfiguration, more capacity from EMSC Service Managers will now be aligned to coroner statement completion, which it is anticipated will help to manage the ongoing demand from HMCs across Wales.

Red Code Breathing Problem

The Operations Quality team has been examining the increase in incidents related to ineffective breathing (Red) over an extended period. Numerous reports have been prepared for both the Operations Senior Leadership Team and the Executive Leadership Team, reviewing the rise in Red calls since 2019. There has been a sustained increase in Red calls related to breathing problems since 2019, with a further notable escalation occurring in 2024. Previous SBARs identified issues with call coding and recommended measures, such as training EMS Coordination staff and clarifying call processing post-Red Review.

Detailed analysis targets the top five MPDS determinants for breathing problems, especially the 06E01 code, and examines age-related variations, focusing on the 0-4 age group. Several process changes may have contributed to the increase in ineffective breathing Reds, including modifications to Echo determinant codes, the introduction of Red Review, and pandemic protocol adjustments. An extensive MPDS audit revealed a significant proportion of non-compliant calls, identifying instances of over-coding. Concerns also exist regarding under-coding within this chief complaint, which is a challenge reported by other ambulance Trusts as well.

The analysis indicates a decline in the proportion of 06E01 incidents resulting in hospital transport, with a rise in those treated at the scene or using their own transport after ambulance arrival. There has been a notable increase in 06E01 incidents originating from 111 calls, particularly within the 0-4 age group, suggesting possible over-triaging. Immediate actions have been taken for clinical validation before such incidents are transferred from 111 to 999, and efforts are ongoing to understand the issue between the Integrated Care and EMS Coordination teams.

IMTP

E-Timesheet Workshop

In November stakeholders from across the Trust and partner organisations, including Trade Union Partners, met to discuss the implementation of the electronic timesheet within our current rostering system. This project has been on the agenda for some time, but this date marks a significant step forward, moving into the scoping phase of the project with implementation planned for 2025. It was useful to understand the key issues and challenges, but with a clear focus from all present that this is an area that we need to progress for the benefit of all colleagues. The inaugural Project Board will be in January 2025 with the Assistant Director of Operations, Resourcing and EMSC as the Senior Responsible Owner. The project documentation is currently being drafted to ensure that all the requirements, benefits and risks to the project are clearly set out.

General Update

EMS Coordination Restructure and Reconfiguration

The restructure and reconfiguration programme went live on the week of the 25 November 2024. This is probably the most significant change our control rooms have experienced in decades and marks the start of a new era for EMS Coordination with improved ways of working, a much-needed progressive career structure, and capacity to better support our people. Over the last few months, the team have been actively recruiting into the centres and have appointed four new Locality Managers, which includes one for each EMSC centre and the fourth to manage the Clinical Navigators. Alongside this we have also appointed seven Operations Managers to provide 24/7 coverage across the 3 centres and to be the first point of contact for any significant or critical incidents which may occur.

Rapid Clinical Screening

On 4 November 2024, we welcomed nineteen Clinical Navigators into EMS Coordination. These roles are vital as we move into the first phase of our Clinical Services Model. Our new Clinical Navigators commenced their training ready for the Rapid Clinical Screening go live on 18 November. This was the first cohort of Clinical Navigators, and we will welcome a further six colleagues who join us from other NHS organisations in January 2025. This marks the first major step forward into our new model and will be an exciting time for the Trust as we start to shape the future service offer.

Medical Transfer Protocol Suite (MTPS)

MTPS is a suite of three Medical Priority Dispatch System (MPDS) protocols for interfacility (hospital) transfers for use by health care professionals. A review of the success of these protocols is ongoing and analysis of the non-emergency protocols so far has been positive. The emergency protocol (Protocol 45) has shown a high ratio of reds. Whilst these meet the operational performance target for reds, a paper is being refined with the findings and options to address any identified issues.

Emergency Medical Service

Challenges

Powys Major Incident Train Crash

WAST declared a Major Incident on 21 October 2024 for a train crash at Stay Little (Talerddig) Powys. The crash involved two passenger trains with initial reports indicating a high number of casualties. WAST declared a level 5 Major Incident and mobilised over 20 resources to the

scene including EMRTS and HART. As the incident progressed and more information was available from the scene, it became apparent that the patient numbers were not as high as initially thought and some resources were stood down.

WAST treated 15 casualties, the majority of which were minor injury patients with 1 deceased patient on scene. An internal debrief has been held and WAST has hosted the multiagency debrief. Both reports are being collated, but initial lessons identified include the challenges associated with a rural location, access for commanders to the scene and the need to activate the command groups promptly. Unsurprisingly, there are some synergies with some recommendations made to commissioners following our work focussed on the MAI.

December Critical Incident

On Monday 30 December, the Trust experienced high activity following the Christmas break, compounded by significant lost capacity due to handover delays, which severely hampered our ability to respond effectively. As the day progressed, the number of waiting incidents escalated, leading to increased community wait times. In response, the Trust initially escalated to REAP Level 4 (Extreme Pressure), prioritising all available capacity to front line services. However, this proved insufficient to meet the demand levels, necessitating the declaration of a Critical Incident. At the peak, more than 400 calls were awaiting ambulance response, and consistently over 50% of emergency ambulances were unavailable due to handover delays. The situation was further exacerbated by high rates of respiratory illness, resulting in extremely high hospital bed occupancy and reduced patient flow.

Command arrangements were established and remained in place until the incident was stood down in the early hours of 1 January. Activity on 31 December offered some respite, allowing the team to recover the waiting incident numbers. The evening of New Year's Eve, while busy, was fortunately uneventful and this may have been helped by the high profile and proactive media engagement.

IMTP

Advanced Paramedic Organisational Change Process

Operations and Clinical teams are working together to align the APP structure as part of the Trust's transformational work which will see a senior APP role at Band 8a and other APP roles including prescribing at Band 7. An OCP is currently underway for this work. The 24/25 APP recruitment process is well underway with applicants being appointed from both internal and external environments with final advert being released for the March term.

EMT Transition Programme

Further to the Trust's EMT transition programme to enhance the training and education of EMT2 to Emergency Ambulance Practitioners, we are now working closely with the Learning and Development team to ensure that all EMT 2s who are eligible and wish to undertake the EAP training is allotted a place on an available course. Courses are running into 2026.

General Update

Quality & Support Days

The Operations Directorate completed an operational effectiveness Quality and Support Day on Monday 28 October to further work to improve compliance against key performance indicators and to provide feedback to operational staff. While overall results were positive, the feedback did highlight a need for further consolidation of the hospital dual pin handover processes. Heads of Service and Service Managers have secured time on new starter courses and next year's MIST courses to reinforce and refresh all operational effectiveness items such as key performance indicators and dual PIN handover.

End of Shift Overruns EMS

To further support the work to reduce end of shift overruns, another end of shift handover POD is operational in Glangwili Hospital, Carmarthen. Due to the rurality of Hywel Dda it is hoped that this will make a difference to staff wellbeing and prevent lengthy end of shift overruns. This is a milestone for Hywel Dda, and once a brief period of evaluation has taken place, the local team will look to roll out similar infrastructure on Withybush and Bronglais sites.

Palliative Care

To further consolidate the End of Life Care work in the Swansea Bay Health Board area, Hywel Dda has established a 6 month trial of a Palliative Care Paramedic response car to provide essential advanced knowledge and treatment regimes for the complex needs of End of Life Care patients.

Ambulance Care

Challenges

NEPTS Roster Review
Work has continued to progress a service wide review of NEPTS rosters. This is the first ever national review of the services rosters and should hopefully deliver improved performance and efficiency. ORH have produced roster keys, which have gone through internal validation and the review will now move to the engagement and consultation phase.

Service Performance
Maintaining recent performance levels has become more challenging in the face of increasing pressures in planned care activity and the need to operate within the available resource envelope. Engagement with the commissioners has begun to identify solutions to address these challenges and to ensure the service remains in a robust position to continue to support planned care recovery in the future. The Trust is holding out not to return to our previous overspend position.

Recruitment Following Transition
Following recent EMT recruitment and many of the successful candidates being from ACA2 roles, this has left a reduced workforce in a number of areas. As EMT transition courses continue, this has limited the the availability to source additional training capacity. While there are pre-planned ACA courses, these were planned over 12 months ago to cover normal recruitment and attrition and will not provide adequate capacity to meet the required demand.Where budget is available, the service will utilise alternative resource options to address areas of sub-optimal resourcing.

IMTP

End of Shift Overruns UCS

The Ambulance Care team have been focused on reducing shift end over runs for the Urgent Care Service line. Initial focus was on reducing overruns greater than 2 hours, this was refocused to 90 mins+ in the summer after significant improvements were observed and 2hr+ overruns were almost eradicated. Following further improvements in the 90+ sector, the team will further reduce this target to 60 minutes from January 2025.

Ambulance Care Practice

Work to focus the Urgent Care Service on its core purpose, and ensure that UCS staff work only within their scope of practice, has progressed well and the calls allocated to the service are now much more aligned. Further work will commence in early 2025 to introduce a number of ambulance care practice development roles that will help review and develop Ambulance Care practice across all service lines. This will be a first for this area of the business and will also complement succession planning and service integration across operations.

General Update

Quality Assurance

The NEPTS service has continued to utilise and develop its balanced scorecard approach to performance management. This is gathered via a dashboard which includes activity, performance, staff compliance, patient experience and management compliance measures. The dashboard is informed not only by data from WAST systems, but also from patient feedback gained via online, postal and text patient surveys and annual birthday calls for regular travellers. The outcomes of the dashboard are used to identify areas of development for the service that can improve experience and outcomes.

Integrated Care

Challenges

Establishment

Recruitment for 111 call handlers across Wales has presented ongoing challenges, but we are committed to addressing these obstacles and improving our staffing levels. Despite difficulties, we've successfully recruited 65.4 full time equivalents to join the 111 Call Handling Team resulting in much improved levels of resourcing going into the winter period.

The establishment of clinicians has faced some challenges due to staff transitioning into new roles within the Clinical Navigation team. However, we have maintained a stable UHP despite these changes. To address this, we are actively recruiting and have enhanced our recruitment strategy to ensure we attract the best candidates.

The recruitment plan for band 6 clinicians is progressing well, with the three planned cohorts already advertised. Cohort one will start on 6th January 2025, cohort two on 24th February 2025, and cohort three on 7th April 2025. Additionally, two more inductions are planned for the summer months, with these still to be advertised. We're confident that these efforts will strengthen our team and support continued growth.

The Duty Operations Manager (DOM) team establishment is also challenged, and we are actively recruiting to backfill these positions. There are three vacancies to fill, two have now been recruited into with a start date of 20th January 2025. The third vacancy is actively looking to be backfilled.

Sickness

Sickness absence remains a cause of concern across Integrated Care despite considerable efforts to target the causes of sickness absence. Integrated Care is taking the necessary steps to understand the key drivers and develop meaningful interventions. Integrated Care has commenced a trial with Occupation Health to allow those colleagues who are unwell to get access to immediate occupational health and wellbeing support.

IMTP

Mental Health Response Vehicle (MHRV)

Following a successful trial, the availability of the MHRV has been expanded across 3 Southeast health boards, 7 days a week between the hours of 1300-0100. A Senior WAST Mental Health Practitioner and Emergency Medical Technician will work together on the vehicle to assess and treat patients in the community for a timelier response, and to reduce avoidable hospital admissions.

The Mental Health Response Vehicle (MHRV) has been active since the 3rd of November 2024. Recent recruitment has increased the number of Mental health practitioners (MHP) from 8 to 10, with the 2 additional remaining in training until 17th January 2025. The MHRV has responded to 144 patients where 40.2% of those patients were treated at scene. and a further 9.38% conveyance rate. The average time on scene for the MHPs has been 41:08 minutes.

Clinical Model Transformation

The Clinical Model Transformation has continued to be a significant focus throughout this quarter. Below are some of the recent works and upcoming implementations:

- **Rapid Clinical Screening** includes high acuity live review, queue safety, remote clinical support, and green call screening, all of which are operational. Screening of Amber 2 calls is scheduled to go live the week commencing 16th December. Screening of Amber 1 calls is set to go live at the end of January, coinciding with the commencement of the remaining appointed clinical navigators.
- **Call Categorisation** is currently with WG for approval and undergoing review. Findings will be communicated once available.
- Remote Integrated Care Service has **Care Planning** now live and the **CPSS winter desk** is now also live. Capacity has been freed up in CSD to conduct remote clinical assessments on 999 screened calls. 111 access to 999 pathways is available and live, providing greater access to urgent primary care appointments.
- Urgent Community Response Service has developed an appointment scheduling SOP, which will be presented to STB with recommendations. APP OCP is underway.

General Update

Welsh Improvement Plan 2024

The 111 Service Welsh Improvement Plan 2024 addresses the challenges and measures implemented to enhance the performance of the 111 service in handling Welsh-language calls. Performance at the Start of 2024 answer rate ranged between 50–58% and has increased to 75%. During the summer, a targeted plan was developed to address the issues and improve the Welsh-language call handling this is ongoing, and work will continue to improve access for our Welsh speaking callers. Integrated Care was very honoured to receive a Trust award for the work that has been completed to increase access ongoing.

Quality & Support Days

Integrated Care has successfully introduced monthly Quality and Support Days across Wales, with four highly successful events already completed. During these days, Integrated Care Managers have met with as many staff members as possible, fostering open conversations and increasing their visibility within the workforce. These events have generated valuable insights and data, with key themes covered across the days:

· Day 1: Performance and Understanding Performance

· Day 2: Communication and Workplace Morale

· Day 3: Sexual Safety and Reporting

· Day 4: 'You Said, We Did' – A review of feedback from the previous quarter

The feedback has been overwhelmingly positive, and we are excited to continue this model, aligning it with the excellent results from our recent staff survey. This initiative is helping to strengthen communication, improve staff morale, and ensure that we continue to evolve in line with the needs and suggestions of our teams.

AGENDA ITEM No	**6**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**4**

2024/25 COMMITTEE EFFECTIVENESS REVIEW

MEETING	Quality, Patient Experience and Safety Committee
DATE	04 February 2025
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Trish Mills, Director of Corporate Governance/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 approach for the 2024/25 effectiveness review for this committee sees a move away from the lengthy questionnaires of the past, and a focus on its delegated remit and the assurance reporting in particular that it receives on a regular basis.

3. The board has established this committee to support it in discharging its responsibilities effectively. The operating arrangements of this committee should allow it to spend time to delve deeper into issues within its remit, identify assurance gaps, and set the necessary context for informed decision-making. It is vital therefore that that time is spent effectively and that the delegated remit is both appropriate and manageable. Essential to this is a clear work programme and robust reporting.

4. A presentation will accompany this paper in committee; however, members are requested to review the committee's remit (summarised below and in full in the current attached terms of reference) and its cycle of business ahead of the meeting.

RECOMMENDATION

5. Members are invited to assess whether the committee's remit, as outlined below and in its terms of reference, remains appropriate for 2025/26. Consideration should be given to any desired amendments, additions, or removals, as well as any areas that might be better addressed by another committee.

6. Members are invited to evaluate the cycle of business included in this pack. Reflecting on the hallmarks of effective assurance reporting, members are asked to propose potential improvements to enhance the strength and efficiency of assurance processes for the committee, including any individual reports.

7. Additionally, members are asked to take part in a short Mentimeter quiz during the meeting to answer the following questions:

   (a) What would help you as report writers/reviewers/receivers of assurance
   (b) What works well in this committee
   (c) What improvements could we make in this committee

8. The Committee is requested to review the draft Annual Report and provide any comments ahead of it being finalised and circulated for email approval by Chair's Action.

KEY ISSUES/IMPLICATIONS

As set out above.

REPORT APPROVAL ROUTE

Terms of reference and final annual report to be approved by way of Chair's Action following this meeting and presented to ARAC and the board thereafter.

REPORT APPENDICES

Annex 1 – Committee remits for 2024/25
Annex 2 – Committee terms of reference
Annex 3 – Committee cycle of business
Annex 4 – Draft committee annual report

REPORT CHECKLIST			
Confirm that the issues below have been considered and addressed		**Confirm that the issues below have been considered and addressed**	
EQIA (Inc. Welsh language)	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

2024/25 COMMITTEE EFFECTIVENESS REVIEW

SITUATION

1. Annual effectiveness reviews are designed to evaluate the efficacy of the committee, review operating arrangements, and propose changes to improve its support, challenge, scrutiny and oversight responsibilities.

2. Whilst our commitment to the duty means we adopt a continuous improvement methodology throughout the year, this annual effectiveness review is an opportunity to formally review this committee's remit and membership, consider the reports it receives, and look back at the work of the Committee in 2024/25.

BACKGROUND

Role of the Board and its Committees

3. The Trust Board is accountable for governance, risk management and internal controls at WAST. It focuses on the following key areas:

    - Developing the **strategy, vision, and purpose** of the Trust. Identifying priorities, establishing goals and objectives, applying resources, understanding risks to the achievement of objectives, and allocating funds to support the decisions that need to be made around strategic planning.

    - Shaping the **culture** of the Trust in several ways, including the way in which it engages with our people, our patients and stakeholders, the way it manages its agenda, by the nature of the discussions at the Board and the relative emphasis given to different performance criteria, by the visibility of its members in the organisation, and by where it chooses to invest time and resources. Board and committee members must live up to the highest ethical standards of integrity and probity and abide by the Nolan Principles.

    - Setting organisation wide expectations and accountability for high performance and compliance with the **duty of quality** and the **duty of candour** as set out in the Health and Care (Quality and Engagement) (Wales) Act 2020. Ensuring that all staff understand their role in the effective and high-quality provision of care in a governance framework that ensures a balance between trust, constructive debate, and effective challenge in a culture of openness and learning.

- Ensuring there is a robust system of **risk management and internal controls** in place, and that the board are sighted on the mitigations in place for the principal risks to the delivery of the strategy.

- **Holding to account,** and being held to account, for the delivery of the strategy in accordance with the strategic and performance frameworks developed by the Board.

4. The board has established several committees to support it in discharging its responsibilities effectively. These committees are designed to undertake the detailed work required to provide robust assurance, explore risks and performance issues, and examine key matters within their specific remits. By doing this 'heavy lifting,' they have the capacity to delve deeper into issues, identify assurance gaps, and set the necessary context for informed decision-making. Attached at **Annex 1** is a snapshot of the remits of all six committees of the Trust Board, and the Corporate Trustee framework.

5. Committees meet for extended periods, allowing them to afford the time and attention to critical matters that the full board cannot. This structure ensures that items are thoroughly examined and discussed, enabling a more expert understanding of their implications. Following each meeting, committees report back to the board and corporate trustee on the assurance they have received and escalate any significant issues or concerns for further consideration. This approach ensures that the board is well-informed and able to focus on strategic oversight.

<u>Effectiveness</u>

6. The Trust's Standing Orders, committee terms of reference, and codes of governance provide that boards should routinely assess the effectiveness of their governance arrangements, of which this committee forms an integral part. Each committee is required to submit an annual report to the board setting out its activities during the year and a review of its performance.

7. In 2022/23 and in 2023/24 these reviews consisted of a lengthy questionnaire completed by members, and a pre-review of the terms of reference and questionnaire responses by the committee Chair, Executive Lead and Corporate Governance Team. These were then presented to the committee with proposed changes to both the remit and operating arrangements. The survey and the presentation of results in the committee meeting garnered waning engagement as reviews progressed through the seven committees. This was in part because of the time of year these were undertaken (which was during the busy winter period

for the Trust), and because there is duplicative membership across several committees.

8. In April 2024 the Audit, Risk and Assurance Committee (ARAC) agreed a different approach to these reviews for the 2024/25 year to garner further engagement of members.

9. The new approach for committees other than ARAC[1] centres on discussion in the meeting on the delegated remit of the committee and assurance reporting. The pre-submitted questionnaire will be replaced by a few simple questions for the interactive committee session on best practice and improvements that could be made.

ASSESSMENT

10. This committee's terms of reference are attached at **Annex 2**.

<u>The Remit of this Committee</u>

11. The terms of reference set out its purpose, membership, operating arrangements, members' commitment to the duty of quality, and its delegated duties and remit. The current high level remit of this committee can be summarised as follows:

    - Receive assurance that the organisation has the right systems and processes in place to deliver services consistent with the six domains of quality (person centred, safe, equitable, timely, effective and efficient). Advise the Board on the relevant key indicators for quality, patient experience and clinical safety and monitor performance against those indicators.

    - Receive assurance on 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 to improve the quality of healthcare provided by the Trust and to support the delivery of an open and honest reporting and continuous learning culture.

[1] ARAC follows the National Audit Office questionnaires as best practice

The Work Programme of this Committee

12. The terms of reference are accompanied by a cycle of business (otherwise known as a work programme) for each committee. This committee's cycle is attached at **Annex 3**. The text in red is a direct lift from the terms of reference narrative and what follows then is the reporting that has been agreed will provide the necessary assurance and/or opportunities for scrutiny and challenge on the duties delegated to this committee by the board. This cycle of business and its accompanying notes were approved by the committee in May 2024.

13. Cycles of business play a pivotal role in the effectiveness and efficiency of the committee. They are the basis upon which agenda are drafted to inform a fulsome commissioning of papers. The notes section contains context added from a number of sources including audit reports, directions from the committee, agreed approaches or policy positions.

14. The cycle of business should aim to cover 90% of the items expected to come before the committee. This framework enables directors and their teams to plan the internal governance pathways that each report should follow before reaching the committee.

15. The cycle of business is accompanied by a detailed schedule of submission deadlines, ensuring papers are lodged with the Corporate Governance Team in a timely manner for each committee meeting and published in line with the Trust's Standing Orders.

Internal Governance and Flows of Assurance

16. With the exception of the People and Culture Committee and the Charity Committee, the board has not established sub-committees reporting to its committees. Instead, the Trust has implemented internal governance structures that serve as integral components of the broader governance framework. These structures link operational management activities with the strategic oversight provided by the board and its committees. Importantly, these forums (outlined below) do not report directly to any board committee:

    - **Organisational Governance**
      Includes governance forums reporting to the Executive Leadership Team (ELT), along with their sub-committees and task-and-finish groups.

    - **Strategy Development and Delivery**
      Encompasses the Strategic Transformation Board, its sub-committees, and working groups.

- **Directorate Governance**
  Refers to governance structures established by individual directors within their directorates.

17. These forums enable directors to:

- Address specific portfolio areas effectively;
- Foster a collaborative approach across the Trust;
- Establish robust monitoring and assurance processes;
- Escalate issues for resolution as needed;
- Formulate assurance reports to meet their accountability responsibilities to the board and relevant committees.

A well-defined cycle of business for the committee is essential to support directors in creating appropriate forums, providing clarity to report writers, and ensuring the smooth flow of reporting.

18. The cycle of business will guide the type of reporting needed; however, all assurance reporting must meet high standards to support effective decision-making. The hallmarks of a good board or committee paper include:

- Clarity and accessibility, ensuring the paper is:
  - free from jargon and accessible to all board and committee members, regardless of technical expertise;
  - presented with a clear, logical structure and relevant headings;
  - focused on key issues within the committee's remit, avoiding unnecessary detail;
  - complimented by an executive summary highlighting key points for quick reference; and
  - not duplicative.

- Strategically aligned and clearly identifies key risks, their potential impact, and how these risks are managed or mitigated.

- Evidence-based and balanced, ensuring it:
  - Is drawn from robust, reliable data and evidence;
  - provides a balanced view by presenting both positive and negative findings; and
  - includes trends and comparisons (e.g., performance over time or against benchmarks).

- Offers actionable recommendations for addressing issues or enhancing performance, clearly defining next steps and responsibility for implementation.

- Uses visual aids (e.g., charts, graphs, dashboards) to present data clearly.

- Highlights the implications of findings for patients and other key stakeholders.

- Demonstrates learning from incidents, audits, and external inspections, showing how findings contribute to a culture of improvement and excellence.

By adhering to these principles, the Trust can ensure that assurance reports effectively supports the board and its committees in making informed and strategic decisions.

19. While it is essential to define the bulk of the work to be received by a board committee through the cycle of business, it is equally important to recognise that not all items received by the committee serve as assurance. Some reports provide valuable context for complex issues or deliver information that, while not strictly assurance, supports a broader understanding of the Trust's operations and strategic priorities.

20. Assurance itself extends beyond formal reporting. It includes qualitative inputs such as patient and staff stories, which bring a human perspective to the committee's work. Additionally, the triangulation that occurs during board visits - when members engage directly with our people and patients - provides invaluable insights that complement formal assurance processes. Together, these elements enrich the committee's ability to make informed and well-rounded decisions.

21. Bearing the above in mind, members are invited to consider the reporting that the committee receives on a regular basis in particular and reflect on and suggest improvements that may be made to strengthen and/or streamline assurance to the committee.

<u>Annual Report</u>

22. The committee's annual report has been prepared in draft and is attached at **Annex 4**. The report provides assurance to the board on the discharge of the committee's responsibilities through the year, progress against priorities, and membership/quorum.

23. Following this committee meeting, any amendments to the terms of reference and feedback from members on its effectiveness will be incorporated into a revised draft, which will be circulated to members for review.

Next Steps

24. ARAC, at its early May 2025 meeting, will review the committee's annual report and its effectiveness evaluation, as well as any proposed changes to its terms of reference and operating arrangements. ARAC will be asked to assure the board at its May 2025 meeting that the arrangements the board has in place for its committee structure and spread of delegations is appropriate and manageable into 2025/26.

25. The next meeting of this committee falls after the early May 2025 ARAC meeting, therefore any changes to the terms of reference and the annual report will be circulated to the committee for email approval by Chair's Action following this meeting. The Committee Chair will also propose priorities for 2025/26 as result of the discussions from today's meeting.

RECOMMENDATION

26. Members are invited to assess whether the committee's remit, as outlined below, remains appropriate for 2025/26. Consideration should be given to any necessary amendments, additions, or removals, as well as any areas that might be better addressed by another committee.

27. Members are invited to evaluate the cycle of business included in this pack. Reflecting on the hallmarks of effective assurance reporting, members are asked to propose potential improvements to enhance the strength and efficiency of assurance processes for the committee.

28. Members are asked to take part in a short Mentimeter quiz in the meeting answering the following questions:

    (d) What would help you as report writers/reviewers/receivers of assurance
    (e) What works well in this committee
    (f) What improvements could we make in this committee

29. The Committee is requested to review the draft Annual Report and provide any comments ahead of it being finalised and circulated for email approval by Chair's Action.

Ymddiriedolaeth Brifysgol GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
University NHS Trust

WAST BOARD COMMITTEE REMITS – 2024/25

Quality, Patient Experience and Safety Committee

- Duty of Quality and Duty of Candour
- KPIs in remit
- Clinical & quality plans
- Health and Care Quality Standards
- Quality Impact Assessment
- Mental health
- Infection prevention and control
- Safeguarding
- Continual quality improvements
- Learning
- Mortality reviews
- Putting Things Right
- Clinical negligence & personal injury
- Clinical effectiveness
- Clinical audit
- Citizens voice & patient experience
- Clinical and quality governance
- Risks, audits, policies in remit

People and Culture Committee

- People & Culture plan and metrics
- KPIs in remit
- Trust Behaviours
- Health and wellbeing
- Staff & volunteer experience
- Speaking up safely
- Equality, diversity, and inclusion
- Recruitment and retention
- Trade Union relationships
- Leadership & development
- Succession plans
- Welsh language
- Health and safety
- Health and Care Standards in remit
- Registration and revalidation
- Partnerships and engagement
- Risks, audits, policies in remit

Advisory Group (WASPT) reports to this Committee with onward reporting to Board via the AAA

Finance and Performance Committee

- Long term strategic direction
- Long term financial direction
- Capital and revenue monitoring
- Financial sustainability
- Business cases and PIRs
- Compliance with statutory duties
- IMTP endorsement and delivery
- Value based healthcare
- Performance against targets set by Commissioners and Welsh Gov.
- Quality &Performance Management Framework (QPMF) outcomes
- Trust wide KPIs (MIQPR)
- Recovery plans for performance
- Demand and capacity
- Estates
- Fleet
- Environment and sustainability
- Digital systems
- Digital plan direction
- Information governance
- Information security
- Major Incident Plan and Business Continuity Plan
- Cyber resilience & security
- Risks, audits, policies in remit

Audit, Risk and Assurance Committee

- Governance and assurance
- Effective systems of good governance, risk management and internal control
- Board Assurance Framework
- Annual Report
- Audited financial accounts
- Standing Orders and SFIs
- Accounting policies
- Assurance processes
- Policies for reg. compliance
- Schedule of losses & special payments
- Single tender actions
- Internal audit (inc annual plan; reports; HOIA Opinion)
- Audit Wales (inc annual plan; ISA260; structured assessment; reports;
- QPMF implementation
- Audit management responses
- Local Counter Fraud Service
- Standards of business conduct
- Whistleblowing processes
- Patient's property
- Policies in remit

Remuneration Committee

- Contractual arrangements for staff
- Appointment, termination, remuneration, terms of service and appraisal for Chief Executive; Executive Directors (including interim); Very Senior Managers
- Redundancy, VERs, Settlement settlements

Academic Partnerships Committee

- Strategic collaboration with education providers and commercial partners
- Collaboration with partners in health, social care, local authority and third sector
- Partnership arrangements
- University Trust Status
- Plans to build capacity of whole workforce
- Research governance framework
- Risks, audits, policies in remit

Charity Committee (Corporate Trustees)

- Charity strategic direction
- Charitable funds monitoring including systems and processes
- Review by Audit Wales of accounts
  Fundraising
- Bursary Panel
- Promote the charity
- Annual Report and Financial Accounts
- Approve expenditure over £5,000
- Bids Panel
- Risks, audits, policies in remit

QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE

TERMS OF REFERENCE AND OPERATING ARRANGEMENTS 2024/25

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 Quality Standards 2023 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.

1.3. The Board Committees play an important role in supporting the Board in fulfilling its responsibilities by:

- providing advice on strategic development and performance within the terms of reference;
- undertaking scrutiny and gaining assurance on key aspects of organisational performance, and supporting achievement of the Trust's strategic goals;
- carrying out specific responsibilities on the Board's behalf; and
- providing a forum where ideas can be explored in greater detail than Board meetings are able to allow, providing time and space to consider issues in greater depth.

Regular and timely reporting and escalations to the Board on the issues within the Committee's remit allow for more focused discussions by the Board.

2. PURPOSE

2.1. The Committee is responsible for scrutinising improvements in outcomes in quality, patient experience, effectiveness, and safety to reduce incidences of avoidable harm.

2.2. During the 2024/25 financial year the Committee will continue to oversee the systems and process 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 and 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 on areas within its remit.

2.4. The committee shall, in carrying out its functions and responsibilities, consider how their decisions secure an improvement in the quality of health services (the duty of quality) as outlined in The Health and Social Care (Quality and Engagement) (Wales) Act 2020. This includes but is not limited to ensuring the provision of high-quality, safe, and effective healthcare services that meet the needs of patients, service users, and their families.

2.5. The committee shall demonstrate the duty of quality through its own operating arrangements, ensuring that its processes, procedures, and decision-making mechanisms uphold the highest standards of transparency, accountability, and governance. It shall regularly review and refine its operating procedures to align with best practices and legal requirements, fostering an environment of continuous improvement. Furthermore, the committee shall monitor, assess, and report on the implementation of Health and Care Quality Standards, outcomes, and performance indicators where relevant within their remit.

3. DELEGATED POWERS AND AUTHORITY

The Committee will:

3.1. Receive assurance that the organisation has the right systems and processes in place to deliver services consistent with the six domains of quality (person 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. Receive assurance on 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 to improve the quality of healthcare provided by the Trust and to support the delivery of an open and honest reporting and continuous learning culture.

Strategy

3.4. 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.

3.5. Monitor the implementation of strategies and plans within the remit of the Committee where that is not already done by the Finance and Performance Committee.

3.6. Receive assurance that there is clear, consistent strategic direction, strong leadership, transparent lines of accountability.

Safe Care

3.7. Receive assurance that the Health and Care Quality Standards 2023, and Commissioning Quality Core Requirements are embedded Trust wide with actions taken in relation to any identified non-compliance.

3.8. Receive assurance that 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.

3.9. 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.

3.10. Receive assurance that the Trust is compliant with the Mental Health Act 1983, Code of Practice, and the Mental Capacity Act 2005.

3.11. Review the annual infection prevention and control plan and monitor its implementation.

3.12. Receive assurance that the Trust is meeting its obligations with respect to safeguarding of children and vulnerable adults.

3.13. 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.

3.14. Receive assurance that 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.

Effective Care

3.15. Receive assurance that 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.

3.16. Approve the Trust's 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;

3.17. Receive assurance that 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.

Citizen Voice and Patient Experience

3.18. Approve the patient experience/engagement plan and monitor its implementation.

3.19. Receive assurance that the organisation has a citizen centred approach, putting patients, patient safety, quality of care and safeguarding above all other considerations.

3.20. Receive assurance that 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.

3.21. Receive assurance that 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.

3.22. Receive assurance that there is good collaborative team and partnership working to provide the best possible outcomes for its citizens.

3.23. Ensure any matters raised by the Executive Director of Quality & Nursing (including in their role as Caldicott Guardian), Executive Director of Paramedicine, or other Directors in relation to patient safety and clinical risk are considered and addressed promptly and fully.

Governance

3.24. 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.

3.25. Receive and gain assurance from internal and external audits in their remit. It will also monitor management actions to address recommendations via the audit tracker and where appropriate scrutinise the impact of actions in response to audit recommendations.

3.26. Review and recommend to the Board the Trust's annual Duty of Candor and Quality Report(s) and quality improvement priorities for the coming year, monitoring progress against these priorities and their impact on patient safety.

3.27. Review policies in its remit and endorse policies for Board approval that relate to complaints and incidents in line with Putting Things Right.

3.28. Monitor the key risks relevant to its remit. It will consider the controls and mitigations of related risks and provide assurance to the Board that such risks are being effectively controlled and managed.

Authority

3.29. 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.

3.30. 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.

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

Chair's Action

3.32. There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Committee. This is most likely, but not exclusively, to arise with respect to approval of policies particularly given the current backlog.

3.33. In these circumstances, the Chair and the Lead Executive, supported by the Board Secretary as appropriate, may deal with the matter on behalf of the Committee after first consulting with at least two other Members (Non-Executive Directors).

3.34. The Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

Sub-Committees

3.35. 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.

Prescribed Attendees

4.2. The core membership will be supported by the attendance of the following at each meeting:

- Executive Director of Quality and Nursing (Committee Lead)
- Executive Director of Paramedicine
- Executive Director of Operations
- Executive Director of Strategy, Planning and Performance
- Director of Digital Services
- Trade Union Partners (x 3)
- Chairs of Sub-committees (where established)
- Board Secretary

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:

(a) arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and
(b) 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 People and Culture.

Quorum

4.9. 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

4.10. 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

4.11. 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.

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

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

5.2. 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:

(a) joint planning and co-ordination of Board and Committee business; and
(b) 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.

5.3. 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.

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

6. REPORTING AND ASSURANCE ARRANGEMENTS

6.1. The Committee Chair shall:

(a) report formally, regularly and on a timely basis to the Board and the Chief Executive (Accountable Officer) on the Committee's activities. This includes a written highlight report, the submission of Committee minutes and written reports where appropriate throughout the year;

(b) bring to the Board and the Chief Executive (Accountable Officer's) specific attention any significant matter under consideration by the Committee; and

(c) 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.

6.2. 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.

7. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

7.1. 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)

8. REVIEW

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

PAPER	PRE C'EE FORUM	FREQUENCY	Q1	Q2	Q3	Q4	LEAD	PURPOSE	COMMENT/COMPLIANCE
QUEST COMMITTEE - CYCLE OF BUSINESS 2024/25									
TERMS OF REFERENCE NOTED IN RED TEXT									
3.2 Advise the Board on a set of key indicators for quality, patient experience and clinical safety, and monitor performance against those indicators.									
3.14 Receive assurance that 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									
3.17 Receive assurance that 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									
MIQPR review of metrics	ELT	Annually	■				EDSPP	Approval	To review and agree Board level metrics for coming year
Committee QPSE review of metrics in PTR report	CQGG	Annually	■				EDQN	Approval	To review and agree the Committee level metrics for the coming year (over and above MIQPR metrics - if any) currently contained in PTR report
MIQPR report	ELT	Quarterly	■	■	■	■	EDSPP	Assurance	Includes balanced scorecard of all Board level metrics
Putting Things Right Report	CQGG	Quarterly	■	■	■	■	EDQN/DP	Assurance	See Note 1
3.3 Receive assurance on compliance with the Duty of Quality and Duty of Candour as set out in the Health and Social Care (Quality and Engagement) (Wales) Act 2020 to improve the quality of healthcare provided by the Trust and to support the delivery of an open and honest reporting and continuous learning culture - See Note 2 (see also QIAs below)									
3.26 Review and recommend to the Board the Trust's annual Duty of Candor and Quality Report(s) and quality improvement priorities for the coming year, monitoring progress against these priorities and their impact on patient safety.									
3.24 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									
Quality Report	CQGG	Annually	■				EDQN	Approval	Guidance to be provided by WG. H&SC(Q&E) Act. See Note 3
Duty of Candour Report (Annual PTR Report)	CQGG	Annually	■				EDQN	Approval	See Note 4.
STRATEGY									
3.1 Receive assurance that the organisation has the right systems and processes in place to deliver services consistent with the six domains of quality person centred; safe; equitable; timely; effective; and efficient).									
3.4 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.									
3.5 Monitor the implementation of strategies and plans within the remit of the Committee where that is not already done by the Finance and Performance Committee..									
3.6 Receive assurance that there is clear, consistent strategic direction, strong leadership, transparent lines of accountability.									
Quality Plan aligned to Delivering Excellence 2030	CQGG/TB	Initial and cyclical review					EDQN	Approval	Planning & engagement for new quality plan will take place during 24/25. See AW quaity governance follow up recommendations in Note 16
Clinical Plan aligned to Delivering Excellence 2030	CQGG/TB	Initial and cyclical review					EDP	Approval	
Dementia Standards Report	CQGG	TBC			■		EDQN	Assurance	Reporting developing in 23/24 - see Note 5
Committee elements of IMTP	STB	Annually			■		EDSPP	Endorsement	Proposed QPSE elements of IMTP to QUEST for review ahead of full IMTP review by F&P and Board
IMTP exception reporting	STB	Ad Hoc					Relevant Director	Assurance	F&P monitor delivery of strategy via IMTP. Exception reports to QUEST by director or by F&P request where required.
SAFE CARE									
3.7 Receive assurance that the Health and Care Quality Standards 2030, Commissioning Quality Core Requirements are embedded Trust wide with actions taken in relation to any identified non-compliance. See Note 6									
3.8 Receive assurance that 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									
Health and Care Quality Standards	CQGG	TBC					EDQN	Assurance	See Note 7
Quality Impact Assessments	CQGG	Ad Hoc					EDQN/DP	Assurance	See Note 8
3.9 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									
External and/or peer reports	Various	Ad Hoc					Relevant Director	Assurance	May include reports from HIW/DU/Audit Wales/peer reviews/regulation 28 etc.
3.10 Receive assurance that the Trust is compliant with the Mental Health Act 1983, Code of Practice, and the Mental Capacity Act 2005.									
Annual Mental Health Report	CQGG/TB	Annually			■		EDQN	Assurance	See Note 14 re legislative compliance reporting requirement
3.11 Review the annual infection prevention and control plan and monitor its implementation									
Annual IPC report	CQGG/TB	Annually		■			EDQN	Assurance	Report to include compliance requirements and details of how Quest will monitor implementation per TOR
3.12 Receive assurance that the Trust is meeting its obligations with respect to safeguarding of children and vulnerable adults									
Annual safeguarding reports	CQGG/TB	Annually		■			EDQN	Assurance	Annual safeguarding report (All Wales and WAST). Quarterly metric in MIQPR on risk report data and referrals
3.13 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									
Referrals from PCC	PCC	Ad Hoc					Relevant Director	Discuss/Assure	PCC has oversight of registration, revalidation and training and may refer to QUEST matters that affect patient safety
EFFECTIVE CARE									
3.15 Receive assurance that 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.									
3.16 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									
Clinical audit plan	CQGG/AC	Annually				■	EDP	Approval	QUEST report to Audit Committee that plan endorsed. See Note 9
Monitoring report on clinical audit	CQGG	Quarterly	■	■	■	■	EDP	Assurance	
Spotlight On' clinical indicators	CQGG	Quarterly	■	■	■	■	EDP	Assurance	To provide more focus on clinical care (started in Q2 23/24)
Mortality Report	CQGG	Bi-annually	■		■		EDQN	Assurance	See Note 12
Meds management report	CQGG	Annually	■				EDP	Assurance	Standalone report in Q1 on meds management (& medical devises by exception) & exception report - see Note 10
CITIZEN VOICE AND PATIENT EXPERIENCE									
3.19 Receive assurance that the organisation has a citizen centred approach, putting patients, patient safety, quality of care and safeguarding above all other considerations.									
3.18 Approve the patient experience/engagement plan and monitor its implementation.									
3.20 Receive assurance that 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									
3.21 Receive 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									
3.22 Receive assurance that there is good collaborative team and partnership working to provide the best possible outcomes for its citizens									
PECI report	TBC	Bi-annually	■		■		EDQN	Assurance	See note 11
Patient story	N/A	Quarterly	■	■	■	■	EDQN	Assurance	Patient stories topical to main issues where possible
Patient story updates	N/A	Quarterly	■	■	■	■	EDQN	Assurance	Driver diagram demonstrating feedback loop and learning. Letter of thanks to patient.
3.23 Ensure any matters raised by the Executive Director of Quality & Nursing (including in their role as Caldicott Guardian),Executive Director of Paramedicine, or other Directors in relation to patient safety and clinical risk are considered and addressed promptly and fully									
GOVERNANCE									
3.25 Receive and gain assurance from internal and external audits in their remit. It will also monitor management actions to address recommendations via the audit tracker and where appropriate scrutinise the impact of actions in response to audit recommendations.									
3.27 Review policies in its remit and endorse policies for Board approval that relate to complaints and incidents in line with Putting Things Right.									
3.28 Monitor the key risks relevant to its remit. It will consider the controls and mitigations of high level workforce related risks and provide assurance to the Board that such risks are being effectively controlled and managed.									
Audit recommendation tracker	ELT	Quarterly	■	■	■	■	BS	Assurance	
Audits within purview of Committee	Audit	Ad Hoc					Relevant Director	Assurance	
Report from policy group	Policy Group	Annually				■	BS	Assurance	
Policies for review and approval	Policy Group	Ad Hoc					BS	Approval	Board to approve PTR policy (SoRD). Note AW recommendations on PTR and Adverse Incident Policies in the 2024 quality governance review follow up
Board Assurance Framework	ELT	Quarterly	■	■	■	■	BS	Assurance	
Corporate Risk Register	ELT	Quarterly	■	■	■	■	BS	Assurance	
SUB-GROUPS									
Where applicable	N/A	Ad Hoc					N/A	N/A	No sub-committees - however may set up task and finish groups from time to time
GOVERNANCE									
Committee effectiveness review annual report	Audit/Board	Annually				■	BS	Approval	TORs provide that this is the first meeting of the year. Reports go to Audit C'ee in April and Board May
Review of Terms of Reference	Audit/Board	Annually				■	BS	Approval	TORs provide that this is the first meeting of the year. Reports go to Audit C'ee in April and Board May
Committee Cycle of Business annual refresh	N/A	Annually	■				BS	Approval	
Committee Cycle of Business monthly review	N/A	Quarterly	■	■	■	■	BS	Review	Review against cycle progress at each meeting
Committee Review of Annual Priorities	N/A	Quarterly		■	■	■	BS	Review	
PROMPTS									
Operations Report	SLT	QUarterly	■	■	■	■	EDO	Information	
External Reports	N/A	Ad Hoc					TBC	TBC	

EDQN = Executive Director of Quality and Nursing
EDO = Executive Director of Operations
EDP = Executive Director of Paramedicine
EDSPP = Executive Director Strategy, Planning and Performance
BS = Board Secretary

■ Cycled for each meeting
Ad hoc item - prompt for agenda setting
Reporting developing

QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE (QUEST)
ANNUAL REPORT 2024/25

INTRODUCTION

1. The Trust's Standing Orders and Committee Terms of Reference require that Board Committees evaluate their effectiveness annually and present an annual report to the Trust Board.

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 codes of governance provide that boards should routinely assess the effectiveness of their governance arrangements, of which the board's committees form an integral part.

4. The committee met on 04 February 2025 and through a facilitated discussion reviewed its effectiveness, its terms of reference, and its operating arrangements. This Annual Report reflects on the effectiveness of the committee in 2024/25 and proposes changes to terms of reference.

PURPOSE OF THE COMMITTEE

5. The committee is established to for scrutinise improvements in outcomes in quality, patient experience, effectiveness, and safety to reduce incidences of avoidable harm. It provides oversight of and seeks assurance on statutory and regulatory compliance, including but not limited to the Duty of Quality and the Duty of Candour as set out in the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

MEMBERSHIP AND ATTENDANCE

6. The committee met four times as scheduled in 2024/25 and was quorate on each occasion.

7. The committee is supported by the Chair and three Non-Executive Directors as members, and a number of core attendees. The number of Non-Executive Directors was reduced in year to three, as of the 01 January 2025. The chart below illustrates attendance of members and attendees as listed in the terms of reference for 2024/25. The committee welcomed non prescribed attendees at various meetings as well as external guests.

COMMITTEE ATTENDANCE				
NAME	**07 MAY 2024**	**13 AUGUST 2024**	**05 NOVEMBER 2024**	**04 FEBRUARY 2024**
Bethan Evans (Chair)				
Kevin Davies				
Ceri Jackson	Chair			
Liam Williams				
Andy Swinburn		From 1100[1]		
Lee Brooks	Jonathan Edwards	Pete Brown (open)		
Rachel Marsh	Hugh Bennett	From 1120[2]	Hugh Bennett until 2pm	
Jonny Sammut				
Trish Mills	Julie Boalch			
Mark Marsden				
Hugh Parry				
Henry Garrard				

	Attended
	Deputy attended
	Apologies received
	No longer member

8. The membership of the committee was revised effective quarter four of 2024/25 in response to changes to the Non-Executive Director membership of the Trust Board, as indicated above. This includes Rhiannon Beaumont-Wood as a member of the committee. The February 2025 meeting of the committee will be her first meeting.

9. No changes to membership are proposed at this stage.

COMMITTEE'S VIEWS ON EFFECTIVENESS

10. The committee's effectiveness was assessed through a facilitated discussion held at the meeting on the 04 February 2025, which included a review of its terms of reference and cycle of business.
[insert here following the 04 February meeting the views of the members on the effectiveness of the committee]

11. The committee has a cycle of business that is aligned to its terms of reference. All matters scheduled for oversight and review have been brought to the committee and in this respect, it has discharged its responsibilities in providing assurance to the Board. The committee's business in 2024/25 included:

11.1. In 2024/25 the Trust continued to review and evolve its clinical model, and the committee heard updates on the progress of this work through the **Clinical Model Transformation Programme (CMT)**. Assurance was given to the committee on the internal governance arrangements for the programme through the CMT Programme Board that reports to the Strategic Transformation Board. In particular the committee received the following information and assurances on the CMT:

11.1.1. The committee heard of the introduction of the new **Clinical Navigator role,** which will allow clinicians to use their expertise to quickly assess patients and determine whether they require immediate emergency ambulance dispatch or are suitable for remote clinical management.

11.1.2. The **Clinical Advisory Group (CAG)** was established in year to provide clinical oversight and strategic support to the CMT. The committee heard that the CAG reports to the already established Clinical Quality Governance Group and the CMT Programme Board.

11.1.3. The committee received the **Quality Impact Assessment** (QIA) for the CMT in private session in November and a revised QIA in February 2025 in open session. Members gained assurance on the processes around, and the quality of the work associated with, this programme. The committee commended the Trust on its approach to this development and the challenge of successfully implementing service changes during a very busy period.

11.1.4. [insert detail here from February meeting regarding the Equality Impact Assessment (EqIA) for the CMT]

11.2. **The Putting Things Right** (PTR) (previously the Patient Safety Highlight Report) and **MIQPR reports** are received at each meeting. These include a range of metrics, some of which the board sees through the MIQPR and others that are specific to the committee. The outputs of discussions are reported to the board and escalations made where required.

11.3. An update on the **Putting Things Right Recovery Plan** was received in May, which linked with the Joint Investigation Framework Internal Audit and outlined key improvement actions for the Trust over the following 12 months to aid the Trust meet its targets and ensure that patients and families receive the best service.

11.4. A **'no and low harm incident'** report was received by the committee. Members noted the large volume grade 1 and 2 complaints (none or low harm categories), which after investigation, are assessed as not having resulted in harm and are near miss opportunities for learning. Assurance that this committee was monitoring this was provided to the Audit, Risk and Assurance Committee (ARAC) by the Chair.

11.5. The **Learning From Deaths** bi-annual reports were received. These reports highlighted themes and trends that largely relate to delays attending in the community. The committee recognised that there is more to do to understand the differential impact of skill mix on patient outcomes and use of electronic patient clinical record (ePCR) records to identify patterns in death related to or following care.

11.6. The committee continued its quarterly **focus on clinical indicators** taking deeper dives into the indicators of **fractured neck of femur**; **hypoglycaemia** including a presentation on the care bundle criterion which is completed ePCR; **ST segment elevation myocardial infarction (STEMI) (heart attack)** including a presentation on criteria measurement, data quality, reporting, improvements, and next steps; and **stroke**. These have proved invaluable for the committee to understand these indicators more widely.

11.7. At the May meeting the committee received a position update on the **changes to the stroke categorisation** and assurance was given that there is no evidence that these changes have impacted the Amber 1 response times. The Trust continues to work with the Welsh Stroke Network in line with the UK guidelines and recommendations made by Health Inspectorate Wales. Placement of the specialist hyper acute stroke units is still being determined which will influence the Trust's modelling in the future. A deep dive on the clinical indicator for stroke was held at the February 2025 meeting.

11.8. Each meeting heard a **patient story** (and received and update on the previous meeting's patient story):

- In May the committee heard from **Fiona Maclean**, a Patient Experience and Community Involvement Manager, and **Julie Starling**, from Save A Life Cymru, who spoke about their efforts to actively promote the learning of life saving skills throughout the year. Through this work it has become clear that not everyone can perform CPR and for those who do, some were left with symptoms of Post Traumatic Stress Disorder. The Trust is working with Save A Life Cymru to improve the support available to the public.

- In August the committee heard from **Linda Erro Castillo**, who shared the experience of her family after calling am ambulance for her son Guy, who was in distress and unable to breath. Guy has learning difficulties, and Linda's concerns included the need to ensure that call handlers bear in mind the experience of vulnerable people who may not be able to answer questions in response to a 999 call. Guy's situation worsened and Linda was fearful that Guy was going to die and could not access the help he needed. Members sought to understand the pace of the work being done to improve the experiences of patients with learning difficulties and their families given similar issues have been raised in patient stories.

- In November the committee heard from **Sian Davies-Kumar**, a Palliative Care Paramedic who shared her experience supporting patients with end of life care. Sian described how she co-ordinated with the palliative care team, GP, district nurses, to set up the required support for the patient she attended. Her story exemplifies the aspiration to provide the best possible death in the place of choice, with adequate support for the family. The committee noted the need for more consistent and comprehensive end-of-life care for more patients from the wider NHS system. It was heard that the future WAST clinical model aims to involve enhanced support from Advanced Paramedic Practitioners and the remote integrated care service to assist frontline clinicians and ensure appropriate escalation when needed.

    - In February the committee heard from **Gemma** following her experience with the NHS Wales 111 Service where she made a formal complaint to the Trust about her experience as a deaf service user. Gemma's experience has highlighted the improvements needed to ensure equity of access and the Trusts' ability to respond to Deaf service users.

The Patient Experience and Community Involvement (**PECI**) bi-annual reports were received providing positive assurance we are meeting with and consulting with the public and out stakeholders, including with Llais (the Citizens Voice Body). The level of ambition and commitment was recognised, drawing through focus on continuous improvement and the value of patient experience reporting.

11.9. A report was given on various initiatives in **maternity and neonatal care**, which included improvements in neonatal and thermoregulation care and the use of the maternity red phone service, which offers a single point of access from the Trust to Maternity Units and has been implemented across four Health Boards.

11.10. An assurance report was received regarding infection, prevention and control **preparedness and emerging health risks with MPOX** and the Trust's preparedness for an outbreak of a highly contagious infectious disease as set out by NHS Wales Executive.

11.11. Members received a presentation on the revision to the **Clinical Plan**, previously known as the 'Delivering Clinical Excellence in Wales Clinical Strategy'. The content was significantly revised with a changing emphasis on how clinical data is used in terms of our ambitions, transforming our service and how patients are managed differently to prevent avoidable harm.

11.12. The Trust's **annual Clinical Audit Plan for 2024/25**, which allows the planning and prioritisation of clinical audits across the financial year, was approved. It is not always possible to predict all of the topics that require evaluation and therefore this is a dynamic document which is updated quarterly with oversight by this Committee. This supports recommendations in the Audit Wales Clinical Governance Review 2022. An update on the progress against the Clinical Audit Plan through the audit tracker was received at each meeting and assurance provided to ARAC by the Chair that this plan was in place.

11.13. Various **Trust policies** have been received for approval throughout the year, following the update regarding the backlog of policies for review in 2023/24. These policies were noted as:

- Consent to Examination and Treatment
- Management of Controlled Drugs
- Non-Medical Prescribing
- Premises and Vehicle Cleaning

- Clinical Supervision
- Dispatch Cross Reference Table Policy
- Management of Medical Devices Policy
- Airway Policy
- Safeguarding Children and Adults at Risk of Harm Policy
- Violence Against Women, Domestic Abuse and Sexual Violence Policy

11.14. **Operational updates** are received at each meeting and often generate a good deal of discussion, particularly related to system pressures. A focus on the updates throughout 2024/25 included the recommendations related to the Manchester Arena Inquiry and ongoing challenges to recruit to the 111 Wales call handler roles. The Quality Impact Assessment for the Manchester Arena Inquiry Project was received in closed session which was approved by the committee.

11.15. **Reflections** are taken at the end of each meeting and included:

- In May: Members reflected that good assurance had been received and an appropriate level of discussion had taken place on each of the reports. An appreciation of the staff story was highlighted as an important element of the meeting along with recognition of the social responsibility on the action plan. Members thanked the Chair for stepping in at short notice and for excellent chairing.

- In August: Members reflected that the papers were of a good quality, as were the presentations. Members noted that there are challenges across the system in terms of patient journey and patient outcome, and that the Trust is involved in the discussions about pathways and outcomes as a key partner. Additionally, contributions from wider attendees of the committee are always welcome.

- In November: Members reflected on the challenge of balancing detailed information with the need for concise reporting, thanked colleagues for the quality of presentations and reports, and that the level of challenge from members was considered to be robust. The need to consider how best to focus business to ensure concise reporting.

- In February: XXXX

11.16. The Health and Care Standards (2015) have now changed to the **Health and Care Quality Standards (2023)** with six domains and six enablers. The domains are Safe, Effective, Timely, Efficient, Equitable and Person Centred. The enablers include Leadership, Culture, Information, Learning Improvement & Research, and Whole System Approach. An update on the work in developing a self-assessment against the Health and Care Quality Standards was received in February 2025.

11.17. The first **Duty of Quality Annual Report for 2023/24**, following the introduction of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 was received prior to approval by the Trust Board. The final iteration of the report was received in August after approval.

11.18. An update was received on the **Quality Strategy 2021-2024 implementation plan**, as well as the development of its successor, the Quality Plan 2025-2028. A key focus for the **Quality Plan 2025-2028** is co-production include understanding the voices of our citizens and service users as well as those of our people. The Committee approved the approach to the plan and an extension of the current strategy to 1 April 2025 to allow for its development.

11.19. The committee noted that the **111 Clinical Assessment Software Replacement Project** went live on the 30 April 2024, as planned. In closed session the committee received assurance that there have been no reported clinical incidents, and no serious adverse incidence and no patient experience complaints related to the use of the system. The committee heard that whilst it was introduced as a replacement to the former system, however within the emerging Trust Clinical Model Transformation Programme there were significant opportunities for enhancing patient experience, reducing inequity in patients accessing services, and build more efficient Trust services and processes.

11.20. The Committee **cycle of business** was approved at its May meeting Focus was given to including the Trust's compliance against the Health and Care Quality Standards throughout 2024/25.

11.21. The following **annual reports** were received for assurance and discussion:

- Mental Health and Dementia Annual Report 2023/24
- Annual Safeguarding Report 2023/24
- Annual Infection, Prevention and Control Report 2023/24

11.22. **Risks** relevant to this Committee – 223 and 224 – are reviewed at each meeting and the agenda is driven by these risks. Risks to the committee heard that lost hours due to handover delays remained significant throughout the year. This presents patient safety risks and extended waits in the community, with deteriorating Red performance being outside of what is acceptable to deliver a safe emergency service. Members were assured that with reference to these risks, whilst not moving in score, the position is dynamically reviewed regularly and closely monitored at many of the Board's Committees as well as at internal forums. Furthermore, the approach to these risks was considered in year by the Trust Board, given that their score has remained catastrophic for a significant period. This thinking will develop throughout 2025/26.

11.23. The **annual effectiveness review** was conducted in the February 2025 meeting of the committee.

11.24. The revised **Audit** tracker and process was reviewed and good progress has been made to close down management recommendations throughout the year.

11.25. The follow up **Review of Quality Governance Arrangements** audit report from Audit Wales was received in February 2025. This report found that the Trust has made some improvements to its quality governance structures, including responding to the duties of quality and candour, but that there is scope for future improvements in some areas to strengthen assurance relating to the quality and safety of its services.

11.26. The committee received a suite of **internal audit** reports:

11.26.1. **Serious Adverse Incidents** (reasonable assurance). The matters which required management attention included areas of non-compliance with Section 4 (Joint Investigation Process) of the NHS Wales National Policy and noted that a review of the National Policy should be undertaken;

11.26.2. **Electronic Patient Clinical Record: Clinical Compliance** (reasonable assurance). Management attention was required in respect of oversight of training completion, on the limitations of reporting and associated data quality;

11.26.3. **Seatbelt Action Plan** (reasonable assurance). The matters for management attention included the limited number of internal quality assurance inspections completed, improvements

required around reporting of results and monitoring of related health and safety inspections;

11.26.4. **Clinical Audit** (reasonable assurance). The report actions included where (a) the Clinical Strategy lacks sufficient reference to clinical audit and its role within the Trust; and (b) the Clinical Audit Plan could be strengthened to demonstrate alignment between individual audits and the Trust risk register and priorities.

11.26.5. **Patient Experience and Community Involvement (PECI)** (reasonable assurance). The matters that required management attention included enhancement of the expected activity to be undertaken by the PECI team and enhancement of reporting on the impact and outcomes of the engagement activities.

11.27. The **Committee's priorities for 2024/25**are reviewed at each meeting and a more detailed update appears later in this report. The Committee also reviews progress against its cycle of business at each meeting.

12. The Board received a highlight (AAA) report from this Committee by email circulation following each meeting which included alerts, advice, and areas of assurance. This was also presented to the next public Board meeting by the Chair of the Committee. Each of the AAA report escalated the issue of handover delays and the impact of this on our patients and our people; the highest rated risks 223 and 224.

13. The committee is not currently serviced by any Sub-Committees.

PROPOSED CHANGES TO THE TERMS OF REFERENCE

14. The proposed changes to terms of reference for this committee for 2024/25 are marked up in [Annex 1] and include XXX.

[to be completed following the 04 February meeting]

15. In addition, there will be some changes to operating arrangements which include: [to be completed following the 04 February meeting]

COMMITTEE PRIORITIES

16. The Committee received an update on progress against its priorities at each meeting. The 2024/25 priorities were:

Priority	Progress
• Continue to monitor the duty of quality and duty of candour i.e. Committee will monitor implementation of the Duty of Quality and Duty of Candour following the Health and Social Care (Quality and Engagement) (Wales) Act.	• An update on the Duty of Quality Implementation Plan was received by the committee in February 2025. With this report an update will be provided on the progress on developing self-assessments against the Health and Care Quality Standards. • The Duty of Quality Annual Report for 2023/24 was received by the Committee at its meeting in May 2024 and approved by the Trust Board in July 2024 for publication.
• Monitor the delivery of the Quality Strategy (Plan)	• At the Committee in August 2024 the revised approach to the development of the Quality Plan for 2025-28 was approved, as was an extension of the current strategy until the 01 April 2025 to allow for the development of a robust Quality Strategic Plan for 2025-28. • Additionally, at the August 2024 meeting a general update on the delivery against the extant Quality Plan was received. This area of business is included on the Cycle of Business which will inform each agenda setting meeting.
• Monitor the organisation's compliance with the Health and Care Quality Standards 2024	• At the November 2024 meeting of the Committee members noted that the Trust intended to prepare a position paper on the implementation of / compliance against the Health and Care Quality Standards 2024 for the meeting of the Committee in February 2025. This was received at the February 2025 committee.

Priority	Progress
	• The final Duty of Quality Annual Report for 2023/24 and the associated self-assessment against the Health and Care Standards was received by the Committee at its meeting in August 2024.

17. It is good practice for committees to set priorities for the forthcoming year when they review their effectiveness. Accordingly, the committee has agreed the following priorities for 2025/26:

[to be completed following the 04 February meeting]

18. Progress on priorities will be reported to the Committee quarterly and to the Board through its highlight report.

NEXT STEPS

19. The next steps are as follows:

19.1. Ensure changes to operating arrangements agreed at paragraph 15 are cycled into work programme for review in 2025/26

19.2. Update the cycle of business with revised terms of reference.

RECOMMENDATION

20. The Trust Board is requested to

20.1. Receive and note the contents of the Committee Annual Report for 2023/24 and analysis of its effectiveness; and

20.2. Approve the changes to the Terms of Reference.

Ymddiriedolaeth Brifysgol GIG Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services University NHS Trust

AGENDA ITEM No	**9**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**2**

AUDIT WALES QUALITY GOVERNANCE FOLLOW UP REVIEW 2024

MEETING	Quality, Patient Experience & Safety Committee
DATE	4 February 2025
EXECUTIVE	Liam Williams, Executive Director of Quality and Nursing
AUTHOR	Kate Blackmore, Assistant Director of Quality Governance
CONTACT	kate.blackmore@wales.nhs.uk

EXECUTIVE SUMMARY

1. Audit Wales have undertaken a Follow up Review on the Quality Governance Arrangements within the Trust during 2024. This Review assessed activity taken against the original recommendations as well as expanding the Review to consider the implementation of the Duty of Candour and Duty of Quality within the Trust.

2. The 2022 Review identified areas needing improvement to ensure the Trust was fully informed about the quality and safety of its services, making 8 recommendations.

3. The 2024 Review identified a number of recommendations made in the 2022 to remain in progress, in contradiction to the Trusts Assessment. A further 5 recommendations were made based on the extended terms of the Follow up Review.

4. Management responses were generated in collaboration with appropriate Leads across the Trust and following feedback from Executive Leadership Team are explicit in the governance/evidence required to demonstrate completion.

RECOMMENDED that the Quality, Patient Experience & Safety Committee acknowledges the 2024 Quality Governance Follow up Review and the associated management responses.

KEY ISSUES/IMPLICATIONS

Not Applicable

REPORT APPROVAL ROUTE	
Clinical & Quality Governance Group	21 January 2025
Quality, Patient Experience & Safety Committee	4 February 2025

REPORT APPENDICES
ANNEX 1 – SBAR
ANNEX 2 - Quality Governance Follow up Review 2024

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

ANNEX 1

SITUATION

1. This paper provides an update on a comprehensive Review of the Quality Governance arrangements within the Trust, following up on the initial Review undertaken by Audit Wales in 2022.

BACKGROUND

2. During 2021/22 the Auditor General reviewed quality governance arrangements across all Health Boards and Trusts in Wales.

3. The 2022 Review of the Trust found that improvements were required in some areas of quality governance to ensure that Trust was fully informed of the quality and safety of its services. In addition, action was needed to strengthen the serious incident reporting across organisational boundaries. In total 8 recommendations were made.

4. Management responses to these recommendations were translated into actions which were monitored through Committee.

5. Subsequent to this review the Health & Social Care (Quality & Engagement) (Wales) Act 2020 came into power introducing the Health & Care Quality Standards 2023, as well as the Duties of Quality and Candour.

6. The 2024 Follow up Review focused not only the progress made against the original recommendations but also the assurance provided to the Board that the Trust is taking steps to respond to the requirements of the Act.

ASSESSMENT

7. A number of the 2022 recommendations which had been considered closed by the Trust were subsequently considered as in progress or superseded by the 2024 Follow up Review.

8. In addition, a further 5 recommendations were made based on the Follow up Assessment.

2022 Recommendations

- ***Recommendation 1*** related to the Implementation Plan associated with the Quality Strategy 2021-2024. This recommendation was considered superseded by Recommendation 1 of the 2024 Review.

- ***Recommendation 2*** related to the Clinical Audit Plan. Both sections of this recommendation were considered complete however a further recommendation was made as part of the 2024 Review.
- ***Recommendation 3 and 4*** related to the assurance of Mortality Reviews and the Trust plans to reduce the backlog in this activity. Section 3.4 which related to the progress of implementing the all-Wales Learning from Mortality Reviews Framework was considered complete. All other sections continue to be assessed as in progress.
- ***Recommendation 5*** related to the PADR process and compliance, whilst it is acknowledged that compliance has improved, we remain below target and so the recommendation was assessed as in progress.
- ***Recommendation 6*** related to Board Member walkabouts which given the work undertaken in this area with Standard Operating Procedure in place and evidence of the value associated with staff and patient stories. Whilst the frequency and coverage of Board visits is variable and doesn't consistently capture feedback the recommendation was assessed as complete.
- ***Recommendation 7*** related to the Joint Escalation Framework, the process for which has been reviewed and is monitored by Committee. As such this recommendation was assessed as complete.
- Finally, ***Recommendation 8*** related to quality performance reporting and learning. It is acknowledged that data linkage is key to the Trust being able to adequately report outcome related intelligence across organisational boundaries. Whilst section 8.2 has been superseded as it specifically related to COVID-19 data the other sections remain in progress.

2024 Recommendations

- ***Recommendation 1*** relates to learning from the challenges experienced in implementing the Quality Strategy 2021-2024 and sets out the requirements to ensure that future Strategic Plans are developed with an understanding of achievability within resources available stepping out the funding required, and the risk associated with under-delivery. An Implementation Plan needs to underpin this Strategy.
- ***Recommendation 2*** relates to the monitoring of this Strategy ensuring that regular Progress Reports are provided to Committee including clear timescales of expected delivery and differentiating between individual actions and the strategic outputs.
- ***Recommendation 3*** builds on the 2022 recommendations regarding Clinical Audit, suggesting clarity of changes and the capture of key findings, outcomes and learning.
- ***Recommendation 4*** relates to the roll out of Duty of Candour and Duty of Quality training to ensure that staff have a good understanding of their responsibilities under the requirements. This activity was already progressing through the Quality Management Group.

- ***Recommendation 5*** relates to the review of both the Putting Things Right and Adverse Incident Policies to ensure that they reflect the Duty of Candour and the Duty of Quality. This activity has already been completed in April 2023, but a further content check was completed by the Assistant Director of Putting Things Right and the recommendation reported as complete at the time the Audit was published.

Management Responses

- All elements of the Audit were reviewed and content considered with appropriate Department Leads collaboratively across the Trust.
- Management Responses were generated not only for the new 2024 recommendations but also updated for the original 2022 recommendations identified as in progress.
- Following discussion at Executive Leadership Team it was noted that recommendations should include clarity on what governance/evidence was required to complete the Actions to prevent a recurrence of differing levels of assessment for future Reviews.
- All management responses were reviewed by the Executive Director of Quality and Nursing, the Deputy Director for Nursing, Quality and Governance and the Director of Corporate Governance prior to submission to Audit Wales.

Archwilio Cymru
Audit Wales

Quality Governance Follow up Review – **Welsh Ambulance Services University NHS Trust**

Audit year: 2023-4

Date issued: September 2024

Document reference: 4055A2024

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

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We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

Mae'r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

Contents

Summary report

Introduction

1 Quality should be at the ‘heart’ of all aspects of healthcare and ‘putting quality and safety’ above all else is one of the core values underpinning the NHS in Wales.

2 The drive to improve quality has been reinforced in successive health and social care strategies and policies over the last two decades. In June 2020, the Health and Social Care (Quality and Engagement) (Wales) Act 2020 (the Act) became law. The Act has strengthened the duty to secure system-wide quality improvements, as well as placing a duty of candour on NHS bodies, requiring them to be open and honest when things go wrong to enable learning. The Act indicates that quality includes, but is not limited to, the effectiveness and safety of health services and the experience of service users.

3 During 2021-22, the Auditor General reviewed quality governance arrangements across all Health Boards and Trusts in Wales. That work focused on:

- operational and corporate approaches to quality governance;
- organisational culture and behaviours;
- strategy, structures, and processes; and
- information flows and reporting.

4 Our 2022 review of quality governance at the Welsh Ambulance Services NHS Trust (the Trust) found that whilst many facets of its quality governance arrangements were working well, improvements were required to ensure the Trust is fully informed on issues relating to the quality and safety of its services. We also found the Trust also needed to strengthen serious incident reporting across organisational boundaries. We made eight recommendations for the Trust to address, which are shown in **Appendix 1**.

5 Since undertaking our 2022 review, the specific requirements underpinning the Duties for Candour and Quality (introduced under the Act) have been agreed, and all health bodies should have made good progress to implement arrangements to meet those requirements.

6 This quality governance follow-up review therefore will not only assess the Trust’s progress in implementing the recommendations we made in our 2022 quality governance review but will also consider the assurance provided to the Board that the Trust is taking steps to respond to the requirements of the Act.

7 The methods we used to deliver our work are summarised in **Appendix 2**.

Key findings

8 Overall, we found **the Trust has made some improvements to its quality governance structures, including responding to the duties of quality and candour. However, there is scope for further improvements in some areas to strengthen assurance relating to the quality and safety of its services.**

Implementation of previous audit recommendations

9 We found **whilst the Trust can demonstrate some progress in implementing previous audit recommendations, there remains more to do to fully address the recommendations.**

10 Our review of progress against our 2022 quality governance review recommendations found that three of the past eight recommendations have been completed. The completed recommendations relate to the Trust's information on and monitoring of clinical audits, developing better arrangements for board member visits and implementing recommendations relating to the joint investigation framework. We superseded our recommendation on monitoring the delivery of the Quality Strategy 2021-24.

11 For four recommendations, we found that, whilst action has been taken to address them, there is more to do to consider them complete. These included reaching the Trust's target for Personal Appraisal and Development Reviews (PADRs), progressing its plans to address the mortality review backlog, increasing its triangulation of quality performance information across metrics, and continuing to work with partners to join-up information to support identifying outcomes and information. We will continue to monitor progress to implement these four remaining recommendations alongside the new recommendations arising in this review.

Responding to the requirements of the Duty of Candour and Duty of Quality

12 We found **the Trust has taken steps to implement the duties of quality and candour, however, there are weaknesses in the clarity of reporting progress and there is scope to improve training uptake and monitoring.**

13 Prior to the implementation of the Health and Social Care (Quality and Engagement) Act 2020 came into effect in April 2023 the Trust assessed its readiness against the Welsh Government baseline.

14 The Trust held Board sessions to raise awareness of the new Act. Staff were supported via e-learning modules to help understand and respond to the new requirements. However, there remain challenges. While training is in place for the duties of quality and candour, low compliance rates and difficulties understanding

how many staff had completed some training creates a risk that there is insufficient staff understanding.

15 The Trust told us it tracks progress to implement requirements under the duties of Candour and Quality using the Welsh Government roadmap and has developed an implementation plan. However, there is scope to strengthen assurance through greater clarity within progress reports to the Quality, Patient Experience and Safety (QuESt) committee. Finally, due to a backlog of policies overdue for review the Trust has yet to review and update key policies as appropriate to reflect the requirements of the duties of quality and candour.

Recommendations

16 The status of our 2022 audit recommendations is summarised in **Exhibit 1**. **Appendix 1** contains our assessment of progress for each of our 2022 recommendations.

Exhibit 1: status of our 2022 recommendations

Completed	In progress	No action	Superseded	Total
3	4	0	1	8

17 **Exhibit 2** details the new recommendations arising from this review. The Trust's response to our 2024 recommendations is summarised in **Appendix 3,** which also contains updated management actions against the 2022 recommendations that we considered to be incomplete (i.e. in progress) at the time of our review.

Exhibit 2: 2024 recommendations

Recommendations
Quality Strategy R1 As the Trust develops a new Quality Plan in 2024, it should ensure that delivery is achievable within the resources available. The plan should clearly detail the funding required, the risks of under-delivery (due to capacity and resource constraints) and be underpinned with an implementation plan.
Quality Strategy monitoring R2 There is scope to strengthen quality strategy implementation plan delivery reporting. To enhance clarity, the Trust should, in its progress reports:

Recommendations

2.1 Provide timescales for the expected delivery of each action;
2.2 Differentiate between the progress of individual actions and strategic outputs; and
2.3 Ensure that progress reports are reported regularly and are included in the QuESt cycle of business.

Clinical Audit Plan

R3 There are opportunities to further enhance reports on the Trust's Clinical Audit function, by:

3.1 More clearly highlighting any changes made to the approved Clinical Audit Plan; and
3.2 Capturing key findings, outcomes and learning from completed audits.

Duty of Candour and Quality training

R4 The Trust should take steps to increase uptake rates for duty of quality and duty of candour training to ensure staff have a good understanding of their responsibilities under the requirements.

Policy review

R5 The Trust should that its Putting Things Right and Adverse Incident policies are updated to reflect the requirements of the Duty of Candour and Duty of Quality as soon as is reasonably possible.

Detailed report

Implementation of 2022 audit recommendations

18 We considered the Trust's progress in implementing each of our 2022 audit recommendations.

Quality Strategy delivery recommendation

2022 Recommendation 1

We found that delivery of the Trust's renewed Quality Strategy (2021-2024) has been severely hampered by resource pressures caused by the pandemic and a lack of funding to support four senior quality lead posts which are central to delivery.

The Trust should update its implementation plan outlining how it will deliver its quality ambitions.

19 We considered whether the Trust had taken additional steps to outline how it will deliver its Quality Strategy. We expected to see the following:

- A resourced supporting Quality Implementation Plan with suitable monitoring arrangements.

20 We found **delivery of the Quality Strategy 2021-24 has continued to be slower than planned due to ongoing resourcing and capacity issues, and there is scope to improve progress reporting**.

21 The Trust monitors delivery of its Quality Strategy 2021-24 via an implementation plan. This implementation plan was updated in May 2023 and February 2024 and delivery reported to the Quality, Experience and Safety Committee (QuESt) as part of an implementation plan progress report. The Board is kept up to date of progress by QuESt's 'Alert, Assure, Advise' reports which highlight key issues discussed during each meeting and are discussed at Board meetings.

22 However, progress in delivering the Quality Strategy 2021-24 has been slower than intended, with the May 2023 progress report showing that only half of the actions were complete or on-track. The report to QuESt in February 2024 showed improved progress, in that nearly two-thirds of the listed actions for delivering the quality implementation plan were either complete or on track at the time of reporting. Outstanding actions as of February 2024, included actions such as developing training on the Trust's new quality management system and undertaking an evaluation of roles and responsibilities for quality across the organisation.

23 The Trust told us there are several reasons for why delivery has been off-track for some actions including pressures caused by ongoing waves of the COVID-19, winter peaks in demand and workforce industrial action. However, the most significant issue has been a continued lack of capacity. In 2022, we commented on issues in securing funding for the four senior quality lead posts set out in the

Quality Strategy 2021-24. Since that time, the Trust has undergone an internal restructure to provide two of these posts which have now been filled as well as a senior quality governance lead and invested into its Putting Things Right team. However, the inability to fund and recruit to these posts at the outset of the Strategy lifecycle has impacted the Trust's ability to deliver all of the actions of its Quality Strategy at the pace it intended.

24 As the Trust looks to develop a new Quality Plan in 2024[1], it should take steps to ensure that its ambitions are achievable and resourced. The Trust should be clear at the outset what the cost implications are for delivering its quality ambitions, as well as the risks associated with under-delivery (such as capacity and resource constraints). **We have superseded our 2022 Recommendation 1 with 2024 Recommendation 1 to reflect ongoing quality resource challenges and because a new Quality Plan is being developed.**

25 There is significant scope to improve the clarity of reporting progress to deliver the implementation plan. The progress reports presented in May 2023 and February 2024 did not detail the expected timescales for achieving actions listed within the implementation plan. Consequently, it was difficult for committee members to understand how off-track actions were at the point of reporting and the associated risks. It was also unclear as to whether the reports measure the completion of specific actions or delivery of strategic outputs, as, in some instances multiple actions were grouped together and in others, multiple strategic outputs were grouped together. Progress reporting to QuESt has been irregular to date with only two updates [in May 2023 and February 2024] at the time of writing, however, during our fieldwork, the Trust informed us that it is intending to introduce quarterly updates from August 2024 **(2024 Recommendation 2**).

Clinical Audit Plan recommendations

2022 Recommendation 2

We found that the clinical audit plan is not approved in a timely manner and the QuESt Committee does not have adequate oversight of progress and delivery.

The Trust should ensure that:

2.1 The QuESt Committee scrutinises and approves a clinical audit plan ahead of each financial year.

2.2 The QuESt Committee receives quarterly updates on delivery of the approved clinical audit plan, assurance reports including learning and improvement actions resulting from this work.

[1] The Quality Strategy 2021-24 will be replaced with a Quality Plan.

26 We considered whether the Trust has an annually approved clinical audit plan with routine reporting on delivery progress and resulting improvement actions. We expected to see the following:

- Annually approved clinical audit plans, with regular progress reports received by QuESt, and
- Evidence of learning from clinical audit and associated improvement actions.

27 We found **the Trust approves the Clinical Audit Plan annually and there are regular updates on progress of the Plan to QuESt, although there remains scope to improve reporting of outcomes and learning**.

28 The Clinical Audit Plan is informed by a variety of sources, including discussions at internal clinical groups, submissions from clinical managers and clinical directorates and identified as required due to clinical service changes. The Trust's Clinical Audit function was reviewed in March and April 2024 by Internal Audit who provided a reasonable assurance opinion. Amongst the key matters raised in the report was a need to strengthen the alignment between the Clinical Audit Plan and the Trust's Clinical Strategy, the operational risk register, and strategic priorities as set out in the Integrated Medium-Term Plan. The Trust has identified actions to address Internal Audit's recommendations and plans to implement them during 2024-25.

29 QuESt approved the Clinical Audit Plan in both 2023-24 and 2024-25. **We consider 2022 Recommendation 2.1 to be completed**.

30 However, whilst the Trust emphasises in the Clinical Audit Plan that it may adjust the audit programme when it is appropriate to do so (for instance, to appropriately prioritise a new clinical audit), delivery progress reports have not consistently highlighted changes to the Plan and QuESt is not asked to approve any changes **(2024 Recommendation 3**).

31 QuESt has received quarterly delivery progress updates against the Clinical Audit Plan since May 2023. **We consider 2022 Recommendation 2.2 to be completed**.

32 Whilst more recent clinical audit progress reports have provided a better summary of progress, there remains scope for reports on clinical audit to provide stronger assurance to the QuESt on its activity. The accompanying clinical audit tracker provides members with an update on recommendations arising from clinical audits, however, our review found that papers could more clearly identify the key issues raised as they only capture recommendations, and progress reports do not currently highlight any findings from clinical audits. The Internal Audit review found that actions to address recommendations are monitored via relevant internal groups. However, it remains difficult for QuESt members to be assured about the outcomes of clinical audit activity, and whether learning from clinical audits is becoming embedded to improve the Trust's performance without the inclusion of further narrative within progress reports **(2024 Recommendation 3**).

Mortality review recommendations

2022 Recommendation 3

The QuESt Committee does not receive adequate assurances on mortality reviews. The Trust should ensure the QuESt Committee receives quarterly update reports to include:

3.1 The number of reviews undertaken, and the numbers of reviews required but not yet complete.

3.2 Any significant concerns, lessons learned and what changes have been made as a result.

3.3 Updates on actions to address the mortality review backlog.

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

2022 Recommendation 4

The Trust has a significant backlog of mortality reviews.

The Trust should develop an action plan to reduce the backlog, reporting progress at each QuESt meeting.

33 We considered whether QuESt receives adequate assurance on mortality reviews[2], including progress to address the significant 2022 backlog, and implement lessons learnt from reviews. We expected to see the following:

- The all-Wales learning from mortality reviews framework implemented[3];
- Evidence of learning from mortality reviews;
- A reduction in the mortality review backlog**;** and
- Regular mortality review updates received by QuESt.

34 We found **the Trust has implemented the new national framework for mortality reviews, however it has not yet progressed as planned as there is fluctuating performance relating to delivering timely mortality reviews and there is scope for more consistent reporting of mortality review activity, outcomes and learning**.

35 The Trust has made improvements to the information presented to QuESt on mortality reviews since our last review. However, while QuESt receives regular information on mortality reviews, the information is not consistently reported, which makes it difficult to understand progress and ongoing challenges. Our review of

[2] Mortality reviews are conducted when a patient dies whilst in the Trust's care, including whilst waiting for an ambulance to arrive.

[3] The All-Wales Learning from Mortality Review Model Framework was originally introduced in August 2021 and then revised in September 2022.

papers found that the Trust has reported its backlog figure to four of the past six meetings, and only in August 2023 did QuESt receive data on how many referrals had been received compared to how many were awaiting review. **We consider 2022 Recommendation 3.1 to be in progress**.

36 Challenges in undertaking timely mortality reviews at the time of our 2022 review had led to a backlog which stood at 800 in August 2022. Data reported to QuESt since 2022 suggests that performance has fluctuated significantly; The reported backlog in August 2023 was 298, which increased to 800 in February 2024 and then reduced to 600 in May 2024. This position will be exacerbated by the deteriorating performance within the broader urgent and emergency care system, and further pressure is likely to arise from the new statutory role of the Medical Examiner introduced in September 2024. Whilst the backlog is lower than it was at the time of our 2022 review, it remains high. We have not seen evidence of an action plan with a clear trajectory to reduce the backlog and sustainably keep it at a more manageable level. However, QuESt does receive assurance that all referrals are screened on receipt by a member of the patient safety team and escalated as required. **We consider 2022 Recommendations 3.3 and 4 to be in progress.**

37 Key themes arising from mortality reviews have been reported through various reports to QuESt in three of the six meetings held between November 2022 and May 2024. The May 2023 report indicated that identified learning from mortality reviews was being provided to paramedics. The August and October 2023 reports highlighted key themes largely relating to delays in the community, call categorisation and end of life care. However, there was no reference to lessons learned and resulting actions. **We consider 2022 Recommendation 3.2 to be in progress.**

38 In September 2022, the Trust's Clinical Quality Governance Group (CQGG) approved the all-Wales Learning from Mortality Reviews Framework. The Framework provides a co-ordinated and systematic all-Wales approach to the mortality review process to enable local and national implementation of learning. To implement the Framework, in October 2023 the Trust established a Learning from Deaths Forum which reports to the CQGG. **We consider 2022 Recommendation 3.4 to be complete.**

Appraisal and Development Review recommendation

2022 Recommendation 5

The Trust has low Personal Appraisal and Development Reviews (PADR) compliance rates, for example in June 2022 the Trust's compliance was 59% against the 85% target.

As part of embedding its new behaviours, the Trust should ensure that PADR rates are improved and set out the actions it will take to achieve this.

39 We considered whether the Trust has improved completion rates for its Personal Appraisal and Development Reviews (PADR), which were achieving 59% against the 85% target at the time of our review in 2022. We expected to see the following:

- Improved PADR compliance; and
- Robust plans in place to achieve further improvements and the required 85% target.

40 We found **whilst PADR completion rates have improved since our original review, they continue to be below the Trust's target rate**.

41 PADR rates have improved since our original review, with reported monthly rates remaining above 70% since August 2022, and at an average of 74% for the year 2023-24. However, performance continues to remain below the Trust's target of 85%.

42 There is regular monitoring of PADR compliance. The Trust's People and Culture Committee continues to monitor PADR compliance via the workforce scorecard at each meeting. However, there are ongoing challenges which make reaching the 85% target difficult. Lower compliance continues to be primarily within operational Emergency Medical Services, where staff are required to be booked out of operational duties to attend the PADR meeting with their manager. This is recognised as an ongoing logistical barrier to improving PADR performance, particularly given the service pressures currently facing the Trust. The Trust has plans to further improve performance by gaining insights into how it can increase rates in areas with lower compliance. However, The Trust informed us that it was also considering re-evaluating its target within this context. **We therefore consider 2022 Recommendation 5 to be in progress.**

Board member walkabout recommendation

2022 Recommendation 6

Prior to the pandemic, Board members regularly participated in ambulance ride-outs and station visits, but these were ad-hoc in nature and feedback was not collated in a structured way.

Now that visits can restart, the Trust should develop a standard operating procedure which clarifies the process, frequency of the visits and ensures coverage across the Trust's operations and geographical areas. It should also include a standard template to capture feedback and learning.

43 We considered whether the Trust has developed a clear process for visits by Board members across the organisation's business and to consistently capture learning by hearing directly from patients and staff. We expected to see the following:

- A clear standard operating procedure in place, with a standard template to capture feedback and learning; and

- A schedule of Board walkabouts covering all areas of service delivery.

44 We found **the Trust has a standard operating procedure for Board members conducting visits, however the frequency and coverage of visits, whilst increasing are variable and it currently does not consistently capture and report feedback and learning to the Board**.

45 The Trust has a clear process to support Board members to undertake visits. In 2022, the Trust established a Standard Operating Procedure for Board Visits which includes prompts and a template for capturing feedback and suggested actions.

46 Our observations of Board and committee meetings show that Board members highly value opportunities to hear from staff and patients directly, such as via staff and patient stories. However, although the Standard Operating Procedure for Board Visits includes a form for capturing feedback, the Trust does not currently require Board members to complete it, with it tending to be used only to raise a formal concern. The Trust said this is to avoid the process becoming too bureaucratic. Instead, Board members often provide direct informal feedback or seek further information to the relevant directors via email or during Board development meetings. However, this provides only limited feedback and the Trust would likely benefit from providing further opportunities for reporting back on learning from visits, such as via Non-Executive Director meetings or regular sessions at board development. This would strengthen the Board's ability to triangulate the intelligence gathered with other information, to highlight any areas of concern or risk or to celebrate and share good practice.

47 The Trust's Chair refers to recent visits he's undertaken via the Chair's report to each Board meeting. More recently this report also includes a list of visits undertaken by the Vice-Chair. As part of its Standard Operating Procedure for visits, the Trust also has a process for recording the location and timing of Board visits which provides an interactive heat map. The heat map shows visits in real-time and overseen via bi-annual updates to the Executive Leadership Team and the Board. The 2023-24 heat map shows significant variation in the geographical and service area coverage as well as the number of visits made by each Board member. Generally, rural areas received fewer visits, with higher numbers of visits in urban areas, and particularly in Cardiff and Swansea. In addition, the frequency of visits to administrative service areas were higher than to ambulance stations and 111 centres. Except for the Chair, Non-Executive Directors conducted fewer visits than other Board members, due in part to the limited time contractually available for Non-Executive Directors to undertake their roles. We are aware that there has been an increase in the number of visits since April 2024, as well as increased coverage of areas in central Wales.

48 While the Trust does not currently have a forward schedule for board visits, at the time of our fieldwork it was considering how to increase the number and geographical coverage of future visits. The Trust told us it was considering resuming its pre-2023 practice of geographically rotating its Board meetings around Wales to provide greater opportunities for Board members to meet and

engage with Trust staff across Wales. **We therefore consider 2022 Recommendation 6 to be complete.**

Joint Escalation Framework recommendation

2022 Recommendation 7

The Joint Investigations Framework in place with health bodies is no longer effective. The Emergency Services Ambulance Committee is coordinating action to strengthen those arrangements.

The Trust must ensure that the recommendations made by the Delivery Unit are effectively responded to in a timely fashion and progress reported regularly to the Board and QuESt.

49 We considered whether the Trust has strengthened the process for addressing serious incidents where other organisations are involved in the care of the patient. We expected to see the following:

- An effective Joint Investigations Framework in place for serious patient incidents: and.
- Recommendations made by the Delivery Unit addressed, with evidence of progress being reported to Board and the QuESt committee.

50 We found **the process for jointly investigating serious incidents with partners has been revised since our previous review, which continues to be monitored by the QuESt.**

51 In 2022, the Delivery Unit raised concerns around the application of the Joint Investigation Framework in place to address serious patient safety incidents. In response a task and finish group was established between partners to refine the Joint Investigations Framework. The NHS Wales National Policy on Patient Safety Incident Reporting & Management was updated in April 2023 to ensure consistent practices across Wales. QuESt approved the adoption of the National Policy and its supporting appendices in August 2023.

52 QuESt did not receive updates against the recommendations made by the Delivery Unit in 2022 by way of its audit tracker, as the audit tracker is limited to recommendations made by internal and external audit and Healthcare Inspectorate Wales. However, we understand that the Trust considers each of the four recommendations (which included the establishment of a task and finish group to review the Joint Investigations Framework) to have been completed.

53 The numbers and general themes of incidents falling under the Joint Investigations Framework (both shared and received) are reported to each QuESt meeting within the quarterly Putting Things Right Report. Interviewees felt confident that the Joint Investigation process has improved due to stronger governance arrangements,

including weekly meetings between the Trust and health boards to discuss each incident.

54 There has not, to date, been an assessment of the effectiveness of the new Joint Investigations Framework for managing incidents with health bodies. However, in late 2023 Internal Audit undertook a review of the Trust's compliance with the Joint Investigation Framework and provided a reasonable assurance opinion. The report was received by the Audit, Risk and Assurance Committee in May 2024. It included six recommendations, two of which were medium priority and four of which were low priority. One of the key matters raised in the report related to a need for the Trust's Adverse Incident and Reporting Policy to be more aligned to the NHS Wales National Policy on Patient Safety Incident Reporting & Management. The Trust has committed to a full policy review once Welsh Government updated Putting Things Right Regulations are available (due Autumn 2024). **We therefore consider 2022 Recommendation 7 to be complete.**

Quality performance reporting and learning recommendation

Recommendation 8

We found that QuESt is well served with quality information, but there are opportunities for improvement. The Trust should:

8.1 Develop a system to triangulate learning themes across its quality assurance reports. This should ensure clarity about what improvement actions have been taken as a result and how learning has been disseminated across the organisation.

8.2 Enhance Covid-19 reporting in the integrated quality and performance report by including information about the harm caused to patients by ongoing service pressures caused by the virus.

8.3 Work with health bodies so that there are systems to determine the outcomes for patients who have received emergency ambulance services. This should particularly seek to understand the consequence and harm resulting from service failures such as long ambulance waits.

8.4 Develop patient outcome measures to support its existing quality measures.

55 We considered whether the Trust has enhanced its performance information by triangulating information from different sources and developing a greater number of patient outcome measures. We expected to see the following:

- Enhanced performance reporting and monitoring arrangements which support triangulation and identification of themes;
- Effective joint working with health boards to monitor outcomes for patients, including focus on the consequences of long ambulance waits; and

- Patient outcome measures in place, which are routinely monitored.

56 We found **the Trust continues to face challenges in reporting patient outcomes due to difficulties in joining up information across organisations. However, there is more the Trust can and should do to triangulate themes across metrics and identify learning.**

57 The Trust has established mechanisms for monitoring and reporting on performance data, but could do more to identify themes and analysis. Quality metrics are mainly reported via the Monthly Integrated Quality and Performance Reports (MIQPR) and quarterly Putting Things Right Reports. The MIQPR contains data on clinical outcomes such as the percentage of 'Stroke Patients with Appropriate Care' as well as quality indicators such as percentage of 'Concerns Response within 30 Days' and numbers of patients who did not receive an ambulance due to receiving a 'Can't Send' response. The Putting Things Right Report includes data relating to the numbers and trends of concerns and incidents. Both reports are received at each QuESt meeting. The Putting Things Right report summarises some of the key themes from joint investigations and incidents, but not others such as concerns or mortality reviews. However, neither reports provide triangulation across metrics to identify main themes and there is limited information on what is being done to address challenges and identify and implement learning. **We therefore consider 2022 Recommendation 8.1 to be in progress.**

58 Our review of the Trust's MIQPR found that it continued to report on COVID-19 in relation to its impact on staff, sickness absence rates and vaccination rates. We did not find any measures within the report relating to the impact of COVID-19 on harm to patients. However, given the decreased level of risk posed by COVID-19 since 2023 **we consider 2022 Recommendation 8.2 to be superseded.**

59 The Trust has good arrangements to engage with the public through its People Engagement and Community Involvement Team and hear feedback from patients. Patient feedback is considered alongside complaints and incidents information. However, there is a significant data weakness because information governance rules do not enable the Trust to track outcomes for patients who were treated via Consult and Close or referred to an alternative (non-ambulance) pathway, i.e. whether they later required and accessed further services. The Trust informs us that it is proactively engaging with the Information Commissioners Office to try and find solutions that enable better systematic access to patient feedback.

60 The Trust has implemented the electronic Patient Clinical Record (ePCR) which links up information between the Trust and health boards and allows feedback on patient outcome for some conditions (such as return of spontaneous circulation, stroke bundles, fractured neck of femur), however these indicators are limited in number. The Trust has plans to develop further measures for falls and older people, however, at present there continue to be issues with the completeness of records in ePCR which is inhibiting the quality of data. **We consider 2022 Recommendation 8.4 to be in progress**.

61 Currently, the Trust's performance reports provide some information on potential harm to patients, such as modelled scenarios on the level of harm likely to occur due to the level of handover delays experienced in the preceding month. However, as discussed in **paragraph 59** the identification of actual patient harm across the whole Urgent Care Pathway is challenging, partly due to incomplete ePCR records and also because impacts to patients are not always immediately apparent. The Trust is taking steps to provide more clarity on actual harm caused, such as by working with colleagues from the All-Wales Tissue Viability Network to determine how to identify avoidable harm across the system in respect of pressure damage. The Trust is also working on developing a Civica Patient Experience dashboard which will provide improved level of detail on experiences, including actionable improvements that the Trust could make, for instance in how they move and handle patients. **We consider 2022 Recommendation 8.3 to be in progress.**

Responding to the requirements of the Duty of Candour and Duty of Quality

62 We considered the extent to which the Trust has taken steps to implement both the Duty of Quality and Duty of Candour. We expected to see the following:

- The Trust has considered what it needs to do to implement the duties of Quality and Candour, with plans in place to address any gaps;
- The Trust has clear arrangements in place for monitoring implementation which reflects the timescales and risks associated with delivering the plan.
- Progress in implementing the duties of quality and candour is routinely reported to the Board and its committees;
- Board members have sufficient awareness and have received appropriate training in relation to the duties of quality and candour;
- Roles and responsibilities in relation to implementing the duties of quality and candour at all levels of the organisation are clearly documented and understood. The Trust has assessed the skills / capability and capacity required to implement the duties of quality and candour at both a corporate and operational level and has put appropriate arrangements in place to address any shortfalls and gaps;
- Staff training has been delivered to raise awareness of the requirements under the two duties. The Trust has identified appropriate strategic, senior, and operational leadership to oversee and deliver the duties. All staff understand their respective responsibilities; and
- The Trust has reviewed and appropriately updated its existing policies and standing operating procedures as required.

63 We found **the Trust has taken steps to implement the duties of quality and candour, however, there are weaknesses in the clarity of reporting progress and there is scope to improve training compliance and monitoring.**

64 The Health and Social Care (Quality and Engagement) Act 2020 came into force on 1 April 2023. The Trust assessed its preparedness for complying with the requirements of the Duty of Quality and Duty of Candour using an assessment against the Welsh Government baseline position, which it reported in February 2023. It subsequently assessed itself against the Welsh Government implementation road map in August 2023 and developed an implementation plan in October 2023. Within the Trust's self-assessment against the implementation road map in August 2023 it marked its progress as 'yellow' (organisation has identified that delivery is at risk but manageable or behind schedule but within tolerance) and indicated confidence in being compliant with the Act in relation to specific aspects such as falls prevention, but concerns remain related to the pace of implementation due to resources, particularly in relation to the Duty of Candour.

65 The Trust's implementation plan is monitored at an operational level by the Trust's Quality Management Group, but there is scope to better describe progress to QuESt. Monitoring of the Trust's response to the Act has been listed as QuESt's key priority for 2022-23, 2023-24 and 2024-25. However, our review of papers received by QuESt found that it is not always easy to understand the Trust's progress. Despite the October 2023 update report stating that QuESt would have oversight of the implementation plan, the plan has not been formally received by the committee to date. Therefore, updates to QuESt in 2023-24 have mainly commented on the ongoing activity of the Trust, rather than providing a balanced view of progress to implement actions within timescales. While minutes evidence some challenge from members to clarify progress, papers could better highlight progress and ongoing issues and risks to better equip members' understanding in advance of meetings.

66 The Trust has taken steps to provide Board members with an understanding of the new requirements under the duties of quality and candour. It organised a Board development session in March 2023 prior to the enforcement of the legislation and at the time of our review, further separate sessions on each duty were planned for later in 2024.

67 The Trust has identified appropriate strategic and senior leadership to the implementation of the duties of quality and candour across the organisation. The Executive Director of Quality and Nursing is the identified strategic lead for the duties, whilst the duty of quality is assigned at a senior level to the Assistant Director of Quality Governance and the duty of candour is assigned at a senior level to the Assistant Director of Quality and Nursing. As discussed in **paragraph 23,** the Trust undertook a restructure and secured investment into its quality and putting things right teams, including a Senior Quality Governance Lead and a Quality Governance Lead for Putting Things Right during 2023 and early 2024.

68 Training for staff has also been delivered to support compliance. External training on quality management systems was procured for a select number of staff which interviews suggest were helpful. In January 2024, the Trust introduced e-learning modules on both duties which staff across the organisation are asked to complete. However, a technical error has meant that the system failed to recognise the

completion of the duty of candour course by participants, meaning completion rates are unavailable. Completion rates for the duty of quality training were 33.2% as at June 2024. The Trust were considering options for increasing compliance at the time of our fieldwork, such as making the training mandatory, making it more user-friendly and more visibly promoted by leaders in the organisation **(2024 Recommendation 4**). More broadly, the Trust has raised awareness amongst its staff of the new requirements through its intranet site as well as during its annual Chief Executive Officer Roadshow sessions. The training has been incorporated into induction training for new starters.

69 Reports to QuESt during 2023 stated that going forward, policies due for renewal should consider the and reflect the requirements under the duties of quality and candour. Positively, as the Trust undertakes policy review, its clinical quality governance group ensures a quality lens is applied during the process. The Putting Things Right policy and Adverse Incident policy (due to be reviewed in March and April 2023 respectively) were highlighted as key policies to be updated considering the Act. However, whilst the Trust did adopt the National Patient Safety Policy and supporting appendices, we could find no evidence that the two policies (Putting Things Right policy and Adverse Incident policy) have been updated (**2024 Recommendation 5**).

Appendix 1

Our 2022 quality governance recommendations

Exhibit 3 sets out the recommendations we made in our 2022 review of quality governance arrangements at the Trust and our current assessment of progress made to meet those arrangements.

2022 Recommendations	Audit Wales assessment of completeness (as at August 2024)
Recommendation 1 - Quality Strategy delivery We found that delivery of the Trust's renewed Quality Strategy (2021-2024) has been severely hampered by resource pressures caused by the pandemic and a lack of funding to support four senior quality lead posts which are central to delivery. The Trust should update its implementation plan outlining how it will deliver its quality ambitions.	**Superseded**
Recommendation 2 - Clinical Audit Plan We found that the clinical audit plan is not approved in a timely manner and the QuESt Committee does not have adequate oversight of progress and delivery. The Trust should ensure that: 2.1 the QuESt Committee scrutinises and approves a clinical audit plan ahead of each financial year. 2.2 the QuESt Committee receives quarterly updates on delivery of the approved clinical audit plan, assurance reports including learning and improvement actions resulting from this work.	**Completed**

Recommendation 3 - Mortality reviews The QuESt Committee does not receive adequate assurances on mortality reviews. The Trust should ensure the QuESt Committee receives quarterly update reports to include: 3.1 the number of reviews undertaken, and the numbers of reviews required but not yet complete. 3.2 any significant concerns, lessons learned and what changes have been made as a result. 3.3 updates on actions to address the mortality review backlog 3.4 updates on progress implementing the all-Wales Learning from Mortality Reviews Framework	**In progress**
Recommendation 4 - Mortality reviews The Trust has a significant backlog of mortality reviews. The Trust should develop an action plan to reduce the backlog, reporting progress at each QuESt Committee	**In progress**
Recommendation 5 - Personal Appraisal and Development Reviews (PADR) The Trust has low PADR compliance rates, for example in June 2022 the Trust's compliance was 59% against the 85% target. As part of embedding its new behaviours, the Trust should ensure that PADR rates are improved and set out the actions it will take to achieve this.	**In progress**
Recommendation 6 - Board member walkabouts Prior to the pandemic, Board members regularly participated in ambulance ride-outs and station visits, but these were ad-hoc in nature and feedback was not collated in a structured way. Now that visits can restart the Trust should develop a standard operating procedure which clarifies the	**Completed**

process, frequency of the visits and ensures coverage across the Trust's operations and geographical areas. It should also include a standard template to capture feedback and learning.	
Recommendation 7 - Joint Escalation Framework The joint investigations framework in place with health bodies is no longer effective. The Emergency Services Ambulance Committee is coordinating action to strengthen those arrangements. The Trust must ensure that the recommendations made by the Delivery Unit are effectively responded to in a timely fashion and progress reported regularly to the Board and QuESt Committee.	**Completed**
Recommendation 8 - Quality performance reporting and learning We found that the QuESt Committee is well served with quality information, but there are opportunities for improvement. The Trust should: 8.1 develop a system to triangulate learning themes across its quality assurance reports. This should ensure clarity about what improvement actions have been taken as a result and how learning has been disseminated across the organisation. 8.2 enhance Covid-19 reporting in the integrated quality and performance report by including information about the harm caused to patients by ongoing service pressures caused by the virus. 8.3 work with health bodies so that there are systems to determine the outcomes for patients who have received emergency ambulance services. This should particularly seek to understand the consequence and harm resulting from service failures such as long ambulance waits. 8.4 develop patient outcome measures to support its existing quality measures.	**In progress**

Appendix 2

Audit methods

Exhibit 4 sets out the methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below.

Element of audit approach	Description
Documents	We reviewed a range of documents, including: • Quality Strategy 2021-24; • Internal Audit reports (namely relating to Clinical Audit and Joint Investigation Framework); • Mortality Review reports: • Putting Things Right reports; • MIQPRs; and • Annual Quality Report.
Interviews	We interviewed the following: • Executive Director of Quality and Nursing; • Executive Director of Paramedicine; • Assistant Director of Quality Governance; • Senior Quality Governance Lead; • Assistant Director of Clinical Development; • Chair of Quality, Experience and Safety (QuESt) Committee;

Element of audit approach	Description
	• Board Secretary; • Assistant Board Secretary; and • Senior Workforce Transformation Manager.
Observations	We observed the following meeting(s): • QuESt February 2024 • QuESt May 2024 • Board May 2024

Appendix 3

Organisational response to 2022 and 2024 audit recommendations

Exhibit 5 sets out the Trust's response to our new audit recommendations.

Ref	Recommendations	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R1	**Quality Strategy** As the Trust develops a new Quality Plan in 2024, it should ensure that delivery is achievable within the resources available. The plan should clearly detail the funding required, the risks of under-delivery (due to capacity and resource constraints) and be underpinned with an implementation plan.	The Quality Strategy is now in development with a change of nomenclature to Quality Plan, acknowledging that the long term organisational strategy is Delivering Excellence: Our vision for 2030. The approach to development has been approved by committee including engagement with internal and external stakeholders and is expected to be approved in Q4 2024-25 for implementation in Q1 2025-26. The quality plan is intended to identify deliverables that follow the principles of the duty of quality being efficient and effective, as well as demonstrating commitment to value based health care. With this in mind the	30th June 2025	Assistant Director of Quality Governance

		intention is to deliver the quality plan within our existing structures without additional investment and through use of our existing infrastructures and networks. The approval of the Quality Plan including the executive summary which steps out the need to ensure that the plan is deliverable within existing establishment constraints will close this action. This will be demonstratable through approved papers and minutes from QuESt committee.		
R2	**Quality Strategy monitoring** There is scope to strengthen quality strategy implementation plan delivery reporting. To enhance clarity, the Trust should, in its progress reports: 2.1 Provide timescales for the expected delivery of each action; 2.2 Differentiate between the progress of individual actions and strategic outputs; and 2.3 Ensure that progress reports are reported regularly and are	The approved Quality Plan will be supported by a robust implementation plan clearly articulating measurable actions and timescales for delivery against responsible and accountable owners. Updates will be provided via the governance structures to ensure regular updates are provided to QuESt via the cycle of business. The Assistant Director of Quality Governance will work with Corporate Governance leaders to ensure a clear cycle of updates and escalation is included within the implementation plan. The review of minutes from QuESt committee which includes these progress reports, through four cycles of business will close this action.	30th March 2026	Assistant Director of Quality Governance

	included in the QuESt cycle of business.			
R3	**Clinical Audit Plan** There are opportunities to further enhance reports on the Trust's Clinical Audit function, by: 3.1 More clearly highlighting any changes made to the approved Clinical Audit Plan; and 3.2 Capturing key findings, outcomes and learning from completed audits.	We will review the communication lines between CQGG, ELT and QuESt to provide clearer visibility on the key findings, outcomes and learning identified through Clinical Audit reports. Whilst amendments to approved clinical audit plans should not be delayed as a result of timescales associated with the cycle of business, quarterly updates will include more detail on the changes to the approved plan including the rationale. The review of minutes from QuESt committee which includes these findings, through four cycles of business will close this action.	31st March 2026 31st March 2026	Head of Clinical Intelligence & Assurance
R4	**Duty of Candour and Quality training** The Trust should take steps to increase compliance rates for duty of quality and duty of candour training to ensure staff have a good understanding of their responsibilities under the requirements.	Access to both Duty of Quality and Duty of Candour training is available via ESR with Duty of Quality training also available via Learning@Wales.	30th September 2025	Assistant Director of Quality Governance

		It is important to balance not just the compliance to the training request but also the impact that training has. In order to increase uptake rates the Duty of Quality training content has been duplicated onto Learn365 which allows the training to be more accessible and stress-free increasing uptake and engagement. Quality Management Group are now monitoring a similar approach for the Duty of Candour training. Engagement with the training is monitored via the Education and Development Team as well as by the Quality Management Group. Local teams will receive regular updates on their compliance with this training and will receive support via QMG on how to improve uptake rates of training. Highlight reports from QMG to CQGG which include the actions taken to increase uptake rates alongside the current completion rates across the organisation will close this action. This will be demonstrable through three Alert, Advise, Assure (AAA) Highlight reports.		

R5	**Policy review** The Trust should ensure that its Putting Things Right and Adverse Incident policies are updated to reflect the requirements of the Duty of Candour and Duty of Quality as soon as is reasonably possible.	The Putting Things Right Policy and the Adverse Incident Policy were both updated and approved through the Policy Group to include references to the Duty of Quality and Duty of Candour on 25th April 2023. These updated policies were subsequently published on 1st June 2023. Both Policies have been subject to a content check by the Assistant Director of Putting Things Right to confirm this content is in place. **This action is complete**	Complete	Assistant Director of Putting Things Right
2022 R3	**Mortality reviews** The QuESt Committee does not receive adequate assurances on mortality reviews. The Trust should ensure the QuESt Committee receives quarterly update reports to include: 3.1 the number of reviews undertaken, and the numbers of reviews required but not yet complete. 3.2 any significant concerns, lessons learned and what changes have been made as a result. 3.3 updates on actions to address the mortality review backlog	The learning from deaths forum and associated sub groups Terms of Reference include the sharing of learning at a local level as well as contributing to learning on a national basis. This information is shared via the Alert, Advise, Assure (AAA) highlight report. The content of the highlight report will be reviewed through governance processes to ensure consistency of reporting aligned to the Agendas of these fora. Four highlight reports which include this consistency of data alongside QuESt committee minutes will close action 3.1 A twice yearly paper communication learning from mortality is shared with QuEST committee	31ST December 2025. 31st December 2025. 31 December 2025.	Assistant Director of Putting Things Right.

	3.4 updates on progress implementing the all-Wales Learning from Mortality Reviews Framework	to provide assurance on the process, completion rates, themes and associated improvements. The QuESt committee minutes where these papers are discussed will close action 3.2 The Trust recognises that further development work is required on the national electronic Mortality Review module in the Datix Cymru system to improve the recording of trends and themes that in turn support learning and improvement. The Trust is engaged regularly in the National Mortality Safety & Learning Network and the Once for Wales Datix Cymru Mortality Review workstream to inform this development work and ensure that the unique nature of our services within the Welsh context is being appropriately represented. Updates provided on engagement with the all-Wales Learning from Mortality Reviews framework demonstrated through QuESt committee minutes across two cycles of business will close action 3.4 A PTR Improvement plan is currently in place which includes actions to address the backlog of ME referrals. Following the introduction of governance forums ME referrals are contemporaneously triaged in line with	3.4 assessed as Complete during 2024 review	

		framework. The organisation acknowledges the need to fully mature the structures and learning themes and believe these will occur over time within the new governance structures. Updates provided on the PTR improvement plan which specifically set out the work undertaken to reduce the baglog demonstrated through QuESt committee minutes across two cycles of business will close action 3.3		
2022 R4	**Mortality Reviews** The Trust has a significant backlog of mortality reviews. The Trust should develop an action plan to reduce the backlog, reporting progress at each QuESt Committee	A PTR Improvement plan is currently in place which includes actions to address the backlog of ME referrals. Following the introduction of governance forums ME referrals are contemporaneously triaged in line with framework. The organisation acknowledges the need to fully mature the structures and learning themes and believe these will occur over time within the new governance structures. Updates provided on the PTR improvement plan which specifically set out the work undertaken to reduce the baglog demonstrated through QuESt committee minutes across two cycles of business will close this action.	31st December 2025	Assistant Director of Putting Things Right.

2022 R5	**Personal Appraisal and Development Reviews (PADR)** The Trust has low PADR compliance rates, for example in June 2022 the Trust's compliance was 59% against the 85% target. As part of embedding its new behaviours, the Trust should ensure that PADR rates are improved and set out the actions it will take to achieve this.	We are implementing a range of measures aimed not only at increasing compliance but also at enhancing the quality and value of PADR conversations. The Trust is committed to improving PADR compliance while also ensuring that these reviews provide real value to staff and managers. We will continue to monitor progress and adjust our strategies as necessary, while also considering how our target metrics or measures of success can better reflect our commitment to meaningful and impactful conversations. Minutes of People & Culture committee where updates are received regarding compliance to target and actions taken to improve the value to staff and managers across three cycles of business will close this action.	31st December 2025	Head of Culture and Organisational Development
2022 R8	**Quality performance reporting and learning** We found that the QuESt Committee is well served with quality information, but there are opportunities for improvement. The Trust should:	Through our Quality Performance Management Framework we will explore how we can draw focus across departments and directorates to triangulate information identifying themes for learning and improvement. This will be used either for internal continual improvement where this is within our boundaries or to share as part of external collaborative working both with health boards and commissioners. Committee	30th September 2025	Assistant Director of Commissioning & Performance

8.1 develop a system to triangulate learning themes across its quality assurance reports. This should ensure clarity about what improvement actions have been taken as a result and how learning has been disseminated across the organisation. 8.2 enhance Covid-19 reporting in the integrated quality and performance report by including information about the harm caused to patients by ongoing service pressures caused by the virus. 8.3 work with health bodies so that there are systems to determine the outcomes for patients who have received emergency ambulance services. This should particularly seek to understand the consequence and harm resulting from service failures such as long ambulance waits. 8.4 develop patient outcome measures to support its existing quality measures.	minutes containing reference in both the MIQPR and PTR report which includes triangulation of metrics across two cycles of business will close action 8.1. Action 8.2 has been superseded the audit report will provide evidence of closure of this action. Whilst we remain limited by data accessibility we continue to pursue patient outcome data through ePCR as well as linking our critical systems to the Welsh Demographic Service allowing the first steps into linking remote clinical assessment with patient outcomes. The ability to achieve truly robust outcome measures without data linkage is limited, we continue to work with DHCW to resolve barriers to data sharing across NHS Wales. Three Alert, Advise, Assure (AAA) Highlight reports from Information Governance Steering Group will provide evidence of this ongoing work and will close both action 8.3 and 8.4	8.2 Superseded in 2024 review. 30th September 2025 30th September 2025	

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Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Ymddiriedolaeth Brifysgol GIG Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services University NHS Trust

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

HEALTH AND CARE QUALITY STANDARDS SELF ASSESSMENT

MEETING	Quality, Patient Experience & Safety Committee
DATE	4 February 2025
EXECUTIVE	Liam Williams, Executive Director of Quality and Nursing
AUTHOR	Kate Blackmore, Assistant Director of Quality Governance
CONTACT	kate.blackmore@wales.nhs.uk

EXECUTIVE SUMMARY

1. The **Health & Social Care (Quality & Engagement) (Wales) Act 2020** came into effect on 1 April 2023, introducing the **Health & Care Quality Standards 2023**, which replaced the 2015 Standards. These Standards apply to both clinical and non-clinical functions.

2. **Health Inspectorate Wales (HIW)** reviews and investigates health care provision for Welsh Government Ministers, considering the Health & Care Quality Standards in their evaluations.

3. The Duty of Quality Annual Report for 2023/24 was created collaboratively, highlighting service content, Quality Management Systems, and a balanced assessment of both improvements and challenges against the Standards.

4. Following an NHS Wales National Workshop on 10 October 2024, the Chief Nursing Officer for Wales supported the decision not to create a National Template for the Self-Assessment Tool.

5. A draft **Health & Care Standards Assessment Framework** was created to facilitate the self-assessment process using a Maturity Matrix approach. This Framework was developed in collaboration with Departmental Leaders and experts across the Trust.

6. The Framework includes specific statements for assessment, aligned with current indicators, and considers quantitative metrics, assurance evidence, experiential information, and other intelligence.

7. The purpose of the Self-Assessment Framework is to identify performance gaps, create a culture of continuous improvement, provide a standardised Framework for

measuring progress, and facilitate clear communication and a shared understanding of goals.

RECOMMENDED that the Quality, Patient Experience & Safety Committee note the Health and Care Standards Assessment Framework being adopted organisationally to secure assurance on compliance.

KEY ISSUES/IMPLICATIONS
Not Applicable

REPORT APPROVAL ROUTE	
Clinical & Quality Governance Group	21 January 2025
Executive Leadership Team	29 January 2025
Quality, Patient Experience & Safety Committee	4 February 2025

REPORT APPENDICES
ANNEX 1 - SBAR Health and Care Quality Standards Self Self-Assessment
ANNEX 2 - Health and Care Quality Standards Self Self-Assessment 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)	N/A	Financial Implications	N/A
Environmental/Sustainability	N/A	Legal Implications	YES
Estate	N/A	Patient Safety/Safeguarding	YES
Ethical Matters	N/A	Risks (Inc. Reputational)	YES
Health Improvement	YES	Socio Economic Duty	N/A
Health and Safety	YES	TU Partner Consultation	N/A

ANNEX 1

SITUATION

1. The Duty of Quality Statutory Guidance 2023 sets out the reporting requirements for the NHS bodies associated with the Duty of Quality.

2. Section 9.12 of the Statutory Guidance advises that NHS bodies will assess the extent of any improvement in outcomes which will help to inform the Duty of Quality Annual Report.

3. This paper steps out the consideration of utilising a Self-Assessment Framework to support an Assessment of our adherence to the Duty of Quality and the Health & Care Quality Standards.

BACKGROUND

4. On 1 April 2023, the Health & Social Care (Quality & Engagement) (Wales) Act 2020 came into power. This legislation was supported by the introduction of the Health & Care Quality Standards 2023, replacing the historic Health & Care Standards 2015.

5. The Standards were updated to reflect the wider remit of the Duty of Quality which is relevant when exercising non-clinical, as well as clinical, functions. As an NHS body we are required to take these standards into account in order to discharge the Duty of Quality.

6. Health Inspectorate Wales (HIW) have the function to undertake reviews and investigations into the provision of health care for Welsh Government Ministers and as will consider the Health & Care Quality Standards in their process.

7. To ensure that our organisation consistently fulfils the Duty of Quality, it is essential to evaluate ourselves both at an organisational level and within local Directorates. This assessment against established standards will help us guide improvements and continuously, reliably, and sustainably meet the needs of the population we serve.

8. The Duty of Quality Annual Report for 2023/24 was generated through a collaborative approach with content providers and leaders across the organisation. As our first Report we included content on our services, our quality management systems and ensured that each Standard included a balanced assessment of both positive improvement initiatives and challenges experienced. This provided a first Assessment against the Standards.

9. A National Duty of Quality/Quality Standards Stakeholder Workshop was held on 10 October 2024 to explore the development of a Quality Standards Self-Assessment Tool. The feedback in this Workshop included:

- Concern that making the Self-Assessment Tool meaningful for all organisations with different perspectives and remits might be challenging without either becoming too complex or too high-level to add value:

    - Many organisations are already working to meet the Quality Standards within their own context, so sharing and building on this existing work might be more beneficial.
    - The importance for organisations to ensure they have a comprehensive Quality Management System that helps them become learning organisations and incorporates the Quality Standards.
    - Possible duplication between any Quality Standards Self-Assessment Tool and the ongoing work on the Quality Outcomes Framework.

10. The feedback from the Workshop was discussed with the Chief Nursing Officer for Wales who was supportive of the Stakeholder Group focussing on Duty of Quality and Quality Management Systems and therefore a National Template for a Self-Assessment Tool would not be created.

ASSESSMENT

11. A draft Health & Care Standards Assessment Framework has been created for the Trust to facilitate the Self-Assessment Process. The Framework uses a maturity matrix approach to evaluate the development of capabilities and processes in line with the Health & Care Quality Standards 2023.

12. The development of the Framework has been undertaken in collaboration with relevant Departmental Leaders and experts across the Trust.

13. The Health and Care Quality Standards are set out with the associated narrative broken down into specific statements for assessment.

14. Each statement is aligned with current indicators that are publicly available or regularly reported at Committee Meetings.

15. In accordance with quality assurance methodology, it is essential to consider not only quantitative metrics but also assurance evidence, experiential information, and other intelligence. Therefore, a series of examples are provided to guide the assessor on the types of evidence that may be presented in addition to the associated metrics.

16. The Assessment Process requires a RAG rating application, examples of good practice, innovation and improvement, challenges identified, the recording of any legislation, Statutory Guidance or national drivers that support the assessment as well as recording the Committee oversight for the specific statement.

17. Where challenges are identified there is a cross referenced Workplan to record Actions for Improvement as well as the opportunity to report the trend data from previous assessments.

18. The purpose of the Self-Assessment Framework is to:

- Identify performance gaps
- Create a culture of continuous improvement
- Provide a standardised Framework for measuring progress
- Facilitate clear communication and a shared understanding of goals

19. The function of the Quality Management Group is to ascertain the performance of the organisation across the Health & Care Quality Standards utilising expertise to assess, assure and inform stakeholders of organisational performance. This forum provides an integrated forum for Directorate Trams and organisational functions to strengthen quality governance, improve responsive ness to quality matters and promote clinical and quality excellence in Trust activities and initiatives. Workplans identified from the Self-Assessment Framework can be monitored in this forum, helping to inform improvement initiatives and quality planning activities.

20. Work is ongoing with the Corporate Governance to reframe the templates for Executive Summary covers to include clear reference to the Standards addressed within document, this action will then support evidencing the consideration of quality in decision making as set out in the Health & Care (Quality & Engagement) (Wales) Act 2020.

Standard	Statement	Indicator	Examples
Leadership	Our health care system has visible and focused leadership at all levels, with its activities driven by the organisations' vision and values for quality.	Total number of board member visits Total Roadshow and Events attendances by board members Total number of ED visits by board members	Consider the level of representation and presentation at WAST Q and Leadership Symposium focussed on leadership and quality focus. Engagement at local levels around QPMF and Quality Management systems. Quality Management Group and Quality Live
	Our leaders and managers take a long-term, stakeholder-centric view to develop a clear organisational vision.		Consider how we have responded to the feedback we have received from service users and how this has influenced and informed service change and improvement initiatives
	They have the appropriate skills and capacity to create the conditions for a functioning quality management system.		Consider the content at the WAST leadership symposiums and opportunities provided to develop leaders including delegates at Academi Wales Summer and Winter schools. Think about the introduction of the WASTQ events and the hosting of the Ambulance Q event. How else have we supported skills and what are the challenges for capacity and how are we supporting these.
	We ensure our governance, leadership and accountability is effective in sustainably delivering care.		Consider the work undertaken on the Integrated Governance Framework. Think about the development of 'Our WAST Way'
Workforce	Our healthcare system recruits, retains, develops and extends roles to ensure we have enough, confident people with the right knowledge and skills available at the right time to deliver safe care.	% of employees leaving the organisation expressed as FTE Proportion of staff who have undertaken their annual Personal Appraisal & Development Review or Medical Appraisal combined % of staff who are compliant with required stat/mand training % Compliance for level 1 compentices within the core skills and Training framework Apprenticeships in progress Apprenticeships completed Numbers of staff being supported into Advanced Practice	consider other evidence of retention, development and support such as workforce length of service, the number of role changes during length of service to demonstrate vertical progression or horizontal skill development, evidence of support through bursaries, secondment opportunities and internal only recruitment opportunities. consider paramedics and nurses are resgistrants of professional bodies.
	We value our people and the commitment and resilience they demonstrate in the care they provide.		consider evidence of how we demonstrate the value with which we hold our staff such as recognition events (eg staff awards and long service medals) and commendations. You could also consider the correlation of recognition events versus disciplinary investigations.
	We care about their wellbeing, protect their rights and support them to feel well and happy at work; and provide them with the tools, systems and environment to work safely and effectively.	Staff sickness absence volumes as % of Trust establishment Monthly % of absence attributed to Anxiety, Depression and other Psychiatric illness (based on available fte) The number of shifts which exceeded their planned length by over 2 hours Volume of RIDDOR Reports by Month Total Violence & Agression Reports by Month Volume of MSK incidents by month	Sources of information could relate to Speaking up safely activity, compliance with DSE legislation, IPC premises and vehicle audits, workplace assessments. Other evidence could include the Sexual Safety campaign, Domestic Abuse support of workforce, Robust Management of Professional Concerns, the IOSH leading safely programme, Legislative compliance register assessment, H&S climate surveys, and policies such as Substance Misuse Policy.
	Our workforce planning focuses on investing in our people and nurturing, growing and transforming our workforce to create a sustainable workforce for the future		consider how the strategic workforce plan supports this delivery in your area. Included in the strategy are plans to develop our teams and leaders, develop local plans, review recruitment processes, improve our people's workplace experiences through things like beneftis and value propositions.
Culture	Our healthcare system creates the right climate and culture to nurture and encourage quality and system safety, valuing people in a supportive, collaborative and inclusive workplace so that our people feel psychologically safe to raise concerns and try out new ideas and approaches.	Volume of Disciplinary Cases by Month Staff survey completion rate Network Membership Volume of Formal requests for resolution Average rating of experience (3 month check in data) % recommending WAST workplace (12 month celebration)	a good cultural indicator would be the Volume of incidents reported via highly confidential datix and Speaking up Safely platforms rather than through direct contact with leadership teams. Consider themes and trends from sources such as the cultural review, exit interviews, Capability processes. indicators could include Response rates to Hive Survey and Staff Survey output plans
	Relationships within teams and with the people we serve are effective and based on transparency, accountability, ethical behaviour, trust and just culture, where people can thrive.	Open Employee Relations cases Duty of Candour Notifications	consider what we learn from surveys and engagement including the NHS Staff Survey or staff stories, and how we use this through output plans to make transformational change. Think about our vision of culture and behaviours and how this is respresented across the organisation includin in PADRs. How do our staff networks and champions impact in this space.
Information	Our healthcare system ensures information is available and shared appropriately for all who need it.	Data breach incidents reported to the information commissioners office Volume of records requests Volume of Police Requests Volume of NIIAS Notifications Data sharing agreements that are up to date and reviewed as per schedule FOI request compliance Information Governance statutory/mandatory training compliance	consider any Data Protection Impact Assessments and cloud security assessments that have been completed where necessary. You can also think about the records management code of practice & WAST records retention schedule.
	We turn data to knowledge by triangulating quantitative and qualitative performance, experience and outcome measures to understand the quality of services, efficacy of improvement work and impact of decisions made.		consider how you triangulate data from multiple sources to understand the underlying issues and relational impact and use this information to make improvements. Also think about how you are measuring and monitoring the impacts of decisions you've made, consider how you identified monitoring and evaluation methods during QIA development and what you have learned from this activity.

	We monitor, report and escalate indicators through our governance structures to ensure that appropriate action is taken at every level in terms of learning, improvement and accountability.		Sources of evidence could include Terms of Reference, Integrated Governance Map, Highlight Reports and Committee Papers. Consider where you monitor this information and what you do with the learning to you glean from it.
Learning, Improvement and Research	Our healthcare system creates the conditions and capacity for an organisation and system-wide approach to continuous learning, quality improvement and innovation, which it actively promotes.		Consider initiatives that have been idenfied by our teams either through the WIIN Network, Quality Management Group, QI Roadshow or direct engagement at a local level. This may be activity supported through the Quality Improvement Hub.
	We use new knowledge to influence improvements in practice and to inform our decision-making.		Consider data, information and storytellling shared through quality governance and business forums that have influenced improvement activities and supported decision making. Think about Quality Impact Assessments and the information used to monitor and evaluate success.
	We ensure our learning and improvement activity is linked to our strategic vision to deliver transformational, organisation-wide change.		Consider how themes, trends and learning opportunities are linked to organisation and quality planning
	We commit to participating in research because research-active organisations provide improved quality of care and outcomes for people.		Consider Research Projects currently ongoing and any that have been completed, particularly where they have led to the publication of academic articles. Do we store all our research in a Publication library and if so how do we use this to inform our strategies. Think about the 10 pillars outline the features of a research supportive NHS organisation and how we demonstrate this in WAST.
Whole Systems Approach	Our healthcare system ensures safety in healthcare goes beyond individual patient safety.		
	We will look within and beyond our organisational boundaries to learn how we can continually, reliably and sustainably meet the evolving needs of people.	% of Total Conveyances taken to a service other than a Type 1 ED	
		% of Patients conveyed to SDEC	
	We will strengthen relationships and work with all of our partners to achieve good outcomes.	Number of incidents reviewed at SCIF reported to Health Board on JIF	
	Our policies incorporate the broader ambitions within the seven well-being goals and five ways of working in the Well-being of Future Generations Act.		
Safe	Our healthcare system is a high quality, highly reliable and safe system that avoids preventable harm, maximising the things that go right and learning from when things go wrong to prevent them occurring again.	Modelled Harm coming to patients who wait >60 mins for a hospital handover	other indicators could include the themes of the recommendations of prevention of future deaths notices received from coroners, as well as learning from events reports and organisational learning logs. Thematic information could also be gleaned from the RL Datix Cymru platform. Consider the numbers of incidents relating to patients with additional needs. You could also consider clinical practice in line with the administration of medicines under Schedule 17 of the Human Medicines regulation (2012)
		Number of NRIs reported to NHS Exec - All Wales	
		Number of PFD Reports received.	
		Number of patients with Can't Send or Cancelled ambulance requests	
		% of time spent utilising Clinical Safety Plan levels >2C	
		Patient Safety Solutions Compliance (Alerts & Notices)	
	People's health, safety and welfare are actively promoted and protected;		
	risks are identified and monitored and where possible, risks to safety are reduced or prevented.		The risk management approach of the Trust is supported by the Risk Management Policy: Consider the number of Open Risks, the frequency with which open Risks have been reviewed, the number of outstanding treatments (actions) to mitigate risks, Highlight (AAA) Reports where risks are escalated.
	We promote and protect the wellbeing, and safety of children and adults who become vulnerable or at risk at any time.	Safeguarding Training compliance	Consider content and awareness of the High Risk Register Policy, any available High Intensity User Metrics. Consider the work that PECI undertake in regards to engagement and network events and identify any activity that has been undertaken at a local level with this in mind Explore how we have achieved our Children's Promises
	Where children or adults may be experiencing or are at risk of abuse or neglect, we take appropriate, timely action and report concerns	Number and % of Child Safeguarding Reports sent within 24 hours	
		Number and % of Adult at Risk reports sent within 24 hours	
Timely	Our healthcare system ensures people have access to the high-quality advice, guidance and care they need quickly and easily, in the right place, first time.	NHS111 call handling abandonment rates	
		111 Clinical Triage Call back time (P1)	
		999 Call answer times 95th percentile	
		999 Amber 1 median	
		Oncology Journeys arriving within 45 mins and up to 15 mins after appointment time	
		Advanced Discharge & Transfer journeys collected less than 60 minutes after booked time (NEPTS)	
		% of notification to handover within 15 minutes of arrival at hospital	
	We care for those with the greatest health need first, and where treatment is identified as necessary, we treat people based on their identified and agreed clinical priority.	999 Red Response within 8 minutes	Consider our clinical model and patient needs assessments, the clinical safety plan and capacity management plan are designed around prioritising those service users with the most clinically acute needs first
		% of enhanced renal journeys arriving within 30 mins prior to their appointment time and not late	
		Stroke Call to Door times	
		STEMI Call to Door times	
Effective	Our healthcare system ensures decision-making, care and treatment reflects evidence-based best practice, to ensure that people receive the right care to achieve the optimal and possible outcomes that matter to them.	Stroke bundle compliance	Consider the impact of cancellation rates such as can't send, cancelled by patient or impacts of capacity management plans.
		STEMI bundle compliance	
		ROSC bundle compliance	
		Hypo bundle compliance	
		NOF bundle compliance	
		111 Calls by Final Outcome	
		111 Calls by Final Outcome Type	
		111 Website Hits	
		Use of MPDS	
		See and Treat Responses (EASC Performance Report)	
		Re-contact % within 24 hours of Consult & Close	
		APP vs non-APP Conveyance Rates	

	We design transformative, evidenced-based, whole-of-life pathways that cover prevention, care and treatment, rehabilitation and embed these into local service delivery.		Consider end of life engagement information and end of life pathways the contribution of palliative care paramedics and just in case medicines.
Efficient	Our health care system takes a value-based approach to improve outcomes that matter most to people in a way that is as sustainable as possible and avoids waste.	Financial balance	
		Actual Savings as % of Planned Savings	
		% of Non NHS Invoices Paid within 30 days	
	We make the most effective use of resources to achieve best value in an efficient way.	EMS Actual Hours Produced	
		EMS Abstracted Hours	
		FTE Variance	
		Volume of on the Day Cancellations	
		Utilisation % by Vehicle Type	
		Total Hours Lost to handover > 15 minutes	
	We only do what is needed and undertake treatments that ensure any interventions represent the best value that will improve outcomes for people.	Successful Consult & Close Outcomes %	
		Successful Consult & Close Outcomes by Type	
Equitable	Our healthcare system provides everyone with an equal opportunity to attain their full potential for a healthy life which does not vary in quality by organisation providing care, location where care is delivered or personal characteristics (such as age, gender, sexual orientation, race, language preference, disability, religion or beliefs, socio-economic status, political affiliation).	% of 111 Calls Answered in Welsh	Other evidence may be the use of BSL across the service, access to text talk services through BT and use of translation services through Language Line.
		% of NEPTS calls answered in Welsh	
	We embed equality and human rights in our health care system.	% of applicants shortlisted from under-represented groups	
Person Centred	Our health care system meets people's needs and ensures that their preferences, needs and values guide decision-making that is made in partnership between individuals and the workforce.		Consider Quality Impact Assessments and Equality Impact Assessments used to support strategic decision making. How have patient stories helped to inform learning and improvement through patient story trackers at committee and board. How have our patient networks supported co-design and co-production of initiatives.
	We care about the well-being of individuals, their families, carers and our staff.		Consider our staff survey's and associated action plans. Also consider information within our annual reports with a specific focus on PECI annual report.
	We ensure that everyone is always treated with kindness, empathy and compassion and we respect their privacy, dignity and human rights.		Consider the compliments received particularly identifying positive engagement. Civica Word Cloud reports that pull through the language used in feedback. What do the themes and trends from our concerns tell us about how we can improve.
	We are committed to working better together to put people and their families at the centre of decisions, seeing them as experts working alongside professionals to get the best outcome and experience.	% of concerns with a response within 30 working days	Consider the number of events and engagement opportunities undertaken as part of improvement and transformation work. How have patient and staff stories informed and influenced our improvement activities. Track learning from patient stories presented to Trust Board and Committees. Consider voumes of Ombudsman cases and what we have learned from these.
		Civica Experience Scores	

	**Workforce**	Our healthcare system recruits, retains, develops and extends roles to ensure we have enough, confident people with the right knowledge and skills available at the right time to deliver safe care.
		We value our people and the commitment and resilience they demonstrate in the care they provide.
		We care about their wellbeing, protect their rights and support them to feel well and happy at work; and provide them with the tools, systems and environment to work safely and effectively.
		Our workforce planning focuses on investing in our people and nurturing, growing and transforming our workforce to create a sustainable workforce for the future
	**Culture**	Our healthcare system creates the right climate and culture to nurture and encourage quality and system safety, valuing people in a supportive, collaborative and inclusive workplace so that our people feel psychologically safe to raise concerns and try out new ideas and approaches.
		Relationships within teams and with the people we serve are effective and based on transparency, accountability, ethical behaviour, trust and just culture, where people can thrive.
	**Information**	Our healthcare system ensures information is available and shared appropriately for all who need it.
		We turn data to knowledge by triangulating quantitative and qualitative performance, experience and outcome measures to understand the quality of services, efficacy of improvement work and impact of decisions made.
		We monitor, report and escalate indicators through our governance structures to ensure that appropriate action is taken at every level in terms of learning, improvement and accountability.
	**Learning, Improvement and Research**	Our healthcare system creates the conditions and capacity for an organisation and system-wide approach to continuous learning, quality improvement and innovation, which it actively promotes.
		We use new knowledge to influence improvements in practice and to inform our decision-making.
		We ensure our learning and improvement activity is linked to our strategic vision to deliver transformational, organisation-wide change.
		We commit to participating in research because research-active organisations provide improved quality of care and outcomes for people.
	**Whole Systems Approach**	Our healthcare system ensures safety in healthcare goes beyond individual patient safety.
		We will look within and beyond our organisational boundaries to learn how we can continually, reliably and sustainably meet the evolving needs of people.
		We will strengthen relationships and work with all of our partners to achieve good outcomes.
		Our policies incorporate the broader ambitions within the seven well-being goals and five ways of working in the Well-being of Future Generations Act.
	**Leadership**	Our health care system has visible and focused leadership at all levels, with its activities driven by the organisations' vision and values for quality.
		Our leaders and managers take a long-term, stakeholder-centric view to develop a clear organisational vision.

		They have the appropriate skills and capacity to create the conditions for a functioning quality management system.
		We ensure our governance, leadership and accountability is effective in sustainably delivering care.
	**Safe**	Our healthcare system is a high quality, highly reliable and safe system that avoids preventable harm, maximising the things that go right and learning from when things go wrong to prevent them occurring again.
		People's health, safety and welfare are actively promoted and protected;
		risks are identified and monitored and where possible, risks to safety are reduced or prevented.
		We promote and protect the wellbeing, and safety of children and adults who become vulnerable or at risk at any time.
		Where children or adults may be experiencing or are at risk of abuse or neglect, we take appropriate, timely action and report concerns
	**Timely**	Our healthcare system ensures people have access to the high-quality advice, guidance and care they need quickly and easily, in the right place, first time.
		We care for those with the greatest health need first, and where treatment is identified as necessary, we treat people based on their identified and agreed clinical priority.
	**Effective**	Our healthcare system ensures decision-making, care and treatment reflects evidence-based best practice, to ensure that people receive the right care to achieve the optimal and possible outcomes that matter to them.
		We design transformative, evidenced-based, whole-of-life pathways that cover prevention, care and treatment, rehabilitation and embed these into local service delivery.
	**Efficient**	Our health care system takes a value-based approach to improve outcomes that matter most to people in a way that is as sustainable as possible and avoids waste.
		We make the most effective use of resources to achieve best value in an efficient way.
		We only do what is needed and undertake treatments that ensure any interventions represent the best value that will improve outcomes for people.
	**Equitable**	Our healthcare system provides everyone with an equal opportunity to attain their full potential for a healthy life which does not vary in quality by organisation providing care, location where care is delivered or personal characteristics (such as age, gender, sexual orientation, race, language preference, disability, religion or beliefs, socio-economic status, political affiliation).
		We embed equality and human rights in our health care system.
	**Person Centred**	Our health care system meets people's needs and ensures that their preferences, needs and values guide decision-making that is made in partnership between individuals and the workforce.
		We care about the well-being of individuals, their families, carers and our staff.
		We ensure that everyone is always treated with kindness, empathy and compassion and we respect their privacy, dignity and human rights.
		We are committed to working better together to put people and their families at the centre of decisions, seeing them as experts working alongside professionals to get the best outcome and experience.

Ymddiriedolaeth Brifysgol GIG Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services University NHS Trust

AGENDA ITEM No	**12**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**3**

DATIX RECOVERY AND IMPROVEMENT PLAN

MEETING	Quality, Patient Experience & Safety Committee
DATE	4 February 2025
EXECUTIVE	Liam Williams, Executive Director of Quality and Nursing
AUTHOR	Kate Blackmore, Assistant Director of Quality Governance
CONTACT	kate.blackmore@wales.nhs.uk

EXECUTIVE SUMMARY

1. The RL Datix Cymru System, also known as the 'Once for Wales' Concerns Management System, is a nationally procured Electronic Risk Management System that contains incident reporting data for patient, staff and contractor safety concerns, as well as bespoke Modules for Feedback (Complaints and Compliments), Redress, Inquests/Claims and Mortality Review.

2. In September 2024 a National Workshop was held by the Quality, Safey & Patient Experience (QPSE) Directorate engaging with key internal and external stakeholders in order to identify the current challenges with the Trust governance and infrastructure associated with Datix Cymru system management. The outputs of this Workshop allows for the development of a Datix Recovery and Improvement Plan which will be shared with, and monitored by, the Quality and Performance Management Steering Group.

3. The Datix Workshop considered the quality and governance surrounding the five Modules currently in active use within the Trust, as well as the potential use of the Safeguarding Module and Risk Module which are both now commencing roll out. Key areas of discussion included:

- System Governance
- Quality of Content
- Business Intelligence
- Information Governance
- Education
- Corporate Governance
- Improvement Opportunities

4. Improvement opportunities were documented throughout the workshop and were aligned to a Priority Matrix for delivery of key essential activity through to longer term developmental initiatives with an overarching requirement to consider education at every level of the Recovery Plan.

RECOMMENDED that the Quality, Patient Experience & Safety Committee:

(1) Notes the current risks and challenges within the Datix Web and RL Datix Cymru platforms; and

(2) Notes the attached Recovery and Improvement Plan designed to mitigate the challenges stepped out in this paper.

KEY ISSUES/IMPLICATIONS
(i) The Quality, Safety and Patient Experience Directorate are the stewards of the intelligence, mitigation and consequence management for this area but are not the owners of incidents which remain aligned to the appropriate Health Boards, Teams and Directorates. We remain reliant on our stakeholders in the broader NHS Wales economy to support and provide intelligence to understand the outcomes for incidents of moderate and above levels of harm. Data linkage through work with Digital Health and Care Wales (DHCW) amongst others is key in this area.
(ii) In order to transform the information within the Datix Platforms into actionable intelligence we need to reduce unnecessary data fields and improve data flow, supporting end users with clear actionable insights for improvement.
(iii) This work and clear governance and accountability arrangements will support a shift to locally owned insights supported by Content Teams. The current structures result in teams relying on specialist teams such as patient safety or health and safety to interpret the data to inform improvement, a move to local ownership will create long-term sustainability.
(iv) As identified through the QSPE Organisation Change Process (OCP) resources are a key barrier to the necessary work to address the broader impacting factors. The Directorate Plan for QSPE includes the clarification of resource requirements for the Datix System management functions, which is particularly important for data cleansing and field optimisation.
(v) In the short-term additional capacity has been obtained utilising underspend in the pay and non-pay budget within the Quality Governance Teams. Alongside the appointment of a new Datix System Lead additional temporary capacity has been appointed for the remainder of this fiscal year to support the Recovery and Improvement Plan. In addition, dedicated capacity has been negotiated with the Once for Wales Team to complete a system health check and any associated recovery work not already identified as part of the Workshop.
(vi) These activities will then support the building of a Business Case for any recurring investments required for maintaining and enhancing Datix and the

associated systems, ensuring that these are included in our Integrated Medium-Term Plan and prioritised appropriately.

(vii) It was evident from discussions during the Workshop that the Datix System governance (both Datix Web and RL Datix Cymru) currently operates in isolation from other key Software and Governance Platforms within the organisation. There is no clear forum or process for approval of changes to configuration or allocation of Approval Groups.

(viii) The current configuration and maintenance of the system lacks structure and requires review to understand the profiles and security groupings available and how these could be better standardised to ensure equity of access.

(ix) The design of RL Datix Cymru to meet the needs of all health bodies within Wales was always going to present challenges, particularly for those non-Health Board bodies such as the Welsh Ambulance Services University NHS Trust (WAST). It has become increasingly evident that update requests are urgently required to address key issues such as person affected data and contact details required for Duty of Candour triggering and reporting.

(x) The volume and quality of reports generated within the RL Datix Cymru Platform is adding to the lack of structure surrounding the system, creating duplication and introducing variance in outcome data.

(xi) A review of current practice and guidance as well as system configuration is required to provide us with assurance of our responsibilities with information governance.

REPORT APPROVAL ROUTE	
Quality Management Group	16 October 2024
Senior Quality Leadership Team	21 October 2024
Clinical & Quality Governance Group	17 December 2024
Quality, Patient Experience & Safety Committee	4 February 2025

REPORT APPENDICES
ANNEX 1 - SBAR: Datix Recovery and Improvement Plan
ANNEX 2 - Once for Wales Concerns Management System Health Check (WAST)
ANNEX 3 - Datix Recovery & Improvement Plan

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

ANNEX 1

SITUATION

1. The Trust currently utilise two Digital Platforms provided by RLDatix, a Healthcare Technology Company who provide products across a number of UK and international health care providers to support quality and risk management.

2. Datix Web is the historic Software Platform which was housed and maintained internally until the RL Datix 'Once for Wales' Platform was introduced in 2022. Datix Web continues to operate in the Trust to support risk management pending the introduction of a Risk Module in the 'Once for Wales' Platform.

3. Concerns have been identified with the quality and governance structures of the Platform historically and since the introduction of the RL Datix Platform. This has resulted in concerns regarding the validity of the information being reported both internally and externally.

4. A Workshop of key stakeholders has been completed to identify a Recovery and Improvement Plan for the Trust to provide confidence in the reporting and learning outcomes provided from investigation utilising these platforms.

5. This paper steps out the activity taken and provides an overview of the Recovery Plan required.

BACKGROUND

6. The RL Datix Cymru System, also known as the 'Once for Wales' Concerns Management System, is a nationally procured Electronic Risk Management System that contains incident reporting data for patient, staff and contractor safety concerns, as well as bespoke Modules for Feedback (Complaints and Compliments), Redress, Inquests/Claims and Mortality Review.

7. Modules are developed and introduced as part of the Once for Wales Concerns Management Programme and will soon include Risk, Safeguarding and Safety Alerts Modules.

8. The Platform was introduced to the Trust in May 2022 and is a key source of intelligence to demonstrate our commitment and compliance with the Health & Social Care (Quality & Engagement) (Wales) Act 2020. It should serve as a single solution for recording and managing the corporate and clinical governance activities listed above, as well as being a valuable data asset for quality and safety performance, assurance, learning and improvement purposes.

9. Alongside national challenges with the functionality and stability of the system, which is monitored and maintained by the Once for Wales Shared Services Team, the Trust has consistently struggled to secure the expertise and systematic working necessary to apply the solution effectively.

10. In November 2023, the Head of Quality Assurance and Datix produced a Quality Plan considering the Trust governance arrangements to ensure that the system is used in a consistent manner and that intelligence produced, to inform quality assurance and quality improvement decisions, is compliant with data quality standards.

11. From early February 2024 the Datix System Lead/Analyst was absent for a protracted period. Without sufficient infrastructure within the team to support resilience, capacity was provided by realigning a proportion of the Quality Assurance Lead capacity and through external system support from the Once for Wales Shared Services Team at financial cost. After their return to duty in April 2024 there was an associated phased Return to Work Programme and then additional leave absence which impacted on development and improvement activities.

12. Recent appointments to the QSPE Directorate have enabled progress to be made in remedying understanding and identifying more effective use of Datix Cymru whilst continuing to engage with the Once for Wales Shared Services Team.

13. The Final Outcome Document following the recent Quality, Safety & Patient Experience (QSPE) Directorate Organisation Change Process (OCP) acknowledged that the Datix Team had identified resourcing challenges. The Head of Service was encouraged to undertake workforce analysis and develop a Business Case for consideration through the Senior Quality Team (SQT) and Senior Quality Leadership Team (SQLT). This Business Case must identify whether any improvements are achievable within the Directorate financial envelope or whether financial investment is required from outside the Directorate.

14. In June 2024 the Assistant Director of Putting Things Right escalated a number of concerns regarding Datix System administration/governance and the capacity impacting the timely resolution of these concerns. These issues included support for regular data monitoring and report development, clarity on system direction and decision making which contributed to issues of poor quality, increasing risk in practice and data quality.

15. In September 2024 a National Workshop was held by the QSPE Directorate engaging with key internal and external stakeholders in order to identify the current challenges with the Trust governance and infrastructure associated with Datix Cymru System management. The outputs of this Workshop allow for the development of a Datix Recovery and Improvement Plan which will be shared

with, and monitored by, the Quality and Performance Management Steering Group.

ASSESSMENT

Broader Impacting Factors

16. The Quality, Safety and Patient Experience Directorate are the stewards of the intelligence, mitigation and consequence management for this area but are not the owners of incidents which remain aligned to the appropriate Health Boards, Teams and Directorates. We remain reliant on our stakeholders in the broader NHS Wales economy to support and provide intelligence to understand the outcomes for incidents of moderate and above levels of harm. Data linkage through work with DHCW amongst others is key in this area.

17. In order to transform the information within the Datix Platforms into actionable intelligence we need to reduce unnecessary data fields and improve data flow, supporting end users with clear actionable insights for improvement.

18. This work and clear governance and accountability arrangements will support a shift to locally owned insights supported by Content Teams. The current structures result in teams relying on specialist teams such as patient safety or health and safety to interpret the data to inform improvement, a move to local ownership will create long-term sustainability.

19. As identified through the QSPE OCP resources are a key barrier to the necessary work to address the broader impacting factors. The Directorate Plan for QSPE includes the clarification of resource requirements for the Datix System management functions, which is particularly important for data cleansing and field optimisation.

20. In the short-term additional capacity has been obtained utilising underspend in the pay and non-pay budget within the Quality Governance Teams. Alongside the appointment of a new Datix System Lead additional temporary capacity has been appointed for the remainder of this fiscal year to support the Recovery and Improvement Plan. In addition, dedicated capacity has been negotiated with the Once for Wales Team to complete a system health check and any associated recovery work not already identified as part of the Workshop.

21. These activities will then support the building of a Business Case for any recurring investments required for maintaining and enhancing Datix and the associated systems, ensuring that these are included in our Integrated Medium-Term Plan and prioritised appropriately.

Historic Improvement Plan

22. The Datix Quality Plan (v4) produced in November 2023 identified key themes for improvement as follows:

- Training Packages
- Staff Training delivery
- Standard Operating Procedures and Governance Processes
- Open Incident Dashboards
- Digitising system request forms
- Communication Plan

23. Some but not all the improvement activity has been completed and delivery has been impacted by capacity within the Datix System and Content Teams. Elements of training packages have been developed and initial Standard Operating Procedures have been published. A Quality Assurance Dashboard has been developed on PowerBI to support Quality Management Group and following assurance by Information Governance and Health Informatics Teams is now available for use by local teams. Access and Communication Platforms have been updated and work has been completed within local teams including the Operations Directorate to reduce unnecessary reporting impacting the volume and validity of records within the Incident Module.

Datix Workshop Structure

24. The Datix Workshop considered the quality and governance surrounding the five Modules currently in active use within the Trust, as well as the potential use of the Safeguarding Module and Risk Module which are both now commencing roll out. Key areas of discussion included:

- System Governance
- Quality of Content
- Business Intelligence
- Information Governance
- Education
- Corporate Governance
- Improvement Opportunities

25. The Joint Emergency Services Group (JESG) online form/database was not considered due to lack of attendance from the JESG Practitioners Group membership and limited experience of the attending membership. This is a bespoke Module that was created specifically for JESG and WAST as part of the RL Datix Cymru implementation, a previous version had been used to good effect on Datix Web.

26. The Safety Alerts Module was not discussed during the Workshop and is subject to a separate paper and recommendations.

27. Key considerations during the Workshop were the importance of intra-operability between Modules and health bodies to make the Once for Wales solution a robust and efficient solution. Consideration was also given to clinical involvement in investigations as well as Clinical Audit and how this learning could be logged and linked to the appropriate modules.

System Governance

28. The resilience of system integrity and governance was of concern due to the capacity within the existing System Lead Team (QSPE). The current infrastructure provides a single System Lead and a Directorate Support Officer creating single points of failure. Capacity in the wider Quality Assurance Team is also limited with a single Quality Assurance Lead supported by a Quality Assurance Analyst (both of which posts are vacant). Investment into the Datix System Team to ensure resilience, succession planning and capacity for system development was identified as a key deliverable in providing robust governance and system architecture as the Trust moves forward with innovative Clinical Model Transformation. It should also be noted that the level of expertise to support system architecture on the Datix Web Platform, which houses the Trust's enterprise risk management solution, is limited. This has resulted in delays updating platforms to include legislative standards such as the replacement of Health & Care Standards 2015 with the Health & Care Quality Standards 2023. As such it is currently impossible to appropriately align enterprise risk to the relevant legislative standards on this platform.

29. It was evident from discussions during the Workshop that the Datix System governance (both Datix Web and RL Datix Cymru) currently operates in isolation from other key software and governance platforms within the organisation. There is no clear forum or process for approval of changes to configuration or allocation of Approval Groups. Despite the existence of Change Advisory Boards within digital infrastructures, as well as an operational planning forum chaired by the Assistant Director of Digital for ICT, system updates and configuration changes are managed independently without any firm governance or assurance forums. The Senior Quality Team, introduced in September 2023, has made initial inroads in this space but governance at this Forum has been limited to the approval of Standard Operating Procedures and Guidance Documents, not the infrastructure developments themselves. Senior Leaders across the Trust provide attendance at multiple Networks and Workstream Meetings hosted by the Once for Wales Shared Services Team, but there is no central Governance Forum to share outputs from these networks or approve requests for change or developments on the Trusts behalf, before submission in these fora.

30. Creation of self-serve reporting and exporting of data needs to have clear guidance and governance to ensure that information being reviewed and exported was an accurate representation of the individual need. Ensuring the correct data definitions and appropriate fields for reporting was key to consistency in information provided both for internal and external assurance and reporting. In addition, governance arrangements require clear accountability lines and provision of assurance in the quality of system content and data exports.

Content Quality

31. The quality of content within the Datix Platforms forms the responsibility of all users, Specialist Content Teams and the Datix System Team. The current configuration and maintenance of the system lacks structure and requires review to understand the profiles and security groupings available and how these could be better standardised to ensure equity of access.

32. The quality of content being entered by reporters is having an impact on the quality and timeliness of investigations, as well as the thematic analysis for improvement opportunities. Often records are sparsely populated, possibly due to time constraints, with a review of content identifying prolific use of N/A, see above or a full stop to move through mandatory fields. System knowledge, encompassing the why as well as the what, is required to ensure that appropriate quantity and quality of content is recorded with consideration of relevance of content and completeness of records. Lack of information will impact on the quality of any investigation undertaken. Importantly constructive and consistent feedback cannot be provided where entries of this kind are completed in the feedback field. This impacts on the value felt by reporters as they will have no understanding of the investigations undertaken or the outcome reached by the Investigating Officer. Where reporters don't feel their contribution is valued or is impacting improvement this may drive further poor-quality reports.

33. The engagement of relevant Content Teams, such as Health & Safety or Patient Safety Teams, is pivotal to the quality of investigations and documentation within the Platform. Lack of guidance, governance and structure has led to the Datix Platforms being used to record information outside of their normal purpose which has impacted on the effectiveness of the Platform to identify organisational learning. This practice has been identified by Quality Management Group and improvement activities have now reduced the volume of this content moving forward, however the historic open records associated with this activity remains unresolved creating an unsafe system where harm and learning cannot be easily identified.

34. The design of RL Datix Cymru to meet the needs of all health bodies within Wales was always going to present challenges, particularly for those non-Health Board

bodies such as WAST. It has become increasingly evident that update requests are urgently required to address key issues such as person affected data and contact details required for Duty of Candour triggering and reporting. Our operating environment in the pre-hospital environment does not always allow that and as such impacts on the quality of our reporting.

Business Intelligence

35. The volume and quality of reports generated within the RL Datix Cymru Platform is adding to the lack of structure surrounding the system, creating duplication and introducing variance in outcome data. Duplication and variance introduce a lack of confidence in the validity of the data and impacts our ability to thematically analyse areas for learning and improvement within our systems. In order to have assurance of the reporting provided, particularly for external reporting standards, it is important to have a single source of truth ideally held centrally in the Data Warehouse.

36. Centrally held data will provide the opportunity for quality assured reporting across the organisation to support not only external reporting requirements but also the ability for internal Dashboards to support a robust Quality Management System delivered locally. This approach to qualitative reporting would also allow clear data definitions of the fields used to ensure consistent reporting metrics with properly governed naming conventions allowing for a Technical Guidance Document to support self-service reporting opportunities.

Information Governance

37. As previously referenced the current configuration of the Datix Platforms requires review and structure particularly when considering access profiles and Security Groups. A review of these profiles and security groups will give assurance that we are adhering to GDPR Regulations in regard to access to information, as well as identifying permissions and structures in place to close incidents and release data outside of the organisation. It was identified during the Workshop that notification lists are excessively broad resulting in unnecessary access to personal identifiable information for Managers who do not require it.

38. Clear governance documentation such as Policy and Procedure Documents should consider how information is uploaded and downloaded from Datix Platforms to support reporting and investigation purposes. Feedback during the Workshop acknowledged that teams often store information on local devices or SharePoint in order to connect with the Datix Platforms but there is no assurance that this information is then deleted locally once stored on the central Database. This creates information governance concerns.

39. In addition, the Datix Platform is not currently maintained against the agreed retention schedule for the organisation. Whilst this may not be unique to WAST strong information governance is required across all our platforms to ensure we are not storing personal identifiable information inappropriately.

Education

40. Key to the success of Development and Improvement Plans across the use of Datix Platforms is the importance of education, training and awareness throughout the organisation. There is currently no formal training structure for the use, and management of, records across the modules including within the Datix Platforms. Whilst there are currently varying practices in place across teams including bite size training sessions, 1:1 training and digital user guides there is a lack of governance around the quality assurance of the training and/or training materials provided.

41. The development of robust and quality assured training, with a back to basics focus, is required including Training Schedules that are achievable for those delivering the content and valuable to those receiving it. Training needs to be meaningful for the intended audience and when aligned with the importance of feedback for reporters will help the broader workforce understand the importance and value in reporting near miss and adverse events.

Corporate Governance

42. When considering the infrastructure and improvement opportunities within the Datix Platforms Corporate Governance Teams are key internal stakeholders due to their responsibilities for policy, risk management and facilitation of Freedom of Information requests. The Assistant Director of Corporate Governance and Risk joined the Workshop and provided strategic direction in this area.

43. Risk management transformation is currently underway within the Trust and consideration has also been given to the contract limitations for Datix Web which houses the current Risk Module, the cost implications for the Datix Web infrastructure as well as the life span of the internal server structure which houses it.

Improvement Opportunities

44. Improvement opportunities were documented throughout the Workshop and were aligned to a Priority Matrix for delivery of key essential activity through to longer term developmental initiatives with an overarching requirement to consider education at every level of the Recovery Plan.

45. This matrix was then used to develop the Recovery Plan document with activities aligned to key stakeholders across the organisation.

RECOMMENDED that the Quality, Patient Experience & Safety Committee:

(1) Notes the current risks and challenges within the Datix Web and RL Datix Cymru platforms; and

(2) Notes the attached Recovery and Improvement Plan designed to mitigate the challenges stepped out in this paper.

Once for Wales Concerns Management System

Datix Cymru - System Health Check

Organisation: Welsh Ambulance Service University NHS Trust (WAST)

Date of Report: 20th September 2024

Report produced by: Maria Stolzenberg, Principal Systems Lead

Contents

1. Summary

The Datix Cymru System Health Check was carried out by the Once for Wales CMS (OfWCMS) Central Team following a request from the WAST Leadership team. The Health Check aims to identify issues requiring action along with sharing good practice in the use of the system. The review focusses' on the areas of system administrative functions that are controlled by the WAST Local System Leads (LSL's).

Administration of Datix Cymru is partially devolved, with operational functionality in the control of LSL's who are appointed by a Health Body. Some administrative functions are reserved to the OfWCMS Central Team. The appointed WAST LSL's received comprehensive training from RLDatix and the OfWCMS Central Team. This training provided confirmation and expected actions on how to manage Security Groups, Profiles, Users, Locations and Services. During the system implementation phase the appointed WAST LSL's were provided with training in optimum hieratical design for effective use of Datix Cymru.

In this Health Check, issues were identified with the Security Group and Profiles, as well as potential issues where users are not being reviewed and managed. A review of Locations and Services to best meet the needs of WAST is also recommended. Full details of the issues identified are contained in this report with recommendations for improvement. A summary of the actions recommended is provided in Appendix B.

2. Overview

2.1. Modules in current use

- Incidents
- Feedback
- Claims and Inquests
- Mortality Review
- Redress
- Dashboards
- Actions
- Contacts
- Medication

2.2. Scope of the System Health Check

The Health Check focussed on the set up of the following parts of the system:

- Capture Security Groups
- Capture Profiles
- Reports (high level view)
- Locations & Services
- Users

2.3. Conduct

The System Health Check was conducted by Once for Wales CMS Central Team between 03/09/2024 and 09/09/2024.

3. Capture Administration

3.1. Security Groups

3.1.1. Background

Security groups allow you to set up and control record level access for application users.

Security groups specify which records users can access and with what level of permissions. In some modules, security groups also allow you to separate users' ability to receive email notification about records from users' ability to access these records through searches and reports functionality.

Once created, security groups can be added to profiles, they can also be added directly to user accounts. Unlike with profiles (users can only be assigned one profile each), you can assign your users to as many security groups as required. A user takes on the record access permissions associated with each of the security groups to which the user belongs.

3.1.2. Health Check Findings

REF	Finding	Action	Benefit
3.1.2.1	There are 111 Security groups in the system.	Review all security groups and identify if there are any gaps.	Having the correct security groups ensures that users have access to the correct records.
3.1.2.2	Security groups are not consistently named and do not follow the best practice guidance of *module name - Access Level - access to which record types - email or no email.*	Review all the security groups to ensure that they follow the best practice naming convention.	A consistent naming convention makes it easier to identify security groups correctly.
3.1.2.3	Group 121 gives access to multiple modules. While it is possible to create these groups, it is considered extremely bad practice to do so and RLDatix advise against the use of them.	Delete group 121 and replace with groups for individual models.	Having individual groups for each module allows for better control over access and reduces admin.
3.1.2.4	There are several groups where the record access given by the WHERE clause does not match the access described in the name of the group. Example Groups: 117, 118, 103 This is can lead to confusion when assigning groups.	Review all the security groups to ensure that the WHERE clause and the access in the group's name match.	Ensuring that the WHERE clause matches the description of the group makes it easier to identify security groups correctly.
3.1.2.5	The only security group for Dashboards gives full access, meaning that all users can create them.	Amend security groups to remove access from all users to only users that require it.	Having the correct security groups ensures that users have access to the correct records.

3.2. Profiles

3.2.1 Background

Profiles organise application users into easy-to-manage clusters based on certain characteristics (e.g., job role, geographic location and so on). Using profiles allows you to tailor the organisation-wide Datix Cymru system configuration settings to specific user population. Profiles also enable you to configure a number of the configuration settings, which are not available organisation-wide.

3.2.2 Health Check Findings

<table>
<tr><th>REF</th><th>Finding</th><th>Action</th><th>Benefit</th></tr>
<tr><td>3.2.2.1</td><td>There are 95 Profiles. This is a large number of Profiles for a system.

As an example, Profile #24 - '111 Clinical / Site Leads' has the same permissions as, Profile #49 - 'Clinical Leads Regional'</td><td>Review all the Profiles and look at merging ones that are giving similar access.</td><td>Reduces the admin burden and ensures consistency of user access to groups of staff.</td></tr>
<tr><td>3.2.2.2</td><td>Profiles have inconsistent naming conventions and the profile descriptions do not follow best practice of stating who the Profile is relevant to and what access it gives.

For example:<table><tr><td>Name</td><td>Description</td></tr><tr><td>Clinical Leads Regional</td><td>Row 51</td></tr><tr><td>Incident Handler/Investigator General</td><td>Incident Access For Handlers/Investigators</td></tr><tr><td>Quality Bot</td><td>Incidents access</td></tr></table>See Section 5.2. for a list of all profiles</td><td>Review the naming convention of Profiles. Improve the descriptions so that they clearly show:
What the user roles the profile is relevant to.
What module access is attached to the profile, including what type of records and the level of access given.
Any configuration settings that are relevant e.g. if they grant users the ability to reject contacts, generate records from another record or copy incidents.</td><td>Makes it easier to identify that users are in the correct profile, with the correct access levels.</td></tr>
<tr><td>3.2.2.3</td><td>A default profile is set for new users that gives 'reporter only' access to a limited set of modules.</td><td>None</td><td>It is good practice to automatically place new users in a limited access profile.</td></tr>
<tr><td>3.2.2.4</td><td>Profile permissions appear to be appropriate for the users attached to them</td><td>None</td><td>Setting appropriate permissions in a profile ensures that users are not able to perform actions such as copying records and removing attachments from records. It also ensures that they have forms that are appropriate for their role.</td></tr>
</table>

3.3. Reports Administration and Dashboards

3.3.1. Background

The Reports Administration screen allows LSL's to create base listing reports and design packaged reports that can accessed by users via the 'my reports' menu in each Capture module. This means that you can create standardised reports across the whole organisation and run with minimal input for the user.

Dashboards provide a way of sharing a collection of reports that update every time the Dashboard is opened.

3.3.2. Health Check Findings

REF	Finding	Action	Benefit
3.3.2.1	A dashboard creation account is in use.	Check that the dashboard creation account has appropriate permissions and who has access to it.	A dashboard account allows dashboards and reports to be created by a single user account, getting around the issue of dashboard access when the person creating them leaves or is unavailable.
3.3.2.2	There are packaged reports available in the Capture modules.	Check that the packaged reports match user requirements.	Packaged reports, assigned to the appropriate users, reduce the report generation burden.

4. System Administration

4.1. Users

4.1.1. Background

User accounts are used to manage user access to features and records in Datix Cymru and to configure various feature-related preferences.

4.1.2. Health Check Findings

REF	Finding	Action	Benefit
4.1.2.1	Total of 3800 users. 2697 of these waiting for review, so at first review it could look like they haven't been checked by a LSL.	Review all unverified users and check that they are assigned to the correct profiles.	Reviewing users after they authenticate for the first time ensures that they are in the correct User Group and Profile.
4.1.2.2	There are 38 users that are not assigned to a capture profile.	Review users not assigned to a capture profile and assign to an appropriate profile.	Profiles ensure that users have the correct access permissions.
4.1.2.3	There are 97 users who appear to have never logged into the system. Of these users 65 are set to appear in the staff dropdown lists.	Review users who have not logged in and appear in drop down options and update their user accounts as necessary.	Good user housekeeping ensures that users have appropriate access and those that are no longer with the organisation are not assigned to active records.
4.1.2.4	There are 2399 users who have not logged in for over 90 days. There are 941 users who have not logged in for over 365 days. There are 200 users who have not logged in for over 730 days. There are 4 users who have not logged in for over 1000 days.	Review users who have not logged in for an extended period and update their user accounts as necessary.	Good user housekeeping ensures that users have appropriate access and those that are no longer with the organisation are not assigned to active records.

4.2. Services and Locations

4.2.1. Background

The Locations module allows you to create and manage a hierarchy of physical locations in your organisation.

The Services module allows you to create and manage a hierarchy of services provided by your organisation.

Both the Service and Location structure should match the structures used in other systems across the organisation.

4.2.2. Health Check Findings

REF	Finding	Action	Benefit
4.2.2.1	The locations are structured by the NHS Wales Health Board geography.	Review the locations available in the system and verify that they match the locations used by internal reporting and analytics teams, adjusting as necessary. (effect the change from 01/04/2025)	Ensures that any reports generated from data in the Datix Cymru system match up with data provided from other systems.
4.2.2.2	The Services structure includes levels that are not part of WAST e.g. GP practices and pharmacy services. It is recognised that WAST provide care in a range of environments and it is important to verify services are appropriate.	Review the Services and check that they match the locations used by internal reporting and analytics teams.	Ensures that any reports generated from data in the Datix Cymru system match up with data provided from other systems.
4.2.2.3	There is a limited use of Tags within the Locations and Services modules.	Review the current Tag list and add more as needed. Add Tags to Locations and Services to use them in reporting.	Tags provide an easy way to group service and location types for report generation.

5. Appendix A - Capture Administration

5.1. Security Groups

ID	Group Name	Description	Group Type	WHERE Clause
1	Mortality - Record Access - Full Access - Email Notification ON	Mortality - Record Access - Full Access - Email Notification ON	Record access and email notification	1=1
2	Incidents - All Records - Final Approval - Email notification LSL	Incidents - All Records - Final Approval - Email notification LSL	Record access and email notification	1=1
3	Contacts - Full access -all staff	Contacts - Full access - all staff	Record access	1=1
4	Actions Dashboard - Full Access	Actions Dashboard - Full Access	Record access	1=1
6	Incidents - Input Only	Incidents - Input Only	Record access	1=1
7	Redress - full access - no emails	Redress - full access - no emails	Record access	1=1
8	Feedback - Full access to FEE2 - NO EMAILS	Feedback - Full access to FEE2 - NO EMAILS	Record access	1=1

ID	Group Name	Description	Group Type	WHERE Clause
10	Feedback10 - Full access to COM2 - when assigned as handler, manager or investigator - email ON	Feedback - Full access to COM2 - when assigned as handler, manager or investigator - email ON	Record access and email notification	compl_main.recordid IN (SELECT compl_main.recordid FROM compl_main WHERE (((compl_main.com_curstage IN ('INV'))) AND ((compl_main.com_type IN ('COMPLA'))) AND ((compl_main.com_mgr = '@user_initials')) OR ((compl_main.com_head = '@user_initials')) OR (((compl_main.com_investigator LIKE '@user_initials' OR compl_main.com_investigator LIKE '@user_initials %' OR compl_main.com_investigator LIKE '% @user_initials' OR compl_main.com_investigator LIKE '% @user_initials %')))) GROUP BY compl_main.recordid)
11	Feedback - Full access to COM2 - if Service area = EMS OPS - NO EMAILS	Feedback - Full access to COM2 - if Service area = EMS OPS - NO EMAILS	Record access	compl_main.recordid IN (SELECT compl_main.recordid FROM compl_main WHERE (((compl_main.service_id = '@user_initials'))) GROUP BY compl_main.recordid)
12	Feedback12 - Full access based on service AND location - WITH EMAILS	Feedback - Full access based on service AND location - WITH EMAILS	Record access and email notification	compl_main.recordid IN (SELECT compl_main.recordid FROM compl_main WHERE (((compl_main.location_id = '@user_location_id')) AND ((compl_main.service_id = '@user_service_id'))) GROUP BY compl_main.recordid)
13	Feedback - Read Only - All NEPTS Complaints - NO EMAILS	Feedback - Read Only - All NEPTS Complaints - NO EMAILS	Record access	compl_main.recordid IN (SELECT compl_main.recordid FROM compl_main WHERE (((compl_main.service_id IN (SELECT lchild.id FROM location lparent LEFT JOIN location lchild ON lparent.[left] <= lchild.[left] AND lchild.[left] < lparent.[right] WHERE lparent.id = '89')))) GROUP BY compl_main.recordid)
14	Feedback - Full Access EMS CCC Complaints - No Emails	Service searched for as CCC	Record access	compl_main.recordid IN (SELECT compl_main.recordid FROM compl_main WHERE (((compl_main.service_id IN ('69')))) GROUP BY compl_main.recordid)
15	Feedback15 - Full access to COM2 EMS CCC complaints by service area - emails OFF	Feedback - Full access to COM2 EMS CCC complaints by service area - emails OFF	Record access	compl_main.recordid IN (SELECT compl_main.recordid FROM compl_main WHERE (((compl_main.service_id IN (SELECT DISTINCT id FROM service WHERE [left] BETWEEN (SELECT [left] from service where id =69) AND (SELECT [right] from service where id =69))))) GROUP BY compl_main.recordid)

ID	Group Name	Description	Group Type	WHERE Clause
16	Feedback - Full access all EMS CCC Complaints and User Location - With Emails	Feedback - Full access all EMS CCC Complaints and User Location - With Emails	Record access and email notification	compl_main.recordid IN (SELECT compl_main.recordid FROM compl_main WHERE (((compl_main.location_id = '@user_initials')) AND ((compl_main.service_id IN ('69')))) GROUP BY compl_main.recordid)
18	Feedback18 - Full access to COM2 based on Location OR Service - With No Emails	Feedback - Full access to COM2 based on Location OR Service - With No Emails	Record access	compl_main.recordid IN (SELECT compl_main.recordid FROM compl_main WHERE (((compl_main.location_id = '@user_location_id')) OR ((compl_main.service_id = '@user_service_id'))) GROUP BY compl_main.recordid)
19	Feedback - Full access to COM2 - all NHSDW/11 Complaints + @user location - WITH EMAILS	Feedback - Full access to COM2 - all NHSDW/11 Complaints + @user location - WITH EMAILS	Record access and email notification	compl_main.recordid IN (SELECT compl_main.recordid FROM compl_main WHERE (((compl_main.location_id = '@user_initials')) AND ((compl_main.service_id IN ('100','101','102','103','104','105','106','107','108','109')))) GROUP BY compl_main.recordid)
23	Feedback - Full access by Primary location AND Service - Emails OFF	Feedback - Full access by primary location AND service - Emails OFF	Record access	compl_main.recordid IN (SELECT compl_main.recordid FROM compl_main WHERE (((compl_main.location_id = '@user_location_id')) AND ((compl_main.service_id = '@user_service_id'))) GROUP BY compl_main.recordid)
24	Redress - Full access with emails	Redress - Full access with emails	Record access	1=1
25	Claims - Full access with emails	Claims - Full access with emails	Record access and email notification	1=1

ID	Group Name	Description	Group Type	WHERE Clause
26	Claims - Full access - no emails	Claims - Full access - no emails	Record access	1=1
27	Safeguarding - Full access & ability to close records - no emails	Safeguarding - Full access & ability to close records - no emails	Record access	1=1
29	Safeguarding - Full access & NO ability to close records - no emails	Safeguarding - Full access & NO ability to close records - no emails	Record access	1=1
30	Safeguarding - Full access & NO ability to close records - WITH EMAILS	Safeguarding - Full access & NO ability to close records - WITH EMAILS	Record access and email notification	1=1
31	Feedback - FEE1 input only - no emails	Feedback - FEE1 input only - no emails	Record access	1=1
32	Actions assigned to	Actions assigned to	Record access and email notification	ca_actions.recordid IN (SELECT ca_actions.recordid FROM ca_actions WHERE (((ca_actions.act_to_inits = '@user_initials'))) GROUP BY ca_actions.recordid)
33	Organisation - Full Access - No Emails	Organisation - Full Access - No Emails	Record access	1=1
34	Payments - full access	Payments - full access - No Email	Record access	1=1
35	Local System Leads - User Admin - NO EMAILS	Local System Leads - User Admin - NO EMAILS	Record access	1=1

ID	Group Name	Description	Group Type	WHERE Clause
36	Dashboard - Full access	Dashboard - Full access	Record access	
38	INC38 - Final Approval Access All Records - @User = Incident Manager/Investigator email ON or Access to the Incident	INC38 - Final Approval Access All Records - @User = Incident Manager/Investigator email ON or Access to the Incident	Record access and email notification	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main LEFT JOIN udf_values AS udf_1 ON (((incidents_main.recordid = udf_1.cas_id AND udf_1.mod_id = '3' AND udf_1.field_id = '835' AND udf_1.group_id = '0'))) WHERE (((incidents_main.inc_mgr = '@user_initials')) OR (((udf_1.udv_string LIKE '@user_initials' OR udf_1.udv_string LIKE '@user_initials %' OR udf_1.udv_string LIKE '% @user_initials' OR udf_1.udv_string LIKE '% @user_initials %'))) OR (((incidents_main.inc_investigator LIKE '@user_initials' OR incidents_main.inc_investigator LIKE '@user_initials %' OR incidents_main.inc_investigator LIKE '% @user_initials' OR incidents_main.inc_investigator LIKE '% @user_initials %')))) GROUP BY incidents_main.recordid)
46	INC46 - Review access & Email notification linked to Reporters Location AND Service OR Investigator or handler (mgr)	INC46 - Review access & Email notification linked to Reporters Location AND Service OR Investigator or handler (mgr)	Record access and email notification	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main WHERE (((incidents_main.inc_mgr = '@user_initials')) OR ((incidents_main.other_location = '@user_location_id')) AND ((incidents_main.other_service = '@user_service_id')) OR (((incidents_main.inc_investigator LIKE '@user_initials' OR incidents_main.inc_investigator LIKE '@user_initials %' OR incidents_main.inc_investigator LIKE '% @user_initials' OR incidents_main.inc_investigator LIKE '% @user_initials %')))) GROUP BY incidents_main.recordid)
50	INC50 - Review Access if @User=Reporters Service - No email Notification	INC - Review Access if @User=Reporters Service - No email Notification	Record access	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main WHERE (((incidents_main.other_service = '@user_service_id'))) GROUP BY incidents_main.recordid)
51	INC51 - Final Approval with Email Notification based on Reporters Service	INC - Final Approval with Email Notification based on Reporters Service	Record access and email notification	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main WHERE (((incidents_main.other_service = '@user_service_id'))) GROUP BY incidents_main.recordid)

ID	Group Name	Description	Group Type	WHERE Clause
52	INC52 - Final Approval with Email Notification of Medication Incidents (Type) Or Additional Information	INC - Final Approval with Email Notification of Medication Incidents (Type) Or Additional Information	Record access and email notification	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main WHERE (((incidents_main.inc_type_tier_one IN ('TR15'))) OR ((incidents_main.show_medication IN ('Y')))) GROUP BY incidents_main.recordid)
53	INC - Review Access with Email Notification of Medication Incidents (Type) Or Additional Information	INC - Review Access with Email Notification of Medication Incidents (Type) Or Additional Information	Record access	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main WHERE (((incidents_main.inc_type_tier_one IN ('TR15'))) OR ((incidents_main.show_medication IN ('Y')))) GROUP BY incidents_main.recordid)
54	INC54 - Final approval & Email Notification linked to medication (type) OR additional info medication incident = Y	INC54 - Final approval & Email Notification linked to medication (type) OR additional info medication incident = Y	Record access and email notification	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main WHERE (((incidents_main.inc_type_tier_one IN ('TR15'))) OR ((incidents_main.show_medication IN ('Y')))) GROUP BY incidents_main.recordid)
55	INC - Review Access and Email Notification On Infection Related Incidents or if COVID 19 related	INC - Review Access and Email Notification On Infection Related Incidents or if COVID 19 related	Record access and email notification	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main LEFT JOIN udf_values AS udf_1 ON (((incidents_main.recordid = udf_1.cas_id AND udf_1.mod_id = '3' AND udf_1.field_id = '156' AND udf_1.group_id = '0'))) WHERE (((incidents_main.inc_type_tier_one IN ('TR10'))) OR ((udf_1.udv_string IN ('YES')))) GROUP BY incidents_main.recordid)

ID	Group Name	Description	Group Type	WHERE Clause
56	INC56 - Review Access and Email Notification On Type = Equipment Related Incidents or if Additional Info Equipment = Yes	INC - Review Access and Email Notification On Type = Equipment Related Incidents or if Additional Info Equipment = Yes	Record access and email notification	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main WHERE (((incidents_main.inc_type_tier_two IN ('T178','T74','T100'))) OR ((incidents_main.show_equipment IN ('Y')))) GROUP BY incidents_main.recordid)
57	INC - Review Access and Email Notification On Sub Type PPE	INC - Review Access and Email Notification On Sub Type PPE	Record access and email notification	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main WHERE (((incidents_main.inc_type_tier_two IN ('T100')))) GROUP BY incidents_main.recordid)
59	INC59 - Final Approval with access to all records and Email notification linked to Type = S/G or Additional Info = Safeguarding Y/DK	INC59 - Final Approval with access to all records and Email notification linked to Type = S/G or Additional Info = Safeguarding Y/DK	Record access and email notification	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main LEFT JOIN udf_values AS udf_1 ON (((incidents_main.recordid = udf_1.cas_id AND udf_1.mod_id = '3' AND udf_1.field_id = '171' AND udf_1.group_id = '0'))) WHERE (((incidents_main.inc_type_tier_one IN ('TR22'))) OR ((udf_1.udv_string IN ('YES','DONTKN')))) GROUP BY incidents_main.recordid)
60	INC60 - Final Approval if Type=Records Management - Email Yes	INC - Final Approval if Type=Records Management - Email Yes	Record access and email notification	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main WHERE (((incidents_main.inc_type_tier_one IN ('TR20')))) GROUP BY incidents_main.recordid)

ID	Group Name	Description	Group Type	WHERE Clause
61	INC - Review access and Email notification Manual Handling (sub type) incidents	INC - Review access and Email notification Manual Handling (sub type) incidents	Record access and email notification	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main WHERE (((incidents_main.inc_type_tier_two IN ('T71','T72')))) GROUP BY incidents_main.recordid)
62	INC - Review access and Email notification Violence & Aggression (Type Abuse) incidents	INC - Review access and Email notification Violence & Aggression (Type Abuse) incidents	Record access and email notification	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main LEFT JOIN udf_values AS udf_1 ON (((incidents_main.recordid = udf_1.cas_id AND udf_1.mod_id = '3' AND udf_1.field_id = '176' AND udf_1.group_id = '0'))) WHERE ((((udf_1.udv_string LIKE 'NOT8' OR udf_1.udv_string LIKE 'NOT8 %' OR udf_1.udv_string LIKE '% NOT8' OR udf_1.udv_string LIKE '% NOT8 %')))) GROUP BY incidents_main.recordid) OR incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main WHERE (((incidents_main.inc_type_tier_one IN ('TR5')))) GROUP BY incidents_main.recordid)
63	INC63 - Review Access and Email Notification if subtype = Needlestick injuries	INC63 - Review Access and Email Notification if subtype = Needlestick injuries	Record access and email notification	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main WHERE (((incidents_main.inc_type_tier_two IN ('T32')))) GROUP BY incidents_main.recordid)
65	INC- Final Approval and Email notification Covid related Incidents	INC- Final Approval and Email notification Covid related Incidents	Record access and email notification	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main LEFT JOIN udf_values AS udf_1 ON (((incidents_main.recordid = udf_1.cas_id AND udf_1.mod_id = '3' AND udf_1.field_id = '156' AND udf_1.group_id = '0'))) WHERE (((udf_1.udv_string IN ('YES')))) GROUP BY incidents_main.recordid)
66	INC- Final Approval with No Email notification Covid related Incidents	INC- Final Approval with No Email notification Covid related Incidents	Record access	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main LEFT JOIN udf_values AS udf_1 ON (((incidents_main.recordid = udf_1.cas_id AND udf_1.mod_id = '3' AND udf_1.field_id = '156' AND udf_1.group_id = '0'))) WHERE (((udf_1.udv_string IN ('YES')))) GROUP BY incidents_main.recordid)

ID	Group Name	Description	Group Type	WHERE Clause
70	Incidents - Full access & Review of - All records - No email	Incidents - Full access & Review of - All records - No email	Record access	1=1
71	INC71 - Final Approval D2 - Full access all incidents with email notification	INC - Final Approval - Full access to all incidents with email notification	Record access and email notification	1=1
73	ID 73 Doms - Closure of incidents no harm or low harm by Location & Service	Closure of Incidents by Doms where no harm or low harm based on Service and Location	Record access and email notification	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main WHERE (((incidents_main.inc_level_harm IN ('NONE','LOW'))) AND ((incidents_main.other_location = '@user_location_id')) AND ((incidents_main.other_service = '@user_Service_id'))) GROUP BY incidents_main.recordid)
80	INC80 - Final Approval - email notification & record access linked to reporters location OR service area	INC80 - Final Approval - email notification & record access linked to reporters location OR service area	Record access and email notification	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main WHERE (((incidents_main.other_location = '@user_location_id')) OR ((incidents_main.other_service = '@user_service_id'))) GROUP BY incidents_main.recordid)
81	INC - Deny Access sensitive issue	INC - Deny Access sensitive issue	Deny access	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main LEFT JOIN udf_values AS udf_1 ON (((incidents_main.recordid = udf_1.cas_id AND udf_1.mod_id = '3' AND udf_1.field_id = '160' AND udf_1.group_id = '0'))) WHERE (((udf_1.udv_string IN ('Y')))) GROUP BY incidents_main.recordid)

ID	Group Name	Description	Group Type	WHERE Clause
82	INC82 - Final Approval all incidents linked to Reporters Location AND Service Area_notification emails on	INC82 - Final Approval all incidents linked to Reporters Location AND Service Area_notification emails on	Record access and email notification	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main WHERE (((incidents_main.other_location = '@user_location_id')) AND ((incidents_main.other_service = '@user_service_id'))) GROUP BY incidents_main.recordid)
84	Insurance Policies - Full access to all records	Insurance Policies - Full access to all records	Record access	1=1
85	User admin - full access	User admin - full access	Record access	1=1
87	INC87 - Final Approval - reporter & incident service = CCC, cdesk, EMStaxi, - Email notification ON	INC - Final Approval - reporter & incident service = CCC, cdesk, EMStaxi, - Email notification ON	Record access and email notification	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main WHERE (((incidents_main.service_id IN (SELECT DISTINCT id FROM service WHERE [left] BETWEEN (SELECT [left] from service where id =82) AND (SELECT [right] from service where id =82) OR [left] BETWEEN (SELECT [left] from service where id =68) AND (SELECT [right] from service where id =68) OR [left] BETWEEN (SELECT [left] from service where id =82) AND (SELECT [right] from service where id =82)))) AND ((incidents_main.other_service IN (SELECT DISTINCT id FROM service WHERE [left] BETWEEN (SELECT [left] from service where id =69) AND (SELECT [right] from service where id =69) OR [left] BETWEEN (SELECT [left] from service where id =82) AND (SELECT [right] from service where id =82) OR [left] BETWEEN (SELECT [left] from service where id =68) AND (SELECT [right] from service where id =68))))) GROUP BY incidents_main.recordid)
88	Leavers staff / employees	Leavers staff / employees	Deny access	

ID	Group Name	Description	Group Type	WHERE Clause
89	INC89 - Review Access if Incident Mgr / Investigator / Who else reqs Access - emails ON	INC Review Access & Emails on if Incident Mgr OR Investigator	Record access and email notification	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main LEFT JOIN udf_values AS udf_1 ON (((incidents_main.recordid = udf_1.cas_id AND udf_1.mod_id = '3' AND udf_1.field_id = '835' AND udf_1.group_id = '0'))) WHERE (((incidents_main.inc_mgr = '@user_initials')) OR (((udf_1.udv_string LIKE '@user_initials' OR udf_1.udv_string LIKE '@user_initials %' OR udf_1.udv_string LIKE '% @user_initials' OR udf_1.udv_string LIKE '% @user_initials %'))) OR (((incidents_main.inc_investigator LIKE '@user_initials' OR incidents_main.inc_investigator LIKE '@user_initials %' OR incidents_main.inc_investigator LIKE '% @user_initials' OR incidents_main.inc_investigator LIKE '% @user_initials %')))) GROUP BY incidents_main.recordid)
90	INC90 - Review access only - No Email notification OFW	INC - Review access only - No Email notification OFW	Record access	1=1
91	INC91 - Infection Control Type - COVID Y - Closure Y - Email notification ON	INC91 - Infection Control Type - COVID Y - Closure Y - Email notification ON	Record access and email notification	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main LEFT JOIN udf_values AS udf_1 ON (((incidents_main.recordid = udf_1.cas_id AND udf_1.mod_id = '3' AND udf_1.field_id = '156' AND udf_1.group_id = '0'))) WHERE (((incidents_main.inc_type_tier_one IN ('TR10'))) OR ((udf_1.udv_string IN ('YES')))) GROUP BY incidents_main.recordid) OR incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main WHERE (((incidents_main.inc_type_tier_one IN ('TR2'))) AND ((incidents_main.inc_type_tier_two IN ('T32')))) GROUP BY incidents_main.recordid)
92	INC92 - Information Governance type - IG issues Y DK - Closure Y - Email notification ON	INC - Information Governance type - IG issues Y DK - Closure Y - Email notification ON	Record access and email notification	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main LEFT JOIN udf_values AS udf_1 ON (((incidents_main.recordid = udf_1.cas_id AND udf_1.mod_id = '3' AND udf_1.field_id = '166' AND udf_1.group_id = '0'))) LEFT JOIN udf_values AS udf_2 ON (((incidents_main.recordid = udf_2.cas_id AND udf_2.mod_id = '3' AND udf_2.field_id = '176' AND udf_2.group_id = '0'))) WHERE (((incidents_main.inc_type_tier_one IN ('TR11'))) OR ((udf_1.udv_string IN ('YES','DONTKN'))) OR (((udf_2.udv_string LIKE 'NOT12' OR udf_2.udv_string LIKE 'NOT12 %' OR udf_2.udv_string LIKE '% NOT12' OR udf_2.udv_string LIKE '% NOT12 %')))) GROUP BY incidents_main.recordid)

ID	Group Name	Description	Group Type	WHERE Clause
93	INC93 - Final Approval - Record Access & Email ON if Sub subtype = MPDS	INC - Final Approval - Record Access & Email ON if Sub subtype = MPDS	Record access and email notification	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main WHERE (((incidents_main.inc_mgr = '@user_initials')) OR ((incidents_main.inc_type_tier_three IN ('TR686','TR22','TR871','TR23','TR889','TR21','TR868','TR870','TR869'))) OR (((incidents_main.inc_investigator LIKE '@user_initials' OR incidents_main.inc_investigator LIKE '@user_initials %' OR incidents_main.inc_investigator LIKE '% @user_initials' OR incidents_main.inc_investigator LIKE '% @user_initials %')))) GROUP BY incidents_main.recordid)
94	INC94 - HART Review Access - Email ON - All Incidents relating to HART	INC - HART Review Access - Email ON - All Incidents relating to HART	Record access and email notification	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main WHERE (((incidents_main.other_location IN (SELECT DISTINCT id FROM location WHERE [left] BETWEEN (SELECT [left] from location where id =1583) AND (SELECT [right] from location where id =1583)))) OR ((incidents_main.other_service IN (SELECT DISTINCT id FROM service WHERE [left] BETWEEN (SELECT [left] from service where id =78) AND (SELECT [right] from service where id =78))))) GROUP BY incidents_main.recordid)
95	INC95 - Final Approval - Notification Email ON - Highly Confidential / Sensitive Issue Incidents	INC - Final Approval - Notification Email ON - Highly Confidential / Sensitive Issue Incidents	Record access and email notification	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main LEFT JOIN udf_values AS udf_1 ON (((incidents_main.recordid = udf_1.cas_id AND udf_1.mod_id = '3' AND udf_1.field_id = '160' AND udf_1.group_id = '0'))) WHERE (((udf_1.udv_string IN ('Y')))) GROUP BY incidents_main.recordid)
96	INC - Occupational Health Top 5	Access to IPC, Manual Handling, V&A, H&WB, Covid 19	Record access and email notification	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main LEFT JOIN udf_values AS udf_1 ON (((incidents_main.recordid = udf_1.cas_id AND udf_1.mod_id = '3' AND udf_1.field_id = '156' AND udf_1.group_id = '0'))) WHERE (((incidents_main.inc_affecting_tier_zero IN ('STF'))) AND ((incidents_main.inc_type_tier_one IN ('TR5','TR9','TR10','TR13','TR17','TR23','TR18','TR2'))) OR ((udf_1.udv_string IN ('YES')))) GROUP BY incidents_main.recordid)

ID	Group Name	Description	Group Type	WHERE Clause
97	INC97 - Final Approval - Email notification Y = Person Affected Patient / Organisation by reporter location	INC - Final Approval - Email notification Y = Person Affected Patient / Organisation by reporter location	Record access and email notification	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main WHERE (((incidents_main.inc_affecting_tier_zero IN ('ORG','PT123'))) AND ((incidents_main.other_location = '@user_location_id')) AND ((incidents_main.other_service = '@user_service_id'))) GROUP BY incidents_main.recordid)
99	Feedback11 - Record access if Handler-Investigator-Manager Email notification OFF	Feedback - Full access if Handler_Investigator_ Manager Email notification OFF	Record access	compl_main.recordid IN (SELECT compl_main.recordid FROM compl_main WHERE (((compl_main.com_type IN ('COMPLA'))) AND ((compl_main.com_mgr = '@user_initials')) AND ((compl_main.com_head = '@user_initials')) AND (((compl_main.com_investigator LIKE '@user_initials' OR compl_main.com_investigator LIKE '@user_initials %' OR compl_main.com_investigator LIKE '% @user_initials' OR compl_main.com_investigator LIKE '% @user_initials %')))) GROUP BY compl_main.recordid)
100	INC - Review access, email notification = vehicle & RTC by reporters location	INC - Review access, email notification = vehicle & RTC by reporters location	Record access and email notification	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main WHERE (((incidents_main.inc_type_tier_two IN ('T124','T157','T132'))) AND ((incidents_main.other_location = '@user_location_id'))) GROUP BY incidents_main.recordid)
101	INC101 - Review Access_All records - Email OFF	INC - Review Access_All records - Email OFF	Record access	1=1
102	INC102 - Final Approval - Incidents relating to Estates - Email Y	INC102 - Final Approval - Incidents relating to Estates - Email Y	Record access and email notification	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main LEFT JOIN udf_values AS udf_1 ON (((incidents_main.recordid = udf_1.cas_id AND udf_1.mod_id = '3' AND udf_1.field_id = '176' AND udf_1.group_id = '0'))) WHERE (((incidents_main.inc_type_tier_one IN ('TR13'))) AND ((incidents_main.inc_type_tier_two IN ('T22','T164','T24','T161','T49','T52','T89','T128','T132','T133','T136','T148','T150'))) OR (((udf_1.udv_string LIKE 'NOT3' OR udf_1.udv_string LIKE 'NOT3 %' OR udf_1.udv_string LIKE '% NOT3' OR udf_1.udv_string LIKE '% NOT3 %')))) GROUP BY incidents_main.recordid)

ID	Group Name	Description	Group Type	WHERE Clause
103	INC103 - Review access - email Yes - Type=Pt OR Org + Location OR Service=111	INC103 - Review access - email Yes - Type=Pt OR Org + Location OR Service=111	Record access and email notification	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main WHERE (((incidents_main.inc_affecting_tier_zero IN ('ORG','PT123'))) AND ((incidents_main.other_location = '@user_location_id')) OR ((incidents_main.other_service = '@user_location_id'))) GROUP BY incidents_main.recordid)
104	INC 104 - Review Access & Emails if Handler or Investigator if NEPTS ACS	INC - Review Access & Emails if Handler or Investigator if NEPTS ACS service	Record access and email notification	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main WHERE (((incidents_main.service_id IN (SELECT DISTINCT id FROM service WHERE [left] BETWEEN (SELECT [left] from service where id =99) AND (SELECT [right] from service where id =99))))) GROUP BY incidents_main.recordid)
105	INC105 - JESG Admin	INC105 - JESG Admin incident reported to all regions CCC	Record access	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main LEFT JOIN udf_values AS udf_1 ON (((incidents_main.recordid = udf_1.cas_id AND udf_1.mod_id = '3' AND udf_1.field_id = '440' AND udf_1.group_id = '0'))) LEFT JOIN udf_values AS udf_2 ON (((incidents_main.recordid = udf_2.cas_id AND udf_2.mod_id = '3' AND udf_2.field_id = '794' AND udf_2.group_id = '0'))) WHERE (((udf_1.udv_string IN ('REP2','REP1','REP3'))) OR ((udf_2.udv_string IN ('ABT2','ABT1','ABT3')))) GROUP BY incidents_main.recordid)
106	Mortality - Record Access - Full Access - No Emails	Mortality - Record Access - Full Access - No Emails	Record access	1=1
109	INC 109 - Handler/Investigator General	Incident Access For Handlers/Investigators with Email	Record access and email notification	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main WHERE (((incidents_main.inc_mgr = '@user_initials')) OR (((incidents_main.inc_investigator LIKE '@user_initials' OR incidents_main.inc_investigator LIKE '@user_initials %' OR incidents_main.inc_investigator LIKE '% @user_initials' OR incidents_main.inc_investigator LIKE '% @user_initials %')))) GROUP BY incidents_main.recordid)
110	Feedback 14 - Full Access to Compliments only	Feedback - Full Access to Compliments only	Record access	compl_main.recordid IN (SELECT compl_main.recordid FROM compl_main WHERE (((compl_main.com_type IN ('COMPLI')))) GROUP BY compl_main.recordid)

ID	Group Name	Description	Group Type	WHERE Clause
111	ACT1 - Actions Assigned from	Actions assigned from	Record access and email notification	ca_actions.recordid IN (SELECT ca_actions.recordid FROM ca_actions WHERE ((((ca_actions.act_from_inits LIKE '@user_initials' OR ca_actions.act_from_inits LIKE '@user_initials %' OR ca_actions.act_from_inits LIKE '% @user_initials' OR ca_actions.act_from_inits LIKE '% @user_initials %')))) GROUP BY ca_actions.recordid)
112	INC - full access no email notification for OFW Team (created by C Buckland)	INC - full access no email notification for OFW Team	Record access	1=1

113	Mortality - Full access & Email ON if @user = Initial Clinical Review	Mortality - Full access & Email ON if @user = Initial Clinical Review	Record access and email notification	mortality_main.recordid IN (SELECT mortality_main.recordid FROM mortality_main LEFT JOIN udf_values AS udf_1 ON (((mortality_main.recordid = udf_1.cas_id AND udf_1.mod_id = '48' AND udf_1.field_id = '504' AND udf_1.group_id = '0'))) LEFT JOIN udf_values AS udf_2 ON (((mortality_main.recordid = udf_2.cas_id AND udf_2.mod_id = '48' AND udf_2.field_id = '501' AND udf_2.group_id = '0'

```
)
)
)
LEFT JOIN udf_values AS udf_3 ON (
(
(
mortality_main.recordid = udf_3.cas_id
AND udf_3.mod_id = '48'
AND udf_3.field_id = '513'
AND udf_3.group_id = '0'
)
)
)
LEFT JOIN udf_values AS udf_4 ON (
(
(
mortality_main.recordid = udf_4.cas_id
AND udf_4.mod_id = '48'
AND udf_4.field_id = '514'
AND udf_4.group_id = '0'
```

```
)
)
)
LEFT JOIN udf_values AS udf_5 ON (
(
(
mortality_main.recordid = udf_5.cas_id
AND udf_5.mod_id = '48'
AND udf_5.field_id = '515'
AND udf_5.group_id = '0'
)
)
)
LEFT JOIN udf_values AS udf_6 ON (
(
(
mortality_main.recordid = udf_6.cas_id
AND udf_6.mod_id = '48'
AND udf_6.field_id = '516'
AND udf_6.group_id = '0'
```

ID	Group Name	Description	Group Type	WHERE Clause
				)
				)
				)
				WHERE (
				((mortality_main.reviewer = '@user_initials'))
				AND ((udf_1.udv_string IN ('5')))
				OR ((udf_2.udv_string = '@user_initials'))
				OR ((udf_3.udv_string = '@user_initials'))
				OR ((udf_4.udv_string = '@user_initials'))
				OR ((udf_5.udv_string = '@user_initials'))
				OR ((udf_6.udv_string = '@user_initials'))
				)
				GROUP BY mortality_main.recordid
				)

ID	Group Name	Description	Group Type	WHERE Clause
114	INC110 - Final Approval - email notification & record access for MRD OR Decontamination	INC110 - Final Approval - email notification & record access for MRD OR Decontamination	Record access and email notification	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main WHERE (((incidents_main.inc_type_tier_one IN ('TR10'))) AND ((incidents_main.inc_type_tier_two IN ('T143'))) OR ((incidents_main.service_id IN (SELECT DISTINCT id FROM service WHERE [left] BETWEEN (SELECT [left] from service where id ='79') AND (SELECT [right] from service where id ='79'))))) GROUP BY incidents_main.recordid)
115	INC - Access only	Incidents Read only access by Service	Record access	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main WHERE (((incidents_main.other_location = '@user_location_id')) AND ((incidents_main.other_service = '@user_service_id'))) GROUP BY incidents_main.recordid)

117	ID 117 DOMS or OTL Mgr or Investigator and harm is None or Low	EMS Doms or NEPTS OTL can close incs where mgr/investigator and harm level is none or low	Record access and email notification	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main WHERE (((((incidents_main.inc_mgr = '@user_initials')) OR (((incidents_main.inc_investigator LIKE '@user_initials' OR incidents_main.inc_investigator LIKE '@user_initials %' OR incidents_main.inc_investigator LIKE '% @user_initials' OR incidents_main.inc_investigator LIKE '% @user_initials %')))) AND (((incidents_main.inc_level_harm IN (

ID	Group Name	Description	Group Type	WHERE Clause
				'NONE' ,'LOW')))))) GROUP BY incidents_main.recordid)

118	ID118 Doms or NEPTS OTL If mgr or investigator for moderate and above then view and awaiting closure only	EMS Dom or NEPTS OTL inc mgr or investigator for moderate and above then view and awaiting closure only	Record access and email notification	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main WHERE (((incidents_main.inc_mgr = '@user_initials')) OR (((incidents_main.inc_investigator LIKE '@user_initials' OR incidents_main.inc_investigator LIKE '@user_initials %' OR incidents_main.inc_investigator LIKE '% @user_initials' OR incidents_main.inc_investigator LIKE '% @user_initials %')) AND ((incidents_main.inc_level_harm IN ('SEVERE' ,'MODERA' ,'DEATH'

ID	Group Name	Description	Group Type	WHERE Clause
				)
				)
				)
				)
				)
				GROUP BY incidents_main.recordid
				)

ID	Group Name	Description	Group Type	WHERE Clause
119	INC119 - FA Access to Incidents if Service=Renal or description=renal or dialysis	INC119 - FA Access to Incidents if Service=Renal or desc=renal or dialysis	Record access and email notification	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main WHERE (((incidents_main.service_id IN (SELECT DISTINCT id FROM service WHERE [left] BETWEEN (SELECT [left] from service where id ='162') AND (SELECT [right] from service where id ='162')))) OR ((incidents_main.other_service IN (SELECT DISTINCT id FROM service WHERE [left] BETWEEN (SELECT [left] from service where id ='162') AND (SELECT [right] from service where id ='162'))))) GROUP BY incidents_main.recordid)
120	ID 120 Doms Access/Review where incs are Moderate or above	Doms Inc Access/Review where incs of harm are Moderate or above by Location and Service Area	Record access and email notification	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main WHERE (((incidents_main.inc_level_harm IN ('MODERA','SEVERE', 'death'))) AND ((incidents_main.other_location = '@user_location_id')) AND ((incidents_main.other_service = '@user_Service_id'))) GROUP BY incidents_main.recordid)
121	WRP Assessors - full access to all modules	WRP Assessors - full access to all modules	Record access	1=1|528;;;1=1|784;;;1=1|12304;;;1=1|12544;3|12559;3|12800;3|12815;3|12816;;;1=1
122	INC 122 FA Access To Incs if Description is Renal or dialysis	INC 122 FA Access To Incs if Description is Renal or dialysis	Record access and email notification	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main WHERE (((CONTAINS(incidents_main.inc_notes, '"Renal"')))) OR incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main WHERE (((CONTAINS(incidents_main.inc_notes, '"Dialysis"')))) GROUP BY incidents_main.recordid) GROUP BY incidents_main.recordid)
123	Quality Bot	Quality Bot	Record access and email notification	1=1

ID	Group Name	Description	Group Type	WHERE Clause
124	INC124 - JESG North CCC	INC - JESG Incidents reported to North CCC	Record access and email notification	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main LEFT JOIN udf_values AS udf_1 ON (((incidents_main.recordid = udf_1.cas_id AND udf_1.mod_id = '3' AND udf_1.field_id = '794' AND udf_1.group_id = '0'))) WHERE (((udf_1.udv_string IN ('ABT1')))) GROUP BY incidents_main.recordid)
125	INC125 - JESG CW CCC	INC125 - JESG incidents reported to CW CCC	Record access and email notification	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main LEFT JOIN udf_values AS udf_1 ON (((incidents_main.recordid = udf_1.cas_id AND udf_1.mod_id = '3' AND udf_1.field_id = '794' AND udf_1.group_id = '0'))) WHERE (((udf_1.udv_string IN ('ABT2')))) GROUP BY incidents_main.recordid)
126	INC126 - JESG SE CCC	INC126 - JESG incident reported to SE CCC	Record access and email notification	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main LEFT JOIN udf_values AS udf_1 ON (((incidents_main.recordid = udf_1.cas_id AND udf_1.mod_id = '3' AND udf_1.field_id = '794' AND udf_1.group_id = '0'))) WHERE (((udf_1.udv_string IN ('ABT3')))) GROUP BY incidents_main.recordid)
127	JESG - Deny Access	JESG - Deny Access	Deny access	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main LEFT JOIN udf_values AS udf_1 ON (((incidents_main.recordid = udf_1.cas_id AND udf_1.mod_id = '3' AND udf_1.field_id = '440' AND udf_1.group_id = '0'))) WHERE (((udf_1.udv_string IN ('REP2','REP1','REP3','REP5','REP4','REP6','REP8','REP9','REP7','REP10')))) GROUP BY incidents_main.recordid)
128	Feedback 11B	Feedback full access if investigator	Record access	compl_main.recordid IN (SELECT compl_main.recordid FROM compl_main WHERE (((compl_main.com_type IN ('COMPLA'))) AND (((compl_main.com_investigator LIKE '@user_initials' OR compl_main.com_investigator LIKE '@user_initials %' OR compl_main.com_investigator LIKE '% @user_initials' OR compl_main.com_investigator LIKE '% @user_initials %')))) GROUP BY compl_main.recordid)

ID	Group Name	Description	Group Type	WHERE Clause
129	INC 129 - Review access linked to Reporters Location And Service Or Investigator or handler (mgr)	INC 129 - Review access linked to Reporters Location And Service Or Investigator or handler (mgr)	Record access	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main WHERE (((incidents_main.inc_mgr = '@user_initials')) OR ((incidents_main.other_location = '@user_location_id')) AND ((incidents_main.other_service = '@user_service_id')) OR (((incidents_main.inc_investigator LIKE '@user_initials' OR incidents_main.inc_investigator LIKE '@user_initials %' OR incidents_main.inc_investigator LIKE '% @user_initials' OR incidents_main.inc_investigator LIKE '% @user_initials %')))) GROUP BY incidents_main.recordid)
130	INC 130 Needlestick	INC 130 Needlestick	Record access and email notification	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main WHERE (((CONTAINS(incidents_main.inc_notes, '"needle*"')))) GROUP BY incidents_main.recordid)
131	Incs Auditors	Incs Auditors - for specific incs only	Record access	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main WHERE (((incidents_main.recordid IN ('10536','8302','8577','10627','7914','10575','10625','1860','8667','9783','10324','8323','9378','10427','9695','12820', '13798', '13876', '14026', '14029', '15043', '13947')))) GROUP BY incidents_main.recordid)
132	Inc Auditors2	Incs Auditors 2- for specific incs only	Record access	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main WHERE (((incidents_main.inc_affecting_tier_zero IN ('ORG','PT123'))) AND ((incidents_main.inc_type_tier_three IN ('TR142','TR5','TR7')))) GROUP BY incidents_main.recordid)
133	Incidents - All records	Incidents - All records	Record access	1=1
134	INC134 - Final Approval CFR Incidents on Responsible Service and Reporters Service	Final Approval CFR Incidents on Responsible Service and Reporters Service	Record access	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main WHERE (((incidents_main.service_id IN (SELECT DISTINCT id FROM service WHERE [left] BETWEEN (SELECT [left] from service where id ='75') AND (SELECT [right] from service where id ='75')))) OR ((incidents_main.other_service IN (SELECT DISTINCT id FROM service WHERE [left] BETWEEN (SELECT [left] from service where id ='75') AND (SELECT [right] from service where id ='75'))))) GROUP BY incidents_main.recordid)

ID	Group Name	Description	Group Type	WHERE Clause
135	Mortality - Full access & Email ON if @user = Initial Clinical Review AO	Mortality - Full access & Email ON if @user = Initial Clinical Review AO	Record access	mortality_main.recordid IN (SELECT mortality_main.recordid FROM mortality_main WHERE (((mortality_main.reviewer = '@user_initials'))) GROUP BY mortality_main.recordid)
136	Inc136- Awaiting approval - Reporter & Incident Service = CCC, Cdes, EMSTaxi - Emails On	INC - Awaiting approval - Reporter & Incident Service = CCC, Cdes, EMSTaxi - Emails On	Record access and email notification	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main WHERE (((incidents_main.service_id IN (SELECT DISTINCT id FROM service WHERE [left] BETWEEN (SELECT [left] from service where id =82) AND (SELECT [right] from service where id =82) OR [left] BETWEEN (SELECT [left] from service where id =68) AND (SELECT [right] from service where id =68) OR [left] BETWEEN (SELECT [left] from service where id =82) AND (SELECT [right] from service where id =82)))) AND ((incidents_main.other_service IN (SELECT DISTINCT id FROM service WHERE [left] BETWEEN (SELECT [left] from service where id =69) AND (SELECT [right] from service where id =69) OR [left] BETWEEN (SELECT [left] from service where id =82) AND (SELECT [right] from service where id =82) OR [left] BETWEEN (SELECT [left] from service where id =68) AND (SELECT [right] from service where id =68))))) GROUP BY incidents_main.recordid)
137	INC137 - Awaiting approval access all records - @User = Incident Manager/Investigator email On or Access to the Incident	Awaiting approval access all records - @User = Incident Manager/Investigator email On or Access to the Incident	Record access and email notification	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main LEFT JOIN udf_values AS udf_1 ON (((incidents_main.recordid = udf_1.cas_id AND udf_1.mod_id = '3' AND udf_1.field_id = '835' AND udf_1.group_id = '0'))) WHERE (((incidents_main.inc_mgr = '@user_initials')) OR (((udf_1.udv_string LIKE '@user_initials' OR udf_1.udv_string LIKE '@user_initials %' OR udf_1.udv_string LIKE '% @user_initials' OR udf_1.udv_string LIKE '% @user_initials %'))) OR (((incidents_main.inc_investigator LIKE '@user_initials' OR incidents_main.inc_investigator LIKE '@user_initials %' OR incidents_main.inc_investigator LIKE '% @user_initials' OR incidents_main.inc_investigator LIKE '% @user_initials %')))) GROUP BY incidents_main.recordid)
138	Mortality testing module SG	Mortality testing module SG	Record access and email notification	mortality_main.recordid IN (SELECT mortality_main.recordid FROM mortality_main WHERE (((mortality_main.reviewer = '@user_initials'))) GROUP BY mortality_main.recordid)

ID	Group Name	Description	Group Type	WHERE Clause
139	INC139 - WRP Assessment Auditors Review only	INC139 - WRP Assessment Auditors Review only	Record access	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main WHERE (((CAST(FLOOR(CAST(incidents_main.inc_dreported AS FLOAT)) AS DATETIME) BETWEEN '2024-01-01 00:00:00.000' AND '2024-03-31 00:00:00.000'))) GROUP BY incidents_main.recordid)
140	FEEDBACK140- WRPA Assessment Auditors Review only	FEEDBACK140- WRPA Assessment Auditors Review only	Record access	compl_main.recordid IN (SELECT compl_main.recordid FROM compl_main WHERE (((CAST(FLOOR(CAST(compl_main.com_dreceived AS FLOAT)) AS DATETIME) BETWEEN '2024-01-01 00:00:00.000' AND '2024-03-31 00:00:00.000'))) GROUP BY compl_main.recordid)
141	REDRESS141 - WRP Assessment Auditors	REDRESS141 - WRP Assessment Auditors	Record access	redress_main.recordid IN (SELECT redress_main.recordid FROM redress_main WHERE (((CAST(FLOOR(CAST(redress_main.date_record_opened AS FLOAT)) AS DATETIME) BETWEEN '2024-01-01 00:00:00.000' AND '2024-03-31 00:00:00.000'))) GROUP BY redress_main.recordid)
142	Claims Inquests 142 - WPR Assessment Auditors Review only	Claims Inquests 142 - WPR Assessment Auditors Review only	Record access	claims_main.recordid IN (SELECT claims_main.recordid FROM claims_main WHERE (((CAST(FLOOR(CAST(claims_main.cla_dopened AS FLOAT)) AS DATETIME) BETWEEN '2024-01-01 00:00:00.000' AND '2024-03-31 00:00:00.000'))) GROUP BY claims_main.recordid)
143	INC143 - EMS CCC Access and review of low or no harm incidents	EMS CCC Access and review of low or no harm incidents	Record access	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main WHERE (((incidents_main.inc_level_harm IN ('NONE','LOW'))) AND ((incidents_main.other_location = '@user_location_ID')) AND ((incidents_main.other_service = '@user_service_ID'))) GROUP BY incidents_main.recordid)
144	INC144 - HART and Specialist Operations Final approval on All Incidents relating to HART and Specialist Operations with Email	Specialist Operations HART, MRD and SORT on Responsible Service	Record access and email notificati on	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main WHERE (((incidents_main.service_id IN (SELECT DISTINCT id FROM service WHERE [left] BETWEEN (SELECT [left] from service where id ='78') AND (SELECT [right] from service where id ='78') OR [left] BETWEEN (SELECT [left] from service where id ='79') AND (SELECT [right] from service where id ='79') OR [left] BETWEEN (SELECT [left] from service where id ='85') AND (SELECT [right] from service where id ='85'))))) GROUP BY incidents_main.recordid)

ID	Group Name	Description	Group Type	WHERE Clause
146	INC146 - HART and Specialist Operations Final approval on All Incidents relating to HART and Specialist Operations with Email	Specialist Operations HART, MRD , SORT and EPRR	Record access and email notification	incidents_main.recordid IN (SELECT incidents_main.recordid FROM incidents_main WHERE (((incidents_main.other_service IN (SELECT DISTINCT id FROM service WHERE [left] BETWEEN (SELECT [left] from service where id ='78') AND (SELECT [right] from service where id ='78') OR [left] BETWEEN (SELECT [left] from service where id ='79') AND (SELECT [right] from service where id ='79') OR [left] BETWEEN (SELECT [left] from service where id ='85') AND (SELECT [right] from service where id ='85') OR [left] BETWEEN (SELECT [left] from service where id ='185') AND (SELECT [right] from service where id ='185'))))) GROUP BY incidents_main.recordid)
147	Incidents - All Records - Final Approval - No Email notification	Incidents - All Records - Final Approval - No Email notification	Record access	1=1
148	Safeguarding - Full Reporter Access - no abilty to close records reported - NO email	Safeguarding - Full Reporter Access - no abilty to close records reported - NO email	Record access	safeguarding_main.recordid IN (SELECT safeguarding_main.recordid FROM safeguarding_main LEFT JOIN udf_values AS udf_1 ON (((safeguarding_main.recordid = udf_1.cas_id AND udf_1.mod_id = '51' AND udf_1.field_id = '529' AND udf_1.group_id = '0'))) WHERE (((udf_1.udv_string IN ('SFG001','SFG003'))) AND ((safeguarding_main.createdby = '@user_initials'))) GROUP BY safeguarding_main.recordid)

5.2. Profiles

ID	Name	Description
2	Local System Lead (datix admin)	Row 3 WAST Profiles (** Non default forms assigned to this profile)
3	EMS Service Managers	Row 4
4	EMS Heads of Service	Row 5
5	EMS Locality Manager (LM)	Row 6
7	EMS HART Supervisors	Row 8
8	EMS SORT Supervisors	Row 9
9	EMS Community First Responders (CFRs) Operations Assistants	Incidents Review and Investigate
10	EMS Admin Support	Row 11
11	NEPTS Service Managers	Incidents relates to reporters service and location. Feedback to Primary location & service
12	NEPTS Operational Managers	NEPTS Operational Managers - specialty/locality
13	NEPTS/UCS Ambulance Care Operational Team Leaders (OTL)	NEPTS Operational Managers grant access via IO field OR Handler field. Review access
14	NEPTS Control Managers	HB & Service Area or Invest or Handler
15	NEPTS Control/NET Centre Team Leaders	Access Handler & Investigator Only
16	NEPTS Control/Net Centre Complaints Leads	Row 17
17	CCC Head of Service	INC_FA if @location AND @service = CCC OR @user = Incident Mgr or Investigator / FEED_Full Access = EMS CCC / Form design = default
19	CCC Duty Control Managers	INC_FA if @user = Incident Mgr or Investigator / FEED_Record access if handler OR mgr

ID	Name	Description
20	CCC Senior Clinicians (CSD)	INC_FA if reporters service = CCC, cdesk, EMStaxi / FEED_full access if reporters service = CCC / Form design = default
21	CCC Complaints Investigators	INC_FA if @user = Incident mgr OR investigator OR service = @user (CCC) / FEED_Full Access if @user = handler OR mgr OR @service = CCC / MORT full access / Form design =default
22	Resource Centre Managers	Row 24
23	111 Service Managers	INC_FA if @user Location OR @user Service = 111 OR user = incident manager OR Investigator / FEED_full acess if @user Location OR @user Service = 111 / Form design = default
24	111 Clinical / Site Leads	INC_FA if @user Location OR @user Service = 111 OR @user = incident mgr OR investigator
25	111 Senior Nurse Advisors	INC_review access if @user=incident mgr OR investigator / FEED_no access
26	111 Call/Health Information Co-ordinator	INC_Review Access if @user = Incident Mgr or Investigator
27	Safeguarding Leads	Access to all incidents IF Type=safeguarding - Additional info=safeguarding - Assigned as Incident Mgr or Investigator OR Access is required to this incident - Email ON Incidents V2D/0123 Dif2_No mandatory fields assigned
29	Driver Training Leads	Row 31
30	Mental Health Team	Row 32
31	Information Governance Team	Row 33
32	Fleet Managers	Row 34
33	Fleet Team Leaders	Row 35
34	Estates Managers	Row 36
35	Environmental Lead	Row 37
36	ICT Managers	Row 38

ID	Name	Description
37	ICT Team	Row 39
38	ESMCP Project Team	Row 40
39	Manual Handling Lead	Row 41
40	Violence and Abuse Lead	Row 42
41	Frequent Service User Leads	Row 43
42	Occupational Health Lead - Needlesticks	Row 44
43	Occupational Health Lead - General	Row 45
44	IPC Lead	Row 46
45	Equipment/Medical Devices/PPE/Uniform Lead	Row 47
46	Medical Director	Row 48
47	Medicines Management Lead	Row 49
49	Clinical Leads Regional	Row 51
50	Clinical Leads HB	Row 52
51	Clinical Audit - Electronic Patient Clinical Record (EPCR)	Row 53
52	EMS MPDS Audit Team	Row 54
53	Clinical Research/Trial Team	Row 55
54	QSPE Senior Managers	QSPE Senior Manager with NRI Portal access
55	H&S Team	INC_full access_close_email notifcation, CON_full access_approval, FEE_no access, RED_no access, ACT_assigned to DIF2 form V2D no mandatory fields assigned to Users
56	Patient Safety & Concerns Managers	Access to all modules - INC=full access to all incidents - Closure=Y - Email=ON.
57	Putting Things Right Team (PTR) admin	Registering new concerns.
58	Legal Services Team	Row 61
60	Covid 19 - with email	Row 63
61	Covid 19 - staff testing	Row 64
62	Make Ready & Mobile Testing Unit (MTU) Managers	Row 65
64	H&S Managers by HB	Currently not in use

ID	Name	Description
65	Reporter / New starter Profile - Input only	Reporter Only - Access restricted to reporting a new Incident
70	EMS Duty Operational Managers (DOMs)	Row 7
74	Leavers staff / employees	Staff / Employee Leavers
76	EMS Senior Paramedic	Incidents - Handler & Investigator / Feedback - Handler, Manager, Investigator
77	CCC Service Managers EMS	Row 18
79	EMS Operational Delivery Unit (ODU)	Row 6
80	**Highly Confidential /sensitives Issue**	Highly confidential sensitive issue
81	111 Clinical Specialist Leads	INC_Review Access if Type=Pt OR organisation + Location OR Service = 111 / FA if @user = Incident mgr OR investigator / Form design = default / FEED no access
82	People Services	INC - Final Approval & Full Access if @user = Investigator and/or Manager
83	NEPTS Volunteer Ambulance Car Services (VCS)	NEPTS Volunteer Ambulance Car Services
84	Assistant Directors (datix)	INC_full Access / Feed_full Access / Claims_full Access / Dashboard / Mortality_full access / Contact_full access
85	Incident Handler/Investigator General	Incident Access For Handlers/Investigators
86	JESG Admin	JESG Access to all incidents
87	PECI Team - Full access to compliments only	Full Access to compliments & Incident Reporter only.
88	EMS Ops all Wales (Ass DoOps)	Row 5
89	Records Management	Access to all incident records if Type=Records, Information
90	NEPTS Administrator	Dashboard access only
91	Putting Things Right Team (PTR) ISOs	Row 59

ID	Name	Description
92	Once for Wales Central Team	This profile has been created for the OFW central team with full access - no email notifications. The profile has been created so the team can carry out checks/investigations when required.
93	NEPTS/UCS Ambulance Care Service OTLs Close	Ambulance Care Service (NEPTS/UCS) NEPTS OTLs can close incidents where they are the incident manager or investigator for Reporters harm of low or none.
94	NEPTS - National Renal Service	Access to all incident relating to Renal Services and/or renal/dialysis in description
95	JESG North CCC	JESG North CCC = about North CCC
96	JESG CW CCC	JESG CW CCC = Incidents about CW CCC
97	JESG SE CCC	JESG Access to all incidents SE CCC
98	Patient Safety & Concerns Corporate Team with Highly Confidential /sensitives Issue	Highly confidential sensitive issue access With Access to all modules - INC=full access to all incidents - Closure = Y Email =ON Similar to ID 56
99	Quality Bot	Incidents access
100	NEPTS Operational Managers (Copy)	NEPTS Operational Managers - specialty/locality
101	CCC Service EMS	Access and investigate LLangunor CCC incidents
102	Auditors	Incidents access - no email notifications
105	People Services With Highly Confidential/Sensitive issues Access	INC - Final Approval & Full Access if @user = Investigator and/or Manager
106	EMS Community First Responders (CFRs) Operations Managers	Incidents Final Approval
107	Safeguarding Leads - **with access to highly confidential**	Access to all incidents IF Type=safeguarding - Additional info=safeguarding - Assigned as Incident Mgr or Investigator OR Access is required to this incident - Email ON Incidents V2D/0123 Dif2_No mandatory fields assigned **Access to Highly Confidential Incidents**

ID	Name	Description
108	CCC Senior Clinicians (CSD DOMs) Duty Operational Managers	INC_FA if reporters service = CCC, cdesk, EMStaxi / FEED_full access if reporters service = CCC / Form design = default = Awaiting Approval
109	Mortality Testing	Mortality Testing module on 14 may 2024
110	WRPA Assessment Audit	WRPA Auditors Read only access
111	EMSC Administrators	Access is time limited
112	Patient Safety & Concerns Corporate Team with Highly Confidential /sensitives Issue (NRI)	Highly confidential sensitive issue access With Access to all modules - INC=full access to all incidents - Closure = Y Email =ON Similar to ID 56
113	EMS Head of Service Specialist Operations	Specialist Operations includes, HART, MRD, SORT, EPRR

6. Appendix B - Action Plan

Ref	Finding	Action	Benefit
3.1.2.1	There are 111 Security groups in the system.	Review all security groups and identify if there are any gaps.	Having the correct security groups ensures that users have access to the correct records.
3.1.2.2	Security groups are not consistently named and do not follow the best practice guidance of *module name - Access Level - access to which record types - email or no email.*	Review all the security groups to ensure that they follow the best practice naming convention.	A consistent naming convention makes it easier to identify security groups correctly.
3.1.2.3	Group 121 gives access to multiple modules. While it is possible to create these groups, it is considered extremely bad practice to do so and RLDatix advise against the use of them.	Delete group 121 and replace with groups for individual models.	Having individual groups for each module allows for better control over access and reduces admin.
3.1.2.4	There are several groups where the record access given by the WHERE clause does not match the access described in the name of the group. Example Groups: 117, 118, 103 This is can lead to confusion when assigning groups.	Review all the security groups to ensure that the WHERE clause and the access in the group's name match.	Ensuring that the WHERE clause matches the description of the group makes it easier to identify security groups correctly.
3.1.2.5	The only security group for Dashboards gives full access, meaning that all users can create them.	Amend security groups to remove access from all users to only users that require it	Having the correct security groups ensures that users have access to the correct records.
3.2.2.1	There are 95 Profiles. This is a large number of Profiles for a system. As an example, Profile #24 - '111 Clinical / Site Leads' has the same permissions as, Profile #49 - 'Clinical Leads Regional'	Review all the Profiles and look at merging ones that are giving similar access.	Reduces the admin burden and ensures consistency of user access to groups of staff.

3.2.2.2	Profiles have inconsistent naming conventions and the profile descriptions do not follow best practice of stating who the Profile is relevant to and what access it gives.	Review the naming convention of Profiles. Improve the descriptions so that they clearly show: • What the user roles the profile is relevant to. • What module access is attached to the profile, including what type of records and the level of access given. Any configuration settings that are relevant e.g. if they grant users the ability to reject contacts, generate records from another record or copy incidents.	Makes it easier to identify that users are in the correct profile, with the correct access levels.
3.3.2.1	A dashboard creation account is in use	Check that the dashboard creation account has appropriate permissions and who has access to it.	A dashboard account allows dashboards and reports to be created by a single user account, getting around the issue of dashboard access when the person creating them leaves or is unavailable.
3.3.2.2	There are packaged reports available in the Capture modules.	Check that the packaged reports match user requirements.	Packaged reports, assigned to the appropriate users, reduce the report generation burden.
4.1.2.1	Total of 3800 users. 2697 of these waiting for review, so at first review it could look like they haven't been checked by a LSL.	Review all unverified users and check that they are assigned to the correct profiles.	Reviewing users after they authenticate for the first time ensures that they are in the correct User Group and Profile.
4.1.2.2	There are 38 users that are not assigned to a capture profile.	Review users not assigned to a capture profile and assign to an appropriate profile.	Profiles ensure that users have the correct access permissions.
4.1.2.3	There are 97 users who appear to have never logged into the system. Of these users 65 are set to appear in the staff dropdown lists.	Review users who have not logged in and appear in drop down options and update their user accounts as necessary.	Good user housekeeping ensures that users have appropriate access and those that are no longer with the organisation are not assigned to active records.

4.1.2.4	There are 2399 users who have not logged in for over 90 days. There are 941 users who have not logged in for over 365 days. There are 200 users who have not logged in for over 730 days. There are 4 users who have not logged in for over 1000 days.	Review users who have not logged in for an extended period and update their user accounts as necessary.	Good user housekeeping ensures that users have appropriate access and those that are no longer with the organisation are not assigned to active records
4.2.2.1	The locations are structured by the NHS Wales Health Board geography.	Review the locations available in the system and verify that they match the locations used by internal reporting and analytics teams, adjusting as necessary. (effect the change from 01/04/2025)	Ensures that any reports generated from data in the Datix Cymru system match up with data provided from other systems.
4.2.2.2	The Services structure includes levels that are not part of WAST e.g. GP practices and pharmacy services.	Review the Services and check that they match the locations used by internal reporting and analytics teams.	Ensures that any reports generated from data in the Datix Cymru system match up with data provided from other systems.
4.2.2.3	There is a limited use of Tags within the Locations and Services modules.	Review the current Tag list and add more as needed. Add Tags to Locations and Services to use them in reporting.	Tags provide an easy way to group service and location types for report generation

Project name	Datix Recovery & Improvement Plan
Project manager	Kate Blackmore
Project start date	07/10/2024
Project finish date	29/08/2025
Duration	255 days
% complete	0%
Exported on	08/10/2024

Task number	Outline number	Name	Assigned to	Start	Finish	Duration	% complete	Priority	Notes	Completed	Checklist Items
1	**1**	**System Governance**		**09/09/2024**	**31/03/2025**	**146 days**	**0%**	**Medium**			
2	1.1	WAST User Group	Caroline Miftari	01/11/2024	03/01/2025	46 days	0%	Important	Introduce a WAST user group for Datix Case management and risk management systems. The group should meet regularly and could include OfWCMS team in a business partner type model.		
3	1.2	Link to Service Desk	Tracey Thomas	01/01/2025	31/03/2025	64 days	0%	Medium	Create a link between Datix system team and management of joiners/leavers/role changes via ICT service desk to ensure that security groups and profiles are correctly aligned as part of information governance activity.		
4	1.3	Review Notification Lists	Tracey Thomas				0%	Important	No more than 5 leaders should be notified of incidents with additional notifications being managed through the allocation of investigators etc.		
5	1.4	Governance Route for Change Approval	Caroline Miftari	02/12/2024	31/01/2025	45 days	0%	Medium	Governance of system configuration is lacking with no clear forum or process for approval of changes to configuration or allocation of approval groups. Consider how change/development requests are managed and referred to OfW linking to networks and workstreams.		
6	1.5	Demand & Capacity Review of System Team	Caroline Miftari	09/09/2024	31/03/2025	146 days	0%	Medium	QSPE OCP identifies the need for a business case for datix as part of consultation. Demand & Capacity review is required to support this business case.		
7	1.6	Clarify use of Audit Tool	Caroline Miftari	06/01/2025	28/02/2025	40 days	0%	Medium	Assurance is provided regarding the use of an audit tool within RL Datix Cymru and consideration was given by the group to how this audit tool is currently used (if at all) and what business intelligence reports could be used to support user access controls. It was acknowledged however that the audit tool does not record changes to user profiles and so governance structures (such as record noting) are required to maintain a level of assurance in this area.		
8	1.7	Configuration Review of Forms	Lucie Jones, Nicola White, Vicky Maxwell, Caroline Miftari	07/10/2024	29/11/2024	40 days	0%	Urgent	Configuration review of forms for relevance.		
9	1.8	Review of Coding	Claire Appleton, Sarah McGarrity, Lucie Jones	01/11/2024	31/12/2024	43 days	0%	Important	Review of Coding with consideration of national patient index to capture incidents that are occurring.		
10	1.9	Joint Investigation Module	Claire Appleton, Lucie Jones, Sarah McGarrity				0%	Low	Review and consider the Joint Investigation Module		
11	1.10	Recording Opportunities for Data Lenses	Caroline Miftari, Kate Blackmore, Claire Appleton, Leanne Hawker				0%	Low	Identify recording opportunities for data to knowledge lenses such as socio-demographic and protected characteristics		
12	1.11	Build Case for Digital Workforce	Claire Appleton, Kate Blackmore, Leanne Smith	07/10/2024	29/11/2024	40 days	0%	Medium	Articulate the benefits both in capacity and data quality for developing automated digital workforce options for Datix and PTR		
13	**2**	**Quality of Content**		**07/10/2024**	**31/12/2024**	**62 days**	**0%**	**Medium**			

14	2.1	Review/Cleanse Profiles and Security Groups	Tracey Thomas	07/10/2024	31/12/2024	62 days	0%	Urgent	Review to understand the profiles and security groupings currently available and how these could be better standardised to ensure equity of access . Undertaking a mapping exercise would allow us to understand who has what access to reduce duplication and variance .	0/2	Consider changes associated with CMT;Review of Hierarchy
15	2.2	Review/Cleanse volume and quality of reports	Tracey Thomas	04/11/2024	31/12/2024	42 days	0%	Medium	The volume and quality of reports (including listing and package reports) is adding to the lack of structure creating duplicatio n and introducing variance in outcome data which brings lack of confidence and ability to thematically analyse areas for improvement within our systems . Engaging with system users to understand w hy they need available reports and what information they are trying to attain will allow for a redesign to provide quality assurance in the data available and again reduce variation.		
16	2.3	Develop guidance for use of Contacts Fields	Andrew Morgan, Lucie Jones, Caroline Miftari	07/10/2024	31/10/2024	19 days	0%	Urgent	In order to be able to identify staff specific learning and support it is important to utilise the contact f ields correctly. system update requests are required for WAST when considering things like person affected data for duty of candour triggering . Due to the nature of our business WAST will not always have this information and the ability to trigger without it is a governance and reporting issue.		
17	2.4	Review required system updates and link to system governance					0%	Medium			
18	2.5	Review/Cleanse Location & Services	Tracey Thomas	07/10/2024	13/11/2024	28 days	0%	Important			
19	**3**	**Business Intelligence**		**30/09/2024**	**29/08/2025**	**240 days**	**0%**	**Medium**			
20	3.1	Technical Guidance Document	Simon Thomas, Tracey Thomas	18/11/2024	31/12/2024	32 days	0%	Medium	technical guidance documents required to support reporting within the organisation . There are vast quantities of fields available within the RL Datix Cymru system and not all of these fields are currently active . When building reports it is essential to understand the use volume of the field and what it pertains to in order to ensure the quality of reporting exported . It is important for the organisation to understand what field s are operational and which fields are used in which circumstances. to have assurance of the reporting provided particularly for external reporting standards it is important to have a single source of truth .	0/1	Technical Guidance document should include naming convention
21	3.2	Centralised Data Repository within Data Warehouse	Simon Thomas				0%	Medium			
22	3.3	Develop suite of dashboards		06/01/2025	29/08/2025	170 days	0%	Medium	development of a suite of dashboard to provide key metrics and linking datix data to other key performance reports		
23	3.4	Data Export	Tracey Thomas, Simon Thomas	30/09/2024	29/11/2024	45 days	0%	Important		0/3	Move to scheduled extraction of required fields once Quality Assurance activity completed;Quality Assurance front end data to extraction tool data;HI permission access to allow manual export of data from front end system
24	3.5	Key Quality & Performance Indicators	Caroline Miftari				0%	Medium	it is important to understand what the key metrics for the organisation are as well as how Information standards impact WAST . Moving forward we need to understand health inequalities and how our reports can reflect this. what business intelligence reports could be used to support user access controls		
25	3.6	User Access Controls (BI Reports)					0%	Medium			
26	3.7	Data Quality Audits of KPIs		07/10/2024	29/11/2024	40 days	0%	Urgent			
27	3.8	Understand Contacts intelligence and how this is used.					0%	Medium			

28	3.9	Data Linkage					0%	Low	Explore better data linkage in datix and between systems (ie civica)		
29	**4**	**Information Governance**		**03/02/2025**	**03/02/2025**	**1 day**	**0%**	**Medium**			
30	4.1	Permissions & Structures to release data outside of WAST	Caroline Miftari, Kelly Holding, Claire Appleton	03/02/2025	03/02/2025	1 day	0%	Medium			
31	4.2	Review Records Retention Schedule for Datix platforms	Caroline Miftari				0%	Medium	Consideration was given to the records retention schedule and how this applies to records within RL Datix Cymru . WASTs current records retention schedule does not include a specific section for Datix entries instead the different retention rules would be applied to different records, in different modules and categories. Once breached records should be deleted from the datix platform which is a function that must be completed locally and would be a trust responsibility based on our Information Governance standards and schedules.		
32	4.3	Import/Export Process Review					0%	Medium	Discussions included how information is currently imported and exported from datix and where this information is stored (examples given related to documents being downloaded to allow import into datix and whether these documents were then deleted appropriately as well as data being exported for reporting purposes etc and again whether this information was being stored securely.		
33	4.4	Introduce Information Governance Structures within Datix	Caroline Miftari				0%	Medium		0/3	DPIA screening checklists;Information Assets Controls;Access Controls Regime
34	**5**	**Education**					**0%**	**Medium**			
35	5.1	Design Training Structures for Datix Platforms					0%	Medium		0/5	Wider appreciation of the time taken to complete investigation and closing of incidents;Clearer explanation of what is expected of reporters, incident managers and investigators;Identify training packages for submission & investigation;Develop training programme;Consider impact of quarterly system updates on training packages

36	5.2	Back to Basics Training	Claire Appleton, Vicky Maxwell, Caroline Miftari, Nicola White, Andrew Morgan, Kate Blackmore				0%	Important	In order to effectively recover this is likely to require a phased approach for immediate priorities, a return to baseline levels of education and then enhancements based on the development of the system . What is pivotal however is the need to engage with education & development team when designing the future of education in this area.	0/5	Importance of constructive and consistent feedback.;Content teams to support incident managers around the content of records being investigated;Sparsely recorded content impacts on the quality of any investigation undertaken;Users Need to understand why questions are asked to assure quality & quantity of content;Possibility of training for EMSC transformation as pilot area
37	5.3	Untitled task					0%	Medium			
38	5.4	Information Asset Training					0%	Medium			
39	5.5	Information Governance elearning					0%	Medium			
40	5.6	Measure the effectiveness of education and communication platforms					0%	Medium			
41	5.7	Link to Management Essentials Framework					0%	Medium			
42	5.8	Survey Intelligence Informing Education					0%	Medium		0/2	Introduce staff experience questionnaire for front end users using civica platform as part of QMS;Receive Feedback from National user/incident manager survey
43	**6**	**Corporate Governance**		**09/09/2024**	**15/11/2024**	**50 days**	**0%**	**Medium**			
44	6.1	Understand System Configuration responsibilities for new risk platform					0%	Medium			
45	6.2	Review alignment of Health & Care Quality Standards 2023 to current systems					0%	Medium			
46	6.3	Risk assess Datix Web platform					0%	Medium	Consideration was given to risk assessing the outdated system for risk and how this would be resolved and mitigated through the transformational work currently ongoing within corporate governance.		
47	6.4	QSPE Contact and linkage for FOI Requests					0%	Medium	t was agreed that the facilitation of FOI responses required liaison and a joint thinking approach the collation of the appropriate and relevant information to answer the request. Consideration of a single point of contact to link subject experts with data extraction was presented with acknowledgement within the quality teams that the responsibility for data extraction from the datix platforms remaining with the Datix System lead/Analyst however the quality assurance of the data extracted would require oversight by content leads and links with subject experts .		
48	6.5	Organisation Commitment to Change/Improve	Kate Blackmore, Claire Appleton	09/09/2024	31/10/2024	39 days	0%	Important		0/2	Datix Recovery & Improvement;PTR Reporting Escalation
49	6.6	Risk assessment & Stratefication of Open Incidents	Lucie Jones, Caroline Miftari, Nicola White	07/10/2024	15/11/2024	30 days	0%	Urgent	Review current historic open records and undertake risk assessment/stratification of historic records for low/no harm to identify alternative solution to reduce volumes of open records.		

Ymddiriedolaeth Brifysgol GIG Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services University NHS Trust

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

PUTTING THINGS RIGHT REPORT
QUARTER 3, 2024/25 (OCTOBER - DECEMBER)

MEETING	Quality, Patient Experience & Safety Committee
DATE	4 February 2025
EXECUTIVE	Liam Williams, Executive Director of Quality and Nursing
AUTHOR	Wendy Herbert, Deputy Director of Putting Things Right Claire Appleton, Assistant Director, Putting Things Right
CONTACT	Wendy.herbert3@wales.nhs.uk Claire.appleton2@wales.nhs.uk

EXECUTIVE SUMMARY

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

In summary the Report for Quarter 3, 2024/25 highlights:

1. The impact of high demand across Trust Emergency and Non-Emergency Services:

- harm due to extensive response times in the community for emergency care.
- distress caused by cancellations of pre-booked transport.
- large volume of high harm cases shared with Health Boards for joint investigation. The report notes the changing profile of different Health Boards
- two Prevention of Future Death Reports have been received relating to delayed response times.

2. Performance across the PTR & Legal portfolio has improved following investment in the Department but full attainment of external targets remains challenging.

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

KEY ISSUES/IMPLICATIONS
(i) The timeliness of complaints management has improved (currently 73%) following a concerted effort to reduce open cases last quarter. (ii) The quality of complaints management will be a future area of focus as the Trust is due to receive two Section 23 Ombudsman Reports and is preparing for revisions to the Concerns Regulations and PTR Guidance. (iii) Service level and organisational learning is being captured and driven through maturing Quality and Safety Governance Groups, although the impact of past challenges are still visible due to the lead times associated with Learning from Events Reports (LFER) performance. (iv) Gradual improvements in Nationally Reportable Incident (NRI) management and associated timescales are noted.

REPORT APPROVAL ROUTE	
Clinical & Quality Governance Group	21 January 2025
Executive Leadership Team	29 January 2025
Quality, Patient Experience & Safety Committee	4 February 2025

REPORT APPENDICES
ANNEX 1 - SBAR Report **ANNEX 2** - PTR and Legal quarterly data

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

ANNEX 1

REPORT ABBREVIATIONS			
ACS	Ambulance Care Service	NRI	Nationally Reportable Incident
BCUHB	Betsi Cadwaladr University Health Board	PFD	Prevention of Future Deaths
CCP	Complex Case Panel	PNA	Patient Needs Assessment
CMP	Capacity Management Plan	PSOW	Public Service Ombudsman for Wales
CMT	Clinical Model Transformation	PTHB	Powys Teaching Health Board
CPR	Cardio-Pulmonary Resuscitation	PTR	Putting Things Right
CSP	Clinical Safety Plan	QMG	Quality Management Group
C&VUHB	Cardiff & Vale University Health Board	RCS	Rapid Clinical Screening
EMD	Emergency Medical Dispatchers	REAP	Resource Escalation Action Plan
EMS	Emergency Medical Service	SCIF	Serious Case Incident Forum
IAED	International Academy of Emergency Dispatch	SOT	Senior Operations Team
LFER	Learning From Events Report	WRP	Welsh Risk Pool
MPDS	Medical Prioritisation and Dispatch System		

SITUATION

1.1 This Putting Things Right Report covers the period from 1 October 2024 to 31 December 2024.

1.2 This report covers the PTR functions which broadly includes:

- Patient Safety (proactive & reactive)
- Patient/family complaints
- Ombudsman relationships, information sharing, reports, and responses
- Coroner relationships, information sharing, reports, and responses
- Redress cases
- Claims cases

- Organisational learning (including Learning from Events and Welsh Risk Pool submissions)

1.3 Although the PTR and Legal Services Team also lead on the learning from mortality agenda, this is covered within the separate twice-yearly Learning from Mortality Report to this Committee.

BACKGROUND

2.1 As requested at previous Committees, the structure, format and content of this Report has been reviewed, and incremental development will continue in response to Committee member feedback. The Report now consists of two elements:

- **ANNEX 1**: The Report has been structured to provide a succinct overview of three core areas: Assurance, Performance and Learning. The narrative is drawn from the data provided in **ANNEX 2** as well as qualitative organisational intelligence flowing through the Trust's Quality and Safety Governance Groups.

- **ANNEX 2**: A new format for PTR and Legal data reporting. It includes a compliance heatmap (enabling focused attention on statutory requirements), Assurance overview (a more detailed picture of statutory and regulatory functions), performance overview (indicative of potential risks to future assurance) and a thematic visual presentation of themes and learning (areas that are informing organisational development and improvement).

2.2 It is noted that the data presented has limitations around data collection, thematic analysis, visualisation and triangulation with other data sources. A number of ongoing actions will gradually address these limitations:

- Work to enable Datix Cymru and iCase data flow into the Trust Data Warehouse
- Increased engagement in national Datix Cymru coding workstreams
- Team development work within PTR & Legal Services
- Trust Datix Recovery and Improvement Plan

2.3 Additional metrics and changes to visualisations will be included in future reports dependent on the progress of actions outlined above.

2.4 Collation and analysis of data related to Claims, Redress and Inquest management requires further development work which has been de-prioritised due to the transfer of Electronic Management Systems for non-clinical claims that is due to take place during Quarter 4. Team capacity for improvement work has been directed toward the development of the new iCase System to ensure the system configuration and workflows align with Trust working practices.

ASSESSMENT

3.1 ASSURANCE

External assurance

3.1.1 The Annual WRP Concerns Assessment is due to be received during Quarter 4, 2024-25 for fieldwork undertaken on case management during Quarter 4, 2023-24. Details of the assurance ratings, recommendations and associated Action Plan will be provided to members at a future Committee Meeting.

3.1.2 The PSOW has advised the Trust that it intends to publish two Section 23 Reports relating to complaint investigations. Further information will be provided to Committee members once finalised reports are received.

3.1.3 Two Regulation 28 PFD Reports were received during October issued by North Wales (East & Central) and Swansea and Neath Port Talbot Coroners. Both related to extensive delays in being able to provide an in-person conveying response to patients waiting in the community due to resources being held at hospitals waiting to transfer patient care. Organisational responses have been provided to both Coroners within the stipulated 56-day timeframe.

3.1.4 The Trust has maintained its accredited status with the IAED through demonstrably high quality in its MPDS Audits. The link between audit outcomes and incident reporting has been strengthened.

Compliance heatmap

3.1.5 There is a gradual reduction noted in the number of overdue NRIs. This metric has not been routinely recorded within the Trust in the past. It has been selected as a key metric as it denotes timely investigation of the most serious concerns. The overall number of NRIs open with the NHS Wales Executive has also reduced since Quarter 1, when there were 70 cases, compared to 42 at the end of Quarter 3.

3.1.6 Complaint acknowledgement and response times have improved since additional investment into the Department; however, challenges remain and there is a concern that performance may plateau beneath target level. The quality of responses is assured through a dual approval process involving team leads as well as senior oversight.

3.1.7 There is a fluctuating picture of compliance to the five working day target for issuing Duty of Candour initial letters after the 'in-person' notification. Adherence to the target has over the past quarter been affected by improvement work on the quality of letters in terms of senior oversight and

providing an increased level of individualisation and compassion which has elongated drafting times.

3.1.8 The Trust continues to achieve target levels of compliance with National Patient Safety Alerts and Notices and its response times for PFD Regulation 28 Reports.

Assurance profile

3.1.9 The rates of NRI reporting and the number of cases shared with Health Boards as joint investigations demonstrate seasonal changes. These are likely to correspond to the number of SCIFs being increased/decreased at times of increased reporting. The embedding of effective processes for reviewing Medical Examiner Referrals has created additional cases requiring review at SCIF.

3.1.10 The inclusion of PTHB within the joint investigation profile is notable in the last two quarters, given its absence last winter. This is possibly reflective of growing pressure within NHS England Acute Trusts but could also be reflective of a change in data collection practices or conveyance rates. This issue requires further exploration to interrogate the data finding.

3.1.11 The very low number of C&VUHB cases this winter in the joint investigation profile is noted as a welcome improvement and is likely resulting from the efforts made by the Health Board to minimise delays in transfers of care.

3.1.12 A year-on-year increase in complaint volumes is apparent, although the upper warning limit has not yet been reached this year. The increasing trend jeopardises timely acknowledgement and resolution of complaints, in spite of increased investment.

3.1.13 The Trust's CCP continues to review all complaints and incidents where the Redress provisions may be engaged. The Panel agrees cases which will trigger the WRP Learning from Events process. The slight increase noted in LFER trigger rates can be explained by the scheduling of CCPs affecting the flow of cases being reviewed.

3.1.14 The decreasing number of Medical Examiner Referrals since April 2024 is believed to be due to relational work undertaken with other health bodies to reduce the duplication of cases, whereby the same case was, at times, previously being sent by both the Medical Examiner Service and the associated Health Board. This trend will, however, be monitored closely to assess whether there are other influencing factors.

3.2 **PERFORMANCE**

3.2.1 Data on the number of open incidents is now presented regularly at QMG and SOT. Services are being advised to focus on current year incidents. A number of barriers to effective incident management and closure have been identified as part of the groundwork which has informed the Datix Recovery and Improvement Plan. Work is already underway to address these challenges. In addition to the system configuration and workforce education required, it is recognised that a cultural shift is needed within the organisation and that effective data visibility is a key lever through which enhanced incident management practices can be achieved.

3.2.2 Current complaints performance has improved, however the increasing number of open complaints and the proportion of which are overdue presents a challenging picture of future performance. The development and introduction of CMT initiatives, operational pressures (REAP 4, Critical Incident), and constrained non-corporate investment in quality and safety capacity in some services are identified as contributory factors to address.

3.2.3 Medical Examiner Level 1 triage is occurring on a regular weekly basis. The recently formed Level 2 Medical Examiner Learning Panel is gaining traction and increasing the pace of Case Reviews as Panel members gain familiarity and confidence in the process.

3.2.4 As the portfolio of LFER work transitions between teams, new approaches to collaborative completion and enhanced organisational oversight through QMG will improve the delivery of high quality LFER Reports. There remain a small number of cases from prior to the PTR investment and OCP for which final completion timelines are likely to prove challenging however there is strong assurance regarding the process through which newly triggered cases are being managed.

3.2.5 The number of Coronial approaches has decreased during Quarter 3, although is largely comparable with Quarter 3 of the previous financial year. The workload of the team however remains high due to the large number of statements being requested, an increase in the use of jury inquests and increased number of witnesses being called. The Legal Services Team provides individualised preparation and support to all Trust staff.

3.3 LEARNING AND IMPROVEMENT

Sensory loss and disability assistance

3.3.1 The Patient and Family Relations Team have noted a theme of complaints being received from patients who have sensory loss or require reasonable adjustments for their disabilities.

3.3.2 One of the Patient and Family Relations Officers has contributed to a patient and staff story regarding the challenges of communicating effectively and providing equitable support through the PTR process for a deaf patient. Ongoing improvements in our organisational offer will be monitored through the corresponding Patient Story Tracker.

3.3.3 Ambulance Care colleagues are now working with a specialist charity (Assistance Dogs UK) and seeking advice from counterparts in the Scottish Ambulance Service to develop a Wales-wide approach to assistance animals. This will include appropriate Risk Assessments to protect other patients and staff as well the animal's safety and well-being.

3.3.4 This is an emerging area of consideration for many organisations and early scoping has identified the existence of profiteering schemes offering to 'register' animals at a cost but with no definitive checks or legal standing. The Patient and Family Relations Team and ACS have become aware of these schemes through this piece of learning and will support patients on an individual basis until a clear national position is agreed.

Demand management in the ACS

3.3.5 In response to a decreasing but continued level of complaint and incident activity, largely related to high demand and resultant Capacity Management Plan (CMP) cancellations, the Ambulance Care Management Team are driving forward a suite of improvements.

3.3.6 The CMP provides a framework for Ambulance Care to respond to situations where the demand for services is greater than the available resources. The current CMP allows provisional bookings from non-eligible service users. Eligibility is assessed via a Patient Needs Assessment (PNA), the criteria for which is set out by Welsh Government in Welsh Health Circular (2007)005.

3.3.7 Non-eligible patients are advised that their booking is provisional and may be cancelled. The matching of resources to requested journeys occurs 48 hours before travel and it is at this stage that provisional journeys may be cancelled but this can happen up to 24 hours before the time of travel and there are times

when the service is unable to contact the patient successfully meaning they do not realise until the time of travel.

3.3.8 Proposed changes include: the service will begin implementing a higher eligibility threshold for mobile non-eligible patients; a text message confirmation service will be implemented to reduce patient-initiated cancellations; in BCUHB, outpatient clinic days for patients using ACS are being adjusted to days where demand is traditionally lower meaning the likelihood of cancellations is reduced by spreading demand across the working week.

3.3.9 Whilst short-term increases in PTR activity are predicted as changes are implemented, the measures are vital to ensure the Trust prioritises patients with a definitive medical need for transport.

Address location for tourists

3.3.10 Several cases have been discussed at SCIF where difficulties were encountered in accurately locating tourist accommodation (camping/'glamping'). Although this was not believed to be causative of harm in any of the cases discussed, the delay in locating patients caused additional distress and confusion to callers, EMDs and clinical staff.

3.3.11 Service Teams in the Powys area are attempting to promote the use of 'What 3 Words' geolocation to temporary/tourist accommodation providers and trialling the collation of this within the Trust. Depending on the viability of this exercise, it will be extended to other regions.

Joint investigations

3.3.12 Themes following joint investigations remain the same with over-crowded Emergency Departments and wider system pressures resulting in high levels of escalation, lack of End-of-Life Care or ceilings of care planning and discharge delays.

3.3.13 The development of a prototype Joint Investigation Module within Datix Cymru has been completed and shared for review with a pilot Health Board. Further pilot engagement is being sought before national engagement and testing. If national agreement on its structure, adoption and associated governance can be achieved, it will provide a national learning repository for joint investigations.

NRIs

3.3.14 The incidents that have been reported as NRIs this quarter related to:

- Clinical concerns - decision to discharge at scene.

- Call management - incorrect call prioritization, Welfare Call Policy not being followed, missed ineffective breathing descriptors and incorrect address recording.

LFERs

3.3.15 Cases reviewed this quarter that will require LFERs were all related to EMS Coordination practice. Common themes related to difficulties in accurately assessing breathing and conscious status. Call handling oversight resulted in under-prioritisation of calls, leading to delayed responses and also missed opportunities to use breathing verification tools and provide correct CPR advice.

3.3.16 Correct assessment of breathing is recognised as a nuanced and challenging area of emergency call handling by the IAED as both 'under' and 'over' coding contributes to potential harm and the Operations Quality Team continues to closely monitor and intervene when the delicate balance of performance is threatened.

3.3.17 The anticipated expansion of the new RCS service to 'Amber 1' calls could offer an important 'safety net' to EMD call handling, with Clinicians being able to adjust priority levels based on informed professional judgement, providing a greater degree of sensitivity to breathing problems than the MPDS algorithm is able to achieve.

3.3.18 Learning themes from mortality, including Medical Examiner Referrals are being captured and considered at the quarterly Learning from Death Forum. Information and assurance will be provided to the next Committee Meeting in the scheduled Learning from Mortality Report.

3.4 HORIZON SCANNING

3.4.1 Organisational transformation work as part of the CMT Programme has commenced, with the introduction of RCS and the Clinical Navigator role in late November 2024 as well as changes to the CSP during December 2024. Senior clinical oversight to the CMT clinical and safety is provided by a new Sub-Group of the Clinical and Quality Governance Group (CQGG), the Clinical Advisory Group (CAG), formed to ensure early identification of learning opportunities.

3.4.2 PTR and Legal Services Teams are being kept informed of changes and alert to identifying impacts (benefit realisation and increased risks). Future reports will include detail on how these transformational efforts are manifesting within the PTR & Legal Services portfolio.

3.4.3 The Senior PTR & Legal Services Managers actively supports the Programme through consultation on written control documents, stakeholder engagement

and involvement in newly implemented daily safety huddles. These activities demonstrate a shift towards improving our Safety Management System and a desire to undertake proactive and prospective patient safety assurance.

3.4.4 The Welsh Government has published its response to the public consultation on the 'Putting Things Right' Process. An Implementation Group has been formed and engagement opportunity offered regarding possible shifts in oversight and assurance. A draft version of the updated Guidance is anticipated during Quarter 4 to enable organisations to appraise workforce and resource requirements as well as training and upskilling. A future update will be provided to members once this has been received. No formal timescale has been confirmed for an implementation date.

Welsh Ambulance Services University NHS Trust

PTR & Legal Services – Quarterly data

GIG CYMRU NHS WALES

Ymddiriedolaeth Brifysgol GIG
Gwasanaethau Ambiwlans Cymru

Welsh Ambulance Services
University NHS Trust

PTR & Legal Services – Quarterly data
Version 1.0
Released: January 2025

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by Claire Appleton
Assistant Director of PTR & Legal Services

Compliance Heatmap - *how well are we meeting national legislation & regulation?*

Assurance Profile - *what does our PTR & Legal Services data tell us about quality and safety in the Trust?*

Performance Profile - *how effectively are we managing the Putting Things Right & Legal Services functions?*

Thematic Learning – *where should we target our improvement efforts?*

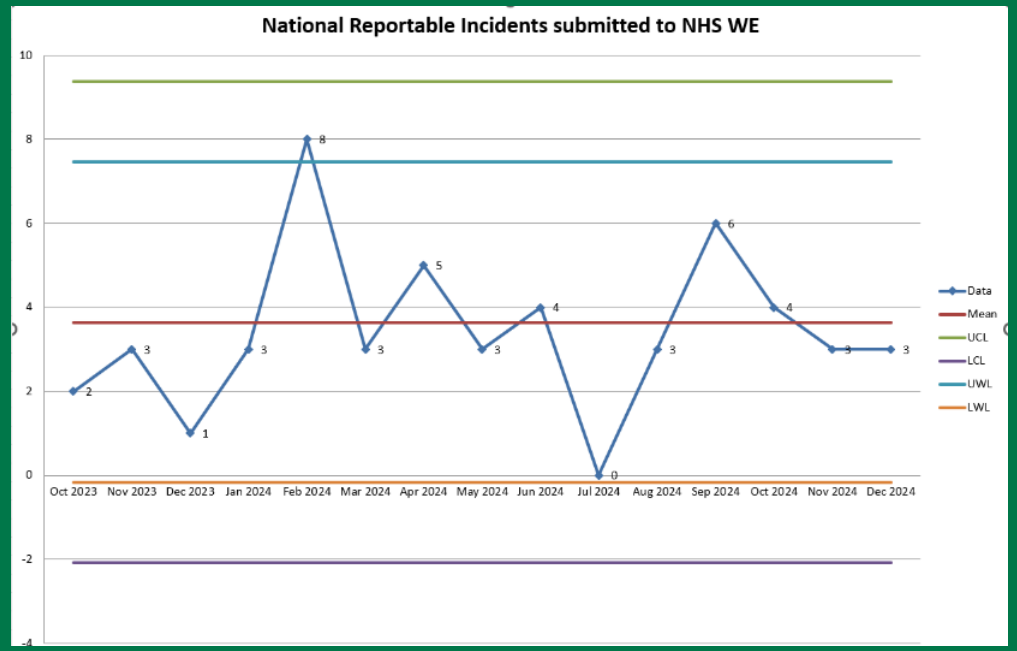
Data contained within this report is accurate at the time of reporting.

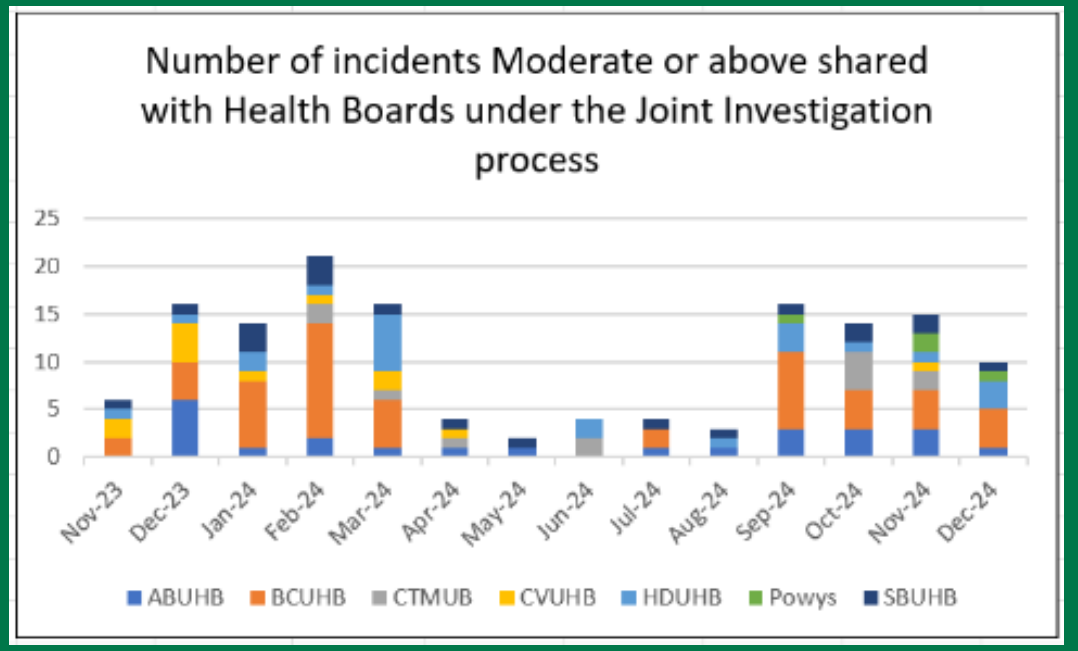
Data may be subject to change following validation, retrospective reviews and audits and ongoing clinical governance processes including regrading of incidents.

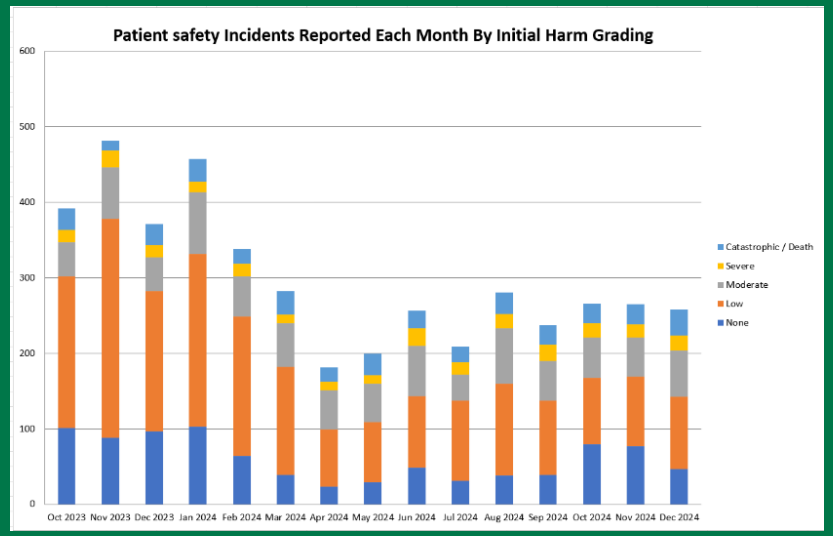
Compliance heat map

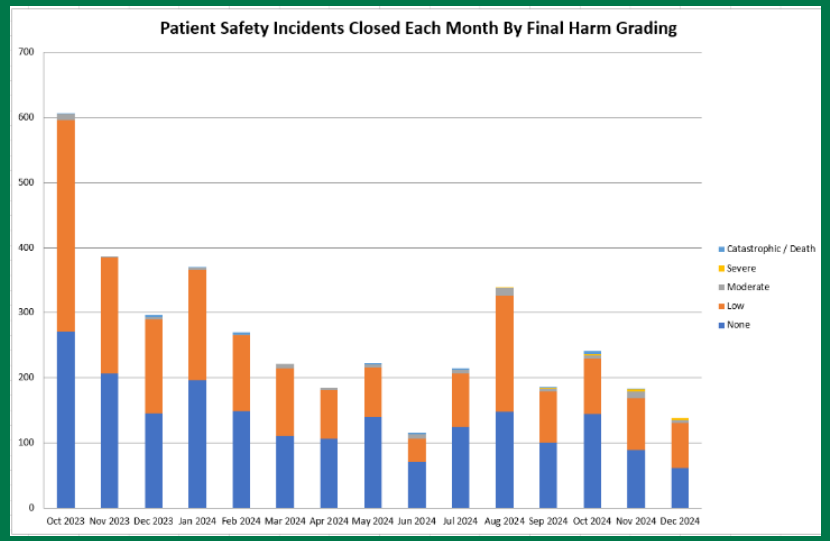
METRIC	SCORING	Q3 2023-24			Q4 2023-24			Q1 2024-25				Q2 2024-25			Q3 2024-25	
		Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Overdue NRIs	R: 10 A: 1 G: 0												40	34	29	30
Patient Safety Alerts/Notices overdue	R: 2 A:1 G: 0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Complaints acknowledged within 5 working days	R: 80% A: 90% G: 100%	71%	99%	100%	99%	95%	99%	62%	87%	98%	100%	100%	100%	99%	95%	98%
Complaints responded to within 30 working days	R: 55% A: 65% G: 75%	21%	38%	58%	53%	35%	56%	62%	50%	88%	70%	40%	46%	65%	72%	73%
Duty of Candour letters issued within 5 working days	R: NO G: YES	YES	--	NO	YES	YES	YES	NO	NO	YES	NO	YES	YES	NO	YES	--
Regulation 28 PFD reports responded to on time	R: NO G: YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Public Interest reports published by the PSOW	R: >1 A: 1 G: 0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

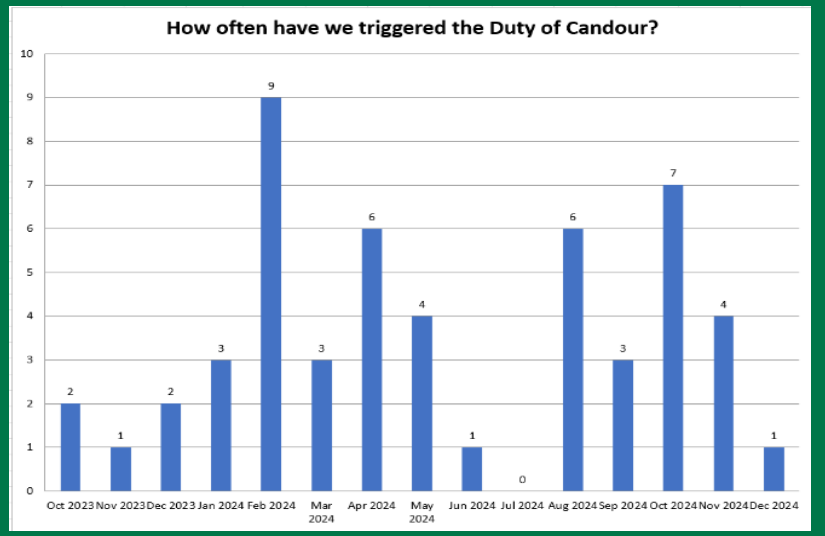
Assurance Profile – Incidents & Duty of Candour



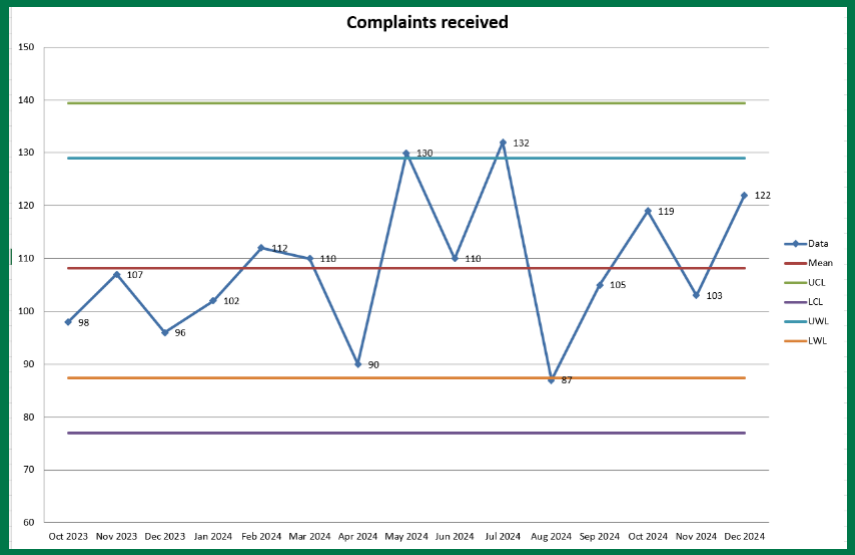


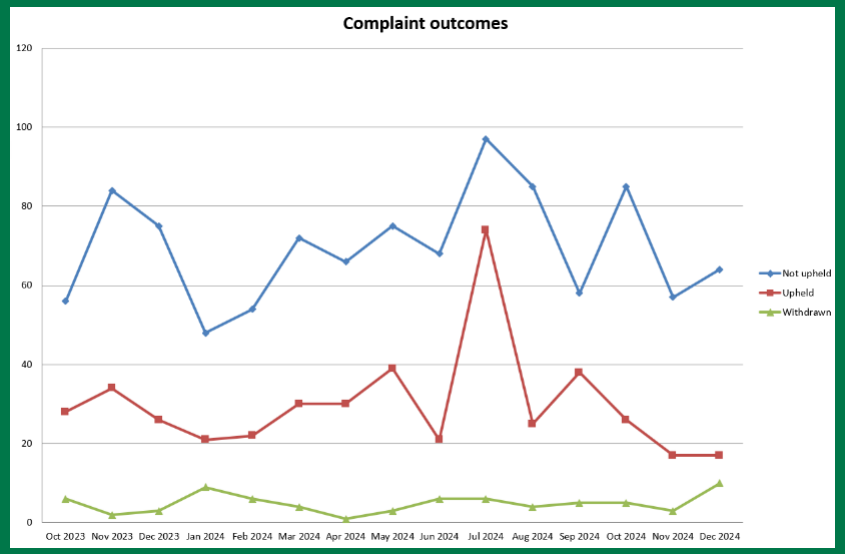




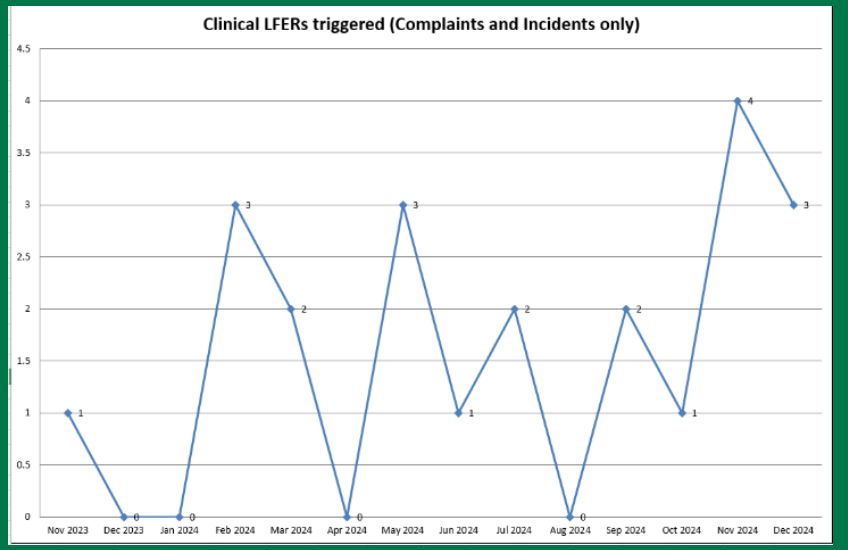


Assurance Profile – Complaints, PSOW and PTR outcomes





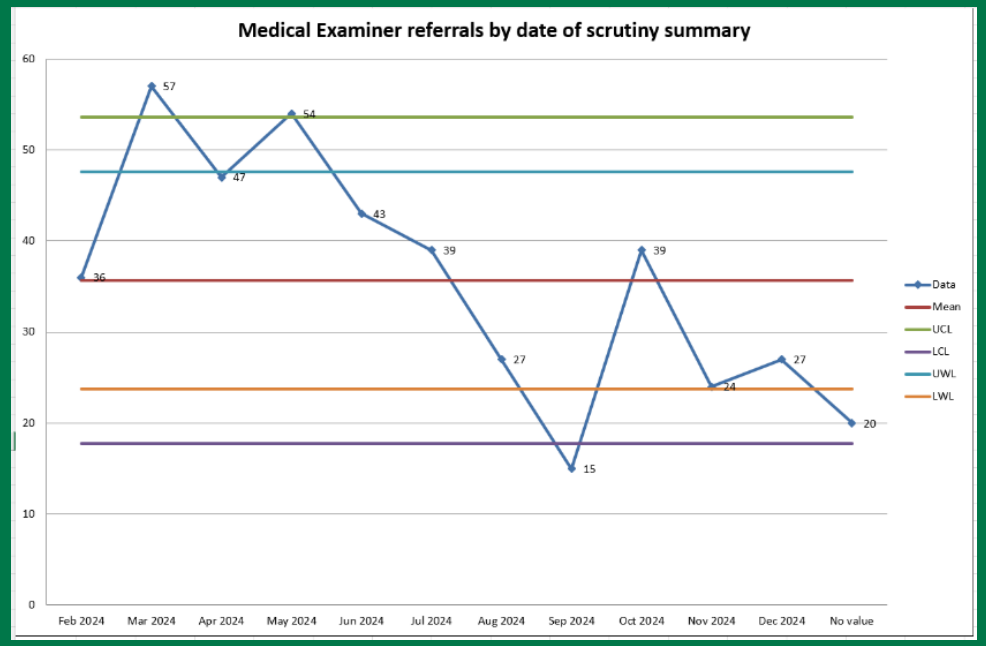
Open Ombudsmen Cases	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Open as of the end of the month	12	12	8	11	10	9	8	6	6	7	6	6	6	5	4
Cases Received	4	4	3	3	2	3	3	0	1	1	0	3	2	3	0
Cases Closed	1	1	7	0	3	4	4	2	1	0	1	3	2	3	2
Reports Received	0	0	2	2	0	0	0	1	0	1	1	0	1	1	2

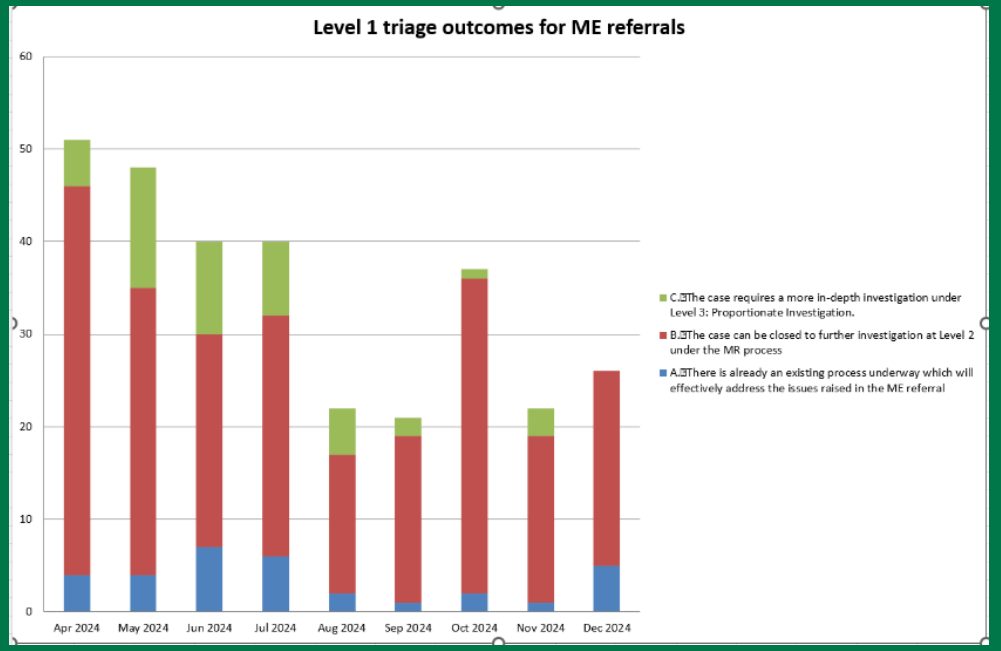


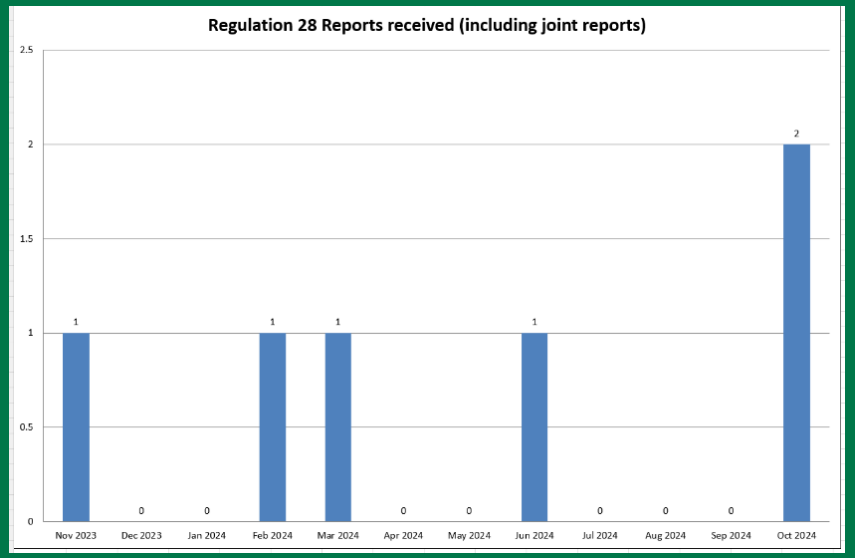
Assurance Profile –Legal Services

		Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Claims opened	Personal Injury (PI)	3	3	0*				2	0	1	1	2	0	3	1
	PI Road Traffic Accident	1	0	2*				1	0	0	4	0	2	0	1
	Clinical Negligence	5	6	5	7	5	5	4	2	2	3	6	0	5	2
	Road Traffic Accident	28	13	24*				19	23	19	14	30	14	26	16
	Damage to property	1	0	1*				9	4	2	6	2	3	5	1
Claims closed	Personal Injury (PI)	0	0	0*				0	0	0	0	0	2	0	6
	PI Road Traffic Accident	0	1	0*				0	0	0	0	1	1	1	0
	Clinical Negligence	0	1	1	0	1	0	0	1	3	0	0	1	3	0
	Road Traffic Accident	4	14	19*				17	13	13	18	29	43	30	27
	Damage to property	1	1	3*				1	0	4	1	17	1	6	11
Claims open at the end of the month	Personal Injury (PI)	70	73	73*			84	86	86	87	86	90	88	93	85
	PI Road Traffic Accident	57	56	58*			63	64	64	64	68	67	68	67	56
	Clinical Negligence	145	150	154	161	162	167	171	172	172	175	181	180	182	184
	Road Traffic Accident	293	292	297*			228	230	240	248	249	255	228	225	211
	Damage to property	21	20	18*			29	30	34	33	37	22	24	23	13
		586	***591***		***600***		***571***	***581***	***596***	***604***	***615***	***615***	***588***	***590***	***549***

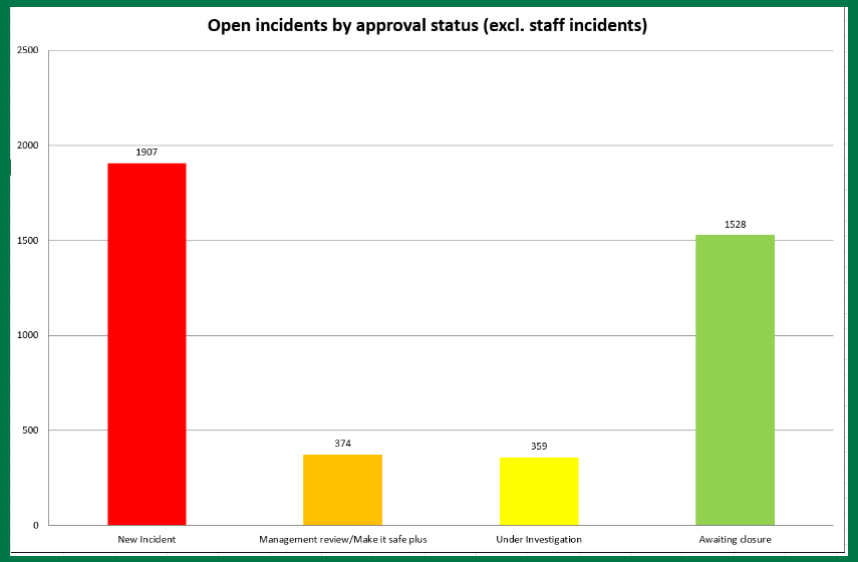
Assurance Profile – Mortality governance

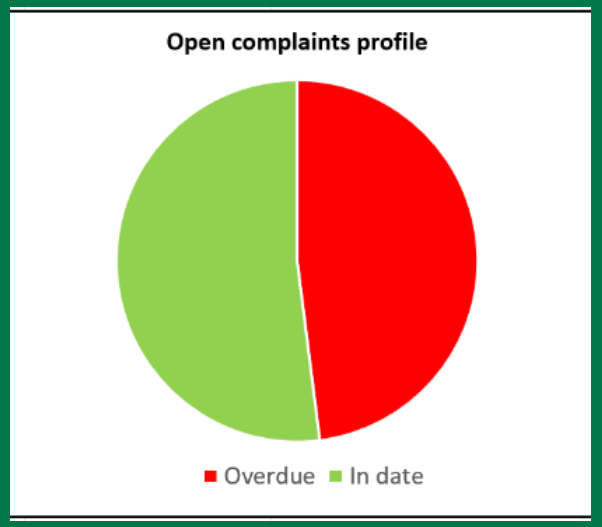


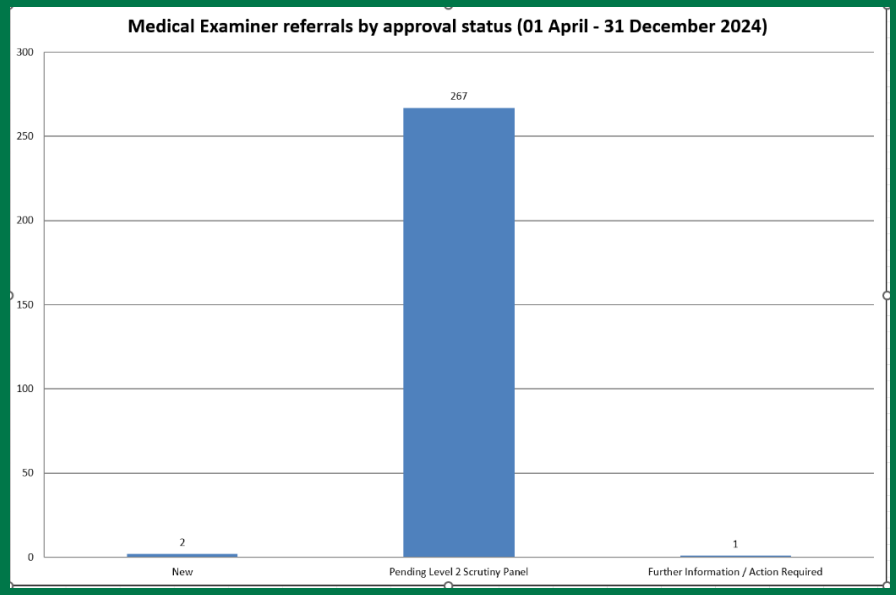


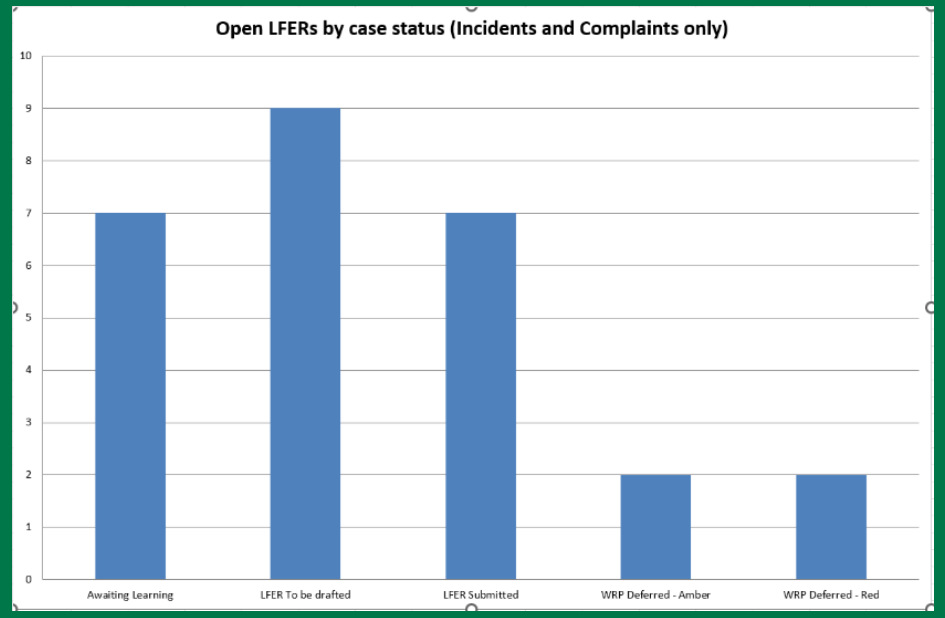


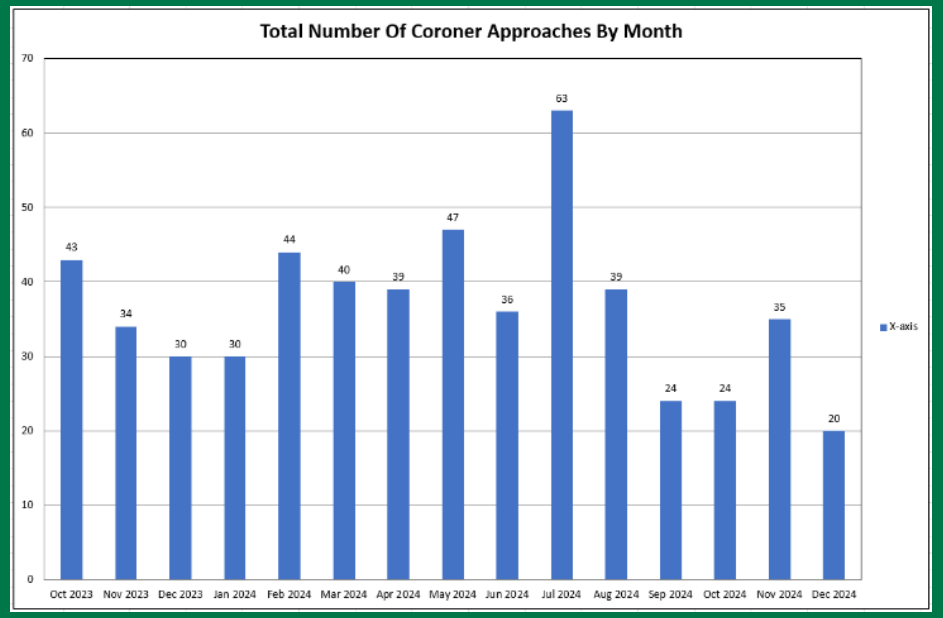
Performance Profile



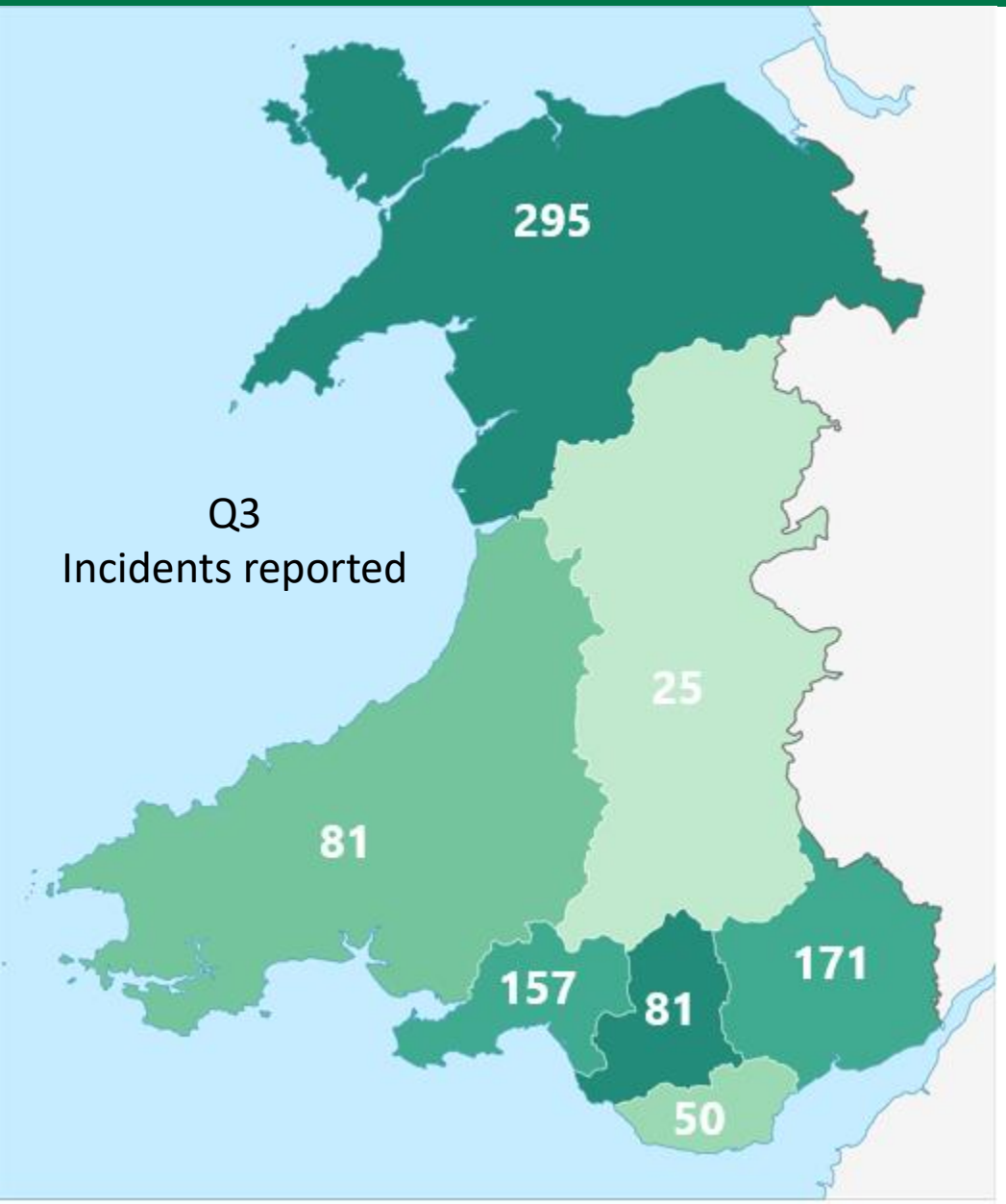








Thematic Learning - Incidents



111 Contact Centre	92
Ambulance Care Service	246
999 Coordination Centre	307
Emergency Medical Services	351

Thematic Learning -Incidents

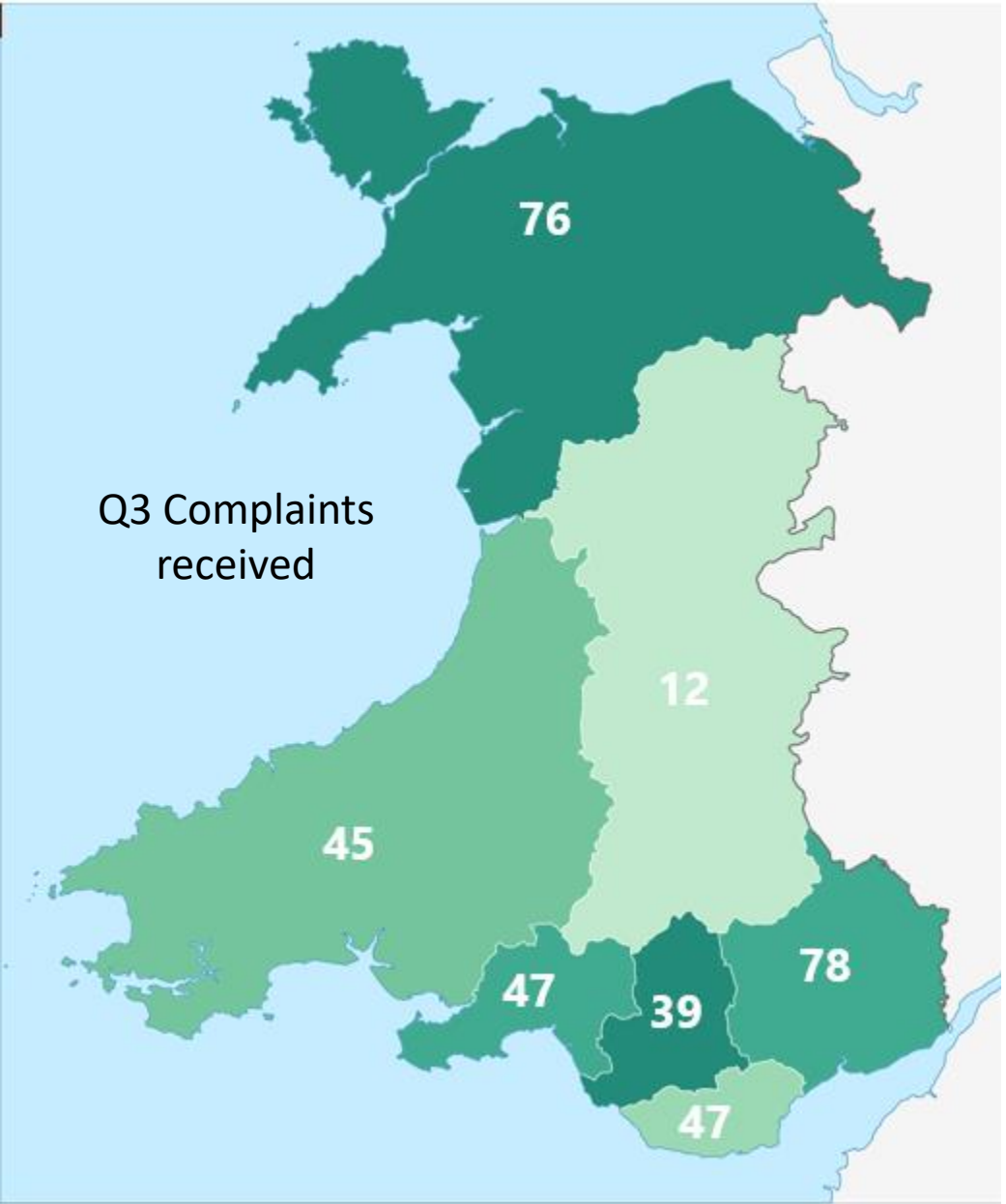
ACCESS & ADMISSION
Approximately 50% of incidents reported related to delays in admission, appointments, transfer or transport.

COMMUNICATION
Incidents were largely between healthcare staff rather than with patients

ACCIDENT AND INJURY
Patient accidents and injuries related to skin tears, falls, as well as unwitnessed falls in care homes and some safeguarding matters

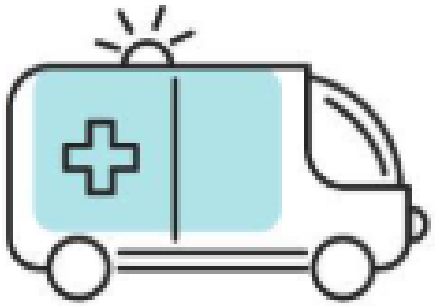
ASSESSMENT, INVESTIGATION AND TREATMENT
Incidents often originated from other provides or needed us to share them with other providers

Thematic Learning -Complaints



111 Contact Centre	29
Ambulance Care Service	152
999 Coordination Centre	110
Emergency Medical Services	53

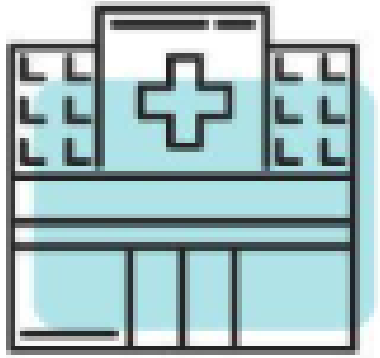
Thematic Learning - Complaints



ACCESS TO SERVICES
Delays, being asked about alternative transport and asked to self-convey

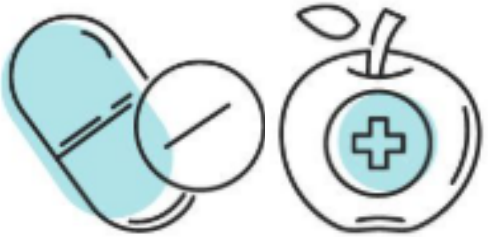
COMMUNICATION
Not receiving call-back or welfare calls, frustration & dissatisfaction with scripting and repetition

APPOINTMENTS
Distress and difficulties caused by same-day cancellations



ATTITUDE & BEHAVIOUR
Importance of patience and empathy when informing, particularly when advising of cancellations or increased waiting times

CLINICAL TREATMENT & ASSESSMENT
Largely centered on decisions not to convey and feeling the treatment advice or plan offered ought to have been more robust



AGENDA ITEM No	14
OPEN	OPEN
No of ANNEXES ATTACHED	1

MONTHLY INTEGRATED QUALITY & PERFORMANCE DASHBOARD – November/ December 2024

MEETING	QUEST
DATE	4 February 2025
EXECUTIVE	Rachel Marsh – Executive Director of Strategy, Planning & Performance
AUTHOR	Melanie O'Connor - Senior Performance Analyst Mark Thomas – Commissioning & Performance Manager Hugh Bennett - Assistant Director, Commissioning & Performance
CONTACT	Melanie.O'Connor@wales.nhs.uk Mark.Thomas12@wales.nhs.uk Hugh.Bennett2@wales.nhs.uk

EXECUTIVE SUMMARY

1. The purpose of this report is to provide senior decision makers in the Trust with an integrated dashboard (Our Patients, Our People, Value and Partnerships/System Contribution) focused on the "vital few" key metrics. This report is for **November/December 2024.**

2. The report aims to provide an integrated view of quality & performance, so is made available to all three committees, to give that overview, with more specific and detailed reports supplementing it. Whilst giving an integrated overview, each slide contains an icon denoting the lead committee for each set of indicators.

3. Data quality issues have been identified and are being addressed within 111, APPs and throughout the quality indicators, with the result that there are a number of Board approved metrics which are not available at this time.

4. The response times for red 8-minute performance was 47.59 % in December 2024, with performance being maintained compared to November, despite winter pressures. Amber 1 median was 3 hours, as forecasted and modelled, and much longer than the one hour/one and a half hours the Trust has normally been experiencing. The Trust knows these extended times (the ideal is 18 minutes) leads to avoidable patient harm. The Trust continues to work on tactical actions within its control to mitigate this risk including maintaining high levels of EA production (95% in December, achieving the benchmark) and fully rolling out the CHARU service (89% in December, highest achieved

to date); whilst also undertaking more transformative actions through the Clinical Model Transformation (CMT) Programme.

5. The Trust lost 25,195 hours to handover in December 2024. This level of lost capacity is difficult to compensate for, despite all the actions being taken by the Trust.

6. The 2024/25 budget includes further investment in activities designed to shift demand left and mitigate the impact of handover lost hours, in particular, investing in clinical screening and APPs, which form part of the CMT Programme.

7. 111 call handling performance has stabilised post-delivery of the new 111 CAS. The service did not achieve the 5% abandonment rate in December 2024, although performance was just outside the upper control live (13%) at 14.5% Planned production for December was boosted, based on demand forecasts, and as part of the Trust's winter planning, but was affected by high sickness reflecting wider sickness in the population.

8. Ambulance Care, in particular, Non-Emergency Patient Transport Service's (NEPTS) performance is stable, with oncology remaining above target, however, renal performance dropping below target for the third consecutive month since March 2020. Both the NET Centre and NEPTS transport are due to be re-rostered in 2024/25, a key efficiency.

9. The Trust continues to focus on its people, with a range of actions in place to improve workplace experience including, for example, reducing shift overruns, whilst also continuing with the more strategic focus on the People & Culture Plan. Sickness absence was 8.69% in December 2024 being above 8% for the second month since March 2024. The IMTP ambition is to reach 6%. The Trust will continue its focus on sickness absence. EMS abstractions was slightly above the 30% benchmark in December 2024 at 31.05%.

10. The Trust is continuing to deliver its Clinical Model transformation (CMT) programme at pace. Key parts went live in December, in particular, remote clinical screening (RCS), which was a cultural shift in how the Trust manages 999 demand.

RECOMMENDATION
QUEST is asked to: -

i. Consider the November/December 2024 Integrated Quality & Performance Report and actions being taken and determine whether:
a) The report provides sufficient assurance.
b) Whether further information, scrutiny or assurance is required, or

c) Further remedial actions are to be undertaken through Executives.

REPORT APPROVAL ROUTE
21.01.25 Assistant Director Commissioning & Performance 29.01.25 Executive Leadership Team (ELT) 30.01.25 Trust Board (TB)

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

SITUATION

1. The purpose of this report is to provide senior decision makers in the Trust with an integrated dashboard (Our Patients, Our People, Value and Partnerships/System Contribution) focused on the "vital few" key metrics. This report is for **November/December 2024.**

2. The report aims to provide an integrated view of quality & performance, so is made available to all three committees, to give that overview, with more specific and detailed reports supplementing it. Whilst giving an integrated overview, each slide contains an icon denoting the lead committee for each set of indicators:-

Slide Title	Slide Number
Red Performance Indicators	6
Amber Performance Indicators	7
Clinical Indicators	9
Clinical Indicators	10
Patient National Reportable Incidents & Patient Concerns	11
Patient & People Safety Indicators	12
Coroners, Mortality and Ombudsmen Indicators	13
Handover Indicators	30
Handover Lost Hours Against Red & Amber 1 Responded Incidents	31

BACKGROUND

3. This Integrated Quality & Performance Report contains information on key indicators at a highly summarised level which aims to demonstrate how the Trust is performing across four integrated areas of focus: -

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

4. As previously agreed, the metrics which form part of this committee/Board report are updated on an annual basis, to ensure that they continue to represent the best way of tracking progress against the Trust's plans (IMTP) and strategies. The 2024/25 revised metrics have been agreed.

ASSESSMENT

Our Patients – Quality, Safety and Patient Experience

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

6. **999** call answering times declined in December with the 95th percentile at 1 minute 10 seonds, compared to 1 minute in November 2024. The 65th percentile and median performance remain consistently good, however data quality checks are being undertaken.

7. **111 call answering performance has declined over recent weeks,** and the call abandonment performance was at 14.5% in December, not achieving the 5% target. One of the key issues has been the temporary reduction in call handling staff in post caused by a redirection of available training capacity towards the delivery of the new 111CAS system. Recruitment has been undertaken to recover the staff in post to establishment position and this along with bank and overtime is being used to boost production in December above the 95%-unit hours production benchmark. It should be noted that there is also a reduction in the commissioned level of call handler FTEs in 2024/25 compared to last year (-4%).

8. 111 demand in December 2024 was 1.4% higher than during December 2023, resuming the longer term upward trend. The Trust is on target to procure a third party in January 2025 to undertake a collaborative (with commissioners) and independent review of the Trust's 111 call handler rostering practices, including a review of demand levels and required staffing capacity.

9. **111 Clinical response:** clinical ring back times for patients with the highest priority remained above target at 93.4%. Response times for lower priority calls dropped just below target this month, recording 74.1% and 74.2% for P2CT and P3CT respectively.

10. **Ambulance Response** (safety / patient experience): the red 8-minute response performance for December 2024 was 47.59%, remaining below the 65% target, but maintaining performance compared to November. The Trust is reaching more red patients in 8 minutes, but the denominator (demand) has also grown. The Amber 1 median in December was 3 hour and the Amber 1 95th percentile was 12 hours 11 minutes. The Clinical Safety Plan and CHARUs will protect red demand, but Amber is where the impact of handover lost hours is felt i.e. there is a strong correlation. These long response times have a known impact on avoidable patient harm.

11. Traditionally the main factors which affect response times are demand and capacity (recruitment and lost hours). A recruitment gap has been identified and

is currently being addressed through a series of corrective actions, but the lost capacity through handover at hospital remains extremely challenging and largely out of the Trust's control to address. The Trust's main focus is to implement a material change in how it responds to patient demand by evolving its clinical model through the Clinical Model Transformation (CMT) programme, elements of which will be implemented before winter. Areas of focus include: -

- Data quality issues have been identified with APPs and these are currently being addressed.
- Further investment into remote clinical capacity (+28.5 FTEs);
- Further investment in APPs (+32 APPs);
- Development of the remote integrated care service (111 clinicians and CSD clinicians);
- Continued focus on a range of responses that support non-conveyance, where it is clinically safe and appropriate to do so: Connecting Support Cymru, mental health response pilot, Falls response etc.
- Formal reporting of the 2023 collaborative and independent EMS Demand & Capacity review.

12. The one area of particular focus for recruitment is CHARU: with the Trust looking to recruit up to the modelled 153 FTEs; and connected to this a focus on CHARU productivity. The Trust achieved an 89% CHARU UHP in Dec-24, the highest it has achieved and is now seeking to close the remain gap through the recruitment of fully qualified paramedics.

13. As above, the extreme level of lost hours to **handover outside Emergency Departments** remains the critical component of long waiting times and patient safety incidents. 25,195 hours were lost during December 2024. Cardiff & Vale's handover lost hours continue to remain comparably much lower, due to an organisational focus within the health board. While some small improvements have been seen in other health boards in recent months, Betsi Cadwaladr health board remains significantly high and above its two-year average figure (7,757). WG have re-iterated to health boards the critical importance of improvements in this area. The WG pan-Wales target of no handovers of more than one hour, equates to 7,500 lost hours.

14. **Ambulance Care (Patient Experience)**: Oncology performance in December 2024 was 77.58%, hitting the 70% target. Renal performance remained below target for the third month at 69.14%. Advanced discharge & transfer journey performance decreased compared to the previous month to 75% and remains below the 95% target. Overall demand for NEPTS continues to increase and is now above pre-pandemic levels. The Trust has a comprehensive Health Transport transformation workstream in place, which includes delivering a range of efficiencies and improvements. The Trust is also about to re-roster NEPTS

transport which will better align available capacity with changing demand patterns (on target).

15. **National Reportable Incidents (NRIs) / Concerns Response**: the Trust reported three NRI's to the NHS Executive in December 2024, remaining consistent with November 2024; and 10 serious patient safety incidents were referred to health boards under the Joint Investigation Framework. In December 2024 complaint response times improved to 73%, an improvement on the 71% recorded in November 2024, remaining just below the 75% target, with cases remaining complex.

16. **Clinical outcomes**: The percentage of suspected stroke patients who are documented as receiving an appropriate stroke care bundle was 88.7% in December 2024, remaining below the 95% performance target. Work is ongoing to improve reporting and compliance through the ePCR system and this improvement is being seen clearly in most of the clinical indicators. The return to spontaneous circulation (ROSC) compliance rate increased to 22.3% in December 2024 compared to 19.1% in November 2024.

17. The Trust can report on call to door times for Stroke and STEMI patients. For December 2024, these highlight call to hospital door times of three hours and 6 minutes for stroke patients and two hours and sixteen minutes for STEMI. Clearly these times are too long and are representative of the longer response times for all calls, as a result of the pressures and issues outlined in this report.

18. In December 2024, 10,528 patients **cancelled** their ambulance, and the Trust was unable to send an ambulance due to the application of the Clinical Safety Plan levels to approximately 474 callers. The Trust believes that 50% of this combined number is unmet demand and is likely to be presenting elsewhere in the system. Anecdotal evidence from health boards supports this view, but data linking planned for 2024/25 is a key enabler to properly evidence this. The Trust changed its Clinical Safety Plan in December, removing the "can't send" application as higher level of the olde plan, with the option remaining at the strategic commander's discretion in the new plan.

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

19. **Hours Produced**: The Trust produced 124,279 Ambulance Response unit hours in December 2024 and delivered an emergency ambulance unit hours production (UHP) of 95%, achieving the 95% target.

20. **Response Abstractions:** EMS abstraction levels decreased to 31.05% in December 2024, fractionally above the 30% benchmark figure. Response sickness abstractions stood at 8.44% (benchmark 5.99%).

21. **Trust sickness absence:** the Trust's overall sickness percentage was 8.69% in December 2024, a slight increase on the 8.06% recorded in November 2024. Actions within the IMTP concentrate on staff well-being with an aim to continue to reduce this level supported by the ten-point plan. The 8% is above the 2023/24 IMTP ambition of 6%.

22. **Staff training and PADRs:** PADR rates did not achieve the 85% target in December 2024 but have been remaining consistent (76.55%). Compliance for Statutory and Mandatory training increased slightly to 85.51%, achieving the 85% target for the first time since November 2022.

23. **People & Culture Plan**: the Trust launched its People & Culture Plan in April 2023 and workstreams are being delivered around behaviours, in particular, sexual safety, Freedom to Speak Up, 111 culture review, flexible working, and the introduction of a staff pulse survey tool. The Executive Leadership Team undertook another round of a pan-Wales of CEO Roadshows in October 2024. The next round of CEO Roadshows are planned for April 2025.

Finance & Value

24. **Financial Balance**: the reported outturn performance at Month 9 is a surplus of £42k and the Trust is forecasting to achieve both its External Financing Limit and its Capital Expenditure Limit.

Partnerships & System Contribution

25. We are not able to report on the consult & close rates as the 111 contribution is not available due to issues with system changes within the 111 CAS system. The IMTP ambition (and Welsh Government target) remains 17% at this point in time. The Trust is currently validating new data in this area.

26. Same Day Emergency Care (SDEC) centres continue only see a low level of ambulance activity and handover levels remain extreme, which make the work on the updated clinical model, before next winter, a tactical imperative. Data quality checks are underway.

Summary

27. The indicators used at this high-level highlight that 111 was more resilient this December, than in in previous years. For the 999-emergency pathway, the Trust produced good metrics on what it can control e.g. production, abstractions etc. and managed to turn on new elements of its clinical model transformation programme, however, hospital handover lost hours remain extreme. These levels give further imperative to continuing with the clinical model transformation.

NEPTS performance was stable, with the Trust about to re-roster NEPTS transport.

RECOMMENDATIONS

QUEST is asked to: -

i. **Consider the November/December 2024 Integrated Quality & 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.

Welsh Ambulance Services University NHS Trust

Monthly Integrated Quality & Performance Report

October/November 2024

Annex 1 – Top Indicator Dashboard

GIG CYMRU NHS WALES

Ymddiriedolaeth Brifysgol GIG
Gwasanaethau Ambiwlans Cymru

Welsh Ambulance Services
University NHS Trust

Annex 1 – Top Indicator Dashboard
Version 1.0
Released: January 2024

by Commissioning & Performance Team

Section 1: Monthly Indicators / Top Indicator Dashboard

Top Monthly Indicators	Target 2024/25	Oct-24	Nov-24	2 Year Average	RAG
Our Patients					
Timeliness Indicators					
NHS111 Call Handling Abandonment Rates	< 5%	5.0%	5.0%	10.5%	G
111 Clinical Triage Call Back Time (P1)	90%	100.0%	97.7%	98.4%	G
999 Call Answer Times 95th Percentile	00:06	00:25	01:00	00:18	R
999 Red Response within 8 minutes	65%	50.4%	47.6%	49.2%	R
999 Amber 1 Median	00:18	01:43	01:56	01:24	R
Oncology Journeys arriving within 45 mins and up to 15 minutes after appointment time	70%	73.3%	75.2%	72.5%	G
Advanced Discharge & Transfer journeys collected less than 60 minutes after booked time (NEPTS)	90%	80.6%	76.3%	81.1%	R
Clinical Outcomes / Quality Indicators					
Return of Spontaneous Circulation (ROSC)	Increasing Trend	16.8%	19.1%	18.7%	G
Stroke Patients with Appropriate Care	95%	88.6%	90.5%	79.7%	A
Stroke Call to Hospital Door Times	Reduction Trend	02:37	02:48	02:20	R
ST-Elevation Myocardial Infarction (STEMI) with Appropriate Care	95%	60.2%	70.1%	48.5%	R
National Reportable Incidents reports (NRI)		4	3	4	
Can't Send & Cancelled by Patient Volumes	Reduction Trend	10,867	11,154	9,066	A
Concerns Response within 30 Days	75%	65.0%	71.0%	44.5%	A
Enactment of the Duty of Candour Total		7	4	4	
Our People					
Capacity					
Hours Produced for Emergency Ambulances	95-100%	93%	95%	90%	G

Top Monthly Indicators	Target 2024/25	Oct-24	Nov-24	2 Year Average	RAG
Health & Well-being					
Sickness Absence *(all staff)*	6.0%	7.74%	8.00%	7.99%	R
Mental Health Absence Rates	Reduction Trend	2.49%	2.58%	2.25%	A
Staff Turnover Rate	Reduction Trend	8.02%	8.45%	8.91%	G
Statutory & Mandatory Training	>85%	83.35%	84.47%	75.44%	A
PADR/Medical Appraisal	>85%	77.22%	76.51%	73.05%	A
Number of Shift Overruns	Reduction Trend	3,646	3,534	3,653	A
Inclusion & Engagement / Culture					
NEPTS % of Total Calls Answered in Welsh	Increasing Trend	1.9%	1.6%	1.6%	G
Value					
Financial balance - annual expenditure YTD as % of budget expenditure YTD	100%	100.00%	100.00%	100%	G
EMS Utilisation Metric (CHARU)	Increasing Trend	27.3%	28.1%	27%	G
Average Jobs per Shift (All Vehicles)	Increasing Trend	2.25	2.26	2.32	R
NEPTS on the Day Cancellations	Reduction Trend	13.9%	13.8%	13%	R
Partnerships / System Contribution					
Inverting the Triangle					
Successful Consult & Close Outcome	17.0%	N/A	N/A	13.3%	
% Of Total Conveyances taken to a Service Other Than a Type One Emergency Department	Increasing Trend	11.31%	11.46%	11.3%	G
Number of Handover Lost Hours	7,500	21,880	20,995	22,293	R

In-Month RAG Indicates =

Green: Performance is at or has exceeded the target *(Indicates no action is required)*

Amber: Performance is at or within 10% of target *(Indicates some issues/risks to performance (monitoring is required))*

Red: Performance is less than 10% of target (Indicates close monitoring or significant action is required)

TBD: Status cannot be calculated (To Be Determined)

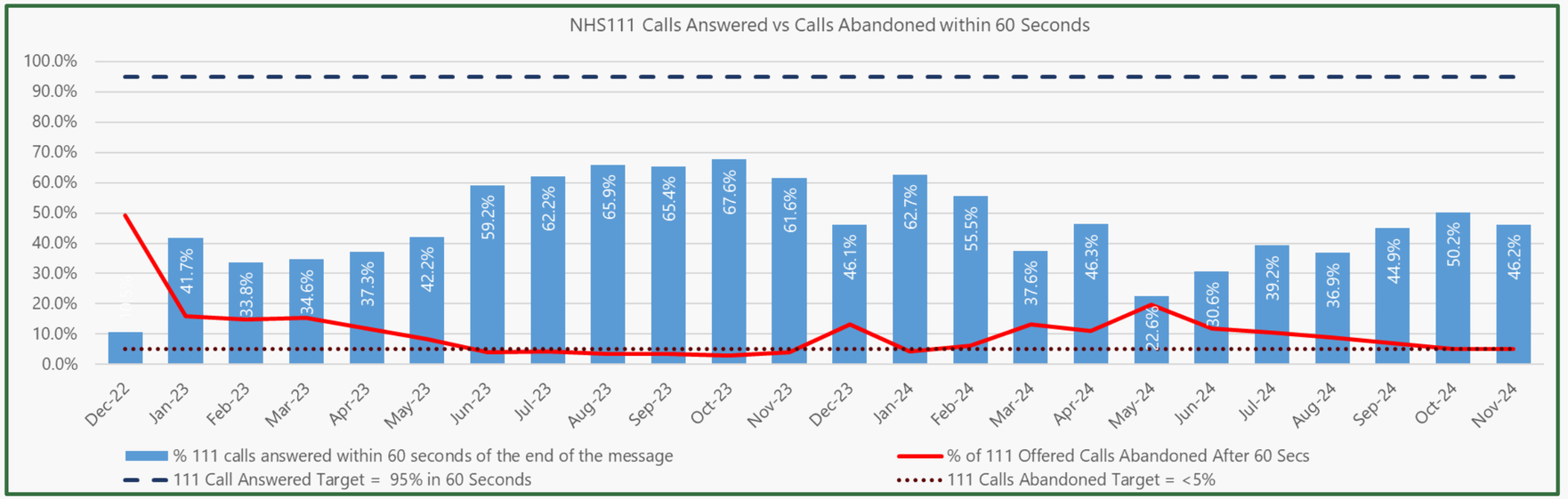
Our Patients: Quality, Patient Safety & Experience
111 Call Answering/Abandoned Performance Indicators

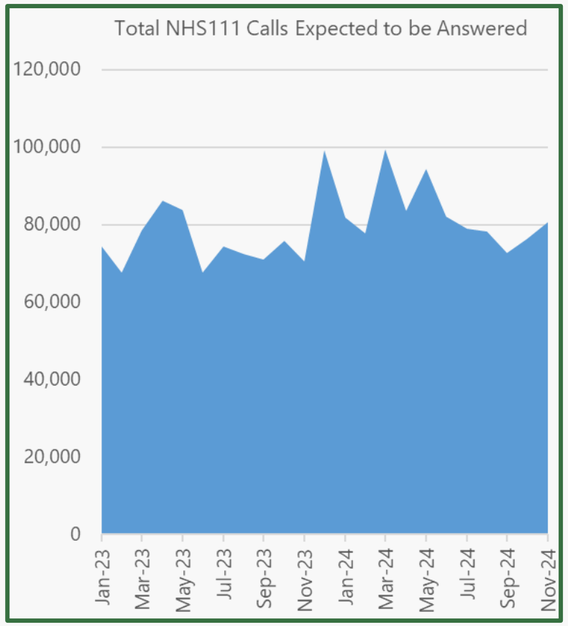
(Responsible Officer: Lee Brooks)

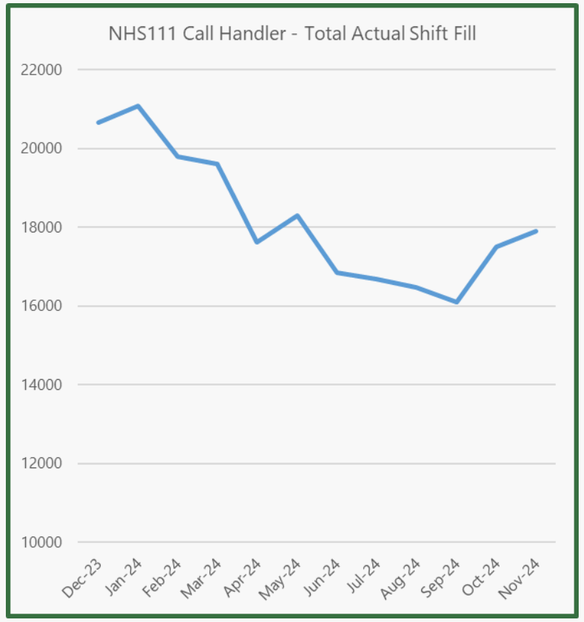
Abandonment Rate G

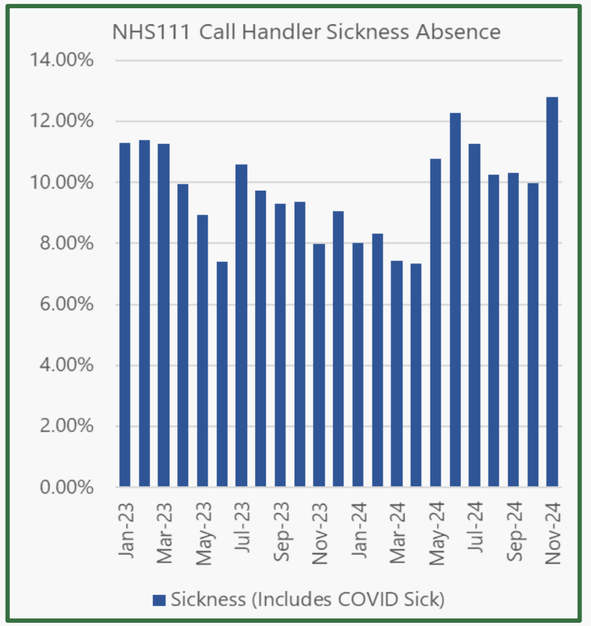
FPC

Influencing Factors – Demand and Call Handling Hours Produced









Analysis

The 111-call abandonment rate remained consistent at 5% in November 2024, achieving the 5% target for the second time in 10 months. The percentage of 111 calls answered within 60 seconds decreased, from 50.2% in October 2024 to 46.2 % in November 2024 and continues to remain below the 95% target.

Performance declined during the middle part of the year, due mainly to the introduction of the new 111CAS system, which went live on 30th April 2024. In the run up to this implementation staff were abstracted for training, recruitment was paused and after go-live, staff were familiarising themselves with the system, all of which had an impact on efficiency. Since that time there has been a steady improvement in performance.

Remedial Plans and Actions

Key actions include:

- Actions have been undertaken to try and improve the call handling position across the Winter months with record levels of resourcing planned for December as well as opportunities for further bolstering including overtime, bank and managers/supervisors also re-aligned to call handling.
- A focus on realising the benefits of the new 111CAS;
- A 111-re-roster pre-work review that takes account of the increased demand the Trust is seeing; what levels of performance commissioners want and the mix of capacity and efficiencies to achieve this.

Expected Performance Trajectory

The expectation is that with the recruitment of additional staff, performance will continue to improve; however, there are risks including higher levels of demand and high sickness levels.

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

(Responsible Officer: Lee Brooks)

P1CT G

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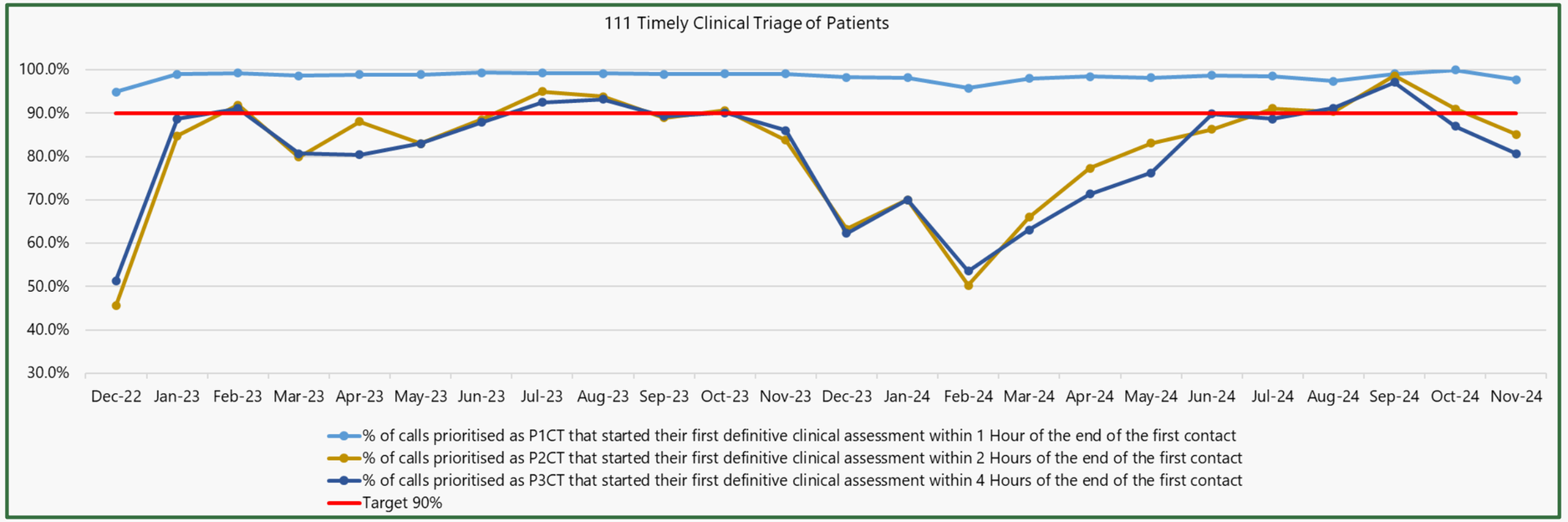
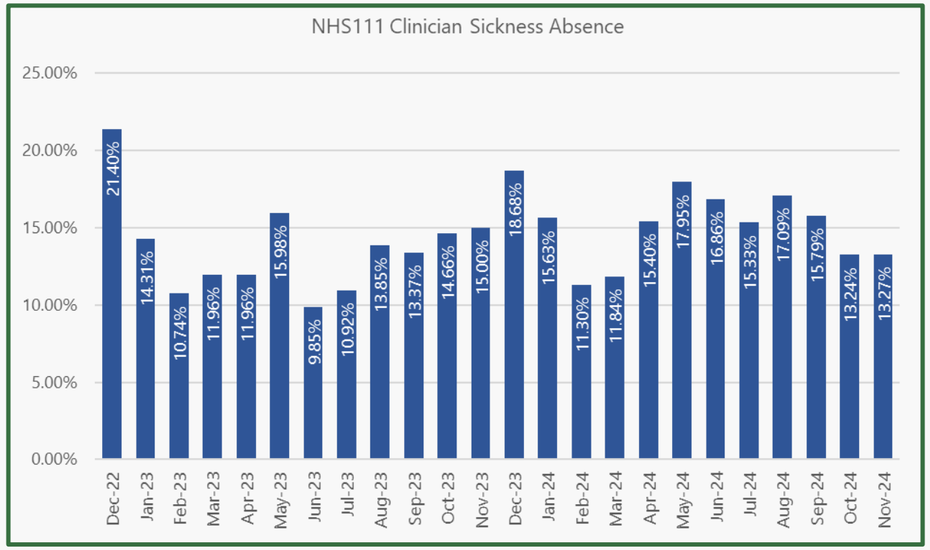
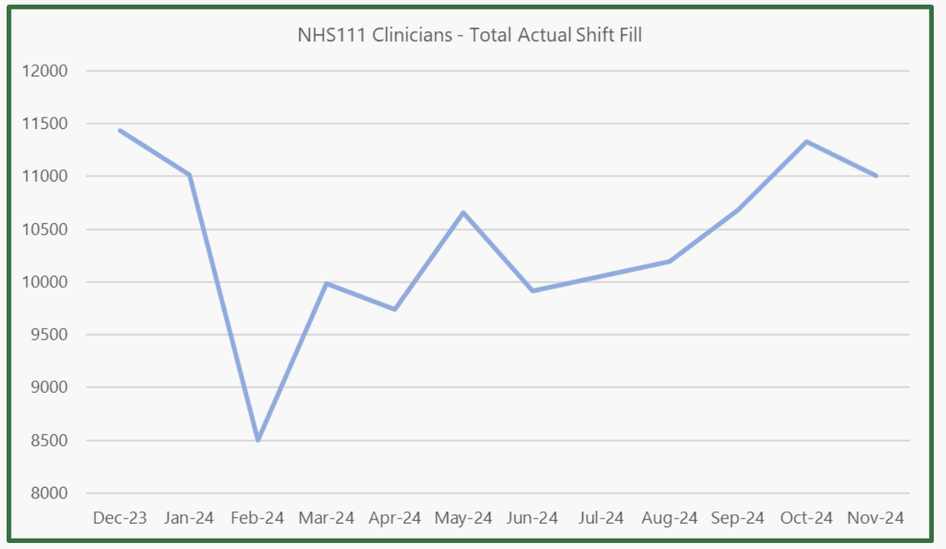
NB: Data quality issues have been identified in 111. These are currently being addressed.







Analysis

The highest priority calls, P1CT, achieved the 90% target, recording 97.7% in November 2024.

Ring back times for lower category calls have improved since February 2024, reversing a previous deterioration in performance, this was despite a drop in shift fill levels during June 2024.

Numbers of clinician hours produced declined slightly in November 2024 to 11,007 from 11,328 in October 2024. Clinician sickness absence also deteriorated slightly during the month to 13.27%.

Remedial Plans and Actions

The key actions include:

- A focus on delivering the benefits of the new 111CAS.
- Recruitment up to commissioned levels of clinicians
- A demand and capacity review to determine appropriate levels of capacity to meet increasing demand (this may now be delayed to enable the impact of the work on the digital front end to take effect).

Expected Performance Trajectory

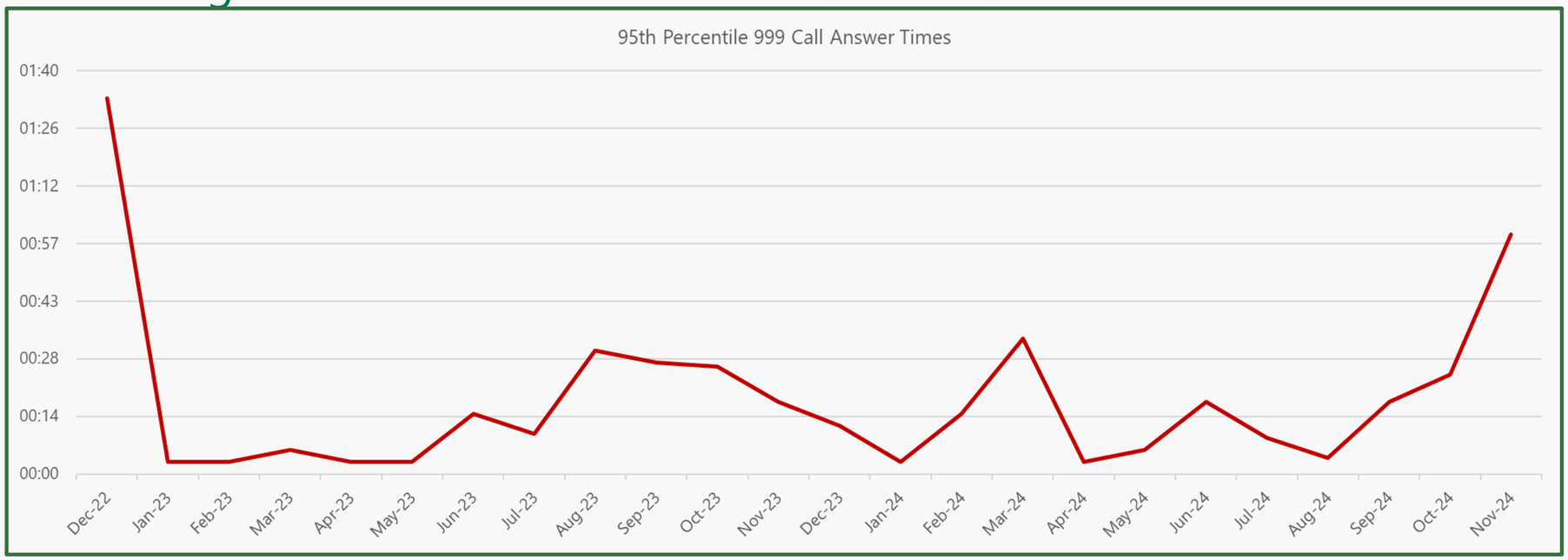
The new 111CAS will bring performance benefits. Welsh Government have asked that WAST model call handling performance through the winter. This is not the same as clinician performance but should provide useful intelligence on what the Trust may achieve for clinical triage performance.

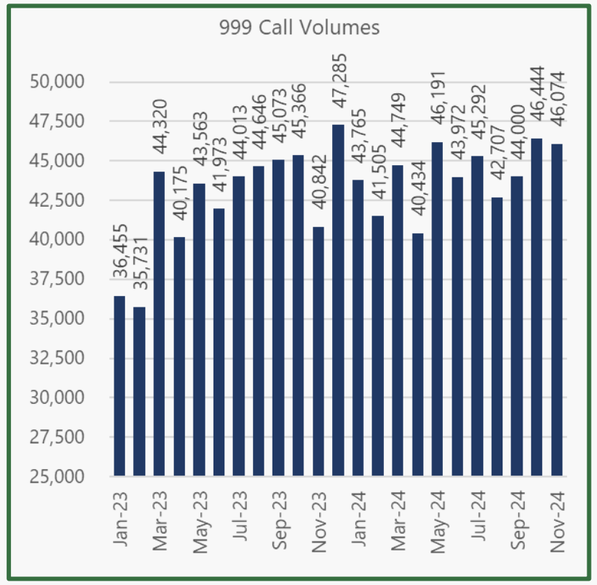
Our Patients: Quality, Safety & Patient Experience
999 Call Performance Indicators

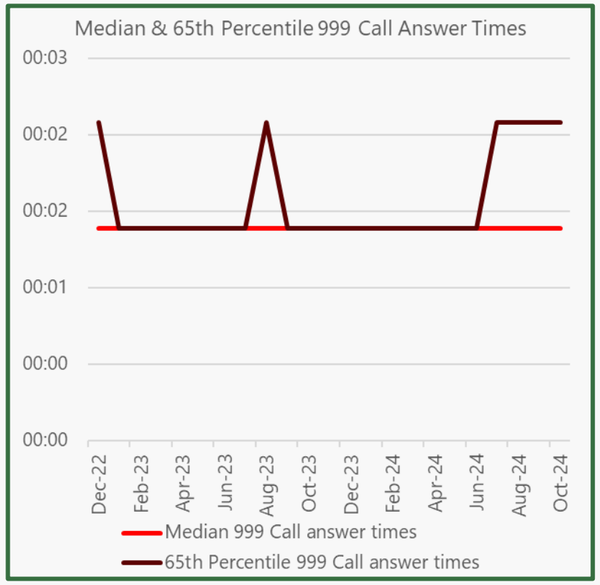
(Responsible Officer: Lee Brooks)

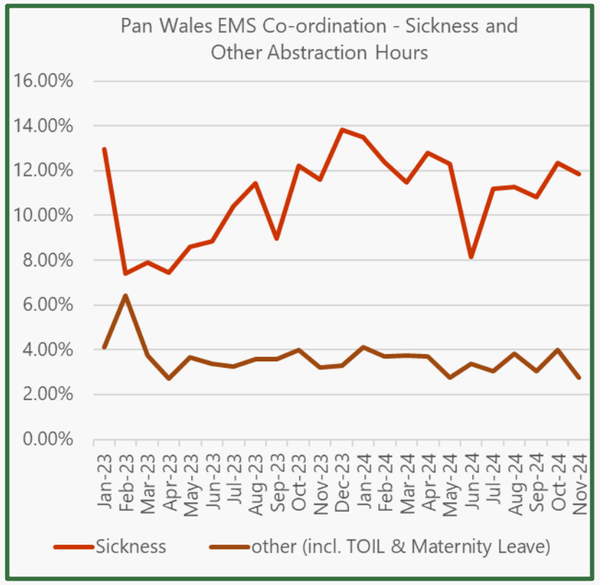
R FPC CI

Influencing Factors – Demand and Hours Produced









Analysis

The 95th percentile 999 call answering performance did not achieve the 6 second target (01:00) in November 2024; however, the median call answer time for the 999-service remains consistently good at 2 seconds in October 2024. However, due to the migration of the 999-telephony service, data quality is being undertaken for November 2024 data.

There was a very slight decrease in demand in November 2024 to 46,074 calls from 46,444 in October 2024.

Sickness levels saw a decrease from 12.34% in October 2024 to 11.86% in November 2024.

Remedial Plans and Actions

- Over establishment has been approved for EMSC by the Executive Director of Operations with call takers currently above establishment (105.76 FTEs v 122 WTEs).
- Will continue to overrecruit for the next few months (as approved by the ADO and the EDoOps) into the winter months which will also support potential losses from the Bryn Tirion move to Ty Elwy.
- Further recruitment drives in all three centres are planned for November, January & March with 12 per cohort.

A transformation programme concluded in November:

- **Roster Review.** A dispatch roster review for Allocators and Dispatchers.
- **Boundary changes.** Realignment of dispatch boundaries to balance workload and pressures for individual dispatch teams.
- **Broader Ways of Working**. This project is looked to create efficiency, effectiveness and improved productivity through a review of processes and procedures as well as providing consistency and reduction in variation across centres.

Expected Performance Trajectory

The median and 65th percentile are performing very well and are stable. The above changes should provide further resilience. There is some resilience to demand increases, but this needs to be kept under review.

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

Influencing Factors – Demand, Hours Produced and Hours Lost

(Responsible Officer: Lee Brooks)

8 Min
R

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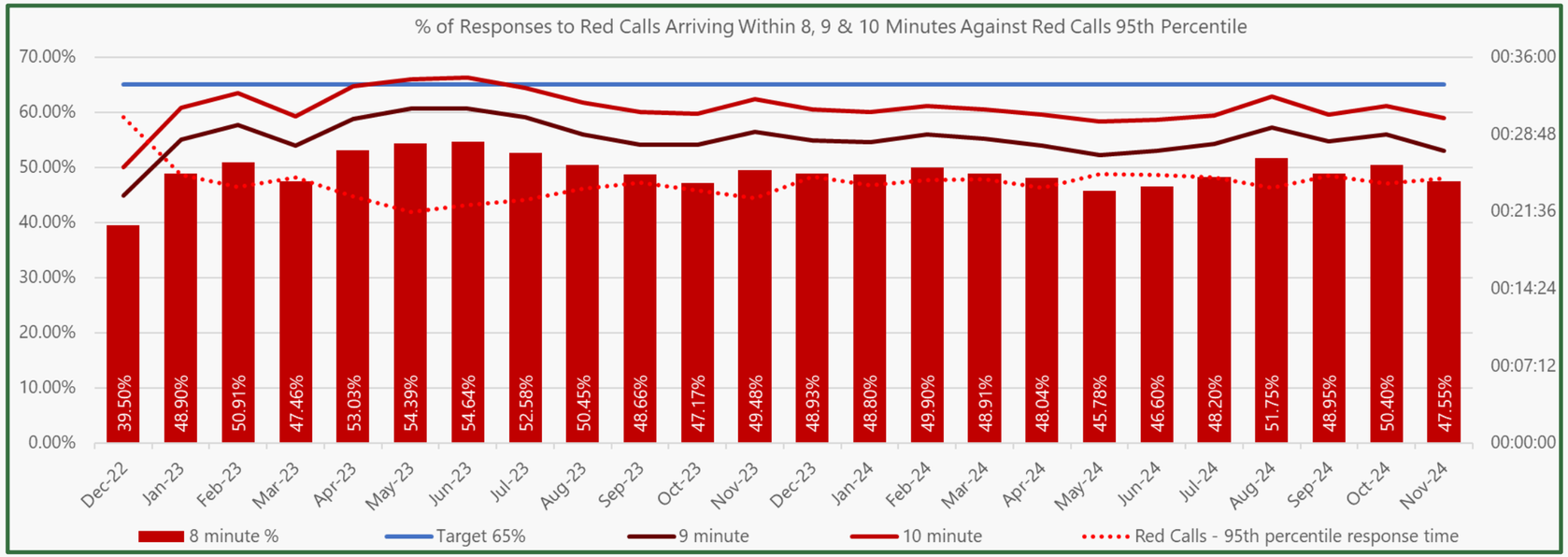

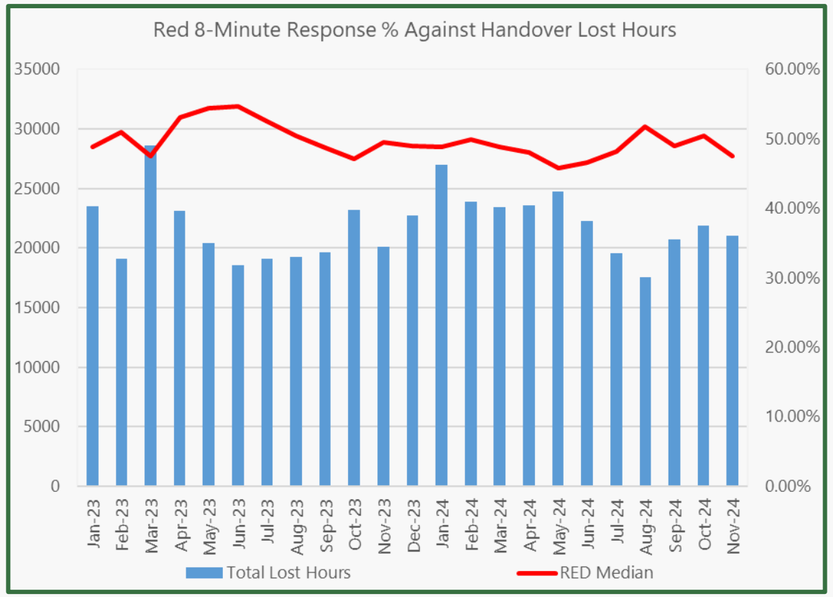

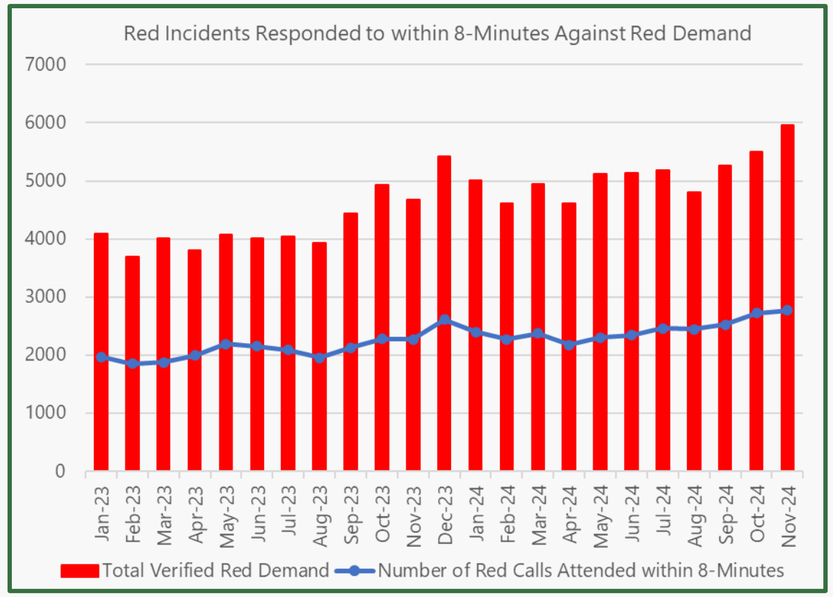

Analysis

Red 8-minute performance continues to remain below the 65% target decreasing marginally during November 2024 to 47.55%.

Red 10-minute performance for November 2024 was 59%, which is marginally below the 2-year average (60.9%).

One of the main determinants is **red demand**, which has **increased** over the last few years, with red demand in November 2024 being 27.48% higher than that seen in November 2023. As red demand has increased, so too has the number of red incidents responded to within 8-minutes, with the figure for November 2024 of 2,775, being 22.03% higher than the figure for November 2023, and the highest figure yet recorded. i.e. the Trust is reaching more red calls in 8 minutes, but the denominator is also increasing.

The lower left graph demonstrates the correlation between overall Red performance and **hospital handover lost hours**, which shows that as handover rates decrease, so red performance improves. There were 20,995 lost hours in November 2024.

Remedial Plans and Actions

The main improvement actions in the Trust's gift are:

- To maintain commissioned establishment in post levels overall.
- To recruit an additional cohort of 21 EMTs during November (linked to above).
- Full roll out of the Cymru High Acuity Response Unit (CHARU), now largely complete (128 FTEs v target of 153 FTEs) with the exception of some hard-to-reach areas.
- Continued focus on production and abstractions
- The rapid deployment, before winter 2024/25 of the first phase of actions towards an updated clinical model e.g. rapid clinical screening, as outlined in our IMTP.

Expected Performance Trajectory

Modelling for winter has now been completed and the results shared with Welsh Government as part of winter planning.

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

(Responsible Officer: Lee Brooks)

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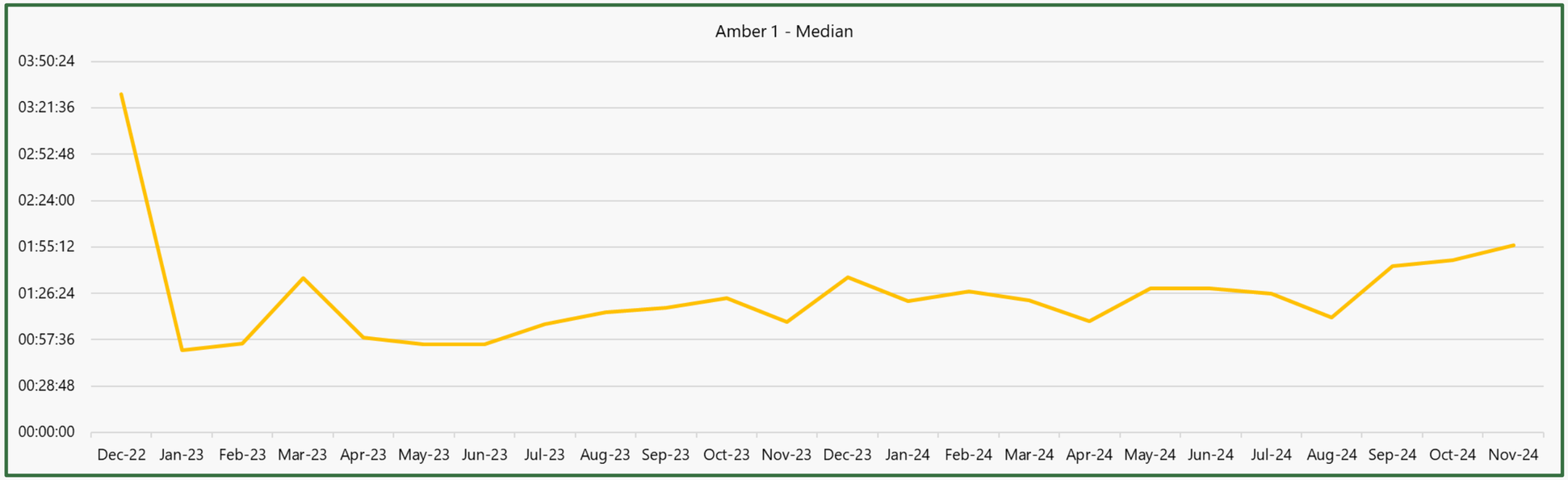
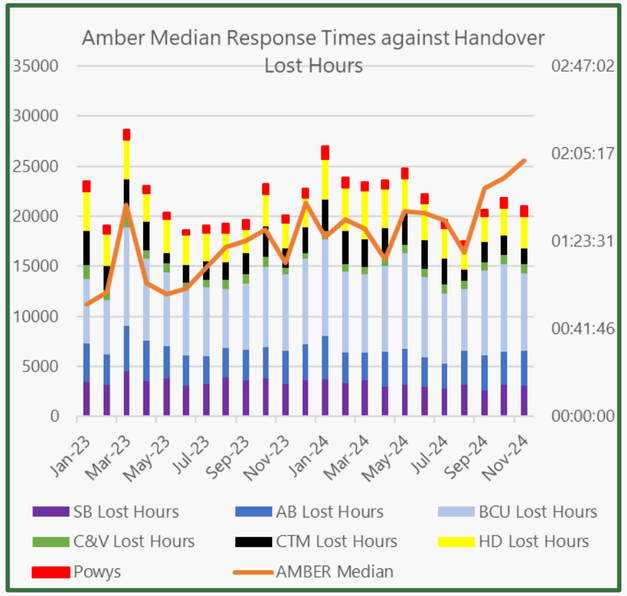
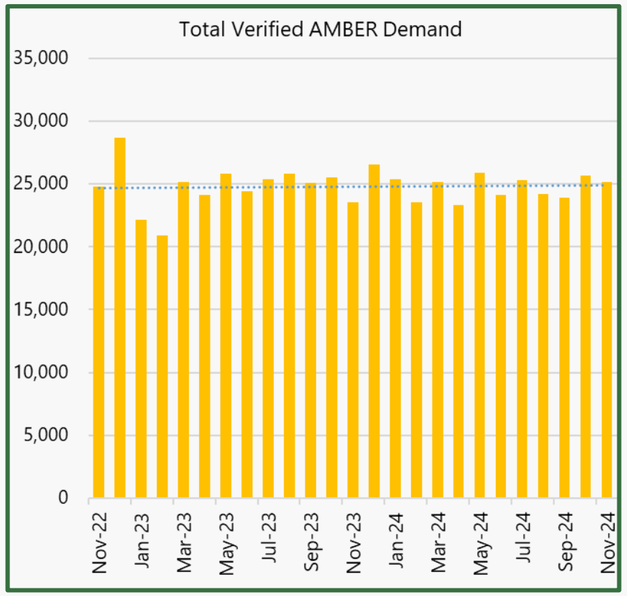
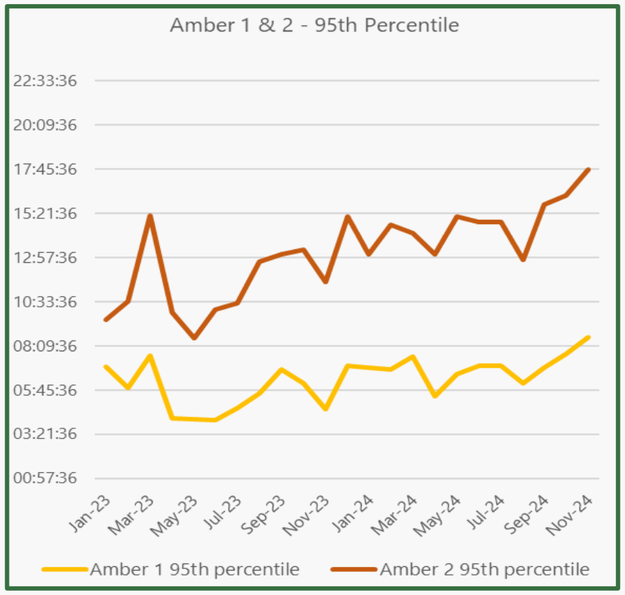
Influencing Factors – Demand, Hours Produced and Hours Lost









Analysis

The Amber 1 median performance time increased during November 2024 to 1 hour 56 minutes compared to 1 hour 46 minutes in October 2024. The ideal Amber 1 median response time remains at 18 minutes.

The Amber 1 95th percentile also increased during November 2024 to 8 hours 39 minutes, up from 7 hours 43 minutes in October 2024. This time remains far too long and remained above the 2-year average figure of 6 hours 39 minutes.

As with Red, there is a strong correlation between Amber performance and lost hours due to handover delays.

Remedial Plans and Actions

The actions being taken are largely the same as those related to Red performance on the previous slide.

Expected Performance Trajectory

The Trust is currently evolving its clinical model and has completed a new 2023 EMS Demand & Capacity Review.

Our Patients: Quality, Safety & Patient Experience

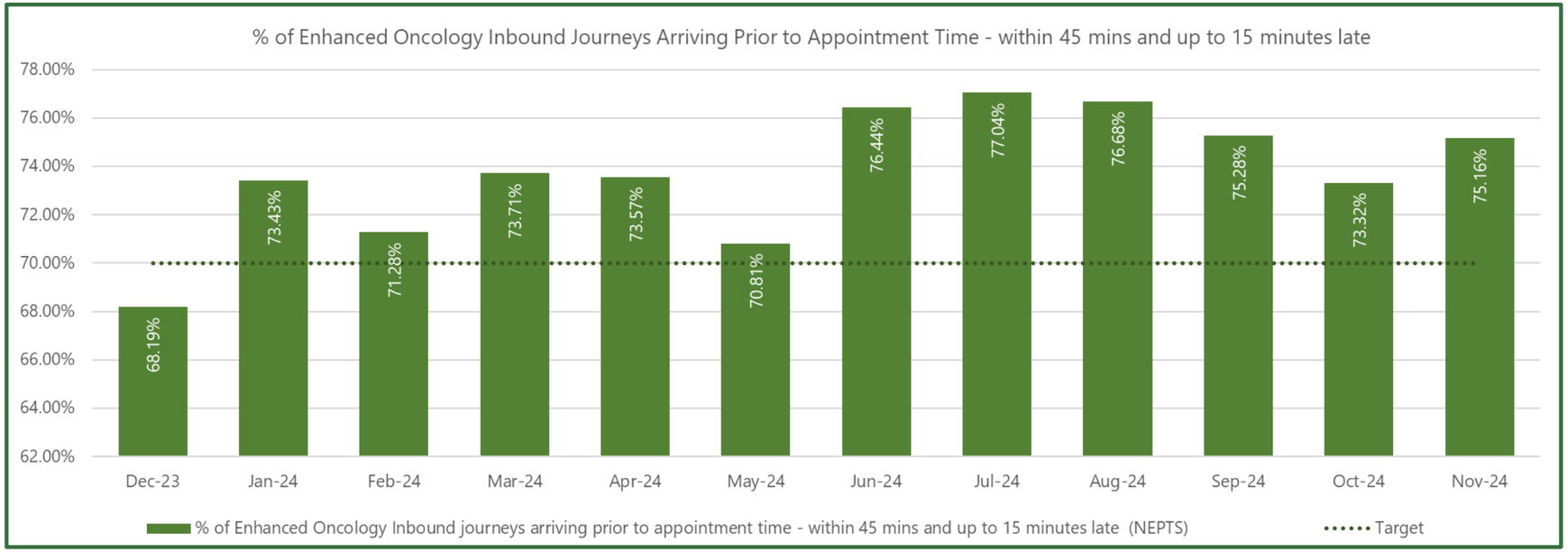
Patient Experience – Influencing Ambulance Care Indicators

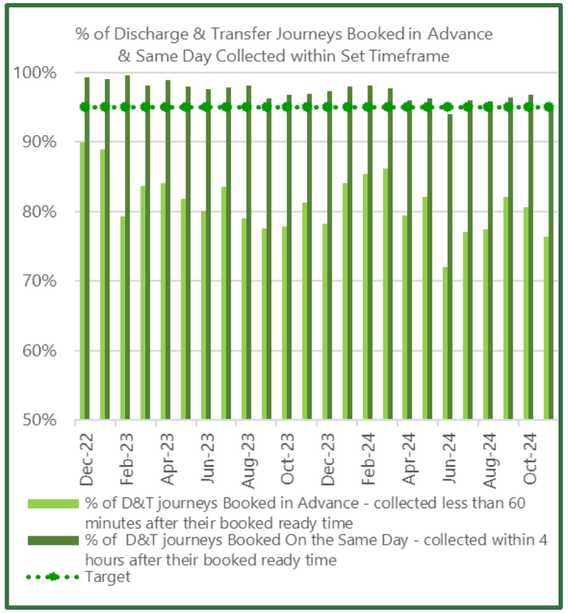
(Responsible Officer: Lee Brooks)

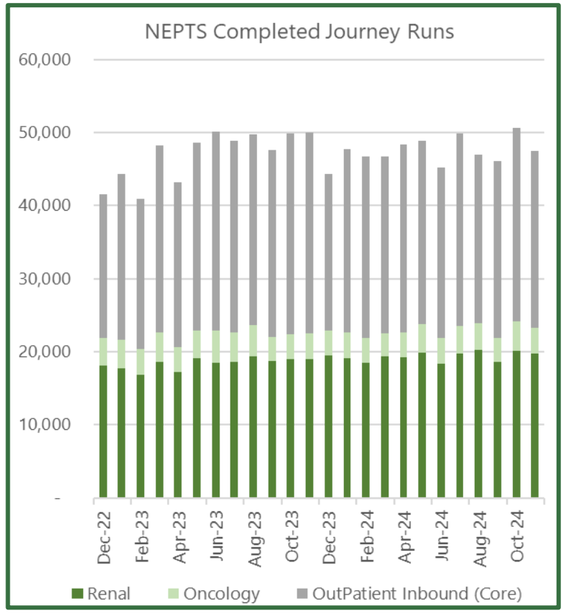
D&T	Oncology	Welsh Calls
R	G	G

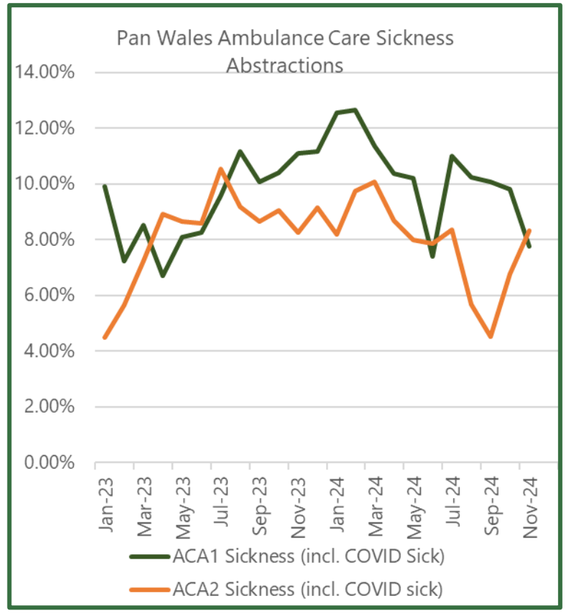
FPC

CI









Analysis

75.16% of enhanced Oncology journeys arrived within 45 minutes prior and up to 15 minutes late of their appointment time, achieving the 70% target for the eleventh month in a row. Oncology performance continues to be an area of focus for the service, and we continue to invest both time and resources on these journeys.

Discharge and Transfer journeys booked in advance and collected less than 60 minutes after their appointment remains below target (95%) at 76% in November 2024, and a slight decrease from the 81% in October 2024.

Enhanced Renal journeys, decreased to 68%, which therefore did not achieve the agreed performance standard (70%) for the second consecutive month, however the first period since March 2020 due to increased demand and increased system pressures, which are now above pre-pandemic levels.

Call volumes answered decreased slightly in November 2024 to 20,551 compared to 21,402 in October 2024; however, the average speed of call answering increased from 41 minutes 11 seconds in October to 2 minutes 18 seconds in November.

Both ACA1 And ACA2 sickness remain above the 5.99% target, attaining 7.77% and 8.31% in November 2024, respectively.

Remedial Plans and Actions

Increased performance on data management and journey recording times is underway, with enhanced focus on weekend performance. Projecting an improvement in performance over next few months, although caution on achieving the 95% figure as this was always an aspirational target that needs engagement and system change from Health Boards which is complex and challenging to achieve.
New rosters keys are just being finalised based on updated demand, which will then be taken into a NEPTS transport roster review.
Enhanced sickness monitoring has been implemented at the ADO/HoS level and all long term and complex cases are being reviewed regularly.

Expected Performance Trajectory

Performance is anticipated to follow recent trends.

Our Patients: Quality, Safety & Patient Experience
Clinical Indicators

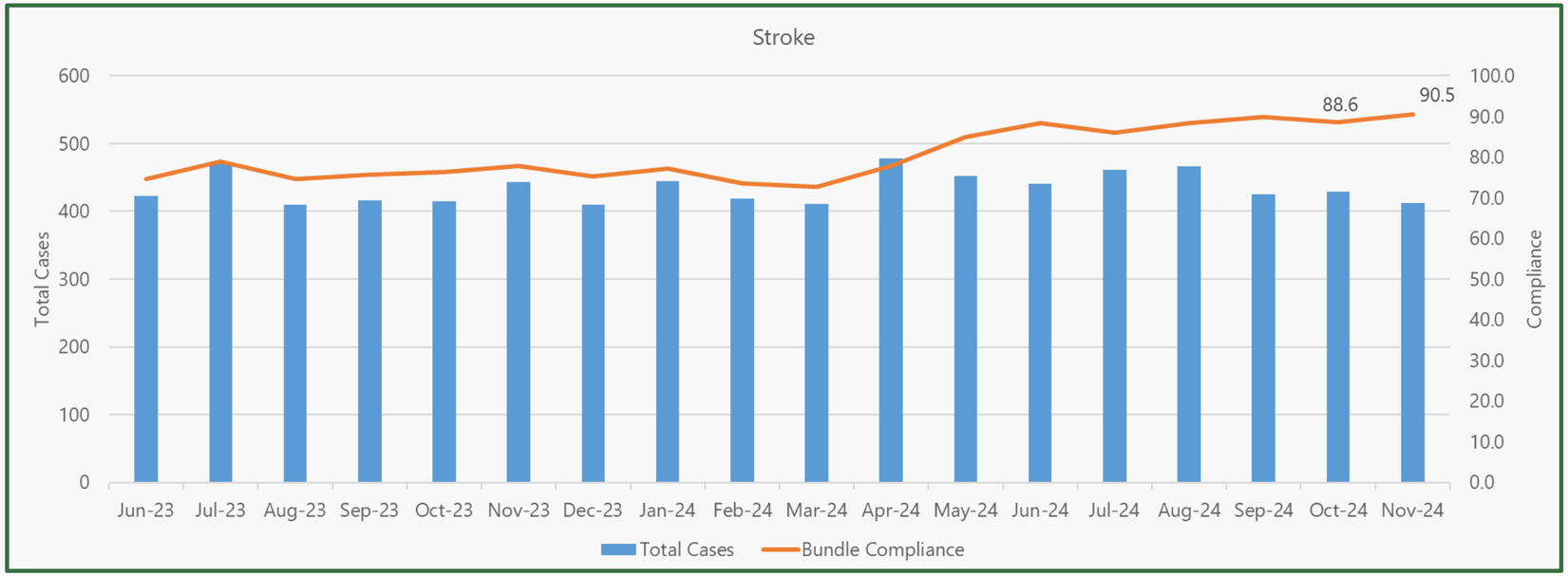
Return of Spontaneous Circulation, Suspected Stroke Patients with Appropriate Care, ST-elevation myocardial infarction (STEMI) with Appropriate Care

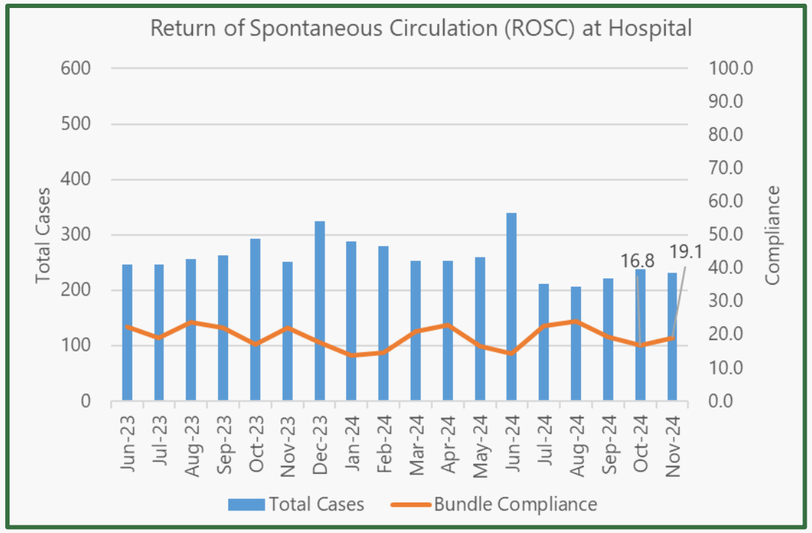
Stroke	ROSC	STEMI
A	G	R

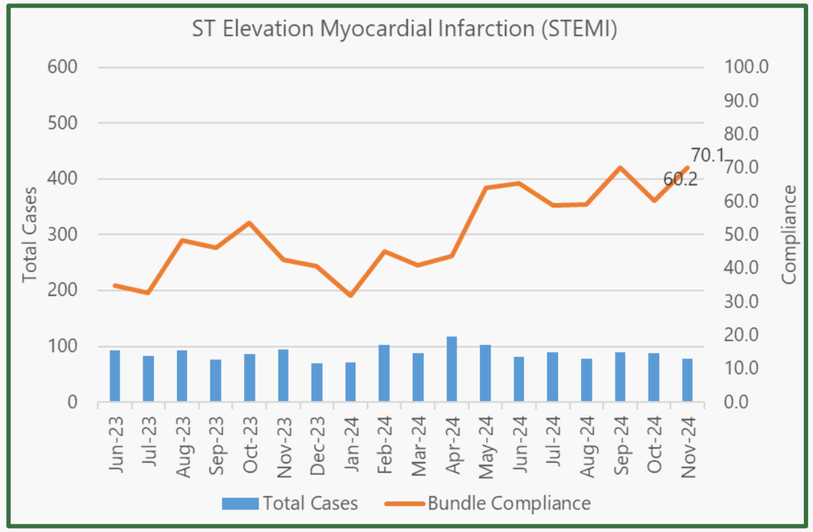
Self-Assessment: Strength of Internal Control: Moderate

QUEST

(Responsible Officer: Andy Swinburn)







Analysis

The percentage of patients documented as receiving appropriate care bundles in November 2024 was:

Stroke – 90.5%, an increase from 88.6% in October. There is a close correlation between documenting FAST (a test to detect symptoms of stroke) and care bundle compliance which has contributed to improvements in the November data.

STEMI (heart attack) – 70.1%, an increase from 60.2% in October. There was a marked improvement in documenting the administration of analgesia and GTN. A 'nudge' to improve electronic Patient Clinical Record completion and compliance to Aspirin and GTN was implemented at the end of October, and User Interface changes for justified exceptions with GTN were implemented in November. These contributed to the improvements for the November data.

Return of Spontaneous Circulation at hospital (from cardiac arrest) – 19.1%, an increase from 16.8% in October. An update was made to the ROSC coding scripting which affected the data from July 2024. This resulted in a step change with August 2024 being the highest since ePCR was implemented. A 'nudge' to improve documentation for specific fields including outcome was implemented in October 2024.

N.B. Due to the nature of this metric, common cause variation occurs which can result in a marked reduction in performance from small numbers of unsuccessful resuscitations attempts. The factors that influence this are multifactorial and as such it is not possible to identify the specific element.

Following the switch to the electronic Patient Clinical Record , the way data is collected has changed. Automated Clinical Indicator reports are generated from data directly inputted by clinicians. As a result of the anticipated low compliance, risk 535 was generated with three key mitigations to work on:

- Design of the electronic Patient Clinical Record User Interface
- Clinician interaction with the electronic Patient Clinical Record
- Accuracy of the scripting to extract the data from the data warehouse to create the reports.

Further electronic Patient Clinical Record User Interface changes are planned for the next update scheduled for Spring 2025, the impact will be monitored by the Clinical Intelligence & Assurance Group.

Our Patients: Quality, Safety & Patient Experience
Clinical Indicators

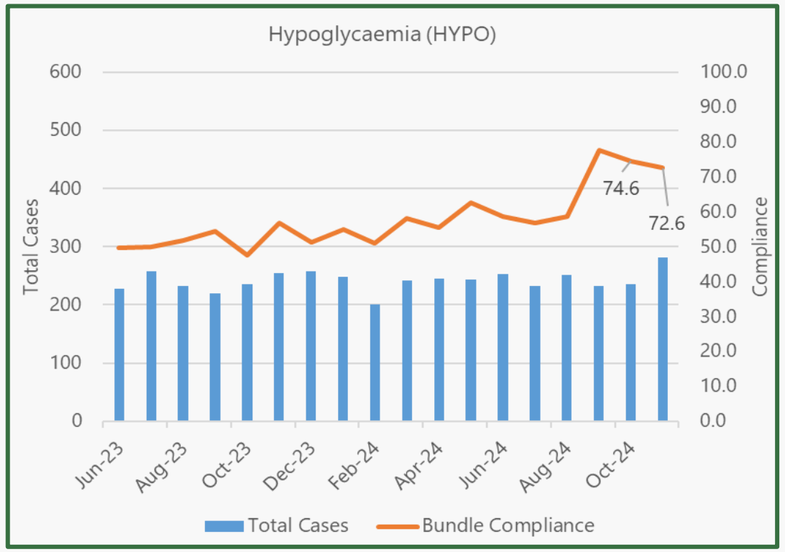
Hypoglycaemia, Fractured Neck of Femur (#NOF) and Time-Based metrics (Stroke & STEMI)

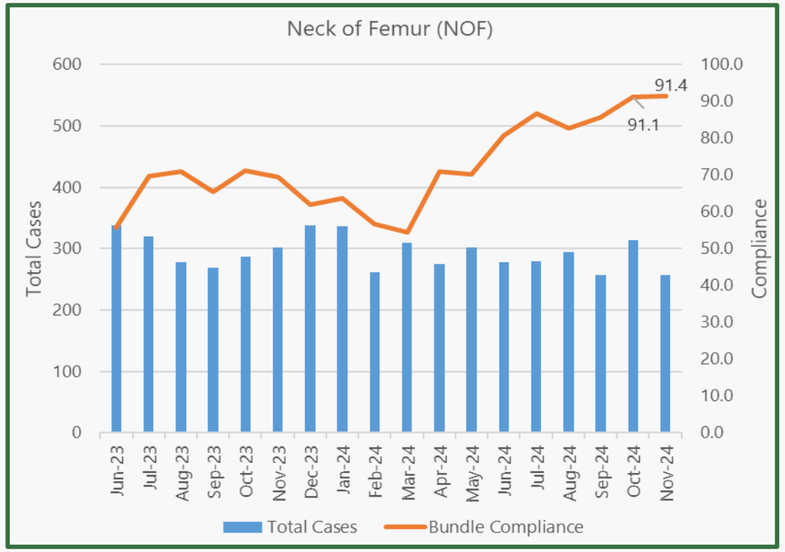
Call to Door
R

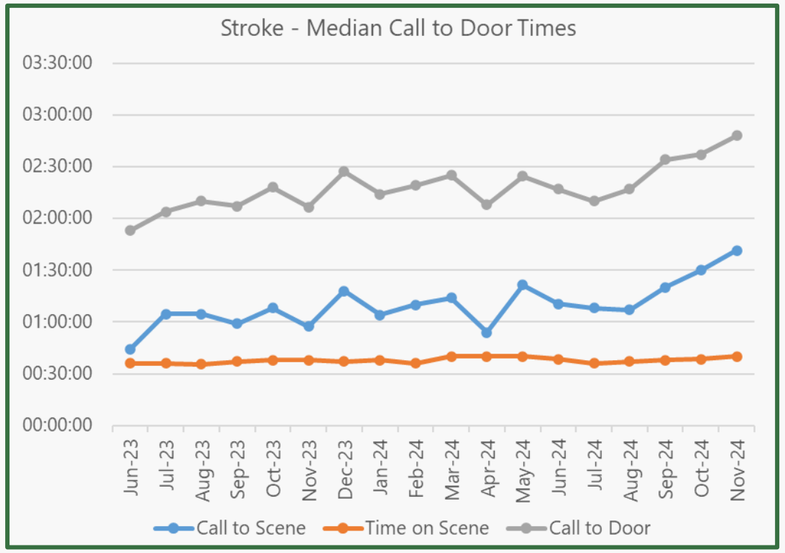
Self-Assessment: Strength of Internal Control: Moderate

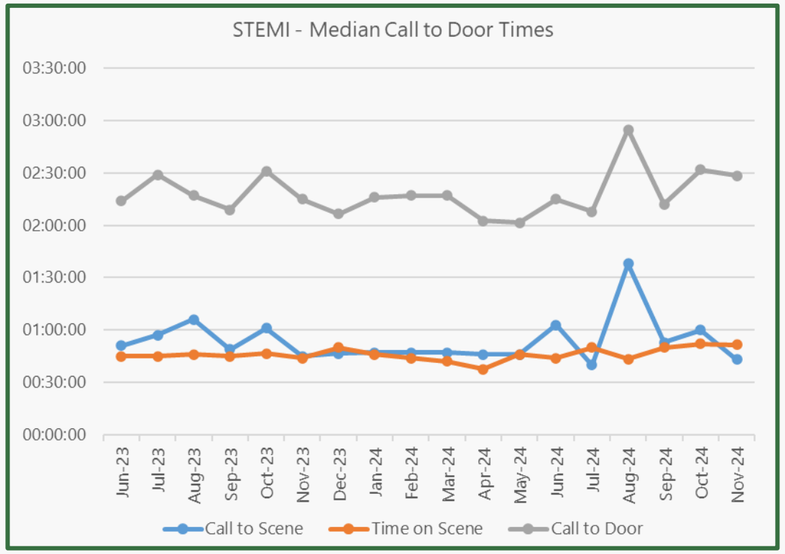
QUEST

(Responsible Officer: Andy Swinburn)









Analysis

The percentage of patients documented as receiving appropriate care bundles in October 2024 was:

Hypoglycaemia (diabetic patients with low blood glucose) – 72.6%, a slight decrease from 74.6% % in October. There has been a 3% reduction in documenting post treatment blood glucose checks which impacted on the bundle compliance. CI improvement work continues which includes electronic Patient Clinical Record User Interface changes for documenting non-diabetic patients with a low blood glucose level.

Fractured Neck of Femur (hip fracture) – 91.4%, a slight increase from 91.1% in October. The use of a 'nudge tool' for analgesia implemented in June provided a prompt when important information is not documented. This, along with an improvement in documenting pain score over the last 3 months has contributed to the improved bundle compliance.

Call to door times for Stroke and STEMI – Extended call to scene times for both stroke and STEMI during October impacted on the call to door times. Some improvement can be seen for STEMI in November, however for stroke, there are extended times.

Remedial Plans and Actions

A recovery plan implemented from April – September 2024:

- Focussed on communication with clinicians to use the bespoke electronic Patient Clinical Record fields (in addition to the narrative).
- Provided weekly non-compliant data to support Senior Paramedics conversations with clinicians to improve compliance.
- Promoted Clinical Indicators, care bundles and electronic Patient Clinical Record completion at Health Board area focussed workshops.
- Supported a review of scripting used for reports.
- Supported further use of the 'nudge' tool with those for Aspirin & GTN with STEMI, and aspects of ROSC implemented at the end of October.

Expected Performance Trajectory

As a result of the work from the CI Recovery Group T&F group and the ongoing improvement interventions, a continued increase in compliance rates is expected and will be monitored by the Clinical Intelligence & Assurance Group.

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

(Responsible Officer: Liam Williams)

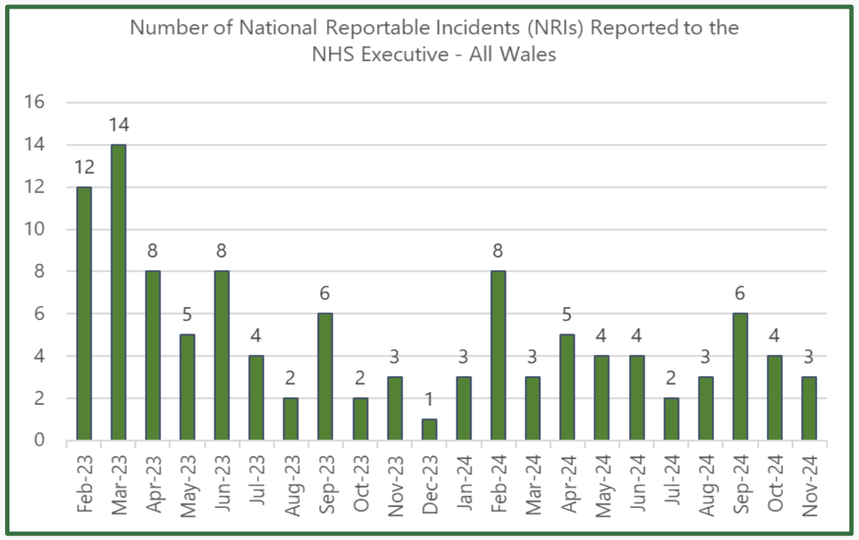
Concerns.

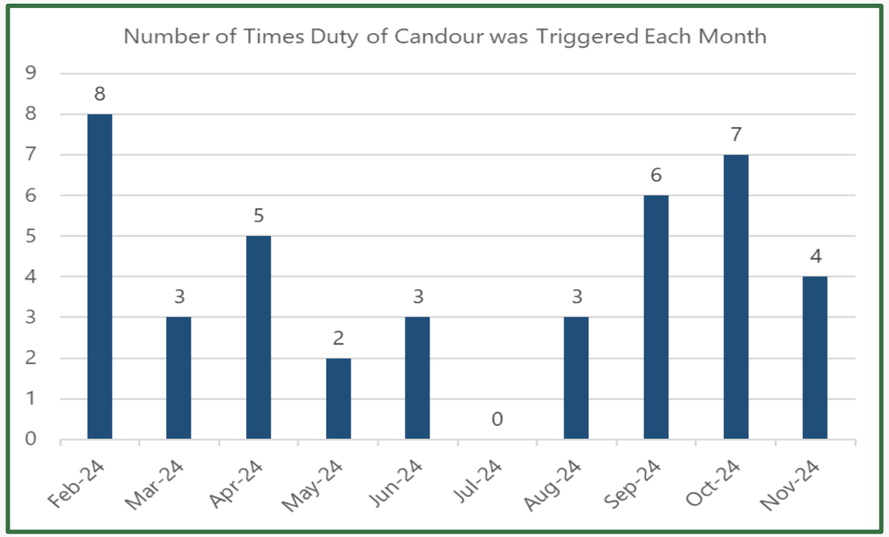
A

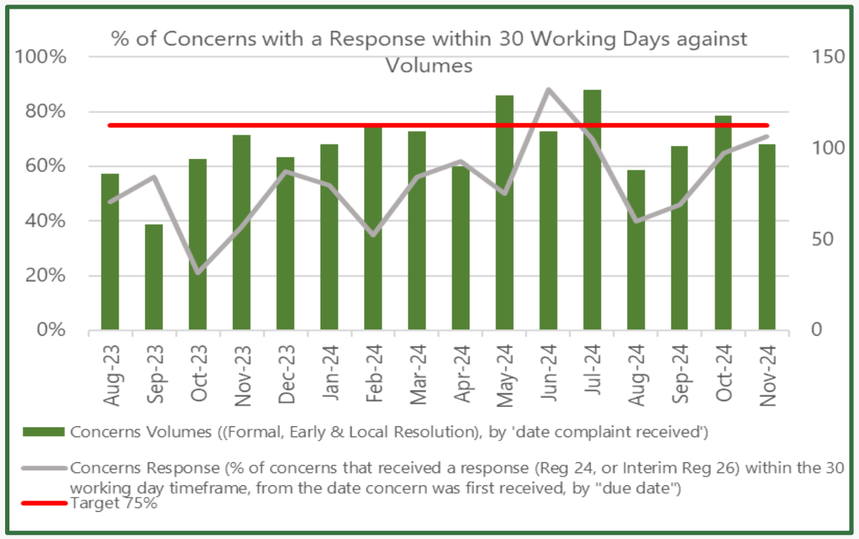
Self-Assessment: Strength of Internal Control: Moderate

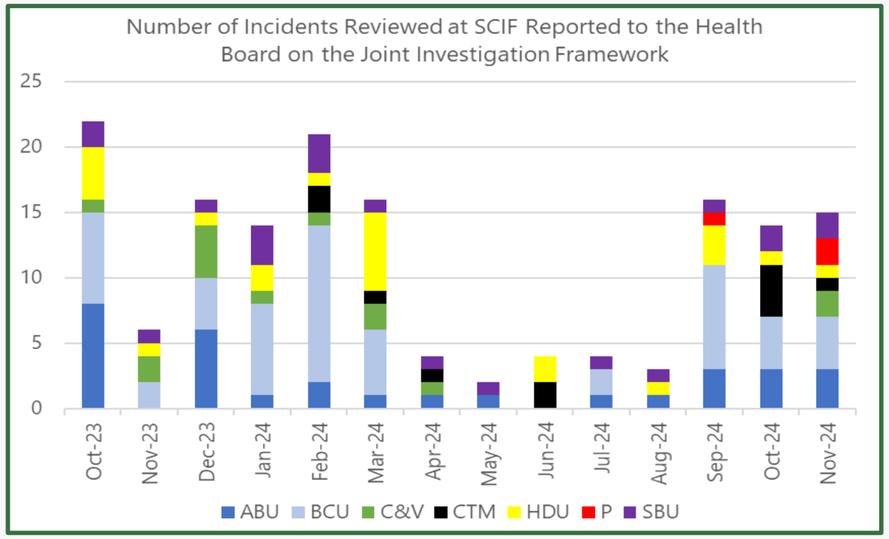
QUEST

Health & Care Standard
Health - Safe Care / Timely Care









Analysis

The Trust's performance against the target of 75% responses issued within 30 working days has recovered following an exercise to reduce number of overdue open complaints.

Open complaint volumes are however gradually increasing again, reflective of the Trust receiving more complaints than it closes each month.

This will be an area of focus; however, operational pressures over the winter period present a risk to maintaining progress.

The number of NRIs reported and number of Joint Investigations of Moderate harm or above identified remains at a reasonably consistent level, although it is anticipated that this may increase over the winter months.

Remedial Plans and Actions

- Ongoing monitoring of national incident reporting, enactment of the Duty of Candour and Complaints performance is monitored by team leads on a regular basis.
- All teams are working to achieve national timescales and a benchmarking position comparative to other NHS Wales organisations as visible in the national Quality and Safety dashboard, Beacon

Expected Performance Trajectory

Patient and Family Relations and Patient Safety Teams will be focusing on working towards national performance targets as part of a PTR & Legal Services Department 'Recovery Plan'. The teams anticipate an increased workflow over the winter period and therefore will be focused on effective allocation of resources in order to prioritise mandatory and statutory service delivery.

**NB: Data correct on the date and time it was extracted; therefore, these figures are subject to change **NB: 30 Day Compliance reported from Power BI and therefore data is not yet validated*

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

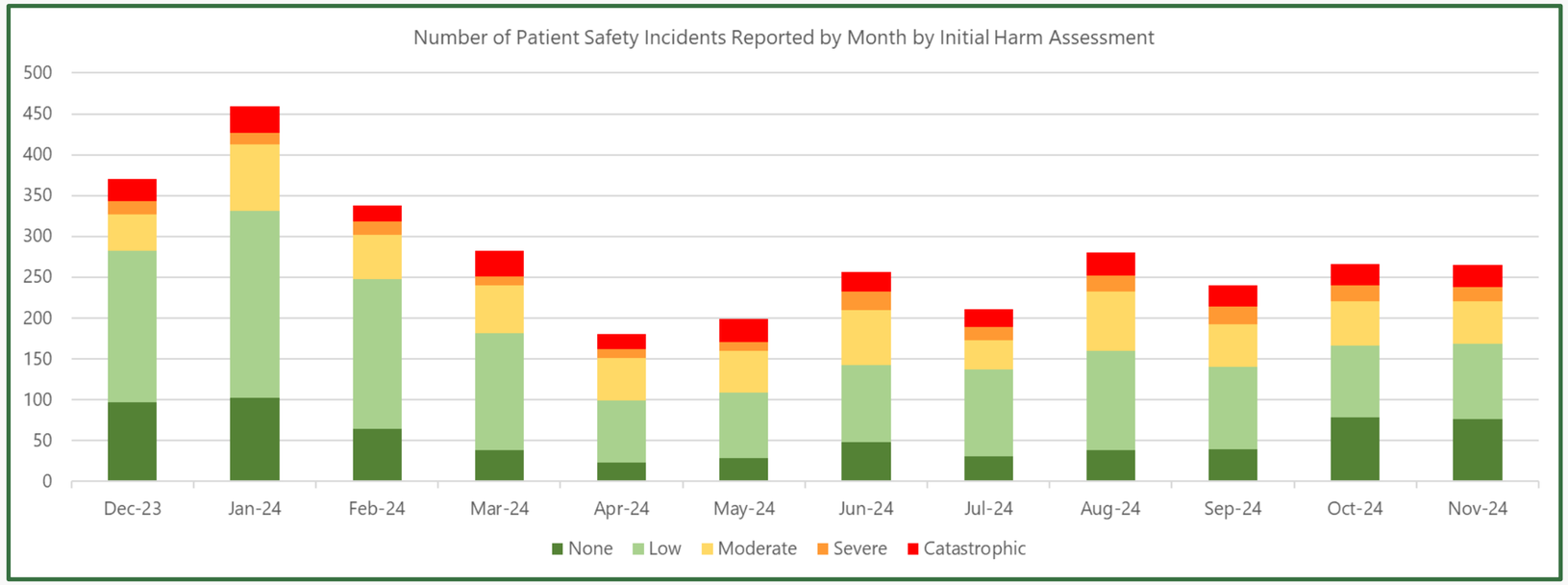
Our Patients: Quality, Safety & Patient Experience
Patient & People Safety Indicators

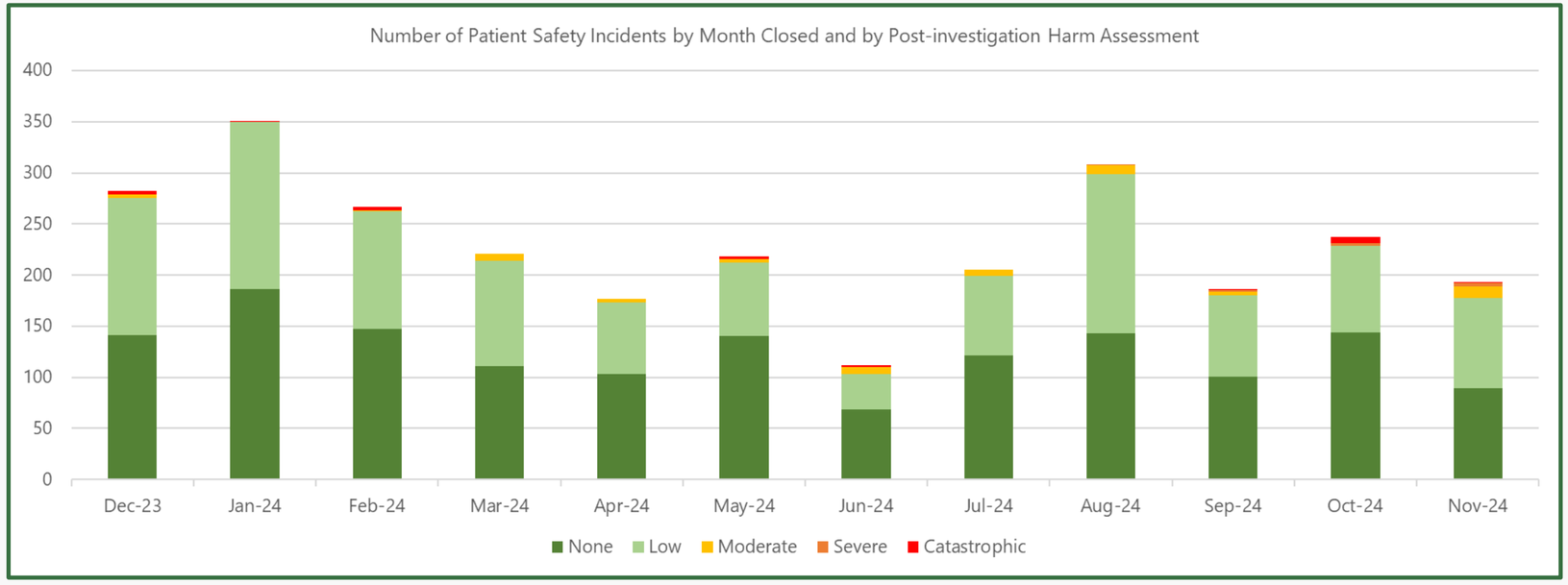
(Responsible Officer: Liam Williams)

Self-Assessment: Strength of Internal Control: Moderate

QUEST

Health & Care Standard
Health – Safe Care





Analysis

There is a gradual increase in incident reporting since the beginning of the financial year across all harm gradings. This is being monitored across the months to assess the impact of seasonal system pressures. The proportional levels of harm being reported remain reasonably consistent.

Monthly volumes should be interpreted with caution as incidents can be duplicated on the system (for example two crews submitting the same incident); however, the introduction of the Rejection SOP by the Quality Team has reduced the risk of duplication. Incident volumes include those reported internally by WAST staff, but also those reported by Health Board colleagues about WAST services or care.

Harm levels for November 2024 were: -

- No harm or hazard - 77
- Low - 92
- Moderate - 52
- Severe harm - 17
- Catastrophic/Death - 27

Remedial Plans and Actions

- Incident management culture and processes are being considered as part of an emerging Datix Recovery and Improvement Plan and monitored carefully to support the Clinical Model Transformation work.
- Temporary staffing resource within the Datix team will enable development of pivotal business intelligence products to facilitate greater awareness and analysis of our patient safety incident data.

Expected Performance Trajectory

Incident volumes are anticipated to increase further over winter and with the introduction of new service models where near-miss reporting is being encouraged. It is also predicted that a higher number of patient contacts across their wait time will result in more incidents occurring but with a gradual downwards trend in the number of Severe/Catastrophic and Death incidents occurring.

Data source: Datix

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

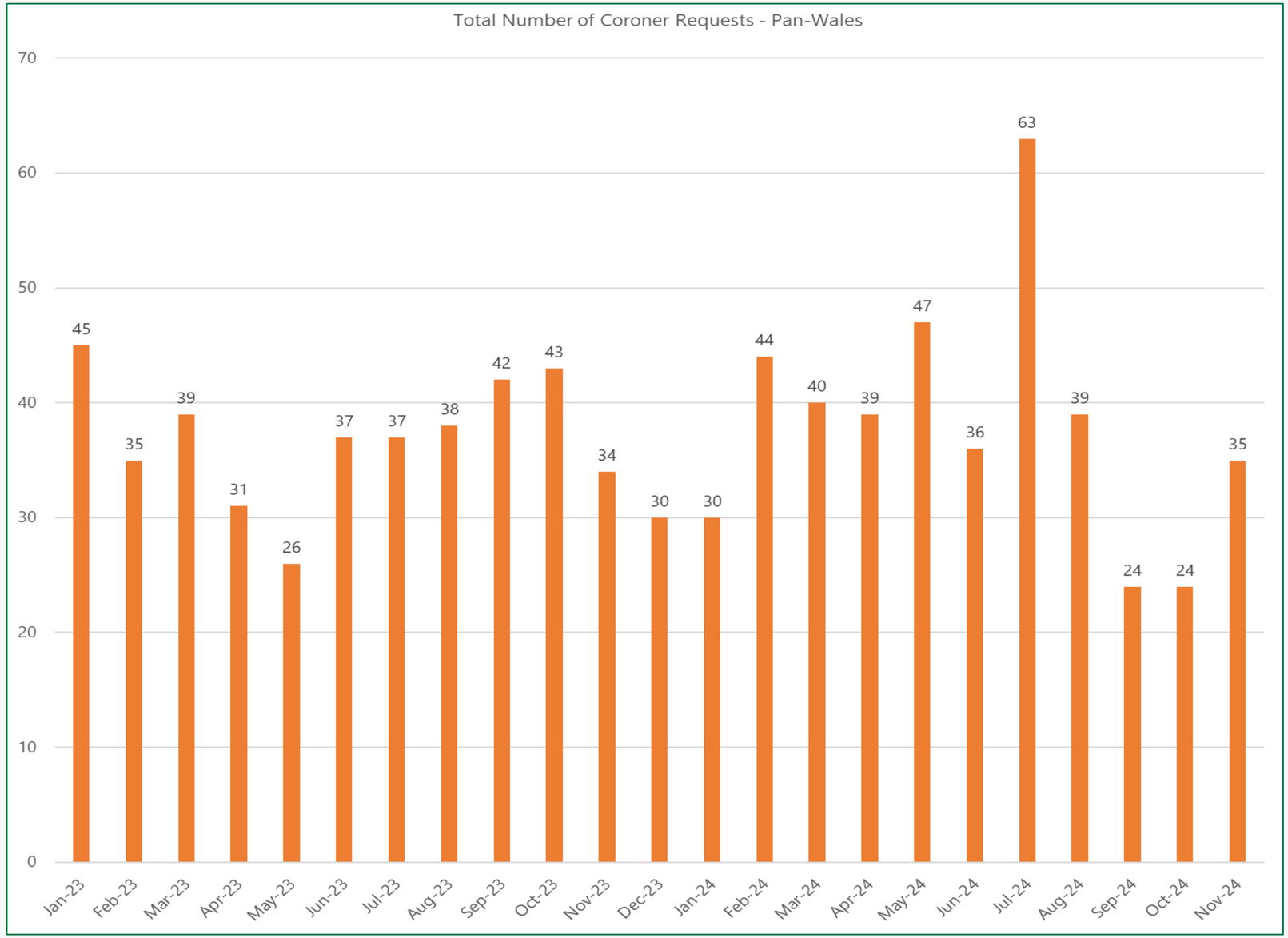
(Responsible Officer: Liam Williams)

Coroners Self-Assessment: Strength of Internal Control: Moderate

Mortality Self-Assessment: Strength of Internal Control: Moderate

QUEST

Health & Care Standard
Health – Safe Care



Analysis
The number of coroner approaches remains variable and unpredictable. Inquest cases continue to present with increased complexity and large numbers of statements and witnesses being called. It is noticeable that many requests are accompanied by short timescales. These factors combined makes this an area of continued pressure across Trust services, and a source of additional burden to staff involved, often revisiting events from several years past. The Trust has responded to two Regulation 28 Prevention of Future Death reports this month. Both were responded to within the 56-day stipulated timeframe. Themes of inquests continue to relate to delays in providing a response in the community.

Mortality - Since September 2024, the Trust has started to receive cases from the medical examiner in relation to community deaths. The patient safety team, have completed a significant number of Level 1 mortality reviews, which is achieved by triaging cases on a weekly basis. The process is now embedded within both teams.

In October 2024, the first ME learning panel took place which was equivalent to the level 2 MDT screening panel outlined in the national Mortality Review Framework. During October two Public Interest Ombudsman Draft Reports were received from the PSOW. Public Interest Reports have not been received in relation to the Trust previously.

Remedial Plans and Actions
- Additional temporary resource in the Legal Services team is supporting the management of inquest coordination and activity across the Trust.
- Operational teams are trialling a collaborative style of statement across services to ensure, as service delivery models become increasingly sophisticated, that our statements accurately represent the patient pathway of care and provide a coherent chronology and explanation of events.

Expected Performance Trajectory
Coroner activity will continue to be monitored and delays in statement gathering escalated and prioritised internally as appropriate.

Mortality Reviews Data source: Internal Web Application

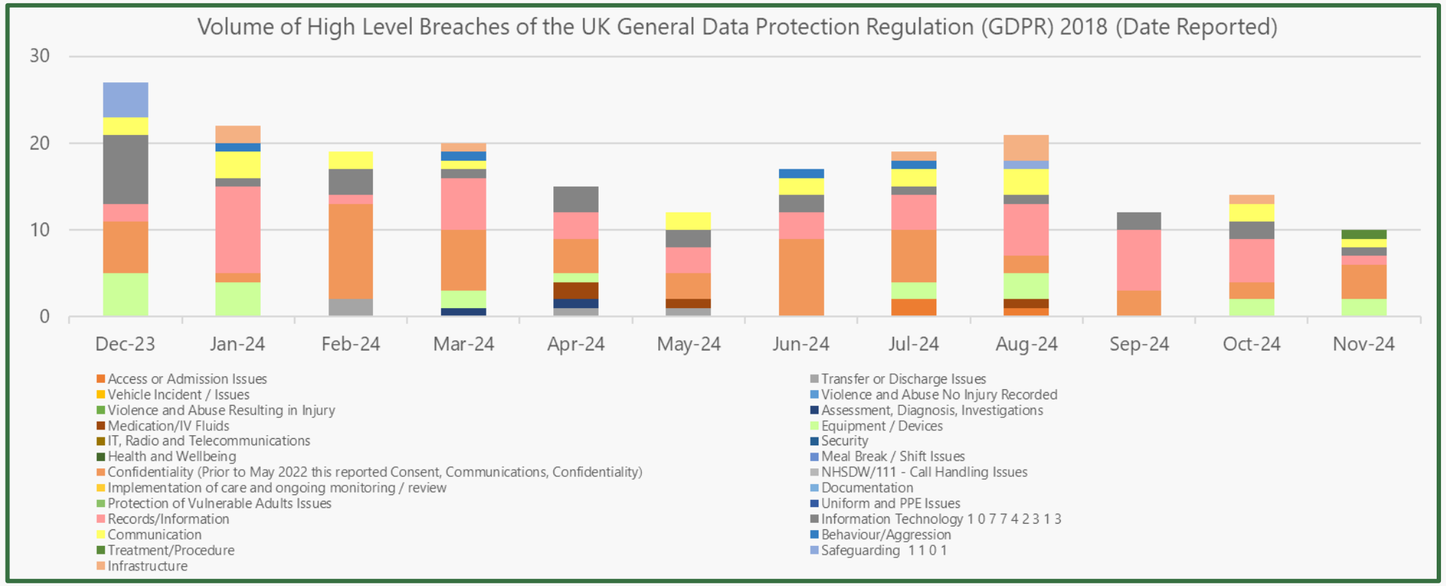
Our Patients: Quality, Safety & Patient Experience Safeguarding, Data Governance & Public Engagement Indicators

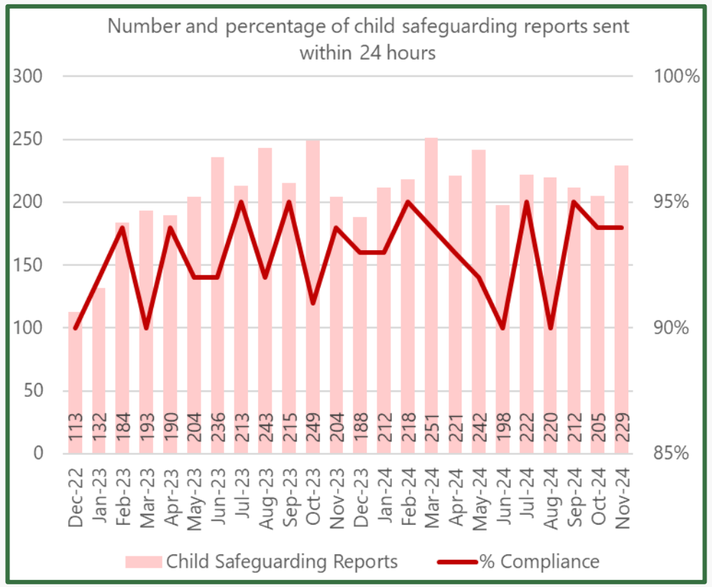
(Responsible Officers: Jonny Sammut & Liam Williams)

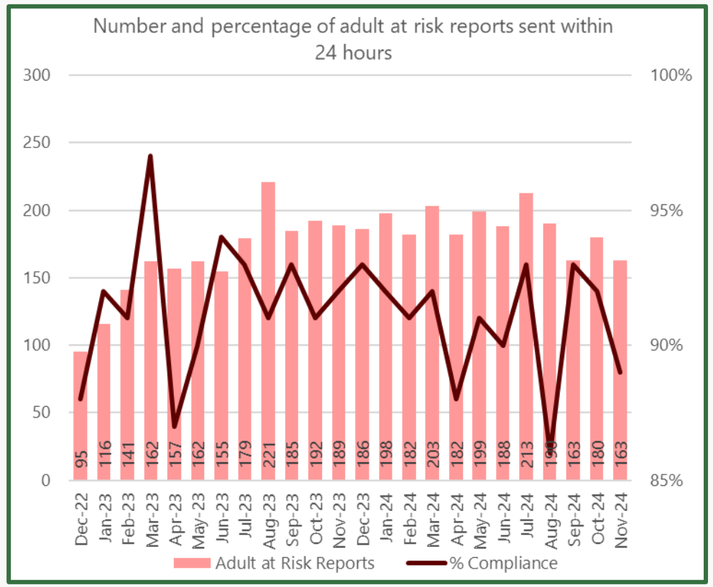
Health & Care Standard
Health – Safe Care

Self-Assessment: Strength of Internal Control: Strong

PCC







Analysis

Safeguarding: In quarter 3 of 2024/25 WAST colleagues submitted a total of 529 Adult at Risk Reports, 89% of these were processed within 24 hours. Whilst the Trust does not report on Adult Need for Care & Support reports (wellbeing); 1,901 reports were shared with local authorities across Wales during this reporting period. There have been 625 Child Safeguarding Reports submitted in quarter 3, 94% of these were processed within 24 hours.

Data Governance: In November 2024, there were 10 information governance (IG) related incidents reported on Datix Cymru categorised as an Information Governance (IG) breach. Of these 10 breaches, 1 related to Records/Information, 1 Information Technology, 1 Communication, 2 Equipment/Devices, 4 IG/Confidentiality and 1 Treatment / Procedure.

Public Engagement: During November, PECI attended 10 community engagement opportunities, engaging with approx. 500 people. This included exhibiting at two Learning Disability Wales conferences where we were able to continue engagement with the learning disability community and share information with them about enhancements made to the ePCR which will now record information about a patient's learning disability.

Remedial Plans and Actions

Safeguarding: The Trust manages all safeguarding reports digitally via Doc-works Scribe and regular monitoring of the system by the Safeguarding Team provides a means to identify any problems with delayed reports with appropriate action taken to support WAST colleagues with using the system and liaising with local authorities when required.

Data Governance: During the reporting period, of the 10-information governance related incidents reported on Datix, one incident was reported to the Information Commissioner's Office (ICO) as it met the risk threshold. Following a review, the ICO closed the incident on the basis of the report and remediation actions taken. The IG Team continues to review and provide advice on reported incidents where applicable.

Public Engagement: The work delivered by the PECI Team is supporting the Trust's principles of providing the highest quality of care and service user experience as a driver for change and delivering services which meet the differing needs of communities we serve without prejudice or discrimination.

Expected Performance Trajectory

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

Data Governance: The IG Toolkit Improvement Action Plan continues to be progressed in readiness for the submission deadline in March 2025. The status of the Action Plan is reported to and monitored by IGSG and it is anticipated all remaining actions will be completed by the deadline date.

Public Engagement: All feedback received is shared with relevant Teams and Managers and continues to be used to influence ongoing service improvement. Patient experience and community engagement information is now shared weekly at the Senior Quality Team meeting.

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

Safeguarding Data source: Doc Works

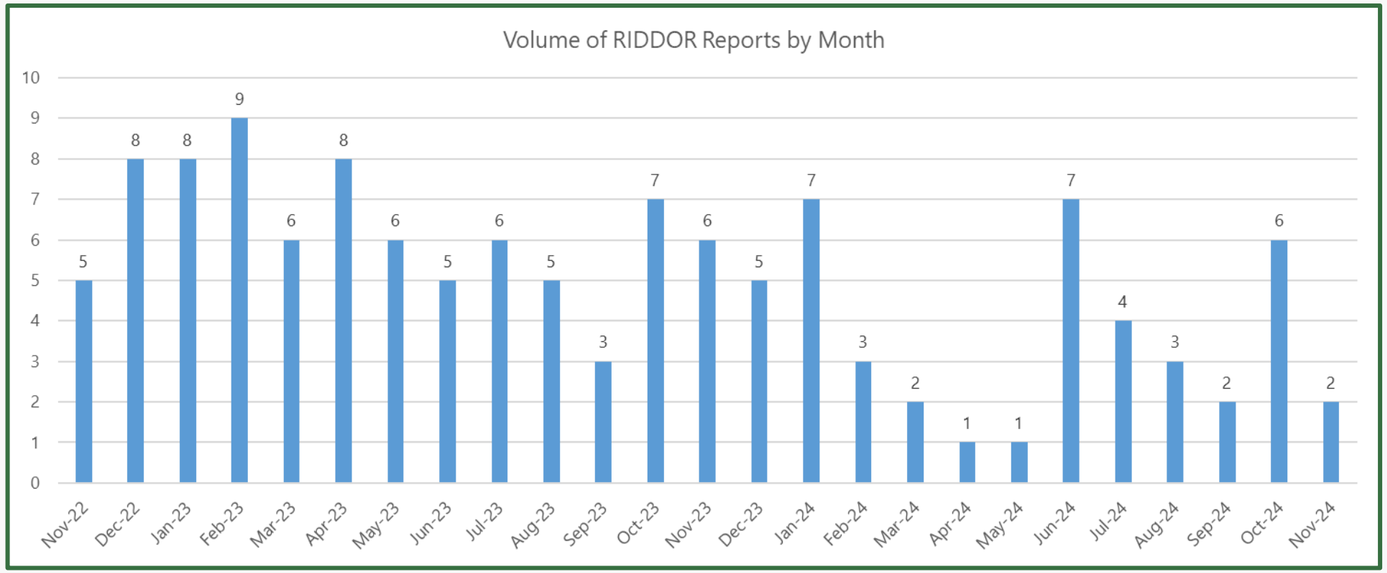
Our Patients: Quality, Safety & Patient Experience
Health & Safety (RIDDORS) Indicators

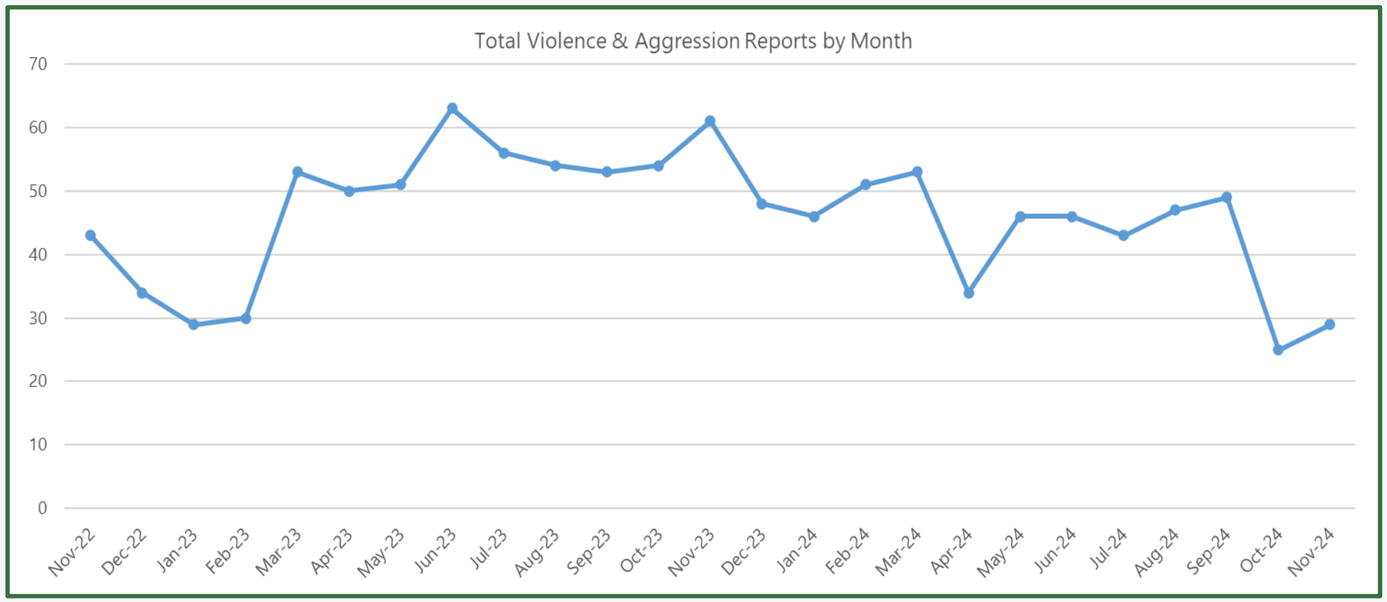
(Responsible Officer: Liam Williams)

Self-Assessment: Strength of Internal Control: Moderate

PCC

Health & Care Standard
Health – Safe Care





Analysis

RIDDOR: There were 15 incidents requiring reporting under RIDDOR during Quarter 3 2024 12 were Most being unable to perform their normal duties for more than 7 days and 3 were Most specified reporting injuries. 90% of the RIDDOR's were submitted within the HSE reporting timelines due to good working relationships with the H&S and Operational Teams. Manual Handling Patients (8 RIDDORS) and Slips and Trips (4 RIDDORS) continue to be the most consistent theme for RIDDOR submissions.

Violence and Aggression: A total of 91 incidents have been reported of V&A in Quarter 3 2024. 7 Physical Assaults on staff were reported during the quarter with 84 incidents of verbal abuse. 24 incidents were reported as Moderate in harm and 39 noted as low harm with 3 cases being noted as causing severe harm. The number of moderate and low harm incidents have returned to the lower levels previously seen within the Trust. Such variations can have a number of causes which are being investigated by the V&A function.

Remedial Plans and Actions

RIDDOR: Work continues to improve communication between H&S and Operations Department to ensure efficient reporting and suitable corrective actions for RIDDOR incidents. A review of manual handling provisions within the Trust has been undertaken and SBAR prepared noting areas for improvement.

Violence and Aggression: V&A incident causation is being trended to identify the suitability of recording incidents in response to the volume of low harm and no harm incidents to with the aim of undertaking suitable investigations and providing sufficient support for staff members affected. Of note is Most staff on staff reported incidents The team continue working with the Clinical Support Desk to explore mechanisms to better protect staff by use of Community Behavioural Orders via the Patient Care Plans.

Expected Performance Trajectory

RIDDOR: The number of manual handling injuries sustained by staff continues to be main cause of RIDDOR incidents and this is expected to remain the case whilst the improvements in manual handling aides and training are being implements. The other main cause of RIDDOR incidents, slips and trips, varies inline with the prevailing weather conditions as these improve going into the spring it is expected they will reduce.

Violence and Aggression: Whilst there has been a downward trend in V&A incident numbers the current performance remains steady in terms of numbers. The majority of incidents recorded are verbal in nature arising from our call centres. Work is being undertaken to improve the reporting of incidents.

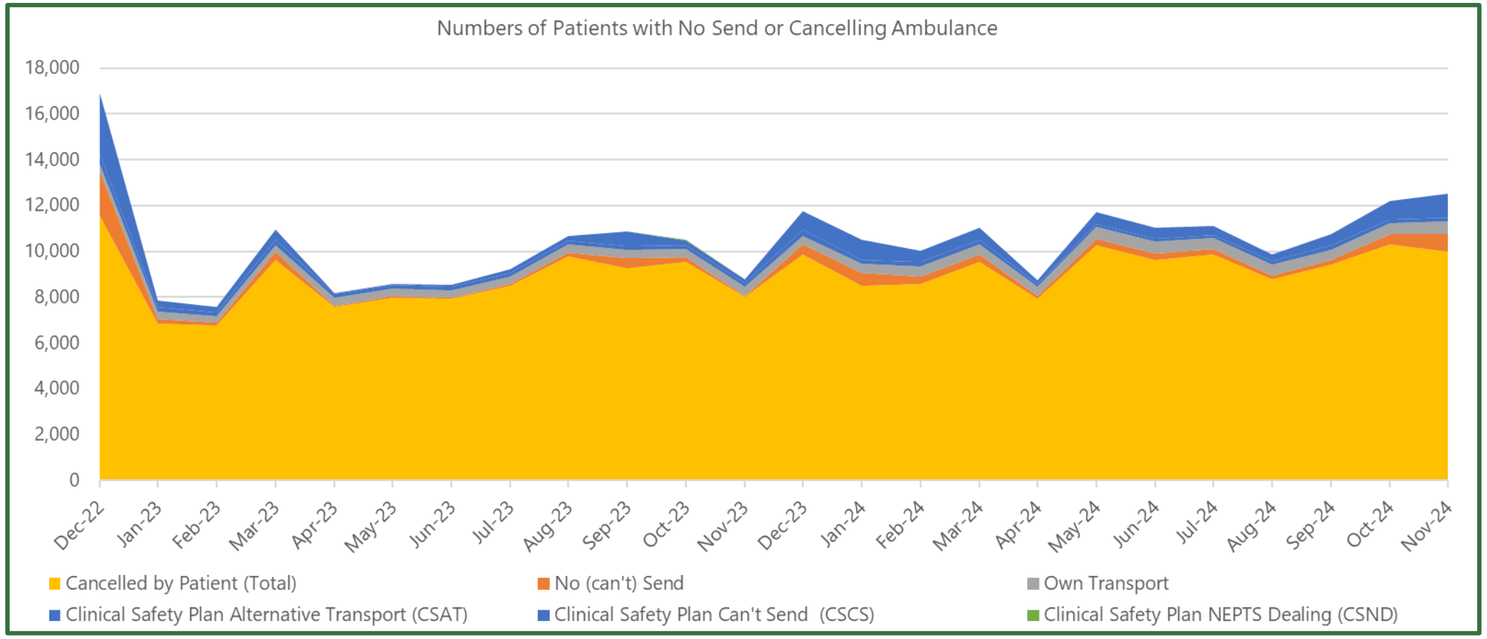
Data source: Datix

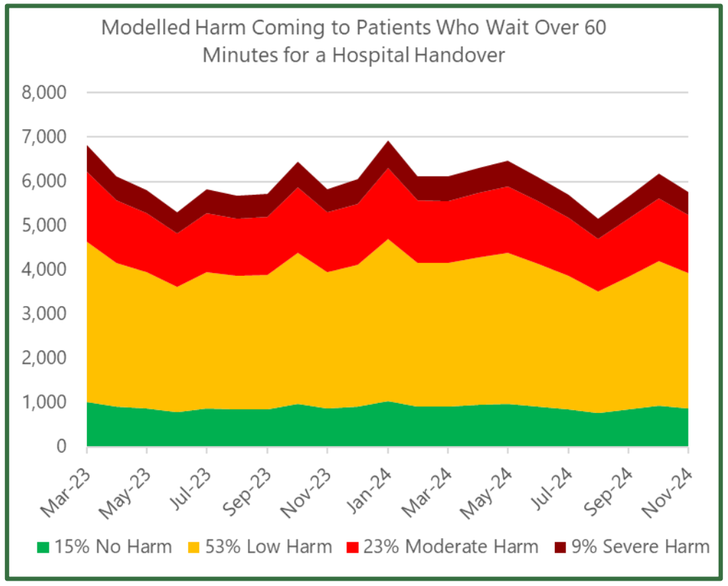
Our Patients: Quality, Safety & Patient Experience
Potential Patient Harm Indicators

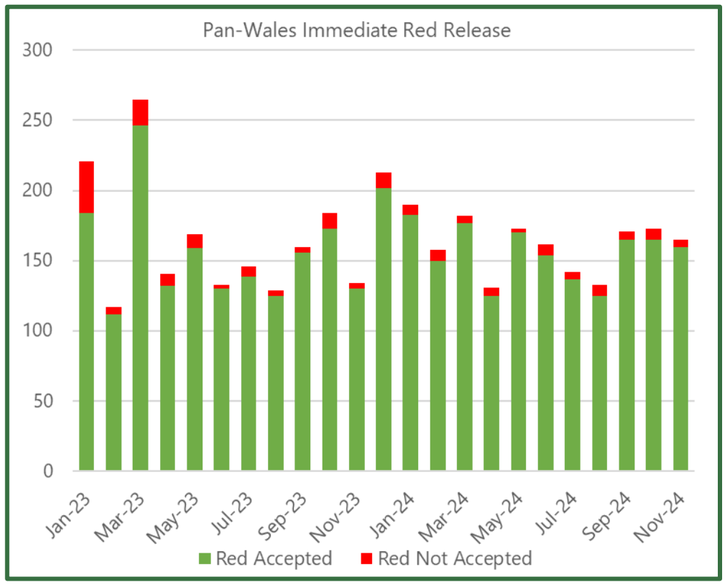
(Responsible Officer: Andy Swinburn)

A

FPC







Analysis

In November 2024, 181 ambulances were stopped due to Clinical Safety Plan (CSP) alternative transport and 1020 were stopped due to CSP 'Can't Send' options. In addition, 11,154 ambulances were cancelled by patients (including patients refusing treatment at scene) an increase from the 10,320 in October 2024.

There were 663 requests made to Health Board EDs for immediate release of Red or Amber 1 calls in November 2024. Of these 160 were accepted and released in the Red category, with 5 not being accepted. Further to this, 151 ambulances were released to respond to Amber 1 calls, but 347 were not.

The graph in the bottom left shows that in November 2024 of the 5,770 patients who waited outside an ED for over an hour to be handed over to the care of the hospital, the Trust could assume that 15% (865 patients) would experience no harm, 53% (3,058 patients) would experience low harm, 23% (1,324 patients) would experience moderate harm and 9% (519 patients) would experience severe harm.

In November 2024 CSP levels for the Trust were:

Remedial Plans and Actions

Red immediate release is monitored weekly by the Chief Executive and reported through to Health Board CEOs with the expectation that there are no declines for Red Release from any of the 7 Health Boards. All health boards have agreed to this measure. Integrated Commissioning Action Plan (ICAP) meetings had been paused as the Trust moves into the new commissioning arrangements but have now restarted. The NHS Wales Performance Delivery framework 2024/25 has a target of no handovers of more than one hour, this equates to 7,500 hours of handover lost hours.

Expected Performance Trajectory

The Trust continues to monitor CSP levels both daily through the ODU and weekly through the Weekly Operations Performance Meeting and mitigations are actioned to reduce the impact on the Trust's ability to respond to demand. See also slides on Red performance and Amber performance, in particular, remedial actions.

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

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

(Responsible Officer: Liam Williams)

Self-Assessment: Strength of Internal Control: Moderate

PCC

Health & Care Standard
Health – Safe Care

November 2024		
NEPTS (176 responses)	Benchmark	Score
How long did you wait for your transport to take you home after your appointment.	85	82
Were you happy with the transport you received?	85	95
999 (14 responses)	Benchmark	Score
The 999-call taker who answered your call was reassuring.	85	85
The 999-call taker who answered your call explained what was going to happen next.	85	85
You felt confident in the call taker ability to manage your call and provide appropriate advice.	85	85
The length of time I waited for an ambulance to arrive was acceptable.	85	58
111 (16 responses)	Benchmark	Score
Do you feel your call to 111 Wales was helpful?	85	71
Did you follow the advice given to you by NHS 111 Wales?	85	87
Would you consider using NHS 111 Wales again?	85	73
WAST Overall - Friends & Family Test How was your overall experience with the service today?	Ranked from very poor to very good.	
• Ambulance care	89.40% Good	5.30% Poor
• Integrated Care (NHS 111 Wales Telephone line only)	60.00% Good	27.78% Poor
• EMS (including CSD)	78.57% Good	5.30% Poor
• NHS 111 Wales Online	80.00% Good	20.00% Poor
	* Where totals above do not add up to 100%, this is because a 'Do Not Know' answer was given, these are excluded from overall total.	

Analysis

Within the NEPTs survey responses provided show that people are satisfied with the overall service they receive. With the question 'Were you happy with the transport your received', came out above the 85-benchmark figure (n=95).

However, the length of time waited for transport home following an appointment continues to be problematic and did not hit the benchmark in relation to the question 'How long did you wait for your transport to take you home after your appointment.

Some questions within the 999-section just reached the 85 benchmark, those being 'The 999-call taker who answered your call was reassuring' (n=85). 'You felt confident in the call taker ability to manage your call and provide appropriate advice?' (n=85), and 'The 999-call taker who answered your call explained what was going to happen next (n=85). The question 'The length of time I waited for an ambulance to arrive was acceptable?' failed to reach its benchmark (n=58). Whilst within 111 only one question 'Did you follow the advice given to you by NHS 111 Wales' achieved the benchmark (85) with 87, however the other questions failed to achieve the benchmark.
Response rates to the 999 and 111 surveys remain low and it's acknowledged that these do not reflect an entirely representative picture based on overall call volumes.

Remedial Plans and Actions

We continue to make available 4 core Patient Experience surveys, covering the Trust's main service delivery areas:
999 EMS Response (incorporating CSD)
Ambulance Care (NEPTS)
NHS 111 Wales Telephony
NHS 111 Wales Online

A DPIA to be submitted to the ICO for their consideration about use of SMS text messages to directly distribute survey requests to 999 service users is complete and is with colleagues in Information Governance before submission to the ICO.
Plans to place QR codes in the back of EMS vehicles to increase patient feedback are progressing and we have spoken to IPC and Fleet colleagues about what is needed to proceed.

We continue to engage with the Once for Wales Programme Board who have updated the 'All Wales Patient Experience Question Set' and 'People's Experience Framework'.

Expected Performance Trajectory

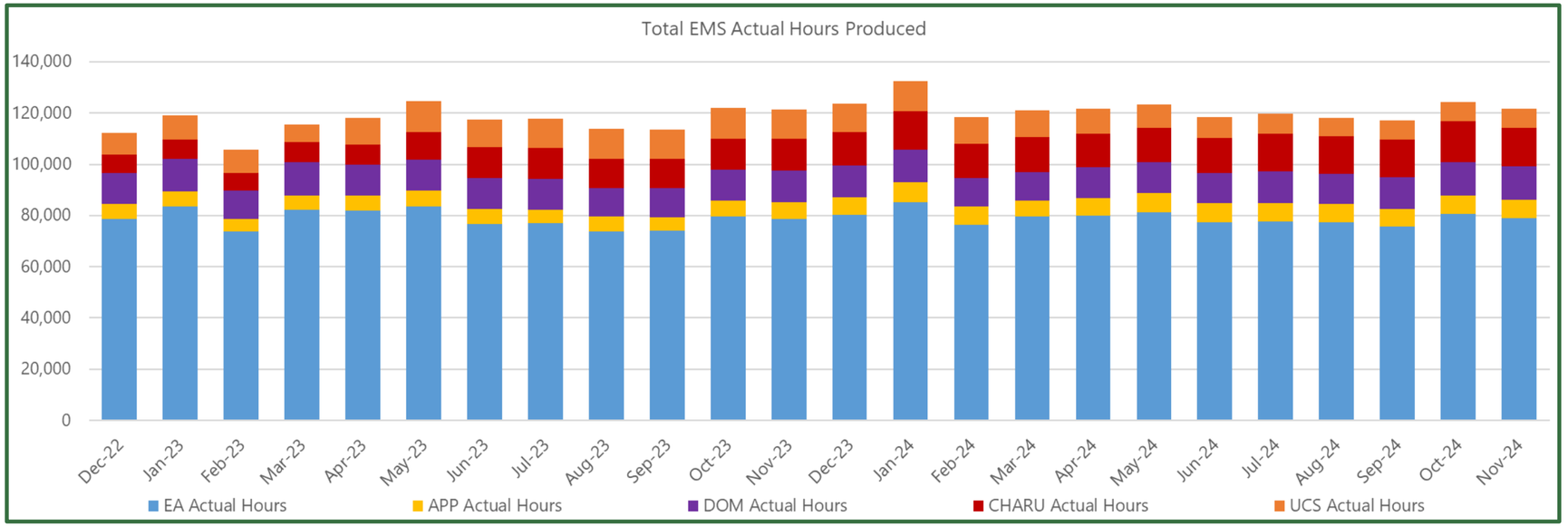
An overall aim of increasing visibility of experience surveys and maximising opportunities to capture patient experience data.

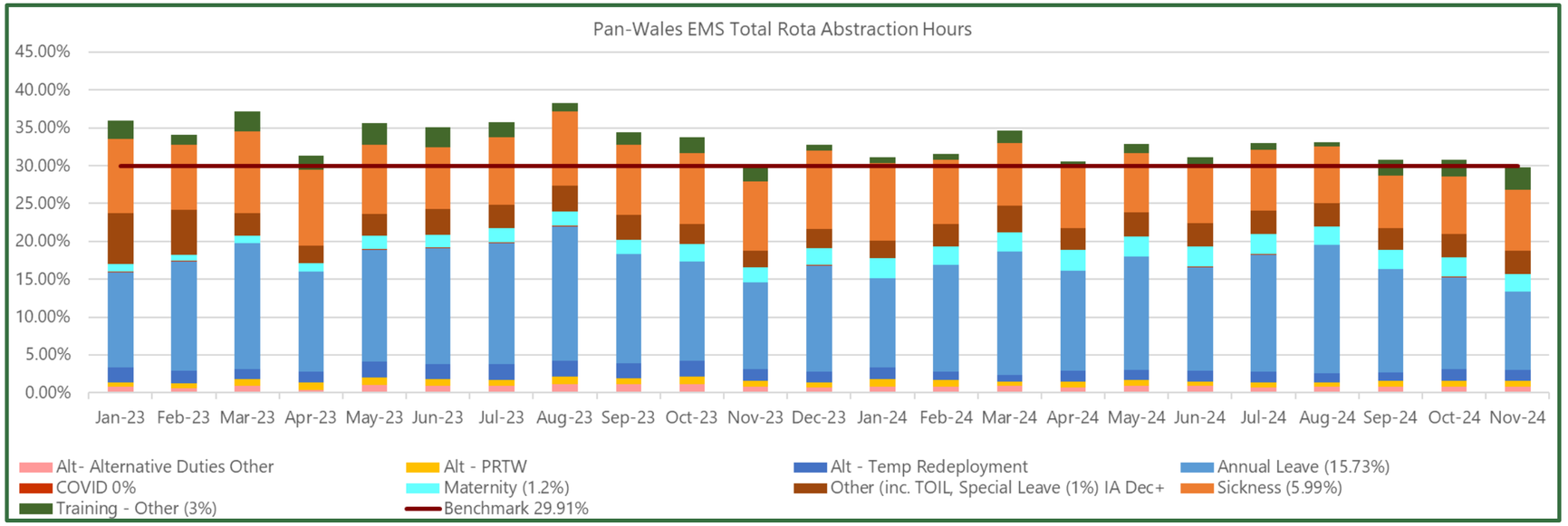
Our People
Capacity - Ambulance Abstractions and Production Indicators

(Responsible Officer: Lee Brooks)

EA Production	Abstractions
G	R

CI PCC FPC





Analysis

The total EMS hours produced is a key metric for patient safety. The Trust produced 121,671 hours during November 2024, a slight increase compared to the 121,349 hours produced during November 2023. The Trust is delivering good levels of production.

As shown in the bottom graph, monthly abstractions from the rosters are key to managing the number of hours the Trust has produced, as are the total number of staff in post. November 2024, saw a total EMS abstractions (excluding Induction Training) of 29.79%. This was a minimal decrease on the 30.82% recorded in October 2024, however achieving the 29.91% benchmark for the first time since November 2023. The highest proportion of abstractions was due to annual leave at 10.36% followed by sickness at 8.09%.

Emergency Ambulance Unit Hours Production (UHP) achieved 95% in November 2024 which equated to 79,086 Actual Hours.

In November 2024 CHARU UHP was 87% against the full roll out requirement.

Remedial Plans and Actions

- Continued focus on managing attendance across the Trust and managing abstractions from rosters.
- Full roll out of CHARUs.
- Continued focus on staff in post to establishment, aiming for 95% benchmark.
- Smoothing of staff between urban and rural areas.
- Focus on recruitment to reduce identified vacancy gap, in particular, EMTs and APPs.

Expected Performance Trajectory

UHP estimates, based on recruitment levels, estimated abstractions and overtime have been provided to ELT. Production is good.

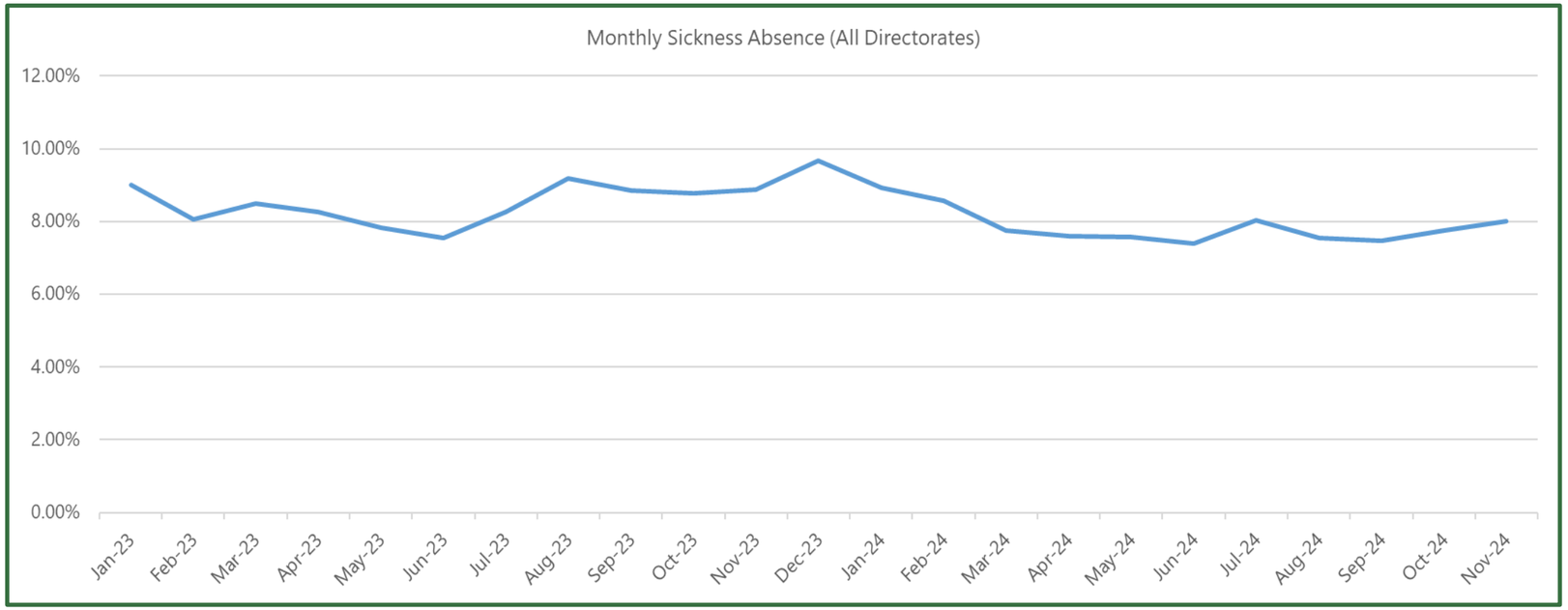
The Trust maintains an ambition to reduce sickness to 6% and maintain abstractions to 30%. This has not yet been achieved for sickness, but the direction of travel is good, while the abstractions benchmark has been achieved a number of times this year.

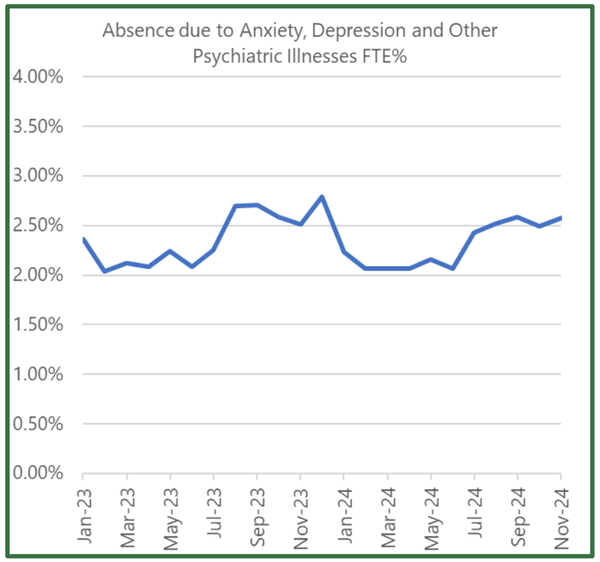
Our People
Capacity - Sickness Absence Indicators

(Responsible Officer: Angela Lewis)

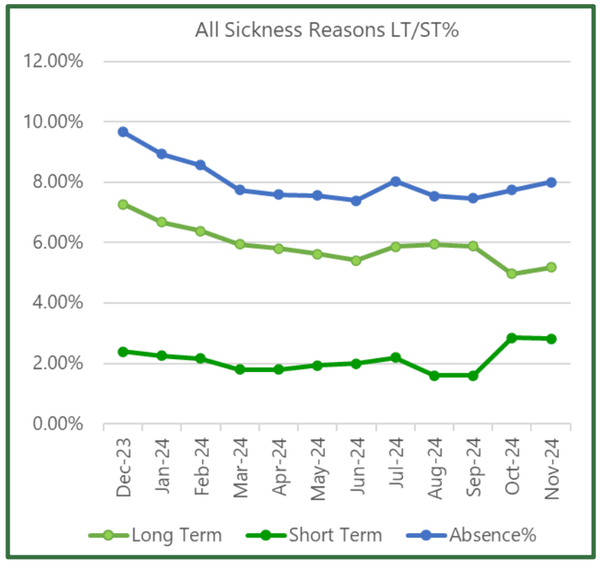
Mental Health A

PCC CI





Average working days lost per FTE (Annual)	
18.29 days	
Single month Absence %	
8.00%	
Long Term	**Short Term**
5.18%	2.82%
Mental Health	**Other MSK**
(S10 Stress/Anxiety)	(excluding Back)
2.58%	0.82%



November 2024

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

Analysis

There was a slight increase in overall sickness absence rates between October 2024 and November 2024, rising from 7.74% to 8%. Long term absence also increased from 4.96% in October 2024 to 5.18 % in November 2024, while short-term absence decreased slightly to 2.82% in November from October 2024 (2.85%).

The highest reasons for absence in November 2024 were Anxiety/ Stress/ Depression, other musculoskeletal problems, Gastrointestinal problems, injury fracture and cold/cough/flu/influenza. Absence due to Mental Health increased from 2.49% in October 2024 to 2.58% in November 2024.

From the start of the flu campaign until end of Dec-24, 1326 flu vaccines have now been administered by our WAST OH / Peer Vaccinators. 959 were given to WAST employed staff with 208 WAST staff also confirming they have received the flu vaccine elsewhere i.e. GP / Pharmacy, therefore, 26.4% of the WAST workforce has now been vaccinated. A further 232 WAST staff have completed our Microsoft Form to state they wish to opt-out from having the flu vaccine this year.

Remedial Plans and Actions

- Monitoring continues with ongoing reviews in both long term and short-term absences with monthly meetings to track sickness and provide support.
- MAAW training and bitesize training sessions continue to be scheduled on a bi-monthly (MAAW) and monthly basis (Bitesize sessions).
- Audits for all Directorates, will be undertaken on a monthly basis over the next 6 months and the People Services Team will provide targeted support to line managers on reasonable adjustments and the appropriate use of discretion in areas identified as hot spots.
- Communications will continue to drive and promote the Flu Campaign to engage with the highest number of staff possible. Many events have been attended by Occupational Health / Peer Vaccinators so far and there are still several key events upcoming where Vaccinators will be available to further promote the flu vaccine.

Expected Performance Trajectory

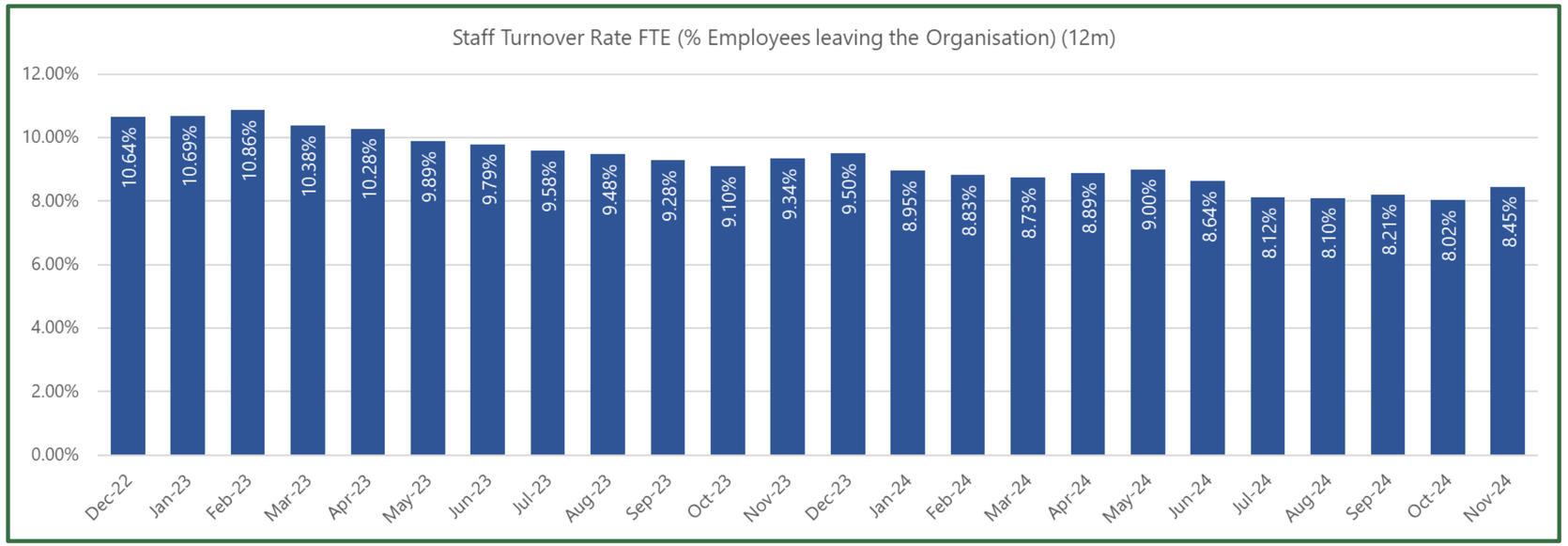
The Trust has indicated through its IMTP that sickness levels will fall in this financial year, but that there remain risks to delivery.

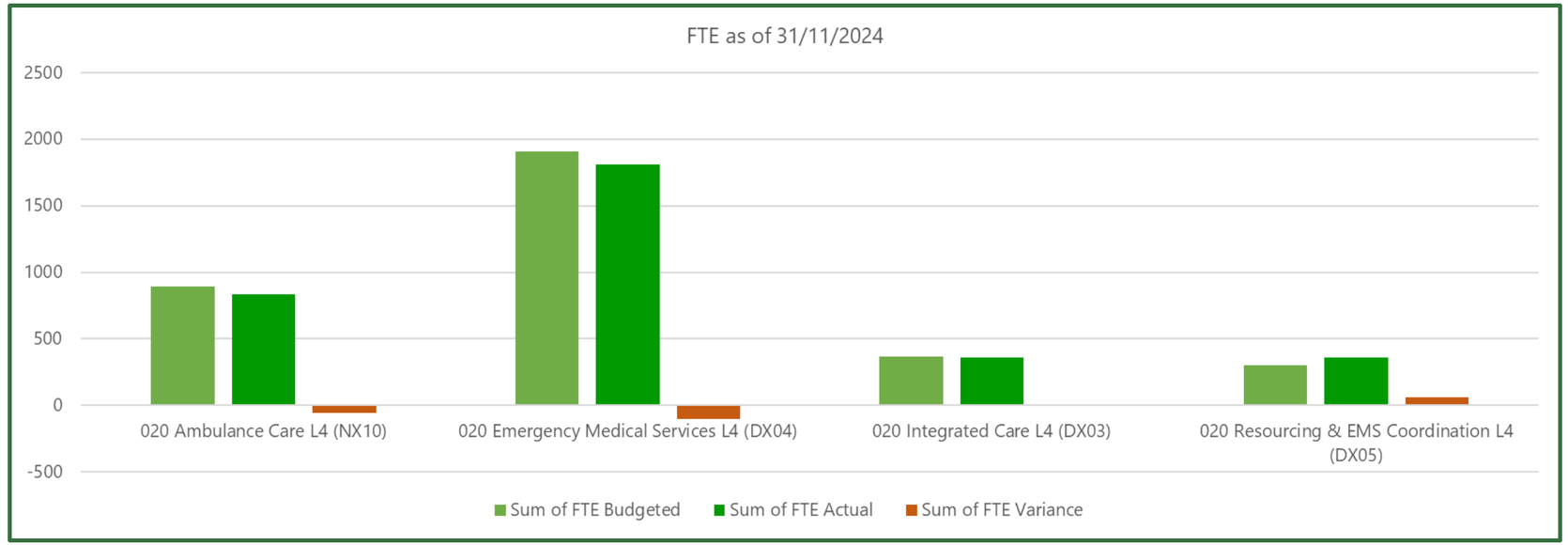
Our People
Capacity - Turnover

(Responsible Officer: Angela Lewis)

G

PCC





Analysis

Staff turnover rates in November 2024 were 8.45%, a slight increase from the 8.02% recorded in October 2024. November saw 21 leavers (19.50 FTE). Turnover in months at the end of the quarter are generally higher. This was disproportionate with 48 joiners (46.92 FTE) in November, of those leaving, the group with the greatest number were Technicians (5 people). and Emergency Medical Dispatchers (5 people).

Due to staff sickness and staff changes our occupational health waiting times have slightly increased. Currently colleagues are waiting around 29 working days, this KPI is achieved 80% of the time. From receipt of Wellbeing referrals to first call (from one of our Wellbeing Practitioners), the waiting time is still 1-2 days.

Remedial Plans and Actions

- Improved data collection through Our MI system (Opas G2). The (All Wales) decision has been made to extend the contract with Civica for 1 year (as opposed to 2 years) for our MI system, Opas G2.
- Work is ongoing to standardise reporting with Health Board colleagues, however, in addition to this we have internal customised reports, to identify themes and trends.
- The Health and Wellbeing strategy for 2025/29 is out for consultation.

Expected Performance Trajectory

The People and Culture Strategy continues with its wellbeing focus. We are currently in the process of writing the WAST Health and Wellbeing strategy for 2025/29.

Our People
Capability - PADR and Training Rates Indicators

(Responsible Officer: Angela Lewis)

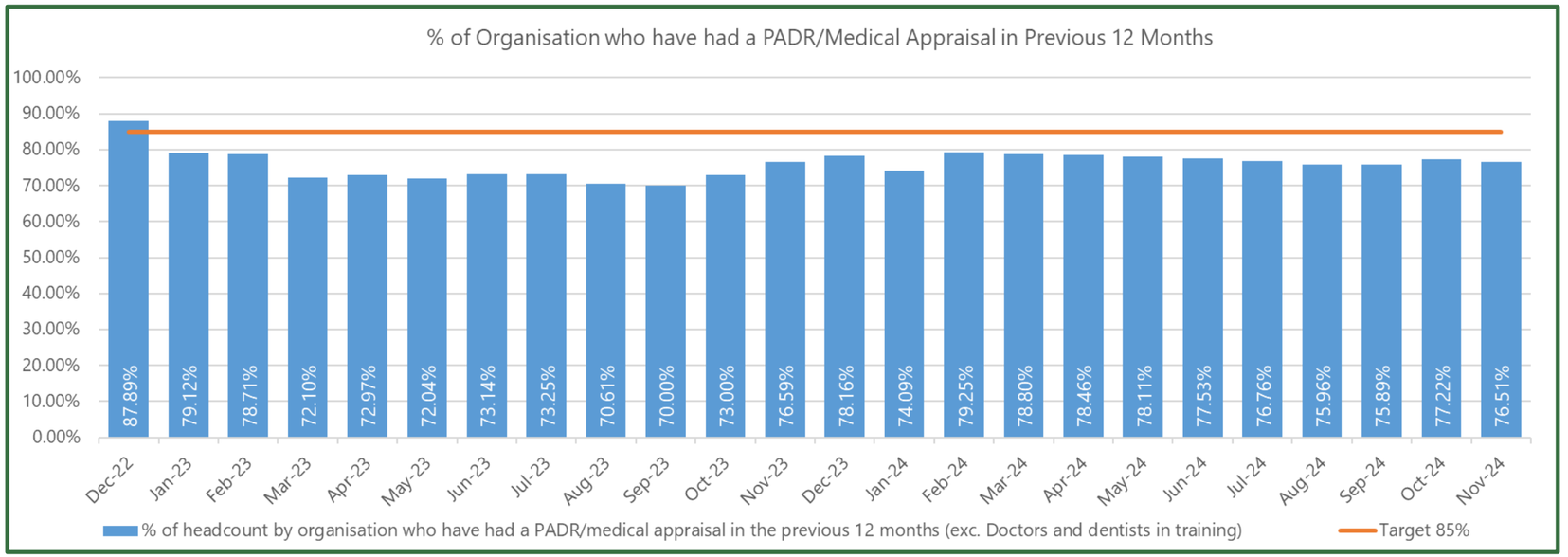
PADR A

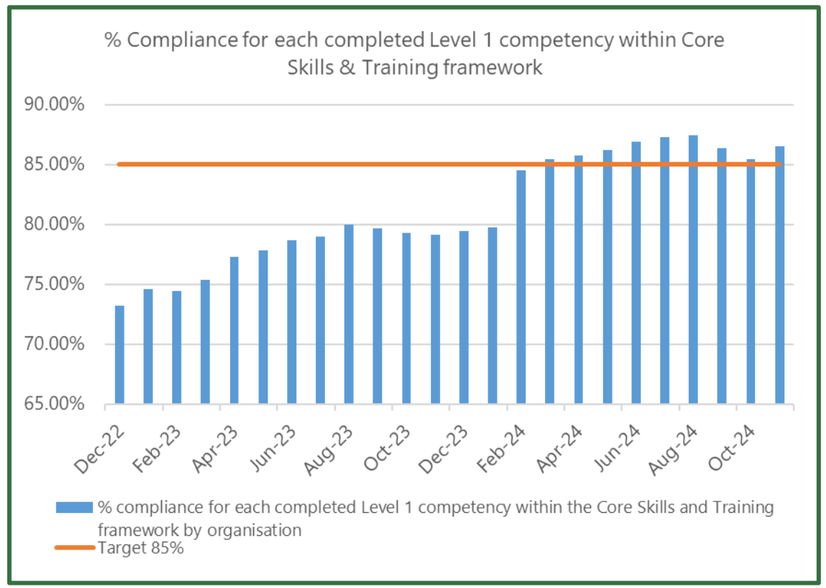
Stat & Mand A

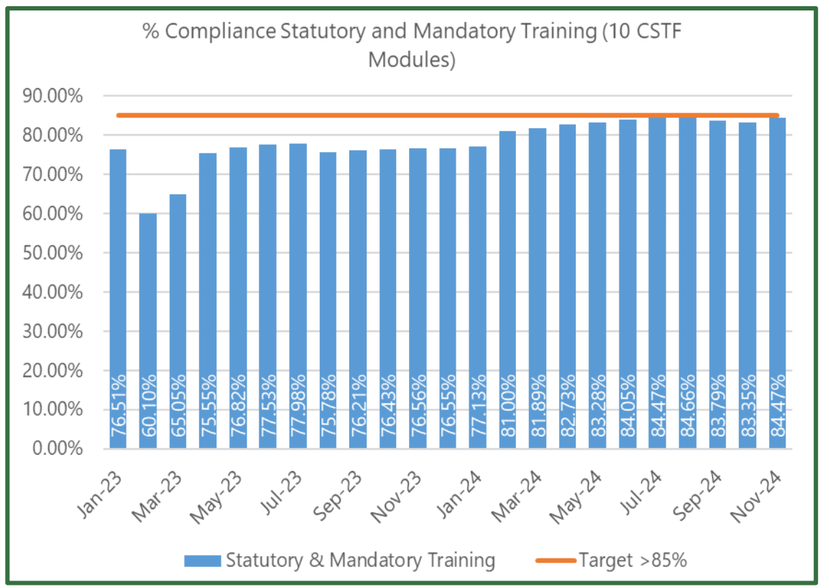
CI PCC

Health & Care Standard Health – Staff & Resources

Self-Assessment: Strength of Internal Control: Strong







Analysis

PADR rates minimally decreased from 77.22% in October 2024 to 76.51% in November 2024 and remains below the 85% target. Over the reporting period this target has only been achieved once, in December 2022.

In November 2024 Statutory & Mandatory Training rates reported a combined compliance of 84.47%; which is an increase and just short of achieving the 85% target. However, only Dementia Awareness (95.84%), Moving & Handling (94.06%) and Safeguarding Adults (87.41%), achieved the 85% target. Equality & Diversity (82.29%), Fire Safety (79.01%), Information Governance (76.95%), Paul Ridd (73.35%), Violence Against Women, Domestic Abuse & Sexual Violence (72.70%), Fraud Awareness (70.53%) and Welsh Language Awareness (67.59%) all remain below this target.

There are currently 18 Statutory and Mandatory courses that NHS employees must complete in their employment. These are listed in the table:

Remedial Plans and Actions

Engagement in the PADR process serves as a Key metric for evaluating team cultural health. By increasing engagement with the PADR process, our goal is to enhance employee Development, support better Communication between managers and employees and develop a culture of accountability and continual improvement.

There has been a continuation of the climb toward achievement of the 85% target across the remainder of the Core Skills Training Framework competencies which is projected to continue to increase as more learning content is moved to the user friendly environment enabling easier access to these reportable competencies.

Expected Performance Trajectory

Performance is improving as compliance has risen.

Skills and training Framework	NHS Wales Minimum Renewal Standard
Equality, Diveristy & 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	Yearly
Safeguarding Adults Level 1	3 years
Safeguarding Children Level 1	3 years
Violence & Aggression (Wales) Module A	No Renewal
Mandatory Courses	
Violence Against Women, Domestic Abuse and Sexual Violence	3 years
Dementia Awareness	No renewal
Welsh Language Awareness	3 years
Paul Ridd Learning Disability Awareness	No Renewal
Enviroment, Waste and Energy (Admin & Clerical Staff only)	Yearly
Duty of Quality	3 years
Fraud Awareness	3 years
Prevent Awareness	No Renewal

Data source: ESR

Our People
Health and Well-being – Shift Overruns

(Responsible Officer: Angela Lewis)

Overruns
A

CI

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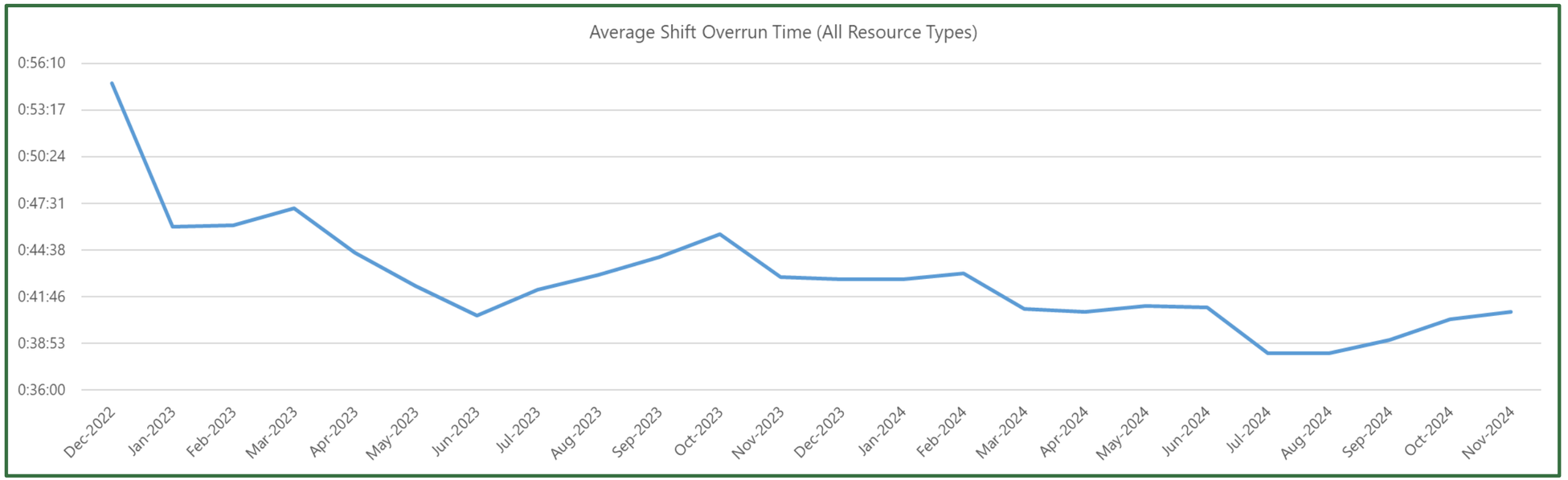
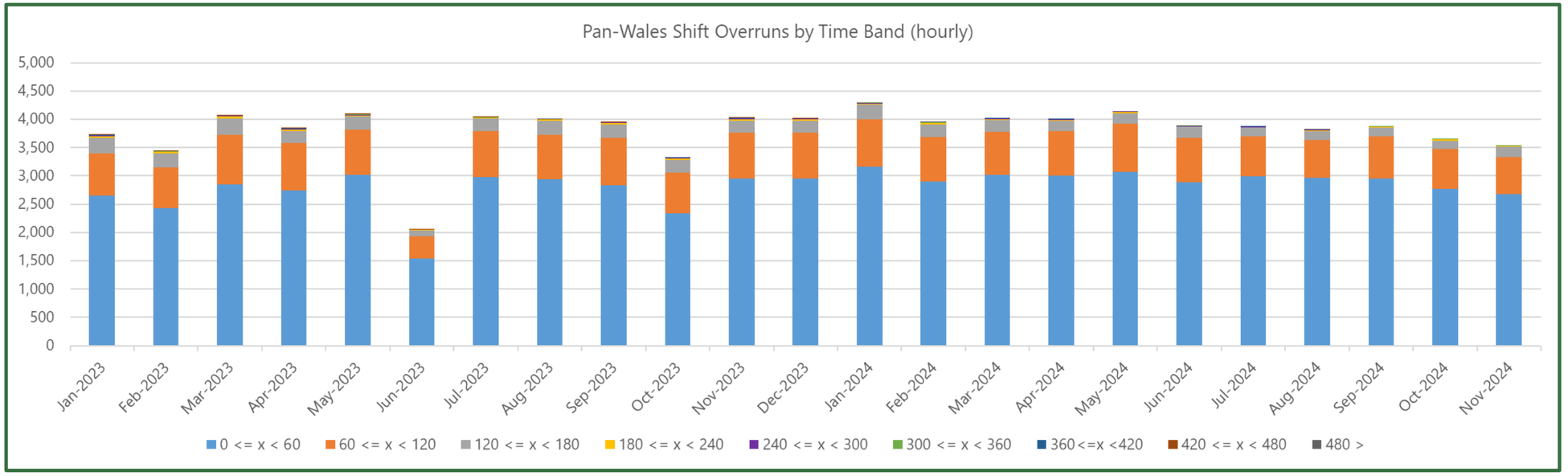




Analysis

The average overrun figure for November 2024 was 40 minutes and 49 seconds, a minimal increase from October 2024 (00:40:22). The trend continues to be downward over the past two years.

The highest volume of shift overruns occur within the 0 to 60-minute category, accounting for 75.2% of the total. 19.4% fall within the 61 to 120-minute category, 4.9% in the 121 to 180-minute category, 0.4% in the 181 to 240-minute category and 0.2% in the 241 minutes and over category.

Remedial Plans and Actions

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

As part of the Trust's winter resilience planning, it introduced "pods" at some hospital locations to aid staff finishing on time. These are continuing, at this time, into 2024/25.

Expected Performance Trajectory

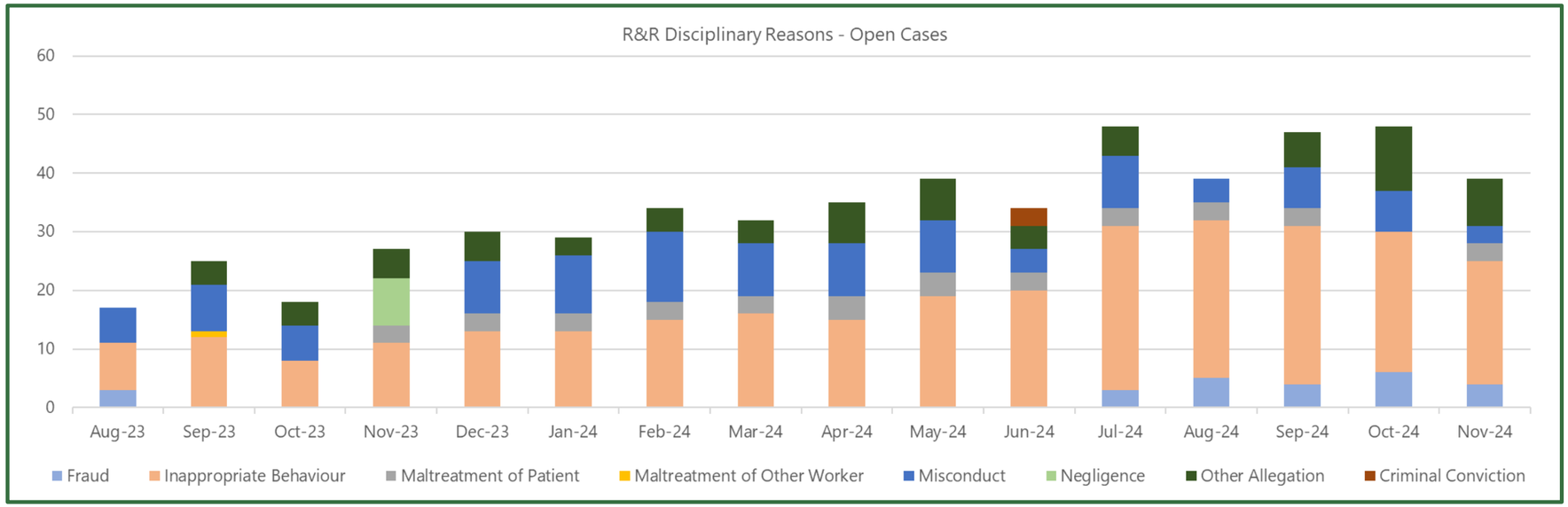
Overruns correlate with handover lost hours and may increase in December and January.

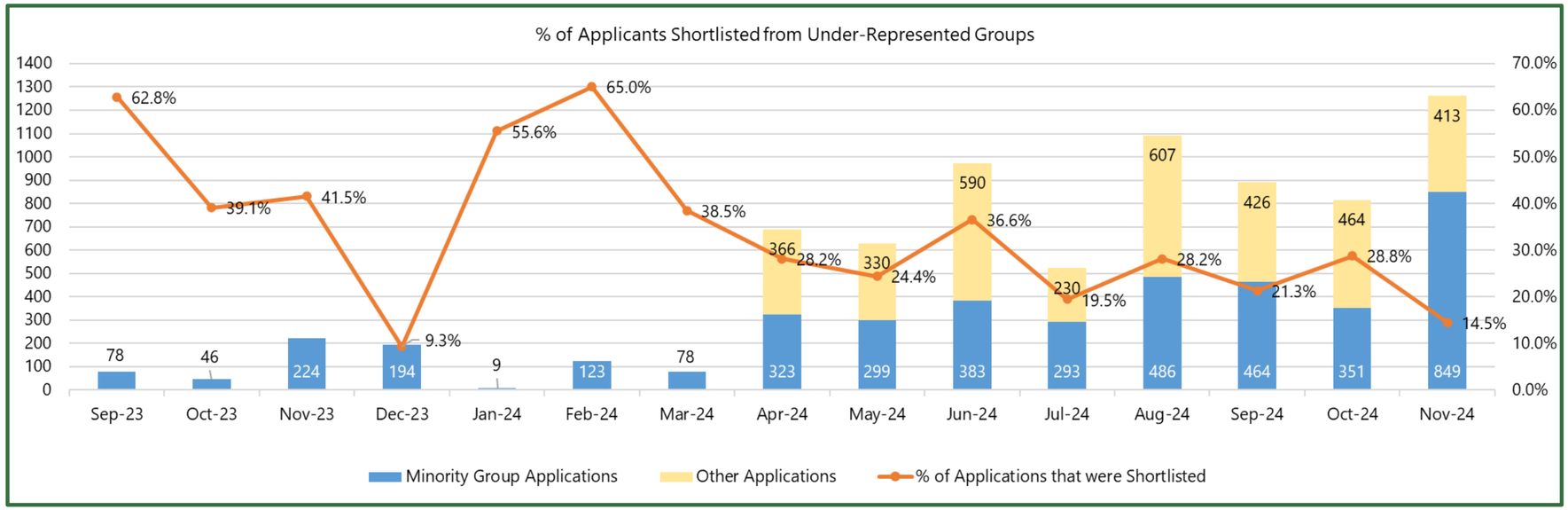
Our People
Culture – Number of R&R Disciplinary Hearings and Number of Applicants Shortlisted from Under-Represented Groups

(Responsible Officer: Angela Lewis)

Self-Assessment: Strength of Internal Control: Moderate

PCC





Analysis

There were 39 open formal disciplinary cases recorded at the end of November 2024, which is a decrease compared to 48 in October 2024. Of these Disciplinary cases, the majority are again due to allegations of inappropriate behaviour, followed by fraud.

There were 13 open formal Respect and Resolution cases submitted by employees in November 2024, a slight increase from October 2024 (11). These are a mixture of both Respect and Resolution Grievances and Dignity at work.

The bottom graph shows that in November 2024, 1,262 job applications were processed, and 224 interviews planned.

Of the 1,262 applications, a total of 849 were from under-represented groups with 625 in the category of Ethnicity, 121 within Disability and 103 identifying within Sexual Orientation.

In November 2024, 14.5% (n=123) of all applications from under-represented groups made it through shortlisting and were invited for interview. This was a decrease from the 28.8% in October 2024.

Remedial Plans and Actions

R&R Formal Disciplinary Cases: Continue to monitor. The Trust has a substantial programme of work in place, connected to behaviours.

Applications: The inclusive recruitment work is ongoing to develop targeted recruitment campaigns and events. One workshops has taken place, with a second to take place in Nov-24 to recruit for Black, Asian and Ethnically diverse applicants into our digital roles.

Expected Performance Trajectory

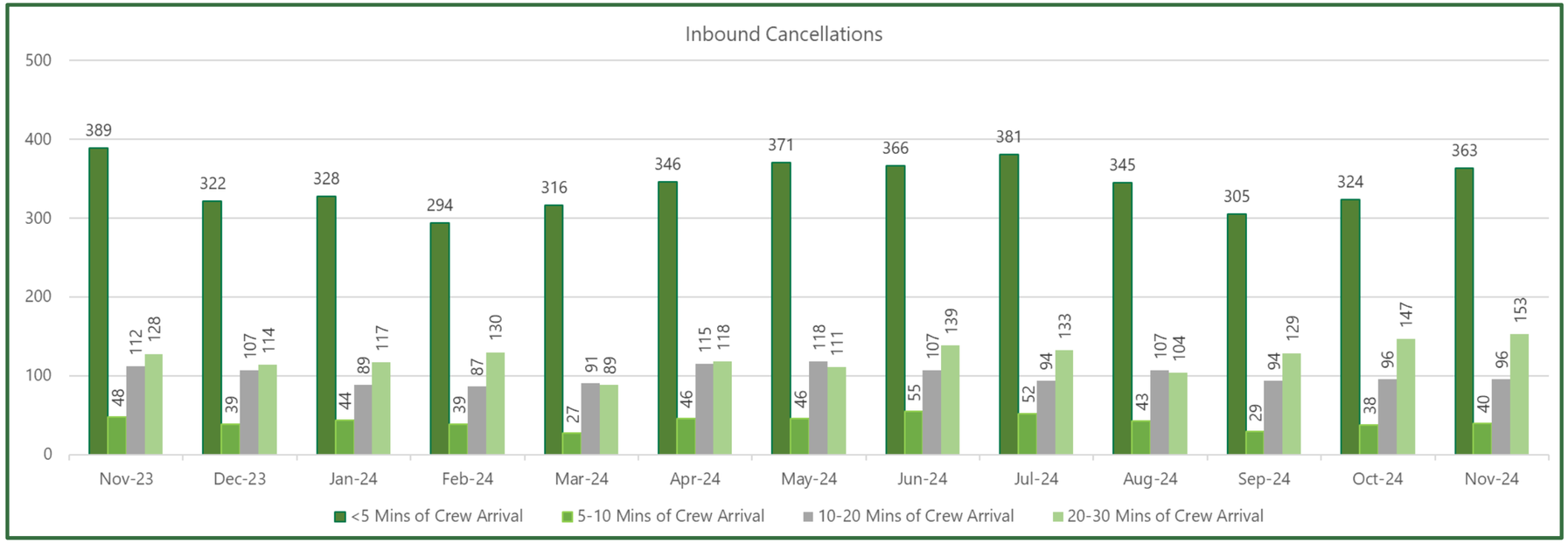
Continue to monitor levels, no trajectory for this measure.

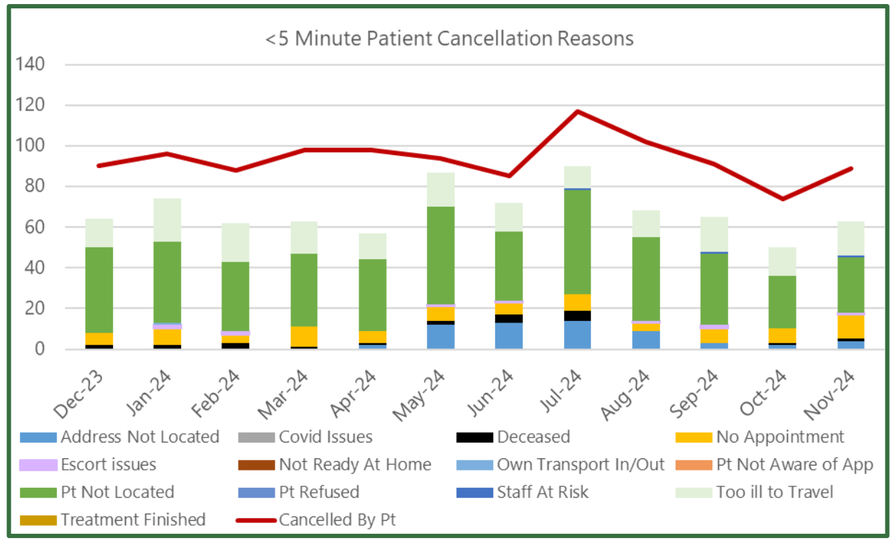
Finance, Resources and Value
Value: Ambulance Care Indicators

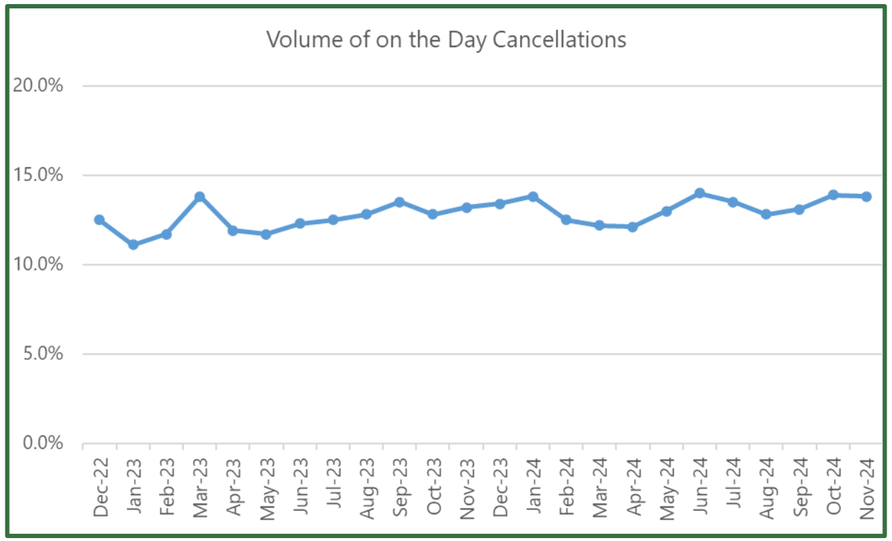
(Responsible Officer: Lee Brooks)

Cancellations
R

FPC







Analysis

Inbound cancellations of 5 minutes or less of the crew arrival time saw an increase in November 2024 to 363, compared to 324 in October 2024. The total number of cancellations within 30 minutes increased from 605 in October 2024 to 652 in November 2024.

In November 2024 there were 89 travel bookings cancelled by patients, increasing from 74 in October 2024.

The other top reasons for less than 5-minute cancellations included: 27 patients not located, 17 unwell/too ill to travel and 12 no appointment.

Same day cancellations decreased slightly in November to 13.8% from October 2024 (13.9%).

Remedial Plans and Actions

Work with Hywel Dda to develop a direct link between their PAS system and our CAD but has been delayed by a clash of organisational priorities. Once in place this will allow for WAST to be notified once the health board cancels or alters an appointment.

Work is also underway to enhance the service's text messaging options to improve notification to patients.

Expected Performance Trajectory

Until this work is completed, we do not anticipate a significant shift in the trajectory as many of the factors affecting this are outside of our direct control.

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

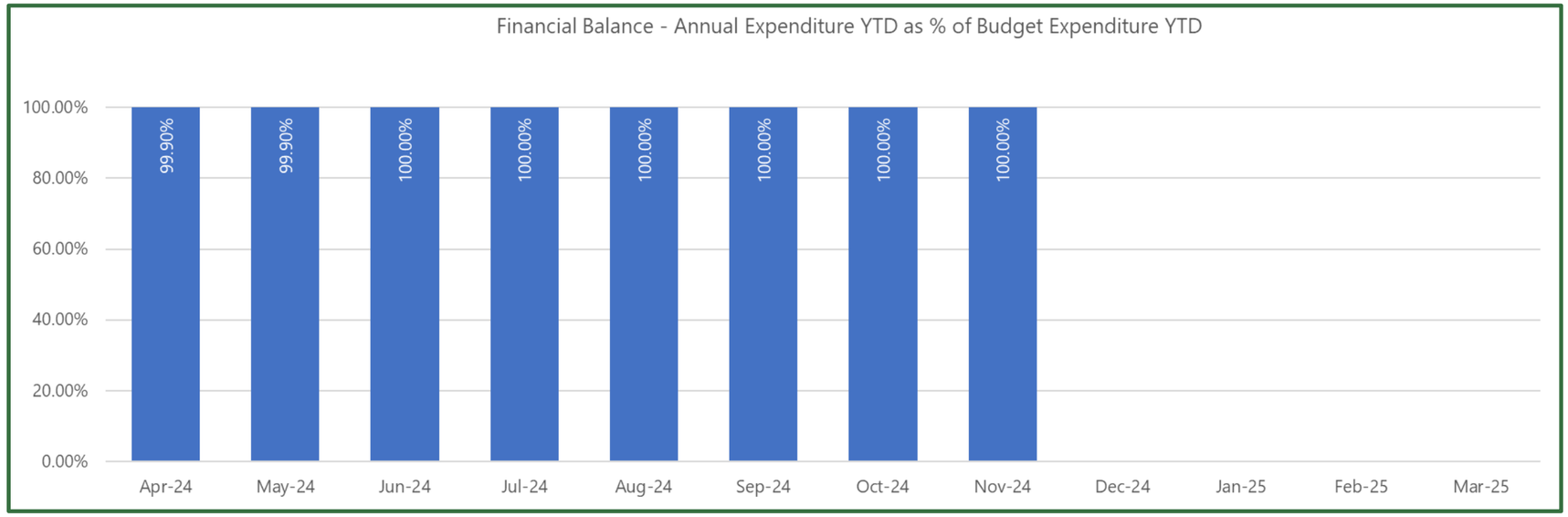
**Please note that MDTs do not appear to provide specific cancellation reasons for either inbound or outbound journeys. There are at present multiple and duplicated reasons both crews, control and the liaison desk can select.*

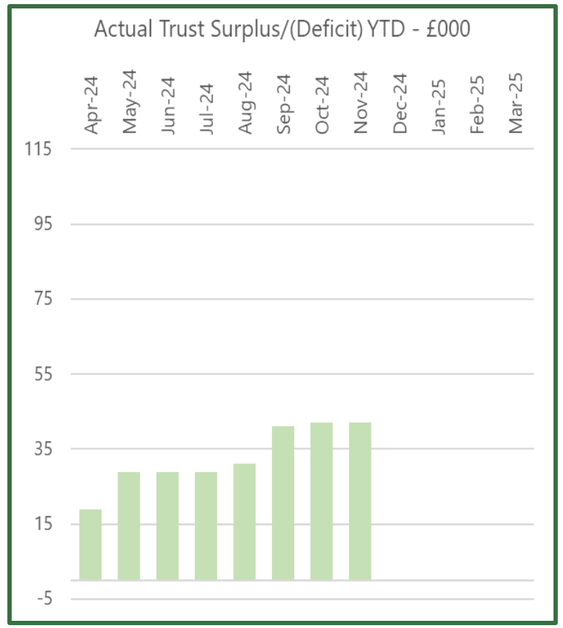
Finance, Resources and Value
Value - Finance Indicators

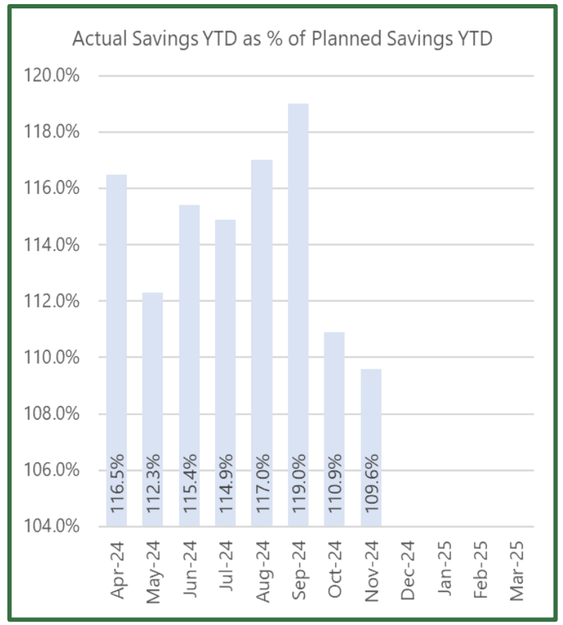
(Responsible Officer: Chris Turley)

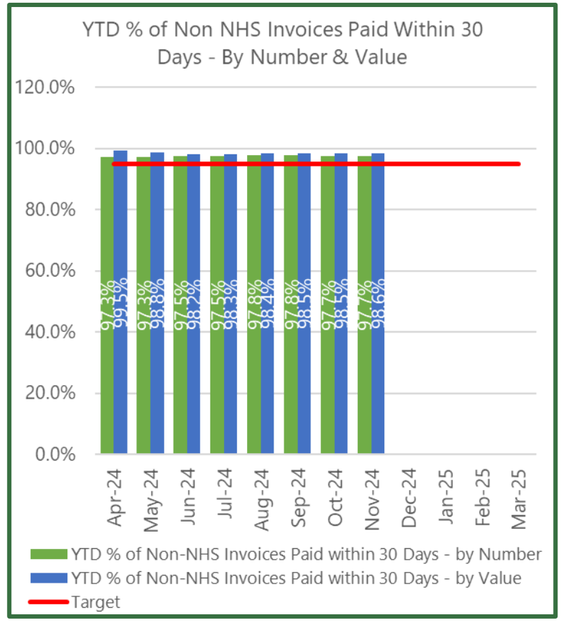
G

FPC









Analysis

The reported outturn performance at Month 8 is a surplus of £42k, with a forecast to the yearend of breakeven

For Month 8 the Trust is reporting planned savings of £4.640m and actual savings of £5.086m (an achievement rate of 119.6%).

The Trust's cumulative performance against PSPP as at Month 8 is 97.7% against a target of 95%.

At Month 8 the Trust is forecasting to achieve both its External Financing Limit and its Capital Expenditure Limit.

Remedial Plans and Actions

There is no remedial plan required given the Trust is forecasting to breakeven; however, key areas of focus include:-

- Undertaking a review of commercial opportunities for income generation (Report being considered by FSP group).
- A continued focus on the Trust's financial sustainability programme.
- Improved governance for Value Based Health Care, with a particular focus on benchmarking; and
- An improved approach to benefits realisation

Expected Performance Trajectory

The expectation is that the Trust will continue to meet its statutory financial duties, as outlined in its IMTP for the 2024/25 financial year; however, it is expected that the Trust will continue to operate in a challenging financial environment and will need to deliver a planned level of savings in the 2024/25 financial year of c£6.4m.

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

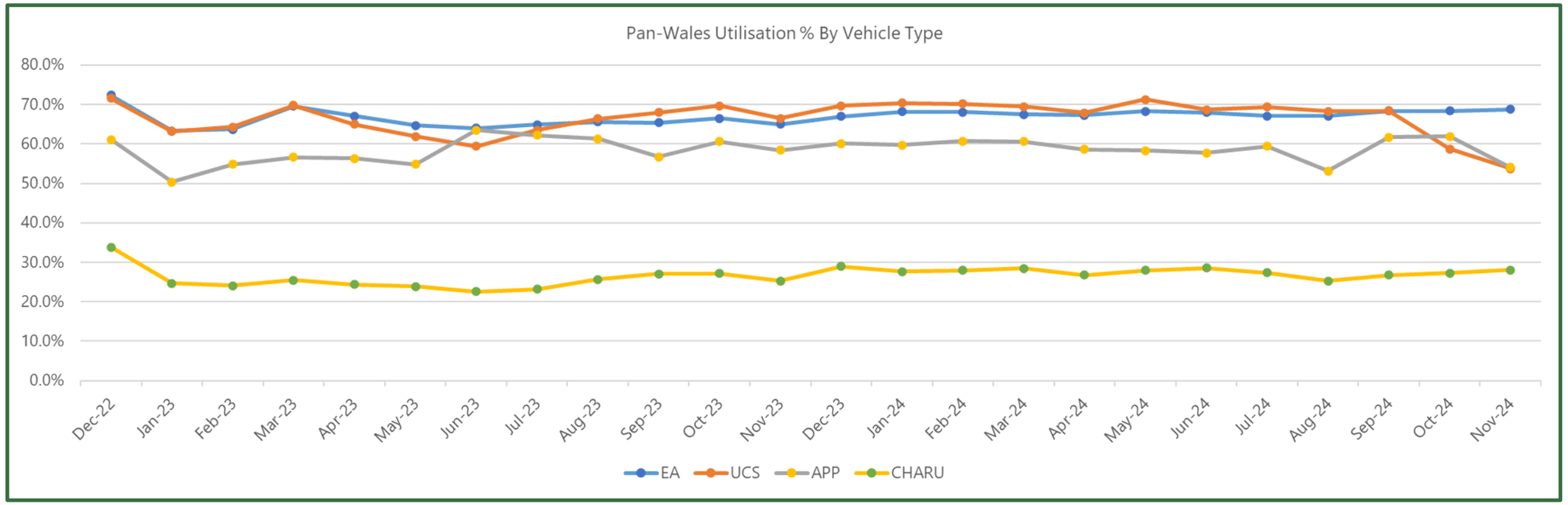
(Responsible Officer: Lee Brooks)

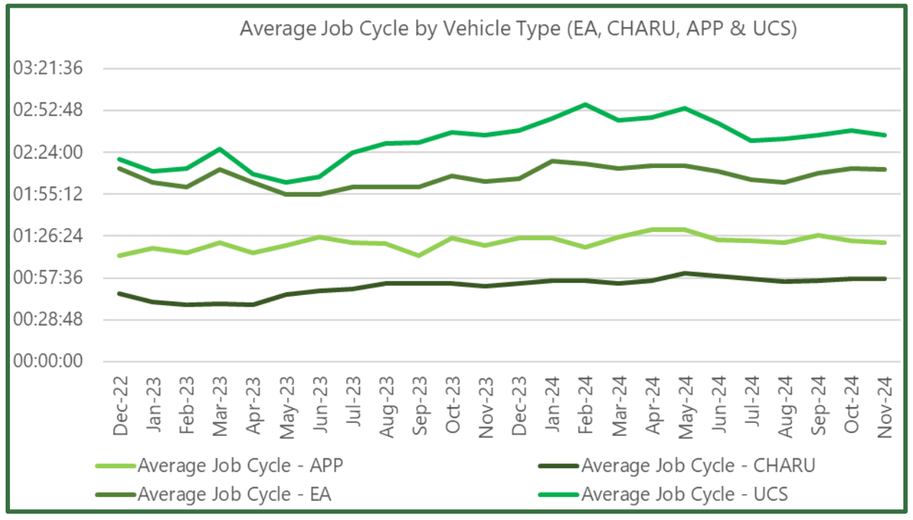
Jobs Per Shift: R

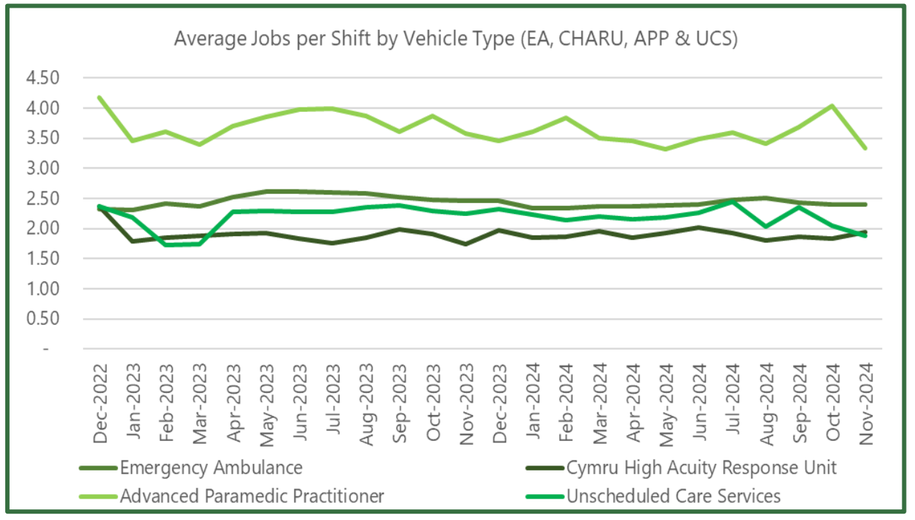
CHARU Utilisation: G

FPC

NB: Data quality issues have been identified within APP data. These are currently being addressed.







Analysis

Pan Wales Utilisation metrics in November 2024 were 57.3% for all vehicles types, decreasing slightly from 57.4% in October 2024. EA was the highest rate during the month at 68.8%, which has seen a generally stable trend over the past two years. The optimal utilisation rate for EAs needs to be lower so that they are free to respond to incoming calls.

As demonstrated in the bottom left graph, the average job cycle decreased in all categories in November 2024, 57 minutes for CHARU, 2 hours and 36 minutes for UCS, EAs to 2 hours 12 minutes and1 hour, 22 minutes for APPs.

Overall average jobs per shift was 2.26 in November 2024, indicating a slight increase from October 2024 (2.25). EAs averaged 2.40 jobs per shift and UCS crews 1.89 jobs per shift This is more than what would be ideal and a product of handover delays.

APPs attended on average 3.34 jobs per shift and CHARU's 1.94 jobs per shift. Both sets of data are under review.

Remedial Plans and Actions

EA and UCS jobs per shift is fundamentally a product of handover delays.

For APPs, the newly created APP Recruitment Task & Finish Group will give a focus on further improvement, in particular, improved information and a re-roster.

CHARU is a particular area of focus. Initial analysis indicates that CHARU contribution to Red compares favourably with the previous resource: RRVs.

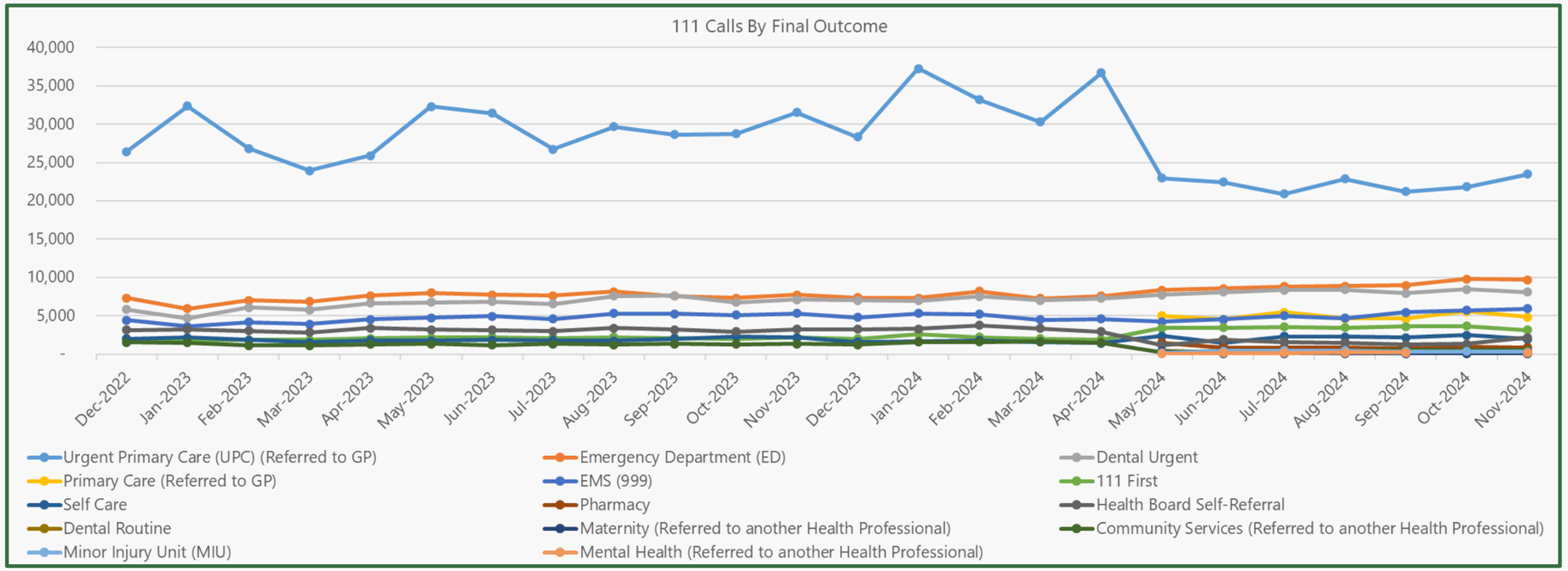
Expected Performance Trajectory

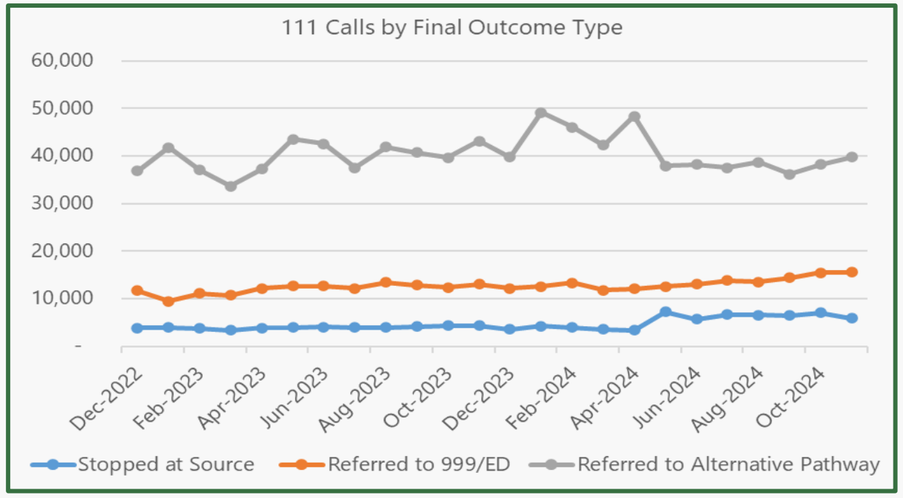
The Trust's ability to reduce the high utilisation rates for EAs and UCS is a product of handover, which it does not control. The Trust would expect an increase in APP and CHARU utilisation during 2024/25 linked to the remedial actions identified above.

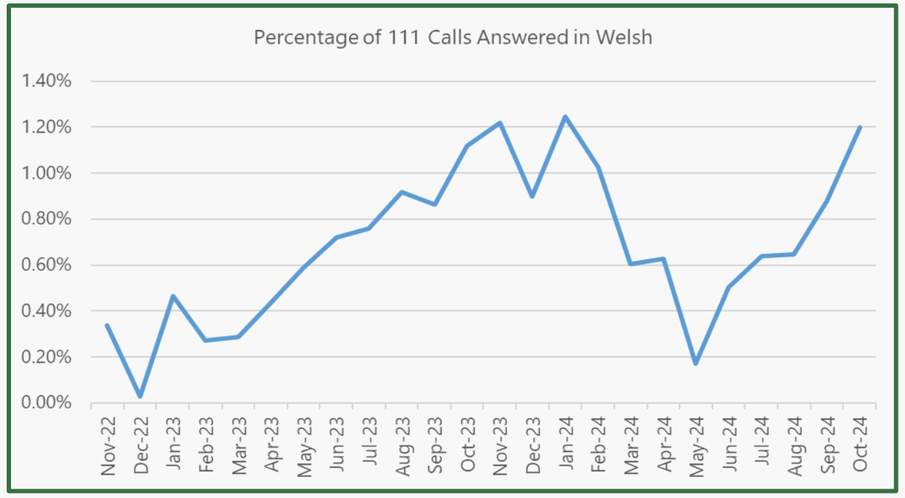
Partnerships / System Contribution
NHS111 Hand Off Metrics and NHS111 Consult & Close Indicators
Influencing Factors – Demand and Clinical Hours Produced

(Responsible Officer: Lee Brooks)

NB: Data quality issues have been identified in 111. These are currently being addressed.







Analysis

During November 2024, 61,264 calls were allocated into the 14 categories displayed in the graph opposite, an increase compared to the 60,779 seen during October 2024. However, data quality issues have been identified in 111 which are currently being addressed.

Calls Referred to a General Practitioner (handover of care) continued to be the top outcome for NHS111 accounting for 38.29% of all calls during November 2024, but there has been a material drop since the implementation of new 111CAS.

As the bottom left graph highlights, in November 2024, 5,927 calls were 'Stopped at Source', with no onward referral, a decrease from the 7,092 in October 2024. 15,619 calls were referred to 999/ED in November, an increase from the 15,479 in October 2024.

The percentage of 111 calls answered in Welsh increased from 0.88% in September 2024 to 1.20% in October 2024. This equated to 68% of all 111 calls being offered in Welsh being answered.

Remedial Plans and Actions

There is currently a 111 Measures Task and Finish Group. This is a collaborative meeting between WAST, Six Goals, commissioners and DHCW. The focus is the development of a nationally reportable 111 data set. Similar to what is currently in place for Ambulance Service Indicators (ASIs). Part of this work involves looking at the reporting of disposition final outcomes.

Expected Performance Trajectory

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

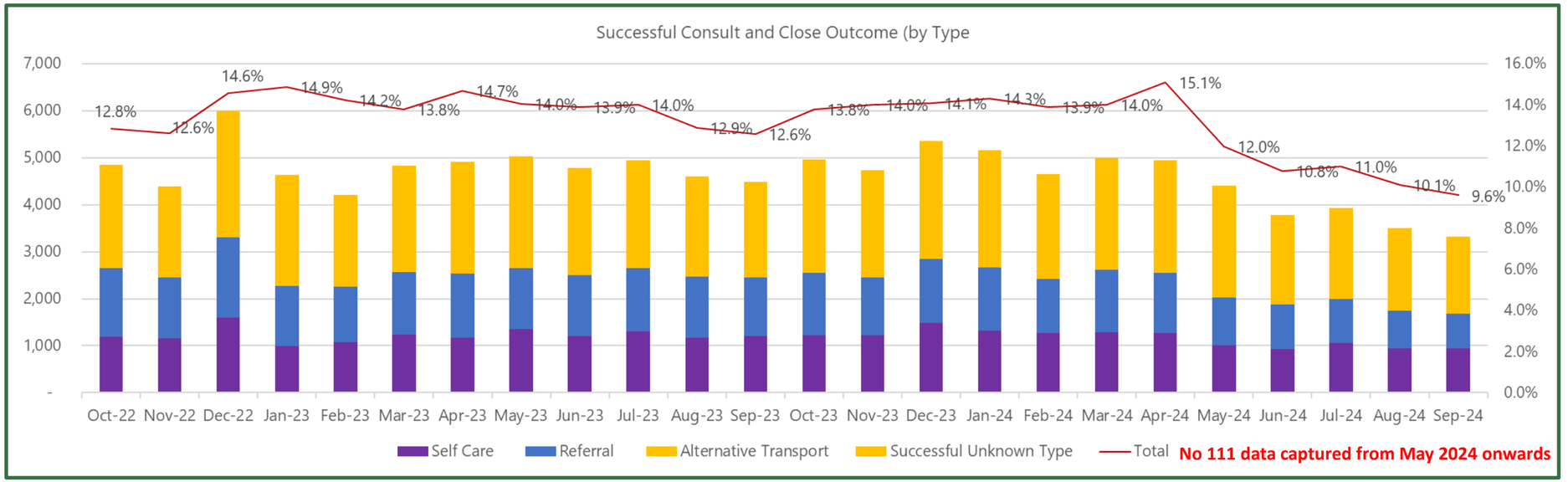
Partnerships / System Contribution
Consult & Close Indicators

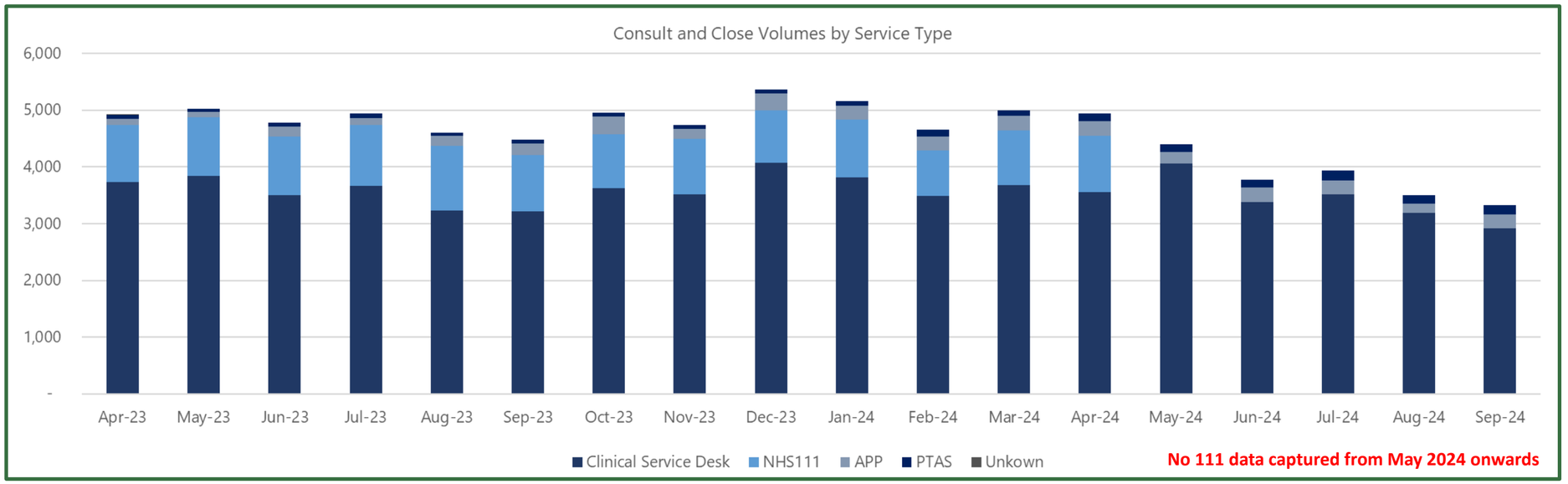
(Responsible Officer: Lee Brooks)

C&C Outcomes

FPC

NB: Data quality issues have been identified in 111. These are currently being addressed.





No additional analysis possible given no 111 data is currently available on these metrics.

Partnerships / System Contribution
Conveyance to ED Indicators

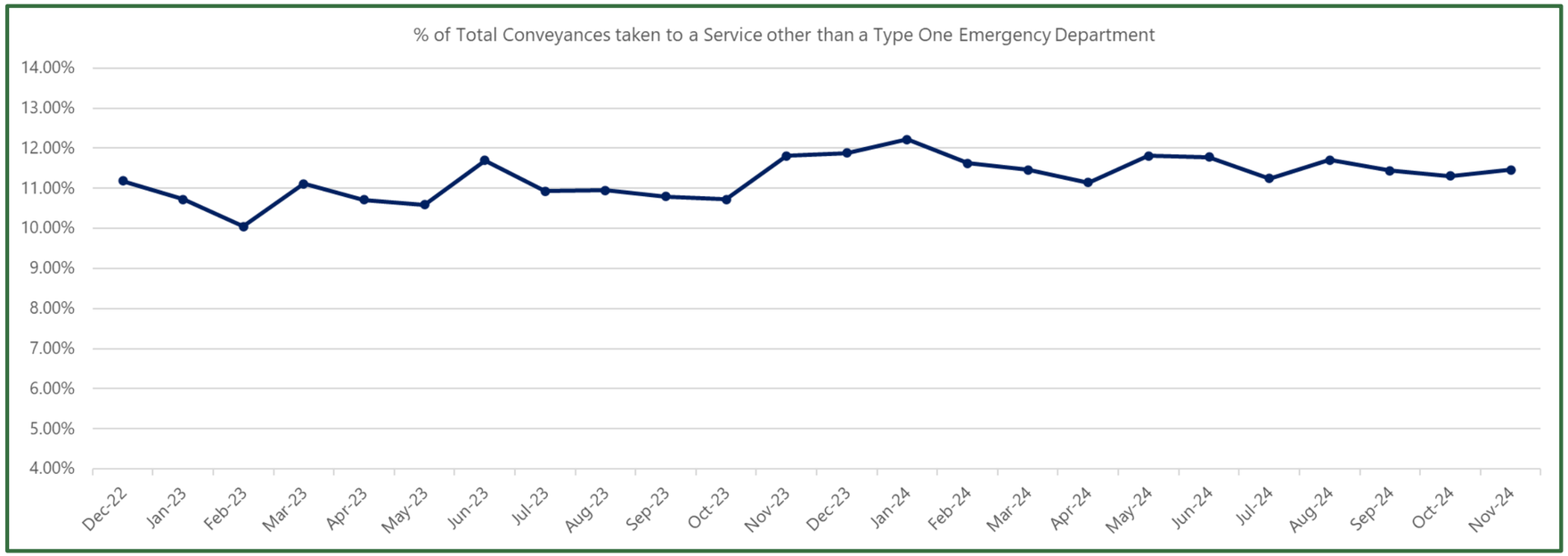
(Responsible Officer: Andy Swinburn)

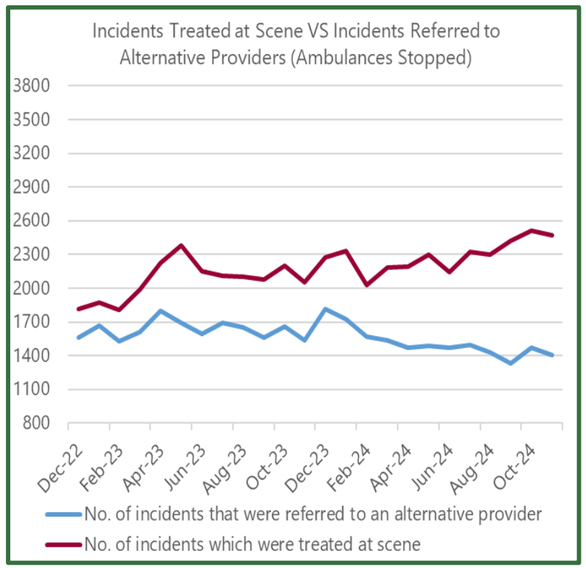
Conveyances
G

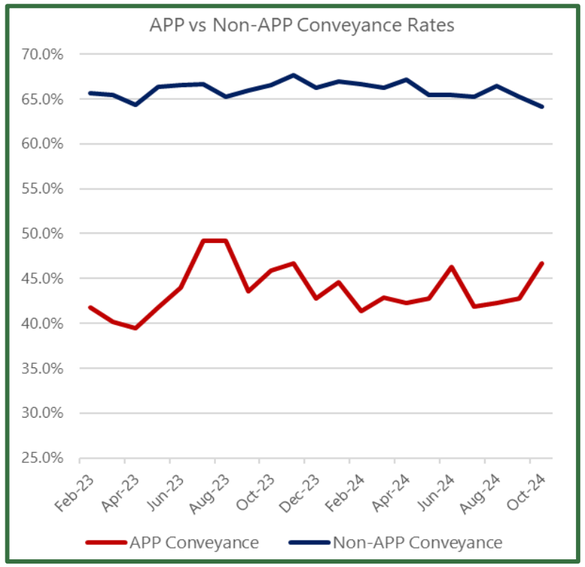
FPC

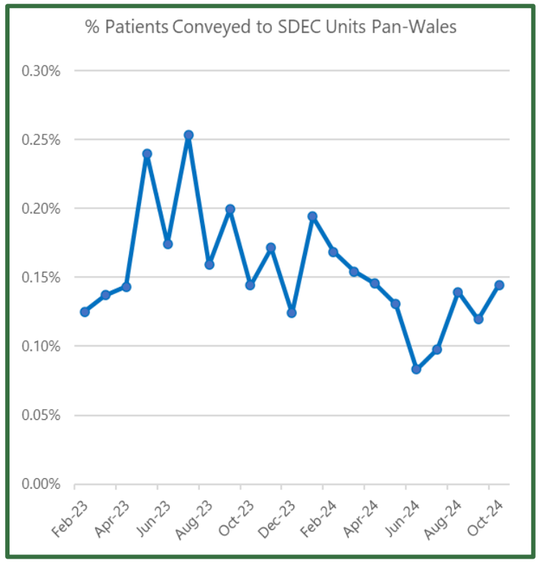
Ministerial Measure

NB: Data quality issues have been identified in APP data. These are currently being addressed.









Analysis

In November 2024 11.46% of patients (1,557) were conveyed to a service other than a Type One ED, while 33% of patients were conveyed to a major ED, as a percentage of verified incidents.

The combined number of incidents treated at scene or referred to alternate providers decreased slightly, from 3,982 in October 2024 to 3,884 in November 2024.

The APP conveyance rate was 46.6% in October 2024 and continues to experience a generally increasing trend since March 2023; whilst the DCR table highlights by code the incidents where the preferred response should be an APP (if available). Pilot schemes are in place to clinically dispatch advanced and enhanced clinical resource to safely manage care closer to home, however, data quality issues around accurately capturing APPs on shift is likely to be contributing to discrepancies in this figure.

Patients conveyed to SDEC's in October 2024 remained low at 0.14%.

Remedial Plans and Actions

- Continued contribution to the SDEC strategy the 6 goals programme with HB actions around reporting measures from referral and bedding of SDECs in times of escalation. It should be noted that WAST data reflects a direct referral to an SDEC where some HB models require a conveyance to ED initially and then streaming to SDEC on this basis.
- Further investment in the APP workforce in 2024/25 (+32 APPs).
- Formal education support and induction package for APPs agreed trust-wide.
- Embedding the Urgent Care response within the Clinical Model Transformation, tasking optimisation (alongside HB partners if available), scheduling care and APP development and workforce.
- Inclusion of specific Frailty and Falls workstream within Urgent Care Response Service with involvement in the review of the All Wales Falls Response Framework alongside NHS Executive Colleagues.

Expected Performance Trajectory

The 2023 EMS Demand & Capacity Review (strategic) models various future states. The modelled scenarios indicate that the Trust will need to evolve its clinical model with health boards also significantly reducing handover e.g. 12,000 hours or 7,500 hours, alongside varying levels of investment. Seasonal modelling continues to be undertaken.

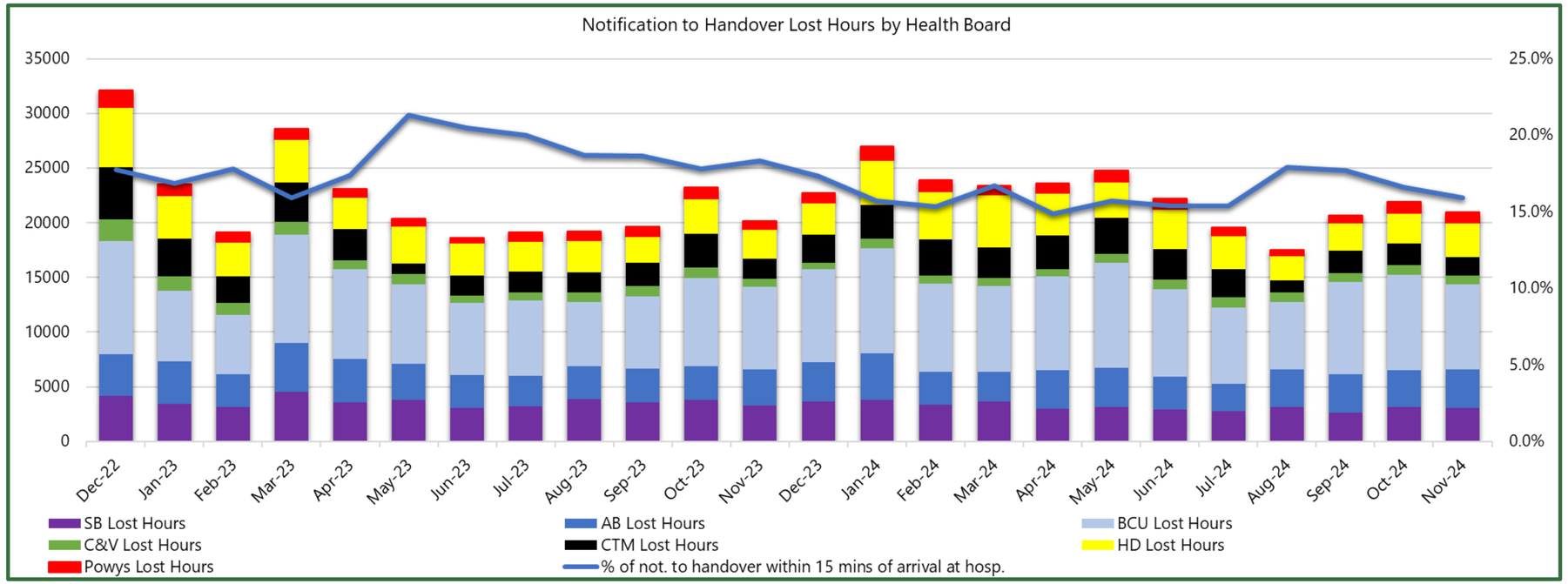
Partnerships / System Contribution Handover Indicators

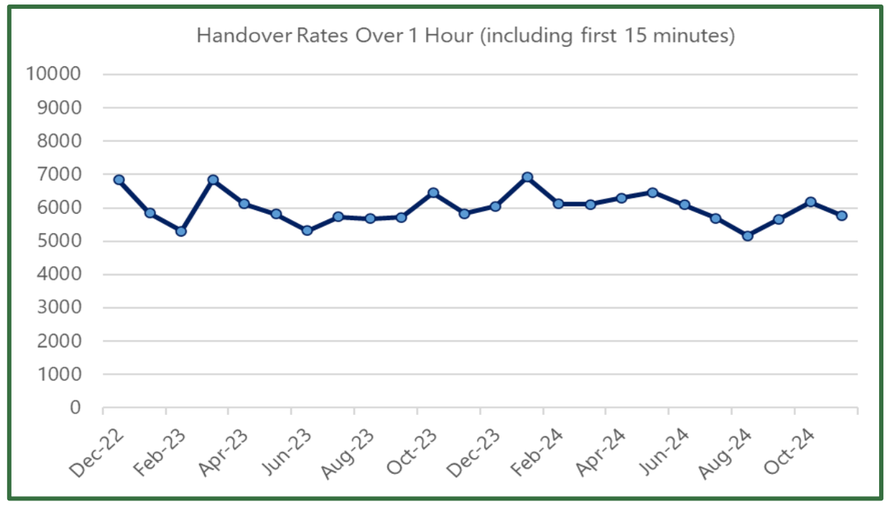
(Responsible Officer: Health Boards)

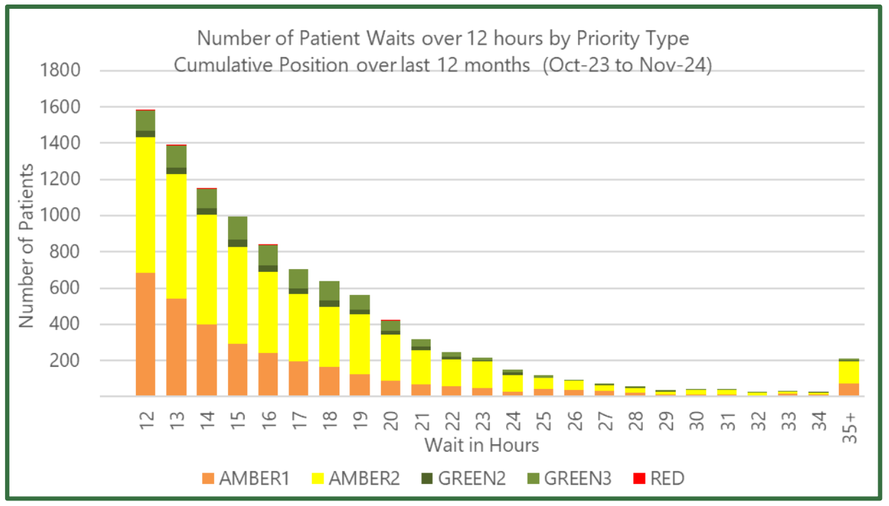
Lost Hours R

CI

QUEST







Analysis

268,361 hours were lost to Notification to Handover, i.e. hospital handover delays, over the last 12 months (Dec-23 to Nov-24), compared to 266,713 hours over the same timeframe the previous year. There were 20,995 hours lost in November 2024, which is 4.3% higher than the 20,124 hours lost during November 2023.

The hospitals with the highest levels of handover delays during November 2024 were:

- Grange University Hospital (ABUHB) at 3,365 lost hours
- Morriston Hospital (SBUHB) at 2,988 lost hours
- Ysbyty Gwynedd Hospital (BCUHB) at 2,612 lost hours
- Maelor General Hospital (BCUHB) at 2,492 lost hours

Notification to handover lost hours averaged 700 hours per day during November 2024 compared to 706 hours per day in October 2024.

In November 2024, the Trust could have responded to approximately 6,623 more patients if handovers were reduced, which highlights the impact these numbers are still having on the service.

In November 2024, 900 patients waited over 12 hours for an ambulance response. In November 2024 60 compliments were received from patients and/or their families.

Remedial Plans and Actions

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

Expected Performance Trajectory

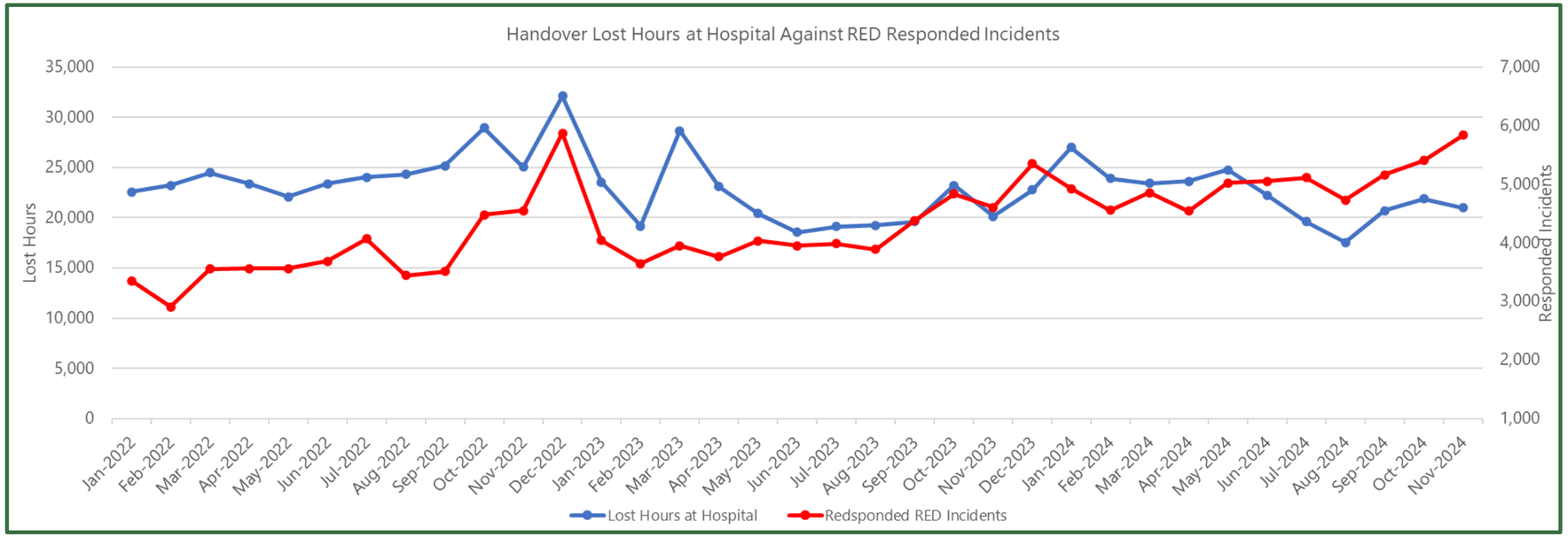
The Welsh Government handover target for 2024/25 is no waits over one hour; this equates to 7,500 hours lost to handover delays per month. There would need to be a 60% reduction in current handover levels for this to be achieved.

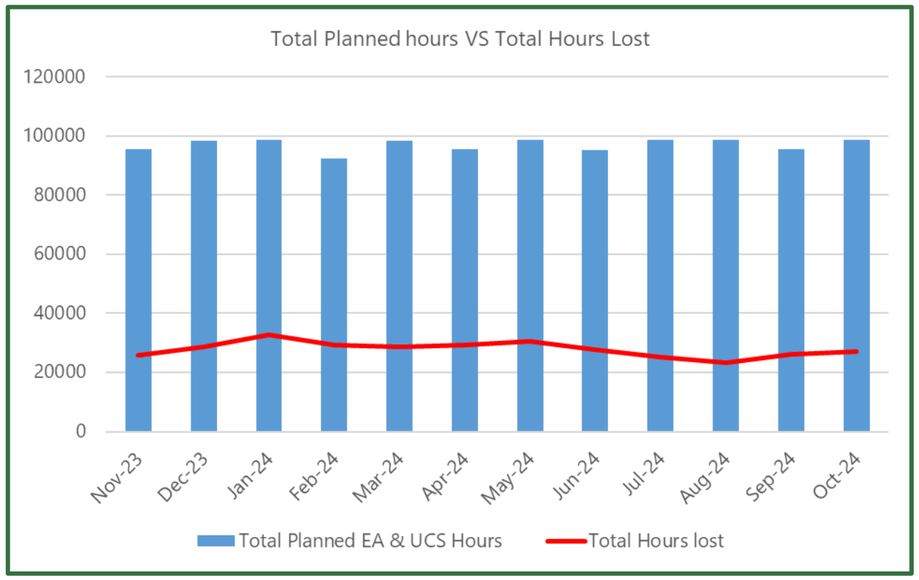
Partnerships / System Contribution

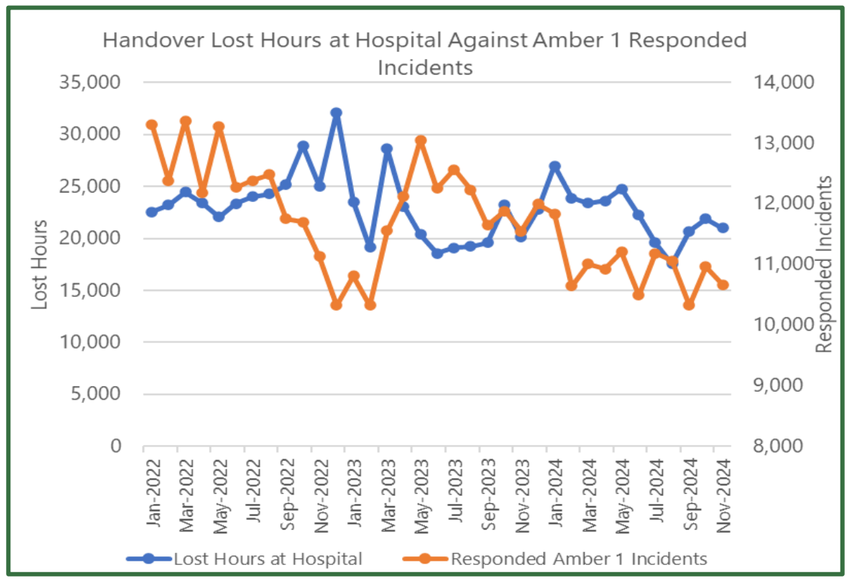
Handover Lost Hours Against Red & Amber 1 Responded Incidents

(Responsible Officer: Health Boards)

CI QUEST







Analysis

The top graph highlights that as handover lost hours have increased since November 2021, so too have the number of Red incidents being responded to. This shows that when CSP is in periods of high demand and hospital handover increases, Red responses are protected, even during high pressure within the system.

However, as the bottom right graph illustrates, there is a correlation between lost hours increasing and a decrease in the number of Amber 1 incidents being responded to, particularly at times of high demand, such as during December 2022. This is notwithstanding that some of these patients within the Amber 1 category will still be seriously ill.

Remedial Plans and Actions

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

Expected Performance Trajectory

The Welsh Government target is no patient handovers of more than one hour, which equates to 7,500 lost hours a month. Welsh Government want to see a 30% reduction by December 2024 as a move towards this target. The Trust is currently experiencing lost hours in excess of 20,995 hours. Handover in November 2024 was 4.3% higher than November 2023.

**NB: Data correct at time of abstraction*

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

Definition of Indicators

Indicator	Definition	Indicator	Definition
111 Abandoned Calls	An offered call is one which has been through the Interactive Voice Response messages and has continued to speak to a Call Handler. There are several options for the caller to self-serve from the options presented in the IVR and a proportion of callers choose these options. An example is to guide the caller to 119 if they wish to speak to someone about a Coronavirus test. Once the caller is placed in the queue for the Call Handler if they hang up, they are counted as "abandoned" as we did not answer the call. The threshold starts at 60 seconds after being placed into the queue as this allows the callers to respond to the messages and options presented as it often takes a short while for the caller to react. Starting the count at 60 seconds provides a picture of abandonment where the caller has chosen not to wait, despite wanting to speak to a Call Handler	**Hours Produced for Emergency Ambulances**	Proportion of hours produced within the calendar month for Emergency Ambulance Vehicles (Target 95%).
111 Patients Called back within 1 hours (P1)	(Welsh Government performance target) which prescribes that 111 has up to 1 hour (longer for lower priory callers) for a 111 Clinician to call the patient to discuss their medical issue. These callers will already have been screened by Call Handlers and received an outcome which needs a conversation with a 111 Clinician. WAST operates a queue and call back method for all Clinical Calls.	**Sickness Absence (all staff)**	Staff sickness volumes as a percentage for all staff employed within the Welsh Ambulance Services NHS Trust.
999 Call Answer Times 95th Percentile	Time taken (in Minutes) to answer 999 emergency calls by call handlers. A percentile (or a centile) is a measure used in statistics indicating the value below which a given percentage of observations in a group of observations fall. For example, the 95th percentile is the value below which 95 percent of the observations may be found.	**Frontline COVID-19 Vaccination Rates**	Volume of frontline (patient facing and non-patient facing) who have received a second COVID-19 vaccination.
999 Red Response within 8 Minutes	Percentage of 999 incidents within the Red (immediately life-threatening) category which received an emergency response at scene within 8 minutes.	**Statutory and Mandatory Training**	Combined percentage of staff who are compliant with required statutory training undertaken by staff where a statutory body has dictated that an organisation must provide training based on legislation and mandatory training which relates to trade-specific training that the employer considers essential or compulsory for a specific job. (A detailed list of these can be found on slide 20).
Red 95th Percentile	Time taken (in minutes) for emergency response to arrive at scene for Red (immediately life-threatening) calls (NB: The 95th percentile is the value below which 95 percent of the observations may be found).	**PADR/Medical Appraisal**	Proportion of staff who have undertaken their annual Performance Appraisal & Development Review (PADR) or Medical Appraisal. This is a process of self-review supported by information gathered from an employees work to reflect on achievements and challenges and identify aspirations and learning needs. It is protected time once a year.
999 Amber 1 95th Percentile	Time taken (in minutes) for emergency response to arrive at scene for Amber 1 calls (other life-threatening emergencies – including cardiac chest pains or stroke). (NB: The 95th percentile is the value below which 95 percent of the observations may be found.	**Ambulance Response FTEs in Post**	Number of Emergency Medical Services, Full Time Equivalent (FTE) staff working for the Welsh Ambulance Services NHS Trust.
Return of Spontaneous Circulation (ROSC)	Percentage of patients for whom Return Of Spontaneous Circulation occurs. This refers to signs of restored circulation (more than occasional gasp, occasional fleeting pulse or arterial waveform) evidenced by breathing, a palpable pulse or a measurable blood pressure.	**Ambulance Care, Integrated Care, Resourcing & EMS Coordination FTEs in Post**	Number of Ambulance Care, Integrated Care, Resourcing & EMS Coordination Full Time Equivalent (FTE) staff working for the Welsh Ambulance Services NHS Trust.
Stroke Patients with Appropriate Care	Proportion of suspected stroke patients who are documented as receiving an appropriate stroke care bundle (a bundle is a group of between three and five specific interventions or processes of caret hat have a greater effect on patient outcomes if done together in a time-limited way ,rather than separately).	**Financial Balance – Annual Expenditure YTD as % of budget Expenditure**	Annual expenditure (Year to Date) as a proportion of budget expenditure.
Acute Coronary Syndrome Patients with Appropriate Care	Proportion of STEMI patients who receive appropriate care. ST segment elevation myocardial infarction - occurs when a coronary artery is totally occluded by a blood clot.	**Duty of Candour**	A notifiable adverse outcome is any incident whereby harm (moderate harm, severe harm and death) is caused, which is unintended or unexpected and that the provision of the health care was or may have been a factor in the service user suffering that outcome.
Renal Journeys arriving within 30 minutes of their appointment (NEPTS)	Proportion of renal journeys which arrive at hospital appointments within 30 minutes (+/-) of their appointment time.	**111 Consult and Close**	Consult and Close refers to the response to 999 callers where an alternative to a scene response has been provided. A cohort of 999 calls are passed to 111 where they are low acuity and the Clinicians in 111 may be able to help the caller with self-care, referral, etc. This is similar to the work of the Clinical Support Desk but for a lower acuity of caller. Where the outcome from the 111 clinical consultation ends in a Consult and Close outcome (self-care, referral, alternative transport) this is captured and forms part of the Trust's Consult and Close reporting. Over 50% of calls passed to 111 in this way are successfully closed without an ambulance response.
Discharge & Transfer journeys collected less than 60 minutes after booked ready time (NEPTS)	Proportion of journeys being discharged from and/or transferred between hospitals which were collected within 60 minutes of the hospital booked ready time.	**999 / 111 Hear and Treat**	Proportion of 999/111 calls which are successfully completed (closed) without dispatching an ambulance vehicle response. This may include advice, self-care or referral to other urgent care services.
National reportable Incidents (NRI)	Volume of patient safety incidents reported in the month which caused or contributed to the unexpected or avoidable death, or severe harm, of one or more patients, staff or members of the public, during NHS funded healthcare.	**% Incidents Conveyed to Major EDs**	Proportion of patients transported to a hospital Emergency Department following initial assessment at scene by a Welsh Ambulance Services NHS Trust Clinician, as a proportion of total verified incidents. (NB: An ED provides a wide range of acute in-patient and out-patient specialist services together with the necessary support systems, which allow emergency admissions, and which usually has an Accident and Emergency Department).
Concerns Response within 30 Days	Proportion of concerns responded to by the complaints team within 30 working days of receiving the concern.	**Number of Handover Lost hours**	Number of hours lost due to turnaround times at EDs taking more than 15 minutes. Transferring the care of a patient from an ambulance to an ED is expected to take no longer than 15 minutes, with a further 15 minutes for ambulance crews to make their vehicle ready for the next call.
EMS Abstraction Rate	The percentage of Emergency Medical Services (EMS) staff unavailable for rostered duties due to reasons, such as: annual leave, sickness, alternative duties, training, other and COVID-19.	**Immediate Release requests**	The number of requests submitted to Health Boards for the immediate release of vehicles at Emergency Departments to release them back into the community to respond to other urgent and life-threatening calls

Ymddiriedolaeth Brifysgol GIG Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services University NHS Trust

AGENDA ITEM No	**15**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**1**

Focus on Clinical Indicators - Stroke

MEETING	Quality, Patient Experience and Safety Committee
DATE	4th February 2025
EXECUTIVE	Andy Swinburn, Executive Director of Paramedicine
AUTHOR	Kevin Webb, Head of Clinical Intelligence and Assurance
CONTACT	kevin.webb@wales.nhs.uk

EXECUTIVE SUMMARY

During 2024, QuEST requested a series of updates to be presented in relation to a focus on Clinical Indicators (CIs). A focus on ROSC at hospital, Stroke, Fractured Neck of Femur (#NoF – hip fracture), Hypoglycaemia (diabetic with low blood sugar) and on STEMI (heart attack) were presented. This update on stroke highlights the work and improvements made during the year.

Within this update we will highlight:

- What we measure (criteria)
- Data quality and reporting
- Improvements to date
- Next steps to improvement
- Clinical Indicator Recovery Plan

Further progress has been made with improving the CI dashboard which now includes the time-based metric for stroke; 'Call to scene', 'Time on scene' and 'Call to hospital door'. These are now reported on as part of the Ambulance Service Indicators to the NHS Wales Joint Commissioning Committee.

RECOMMENDED: That the committee:

Note the PowerPoint update for the Stroke Clinical Indicator.

KEY ISSUES/IMPLICATIONS

Work is progressing to develop the 'Tenant Structure' to enable CIs to be reported at a range of levels (Trust wide, HB area, Locality, Team, Individual). This requires funding and potentially external resources to develop an appropriate app.

REPORT APPROVAL ROUTE
Quality, Patient Experience and Safety Committee – 4th February 2025

REPORT APPENDICES
Focus on CIs – Stroke PowerPoint presentation

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 University NHS Trust

Clinical Indicators
Focus on Stroke

GIG CYMRU NHS WALES
Ymddiriedolaeth Brifysgol GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
University NHS Trust

Clinical Indicators – Focus on Stroke
Version 0.1
Released: January 2025

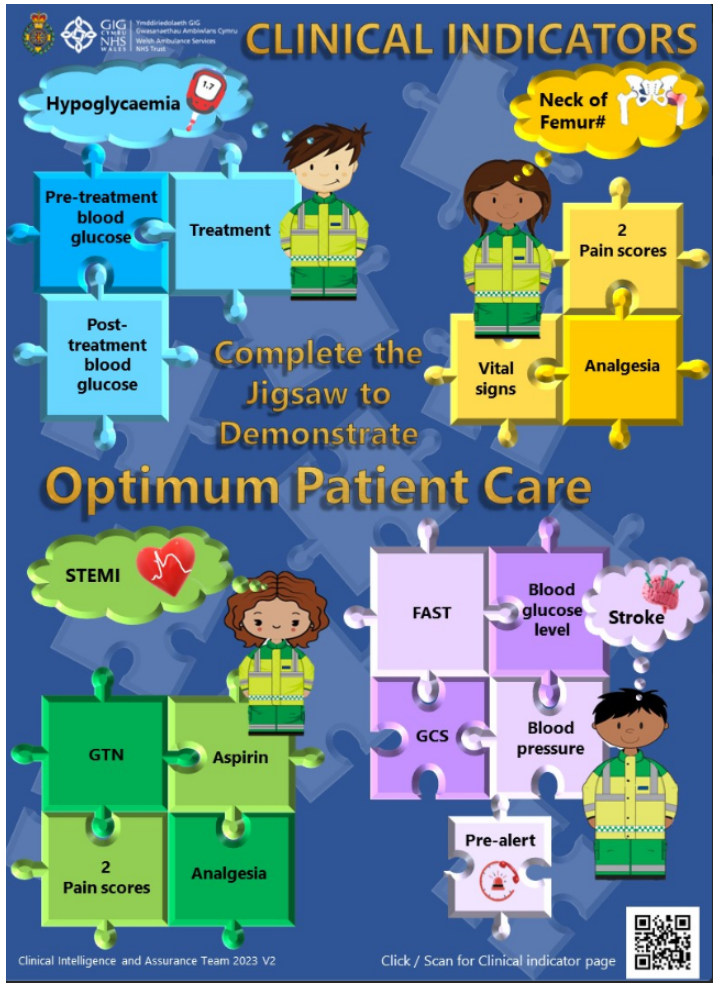
Kevin Webb
Head of Clinical Intelligence & Assurance
Kevin.webb@wales.nhs.uk

Introduction

During 2024, PowerPoint slides were produced for all Clinical Indicators in the 'Focus on CIs series'.
Stroke was presented in February 2024; this is an update to highlight the work and improvements made during the year.

Within this we will highlight:

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



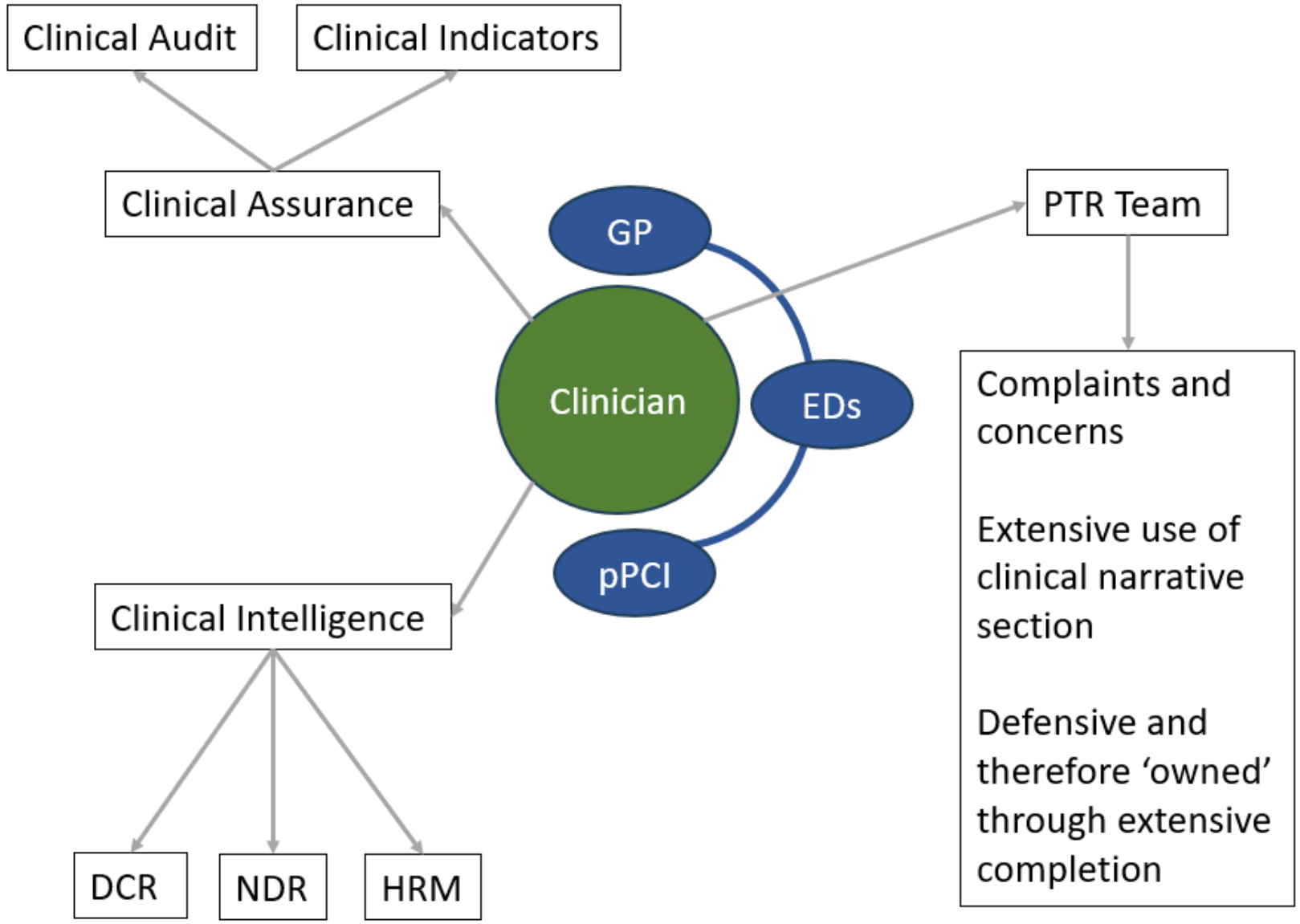
ePCR Users

Operational clinicians are the main users of ePCR. What data do they own?

A clinician might be more inclined to provide a clear clinical narrative and own that section as they may be challenged on it later. This is reinforced through education, feedback and the investigation process.

We do not encourage the same ownership on other data items at an individual level.

Can we change this?

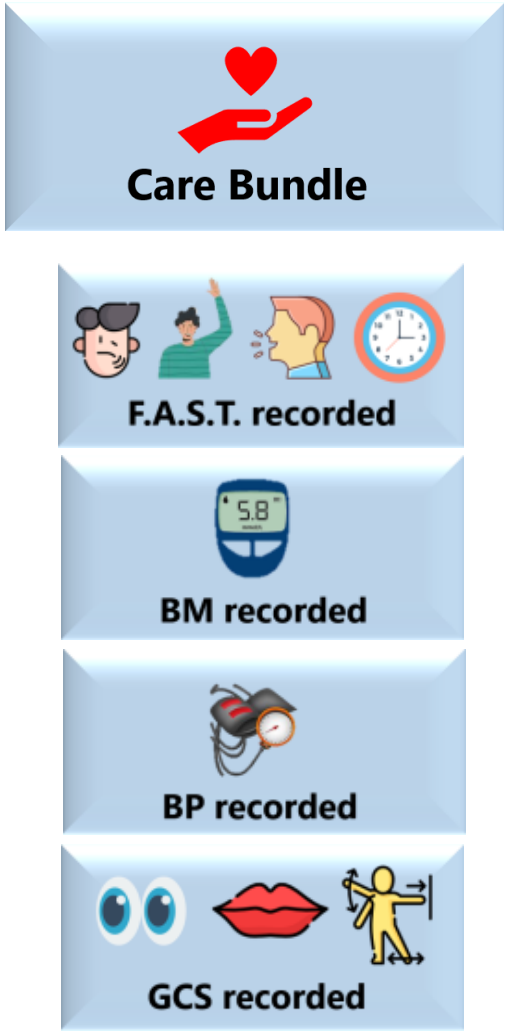


What we measure (*care bundle*)

- **Number of Stroke & FAST+ve patients attended (Diagnostic Codes for CVA or TIA) (*denominator*)**
  (excluding head trauma/cardiac arrest/inter-hospital transfers)

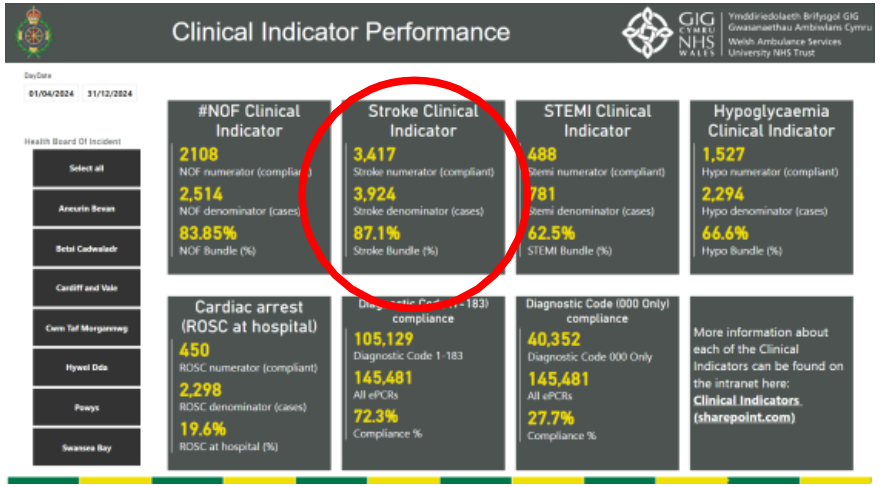
- **Compliance to the care bundle requires each criterion of care (*numerator*) to be completed:**
  - **F.A.S.T undertaken**
  - **Blood Glucose (BM)**
  - **Blood Pressure (BP)**
  - **Glasgow Coma Scale**

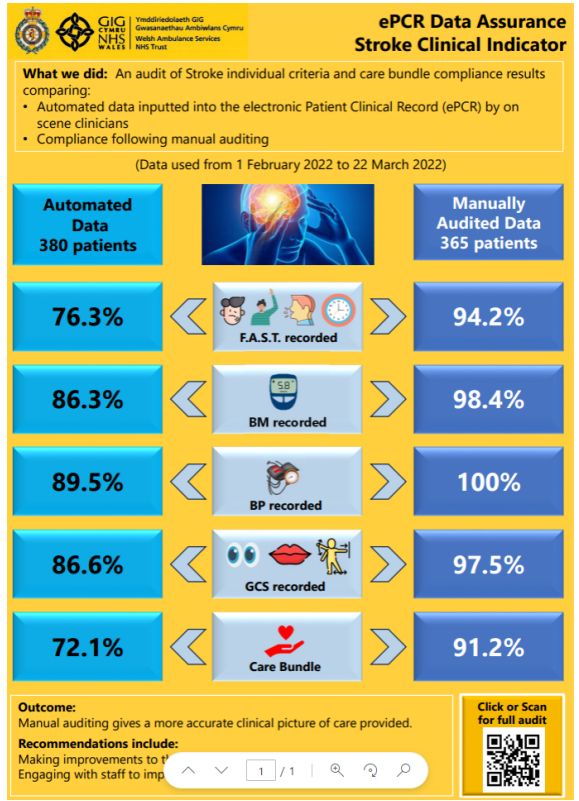
Providing a pre-alert is not part of the care bundle but is reported on as it has a positive impact on patient outcome



Data quality and reporting

- An ePCR technical specification was created to enable reporting
- Since the implementation of ePCR all CIs are reported on using 'raw' data inputted by clinicians (*no manual auditing prior to reporting*)
- Due to staff being unfamiliar with a new system, a reduction in CI compliance was anticipated (as in other UK Trusts), risk 535 (monitored by CIAG) was created to highlight three elements:
  - User behaviour
  - User interface
  - Scripting
- Development of a Clinical Indicator dashboard to include Stroke
- The CIAT undertook a QA (deep dive) audit to:
  - Provide a more accurate clinical picture of the care delivered
  - Highlight the variation between automated and audited data
  - Help inform future reporting and caveats
  - Help inform an improvement plan and changes to the ePCR User Interface





Stroke CI compliance April 2022 – December 2024

Stroke - Care Bundle & Individual Metrics

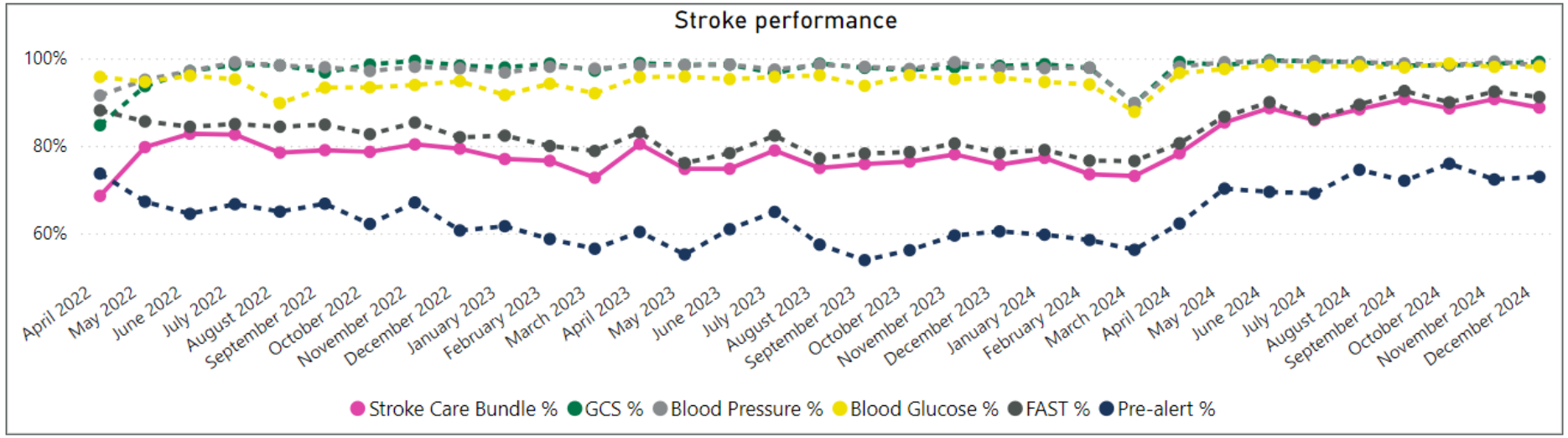
Ymddiriedolaeth Brifysgol GIG Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services University NHS Trust

DayDate

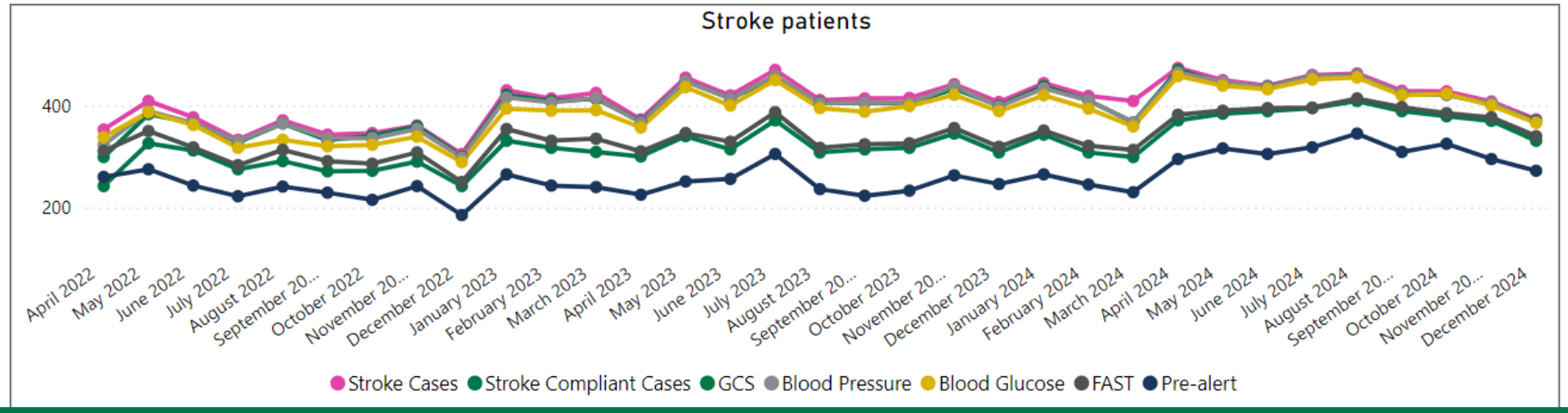
01/04/2022 31/12/2024

Health Board Of Incident

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



Pre-alert is not a component of the Stroke Care Bundle



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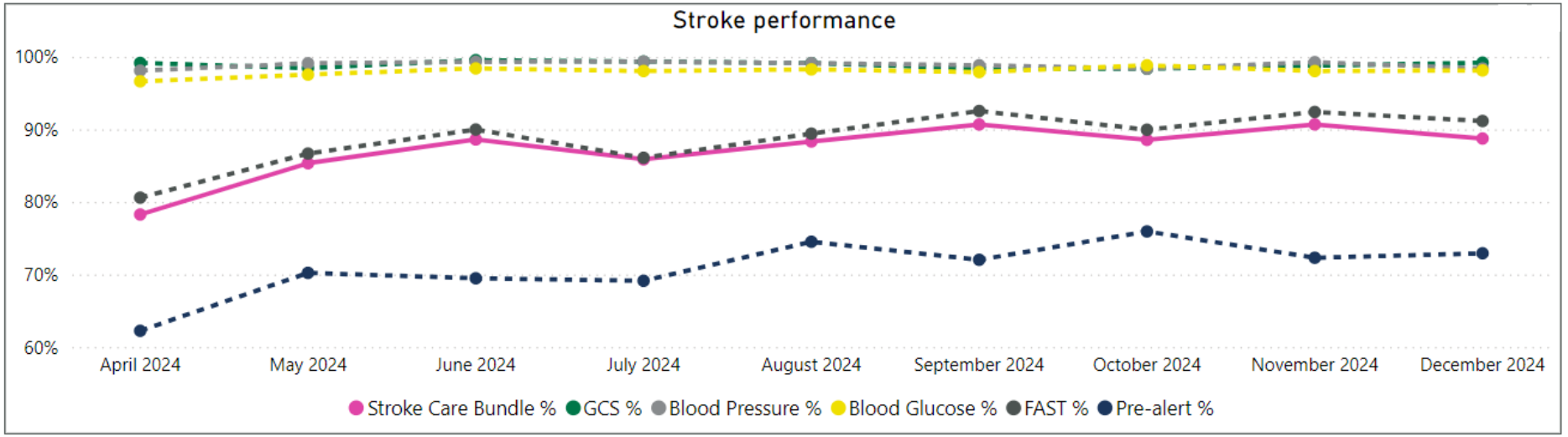

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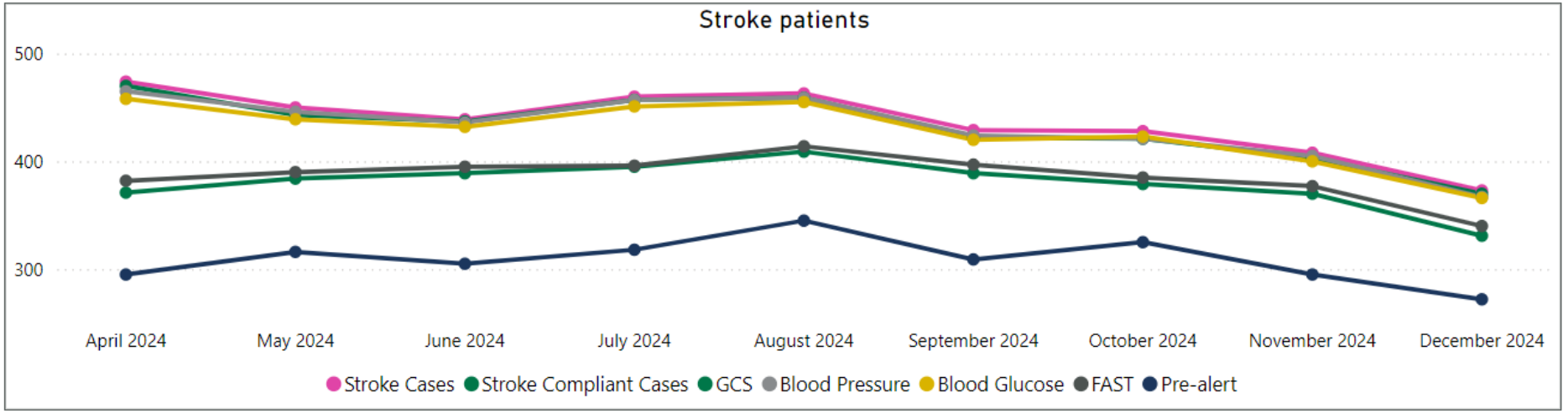


Improvements to date (for all CIs)

- ePCR Clinical Data Assurance clinical audit completed
- Deep dive for CI data (April 2024) – provided opportunities to review and update the scripting used to generate CI reports
- A stand at the CEO Roadshows in April & October 2024 made available to promote ePCR completion and CI compliance
- User Interface changes implemented in June 2024, further scheduled for Spring 2025
- A revision of the scripting used to generate CI reports, along with further support from Senior Paramedics for ePCR completion and CI compliance
- Development of a revised CI 'Jigsaw Poster' following requests from staff to use as an aide memoir
- Development of infographics to be used on iPad lock screens to support ePCR completion and improve CI compliance

Next steps to improvement (for all CIs)

- **User Interface change to update the 'nudge tool' to improve ePCR compliance for specific fields at point of ePCR closure (*changes managed by the ePCR Compliance Approval Group*)**
  - ***To enable message prompts and quick access to non-compliant fields prior to closing ePCRs***
  - ***This was successfully tested (v1) in June 2024 for analgesia administered in # NOF***
  - ***The next planned nudges in this stepwise approach are for Aspirin & GTN in STEMI, and some of the cardiac arrest fields to include 'Outcome'***

- **Complete the review and update of the scripting required to extract data for CI reports, to date #NOF, Stroke, Hypoglycaemia and STEMI have been completed. UK wide changes to cardiac arrest guidelines are in development, the ROSC scripting will then be reviewed.**

- **Complete the development of a 'Tenant Structure' to enable CIs to be reported at a range of levels (Trust wide, HB area, Locality, Team, Individual). Requiring funding and external resources**

NB: A prehospital video pilot trial is due to take place where triage may result in an arranged destination for the patient. A pre-alert will not then be required and a decline in pre-alerting may be observed in reports**. Pre-alert does not contribute to the care bundle.**

Clinical Indicator Recovery Plan (for all CIs)

- Following the switch to ePCR, the way data is collected when with the patient has changed. There are theoretical advantages to the new process, however this was not fully realised with the monthly results. A Clinical Indicator Recovery Plan was implemented.

- Actions within the plan included:
  - ✓ Focussed communication with WAST clinicians to use the bespoke ePCR boxes for CIs
  - ✓ Supporting Senior Paramedics to have conversations about CIs
  - ✓ Health Board focussed clinical workshops to promote understanding of CIs and care bundles
  - ✓ Review scripting in a structured way for each CI bundle, monitor and repeat annually
  - ✓ Plan to provide clinical data at an individual level to all clinicians

- WAST aims to provide an efficient reporting structure that enables 'always on' automatic reporting, enabling accurate and almost live data for reporting at various levels for all appropriate records. This differs from English Ambulance Trusts who use a sample of a smaller clinical case.

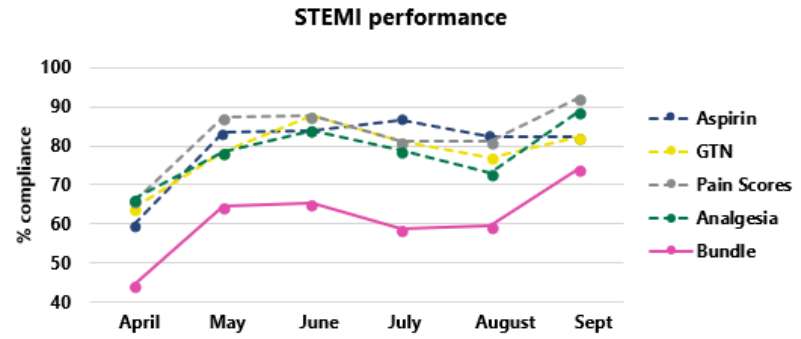
- As part of the CI Recovery Plan , a Task & Finish Group was established (April – September 2024). During that time, following various interventions, improvements were observed across all CIs. The group was then closed and CI performance continued to be monitored monthly by the CIAG.

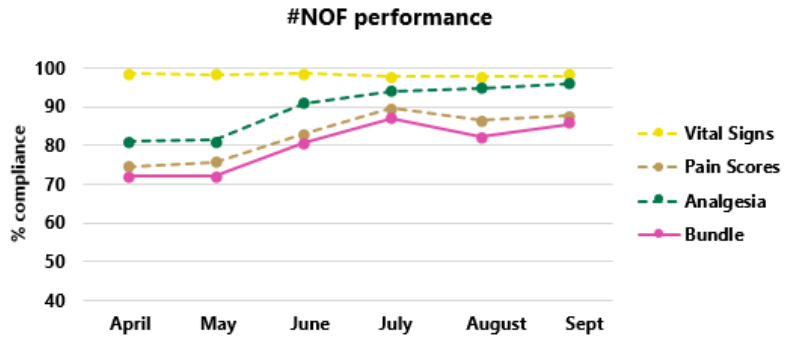
Clinical Indicator Improvement

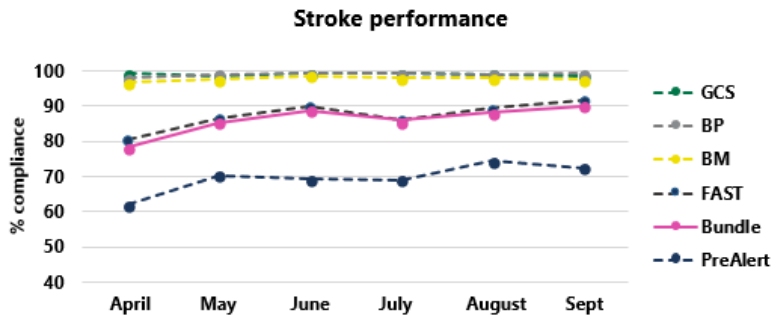
- In April 2024, the CI Improvement Group was established *(CEO action to facilitate improvement within six months)*
- The focus was to implement the CI improvement plan at pace, and to demonstrate and sustain improvements
- The group had representation from Senior Clinical Managers, Clinical intelligence, Clinical Improvement and from the ePCR Clinical Lead
- Improvements can be seen across the CIs. This slide shows the positive impact from April to September 2024 and the following slide shows the interventions

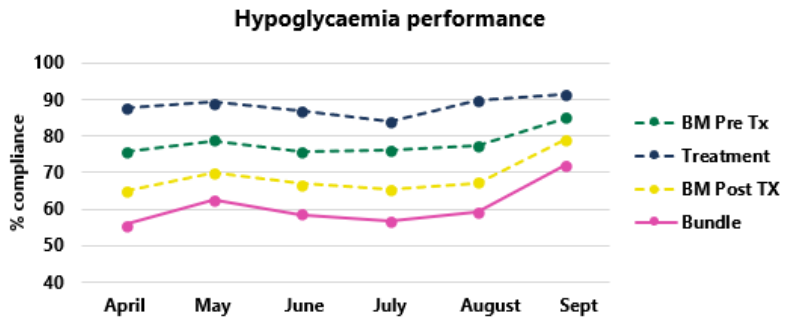
Clinical Indicator Improvement - Storyboard

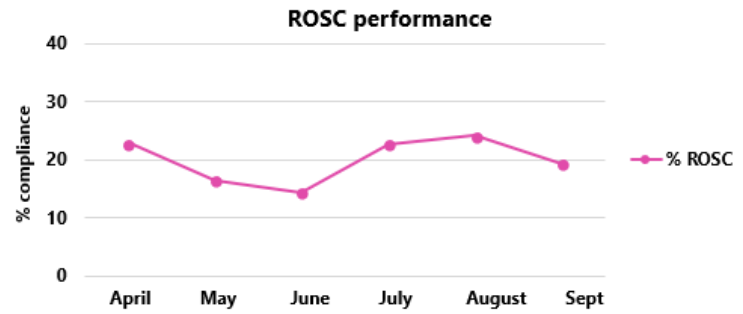
(April– September 2024 (data extract 03/10/2024)



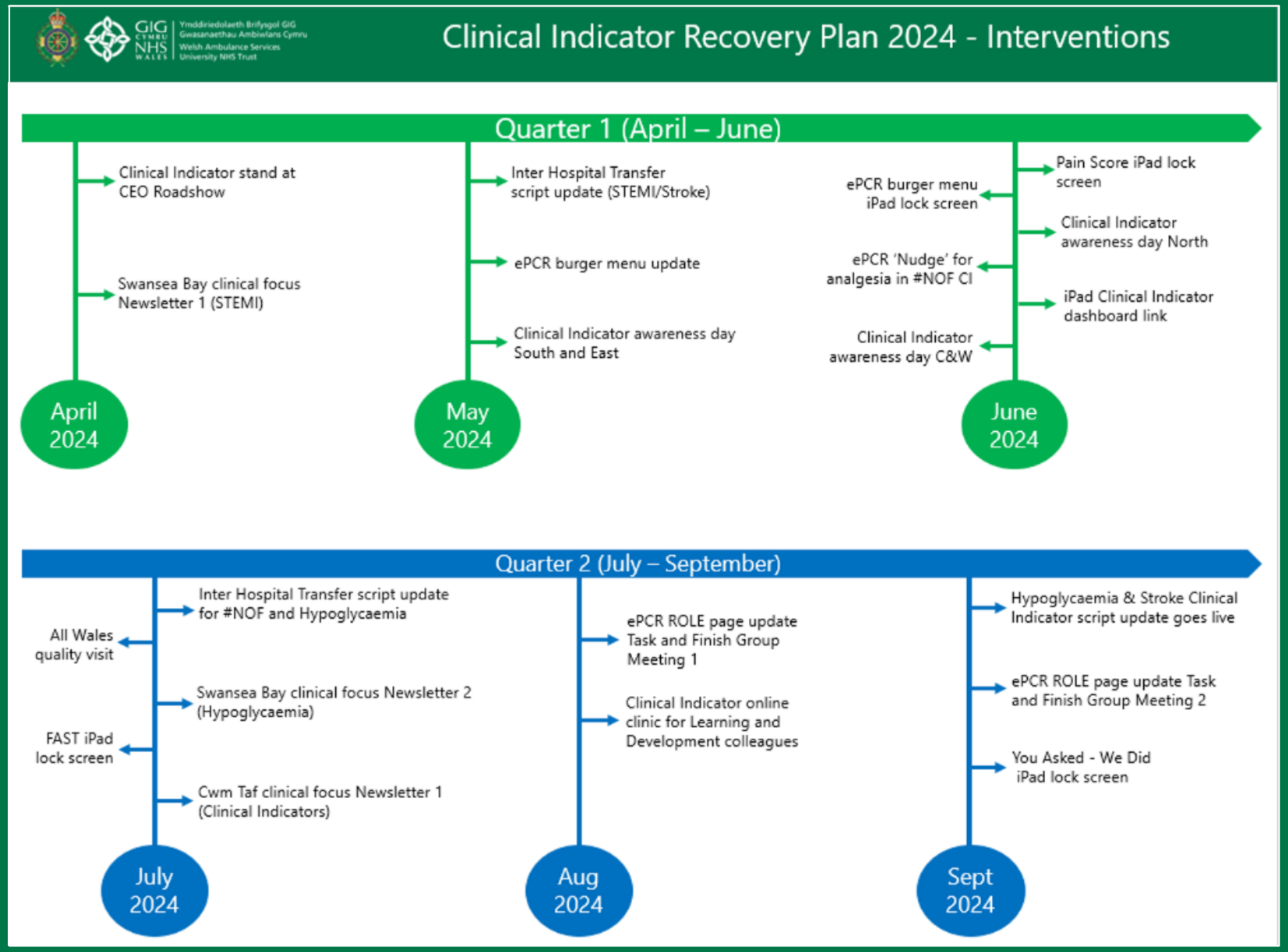








CI Improvements (Timeline of improvement initiatives)



Thank you for listening

Any questions or comments?

Ymddiriedolaeth Brifysgol GIG Gwasanaethau Ambiwlans Cymru Welsh Ambulance Services University NHS Trust

AGENDA ITEM No	**16**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**4**

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

MEETING	Quality, Patient Experience & Safety Committee
DATE	04 February 2025
EXECUTIVE	Trish Mills, Director of Corporate Governance / Board Secretary
AUTHOR	Julie Boalch, Assistant Director of Corporate Governance & Risk
CONTACT	Julie.Boalch@wales.nhs.uk

EXECUTIVE SUMMARY

1. The purpose of the report is to provide assurance in respect of the management of the Trust's principal risks, specifically the 2 risks that are relevant to Committee's remit for oversight.

2. A summary of these risks is set out in Annex 1 with a detailed description contained within the Board Assurance Framework (BAF) in Annex 4.

3. The more detailed description contained within the BAF provides the Committee with an opportunity to review the controls in place against each of these principal risks and the assurance provided against those controls where applicable. This will assist Members in evaluating current risk ratings supported by the frameworks in Annex 2.

4. Both principal risks were presented to the Trust Board on 29 November 2024. and have been reviewed during this reporting period in line with the agreed schedule detailed at Annex 3.

5. Updates are highlighted in blue on the BAF which show changes to the narrative, mitigating actions, controls, and assurances.

6. The Trust's two highest scoring risks **223** (*the Trust's inability to reach patients in the community causing patient harm and death*) and **Risk 224** (*Significant handover of care delays outside accident and emergency departments impacts on access to definitive care being delayed and affects the Trust's ability to provide a safe & effective service for patients*) remain static at the highest score of 25. These scores reflect individual cases of avoidable harm, highlighting ongoing challenges in the unscheduled care system due to the levels of handover delays.

7. The number of lost hours due to handover delays remained significant in September 2024 at 20,693 which is higher than the same period in 2023.

8. Handover delays continue to present patient safety risks and extended waits in the community with a deteriorating Red performance being outside of what is acceptable to deliver a safe emergency service. Delays are also presenting as a theme in the Medical Examiner Service referrals for the first two quarters of 2024/25.

9. The Trust Board continues to focus on the actions to mitigate these two risks that are within its control, and these are highlighted in the avoidable harm action plan which is presented at each Board meeting. Further mitigations and transformative actions are described in the Integrated Medium Term Plan (IMTP) to address these risks.

10. There are a range of efficiencies described in the report that the Trust has undertaken in mitigation of these two risks. Two key ones being the number of calls being closed safely and efficiently by clinicians through the Consult and Close initiative in the contact centres as well as a significant improvement in sickness and attendance levels.

11. Most of the Trust's actions in the action plan have been completed and a several efficiencies and improvements implemented that have stabilised performance; however, the Trust is unable to mitigate the scale of handover lost hours due to the environment which it is operating in or make improvements in performance because of the continued challenges in the urgent and emergency care system.

12. To support the continued, detailed review and mitigation of these risks, a workshop took place on 06 September 2024 with the Risk Owners and teams to consider a different approach to managing and monitoring those areas that are within the Trust's control and those that are not. A follow up workshop is planned for late January 2025 to complete the work to brigade controls into six internal and external themes.

RECOMMENDATION:

13. **Members are asked to consider the contents of the report.**

KEY ISSUES/IMPLICATIONS
14. The key issues are set out in the Executive Summary above.
REPORT APPROVAL ROUTE
• The BAF was considered by: • Assistant Directors Leadership Team (14 October 2024) • Executive Leadership Team (23 October 2024) • Audit, Risk and Assurance Committee (21 November 2024) • Trust Board (29 November 2024)

REPORT ANNEXES
• Annex 1 - Summary table describing the Trust's Corporate Risks. • Annex 2 – Scoring Matrix • Annex 3 – Frequency of Risk review • Annex 4 - Board Assurance Framework

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

Annex 1 – Corporate Risk Register Summary

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
223 QuEST	The Trust's inability to reach patients in the community causing patient harm and death	**IF** significant internal and external system pressures continue **THEN** there is a risk of an inability and/or a delay in ambulances reaching patients in the community **RESULTING IN** patient harm and death	Director of Operations	**25 (5x5)** →
224 QuEST	Significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service	**IF** patients are significantly delayed in ambulances outside A&E departments **THEN** there is a risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised **RESULTING IN** patients potentially coming to harm and a poor patient experience	Director of Quality & Nursing	**25 (5x5)** →

Annex 2 - Risk Scoring Matrix

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

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

Annex 3 - Frequency of Risk Review

Risk Score	Review Frequency	Risk Rating
15 – 25 Red	Review monthly	High
8 – 12 Amber	Review quarterly	Medium
1 – 6 Green	Review every 6 months	Low

Annex 4 – Board Assurance Framework

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	01/10/2024	TREND	25 (5x5)
		Date of Next Review:	01/11/2024	➡	

IF	THEN	RESULTING IN
significant internal and external system pressures continue	there is a risk of an inability and/or a delay in ambulances reaching patients in the community	patient harm and death

	Likelihood	Consequence	Score
Inherent	4	5	20
Current	5	5	25
Target	2	5	10

IMTP Deliverable Numbers: 1, 2, 3, 4, 5, 6, 7, 8, 10, 14, 15, 20, 22, 24, 25, 27

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

Risk Commentary Q1 2024/2025

The risk score remains constant at 25 (almost certain & catastrophic). Internal and external assurances remain weak as there remains a daily risk of actual patient harm and death because of the Trust not being able to reach patients in the community. The Trust continues to receive Prevention of Future Death Reports (Regulation 28) from Coroners across NHS Wales. **Handover lost hours in June were 22,230, July were 19,599 and August were 17,540.**

The impacts on patients waiting for extended periods of time both in the community and then outside emergency departments is well documented (AACE Delayed Hospital Handovers: Impact assessment of patient harm, 2021) and includes pressure damage, acute kidney injury, deconditioning, poorer outcomes, and extended recovery times. Delays across the system continue to be the focus of patient safety incidents, complaints, Coronial enquires and redress / claims. The effectiveness of our controls in many areas are dependent on external partners acknowledging and having ownership of the risk across the urgent and emergency care system. Key to moving the position is to continue to work in collaboration influencing system partners, being present and engaging in key conversations, whilst continually seeking opportunities internally to swiftly identify and mitigate the risks within our control and share those with relevant system partners that we cannot control. Of note, recent data analysis highlights the increased levels of red activity which has doubled since the pre covid period, plus an average increased on scene time of circa 10 minutes. Both measures are reflective of an increasingly challenged system with WAST crews fully exploring admission avoidance alternatives.

Improvement actions led by Welsh Government and system partners include: -

a) Audit Wales's investigation of Urgent and Emergency Care System. Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time? (E)
b) Consideration of additional WAST schemes to support risk mitigation through winter (I)
c) NHS Wales reduces emergency department handover lost hours by 25% (E)
d) NHS Wales eradicates all emergency department handover delays in excess of 4 hours (E)
e) Alterative capacity equivalent to 1000 beds (E)
f) Implement nationwide approach to emergency department 'Fit 2 Sit' (E)
g) Implementation of Same Day Emergency Care services in each Health Board (E)
h) National Six Goals programme for Urgent and Emergency Car (E)

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Regional Escalation Protocol	1. Daily conference calls to agree RE levels in conjunction with Health Boards
2. Immediate release protocol	2. The Immediate Release Protocol is a Nationally agreed NHS Wales protocol. Refusals by Health Boards are Datixed by WAST and compliance report shared weekly with the Health Board Chief Operating Officers (COOs)**. V1.3 has been reviewed, updated and released (August 2024).**
3. Resource Escalation Action Plan (REAP)	3. Weekly review by Senior Operations team with assessment of action compliance. The Senior Leadership Team convenes every Tuesday as the Weekly Performance Meeting to review performance and demand data, and review/assign REAP Levels as appropriate. Dynamic escalation via Strategic Command structure. REAP has undergone an annual review with v4.1 released in November 2023.
4. 24/7 Operational Delivery Unit (ODU)	4. Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end. Provides operational oversight with dynamic CSP review and system escalation as required.
5. Strategic, Tactical and Operational 24 hour/ 7 day per week system to manage escalation plans	5. Same as **4** - Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end. Provides operational oversight with dynamic CSP review and system escalation as required. On Call cover is reviewed weekly at SLT Performance Meetings.
6. Limited Alternative Care Pathways in place	6. Limited Assurance - Health Informatics reports, APP dashboard monitors, reports on app use by Consultant Connect, APP development and expansion, and bids for additional prescribing APPs.
7. Consult and Close (previously Hear and Treat)	7. The Trust ambition is to attain 17% Consult and Close rate, with an improvement plan in place to achieve this. The Trust has however already achieved the inclusion of Mental Health Practitioners in CSD, a key contributor to the achievement of Consult and Close rates. Reported through integrated quality meeting. Whilst Consult and Close is in place, the action to increase compliance is detailed in the action plan.
8. Advanced Paramedic Practitioner (APP) deployment model / APP Navigation	8. WAST has attempted to secure additionality within its APP numbers, as the evidence illustrates a dramatic impact upon ED avoidance with more people being managed within the community. At this stage, no additional funds have been secured.

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	01/10/2024	TREND	25 (5x5)
		Date of Next Review:	01/11/2024	➡	

IF significant internal and external system pressures continue	THEN there is a risk of an inability and/or a delay in ambulances reaching patients in the community	RESULTING IN patient harm and death		Likelihood	Consequence	Score
			Inherent	4	5	20
			Current	5	5	25
			Target	2	5	10

	However, it remains the case the prospective APPs are completing their education and could be deployed into the operational setting to mitigate the risk. ELT has therefore agreed to grow the APP numbers further this year, redirecting existing operational spend to bolster APP growth. This is part of the IMTP Deliverables 2024-2027.
9. Clinical Safety Plan	9. Clinical agreement – agreeing escalation to higher levels, ODU dashboard, AACE paper through National Director of Operations group. In December 2023, Version 2.21 of the Clinical Safety Plan was released. The subsequent reduction in the demand is the assurance which is dynamically monitored via ODU.
10. Recruitment and deployment of CFRs	10. 11 new onboarding courses for June to December with projection of 110 new CFRs by 3rd December 2024. Currently 400 volunteers supporting 6500 hours every month. Response data indicates that our CFRs are reaching more patients, especially those with life threatening conditions in 8 minutes compared to this time last year. Numbers of CFR's, percentage of contribution to performance a governance framework is in place. Monitoring through AD 1:1's and volunteer highlight report (IMTP).
11. ETA scripting	11. The ETA Dashboard is a tactic that was signed off by ELT. The dashboard supports scripting analysed by comparing with real time data. ETA performance is reviewed weekly at SLT weekly performance meeting. The effect of the ETA scripting results in cancellations of ambulances which is monitored through algorithmic review process.
12. Clinical Contact Centre (CCC) emergency rule	12. Emergency Rule is incorporated into CSP 999 levels.
13. National Risk Huddle	13. This is a tactic contained in REAP ratified through SPT and EPT. Daily risk huddles are recorded, and documented actions are shared with stakeholders and progress monitored via the ODU.
14. Summer/Winter initiatives	14. Monitoring through SLT and STB. Senior Planning Team (SPT) was stood up for the duration of Winter 2023/24. Christmas Planning Meetings established from April 2024 for winter period 2024/2025.
15. CHARU implementation	15. Recruitment of 153 WTE has continued; To lift further, a trial of a rotational model is due to be trialled in Aneurin Bevan Health Board area.
16. Clinical Model and clinical review of code sets	16. Reported through CPAS and DCR Review reporting through CQGG
17. Remote clinical support enabling discharge at scene	17. Strategic Transformation Board – IMTP deliverable; Providing support to the Community Welfare Responders (CWR) initiative and supporting CFRs to discharge at scene with current non conveyance rates for CFRs in excess of 40%
18. Trust Board paper (28/07/22) detailing actions being taken to mitigate the risks (see actions section for details of specific work streams being progressed to mitigate this risk)	18. Formally documented action plan – actions captured are contained within and monitored via the Mitigating avoidable harm paper from PIP.
19. Information sharing	19. Information Sharing: Patient Safety Reports, Chief Operating Officer (COO) Data Pack, Immediate Release Declined (IRD) Reports.
20. Completed EMS Roster Review	20. Helps to ensure that we have the maximum available capacity to respond to dispatch to 999 calls received in a timely manner. Monitor production against the rosters weekly at performance meeting and that provides a level of UHP as a percentage.
21. Delivered a reduction in the number of multiple vehicle attendances dispatched to red calls	21. This will increase vehicle availability generally across the Trust and is monitored through SLT weekly performance meeting.
22. Transfer of Care	22. WAST has clearly articulated to the Health Board COOs the risk associated with delayed handovers. Consequently, work has commenced to withdraw WAST staff from portering duties on hospital premises, cease the practice of ED swaps and cease the use of WAST equipment in EDs across Wales. Please refer to the following documents: i) Letter to COO Handover Delays 30.03.2023 ii) Letter to COO Handover Delays iii) WAST – Transfer of Care Brief
23. Virtual Ward – Connect Support Cymru	23. Multi phased approach commenced in Dec 2022 with St John Ambulance Cymru virtual ward responder, a digital and telehealth platform, and a Community Welfare Responder model to enhance community resilience. • Phase 1 delivered through St John Ambulance Cymru with a further extension in place. • Funding also obtained through external grant funding to pilot a volunteer phase. which went live mid-October with twelve teams piloting the approach and has now completed. • Work ongoing to recruit CWR volunteers with engagement taking place with organisations across Wales. • St John Ambulance Cymru virtual ward now extended to the end of May 2024.

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IF significant internal and external system pressures continue	THEN there is a risk of an inability and/or a delay in ambulances reaching patients in the community	RESULTING IN patient harm and death

	Likelihood	Consequence	Score
Inherent	4	5	20
Current	5	5	25
Target	2	5	10

24. ARA – - YGC, Swansea Bay and GUH	24. ARA in GUH finished 31st March 2024. Holding area in Swansea and YGC remains ongoing.
25. WAST Serious Clinical Incident Forum (SCIF) is in place to discuss patient safety incidents, learning and improvement actions to prevent future harm, working in collaboration with Health Boards / NHS Wales Executive Delivery Unit under the Joint Investigation Framework which was formalised in the National Patient Safety Policy in May 2023. Sharing of potential case of serious avoidable harm/death with Health Boards for investigation when response delay associated with system congestion is the primary cause. CNO and CMO plus peer group and COOs regularly updated on patient safety incidents. Patient safety reporting and escalation through the Serious Clinical Incident Panel (SCIF), Patient Safety Highlight Reports, Health Board specific reports in place with escalation through WAST governance framework.	25. Patient safety reporting and escalation through the Serious Clinical Incident Panel (SCIF), Patient Safety Highlight Reports, Health Board specific reports in place with escalation through WAST governance framework.
26. WAST membership of the working group (Executive Director of Quality & Nursing) to reform the Framework for the Investigation of Patient Safety Serious Incidents (SIs) national investigation framework with system partners. Chaired by the Deputy Chief Ambulance Commissioner and commenced in August 2022.	26. Workshop with system partners in place with executive directors of nursing attendance and to date is working well with good engagement from health board colleagues. Following the last meeting on 25.01.2023 it was agreed that sub-groups would be formed to meet more frequently to gather themes / evaluation / develop more consistency which would include aligning the outputs / outcomes with the 'Six Goals for Urgent and Emergency Care' work.
27. Undertake the next 5-year strategic EMS Demand and Capacity review (the 2019 version will run out this year – 2024)	**27. Review has been undertaken and has been reported to close F&P committee July 2024 and Trust Board July 2024. This review details the level of resourcing required in different handover lost hour scenarios with different ways to respond to it e.g. traditional model or evolved CRN.**
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Acknowledgement and acceptance of risk by Health Boards and balancing the risks across the whole system	1. Improvement in handover delays across Cardiff and Vale and more latterly across AB have led to improved handovers at Eds. This has now been sustained for some months across C&V in a phased programme of improvement with no delays in excess of 2 hours. Programme of improvement underway in AB, commencing at 4hour tolerance with a plan to reduce over time. In other Health Boards, there remains little or no controls, with variation in both handovers and risk levels across Health Boards. An extraordinary incident declared by WAST on 22 October 2023 as direct result of system risk associated with handover delays at Morrison hospital has increased focus on handover delays with external partners and across the media. Some plans are in train (detailed in actions) following a meeting with Swansea Bay COO to include mobile imaging, pathways to bypass ED and a pod solution ahead of winter.
2. Blockages in system e.g., internal capacity within Health Boards which affect patient flow	
3. Local delivery units mirroring WAST ODU	
4. Handover delays link to risk 224	
5. There is an ambition that no handover should exceed 4 hours and for lost hours to handover to be reduced by 25% but given the track record over last 12 months there is a low confidence in attaining this.	5. The majority of Health Boards have failed to deliver on this ambition; With the exception of Cardiff and Vale University Health Board, the remaining 5 Health Boards with acute Trusts that were required to deliver on this target, have failed to do so.
6. Handover Improvement Plans agreed between WAST and Health Boards	6. Performance targets for Handover with Health Boards have been introduced by the commissioner.
7. Access to Same Day Emergency Care (SDEC) for paramedic referrals	7. This forms part of the handover improvement plans in place with Health Boards; however, assurance is limited given that the uptake is low (less than 1% of total demand). There is an inconsistency in approach from Health Boards on eligibility and availability; The national Once for Wales acceptance criteria has not been uniformly deployed by Health Bards across Wales.
8. Mental Health users connecting via the 999 system to 111 press 2 services. Discrepancies in pathway between 111 and CSD – point of entry influences pathway.	
9. Volunteer Alternative Responder Scheme (VARS)	9. Live from June 2024 with further scheme due to rollout across Wales.
10. There is currently no JCC implementation plan associated with the 2023 Demand and Capacity Review	10. The requirements for a funded implementation plan for the review i.e. resource envelope change from the JCC. The review is being reported to JCC board development session in August 2024 and is expected to go to JCC committee later this year. The expectation is that the 2025/26 commission intentions will respond to the review.
Please note that the gaps listed are not WAST's and are therefore outside of the control of WAST	

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IF significant internal and external system pressures continue	THEN there is a risk of an inability and/or a delay in ambulances reaching patients in the community	RESULTING IN patient harm and death

	Likelihood	Consequence	Score
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Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Exploring Rural model options (Paused during Pandemic Response) – subject to funding through IMTP. Now refreshed to wider rural model opportunities to include recruitment of CFRs. Additional funding has been sourced to increase posts within the volunteer function.	Assistant Director of Operations EMS / Assistant Director of Operations – National Operations & Support	Superseded	Rural model superseded by Action 9 below (Recruitment and deployment of CFRs)
2. Leading Change Together (forum to progress workforce related work streams jointly with TUPs)	ADLT Sub-Group	30.09.22 - Superseded	
3. Recruit and train more Advanced Paramedic Practitioners – Value Based Healthcare Fund bid for up to 50 WTE (I) [Source: Action Plan presented to Trust Board 28/07/22]	Director of Paramedicine / Director of People & Culture	**Superseded**	WAST has attempted to secure additionality within its APP numbers, as the evidence illustrates a dramatic impact upon ED avoidance with more people being managed within the community. At this stage, no additional funds have been secured. However, it remains the case the prospective APPs are completing their education and could be deployed into the operational setting to mitigate the risk. ELT has therefore agreed to grow the APP numbers further this year, redirecting existing operational spend to bolster APP growth. May24 - Initial bid unsuccessful however an action within the new IMTP to grow our APP workforce by up to 40 per year for the next 3 years. Updates will progress through the IMTP within quarters. Milestone changed from March 2024 to June 2024.
4. APP recruitment	Assistant Director of Operations	**March 2025**	Aug24 – Modelling of APP growth trajectory to be modelled through the APP recruitment Steering Group for approval at ELT. Numbers to be confirmed at point of approval.
5. IMTP Deliverables 2027-2027 – implementation of new clinical model.	Assistant Director of **Integrated Care (with SRO through CMT Board)**	March 2025	Phase 1 for winter May24 – Ops engagement commenced April 2024. Temporary ADO recruited to support winter actions. Plans to deployment between October 2024 and March 2025.
6. Overnight Falls Service extension (I) [Source: Action Plan presented to Trust Board 28/07/22]	Assistant Director of Quality & Governance / Head of Quality Improvement	Ended March 2023	The temporary extension of the SJAC contract for overnight provision was evaluated, demonstrating on available evidence a positive performance impact over the period of operation (Jan-April 2023). The evaluation report was presented to EMT on 5 April 2023. The contract extension (as a temporary arrangement) ceased on 5 April 2023. Falls service enhanced day and night provision remains in place and utilisation of resources is reviewed at weekly performance meetings by Operations SLT.
7. New 2023 EMS Demand and Capacity (roster) review	Assistant Director of Planning & Performance	**Completed**	ORH modelling underway. Initial findings January 2024, full report to Trust Board and EASC in March. May24 - The review is scheduled to be presented to Trust Board end of July 2024. Milestone changed from March 2024 to August 2024.
8. Connected Support Cymru – is initially designed to utilise NHS and voluntary-sector resources and responders to enable patients to be supported in their own home whilst waiting for an urgent healthcare need to be managed. The service will employ digital health technologies to connect patients, communities and clinicals to achieve better health outcomes. The initiative will improve patient experience and safety, while supporting the healthcare system in directing patients to the right pathway at an appropriate time for their care need. It is expected this will help reduce unnecessary demand upon Emergency Departments.	Assistant Director of Quality Governance	**Superseded with the implementation of the new model (ref: Action 5)**	**Multi phased approach commenced in Dec 2022 with St John Ambulance Cymru virtual ward responder, a digital and telehealth platform, and a Community Welfare Responder model to enhance community resilience.** **• Phase 1 delivered in partnership with St John Ambulance Cymru to deliver the CWR element. Initial phase due to conclude in March 2024, further extended to May 2024 due to SJAC funding accommodating extension arrangement.**

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IF significant internal and external system pressures continue	THEN there is a risk of an inability and/or a delay in ambulances reaching patients in the community	RESULTING IN patient harm and death

	Likelihood	Consequence	Score
Inherent	4	5	20
Current	5	5	25
Target	2	5	10

			• **NHS Charities Together (grant) funding obtained through external application, to develop internal volunteer capacity/volunteer workforce as CWRs. Piloting of the CWR model commenced in Spring 2024, with an expansion of the model in mid-October. Recruitment, onboarding and training continues with aspiration to recruit CWRs across Wales.** • **The SBRI innovation challenge has supported a phase 2 delivery of the digital ward model: enabling remote clinicians to care for patients in a 'virtual ward' capacity. It is envisioned this will enable patients to reach to right care at the right time, whilst being monitored remotely. The pilot has commenced for care homes in Wales, and a dedicated remote clinician is supporting the initiative generating organisational learning to expand remote care planning role the Trust can provide for the NHS Wales. The pilot initiative will conclude in March 2025.** • **The nature of this project of work aligns to the RICs workstream of the Clinical Model Transformation programme; the work will form part of the RICs workstream from September 2024.**
9. Maximise the opportunity from Consult and Close: - Successful resolution without ambulance (double EMS) - Successful resolution without conveying to ED		March 2025	Trust ambition is to improve Consult and Close rate, with an improvement plan in place to achieve this. The Trust has however already achieved the inclusion of Mental Health Practitioners in CSD, a key contributor to the achievement of Consult and Close rates. Consult and Close compliance remains around 14%. Action plan activities therefore continue with a review of triage processes which may lead to shorter triage durations, along with increase in staffing, which together will enable more triages to take place, thus increasing the number of successful resolutions without a double EMS ambulance and numbers conveyed to an ED.
10. Palliative Care Paramedic Unit	Assistant Director of Operations	Extended to May 2024 - **new date TBC**	Reducing demand via APPs – 15th January Start. 15/04/2024 - 3 Month Health Board funded trial ended. Whilst utilisation was low, the results demonstrated a circa 75% ED avoidance therefore local decision made to extend for a further 2 months, however, opening the trial up to wider community and crew referrals. 21/06/2024 - Unit still ongoing.
11. Audit Wales investigation of Urgent and Emergency Care System: Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time?	CEO	Q1 2024-2025	• **01/10/2024 - The review of the unscheduled care report part 2 (accessing urgent and emergency care) is underway and will come to the committee in November 2024.** • Conducted in three phases Audit Wales will independently investigate and report on patient flow out of hospital: access to unscheduled care services and national arrangements (structure, governance, and support) • WAST will proactively support this work and offer best practice examples from other jurisdictions that can support benchmarking and improvement activities. • Expected outcomes in 2023/24.
12. Royal Glamorgan Early Diagnostic	Executive Director of Operations	**August 2024**	• Initial data from Qlik shows that there has been no reduction in N2H times however data received from Health Board show indication of

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IF significant internal and external system pressures continue	**THEN** there is a risk of an inability and/or a delay in ambulances reaching patients in the community	**RESULTING IN** patient harm and death		**Likelihood**	**Consequence**	**Score**	
			Inherent	**4**	**5**	**20**	
			Current	**5**	**5**	**25**	
			Target	**2**	**5**	**10**	
				patient benefit to reach earlier diagnostic. Local meetings this month to discuss findings and explore opportunities. • May 24 – No improvement in N2H time. Local management having discussions with Health Board for review and next steps.			

Risk ID 224	Significant Handover of Care Delays Outside Accident and Emergency Departments Impacts on Access to Definitive Care Being Delayed and Affects the Trust's Ability to Provide a Safe & Effective Service for Patients	Date of Review:	06/09/2024	TREND	25 (5x5)
		Date of Next Review:	06/10/2024	→	

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

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

IMTP Deliverable Numbers: 1, 3, 8, 14, 15, 22, 23, 24, 25, 26, 27, 30, 31

EXECUTIVE OWNER	Director of Quality & Nursing	ASSURANCE COMMITTEE	Quality, Safety and Patient Experience Committee

Risk Commentary Q2 2024/25

- The risk score remains constant at 25 for quarter 2 2024/25 (almost certain & catastrophic). Internal and external assurances remain weak as there remains a daily risk of actual patient harm due to handover of care delays. JCC EASC set a target of 15,000 hours lost by the end of Q2 and 12,000 hours lost by the end of Q3. Handover lost hours in April 2024 were 23,614 compared to 23,082 in April 2023. Eradication of handover waits of > 4 hours: there were 3,404 over four-hour patient handovers in April 2024, compared to 2,730 in April 2023. The expectation is that these would have been eradicated by end of 2023/24. Cardiff & Vale UHB has demonstrated material improvement and is a positive outlier when compared to other health boards. Recently, Welsh Government have re-iterated to Health Boards that the reduction in long handovers is a priority for this year with an expectation that over 1 hour waits would be reduced by 30% by December 2024.The impacts on patients waiting for extended periods of time both in the community and then outside emergency departments is well documented (AACE Delayed Hospital Handovers: Impact assessment of patient harm, 2021) and includes pressure damage, acute kidney injury, deconditioning, poorer outcomes, and extended recovery times. Delays across the system continue to be the focus of patient safety incidents, complaints, coronial enquiries and redress / claims. The Trust continues to receive Prevention of Future Death Reports (Regulation 28) from Coroners across NHS Wales. The Trust received the first Prevention of Future Deaths Report in February 2024 relating to pressure damage, which is a joint Report with Swansea Bay University Health Board. On 22.02.2024 a Prevention of Future Deaths Report was sent solely to the Minister for Health and Social Services, Welsh Government in respect of delays responding to a patient in community which also references handover of care delays. The effectiveness of our controls in many areas are dependent on external partners acknowledging and having ownership of the risk across the urgent and emergency care system. Key to moving the position is to continue to work in collaboration influencing system partners, being present and engaging in key conversations, whilst continually seeking opportunities internally to swiftly identify and mitigate the risks within our control and share those with relevant system partners that we cannot control. WAST CEO and Directors have ensured that system safety and avoidable harm remain a live topic of discussion in all relevant forums and continue to seize opportunities as they emerge that can contribute to mitigating avoidable harm. Given the long-standing nature of the system pressures and long handover times, we have commenced work to better define mitigations to safety risks and quality of care deriving from extended periods in an ambulance; these include the application of Mental Capacity Act and Deprivation of Liberty Safeguards and, Fundamentals of Care including pressure area care, mobilisation and nutrition. One specific area of focus is the development of a prototype mattress for our ambulance trolleys.

Improvement actions led by Welsh Government and system partners include:

a) Right care, right place, first time Six Goals for Urgent and Emergency Care - A policy handbook 2021–2026. Goal 4 'Improving ambulance patient handover, ensuring no one arriving by ambulance at an Emergency Department waits more than 60 minutes from arrival to handover to a clinician – (Welsh Government) ***by the end of April 2025***
b) National Six Goals programme for Urgent and Emergency Care: Led by the NHS Wales Deputy Chief Executive this programme seeks to modernise access to and the provision of Urgent and Emergency Care across Wales. WAST is represented on the Clinical Reference Group by the Director of Paramedicine and on the overarching programme board by the Executive Director of Strategy, Planning & Performance.
c) The Trust also has a presence on all the individual goal boards. The Trust has been asked to provide a presentation on its offer to the system at the next Six Goals Programme Board (24 January 2024).
d) NHS Wales eradicates all emergency department handover delays more than 4 hours (LHB CEOs) ***revised to March 2023/24.***
e) Alternative capacity equivalent to 1,000 beds project (LHB CEOs) – 678 additional beds delivered, a significant achievement, but short of the target of 1,000.
f) Investigation of Urgent and Emergency Care System: Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time? (Audit Wales)
g) Implement nationwide approach to emergency department 'Fit 2 Sit' (Welsh Government: Chief Medical Officer and Chief Nursing Officer) – paused. Health boards have previously been required to develop handover reduction action plans, which are monitored at their Integrated Quality, Planning & Delivery (IQPD) meetings by Welsh Government. Handover is also discussed at the Integrated Commissioning Action Plan (ICAP) meetings (currently paused as commissioning arrangements transition into the new Joint Commissioning Committee) which are held monthly between the CASC, the Trust and each Health Board.

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. WAST Serious Clinical Incident Forum (SCIF) is in place to discuss patient safety incidents, learning and improvement actions to prevent future harm, working in collaboration with Health Boards / NHS Wales Executive Delivery Unit under the Joint Investigation Framework which was formalised in the National Patient Safety Policy in May 2023. Sharing of potential case of serious avoidable harm/death with Health Boards for investigation when response delay associated with system congestion is the primary cause. CNO and CMO plus peer group and COOs regularly updated on patient safety incidents.	1. Patient safety reporting and escalation through the Serious Clinical Incident Panel (SCIF), Patient Safety Highlight Reports, Health Board specific reports in place with escalation through WAST governance framework.
2. WAST membership of the working group (Executive Director of Quality & Nursing) to reform the Framework for the Investigation of Patient Safety Serious Incidents (SIs) national investigation framework with system partners. Chaired by the Deputy Chief Ambulance Commissioner and commenced in August 2022.	2. Workshop with system partners in place with executive directors of nursing attendance and to date is working well with good engagement from health board colleagues. Following the last meeting on 25.01.2023 it was agreed that sub-groups would be formed to meet more frequently to gather themes / evaluation / develop

Risk ID 224	Significant Handover of Care Delays Outside Accident and Emergency Departments Impacts on Access to Definitive Care Being Delayed and Affects the Trust's Ability to Provide a Safe & Effective Service for Patients	Date of Review:	06/09/2024	TREND	25 (5x5)
		Date of Next Review:	06/10/2024	➡	

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

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

	more consistency which would include aligning the outputs / outcomes with the 'Six Goals for Urgent and Emergency Care' work. An event reviewing the effectiveness of the Joint Investigation Framework is currently being scoped nationally.
3. WAST and system compliance with National Standards - 15-minute handover (NHS Wales Hospital Handover Guidance v2 (May 2016)	3. Monthly Integrated Quality and Performance Report, Health Informatics reports, APP dashboard on app use by Consultant Connect and shared at local and corporate meetings regarding patient safety and handover of care position across NHS Wales and NHS England.
4. WAST Clinical Notice in place - Escalating a clinical concern with a deteriorating patient outside the Emergency Department (11.02.2021). National Early Warning Score (NEWS) trigger of 5 or above for escalation to hospital clinicians. NEWS data available via EPCR (electronic patient care record).	4. NEWS data now available via ePCR and escalation system in place via local managers and the Operational Delivery Unit.
5. Workstreams put in place to meet requirements of *Right care, right place, first time Six Goals for Urgent and Emergency Care A policy handbook 2021–2026.* Goal 4 incorporates the reduction of handover of care delays through collective system partnership.	5. Monthly Integrated Quality and Performance Report and WAST is represented on the Clinical Reference Group by the Director of Paramedicine and on the overarching programme board by the Executive Director of Strategy, Planning & Performance. The Trust also has a presence on all the individual goal boards.
6. Hospital Ambulance Liaison Officer (HALO) (Some Health Boards).	6.
7. Regional Escalation Protocol and Resource Escalation Action Plan (REAP). Proactive and forward-looking weekly review of predicted capacity and forecast demand. Deployment of predetermined actions dependant on assessed level of pressure. Consideration of any bespoke response/actions plans in the light of what is expected in the coming week. WAST has updated the REAP in advance of winter, including revised triggers (higher) for handover lost hours.	7. The Senior Leadership Team convenes every Tuesday as the Weekly Performance Meeting to review performance and demand data, and review/assign REAP Levels as appropriate. Dynamic escalation is via the Strategic Command structure. REAP has undergone an annual review with v4.1 released in November 2023.
8. Staff from WAST, Health Boards and third sector organisations assisting to meet patient's Fundamentals of Care as best they can in the circumstances.	8. Confirmed through Healthcare Inspectorate Wales (HIW) workshops and Health & Care Standards self-assessment process and Putting Things Right Quarterly Reports to Clinical Quality Governance Group and QuEST
9. 24/7 operational oversight by ODU with dynamic Clinical Safety Plan review and system escalation as required. Realtime management and escalation of risks and harm with system partners. Triggering and escalation levels within CSP to best manage patient safety in the context of prevailing demand and available response capacity. Monitoring, escalation and reporting of extreme response or handover delays.	9. Shift reports from ODU & ODU Dashboard received by Executive Management Team (EMT), Senior Operations Team (SOT) and On-Call Team at start/end. Realtime management and escalation of risks and harm with system partners. Triggering and escalation levels within CSP to best manage patient safety in the context of prevailing demand and available response capacity. Monitoring, escalation and reporting of extreme response or handover delays. In December 2023, Version 2.21 of the Clinical Safety Plan was released. The reduction in the demand is the assurance which is dynamically monitored via ODU.
10. Gold/Strategic, Silver/Tactical and Bronze/Operational 24 hour/ 7 day per week system to manage escalation plans.	10. Shift reports from ODU & ODU Dashboard received by EMT, SOT and On-Call Team at start/end. On Call cover is reviewed weekly at SLT Performance Meetings.
11. Escalation forums to discuss reducing and mitigating system pressures.	11. Daily risk huddles are recorded, and documented actions are shared with stakeholders and progress monitored via the ODU.
12. WAST Education and training programmes include deteriorating patient (NEWs), tissue viability and pressure damage prevention, dementia awareness, mental health.	12. Monthly Integrated Quality and Performance Report (April 2024 overall 82% - Safeguarding is 78% and dementia awareness remains over 91%).
13. Clinical audit programme in place.	13. Clinical audit programme in place (dynamic document) with oversight from the Clinical Quality Governance Group and QuEST.
14. Workshop set up by the Deputy Chief Ambulance Commissioner to respond to the findings in the Health Care Inspectorate Wales (HIW) Report *Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover* (undertaken 2021). WAST has senior representation at this meeting. – assurance is that HIW approve and sign off WAST elements and Health Board elements of recommendations.	14. Workshop set up by the Deputy Chief Ambulance Commissioner to respond to the findings in the Health Care Inspectorate Wales (HIW) Report Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover (undertaken 2021). WAST has senior representation at this meeting. A collective response from WAST and Health Boards is being overseen by EASC.
15. Escalation of patient safety concerns by Trust Board: featured in provider reports to the Emergency Ambulance Committee (EASC); been the subject of Accountable Officer correspondence to the NHS Wales Chief Executive; numerous escalations to professional peer groups initiated by WAST Directors; and coverage at Joint Executive Meetings with Welsh Government.	15. Monthly Integrated Quality and Performance Report, CEO Reports to Trust Board including 'Actions to Mitigate Avoidable Patient Harm Report' (last presented to Trust Board May 2024) and Board sub-committee oversight and escalation through 'Alert, Advise and Assure' reports.

Risk ID 224	Significant Handover of Care Delays Outside Accident and Emergency Departments Impacts on Access to Definitive Care Being Delayed and Affects the Trust's Ability to Provide a Safe & Effective Service for Patients	Date of Review:	06/09/2024	TREND	25 (5x5)
		Date of Next Review:	06/10/2024	➡	

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

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

Evidence submission to Senedd Health and Social Care Committee. Written evidence submitted during Q4 21/22 to the committee to assist their inquiry into Hospital Discharge and its impact on patient flow through hospitals. Report published in June 2022 containing 25 recommendations with recommendation six specifically WAST related stating "The Welsh Government should explain how the targets outlined in the Minister for Health and Social Service's statement of 19 May 2022 on urgent and emergency care and the Six Goals Programme to eradicate ambulance patient handover delays of more than four hours and reduce the average ambulance time lost per arrival by 25 per cent (from the October 2021 level) have been set. It should also confirm the target dates for the achievement of these targets."	
16. Implementation of Duty of Quality, Duty of Candour, and new Quality Standards requirements in April 2023.	16. Welsh Government Road Map in place (soft launch) with milestones for organisations – baseline assessment and monthly updates (RAG ratings) in place with Trust Board oversight. The current internal assessment overall as of May 2024 is 'Implementing and operationalising'. The Trust has representation on the All Wales Duty of Candour Implementation Group and is actively engaged in developing resources. From April 2024 the Trust will publish an annual quality report and compliance with Duty of Candour. Operational oversight occurs at the Quality Management Group and Executive oversight is via the Clinical & Quality Governance Group.
17. Clinical Support Desk First in place	17.
18. Summer/Winter initiatives	18. Monitoring through SLT and STB. Senior Planning Team (SPT) is now stood up for the duration of Winter 2024/25.
	External Sources of Assurance Management (1st Line of Assurance)
	1. Monitoring and oversight of the Ambulance Quality Indicators (AQIs) including handover of care timeliness and Commissioning Framework by the Chief Ambulance Services Commissioner (CASC), the Emergency Ambulance Services Committee (EASC) including the Integrated Commissioning Action Plans (ICAPS) and Joint Executive Team (JET) meetings with Welsh Government (I&E).
	2. Healthcare Inspectorate Wales (HIW) 'Review of Patient Safety, Privacy, Dignity and Experience whilst waiting in Ambulances during Delayed Handover' Report and system wide improvement plan with working group in place with WAST senior representation. Oversight by HIW and EASC
	3. Duty of Quality and Duty of Candour readiness returns assessment by Welsh Government.
	4. Internal Audit Report (April 2024) Serious Incidents: Joint Investigation Framework (WAST internal processes) provided 'Reasonable Assurance' with low to moderate impact on residual risk exposure until resolved. Improvement actions are monitored via the Audit Tracker.
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Lack of capacity in the Putting Things Right Team to deliver across the functions due to competing priorities resulting from sustained system pressures – recruitment in line with Organisational Change Process is progressing with full establishment expected by July 2024.	
2.	1. Implementation of the revised Joint Investigation process with good engagement seen by system partners. Several overdue patient safety investigations remain presenting a risk to patient safety across the system. The Trust has 56 overdue nationally reportable incident (NRI) investigations, with 63 NRIs open in total. Shared system learning from the Joint Investigation Framework is currently limited with no new learning identified to date.
3. Lack of implementation and holding to account regarding the NHS Wales of the Handover Guidance v2 and recognition of the patient safety risks pan NHS Wales.	2. 15-minute handover target is not being achieved pan-Wales consistently and has led to a substantial growth in emergency ambulance handover lost hours. In October 2023, 23,232 hours were lost with 1,888 +4 hour delayed patient handovers.
4. Variation in responsiveness at Emergency Departments to the escalating concerns regarding patients' NEWS.	3. Strengthening of patient safety reports and audit processes as e PCR system embeds.
5. Variation pan Wales / England as position not implemented across all emergency departments.	4. New Quality Management System in development which will include monitoring of the new Quality Standards & Enablers and underpinning governance structure.

Risk ID 224	Significant Handover of Care Delays Outside Accident and Emergency Departments Impacts on Access to Definitive Care Being Delayed and Affects the Trust's Ability to Provide a Safe & Effective Service for Patients	Date of Review:	06/09/2024	TREND	25 (5x5)
		Date of Next Review:	06/10/2024	➡	

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

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

6. National steer required to confirm the accountability arrangements regarding patients in ambulances outside of the emergency departments. The seven Local Health Boards (LHBs) in Wales are responsible for planning and securing delivery of primary, community, secondary care services, and also the specialist services for their areas.

5. HIW approve and sign off WAST elements of recommendations.

External Gaps in Assurance

1. Lack of escalation and response to AQIs by the wider urgent care system and regulators

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Handover checklist implementation – Nationally WAST Quality Improvement (QI) Project	WAST QI Team (QSPE)	TBC – Paused	• Timeframes awaited via Emergency Department Quality & Delivery Framework (EDQDF).
2. Implement patient safety dashboards (live and look back data) triangulating quality metrics / KPIs and performance data sourcing health informatics resource.	Assistant Director of Quality & Nursing	Q3 2024/25	• Incremental improvements to quality and safety data and information to enable triangulation / collective intelligence at Trust and system level. • Access to ePCR data (NEWS) now available and access for the Patient safety Team is being explored. Work on-going with Health Informatics regarding patient safety and health board dashboards capacity in Health Informatics impacting and dates revised. • Local dashboards have been developed but requiring manual data extraction
3. Continued Health Board interactions – my next patient (boarding), patient safety team dialogue – proactive conversations with Health Board Directors of Quality & Nursing.	Executive Director of Quality & Nursing	Monthly and as required.	• Monthly meetings continue to be held and networking through EDoNS.
4. Recruit and train more Advanced Paramedic Practitioners.	Director of Paramedicine	Q4 2024/25	• The Trust uplifted its APP establishment by a further 15.7 FTEs in • 2023/24 (funded through internal movements). For 2024/25 the Trust • is funding a further uplift of 32 APPs (additional funding, not internal • movements). • The above uplifts will increase the APP establishment to 120.7 FTEs.
5. Overnight falls service extension and future modelling	Executive Director of Quality & Nursing	31.09.2024	•Overnight falls service extension and future modelling • Night Car Scheme extension agreed to 31 September 2024 (2 regional resources) • Utilisation rates continue to be monitored: • Nighttime utilisation: - Q2 65% Q3 64% Q4 to date 64% April 2024 - 67% • Daytime utilisation: - Q2 57% Q3 56% Q4 to date 58% April 2024 – 54% • Combined day and night Q2-Q3 58% Combined day and night Q4 to date 59% Combined day and night April 2024- 55% There is now also an additional Level1 nighttime resource through RPB and Gwent Resilience Plan ringfenced to ABUHB. AB dedicated level 1 62% for April 2024 The 2023 EMS Demand & Capacity Review has completed its modelling of falls level 1 and level 2 resources. This will now need to be considered further by the Trust, commissioners and health boards. There is an immediate focus on the contract beyond September 2024. The 2023 EMS Demand & Capacity Review will be formally reported to Trust Board in July 2024.

Risk ID 224	Significant Handover of Care Delays Outside Accident and Emergency Departments Impacts on Access to Definitive Care Being Delayed and Affects the Trust's Ability to Provide a Safe & Effective Service for Patients	Date of Review:	06/09/2024	TREND	25 (5x5)
		Date of Next Review:	06/10/2024	➡	

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

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

6. Duty of Quality, Duty of Candour and new Quality Standards implementation from April 2023 with development of a Quality Monitoring System supporting monitoring and oversight systems in place and embedded. Quality Report development underway – mandatory requirement to publish 2024/25 (no fixed date for publication nationally).	Executive Director of Quality & Nursing	Q4 2024/25	• Monthly updates to progress against actions following the baseline assessment and readiness returns continued. • RL Datix Dashboards and KPIs under development nationally by National Quality & Safety Group. • Key policies updated and approved further updates following release of revised Putting Things Right Regulations which is delayed now expected release by Welsh Government in Autumn 2024 therefore timescale amended. • Participation in the All Wales Duty of Candour implementation group by Patient Safety Team – monthly.
7. Connected Support Cymru is initially designed to utilise NHS and voluntary-sector resources and responders to enable patients to be supported in their own home whilst waiting for an urgent healthcare need to be managed. The service will employ digital health technologies to connect patients, communities and clinicals to achieve better health outcomes. The initiative will improve patient experience and safety, while supporting the healthcare system in directing patients to the right pathway at an appropriate time for their care need. It is expected this will help reduce unnecessary demand upon Emergency Departments.	Executive Director of Quality & Nursing	Q2 2024/25	• Currently awaiting WG feedback on the submitted business case. • Further meetings arranged with between the Executive Director of Quality & Nursing and Six Goals Programme/WG/. Trust has also approach WG with a smaller ask to facilitate 7 FTE CSD clinicians to provide a continuation of the Luscii solution - this would enable a proof of value pilot to further inform a business case.
8. Organisational change process (OCP) of Putting Things Right Team (PTR) to enable increased capacity across all functions to manage increasing complexity and demands.	Executive Director of Quality & Nursing	Q2 2024/25	• OCP commenced 25.09.2023 and the consultation period has concluded with the final new structure confirmed. Next steps are to recruit to vacant positions which has commenced. It is anticipated that all positions will be filled by May 2024 (taking notice periods into account). Recruitment is progressing well with multiple applications for each post and some internal promotion opportunities. • Final posts due to be recruited to and in place by July 2024.
9. Audit Wales investigation of Urgent and Emergency Care System: Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time?	CEO	Q2 2024/25	• Conducted in three phases Audit Wales will independently investigate and report on patient flow out of hospital: access to unscheduled care services and national arrangements (structure, governance, and support). • WAST will proactively support this work and offer best practice examples from other jurisdictions that can support benchmarking and improvement activities. Expected outcomes in 2023/24. • The audit is proceeding. Trust awaiting the outcome. AD Commissioning & Performance has requested an update from Audit Wales. • Audit Wales have confirmed this has been reprofiled into 2024/25.
10. Patient handover actions.	Executive Team	Under review	• Some English ambulance services operate a system whereby handovers are mandated or forced after a certain period e.g. WMAS and LAS. This will be reviewed by the Executive team.
11. Work in progress to better define mitigations to safety risks and quality of care deriving from extended periods in an ambulance; these include the application of Mental Capacity Act and Deprivation of Liberty Safeguards and Fundamentals of Care including pressure area care, mobilisation and nutrition. One specific area of focus is the development of a prototype mattress for ambulance trolleys.	Executive Director of Quality & Nursing	Q3 2024/25	• Fundamentals of Care meeting, chaired by the Executive Director of Quality & Nursing held on 08.03.2024.
12. Trust to produce its own six goals plan (Goal 4 links to handover of care)	Executive Director of Strategy, Planning &		• Trust to produce its own six goals plan (Goal 4 links to handover of care)

Ymddiriedolaeth Brifysgol GIG Gwasanaethau Ambiwlans Cymru Welsh Ambulance Services University NHS Trust

AGENDA ITEM No	**17**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**0**

Cancelled Calls Potential Impact Analysis

MEETING	Quality, Patient Experience and Safety Committee
DATE	4 February 2025
EXECUTIVE	Andy Swinburn, Director of Paramedicine
AUTHOR	Jonathan Chippendale, Asst. Director of Clinical Development
CONTACT	jonathan.chippendale@wales.nhs.uk

EXECUTIVE SUMMARY

At the QuEST meeting of 5th November 2024, following the presentation of item 9 (Monthly Integrated Quality Performance Report (MIQPR) performance reporting) reference was made in the subsequent discussion to system effect of cancelled calls.

An analysis of some data from an APP perfect day PDSA had previously been presented internally and a board member referenced this in response to the potential cancelled calls effect. QuEST Committee members requested a short presentation of this analysis at the February 2025 meeting.

During 2024 the Clinical directorate instigated a number of PDSA cycles under the banner of "APP perfect days".

The principle of these tests was to "flood" a particular area with an increased advanced practice workforce.

Through evolving PDSA cycles, further resource types were included and additionally the "tasking" of available resources was opened to APPNAV schemes where available.

PDSA 6 of this evolution involved the "flooding" of the Swansea Bay Health Board area with additional responding APP resources (5), a responding resource crewed by a Palliative Care Paramedic (PCP) and an additional APPNAV working on stack management in the SDEC/UPCC within Morriston hospital.

Initially the reporting mechanisms within the Trust presented data through the Optimising Conveyance Group based on outcomes solely focussed on incidents attended by these additional resources.

A retrospective review of PDSA 6 data from a system and flow perspective was conducted a number of weeks after the operational day. The following presentation will highlight this analysis.

RECOMMENDED: That the Committee Notes the PowerPoint presentations and subsequent analysis.

KEY ISSUES/IMPLICATIONS
Not applicable.

REPORT APPROVAL ROUTE
Not applicable.

REPORT APPENDICES
PowerPoint presentation post board meeting

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

Ymddiriedolaeth Brifysgol GIG Gwasanaethau Ambiwlans Cymru Welsh Ambulance Services University NHS Trust

AGENDA ITEM No	**18**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**1**

Clinical Audit Plan 2025/26

MEETING	Quality, Patient Experience and Safety Committee
DATE	4th February 2025
EXECUTIVE	Andy Swinburn, Executive Director of Paramedicine
AUTHOR	Kevin Webb, Head of Clinical Intelligence and Assurance
CONTACT	kevin.webb@wales.nhs.uk

EXECUTIVE SUMMARY

Following an 'Audit Wales' review of WAST's Quality Governance Arrangements, one of the recommendations was for the Clinical Audit Plan to be submitted to QuEST for scrutiny and approval ahead of each financial year, and then monitored on a quarterly basis.

The plan is developed in consultation with the Clinical Intelligence & Assurance Team, Clinical Intelligence & Assurance Group, and senior clinical, and non-clinical managers within the Trust. Consideration is given to linking audit topics to the IMTP, LDPs, and risk registers where possible.

RECOMMENDED: That the Committee approve the Clinical Audit Plan 2025/26.

KEY ISSUES/IMPLICATIONS

Many of the audits and re-audits can be undertaken solely by the Clinical Intelligence & Assurance Team. However, support is required for some topics where subject matter experts are needed as authors, and the support of sponsors to ensure completion of the audits and subsequent actions.

It is not always possible to predict at the start of a financial year all of the topics that will require evaluation and therefore flexibility in setting a Clinical Audit Plan is required, resulting in the annual plan being a dynamic document, updated quarterly.

REPORT APPROVAL ROUTE

Quality, Patient Experience and Safety Committee - 04/02/2025

REPORT APPENDICES
Clinical Audit Plan 2025/2026

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

SITUATION

1. Following an 'Audit Wales' review of WAST's Quality Governance Arrangements, one of the recommendations was for the Clinical Audit Plan to be submitted to QuEST for scrutiny and approval ahead of each financial year, and then monitored on a quarterly basis.

BACKGROUND

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

3. The plan is developed in consultation with the Clinical Intelligence & Assurance Team, Clinical Intelligence & Assurance Group, and senior clinical, and non-clinical managers within the Trust. Consideration is given to linking audit topics to the IMTP and LDPs, and risk registers where possible.

4. Care, treatment, and decision making should reflect best practice based on evidence to ensure that people receive the right care and support to meet their individual needs.

5. The Trust's Clinical Audit Plan allows the planning and prioritisation of clinical audits across the financial year. It is a dynamic document, and audits will be added during the reporting year as required.

6. Various groups and committees receive quarterly updates for the clinical audit plan to reflect those audits that are either planned, currently underway, or have been completed, and it is made available on the Trust's Intranet.

7. This plan and the subsequent action tracker to monitor learning from each of the audits is monitored by the Clinical Intelligence & Assurance Group, and an update noted at Clinical Directorate Business meetings.

8. Following an Internal Audit report issued in May 2024 on Clinical Audit, of the four objectives, three resulted in 'Reasonable Assurance' (Clinical Audit Strategy, Clinical Audit Planning & Clinical Audit Outcome Reporting). The fourth resulted in 'Substantial Assurance' (Benefits Realisation and Lessons Learned).

9. The Clinical Intelligence & Assurance Team are progressing with the recommendations from the Internal Audit relating to the Clinical Audit Plan.

    - Where possible clinical audits are linked to the IMTP, LDPs and risk registers. Specific fields for IMTP/LDP/Risk are now included on the audit proposal form. In addition, the decision log contains further information to justify the inclusion of audits.

    - More detailed information is now contained in the Clinical Audit Delivery Plan in relation to audits being included, and delays and issues if required. This is reported monthly to the Clinical Intelligence & Assurance Group

ASSESSMENT

10. The Clinical Audit Plan 2025-2026 (attached) includes two tables:

    a) Table 1 - a summary of the confirmed clinical audits along with a RAG status as an easy reference to progress for each audit

    b) Table 2 – contains additional information in a comments column to provide details of progress or issues with each audit

11. Many of the audits and re-audits can be undertaken solely by the Clinical Intelligence & Assurance Team. However, support is required for some topics where subject matter experts are needed as authors, and the support of sponsors to ensure completion of the audits and subsequent actions.

RECOMMENDED:
That the Committee approve the Clinical Audit Plan for 2025/26.

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Welsh Ambulance Services
University NHS Trust

Welsh Ambulance Services University NHS Trust

Clinical Audit Plan

2025/2026
Quarter 1

DRAFT v0.1 Last Updated 3rd January 2025

Introduction

Clinical audit is one of a range of quality improvement methodologies that can deliver improved processes and outcomes. It measures against a standard, and can improve quality and unwarranted variations in practice, and support continuous and sustainable improvement. Clinical audit is a key enabler in evidencing the Health & Care Quality Standards 2023, providing assurance and compliance with the duty of quality.

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

The plan is developed in consultation with the Clinical Intelligence & Assurance Team (CIAT), and senior clinical, and non-clinical managers within the Trust. It is expected that managers will ensure there is an opportunity for staff at all levels to contribute to the development of the plan and undertake clinical audits.

Following requests to undertake clinical audits, a proposal form will be provided by the CIAT allowing the aims, objectives, author, and a sponsor to be identified, along with identifying the necessary data and level of support required from the CIAT. A How to Undertake a Clinical Audit document is available on the Trust's intranet to guide and support staff.

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

- Local and Trust priorities (e.g. Integrated Medium-Term Plan (IMTP) and Local Delivery Plans (LDPs))
- Clinical risk (e.g., linked to clinical risk registers or identified potential risks)
- Opportunities to improve clinical effectiveness and evidence-based practice (e.g., efficacy of treatment, new initiatives, pilot projects)
- Opportunities to quality assure clinical data (e.g., Clinical Indicator reports from electronic Patient Clinical Record (ePCR) data)
- National inquiries/patient safety incidents/Regulation 28 reports

- Guidance documents (e.g., National Institute for Health and Care Excellence (NICE), Association of Ambulance Chief Executives (AACE), and the Joint Royal Colleges Ambulance Liaison Committee (JRCALC)
- National Ambulance Service Clinical Quality Group
- Policy documents relating to health and healthcare
- Other benchmarking activities as appropriate

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

It is not always possible to predict at the start of a financial year all the topics that will require evaluation and therefore flexibility in setting a Clinical Audit Plan is required, resulting in the annual plan being a dynamic document, updated quarterly.

As part of the development and updating of this plan, the CIAT have streamlined and improved the process, forms and templates used. This approach has been further supported following and internal audit. When the CIAT receive topics for suggested audits, they are added to a spreadsheet and a prioritisation tool is used to assist in identifying the order for inclusion on the plan. These will then be presented to the Clinical Intelligence and Assurance Group to approve their inclusion in the plan.

The aim of this plan is to detail the clinical audits that are either planned, currently underway or have been completed during the financial year **(Table 1 & Table 2)**

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

The completed clinical audit reports are available on the Clinical Audit page of the Trust's Intranet website. (https://nhswales365.sharepoint.com/sites/AMB-Intranet-Medical/SitePages/Clinical-Audit-Programme.aspx)

Head of Clinical Intelligence & Assurance

Table 1 – Summary (Full information in Table 2)

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

This section contains confirmed clinical audits
(This is a dynamic document, and topics will be added during the reporting year as required)

Ref	Tier	Clinical Audit Title	Clinical Audit Author	Clinical Audit Sponsor	Audit Start Date	Current Status (RAG)*				
						Q4 2024/ 2025	Q1	Q2	Q3	Q4
23_009	1	ePCR Clinical Data Assurance - STEMI Clinical Indicator follow up audit	Clinical Intelligence & Assurance Team	Head of Clinical Intelligence & Assurance	Indicative Q4 24/25					
TBC	1	ePCR Clinical Data Assurance - Return of Spontaneous Circulation (ROSC) at Hospital Clinical Indicator Re-audit	Clinical Intelligence & Assurance Team	Head of Clinical Intelligence & Assurance	To commence after ePCR changes implemented	N/A				
24_005	1	Drug administration documentation	Clinical Intelligence & Assurance Team	Head of Clinical Intelligence & Assurance	December 2024					
TBC	1	Failed Pathways Recording on ePCR Audit	TBC	Assistant Director of Clinical Development	TBC	N/A				
25_001	1	ROLE Form Images in ePCR follow up audit	Clinical Intelligence & Assurance Team	Head of Clinical Intelligence & Assurance	Q4					
TBC	1	Clinical Frailty Scale (CFS) – follow-up audit (action from CIAT23_003)	Clinical Intelligence & Assurance Team	Head of Clinical Intelligence & Assurance	TBC	N/A				

TBC	1	Use of Magnesium Sulfate	Clinical Intelligence & Assurance Team	Head of Medicines Management	Indicative Q4	N/A				
TBC	1	CI Care bundle compliance in IHT patients.	Clinical Intelligence & Assurance Team	Head of Clinical Intelligence & Assurance	Indicative Q1	N/A				
TBC	1	Non-medical prescribing	Clinical Intelligence & Assurance Team	Head of Medicines Management	Indicative Q2	N/A				
TBC	1	Trauma in older people Tool	Clinical Intelligence & Assurance Team	TBC	Indicative Q4	N/A				

Table 2 – Full Information

Ref	Clinical Audit Title	Rationale/Drivers	Clinical Audit Author	Clinical Audit Contact/Support	Audit Start Date	Comments
23_009	ePCR Clinical Data Assurance - STEMI Clinical Indicator follow up audit	To ascertain if improvements have resulted following completion of actions from the previous audit.	Clinical Intelligence & Assurance Team	Head of Clinical Intelligence & Assurance	Indicative Q4 24/25	Update further delayed, and problems with consistent roll out @19/12, and whether all changes have been implemented. UI changes investigated, and SBAR presented to ePCR-CRG (28/3) to confirm outstanding issues. Following Autumn 24 UI release – the CI technical specification was updated and deployed by IDS. Start date of audit anticipated January 25.
TBC	ePCR Clinical Data Assurance - Return of Spontaneous Circulation (ROSC) at Hospital Clinical Indicator Re-audit	To ascertain if improvements have resulted following completion of actions from the previous audit.	Clinical Intelligence & Assurance Team	Head of Clinical Intelligence & Assurance	TBC	Funding required for these specific changes. Autumn 2024 deployment. The 'Point of closure nudge tool' has been activated to improve outcome compliance. Technical spec updated and being reviewed by IDS
24_005	Drug administration documentation	To ensure that drugs administered to the patient are documented within the ePCR drugs section in line with the	Clinical Intelligence & Assurance Team	Clinical Intelligence & Assurance Team	Q3 24/25	SQL developed. SBAR completed in preparedness for December

Ref	Clinical Audit Title	Rationale/Drivers	Clinical Audit Author	Clinical Audit Contact/Support	Audit Start Date	Comments
		relevant parts of section 10.0 of the Medicines Management Policy 4.0				2024 CIAG. However, due to REAP4 paper shared for information via email. No comments received as of 02.01.25 suggesting changes required to criterion table. Approved.
TBC	Failed Pathways Recording on ePCR Audit	Following an update to the ePCR User Interface to record the inability to refer patients onto pathways, an audit would assist in identifying areas for improvement for patient care and avoid unnecessary admission to Emergency Departments.	TBC	Clinical Intelligence & Assurance Team	TBC	Required UI changes presented to ePCR CRG 29.05.24 CR0048, likely release Oct/Nov 2024 Revised date for UI changes Spring 2025 Sponsor has requested a clinical intelligence report be generated to inform the need for the audit.
25_001	ROLE Form Images in ePCR re-audit	To ascertain if improvements have resulted following completion of actions from the previous audit.	Clinical Intelligence & Assurance Team	Clinical Intelligence & Assurance Data Specialist	Q4 24/25	SQL developed and data obtained.
TBC	Clinical Frailty Scale (CFS) – follow-up audit (action from CIAT23_003)	This is an action from an audit undertaken in 2023	Clinical Intelligence & Assurance Co-ordinator	Clinical Intelligence & Assurance Co-ordinator	TBC	
TBC	Use of Magnesium Sulfate	PGD being developed in 2025, potential need for audit when embedded into practice.	Clinical Intelligence & Assurance Co-ordinator	Clinical Intelligence & Assurance Team	TBC	Indications for use, severe asthma in adults and children Pre-eclampsia, Eclampsia, Torsade de Pointes.

Ref	Clinical Audit Title	Rationale/Drivers	Clinical Audit Author	Clinical Audit Contact/Support	Audit Start Date	Comments
TBC	CI Care bundle compliance in Interhospital Transfer (IHT) patients.	CIAG approved change to global IHT metric encompassing many more cases which would have previously been included in a Clinical Indicator. CIAG requested an audit to provide assurance going forwards relating to the care bundle in CI patients transported by WAST from smaller NHS premises to definitive care.	Clinical Intelligence & Assurance Co-ordinator	Clinical Intelligence & Assurance Team	TBC	
TBC	Non-medical prescribing	Policy 9.3 :- Regular programmes of audit of compliance with information governance, records management standards and prescribing practice will be established. The Head of Medicines Management must include non-medical prescribing audits as part of the Trust's annual clinical audit plan, reporting these results through the Advanced Clinical Practice Delivery Group and Optimising Care Group and available for assurance.	Clinical Intelligence & Assurance Co-ordinator	Clinical Intelligence & Assurance Team	TBC	
TBC	Trauma in older people Tool	Trauma in Older People Tool is a rebranding and is due for re-launch Potential need for audit once embedded into practice.	Clinical Intelligence & Assurance Co-ordinator	Clinical Intelligence & Assurance Team	TBC	

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Welsh Ambulance Services University NHS Trust

AGENDA ITEM No	**18.2**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**1**

Clinical Audit Plan & Action Tracker Q3 (update) 2024/25

MEETING	Quality, Patient Experience and Safety Committee
DATE	4th February 2025
EXECUTIVE	Andy Swinburn, Executive Director of Paramedicine
AUTHOR	Kevin Webb, Head of Clinical Intelligence and Assurance
CONTACT	kevin.webb@wales.nhs.uk

EXECUTIVE SUMMARY

Following an 'Audit Wales' review of WAST's Quality Governance Arrangements, one of the recommendations was for the Clinical Audit Plan to be monitored on a quarterly basis at QuEST.

This is the Q3 2024-25 update to highlight progress with audits (the plan) and also to actions from the completed audits (action tracker).

The Q3 2024-25 Clinical Audit Plan contains 14 audits covering a range of topics including clinical conditions, medicines, and compliance to documentation. This is a dynamic plan and since the Q2 update, the Drug Administration Documentation' audit was approved for inclusion at the Clinical Intelligence & Assurance Group and commenced in December 2024.

Of those indicated on the plan:

- 5 have been completed, one in Q1, one in Q2 and three in Q3.)
- 3 of the 4 ePCR Clinical Data Assurance Re-audits will not commence as they are reliant on ePCR User Interface changes being implemented.
- 1 of the ePCR Quality Assurance audits, STEMI* (*heart attack*) will be undertaken and demonstrate the improvements made which can broadly be applied to the three that are not to commence.
- 5 are yet to start, some are reliant on ePCR User Interface changes being implemented**,** some are not due to start until Q4.

** As some changes have been possible outside of the next scheduled ePCR User Interface update (Spring 2025), the CIAT will undertake a 'Follow up' audit for STEMI (heart attack) which will demonstrate the benefits from the improvement work aimed to provide greater assurance with raw (non-audited) data.*

There are currently six completed clinical audits on the Action Tracker, with a total of 27 actions. Of those:

- 12 have been completed
- 15 are on track as planned

RECOMMENDED: That the committee:

- **Note the Q3 2024-25 Clinical Audit Plan and Action Tracker update.**

KEY ISSUES/IMPLICATIONS
Many of the audits and re-audits can be undertaken solely by the Clinical Intelligence & Assurance Team. However, support is required for some topics where subject matter experts are needed as authors, and the support of sponsors to ensure completion of the audits and subsequent actions.

REPORT APPROVAL ROUTE
Quality, Patient Experience and Safety Committee - 04/02/2025

REPORT APPENDICES
Clinical Audit Plan 2024/2025 Quarter 3 – For noting

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

SITUATION

1. Following an 'Audit Wales' review of WAST's Quality Governance Arrangements, one of the recommendations was for the Clinical Audit Plan to be monitored on a quarterly basis at QuEST.
2. This is the Q3 2024-25 update to highlight progress with audits (the plan) and also to actions from the completed audits (action tracker).

BACKGROUND

3. The development of this annual plan takes into consideration a number of aspects including the resources available both in terms of funding and skills. As is often the case in healthcare there are substantially more requests for clinical audits than there are resources available to manage them. For this reason, it has been necessary to tailor the plan so that it is realistic, achievable and that expectations are not overreached.
4. The plan is developed in consultation with the Clinical Intelligence & Assurance Team, Clinical Intelligence & Assurance Group, and senior clinical, and non-clinical managers within the Trust. Consideration is given to linking audit topics to the IMTP, LDPs, and risk registers where possible.
5. Care, treatment, and decision making should reflect best practice based on evidence to ensure that people receive the right care and support to meet their individual needs.
6. The Trust's annual Clinical Audit Plan allows the planning and prioritisation of clinical audits across the financial year. It is a dynamic document, updated quarterly to reflect those audits that are either planned, currently underway or have been completed. Various groups and committees receive quarterly updates for the clinical audit plan, and it is made available on the Trust's Intranet.
7. This plan and the subsequent action tracker to monitor learning from each of the completed audits is monitored by the Clinical Intelligence & Assurance Group, and an update noted at Clinical Directorate Business meetings.
8. Following an Internal Audit report issued in May 2024 on Clinical Audit, of the four objectives, three resulted in 'Reasonable Assurance' (Clinical Audit Strategy, Clinical Audit Planning & Clinical Audit Outcome Reporting). The fourth resulted in 'Substantial Assurance' (Benefits Realisation and Lessons Learned).
9. The Clinical Intelligence & Assurance Team are progressing with the recommendations from the Internal Audit relating to the Clinical Audit Plan.
    - Where possible clinical audits are linked to the IMTP, LDPs and risk registers. Specific fields for IMTP/LDP/Risk are now included on the audit proposal form. In addition, the decision log contains further information to justify the inclusion of audits.

- More detailed information is now contained in the Clinical Audit Delivery Plan in relation to audits being included, and delays and issues if required. This is reported monthly to the Clinical Intelligence & Assurance Group.

ASSESSMENT

10. The Q3 2024-25 Clinical Audit Plan contains 14 audits covering a range of topics including clinical conditions, medicines, and compliance to documentation. This is a dynamic plan and since the Q2 update, the Drug Administration Documentation' audit was approved for inclusion at the Clinical Intelligence & Assurance Group, this commenced in December 2024.

11. Of those indicated on the plan:
    - 5 have been completed, one in Q1, one in Q2 and three in Q3. These were approved at the Clinical Intelligence & Assurance Group.
    - 3 of the 4 ePCR Clinical Data Assurance Re-audits will not commence as they are reliant on ePCR User Interface changes being implemented. These were to be undertaken when all actions had been completed from the initial ePCR Quality Assurance audits in 2022.
    - 1 of the ePCR Quality Assurance audits, STEMI (*heart attack*) will be undertaken and demonstrate the improvements made which can broadly be applied to the three that are not to commence. This will demonstrate the benefits from the improvement work aimed to provide greater assurance with raw (non-audited) data.
    - 5 are yet to start, some are reliant on ePCR User Interface changes being implemented**,** some are not due to start until Q4.
    - The changes above were approved by the Clinical Intelligence & Assurance Group in November 2024 which also allowed resources to be realigned to more recent higher priority audits, e.g. The Drug Administration Documentation audit.
12. The Clinical Audit Action Tracker is a dynamic document used to monitor and progress the actions as a result of learning from clinical audits. Progress with actions is monitored and supported by the Clinical Intelligence & Assurance Group, and at the Clinical Directorate Business meetings.

13. There are currently six completed clinical audits on the Action Tracker, with a total of 27 actions. Of those:
    - 12 have been completed
    - 15 are on track as planned

RECOMMENDATION: The committee Note the Q3 2024-25 Clinical Audit Plan and Action Tracker update.

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Welsh Ambulance Services University NHS Trust

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Clinical Audit Plan

2024/2025
Quarter 3

FINAL V1.0 Last Updated 23rd December 2024

Introduction

Clinical audit is one of a range of quality improvement methodologies that can deliver improved processes and outcomes. It measures against a standard, and can improve quality and unwarranted variations in practice, and support continuous and sustainable improvement. Clinical audit is a key enabler in evidencing the Health & Care Standards 2023, providing assurance and compliance with the duty of quality.

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

The plan is developed in consultation with the Clinical Intelligence & Assurance Team (CIAT), and senior clinical, and non-clinical managers within the Trust. It is expected that managers will ensure there is an opportunity for staff at all levels to contribute to the development of the plan and undertake clinical audits.

Following requests to undertake clinical audits, a proposal form will be provided by the CIAT allowing the aims, objectives, author, and a sponsor to be identified, along with identifying the necessary data and level of support required from the CIAT. A How to Undertake a Clinical Audit document is available on the Trust's intranet to guide and support staff.

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

- Local and Trust priorities (e.g. Integrated Medium-Term Plan (IMTP) and Local Delivery Plans (LDPs))
- Clinical risk (e.g., linked to clinical risk registers or identified potential risks)
- Opportunities to improve clinical effectiveness and evidence-based practice (e.g., efficacy of treatment, new initiatives, pilot projects)
- Opportunities to quality assure clinical data (e.g., Clinical Indicator reports from electronic Patient Clinical Record (ePCR) data)
- National inquiries/patient safety incidents/Regulation 28 reports
- Guidance documents (e.g., National Institute for Health and Care Excellence (NICE), Association of Ambulance Chief Executives (AACE), and the Joint Royal Colleges Ambulance Liaison Committee (JRCALC)

- National Ambulance Service Clinical Quality Group
- Policy documents relating to health and healthcare
- Other benchmarking activities as appropriate

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

It is not always possible to predict at the start of a financial year all the topics that will require evaluation and therefore flexibility in setting a Clinical Audit Plan is required, resulting in the annual plan being a dynamic document, updated quarterly.

As part of the development and updating of this plan, the CIAT have streamlined and improved the process, forms and templates used. This approach has been further supported following and internal audit. When the CIAT receive topics for suggested audits, they are added to a spreadsheet and a prioritisation tool is used to assist in identifying the order for inclusion on the plan. These will then be presented to the Clinical Intelligence and Assurance Group to approve their inclusion in the plan.

The aim of this plan is to detail the clinical audits that are either planned, currently underway or have been completed during the financial year **(Table 1 & Table 2)**

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

The completed clinical audit reports are available on the Clinical Audit page of the Trust's Intranet website. (https://nhswales365.sharepoint.com/sites/AMB-Intranet-Medical/SitePages/Clinical-Audit-Programme.aspx)

Kevin Webb – Head of Clinical Intelligence & Assurance

Table 1 – Summary (Full information in Table 2)

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

This section contains confirmed clinical audits

Ref	Tier	Clinical Audit Title	Clinical Audit Author	Clinical Audit Sponsor	Audit Start Date	Current Status (RAG)*				
						Q4 2023/ 2024	Q1	Q2	Q3	Q4
23_004	1	ePCR Clinical Data Assurance – Fractured Neck of Femur (#NOF) Clinical Indicator Re-audit	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	Revised Q3 24/25					
23_008	1	ePCR Clinical Data Assurance - Stroke Clinical Indicator Re-audit	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	Indicative Q4 24/25	N/A	N/A	N/A		
23_009	1	ePCR Clinical Data Assurance - STEMI Clinical Indicator Re-audit	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	Indicative Q4 24/25	N/A	N/A	N/A	N/A	
23_005	1	ePCR Clinical Data Assurance - Hypoglycaemia Clinical Indicator Re-audit	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	Revised Q3 24/25					
TBC	1	ePCR Clinical Data Assurance - Return of Spontaneous Circulation (ROSC) at Hospital Clinical Indicator Re-audit	Clinical Intelligence & Assurance Team	Kevin Webb	To commence after ePCR changes implemented	N/A	N/A	N/A	N/A	

				Head of Clinical Intelligence & Assurance						
23_003	1	Clinical Frailty Scale (CFS) in Patients Aged ≥65 years Follow Up Audit	Richard Teulon Clinical Intelligence & Assurance Co-ordinator	Duncan Robertson Assistant Director of Clinical Development	February 2024					
24_001	1	Older Adult Fallers Discharged at Scene - ePCR Clinical Data Assurance	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	April 2024	N/A				
24_002	1	Tranexamic Acid (TXA) Administration Audit	Clinical Intelligence & Assurance Team	Greg Lloyd Assistant Director of Clinical Delivery	July 2024	N/A	N/A			
24_003	1	Major Trauma Tool Audit	Carl Powell, Clinical Lead – Acute Care	Greg Lloyd Assistant Director of Clinical Delivery	July 2024	N/A	N/A			
24_004	1	Newborn Normothermia – Monitor and Maintain in the Pre-Hospital Setting	Bethan Jones, Local Safety Champion, Midwife	Steve Magee, Regional Clinical Lead	September 2024	N/A	N/A			
24_005	1	Drug Administration Documentation	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	December 2024	N/A	N/A	N/A		
TBC	1	Failed Pathways Recording on ePCR Audit	TBC	Jonathan Chippendale Assistant Director of Clinical Development	Indicative Q4	N/A	N/A	N/A	N/A	
TBC	1	ROLE Form Images in ePCR Re-audit	Clinical Intelligence & Assurance Team	Kevin Webb	Indicative Q4	N/A	N/A	N/A	N/A	

				Head of Clinical Intelligence & Assurance						
TBC	1	Safeguarding Adolescent Audit Follow Up	Gwenan Jones-Parry Safeguarding Specialist Paramedic	Rhiannon Thomas Senior Professional Safeguarding	TBC	N/A	N/A	N/A	N/A	

Table 2 – Full Information

Ref	Clinical Audit Title	Rationale/Drivers	Clinical Audit Author	Clinical Audit Contact/Support	Audit Start Date	Comments
23_004	ePCR Clinical Data Assurance – Fractured Neck of Femur (#NOF) Clinical Indicator Re-audit	To ascertain if improvements have resulted following completion of actions from the previous audit.	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	Revised Q3 24/25	Update further delayed, and problems with consistent roll out @19/12, and whether all changes have been implemented. UI changes investigated, and SBAR presented to ePCR-CRG (28/3) to confirm outstanding issues. UI changes delayed until 10th June 2024 Start date of audit TBC. Awaiting full UI change to be employed. Autumn release expected. Update paper to CIAG November CIAG 2024, agenda item 11a remove from plan.
23_008	ePCR Clinical Data Assurance – Stroke Clinical Indicator Re-audit	To ascertain if improvements have resulted following completion of actions from the previous audit.	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	Indicative Q4 24/25	Update further delayed, and problems with consistent roll out @19/12, and whether all changes have been implemented. UI changes investigated, and SBAR presented to ePCR-CRG (28/3) to confirm outstanding

Ref	Clinical Audit Title	Rationale/Drivers	Clinical Audit Author	Clinical Audit Contact/Support	Audit Start Date	Comments
						issues. Start date of audit TBC. Awaiting full UI change to be employed. Autumn release expected. November CIAG 2024, agenda item 11a remove from plan.
23_009	ePCR Clinical Data Assurance - STEMI Clinical Indicator Re-audit	To ascertain if improvements have resulted following completion of actions from the previous audit.	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	Indicative Q4 24/25	Update further delayed, and problems with consistent roll out @19/12, and whether all changes implemented. UI changes investigated, and SBAR presented to ePCR-CRG (28/3) to confirm outstanding issues. Following Autumn 24 UI release – the CI technical specification was updated and deployed by IDS. Start date of audit anticipated Jan 25.
23_005	ePCR Clinical Data Assurance - Hypoglycaemia Clinical Indicator Re-audit	To ascertain if improvements have resulted following completion of actions from the previous audit.	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	Revised Q3 24/25	Update further delayed, and problems with consistent roll out @19/12, and whether all changes have been implemented. UI changes investigated, and SBAR presented to ePCR-CRG (28/3) to confirm outstanding issues.

Ref	Clinical Audit Title	Rationale/Drivers	Clinical Audit Author	Clinical Audit Contact/Support	Audit Start Date	Comments
						UI changes delayed until 10th June 2024 Start date of audit TBC. Awaiting full UI change to be employed. Autumn release expected. CIAG November 2024, agenda item 11a remove from plan.
TBC	ePCR Clinical Data Assurance - Return of Spontaneous Circulation (ROSC) at Hospital Clinical Indicator Re-audit	To ascertain if improvements have resulted following completion of actions from the previous audit.	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	TBC	Funding required for these specific changes. Potential to use 'Point of Closure' changes to improve compliance.
23_003	Clinical Frailty Scale (CFS) in Patients Aged ≥65 years Follow Up Audit	To ascertain if improvements have resulted following completion of actions from the previous audit.	Richard Teulon Clinical Intelligence & Assurance Co-ordinator	Ruth Saele Clinical Intelligence & Assurance Data Specialist	February 2024	Completed Q1 2024/25.
24_001	Older Adult Fallers Discharged at Scene - ePCR Clinical Data Assurance	To ascertain the availability and quality of raw ePCR data to inform the development of a Clinical Indicator.	Clinical Intelligence & Assurance Team	Ruth Saele Clinical Intelligence & Assurance Data Specialist	April 2024	A pilot audit was undertaken in collaboration with UK Ambulance Trusts. WAST to now look at specific criteria for a Clinical Indicator. Criteria developed in collaboration with Falls in older adult lead and agreed in CIAG 08.03.24

Ref	Clinical Audit Title	Rationale/Drivers	Clinical Audit Author	Clinical Audit Contact/Support	Audit Start Date	Comments
						Final report presented July 2024
24_002	Tranexamic Acid (TXA) Administration Audit	This audit will be of Trust wide ePCR data and broadens the scope of the initial audit (SWTN digital pen data), by including all JRCALC indications. This is will also ascertain if improvements have resulted following completion of actions from specific areas in the previous audit.	Clinical Intelligence & Assurance Team	Ruth Saele Clinical Intelligence & Assurance Data Specialist	July 2024	CIAT have ongoing discussions with the sponsor and subject matter experts. Completed in preparedness for Dec CIAG. However, due to REAP4 paper rescheduled for January 2025 CIAG
24_003	Major Trauma Tool Audit	In addition to the TXA audit, this would include contact with the Trauma Desk and disposition (Trauma Unit etc).	Carl Powell Clinical Lead Acute Care	Clinical Intelligence & Assurance Team	July 2024	Confirmed by GL that audit to progress during 2024/25. Audit to cover all-Wales to include patient disposition if outside the area of the SWTN. Completed in preparedness for Dec CIAG. However, due to REAP4 paper rescheduled for January 2025 CIAG
24_004	Newborn Normothermia – Monitor and Maintain in the Pre-Hospital Setting	To provide assurance and continuously monitor the ongoing improvements to monitor and maintain thermoregulation in the prehospital setting.	Bethan Jones, Local Safety Champion, Midwife	Claire Muxworthy, Clinical Intelligence and Assurance Co-ordinator	September 2024	Audit proposal approved in CIAG meeting on 08.08.2024 Completed in preparedness for Dec CIAG. However, due to REAP4 paper rescheduled for January 2025 CIAG

Ref	Clinical Audit Title	Rationale/Drivers	Clinical Audit Author	Clinical Audit Contact/Support	Audit Start Date	Comments
24_005	Drug administration documentation	To ensure that drugs administered to the patient are documented within the ePCR drugs section in line with the relevant parts of section 10.0 of the Medicines Management Policy 4.0	Clinical Intelligence & Assurance Team	Clinical Intelligence & Assurance Team	Q3	SQL developed. SBAR completed in preparedness for Dec CIAG. However, due to REAP4 paper shared for information via email. No comments received as of 02.01.25 suggesting changes required to criterion table. Approved.
TBC	Failed Pathways Recording on ePCR Audit	Following an update to the ePCR User Interface to record the inability to refer patients onto pathways, an audit would assist in identifying areas for improvement for patient care and avoid unnecessary admission to Emergency Departments.	TBC	Clinical Intelligence & Assurance Team	Indicative Q4	Required UI changes presented to ePCR CRG 29.05.24 CR0048, likely release Oct/Nov 2024 Revised date for UI changes Jan/Feb 2025
25_001	ROLE Form Images in ePCR Re-audit	To ascertain if improvements have resulted following completion of actions from the previous audit.	Clinical Intelligence & Assurance Team	Ruth Saele Clinical Intelligence & Assurance Data Specialist	Indicative Q4	SQL developed
TBC	Safeguarding Adolescent Follow-up Audit	To ascertain if improvements have resulted following completion of actions from the previous audit.	Gwenan Jones-Parry Safeguarding Specialist Paramedic	Claire Muxworthy Clinical Intelligence & Assurance Co-ordinator	TBC	Initially planned to commence Q1 New Head of Safeguarding started end of May 2024 - audit delayed. Contact made with Safeguarding Specialist Paramedic 30.09.24 and 31.12.24 for update.

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Welsh Ambulance Services University NHS Trust

AGENDA ITEM No	**19**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**2**

INFECTION PREVENTION AND CONTROL SERVICE REPORT

MEETING	Quality, Patient Experience & Safety Committee
DATE	4 February 2025
EXECUTIVE	Liam Williams, Executive Director of Quality and Nursing
AUTHOR	Marisa Alexis, Head of Infection, Prevention and Control (Interim) Penny Durrant, Deputy Director of Nursing, Quality & Governance (Interim)
CONTACT	Marisa.alexis@wales.nhs.uk Penny.Durrant@wales.nhs.uk

EXECUTIVE SUMMARY

1. This document provides an overview of the current challenges facing the Infection Prevention and Control (IPC) Team and outlines the Strategic Plan for service enhancement during the 2025-26 financial year.

2. Over the past year, the IPC Team has navigated a number of challenges influenced by factors such as workforce changes, leadership transitions, staffing shortages, and a reduction in training opportunities. These elements have impacted the team's capacity and operational effectiveness, creating a need for thoughtful reflection and targeted improvement.

3. This presents an opportunity to enhance the team's ability to consistently deliver safe, effective, and compliant IPC functions. Our commitment remains steadfast to upholding high standards of safety for patients, staff, and the wider community.

4. Governance offers a key avenue for improving the consistency in the implementation and monitoring of IPC Policies. A formalised Board Assurance Framework will be established to strengthen oversight and accountability. Furthermore, the organisation is dedicated to building upon lessons learned from the 2023-24 reporting process to create more comprehensive and timely reports. These efforts will enhance strategic planning, promote transparency, and support continuous improvement.

5. While this has been a challenging period, these factors have paved the way for significant opportunities to refine and elevate the IPC Team's performance. Our goal is to consistently deliver safe, effective, and compliant IPC functions, ensuring the highest standards of safety for patients, staff, and the public.

6. Notwithstanding the challenges faced, it is of note that the team have contributed significantly to the implementation of new respiratory protective equipment for our staff. At present, the majority of areas have either direct access to vehicle-issued powered air-purifying respirators or access through locally positioned teams. The completion of the vehicle-based rollout remains contingent on supply chain deliveries, which are being proactively monitored and advanced through the ongoing efforts of the Procurement Team.

7. The Improvement Plan focuses on addressing these challenges through targeted actions, such as the recruitment of skilled professionals, the development of robust Governance Processes, alignment of Policies with National Standards, and the implementation of structured reporting and Audit Frameworks.

8. By adopting these measures, the organisation aims to strengthen the IPC Service, provide greater assurance, and maintain compliance with both Regulatory and Organisational Standards. This Plan reflects our dedication to reinforcing confidence in IPC practices and promoting the health and safety of all stakeholders.

RECOMMENDED that the Quality, Patient Experience & Safety Committee receives this report and the 2023/24 Annual Report

EY ISSUES/IMPLICATIONS
(i) The IPC Team faces challenges due to workforce issues, leadership changes, and limited training, impacting capacity and effectiveness.
(ii) Governance needs strengthening through a formal Board Assurance Framework and improved reporting.
(iii) The Improvement Plan focuses on targeted actions to enhance IPC functions, ensure safety, and maintain compliance.

REPORT APPROVAL ROUTE	
Clinical & Quality Governance Group	21 January 2025
Quality, Patient Experience & Safety Committee	4 February 2025

REPORT APPENDICES
ANNEX 1 - SBAR **ANNEX 2** - IPC Annual Report

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

ANNEX 1

SITUATION

1. The IPC Team has experienced challenges in meeting expectations due to workforce and governance issues. Leadership gaps, staffing shortages, and limited access to effective training have impacted the team's capacity.

2. The 2023-24 IPC Annual Report has created an opportunity to gather valuable data that will support enhanced assurance and more effective planning moving forward.

BACKGROUND

3. The IPC Team has been navigating ongoing workforce challenges, which have impacted its ability to consistently deliver an effective service. Key areas identified for development include addressing leadership gaps, implementing a structured Service Delivery Model, and enhancing training for team members.

4. The IPC Team has been navigating a temporary leadership gap due to the absence of a substantive Head of Service. To ensure ongoing operational stability and maintain essential oversight, an interim Head of Service has been contracted in. This interim arrangement has helped address immediate priorities, but there is an opportunity to establish a more stable and strategic leadership structure to support long-term growth and development. The team continues to adapt to these changes, with a focus on maintaining effective collaboration and ensuring that key processes are managed efficiently.

5. Additionally, the team has experienced several staff departures that have increased operational pressures.

6. The cumulative impact of these departures has placed the IPC Team under increased pressure, but there are as a result, opportunities to strengthen the team and improve service delivery.

7. Professional training within the existing team has faced some challenges, as not all team members have had the opportunity to consistently engage in up-to-date training aligned with core IPC competencies. However, this is being addressed and the development of a comprehensive Training Programme designed to address these gaps and build staff confidence is nearing completion.

8. This initiative will support the team in effectively managing complex IPC situations, ensuring the implementation of evidence-based practices, and providing well-informed support across both clinical and non-clinical roles. The aim is to ensure that the team is equipped with the knowledge and skills necessary to meet IPC Standards and deliver high-quality care.

9. Efforts to establish robust Governance Frameworks for IPC Policies are ongoing. While challenges remain, steps are being taken to implement a formal structure for monitoring IPC compliance and performance. This will improve the organisation's ability to demonstrate compliance with statutory requirements and offer assurance to stakeholders.

10. The 2023-24 IPC Annual Report provides a snapshot of performance at a specific point in time. Moving forward, we are implementing measures to ensure more comprehensive and effective reporting, allowing for a clearer understanding of IPC performance and better alignment with organisational goals. This will support our ongoing commitment to delivering high standards of infection prevention and control.

RECOMMENDED that the Quality, Patient Experience & Safety Committee receives this report and the 2023/24 Annual Report.

Introduction

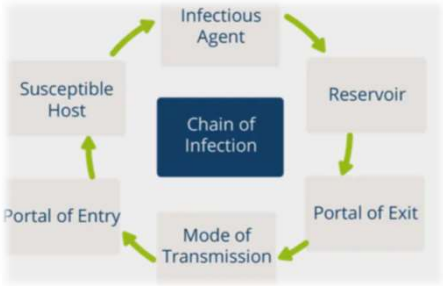
The Infection Prevention and Control Annual Report provides an overview of the efforts and outcomes in maintaining a safe and healthy environment within our healthcare facility. This report highlights the importance of infection prevention and control practices in reducing the spread of infectious diseases and ensuring the well-being of our patients and staff.

Guidance is provided within the National Infection Prevention and Control Manual NIPCM Wales. In addition, annex guidance is provided from the Association of Ambulance Chief Executives and Public Health Wales in addition to the Welsh Government IPC Codes of Practice. All Wales IPC Code of Practice

Key Achievements
Throughout the past year, we have made significant strides in implementing various infection prevention and control measures. The efforts are to decrease healthcare-acquired infections ,improved adherence to best practices in hand hygiene, environmental cleaning, and personal protective equipment usage. The infection prevention and control team have worked tirelessly to educate staff, develop policies and procedures, and monitor compliance with infection control guidelines.

Challenges and Opportunities
While we have seen progress in our infection prevention efforts, there are still challenges that need to be addressed. The emergence of new infectious diseases, antibiotic resistance, and the increasing complexity of healthcare settings all present ongoing challenges in infection control. Moving forward, we must continue to adapt and enhance our strategies to effectively prevent and manage infections in our Trust.

Future Directions
As we look to the future, we are committed to further improving our infection prevention and control program. This includes increasing surveillance efforts, enhancing staff training and education, and implementing new technologies and innovations in infection control. By staying proactive and vigilant in our approach, we can continue to safeguard the health and safety of everyone who requires our service.



IPC Workplan Deliverables 2023/2024

- Implement and monitor recommendations from the Internal IPC audit review completed in Jan 2023.
- Increase the functionality of the IPC Strategic Group and ensure this committee has oversight of the IPC Action Plan.
- Business as usual IPC Guidance
- Fit Testing and RPE Oversight
- Completion of IPC Audits
- Examination and Monitoring of Datix incidents relating to IPC
- COVID-19 Public Enquiry data collection
- Education and Training
- Management of IPC Risks to align with approved documents

Internal Audit IPC: Management Actions

Governance:
Policies, Guidance and Standard Operating Procedures.

Action: The Trust should map IPC and related policies, responsibilities, ownership, monitoring and governance arrangements to support future review and development of policies and guidance

Action: IPC Strategic Group - The Terms of Reference, membership and format of the IPC strategic Group should be reviewed to align with the IPC Workplan.

Action: Education and Training -the Trust should ensure online resources contain up to date links and guidance.

Action: Ensuring all policies align with AACE guidance.

Action: Assurance and Audit - The Trust should develop a prioritised schedule of audits which can be delivered by the IPC team for the remainder of 2022/23

Action: Sustainable Respiratory Protection - Options Appraisal Paper presented to EMT October 2023.

Four options including benefits realization exercise provided, option four approved: Vehicle and Station based Power Assisted Respiratory Protection(PAPR) (Versaflo).

The Task and Finish Group is now working on the implementation of Option Four, balancing the replacement of the model whilst continuing the existing compliance monitoring.

IPC Governance: Policies

IPC Policy

Three-year review and update combining AACE national IPC Policy, Welsh Government IPC codes of Practice and Welsh Government Health and Care Standards.

Premise and Vehicle Cleanliness Policy

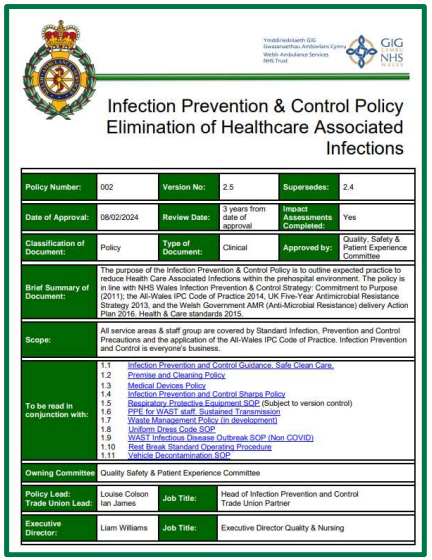
Three Year Review and update. Still awaiting completed but unpublished Ambulance Cleaning Standards. Current national standards published in 2019 for secondary care.

ANTT Policy

All Wales ANTT Policy review, approved via Policy Group.

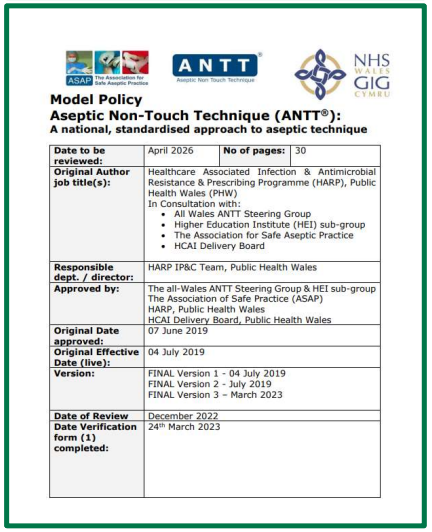
Sharps Policy

Currently under review and scheduled to go to Policy Group on the 20th August 2024.



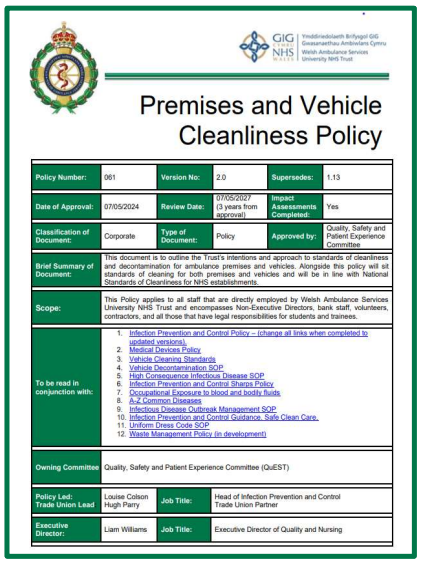
Infection Prevention & Control Policy
Elimination of Healthcare Associated Infections

Policy Number:	002	Version No:	2.5	Supersedes:	2.4
Date of Approval:	08/02/2024	Review Date:	3 years from date of approval	Impact Assessments Completed:	Yes
Classification of Document:	Policy	Type of Document:	Clinical	Approved by:	Quality, Safety & Patient Experience Committee
Brief Summary of Document:	The purpose of the Infection Prevention & Control Policy is to outline expected practice to reduce Health Care Associated Infections within the prehospital environment. The policy is in line with NHS Wales Infection Prevention & Control Strategy: Commitment to Purpose (2011), the All-Wales IPC Code of Practice 2014, UK Five-Year Antimicrobial Resistance Strategy 2013, and the Welsh Government AMR (Anti-Microbial Resistance) delivery Action Plan 2016, Health & Care standards 2015.				
Scope:	All service areas & staff group are covered by Standard Infection, Prevention and Control Precautions and the application of the All-Wales IPC Code of Practice. Infection Prevention and Control is everyone's business.				
To be read in conjunction with:	1.1 Infection Prevention and Control Guidance, Safe Clean Care. 1.2 Premise and Cleaning Policy 1.3 Medical Devices Policy 1.4 Infection Prevention and Control Sharps Policy 1.5 Respiratory Protective Equipment SOP (Subject to version control) 1.6 PPE for WAST staff, Sustained Transmission 1.7 Waste Management Policy (in development) 1.8 Uniform Dress Code SOP 1.9 WAST Infectious Disease Outbreak SOP (Non COVID) 1.10 Rest Break Standard Operating Procedure 1.11 Vehicle Decontamination SOP				
Owning Committee	Quality Safety & Patient Experience Committee				
Policy Lead: Trade Union Lead:	Louise Colson Ian James	Job Title:	Head of Infection Prevention and Control Trade Union Partner		
Executive Director:	Liam Williams	Job Title:	Executive Director Quality & Nursing		



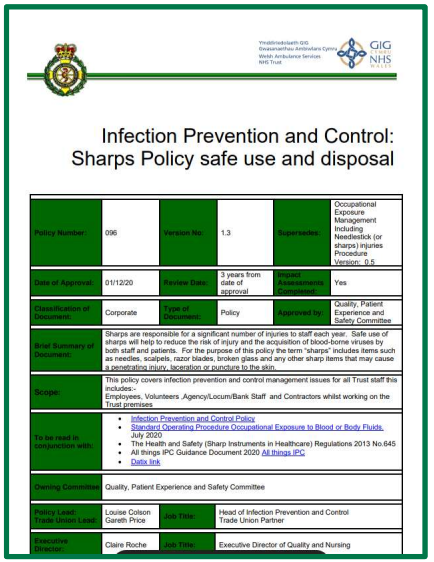
Model Policy
Aseptic Non-Touch Technique (ANTT®):
A national, standardised approach to aseptic technique

Date to be reviewed:	April 2026	No of pages:	30
Original Author job title(s):	Healthcare Associated Infection & Antimicrobial Resistance & Prescribing Programme (HARP), Public Health Wales (PHW) In Consultation with: • All Wales ANTT Steering Group • Higher Education Institute (HEI) sub-group • The Association for Safe Aseptic Practice • HCAI Delivery Board		
Responsible dept. / director:	HARP IP&C Team, Public Health Wales		
Approved by:	The all-Wales ANTT Steering Group & HEI sub-group The Association of Safe Practice (ASAP) HARP, Public Health Wales HCAI Delivery Board, Public Health Wales		
Original Date approved:	07 June 2019		
Original Effective Date (live):	04 July 2019		
Version:	FINAL Version 1 - 04 July 2019 FINAL Version 2 - July 2019 FINAL Version 3 - March 2023		
Date of Review	December 2022		
Date Verification form (1) completed:	24th March 2023		



Premises and Vehicle Cleanliness Policy

Policy Number:	061	Version No:	2.0	Supersedes:	1.13
Date of Approval:	07/05/2024	Review Date:	07/05/2027 (3 years from approval)	Impact Assessments Completed:	Yes
Classification of Document:	Corporate	Type of Document:	Policy	Approved by:	Quality, Safety and Patient Experience Committee
Brief Summary of Document:	This document is to outline the Trust's intentions and approach to standards of cleanliness and decontamination for ambulance premises and vehicles. Alongside this policy will sit standards of cleaning for both premises and vehicles and will be in line with National Standards of Cleanliness for NHS establishments.				
Scope:	This Policy applies to all staff that are directly employed by Welsh Ambulance Services University NHS Trust and encompasses Non-Executive Directors, bank staff, volunteers, contractors, and all those that have legal responsibilities for students and trainees.				
To be read in conjunction with:	1. Infection Prevention and Control Policy – (change all links when completed to updated versions). 2. Medical Devices Policy 3. Vehicle Cleaning Standards 4. Vehicle Decontamination SOP 5. High Consequence Infectious Disease SOP 6. Infection Prevention and Control Sharps Policy 7. Occupational Exposure to blood and bodily fluids 8. A-Z Common Diseases 9. Infectious Disease Outbreak Management SOP 10. Infection Prevention and Control Guidance, Safe Clean Care. 11. Uniform Dress Code SOP 12. Waste Management Policy (in development)				
Owning Committee	Quality, Safety and Patient Experience Committee (QuEST)				
Policy Lead: Trade Union Lead	Louise Colson Hugh Parry	Job Title:	Head of Infection Prevention and Control Trade Union Partner		
Executive Director:	Liam Williams	Job Title:	Executive Director of Quality and Nursing		



Infection Prevention and Control:
Sharps Policy safe use and disposal

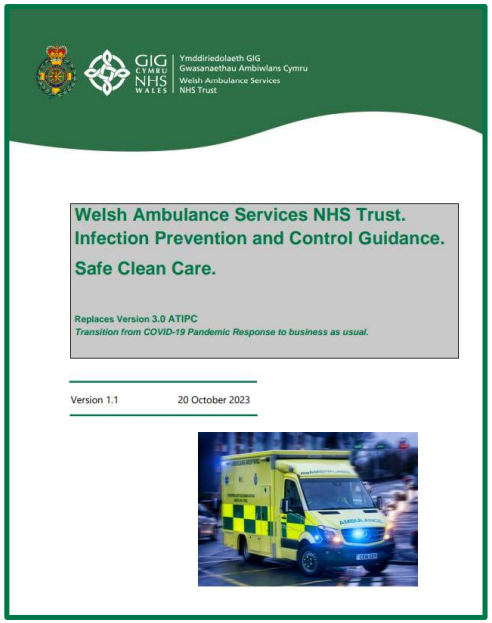
Policy Number:	096	Version No:	1.3	Supersedes:	Occupational Exposure Management Including Needlestick (or sharps) injuries Procedure Version: 0.5
Date of Approval:	01/12/20	Review Date:	3 years from date of approval	Impact Assessments Completed:	Yes
Classification of Document:	Corporate	Type of Document:	Policy	Approved by:	Quality, Patient Experience and Safety Committee
Brief Summary of Document:	Sharps are responsible for a significant number of injuries to staff each year. Safe use of sharps will help to reduce the risk of injury and the acquisition of blood-borne viruses by both staff and patients. For the purpose of this policy the term "sharps" includes items such as needles, scalpels, razor blades, broken glass and any other sharp items that may cause a penetrating injury, laceration or puncture to the skin.				
Scope:	This policy covers infection prevention and control management issues for all Trust staff this includes:- Employees, Volunteers Agency/Locum/Bank Staff and Contractors whilst working on the Trust premises				
To be read in conjunction with:	• Infection Prevention and Control Policy • Standard Operating Procedure Occupational Exposure to Blood or Body Fluids, July 2020 • The Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 No.645 • All things IPC Guidance Document 2020 All things IPC • Datix link				
Owning Committee	Quality, Patient Experience and Safety Committee				
Policy Lead: Trade Union Lead	Louise Colson Gareth Price	Job Title:	Head of Infection Prevention and Control Trade Union Partner		
Executive Director:	Claire Roche	Job Title:	Executive Director of Quality and Nursing		

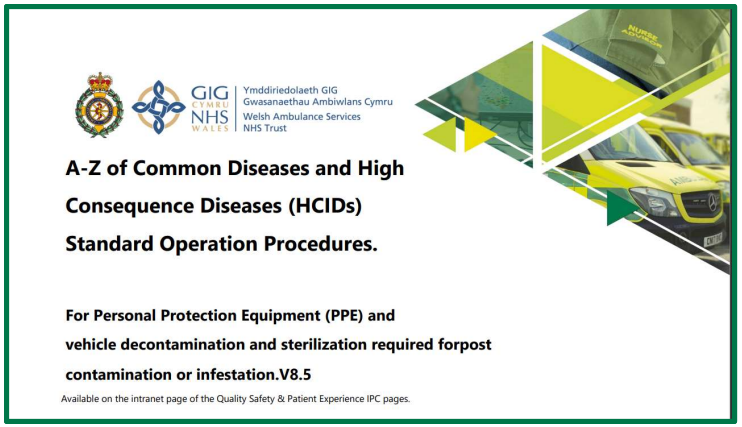
IPC Governance: Guidance Documents

Version 1.0 of the **Safe Clean Care** (SCC) Guidance published 21st July 2023 replacing version 3, of the **Transition from COVID-19 Pandemic Response to business as usual.** Version 1.1 updates to the guidance was made in October 2023.

Measles Guidance developed on guidance released by UKHSA on the 4th September 2023. Version 2 Updated following position statement from AACE 6th February 2024.

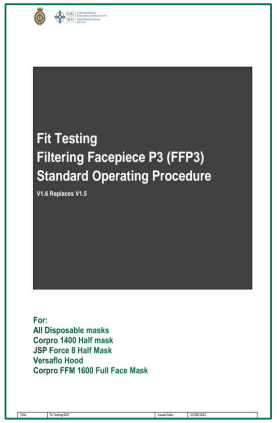
A-Z Common Diseases , now available to staff via JRCALC.

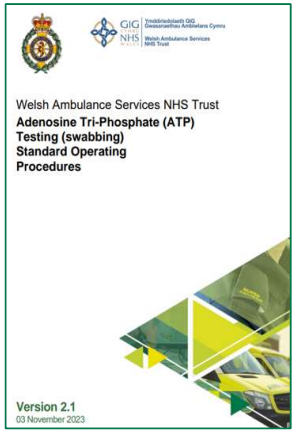


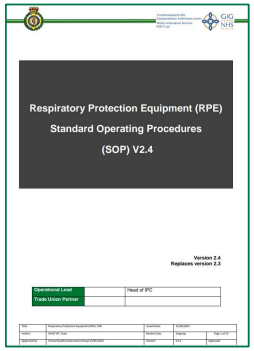


IPC Governance: Standard Operating Procedures (SOPs)

Approved SOPs

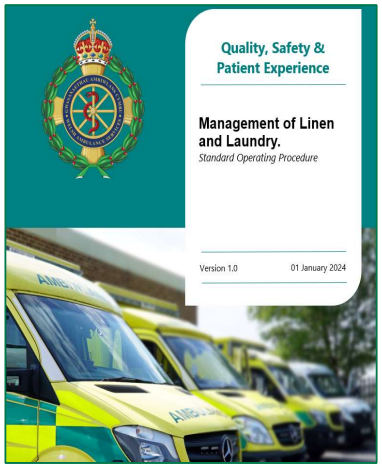






HCID SOP
3P Project
Notices
Risk Assessments

SOPs to be presented for approval.



IPC Governance 3P Project. Power Policies and Procedures.

Infection Prevention and Control 3 P													
Policy	**RACI**	**Guidance Document**	**RACI**	**Standard Operating Procedures**	**RACI**	**Standards of Practice**	**RACI**	**Audit Tools**	**RACI**	**Risk Assessments**	**RACI**	**Training**	**RACI**
Infection Prevention and Control, Elimiation Of Healthcare Assiciated Infections (Current three year review in progress)	QSPE IPC	Infection Prevention and Control IPC Guidance Safe Clean Care V1 A-Z Common Diseases v 8.4	QSPE IPC QSPE IPC	Fit Testing SOP RPE SOP ATP Swabbing SOP Hand Hygine and BBE SOP Linen SOP HCID SOP Outbreak Management SOP Uniform Dress CODE SOP	QSPE IPC Med/Dir Operations	Hand Hygiene Standards of Practice Use of Personal Protective Equipmen (PPE) Respiratory hygiene / cough etiquette	QSPE IPC TBC TBC	Vehicle Cleaning Audit Hand Hygiene Maintenance Logs ESR Reports	QSPE IPC	Hand Hygiene Management of Linen Patient friendly wipes Corpro valve replacement FIT testing Red level PPE and Versaflo training RPE filter change on versaflo hood units Cleaning of Versaflo Hoods	QSPE IPC	Level 1 Level 2 Pre-Hospital Care Level 2 Best Practice and Behaviours MOOC On Click Training MIST Training for IPC	
IPC Sharps Policy (Review due 01/12/23)	QSPE IPC	Health and Safety Regulations 2013	QSPE IPC	Occupational Exposure to Blood and Bodily fluids Invasive Procedures SOP	PSH Occ Health MED/Dir	Sharps safety Safe injection practices National Safety Standards for Invasive Procedures (Aug 2023)	TBC TBC	None Known ANTT Audit	TBC TBC		?	On Click Training	
Premise and Vehicle Cleanliness Policy (Current three year review in progress)	QSPE IPC	Workstation Cleaning Guidance	QSPE IPC	Vehicle Decontamination SOP		[illegible] Cleaning Standards Vehicle Cleaning Standards UK National Cleaning Standards	QSPE IPC	Environmental Cleaning Audit	QSPE IPC	How to clean a vehicle contamina	QSPE IPC	On Click Training Training videos MIST [illegible]	
Waste Management Policy (New Policy currently going through Policy Group Process)	Estates		Estates	Dispoal of Healthcare Was	Estates								
Medical Devices Management Policy Equipment (Under review via Policy Group)	MED/DIR	Manufactureres Decontamination Library	TBC			Sterile instruments and devices.				Decontamation of mobile devices			
ANTT Policy (recent review from PHW requires WAST update)	OSPE/IPC									ESR Emergency ANTT National ANNT Training ESR			
Multi Drug Resistance Organisms (MDRO) Policy (replaces the AMR Delivery	MED/Dir												

Respiratory Protection Equipment (RPE)

An SBAR paper was presented to the Senior Operational Team (SOT) on 28 April 2023 highlighting some of the challenges in relation to RPE provision long term with the recommendation that a task and finish group be established to explore and find options for a long-term sustainable model.

Four Options were presented with a recommendation that the preferred Option was 4.

	Description	Advantages/Benefits	Disadvantages & Risks
Option 4	To cease fit testing and provide two **vehicles based** PAPRs, with two full hoods for EMS services. All EMS patient facing staff provided with half hoods. Non-Emergency Services provided with two localities based PAPR units with two full hoods and two half hoods. Risk Assessment in progress for PPE requirement of ACA1's and CFR's	• The highest standard of RPE protection due to little chance of miss-fitting and no mask seal disruption during use. • WAST legally meeting its obligations. • Lower cost than option 2 • Substantial cost saving due to lower numbers of turbo units, hose, filters, and belts required. • No fit testing required. • No Fit testing required. • No 3 yearly re-testing required. • 80% less training time required than in option 1. • Training easily provided by local competent person. • No need for Fit testing kits. • 50% Reduction of Portacount annual costs • Less UHP lost.	• Second Highest initial cost. • Procurement of stock for resilience. • Staff complying with its indicated use. • Staff complying with mandatory maintenance logs regarding the hoods. • Safe storage of equipment on vehicle. • Responsible person to be identified locally to manage maintenance, repair, and availability of shared equipment to duty staff. • CFRs would be unable to share equipment in some instances, dependent on deployment procedures, i.e., using own vehicle to respond and nobody locally to share PAPR equipment with. • Staff competency in donning and doffing Maintaining resilience in having only one form of RPE. • Maintenance checks and cleaning

Progress

- T&F group now moved into Implementation Group to reflect progress
- Monthly AAA progress reports sent to Senior Quality Team, QSPE and Senior Operation Team.
- Pilot to commence in the North of Wales
- Currently populating units onto identified areas within vehicles/premises for AC.
- Main current challenge assurance regarding maintenance and cleaning.

Training and Education

Previous Training Modules developed during COVID-19 Pandemic

WAST learning zone
WELSH AMBULANCE SERVICES NHS TRUST

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

Infection Prevention and Control Courses

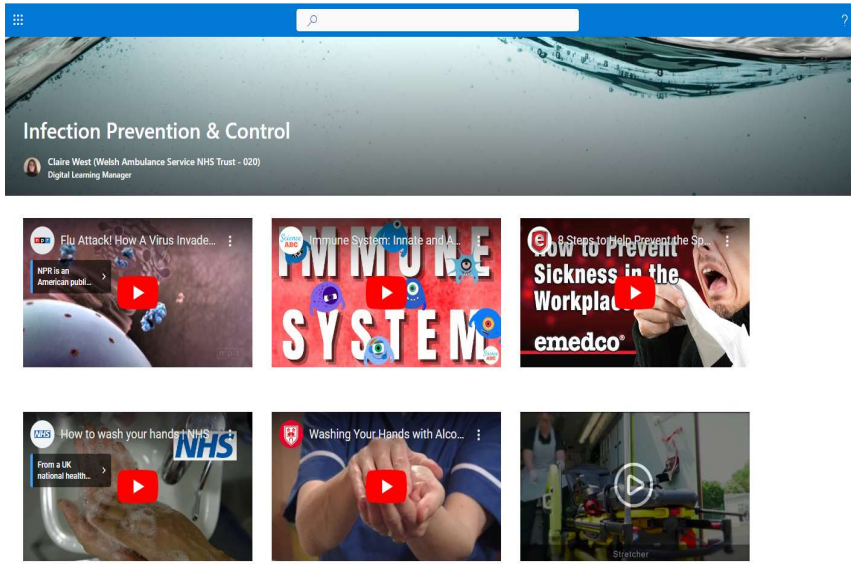
Please select from the Infection Prevention and Control courses below:

- Transmission of Infectious Diseases
- Evolution of a Pandemic
- Personal Protective Equipment (PPE) (Part A)
- Powered Respiratory Protective Hood (Part A)
- Day in the Life on the Frontline
- Vehicle Cleaning, Sharps and Waste Management

On Click Modules are no longer being used as the primary educational platform for IPC Training.
These were largely developed as a result of the COVID pandemic.

IPC Training 2024

All IPC Educational resources have been transferred to LMS365. All have been updated. Reporting of compliance will remain under ESR reporting.
There are four IPC modules to complete the Evolution of a Pandemic and a Day in the Life on the Frontline were COVID specific and are no longer required.



As each module goes live reporting from LMS365 will replace the reporting from the on click resources.

Team Activity: External Partners

Peer Reviews
The IPC service within the Trust has participated in two peer reviews.
The first on the 9th May 2023, this was a peer review of WAST IPC services done by South Central Ambulance Service IPC Lead.

The Head of IPC in return completed a peer review in the Southwest Ambulance Service on the 29th September.

Both reports are currently with the Association of Ambulance Chief Executive (AACE) and to date have not been published.

Public Enquiry
Much time has been dedicated over the last twelve months and still, for the preparation of documents, statements and information for the COVID- 19 public enquiry. This will likely continue into 2024/25.

Team Activity: Audits Completed

Audit Area	Key Issues	Positive Finding	Areas of focus	Actions to be Taken
Vehicle Audits (10% of Fleet Snapshot)	Excessive debris, floor damage, and poor cleaning consistency	ATP testing implemented to assess cleaning quality	Inconsistencies in vehicle hygiene processes	Standardise vehicle hygiene protocols and ensure staff compliance
Premises Audits (10% Premises Snapshot)	Structural wear (e.g., old flooring, missing door handles), food debris, and cleanliness gaps	Audits highlight specific areas needing improvement	Contractor compliance and monitoring	Strengthen contractor oversight and address structural issues
Sharps Management	Overfilled sharps containers and improper assembly	Evidence of heightened awareness of sharps management	Improved staff adherence to sharps policy	Provide targeted training and reinforce sharps management policies
Respiratory Protection Equipment (RPE)	Transition to Power-Assisted Respiratory Protection (PAPR) underway	PAPR rollout initiated with pilot program in place	Maintenance and cleaning of PAPR units	Conduct regular audits and improve maintenance processes for PAPR
Education & Training	Transition from pandemic-focused resources to ongoing LMS365 modules	Updated resources available on LMS365	Compliance tracking during transition	Monitor compliance rates and provide ongoing training via LMS365
**Digital Audit Tools Development*	*Objective to automate infection control audits for vehicles, premises, and processes*	*Automation planned to streamline processes*	*Delayed digitisation of audit processes*	*Finalise automation URD development and move to an appraisal of 'buy v build'*

**Not direct audit activity but requiring people resource dedicated to addressing inefficiencies, improving compliance management and enhancing reporting capabilities.*

Key Priorities for 2024-2025

Respiratory Protection Implementation Group

This group will continue to work for at least the next twelve months to ensure full completion of the project.
The biggest challenge at this point is to ensure that as many current RPE units in circulation can be identified and repurposed.
Ensure that the project does not overspend
There are clear standard operating procedures in place
There are clear maintenance guidelines and that audits are done to ensure compliance

Team Resources

Since April 2024 the team has seen shifts in roles and working hours. Over the last twelve months the team have welcomed three new members of staff and there is currently a vacant Band 7 post currently being recruited into.
Sickness within the team is low with good morale and motivated staff.
All PADRs have been completed along with Mandatory Training.
One member of staff is due to commence her Masters in IPC at Leeds University which will be essential for succession planning and the future of IPC services within the Trust.

IPC Roadshows

There is at the latter part of 2024 an appetite to reinvigorate the Safe Clean Care Campaign designed pre COVID-19 pandemic, the planning, logistics and content is under development currently.
Digital Services and Audit Tools

Key Priorities for 2024-2025 contd.

Digital Services: Current Audit Tools Versus The Future

The IPC team along with Digital colleagues within the Trust are currently at the early stages of developing a robust IPC User Requirement Document (URD). a High-Level Design Specification for an IPC Internal Audit automation tool for WAST that has the potential to benefit other areas such as Health & Safety. This iterative process will explore two strategic options: 'Buy vs Build', evaluating whether to procure an off-the-shelf solution or develop a custom-built system. The process and URD document translates our requirements into system design components, focusing on architecture, functionality, and technology solutions based on the Microsoft technology that will enable automation and digitalisation of our Infection Prevention Control audit processes, addressing inefficiencies, improving compliance management, and enhancing reporting capabilities.

Audits for consideration in this process include the following:

- ANTT audits, previously this was done by the clinical effectiveness team printing off almost 1000 patient care records and the team trawling through them, we are in the process with the clinical effectiveness team now looking at extracting this information from the ePCR.
- Hand Hygiene and BBE.
- Premise Audit tool (we currently have this on Microsoft tools that the IPC team developed).
- Vehicle Audit tool (we currently have this on Microsoft tools that the IPC team developed).
- Waste Management (currently no audit tools)
- Sharps (currently included in the vehicle audit tool but no stand-alone audit tool).

Conclusion

This Annual Report on IPC highlights the dedicated work of the IPC team within the Trust and the critical importance of maintaining stringent measures to safeguard the health of our patients ,staff and the community at large.

Over the past year we have observed challenges in our IPC practices, yet as a team we have seen notable successes in meeting these challenges, underscoring our commitment to continuous improvement.

In a bid to reduce our contributions to Health Care Associated Infections, our dedicated team have actively sought opportunities to implement evidence-based strategies, monitor compliance with established protocols and facilitated regular staff training sessions.

Though global threats to infection control efforts remain, with emerging pathogens, mutated pathogens combined with an increased ease in societies abilities for worldwide travel, we remain alert to the need to remain vigilant, adaptable and proactive is addressing these challenges. Our collaboration with local health board partners and external agencies is vital to this, with an emphasis on research and best practices being essential in continuing to enhance our IPC strategies.

Looking forward we aim to build upon the successes of this past year. Objectives include enhancing our monitoring and surveillance, improve our data collection, audit data and analysis with a bespoke audit tool as well as continuing to promote a culture of safety and accountability across all levels of the Trust.

Our commitment to good infection prevention and control is unwavering. The health and safety of our staff and patients are at the heart of what we do, and our continued IPC success will require the continued WAST wide collective efforts and dedication.

THANKYOU

GIG CYMRU NHS WALES

Ymddiriedolaeth Brifysgol GIG
Gwasanaethau Ambiwlans Cymru

Welsh Ambulance Services
University NHS Trust

Ymddiriedolaeth Brifysgol GIG Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services University NHS Trust

AGENDA ITEM No	**20**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**1**

PATIENT EXPERIENCE AND COMMUNITY INVOLVEMENT INTERNAL AUDIT REPORT

MEETING	Quality, Patient Experience & Safety Committee
DATE	4 February 2025
EXECUTIVE	Liam Williams, Executive Director of Quality and Nursing
AUTHOR	Penny Durrant, Deputy Director of Nursing, Quality and Governance (Interim)
CONTACT	Penny.durrant@wales.nhs.uk

EXECUTIVE SUMMARY

1. The Patient Experience and Community Involvement (PECI) Report provides the Board with a clear and comprehensive view of the Trust's efforts to embed public engagement into its governance and operational structures.

2. Significant assurance mechanisms are in place, supported by Governance Frameworks such as the Quality Management Group (QMG) and the Quality, Patient Experience and Safety (QuESt) Committee, which oversee the integration of public feedback into service design and delivery. The Duty of Quality Annual Report further reinforces external accountability, demonstrating the Trust's commitment to transparency and continuous improvement.

3. The Report highlights the depth of engagement activities conducted, including 147 logged events since January 2023, and the systematic reporting of themes and outcomes through the PECI Bi-Annual Reports. The QMG, with its dedicated focus on Citizen Voice and Patient Experience, plays a critical role in ensuring public feedback informs strategic decision-making. The robust governance structures in place allow for regular updates to stakeholders, including the Trust Board, providing assurance that engagement activities are being actively monitored and acted upon.

4. However, the review also identifies opportunities to strengthen these assurance mechanisms further. While engagement activities and outcomes are reported, there is limited evidence of formalised feedback loops that demonstrate the tangible impact of public involvement on service delivery.

5. To address this, Management Actions include enhancing the Public Engagement Log to track specific questions, the actions taken, and feedback provided. This will ensure greater accountability and transparency, enabling the Board to better understand how public feedback translates into service improvements.

6. Additionally, the PECI Team's Work Plan will be refined to align more closely with operational priorities and transformation goals. This includes introducing a population health-based approach to analysing feedback and reporting variations in outcomes across Wales. These enhancements will allow for more targeted and meaningful engagement, ensuring that public feedback reflects the diverse needs of the communities served by the Trust.

7. Survey participation remains a key focus, with measures being implemented to increase response rates and ensure questions remain relevant. The QMG will oversee an annual review of Survey questions, strengthening the link between feedback and operational improvements. Assurance mechanisms will also be bolstered through formal processes requiring Operational Teams to review feedback and report on actions taken, with oversight provided by QuESt and other Governance Groups.

8. Overall, the assurance provided through existing Frameworks is robust, but the proposed enhancements will significantly strengthen the Trust's ability to demonstrate the value and impact of public engagement. By implementing these actions, the PECI Team will ensure that public feedback is systematically captured, acted upon, and reported, offering the Board greater confidence in the Trust's commitment to patient-centred care and continuous improvement.

RECOMMENDED that the Quality, Patient Experience & Safety Committee notes the Internal Audit outcomes, recommendations, Management Responses and next steps.

KEY ISSUES/IMPLICATIONS
(i) Regular review of Survey questions and responses will need to factor in the revised Welsh Government's People's Experience Framework, its Patient Reported Experience Measures (PREMS) and validated core questions. To increase number of Surveys and returns the Trust can utilise the SMS text messaging facility within the (Once for Wales) Civica System and survey 999 callers. A Data Protection Impact Assessment (DPIA) covering sending Experience Surveys to 999 callers has been drafted and is currently with the Information Governance Lead for approval ahead of a formal consultation with the Information Commissioner's Office.

(ii) To demonstrate that appropriate safeguards are in place that will avoid Surveys being sent to vulnerable or inappropriate call types, the Dispatch Cross Reference (DCR) Table of over 2,000 potential dispatch codes has been reviewed to identify codes that will be excluded from receiving a request for feedback.

(iii) Reporting of impact and outcomes of improvements to service provision will be achievable by ensuring a systematic approach to engaging with operational services to enable a more defined approach to public engagement and community involvement.

REPORT APPROVAL ROUTE	
Clinical & Quality Governance Group	21 January 2025
Quality, Patient Experience & Safety Committee	4 February 2025

REPORT APPENDICES
ANNEX 1 - Patient Experience and Community Involvement Audit Report

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

Patient Experience & Community Involvement

Final Internal Audit Report

November 2024

Welsh Ambulance Services University NHS Trust

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

GIG CYMRU NHS WALES
Ymddiriedolaeth Brifysgol GIG Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services University NHS Trust

Contents

Review reference:	WAST-2425-08
Report status:	Final
Fieldwork commencement:	30 August 2024
Fieldwork completion:	26 September 2024
Debrief meeting:	07 October 2024
Draft report issued:	10 October 2024
Management response received:	7 November,11 November & 19 November 2024
Final report issued:	20 November 2024
Auditors:	Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit; Henry Wellesley, Audit Manager
Executive sign-off:	Liam Williams, Director of Quality & Nursing
Distribution:	Leanne Hawker, Head of Patient Experience & Community Involvement; Penny Durrant, Interim Deputy Director of Nursing, Quality & Governance; Estelle Hitchon, Director of Partnerships & Engagement; Wendy Herbert, Assistant Director of Quality & Nursing
Committee:	Audit, Risk & Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

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

Executive Summary

Purpose

To provide assurance on compliance with the Health and Social Care Quality Engagement Act and alignment with the Trust's IMTP.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Enhancement of expected activity to be undertaken by the PECI Team;
- Regular review of survey questions posed to ensure relevancy and provision of meaningful feedback for service providers;
- Enhancement of the detail included in the log of public engagements; and
- Enhancement to reporting on the impact and outcomes that engagement activities has had on service delivery.

Other recommendations / advisory points are within the detail of the report.

Report Opinion

		Trend
Reasonable 	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.	N/A

Assurance summary[1]

Objectives		Assurance
1	Framework for public engagement practice	Reasonable
2	Output from public engagement activities	Reasonable
3	Reporting and monitoring of progress and outcomes	Reasonable

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Enhancement of expected PECI Team activity	1	Design	Medium
2	Enhancements required to the public engagements log	2	Design	Medium
3	Regular review of survey questions and responses	2	Operation	Medium
4	Reporting of impact and outcomes of improvements to service provision	3	Design	Medium

1. Introduction

1.1 Effective service user, carer and public engagement is vital in helping develop more effective services that better meet patients' needs, with higher quality user experience, greater community support, improved staff morale, and higher levels of productivity and efficiency. Welsh Government guidance on public engagement and consultation requires health bodies and trusts to have in place arrangements for continuous engagement with the public through which most significant service change plans will be shared. NHS bodies are expected to monitor quality and safety at board level and throughout the entirety of services, partnerships, and care settings.

1.2 The Welsh Ambulance Services University NHS Trust (the Trust) captures and reports the experience of patients and their families directly using the Trust's continuous engagement model and various channels for experience feedback. Although there is a subjective nature to this indicator of quality, experiences and feedback are essential components for monitoring and serving as quality indicators, as outlined in the Health and Social Care (Quality and Engagement) (Wales) Act.

1.3 Patient experience at the Trust is influenced by the many interactions people have with its staff, their expectations when in need, and their first and lasting impressions of those interactions.

1.4 Management of this patient experience is through the Patient Experience and Community Involvement (PECI) Team, which sits within the Quality, Safety & Patient Experience (QSPE) Directorate; and we note the recognition received for their work in this area. Most recently, being named as 2024 finalists in the Patient Experience Network National Awards (PENNA) within the following categories:

- Engagement/Championing the Public – for work on improving the experiences of people with learning disabilities.
- Innovative use of technology/social and digital media – for work with children and young people in developing the blue light app based on evidence-based research, using technology and digital solutions to engagement.
- Partnership Working to improve the Experience – for promoting work undertaken across all health, social care, business and voluntary sectors to reach, engage and improve experiences of communities across Wales.

1.5 The risks considered during the course of this review included the Trust failing to implement an effective and continuous approach to engagement; and non-compliance with legislation and guidance on public consultation.

2. Detailed Audit Findings

2.1 The table below summarises the recommendations raised by priority rating:

	Recommendation Priority			
	High	Medium	Low	Total
Control Design	-	3	-	3
Operating Effectiveness	-	3	-	3
Total	-	6	-	6

2.2 Our detailed audit findings are set out below. All matters arising and the related recommendations and management actions are detailed in Appendix A.

Objective 1: The Trust has a framework in place which sets out the approach to ensuring the application of good and effective public engagement practice, and in accordance with the Act.

2.3 The responsibility for formal engagement and public consultation within the Trust sits with the Partnerships and Engagement Directorate, and the PECI Team has an important role to support and contribute to this work.

2.4 The Trust's Engagement Framework was approved by Board in July 2022. This is being supported through the Engagement Framework Delivery Plan which was presented to Board in January 2023; and sets out, at high level, the proposed phases of engagement and potential consultation required with stakeholders, staff and the public.

2.5 The Plan provides detail as to the phasing in of proposed engagement, spanning an indicative period of two years, linked to the Trust's vision of altering its traditional service model and how it will manage demand differently. The model is reliant on engagement with the public and partners to develop a model where more patients are referred to other services, e.g. pharmacies, or are treated in their home, by an advanced paramedic or the Falls Service.

2.6 At the conclusion of our fieldwork, we were advised that this document has recently been recast as the Programme Engagement Plan supporting the Trust's Clinical Model Transformation (CMT) programme. We understand that while in essence the tenets of the plan remain the same, the revised version provides further detail and messaging and has been shared with the Citizen Voice Body for Health and Social Care (Llais) at a national level. We note that the plan was submitted for approval to the September meeting of the CMT Board, with the minutes noting some areas for refinement; and we note that delivery and implementation of such will be monitored at the CMT Board.

2.7 The National Health Service (Wales) Act 2006 requires Local Health Boards and NHS Trusts, with regard to services they provide or procure, to involve and consult citizens. The Delivery Plan outlines the Trust's approach to ensuring there is a

shared understanding of issues and gain public support for, and input into, options for change as:

- To begin a dialogue with the public/interest/patient groups on future direction of travel/provision of services.
- To ensure public is aware of challenges, reasons for them, what has been done to-date to tackle them and why more of the same is no longer sustainable; and
- To gain support for the development of options.

2.8 The Plan does not outline the details of its approach to public engagement, but we note that this is in the early stages of being reviewed for update (see para 2.6), recognising that engagement is phased across stakeholders (with the public not being in the first phase).

2.9 We were able to evidence a significant level of engagement activity that has informed the development of the Trust's IMTP 2024-27 (refer to ***audit objective* 2**), and we note that the QSPE Directorate's Local Delivery Plan sets out a range of objectives for the PECI Team on their wider delivery linked to the IMTP. Whilst the PECI Team have a schedule of activity in place, we understand that they were set an objective to better define population understanding through the lens of economic status, geography, ethnicity and age, however there was no evidence of this (see **Matter Arising 1**). Activity defined should formally capture areas such as:

- The geographical coverage.
- The targeted level of survey responses and characteristics.
- The services being surveyed; and
- The feedback mechanism.

2.10 Government guidance, following the establishment of Llais, requires sustained and continuing engagement with citizens, Llais and staff, as well as partners, on a routine basis. The engagement should give people and organisations the opportunity to understand the NHS body's aspirations and achievements and the challenges it faces so they can influence and inform decisions about service changes.

2.11 Therefore, it is important for WAST to demonstrate that it has been listening and taking appropriate action on the feedback it receives. The guidance states that NHS bodies should undertake stakeholder mapping to help identify stakeholders and those who can help the NHS engagement with them. Such is evidenced within the identified phases of the Delivery Plan.

Conclusion:

2.12 The Trust's Engagement Framework and supporting Delivery Plan (which has recently evolved to a Public Engagement Plan to support the Clinical Model Transformation programme) set out the principles for public engagement with service change proposals for which the responsibility sits with the Partnerships and

Engagement Directorate, with input from the PECI Team. The QSPE Directorate's LDP set out a range of objectives for the PECI Team on their wider delivery; however, there is a need to better define and coordinate its activities. Therefore, we have provided **reasonable** assurance for this objective.

Objective 2: Experiences and feedback received from public engagement activities are considered to inform service change.

2.13 Service changes arise from a wide variety of sources and may be incorporated into Trust delivery plans as individual IMTP deliverables, or as part of a broader transformation programme. The Transformation Support Office support the strategic transformation agenda across the organisation.

2.14 As per para 2.9, the PECI Team has a schedule in place to capture public engagement activity. However, this was not explicitly evidenced as linked to planned service transformation, within the Trust, indicating there is a lack of a systematic approach to engaging with operational services to enable a more defined approach to their patient experience and community involvement work. PECI are not always aware of the service changes that require engagement, and would drive their activity, which should be based on an assessment of the scale, scope and impact of the proposed service change against set criteria (see **Matter Arising 1**).

2.15 The PECI Team logs all public engagements undertaken onto the CIVICA database. As at the date of fieldwork, since January 2024, 147 events had been recorded. Included in the information recorded is the detail of the PECI Team member who attended the event, the number of people engaged with; and the learning outcomes taken from the event, the themes of which will be discussed at Quality Management Group for onward consideration at Service quality groups, if applicable. However, we note that no details are recorded on the database for questions asked (and by whom), the key actions following the event; and whether, once action has been taken has such been communicated to the member of the public. (see **Matter Arising 2**).

2.16 A review of the events attended found that the geographic spread of these events was not consistent (ref para 2.7). The PECI Team acknowledge this location disparity and are taking steps to address it (see **Matter Arising 2**).

2.17 We do, however, recognise where action has been taken as a result of the engagement activities. For example,

- The development of a 'blue light app' for children which helps them understand the services offered by the Trust and how to engage with its services.
- Engagement with the Learning Needs community to understand the accommodations and adjustments that would be needed when attending a patient with additional needs. This has resulted in the development of a new ePCR tab, live from 1 October, providing prompts to responders to ensure better support for Autistic, Learning Disability and Neurodiverse patients across Wales.

- Reminiscence Interactive Therapy Activity (RITA) recognising the patient feedback and safety concerns for patients living with dementia, as well as those with sensory loss, and how important the environment is for them when receiving ambulance care. The Trust has received several awards for its work in this area.

2.18 Further, the team use patient stories to work with patients, their families and their carers to share their experiences through videos and case studies. These allow readers to experience the frustration and obstacles faced by patients or their carers and are used to inform Trust Board, train staff and implement service change.

2.19 The PECI Team also undertakes four core surveys that are constantly available to the public on its website:

- 999 EMS - Experience Survey (*October 2023 – March 2024: 69 responses).*
- NHS 111 Telephony service – Experience Survey (*October 2023 – March 2024: 100 responses).*
- NHS 111 Website – Experience Survey (*October 2023 – March 2024: 228 responses).*
- Non-Emergency Patient Transport Service (NEPTS) – Experience Survey (*October 2023 – March 2024: 702 responses).*

2.20 As reported in the PECI bi-annual report to the Quality, Patient Experience and Safety (QuEST) committee (May 2024), the volume of responses (as per para 2.16) was an area which needed to be addressed to ensure that analysis of responses was meaningful (see **Matter Arising 3**). We understand that the PECI Team is in the process of submitting a Data Protection Impact Assessment (DPIA) to the Information Commissioner's Office, post engagement with the Trust Public Network to demonstrate engagement with the affected stakeholders, with the objective being to permit users of the service to be sent a text message inviting them to a survey.

2.21 As well as recognising the importance of increasing the response rate to surveys to shape the future delivery of WAST services; there is a need for the questions included to be reviewed to ensure they remain relevant to allow the responses to provide meaningful feedback to those delivering the services (see **Matter Arising 3**). We were only able to ascertain survey questions having been reviewed by one service (the 999 clinical contact centre).

2.22 Survey responses/feedback is reported to the Quality Management Group (meets weekly), and onward to QuEST yet we were not able to identify that services had formally responded where there is a suggestion that there is a need to address a weakness (see **Matter Arising 4**).

Conclusion:

2.23 There is a process for the analysis, assessment and reporting of engagement responses, which has led to service change, but further enhancements are required to review the integrity of the content of surveys as well as to complete the feedback loop. Whilst acknowledging the extent of engagement that is undertaken, there is

no systematic approach to planning engagement based on known transformation projects. Therefore, we have therefore provided **reasonable** assurance for this objective.

Objective 3: Committees and Board oversee the overall approach to public engagement, and the progress and outcomes of the service development activities.

2.24 The Quality Management Group (QMG) is a weekly quality group chaired by the Assistant Director of Quality Governance, and reports into the Clinical & Quality Governance Group. The QMG's role is to '*ascertain the performance of the Trust across the quality domains and enablers, as set out in the Statutory Guidance and Quality Standards 2023, utilising expertise to assess, assure and inform stakeholders of organisational performance'*. As stated in the QMG terms of reference, one of its duties is to *listen to, and act upon, the experience of services with communities and service users, so that services are designed to meet the needs of the citizens that the Trust serves.*

2.25 Review of the agendas for the QMG notes the standing agenda item for Citizen Voice and Patient Experience. Further, review of the AAA (Alert, Advise and Assure) reports prepared post the QMG meetings notes the detail of the updates that have been provided regarding actions taken post receipt of patient feedback/experience.

2.26 Reporting is also undertaken to the QuEST committee through the bi-annual report produced by the PECI team. The last report, presented to the May 2024 meeting, covered the period October 2023 to March 2024. The report sets out the key themes arising from feedback during the period as well as the focus of the team's work programme for the same period.

2.27 Assurance on the activities of the PECI Team have also been provided to Trust Board through the AAA report. However, we noted there is minimal reporting on the impact the engagement activities have had, where applicable, on improvements to service delivery. See **Matter Arising 4**

2.28 The first Duty of Quality Annual Report was issued in July 2024 for 2023/24. This has been shared in the public domain and provides information setting out the quality of services provided by the Trust; and the systems in place to identify and implement improvements. There is a section included on '*Listening to our citizens'* setting out the work undertaken in the year.

Conclusion:

2.29 An appropriate reporting framework is in place to detail the public engagement that has been undertaken; with external reporting to the wider population and stakeholders through the Duty of Quality Annual Report. Further work is required to strengthen the reporting on the impact and outcomes that engagement activities have had on service delivery. Noting this, we have provided **reasonable** assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Enhancement of expected PECI Team activity (Design)	Impact
Government guidance states that NHS bodies should undertake stakeholder mapping to help identify stakeholders and those who can help the NHS engagement with them. Such is evidenced within the identified phases of the Trust's Delivery Plan however it doesn't outline the details of its approach to public engagement. Whilst we were able to evidence a significant level of engagement activities, and also understand that the PECI Team were set an objective to better define population understanding through the lens of economic status, geography, ethnicity and age, however there was no evidence of this. Activity defined should formally capture areas such as: • The geographic coverage. • The targeted level of survey responses and characteristics. • The services being surveyed; and • The feedback mechanism. Further, the schedule of activity was not explicitly evidenced as linked to planned service transformation within the Trust, indicating there is a lack of a systematic approach to engaging with operational services to enable a more defined approach to their public engagement and community involvement.	Potential risk of: • Unrepresentative feedback. • Lack of buy-in from services. • Failure to communicate service change.

Recommendations		Priority
1.1	The PECI team's work plan should be reviewed to better define and coordinate their activity.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
1.1	1. A Masterclass in the use and effectiveness of the PECI team intelligence and feedback to be undertaken with Trust ADLT in Q4 2024/25.	March 2025	Leanne Hawker, Head of Patient Experience and Community Involvement
	2. PECI team to continue ongoing input and liaison with regard the CMT Programme and Engagement Plan to ensure alignment and support to community conversations and involvement.	February 2025	
	3. PECI team to devise a proforma for directorates and quality improvement programmes/projects to request support and involvement to their scheme of work.	April 2025	
	4. PECI team to develop a population health-based approach to analysing interventions and involvement across Wales, enhancing reporting to inform where variation occurs and linking with Clinical and Quality teams to confirm how/where PECI team can support increased improvements in outcomes.	August 2025	

Matter Arising 2: Enhancements required to the public engagements log (Design)			Impact
A log of all public engagements is maintained by the PECI team. As at the date of audit fieldwork, 147 events had been logged since January 2023. The log records the PECI team member who attended, the number of people engaged with, and the learning outcomes taken from the event. However, it does not require the user to log what questions were asked and by whom, the key actions following the event and whether once action was taken was this fed back to the member of the public. A review of the events attended found that the geographic spread of these events was not consistent (see Matter Arising 1). We understand that the geographically spread was not as wide as the PECI team would have liked due to capacity constraints.			Potential risk of: • The Public do not receive feedback to their questions. • WAST cannot demonstrate its level of engagement with the public. • Feedback does not geographically reflect the whole of Wales.
Recommendations			**Priority**
2.1	The log of public engagements should be enhanced to identify what questions were asked, by whom, what action followed the event; and evidence of feedback provided to the originator of the question.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	The PECI reporting tool (engagement log) will be enhanced to offer the opportunity for individuals to have their personal details recorded to enable feedback on questions asked and offer feedback on actions taken as a result. A section will be included with link to evidence of email/correspondence sent in response to question/feedback.	December 2024	Leanne Hawker, Head of Patient Experience and Community Involvement

Matter Arising 3: Regular review of survey questions and responses (Operation)	Impact
It is recognised by the Trust that survey participation from the public needs to improve. Whilst the 999 service had the fewest number of survey feedback, 69 people between October 2023 and March 2024, the 111Wales survey was completed by 100 people in the same period. Survey responses to the 111Wales website were 228 people and for the NEPTS 702 surveys were completed. To be able to place more emphasis on the answers provided by survey responses it is important for the Team to continue their efforts to increase survey participation. As well as volumes another important aspect for surveys to play an important role in shaping the future delivery of WAST services it is important for the questions to be reviewed by operations, to ensure that the questions remain relevant and are that the responses are providing meaningful feedback to those delivering the services. We were only able to ascertain survey questions being reviewed by one service (the 999 call centre). Whilst survey and feedback is reported to the weekly Quality Management Group, and also to QUEST we were not able to identify that services formally respond to feedback where there is a suggestion that there is a need to address a weakness. Where improvements were identified and reported following feedback from the public, such as issues faced by users with learning difficulties accessing 999 services, the improvements to the service were led by the PECI team not the Service itself.	Potential risk of: • Survey feedback does not reflect the general view of service users. • Lack of buy in from operational services. • Failure to address operational weaknesses.

Recommendations		Priority
3.1	The Team should continue its work to increase survey responses to ensure there is significant level of response, to provide a level of assurance that responses reflect the views of the public.	**Medium**
3.2	Survey questions should be reviewed, at least annually, by Services and PECI, to ensure that the questions are still relevant and that the responses provide meaningful information for service providers, to identify any negative feedback which needs to be addressed.	
3.3	There should be a formal mechanism in place, to confirm that services have reviewed feedback and provide an update of the action taken, where applicable.	

Agreed Management Action		Target Date	Responsible Officer
3.1	1. A Data Protection Impact Assessment (DPIA) covering contacting 999 user by SMS Text message will be submitted to the Information Commissioner in November. The DPIA will identify and address risks and issues including what are the reasonable expectations of callers/patients to be contacted (this would be the first time in our Trust history that 999 callers would be contacted in this way), the lawful basis and opt-out process. A final public consultation on the proposal has been recommended; we will share details with the Trust's People & Community Network and invite feedback that will be included in the DPIA. The DPIA will be presented to IGSG in November before submission to the ICO. 2. Liaising with Fleet to explore use of QR Codes on vehicles to enable patients/families to access feedback surveys whilst waiting. 3. Liaising with PTR team the feasibility of including links to experiences surveys in all PTR touchpoints and correspondence.	December 2024 March 2025 March 2025	Leanne Hawker, Head of Patient Experience and Community Involvement
3.2	QMG will be the forum for annual review of survey questions. Terms of reference to be updated to include this requirement.	December 2024	Leanne Hawker, Head of Patient Experience and Community Involvement
3.3	QuEST will continue to receive assurance through QMG and other Trust groups that services have reviewed feedback and action has been taken, where applicable, as a result of PECI public engagement and involvement.	November 2024	Leanne Hawker, Head of Patient Experience and Community Involvement

Matter Arising 4: Reporting of impacts and outcomes of improvements to service provision (Design)	Impact
The bi-annual report from PECI includes details on the focus of their work programme as well as the key themes arising from feedback received for that period. Whilst assurances on the delivery of work is provided within the Trust, we noted there was minimal reporting undertaken in respect of the impact of this feedback / wider engagement activities has had in relation to service delivery, where applicable. There is scope to enhance the reporting within the CIVICA database (see Matter Arising 2) to collate the data to provide this feedback loop; as well as to enhance the reporting through Equality Impact Assessments.	Potential risk of: • The Trust not demonstrating the impact of engagement on service delivery.

Recommendations		Priority
4.1	Reporting should be enhanced to demonstrate the impact feedback and engagement activities have had on service provision.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
4.1	The CIVICA system hosts data around patient experience, developing a proposal form for engagement (see 1.1 above) will enable us to report enhanced impact from activities and demonstrate whether services are listening/acting on feedback.	April 2025	Leanne Hawker, Head of Patient Experience and Community Involvement

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**Unsatisfactory assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

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Welsh Ambulance Services University NHS Trust

AGENDA ITEM No	**21**
OPEN or CLOSED	**OPEN**
No of ANNEXES	**1**

AUDIT TRACKER 2.0 – DECEMBER 2024 (Q3)

MEETING	Quality, Experience and Patient Safety Committee (QuEST)
DATE	04 February 2025
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Trish Mills, Director of Corporate Governance/Board Secretary Lisa Trounce, Head of Compliance & Assurance
CONTACT	trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. This paper provides the Committee with the current position with respect to management actions for audits within the purview of the Quality, Experience and Patient Safety Committee (QuEST).

2. Of those internal audit recommendations relevant to this Committee**,** two have been closed in quarter of a total of eleven (18%). There are five recommendations which have had a change in date proposed (marked in blue). There are two open actions on their third revised date; action 604 (Pain Management internal audit) and action 683 (Electronic Patient Clinical Records (ePCR) Clinical Compliance internal audit).

3. Of those external audit actions relevant to this Committee, none have been closed in quarter of a total of three. One of the external audit actions has a new revised date proposed (marked in blue) taking it to the third revised date; 139 National Review of Patient Flow – A Journey Through The Stroke Pathway. There is specific reference to the two outstanding actions regarding the Review of Quality Governance:

    3.1 The Committee's attention is drawn to the two open actions – actions 106d and 106e. Based on the completion of the recent 'Quality Governance Follow Up Review' by Audit Wales it has been recommended that these actions will be replaced with new management actions and should remain open until then.

3.2 A corresponding narrative has been included on the Tracker, for the formal record.

4. The current version of the tracker is now open for Directorate review for actions due in January, February, and March 2025. These updates will then be reported to the Committee at its meeting in May 2025.

RECOMMENDATION:

5. The Committee is requested to:

(a) Receive and review any Internal Audits and Audit Wales reviews within their remit where relevant. There are none required for review at this meeting;

(b) Monitor management actions to address recommendations in the Tracker, noting any revised dates for actions (in blue).

KEY ISSUES/IMPLICATIONS
As set out above.
REPORT APPROVAL ROUTE
2024/25 Q3 Audit Tracker presented to ADLT on the 20 January 2025.

REPORT APPENDICIES
Annex 1 – Tracker 2.0 24-25 Q3 (October-December 2024) for Committee Reporting

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

SITUATION

6. This paper provides the Committee with the current position with respect to management actions for audits within the purview of the Committee.

BACKGROUND

7. In September 2023, the Audit Committee approved the Audit Process and Reporting Handbook. The Handbook has been further revised since this date to include Audit Wales content.

8. The Handbook includes roles and responsibilities for the various stakeholders including:

   - The Assistant Directors Leadership Team (ADLT) as the forum to agree closure of actions, taking a check and challenge role on the Tracker.

   - Different reporting for the Audit Committee and Executive Leadership Team (ELT) to that provided to Committees, with the latter focused more on individual audits, progress and impact, and Audit Committee and ELT on the broader audit framework, progress, and exposure. This will commence when Tracker 3.0 is developed which will draw the agreed reporting from the tracker via Power BI.

   - The introduction of a point of contact in Directorates for audits. This person(s) steers the audit with the Director and Assistant Directors/Deputies, ensuring internal audits feature on the directorate agenda monthly, they update the Tracker, and escalate issues as appropriate.

9. The Tracker has been updated at the end of Quarter three 2024/25, reflecting the position as of 31 December 2024. Members will receive a copy of the Tracker by email and are invited to filter the excel sheet to their respective Committee to view the relevant audit actions. A copy of the Tracker is also reproduced at Annex 1 filtered to the actions assigned to this Committee for oversight.

10. The team continues to work on the development of the SharePoint solution for Tracker 3.0 with colleagues in the Digital Directorate. It is intended that this solution will be ready to implement / use with effect from 2025/26 quarter one, with further required work being undertaken during 2024/25 quarter four to enable the transition from Tracker 2.0 to Tracker 3.0.

ASSESSMENT

11. The Handbook notes that it is the responsibility of a Board Committee (other than Audit Committee) to:

- Receive audits in their remit;
- Monitor management actions to address recommendations; and
- Scrutinise impact of actions in response to audit recommendations in terms of, for example, quality improvement, the provision of more efficient and effective patient care, improved governance, better use of resources etc.

Internal Audit

12. Of those internal audit recommendations relevant to this Committee**,** two have been closed in quarter of a total of eleven (18%). There are five recommendations which have had a change in date proposed (marked in blue). There are two open actions on their third revised date; action 604 (Pain Management internal audit) and action 683 (Electronic Patient Clinical Records (ePCR) Clinical Compliance internal audit).

13. Of those external audit actions relevant to this Committee, none have been closed in quarter of a total of three. One of the external audit actions has a new revised date proposed (marked in blue) taking it to the third revise date; 139 (National Review of Patient Flow – A Journey Through The Stroke Pathway). There is specific reference to the two outstanding actions regarding the Review of Quality Governance:

13.1 The Committee's attention is drawn to the two open actions – actions 106d and 106e. Based on the completion of the recent 'Quality Governance Follow Up Review' by Audit Wales it has been recommended that these actions will be replaced with new management actions and should remain open until then.

13.2 A corresponding narrative has been included on the Tracker, for the formal record.

Management and Development of the Tracker

14. Discussions have also taken place on historical actions and those where management actions may need to be amended in view of the current operating context. There has been some traction with these, and discussions will continue with a view to closing or revising as many as possible.

15. With respect to the Committee's responsibility to scrutinise the impact of actions, in 2023 the Committee agreed that the most effective way to improve the scrutiny of

the impact of actions was by identifying actions within audits as audit reports are reviewed by the Committee, going forward.

16. The current version of the tracker is now open for Directorate review for actions due during 2024/25 quarter four (January to March 2025). These updates will then be reported to the Committee at its next meeting in May 2025.

17. During 2024/25 quarter four the Corporate Governance Team will work with Directorate points of contacts to ensure a smooth transition between Tracker 2.0 and 3.0 in readiness for implementation of Audit Tracker 3.0 in 2025/26 quarter one.

18. There continues to be good engagement with the Directorate points of contact to support the management of the actions in the Tracker. The Corporate Governance Team will work closely with the points of contact as the SharePoint Tracker 3.0 develops.

RECOMMENDATION: The Committee is requested to:

(a) Receive and review any Internal Audits and Audit Wales reviews within their remit where relevant. There are none required for review at this meeting;

(b) Monitor management actions to address recommendations in the Tracker, noting any revised dates for actions (in blue).

Points of Contact, Directors and Owners of Audit Actions - Do Not Amend Any Column With a Red Header
When proposing a revised 1st, 2nd or 3rd date, include the rationale for the movement and any progress on the action to date
ALL FINAL INTERNAL AUDIT REPORTS CAN BE FOUND ON THE CORPORATE GOVERNANCE SIREN PAGE

Trust Ref. No:	Year/ Audit Plan	Commissioned assigned to	Report title	Assurance Rating	Responsible Officer	Director	Priority Level	Rec. No in Audit	Recommendation	Respons e No in Audit	Management Response	Agreed Deadline in Report	Status - met or not met agreed deadline in report	1st revised date	2nd revised date	3rd revised date	Closure Status	Where a management action has not met the agreed or revised date, Director must include here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. Please add most recent update first
604	22/23	Quest	Pain Management	Limited	Jonathan Chippendale	Andy Swinburn	High	1.2(c)	The Trust should ensure all PGDs follow the Medicines Management policy, with a review undertaken every three years as a minimum.	1.2 (c)	The PGD development and review process is resource intensive, and pharmacist input is an essential requirement. Pharmacist Advisor availability is currently limited to 4-hours per month and does not currently meet the needs of the organisation, particularly given the uplift in advanced practitioners and extended skills (enhanced analgesia) of the paramedic workforce. We will develop an options appraisal to determine a costed and effective way forward to provide additional Pharmacist Advisor capacity.	Mar-24	Not Met	May-24	Sep-24	Mar-25	Open	**201224:** Pharmacist Advisor availability now resolved as Sofia Fernandez (Lead Pharmacist) has now joined the Trust. A Medicines Management Group will be established in January 2025 as a forum for the PGD schedule and review as a standing item at every meeting to review purpose and against the policy. A AAA report of the reviewed PGDs will then be submitted to APSG. **071024:** (AP) In line with update given in July 2024, action can only be closed when the backlog of PGDs has been reviewed. Given that and that the Pharmacist begins in post mid-Q3 24/25, requested that a revised date of March 2025 be applied to permit this to take place. Revised date of March 2025 added in Q2 24/25. 080724: Revised date of September 2024 added in Q1 2024/25. When Pharmacist Advisor recruited the role holder will be reviewing the Patient Group Directives outstanding. At that point this will be an ongoing responsibility of the PA. Action to be closed when backlog of PGDs reviewed. 050724: Proposure not accepted; post holder needs to be in post before closure. Last Updated 270624: (JL) Additional support approved and agreed at TFG 27/03/24. Lead Pharmacist role is currently out for recruitment and second Head of Medicines Management role expected to be out for recruitment in next few days. Action recommended for closure.
668	23/24	Quest	Serious Adverse Incidents - Joint Investigation Framework	Reasonable	Wendy Herbert	Liam Williams	Medium	1.1	The Trust's 'Adverse Incident and Reporting Policy' should be reviewed and updated to reflect the requirements set out within the NHS Wales policy.	1.1	The Putting Things Right Team plan was to review relevant policies following the release of the new Putting Things Right Regulations by Welsh Government in May 2024. A recent update from Welsh Government has confirmed that the release will now be Autumn 2024. At which point the review will be undertaken. The Trust has approved policies in respect of incident reporting and management and a Putting Things Right Policy which are included on the intranet site (review dates are both April 2026). Staff also have access to User Guides on the intranet site for Datix Cymru. The All Wales Patient Safety Policy (NHS Executive) (May 2023) is also due review in March 2024 and will be updated internally when released nationally	Nov 24 On release from NHS Wales Exec	Not Met	Dec-25			Open	**200125: (LT) ADLT noted 1st revised date (Dec25)** **061224:** The Putting Things Right Regulations by Welsh Government are yet to be updated. The latest position provided by the Stakeholder Reference Group is for Autumn 2025. The proposal is to move deadline date to December 2025 to allow for Policy rewrite and approval post national release. The NHS Wales Executive have confirmed to the HOPE Network on 27 November 2024 that there is no anticipated revision of the National Patient Safety Incident Policy. What will close the action: Updated version of the Putting Things Right Policy (following release of the new Putting Things Right Regulations in Autumn 2025). **The element of this action related to the adoption of the updated National Patient Safety Incident Reporting and Management Policy can be closed based on the update provided above.** What will you provide as evidence for the closure: Copy of Putting Things Right Policy Is date reasonable: Dependant on release date of Putting Things Right Regulations by Welsh Government .
681	23/24	Quest	Electronic Patient Clinical Records: Clinical Compliance (ePCR)	Reasonable	Jonathan Chippendale	Andy Swinburn	Medium	1.1	To confirm accuracy of the self-certification compliance rate, management should consider capturing the method of training delivery on ESR.	1.1	For future training, the method of instruction will be captured as part of the ESR sign-off process (for example, classroom based, individual learning using the training materials, one to one instruction using the training zone in the application).	Jun-24	Not Met	Sep-24	Mar-25		Open	**20.12.2024:** Following appointment of CCIO who now holds responsibility for ePCR developments, this action should be transferred from the Clinical Directorate to Digital Services Directorate with the Responsible Officer as CCIO (Keith Dorrington). A meeting needs to be held with Audit Management Team in the new year as this and may of the ePCR deliverables are now unfit for purpose given the resources that will consumed to complete these actions. Jonathan Chippendale, Keith Dorrington, Jen Lloyd and Lisa Trounce to meet to discuss how this can be amended with likely meeting required with Auditors for KD to be able to close actions. Date of meeting tbc Q4. **021024:** (AP) Revised date of March 2025 applied in Q2 24/25, in line with update. Last updated **01102024:** Revised date of Q4 requested to enable the capture of this info.
683	23/24	Quest	Electronic Patient Clinical Records: Clinical Compliance (ePCR)	Reasonable	Jonathan Chippendale	Andy Swinburn	Medium	1.3	Management should consider including a test in ESR to confirm competency before successfully self-certifying.	1.3	At the ePCR CRG WAST will discuss including a test to assess understanding at the completion of training.	Jun-24	Not Met	Sep-24	Dec-24	Mar-25	Open	**20.12.2024:** As above - Following appointment of CCIO who now holds responsibility for ePCR developments, this action should be transferred to the Digital Directorate with the Responsible Officer as CCIO (Keith Dorrington). A meeting needs to be held with Audit Management Team in the new year as this and may of the ePCR deliverables are now unfit for purpose given the resources that will be consumed to complete these actions. Jonathan Chippendale, Keith Dorrington, Jen Lloyd and Lisa Trounce to meet to discuss how this can be amended with likely meeting required with Auditors for KD to be able to close actions. Date of meeting tbc Q4. NB L&E Team have indicated low levels or resource to be able to support this. **021024:** (AP) Revised date of December 2024 in Q2, as requested. **011024:** Awaiting transfer to LMS 365. Revised date of Q3 requested to determine Education team capacity and to enable this transfer. **11092024:** This was discussed at ePCRCRG on 27 June 24 and agreed that training materials would transfer from learning launch pad to LMS365 with integrate competency assessment. **040724:** (AP) Revised date to September 2024 added in Q1 24/25. Last updated 270624: (JL) ePCR CRG have discussed and agreed that a self-test will be included in the training materials. This will be incorporated following migration of the training materials to the LMS365 platform. Request deadline extended to end Q2. **04.04.2024** Work has yet to be commence due to meeting cycles. Will be an agenda item at the ePCR Clinical Reference Group on the 28th March (agenda to be competed on the 21st March 2024).
684	23/24	Quest	Electronic Patient Clinical Records: Clinical Compliance (ePCR)	Reasonable	Jonathan Chippendale	Andy Swinburn	Medium	1.4	Whilst we acknowledge there are different methods of training delivery, management should review lower viewed training modules, to confirm that the completed ePCRs are compliant with expectations in this area.	1.4	Through the ePCR Clinical Reference Group (CRG) we will review the lower viewed modules as set out in Appendix B of this report. This will build on knowledge discussed at the most recent ePCR CRG where a small audit has identified that the obstetric section is not being completed. However, we currently have only opened access to the Welsh GP Record (WGPR) for our cohort of Advanced and Senior Paramedics. The pathways section of the ePCR is not currently live and requires testing prior to going live, which explains the disparity reported in these sections of Appendix B.	Sep-24	Not Met	Dec-24	Mar-25		Open	**200125: (LT) ADLT noted 2nd revised date (Mar25)** **20.12.2024:** As above - Following appointment of CCIO who now holds responsibility for ePCR developments, this action should be transferred to the Digital Directorate with the Responsible Officer as CCIO (Keith Dorrington). A meeting needs to be held with Audit Management Team in the new year as this and may of the ePCR deliverables are now unfit for purpose given the resources that will consumed to complete these actions. Jonathan Chippendale, Keith Dorrington, Jen Lloyd and Lisa Trounce to meet to discuss how this can be amended with likely meeting required with Auditors for KD to be able to close actions. Date of meeting tbc Q4. **01102024:** On track for completion in Q3 and discussed at Sept ePCRCRG on 26/09. **110924:** Pathways section is now live on ePCR. The lower viewed modules will reviewed and reported back to ePCRCRG for December closure date. **040724:** (AP) Revised date to December 2024 added in Q1 24/25 to end of Q3. **270624:** (JL) Action has yet to commence in order to accommodate earlier actions. Request deadline extended to end Q3 to enable earlier actions to be completed Q2 and then for this is take place Q3. **04.04.2024** Work has yet to be commence due to meeting cycles. Will be an agenda item at the ePCR Clinical Reference Group on the 28th March (agenda to be competed on the 21st March
686	23/24	Quest	Electronic Patient Clinical Records: Clinical Compliance (ePCR)	Reasonable	Jonathan Chippendale	Andy Swinburn	High	2.2	Management should ensure the tenant structure is developed to provide data at both a team and individual level to assist in identifying training needs and drive improvement in ePCR compliance.	2.2	Reporting into CIAG, we will set up a Task and Finish Group to write the plan to deliver the dashboards against the Tenant Structure. This is a complex piece and requires input from multiple directorates. It is also dependent on the capacity within teams to deliver the dashboards, therefore the output of the T&F might be a business case jointly developed between the Digital and Clinical Directorates to outline the resources required and what this would cost to deliver.	Sep-24	Not Met	Mar-25			Open	**201224:** As above - Following appointment of CCIO who now holds responsibility for ePCR developments, this action should be transferred to the Digital Directorate with the Responsible Officer as CCIO (Keith Dorrington). A meeting needs to be held with Audit Management Team in the new year as this and may of the ePCR deliverables are now unfit for purpose given the resources that will consumed to complete these actions. Jonathan Chippendale, Keith Dorrington, Jen Lloyd and Lisa Trounce to meet to discuss how this can be amended with likely meeting required with Auditors for KD to be able to close actions. Date of meeting tbc Q4. **021024:** (AP) Revised date of March 2025 applied in Q2 24/25, as requested. **011024:** Request for revised completion date of Q4. Project Manager assigned to work with newly appointed CCIO on this to develop the business case. The ability to role this out will be entirely dependent on capacity and funding but the Task & Finish Group will work to build up the business case for how it would be done. **110924:** Project manager assigned to this with T&F group to start October 2024. Request extended deadline for end of Q4 to produce business case. **270624:** (JL) Following HI pause, leads for this work within the digital directorate have been identified. Work will commence late June 2024 to enable initial scoping to be undertaken. Request deadline extended to end Q2. **04.04.2024** Work has yet to be commence due to meeting cycles. Will be an agenda item at the ePCR Clinical Reference Group on the 28th March (agenda to be competed on the 21st March 2024).
698	23/24	Quest	Seatbelt Action Plan	Reasonable	Mark Harris	Lee Brooks	Medium	3.1	Consideration should be given to undertake a higher number of internal inspections per annum to provide sufficient coverage and assurance that the Trust is compliant with required standards.	3.1	The decision to include internal inspections has been driven internally by the Operations Directorate although capacity remains a limiting factor. Whilst the audit has highlighted the need to undertake a higher number of inspections, we remain committed to four per annum with more being undertaken should capacity permit	Dec-24	Met				Closed in Quarter	**200125: (LT) ADLT noted closure.** **161224:** (TMN) The contents of evidence sent to LT include 3 quarters of Quality Assurance Inspections that are reported to SOT including the SOT highlight reports. There are also plans for a Q4 report which we will see early April 2025 however content 3 quarters of inspections sufficient to **propose closure.**

Trust Ref. No.	Year/ Audit Plan	Committee assigned to	Report Title	Assurance Rating	Responsible Officer	Director	Priority Level	Rec. No.in Audit	Recommendation	Report's No.in Audit	Management Response	Agreed Deadline in Report	Status - met or not met agreed deadline in report	1st revised date	2nd revised date	3rd revised date	Closure Date	Where a management action has not met the agreed or revised date, Director must include here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. Please add most recent update first
701	23/24	Quest	Clinical Audit	Reasonable	Jonathan Chippendale	Andy Swinburn	Medium	1.1	The Trust should ensure appropriate detail in relation to clinical audit is included and documented it within its organisational documents.	1.1	There are workshops scheduled (4th, 9th and 10th July 2024) to plan the next iteration of the Trust clinical strategy. The Clinical Directorate will ensure that clinical audit is given the space it needs to articulate the need for, and link to the guidelines on how to undertake an audit in the final approved document. Where update presentations are given up to, and including, board level meetings, the Clinical Directorate will ensure clinical audit is included. The clinical strategy will articulate clearly how clinical audit meets HQIP standards and will link to the clinical audit plan (for example, to the Clinical Audit section on the Trust intranet).	Mar-25	Not Yet Due	Jun-25			Open	200125: (LT) ADLT noted 1st revised date (Jun25) 011024: The development of the Trust Clinical Plan has been proposed for delay until Q4/Q1 2025 due to capacity contraints on the team. The Assistant Director for Clinical Development has informed the Director of Paramedicine of the need for reference to this in the Clinical Plan and this will be incorporated into the Plan development. Currently on track but dependent on the timing of the first draft of the Clinical Plan. **Requested extension to end of 25-26 Q1 (Jun25).** **11092024:** To be included in Clinical Plan 2025-2030 - to be picked up by T&F group delivering Clinical Plan adn draft to be shared when it goes to QuEST. On track for end Q4. **270624:** (JL) Awaiting Clinical Strategy development days (9-10 July) to incorporate clinical audit activity.
702	23/24	Quest	Clinical Audit	Reasonable	Kevin Webb	Andy Swinburn	Medium	2.1	The Trust should link all clinical audits to either the clinical directorate risk register or Trust/Directorate priorities to support the justification for undertaking them. Where a link cannot be made, additional narrative should be included to justify the inclusion of the clinical audit within the audit plan.	2.1	Work will be undertaken to ensure relevant risks are linked to clinical audit activity; specifically, a mandatory field will be added to the proposal form to link to either a clinical risk or organisational clinical priority. This form will be submitted to CIAG for approval. The Trusts/Directorate priorities are not always clearly identifiable, but we will look to include in the 2024/25 CAP a justification linked to the IMTP/LDP.	Sep-24	Not Met	Dec-24	Jan-25		Open	200125: (LT) ADLT noted 2nd revised date (Jan25) to allow time for approval of actions to support closure. 201224: Identified and potential risks considered as part of new Clinical Audit Prioritisation form which has been taken to CIAG. This will be included in an SBAR for the January 25 CIAG meeting. KW meeting with team on 03.01.2025 to consider the 2025/26 clinical audit plan to go to QuEST for approval in Feb 25. **To be reviewed for closure in January 25 so extension requested just to approve all actions to close the recommendation.** **021024:** (AP) Revised date of December 2024 in Q2, as requested. **011024:** Request to revise the completion date to Q3. ADCD is attending CIAT in November which will enable justification of Trust priorities. This will be discussed at the next Business Meeting for the Directorate to align to any Directorate priorities. Additional time will enable new AD to enact this recommendation and amend clinical audit reporting to link to priorities. **270624:** (JL) New actions, meeting scheduled for 29 July to look at actions and revision of forms, Some work already ongoing to draft changes to consider and to include more detail in decisions logs. Request to identify clinical priorities and risks to inform the audit plan and opportunities for clinical improvement proposed to QMG meeting in June. Further updates with actions to be completed to be provided after July meeting.
703	23/24	Quest	Clinical Audit	Reasonable	Kevin Webb	Andy Swinburn	Medium	2.2	The development of the clinical audit plan should be formally documented to provide assurance on the appropriateness of inclusion of individual audits.	2.2	The CIAT decision log and proposal form to include more detail outlining the priority of the audit activity and the justification for inclusion in the workplan, which will also be reflected in the completed audit reports. A review of the clinical audit documentation is scheduled. This will be reported for approval to the CIAG	Sep-24	Not Met	Dec-24	Jan-25		Open	200125: (LT) ADLT noted 2nd revised date (Jan25) to allow time for approval of actions to support closure. 201224: As with 702 above, more detail is included in the Clinical Audit Delivery Plan that is submitted to CIAG monthly with the proposal form to be updated and a brief SBAR to cover off the actions for January Business Directorate meeting. **Recommended for closure in Jan 25,** request extension till then to close down these actions. **021024:** (AP) Revised date of December 2024 in Q2, as requested. **011024:** As above, request to revise the completion date to Q3. Additional time will enable new AD to enact this recommendation and review CIAT documentation for CIAG. **270624:** (JL) New actions, meeting scheduled for 29 July to look at actions and revision of forms, Some work already ongoing to draft changes to consider and to include more detail in decisions logs. Request to identify clinical priorities and risks to inform the audit plan and opportunities for clinical improvement proposed to QMG meeting in June. Further updates with actions to be completed to be provided after July meeting.
704	23/24	Quest	Clinical Audit	Reasonable	Jonathan Chippendale	Andy Swinburn	Low	3.1	A review of the CIAG Members within the Terms of Reference should be undertaken to ensure Membership is appropriate.	3.1	The TOR is scheduled for review by CIAG and membership will be reviewed at this time. In addition, the stated action regarding missing meetings and follow-up will be similarly reviewed.	Jul-24	Not Met	Dec-24			Closed in Quarter	200125: (LT) ADLT noted closure 201224: ToR updated and taken to CQGG meeting as AAA agenda item on 17.12.2024 where they were approved. JL to send copy of minutes to LT for evidence. **Recommended for closure.** **071024:** (AP) Evidence of the approval of the CIAG ToR at CQGG not yet received; although they were presented at CQGG on the 15 August 2024 approval of the ToR is not recorded. AP advised that must be returned to CQGG for approval. Revised date of December 2024 applied in Q2 24/25. **011024:** Recommended for closure, reviewed ToR provided as evidence.

Points of Contact, Directors and Owners of Audit Actions - Do Not Amend Any Column With a Red Header
When proposing a revised 1st, 2nd or 3rd date, include the rationale for the movement and any progress on the action to date

Trust Ref No.	Audit Wales or HIW Report	Year	Committee Assigned to	Report Title	Responsible Officer	Director	Priority Level	Rec. No. in Audit	Recommendation	Respons e no. in Audit	Management Response	Agreed Deadline in Report	Status	1st revised date	2nd revised date	3rd revised date	Status	Where a management action has not met the agreed or revised date, Director must inlcude here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. **Please add most recent update first**	Closure Status
106	Audit Wales	22/23	QUEST	Review of Quality Governance Arrangments	Jonathan Turnbull-Ross/ Wendy Herbert /Hugh Bennett	Liam Williams			R8 We found that the QuEST Committee is well served with quality information, but there are opportunities for improvement. The Trust should: develop a system to triangulate learning themes (d) work with health bodies so that there are systems to determine the outcomes for patients who have received emergency ambulance services. This should particularly seek to understand the consequence and harm resulting from service failures such as long ambulance waits.		d) The Trust will continue to share information and intelligence with partners that detail the consequences of system failures. Whilst particularly evident where experience or outcome is poor and results in complaint or adverse incident. The Trust will pursue patient outcome data through development of the ePCR over 2022/23.	Mar-23	Not Met	Dec-23	Mar-24	Jul-24	Partially complete	**October 2024: Based on the Quality Governance Review Follow Up report, Audit Wales has noted that this audit action should remain open. New management responses/actions will be developed, at which point this action will be closed and superseded by a new action in relation to the Follow Up Audit (but will remain on this Tracker for the formal record).** **250424**: Date changed in Q4 to July 2024 in line with AW timelines for conclusion of related follow up audit. **150424**: This will remain open until AW confirm as part of the current quality governance audit that it can close. Date will change in quarter (from March 2024 to new date). Update 14032024 from Duncan Robertson: The Health Informatics team are currently working with DHCW to enable a flow of data relating to out of hospital cardiac arrest. This it to test the systems and processes. When complete, this learning will be applied to other presentations for analysis. TM will engage with Audit Wales on a potential revised approach for this action. **201223**: Given the comment below Board Secretary suggests a 'check in' date of 31 March 2024. Audit Wales will be doing a further review at that time and may wish to reframe this recommendation. **11.12.23** Update from Duncan Robertson: The WAST and DHCW data-sharing agreement is with the ICO and Welsh Government as part of a consultation. This will provide the legal basis to share data. No completion date has been provided, therefore the December target date will not be met. It is completely outside of WAST's gift to propose a completion date The Putting Things Right Team are strengthening the Putting Things Right Quarterly Reports to include themes, patterns and trends. REVISED DATE OF DECEMBER 2023 **21.11.23**: Update 121023: Work Ongoing and will take a period to complete. Conversations continue with DHCW and the Ambulance Data Set (ADS) lead in England to define the ePCR definitions. Work is also continuing with DHCW to establish data sharing to enable joining up of patient records to report on outcome data. no timeline as yet and meeting with DHCW continue to clarify some of the definitions following discussions with the lead for the ADS in England. Trust Information Governance colleagues are working with DHCW for this. 26.09.23: Duty of Quality Implementation plan includes the four quadrants of quality management system as set out in the 'road map'. Quality & Performance Management Steering Group continue to monitor and review the development of 'always on' reporting in line with the requirements of the act. Additional metrics have been approved by Trust Board for inclusion in the MIQPR including PREMS/PROMS, Duty of Candour metrics. New HI post now appointed to support MIQPR move to Power BI dashboard. Proposed Revised date 31.12.23 rationale for extension is to allow BI Dashboard work to commence to allow analysts to identify how best to report 'Patient Reported Experience' measures that add value to decision making. Historic Update: We continue to work with Welsh Government colleagues and NHS Executive in the development of the 'all-Wales' Quality Management System, including how the QMS will 'join up' and detail the impact of ambulance performance on HBs/patient care. The Trust PECI Team have also continued to develop the Civiva patient experience software, alongside HBs, to enable analysis of patient experiences of services.	Open
106	Audit Wales	22/23	QUEST	Review of Quality Governance Arrangments	Jonathan Turnbull-Ross/ Wendy Herbert/ Hugh Bennett	Liam Williams			R8 We found that the QuESt Committee is well served with quality information, but there are opportunities for improvement. The Trust should: (e)develop patient outcome measures to support its existing quality measures.		e) The Trust is often limited by data accessibility where the patient journey extends beyond the organisational boundary. The Trust will pursue patient outcome data through development of the ePCR over 2022/23, which will enable 'joining up' of patient records. Furthermore, the Trust will further consider accessibility and governance matters for wider adoption of Patient Reported Outcome Measures, and Patient Reported Experience Measures.	Mar-23	Not Met	Mar-24	Jul-24		Partially complete	**October 2024: Based on the Quality Governance Review Follow Up report, Audit Wales has noted that this audit action should remain open. New management responses/actions will be developed, at which point this action will be closed and superseded by a new action in relation to the Follow Up Audit (but will remain on this Tracker for the formal record).** **250424**: Date changed in Q4 to July 2024 in line with AW timelines for conclusion of related follow up audit. **150424**: This will remain open until AW confirm as part of the current quality governance audit that it can close. Date will change in quarter (from March 2024 to new date). Update 14032024 from Duncan Robertson: The Health Informatics team are currently working with DHCW to enable a flow of data relating to out of hospital cardiac arrest. This it to test the systems and processes. When complete, this learning will be applied to other presentations for analysis. TM will engage with Audit Wales on a potential revised approach for this action. **201223**: Given the comment below Board Secretary suggests a 'check in' date of 31 March 2024. Audit Wales will be doing a further review at that time and may wish to reframe this recommendation. **11.12.23** DEVELOPMENT OF EPCR: Update will be provided by Duncan Robertson via update of item d) PATIENT REPORTED OUTCOME MEASURES: The Trust has defined standardised data to measure. Minimum dataset of approximately 600 definitions to agree with DHCW. Currently linking with England to assess available datasets and definitions. Data sharing agreements currently sit with DHCW and Welsh Government for approval. Instruction letters shared and awaiting response. (Leanne Hawker liaising with Alex Crawford on completion date) PATIENT REPORTED EXPERIENCE MEASURES: Data survey and narrative for generalised PREMs has been standardised and feeds into the MIQPR. A bespoke PREM is being developed in relation to Pain Management and Learning Disability (should be completed by end January 2024) REVISED DATE OF MARCH 2024 **121023**: PREMS live, but in development. PLICS is due to come on stream in Mar-24. PROMS is in development and dependent on DCHW. Business Care Process and Project Management Pathway are relevant considerations.	Open
139	HIW	23/24	Quest	National Review of Patient Flow – a journey through the stroke pathway	Andy Swinburn	Liam Williams Andy Swinburn		32(b)	WAST must consider its current response times for patients awaiting interhospital transfers for urgent thrombectomy treatment which are classified as 'Red'. This is to ensure a thrombectomy can be completed within the six-hour timescale from the onset of symptoms.	32(b)	WAST will review this process in due course and ascertain its success and determine if any further actions are required	Jun-24	Not Met	Sep-24	Dec-24	Mar-25		**160124: (LT) ADLT noted 3rd revised due date (Mar25)** **021024**: (AP) Revised date in Q2 24/25 applied to December 2024, as requested. Last updated 01102024: Request to review due date to Q3 to enable a full quarter of data collection for review of the new process. The data is being collected and can be demonstrated through Power BI but additional time would enable leads to review a full quarter data set for discussion and to develop response to recommendation. **110724**: Action: 1) Review the process agreed with the Health Boards, and ascertain its success / determine if any actions required. It is noted that The process we agreed in 2022 was for the trauma desk to take the transfer requests for thrombectomy. From 30th July 2024 a new process is being introduced for all transfers in WAST (including thrombectomy), this is a new protocol called Medical Transfer Protocol Suite (MTPS) and will specifically handle transfer requests. Evidence: 1) The communication to the Health Board is evidence of the agreed process (the Commissioning Policy). The new MTPS is going live on the 30 July 2024, which includes the provision of thrombectomy transfers which are categorised as Red calls. The process was agreed in 2022 however the new MTPS process begins in mid-2024, therefore a review cannot be undertaken until later in 2024. **150724**: Due to position with new system going live in July 2024, revised date added in Q1 24/25 to September 2024. Last updated 28062024: (JL) The process for requesting an interhospital transfer for patients requiring thrombectomy has been reenforced, confirming that the clinician requesting this transfer should utilise the dedicated number (not 999) where they will speak to a clinician, their request for transfer will be process as a red response and this has been communicated as required.	Open

Ymddiriedolaeth Brifysgol GIG Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services University NHS Trust

POLICIES RECOMMENDED FOR COMMITTEE APPROVAL AND ADOPTION

Committee	Quality, Patient Experience and Safety Committee	**Date of Meeting**	04/02/2025

Presenting Officer	Lisa Trounce, Head of Compliance & Assurance [Chair of Policy Group]

Policy Name	Directorate	EqIA	Date of Policy Group	Date of ADLT	Points of Note
Safeguarding Adults and Children at Risk of Harm Policy	Quality & Nursing	Completed No Issues	18/12/2024	20/01/2025	FOR APPROVAL
Violence Against Women, Domestic Abuse & Sexual Violence (VAWDASV) 'Ask & Act' Policy	Quality & Nursing	Completed No Issues	18/12/2024	20/01/2025	FOR APPROVAL

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Welsh Ambulance Services University NHS Trust

Safeguarding Children and Adults at Risk of Harm Policy

Policy Number:	003	**Version No:**	v.3.9 Draft	**Supersedes:**	v3.0 Published
Date of Approval:	TBC	**Review Date:**	3 years from date of approval	**Impact Assessments Completed:**	Yes (07/10/2024)
Classification of Document:	Safeguarding	**Type of Document:**	Policy	**Approved by:**	Quality, Patient Experience and Safety Committee
Brief Summary of Document:	The Welsh Ambulance Services University NHS Trust (WAST) recognises that all service users have the right to expect health care that is safe and to be protected from harm. This policy outlines how the Trust will safeguard and protect children and 'adults at risk' of harm.				
Scope:	The Trust recognises it has a legislative safeguarding responsibility and is committed to promoting well-being, to safeguarding and protecting people from harm. This policy outlines the collective and individual requirements of all WAST colleagues to follow safeguarding legislation and to provide them with the information required to act upon safeguarding concerns.				
To be read in conjunction with:	The following WAST documents; WAST Information Governance Policy (2018) WAST Management of Allegations (2017) [2024 under review currently] WAST Violence Against Women, Domestic Abuse and Sexual Violence (2019) [VAWDASV - 2024 under review currently] WAST Recruitment and Selection Policy, Process and Guidance (2016) [2024 under consultation currently] WAST Putting Things Right Policy (2023) WAST Adverse Incident Reporting Policy and Procedure (2023) WAST Consent to Examination & Treatment Policy (2024) WAST Data Protection Policy (2024) The following National Guidance: National Procedural Response to Unexpected Death in Childhood (PRUDiC) (2023) Guidelines Welsh Government Safeguarding Guidance				

Owning Committee	Quality, Safety & Patient Experience Committee		
Policy Lead: **Trade Union Lead:**	Vicky Maxwell Christian Fox	**Job Title:**	Assistant Director of Safeguarding Trade Union Partner
Executive Director:	Liam Williams	**Job Title:**	Executive Director of Quality & Nursing

Version Control Sheet

Version	Date	Author	Summary of Changes
v1.0	14/07/2017	Nikki Harvey	Significant Harm replaced with "at risk"
v2.0	08/08/2017	Nikki Harvey	Approved control documents added
v2.1	31/08/2017	Tim Griffiths	Equality Impact Assessment added
v3.0	08/09/2017	Tim Griffiths	EQIA table removed, details for access added. Footers updated. Policy approval route updated.
v 3.1	21/09/2024	Gwenan Jones-Parry	Full policy review in collaboration with new Assistant Director of Safeguarding. Ensured updated legislation and digital reporting process included.
v3.2	07/10/2024	Gwenan Jones-Parry	Incorporated suggestions/comments from Trade Union Lead, Information Governance, Patient Experience & Community Involvement, Putting Things Right, Safeguarding and Policy Teams.
V3.3	18/10/2024	Lisa Trounce	Final review and formatting throughout prior to submission to Policy Group to approve / recommend for approval
V3.4	29/10/2024	Gwenan Jones-Parry	Updated following comments from Policy Review Group on 23/10/2024 ready for Trust wide consultation.
V3.5	30/10/2024	Lisa Trounce	Formatting prior to Trust-wide consultation
V3.6	01/12/2024	Gwenan Jones-Parry	Amendments made to policy following Trust-wide consultation: 1.4 Amended as assurance provided by Executive Director of Quality and Nursing (see 9.2) rather than the Safeguarding Team. 2.1 Non-Executive Directors added

Version	Date	Author	Summary of Changes
			3.3.8 Amended re: support for Doc-works Scribe system 3.3.9 Reference to WAST Records Management Policy added 3.5.3 Reference to WAST Supervision Policy added 3.7.1 Recruitment and Selection Policy added 9.3 Reporting arrangements added 9.5 'Evaluate' removed 10.2 Specific roles and responsibilities of Executive Director of Quality and Nursing drawn out/added 10.7 Assistant Director of Corporate Governance & Risk changed to Head of Compliance and Assurance 10.10 'Employed or Volunteers' replaced with 'colleagues' Appendix B Abbreviations updated
V3.7	13/12/2024	Lisa Trounce	Review, edit and formatting prior to representation to Policy Group on 18/12/2024: - Version Control Sheet updated to detail specific changes made post consultation - Approval Route updated - Some minor formatting
V3.8	18/12/2024	Lisa Trounce	Front cover and policy approval route updated in readiness for onwards travel to ADLT 20/01/25 – recommended for approval by committee
V3.9	24/01/2025	Lisa Trounce	Front cover and policy approval route updated in readiness for onwards travel to Quality, Safety and Patient Experience (QuEST) Committee for approval and adoption.
Keywords	Safeguarding, Adult at Risk, Children, Abuse, Neglect, Harm.		

Impact Assessment Reviews

Area	Date of Review	Name of Reviewer
Data Protection	04/10/2024	Kelly Holding
EqIA	01/10/2024	Kathryn Cobley
Welsh Language	04/10/2024	Melfyn Hughes
Environment	04/10/2024	Nicci Stephens
Quality	04/10/2024	Kate Blackmore

Policy Approval Route

Meeting Title	Meeting Date	Purpose/Outcome
Policy Group	23/10/2024	Approved for Trust-wide consultation
28-day Consultation Period	30/10/2024 – 27/11/2024	Trust wide consultation
Policy Group	18/12/2024	Review post consultation and recommended for approval
Assistant Directors Leadership Team	20/01/2025	Recommended for approval
Quality, Patient Experience and Safety Committee (QuEST)	04/02/2025	Approval and adoption

Disclaimer
If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Amb_policies@wales.nhs.uk

Contents

1. INTRODUCTION AND AIM

1.1 This policy document supersedes any previously identified WAST policy for safeguarding children, young people and adults at risk.

1.2 The Welsh Ambulance Services University NHS Trust (WAST) recognises its responsibility to take all reasonable steps to protect and safeguard the welfare of children, young people and adults at risk of harm, abuse and neglect.

1.3 WAST has a statutory duty under legislation, including but not limited to, the Children Act (2004) and the Social Services and Well-being (Wales) Act (2014) and Wales Safeguarding Procedures (2019) to ensure processes are in place to support this.

1.4 The Trust has legislative safeguarding duties which includes the requirement for relevant safeguarding policies..

1.5 WAST has a duty of care to look after the physical and psychological well-being of colleagues who have been exposed to traumatic, distressing or challenging incidents. It is recognised that this may include incidents where safeguarding and adult at risk or child is required. Please see further information on the WAST Wellbeing SharePoint.

1.6 Safeguarding advice, support and case focused supervision can be provided to WAST colleagues upon request by the WAST Safeguarding Team.

1.7 WAST recognises that all service users and WAST colleagues have the right to be safeguarded from harm and live in a fear free environment. The Trust operates an open, aware and safe culture, which listens to service users and their advocates to support its vision of being a leading ambulance service providing the best possible care through a skilled professional and healthy workforce. This policy outlines in broad terms how the Trust will safeguard and protect children and adults at risk of harm.

1.8 The aim is that by working collaboratively with multi-agency partners the Trust will meet its legislative obligations in relation to safeguarding and protecting children and adults at risk of harm.

1.9 The objective are to provide all WAST colleagues with the information needed to act upon safeguarding concerns, ensuring that children, young people and adults at risk have access to the services that can support them and reduce the risk of future harm.

2. SCOPE

2.1 To outline the collective and individual requirements of all WAST colleagues to follow safeguarding legislation. Included within WAST colleagues are employees, volunteers, non-executive director board members appointed by Welsh Government, students, apprentices and any individual representing WAST.

2.2 To provide all WAST colleagues with the information needed to act upon safeguarding concerns, ensuring that children, young people and adults at risk have access to the services that can support them and reduce the risk of future harm.

2.3 Safeguarding is everyone's responsibility. WAST colleagues have a duty to report safeguarding concerns both in and out of the workplace.

2.4 The Trust recognises that has a legislative responsibility and is committed to promoting well-being, to safeguarding and protecting people from harm.

2.5 This Policy should be read in conjunction with the listed policies and relevant standard operating procedures (SOPs).

3. SAFEGUARDING CHILDREN AND ADULTS AT RISK

3.1 Safeguarding Children and Young People

3.1.1 Safeguarding Children is a statutory duty as outlined by the Social Services and Wellbeing (Wales) Act (2014) and the Children Act (2004); all WAST colleagues have a duty to report any child safeguarding concerns to the relevant Local Authority.

3.1.2 Safeguarding children legislation and guidance apply to the unborn child and all children and young people from birth up to their eighteenth birthday.

3.1.3 Local Authorities have an obligation to offer ongoing support to young people who have been looked after by the Local Authority as they may have ongoing care and support needs. Transition to adulthood should be considered when deciding whether a safeguarding report is required.

3.1.4 WAST, alongside Local Authorities, have an obligation to offer ongoing support to ensure care experienced children and young people have the same life chances and experiences as other young people in Wales. As part of this responsibility WAST have committed to the Welsh Government Corporate Parenting Charter.

3.1.5 Autistic, Attention Deficit Hyperactivity Disorder (ADHD) or patients with other neurodiversities can present differently to neurotypical patients, in both adults and children. Being neurodivergent does not affect mental capacity but can increase vulnerability to abuse and neglect.

3.1.6 Colleagues should consider neurodiverse conditions, learning difficulties and mental health issues when caring for children and young people and this should be incorporated in any safeguarding vulnerability assessment.

3.1.7 **Consent** – under safeguarding legislation, the needs of the child are paramount. This means that where abuse, or the risk of abuse, is identified a safeguarding report can be completed and shared with the relevant Local Authority **with or without the consent** of a parent, carer or guardian.

3.1.8 However, WAST colleagues are expected to ask for consent to make a safeguarding report from a parent/carer/guardian (with parental responsibility under the Children Act 1989, 2004) if **it is safe to do so**.

3.1.9 A young person can provide their own consent to a report if they are deemed as competent to consent by the reporter. The wishes and feelings of the child or young person should be included where possible.

3.1.10 Examples of exceptions to obtaining consent for a child safeguarding report would include:

- If obtaining consent would increase the risk of significant harm to the child or young person
- If obtaining consent would increase the risk of harm to a WAST colleague
- If obtaining consent would increase the risk of harm to a member of the public

3.1.11 Where actions are taken without consent, this must be clearly recorded in the safeguarding report, with the rationale for not obtaining consent.

3.1.12 Lack of consent should not prevent WAST colleagues from completing a child safeguarding report.

3.2 Safeguarding Adults

3.2.1 Safeguarding Adults is a statutory duty as outlined by the Social Services and Wellbeing (Wales) Act (2014); all WAST colleagues have a duty to report any safeguarding concerns in relation to an adult at risk to the relevant Local Authority.

3.2.2 Safeguarding adult legislation and guidance apply to all individuals from the age of 18 years.

3.2.3 Adult safeguarding reports can be submitted for individuals who meet the criteria of an 'Adult at Risk' as defined by the Social Services and Well-being (Wales) Act (2014). An 'Adult at Risk' is an adult who:

- *"Is experiencing or is at risk of abuse or neglect,*
- *Has needs for care and support (whether or not the authority is meeting any of those needs), and*
- *As a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it." (Safeguarding Wales, 2024)*

3.2.4 Autistic, ADHD or patients with other types of neurodiversity can present differently to neurotypical patients, in both adults and children. Being neurodivergent does not affect mental capacity but can increase vulnerability to abuse and neglect.

3.2.5 WAST colleagues should consider neurodiverse conditions, learning difficulties, mental health issues, alcohol and substance misuse, chronic health conditions, needs of older people when caring for adults and this should be incorporated in any safeguarding vulnerability assessment.

3.2.6 WAST colleagues should take appropriate steps to reduce barriers to communication, such as use of a patient's communication aids, written and verbal information and repeating information when required.

3.2.7 If you have contact with patients who present with care and support needs who find it difficult to look after themselves, you can request a social care assessment on their behalf. If they already have a care plan in place which you believe requires amendment, you can request a review on their care assessment.

3.2.8 **Consent** – all WAST colleagues are expected to ask for consent from the adult with capacity, if it is safe to do so, before submitting a safeguarding report.

3.2.9 Under adult safeguarding legislation, an adult who has been assessed as having the mental capacity (Mental Capacity Act, 2005) to make decisions about their care, has the right to refuse a safeguarding or social care assessment report, even when care and support needs and/or abuse (or the risk of abuse) has been identified.

3.2.10 If following assessment and adult at risk is deemed as not having the mental capacity, whether temporary or permanent, to make decisions around the identified safeguarding risk, consent to make a safeguarding report is not required and one submitted in the best interest of the patient. It should be documented clearly that a **best interest decision is being made**.

3.2.11 Where actions are taken without consent, this must be **clearly recorded** in the patient clinical record and safeguarding report, with the rationale for not obtaining consent.

3.2.12 There are some circumstances where a safeguarding report can be submitted in the interest of the wider public, without the consent of the adult at risk. An example of this is self-neglect and hoarding which presents a risk to neighbours or professionals who need to enter the property. Another example would be if there is an allegation in relation to a professional who provides care for other adults at risk. This rationale should be **clearly recorded** in the safeguarding report.

3.2.13 Where a service user objects WAST **may** be able to rely on the public interest exemption under the common law duty of confidentiality, on a case-by-case basis and only in circumstances where sharing of confidential information is considered necessary to prevent a **serious risk of harm to the patient**. In effect, WAST must be satisfied that the 'public interest' in disclosure (i.e., avoiding serious harm), outweighs both: (I) the patient's right to confidentiality; and (ii) the broader public interest in ensuring that confidentiality is maintained in the provision of health services

3.2.14 The sharing of this information must only be based on supporting the patient (i.e., not for secondary purposes such as analytics). Sharing confidential information against the patient's wishes should be considered an exceptional circumstance and the rationale for doing so should be **well-documented**.

3.2.15 The General Medical Council (GMC) provides important guidance when relying on the public interest exemption. The relevant guidance can be found in paragraphs 67 and 68 of the 'Disclosures for the protection of patients and others' guidance.

3.3 Safeguarding Reporting Process

3.3.1 Where it is recognised that a child, young person or adult at risk has been harmed, or is at risk of harm, a safeguarding report must be completed to the appropriate Local Authority. **WAST utilise the digital reporting system Doc-works Scribe and you should refer to your relevant SOPs for further guidance.**

3.3.2 WAST colleagues should endeavour to gather sufficient information to enable the Local Authority to identify the involved individuals and assess the risks.

3.3.3 Professional curiosity is encouraged to ascertain facts that will support the identification of safeguarding risk, however WAST colleagues are not responsible for conducting safeguarding enquiries and should avoid questions and enquiries that could jeopardise external investigations.

3.3.4 When considering any safeguarding concerns WAST colleagues should avoid any questioning that may increase the risk to the child, young person, 'adult at risk'. For example, asking questions that could alert the alleged perpetrator to your suspicions and lead to further abuse.

3.3.5 The Safeguarding Team are available during office hours on 01792 315884 or amb_wastsafeguarding@wales.nhs.uk

3.3.6 If a crime is taking place or a child, young person or adult at risk is in immediate risk of harm, abuse or neglect, WAST colleagues should contact the relevant Police service. If there are immediate safeguarding concerns, consideration should be given to phoning the Local Authority directly, there is always an on duty professional available. Consideration should be given to conveying to a place of safety or remaining on scene until other services arrive. These actions and discussions should be documented clearly on the ePCR and within the safeguarding report.

3.3.7 **In accordance with legislation, if the Local Authority is contacted directly this must be followed up with a written safeguarding report.**

3.3.8 Safeguarding reports are submitted digitally via the Doc-works Scribe system. Should there be any system issues colleagues should follow the relevant contingency process. The Safeguarding Team are available to support.

3.3.9 All safeguarding concerns and actions must be clearly documented in the electronic patient record (as appropriate). This should include the rationale for completing or not

completing a safeguarding report. All documentation should be clear, concise, complete, factual and limited to what is necessary. Further guidance about record keeping can be obtained from the WAST Records Management Policy.

3.3.10 There may be occasions whereby WAST colleagues believe that appropriate actions have not been taken by a Social Care team following the submission of a child or adult at risk safeguarding report. In this situations the WAST colleague should contact the WAST Safeguarding Team on amb_wastsafeguarding@wales.nhs.uk evidencing a rationale for their concerns. The WAST Safeguarding Team will support the resolution of these concerns through the relevant Local Authority escalation policy.

3.3.11 There will be occasions where WAST colleagues have safeguarding concerns for individuals they know outside the workplace. These non WAST related safeguarding reports should be submitted via the relevant Local Authority reporting process.

3.4 Safeguarding Children and Adults when a concern/allegation is raised against a WAST colleagues

3.4.1 WAST colleagues are encouraged to raise concerns about any inappropriate behaviour or conduct of individuals or colleagues, at an early stage. The Trust is committed to the delivery of high-quality care to all the patients that come into contact with its services. This relates also to concerns which may be identified outside a colleagues professional remit. For further details, see the Management of Allegations Policy.

3.5 Safeguarding Supervision

3.5.1 Safeguarding supervision is an accountable process to support, assure and provide critical reflection regarding safeguarding cases, to develop the knowledge, skills, and values of a colleague.

3.5.2 Safeguarding supervision is specified for competency at Level 3 within the Intercollegiate Documents for Adults and Children.

3.5.3 WAST colleagues can obtain supervision as required upon request from the Safeguarding Team. WAST Supervision Policy should be referred to for guidance on supervision.

3.6 Duty of Candour

3.6.1 Effective safeguarding practice requires transparency, honesty and trust. There is a legal Duty of Candour on heath service bodies to inform people both in person and in writing, about mistakes and incidents which have not had the desired outcome. Further information can be found in The Duty of Candour Procedure (Wales) Regulations (2023).

3.6.2 WAST Safeguarding Team provide assurance to both internal and external partners that WAST are meeting their statutory safeguarding responsibilities.

3.6.3 WAST Safeguarding Team attend the internal Serious Case Incident Forum (SCIF), liaise with the Patient Safety Team within the QSPE Directorate.

3.6.4 The Trust recognises the importance of listening to what patients and service users say, taking opportunities to modify services that reflect their needs where appropriate. If changes cannot be made, then clear explanations should be given as to the reasons.

3.7 Disclosure and Barring Service (DBS)

3.7.1 The Trust's Recruitment and Selection Policy, procedure and guidance notes highlight the Trust's commitment to safe and informed recruitment. It is the responsibility of the appointing officer to decide on the type of disclosure required, in consultation with People Services.

4. PARTNERSHIP WORKING

4.1 Safeguarding Boards

4.1.1 The Trust will maintain effective Safeguarding Board partnership arrangements as required by the Social Services and Wellbeing (Wales) Act (2014) and the Violence Against Women Domestic Abuse and Sexual Violence (Wales) Act (2015) within the context of a relevant partner and national organisation delivering services locally.

4.1.2 The Assistant Director of Safeguarding will fulfil the strategic safeguarding role and will provide senior leadership on behalf of the executive lead with Safeguarding Boards.

4.2 Single Unified Safeguarding Review (SUSR)

4.2.1 WAST must ensure contribution to the SUSR processes, and this will be coordinated by the Assistant Director of Safeguarding.

4.2.2 If operational colleagues are requested to attend an SUSR meeting, full guidance will be provided by the WAST Safeguarding Team. If WAST colleagues are invited to attend directly by external agencies, please liaise with the WAST Safeguarding Team.

4.3 Multi-agency working

4.3.1 WAST supports multi-agency working as a key requirement in effective arrangements for safeguarding. There will be situations where colleagues may need to liaise with multiagency professionals to ensure adequate joint working

4.3.2 The Safeguarding Team, with the support of the Patient Experience and Community Involvement Team, identify opportunities that can be developed and progressed to reflect safeguarding of service users within the wider remit of the Patient and Public Involvement Strategy as identified in various national standards.

4.4 Procedural Response to Unexpected Deaths in Childhood (PRUDiC)

4.4.1 This procedure sets out a minimum standard for a response to unexpected deaths in infancy and childhood. It describes the multi-agency process of communication, collaborative actions and information sharing following the unexpected death of a child.

4.4.2 Aim of the PRUDiC is to ensure that the response is safe, consistent and sensitive to those concerned, and that there is uniformity across Wales.

4.4.3 Further guidance is available for WAST colleagues in the PRUDiC Guidance (2023).

4.4.4 On occasion there may be an unexpected child death which does not trigger the PRUDiC process, the Safeguarding Team should always be notified of these incidences.

4.5 Prevent Duty

4.5.1 Preventing someone from becoming a terrorist or supporting terrorism is a key safeguarding responsibility. Where there are signs that someone is vulnerable to being drawn into terrorism WAST colleagues should consider whether a report is indicated.

4.5.2 Prevent referrals are completed via the Doc-works Scribe system.

4.5.3 Prevent is based on the active engagement of the vulnerable individual and is at a pre-criminal stage before any crime has been committed. If appropriate consent should be

obtained from the individual involved (or their parents or guardian if aged under 18 years) prior to a referral to Prevent.

4.5.4 Consider wider safeguarding and mental health concerns and whether adult or child safeguarding or mental health reports are needed alongside or instead of a prevent report.

4.5.5 **If you believe there is an immediate terrorist threat: an immediate risk to persons or property or, a crime has been committed, then the police should be contacted on 999 without delay. Consent of the individual does not need to be obtained.**

4.6 Child safeguarding concerns beyond the family

4.6.1 Young people often have many complex social relationships outside of their family unit, which can place them at risk of harm. This includes concerns around criminal exploitation, sexual exploitation, serious youth violence, substance and/or alcohol use.

5. INFORMATION SHARING

5.1 It is important that all service users remain confident that their personal information is kept secure and safe.

5.2 Timely and effective information sharing is a key factor in safeguarding. WAST colleagues should share information in line with the WAST Information Governance Policy (2018), the WAST Data Protection Policy (2024) and Confidentiality Code of Conduct (2021).

5.3 WAST colleagues should ensure they are familiar with the Data Protection Act (2018), General Data Processing Regulations (2018), and their responsibilities through statutory and mandatory information governance training.

5.4 Safeguarding concerns should be shared in accordance with the "Seven Golden Rules for Information Sharing", Appendix A.

5.5 Any information shared with external agencies must be documented in WAST records.

5.6 Disclosures can be permitted if it is required by law or is permitted by a statutory process that sets aside the duty of confidentiality.

5.7 If WAST colleagues are not sure about information sharing or consent issues in relation to safeguarding concerns, they should seek advice from the Safeguarding Team, Caldicott Guardian (The Caldicott Principles, 2020) or Information Governance Team.

6. IMPACT ASSESSMENTS

6.1 Equality Impact Assessment

EQIA screening was undertaken and reflects a positive outcome. The full EQIA document can be accessed by request to the Assistant Director of Safeguarding.

6.2 Welsh Language Impact Assessment

The impact on Welsh Language was assessed as part of the EqIA. The impact was overall positive, with some aspects not applicable. This policy treats the Welsh language no less favourably and supports that care is provided to service users in the language of their choice. When safeguarding reports are submitted to Local Authorities, there is a specific question which asks for their preferred language for communication, to ensure the Local Authority is informed.

6.3 Environmental Standards and Impact Assessment

This policy will put the relevant requirements in place (such as waste management plan, reduction of CO_2 emissions & reduction of carbon footprint) in order to ensure that the Welsh Ambulance Services NHS Trust ongoing commitment to reduce its impact on the environment is maintained and to become a more sustainable organisation in line with Trust policy and Environmental Governance System.

The digitalisation of the safeguarding reporting process has reduced the requirement for high numbers of paper safeguarding reports. Paper safeguarding reports are required at a much lower number as they are only required for the contingency process.

6.4 Counter Fraud

WAST is committed to taking all necessary steps to counter fraud, bribery and corruption within the Trust. Colleagues should report suspected incidents of fraud and corruption to the Trust Local Counter Fraud Specialist, who will be happy to discuss any issues or concerns. Alternatively colleagues may contact the confidential NHS Counter Fraud Authority, Fraud and Corruption Reporting line on 0800 028 40 60; or the on-line reporting facility Service https://cfa.nhs.uk/report-fraud Fraud investigations may lead to disciplinary action and / or prosecution and civil recovery procedures.

6.5 Records Management

WAST recognises the importance of sound records management arrangements for both clinical and corporate records. The Trusts' records are its corporate memory, providing evidence of actions and decisions and representing a vital asset to support daily functions and operations. Records support policy formation and managerial decision-making, protect the interests of the Trust and the rights of patients, colleagues and members of the public. Further information in the Trust's Records Management Policy 2017 as a guide.

6.6 Information Governance

Information Governance is an overarching term used to describe all aspects of information management. The Trust and its colleagues shall ensure that they provide satisfactory assurance to stakeholders as to how the organisation fulfils its statutory and organisational responsibilities in relation to the management of information. It will enable management and colleagues to make correct decisions, work effectively and comply with relevant legislation and the organisations aims and objectives.

The IG framework ensures that it sets out the high level principles for confidentiality, integrity and availability of information to promote and build a level of consistency across the Trust. Further information in the Trust's Information Governance Policy 2018.

6.7 Health & Care Quality Standards 2023

In line with the Health & Social Care (Quality & Engagement) (Wales) Act (2020) and the Duty of Quality (2023), twelve health and care quality standards have been developed to help us understand what good quality means and how we apply it in practice.

These standards are intended to apply broadly to the wide range of services provided by the NHS in Wales and provide a high level framework to support the Trust in planning, delivering and monitoring our services.

When considering this policy the following standards and associated statements are of particular importance:

- Safe: People's health, safety and welfare are actively promoted and protected; risks are identified and monitored and where possible risks to safety are reduced or prevented. We promote and protect the wellbeing, and safety of children and adults who become vulnerable or at risk at any time. Where children or adults may

be experiencing or are at risk of abuse or neglect, we taken appropriate, time action and report concerns.

- Person Centred: We care about the wellbeing of individual, their families, carers and our colleagues. We ensure that everyone is always treated with kindness, empathy and compassion and we respect their privacy, dignity and human rights.

- Workforce: We care about our people and their wellbeing, protect their rights and support them to feel well and happy at work; and provide them with the tools, systems and environment to work safely and effectively.

- Culture: Relationships within teams and with the people we serve are effective and based on transparency, accountability, ethical behaviour, trust and just culture where people can thrive.

7. TRAINING

7.1 WAST is committed to providing high quality evidence-based education to an engaged and skilled workforce operating within an organisational culture and framework that enables colleagues to work to the top of their skill set to deliver high quality care and services with competence and confidence.

7.2 The Safeguarding Team will review a training needs analysis annually to inform the organisational safeguarding training requirements commensurate to all roles.

7.3 WAST safeguarding training will consider Social Care Wales (2023) standards and the relevant intercollegiate documents.

7.4 WAST colleagues are encouraged to discuss any concerns or queries regarding education and training with a member of Workforce Education and Development Team, by telephoning 0300 123 2319 or emailing amb_EandDHub@wales.nhs.uk

8. IMPLEMENTATION PLAN

8.1 The latest approved version of this Policy will be posted on the Safeguarding SharePoint page for all WAST colleagues.

8.2 The policy will be circulated in Trust wide communications.

8.3 References to this policy will be made during statutory and mandatory training, safeguarding advice, support and supervision.

9. AUDIT AND MONITORING

9.1 Safeguarding Team has a responsibility to undertake regular audit to monitor compliance and effectiveness of this policy.

9.2 The Safeguarding Strategic Group (SSG) has been established to support the Trust Executive Lead for Safeguarding in the provision of assurance to the Board on all matters relating to safeguarding children and adults at risk.

9.3 Reporting and monitoring of safeguarding standards is completed via internal reporting mechanisms. SSG reports and escalates matters to Clinical Quality Governance Group (CQGG), which in turn reports and escalates matters to ELT.

9.4 Themes, trends or lessons learned will be communicated to WAST colleagues through a variety of means including bulletins and operational updates, communicated through training and notices.

9.5 WAST Safeguarding Team review, monitor and record feedback from Local Authorities in relation to WAST safeguarding reports and act as necessary.

10. ROLES AND RESPONSIBILITIES

10.1 Chief Executive

The Chief Executive, as Accountable Officer, has overall responsibility for ensuring the Trust has appropriate policies in place to ensure the organisation works to best practice and complies with all relevant legislation.

The Chief Executive is the executive member of the Trust Board with overall accountability in relation to safeguarding, ensuring that the Trust has policies and procedures in place and complies with its legal statutory obligations.

10.2 Executive Director of Quality and Nursing

The Executive Director of Quality and Nursing provides assurance to the Trust board, commissioners, partner agencies and the public that the Trust are completing its corporate safeguarding functions. The Executive Director of Quality and Nursing chairs the SSG.

10.3 Assistant Director of Safeguarding

The Assistant Director of Safeguarding (previously known as the Head of Safeguarding) is the 'Named Professional' who ensures the strategic management of safeguarding providing leadership, expert and specialist guidance on safeguarding matters.

The Assistant Director of Safeguarding has strategic responsibility for the development and implementation of systems and processes for safeguarding, working with partner agencies in line with local and national standards and legislation. This includes overall responsibility for policy development, safeguarding operational oversight, education content guidance, and safeguarding supervision. The Assistant Director of Safeguarding oversees the Safeguarding Team.

10.4 Safeguarding Team

To fulfil the role, the Assistant Director of Safeguarding is supported by the Safeguarding Team, who ensure that the Trust and its colleagues comply with relevant legislation, regulation and guidance.

The Safeguarding Team are responsible for the safeguarding corporate function and provide specialist support, peer review, supervision, and ensuring compliance with training, The Safeguarding Team provide expert opinion for safeguarding adults, children and young people; in addition to the management of allegations of abuse or neglect against WAST colleagues.

10.5 Director of Corporate Governance / Board Secretary

The Board Secretary is responsible for the effective management of, and compliance with, this policy. This includes ensuring that:

- A database of policies and procedures is maintained.
- Policies are approved as part of the Governance framework at the appropriate level in the organisation.
- The documents are accessible to all relevant colleagues.
- Documents are cascaded appropriately across the organisation.
- All policies are reviewed in a timely manner.

10.6 Directors

The Executive Directors are responsible for the effective management of and compliance with this policy. They are responsible for ensuring that all policies within their remit are maintained and updated by liaising with the appropriate policy leads. They are responsible for ensuring that the appropriate advice and assistance is provided to authors and that consideration is given to any training and resources implications that are defined. Each Director will appoint a Policy Lead for their Directorate.

10.7 Head of Compliance and Assurance

The Head of Compliance and Assurance will act as the Trust's 'Policy Process Manager' and operational gatekeeper with the responsibility for providing guidance, advice and support for the process on behalf of the Trust.

In addition, be responsible for:

- Managing the maintenance of the Trust's central Policy tracker and database (including a record of equality impact assessments).
- Facilitation of the Trust's internal Policy Group.
- Managing the Trust wide consultation process for all policies.
- Providing a link between the Policy Group and Employment Policy Sub Group.
- Issuing reminder notices to ensure the timely review of policies.
- Ensuring up to date guidance and documentation regarding the policy process is accessible.
- Publishing policies onto the Trust's internet/intranet sites and working with the Communications Team to ensure comprehensive notification that new policies is maintained across the Trust.
- Maintain an archive of previous versions of any revised or reviewed policies.

10.8 Service Managers / Clinical Leads / Locality Managers

Are responsible for**:**

- Ensuring that new colleague that join the Trust are made aware of the policy control system at local induction, and how to access Trust wide and local policy documents specific to their area.
- Understanding the policy process and their role in supporting best practice.
- Working with colleagues without access to the intranet to ensure they have access to relevant documentation.
- Ensuring that local arrangements are established to monitor the receipt and understanding of all relevant Trust documents; thus reducing the risk of misuse of misinterpretation.

10.9 Line Managers

Are responsible for ensuring that WAST colleagues for whom they are responsible are aware of and adhere to this document. This includes ensuring that:

- Copies of the Trust policies are readily available and accessible to all colleagues
- Information is disseminated on a regular basis, to ensure colleagues have read and understood the relevant documents and are aware of any new guidance or revisions.
- The identification of specific colleague training needs on the implementation of new or updated documents.
- Systems exist to enable the review, audit and compliance testing of all relevant departmental policies as required.

10.10 All WAST Colleagues

All WAST colleagues have safeguarding responsibilities, to appropriately identify and report safeguarding concerns to the relevant Local Authority. All WAST colleagues have a responsibility to maintain their safeguarding training to a level commensurate with their role.

WAST recognises that many colleagues do not work directly with children or adults at risk of harm. However, they may have contact with adults, children or carers who may pose a transferable risk.

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12. APPENDICES

Appendix A	Seven Golden Rules for Information Sharing
Appendix B	Abbreviations
Appendix C	Glossary

Appendix A: Seven Golden Rules for Information Sharing

1. All children have a right to be protected from abuse and neglect. Protecting a child from such harm takes priority over protecting their privacy, or the privacy rights of the person(s) failing to protect them.

2. When you have a safeguarding concern, wherever it is practicable and safe to do so, engage with the child and/or their carer(s), and explain who you intend to share information with, what information you will be sharing and why.

3. You do not need consent to share personal information about a child and/or member of their family if a child is at risk or there is a perceived risk of harm.

4. Seek advice promptly whenever you are uncertain or do not fully understand how the legal framework supports information sharing in a particular case.

5. When sharing information, ensure you and the person or agency/organisation that received the information take steps to protect the identities of any individuals (e.g. the child, a carer, a neighbour or a colleague) who might suffer harm if their details became known to an abuser or one of their associates.

6. Only share relevant information with individuals or agencies/organisations that have a role in safeguarding the child and/or providing their family with support, and only share the information they need to support the provision of their services.

7. Record the reasons for your information sharing decision, irrespective of whether or not you decide to share information.

Information sharing advice for safeguarding practitioners - GOV.UK (www.gov.uk)

Appendix B: Abbreviations

ADHD	Attention Deficit Hyperactivity Disorder
DBS	Disclosure & Barring Service
ELT	Executive Leadership Team
EQIA	Equality Impact Assessment
GMC	General Medical Council
PRUDiC	Procedural Response to Unexpected Deaths in Childhood
QuEST	Quality, Patient Experience and Safety Committee
SSG	Safeguarding Strategic Group
SUSR	Single Unified Safeguarding Review
VAWDASV	Violence Against Women, Domestic Abuse & Sexual Violence
WAST	Welsh Ambulance Services University NHS Trust

Appendix C: Glossary

Term	Definition
Abuse	This describes physical, sexual, psychological, emotional or financial abuse (and includes abuse taking place in any setting, whether in a private dwelling, an institution or any other place).
Adult Protection Conference	The adult protection conference is a multi-agency meeting which includes the individual adult at risk, their advocate and relevant others, as appropriate. A conference should support and as much as possible be steered by the adult at risk.
Adult Protection and Support Orders (APSOs)	The aim of an APSO is to enable adults at risk to express their views independently. These should be sought rarely after less interventionist approaches have been considered and/or attempted. However, in circumstances when a social services practitioner, or other practitioner acting on the local authority's behalf, is prevented from speaking to the adult suspected of being at risk because of abuse or neglect or the practitioner suspects the adult may be being coerced or threatened into not speaking to the practitioner the local authority can apply for an APSO.
Adult at risk	Describes anyone over 18 years of age who is experiencing or is at risk of abuse or neglect and has needs for care and support (whether or not the authority is meeting any of those needs), and as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it. (S126 of the Social Services and Well-being Act 2014)
Advocacy	Advocacy is defined as any action that supports and represents the voice of the child or adult at risk ensuring that their rights are upheld and the child or adult at risk's views and experiences are heard and respected.
Assessment Framework see the Framework for Assessment of Children and their Families	The Assessment Framework is frequently used in Wales to assess children with care and support needs and those with care and support protection needs. The Framework consists of three domains: child's developmental needs; parenting capacity and family and environmental factors. Each domain is sub-divided into dimensions that is areas that should be considered for each domain.

Authorised Officer re: APSOs	An authorised officer is employed by the local authority and has undertaken specialist training and is required to keep their skills up to date. Their responsibility is to ascertain whether a person is making decisions freely to properly assess whether the person is an adult at risk and to decide, as required by s.126(2) of the Social Services and Well-being (Wales) Act 2014, what, if any, action should be taken.
Care and Support Protection Plan Co-ordinator	Each child, whose name is placed on the child protection register, should have a Care and Support Protection Plan Co-ordinator. They are the named social worker who carries the practitioner responsibility for the case. The social worker must be employed by social services, registered with Social Care Wales and have appropriate qualifications, training and experience to undertake the role of the care and support plan coordinator. They are responsible for coordinating the preparation, completion, review, delivery and revision of the plan. They should actively engage with the child.
Care and support protection plan for adults at risk experiencing abuse or neglect	This is the plan developed by the strategy group. The care and support protection plan seeks to remove or reduce the risk of abuse or neglect. The plan should include all elements of a plan required under Part 4 s19 or 24 of the 2014 Act but emphasise the protection or risk management to support the individual achieve their personal outcomes.
Care and support protection plan for children	Under s.37 of the Social Services and Wellbeing Act 2014 the Local Authority must meet the care and support needs of a child in order to protect them from: abuse or neglect; a risk of abuse or neglect; other harm; a risk of such harm. The detail of the actions required to meet the child's needs and by whom are referred to as care and support protection plans.
Categories of risk of harm	A decision should be made at conference as to whether each child considered is at ongoing risk of significant harm. If this is the case the practitioners at the child protection conference, should decide and record continuing risk of abuse, neglect or harm as being under one, or more, of the following categories: • physical; • emotional or psychological; • sexual; • financial; or

	• neglect The category, or combination of categories, used in registration will indicate to those consulting the register the primary presenting concerns at the time of registration.
Child	An individual under the age of 18 years.
Child Assessment Order	A Child Assessment Order, can be used if parents continue to refuse access to a child for the purpose of establishing basic facts about the child's condition but concerns about the child's safety are not so urgent as to require an Emergency Protection Order. The Order enables the Court to direct the parents to co-operate with an assessment, the details of which will be specific, but does not allow for the removal of the child from home. The Order does not take away the child's own right to refuse an assessment. The parents should be informed of the legal steps that could be used.
Child at risk	This describes an individual under the age of 18 years who is experiencing or is at risk of abuse, neglect or other kinds of harm; and who has needs for care and support (whether or not the authority is meeting any of those needs). When a child has been reported under section 130 of the Social Services and Well-being Act 2014, the local authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare under section 47 of the Children Act (1989).
Child criminal exploitation (CCE)	Occurs when a child under the age of 18 years is involved in criminal activities including the movement of drugs or money which results in personal gain for an individual, group or organised criminal gang. It involves an element of exchange and can still be exploitation even if the activity appears consensual. CCE involve force and/or enticement-based methods of compliance and is often accompanied by violence or threats of violence. It is typified by some form of power imbalance in favour of those perpetrating the exploitation.
Child neglect	Child neglect is a failure on the part of either the male and/or female caregiver or pregnant mother to complete the parenting tasks required to ensure the developmental needs of the child are met. This failure may be associated with parenting issues such as

	such a drug and alcohol misuse. Neglect should be differentiated from poverty and occurs despite reasonable resources being available to enable the carer/s to complete the parenting tasks to a good enough standard. Whilst neglect is likely to be ongoing and cause cumulative harm one-off incidents and episodic neglect can affect the health and development of the child. There are a range of parenting behaviours that can be described as neglect: Medical neglect: a failure to seek and provide appropriate medical, dental and optical care; Nutritional neglect: occurs when the carer fails to pay sufficient attention to the diet for the child who may become obese or fail to thrive; Supervisory neglect: happens when the carer fails to provide the level of guidance and supervision that ensures the child is safe and protected from harm; Educational neglect: is more than securing school attendance it includes a failure on the part of the carer to provide an environment allowing the child to achieve their cognitive potential; Physical neglect: happens when the child does not receive appropriate physical care necessary for their age and development and/or where the child lives in a physical environment that is not conducive to their health and development healthy and/or is unsafe; Identity neglect occurs when a parent or carer fails to recognise and address the child or young person's needs in terms of culture, religion, gender and sexuality.
Child protection register	The child protection register lists all children in a local authority area who are suffering or likely to suffer significant harm and who are currently subject of a care and support protection plan. The child's name is placed on the register in order to: alert all practitioners working with a child to their risk of harm; confirm that a care and support protection plan for the protection of the child is in place and must be complied with; that a social worker and a core group of practitioners are working with the child and family.
Child-centred practice	This means concentrating on the child at each stage of the safeguarding process. This is achieved by focusing on the needs and views of the child by listening to what they have to say, informing and engaging them in the process and having due regard for their wishes when deciding what services are required to meet their needs. Children who are very young, have mental

	health issues, a communication impairment, learning disabilities or wish to be represented or supported should be offered an advocate (see definition of advocacy).
Children's Guardian	Sometimes referred to as a guardian ad litem (GAL) is the person the court appoints to establish what actions are in the "best interests of a child."
Co-production	This means developing a working relationship with the adult at risk and/or the child and their family, so that the individual and their family feel respected and informed, they believe professionals are being open and honest. In turn, they are confident about providing relevant information about themselves, or the child and their circumstances.
Concerns	Suspicion of abuse or neglect may take the form of 'concerns' rather than 'known facts' because evidence of harm may not always be present. Rather, practitioners may suspect abuse or neglect of a child or adult at risk. Alternatively, concerns may be based on information derived from a variety of sources and accumulated over time. Practitioners should also remember that their concerns may, in isolation, not be significant. However, alongside those from other agencies and sources they may build up a picture which suggests that a child or adult at risk may be suffering harm, abuse or neglect.
Conference chair	The primary role of the conference chair is to ensure that the conference is child-centred and that the protection, care and support needs of the child/ren are identified and addressed. The chair should be independent of operational or line management responsibility for the case.
Core group	The core group is a multi-agency group of practitioners with responsibility for developing and delivering the care and support, protection plan. The care and support protection plan co-ordinator should convene the group. All members of the core group have equal ownership of and responsibility for the detailed care and support, protection plan and should co-operate to achieve its aims. Core group members have a responsibility to challenge and report concerns where they believe the plan is not protecting the child from the risk of abuse, neglect or other forms of harm.

Court of Protection	If the adult at risk has been assessed as lacking mental capacity in relation to a matter relating to their welfare, the Court of Protection has the power to make an order under Section 16(2) of the MCA relating to a person's welfare, which makes the decision on that person's behalf to allow access to an adult lacking capacity. The Court can also appoint a deputy to make welfare decisions for that person.
Criminal offence	Abuse or neglect may constitute a criminal offence. These include offences against the person (violent offences), sexual offences and property offences such as theft. If abuse or neglect is motivated by someone's personal characteristic – disability, race and ethnicity, religion and belief, sexual orientation and transgender / gender identity– then this may be a hate crime.
Delegated lead co-ordinator	In certain circumstances an employee from an agency, other than social services, may chair the conference where that agency has more appropriate professional expertise or experience.
Designated Officer for Safeguarding (DOS)	The nominated person within a local authority who is responsible for managing and monitoring safeguarding allegations in relation to paid and unpaid social care workers. Providing advice, information and guidance to employers and voluntary organisations around safeguarding allegations and concerns in relation to practitioners/volunteers. This is a delegated role from the Local Authority Designated Officer (LADO), if in place.
Designated Safeguarding Person (DSP)	Is the identified person within the organisation who is available to discuss safeguarding concerns. They should be consulted as to whether to raise a safeguarding concern with the local authority, will manage any immediate actions required to ensure the individual at risk is safe from abuse. All practitioners should know who to contact in their agency for advice and they should not hesitate to discuss their concerns no matter how insignificant they may appear.
Determination	This term is used within the Social Services and Well-being (Wales) Act 2014 and Handling Individual People to describe the decisions that practitioners should make, in line with legislation and guidance, to address any care and support/protection needs of a child or adult at risk.

Domestic abuse and violence	Domestic violence or abuse is abusive behaviour taking place in a relationship as a way for one person in that relationship to gain or maintain control over another. It includes physical sexual emotional psychological and financial abuse.
Duty to co-operate	If a local authority requests the co-operation of a relevant partner in the exercise of any of its social services functions, the person must comply with the request unless the person considers that doing so would be incompatible with the person's own duties, or otherwise have an adverse effect on the exercise of the person's functions.
Duty to report	For the purposes of this guidance a duty to report to the local authority will be taken to mean a referral to social services who, alongside the police, have statutory powers to investigate suspected abuse or neglect. Concerns about abuse and neglect may be present when a child or adult at risk is already known to Social Services. Do not presume because they are known that there is no need to report. Always report.
Emergency Protection Order (EPO)	An Emergency Protection Order is an order from the court that allows the child to be removed from home if the child is in imminent danger and grants parental responsibility to the local authority. An Emergency Protection Order lasts up to 8 days, but can be extended once, for a maximum of 7 days.
Emergency duty team also known as out of hours team	This describes the arrangements made by the local authority to allow other agencies, practitioners and members of the public to report concerns about a child or adult at risk of abuse that may require a response outside office hours.
Emotional abuse	Emotional abuse is the ongoing emotional maltreatment of a child. It's sometimes called psychological abuse and can seriously damage a child's emotional health and development. Emotional abuse can involve deliberately trying to scare or humiliate a child or isolating or ignoring them. Children who are emotionally abused are often suffering another type of abuse or neglect at the same time Emotional abuse includes: humiliating or constantly criticising a child threatening, shouting at a child or calling them names making the child the subject of jokes, or using sarcasm to hurt a child blaming, scapegoating making a child perform degrading acts not recognising a child's own individuality, trying to control their lives pushing a child too hard or not recognising

	their limitations exposing a child to distressing events or interactions such as domestic abuse or drug taking failing to promote a child's social development not allowing them to have friends persistently ignoring them being absent manipulating a child never saying anything kind, expressing positive feelings or congratulating a child on successes never showing any emotions in interactions with a child, also known as emotional neglect.
Enquiries	Following a report, social services have a duty to make enquires, if there is reasonable case to suspect that a person within its area (whether or not ordinarily resident there) is a child or an adult at risk. This term describes the information-gathering undertaken by social services in order to determine whether any action should be taken to safeguard the child or adult at risk.
Exclusion Orders	These allow for a perpetrator to be removed from the home, instead of removing the child. They can be used in conjunction with an Emergency Protection Order.
Factual accuracy	It is the responsibility of those involved in an assessment of a child or an adult at risk to distinguish between events, occurrences, incidents and state of affairs known to have happened and opinion or suspicion.
Female Genital Mutilation	Female genital mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons The FGM mandatory reporting duty is a legal duty provided for in the FGM Act 2003 (as amended by the Serious Crime Act 2015). The legislation requires regulated health and social care professionals and teachers in England and Wales to make a report to the police if they have reason to believe a girl under the age of 18 years has been subject to FGM. The duty does not apply in relation to at risk or suspected cases or in cases where the woman is over 18. In these cases, local safeguarding procedures should be followed.
Financial abuse	Financial abuse includes theft, fraud, pressure about money, misuse of money.
Framework for the Assessment of Children and their Families (also known as the	The Assessment Framework is frequently used in Wales to assess children with care and support needs and those with care and support protection needs. The Framework consists of three domains: child's developmental needs; parenting capacity and

Assessment Framework or Assessment Triangle)	family and environmental factors. Each domain is sub-divided into dimensions that is areas that should be considered for each domain.
General Data Protection Regulation 2018 (GDPR)	This is Europe's framework for data protection. It applies in the UK and relates to the collection and process of personal data and information.
Gillick competence	This test of competence is used to determine whether a child has reached the stage of development whereby they have sufficient understanding and level of intelligence that means they are capable of making up their own mind on the matter requiring a decision. If the child is deemed to be Gillick competent parents right yield to the child's right to make their own decisions.
Harm	Harm means abuse or the impairment of (a) physical or mental health, or (b) physical, intellectual, emotional, social or behavioural development. The references to 'harm', in relation to section 47 enquiries, referred to in handling individual cases vol 5, means significant harm. Therefore, practitioners must where the question of whether harm is significant turns on the child's health or development, the child's health or development is to be compared with that which could reasonably be expected of a similar child.
Independent Mental Health Advocate (IMHA)	An IMHA is an independent advocate who is trained to work within the framework of the Mental Health Act 1983 to support people to understand their rights under the Act and participate in decisions about their care and treatment.
Independent Professional Advocate (IPA)	Children and young people are entitled to an active offer of advocacy from a statutory Independent Professional Advocate (IPA) when they become looked after or become subject of child protection enquiries leading to an Initial Child Protection Conference".
Initial Child Protection Conference (ICPC)	The initial child protection conference follows s47 enquiries where there are concerns of continuing risk of harm to a child/ren. The conference brings together family members (and the child where appropriate), with the supporters, advocates and practitioners most involved with the child and family, to make decisions about the child's future safety, well-being and development.

Initial evaluation	The initial evaluation builds on the accuracy and factual screening to decide what action should be taken to support and protect the adult at risk. This is achieved by collecting, reviewing and collating information obtained from the adult at risk, and/or practitioners who know the adult and carers during the s.126 enquiries.
Initial screening	Drawing on sufficient i.e. proportionate information, practitioners determine whether further action is required to meet the care and support/protection needs of the adult at risk.
Inter-agency	This term, in the context of these procedures refers to two agencies working collaboratively to identify and meet safeguarding needs. For example, police and social services.
Investigation	These are undertaken by the police when a criminal offence relating to the abuse and neglect is suspected to have occurred. (See also criminal offence.)
Lead care and support protection plan practitioner also known as lead practitioner	This practitioner takes the multi-agency lead and actively engages with and works in partnership with the adult at risk on the care and support protection plan.
Lead co-ordinator	Is a social services local authority employee who should ensure that an adult protection conference is convened, chaired and a record taken. The Lead Co-ordinator must be an individual who is been employed within Social Services and where possible be a qualified social worker registered with the Social Care Wales.
Lead practitioner also known as the lead care and support protection plan practitioner	This practitioner takes the multi-agency lead and actively engages with and works in partnership with the adult at risk on the care and support protection plan.
Local Authority Designated Officer (LADO)	The nominated person with a Local Authority who is responsible for managing and monitoring safeguarding allegations in relation to paid and unpaid social care workers. Providing advice, information and guidance to employers and voluntary organisations around safeguarding allegations and concerns.
Local authority	Local authorities have a key role in identifying and addressing care and support protection needs for both adults and children. This role is set out in a number of statutes.

MAPPA	MAPPA stands for Multi-Agency Public Protection Arrangements and it is the process through which criminal justice agencies work together with other relevant agencies to protect the public by managing the risks posed by violent and sexual offenders living in the community.
MARAC	A multi-agency risk assessment conference (MARAC), is a meeting where information is shared and a co-ordinated action plan developed in high-risk domestic violence situations. The primary aim is to safeguard those experiencing domestic violence. MARACs are attended by representatives of relevant agencies such as local police, probation, health, child protection, housing practitioners, domestic violence advisors and other specialists from the statutory and voluntary sectors.
Mental Capacity Act 2005	The Mental Capacity Act is designed to protect and empower individuals such as adults at risk who may lack the mental capacity to make their own decisions about their care and protection. The Act recognises that an individual may lack capacity to make some decisions but still have the capacity to make other. Moreover, a person may lack capacity to make specific decisions at one point in time but may be able to make the same decision at a later time. The Act assume a person has the capacity to make a decision themselves, unless it's proved otherwise It applies to people aged 16.
Modern Slavery	Modern slavery describes forced labour practices with the perpetrator – the slave master- trapping and controlling the victim. The most common form of modern slavery is sexual exploitation. Labour exploitation is the second most common form of slavery occurring most frequently in the agricultural, food, hospitality and construction sectors. Victims may be vulnerable UK or foreigner citizens. Police, Local Authorities, the National Crime Agency and the Gangmasters Labour and Abuse Authority who encounter a potential victim of modern slavery or human trafficking have a duty to notify the Home Office under Section 52 of the Modern Slavery Act 2015.
Multi-agency	The term, in the context of these procedures, describes a diverse range of organisations working jointly or collaboratively to identify and meet the safeguarding needs of children and adults at risk of abuse or neglect.

Multi-disciplinary	In this context multi-disciplinary means practitioners from different disciplines working together and drawing on their varied expertise and skills to achieve specific objectives, for example delivering a care and support protection plan. Practitioners may be from the same and/or different organisations.
Neglect	This means a failure to meet a person's basic physical, emotional, social or psychological needs, which is likely to result in an impairment of the person's well-being (for example, an impairment of the person's health).
Neglect to an adult at risk	This includes a failure to access medical care or services, emotional neglect, negligence in the face of risk taking, failure to give prescribed medication, failure to assist in personal hygiene or the provision of food, shelter or clothing.
Office of the Public Guardian	The Office of the Public Guardian (OPG) protects people in Wales and England who may not have the mental capacity to make certain decisions for themselves, such as about their health and finance.
Out of hours team also known as emergency duty team	This describes the arrangements made by the local authority to allow other agencies, practitioners and members of the public to report concerns about a child or adult at risk of abuse that may require a response outside office hours.
Part 3 assessments under The Social Services and Wellbeing (Wales) Act 2014	Part 3 of the Act outlines the local authority responsibilities to assess a person's needs for care and support or a carer's needs for support.
Person-centred	Being person-centred means putting the needs of the person at the centre of decision-making. This means engaging with the adult at risk throughout the safeguarding process; enabling them to determine how risks are managed and ensuring decision-making takes account of what they want to happen and the personal outcomes they wish to achieve. It is a legal duty to consider a person's need for advocacy and to provide appropriate support to enable people to participate. This may be through professional advocacy or informal advocates such as family members/carers. It is important that practitioners assume a person has the mental capacity to engage in the process and

	make decisions unless it is established that they lack capacity to make specific decisions at a specific time.
Physical abuse to a child	Physical abuse means deliberately hurting a child or young person. It includes: physical restraint; such as being tied to a bed, locked in a room inflicting burns cutting, slapping, punching, kicking, biting or choking stabbing or shooting withholding food or medical attention drugging denying sleep inflicting pain shaking or hitting babies fabricating or inducing illness (FII).
Physical abuse to an adult at risk	This includes hitting, slapping, over or misuse of medication, undue restraint or inappropriate sanctions.
Police Powers of Protection	Police Powers of Protection can be used without reference to a Court and is only used in emergency situations where a delay in an Emergency Protection Order may put a child at risk. Police Powers of Protection lasts up to 72 hours.
Practitioner	The term 'practitioner' has been used as a blanket term to describe anyone who is in paid employment as well as unpaid volunteers.
Professional abuse	Where a professional whose work, either in a paid or voluntary capacity, brings them into contact with children or adults at risk, or have caring responsibilities for children or adults, and their employment brings them into contact with children or adults at risk, who then in a position trust abuse or neglect children or adults at risk in their care.
Psychological abuse	Threats of harm or abandonment, coercive control, humiliation, verbal or racial abuse, isolation or withdrawal from services or supportive networks, witnessing abuse of others.
Psychological abuse to an adult at risk	This includes threats of harm or abandonment, coercive control, humiliation, verbal or racial abuse, isolation or withdrawal from services or supportive networks; coercive control is an act or pattern of acts of assault, threats, humiliation, intimidation or other abuse that is used to harm, punish or frighten the victim.
Referral	For the purposes of these procedures a report to social services will be taken to also mean a referral.
Referrer aka report-maker	The practitioner or member of the public who reports to social services concerns about possible abuse, neglect of an adult at risk or harm, abuse or neglect to a child.

Regional Safeguarding Boards	These are the six multi-agency strategic boards of relevant partner agencies set up across Wales designed to protect children and adults at risk of, abuse or neglect and to prevent those children and adults from becoming at risk of abuse or neglect. Members of the board are referred to as relevant partners Under Part 7 of the Social Services and Well-being (Wales) Act 2014, (SSWA 2014) local authorities must establish Safeguarding Children Boards comprised of representatives from local authorities, the local police body, local health board, NHS Trust, probation board, youth offending team and others.
Relevant partners	The Social Services and Wellbeing (Wales) Act 2014 s 128, 129 and 130 specifies the duty placed on practitioners deemed to be 'relevant partners' under section 162 of the Act to report both adults and children, including unborn children, they have reasonable cause to suspect are at risk of abuse. This includes employees of policing body, local authority, probation and offender management services, health boards and NHS trusts and those discharging functions under Part 2 of the Learning and Skills Act 2000. All those whose agencies are not included as 'relevant partners' as listed above are still expected to report any safeguarding concerns in the same way as those with a specific duty to report. This includes both paid and non-paid practitioners in third sector organisations (this includes: voluntary, independent contractors and sub-contractors, independent professionals and private organisations).
Report-maker aka referrer	The practitioner or member of the public who reports to social services concerns about possible abuse, neglect of an adult at risk or harm, abuse or neglect to a child.
Report-taker	The social services practitioner who receives the report, completes initial checks and establishes whether immediate action is required.
Safeguarding	Safeguarding means preventing and protecting children and adults at risk from abuse or neglect and educating those around them to recognise the signs and dangers.
Safeguarding lead	is the identified person within the organisation who: is available to discuss safeguarding concerns; should be consulted, when possible, as to whether to raise a safeguarding concern with the local authority; will manage any immediate actions required to

	ensure the individual at risk is safe from abuse. All practitioners should know who to contact in their agency for advice and they should not hesitate to discuss their concerns no matter how insignificant they may appear.
Section 126(2) Social Services and Well-being (Wales) Act 2014	Safeguarding enquiries into concerns about abuse and neglect of an adult at risk are made under s.126 of the Social Services and Well-being (Wales) Act 2014. They may be referred to as s126 enquiries.
Section 47 Enquiries under the Children Act 1989	The purpose of the Children Act 1989 Section 47 enquiries is to establish whether a child is suffering or is likely to suffer significant harm and requires intervention to safeguard and promote their well-being. Social services have lead responsibility for the enquiries. Other practitioners, such as the police, health, education and other relevant partners have a duty to co-operate and help Social Services undertake its enquiries.
Sexual abuse to a child	There are 2 different types of child sexual abuse. These are called contact abuse and non-contact abuse. Contact abuse involves: touching activities where an abuser makes physical contact with a child, including penetration. It includes: sexual touching of any part of the body whether the child's wearing clothes or not rape or penetration by putting an object or body part inside a child's mouth, vagina or anus forcing or encouraging a child to take part in sexual activity making a child take their clothes off, touch someone else's genitals or masturbate. Non-contact abuse involves: non-touching activities, such as grooming, exploitation, persuading children to perform sexual acts over the internet and flashing. It includes encouraging a child to watch or hear sexual acts not taking proper measures to prevent a child being exposed to sexual activities by others meeting a child following sexual grooming with the intent of abusing them online abuse including making, viewing or distributing child abuse images allowing someone else to make, view or distribute child abuse images showing pornography to a child sexually exploiting a child for money, power or status (child exploitation).
Sexual abuse to an adult at risk	This includes rape and sexual assault or sexual acts to which the adult has not or could not consent and / or was pressured into consenting.

Sexual exploitation	Sexual exploitation is the coercion or manipulation of children or adults at risk into taking part in sexual activities. It is a form of sexual abuse involving an exchange of some form of payment which can include money, mobile phones and other items, drugs, alcohol, a place to stay, 'protection' or affection. The vulnerability of the individual and grooming process employed by perpetrators renders them powerless to recognise the exploitative nature of relationships and unable to give informed consent.
Significant harm	Where the question of whether harm is significant turns on the child's health or development, the child's health or development is to be compared with that which could reasonably be expected of a similar child.
Social Services	Social services are a department of the local authority responsible for the provision of social care for adults at risk and children. They act on behalf of the local authority to discharge the local authority's statutory duties and powers to make enquiries and intervene when necessary when there is reason to believe a child or adult is at risk.
Strategy discussion or meeting concerning a child believed to be at risk of or experiencing harm	The purpose of a strategy meeting/discussion is to determine whether there are grounds for a Section 47 enquiry under the Children Act 1989. This usually takes place when the indications from the initial enquires are that there are reasonable grounds to believe a child has suffered or is likely to suffer significant harm. Strategy meetings should be multiagency involving, at a minimum, social services and the police. Other key practitioners involved with the child and their family should also attend.
Strategy discussion/meeting for adults at risk experiencing abuse and neglect	This is the forum for sharing information, making sense of the information and deciding what action should be taken by whom and by when. It is also the vehicle for developing, implementing and reviewing the care and support protection plan. Such as meeting may be held virtually if urgency demands.
Strategy group for adults at risk of abuse or neglect	The strategy group are the practitioners who attend the strategy meeting/s or discussions/s, establish whether the adult at risk is experiencing abuse and neglect and whether they need a care and support protection plan. They are also responsible for developing, implementing and reviewing the care and support protection plan.

Trafficking	Child trafficking describes the recruitment, transportation, transfer, harbouring or receipt, of a child which includes an element of movement from one place to another. The child may be suffering abuse through sexual exploitation, criminal exploitation, forced labour or domestic servitude, slavery, financial exploitation, illegal adoption or removal of organs. It occurs to those up to the age of 18 years old. Adult trafficking describes the recruitment, transportation, transfer, harbouring or receipt, of an adult at risk which includes an element of movement from one place to another. The adult at risk may be suffering abuse through sexual exploitation, criminal exploitation, forced labour or domestic servitude, slavery, financial exploitation, or removal of organs.
Transferable Risk	Behaviour which could have an impact on suitability to work with, or make decisions about the care of, children, young people or 'adults at risk'.
VAWDASV	VAWDASV stands for Violence Against Women, Domestic Abuse and Sexual Violence. It incorporates Violence Against Women (and Girls), Domestic Abuse, Rape and Sexual Violence, Sexual Harassment, Female Genital Mutilation, Honour based violence, Forced Marriage, Stalking, Trafficking and other forms of violence.

Ymddiriedolaeth Brifysgol GIG Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services University NHS Trust

Violence Against Women, Domestic Abuse, and Sexual Violence "Ask and Act" Policy

Policy Number:	081	**Version No:**	1.19 Draft	**Supersedes:**	1.5 Published 26/11/2019
Date of Approval:	TBC	**Review Date:**	3 years from date of approval	**Impact Assessments Completed:**	Yes (04/10/2024)
Classification of Document:	Safeguarding	**Type of Document:**	Policy	**Approved by:**	Quality, Patient Experience & Safety Committee
Brief Summary of Document:	The Welsh Ambulance Services University NHS Trust (WAST) is committed to the health and well-being of its patients and colleagues. This includes raising awareness of domestic abuse, gender based violence and sexual violence and providing a framework which supports appropriate care and actions for victims of such abuse and their families.				
Scope:	This policy applies to all WAST colleagues. Included within WAST colleagues are employees, volunteers, non-executive director board members appointed by Welsh Government, students, apprentices and any individual representing WAST				
To be read in conjunction with:	The following WAST documents; WAST Information Governance Policy (2018) WAST Management of Allegations (2017) [2024 under review currently] WAST Data Protection Policy (2024) WAST Safeguarding Children and Adults at Risk Policy (2017)[2024 under review currently] WAST Management of Concerns / Allegations of Abuse or Neglect of a Child/Young Person or Adult at Risk Against an Employee of the Welsh Ambulance Services University NHS Trust [2024 under review currently] WAST Live Fear Free SOPs The following National Guidance: Welsh Government Safeguarding Guidance				
Owning Committee	Quality, Patient Experience and Safety Committee				
Policy Lead: **Trade Union Lead:**	Rhiannon Thomas Maldwyn Jones	**Job Title:**	Safeguarding Specialist Trade Union Partner		
Executive Director:	Liam Williams	**Job Title:**	Executive Director of Quality and Nursing		

Version Control Sheet

Version	Date	Author	Summary of Changes
For approval route 2017-2019 please see previous version of published policy			
1.6	10/05/2024	Lisa Trounce	Previous policy transferred to current template reflecting new Crown badge, Trust logo, correct colours. Front page partially updated. Version Control Sheet updated.
1.7	29/07/2024	Rhiannon Thomas	Amendments: title, job roles, policy lead information, task and finish group review updates
1.8	06/08/2024	Rhiannon Thomas	Reviewed objectives and added update. Section 6 updated description of domestic abuse (DA), updated statistics as relevant. Removed “Routine Enquiry” as no longer applicable Key words added
1.9	19/08/2024	Rhiannon Thomas	Hyperlinks reviewed, grammar corrected, task and finish group review amendments completed.
1.10	18/09/2024	Lisa Trounce	Review of partially updated draft policy – formatted, amended and comments supplied for action by Policy Lead.
1.11	25/09/2024	Task and Finish Group, and Safeguarding Team	Amendments and comments added
1.12	07/10/2024	Rhiannon Thomas	Added Health and Quality Care Standards, and Impact Assessment information from relevant Leads. Minor formatting.
1.13	18/10/2024	Lisa Trounce	Final review and formatting prior to submission to Policy Group
1.14	29/10/2024	Rhiannon Thomas	Amendments following review by Policy Group
1.15	30/10/2024	Lisa Trounce	Formatting prior to Trust-wide consultation
1.16	03/12/2024	Rhiannon Thomas	Amendments made to policy following Trust-wide consultation: - Front cover updated (classification, scope, documents)

Version	Date	Author	Summary of Changes
			- 2.0 Trust name replaced with WAST, and 'employees' changed to 'WAST colleagues. - 3.0 Additional sentence added to Scope - 4.0 Reference to National Training Framework on VAWDASV 2016 removed - 6.0 Reference to National Abuse Act 2021 added - 6.2 'Principles based approach' added, and Link to The Principles of Ask and Act WH33526 (gov.wales) removed - 6.3 Action options – amended - 6.4 Pathway for Patients or Service Users – amended - 6.5 Pathway for WAST Colleagues who have experienced VAWDASV – amended - 6.6 Information Sharing: link to Striking the Balance (publishing service.gov.uk – removed; and reference to Department of Health 2012 added - 8.3 Reference to 'five-year training plan' removed - 9.0 Impact Assessment section updated specific to outcomes of EqIA for this policy - 10, Roles and responsibilities amended - 11. Audit and Monitoring section strengthened - 12. References added
1.17	13/12/2024	Lisa Trounce	Review and formatting prior to presentation of post consultation policy to Policy Group on 18/12/2024.
1.18	18/12/2024	Lisa Trounce	Front cover and policy approval route updated in readiness for onwards travel to ADLT 08/01/25 – recommended for approval by committee
1.19	24/01/2025	Lisa Trounce	Front cover and policy approval route updated in readiness for onwards travel to Quality, Safety and Patient Experience (QuEST) Committee for approval and adoption.

Impact Assessment Reviews

Area	Date of Review	Name of Reviewer
Data Protection	03/10/2024	Kelly Holding (Data Compliance Manager)
EqIA	26/09/2024	Kathryn Cobley (Head of Inclusion and Engagement)
Welsh Language	03/10/2024	Melfyn Hughes (Welsh Language Services Manager)
Environment	03/10/2024	Nicci Stephens, Environment & Sustainability Manager
Quality	04/10/2024	Kate Blackmore (Senior Quality Governance Lead)

Task and Finish Group Members

Name	Job Title
Rhiannon Thomas	Safeguarding Specialist
Maldwyn Jones	TU Partner
Christine Hinton	Safeguarding Specialist
Linda Bladen	Locality Manager
Kathy Lodwig	Senior Practitioner Educator/Practice coach Team Leader

Policy Approval Route

Meeting Title	Meeting Date	Purpose/Outcome
Safeguarding Team meeting	25/09/2024	Draft review
Policy Group	23/10/2024	Final Draft reviewed – approved from Trust-wide consultation
28-day Consultation Period	30/10/2024 – 27/11/2024	Trust wide consultation
Policy Group	18/12/2024	Post Consultation Review - Recommended for Approval
Assistant Directors Leadership Team	08/01/2025	Recommended for approval by Committee
Quality, Patient Experience and Safety Committee (QuEST)	04/02/2025	For Approval and Adoption

Disclaimer
If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Amb_policies@wales.nhs.uk

Contents

1. INTRODUCTION

1.1 Incidents of domestic abuse, gender-based violence against women, and sexual violence have a significant impact on those who experience it. Identifying abuse at an early stage can prevent an escalation in severity and frequency.

The Welsh Ambulance Services University NHS Trust (WAST) is committed to acting to better identify and respond to incidences of this form of violence and abuse. This includes victims who are patients, service users, their families and in the workplace when the victim is a WAST colleague.

1.2 The Trust recognises that within its workforce there are potentially a significant number of employees or volunteers who have experienced or who are currently experiencing abuse in their personal or professional lives and those who are perpetrators of abuse.

It is therefore essential that the Trust develops an effective response to help minimise the impact of this abuse. *This policy provides a framework for the management of these situations.* This ensures that those involved are supported in an appropriate manner.

1.3 The National Institute of Health and Care Excellence (NICE 2014) and the World Health Organisation (2013) recommended a system of targeted or clinical enquiry across Health and Social Care to better identify and respond to domestic abuse.

"The Government of Wales Act 2006, section 60, proposes a principles-based approach of targeted enquiry for "Ask and Act" to be implemented across Public Services. This is further supported by The Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 and associated guidance on "Ask and Act" under section 15" of the Act.

1.4 The Welsh Ambulance Services University NHS Trust is committed to implementing this principles based approach, which will assist patients/service users and employees of the Trust who are involved in, or who are the victims of domestic abuse, gender based violence and sexual violence when these circumstances become known. Domestic abuse, gender- based violence and sexual violence includes:

- Domestic abuse
- Sexual violence (within and not within relationships)
- Controlling or coercive behaviour
- Female Genital Mutilation (FGM)
- Forced marriage
- "Honour" based abuse
- Stalking and harassment (within and not within relationships)
- Sexual Exploitation.

2. POLICY STATEMENT

WAST has a duty under The Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 (VAWDASV) to fulfil its obligations as a public body as set out in the Act.

The Trust is committed to the health and well-being of patients, service users and WAST colleagues. The Trust recognises that domestic abuse is a crime, which adversely affects the health of individuals, families and communities. Identifying abuse and/or violence at an early stage can be an effective measure in preventing an escalation in severity and frequency and can assist to ensure appropriate and timely support is provided. Taking a responsive and enabling approach is fundamental in encouraging adults who are experiencing violence, threats, intimidation, and other abuse to disclose.

3. SCOPE

This policy applies to all WAST colleagues. Included within WAST colleagues are employees, volunteers, non-executive director board members appointed by Welsh Government, students, apprentices and any individual representing WAST.

This policy applies to all patients/service users and WAST colleagues. It will apply equally regardless of age, gender, sexual orientation or other protective characteristic to all patients/service users or WAST colleagues who seek care, support, advice or assistance for the circumstances highlighted within this policy.

This policy outlines the commitment of the Trust and its agreement that professionals will be able to identify domestic abuse, gender- based violence and sexual violence, and be confident to ask about these issues in a safe setting and to ensure an appropriate response and action as required. The process of “Ask and Act” must be implemented within a culture and environment where the confidentiality, privacy and data of victims is respected and treated in accordance with the lawful basis for processing Safeguarding information and the General Data Protection Regulations.

4. AIM

This policy aims to ensure the Trust meets the legal requirements of the VAWDASV (Wales) Act 2015 and the legislative aim to ‘Improve the responses of Public Bodies to all forms of Violence against Women, Domestic Abuse and Sexual Violence’.

This will be achieved through the adoption of “Ask and Act”, a Welsh Government policy of targeted enquiry to be practised across the public services for domestic abuse, gender-based violence and sexual violence.

5. OBJECTIVES

The Trust will achieve this Aim by:

- Enabling the "Ask and Act" system and approach of targeted enquiry.
- Ensuring relevant staff roles, working within the Trust are skilled to recognise potential indicators of such violence and abuse and take appropriate action.
- Ensuring the requirements of the National Training Framework (NTF) are met.
- Promoting awareness of VAWDASV and promoting working practices to increase support for victims.
- Working in partnership with other agencies both statutory and voluntary within Wales to fulfil the requirements of the Act.
- Creating a culture across the Trust where addressing violence against women, domestic abuse and sexual violence is an accepted aspect of expected behaviour and where disclosure is supported and facilitated.
- Ensuring that the required Safeguarding procedures are followed in relation to these issues under the Children Act 2004, Social Services and Wellbeing (Wales) Act 2014.

6. VIOLENCE AGAINST WOMEN, DOMESTIC ABUSE AND SEXUAL VIOLENCE

"Domestic abuse is any single incident, course of conduct or pattern of abusive behaviour between individuals aged 16 or over who are "personally connected" to each other as a result of being, or having been, intimate partners or family members, regardless of gender or sexuality", Domestic Abuse Act (2021).

Recent changes in legislation made by the Domestic Abuse Act (2021) aim to transform the response of statutory and non-statutory agencies to domestic abuse. This includes an extension of legislative guidance, which aims to improve support for victims of abuse. Domestic abuse needs to be understood, viewed as unacceptable, and actively challenged across organisations in Wales. The Act puts the definition and accompanying guidance on a statutory footing. It sets out who can be a victim of domestic abuse and establishes how victims need to be personally connected to the perpetrator. The definition of personally connected applies to partners, ex partners and family members. The parties do not need to be cohabiting or currently in a relationship for the definition to apply.

6.1 Statistics

Whilst statistics demonstrate that domestic abuse disproportionately affects women (ONS 2022). This policy acknowledges that anyone can be affected by domestic abuse and sexual violence; regardless of age, gender, sexual orientation, socio economic status or other protected characteristics.

Domestic abuse, gender-based violence and sexual violence are a large scale, pervasive problem, which every year causes needless deaths and damage to thousands of lives across Wales.

- The British Crime Survey 2022 reported 1.6 million incidents of domestic abuse in England and Wales.
- There were also 786,000 incidents of sexual assault reported in the same year.
- Domestic abuse currently costs UK businesses over £2.7 billion a year.
- Economic pressures in Wales have a profound impact on the vulnerability of individuals to domestic abuse and sexual violence (VAWDASV-National Advisers annual report 2022-23)
- 75% of women that experience domestic abuse are targeted at work - from harassing phone calls and abusive partners arriving at the workplace unannounced, to physical assaults.
- 15% of men aged 16-59 state they have been physically assaulted by a current or former partner at some time in their lives.
- In 2021 it is estimated that 137,000 women resident in England and Wales have been subjected to female genital mutilation
- In 2023, 283 cases were handled by the UK Forced Marriage Unit 195 cases involved female victims and 88 involved male victims. Violence and abuse in any form is unacceptable.

6.2 "Ask and Act"

This is a principles-based approach of targeted enquiry (VAWDASV Act 2015). The primary objective of this is to enable relevant professionals to "ask" potential victims when the indicators of concern have been identified and to "Act" so that suffering and harm as a result of the violence and abuse, is prevented or reduced.

This approach aims to strengthen health professionals' response, compliance and actions to support the needs of victims and their families in such circumstances across Wales.

6.3 Action Options

Patients, service users and WAST colleagues who experience domestic abuse, gender-based violence and sexual violence in their personal lives will require the Trust to take appropriate actions and ensure support.

There are three options available for WAST colleagues to achieve this:

- An Adult Safeguarding report to local authority for those who meet the definition of an adult at risk.
- A Child Safeguarding report for children affected by this form of abuse.
- Utilising WAST Pathway to the specialist VAWDASV services provided by the Live Fear Free national helpline for Wales. Further information on the Live Fear Free SharePoint page.

6.4 Pathway for patients or service users

All WAST colleagues can refer a patient or service user to the Live Fear Free helpline. Please see the relevant Standard Operating Procedure (SOP) on the Safeguarding SharePoint Pages.

6.5 Pathway for WAST colleagues who have experienced VAWDASV

- Managers of WAST colleagues experiencing this form of violence should liaise with WAST People Services department and the Safeguarding Team as appropriate to ensure that supportive measures are actioned as required for victims of these issues.

- Disclosures may also be made to colleagues and other services within WAST e.g. the Wellbeing Team.

There is further guidance, including support for managers, on the Safeguarding SharePoint Pages.

All Pathways must be considered alongside safeguarding duties, in accordance with legislation and the WAST Safeguarding Children and Adults at Risk of Harm Policy.

6.6 Information Sharing

To meet the requirements of sharing information for these circumstances; the provisions of the Children Act 1989 and 2004, the Social Services and Wellbeing (Wales) Act 2014, the Violence Against Women, Domestic Abuse and Sexual Violence Act 2015, the General Data Protection Regulations 2018 and the Caldicot Principles apply.

“This provides a ground rule for Caldicott Guardians - all information shared about both victims and perpetrators must be in the context of the normal requirements of information sharing without consent, in this case on the basis of prevention and detection of crime or serious harm.” (Department of Health, 2012)

6.7 WAST colleagues who may be alleged perpetrators

When colleagues working within WAST are alleged perpetrators of these forms of violence; please refer to WAST policy on “Allegations of Abuse or Neglect of a Child/Young Person or Adult at Risk against an Employee” (2017) currently under review

7. EQUALITY

EQIA screening was undertaken and evidenced a positive impact. The Policy will have a positive effect on all relevant groups except the Welsh Language where its effect is considered to be neutral.

The full EQIA document can be accessed by request to the Assistant Director of Safeguarding.

8. TRAINING AND IMPLEMENTATION

8.1 WAST is committed to providing high quality evidence-based education to an engaged and skilled workforce operating within an organisational culture and framework that enables colleagues to work to the top of their skill set to deliver high quality care and services with competence and confidence. To implement this policy Welsh Government has published statutory guidance for "Ask and Act" as well as the National Training Framework (NTF) which provides the mechanism for achieving compliance with the requirements of the VAWDASV Act 2015.

8.2 Under the guidance WAST is required to comply with Group 1, 2, 3 and 6 of the NTF as follows:

NTF	Objective	Staff Group	Statutory Requirement
Group 1	Group1 training aims to provide a basic awareness introduction to the issues of VAWDASV.	All employees of WAST	Every 3 years
Group 2	Group 2 training aims to provide understanding of the issues and actions required by staff who are most likely to make contact either directly or indirectly with those experiencing VAWDASV as part of their role	Paramedics, EMT, ACA2/UCS, ACA1/NEPTS, Nurses	Every 2 years
Group 3	The aim of Group 3 is to ensure a proportion of staff who are ready and able to support colleagues and clients when victims of VAWDASV are identified. Professionals in Group 3 require an enhanced understanding (beyond Group 2) of the topic in order to support the mitigation of risk for victims and their families when there is contact with our service	Trained Trainers, Champions	Group 2 Every 3 years
Group 6	Group 6 of the Framework aims to encourage building towards a culture and infrastructure which provides leadership and management support to introduce and implement knowledge and practice direction.	WAST Executive and Senior Management	Annually Reviewed Strategic Engagement Plan

8.3 Training requirements will be embedded within WAST Safeguarding Training Strategy. The Safeguarding Team will complete the Train the Trainer accreditation course and deliver the required training to WAST colleagues. WAST colleagues are required to achieve Groups 1, 2 and 3 of the VAWDASV NTF. This training has been incorporated into a five-year training plan. This training is delivered by WAST Safeguarding Team's accredited trainers on induction and via bespoke training sessions.

8.4 The Trust is required to report annually to Welsh Government on compliance with the NTF organisational training plan. The responsibility for this sits with the nominated Ask and Act lead and the Safeguarding Team.

9. IMPACT ASSESSMENTS

9.1 Equality Impact Assessment

EQIA screening was undertaken and evidenced a positive impact. The Policy will have a positive effect on all relevant groups.

The full EQIA document can be accessed by request to the Assistant Director of Safeguarding.

9.2 Welsh Language Impact Assessment

This policy facilitates support for service users and WAST colleagues who have experienced VAWDASV from the relevant Local Authority or Specialist Helpline through the medium of Welsh as needed. It is therefore determined as having a positive effect.

9.3 Environmental Standards and Impact Assessment

WAST referral and reporting process has been digitalised, significantly reducing the requirement for paper safeguarding reports as these are now only part of the contingency reporting process. This will have a positive impact on the environment.

9.4 Counter Fraud

WAST is committed to taking all necessary steps to counter fraud, bribery and corruption within the Trust. Colleagues should report suspected incidents of fraud and corruption to the Trust Local Counter Fraud Specialist, who will be happy to discuss any issues or concerns. Alternatively colleagues may contact the confidential NHS Counter Fraud Authority, Fraud and Corruption Reporting line on 0800 028 40 60; or the on-line reporting facility Service https://cfa.nhs.uk/report-fraud Fraud investigations may lead to disciplinary action and / or prosecution and civil recovery procedures.

9.5 Records Management

WAST recognises the importance of sound records management arrangements for both clinical and corporate records. The Trusts' records are its corporate memory, providing evidence of actions and decisions and representing a vital asset to support daily functions and operations. Records support policy formation and managerial decision-making, protect the interests of the Trust and the rights of patients, WAST colleagues and members of the public.

9.6 Information Governance

The Trust and WAST colleagues shall ensure that they provide satisfactory assurance on how the organisation fulfils its statutory and organisational responsibilities in relation to the management of information. It will enable management and colleagues to make correct decisions, work effectively and comply with relevant legislation and the organisations aims and objectives.

The General Data Protection Regulation (GDPR) and safeguarding policies work together to ensure that information is shared appropriately and confidentially to protect children and adults at risk of harm (Data Protection Commission, 2019).

The IG framework ensures that it sets out the high-level principles for confidentiality, integrity and availability of information to promote and build a level of consistency across the Trust.

9.7 Health & Care Quality Standards 2023

In line with the Health & Social Care (Quality & Engagement) (Wales) Act 2020 and the Duty of Quality, twelve health and care quality standards have been developed to help us understand what good quality means and how we apply it in practice. These standards are intended to apply broadly to the wide range of services provided by the NHS in Wales and provide a high level framework to support the Trust in planning, delivering and monitoring our services.

When considering this policy the following standards and associated statements are of particular importance:

- Safe: People's health, safety and welfare are actively promoted and protected; risks are identified and monitored and where possible risks to safety are reduced or prevented. We promote and protect the wellbeing, and safety of children and adults who become vulnerable or at risk at any time. Where children or adults may be experiencing or are at risk of abuse or neglect, we taken appropriate, time action and report concerns.

- Person Centred: We care about the wellbeing of individual, their families, carers and our colleagues. We ensure that everyone is always treated with kindness, empathy and compassion and we respect their privacy, dignity and human rights.

- Workforce: We care about our people and their wellbeing, protect their rights and support them to feel well and happy at work; and provide them with the tools, systems and environment to work safely and effectively.

- Culture: Relationships within teams and with the people we serve are effective and based on transparency, accountability, ethical behaviour, trust and just culture where people can thrive.

10. ROLES AND RESPONSIBILITIES

10.1 Chief Executive

The Chief Executive holds the ultimate responsibility for this within the Trust and for the organisational arrangements necessary to achieve compliance. The Chief Executive delegates responsibility to all Executive Directors for the effective management of these issues within their Directorate.

10.2 The Quality Safety and Patient Experience Directorate

The Executive Director of Quality and Nursing is the Executive Director with a lead responsibility for domestic abuse, gender-based violence against women and sexual violence as determined by the Act (2015).

The Assistant Director of Safeguarding ensures the strategic management of these issues, providing leadership, expert and specialist guidance to the organisation. The Assistant Director of Safeguarding delegates responsibility for meeting the requirements of the NTF to the nominated lead for “Ask and Act”.

The “Ask and Act” lead has a responsibility for coordinating the Trust’s response and training plan to achieve the requirements of the NTF. The “Ask and Act” lead will delegate responsibility for the management of training to the approved trainers in accordance with the NTF.

10.3 The Safeguarding Team

The Safeguarding Team support the work of the Assistant Director of Safeguarding and the “Ask and Act” lead.

The Team has a responsibility to monitor and manage VAWDASV issues highlighted through the established safeguarding referral processes and pathways.

The Safeguarding Team will also provide support, advice and direction to WAST colleagues on VAWDASV issues as required.

10.4 Managers and Departmental Leads

Managers and Departmental Leads are responsible for leadership and responsible attitudes towards all aspects of domestic abuse, gender- based violence against women and sexual violence; for patients, service users, staff and volunteers affected by the activities under their managerial control.

This includes compliance with legislation, statutory training, policy and procedures.

10.5 All WAST Colleagues

All WAST colleagues are expected to have an awareness of the issues involved in domestic abuse, gender-based violence against women and sexual violence as required by Group 1 of the NTF.

All clinical practitioner colleagues are expected to be compliant with Group 2 of the NTF. This will be achieved in accordance with the Trust’s five-year training plan and then with the statutory training compliance as required by the NTF.

All WAST colleagues are required to fulfil their duty to protect, support and take appropriate action for victims and their families who experience these forms of abuse and violence.

10.6 The Safeguarding Strategic Group (SSG)

SSG has been established to support the Trust Executive Lead for Safeguarding in the provision of assurance to the Board on all matters relating to safeguarding. SSG has the responsibility for ensuring the governance and infrastructure to effectively manage the requirements of the VAWDASV Act and associated statutory training of the NTF.

11. AUDIT AND MONITORING

Reporting and monitoring of safeguarding standards is completed via internal reporting mechanisms. SSG has responsibility for ensuring governance and infrastructure for the NTF implementation, audit and monitoring of compliance. SSG reports and escalates matters to Clinical Quality Governance Group (CQGG), which in turn reports and escalates matters to ELT.

The “Ask and Act” Lead will provide quarterly reports on the Trusts compliance with training for the specified groups. This mechanism will support the organisations compliance with the legislative requirements of the VAWDASV Act 2015.

WAST Safeguarding Team has responsibility for reporting on the impact of “Ask and Act” and associated data on the Pathways and Safeguarding referrals related to these issues. This will be provided quarterly to the Safeguarding Strategic Group and annually to the Trust and Welsh Government.

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GLOSSARY

Term	Definition
Abuse	This describes physical, sexual, psychological, emotional or financial abuse (and includes abuse taking place in any setting, whether in a private dwelling, an institution or any other place).
Adult at risk	Describes anyone over 18 years of age who is experiencing or is at risk of abuse or neglect and has needs for care and support (whether or not the authority is meeting any of those needs), and as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it. (S126 of the Social Services and Well-being Act 2014)
Advocacy	Advocacy is defined as any action that supports and represents the voice of the child or adult at risk ensuring that their rights are upheld and the child or adult at risk's views and experiences are heard and respected.
Child	An individual under the age of 18 years.
Child at risk	This describes an individual under the age of 18 years who is experiencing or is at risk of abuse, neglect or other kinds of harm; and who has needs for care and support (whether or not the authority is meeting any of those needs). When a child has been reported under section 130 of the Social Services and Well-being Act 2014, the local authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare under section 47 of the Children Act (1989).
Child protection register	The child protection register lists all children in a local authority area who are suffering or likely to suffer significant harm and who are currently subject of a care and support protection plan. The child's name is placed on the register in order to: alert all practitioners working with a child to their risk of harm; confirm that a care and support protection plan for the protection of the child is in place and must be complied with; that a social worker and a core group of practitioners are working with the child and family.
Co-production	This means developing a working relationship with the adult at risk and/or the child and their family, so that the individual and their family feel respected and informed, they believe professionals are being open and honest. In turn, they are confident about providing relevant information about themselves, or the child and their circumstances.
Concerns	Suspicion of abuse or neglect may take the form of 'concerns' rather than 'known facts' because evidence of harm may not always be present. Rather, practitioners may suspect abuse or neglect of a child or adult at risk. Alternatively, concerns may be based on information derived from a variety of sources and accumulated over time. Practitioners should also remember that their concerns may, in isolation, not be significant. However, alongside those

	from other agencies and sources they may build up a picture which suggests that a child or adult at risk may be suffering harm, abuse or neglect.
Criminal offence	Abuse or neglect may constitute a criminal offence. These include offences against the person (violent offences), sexual offences and property offences such as theft. If abuse or neglect is motivated by someone's personal characteristic – disability, race and ethnicity, religion and belief, sexual orientation and transgender / gender identity– then this may be a hate crime.
Designated Safeguarding Person (DSP)	The identified person within the organisation who is available to discuss safeguarding concerns. They should be consulted as to whether to raise a safeguarding concern with the local authority, will manage any immediate actions required to ensure the individual at risk is safe from abuse. All practitioners should know who to contact in their agency for advice and they should not hesitate to discuss their concerns no matter how insignificant they may appear.
Domestic abuse and violence	Domestic violence or abuse is abusive behaviour taking place in a relationship as a way for one person in that relationship to gain or maintain control over another. It includes physical sexual emotional psychological and financial abuse.
Duty to co-operate	If a local authority requests the co-operation of a relevant partner in the exercise of any of its social services functions, the person must comply with the request unless the person considers that doing so would be incompatible with the person's own duties, or otherwise have an adverse effect on the exercise of the person's functions.
Duty to report	For the purposes of this guidance a duty to report to the local authority will be taken to mean a referral to social services who, alongside the police, have statutory powers to investigate suspected abuse or neglect. Concerns about abuse and neglect may be present when a child or adult at risk is already known to Social Services. Do not presume because they are known that there is no need to report. Always report.
Emotional abuse	Emotional abuse is the ongoing emotional maltreatment of a child. It's sometimes called psychological abuse and can seriously damage a child's emotional health and development. Emotional abuse can involve deliberately trying to scare or humiliate a child or isolating or ignoring them. Children who are emotionally abused are often suffering another type of abuse or neglect at the same time. Emotional abuse includes: humiliating or constantly criticising a child threatening, shouting at a child or calling them names making the child the subject of jokes, or using sarcasm to hurt a child blaming, scapegoating making a child perform degrading acts not recognising a child's own individuality, trying to control their lives pushing a child too hard or not recognising their limitations exposing a child to distressing events or interactions such as domestic abuse or drug taking failing to promote a child's social development not allowing them to have friends persistently ignoring them being absent manipulating a child never

	saying anything kind, expressing positive feelings or congratulating a child on successes never showing any emotions in interactions with a child, also known as emotional neglect.
Enquiries	Following a report, social services have a duty to make enquires, if there is reasonable case to suspect that a person within its area (whether or not ordinarily resident there) is a child or an adult at risk. This term describes the information-gathering undertaken by social services in order to determine whether any action should be taken to safeguard the child or adult at risk.
Exclusion Orders	These allow for a perpetrator to be removed from the home, instead of removing the child. They can be used in conjunction with an Emergency Protection Order.
Female Genital Mutilation	Female genital mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons The FGM mandatory reporting duty is a legal duty provided for in the FGM Act 2003 (as amended by the Serious Crime Act 2015). The legislation requires regulated health and social care professionals and teachers in England and Wales to make a report to the police if they have reason to believe a girl under the age of 18 years has been subject to FGM. The duty does not apply in relation to at risk or suspected cases or in cases where the woman is over 18. In these cases, local safeguarding procedures should be followed.
Financial abuse	Financial abuse includes theft, fraud, pressure about money, misuse of money.
General Data Protection Regulation 2018 (GDPR)	This is Europe's framework for data protection. It applies in the UK and relates to the collection and process of personal data and information.
Harm	This test of competence is used to determine whether a child has reached the stage of development whereby they have sufficient understanding and level of intelligence that means they are capable of making up their own mind on the matter requiring a decision. If the child is deemed to be Gillick competent parents right yield to the child's right to make their own decisions.
Inter-agency	Drawing on sufficient i.e. proportionate information, practitioners determine whether further action is required to meet the care and support/protection needs of the adult at risk.
Local authority	The nominated person with a Local Authority who is responsible for managing and monitoring safeguarding allegations in relation to paid and unpaid social care workers. Providing advice, information and guidance to employers and voluntary organisations around safeguarding allegations and concerns.

MARAC	A multi-agency risk assessment conference (MARAC), is a meeting where information is shared and a co-ordinated action plan developed in high-risk domestic violence situations. The primary aim is to safeguard those experiencing domestic violence. MARACs are attended by representatives of relevant agencies such as local police, probation, health, child protection, housing practitioners, domestic violence advisors and other specialists from the statutory and voluntary sectors.
Modern Slavery	Modern slavery describes forced labour practices with the perpetrator – the slave master- trapping and controlling the victim. The most common form of modern slavery is sexual exploitation. Labour exploitation is the second most common form of slavery occurring most frequently in the agricultural, food, hospitality and construction sectors. Victims may be vulnerable UK or foreigner citizens. Police, Local Authorities, the National Crime Agency and the Gangmasters Labour and Abuse Authority who encounter a potential victim of modern slavery or human trafficking have a duty to notify the Home Office under Section 52 of the Modern Slavery Act 2015.
Multi-disciplinary	The term, in the context of these procedures, describes a diverse range of organisations working jointly or collaboratively to identify and meet the safeguarding needs of children and adults at risk of abuse or neglect.
Neglect to an adult at risk	This means a failure to meet a person's basic physical, emotional, social or psychological needs, which is likely to result in an impairment of the person's well-being (for example, an impairment of the person's health).
Out of hours team also known as emergency duty team	This describes the arrangements made by the local authority to allow other agencies, practitioners and members of the public to report concerns about a child or adult at risk of abuse that may require a response outside office hours.
Physical abuse to an adult at risk	Physical abuse means deliberately hurting a child or young person. It includes: physical restraint; such as being tied to a bed, locked in a room inflicting burns cutting, slapping, punching, kicking, biting or choking stabbing or shooting withholding food or medical attention drugging denying sleep inflicting pain shaking or hitting babies fabricating or inducing illness (FII).
Practitioner	The term 'practitioner' has been used as a blanket term to describe anyone who is in paid employment as well as unpaid volunteers.
Professional abuse	Where a professional whose work, either in a paid or voluntary capacity, brings them into contact with children or adults at risk, or have caring responsibilities for children or adults, and their employment brings them into contact with children or adults at risk, who then in a position trust abuse or neglect children or adults at risk in their care.
Psychological abuse to an adult at risk	This includes threats of harm or abandonment, coercive control, humiliation, verbal or racial abuse, isolation or withdrawal from services or supportive networks; coercive control is an act or pattern of acts of assault, threats,

	humiliation, intimidation or other abuse that is used to harm, punish or frighten the victim.
Referral	For the purposes of these procedures a report to social services will be taken to also mean a referral.
Relevant partners	These are the six multi-agency strategic boards of relevant partner agencies set up across Wales designed to protect children and adults at risk of, abuse or neglect and to prevent those children and adults from becoming at risk of abuse or neglect. Members of the board are referred to as relevant partners Under Part 7 of the Social Services and Well-being (Wales) Act 2014, (SSWA 2014) local authorities must establish Safeguarding Children Boards comprised of representatives from local authorities, the local police body, local health board, NHS Trust, probation board, youth offending team and others.
Safeguarding	Safeguarding means preventing and protecting children and adults at risk from abuse or neglect and educating those around them to recognise the signs and dangers.
Sexual abuse to a child at risk	There are 2 different types of child sexual abuse. These are called contact abuse and non-contact abuse. Contact abuse involves: touching activities where an abuser makes physical contact with a child, including penetration. It includes: sexual touching of any part of the body whether the child's wearing clothes or not rape or penetration by putting an object or body part inside a child's mouth, vagina or anus forcing or encouraging a child to take part in sexual activity making a child take their clothes off, touch someone else's genitals or masturbate. Non-contact abuse involves: non-touching activities, such as grooming, exploitation, persuading children to perform sexual acts over the internet and flashing. It includes encouraging a child to watch or hear sexual acts not taking proper measures to prevent a child being exposed to sexual activities by others meeting a child following sexual grooming with the intent of abusing them online abuse including making, viewing or distributing child abuse images allowing someone else to make, view or distribute child abuse images showing pornography to a child sexually exploiting a child for money, power or status (child exploitation).
Sexual abuse to an adult at risk	This includes rape and sexual assault or sexual acts to which the adult has not or could not consent and / or was pressured into consenting.
Social Services	Social services are a department of the local authority responsible for the provision of social care for adults at risk and children. They act on behalf of the local authority to discharge the local authority's statutory duties and powers to make enquiries and intervene when necessary when there is reason to believe a child or adult is at risk.

VAWDASV	VAWDASV stands for Violence Against Women, Domestic Abuse and Sexual Violence. It incorporates Violence Against Women (and Girls), Domestic Abuse, Rape and Sexual Violence, Sexual Harassment, Female Genital Mutilation, Honour based violence, Forced Marriage, Stalking, Trafficking and other forms of violence.

AGENDA ITEM No	**23**
OPEN or CLOSED	**Open**
No of ANNEXES	**1**

COMMITTEE PRIORITIES AND CYCLE OF BUSINESS MONITORING REPORT

MEETING	Quality, Patient Experience and Safety Committee
DATE	04 February 2025
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Trish Mills, Director of Corporate Governance/Board Secretary Alex Payne, Corporate Governance Manager
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. This report updates the Committee on progress against the agreed cycle of business for the Committee. Progress is steady across all priorities and there is nothing to escalate from the cycle of business.

RECOMMENDATION: The Committee is asked to note the update.

KEY ISSUES/IMPLICATIONS

No issues to raise.

REPORT APPROVAL ROUTE

Not applicable.

REPORT APPENDICES

Annex 1 – QuEST Committee Cycle of Business Monitoring Report 2024/25

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

COMMITTEE PRIORITIES AND COMMITTEE CYCLE MONITORING REPORT FOR 2024/25

SITUATION

2. This report updates the Committee on progress against the agreed cycles of business and the priorities that it set for 2024/25. Progress is steady across all priorities and there is nothing to escalate from the cycle of business.

BACKGROUND

3. During the course of the effectiveness reviews, it was agreed that it is good practice for Committees to set priorities for the forthcoming year. The Committee's priorities, which are set out below, were agreed by the Trust Board in May 2024 and will be tracked quarterly.

4. The Committee's cycle of business was approved by the Committee in May 2024. The agenda is set with reference to that cycle, together with the forward planner, action log and highest rated principal risks.

5. The monitoring report is at Annex 1. The 'pre-agenda setting' key indicates that items in green show where they are cycled for a particular meeting. Items in beige indicate they are a prompt at agenda setting as they may be *ad hoc* items such as business cases or external reports.

6. The 'post-agenda setting' key indicates that items in blue were either on the agenda as scheduled or is an *ad hoc* item which was discussed in agenda setting and scheduled. The orange indicates where an item was programmed for receipt but has been deferred to a future meeting.

ASSESSMENT

7. The **Committee priorities**, and progress against them is as follows:

Priority	Progress
• Continue to monitor the duty of quality and duty of candour i.e. Committee will monitor implementation of the Duty of Quality and Duty of Candour following the Health and Social	**2024/25 PROGRESS** • An update on the Duty of Quality Implementation Plan is scheduled for receipt in February 2025. With this report an update will be provided on the progress on developing self-assessments against the Health and Care Quality Standards.

Care (Quality and Engagement) (Wales) Act.	• The Duty of Quality Annual Report for 2023/24 was received by the Committee at its meeting in May 2024 and approved by the Trust Board in July 2024 for publication. <u>2023/24 PROGRESS (included as this priority was carried over into 2024/25)</u> • A report was received at the Committee meeting in August 2023. At this meeting the Committee noted that this business would be cycled as required. • An update report was scheduled for receipt and discussion at the October 2023 Committee meeting (and would be cycled into each meeting of the Committee as required). • The October 2023 update will provide the status of the Welsh Government (WG) gateway report and provide an indicator on the quality strategy implementation.
• Monitor the delivery of the Quality Strategy (Plan)	**2024/25 PROGRESS** • At the Committee in August 2024 the revised approach to the development of the Quality Plan for 2025-28 was approved, as was an extension of the current strategy until the 01 April 2025 to allow for the development of a robust Quality Strategic Plan for 2025-28. Additionally, at the August 2024 meeting a general update on the delivery against the extant Quality Plan was received. This area of business is included on the Cycle of Business which will inform each agenda setting meeting. <u>2023/24 PROGRESS (included as this priority was carried over into 2024/25)</u> • At the August 2023 Committee meeting it was noted that the Quality Strategy Implementation Strategy will be received in Q3 (the November 2023 Committee meeting).

	• The November 2023 Committee received an update on the Duty of Quality implementation and on the status of the Welsh Government gateway report; which will provide an indicator on the quality strategy implementation.
• Monitor the organisation's compliance with the Health and Care Quality Standards 2024	**2024/25 PROGRESS** • At the November 2024 meeting of the Committee members noted that the Trust intended to prepare a position paper on the implementation of / compliance against the Health and Care Quality Standards 2024 for the meeting of the Committee in February 2025. • This report is scheduled for receipt at the February 2025 meeting as planned and will include the template self-assessment against the Standards which will inform the flow of business across the Board Committee framework as we move into 2025/26. • The final Duty of Quality Annual Report for 2023/24 and the associated self-assessment against the Health and Care Standards was received by the Committee at its meeting in August 2024.

8. **RECOMMENDATION: The Committee is asked to note the update.**

PAPER	PRE C'EE FORUM	FREQUENCY	Q1	Q2	Q3	Q4	LEAD	PURPOSE	COMMENT/COMPLIANCE
QUEST COMMITTEE - CYCLE OF BUSINESS 2024/25									
TERMS OF REFERENCE NOTED IN RED TEXT									
MIQPR review of metrics	ELT	Annually	→				EDSPP	Approval	Q1: Programmed for Q1 however deferred to Q2 (and programmed for Q2); programmed for Q2 but not rec'd as rec'd by Board in July 2024.
Committee QPSE review of metrics in PTR report	CQGG	Annually					EDQN	Approval	
MIQPR report	ELT	Quarterly					EDSPP	Assurance	
Putting Things Right Report [Note 1]	CQGG	Quarterly					EDQN/DP	Assurance	Q1: Includes PTR Recovery Plan in addition to PTR Report.
Quality Report [Note 3]	CQGG	Annually					EDQN	Approval	Q2: Final report (post Board approval) and to inc. position on compliance w/Standards (as a consent item - adjusted July 24).
Duty of Candour Report (Annual PTR Report) [Note 4]	CQGG	Annually	→	→			EDQN	Approval	Agreed that not required as separate report in Q3 therefore not programmed. Content included in the Q4 PTR report.
Quality Plan aligned to Delivering Excellence 2030	CQGG/TB	Initial and cyclical review					EDQN	Approval	Q4: Quality Strategy Update - not being received in Q4.
Clinical Plan aligned to Delivering Excellence 2030	CQGG/TB	Initial and cyclical review					EDP	Approval	Q1: Update on Clinical Plan.
Dementia Standards Report [Note 5]	CQGG	TBC					EDQN	Assurance	Q3: Report combined with the Mental Health Annual Report.
Committee elements of IMTP	STB	Annually					EDSPP	Endorsement	Q3: Agreed not to receive at separate Commitees in Q3. IMTP development / consultation direct with the Board.
IMTP exception reporting	STB	Ad Hoc					Relevant Director	Assurance	
Health and Care Quality Standards [Note 7]	CQGG	TBC					EDQN	Assurance	Q3: Reporting in development. Q4: DoQ Implementation Plan Update, to include HCQS position.
Quality Impact Assessments [Note 8]	CQGG	Ad Hoc					EDQN/DP	Assurance	Q3: MAI QAI programmed for closed session. Q4: CMT QIA in closed.
External and/or peer reports	Various	Ad Hoc					Relevant Director	Assurance	
Annual Mental Health Report [Note 14]	CQGG/TB	Annually					EDQN	Assurance	Q3: Programmed, but to sit with the Dementia Standards Report.
Annual IPC report	CQGG/TB	Annually		→	→		EDQN	Assurance	Q2: Commissioned for August but deferred at EDON's request for Q3 (300724). Q3: Commissioned, but then requested to defer to Q4 (231024) post-commissioning.
Annual safeguarding reports	CQGG/TB	Annually					EDQN	Assurance	
Referrals from PCC	PCC	Ad Hoc					Relevant Director	Discuss/Assure	
Clinical audit plan [Note 9]	CQGG/AC	Annually					EDP	Approval	
Monitoring report on clinical audit	CQGG	Quarterly					EDP	Assurance	
Spotlight On' clinical indicators	CQGG	Quarterly					EDP	Assurance	Q1: Fractured Neck of Femur; Q2: Hypoglaycaemia. Q3: STEMI.
Mortality Report [Note 12]	CQGG	Bi-annually	→				EDQN	Assurance	Deferred from Q1 to Q2. Programmed for Q3 to include Q1/2 of 24/25 (therefore back in line with CoB schedule).
Meds management report	CQGG	Annually					EDP	Assurance	Received in Q4 23/24 in discussion with EDP re appropriate timing for 24/25.
PECI report [Note 11]	TBC	Bi-annually					EDQN	Assurance	
Patient story	N/A	Quarterly					EDQN	Assurance	
Patient story updates	N/A	Quarterly					EDQN	Assurance	
Audit recommendation tracker	ELT	Quarterly					BS	Assurance	
Audits within purview of Committee	Audit	Ad Hoc					Relevant Director	Assurance	
Report from policy group	Policy Group	Annually					BS	Assurance	Q4: Agreed not required as position paper received by ARAC. Policies for approval, adoption, noting still included.
Policies for review and approval	Policy Group	Ad Hoc					BS	Approval	Q1: 5 Policies for approval; Q2: 1 Policy.
Board Assurance Framework	ELT	Quarterly					BS	Assurance	
Corporate Risk Register	ELT	Quarterly					BS	Assurance	
SUB-GROUPS									
Where applicable	N/A	Ad Hoc					N/A	N/A	
GOVERNANCE									
Committee effectiveness review annual report	Audit/Board	Annually					BS	Approval	
Review of Terms of Reference	Audit/Board	Annually					BS	Approval	Q4: Review of ToR to follow post effectiveness review discussion in Q4.
Committee Cycle of Business annual refresh	N/A	Annually					BS	Approval	
Committee Cycle of Business monthly review	N/A	Quarterly					BS	Review	
Committee Review of Annual Priorities	N/A	Quarterly					BS	Review	
PROMPTS									
Operations Report	SLT	QUarterly					EDO	Information	
External Reports	N/A	Ad Hoc					TBC	TBC	

EDQN = Executive Director of Quality and Nursing
EDO = Executive Director of Operations
EDP = Executive Director of Paramedicine
EDSPP = Executive Director Strategy, Planning and Performance
BS = Board Secretary

Key: Pre-agenda setting
Cycled for each meeting
Ad hoc item - prompt for agenda setting
Reporting developing

Key: Post-agenda setting
Presented as cycled
Ah hoc / item considered - not programmed
→ Item deferred
Reporting developing

1	**Putting Things Right Report**	Audit Wales Quality Governance Review 2022 - QuESt Committee is well served with quality information, but there are opportunities for improvement. R8(a) The Trust should Develop a system to triangulate learning themes across its quality assurance reports. This should ensure clarity about what improvement actions have been taken as a result and how learning has been disseminated across the organisation. It was suggested that whilst quality metrics are available separately in the patient safety report, quality highlight report, PECI report, Ops update etc there is merit in the Committee receiving a quality assurance report which highlights and triangulates key themes, trends and learning points. Management response includes the quality management system as a way to improve triangulation. The NHS Wales Delivery Unit published a Patient Safety Incidents Policy in June 2021 with revised reporting and oversight arrangements. Subsequently a joint Learning from Events Report (LFER) in conjunction with Welsh Risk Pool covering serious incidents, redress and claims has been introduced to provide a consistent approach to learning across NHS Wales. The National Audit Office survey completed by Audit Committee recommends Audit Committee reviews information on near misses to help determine whether the systems in place are sufficiently robust to mitigate future risk events. Audit Committee 25 July 2023 agreed that near misses would be monitored by QUEST. It noted that QUEST receives patient safety reporting which is predominantly based on the significant and catastrophic harm with moderate harm and near misses incorporated into thematic content. A more explicit near miss reporting will be developed, however there is limited capacity in the team to do so this year given the need to deal with the core requirements of national reportable incidents, Coroner requests and the Duty of Candour. Note in February 2024 Quest PTR report that future reports will move to aggregated thematic reviews to determine patters and trends corporately and at Health Board levels. 05 November 2024 meeting: Discussion re reporting of low and no harm events (in relation to the near-miss report). Need to consider how best to receive / frequency.
2	**Duty of Quality and Duty of Care**	Policy position: A Healthier Wales 2018 (quality and safety above all else); National Clinical Framework 2021 (all organisations will adopt a quality management system and provide annual reports on quality); Quality and Safety framework 2021 (address the six domains of quality: safe, timely, effective, efficient, equitable, person-centred (STEEEP). NHS Exec to oversee establishment of a quality and safety programme. Health and Social Care (Quality and Engagement) (Wales) Act 2020: Duty of Quality; Duty of Candour, CVB; VCs Duty of Quality = improved quality of health services; better outcomes for population. Achieved through leadership and culture focused on good quality; system wide approach to quality; shared responsibility for quality; quality driven (and demonstrated) decision making; demonstrable learning and improvement; strengthened quality management systems and revised H&C Standards. Quality management = quality planning; quality improvement; quality control; quality assurance Annual Quality Report and Always On reporting - make use of existing performance, outcome and delivery indicators and measures where possible; patient and staff experience, information and stories; reporting from inspectorate and licensing bodies; consideration of national clinical audits, reports, inquiries. Dashboard in development by DU. Consistent approach desired as appropriate across NHS bodies; align reporting to our local strategic objectives.
3	**Annual Quality Report**	H&C (Q&E) Act will have a requirement to publish an annual report setting out the steps taken to secure improvements in the quality of health services. WG is also required to publish an annual report on the steps they have taken to comply with the duty of quality also. Introduced for end of 23/24
4	**Annual Duty of Candour Report**	H&C(Q&E) Act s.7; publish report after the end of the reporting year (s.8(1)). Duty of Candour Regulations will be developed 23/24. Introduced for end of 23/24. The DoC Annual report will not be a standalone annual report, Details will be presented in the Annual PTR report to prevent duplication.
5	**Dementia Standards**	Funding requests made annually to WG for dementia programme. The All Wales Dementia Care Pathway of Standards published in 2021. WG national steering group with WAST representation. Reporting on compliance against the 20 dementia care pathway standards being developed in 23/24 (see Nov 22 QUEST paper for link to standards).
6	**Commissioning Quality Core Requirements**	From a commissioning perspective the core requirements underpin delivery across the 5 steps for EMS and Ambulance Care. The headings are governance, patient experience and satisfaction, equity, patient care, staffing and safety. Commissioning Quality Core Requirements are reported to EASC with quality and patient safety elements included in MIQPR.
7	**Health and Care Quality Standards**	Reporting on compliance with the Health and Care Quality Standards 2030 to be developed in 2024/25 with the introduction of these new standards linked to the Health and Care (Quality and Engagement) (Wales) Act 2020. Assurance includes through the QPMF (F&P); audits; sub-structure review/assurance; reporting mapped to six domains; IMTP linked to six domains. TBC if stand alone self-assessment desired/required.
8	**QIA**	The QIA *process* was endorsed by QUEST. Thereafter CQGG reviews all QIAs and the Chairs of CQGG will escalate those in their professional judgment should be reviewed by QUEST. QUEST paper 110523 - CQGG will: (a) Be assured that there is an appropriate QIA process undertaken for all new and existing Trust wide service redesign/transformation, projects and cost improvements; (b) Receive oversight reports on new and existing Trust wide schemes/projects that have undergone a full QIA to ensure risk planning is robust and the impact on quality and performance is being thoroughly assessed and negative impact mitigated (c) Have oversight of the framework and central repository for all QIA's; initial screening and full QIA. (d) have oversight of onward report to the Executive Management Team; Quality, Patient Experience and Safety (QuEST) Committee and; Trust Board, as appropriate.
9	**Clinical Audit**	Clinical audit is an important way of providing assurance about the quality and safety of services. The Trust's Clinical Audit Team provides training and support to clinical team leaders such as senior paramedics. The type of support provided by the team includes developing audit proposals, preparing and collating data (for example patient clinical records) and writing audit reports. The Trust does not have a clinical audit policy but follows an internal audit recommendation has developed a clinical audit guide and audit proposal template to support staff. Audit Wales Quality Governance Review August 2022 recommendation 2: *We found that the clinical audit plan is not approved in a timely manner and the QuEST Committee does not have adequate oversight of progress and delivery. The Trust should ensure that: (a) the QuEST Committee scrutinises and approves a clinical audit plan ahead of each financial year; and (b) the QuEST Committee receives quarterly updates on delivery of the approved clinical audit plan, assurance reports including learning and improvement actions resulting from this work.* QUEST to assure Audit Committee that clinical audit plan in place via AAA from Chair of QUEST.
10	**Meds Management and Medical Devices**	Meds management sits in the Ambulance Practice Steering Group that feeds into CQGG. It reviews compliance with controlled drugs; patient group directives (directives for registrants for prescription only drugs e.g. flu vaccine etc) which are regularly reviewed; JRCALC guidelines; meds management and controlled drugs policy; audit of controlled drugs. Standalone report will be presented to QUEST in Q4 setting this out and proposing assurance reporting. Any exception reporting on meds management or medical devices to Quest by exception. MM audit compliance in Q1 New Meds Management Policy August 23 says at 16.6 To support the principles of antimicrobial stewardship, an annual audit of antimicrobial use by APs will be conducted and the findings reported to the Trust Ambulance Practice Steering Group, appropriate Trust Committees and where appropriate, National Antimicrobial Stewardship Forum. **Note for 2024/25 monitoring:** The Meds management was received in Q4 23/24 so it was notreceived in Q1 24/25. This meant that the medicines management audit compliance report was not received (as both should be received together). Noted that when these are received in Q1 20225/26 they will be retrospective to January 2024. Position agreed with Board Secretary.
11	**Patient Experience**	Reports bi-annually on a PE template to WG. H&C Quality Standards integral to the plan golden thread and forms core part of the workplan. PECI report demonstrates how we meet mandatory responsibility to listen and learn from people's experiences and capture and report in line with the National Service User Framework (2014); the NHS Wales Planning Framework; NHS Delivery Framework (2018/19); WG National Framework for Assuring Service User Experience (2015); and Health Care Standards for Wales (WG, 2015b). Engagement (triangles) and consultation process. Embedded in forums and contacts around country. Driven by the IMTP as enabler; citizen centred approach embedded in plan; continuous engagement model;
12	**Mortality reviews**	In August 2021 the Delivery Unit issued the All Wales Learning from Mortality Review Framework. The Framework is a significant shift from the Trust's previous method of undertaking Mortality Reviews. The Framework document sets out that NHS organisations in Wales should undertake Mortality Reviews in relation to requests for information from the newly formed Medical Examiners (ME) in Wales. Mortality review meetings provide a systematic approach for the peer review of patient deaths to reflect, learn and improve patient care. Mortality reviews are conducted when a patient dies whilst in the Trust's care, including whilst waiting for an ambulance to arrive. To aid learning the Trust also reviews cardiac arrests where patients have survived. A Serious Case Incident Forum scrutinises issues identified through mortality reviews Identification of cases is via several sources including ME referral, incident reporting (internal and from system partners), HM Coroner, internal clinical reviews, clinical audit processes and horizon scanning. See Mortality Reviews Framework (QUEST 110523) with reporting to Quest at 7.1 and proposed to come via the Patient Safety Report with numbers of reviews, learning and actions. Oversight of the mortality review process is by CQGG at least six monthly. Audit Wales Quality Governance Review Recommendation 3: The QuESt Committee does not receive adequate assurances on mortality reviews. The Trust should ensure the QuESt Committee receives quarterly update reports to include: (a) the number of reviews undertaken and the numbers of reviews required but not yet complete; (b) any significant concerns, lessons learned and what changes have been made as a result (c) updates on actions to address the mortality review backlog; (d) updates on progress implementing the all-Wales Learning from Mortality Reviews Framework. Management Response: Monthly oversight of the All Wales Mortality Review Framework now occurs at the Clinical Quality Governance Group (CQGG) via the Alert / Advise / Assure process (Executive led) with onward assurances / updates to QuESt through the CQGG reporting mechanisms. Detailed reporting including organisational and system learning will be included in the Quarterly Patient Safety Report (standing agenda item at QuESt) from Q2 2022/3. Audit Wales Quality Governance Review August 2022 Recommendation 4: The Trust has a significant backlog of mortality review. The Trust should develop an action plan to reduce the backlog, reporting progress at each QuESt Committee. Management response: Action will be taken to establish the challenges in this area and implement process improvement to resolve future backlogs. A report will be provided to CQGG on progress (Q3 22/23)
13	**Information Governance**	Information Governance (IG) is a framework for managing information processes and procedures in accordance with the law and associated standards. It describes the approach within which accountability, standards, policies and procedures are developed, implemented and maintained to ensure that all types of information used in the Trust are sourced, stored and used appropriately, legally, and securely The Information Governance Steering Group oversees the Information Governance and Security strategy, policies, systems, processes and practices across the Trust and provides assurance that the organisation is compliant, and managing any risk to compliance. The strategic management of Information Governance forms part of the Digital Directorate under the leadership of the Director of Digital Services who holds the position of Senior Information Risk Owner (SIRO). Includes FOI (targeted percentage); Subject Access Request and Access to Health Records Requests (targeted percentage); Police Requests (no regulatory target). Data security and protection incidents: must notify ICO of personal data breaches within 72 hours. WG notified of significant impact on continuity of essential services under the Network and Information Systems Regulations (NIS Regs). H&C Standards x 3 related to IG and identified metrics against these (see annual report) The **Welsh IG Toolkit for NHS** is an assessment tool that allows organisations to measure their performance against agreed national information governance ~~and data security~~ standards and legislation. All organisation that have access to NHS patient data and systems must use the toolkit to demonstrates compliance with DPA 2018; expected data security standards for health and social care for processing personal data; and readiness to access secure health and digital methods of information sharing such as NHS Email, Welsh healthcare records and systems and local information sharing solutions and agreements. The Trust is required to demonstrate whether it complies with each of the 225 evidence items with each item weighted and a level of compliance generated (foundation stage; satisfactory stage; competent stage). IGSG monitors the toolkit improvement plan. Information Commissioner's Office (ICO) monitors compliance with key legislation (DPA 2018, UK GDPR and FOIAct) Finance and Performance Committee oversees the digital strategy and reviews and monitors major projects as well as cyber security and cyber resilience Information governance and data protection predominantly apply to our confidential patient data, but we also hold a large amount of staff and organisational data, so QUEST has remit over IG from a quality point of view. Liam Williams is Caldicott Guardian. TBC if an annual SIRO and/or Caldicott Guardian report is required. QUEST will see it with regards to people awareness of Info Sec, FPC will see it from pov of the layer of defense our people provide to our overall Cyber Sec. QUEST = reporting on people-led metrics i.e. where an individual staff member has a responsibility to keep data safe oE.g. Phishing rates, training compliance, individual breaches oTherefore, this includes near misses related to people / staff
14	**Mental Health**	Reporting to include compliance Mental Health Act 1983, Code of Practice, and the Mental Capacity Act 2005, DoLS etc See consent to examination and treatment policy endorsed at ELT 130224 with monitoring through clinical audit plan and responsibilities listed.
15	**General**	These cycles are developed with reference to the specific lines of the TOR for this Committee. This methodology seeks to ensure that all responsibilities in the TOR are discharged by the Committee on behalf of the Board