Bundle Quality, Patient Experience and Safety Committee 9 February 2023

Agenda attachments

ITEM 0 Open Quest Agenda -9 February 2023 v.2.docx

0	09:30 - OPENING ITEMS
1	Chair's welcome, apologies, and confirmation of quorum
2	Minutes of last meeting ITEM 2 QUEST OPEN MINUTES 10 November 2022.docx
3	Action log and matters arising *AAA Report - Escalations to Board is attached* ITEM 3 CURRENT Quest Action and Decisions Log.pdf ITEM 3.1 Quest Committee Highlight Report November 2022.docx
4	09:40 - Operations Directorate Quarterly Report Q3 2022/23 ITEM 4 Operations Quarterly Report for Committees 22-23 Q3.docx
4.a	ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION
5	09:50 - Patient Experience
6	10:20 - Monthly Integrated Quality Performance Report ITEM 6 MIQPR SBAR QUEST December 2022.docx ITEM 6.1 Annex 1 MIQPR QUEST December 2022.pdf ITEM 6.2 Top indicators MIQPR Dashboard December 2022.xlsx
7	10:40 - Patient Safety Report Q3 2022/23 ITEM 7 Patient Safety Report-Quarter 3.pdf
8	10:55 - Risk Management and Board Assurance Framework Report ITEM 8 Executive Summary Risk Management Report QuEST 090223 1.docx
9	11:05 - Patient Experience and Community Involvement Quarterly Report. ITEM 9 PECI Quarter 3 Report (October - December).docx ITEM 9.1 PECI Quarter 3 Report (October - December) - Annex 1.pdf ITEM 9.2 PECI Quarter 3 Report (October - December) - Annex 2.docx ITEM 9.3 PECI Quarter 3 Report (October - December) - Annex 3.pdf
9.a	11:20 - BREAK – 10 MINUTES
10	11:30 - Duty of Quality/Duty of Candour Preparedness *Item 10 (Exec Summary) is a replacement paper* ITEM 10 Exec. Summary Duty of Quality Duty of Candour - 09.02.2023 v1.0.docx ITEM 10.1 Duty of Quality and Duty of Candour preparedness - Appendix 1.docx
11	12:00 - Committee Annual Effectiveness Review and Annual Report ITEM 11 Quest Effectiveness Review SBAR 22-23.docx ITEM 11.1 QUEST 2022-23 - Results for Feb QUEST.pptx ITEM 11.2 QUEST Draft Annual Report 2022-23.docx ITEM 11.3 QUEST Committee TOR 2023-24 DRAFT v.02.docx
12	12:20 - Internal Audit Tracker Update - TO FOLLOW *12.1 Infection Prevention Control* *12.2 Immediate Release Request*
13	12:35 - WAST Annual Safeguarding Report ITEM 13 Safeguarding Annual Report 2021-2022.docx ITEM 13.1 Safeguarding Annual Report 2021-2022 (Annex 2).pdf
13.a	12:45 - CLOSING ITEMS
14	Summary of actions and decisions made
15	Key messages for Board

16 Any other business

17 Date and time of next meeting 11 May 2023 at 09:30

MEETING OF THE QUALITY, PATIENT AND SAFETY EXPERIENCE COMMITTEE

Held on 9 February 2023 from 09:30 to 12:50
Meeting held virtually via Microsoft Teams

AGENDA

No.	Agenda Item	Purpose	Lead	Format	Time
OPENING ITEMS					
1.	Chair's welcome, apologies, and confirmation of quorum	Information	Bethan Evans	Verbal	10 Mins
2.	Minutes of last meeting	Approval	Bethan Evans	Paper	
3.	Action log and matters arising *Includes AAA Report – Escalations to Board	Review	Bethan Evans	Paper	
4.	Operations Directorate Quarterly Report Q3 2022/23	Discussion	Lee Brooks	Paper	10 Mins
ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION					
5.	Patient Experience	Information Discussion	Leanne Hawker	Verbal/Video	30 Mins
6.	Monthly Integrated Quality Performance Report	Assurance	Rachel Marsh	Paper	20 Mins
7.	Patient Safety Report Q3 2022/23	Assurance	Wendy Herbert	Paper	15 Mins
8.	Risk Management and Board Assurance Framework Report	Assurance	Julie Boalch	Paper	10 Mins
9.	Patient Experience and Community Involvement Quarterly Report.	Assurance	Leanne Hawker/ Liam Williams	Paper	15 Mins
BREAK – 10 MINUTES					
10.	Duty of Quality/Duty of Candour Preparedness	Assurance	Jonathan Turnbull-Ross	Paper	30 Mins
11.	Committee Annual Effectiveness Review and Annual Report	Approval	Trish Mills	Paper	20 Mins
12.	Internal Audit Tracker Update 12.1 Infection Prevention Control 12.2 Immediate Release Request	Assurance	Julie Boalch	Paper	15
13.	WAST Annual Safeguarding Report.	TBC	Nikki Harvey	Paper	10
CLOSING ITEMS					
14.	Summary of actions and decisions made	Discussion	Bethan Evans	Verbal	5 Mins
15.	Key messages for Board	Discussion	Bethan Evans	Verbal	
16.	Any other business	Discussion	Bethan Evans	Verbal	

17.	Date and time of next meeting 11 May 2023 at 09:30	Information	Bethan Evans	Verbal	

Lead Presenters

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

WELSH AMBULANCE SERVICES NHS TRUST

UNCONFIRMED MINUTES OF THE OPEN SESSION OF THE MEETING OF THE QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE HELD ON 10 NOVEMBER 2022 VIA TEAMS

PRESENT:

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

IN ATTENDANCE:

Lee Brooks	Executive Director of Operations
Andrew Clement	Partners in Healthcare, Resource Development Coordinator
Leanne Hawker	Head of Patient Experience and Community Involvement
Wendy Herbert	Assistant Director of Quality and Nursing
Peter Hindley	Community Health Council
Ian James	Trade Union Partner
Alison Johnstone	Partners in Healthcare Manager
Bethan Jones	Midwife (on secondment from BCUHB) - Observer
Mark Jones	Consultant Mental Health Nurse
Alison Kelly	Business and Quality Manager
Dr Brendan Lloyd	Executive Medical Director
Bethan Lowry	Concerns Admin Support
Mark Marsden	Trade Union Partner
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Trish Mills	Board Secretary
Steve Owen	Corporate Governance Officer
Hugh Parry	Trade Union Partner
Alex Payne	Corporate Governance Manager
Felicity Quance	Internal Audit
Duncan Robertson	Assistant Director of Research, Audit and Service Improvement (North)
Leanne Smith	Interim Director of Digital Services
Gaynor Sollis	Patient Safety Manager
Andy Swinburn	Director of Paramedicine
Gareth Thomas	Patient Experience and Community Involvement Manager
Lisa Trounce	Business Manager
Jonathan Turnbull-Ross	Assistant Director of Quality Governance
Liam Williams	Executive Director of Quality and Nursing
Debbie Young	Executive Assistant

Apologies:

Non Recorded

49/22 PROCEDURAL MATTERS

The Chair extended a warm welcome to everyone with a special welcome to: Alex Payne, Bethan Jones, Bethan Lowry, Gaynor Sollis and Felicity Quance.

Minutes

The Minutes of the meeting held on 11 August 2022 were approved.

Action Log

The action log was considered:

Action Number 16/21: To provide updates on the viability of Community First Responders (CFR) to administer pain relief. An update was provided by Andy Swinburn; action to remain open to receive further updates going forward.

Action Number F&P 1/21-22: Review of performance related metrics, action was closed with a further update to be provided once information was available with an update at the February meeting.

Action Number 50/21a: Ongoing work in improving symptom checkers on website. A comprehensive update was attached to the action log, action was closed.

Action Numbers 32/22a and 33/22b: Both related to patient experience; a written update had been provided and the actions were closed.

Action Number 35/22: To strengthen the wording on the Monthly Integrated Quality Performance Report (MIQPR) recommendation: Agreed that this action was to be closed.

Action Number 36/22a: Collaboration with the private sector in relation to older people; an update was provided on the action log and the action closed.

Action Number 36/22b: Update on care home focused improvements. A detailed update was on the action log, and it was agreed to remain open until the next meeting pending further details.

RESOLVED: That

(1) the Minutes of the Open meeting held on 11 August 2022 were confirmed as a correct record; and

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

50/22 OPERATIONS DIRECTORATE QUARTERLY REPORT – 2022 -23 Q2

Lee Brooks introduced the revised format of the Operations Quarterly Report as read, and drew attention to the latest position on the current pressures.

Comments:

1. Members welcomed the revised format of the report adding that it read well and clearly demonstrated the extreme pressure the whole NHS continued to sustain. Members queried whether this report had been sent to Commissioners; Lee Brooks stated it had not, and agreed to share it with the Chief Ambulance Services Commissioner going forward.

2. It was asked whether volunteers received a Performance Appraisal and Development Review (PADR). Lee Brooks commented that in his view, PADRs were not completed, however he was confident that scheme coordinators were in frequent contact with volunteers. He agreed to confirm the reporting mechanism for volunteers at a future meeting.

3. In response to a query regarding roster reviews and rural response in Powys, Lee Brooks advised that overall the roster review was on track to be deployed by the end of the year. Work was ongoing in terms of rural response in that the Trust was considering different models of care, and whether this would improve patient care in rural areas.

4. It was asked whether the 111 rostering activity had been successful. Lee Brooks stated that it was too early to comment, but ensured it would be included in the next update.

5. With respect to Emergency Medical Despatcher (EMD) recruitment and retention were there any themes or trends which were contributing to the high level of turnover. Lee Brooks explained that the rate of attrition was in the region of 23% which was high; part of this was due to existing vacancies which increased the workload and pressure on staff.

   The Trust has continued to recruit and was confident that by the winter period sufficient staff will be in place; adding there were around 50 currently in training. Paul Hollard added that the next People and Culture Committee meeting will receive a report on the EMD turnover rates, which should provide further information regarding recruitment and retention patterns.

RESOLVED: That the report was received.

51/22 PATIENT EXPERIENCE

1. The Committee were shown a video in which Fiona Philpott told of the extremely poor patient experience of her 99-year-old mother Brenda Patton, who fell at home in the bathroom and waited 8.5 hours for an emergency ambulance to arrive.

2. During that time Brenda was crying in pain and her condition deteriorated. Fiona told the Committee of the stress and anguish this caused both her and her mother, particularly as there was no-one available to administer pain relief while they waited for the ambulance to arrive. Fiona recognised the ambulance service was under a huge amount of pressure and expressed her outrage that the service did not afford her mother the care expected, adding that in her opinion the NHS service was not fit for purpose.

Comments:

3. Leanne Hawker informed the Committee that following an investigation it was noted there had been a high number of 999 calls and long delays in handovers at hospitals within the Betsi Cadwaladr University Health Board (BCUHB). Leanne added that

work was underway jointly with BCUHB to develop the falls response service; and a second falls response vehicle was due to start in November, covering Conwy and Denbighshire, subject to funding being confirmed. Liam Williams added that a commitment had been made from the Executive Director Nursing (EDN) network to expedite the falls level 2 work across Wales. Further to this he commented that the EDN's had sent correspondence to NHS Wales Chief Executive, supported by the Chief Operations Officers and Medical Director, network to focus on the high impact issues. Additionally, Liam Williams stated that linking patient data analysis effectively would provide the basis to better align resources to meet the needs of the population of Wales. Jonathan Turnbull-Ross assured the Committee that extensive engagement was ongoing, particularly with BCUHB in terms of the falls work. It was noted that the outcomes of the investigation had been shared with Fiona Philpott.

4. Members felt the severe impact of Fiona and Brenda's powerful experience, particularly in the context of the very long delays currently being experienced by so many patients in the community, and the very real prospect of the delays deteriorating over the winter months. The Committee also recognised that during the 8.5 hour waiting period there was nothing different the Trust could have done, and this was extremely worrying. Members felt that the Trust had done everything in its power to improve the system but were becoming increasingly frustrated that it was futile and could not see any improvements in the near future.

5. Members asked what, if anything further they could meaningfully do to escalate the issues raised and were assured that the Trust was doing all it could within its gift. Liam Williams advised that the risks were high up on the Board agenda. He added that the Trust Chair has escalated the issue of handover delays to the Minister for Health and Social Services, and that the Trust Chief Executive continues to discuss the issue in other forums. He added that recruitment across the Trust was continuing with a view to increasing front line capacity. Furthermore, Audit Wales was carrying out work to look at patient flow in hospitals and how to seek improvement; it was hoped this would lead to an improvement in patient flow and release more ambulance resource to respond to patients in the community.

   It was asked whether there were further actions that could be taken within the Trust to improve the situation. For example, when someone calls repeatedly, instead of going through the same questions, to divert them to a dedicated phone number. Lee Brooks outlined details of the Medical Despatch Priority System (MDPS) explaining it was process driven and the caller would only have to repeat the same answers if there was a change to the patient's condition.

6. The Committee expressed their thanks to Fiona and Brenda for sharing this story and would review the learning that was taken from this incident at its meeting in February.

RESOLVED: That the patient story was noted and recognised that discussions on the severe delays and system pressures would be heard at the Trust Board meeting later this month.

52/22 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK REPORT

1. Trish Mills informed the Committee there were three corporate risks assigned to the Committee, two of which were rated as high risks with no changes to scores since the last review. Risk 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', were both rated at 25. These

risks continued to be actively managed and are monitored and reviewed regularly by the Assistant Directors Leadership Team and the Executive Management Team.

2. The management and mitigation of these risks were discussed significantly throughout earlier items in this meeting, and the Committee noted that despite further controls being applied in the last quarter, there was no movement on either the likelihood or consequence scores for either ; therefore they remain at the highest score of 25.

3. The Committee agreed to the closure of risk 303, 'delayed administration of chest compressions to patients as part of resuscitation', as all actions have been completed, and the score reduced to its target.

RESOLVED: The Committee accepted the status of the three corporate risks which it has been assigned to oversee the management of – risk 223, 223 and 303. The Committee received the relevant sections of the Board Assurance Framework and noted the ongoing mitigating controls. The Committee agreed to close risk 303.

53/22 MONTHLY INTEGRATED QUALITY PERFORMANCE REPORT

Rachel Marsh presented the Monthly Integrated Performance Report (MIQPR) for September, and reviewed in detail with the following to note:

1. 111 clinical ring back had improved greatly following the introduction of tactical actions as part of the recent business continuity incident. This improvement is despite the difficulty to recruit the right numbers and types of clinicians into post.

2. Hospital handover delays continued to worsen with over 28,000 ambulance hours lost in October, which represented 37% of the Trust's capacity to respond. From a patient experience perspective one of the impacts was that the number of patients cancelling ambulances was over 10,000 per month.

3. Rachel Marsh referenced the workforce related metrics contained within the report which include sickness, staff training and PADR completion rates, all of which were improving.

Comments:

1. Members queried whether staff were being encouraged to have the Covid booster vaccination, as the uptake seemed low. Andy Swinburn confirmed that messages had been sent to staff.

2. It was asked whether there was an update on the immediate release requests. The Committee were advised that whilst during this quarter 47% of immediate release directives were declined, there has been an improving position proportionately across Wales for red releases in September. However, the number of amber releases declined was of concern. A process was in place to investigate those declined with details being reported to Health Board Chief Executives weekly. The Committee is due to receive an internal audit review on immediate release requests at its next meeting, which will test the Trust's compliance on process to determine any internal improvements. Brendan Lloyd added that until the culture in health boards changes, and while ambulance waits were the most intolerable part of the patient flow, some Emergency Departments (ED) will continue to feel justified in declining immediate release requests on the basis that ED's were already overcrowded.

3. In terms of strokes, it was asked whether there were opportunities to capture patient outcomes. The Committee were advised that work on capturing stroke patient outcomes, as well as the call to door target - which was reviewed by the Emergency Ambulance Services Committee – and further progress on linking the end-to-end pathway, would be reported back to the Committee at a future date. Going forward the ambition is to align the data between the Electronic Patient Care Record (ePCR) and the Computer Aided Dispatch (CAD) system, and look at the time segments to see where improvements could be made the Trust's performance. Brendan Lloyd added that the Trust does not currently have the ability to link the data with its patients through to the outcome. It was noted that Digital Healthcare Wales were working on improving this link.

4. Andy Swinburn outlined the improvements to the fact that the Trust was conveying fewer patients to ED's as it was managing more patients at home.

5. Liam Williams commented that he and Rachel Marsh would welcome any feedback from colleagues in improving this report going forward.

RESOLVED: That the report was considered and provided sufficient assurance of progress against the 24 key performance indicators detailed, which demonstrate how the Trust is performing against the following areas of focus: - Our Patients (Quality, Safety and Patient Experience); Our People; Finance and Value; and Partnerships and System Contribution.

54/22 PATIENT SAFETY REPORT Q2 2022/23

Wendy Herbert gave an outline of the report and drew the Committee's attention to the following areas:

1. Continued high numbers of concerns being received and whilst there was a slight improvement in 30-day response times, they were significantly behind the 75% target, at 28%. The Trust have invested additional resources into the Putting Things Right team, and as a result the 2-day acknowledgement time had improved significantly.

2. Coroner activity remained significantly high which has impacted on Clinical Contact Centre staff particularly in responding to requests for information in a timely manner.

3. Serious Case Incident Forums (SCIF) continued to meet on a twice weekly basis due to the volume of incidents being reviewed. During this reporting period there were 20 SCIFs which considered a total of 111 incidents.

4. There had been an increase in the number of Appendix B incidents being forwarded to Health Boards.

5. In order to improve the Trust's position with concerns, £100k of additional funding has been made available to increase resources in key posts.

6. During this reporting period a total of 1,257 patient safety incidents were reported; 538 in July, 416 in August, and 303 in September. This is a decrease in comparison to the previous quarter, but an increase in comparison to the same period last year where there were 1099 incidents reported.

7. During the quarter there were a total of 2,883 Immediate Release Requests made to Health Boards. These requests were made to release an emergency ambulance to respond to a patient in the community who had a potentially life threating or serious condition. Of these, 1,528 were accepted (53%) and 1,355 were declined (47%).

Comments:

1. The Committee recognised the work involved and asked for a note of thanks to all those involved with concerns to be recorded, also noting that the report demonstrated the Trust's Duty of Candour, which was welcomed.

2. With respect to clinical incidents and where errors had occurred, the Committee were advised by Andy Swinburn that there was clear support for staff, despite the ongoing pressures. This position was echoed by Paul Hollard and Liam Williams. Liam Williams added that for the next meeting a report would be provided that gave front line staff assurance that the Trust was a learning organisation which would be aligned to the ongoing all Wales work on preceptorship and clinical supervision.

RESOLVED: That the update was received, recognising that several issues had been discussed in previous items.

55/22 AUDIT WALES - REVIEW OF QUALITY GOVERNANCE ARRANGEMENTS

Liam Williams presented the report and informed the Committee that a further update would be provided at the next meeting which will include the work conducted by other organisations. Jonathan Turnbull-Ross added that the update report would include the work from Health Inspectorate Wales and Internal Audit, the Trust's work around Duty of Candour, Duty of Quality, and the Health Care standards.

Comments:

1. Members recognised that the Trust's business as usual work had already identified some of the issues raised at this review.

2. It was asked whether the revised implementation was plan due for completion in November. Jonathan Turnbull-Ross explained that it had been drafted and would be concluded on 21 November, with the final report being published on 12 December.

3. It was asked whether there was an update available regarding internal resources. The Committee were advised that several roles have been included in the plan which were expected to be agreed.

RESOLVED: The Committee noted the update and recognised that a more conclusive update would be provided at the February meeting.

56/22 HEALTH INSPECTORATE WALES ANNUAL REPORT 2021-2022

Liam Williams explained that the report acknowledged the significant pressure across NHS Wales, specifically noting the challenges for the Trust in staff abstractions impacted by COVID-19 related absence. The report also detailed the work undertaken by Health Inspectorate Wales (HIW) which included seeking assurance on the safety and quality of care provided by the Trust. The report also detailed the system-wide recommendations made by HIW for improvement on this issue, including a need for collaboration with Health Boards across Wales.

Comments:

1. The Committee noted that the HIW Annual Review would be presented to the Trust Board at its meeting on 24th November.

2. Members also acknowledged in particular, the work of the Operational Delivery Unit to manage variance across EDs and Health Boards. Andy Swinburn explained this work should not be underestimated, adding that each ED would have different structures to improve its patient flow.

3. The Committee sought clarification in terms of who had ultimate responsibility for the patient inside an ambulance waiting outside the ED; it was agreed that this would be raised at the Board meeting later in the month. Furthermore, clarification would also be sought on the strategic collaboration and the statement on collaborative working within the report.

RESOLVED: That the Committee received the report and noted that the issues contained in bullet point 3 above would be raised at the Board meeting later in the month.

57/22 PATIENT EXPERIENCE AND COMMUNITY INVOLVEMENT (PECI) QUARTERLY REPORT

Leanne Hawker outlined several areas within the report and drew the Committee's attention to the following:

Feedback from the communities was very positive with patients showing a high regard for Trust staff; however, there were some negative experiences especially around long waits for an ambulance. This also impacted on relatives of patients, and the Trust continued to review its resources, for example, several projects were in the pipeline aimed at improving the overall patient experience going forward.

Comments:

It was unclear what was meant by non-applicable in the graph illustrating patient experiences of calling 999. The Committee asked that in future reports that the ratings included in such info graphics be clearer.

RESOLVED: The Committee approved the Highlight Report for release to the NHS Wales Patient Experience Network, WAST People & Community Network and external stakeholder; and noted and support the actions being taken forward.

58/22 NHS WALES SAFEGUARDING ANNUAL REPORT 2021-22

The Committee noted the report was presented for information purposes.

RESOLVED: That the Committee noted the contents of the report

59/22 DEMENTIA UPDATE

Alison Johnstone drew the following to the Committee's attention:

1. The All Wales Dementia Care Pathway of Standards was published by Improvement Cymru in 2021, following extensive engagement with individuals living with dementia, carers, voluntary organisations and health and care professionals. The implementation of the standards was supported nationally and regionally by the Dementia National Steering Group, and by five work streams which are: Community Engagement, Memory Assessment Services, Dementia Connector, Hospital Charter and Workforce / measurement.

2. The Trust was working on a software pilot called Reminiscence Interactive Therapy Activities (RITA). RITA is an all-in-one touch screen solution which offers digital reminiscence therapy to blend entertainment with therapy, and to assist patients (particularly with memory impairments) in recalling and sharing events from their past through various media outlets.

3. Work was also ongoing with Alzheimer Society Cymru, looking at a referral process to dementia connect; this will allow members of staff to provide an onward referral into the society.

4. A great deal of work has been achieved to connect the WAST dementia agenda with other services to improve personal, home and community safety; emergency response to dementia calls; joint learning and development opportunities, and engagement across services.

Comments:

1. The Committee welcomed the update, and the team were commended on the significant number of achievements and its alignment to the Trust's strategy to provide more care closer to home.

2. It was asked if the Trust was aware of the prevalence of dementia in Wales. Alison Johnstone advised there was an ability within the system to extract raw data and going forward it was anticipated this would be refined further.

3. The Committee also recognised the link to a previous QUEST patient story with respect to the work underway to develop dementia training for 111 and the Clinical Support desk (CSD) staff.

RESOLVED: The Committee noted the work and progress against national dementia programme work streams.

60/22 INTERNAL AUDIT TRACKER REPORT

Trish Mills provided the update and asked the Committee to note the following:

There were two overdue high priority recommendations that related to the Committee; ID 460, 'Role of the Advanced Paramedic Practitioner' and ID 527, 'Respiratory Protective Equipment' discussions were ongoing with the Infection Prevention Control Strategic Group to consider if the latter risk could be closed. In respect of the other eight recommendations, these have all been reviewed and actions were in progress.

RESOLVED:

(1) Noted and considered the contents of the report;

(2) Considered the Internal Audit Plan activity; and

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

61/22 JOINT INVESTIGATIONS PILOT

1. Liam Williams outlined the report and explained that following a sustained period of operational pressures across Wales and increasing numbers of National Reportable Incidents relating to catastrophic or severe harm, the Appendix B process was implemented for WAST Serious Incidents.

2. Several meetings and work occurred over the summer to agree the Joint Investigations framework through a Task and Finish Group that has had membership from every Health Board, WAST and wider NHS Partners. A key outcome of the process was the requirement for a joint meeting to confirm a serious incident had occurred, confirm if a joint investigation was required and subsequently, which organisation would lead the investigation.

3. Implementation of the Joint Investigations Process was due to take place through a Pilot that would report to the Emergency Ambulance Services Committee and the NHS Wales Delivery Unit. Further work was required on the supporting performance metrics for the new process, and there was an urgent requirement for development time in the All-Wales web-based DATIX platform to enable efficient cross-organisational working.

4. It was not expected that this process would have a significant impact on WAST in reporting or investigating incidents; however, it was expected that there will be an impact for Health Boards seeking higher levels of engagement from General Practice and Social Care.

Comments:

1. Rachel Marsh commented that as a word of caution with the Trust being the lead investigator, this may impact on the Trust's resources.
2. It was asked how the national policy was endorsed, and to what extent the Trust had engaged with other stakeholders, such as General Practitioners and local authorities. - Liam Williams advised that the National Delivery Unit had oversight. In terms of the level of engagement being sought from health board colleagues and adult social care, at this stage it was unclear whether the timescales will be met.
3. Wendy Herbert advised this was nothing new, and had been signed off several years ago as an approved process; provided the process was robust that was the main thing.

4. Liam Williams explained that the learning from this process was critical to improving the quality of service going forward. Further to this the Trust would demonstrate its learning through the Duty of Candour.

RESOLVED: The Committee approved that the revised Joint Investigation Pilot be implemented.

62/22 PATIENT STORY DRIVER DIAGRAM

This was presented for information and to note is was Matt Hughes' story

RESOLVED: The Committee noted the update

63/22 COMMITTEE PRIORITIES UPDATE

This was presented for information.

RESOLVED: The Committee noted the update.

64/22 KEY MESSAGES FOR BOARD

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

RESOLVED: This was noted.

65/22 ANY OTHER BUSINESS

The Committee noted it was Kevin Davies' last meeting and thanked him for his support over the past years.

Date of Next meeting: 9 February 2023

ACTION LOG - FROM NOVEMBER 2021
QUEST COMMITTEE

Minute Ref	Date	Agenda Item+C1:H13	Action Note	Responsible	Due Date	Progress/Comment	Status
16/21	7 May 2021	Patient experience	To provide updates on the viability of CFR's to administer pain relief	Andy Swinburn	9 February 2023	Update from 16th November meeting: Andy Swinburn updated the Committee explaining that 2 Business Cases were being developed; one from the development of the Omnicell cabinet perspective (readjust for penthrox inclusion) and one from the revenue perspective (purchasing of penthrox). Dr Brendan Lloyd explained the reasons for the delay in developing this and would continue to update the Committee. Update for 17th February meeting: The amendments to the safe have been agreed and purchase of the additional fittings for the cabinets has taken place. Work is still ongoing to identify the revenue funding for penthrox but new avenues are being explored, with the NCCU, to establish whether central funding, aligned to the decarbonisation agenda, may be applicable. Update for 12 May meeting: The introduction of Penthrox continues to be one of the items that is listed for consideration against this years list of items in which financial support is required. Further opportunities to support the introduction are being worked through with commissioners (as a potential carbon reduction measure). It was anticipated this action will be completed by 11 August 2022. There had been no further updates and it was agreed that an update would be provided on 10 November 2022. Update for 10 November The option of using Penthrox still remained and as an interim step oral paracetamol will continue. Andy Swinburn added that in line with current evidence, oral paracetamol had a similar impact. Work still continued with a further update to be provided at the next meeting, Update for 9 February Verbal Update	Open
36/22b	11 August 2022	Quality Highlight report	Going forward, the Committee requested to see more information relating to care home focused improvements work beyond the geographical area of Pembrokeshire	Jonathan Turnbull-Ross	9 February 2023	Update for 10 November meeting A value based healthcare bid was developed and successful supported for further provision of Care Home training and support in Powys – approved funding for a Paramedic to provide training for a six-month period. Project management, administration and analysts support will be undertaken by the Health Board in assessing its effectiveness, to include benefits to WAST. The action is noted in detailing wider provision of activities in forthcoming reports. Jonathan Turnbull Ross advised the Committee this would remain open with further details at the next meeting. Update for 9 February Verbal Update	Open
54/22	10 November 2022	Patient safety report	To reproduce a report to give front line staff the assurance that the Trust is a learning organisation and to align it to the ongoing all Wales work on preceptorship and clinical supervision. Update on this report to be provided to the next meeting.	Wendy Herbert	9 February 2023	Update for 9 February meeting The Patient Safety and Experience Learning and Monitoring Group (Going forward 'Learning from Events (LFE) Group') met on 16.01.2023 and discussed both the functions of the group and organisational learning. Example templates of the 'Learning from Events' publication (kindly developed by Andrew Clement in PECI) were shared and well received (these are iPad friendly). The LFE Group will have responsibility for the content of the publication which will be shared via the AAA report to the Clinical Quality Governance Group ahead of distribution. The publication will include activity and learning from the Serious Incident Case Forum, Complex Case Panel, Claims, Ombudsman feedback, internal or external reviews, horizon scanning, and any themes and trends obtained through other forums. The next meeting will be in March and the plan is to take the first version to this meeting.	Open
55/22	10 November 2022	Review of Quality Governance Arrangements	Noting that the Audit Wales report refers to the revised quality strategy implementation plan being developed, this will be presented a the next meeting.	Jonathan Turnbull-Ross	9 February 2023	Update for 9 February meeting On Agenda - Included under Item 10	Open
56/22	10 November 2022	Health Inspectorate Wales Annual report	To clarify with HIW at the Board meeting on 24 November, strategic collaboration and the statement on collaborative working	Liam Williams	24 November 2022	Update for 9 February meeting HIW already presented - recommended to be closed	Open
57/22	10 November 2022	Patient Experience and Community Involve report	In respect of patient experience calling 999, it was agreed that clarity on the N/A ratings would be included within the next report	Leanne Hawker	9 February 2023	Update for 9 February meeting We recognised that the way N/A data collected though patient experience surveys was being presented appeared confectioning. For this report, we have removed the data tables that include N/A data and have chosen to visualise an alternative question that does not collect N/A data, removing any potential ambiguity. Over the coming months we will transition to use a new Patient Experience Survey system which will offer improved options for how we visualise data collected and plan to use this system to review options for presenting data sets which contain N/A responses in a way which reflects the data collected more accurately.	Open
59/22	10 November 2022	Dementia Update	The Trust had recorded 11500 patients with an indication of dementia from the ePCR from 1 April to 8 November (EMS only). Work was ongoing to improve this data collection and an update on this work was requested at the next meeting. The Committee recognised this information was not captured on NEPTS vehicles.	Duncan Robertson	9 February 2023	Update for 9 February meeting A change request form for improving dementia data collection via ePCR was received and approved at the January 2023 ePCR Clinical Reference Group (18th January 2023). This will be sent to the suppliers for them to complete an impact assessment and produce costings prior to final approval for the work to go ahead, which anticipated for the February 2023 ePCR CRG Meeting. Action recommended for closure.	Open

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	24 November 2022
Committee Meeting Date	10 November 2022
Chair	Bethan Evans

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. With handover lost hours in October in excess of 28,940 representing 36% of our conveyancing capacity, and sustained high levels of CSP[1] there is **clear evidence of continued harm to patients** who are having to wait for an ambulance. The very poor patient experience and risk of continued harm ran through most of the items discussed at this meeting, with the patient story bringing the full impact of delays starkly to the Committee.

   The Committee is aware of the actions being taken by WAST to mitigate harm and of the escalations and actions in the system and with Welsh Government. Progress against these actions is a focus at the November Public Board, however a continued high number of concerns raised, and incidents reviewed regarding timeliness demonstrates that **more pace is required to address the issue at a system and strategic level**. The potential to reduce increasing numbers of conveyances with investment in advance practice paramedics and the clinical support desk was evident when looking at the performance in this area over the last year. Whilst this will not completely counter the unprecedented lost hours due to handover delays, it could reduce them by 7,000 hours a month, significantly improve patient experience and support our ambition to close more episodes at care closer to home.

   Members will continue to challenge on further actions that can be put in place, raise the issue in their respective forums, and will keep a close eye on the national review by Audit Wales into the effectiveness of unscheduled care services in Wales to provide further insight into the root causes of flow and delays.

2. **Risks 223 and 224** remain at scores of 25, with further information in the risk section of this report.

ADVISE

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

3. **The patient story from Fiona Philpott** told of the extremely poor patient experience of her 99 year old mother Brenda Patton who fell at home and had a 8.5 hour wait for the ambulance to arrive.

[1] The clinical safety plan (CSP) allows the Trust to prioritize acutely unwell patients when demand is greater than available resources, primarily as a result of handover delays

During that time Brenda was in pain and her condition deteriorated. Fiona told the Committee of the stress and anguish this caused for both her and her mother, particularly as there was no-one available to administer pain relief while they waited for the ambulance to arrive. Fiona said this was outrageous and shameful and did not afford her mother any levels of dignity. The impact of Fiona and Brenda's story was acutely felt by members, particularly in the context of the very long delays being experienced by so many of our patients in the community at the moment and the very real prospect of that worsening over the winter months.

The Committee heard that there was a high number of 999 calls and long handover delays in the Betsi Cadwalladr University Health Board (BCUHB) area at the time which meant there were no resources available to get to Brenda in a timely way, and for that the Trust was extremely sorry. There is work underway with BCUHB to develop the falls response service and a second falls response vehicle is due to start in November covering Conwy and Denbighshire subject to funding being confirmed.

The Committee expressed their thanks to Fiona and Brenda for sharing their story and will review the learning that was taken from this incident when they meet in February.

4. The Committee received the quarterly **Operational Update** as a standing agenda item. This report in its new format continues to provide helpful context for the Committee in its oversight role for quality, patient experience and safety.

5. The **Healthcare Inspectorate Wales (HIW) Annual Review 2021-21** was reviewed by the Committee and is before the Trust Board at its meeting on 24th November presented by HIW. The contents were noted and in particular the work of the Operational Delivery Unit to manage variance across emergency departments and health boards.

6. Following a review of the Appendix B process by the Emergency Ambulance Services Committee (EASC) and the NHS Wales Delivery Unit (DU) a **revised joint investigations process** was approved that will begin with a pilot reported through to EASC and the DU. It is expected that this new process will see higher levels of engagement from general practice and social care. The Committee will be updated on the pilot at future meetings.

7. The Committee continues to receive updates on the introduction of **Penthrox** and the challenges with respect to funding, however the ability for Community First Responders to administer oral paracetamol was welcomed.

ASSURE

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

8. The Audit **Wales review** of **quality governance arrangements report** was received by the Committee. The report acknowledges the "extreme service pressures driven by whole system issues" that impact upon the Trust. Overall, the report demonstrates that many components of the Trust's quality governance arrangement are working effectively and made recommendations for improvement in a number of areas to ensure the Trust is more fully informed of safety and quality issues. Specific areas identified were Clinical Audit planning and information sharing, assurance and information arising from mortality reviews and, quality performance reporting & learning. The Committee will continue to review progress against the recommendations in the review. Implementation of the Quality Strategy Implementation Plan commenced in April 2022 but has been delayed and this is noted in the review. The February 2023 meeting will receive the revised implementation plan.

9. The **Dementia Update** was received by the Committee and the team were commended on the significant number of achievements and its alignment to the Trust's strategy to shift left and provide

more care closer to home. It was noted that funding for the dementia programme since 2018 has been through the Integrated Care Funds and that the WAST team is leading the refresh of the UK Emergency Services Dementia Commitment. The link to a previous QUEST patient story was noted with respect to the work underway to develop dementia training for 111 and CSD staff.

10. The **Monthly Integrated Performance Report (MIQPR)** for September and the **Q2 Patient Safety Highlight Report** were received and reviewed in detail with the following focus:

    - Continued high numbers of concerns being received and whilst there was a slight improvement in 30-day response times they are significantly behind the 75% target at 28%. More resources are being put into the Putting Things Right team and as a result the 2-day acknowledgement time has improved significantly.
    - The continued escalated level of incidents being reviewed at the Serious Case Incident Forum.
    - The increase in the number of Appendix B incidents passed to Health Boards, with the DU noting there has been visible improvement in local assessment of these.
    - The slight decrease in the number of Nationally Reportable Incidents (NRIs) identified.
    - Continued increase in Coroner activity and the resource intense aspect of this particularly for clinical contact centre staff in responding to requests for information.
    - Whilst during the quarter 47% of immediate release directives were declined, there has been an improving position for red releases in September however the number of amber releases declined was concerning. A process is in place to investigate those declined with reporting to Health Board Chief Executives weekly. The Committee will review an internal audit on immediate release requests at the next meeting to determine any internal improvements that can also be made.
    - 111 clinical ring back is much improved following the introduction of tactical actions as part of the recent business continuity incident. This improvement is despite the difficulty to recruit clinicians into post.
    - Work on capturing stroke patient outcomes as well as the call to door target was reviewed at EASC and further progress on linking the end-to-end pathway will be reported back to the Committee.
    - With respect to clinical outcome measures, work is underway to ensure all users of the electronic patient care record (ePCR) are aware of the adjusted workflows and data points with respect to the clinical indicator for stroke and a deep dive audit into return of spontaneous circulation (ROSC) at hospital will be completed in November with resultant recommendations for reporting

11. **Learning from incidents** was presented and will be used to develop messaging so that frontline staff have increased confidence in the support they will receive following incidents and aligned this to the preceptorship and clinical supervision model.

12. The **Patient Experience and Community Involvement (PECI)** quarterly report for July to September 2022 was received and although there were largely positive comments in respect to the 999 and NEPTS survey, the continued theme is long delays for ambulances in the community and harm which is coming to patients waiting in the community.

13. The **audit tracker** was reviewed for audits within the remit of the Committee and noted that overdue recommendations had recovery plans in place.

14. Progress against the **Committee Priority for 2022/23** was reviewed and progress is being made. However, following the Welsh Government's presentation on the Duty of Quality and the Duty of Candour at the Board development session in October, the February 2023 meeting of the Committee will focus on the Trust's readiness for implement the Health and Social Care (Quality and Engagement) (Wales) Act.

RISKS

Risks Discussed: There are three corporate risks assigned to the Committee, two of which are rated as high risks with no changes to scores since the last review. **Risk 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 are both rated at 25. The theme of these risks arose throughout the agenda items discussed at this meeting and the Committee noted that despite further controls being added to the risks in the last quarter, there was no movement on either the likelihood or consequence scores for these risks, therefore they remain at the highest scoring of 25. Additional actions – both from WAST and the wider system – were added to both risks and were reviewed by the Committee.

Risk 303: delayed administration of chest compressions to patients as part of resuscitation has been closed as all actions have been completed and the score reduced to its target.

New Risks Identified: No new risks were discussed in this meeting.

COMMITTEE AGENDA FOR MEETING		
Patient experience	Operations Directorate Quarterly Report for Q2	Risk Management and Board Assurance Framework Report
Monthly Integrated Quality Performance Report	Patient Safety Report Q2	Audit Wales – Review of Quality Governance Arrangements
HIW Annual Report 2021-22	Patient Experience and Community Involvement Report	Public Health Safeguarding Annual Report 2021-22
Dementia update	Internal Audit Tracker Report	Joint Investigation Pilot
Patient Story Driver Diagram	Committee Priorities Update	

COMMITTEE ATTENDANCE				
Name	**12 May 2022**	**11 August 2022**	**10 November 2022**	**9 February 2023**
Bethan Evans				
Kevin Davies				
Paul Hollard				
Ceri Jackson				
Hannah Rowan				
Wendy Herbert		In attendance	In attendance	
Liam Williams		First meeting		
Andy Swinburn				
Lee Brooks				
Andy Haywood				
Leanne Smith		First meeting		
Rachel Marsh	Hugh Bennett			
Trish Mills				
Angela Roberts				
Mark Marsden			First meeting	
Hugh Parry				
Craig Brown				
Ian James		First meeting		

	Attended
	Deputy attended
	Apologies received
	No longer member

OPERATIONS DIRECTORATE
QUARTERLY REPORT FOR COMMITTEES
2022-23 Q3 (Oct – Dec 22)

National Operations & Support

Challenges

Civil Contingency Act Obligations

A new corporate risk has been raised to highlight the Trust's inability to provide a civil contingencies response in the event of a major incident or mass casualty incident, and maintain business continuity, with potentially catastrophic consequences. This risk is articulated in the climate of ongoing external pressures across NHS Wales which precludes our ability to fulfil the pre-determined attendance requirements for major incidents as detailed within the Incident Response Plan. This could impede the Trust's legal obligations as a Category 1 responder under the Civil Contingencies Act 2004.

Industrial Action

December 2022 saw three dates of industrial action; 2 by RCN, predominantly affecting the Integrated Care portfolio, and 1 by GMB, which had more widespread impact across the Operations Directorate. An Industrial Action Planning Team was established in late November led by the Emergency Preparedness, Resilience & Response (EPRR) team and consisting of senior reps from across the Trust, and the team will continue to make arrangements for future strike dates. It is anticipated that industrial action will continue into Q4 with significant disruption as a result. The IA Planning Team will provide assurance to The Industrial Action Cell and Senior Business Continuity Planning Team (SBCPT) on planning arrangements for anticipated and confirmed industrial action.

IMTP

Manchester Arena

Following the Manchester Arena Inquiry, 149 recommendations have been identified within volumes 2 and 3 of the report. WAST's EPRR team will now need to consider and plan a response to these recommendations. Asks will need to be made to NHS commissioners for the additional resources required to ensure an effective response following the assessment against the recommendations.

A report is being considered at Emergency Ambulance Services Committee (EASC) on 17th January 2023 to note that for WAST to receive, review, consider and plan the response to all recommendations relating to the Manchester Arena Inquiry, additional resource to support the EPPR team to achieve this will need to be established. A plan is being prepared to protect resource to achieve this.

Volunteering

The Trust has commenced a rollout of analgesia (pain relief) provision for Community First Responders (CFRs). Initially this will consist of 500mg oral paracetamol as part of a stepped approach to further analgesia roll out at a later date. This is a significant development for volunteering and for patient experience, consistent with our Volunteer Action plan, given that because of protracted hospital handover, CFRs are experiencing extended on scene times with patients who are in pain.

General Update

Christmas

Christmas hampers were provided to all ambulance stations and were received well. Christmas dinners were also provided by hospitality establishments from across Wales for all staff working Christmas Day on a shift commencing before 14:00 hrs. Many establishments provided the dinners free of charge, and others were purchased through Charitable Funds. A further bid to Charitable Funds has been supported for additional winter welfare refreshments for all staff via the Senior Business Continuity Planning Team.

Resourcing & EMS Coordination

Challenges

EMD Recruitment and Retention

Recruitment and Retention has been an issue for some time but has been acute over the last 6-12 months. The current rate of external attrition for the 2022 calendar year pan-Wales is 24%, up from 14% for the 2021 calendar year, with more staff leaving to take up internal vacancies across the Organisation. Recruitment to other roles within EMS Coordination is generally achieved through recruitment internal to the department, and this has left the Emergency Medical Dispatcher (EMD) establishment under significant pressure. Of the current funded establishment of 111.76 WTE in the EMD function, 61 new EMDs (55%) have taken up post since August. This has a profound impact on the performance across the unit as new EMDs try to acclimatise to the operational environment after training, and also seriously diminishes the availability of experienced colleagues to support the new recruits. A further 20 EMDs have been recruited to start with EMS Coordination in January 2023 mitigating the 14 team members who are due to move to alternative positions within WAST, primarily ACA in Q4.

Concerns

The number of Concerns flowing through from the ‘Putting Things Right’ Team continues to challenge staff across Operations Quality. The number of investigations, audits and statements required as part of the investigation process remains high at circa 170. This activity is not solely related to the concerns of service users but also includes coronial work, medical examiner requests and briefings for Serious Case Incident Forums (SCIF). The Operations Quality team continues to work collaboratively with the ‘Putting Things Right’ team cross directorate to deliver a joint solution that meets the legislative requirements and patient safety needs with a proportionate investigative process.

Intelligent Routing Platform
Over the last 2 years the demand for 999 call answering services has increased dramatically and the ability of UK ambulance services to meet this demand has been challenged. This can impact BT's ability to answer incoming 999 calls. UK ambulance services are required to have pre-determined arrangements in place for BT to be able to direct 999 calls to an alternative site should the home Trust be unable to answer the call within an agreed timeframe. The current agreed timeframe is 5 minutes.

In November 2022, the 999 Intelligent Routing Platform (IRP) replaced the existing network partner arrangements by using automated technology to improve the speed and accuracy of manual practices. Following the implementation of IRP, WAST experienced increasing demand to support other UK ambulance services, peaking on the 18th of December 2022 at more than 600 calls being taken in a 24-hour period, equating to 34% of the total calls re-routed across the UK and 22% of WAST's total 999 demand.

Due to wider system pressures and the demand coming into the service, a Critical Incident was declared on 19 December 2022, and because of the significant and sustained pressure on the system, it was decided to withdraw WAST from the IRP. The Operations Directorate Senior Leadership Team (SLT) along with the EMS Coordination team continue to work with colleagues across NHS England and AACE on a solution to safely allow WAST to return to this process without compromising our call handling capacity and performance.

IMTP

Research & Innovation - Upgrade 999 Platform
An upgrade of the 999 platform is required to improve resilience, flexibility, and interoperability for 999 call processing. Discussions continue with ICT regarding funding to support the rollout of the new platform with an expected decision in Q4.

The Assistant Director of Operations, Resourcing & EMS Coordination has been in discussion with the Head of ICT regarding the approach to funding, and discussions are ongoing with the supplier in relation to the actual cost of the upgrade. Progress has been delayed slightly as the supplier has been through a change of ownership during the negotiation discussions.

EMSC Reconfiguration
The EMS Coordination Reconfiguration Project has been ongoing since 2018, and the current key workstreams include:

- Roster review: a collaborative review of rosters in partnership across Wales to better match our staffing profiles to demand and support our teams' wellbeing
- Boundary changes: to provide an improved balanced workload for dispatch staff and greater resilience to the service
- Broader ways of working: an assessment to provide improved productivity and effectiveness while improving processes and procedures for QPS

The first tranche of work in the roster review is complete. This included the provision of roster options for EMDs completed collaboratively with Resourcing, and with voting mechanisms and ratification of preferred options. Revised rosters for EMDs are rolling out in Q4. Work on the boundary changes and broader ways of working have begun but have been paused to allow the EMS Coordination team to react accordingly to managing the industrial action period. The next set of roster reviews is not now anticipated until Q1 of 2023/24.

General Update

Control Room Solution

In line with the Emergency Services Network (ESN) programme, and in collaboration with the Ambulance Radio Programme (ARP), EMS Coordination is supporting the role out of a new Integrated Communication Control System (ICCS) provided by Frequentis. The LifeX solution is due to launch at the end of Q4, and WAST will be the first large scale ambulance service in the UK to go live on the new platform (Isle of Wight has been piloting the solution on a smaller scale).

ICT colleagues, EMS Coordination teams and the ESMCP project managers have been working with ARP to ensure infrastructure, operational plans and testing is completed and to the standard WAST requires to lead the UK with this innovative cloud-based product.

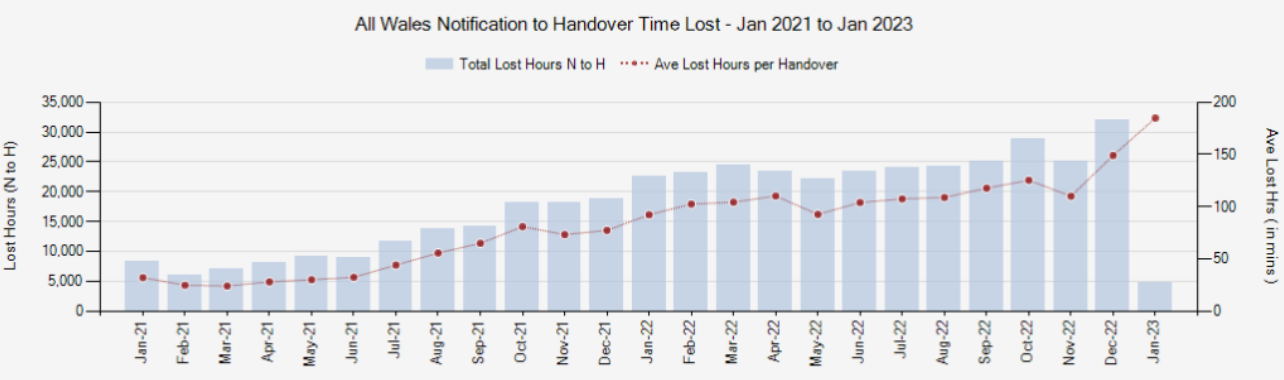
Instructors have been trained in readiness and a training programme has been designed in collaboration with ARP. January 23 will see those instructors and superusers receive refresher training in readiness for the wider rollout of system training to EMS Coordination teams in February and March 23.

Emergency Medical Service

Challenges

Continued System Pressure

Delayed handover of care at Emergency Departments across Wales remains a significant challenge in being able to provide a safe level of emergency service. 32,050 hours were lost in December 2022, an increase on the previous month of 7029 and resulting in a c38% loss of conveying capacity in Q3. In addition, several Health Boards across Wales have made business continuity and critical incident declarations in recent weeks.



Targeted Overtime
Following an increase in demand, handover delays outside EDs and the Trust's declaration of a Critical Incident on 19th December 2022, the Trust approved additional overtime payments for overtime worked during anticipated periods of high demand over the Christmas period, resulting in the following production uplift on the 5 enhanced dates:

	17	18	23	24	31	shift hou	unit hours	UHP%
EA	459.5	716	459.5	498	919.5	3052.5	1526.25	9%
CHARU	23	23	23	20	23	112	112	6%
APP	11.5	11.5	21	21	29.5	94.5	94.5	8%
DOM	23	53.5	29.5	45	68	219	219	9%
UCS	168.5	78.5	109.5	110	221.5	688	344	16%
						4166	2295.75	10%
other EMS*	90.5	19.5	93.5	78	46.5	328		
CSD	33.5	48	22	49.5	86.5	239.5	239.5	16%
CCC	55	71.5	28	71.75	95.75	322	322	5%

*CV: MRT,CRU, Triage; BCU: Berwyn Prison; SB: PCT; AB: Falls, PRU

IMTP

EMS Roster Review
The introduction of the **Cymru High Acuity Response Unit (CHARU)** has been deployed to support patients with suspected critical illness or injury. The CHARU has replaced the traditional RRV model and includes responding to an agreed dispatch criteria along with all red category calls.

All EA and UCS rosters are now live with 3 remaining which are still subject to internal processes but will be finalised in the next few weeks. CHARU is now live across Wales with the final part of recruitment taking place. Early indications are that the benefits are being realised with early intervention and leadership at critical incidents and positive feedback from CHARU operatives.

Improving Response Times in Rural Areas
EMT recruitment and recruitment to address the shortfalls in Powys continue. A workshop took place in Q3 with an accompanying paper due to be completed in Q4.

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

General Update

Business as Usual (BAU) Alongside Industrial Action Planning
It is recognised that with industrial action anticipated to last a number of months, there is also a requirement to service BAU needs in relation to winter pressures and other operational requirements. Following the first GMB strike day, the team is now seeking to balance responsibilities of industrial action planning and BAU workstreams to ensure service delivery is maintained.

Ambulance Care

Challenges

Contract Redesign Process

The implementation of the contract redesign process is progressing well. Of the 30+ contracts awarded, all but two commenced in December 22. The transition to the new providers has been smooth to date with no issues of note to report.

During the awards process, it was decided to not award contracts for 5 lots and to reissue the tenders to reflect an updated set of requirements. These lots were submitted for tender in December 22 and bidding has now closed with evaluation underway. It is proposed to award these as individual lots in line with the Trust scheme of delegation.

Of the two contracts yet to commence, the Cardiff & Vale discharge contract commences on Monday 16 January, and regular assurance meetings have been held with the incoming and outgoing providers as well as locally with the Health Board. There are several staff to transfer under the TUPE process and appropriate arrangements are in place to facilitate this.

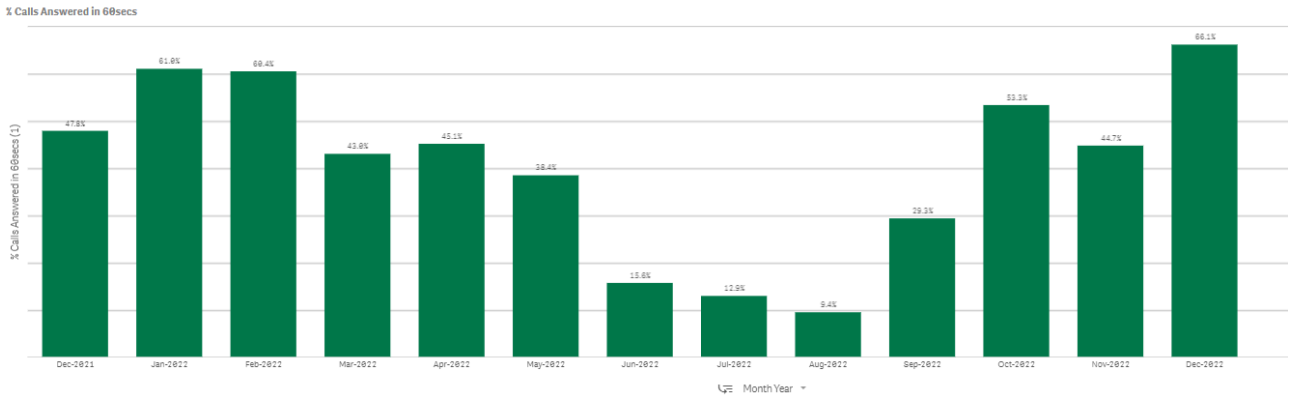
The Swansea renal contract will commence on 1 March 2023. At present, both providers are working through the TUPE process. Whilst this has proved more challenging than anticipated for reasons outside of WAST's control, confidence is high that a smooth transition will occur.

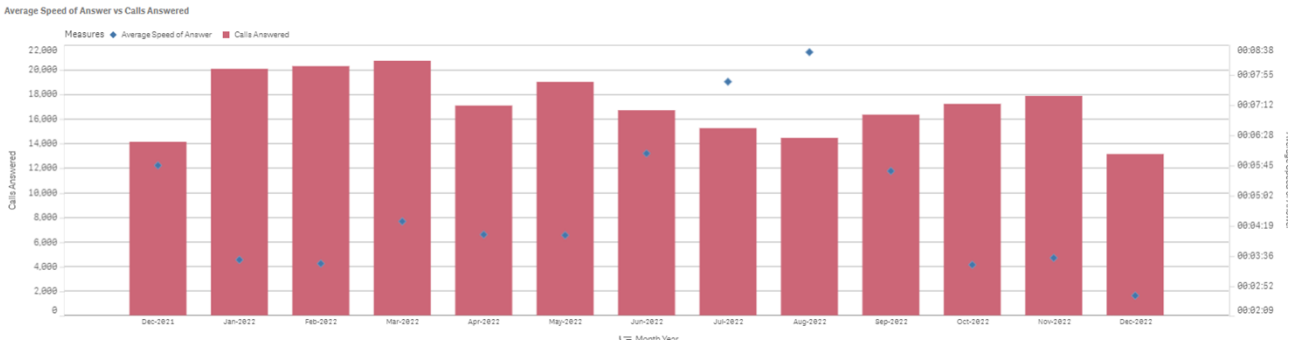
NEPTS Cleric Upgrade
Following completion of the new externally hosted environment for the upgraded NEPTS Computer Aided Dispatch (CAD), the new CLERIC Pink system was due to go live in December 2022. However, this date was delayed to allow the provider to respond to the findings of an audit on the security of the hosted environment. These findings have now been addressed and a new date has been set for the 11 January 2023. Due to industrial action announced for this date, it has been decided to reschedule this date to the end of January 23.

NEPTS Journey Booking Telephony Performance
The performance of the NEPTS journey booking service has at times in 2022 been below expectations. In July 2022, an action plan was implemented to deliver a recovery in the performance of the service.

Whilst there is still more improvement to make, the service is starting to deliver a more consistent level of performance, which can be observed below.

Further actions are underway to continue this improvement including recruitment, changes to HCP booking arrangements and a review of staff rosters to address current hotspots of challenged performance.





IMTP

Demand & Capacity Review
The revised roster keys have been developed. A PDSA has been written to test the ORH keys against the revised keys (ORH+) and the PID was completed in November 2022. The NET centre roster keys are currently being reviewed through the support of Erlang-C modelling from Optima. As this is a small and simple roster, it is not anticipated that there will be a delay on this process beyond the targeted completion date of 31st March 2023 (depending on organisational prioritisation).

NEPTS Operational Improvement
The review and implementation of the Resource Downtime workstream has been completed. The new report is in place and is being reviewed regularly under BAU arrangements. Contact has been made with BCUHB to restart the discharge lounge trial and data is being collated in relation to the oncology booking process PDSA and will be shared at the next ACT programme board.

Transfer and Discharge Service
The project team has been established and the PID has been approved by the transformation board. Work is in progress with regards to the modelling (ToR agreed, now at procurement stage) to help understand the data in support of the development of a concept for consideration by EASC at the end of the financial year.

Ready Times Refresh
One of the largest impacts within the D&C review was aligning the system allocated times for a return journey more closely with the actual position. This will aid planning, improve patient experience and minimise hours lost from crews waiting at sites for patients.

Significant work has been completed to review and refresh this process with 100 clinics reviewed already and a further 250 clinics in the review process, using a PDSA cycle to test the agreed processes. A system generated report has been developed that will allow all clinics to be reviewed and updated en-masse. Providing the latest PDSA cycle test shows the changes made to date have been effective, the process will be rolled out to all clinics nationally.

General Update

Winter Support Vehicles
The Ambulance Care Service was awarded £300k of funding to provide additional resource to support winter pressures. This allocation has been utilised to procure additional resources that are regional based and will be allocated to the areas with the greatest service pressures.

The resource procured is a mix of UCS and NEPTS resource and will be employed to support the service until 31 March 2023.

UCS Demand & Capacity Review
Following completion of the transfer of the Urgent Care Service from EMS to Ambulance Care, a strategic review has been commissioned through ORH to identify and understand how the UCS service works, what work it completes and to consider its role moving forward. This review commenced in November 22 and should be completed in April 23. The outcomes of this exercise will be used to inform decisions on how the service functions in the future. This review will be the first review solely focused on the service.

Integrated Care

Challenges

111 Adastra Outage
While the business continuity incident has ended for the Health Boards and Adastra systems have resumed, the “Concentrator” which joins the Adastra system to the WAST system is still out of action. Until this is resolved, WAST is on a heightened sense of awareness of the issue. The DHCW solution involving “robots” continues to operate to pass calls to the Health Boards, and this is expected to be in place until the concentrator is functional which is now expected in February 2023.

IMTP

Use of Video Consultation in Clinical Support Desk
The video element used within the ECNS triage system in CSD has been successfully implemented in December 2022. Used to enhance the patient/clinician interaction, video enables a closer look at ailments or specific injuries where this will benefit the consultation. We hope to glean intelligence regarding user experience to inform how this functionality is best used.

Clinical Support Desk Roster and Resourcing Review
The team in CSD have initiated a review of the recent update to the rosters. Feedback has been received from TU partners on some changes which are proposed by the staff, and the views have been understood in detail through a staff survey which concluded in December. This will be reviewed, and potentially changes to the existing rosters will be shared with the staff for input with a view to implementation around Easter 2023.

Consult and Close in the WAST surpasses 15%
Late December saw an increase in consult and close activity in CSD, 111 and with APP and HB partners. Coupled with the increased demand for service, consult and close rates of over 17% were seen on some days over the festive period. It is anticipated that consult and close will remain over 15% into 2023. This figure is potentially aided as a consequence of the use of the Clinical Safety Plan, and our operationalisation of the plan in the new version.

General Update

Integrated Care Estate
111 has moved into the new centre in Vantage Point House. The new facility is the main part of the VPH renovations which are still ongoing and has been firmly welcomed by the team. Work continues to provide a new welfare area and training facilities for all centres in VPH with expected completion in February 23. The works at Cardiff Ambulance station will complete in Q4.

AGENDA ITEM No	**6**
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	1

MONTHLY INTEGRATED QUALITY & PERFORMANCE DASHBOARD – December 2022

MEETING	Quality, Patient Experience & Safety Committee
DATE	9 February 2023
EXECUTIVE	Rachel Marsh – Executive Director of Strategy, Planning and Performance
AUTHOR	Hugh Bennett – Assistant Director of Commissioning and Performance Melanie O'Connor – Commissioning & Performance Officer
CONTACT	Hugh.bennett2@wales.nhs.uk Melanie.O'Connor@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 **December 2022** (with the exception of Sickness where November 2022 is reported).

2. This Report contains information on 24 key indicators. The indicators used at this high-level show, in many areas, a continued poor picture in terms of the quality and safety of the service that the Trust can provide to patients.

RECOMMENDATION

Trust Board is asked to: -

- **Consider** the December 2022 Integrated Quality and Performance Report and actions being taken and determine whether:

  a) The report provides sufficient assurance.

  b) Whether further information, scrutiny or assurance is required, or

  c) Further remedial actions are to be undertaken through Executives.

SITUATION

1. The purpose of this report is to provide senior decision makers in the Trust with an integrated dashboard (Our Patients, Our People, Value and Partnerships/System Contribution) focused on the "vital few" key metrics. This report is for **December 2022.**

BACKGROUND

2. This Integrated Quality & Performance Report contains information on 24 key indicators at a highly summarised level which aims to demonstrate how the Trust is performing across four integrated areas of focus:-

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

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

4. As previously agreed, the metrics which form a part of this committee/Board report will be updated on an annual basis, to ensure that they continue to represent the best way of tracking progress against our plans (IMTP) and strategies. This annual review is complete and was endorsed at the July 2022 Finance & Performance Committee and Trust Board meetings; some final amendments are still required in the next iteration.

ASSESSMENT

Our Patients – Quality, Safety and Patient Experience

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

6. 999 answering times have been challenged through significant increases in call demand. The median and 65th percentile performance remain good; however, the call answering tail increased in December 2022 to 1 minutes 34 seconds, which is higher than the Trust would want. An Intelligent Routing Platform (IRP) was switched on in November 2022. The IRP enables BT to re-route 999 calls between different ambulance services in the UK. These re-routed 999 calls accounted for up to 9% of the Trust's daily 999 demand. This percentage continued to increase during December and on the 21 December 2022 it was suspended, with a clear uplift in the Trust's performance as a result.

7. No additional funding was secured into 2022/23 for 999 call handlers (relief gap 39 FTEs). Forecasting and modelling has been completed and fed into the EMS Co-ordination Reconfiguration project with a re-rostering project on target for completion by March 2023, although this may now be delayed by maximum

escalation in December 2022 and strike action. The roster review is proceeding without the funding for the relief gap in call handlers.

8. 111 call answering performance remains poorer than the Trust would want. December saw the service reach an unprecedented demand which resulted with a business continuity incident issued. Calls reached as high as 3,000 – 4,000 calls on the weekdays in late December with the weekend reaching highs of 6,000 plus calls. Christmas to new year weekend saw the highest ever demand, recording over 8,000 calls on Sunday. The demand resulted in the infrastructure systems not being able to support the number of calls. Immediate resolutions were required to keep the service online including changing the call waiting length of time along with additional servers installed to meet the demand. Negotiations with commissioners earlier in the year suggested that the Trust has broadly the right number of commissioned and funded call handlers in post, however, there has been a recent agreement to uplift numbers by 10 WTE and work is ongoing to recruit these additional staff. Further work is required to reduce capacity lost through sickness absence, aligning capacity with demand and improving the efficient use of resource. A peer review of the 111 service has just been completed, which the Trust is currently considering; a key area of focus is likely to be re-rostering and moving to fixed roster patterns. A project initiation document is currently being developed for the potentail re-rostering project.

9. **111 Clinical response:** whilst the Trust continues to see achievement of the clinical call back times for the highest priority 111 calls, and improvements have been made in the last three month for other priorities, there is still much to do. Recruitment and retention of clinicians remains a priority, with significant numbers of clinical vacancies. An urgent set of actions within a focused plan are now in place to increase clinician numbers. This includes introduction of a new base for staff within the Cardiff area, a more focussed recruitment campaign and consideration of expanded numbers of clinical professions. The commissioned number of clinicians for 111 is 140 FTEs i.e. the funded establishment, but the modelled need is higher at 168 FTEs (based on a 40% Clinical Advice Line – CAL – rate from call handlers) with the curent action at 101 FTEs. The modelled need will be below the recent spike in 111 call volumes.

10. **Ambulance Response** (safety / patient experience): the Red 8 minute response performance for December 2022 was 39.5%, the lowest recorded. Amber response also declined in performance across the percentiles; with, Amber 1 waiting times remaining far too long, for example, the 95th percentile was fifteen hours 44 minutes. These long response times have a direct impact on outcomes for many patients. Actions within the Trust's control include:
Capacity:

    - Recruitment: the Trust has received an additional £3m (payment on results) in 2022/23 which will allow the Trust to recruit 100 FTEs over and above the existing establishment. The Trust is on target to deliver this uplift in quarter four, but not for the 23 January 2023 milestone date due to higher levels of attrition as identified in this report. Further funding is required to fully populate the new rosters with an identified gap of 64 FTEs. Executive Management Team will receive a report on recruitment & training for 2023/24 w/c 23

January 2023 with detailed workforce and recruitment & training then being undertaken.

- Additional Unscheduled Care Service (UCS) Capacity: the Trust has made for additional funding available for third party capacity that it can procure for the UCS. Four vehicles a day, seven days a week have been secured with funding through to the end of the financial year.

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

- The Ambulance Response roster review completed its go live in November 2022. This has been a complex large-scale project involving 1,800 staff, 146 rosters, and 60 working parties. This will have had the equivalent performance impact of +72 FTEs. A project evaluation is planned for quarter four.

- A Managing Attendance Programme has been agreed with EMT, which includes seven work-streams. This is now live and being reported to EMT every two weeks. The aim is to reduce sickness absence in line with a trajectory included in the IMTP (8% by March 2023). Whilst there have been some spikes, there is a clear downward trend, with particular improvements noticeable in long term sickness.

- Discussions with trade union partners on a range of other potential workforce efficiencies; however, dialogue between the Trust and TU partners on options for change has paused due to industrial action.

Demand Management

- The Trust has prioritised 41 additional clinicians into the Clinical Support Desk, with 36 Paramedic FTEs and five mental health practitioners successfully recruited and now in place. As well as improving the safety of the calls that are waiting, this investment will also mean an increase in consult and close rates, with the Trust now aiming to achieve a 15% rate by December 2022, an increase in the previous target of 10.2% which has been delivered. The Trust achieved 12.5% in November 2022; however, early indications are that the December performance is close to the 15% benchmark.

11. One of the key factors in relation to response times is the capacity lost to handover outside Emergency Departments. 32,098 hours were lost in December 2022 which represents 37% of the total number of conveying resource hours produced for the month. The levels are so extreme that all the actions within the Trust's control cannot mitigate and offset this level of loss. Urgent and high-level discussions have taken place between the Trust, Health Board CEOs and the CEO of NHS Wales. A number of mitigating actions have been agreed and a target of no >4 hour waits and a reduction of 25% in minutes per ambulance arrival (from Oct. 21 baseline). Whilst this is a target and trajectories are in place, improvements have not yet been seen and the position has actually significantly worsened. There has been a noticeable improvement in Cardiff & Vale's handover lost hours linked to an organisational focus. Immediate Release figures for December were: Red 449 accepted and 88 declined; and Amber 1 156 accepted and 541 declined.

12. **Ambulance Care (formally NEPTS) (Patient Experience)**: performance remains above target for enhanced renal patient arrivals prior to appointment in December 2022 and improved for patients requiring discharge. Overall demand for the service continues to increase, although it has not yet recovered to pre CoVID-19 levels. The Trust has a comprehensive Ambulance Care Transformation Programme in place, which includes delivering a range of efficiencies and improvements, for example: improved procurement through the plurality model, aligning clinic patient ready times to ambulance availability, re-rostering (NET Centre and NEPTS transport).

13. **National Reportable Incidents (NRIs) / Concerns Response**: the Trust reported zero NRIs to the Delivery Unit in December 2022, compared to two in November 2022; and eighteen serious patient safety incidents were referred to health boards in December 2022 and one was received under the Joint Investigation Framework (previously "Appendix B" arrangement), increasing from the previous month of November 2022. It should be noted that the relatively small numbers may represent a delay in referral across rather than an actual drop in numbers of serious cases. In December 2022 complaint response times decreased to 27%, failing to meet the 75% target. In the main, many of these incidents will be because of continued longer response times and the actions outlined above therefore are key. The Trust is putting more capacity into the Putting Things Right team. The Trust is also concerned for the welfare of the team, given the nature and volume of what colleagues are reviewing. Consideration is being given to what further support can be provided.

14. **Clinical outcomes**: the Trust is unable to fully report on the performance of all clinical indicators whilst work continues to link ePCR with the CAD and quality assure metrics. The percentage of suspected stroke patients who are documented as receiving an appropriate stroke care bundle was 79.4% in December 2022**,** below the 95% performance target. The introduction of ePCR enables the collection and sharing of information and data in a more timely and accurate manner. This will enable the Trust to better showcase clinical care provided to patients. Work is ongoing on the new call to door time-based metrics for STEMI and Stroke using the following roll out plan:

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

    <u>Our People (workforce resourcing, experience, and safety)</u>

15. **Hours Produced**: 112,225 Ambulance Response ambulance unit hours were produced in December 2022. The emergency ambulance unit hours production (UHP) was 91% in December 2022 and CHARU UHP increased from the previous month of 55% (note: the CHARU service was coming on stream in November, so this UHP figure needs to be treated with caution) to December's CHARU UHP of 79%). Key to the hours produced are roster abstractions which remain high and completing the planned recruitment into the CHARUs and the

100 FTEs. It is important to note that the Trust is not fully funded on the CHARUs.

16. **Response Abstractions:** Abstraction levels increased to 44% in December 2022, and are much higher than the 30% benchmark. COVID-19 has had a significant impact on abstractions with sickness abstractions being 11.64% in December 2022 (benchmark 5.99%). The training abstraction is also high, driven by internal movements linked to recruitment (more than 6% currently).

17. **Trust sickness absence:** the Trust's overall sickness percentage was 8.77% in November 2022 which represents an improvement. Actions within the IMTP concentrate on staff well-being with an aim to start to reduce this level. A specific Managing Attendance programme has been established, led by the Deputy Director of WOD, to identify and implement actions across a range of areas to improve sickness absence and alternative duties.

18. **Staff training and PADRs:** PADR rates have been improving achieving the 85% target, however compliance for Statutory and Mandatory training has dropped below the target for the first time since March 2022.

Finance and Value

19. **Financial Balance**: the Trust has reported outturn performance for November 2022 with a surplus of £5,000, and a forecast to the year-end of breakeven. At present the Trust is forecasting achievement of both its External Financing Limit and its Capital Resource Limit for 2022/23.

20. **Post-production lost hours**: the efficient and effective use of the capacity that the Trust produces is a key indicator. This is measured within the EMS service by the calculation of post-production lost hours (PPLHs). The reasons for PPLHs are many and varied. The EMS Demand & Capacity Review identified that the Trust benchmarked favourably on all elements of PPLH other than return to base meal breaks. Dialogue between the Trust and TU partners on options for change has paused due to industrial action.

Partnerships/ System Contribution

21. **Shift left:** much of Trust's work relates to working with health boards and other partners to provide the right care closer to home and reducing the number of patients who need to be conveyed to hospital. Good progress has been made through the year in increasing **consult and close** rates after 999 calls; and the Trust achieved 14.6% in December 2022, compared to the benchmark of 10.2%, which was exceeded during 2021/22. The benchmark has been revised up to 15%, to be achieved by December 2022, but as above early indications are that performance in December is close to the ambition of 15%.

22. The Trust **conveyed** 27% of patients to emergency departments in December 2022. This figure needs to be treated with caution as analysis shows that conveyance rates are linked to pressures within the system and the application of the Clinical Safety Plan (CSP), which will trigger the Trust being unable to send ambulances to lower acuity calls, with many patients cancelling the ambulance due to the long response times. In December, over 11,614 patients cancelled their ambulance, and the Trust was unable to send an ambulance due to application of CSP levels to approximately 2,650 callers. In the longer term, as

the Trust knows, the system needs to transform if it is to become more sustainable. A formal programme to take forward “inverting the triangle” has been established. A bid was submitted to Welsh Government to start to increase numbers of APPs being trained; this was not successful, but the Trust has decided to proceed with the option of an additional 10 MSC places from September 2022 and a further eight later in the year. The Trust has also appointed a Head of Strategic Development to take forward the “inverting the triangle” work, with the appointee now having started in the role. The Trust has agreed with CHCs that it will undertake an 8–12-week public engagement in spring of next year. Prior to that, further work will be required to engage with stakeholders.

Summary

26. The indicators used in this high-level report paint a continued poor picture in terms of the quality and safety of the service that the Trust provides to its patients. Patient demand across the 111 and EMS services has increased with exceptionally high call demand in both services, however, other factors such as the continuation of the CoVID-19 variants, levels of abstractions (including CoVID-19 related absence) and extreme handover lost hours continue to impact on the Trust. EASC, WG and the 111 Programme Board have been very supportive of the Trust through the pandemic, investing in a range of mitigations; however, funding for further initiatives is currently limited and is expected to worsen significantly in 2023/24. For 111 and Ambulance Care (NEPTS) the Trust can look to take a range of actions to optimise the balance between patient demand and capacity; however, for EMS the Trust cannot take sufficient actions within its control to mitigate the impact of the extreme handover lost hours. As a result, all three committees have expressed serious concern about the impact of handover lost hours on patient safety and staff well-being. The Trust has received further funding (£3m) for +100 FTEs into EMS, which is welcome, but it remains critical to patient safety that handover lost hours are reduced in line with Ministerial expectation.

RECOMMENDATIONS

Trust Board is asked to: -

- **Consider** the December 2022 Integrated Quality and Performance Report and actions being taken and determine whether:

  a) The report provides sufficient assurance.

  b) Whether further information, scrutiny or assurance is required, or

  c) Further remedial actions are to be undertaken through Executives.

REPORT APPROVAL ROUTE	
Date	**Meeting**
26 Jan-23	Trust Board

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

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru

Welsh Ambulance Services
NHS Trust

Monthly Integrated Quality & Performance Report

January 2023

Annex 1 – Top Indicator Dashboard

Section 1: Monthly Indicators / Top Indicators Dashboard

Top Monthly Indicators	Target 2022/23	Baseline Position (2021/22)	Oct-22	Nov-22	Dec-22	2 Year Trend	RAG
Our Patients - Quality, Safety and Patient Experience							
NHS111 Abandoned Calls	< 5%	18.60%	14.8%	13.6%	49.5%		R
999 Call Answer Times 95th Percentile	95% in 00:00:05	00:52	01:03	01:11	01:34%		R
999 Red Response within 8 minutes	65%	55.2%	48.0%	48.0%	39.5%		R
999 Amber 1 Median	00:18	01:10	01:42	01:34	03:30		R
Stroke Patients with Appropriate Care	95%	TBD	78.2%	80.2%	79.4%		R
Acute Coronary Syndrome Patients with Appropriate Care	95%	TBD	37.5%	42.3%	37.9%		R
Renal journeys arriving within 30 minutes of their appointment (NEPTS)	70%	79%	74%	75%	74%		G
Discharge & Transfer journeys collected less than 60 minutes after booked time (NEPTS)	90%	81.00%	85%	90%	90.0%		G
National Reportable Incidents reports (NRI)	Reduction Trend	5	8	2	0		G
Concerns Response within 30 Days	75%	61%	28%	24%	27.0%		R

Top Monthly Indicators	Target 2022/23	Baseline Position (2021/22)	Oct-22	Nov-22	Dec-22	2 Year Trend	RAG
Our People							
Capacity							
EMS Abstraction Rate	29.92%	42.00%	40%	40%	44.0%		R
Hours Produced for Emergency Ambulances	95%	95.0%	90%	92%	91.0%		A
Health and Wellbeing							
Sickness Absence *(all staff)*	8.00%	10.48%	9.48%	8.77%	-		A
EMS Operations Sickness Rates	8.00%	7.76%	10.12%	9.45%	11.64%		R
Staff Turnover Rate	TBD	8.71%	11.11%	10.70%	10.64%		R
Statutory & Mandatory Training	>85%	82.3%	85.58%	85.40%	84.63%		A
PADR/Medical Appraisal	>85%	60%	80.49%	80.75%	87.9%		G
Value							
Financial balance - annual expenditure YTD as % of budget expenditure YTD	100%	100%	100.00%	100.00%	100.00%		G
Post-Production Lost Hours (EA, RRV, UCS)	Reduction Trend	TBD	9385	9224	9379		A
Partnerships / System Contribution							
NHS111 Consult and Close	Improve	7,843	17,695	15,362	15,955		A
Combined 999 & NHS111 Consult & Close	15.0%	10.4%	12.8%	12.5%	14.6%		A
% Of Total Conveyances taken to a Service Other Than a Type One Emergency Department	Improvement Trend	TBD	10.65%	11.04%	11.18%		TBD
Number of Handover Lost Hours	25% reduction from Oct-21 position	15,955	28,038	25,020	32,098		R

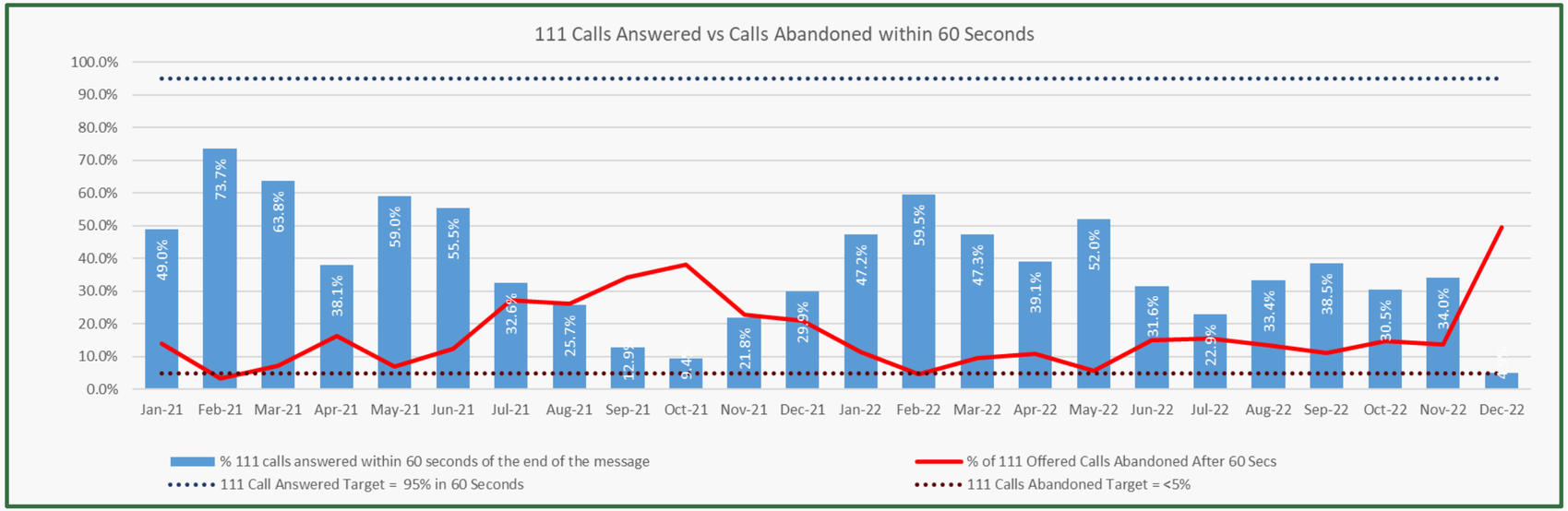
In-Month RAG Indicates =
Green: Performance is at or has exceeded the target *(Indicates no action is required)*
Red: Performance is less than 10% of target (Indicates close monitoring or significant action is required)
Amber: Performance is at or within 10% of target *(Indicates some issues/risks to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

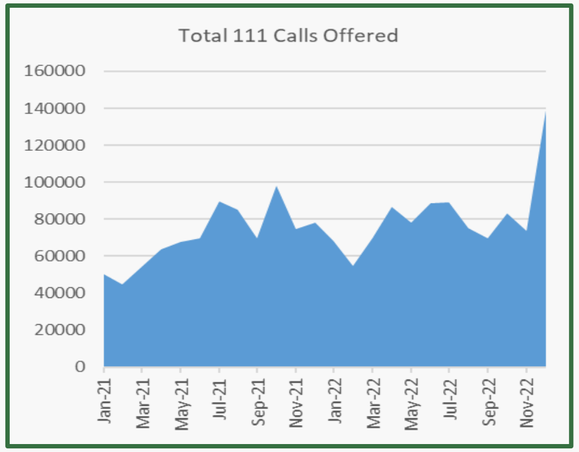
Our Patients: Quality, Patient Safety & Experience
111 Call Answering/Abandoned Performance Indicators

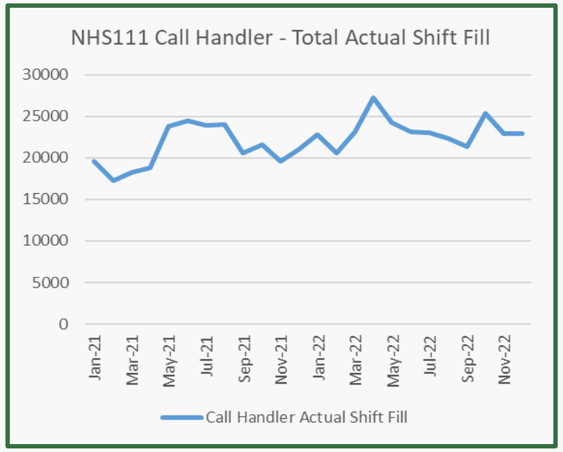
R

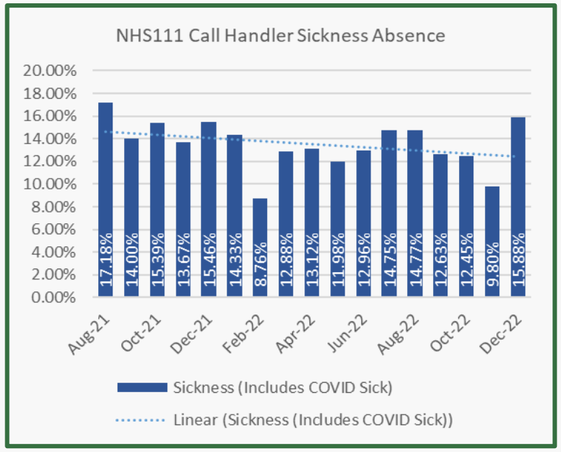
FPC

Influencing Factors – Demand and Call Handling Hours Produced









Analysis

111 call abandonment is a key patient safety indicator for the service**. December 2022** saw an abandonment rate of 49.5%, therefore failing to meet the 5% target.

The percentage of 111 calls answered within 60 seconds of the end of the message decreased in December 2022 to 4.9%. 111 call demand increased when compared to November 2022..

Capacity (staff hours) has generally been increasing in line with the roll-outs and as planned, however this is impacted by sickness abstractions for Call Handlers (which includes COVID-19 Sickness) which although decreased in November 2022, remain higher than the agreed trajectory at 15.88%.

December saw the service reach an unprecedented demand which resulted with a business continuity incident issued. Calls reached as high as 3,000 – 4,000 calls on the weekdays in late December with weekend reaching highs of 6,000 plus calls. Christmas to new year weekend saw the highest demand, recording over 8,000 calls on Sunday. The demand resulted in the infrastructure systems not being able to support the number of calls, immediate resolutions were required to keep the service online, this included changing the call waiting length of time along with additional servers installed to meet the demand.

Remedial Plans and Actions

The key to improving call answering times is having the right number of call handlers, rostered at the right time to meet demand, and to maximise efficiency.

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

Expected Performance Trajectory

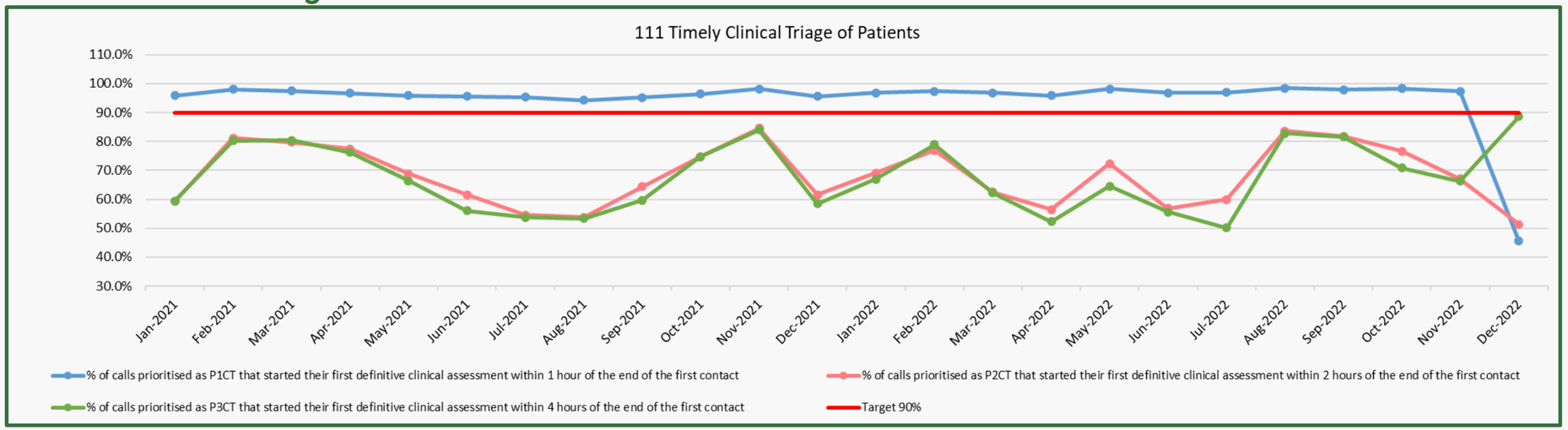
With call handler numbers broadly at commissioned levels, call answering times will only be improved through improved efficiency gains (reducing sickness absence, re-rostering, reducing time for CAL line).

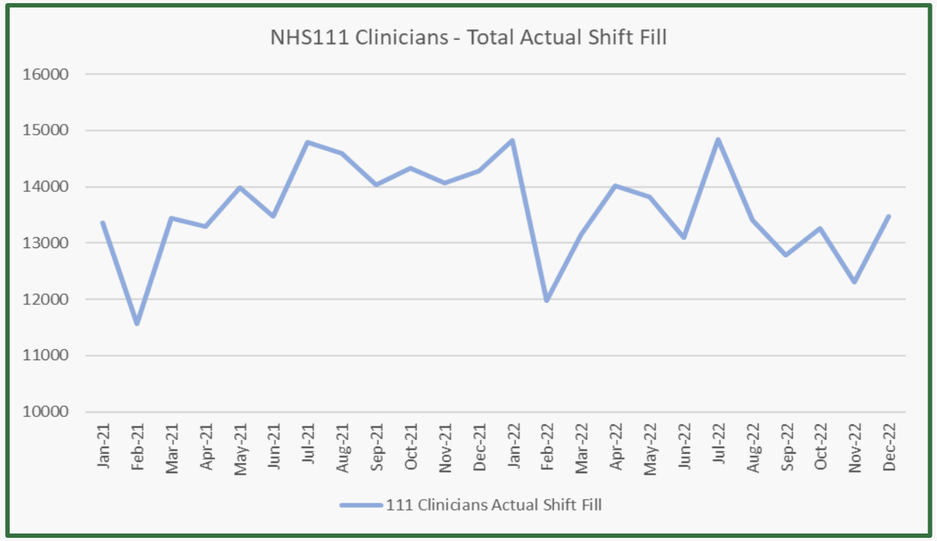
If demand continues to be so high performance will be affected due to levels of call handlers and clinicians not matched.

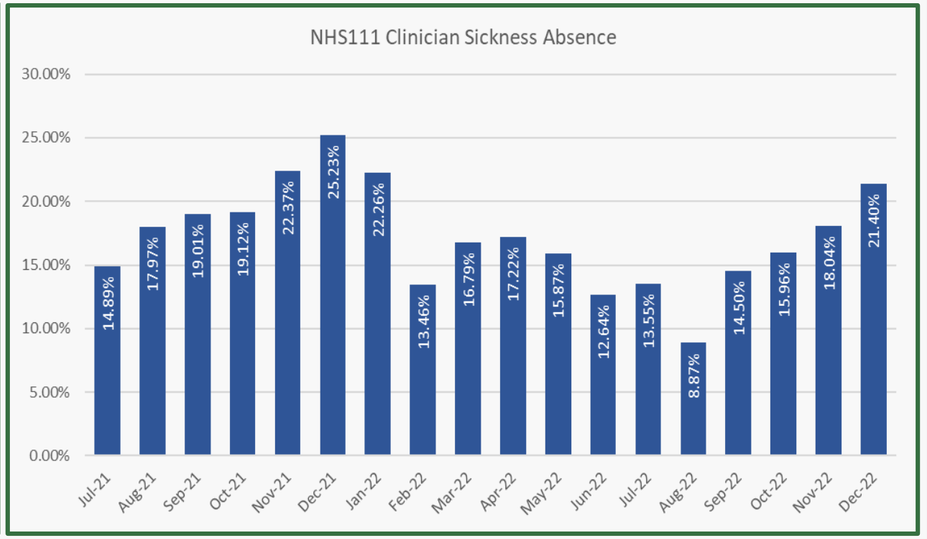
Our Patients: Quality, Safety & Patient Experience
111 Clinical Assessment Start Time Performance Indicators

P1CT G FPC

Influencing Factors – Demand and Clinical Hours Produced







Analysis

The performance of **111 calls receiving a timely response to start their definitive clinical assessment has seen a decrease across the priorities. For the first time in 2 years, the highest priority calls, P1CT, failed to** achieve the 90% target (45.6%).

For lower category calls the Trust are not meeting the 90% target, and unlike the previous improving trajectory P2CT performance decreased, however P3CT improved. Demand for the service has grown significantly as the service has been rolled out, and there was a significant increase in demand in December above that seen in November.

Recruitment and retention of clinical staff is the key issue .

13,479 hours were filled by clinicians in December 2022 an increase when compared to 12,311 in November 2022. Clinician sickness absence increased from 18.04% in November to 21.40 % in December. At present there are 101.1 (FTE) nurses and paramedics employed within NHS111 and 39.01 FTE vacancies *(data correct as of 12/01/23 and therefore subject to change).*

Remedial Plans and Actions

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

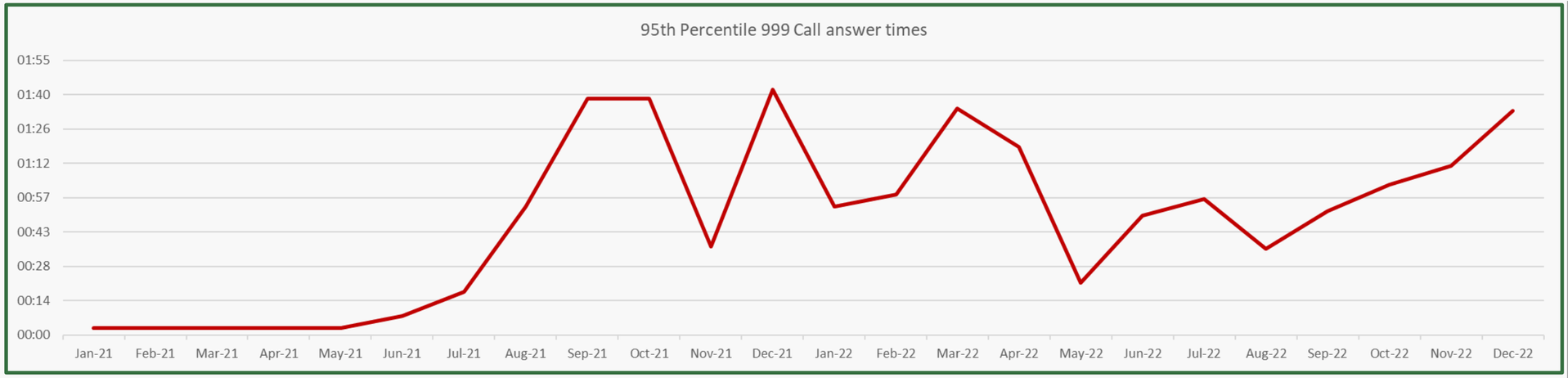
- Utilisation of other clinicians to fill vacancies;
- Maximising opportunities through remote / agile working;
- Review of existing staff bases including agreement to creating an additional Cardiff base, operational from mid December;
- Review of service model following Adastra outage / BCI;
- Targeted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

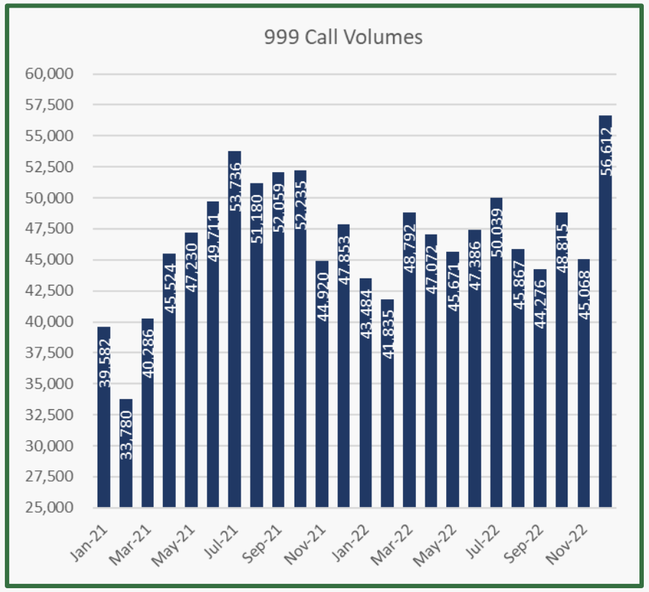
Expected Performance Trajectory

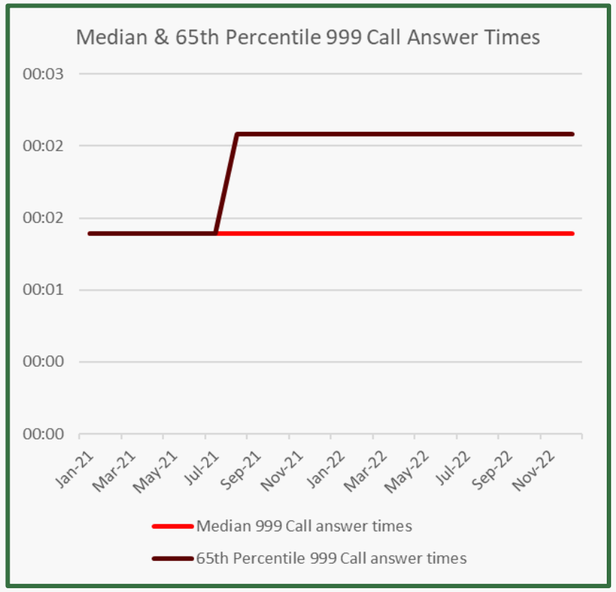
Risks have been highlighted in previous reports about the ability to recruit sufficient clinicians and this is now being seen. Although urgent actions are in play as set out above, performance is likely to be below levels expected until these bear fruit into Q4. Demand for the 111 service is also more difficult to forecast as it is often linked to government announcements or media coverage.

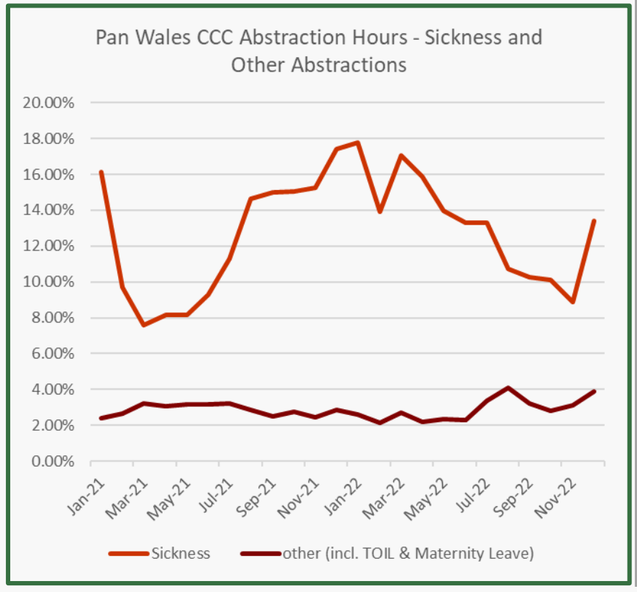
Our Patients: Quality, Safety & Patient Experience
999 Call Performance Indicators
Influencing Factors – Demand and Hours Produced

R FPC CI









Analysis

The 95th percentile 999 call answering performance increased in December 2022 to 1 minute 34 seconds, compared to 1 minute 11 seconds in November 2022. Delays in call answering times are a significant concern in relation to patient safety. 79.4% of calls were answered within 6 seconds in December 2022.

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

The Trust received 56,612 emergency 999 calls in December 2022, an increase compared to November 2022. December 2022 saw an increase in sickness abstractions, not in line with the planned trajectory.

Some of the volume of calls can be correlated to the switch on of the Intelligent Routing Platform (IRP) in November.

Remedial Plans and Actions

EMS CCC meet twice weekly to review demand profiles and align staffing levels appropriately. .

- No additional funding is available this year to increase numbers of call handlers.
- Increased pressure and sustained levels of 999 demand is impacting on staff attrition and wellbeing.
- WAST requested exclusion from UK Intelligent Routing Platform as part of Critical Incident 19th December 2022.
- CCC FTE is currently 123.34 *(data correct as of 16/01/23)*

Expected Performance Trajectory

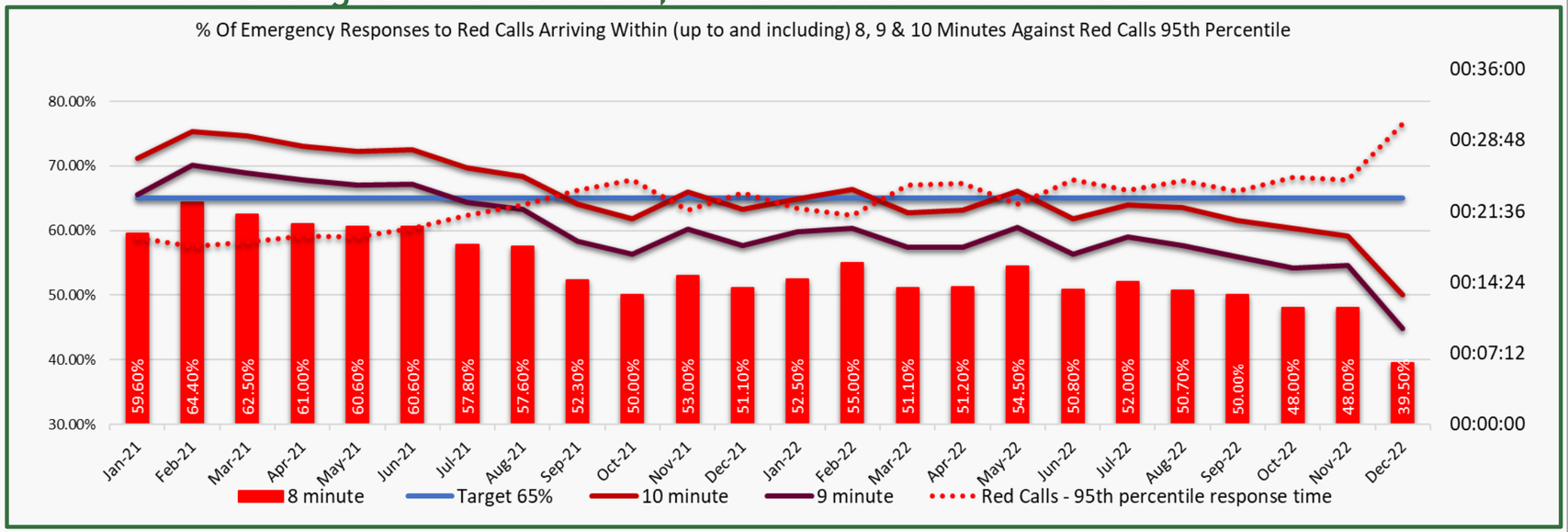
Performance has recovered since the exclusion from IRP. A further EMD cohort is scheduled to commence in Carmarthen and Bryn Tirion on 23rd January 2023 allowing EMSC to begin to align skill into vacancies in the dispatch function. Further recruitment is planned for an April start date. A 24 hour return to IRP is scheduled for 17th January 2023 to review the changes made to the configuration of the platform and reduction in demand now being managed, following this 24-hour WAST will exclude again to review implications before agreeing a more permanent return to the platform.

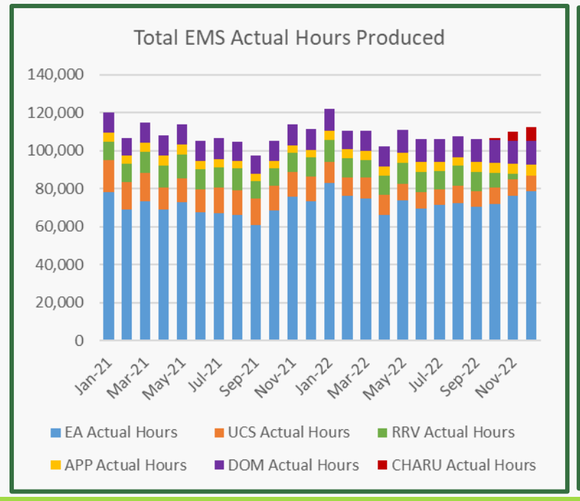
Our Patients: Quality, Safety & Patient Experience
Red Performance Indicators

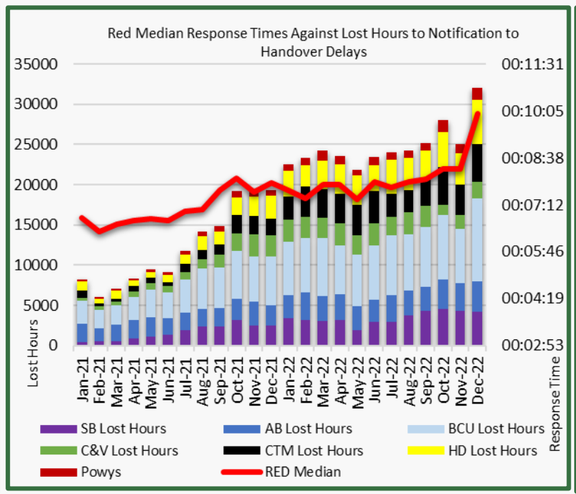
65% R | 95% R

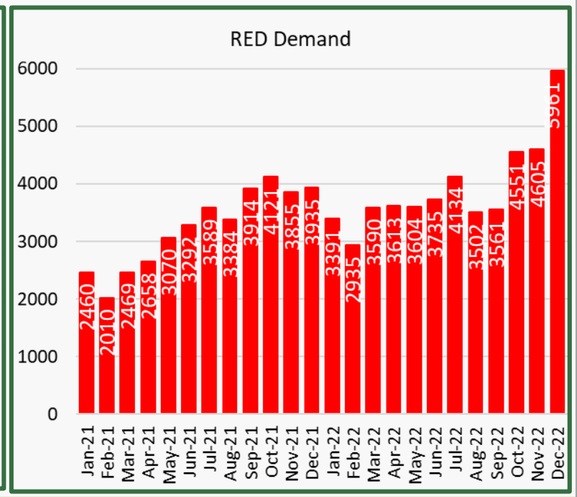
CI | QUEST | FPC

Influencing Factors – Demand, Hours Produced and Hours Lost









Analysis

Red performance decreased in December 2022; remaining significantly lower than the 65% target; the target has not been achieved since July 2020. There was also significant health board level variation with none of the seven health board areas achieving the 65% target. A continuing level of poor performance was forecast based on predictions of demand, lost hours and hours produced. Red 10-minute performance was 50.1% in December 2022.

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

Red demand in the last 2 years has seen a particular increase, outside of normal expected variation which is impacting on response times. The change in DCR tables implemented in October has led to a further step up in demand as expected.

The lower centre graph demonstrates the correlation of performance with hospital handover lost hours, with extreme levels of losses continuing to be seen with 32,098 hours lost in December.

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

Remedial Plans and Actions

The main improvement actions are:

- Increase capacity where funded - recruitment of 100 FTEs, EMTs and ACA2s during 2022/23 (off target for all operational by end of Jan 2023, now end of February 2023);
- Reduce hours lost through sickness absence through managing attendance programme – trajectory for improvement in place as part of IMTP (8% by Mar-23 attainable).;
- Health Board handover reduction plans are in place, but handover levels continue to increase and went over 30,000 for the first time in Dec-22;
- Improving efficiency; the role out of new Response rosters, will provide the equivalent of 72 WTE additional staff (action complete);
- A clinical review of Red demand using ePCR data (initial findings reported to EMT);
- Tactical responses linked to escalation including: clinical managers responding, DOMs responding, targeted overtime on demand hot spots(actioned);
- Modelling of additional tactical resource required to achieve a higher level of Red performance (complete); and
- Modelling of full roll out of Same Day Emergency Care (SDECs) by health boards (results expected w/c 23 Jan-23)...

Expected Performance Trajectory

Winter modelling (March 2023) indicated that without reductions in handover in line with the Welsh Government directives, the Trust can expect to see Red 8 minute performance reduce to below 40% without the application of the Clinical Safety Plan to levels 3 and above and the recruitment of the +100. This is what has started to happen in December. Further modelling for Q1 2023/24 to be undertaken in Feb-23.

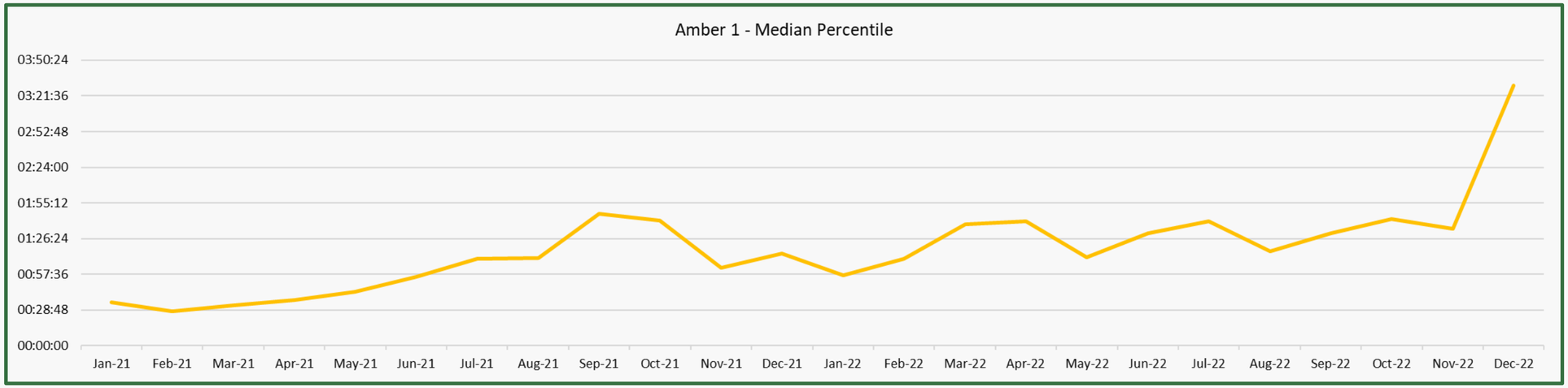
NB: Data correct at time of abstraction

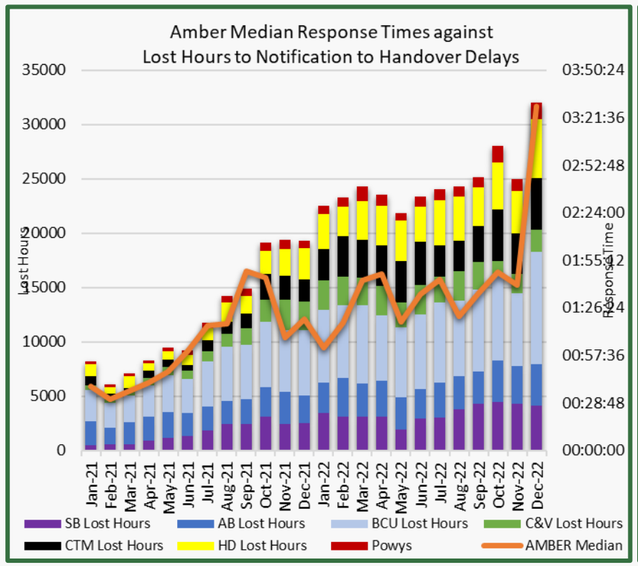
(Responsible Officer: Lee Brooks)

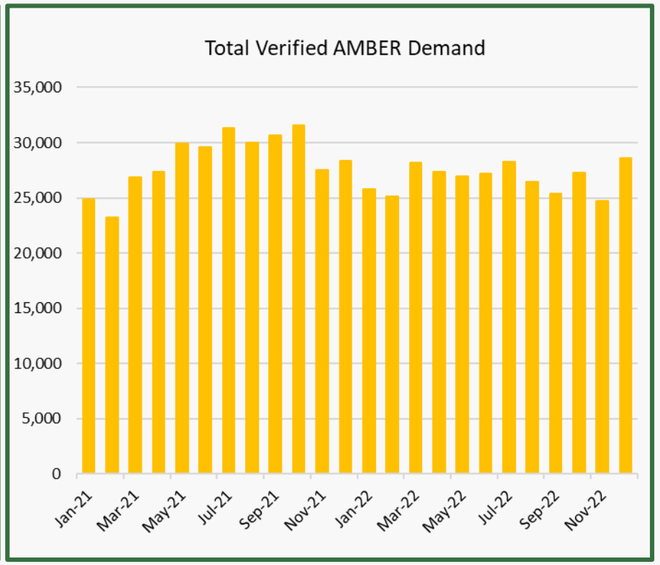
Our Patients: Quality, Safety & Patient Experience
Amber Performance Indicators

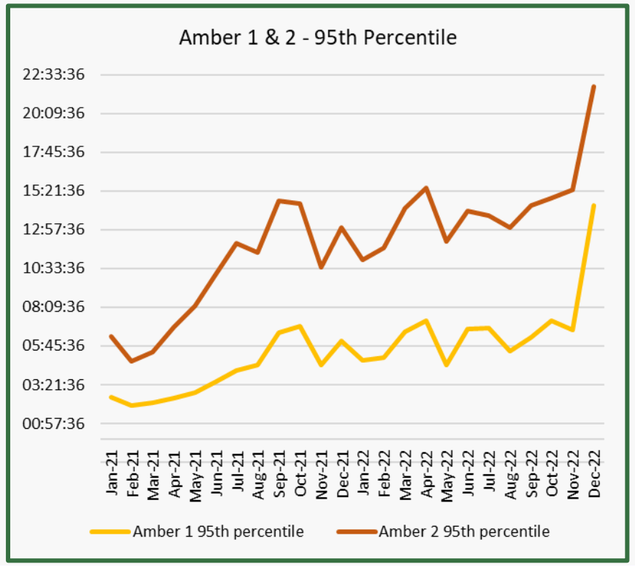
Influencing Factors – Demand, Hours Produced and Hours Lost

R CI FPC QUEST









Analysis

Amber response times declined across the percentiles in December 2022. In addition, there were some some very long patient waits in December (see below). The ideal Amber 1 median response time is 18 minutes, in December 2022 the Trust recorded median response times of 3 hours 30 minutes.

In December 2022, 2,064 patients (all categories, not just Amber) waited over 12 hours, an increase when compared to November 2022, continuing to represent very poor quality and experience of service. 1,943 of these patients were in the Amber category.

Amber demand increased in December 2022 although it has been broadly stable.

There is strong correlation between Amber performance and lost hours due to notification to handover delays. The number of hours lost to notification to handover delays in December 2022 were extreme at 32,098, going over 30,000 for the first time.

Remedial Plans and Actions

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

Expected Performance Trajectory

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

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

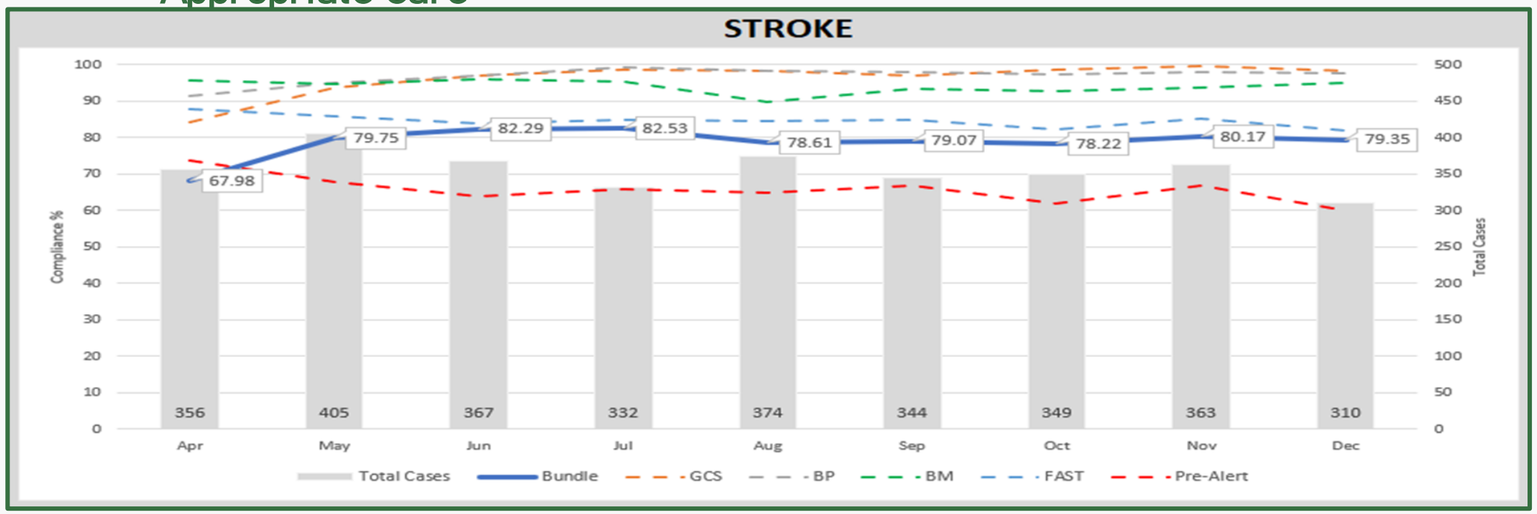
Our Patients: Quality, Safety & Patient Experience
Clinical Outcomes Indicators

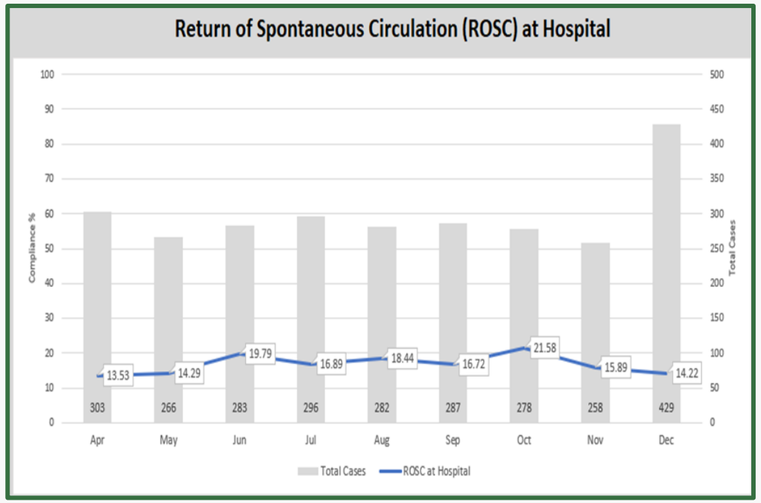
Stroke/Hip Fracture/Hypo glycaemic.
R

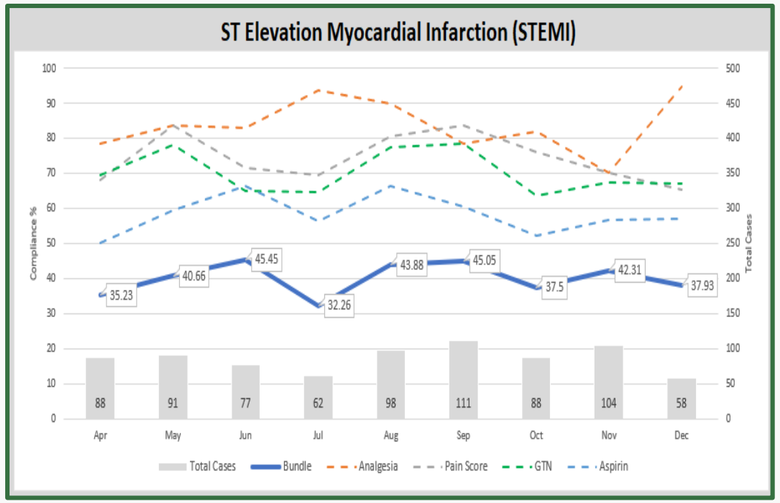
Self Assessment: Strength of Internal Control: Moderate

QUEST

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







Analysis

Clinical: The Trust currently uses ePCR to report on five clinical indicators (CI) to the Emergency Ambulance Service Committee (EASC) , Fractured Neck of Femur (#NOF), Stroke, ST elevation Myocardial Infarction (STEMI), Hypoglycaemia and Return Of Spontaneous Circulation (ROSC at hospital). Work continues to develop, and quality assure metrics.

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

Remedial Plans and Actions

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

New agreed indicators for this year (commissioning intention) include call to door time for STEMI and Stroke, and Reporting on Outcomes (by response type). There is a lot of work required to agree and then report on these indicators, with the following roll out plan:

Q3 (Oct – Dec 2022)
A decision will be made on the criteria to define 'call to door' and 'at hospital' for the STEMI & Stroke time-based metrics, and begin developing a reporting dashboard.
Establish initial requirements with the NCCU for Reporting on Outcomes (by response type).

Q4 (Jan – Mar 2023)
Work continues with CIAT/HI/NCCU to decide on the most appropriate data points, taking into consideration those used by English Ambulance Trusts.
Finalise the time-based metrics dashboard and test the data internally to include data from April 2022.
Review potential data points for use as test data/discuss with NCCU
Test reporting with initial data points/discuss with NCCU

April 2023
Approve time based metrics for ASI reporting

The Trust's introduction of the Cymru High Acuity Response Unit (CHARU) model, based on improved clinical leadership and enhanced training, will further improve outcomes for patients. This commenced in October 2022 in some areas.

Expected Performance Trajectory

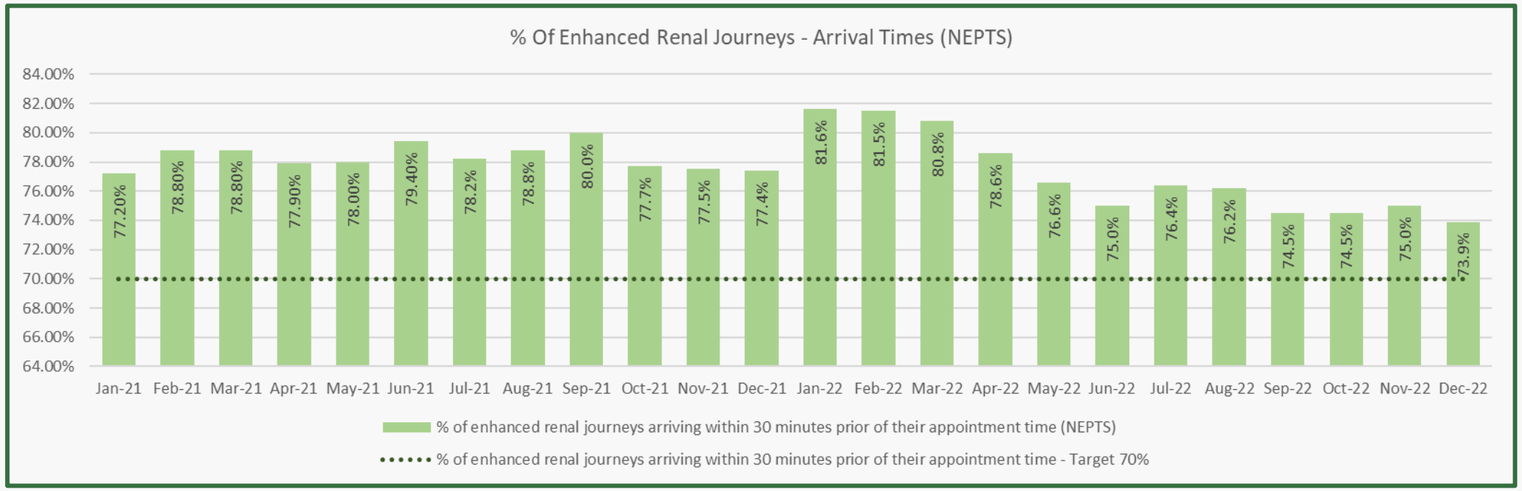
Clinical: As shown throughout the UK, the implementation of CHARUs will aid the Trust in successfully increasing ROSC rates. Once CHARU has been implemented it is anticipated that ROSC rates should increase.

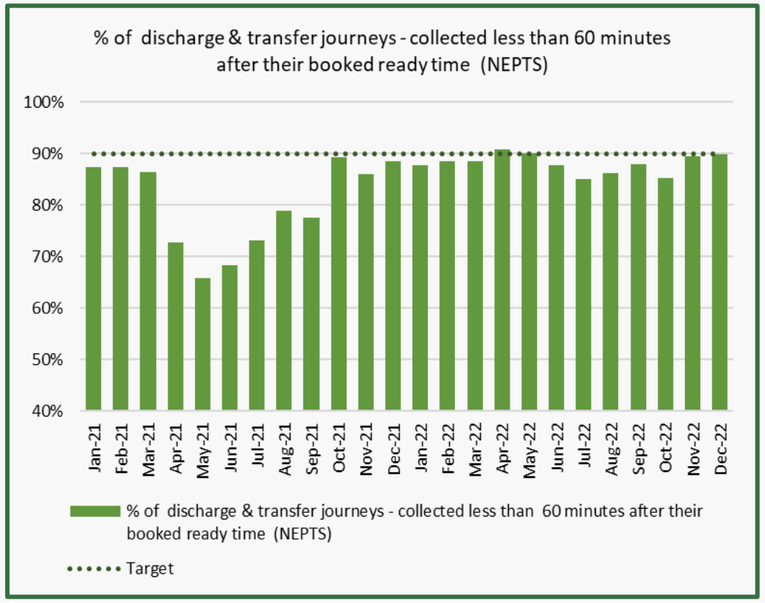
Our Patients: Quality, Safety & Patient Experience
Ambulance Care Indicators

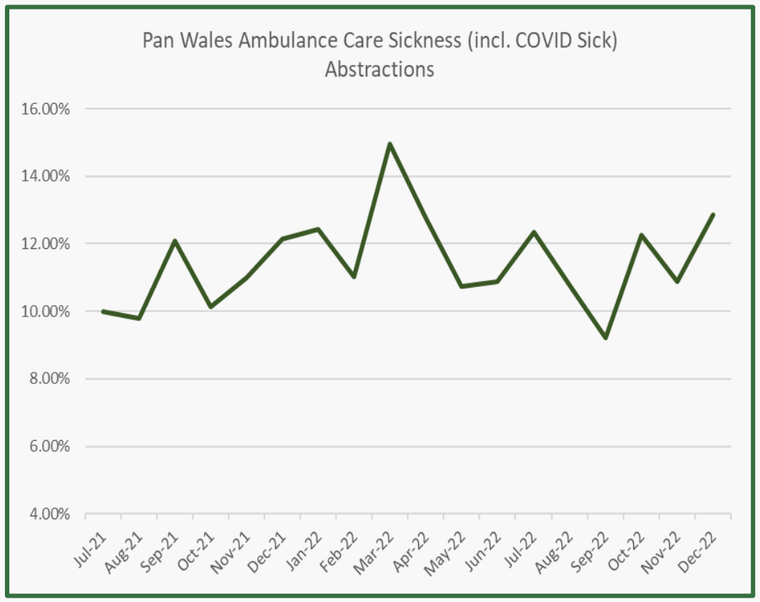
Renal	D&T
G	G

CI FPC

Patient Experience







Analysis

Ambulance Care (NEPTS element) performance is stable. 73.9% of enhanced renal journeys arrived within 30 minutes prior to their appointment time, achieving the 70% target in December 2022.

90% of discharge & transfer journeys were collected within 60 minutes of their booked ready time, therefore achieving the 90% target.

Key factors affecting these indicators are demand and capacity:

- **Capacity** continues to be adversely affected by other factors such as sickness absence levels, which increased in December 2022 to 12.86%. Annual Leave returned to levels below the 20% cap at 13.22%.
- Overall demand has been increasing since the initial reduction at the beginning of the pandemic, but overall it is still not quite at pre-pandemic levels.
- As the Trust emerges out of pandemic response and the health system is "re-set" it is anticipated that further demand increases could be experienced at which point capacity may be an issue. This has been modelled and mitigations put in place.

Remedial Plans and Actions

- D&C Project: currently awaiting feedback from tests of change for revised roster keys. Once received, the draft PID will be completed. Aim was to deliver by Nov-22, but delayed linked to escalation levels.
- NEPTS Operational Improvement: Discharge Lounge trial restarted on 21st November. However, HB operational pressures have brought the very brief start to a halt. WAST will again be engaging with BCUHB to establish a trial to be completed in the face of escalation. WAST may need to look at another HB to trial.
- Transfer and Discharge Project: Work is in progress with regards to the modelling with aim to complete by end of the financial year.
- Transfer and Discharge Service: work is in progress with regards to the modelling (ToR created and data collection almost complete with weekly project call now in place). Aim is to have the modelling complete by year end..
- Transport Solutions: Training of Health Boards for the online booking system is on track to be completed within December 2022, after which telephone bookings from HCP's will no longer be accepted. A position paper on eligibility is being created and has been discussed with NCCU with the view of then sharing with WG.
- NEPTS Plurality Model: Majority of all lots have been awarded; the last contract due to commence on 16 Jan-23.
- NEPTS CAD Upgrade: second penetration (PEN) test took place on 28th November and all identified issues were rectified. The scheduled go live has been postponed twice now due industrial action dates and has been rescheduled with the go live day being the 31st January 2023.

Expected Performance Trajectory

At present, the uncertainty around demand as HB's move through system recovery following the pandemic with the potential addition of austerity means that it is difficult to forecast performance. WAST will continue to work with the HB's through the commissioning DAG (NCCU) to deliver the best performance possible for the patient. It is likely that the service will experience both positive and negative fluctuations of performance until activity normalises across the system.

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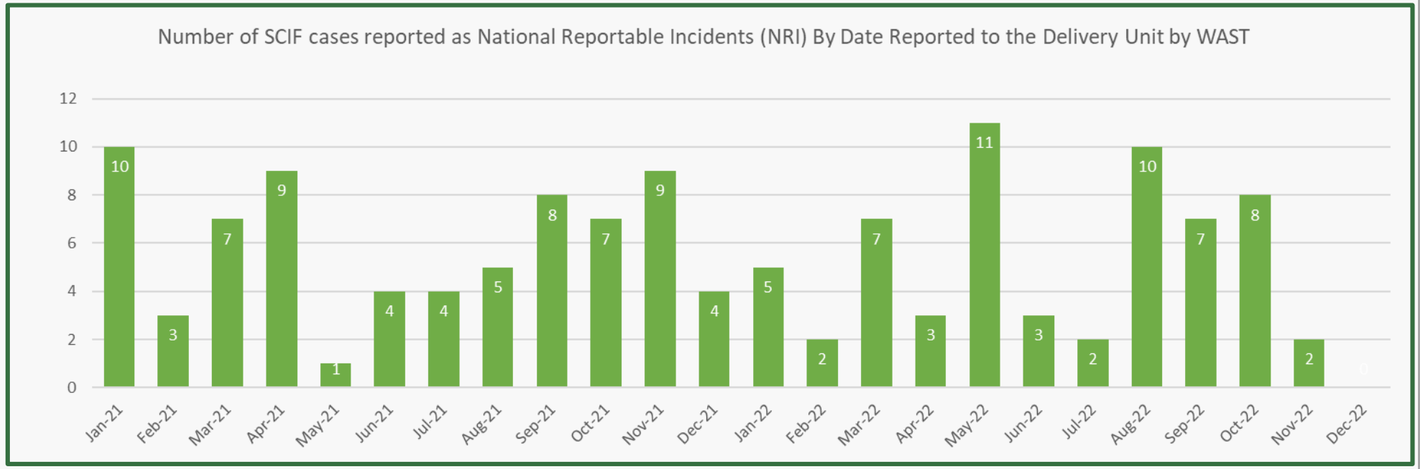
Our Patients: Quality, Safety & Patient Experience
Patient National Reportable Incidents & Patient Concerns Responses Indicators

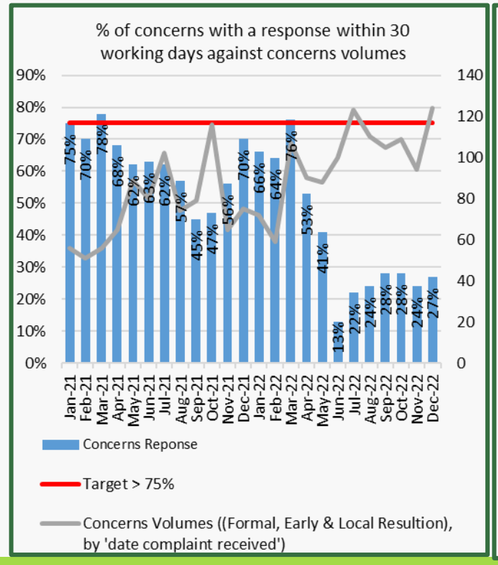
SCIF. G

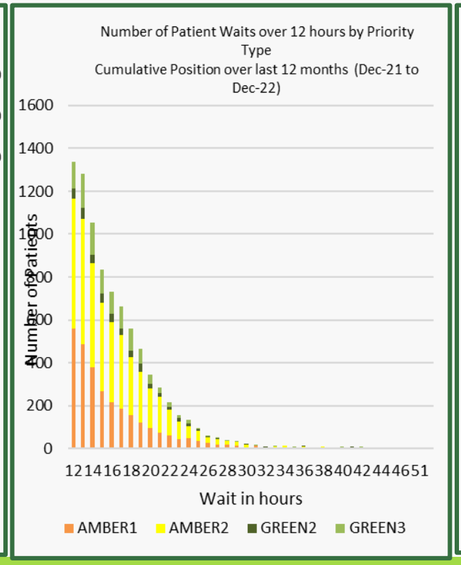
Self Assessment: Strength of Internal Control: Moderate

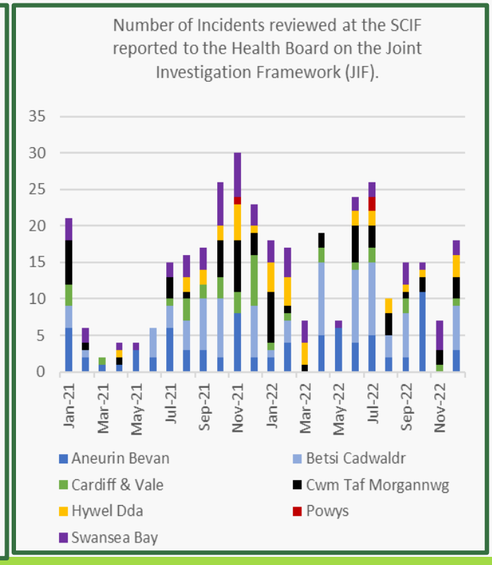
QUEST

Health & Care Standard
Health - Safe Care / Timely Care









Analysis

The percentage of responses to concerns remains static in December 2022 at 27% against a 75% target. Several factors continue to affect the Trust's ability to respond to concerns, including, overall increased demand, a rise in the number of inquests, continuing volumes of Nationally Reportable Incident's (NRIs) and timely response to requests for information from key parties. The number of total concerns increased in December (124) when compared to November 2022 (94).
In December 2022 there were seven Serious Case Incident Forums (SCIF), and 36 cases were discussed, no cases were reported to the NHS Wales Delivery Unit and eighteen cases were referred to Health Boards for investigation and one was received from the Health Boards under the Joint Investigation Framework (JIF). This has replaced Appendix Bs.
Themes relating to incidents reported to the NHS Wales Delivery Unit as Nationally Reportable Incidents (NRIs) include call categorisation and clinical aspects of care including misdiagnosis and subsequent management. The ineffective breathing descriptor remains a theme, as it does UK wide.

In December 2022 there were 0 NRIs relating to Red calls, Amber calls and Green calls. As reported earlier, in December 2022, 2,064 patients waited over 12 hours for an ambulance response, an increase month on month, also an increase when compared to 625 in December 2021 and 606 in December 2020.

37 Compliments were received from patients and/or their families in December 2022, an increase compared to the previous month (47).

Remedial Plans and Actions

A range of actions are in place:-

- Additional resources for complaints handling administration has been agreed by the Executive Management Team. Recruitment, redeployment and assessment of workload and where to best place resources continues.
- The general theme in relation to the Trust's concerns portfolio remains timeliness to respond.
- The Joint Investigation Framework pilot (to replace the appendix b process) is in progress with good engagement from system partners to date. Early feedback from health boards is there are some challenges regarding the 72-hour timeframe to arrange a meeting including all relevant system partners.
- Immediate improvement actions following the SCIF include education and training for individual staff, updates to operating procedures and circulation of bulletins to share learning and provide updates.
- Health care professionals (HCPs) diagnosing patients with life threatening conditions (Amber1) with protracted waits has been identified as a theme at the Serious Case Incident Forum (SCIF) also. In response a new HCP call task and finish group, led by the Assistant Director of Quality and Nursing is meeting currently to review the cases and determine any improvement actions.
- The key strategic action is the EMS Operational Transformation Programme.

Expected Performance Trajectory

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

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

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

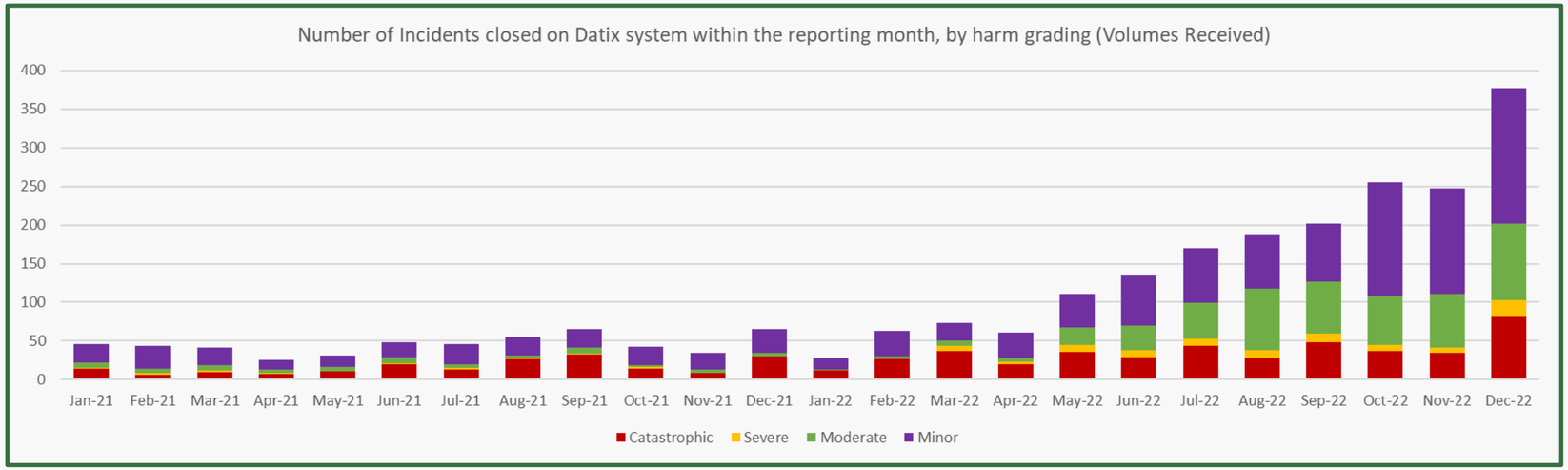
NRI & Concerns Data source: Datix / Longest Waits Data Source: Report Manager

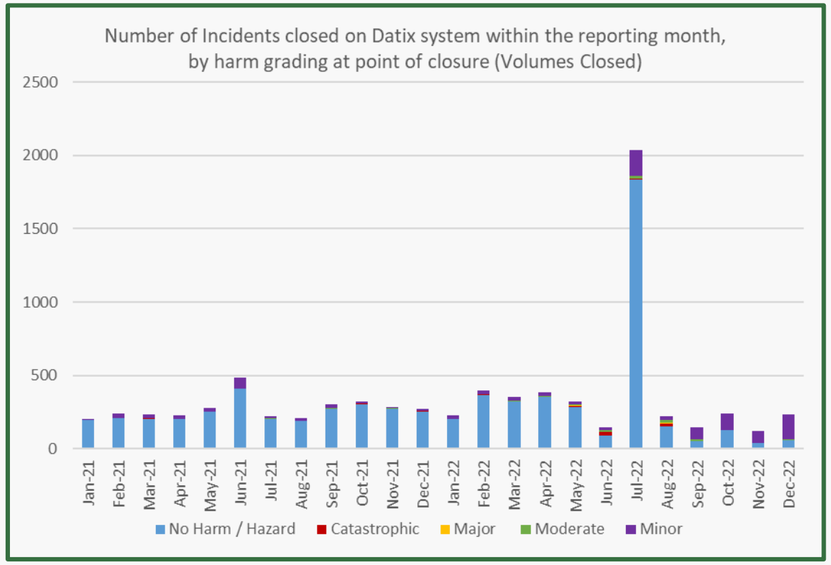
Our Patients: Quality, Safety & Patient Experience
Patient & People Safety Indicators

Self Assessment: Strength of Internal Control: Moderate

PCC

Health & Care Standard
Health – Safe Care





Slide under Development: Future iterations of the report will include: 12 Month Rolling Percentage RIDDOR Reported Within HSE Timescale

Analysis

The number of patient safety adverse incidents volumes submitted on Datix Cymru via frontline crews, health boards, the Operational Delivery Unit (ODU) and CCC within December 2022 increased to 586 when compared to 448 in November 2022. The 586 reports relate to incidents where the outcome for our patients was:

- No harm or hazard – 209
- Minor harm – 175
- Moderate harm - 99
- Severe Outcomes - 21
- Catastrophic - 82

Once cases are investigated and any improvement actions / learning is identified by the Patient Safety or Clinical Team, (or for instances where serious harm has occurred referred to the Serious Case Incident Forum (SCIF) for review) they are closed; 232 cases were closed in December 2022. Monthly volumes should be interpreted with caution as incidents can be duplicated on the system (for example; 2 crews submitting the same incident), however the increase in incident volumes is attributed to the current rise in hospital handovers.

Remedial Plans and Actions

The PTR and PS team is undergoing an OCP lead by the Assistant Director of Quality and Nursing. The team is currently mis-aligned with the new Operational Territories and work is ongoing to correct this.

Workload for all members of the team has increased during the current winter pressures with a long tail of PTR concerns.

Engagement with all WAST stakeholders and support to audit teams will enable the PTR team to comply with PTR Regulations consistently.

Expected Performance Trajectory

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

Tier one 30-day targets have showed an improvement this month, where concerns completion accountability sits with the Head of Patient Safety but the completion of such is without his control.

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

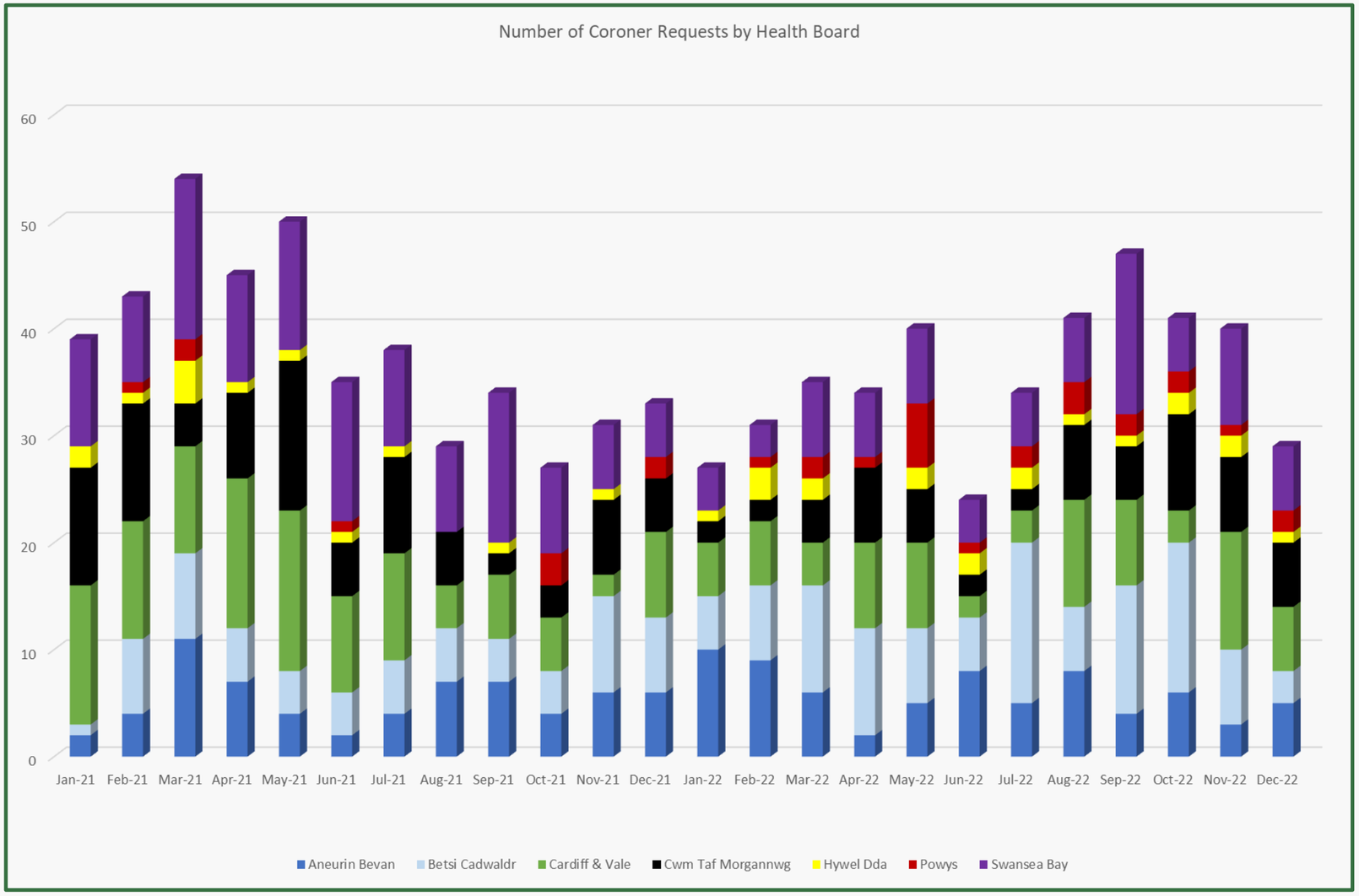
Data source: Datix

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

Self Assessment: Strength of Internal Control: Strong

QUEST

Health & Care Standard
Health – Safe Care



Analysis

Coroners: The number of in month request continues to be higher than pre pandemic. December 2019 the Trust received 13 requests. That being said the increased numbers have continued and are now the norm, rather than the exception.

At the end of December 2022 there are 432 claims open; these relate to Personal Injury (77 Claims); Personal Injury - Road Traffic Accidents (47 Claims), Clinical negligence (120 claims); Road Traffic Accident (180 claims) and Damage to Property (8 claims).

Ombudsman: There are currently 11 open Ombudsman cases in December 2022. At present cases are not being investigated, which supports the Trusts actions.

Mortality Review: The Trust participates in Health Board led mortality reviews as appropriate, with attendance from the patient safety team and clinical colleagues. Work is currently underway to address a backlog of mortality reviews with oversight from the Clinical Quality Governance Group. The Trust provides data and information to the Medical Examiner Service (MES) to inform their reviews. To date the Trust has not received any requests to undertake a Level 2 mortality review of patients in our care. Currently the focus of mortality reviews is acute care, and the plan is for all non coronial deaths to be reviewed by the MES from June 2023.

Remedial Plans and Actions

Coroners: Cases continue to be registered and distributed in a timely manner. If there is likely to be a delay in responding the Trust ensures that the coroner is kept informed of the expected date of response. Inquests are now being arranged into Feb & March 2023. The Team has now recruited to vacancies, and following some training , the numbers on hand have started to reduce.

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

Mortality Review: The Trust is in the process of developing the internal mechanisms in order to facilitate mortality reviews under the new approach. Meeting dates for the All-Wales Mortality Working Group have been shared recently by the NHS Wales Delivery Unit, at which WAST are represented.

Expected Performance Trajectory

Coroners: The number of cases on hand remains high due to some delays in obtaining statements, which require an MPDS audit.

Ombudsmen: A report in relation to lessons learned is prepared and taken to the Patient Safety and Experience Learning and monitoring Group.

Mortality Review: Whilst the multiple benefits of the ME process are recognised there will undoubtedly be significant resource implications for the Trust, particularly as the process expands to every non-coronial death in NHS Wales and the Health Boards (who are at different levels of maturity regarding mortality reviews) start to develop and embed their processes. It is recognised that some cases will have already been reviewed via PTR processes internally.

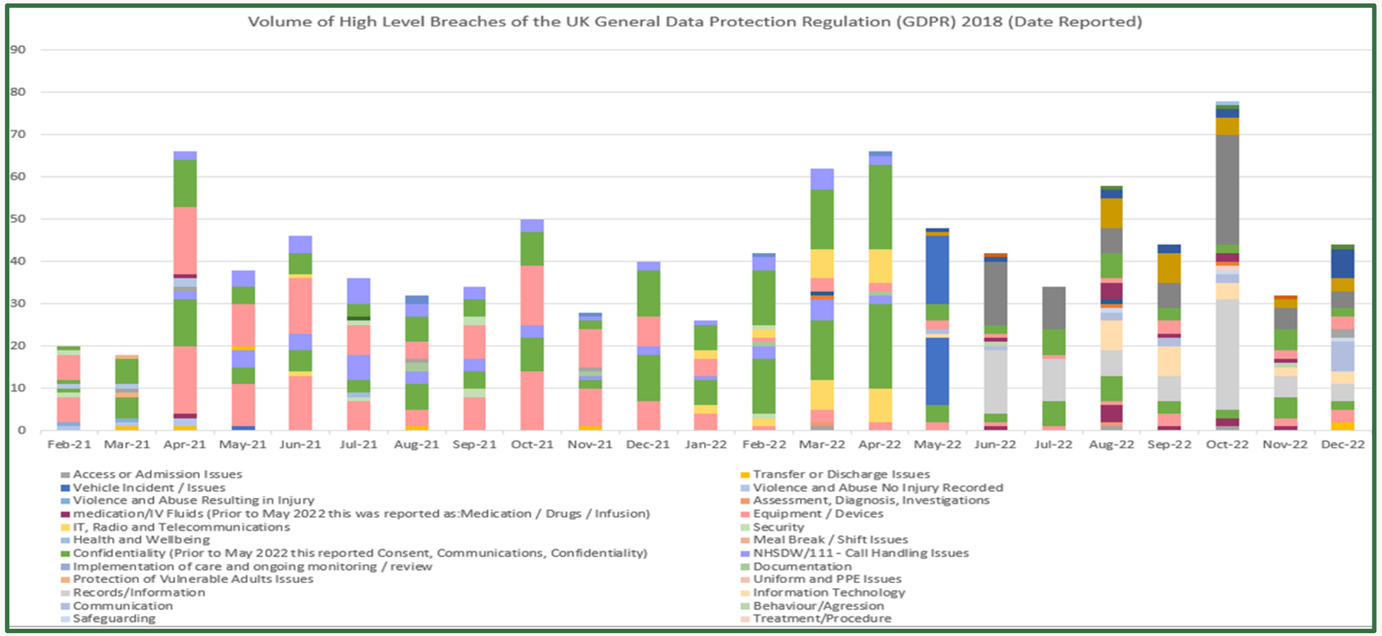
Mortality Reviews Data source: Internal Web Application *Data source: Datix*

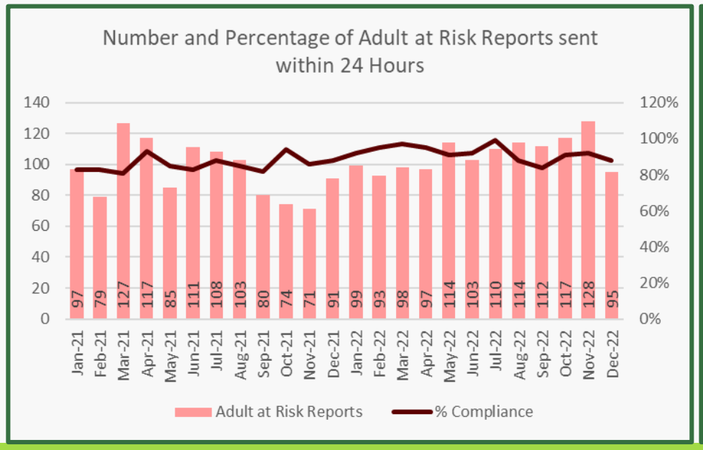
Our Patients: Quality, Safety & Patient Experience
Safeguarding, Data Governance & Public Engagement Indicators

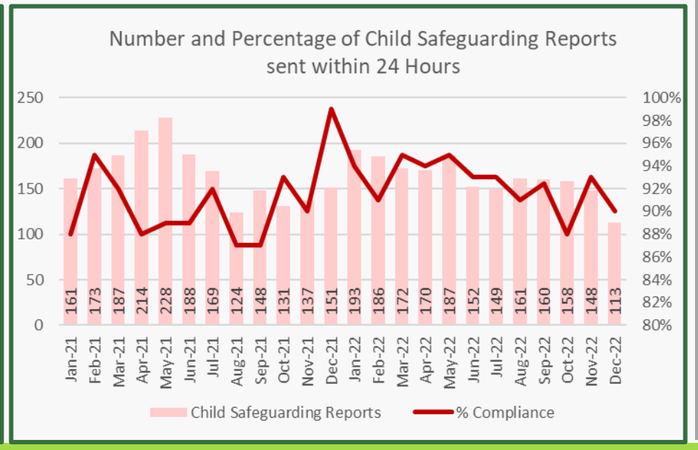
Health & Care Standard
Health – Safe Care

Self Assessment: Strength of Internal Control: Strong

QUEST







Analysis

Safeguarding: In December 2022 staff completed a total of 95 Adult at Risk Reports, 88% of these were processed within 24 hours. Whilst the Trust does not report on Adult Social Need reports, 379 referrals were received and processed to the local authority during this reporting period. There have been 113 Child Safeguarding Reports in December 2022, 90% of these were sent within 24 hours.

Data Governance: In December 2022 there were 22 information governance (IG) related incidents reported on Datix Cymru categorised as an Information Governance (IG) breach, an increase when compared to the previous month. Of these 22 breaches, 7 related to communication, 3 Information technology, 4 records/information, 2 Confidentiality, 3 equipment / Devices, 2 transfer / discharge issues, and 1 safeguarding.

Public Engagement: During December, the PECI Team attended 25 engagement opportunities, engaging with 173 people. At engagement evets throughout December, we placed an emphasis on sharing information about pressures being experienced by the Trust and wider NHS and were able to provide information about other services people can access in their communities that can help. Outcomes of our engagement with people and communities across Wales tells us that people are concerned that help will not be available when they need it. People who have called 999 were concerned about long waits for help to arrive. 111 callers have told us that they experienced long waits for their calls to be answered and reported long waits for call backs. NEPTS users told us that overall, they continue to be happy with the transport they receive but experience long delays when making their initial telephone booking.

Remedial Plans and Actions

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

Data Governance: During the reporting period, of the 22-information governance related incidents reported on Datix, 0 incidents were deemed to meet the risk threshold for reporting to the Information Commissioner's Office (ICO). Incidents have been reviewed and investigated where necessary by the IG team and remedial actions taken where appropriate, with some still being reviewed. Guidance on actions to take to avoid data breaches have been issued to relevant teams where incidents have been reported.

Public Engagement: Community involvement and engagement with patients/public will form an integral part of the Trusts ambition to 'invert the triangle' and deliver value-based healthcare evaluated against service users' experiences and health outcomes. 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. The PECI team will continue to engage in an ongoing dialogue with the public on what they think are important developments the Trust could make to improve services they receive. Throughout December the Trust faced severe to extreme pressures and declared a critical incident. The team supported the push in public messaging to promote NHS 111 Wales and its health information website. Key public health concerns were predominately driven by; Respiratory issues; Strep A; Flu and Covid. People have been encouraged to share their concerns which have mainly focused around length of wait for an emergency ambulance; length of wait for calls to be answered by NHS 111 Wales and accessibility of information on the NHS 111 Wales website. The team also engaged with local communities as a response to the demands on the Trust in the provision of information on a range of other services across communities that could help when faced with a health emergency. This included attendance at a large number of Food Banks; engaged, listened and captured people's feedback and experiences through face-to-face meetings; online events and experience surveys and reported back to communities to strengthen relationships and confidence that the Trust is listening and acting to improve services. All feedback received has been shared with relevant Teams and Managers and continues to be used to influence ongoing service improvement.

Expected Performance Trajectory

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

Data Governance: Progress continues to be made with the IG Toolkit improvement actions. The next submission is due to open in January 2023.

Public Engagement: All feedback received has been shared with relevant Teams and Managers and continues to be used to influence ongoing service improvement.

Safeguarding Data source: Doc Works

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

(Responsible Officer: Liam Williams)

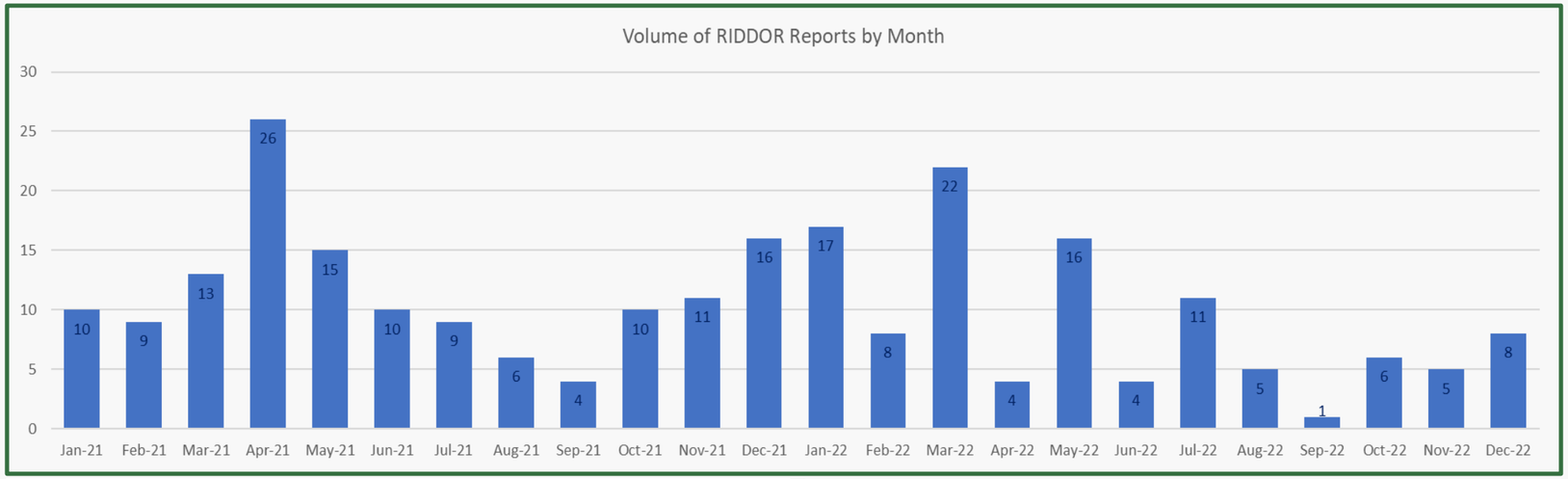
Welsh Ambulance Services NHS Trust

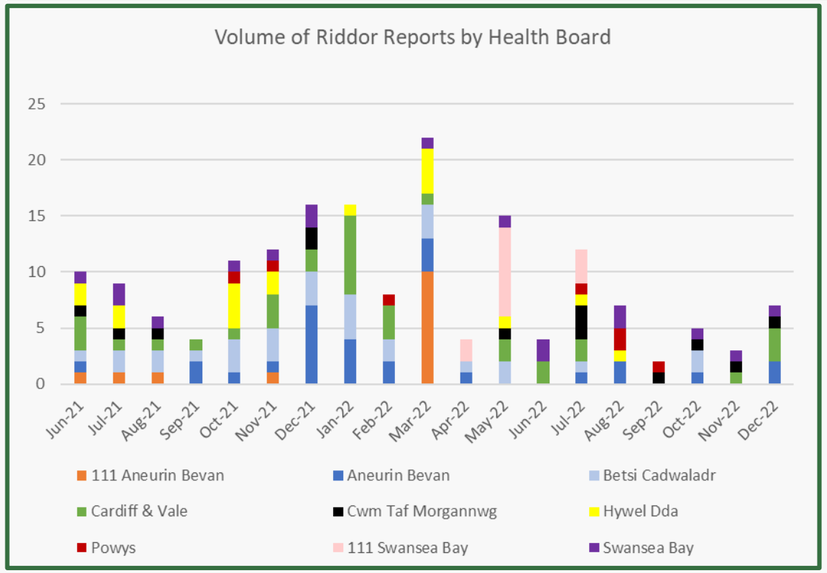
Our Patients: Quality, Safety & Patient Experience
Health & Safety (RIDDORS) Indicators

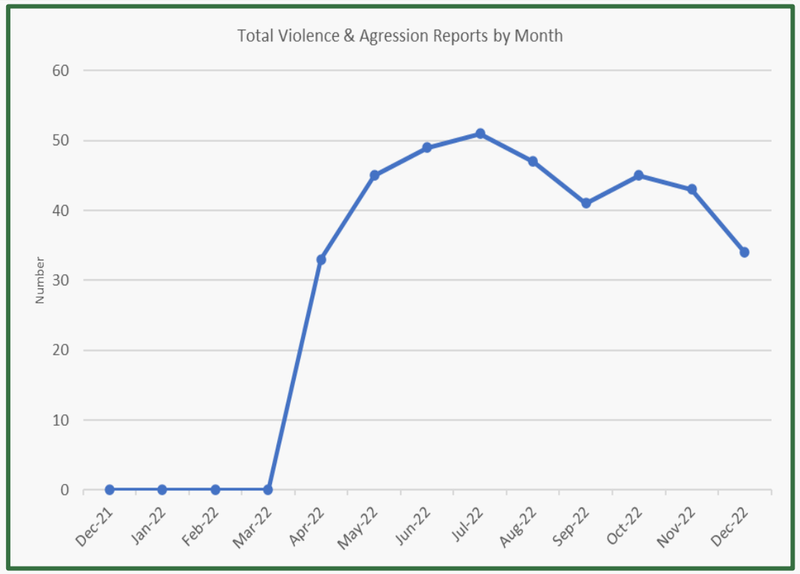
Self Assessment: Strength of Internal Control: Moderate

PCC

Health & Care Standard
Health – Safe Care







Analysis

RIDDOR: whilst there is a strong level of internal control with respect to metrics provided to the Health & Safety Executive (HSE), there are moderate levels of internal control. Challenges around incident reporting times or handlers confirming staff sickness absence to the H&S function continue to impact on the timeliness of Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDORS) to the Health and Safety Executive (HSE).
Risk 199 is currently rated as 15. This was reduced in Q2 as a result of work undertaken via the Working Safely Programme and funding secured for the Workforce review which commenced on 3rd October 2022. This risk is reviewed monthly.
15 RIDDORS were reported in December all reported inline with HSE requirements. Over 7-day injuries continue to be the highest reported for RIDDOR reportable category. Slips, trips and falls injuries are the highest reported RIDDOR trend in December. 24 RIDDOR reports were submitted for Manual Handling injuries in 2022/23 with 18 for moving patients and 6 for inanimate loads.

Violence and Aggression: 112 incidents for aggressive non-physical behaviour were reported in Q3. 10 incidents for physical behaviour were reported during Q3. 2 incidents reported as physical acts of V&A categorised as severe harm at the time of collation of data. This have since been reclassified as moderate and low harm following investigation closure.

Remedial Plans and Actions

RIDDOR: DATIX incident review meetings continue to be held on a weekly basis to review non-patient safety incidents to check for potential RIDDORS and associated coding and allows for further scrutiny. Non patient health and safety incidents are reviewed daily by the Health and safety Advisors. RIDDOR performance is presented in monthly reports and service units business meetings. A RIDDOR awareness poster has been developed and communicated across the Trust to improve RIDDOR compliance rates.
Violence and Aggression: The V&A Manager was appointed into the function in Q3 2022. The postholder will undertake a strategic lens in relation to V&A processes within the Trust with an evaluation report to be presented during Q4 2022.
Collaborative working is ongoing with Training team in the review of V&A training.
Reestablishment of working relationships with all four Welsh police forces have been undertaken.

Expected Performance Trajectory

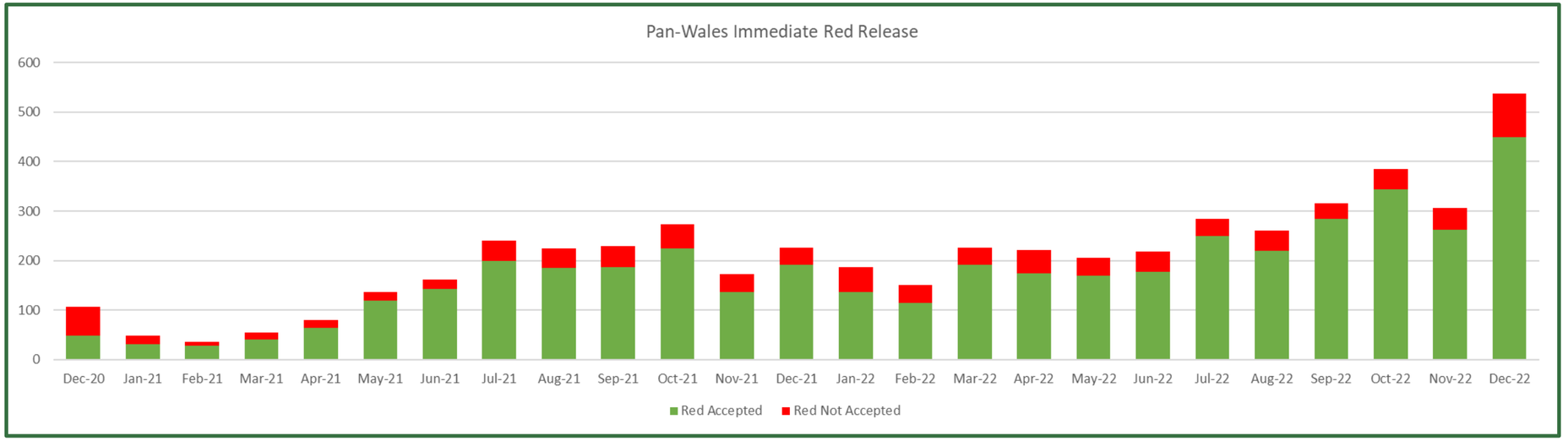
RIDDOR: Work is underway in the development of utilising Power BI to allow for intelligence to be relevant when required removing the challenges with data inconsistencies due to fluctuation as investigations are closed out and associated coding's changed. RIDDOR compliance is to be presented at EMS business meetings for visibility and allow for further scrutiny at local levels . This should further improve performance data to a consistent 80-90% compliance.
Violence and Aggression: Work is underway in the development of further DATIX dashboards to allow for further scrutiny into V&A incidents to influence strategic interventions where required.
***NB: December 2022 data is correct on the date and time it was extracted; therefore, these figures are subject to change**

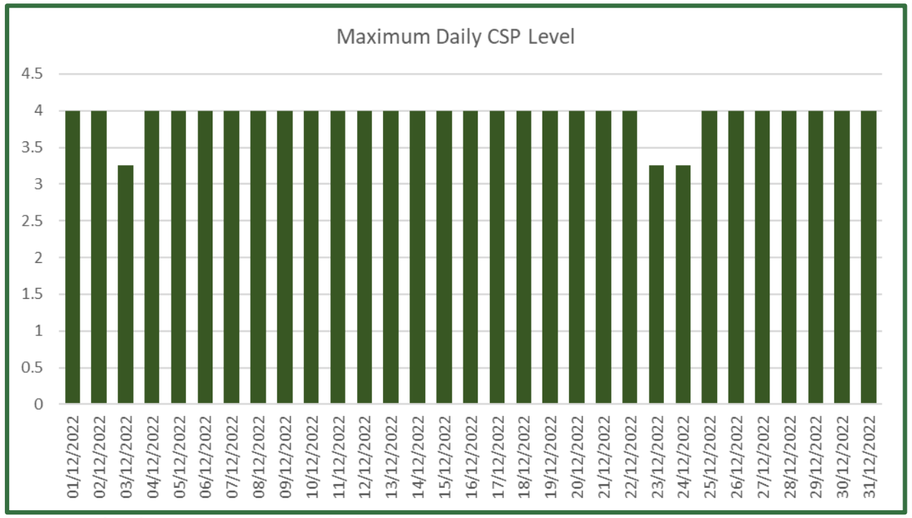
Data source: Datix

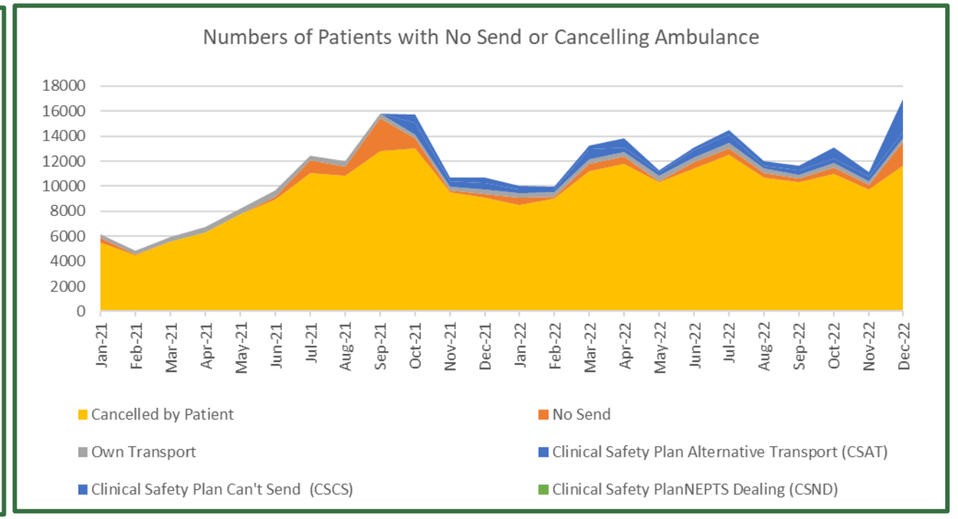
Our Patients: Quality, Safety & Patient Experience
Escalation and Patient Experience

TBD

FPC







Analysis

There were 1,234 request made to Health Board EDs for immediate release of Red or Amber 1 calls in December. Of these 449 were accepted and released in the Red category, 88 were not accepted. In conjunction to this, 156 ambulances were released to respond to Amber 1 calls, but 541 were not.

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

In December 2022, 444 ambulances were stopped due to CSP alternative transport and 2,652 were stopped as a result of CSP Can't send options. In addition, 11,614 ambulances were cancelled by patients (including patients refusing treatment at scene) and 309 patients made their way to hospital using their own transport.

Remedial Plans and Actions

Red immediate release is monitored weekly by the Chief Executive and reported through to Health Board CEOs with the expectation that there are no declines for Red Release from any of the 7 Health Boards. All health boards have agreed to this measure.

Expected Performance Trajectory

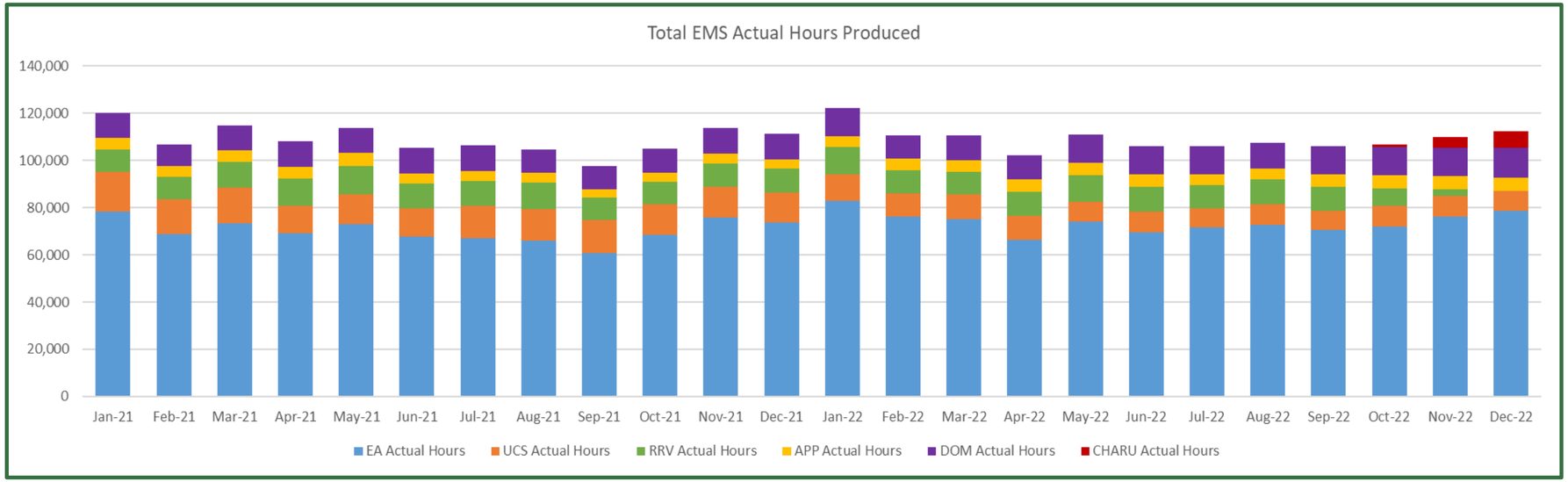
The Trust continues to monitor CSP levels both daily through the ODU and weekly through the Weekly Operations Performance Meeting and mitigations are actioned to reduce the impact on the Trusts ability to respond to demand. Winter pressures will impact the Trust and seasonal planning is being used to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

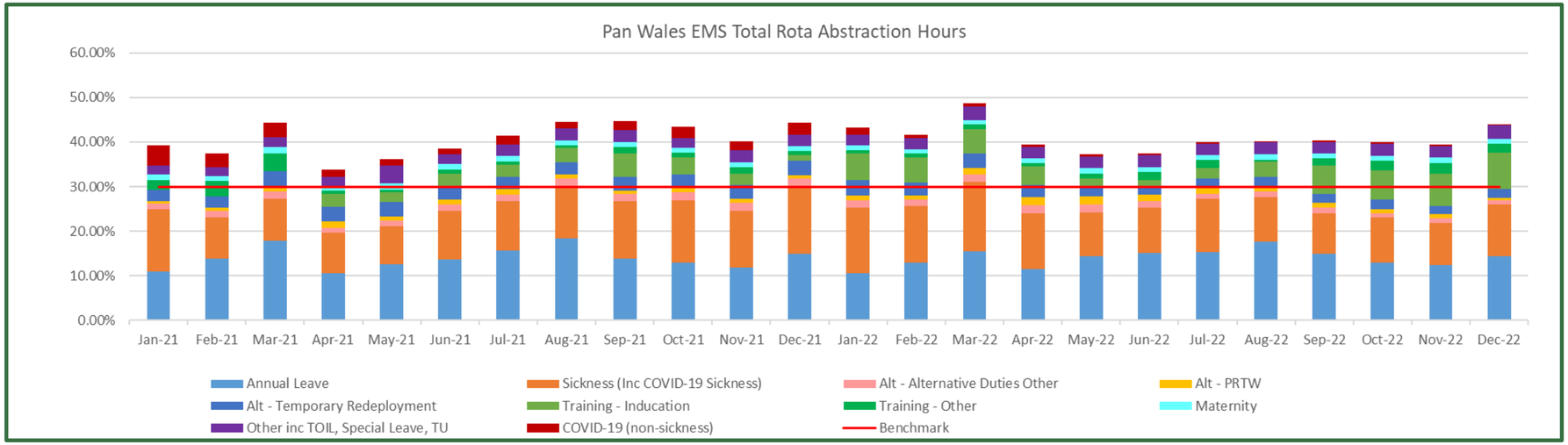
NB: CSP updated as per V2 CSP EMS (08/12/22)

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

Our People
Capacity - Ambulance Abstractions and Production Indicators

EA Production: A | Abstractions: R | CI | PCC | FPC





Analysis

As shown in the bottom graph, monthly abstractions from the rosters are key to managing the number of hours the Trust has produced. In December 2022, total abstractions stood at 44.00%. This compares to a benchmark set in the Demand & Capacity Review of 30% which the Trust was achieving pre-COVID-19. The highest proportion was Annual Leave at 14.29% and sickness at 11.64%. Sickness abstractions for December 2022 were lower when compared to the previous year (14.98%). COVID-19 (non-sickness) related abstractions decreased in December 2022 when compared to the previous month and when compared to the same period last year accounted for 0.28% of overall abstractions.

Emergency Ambulance Unit Hours Production (UHP) was 91% in December 2022 (78,660 Actual Hours), therefore failing to achieve the 95% benchmark. CHARU UHP achieved 79% (7,070 Actual Hours) compared to 55% in November 2022. The total hours produced is a key metric for patient safety. The Trust produced 112,225 hours in December 2022.

Remedial Plans and Actions

The EMS Demand & Capacity Review benchmark for GRS sickness absence abstractions is 5.99%. A formal programme of work has commenced to review and take action to reduce sickness absence / alternative duties, which is reported into EMT every two weeks.

The Trust has a budgeted establishment of 1,661 FTEs for 2022-23. The key actions to maximise production will continue to be the EMS Demand & Capacity Review with an additional 100 WTE to be recruited this year. The original target date was by 23 Jan-23. Due to higher than forecast attrition this date has been pre-programmed to the end of Feb-23.The new EMS Response rosters are now live; implementation of rosters, which concludes a two and a half year project.

Expected Performance Trajectory

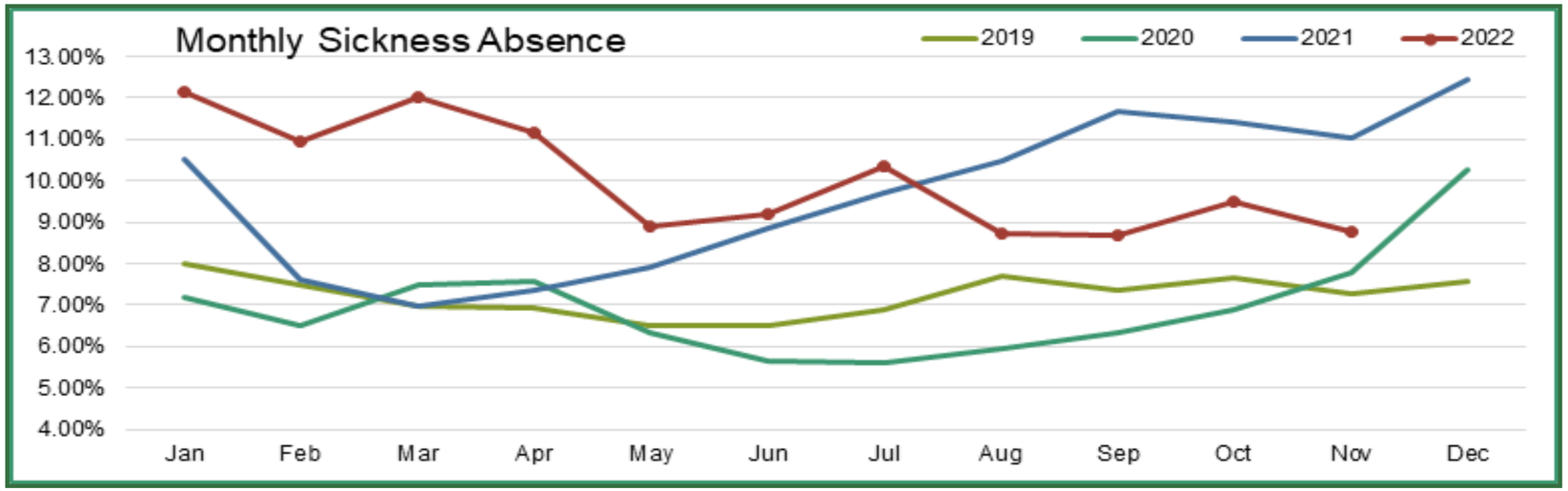
Subject to the longer-term impact of COVID-19 the benchmark is a UHP of 95% across the Trust's three main resource types and an abstraction rate of 30%.

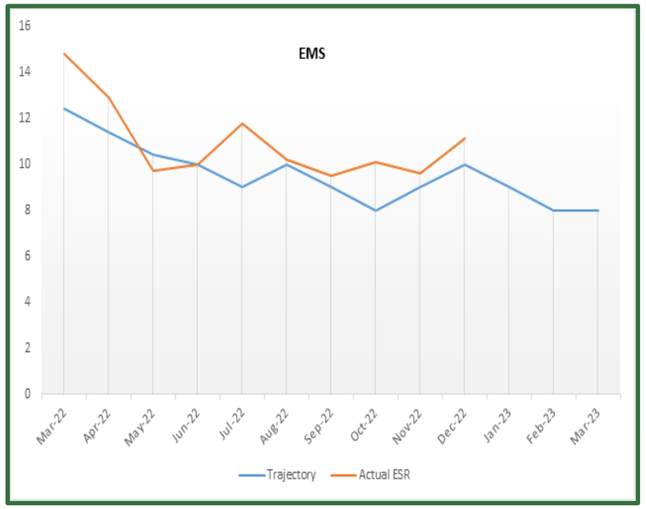
Our People
Health & Wellbeing - Sickness Absence Indicators

A

CI

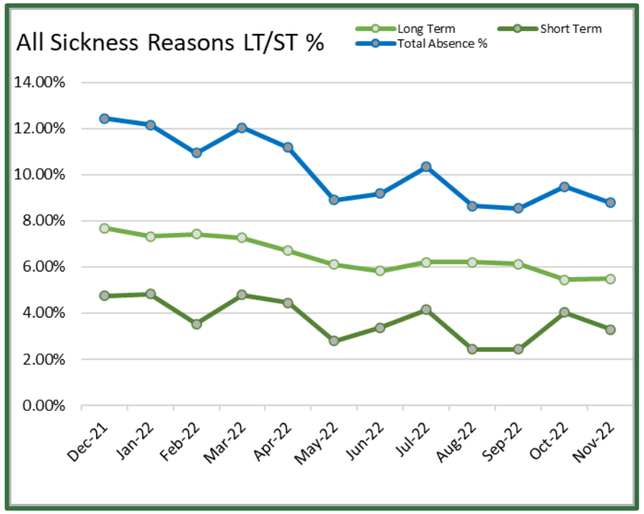
NB: Sickness data will always be reported one month in arrears (except for ESR reported Sickness Trajectory)





Average working days lost per FTE (Annual)	
23.30	days
Single month Absence %	
8.78%	
Long Term	**Short Term**
5.49%	3.29%
Mental Health	**Other MSK**
(S10 Stress/Anxiety)	(excluding Back)
2.44%	1.06%

November 2022



Analysis

- There was a decrease in sickness absence in November, going from 9.48% to 8.77%. There has also been an increase in short-term sickness absence due to COVID and seasonal illnesses
- Indicative figures show an increase in sickness absence for December. Figures indicate an increase in COVID related absence in December as well
- Sickness absence was low at the start of November but has increased throughout.
- Physiotherapy: 37 referrals were received in November 2022. This is 10 more than in November 2021

Remedial Plans and Actions

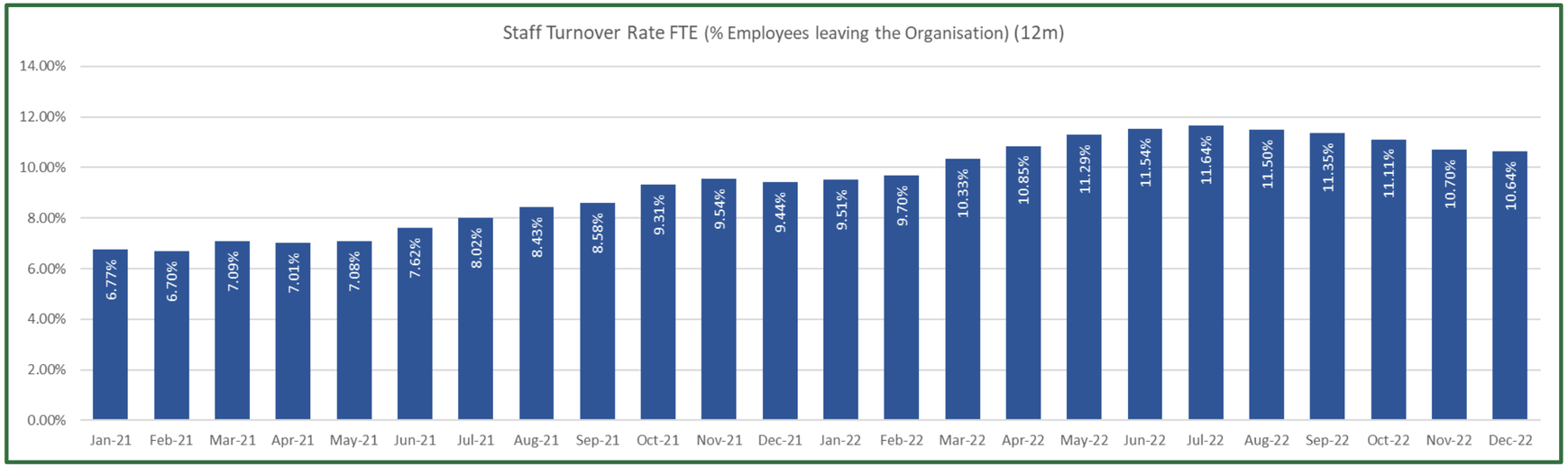
- Targeted support is being directed to current 'hotspot' areas with a recent case review in one health board area which is an outlier. Investigations noted the need for more accurate reporting of reasons for absence and that most absences last 8-14 days. Additional support for effective welfare calls is being delivered and managers in the region attended training on 01 December 2022.
- 16 training sessions have been delivered with 546 managers attending.
- Long term sickness case management continues. Internal audit report received for MAAW – meeting to agree actions scheduled for January 2023.
- Team are analyzing data in different ways e.g. average length of short-term absences and absence by role. When complete this will be shared with the organisation.
- Occupational Health continue to engage with Health Board colleagues to fast track appointments and treatment to reduce length of absences
- Long COVID cases are reducing – five compared to 15 in July 2022, with comprehensive RTW plans are developed

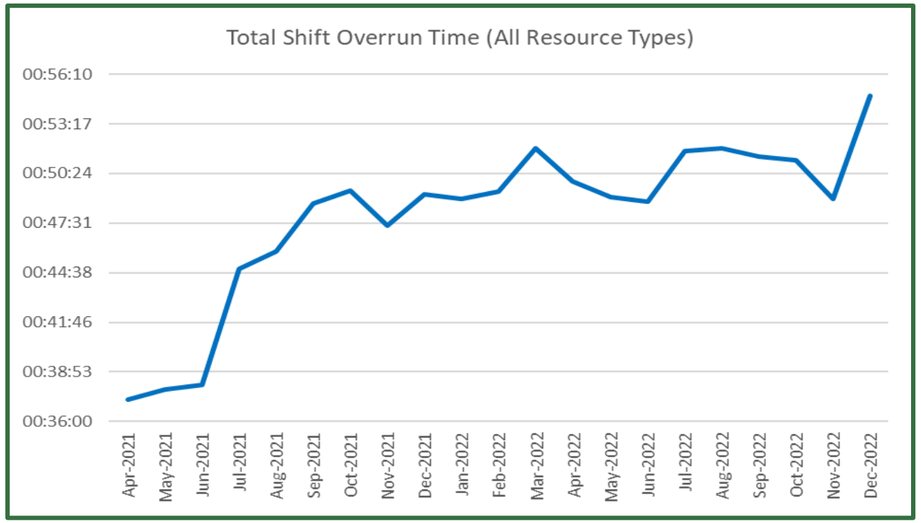
Expected Performance Trajectory

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

Our People
Health and Wellbeing - Turnover

R





FTE by Month				
Org L4		2022 / 10	2022 / 11	2022 / 12
020 Ambulance Care L4 (NX10)		782.33	842.76	881.91
020 Emergency Medical Services L4 (DX04)		1,801.56	1,811.30	1,802.07
020 Integrated Care L4 (DX03)		431.01	423.65	407.07
020 National Operations & Support L4 (DX02)		156.52	159.32	155.72
020 Resourcing & EMS Coordination L4 (DX05)		346.70	362.99	355.52
Grand Total		**3,518.12**	**3,600.02**	**3,602.30**
Ambulance Response:				**1545.8656**

Analysis
Staff turnover rates in December 2022 were 10.64%. In comparison staff turnover rates were 9.44% in December 2021. As highlighted in the Staff & Wellbeing Deep Dive presented to People and Culture Committee on 06 September 2022 the number of staff leavers has increased over the last 3 years and were lower pre-pandemic; staff leave the Trust for a variety of reasons including promotions, relocations and due to pressures of NHS working.

Shift overruns are a key element of staff wellbeing and work is ongoing to mitigate these in conjunction with handovers, as although not shown here there is a clear correlation.

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

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

A direct survey was undertaken with colleagues across the Trust in November 2020 which identified that colleagues would like to see improvements in:

- Improved training and development opportunities
- Managers who listen more
- More focus on staff wellbeing
- An end to bullying and harassment
- Increased professionalism and positive behaviours

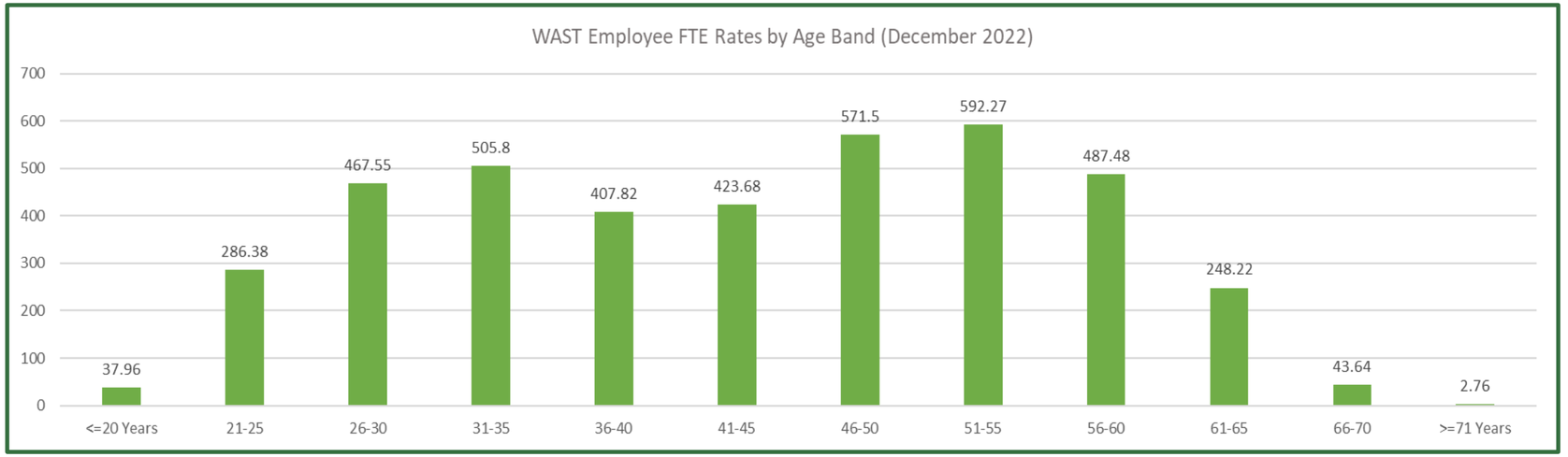
The Swansea University Report into Staff Wellbeing undertaken at the end of 2021 – beginning of 2022 has been received and its recommendations are being considered which may drive forward further actions regarding Wellbeing of staff. Information is also submitted to the Board regarding Occupational Health & Wellbeing plans and actions which compliment this work

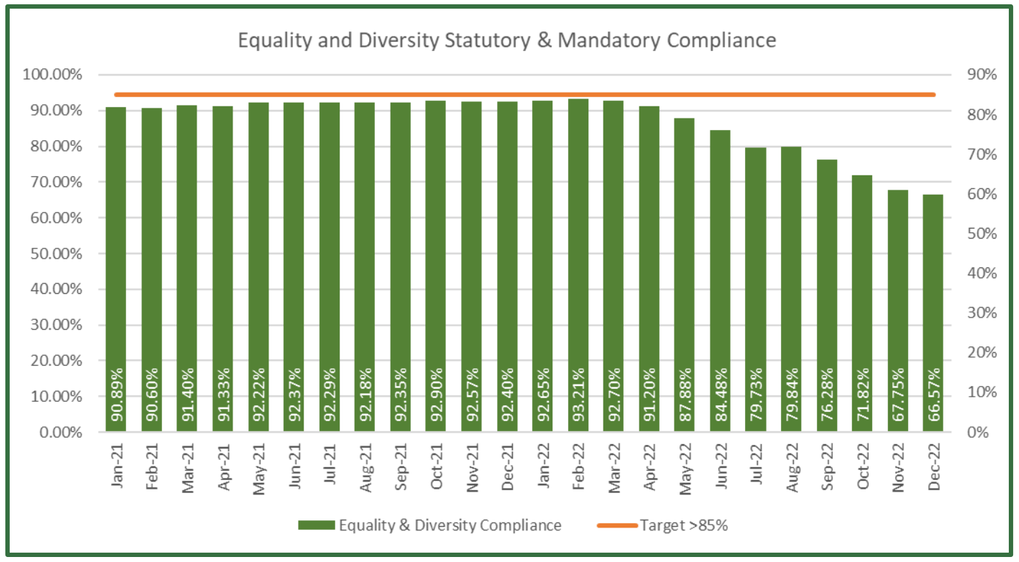
Expected Performance Trajectory
The situation regarding wellbeing of staff remains challenging, many of the difficulties and frustrations are difficult to influence and change. Management development will continue with a focus on people skills and support with robust wellbeing offers so colleagues know where to get support, financial advice and the Trust will work at a local level recruiting champions. The People and Culture Strategy will continue with its wellbeing focus.

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

Our People
Inclusion and Engagement

CI





	Female	Male
Band 2	1.35	1.54
Band 3	16.99	14.40
Band 4	8.42	10.64
Band 5	4.88	4.12
Band 6	11.97	13.17
Band 7	2.91	5.11
Band 8 - Range A	0.91	1.27
Band 8 - Range B	0.51	0.42
Band 8 - Range C	0.17	0.51
Band 8 - Range D	0.13	0.11
Other	0.23	0.25

Analysis

In December 2022 of the 4,737 employees at the Trust, 0.89% fall in the under 20 category and 0.36% in the over 71 age category. 85.90% of staff employed at the Trust define themselves within the White ethnic grouping; with 70.91% of staff identifying in the White, British category, 0.11% identify within black ethnic groups, 0.34% within Asian ethnic groups and 0.72% are of mixed heritage. 0.17% of staff fall into other ethnic groups. 4.54% fall in the unspecified category and 8.23% have not stated ethnicity.

As of December 2022, 66.57%, of staff have completed mandatory Equality and Diversity Training a decrease compared to November 2022, therefore failing to meet the 85% target.

Gender pay as a percentage of the workforce indicates that in December 2022 for those employed within bands 2 - 5 employment is more equally distributed, with 31.64% of females and 30.69% of males fulfilling those roles; however, there are higher levels of men employed within the more senior grades. 14.88% of females are employed in Band 6 and 7 roles compared to 18.28% of males and of those employed within Band 8 roles 1.71% are females and 2.30% are males.

100 colleagues have begun Allyship journeys, including Board members, and the programme continues to be well received; work is underway to ensure the programme is updated and bespoke wherever possible to ensure greater engagement.

Remedial Plans and Actions

EMT focused on the fall in E&D compliance. This is currently under review, initially checking there is no issue with the data. Once this is completed mitigations will be developed. The roll out of the Allyship programme has been positive and it is now being reviewed to ensure it is fit for purpose and valuable to staff.

The slide will be developed further with metrics around Welsh language. The accuracy of the various metrics available to the Trust is currently being assured.

Expected Performance Trajectory

Having listened to feedback from communities, stakeholders and colleagues the Trust has developed seven new behaviours to ensure we can always be our best and is more committed than ever to improving the future and embracing new ways of working.

The Trust continues to follow guidance issued for Welsh Language standards (2015) to ensure compliance when advertising vacancies, which are advertised in both the English and Welsh language for any posts where Welsh language skills are essential or desirable.

Our People
Staff Vaccination Indicators

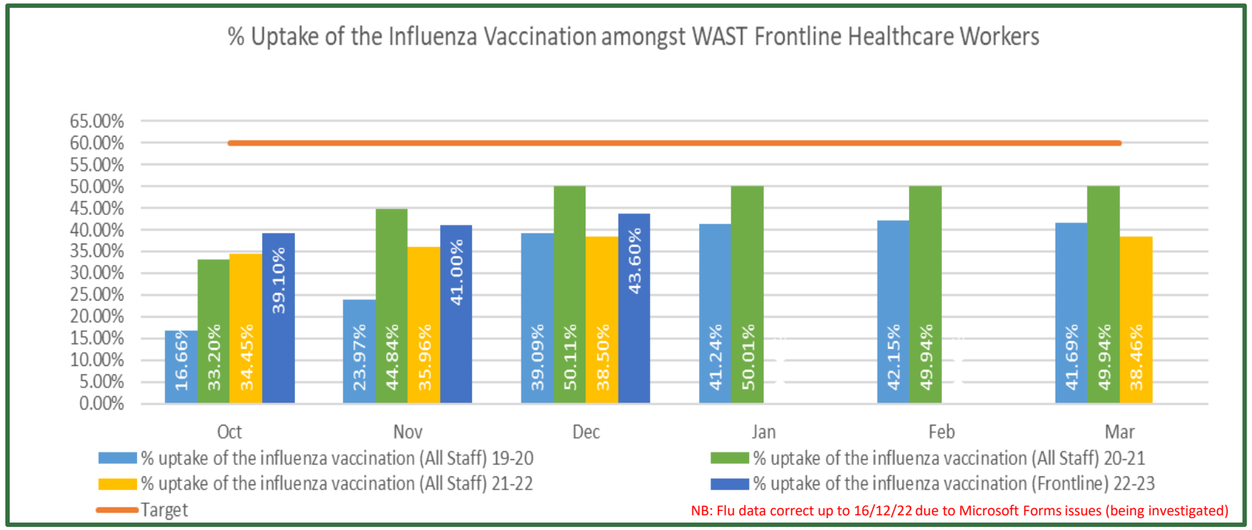
Self Assessment: Strength of Internal Control: Moderate

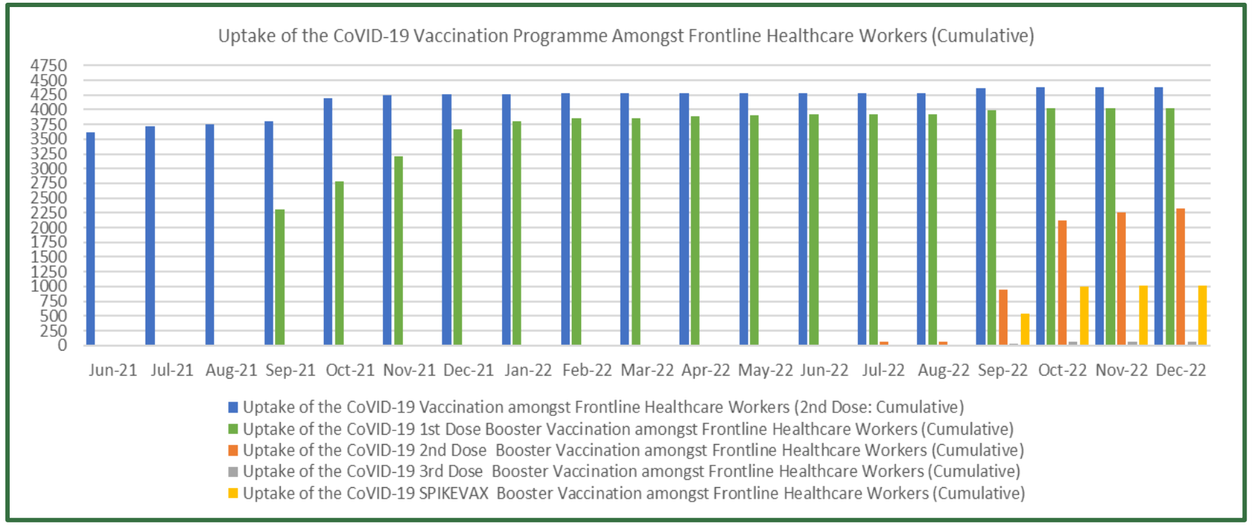
Flu: R

CI

PCC

Health & Care Standard - Health (PPI)





Analysis

1,780 flu vaccines have been administered by Occupational Health Vaccinators and Peer Vaccinators (this includes flu vaccines administered to PHW staff / Students / HCS staff etc.) since the launch of the 2022/23 campaign.

1,852 WAST staff received their flu vaccine in a WAST setting with further 275 WAST staff receiving the vaccine elsewhere (i.e. GP Surgery / COVID-19 Booster Setting). A total of 1,852 WAST staff are now protected against the flu, equating to 43.6% of the overall workforce. Since the launch in September, we have surpassed the overall flu vaccine uptake figure of 38.5% from last year's Flu Campaign.

The total engagement has now reached 49.1% of WAST staff completing the flu consent / opt-out form to state whether they would like to receive the vaccine or not.

As of December 2022 front line (Patient Facing and Non-Patient Facing staff), 94% (4,401) of staff have received a first dose COVID-19 vaccination, 94% (4,374) have received a second dose and 35% (1011 Staff) have received the SPIKEVAX booster vaccination.

Remedial Plans and Actions

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

Expected Performance Trajectory

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

NB: *Due to a technical error in the downloading of data for the Trust are unable to report monthly flu data for January & February 2022.*
NB: COVID Vaccinations are reported using the WAST definition of Frontline Pacing Facing employees and therefore includes those employed within Clinical Contact Centres.
NB: Flu data accurate as of 16th December 2022,
:NB: Spikevax vaccination data correct up to 22/12/22

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

Our People
Health and Wellbeing - PADR and Training Rates Indicators

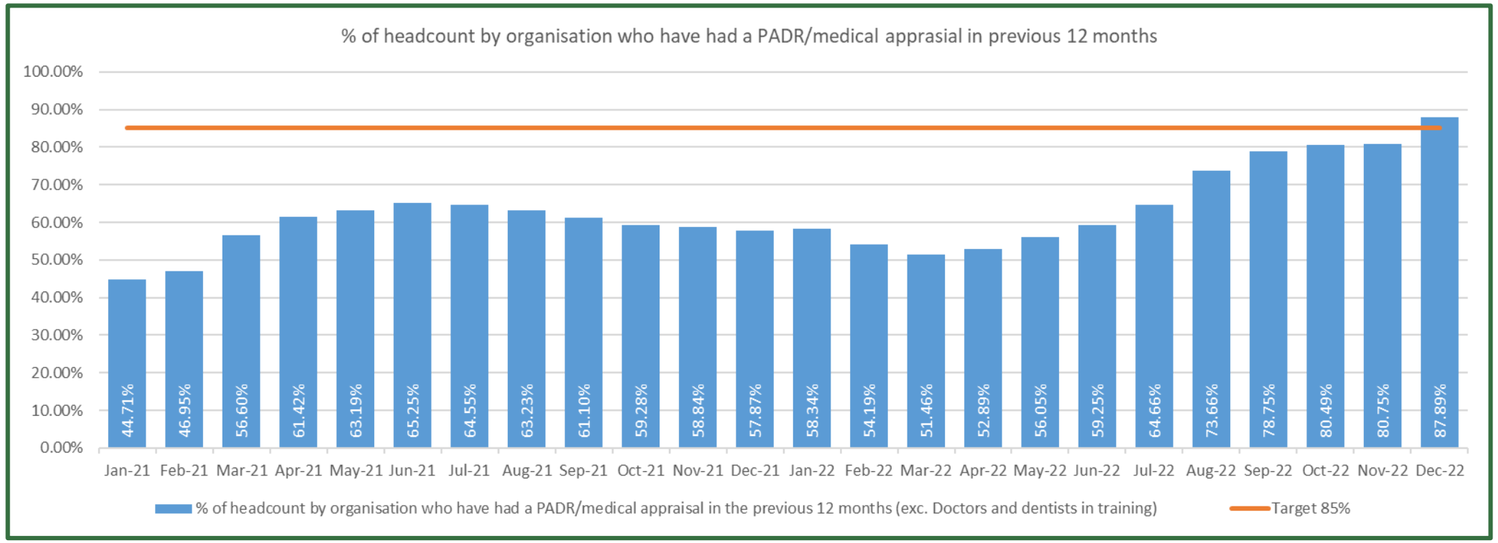
G

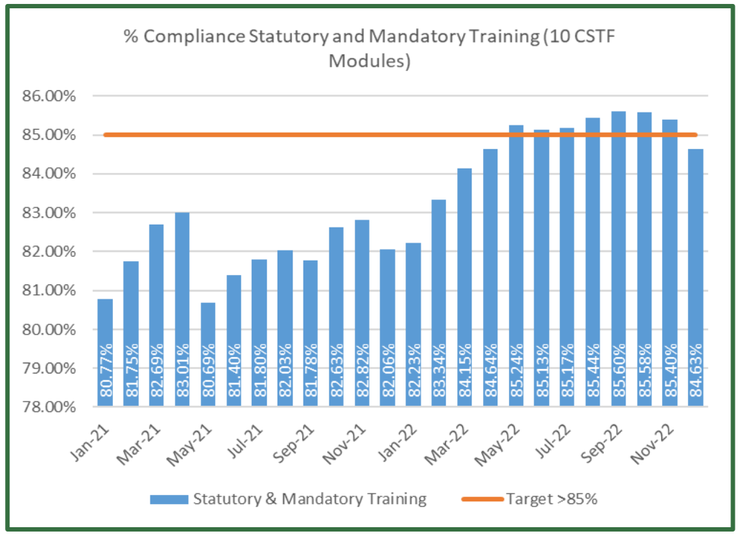
Self Assessment: Strength of Internal Control: Strong

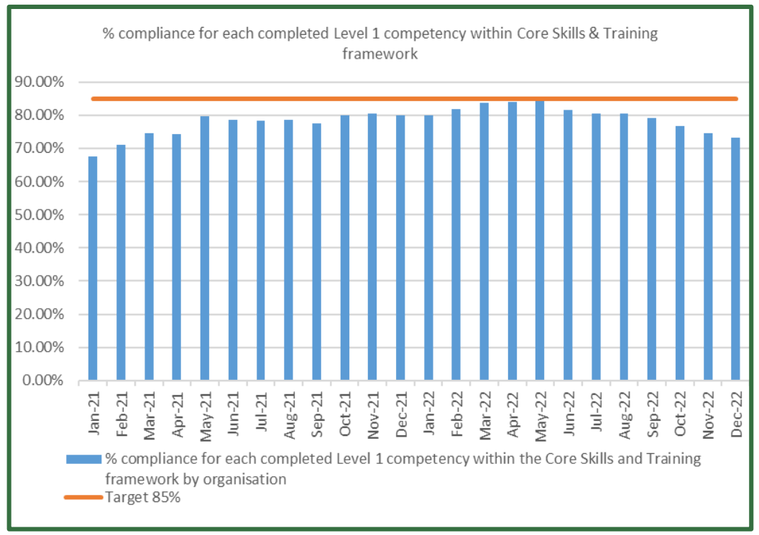
CI

PCC

Health & Care Standard
Health – Staff & Resources







Analysis

PADR rates for December 2022 improved for the eighth consecutive month to 87.89% and are on an upward trajectory, achieving the 85% target for the first time.

December 2022 Statutory & Mandatory Training rates decreased by 0.77 from the November 2022 figure and dropped below the 85% target for the first time since April 2022. Moving & Handling (80.98%), Information Governance (79.18%), Fire Safety (67.98%), and Equality & Diversity (66.57%) failed to achieve the 85% target; however, Dementia Awareness (87.14%) and Safeguarding Adults (88.10%) achieved the target in December 2022.

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

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

Remedial Plans and Actions

In December we had scheduled MIST days but due to the escalation to REAP4, 3 of them were cancelled. Of the 5 that ran, 37 colleagues attended. Unfortunately, several colleagues who had booked on did not turn up, hence the lower-than-expected numbers. As we were not informed in advance, we were unable to offer their places out as we have a set number of places on each session.

As we move into quarter 4 of 2022/ 2023 we have scheduled a significant number of MIST days pan Wales commencing W/S 30th January. These dates have been advertised on Siren, Yammer and the Learning Launchpad (these were released just before Christmas). Colleagues within the education and training team are monitoring the bookings and as we come closer to the date of delivery, those sessions with fewer bookings will be highlighted and we will liaise with relevant ops managers in those areas to encourage uptake.

PADR: Phase 2 of the PADR Refresh process is underway with a toolkit and bitesize session developed in order to support colleagues and managers through the revised PADR process. This bitesize session has been piloted with colleagues and is designed to improve the completion rate of PADRs. Work on Phase 3 of the revised process has begun. The form is now on Siren (the new PADR form) however, the digital form (ESR) is still under development by the ESR team. Due to resource issues this has not yet been completed and we are trying to get a timeframe on this.

Expected Performance Trajectory

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

Data source: ESR

Finance, Resources and Value
Finance Indicators

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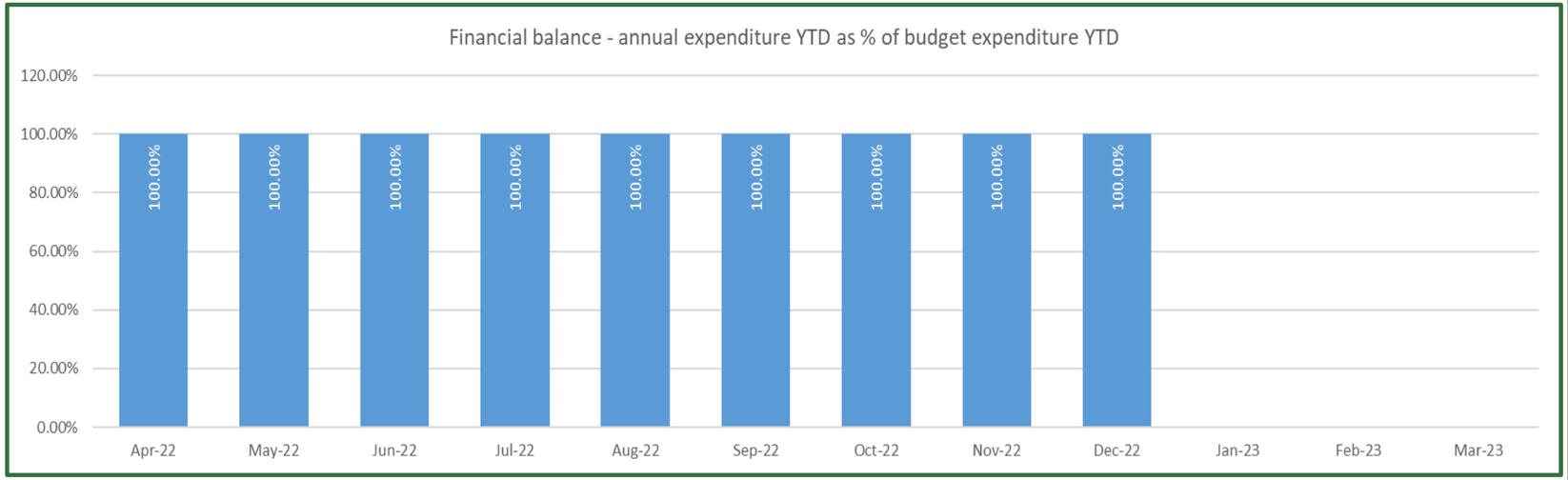
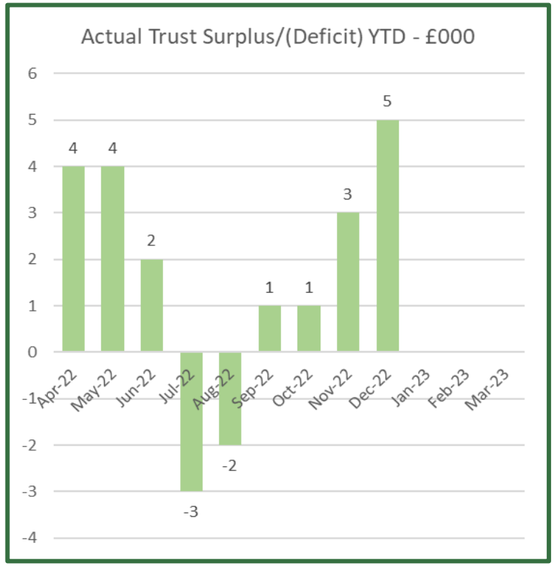
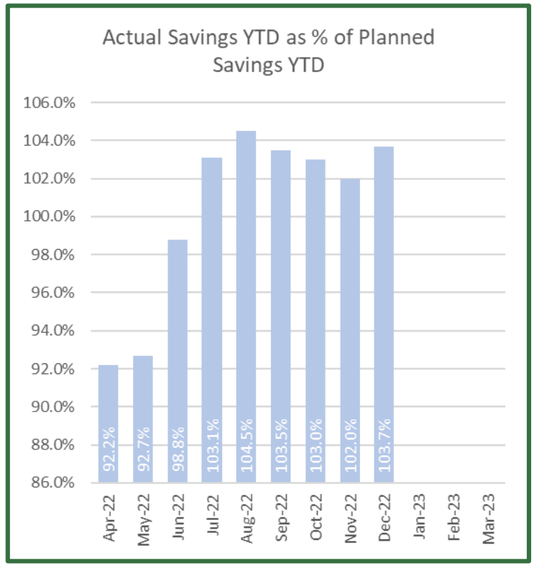
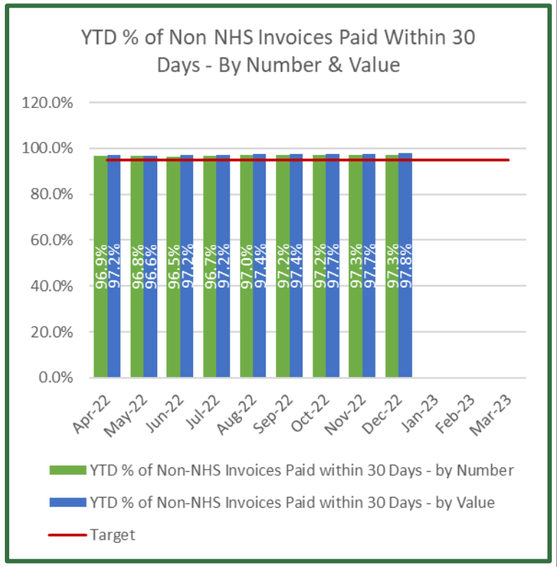
FPC









Analysis

The reported outturn performance at Month 9 is a surplus of £5k, with a forecast to the yearend of breakeven.

For Month 9, the Trust is reporting planned savings of £3.228m and actual savings of £3.346m (an achievement rate of 103.7%).

The Trust's cumulative performance against PSPP as at Month 9 is 97.3% against a target of 95%.

There was an increase seen in agency spend in December 2022 (0.8%) from the November 2022 position (0.5%).

Remedial Plans and Actions

The Trust's financial plan for 2022-25 has been built on the plans and financial performance of the last few financial years, in which the Trust has, year on year, achieved financial balance; the 2022-25 financial plan was submitted to WG following Board sign off on 31st March 2022.

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

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

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

Expected Performance Trajectory

The expectation is that the Trust will continue to meet its statutory financial duties, as outlined in its IMTP for the 2022/23 financial year; however, it is expected that the Trust will continue to operate in a challenging financial environment and will need to deliver further significant level of savings into the 2023/24 financial year.

Finance, Resources and Value
Resource and Value Indicators

Decarbonisation
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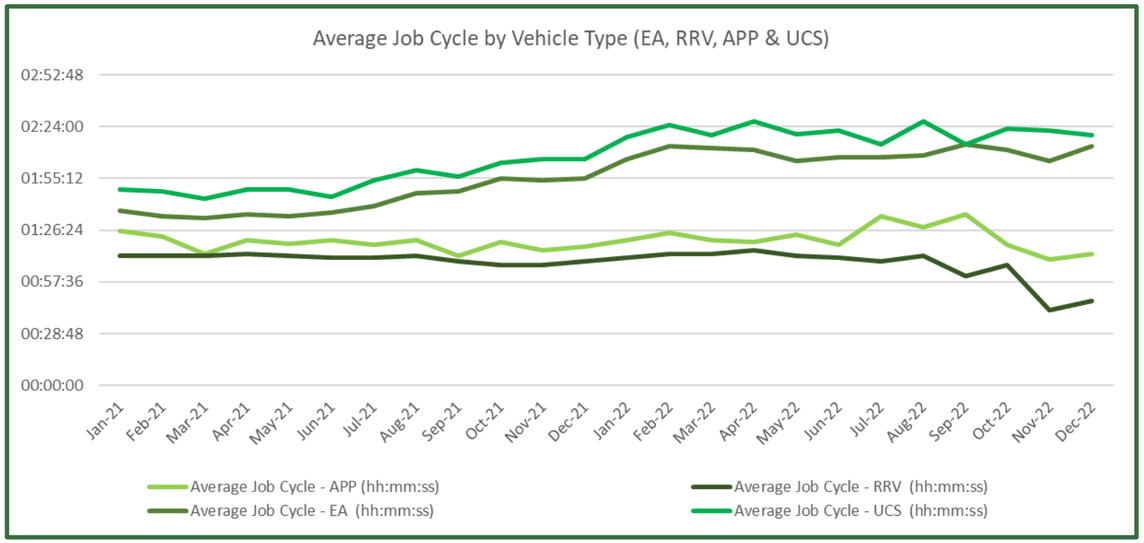
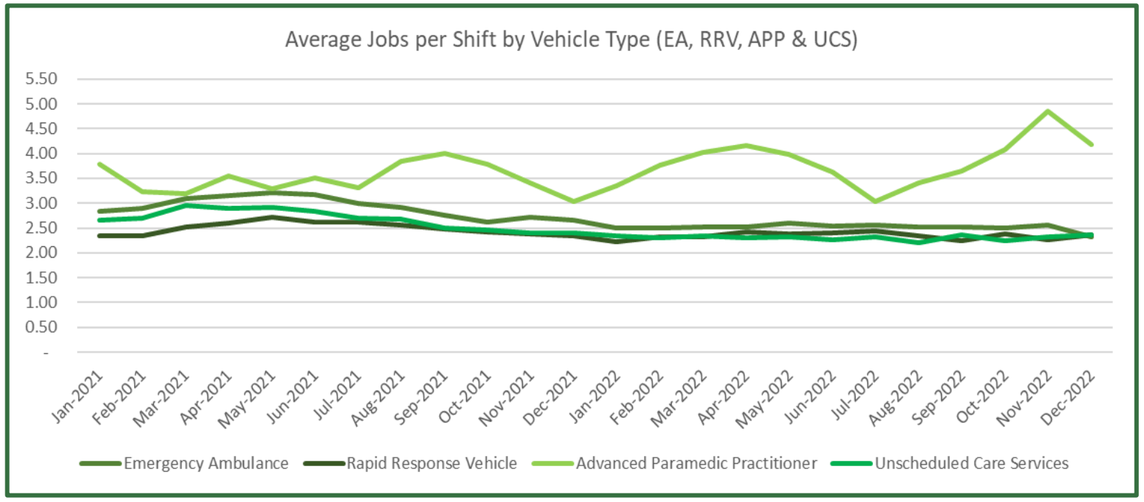
FPC





Value – Job Cycle and Volume
Analysis
As demonstrated in the top graph, the average job cycle decreased in December 2022 for Advanced Paramedic Practitioners (APP), and EA calls but increased for UCS. EA calls averaged 2 hours and 13 minutes in December 2022 , in line with the increasing trajectory.

Average shifts attended by EA and APP crews decreased in December 2022; EAs on average attended 2.33 jobs per shift and APPs attended 4.18 jobs per shift. In contrast the average jobs RRV and UCS crews attended per shift increased when compared to the previous month to 2.37 jobs for both RRV and UCS.

Overall average jobs per shift has remained relatively static for EA, RRV and UCS through 2022 following a period of decline through 2021 and has not recovered to pre-pandemic levels.

Except for December 2022 average jobs per shift for APPs is on an increasing trajectory.

Remedial Plans and Actions
The increase in average job cycle time since 2021 can be attributed to numerous factors including the introduction of ePCR and increasing hospital delays (staff pre-empting and packaging patients in readiness for long waits and patients waiting longer for an ambulance response therefore requiring more treatment/assessment). These times are monitored at Weekly Performance Meeting and local work to establish appropriate efficiency initiatives is ongoing

Expected Performance Trajectory
The increase in job cycle time since 2021 is caused by numerous complex factors. As ePCR embeds, a decrease may be seen, but with the factors outside of WAST's control a reduction to pre pandemic levels may not been seen.
***NB: Average jobs per shift only includes data where the full shift worked is less than 20 hours.*
Total shift hours currently includes the meal break for the shift
Total shift hours also includes Postproduction Lost Hours

NB: CHARU data is not yet available

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

Remedial Plans and Actions
WAST Decarbonisation Action Plan is currently reporting internally as Amber with items of progress with funding from the Welsh Government in the 2022/23 year and 24/25 Estates and Facilities Advisory Board funding. This will allow for investment in Building Management Systems, a design guide for retrofit of estate to continue being developed, however, further funding will be required. The Trust is also scoping WAST estate infrastructure for EV charging and work is ongoing with Welsh Government Energy Services on rapid EV charging. Establishment of programme management arrangements and first Decarbonisation Programme Board meeting to take place at end of January 2023.

Responses to both internal audit report and Audit Wales report

Confirmation of successful bids against 23/24

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

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

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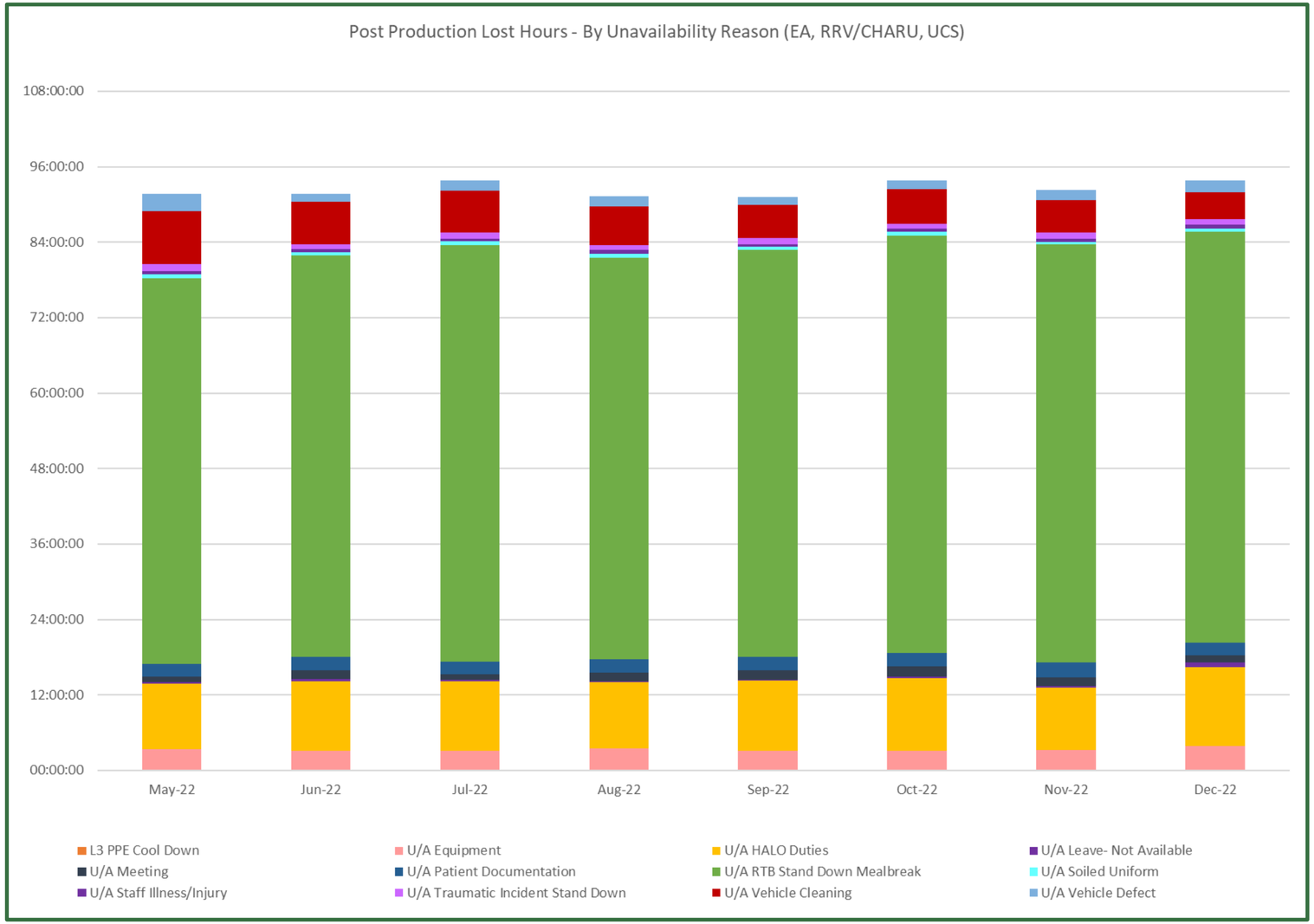

Analysis

There were 9,379 postproduction lost hours (PPLH) across EA, RRV/CHARU & UCS vehicles in December 2022; a slight increase when compared to November 2022 (9,224).

PPLH are due to numerous factors as outlined in the bar chart. There was an identified issue with the data set in relation to the U/A RTB Stand Down Meal break reason whereby the data was not being pulled through correctly and was being under reported. The issue was previously fixed; however, this was only for data being reported after the fix and not retrospectively. A retrospective fix has now taken place from May 2022 inclusive which is when the revised/amended codes were implemented. The bar chart demonstrates that PPLH have remained relatively consistent from May 2022 albeit with some smaller variations mostly attributed to the unavailable RTB Stand Down Meal break reason.

The Operations Directorate is working in partnership with Health Informatics to undertake extensive investigations to ensure reliable reporting which has resulted in more accurate reporting of unavailability through PPLH and 90th percentiles for codes, including soiled uniform, vehicle cleaning, equipment and meetings.

Remedial Plans and Actions

The Trust will not be able to eliminate PPLH, however, efficiency options continue to be worked through, and PPLH are monitored and scrutinised closely, forming part of the weekly performance meeting. Other PPLH reasons remain at a relatively consistent trajectory. Current work is ongoing in relation to the U/A RTB Stand Down Meal break reason and is at the TU engagement stage (currently paused due to strike action).

Expected Performance Trajectory

The current data needs to be treated with a degree of caution. As stated above, the Trust will not be able to eliminate PPLH, and the data prior to May 2022 has not had the retrospective fix. The reasons for the rise in PPLH from 2021, which is also attributed to the U/A Stand Down Meal break reason, is that during the pandemic and with less handover delays at hospitals, resources were returning to base for resting in the meal break window. The resource would not be assigned an unavailable status as it would still be available for certain category of calls (RED) and, therefore, would not have contributed to PPLH

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

Partnerships / System Contribution
NHS111 Hand Off Metrics and NHS111 Consult & Close Indicators

Influencing Factors – Demand and Clinical Hours Produced

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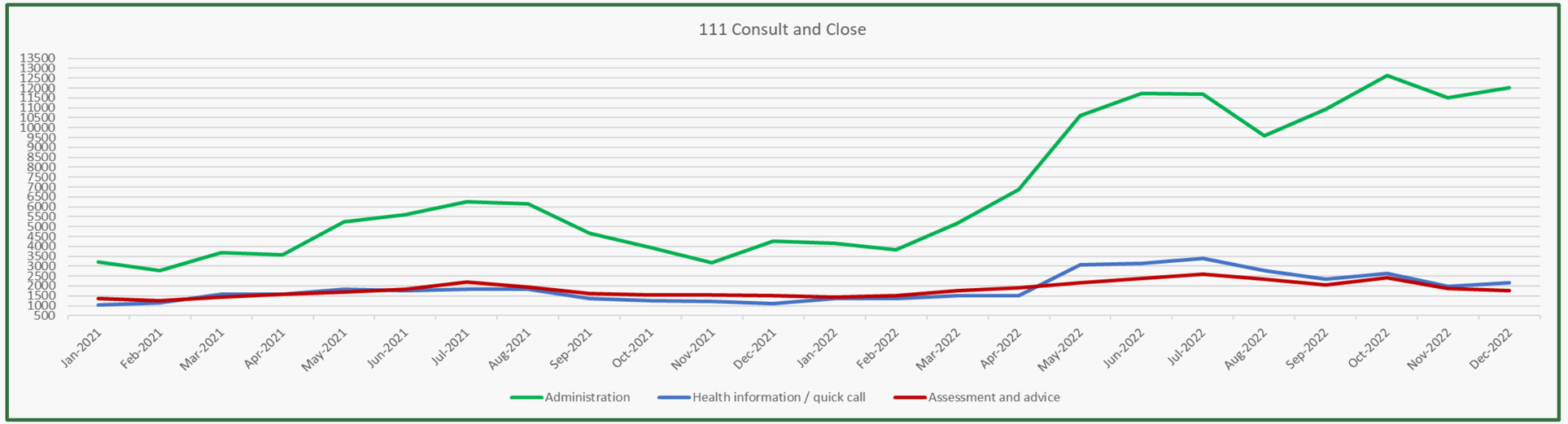

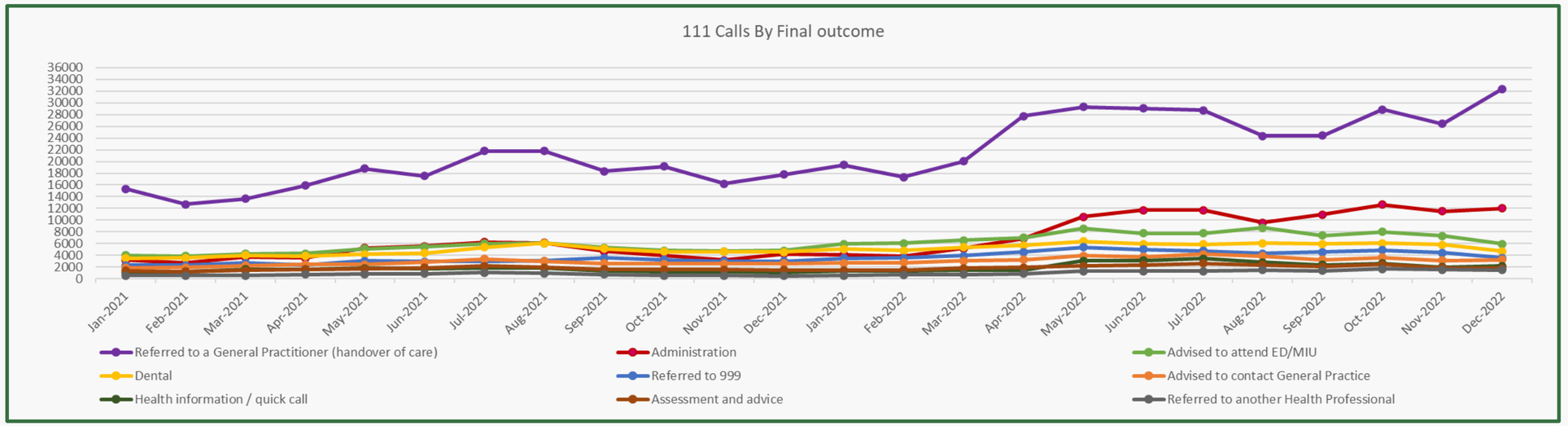

Analysis

The top graph depicts the outcomes for calls handled through NHS111 Consult and Close with administration calls (those calls resulting in no action) accounting for the highest volume (12,028 calls); callers requiring health information accounted for 2,156 calls and callers requiring assessment and advice accounted for 1,771 calls.

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

In December 2022 67,221 calls were received in the 9 categories displayed in the bottom graph, an increase when compared to 63,992 in November 2022; however, a significant increase when compared to 31,938 in December 2020 and 40,077 in December 2021.

Remedial Plans and Actions

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

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

Expected Performance Trajectory

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

Partnerships / System Contribution
Consult & Close Indicators

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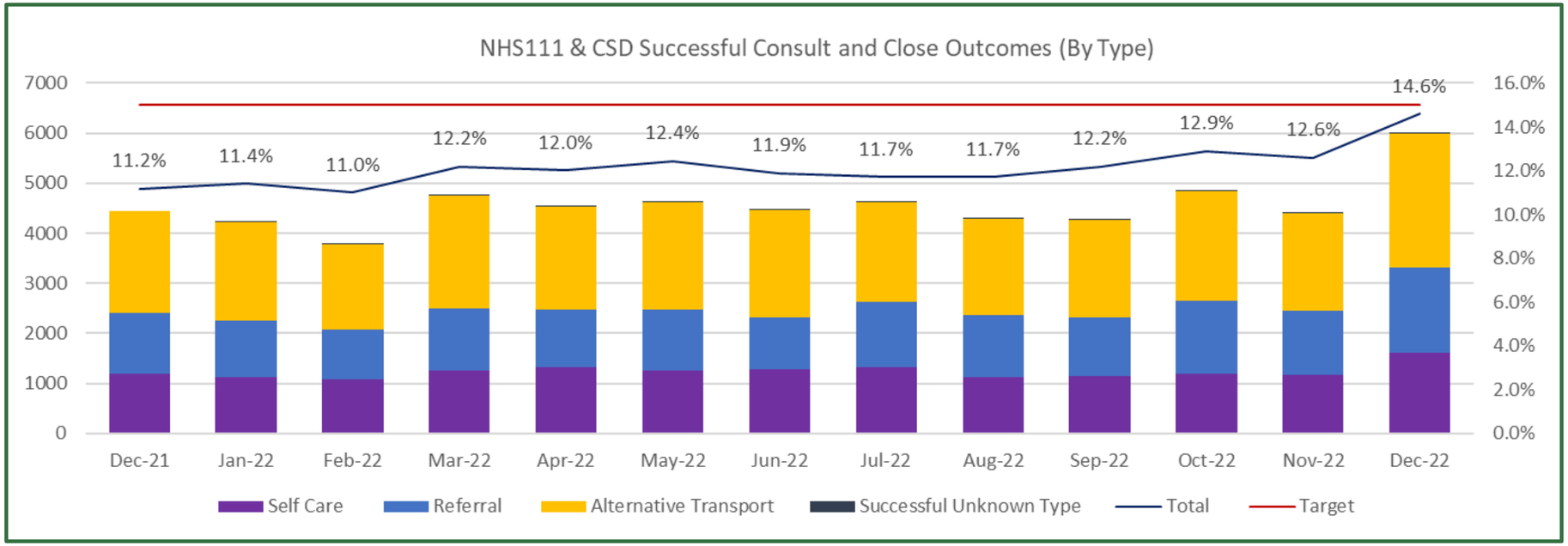

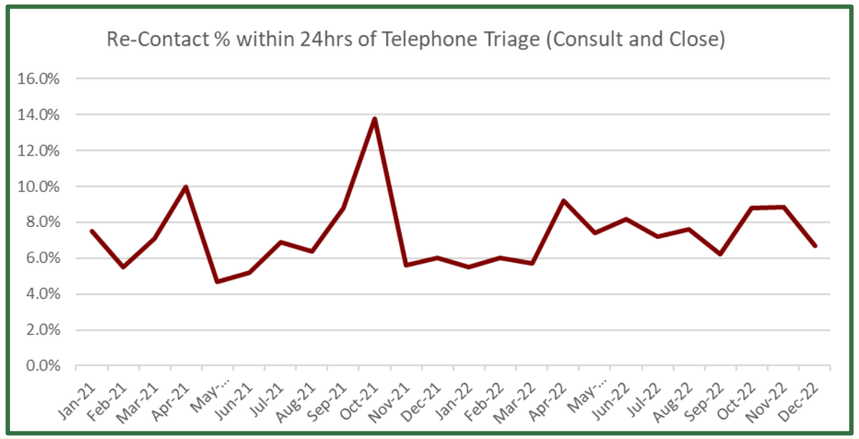

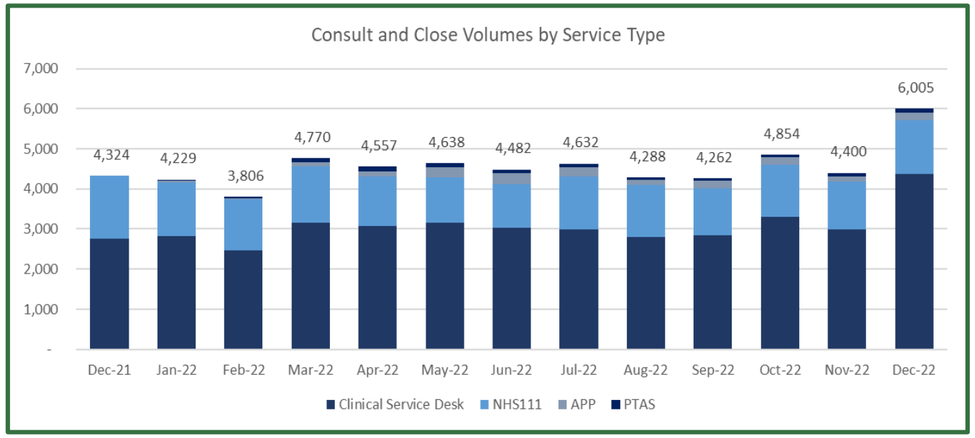

Analysis

The **Clinical Service Desk (CSD) and NHS111 (Consult & Close)** achieved 14.6% performance in December 2022, therefore continuing to achieve the historical 10.2% benchmark and just short of the new 15% benchmark.

10.6% of consult & close volumes were achieved by the CSD (4,371 calls) in December 2022. In comparison, 3.3% of consult & close was by NHS111 (1,338 calls) and 0.7% were triaged by PTAS (113 calls) and APP's (183 calls).

Of the calls successfully closed 1.604 patients received an outcome of self care in December 2022; 1,701 patients were referred to other services (including to Minor Injury Units and SDEC). 2,689 patients were advised to seek alternative transport services to seek treatment and 13 had an outcome of Successfully being closed but the outcome type was unknown.

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

Re-contact rates in December 2022 were 6.7% n decrease compared to 8.9% in November 2022 and compared to 7.6% in December 2021.

Remedial Plans and Actions

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

Expected Performance Trajectory

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

Partnerships / System Contribution
Conveyance to ED Indicators

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Ministerial Measure

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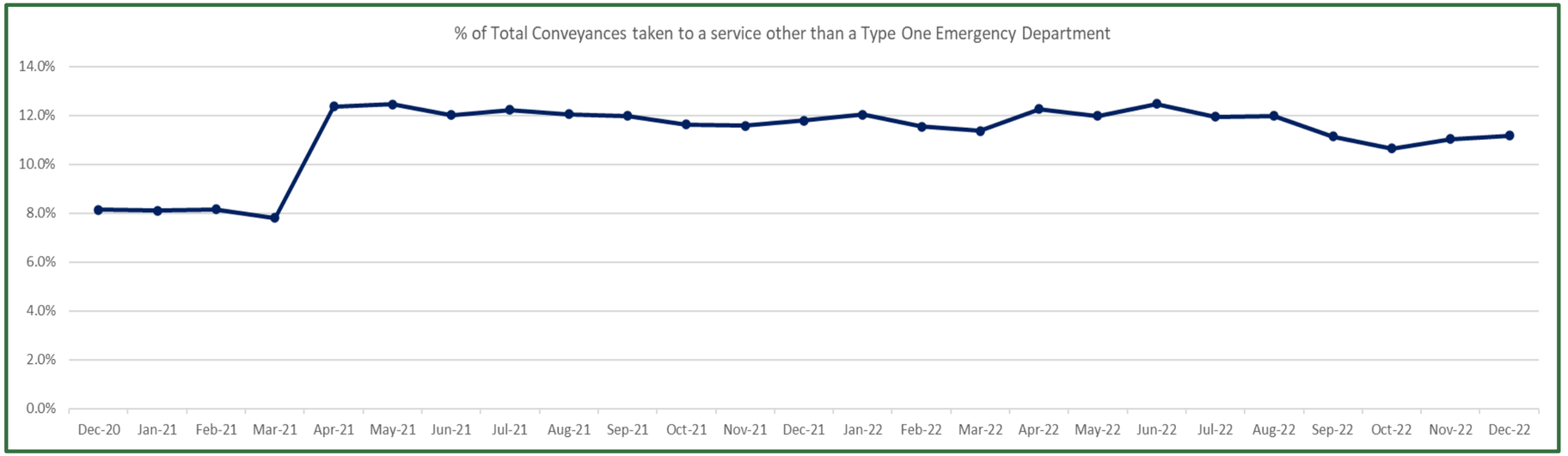

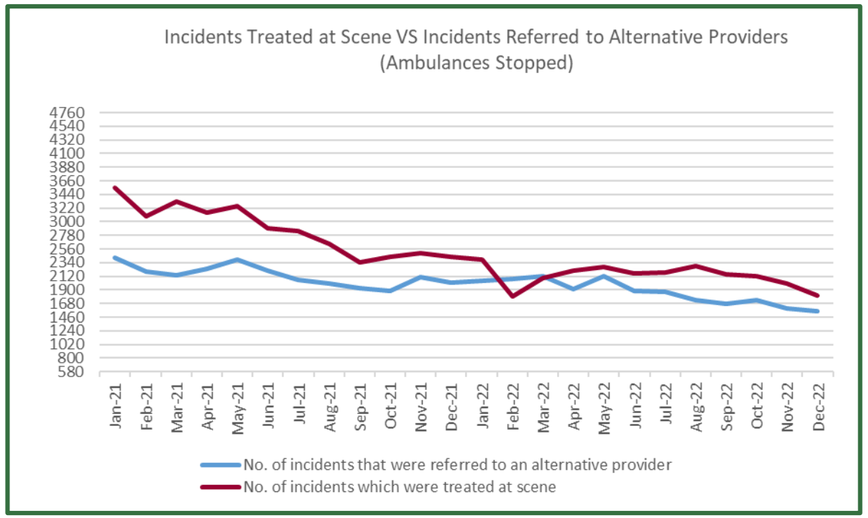

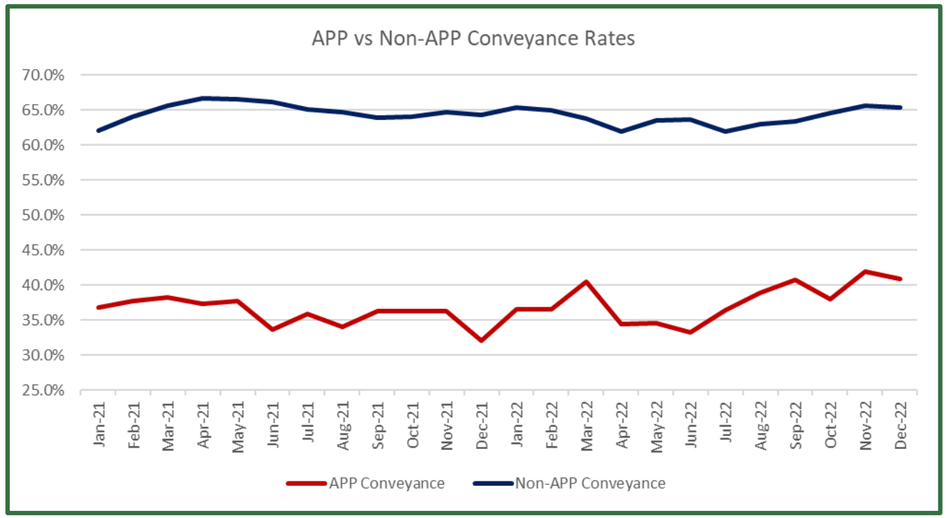

Analysis

In December 2022 11.18% of patients (1,380) were conveyed to a service other than a Type One ED. Although not shown here, the percentage of patients conveyed to EDs decreased compared to the same period last year. In December 2022 conveyance to EDs as a proportion of total verified incidents was 26.68% (compared to 32.92% in December 2021).

The combined number of incidents treated at scene and referred to alternate providers decreased marginally in December 2022. 1,559 incidents were referred to alternative providers in December 2022 and 1,812 incidents were treated at scene; however, a review of other outcomes shows that there are a number of incidents where there was a no send due to escalation of the Clinical Safety Plan (CSP).

Remedial Plans and Actions

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

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

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

Expected Performance Trajectory

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

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

Partnerships / System Contribution
Handover Indicators

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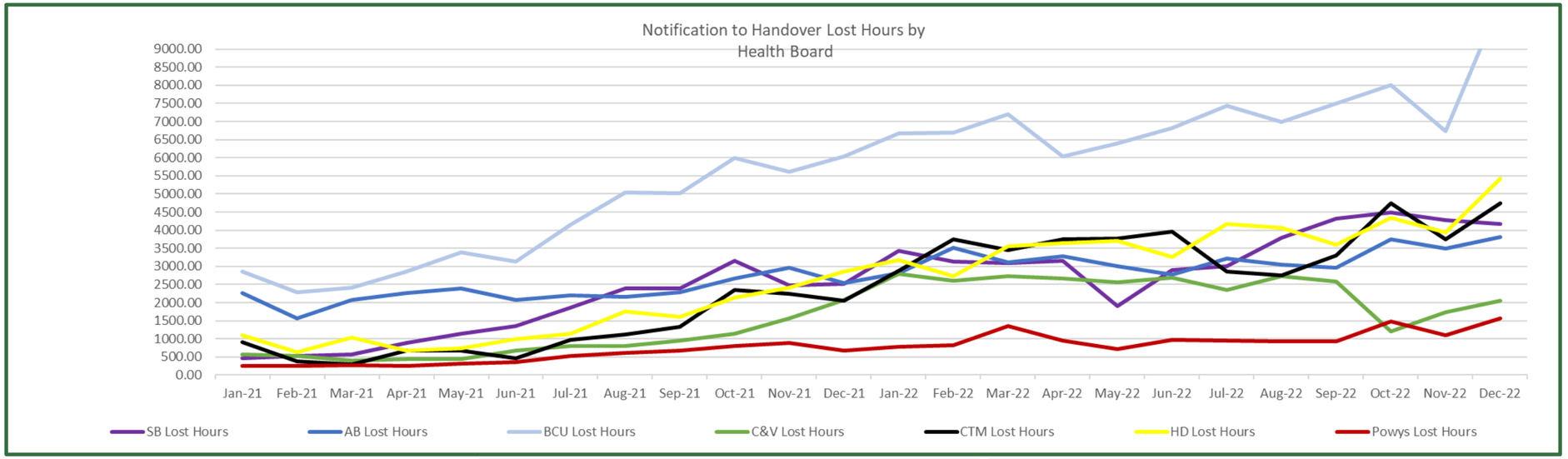
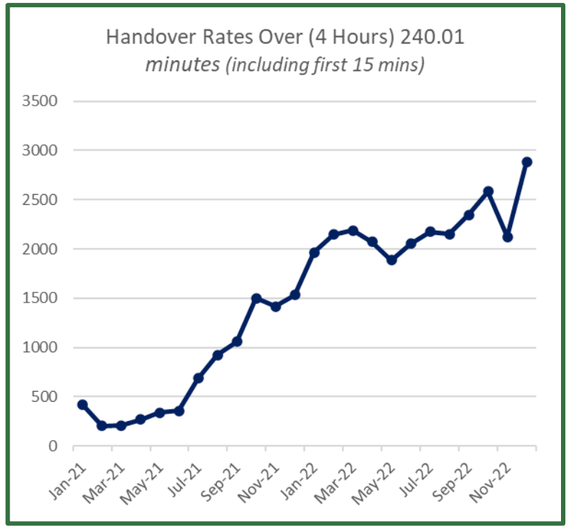
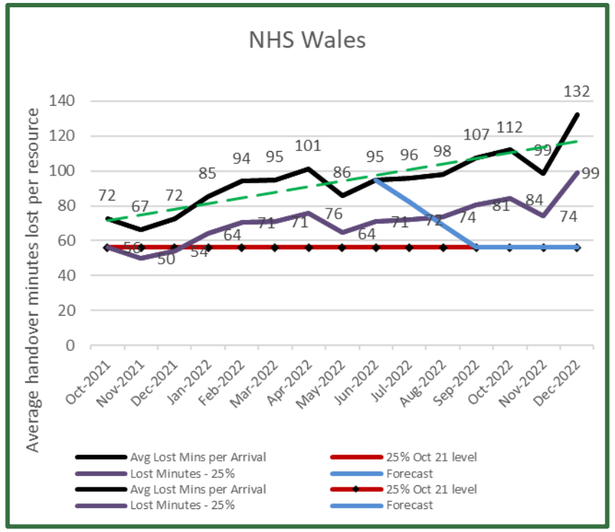
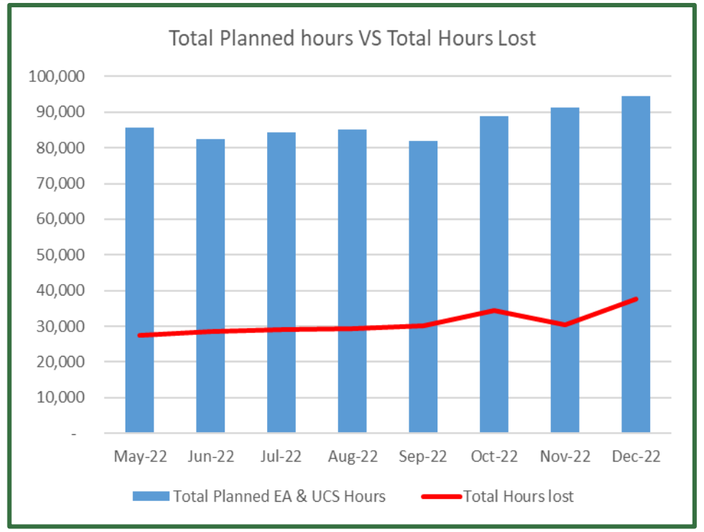








Analysis

298,654 hours were lost to Notification to Handover, i.e. hospital handover delays, over the last 12 months, compared to 142,812 in same period a year ago (January 2020 to December 2021). 32,098 hours were lost in December 2022, an increase compared to 18,773 lost hours in December 2021. The hospitals with highest levels of handover delays during December 2022 were:

- Morriston Hospital (SBUHB) at 4,299 lost hours
- Ysbyty Gwynedd Hospital (BCUHB) 3,622 lost hours
- Glan Clwyd Hospital Bodelwyddan (BCUHB) at 3,607 lost hours
- The Grange University Hospital (ABUHB) at 3,481 lost hours

Notification to handover lost hours averaged 1,033 hours a day in December 2022.

In December 2022 the Trust could have responded to approximately 10,110 more patients if handovers were reduced.

Remedial Plans and Actions

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

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

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

Expected Performance Trajectory

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

NB: Data correct at time of abstraction.

Definition of Indicators

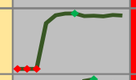
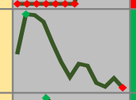
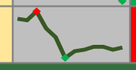
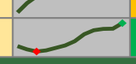
Indicator	Definition	Indicator	Definition
111 Abandoned Calls	An offered call is one which has been through the Interactive Voice Response messages and has continued to speak to a Call Handler. There are several options for the caller to self serve from the options presented in the IVR and a proportion of callers choose these options. An example is to guide the caller to 119 if they wish to speak to someone about a Coronavirus test. Once the caller is placed in the queue for the Call Handler if they hang up they are counted as “abandoned” as we did not answer the call. The threshold starts at 60 seconds after being placed into the queue as this allows the callers to respond to the messages and options presented as it often takes a short while for the caller to react. Starting the count at 60 seconds provides a picture of abandonment where the caller has chosen not to wait, despite wanting to speak to a Call Handler	**Hours Produced for Emergency Ambulances**	Proportion of hours produced within the calendar month for Emergency Ambulance Vehicles (Target 95%).
111 Patients Called back within 1 hours (P1)	(Welsh Government performance target) which prescribes that 111 has up to 1 hour (longer for lower priory callers) for a 111 Clinician to call the patient to discuss their medical issue. These callers will already have been screened by Call Handlers and received an outcome which needs a conversation with a 111 Clinician. WAST operates a queue and call back method for all Clinical Calls.	**Sickness Absence (all staff)**	Staff sickness volumes as a percentage for all staff employed within the Welsh Ambulance Services NHS Trust.
999 Call Answer Times 95th Percentile	Time taken (in Minutes) to answer 999 emergency calls by call handlers. A percentile (or a centile) is a measure used in statistics indicating the value below which a given percentage of observations in a group of observations fall. For example, the 95th percentile is the value below which 95 percent of the observations may be found.	**Frontline COVID-19 Vaccination Rates**	Volume of frontline (patient facing and non-patient facing) who have received a second COVID-19 vaccination.
999 Red Response within 8 Minutes	Percentage of 999 incidents within the Red (immediately life-threatening) category which received an emergency response at scene within 8 minutes.	**Statutory and Mandatory Training**	Combined percentage of staff who are compliant with required statutory training undertaken by staff where a statutory body has dictated that an organisation must provide training based on legislation and mandatory training which relates to trade-specific training that the employer considers essential or compulsory for a specific job. (A detailed list of these can be found on slide 20).
Red 95th Percentile	Time taken (in minutes) for emergency response to arrive at scene for Red (immediately life-threatening) calls (NB: The 95th percentile is the value below which 95 percent of the observations may be found).	**PADR/Medical Appraisal**	Proportion of staff who have undertaken their annual Performance Appraisal & Development Review (PADR) or Medical Appraisal. This is a process of self-review supported by information gathered from an employees work to reflect on achievements and challenges and identify aspirations and learning needs. It is protected time once a year.
999 Amber 1 95th Percentile	Time taken (in minutes) for emergency response to arrive at scene for Amber 1 calls (other life-threatening emergencies – including cardiac chest pains or stroke). (NB: The 95th percentile is the value below which 95 percent of the observations may be found.	**Ambulance Response FTEs in Post**	Number of Emergency Medical Services, Full Time Equivalent (FTE) staff working for the Welsh Ambulance Services NHS Trust.
Return of Spontaneous Circulation (ROSC)	Percentage of patients for whom Return Of Spontaneous Circulation occurs. This refers to signs of restored circulation (more than occasional gasp, occasional fleeting pulse or arterial waveform) evidenced by breathing, a palpable pulse or a measurable blood pressure.	**Ambulance Care, Integrated Care, Resourcing & EMS Coordination FTEs in Post**	Number of Ambulance Care, Integrated Care, Resourcing & EMS Coordination Full Time Equivalent (FTE) staff working for the Welsh Ambulance Services NHS Trust.
Stroke Patients with Appropriate Care	Proportion of suspected stroke patients who are documented as receiving an appropriate stroke care bundle (a bundle is a group of between three and five specific interventions or processes of caret hat have a greater effect on patient outcomes if done together in a time-limited way ,rather than separately).	**Financial Balance – Annual Expenditure YTD as % of budget Expenditure**	Annual expenditure (Year to Date) as a proportion of budget expenditure.
Acute Coronary Syndrome Patients with Appropriate Care	Proportion of STEMI patients who receive appropriate care. ST segment elevation myocardial infarction - occurs when a coronary artery is totally occluded by a blood clot.	**Post Production Lost Hours**	Number of hours lost due to ambulance vehicles being unavailable due to a variety of reasons (A detailed list of these is show in the graph on slide 22).
Renal Journeys arriving within 30 minutes of their appointment (NEPTS)	Proportion of renal journeys which arrive at hospital appointments within 30 minutes (+/-) of their appointment time.	**111 Consult and Close**	Consult and Close refers to the response to 999 callers where an alternative to a scene response has been provided. A cohort of 999 calls are passed to 111 where they are low acuity and the Clinicians in 111 may be able to help the caller with self-care, referral, etc. This is similar to the work of the Clinical Support Desk but for a lower acuity of caller. Where the outcome from the 111 clinical consultation ends in a Consult and Close outcome (self-care, referral, alternative transport) this is captured and forms part of the Trust’s Consult and Close reporting. Over 50% of calls passed to 111 in this way are successfully closed without an ambulance response.
Discharge & Transfer journeys collected less than 60 minutes after booked ready time (NEPTS)	Proportion of journeys being discharged from and/or transferred between hospitals which were collected within 60 minutes of the hospital booked ready time.	**999 / 111 Hear and Treat**	Proportion of 999/111 calls which are successfully completed (closed) without dispatching an ambulance vehicle response. This may include advice, self-care or referral to other urgent care services.
National reportable Incidents (NRI)	Volume of patient safety incidents reported in the month which caused or contributed to the unexpected or avoidable death, or severe harm, of one or more patients, staff or members of the public, during NHS funded healthcare.	**% Incidents Conveyed to Major EDs**	Proportion of patients transported to a hospital Emergency Department following initial assessment at scene by a Welsh Ambulance Services NHS Trust Clinician, as a proportion of total verified incidents. (NB: An ED provides a wide range of scute in-patient and out-patient specialist services together with the necessary support systems, which allow emergency admissions, and which usually has an Accident and Emergency Department).
Concerns Response within 30 Days	Proportion of concerns responded to by the complaints team within 30 working days of receiving the concern.	**Number of Handover Lost hours**	Number of hours lost due to turnaround times at EDs taking more than 15 minutes. Transferring the care of a patient from an ambulance to an ED is expected to take no longer than 15 minutes, with a further 15 minutes for ambulance crews to make their vehicle ready for the next call.
EMS Abstraction Rate	The percentage of Emergency Medical Services (EMS) staff unavailable for rostered duties due to reasons, such as: annual leave, sickness, alternative duties, training, other and COVID-19.	**Immediate Release requests**	The number of requests submitted to Health Boards for the immediate release of vehicles at Emergency Departments to release them back into the community to respond to other urgent and life-threatening calls

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

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru

Welsh Ambulance Services
NHS Trust

Welsh Ambulance Services NHS Trust
Integrated Performance Report
2020/21

Top Monthly Indicators	Target 2022/23	Baseline Position (2021/22)	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	2 Year Trend	RAG
Our Patients - Quality, Safety and Patient Experience																		
NHS111 Abandoned Calls	< 5%	18.60%	22.8%	21.1%	11.4%	4.7%	9.6%	10.8%	5.6%	15.0%	15.6%	13.3%	11.2%	14.8%	13.6%	49.5%		R
999 Call Answer Times 95th Percentile	95% in 00:00:05	0:52	0:37	1:43	0:54	0:59	1:35	1:19	0:22	0:50	0:57	0:36	0:52	1:03	1:11	01:34%		R
999 Red Response within 8 minutes	65%	55.2%	53.0%	51.1%	52.5%	55.0%	51.1%	51.2%	54.5%	50.8%	52.0%	50.7%	50.0%	48.0%	48.0%	39.5%		R
999 Amber 1 Median	0:18	1:10	1:02	1:14	0:57	1:10	1:38	1:40	1:11	1:30	1:40	1:16	1:30	1:42	1:34	3:30		R
Stroke Patients with Appropriate Care	95%	TBD	98.40%	-	-	-	-	68.0%	79.8%	82.3%	82.5%	78.6%	79.1%	78.2%	80.2%	79.4%		R
Acute Coronary Syndrome Patients with Appropriate Care	95%	TBD	85.70%	-	-	-	-	-	-	-	-	43.9%	45.0%	37.5%	42.3%	37.9%		R
Renal journeys arriving within 30 minutes of their appointment (NEPTS)	70%	79%	78%	77%	82%	82%	81%	79%	77%	75%	76%	76%	74%	74%	75%	74%		G
Discharge & Transfer journeys collected less than 60 minutes after booked time (NEPTS)	90%	81.00%	86%	88%	87%	88%	88%	91%	90%	87%	85%	86%	88%	85%	90%	90.0%		G
National Reportable Incidents reports (NRI)	Reduction Trend	5	9	4	5	2	7	3	11	3	2	10	7	8	2	0		G
Concerns Response within 30 Days	75%	61%	56%	70%	66%	64%	76%	53%	41%	13%	22%	24%	28%	28%	24%	27.0%		R
Our People																		
Capacity																		
EMS Abstraction Rate	29.92%	42.00%	40%	44%	43%	42%	49%	39%	37%	37%	40%	40%	41%	40%	40%	44.0%		R
Hours Produced for Emergency Ambulances	95%	95.0%	103%	96%	109%	110%	98%	90%	96%	94%	94%	95%	96%	90%	92%	91.0%		A
Health and Wellbeing																		
Sickness Absence *(all staff)*	8.00%	10.48%	11.05%	12.44%	12.14%	10.93%	12.04%	11.18%	8.88%	9.15%	10.33%	8.75%	8.68%	9.48%	8.77%	-		A
EMS Operations Sickness Rates	8.00%	7.76%	12.71%	15.04%	14.89%	12.76%	15.47%	12.54%	9.90%	10.07%	11.98%	9.87%	9.26%	10.12%	9.45%	11.64%		R
Staff Turnover Rate	TBD	8.71%	9.54%	9.44%	9.51%	9.70%	10.33%	10.85%	11.29%	11.54%	11.64%	11.50%	11.35%	11.11%	10.70%	10.64%		R
Statutory & Mandatory Training	>85%	82.3%	82.82%	82.06%	82.23%	83.34%	84.15%	84.64%	85.24%	85.13%	85.17%	85.44%	85.60%	85.58%	85.40%	84.63%		A
PADR/Medical Appraisal	>85%	60%	58.84%	57.87%	58.34%	54.19%	51.46%	52.89%	56.05%	59.25%	64.66%	73.66%	78.75%	80.49%	80.75%	87.9%		G
Value																		
Financial balance - annual expenditure YTD as % of budget expenditure YTD	100%	100%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%		G
Post-Production Lost Hours (EA, RRV, UCS)	Reduction Trend	TBD							9166	9167	9379	9131	9121	9385	9224	9379		A
Partnerships / System Contribution																		
NHS111 Consult and Close	Improve	7,843	5,915	6,875	6,943	6,699	8,432	10,295	15,819	17,208	17,694	14,729	15,342	17,695	15,362	15,955		A
Combined 999 & NHS111 Consult & Close	15.0%	10.4%	10.0%	11.0%	11.1%	10.8%	11.8%	11.8%	12.2%	11.8%	11.6%	11.8%	12.3%	12.8%	12.5%	14.6%		A
% Of Total Conveyances taken to a Service Other Than a Type One Emergency Department	Improvement Trend	TBD	11.59%	11.79%	12.05%	11.55%	11.37%	12.27%	11.99%	12.48%	11.95%	11.99%	11.14%	10.65%	11.04%	11.18%		TBD
Number of Handover Lost Hours	25% reduction from Oct-21	15,955	18,160	18,773	22,563	23,232	24,479	23,382	22,080	23,380	24,021	24,295	25,174	28,038	25,020	32,098		R

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

PATIENT SAFETY REPORT
QUARTER 3 (OCTOBER - DECEMBER 2022)

MEETING	Quality, Patient Experience & Safety Committee
DATE	9 February 2023
EXECUTIVE	Executive Director of Quality & Nursing
AUTHOR	Assistant Director of Quality & Nursing
CONTACT	Wendy Herbert 07966 205399 Wendy.herbert3@wales.nhs.uk

EXECUTIVE SUMMARY

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

In summary the report for this quarter identifies:

- A continued increase in the number of concerns being received
- A continuing number of incidents being reviewed at the Serious Case Incident Forum (SCIF)
- A continuing number of Joint Investigations passed to Health Boards
- A continuing number of Nationally Reportable Incidents (NRIs) identified
- A slight decrease in Political complaints received since April 2021
- A continued upward trend in Coroner's requests for information
- A decrease in the number of personal injury claims, albeit they are of a more complex nature
- The Trust received two Regulation 28 Reports during this period and has responded to all previous reports within the given timescales
- A detailed breakdown of Joint Investigation Reports and immediate release reports by Health Board
- Additional funding has been received to support and improve our compliance against our PTR and Patient Safety functions.

RECOMMENDED that the Committee receives the report for discussion.

KEY ISSUES/IMPLICATIONS
(i) There continues to be an increase in activity in the majority of areas across PTR (ii) There continues to be a high-level volume of concerns being received. (iii) A significant improvement in our two-day acknowledgement of concerns, but a our thirty-day compliance remains low. (iv) There has been an increase in the number of patient safety incidents received this quarter (1592 compared with 1257 the previous quarter). At the time of reporting, we have seen a considerable increase in the patient safety incidents recorded to potentially be catastrophic or severe, particularly in December 2022 due to further deterioration in performance across the healthcare system.

REPORT APPROVAL ROUTE	
Executive Management Team	18 January 2023
Quality, Patient Experience & Safety Committee	9 February 2023

REPORT APPENDICES
ANNEX 1 - SBAR providing background information.

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

ANNEX 1

PUTTING THINGS RIGHT						
	Quarter 2, 22-23			Quarter 3, 22-23		
	July 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022
Patient Safety Incidents						
Catastrophic	43	28	48	37	34	82
Severe	10	10	12	8	7	21
Moderate	46	79	67	64	70	99
Low	71	71	75	146	136	175
None	368	228	101	303	201	209
Total	538	416	303	558	448	586
Concerns						
Total Received	123	110	105	109	94	124
Total Closed	70	86	99	81	97	108
2 Day Acknowledgment %	62%	92%	92%	96%	99%	89%
30 Day Response due %	22%	24%	28%	28%	24%	27%
Ombudsman						
Cases Received	1	4	1	2	4	2
Cases Closed	4	2	1	1	5	8
Reports Received	1	0	1	0	0	0
Coroners						
Information request	128	137	152	157	160	148
Identified as Interested Party	21	19	20	20	23	26
Staff attending	5	4	3	3	3	4
Regulation 28 issued	0	0	0	1	1	0
Response to Regulation 28 in 56 working days	0	1	0	0	0	1
Response to Regulation 28 outside 56 working days	0	0	0	0	0	0
Nationally Reportable Incidents (NRIs) to Delivery Unit (reporting date)						
Serious Case Incident Forums held	5	8	7	6	5	7
Serious Case Incident Forums Cases	34	38	39	42	26	36
WAST NRIs reportable to Delivery Unit	2	10	7	8	2	0
Joint Investigation Framework - Passed	26	10	15	15	7	18
Joint Investigation Framework - Received					3	1
NRI Closures Submitted - Total	26	1	2	6	3	6
NRI Closed by Delivery Unit - Total	0	18	0	0	0	0
Claims						
Personal Injury - Received	1	2	5	1	4	1
Personal Injury - Closed	1	0	2	0	0	4
Clinical Negligence - Received	0	3	0	0	*	1
Clinical Negligence - Closed	0	1	0	4	*	0
Road Traffic Collision & Damage to Property - Received	20	17	22	17	30	26
Road Traffic Collision & Damage to Property - Closed	17	10	15	16	37	20

*** During the last 2 months the Clin Neg cases have been moved from RL Datix to the new Datix Cymru. This means it is not possible to establish when cases were originally opened within the Trust.**

SETTING THE CONTEXT FOR THIS PERIOD

1 During Quarter 3 (October- December 2022), the Trust's verified incidents were **113,855** compared to **122,083** for the same period last year. For the same periods, 111 call volumes were **295,538** and **250,718** respectively.

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

(i) Red - **15,117** compared to **11,911**
(ii) Amber - **80,627** compared to **87,453**
(iii) Green - **18,111** compared to **22,719**

3 Overall total verified incident demand saw a **7%** decrease in Quarter 3 compared to the same period the previous year.

4 The Trust lost a total of **86,006** hours to notify to handover delays across this quarter, an increase when compared to the previous quarter (July - September 2022).

5 Red performance remains a challenge and the **65%** target has not been achieved for **29** months. In Quarter 3 the Trust achieved **48.0%** in both October and November and **39.5%** in December, therefore continuing to fall below the **65%** target. This performance percentage was lower than the same periods in 2021, **50.0%, 53.0%** and **51.1%** respectively.

6 During this quarter, the number of patients attended in the Red category was **14,900** compared with **11,777** in 2021. December saw the largest variation with **5,873** Red responses in 2022 compared to **3,890** in 2021, which is an increase of **34%**.

7 Amber median performance during Quarter 3 was **1** hour **48** minutes (**1** hour **45** minutes), **1** hour **40** minutes (**1** hour **08** minutes) and **3** hours **29** (**1** hour **20** minutes) respectively. The figures in brackets are for the same period in 2021.

SITUATION

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

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

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

BACKGROUND

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

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

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

13 Following recruitment of two new Concerns Administrators the two-day acknowledgement Key Performance Indicator (KPI) average for Quarter 3 was **95%** in comparison to **82%** for the previous quarter. This is expected to be maintained over the course of the next quarter, though it is noted that one of the substantive Administrators has been seconded into the Emergency Medical Services (EMS) Co-ordination Team from January 2023.

14 Our 30-day compliance average for this quarter was below what is expected, sitting at **26%**. This is due to multiple factors, including:

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

15 To support and improve the above position, a Business Case was presented to the Executive Management Team. The purpose of the Business Case was to highlight the pressures and the lack of capacity within the Corporate PTR team/Legal Team and within the CCC PTR Team. The funding is supporting a number of posts across Corporate and CCC Teams. Secondment opportunities have also enabled key functions (including MPDS audits) to be covered. Recruiting staff with the required skill sets has been challenging.

16 The Legal Services Team has successfully recruited into the position of Claims Investigation Officer.

17 Following the transition from Datix Web to the Once for Wales (OfWs) RL Datix, the procedure for managing Redress cases on the system has improved, allowing better reporting metrics on complaints that are reviewed at Complex Case Panel (CCP) and the number which trigger Redress. It was expected that reporting could commence from Quarter 2 but due to the volume of CCP cases still being managed on the historic Datix system this cannot commence at present.

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

ASSESSMENT

Patient Safety Incidents

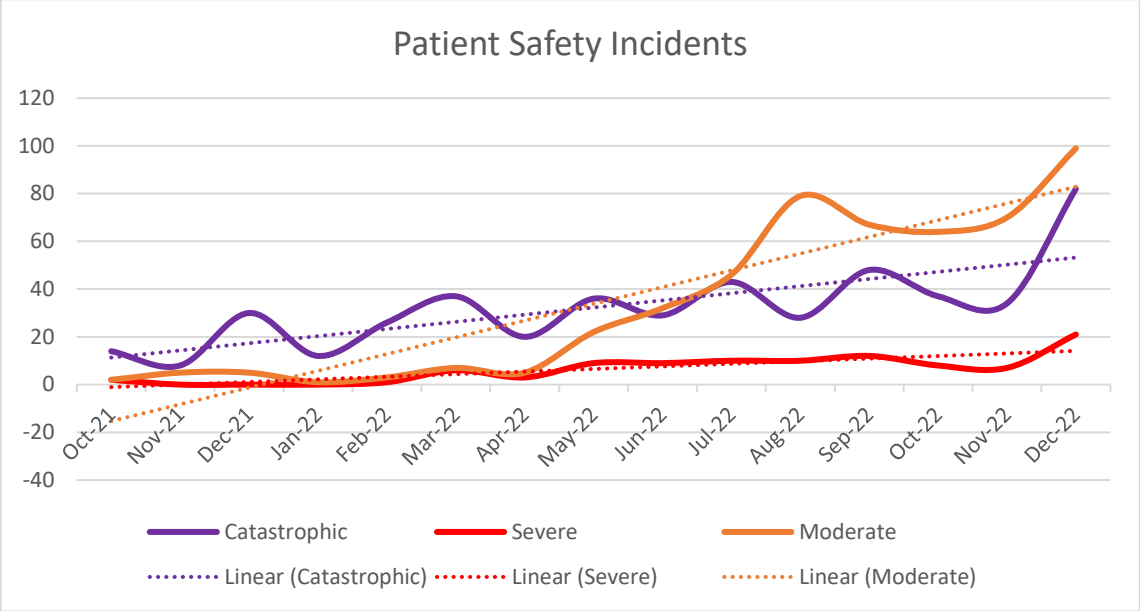
19 **Patient Safety Incidents (PSI) reported as catastrophic are usually related to patient outcome. In all cases an investigation is pending and it has not been established whether the outcome was due to any act or omission by The Welsh Ambulance Services NHS Trust (WAST) or whether it was due to the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

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

21 During this period a total of **1,592** patient safety incidents were reported, **558** in October, **448** in November and **586** in December. This is an increase in comparison to the previous quarter, but an increase in comparison to the same period last year where there were **1,257** incidents reported. All incidents with an initial harm grading of moderate, severe or catastrophic are reviewed weekly by the Patient Safety Team and re-graded if required. **It must be noted that the harm grading may change subject to the conclusion or outcome of any investigation.**

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

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



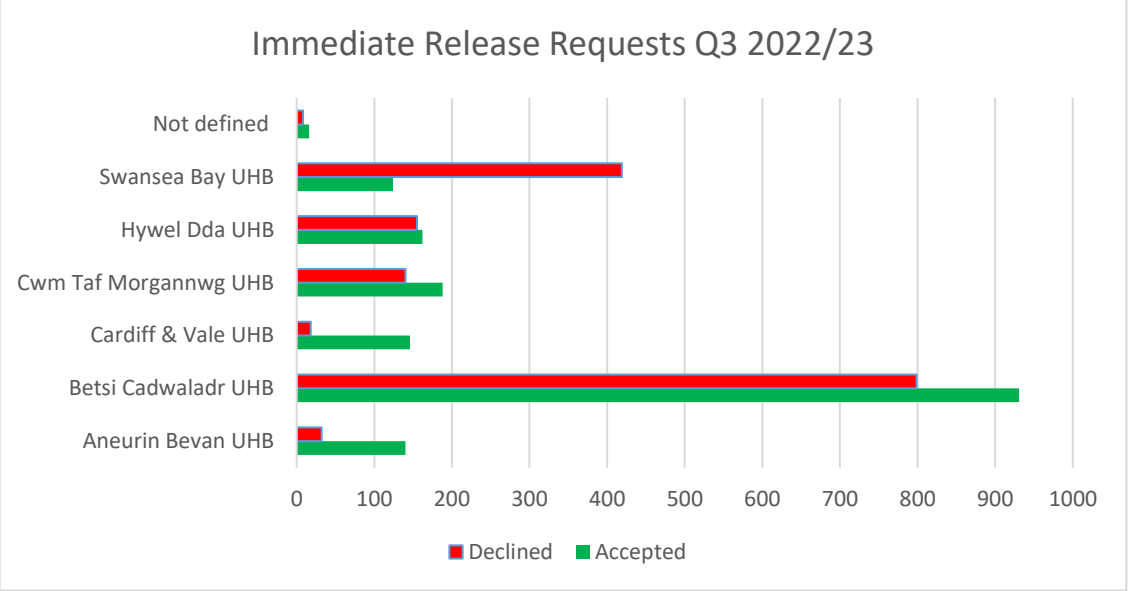
24 Following a comprehensive risk assessment on *013 Ligature and ligature point risk assessment tools and policies* recommendations has been reported to the Clinical & Quality Governance Group. Compliance has been confirmed with Patient Safety Wales.

NHS Wales Immediate Release Requests

25 During the quarter there were a total of **3,278** Immediate Release Requests made to Health Boards. These requests are made to release an emergency ambulance to respond to a patient in the community who has potentially a life threating or serious condition. The Trust continues to work with Health Boards, Welsh Government and Commissioners to influence immediate release requests.

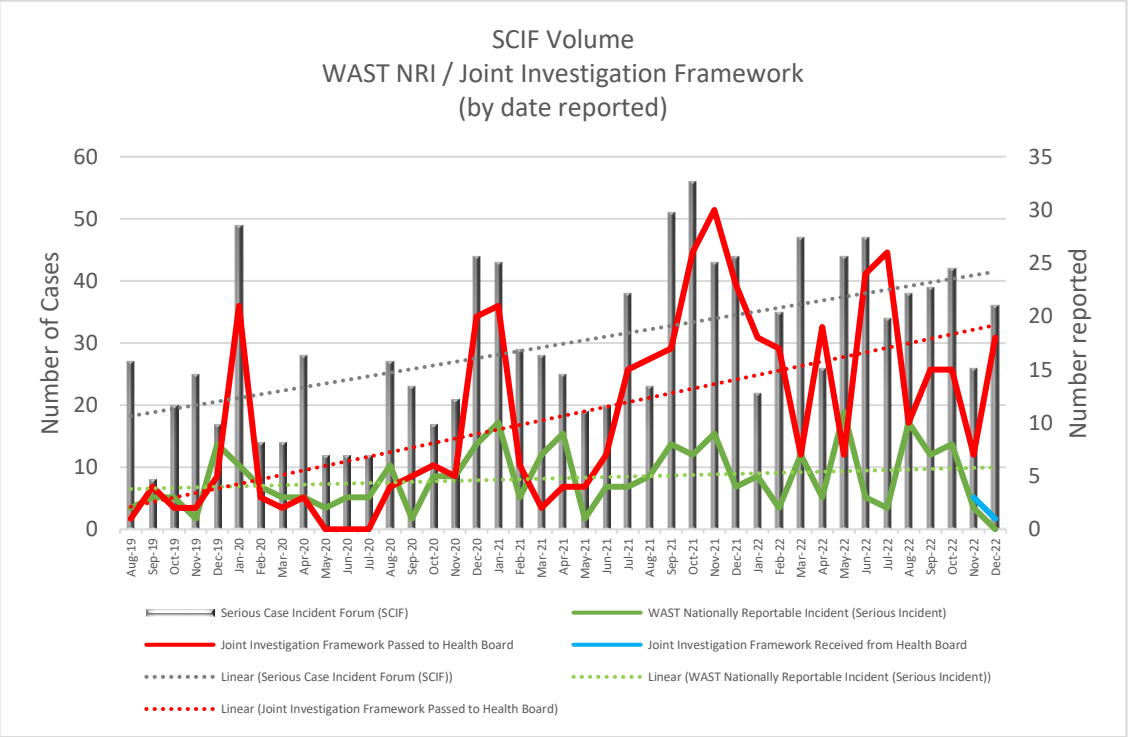
26 Of these, **1,707** were accepted (**52%**) and **1,571** were declined (**48%**). This is illustrated in the chart below:

Health Board Quarter 3 2022/23	Number accepted	Number declined	% Declined
Aneurin Bevan University Health Board	140	32	19%
Betsi Cadwaladr University Health Board	931	799	46%
Cardiff & Vale University Health Board	146	18	11%
Cwm Taf Morgannwg University Health Board	188	140	43%
Hywel Dda University Health Board	162	155	49%
Swansea Bay University Health Board	124	419	77%
Not defined	16	8	33%
Total (n)	1,707	1,571	48%
Overall Total (n)		3,278	
Total (%)	52%	48%	

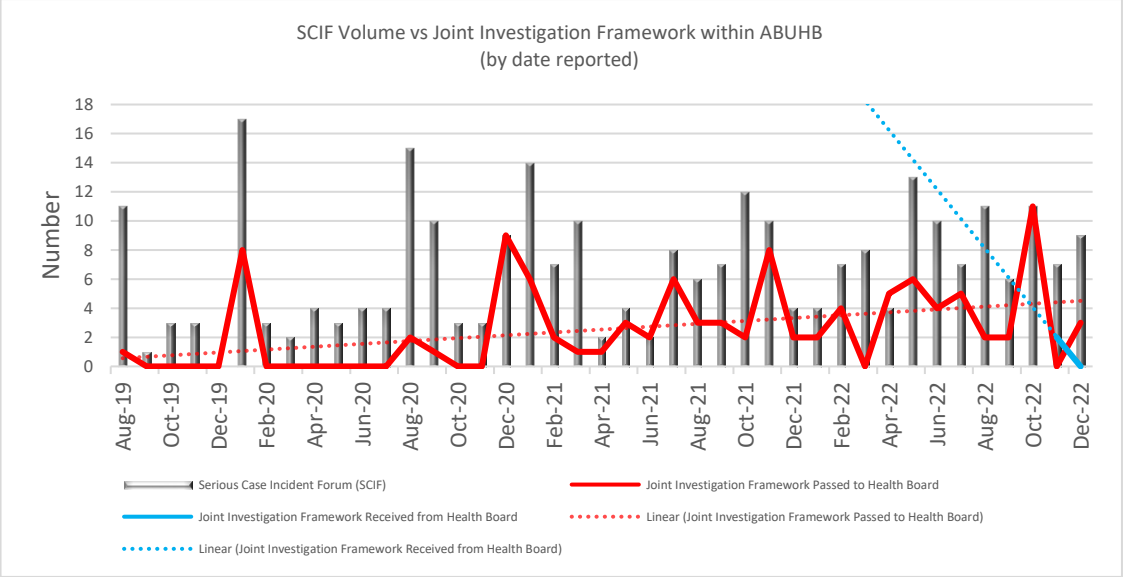


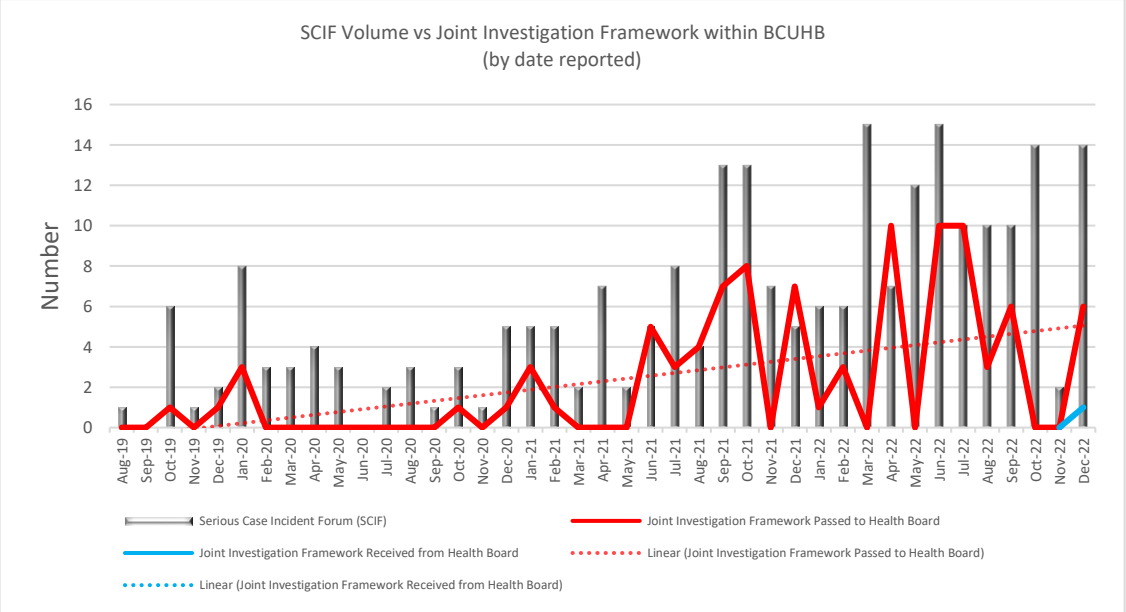
Serious Case Incident Forum (SCIF) and Nationally Reportable Incidents (NRIs)

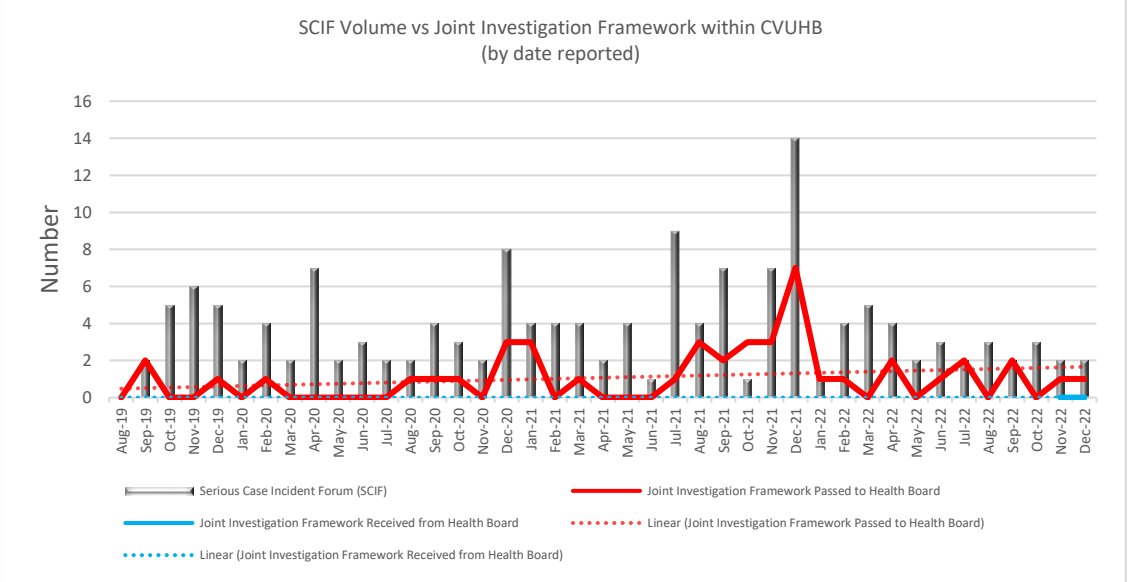
27 The chart below details the number of cases discussed at the SCIF and those reported either to the Health Boards for further investigation (Appendix B) and those reported and investigated internally. Incidents not reaching the threshold are managed as lower graded patient safety incidents (low or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

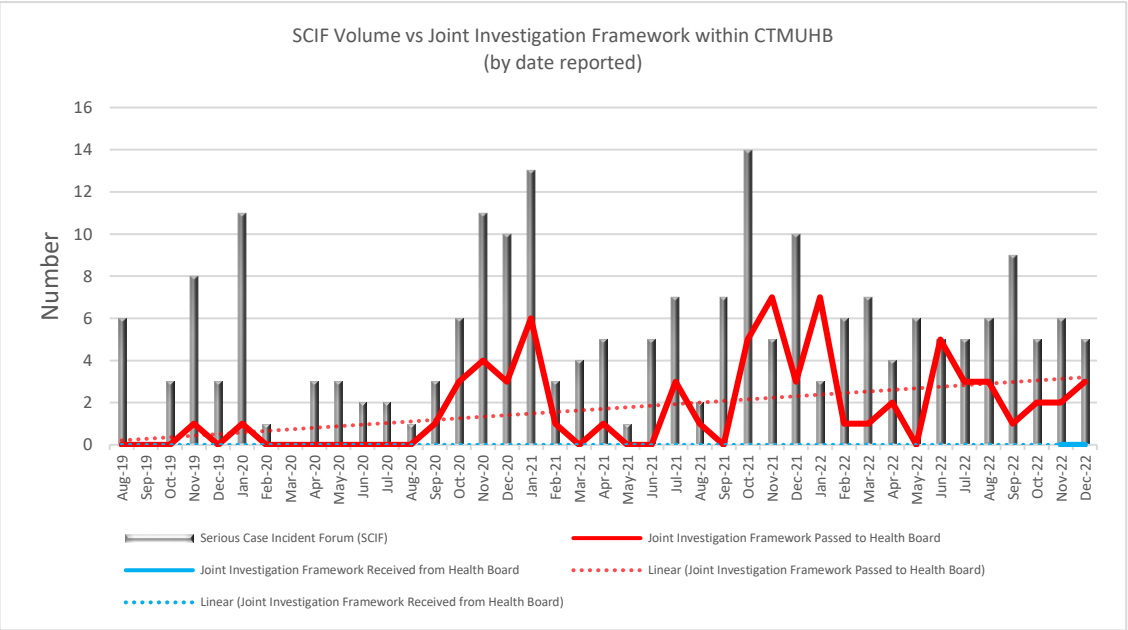


28 The following charts detail individually by Health Board, the number of cases discussed at the SCIF passed to Health Boards and received from Health Boards under the Joint Investigation Framework (previously Appendix B):


SCIF Volume vs Joint Investigation Framework within ABUHB
(by date reported)
Number
Serious Case Incident Forum (SCIF)
Joint Investigation Framework Passed to Health Board
Joint Investigation Framework Received from Health Board
Linear (Joint Investigation Framework Passed to Health Board)
Linear (Joint Investigation Framework Received from Health Board)


SCIF Volume vs Joint Investigation Framework within BCUHB
(by date reported)
Number
Serious Case Incident Forum (SCIF)
Joint Investigation Framework Passed to Health Board
Joint Investigation Framework Received from Health Board
Linear (Joint Investigation Framework Passed to Health Board)
Linear (Joint Investigation Framework Received from Health Board)


SCIF Volume vs Joint Investigation Framework within CVUHB
(by date reported)
Number
Serious Case Incident Forum (SCIF)
Joint Investigation Framework Passed to Health Board
Joint Investigation Framework Received from Health Board
Linear (Joint Investigation Framework Passed to Health Board)
Linear (Joint Investigation Framework Received from Health Board)


SCIF Volume vs Joint Investigation Framework within CTMUHB
(by date reported)
Number
16
14
12
10
8
6
4
2
0
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20
Nov-20
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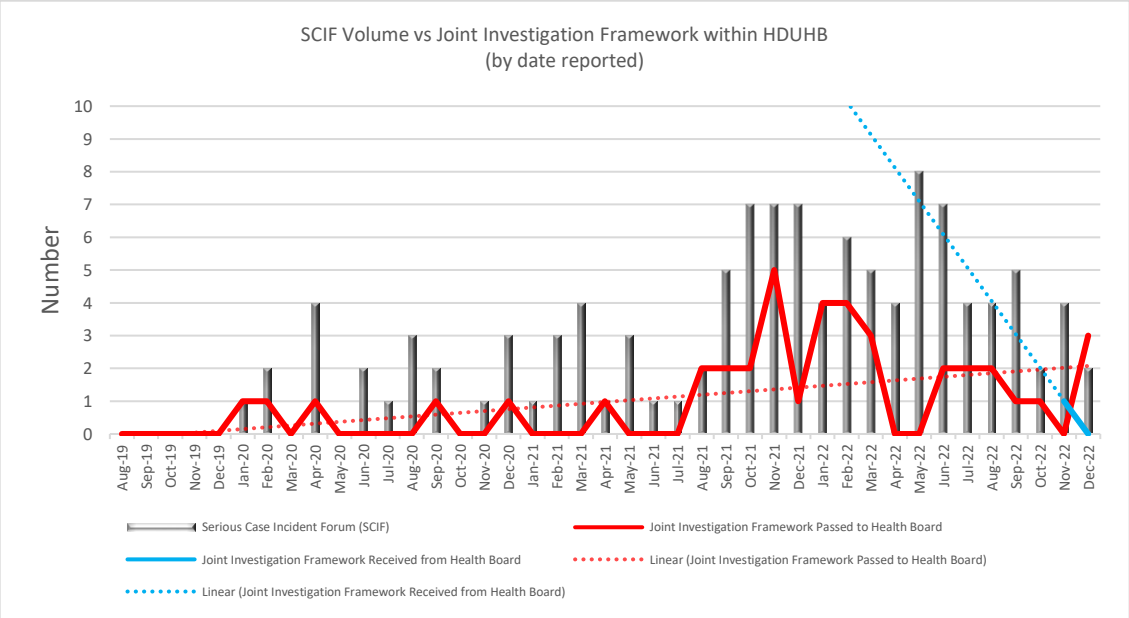
Feb-22
Mar-22
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Serious Case Incident Forum (SCIF)
Joint Investigation Framework Passed to Health Board
Joint Investigation Framework Received from Health Board
Linear (Joint Investigation Framework Passed to Health Board)
Linear (Joint Investigation Framework Received from Health Board)


SCIF Volume vs Joint Investigation Framework within HDUHB
(by date reported)
Number
10
9
8
7
6
5
4
3
2
1
0
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
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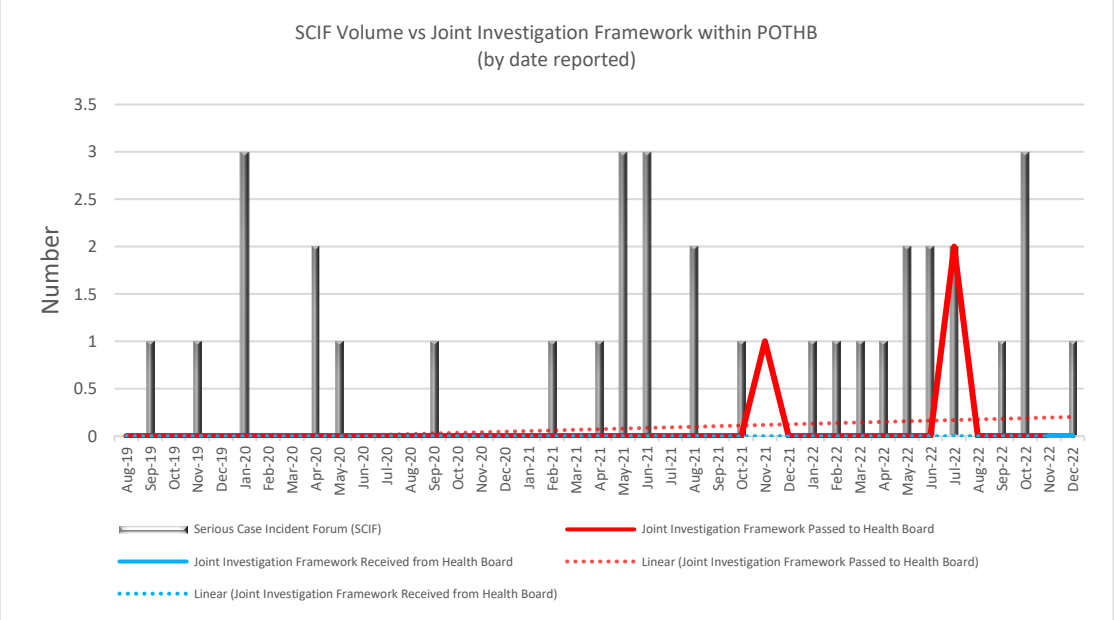
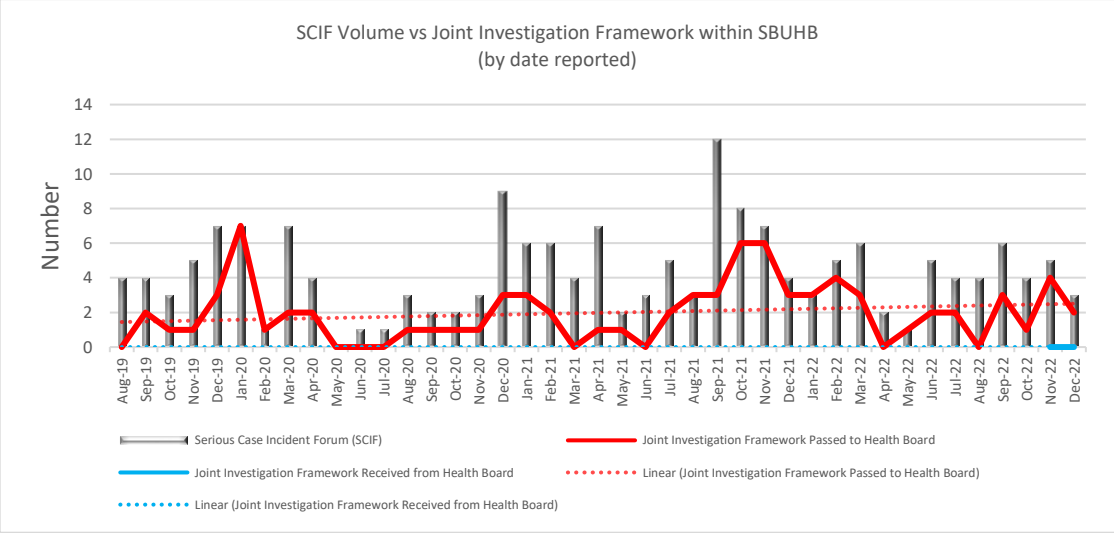
Dec-22
Serious Case Incident Forum (SCIF)
Joint Investigation Framework Passed to Health Board
Joint Investigation Framework Received from Health Board
Linear (Joint Investigation Framework Passed to Health Board)
Linear (Joint Investigation Framework Received from Health Board)





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

30 A series of meetings have been held between the NHS Wales Delivery Unit, the Emergency Ambulance Services Committee (EASC) Health Boards and the Welsh Ambulance Services NHS Trust (WAST), to progress the review and update the Joint Investigation Framework. A new process for Joint Investigations is progressing well to date with Health Board colleagues. Work continues with each Health Board to ensure the new process is embedded.

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

32 During the reporting period **10** incidents have been reported as NRIs to the Delivery Unit (DU) and **40** incidents were referred under the Joint Incident Framework (JIF) to the respective Health Board.

33 Following review of the **10** Incidents reported as NRIs to the DU the overarching high-level themes and trends were identified:

(i) Call categorisation (**3**), (**2** of which were missed ineffective breathing)
(ii) Call stopped in error (**1**)
(iii) Location issue **(1)**
(iv) Clinical assessment and/or treatment (**2**)
(v) Cardiopulmonary resuscitation (CPR) Instructions **(1)**
(vi) Missed opportunity to safeguard patient **(1)**
(vii) Welfare check **(1)**

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

34 Key Definitions:

(i) *Early Resolution* - 2-day informal response
(ii) *Formal* - This requires a formal letter of response within 30 working days, as required under the Regulations. These are currently signed off by the Chief Executive Officer, following quality assurance of the investigation and letter. The Key Performance Indicator (KPI) is **75%**, which requires the closure of the response letter.

35 The PTR Department continues to receive a steady number of concerns within this reporting period (**327**). This is an increase in comparison to the same reporting period last year where **256** concerns were received.

36 As of 10 January 2023, there were **309** open concerns with **208** in backlog (**187** of which are formal). This is an increase in the number of open concerns and an increase in the number in backlog.

37 As of 10 January 2023, there were **42** open Redress cases. There are **17** for review at the Clinical Complex Case Panel as recorded on Datix Cymru (this does not include those cases on the old Datix system).

38 During this reporting period the 2-day acknowledgement performance was **96%**, **99%** and **89%** with the 30-day target achieving **28%**, **24%** and **27%** respectively.

39 The average across this period is therefore **85%** for 2-day acknowledgement and **26%** for 30-day target.

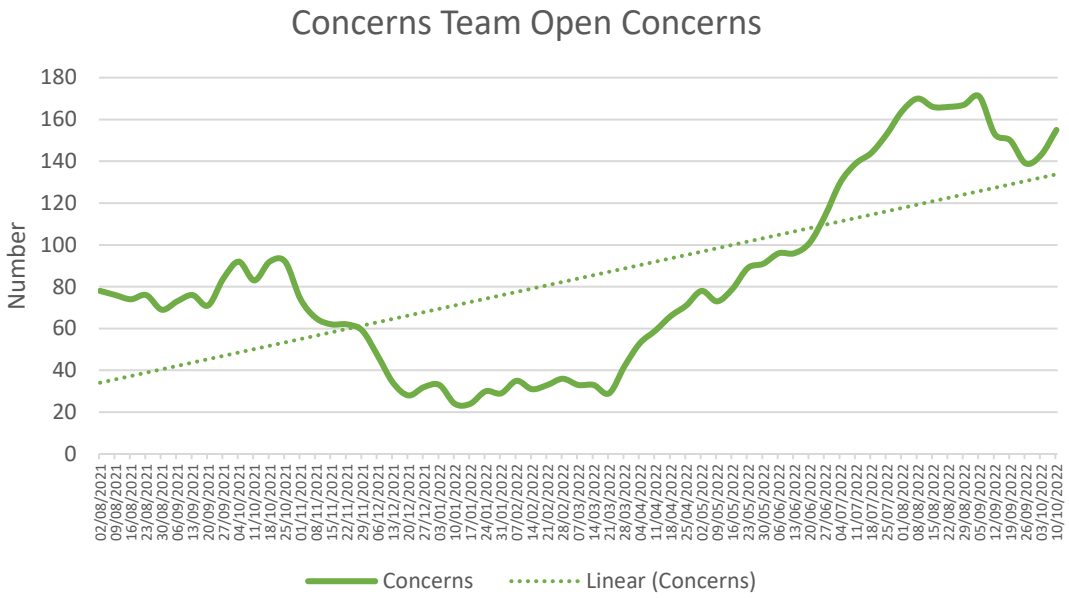
40 Following on from the unprecedented pressures of the last quarter, this reporting period has remained busy with the volume of concerns increasing.

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

EMS Co-ordination and Resourcing Centre Concerns Breakdown

42 The number of concerns coming into the EMS Co-ordination and Resourcing Centre continues to rise however, a new process to review and investigate grade

1 & 2 concerns enables a more timely response for the complainant focusing on their questions and concerns. The overall total of open concerns remains high:



Ombudsman and Political Investigations

43 There are currently **11** open Ombudsman cases. The Trust has submitted all documentation to the Public Service Ombudsman for Wales (PSOW) and is awaiting conclusion of the investigation.

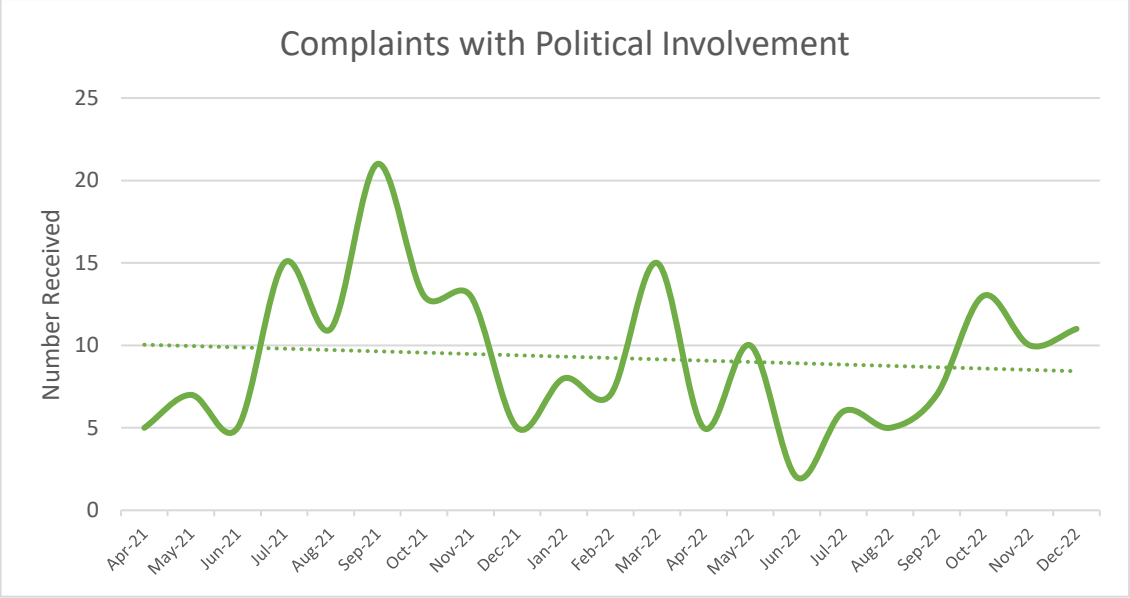
44 During the reporting period there have been no final reports received. The Trust has agreed to various early settlement agreements or cases have been closed by the Ombudsman, as they have decided not to undertake investigations.

45 Early settlement agreements have included such things as:

(i) Further letters to address questions not addressed fully in the initial regulatory responses
(ii) Further investigation/clarification surrounding issues raised
(iii) Updates on ongoing concerns
(iv) Apologies for maladministration/clerical errors
(v) Financial compensation for clerical errors made

46 This quarter has seen an increase in the number of political concerns being received (**34**).

47 There are currently **33** open political concerns.

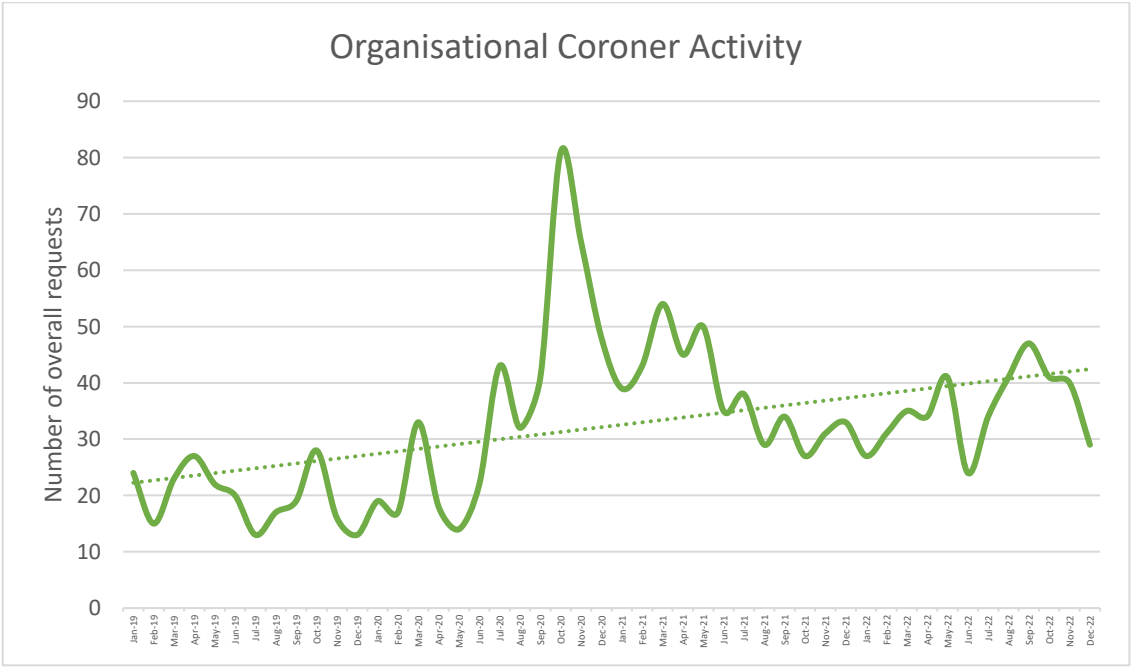


Organisational Coroner's Activity

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

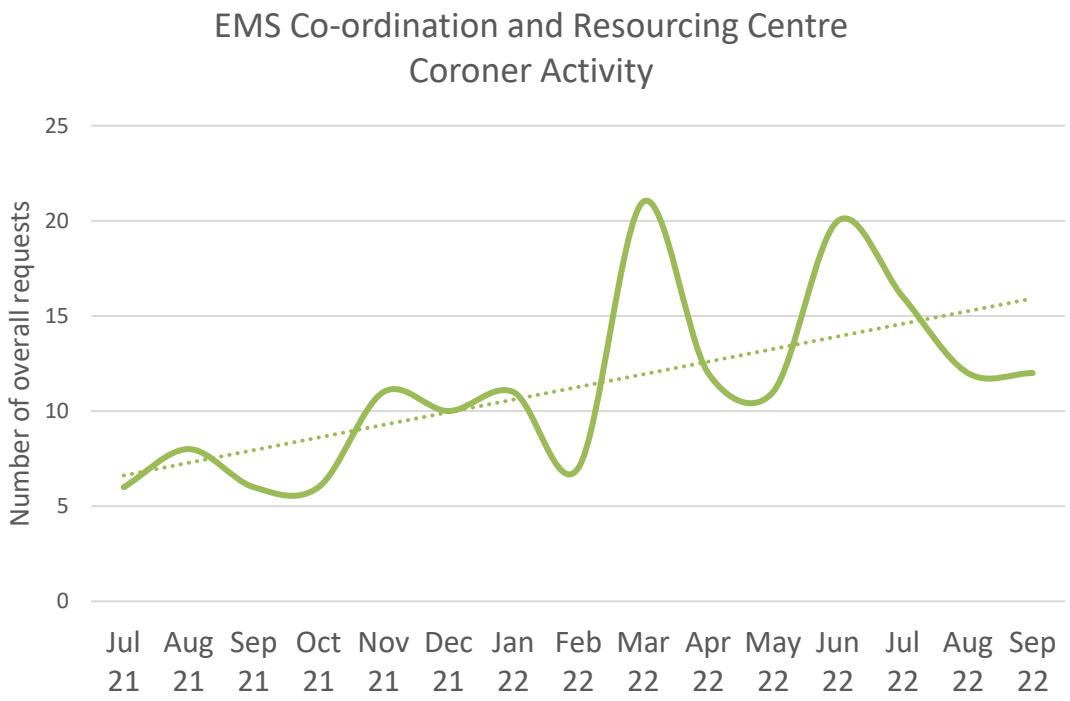
49 The work on hand with the team has increased month on month due to the delay in receiving statements. Many of the statements rely upon MPDS audits and there have been delays in the audits being undertaken:

50 Please refer to the chart below which illustrates the continuing pattern:



EMS Co-ordination and Resourcing Centre Coroner Activity

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



Prevention of Future Death Reports (Regulation 28)

52 During the reporting period the Trust received two Regulation 28 (Prevention of Future Deaths) Reports and issued one response within the 56-day target.

53 Both Regulation 28 reports relate to delays in responding to requests and were issued jointly with the associated Health Board area:

(i) Ref 7652: A request was received to transfer a patient from one hospital to another in North Wales. The patient required vascular surgery and there were no vehicles available to send, until such time as it was too late for surgery. The report required action to resolve delays in patients experiencing delays when being transferred to a vascular centre.

(ii) Ref 7569: A call was received to attend a patient in South East Wales. There were no vehicles available to attend and after two hours the patient deteriorated and passed away at the home address. The report required the Trust to consider the categorisation given to calls when patients could deteriorate.

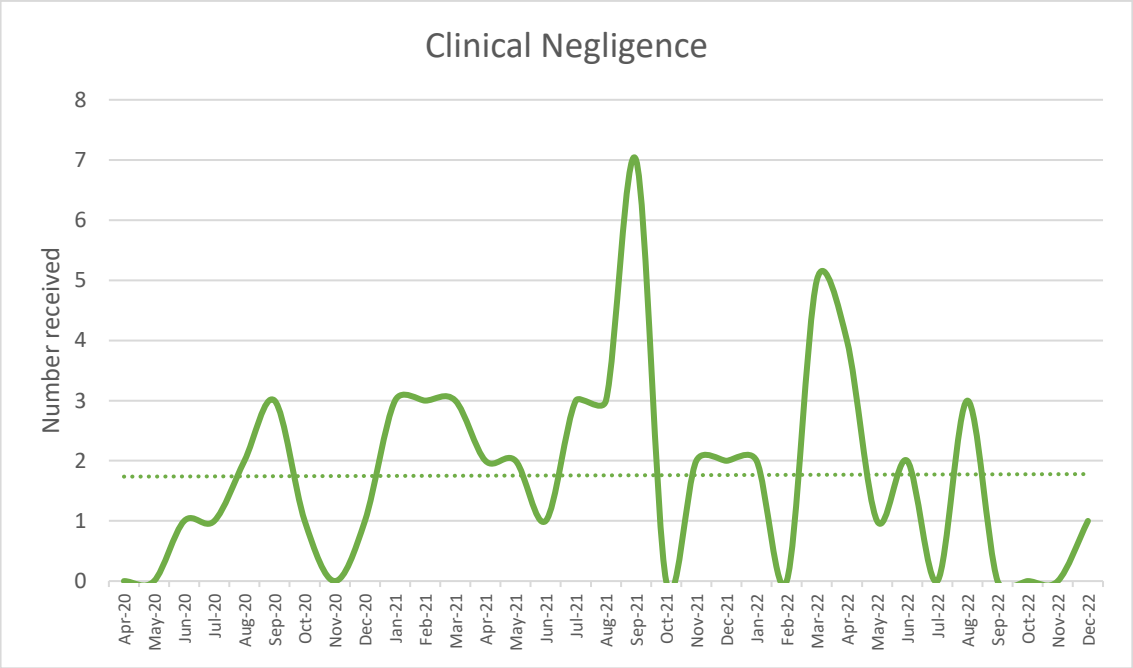
Regulation 28 Improvement Plan Update

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

55 Relevant improvement actions have been mapped to current programmes of work contained in the Integrated Medium-Term Plan (IMTP) as a number of the improvement actions continue to relate to wider system pressures. The ADLT reviewed and approved the mapping exercise and current plan in November 2022. All Regulation 28 improvement actions are contained in one overarching Improvement Plan.

Legal Claims

56 During this quarter all of the existing Clinical Negligence cases have been transferred to the new Datix Cymru system and therefore we are unable to report on the number of cases received (as they all have an opening date between 01/10/2022 and 31/12/2022. There has been a significant ongoing increase in the number of clinical negligence claims (actual and potential) being received by the Trust, many of which stem from delayed responses to patients at a time of escalation:



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

58 Whilst personal injury claims (including claims linked to road traffic incidents) received have decreased to **8**, from **12**, during this quarter, these numbers alone do not capture the increased complexity and value in the legal claims.

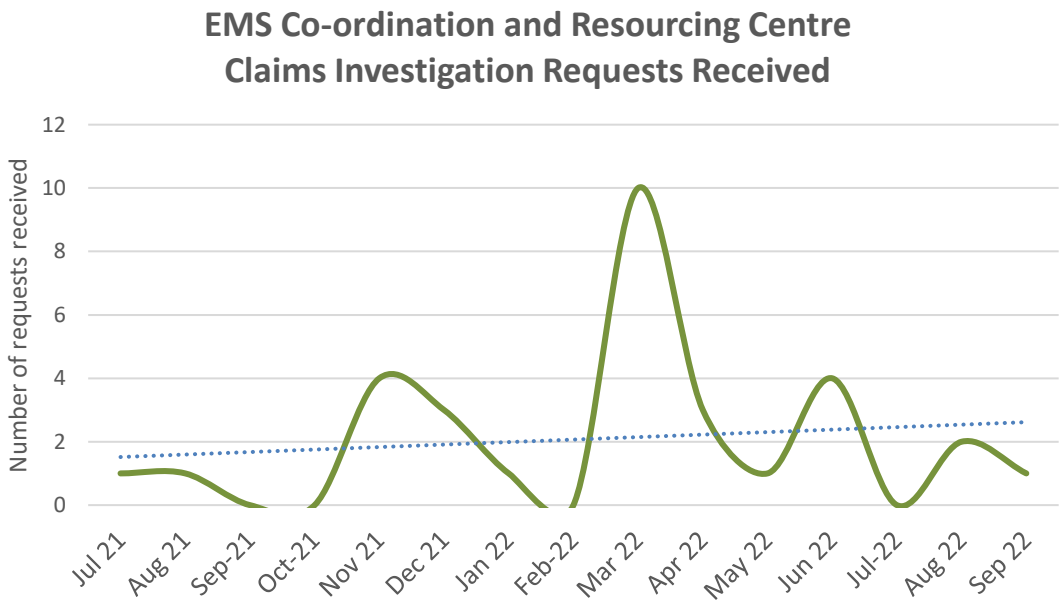
59 The Trust continues to not only contesting liability in many cases and testing the strength of our evidence, but the extent of injuries and value of damages being claims. The staff claims relate primarily to issues with equipment. Recent cases have collapsed following the death of a key witness, where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

60 During the reporting period the number of road traffic accident and damage to property incidents have returned to the usual seasonal volume. However, these too have increased in complexity and value. Like other aspects of the current financial situation, the cost of repairs and hire charges have increased. We are starting to see more people entering credit hire, as they do not have funds to hire a vehicle without entering a credit agreement. This carries additional costs for the Trust.

61 The Trust previously reported nationwide issues with spare parts, causing major delays in repairs, with the associated knock-on effect of longer periods of car hire and associated costs. This has seen an increase in the number of cases where the Trust is asked to pay for repairs in advance of the repairs being undertaken. This is an issue that the Trust is currently monitoring.

EMS Co-ordination and Resourcing Centre Claims Investigation Requests

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



Medical Examiner Service and Mortality Review Process - Update

63 Recommendations of numerous inquiries from Shipman Inquiry third report 2003, report of the Mid Staffordshire NHS Foundation Trust Public Inquiry - Vol 2 - 2013, Morecambe Bay Investigation 2015 to more recently learning from Gosport 2018 have called for strengthening of safeguards for the public by providing additional independent scrutiny of the medical circumstances and cause of deaths.

64 Initially introduced as a non-statutory the Medical Examiner (ME) Service it is planned to become statutory in NHS Wales in Spring 2023.

65 Currently the focus of the ME Service has been on acute care and next steps are to ensure that every non-coronial death in Wales is independently scrutinised by the ME Service (Level 1 review), which includes deaths in primary care from June 2023.

66 The Patient Safety Team, Clinicians and local Managers currently engage in Mortality Review Meetings across the Health Boards, with the focus on one system investigation for the family.

67 Whilst the multiple benefits of the ME process are recognised there will undoubtedly be significant resource implications for the Trust, particularly as the process expands to every non-coronial death in NHS Wales and the Health Boards (who are at different levels of maturity regarding mortality reviews) start to develop and embed their processes.

68 The WAST Framework (adopting the All-Wales Mortality Framework) has been developed in consultation with NHS Wales Delivery Unit (DU) and was approved in September 2022 by the Clinical Quality Governance Group. The WAST Framework has been shared with the NHS Wales Delivery Unit who advise that a summary of the process in WAST will be included in the next iteration of the All-Wales Framework.

69 To date the Trust has not received a referral from the ME Service to undertake a level 2 Mortality Review. The Trust continue to provide information to inform ME Level 1 reviews as requested.

70 The Trust has representation on the All-Wales Mortality Group which meets on a monthly basis.

Organisational Learning

71 Organisational learning occurs through several routes. Examples of learning and improvement actions are detailed throughout this section. The Patient Safety Team is currently looking to develop an Organisation Learning Bulletin which would include inputs from all services and will be reviewed at the Patient Safety Learning from Events Monitoring Group.

Clinical Notices issued October:

(i) CN 33/2022 Clinical Response Model MPDS Categorisation Update
(ii) CN 34/2022 Class 2 Medicines Recall-Amiodarone Hydrochloride for Solution 50mg/ml (150mg/3ml) concentrate for solution for Injection/Infusion
(iii) CN 35/2022: Ambulance Service Indicators - STEMI

Clinical Notices Issued November:

(i) CN 36/2022 Procheck Advance Blood Glucose Meter
(ii) CN 37/2022 Unauthorised Access to Clinical Records
(iii) CN 38/2022 Non-Injury Fallers Pathway
(iv) CN 39/2022 Glan Clwyd Paramedic - SDEC Referral Pathway Update
(v) CN 40/2022 Airway Log Compliance
(vi) CN 41/2022 Vascular Pathway

Clinical Notices Issued December:

(i) CN 42/2022 Same Day Emergency Care Services (Surgical Only) Available in University Hospital Wales, CVUHB
(ii) CN 43/2022 Same Day Emergency Care Services Available in Morriston, SBUHB
(iii) CN 44/2022 SBCPT - HCPC Statement
(iv) CN 45/2022 Airway Log Compliance

Learning from Clinical Reviews by Health Board Area:

Clinical Reviews by Health Board October to December 22	No.	Brief Description of Review	Themes	Learning Opportunities and Improvements
Aneurin Bevan	9	• Review of care provided at CA following birth, patient deceased. Supporting WAST staff due to their high-quality clinical care during incident. • Patient concealed pregnancy, breach birth and born with cord around neck. Did not respond to the care of the new-born treatment. Patient successfully resuscitated and clinical care to mother also. • Patient RED call for ineffective breathing, refused to travel and second call 7 days later patient conveyed and died in hospital. • 999 call following fall and head injury, later died in hospital. Family complained they weren't listened to and didn't document the injuries. PCR very clear documentation • Fall in care home with no obvious injuries and treated at scene. Later died that week from ICH. Supporting crew involved as no indication of time given • Review of clinical care given following symptoms of CVA and delay in RRV response. Crew supported and followed pathway. • Concern received for clinical care provided to individual who passed away. Crew being supported for appropriate care in line with ePCR. Clear documentation of decision making	• Cardiac Arrest • Child born in the community • RTT • Clinical Management • Patient treated in the community with HI • Clinical care of CVA • Clinical care of SOB and hypoglycaemia. • Delayed response	• Continued staff support following traumatic incidents • Patient advise around conveyance and seeking help • Patient family communication • Treatment in the community setting and follow up • Good application of pathway • Ongoing support of staff welfare

		• Delayed response and family question care provided. No issues identified with clinical care • Escalation of a deteriorating patient	• Handover delays • Lack of poor observations • Poor documentation	• Timeliness of resources • Improved ePCR completion
Betsi Cadwaladr	2	• Patient disposition with primary care colleagues • Collective failures in recording of continuous observations, escalating concerns to NIC alongside on vehicle triage by ED doctor, not fully comprehensive in asking for current observations	• Communication • Patient Pathways • Handover delays • Failure to examine patient adequately • Lack of observations	• Identification of alternative pathways • Patient disposition options for EMS staff • Handover delays • Reg 28 escalation of a deteriorating patient
Cardiff and Vale	5	• Paediatric patient deemed appropriate for GP referral due to observations however parent was unhappy with decision and requested to be taken to A&E which was accommodated. When admitted, issued with an inhaler and prescribed an inhaler in ED. Concerns raised around crew decision making. • Patient had a DNACPR and an advanced directive which included no invasive procedures. Paramedic discussed with patient's GP and palliative team who agreed with the decision to leave the patient at home. • Poor ePCR completion with failure to identify and highlight high NEWS score. There was no escalation of deteriorating patient	• Decision making • Poor documentation • Decision making • Poor documentation • Identification and escalation of deteriorating patient	• Improved decision making • Improved ePCR completion • Good decision making • Revisiting ePCR training • Managing a deteriorating patient • Pre-alert guidance

		• Baby passed away following Mum haemorrhaging at 36 wks. Concern around timings of the crew leaving the property and transfer to hospital. • Paramedic attended patient at a care home whose GP had advised admission due to lacking capacity and concern for mental health. Paramedic states patient had capacity and refused admission. No safety netting completed by paramedic, he advised to recall GP if patient worsened and gave recall advise.	• Communication with family during treatment • Mental Capacity Act protocol • Safety Netting	• No clinical concerns around treatment provided, this was confirmed by maternity colleagues. • Mental Capacity Act refresher and consent to be completed, WAST on-click MCA package to be completed.
Cwm Taf	4	• 16 hour wait in ED and concern raised regarding pressure area development. PCR review demonstrated good assessment of patient by crew. • Inadequate assessment of patient • Mental capacity act assessment of patient • Practice review to scope WAST contact with patient	• Pressure damage • Patient assessment • Mental Capacity Act • Safeguarding • Poor documentation;	• Demonstration of pressure ulcer awareness • Appropriateness of assessment • Refresher of Safeguarding guidance • Improved ePCR completion
Hywel Dda	1	• Endotracheal intubation of patient not in cardiac arrest	• Alternative management of airway	• Airway management guidance
Powys	1	• Attending paramedic missed STEMI on 12 lead ECG and treated patient for acute asthma attack with IM adrenaline administered by student	• Failure to identify STEMI • Poor documentation	• Improved ECG assessment • Reflective practice • Responsibilities as a PPEd • Review of patient disposition

		paramedic (under instruction of paramedic). EMRTS supported crew and raised concern.	• Student's scope of practice and guidance from experienced staff	• ePCR refresher
Swansea Bay	4	• Paramedic attended a patient who had fallen many hours before and had been put back to bed. Call was for head injury. Paramedic attended and discussed head injury with GP and left patient at care home. Call next day to say patient couldn't wait-bare. Patient found to have sustained a #NOF	• Assessment	• ePCR completion • Patient assessment post injury
		• EMRTS raised concern surrounding paramedic attempting intubation on a patient making respiratory effort	• Airway management	• Application of airway management guidance
		• Wrong drug administered	• Drug administration error	• Opportunity to revisit 6 rights of drug administration
		• Not thoroughly checking the name on a DNACPR	• Poor attention to detail	• Need to thoroughly check patient information

Welsh Risk Pool Learning from Events Reports

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

Call Handlers	Dispatchers
Solo response	Management of calls along Trust borders
Estimated time of Arrival	Place of safety
111 calls no address available	Escalating calls after resources have arrived and cleared scene
Care and nursing home	Clinical Safety Plan v2.1; dispatcher ring backs
Tourniquet	Clinical Safety Plan v2.1; duplicate call management
	Clinical Safety Plan v2.1; can't send for calls suitable for 111 & CSD
	P2 back-up takes priority over Amber1 calls
	Rest break management
	Defibrillator allocation
	Duplicate call process when Red call received
	Level 2 falls responders – Red calls

73 Focused audits have been undertaken on the following topics:

(i) Tourniquet use
(ii) Ineffective breathing protocol 6

Next steps

74 Developments/considerations for this report include:

- Further development of patient safety metrics and a workshop is planned in quarter 4
- Information breakdown of data at service level i.e., Ambulance Care, Emergency Medical Services & 111 (appendices)
- Continue to identify themes and trends to improve organisational learning, patient safety and experience

AGENDA ITEM No	**8**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**4**

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

MEETING	Quality, Patient Experience & Safety Committee
DATE	9th February 2023
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Julie Boalch, Head of Risk, Deputy Board Secretary
CONTACT	Julie.Boalch@wales.nhs.uk

EXECUTIVE SUMMARY

1. The purpose of the report is to provide assurance in respect of the management of the Trust's principal risks, specifically the 2 risks that are relevant to Committee's remit.

2. A summary of these risks is set out in Annex 1 with a detailed description contained within the Board Assurance Framework (BAF) in Annex 2.

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

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

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

RECOMMENDATION:

6. **Members are asked to consider the contents of the report and:**
   a. **Discuss the risks relevant to Committee.**
   b. **Review the Board Assurance Framework.**

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

REPORT APPROVAL ROUTE
7. The report has been considered by: • ADLT – 12th December 2023 • ADLT – 9th January 2023 • EMT – 18th January 2023 • Trust Board – 26th January 2023

REPORT ANNEXES
• SBAR report. • 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

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

SITUATION

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

2. A summary report describing the principal risks as of 17th January 2023 is detailed in Annex 1 as an extract from the Corporate Risk Register (CRR).

3. The risk owners continue to update progress against the Corporate Risks in accordance with the review schedule and agreed governance routes set in the reporting cycle approved by Audit Committee. This means the highest scoring risks are reviewed monthly; however, given current operational pressures including Industrial Action, several updates have been received post their formal review date and these will be included in the January reviews and reported through February and March 2023.

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

BACKGROUND

5. The Board Assurance Framework provides Members with an opportunity to review the controls in place against each principal risk and the assurance provided against those control where applicable. This will assist Members in evaluating current risk ratings.

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

ASSESSMENT

7. There are currently 17 Corporate Risks on the register, 2 of which are assigned to QuEST for oversight, and these are described in the summary table in Annex 1. The table sets out the rearticulation of each of the Corporate Risks including titles and summary descriptions, utilising an '*if, then, resulting in*' approach, the Executive Owner of the Risk and the Risk score with any changes that have occurred during the period.

8. The EMT has approved the risks contained within this paper and these were presented to Trust Board in January 2023.

Corporate Risks

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

10. In addition, Members are asked to note that the actions, which were contained in the July 2022 Board paper on avoidable harm and outlined at the last meeting, are included in the action section of the BAF for the Trust's highest scoring risks 223 and 224 which are both rated 25. These actions seek to mitigate in real time, avoidable harm in the context of extreme and sustained pressure across the urgent and emergency care service.

Closure and De-Escalation of Risks

11. No risks relevant to QuEST have been closed during the period.

Transfer of Risks

12. No risks have transferred between Directorates or Committees during this reporting period.

Changes to Risk Scores

13. There have been no changes to the risk scores since the last meeting in November 2022.

Further Review of Risks

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

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

RECOMMENDED:

15. **Members are asked to consider and discuss the contents of the report and:**
    a. **Discuss the risks relevant to Committee.**
    b. **Review the Board Assurance Framework.**

Annex 1 – Corporate Risk Register Summary

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

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

Annex 3 - 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:	13/01/2023	TREND	25 (5x5)
		Date of Next Review:	13/02/2023	➡	

IF	THEN	RESULTING IN		Likelihood	Consequence	Score
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	Inherent	4	5	20
			Current	5	5	25
			Target	2	5	10

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

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

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

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	13/01/2023	TREND	25 (5x5)
		Date of Next Review:	13/02/2023		

IF significant internal and external system pressures continue	THEN there is a risk of an inability and/or a delay in ambulances reaching patients in the community	RESULTING IN patient harm and death		Likelihood	Consequence	Score
			Inherent	4	5	20
			Current	5	5	25
			Target	2	5	10

19. Conveyance Reduction	19. This is part of the weekly performance review and aligned to Care Closer to Home Programme
20. Access to Same Day Emergency Care (SDEC) for paramedic referrals	20. This forms part of the handover improvement plans in place with Health Boards
21. Mental Health Practitioners in cars	21. Part of the Care Closer to Home workstream
22. Roll out of ECNS	22. Reported through QuEST
23. Clinical Model and clinical review of code sets	23. Reported through QuEST
24. Remote Clinical Support Strategy	24. Strategic Transformation Board – IMTP deliverable
25. Trust Board paper (28/07/22) detailing actions being taken to mitigate the risks (see actions section for details of specific work streams being progressed to mitigate this risk)	25. Formally documented action plan – actions captured are contained within and monitored via the Performance Improvement Plan (PIP)
26. Information sharing	26. Information Sharing: Patient Safety Reports, Chief Operating Officer (COO) Data Pack, Immediate Release Declined (IRD) Reports.
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Acknowledgement and acceptance of risk by Health Boards and balancing the risks across the whole system	None immediately identified but subject to continual review
2. Blockages in system e.g. internal capacity within Health Boards which affect patient flow	
3. Covid capacity streaming	
4. Transition Plan/Inverted Triangle – bid for transition plan has been put in and is now subject to funding	
5. Local delivery units mirroring WAST ODU	
6. Handover delays link to risk 224	
7. Tolerance in Health Boards has become the norm. As delays have increased, there appears to be no visible appetite to address these issues	
8. There is an ambition that no handover should exceed 4 hours and for lost hours to handover to be reduced by 25% but given the track record over last 6 months there is a low confidence in attaining this.	
9. Outputs from the NHS System Reset – it is a closer collaboration to address some of the system blockages and reduce system pressures. This is the aspiration	
Please note that the gaps listed are not WAST's and are therefore outside of the control of WAST	

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Exploring Rural model options (Paused during Pandemic Response) – subject to funding through IMTP. Now refreshed to wider rural model opportunities to include recruitment of CFRs. Additional funding has been sourced to increase posts within the volunteer function.	Assistant Director of Operations EMS / Assistant Director of Operations – National Operations & Support	31.12.22	Rural model options are being explored. Discussions have been opened up with one workshop held another scheduled for 28th October 2022 with the aim of producing a set of recommendations for consideration by SLT and EMT.
2. Leading Change Together (forum to progress workforce related work streams jointly with TUPs)	ADLT Sub-Group	30.09.22 - Paused	
3. EMS Demand & Capacity i.e. review and implementation of new EMS rosters	Assistant Director of Operations EMS	Extended from 30.09.22 to 31.12.22	On schedule to implement all EA and UCS rosters by the end of November 2022. CHARU rosters may drift into December 2022 due to recruitment and training.
4. Transition arrangements post pandemic	Executive Pandemic Team / Assistant Director of Strategic Planning (BCRT Chair)	Complete 30/08/22	Transition complete
5. Recruit and train more Advanced Paramedic Practitioners – Value Based Healthcare Fund bid for up to 50 WTE (I)	TBA	TBA	

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	13/01/2023	TREND	25 (5x5)
		Date of Next Review:	13/02/2023		

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

[Source: Action Plan presented to Trust Board 28/07/22]			
6. Maximise the opportunity from Consult and Close – stretch to 15% and beyond (I) [Source: Action Plan presented to Trust Board 28/07/22]	Assistant Director of Operations, Integrated Care	31.12.22	Work undertaken to map influences and progress towards each. Trajectory cast until December 2022 - 15% to be achieved through efficiencies.
7. 24/7 operational oversight by ODU with dynamic CSP review and system escalation as required (I) [Source: Action Plan presented to Trust Board 28/07/22]	Assistant Director of Operations, National Operations & Support	Complete	System in place and ongoing.
8. Weekly REAP review by senior Operations Directorate team with assessment of action compliance (I) Source: Action Plan presented to Trust Board 28/07/22]	Director of Operations / Operations Senior Leadership Team	Complete	In place and ongoing - Weekly Performance Meetings occur every Tuesday lunchtime to review performance, etc and determine REAP level.
9. Recruitment and deployment of new CFRs (I) [Source: Action Plan presented to Trust Board 28/07/22]	Assistant Director of Operations, National Operations & Support / National Volunteer Manager	Ongoing	Additional CFR Trainers and Operations Assistants appointed to support recruitment and training of new CFRs. Volunteer Management Team, supported by the Volunteer Steering Group, now embarking on volunteer recruitment programme and increasing public engagement to raise awareness about volunteering opportunities available within WAST.
10. Transition Plan (I) [Source: Action Plan presented to Trust Board 28/07/22]			
11. Overnight Falls Service extension (I) [Source: Action Plan presented to Trust Board 28/07/22]	Assistant Director of Quality & Governance / Head of Quality Improvement	TBA	Level 2 Falls Service implemented as a pilot. Awaiting evaluation of the pilot and assessment of outcomes and potential longevity of this initiative.
12. External Controls detailed within the Action Plan presented to Trust Board on 28/07/22: a. Audit Wales's investigation of Urgent and Emergency Care System. Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time? (E) b. Consideration of additional WAST schemes to support risk mitigation through winter (I) c. NHS Wales educes emergency department handover lost hours by 25% (E) d. NHS Wales eradicates all emergency department handover delays in excess of 4 hours (E) e. Alterative capacity equivalent to 1000 beds (E) f. Implement nationwide approach to emergency department 'Fit 2 Sit' (E) g. Implementation of Same Day Emergency Care services in each Health Board (E) h. National Six Goals programme for Urgent and Emergency Car (E)			

Risk ID 224	Significant Handover of Care Delays Outside Accident and Emergency Departments Impacts on Access to Definitive Care Being Delayed and Affects the Trust's Ability to Provide a Safe & Effective Service for Patients	Date of Review:	09/01/2023	TREND	25 (5x5)
		Date of Next Review:	09/02/2023	➡	

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

IMTP Deliverable Numbers: 7,9, 10, 11, 12, 13, 14, 15, 16, 23, 24, 25, 26, 33, 35

EXECUTIVE OWNER	Director of Quality & Nursing	ASSURANCE COMMITTEE	Quality, Safety and Patient Experience Committee

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. WAST Serious Clinical Incident Forum (SCIF) is in place to discuss patient safety incidents, learning and improvement actions to prevent future harm, working in collaboration with Health Boards / NHS Wales Delivery Unit under the Joint Investigation Framework which is currently in pilot phase and an evaluation is to be undertaken in quarter 4 2023.	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 – the pilot has commenced, and the next meeting is due to be held on 25.01.2023.To date the pilot is working well with good engagement from health board colleagues.
3. WAST and system compliance with National Standards - 15-minute handover (NHS Wales Hospital Handover Guidance v2 (May 2016)	3. Monthly Integrated Quality and Performance Report, Health Informatics reports, APP dashboard monitors, reports on app use by Consultant Connect and shared at local and corporate meetings regarding patient safety and handover of care position across NHS Wales and NHS England.
4. WAST Clinical Notice in place - Escalating a clinical concern with a deteriorating patient outside the Emergency Department (11.02.2021). National Early Warning Score (NEWS) trigger of 5 or above for escalation to hospital clinicians. NEWS data available via EPCR (electronic patient care record).	4. NEWS data now available via ePCR and escalation system in place. Learning from incident reporting processes.
5. Workstreams put in place to meet requirements of *Right care, right place, first time Six Goals for Urgent and Emergency Care A policy handbook 2021–2026.* Goal 4 incorporates the reduction of handover of care delays through collective system partnership. WAST membership at system workshops supported by Commissioners looking at handover of care delays which includes the implementation of the Fit2Sit programme and handover of care checklist pan NHS Wales. Learning from NWAS shared that indicates up to 20% of ambulance arrivals may be suitable for Fit 2 Sit Additionally, the Emergency Ambulance Services Committee (EASC) have stated that no delay should exceed 4 hours.	5. Monthly Integrated Quality and Performance Report
6. Hospital Ambulance Liaison Officer (HALO) (Some health Boards).	6. Patient Flow Coordinators (PFCs) are a commissioned service by the Health Board (x2 in ABUHB specifically for GUH) with a bespoke job description, these link directly with the National Delivery Managers in ODU.
7. Regional Escalation Protocol and Resource Escalation Action Plan (REAP).	7. The Senior Leadership Team convenes every Tuesday as the Weekly Performance Meeting to review performance and demand data, and review/assign REAP Levels as appropriate. Dynamic escalation via Strategic Command structure.
8. Staff from WAST, Health Boards and third sector organisations assisting to meet patient's Fundamentals of Care as best they can in the circumstances.	8. Confirmed through Healthcare Inspectorate Wales (HIW) workshops and Health & Care Standards self-assessment process
9. 24/7 Operational Delivery Unit (ODU) escalating handover delays / patient condition to Health Board colleagues.	9. Shift reports from ODU & ODU Dashboard received by 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
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.
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. Integrated Quality and Performance Report (November 2022 overall 85% mandatory training target met)
13. Clinical audit programme in place.	13. Clinical audit programme with oversight from the Clinical Quality Governance Group and QuEST.

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:	09/01/2023	TREND	25 (5x5)
		Date of Next Review:	09/02/2023	➡	

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**

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. Evidence submission to Senedd Health and Social Care Committee. Written evidence submitted during Q4 21/22 to the committee to assist their inquiry into Hospital Discharge and its impact on patient flow through hospitals Report published in June 2022 containing 25 recommendations with recommendation six specifically WAST related stating "The Welsh Government should explain how the targets outlined in the Minister for Health and Social Service's statement of 19 May 2022 on urgent and emergency care and the Six Goals Programme to eradicate ambulance patient handover delays of more than four hours and reduce the average ambulance time lost per arrival by 25 per cent (from the October 2021 level) have been set. It should also confirm the target dates for the achievement of these targets."	15. Monthly Integrated Quality and Performance Report, CEO Reports to Trust Board (including 'Actions to Mitigate Avoidable Patient Harm Report') and Board sub-committee oversight and escalation.
	External Sources of Assurance **Management (1st Line of Assurance)**
	1. Monitoring and oversight of the Ambulance Quality Indicators (AQIs) including handover of care timeliness and Commissioning Framework by the Chief Ambulance Services Commissioner (CASC) and Joint Executive Team meeting Welsh Government (I&E).
	2. Healthcare Inspectorate Wales (HIW) 'Review of Patient Safety, Privacy, Dignity and Experience whilst waiting in Ambulances during Delayed Handover' Report and system wide improvement plan with working group in place with WAST senior representation. Oversight by HIW and CASC
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Patient safety reporting and escalation through the Serious Clinical Incident Panel (SCIF), Patient Safety Highlight Reports, Health Board specific reports in place with escalation through WAST governance framework.	1. Strengthen and triangulate patient safety metrics and look back data at ED, service and corporate level for baseline data for improvement projects and WAST reports.
2. Inconsistent review of potentially serious / catastrophic patient safety incidents in line with the Framework for the Investigation of Patient Safety Serious Incidents (SIs) V2.2, dated July 2019 (frequently referenced as 'Appendix B' Reports) by Health Boards pan NHS Wales and lack of ownership of system risks. Lack of whole system approach to handling patient safety incidents resulting from system pressures*.	2. Implementation of revised process, engagement and outcome and improvement measures at system level – early work commenced with the pilot in progress of the Joint Investigation Framework.
3. Lack of implementation and holding to account regarding the NHS Wales of the Handover Guidance v2 and recognition of the patient safety risks pan NHS Wales*.	3. 15-minute handover target is not being achieved pan-Wales consistently and has led to a substantial growth in emergency ambulance handover lost hours from c6000 hours per month at the end of 2018 to in excess of 28,038 hours in October 2022. This scale of lost emergency ambulance capacity has peaked at 30% per month of the entire emergency ambulance fleet in October 2022.
4. Variation in responsiveness at Emergency Departments to the escalating concerns regarding patients' NEWS*.	4. Strengthening of patient safety reports and audit processes as system embeds.
5. (a) Variation in appetite across the Health Boards to implement Fit2Sit, citing overcrowded emergency department waiting rooms as the reason. Limited confidence in system engagement to address Goal 4 and achieve reduction in handover delays*. 5. (b) Protracted timescales in the Right care, right place, first time Six Goals for Urgent and Emergency Care - A policy handbook 2021–2026. Goal 4 'Improving ambulance patient handover, ensuring no one arriving by ambulance at an Emergency Department waits more than 60 minutes from arrival to handover to a clinician – by the end of April 2025. The number of people waiting over this period for ambulance patient handover will reduce on an annual basis until that point'. No detail on incremental improvements required at emergency department level or oversight mechanisms. EASC have stated that no delay should exceed 4 hours although WAST is yet to see any demonstrable plans to support this*.	5. 15-minute handover target is not being achieved pan-Wales consistently.

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:	09/01/2023	TREND	25 (5x5)
		Date of Next Review:	09/02/2023	➡	

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. Variation pan Wales / England as position not implemented across all emergency departments*.	6.
7.	7.
8. Variation pan Wales / England as position not implemented across all emergency departments*.	8. Health & Care Standards self – assessment in progress.
9. Variable response pan Wales / England. WAST have minimal control on this at patient level*.	9.
10.	10.
11. Variable response pan Wales / England. WAST have minimal control on this at patient level*.	11.
12.	12.
13. Transition to ePCR impacting on data temporarily	13.
14. National steer required to confirm the accountability arrangements regarding patients in ambulances outside of the emergency departments. The seven Local Health Boards (LHBs) in Wales are responsible for planning and securing delivery of primary, community, secondary care services, and also the specialist services for their areas*.	14. HIW approve and sign off WAST elements of recommendations.
15.	15.
	External Gaps in Assurance 1. Lack of escalation and response to AQIs by the wider urgent care system and regulators
	2. Lack of collective system response to HIW 'Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover' Report. Meetings cancelled x 2 in May 2022. WAST has representation on the working group*

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Right care, right place, first time Six Goals for Urgent and Emergency Care A policy handbook 2021–2026 – Goal 4: Rapid response in physical or mental health crisis.	CEO	• Checkpoint Q4 2022/23	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 will be represented on the Clinical Reference Group by the Director of Paramedicine (not yet established though or invite not received). • The Trust is also working with the National Collaborative Commissioning Unit to develop integrated commissioning action plans in each Health Board which will support the ambitions within the Six Goals programme, particularly, goal 4 "Rapid response in a physical or mental health crisis". The Trust has also mapped the interactions nationally and locally into the Six Goals Programme, with updates brought via the Integrated Strategic Planning Group to Strategic Transformation Board to consider impact for WAST strategic planning.
2. Handover checklist implementation – Nationally WAST Quality Improvement (QI) Project	WAST QI Team (QSPE)	• Checkpoint Q4 2022/23	Timeframes awaited via Emergency Department Quality & Delivery Framework (EDQDF)
3. Implement nationwide approach to emergency department 'Fit 2 Sit'	CMO/CNO	• Checkpoint Q4 2022/23	Acceptance at meeting of Chairs and CEOs led by JP

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			on 8/6/2022 that a national approach to Fit 2 Sit should be adopted. Learning from NWAS shared that indicates up to 20% of ambulance arrivals may be suitable for Fit 2 Sit. Meetings brokered by National Collaborative Commissioning Unit. Attendance at meetings often in excess of 50 attendees. WAST proposed clinician guidance document circulated to all health boards. Challenges around universal patient criteria. Challenges around rapid handover with patient booking self in. Challenges within some hospitals in infrastructure to host monitored area of fit2sit patients. Fit to Sit SBAR (6 September 2022) sent to the Trust from the NCCU. To be discussed at the next IQPD meeting to focus on the variation in practice being seen. More data identified as a key area for development before an evaluation can take place. Commitment to no >4 hour waits and a reduction in 25% overall. These have not yet had any impact in most areas.
4. Implement patient safety dashboards (live and look back data) triangulating quality metrics / KPIs and performance data sourcing health informatics resource.	Assistant Director of Quality & Nursing	• Checkpoint Q4 2022/23	Incremental improvements to quality and safety data and information to enable triangulation. Access to ePCR data (NEWS) now available.
5. Continued Health Board interactions – my next patient, patient safety team dialogue – proactive conversations with Health Board Directors of Quality & Nursing.	Executive Director of Quality & Nursing	• Monthly • Checkpoint Q4 2022/23	Monthly meetings continue to be held and the content of the health board reports are currently under review.
6. HIW Improvement Plan / Workshop– WAST inputs / influencing improvements Response and improvement actions to Healthcare Inspectorate Wales Inspection report (2021) 'Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover' which links to Fundamentals of Care.	Assistant Director of Quality & Nursing	• August 2022 in progress • Checkpoint Q4 2022/23	
7. Participation in the CASC led workshop to reform *the Framework for the Investigation of Patient Safety Serious Incidents (SIs) V2.2, dated July 2019*.	Executive Director of Quality & Nursing	• Checkpoint post pilot Q4 2022/23	Revised joint investigation approach agreed which is to be piloted from November 2022.
8. Recruit additional frontline capacity – additional £3m non recurrent 22/23 allocation	Director of Workforce & Organisational Development	• Q4 2022/23	Good progress with pilot of payment of the C1 license proved a positive move. Over 370 new starters recruited this year. 60 of the 100 will be operational on 23.0123 with 30 more operational at the end of Feb. 99.5% of the establishment of 1761 will be in post at the end of March. Higher attrition that forecast was experienced at the end of 2022.
9. Recruit and train more Advanced Paramedic Practitioners – Value Based Healthcare Fund bid for up to 50 WTE	Director of Paramedicine	• Checkpoint Q4 2023/24	Bid not successful. Feedback received from Welsh Government that will be incorporated into future bids. However, Trust decision to proceed with 18 MSC places. 10 started in September (North) with the balance (eight) on target for March 2023 start.

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			• RAG status reframed around the new timelines / programme
10. Senior system influencing	Trust Chair Chief Executive Officer	• Checkpoint Q4 2022/23	CEO and Directors have ensured that system safety and avoidable harm remain a live topic of discussion in all relevant fora e.g. recent paper provided by EDQNs to CEOs on pressures and risk. Continue to seize opportunities as they emerge that can contribute to mitigating avoidable harm, with potential CEO summit to be arranged following recent meeting with Minister.
11. Emergency Department cohorting	Director of Operations	• Closed	Evaluation of cohorting has been completed and as a result, there has been an agreement to terminate these arrangements in Morriston and GUH.
12. Transition Plan	Chief Executive Officer	• Checkpoint Q4 2022/23	Formally submitted to Commissioners in December 2021. As above +100 FTEs secured although nonrecurring at this point in time. Also, funding for additional APPs not secured via Value Based Healthcare fund; however, decision of Trust to proceed with take up of 18 MSC places anyway. Further discussions with funders as part of IMTP 2023-2026 required and also possible rebasing of EMS Demand & Capacity Review with increased system pressures built in, during 2023. This is now a required action with terms of reference to be developed.
13. Overnight falls service extension	Executive Director of Quality & Nursing	• Scheme extension agreed to 31 March 2023 • Checkpoint Q4 2022/23	A Falls Utilisation Task and Finish Group has been set up. Aim to achieve 60% utilisation of Falls Assistant resources, by December 2022 and achieve consistent utilisation of 60% + through January-March 2023. Utilisation was 58% in August and September 2022 and 65% in October 2022, demonstrating an increase of 7% in utilisation. Current utilisation for the night vehicles for November (up to 13th) is 64%. 117 incidents were attended in September compared to 158 incidents in October 2022. Additional 'ideal code set' identified though Utilisation Task & Finish group and approved by CPAS, which went live 08 November 2022. Anticipated to support sustained improved utilisation. The Trust now has 6 ideal code sets. Falls level 1 and 2 impact evaluation report well underway, anticipated to be available for end of November 2022.

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14. Audit Wales investigation of Urgent and Emergency Care System: Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time?	Chief Executive Officer	• Checkpoint Q142023/2024	Conducted in three phases over the next 6 to 9 months Audit Wales will independently investigate and report on patient flow out of hospital; access to unscheduled care services and national arrangements (structure, governance and support) WAST will proactively support this work and offer best practice examples from other jurisdictions that can support benchmarking and improvement activities Audit Wales updated the Audit Committee on the Review of Unscheduled Care work they are undertaking at its meeting on 15 September 2022.
15. Consideration of additional WAST schemes to support overall risk mitigation through winter	Director of Operations	• Checkpoint Q4 2022/23	Winter modelling complete and being reported to Welsh Government via Joint Executive Team meeting (16 November 2022). Winter schemes identified and funded e.g. additional UCS, additional overtime etc. Performance Improvement Plan (the Trust's rolling tactical seasonal plan up to date). Good progress on Performance Improvement Plan (and associated schemes). Winter event undertaken 16 November 2022. Specific seasonal structures (business continuity) approved and currently being enacted.
16. National 111 awareness campaign	Director of Partnerships and Engagement Director of Digital	• Checkpoint Q4 2022/23	National public awareness campaign funded by Welsh Government to promote appropriate use of services (111 as an alternative to 999/ED where appropriate) Upgrade to 111 website and symptom checkers also underway
17. 24/7 Operational oversight by ODU with dynamic review and system escalation as required	Director of Operations	• Checkpoint Q4 2022/23	Realtime management and escalation of risks and harm with system partners Triggering and escalation levels within Clinical Safety Plan 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.
18. Implementation of Same Day Emergency Care (SDEC) services in each Health Board	NHS Wales Health Boards	• Checkpoint Q4 2022/23	Welsh Government funding provided to each Health Board to implement SDEC WAST has nationally agreed referral rights to these services enabling us to avoid the emergency department with suitable patients SDEC Implementation: four sites live in Hywel Dda and one in Betsi Cadwaldr. Expectation is at least one per health board, 12 hours a day seven days a week. Ongoing discussions with other Health Board to agree implementation plan.

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Welsh Government has asked the Trust to forecast the level of patient flow into the existing and proposed SDECs, which may be lower than anticipated.
Also, the Forecasting & Modelling Group is planning to model the impact of SDECs, which again may be lower than anticipated.

IMTP Deliverable Key

No.	IMTP Deliverable
1	We will recover our systems of working and implement new ways of working developed during the pandemic as we learn to live with COVID-19
2	We will engage with a range of stakeholders, developing genuine Pan-Wales representation on partnership structures and delivering strong political and media relationships across the spectrum
3	We will develop and deliver a collaborative programme of work to design and implement new models within EMS (Inverting the Triangles)
4	We will work with partners to promote and expand use of 111 across Wales
5	We will increase the capacity and capability of the clinical teams for 111 and 999 callers, increasing clinical information available to them and we will create one integrated national team
6	We will work with partners to increase the number of seamless 24/7 pathways from the 111 clinical team to appropriate face to face consultations
7	We will take steps to continuously improve the safety and quality of the service and provide an improved patient experience
8	We will increase accessibility, content and user experience of the 111 Digital front end, which can offer increasingly personalised advice
9	We will increase and balance response capacity and capability across urban and rural area of Wales
10	We will increase skill levels and resources (information, equipment and technology) available to clinicians on scene to allow them to most effectively assess and treat patients
11	We will work with partners to increase number of seamless 24/7 referral pathways as alternatives to ED conveyance and improve hospital handover
12	We will take steps to continuously improve the safety and quality of the service and provide an improved patient experience
13	We will develop and deliver an improvement plan for NEPTS and increase capacity where required to meet demand
14	We will develop and implement with partners an-All Wales transfer and discharge service
15	We will continue to deliver against our Transport Solutions Programme to embed as a business-as-usual approach to service delivery
16	We will take steps to continuously improve the safety and quality of the service and provide an improved patient experience
17	We will improve resource availability, tackling absence and recruitment challenges to deliver improved performance
18	We will effectively manage risk, governance and compliance to promote and protect colleague and patient safety, and ensure a safe, productive and fair work environment
19	We will purposefully shape our future People and Culture Strategy to equip our people to thrive in a changing environment
20	We will foster a culture of belonging and wellbeing where our people can engage, feel supported and represented
21	We will improve access to, and availability of services via the 111 Wales website and other digital channels (NHS Wales app)
22	Improved signposting to the most appropriate service
23	Improved digital tools and services to empower our teams to do their best
24	We will use modern technology to reduce repeat tasks and improve processes
25	Standardised information architecture and common approach to data and analytics across the organisation
26	We will deliver greater insights to WAST and NHS Wales, through improved data sharing, analytics and visualisation
27	Improved resilience, flexibility and interoperability for the 999-call platform
28	We will provide an improved financial plan to support our ambitions
29	Finalise our organisational position on achieving University Trust Status (UTS) in collaboration with WG, embracing a culture of learning, research and innovation
30	We will deliver the Estates Strategic Outline Plan
31	We will implement the Environmental and Sustainability Strategy
32	Deliver the Fleet SOP
33	We will secure and implement Quality Management and control systems
No.	**IMTP Deliverable**
34	We will transform the way we work and engage with people
35	We will revisit and implement the Public Health Plan
36	We will implement the Clinical Strategy to support developments across our service ambitions
37	We will deliver a values-based approach
38	We will deliver strong risk management processes and embed a Trust-wide risk culture that embeds the principles of good governance

AGENDA ITEM No	**9**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**3**

PATIENT EXPERIENCE & COMMUNITY INVOLVEMENT QUARTER 3 REPORT (OCTOBER - DECEMBER 2022)

MEETING	Quality, Patient Experience & Safety Committee
DATE	9 February 2023
EXECUTIVE	Liam Williams, Executive Director Quality & Nursing
AUTHOR	Leanne Hawker, Head of Patient Experience & Community Involvement
CONTACT	Leanne Hawker 01792 311773 Ext 5440 Leanne.Hawker@wales.nhs.uk

EXECUTIVE SUMMARY

1. This report presents an overview of patient experience activity across the Trust during Quarter 3, October - December 2022.

2. Community Involvement and engagement with patients/public is integrated within the Trusts ambitions in 'inverting the triangle' and delivering value-based healthcare evaluated against service users' experiences and health outcomes.

3. The work delivered by the Patient Experience & Community Involvement (PECI) Team is supporting the Trusts 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 each of our communities we serve without prejudice or discrimination.

4. As outlined in the Trusts Integrated Medium Term Plan (IMTP), the PECI Team continues to engage in an ongoing dialogue with the public on what they think are important developments the Trust could make to improve services they receive.

5. Throughout this period the Trust faced severe to extreme pressures and declared a critical incident during December.

6. The team supported the push in public messaging to promote NHS 111 Wales and its health information website. Key public health concerns were predominately driven by:

    - Respiratory issues
    - Strep A
    - Flu and
    - Covid

7. People have been encouraged to share their concerns which have mainly focused around:

    - length of wait for an emergency ambulance
    - length of wait to be answered by NHS 111 Wales
    - accessibility of information on the NHS 111 Wales website

8. The team also engaged with local communities as a response to the demands on the Trust in the provision of information on a range of other services across communities that could help when faced with a health emergency. This included:

    - Attendance at a large number of food banks
    - Engaged, listened and captured peoples feedback and experiences through face to face meetings; online events and experience surveys
    - Reported back to communities to strengthen relationships and confidence that the Trust is listening and acting to improve services.

9. The feedback captured and reported within the Highlight Report demonstrates how patient experience is a key indicator of the level of quality being provided and the need to improve patient experiences, patient safety and patient outcomes.

10. During this quarter the Trust also delivered its sixth annual Shoctober Schools Campaign with 19 schools and Restart a Heart. Evaluation Reports are attached (**Annex 2** and **Annex 3** respectively)

11. This report is predominantly created for external partners and has required Quality, Safety & Patient Experience (QuESt) Committee approval for distribution in the past. It is proposed that in future this report is approved by the Executive Director of Quality and Nursing for external distribution and shared with QuESt as a 'paper for information'. The team will then submit a separate SBAR to QuESt twice yearly outlining the work of the PECI Team in contributing to the Trusts strategic objectives and clinical transformation agenda.

RECOMMENDED: That

(1) That the Committee approve the Highlight Report for release to the NHS Wales Patient Experience Network; Welsh Ambulance Services NHS Trust People & Community Network and external stakeholders; and note and support the actions being taken forward; and
(2) That the Committee agree the proposal to receive this report for information in future and receive a six monthly SBAR focused on the Trusts strategic objectives and clinical transformation agenda.

KEY ISSUES/IMPLICATIONS

12. Themes around long waits for an emergency ambulance remains consistent along with poor experiences being shared on the impact on families where trauma and bereavement have resulted in a long wait. These experiences are well documented with plans well underway to increase capacity within the Emergency Medical Service.

13. We have also consistently heard around poor experiences of long waits on the NHS 111 Wales number with people being cut off after waiting for up to two hours. This is also exacerbated by frustrations in navigating the NHS 111 Wales website and looking for appropriate service and health information. It is clear that people are looking for easily accessible, bite sized, interactive features instead of lengthy pages of text.

14. This will require some investment in the development of the website which has been acknowledged in the Trusts IMTP 2022 - 2025 along with improving call answering and ring back times in the 111 service.

15. Following the passing of the Curriculum and Assessment (Wales) Bill in March 2021, Wales now joins England and Scotland in teaching cardiopulmonary resuscitation (CPR) and Automatic External Defibrillator (AED) awareness in secondary schools.

16. The Trust continues to be an active partner co-ordinating Restart a Heart Day in secondary schools but we are experiencing difficulties attracting volunteers to deliver the sessions. This has been noticeable since the coordination of Restart A Heart Day transferred from the Medical & Clinical Directorate to the Quality, Safety & Patient Experience Directorate in 2019 along with two years of virtual engagement due to COVID-19 and socialising restrictions. This will require further discussions going forward to increase the number of volunteers for next year.

REPORT APPROVAL ROUTE
Quality, Patient Experience & Safety Committee 9 February 2023

REPORT APPENDICES
ANNEX 1 - Patient Experience & Community Involvement (PECI) Highlight Report **ANNEX 2** - Shoctober Evaluation Report 2022 **ANNEX 3** - Restart a Heart Evaluation Report 2022

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

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
NHS Trust

Patient Experience & Community Involvement Highlight Report

October – December 2022

www.ambulance.wales.nhs.uk @WelshAmbPECI

This report is written and presented in a way that can be understood by those who use the services provided by the Welsh Ambulance Service and is shared with the general public each quarter as a way to 'tell the story' of how we are striving to improve the quality of our services and meet the publics need through a range of community involvement work and methods to collect service user feedback and experiences. Included within this report is evidence of social media activity and our involvement in public health also.

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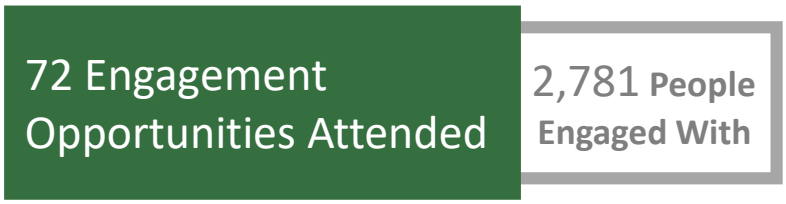
Overview

Within this reporting period, we have engaged with:



This engagement has included:

- Engaging with children and young people across Wales to raise awareness and provide skills and confidence to perform bystander CPR and defibrillation as part of our Shoctober campaign. Supporting the Out of Hospital Cardiac Arrest Plan and Save a Life Cymru objectives to improve survival rates of a cardiac arrest across Wales.

- Engagement with older people across Wales as part of local authority Ageing Well steering groups. Strengthening social partnership working and encompassing Welsh Government recommendations from the Leave No-one Behind directive, to ensure that older people can get the help and support they need and are not excluded or left behind as Wales looks towards its recovery from the coronavirus pandemic.

Patient Reported Experience Measures (PREMS)

- Your experience of calling 999 – 54 surveys completed
- Your Non-Emergency Patient Transport experience - 194 surveys completed
- Your experience of calling NHS 111 Wales - 84 surveys completed
- Your experience of calling visiting NHS 111 Wales online - 69 surveys completed

What was good?

✓ **Learning Disability E-Learning**

- *The Trust' understanding learning disability E-learning module is now active. In its first quarter it has amassed over 360 participants, with discussions ongoing to ensure it gets included in CPD days across all areas of the service. This comes alongside proposed developments to the EPCR system which will allow staff to capture more information on the reasonable adjustments that have been made for people with a Learning Disability, helping to better inform future recommendations and highlight further training needs.*

What could be improved?

✖ **NHS 111 Wales callers have reported poor experiences over the past quarter.**

- *Many people have told us that they experienced very long waits for their calls to be answered or that calls were routinely cut off before being answered. People also went on to tell us they found their call to the service 'Unhelpful' and that they had to re-contact the service at a later date for further help or advice. This feedback has been shared with the 111 team with individual responses being provided where requested explaining the high demand on the service and options available to access other sources of help in their community. Feedback continues to be used as part of ongoing improvement across the 111 service.*

Positive Experiences

Compliments

The Trust received **123** compliments between October and December 2022.

Service Area	Compliments Received
111	10
EMS Ops	99
EMS CCC	2
NEPTS Ops	9
NET Centre	1
CFR's	2

Despite the challenging backdrop of long waits in the community for help to arrive that many patients tell us they are experiencing, people continued to provide positive feedback about their interactions with our staff, their professionalism, empathy and friendliness.

"My Nan who is 88 years old dislocated her hip around midday Friday afternoon. My mother and sister contacted the emergency services and they were told that the best thing for them to do is to get her to A&E in the car. They tried to get her to the car but as you can imagine she was in excruciating pain and they failed to move her. They then phoned the emergency services around 3pm again on Friday and we were told that an ambulance will be on its way but my Nan was a low priority. My mother and sister tried to keep her comfortable through the afternoon and night but they struggled, and by the time I managed to get to my Nan's house at 9am Saturday morning my Nan was in a lot of distress and pain and my mother and sister were very upset seeing her like that.

At approximately 10am your Ambulance crew arrived, two gentlemen and one lady. I learned that they had travelled all the way from Pontypridd to my nans address in Neath. Straight away the team were very apologetic about how long we had waited, I did not prompt any discussion on waiting times, they were aware and made a point of apologising even though it's not their fault.

When the team assessed my Nan, their interaction and the way they were treating her immediately raised her spirits to a point where she went from crying in pain to having conversation and jokes with the team. The team were very professional and in a very short period of time my Nan had received pain relief and she was safely in the Ambulance ready to go to hospital.

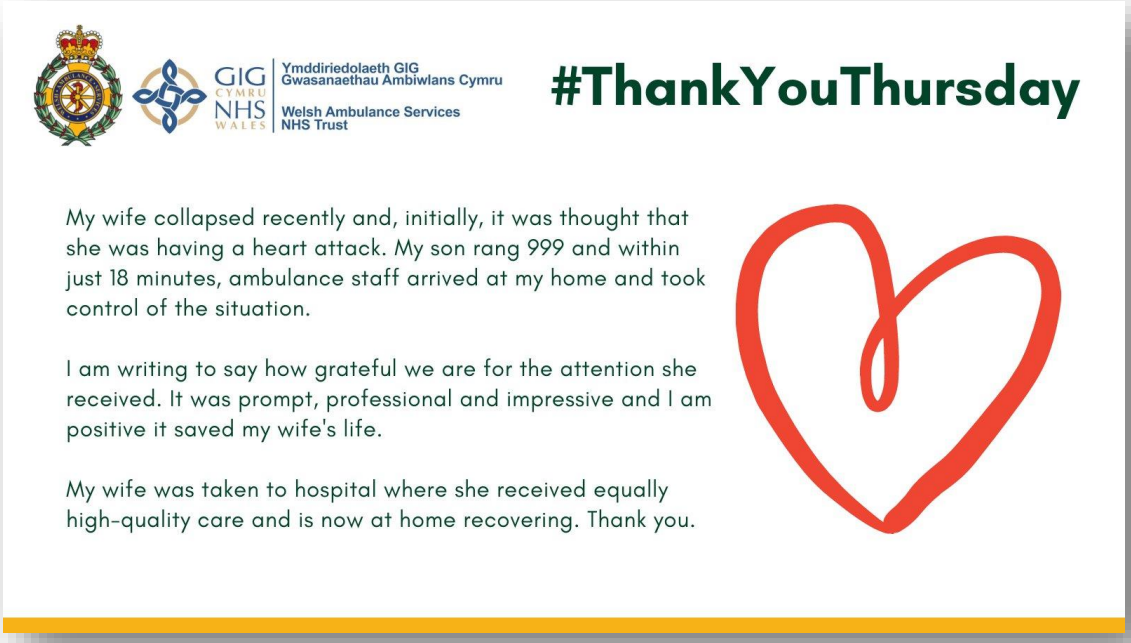
I wanted to contact you to make you aware that your Ambulance Crew managed to make a VERY BAD experience for my Nan good in the end, the way they arrived, spoke, acted, and executed their work was exemplary.

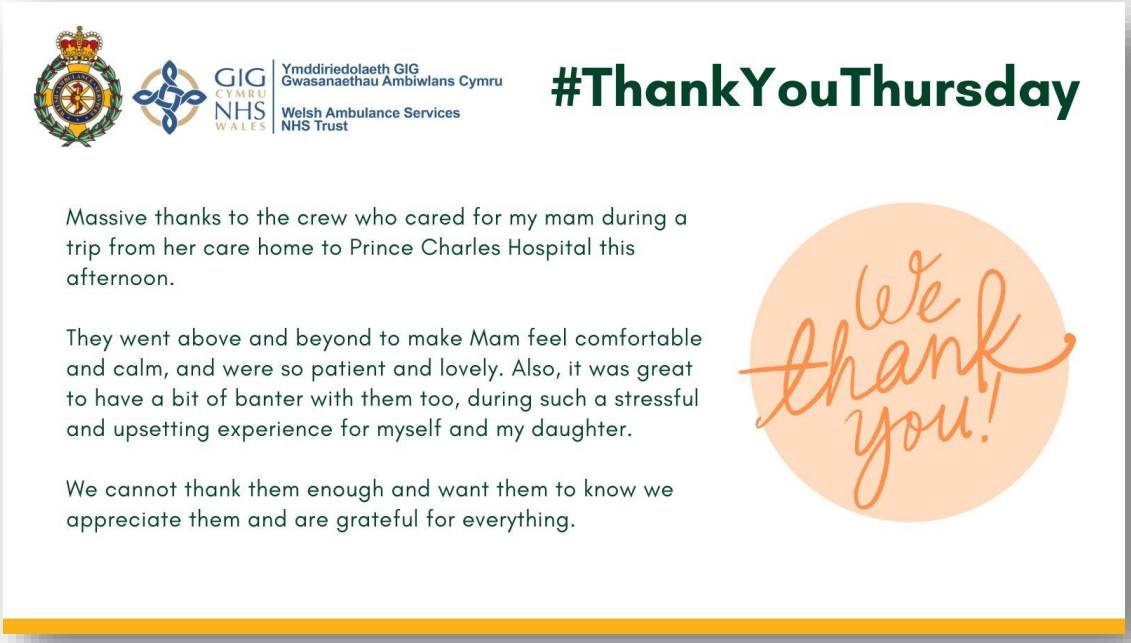
I know it is their job but, in a time where things are so bad, we need to praise and recognise the really good, and your Ambulance Crew were REALLY good"

#ThankYouThursday - Celebrating Positive Experiences

Every month we receive many letters, cards and emails from patients, service users and their families who want to say thank you for the care, support and compassion that our staff and volunteers have shown them at their time of need.

These compliments are captured, staff involved are informed and the number of compliments received is formally reported, but we wanted to do something that celebrated these positive stories a little more. Using the hashtag #ThankYouThursday, we continue to highlight one compliment a week that we share across our social media platforms, and more widely with staff inside the organisation, to draw attention to the many words of gratitude that we receive.





The Patient Story

Fiona's Story.

At the last Quality, Safety and Patient Experience Committee (QuEST) in November we shared Fiona's story. Following an incident in March 2022 Fiona made a formal complaint which was investigated through the PTR process. It concluded that Fiona's mother received the earliest possible response at the time of the 999 calls. Unfortunately, delay experienced was due to longer than expected handover times at all hospitals across the Local Health Board and a high number of 999 calls being received. This affected the Trust's ability to respond to waiting 999 calls within the community. The ensuing discussion focused on the following;

- Proposed expanding of response codes and scope of the Falls Response service in Betsi Cadwaladr University Health Board and introduction of oral paracetamol for pain relief.
- Assurance was sought that the types of issues raised in the story were being highlighted at the highest levels across NHS Wales, as it was acknowledged that such incidents are taking place regularly in all Health Board communities.
- Attention was drawn to the Board Assurance Framework which identifies steps to address The Trust's inability to reach patients in the community causing patient harm and death.
- It was acknowledged that the repetitive questioning encountered on subsequent 999 calls was a source of frustration for callers but was a necessary process to determine patient-safety.

Fiona's story has since been shared with the EMS Coordination Quality Group. Commitment to address hand over delays has been reaffirmed by the Minister through the CEO and Chair meeting on 23 June 2022.

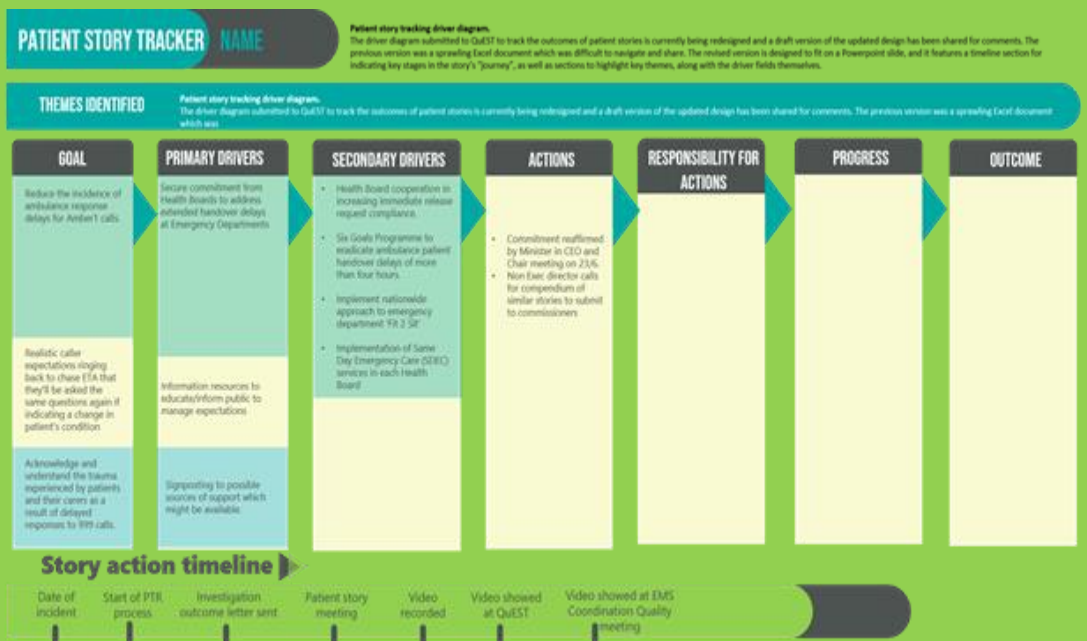
We are currently planning on creating a compendium of similar stories for further discussion with ambulance commissioners.

Patient story tracking driver diagram.

The diagram used to track outcomes of patient stories is currently being redesigned to map to relevant IMTP priorities/work-streams. This draft version has been circulated for comments. The previous diagram was presented in an excel document that was difficult to navigate and share.

The revised version is designed to fit on a PowerPoint slide.

It features a timeline for indicating key stages in the story's "journey", as well as sections to highlight key themes, along with driver fields themselves.



Engaging with Communities

Proactively engaging with people and communities across Wales is of increasing strategic importance given the ambition of the Trusts IMTP. Engaging through our continuous engagement model allows us to have meaningful conversations with people about using the services we provide; helping communities to feel listened to and empowered to drive change. It strengthens our visibility, accountability and trust with communities.

Over the past three months we have attended a range of different events and groups in the community where we've engaged with large numbers of people and have provided information about the Welsh Ambulance Service, we have gathered feedback, promoted volunteering and career opportunities and provided CPR and Defibrillator demonstrations. These have included engagements with:

- Older people's groups
- Ethnic minority communities
- LGBTQ+ groups
- Children & Young People
- Learning Disability groups and
- Food banks

BSL Law

In November we met with BDA Wales regarding Deaf access, opportunities for the Deaf community to be involved with service improvements and review plans to ensure we were adhering to the BSL Act.

The BSL Act law came into force 28th June 2022 and legally recognises BSL as a language for England, Wales, and Scotland. Under the law we are required to report on how we are promoting and facilitating the use of BSL and how we meet the needs of people who use BSL as their first or preferred language.

In previous IMTP Deaf accessibility was covered but has since been strengthened in the latest version to demonstrate what we are doing next in making our services more accessible and inclusive. This also needs to map across the work being progressed on Inverting the Triangle and all that we do. We must continue to capture accessibility issues and work on the EQIA for all new developments across the Trust.

We are expecting further guidance on the law and will continue to meet with BDA Wales on our progress.

After two years of face-to-face engagement being put on hold due to social restrictions, we were delighted to be back on the road visiting primary schools across Wales.

Now in its sixth year, with the support from 32 volunteers across 6 local health boards from across the Trust, local health boards and medical schools, we engaged with over 1,800 pupils throughout October.

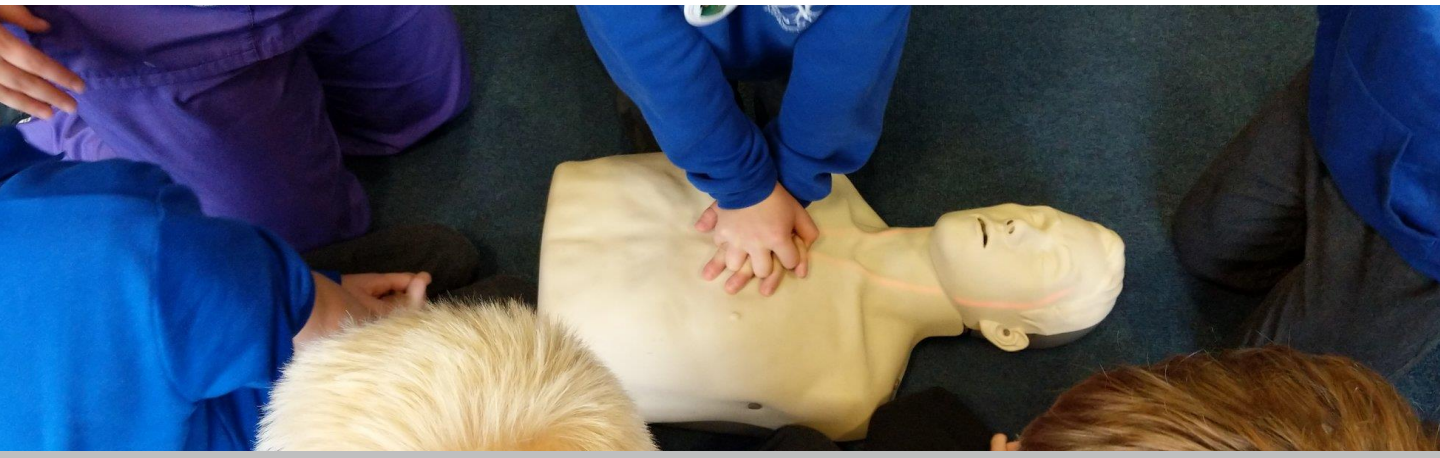
Supporting the Trust's ambition of 'inverting the triangle' by positively influencing behaviour, educating pupils about other community services and life saving skills the aim is to make them stronger adults and contribute to help build resilient communities.

To help shape next year's campaign, an evaluation survey was sent to all schools. Of the 19 schools that responded, 17 schools were confirmed that they had never previously participated. All respondents felt the sessions were delivered at the right level for pupils, various learning aids used were suitable and pupils engaged and understood what was being delivered.

This year with the support of 28 volunteers, over 2,600 secondary students at 14 schools were taught CPR and AED awareness simultaneously as part of Restart a Heart Day.

The aim is to give students the skills and confidence to act if called upon, and help towards increasing survival rates.

Based on volunteer feedback that responded to an evaluation survey (13), 62% were new volunteers to the campaign and 100% are likely to sign up next year.



Learning Disability Community

As part of the ongoing drive to promote self-advocacy, engagement and collaboration; November saw the recommencement of some of the work that was rescheduled at the start of the pandemic. The follow-on from the Easy Read 7 Important Checks leaflet began with visits to groups in Cardigan and Aberystwyth, as we explored the equipment that is used in the 7 basic observations our crews carry out with patients. 2 Fun filled days left smiles on the faces of everyone who attended. People were delighted to have had the opportunity to sit in an ambulance and to learn about the equipment.

One lady with a learning disability and severe visual impairment felt very brave sitting on the stretcher and feeling the vehicle move as people walked around the back. We answered questions about what was making all the different sounds, like the tail lift and the monitors, and ease some of the concerns that she might have had in an emergency situation. We could explain why the light was changing from dark to light as we closed doors and why the cupboards sounded so noisy when opening and closing. Another participant said they would know what to do, and what would happen if the parent they cared for should fall or become ill.

“I know I can press the necklace button, and only phone 999 if it’s a real emergency. They might need one of those cushions maybe, to help lift them up.”

Following a request to attend a national supported-housing association conference in Cardiff, we repeated the theme with a much larger audience with more varied levels of learning disability. While the presentations of equipment went down well with all who attended, this larger event was an education in how this thread will need to be explored and adapted to include people with more complex needs. There will be plenty to think about before the proposed return to Lampeter in 2023 for an event aimed predominantly at those with more profound and complex needs and the people in their networks of support.

Learning Disability continued

There have also been developments for the Learning Disability community behind the scenes, with discussions in progress to improve our ability to record Learning Disability on our EPCR system. The proposals will allow staff to capture more information on the reasonable adjustments that have been made for people with LD on scene, helping to better inform future recommendations and highlight further training needs.

The Trust's 'understanding learning disability E-learning module' is active. In its first quarter it has amassed over **360 participants**, with discussions ongoing to ensure it gets included in CPD days across various aspects of the service. Alongside the ongoing plans for a supplementary module around pain and learning disability, the opportunities for improving experiences for people with a learning disability is looking very promising.

This work supports the Learning Disability Education Framework for healthcare staff, which is a strategic priority area within the Welsh Governments 'Learning Disability Delivery & Implementation plan' 2022-2026.

Thank you for explaining everything to me in a way I could understand. I don't understand big words and long sentences, but you answered my questions in a way that I could understand what things are, and why they need to do the things.

I saw my friend go on the ambulance and I was scared cos I didn't know what it was like and what would happen. She would have been safe on here, you are all nice and there's all these things to help people.

999 Rescue Event

South Wales Fire and Rescue Service (SWFRS) hosted this year's 999 Rescue Event, which took over Cardiff Bay's Roald Dahl Plass, on Saturday 22 October.

Welsh Ambulance Services NHS Trust attended the event, packed with exciting rescue demonstrations, competitions and activities for all the family, alongside multiple partners from across South Wales, including: South Wales and Gwent Police, National Lifeboat Institution (RNLI), the Coastguard, MedServe, St John Ambulance Cymru and The Welsh Blood Service.

Staff and volunteers from across the Trust joined in the event's activities, inviting members of the public to discover more about #TeamWAST. Our Teams had the opportunity to hold conversations about volunteering and recruitment, and the challenges faced by emergency services (inc., Accident & Emergency) at the current time - conversations such as these help members of the public better understand what to do in an emergency situation.

Volunteer Community First Responders were on hand to deliver Cardiopulmonary resuscitation (CPR) demonstrations and respond to questions about using a defibrillator or responding to a child choking.

There was an impressive display of personnel and resource, including: an Emergency Ambulance, RRV and Hazardous Area Response Team (HART) Welfare Vehicle, Non-Emergency Patient Transport Service to help familiarise members of the public with these environments. The Trust's Cycle Response Unit were also on hand to showcase their unique response skills.

Below are the staff and volunteers from Emergency Medical Services, Hazardous Area Response Team (HART), Emergency Preparedness, Resilience and Response (EPRR) Community First Responders (CFRs), Non-Emergency Patient Transport Services and Corporate Services who help celebrate all thing's emergency services.

Older People's Groups

Over the past quarter we have continued to engage with older people's groups. Members raised a number of similar concerns about accessing services in the community when they need them.

Using Digital

People had mixed feelings about the drive to use online and digital platforms to access services and information. People understood that while these options were good for some people and offered additional ways of accessing services for some, online and digital should not be the only option and people should not be disadvantaged for wanting to access services or information in more traditional ways.

We continue to ensure that this feedback, along with the Older Peoples Commissioner Guidance to Local Authorities and Health Boards on 'Ensuring access to information and services in a digital age' is considered in internal meetings to improve quality of services and experiences.

"We're being blackmailed into using a mobile phone"

Also queried was the availability of digital literacy classes and/or mobile phone tuition. This presents an opportunity to explore working with local education providers to deliver digital sessions on using NHS 111 Wales or share content for already established classes.

The Golden Hour

Several attendees shared concern about ambulance waiting times, in particular calling 999 when a patient was experiencing a stroke and therefore "miss the golden hour" for treatment. Reassurance was given that the whole organisation were conscious of the harm caused when ambulance waits in the community are experienced; we assured group members that the Trust and colleagues across NHS Wales were taking steps to improve this situation.

Living Alone

People who live alone shared their concerns about how they might call for help in an emergency or how emergency staff would know who to inform that something has happened. We shared information about Lions Clubs' Message in a Bottle (MIAB) initiative and several Bottles were shared amongst attendees who lived alone or knew of friends/neighbours/family living alone.

Confidence in the Community

One attendee shared their experience of requesting a home visit through the GP Out-of-Hours (GPOOH) service:

This was a person who was familiar with the Primary Care system and had the confidence or self-efficacy to 'insist' on receiving the level of service they required. This may not be the case for many people across our communities in Wales.

"I called 111… they put me through to 999… I was told I would have to wait. In the end, I spoke to the GPOOH and insisted on a home visit… that's what I needed… I couldn't leave the house and they came out to me. The trouble is, the ambulance service are asked to do this and there isn't the resource. We need home visits (from Primary Care)."

Socio-Economically Deprived Communities

We have continued to work in partnership with colleagues from Dyfed Powys Police, Mid & West Fire and Rescue Service and a range of other service providers, including Dyfed Drug & Alcohol Service; Mind Cymru; The Wallich; The Department for Work & Pensions and Carmarthenshire County Council, participating in a community outreach scheme targeting more deprived areas and towns in West Wales who typically experience lower levels of good health, lower levels of employment, poorer educational attainment and an increased risk of being a victim of crime. The initiative has aimed to take information, advice and support directly to the community.

We have also worked closely with food banks across the area, engaging with their users to distribute information about the Welsh Ambulance Service, NHS 111 Wales and how to use our services wisely to support their health and wellbeing.

"A huge thank you to the Welsh Ambulance Service for working with us, the information and resources you've been able to provide for our users has been invaluable"

Our participation in these initiatives helps strengthen social partnership working and helps support the Trust to deliver against its duty to improve inequality of outcome for people who suffer socio-economic disadvantage, as well as ensuring we are working closer with our emergency service colleagues to make the best use of resources, as recommended by Audit Wales's Joint Working Between Emergency Services report. The initiative has proven very successful, and we look forward to working with colleagues across the area as the scheme is rolled out further.

Community Health Councils

Over the last quarter, the PECI Team have continued to meet with Community Health Councils (CHCs) in the 7 Health Board areas across Wales.

The Team have attended a range of meetings with respective Councils introducing the work of the PECI Team and the People & Community Network; sharing patient feedback from across all our services; and identifying ways of working together to strengthen the voice of patients, service users and the citizens of Wales.

Regular attendance at these meetings has been welcomed by council officers and members alike and will help strengthen our working relationship as the CHCs transition to the Citizen Voice Body (CVB) from April 2023.

Going forward, sharing the findings of the PECI Quarterly Report will be a significant part of this relationship, building on a culture of openness and transparency, and opportunities for CHC members to take part in gathering service user feedback for the Trust has also been encouraged.

“Thanks so much for meeting with me yesterday, it was very exciting to make this new connection and I hope the CHC is able to help out in some patient experience work you’re planning. The mystery shopper for 111 will be an activity our members would certainly be keen to come forward for.”

~ Jemma Morgan, Chief Officer Aneurin Bevan CHC

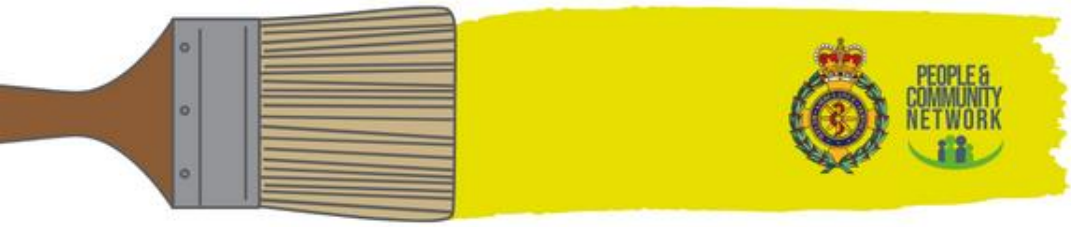
Attending these meetings, alongside operational colleagues, will provide a valuable, two-way conversation about patient experience and community involvement as well as local performance, while also providing the opportunity for questions and answers from both parties.

The following was captured during a Q&A session at a Full Council meeting for Hywel Dda Community Health Council. The Q&A session allows attendees to ask questions about the service, share concerns and share their personal experience.

“My husband received excellent treatment when he had a heart attack in July. He had fallen in the garden and banged his head. He deteriorated rapidly so I called back. It wasn't until I called for the third time and shared that he was in and out of consciousness that an ambulance was sent. He is still here today. All I can say is thank God, and was I lucky? Had I not made a third call… I have nothing but admiration for you all.”

~ Council member, HDCHC Full Council meeting

People & Community Network



Network Members:

95

Network Refresh

Work has been ongoing throughout 2022 to refresh the People & Community Network. The Network has been growing steadily by word of mouth, but we wanted to do more: to improve visibility of the Network and create renewed motivation in its actions and ambitions.

The Network is now an integral component in the delivery of quality and value focused aspects of the IMTP. We continue to develop the People & Community Network as a mechanism to amplify the citizen voice at all levels across the Trust.

The launch of the refreshed network, originally scheduled for September 2022, has been ongoing to ensure we have multi-lingual communications for current and prospective Network members, specifically for people with a learning disability or sensory loss, and for those new to Wales for who English or Welsh is not their first language.

To this end, the 'official' launch will now take place in early Spring 2023.

#TeamWAST & The Network

News of the People & Community Network is growing across the Trust. We are actively encouraging colleagues who are involved in initiatives or projects that would benefit from input from members of the public to get in touch. Throughout the last quarter, the Team have already met with colleagues from across the Trust interested in securing service user feedback on potential service developments in areas such as Directory of Services and the Falls and Frailty Service.

Planning meetings for the NHS 111 Wales (Telephone) Mystery Shopper Campaign are also due to restart in January 2023. These meetings have been on hold since the Business Continuity Incident for the 111 Service was declared in August 2022. Next steps for the group include sharing plans for Phase I with Clinical Contact Centre Operational Leadership Team.

Alongside external communications, internal communication channels will be utilised to inform colleagues across the Trust of the changes to the Network and the benefits for their teams.

Your Experience of Calling 999

Over the last quarter we have continued to encourage people to provide feedback about their experience of calling 999 in an emergency, using an online patient experience survey. This survey can be accessed online through the Welsh Ambulance Service website and has been promoted publicly across all of the Trust's social media platforms.

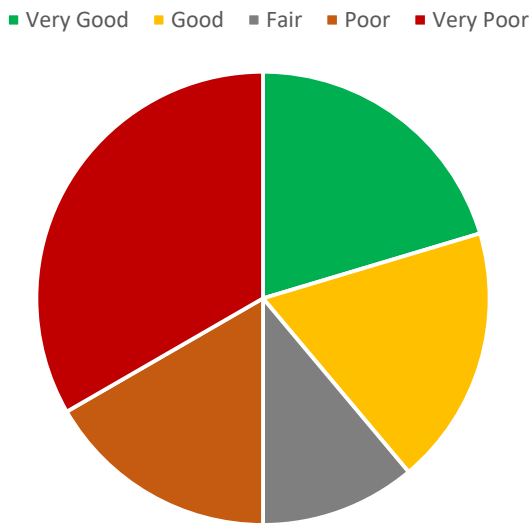
From October to December 54 people used the survey to provide feedback. We are still unable to directly contact 999 service users to ask for feedback. Instead, we rely on them seeking out opportunities to provide feedback independently.

During this quarter, responses were received from all Health Board areas across Wales.

A majority (48%) told us that this was the first time they had needed to call 999 in the past 12 months, whilst 11% told us they had needed to call 999 at least 3 times in the past 12 months. .

- **70% of respondents said they felt confident in the ability of the person who answered their call to manage the call and provide appropriate advice.**
- **74% of respondents said they did not receive a call back from a clinical advisor.**
- **Of those who did receive a call back from a clinical advisor, 50% said they felt they were given enough advice about what to do next.**
- **Of those who said an ambulance was sent, 57% said they waited over 1 hour for help to arrive. With 11 respondents telling us they decided to make their own way to hospital after being advised there would be long wait.**

How would you rate your overall experience



Approximately 50% of people who completed the survey rated their overall experience as 'Poor' or 'Very Poor'.

Please tell us why you gave the ratings above:

"I needed to call an ambulance on Christmas Day with family when an elderly gentleman on a nearby table at the restaurant collapsed on the floor unconscious. There was a 6 hour delay for an ambulance! The elderly gentleman remained unconscious on the floor whilst his relative summoned other help by phone. Once the family arrived the elderly man still unconscious was carted unceremoniously out of the restaurant to who knows where? Surely this kind of situation cannot be right in 2022 in Wales?"

"The reason for the rating is because we called 999 for my father who was having a stroke we explained to the person on the phone all his underlying health conditions and got told he is category 2 call and it will take 1 - 4 hours, the person on the phone said can't we take him in to A&E we explained that won't be possible as he can't walk".

"Had to wait 26 hours for an ambulance for my husband who has COPD with very low oxygen levels. Turned out he had an infection rate of nearly 100% by the time he arrived at hospital. Very scary experience".

"I was REALLY frightened for my husband as he was so ill . Emergency operator was very professional and a paramedic was in our house in minutes after my call. Ambulance arrived quickly and he was seen and diagnosed. Can't fault the service at all. Very grateful for the help".

"Waited 17 hrs for Ambulance .They rang on 17th hour to say nothing was coming".

"Child with sepsis advised of a 7 hour wait. The call should have been prioritised better, Patient was a child with clear signs of sepsis and was in/out of consciousness, that should not warrant a minimum of 7 hour wait".

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

"My Mum was very unwell and we were desperate for help. She died in pain waiting for help that never arrived".

Overall, there was a fairly even split in responses received from people rating their experience as Good verses Poor. However, of those saying their experience was poor, long waits in the community for help to arrive was a clear and consistent theme in these respondents' feedback and comments.

Some respondents did indicate that they understood this was a whole system problem, and that there was little that the Welsh Ambulance Service could do in isolation to improve the situation:

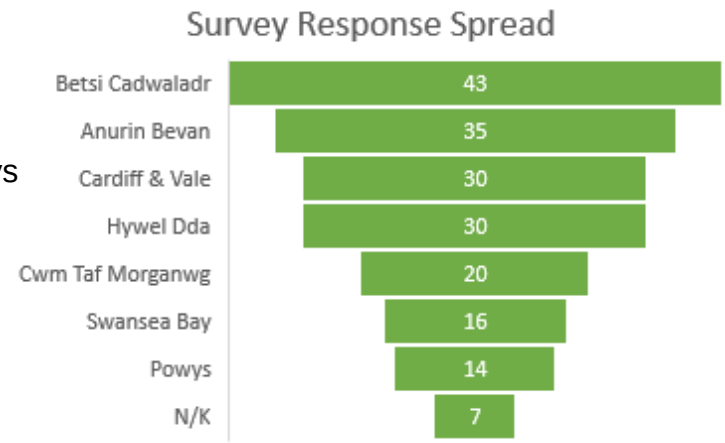
"On arrival at hospital we saw there were at least a dozen other ambulances waiting to handover, therefore staff couldn't get back to patients waiting in the community".

Non-Emergency Patient Transport Service

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

Between October and December 2022, a total of 194 NEPTS patient experience surveys were completed. The responses received come from people who were sent a text message asking them to complete a survey, people who asked to receive a postal survey or NEPTS users who visited the Welsh Ambulance Service website to complete an online survey.

Responses were received from all Health Board areas, we continue to see the highest levels of engagement with the survey in the Betsi Cadwaladr and Aneurin Bevan areas. With Swansea Bay and Powys again receiving the fewest responses.



These results showed us that:

- A majority of people (87%) found the booking process easy. Those who answered negatively here said it was because of long delays for booking calls to be answered.
- 91% said they were happy with the transport they received.
- A majority of people (89%) scored their NEPTS experience 8 out of 10 or higher.

The NEPTS patient experience survey results continue to be positive and offer high levels of assurance that NEPTS users are satisfied with the service. Less positive responses continue to follow historical trends and focus on wait time for booking calls to be answered, with an increase in the number pf people telling us that they were unhappy with the length of time they had to wait for their booking call to be answered.

What was Good:

"Efficient, pleasant hard working staff. Thank you as always"

"I like being given the mobile number of the driver picking me up, the volunteer drivers do this more than paid staff. It is enormously helpful having a call to let me know approximate pick up time"

"I would struggle getting to my regular appointments if it wasn't for hospital transport. It is a big help, the crew or driver are always very friendly and supportive."

What was Bad:

"Always I have to bring a cushion, seats are very hard especially when going over bumpy roads. Hurt my back"

"It took me two days to book. I would sit on the phone for over half an hour so presumably near the front and they cut me off"

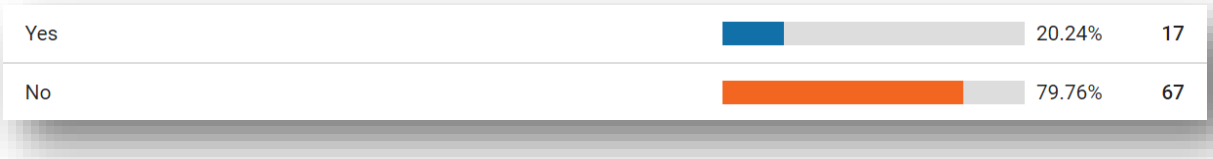
"It takes 45mins to an hour and a half to wait on the line for it to be answered - not to good"

Patient Experience Surveys

NHS 111 Wales Telephony Service

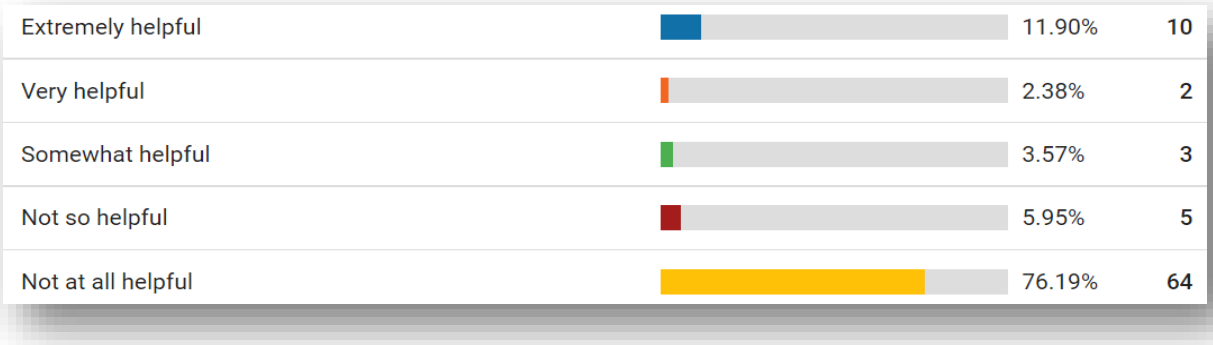
We have continued to promote a survey, encouraging people to share their experiences with us of calling the NHS 111 Wales service. **Between October and December 84 people completed the survey.** Responses were received from all Health Board areas, providing a mixed response about their experience of using the telephony service.

When asked if they had contacted another service before calling NHS 111 Wales, a majority of people said no, 111 had been their first port of call.



Of those who had contacted another service, people told us they had been advised to call 111 by their GP, pharmacist or Dentist, or had visited the website first.

80% of respondents told us they were Dissatisfied or Very Dissatisfied with the length of time it took for their call to be answered (a noticeable increase from 51% in the previous quarter). 76% of respondents told us they found their call 'Not at all helpful' with only 12% saying their call was 'Extremely helpful'. 43% of respondents said they went on to follow the advice given to them.



42% of respondents said they needed to re-contact NHS 111 Wales at a later time or date for further information or advice about the same health problem.

"I phoned on 26.12.22 at 3pm and was told by an automated system there would be a wait of around one hour. After being on hold waiting to speak to someone for 2 hours and 8 minutes I was cut off and not able to speak to someone. At this point we were already on our way to A&E with my daughter as seriously worried about her health. 111 system is not working"

"Called 111, advised calls would take over 1 hour to be answered, held on and when call went unanswered for 2 hours I was cut off. Not happy at all. If calls ate not going to be answered for 2 hours say and not let people hanging"

We will continue to make this survey available to the public through the NHS 111 Wales website and social media platforms and will share survey findings with the NHS 111 Wales Team to help identify opportunities for learning and improvement.

Patient Experience Surveys

NHS 111 Wales Online

To ensure the data we capture from users is meaningful and feedback can be acted upon, in October 2022 questions contained within the NHS 111 Wales website experience survey were reviewed and updated to include questions which help us understand what Health Board area people live in, what sections of the website they specifically visited, whether they intend following the advice provided and if not, why not.

In the last quarter 69 people completed a website experience survey

Just over half of respondents (53%) told us that they found the information they were looking for easy/somewhat easy to find, with 42% stating that they intended to follow the advice. Reasons for not following the advice included not agreeing with the advice, tried following the advice but it notworking or they were unable to follow the advice. As a result of the advice given, the biggest proportion of respondents (59%) said their enquiry remained the same.

Over half of respondents (58%) rated their overall experience as poor or very poor, however the majority of reasons were in relation to the 111 telephony service and not the website. Examples included long wait times, being cut off or not being able to obtain advice in a timely manner.

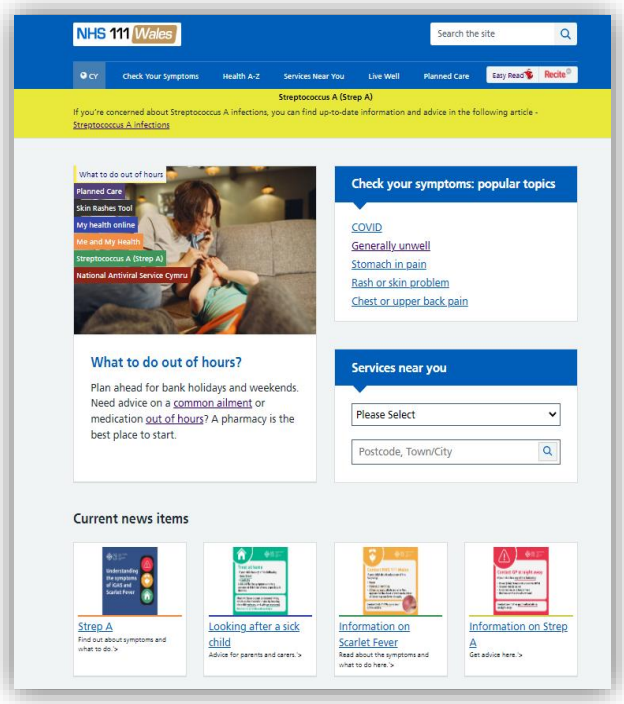
For this quarter, improvements suggested by users included live chat, improvement of search terms and the ability to input multiple symptoms when using the symptom checker.

Website Developments

During this quarter, a new ‘Planned care’ section was hosted on the homepage on behalf of Welsh Government, providing data on how long people in each local health board were waiting to be referred to or under the care of a specialist.

During December, an increase in the search term ‘Scarlet fever’ had already been identified prior to reported cases in the media and calls to 111 telephony service. To support the worried well and other users, information was developed on looking after a sick child, Strep A and Scarlet Fever.

With a four day bank holiday over the festive period, users were also reminded about planning ahead and advised what they could do out of hours with and without a prescription. An all Wales pharmacy rota was also made available.



Social Media

Patient Experience & Community Engagement

Social Media allows us to engage and respond to the public & organisations in real time and keep appropriate use of 999 services and the NHS 111 Wales service at the forefront of people's minds. It's also a great way to capture feedback, share compliments, signpost visitors and demonstrate how users' feedback can influence service delivery.

Twitter Summary, October - December 2022	
	@WelshAmbPECI
Tweet impressions (how many people our tweets have reached)	52,833
New followers	0
Current Number of Followers	4,630

This period's most popular tweet from @WelshAmbPECI was made in October and celebrated the success of Shoctober, our annual schools campaign which aims to teach young people about to do in an emergency, how to perform effective CPR and how to find and use a public access defib. During October the Patient Experience & Community Involvement Team, supported by 32 volunteers, visited 32 schools across Wales, teaching over 1,800 young people these vital life saving skills.

That's it folks. Throughout October...
☑ we've engaged with over 1,800 pupils
☑ with the support of 32 **#Shoctober** volunteers
☑ at 32 schools
☑ across 6 health boards
Thank you to all **#Volunteers** for educating our next generation of **#lifsavers** ❤
Until next year!
Shoctober Team pic.twitter.com/rrWxDFAtqJ

Social media continues to play a vital role in helping us to engage with people right across Wales. Sharing information about using our services responsibly and offering opportunities for people to interact with us, providing feedback, asking questions, sharing experiences and completing surveys.

NHS 111 Wales Overview

Compliments

	Compliments Received
NHS 111 Wales	10

"I telephone 111 service with dread. Thinking of all the tales of the NHS I had heard over the media. Yes 111 service took me 45mins to get through to the service but the lady who answered my call was simply lovely wanting to help me & listened. Then I was told I had done right thing in contacting, and you need to speak to either a nurse or Dr. This could take up 2hours. It took one hour and again the Dr was wonderful. Asking many questions with sympathy and wanted to help"

	Total Website visits (English)	Total Website visits (Welsh)	Top Page Viewed
October	405,915	923	homepage
November	381,004	723	homepage
December	502,720	973	homepage
Total	1,289,639	2,916	

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

- Generally unwell – 81,989
- Abdominal pain – 54,052
- Rash or skin problems – 38,378

Twitter Summary, @NHS111Wales October – December 2022	
Tweet impressions (how many people our tweets have reached)	160,400
New followers	109
Current Number of Followers	7,222

Facebook October – December 2022	
Facebook Reach (how many people our Facebook posts reached)	29,624

Looking Ahead…

#Defibuary
In February the Trust will once again run our online social media campaign #Defibuary, encouraging communities to be more aware of public access defibrillators, ensuring they are registered on ‘The Circuit’ and highlighting the importance of bystander CPR.

Ageing Well in Cardiff & Vale
Invitation to attend regular Falls Prevention Group meetings organised by Cardiff and Vale University Health Board, Local Public Health Team. Attendees of this meeting include a range of individuals, organisations and partners working with Older People across the Health Board area.

Working Together: Supporting People to Live Well with Long-term Conditions
Invitation to fortnightly Co-Production Forum, with a focus on working together to co-produce a range of ways to support people with long-term conditions in Cardiff and the Vale. Organised by Cardiff and Vale University Health Board, this is an opportunity to break down the barriers between individuals and service providers and to accurately meet the long term needs of the population, by working as a community and making decisions collectively.

Glamorgan Voluntary Services (GVS) Big Volunteering Fayre
GVS are hosting the Big Volunteer Fayre for charities and community projects to showcase their projects and recruit volunteers. This is a great opportunity to network with third sector organisations serving the communities of Cardiff and the Vale, while also talking first-hand to members of the public of all ages.

Cardiff Mela and Cardiff Minority Ethnic Community Health Fair
As the Welcome Pack containing information for diverse communities and people whose first language isn't English nears its completion, planning for its launch has begun. Part of this will involve our presence at the annual Cardiff Mela, Wales' biggest Multicultural celebration event, and the health fair for Minority Ethnic Communities, also in Cardiff. Sponsorship and advertisement packages are being explored as a means of maximising exposure both at the events and in their run ups. The focus will be both the welcome pack and the function to translate NHS 111 Wales to over 100 languages that is available through the ReciteMe tool, with a view to opening opportunities for engagement with communities.

Quality Safety & Patient Experience Directorate

Shoctober Evaluation Report 2022

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1. Background

Shoctober is an annual, month-long education campaign that runs every October. Now in its sixth year, it is designed to engage, educate and inform Primary pupils in years four, five and six about appropriate use of 999 and lifesaving skills.

Every year in Wales, over 6,000 people will have an out of hospital cardiac arrest. With 80% of cardiac arrest occurring at home happening to anyone at any age, often occurring suddenly and without warning [1], every minute without Cardio Pulmonary Resuscitation (CPR) will significantly reduce the chance of survival.

Following the passing of the Curriculum and Assessment (Wales) Bill in March 2021, Wales now joins England and Scotland in teaching CPR and Automatic External Defibrillator (AED) awareness in secondary schools only. While the Trust continues to be an active partner co-ordinating Restart a Heart Day in secondary schools, Shoctober aims to develop children's awareness of CPR and defibrillation skills at a younger age. Although the European Resuscitation Council (ERC) recommend 12 years as a minimum age to perform quality CPR and sustainably increase bystander CPR rates, Shoctober aims to instil pupils with confidence to act if called upon as "younger children are able to perform basic tasks well, including use of AEDs"[2]. The campaign also aims to help children understand why CPR is being administered should they witness it.

The campaign aligns with WAST IMTP (2022-25) supporting the Trusts' ambition of 'inverting the triangle' by positively influencing behaviour, educating pupils about others community services that can help and explaining WAST Clinical Response Model (CRM).

It is acknowledged that whilst we may not see any immediate results, it is imperative that children and young people are engaged to make them stronger adults and contribute to help build resilient communities. This we see as fundamentally supporting the work of the Children's Commissioner for Wales, UN Convention on the Rights of the Child; Article 29: "Education must promote your rights and help you to develop your skills and talents to the full", Well-being of Future Generations (Wales) Act 2015 and A Healthier Wales.

2. Co-ordination of Shoctober visits

Adhering to Welsh Government's request not to directly contact schools, promotion and information to register expressions of interest are featured in their education newsletter Dysg (pre-11) which all schools receive.

Following volunteers and schools registering their preferred dates, the Patient Experience & Community Involvement (PECI) team allocate volunteers to schools. Confirmation of attendance is confirmed with both volunteers and schools at the earliest convenience, and the Shoctober PowerPoint is sent to all, providing an outline of the session and ensuring consistent messages are being delivered by all volunteers.

3. Shoctober Content

During the one to one hour and thirty minute session (maximum), learning objectives include:

- Provide information on number of daily emergency calls, resources available and Clinical Response Model (CRM)
- Appropriate use of 999 - delivered by an interactive 'Big and little accident' quiz based on different child-based health scenarios
- Audio 999 call explaining what happens when you call 999

To give pupils the confidence and knowledge of how to look after someone while 'help is on its way', the following life savings skills are also delivered using various learning aids:

- Recovery Position
- Hands only CPR
- Awareness and demonstration of a defibrillator; how it works, ease of use, where they can be found and why they are used
- Ways to help someone who is choking

Pupils are reassured throughout the session that the call taker will remain on the line and will talk them through what is required until help arrives.

4. Implementation & impact of 2019 recommendations

As face-to-face engagement was put on hold during 2020/21 due to social restrictions, the following recommendations were implemented from 2019 campaign:

i. Strengthen administrative function by creating a Amb_Shoctober mail box for all enquiries to be sent from/to. A Microsoft form was created to allow all volunteers and Schools to register expressions of interest.

ii. Promote What3Words app to reassure pupils that no matter where their location, WAST can precisely identify their location.

iii. On request, provide tailored Shoctober training session to other groups outside of mainstream schools, to allow them to fully participate equally and not inadvertently be discriminated against.

iv. Planning was slightly delayed due to implementing outstanding 2019 recommendations. Therefore registration opened end of May 2022.

v. Following advice from WAST People Services and adhering to Disclosure & Barring Service; 'Regulated activity with children in Wales' no additional safeguarding measures were required i.e proof of a DBS check, as appropriate

safeguarding measures were already in place.

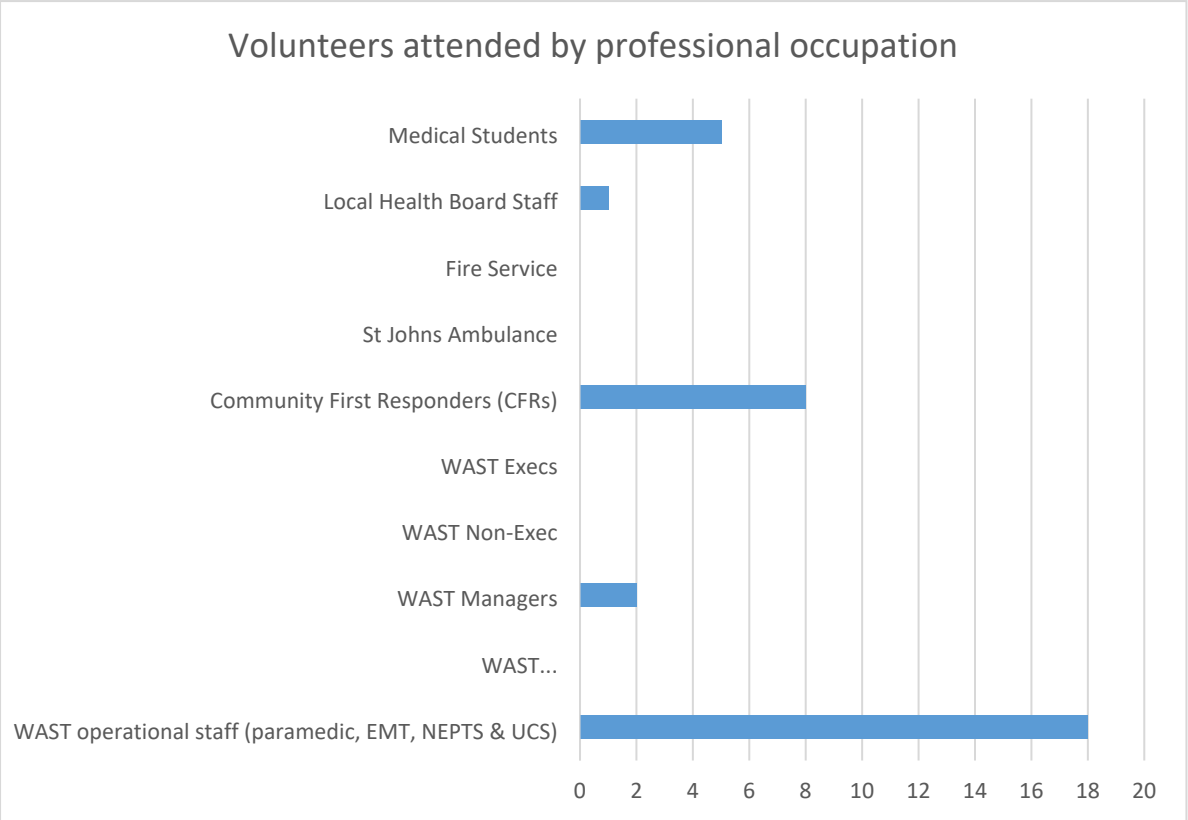
vi. While downloadable certificates were not offered to schools this year, this has been asked as part of 2022 school feedback form.

vii. ***The following was not recommended in 2019 Shoctober campaign, but suggested at Cardiff School Holiday Enrichment Programme (SHEP).** Develop a mock audio 999 call to enable pupils to familiarise themselves with what happens when you call 999 and questions we ask. This offered another learning style, complimenting the existing Shoctober session; visual and kinesthetic. The call was developed in partnership with MPDS Quality Auditor, EMT and young person to ensure it reflected the service, accurately generating the correct protocol and a scenario that was relatable to pupils.

5. Review of performance

Volunteer Engagement

Organisation/Position	**2017**	**2018**	**2019**	**2020/21 (Pandemic)**	**2022**
WAST operational staff (paramedic, EMT, NEPTS & UCS)	19	23	19	On hold	18
WAST non-operational/clinical staff	3	7	4	On hold	0
WAST Managers	1	1	2	On hold	2
WAST Non-Exec	0	0	0	On hold	0
WAST Execs	0	0	0	On hold	0
Community First Responders (CFRs)	17	15	26	On hold	8
St Johns Ambulance	1	2	1	On hold	0
Fire Service	1	0	1	On hold	0
Local Health Board Staff	5	5	5	On hold	1
Medical Students	0	6	7	On hold	5
Total no. of volunteers	**47**	**59**	**61**		**34**

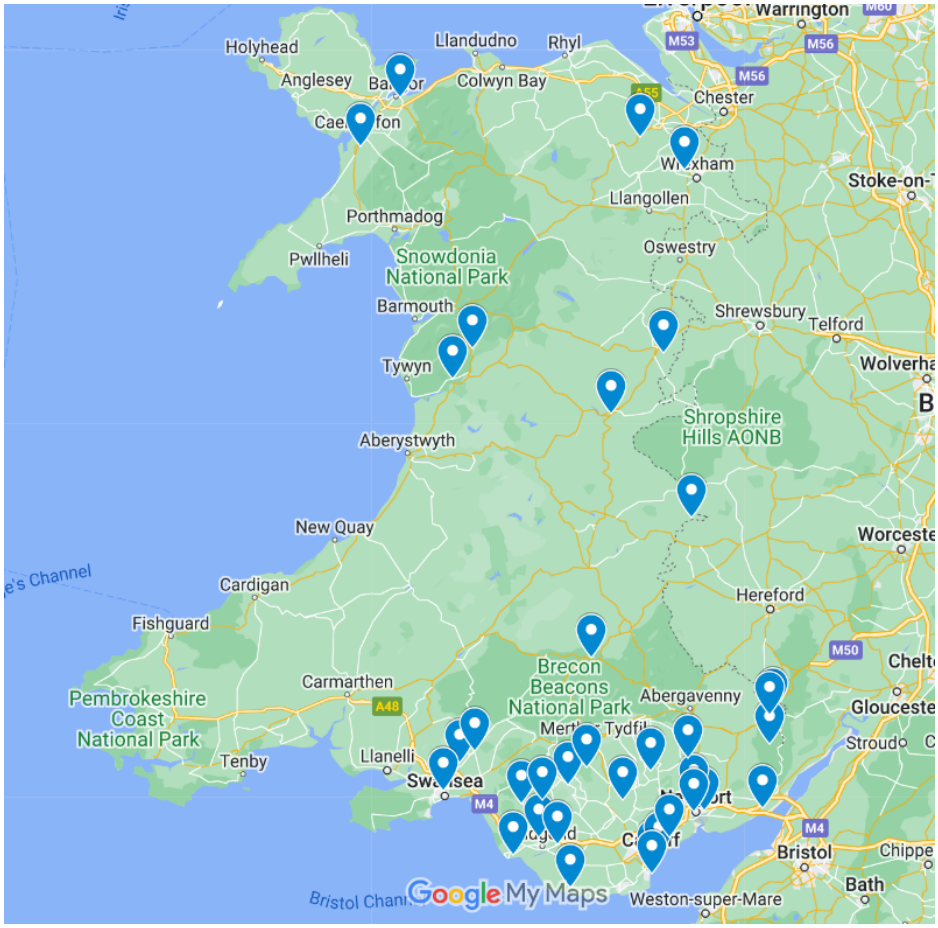


School involvement	**2017**	**2018**	**2019**	**2020/21** (Pandemic)	**2022**
Number of schools registered (mainstream)	33	46	52	On hold	35
Number of schools attended	25	38	36	On hold	32

Whilst the Shoctober presentation is available in both English & Welsh, delivery in Welsh is based on the availability of Welsh speaking volunteers.

Pupil engagement	**2017**	**2018**	**2019**	**2020/21** (Pandemic)	**2022**
Number of pupils engaged with	2000	2137	2467	On hold	1855
Hours taught	76	103	122	On hold	88

By geographical location:



6. Issues identified in 2022 campaign

Due to volunteers being unavailable on specific dates schools provided, two schools were declined a visit in the Powys health board area. In addition, one school cancelled after registration due to an inspection, and two schools did not confirm dates after registration despite repeated attempts to contact them.

Despite having volunteers in the Hywel Dda health board area, no schools registered for Shoctober 2022.

7. Estimated project resources

The campaign was undertaken by the PECI team with no external funding. Costs associated with the campaign have been to purchase children and young people's resources; '*Jacks tells you other people that can help'* comic, '*Blue Light Hub*' app and '*7 important checks'* all of which have been developed in-house and explains equipment crew use during observation and why. The Trust pool car

is also utilisedto facilitate sessions and occasional postage costs to deliver resources to other volunteers delivering sessions across Wales.

8. Feedback

School feedback

Of the 19 schools that responded to the school evaluation survey, 17 (89%) had never previously participated in Shoctober. 100% of respondents felt the sessions were delivered at the right level for pupils, learning aids used were suitable, pupils were engaged and understood what was being delivered.

When asked to recommend changes to next year's programme, one school stated they would like pupils to be able to participate in practicing CPR rather than watch a demonstration. While this is part of the programme, volunteers on the day of the visit did incur some schools reducing time slots which may have been the cause of this.

Moving forward, all schools stated they would like certificates issued to pupils next year. One school also suggested basic first aid skills being delivered. Unfortunately, due to time restrictions and 'Shoctober' content specifically aiming to instil pupils with confidence to administer CPR and use of an AED to improve survival rates, this will not be viable.

100% of schools also rated their experience with the Shoctober team as either good (16%) or very good (84).

Volunteer feedback

Of the 11 volunteers that responded, 82% were new volunteers to Shoctober. 91% felt the school understood what was going to be delivered and 100% felt the content was appropriate for pupils.

As anticipated, only 64% were able to deliver all content of the programme. 34% confirmed that advice regarding how to help someone who is choking could not be delivered due to time constraints. 73% of volunteers also agreed with removing it from Shoctober 2023 campaign. Anecdotal feedback suggested that pupils may not have the physical reach to complete stomach thrusts and may feel helpless especially if there is an unsuccessful outcome.

Moving forward, suggestions included displaying different images of AEDs at various locations e.g village halls, telephone boxes, school reception, lampposts to allow pupils to visually relate to them. A minimum of two volunteers was also suggested during each session. Whilst this is something that the Shoctober team endeavours to achieve, this is not always possible. However prior to cancelling a

visit, the lead volunteer is always contacted to see if they are comfortable attending alone (maximum number of 30 pupils).

Overall experience of correspondence with the Shoctober team rated fair 9%, good (18%) and very good 73% with all volunteers stating they enjoyed the session.

Comments included; "*Excellent team"*, "*very approachable and easy to talk to*", "*I think the interactivity of the sessions were amazing*", "*all the children interacted well and showed interest*", "*excellent organisation as ever by the PECI team. Kids loved the session and it felt a really worthwhile of our time. Could do this every day*", "*Proud to be a WAST ambassador in the community and able to pass on potential life saving skills*" and "*enjoyed working with colleagues I have never met*".

9. Recommendations for 2023

1. Shoctober team to identify key contacts within Fire & Rescue Service, St John Cymru, Medical schools & other supporting agencies prior to opening of volunteer registration
2. Open registration at the beginning of May
3. Reduce sessions to one hour
4. Sessions delivered by the Children & Young People Engagement Lead explained the CRM in a child friendly manner together with statistics of daily number of calls and resources. As this may have not been delivered consistently across Wales, this message will be strengthened as an infographic for 2023 campaign
5. Remove choking from Shoctober presentation, however explore other opportunities to share this lifesaving skill with children & young people
6. Record a 999 mock call to feature a younger child who does not know their address. This will enable pupils to learn about where in the home they can find a postal address
7. Provide option to schools and volunteers to download certificate of attendance

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[1] Save a Life Cymru (no date): *Save a Life Cymru - NHS Wales Health Collaborative*. Accessed 11 Dec 2022.

[2] Plant N, Taylor K. *How best to teach CPR to schoolchildren: a systematic review. Resuscitation.* 2013 Apr;84(4):415-21. doi: 10.1016/j.resuscitation.2012.12.008. Epub 2012 Dec 11. PMID: 23246989.

Quality Safety & Patient Experience (QSPE) Directorate
Restart a Heart Evaluation Report 2022

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2.0 Co-ordination of Restart a Heart visits.....2
3.0 Restart a Heart Content.....3
4.0 Issues identified in 2019 & recommendations.....3
5.0 Review of performance.....4
6.0 Estimated project costs.....6
7.0 Feedback.....6
8.0 Issues & resolutions.....7
9.0 Recommendations.....7

1.0 Background

Restart a Heart Day (RAH) day was established in response to the Resuscitation Council's 'Restart a Heart Day' delivery plan in association with the British Heart Foundation (BHF). Held on 16th October, RAH is an annual free event led by Resuscitation Council (UK) in partnership with St John Ambulance, the BHF, British Red Cross and Yorkshire Ambulance Service. Throughout the day, charities and Ambulance Trusts engage with the general public and secondary school students across the UK to provide the skills and confidence to deliver lifesaving cardiopulmonary resuscitation (CPR). The aim is to improve survival rates from those suffering a cardiac arrest by increasing the number of potential bystanders trained in CPR.

With over 6,000 people in Wales every year having an out of hospital cardiac arrest and 80% of cardiac arrest occurring at home happening to anyone at any age, often occurring suddenly and without warning [1], every minute without CPR will significantly reduce the chance of survival. The RAH campaign supports the 'NHS Wales out of Hospital Cardiac Arrest Plan' (June 2017) & Save a Life Cymru programme.

Following the passing of the Curriculum and Assessment (Wales) Bill in March 2021, Wales now joins England and Scotland in teaching CPR and Automatic External Defibrillator (AED) awareness in secondary schools, however this is down to the discretion of the school.

As face-to-face engagement was put on hold during 2020/21 due to social restrictions, this is the first full year the Patient Experience & Community Involvement (PECI) have fully co-ordinated the campaign under the branding of RAH team since its handover from the Medical Directorate in 2019.

The report outlines the level of engagement, review of performance, issues and recommendations to build on the delivery of next year's RAH Day.

2.0 Co-ordination of Restart a Heart visits

As RAH Day this year was held on a Sunday and WAST continue to target secondary school students, all sessions were held on Friday 14th October 2022, pausing all Shoctober activity to free up volunteers.

Implementing a 2019 recommendation, schools were not able to complete registration until they confirmed they had access to BHF Call Push Rescue (CPR) kit bags which contain inflatable manikins and are required to run the sessions. Once fully registered, the RAH team allocate volunteers to a school within their locality.

3.0 Restart a Heart content

Prior to the Covid-19 pandemic, a BHF DVD contained within the CPR kit bags were provided. However following Resuscitation Council UK social distancing safety measures, online training videos were made available on the BHF website. Content includes:

- Preparing the manikin (which we signpost schools to prior to volunteers arrival)
- Shake & shout and adult CPR
- Child CPR
- Defibrillator awareness

4.0 Issues identified in 2019 & recommendations

I. No way of identifying those volunteers who had a current DBS check - Following advice from WAST People Services and adhering to Disclosure & Barring Service; 'Regulated activity with children in Wales' no additional safeguarding measures were required i.e proof of a DBS check, as appropriate safeguarding measures were already in place.

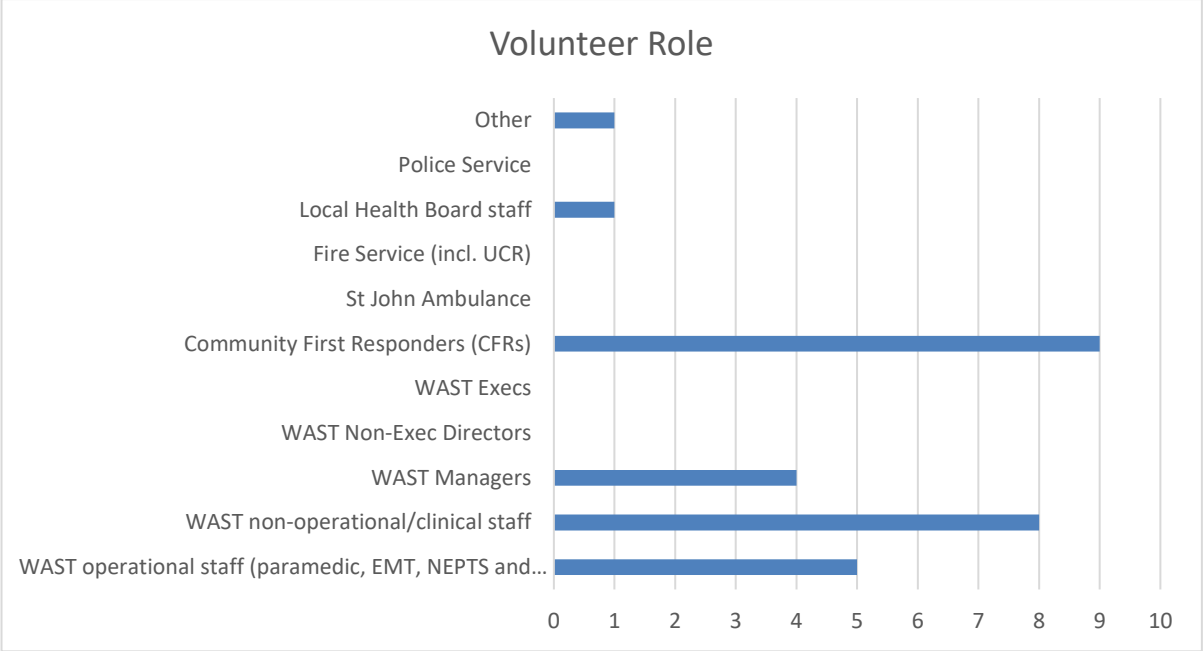
II. Some volunteers were put off when requested to be a 'Lead Facilitator' leading to a lack of volunteer and cancelling some school visits – In 2022 the RAH team requested a 'Lead volunteer'.

III. Nonmainstream schools or schools who cater for special needs/learning disabilities do not meet the BHF criteria to apply for CPR kit bags – The RAH team will continue to endeavour to arrange school visits for those students using WAST manikins at a later date.

5.0 Review of performance

Volunteer Engagement	2017	2018	2019	2020/21	2022
	160	200	63	0	28

Organisation/Position	2017	2018	2019	2020/21 (Pandemic)	2022
WAST operational staff (paramedic, EMT, NEPTS and UCS)	31	56	13	On hold	5
WAST non-operational/clinical staff	7	10	1	On hold	8
WAST Managers	14	9	0	On hold	4
WAST Non-Exec Directors	1	0	0	On hold	0
WAST Execs	6	2	0	On hold	0
Community First Responders (CFRs)	57	55	18	On hold	9
St John Ambulance	3	1	1	On hold	0
Fire Service (incl. UCR)	5	5	0	On hold	0
Local Health Board staff	14	36	3	On hold	1
Police Service	11	11	2	On hold	0
Other	11	15	11	On hold	1
Total	**160**	**200**	**63**		**28**



School Engagement	**2017**	**2018**	**2019**	**2020/21**	**2022**
Number signed up	67	86	52	On Hold	28
Engaged with on 14th October	53	70	27	On hold	14

Students Trained	**2017**	**2018**	**2019**	**2020/21**	**2022**
Number trained	9,285	10,500	est 4384	On Hold	2,600

By geographical location:

6.0 Estimated project costs

This project was undertaken by the Patient Experience & Community Involvement (PECI) team with no additional funding. The Trust pool car was utilised to facilitate sessions.

7.0 Feedback

School Feedback

Out of the 10 schools that responded to the school evaluation survey, 30% had never participated in the campaign however 100% of schools understood the purpose of the visit. 80% found the registration process easy or very easy, with 20% felt it was neither easy nor difficult. 90% of schools rated their overall experience as good or very good and 100% were either likely or very likely to register next year.

Moving forward, schools added comments that an earlier confirmation email would be beneficial as schools need time to prepare for the event. Whilst the RAH team endeavour to confirm visits at the earliest convenience, this isn't always possible as we're reliant of volunteers to confirm their attendance and need to ensure that there are enough volunteers attending depending on the ratio of pupils.

Unfortunately whilst one comment stated that the video is "too boring" for secondary learners, this is the BHF training video that supports the campaign.

Volunteer feedback

Of the 13 volunteers that responded to the volunteer evaluation survey, 62% were new volunteers to the campaign. 92% rated the registration process either easy or very easy. Volunteers felt that the registration process was simple, straightforward, and a clear process, however one volunteer felt that it took too long to receive a reply from the Restart a Heart team about whether you were allocated to a school. Due to delayed responses from schools even after several correspondence, this at times was unavoidable. 100% of volunteers understood what was expected from them ahead of the day, 100% rated their experience of participating in RAH as good (15%) or very good (85%) and all are likely to sign up for next year's campaign.

When asked for any other comments to improve next year's campaign, volunteers stated that some schools had not inflated the manikins in readiness for the session and played the wrong training video (pre Covid DVD). Both of these matters were addressed during correspondence to the school ahead of the day. Whilst some volunteers stated that a better DVD is required, unfortunately this is out of our control as it is a BHF led campaign.

8.0 Issues and resolutions

1. When the Medical Directorate co-ordinated RAH, office based operational staff were assigned to volunteer at schools, however since the campaign has moved to the QSPE Directorate, this is no longer the case which significantly impacts and reduces the number of volunteers available to support the campaign and number of students being taught CPR. On occasions resulting in schools having to be declined a visit. In 2023 the RAH team will individually invite identified office based operational staff to volunteer for the campaign.

2. As volunteers may live in different health board areas to their work base, in 2023 a list of all schools registered for RAH will be sent out to volunteers to allow them to choose their preferred school location.

3. RAH registration form – As two questions within the 2022 registration form caused confusion among schools regarding number of manikins they had, and number of pupils per year group they wanted to attend during the session, these questions will now be made clearer in 2023 form to assist RAH team during the planning stage.

4. Schools not knowing or being able to source the BHF CPR kit bags - While we were able to confirm via the BHF website whether a school has received a kitbag, we are only able to describe the kit bags to schools. Schools are only allowed to request kit bags once from BHF.

5. As some schools may still have access to the RAH DVD (pre covid) that accompanied the CPR kits bags, links to the three latest online training video's; CPR adult, CPR child & defibrillator awareness will be sent to both schools and volunteers.

9.0 Recommendations

1. Request that the Medical Directorate support the RAH team in identifying office based operational staff

2. Amend RAH registration form to ensure questions are clearer.

3. Open registration at the beginning of May

4. Inform all volunteers ahead of the visit, names of those attending with them.

[1] Save a Life Cymru (no date): Save a Life Cymru - NHS Wales Health Collaborative. Accessed 11 Dec 2022.

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

DUTY OF QUALITY/DUTY OF CANDOUR PREPAREDNESS

MEETING	Quality, Patient Experience & Safety Committee
DATE	9 February 2023
EXECUTIVE	Executive Director of Quality & Nursing
AUTHOR	Head of Quality Assurance
CONTACT	Caroline Miftari Caroline.miftari@wales.nhs.uk

EXECUTIVE SUMMARY

The Health & Social Care (Quality and Engagement) Act 2020 comes into force on 1 April 2023. This report considers the preparedness of the Trust to comply with the requirements of the Duty of Candour and Duty of Quality.

The Health & Care Standards (HCS) 2015 are interdependent to the implementation of the Health & Social Care (Quality and Engagement) Act 2020 and Duty of Quality. The Standards outline the expected care required, ensuring focused quality-driven decision making and planning to deliver better outcomes for all people who use the Trust commissioned services.

The Welsh Government has set a baseline position to be achieved by all NHS organisations by April 2023 for both the Duty of Quality (DOQ) and Duty of Candour (DOC). The findings within the report for the Duty of Quality are sourced from the HCS Compliance Review. The Trust has commenced a monthly return to the Welsh Government from January, alongside other NHS organisations, and the February return currently being drafted for consideration at EMT.

The Quality, Safety and Patient Experience team have sought evidence from across the Trust to demonstrate compliance against the Act's domains and known standards. Defining evidence requirements and the internal standards for compliance is work that remains ongoing and is an area of specific focus over the coming weeks at a Trust, NHS Wales and Welsh Government level. Engagement has been challenging across the Trust due to the service demand resulting from seasonal and community acquired pressures and, the continuation of industrial action.

The NHS Wales Delivery Unit have recently shared a draft dashboard of metrics through the National Quality and Safety Advisory Group for comment by Trust's and Health Boards which is an important digital enabler to demonstrating outcomes improvement at organisational and population levels. Welsh Government and the NHS Wales Delivery Unit are also reviewing a compendium of resources, developed

by Improvement Cymru, to be made available in support of Health Boards and Trusts on Quality Improvement systems that could be considered.

The Director of Quality and Nursing is currently reviewing the existing resource and structure for demonstrating compliance to the forthcoming Act's and in particular, the likely additional requirements necessary to support the Duty of Candour.

The following points are required to ensure compliance with the Duty of Quality and Duty of Candour, most of which will have a resource investment requirement.

Leadership and Culture

The Trust have Executive and Operational leadership representing the Trust on the Duty Implementation Board, Duty of Candour Group coordinated by the Welsh Risk Pool/NHS Wales Shared Services Partnership (NWSSP) and Quality Group coordinated by the NHS Collaborative. Further development of the Trust's emerging Quality Management Group is required, to include senior leadership from across the organisation, and greater integration of data-enabled decision making to implement the DOQ/DOC. Welsh Government are developing a training package for Health Board and Trust's to nominate a minimum of one executive to complete; on receipt it is likely that WAST will want to ensure several members of the Board have the opportunity to complete this training.

Decision making

To assure learning and strategic decisions are made through the lens of improving the quality of services, the Trust will need to enable the 'Always On' approach to quality monitoring and reporting, enabling early escalation, intervention and sharing intelligence with stakeholders. Whilst it is recognised that the Trust has an overall effective quality governance infrastructure, as noted in Audit Wales 2022 Quality Governance Review, it is essential that all staff utilise this in a uniform and consistent way. The HCS Compliance Review suggests there is variation in the use and consistent approach relating to reporting routes. Further systematic review and support of teams locally to implement the Trust's Quality & Performance Management Framework will strengthen organisational assurance.

The Trust will also require a publication and reporting schedule for all stakeholders (internal and external). Reporting should focus on information that will demonstrate the duty of quality and duty of candour in decision making, action taken following learning, quality improvement and improved outcomes.

Quality Standards

Timely and accurate intelligence is key to quality decision confidence that are made at all levels of the Trust. However, further investment into the Trust digital infrastructure will be required as outlined in the main body of the report.

Governance and accountability structures

The Trust will need to consider how the DOQ & DOC can be incorporated into all relevant agendas to monitor indicators, report and escalate matters and measures through the governance structures ensuring that appropriate action is taken at every level to enable learning, improvement and accountability. This should be subject to routine assessment of compliance.

All related Policies and procedures, in particular: Review of Putting Things Right Policy (in line with Duty of Candour) and Adverse Incident Policy should be reviewed.

Training and education

Welsh Government are developing an e-learning package for all NHS staff to support understanding of the Duty of Quality and Duty of Candour that will be available in summer 2023.

Formalise a Trust wide training needs analysis and underpinning Training Plan following receipt of the Welsh Government education packages using existing Forums/Education Programmes where appropriate to ensure staff understanding of the duty of quality and duty of candour, and their roles within it.

The Trust to also consider that staff have the appropriate skills, knowledge and capacity to create the conditions for a functioning quality management system.

Quality Management System

Key to the implementation of the Act, the Trust will need a Quality Management System (QMS) supported by a fit for purpose digital infrastructure. Lead experts will also need to agree and align current quality measures to the April 2023 Quality Standards, including defining what good looks like for each quality domain, with Improvement Plans where appropriate. The Trust also need to consider and agree the evidence to be used to assess the duty of quality, duty of candour and improvement.

Commissioning and Hosting

All Trust commissioning arrangements and hosting arrangements should consider the Duty of Quality and Duty of Candour are incorporated.

Resources

Consideration of the Act and its requirements has highlighted the need for additional resources and investment to improve the digital infrastructure, support the implementation of the Quality Strategy, Duty of Candour, publication of quality outcomes and improvements during the reporting year and develop quality knowledge, skills and capacity across the Trust.

KEY ISSUES/IMPLICATIONS
The Quality, Patient Experience & Safety Committee are requested to review this report, consider the next steps and, support the continued prioritisation of work to ensure appropriate levels of compliance in line with Welsh Government expectations from April 2023.

REPORT APPROVAL ROUTE	
Quality, Patient Experience & Safety Committee	9 February 2023

REPORT APPENDICES	
ANNEX 1	- SBAR which provides an overview of the Duty of Quality/Duty of Candour Preparedness
APPENDIX 1	- Health & Care Standards Compliance Review 2022

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

SITUATION

1 The report considers the preparedness of the Trust to comply with the requirements of the Duty of Candour and Duty of Quality.

BACKGROUND

2 The Health & Social Care (Quality and Engagement) Act 2020 comes into force on 1 April 2023. There are four key components to the Act: Duty of Quality, Duty of Candour, Citizens Voice and Vice Chairs. This report considers the Duty of Candour and Duty of Quality.

3 The Duty of Candour serves service users by ensuring that, if the service user experiences, or if the circumstances are such that the service user could experience, any unexpected or unintended harm that is more than minimal and the provision of health care was or may have been a factor, the service user (or person acting on their behalf) is informed, provided with an apology and offered details of relevant services or support.

4 The Duty of Candour is triggered when two conditions are met:

- a Service User to whom health care is being or has been provided by an NHS body has suffered an adverse outcome.
- The provision of health care was or may have been a factor in the Service User suffering that outcome.

5 The outcome must relate to the provision of care by the NHS body rather than being solely attributable to the person's illness or underlying condition. It need not be certain that the health care caused the harm. It is sufficient that the health care may have been a factor.

6 The Act also requires the Trust to report annually on whether the duty of candour has come into effect in relation to the NHS Body during the reporting year (each financial year).

7 The Duty of Quality requires the Trust to:

- Ensure that strategic decisions are made through the lens of improving the quality of services provided.
- Exercises functions in a way that considers quality and outcomes will be improved on an ongoing basis.
- Activity monitors progress on the improvements of quality services and outcomes and routinely sharing the information with stakeholders.
- Strengthen governance arrangements by reporting annually on the steps taken to comply with the Duty and assess the extent of improvements in outcomes.
- Develop a Quality Management System (QMS) with appropriate focus on quality control, quality planning, quality improvement and quality assurance with the aim of achieving a learning and improving environment.

8 The Duty of Quality also requires the Trust to report annually on quality outcomes and improvements during the reporting year (each financial year). Examples of evidence to be used to assess the duty of quality and improvement in outcomes include:

- Existing performance, outcome and delivery indicators and measures from the QMS.
- Patient Reported Outcome Measures (PROMS) and Patient Reported Experience Measures (PREMS).
- Mortality data.
- Information contained within the Once for Wales Concerns Management System such as Incidents and Concerns.
- Patient and Staff Stories.
- Strategic decision making that has been driven by the quality principals within the Duty of Quality Statutory Guidance 2023 and Quality Standards 2023.
- Inspections, for example, resulting from those conducted by Health Inspectorate Wales.

9 The Trust will be required to have an 'Always On' approach to monitoring, reporting, early escalation, intervention and sharing of quality outcomes/ intelligence with stakeholders ensuring a whole system approach.

10 The current Health and Care Standards will change to six domains and five enablers in April 2023. The new domains are Safe, Effective, Timely, Efficient, Equitable and Person Centred. The new enablers include Leadership, Culture and Valuing People, Data to Knowledge, Learning, Improvement and Research and Whole System Perspective.

11 As part of this work, the Trust undertook a compliance review against the current All Wales Health and Care Standards 2015 (HCS). This review is a subjective self-assessment undertaken by the lead experts in the Trust across all domains and includes seven domains / 150 criteria. The review included the Trust quality outcome measures, source data, reporting routes, compliance and risks/issues determined by the lead experts (**Appendix A**). This review is not the focus of this paper but has informed assessment of preparedness for the new legislation.

12 The HCS Compliance Review concludes assurance is variable across standards, due to quality outcome measures not being clearly defined across all areas, not unanimously agreed with tolerances, or issues with source data identified. Evidence of compliance to support the narrative statements has not been requested as part of the review; the review also found some variation/inconsistency in staff utilising the appropriate Trust governance reporting routes.

13 The review offers opportunities for learning in the integration of the new Quality Standards, which will have a firmer basis in quality management and data-orientated performance monitoring. Further to completion of the compliance review against the HCS, consideration is being given to an internal peer review to discourage bias or interpretation issues at a local level. Evidence of compliance to support the narrative will also be required in future from the lead experts.

ASSESSMENT

14 The Welsh Government (WG) has set a baseline position to be achieved by all NHS organisations by April 2023 for both the Duty of Quality and Duty of Candour.

15 The Trust has utilised the Health and Care Standards (HCS) 2015 compliance review as a vehicle to identify gaps outlined within the WG baseline requirements for the Duty of Quality. The following points should be read in conjunction with the HCS Compliance Review and Appendix A.

16 The Assessment also considered the Quality Strategy Implementation Plan.

Duty of Quality Baseline Position

Theme	Minimum requirement by April 2023	Trust Position	Next Steps
Leadership and culture	Senior responsible leadership in place and driving implementation work All staff recognise and understand the organisation's Quality vision, and their roles within it Commitment, resources, and infrastructure in place to implement Duty effectively	A Board development session has been undertaken and there is a Non-Executive Lead for Quality. There are identified Executive and Operational leadership who will represent the Trust on the Duty Implementation Board, Duty of Candour Group coordinated by the WRP / NWSSP and Quality Group coordinated by the NHS Collaborative. A developing Quality Management Group with a focus on the Duty of Quality and Quality Management system (QMS) agenda is in place. Awaiting Welsh Government (WG) Education packages and internal engagement plan to ensure all staff understand the quality vision through the lens of the Duty of Quality (DOQ) and Duty of Candour (DOC) and their role within it. Realisation of the Trust Quality Strategy has been reliant on the recruitment of senior quality leads. There are also resourcing issues within quality functions. However, following the Organisational Change Process completed in January 2023 this element is partially resolved and active recruitment into available posts has commenced.	Further expansion of the Quality Management Group, to include Senior Leadership team from across directorates to consider DOQ/DOC implementation using the Quality Management System as a vehicle to monitor, report, triangulate data, escalating where appropriate. Utilise the WG education packages to develop skills and knowledge within the workforce, enabling understanding and application of the DOQ The Trust will require resources to disseminate education packages using digital and other mediums. Quality Management system education packages need to be developed internally to support all staff to utilise the QMS in real time once developed. Review of resources to ensure staff have the appropriate skills, knowledge, and capacity to create the conditions for a functioning quality management system and quality strategy. Consider investment into the Trust digital infrastructure to ensure accuracy and inter-operability of all quality source data/intelligence systems.
Decision-making	Processes and systems in place to provide demonstrable evidence that Board decisions have been made through Quality lens	Whilst it is recognised that the Trust has a strong governance infrastructure, it is essential that all staff utilise this in a uniform and consistent way, to monitor, report, triangulate data, escalating where appropriate. The HCS compliance review suggests there is variation in the utilisation of reporting routes. There have been risks raised in relation to quality outcome measures	To assure learning and strategic decisions are made through the lens of improving the quality of services, the Trust will need to clearly outline, communicate, and promote the 'Always On' approach to quality monitoring and reporting, enabling early escalation, intervention and sharing intelligence with stakeholders. This will include; • Incorporate the DOQ & DOC into all agendas floor to

		source data. Accuracy and confidence in the data/intelligence is critical in assuring good quality decisions are made at all levels. The risks are outlined below, raised by the expert leads; • Utility of clinical telephone triage systems requiring upgrade - CAS and Salus system implementation is delayed; • Lack of Content Management System to enable full potential of the 111 Website symptom checkers; • Tracking of Medical devices is currently manual which would be benefited by automated systems. • Lack of Trust wide digital audit capability for clinical and non-clinical areas. • Further investment into digital records document management to prevent financial penalty from the Information Commissioners Office • Lack of Trust wide digital system to manage the receipt, review, and disseminated of external notifications/alerts within the agreed timescales and that appropriate action is taken, central repository for all training requirements. • Continued use of excel spreadsheets as a means of gathering data.	Board, to monitor, report and escalate indicators and measures through our governance structures to ensure that appropriate action is taken at every level in terms of learning, improvement, and accountability. • Develop reporting and publication schedule for all stakeholders. • Agree the evidence to be used to assess the duty of quality, duty of candour and improvement, this will inform the QMS development. Expedite the implementation of Salus for telephony triage. Review of digital infrastructure and data sources, considering the purchase of an Asset Management system to track all medical devices ensuring compliance regulatory standards; new Content Management System for 111 Website symptom checkers; Digital Audit software to improve audit capability across the non-clinical and clinical areas to establish risks/improvement priorities; Digital Records Management System; new software to support notifications/alerts received from a range of external organisations e.g., NICE, Welsh Government.
Governance and accountability structures	Board is assured that DoQ is being considered across system Routine governance documentation is DoQ-ready	Currently DOQ and DOC are not formally part of Trust agendas. All Policies that come up for renewal should consider the DOQ and DOQ. However, PTR Policy and Adverse Incident Policy, should be considered as soon as possible. Further investment into Trust Records Management structure within the digital directorate should be in place to ensure that all Trust records are managed in line with Trust Policy & Procedure. A Records Management administrator/s should be in place to manage and audit all Trust records procedures. This would address the following risks identified; • audit procedure for the download of calls required;	The Trust will need to incorporate the DOQ & DOC into relevant forums at operational and strategic levels to monitor, report and escalate indicators and measures through our governance structures to ensure that appropriate action is taken at every level in terms of learning, improvement, and accountability. Consider all related Policies, in particular: Review of PTR Policy (in line with Duty of Candour) and Adverse Incident Policy. In addition, development of a Policy which reflects a Quality Management System. Implement Records Management Policy and audit programme across the Trust to mitigate risk.

		• system resilience challenges during Down Time/ Telephony, • EPCR records lost due to software technical issues;	
Reporting and information (data to knowledge)	Mechanism and publication schedule / plan in place for sharing DoQ progress information externally Quality-related information escalation mechanisms in place, with plans for review and consideration at appropriate level	To assure quality related intelligence/knowledge, we need to have clearly defined and agreed quality outcome measures, the digital infrastructure to support and all staff consistently utilising the Trust reporting and monitoring routes (operational, tactical, and strategic). However, the HCS Compliance Review has illustrated that more work is required in this area. Publication schedule for sharing DOQ information externally requires further development. Schedule for the review of quality outcome measures requires further development. The current management of quality outcome source data has highlighted risks as mentioned earlier.	Develop digital infrastructure to support the quality standards, meet information governance requirements and inter-operability. Agreed Quality Standards, defining what good looks like (Including tolerances) for each quality domain an enabler. Define quality outcome monitoring and reporting routes (Operational, tactical, and strategic). Ensure the Trust Clinical Audit plan is linked into the respective governance routes. Ensure the DOQ & DOC are formally part of all agendas within the governance structures floor to Board.
Commissioning & Hosting	A clear and corporately agreed understanding of changes required to incorporate DoQ requirements into all commissioning arrangements	The Trust and Commissioners are working through potential changes to incorporate aspects of the Act into all commissioning and hosting arrangements.	Ensure the Duty of Quality and Duty of Candour are incorporated into all commissioning arrangements and hosting arrangements.
Quality Standards	A clear understanding of changes required to existing quality infrastructure and agreed programme of work to align with Quality Standards 2023	Review of uniformity between reporting routes required to ensure whole system monitoring, reporting and escalation. This would provide an overall quality picture with identified focused areas. The Trust requires further development/agreement on the suite of quality outcome measures that determine what good/gold standard across all Health and Care, essential to establishing a gap analysis towards compliance or 'best practice' performance. Further clarity is required on compliance with Medical Devices Regulation and standards. There is a question as to whether ECNS (Emergency Communication Nurse System)/ CAS/EPCR and Salus are classed as a Medical Device. If they are classed as a Medical Device	Agreed programme of work by lead experts to align current quality measures to the April 2023 Quality Standards, including defining what good looks like for each quality domain. Implementation of business cycles within each directorate to monitor compliance with the Health and Care Standards, with highlight reports to escalated good/poor practice as required, escalation to CQGG (Clinical and Quality Governance Group) where appropriate. Identification of improvement plans where appropriate by the respective expert lead.

		the Trust further work will be required to assure the Trust is compliant.	
Quality management system – general	A clear understanding of, and commitment to, a quality management system, with plans in place to identify requirements and current gaps	The development of a Quality Management System (QMS) to include planning, improvement, control, and assurance is in its initial stages that require investment. Further work required to outline the governance arrangement around the QMS i.e. A Duty of Quality Framework (DOQF)	Scope the requirements and implementation of a Trust wide Quality Management System (QMS), including data and information system requirements and cost. Consider a Duty of Quality Framework (DOQF) supporting the governance arrangements of the QMS.
Communication and engagement	All staff are aware of key DoQ messages tailored to their organisation	Knowledge regarding the DOQ is limited across the Trust due to resourcing constraints in implement a comprehensive programme based on the WG education packages.	Implementation of an education and awareness programme for all staff to ensure understanding of the Trust Quality vision, and their roles within it. This Programme should be supported by educational resources from the Welsh Government and a Communication and Engagement plan.
Training and education	At least one member of Board trained, knowledgeable and able to influence Board in relation to DoQ		

Duty of Candour Baseline Position

Theme	Minimum requirement by April 2023	Trust Position	Next Steps
Leadership and culture	Senior responsible leadership in place and driving implementation work Strategic led identified and trained (IM or Non-Exec) Operational lead identified (executive officer level) Board awareness training completed	There are identified executive and operational leads who will represent the Trust on the Duty Implementation Board and Duty of Candour Group coordinated by the Welsh Risk Pool (NHS Wales Shared Services Partnership). The Serious Case Incident Forum (SCIF) is well established group meeting twice weekly to review patient safety incidents. This Group is led by the Assistant Director of Quality and Nursing and is well represented by colleagues across the organisation with colleagues external to the Trust attending and providing positive feedback on the process. The Duty of Candour Statutory Guidance (2023) is clear that the introduction of the statutory duty of candour for NHS bodies in Wales will complement the existing professional duty of candour required of individual healthcare professionals by the Nursing and Midwifery Council, the General Medical Council, Health and Care Professions Council and many other professional regulatory bodies. Healthcare professionals who are subject to a professional duty of candour must be open and honest with service users, colleagues, their employers and relevant organisations, and must take part in reviews and investigations when requested. The fundamental principles of a Duty of Candour are therefore already embedded across a wide section of NHS bodies. It is recognised externally that the Trust has a positive incident reporting culture and already engages early with patients and families following a patient safety incident. The Patient Safety Team as a minimum currently review all patient safety incidents graded severe or catastrophic and other incidents as required. Fundamental changes to communication with patients and families has already been adopted by the Putting Things Right (PTR) team. A Board development session has been undertaken and there is a Non-Executive Lead for Quality.	Resources for PTR functions are planned to undergo an organisational change process and will consider the implications of the implementation of the Duty of Candour in the context of sustained system pressures and the resulting impacts for patients and families. Oversight arrangements for moderate and above patient safety incidents will be in place by March 2023. Relevant policies / procedures will be updated to reflect this change.

Governance and accountability struc**tu**res	Fully developed and signed off Implementation plan for the duty	The Trust's Putting Things Right Policy (version 2.5) was updated and approved in July 2021 and includes a section on the implementation of the Duty of Candour (section 16.2). The Trust's Adverse Incident Reporting Policy And Procedure (version 1.17) was approved in July 2021 includes a section on the Duty of Candour (section 6.1) and is referenced throughout the document. Responsibilities and oversight arrangements regarding enacting the Duty of Candour are also included.	Amendments to the Trust's Putting Things Right Policy to reflect the agreed threshold for the enactment of the Duty of Candour and reporting and oversight arrangements. Welsh Government have recently published a revised version of the national Putting Things Right Policy to align to the Duty of Candour and any other updates will be considered in the Trust's revised policy by March 2023. Updates to other internal PTR and patient safety procedural documents will be undertaken as required. Updates to the terms of reference of key groups to reflect the Duty of Candour will be made by March 2023 including SCIF. Updating the Trust's Adverse Incident Reporting Policy And Procedure to reflect the agreed threshold for the enactment of the Duty of Candour and reporting and oversight arrangements.
	Implementation of the actions in the implementation plan due to enable duty to be enacted in April.		
	Policy-ratified and published		
	Any additional SOP's or policies completed		
Reporting and information (data to knowledge)	Training Needs analysis for reporting requirements for the duty	The Trust uses the Datix Cymru system and participates in all Wales working groups focussed on different modules. The facility to include Duty of Candour decisions is already built into the software, therefore with Business Intelligence software (as the system develops) will provide data and information with oversight by the Patient Safety Team. The Patient Safety Highlight Report is published in the public domain via the Quality Patient Safety and Experience Committee (QuEST). Duty of Candour data and information will form part of this report.	PTR team to undertake relevant all Wales training on the Datix Cymru system as available. Development of patient safety dashboards to provide a more real time collective system perspective. Duty of Candour reporting to be included from Q1 2023.
	Candour-related information validation and mechanisms for escalation in place, with plans for review and consideration at appropriate level		
	Facilities for primary care providers in place and functionality tested		

	Mechanism and publication schedule / plan in place for Candour Reporting Requirements.		
Commissioning & Hosting	A clear and corporately agreed understanding of changes required to incorporate DoC requirements into all commissioning arrangements	The Trust and Commissioners are working through potential changes to incorporate aspects of the Act into all commissioning and hosting arrangements.	
Communication and engagement	All staff are aware of key DoC messages tailored to their organisation Engagement with workforce and key stakeholders e.g., Service Users	The National Candour Implementation Group have produced a patient flyer that encompasses the key issues and themes around the new legislation. The Patient Engagement and Community Involvement Team (PECI) already have a programme of work in place which includes obtaining and sharing patient stories.	Adoption of the information leaflet when finalised by Welsh Risk Pool and share Trust wide. Using existing forums to educate and share Duty of Candour messages including SCIF, patient safety meetings and induction / ongoing education programmes. PECI to consider any further requirements as part of their work programme.
Training and education	Training Needs analysis for the duty Based on training needs analysis Key and specialist staff training identified and completed	Awaiting Welsh Government (WG) Education packages to ensure all staff understand the quality vision through the lens of Duty of Candour (DOC) and their role within it. It is recognised externally that the Trust has a positive incident reporting culture. The Patient Safety Team (led by the Assistant Director of Quality and Nursing) already lead on this agenda.	Formalise a Trust wide training needs analysis and underpinning training plan following receipt of the WG education packages using existing forums / education programmes where appropriate.

Quality Strategy

17. There have been resourcing challenges in progressing the Trust Quality Strategy which has three strategic aims:

    - Supporting a learning culture that will deliver enhanced knowledge, skills, learning, improvements and professionalism (Duty of Candour). Through actions to improve/ develop psychological safety, appreciation of complex clinical judgements (Person Centred Care), openness to new approaches and resources to support reflection and learning, education and training (Duty of Candour), day-to-day 'Duty of Candour' implementation, process and principles in which open, honest and transparent learning is undertaken.
    - Quality Management System that will deliver quality driven decisions, integrating quality management, strong governance and accelerating quality responsiveness. Achieved through actions that ensure quality is everyone's responsibility, systems that integrate and triangulate data, collaborative forums for patient and service users, including, empower local leaders using training package – Duty of Quality, quality management training/ education and establish 'working together' with Senior Quality Leads.
    - Integrating the citizen's voice that will deliver People & Community Network and Integration of Citizen Voice within Quality cycle (planning) through actions of Inclusivity, Innovation, Influencing, Involvement and Effective Citizen Participation in service change and delivery.

18. However, implementation of the strategy has been reliant on several key components. These included the recruitment of 4 senior quality leads, Welsh Government Duty of Candour and Duty of Quality education packages, all of which are not currently available. There are also resourcing issues within quality functions. However, following the Organisational Change Process in completed in January 2023 this element is progressing and active recruitment into available posts has commenced.

NEXT STEPS

19. Embed a Trust wide QMS to promote the 'Always On' approach to quality monitoring and reporting, enabling early escalation, intervention and sharing intelligence with stakeholders. Reporting should focus on information that will demonstrate the duty of quality in decision making, action taken following learning, quality improvement and improved outcomes. The following actions should be taken to facilitate:

    - Agree Trust quality outcome measures (what good looks like) aligned to the new domains are Safe, Effective, Timely, Efficient, Equitable and Person Centred. The new enablers include Leadership, Culture and Valuing People, Data to Knowledge, Learning, Improvement and Research and Whole System Perspective.
    - Agree the operational, tactical, and strategic monitoring and reporting routes for the quality outcome measures to ensure early escalation, intervention and

sharing of quality outcomes/ intelligence with stakeholders.

- Agree the reporting and publication schedule for all stakeholders and the evidence to be used to assess the duty of quality, duty of candour and improvement.
- Develop of improvement plans and stakeholder engagement.
- Incorporate the annual internal audit and clinical audit programmes.
- Review of resources to support the implementation of the Quality Strategy and staff with the required skills, knowledge and capability across the Trust.

20. Development of a digital infrastructure that provides assurance on quality related intelligence/knowledge to include:

- Expedite the implementation of Salus for telephony triage system.
- Asset Management system to track all medical devices ensuring compliance regulatory standards.
- Content Management System for 111 Website symptom checkers.
- Digital Audit software to improve audit capability across the non-clinical and clinical areas to establish risks/improvement priorities.
- Digital Records Management System.
- Consider new software to support notifications/alerts received from a range of external organisations e.g., NICE, Welsh Government.
- Quality Management System (QMS) with appropriate focus on quality control, quality planning, quality improvement and quality assurance with the aim of achieving a learning and improving environment.

END

1. **Standard 1.1 Health Promotion, Protection and Improvement** This standard incorporates the Health Promotion, Protection and Improvement outlining that People are empowered and supported to take responsibility for their own health and wellbeing and carers of individuals who are unable to manage their own health and wellbeing are supported. Health services work in partnership with others to protect and improve the health and wellbeing of people and reduce health inequalities.			
The expert leads from across all directorate were asked to self-assess compliance using their defined outcome measures against the following HCS criteria;	**Outcome measures self- assessed by the experts as being fully compliant against their outcome measures include;**	**Outcome measures self- assessed as being partial compliant against their outcome measures include;**	**Outcome measures self-assessed as being nil compliant (inclusive of those not reported or difficult to interrogate data source against outcome measures include;**
People understand what care, support and opportunities are available, locally, regionally and nationally **People are supported to make decisions about their health behavior and well-being** **People are supported to avoid harm to their health and well-being by making healthy choices** **Systems, resources and plans are in place to identify and act upon significant public health issues** **Systems and processes in place that play a part in reducing inequalities and protect and improve the health and well-being of the population**	Provide Callers with realistic expectations (Clinical Safety Plan) Callers into 999 and 111 are provided with evidence based instructions/advice. MDPS call audits undertaken to ensure standards are achieved and themes and trends identified. Evidence Based Telephone Triage and Health Information supporting callers to make informed decisions (ECNS FOR 999 calls, CAS for 111 calls)	Seasonal Based 111 Service Health Promotion and Symptom Checkers Public Health Information Directory of Services Promotion of auto allocation to falls resources with 60 % utilisation rates Community & Public Engagement Events to influence inequality agenda Self-Care advice offered by Clinical Support desk Provision of local service information, primary, secondary care and links to third section (Interlinked with symptom checkers) Health living section on NHS 111 website. Provision of 111 A-Z of Health Conditions available to the public. Emergency Communication nurse system (ECNS) for 999 Dementia pathways	On scene paramedic enables the patient making an informed decision following clinical assessment and conversation with the patient. Directory of service available to available to clinicians Introduction of video into Emergency Communication nurse system (ECNS) for 999

		Utilisation of the Consultant Connect APP Developing clinical expertise within the CCC i.e. mental health practitioner and Midwife as examples 111- 2/CSD – 5 mental health practitioners/Midwife on secondment Once for Wales Midwifery line (Cwm Taf report)	

Source Data

CAD/ Emergency Communication nurse system (ECNS) for 999/ PECI Internal Plan (spreadsheet)/ Computer Assessment Software (CAS)- 111/ Consultant Connect APP/ Referral Pathways/ 111 website - Google analytics/ Salus/ Civica/ Public Health Wales Website/ Medical Priority Dispatch System (MPDS) Audits/ Stats Wales Website (WG website)

Reporting Routes

internal reporting, heads of service, Quest, Welsh Government, Ambulance

Risks/Issues (highlighted by the lead experts)

Specific

1. The CAS system outlined within the source data section is used in the NHS 111 setting as a clinical decision support software, however has not been updated for some time. It stopped being supported by the developer some years ago, and we stopped receiving any updates. The current system's fragility means we cannot update the system (Clinical CAS and non-clinical CSPT). The replacement system SALUS which is heavily delayed, and whilst we have some mitigation elements through staff bulletins and coaching tips This exists as high risk on the corporate risk register.
2. The Trust currently promotes symptom checkers on its 111 website to assist the public in understanding their symptoms, it does not replace the requirement for medical care. However currently we are not able to collate data on self-care dispositions on the symptom checkers and they are only available for aged 12 and above. NEW Content Management System required to enable to realize the full potential of the Symptom checker

General

3. Some outcome measures are relying on excel spreadsheets to capture data and make decisions. This will hinder the trust ability to ensure all systems are interoperable.
4. Where we have nil compliance it has been suggested that it is difficult to interrogate the data source

Safe Care

Standard 2.1 Managing Risk and Promoting Health and Safety

People's health, safety and welfare are actively promoted and protected. Risks are identified, monitored and where possible, reduced or prevented

The expert leads from across all directorate were asked to self-assess compliance using defined outcome measures against the following HCS criteria;	**Outcome measures self- assessed by the experts as being fully compliant against outcome measures include;**	**Outcome measures self- assessed as being partial compliant against outcome measures include;**	**Outcome measures self-assessed as being nil compliant (inclusive of those not reported or difficult to interrogate data source) against outcome measures include;**
Best practice is applied in assessing, managing and mitigating risk which draws on peoples experience of the service **Risk Management and Health and Safety are embedded and are monitored to ensure continuous improvement** **Access to up to date and relevant information is readily available to identify, priorities and manage real risk that may cause serious harm** **Safety notices, alerts, and any such communications are acted upon** **Measures are in place to prevent serious harm** **Issues relating to the environment such as security, safe and sustainable design, clear signage, planning,**	NICE guidance embedded within Practice with appropriately targeted audit. Processes in place to escalate appropriate calls to Clinical Support Desk where concerns from Health Care Professionals (HCP) or Emergency Medical Dispatcher (EMD) Caller are established. Risk management Policy, procedures, and Risk Assessments and training packages available. Risk registers maintained and monitored through the business meeting agendas utilizing the Once for Wales Datix Risk Module Detailed review of each Corporate Risk. Dynamic risk assessments undertaken by all patient facing staff. Board Assurance Framework (BAF) aligned to the 2030 Delivering Excellence objectives. Monitoring of Clinical Indicators and undertaking clinical audits, clinical practice	Programme of risk management training and education delivered to the organisation. Board education on Risk Management and development of Risk Appetite Statements. Risk dashboard built into Datix for all managers within EMS/111, with themes and trends. Risk management process embedded through management groups. Risk identified through Information Asset Risk Assessments/ Data breach risk assessments/ Data Protection Impact Assessment (DPIA) process/ records access requests. Information Risk Policy, e-Datix risks are raised as Local / Directorate / Corporate as necessary Policies and Procedures in place across the Trust to guide practice and performance Patient clinical assessment Record (EPCR) Evident based expert advice with practical guidance JRCALC Working Safely Programme/ Legislative Compliance Register assessment and review/ Hazard Register assessment and review.	Evidence Based telephone triage (CAS and non-clinical CSPT) Evidence Based telephone triage SALUS (in development) Access for operational staff to Policies to support compliance with Health & Safety Legislation Fleet Maintenance records Induction training to include Dynamic risk assessments, safe systems of work, equipment maintenance schedules.

privacy, fire safety, age related general health and safety, and disability accessibility are considered. **There is compliance with legislation and guidance to promote safe environment that are; Accessible; Well maintained; Fit for purpose; Safe and secure; Protect privacy; Sustainable** **There is compliance with the requirements of the Civil Contingencies Act 2004 and supporting guidance**	reviews and clinical concerns. Promotion and monitoring of the Clinical safety plan for EMS and 111, REAP Implementation of CAD upgrades where appropriate to assure the integrity of the system. Incident Reporting via Datix across all functions. Business Continuity Plans and Business Impact Plans across all Directorates. Monitoring of all requirement under the Civil Contingency Act; o Assess the risk of an emergency occurring to inform contingency planning o Maintain plans to respond to emergencies o Maintain plans to warn and inform the public in the event of an emergency o Share information with other responders to enhance co-ordination	Health and Safety Climate Survey (draft expectation to roll out Q4 2022) Workplace premise audits process with review of themes and trends. IOSH Leading Safely Programme/IOSH Managing Safely training Programme/ Leading Safely Positive conversation training Programme. Joint Emergency Services Committee (JESC) dashboard to inform risk management H&S webpage AND Risk Assessment database Display Screen Equipment training and assessment package in place. Safety Alerts and Notices available on SharePoint via the Trust intranet and produced in paper copy for posting on H&S notice boards. Welsh Government Health Circulars logged by Board Secretary and reported in the corporate annual report. Action against any circulars relevant to WAST is recorded and the report will go to EMT. Data security alerts of breaches may be received through IGMAG or OSSMB escalated as necessary Patient Safety Alerts and Notices received from the Welsh Government Delivery Unit. RIDDOR reporting/ Workplace Premise Audits. Serious Case Incident Forum (SCIF)/Nationally Reportable Incidents (NI)/ Concerns (30 days) Putting Things Right Regulations/Coroners Regulation 28/ Learning from events	

		reports (CLAIMS/ Safeguarding Referral/Reports/ Ombudsman REPORTS Clinical Response Model/ REAP to manage patient risk in line with demand and capacity Estates Helpdesk, Datix. Fire safety group, as well as the health and safety working safely Programme board to manage Estate risks. Environmental and Sustainability issues managed through the ISO14001 accreditation route. A safe working environment is managed through the estates team with a dedicated compliance officer, overarching annual reviews of the estate are captured through the shared services annual submission as part of the NHS Wales estate forum	

Source Data

ECNS/ CAD/ MPDS/EPCR/CAS -111/SALUS/JRCALC/CSPT/Citrix/ESR/DATIX /Policy Library on SharePoint/Paramount ProQA algorithms/EMDQ audit monthly/SharePoint, /Yammer/DPIA Risks Log/Data Breach log/Specialist Practitioner Dashboard/Serious Case Incident Forum(SCIF)/ IGMAG and OSSMG alerts/Environmental audits with ISO inspector/Maintenance records (? format)/Training records? format / Communications bulletin/ H&S Monthly, Quarterly and Annual Report/Working Safely Action Tracker (EXCEL)/NARSF and NASEG/Public Health Website/Government websites/Medical Directors Group/NDOG/Nursing Director meetings/ACCE/All Wales Patient Safety Reference Group (AWPSSRG)/Board Assurance Framework Document/ Business Continuity Plans

Reporting Routes

National H&S Committee/ADLT/National H&S Committee/People and Culture Committee/ Working Safely Strategic Transformation Board/CIAG/APSG/ IGSG/ EMT/ Trust Board/EMS Business Meeting/ /111 Op leadership meeting/Digital Leadership Group/Clinical Quality and Governance Group/Corporate Annual Report/ Yammer/ Siren/ Training team reporting/HSE/QSPE/Welsh Risk Pool/Senior Operations Team / QUEST

Risks/Issues (highlighted by the lead experts)

Specific

- The CAS system outlined within the source data section is used in the NHS 111 setting as a clinical decision support software, however has not been updated for some time. It stopped being supported by the developer some years ago, and we stopped receiving any updates. The current system's fragility means we cannot update the system (Clinical CAS and non-clinical CSPT). The replacement system SALUS which is heavily delayed, and whilst we have some mitigation elements through staff bulletins and coaching tips This exists as high risk on the corporate risk register.

- Difficulties establishing Trust compliance with Policies held on the Policy library, process required to establish individual compliance
- Difficulties establishing who has read Alerts/ Notifications, currently the system is disjointed across the Trust even though there is a Trust Notification procedure in place, a more robust digital solution is required.
- Challenge in establishing whether operational leads can view training records and whether their staff are up to date.

General

- Some outcome measures are relying on excel spreadsheets to capture data and make decisions, this can effect data standards , it's hard to integrate and does not enable interoperability between systems

Standard 2.2 Preventing Pressure and Tissue Damage People are helped to look after their skin and every effort is made to prevent people from developing pressure and tissue damage			
The expert leads from across all directorate were asked to self-assess compliance using defined outcome measures against the following HCS criteria;	**Outcome measures self- assessed by the experts as being fully compliant against outcome measures include;**	**Outcome measures self- assessed as being partial compliant against outcome measures include;**	**Outcome measures self-assessed as being nil compliant (inclusive of those not reported or difficult to interrogate data source) against outcome measures include;**
People are assessed for risk of pressure and tissue damage and if considered at risk, they receive further assessment and a care plan is developed and implemented.		Telephone advice is provided to 111 users as required to reduce risk of tissue and pressure damage Monitoring via CSD recognizing long lies and falls All staff have been encourage to compete the online Pressure Ulcer Prevention Module on click through the WAST Learning Zone. This module has also been part of the paramedic Band 6 competencies. Themes / trends of complaints / incidents reported of patients	

		developing pressure damage in our care**.** Links to Risk 224 A process for flagging patients to health board colleagues to influence risk assessments and care is in development. Compliance with Fit 2 Sit Programme to be launch NHS Wales wide (reducing patient deconditioning / pressure damage) Incremental progress with the Six Goals of Emergency & Urgent Care Goal 4 (strategic work to address system pressures) causing delays in community and outside E.Ds. Education and training (resources are available in On Click and on the JRCALC App for pressure damage prevention tailored to WAST to sign post staff to. This is not mandatory (and isn't in the HBs). Clinical Notices are posted for teams to access (last clinical notice related to repose mattresses April 2022) and references Unclick and importance of escalation to nursing teams if concerns re pressure damage identified. EPCR enables recording of pressure sores and frailty scoring.	

Source Data

CAS/ Practice Bulletin/CSD – Low Code/Clinical notices/ ECNS /On click Trust Learning Zone /Patient Safety Report/ePCR/ Datix /Quality & Performance Framework metric

Reporting Routes

Internal reporting/Strategic Transformation Board/ Serious Case Incident Forum/QUEST/ Clinical Quality Governance Group/Executive Management Board

Risks/Issues (highlighted by the lead experts)

Specific

- The CAS system outlined within the source data section is used in the NHS 111 setting as a clinical decision support software, however has not been updated for some time. It stopped being supported by the developer some years ago, and we stopped receiving any updates. The current system's fragility means we cannot update the system (Clinical CAS and non-clinical CSPT). The replacement system SALUS which is heavily delayed, and whilst we have some mitigation elements through staff bulletins and coaching tips This exists as high risk on the corporate risk register.

- Partial compliance for pressure damage from a patient safety system learning perspective and HIW feedback on actions awaited. The Trust has a well embedded process for the reporting and multidisciplinary review of incidents (potential / actual moderate / serious harm). However, from a patient safety system perspective there are improvement opportunities in respect of data and information sharing with health board colleagues to influence patient care. In respect of pressure damage investigations, the Trust is rarely contacted by health boards to share information across the patient pathway. The new joint investigation process (pilot) will be a positive move towards a more system-based approach to patient safety, with the development of appropriate metrics.

- The Trust has contributed to the Healthcare Inspectorate Wales improvement plan in response to the 'Review of Patient Experience Whilst Waiting in Ambulances during Delayed Handover' October 2021 (response coordinated by EASC) which includes pressure damage prevention (response from HIW awaited)

General

- Some outcome measures are relying on excel spreadsheets to capture data and make decisions, this can effect data standards , it's hard to integrate and does not enable interoperability between systems

Standard 2.3 Falls Prevention People are assessed for risks of falling and every effort is made to prevent falls and reduce avoidable harm and disability.			
The expert leads from across all directorate were asked to self-assess compliance using defined outcome measures against the following HCS criteria;	**Outcome measures self- assessed by the experts as being fully compliant against outcome measures include;**	**Outcome measures self- assessed as being partial compliant against outcome measures include;**	**Outcome measures self-assessed as being nil compliant (inclusive of those not reported or difficult to interrogate data source) against outcome measures include;**
Falls prevention strategies are implemented based on national standards and evidence based guidelines **People are assessed for risks to their own safety and the safety of others. A plan for managing risk is agreed between the person being cared for and**	Trust attendance at National Falls Prevention Task Force Falls Prevention- Falls and Frailty Framework (assurance provided by Older Persons Improvement Group) Evidence reviewed by Older Persons Improvement Group and advice provided to QUEST if required. Number of Patients Assessed by Level 1 and Level 2 Falls Team	Referral to frailty and falls prevention teams(reactive not preventative) Callers identified as at risk of falling are referred to local HB falls services Training is provided to all staff of falls referrals and information available on DOS CPD	

those caring for them. **Staff receive appropriate information, training and supervision to ensure that people and their cares are safe.** **People are encouraged to develop or maintain the level of independence they wish, striking a responsible balance between risk and safety.** **People are able to summon help easily at all times, using a telephone, bell or other convenient means. If unable to do so theirs needs will be checked regularly**	Conveyance %/Cared for at Home Level 2- Multidisciplinary Team- Referrals to community service Conveyance %/Cared for at Home Number of patients referred via falls pathway % of Falls Demand, responded by specific Falls Resources Utilisation of Falls Resources- maximizing attendance at scene Number of patients cared for at home by Level 1/Level 2 Falls Service Number of patients cared for at home by Fire and Rescue/CFR Older Persons Framework- Improving access Engagement with Care providers/Care alarm organizations. Engagement/ work streams with care homes involving ISTUMBLE Training	Flagging on MPDS Numbers of EMT provided Falls awareness/falls assessment training Number of Student Paramedics provided fall awareness Training (Pre-registration). Working with HB to facilitate falls prevention	
Source Data CAS/CAD/Number of Falls Referrals via pathway / Falls Prevention Task Force/Qlik Sense/Report Manager/CARELINE/ ECNS/ESR/TRAINING Records /CAD			
Reporting Routes HI/EPCR/Older Persons Improvement Group (OPIG)/Senior Operations Team-			
Risks/Issues (highlighted by the lead experts) **Specific** o The CAS system outlined within the source data section is used in the NHS 111 setting as a clinical decision support software, however has not been updated for some time. It stopped being supported by the developer some years ago, and we stopped receiving any updates. The current system's fragility means we cannot update the system (Clinical CAS and non-clinical			

CSPT). The replacement system SALUS which is heavily delayed, and whilst we have some mitigation elements through staff bulletins and coaching tips This exists as high risk on the corporate risk register.

General

- Some outcome measures are relying on excel spreadsheets to capture data and make decisions, this can effect data standards , it's hard to integrate and does not enable interoperability between systems

Standard 2.4 Infection Prevention and Control (IPC) and Decontamination			
Effective infection prevention and control needs to be everybody's business and must be part of everyday healthcare practice and based on the best available evidence so that people are protected from preventable healthcare associated infections.			
The expert leads from across all directorate were asked to self-assess compliance using defined outcome measures against the following HCS criteria;	**Outcome measures self- assessed by the experts as being fully compliant against outcome measures include;**	**Outcome measures self- assessed as being partial compliant against outcome measures include;**	**Outcome measures self-assessed as being nil compliant (inclusive of those not reported or difficult to interrogate data source) against outcome measures include;**
There are appropriate Organisational structures and management systems in place for infection prevention and control and decontamination in place. **Physical environments are maintained and cleaned to a standard that facilitates infection prevention and control and minimizes the risk of infection.** **Suitable, timely and accurate information on infections is provided to any person concerned with providing further support or nursing/medical care when a person is**	IPC Strategic Group with agreed ToR Established governance structure Epishuttle used by HART and SORT teams IPC Policies available via IPC intranet page on SharePoint	Premise and Vehicle Cleaning Audits part of H&S Inspections All stations and premise have cleaning Facilities ATP swabbing as routine QA IPC Policy /Premise and Vehicle Cleaning Policy/Make Ready Depot Cleaning SOP/Vehicle decontamination SOP/Premise Cleaning Standards / High Consequence Infectious Disease (HCID) SOP/ Transfer Policy / All Wales ANTT Policy/ RPE SOP**/** Fit testing SOP Internal Horizon Scanning **/**Public Health Wales Notices	

moved from one organization to another or within the same organization. **Adequate isolation facilities are provided to support effective infection prevention and control** **Staff employed to provide care in all settings are fully engaged in the process of infection prevention and control.** **Polices on infection prevention and control are in place and made readily accessible to all staff.** **So far as is reasonably practicable staff are free of and are protected from exposure to infections that can be acquired or transmitted at work.** **Staff are suitable trained and educated in infection prevention and control associated with the provision of healthcare.**		Risk assessments Record of all Internal and External notices Promotion of good IP&C practice. IP&C vaccination clinics(Hep B/ MMR and TB) Training and Educational Resources IPC Compliance Audits e.g. ANTT National and local IPC Guidance Documents IPC PPE Guidance based on National Guidance and PHW standards IPC Education and Training Available PPE Safe and Effective Face Fit Testing	

Source Data

Regular reports and meetings /IPC annual Report / IPC intranet page- Share point/ Excel documentation/111 Website /Symptom Checkers/On Click /EPCR IPC audits (ANTT)/NATC/ Welsh Health Circulars (WHC)/Yammer/Public Health Wales/Stat Mandatory Training (ESR)/ Communication Bulletins/Notices/ CAS/ ECNS/ Cohort system for vaccinations// Power BI

Reporting Routes

IPC Strategic Group/CQGG/ ADLT/SOT/EMT /Directorate Meetings

Risks/Issues (highlighted by the lead experts)

Specific

- Continuous Professional Development training records repository- further information required

- Audit data on compliance is currently limited- further information required

General

- Some outcome measures are relying on excel spreadsheets to capture data and make decisions, this can effect data standards , it's hard to integrate and does not enable interoperability between systems

Standard 2.5 Nutrition and Hydration People are supported to meet their nutritional and hydration needs, to maximize recovery from illness or injury.			
The expert leads from across all directorate were asked to self-assess compliance using defined outcome measures against the following HCS criteria;	**Outcome measures self- assessed by the experts as being fully compliant against outcome measures include;**	**Outcome measures self- assessed as being partial compliant against outcome measures include;**	**Outcome measures self- assessed as being nil compliant (inclusive of those not reported or difficult to interrogate data source) against outcome measures include;**
People's nutritional needs and physical ability to eat and drink are assessed, recorded and addressed. They are reviewed at appropriate intervals and are referred to dietetic services as required for specialist advice and support.			Appropriate advice is provided to callers regarding nutritional support based on needs identified and shared during telephone contacts Hot Weather advice by operational teams Compliance with EOC protocols (External accreditation) and Managing Delayed Responses SOP (including welfare checks) Monitoring of incidents / complaints re patients not receiving appropriate nutritional needs or lack of assessment re physical ability to eat and drink. Arrangements in place with EDs regarding assessment and the provision of food and drink for patients waiting as appropriate.
Source Data Symptom Checkers/111 Website/Serious Case Incident Forum/Patient Safety Report			

Reporting Routes
Clinical Quality Governance Group

Risks/Issues (highlighted by the lead experts)

Specific

- Further collaboration with Health Boards and ED colleagues to establish risks to patients in relation to Handover delays

General

- Exploration of data management to capture patient risks in relation to handover delays and nutrition and hydration

Standard 2.6 Medicines Management People receive medication for the correct reason, the right medication at the right dose and at the right time.			
The expert leads from across all directorate were asked to self-assess compliance using defined outcome measures against the following HCS criteria;	**Outcome measures self- assessed by the experts as being fully compliant against outcome measures include;**	**Outcome measures self- assessed as being partial compliant against outcome measures include;**	**Outcome measures self- assessed as being nil compliant (inclusive of those not reported or difficult to interrogate data source) against outcome measures include;**
There is compliance with legislation, regulatory and professional guidance and with local guidance for all aspects of medicines management. **Health professional are qualified, registered with their respective regulatory bodies and fit for practice to prescribe, dispense, dispense and administer medicines within their professional competence and appropriate needs of the patient**	Medicines Management Policies are in date and consistent with legislation and best practice. Policies are prepared in line with Trust Policy requirements (policy on policies) All controlled drugs related incidents are investigated and reported • Omnicell Cycle count compliance • Vehicle Medicines Audit compliance • Abloy CD Key confirmation of receipt Patient Group Direction compliance		

	Paramedics are required to be registered with the HCPC. Paramedics administer a range of medicines under Schedule 17 of the Human Medicines Regulations (2012). As registrants, they are permitted to administer additional medicines under Patient Group Directions (PGDs). PGDs are prepared /reviewed in collaboration with the Trust Pharmacist Advisor Emergency Medical Technicians administer a limited number of medicines under Schedule 19 of the Human Medicines Regulations (2012). Prescribers – applications for J numbers and prescription pads are managed in line with the processes described in the Trust Prescribing Policy Medication errors are reported on Datix and investigated by an appropriate manager (DOM/LM/SP/HBCL). Incident reports reviewed by Head of Medicines Management. Appropriate reporting format currently being explored, for review by Ambulance Practice Steering Group. JRCALC Guidelines		
Source Data Share point /Medicines Management Policy/Controlled Drugs Policy/ Prescribing Policy / CD Quarterly Occurrence Reports prepared by Head of Medicines/Human Medicines Regulations (2012)/Prescribing Policy/ Medicines Management Assurance Report/ESR/Joint Royal Colleges Ambulance Liaison Committee (JRCALC) drug administration guidelines/ Medicines Management Policy/ Localities have access to ESR dashboard that contains HCPC status and can cross-check against HCPC Register/Professional Standards Policy/Human Medicines Regulations (2012)			
Reporting Routes Ambulance Practice Steering Group /Clinical Directorate Business Meeting/ Clinical Quality Governance Group / Senior Operations Team/ APSG – CQGG/SOT/Reporting to QUEST			

Risks/Issues (highlighted by the lead experts)

Specific

-

General

-

Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk Health services promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time.			
The expert leads from across all directorate were asked to self-assess compliance using defined outcome measures against the following HCS criteria;	**Outcome measures self- assessed by the experts as being fully compliant against outcome measures include;**	**Outcome measures self- assessed as being partial compliant against outcome measures include;**	**Outcome measures self-assessed as being nil compliant (inclusive of those not reported or difficult to interrogate data source) against outcome measures include;**
There is compliance with legislation and guidance to include; All Wales Child Protection and Vulnerable Adult procedures (Social Service & Wellbeing Act 2014 All Wales Safeguarding Procedures **Mental Health Act 1983 in relation to persons liable to be detained, and the Mental Capacity Act 2005 regarding Deprivation of Liberty Safeguards.** **Assurance of safeguarding services and processes is evident across all levels of the organization.** **Effective multi-professional and multi-agency**	MCA captured on EPCR and Safeguarding referral forms DOLs safeguarding Safeguarding self-assessment maturity matrix self-assessment for Peer review across Wales • Governance and right space approach • Safe care • Adverse Childhood experience (ACE) • Learning Culture • Multi agency partnership working	Monitoring safeguarding referral reports Audit safeguarding calls – children 11-17 to understand safeguarding activity and reporting	

and co-operation are in place complying with the Social Services and Well Being Act (Wales). **Staff are trained to recognize and act on issues and concerns, including sharing of information and sharing good practice and learning.** **People are informed how to make their concerns known.** **Priority is given to providing services that enable children and vulnerable adults to express themselves and to be cared for through the medium of the welsh language because their care and treatment can suffer when they are not treated in their own language.** **Suitable arrangements are in place for people who put their safety or that of others at risk to prevent abuse and neglect.** **Risk is managed in ways which empower people to feel in control of their life.**	Benchmarking against UK Ambulance services Referral processes and links with the safeguarding team in place. Safeguarding maturity matrix as above Provide local authority with intelligence on referrals within a month Regularly participate with practice reviews within the regional safeguarding Boards Level 2 & 3 Safeguarding training Induction training /Bespoke training /7-minute briefings Safeguarding referral process Bespoke evaluation forms to evaluation safeguarding training. Scenario training Support staff to make the right referrals Wish upon a star TRIM		
Source Data Maturity Matrix (paper records)/ Regional Safeguarding Board Annual report/Docwork/ ESR/ 7 Minute briefings (SharePoint page)/CPD/Yammer/Siren			
Reporting Routes Quest / ACCE/ Safeguarding Boards/Public Health Wales/ Annual report to QUEST and Welsh Government			

Risks/Issues (highlighted by the lead experts)

Specific

- Nil of note

General

- Paper records used in relation to the Maturity Matrix

Standard 2.9 Medical Devices, Equipment and Diagnostic Systems Health services ensure the safe and effective procurement, use and disposal of medical equipment, devices and diagnostic systems.			
The expert leads from across all directorate were asked to self-assess compliance using defined outcome measures against the following HCS criteria;	**Outcome measures self- assessed by the experts as being fully compliant against outcome measures include;**	**Outcome measures self- assessed as being partial compliant against outcome measures include;**	**Outcome measures self- assessed as being nil compliant (inclusive of those not reported or difficult to interrogate data source) against outcome measures include;**
There is compliance with Health, safety and environmental legislation, regulation and guidance. **Processes ensure that equipment and devices are maintained, cleaned and calibrated in accordance with manufactures guidelines, ensuring they are appropriate for their intended use and for the environment in which they are used.** **An ongoing Programme of training and competence assessment covers staff and users.** **Timely reporting and management arrangement exist to address any device, equipment or system faults in use or in stock, including any alerts or warning notices issued**	Management of Medical Devices Policy	Devices disposed of via NHS Wales Authorized Medical Disposal Agents Service and calibration compliance. Management of Medical Devices Policy Clinical notices, patient safety alerts Procedure for receiving, reviewing and disseminating notifications	Compliance with medical devices regulation and standards, currently unsure as to whether ECNS/ CAS/EPCR Salus are classed as a Medical Device. If they are classed as a Medical Device we are not compliant. Vehicle and equipment checks to be undertaken at shift commencement All staff receive training during employment role training, or specific training for new equipment by DOMs locally DATIX completion for any damaged or defective equipment

by appropriate agencies such as MHRA **Suitable and sustainable systems, policies and procedures are in place for medical device decontamination by competent staff in an appropriate environment.**			

Source Data

Service records (excel) NATC training databases/ locality records for new equipment cascade training/ Contamination status Certificates/Microsoft forms/Datix/ Datix/Vehicle MDT/Trust Asset Register/Contamination status Certificates/Medical device alerts/Field safety Notices issued by manufacturers

Reporting Routes

Clinical Equipment Working Group

Risks/Issues (highlighted by the lead experts)

Specific

- Asset management RECORD system required to track all medical devices (manual tracing is undertaken at the moment)
- Compliance with medical devices regulation and standards, currently unsure as to whether ECNS/ CAS/EPCR Salus are classed as a Medical Device. If they are classed as a Medical Device we are not compliant.
- Clarity on recording system for Medical Device Alerts for the recording, dissemination and action.

General

- Audit programme required to audit the above

Effective Care
Standard 3.1 Safe and Clinically Effective Care

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.

The expert leads from across all directorate were asked to self-assess compliance using defined outcome	**Outcome measures self- assessed by the experts as being fully compliant against outcome measures include;**	**Outcome measures self-assessed as being partial compliant against outcome measures include;**	**Outcome measures self- assessed as being nil compliant (inclusive of those not reported or difficult to interrogate data source) against outcome measures include;**

measures against the following HCS criteria;			
People are safe and protected from avoidable harm through appropriate care, treatment, information, support and early detection of risks. **People are supported to protect their own health and their families health** **Welsh speakers are able to use the Welsh Language to express themselves and information is communicated effectively** **Practice evolves to reflect new evidence and provides an efficient and effective response to promote safe and clinically effective care.** **System and processes comply with safety and clinical directives in a timely way, including alerts.** **Systems ensure that non- compliance or variance from best practices is properly recorded and audited and any risks identified are managed appropriately**	Improved compliance to Clinical indicators (ROSC, Suspected Stroke Patients with Appropriate Care, Acute Coronary Syndrome Patients with Appropriate Care)as part of the suite of Ambulance Service Indicators and Clinical Audit Airway management policy and compliance with monthly audits Ride outs with Senior Paramedic twice per year for EMT and Paramedics to ensure quality of care, clinical updates and practice feedback. Clinical reviews following incidents JRCALC guidelines are reviewed against the evidence base and changes to practice made and updates provided to each Trust and user of the host application. Clinical alerts circulated via JRCALC+ App Acknowledgement of updates and bulletins available via JRCALC+ application – report to be devised Clinical reviews SP ride outs and performance on clinical practice EPCR contains the full care record. This forms the basis of data used to populate the Clinical Indicators and Clinical Audits. Noncompliance with Care Bundles or audit criteria can be directly measured, and improvement plans initiated.	Nil Reported	Utilisation of telephone triage via ECNS and CAS Red call 8 minute response WG KPI Cymru High Acuity Response Unit (CHARU) to support high quality management of critical incidents Mortality reviews- medical examiner cases not all deaths Escalation of clinical concerns outside the ED National Early Warning Scores are embedded in the ePCR system for adults (NEWS) and children – Pediatric Observation Priority Score(POPS) Health Information and telephone triage via 111/CSD Clinically support individual decisions, including referral to alternative care pathways Language line is available where required to support Welsh speakers in a clinical context Practice bulletins to mitigate risk of CAS being out of date Senior Clinical Advice line /Clinical Safety Plan

	Clinical indicator plan and clinical audit plan for 2022/23 agreed		

Source Data

CAS/SCIF/NATC Training records/ Qliksense/Electronic airway log/ECNS/ESR/ clinical audits/Datix/Clinical Notices/JRCALC/ Electronic Patient Clinical Record (ePCR)/Senior paramedic dashboard/PADR

Reporting Routes

CASC/EASC/WG/QUEST/Workforce reports and locality summary report/CIAG/CQGG/ MQIPR/Clinical Intelligence and Assurance Group (CIAG)/EASC/Quest/Audit Committee/ Ambulance Practice Steering Group/Clinical Directorate Business Meeting/Welsh language advisory group/People and Culture Committee

Risks/Issues (highlighted by the lead experts)

Specific
General

- A number of measures in the nil compliant category did not have a compliance response.

Standard 3.2 Communicating Effectively

In communicating with people health services proactively meet individual language and communication needs.

The expert leads from across all directorate were asked to self-assess compliance using defined outcome measures against the following HCS criteria;	**Outcome measures self- assessed by the experts as being fully compliant against outcome measures include;**	**Outcome measures self- assessed as being partial compliant against outcome measures include;**	**Outcome measures self- assessed as being nil compliant (inclusive of those not reported or difficult to interrogate data source) against outcome measures include;**
Welsh speakers are offered language services that meet their needs as a natural part of their care **Open and honest communication is emphasized in the spirit of co-production** **Special care is taken in communicating with those**	111 Website and 111 & NEPTs services provide welsh language option when the public call for advice. Face to face meetings/engagement is also facilitated through welsh language if	Training and awareness training for staff how to tailor conversations with those with protected characteristics Alignment with older people's	Welsh speaker cover is rostered to all shifts by Resource Planning in 111. Unplanned absence can impact on availability (no response on compliance) All 111 staff are trained in effective and

whose mental capacity maybe temporarily or permanently impaired **Language and Communication needs are addressed for people with specific care needs; including disabilities, dementia, stroke, sensory loss, neurological developmental problems.** **Effective, accessible, appropriate and timely communication is tailored to each individual person and reasonable adjustments made as defined by the Equality Act 2010** **Method of on and off line communication in various languages and accessible formats are used.** **There is compliance with legislation and guidance to ensure effective, accessible, appropriate and timely communication and information sharing.**	required (PECI & PTR). Community Engagement events Engaging with Community Health Council networks People and community network EPCR work in development to capture special characteristics to map health in equalities All engagement and resources developed take into consideration language and communication needs.	commissioners' recommendations; Sensory loss standards in Wales amongst others. 111 website – recite me (100's of different languages) British Sign Language line Triple tick for the website if assurance on information (w3c web content accessibility) WASPI Information Sharing Confidentiality Code of Conduct	appropriate communication(no response on compliance) 111 provides access for callers with disabilities and all staff are trained on communicating with callers with specific needs. Low Code on CSD using video from next week(no response on compliance) 111 uses language line as required

Source Data

Resource planning weekly report/Protected Characteristics groups engagement plan(excel)/111 website/PECI expertise captures source data (excel) /Training records On click/Civica System/CAS/Clinical Support Desk- ECNS data/Data Sharing Agreement Log excel/GRS analytics (website) mostly bilingual/Telephony stats/Stats from BSL British Sign Language

Reporting Routes

Welsh Language Advisory Group/People and Culture Committee PECI Quest report and Welsh Government/Bi-annually reports on sensory loss, learning disability and patient experience to Welsh Government/QUEST Committee

Risks/Issues (highlighted by the lead experts)

Specific
General

- A number of measures in the nil compliant category did not have a compliance response
- Some outcome measures are relying on excel spreadsheets to capture data and make decisions, this can effect data standards , it's hard to integrate and does not enable interoperability between systems

Standard 3.3 Quality Improvement, Research and Innovation Services engage in activities to continuously improve by developing and implementing innovative ways of delivering care. This includes supporting research and ensuring that it enhances the efficiency and effectiveness of services			
The expert leads from across all directorate were asked to self-assess compliance using defined outcome measures against the following HCS criteria;	**Outcome measures self- assessed by the experts as being fully compliant against outcome measures include;**	**Outcome measures self- assessed as being partial compliant against outcome measures include;**	**Outcome measures self-assessed as being nil compliant (inclusive of those not reported or difficult to interrogate data source) against outcome measures include;**
Local capacity and capability is developed to support and enable teams to identify and address improvement priorities, including participation in audit and recognized quality improvement methodologies, activities and programmes. **Progress is measured, recorded and learning is shared.** **There is consistent application of the principals and requirements of the framework for Health and Social Care Research and Development.** **Research and innovation has a direct impact on improving the efficiency and effectiveness of services, delivering better health and well-being outcomes for**	WIIN to be covered by quality directorate WAST have a developed clinical audit plan and a dedicated team for developing and delivering clinical audits. Audit activity is covered on the Senior Paramedic Induction The research and innovation study tracker is presented to the Clinical Services Directorate Business Meeting monthly, this includes information and updates on both studies that are active and in development, as well as the department risk log for all studies and the governance items that surround the studies (I.e. dates of official approvals, submissions for funding and approvals etc.). This not only informs the directorate on research activities but encourages discussions around research with the wider directorate, such as potential study ideas. All studies identified as research undergo a rigorous governance and approvals processes, meeting the requirements of the Policy Framework	Capacity and capability An Innovation Coordination hub model was established by Welsh Government to co-ordinate, align and strengthen the innovation infrastructure across Welsh health and social care. Complementing Public Health Wales, Velindre University NHS Trust and the regional (RPB footprint) hub network, the WAST Innovation Coordination hub advances quality and value of innovation, according to *A Healthier Wales (2018)* plan, by stimulating cross-sector engagement, good practice capture and collaboration potential. Prioritizing Innovation: A business intelligence data platform (in design) will capture the service user experience, and lessons learnt from external inspections, to enhance WASTs data intelligence profile for prioritizing I&I activity: through data triangulation, synthesis, and solution co-ordination. Enabling Innovation Thematic analysis of WAST Innovation and Improvement Network (WiiN) DataStream's add to WASTs intelligence profile by aggregating staff ideas - facilitating I&I adoption and spread Pertinent good practice capture of 'innovation potential' is	TRIM Remote workers Study (effects of home working on individuals) (no response on compliance) ECNS –emergency communication nurse system (governance package that wraps around low code) (no response on compliance)

people, and improving the experience of care. **There is a structured approach to promoting and supporting research and innovation and it is applied in everyday practice.** **There is clear leadership and a strong collaborative approach with university and industry partners**	for Research in Health and Social Care, Health Research Authority (HRA) and Health and Care Research Wales (HCRW). The WAST Innovation and Improvement Network (WiiN) is now deeply embedded within the organization's improvement and innovation profile, delivering a central and transparent platform for idea synthesis and knowledge mobilization. Innovative projects are presented to the Assistant Director Leadership Team (ADLT WiiN sub-group), strengthening Organisational support mechanisms at the highest level, whilst endorsing and driving an innovation culture. Research and Development Office have a structured approach to research, including promoting inclusion and participation in studies. Encouraging research to be a foundation to new projects and to generate innovations and ideas. The department has weekly departmental meeting to discuss research activities as well as study-specific trial and research management group meetings which are attended by various external stakeholders including other NHS organizations, private organizations and university institutions. Meetings are attended by the Head of Research and Innovation with various internal and external research colleagues to discuss NHS Research and Innovation opportunities, governance, and processes. These include, the innovation leads meeting, Research Management Operational	communicated to members of the Welsh Government led Research Innovation Coordination Hub (RICH) network. The hub *network* provides a pan-Wales platform for engaging with public, private and third sector bodies. With a comprehensive and current overview and analysis of innovation activity, the network is able to identify and progress collaborative and mutually beneficial opportunities A WG approved innovation activity plan for WAST includes hub aims and objectives, from macro (overview) to granular (deliverables) level, facilitating robust forward planning, goal evaluation and clear governance mechanisms. Strategic alignment is maintained throughout the activity plan according to the business planning context, at NHS Organisational level, and NHS Wales strategic and policy context. The WAST Innovation Coordination hub is built on four pillars and framed by principles that seek to: ensure the organization is intelligence led - by understanding challenges, root causes and underlying enablers/barriers to change; design solutions that align with evolving strategic contexts and Organisational needs; maximize utility of available assets and funding streams; and to maximize efficiency, effectiveness, and the service experience - translating innovative ideas into tangible, meaningful outcomes. A *Welsh NHS Trust innovation partnership* model, comprising WAST, PHW and Velindre, promotes and facilitates large programmers of collaborative work with key stakeholders, university, and industry partners. Contributors are expanding and currently include the Office for National Statistics, PHW Intelligence and Surveillance Unit, Digital Health & Care Wales, and NHS Wales Delivery Unit. Work is progressing on a mission and benefit for NHS Wales, key outcome deliverables, themes,	

	Group, NARSG, RHCW Steering Group, and NHS R&D Leadership group.	goals, and legal structure.	

Source Data

RIIC HUB Quarterly Updates/ Publications Academic Partnership/ **R&I Tracker (? excel)**

Reporting Routes

Clinical Directorate Business Meeting/ ADLT WIIN Subgroup/CIAG

Risks/Issues (highlighted by the lead experts)

Specific
General

- Some outcome measures are relying on excel spreadsheets to capture data and make decisions, this can effect data standards , it's hard to integrate and does not enable interoperability between systems

Standard 3.4 Information Governance and Communications Technology

Health services ensure all information is accurate, valid, reliable, timely, relevant, comprehensible and complete in delivering, managing, planning and monitoring high quality, safe services. Health services have systems in place, including information and communications technology, to ensure the effective collection, sharing and reporting of high quality data and information within a sound information governance framework.

The expert leads from across all directorate were asked to self-assess compliance using defined outcome measures against the following HCS criteria;	**Outcome measures self- assessed by the experts as being fully compliant against outcome measures include;**	**Outcome measures self- assessed as being partial compliant against outcome measures include;**	**Outcome measures self-assessed as being nil compliant (inclusive of those not reported or difficult to interrogate data source) against outcome measures include;**
Safe and secure information systems are developed in accordance with legislation and	Data Protection Impact Assessments, cloud security and NIS assessments completed where necessary.	Information Asset Management is assessed as part of the NHS Wales IG Toolkit.	

within a robust governance framework **Processes exist to operate and manage information and data effectively, to maintain business continuity and support and facilitate patient care and delivery** **Data and information are accurate, valid,reliable,timely,relevant,comprehensible and complete** **Information is used to review, assess and improve services** **Information is shared with relevant partners using protocols when necessary to provide good care for people.**	No. of serious breaches of the UK GDPR and Data Protection Act 2018 No. data breaches reported to the ICO under the GDPR 72-hour requirement	Business continuity assessed in the organisation's individual Welsh Cyber Assurance Process (WCAP). Business continuity arrangements for data is a question contained within the Data Protection Impact Assessment and Cloud Security Assessments. Data accuracy, integrity and availability are key principles of Data Protection Legislation and the Records Management Code of Practice. Data quality, accuracy and records management are sections of the NHS Wales IG Toolkit Assessment (annual). Information Governance Policy/Information Risk Policy/ Information Asset Owner Handbook Outcomes from the IG Toolkit assessment submissions are used to review, assess and improve areas of information governance (applicable across the Trust) based on priority and risk. Data Sharing Agreements are in place where necessary. Agreements are logged in the Data Sharing Log and reviewed regularly. Records Requests by partners (such as Police and the HCPC) are handled promptly. No. of FOI Requests; response rates of response within 20 working days	
Source Data DPIA Log and Procedure/ IGSG Report Update/ formation Governance Policy /Information Risk Policy/Information Asset Register / Information Asset Owner Handbook / Information Asset Register/ IG Toolkit -Information Assets/ Data Protection Impact Assessments			
Reporting Routes Information Governance Steering Group (IGSG)			

Risks/Issues (highlighted by the lead experts)

Specific
General

- Capacity issues within IG sighted as rationale for not being fully compliant

Standard 3.5 Record Keeping Good record keeping is essential to ensure that people receive effective and safe care. Health services must ensure that all records are maintained in accordance with legislation and clinical standards guidance.			
The expert leads from across all directorate were asked to self-assess compliance using defined outcome measures against the following HCS criteria;	**Outcome measures self- assessed by the experts as being fully compliant against outcome measures include;**	**Outcome measures self- assessed as being partial compliant against outcome measures include;**	**Outcome measures self-assessed as being nil compliant (inclusive of those not reported or difficult to interrogate data source) against outcome measures include;**
Paper and electronic clinical record quality is improved through the adoption of the Academy of Medical Royal Colleges standards for the clinical structure and content of patient records. **Clear accountability for record keeping supports effective clinical judgements and decisions** **There is effective communication and sharing of information between members of the multi-professional healthcare team and the patient.** **Record keeping supports clinical audit, research, allocation of resources and performance planning**	The Record Services & Archives Team requests for Trust records. Access to Personal Information Policy. Records maintained on CAD for all contacts MPDS Audits on Aqua Improved quality of ePCR data to demonstrate care and inform improvements through clinical indicators and clinical audits	Storage of clinical records for 25 years All Information is captured from call taker, allocator and dispatcher on CAD 111 triage and health information on CAS All Trust records should be produced and managed in line with Trust Policy IG tool kit –submitted to ICO annually	All Trust clinical records in all formats can be used as a means to improve and maintain the required standards of health care provision by WAST. Under the Trust Records Management Policy and the Trust Retention Schedule (signed off by Trust Board) all WAST employees have a responsibility to manage and maintain records based on their role, DPA 2018 & UKGDPR.

Evidence shows how decisions relating to patient care were made **Identification of risks enable early detection of complications** **Record keeping supports the delivery of services, patient care and communications.** **Records are designed, prepared, reviewed and accessible to meet the required needs.** **Records are stored securely, maintained, are retrieved in a timely manner and disposed of appropriately** **Records are accurate, up to date, complete, understandable and contemporaneous in accordance with professional standards and guidance; and shared when appropriate** **People personal records are regularly updated and available to them. To ensure confidentiality, they are kept secure and comply with the Data Protection Act 1998.** **Care, treatment and decision making is supported by structured, accurate and accessible patient records documenting the conversations between people and health professionals and the resulting decisions and actions taken and reflects best practice founded on the evidence base.**	Clinical risk for individual patients identified through assessment and examination which are documented on the ePCR with sections for physiological measures, including NEWS scores (adults) and POPS scores for children. Forms part of some clinical indicators Clinical indicators Access to patient's previous ePCR records is available. Access to GP records is in development	Compliance with Data protection act 2018 and UK General Data protection Regulation	The Policy & Trust Retention Schedule. A formal Trust Records Management structure in order to ensure that all Trust records are managed in line with Trust Policy & Procedure. Under Trust Policy, Procedure and formal training all decisions relating to patient care are documented in the appropriate format and stored in line with Trust Retention Schedule. A formal Records Management structure *should* be in place throughout the Trust in order to ensure that all Trust records are managed in line with Trust Policy & Procedure. A Records Management administrator/s should be in place to manage and audit all Trust records procedures Staff records HR (6 years retention)

Source Data
C3 CAD/ CAS/ MPDS/ Call recording audits

Reporting Routes
MQIPR/EASC/ **E**PCR Clinical Reference Group

Risks/Issues (highlighted by the lead experts)

Specific

- No audit procedure for the download of calls
- Unable to audit Trust records management adherence due to no software/source data in place collectively
- Electronic document management system required (naming conventions/ central repository) Financial penalty if ICO pick up on it
- Individual audits on individual record keeping systems, however there is no Trust overview to establish risks/improvement priorities.
- Lack of system resilience as when Down Time/ Telephony outage occurs, Manual records and retrospective input by CCC staff if the system crashes records can be lost.
- EPCR records lost due to software technical issues
- No robust system in place to identify trust wide risks relating to records management
- A formal Records Management structure ***should*** be in place throughout the Trust in order to ensure that all Trust records are managed in line with Trust Policy & Procedure.
- A Records Management administrator/s should be in place to manage and audit all Trust records procedures
- No formal records management process/policy in place to establish compliance

General

- Some outcome measures are relying on excel spreadsheets to capture data and make decisions, this can effect data standards , it's hard to integrate and does not enable interoperability between systems

Standard 4.1 Dignified Care			
People's experience of health care is one where everyone is treated with dignity, respect, compassion and kindness and which recognizes and addresses individual physical, psychological, social, and cultural, language and spiritual needs.			
The expert leads from across all directorate were asked to self-assess compliance using defined outcome measures against the following HCS criteria;	**Outcome measures self- assessed by the experts as being fully compliant against outcome measures include;**	**Outcome measures self- assessed as being partial compliant against outcome measures include;**	**Outcome measures self-assessed as being nil compliant (inclusive of those not reported or difficult to interrogate data source) against outcome measures include;**
People are treated with respect, courtesy and politeness. **People are able to access free and independent advice so they can make choices about their care and lifestyle.** **Individuals are addressed by their preferred name** **Welsh language needs are responded to sensitively** **Confidentiality, modesty, personal space and privacy are respected.** **People's feelings, needs and problems are actively listened to, acknowledged and respected.** **All care is recognised as holistic and includes a spiritual, pastoral and religious dimension.**	The revised NHS 111 Wales website has relevant information on health and lifestyle. People are actively signposted to the site	Regular experience is captured through face to face and survey work, this includes asking people what dignity means to them and what dignified care should feel like. People's preferences are always taken into consideration and met where practicable. We work to ensure that the Rights of Older People and Children, as outline in the ECHR underpin engagement with these groups. Dignity campaigns Hello my name is Welsh language standards / Welsh Governments More Than Just Words Action Plan 2022- 27. A set of Promises to Older People and Children/Young People were developed in	In the event of face-to-face assessment patients are provided with information about their history and presenting information so they can make choices about their care (NO DATA SET) A variety of pain relief can be administered by paramedics JRCALC Guidelines 9 no data set)

Information and care are always provided with compassion and sensitivity. Ensuring that people and their carers have the freedom to act and decide based on opportunities to participate and on clear and comprehensive information **Consideration is given to people's environments and comfort so they may rest and sleep.** **People are helped to be as comfortable and pain free as their condition and circumstances allow.** **Continence care is appropriate and discreet and prompt assistance is provided as necessary taking into account peoples specific needs and privacy.**		partnership with the public that provide the basis to assess quality of care and experience. These promises are continuously reviewed to ensure they reflect the views/expectations of the public/patients. Regular engagement with people and their carers is undertaken with annual surveys carried out and assessment on experience/outcomes.	

Source Data
Consultant Connect and other referral pathways/ Bespoke PECI reporting tool (EXCEL)/Civica/Datix(incidents and concerns)/Patient Stories/EPCR/

Reporting Routes
Welsh Language Commissioner/ EMT/ People and Culture Committee and Board

Risks/Issues (highlighted by the lead experts)

Specific

- Absence of what good looks like
- System issues preventing full compliance

General

- Some outcome measures are relying on excel spreadsheets to capture data and make decisions, this can effect data standards , it's hard to integrate and does not enable interoperability between systems

Standard 4.2 Patient Information People must receive full information about their care which is accessible, understandable and in a language and manner sensitive to their needs to enable and support them to make an informed decision about their care as an equal partner.			
The expert leads from across all directorate were asked to self-assess compliance using defined outcome measures against the following HCS criteria;	**Outcome measures self- assessed by the experts as being fully compliant against outcome measures include;**	**Outcome measures self- assessed as being partial compliant against outcome measures include;**	**Outcome measures self-assessed as being nil compliant (inclusive of those not reported or difficult to interrogate data source) against outcome measures include;**
People's rights and individual circumstances are respected so they have a voice and control, empowering them to make decisions that affect their lives. **Welsh speakers are empowered to express their needs and they are able to fully participate in their care as equal partners. Where needed people are provided with access to a translator or a member of staff with appropriate language skills.** **Assistance or specialist aids are provided to those with speaking, sight or hearing difficulties, and special needs such as memory or learning disabilities, enabling them to receive and respond to information.** **People are consulted about any treatment and care they are to receive and opportunities provided to discuss and agree options.**	Specific targeted engagement with protected characteristic groups to ensure they access/receive the appropriate aids/support necessary. A range of easy read; pictorial and audio resources to aid in the provision/access of information. Easy Read Information on 111 Wales Website in conjunction with learning disability Wales, MENCAP Cymru, Downs Coalition. Recite me Welsh Interpretation and translation Service (WITS) contract to ensure people have access to a translator of the language of their need/choice Language line for 999/111(not for Welsh) The 'video booth' allowing people to record their own patient/experience stories; we now have a process in place for ensuring participants have given their permission to participate and have acknowledged that we will use their personal	Data subject rights (patients and staff) Privacy rights Layered Privacy Information Website Privacy Notices / Call Scripts / Verbal information required through SOPs IG Toolkit – Data Subject Rights HI developed Communications App Website communications	In the event of face-to-face assessment patients are provided with information about their history and presenting information so they can make choices about their care (no data set) Welsh language speakers available in the department and for any data subject rights requests (Records Team) All EMS response staff are trained in the MENTAL Capacity Act 2005 with respect of obtaining consent.

Valid consent is obtained in line with best practice guidance. And assessing and caring for people in line with the Mental Capacity Act 2005, and when appropriate the Deprivation of Liberty Safeguards 2009	information for the purpose of gathering patient experience feedback. There is now a DPIA in place covering all of the Information Governance requirements and there is also a standard privacy notice which explains how we will use a person's information, where their information is shared, how their information is stored. It also includes information explaining how someone can change their mind or complain if they believe we have used their information for purposes other than those agreed. People and Community Network/Learning disability Framework/Patient Experience Framework		

Source Data

Consultant Connect and other referral pathways/Report Manager to show level of referrals to alternative providers/ Video Booth/Bespoke PECI plan (excel)/Communication APP on Trust IPAD (? Access stats)/Access to Welsh Interpretation translation service (WIT)/BSL – provider called sign video for 999 and 111/111 Wales Website Records Request Logs (excel)/Language line /111 telephony statistics for 111

Reporting Routes

Heads of Service Reports/QUEST and Welsh Government/IGSG

Risks/Issues (highlighted by the lead experts)

Specific

General

- Some outcome measures are relying on excel spreadsheets to capture data and make decisions, this can effect data standards , it's hard to integrate and does not enable interoperability between systems

Standard 5.1 Timely Access

All aspects of care are provided in a timely way ensuring that people are treated and cared for in the right way, at the right time, in the right place and with the right staff.

The expert leads from across all directorate were asked to self-assess	**Outcome measures self- assessed by the experts as being fully compliant against**	**Outcome measures self- assessed as being partial compliant against outcome measures include;**	**Outcome measures self- assessed as being nil compliant (inclusive of those not reported or**

compliance using defined outcome measures against the following HCS criteria;	**outcome measures include;**		**difficult to interrogate data source) against outcome measures include;**
People's health outcomes are monitored in order to ensure they receive care in a timely way. **All aspects of care are provided, including referral, assessment, diagnosis, treatment, transfer of care and discharge including care at the end of life, in a timely way consistent with national timescales, pathways and best practice.** **Conditions are diagnosed early and treated in accordance with Clinical need** **Accessible information and support is given to ensure people are actively involved in decisions about their care** **There is compliance with the NHS Outcomes and Delivery Framework relating to timely care outcomes**	MPDS priority dispatch system monitored by CCC Compliance with Clinical Indicators MPDS priority dispatch system monitored by CCC Clinical Response Model – auto- allocation for falls for example CSD Triage and sign posting to alternative pathways CAS outcomes		Following patient assessment medicines are administered according to the presenting condition. The effects of the condition and medicine effects are monitored (no data set) Use of Six Goals as an outcome measurement/ National Guidance for 111 in the absence of a National Data set (no response on compliance) • Co-ordination, planning and support for people at greater risk of needing urgent or emergency care • Signposting to the right place, first time • Access to clinically safe alternative to hospital admission • Rapid response in a physical or mental health crisis • Optimal hospital care following admission • Home-first approach and reduce risk of re admission Emergency Medical Dispatch (Nil Compliant) • 999 Call Performance Indicators • Red Performance Indicators • Amber Performance Indicators • Pan Wales Immediate Red Release • Number of patients with no send/ ambulances cancelled • Handover Indicators 111 (no response noted) • 111 Call Answering/Abandoned Performance Indicators

			• 111 Clinical Assessment Start Time Performance Indicators • NHS111 Hand Off Metrics and NHS111 Consult & Close Indicators • Consult & Close Indicators • Conveyance to ED Indicators • End of Life Pathways • All aspects of care are provided to patients by EMS response staff following face-to-face assessment in accordance with the presenting condition & JRCALC guidelines (no data set) • Verbal communication provided with options available are provided following face-to-face patient assessment.(no data set) • Clinicians provide information at the time of call and listen to the concerns of callers

Source Data
MPDS/CAS/ECNS/ JRCALC guidelines/EPCR

Reporting Routes
EASC/CASC/Quest

Risks/Issues (highlighted by the lead experts)

Specific

- Further information is required to establish a true picture of the quality outcome measures in the Nil compliant/no response/ due to lack of clarity on data set (what good looks like to benchmark against)

General

- Some outcome measures are relying on excel spreadsheets to capture data and make decisions, this can effect data standards , it's hard to integrate and does not enable interoperability between systems
- 999/ ECNS/CAS do not work from Diagnosis they work with symptoms.

Individual Care **Standard 6.1 Planning Care to Promote Independence** Care provision must respect people's choices in how they care for themselves as maintaining independence improves quality of life and maximizes physical and emotional wellbeing.			
The expert leads from across all directorate were asked to self-assess compliance using defined outcome measures against the following HCS criteria;	**Outcome measures self- assessed by the experts as being fully compliant against outcome measures include;**	**Outcome measures self-assessed as being partial compliant against outcome measures include;**	**Outcome measures self- assessed as being nil compliant (inclusive of those not reported or difficult to interrogate data source) against outcome measures include;**
The care that people receive will respect their choices in making the most of their ability and desire to care for themselves **Healthcare workers are sensitive to people's linguistic needs and people will receive services through the medium of Welsh as a natural part of their care. People are shown respect for their cultural identify and are able to access Welsh Language services without any obstacles.** **People are supported to get help, when they need it in a way they want it** **Health Services will work with community groups for example those who can help support with protected characteristics**	ePCR enables the recording of patient specific decisions and clinicians will make decisions with patients and aligned to their wishes. Consent is recorded as well as the patient's capacity to consent and decide where that decision may not be in line with the advice provided by the clinician. Non-conveyance paperwork has been developed to outline the decision regarding the patient's care. ECNS has the ability to share via text and chat functionality a range of resources with patients. For example, self-care advice, websites for further information support and education to allow the patient to care for themselves. It can also share location data of community resources for patients to help themselves; such as pharmacies, minor injury units, and local community initiatives that are mapped to the DOS. NHS 111 Wales website contains self-care advice, self-care guides and videos as well as signposting to community resources with mapping and directions available via the Services Near You pages LANGUAGE LINE- WELSH speakers PECI, through its continuous engagement model, engage with a range of community groups who support those with a protected characteristic through a partnership and coproduction approach.		Verbal communication provided with options available are provided following face-to-face patient assessment (NO DATA SET)

	For example, All Wales People First for Learning disability; LGBTQ+ and sensory loss. We are also regularly invited to attend National awareness and celebration days held throughout the year and around Wales.		

Source Data
Consultant Connect and other referral pathways/ Report Manager to show level of referrals to alternative providers/ Language line/Telephony stats/MPDS audit of Welsh Call/ Bespoke PECI reporting system. EXCEL

Reporting Routes
QUEST/Welsh Government

Risks/Issues (highlighted by the lead experts)

Specific
General

-

Standard 6.2 Peoples Rights

Health services embed equality and human rights across the functions and delivery of health services in line with statutory requirement recognizing the diversity of the population and rights of individuals under equality, diversity and human rights legislation.

The expert leads from across all directorate were asked to self-assess compliance using defined outcome measures against the following HCS criteria;	**Outcome measures self- assessed by the experts as being fully compliant against outcome measures include;**	**Outcome measures self- assessed as being partial compliant against outcome measures include;**	**Outcome measures self- assessed as being nil compliant (inclusive of those not reported or difficult to interrogate data source) against outcome measures include;**
Needs of individual are recognised and addressed whatever their identify and background, and their human rights are upheld **Discrimination is challenged, equity and human rights are**	Older Peoples Promises and Promises to Children and Young People. The promises underpin the United Nations Convention on the rights of the child and for older people. Activity carried out through engagement are referenced against these. The organisation is proud to provide a wide variety of training to members of staff that aim to support the needs of individuals. Equality, Diversity and Human Rights E- learning Treat Me Fairly,	Data subject rights and human right to privacy. Additional safeguards under DPA for children's rights. Website Privacy Notices / Call Scripts / Verbal information provided.	

promoted and efforts are made to reduce health inequalities through strategies, equality impact assessment, policies, practices, procurement and engagement. **Strategic equality plans are published setting out equality priorities in accordance with legislation.** **The rights of the child are recognised in accordance with the United Nations Convention on the Rights of the Child (UNCRC)** **The rights for Older people in Wales are recognised in accordance with the Declaration of Rights for Older People in Wales and the UN Principals for Older Persons**	training is mandatory every three years to ensure all employee's knowledge and awareness is maintained and kept up to date. The compliance rate for this training is over 93%. Further training offered by the organisation includes our Allyship Programme which covers all the protected characteristics recognising equality and human rights. In addition, the EDI Team also offers bespoke, tailored training to departments around equality and human rights to teams. Control measures are in place to ensure that the organisation complies with the requirements of equality, diversity and human rights legislation are complied with, including: Developed and produced a new Strategic Equality Plan – Treat Me Fairly 2020-2024;Equality reports to ADLT, EMT and the People and Culture Committee on the UHB's objectives and actions; Outcome Report to the Welsh Government Equalities Team regarding advancing equality and human rights; Equality and Health Impact Assessments are undertaken to ensure that the organisation demonstrates due regard to equality, diversity and human rights when making decisions and developing strategies or policies. Annual Welsh Language Report provided to the Welsh Language Commissioners Office The Trust is required, under the Equality Act 2010 to produce a Strategic Equality Plan (SEP) every four years. The UHB's Strategic Equality Objectives are available to all staff within the organisation. The purpose of a Strategic Equality Plan is to document the steps the organisation is taking to fulfil its Public Sector Equality Duty) under the Equality Act 2010. In preparing and revising its Strategic Equality Plan the UHB is required to engage appropriately and have due regard to relevant equality information. The current SEP Treat Me Fairly 2020-2024 has several key delivery objectives and is premised based on embedding equality, diversity and human rights, and Welsh Language, into UHB business process. The SEP is closely aligned to our ten-year	IG Toolkit – Data Subject Rights	

	strategy, our Intermediate Medium-Term Plan as well as the Well-being of Future Generations Act 2015. All documents meet our legal compliance obligations, including in terms of publication.		

Source Data
Continuous engagement model (Excel)/Have your Say/ Records Request Logs (excel)Option for postal privacy information/

Reporting Routes
QUEST/ Welsh Government/ IGSG/ Equality & Human Rights Commission

Risks/Issues (highlighted by the lead experts)

Specific

- Data subject rights procedures being written.

General

-

Standard 6.3 Listening and Learning from Feedback

People who receive care, and their families, must be empowered to describe their experiences to those who provided their care so there is a clear understanding of what is working well and what is not, and they must receive an open and honest response. Health services should be shaped by and meet the needs of the people served and demonstrate

The expert leads from across all directorate were asked to self-assess compliance using defined outcome measures against the following HCS criteria;	**Outcome measures self- assessed by the experts as being fully compliant against outcome measures include;**	**Outcome measures self- assessed as being partial compliant against outcome measures include;**	**Outcome measures self- assessed as being nil compliant (inclusive of those not reported or difficult to interrogate data source) against outcome measures include;**
Health Services and boards demonstrate how they are responding to user experience to improve services	Patients/public are provided a platform within WAST to share their experiences/feedback/stories. We undertake a series of regular experience surveys on all		

Partners are engaged in supporting and enabling people to be involved in the design planning and delivery of services. **The patients and carers voice is heeded by health services and boards, including through the use of patient stories.** **Feedback is captured, published and acted upon in a way that provides an ongoing and continuous view of performance and demonstrates learning and improvement.** **Service delivery improvement for all people is captured and demonstrated**	aspects of Trust services; these are available online as well as postal. We undertake snap surveys during public face-to-face engagement; there is a dedicated 'Have your Say' online facility for people to provide feedback; a dedicated phone number for calls and an online 'video booth' for people to leave their recorded experiences/stories. We also have a dedicated social media twitter account where people DM us about their Our 'People & Community Network' enables people to 'register' as a member so that people can help improve and influence services delivered by the Trust, there a variety of activities available for people to be involved. Patient Stories and feedback/experiences are collated and shared through various internal and external meetings/committees and improvements discussed and tracked. Individuals are invited to present their experiences in person to various committees/Trust Board		

Source Data
Datix /Have Your Say/Patient Stories/Continuous Model/Civica /Dedicated Network

Reporting Routes

QUEST and Welsh Government

Risks/Issues (highlighted by the lead experts)

Specific
General

-

Staff & Resources **Standard 7.1 Workforce**			
Health services should ensure there are enough staff with the right knowledge and skills available at the right time to meet need. Staff are enabled to learn and develop to their full potential. The leaders of any NHS organization have a duty to set the appropriate tone and promote the right culture, and ensure that individual members of staff can fulfil their responsibility to deliver high quality and safe services.			
The expert leads from across all directorate were asked to self-assess compliance using defined outcome measures against the following HCS criteria;	**Outcome measures self- assessed by the experts as being fully compliant against outcome measures include;**	**Outcome measures self- assessed as being partial compliant against outcome measures include;**	**Outcome measures self- assessed as being nil compliant (inclusive of those not reported or difficult to interrogate data source) against outcome measures include;**
Health services work with partners to develop an appropriately skilled safe and sustainable workforce by; • **Having effective workforce plans which are integrated with service and financial plans** • **Meeting the needs of the population serviced through an appropriate skill mix with staff having Language awareness and the capability to provide services through the welsh language** • **Promoting the continuous improvement of services through better ways of working** • **Enabling plans reflect cross organisational/regional/all Wales workforce requirements where appropriate** **The workforce** • **Have all the necessary recruitment and periodic employment checks and are registered with the relevant bodies** • **Are appropriately recruited, trained, qualified and competent for the work they undertake**	WAST has a detailed workforce plan led by operational needs and aligned to the financial plan which is maintained and a new workforce strategy in development NWSSP undertake checks ESR data /information allows WAST to monitor registration Occupational Health undertake fitness for role medicals in line with the job description and issue clearance Occ Health and Wellbeing promoted Employee Assistance Programme (EAP) Policy and guidelines WAST Behaviours Formal concerns received in line with the Respect and Resolution policy are collated on a monthly basis into a WOD performance scorecard.	Workforce Planning is completed in collaboration with resourcing and planning teams to ensure resource is in the right place for service delivery across Wales. Where necessary, targeted recruitment campaigns by location are delivered Representation on HEIW Steering and Working Groups – active engagement in workforce shaping to meet 6 Goals – 'Grow Our Own'; representation on Regional Learning & Skills Partnerships direct influence re WG policy; Compliance with Welsh Language Standards within Workforce Education & Development with provision available across induction courses in preferred language Welsh Language Standards	Students, new entrants and promotes are supported with role/service appropriate mentoring/supervision; Clinical Supervision will be in place in 2023 for the majority of roles with plans to offer a version of this for non-clinical roles from 2024. A record of staff being managed under either the disciplinary or capability process are recorded by the People Services Team. Figures of employee relation cases are collated on a monthly basis into a WOD performance scorecard Robust Clinical Development to maintain Professional Standards including Stat and Mandatory training <u>Soft Skills</u> A range of opportunities are available internally and outside WAST; This

• **Act, and are treated, in accordance with identified standards and codes of conduct** • **The workforce; are able to raise, in confidence without prejudice, concerns over any aspect of service delivery, treatment or ,management** • **Are mentored, supervised and supported in the delivery of their role** • **Are dealt with fairly and equitably when their performance causes concern** • **Are provided with appropriate skills, equipment and support to enable them to meet their responsibilities to consistently high standards** **The workforce** • **Maintain and develop competencies in order to be developed to their full potential** • **Attend induction and mandatory training programme** • **Have an annual appraisal and a personal development plan** • **Develop their role** • **Demonstrate continuing professional development** • **Access opportunities to develop collaborative practice and team working** • **Work closely together, preventing duplication of effort and enabling more efficient use of resources**	In addition, staff are encouraged to discuss concerns and safety issues as soon as possible and guidance on how to do this is in Trust policies such as Procedure for NHS staff to Raise Concerns, DATIX as appropriate. Access to a comprehensive professional development offer with bespoke interventions provided for identified (self or line manager) additional support. Registrants comply with the HCPC/professional Codes of Conduct, as appropriate Clear use of WAST policies to support employees with performance challenges/issues Records of staff on suspension over a 4-month period Procedure for NHS staff to Raise Concerns. Regulated, accredited programmes for induction for road based staff – hybrid for remaining Operational staff with work on going to move this to regulated provision 2023 on. All other staff engage in a Warm WAST Welcome on induction. Set budget with establishment figures to comply with resourcing requirements and the budget. Undertaken a Demand & Capacity review Check HCPC register on a regular basis to ensure that all Paramedics are registered.	Welsh Language Training Post recruitment, appropriate training is provided to support individuals in their role. Competency is verified using a number of mechanisms such as PADR, Mandatory In-Service Training and CPD Learning engagement with standards to ensure understanding and signposting routes for all staff on induction via the Warm WAST Welcome programme WAST have an annual PADR process which all staff are expected to complete. Individual role development is encouraged via close working with line manager – many roles are clearly delineated with specific Scope of Practice parameters and so role development as such is not possible – in these cases, the focus is on developing clinical skills to be able to consistently operate at the top of Scope. Roles outside these confines actively encourage stretch and challenge whilst ensuring individuals do not work beyond their capabilities. Development in specific task oriented and soft skills are available to all. Cross functional working is encouraged to deliver integrated service with many examples of this extending across the wider NHS system. All WAST people are invited to apply for Bursary funding to support development – this can be to support a current role or to develop individuals for future roles.	includes but is not limited to, structured educational within other functions. programmes supporting specialisms through to secondments Working with Health Boards to provide alternative patient pathways and disposition outcomes (set target for compliance required to establish compliance) All EMS operational staff undertake 2 Senior Paramedic ride-outs per year in their clinical role (set target for compliance required to establish compliance) Introduction of CHARU cars to replace the current RRVs to provide a high acuity response to Red and Amber 1 calls. (set target for compliance required to establish compliance) WAST have the Capability Policy to ensure that staff are supported to maintain the highest standards of performance for patient care. (set target for compliance required to establish compliance)

	All EMS operational staff have 52 hours per year to utilise for a combination of Statutory & Mandatory, and self-directed CPD.		

Source Data

ESR /Financial Plans/Workforce Plan /Roster review documents/GRS/Cohort/Trac/ Learner records/PADR/CPD records/Training record (excel)/Occ health referral system/Datix/Highly Sensitive Platform (electronic)/Respect and resolution – excel/Local Personal Files with manager/Clinical Supervision record? Where/ SPECIALIST Practitioner records/111 Preceptorship records/ self-declarations to HCPC/**HCPC register and locality records/DOM individual staff records/**Consultant Connect and other referral pathways/Report Manager to show level of referrals to alternative providers

Reporting Routes

EMT /Directorate Business Meeting; Equality, Diversity & Inclusion Steering Group; People and Culture Committee/ WOD business meetings/Occupational Health / Trust Occupational Health Trust Peoples services

Risks/Issues (highlighted by the lead experts)

Specific

- set target for compliance required to establish compliance, this is required for a few noted in the nil compliance column for the lead expert to self-assess against

General

- Some outcome measures are relying on excel spreadsheets to capture data and make decisions, this can effect data standards , it's hard to integrate and does not enable interoperability between systems

AGENDA ITEM No	**11**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**3**

COMMITTEE EFFECTIVENESS REVIEW 2022/23

MEETING	Quality, Patient Experience and Safety Committee
DATE	9 February 2023
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Trish Mills, Board Secretary
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

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

2. Minimal changes are proposed to the Committee's terms of reference given the extensive review in early 2022. Acknowledging that the Duty of Quality and Duty of Candour under the Health and Social Care (Quality and Engagement) (Wales) Act 2020 ('the Act') will naturally shape the focus of the Committee in 2023, it is proposed to undertake a review of the terms of reference in Q2 2023/24 and propose any required amendments. At that point the cycle of business will also be aligned to support the Duty of Quality and Duty of Candour as well as ensuring equality of items on future agenda, particularly mental health, information governance and clinical care. The Committee's purpose continues to focus on the developing frameworks to comply with the duties under the Act.

3. This report includes the responses to the questionnaires (at Annex 1), a draft annual report from the Committee to the Board (at Annex 2) and proposed marked up changes to the terms of reference (at Annex 3).

4. Changes in operating arrangements are proposed in this report as a result of responses received to questionnaires.

RECOMMENDATION: The Committee is requested to:

(a) Review and approve changes to name of the Committee and its terms of reference at Annex 3;
(b) Confirm the proposed changes to operating arrangements in response to issues raised in questionnaires;

(c) Set priorities for the Committee for 2022/23; and
(d) Approve the annual report at Annex 2, noting it requires some further adjustment after this meeting.

REPORT APPROVAL ROUTE

Executive Management Team notified of proposed changes by email 31 January 2023.

REPORT APPENDICES

1. Annex 1 – Collated responses to effectiveness questionnaire
2. Annex 2 – Draft Committee annual report to Board
3. Annex 3 – Proposed changes to terms of reference (marked up)

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

COMMITTEE EFFECTIVENESS REVIEW 2022/23

SITUATION

1. Annual effectiveness reviews are designed to evaluate the effectiveness of the Board and its Committees, review its operating arrangements, and propose changes to improve its support, challenge, scrutiny and oversight responsibilities. Whilst we adopt a continuous improvement methodology to the Board and its Committees throughout the year, this annual effectiveness review is an opportunity to formally review membership, look back at the work of the Committee during the year, and set the Committee's priorities for the coming year.

BACKGROUND

2. 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 the Board's Committees form an integral part. Each Committee must submit an annual report to the Board through the Chair setting out its activities during the year and including the review of its performance. The draft annual report for 2022/23 is attached at Annex 2 for review by the Committee.

3. The 2022/23 effectiveness reviews adopted the following cycle:

Stage	Process
Stage 1: Evaluation Design	• Questionnaires for the Board Committees are developed by the Board Secretary in consultation with the Committee Chairs and Executive Leads. It was agreed for 2022/23 to adopt the same questionnaires across all Committees (except for Audit Committee which has a separate questionnaire) to provide a baseline for future reviews.
Stage 2: Evaluation Process	• Questionnaires are issued to Committee members and core attendees as set out in the terms of reference. • Committee Chair, Executive Lead, Governance Officer, Governance Manager and Board Secretary review questionnaires, review terms of reference and propose initial amendments. • Responses are collated and this report summarises the findings and includes proposed recommendations to address issues raised.
Stage 3: Discussion and actions	• The proposed amendments to the terms of reference and the responses to the questionnaires are discussed by the Committee at this meeting.
Stage 4: Presentation to Audit Committee and Trust Board	• Any changes to the terms of reference and operating arrangements are recommended to the Audit Committee firstly on 20 April 2023 and then to the Trust Board together with the Committee's annual report on 25 May 2023.

ASSESSMENT

4. The Committee Chair, Executive Lead and Director of Paramedicine met with the Corporate Governance team for stage 2 on 18 January 2023. Responses to the questionnaires were collated and reviewed and they are attached at Annex 1. The questionnaires sent to members and attendees provided an opportunity to gauge opinion on areas of good practice and areas that require improvement. Sixteen questionnaires were sent out with 7 responses being returned (a 44% return rate).

5. Respondents were asked 27 questions and were encouraged to provide free text answers to explain their choices, particularly where they marked answers as 'disagree' or 'strongly disagree'.

6. Changes to the Committee's operating arrangements and work plan as a result of the responses are proposed to be as follows:

Theme	Proposed Changes to Operating Arrangements
Theme 1: Committee Focus	On remit, agenda and meetings being too long and unmanageable, and on inequality of focus, the terms of reference were reviewed and it was felt they were appropriate however a review will be conducted in Q2 2023/24 to take account of the implemented Duty of Quality and Duty of Candour. However, the following changes are proposed to address the concerns: • Continue with work to address potentially duplicative reporting in the monthly MIQPR and quarterly patient safety and quality assurance reports; • Presenters of papers take the papers as read and draw out highlights, lowlights and red flags only, providing more time for challenge, support and questions. Perhaps adopting a 1/3:2/3 approach to the time allotted, with the presentation of the paper taking only 1/3rd; • Revised SBAR and guidance is in development to aid report writers in compiling concise papers and encouraging appendices and succinct executive summaries; • The cycle of business will be finalised to ensure the annual work programme is both clear and monitored to demonstrate equality of focus; and • A quarterly 'spotlight on' clinical indicators via the CQGG to provide more focus on clinical care
Theme 2: Committee Engagement	• Board visits aligned to the new standard operating procedure for such visits to enable members to triangulate assurance information and better understand the impact of any improvements being made

Theme	Proposed Changes to Operating Arrangements
Theme 4: Committee Effectiveness	• Consideration of a period of reflection at the end of each meeting to take the shape of a summary of actions and decisions, and an invitation to members to give feedback on the meeting any learning/continuous improvement to take forward. • The AAA reports will be distributed to all Committee members and attendees after the meeting and the Chair will feedback on escalations raised to the Trust Board in matters arising.

7. The Committee met four times during 2022/23 as scheduled and was quorate on each occasion. The Committee's draft annual report at Annex 2 illustrates that attendance was excellent despite the operational pressures placed on members throughout the year.

8. The terms of reference were reviewed to ensure all matters within the remit of the Committee were clear and were articulated with the strategic, oversight and scrutiny role of the Committee in mind. Amendments are minimal given the extensive review that took place in early 2022, however the research governance framework has been transferred from this Committee to the Academic Partnerships Committee with effect from 1 April 2023. A further review will take place in Q2 to align the Duty of Quality and Duty of Candour requirements. A marked up copy of the proposed amendments is at Annex 3.

9. Whilst the attendees set out in the terms of reference are not intended to change, the Trust Board Chair will conduct an annual review of Non-Executive Director membership across all Committees in February 2023 and any changes will be reflected in the annual report.

10. The draft annual report details the work carried out by the Committee during the year and progress it made on the priorities set for 2022/23.

11. It is good practice for Committees to set priorities for the forthcoming year when they review their effectiveness. Such priorities may include a particular focus throughout the year, or in particular quarters. For example, the Committee may wish to prioritise more agenda time to new issues it is adopting in its terms of reference; focus on areas it may not have addressed recently due to the pandemic; or review of the Committee's risks, both operational and strategic. It is recommended that such priorities are limited to two or three, and that they are tracked quarterly by way of an assurance report by the Board Secretary report to ensure they are on track. The Committee may wish to consider the following priorities based on the responses from the questionnaires:

    (a) Consider carrying over the Committee priority on the duty of quality and duty of candour.
    (b) Consider a Committee priority on the implementation plan for the quality strategy.

RECOMMENDATION

12. The Committee is requested to:

(a) Review and approve changes to name of the Committee and its terms of reference at Annex 3;

(b) Confirm the proposed changes to operating arrangements in response to issues raised in questionnaires;

(c) Set priorities for the Committee for 2022/23; and

(d) Approve the annual report at Annex 2, noting it requires some further adjustment after this meeting.

Next Steps

13. Ensure changes to operating arrangements and priorities (subject to agreement) are cycled into work programme for review in 2023/24.
14. Conduct a further review of the terms of reference in Q2 2023/24

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
NHS Trust

QUEST Effectiveness Review Survey Results 2022/23

Trish Mills
Board Secretary
18 January 2023

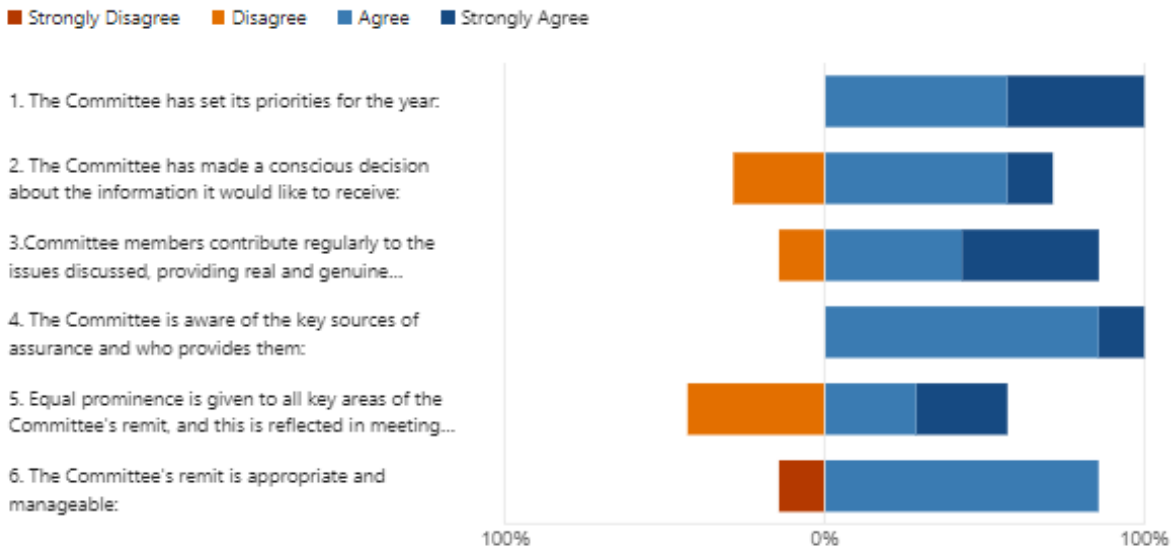
QUEST Annual Effectiveness Review

Survey Respondents included NEDs, management members, TU partners and Committee Governance Officer; 16 surveys sent, with 7 returned [43.75%]. This presentation sets out the results of the survey and groups free text responses into areas of focus.

Respondents were asked to provide more detail where they selected 'disagree' and 'strongly disagree', however some have also used the free text section to elaborate on 'agree' and 'strongly agree' answers.
The raw data can be viewed at the Summary Link.

Non-Executive Director Member	4
Management Member	2
TU Partner (s)	0
Other	1

Theme 1: Committee Focus



REMIT

In regard to key areas if the committee remit**, I feel there is more we need to bring forward in regard to clinical care.** We have made great strides in recent years around delivery of care and **I don't feel the committee has sufficient opportunity to explore these.**

Q2 and Q5 - there **is repetition in the reporting between the MIQPR and other assurance reporting such as the patient safety report** and **the quarterly quality report that should be streamlined.** The Committee's cycle of business when finalised will assist with ensuring the full range of the Committee's business is before it on a regular rhythm.

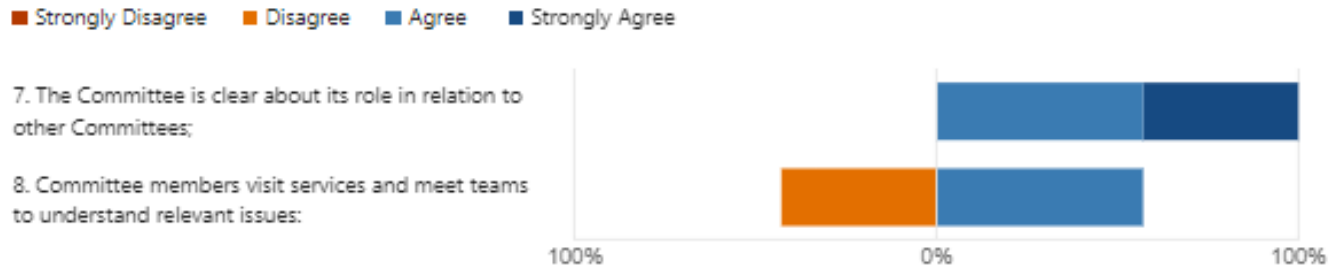
5 & 6: Given the breadth of the remit for the majority of the year, **the Committee will more easily manage its Agenda moving forwards**, in light of the lead responsibility for Health & Safety moving across to P&C Committee mid-2022. 6: the **Agenda is always large and given the significant importance/nature of many of the areas discussed**, the meetings can be very full.

MANAGEMENT OF BUSINESS

The current interpretation of the committee's remit is not manageable - potentially the committee is not receiving information at the right level of detail to retain strategic oversight. Agendas are very lengthy and it's hard to do each item justice.

Theme 6 - understandably the meetings **have a full agenda** and occasionally it would be helpful to **have more time to discuss some agenda items.**

The Committee **is focussed on its remit.**



Theme 2: Committee Engagement

VISITS

Statement 8 - There is **no set cycle of visits to services and individual members decide when and where they are able to visit and is variable amongst members**. This is usually linked to a Board meeting or development session in my experience.

Q8 - Board member - non-executive director in particular - visits will be **improved with the introduction of a Board Visit SOP** which will be finalised by 31 March.

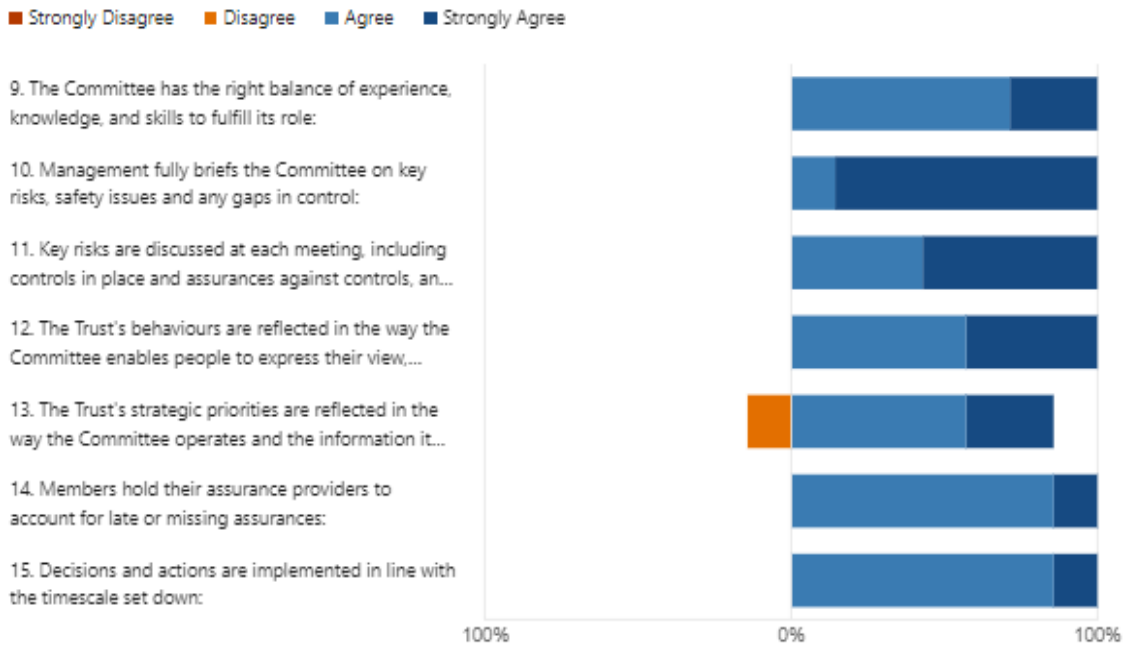
8. Committee **Members have not consistently visited services/met with teams** - the impact of COVID has driven this and we should look to make progress on this in 2023.

ROLE

There have been **several occasions when members have shared their experiences anecdotally** and this has often led to **fruitful discussions**, particularly on the current operational pressures.

7. **Clear feedback** on the work of the Committee **is provided to the Board and other Committees**, as appropriate.

Theme 3: Committee Team Working



TIMELINESS OF DECISIONS / ACTIONS

15: These **can be adversely affected** by the significant system and **service challenges**.

COMPOSITION

There is a **good balance** between the Non-Executive Directors and Executive Directors in that **their roles on the Committee are clearly identified**.

OVERSIGHT OF RISK

11: Each **meeting robustly discussed the key risks and actions to mitigate** against these.

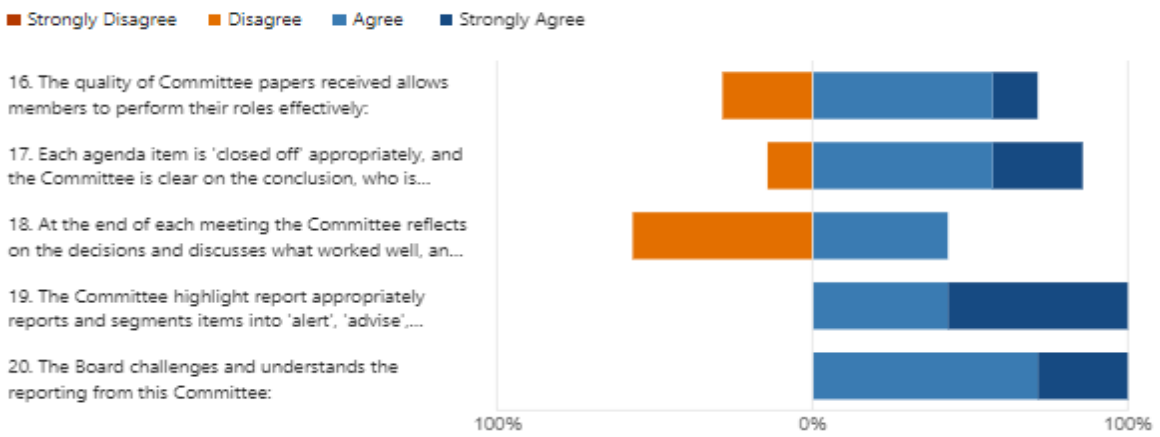
Theme 4: Committee Effectiveness

REFLECTION

More time required for question 18.

18: this is **not done overtly**, although **is implied by the discussions** that have taken place.

Q18 - there is **no section on the agenda to reflect however the chair and lead do so** when setting the agenda for the next meeting which happens soon after the meeting.



REPORTING

The reports being submitted **are adequate for the Committee's needs** and the **AAA reports have been well received** by members.

19: **Reports are clear, detailed and draw attention to the key facts.**

20: **Reporting to Board is clear and followed by robust discussions** of key issues

It's **not always clear how the discussion is being taken forward i**nto an action.

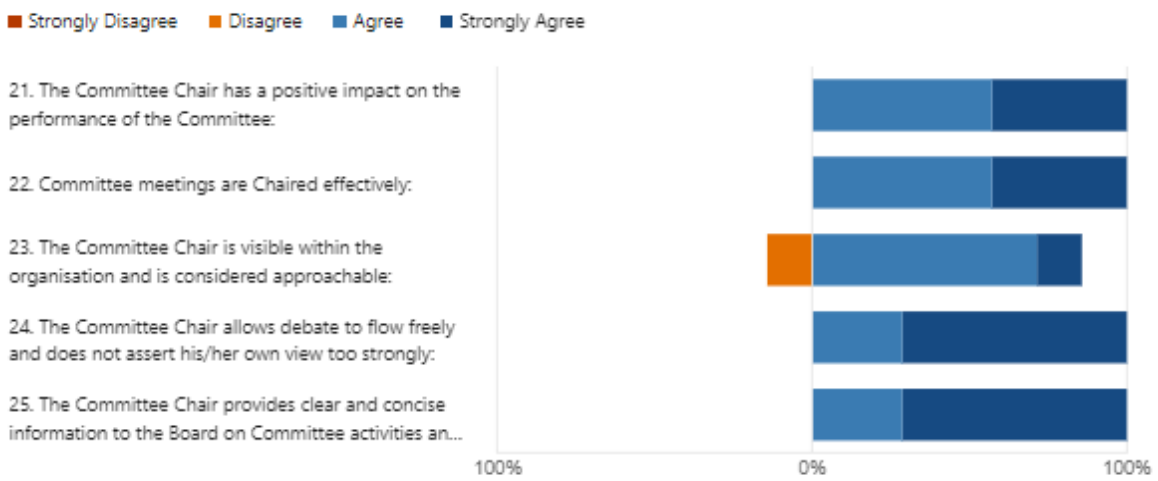
QUALITY OF INFORMATION

16: Papers are **detailed and clear**. It **may be helpful to have more of a summary report in some instances**, which can be **supported by more detailed Appendices** - to ensure that Members are made aware of key issues.

Q16 - **There is duplication in the reporting with some metrics reported quarterly and others reported monthly**. The extensive remit of the Committee means **reporting should be streamlined** and presentation of papers focused on highlights, lowlights and red flags for the Committee.

Theme 16 **- Some of the papers are lengthy and could be more succinct**.

Theme 5: Committee Leadership



The Committee Chair **allows sufficient time for members to express their views** and is able to curtail discussion when required.

Q23 - With the introduction of the **Board Visits SOP** this visibility and opportunities for members to visit (including virtual visits) **will improve this.**

24: Each meeting **has full and fluid discussion and debate**.

What should the Committee stop, start or continue to do?

START

Start: Considering at what level a committee should operate - **make agendas more focused and manageable**.

To clearly **clarify any actions emanating from the meeting and when they are due**.

Start to **actively consider our readiness for the Act, as it comes into force in 2023**.

STOP

Stop: **Sharing patient stories in committee - these would be better suited to public Board** as it shows the public that we're listening.

CONTINUE

The Committee's **cycle of business should be completed within the next 3 months** to allow the full spread of the Committee's business to be timetabled. This should give us an opportunity to see where reporting can be combined and streamlined. **The Committee reports well into the Board and escalates appropriately.**

Continue **to monitor and scrutinise progress on the agreed actions following escalation**. Ensure the Trust has a robust measurable plan to implement the Quality Strategy and ensure a focus on patient outcomes. **Continue to identify areas for deep dives to broaden** understanding and provide insight.

Continue to **prioritise a focus on our Duty of Quality and Duty of Candour.**

Continue to **have a key focus on harm, avoidable harm, risks and risk management.**

Continue to **ensure that the quality of all services is uppermost in the minds of staff** throughout the Trust by regular discussion at all levels of the organisation and calling out where quality falls below acceptable levels.

Are there any learning or development opportunities for members which the Committee should consider?

More **overt discussion around what worked well/not so well at the end of the meeting.**

Discuss possibility of more **consistent visibility within services?**

Summary of Proposed Changes

1. On remit, agenda and meetings being too long and unmanageable, and on inequality of focus, the TORs have been reviewed and it was felt they were appropriate but they will be reviewed again in Q2 2023/24. However, the following changes are proposed to address the concerns:
   (a) Continue with work to address potentially duplicative reporting in the monthly MIQPR and quarterly patient safety and quality assurance reports
   (b) Presenters of papers take the papers as read and draw out highlight, lowlights and red flags only, providing more time for challenge, support and questions. Perhaps adopting a 1/3:2/3 approach to the time allotted, with the presentation of the paper taking only 1/3rd
   (c) Revised SBAR and guidance is in development to aid report writers in compiling concise papers and encouraging appendices and succinct executive summaries
   (d) The cycle of business will be finalised to ensure the annual work programme is both clear and monitored to demonstrate equality of focus
   (e) A quarterly 'spotlight on' clinical indicators via the CQGG to provide more focus on clinical care

2. A Board visits standard operating procedure is being developed with a completion date of 31 March. This will demonstrate visibility of Committee members.

3. Consideration for a period of reflection at the end of each meeting to take the shape of a summary of actions and decisions, and an invitation to members to give feedback on the meeting any learning/continuous improvement to take forward.

4. The AAA reports will be distributed to all Committee members and attendees after the meeting and the Chair will feedback on escalations raised to the Trust Board in matters arising.

QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE ANNUAL REPORT 2022/23

SITUATION

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.

BACKGROUND

2. As the factors underpinning effective governance can change, for example as people leave, organisations restructure, or strategy shifts, regular reviews of Board Committees ensure governance remains fit for purpose.

3. Standing Orders, Committee terms of reference, and 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 9 February 2023 and reviewed its terms of reference, responses to questionnaires completed by members and attendees, and its operating arrangements. Discussions were also held with the Chair, Executive Lead and Director of Paramedicine. Changes are proposed to the terms of reference and this annual report reflects on the effectiveness of the Committee in 2022/23.

ASSESSMENT

Purpose of the Committee

5. The purpose of the Committee set out in its terms of reference is:

   5.1. Scrutinise improvements in outcomes in quality, patient experience, effectiveness and safety and overseeing the development and delivery of strategies to achieve this.

   5.2. A focus on 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.

   5.3. Oversight of and assurance on statutory and regulatory compliance.

   5.4. Oversight of the quality and integrity, safety and security, and appropriate access and use of information (including patient and personal information) to support the provision of high quality healthcare.

Membership and Attendance

6. The Committee met in public four times in 2022/23 and was quorate on each occasion. No private session meetings were held.

7. The Committee is supported by a Chair and three Non-Executive Directors as members, and a number of core attendees. The chart below illustrates attendance of members and attendees (as listed in the terms of reference) for 2022/23: [chart to be updated with 9 February attendance]

COMMITTEE ATTENDANCE				
Name	**12 May 2022**	**11 August 2022**	**10 November 2022**	**9 February 2023**
Bethan Evans				
Kevin Davies				
Paul Hollard				
Ceri Jackson				
Hannah Rowan				
Wendy Herbert		In attendance	In attendance	
Liam Williams		First meeting		
Andy Swinburn				
Lee Brooks				
Andy Haywood				
Leanne Smith		First meeting		
Rachel Marsh	Hugh Bennett			
Trish Mills				
Angela Roberts				
Mark Marsden			First meeting	
Hugh Parry				
Craig Brown				
Ian James		First meeting		

	Attended
	Deputy attended
	Apologies received
	No longer member

8. Attendance is excellent despite the challenges that operational pressures have placed on members throughout the year. The February meeting in particular flexed to enable some reports to be presented on the day and deferred some items to the May meeting given the significant pressures on the Trust as a result of Winter and industrial action.

9. Non-Executive Director membership of all Committees will be reviewed in February 2023 by the Trust Board Chair, but it is anticipated that this Committee will retain at least three Non-Executive Directors in its membership, inclusive of the Chair.

Committee Views on Effectiveness

10. The Committee's effectiveness was assessed through a review of its terms of reference, responses to a questionnaire, discussion with the Chair, Executive Lead and Director of Paramedicine, and at the 9 February Committee meeting.

11. The questionnaires provided an opportunity to gauge opinion on areas of good practice and areas that require improvement. Sixteen questionnaires were sent out with 7 responses being returned (a 44% return rate).

12. Respondents were asked 27 questions and were encouraged to provide free text answers to explain their choices. The responses were reviewed by the Committee on 9 February and it was agreed to make the following adjustments to their operating arrangements as a result:

    12.1. On remit, agenda and meetings being too long and unmanageable, and on inequality of focus, the terms of reference were reviewed and it was felt they were appropriate currently but would be reviewed in Q2 2023/24 following the introduction of the new Act. The following changes are proposed to address the concerns now however:
    - Continue with work to address potentially duplicative reporting in the monthly MIQPR and quarterly patient safety and quality assurance reports;
    - Presenters of papers take the papers as read and draw out highlights, lowlights and red flags only, providing more time for challenge, support and questions. Perhaps adopting a 1/3:2/3 approach to the time allotted, with the presentation of the paper taking only 1/3rd;
    - Revised SBAR and guidance is in development to aid report writers in compiling concise papers and encouraging appendices and succinct executive summaries;
    - The cycle of business will be finalised to ensure the annual work programme is both clear and monitored to demonstrate equality of focus; and
    - A quarterly 'spotlight on' clinical indicators via the CQGG to provide more focus on clinical care.

    12.2. A Board visits standard operating procedure is being developed with a completion date of 31 March. This will support more engagement by and demonstrate visibility of Committee members.

    12.3. Consideration of a period of reflection at the end of each meeting to take the shape of a summary of actions and decisions, and an invitation to members to give feedback on the meeting any learning/continuous improvement to take forward.

    12.4. The AAA reports will be distributed to all Committee members and attendees after the meeting and the Chair will feedback on escalations raised to the Trust Board in matters arising.

13. Notwithstanding the need to ensure the cycles of business are completed as soon as possible to be confident of equitable spread of the agenda, the Committee has been effective in discharging its responsibilities, particularly with respect to patient safety and patient experience and providing timely escalations and assurances to the Board. In 2023/24 the areas of information governance,

mental health and clinical care will feature more regularly. In 2022/23 the Committee:

(a) Received regular reports on patient safety, escalating to the Trust Board the volume of serious incidents and nationally reportable incidents causing avoidable harm and death to patients. In May the Chair of this Committee joined with the Chairs of the People and Culture Committee and the Finance and Performance Committee to escalate to the Trust Board their concerns regarding the significant impact on staff and patients as a result of system pressures. This led to the paper to Trust Board in July on action to mitigate avoidable harm (and subsequent updates), which includes system partner actions as a result of meetings which took place with NHS Wales, Welsh Government and Commissioners as a result of the escalations;

(b) Reviewed cases referred to Health Boards under Appendix B, received a presentation from the National Delivery Unit on their analysis of Appendix B reports at their May meeting, and was updated on the revised joint investigations process at their November meeting;

(c) Received the HIW Annual Review 2021/22 at is November meeting which subsequently went to Trust Board;

(d) Reviewed remedial plans in place and escalated to the Trust Board timeliness of response for Putting Things Right Regulations;

(e) Received reports on Regulation 28 Prevention of Future Deaths reports and actions in place to address concerns raised and learning;

(f) Received a dementia update in November which linked into a previous patient story heard by the Committee;

(g) Heard from a patient or a relative of a patient on their lived experience of the service at each meeting, together with learning and improvements made as a result of the issues raised;

(h) Was updated on the quality strategy implementation plan at each meeting, with the Committee expressing concern at the pace this was able to progress due to resourcing issues. The Committee will include the implementation of the strategy as a priority for 2023/24;

(i) Received the monthly integrated performance report and quarterly quality report at each meeting and reviewed the quality quadrant of the scorecard in detail, escalating areas of poor performance to the Trust Board;

(j) Discussed the learning from incidents report and the ways in which it would be communicated more widely to staff;

(k) Approved the Clinical Audit and Outcome Review Plan 2022/23 in August with assurance on this provided to the Audit Committee;

(l) Reviewed the IPC Annual Report 2021/22;

(m) Received internal audits within the Committee's remit and the audit tracker to monitor progress against recommendations;

(n) Reviewed the Patient Experience and Community Involvement (PECI) report at each meeting with the Committee being assured that the Trust was engaging with patients and the community through the Continuous Engagement Model;

(o) Discussed the deep dive on increased Red demand in May;

(p) Focused on the preparedness for implementation of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 at its February meeting, including our compliance with the Health and Care Standards;

(q) Reviewed its effectiveness and agreed changes to its operating arrangements and terms of reference for 2023/24;

(r) Reviewed the work of the safeguarding team via the Annual Safeguarding Report in February; and

(s) The corporate risk register/BAF was reviewed at each meeting with the agenda being built around the two highly rated risks for this Committee – those being risks 223 and 224. Risk 199 related to health and safety was transferred to the People and Culture Committee in August as they have oversight of this area from 1 April 2022.

14. The Committee's priority for 2022/23 was to further embed oversight of patient safety, openness and transparency, the Committee will monitor the Trust's readiness for the introduction of the Duty of Quality and Duty of Candour when the Health and Social Care (Quality and Engagement) (Wales) Act ('Act') comes in to force in the Spring of 2023. Progress against this priority was reviewed at each meeting as follows:

(a) The Committee heard a patient story at each meeting, demonstrating its commitment to the duty of candour and ensuring that learning is embedded as a result of the experiences of our patients;
(b) The quarterly Quality Highlight Report provides updates on preparations to implement the Act;
(c) At its May meeting further detail was sought on the practical steps being taken to integrate quality into other roles as part of the Quality Strategy. The Committee stressed the importance of this given the requirement to report against the Duty of Quality and Duty of Candour when the Act is implemented in April 2023; and
(d) In October 2022 a Board development session was provided by the Quality Governance Team and Welsh Government on the requirements to implement the Duty of Quality and the Duty of Candour.
(e) The February 2023 meeting of the Committee focused on the Trust's preparedness for the introduction of the duty of quality and the duty of candour in April 2023.

15. The Board received a highlight report from the Committee following each meeting which provided for alerts, advice, and areas of assurance. This is presented to the next public Board meeting by the Chair of the Committee.

16. The Committee is not serviced by any sub-committees or task and finish groups at present.

Proposed Changes to the terms of reference

17. The terms of reference were reviewed to ensure all matters within the remit of the Committee were clear and were articulated with the strategic, oversight and scrutiny role of the Committee in mind. Amendments are minimal given the extensive review that took place in early 2022, however the research governance framework has been transferred from this Committee to the Academic Partnerships Committee with effect from 1 April 2023. A further review will take place in Q2 to align the Duty of Quality and Duty of Candour requirements.

18. A marked up copy of the terms of reference are attached at Annex 1 for approval by the Board.

Priorities Identified for the Committee for 2023/24

19. 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 2023/24:

[to be confirmed by the 9 February 2023 QUEST meeting]

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

Next Steps

21. The next steps are as follows:

(a) Finalise the Committee cycle of business to illustrate compliance requirements and assurance mapping.
(b) Ensure changes to operating arrangements agreed are cycled into work programme for review in 2023/24.

RECOMMENDATION

The Trust Board is requested to

(a) Receive and note the contents of the Committee annual report for 2022/23 and its analysis of effectiveness;
(b) Approve the changes to the terms of reference.

Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services NHS Trust

QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE

TERMS OF REFERENCE AND OPERATING ARRANGEMENTS

1. INTRODUCTION

1.1. The Trust's Standing Orders provide that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*".

1.2. In line with Standing Orders and the Trust's Scheme of Delegation, the Board shall nominate annually a committee to be known as the Quality, Patient Experience and Safety Committee. This Committee has a key assurance role on behalf of the Board in relation to the Trust compliance with the Commissioning Core Quality Requirements, the NHS Wales Health & Care Standards 2015 and the Health and Social Care (Quality and Engagement) (Wales) Act 2020. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set out below.

2. PURPOSE

2.1. The Committee is responsible for scrutinising improvements in ~~-~~outcomes in quality, patient experience, effectiveness and safety to reduce incidences of avoidable harm~~, and will oversee the development and delivery of strategies to achieve this~~.

2.2. During the 2023~~2~~/~~23~~24 financial year the Committee will continue to oversee the systems and process ~~being~~ developed to ensure compliance with the Duty of Quality and the Duty of Candour as set out in the Health and Social Care (Quality and Engagement) (Wales) Act 2020 ~~when it is implemented in 2023~~, and ~~thereafter~~ ensure compliance with the Act to improve the quality of healthcare provided by the Trust.

2.3. The Committee will provide oversight of, and seek assurance on, statutory and regulatory compliance.

2.4. Oversee the quality and integrity, safety and security, and appropriate access and use of information (including patient and personal information) to support the provision of high quality healthcare.

3. DELEGATED POWERS AND AUTHORITY

The Committee will:

3.1. Ensure the organisation has the right systems and processes in place to deliver services consistent with the six domains of quality (patient centred; safe; equitable; timely; effective; and efficient).

3.2. Advise the Board on a set of key indicators for quality, patient experience and clinical safety, and monitor performance against those indicators.

3.3. 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 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

~~3.2.~~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.

~~3.3.~~3.5. Monitor the implementation of strategies and plans within the remit of the Committee.

~~3.4.~~3.6. Ensure there is clear, consistent strategic direction, strong leadership, transparent lines of accountability.

Safe Care

~~3.5.~~3.7. Ensure the Health and Care Standards, and Commissioning Quality Core Requirements are embedded Trust wide with actions taken in relation to any identified non-compliance.

~~3.6.~~3.8. Ensure there is a process in place for quality impact assessments, and consider the implications for quality and safety and equitable care arising from the development of the Trust's corporate strategies and plans, or those of its stakeholders and partners, including those arising from any Committees of the Board

~~3.7.~~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.

~~3.8.~~3.10. Monitor Trust compliance with the Mental Health Act 1983, Code of Practice, and the Mental Capacity Act 2005.

~~3.9.~~3.11. Review the annual infection prevention and control plan and monitor its

implementation

~~3.10.~~3.12. Ensure the Trust is meeting its obligations with respect to safeguarding of children and vulnerable adults

~~3.11.~~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.

~~3.12. Ensure the Trust has systems and processes in place to support the delivery of an open and honest reporting and continuous learning culture in line with the Duty of Candour.~~

~~3.13.~~3.14. Oversee improvements and changes applied as a result of reviews of mortality, clinical incidents, complaints, litigation, external regulator reports etc., and their impact on minimising patient harm and maximising patient experience.

Effective Care

~~3.14.~~3.15. Ensure the care planned and provided across the breadth of the organisation's functions is clinically effective and quality driven and where this falls beneath expected standards, the impact is reviewed to support continuous improvement.

~~3.15.~~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;

~~3.16.~~3.17. 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

~~3.17.~~3.18. Approve the patient experience/engagement plan and monitor its implementation.

~~3.18.~~3.19. Ensure the organisation has a citizen centred approach, putting patients, patient safety, quality of care and safeguarding above all other considerations.

~~3.19.~~3.20. Ensure the Patient Experience & Community Involvement (PECI) continuous engagement model is taken into account in the design and delivery of services, ensuring the full implementation of lessons learnt.

~~3.20.~~3.21. Seek assurance that lessons are learned from patient experience information and patient safety and workforce related incidents, complaints and claims, and that learning from reports and incidents is embedded in the Trust's practices, policies and procedures

~~3.21.~~3.22. Ensure there is good collaborative team and partnership working to provide the best possible outcomes for its citizens

~~3.22.~~3.23. Ensure any matters raised by the Medical Director, Director of Quality & Nursing, Director of Paramedicine, or other Directors in relation to patient safety and clinical risk are considered and addressed promptly and fully

Information Governance and Information Security

~~3.23.~~3.24. Receive assurance the information governance and information security arrangements are appropriately designed and operating effectively to ensure the reliability, integrity, safety and security of information to support the delivery of high quality, safe healthcare across the organisation.

~~3.24.~~3.25. Review progress of measures to improve information security and adherence to Caldicott principles against the Information Governance Toolkit, Network and Information Systems (NIS) Directive (2018), Data Protection Act (2018), and receive assurance on compliance with relevant standards, legislation and regulations.

~~3.25.~~3.26. Receive assurance on, and review effectiveness of the Trust's information security protocols.

~~3.26.~~3.27. Review performance of the Trust in relation to statutory and mandatory information requests and reporting requirements including but not limited to freedom of information requests, data breaches, police requests and subject access requests.

Governance

~~3.27.~~3.28. 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.~~.~~

~~3.28. Approve the research governance framework and oversee its implementation in accordance with the Welsh Government Research Governance Framework for Health and Social Care.~~

3.29. Recommendations made by internal audit and external reviewers are considered and acted upon on a timely basis;

3.30. Review and recommend to the Board the Trust's annual quality statement (as relevant) and quality improvement priorities for the coming year, monitoring progress against these priorities and their impact on patient safety.

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

Corporate Risks and Audit Recommendation Tracker

3.32. The Audit Committee has overall responsibility for ensuring that corporate risks are identified and are being properly managed within the Trust. The Audit Committee also has responsibility for ensuring that there are processes

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

Authority

3.33. 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.

3.34. 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.

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

Sub-Committees

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

4. MEMBERSHIP

Members

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

Chair	Non Executive Director
Members	Three further Non Executive Directors of the Board.

Attendees

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

- Executive Director of Quality and Nursing (Committee Lead)
- Director of Paramedicine
- Executive Director of Operations
- Executive Director of Strategy, Planning and Performance
- Director of Digital Services (SIRO)
- 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 Workforce & Organisational Development.

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 verbal updates on activity, 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.

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

WAST SAFEGUARDING ANNUAL REPORT 2021-2022

MEETING	Quality, Patient Experience & Safety Committee
DATE	9 February 2023
EXECUTIVE	Liam Williams, Executive Director of Quality and Nursing
AUTHOR	Safeguarding Specialist
CONTACT	Rhiannon Thomas 07967 377062 Rhiannon.thomas@wales.nhs.uk

EXECUTIVE SUMMARY

This report will provide information to the Quality, Patient Experience & Safety Committee on how the Trust has met its statutory duties during 2020-2021 under the Children Act 2004, the Social Services and Well-being (Wales) Act 2014, the Violence Against Women Domestic Abuse and Sexual Violence (Wales) Act 2015 and that compliance with the Welsh Government Adult and Child Protection guidance are being fulfilled.

KEY ISSUES/IMPLICATIONS

The Safeguarding Annual Report (**Annex 2**) provides evidence on how the Trust has performed during the 2021-2022 period in relation to safeguarding people in our care. It aims to give the Trust Board information on WAST safeguarding activities, engagement and collaborative working with our partner agencies; as well as the necessary assurances that the statutory duties under the relevant safeguarding legislation and guidance are being fulfilled.

REPORT APPROVAL ROUTE

Safeguarding Strategic Group	22 September 2022
Quality, Patient Experience & Safety Committee	9 February 2023

REPORT APPENDICES

ANNEX 1 - SBAR providing supporting background information
ANNEX 2 - Safeguarding Annual Report 2021-2022

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

ANNEX 1

SITUATION

1 The purpose of this Report is to provide information on the Safeguarding Annual Report to members of the Quality, Patient Experience & Safety Committee (QuESt).

BACKGROUND

2 The Safeguarding Annual Report provides an overview on how the Trust has performed during this reporting period in relation to safeguarding people in our care. It aims to give the Trust Board information on the impact of the pandemic in relation to Welsh Ambulance Services NHS Trust (WAST) safeguarding activities as well as the necessary assurances that the statutory duties under the relevant safeguarding legislation and guidance are being fulfilled.

ASSESSMENT

3 The Safeguarding Governance Frameworks have continued to be part of everyday practices within WAST during a continued challenging reporting period. The data evidenced within this year's report demonstrates an increase of 85% in the total number of reports submitted by WAST staff since the initial launch of Doc Works. Feedback from WAST staff as well as our partner agencies acknowledge that this is an improved mechanism for submitting reports to Local Authorities across Wales.

4 Doc Works has been further developed during this reporting period by the Scribe App 2 update and also the digital ability to submit Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) concerns to Live Fear Free and fire safety concerns to the National Fire Service across Wales.

5 The Trust's Annual Training Plan continues to support statutory safeguarding requirements, ensuring that staff are provided with the right level of training commensurate with their role. This report illustrates compliance of 99% for Level 2 Safeguarding Children and 89% Level 2 adult safeguarding training (target set at 85%) and 89% for Group 1 training as required under the VAWDASV National Training Framework (NTF).

6 **Violence against women, domestic abuse and sexual violence**. This section of the Safeguarding Annual Report outlines the VAWDASV National Training Framework Training Plan for the Trust. The Plan for WAST was reviewed and updated following consultation with the Welsh Government VAWDASV Team. WAST compliance with the National Training Framework (NTF) is included in an Annual NTF Report to Welsh Government in 2021.

7 There is a fundamental obligation for all agencies involved in the care, support and protection of those at risk ensuring the highest possible standards of that care, support and protection are provided and maintained at all times. Part of this obligation is a requirement to learn from mistakes, especially those resulting in the death or serious injury of an individual at risk.

8 This report includes information on WAST activity generated by our ‘Duty to cooperate’. The WAST Safeguarding Team have worked in partnership other agencies as required in all safeguarding activities including: Procedural Response to Unexpected Deaths in Childhood (PRUDiC), Practice and Domestic Homicide Reviews and Safeguarding Strategy Meetings. There has been a noticeable increase in WAST collaborative safeguarding activity associated with core business.

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
NHS Trust

Welsh Ambulance Services NHS Trust

Safeguarding Annual Report 2021-2022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Introduction

The Safeguarding annual report provides an overview on how the Trust has performed over this reporting period in relation to safeguarding people in our care. This reporting period has been particularly challenging for the NHS across Wales. Priority is given within the report to evidence the significant increase in Safeguarding activity within the organisation, staff ability to fulfil their responsibility to recognise and act on issues and concerns in relation to Safeguarding people in our care, the sharing of information on concerns identified as well as sharing good practice, learning from the experiences of WAST Safeguarding activity, improving systems and processes and highlighting the organisation's effective responses to the rapidly changing circumstances and impact in relation to relevant adverse National issues, including the COVID19 pandemic.

This year's report aims to give the Trust Board the necessary assurances that the statutory duties under the Children Act 2004, the Social Services and Well-being (Wales) Act 2014, the Violence Against Women Domestic Abuse and Sexual Violence (Wales) Act 2015 and the Welsh Government Adult and Child Protection guidance are being fulfilled. The Trust complies with the specific requirements under section 25 of the Children Act 2004 that there is a lead executive director for children and young people's services and a designated non-executive director for the purposes of the Act. The Director of Quality, Safety and Patient Experience is currently the executive lead for safeguarding within the Welsh Ambulance Services NHS Trust (WAST).

The Head of Safeguarding has responsibility as Named Professional for Safeguarding Children as well as Adults at Risk. This role ensures the Trust's compliance with Statutory Legislation and Guidance above. The Head of Safeguarding takes the organisational strategic lead on all safeguarding related matters for WAST.

Key functions have included ensuring appropriate policies, procedures, pathways, audit and training are developed and kept updated in line with national legislation and guidance. In addition, the Safeguarding Team monitors and provides recommendations on any service developments and service level agreements which have the potential to impact on the well-being of children and adults at risk. This ensures the organisation's ability to provide safe and effective care which protects vulnerable people from abuse, neglect and exploitation; and compliance with Health and Care Standard 2.7: Safeguarding Children and Adults at Risk.

1. Safeguarding People

Safeguarding People within this report for 2021-2022 relates to the Welsh Ambulance Services NHS Trust's Safeguarding activity to prevent, protect and support service users and their families who are at risk from issues related to abuse, neglect, exploitation, violence against women, domestic abuse and sexual violence. It includes data relevant to the **COVID19 pandemic** experience which has continued to have National recognition of increased vulnerability for Children and Adults at Risk of Abuse.
This section of the report provides insight into our service users by age range for safeguarding referrals made when our duty to protect a person from harm in the context of safeguarding has occurred. This allows us to understand where particular areas of potential vulnerability may exist.

Safeguarding Child Reports where age is known

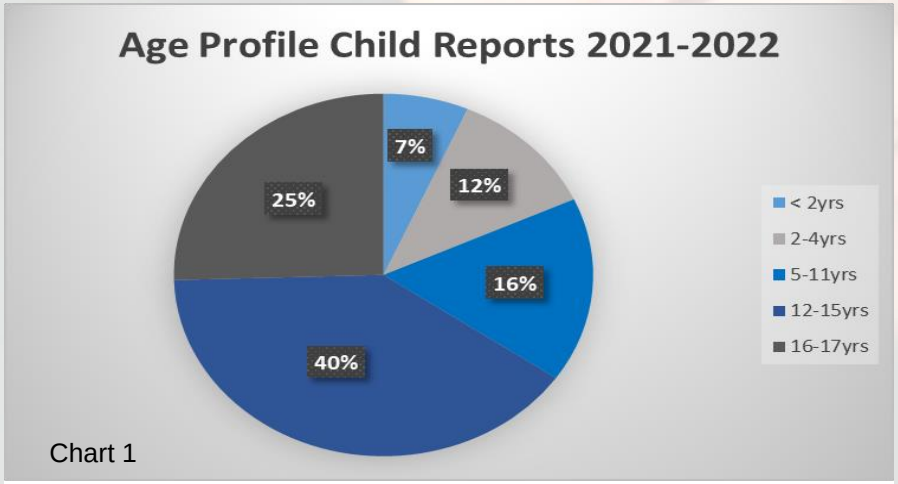


Chart 1

The WAST data 2021/22 profile by age range for child referrals resulted in a higher number of concerns reported for children aged 12-15yrs (40%) and 16-17yrs (25%) in comparison to those aged 10yrs and under. This indicates that a higher vulnerability was identified by WAST staff in relation to Safeguarding concerns for the 11-15yr and 16-17yr olds who had contact with our services during this reporting period. This is a consistent theme noted in the previous reporting period.

Safeguarding Adult Reports where age is known

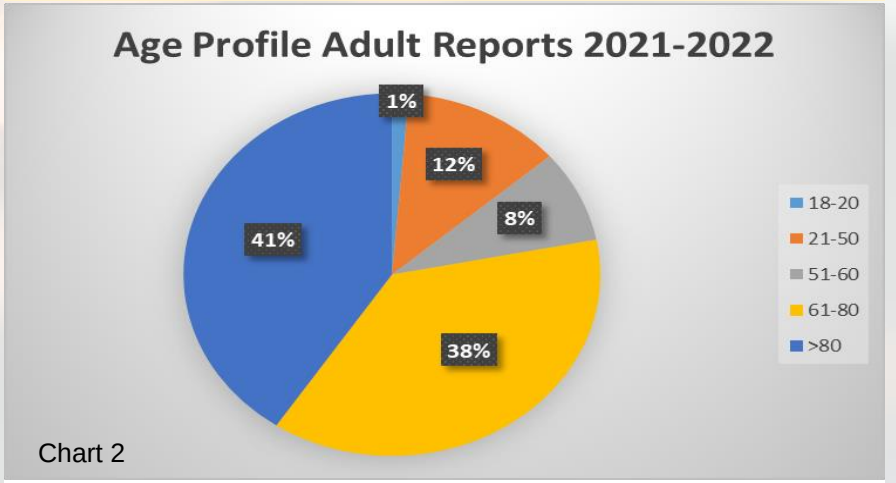


Chart 2

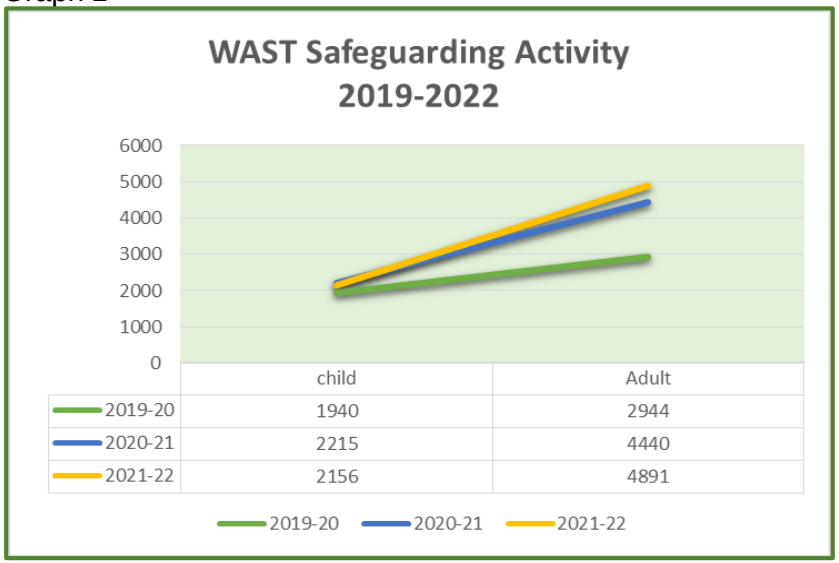
The WAST data for 2021/22 adult referrals made indicates that there were a higher number of concerns reported for adults aged > 80yrs (41%), 61-80yrs (38%). Compared to those aged 60yrs and under with the lowest number of concerns reports for 18-20yr old age range during this reporting period. This indicates higher vulnerability identified by WAST staff in the over 61yr age range; which is expected as potential vulnerability increases with age in general as well as in relation to Safeguarding concerns.

Safeguarding Referral Information

The Safeguarding Team's priority is to ensure that WAST staff provide safe and effective care which protects people at risk of abuse and neglect as well as those in need of care and support. This involves reporting concerns appropriately to the relevant agencies and utilising appropriate pathways which further support victims of domestic abuse and sexual violence following contact with our service. WAST compliance with the requirements from the Children Act 2004, Social Services and Well-being (Wales) Act (SSWA) 2014, Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 (VAWDASV), as well as the Health and Care Standard 2.7 is demonstrated by this activity.

Following contact how many safeguarding concerns have been identified by WAST staff?

Graph 1



DocWorks 2021-22

The introduction of DocWorks has been further progressed during this reporting period with the updated Scribe App 2. In November 2021 WAST staff were also able to submit a digital form for VAWDASV to Live Fear Free and for fire safety concerns to the Fire Service.

Table 1 illustrates a further breakdown of the referrals made by type where known

Table 1

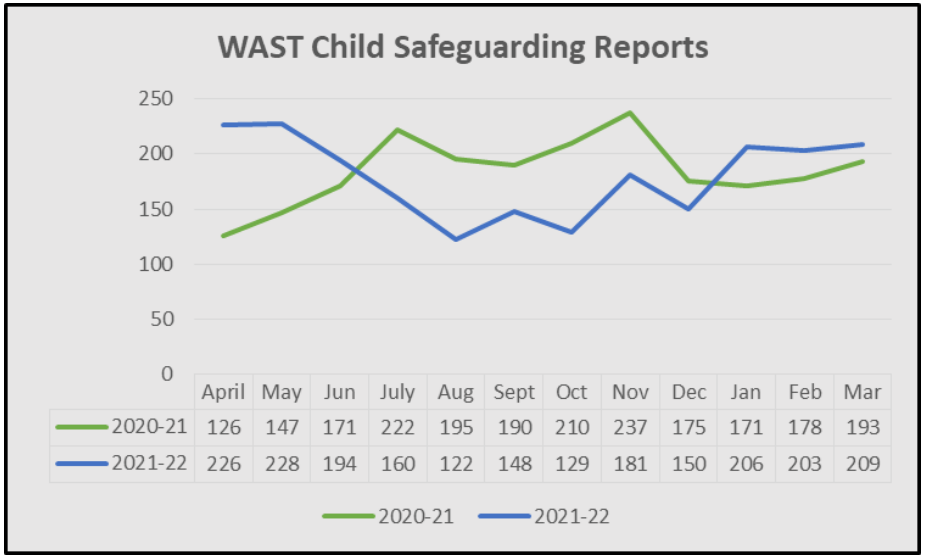
Report	2019/20	2020/21	2021/22
Child at Risk	1486	1461	1303
Child in Need	454	754	853
Adult at Risk	836	1149	1106
Adult social care need	2108	3291	3785
Total	4884	6655	7047

Reporting Rates

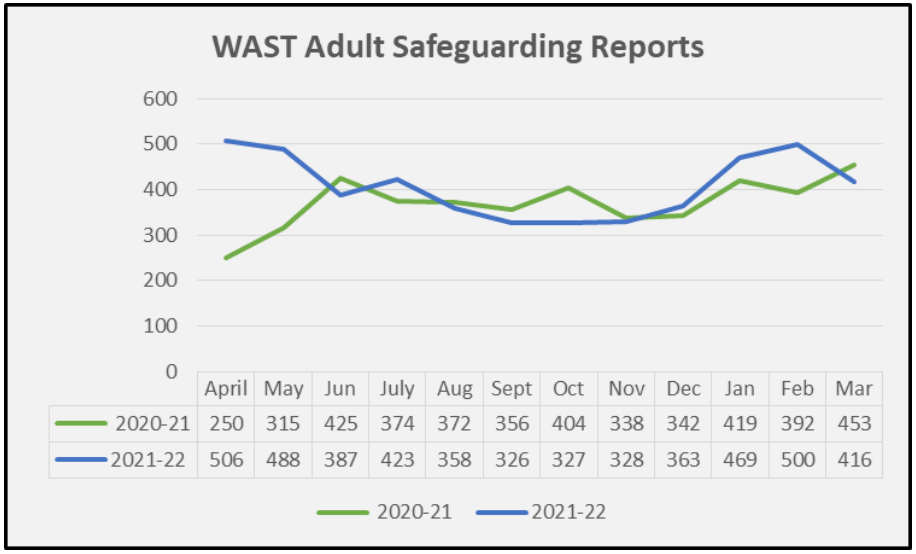
The number of reports submitted by WAST staff has continually increased since the initial launch of DocWorks in 2019. March 31st 2019 – March 31st 2022 demonstrates an increase of 85% in reports made by WAST staff.

The following graphs illustrate WAST Safeguarding reports by Month for 2021/22 and the comparison with the last reporting period, as well as per WAST Health Board Area (Note: a small number of reports made by WAST staff were for areas outside of Wales HB's)

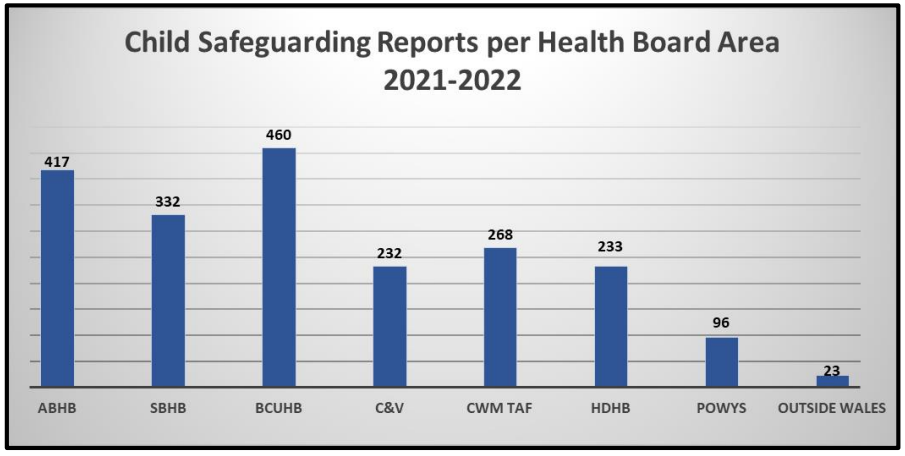
Graph 2



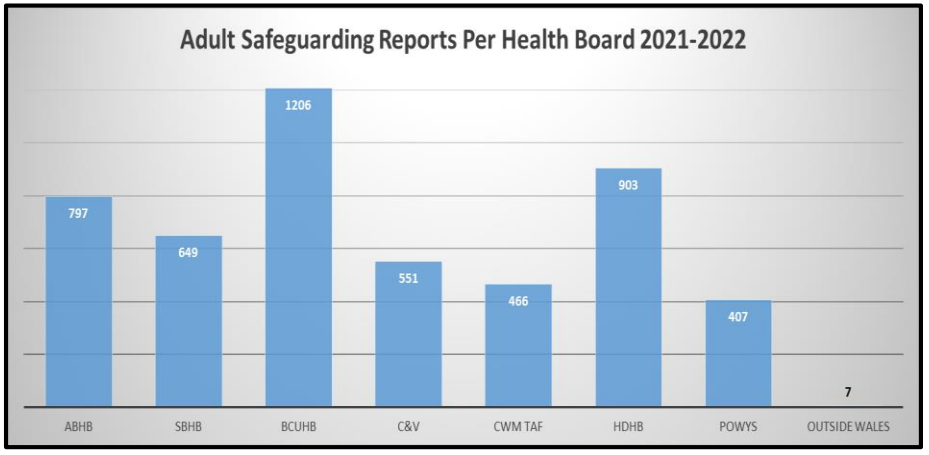
Graph 3



Graph 4



Graph 5



Safeguarding Referral Information

The Safeguarding Team has continued to progress WAST staff skills and understanding of the Safeguarding thresholds met, to ensure that the reports made to Social Services are appropriate and in accordance with the required standard. This includes the identification, appropriate support and that potential actions are taken for victims associated with violence against women, domestic abuse and sexual violence.

Chart 3

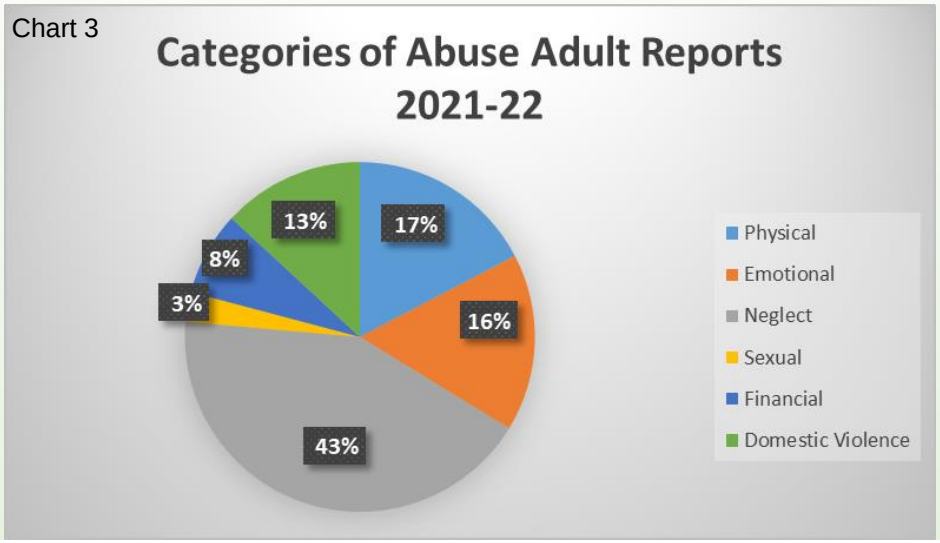
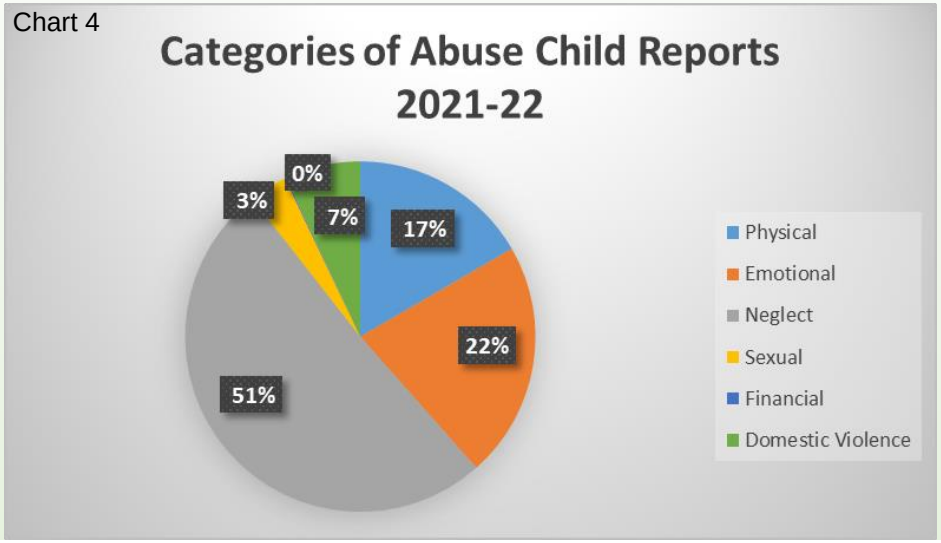


Chart 4



Categories of Abuse reported by WAST staff 2021-2022

WAST ability to capture data relating to financial abuse of children has been included for the first time during this reporting period. The implementation of DocWorks has also enabled an ability to identify data relating to discriminatory abuse, self-neglect, modern slavery and institutional abuse. This information will be included in the next reporting period.

Safeguarding People 'Challenges during the COVID 19 Period'

It is acknowledged that the COVID 19 pandemic has had an adverse effect on those at risk of harm within Wales. The lockdowns and social distancing measures in place across the UK, has made it difficult for some health professionals to keep in regular contact with children and adults at risk to check on their welfare.

However this has not been the case with the frontline emergency services in WAST. Practitioners in both the EMS and NHS 111 have faced unprecedented demand in care and treatment services as well as challenges to support and safeguard vulnerable adults, children and families with reduced availability from partner agencies over the past year.

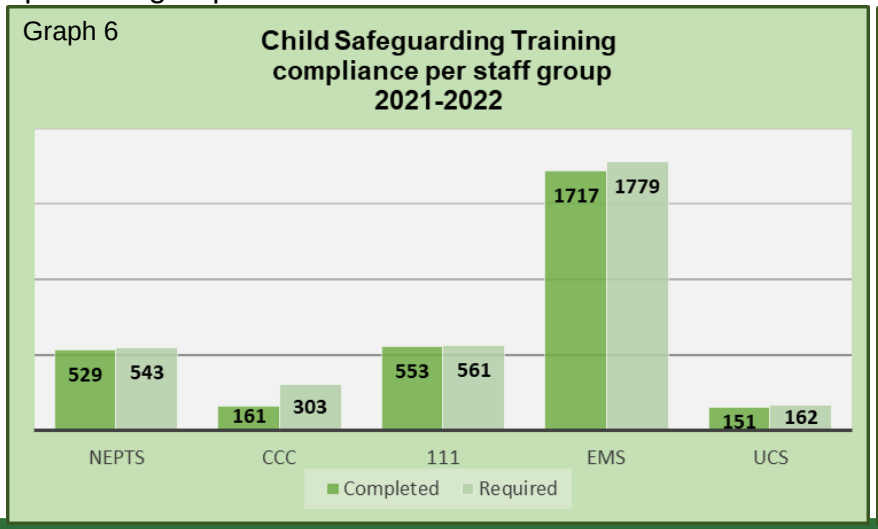
The Trust's annual training plan continues to support statutory safeguarding requirements. This is achieved by ensuring that staff are provided with the right level of training commensurate with their role. Working in partnership with the Training College (NATC) the Safeguarding Team have established a three yearly training program for child and adult Safeguarding.

Safeguarding Training delivered on the 2021-22 induction programme for new staff was achieved by both classroom delivery, where COVID regulations could be followed, and also virtually via Microsoft Teams. All packages were developed to meet the required standards and to ensure a positive learning experience for those participating.

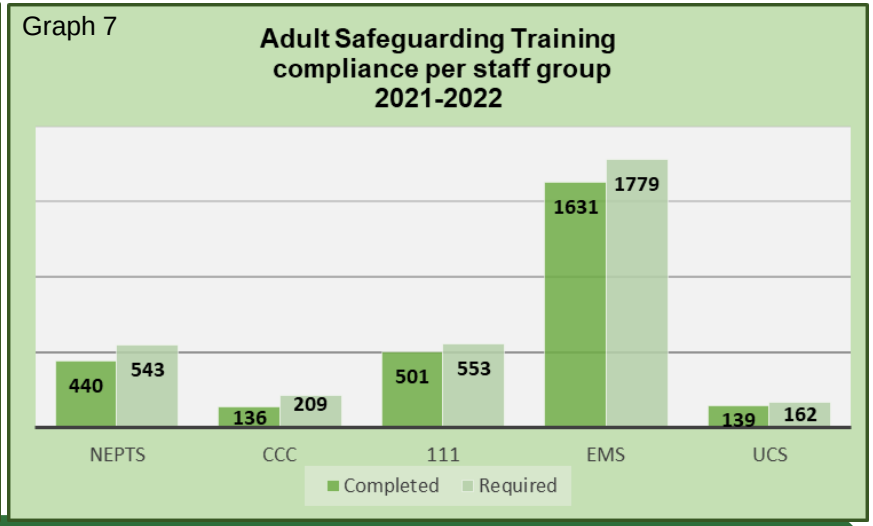
WAST achieved overall compliance of **99%** for Safeguarding Children Training during this reporting period. In addition to the face-to-face induction sessions, staff also accessed training via the NHS e-learning portal.
By utilising this system **89%** of staff completed Level 2 adult safeguarding training during the reporting period.
All new staff received training on induction, those requiring mandatory refresher training will be facilitated during the 2022-2023 CPD programme.

The graphs below illustrate compliance with training as required during 2021-22 per staff group :

Graph 6



Graph 7



Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV)

This section of the Safeguarding Annual report outlines the VAWDASV National Training Framework Training Plan for the Welsh Ambulance Service NHS Trust (WAST). Under Section 15 of the VAWDASV (Wales) Act 2015, WAST "*is required to incorporate training for Groups 1, 2, 3 and 6 into their existing learning and development framework and submit to the Welsh Ministers their own training plan, training needs analysis and annual plan based on this*".
The Plan for WAST was reviewed and updated following consultation with the Welsh Government VAWDASV team in March 2018 and subsequently included in an Annual NTF Report to Welsh Government in May 2022.

Group 1 of the National Training Framework
There has been significant work and progress made since the launch of Group 1 throughout WAST.
Table 2 illustrates the progress made since the initial launch during WG pilot. The number of staff who have completed Group 1 training has been determined by the WAST Online Learning Management and training department records which are recorded on WAST electronic staff records (Target 100% compliance).

Table 2

Total staff employed	Number completed Group 1	% compliant
3213 *March 2017*	**1537**	**48%**
3286 *March 2018*	**2413**	**73%**
3450 *March 2019*	**2795**	**81%**
3617 *March 2020*	**2888**	**80%**
4091 ***March 2021***	**3430**	**84%**
4436 ***March 2022***	**3951**	**89%**

The majority of WAST ancillary staff and those who are office based achieve Group 1 via the ESR online learning module. Face to face Group 1 training is only delivered to frontline staff including Paramedics, Emergency Medical Technicians, Urgent Care Service and Non-Emergency Transport Service staff. This training is delivered by WAST trained trainers who have been approved through the NTF Agored Cymru train the trainer process.

WAST has noted an increase in the total number of staff employed since the launch of this training. This has affected the overall compliance during this reporting period.

Groups 2 and 3 of the National Training Framework

During this reporting period WAST has continued to participate as a pilot site for phase 2 of the National Training Framework for Violence against women, domestic abuse and sexual violence. The challenge of which is being met under the governance of the Safeguarding Strategic Group and operationally by the "Ask and Act" task and finish group. This has given WAST the opportunity to start to deliver a comprehensive training package to our frontline staff so that they are further supported to identify, support and take action for victims and their families.

WAST trained trainers commenced the required training for Group 2 "Ask and Act" as part of the Welsh Government Pilot in October 2018. A total of **1378** staff have been trained to date against a target of **1784** for this period resulting in **78%** compliance with WAST 5 year training plan. It is acknowledged that this has been achieved during the continued challenge of the COVID 19 period.

Table 3 illustrates the evaluation of learning following the completion

Group 2 - % Learners provided a rating as good or excellent		
	Pre Training	Post Training
Q1. Knowledge on the Subject	56%	87%
Q2. Skill regarding the Subject	46%	74%
Q3. Confidence regarding the subject	44%	89%

Next Steps

- Reinstate plan for Group 3 champion training
- Evaluate the Welsh Government survey to assess the impact of the National Training Framework
- Monitor progress of the digitalised Live Fear Free Pathway within WAST utilising DocWorks
- Review and update WAST Ask and Act policy
- Review and update WAST training plan

Table 4 WAST Violence against women, domestic abuse and sexual violence 5 year Training Plan

	2017-18	2018-19	2019-20	2020-21	2021-22
Group 1	Train remaining staff 1676 Commence training CFR volunteers	All new staff and Volunteers	All new staff and Volunteers	All new staff and Volunteers	All new staff and Volunteers
Group 2	Train the Trainers for WAST 12	Group 2 staff 446	Group 2 staff 446	Group 2 staff 446	Group 2 staff 446
Group 3	Train the Trainers for WAST 12	Train WAST Champions 25	Train WAST Champions 25	Train WAST Champions 25	Train WAST Champions 25
Group 6	Strategic Engagement Plan Strengthening Leadership Series	Strategic Engagement Plan Strengthening Leadership Series	Strategic Engagement Plan Strengthening Leadership Series	Strategic Engagement Plan Strengthening Leadership Series	Strategic Engagement Plan Strengthening Leadership Series

The amount of activity generated by our duty to cooperate illustrates a significant decline in requests for WAST engagement during this reporting period. This is attributed to the COVID 19 impact on agencies' ability to comply with Section 7 of the Social Services and Wellbeing (Wales) Act 2014, as well as the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 and continued under Section 9 of the Domestic Violence, Crime and Victims Act 2004.

The rapid introduction of the Coronavirus Act 2020 set out regulations in Wales which relaxed the obligations on Social Services and other agencies so that they could focus on the priorities of meeting the immediate needs of those at increased risk due to the Pandemic.

The Head of Safeguarding, Executive and Assistant Directors within the Quality, Safety and Patient Experience Directorate have ensured engagement at a strategic level. This has also required the support of the Senior Professionals from within the Team during this reporting period.

WAST Safeguarding engagement with the Regional Boards has included activity with the following:

Adult Practice Reviews			Child Practice Reviews			Domestic Homicide Reviews		
2019-20	**2020-21**	**2021-22**	**2019-20**	**2020-21**	**2021-22**	**2019-20**	**2020-21**	**2021-22**
14 Reviews	**2 Reviews**	**3 Reviews**	**6 Reviews**	**3 Reviews**	**5 Reviews**	**11 Reviews**	**0 Reviews**	**4 Reviews**

The Review Process

There is a fundamental obligation for all agencies involved in the care, support and protection of those at risk ensuring the highest possible standards of that care, support and protection are provided and maintained at all times. Part of this obligation is a requirement to learn from mistakes, especially those resulting in the death or serious injury of an individual at risk.

What does this mean for WAST

The challenge lies in sustaining an anticipated escalation in requests for WAST engagement during the next reporting period as a result of the above measures, as well as an acknowledged increase of 85% in WAST reports to local authorities across Wales since March 2019.

Protecting Adults at Risk

Section 7 of the Social Services and Wellbeing (Wales) Act 2014 (SSWA) places a statutory duty on Local Authority, Health Boards and Trusts to work in collaboration and share information where an "Adult at Risk" has been identified. WAST is required to co-operate with our partner agencies at both a strategic and operational level.

Strategy meetings provide an opportunity to focus on the needs of the vulnerable person and allow agencies to appropriately share information, identify risks and take specific action.

To support this the Safeguarding Team work collectively with Locality Managers, Duty Operational Managers and staff in the gathering of the information that is required to support the process.

The Safeguarding Team also work closely with our external partners in completing written reports on individual Adults at Risk as well as attendance at strategy meetings when required.

Graph 8 illustrates WAST compliance with reports submitted, enquiries and strategy meetings attended per health board under our duty to cooperate with this process.

Graph 8

NB
Not all meetings held are as a result of WAST reports. However, where our staff have reported potential abuse of an adult at risk, these tended to involve adults in a care setting where Neglect was identified as the main category of abuse.

Procedural Response to Unexpected Deaths In Childhood (PRUDiC)

The 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 in the multi-agency response to unexpected child deaths.

During this reporting period WAST has contributed to **64** information and planning meetings held under the PRUDiC process.

The graphs and chart below highlight WAST data relating to unexpected child deaths during 2021-2022. This includes the numbers of PRUDiC incidents per WAST Health Board, monthly occurrence and also age range.

Graph 9

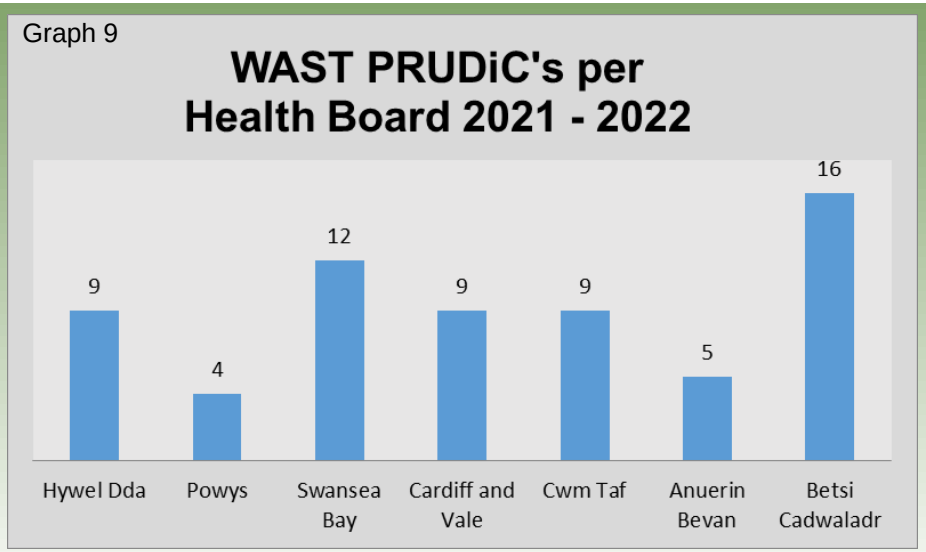
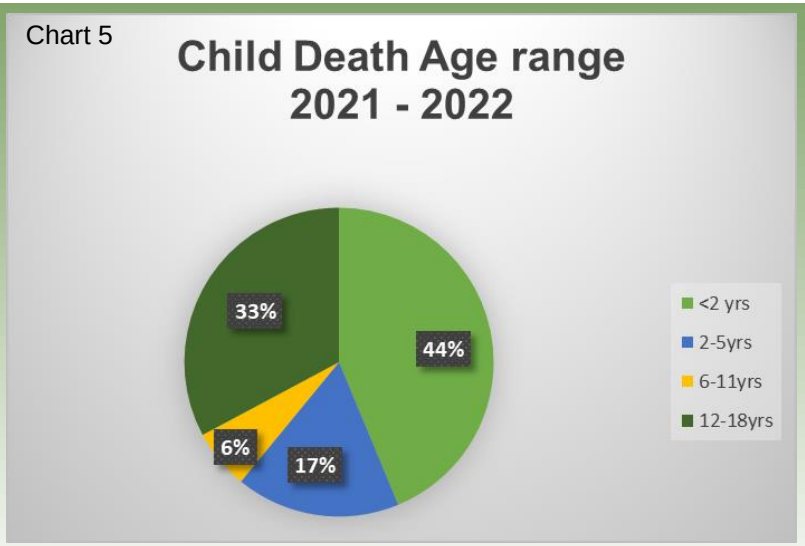
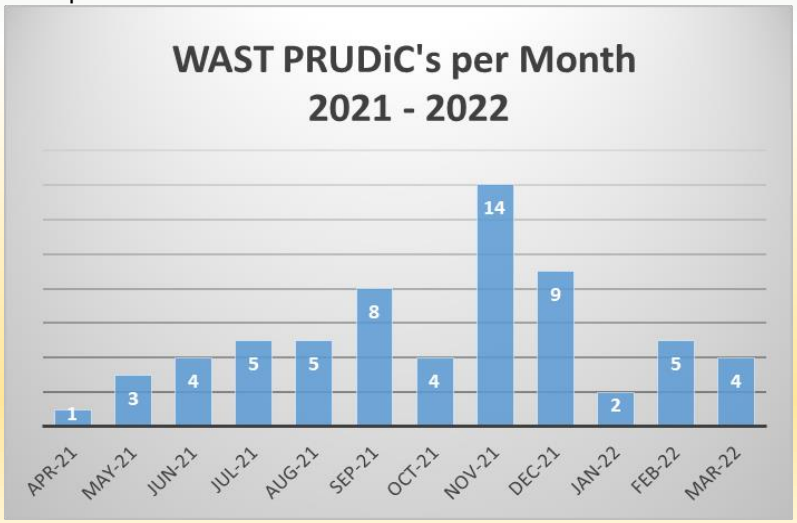


Chart 5



Graph 10



WAST information can be useful for identifying themes and trends. Graph 9 indicates that the highest number of child deaths where the PRUDiC was initiated occurred within Betsi Cadwaladr University Health Board.

The highest percentage age range was for under 2 years of age (44%) and 12-18yrs (33%). There was a significant increase of PRUDiC incidents in November 2021, 43% of these incidents were associated with fatal self harming activity.

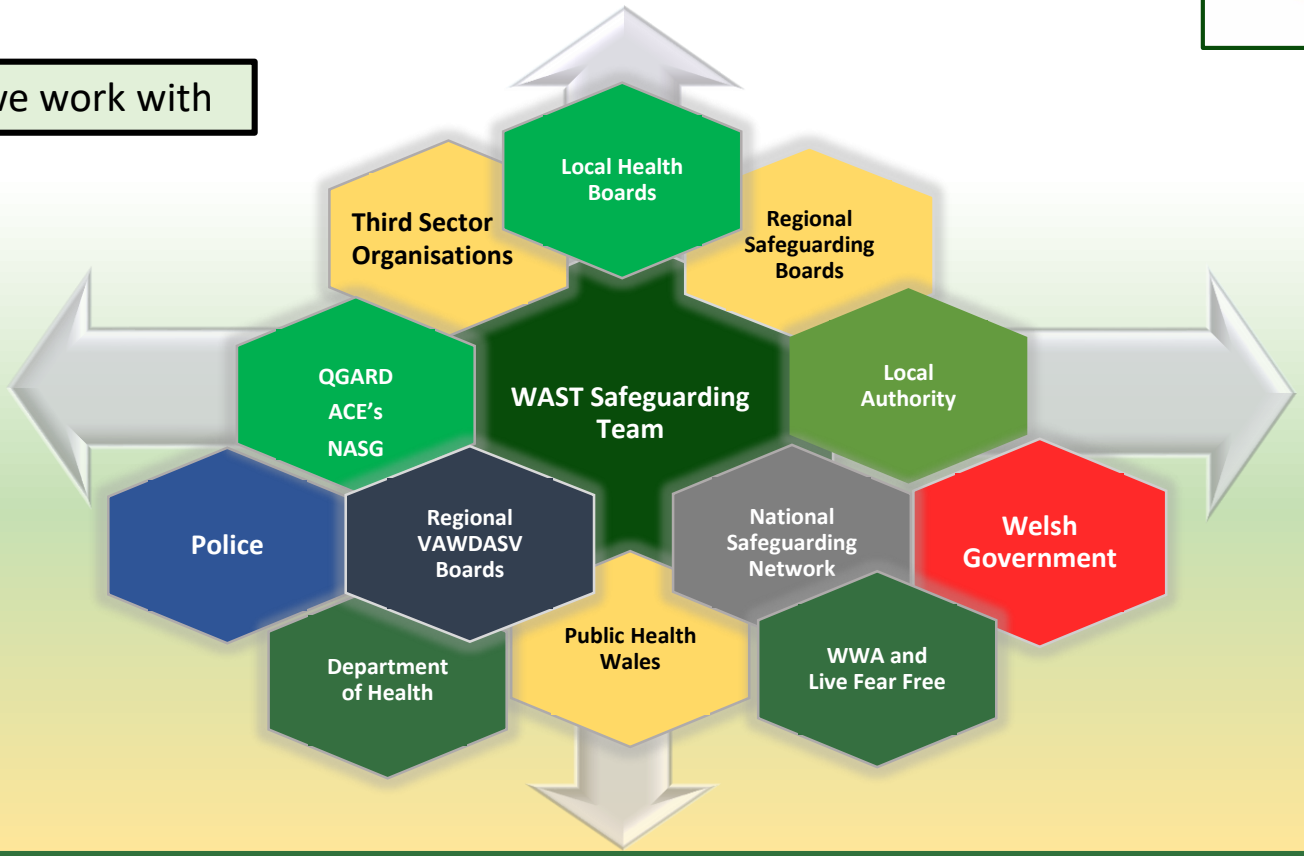
It is noted that this period followed the Welsh Government COVID 19 circuit breaker measures implemented from Oct 23rd – Nov 9th 2021.

Themes and trends are collated by the Public Health Wales child death review panel who provide annual reports from a National perspective. Data collated is then used to promote good practices which reduce harm.

The Safeguarding Team sits within the Quality, Safety and Patient Experience Directorate. The Team carries out a necessary corporate function as well as supporting the specific work of the Directorate. Our commitment to delivering high quality care in safeguarding has been clearly demonstrated by achievements highlighted in previous reporting periods. Effective leadership, management and innovation have been integral to our success.

The Safeguarding Team achieve our Safeguarding objectives by effectively working together with a wide range of services and professionals; so ensuring good outcomes for people who have contact with our service. This requires the Safeguarding Team to establish effective relationships with all departments in our organisation as well as within the wider Safeguarding arena across Wales.

Agencies we work with



Safeguarding Local Delivery Plan

The Safeguarding Team's approach to quality and quality improvement for this reporting period has been to focus on achieving the requirements set within the Safeguarding Local Delivery Plan (LDP). This aims to achieve our targets within the WAST Quality Strategy and prioritises our contribution in delivering the Integrated Medium Term Plan; as well as to identify any actual or potential risks to deliverables during this reporting period and beyond.

WAST is required to report on the Safeguarding position of the organisation both internally and externally. The Safeguarding LDP provides the focus for improving quality as part of the organisation's internal strategy but also incorporates the requirements included in standards and outcomes set by external reporting mechanisms. The Safeguarding LDP & Assurance Framework is mapped to the Health & Care Standards (2015) specifically standard 2.7; safeguarding children and adults at risk. Safeguarding sits within the Quality Theme: Safe Care and Prudent Healthcare. The outcome of which is to ensure *our service users are protected from harm and protect themselves from harm.* The principles of Prudent Healthcare are considered throughout, recognising continued progress is always required to integrate the principles into our safeguarding operational framework.

The following table illustrates the priority areas for achieving this by focussing on the key deliverables specified within the Safeguarding Local Delivery Plan (LDP) for 2020/21. *(Ref kd19 IMTP 4 CR 1-6)*

Table 5

Safe Care and Prudent Healthcare			
Training	Safeguarding Referral Process	Policies and Procedures	Engagement with Partner Agencies

Progress for LDP 2021/22

Training
- Safeguarding Training level 2 delivered as required (**99%** for Level 2 Safeguarding Children and **89%** for Adult Safeguarding training).

Safeguarding Referral Process
- "Docworks" launch of digitalised reports to Live Fear Free and the Fire and Rescue Service across Wales.

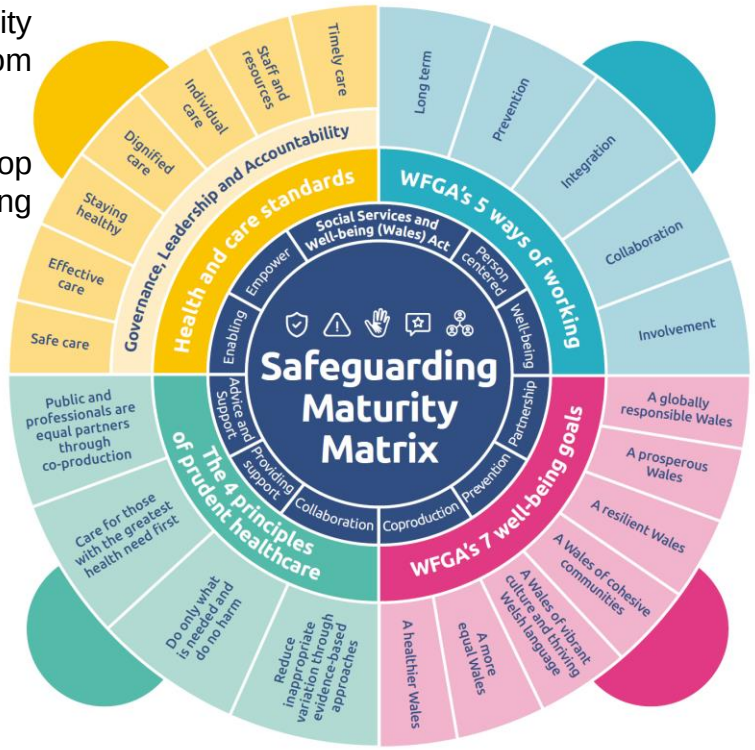
Policies and Procedures
- Review and updates on priority policies completed and approved.

Engagement with Partner Agencies
- High profile as central source for information with partner agencies during COVID 19 Period.

Safeguarding Maturity Matrix

The Safeguarding Maturity Matrix (SMM) is a self- assessment tool agreed by the Chief Nursing Officers Nurse Director Forum in Wales. It addresses the interdependent strands regarding Safeguarding, service quality improvement, compliance against agreed standards as well as learning from incidents and reviews.

The focus of the SMM is then for each Organisation to develop improvement plans which support a consistent approach to Safeguarding across Wales. The scoring system is set against 5 agreed standards.



WAST Maturity Score 2021-22

Standard	Maturity Score
1. Governance and Rights Based Approach	4
2. Safe Care	4
3. ACE Informed	4
4. Learning Culture	4
5. Multiagency Partnership Working	4
SMM score:	20

The Safeguarding Maturity Matrix tool was piloted during this reporting period. Members from WAST Safeguarding team participated in an online peer review process in November 2021 as part of the pilot arrangements. Together with 9 other NHS organisations who, through a facilitated approach, were able to consider and discuss individual self-assessment improvement plans in a collaborative and transparent system of learning.

WAST improvement plan forms part of the Safeguarding priorities set for 2022-2023 and beyond.

Docworks Scribe Referral Pathway
Fire & Rescue Services

Due to the nature of our service WAST are in a **unique position to identify fire risks** within homes. Since 16th November 2021 WAST staff have been able to refer service users for a home safety check by the Fire & Rescue Service.

South Wales, **Mid & West Wales, North Wales Fire & Rescue Services** and WAST have worked together, alongside Docworks Scribe, and developed a bespoke form so staff can share their **home safety concerns via the Docworks Scribe 2 App on their iPads**.

Staff can request that the local Fire & Rescue Service (FRS) get in contact to **offer support** or conduct a **home safety check**. Staff complete a report and it is e-mailed directly to the relevant FRS.

This provides a **streamlined** and **time-efficient collaborative referral process to protect the people of Wales**.

North Wales FRS	Mid & West Wales FRS	South Wales FRS
15	12	11
Number of Reports Submitted from 16 November 2021 – 31 March 2022		

Fire Death Data

- All 10 fatalities from 2021/22 lived alone
- Average age of victims (last 5 years) was 69 years old
- 66% aged over 65, 33% over 80
- Smoking was the most common ignition source, followed by cooking, and combustible items too close to heat source

Feedback

The safeguarding team and the Fire & Rescue Service across Wales have regular progress meetings to discuss the pathway. It is evident that they are very happy with the referrals received to date.
One referral shared was for an elderly gentleman who lived alone, he required a lot of intervention from the Fire & Rescue Service in order to make his home safe and they were only aware of him due to the WAST referral.

Docworks Scribe Referral Pathway
Live Fear Free

Llinell Gymorth Byw Heb Ofn | Live Fear Free Helpline
0808 80 10 800
ffôn • tecst • sgwrsio byw • ebost
call • text • live chat • email

Since 18th November 2021, the **Live Fear Free referral pathway** has been available to staff through the Docworks Scribe 2 App.

Live Fear Free is a free, 24/7 confidential helpline for domestic abuse and sexual violence in Wales. The Live Fear Free referral form is for situations where there are concerns for an adult and/or their families regarding domestic abuse and/or sexual violence. Once consent is gained, staff can complete a form on the Docworks Scribe 2 App requesting the Helpline contact the individual.

The Helpline is also available to all WAST staff and volunteers for specialist advice and support.

Since the launch to 31 March 2022 there have been **8 digital referrals** submitted requesting a call-back to the Helpline by WAST staff. This figure cannot capture contacts where only the Helpline number has been provided.

Decision Guidance Flowchart - Concern in Relation to Domestic Abuse and/or Sexual Violence

Disclosure of Domestic Abuse, Sexual Violence, or positive response to targeted enquiry (HITS)

{Complete Clinical Assessment in accordance with WAST policies}

1

Empower the individual to contact Live Fear Free helpline themselves for further specialist advice and support

Call: 0808 80 10 800
Text: 07860077333
E-mail: info@livefearfreehelpline.wales
Live Chat Online

2

If individual unable to make contact themselves and does not need immediate support complete the

Live Fear Free Form

on Docworks Scribe 2 App
MUST HAVE CONSENT
(Staff without iPads to phone referral through)

3

On rare occasions individuals may need immediate support but are not able to make contact themselves. It is acceptable for WAST staff to use the individual's phone to make initial contact with Live Fear Free helpline. No expectation for WAST staff to remain on scene once support initiated

How Can Live Fear Free Help?

The Helpline will listen, provide help, support, information and a range of services within an individual's local area. The helpline can support with:

- Emergency Accommodation
- Counselling
- Local Support Services
- Welfare & Benefits Rights
- Housing Issues
- Legal Issues
- Child Welfare
- Perpetrator Programmes
- Sexual Assault Referral Centres
- On Scene Advice to Professionals e.g. WAST staff

Making Every Contact Count

In North Wales we have had an attending crew complete safeguarding reports, a Live Fear Free referral and a Fire Risk referral all in relation to one WAST incident. The existence of Live Fear Free and Fire Risk referral pathways enables holistic working from WAST staff, and this evidences how the advancement in IT is supporting staff to complete their statutory duties; all these reports were completed on iPads.

Safer recruitment is central to Safeguarding. The WAST Recruitment and Selection policy and associated process is set out to ensure that recruitment into our service is managed in a consistent and equitable manner which complies with legal requirements and best practice. The recruitment team at NHS Wales Shared Service Partnership (NWSSP) work with WAST to ensure compliance with relevant Safeguarding legislation, policies and procedures.

Disclosure and Barring Service

The Disclosure and Barring Service (DBS) helps employers make safe recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children. In order for WAST to comply with the provisions of the *Safeguarding Vulnerable Groups Act 2006,* all new employees and volunteers who interface with the public must have a satisfactory enhanced check with the Disclosure and Barring Service (DBS) prior to the Trust agreeing a start date. Staff already employed who are being considered for a new position within WAST which requires a DBS check must also have satisfactory clearance.

Safe Retention Practices

The WAST "Safeguarding Children and/or Vulnerable Adults Policy: When an allegation is raised about an Employee or Volunteer" is embedded within the Trust and provides a process framework for action and advice to managers dealing with these issues. This process is followed where an allegation of potential abuse has been raised about an employee or volunteer of the Welsh Ambulance Services NHS Trust. The policy document provides the links with the All Wales policies and procedures agreed between partner agencies.

The policy ensures that focus remains on the welfare of our service users and that WAST retains an appropriate workforce. The allegations made are not always related to practices within the member of staff's role for WAST; however all allegations are investigated in a consistent manner. This ensures appropriate outcomes to protect the welfare of vulnerable groups who have contact with our service as well as protecting and supporting our staff involved in this process. On occasions where WAST is required to prevent unsuitable people from working within a WAST role; disciplinary procedures will be followed. The Disclosure and Barring Service and relevant professional bodies are informed by WAST as appropriate in these situations.

In conclusion the Safeguarding Annual report reflects the significant contribution which the Trust, Safeguarding Team and staff have made in ensuring people are safeguarded from harm during the challenging Pandemic reporting period. The Safeguarding Team's collaborative working ensures that the Trust and it's staff fulfil their safeguarding responsibilities. Our achievements obtained through improved knowledge, skills and attitudes as well as the promotion of our engagement with safeguarding multiagency activity has strengthened our working relationships both at an operational and strategic level.

This annual report demonstrates the progress made in meeting the standards and outcomes set within the safeguarding specific systems and reporting mechanisms of the wider safeguarding arena as well as those set within WAST. Continued focus has been provided within the organisation through the Quality Strategy, Safeguarding Local Delivery Plan, Business Partnership Model as well as the work of the established Safeguarding Strategic group. The safeguarding governance frameworks have continued to be part of everyday practices within WAST.

The increase in the Safeguarding activity for the Trust noted in previous reports has escalated during the past year. This may be attributed to the circumstances of the pandemic as well as being linked to a more efficient and effective mechanism for processing reports via DocWorks. This activity illustrates WAST compliance with Section 7 of the Social Services and Wellbeing (Wales) Act 2014, as well as the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 and continued under Section 9 of the Domestic Violence, Crime and Victims Act 2004.

The Head of Safeguarding, Executive and Assistant Directors within the Quality, Safety and Patient Experience Directorate have been supported by the Senior Professionals within the Team to ensure engagement at a strategic level with the Regional Safeguarding Boards. The operational engagement by the Safeguarding Specialists within the Team with the associated work plans of the Regional Safeguarding Boards has continued.

The Safeguarding Team within WAST is dedicated to providing continual advice, guidance and support to staff at all levels. This is reflected in the provision of safeguarding supervision, promotion of reflective safeguarding practice, additional support sessions held for operational staff, opportunity for shadowing, placement and secondment experience. As well as in the Team's involvement in all safeguarding related matters at a corporate and strategic level. The safeguarding governance frameworks have continued to be part of everyday practices within WAST.

Building on the Safeguarding Team achievements during 2021-22 the following priorities have been identified for future progress.

- To further progress DocWorks capabilities
- To review and improve Safeguarding training resources and methods of delivery
- To review WAST position for Liberty Protection Standards and MCA
- To ensure resilience and required resource for Safeguarding within WAST
- To continue to promote WAST Safeguarding profile Nationally

References

Children Act 1989

Children Act 2004

Social Services and Well-being (Wales) Act 2014

Human Rights Act 1998

Mental Capacity Act 2005

Female Genital Mutilation Act 2003

Serious Crime Act 2015

Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015

Domestic Violence, Crime & Victims Act 2004

Safeguarding Vulnerable Groups Act 2006

All Wales Child Protection Procedures: Welsh Assembly Government (2008)

Safeguarding Children and Young People: Working Together Under the Children Act 2004 (2006)

Wales Interim Policy for the Protection of Vulnerable Adults from Abuse (2010) (updated 2013)

In Safe Hands (WAG, 2000)

Right to be Safe (WG, 2010) Counter Terrorism and Security Act 2015

Welsh Adverse Childhood Experience (ACEs) Study. Adverse Childhood Experiences and their impact on health harming behaviours in the Welsh adult population. Bellisi et al 2015

Right to Choose (H M Government, 2014)

Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews: (H M Government, revised 2013)

Protecting Children in Wales: Guidance for Arrangements for Multi-Agency Child Practice Reviews (WG, 2013)

Public Health Wales (2014) *Achieving Prudent Healthcare in NHS Wales.* Wales: Public Health Wales

Welsh Assembly Government (2015) *Health and Care Standards* Wales: WG

NHS Wales Safeguarding Children Self Assessment Quality Outcomes Framework (QOF): Safeguarding Children Service and Safeguarding Children NHS Network

WAST Quality Strategy 2016 to 2019

Putting Things Right: Guidance on dealing with concerns about the NHS from 1 April 2011, Welsh Government (2013).

Safeguarding Children and Young People: Roles and Competences for Health Care Staff. Intercollegiate Document (ICD) – Royal College of Paediatrics and Child Health (September 2010) (updated 2014)

Disclosure & Barring Service (DBS) Guidance

Procedural Response to Unexpected Deaths in Childhood (PRUDiC) 2014 (Public Health Wales)

All Wales Safeguarding Children Supervision Strategy 2014 (Public Health Wales)

All Wales Emergency Care Plan Pathway for a Child/Young Person (All Wales Managed Clinical Network for Children's Palliative Medicine) 2014

Lord Laming Inquiry (2003)