Bundle Quality, Patient Experience and Safety Committee 8 February 2024

Agenda attachments

ITEM 0 Open Quest Agenda - 8 February 2024

0 09:30 - OPENING ITEMS

1 Chair's welcome, apologies, and confirmation of quorum

2 Declarations of Interest
Declarations of Interest

3 Minutes of the Previous Meeting – 31 October 2023
Item 3.1 Ratification of a Chair's Action
ITEM 3 Draft Open QUEST Committee Minutes - 31 October 2023
ITEM 3.1 Chairs Action for Ratification - Infection, Prevention and Control Policy
ITEM 3.1a IPC Policy Updated v2.4 (17012024)

4 Action Log & Matters Arising
4.1 Committee Highlight Report from 31 October 2023
ITEM 4 Action Log (Public) Quest Committee
ITEM 4.1 Quest Committee Highlight Report October 2023

5 09:40 - Operations Directorate Quarterly Report Q3 2023/24
ITEM 5 Operations Quarterly Report for Committees 23-24 Q3 FINAL 4 Jan

5.1 ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION

6 10:00 - Patient Story
Alison Cassidy
ITEM 6 Patient story update Alison Cassidy

7 10:30 - Putting Things Right Report Quarter 3, October – December 2023
ITEM 7 Putting Things Right Report, Quarter 3, October - December 2023

8 10:50 - Monthly Integrated Quality Performance Report
ITEM 8 MIQPR SBAR QUEST December 2023
ITEM 8.1 MIQPR

8.1 11:05 - Comfort Break

9 11:20 - IMTP Quest Committee Elements [Verbal]

10 11:35 - Quality Strategy Implementation Plan Update
ITEM 10 Quality Strategy Implementation Plan Update
ITEM 10.1 Quality Strategy Implementation Plan Update - Annex 2

11 11:45 - Spotlight on Clinical Indicators
ITEM 11 SBAR - Focus on CIs - Stroke
ITEM 11.1 Focus on CIs - Stroke - v3 10.1.2024

12 12:00 - HIW National Review of Patient Flow – A journey through the Stroke pathway and Improvement Plan
12.1 HIW Annual Report
ITEM 12 SBAR HIW Review of Stroke Pathway Report and Improvement Plan
ITEM 12 HIW Report - National Review of Patient Flow, A Journey Through the Stroke
ITEM 12.1 HIW Annual Report 2022-23

13 12:15 - Clinical Audit Plan and Action Tracker Quarter 3 Update and Clinical Audit Plan Q1 2024/25
ITEM 13 SBAR - Clinical Audit Plan & Action Tracker Q3 2023-24
ITEM 13.1 Clinical Audit Plan Q3 - December 2023
ITEM 13.2 Clinical Audit Action Tracker 23.01.2024
ITEM 13.3 SBAR - Clinical Audit Plan Q1 2024-25
ITEM 13.4 Clinical Audit Plan 2024 - 25 FINAL DRAFT Q1 25.1.2024

14 12:25 - Medicines Management Assurance Report for 2023
ITEM 14 MMAR SBAR QuEST 25012024
ITEM 14.1 Medicines Management Assurance Report - Annual Summary 2023 FINAL

14.1 12:35 - Lunch

- *Responses to questionnaire*
- *Committee Annual Report*
- *Proposed Changes to ToR*

ITEM 15 QUEST SBAR on Committee Effectiveness 2023-24
ITEM 15.1 QuEST 2023-24 Results final
ITEM 15.2 QUEST Annual Return 2023-24 DRAFT
ITEM 15.3 QUEST Committee TOR 24-25 draft for discussion

16 13:20 - Risk Management and Board Assurance Framework Report
ITEM 16 Executive Summary Risk Management Report QuEST 080224

17 13:30 - Policies for Approval/Adoption:
Data Protection Policy
ITEM 17 Executive Summary Data Protection Policy 080224
ITEM 17.1 Data Protection Policy v2.1 final 180124

18 13:35 - Audit Tracker and Audit Reports
18.1 Audit tracker
18.2 Records Management Internal Audit Report
ITEM 18 SBAR Audit Tracker to QuEST Q3 Reporting - February 2024
ITEM 18.1 Audit Tracker 2.0 Q3 October-December 2023
ITEM 18.1a HIW Audit Tracker 2.0 Q3 October-December 2023
ITEM 18.2 WAST_2324-13_Records Management_Final Internal Audit Report

19 13:45 - Information Governance Report - Key Metrics
ITEM 19 Information Governance & Security Reporting
ITEM 19.1 IG and InfoSec KPI Reporting Jan24

20 13:55 - Welsh Risk Pool Concerns Assessment
ITEM 20 Welsh Risk Pool Concerns Assessment
ITEM 20.1 Welsh Risk Pool Concerns Assessment - Annex 2
ITEM 20.2 Welsh Risk Pool Concerns Assessment - Annex 3

20.1 CONSENT ITEMS
The items that follow are for information only. Should a member wish to discuss any of these items they are requested to notify the Chair so that time may be allocated to do so.

21 Cycle of Business Monitoring Report
ITEM 21 QuEST Committee Cycle of Business Monitoring Report
ITEM 21.1 Quest Committee Cycle of Business 2023-24 - Monitoring Report

22 Patient Story Updates
ITEM 22 Patient Experience Story Tracker Steven Parsons pdf

22.1 14:05 - CLOSING ITEMS

23 Key Messages for Board Decisions & Actions

24 Reflections of the Meeting

25 Any Other Business

26 Date and Time of Next Meeting: 7 May 2024 at 09:30

MEETING OF THE OPEN QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE
Held on **8 February 2024** from **09:30 – 14:15**
Meeting held virtually via Microsoft Teams

Comfort Break: 15 Minutes
Lunch Break: 30 Minutes

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.	Board Member Register of Interests	To State Conflicts	Bethan Evans	Verbal	
3.	Minutes of the Previous Meeting – 31 October 2023 3.1 Ratification of Chair's Action	Approval Ratification	Bethan Evans	Paper	
4.	Action Log & Matters Arising 4.1 Committee Highlight Report from 31 October 2023	Review	Bethan Evans	Paper	
5.	Operations Directorate Quarterly Report Q3 2023/24	Information	Mark Harris	Paper	20 Mins
ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION					
6.	Patient Story Alison Cassidy	Discussion	Liam Williams	Video	30 Mins
7.	Putting Things Right Report Quarter 3, October – December 2023	Assurance	Wendy Herbert	Paper	20 Mins
8.	Monthly Integrated Quality Performance Report	Approval	Mark Thomas (Rachel Marsh)	Paper	15 Mins
COMFORT BREAK 15 Minutes					
9.	IMTP Quest Committee Elements	Assurance	Trish Mills	Verbal	15 Mins

No.	Agenda Item	Purpose	Lead	Format	Time
10.	Quality Strategy Implementation Plan Update	Assurance	Liam Williams	Paper	10 Mins
11.	Spotlight on Clinical Indicators: Stroke	Assurance	Duncan Robertson	Paper/ Presentation	15 Mins
12.	Healthcare Inspectorate Wales (HIW) National Review of Patient Flow – A Journey through the Stroke Pathway (and Trust actions) & Improvement Plan 12.1 HIW Annual Report 22-23	Assurance	Andy Swinburn Liam Williams	Paper	15 Mins
13.	Clinical Audit Plan and Action Tracker Quarter 3 Update and Clinical Audit Plan Q1 2024/25	Assurance	Duncan Robertson	Paper	10 Mins
14.	Medicines Management Assurance Report for 2023	Assurance	Andy Swinburn	Paper	10 Mins
LUNCH – 30 Minutes					
15.	Committee Annual Effectiveness Review 23/24 - Responses to questionnaire - Committee Annual Report - Proposed Changes to ToR	Approval	Trish Mills	Paper	15 Mins
16.	Risk Management and Board Assurance Framework Report	Assurance	Julie Boalch	Paper	10 Mins
17.	Policies for Approval/Adoption: Data Protection Policy	Approval	Leanne Smith	Paper	5 Mins
18.	Audit Tracker and Audit Reports 18.1 Audit Tracker 18.2 Records Management Internal Audit Report	Assurance	 Trish Mills Leanne Smith	Paper	10 Mins
19.	Information Governance Report and Information Security Key Performance Indicators (KPI) Reporting	Assurance	Leanne Smith	Paper	10 Mins

No.	Agenda Item	Purpose	Lead	Format	Time
20.	Welsh Risk Pool Concerns Assessment	Assurance	Liam Williams	Paper	10 Mins
CONSENT ITEMS **The items that follow are for information only. Should a member wish to discuss any of these items they are requested to notify the Chair so that time may be allocated to do so.**					
21.	Cycle of Business Monitoring Report	Information	Trish Mills	Paper	-
22.	Patient Story Updates	Information	Liam Williams	Paper	
CLOSING ITEMS					
23.	Key Messages for Board Decisions & Actions	Discussion	Bethan Evans	Verbal	10 Mins
24.	Reflections of the Meeting	Discussion	Bethan Evans	Verbal	
25.	Any Other Business	Discussion	Bethan Evans	Verbal	
26.	Date and Time of Next Meeting: 7 May 2024 at 09:30	Information	Bethan Evans	Verbal	

Lead Presenters

Name	Position
Julie Boalch	Head of Risk/Deputy Board Secretary
Mark Harris	Assistant Director of Operations
Bethan Evans	Non-Executive Director and Committee Chair
Wendy Herbert	Assistant Director of Quality and Nursing
Trish Mills	Board Secretary
Andy Swinburn	Executive Director of Paramedicine
Duncan Robertson	Assistant Director of Clinical Development
Leanne Smith	Assistant Director of Digital Services: Data and Analytics
Mark Thomas	Commissioning & Performance Manager
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 31 OCTOBER 2023 VIA TEAMS

Meeting started at 09:30

PRESENT:

Bethan Evans	Non-Executive Director and Chair
Professor Kevin Davies	Vice Chair of the Board and Non-Executive Director (Chaired Meeting)
Paul Hollard	Non-Executive Director
Ceri Jackson	Non-Executive Director

IN ATTENDANCE:

Hugh Bennett	Assistant Director, Commissioning and Performance
Louise Colson	Head of Infection Prevention and Control
Leanne Hawker	Head of Patient Experience and Community Involvement
Wendy Herbert	Assistant Director of Quality and Nursing
Fflur Jones	Audit Wales
Alison Kelly	Business and Quality Manager
Mark Marsden	Trade Union Partner
Trish Mills	Board Secretary
Hugh Parry	Trade Union Partner (Left meeting during Item 55/23)
Steve Owen	Corporate Governance Officer
Alex Payne	Corporate Governance Manager
Felicity Quance	Deputy Head of Internal Audit, NWSSP
Duncan Robertson	Assistant Director of Clinical Development
Jonny Sammut	Director of Digital Services
Andy Swinburn	Director of Paramedicine
Sonia Thompson	Assistant Director of Operations EMS (Left meeting during Item 55/23)
Jonathan Turnbull-Ross	Assistant Director of Quality Governance
Liam Williams	Executive Director of Quality and Nursing

Apologies:

Kate Blackmore	Senior Quality Governance Lead
Lee Brooks	Executive Director of Operations

Julie Boalch	Head of Risk/Deputy Board Secretary
Ian James	Trade Union Partner
Mark Jones	Consultant Mental Health Nurse
Brendan Lloyd	Executive Medical Director Executive
Osian Lloyd	Head of Internal Audit
Rachel Marsh	Director of Strategy, Planning and Performance
Caroline Miftari	Head of Quality Assurance

49/23 PROCEDURAL MATTERS

The meeting was chaired by Professor Kevin Davies with Bethan Evans in attendance.

The Chair extended a warm welcome to everyone advising that the meeting was being recorded. Apologies were noted from Kate Blackmore, Lee Brooks, Julie Boalch, Ina James, Mark Jones, Brendan Lloyd, Osian Lloyd, Rachel Marsh, and Caroline Miftari.

Declarations of Interest

There were no further declarations of interest to those already listed in the register.

Minutes

The Minutes of the meeting held on 10 August 2023 were confirmed as a correct record subject to amending the job title of Andrew Clement to Visual Design Specialist.

Action Log

The action log and the Committee Highlight AAA report from the last Quest meeting was considered:

Action 16/23: Agreed that a meeting be coordinated with the Quest Committee and the People and Culture Committee to discuss the situation regarding the challenges faced by the Putting Things Right (PTR) Team. Liam Williams advised, further to the update given at the last Quest Committee meeting that PTR investment had been approved by the Executive Leadership Team, also noting that the Organisational Change Process (OCP) was nearing completion. The Committee were assured that the risk of not currently having the full establishment in place was being managed. Action Closed.

Action 34/23: PTR reports, Future reports to indicate whether any external issues and factors that have contributed to delays. Liam Williams advised Members that the report on the agenda contained the relevant information. Going forward, there would be more thematic analysis with future reports continuing to develop. Action closed.

Action 34/23a: Spotlight on Clinical Indicators. As work developed beyond the five indicators currently reported on, ongoing updates would be provided. A presentation on Return of Spontaneous Circulation (ROSC) rates was on the agenda. Action closed.

Action 38/23: Internal Audit tracker, Update on how the Trust was dealing with historical actions. Details were included in the report on the agenda. Action closed.

Action 43/23: Policy report, Details of the current number of policies outside their review date be captured within the alert section of the AAA report. Information included in the report on the agenda. Action Closed.

Committee AAA report dated 10 August 2023

The Chair drew the Committee's attention to the contents of the AAA report for their information; this highlighted the key points from the Committee's last meeting on 10 August 2023. Attention was drawn to the two items in the alert section: risks around patient safety and the PTR response times.

RESOLVED: That

(1) Apologies were recorded for Kate Blackmore, Lee Brooks, Julie Boalch, Mark Jones, Brendan Lloyd, Osian Lloyd, Rachel Marsh and Caroline Miftari.

(2) The Minutes of the Open meeting held on 10 August 2023 were confirmed as a correct record subject to amending the job title of Andrew Clement to Visual Design Specialist; and

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

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

Sonia Thompson introduced the Operations Quarterly Report as read, and drew attention to the following pertinent elements within it:

Progress in completing the actions from the Manchester Arena Inquiry continued at pace. There were 71 recommendations which were relevant to the Trust; nine had been completed with 17 being assessed as they required national guidance. Monitoring and completing of the remaining actions were ongoing. Members noted that Commanders in the Trust were mandated to undertake Marauding Terrorist Attack (MTA) training.

The EMS Coordination (EMSC) Culture Programme has commenced with meetings chaired by the Director of People and Culture. Senior Leaders in the EMSC team have met with Trade Union Partners to discuss culture, behaviours, and concerns to design an action plan for improvement. This has been a great opportunity for staff to share their experiences of working in EMSC.

Following the Sexism and Sexual Safety at Work Survey and WAST Voices, action plans have been implemented across the four territories to raise awareness and to positively influence behaviour and culture within the Trust.

In terms of Ambulance Care, the system has been improved which now prioritises eligible patients over non-eligible patients transport requests.

A pilot in the Clinical Service Desk has been implemented to engage with South Wales Police looking to broaden the Remote Clinical Support to Police when they are waiting with patients for an ambulance response.

Comments:

Following a query in terms of the Trust's preparation for Winter regarding resources, Sonia Thompson explained that the Trust would be implementing a whole system escalation process which will include exercises with partners in November to test this, with any lessons learned being implemented. Members also acknowledged the ongoing work on the national whole system escalation framework, emphasising the importance of gaining a comprehensive system-level understanding of clinical risk and enhancing the management of the population's needs.

Members were keen to understand the EMS CSD reconfiguration following the outcome of the new Demand and Capacity review which was currently underway. It was understood the final draft would be ready for the Quest meeting in February 2024 and agreed that Hugh Bennett would arrange for it to be included at the meeting.

The Committee discussed and welcomed the MTA training being undertaken by Commanders.

In respect of the Non-Emergency Patient Transport Services (NEPTS) Eligibility matrix, the Committee requested an update to see if there had been any push back from Local authorities and Welsh Government in the way the matrix was being applied and whether people had been disadvantaged due to the adjusted service criteria. Liam Wiliams added that people would be disadvantaged if they did not meet the eligibility criteria.

RESOLVED: That the report was received.

51/23 EMS CLINICAL CONTACT CENTRE HEALTH INSPECTORATE WALES UPDATE

Sonia Thompson explained that the paper provided a summary and overview of the progress made on the actions agreed in response to the Health Inspectorate Wales (HIW) EMS Clinical Contact Centre (CCC) Patient Safety Review.

There were two actions which remained open, and progress was underway through workstreams that were incorporated in the IMTP. While there have been delays, the Committee can be assured that management remains focussed on full conclusion of all recommendations and continue to monitor progress. Details of the outstanding actions were given below:

Action 21.1: Complete the North Wales EMS CCC estate strategy and identify opportunities for improvements. A project board has been set up with project

support allocated with all interested parties including TU partners invited to the inaugural meeting with a view to develop the Organisational Change Process (OCP) of relocation staff from Bryn Tirion to alternative site(s). The ambition is to have the majority of this in place by the end of this financial year.

Action 12.1 Continue with the work of the Computer Aided Despatch (CAD) Phase 3 project to realign workloads within the EMSCCC for more efficient operation. As a result of securing updated data from ORH in relation to EMSC activity, it has been decided to reinvigorate and review the original EMT paper regarding resources and reconfiguration of work including boundaries and workloads. Initial conversations with TU partners have taken place and a proposed structure will go through operational governance processes over the forthcoming months.

RESOLVED: The Committee:

(1) Noted the update provided for the status update of the actions detailed in this paper and in the appended tracker;

(2) Confirmed its assurance that whilst actions 12.1 and 21.1 are overdue, progress is underway in structured workstreams; and

(3) Agreed that further update be provided to Committee either on completion, or if there are further impediments to completion.

52/23 PATIENT STORY

Prior to hearing the story Members were reminded of the distress and anxiety and the impact on families these patient stories caused. Liam Williams added that the narrative and context of the story was seen throughout the agenda.

Steven Parsons recounted his distressing experience of being unable to get an ambulance for his grandfather, who he thought was suffering a stroke. On this particular day, Steven's grandfather called him asked to come over the to the house as he wasn't feeling well. Initially Steven called 111 that night and was told by a Doctor that as long as his grandfather ok he could wait and see the GP in the morning. A short time later, Steven's grandfather collapsed, and he called 999 but was told there were no ambulances available at that time because of the system pressures. Believing it was a stroke, Steven decided to transport his grandfather to the hospital himself. Upon arrival Steven began to assist his grandfather and on arrival at reception his grandfather collapsed. His grandfather was rushed to A&E and Steven was advised that he was in cardiac arrest. Fortunately, he was resuscitated in the Emergency Department.

Whilst the Trust was operating under extremely high demand on the service at the time of Steven's call, the experience that Steven and his family had underlined the trauma families experience when there are no resources to send in response to their call. Steven raised a formal concern with the Trust with the incident being formally investigated and a written explanation of the findings was sent to Steven.

Whilst he understood that the NHS was understaffed and overworked, Steven emphasised that the ordeal his grandfather and his family endured should not have happened and expressed a desire to share his experience to help others understand that impact. The Patient Experience and Community Involvement (PECI) team were working with Steven and his family addressing some of the issues that arose, and Jason Killens has had an opportunity to meet with Steven and his sister as part of the Trust's duty of candour and putting things right process.

Comments

Leanne Hawker added that Patient Experience and Community Involvement (PECI) team were working with Steven and his family addressing some of the issues that arose, and Jason Killens has had an opportunity to meet with Steven and his sister as part of the Trust's Duty of Candour and Putting Things Right process. It was at this meeting that Steven expressed his desire to share this experience to highlight the effects of handover delays on patients and their families.

Leanne Hawker informed Members that this incident was a consistent theme emerging from the system pressures on Health Boards. Wendy Herbert added that Steven wanted the system to recognise the harm in the community because of the pressure. Of note and after this story, Steven's grandfather has required to access 999 on several occasions with more positive outcomes. It was also noted this story will be shared at Trust Board in November.

Liam Williams assured Members that managing the clinical risk was a key area of focus across all the health boards with a recognition that harm was occurring across the system. He added it was important to provide the necessary support to families following events of this nature when their needs have not been met.

Wendy Herbert raised the issue of families making the best decision under these circumstances, i.e. taking the patient to hospital or not. The emotional impact on families was extremely difficult to manage. She added that it was also very difficult and challenging to explain to loved ones that an ambulance was not available due to the pressures on the system.

Liam Williams advised the Committee that these stories were shared extensively with Health Boards who were able to use them as required.

Following a query as to why Steven was on the phone to 111 for three hours, Liam Williams informed Committee that this incident occurred when the 111 and 999 services were under a level of pressure hitherto not experienced. Call waits were extended beyond acceptable levels. He assured Members that the Trust's ability to escalate 111 calls to 999 calls was extremely effective.

With reference to the urgent and emergency care review in progress by Audit Wales (AW)it was asked whether AW received such stories to inform their work and understand the full impact of system pressures. Fflur Jones explained that stories like

this would be considered when completing part two of the review.

It was highlighted that the Operational Delivery Unit have informed the Stroke Association that they were conducting an Audit on self-presentation to emergency departments. Liam Williams agreed this would be reported through to Quest if there was a material consideration.

The Committee recognised that the issues raised in this story were constantly discussed at this meeting and the Board. Merged into these discussions was the constant reference to the Trust's two highest risks. 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) both rated at 25. The Committee also acknowledged the avoidable harm to patients that continued as a result of the system pressures.

Members, whilst acknowledging that everything possible was being done to improve the system suggested if anything different could be done, for example implement something jointly with health boards.

RESOLVED: That the Patient story was noted.

53/23 PUTTING THINGS RIGHT (PTR) REPORT QUARTER 2, JULY – SEPTEMBER 2023

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

There continued to be a high level of risk of harm to our patients in the community and patients delayed outside of emergency departments.

There was a sustained increase in the number of concerns, and a backlog remains at the processing stage for September 2023.

A continuing high volume of incidents were being reviewed at the Serious Case Incident Forum (SCIF). During this reporting period there were 16 SCIF meetings held, with 73 incidents discussed. 10 incidents have been reported as Nationally Reportable Incidents (NRIs) to the NHS Wales Executive, and 39 incidents were referred under the Joint Investigation Framework to the respective Health Boards. It was noted that no incidents linked directly to the refusal of immediate release requests were identified.

The Trust received three Regulation 28 reports (reports to prevent future deaths) during this period. The number of approaches received from Coroners has increased during the reporting period. 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

The Trust continued to receive a constant number of concerns with 253 received during this reporting period. The PTR Organisational Change Process (OCP) commenced on 25 September 2023 with the aim of increasing staff resource to improve compliance and meet the current demand.

During this period a total of 1,000 patient safety incidents were reported; 386 in July, 329 in August, and 285 in September. It must be noted that the harm grading may change subject to the outcome of any investigation.

In terms of long waits, 186 of the patients waiting over 12 hours had experienced a fall, with the longest waiting patient being 39 hours and 59 minutes.

The Patient Safety Team were working with tissue viability colleagues nationally to explore the contribution from the Trust in providing data and information to inform investigations of patients who have developed pressure damage in the back of ambulances.

There has been an increase in concerns regarding NEPTS activity regarding cancellation of some transport due to a change in the transport eligibility criteria, particularly in the Aneurin Bevan University Health Board area.

The Trust continues to learn lessons from the investigations it conducts and details of these were shared through informative notices across the organisation for the benefit of colleagues.

Comments:

Liam Williams referred to the compliance table within the report which illustrated that the Trust, whilst not fully compliant with the timelines in responding to families, was complying with the Duty of Candour.

Members expressed their concern with the increase in the number of concerns regarding NEPTS, particularly in the South East. Wendy Herbert advised that the Trust was monitoring activity in the North and Central and West, as there were fewer concerns in those areas, and to see what could be done differently to improve the situation.

The Committee raised concern in respect of the upward trend in the number of coroner's requests for information particularly in the North Wall area. Wendy Herbert assured Members that the Trust was engaging with the coroner on initiatives in place to address this trend.

The Committee wished to understand the detail behind one particular patient who had waited almost 40 hours for an ambulance response. It was agreed that context around this would be provided in the next update report.

Members discussed the levels of harm to patients, and it was noted that following investigation into a particular case the level of harm may be readjusted from its initial

assessment. Liam Williams informed Members that the SCIF process initially identified the severity of harm.

The Committee sought clarity on when the timelines to responding to concerns would start to improve. Wendy Herbert advised that part of the OCP would see the additional appointments of senior clinical leadership and administrators, and it was anticipated by January 2024 these posts would be filled. Liam Williams added that once these were in place it would be possible to consider a performance improvement plan, and the associated activity would be fed back to the Committee. . He added that further efficiencies will be made through the appropriate digitisation of administration.

The Committee expressed concern in terms of the risk to patients with pressure relieving devices in temporary environments and were keen to see evidence going forward. Liam Williams explained that when any deterioration occurs while the patient was awaiting hospital transfer, it was the Health Board's responsibility.

Andy Swinburn assured the Committee that the pressure relieving mattresses were being considered as a wider means to support older more frail patients, and not as a means to normalise handover. If the Trust went ahead with this mitigation, roll out would be part of a package of learning and not just a simple 'issue and forget' approach.

RESOLVED: The Committee received the report.

53/23 QUALITY IMPACT ASESSMENTS

Liam Williams explained that Quality Impact Assessments (QIA) have been developed as part of a revised process to ensure that the Trust was able to meet the Welsh Government requirement to maximise financial efficiency opportunities. He then gave an overview of the governance route the QIA's took in order to guarantee the correct scrutiny and monitoring. During the scrutiny process, if there was a need the QIA would be escalated to the Board, especially if there was any reputational impact.

The following QIAs were presented to the Committee who noted that the Executive Leadership Team (ELT) would be reviewing them at its next meeting.

Financial Savings – Non-Emergency Patient Transport Service (NEPTS) Capacity Management Plan

This QIA was undertaken to implement a revised approach to the application of the Non-Emergency Patient Transport Service (NEPTS) eligibility criteria and a revised Capacity Management Plan.

Financial Savings – Mid and West Wales Fire and Rescue Services

This QIA was undertaken for the decommissioning of Mid and West Wales Fire and Rescue Services (M&WWF&RS) support to the Welsh Ambulance Services NHS Trust (WAST) emergency responses.

Comments:

Clarity was sought on the actual financial savings compared to the level of risk. Liam Williams explained the report to Committee focused on the quality and clinical risk while the report to ELT contained the financial detail. Going forward this detail would be included in future QIA reports for the Committee.

Members queried that if there was a reputational risk whether the Board would be made aware, particularly with the Mid and West Wales Fire and Rescue service. Liam Wiliams advised that any high level of reputational risk, would be escalated to the Board if identified at ELT.

Members sought assurance that the ELT considered the Service change in respect of the changes to the eligibility criteria particularly from a disability perspective which would affect patient mobility. Liam Williams assured the Committee that dependant on the person's disability, it was likely to be under the eligibility criteria. However, in cases where the patient is not eligible, the Commissioners would need to be advised as the Trust was servicing a contracted requirement.

Trish Mills advised that work was ongoing to develop an integrated assessment signposting document which will go to the Audit Committee when it's finalised, which will bring together all the EQIA and QIA's in one place.

RESOLVED: That the Committee:

(1) Noted the Non-Emergency Patient Transport Service (NEPTS) Capacity Management Plan QIA and the approval by WAST Executive Leadership Team to implement the commissioned NEPTS eligibility criteria; and

(2) Noted the contents of the Mid and West Wales Fire and Rescue Services (M&WWF&RS) QIA and the Executive Leadership Team decision to approve the decommissioning of M&WWF&RS.

54/23 SPOTLIGHT ON CLINICAL INDICATORS - RETURN OF SPONTANEOUS CIRCULATION (ROSC) RATES

Duncan Robertson gave a presentation on the Return of Spontaneous Circulation in which he pointed out the following details:

The Trust measures the numbers of cardiac arrest cases which include a documented resuscitation attempt and that includes relevant sections completed on the ePCR or where the diagnostic code for Cardiac Arrest is used. These cases were measured at hospital, not in the community.

A deep dive audit was carried out last year as with all the clinical indicators and the ePCR narrative was reviewed where the cardiac arrest was documented but not complete enough for the relevant sections. Following this review a clinical indicator dashboard was introduced and the ROSC rate trend was starting to move upwards. There were roughly 250 to 300 attempted resuscitations per month.

Notable improvements included the implementation of CHARU (Cymru High Acuity Response Unit), the introduction and ongoing enhancements of ePCR, increased participation in Good Sam (with a record of over 10,000 sign-ins across Wales in a single Friday evening), Mandatory in Service Training (MIST), an expanded deployment of public access defibrillators (now exceeding 8,000), and a series of public messaging and events.

Comments:

Following a query in terms of how data was produced, Duncan explained that there several methods used and these were reviewed through the clinical intelligence and assurance group. The Trust, going forward will be able to capture data on the patients who leave hospital following a ROSC, which will enable positive feedback to be shared with all those involved in the ROSC.

Duncan Robertson commented that whilst the data did not explicitly indicate that CHARU was directly involved in the increase of ROSC rates, however it has played a key part in managing cardiac arrests. Andy Swinburn added that work was underway to look at the utilisation of CHARU against the code set determined.

RESOLVED: The Committee noted the update.

55/23 MONTHLY INTEGRATED QUALITY PERFORMANCE REPORT

Hugh Bennett updated the Committee on the MIQPR and drew their attention to the following points:

In terms of system pressure, this continued to be on the rise, hours lost to handover at hospitals was just under 20,000 in September with December likely to be in the region of 25,000.

Continued achievement of the clinical call back time target for the highest priority 111 Wales calls, while the priority 2 and 3 call back times also achieved the 90% performance target in July.

999 call answering continued to be challenging, in the second half of the calendar year the 95th percentile has began to worsen; in August 2023 it was 31 seconds with a small improvement to 28 seconds in September 2023.

The increase in Clinical Support Desk capacity has meant that the Trust was able to increase its consult and close rate through last year, however, it has declined in recent months, achieving 12.6% in September 2023, with an increased ambition of 17% in

2023/24 (quarter 4). Action plans were in place within the service, but there were some risks emerging in terms of delivery.

The Wales Immediate Release figures for September 2023 were: Red 156 accepted and 5 declined; and Amber 1, 156 accepted and 291 declined.

The return to spontaneous circulation (ROSC) rate dropped to 22.1% in September 2023 compared to 23.8% in August 2023.

Response Abstractions: EMS abstraction levels decreased to 33.59% in September 2023, but remained above the 30% benchmark. EMS Response sickness abstractions stood at 9.5% (benchmark 5.99%).

Trust sickness absence: the Trust's overall sickness percentage was 9.22% in August 2023, a deterioration from the 8.23% recorded in July 2023. Actions within the Integrated Medium Term Plan (IMTP) concentrate on staff well-being with an aim to start to reduce this level.

Staff training and PADRs: PADR rates did not achieve the 85% target in September 2023 (70%), while compliance for Statutory and Mandatory training increased slightly to 76.21%.

Comments:

The Committee queried if there was any data regarding call to door times for strokes. Andy Swinburn informed Members that the information would be in the MIQPR going to Trust Board in November.

Following a query into the outcomes of patients with strokes or acute coronary syndrome, Andy Swinburn advised that the data collection had moved from paper to ePCR. The ePCR now allows users to identify any areas where there is missing information in the respective care bundle. Further information regarding this was contained in the update on Clinical Indicators item.

RESOLVED: To Consider the August/September 2023 Integrated Quality and Performance Report was considered which provided sufficient assurance for the Committee.

56/23 LEARNING FROM MORTALITY REVIEWS UPDATE

Wendy Herbert presented the report to the Committee and highlighted several areas:

The Trust has adopted the NHS Wales Learning from Mortality Reviews Framework (the Framework) (2022) which outlines the new approach in NHS Wales to undertaking Mortality Reviews.

The Government in England confirmed in September 2023 that it was launching a statutory inquiry into the Countess of Chester Hospitals NHS Foundation Trust, with the Health Secretary stating that the inquiry will 'examine the cases' wider circumstances', including 'the conduct of the wider NHS and its regulators'.

The Medical Examiner Service is hosted by NHS Wales Shared Services Partnership and will provide independent scrutiny of all deaths in Wales that are not investigated by the Coroner. One of the key functions carried out by the Medical Examiner was to provide bereaved families with greater transparency and opportunities to raise concerns. The Medical Examiner Service will be a statutory function by April 2024. Currently the focus was on secondary care and the Trust was working with the Medical Examiner to bring this service into Communities. The concerns raised by families to the Medical Examiner included; enhanced waiting times for an ambulance and handover of care delays and poignantly following today's patient story, families taking sick relatives to hospital by car.

The Trust is part of the National Mortality review Group which is hosted by NHS Wales Executive. One of the group's responsibilities is the development and updating of the Duty of Candour arrangements.

Members were advised of the next steps in terms of the Trust's learning from deaths which included the establishment of a learning from deaths forum. Part of the learning will also look at Speaking up Safely reporting,

Comments:

Liam Williams informed the Committee that as part of the CEO roadshows next week, there will be a presentation that will be highlighting the Trust's desire to create a culture in an environment where people always feel able to raise concerns.

It was queried the how the Medical Examiner became involved. Wendy Herbert advised that when the Medical Examiner Service was fully functional it will review every single death apart from those being considered by the Coroner.

Duncan Robertson explained that the Medical Examiners will, through ePCRs be able to extract the necessary clinical data; however, it may not necessarily prevent requests for additional data. The Trust can work with them to make access more self-serve rather than the Trust providing them with the data.

The Committee raised their concerns that the workload for staff from the Trust required to assist the Medical Examiner could be significant going forward.

RESOLVED: The Committee discussed the Forward Plan for Mortality Reviews and outputs from the Medical Examiner Service and highlighted any further assurance requirements.

57/23 DUTY OF QUALITY/DUTY OF CANDOUR IMPLEMENTATION

Liam Williams updated the Committee on progress.

The appointment of the Senior Quality Governance Lead and bespoke implementation plan has increased capability and capacity to support full implementation. The current impact of this has been a review of arrangements which has led to some previously reported good progress being revised on the current WG report.

A Highlight Report is submitted monthly by WAST to Welsh Government using a centralised 'Road Map' to track progress against deliverables. The Highlight Report for August 2023 (submitted in September 2023) RAG rated progress as Yellow; this is defined as 'organisation has identified that delivery is at risk but manageable or behind schedule but within tolerance'. The Road Map includes detailed requirements of the legislation, and it is to be expected that the Highlight Report will continue to be expanded as additional deliverables approach milestones.

RESOLVED: The Committee noted the report and took assurance on the progress made to deliver the Duty of Quality and Duty of Candour.

58/23 MENTAL HEALTH AND DEMENTIA ANNUAL REPORT

Wendy Herbert asked the Committee to note the commendable efforts of the Mental Health and Dementia Teams, highlighting their significant and diverse contributions to the well-being of our service users, as highlighted in the comprehensive and impactful annual report.

It was emphasised that both teams received separate funding from the Welsh Government, underlining the importance of securing this funding for the 2024/25 period, given the significant positive impact they have on patients.

The education and training packages that the team have provided has been delivered on a national basis and a number of different platforms. The training has been tailored to respond to any cultural changes and meet the needs of patients. This training was key in delivering an excellent service for patients.

It was interesting to see the changing and emerging themes and trends post pandemic and what the team were responding to and/or experiencing.

It was clearly evidenced throughout the annual report, the importance of working with stakeholders such as Welsh Government and Health Boards, and more importantly service users.

There were several quality improvement initiatives the teams were considering which will form part of the three year Dementia Plan.

The Committee should acknowledge the significant amount of work undertaken by the team and the considerable positive impact in the more vulnerable parts of the population. This work was endorsed by Liam Williams who added that the Trust was not a mental health provider but a good interface for those people in a mental health crisis. In terms of the 111, press 2 service (callers are transferred to a dedicated member of the mental health team), he added that work was ongoing to maintain this health service provision.

Comments

The Committee acknowledged the comprehensive report and commended the team for their continued value in the work they do, albeit under challenging circumstances. It was noted that the report would be presented to the Board appended to the Committee highlight report for their information.

The Committee discussed the sustainability of funding for these two teams underlying the importance of securing funding for 2024/25, given the positive impact they have on patients. It was further discussed whether funding could be sourced from the Trust's Charity, should public sector funding not be given.

RESOLVED: The Committee noted developments of the Mental Health & Dementia Team and progress to date.

59/23 PATIENT EXPERIENCE AND COMMUNITY INVOLVEMENT (PECI) BI- ANNUAL (APRIL – SEPTEMBER 2023) REPORT

Leanne Hawker presented the report which illustrated the engagement with the public noting that the report focused on the experience of patients. In terms of key points from the report they were highlighted as follows:

There was a need to increase the volume of patient experience returns and work to improve this included improved integration through the Civica (a company that provides public sector software) patient experience system. This would enable patients to receive surveys as opposed to patients looking for them through SMS text messaging. Another key feature allows for patients to directly record and upload stories themselves onto the system

The Learning Disabilities Ministerial Advisory Group continues to make key progress to meet the needs of people with learning disabilities.

The overall experience of Ambulance Care (formerly NEPTS) from patients was reported as very good.

The PECI team continued to work with Llais (Citizens Voice Body), and share good practice across the sector and grow the people and community network, who will be involved in the refresh of the national Patient Reported Experience Measures (PREM).

Since the introduction of the Civica patient experience system, there have been some

information governance issues in relation to surveying patients who call 999. Further information and feedback is awaited from the Director of Legal and Risk. The Trust's information governance team have also escalated the issues. Formal guidance from the ambulance information governance group has advised the Trust to cease surveys until such time their guidance has been issued. The Trust continues to seek a viable solution to this complex issue.

Comments:

The Committee welcomed the report and queried if there were further opportunities the team could engage in to acquire further feedback from patients. Leanne explained that the Bevan Commission has commenced activities to gather insight form the public by hosting workshops which has been fully supported by the PECI team. The feedback has been very interesting with the public desire for radical changes in the NHS. Liam Williams added there was a need, as the proportion of feedback was relatively small, to establish a greater understanding of people's experiences by opening up the gateway to a broader population and getting a greater understanding of their experiences particularly when experiences were poor.

In terms of Information Governance, the Committee noted the significant challenges and safeguarding issues since the introduction of the Civica patient experience system. Leanne Hawker explained that the issues concerned the surveying of 999 calls being made by patients. The Trust's Information Governance Team was awaiting further clarification from the Director of Legal and Risk at the Welsh Risk Pool. She added that the Trust was aware of an England NE Ambulance service who were surveying patients through the use of Data Protection Impact Assessments and have since been strongly advised by the Ambulance Information Governance Group to cease this process. The Trust have also been advised to stop these surveys until formal guidance on how to conduct them has been received. There were some sensitivities around who was actually being surveyed and once the issue has been resolved, the Trust can continue to survey patients ensuring that all safeguarding procedures would be adhered to. It was agreed that the Committee would be updated once further clarity on the implications for the Trust was known.

RESOLVED: The Committee

(1) Noted the activities to date and acknowledged that PECI Reports will be shared publicly through the Trust's People & Community Network; and

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

60/23 CLINICAL AUDIT PLAN 2023-2024 MONITORING REPORT - QUARTER 2

Duncan Robertson gave an update on the clinical audit plan advising there were no issues to report to Committee.

RESOLVED: The update was noted.

61/23 INFORMATION GOVERNANCE REPORT

Jonny Sammut in presenting the report drew out the following highlights for the Committee's attention:

Data Protection breaches, there had been 28 Datix incidents recorded in August, and this has been reduced in September and October

An analysis had recently been conducted on password which has revealed that around 1,000 were considered to be fairly weak, work was ongoing to improve this.

Compliance with the Freedom of Information Act remains challenging, recording rates of 41% in August and 45% in September against a target of 90%. However, a review of the process and digital support was expected to lead to improvements in compliance. It should also be noted that some of the requests were becoming more complex in nature.

In terms of mandatory training, this was falling short of compliance on Data Protection and Information Governance. Work was ongoing in the background to communicate to staff that this training where applicable required completion.

A simulated phishing attack had recently been carried out in the Trust. The results, having being reviewed, illustrated there were some users who required further education in this area to avoid answering phishing e mails.

Comments:

Trish Mills commented that as mentioned in the update the Trust was looking to automate the FOI process to increase efficiency.

RESOLVED: The update was noted.

62/23 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK REPORT

Trish Mills reminded the Committee of the two highest scoring risks- 223 (the Trust's inability to reach patients in the community causing patient harm and death) and 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).

Having listened to the patient experience, the report from the PTR team and the information in the MIQPR, these risks clearly were to remain at a score of 25.

The Trust Board, at its meeting in November will be receiving a revised paper around the actions to mitigate avoidable harm with a refresh on some of the narrative in these two highest scoring risks particularly around the context elements.

Members were assured that the two risks, whilst not moving in score, were reviewed regularly and discussed at many of the Board's Committees.

Comments

Liam Williams commented that these two risks were dynamically updated through several Committees and through to the Board following a robust governance process. He added that the risks had and continue to be escalated to Welsh Government.

RESOLVED: The contents of the report were noted.

63/23 POLICIES FOR APPROVAL/ADOPTION

The following policies were presented to the Committee for their adoption/approval:

The All-Wales Aseptic Non-Touch Technique Policy was adopted.

Trish Mills added there will be a chairs action to approve the Infection Prevention and Control policy plus another policy.

Medicines Management Policy – Andy Swinburn advised there was nothing specific to draw out and it was approved.

Information Security Policy - Jonny Sammut explained there was nothing of substantial note to be drawn out, subject to clarification on the hyperlinks at paragraph 7.10 the policy was approved.

RESOLVED:

(1) The Aseptic Non-Touch Technique Policy was adopted; and

(2) The Medicines Management Policy and Information Governance Policy (subject to the clarification stated) were approved.

64/23 AUDIT TRACKER UPDATE

Trish Mills gave an update on the revised Audit tracker explaining there had been some good engagement with Internal Audit and Audit Wales, advising the Committee that an audit process handbook had been presented at the last Audit Committee meeting.

Overall, of all the audit recommendations about 30% in this cycle have been closed, with a higher proportion of closed items for this Committee.

The report was continually maturing and the Committee were advised that work was underway with Digital Health and Care Wales (DHCW) to find a SharePoint solution to improve overall reporting.

There was also a focus now to close off the more historical audit actions particularly those from 2021/22, with two which require further work to be closed off.

An update was also given on the Audit Wales actions which included the Quality Governance review and the Structured Assessment with four of the actions closed.

RESOLVED: The Committee:

(1) Noted the management actions to address recommendations in the Tracker, noting any revised dates for actions (in blue);

(2) Noted the proposal for closer scrutiny of the impact of actions in response to audit recommendations; and

(3) Noted that the Records Management and Senior Paramedic internal audits are nearing completion and will be presented to the next meeting.

65/23 COMMITTEE PRIORITIES AND CYCLE OF BUSINESS MONITORING REPORT

The report was presented for information.

RESOLVED: The Committee noted the report.

66/23 PATIENT STORY UPDATES

The report was presented for noting.

RESOLVED: The update was noted.

67/23 KEY MESSAGES FOR BOARD

Trish Mills would draft the update which will be presented to the Board via the Committee's AAA highlight report.

68/23 REFLECTIONS & SUMMARY OF DECISIONS & ACTIONS

The Chair reflected it was quite remarkable with the size of the agenda that the meeting only ran over by 23 Minutes.

69/23 ANY OTHER BUSINESS

There was no other business.

Date of Next meeting: 8 February 2024

Meeting concluded at 13:23

AGENDA ITEM No	**3.1**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**1**

RATIFICATION OF CHAIR'S ACTION: -
Quality, Patient Experience and Safety Committee
Updated Infection Control Policy (v2.4)

MEETING	QuEST Committee
DATE	08 February 2024
EXECUTIVE	Liam Williams (Executive Director of Quality and Nursing)
AUTHORS	Louise Colson (Head of Infection, Prevention and Control)
CONTACT	Louise.Colson@wales.nhs.uk

EXECUTIVE SUMMARY

RATIFICATOIN OF CHAIR'S ACTION: -
The QuEST Committee is asked to ratify the Chair's Action made 30 January 2024 to approve the Infection, Prevention and Control Policy (v.2.4). The below paper was issued to the Committee via email for decision by Chair's Action on the 19 January 2024 (the Committee is not being asked to approve the Policy again). The Committee considered the request and approved the Policy effective 30 January 2024.

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1. This paper presents to the Quality, Patient Experience and Safety Committee (QuEST), the updated Infection Control Policy v2.4.

2. The Infection, Prevention and Control Policy was due for review in May 2021 during the Covid-19 Pandemic.

3. It has therefore been identified as a priority policy via the Policy Prioritisation Exercise that was undertaken in 2023.

4. The Policy Group received this policy at its' monthly meeting on 23/10/2023 (post consultation) where it was identified that the updated policy would not be available in readiness for QuEST Committee on 30/10/2023.

5. As the next QuEST Committee meeting is scheduled to be held on 08/02/2024, so as not to delay publication of this important policy, Policy Group endorsed the approach for approval to be sought via Chair's Action.

6. The Chair of QuEST Committee is asked to review and approve the updated Infection Control Policy v2.4 by Chair's Action.

It is RECOMMENDED that the QuEST Committee by Chair's Action:

- **Approve the updated Infection Control Policy v2.4.**

KEY ISSUES/IMPLICATIONS
Key highlights for the group to note are: • The revised policy v2.4 now includes the AACE National Model Policy • The policy has been converted to the new policy template • Section 8 Counter Fraud, Section 9 Information Governance and Section 10 Welsh Language Impact Assessment, have all been updated • The policy containing proposed updates was initially presented to Policy Group on 25/04/2023. • The proposed updates were considered by Policy Group to be a material change, the policy was then sent out for staff consultation and now reflects any consultation comments received.

REPORT APPROVAL ROUTE		
WHERE	**WHEN**	**WHY**
Executive Management Team	06/12/2023	Approved
QuEST Chair's Action	19/01/2024 (Issued)	Approval
QuEST Committee	08/02/2024	Ratification of Decision by Chair's Action

REPORT APPENDICES
Appendix 1 – Infection Control Policy v2.4

REPORT CHECKLIST	
Confirm that the issues below have been considered and addressed	**Confirm that the issues below have been considered and addressed**

EQIA (Inc. Welsh language)	YES	Financial Implications	YES
Environmental/Sustainability	NA	Legal Implications	YES
Estate	NA	Patient Safety/Safeguarding	YES
Ethical Matters	NA	Risks (Inc. Reputational)	YES
Health Improvement	YES	Socio Economic Duty	NA
Health and Safety	YES	TU Partner Consultation	YES

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
NHS Trust

GIG CYMRU NHS WALES

Infection Prevention & Control Policy Elimination of Healthcare Associated Infections

Policy Number:	002	**Version No:**	2.4	**Supersedes:**	1.4
Date of Approval:		**Review Date:**	3 years from date of approval TBA	**Impact Assessments Completed:**	Yes
Classification of Document:	Policy	**Type of Document:**	Clinical	**Approved by:**	
Brief Summary of Document:	The purpose of the Infection Prevention & Control Policy is to outline expected practice to reduce Health Care Associated Infections within the prehospital environment. The policy is in line with NHS Wales Infection Prevention & Control Strategy: Commitment to Purpose (2011); the All-Wales IPC Code of Practice 2014, UK Five-Year Antimicrobial Resistance Strategy 2013, and the Welsh Government AMR (Anti-Microbial Resistance) delivery Action Plan 2016. Health & Care standards 2015.				
Scope:	All service areas & staff group are covered by Standard Infection, Prevention and Control Precautions and the application of the All-Wales IPC Code of Practice. Infection Prevention and Control is everyone's business.				
To be read in conjunction with:	1.1 Infection Prevention and Control Guidance. Safe Clean Care. 1.2 Premise and Cleaning Policy 1.3 Medical Devices Policy 1.4 Infection Prevention and Control Sharps Policy 1.5 Respiratory Protective Equipment SOP (Subject to version control) 1.6 PPE for WAST staff. Sustained Transmission 1.7 Waste Management Policy (in development) 1.8 Uniform Dress Code SOP 1.9 WAST Infectious Disease Outbreak SOP (Non COVID) 1.10 Rest Break Standard Operating Procedure 1.11 Vehicle Decontamination SOP				
Owning Committee	Quality Safety & Patient Experience Committee				
Policy Lead: **Trade Union Lead:**	Louise Colson Ian James	**Job Title:**	Head of Infection Prevention and Control Trade Union Partner		
Executive Director:	Liam Williams	**Job Title:**	Executive Director Quality & Nursing		

Version Control Sheet

Version	Date	Author	Summary of Changes
1.0	28/07/2017	Caroline Miftari	
1.1	30/08/2017	Caroline Miftari	Consultation comments & policy checklist
1.1	22/11/2017	Caroline Miftari/Louise Colson	Changes incorporated following consultation period and comments received
1.2	16/01/2018	Louise Colson	Amendments and further comments
1.3	14/02/2018	Louise Colson & Julie Boalch	Amendments following Judith Birkett review.
1.4	10/08/2020	Louise Colson	Amendments made to the Policy following request from HSE
1.4	18/08/2020	Louise Colson	Amendments made following comments from the Policy Group 17th August 2020
1.4	03/09/2020	Louise Colson	Amendments made following review at EMT, request for Policy to reflect IPC PPE Guidance doc
2.0	06/09/2022	Louise Colson	3year review. Revised Policy to include AACE national model policy
2.1	09/07/2023	Julie Boalch	New template and reformatted document
2.1	14/09/2023	Louise Colson	Section 6.16 added following the consultation period in relation to staff carrying food and drink on trust vehicles
2.1	14/09/2023	Louise Colson	Added section 8 Counter Fraud
2.1	14/09/2023	Louise Colson	Added Section 9 Information Governance
2.1	14/09/2023	Louise Colson	Added Section 10 Welsh Language Impact Assessment
2.2	07/11/2023	Louise Colson	Section 6.16 (re: Staff carrying food and beverages on Trust vehicles) reworded as requested by Policy group following review after consultation
2.3	04/01/2024	Lousie Colson	Section 6.16 (re: Staff carrying food and beverages on Trust vehicles) removed following further discussions with TU Partners and ELT.

Version	Date	Author	Summary of Changes
2.3.1	09/01/2024	Sam Weaver	General tidy up and reformat. Appendix one – updated PPE poster to new version
2.4	16/01/2024	Lisa Trounce	Further formatting. Previously supplied but now missing information reinserted in 'Key Words' and 'Impact Assessments' sections.

Keywords	Infection, prevention, control, IPC, practice, standards, precautions, transmission, personal, respiratory, protective, equipment, PPE, RPE, medical, devices, AMR, sharps, ANTT, outbreaks, communicable, diseases, cleaning, alerts, waste, occupational, exposure, blood, bodily, fluids.

Impact Assessment Reviews

Area	Date of Review	Name of Reviewer
Training	N/A	
Counter Fraud	08/07/2023	Lynne Haddow
Information Governance	14/09/2023	Added to policy
Records Management	14/09/2023	Added to policy
EqIA / Welsh Language	19/07/2023	Paola Spiteri
Estates	N/A	
Environment	N/A	
ESMCP	N/A	

Task and Finish Group Members

Name	Job Title
Louise Colson	Head of Infection Prevention and Control
Laurence Neville	Quality Clinical Manager Infection Prevention and Control

Policy Approval Route

Meeting Title	Meeting Date	Purpose/Outcome
Policy Group Meeting	25/04/2023	Approval to begin consultation
Policy Group Meeting	25/09/2023	Amendments following consultation period
Executive Leadership Team	06/12/2023	Approved

QuEST Chair's Action	17/02/2024	Approval
QuEST Committee	08/02/2024	Noting following Approval via Chair's Action

Disclaimer
If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or amb_policies@wales.nhs.uk

Contents

1. INTRODUCTION

The purpose of the Trust Infection Prevention and Control Policy is to minimise the risks associated with the infectious diseases and to provide the Trust Board with an effective approach towards providing a safe, clean environment which is fit for purpose. It will also provide safe working conditions and best practices for staff and the patients within their care.

This policy has been produced to outline our commitment to promoting the highest standards of infection prevention and control within the Trust. The policy and requirements for addressing the management of infection prevention and control has been developed in line with the following:

- The Health and Social Care Act 2008: Code of Practice for the Prevention and Control of Infections and related guidance. (Department of Health; July 2015)
- The National Specifications of Healthcare cleanliness 2021.
- epic3: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England. (2017)
- NICE Guidance.
- Healthcare-associated infections: prevention and control in primary and community care. (CG139)
- Healthcare-associated infections: prevention and control. (PH36)
- Infection prevention and control. (QS61)
- NHS Constitution for England.
- NCGC NICE.
- Healthcare-associated infections: prevention and control in primary and community care. (CG139)
- Healthcare-associated infections: prevention and control. (PH36)
- Infection prevention and control. (QS61)
- Health Technical Manual HTM07-01: Safe management of healthcare waste. 2013
- NHSLA risk management standards for Ambulance Trusts.
- Department of Health's Essential Steps to Safe, Clean Care.
- IPC Commissioning Toolkit- Zero Tolerance of HCAI March. 2013
- EU Directive 2010/32/EU. (The Sharp Directive)
- Health & Safety (Sharp Instruments in Healthcare) Regulations. 2013
- Immunisation Against Infectious Disease: The Green Book; (Public Health England 2013)
- Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use. 2015

All NHS Trusts have a statutory duty to comply with The Code, which stipulates.

"Good infection prevention (including cleanliness)[1] and prudent antimicrobial use are essential to ensure that people who use health and social care services receive safe and effective care. Effective prevention of infection must be part of everyday practice and be applied consistently by everyone. It is also a component of good antibiotic stewardship as preventing infections helps to reduce the need for antimicrobials."

The policy has associated procedures relating to the minimising of risks associated with the control of infection. These procedures reflect current 'best practice' within the health care profession which have been validated by external specialists of infection prevention and control at NHS England, Wales and Scotland, Public Health Agency Northern Ireland, and United Kingdom Health security Agency (UKHSA). Generic and specific risk assessments are included within the Trust's risk management systems and procedures.

The Infection Prevention and Control Policy and Procedures adopt routine protection measures known as 'Standard Precautions' which are based upon treating every patient as if they are a potential source of infection. These precautions will minimise a large area of risk from infection, since the ambulance service will not know with most patients, if there is an infection risk.

The Trust supports the Department of Health research which has led to healthcare organisations adopting a 'bare below the elbows' policy to reduce the risk of infection from contaminated sleeves, watches, and jewellery. Prior to the commencement of a shift patient facing operational staff and staff/volunteers who are expected to respond to patients will be expected to remove all wrist/ hand jewellery (with the exclusion of one plain band ring) and nail adornments/varnish.

The Trust actively promotes an open and just culture and encourages incident reporting. The Trust believes it is imperative that the incident reporting system is used to allow for proactive as well as reactive risk management of healthcare associated infection.

The Trust is committed to ensuring that all staff have responsibility for infection prevention and control and that they receive the appropriate training and support to fulfil this responsibility.

The Trusts Infection Prevention and Control policy and its associated procedures details the requirements set out in the standards, these include information on staff training, staff duties, incident reporting, information for staff and patients and infection prevention and control monitoring.

The Process for monitoring the effectiveness of the above standards is through the following actions:

- Completion of Incident report form and investigation by local managers.
- Incident reporting statistics and trend analysis monitoring.
- 'Lessons learnt' and action plans.
- Infection Prevention and Control Forum (or similar) monitor incidents and make any recommendations.
- Trust Incident learning Forum (or similar) monitor and make any recommendations.
- Training records.
- Annual audit plan and action plan monitoring.

2. POLICY STATEMENT

The Welsh Ambulance Service NHS Trust (hereafter referred to as 'the Trust') is committed to promoting the highest standards of infection prevention and control to ensure that appropriate measures are in place within the Trust to reduce the risk of acquired infections and therefore increase the safety of our patients, staff, and the public.

The Trust Board is fully committed to addressing the risks of healthcare associated infection and serious communicable diseases, through a policy aimed at dealing proactively with the outcomes and continually developing safer working practices.

The Trust recognises that the Health and Social Care Act (2008) Code of Practice on the prevention and control of infections and related guidance (updated 2015) introduced a statutory duty on NHS organisations to observe the provisions of the Code. As a result, the Trust Board regularly reviews its arrangements and assures that it has suitable systems and arrangements in place to ensure that the Code is being observed within the Trust.

Although the Trust does not directly contribute to the National HCAI performance and quality monitoring data collection for Methicillin Resistant Staphylococcus Aureus (MRSA) infections, *Clostridioides difficile (C. Diff)* and gram-negative blood stream infections we are fully committed to reducing all HCAI. All IPC procedures reflect this aim to have a zero tolerance to preventable HCAI.

The Trust actively investigates all HCAI reported by other health organisations and an actively engages with the processes for HCAI and Infection Prevention and Control (IPC) as members of IPC health groups across the region. This includes involvement in post infection review and incident control team meetings (for outbreaks).

The Trust acknowledges that the provision of appropriate training is central to the achievement of this aim.

This document applies to all employees of the Trust with active lead from managers at all levels to ensure that infection prevention and control is a fundamental part of the total approach to quality, quality improvement and patient safety.
This policy will also be shared with external stakeholders, third party providers and volunteers.

The Welsh Ambulance Service Trust (WAST) is committed to a zero tolerance of preventable HCAI's. Actions are prioritised to reduce the risk of HCAI's within the pre-hospital care environment that could impact on the care provided to patients, carers and staff in secondary care and the wider community.

The Trust is committed to working in partnership with all staff, service users and key stakeholders primarily Health Boards, Trusts, Public Health Wales, Health Inspectorate Wales (HIW) and Community Health Councils (CHC's) to: -

- Develop a culture where preventable infections are not tolerated.
- Ensure IPC Leadership is present at all levels of the organisation and across all disciplines.
- Improving quality and safety; embedding IPC core practices and prudent antimicrobial administration into routine practice.
- Measure success; monitoring infection rates, hand hygiene and indicators of good practice i.e., Intravenous care using the principals of Aseptic Non-Touch Technique (ANTT).
- Information sharing and transparency; building and maintaining confidence of the public, service users & Health Boards/Trusts.
- Ensure all staff are suitably trained and educated in IPC associated infections in accordance with their role e.g., clinical/non-clinical and in accordance with UK Core Skills Training Framework.

The Trust will implement the nine standards of the All-Wales Code of Practice 2014 through the implementation of an IPC Improvement Plan 2017-19 approved by the Trust Quality Safety & Patient Experience Committee (QUEST).

2.1. All Wales Code of Practice 2014 – Nine Standards

- Appropriate organisational structures and management systems for IPC are in place.
- The physical environment is maintained and cleaned to a standard that facilitates IPC and minimises the risk of infection.
- Suitable and accurate information on infections is available to service users, their visitors, and the public.
- Suitable, timely and accurate information on infections is provided to any person concerned with providing further support or nursing/medical care when a service user is moved from one organisation to another or within the same organisation.
- All staff employed to provide care in all settings are fully engaged in the process of IPC.
- Adequate isolation facilities are provided to support effective IPC.
- Policies on IPC must be in place and are readily accessible to all staff.
- So far as is reasonably practicable, staff are free of and protected from exposure to infections that can be acquired or transmitted at work.

All staff are suitably trained and educated in IPC in accordance with their role e.g., clinical/nonclinical and in accordance with UK Core Skills Training Framework.

3. SCOPE

This policy applies to all staff in relation to all matters of Infection Prevention and Control.

It applies to all employees and non-executive directors of the Trust. It also extends to agency staff, service users, carers, contractors, volunteers, visitors, and any other persons having lawful reason to be associated with the Trust, its premise, vehicles, and

equipment. The policy equally applies to staff and services of the Trust which operate in the pre-hospital setting, where staff are seconded to other healthcare organisations or people who are on work experience or training placement.

This policy allows for local provision of additional information but no separate or additional policy for local areas is permitted or supported.
The Health & Safety at Work Act 1974 places general duties upon all managers, employees, and suppliers of goods relating to health, safety, and welfare. The introduction of the Management of Health and Safety at Work Regulations 1999 and The Control of Substances Hazardous to Health Regulations 1999, make more specific those duties placed upon Managerial Staff towards staff in their care and the protection of its workforce from infection risks, and any third parties who may be affected by the Trust's undertakings.

Chemical, Biological, Radiological and Nuclear (CBRN) risks require specialist advice and training. The Department of Health provides this information, and the Trust has a team of specialists who are trained to deal with these risks. The key principles contained within this policy are relevant to CBRN activities within the Trust, however the Resilience Team are responsible for providing policies, procedures, training, and risk assessments relating specifically to CBRN/SORT.

3.1. Acknowledgements/Limitations of Policy

Both the employer and individual members of staff are ethically responsible and legally liable for any preventable infection that is negligently transmitted by employees. It is the responsibility of the organisation to provide to employees appropriate and effective infection control advice for colleagues and patients. However, there are limitations on the scope of control of this policy outside of this organisation examples of this can be GP surgeries, patient's homes, and secondary care. In these circumstances accountability for defective infection control measures rests with the individual or organisation concerned.

The Trust is committed to the principles of Equality and Diversity and will strive to eliminate unlawful discrimination in all its forms. We will strive towards demonstrating fairness and Equal Opportunities for users of services, carers, the wider community, and our staff.

4. AIM

The aim of this policy is to clearly outline the roles and responsibilities, clinical practice, monitoring & reporting with respect to each element of the All-Wales IPC Code of Practice. It aims to ensure all elements of the IPC Code of Practice are consistently and diligently applied in the Trust to reduce the transmission of HCAI's, recognising the unique settings of out of hospital care.

The Trust aims to fulfil its duties to its employees by:

- Encouraging and empowering staff, at all levels, to adopt responsibility for their own health, safety, and wellbeing and that of others who may be affected by their acts or omissions.
- Ensuring that staff are aware of how infections are transmitted and the steps they, as an individual, must take to adequately prevent and control such risks.
- Ensuring that staff at all levels receive the appropriate training in infection prevention and control, enabling them to be fully conversant with the risk to themselves and to the patients in their care (where applicable).
- Providing staff with clear work procedures and safe systems of work wherever applicable.
- Ensuring that staff have access to personal protective equipment to help reduce the risk of infection and that they are trained in its correct use.
- Ensuring staff are aware of techniques to maintain good personal hygiene.
- Ensuring staff are aware of techniques required to appropriately decontaminate equipment and vehicles, including all levels of decontamination.
- Ensure that the Trust actively promotes an open and just culture and encourages incident reporting and full investigations into IPC incidents so that lessons can be learned, and risks reduced.

The aim of this policy is to clearly outline the roles and responsibilities, clinical practice, monitoring & reporting with respect to each element of the All-Wales IPC Code of Practice. It aims to ensure all elements of the IPC Code of Practice are consistently and diligently applied in the Trust to reduce the transmission of HCAI's, recognising the unique settings of out of hospital care.

5. OBJECTIVES

- To confirm that the Trust's commitment to the prevention and control of infection and to set the strategic direction for infection prevention and control initiatives.
- To provide a clear and comprehensive policy to assure infection prevention, control, and decontamination arrangements throughout the Trust.
- The policy has a suite of associated procedures which underpin the policy.

6. ORGANISATIONAL FRAMEWORK

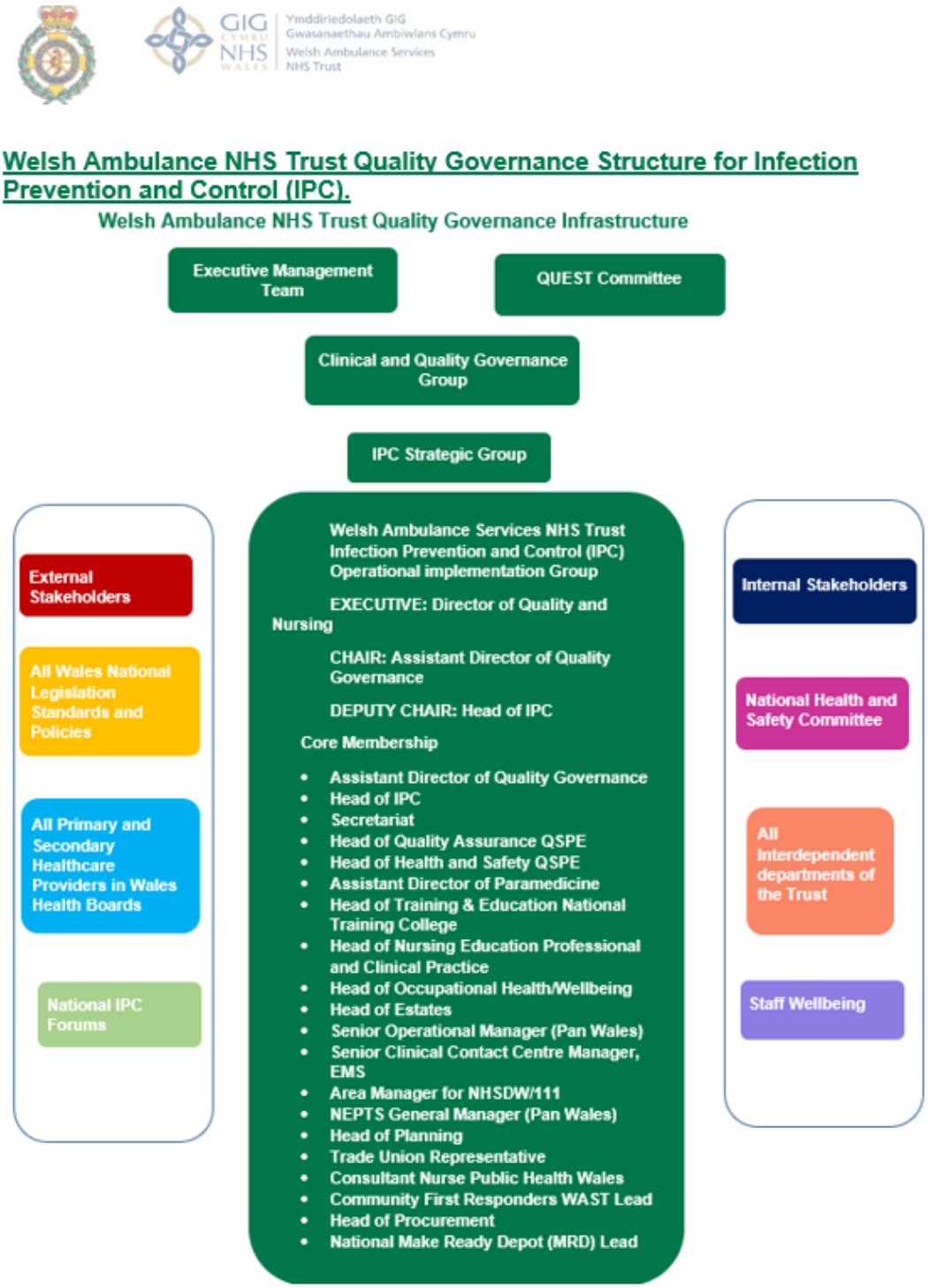
6.1. Quality Governance

Good Governance IPC systems & structures are required to prevent /minimise risks of HCAI's. The Quality Governance Infrastructure outlined in *figure 1* will be used to manage monitor and report against the HCAI's plan & policy to provide assurance to Trust Board.

Assurance of adherence to this policy will be provided via the WAST IPC Strategic Group meetings in line with the Health and Social Care Act 2008 for the prevention and control of Infections. These meetings will be chaired by the Assistant Director of Quality Governance, the chair will provide assurance to the Clinical Quality Governance Group

(CQGG) and the Quality Safety Patient Experience Committee (QUEST) via quarterly highlight reports. An overall IPC Annual report will be written to provide assurance to the Executive Management Team and the Trust Board a summary of good practice, risks or challenges and improvement work required.

Figure 1 Infection Prevention and Control Governance Structure as of 1st September 2023



6.2. Standards

A high level of quality in relation to IPC practice is expected within all areas of business, defined by quality standards outlined below. Compliance against the standards will be monitored and reported via the Trust quality governance infrastructure:

- Health & Care Standards 2015.
- Trust Vehicle cleaning standards in line with National NHS cleaning standards.
- Trust Station Cleaning Standards in line with National NHS cleaning standards.
- Environmental Standards ISO14001.
- "Compliance with the Health and Safety at Work Etc. Act 1974 and any applicable Health and Safety Regulations enabled under the Act".

IPC practices across the United Kingdom are based on the National Infection Control Manual. NIPCM

The following section outlines key elements of IPC practice, an overview is provided in the main body of the document with the full policy procedure in the appendix listed. All documents should be read & complied with.

6.3. Standard Infection Prevention and Control Precautions (SICP's)

SIPC's, covered in this chapter are to be used by all staff, in all care settings, at all times, for all patients whether infection is known to be present or not to ensure the safety of those being cared for, staff and visitors in the care environment.

SICPs are the basic infection prevention and control measures necessary to reduce the risk of transmission of infectious agents from both recognised and unrecognised sources of infection.

Sources of (potential) infection include blood and other body fluid secretions or excretions (excluding sweat), non-intact skin or mucous membranes and any equipment or items in the care environment that could have become contaminated.

The application of SICPs during care delivery is determined by an assessment of risk to and from individuals and includes the task, level of interaction and/or the anticipated level of exposure to blood and/or other body fluids.

To be effective in protecting against infection risks, SICPs must be used continuously by all staff. SICPs implementation monitoring must also be ongoing to ensure compliance with safe practices and to demonstrate ongoing commitment to patient, staff, and visitor safety. (Guidance on this can be found in the IPC guidance Safe Clean Care.)

Appendix 1 SICP's in detail for pre-hospital application and should be read in conjunction with this policy.

6.4. Transmission Based Precautions (TBP's) additional to SICP's precautions for known diseases

Standard Infection Control Precautions (SICPs) may be insufficient to prevent cross transmission of specific infectious agents. Therefore, additional precautions (TBPs) are required to be used by staff. SICPs must still be applied with these additional considerations.

TBPs should be applied when caring for:

- Patients with symptoms of infection.
- Asymptomatic patients who are suspected of incubating an infection; or
- Patients colonised with an infectious agent.

TBPs are categorised by the route of transmission of infectious agents (some infectious agents can be transmitted by more than one route):

- Contact precautions: Used to prevent and control infections that spread via direct contact with the patient or indirectly from the patient's immediate care environment (including care equipment). This is the most common route of cross-infection transmission.
- Droplet precautions: Used to prevent and control infections spread over short distances (at least 3 feet (1 metre)) via droplets (>5µm) from the respiratory tract of one individual directly onto a mucosal surface or conjunctivae of another individual. Droplets penetrate the respiratory system to above the alveolar level.
- Airborne precautions: Used to prevent and control infections spread without necessarily having close patient contact via aerosols (≤5µm) from the respiratory tract of one individual directly onto a mucosal surface or conjunctivae of another individual. Aerosols penetrate the respiratory system to the alveolar level.

(Further guidance on this can be found in the Safe Clean Care Guidance.)

Appendix 2 Transmission Based Precautions (TBP's) additional to SIPC precautions for known diseases in detail for pre-hospital application and should be read in conjunction with this policy.

6.5. Personal Protective Equipment (PPE)

The appropriate level of PPE should be worn following a risk assessment of the presenting patient, and the clinical skills that are required during patient care. Staff should not wear a higher level of PPE than is indicated by their risk assessment and reference to local trust guidance (Safe Clean Care Guidance Sept 2022 and the Trusts A-Z of common diseases). The use of PPE should not detract from the usual IPC risk assessments that staff carry out routinely to underpin all clinical practice and decision making. The Trust use 'red, amber, green' PPE to aid staff to make decisions as to the appropriate level of PPE required to protect themselves (Appendix one). This applies for all infectious diseases unless specific national guidance dictates otherwise as was the case during the COIVD -9 pandemic.

6.6. Correct use of PPE

- Care should be taken to ensure that PPE is donned and doffed correctly to avoid inadvertent contamination.
- All used PPE must be disposed of as category B clinical waste and any reusable items (for example eye protection or powered respirator hoods) must be decontaminated according to manufacturer or Trust instructions. (RPE SOP
- FFP3 face masks must only be used by staff who have been fit tested for the mask they are using, and staff must complete a fit check every time they are required to wear one. All staff using FFP3 face masks must be refit tested every three years as outlined in the Trusts. Fit Testing SOP.
- Powered respirator checks must be performed before each use, in accordance with the trust instructions, including a battery check.
- Although FFP3 masks are effective for longer periods, the general recommendation would be to wear the FFP3 face masks for up to 3 hours. However, the duration of wear is dependent on the outcome of a dynamic risk assessment conducted by the staff member taking into consideration several factors such as the environment, personal comfort/tolerance and the activity or task that is being undertaken.
- Where an FFP3 mask with a non-shrouded valve is worn, these are not fully protected from splash of bodily fluids (they still provide full protection for aerosols) and should be accompanied by a full-face shield/ visor. Where this is not available a risk assessment of the risk of splashing should be undertaken; it is not advised to wear a fluid resistant surgical mask over the FFP3 facemask. If a large splash (as opposed to droplets) does occur, then the FFP3 mask should be replaced immediately.
- Fluid repellent surgical face masks can be worn for the entire patient care episode, the Health, and Safety Executive (HSE) has confirmed that the masks can be worn until damaged or wet.
- All staff and volunteers should take the necessary PPE precautions to minimise risk. Health and safety considerations are paramount; judicious use of PPE is required through assessment of each situation carefully.
- Staff must adhere to PPE guidance provided. Whilst staff may have (or believe to have) immunity or protection from a pathogen (e.g., Covid-19), they must continue to don the appropriate level of PPE. This reduces transmission risk to the individual, other staff, and service users.

The prolonged wearing of Level 3 PPE including in high temperatures.

There are occasions where prolonged use of PPE is required. This may mean staff experience longer periods of time wearing high levels of PPE; this may be at the scene of a prolonged incident, or delayed handover.

Wearing PPE in warm/hot environments increases the risk of heat stress. Heat stress occurs when the body is unable to cool itself enough to maintain a healthy temperature. Heat stress can cause heat exhaustion and lead to heat stroke if the person is unable to cool down.

The time at which PPE use becomes 'prolonged' is subjective. The user of the PPE must make a judgement on their ability to perform the task required, their health and wellbeing. Other variables, such as hot weather and the amount of effort a task requires, will influence the user's ability to continue to work safety in PPE.

The prolonged use of respiratory protective equipment is subjective, but dependent upon the mask type used, an upper time limit or deterioration of the mask will prohibit continued use (see section 10, & RPE SOP).

In these situations, staff must consider the impact of PPE upon their health and safety.

Staff should consider the following if they experience prolonged used of PPE.

- Where staff are experiencing prolonged patient handover times, staff of the receiving unit must be informed that attending ambulance staff continue to wear high levels of PPE and encourage handover as soon as possible.
- Staff should be given the opportunity for breaks and sustenance when requested and as practically manageable. When the temperature exceeds 24 degrees Celsius, following the 'doffing' of PPE, staff are allowed a period to 'cool down' and re-hydrate. A 10-minute cool down period, at an appropriate place (not necessary a station) is acceptable practice.
- Staff must remember the importance of keeping hydrated; between shifts, try and stay cool and hydrated, as this will allow the body a chance to recover.
- Staff should have access to a plentiful supply of water and may use their 'WAST chilly bottles'.
- In the first instance where use of PPE is prolonged staff should notify their CTL or Bronze commander depending on the situation and location. Where they are unable to establish contact to resolve the situation staff should contact CCC for support
- The environment in which staff are waiting to handover the patient, usually a hospital setting (but not exclusively) must be notified that staff continue to wear high levels of PPE and encourage handover as soon as possible.
- Staff should be able to escalate situations to senior trust managers in situations where the above cannot be achieved.
- Wearing PPE in warm/hot environments increases the risk of heat stress. Heat stress occurs when the body is unable to cool itself enough to maintain a healthy temperature. Heat stress can cause heat exhaustion and lead to heat stroke if the person is unable to cool down.
- Measures to control the temperature of clinical environments and enable staff to make behavioral adaptations to stay cool and well hydrated should be made. Staff may require more frequent breaks and the frequency of PPE changes may increase.
- Where possible, staff must consider alternating attending duties, where one can.

6.7. Medical Devices Policy

Please note the Decontamination of medical devices: a development plan for healthcare organisations http://gov.wales/docs/dhss/publications/160107whc050en.pdf

Healthcare organisations are asked to review and develop policies and practice on the basis of the Implementation Plan. The aim of this Decontamination Improvement Plan is to ensure re-usable medical devices are safe for use on a patient and for staff to handle without presenting an infection risk. Decontamination is the combination of processes, including cleaning, disinfection and/or sterilisation.

The essential requirements for good decontamination practice are:

- Management controls are in place and effected.
- Medical devices are used appropriately and are fit for purpose.
- Are used in accordance with manufacturers' instructions.
- Are properly maintained, monitored, and validated.
- Are used by staff who are fully trained and competent.
- Conform to standards and requirements.
- Have track and trace systems link to device usage to individual patients.
- That robust records are maintained throughout the process.
- Appropriate facilities are provided.
- Single use instruments are not decontaminated for subsequent use.

Healthcare organisations are required to ensure that all the requirements of good decontamination practice are complied with to render re-useable devices safe for use. Further guidance can be obtained from the Medical Devices Policy, for all other decontamination guidance please refer to the manufacturer's guidance.

6.8. Antimicrobial Delivery Plan in line with Welsh Government AMR action

To be maintained by Medical Directorate in conjunction with IPC team and Public Health Wales Guidance. WG WHC 2022 014, AMR HCAI Improvement Goals 2021-2023

6.9. Infection Prevention and Control Sharps Policy

To be read in conjunction with this policy.

6.10. Aseptic non-touch technique Policy

The above policy is an All Wales Policy and must be read in conjunction with the IPC Policy.

6.11. Major outbreaks of communicable disease Plan

This model plan ("The Wales Outbreak Plan") should be used as the template for managing all communicable disease outbreaks with public health implications across Wales. Communicable Disease Outbreak Plan for Wales.

In addition, should there be public health implications from environmental or contamination incidents a separate plan should be accessed. Managing Public Health Risks from Environmental Incidents. Guidance for Wales.

In the event that any of the above guidance is activated the trust response will include participation from the IPC Team, the Emergency Planning Response and Resilience (EPRR) team and Business Continuity Leads.

6.12. Premise and Cleaning Policy (with supporting standards)

To be read in conjunction with this policy.

6.13. IPC Health Alerts and CMO/CNO letters

These will be disseminated and noted at the relevant governance groups within the trust.

6.14. Waste Management Policy

This policy is currently in development, further information on this policy and the guidance notes can be obtained from the Head of Estates and Facilities as required.

6.15. Occupational Health. Standard Operating Procedure. Occupational Exposure to Blood or Bodily Fluids

This SOP gives guidance to management and colleagues in the actions that need to be taken following a member of staff having expose to blood or bodily fluids through their working practices. It gives clear guidance for Occupational Health colleagues in the management of WAST colleagues who had had expose to blood or bodily fluids in their working practices.

7. EQUALITY

Each patient and situation are required to be assessed on an individual basis, recognising the potential risks to themselves, other patients, staff, and the organisation. By undertaking this process of eliminating prejudice and discrimination the Trust can deliver services that are personal, fair, and diverse and sustain safety and minimise the risk of cross infection.

Pregnant staff members should avoid contact with contaminated equipment and reduce their risk of exposure to harmful pathogens. Individual risk assessments should be done when notification of their pregnancy is given, these should be documented, and any appropriate action/s taken as relevant to their circumstances.

This policy applies to all staff, volunteers and Contractors for the Trust and an Equality Impact Assessment has been undertaken recording a neutral impact.

8. COUNTER FRAUD

The Welsh Ambulance Services NHS Trust is committed to taking all necessary steps to counter fraud, bribery, and corruption within the Trust. Staff should report suspected incidents of fraud and corruption to the Trust Local Counter Fraud Specialist, who will

be happy to discuss any issues or concerns. Alternatively, staff may contact the confidential NHS Counter Fraud Authority, Fraud and Corruption Reporting line on 0800 028 40 60; or the on-line reporting facility https://cfa.nhs.uk/reportfraud Fraud investigations may lead to disciplinary action and / or prosecution and civil recovery procedures.

9. INFORMATION GOVERNANCE

Information Governance (IG) is an overarching term used to describe all aspects of information management. The Trust and its staff shall ensure that they provide satisfactory assurance to stakeholders as to how the organisation fulfils its statutory and organisational responsibilities in relation to the management of information. It will enable management and staff to make correct decisions, work effectively and comply with relevant legislation and the organisations aims and objectives. The IG framework ensures that it sets out the high-level principles for confidentiality, integrity, and availability of information to promote and build a level of consistency across the Trust.

10. WELSH LANGUAGE IMPACT ASSESSMENT

Under the Welsh Language (Wales) Measure 2011 the Trust's Welsh Language Scheme will be replaced by standards. This means that the Trust, when formulating new policies or reviewing or revising existing policies, shall be required to assess what effect a policy decision would have on opportunities for persons to use the Welsh language and on treating the Welsh language no less favourably than the English language. Further guidance can be obtained from the Welsh Language Officer.

11. TRAINING AND IMPLEMENTATION

The Trust will provide an evidence based IPC training & education programme reflective of the pre-hospital environment & encompass the requirements of the overarching All Wales Infection Prevention and Control Training, Learning and Development Framework for health, social care, early years and childcare, (All Wales Infection Prevention and Control Training, Learning and) and the All Wales IPC Code of Practice. UK Core Skills Training Framework.

The Trust will ensure that all staff, contractors, and other persons receive suitable and sufficient training, information and supervision on the measures required to prevent and control risks of infection. All staff, during their induction process, will receive infection prevention and control awareness.

All staff will receive statutory and mandatory infection prevention and control training and refresher training on a regular basis. This is based on the frequencies and content as outlined in skills for health and updated to include any specific risks identified in the Trust to ensure lessons learnt are disseminated.

Infection Prevention and Control Policies and Procedures will be made available to staff in a variety of formats including electronic and web based. They will be shown where

to access this information as a follow up reference for use as necessary. WAST Infection Prevention and Control Intranet Page

A training needs analysis for all staff will ensure that relevant infection prevention and control training is regularly reviewed and implemented across the Trust, in-line with national guidance.

Local managers will be expected to action where any deficiencies are identified. Training records of infection prevention and control instruction given will be kept offering evidence to internal and external agencies (i.e., Internal Audit Committee, HIW) that all clinical staff are routinely educated in current infection prevention and control practice.

The IPC team are responsible for developing and reviewing the content for all IPC training delivered by Trust educators.

11.1 IPC Training & Education of Staff requirements for all frontline staff EMS, NEPTs & managers

a) Mandatory-Skills for Health IPC module

- Hand Hygiene
- Waste disposal
- Personal Protective Equipment (PPE)
- Management of Blood and Body fluid spillage
- Management of Occupational Exposure (including sharps)
- Management of the Environment
- Management of Care Equipment

b) Task based training

- IV Cannulation
- IO
- Aseptic non-touch technique (ANTT) for all invasive procedures.
- PPE (to include FFP3)

c) Developmental

- Infectious diseases hazard 1-4
- Emergency planning for emerging pathogens e.g., MERSCOV, EBOLA & MDRO
- Sepsis management NEWS score as per the UK Clinical Practice Guidelines for Sepsis Management
- Use of antimicrobials in practice

11.2 Training & Education of Staff requirements for all Corporate Managers

Managers of all services must ensure that staff:

- Are aware and have access to IPC policy documents.
- Have access to education and training on the elements of IPC.
- Have the correct support and resources available to implement, monitor and take corrective action to ensure compliance with IPC.

- With health concerns or who have had an occupational exposure, are referred to the relevant agency, e.g., General Practitioner or Occupational Health
- Managers engage effectively with the IPC team and have access to and maintain communication routes ensuring the most up to date and research-based practice reaches the public end user.

Staff providing care must ensure they:

- Understand an apply the principles of IPC.
- Understand their responsibility for their own practice.
- Maintain competence, skills, and knowledge in IPC through completion of mandatory training and any additional developmental training.
- Have up to date occupational immunisations/health checks/clearances as appropriate
- Report to line managers and document and deficits in knowledge, resources, equipment, facilities, and incidents that may result in a transmission of infection.
- Do not provide direct care while at risk of potentially transmitting infectious agents to others. If any doubt they must consult with their Line Managers, Occupational Health, or the IPC team.

IPC Teams must:

- Engage with staff to develop systems and processes that lead to sustainable and reliable improvements in relation to the application of the IPC policy.
- Provide expert advice on the application of the IPC policy.

Effective management of IPC relies upon the continuous improvement of staff knowledge and user competence, it is essential that staff who participate in providing patient care are fully aware of their role and responsibility through appropriate training and are assessed through observation of daily practice.

12. ASSURANCE AND COMPLIANCE

The Trust has assessed the risks associated with healthcare associated infections and are recorded and managed either as Corporate Risks, Directorate Risks or Local IPC risks, all are managed by the Head of IPC, reporting is via the risk management group and the quarterly IPC highlight report.

Sources of assurances include policies and procedures, internal performance management, Infection Prevention indicators, minutes of meetings, audit reports, and training records.

The Trust are required to sign a declaration to assess itself against core and developmental standards in relation to infection prevention and control, this will be shared with the appropriate regulatory body (CQC in England, HIW in Wales, RQIA in Northern Ireland and HIS in Scotland). The aim of this declaration is to determine priorities, and implement plans, to achieve any progress necessary to meet these standards on an annual basis.

The Trust will ensure external reporting to the Health and Safety Executive (HSE) under the Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR) Regulations 1995, this includes work related dermatitis cases as well as communicable diseases which meet this threshold.
Ensure the Trust is compliant with IPC All Wales Code of Practice Standards to eliminate preventable Healthcare Associated Infections.

12.1 IPC Audit Programme

The Infection prevention and control environmental audits should be performed throughout the Trust, in accordance with the IPC audit programme.

All Trust ambulance station premises and ambulance vehicles will be subjected to regular audit and inspection in line with the Health and Social Care Act 2008.

The Trust's Infection Prevention and Control Audit tool (currently under review) will be developed to look at key performance indicators including:

- The decontamination and cleanliness of ambulance vehicles and medical devices
- The knowledge and competency of staff on IPC practice at the point of care
- The storage of medical consumables and equipment
- The safe management, handling and disposal of clinical waste and sharps
- The safe management and handling of linen
- The general hygiene of ambulance stations, including both clinical and non-clinical areas.
- Local ownership of IPC standards by local management teams
- Hand Hygiene and Bare Below the Elbow compliance
- Fit Testing and Respiratory Maintenance Logs
- Antimicrobial supply and administration and of key clinical practices
- IPC Training & Education of Staff (all frontline staff EMS &NEPTs)
  - Mandatory-Skills for Health IPC module
  - Task based training – ANTT/IO/FFP3
  - Pre-hospital Bespoke IPC Education package in development with PHW to commence 1st April 2018
- Use of ANTT undertaking cannulation, chest drains and intraosseous cannulation and all other invasive procedures

These audits will be undertaken in line with the Trusts IPC audit programme. All audit results will be submitted via the current Governance structure.

12.2 Incident Reporting

All managers are responsible for undertaking a review of all IPC accidents, incidents or risks reported immediately and fully documented using the Trusts reporting procedures. Serious incidents and/or no surprises related to infections are reported in line with WG requirements for 'putting things right' and NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011

12.3 Quality Assurance Review Visits and Internal Audit

There will be times when the IPC practices within the trust will be subject to Internal and External reviews, full co-operation will be given for these reviews and any supporting information required fully disclosed.
A quality assurance review or Internal Audit visit, with a focus on IPC or specific areas of IPC, may be requested by the Executive Director of Quality and Nursing or a Non-Executive Director as appropriate. This may include a review of sharps injuries, hand hygiene audits, work acquired infections, work related injuries etc. as part of Key performance indicator work.

12.4 Peer Review

Peer review is a supportive and useful assessment of a trusts IPC policies and practices and can be requested through and by the National Ambulance IPC Group or QIGARD. This will be completed annually as a desktop exercise (benchmarking) and on alternate years as a direct observation visit to the peer Trust. These can be requested outside of this schedule if there are specific concerns, either by QIGARD or the Trust.

12.5 Monitoring

The Chief Executive and the Board are responsible for monitoring the effectiveness of the Infection Prevention and Control Policy. The Board will receive an annual infection prevention and control report, which is required to be published on the Trust website.

The annual Infection Prevention and Control Report will include but not limited to:

- Progress against the annual infection prevention and control programme and action plan.
- Demonstrate the effectiveness of the policy through the presentation of audit information and identified improvements in infection prevention and control standards.
- Contain a summary of reported incidents reviewed by the infection prevention and control team and resultant in changes to practice where required.
- Number of staff trained in infection prevention and control procedures through induction and statutory and mandatory education.

An infection prevention and control program/plan of work must be produced annually to maintain the Trusts compliance with local and national infection prevention and control policies and standards and, to achieve compliance with the Health and Social care act 2008, the Code of Practice for the prevention and control of infections and related guidance. The implementation and progress of IPC activity will be monitored by the infection prevention and control governance structures and against the infection prevention and control program/plan of work.

This policy and associated infection prevention and control procedures will be monitored for their effectiveness by the Infection Prevention and Control team to ensure that they

continue to reflect best practice and remain consistent with the Trusts clinical protocols and other relevant policies.

13. RESPONSIBILITIES

13.1 The Trust Board

The Trust Board is committed to and responsible for the prevention and control of infection. The Trust Board will ensure that appropriate management systems for the prevention and control of infection are in place. Therefore patients, staff and other persons are protected against the risks of acquiring preventable healthcare associated infections through the provision of clean, safe, evidence-based care with an ethos of causing no preventable harm.

13.2 Chief Executive

The Chief Executive of the Trust has overall statutory responsibility for ensuring that the Trust Infection Prevention & Control Policy for Health Care Associated infections and its associated procedures outlined in the appendix are implemented to prevent Healthcare Associated Infections affecting both staff & patients. The Chief Executive has delegated this responsibility to the Executive Director of Quality and Nursing who is directly accountable to the Trust Board. In addition to this the Chief Executive has appointed a Non-Executive Director lead for infection prevention and control.

13.3 Executive Director of Quality and Nursing

The Executive Director of Quality and Nursing has delegated authority from the Chief Executive to ensure the Trust is compliant with the Trusts Infection Prevention & Control Policy for Health Care Associated infections which has been developed in line with the National Ambulance Services Infection Prevention and Control Model Policy, NHS Wales Infection Prevention & Control Strategy, the All-Wales IPC Code of Practice 2014, UK Antimicrobial Resistance Strategy 2021/23.

13.4 Assistant Director of Quality Governance

The Assistant Director for Quality Governance has delegated responsibility for assisting the Executive Director of Quality and Nursing in their IPC responsibilities.
Within this scope of responsibility, the Assistant Director of Quality Governance must: -

- Provide oversight and assurance on infection prevention (including cleanliness) to the Trust board. They should report directly to the board but are not required to be a board member.
- Be responsible for leading the Trust's infection prevention team.
- Oversee local IPC policies and their implementation.
- Be the chair of the Infection Prevention and Control Strategic Group.
- Have the authority to challenge inappropriate practice and inappropriate antimicrobial prescribing decisions.
- Have the authority to set and challenge standards of cleanliness.

- Assess the impact of all existing and new policies on infections and make recommendations for change.

13.5 Non-Executive Director for Infection Prevention and Control

The Non-Executive Director IPC lead is responsible for acting as a critical friend and providing constructive challenge and support to the DIPC from an independent, external perspective.

13.6 Executives/Directors

Ensure the principles of the Trust's Infection Prevention and Control Policy and Procedures are adhered to within their own area of control, and that all area /directorate issues are reported appropriately throughout the Trust.

13.7 Head of Infection Prevention and Control

- Development of Trust wide Infection Prevention and Control Policies and Procedures compliant with legislation and 'best practice'.
- Monitoring compliance with infection prevention and control policies and procedures across the Trust.
- Ensuring any necessary revisions are undertaken to meet statutory, mandatory and Trust standards.
- To ensure communication to the appropriate member of the Executive Management and Senior Management teams are relayed regarding infection prevention and control issues.
- Responsibility for ensuring the consistent working of the Infection prevention and Control Team.
- Ensure there is appropriate, evidence based and up to date provision of training material for infection prevention and control.
- To ensure that there is a communication mechanism in place for staff at all levels about infection prevention and control issues including infection prevention and control incident reporting.
- To ensure that the Infection Prevention Team in conjunction with Service Delivery completes audits regarding infection prevention and control.
- Development and implementation of annual infection prevention and control plan and annual report.
- Co-ordination of infection prevention and control management across the Trust and development of performance management framework.
- Provision of advice and support in relation to infection prevention and control issues by liaison with Public Health Wales.
- Responsibility for initiating a periodic review of infection prevention and control activities and making appropriate recommendations to ensure that the Trust maintains a current and valid infection prevention and control policy.
- Monitor and reports on any investigations in relation to HCAI incidents which the Trust may have been involved in and asked to investigate by other health organisations.
- Report directly to the Assistant Director of Quality Governance

- Have the authority to challenge inappropriate practice, if appropriate, including antimicrobial prescribing practice.
- Have the authority to set and challenge standards of cleanliness.

13.8 Decontamination Lead (Medical Director Currently)

The Decontamination Lead will have overall responsibility for the decontamination and cleaning of ambulance vehicles and reusable equipment for Service Delivery in line with relevant national guidelines and ensure that there are associated cleaning schedules accessible to be seen by staff and the public.

13.9 All Assistant Directors

Have responsibility for ensuring adherence to the elements of infection prevention and control policy and procedures relevant to their own areas of control.

13.10 Infection Prevention and Control Team

The Trust must have an infection prevention and control team, which is appropriately qualified and has the capacity to oversee and monitor the systems in place to prevent and control the risk of infection. There is no specified structure for the IPC team but at the senior levels these must hold a clinical qualification or an equivalent speciality qualification in infection prevention and control.

13.11 All Managers within the Trust

Managers are responsible for the provision of leadership & supervision to ensure that the implementation & dissemination of the Healthcare Associated Infection Prevention & Control Policy to all staff within their sphere of practice. All managers must ensure that infection prevention & control practices to eliminate Healthcare Associated Infections are an integral part of their everyday role. The Trust will ensure staff have access to polices, ensure resource and equipment is available to comply with the policy and the Management of Health and Safety at Work Regulations 1999. Management of Health and Safety at Work Regulations. Through work-based training, assessment and supervision managers are responsible for ensuring that all employees whom they have direct responsibility for are competent in applying all aspects of the Healthcare Associated Infection Prevention & Control Policy which is an overarching policy with a number of supporting policies and standard operating procedure. These can be found on the IPC Intranet page and are divided into relevant folders for ease of access.

Responsibilities include (not limited to):

- Setting a good example to all staff and acting as a positive role model
- Ensuring that current legislative and mandatory requirements are met.
- Ensuring that the Trust Infection Prevention and Control Policy and procedures are made available to all staff and that it is maintained with necessary updates.
- Compliance with the Trust Infection Prevention and Control Policy and Procedures are monitored and where necessary, appropriate action is taken.

- Adequate liaison and consultation are maintained with members of the IPC team and associated functions for the safety of patients and staff should there arise any issues with IPC practices.
- Regular inspections and audits of the workplace are facilitated and where necessary undertaken, and any defects identified are managed appropriately and action plans implemented where required.
- Information on infection prevention and control related matters is disseminated to all staff.
- All reported incidents, including near misses in relation to infection prevention and control are sufficiently.

13.12 All Employees

The Health and Safety at Work Act 1974 also places duties upon Trust employees about health, safety & welfare. Trust policies also require employees to take responsibility for their own and others safety, there is therefore a statutory obligation under the Health & Safety legislation that all employees must: -

'Take reasonable care for the Health & Safety of themselves and any other persons who may be affected by their acts or omissions at work. This duty also includes taking positive steps to understand the hazards in the workplace, to comply with safety rules and procedures and to ensure that nothing they do or fail to do places others at risk. Co-operate in so far as is necessary, with his/her employer, to ensure that all relevant statutory regulations, policies, codes of practice and departmental procedures are adhered to'.

Therefore, staff employed by the trust in any capacity must:

- Understand their responsibilities under this policy and related guidelines, to maintain and increase their knowledge of the subject relative to their role.
- Take reasonable care of their own safety and that of others who may be affected by their acts or omissions.
- All staff should be up to date with their routine immunisations, e.g., tetanus, diphtheria, polio, and MMR. The MMR vaccine is especially important in the context of the ability of staff to transmit measles or rubella infections to vulnerable groups. While healthcare workers may need MMR vaccination for their own benefit, they should also be immune to measles and rubella to assist in protecting patients. Satisfactory evidence of protection would include documentation of having received two doses of MMR or having had positive antibody tests for measles and rubella. (The Green Book 2013).
- Not intentionally or recklessly interfere with or misuse any equipment provided in the interests of health, safety, and welfare.
- Wear the correct personal protective equipment when required and as part of any guidance documents, nationally or locally, and to immediately report any defects in such equipment.
- Maintain good personal hygiene.

- Ensure the cleanliness of equipment and vehicles they use, to reduce the potential of transmission of infection, thereby promoting patient and staff health, safety, and wellbeing.
- Be compliant with the associated trust policies, procedures and standards of practice which sit alongside this policy.
- Ensure that any equipment for service, maintenance or repair that has been in contact with or has potentially been in contact with body fluids is cleaned and where necessary disinfected, prior to being sent for service, maintenance, or repair.
- Report all incidents including near misses, as per the Trust incident reporting procedure.

13.13 Occupational Health

The Trust provides a nurse led Occupational Health service to all employees. Occupational Health Intranet Page. They work closely with the IPC Team in relation to associated infection prevention and control procedures, advice, and counselling within their scope of expertise.

Occupational Health are responsible for the follow up management and interventions following incidents of contamination, exposure, or inoculation injuries for staff within the Trust.

NB. Please be aware that immediate inoculation management should be undertaken through the local emergency department or general practitioner.

The occupational team has a work-based immunisation programme in place, which is managed with appropriately qualified staff*. (This does not include those vaccines required for foreign travel unless on Trust business).*

As part of the service the Occupational Health Service is responsible for maintaining a database of staff and their vaccine history. This helps to facilitate a timely vaccination program either as a business as usual or emergency response to incidents. Should vaccine stock be low then the Occupational Health Service will dispense as is appropriate in consultation and partnership with stakeholders both internally and external to the Trust. Occupational Health are responsible for ensuring they share vaccination records with staff, and they have access to their immunisation status and accurate records are stored using the most up to date electronic platform.

These vaccines include:

BCG vaccine is recommended for healthcare workers who may have close contact with infectious patients. It is particularly important to test and immunise staff working in maternity and paediatric departments and departments in which the patients are likely to be immunocompromised, e.g., transplant, oncology, and HIV units.

Hepatitis B vaccination is recommended for healthcare workers who may have direct contact with patients' blood or blood-stained body fluids. This includes any staff who are at risk of injury from blood-contaminated sharp instruments, or of being deliberately

injured or bitten by patients. Antibody titres for hepatitis B should be checked one to four months after the completion of a primary course of vaccine. Such information allows appropriate decisions to be made concerning post-exposure prophylaxis following known or suspected exposure to the virus.

Influenza immunisation helps to prevent influenza in staff and may also reduce the transmission of influenza to vulnerable patients. Influenza vaccination is therefore recommended for healthcare workers directly involved in patient care, who should be offered influenza immunisation on an annual basis. This may be delivered through the Trust and not directly through Occupational Health.

Varicella vaccine is recommended for susceptible healthcare workers who have direct patient contact. Those with a definite history of chickenpox or herpes zoster can be considered protected. Healthcare workers with a negative or uncertain history of chickenpox or herpes zoster should be serologically tested and vaccine only offered to those without the varicella zoster antibody.

Pertussis (whooping cough) vaccine is recommended for all susceptible healthcare workers who have direct patient contact. Vaccination is recommended for all staff who have not been vaccinated in the last five years.

Sars-CoV-2 (Coronavirus) vaccine is recommended for all healthcare workers directly involved in patient care and in areas of high risk. Staff should be offered immunisation as part of the wider Covid19 vaccination programme, *in Wales this is facilitated by the Health Boards as part of the wider national vaccination program.*

13.14 Infection Prevention and Control

The Trusts Infection Prevention and Control policy and its associated procedures details the requirements set out in standards, these include information on staff training, staff duties, incident reporting, information for staff and patients and infection prevention and control monitoring.

In order to assure the Trust Board a quarterly highlight report is submitted to the Health and Safety Committee and the Infection Prevention and Control Strategic Group detailing all IPC matters, status position, action plan, challenges and risk and an annual audit programme. Further governance is provided by the Clinical Quality Governance Group (CQGG) and the Quality Safety and Patient Experience Committee (QUEST). In addition, an Annual *Infection Prevention* and Control report will be submitted to the Executive Team and Trust Board. Any risks identified are actioned where appropriate and added to the Risk Register as necessary.

The Process for monitoring the effectiveness of the above standards is through the following actions:

- Completion of Incident report form and investigation by local managers.
- Incident reporting statistics and trend analysis monitoring.
- ‘Lessons learnt’ and action plans.

- Infection Prevention and Control Strategic Group to monitor incidents and make any recommendations.
- Trust Incident learning Forum
- (Or similar) monitor and make any recommendations.
- Training records.
- Annual audit plan and action plan monitoring

13.15 Inoculation and Contamination incidents

All staff have a duty to report any inoculation and contamination incidents. Incidents are monitored by the Health and Safety Team, The Occupational Health Team and the IPC team and will be included in any reporting structure for Infection Prevention and Control. Any deficiencies or issues are actioned accordingly as part of the infection prevention and control action plan. Any risks identified are highlighted and, where appropriate, added to the appropriate risk register.

13.16 Partnership working

In order to effectively manage risks associated with infection control it is essential that close working relationships are developed with other NHS Trust health boards and agencies to ensure a smooth transfer through the patients' care pathway. Sharing of information regarding patients' clinical conditions and the presence of any known infectious disease will assist in reducing the risk of cross infection and improve patient care overall.

Our Partners include:

- Public Health Wales
- Welsh Government
- QGARD Subgroups
- Infection Prevention Society (IPS) Welsh Branch,
- All Health Boards/Trusts IPC Teams,
- NATC, WAST Fleet, NHSDW, All staff and Managers.
- National Ambulance Infection Control Group (NAICG)
- WAST Health & Wellbeing/Occupational Health

13.17 Patient Public Involvement

The Trust will involve service users (patients and the public) on Infection, Prevention and Control procedures and performance through local service user groups, regional patient groups and internal Quality/Service User Experience Groups. The IPC team will work closely with the Patient, Experience & Community Involvement Team (PECI) to ensure there is a public voice to support the IPC program within the Welsh Ambulance Emergency Service and to ensure that the patient's perspective is fully understood.

14. AUDIT

The IPC environmental audits should be performed throughout the Trust, in accordance with the IPC audit programme. All Trust ambulance station premises and ambulance vehicles will be subjected to regular audit and inspection in line with the Health and Social Care Act 2008.

The Trust's Infection Prevention and Control Audit tool will be developed to look at key performance indicators to include the following areas:

- The decontamination and cleanliness of ambulance vehicles and medical devices
- The knowledge and competency of staff on IPC practice at the point of care
- The storage of medical consumables and equipment
- The safe management, handling and disposal of clinical waste and sharps
- The safe management and handling of linen
- The general hygiene of ambulance stations, including both clinical and non-clinical areas.
- Local ownership of IPC standards by local management teams
- The use, maintenance, and storage of personal protective equipment to include the use of face filtering face pieces.

15. INFORMATION SHARING

When transporting patients from one healthcare setting to another the Trust will ensure that information is passed between the two settings including the Patients infection status and that any infection prevention and control risks or issues have been identified and actioned appropriately. Information regarding the risks and nature of HCAI's that are relevant to the patient's own care must be communicated.

Infection Prevention and Control information is shared between the Trust and its occupational health providers to protect staff and patients from risks.

Infection Prevention and Control information is shared with Public Health Wales, Public Health Agency (as appropriate); Commissioners of the Trust services; Enforcement Agencies and other NHS partner organisations to comply with legal requirements or reduce the potential risks associated with the transmission of Healthcare Associated Infection information HCAI's (i.e., MRSA, C Diff etc.).

Infection Prevention and Control information will be made available for Patients and the Public, these can include posters, leaflets, and Internet information. Knowledge of the Trust's Infection Prevention and Control Policies and Procedures, and the Trust's arrangements for reducing HCAI's should be made available and accessible for staff and patients.

16. EQUALITY AND DIVERSITY

This policy embraces diversity, dignity, and inclusion in line with emerging Human Rights guidance. We recognise, acknowledge, and value differences across all people and their backgrounds. We will treat everyone with courtesy and consideration and ensure that no one is belittled, excluded, or disadvantaged in any way, shape, or form.

The Trust supports Equality and Diversity, and an Equality Impact Assessment of this policy has been undertaken.

17. DOCUMENT DEVELOPMENT REVIEW

The Infection Prevention and Control Policy and associated procedures have been developed in consultation with the National Ambulance Service Infection prevention and control Group and Public Health England, Public Health Wales, Public Health Scotland, Public Health Agency (as appropriate).

QGARD and Association Ambulance Chief Executives (AACE) are responsible for the overarching approval of the policy document.

The National Ambulance Service IPC Group is responsible for ensuring that the policy is reviewed on a regular basis. This will ensure that it remains current, complying with legislation, national guidance and therefore reflecting 'best practice'.

18. RELATED POLICIES AND PROCEDURES

Infection Prevention and Control Procedures and Policies continue to develop within the trust, the aim of which is to aid staff in understanding their personal responsibilities for controlling and preventing the spread of infections. These documents provide information and guidance relating to the mechanisms involved in the spread of infection, personal hygiene, and personal protective equipment, cleaning of vehicles and equipment and other issues such as the management of healthcare waste. The IPC team are responsible in ensuring that information regarding IPC is up to date, timely, evidence based, readily accessible and reflect safe clean care and reflects best practice. Included in these procedures are IPC Health Alerts & CMO/CNO letters.

19. DISSEMINATION PLAN

IMPLEMENTATION AND MONITORING PLAN	
Policy Process	Policy for Policies
Intended Audience	All staff, volunteers, and contractors
Dissemination	All staff, volunteers, and contractors
Communications	Notice, SharePoint, Emails, Siren, Yammer, IPC Intranet
Training	IPC Mandatory Training
Monitoring	IPC Audit, IPC Intranet Page views

20. KEY NATIONAL STRATEGIC DOCUMENTS

- NHS Wales Infection Prevention & Control Strategy: Commitment to Purpose (2011); the All-Wales IPC Code of Practice 2014
- UK Five-Year Antimicrobial Resistance Strategy 2013
- Welsh Government AMR (Anti-Microbial Resistance) Delivery Plan 2016.
- UK Ambulance Services Clinical Practice Guidelines. Joint Royal College's Ambulance Liaison Committee JRCALC.
- Decontamination of Medical Devices: a development plan for healthcare organisations January 2016 Welsh Government
- Code of Practice for the Prevention & Control of Healthcare Associated Infections May 2014.Welsh Government
- Commitment to purpose: Eliminating preventable healthcare associated infections (HCAIs) December 2011
- UK Antimicrobial Resistance Strategy.
- COSHH Regulations
- HSE (2013), Personal Protective Equipment Regulations 2002 and the Personal Protective Equipment at Work Regulations 1992
- Health & Safety at Work Act 1974
- Health Technical Memorandum 07-01: Safe management of healthcare waste
- National Standards of Cleanliness in Healthcare Facilities
- H&C standards
- All Wales delegation policy 2010
  WHTM 07-01 Welsh Health Technical Memorandum
  Safe management of healthcare waste
  ISBN 978-1-909899-03-2 © Copyright

21. REFERENCES

epic3: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England (2017)

Health and Social Care Act (2008) Code of Practice on the prevention and control of infections and related guidance (updated 2015)

NICE Guidance: Healthcare-associated infections: prevention and control in primary and community care (CG139)

Healthcare-associated infections: prevention and control (PH36)
Infection prevention and control (QS61)

NHS Constitution for England, available at
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113645.pdf

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113645.pdf

22. APPENDIX ONE

Personal Protective Equipment **RED**, **AMBER**, **GREEN**, **GREY**

ACTION LOG - UPDATE FOR 8 FEBRUARY 2024
QUEST COMMITTEE

Minute Ref	Date	Agenda Item	Action Note	Responsible	Due Date	Progress/Comment	Status
50/23	31 October 2023	Operations Update	Update on the EMS CSD reconfiguration following the outcome of the new Demand and capacity review currently underway. The EMSC reconfiguration (connected to the 2019 D&C) has been delayed due to the pandemic, it is now restarted using data from the new review, that is now live. Further information was sought on the EMSC boundaries and what desks are working in each boundary. Suggested that QuEST receive a copy of the entire review once complete (which is the Trust's strategic response to patient safety and will include CSD). It's a key document (inc. slides and a summary). Final draft is expected in January 2024 and suggest inclusion in February 24 meeting.	Rachel Marsh Hugh Bennett	8 February 2024	Update for 8 February 2024 Details contained in the Ops update report: The current IMTP (legacy) deliverable of reconfiguring EMSC has now been replaced by a proposal for a revised leadership structure, which will also incorporate the original single allocator model and dispatch boundaries recommendations. Initial work was carried out to progress the boundaries recommendation in early 2023 and it became clear that Project Board were keen to refresh the data to ensure that the original (2017) paper and therefore data remained valid in the current context. As a result, further modelling was carried out by ORH in September 2023 that considered more recent and up to date data (Sept 2022 to May 2023). The revised D&C recommendations (Sept 2023) were considered as part of the wider EMS Coordination Reconfiguration Project and an initial paper has set out a proposed structure that will provide a leadership structure that is fit for purpose but will also address the two outstanding recommendations from the original ORH Report in 2017. The final paper, once ready, will be submitted to colleagues and will be shared with Trade Union partners and all elements will feature as part of the Organisational Change Process (OCP).	Open
50/23a	31 October 2023	Operations Update	NEPTS Eligibility matrix, update to see if there has been any push back from Local authorities and Welsh Government in the way the matrix was being applied; and were people being disadvantaged who have no other transport option.	Mark Harris	8 February 2024	Update for 8 February 2024 Verbal Update	Open
51/23	31 October 2023	Patient Story	It was highlighted that the Operational Delivery Unit have informed the Stroke Association that they are conducting an Audit on self-presentation to A&E. Action: Liam Williams agreed this would be reported through to Quest if there was a material consideration.	Liam Williams	8 February 2024	Update for 8 February 2024 28.11.23 Liam Williams linking in with Ceri Jackson to obtain further information on Lead within Operational Delivery Unit.	Complete
52/23	31 October 2023	Putting Things Right Report	In terms of the longest waiting patient for an ambulance (39 hours and 59 minutes), it was requested that context around this be provided.	Wendy Herbert	8 February 2024	Update for 8 February 2024 The context will be inlcuded in the Quarter 3 Report for Committee.	Complete
54/23	31 October 2023	Spotlight on Clinical Indicators - Return of Spontaneous Circulation (ROSC) Rates	Clarity on utilisation rates of Cymru High Acuity Response Unit (CHARU) activated at call centres.	Andy Swinburn	8 February 2024	Update for 8 February 2024 Work continues to define this action. It is recognised that CHARU dispatch requires further development to ensure an appropriate balance between clinical performance/ clinical outcomes/ response time performance and old despatching multi-resources when clinically appropriate. To this end, the CHARU Task and Finish Group will now be converted in a CHARU delivery group which will work with a number of teams across the organisation to continue to hone the delivery of the CHARU service.	Complete

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	23 November 2023
Committee Meeting Date	31 October 2023
Chair	Kevin Davies (in chair for Bethan Evans)

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. Lost hours due to handover delays were at 19,610 hours in September and far in excess of what is acceptable, particularly as we move into Winter. Themes from patient safety incidents continue to be timeliness to respond and handover of care delays, with 1,588 patients receiving a response or wait of over 12 hours, with one patient waiting 39 hours and 59 minutes. The impact on patients and their families was acutely felt by Members when hearing the patient story from Steven Parsons and learning of a further three Regulation 28 notices issues from the North Wales Coroner.

   Handover delays, coupled with many patients waiting in excess of four hours outside Emergency Departments, **continue to present patient safety risks and extended waits in the community.** The ways in which the Trust is continually working with partners to influence system change ran through the agenda and the Trust Board will receive an update to the paper on the system actions to mitigate avoidable harm at its November meeting. Whist risks 223 and 224 have not changed their risk rating, the Committee is assured that they are being regularly reviewed, monitored, and updated to introduce mitigations wherever possible. Members continue to challenge on any further actions that can be put in place by the Trust and its influence on system partner actions and raise the Trust's ongoing concerns in their respective forums.

ADVISE

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

2. **Steven Parsons** recounted his distressing experience of being unable to get an ambulance for his grandfather, who he thought was suffering a stroke. Steven called 999 but was told there were no ambulances available at that time because of the system pressures. Believing it was a stroke, Steven decided to transport his grandfather to the hospital himself. Upon arrival, his grandfather collapsed

but was resuscitated in the Emergency Department. Whilst the Trust was operating in extremis at the time of Steven's call, with long waits for the 111Wales service and high levels of the clinical safety plan and REAP in operation, the experience that Steven and his family had underlines the trauma families experience when there are no resources to send in response to their call. Whilst they understand that the NHS is understaffed and overworked, Steven emphasised that the ordeal his grandfather and his family endured should not have happened and expressed a desire to share his experience to help others understand that impact. The Patient Experience and Community Involvement (PECI) team are working with Steven and his family addressing some of the issues that arose, and Jason Killens has had an opportunity to meet with Steven and his sister as part of the Trust's duty of candour and putting things right process.

3. The Committee received the **Q2 Operational Update**, acknowledging the ongoing national efforts concerning the code of ineffective breathing. The commendable progress on the Manchester Arena Inquiry actions and the effective implementation of mass casualty exercises and simulations, along with the assimilation of insights from a recent extraordinary incident in response to system pressures within the Swansea Bay University Health Board area, were positively received. Members also acknowledged the ongoing work on the national whole system escalation framework, emphasising the importance of gaining a comprehensive system-level understanding of clinical risk and enhancing the management of the population's needs. This was particularly significant in light of the impact highlighted in Steven's story.

4. The Committee received and reviewed the **2023 Annual Report on Mental Health and Dementia**, which is included as Annex 1 for the Board's consideration. The commendable efforts of the Mental Health and Dementia Teams were acknowledged, highlighting their significant and diverse contributions to the well-being of our service users, as highlighted in the comprehensive and impactful annual report. It was emphasised that both teams receive separate funding from the Welsh Government, underlining the importance of securing this funding for the 2024/25 period, given the significant positive impact they have on patients. Members underscored the significance of maintaining the '111Wales press 2' mental health provision.

5. The following **policies were approved**:

   (a) Aseptic Non-Touch Technique Policy
   (b) Medicines Management Policy
   (c) Information Governance Policy

   It was agreed that Chairs Action would be utilised for the Trust IPC Policy nearing completion of the Policy Group consultation stage.

6. Members' **reflections** on the meeting included clear and succinct papers and tangible progress on some longstanding issues.

7. Attached at Annex 2 is the **Infection Prevention and Control Annual Report 2022/23** which was erroneously omitted from the August AAA report of this Committee.

ASSURE

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

8. Two **Quality** Impact **Assessments (QIA)** were reviewed by the Committee. These have been developed to ensure that the Trust is able to meet the 2023/24 Integrated Medium Term Plan (IMTP) budget requirements approved by the Trust Board, to meet the Welsh Government requirement for all NHS organisations to maximise financial efficiency opportunities in this financial year and, to prepare for a challenging financial settlement in 2024/25.

   (a) Implementation of a revised approach to the application of the Non-Emergency Patient Transport Service (NEPTS) eligibility criteria and a revised Capacity Management Plan.
   (b) The Mid and West Wales Fire and Rescue Services (M&WWF&RS) support to the Trust's emergency responses

   The Committee noted that the Executive Leadership Team would be reviewing the QIAs at their meeting the following day for a decision on the way forward with these two issues coupled with any financial benefit. The Committee received assurance that the process of QIAs, that had previously been noted, was in place and appropriate escalations were being followed/assurance taken. It also noted that any reputational impact would be escalated to the Board where appropriate by the Chief Executive.

9. The Welsh Government (WG) Highlight Report for organisations compliance with the **duty of quality and duty of candour** was received for August 2023 which rated the Trust's progress as it is having identified that 'delivery is at risk but manageable' or is 'behind schedule but within tolerance'. This is in line with other NHS organisations across Wales and includes a further nine deliverables recently added to the WG roadmap. The appointment of the Senior Quality Governance Lead and bespoke implementation plan has increased capability and capacity to support full implementation. The current impact of this has been a review of arrangements which has led to some previously reported good progress being revised on the current WG report.

10. The Committee receives assurance by way of the **Monthly Integrated Performance Report** (MIQPR) for August/September and the **Q2 Putting Things Right (PTR) Report**. The organisational learning from clinical reviews were set out in the latter report. The Trust Board will note the escalation in the alert section regarding continued handover delays. The Committee noted as follows in the context of a backlog in processing complaints which has impacted on the September 2023 data:

    - Continued achievement of the clinical call back time target for the highest priority 111Wales calls, while the priority 2 and 3 call back times also achieved the 90% performance target in July.
    - The myriad of factors that influence the red eight minute response were discussed given the slight improvement in terms of system pressure and handover delays not equating to improvement in red response. The primary influencers of demand, capacity and lost capacity remain a focus which the Committee will monitor.
    - The call to door time for stroke will feature in the next iteration of the MIQPR.
    - There is a continued upward trend in Coroner's requests for information. The Trust received three Regulation 28 Reports during this period. The Trust is engaging with the Coroner on the

initiatives it has in place and will continue to do so.

- 1,000 patient safety incidents were reported in Q2 with themes continuing to be timeliness to respond and handover of care delays. Training and support packages are in development for our people working with frail patients undertaking extended journeys or episodes of care.
- There are a number of overdue National Reportable Incidents (NRI) investigations, with capacity the main reason and this is a focus at the Clinical Quality Governance Group and Senior Operations Team.
- With respect to concerns, 253 were received in Q2 with the five-day acknowledgement performance at 88%, 96% and 99% (100% target) with the 30-day target achieving 49%, 47% and 55% respectively (75% target) which was a welcomed rise from the previous quarter. The overwhelming themes and trends through the majority of concerns remains timeliness to responding to calls in the community. Themes related to Ambulance Care include those related to eligibility criteria.
- The Committee raised an alert following their April meeting as to effect of the backlog and volume of concerns on the PTR team. The Executive Management Team have agreed an organisational change process to support these teams which is in the consultation phase. It aims to provide additional leadership, capacity, and development opportunities across the functions and is progressing well.
- A continuing number of incidents are being reviewed at the Serious Case Incident Forum (SCIF) and Joint Investigations passed to Health Boards. General themes received from Health Boards following joint investigations are over-crowded emergency departments and wider system pressures resulting in hospitals being in very high levels of escalation. It was agreed that the next report would draw out the themes in more detail.
- 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.
- 51 cases of Redress decisions were made in the quarter (when the Trust is investigating a concern and identifies an error or omission, it is incumbent on us to consider whether to make an offer of Redress). Themes and trends were discussed.
- A number of clinical notices have been issues following learning from investigations. The newly formed Quality Management Group is the forum responsible for organisational learning and will identify trends and themes and highlight any education and training or clinical audit activities required as a result.

Committee members commended the transparent nature of these reports and that whilst the timeliness for the duty of candour may not be where we would like it to be whilst changes to the PTR team are put in place, we are meeting with patients and their families.

11. The Committee received assurance on the developments internally and externally in respect of **Mortality Reviews** and mortality governance. This includes the processes in place to capture data, analyse patterns, themes and trends and implement appropriate sustainable improvements informed by the learning.

12. During this meeting, the Committee focused on the clinical indicator of **Return of Spontaneous Circulation (ROSC)**, acknowledging substantial enhancements in ROSC rates since April 2022. Notable improvements include the implementation of CHARU (Cymru High Acuity Response Unit),

the introduction and ongoing enhancements of ePCR, increased participation in Good Sam (with a record of over 10,000 sign-ins across Wales in a single Friday evening), Mandatory in Service Training (MIST), an expanded deployment of public access defibrillators (now exceeding 8,000), and a series of public messaging and events. The Committee will remain updated on further initiatives to sustain the upward trend in ROSC rates and expressed strong optimism regarding the progress made and its positive impact on patients.

13. The **Patient Experience and Community Involvement (PECI)** report is now presented to the Committee bi-annually and this report again illustrated the significant engagement that takes place led by the PECI team. This included:

    - Presentation to the Learning Disabilities Ministerial Advisory Group on progress make in key areas and WAST's ambitions to meet the needs of people with learning disabilities;
    - Engagement with the Future Generations Commissioner with Shoctober and Food Fun Wales, and a case study submission with the Children's Commissioners;
    - Patient experience surveys on palliative end of life care, and experience surveys to support the 999, 111Wales and NEPS services. Work is underway to establish processes to increase responses to the 999 and 111Wales surveys using digital follow up technology in particular where numbers of responses are low. There are information governance challenges which need to be addressed to enable the team to increase numbers reached by the surveys.
    - Patients overall experience of the NEPTS service continues to be rated good (11.82%) and very good (76.18%);
    - PECI continue to work with Llais (Citizens Voice Body), share good practice across the sector and grow the people and community network, who will be involved in the refresh of the national Patient Reported Experience Measures (PREM); and
    - Community involvement events are varied and numerous and the PECI team have been requested to support the work of the Bevan Commission as they explore the future sustainable model for health and care in Wales.

14. The Clinical **audit plan update for Q2** was received with no escalations. The Board will note that it is not always possible to predict at the start of a financial year all of the topics that will require evaluation and therefore flexibility in setting a clinical audit plan was agreed, resulting in the annual plan being a dynamic document, updated quarterly.

15. The Committee was presented with the **Information Security and Information Governance Key Performance Indicators (KPIs)**, taking note of the upcoming presentation of the reasonable assurance records management internal audit at the next meeting. Compliance with the Freedom of Information Act remains challenging, recording rates of 41% in August and 45% in September against a target of 90%. However, a review of the process and digital support is expected to lead to improvements in compliance. The digital team will prioritise data quality reporting and resource allocation in the upcoming period

16. An update was received on a revised **Audit tracker** with 42% of management actions closed in the quarter and a number of historical actions revisited to open up discussions on potential revisions of management actions due to the passage of time. There has been excellent engagement on the new process and Members welcomed the revised format.

17. The Committee's **priorities for 2023/24** (implementation of the quality strategy, and the duty of quality and duty of candour) are progressing well. The Committee also reviewed its progress against its cycle of business.

RISKS

Risks Discussed: There are two corporate risks assigned to the Committee 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. Both have been reviewed in September and the scores remain static. The theme of these risks arose throughout the agenda items discussed at this meeting and are part of the escalation section of this report.

Members were assured that these risks, whilst not moving in score, are dynamically reviewed regularly and are discussed at many of the Board's Committees as well as at internal forums.

New Risks Identified: No formal new risks were identified.

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

COMMITTEE AGENDA FOR MEETING		
Operations Directorate Quarterly Report for Q2	Patient experience	Putting Things Right Report Q2
Quality Impact Assessments (financial savings for NEPTs and Mid and West Wales Fire and Rescue Services)	Spotlight on clinical indictors: Return of spontaneous circulation (ROSC) rates	Monthly Integrated Quality and Performance Report
Learning from Mortality Reviews	Duty of Quality/Duty of Candour Implementation	Mental Health and Dementia Annual Report
Patient Experience and Community Involvement bi-annual report	Clinical Audit Monitoring Report Q2	Information Governance Report
Risk Management and Board Assurance Framework Report	Policies for approval	Internal Audit Tracker Update
EMS Clinical Contact Center HIW Update	Committee priorities 2023/24	Patient Story Update

COMMITTEE ATTENDANCE				
NAME	**11 MAY 2023**	**10 AUGUST 2023**	**31 OCTOBER 2023**	**8 FEBRUARY 2024**
Bethan Evans				
Kevin Davies			In chair for meeting	
Paul Hollard				
Ceri Jackson				
Liam Williams				
Andy Swinburn		Duncan Robertson		
Lee Brooks	Steve Clinton		Sonia Thompson	
Leanne Smith	Jon Hopkins			
Jonny Sammut				
Rachel Marsh			Hugh Bennett	
Trish Mills				

Mark Marsden				
Hugh Parry				
Ian James				

	Attended
	Deputy attended
	Apologies received
	No longer member

OPERATIONS DIRECTORATE
QUARTERLY REPORT FOR COMMITTEES
2023-24 Q3 (October - December 2023)

National Operations & Support

IMTP

Manchester Arena Inquiry Recommendations

The work on the Manchester Arena Inquiry (MAI) recommendations has now been ongoing for 6 months, and a mid-year review was completed in December. This reviewed progress and scope and subsequently recategorized some of the recommendations, all of which have been approved through the SLT governance process as supported by the ELT. 27 of the 68 recommendations are complete with a few others nearing completion. Work is now focussed on the completion of the assessment of our capacity to respond to an incident and the subsequent outline resource case to the Commissioner which specifically connects to one of the recommendations.

The following table is a status reflection of the 68 recommendations that WAST is working on. It should be noted that the RAG coding is to aid areas for focus for the team; they are not used conventionally.

Priority	Number of Recommendations	Status
Red	7	
Amber	19	
Green	10	
Deferred	5	Other organisation dependency
Complete	27	For approval/closure

One of the recommendations from the MAI is the introduction of two new triage tools for mass casualty incidents. Ten Second Triage (TST) is designed to be used by anyone responding to a major incident to provide care to casualties prior to the arrival of clinicians on scene, and the Major Incident Triage Tool (MITT) is for use by NHS Responders at scene. Work has been ongoing to introduce this new tool within WAST with the UK Ambulance Services go-live date set for 1 April 2024.

New Marauding Terrorist Attack (MTA) Joint Operating Procedures have been rolled out through Pan Wales multiagency training courses; this has been the first-time tri-service courses have been delivered on this scale to so many emergency service personnel.

The ELT is to receive a full update on progress in its face-to-face meeting in January 2024, and work will continue to bring to the ELT the case for investment in response to recommendations for consideration in March 2024. Alongside this, it will be necessary to also provide updates to the EASC Management meeting in February 2024.

General Update

Volunteering Conferences

More than 200 volunteers attended two conferences in September and October with one held in Llandudno and one in Swansea. The agenda was varied with keynote speakers including Figen Murray OBE, the mother of one of the victims of the Manchester Arena bombing who spoke candidly about the loss of her son and public site security. Other sessions included Ten Second Triage, wellbeing, safeguarding, and first-hand accounts from our volunteers themselves. Our volunteers were also presented with awards aligned to our behaviours at a gala dinner in the evening of both conferences. We are grateful to all who participated, our speakers, our sponsor, and of course our volunteers who make these events worthwhile.

Community Welfare Responders (CWR) Pilot

Twelve of our CFR teams have been piloting the Community Welfare Responder role across Wales since 16 October 2023. At the time of creating this report it is too early to confirm success, however, early results are promising. The ambition to upscale the pilot quickly is being explored, with a focus on capacity within CSD. The pilot tests the concept of the welfare responder through existing volunteers. It remains our intent to introduce an additional volunteer role to which we will recruit new volunteers.

EPRR - Mass Casualty Exercise

A pan Wales Mass Casualty Exercise took place in September to test the All Wales Mass Casualty Arrangements. All the Health Boards participated with WAST undertaking the lead facilitator role. Learning has been identified from the exercise which will be incorporated into the All Wales Mass Casualty Arrangements. It is regretful that testing the release of ambulances from an emergency department was not included, which has been considered against our associated corporate risk.

Joint Emergency Services Interoperability Programme (JESIP) Assurance Visit

A JESIP assurance visit to Wales took place in November, with the assurance team spending time with South Wales Police, South Wales Fire and Rescue and visited WAST on 15 November. This was a pilot visit to review the feasibility of a national assurance program to include devolved nations; however, it also gave WAST the opportunity to have the Trust's compliance with JESIP assessed by the national JESIP team. A report following the visit has been received and will be reviewed for any follow up actions.

Review of Key Plans

During Quarter 3, a number of key plans have been refreshed or rewritten as part of the annual review process. These include:

1. **REAP – Resource Escalation Action Plan**
   In November version 4.1 of the Trust's REAP plan was published. This plan provides the ability to manage our response in situations where demand or other significant factors within the service see an increase, and any challenge to the capacity to manage these demands.

2. **Incident Response Plan (IRP)**
   In November, Version 2.0 of the IRP was released. In light of a number of incidents, changes to key pieces of national guidance, and the release of the Manchester Arena Inquiry reports alongside learning from internal debriefs, the IRP underwent a significant rewrite rather than a simple refresh. It was approved by the ELT and will be presented to the F&P Committee in its usual annual assurance.

3. **Clinical Safety Plan (CSP)**
   In December, Version 2.2.1 of the CSP was released. The CSP provides a framework for WAST to respond to situations where the demand for emergency services is greater than the available resources. This update was a relatively minor update reflecting evolutionary change to CSP with a wider review planned for 2024.

Resourcing, EMS Coordination & Quality

Challenges

Resourcing
High abstraction rates across operational areas and governance in relation to financial savings targets have resulted in an increased workload for the Resource Team. Skill mix remains challenging in some areas particularly Powys due to the numbers of NQPs recruited into paramedic vacancies, with the team continuing to work closely with local management teams.

EMS Coordination
As winter pressures increase, the service is seeking to train and recruit 4 EMD cohorts in Q3 with a view to fully rollout by the end of the financial year. The service continues to support London Ambulance Service with call handling since July 2023. The capacity levels allowed the service to assist LAS with 5% of their calls per hour between the hours of 15:00 – 03:00 each Sunday for 12 weeks and concluded on 31/10/23. This provides income to WAST without detriment to our own service levels as these continue to be monitored closely.

Operations Quality
The outstanding tasks sitting with the Operations Quality (OQ) Concerns Team is at 168. This is down from 209 in Q2. The OQ Team continues to work closely with the Putting Things Right (PTR) Team to prioritise work to meet deadlines and requests. The additionality to the Concerns Team will be realised in January 24 as four WTE ISOs have been appointed. Concerns returns within the Tier 1 target time reduced in Oct and Nov 23 to 70.6% and 67.6% respectively, but this was due to a number being sent to OQ a number of days after they had been registered by the Trust and those awaiting consent. December 23 is in a healthier position at 81.3%, and those concerns with no consent will be investigated in time order with other concerns from Jan 24.

Coroner statement demand remains high; however, 17 coroner's statements are outstanding which is down from 24 in Q2. The majority of these statements have been written and are either in QA or with Legal Services for review. It is anticipated that the coroner statement position will continue to improve once the backlog has been fully addressed and an assurance SBAR went to SOT/SLT to update which was received well.

NRIs remain high at 33 outstanding. The International Academies of Emergency Dispatch (IAED) has audited a number of the ineffective breathing calls and plan to review the remaining before Christmas. An approach to address the learning on ineffective breathing is being developed and an SBAR is being prepared for SOT /SLT and CQGG for January 24.

IMTP

Resourcing Rostering Systems Manager
We have welcomed James Roberts to the team in the new post of Rostering Systems Manager. James who was previously an ICT SQL Systems Engineer, returns to resourcing where he began his WAST career in 2009 as a coordinator. James is a welcome addition to the team and will play a key role in system development and improvement, to streamline current manual processes, and improve capacity within the team. Over 34 workstreams have been initially identified in a comprehensive project plan, to include a review of the ESR/GRS interface, GRS Everbridge and GRS CAD.

Resourcing Policy
The relief planning pilot for 5-week roster publication went live on 25 September for rosters published to 30 October. Monitoring and evaluation will take place monthly from November, and evaluation metrics will include a comparison of UHP, abstractions and additional resources at publication (5 weeks vs 4 weeks vs actual post-production)

EMS Coordination Reconfiguration
The current IMTP (legacy) deliverable of reconfiguring EMSC has now been replaced by a proposal for a revised leadership structure, which will also incorporate the original single allocator model and dispatch boundaries recommendations.

Initial work was carried out to progress the boundaries recommendation in early 2023 and it became clear that Project Board were keen to refresh the data to ensure that the original (2017) paper and therefore data remained valid in the current context. As a result, further modelling was carried out by ORH in September 2023 that considered more recent and up to date data (Sept 2022 to May 2023). The revised D&C recommendations (Sept 2023) were considered as part of the wider EMS Coordination Reconfiguration Project and an initial paper has set out a proposed structure that will provide a leadership structure that is fit for purpose but will also address the two outstanding recommendations (noted above) from the original ORH Report in 2017.

The final paper will be submitted to colleagues and will be shared with Trade Union in partners in January and all elements will feature as part of the Organisational Change Process (OCP).

Bryn Tirion Relocation.
On the 9 October 2023, the inaugural Bryn Tirion Project Board was held to explore options available to relocate staff from the Bryn Tirion site. It has been broadly accepted that the site is not fit for purpose and as a consequence, monies have been set aside from this years' Discretionary Capital budget to relocate staff to a more suitable premises. At the Project Board on the 16 November 2023 an options appraisal of three options for potential new

locations was undertaken, with Ty Elwy being selected as the preferred relocation site. This was ratified by the Strategic Transformation Programme Board on the 27 November 2023.

It is recognised that the decision to move from Bryn Tirion to Ty Elwy, which is some 25 miles further east, is going to be challenging for some of our staff. As a result, a small space has been identified in the Snowdon House facility in Bangor to accommodate staff who would be unable to move to Ty Elwy. This does not in any way reduce the 111 desk numbers in Snowdon House but does involve some minor alterations to the internal infrastructure to release the additional capacity. An OCP process has been instigated and People Services have been engaged to support staff with identifying the main issues and 1:1 session to scope the impact on individuals.

It is acknowledged that the actual relocation of staff from Bryn Tirion is unlikely to happen before June / July 2024 as there is work required to ensure the space set aside in Ty Elwy meets the specific requirements set out by the teams and to enable the necessary technology requirements to be delivered.

General Update

Death of Michelle Perry, Emergency Dispatch Quality Improvement Manager
In November, we announced the sad death of our colleague Michelle, who died peacefully surrounded by her family. Michelle joined the Trust in 1999 having previously worked for Mid and West Wales Fire and Rescue Service. She progressed from a 999 call handler into dispatch and then into learning and development roles within EMSC before becoming an MPDS Facilitator in 2011. Michelle was much loved and respected by colleagues not only in Operations, Quality and EMS Coordination, but throughout WAST and the International Academy of Emergency Dispatch (IAED) who invited Michelle to become a member of the accreditation panel, such was her expertise. We were fortunate to benefit from Michelle's character and knowledge, and she will be sadly missed.

Culture and Behaviours
The Resource team are to be part of a culture pilot supported by People Services. A questionnaire on team behaviours will be circulated during November, followed by an Insights questionnaire during December with an ambition to facilitate a pan Wales workshop in Q4.

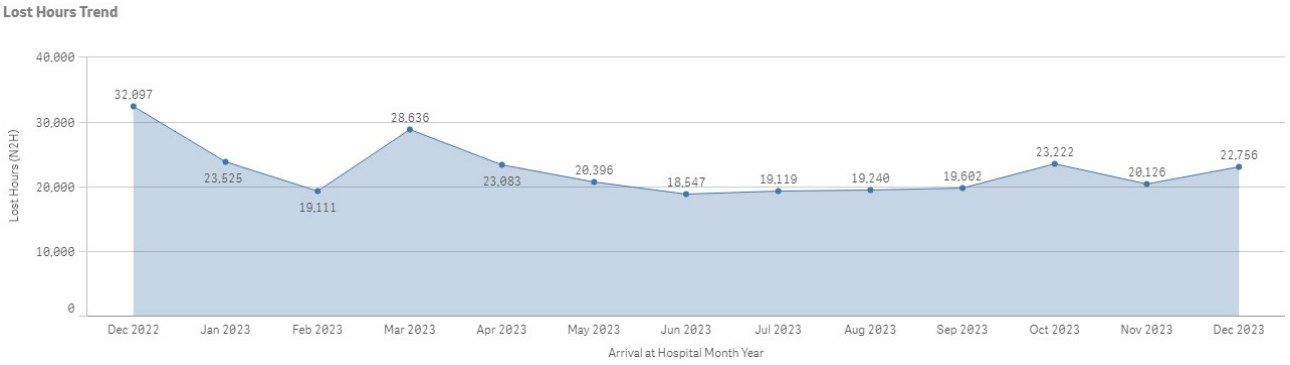
IAED Accreditation
The Trust was awarded reaccreditation for MPDS by the IAED at the UK Navigator Conference. The Trust is now a dual accredited organisation as it was awarded ECNS accreditation for the first time.

EMSC Staff recognition
Members of EMS Coordination in the north were nominated for EMD of the year with one staff member winning, two shortlisted and seven runners up. Four members of EMS Coordination were nominated in the staff awards, all of whom were successful.

Emergency Medical Service

Challenges

Delayed handover of care at Emergency Departments across Wales remains a significant challenge in being able to provide a safe level of emergency service. 19,119 hours were lost in July, 19,240 in August, 19,602 in September, 23,222 in October, 20,126 in November, and 22,756 hours in December. The detrimental impact of the resultant pressure is regularly discussed at Committee and Trust Board.



Overtime Controls

Financial savings is on plan, and in some areas had overachieved on modelling and assumptions. As part of this savings plan, EMS Response has continued to control the level of overtime allocation. However, the overtime allocation allowance for December allows for additional resourcing to respond to the expected increased demand in the build up to Christmas and on key dates. Original data identified predicted UHP levels as a result of implementing the savings plans. The reduced overtime allocation commenced on 1 July 2023 and the resultant UHP levels have been extremely close to the original plan predictions (for example, in October UHP modelling predicted 35% abstractions, with an end of month position of 34.77% abstractions, ranging between 30.89% - 38.49% across the Health Board areas), with monitoring through the Senior Operations team and Senior Leadership Team. Despite controls, not all available overtime has been taken up. Overtime allocations have been determined for the rest of the year and will continue to be monitored closely, redistributing money should it be unspent.

Visit from Health Minister, Eluned Morgan

In December, WAST was pleased to host a visit from Health Minister Eluned Morgan. The Minister spoke with operational crews and attended two incidents including a red release to a cardiac arrest call. Following this, the Minister visited Vantage Point House and attended EMS Coordination and CSD spoking with the CSD Service Manager and team about the work of the Clinical Support Desk, and how CSD is supporting patients who have accessed 999 with alternative appropriate opportunities to access care, safeguarding those that may have a significant wait for an ambulance response and providing remote clinical support for non-clinical staff attending scene. The Minister has thanked the Trust for hosting the visit.

IMTP

IMTP deliverables are on target with the current arrival of Big Bang NQPs making a big difference to the rural (Powys, BCU etc) vacancies and rural recruitment. Retention is often a challenge however and so it will be important to monitor transfer requests.

General Update

Winter Planning
Winter Planning progressed well with the Senior Planning Team stood up during November with a remit to oversee all winter planning arrangements, including planning for any impact of the Junior Doctor Industrial Action scheduled for January 2024.

Ambulance Care

Challenges

Net Centre
Call taking via the NET Centre continues to be a challenge. Whilst there has been a good period of stability with performance, retention of staff has had a detrimental effect on the consistency during peak periods of demand.

Demand
Demand for the service continues to increase as NHS planned care services increase activity. This is particularly the case for those patients requiring ambulance conveyance where activity levels are now in excess of those seen prior to the pandemic. It is not clear at present what is driving this shift in accuity.
Of particular note is Renal activity, which continues to trend at a level higher than the historically funded average. Like other areas of the service patients requiring ambulance conveyance seem to be increasing more rapidly, in August Renal patients requiring ambulance conveyance were higher than at any point over the last 5 years.

This is impacting on wider service delivery as the service prioritises renal transport provision. Forecasts from the Welsh Kidney Network indicate that this growth will continue by 5% per annum.

The Ambulance Care senior team are working closely with commissioners to ensure that the appropriate capacity exists to continue the good levels of performance currently seen within the renal transport service.

Volunteer Car Service Capacity
During the pandemic a considerable proportion of the Volunteer Car Service drivers were either requried to or chose to stand down from active volunteering. This reduction in capacity was offset by a subsequent reduction in demand following reduced planned care activity.

However, as planned care activity increases the ability of the service to absorb additional demand, particularly for Oncology patients, is compromised.

In response, the National Volunteer team is working on increasing VCS driver numbers from 100 to 200 by the end of the financial year. Good progress with recruitment of new volunteer drivers has been made already with 10 new drivers recruited by November and 51 new drivers planned to be in place by end of February 2024.

General Update

CMP (Capacity Management Plan)
The team has reviewed the current Capacity Management Plan, which sets out how the service applies the Welsh Government WHC 2007(005) eligibility criteria for non-emergency transport and the process for managing scenarios where demand for transport exceeds available capacity.

The revised plan, which has been through a EQIA and QIA process, modifies the approach to a position where the service will only take bookings from patients that meet the criteria as per the Welsh Health Circular. Patients who do not meet the eligibility criteria will not be entitled to Non-Emergency Patient Transport and will be signposted to alternative transport solutions only. This plan has been shared with CASC and supported at the DAG meeting.

This refresh will further align the service the Welsh Health Circular, whilst also ensuring that patients that are eligible for transport, in particular those within the enhanced service category, continue to receive the best possible service.

Vehicles development
The delivery and operational roll out of the new B class MAN Ambulances commenced in November. The vehicles will be trialled by UCS colleagues in Barry, Bassaleg and the Grange transfer team. As the vehicles are a very different concept to those currently in service, a full review will be completed and will incorporate colleague feedback and data to help inform decisions on future design.

Integrated Care

Challenges

111
Welsh Language Performance

The 111 Operations team have deployed an action plan designed to improve Welsh call answer performance, specifically the percentage of callers answered in Welsh where this is their chosen language. Performance has been consistently improving and throughout Q3 has remained stable.

Dental Performance
Delivery of the 111 urgent dental care performance indicators has been previously challenged, principally due to the relatively high absence rates within the Dental Advisor Team and vacancies which had been held open in order to support the Directorate savings plan. However, urgent dental care performance is now at 90% as staffing has stabilised.

IMTP

CSD
ECNS Accreditation
The Trust received confirmation on 14 September 2023 that following a review by the Board of the International Academies of Emergency Dispatch (IAED) that the Welsh Ambulance Service was approved as an Emergency ECNS Dispatch Centre of Excellence.

Consult and Close
Work against the consult and close action plan continues. Although consult and close incidents have increased, verified incidents have also increased and therefore percentage of consult and close compliance remains around 14%. Action plan activities therefore continue with a review of triage processes which may lead to shorter triage durations, along with an increase in staffing, which together will enable more triages to take place thus increasing the percentage of consult and close towards the 17%.

General Update

111
Time to Triage
The current 'time to triage' performance is mostly within the KPI standards. However, work has been done to identify opportunities to maintain this performance during the winter season. This was discussed in the 111 Performance Review Group, and as a result, a workshop took place in October. An action plan has been developed, which is overseen by the 111 Performance Review Group.

Business Continuity Exercising
From October, a series of business continuity exercises and training sessions commenced for all 111 operational managers, including Tactical Leads, SCAs, and CHCs. This training involves the EPRR team and the Digital Directorate. Its purpose is to ensure that all 111 managers are well-versed in the 111 business continuity plans and the relevant organizational procedures.

CSD
Police Pilot
Through agreement in the Joint Emergency Services Group (JESG), a second CSD Police Pilot commenced in September 2023. An earlier pilot had low take up, so subsequently the second pilot encompasses a greater geographical area. The trial includes South Wales Police and Gwent police forces and will run for 3 months. The purpose of the trial is to

broaden the Remote Clinical Support offer to Police for circumstances where Officers on scene with a patient are waiting for an ambulance response.

Recruitment

Four clinicians joined CSD in September 2023 with a further eight in November. An additional two Mental health clinicians and a trauma desk clinician have also been recruited and the FTE is now at full capacity for the challenging winter months.

Opportunities for promotion within the team have included one PPED colleague being successful in obtaining a position as Senior Practice Educator and a full time Duty Operations Manager position which has also been filled by a member of the team.

Patient story Tracker
Alison Cassidy

Alison's daughter, Emma, has a rare genetic disorder, severe learning disabilities and epilepsy. She needed urgent dental care requiring general anaesthetic at Glan Clwyd Hospital (regular sedation did not work on her). Was advised by HCPs to access NEPTS to take Emma to her appointment , she was unable to be transported safely due to seizure risk being elevated by the dental pain. NEPTS advised t at least 24 hours' notice needed. Alison told to ring 999; due to system pressures 999 response unavailable. In Emma's escalating distress, she began exhibiting self-harming behaviour, this triggered an "attempted suicide" script from CCC call-taker. Alison believes it was entirely inappropriate and indicative of how AMPDS scripts do not have capacity to effectively assess people with learning disabilities.
After 28hrs Emma was sedated by LD Liaison nurses in the garden at home, supervised by two NW Police officers who arranged a taxi to take Emma with her siblings to hospital. Alison has subsequently been advised that if an HCP had made the request for NEPTS transport it would not have been subject to the need for 24 hours' notice. None of the HCPs involved, nor the NEPTS or CCC staff appeared to be aware of this.

Themes identified

A) Lack of clarity regarding HCPs being able to request NEPTS transport sooner than 24 hours' notice.
B1) AMPDS scripting does not have sufficient capacity to assess people with learning disabilities.; B2) concern that the structure of the 999 script were not flexible for Emma; B3) each time a repeat call is made it 'wipes the slate clean'.
C1) System pressure contributing to delayed responses to 999 amber calls; C2) failings happened because planned care became an emergency.

goal

- Put in place process to ensure seamless access and communication between planned and emergency care/need.
- Consideration for the health, safety and welfare of patients with LD; better integrated awareness of the risks associated emergency care for LD patients, along with an understanding of their specific needs to minimise potential for problems to occur.
- Strengthen communication between HCP and WAST regarding access and transport

Primary drivers

- Pathway that uses ACA2 resource to bridge gap between planned and emergency care.
- Introduce flagging system to identify patients with learning disabilities to increase level of appropriate response.
- Update communication with HCP on access to NEPTs transport
- Scope ability to 'make reasonable adjustments' for those with LD within CCC.
- Collate experiences of callers/patients with LD to have a baseline of data to build upon.

secondary

Local Learning:

- Datix record learning needs to assist with flagging, thematic review etc.
- Access Bespoke care plans for known patients with complex needs
- Review training on LD for staff working within WAST and especially CCC.
- Identify future delivery models and staff training needs.
- Volunteer training - consider learning disabilities.

actions

- Disseminate up to date information to HCPs on contact numbers and access routes to access emergency & non-emergency transport.
- PECI to capture PREMs data of callers/patients with LD.
- Improve ability to capture LD data from staff at scene.
- Explore external funding opportunities for an LD expert within WAST to drive quality.
- Explore potential of LD expertise within CCC"
- Explore training requirements of Mental Health Practitioners on LD and pathways.

RESPONSIBILITY FOR ACTIONS

- NEPTs and Trusts Communications team to pull together numbers and pathways for HCPs to use.
- PECI to work with Once for Wales team on proposal for national LD experience survey.
- PECI team working with ePCR team and training school.
- Mental Health lead/PECI to review training needs of MH Practitioners
- PECI explore externally funding opportunities.

progress

- Funding secured to develop the ePCR functionality to capture LD data.
- A Task and Finish group is looking at maximising data captured through the system.
- The LD module on WAST's OnClick page has been completed by over 642 participants and compliments the mandatory Paul Ridd foundation training on ESR.
- Currently in conversation with Improvement Cymru and NHS Executive on funding opportunities.

outcome

Story action timeline

Date of incident	Start of PTR process	Investigation outcome letter sent	PTR/CHC meeting with Alison	CHC request to record story	Video recorded	Story played to QMG	Story played shared with BCUHB
August 2021	September 2021	December 2021	October 2022	April 2023	July 2023	October 2023	October 2023

Updated
17 October 2023
v3

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

PUTTING THINGS RIGHT REPORT
QUARTER 3, OCTOBER - DECEMBER 2023

MEETING	Quality, Patient Experience & Safety Committee
DATE	8 February 2024
EXECUTIVE	Liam Williams, Executive Director of Quality & Nursing
AUTHOR	Wendy Herbert, Assistant Director of Quality & Nursing
CONTACT	Wendy.Herbert3@wales.nhs.uk

EXECUTIVE SUMMARY

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

In summary the Report for Quarter 3, 2023/24 highlights:

- Continued high level of risk of harm to our patients in community (Corporate Risk 223 rated 25) and patients delayed outside of Emergency Departments (Corporate Risk 224 rated 25).
- A sustained increase in the number of concerns received.
- A continuing high volume of incidents being reviewed at the Serious Case Incident Forum (SCIF).
- A continuing number of Joint Investigations passed to Health Boards.
- A small reduction in the number of Nationally Reportable Incidents (NRIs) identified.
- An overview of incidents meeting the Duty of Candour threshold.
- A continued upward trend in Coroner's requests for information.
- A sustained increase in the number of Road Traffic Incident claims.
- The Trust received 1 Regulation 28 Report during this period.
- The PTR Organisational Change Process has concluded and recruitment to posts is in progress. The new structure is expected to be fully established by April 2024.

RECOMMENDED that the Quality, Patient Experience & Safety Committee receives the report for discussion and identifies any additional assurance requirements.

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) Our thirty-day compliance remains lower than the 75% target but has seen an incremental improvement month on month this quarter. (iv) Delivery of functions remains a significant challenge due to capacity, demand and competing priorities but recruitment to posts is progressing positively.

REPORT APPROVAL ROUTE	
Clinical and Quality Governance Group	24 January 2024
Quality, Patient Experience & Safety Committee	8 February 2024

REPORT APPENDICES
ANNEX 1 - SBAR Report

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

ANNEX 1

SITUATION

1. This Putting Things Right (PTR) Report covers the period from 1 October to 31 December 2023. Table 1 and the 'PTR Overview' overleaf provide an 'at a glance brief' of comparison data quarter on quarter and over on a twelve-month rolling period across each of the functions.

2. This Report covers the PTR functions which broadly includes:

- Patient safety (proactive & reactive).
- Patient/family complaints.
- Patient/family compliments.
- Ombudsman relationships, information sharing, reports, and responses.
- Coroner relationships, information sharing, reports, and responses.
- Redress cases.
- Claims cases.
- Organisational learning (including Learning from Events and Welsh Risk Pool submissions).

3. Please note that the data contained within this report is accurate at the time of reporting. The Quarter 2, 2023/24 PTR Report highlighted a backlog in processing complaints which impacted on the September 2023 data period. This data has been updated and reflected in this report. Data may be subject to change following the Investigation Process including regrading of incidents.

BACKGROUND

4. The PTR Team Organisational Change Process aims to provide additional leadership, capacity and development opportunities across the functions. The new structure was put in place in December 2023 and recruitment to positions is progressing. As of 14 January 2024, nine posts are yet to be recruited to. It is anticipated that the structure will be fully established by April 2024.

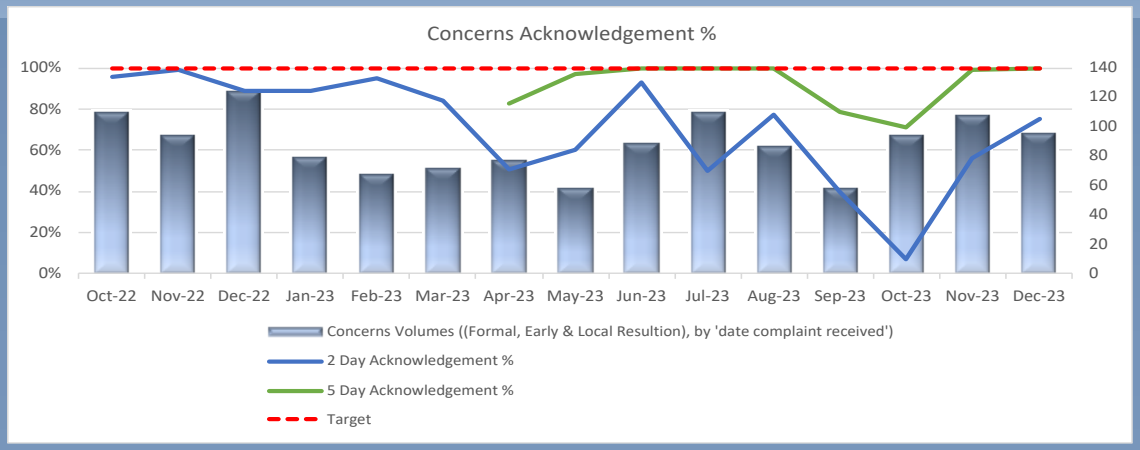
5. The ambition in future reports is to move to aggregated thematic reviews, in order to determine patterns and trends corporately and at service and Health Board levels.

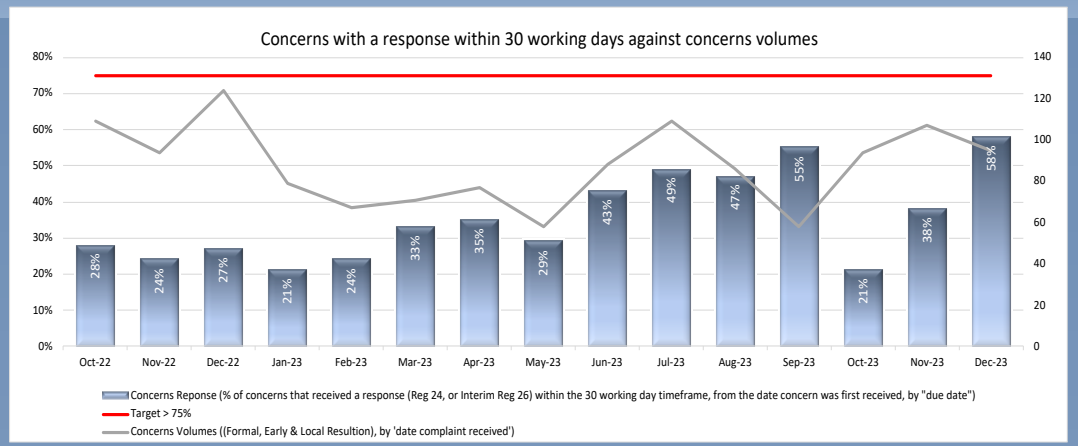
ASSESSMENT

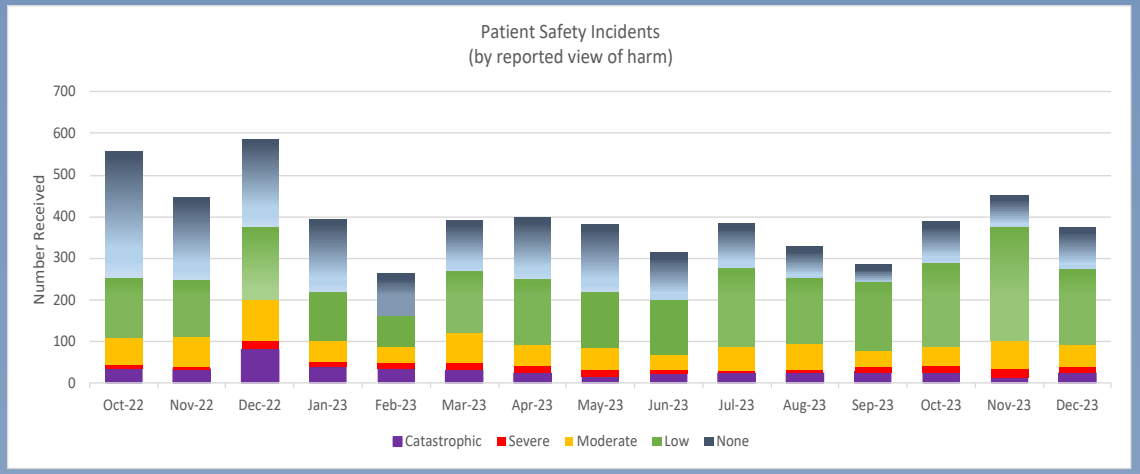
Table 1

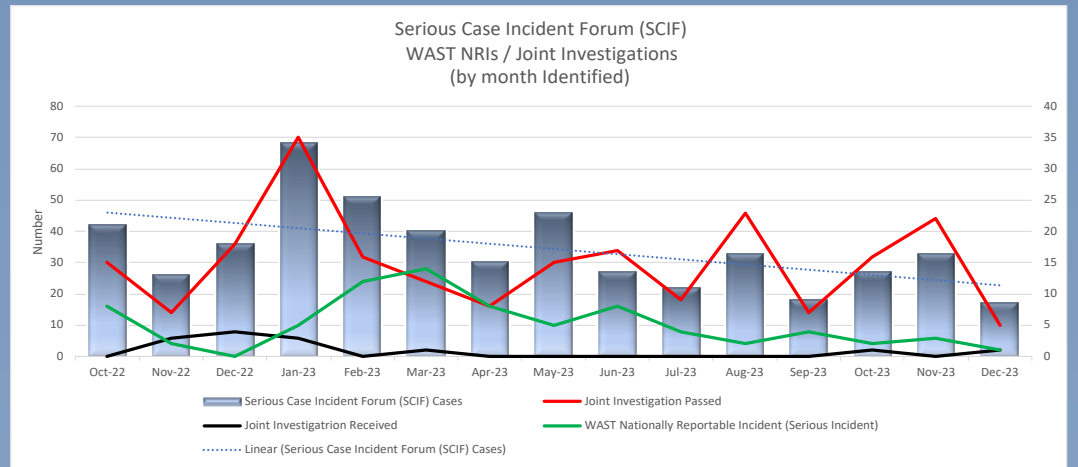
PUTTING THINGS RIGHT						
Comparison of Data Quarter / Year	Quarter 3, 2022-23			Quarter 3, 2023-24		
	October	November	December	October	November	December
	2022	2022	2022	2023	2023	2023
Patient Safety Incidents (Reporters view of harm)						
Catastrophic	37	34	82	27	13	25
Severe	8	7	21	16	22	16
Moderate	64	70	99	48	69	51
Low	146	136	175	200	275	184
None	303	201	209	97	72	97
Total	558	448	586	388	451	373
Concerns						
Total Received	109	94	124	94	107	95
Political Concerns	13	10	11	8	2	4
2 Day Acknowledgment %	96%	99%	89%	7%	56%	75%
5 Day Acknowledgement % (new April 2023)	-	-	-	71%	99%	100%
30 Day Response due %	28%	24%	27%	21%	38%	58%
Ombudsman						
Cases Received	2	4	2	4	4	3
Cases Closed	1	5	8	1	1	7
Reports Received	0	0	0	0	0	2
Coroners						
Information Requests	157	160	148	185	193	207
Identified as Interested Party	20	23	26	42	46	42
Staff Attending	3	3	4	7	5	6
Regulation 28 Issued	1	1	0	0	1	0
Response to Regulation 28 outside 56 working days	0	0	0	0	0	0
Nationally Reportable Incidents (NRIs) to NHS Wales Executive (Reporting date)						
Serious Case Incident Forums held	6	5	7	6	7	5
Serious Case Incident Forums Cases	42	26	36	27	33	17
WAST NRIs reportable to Delivery Unit	9	2	0	2	3	1
Joint Investigation Framework - Passed	15	7	18	16	22	5
Joint Investigation Framework - Received	0	3	4	1	0	1
NRI Closures Submitted - Total	6	3	6	3	4	2
Claims						
Personal Injury – Received	1	4	1	3	3	0
Personal Injury – Closed	0	0	4	0	0	0
Clinical Negligence - Received	0	*	1	5	6	5
Clinical Negligence - Closed	4	*	0	0	1	1
Road Traffic Collision & Damage to Property – Received	17	30	26	29	13	25
Road Traffic Collision & Damage to Property – Closed	16	37	20	5	15	22

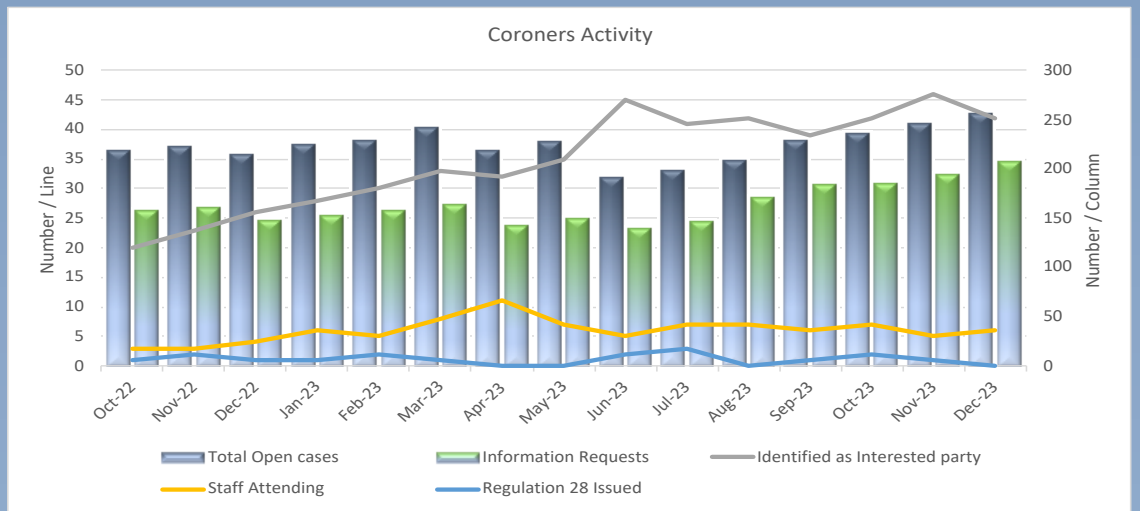
Putting Things Right Overview

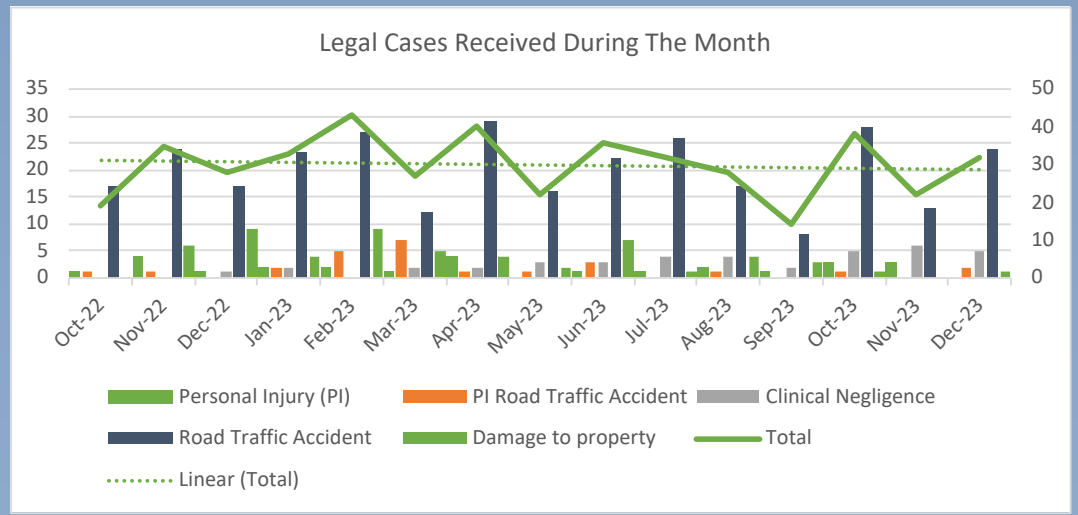












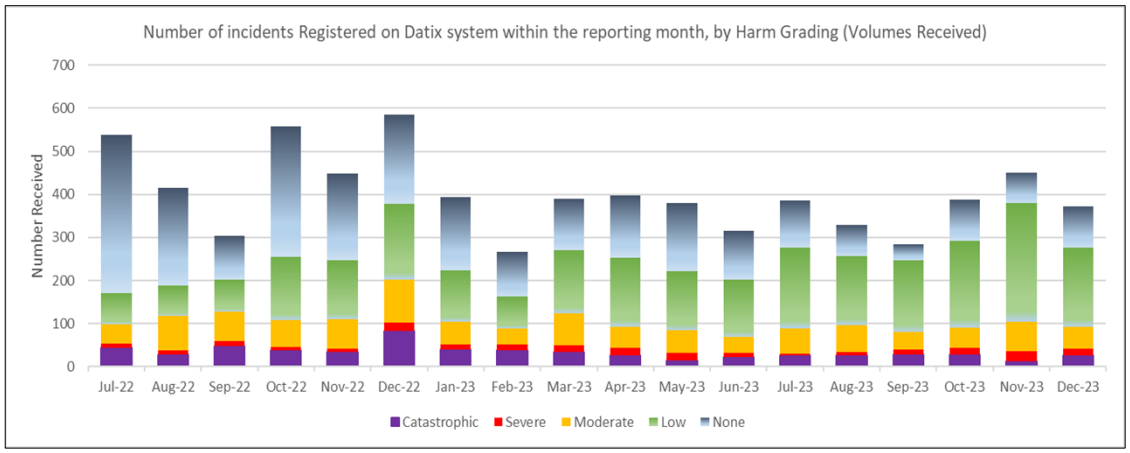
Patient Safety Incidents

6. 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).

7. During this period a total of 1,212 patient safety incidents were reported, 388 in October, 451 in November and 373 in December. It must be noted that the harm grading may change subject to the outcome of any investigation.

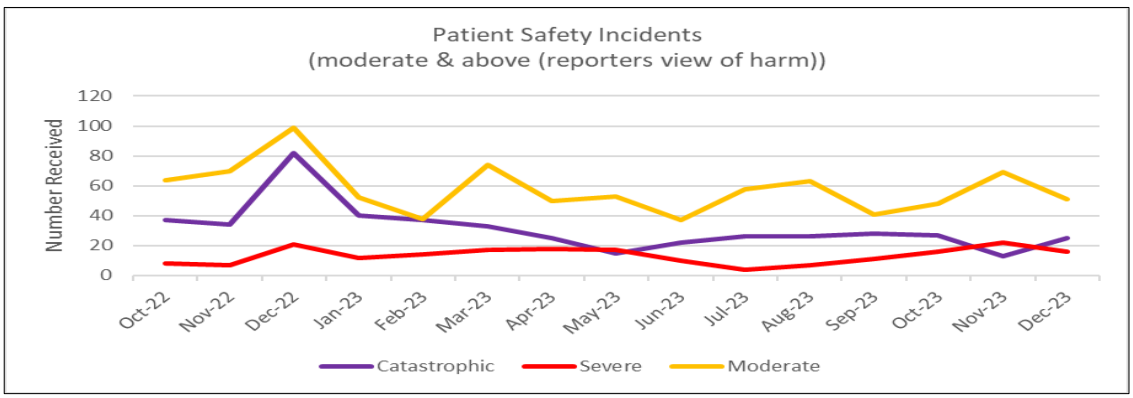
8. The graph below illustrates the number of patient safety incidents reported on a rolling basis from July 2022 by initial grading (reporters view of harm). Themes continue to be timeliness to response and handover of care delays.

Graph 1



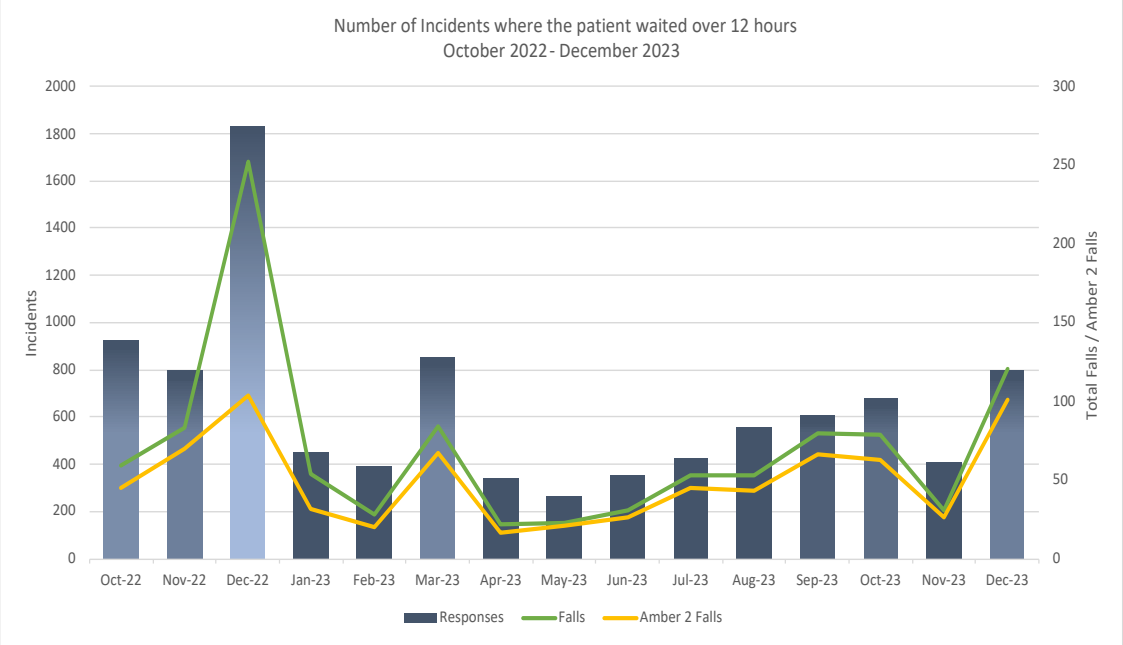
9. Graph 2 below details the number of patient safety incidents rated moderate and above. The Patient Safety Team continue to review incidents graded moderate and above to determine any Duty of Candour (DOC) requirements. Data and information on the enactment of Duty of Candour is included later in this Report.

Graph 2



10. Patients waiting for extended periods of time in the community continues to impact on patient safety as detailed in Graph 3 below. During this period 1880 patients received a response or wait over 12 hours.

Graph 3



11. 231 of the patients waiting over 12 hours had experienced a fall, with the longest waiting patient being 45 hours and 04 minutes. A review of this case has been requested following an initial screen of the sequence of events.

12. 101 (43%) of the patients in this cohort resided at either a nursing or residential care home. Further wider analysis of the data is planned to identify any themes and trends to determine next steps which could include engaging with the All Wales Prevention of Patient Falls Network.

13. Following a review of the care of the patient who waited the longest period of time following a fall in the Quarter 2 Report, the review indicated that the response the patient received was in line with Trust plans as all other calls were categorised as Amber 1. The Trust did receive a complaint from the family in relation to this case which has been responded to.

14. 190 of the 231 patients were in the Amber 2 category for response. It is well documented that this cohort of patients, who are frequently elderly frail, will experience additional harm due to the protracted delays including pressure damage, acute kidney injury, deconditioning and poorer outcomes. Table 2 provides a breakdown of where patients waited by Health Board area.

Table 2

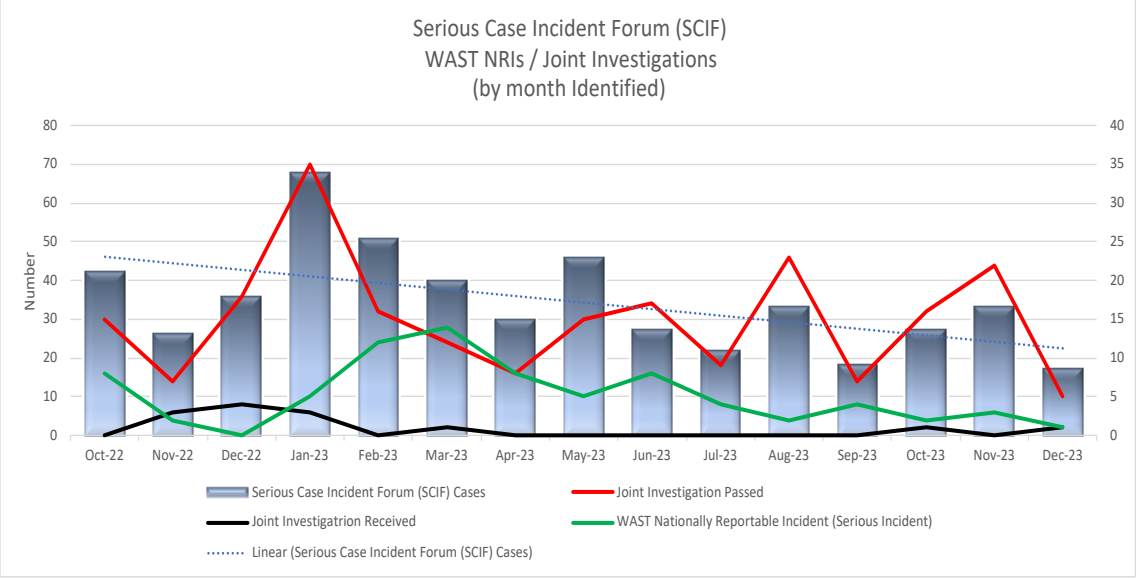
Health Board Area	Number of Patients who have fallen and waited over 12 hours for a response. October to December 2023
Aneurin Bevan UHB	31
Betsi Cadwaladr UHB	72
Cardiff & Vale UHB	11
Cwm Taf Morgannwg UHB	48
Hywel Dda UHB	30
Powys Teaching HB	3
Swansea Bay UHB	36
Total	231

15. Identification of patient harm across the whole Urgent Care Pathway is challenging, as impacts are not always immediately apparent. The Patient Safety Team are working with tissue viability colleagues nationally. A meeting is planned on 17 January 2024 with colleagues from the All Wales Tissue Viability Network to determine next steps in identifying avoidable harm across the system in respect of pressure damage, including information sharing and WAST's role in Health Board pressure damage panels.

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

16. Graph 4 below details the number of cases discussed at the SCIF and those reported either to the Health Boards for further investigation under the Joint Investigation Framework and those reported and investigated internally. Incidents not reaching the threshold are managed as lower graded patient safety incidents.

Graph 4



17. During this reporting period there were 18 SCIF meetings held, with 77 incidents discussed. 6 incidents have been reported as NRIs to the NHS Wales Executive and included clinical practice issues, delayed diagnosis and patient injury whilst being conveyed.

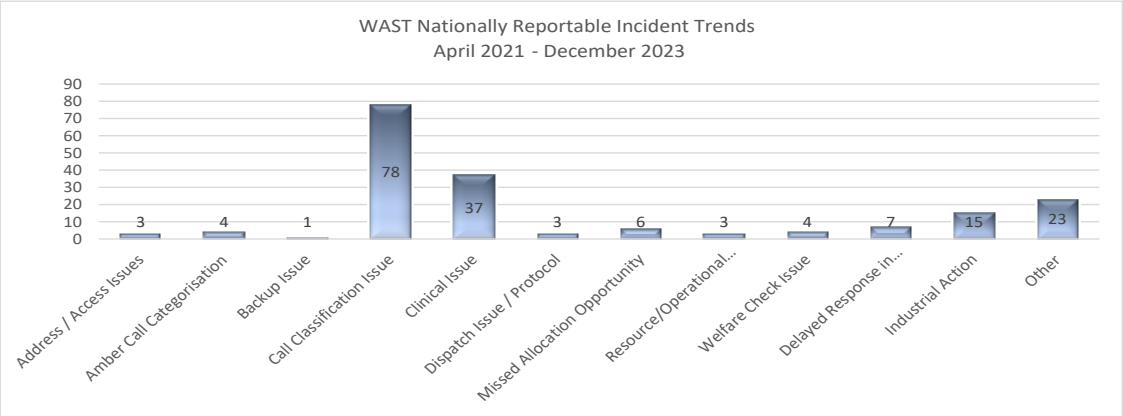
18. 43 incidents were referred under the Joint Investigation Framework to the respective Health Board following a review internally during the period. No recorded incidents linked directly to the refusal of immediate release requests were identified.

19. General themes received from Health Boards following joint investigations remain the same with over-crowded Emergency Departments and wider system pressures resulting in high levels of escalation and discharge delays.

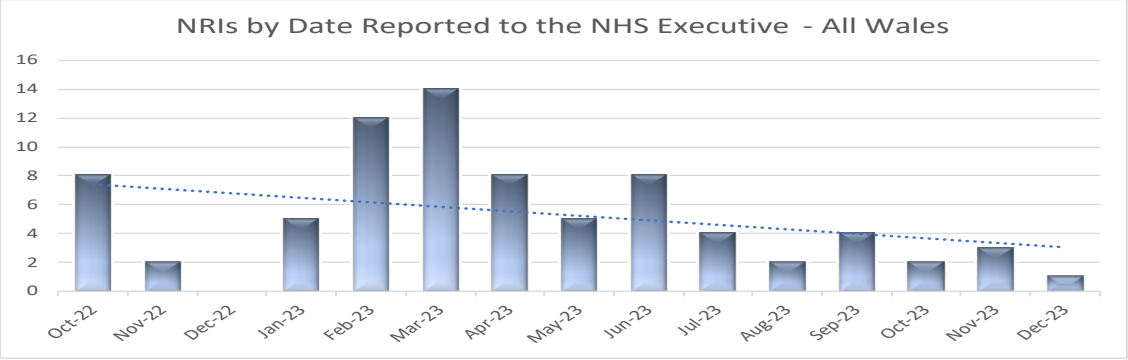
20. One of the Patient Safety Team's priorities following the recruitment to the new structure is to work with system colleagues to identify more meaningful patterns, themes and trends and associated learning opportunities from the Joint Investigation Process.

21. Graph 5 below provides an overview of the themes of Nationally Reportable Incidents (NRIs) from April 2021. Graph 6 provides the numbers of NRIs reported over a rolling twelve-month period.

Graph 5



Graph 6



22. The Patient Safety Team have undertaken a review to align the previous WAST Datix reporting codes to the new All Wales Datix Cymru national codes to improve data capture and analysis. The codes sets are set out in 3 layers and the overarching code set is very broad and limits analysis. Table 3 and 4 provide a breakdown of the current open NRIs (n=59). A high proportion of frequently used WAST codes sit under 'Access, Admission' to Services detailed in Table 3. The subcategory codes provide better analysis and as such the plan is to use these for reporting purposes in future reports (Table 4).

Table 3

Classification	Aneurin Bevan	Betsi Cadwaladr	Cardiff & Vale	Cwm Taf Morgannwg	Hywel Dda	Powys	Swansea Bay	Total
Access, Admission	8	10	6	6	1	1	4	36
Accident, Injury	1			1				2
Assessment, Investigation, Diagnosis	3	1						4
Assessment, investigation, diagnosis (clinical care)		1						1
Behaviour (including violence and aggression)	1							1
Infrastructure (including staffing, facilities, environment)		1						1
Maternity adverse occurrence	1							1
Monitoring, Observations							1	1
Patient/service user death	1			1	3		1	6
Patient/Service User Death (RTC)		1						1
Pressure Damage, Moisture Damage		1						1
Treatment, Procedure	3		1					4
Grand Total	**18**	**15**	**7**	**8**	**4**	**1**	**6**	59

Table 4

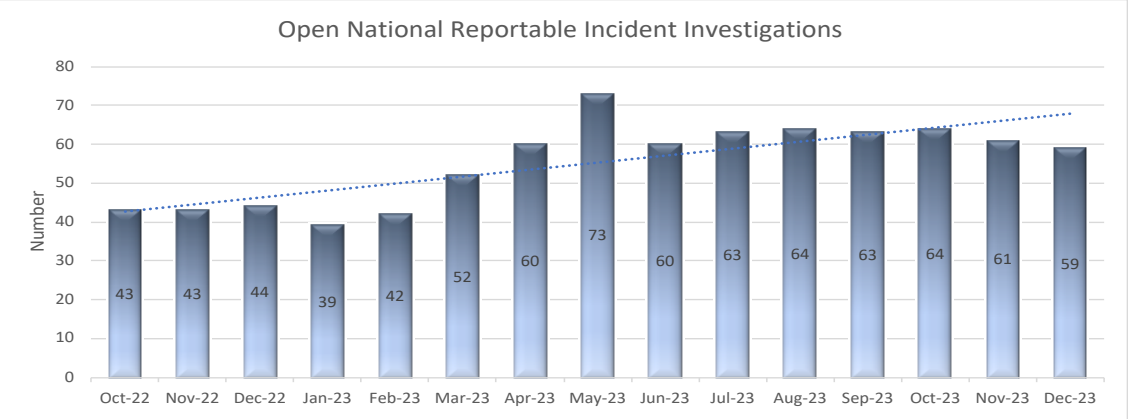
Datix Sub Category	Aneurin Bevan	Betsi Cadwaladr	Cardiff & Vale	Cwm Taf Morgannwg	Hywel Dda	Powys	Swansea Bay	Total
Access to admission delayed	4		1			1	1	7
Access to services delayed	1	1		1	1		1	5
Adult (not known to mental health services)	1				2		1	4
Allocation delay - No / lack of available resources	2	9	3	3			2	19
Care not as directed / clinical practice guidelines not followed	2		1					3
Child/adolescent (not known to mental health services)				1				1
Clinical Assessment, Clinical Diagnosis		1						1
Delay - nearest available resource not allocated				1				1
Delay due to escalation Deployment Management Plan (DMP)	1		1					2
Delay in accessing location/address			1					1
Delivery of baby with no professional in attendance (e.g. Born before admission (BBA))	1							1
Diagnosis delayed	1							1
Failure to monitor patient/service user adequately							1	1
Failure to resource service adequately		1						1
Inadequate clinical assessment	1							1
Injury of unknown origin / unwitnessed	1							1
Involving ambulance (patient on board)				1				1
Medical Priority Dispatch System (MPDS) - Call audit errors identified	1							1
Medical Priority Dispatch System (MPDS) - delay - incorrect prioritisation				1				1
Medical Priority Dispatch System (MPDS) - Incorrect determinant coding		1						1
Neonatal death					1			1
Pressure ulcer developed or worsened during care in this clinical care area/caseload		1						1
Privacy and Dignity	1							1
Treatment or procedure wrong or inappropriate	1							1
Unexpected Death		1						1
Grand Total	**18**	**15**	**7**	**8**	**4**	**1**	**6**	59

23. The International Academy of Emergency Dispatch has been requested to review the Trust's ineffective breathing calls which have resulted in NRIs. An update will be provided to the Clinical and Quality Governance Group in January 2024.

Patient Safety Investigations

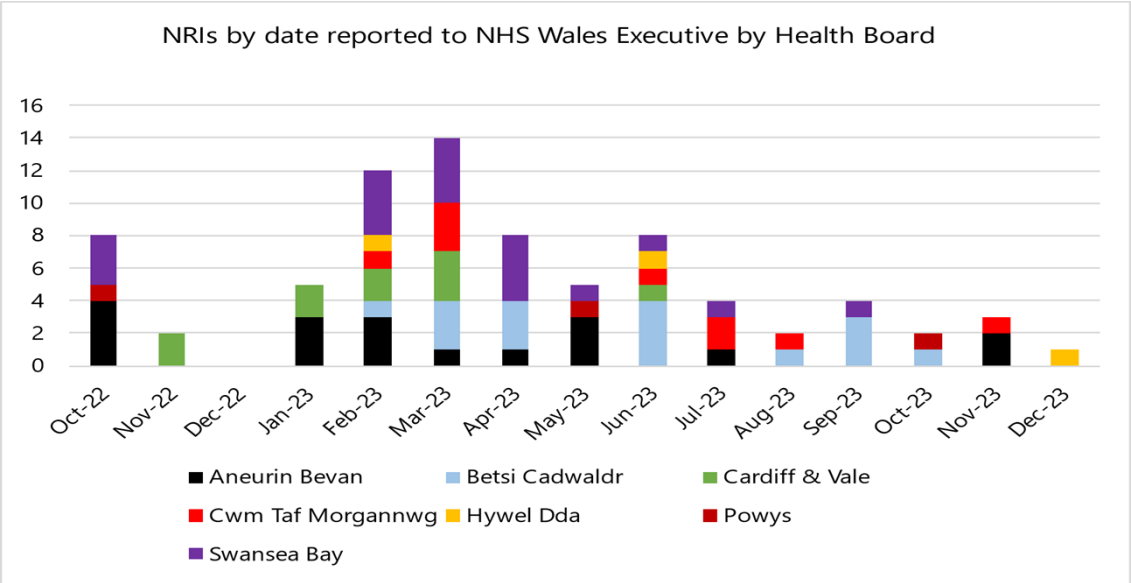
24. The Trust currently have a total of 59 open NRI investigations. Graph 7 below details the number of open NRI cases over time, with a rising trajectory overall.

Graph 7



25. Graph 8 below details the number of NRI reported to the NHS Wales Executive by Health Board area.

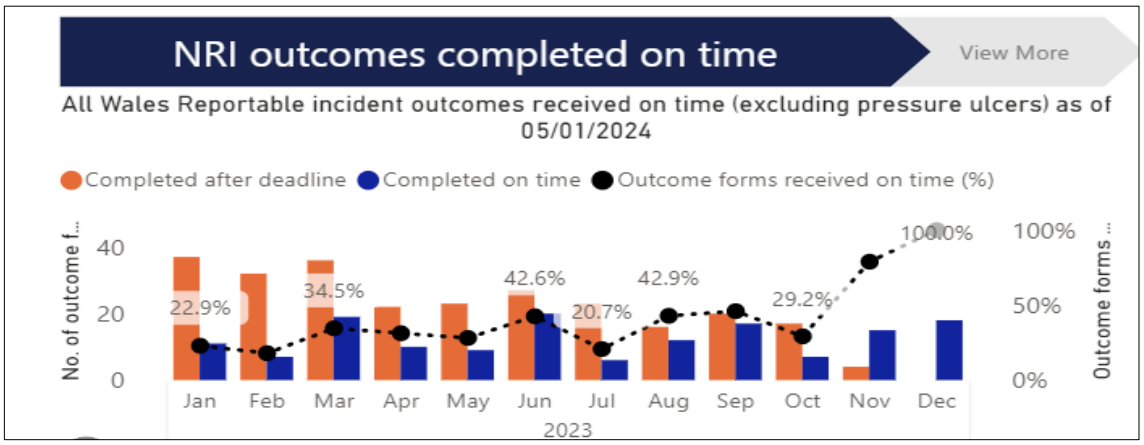
Graph 8



26. The Trust currently have a number of overdue NRI investigations (n=56). There are multiple factors but predominately these are due to capacity, demand and competing pressures.

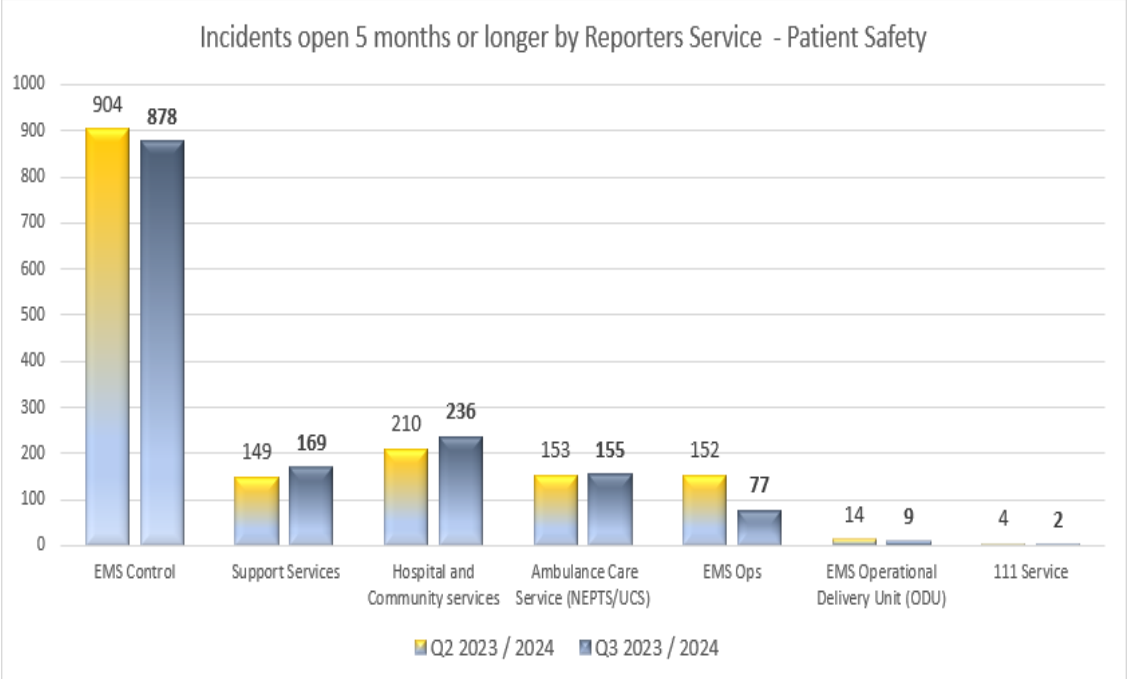
27. Graph 9 is extracted from the new NHS Wales Executive Beacon Dashboard (data last refreshed 5 January 2024) and provides details on the national position in relation to overdue investigations.

Graph 9



28. Graph 10 provides a breakdown of the current position in respect of all grades of patient safety investigations overdue by five months or more. This has been discussed at Clinical and Quality Governance Group with monitoring and oversight occurring at the Senior Operations Team.

Graph 10



Duty of Candour

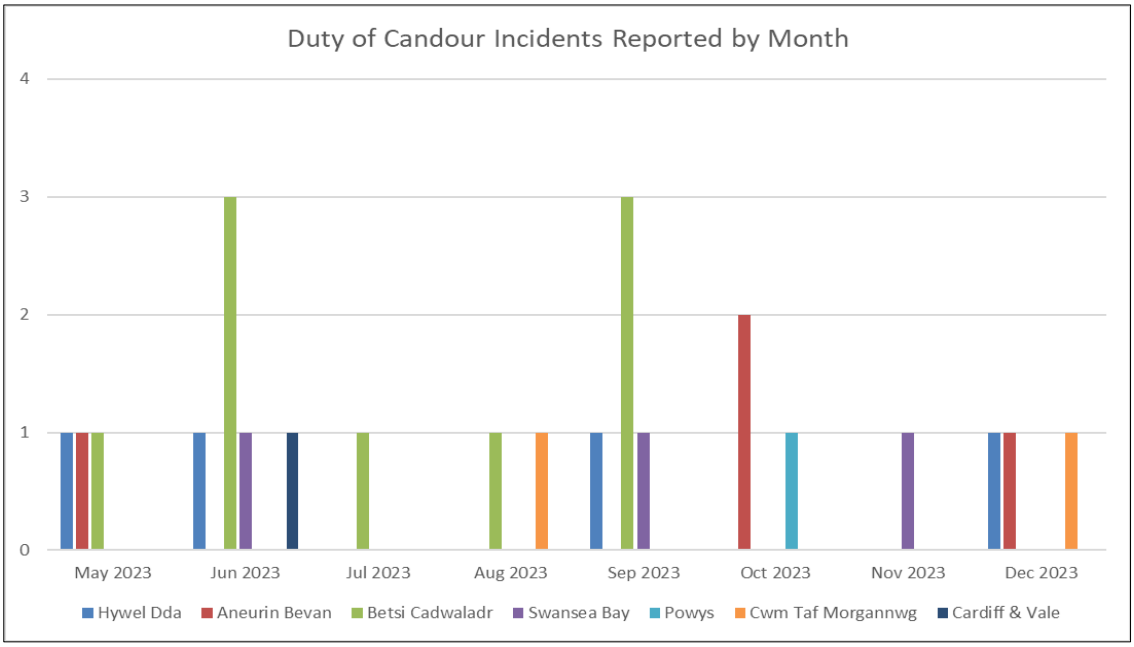
29. The Duty of Quality and Duty of Candour (DoC) Welsh Government Roadmap is updated on a monthly basis with oversight from the Clinical and Quality Governance Group. Progress in respect of DoC is also monitored locally through the PTR Work Plan.

30. DoC education is available on the Electronic Staff Record (ESR) and the plan is to change this to mandatory status as soon as possible. Technical issues with ESR recording the DoC training as complete is being investigated by the local ESR Team.

31. The Trust is represented on the All Wales DoC Network which meets monthly. At the January 2024 meeting refinements to the national dashboard were discussed. The dashboard is included on the Datix Cymru system.

32. Enactment of the Duty of Candour is detailed in Graph 11 below which is drawn from the national dashboard.

Graph 11



33. Since April 2023 when the Duty of Candour Regulations were implemented, the Trust has identified 24 incidents which have resulted in moderate, severe or catastrophic harm. To be notifiable, the harm must be unintended or unexpected. It can be as a result of either an actual intervention/treatment, or an omission in care.

34. Of the 24 incidents Duty of Candour has not been completed in 5 cases for the following reasons:

- Family raised the incident as a concern.
- Unable to locate the patient's next of kin. Health Board Clinical Lead attended the last known address, but the house appeared empty. The Health Board have no contact details.
- Unable to contact the patient's next of kin. The son is the only remaining relative since the patient's husband died. The Patient Safety Team spoke to the Funeral Director who said it was unlikely the son would wish to contact us although he did confirm that he has passed the message on. The son had not consented to sharing his details with the Trust.
- The Health Board shared next of kin details as the patient's ex-partner. The Patient Safety Team contacted the mobile number provided on multiple occasions over a two-week period with no reply and no method to leave a voicemail.
- Multiple attempts were made to contact the patient's next of kin by telephone with no answer. No address noted from the Health Board. Case being discussed at Complex Case Panel in January 2024.

35. The Datix Cymru system has a dedicated panel for DoC to ensure an audit trail is in place to record the enactment of the DoC or when this has not been possible and the rationale. Coding fields for reasons the DoC is not enacted will be developed on the system nationally to aid analysis in future.

36. As part of the joint investigations, working with Health Board colleagues the Patient Safety Team plan to follow up and capture more detailed incident outcomes, NRI reporting and Duty of Candour enactment by Health Board colleagues for incidents referred by WAST for joint investigation.

NHS Wales Patient Safety Alerts/Notices

37. Oversight of alerts and notices occurs at the Clinical and Quality Governance Group. As of 15 January 2024, the Trust has one Patient Safety Notice outstanding.

- PSN066 relates specifically to unidentified patients in ED.

38. Actions taken/planned:

- This currently being reviewed by one of the Regional Clinical Leads/Consultant Paramedic to determine any crossover with patients taken into ED by WAST who are unidentified.

Learning from Deaths (Mortality Reviews and the Medical Examiner Service)

39. A detailed update on the Mortality Review Process was presented under a separate QuESt agenda item at the October 2023 meeting.

40. Refreshed Terms of Reference have been developed for the Learning from Deaths Forum and the Forum is now established with reporting and oversight occurring at the Clinical and Quality Governance Group.

41. The Forum intends to identify categories of deaths in our care that would always trigger a review by the Group outside of a Medical Examiner request.

42. Additionally, through the opportunities provided by the ePCR and other data sets the aim is to develop our data and information to determine any emerging patterns, themes and trends.

43. The Lead Medical Examiner Officer attended the Learning from Deaths Forum in January 2024 and confirmed that all community deaths will be included in the reviews (apart from coronial cases) when the Medical Examiner Service becomes a statutory body from April 2024.

44. The Lead Medical Examiner Officer has kindly offered to do education on the Medical Examiner Service with our Clinical Teams which is being progressed by the Trust's Head of Workforce Education & Development.

45. A plan is in place to fully review the backlog of cases (800 cases) forwarded by the Medical Examiner Service, map the cases to incidents and complaints as relevant and update the Datix Cymru Mortality Module. All referrals have been screened on receipt by a member of the Patient Safety Team and escalated as required.

46. The Datix Cymru Mortality Module is under development and in the near future the functionality will mean the Medical Examiner Service Reviews will transfer directly onto the Trust's module meaning Trust upload of the information will be reduced.

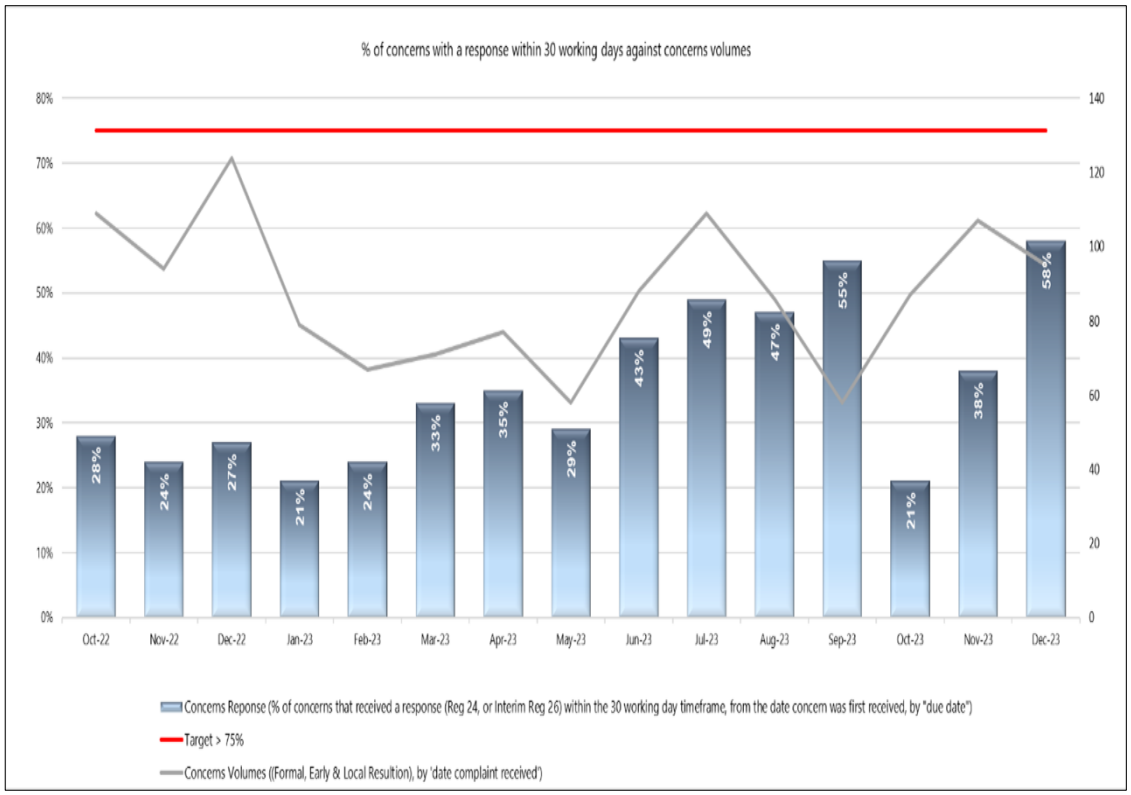
Early Resolution (ER), Local Resolution (LR) and Formal Concerns

47. Key Definitions:

- Early Resolution - two-day informal response.
- 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.

48. Graph 11 below provides the concerns position over time. The Trust continues to receive a steady number of concerns with 253 being received during this reporting period.

Graph 11



49. The acknowledgement date target has been amended nationally to five working days. During this reporting period the five-day acknowledgement performance was 71%, 99% and 100% (100% target) with the 30-day target achieving 21%, 38% and 58% respectively (75% target).

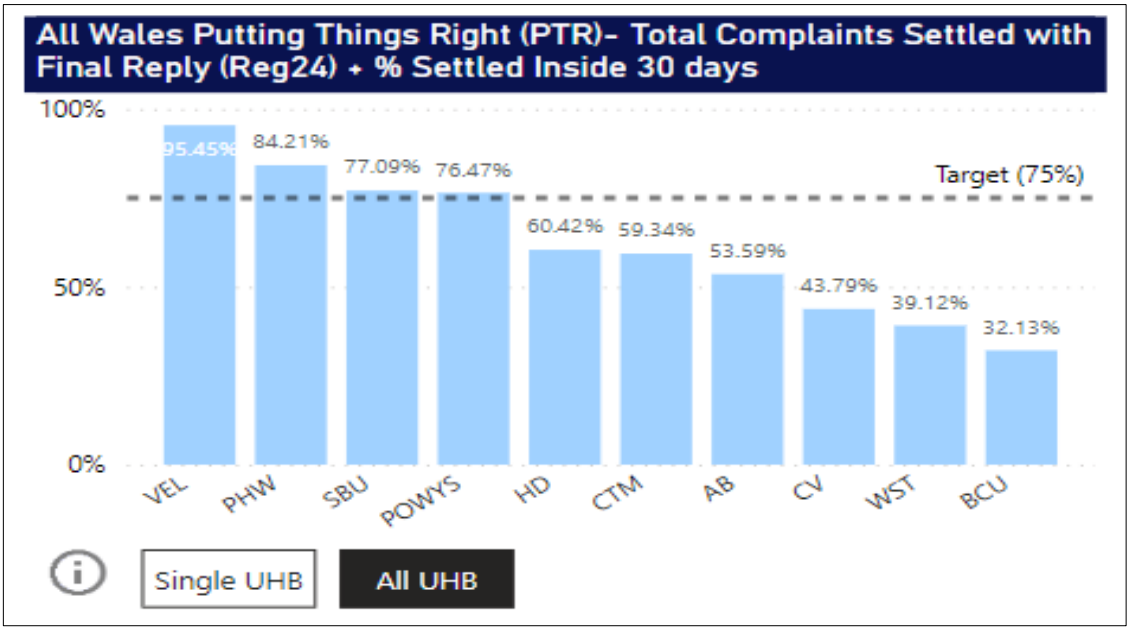
50. The PTR Organisational Change Process is completed and aims to provide additional leadership, resilience and capacity across all of the PTR functions, including concerns management. It is expected that all posts will be recruited to by April 2024. It is expected that the Trust will be consistently at least achieving the 30-day target by the end of Quarter 1, 2024/25.

51. The overwhelming themes and trends through the majority of concerns remains timeliness to responding to calls in the community.

52. Themes were emerging in respect of Ambulance Care regarding cancellation of transport. Through collaborative working the PTR Team and Senior Non-Emergency Patient Transport Service (NEPTS) Managers there has been a significant improvement in the number of open outstanding NEPTS concerns which were predominately in Aneurin Bevan University Health Board (ABUHB) area. The Patient Safety Team continue to work with Senior Managers to ensure sustainability of improvement in answering NEPTS concerns. In August 2023 NEPTS had 43 open concerns which were all overdue. These concerns were all managed and closed by end of September 2023.

53. The national position in response to concerns (complaints) is detailed in Graph 12 below. This is an extract from the NHS Wales Executive Beacon Dashboard (last updated 8 November 2023) and provides a comparison across Health Boards and Trusts.

Graph 12



Emergency Medical Service (EMS) Co-ordination and Resourcing Centre Concerns & Coroners Activity

Prepared by the Service Manager, Operations Quality.

54. The Operations Quality (OQ) Department has seen a reduction in the backlog of outstanding work, including concerns, coroner's statement and Serious Case Incident Forum (SCIF) actions. Additionality to the Investigation Supervising Officer (ISO) cohort was realised on 1 January 2024, increasing the establishment from 4 permanent to 7 permanent and 1 fixed-term (12-months).

55. There are 40 outstanding concerns which is higher than has been previously, however, all but 3 of these are within the Tier 1 Target set by Welsh Government. (WG). Those which have breached are due to a delay in gaining consent. From 1 January 2024, OQ will investigate all concerns regardless of whether consent has been obtained. This was previously paused because of the backlog.

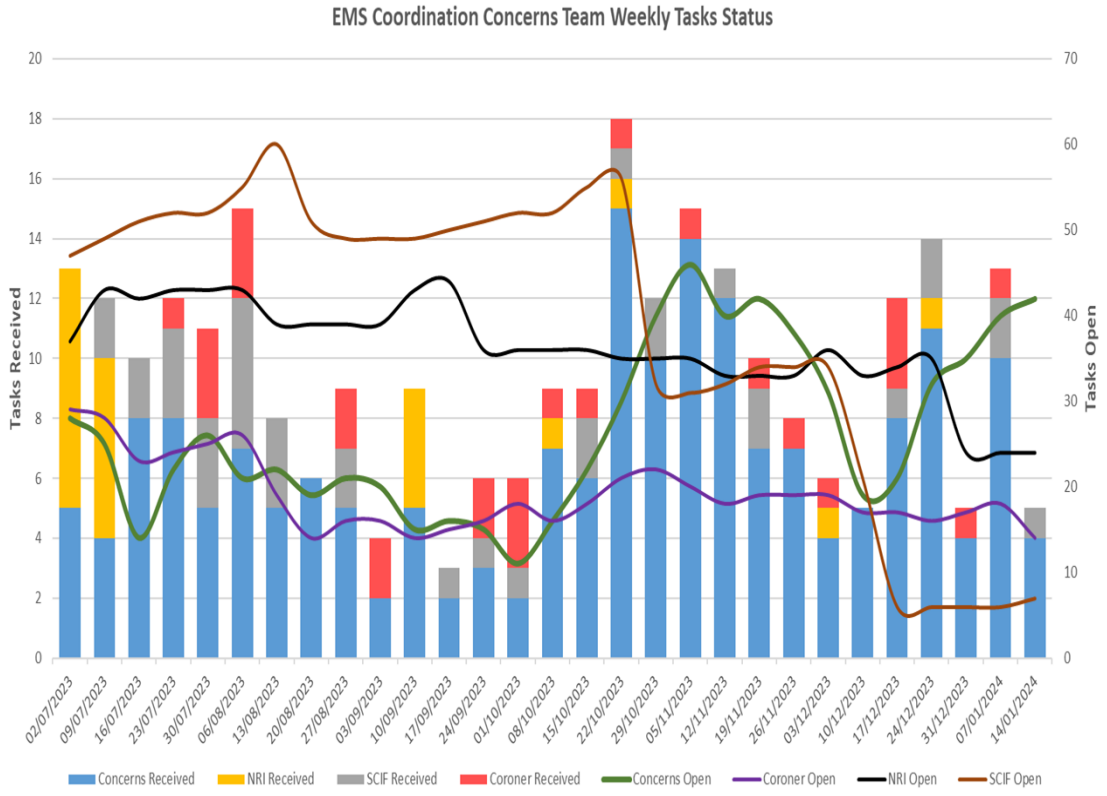
56. Outstanding Nationally Reportable Incidents (NRIs) which require investigating is currently 24. This is an improvement on 36 at the end of September 2023. The International Academies of Emergency Dispatch (IAED) has reviewed the outstanding NRIs relating to missed ineffective breathing and these reports are now being compiled.

57. There are 18 outstanding coroner's statements for OQ/EMS Coordination completion. A new process to ensure coroner's statement completion was implemented in October 2023 with a robust quality assurance (QA) process to improve efficiencies and enable Service Managers to sign coroner's statements in a timely manner. Whilst there is still a backlog, the majority of statements are at some point in the QA process or awaiting feedback from Legal Services before they can be served to HMC. Of the 18 requests, 9 have breached. It is anticipated that the position will continue to improve as the new process fully embeds and the backlog reduces.

58. SCIF actions are now being reviewed monthly to ensure they are being progressed and completed. There are 6 outstanding SCIF actions outstanding which is down from 60 in August 2023.

59. Graph 13 overleaf provides an overview of the activity of the Team up until 7 January 2024.

Graph 13



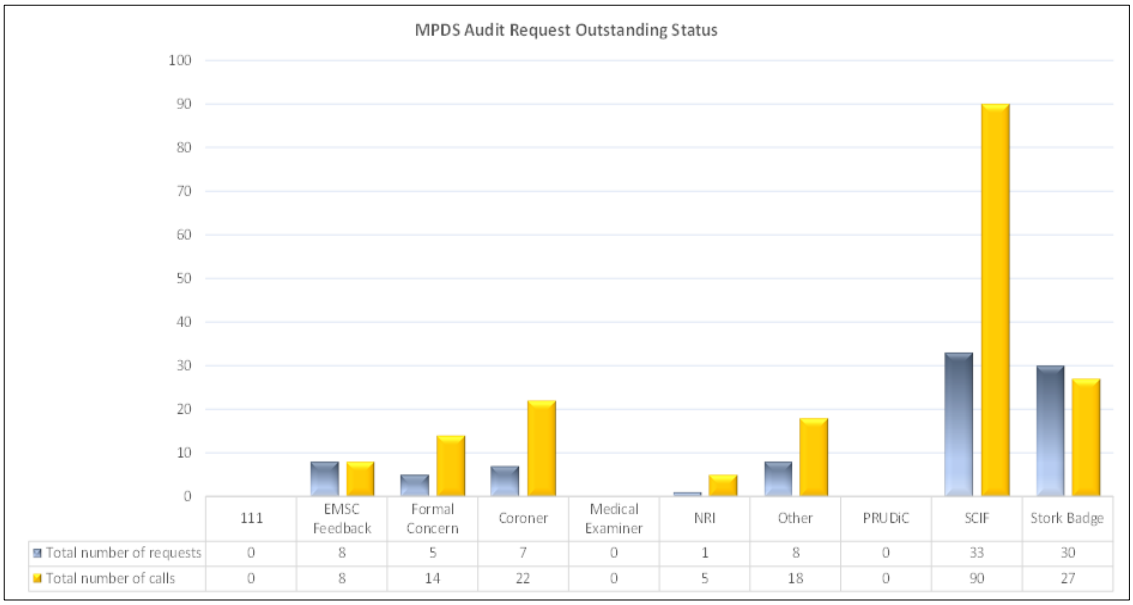
60. Following the review of ineffective breathing NRIs by the IAED, the Service Manager, Operations Quality (SMOQ) is constructing an SBAR paper to take to CQGG and SOT/SLT for assurance and to set out an approach to address any themes and trends. It is anticipated that this paper will be ready to take through governance in late January 2024.

61. There is a review ongoing of the EMD and MPDS SOPs. This will involve incorporating all relevant bulletins into one document. Due to the capacity of the team, this is taking longer than hoped but meetings to review these comprehensive documents continue.

62. Learning from concerns investigations continues to be shared with EMS Coordination Teams by OQ via coaching bulletins, competency signoffs and face-to-face where required. Themes and trends are also considered and discussed at the monthly EMS Coordination Quality Meeting which is chaired by the SMOQ.

63. There is a backlog of audit requests sitting with the OQ Quality Audit Team. There are currently 90 separate call audits required for SCIF, and the total backlog of audits is 187 as detailed in Graph 14 below.

Graph 14



64. The Quality Audit Team has faced a period of significant challenge and change with the sudden passing of the Emergency Dispatch Quality Improvement Manager in November 2023. Arrangements to support the team have been put in place, however, it is recognised that there was a lack of business continuity planning for such an event. The IAED is supporting heavily and colleagues within and outside of OQ will be receiving training from the IAED on any requirements and responsibilities related to IAED accreditation and compliance.

65. Regards the backlog of call audits, the whole OQ Team has partaken in levelling with the IAED to enable wider support for call auditing and overtime is being offered on a short-term basis. It should be noted that in December 2023 alone, 140 separate call audits were requested by the Patient Safety Team which is nearly half the IAED random audit requirement.

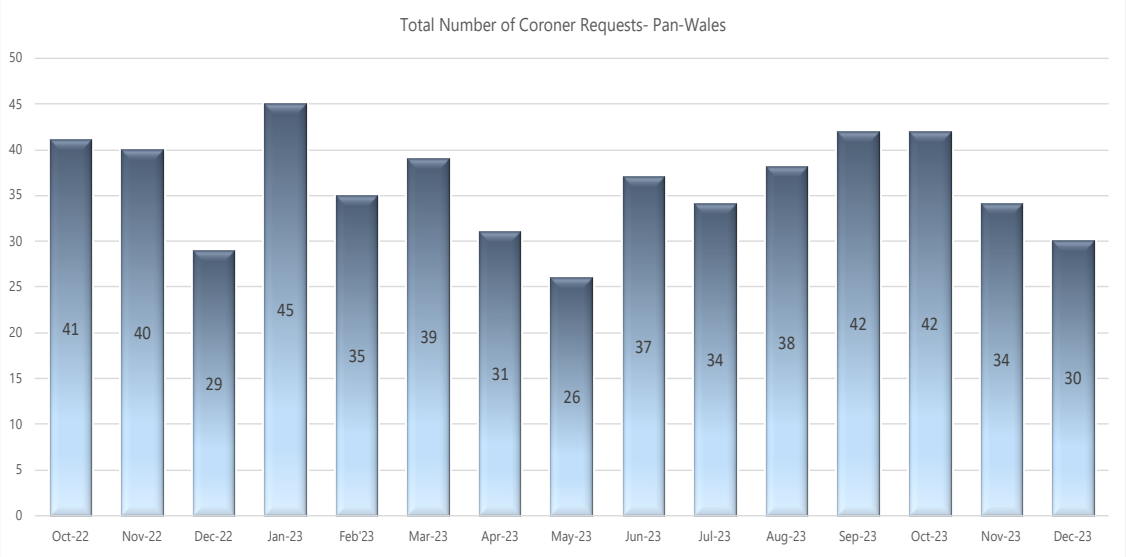
66. It is anticipated that with the additional support and involvement of the wider OQ team and the development of performance management metrics (which is a longer-term ongoing piece of work), the call audit backlog picture will be improved and the SMOQ continues to work with PTR colleagues to develop and improve processes.

Organisational Legal Activity and Coroners

67. The number of approaches received from Coroners has increased during the reporting period. 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.

68. Activity has reduced slightly month on month (Graph 15) 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.

Graph 15



Prevention of Future Death Reports (Regulation 28)

69. During the reporting period the Trust received one Prevention of Future Deaths Report (Regulation 28) from a Coroner in South Wales Central. The Report was also sent to the Chief Executive of Cardiff & Vale University Health Board and the Minister for Health & Social Services.

The matters of concern raised are: -

70. *"The investigation focused upon the causal significance, if any, of a delay of some thirteen hours, or thereabouts in the provision of an ambulance to the deceased.*

I received written & oral evidence from (details removed) of the Welsh Ambulance Service Trust (I annex a copy of the witness statement). I refer you in particular, to paragraph's 43-49. My concern here is that handover delays are impacting upon

response times in respect of patients requiring emergency treatment & for conveyance to hospital. As (details removed) stated in the evidence at para 45, the handover delays experienced at/around the time that the deceased was awaiting assistance were well in excess of the targets enshrined in the Welsh Health Circular of May 2016. Such delays pose a risk to the lives of those requiring emergency treatment/conveyance to hospital".

71. The Legal Services Team coordinate the responses to the Coroners, ensuring information is submitted with in the defined timescales.

Focus on the Public Services Ombudsman for Wales (PSOW) Cases

72. Between 1 October 2022 and 30 September 2023, 1055 concerns were received by the Trust. During the same period 50 approaches were made to the PSOW. This equates to less than 4% of Trust concerns being escalated to the PSOW.

73. Of the 38 cases, only 26% resulted in full investigations. This means 74% of approaches to the PSOW did not result in investigations and supports the Trust actions, both in terms of the quality of investigations and the management of concerns.

74. Of the 12 cases where the investigation has been concluded on 58% were not upheld against the Trust. This supports the robust investigations that have taken place.

75. The PSOW also has specific areas of concerns that form themes within the cases they decide to investigate, currently there is specific consideration of:

- Undertaking joint investigations to ensure that the person raising the concern receives an end-to-end NHS response.
- Standards of documentation/record keeping.

76. The Trust has recently provided feedback on two draft reports:

- The Adviser stated there was no evidence of tachycardia and the Trust has illustrated in two documents (submitted initially) that this was the case and cross referenced with JRCALC. This did not affect any recommendations but corrected the body of the report, which are made public.

- A recommendation was for staff to apologise directly to the person raising the concern. The Trust questioned this for several reasons (regulatory requirement, lack of evidence, staff welfare, staff engagement, case precedents) and the recommendation has now been removed.

77. During the period 11 cases were received, 9 cases were closed, and 2 reports were received. The Legal Services Team oversee the submissions to the PSOW.

Legal Claims

Table 5

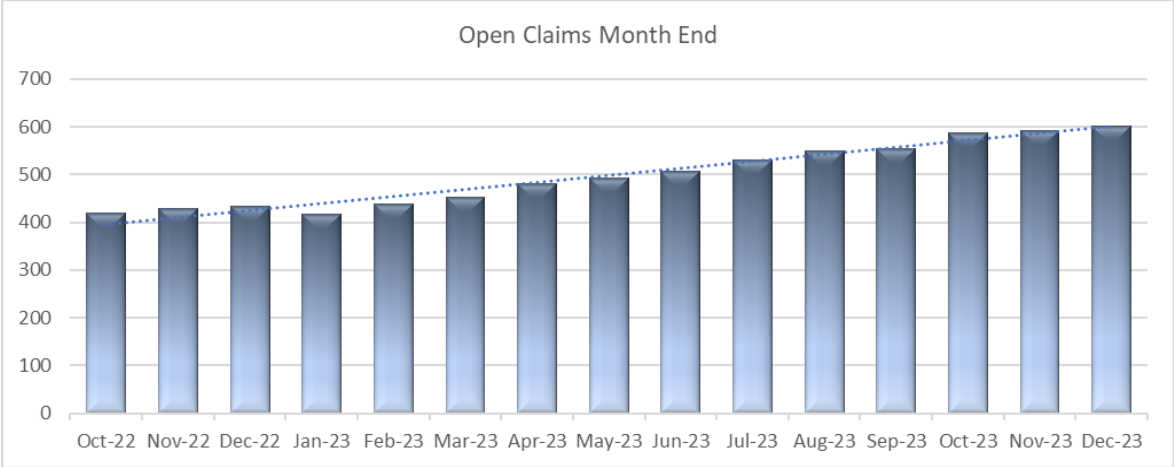
Legal Claims Overview		Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Claims opened	Personal Injury (PI)	1	4	1	2	2	1	4	0	1	1	2	1	3	3	0
	PI Road Traffic Accident	1	1	0	2	5	7	1	1	3	0	1	0	1	0	2
	Clinical Negligence	0	*	1	2	0	2	2	3	3	4	4	2	5	6	5
	Road Traffic Accident	17	24	17	23	27	12	29	16	22	26	17	8	28	13	24
	Damage to property	0	6	9	4	9	5	4	2	7	1	4	3	1	0	1
Claims closed	Personal Injury (PI)	0	0	4	1	0	6	3	0	7	1	0	6	0	0	0
	PI Road Traffic Accident	0	0	1	1	1	0	1	0	2	0	0	5	0	1	0
	Clinical Negligence	4	*	0	0	0	0	0	0	1	1	0	0	0	1	1
	Road Traffic Accident	15	22	11	47	17	11	8	3	11	5	8	4	4	14	19
	Damage to property	1	15	9	4	5	2	4	1	3	2	1	5	1	1	3
Claims open at the end of the month	Personal Injury (PI)	76	80	77	78	80	75	76	76	70	70	72	67	70	73	73
	PI Road Traffic Accident	47	48	47	48	52	59	59	60	61	61	62	56	57	56	58
	Clinical Negligence	109	119	120	122	122	124	126	129	131	134	138	140	145	150	154
	Road Traffic Accident	165	173	180	159	170	177	203	210	223	244	253	269	293	292	297
	Damage to property	22	8	8	9	13	16	16	17	21	20	23	21	21	20	18
		419	***428***	***432***	***416***	***437***	***451***	***480***	***492***	***506***	***529***	***548***	***553***	***586***	***591***	***600***

78. Table 5 provides an overview of the activity in Legal Services. 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.

79. This includes the potential cases that could not be considered under the Redress Regulations, as each potential claim has a potential value in excess of £25,000.00. The trend of increased numbers of personal injury claims continues, the numbers alone do not capture the increased complexity and value in the legal claims.

80. Graph 16 details the current position in respect of open claims which continues on an upward trajectory.

Graph 16



Organisational Learning

81. Organisational learning occurs through several routes. Examples of learning and improvement actions are detailed throughout this section.

82. The Quality Management Group formed to provide operational oversight of the Duty of Quality and Duty of Candour requirements will also be the forum responsible for organisational learning, which will include identifying themes and trends and highlighting any education and training or clinical audit activities.

83. The Trust is engaged in the Welsh Risk Pool Enhancing Learning Programme which is a National Programme providing resources for organisations to enable the release of staff to focus on learning processes within their organisation and network and share good practice. The Programme commenced in September 2023 and concludes in March 2024 with next steps being discussed at the Welsh Risk Pool Committee in March 2024.

84. Learning from investigations - the following notices have been issued this period:

- CN30/23 Mortuaries in Powys Teaching Health Board
- CN31/23 Newborn Thermoregulation
- CN32/23 Reinstating of Home Birth Services in C&VUHB
- CN33/23 Updated PGD's Diazepam and TXA
- CN34/23 Bronchiolitis Pathway Follow Up
- CN15/23 Glan Clwyd Paramedic - SDEC Referral Pathway update
- CN35/23 Updated Medicines Management Policy

85. Examples of learning from clinical reviews are detailed overleaf in Table 6.

Table 6 **- Clinical Reviews**

	Number	**Brief Description**	Themes	Learning Opportunities
Aneurin Bevan	3	• Patient sustained head injury during fall. • Concern raised by family that left at home alone and family not made aware.	• Failure to examine patient adequately. • Safety netting.	• Improved understanding of the risk/potential complication of a head injury in the elderly population. • Importance of appropriate safety netting for patients who remain at home alone.
Betsi Cadwaladr	2	• Patient attended to by an Emergency Ambulance, patient reported as struggling to breathe. • Crew assessed patient and made decision for the patient to remain at home. • The patient was taken to hospital the following day by family and subsequently died.	• Safety netting. • Failure to complete refusal documentation on ePCR. • No documentation in consideration of treatment plan.	• Importance of treatment plan and refusal to attend hospital documentation along with capacity assessment. • Enhanced learning around systematic approach to ECG analysis.

	Number	Brief Description	Themes	Learning Opportunities
Cardiff and Vale	2	• Patient fallen outside sustained head injury. • Solo responder attended on an emergency ambulance as a Falls Frailty Transport Support Resource, patient was transport in rear of ambulance alone.	• Decision making • Inability to manage risk. • Poor documentation.	• Improved understanding of falls in older adults. • Importance of performing a detailed through assessment of the patient relevant to the presentation. • Improvement of documentation.
Cwm Taf	3	• Concern raised by patient regarding attitude of crew and failure to recognise clinical symptoms of sepsis.	• Documentation of administration of drugs in ePCR drug administration blank. • Adherence to the Medicines Management Policy.	• Identification for learning to ensure understanding of the medicines management policy. • Compliance and learning to ensure robust documentation in ePCR medications section.

	Number	Brief Description	Themes	Learning Opportunities
Hywel Dda	1	• Patient reported as unconscious collapsed. • Patient with a NEWS score of 9 and a GCS of 11 was transported to ED without any pre-alert being provided. • Patient required onward transfer to critical care unit after suffering ruptured aortic aneurysm.	• Failure to recognise critically unwell patient. • Pre-alert guidance • Patient assessment	• Improved recognition of a deteriorating patient. • Important of pre-alert in a patient with a reduced GCS and high NEWS. • Importance of a clear working diagnosis or alternative diagnosis.
Powys	0	No new clinical reviews to report		
Swansea Bay	1	• Patient sustained fall at home down approximately 20 steps. • CHARU paramedic attended scene, following assessment and discussion with the trauma desk, decision was made to provide a taxi for the patient and suitable to attend minor injuries unit (MIU). • Patient on arrival at the MIU required transfer to Emergency Department.	• Decision making • ePCR documentation below standard expected.	• Learning around criteria for referring patients to MIU unit. • Improved documentation in ePCR.

Welsh Risk Pool Learning from Events Reports & WRP Committee Outcomes

86. The Welsh Risk Pool (WRP) Service has been delegated responsibility to administer the risk pooling arrangement for NHS Wales and this includes the management of reimbursement to member organisations once claims/redress cases have been settled.

87. As part of this process NHS organisations must complete Learning from Events Reports to evidence improvement actions. Learning from Events Reports and supporting evidence is independently assessed and presented to the National Learning Advisory Panel (LAP) which has multidisciplinary attendance by Health Board and Trust colleagues.

88. WRP have started to apply financial penalties to organisations with deferred cases over 12 months from the decision to settle date.

WRP Committee Outcomes (as of 22 November 2023) & Current Position of Cases Overall (as of 16 January 2024)

Table 7

Learning from Events	Number approved	Number Amber Deferred (requesting some additional information minutes, confirmation of sharing learning, training etc.)	Number Red Deferred (to be represented to the LAP with additional evidence, answers to questions etc.)
Claims	2	1	0
Redress	0	1	0
Previously Deferred Claims	0	0	0
Previously Deferred Redress	0	0	1
Overall position	2	2	1

89. Table 7 provides an overview of the current position with the Trust having 2 amber deferred cases and 1 red deferred case awaiting evidence of learning.

90. Oversight of the status of cases is undertaken by the Legal Services Team.

Horizon Scanning & Key Documents

91. During the period the following key documents/consultations have been published:

- Putting Things Right Regulations (2011): Consultation by Welsh Government on the overhaul of the Regulations. The PTR Team are engaged in the Workshops and contributing/feeding back on the current Regulations.

- The Thirwall Public Inquiry Terms of Reference were published in October 2023 and elements will be considered by the Learning from Deaths Forum. The inquiry will investigate 3 broad areas:

    A. The experiences of the Countess of Chester Hospital and other relevant NHS services, of all the parents of the babies named in the indictment.
    B. The conduct of those working at the Countess of Chester Hospital, including the Board, Managers, Doctors, Nurses and Midwives with regard to the actions of Lucy Letby while she was employed there as a Neonatal Nurse and subsequently, including:

        (i) whether suspicions should have been raised earlier, whether Lucy Letby should have been suspended earlier and whether the police and other external bodies should have been informed sooner of suspicions about her.
        (ii) the responses to concerns raised about Lucy Letby from those with management responsibilities within the Trust.
        (iii) whether the Trust's culture, management and governance structures and processes contributed to the failure to protect babies from Lucy Letby.

    C. The effectiveness of NHS management and governance structures and processes, external scrutiny and professional regulation in keeping babies in hospital safe and well looked after, whether changes are necessary and, if so, what they should be, including how accountability of Senior Managers should be strengthened. This section will include a consideration of NHS culture.

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

MONTHLY INTEGRATED QUALITY & PERFORMANCE DASHBOARD – December 2023

MEETING	QUEST
DATE	8th February 2024
EXECUTIVE	Rachel Marsh – Executive Director of Strategy, Planning & Performance
AUTHOR	Hugh Bennett – Assistant Director of Commissioning & Performance Mark Thomas – Commissioning & Performance Manager Melanie O'Connor - Commissioning & Performance Officer
CONTACT	Hugh.bennett2@wales.nhs.uk Mark.Thomas12@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 2023.**

2. Red 8-minute performance was 48.9% (target 65%) in December 2023 and Amber 1 median one hour and 36 minutes. Clearly, these levels of performance remain concerning, but they are a material improvement on the levels seen in December 2022 of 39.5% and three hours and 30 minutes respectively.

3. This improvement was a product of good seasonal planning by the Trust, with a strong tactical focus on Emergency Medical Service (EMS) production and related initiatives, underpinned by longer term investment and transformation. In December 2023, the Trust delivered 123,727 total unit hours (all emergency types) which was significantly above the 103,769 produced in December 2022. EMS abstractions were 33.75%, below the 36.79% recorded during the same month last year and almost achieving the pre-pandemic benchmark of 30%. The other big contributing factor was handover lost hours, with 22,756 lost hours, compared to 32,098 hours in December 2022. Whilst a material improvement the number of handover lost hours remain extreme and accounted for 25% of the Trust's conveying ambulance production.

4. The Trust has also identified with senior stakeholders the need to achieve its IMTP ambition of 17% consult and close. Performance had dipped earlier in the year, but has now started to improve again, rising to 14.1% in December, with a corrective action plan in place. Cymru High Acuity Response Unit (CHARU) utilisation is just below 30% and an area of focus.

5. 111 is showing continued improvement and is in a more resilient place than last winter as seen in the improved performance when demand increased significantly during December 2023. Even though demand achieved its second highest monthly figure over the past two years, call answer performance and abandonment rates remained above those levels seen at any point during last winter, between October 2022 and March 2023. The abandonment rate in December 2023 was 13.1%, compared to the target of 5%, which the Trust achieved June to November 2023.

6. Ambulance Care, in particular, Non-Emergency Patient Transport Service's (NEPTS) performance has been stable, with oncology dropping just below target and renal performance achieving its target.

7. The Trust continues to focus on its people, with a range of tactical actions in place linked to winter planning e.g. reducing shift overruns, welfare vehicles etc., whilst it also continues with the more strategic focus on the People & Culture Plan. Sickness absence was 9.54% in December compared to 8.82% in November 2023 (rolling two-year average).

8. Overall, the picture is more positive than December 2022, but performance levels for EMS remain a particular concern from a patient safety perspective. The Trust was recently asked by Welsh Government to identify five areas of focus: capacity, demand management, efficient use of resource, pathways and staff well-being, as detailed in the Dec-23 Trust Board harm report. The are all being worked on, but handover lost hours reduction remains critical. The Trust has made an offer to the system, via the Six Goals Programme, on how it can support handover reduction through reduced conveyance with potential areas of focus being the Clinical Support Desk (CSD) and Advanced Paramedic Practitioners (APP). The Trust is also nearing the completion of the strategic EMS Demand & Capacity Review.

9. Finally, the indicators in this report are subject to annual review. All the updates from the most recent review have now been completed, with the exception of: a metric on the duty of candour – this will seek to mirror what is reported at a national level, which is currently being determined; and value indicators for 111/CSD – this needs further consideration linked to health economics data.

RECOMMENDATION: QUEST is asked to: Consider the December 2023 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**
02 February 2024	**Executive Director Strategy, Planning & Performance**
08 February 2024	**QUEST**

REPORT APPENDICES
Appendix 1 – Top Indicator Dashboard

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

SITUATION

1. The purpose of this report is to provide senior decision makers in the Trust with an integrated dashboard (Our Patients, Our People, Value and Partnerships/System Contribution) focused on the "vital few" key metrics. This report is for **December 2023.**

BACKGROUND

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

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

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 part of this committee/Board report are updated on an annual basis, to ensure that they continue to represent the best way of tracking progress against the Trust's plans (Integrated Medium-Term Plan - IMTP) and strategies. A revised set were agreed for 2023/24. All the updates for the revised set have now been completed, with the exception of: a metric on the duty of candour – this will seek to mirror what is reported at a national level, which is currently being determined; completed symptom checkers; and value indicators for 111/CSD – this needs further consideration linked to health economics data.

ASSESSMENT

<u>Our Patients – Quality, Safety and Patient Experience</u>

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

6. **999** call answering times achieved the 6 second answering target during the early part of 2023; however, in the second half of the year the 95th percentile began to worsen; in November 2023 it was 18 seconds with an improvement to 12 seconds in December 2023. The 65th percentile and median performance remain very good.

7. **111 call answering decreased,** as expected over the holiday period**,** with the call abandonment target of <5% not being achieved in December 2023 for the first

time in seven months (13.1%). This was mainly as a consequence of a sharp rise in the number of calls being received during the month. The number of calls being answered within 60 seconds still remains significantly below the 95% target, with it being 46.1% in December 2023. Negotiations with commissioners have indicated that funding is available for 198 call handlers this year and recruitment has been underway to secure this number, but there remain a number of vacancies. It was agreed to recruit another cohort in November, with the aim of getting closer to the 198 level (current estimate for December is 181 Full Time Equivalents (FTE)s, which is further boosted by bank and overtime). It should be noted that the Trust is anticipating a reduction in the commissioned level of FTEs next year. Significant improvement work has been undertaken on improving production and increasing productivity. There is also improved ICT in place since last winter. A priority was a commissioning intention to re-roster 111 (including demand & capacity work); however, the funding for this has been withdrawn.

8. **111 Clinical response:** saw the highest priority 111 calls (P1CT) remain stable and above target at 98.3%. P2 and P3 fell further below the 90% performance target in December 2023, with the respective figures being 63.2% and 62.3%. These decreases have been affected by an expected rise in call demand. The previous improvement has been driven by more efficient working practices and the alignment of capacity to demand. The numbers of clinicians was at 94 FTEs in December 2023 against agreed establishment levels of 106 FTEs.

9. **Ambulance Response** (safety / patient experience): the Red 8-minute response performance for December 2023 was 48.93%, a slight reduction when compared to November 2023, remaining below the 65% target. There was a slight monthly increase in the number of Red incidents that were actually attended within 8-minutes, rising to 2,615 in December 2023. The actual number of Red incidents attended within 8-minutes has seen a general increase over the past two years with the monthly average in 2023 being 2,115 compared to 1,921 in 2022 and 1,813 in 2021. The Amber 1 median was 1 hour 36 minutes (ideal is 30 minutes) and the Amber 1 95th percentile was 7 hours 6 minutes. These long response times have a direct impact on outcomes for many patients. Whilst the response times remain below target and too long, December 2023's performance was materially better than December 2022, which were December 2022 of 39.5% (Red 8 minute) and three hours and 30 minutes (Amber 1) respectively Actions to further improve performance that are within the Trust's control include:

   Capacity:

   - Recruitment: The Trust currently has 95% of commissioned front-line posts in place. There is no significant recruitment planned over the next few months as forecasts identify that there is good coverage until March 2024.

- Some additional funding was made available to pilot the new Connected Support Cymru service in partnership with St John Cymru (SJA). This funding ended in Q3, but the National Collaborative Commissioning Unit (NCCU) directly procured the service through to 31 March 2024. The Trust is also continuing with this project through the volunteer Community Welfare Responders, which is producing some positive early results.

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

- The Managing Attendance Programme continues, delivered through this year's ten-point plan. There was a reduction in overall sickness levels during the middle part of 2023, and although increases have been seen over the past few months, further work is still on-going to reduce to 6% during 2023/24. There remain risks associated with delivery of this level of improvement especially in the context of winter viruses and Covid, as well as the impact of other winter pressures and handover delays.

Demand Management

- The increase in Clinical Support Desk capacity has meant that the Trust has been able to increase its consult and close rate over the past 12 months, with over 5,000 successful consult and close outcomes achieved during December, which is the highest number recorded during 2023. However, the percentage achieved during the month (14.1%) was not quite as high as that seen earlier in the year due to an increase in overall verified demand during December. The Trust has been asked by senior external stakeholders what it can focus on through the winter, with the Trust identifying the 17% ambition as key, along with ambulance production (linked to targeted overtime and reduced abstractions).

Red Improvement Actions

- For Cymru High Acuity Response Units (CHARUs) the aim is to fully populate the CHARU roster keys (153 full time equivalents), with the current estimated staff in post of 115 FTEs. However, recruitment into the more rural parts of Wales is proving problematic. The Clinical Directorate is leading on CHARU recruitment and training, with more scheduled for February 2024. If this does not prove successful, the Integrated Technical Planning Group (ITPG) will look at whether the Trust can recruit fully qualified paramedics (FQP's) into these vacant posts, recognising that there has to be sufficient vacancies in the EA lines to fund this.
- Red review. This is being undertaken within additional resource, when possible, but ideally, as previously identified, would require additional

FTEs. The resource requirement will be considered further through the 2023 EMS Strategic Demand & Capacity Review.

- A more efficient response logic, which went live on 19 June 2023, is reducing the number of multiple attendances to certain categories of red call, releasing resource to respond to other calls.

10. One of the key factors in relation to response times is the capacity lost to **handover outside Emergency Departments**. 22,756 hours were lost during December 2023, which is a material improvement on the 32,098 hours lost in December 2022. These levels remain so extreme that all the actions within the Trust's control cannot mitigate or offset this level of loss, which accounted for 25% of the Trust's conveying ambulance production in December 2023. There has been a noticeable improvement in Cardiff & Vale's handover lost hours linked to an organisational focus, with other health boards reporting that they are seeking to learn lessons. Wales Immediate Release figures for December 2023 were: Red 202 accepted and 11 declined; and Amber 1, 189 accepted and 337 declined. There has been some challenge from health boards on the accuracy of requests, with the Trust engaging in a workshop organised by the NCCU.

11. **Ambulance Care (formally NEPTS) (Patient Experience)**: Oncology performance dropped below the 70% target in December 2023 to 68.16%. Renal performance increased in December 2023, and remained above target at 74.08%. Advanced discharge & transfer journey booked in advance performance decreased compared to the previous month to 78%; remaining below the 95% target. Overall demand for NEPTS continues to increase, but remains below pre-pandemic levels. The Trust has a comprehensive Ambulance Care Transformation Programme in place, which includes delivering a range of efficiencies and improvements, for example: aligning clinic patient ready times to ambulance availability and addressing oncology performance.

12. **National Reportable Incidents (NRIs) / Concerns Response**: the Trust reported one NRI to the NHS Executive in December 2023, a slight decrease from the three reported in November 2023; and 16 serious patient safety incidents were referred to health boards under the Joint Investigation Framework, which has now been adopted NHS Wales wide. In December 2023 complaint response times increased to 58%, a significant improvement on November 2023's 38%, but remains below the 75% target, with cases remaining complex. Reviews of lower graded concerns are being undertaken to ensure proportionate investigations are undertaken. The Trust is currently recruiting to a new structure for the Putting Things Right (PTR) team, which will increase capacity and leadership.

13. **Clinical outcomes**: The percentage of suspected stroke patients who are documented as receiving an appropriate stroke care bundle was 75.3% in December 2023, a slight decrease from the 77.9% seen in November 2023, and remaining below the 95% performance target. Work is ongoing to improve

reporting and compliance through the ePCR system. The return to spontaneous circulation (ROSC) compliance rate decreased to 17.6% in December compared to 22.2% in November 2023.

14. The Trust is now able to report on call to door times for Stroke and STEMI patients. For December 2023 these highlight call to hospital door times of two hours and 27 minutes for stroke patients and two hours and six minutes for STEMI. Clearly these times are too long and are representative of the longer response times for all calls as a result of the pressures and issues outlined in this report.

    Our People (workforce resourcing, experience, and safety)

15. **Hours Produced**: The Trust produced 123,727 Ambulance Response unit hours in December 2023, an increase from the 121,349 produced in November 2023 (longer month). Emergency ambulance unit hours production (UHP) were 93% in December 2023, thus not improving or achieving the 95% target. CHARU UHP increased to 145% (note this is of the commissioned level, not full roll out). Key to the number of hours produced are roster abstractions, which remain above benchmark, but are reducing i.e. improving (see below).

16. **Response Abstractions:** EMS abstraction levels increased to 33.75% in December 2023 remaining above the 30% benchmark. EMS Response sickness abstractions stood at 10.68% (benchmark 5.99%).

17. **Trust sickness absence:** the Trust's overall sickness percentage was 9.54% in December 2023, a slight increase on the 8.82% recorded in November 2023. Actions within the IMTP concentrate on staff well-being with an aim to continue to reduce this level supported by the ten-point plan.

18. **Staff training and PADRs:** PADR rates did not achieve the 85% target in December 2023 (78.16%). Compliance for Statutory and Mandatory training decreased very slightly to 76.55%.

19. **People & Culture Plan**: The Trust launched its People & Culture Plan in April 2023 and workstreams are being delivered around behaviours, in particular, sexual safety, Freedom to Speak Up, 111 culture review, flexible working and the introduction of a staff pulse survey tool. The Executive Leadership Team undertook a pan-Wales round of CEO Roadshows in November 2023. Feedback from attendees identifies workloads as the main cause of stress and pressure.

    Finance and Value

20. **Financial Balance**: The reported outturn performance at Month 9 is a surplus of £108,000, with a forecast to the year-end of breakeven.

    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 14.1% in December 2023, a slight increase from the 14% seen in November 2023, but below the Trust's 2023/24 IMTP ambition of 17%. In relation to increasing the numbers conveyed to places other than a main Emergency Department, little progress has been made through the year. Work continues with health boards on gaining access to their Same Day Emergency Centres.

22. In December 2023, 9,900 patients cancelled their ambulance, and the Trust was unable to send an ambulance due to application of CSP levels to approximately 793 callers. A formal programme to take forward "inverting the triangle" has been established. The Trust has proceeded with growing the numbers of APPs in training. The current focus is on developing a "strategic case for change", a stakeholder engagement process and simulating the inversion through the 2023 EMS Demand & Capacity Review.

Summary

23. The indicators used at this high-level highlight that even though demand, and subsequently, system pressures increased during December 2023, performance remained relatively stable, across all areas, and significantly exceeded the levels achieved during December 2022.

24. Red performance remained relatively stable during December 2023. The number of Red incidents responded to within 8-minutes increased by 15.1% to match a 15.8% rise in Red incident numbers and although the overall percentage declined marginally to 48.9%, this is still above the rate seen during other months of last year when demand was lower.

25. Handover Lost Hours rose in December 2023 to 22,756, but this was expected as demand and system pressure increased, and the scale of this increase was lower than anticipated and significantly below the 32,098 figure seen during December 2022. However, this level of handover is still having a serious impact on the quality, safety, and patient experience that the Trust can deliver (long waits and unmet patient demand).

26. 111 continued to show improvements, with abandonment rates during the latter half of 2023 continuously achieving better than target levels (5%). Even though these targets were not met in December 2023, where the rate rose to 13.1%, as demand increased, call answering still achieved a far better performance level than that seen during December 2022 where abandonment spiked to 49.1%. Ambulance Care, in particular, NEPTS performance has been relatively stable.

27. Overall, the picture remains one in which the Trust can demonstrate clear year on year improvement over some things it controls, even at times of higher demand, but there is a more mixed picture where there are system dependencies e.g., handover lost hours, and these pressures are beginning to increase as the Trust heads into winter.

RECOMMENDATIONS: QUEST is asked to: Consider the December 2023 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.

Welsh Ambulance Services NHS Trust

Monthly Integrated Quality & Performance Report

December 2023

Annex 1 – Top Indicator Dashboard

GIG CYMRU NHS WALES

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru

Welsh Ambulance Services
NHS Trust

Annex 1 – Top Indicator Dashboard
Version 1.0
Released: January 2024

by Commissioning & Performance Team

Section 1: Monthly Indicators / Top Indicator Dashboard

Top Monthly Indicators	Target 2023/24	2 Year Average	Nov-23	Dec-23	RAG
Our Patients					
Timeliness Indicators					
NHS111 Call Handling Abandonment Rates	< 5%	11.5%	4.1%	13.1%	R
111 Clinical Triage Call Back Time (P1)	90%	97.4%	99.0%	98.3%	G
999 Call Answer Times 95th Percentile	00:06	00:40	00:18	00:12	R
999 Red Response within 8 minutes	65%	50.4%	49.5%	48.9%	R
999 Amber 1 Median	00:18	01:23	01:08	01:36	R
Oncology Journeys arriving within 45 mins and up to 15 minutes after appointment time	70%	73.1%	70.5%	68.2%	A
Discharge & Transfer journeys collected less than 60 minutes after booked time (NEPTS)	90%	84.5%	81.3%	78.3%	R
Clinical Outcomes / Quality Indicators					
Return of Spontaneous Circulation (ROSC)	Increasing Trend	18.5%	22.2%	17.6%	A
Stroke Patients with Appropriate Care	95%	77.3%	77.9%	75.3%	A
Stroke Call to Hospital Door Times	Reduction Trend	02:27	2:06	2:27	A
Acute Coronary Syndrome Patients with Appropriate Care	95%	43.2%	42.6%	40.6%	R
National Reportable Incidents reports (NRI)	Reduction Trend	5	3	1	G
Can't Send & Cancelled by Patient Volumes	Reduction Trend	10951	8819	11790	R
Concerns Response within 30 Days	75%	38.3%	38%	58%	A
Our People					
Capacity					
Hours Produced for Emergency Ambulances	95-100%	95%	96%	93%	A

Top Monthly Indicators	Target 2023/24	2 Year Average	Nov-23	Dec-23	RAG
Health & Well-being					
Sickness Absence *(all staff)*	6.0%	9.44%	8.82%	9.54%	R
Mental Health Absence Rates	Reduction Trend	2.38%	2.51%	N/A	A
Staff Turnover Rate	Reduction Trend	10.35%	9.34%	9.50%	R
Statutory & Mandatory Training	>85%	79.46%	76.56%	76.55%	R
PADR/Medical Appraisal	>85%	70.34%	76.6%	78.2%	A
Number of Shift Overruns	Reduction Trend	3787	4021	4020	A
Inclusion & Engagement / Culture					
NEPTS % of Total Calls Answered in Welsh	Increasing Trend	1.2%	1.5%	1.5%	G
Value					
Financial balance - annual expenditure YTD as % of budget expenditure YTD	100%	100%	100%	100%	G
EMS Utilisation Metric (CHARU)	Increasing Trend	31%	25.3%	29.0%	A
Average Jobs per Shift (All Vehicles)	Increasing Trend	2.41	2.29	2.34	A
NEPTS on the Day Cancellations	Reduction Trend	19.5%	19.9%	22.9%	A
Partnerships / System Contribution					
Inverting the Triangle					
Successful Consult & Close Outcome	17.0%	13.1%	14.0%	14.1%	R
% Of Total Conveyances taken to a Service Other Than a Type One Emergency Department	Increasing Trend	11.4%	11.81%	11.88%	A
Number of Handover Lost Hours	15,000	23,129	20,124	22,756	R
NHS111					
NHS111 Dental Calls	Increasing Trend	6,218	6,996	6,971	A
Consult & Close Volumes by NHS111	Increasing Trend	1,122	1,260	919	R

In-Month RAG Indicates =

Green: Performance is at or has exceeded the target *(Indicates no action is required)*

Amber: Performance is at or within 10% of target *(Indicates some issues/risks to performance (monitoring is required))*

Red: Performance is less than 10% of target (Indicates close monitoring or significant action is required)

TBD: Status cannot be calculated (To Be Determined)

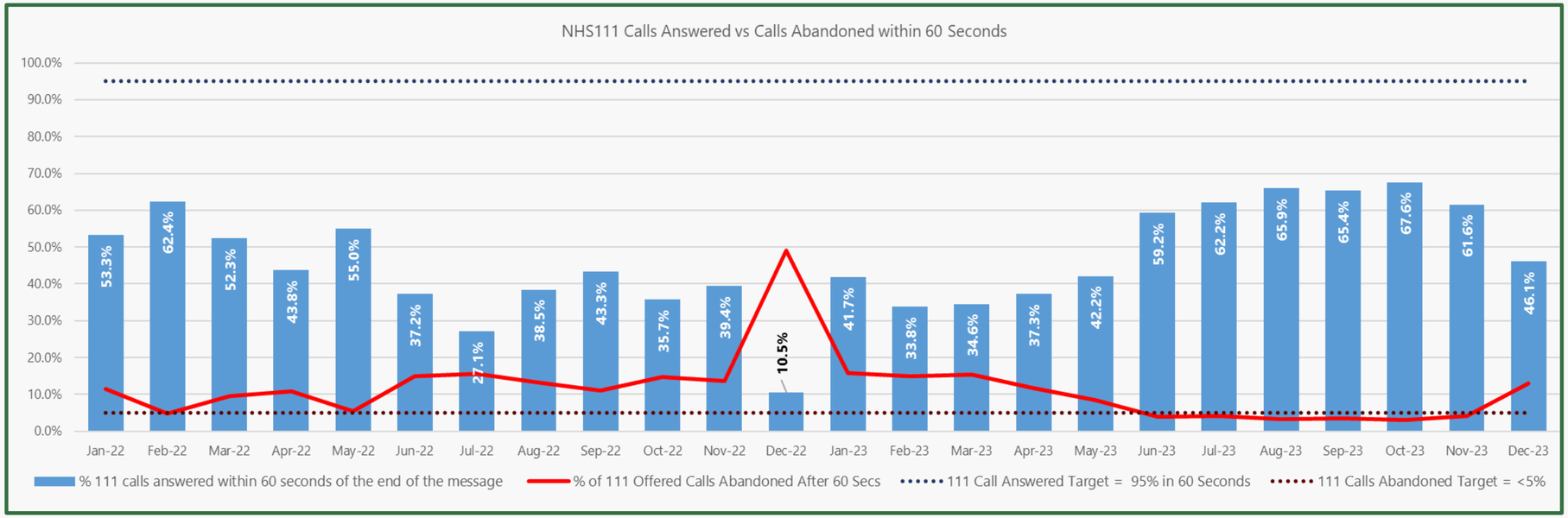
Our Patients: Quality, Patient Safety & Experience
111 Call Answering/Abandoned Performance Indicators

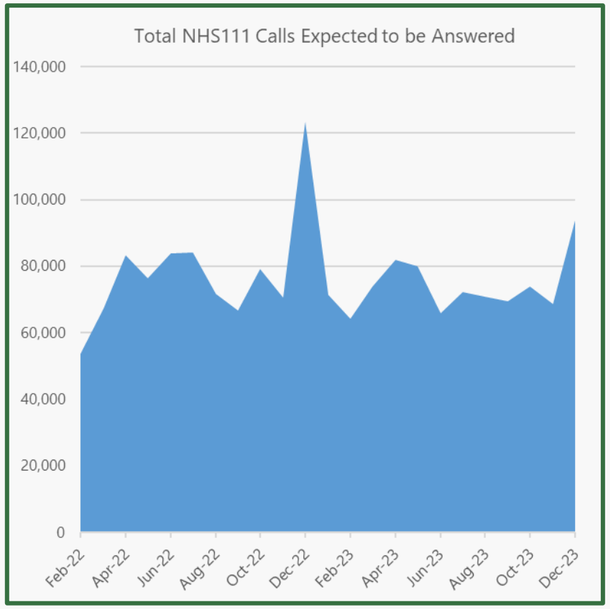
(Responsible Officer: Lee Brooks)

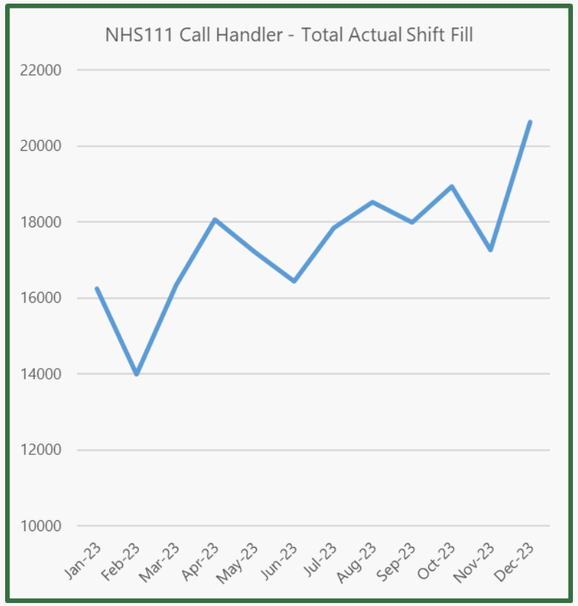
Abandonment Rate R

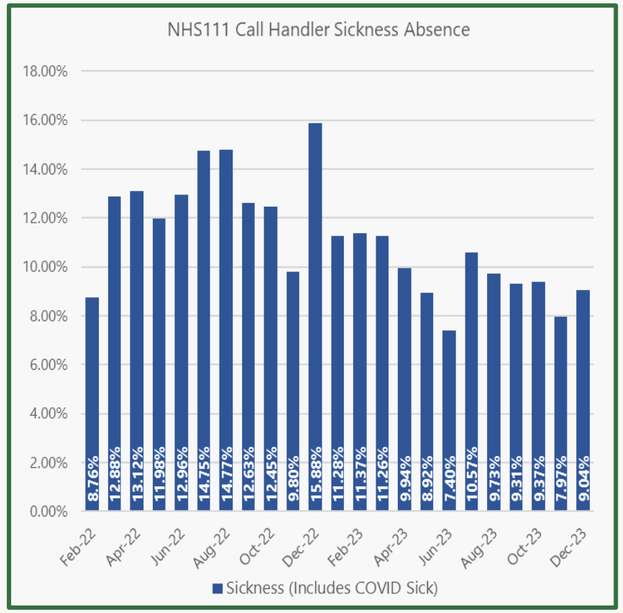
FPC

Influencing Factors – Demand and Call Handling Hours Produced









Analysis

The 111-call abandonment rate rose from 4.1% in November 2023 to 13.1% in December 2023. This is the first time the service failed to achieve the 5% target since May 2023. However, this figure is still well below the 49.1% abandonment rate recorded in December 2022 and, significantly, is also below the abandonment rates seen per month between January and March 2023, when demand was not as high as December 2023.

The percentage of 111 calls answered within 60 seconds also reduced, falling from 61.6% in November 2023 to 46.1% in December 2023. Although this remains below the 95% target, it again is an improvement on the 10.5% figure seen last December and is still higher than the figure recorded in 11 of the 12 months during 2022/23. The drop in performance during December 2023 was due to a spike in demand, to its second highest level over the past two years, but due to increased staffing levels now in place the impact on performance was far less significant than seen during previous months of higher demand. The spikes in demand over the festive / winter period will always be difficult to manage, but the actions taken in this year have meant that the increased demand has been better managed, albeit the targets have not been achieved.

The percentage of 111 calls answered in Welsh decreased from 1.25% in November 2023 to 0.91% in December 2023. Performance in the month is largely a reflection on the pressures on call answering in the month and it is anticipated that performance will recover strongly in January. Additional technical changes are planned for Q4 which will further improve this performance

Abstractions due to sickness absence increased slightly, against the longer-term downward trend. 111 abstractions are lower (better) than benchmark.

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 198 WTE call handlers will be funded in 2023/24. In Dec-23, 179 WTEs were in post for call handlers, with a further 8 WTE capacity being provided by bank and overtime. Call handler numbers are projected to increase to 195 WTEs in Jan-24.
- Work continues sickness absence in line with the Trust's managing absence work programme with an IMTP aim to get organisational sickness down to 6% by the end of 23/24.
- A roster review was planned in collaboration with the 111 commissioners to review rosters and ensure that capacity was aligned to demand, and to try and even out performance through the week. However, funding has been withdrawn, so this project is now paused.

Expected Performance Trajectory

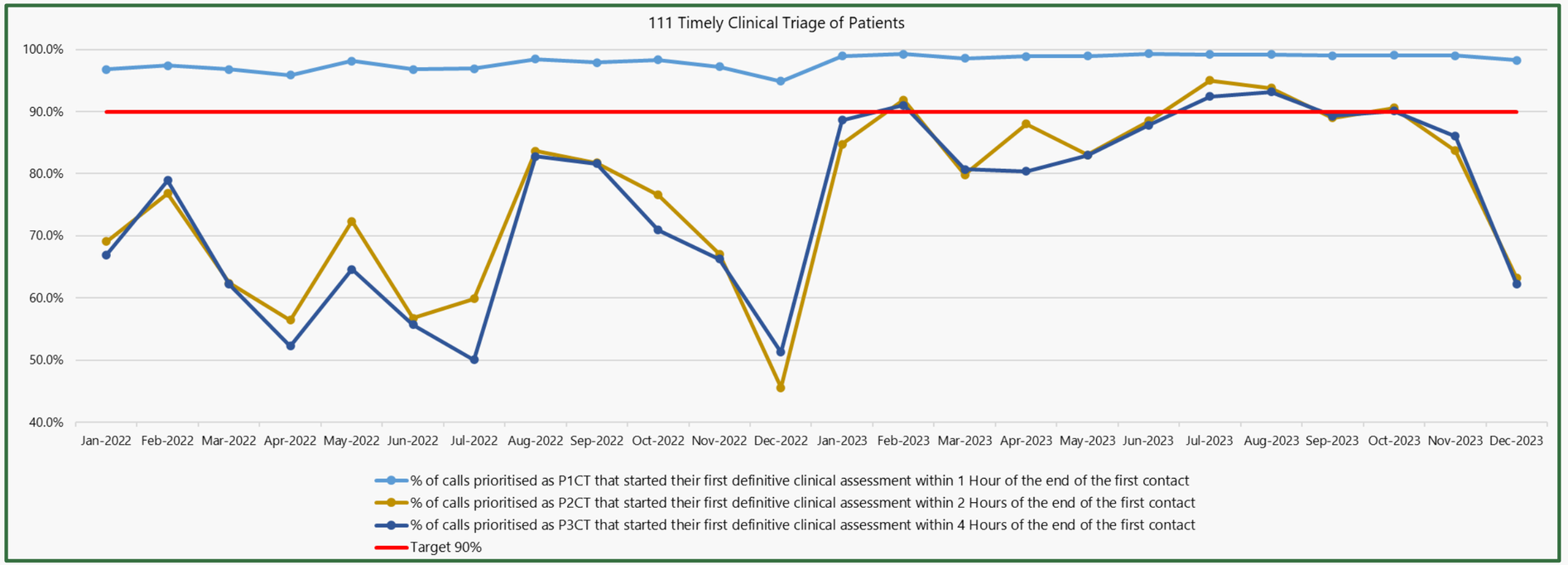
The Trust has improved ICT, compared to last winter, and improved processes and is recruiting up towards the commissioned FTE totals.

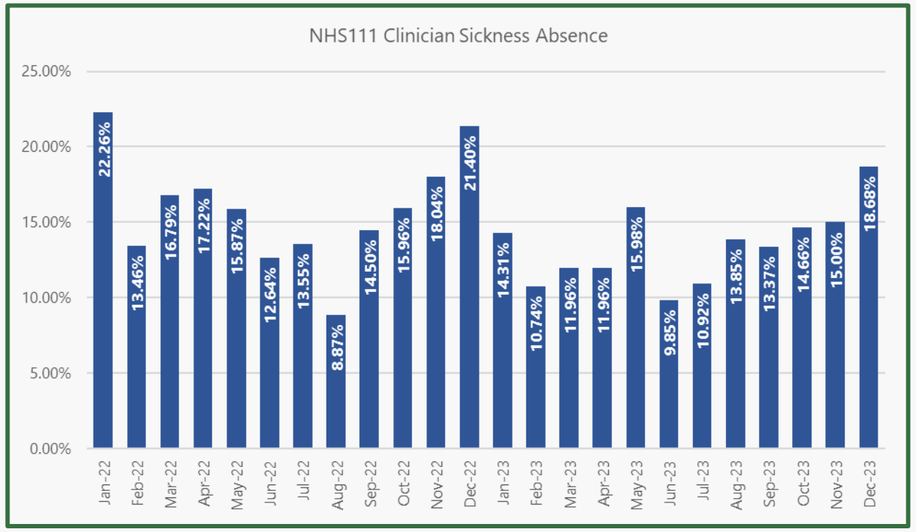
Our Patients: Quality, Safety & Patient Experience
111 Clinical Assessment Start Time Performance Indicators

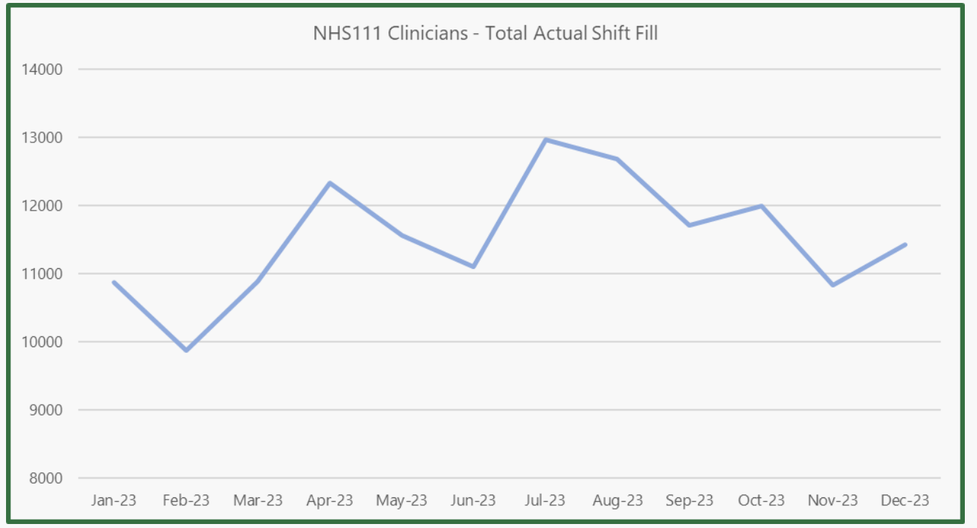
(Responsible Officer: Lee Brooks)

P1CT G FPC

Influencing Factors – Demand and Clinical Hours Produced







Analysis

The highest priority calls, P1CT, achieved the 90% target, recording 98.3% in December 2023.

However, lower category calls both declined during December, in line with a deterioration in other 111 performance metrics, predominantly due to a significant increase in call demand during the month.

P2CT decreased from 83.7% in November 2023 to 63.2% in December 2023, while P3CT fell from 86% to 62.3%.

Clinical staff capacity increased to 11,435 hours during December 2023, an increase of 597 hours when compared to November 2023. Clinician sickness absence increased to 18.68% in December 2023 from the 15% reported in November 2023.

18. Sickness absence management is another core component of capacity and workforce. Current levels within the 111 service, indicate that clinician absence remains too high in Dec-23 and further work is required.

As during December 2022, there was a significant spike in demand during December 2023, although performance levels did not decline as much as in previous months of higher demand, due to the increased staffing levels in place, which has helped to mitigate against these increased demand levels.

Remedial Plans and Actions

The main driver for improved performance will be the correct number of clinicians in post to manage current and expected demand. There were 94 WTE clinicians in post in Dec-23, rising to a projected 101 WTEs in Jan-24 with a further capacity being provided by bank and overtime (9 FTEs in Dec-23)) and commissioners have indicated that they have funding available for 102 WTE, albeit this could change next year.

Expected Performance Trajectory

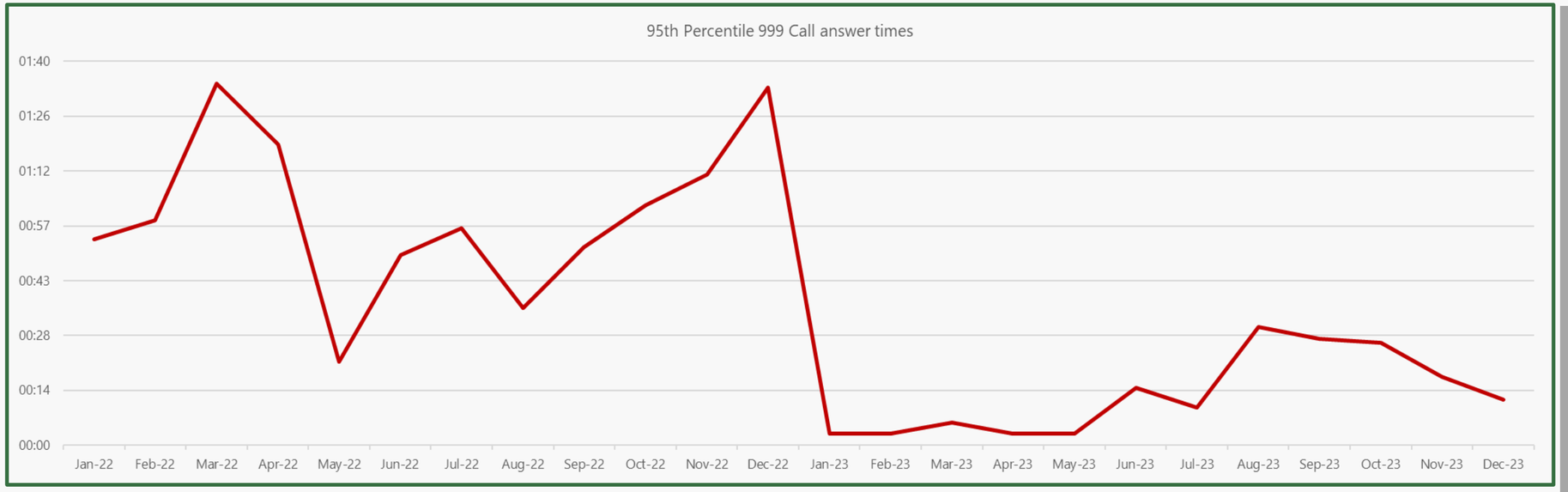
The Trust has now moved into the winter period. The Trust has improved ICT, compared to last winter, and improved processes and is recruiting up towards the commissioned FTE totals. 29. The 111Wales CAS business case has been approved by Welsh Government with the project proceeding at high pace with a hard back stop of needing to have moved to the new system by 30 April 2024. As highlighted above, the increased demand during December 2023 did negatively impact upon performance, albeit not to levels seen during previous demand spikes, and it is anticipated that the service will return to delivering and achieving the targets again, once demand returns to normal monthly levels.

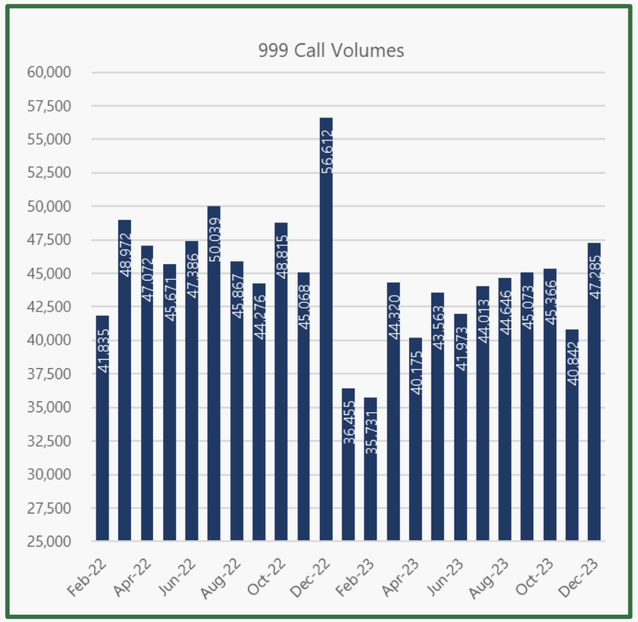
Our Patients: Quality, Safety & Patient Experience
999 Call Performance Indicators

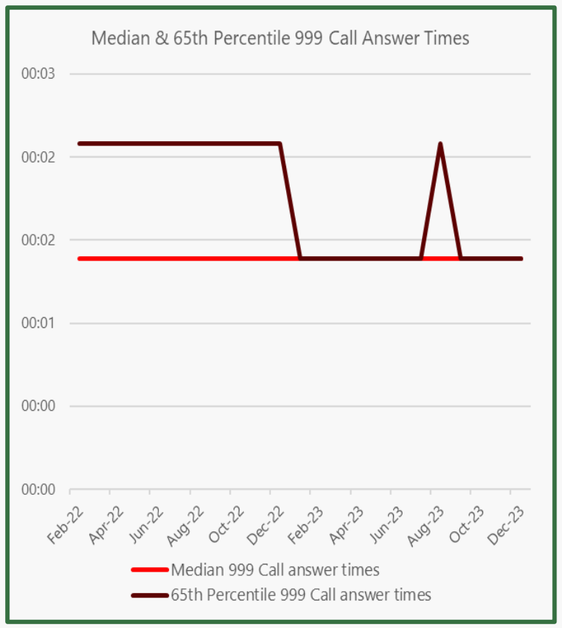
(Responsible Officer: Lee Brooks)

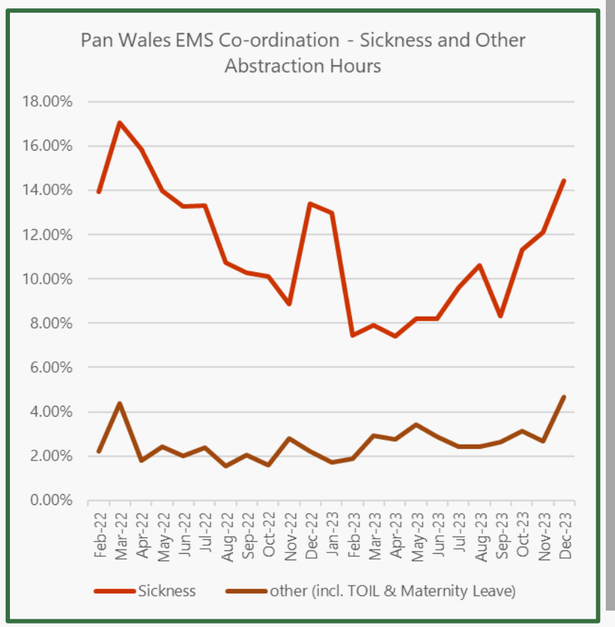
999 R | FPC | CI

Influencing Factors – Demand and Hours Produced









Analysis

The 95th percentile 999 call answering performance improved to 12 seconds in December 2023, down from 18 seconds in November 2023, but remained above the 6 second target. The median call answer time for the 999-service remained consistent at 2 seconds.

The Trust received 47,285 emergency 999 calls in December 2023, an increase from the 40,842 calls received during November 2023.

Overall sickness abstractions within EMS Coordination have risen over the past four months, after being on a downward trajectory until April 2023, rising to 14.4% in December 2023. The EA hours produced has declined slightly since June 2023, whilst overall sickness has been on an update trajectory since July 2023. These factors are likely to be having an impact on overall call answering performance which has not achieved the 6 second target since May 2023.

Remedial Plans and Actions

- Call takers are over established at call taker by 4.979 WTE, following ongoing recruitment.
- There is a further recruitment drive ongoing for Feb and March which should provide an additional 36 WTE (if successful in recruiting) which would mitigate against attrition as well as the Bryn Tirion move to Ty Elwy.
- Over establishment has been approved for EMSC by the Executive Director of Operations
- Intelligent Routing Platform is now in operation following configuration changes.
- Three workstreams are being progressed through the EMS Reconfiguration project (the complete reconfiguration has not commenced due to cost pressures required to fund the agreed model approved by ELT). This is on hold currently but will re commence in the next few weeks pending outcome and approval of a proposed new Structure for EMSC. This will require consultation.

Roster Review. Having successfully implemented an EMD roster review in February 23 the project has now progressed to commencing a dispatch roster review for Allocators and Dispatchers. About to restart, after the revised structures were agreed at Operations SLT in early January 2024.
Boundary changes. EMS Coordination intend to realign dispatch. boundaries to balance workload and pressures for individual dispatch teams About to restart as above..
Broader Ways of Working. This project is looking to create efficiency, effectiveness and improved productivity through a review of processes and procedures as well as providing consistency and lack of variation across centres. About to restart as above.

Expected Performance Trajectory

Performance is expected to get back on track as demand levels decrease and actions being taken to improve performance take effect.

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

Influencing Factors – Demand, Hours Produced and Hours Lost

(Responsible Officer: Lee Brooks)

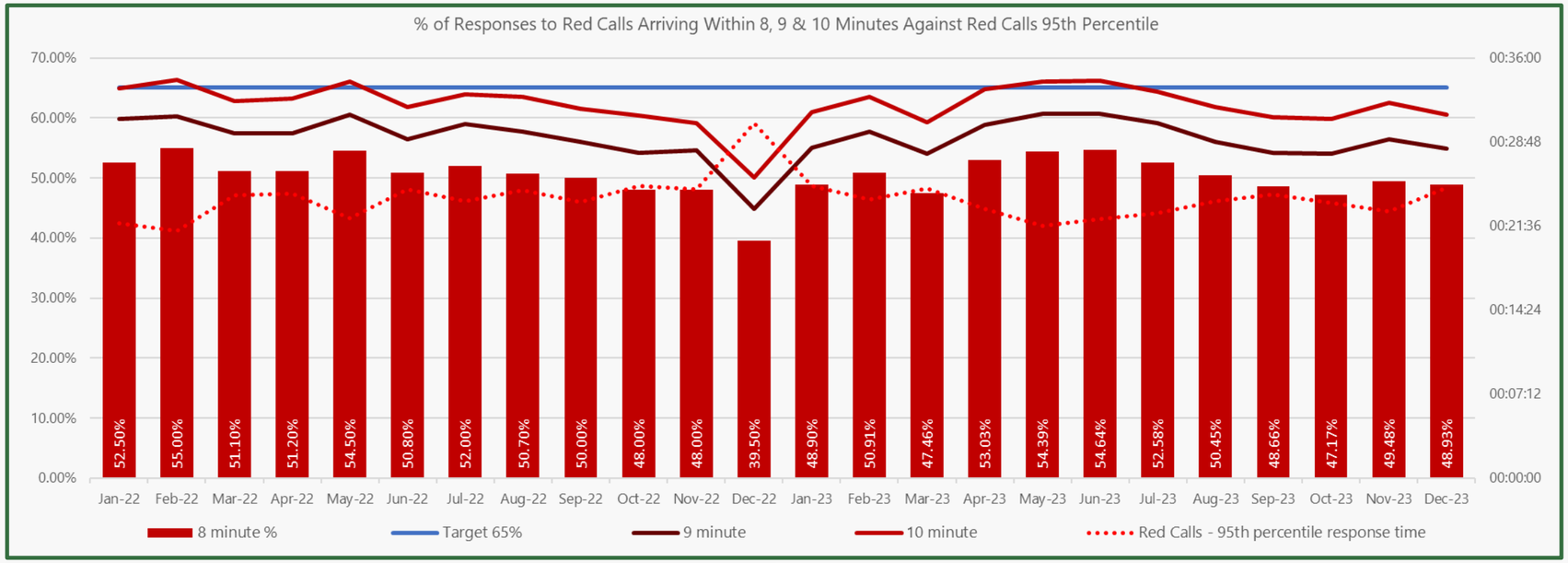
65% R

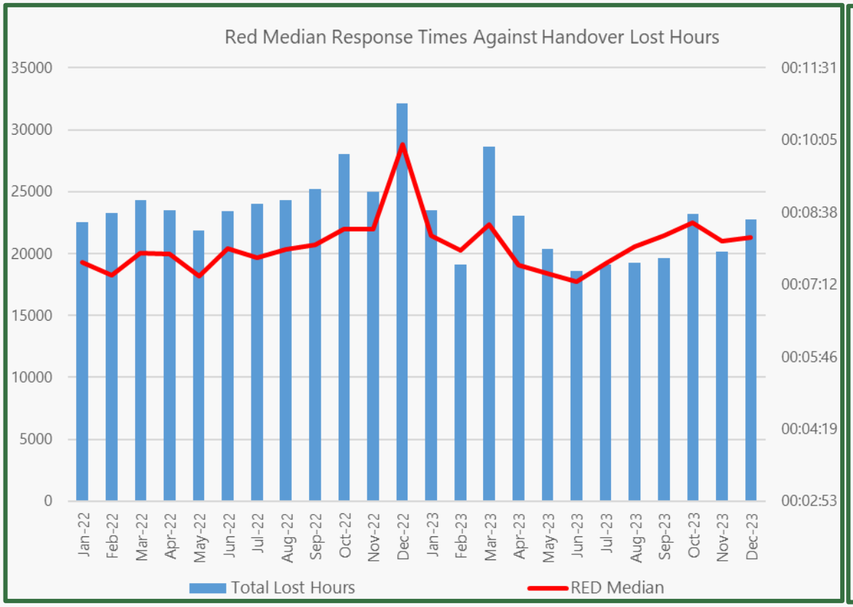
95% R

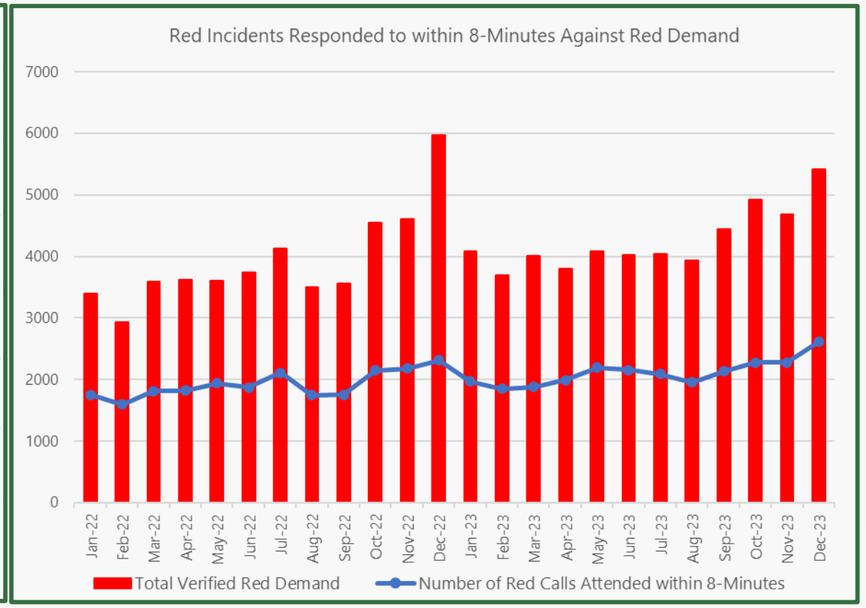
QUEST

FPC

CI







Analysis

Although Red 8-minute performance continues to remain below the 65% target, it only declined marginally during to December 2023 to 48.93%. Although this is a slight deterioration on the November 2023 percentage (49.48%), it is still an improvement on the figures recorded in both September and October 2023, when demand was significantly lower than that seen during December.

Red 10-minute performance for December 2023 was 60.5%, down slightly from 62.5% in November 2023.

The bottom right graph shows that as demand increased, so too did the number of Red incidents responded to within 8-minutes, with this figure increasing by 15% between November and December 2023 (n=341). This would indicate that performance in this area is remaining stable and is mirroring the rise experienced in demand during the month.

The lower left graph demonstrates the correlation between overall Red performance and hospital handover lost hours. December 2023 saw an increase in lost hours to 22,756 compared to 20,124 in November 2023, a rise of 13.1%. However, the December 2023 figure is significantly lower than the 32,098 recorded for December 2022. Overall, a decline is evident in the correlation between verified incidents and lost hours, with lost hours equating to 47 minutes per verified incident in December 2022 compared to 36 minutes per verified incident in 2023.

Remedial Plans and Actions

The main improvement actions are:

- To maintain commissioned establishment levels overall. WG have confirmed funding for the additional 100 will remain in place for this financial year
- Full roll out of the Cymru High Acuity Response Unit (CHARU), now largely complete (127 FTEs v target of 153 FTEs) with the exception of some hard-to-reach areas. Further actions to address;
- Changes to the response logic and clinical screening of red calls, which are now live (19 June 2023);
- Reduce hours lost through sickness absence via managing attendance programme – trajectory for improvement in place as part of the IMTP (6% Mar-24);
- Working closely with Health Boards to support reduction in lost hours and a reduction in conveyances to ED. This is undertaken within local Integrated Commissioning Action Plan meetings and will include work on improvements in referrals to Same Day Emergency Care Units (SDECs).

Expected Performance Trajectory

Winter modelling estimates Red 8 minute (most likely scenario) of 50% in October and November, declining to 45% in December, before recovering somewhat in Q4. The modelling has been shared with Welsh Government and EASC.

*NB: Data correct at time of abstraction

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

(Responsible Officer: Lee Brooks)

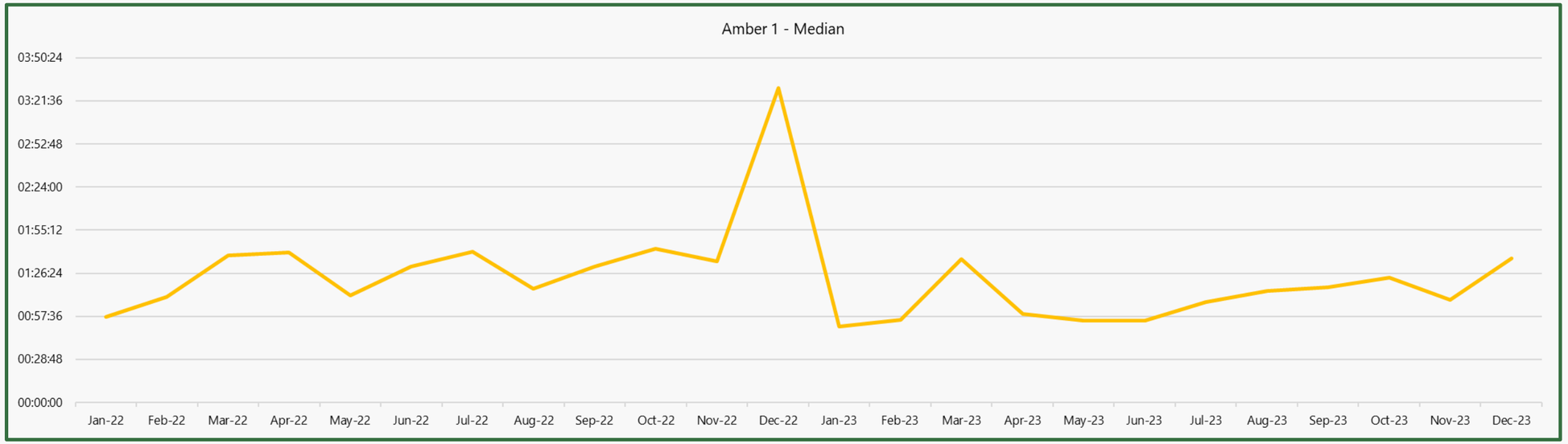
R

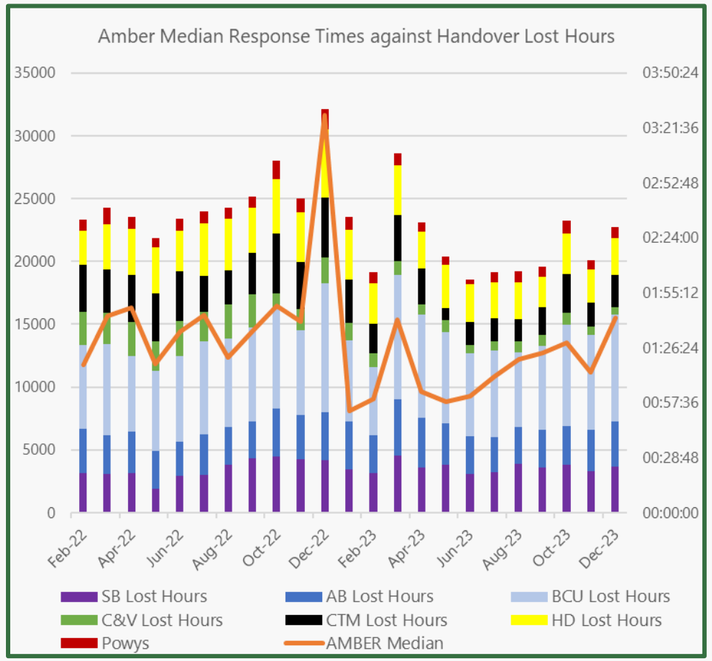
FPC

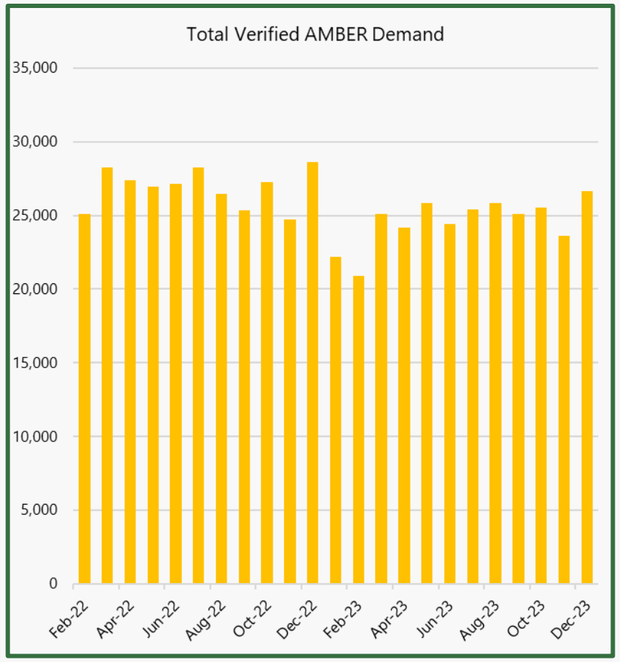
CI

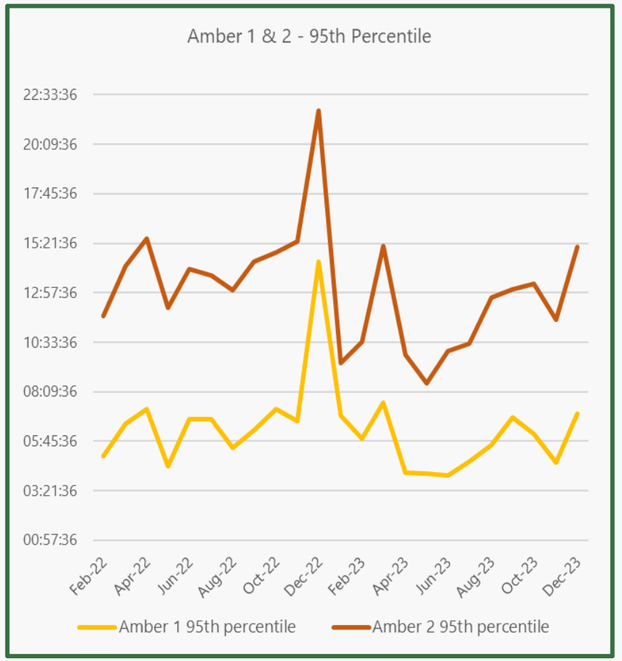
QUEST

Influencing Factors – Demand, Hours Produced and Hours Lost









Analysis

Amber demand increased by 12.7% in December 2023 compared to November 2023, rising from 23,617 verified incidents to 26,622. This however remains considerably lower than the 28,632 incidents registered in December 2022.

Amber 1 median performance time increased during December 2023 to 1 hour 36 minutes, from the 1 hour 9 minutes recorded in November 2023. Although this is the highest figure recorded in this area over the past year, as with Red performance this increase is significantly lower than that seen during December 2022, when the Amber 1 median spiked to 3 hours 30 minutes. The ideal Amber 1 median response time remains at 18 minutes, although this has yet to be achieved during the 3-year reporting period.

The Amber 1 95th percentile also increased during December 2023 to 7 hours and 6 minutes from 4 hours 45 minutes in November 2023.

As with Red, there is a strong correlation between Amber performance and lost hours due to handover delays.

Remedial Plans and Actions

The actions being taken are largely the same as those related to Red performance on the previous slide.

Expected Performance Trajectory

The 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 and system efficiencies, not all of which are within the Trust's control. This programme is now coming to an end, but the Trust is now well advanced with the strategic EMS Demand & Capacity Review.

Our Patients: Quality, Safety & Patient Experience

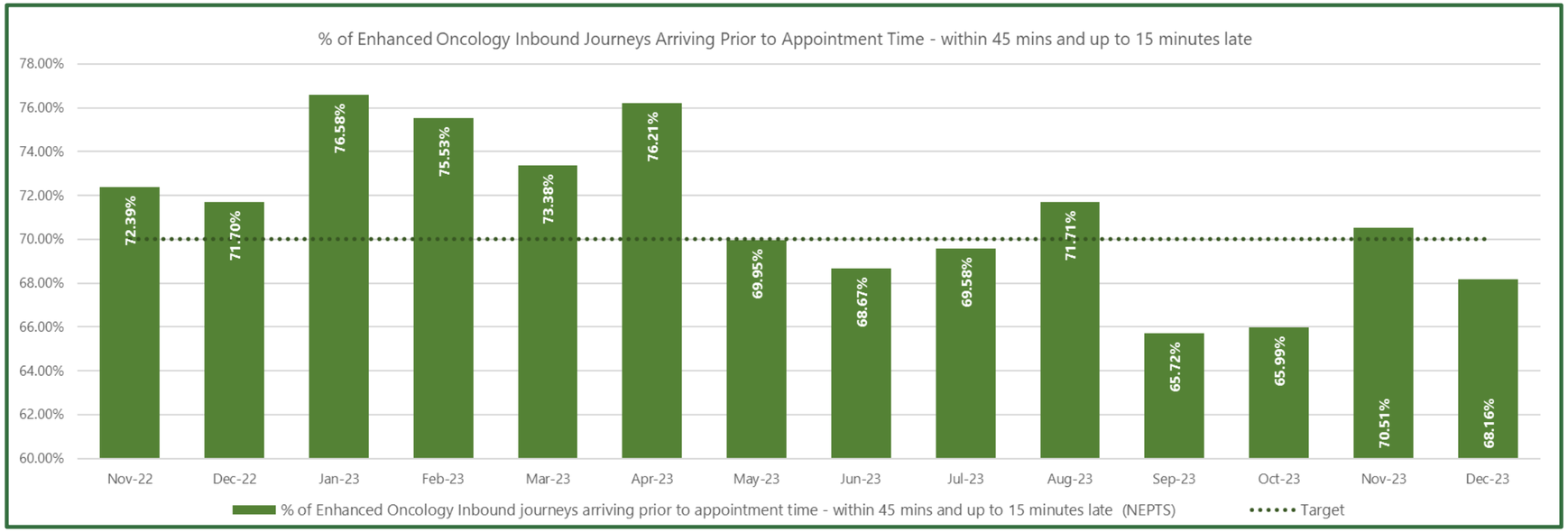
Patient Experience – Influencing Ambulance Care Indicators

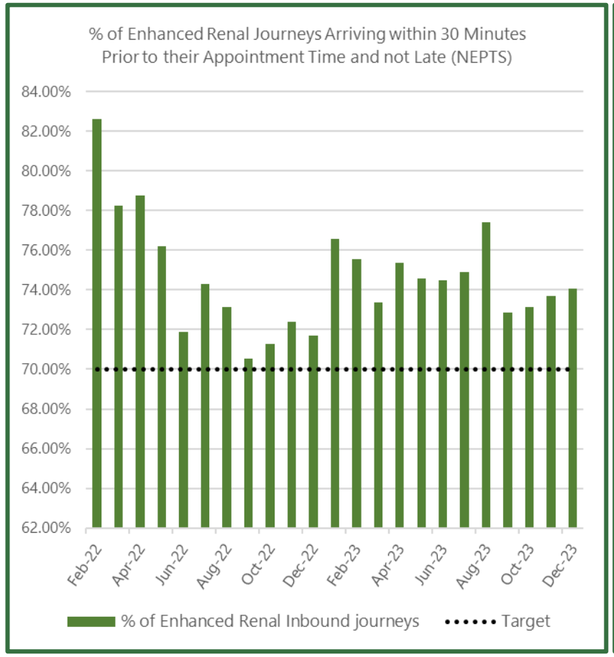
(Responsible Officer: Lee Brooks)

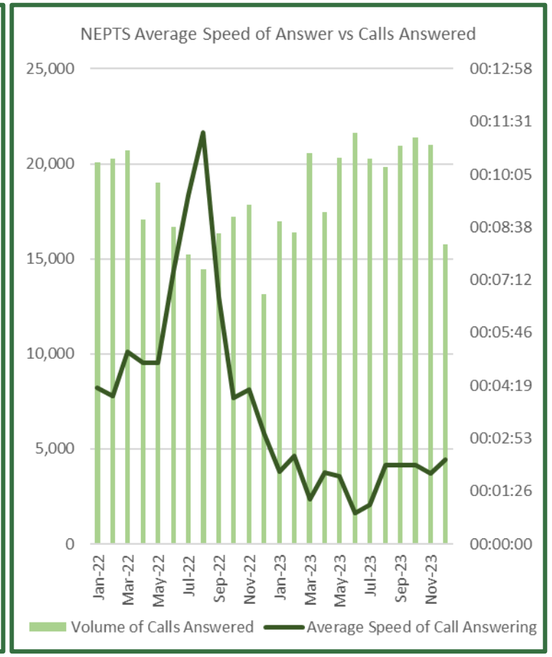
Oncology	Welsh Calls
A	A

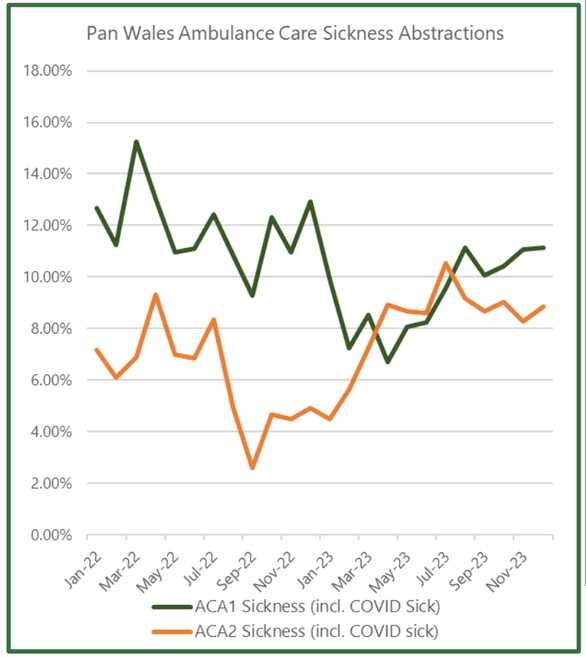
FPC

CI









Analysis

Ambulance Care (NEPTS element) performance decreased slightly during December 2023. 68.1% of enhanced oncology journeys arrived within 45 minutes prior and up to 15 minutes late to their appointment time, a decrease from 70.5% in November 2023, and failing to achieve the 70% target. Enhanced Renal journeys, however, saw a slight improvement, from 73.6% in November 2023 to 74% in December 2023.

Overall demand has continued to increase as the planned care system continues to reset. In particular:-

- Completed journeys for Patients requiring Ambulance Transport – Non T1 & C3 mobility (exc. Discharge & Transfer) are at or in excess of levels seen prior to the pandemic.
- At the heart of the increases are constant increases in renal transport, these journeys are always our highest priority and increases here will reduce capacity elsewhere within the team.
- There has been a notable increase in requests for discharges from the ED. This correlates with EMS no longer facilitating these requests. However, despite good performance in Cardiff & Vale and Cwm Taf Morgannwg, the proportion of bookings made in advance for discharges and transfers has not increased.

Call volumes answered decreased slightly in December 2023 (15,769) compared to November 2023 (21,023) which is to be expected with the reduced clinics running over the holiday period. Average speed of call answering increased in December 2023 (00:02:19) compared to November 2023 (00:01:55). The overall percentage of calls answered within 60 seconds declined slightly in December 2023 to 53.09%, compared to November 2023 (57.7%).

ACA1 (NEPTS) sickness increased in December 2023 to 11.16% compared to 11.08% in November 2023. ACA2 (UCS) sickness also increased to 8.84% in December 2023 compared to 8.27% in November 2023.

Remedial Plans and Actions

- Local management teams are working closely with Health Board colleagues to develop local actions in response to the current level of Oncology performance. This should address the lack of cohesive planning that includes transport as we have in Renal services.
- The volunteer team are bringing online an additional 20+ volunteers during Q4, these will be focused on Oncology performance initially

Expected Performance Trajectory

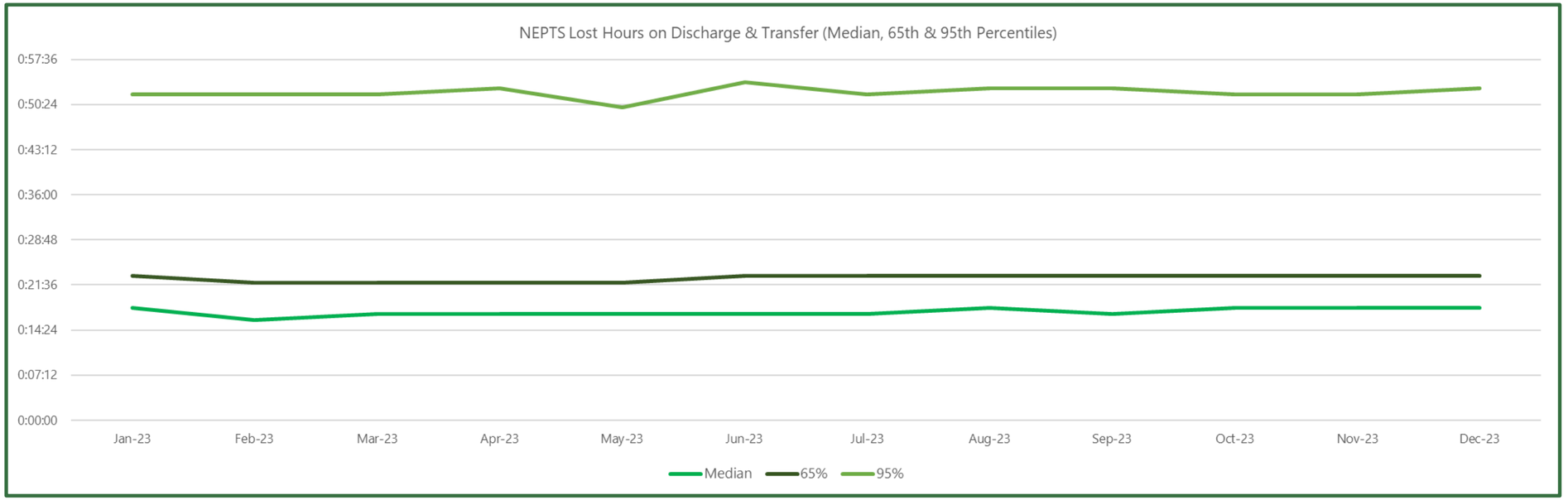
With the implementation of the above actions, it is anticipated that Oncology performance will improve over Q3. Initial improvement trends have already been seen after just a few of the actions have been partly implemented.

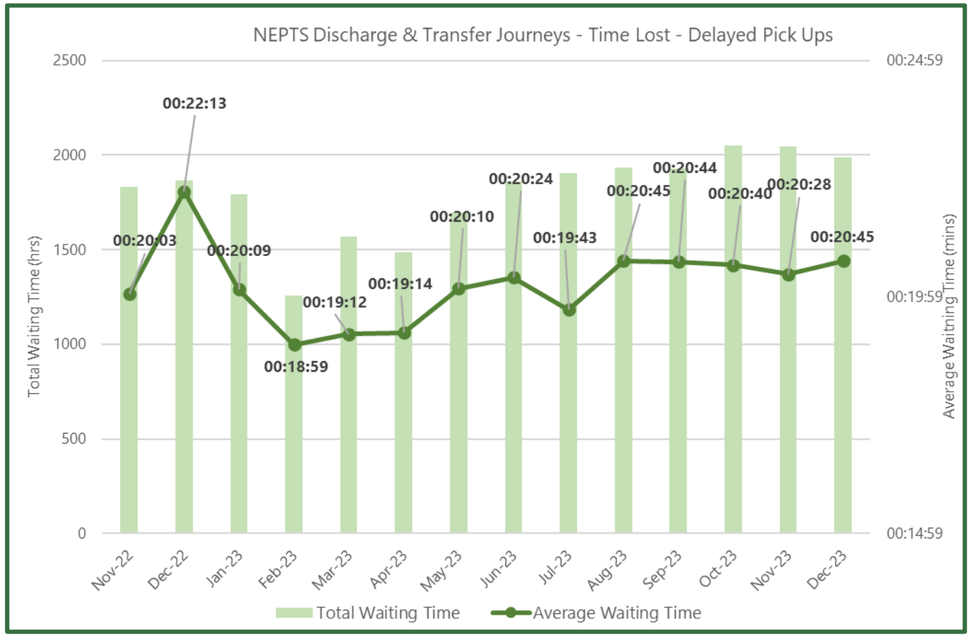
Our Patients: Quality, Safety & Patient Experience
Ambulance Care Indicators

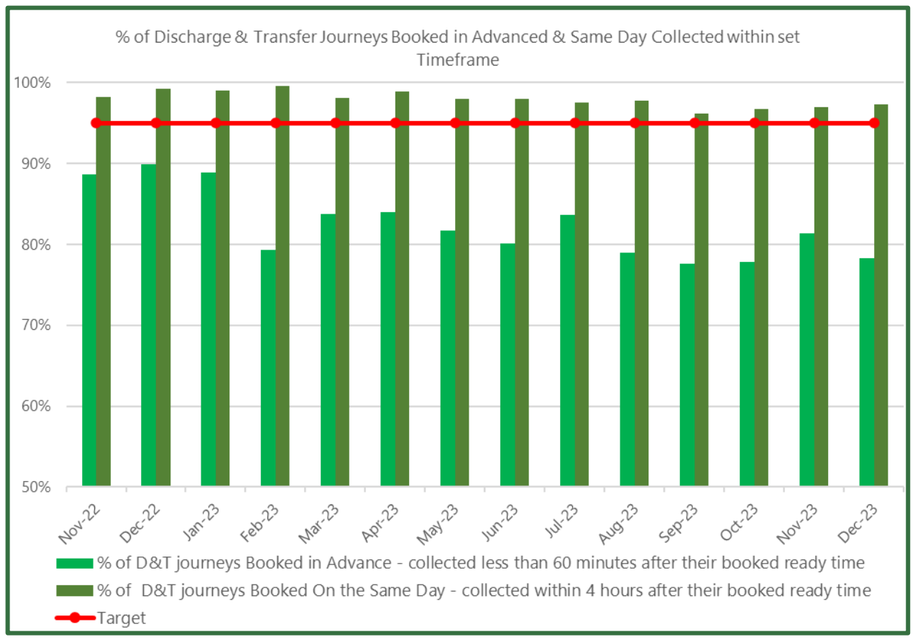
(Responsible Officer: Lee Brooks)

D&T
R

Patient Experience – Hospital>Hospital Transfer Waiting Times







Analysis
Time lost on discharge and transfer pickup has remained consistent for some time now with minimal variation experienced.

The data shows that the average time lost over the past 12 months is 17 minutes, which includes time from arrival at site to when the patient is loaded on the vehicle. The hope is that over time this can be reduced to 15 minutes.

In April 2023, an additional KPI measure was introduced to measure the performance on discharges and transfers. The new measure separated out bookings made in advance and provided a tighter 1-hour target for these. This change also promoted a move to advanced booked discharges, which would help to reduce the time patients are required to wait prior to pick up, when ready for discharge. During this period, whilst there has been a slight increase in the volume of discharges , the overall percentage of bookings made in advance has only increased from 26% in December 22 to 26.4% in December 2023. Of note was Cardiff and Vale, where more than 40% of bookings were consistently made at least the day before discharge. In Cwm Taf Morgannwg, where work is underway to develop a process that can be copied nationally, the percentage of advanced discharge & transfer bookings has increased from 17.9% to 26% during the same period.

78% of discharge & transfer journeys booked in advance were collected within 60 minutes of their booked ready time, a decrease compared to November 2023 (81%), and below the 95% target. 97% of discharge & transfer journeys booked on the same day were collected within 4 hours of their booked ready time, which is consistent when compared to November 2023 (97%), and above the 95% target.

Remedial Plans and Actions
Continue work with CTM on national optimal model

Expected Performance Trajectory
Until the model is developed and rolled out, we do not anticipate any significant variation in this data. However, we continue to work with sites and the teams to identify opportunities to reduce.

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

(Responsible Officer: Andy Swinburn)

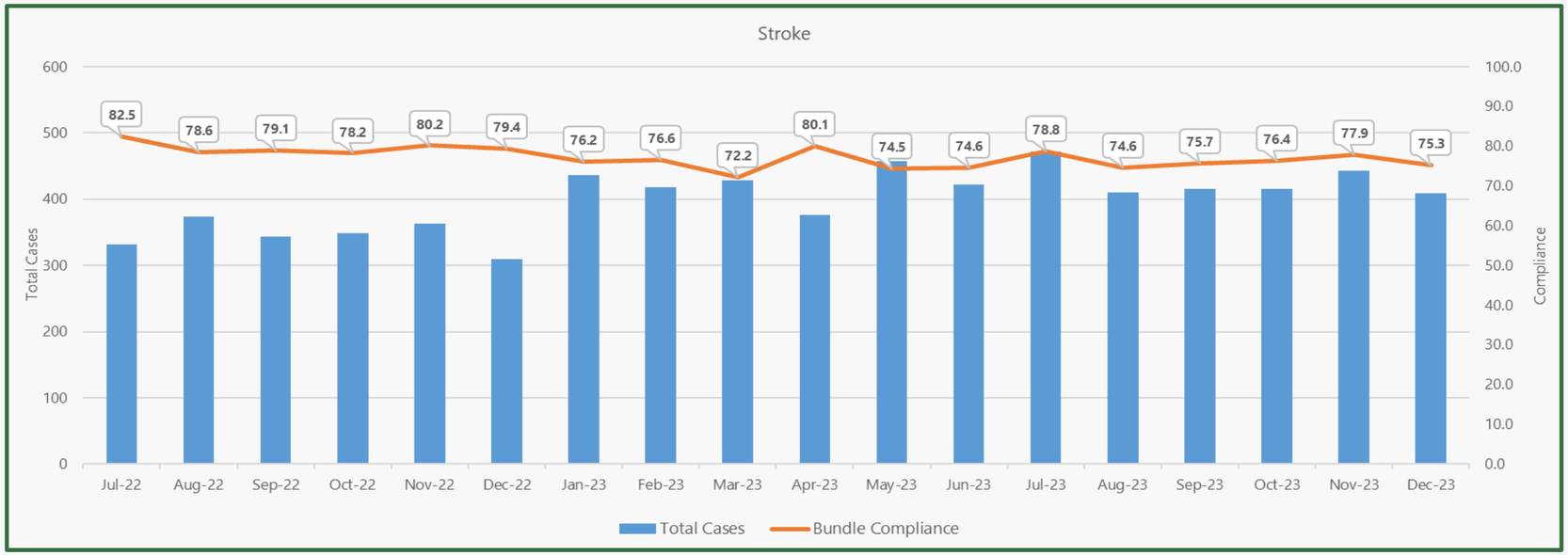
ROSC/Stroke/STEMI

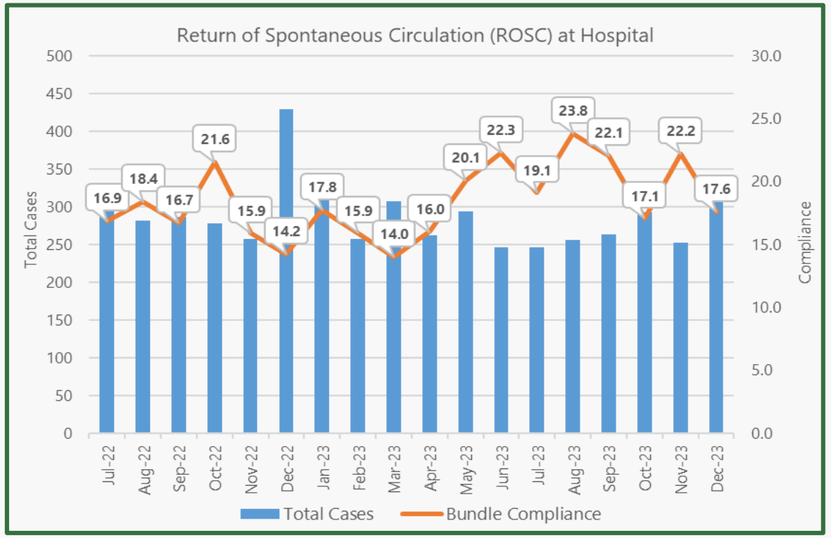
A

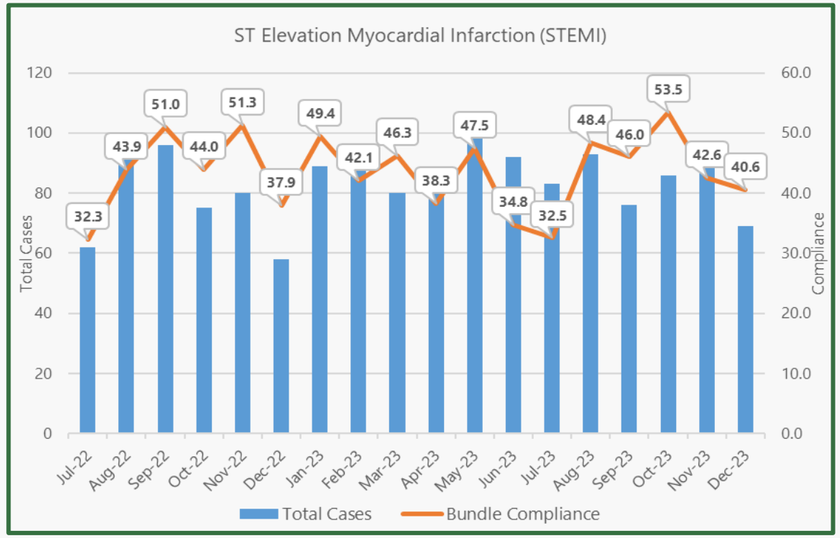
Self-Assessment: Strength of Internal Control: Moderate

QUEST

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







Analysis

The percentage of suspected stroke patients receiving an appropriate care bundle in December 2023 was 75.3%. This was a slight decrease from the 77.9% recorded in November 2023. This was against a total case number of 409 during the month of December. There is a correlation between documenting FAST and the care bundle, this will inform the improvement plan.

The ROSC rate for December 2023 was 17.6% a decrease from 22.2% in November 2023. This was against a total case number of 324 during the month of December. The highest rate recorded since the implementation was seen in August 2023, achieving 23.8% of ePCR.

Due to the nature of this metric, common cause variation occurs which can result in a marked reduction in performance from small numbers of unsuccessful resuscitations attempts.
The factors that influence this may include:

- Response Times
- Bystander Resuscitation
- Response Type/Numbers

The percentage of suspected STEMI patients receiving an appropriate care bundle in November 2023 was 40.6%, a decrease from 42.6% in November 2023. This was against a total case number of 69 during the month of December. There is a correlation between documenting of Aspirin and the care bundle, this will inform the improvement plan.

All CIs remain within the normal bundle control limits

Updates to the UI for the ePCR were rolled out on12th December 2023, in particular around elements of the application that affect the CIs

We were aware that changing from Digital Pen to ePCR necessitated a change in data collection and anticipated a reduction in compliance as Clinical Indicators are now compiled from data recorded by clinicians and is not subject to any validation process.

In addition, other UK ambulance services reported a reduction in clinical indicator compliance when using ePCR data only . We generated risk 535 with three key mitigations to work on:

- User understanding and behaviour with the ePCR application
- Adapting the user interface
- Reviewing the coding used to draw data from the data warehouse

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

Hypoglycaemia, Neck of Femur (NOF) and Time-Based metrics (Stroke & STEMI)

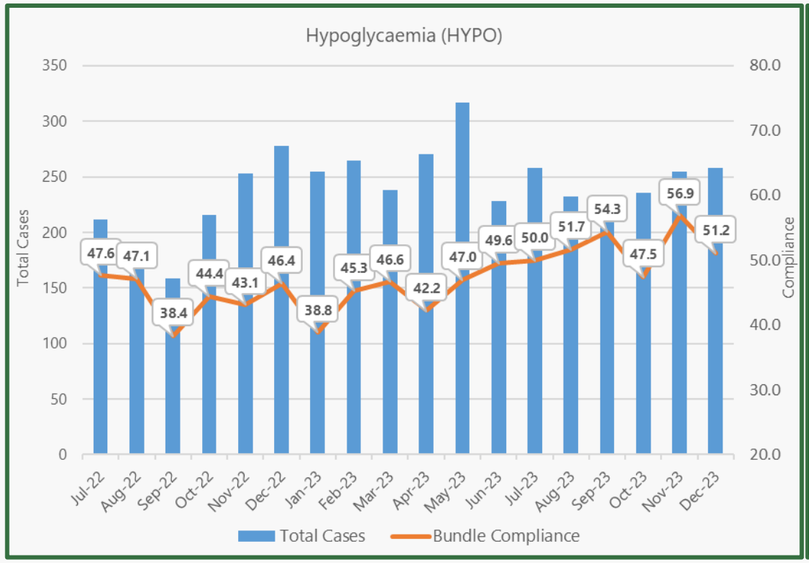
(Responsible Officer: Andy Swinburn)

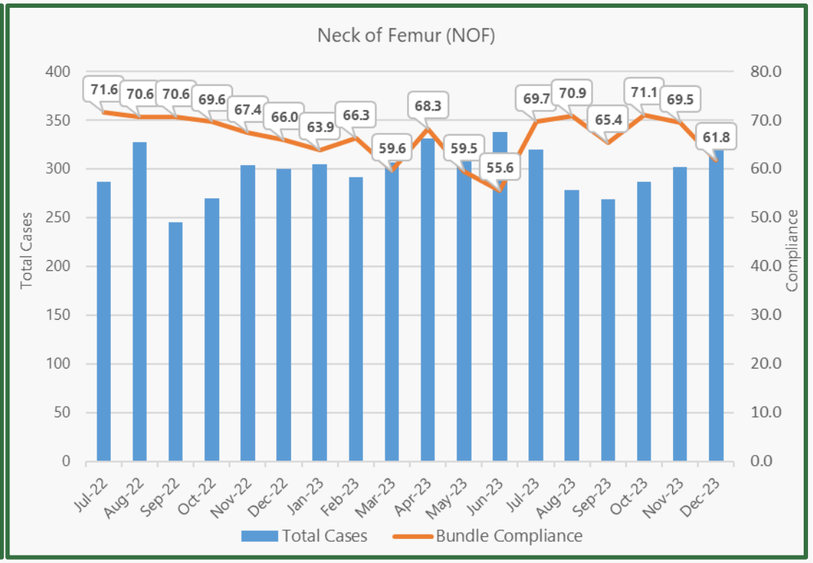
Stroke Door to Doot

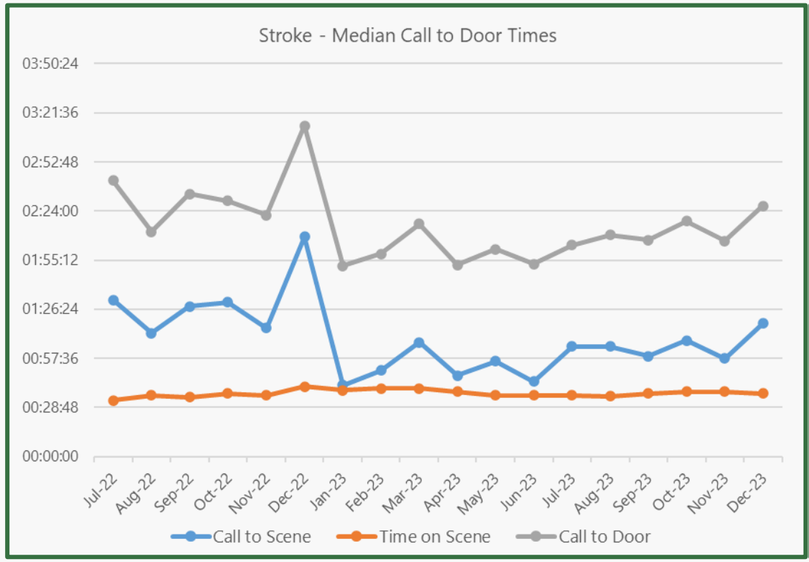
A

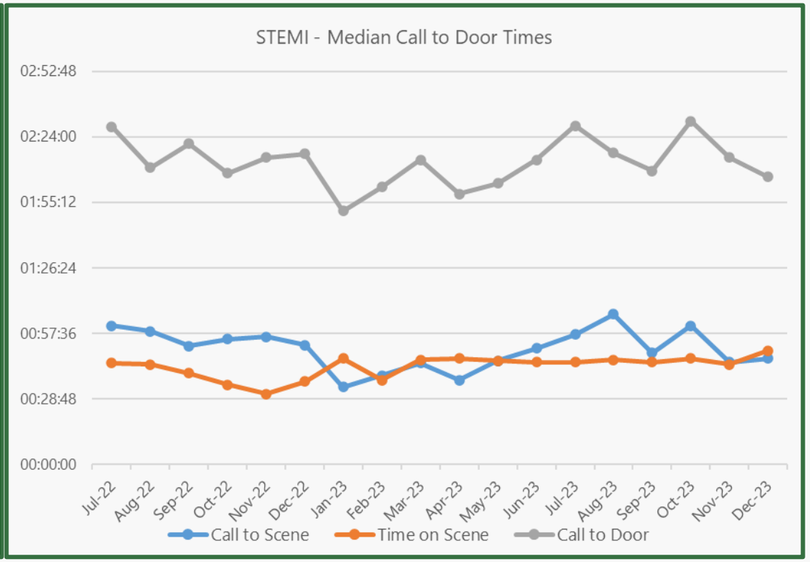
Self-Assessment: Strength of Internal Control: Moderate

QUEST









Analysis

The percentage of hypoglycaemic patients receiving an appropriate care bundle in December 2023 was 51.16%, a decrease from 56.86% in November. This was against a total case number of 258 in December. There is a correlation between documenting BM readings and the care bundle, this will inform the improvement plan.

The percentage of #NOF patients receiving an appropriate care bundle in December 2023 was 61.83%, a decrease from 69.54% in November. There is a correlation between documenting pain score and analgesia and the care bundle which will inform the improvement plan.

The development to enable reporting new clinical indicators relating to call to door times for STEMI and Stroke has been completed and approved. These show the breakdown for:

- Time the call started to time of arrival at scene
- Time on scene of the conveying vehicle
- Time the call started to time of arrival at hospital

Remedial Plans and Actions

An improvement approach has been taken which includes Senior Paramedics support to discuss CIs with WAST clinicians as part of the ride-out process. A CI dashboard (v2) which includes separate diagnostic code pages for '000' & '1-183' was approved by CIAG and is now available, this illustrates performance by HB area and informs discussions.

ePCR User Interface (UI) changes resulting from recommendations based on quality assurance audits conducted for each of the CIs were implemented during December 2023. This includes a further change to allow prompts and messages when an ePCR is being closed and alert the clinician to incomplete fields which will improve compliance.

A pain management framework has been developed in response to an internal audit action to improve assurance on completeness of documented pain management for patients, and the ability to extract data, identifying and reporting themes and trends.

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 and is our main response to improve ROSC rates. This has been in place in some areas since October 2022 and since May 2023 there has been an increase in numbers and availability.

Expected Performance Trajectory

The UI change to allow prompts and messages when an ePCR is being closed and alert the clinician to incomplete fields will be monitored by the ePCR Compliance Approval Group. This, along with continuing improvements in clinical supervision and the support of SPs working with the Clinical Improvement and Clinical Intelligence and Assurance Teams should increase compliance rates.

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

(Responsible Officer: Liam Williams)

Concerns. A

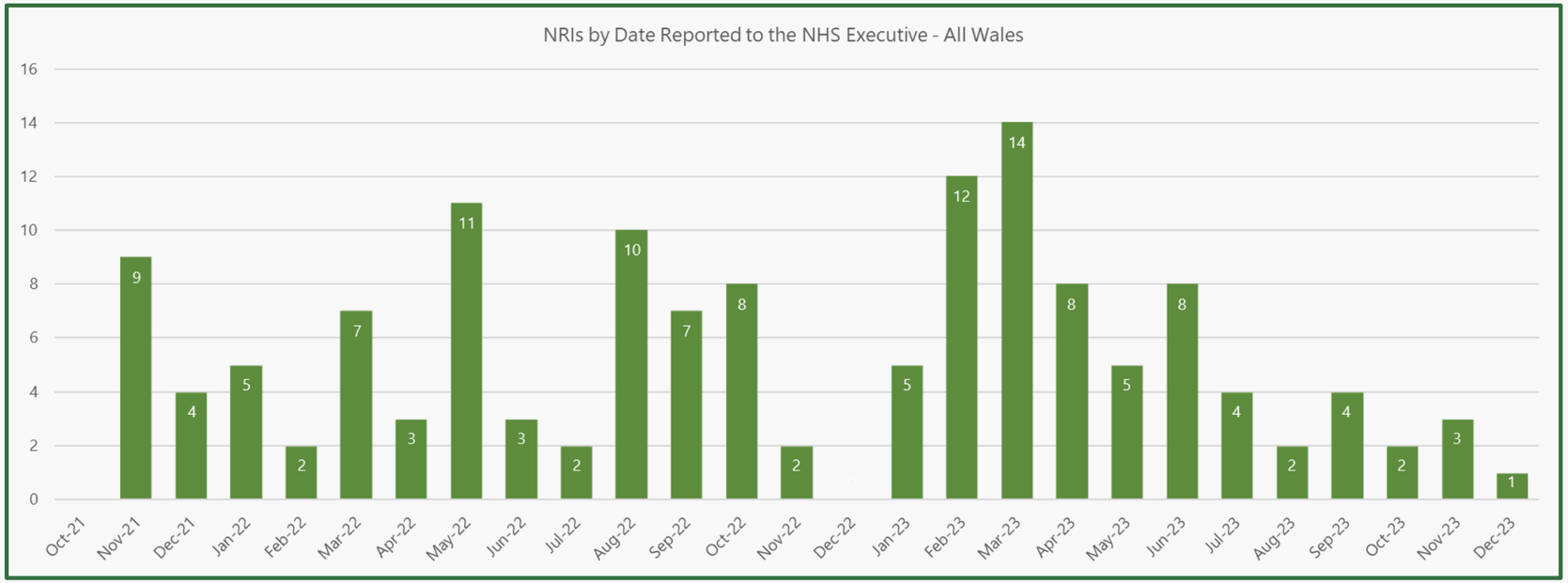
NRI. G

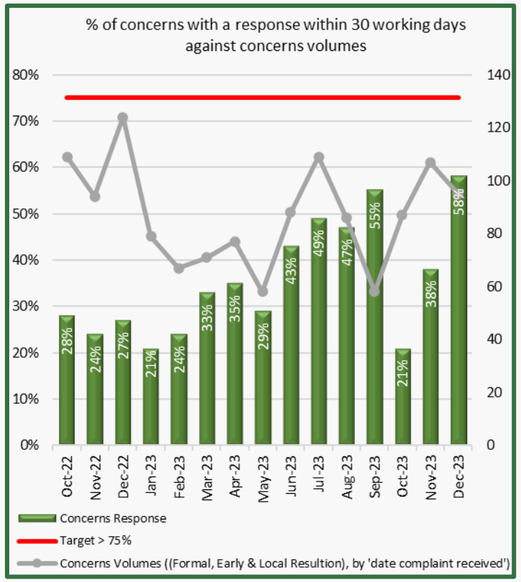
Self-Assessment: Strength of Internal Control: Moderate

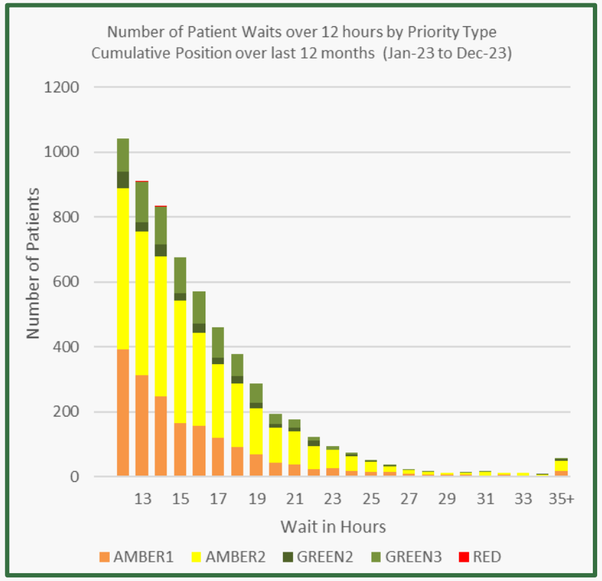
QUEST

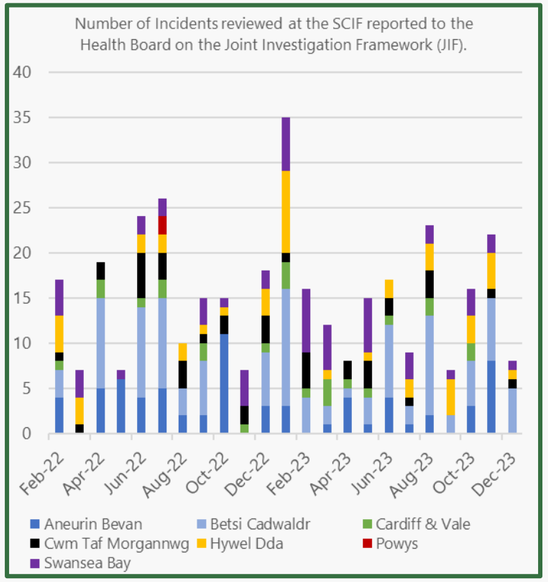
Health & Care Standard
Health - Safe Care / Timely Care

Responses Indicators









Analysis

The percentage of responses to concerns in December 2023 is 58% against a 75% target (30-day response) which is a slightly increased position. 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 has increased with 95 complaints being received and processed in December 2023. These complaints are frequently complex with our concerns administrators taking lengthy calls from distressed patients or family members for up to one hour per call.

Six (6) Serious Case Incident Forums (SCIF) were held during the month and 17 cases were discussed. Following discussion 1 serious patient safety incident was reported to the NHS Wales Executive and 5 cases were referred to Health Boards for investigation under the Joint Investigation Framework. The Trust received no referrals from Health Boards under the Joint Investigation Framework during the period. Learning from the Joint Investigation Framework process remains limited with Health Boards citing high levels of escalation as causal factors.

All patient safety incidents graded moderate or above will continue to be reviewed by the Patient Safety Team, who will consider the requirement to enact the Duty of Candour and contact patients and families as appropriate.

Themes relating to serious patient safety incidents reported to the NHS Wales Executive (Delivery Unit) as Nationally Reportable Incidents (NRIs) include delayed community response times and call categorisation, predominately ineffective breathing which is being discussed at national ambulance forums as a consistent theme.

In December 2023, 793 patients waited over 12 hours for an ambulance response and 45 compliments were received from patients and/or their families.

Remedial Plans and Actions

A range of actions are in place:-

Recruitment, redeployment and assessment of workload and where to best place resources continues corporately and within the Operations Quality Team. Following financial agreement at the Executive Leadership Team in September 2023 an organisational change process commenced in the Putting Things Right Team on 25.09.2023 and posts are currently being recruited to. It is envisaged that the structure will be fully recruited to by April 2024.

Delayed community response (Risk 223) and handover of care delays at hospitals (Risk 224) are the two highest rated risks on the Trust's Corporate Risk Register (both rated 25) and include detailed mitigations and current actions, both are considered at Board sub-committee level and at Trust Board.

The key strategic action is the EMS Operational Transformation Programme.

Delayed community response (Risk 223) and handover of care delays at hospitals (Risk 224) are the two highest rated risks on the Trust's Corporate Risk Register (both rated 25) and include detailed mitigations and current actions, both are considered at Board sub-committee level and at Trust Board. 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 which are detailed on the Corporate Risk Register.

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

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

***NB: 30 Day Compliance reported from Power BI and therefore data is not yet validated*

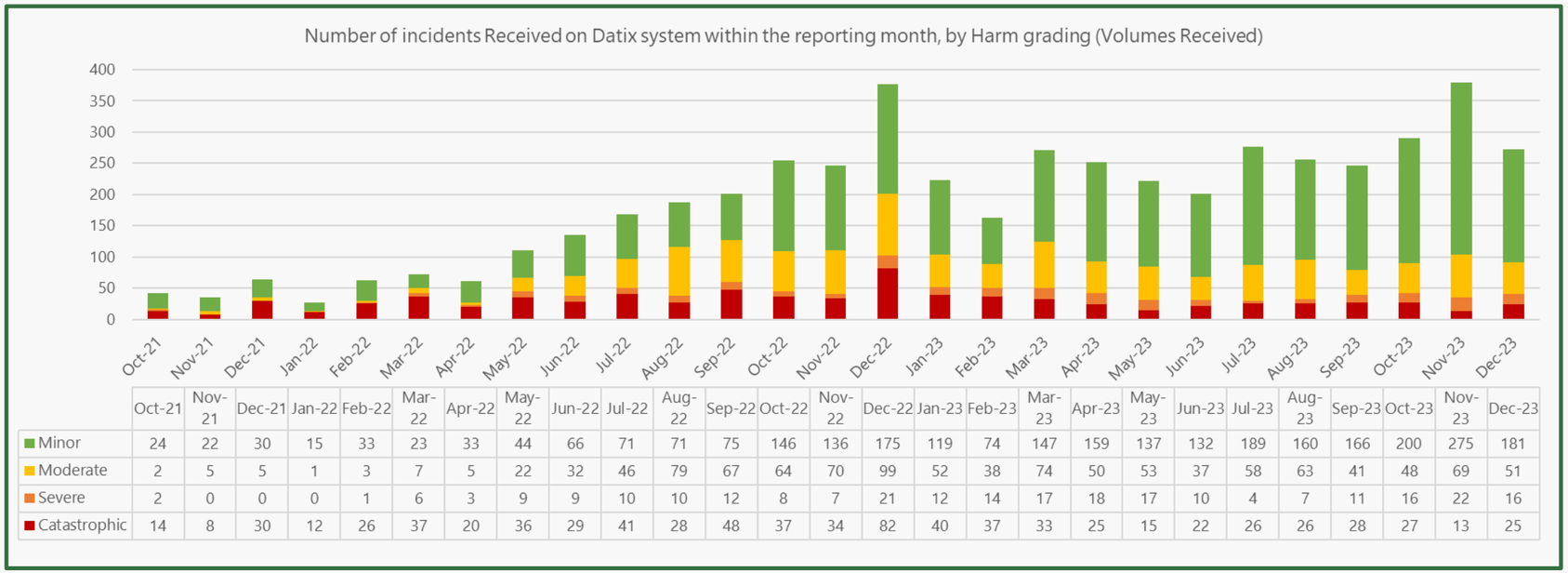
Our Patients: Quality, Safety & Patient Experience
Patient & People Safety Indicators

(Responsible Officer: Liam Williams)

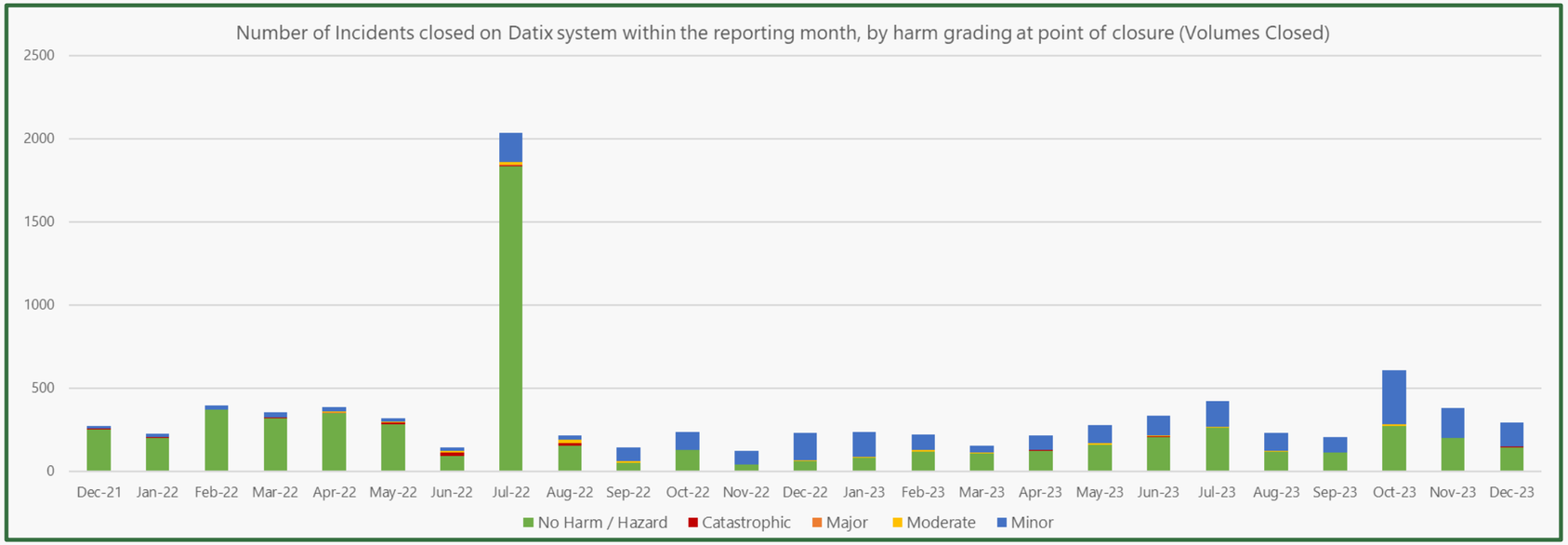
Self-Assessment: Strength of Internal Control: Moderate

PCC

Health & Care Standard
Health – Safe Care



	Oct-21	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	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Minor	24	22	30	15	33	23	33	44	66	71	71	75	146	136	175	119	74	147	159	137	132	189	160	166	200	275	181
Moderate	2	5	5	1	3	7	5	22	32	46	79	67	64	70	99	52	38	74	50	53	37	58	63	41	48	69	51
Severe	2	0	0	0	1	6	3	9	9	10	10	12	8	7	21	12	14	17	18	17	10	4	7	11	16	22	16
Catastrophic	14	8	30	12	26	37	20	36	29	41	28	48	37	34	82	40	37	33	25	15	22	26	26	28	27	13	25



Analysis

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.

All patient safety incidents graded moderate or above will continue to be reviewed by the Patient Safety Team, who will consider the requirement to enact the Duty of Candour and contact patients and families. The Datix Cymru System has recently been updated nationally to allow Duty of Candour to be captured and reported and further work to develop a dashboard is in progress. Monthly volumes should be interpreted with caution as incidents can be duplicated on the system (for example two crews submitting the same incident).

No harm or hazard – 97
Minor harm – 184
Moderate harm - 51
Severe Outcomes - 16
Catastrophic - 25

(*NB: Volumes received).

The bottom graph highlights the 293 Incidents that were closed on the Datix system in December 2023. Monthly volumes should be interpreted with caution as incidents can be duplicated on the system (for example two crews submitting the same incident).

Remedial Plans and Actions

Workload for all members of the team continues to be high due to continued system pressures resulting in a backlog of Putting Things Right concerns which are frequently complex. The combination of the implementation of the Duty of Candour, Duty of Quality and the Medical Examiner Service has meant additional activity for the Putting Things Right Team.

The Putting Things Right Team organisational change process is progressing with posts being recruited to. This new structure has considered our local and national priorities and resources to meet the needs of our patients and families and is expected to be fully recruited to by April 2024.

The Trust is represented at national networks including Duty of Candour, Complaints, Ombudsman, Learning, Mortality, Claims, Redress and Datix Cymru development groups as resources allow. Work is progressing in respect of the development of dashboards and the aggregation of data and information to inform patterns, trends and learning opportunities as part of the quality management system.

Expected Performance Trajectory

The Trust will continue to identify quality and safety improvements through the Putting Things Right processes.

**NB: Data is correct on the date/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

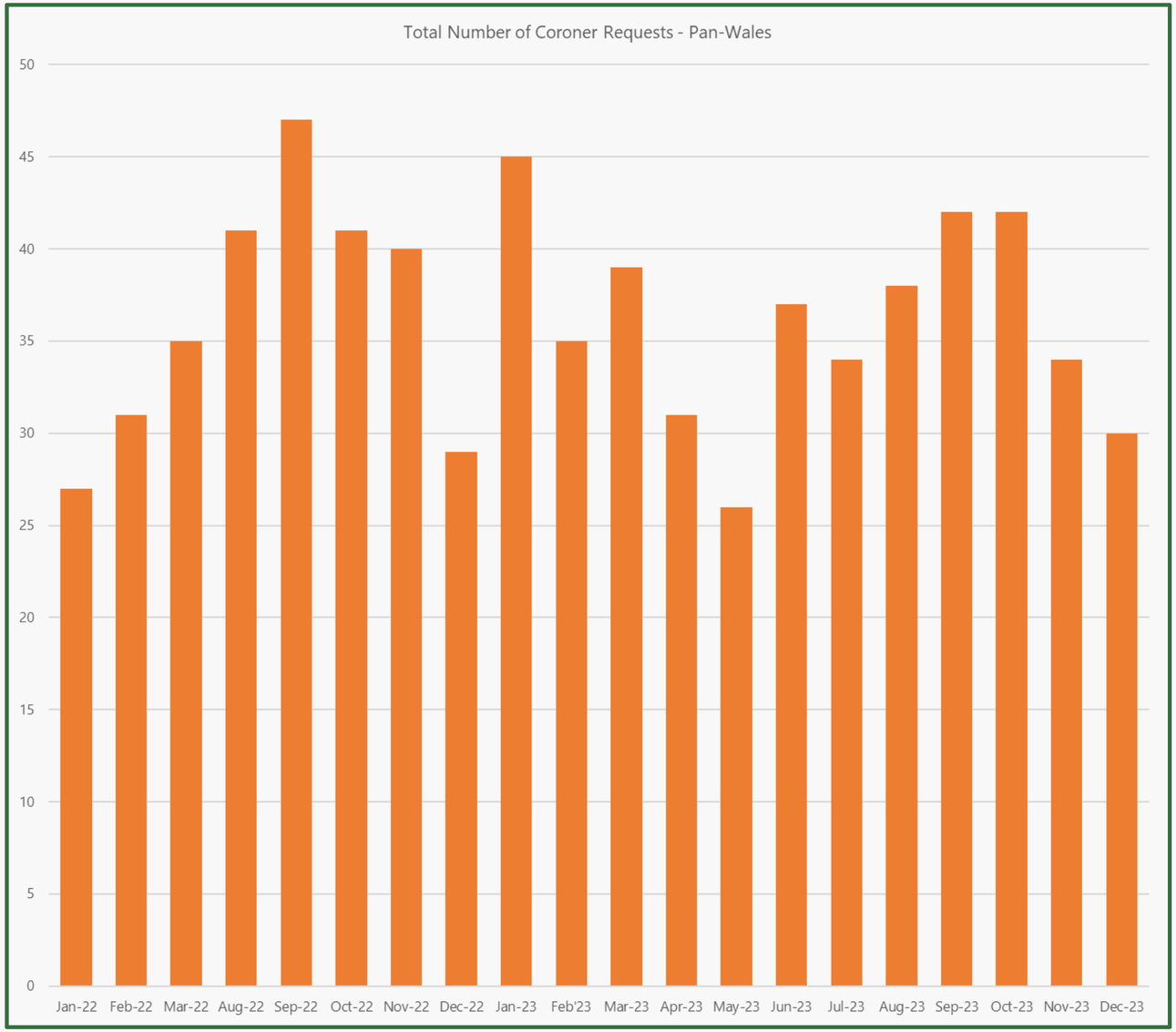
(Responsible Officer: Liam Williams)

Coroners Self-Assessment: Strength of Internal Control: Moderate

Mortality Self-Assessment: Strength of Internal Control: Moderate

QUEST

Health & Care Standard
Health – Safe Care



*NB: Temporary graph at All-Wales level: The Trust is currently unable to report Coroner requests at Health Board level due to the implementation of the new Datix system

Analysis

Coroners: The complexity of the cases remains high, with multiple statements and actions per approach. This is in addition to the work required to manage cases where the Trust has been given IP status. Cases continue to be registered and distributed. Delayed statement requests are escalated to ensure that the Trust does not receive a Schedule 5 summons. At the national network , all Health Bodies reported an increase in both volume and complexity of the coronial work post pandemic. There continues to be additional work due to the illness of the Trust solicitor/claims manager.

Ombudsman: There has been a reduction in initial approaches to the Trust by the PSOW. All PSOW cases are now being managed via Datix Cymru.

Mortality Review: The Trust continues to participate in Health Board led mortality reviews as appropriate, with attendance from the Patient Safety Team and clinical colleagues as available. Data and information is also provided by the Trust as required to the Medical Examiner Service to inform their reviews of deaths in acute care. Feedback from the Medical Examiner Service in respect of themes and trends include timeliness in response to patients in the community, handover of care delays and patients on the end-of-life care pathway being conveyed to acute care.
Currently the focus of the Medical Examiner Service is undertaking mortality reviews in the acute care setting and the plan is for all non-coronial deaths, including community deaths to be reviewed by the Medical Examiner Service by April 2024. An increase in activity for requests / reviews for the Trust is expected when this occurs.

Remedial Plans and Actions

Coroners: There continues to be additional work due to the illness of the Trust solicitor/claims manager. A temporary staff member's contract has been extended to the end of the financial year to try and minimise the impact of the additional work. This has resulted in the Trust being represented by external counsel (such as Legal and Risk Solicitors), all these cases require the instruction of counsel (preparation of bundles, instruction,).

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 aligning to the national approach. This includes consideration of the resources required in the new Putting Things Right (PTR) Team structure with additional roles included in the Patient Safety Team. Recruitment to the new structure is expected to be completed by April 2024. Representation and contribution by the Trust at the All-Wales Mortality Working Group continues. The task and finish group established to review the process for contacting families following their meetings with the Medical Examiner Service has concluded with agreements in place that families will be signposted to current PTR processes in Health Boards and Trusts. The Patient Safety Team are engaged in the meetings lead by the Once for Wales Datix Cymru Team who are developing the Datix Cymru Mortality Module. The Learning from Deaths Forum, chaired by the Assistant Director of Quality & Nursing is established and is currently meeting on a monthly basis, with oversight and reporting to the Clinical Quality Governance Group. Following the finalisation of the All-Wales National Mortality Framework which will include the processes in primary care, the Learning from Deaths Forum will oversee the updates to the Trust's Framework.

Expected Performance Trajectory

Coroners: This level of activity seems to be the new normal and will continue to be monitored.

Ombudsmen: Learning has been placed in a Patient Safety Newsletter, for sharing pan-Wales.

Mortality Review: Whilst the multiple benefits of the Medical Examiner Service 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 by April 2024 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 through the Serious Case Incident Forum. Following the recruitment to the new PTR Structure (expected by April 2024) improvements in the timely review of MES referrals is expected.

Mortality Reviews Data source: Internal Web Application

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

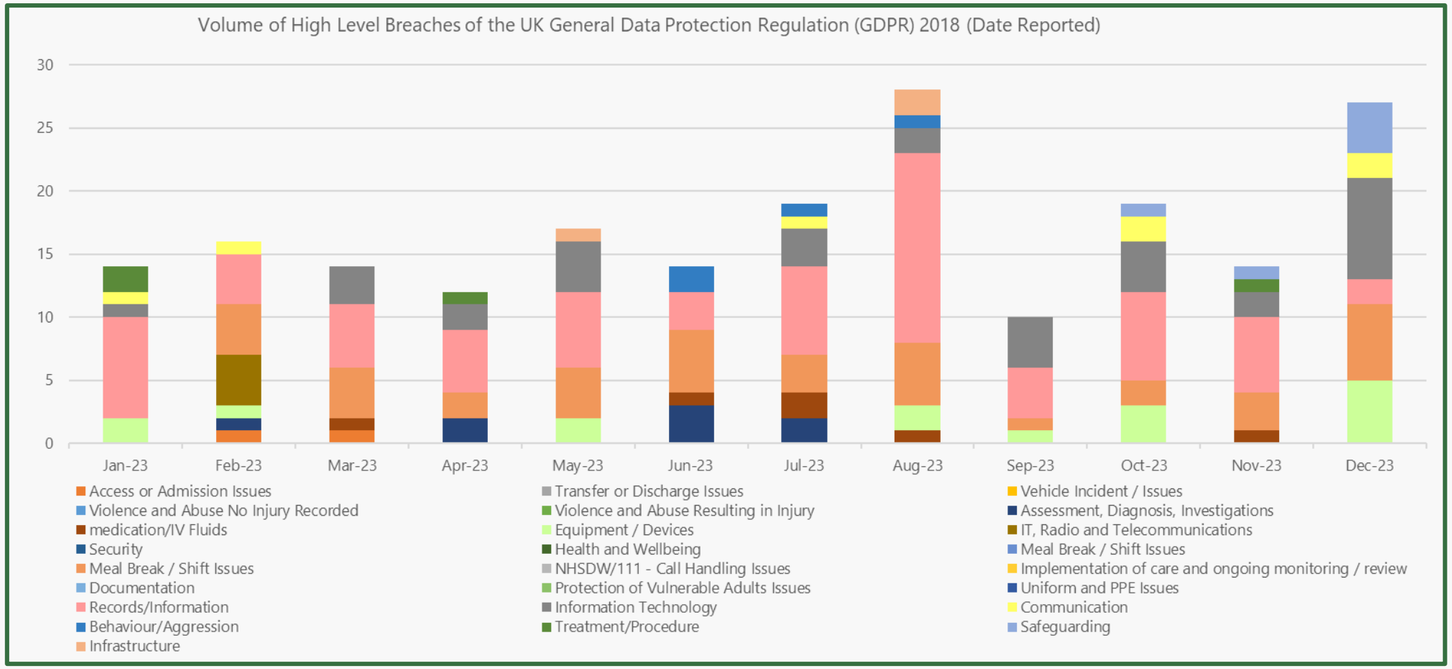
(Responsible Officer: Liam Williams)

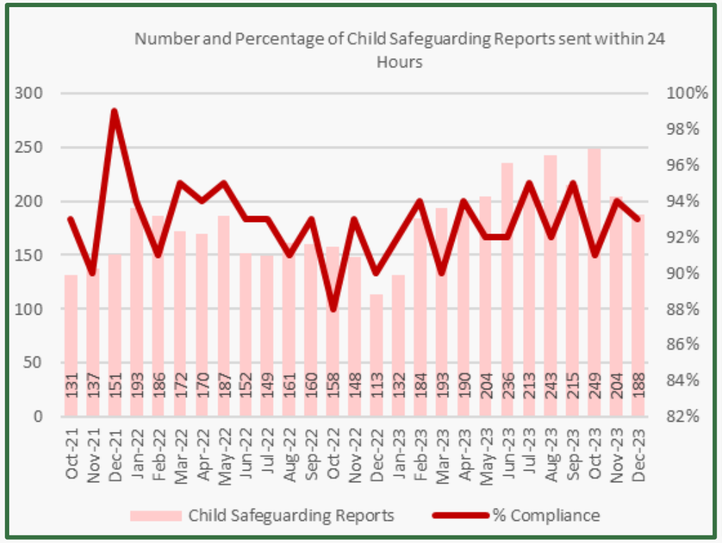
Self-Assessment: Strength of Internal Control: Strong

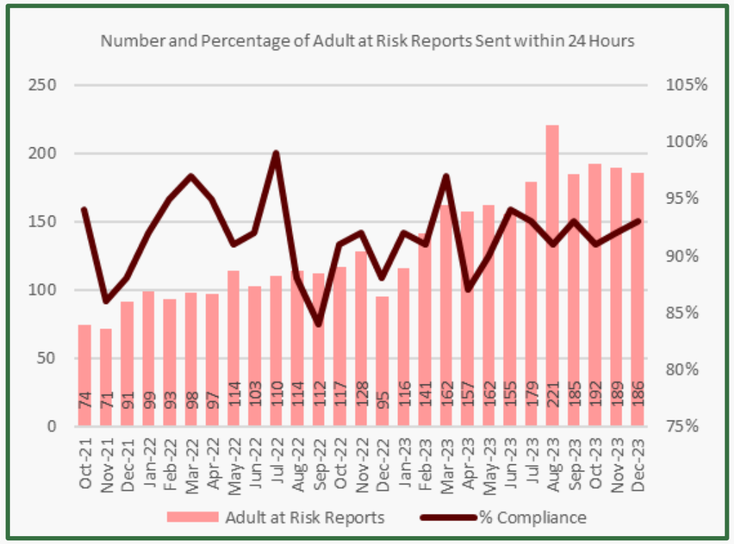
QUEST

Safeguarding Data source: Doc Works

Health & Care Standard
Health – Safe Care







Analysis

Safeguarding: In December 2023 staff completed a total of 186 Adult at Risk Reports, 93% of these were processed within 24 hours. Whilst the Trust does not report on Adult Social Need reports, 581 referrals were received and processed to the local authority. There have been 188 Child Safeguarding Reports in December 2023, 93% of these were processed within 24 hours.

Data Governance: In December 2022 there were 27 information governance (IG) related incidents reported on Datix Cymru categorised as an IG breach. Of these 6 related to information governance/confidentiality, 2 records/information, 8 Information Technology, 4 safeguarding, 2 communication, and 5 equipment/devices.

Public Engagement: During December, the Patient Experience and Community Involvement Team attended 19 community engagement opportunities, engaging with approximately 227 people. This month engagement has included attendance at a number of mental health events and coffee mornings, where we listened to people tell us about their experiences of using the services we provide and how their mental health impacts their ability to manage their physical health and wellbeing. We attended a number of co-production forums, sharing information and best practice about how we can work in partnership more effectively and we also continue to meet regularly with colleagues from Llais as the national Citizen Voice body for Wales, maintaining an open dialog and sharing relevant information and opportunities to collaborate. During December we continued to make a range of Patient Experience Surveys (PREMs) available, asking people to provide feedback about their interactions with our services. Engagement and survey outcomes remain largely consistent and tell us that people continue to be concerned that help will not be available when they need it and that people have experienced delays after calling 999, but that people are generally happy with the care they eventually receive. 111 callers have told us they experienced long waits for their calls to be answered and long waits for call backs. NEPTS users said that overall, they continue to be happy with the transport they receive but experience longer than wanted delays when waiting for their transport home following their appointment.

Remedial Plans and Actions

Safeguarding: The Trust primarily manages all safeguarding reports digitally via Docworks Scribe and regular monitoring of the system by the Safeguarding Team provides a means to identify any problems with delayed reports with appropriate action taken to support 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 .

Data Governance: Of the 27-information governance related incidents reported on Datix, 0 incidents were reported to the Information Commissioner's Office (ICO). The IG Team will continue to review and provide advice on reported incidents.

Public Engagement: Community involvement and engagement with patients/public forms an integral part of the Trust's 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. Response rates to some of our PREM's surveys is disappointingly low and we acknowledge that this means we cannot report a truly reflective picture of what it feels like to be a user of some of our services. We are actively working with colleagues across the Trust in a number of different departments to try and agree on solutions that would allow us to directly contact more patients to ask for feedback about their experiences with us. We have escalated our concerns to barriers which are preventing us from directly contacting patients to colleagues at the Welsh Risk Pool who oversee implementation of the Once for Wales Civica & Datix systems. We are seeking their advice on a way forward following a letter to WAST from the Welsh Risk Pool which highlighted WAST as an outlier in not fully utilising all of the available features in Civica to record and report on patient experience.

Expected Performance Trajectory

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

Data Governance: The IG Toolkit submission for FY22/23 continues to be populated. A weekly meeting has been established to monitor the population of the IG toolkit and outstanding actions. The action plan for the Minimum Expectations criteria currently stands at 52% completed.

Public Engagement: All feedback received is shared with relevant Teams and Managers and continues to be used to influence ongoing service improvement. Patient experience and community engagement information is now shared weekly at the Senior Quality Team meeting.

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

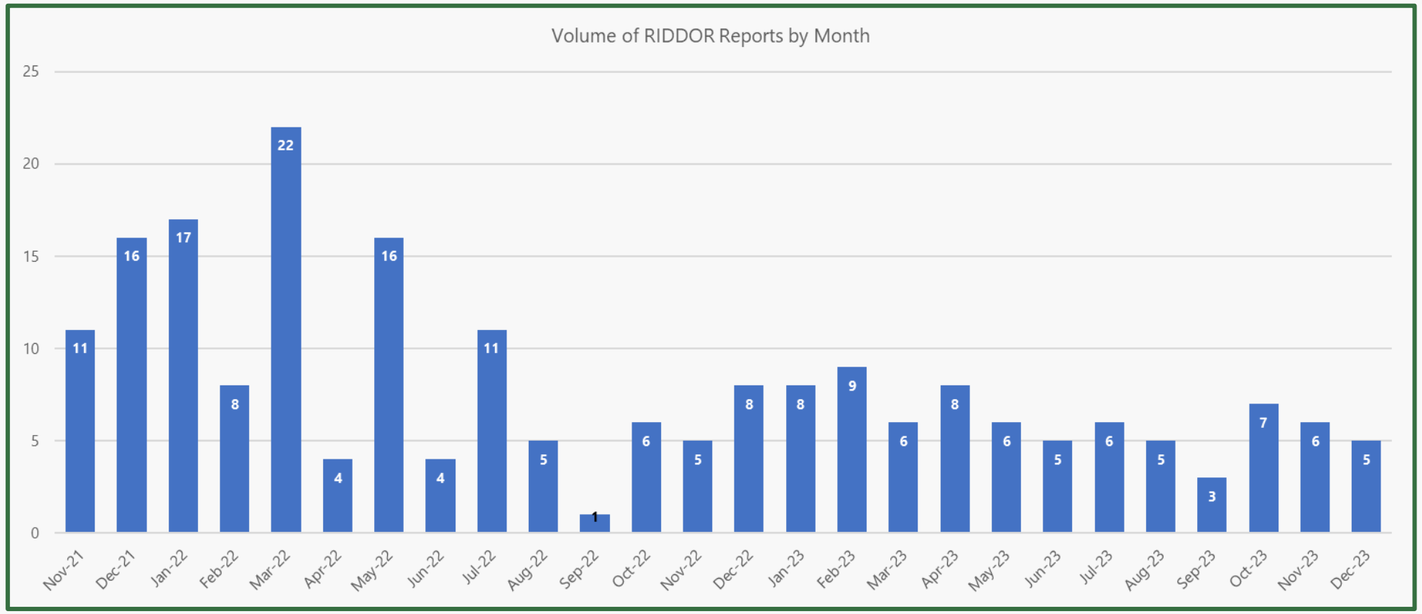
Our Patients: Quality, Safety & Patient Experience
Health & Safety (RIDDORS) Indicators

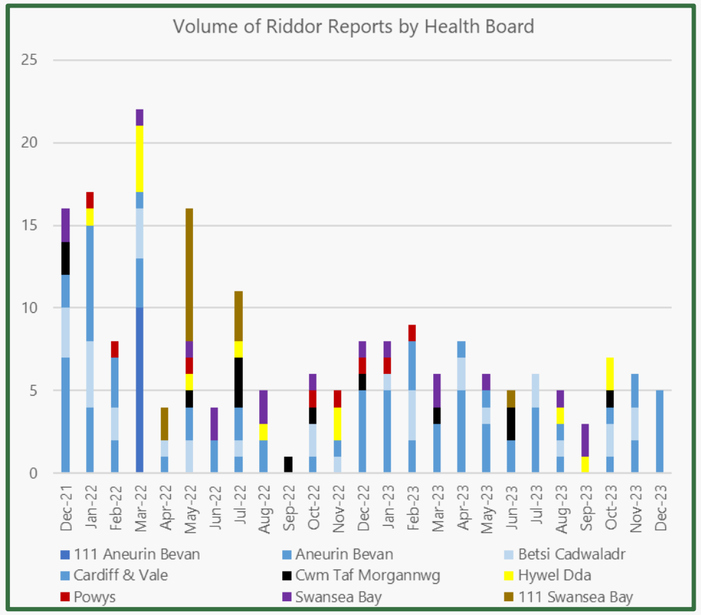
(Responsible Officer: Liam Williams)

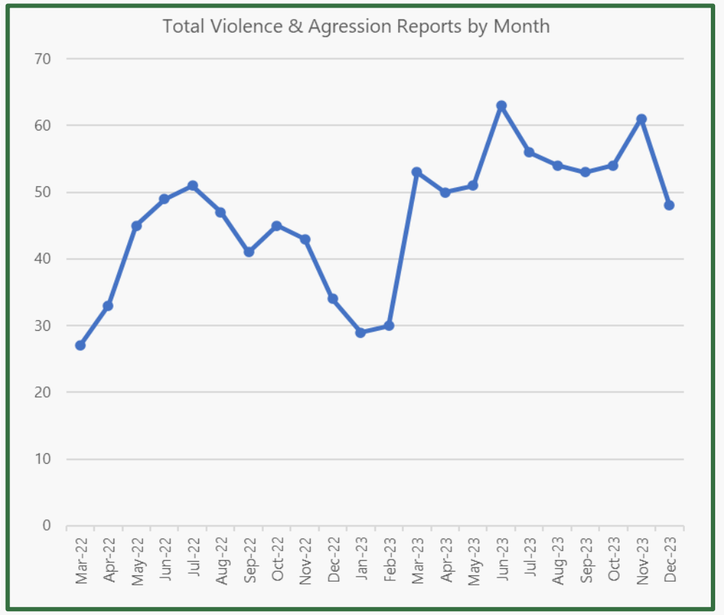
Self-Assessment: Strength of Internal Control: Moderate

PCC

Health & Care Standard
Health – Safe Care







Analysis

RIDDOR: There were 5 incidents requiring reporting under RIDDOR during December. All were due to staff being absent from work for over 7 days as a result of their injury. 100% of the reports were completed within the reporting required time frames.

Health and Safety team will continue to work with Incident Handlers to ensure reports are submitted within the required timescales

3 injuries are a result of manual handling operations were recorded during the month with 2 reports resulting from slip/trip or fall incidents.

Violence and Aggression: A total of 48 incidents have been reported of V&A in December.
1 Sexual Assault and 2 Physical Assaults on staff were reported during the month with incidents of verbal abuse amounting to 45 for the month.

Sexual assault occurred when a member of staff was assisting a previously verbally abusive patient to the Ambulance.

Physical assaults were as a result of one distressed patient's rapid arm movements and another incident where patient assaulted a member of staff whilst restraining them to prevent threat to life.

Aneurin Bevan and Betsi Cadwaladr Health Boards remain the highest reporting area with a total of 10 incidents in Aneurin Bevan and 14 in Betsi Cadwaladr.

14 incidents were reported as Moderate in harm and 21 noted as low harm which the first reduction in reports of moderate since August 2023.

Remedial Plans and Actions

RIDDOR: Bite-sized training modules have been produced to enable investigators to undertake quality investigations that identify the root cause of incidents. This training will be made available via Siren to allow easy access to staff members across Wales.

Violence and Aggression: A V&A Gap Analysis undertaken of V&A incidents across the Trusts was presented to the Senior Operations Team. The progress of work streams to further protect our work force from potential V&A incidents will be monitored at the meeting in the coming months.
Site visits are planned by the V&A Team to provide support to Contact Centre staff with regard to the verbal aggression they experience.

The Case Manager continues to actively support staff who are involved cases being heard at Court to ensure they are given any help they require.

Expected Performance Trajectory

RIDDOR: During the start of winter period, we are seeing an increase in manual handling injuries and slip, trip and fall events. All staff have received advice in the H&S quarterly newsletter on how to reduce this risk during this period.

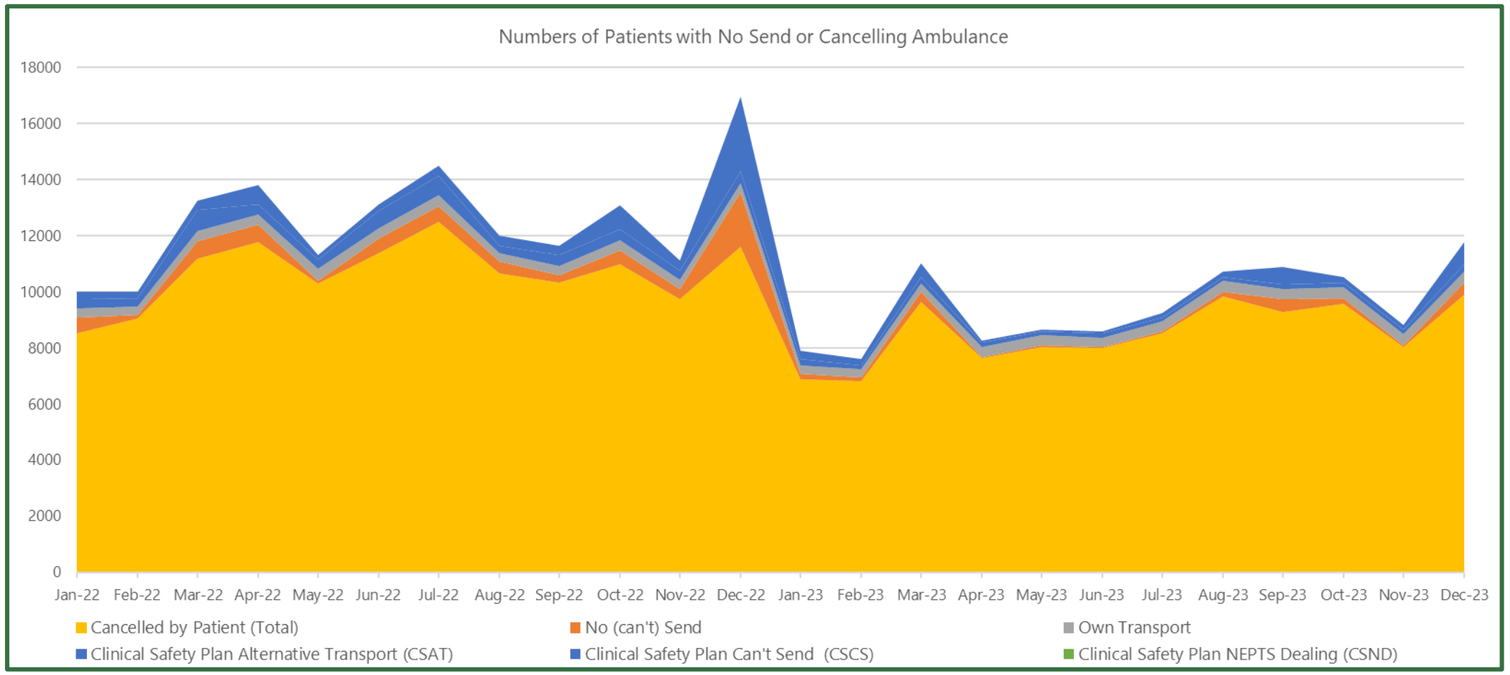
Violence and Aggression: The workstreams identified in the V&A Gap Analysis will assist in the classification and investigation of incidents. This will have the effect of more accurate reporting and improved investigations and outcomes for staff incidents.

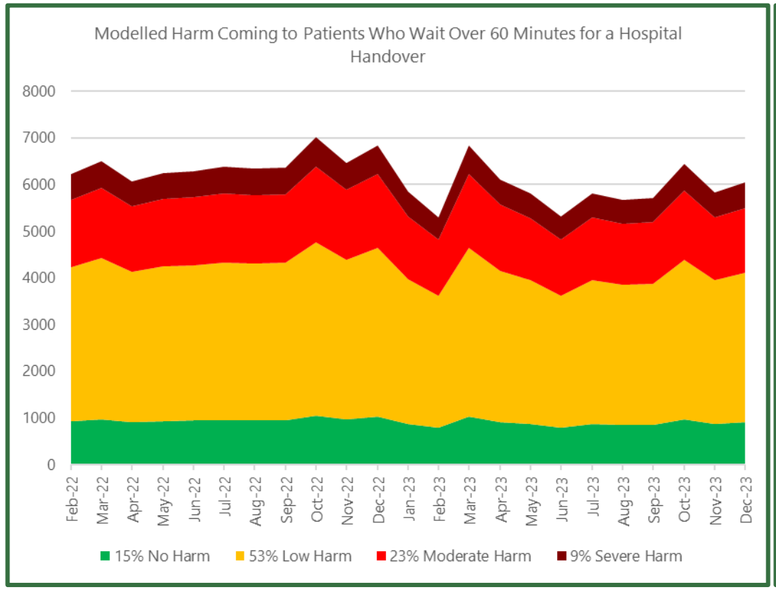
**NB: Data correct on the date and time it was extracted; therefore, these figures are subject to change*

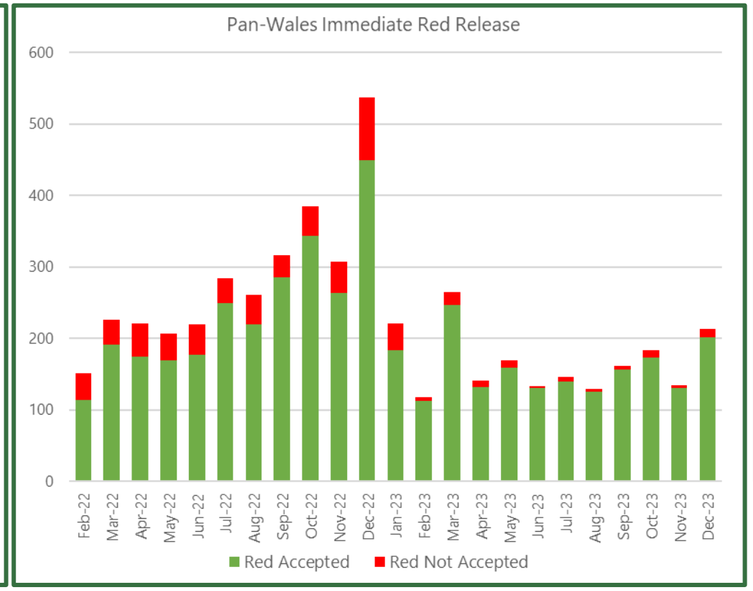
Data source: Datix

Our Patients: Quality, Safety & Patient Experience
Potential Patient Harm Indicators

(Responsible Officer: Andy Swinburn) R FPC







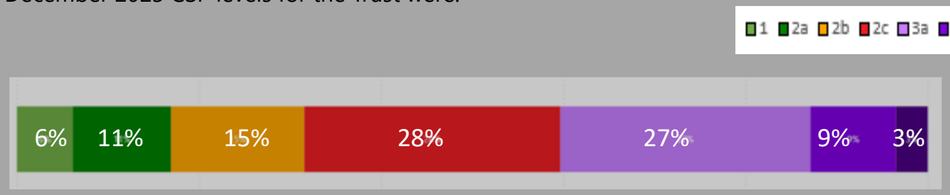
Analysis

In December 2023, 263 ambulances were stopped due to Clinical Safety Plan (CSP) alternative transport and 793 were stopped due to CSP 'Can't Send' options. In addition, 9,900 ambulances were cancelled by patients (including patients refusing treatment at scene) an increase from 8,041 in November 2023 and 389 patients made their way to hospital using their own transport.

There were 739 requests made to Health Board EDs for immediate release of Red or Amber 1 calls in December 2023. Of these 202 were accepted and released in the Red category, with 11 not being accepted. Further to this, 189 ambulances were released to respond to Amber 1 calls, but 337 were not.

The graph in the bottom left shows that in December 2023 of the 6,044 patients who waited outside an ED for over an hour to be handed over to the care of the hospital, the Trust could assume that 15% (906 patients) would experience no harm, 53% (3203 patients) would experience low harm, 23% (1390 patients) would experience moderate harm and 9% (543 patients) would experience severe harm.

In December 2023 CSP levels for the Trust were:



Remedial Plans and Actions

Red immediate release is monitored weekly by the Chief Executive and reported through to Health Board CEOs with the expectation that there are no declines for Red Release from any of the 7 Health Boards. All health boards have agreed to this measure. Integrated Commissioning Action Plan (ICAP) meetings have commenced with Health Boards, the Commissioner and the Trust and performance is reviewed monthly with questions posed to Health Boards regarding immediate release and handover reduction plans and actions.

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. Seasonal pressures impact the Trust and planning is being used to prepare for this through a range of measures including the use of forecasting and modelling.

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

Our Patients: Quality, Safety & Patient Experience
Patient Experience Surveys

(Responsible Officer: Liam Williams)

Self-Assessment: Strength of Internal Control: Moderate

PCC

Health & Care Standard
Health – Safe Care

December 2023		
NEPTS (81 responses)	Benchmark	Score
How long did you wait for your transport to take you home after your appointment.	85	73
Were you happy with the transport you received?	85	89
999 (0 responses)	Benchmark	Score
The 999-call taker who answered your call was reassuring.	85	
The 999-call taker who answered your call explained what was going to happen next.	85	
You felt confident in the call taker ability to manage your call and provide appropriate advice.	85	
The length of time I waited for an ambulance to arrive was acceptable.	85	
111 (11 responses)	Benchmark	Score
Do you feel your call to 111 Wales was helpful?	85	33
Did you follow the advice given to you by NHS Direct Wales?	85	78
Would you consider using NHS 111 Wales again?	85	67
WAST Overall - Friends & Family Test How was your overall experience with the service today?	Ranked from very poor to very good.	
○ Ambulance care	84.85% Good	9.09% Poor
○ Integrated Care (NHS 111 Wales Telephone line only)	33.33% Good	55.56% Poor
○ EMS (including CSD) **No responses received**	0% Good	0% Poor
○ NHS 111 Wales Online	56.52% Good	34.78% Poor
	* Where totals above do not add up to 100%, this is because a 'Do Not Know' answer was given, these are excluded from overall total.	

Analysis
Within the NEPTs survey the responses provided did not hit the benchmark in relation to the question 'How long did you wait for your transport to take you home after your appointment, therefore not providing the level of service the patient expected. However, 90% were happy with the transport they did receive.

It is acknowledged that the small number of respondents for the 999 and 111 surveys does not provide a great enough response to reflect a true patient experience picture, but work is currently underway to develop a process that will increase response rates and make them more meaningful.

Remedial Plans and Actions
We continue to make available 4 core Patient Experience surveys, covering the Trust's main service delivery areas:

- 999 EMS Response (incorporating CSD)
- Ambulance Care (NEPTS)
- NHS 111 Wales Telephony
- NHS 111 Wales Online

The Civica Experience platform provides some enhanced reporting facilities, including the ability to weight questions and produce 'Heat Maps' based on responses. A benchmark is set of 85, with aggregated scores of 85 and above representing a positive response. WAST is currently working through the requirements to add the SMS functionality within the Civica experience platform and other systems as well as strengthening information governance arrangements to increase the data experience returns.

The aim is to increase the number of patient experience feedback returns and to further integrate systems with Civica to push email/text surveys to patients. However, this requires input from the ePCR team to look at opportunities to capture patient permissions to participate in experience surveys.

These surveys are mandatory requirements; Under the Health and Social Care (Quality and Engagement) (Wales) Act 2020. WAST has a duty to secure quality in its services and must exercise its functions with a view to securing improvement in the quality of its services. The Duty of Quality includes the experiences of individuals to whom health services are provided.

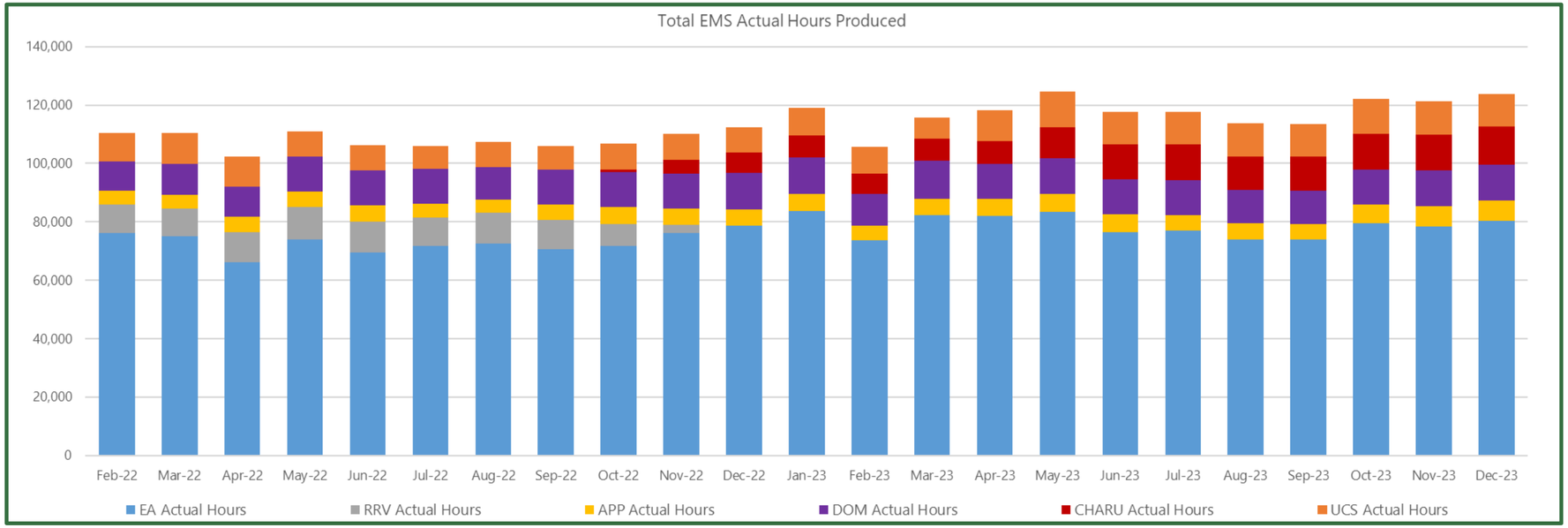
Expected Performance Trajectory
Further integrate our systems with Civica to push email/text surveys to patients. Requires input from ePCR team to look at opportunities to capture patient permissions to participate in experience surveys.

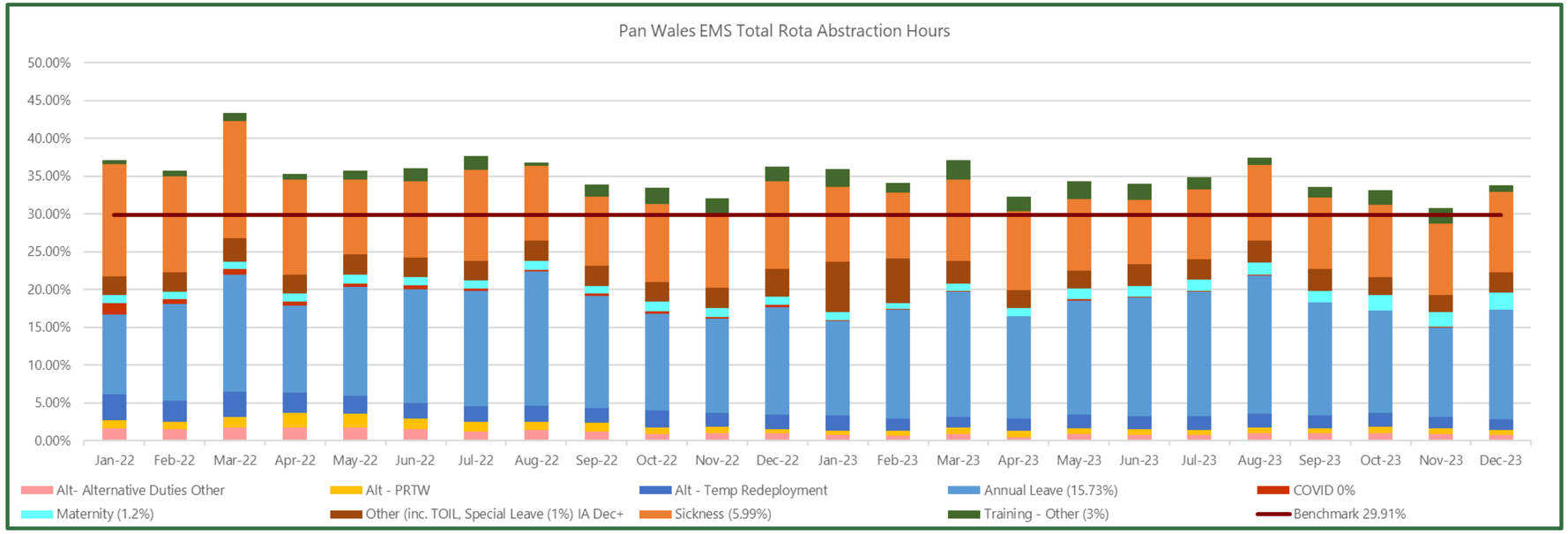
Our People
Capacity - Ambulance Abstractions and Production Indicators

(Responsible Officer: Lee Brooks)

EA Production	Abstractions
A	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, as are the total number of staff in post. In December 2023, total EMS abstractions (excluding Induction Training) stood at 33.75%. This was an increase from the 30.74% recorded in November 2023. This percentage continues to remain above the 30% benchmark figure set in the Demand & Capacity Review. The highest proportion of abstractions was due to annual leave at 14.42% followed by sickness at 10.68%. This figure for sickness abstractions for December 2023 was a decrease when compared to the same month last year (11.62%).

Emergency Ambulance Unit Hours Production (UHP) achieved 93% in December 2023 which equated to 80,326 Actual Hours. This is a 2.1% increase on the 78,660 Actual Hours produced during December 2022.

CHARU UHP achieved 146% (12,935 Actual Hours) compared to 142% in November 2023 (this is the commissioned level not the modelled level).

The total hours produced is a key metric for patient safety. The Trust produced 123,727 hours in December 2023, which is a slight increase on the 121,349 hours produced in November 2023, but a significant increase on the 112,225 hours produced during December 2022. This increase in UHP has helped to minimise the impact on performance levels at a time of increased demand.

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 is currently widening out its focus on sickness absence to look at all abstractions recognising that abstractions are already regularly reviewed in Operations performance meetings.

Expected Performance Trajectory

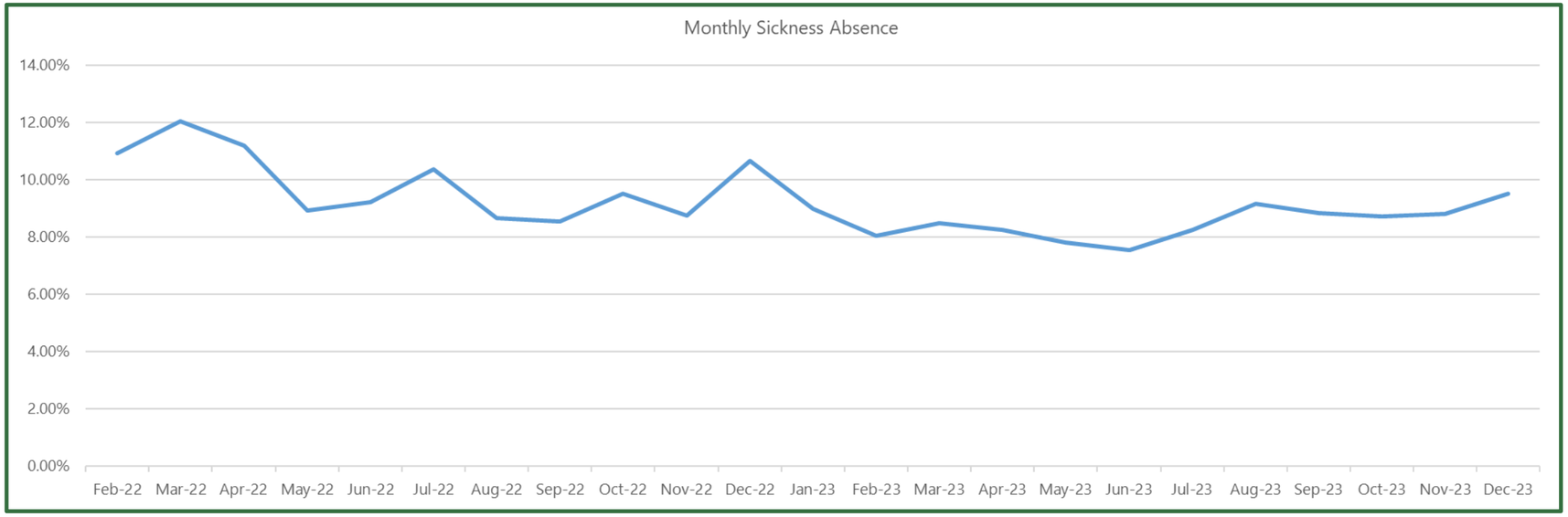
UHP estimates, based on recruitment levels, estimated abstractions and overtime have been provided to ELT. Production is good. The Trust has an ambition to reduce sickness to 6% and abstractions to 30% by March 2024, which would further boost production; however, the handover levels are extreme, and the rosters are simply not designed to cope with over 23,000 lost hours; they were predicated on 6,000 hours.

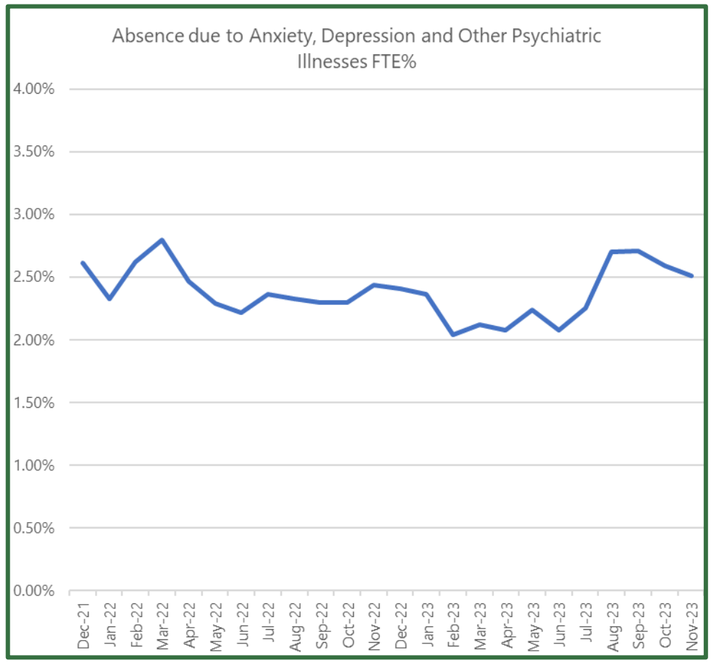
Our People
Capacity - Sickness Absence Indicators

(Responsible Officer: Angela Lewis)

Mental Health
R

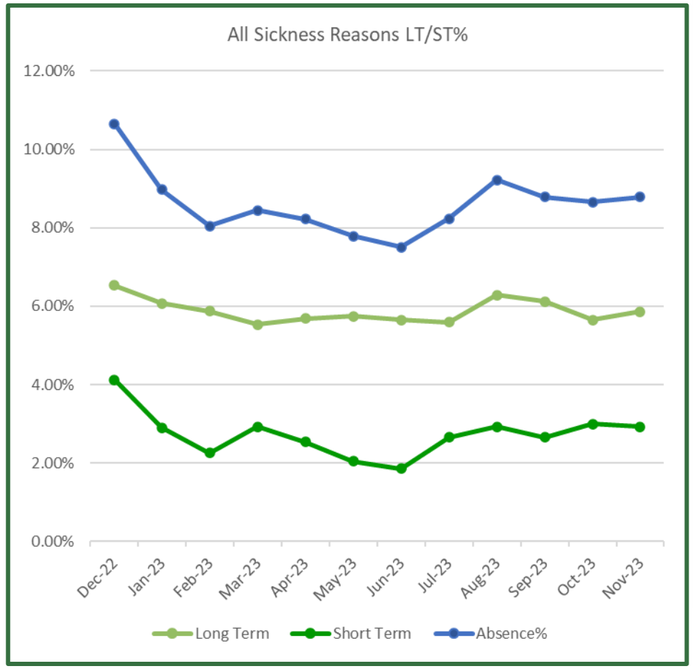
CI





Average working days lost per FTE (Annual)
19.64 days
Single month Absence %
8.79%
Long Term / **Short Term**
5.86% / 2.93%
Mental Health / **Other MSK**
(S10 Stress/Anxiety) 2.51% / (excluding Back) 1.19%

November 2023



Analysis

There was an increase in overall sickness absence rates between November and December 2023, rising from 8.82% to 9.54%.

Long term absence increased from 5.65% in October to 5.86% in November and short-term absence decreased from 3.00% in October to 2.93% in November.

Indicative figures show an increase in sickness absence in December to 9.33%, with long term absence increasing to 6.28% and short-term absence increasing to 3.05%.

The highest reason for short term absence in December was Anxiety/ Stress/ Depression, other musculoskeletal problems and gastrointestinal problems.

Absence due to Mental Health has risen slightly since June 23 and is now at 2.51%, which is back in line with figures seen during the early part of 2022.

Physiotherapy: 33 referrals were received in November – 11 more than in October (22)

Remedial Plans and Actions

- Monitoring continues with ongoing reviews in both long term and short-term absences with monthly meetings to track sickness and provide support. MAAW training and bitesize training sessions continue to be scheduled on a bi-monthly (MAAW) and monthly basis (Bitesize sessions). Bespoke training sessions are provided when identified.
- In line with the Improving Attendance Action Plan, the People Services Advisors have undertaken audits on short term absence occurrences within the Operations Directorate.
- The findings of the audit displayed common themes across all areas within the Operational Directorate, including missing paperwork, no return-to-work meeting and inappropriate discretion applied.
- Audits for all Directorates, will be undertaken on a monthly basis over the next 6 months and the People Services Team will provide targeted support to line managers on reasonable adjustments and the appropriate use of discretion in areas identified as hot spots.

Expected Performance Trajectory

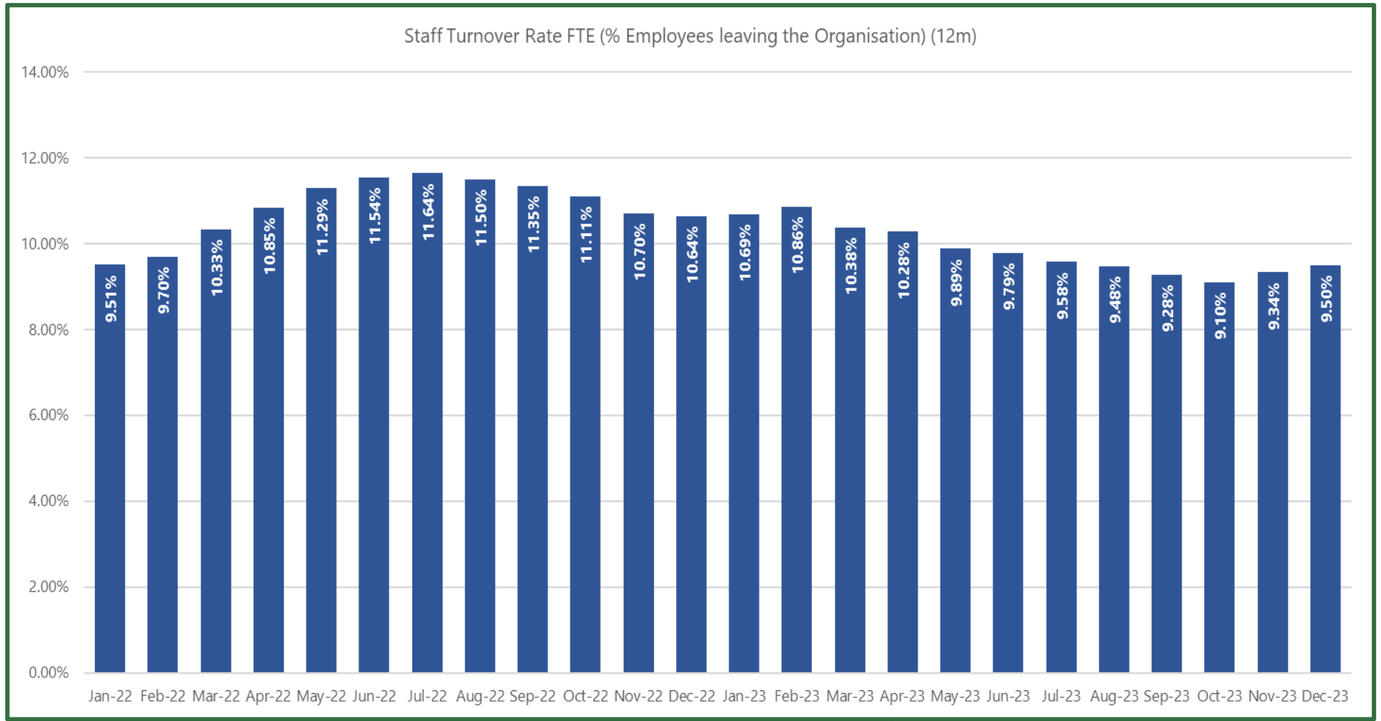
The Trust has indicated through its IMTP that sickness levels will fall in this financial year, but that there remain risks to delivery.

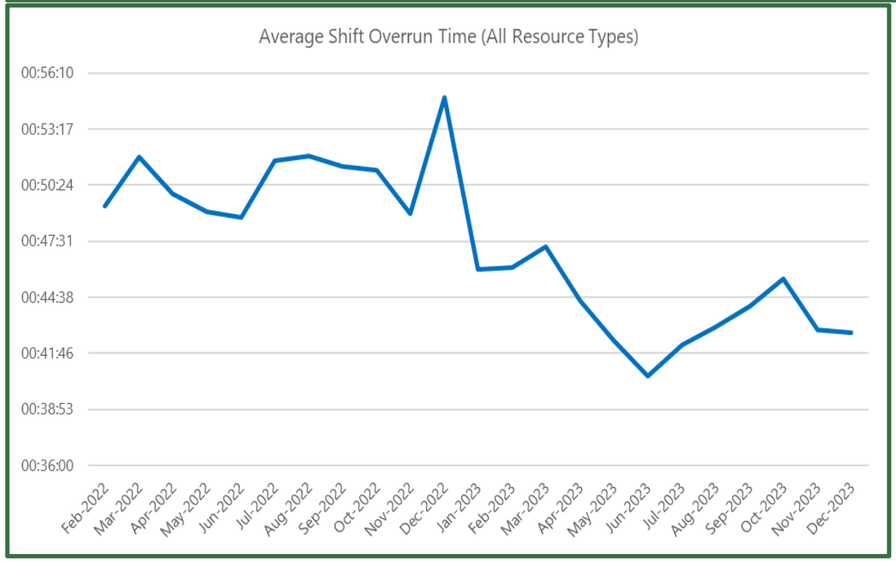
NB: Sickness data will always be reported one month in arrears. It should be noted that the figures reported in this presentation are official to 30th November 2023. All figures for December 2023 are indicative only (as of 27.12.2023).

Our People
Capacity - Turnover

(Responsible Officer: Angela Lewis)

Turnover
R





Dec-23 Org L4	FTE by Post
020 Ambulance Care L4 (NX10)	891.35
020 Emergency Medical Services L4 (DX04)	1,770.62
020 Integrated Care L4 (DX03)	433.49
020 National Operations & Support L4 (DX02)	140.95
020 Resourcing & EMS Coordination L4 (DX05)	347.31
Grand Total	**3,583.73**
Ambulance Response	**1497.04**
020 Ambulance Care L4 (NX10) ACA2/Team Leaders	**260.03**

Analysis

Staff turnover rates in December 2023 were 9.50%, which is an increase from the 9.34% recorded in November 2023, although rates have generally been declining since they peaked in July 2022. Shift overrun average times have been steadily increasing again following a two year low recorded in June 2023. However, the average figure for December 2023 was 42 minutes and 49 seconds compared to 45 minutes and 58 seconds in November 2023. 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.

EAP utilisation: The annualised utilisation for Welsh Ambulance Service Trust is 17.7%. A total of 802 calls have been logged within the reporting period. (1 December 2022 - 30 November 2023) 759 of these were counselling calls, counselling calls account for 94.6% of all calls, sitting above the benchmark of 74.0% by 20.6%. Anxiety was the most common reason, accounting for 30.2% of overall counselling engagement. This was followed by Low Mood 16.1% and Bereavement 7.8%. 43 of the calls were advice calls, advice calls account for 5.4% of all calls, sitting below our benchmark of 26.0% by 20.6%. Childcare was the most common reason, accounting for 30.2% of overall advice engagement. This was followed by Civil 30.2% and Divorce & Separation (Legal) 18.6%. In terms of formal counselling engagement there has been: 31 referrals for face-to-face counselling, with a total of 170 sessions being delivered, 26 referrals for structured telephone counselling, with a total of 146 sessions being delivered, 42 referrals for online counselling, with a total of 222 sessions being delivered, 7 referrals for online CBT counselling, with a total of 10 sessions being delivered. The online portal has received a total of 403 hits within the current reporting period. After engaging in structured therapy, the Generalised Anxiety Disorder (GAD-7) average score reduced from 1.9 to 0.8 and the average Patient Health Questionnaire (PHQ-9) score reduced from 1.5 to 0.6. The Workplace Outcomes Suite (WOS) demonstrates the value of the EAP and the positive impact that the service is having on employees. At the start of therapy 33.3% of employees were out of work, after engaging in therapy this reduced to 22.2% with 33.0% of employees returning to work.

Fast track Physiotherapy: Currently the average length of time from referral to first contact is 1.8 days, the majority of referrals are for back injuries, shoulder injuries. Employees are managed with guided self-management; most are referred for face to face Physiotherapy at a network clinic. The team are currently exploring options to refer to funded provision for physiotherapy.

Remedial Plans and Actions

The implementation in 2023 of the 10 Point Action Plan has a clear focus on supporting managers on all elements of staff wellbeing using the framework of the All-Wales Attendance at Work Policy. The People Services Team attended regular meetings with managers and Occupational Health colleagues to discuss case reviews and ensure all available support is being provided to colleagues, which includes external health providers, personalised support, advice on people policies such as flexible working and OH interventions. The plan also includes comprehensive training packages including the All-Wales Attendance at Work Policy training and bitesize learning. The training also focuses on skilling mangers to use data to help best support individuals (ESR Business Intelligence Reports) and to hold accurate data to ensure appropriate and proportionate actions are being undertaken. We know having a meaningful return to work after a period of absence is essential to welcome the colleague back to work and also ensure all appropriate support is in place to keep them in work. Regular RTW audits are undertaken to not just ensure they are completed but they are meaningful and have a positive impact. As part of the continuing service review, we are currently conducting a tender process Employee Assistance Programme (EAP). Interviews with providers will take place week beginning, 15th January. The successful provider will be appointed in March 2024.

We are in the process of writing the Wellbeing strategy for 2025/29. The team has implemented outcome measures and integrated them into OPAS G2, our MI system, this means that we will be able to send questionnaires to colleagues around mental health assessment measures. This is currently in progress.

The team are currently in consultation with People Services, to determine how we can offer support for their work. We recently revised and updated our criterion for psychological intervention within the team.

We continue to regularly consult with Trust leaders and managers on sickness absence issues. Team members from OH/Wellbeing/TRiM continue to promote the service using our Occupational Health & Wellbeing vehicles, also presenting to new starters within WAST and through attendance at managers' meetings.

The team continue to deliver Drop-in sessions across all of our Clinical Contact Centres, dates for 2024 have been advertised. The REACT (Recognise, Engage, Actively Listen, Check Risk, Talk) training is still proving popular, upcoming dates will be advertised on Siren.

Time to Talk Day is an annual awareness day held at the beginning of February. It's a day for us all to start a conversation about mental health, MIND will be facilitating a session on 1st February.

Our Health and Wellbeing calendar; January's focus is on, 'Red January'. A Health Surveillance programme has been implemented, including, skin surveillance and hearing assessments, lung function and HAVS surveillance introduction is planned for this year. Timelines have been agreed and set to ensure that all checks required are in place to help monitor staff health and to identify any potential health issues early and provide appropriate interventions (where necessary). A project plan for the implementation of a pilot Health Check Programme (for up to x 400 WAST staff, age 46+ years), Health Diagnostics, is being developed looking at reducing risk of cardiac ill health in our older workforce, by implementing a screening programme. The programme will be implemented initially as a pilot.

Expected Performance Trajectory

The People and Culture Strategy will continue with its wellbeing focus. We are in the process of writing the Wellbeing strategy for 2025/29.

A robust wellbeing provision is in place to support staff and managers- the service is regularly reviewed and updated with a focus on continuous improvement. There is a tender process in place for a new EAP and the team are exploring additional (funded) options for referring colleagues to physiotherapy services. Through visits to stations and A+E departments, also to CCCs (where the Wellbeing Practitioners facilitate drop-in sessions) staff are more aware of the wide range of services that they can access.

Our People
Culture - Staff Vaccination Indicators

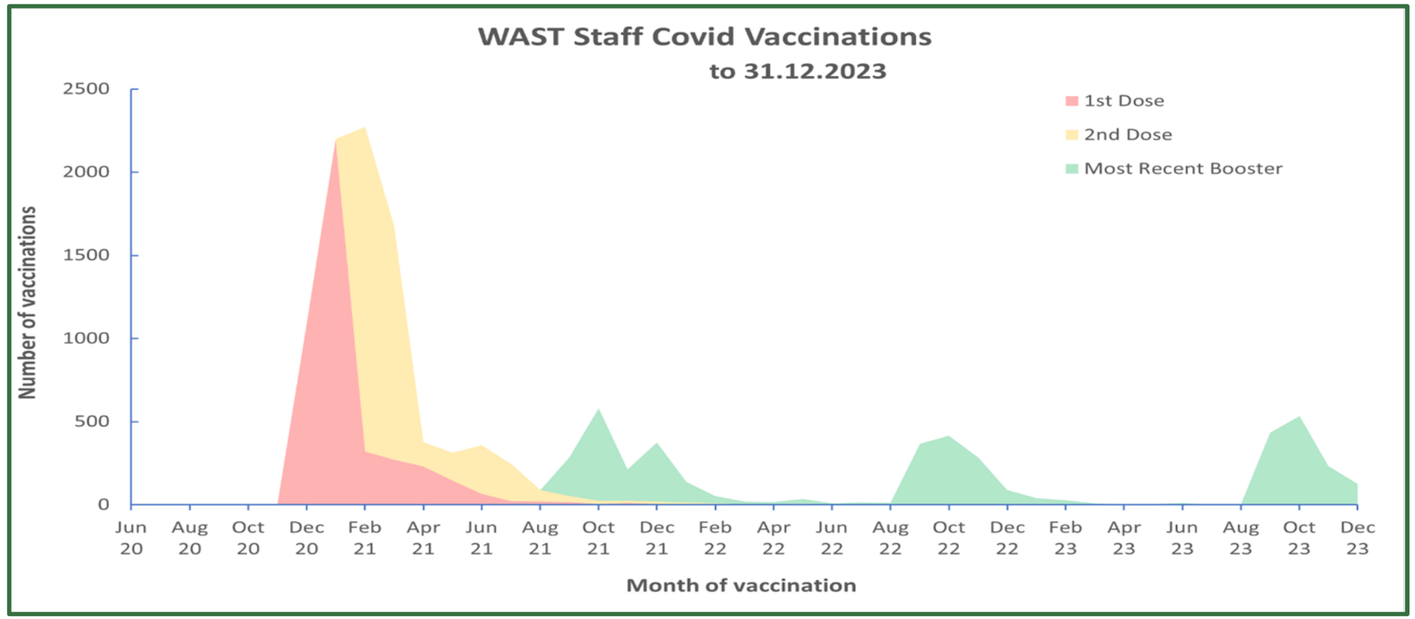
(Responsible Officer: Angela Lewis)

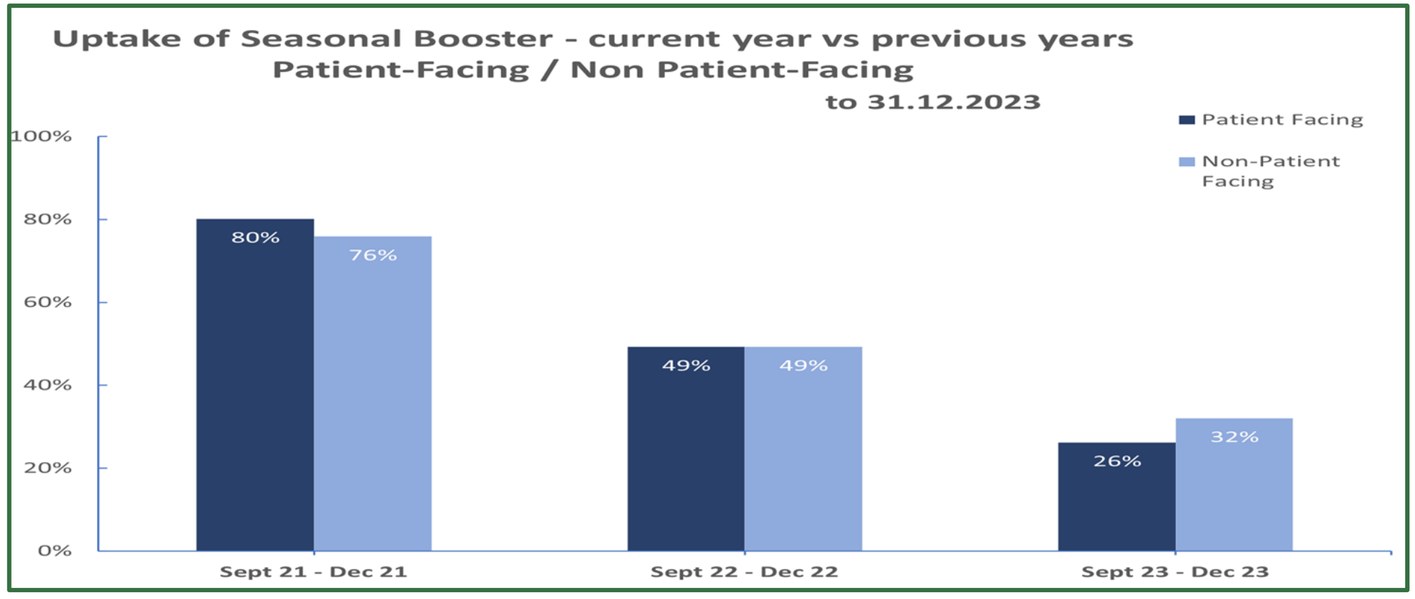
Self-Assessment: Strength of Internal Control: Moderate

PCC

CI

Health & Care Standard - Health (PPI)





Analysis

Flu: During the flu campaign so far, 1,304 flu vaccines have been administered by our Vaccinators (including to staff from the follow groups:- CFRs, EMRTS, HCS, PHW, St John Cymru and Students), with both Occupational Health vaccinators and Peer Vaccinators are continuing to undertake ad-hoc vaccinations. Of these vaccines administered, 1,090 have been received by WAST staff* (*staff who hold an ESR payroll number). A further 377 WAST staff have completed our Trust Microsoft Form to confirm they have received the flu vaccine elsewhere (i.e. at their GP surgery or a COVID Booster setting). Consequently, a total of 1,467 WAST staff have received the vaccination against flu, equating to 33.8% of the overall workforce. Additional engagement has been received from 244 WAST staff completing the Microsoft Form indicating that they have chosen to opt-out of having the flu vaccine, meaning the campaign has reached a 39.4% engagement rate so far.

COVID-19: As of the end of December 2023, 95% of Patient-Facing, and 94% of Non-Patient-Facing staff have received both the first COVID-19 vaccination dose.
As of the end of December 2023, 94% of Patient-Facing, and 94% of Non-Patient-Facing staff have received the second COVID-19 vaccination dose.
86% of Patient-Facing, and 87% of Non-Patient-Facing, WAST staff have received at least one of the Covid-19 boosters offered in the last 3 years.

Since September 2023, 26% of Patient-Facing staff and 32% of Non-Patient-Facing staff have received this season's Covid-19 Booster.

This is compared to 49%/49%, respectively, for the equivalent time period in 2022 and 80%/76%, respectively, for the equivalent time period in 2021.

Remedial Plans and Actions

Flu: In line with this campaign's Communications Plan, staff engagement will continue to encourage WAST staff to complete the Microsoft Form to inform us if they have had the flu vaccine elsewhere or choose to opt-out of having the flu vaccine.
Also, additional notices and posters will be circulated to staff, to inform that flu vaccines are still available via Occupational Health Vaccinators and Peer Vaccinators and also to again promote this campaign's incentives; the prizes will comprise of 6x tier one vouchers of £250 each and 60x tier two vouchers of £20 each.
COVID-19: The four UK CMOs agreed it was appropriate to pause the alert level system, which was suspended on 30th March 2023.
Routine testing was also paused for all symptomatic health and social care workers, care home residents, prisoners and staff and residents in special schools during the spring of 2023.

Expected Performance Trajectory

By continuing to engage with staff, the aim is for as many WAST staff as possible to complete the Microsoft Form to inform us if they have had the flu vaccine in the workplace, elsewhere or choose to opt-out of having the vaccine.

***NB: COVID Vaccinations for the past 2 years have only reported using the WAST definition of Frontline Patient Facing employees and therefore only includes those employed within Emergency Services, and Patient Transport Services..*
****NB: Flu data accurate at time of publication and subject to change / COVID-19 vaccination data correct at time of publication and subject to change.*

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

Our People
Capability - PADR and Training Rates Indicators

(Responsible Officer: Angela Lewis)

PADR: A

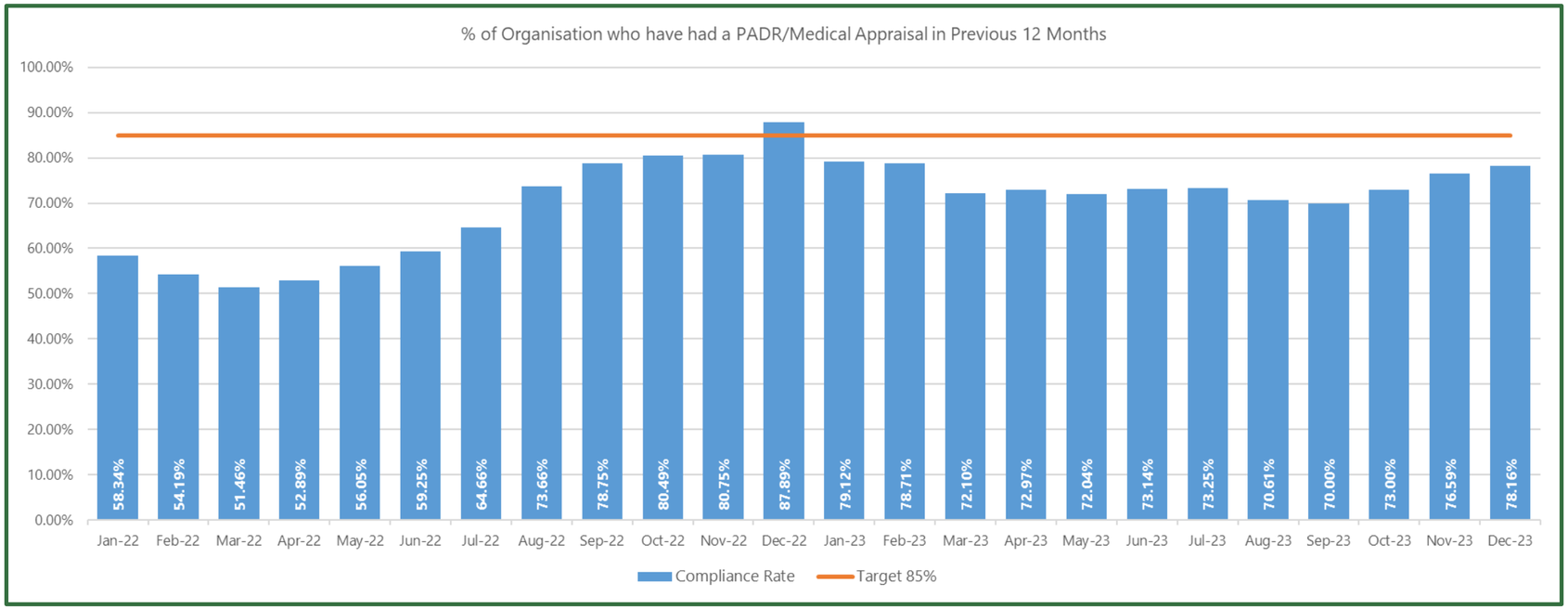
Stat & Mand: R

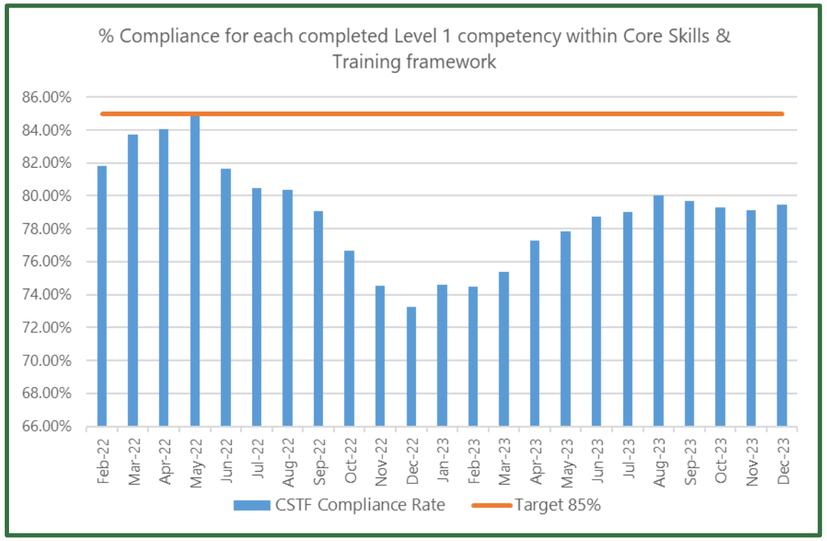
CI

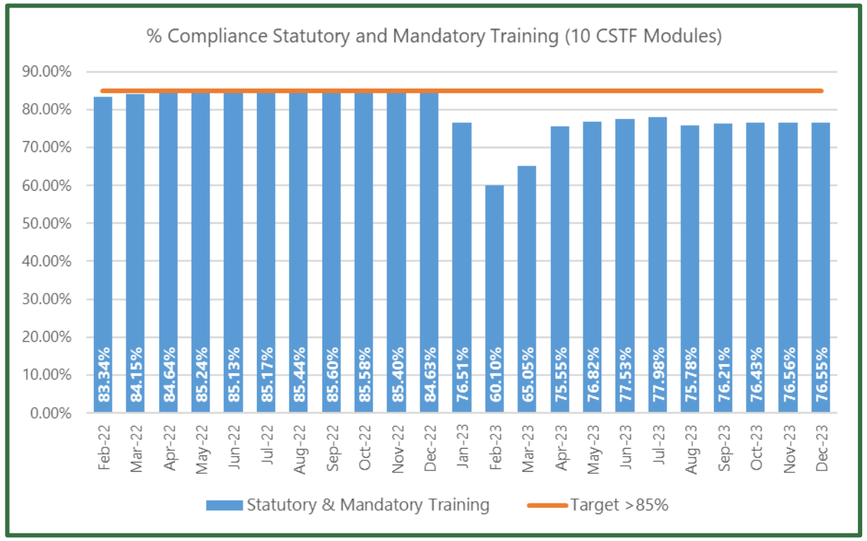
PCC

Health & Care Standard Health – Staff & Resources

Self-Assessment: Strength of Internal Control: Strong







Analysis

PADR rates for December 2023 increased when compared to the previous month to 78.16% but remain below the 85% target. Over the reporting period this target has only been achieved once, in December 2022, although current rates remain higher than during the same period last year.

In December 2023 Statutory & Mandatory Training rates reported a combined compliance of 76.55%; with Dementia Awareness (92.43%) and Safeguarding Adults (89.05%) achieving the 85% target. Moving & Handling (75.75%), Fire Safety (76.55%), Equality & Diversity (79.78%), Information Governance (71.98%), Welsh Language Awareness (54.47%), Fraud Awareness (46.62%), Violence Against Women, Domestic Abuse & Sexual Violence (83.66%) and Paul Ridd (62.54%) all remain below this target.

There are currently 15 Statutory and Mandatory courses that NHS employees must complete in their employment. These are listed in the table below:

Remedial Plans and Actions

The annual face to face Mandatory In-Service & CPD Training programmes are mid delivery and will lead to increases in reportable CSTF competencies - these programmes have engaged with c50% of the relevant workforce with delivery planned to continue for the remainder of this financial year.

Welsh Language Awareness, Fraud Awareness and the Paul Ridd Learning Disability Awareness competencies will be reaching their first anniversary at the end of the financial year when it is expected that compliance will exceed the target of 85%. A targeted approach to assist individuals to access their eLearning and thereby update their knowledge and achieve compliance will be rolled out across the Trust during Q4. This will include achievement of these specific statutory and mandatory courses in addition to the full range of locally mandated provision the Trust offers and new content mandated via Welsh Government including Duty of Quality, Duty of Candour and Consent.

Expected Performance Trajectory

Performance is improving as compliance has risen in relation to Paul Ridd.

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
Welsh Language Awareness	3 Years
Paul Ridd Learning Disability Awareness	No renewal
Environment, Waste and Energy **(Admin & Clerical staff Only)**	Yearly

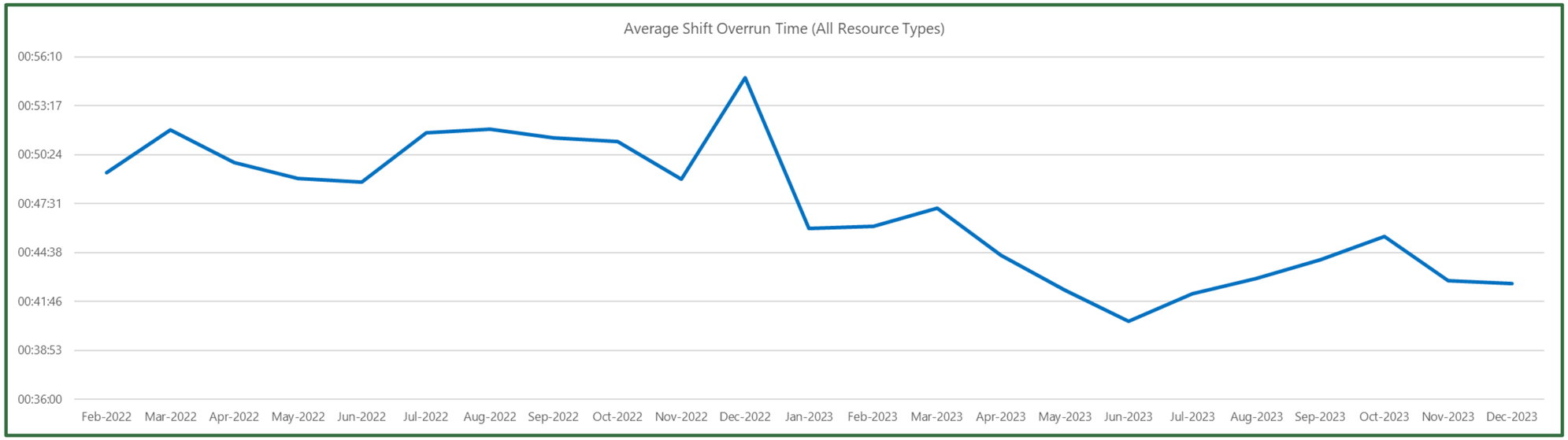
Data source: ESR

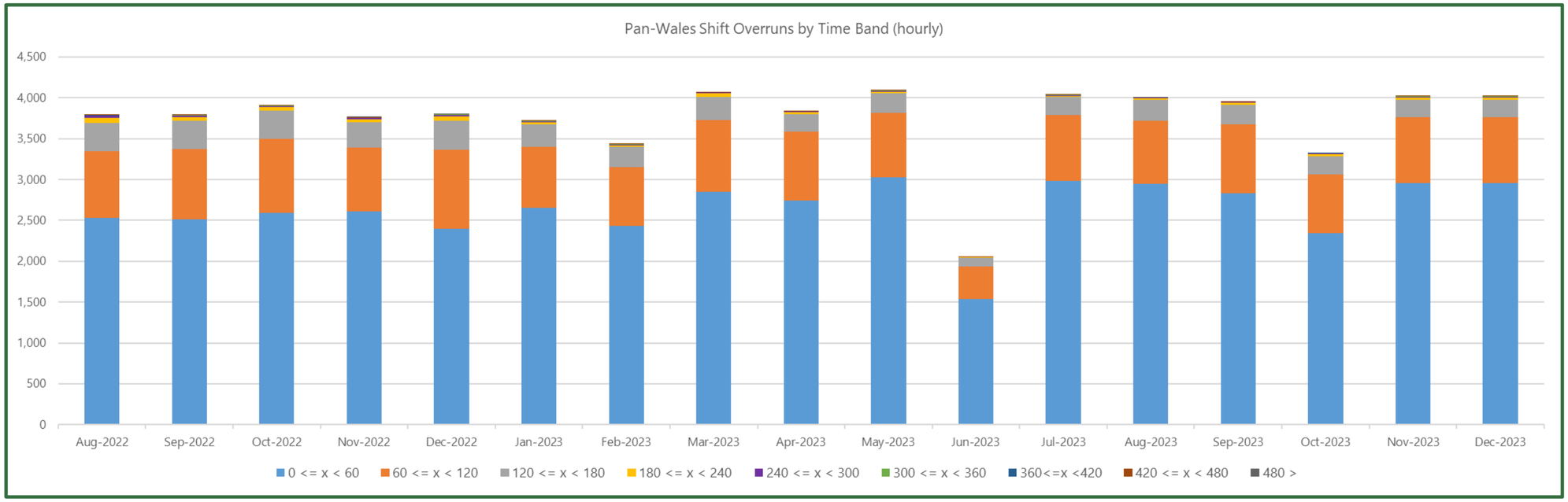
Our People
Health and Well-being – Shift Overruns

(Responsible Officer: Angela Lewis)

Overruns
A

CI





Analysis

Shift overrun average times have been steadily increased between June and October 2023, but have since fallen. The average figure for December 2023 was 42 minutes and 49 seconds compared to 42 minutes and 58 seconds in November 2023.

The highest volume of shift overruns occur within the 0 to 60-minute category, accounting for 72.4% of the total. 20.5% fall within the 61 to 120-minute category, 6.1% in the 121 to 180-minute category, 0.6% in the 181 to 240-minute category and 0.4% in the 241 minutes and over category.

Remedial Plans and Actions

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

As part of the Trust's winter resilience planning, it is introducing "pods" at some hospital locations to aid staff finishing on time.

Expected Performance Trajectory

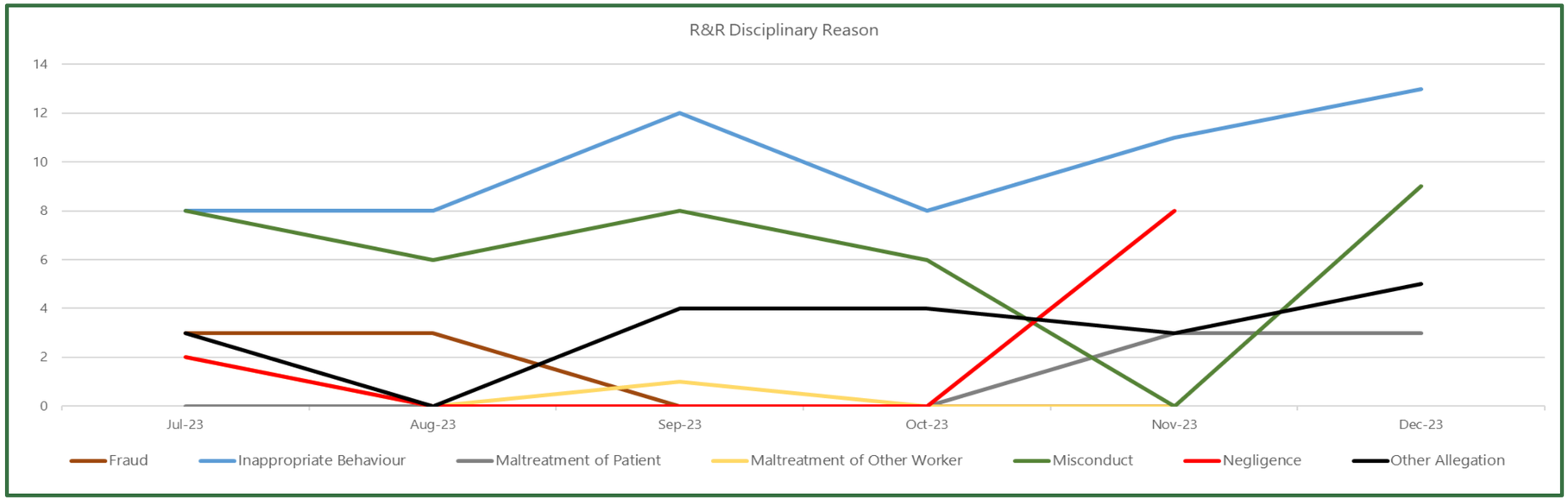
There is clearly an upward trajectory from Jun-23 as handover has started to increase. Whilst the Trust had amended its end of shift policies and introduced "pods" at key sites, as above, as handover increases further into the winter, we may expect overruns to increase.

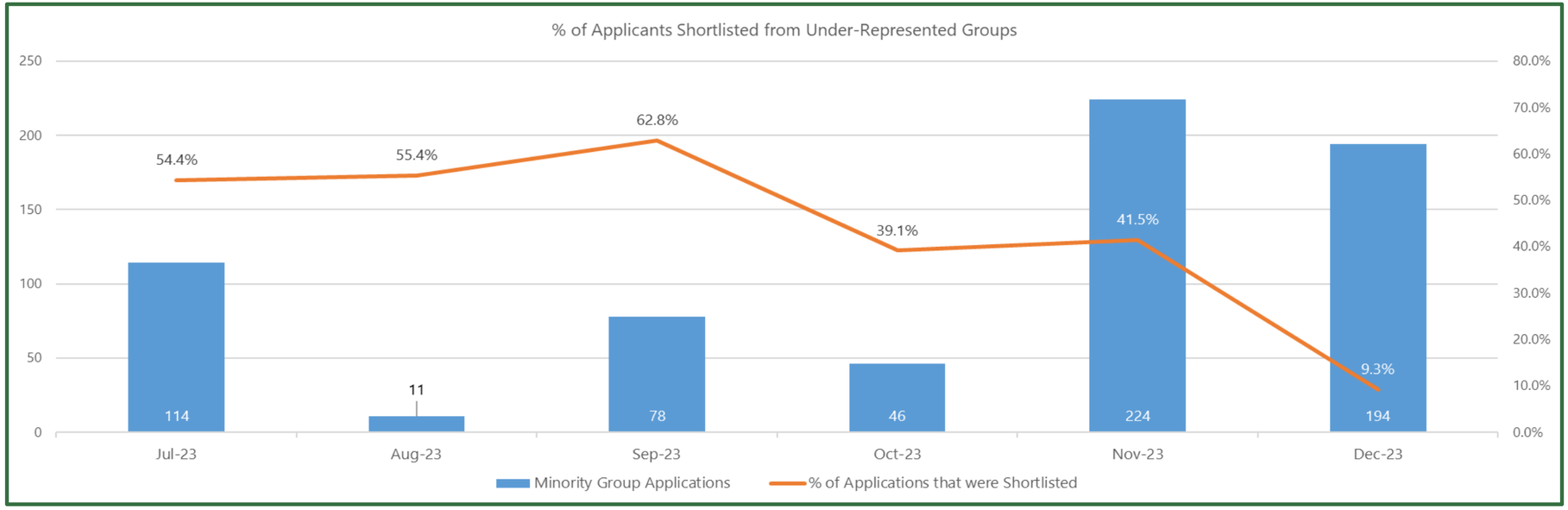
Our People
Culture – Number of R&R Disciplinary Hearings and Number of Applicants Shortlisted from Under-Represented Groups

(Responsible Officer: Angela Lewis)

Self-Assessment: Strength of Internal Control: Moderate

PCC





Analysis

There were 30 open formal disciplinary cases recorded at the end of December 2023, an increase compared to the month of November 2023 where 27 open cases were recorded. Of these Disciplinary cases, the majority are again due to allegations of inappropriate behaviour, followed by misconduct.

There were again 12 open formal Respect and Resolution cases submitted by employees, the same number recorded in November.

In December 2023, 9.3% of all applications from under-represented groups made it through shortlisting and were invited for interview. This was a decrease from the 41.5% in November 2023, while the volume of applications also declined, from 224 to 194. However, there was a spike in recruitment activity during November with it being the highest month of WTE advertised this resulted in a higher number of applications received and interviews conducted.

Of the 194 total applications from under-represented groups in December 2023, 121 were in the category of Ethnicity, 45 within Disability and 28 within Sexual Orientation.

Remedial Plans and Actions

R&R Formal Disciplinary Cases: Continue to monitor. The Trust has a substantial programme of work in place, connected to behaviours.

Applications: The inclusive recruitment work is ongoing to develop targeted recruitment campaigns and events.

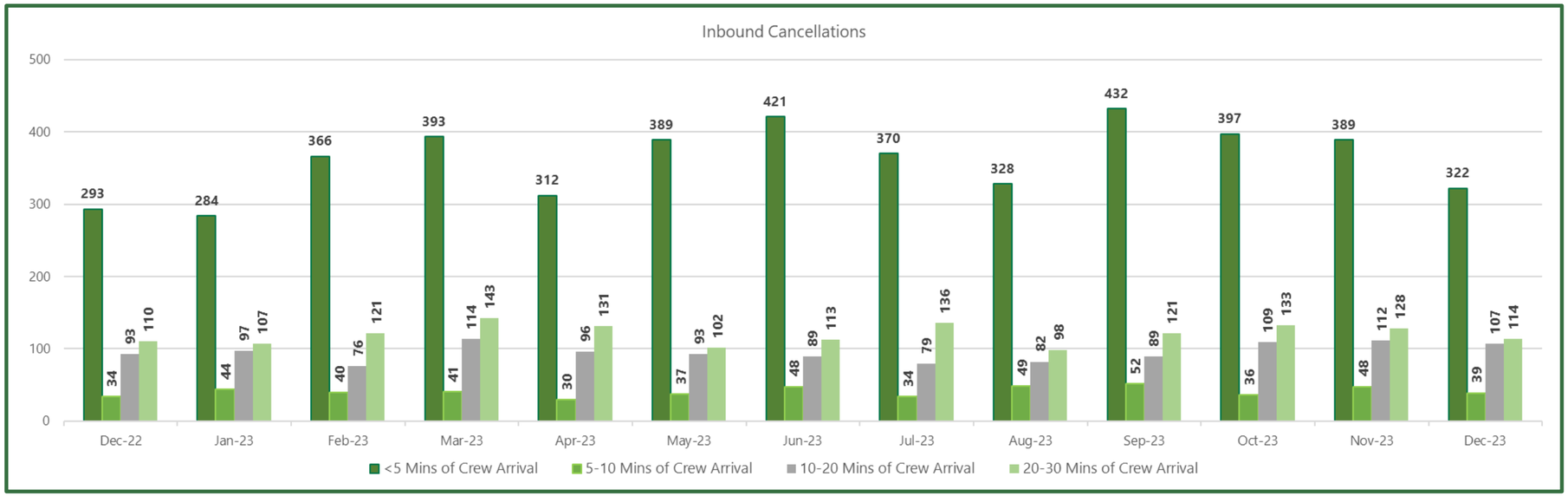
Expected Performance Trajectory

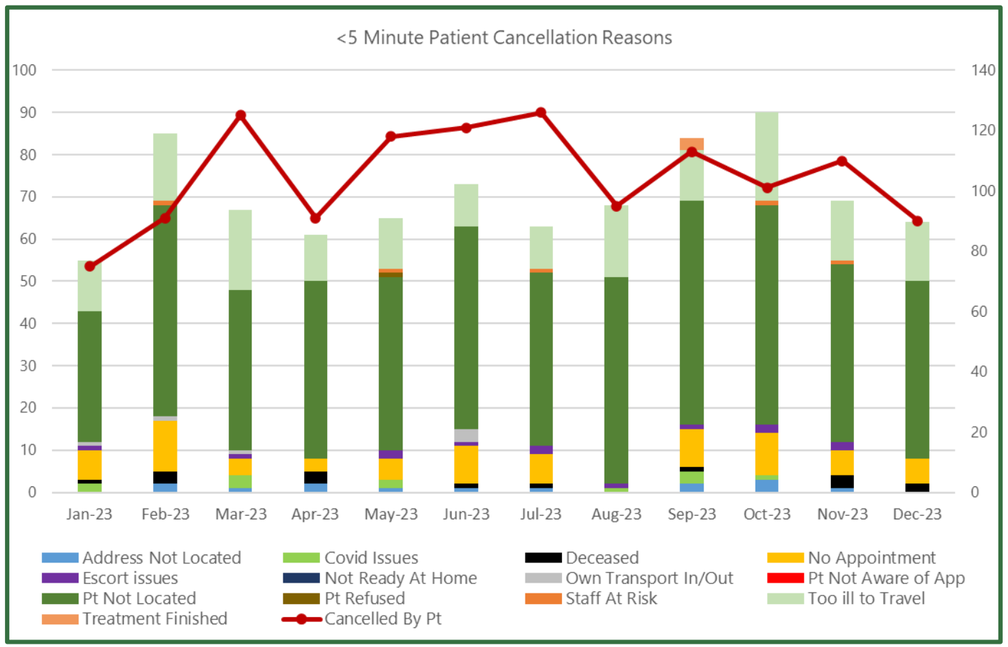
Continue to monitor levels, no trajectory for this measure.

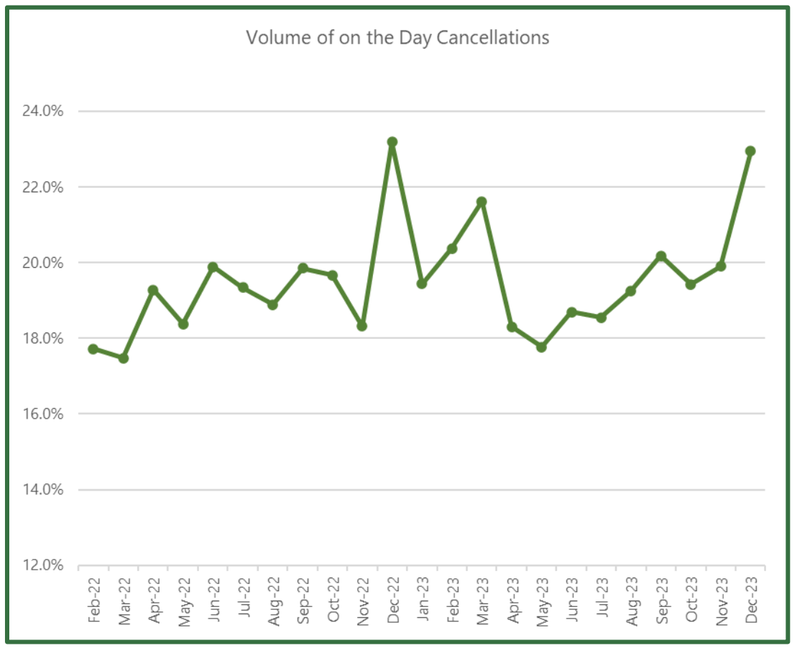
Finance, Resources and Value
Value: Ambulance Care Indicators

(Responsible Officer: Lee Brooks)

Cancellations
A







Analysis

Inbound cancellations of 5 minutes or less of the crew arrival time saw a decrease in December 2023 to 322, compared to 389 in November 2023. The total number of cancellations within 30 minutes also decreased from 677 in November 2023 to 582 in December 2023, however hospital clinics are not open over the holiday period reducing flow throughout the month.

Cancellations within 5-minutes of arrival appears to have seen an overall increase during the past 12 months. In December 2023 there were 90 cancelled by patient* entries made within 5-minutes of crew arrival an increase compared to the previous month of 110. The top reasons for less than 5-minute cancellations included: 42 patient not located, 14 too ill to travel and 6 no appointment. During the past 12 months there has been a minimum of 30 patients not located in the 5-minutes or less each month.

Same day cancellations increased slightly from 19.9% in November 2023 to 22.9% in December 2023.

Remedial Plans and Actions

Work is underway with Hywel Dda to develop a direct link between their PAS system and our CAD. Once in place this will allow for WAST to be notified once the health board cancels or alters an appointment.

This change should reduce the number of cancellations where crews arrive at a property and the patient advises that their appointment has been changed.

Data protection impact assessments have been completed and the systems have been able to connect and send non-identifiable information. Further testing and development is needed to ensure this works robustly and the appropriate governance is in place.

Expected Performance Trajectory

Until this work is completed, we do not anticipate a significant shift in the trajectory.

Please note that that figures may be lower than overall totals due to some records having no cancellation date.

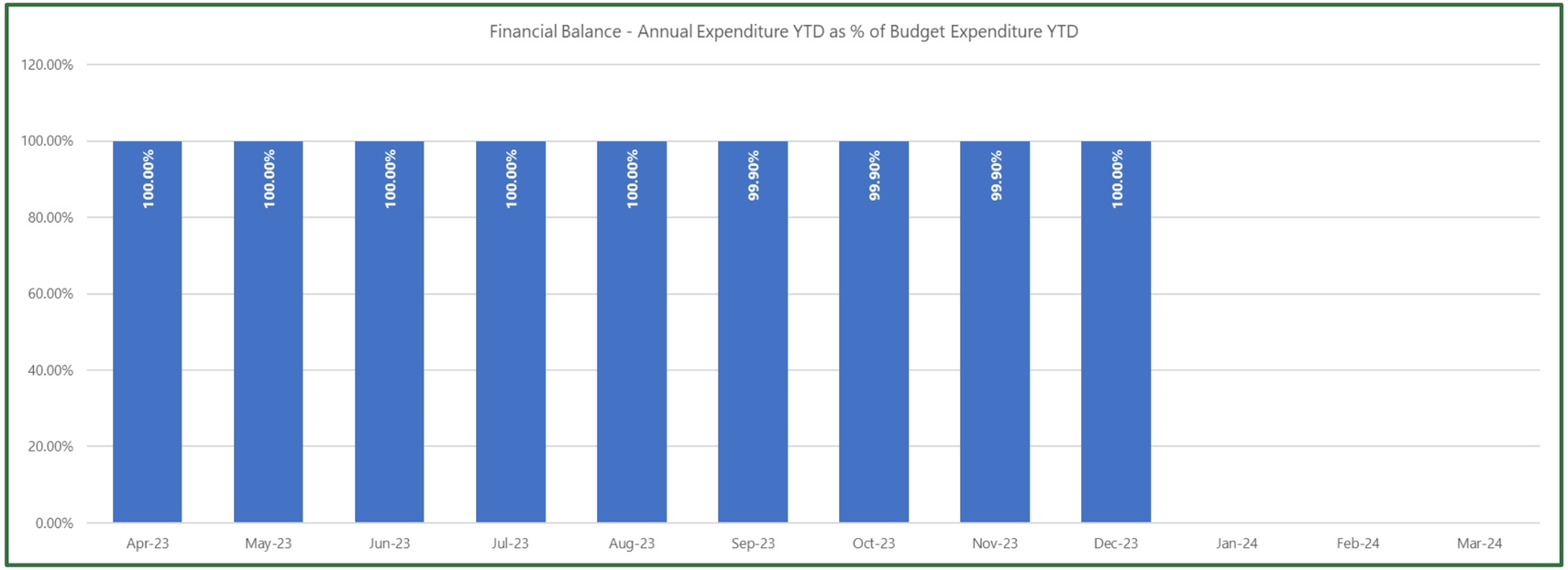
**Please note that MDTs do not appear to provide specific cancellation reasons for either inbound or outbound journeys. There are at present multiple and duplicated reasons both crews, control and the liaison desk can select.*

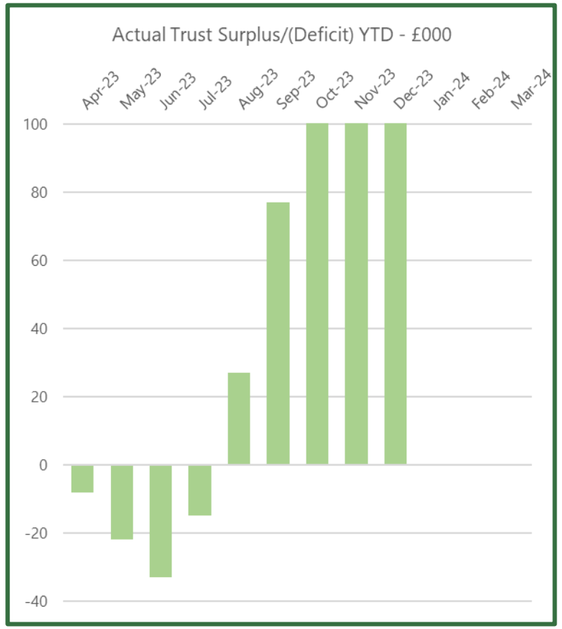
Finance, Resources and Value
Value - Finance Indicators

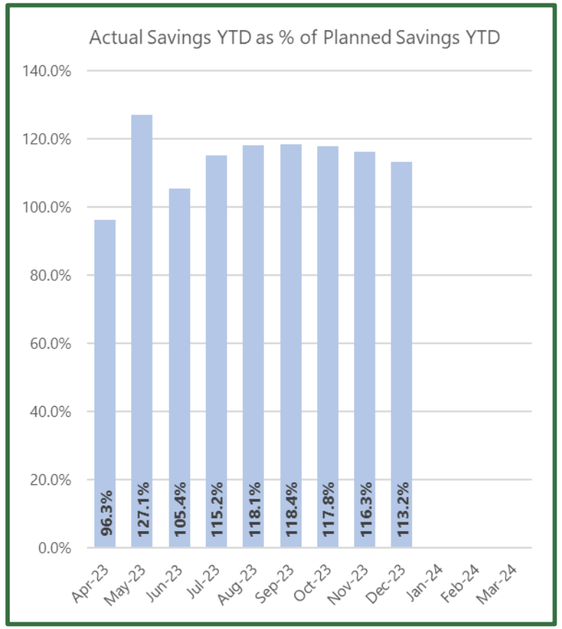
(Responsible Officer: Chris Turley)

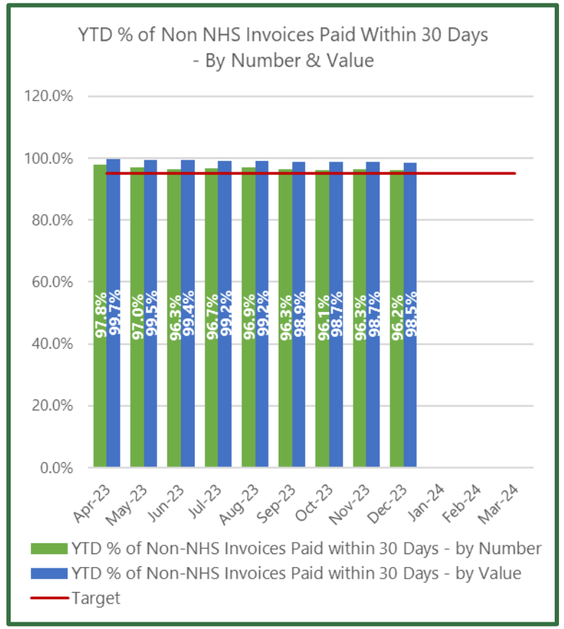
G

FPC









Analysis

The reported outturn performance at Month 9 is a surplus of £108k, with a forecast to the yearend of breakeven.

For Month 9 the Trust is reporting planned savings of £3.755m and actual savings of £4.250m (an achievement rate of 113.2%).

The Trust's cumulative performance against PSPP as at Month 9 is 96.2% against a target of 95%.

At Month 9 the Trust is forecasting achievement of both its External Financing Limit and its Capital Resource Limit.

Remedial Plans and Actions

The Trust's financial plan for 2023-26 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 2023-26 financial plan was submitted to WG following Board sign off on 31st March 2023.

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 2023/24 financial plan and beyond 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 via the Financial Sustainability Program (FSP);

Expected Performance Trajectory

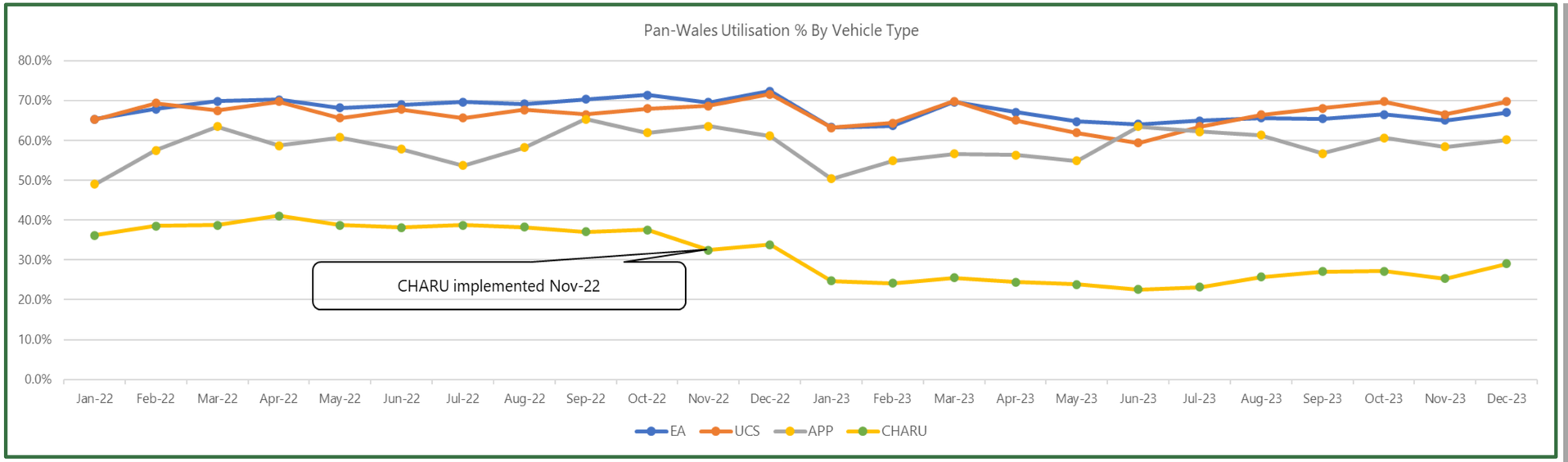
The expectation is that the Trust will continue to meet its statutory financial duties, as outlined in its IMTP for the 2023/24 financial year; however, it is expected that the Trust will continue to operate in a challenging financial environment and will need to deliver further significant level of savings into the 2024/25 financial year.

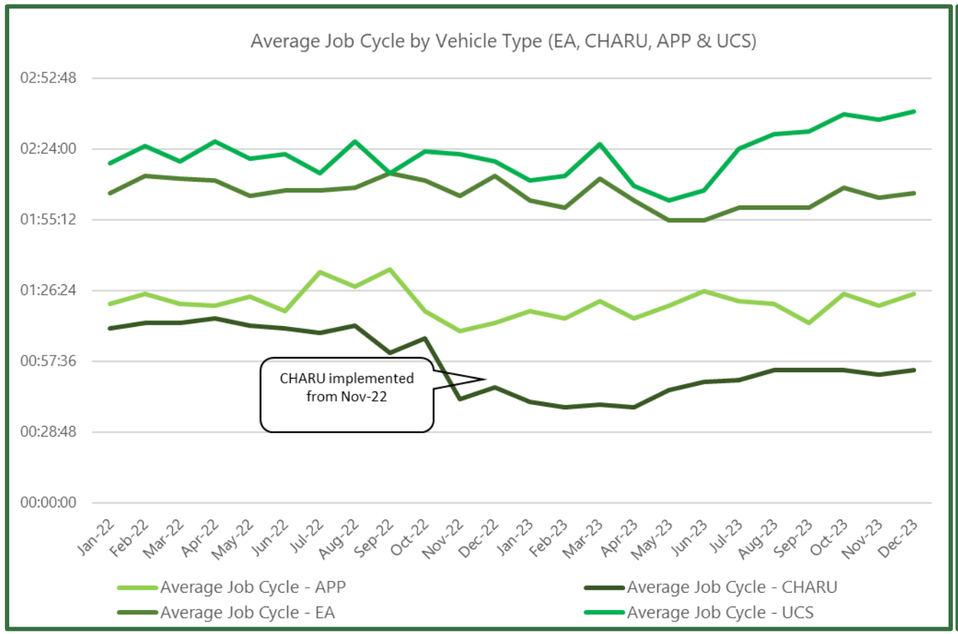
Finance, Resources and Value
EMS Utilisation & Average Job/Shift Times

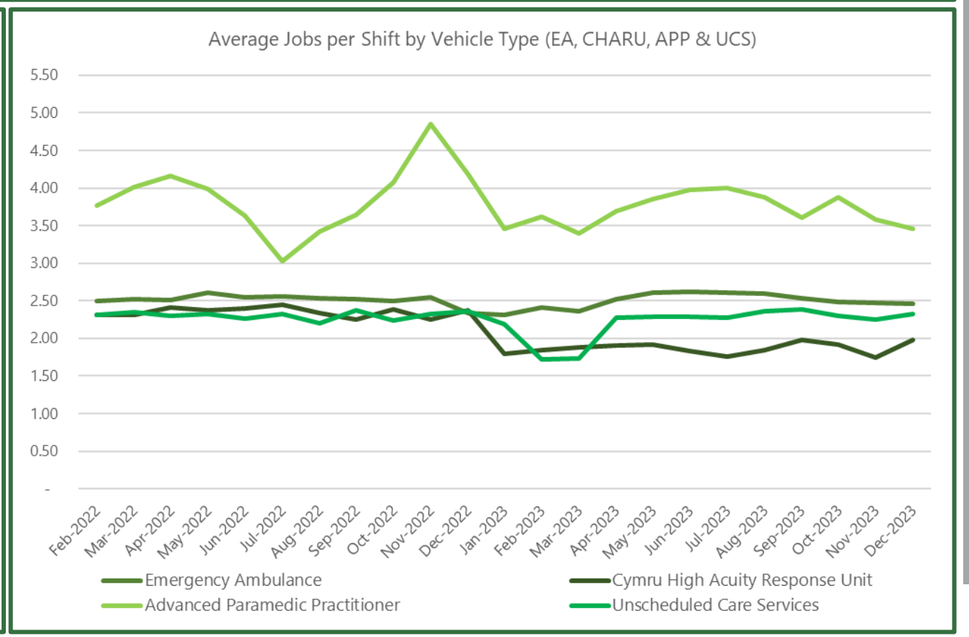
(Responsible Officer: Lee Brooks)

Job Cycle	CHARU Utilisation
A	A

FPC







Analysis

Pan Wales Utilisation metrics in December 2023 were 58.6% for all vehicles types, a slight increase from 56.4% in November 2023. UCS achieved the highest rate during the month at 69.7% while EA was at 67%. Both have seen a generally stable trend over the past two years. The optimal utilisation rate for EAs needs to lower so that they are free to respond to incoming calls.

As demonstrated in the bottom left graph, the average job cycle in December 2023 increased to 2 hours 06 minutes for EAs, and to 2 hours 39 minutes for UCS crews. CHARUs also increased to 54 minutes and APPs increased from 1 hour 20 minutes in November 2023 to 1 hour 25 minutes in December 2023.

Overall average jobs per shift was 2.34 in December 2023, an increase from the 2.29 recorded in November 2023. APPs attended on average 3.46 jobs per shift, EAs 2.46 jobs per shift, UCS crews 2.32 jobs per shift and CHARU's 1.98 jobs per shift.

Overall average jobs per shift has remained relatively static with APP & CHARU resources having a job cycle that is half that of a conveying resource.

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

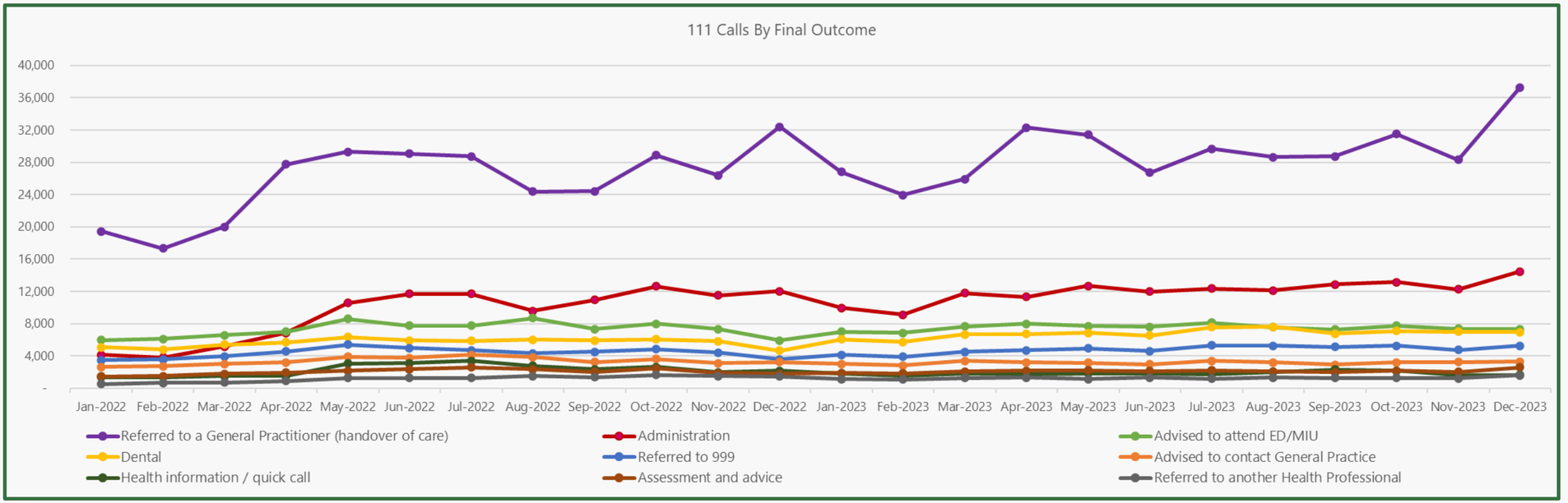
Expected Performance Trajectory

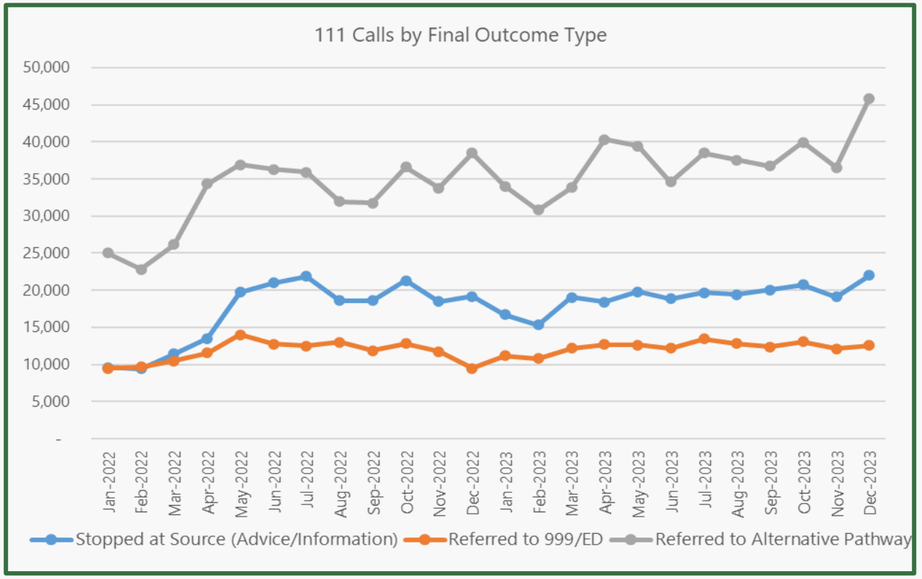
The increase in job cycle time since 2021 is caused by numerous complex factors. As ePCR embeds, a decrease may be seen, but with the factors outside of WAST's control a reduction to pre pandemic levels may not been seen. The EA and UCS utilisation is too high. The APP utilisation is being considered via the inverting the triangle transformation work. The CHARU rate is being reviewed linked to modelling.

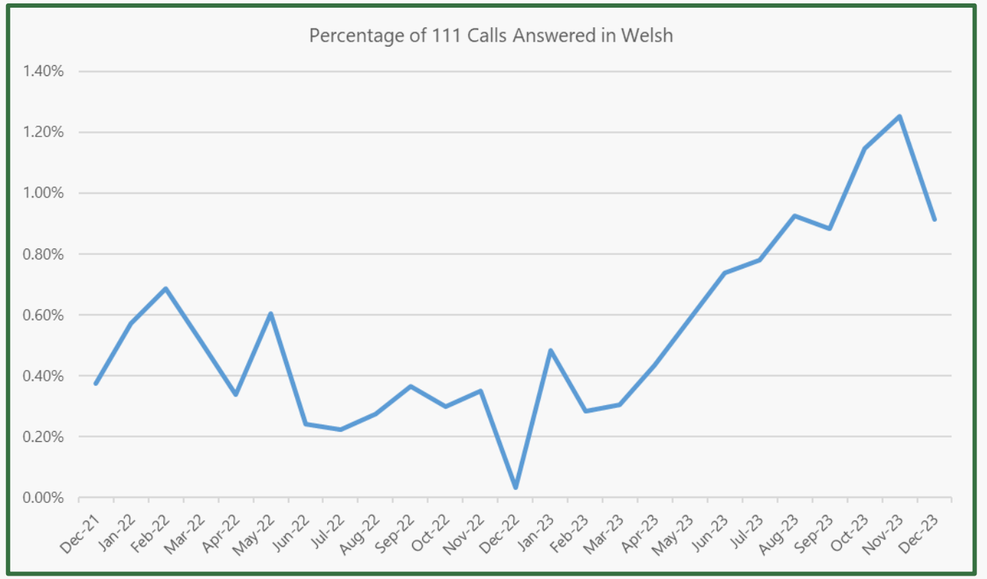
Partnerships / System Contribution
NHS111 Hand Off Metrics and NHS111 Consult & Close Indicators
Influencing Factors – Demand and Clinical Hours Produced

Dental: A | C&C Volumes: R | FPC

(Responsible Officer: Lee Brooks)







Analysis

During December 2023, 80,7449 calls were received into the 9 categories displayed in the graph opposite, an increase compared to the 67,797 received during November 2023.

Calls Referred to a General Practitioner (handover of care) continued to be the top outcome for NHS111 accounting for 46% of all calls during December 2023.

As the bottom left graph highlights, in December 2023, 22,018 calls into 111 were provided with information or advice, with no onward referral, an increase from the 19,135 in November 2023 and from the 19,199 during December 2022.

The percentage of total 111 calls being answered in Welsh decreased in December 2023 to 0.91% compared to 1.25% in November 2023.

This equated to 50.9% of all 111 calls being offered in Welsh being answered, a drop from the 67.9% answered in November 2023.

Remedial Plans and Actions

There is currently a 111 Measures Task and Finish Group. This is a collaborative meeting between WAST its commissioners and DCHW. The focus is the development of a Nationally reportable 111 data set. Similar to what is currently in place for Ambulance Service Indicators (ASIs) Part of this work involves looking at the reporting of disposition final outcomes.

Expected Performance Trajectory

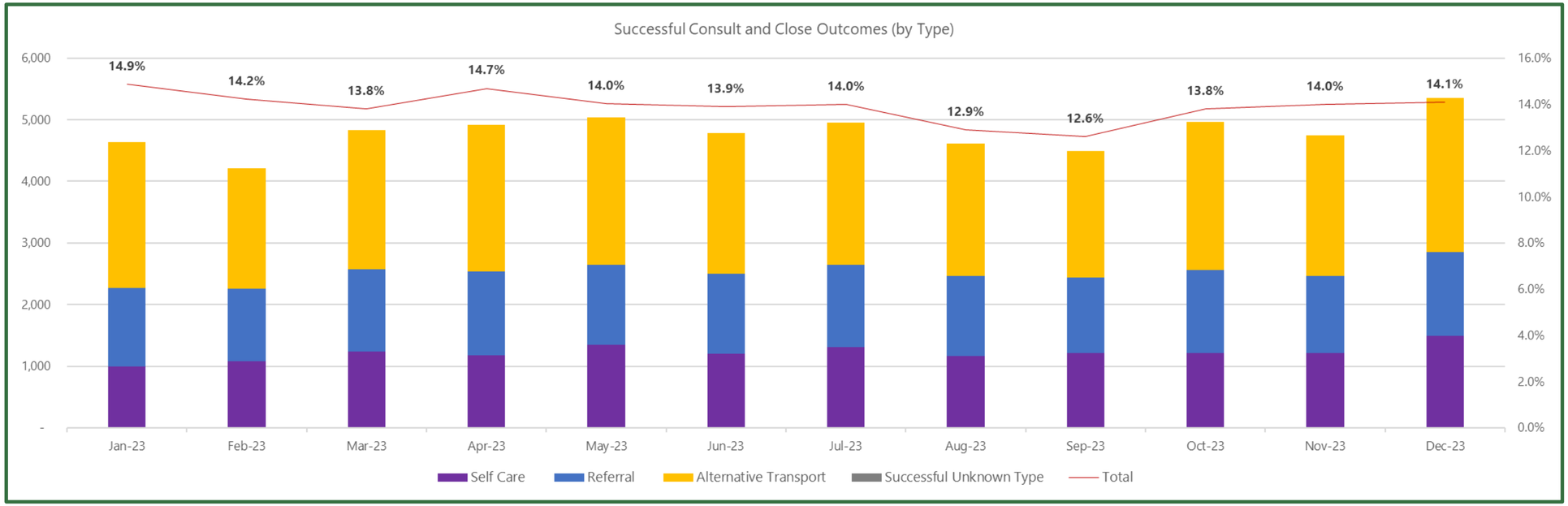
No performance trajectory is set at this time, as the Trust develops is measures and systems around these metrics. Once these have been developed there will be an opportunity to develop benchmarks. The focus remains to shift left, where it is clinically safe and appropriate to do so.

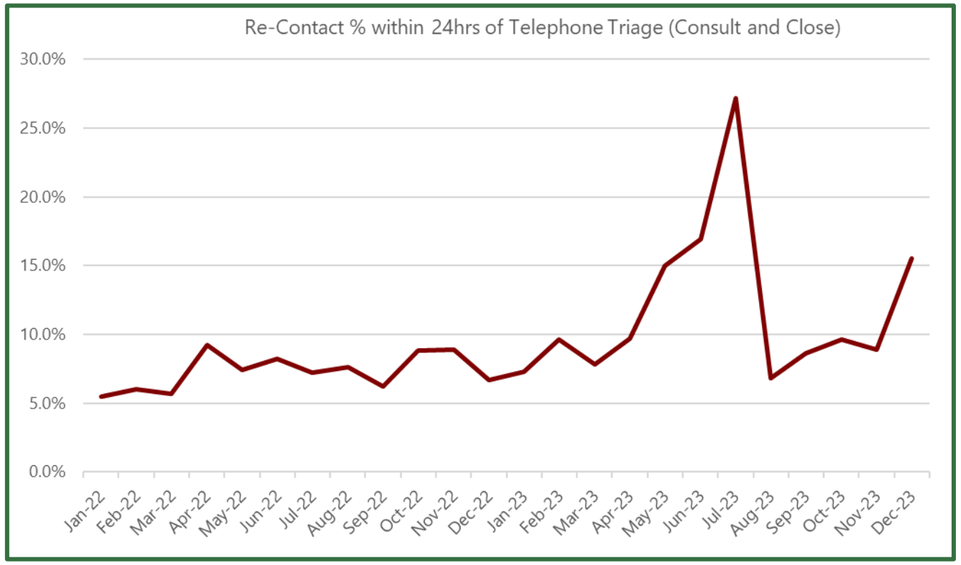
Partnerships / System Contribution
Consult & Close Indicators

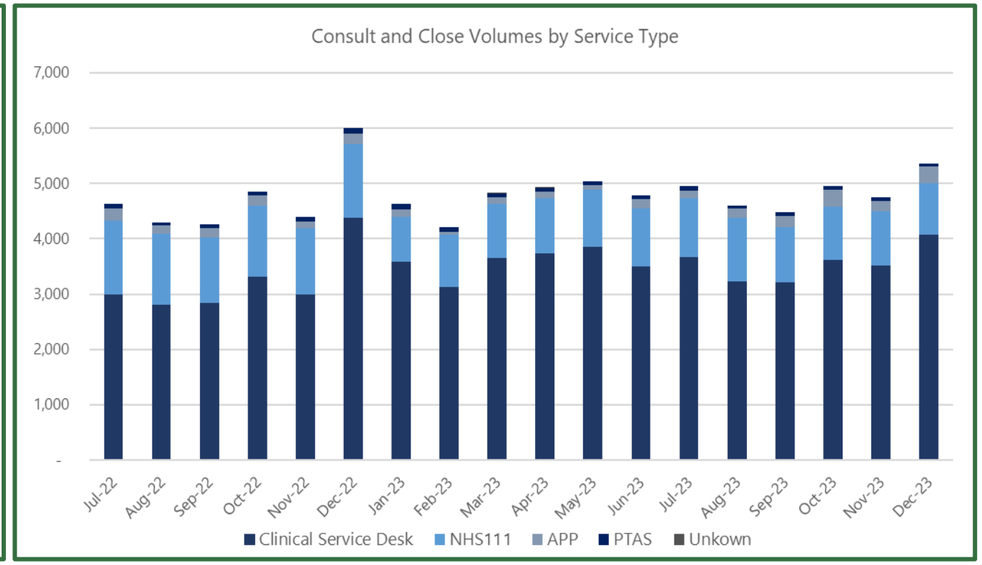
(Responsible Officer: Lee Brooks)

C&C R

FPC







Analysis

Consult and Close, with contributions from Clinical Service Desk (CSD) (10.8%), NHS111 (2.5%), WAST APP (0.8%) and the Health Boards using Physician Triage and Streaming Service (PTAS) (0.2%) achieved 14.1% in December 2023. This was a slight increase on the 14% seen during November 2023, but remained short of the new 17% IMTP ambition. In December 2023, the number of 999 calls resulting in a Consult and Close outcome was 5,366, up from 4,745 in November 2023.

Of the calls successfully closed in December 2023, 1,488 patients received an outcome of self-care; 1,363 patients were referred to other services (including to Minor Injury Units and SDEC) and 2,508 were advised to seek alternative transport services in order to acquire treatment.

Re-contact rates in December 2023 were 15.5%, an increase on the 8.9% seen in November 2023.

Remedial Plans and Actions

- Work underway reviewing processes, has yielded efficiencies in remote clinical support which is recognised by those calling
- Reporting still challenging without telephony data
- Failed contact activity from EMSC has reduced
- Progressing process with 111 to pass calls electronically from CSD, saving time
- More staff are at work in CSD
- Work commenced on PDSA for CSD First

Expected Performance Trajectory

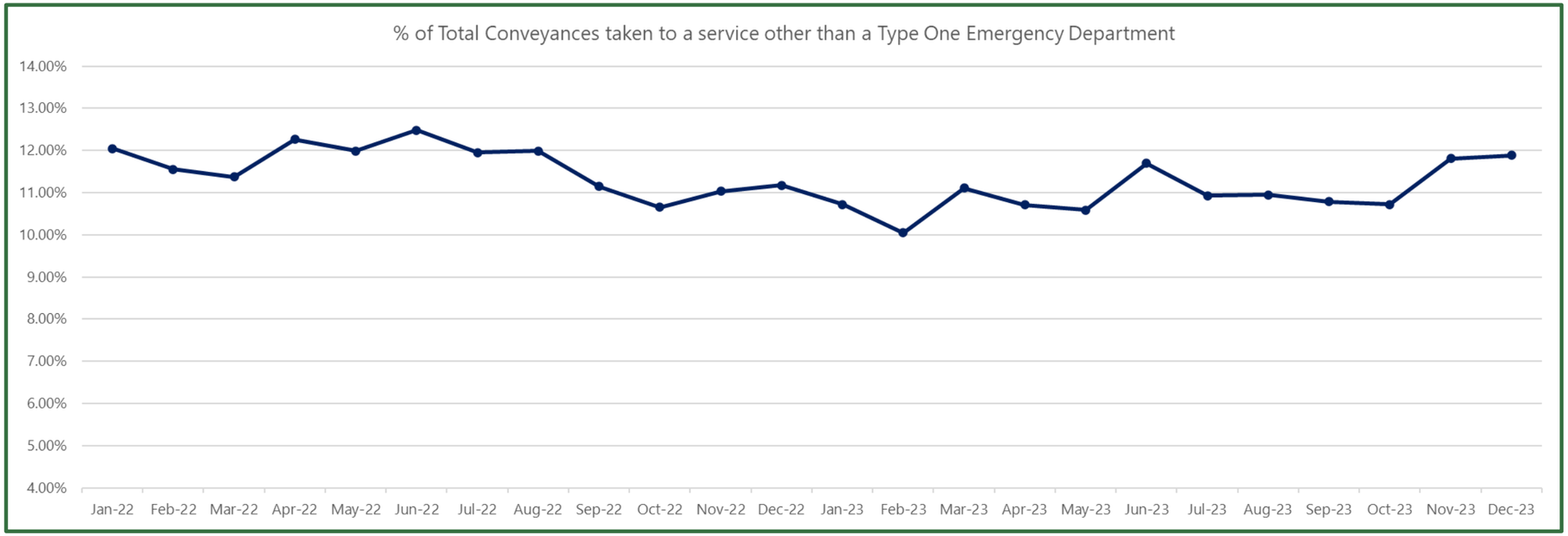
Further improvement is expected linked to CSD staff attendance (reduced abstractions and less vacancies). The ambition remains 17%.

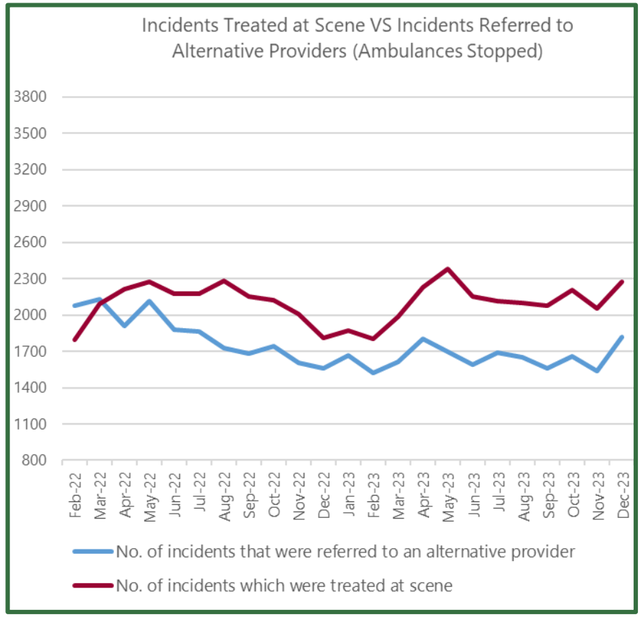
Partnerships / System Contribution
Conveyance to ED Indicators

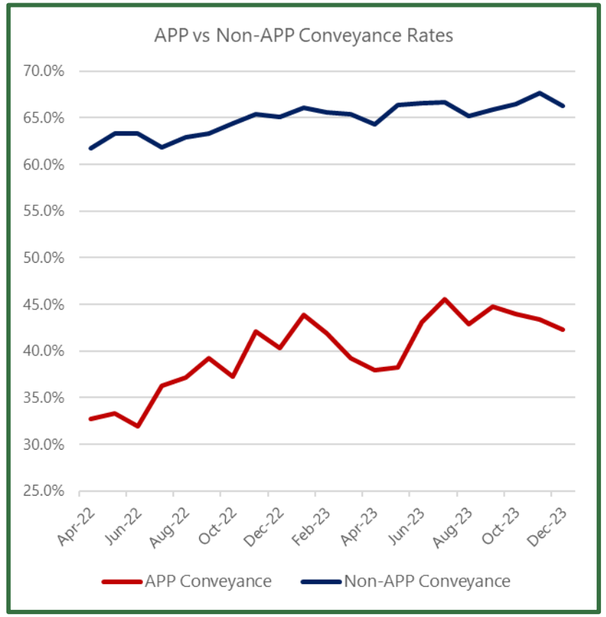
(Responsible Officer: Andy Swinburn)

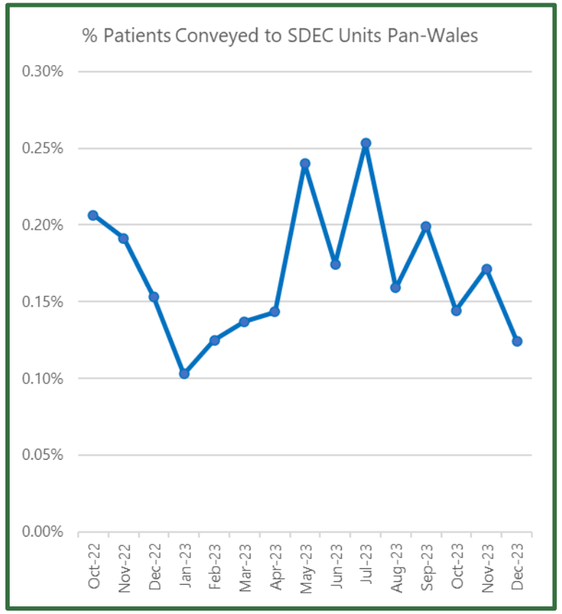
Conveyances
A
FPC

Ministerial Measure









Analysis

In December 2023 11.88% of patients (1,812) were conveyed to a service other than a Type One ED, while 35.51% of patients were conveyed to a major ED, as a percentage of verified incidents.

The combined number of incidents treated at scene or referred to alternate providers increased, from 3,594 in November 2023 to 4,089 in December 2023.

APP conveyance rates decreased slightly to 42.3% in December 2023, although there has been a general increase seen in recent months due to increased levels of CSP, which results in patients choosing to transport themselves to the ED, with only patients who do not have this ability (usually sicker) receiving a response.

Patients conveyed to SDEC's decreased from 0.17% in November to 0.12% in December 2023.

Remedial Plans and Actions

The Trust has modelled the use of same day emergency care (SDEC) services and identified that they could take an estimated 4% of EMS demand; it is currently less than 0.5%. The percentage increase in conveyance to services other than EDs is a Ministerial Priority. The Trust's ability to improve this figure is dependent on pathways that are open to the Trust such as SDECs.

Utilisation of APP resources will continue to be monitored as part of weekly performance reviews and evaluation of the appropriate APP code-set will be undertaken through the Clinical Prioritisation and Assessment Software (CPAS) group.

Expected Performance Trajectory

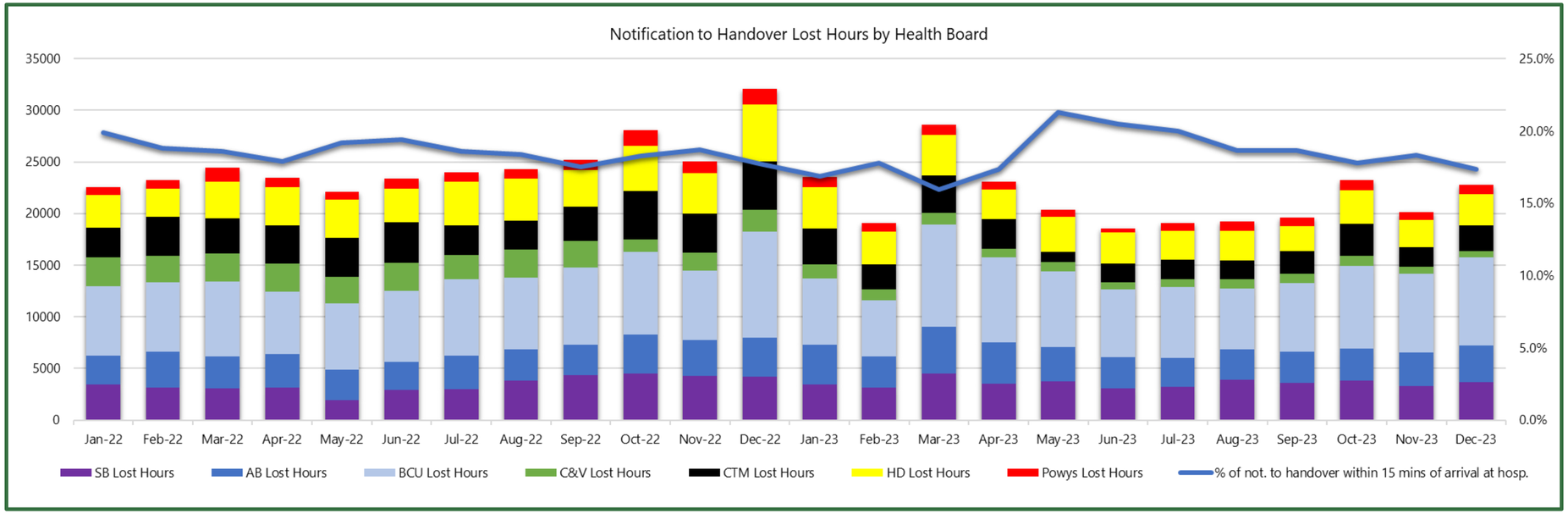
The Trust has completed modelling on a full strategic shift left, which identifies that the Trust could reduce handover levels by c.7,000 hours per month, with investment in APPs and the CSD and optimise allocation; however, the modelling indicates that handover would still be at 10,000 hours per month. 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 starting position of 67).

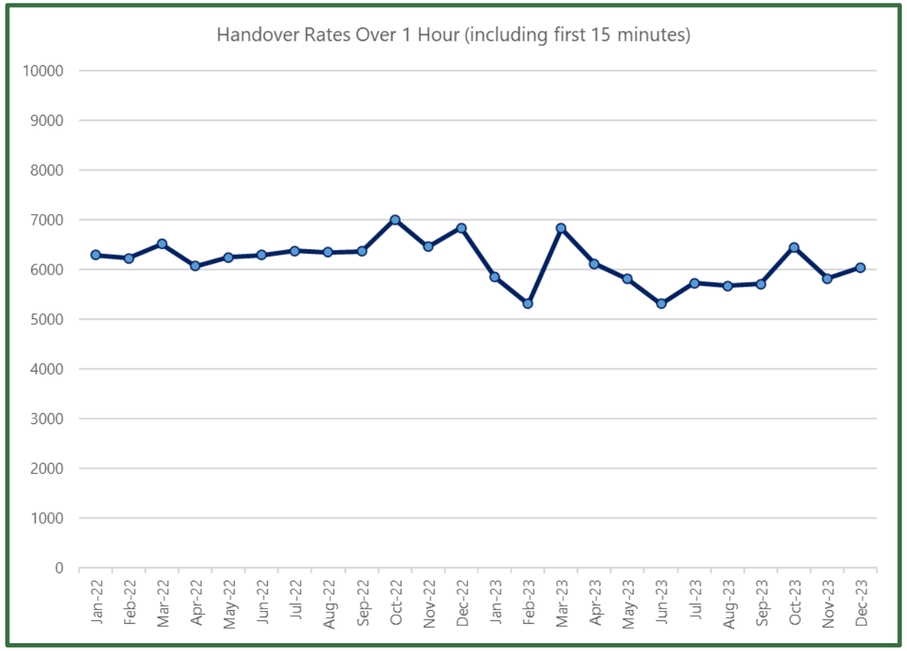
Partnerships / System Contribution Handover Indicators

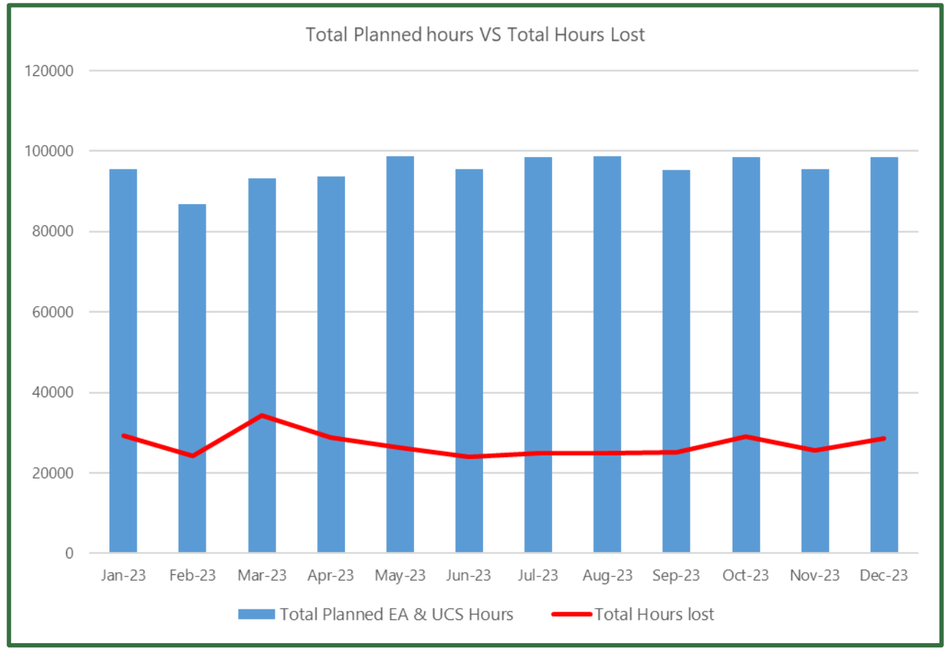
(Responsible Officer: Health Boards)

Lost Hours R

CI QUEST







Analysis

257,370 hours were lost to Notification to Handover, i.e., hospital handover delays, over the last 12 months (Jan-22 to Dec-23), compared to 298,655 over the same timeframe the previous year. There were 22,756 hours lost in December 2023, an expected increase from the 20,124 lost in November 2023. December levels were 9,342 hours below where they were during December 2022 (32,098).

The hospitals with the highest levels of handover delays during December 2023 were:

- Morriston Hospital (SBUHB) at 3,541 lost hours
- The Grange University Hospital (ABUHB) at 3,443 lost hours
- Wrexham Maelor Hospital (BCUHB) at 2,910 lost hours
- Glan Clwyd Hospital (BCUHB) at 2,834 lost hours
- Ysbyty Gwynedd Hospital (BCUHB) at 2,474 lost hours

Notification to handover lost hours averaged 734 hours per day during December 2023 compared to 670 hours a day in November 2023.

In November 2023, the Trust could have responded to approximately 7,178 more patients if handovers were reduced, which highlights the impact the numbers are still having on service.

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).

Expected Performance Trajectory

The Commissioning intention for 2023/24 is that handover lost hours should reduce to 15,000 hours per month, the same seen levels seen in the winter of 2019/20, which were considered extremely high, 12,000 hours by the end of Quarter 2 and sustained and incremental improvement in quarters 3 and 4. The ambition that there should be no waits over 4 hours during 2023/24. Non-release for Immediate Release Requests should become a Never Event.

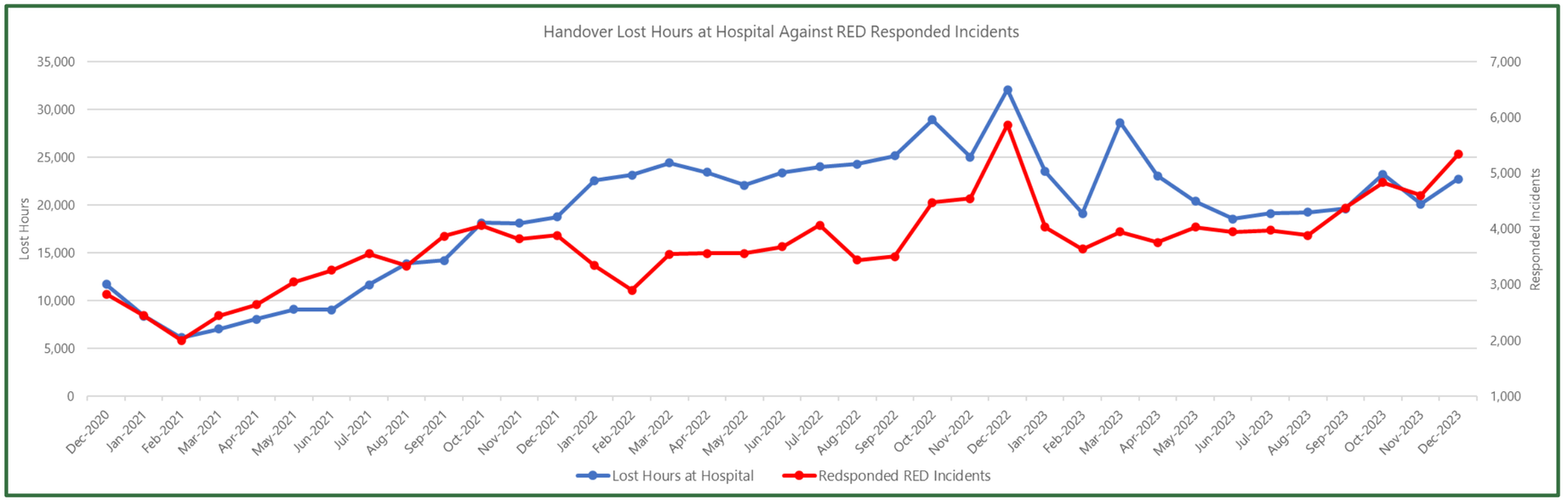
**NB: Data correct at time of abstraction.*

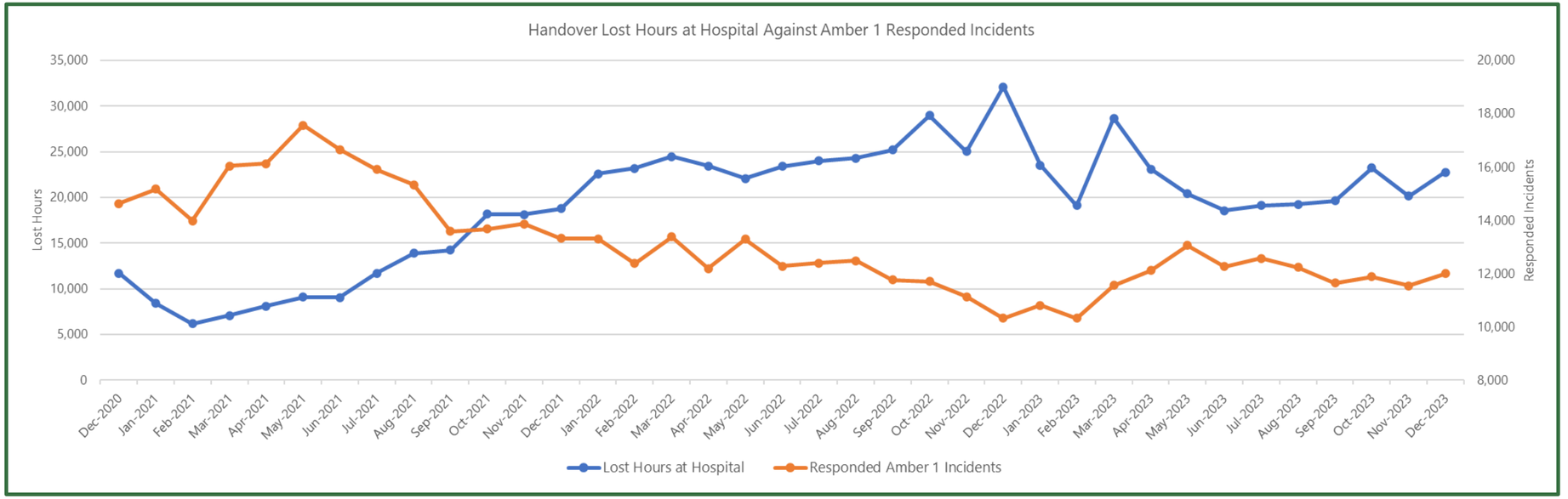
Partnerships / System Contribution

Handover Lost Hours Against Red & Amber 1 Responded Incidents

(Responsible Officer: Health Boards)

CI QUEST





Analysis

The top graph highlights that as handover lost hours have increased since March 2021, so too have the number of Red incidents being responded to. This shows that when CSP is in periods of high demand and hospital handover increases, Red responses are protected, even during high pressure within the system.

However, as the bottom graph illustrates, as the response to Red increases, there is an impact on Amber 1 responses, particularly at times of high demand, such as during December 2022. During these periods, the number of Amber 1 incidents attended decreases, notwithstanding that some of these patients within the Amber 1 category will still be seriously ill, although during December 2023 Amber 1 responses also increased slightly when compared to November 2023.

The bottom graph also highlights that as lost hours have increased since mid-2021, so Amber 1 responses have declined, due to the increased system pressures. However, as lost hours reduced during the first half of 2023, so Amber 1 responses increased, from 10,326 in December 2022 to 13,055 in May 2023. Therefore, it was possible to see the reduction of pressure within the system and subsequent performance improvement through the Amber 1 metric.

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.

Expected Performance Trajectory

The Commissioning intention for 2023/24 is that handover lost hours should reduce to 15,000 hours per month, the same seen levels seen in the winter of 2019/20, which were considered extremely high, 12,000 hours by the end of Quarter 2 and sustained and incremental improvement in quarters 3 and 4. The ambition that there should be no waits over 4 hours during 2023/24. Non-release for Immediate Release Requests should become a Never Event.

**NB: Data correct at time of abstraction.*

Term	Definition	Term	Definition	Term	Definition	Term	Definition	Term	Definition
AB / ABHB	Aneurin Bevan / Aneurin Bevan Health Board	CTM / CTMHB	Cwm Taf Morgannwg Health Board	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	Health 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	Emergency Medical Department	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

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.		
Renal Journeys arriving within 30 minutes of their appointment (NEPTS)	Proportion of renal journeys which arrive at hospital appointments within 30 minutes (+/-) of their appointment time.	**111 Consult and Close**	Consult and Close refers to the response to 999 callers where an alternative to a scene response has been provided. A cohort of 999 calls are passed to 111 where they are low acuity and the Clinicians in 111 may be able to help the caller with self-care, referral, etc. This is similar to the work of the Clinical Support Desk but for a lower acuity of caller. Where the outcome from the 111 clinical consultation ends in a Consult and Close outcome (self-care, referral, alternative transport) this is captured and forms part of the Trust's Consult and Close reporting. Over 50% of calls passed to 111 in this way are successfully closed without an ambulance response.
Discharge & Transfer journeys collected less than 60 minutes after booked ready time (NEPTS)	Proportion of journeys being discharged from and/or transferred between hospitals which were collected within 60 minutes of the hospital booked ready time.	**999 / 111 Hear and Treat**	Proportion of 999/111 calls which are successfully completed (closed) without dispatching an ambulance vehicle response. This may include advice, self-care or referral to other urgent care services.
National reportable Incidents (NRI)	Volume of patient safety incidents reported in the month which caused or contributed to the unexpected or avoidable death, or severe harm, of one or more patients, staff or members of the public, during NHS funded healthcare.	**% Incidents Conveyed to Major EDs**	Proportion of patients transported to a hospital Emergency Department following initial assessment at scene by a Welsh Ambulance Services NHS Trust Clinician, as a proportion of total verified incidents. (NB: An ED provides a wide range of acute in-patient and out-patient specialist services together with the necessary support systems, which allow emergency admissions, and which usually has an Accident and Emergency Department).
Concerns Response within 30 Days	Proportion of concerns responded to by the complaints team within 30 working days of receiving the concern.	**Number of Handover Lost hours**	Number of hours lost due to turnaround times at EDs taking more than 15 minutes. Transferring the care of a patient from an ambulance to an ED is expected to take no longer than 15 minutes, with a further 15 minutes for ambulance crews to make their vehicle ready for the next call.
EMS Abstraction Rate	The percentage of Emergency Medical Services (EMS) staff unavailable for rostered duties due to reasons, such as: annual leave, sickness, alternative duties, training, other and COVID-19.	**Immediate Release requests**	The number of requests submitted to Health Boards for the immediate release of vehicles at Emergency Departments to release them back into the community to respond to other urgent and life-threatening calls

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

QUALITY STRATEGY IMPLEMENTATION PLAN UPDATE

MEETING	Quality, Patient Experience & Safety Committee
DATE	8 February 2024
EXECUTIVE	Liam Williams, Executive Director Quality & Nursing
AUTHOR	Kate Blackmore, Senior Quality Governance Lead
CONTACT	kate.blackmore@wales.nhs.uk

EXECUTIVE SUMMARY

1. The last update to Quality, Patient Experience & Safety Committee (QuESt) was provided in May 2023 articulating the challenges in progressing the Implementation Plan as a result of Pandemic, Pandemic recovery, winter pressures and industrial action. This update acknowledged that a cost-neutral Organisational Change Process (OCP) had completed in Quarter 4, 2022/23 and assured QuESt that recruitment and onboarding to roles was taking place.

2. The Health and Social Care (Quality & Engagement) (Wales) Act 2020 came into force from 1 April 2023 supported by the Statutory Guidance and Quality Standards 2023. The Trust's alignment for the Roadmap to implementation is now reported separately through the Duty of Quality Implementation Plan following an update to QuESt in October 2023.

3. The Senior Quality Team (SQT) meeting structure commenced in September 2023. Attended by the Department Heads and appropriate Business Partners this group meets formally every two weeks. Oversight for the Quality Strategy Implementation Plan now forms part of the regular agenda for SQT.

4. May 2023 action updates as of end April 2023:

Complete	On Track	Challenged	Not Started	Total
1	10	7	4	22

5. Action updates as of end December 23:

Complete	On Track	Challenged	Not Started	Total
1	15	6	3	25

RECOMMENDED that the Quality, Patient Experience & Safety Committee notes the progress against the Implementation Action Plan.

KEY ISSUES/IMPLICATIONS

1. **Supporting a Learning Environment**
The suite of support tools and resources supporting reflective practice and continuous development is yet to commence but Senior Quality Leads have now been appointed and are working towards the creation of a quality hub of which the suite of tools and resources will form a key element.

2. **Enhancing Knowledge, Skills, and Professionalism**
Current challenges identified with e-learning roll out are related to how our volunteers can access this training due to restrictions on the platforms selected. Quality Leads are working with Learning and Development Teams and the volunteer's Management Team to address these challenges to ensure all elements of the Welsh Ambulance Services NHS Trust (WAST) have sufficient knowledge, skills and professionalism.

3. **Delivering Learning & Improvements**
Careful consideration has been taken with the Operations Directorate in assessing the alignment of operational governance structures. Continued collaborative working through the two Directorates has allowed the Quality Management Group (QMG) to establish a growingly effective forum, embedding patient safety and learning into this agenda with a revised Terms of Reference (ToR) tabled for Clinical and Quality Governance Group (CQGG) on 24 January 2024.

REPORT APPROVAL ROUTE

Clinical and Quality Governance Group	24 January 2024
Quality, Patient Experience & Safety Committee	8 February 2024

REPORT APPENDICES

ANNEX 1 - SBAR Report
ANNEX 2 - Quality Strategy Implementation Plan

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

SITUATION

1. The Trust Quality Strategy for 2021-24 broadly contained three Strategic Aims:

   (i) Supporting a quality-based learning culture that will deliver enhanced knowledge, skills, learning, improvement and professionalism.
   (ii) Develop a Quality Management System that will deliver quality driven decisions, integrating quality management, strong governance and accelerating quality responsiveness.
   (iii) Integrating the citizen's voice into the Trust's service design, transformation and improvements.

2. This paper provides an overview of progress against the Quality Strategy Implementation Plan and describes the link to the previously reported duty of quality/candour implementation.

BACKGROUND

3. The last update to the Quality, Patient Experience & Safety Committee (QuESt) was provided in May 2023 articulating the challenges in progressing the Implementation Plan as a result of Pandemic, Pandemic recovery, winter pressures and industrial action. This followed previous updates on the resourcing of the intended Strategy, particularly including the recruitment of Quality Lead roles to embed across the organisation as part of an operational-clinical-quality triumvirate leadership structure. The May 2023 update acknowledged that a cost-neutral Organisational Change Process (OCP) had completed in Quarter 4, 2022/23 and assured QuESt that recruitment and onboarding to roles was taking place.

4. May 2023 action updates as of end April 2023:

Complete	On Track	Challenged	Not Started	Total
1	10	7	4	22

5. Importantly, the Health and Social Care (Quality & Engagement) (Wales) Act 2020 came into force from 1 April 2023 supported by the Statutory Guidance and Quality Standards 2023. The Trust's alignment for the Roadmap to implementation is now reported separately through the Duty of Quality Implementation Plan following an update to QuESt in October 2023.

ASSESSMENT

6. Action updates as of end December 23:

Complete	On Track	Challenged	Not Started	Total
1	15	6	3	25

7. The Senior Quality Team (SQT) meeting structure commenced in September 2023. Attended by the Department Heads and appropriate Business Partners this group meets formally every two weeks and is chaired by the Senior Quality Governance Lead with the Consultant Clinician for 111 as vice chair. SQT reports into the Senior Quality Leadership Team (SQLT) monthly.

8. Oversight for the Quality Strategy Implementation Plan now forms part of the regular agenda for SQT.

9. Strategic Quality Aims:

A. **Quality Culture/Duty of Candour**:

(i) Supporting a Learning Environment**:**

- In order to support and create a quality-based learning environment the Strategy sets out the need for psychological safety. In early October 2023 WAST launched the 'Freedom to Speak Up' Campaign. The National Guardian's office emphasises the importance of speaking up and this year 'Speak Up Month' focuses on 'Breaking Barriers'. In parallel to the National Campaign the Trust has initiated the digital platform 'Work in confidence' to facilitate an anonymous voice for all those staff who feel particularly vulnerable.

- We have enabled colleagues from across the organisation to make contact anonymously with our guardians through a generic secure email or facilitated indirectly through the digital platform. Having a digital platform will assist with the high-level collation and evaluation of concerns to guide the Trust to potential thematic areas for improvement.

- The guardians have actively engaged in communications across the organisation emphasising the significance of creating a safe environment for colleagues to voice their concerns. This has been re-emphasised as part of the Leadership Symposium to support compassionate leadership across the organisation.

- ***The suite of support tools and resources supporting reflective practice and continuous development is yet to commence but Senior Quality Leads have***

now been appointed and are working towards the creation of a quality hub of which the suite of tools and resources will form a key element.

(ii) Enhancing Knowledge, Skills and Professionalism

- Duty of Candour training materials have been launched on the Electronic Staff Record (ESR) but are not currently part of a mandatory training requirement. Some challenges have been identified with accessing the training from the ESR platform and this combined with the non-mandatory nature of the training provided is impacting on compliance reporting. Learning and Development Teams have access to the package and include this guidance as part of induction packages.

- Duty of Quality training materials have also been launched on ESR, as well as the Learning@Wales platform. Again, this training is not identified by NHS Executive as mandatory. Updated communications due for release in 2024 will support the workforce to access this training package and will also communicate the Duty of Quality and our roles within it.

- Awareness sessions for both the Duty of Candour and Duty of Quality as well as Citizen Voice formed part of the presentations at the CEO Roadshow in November 2023.

- ***Current challenges identified are related to how our volunteers can access this training due to restrictions on the platforms selected. Quality Leads are working with Learning and Development Teams and the volunteers Management Team to address these challenges to ensure all elements of WAST have sufficient knowledge, skills and professionalism.***

- National Patient Safety Policy June 2023 has been adopted and implemented and as a result there are means to review what is listed as Duty of Candour within the Once for Wales RL Datix dashboards.

- Quality Assurance and Patient Safety Teams are working together to develop a dashboard to support Duty of Candour monitoring of incident levels and thematic trends on a weekly basis.

(iii) Delivering Learning & Improvements

- The Quality Management Group (QMG) is now operational, meeting weekly with a four-weekly rotation of focussed areas to encompass the organisational Directorates. Presentations have been made to Senior Operations Team (SOT), Senior Leadership Team (SLT) and Assistant Directors Leadership Team (ADLT) in order to embed QMG into departmental governance arrangements. The agenda

for QMG is based around the four quadrants of the quality management system with additional elements aligned to Citizen Voice, communication and education.

- ***Careful consideration has been taken with the Operations Directorate in assessing the alignment of operational governance structures. Continued collaborative working through the two Directorates has allowed the QMG to establish a growingly effective forum, embedding patient safety and learning into this agenda with a revised TOR tabled for CQGG on 24 January 2024***.

B. **Quality Management System**

(i) Quality Driven

- Following the internal OCP, the Senior Quality Leads are appointed and took post as of September 2023. An Engagement Plan has been developed with delivery continuing in Quarter 4. This will ensure regular engagement with clinical, operational and corporate functions to support quality improvement and provide specialist advice. This, alongside the QMG forum, allows for thematic prioritisation of areas for improvement and highlights areas of good practice.

- The first stage of development for the quality hub is due to be completed by the end of December 2023 with a proposed launch in early 2024. The first phase will focus on the Welsh Ambulance Services NHS Trust Improvement and Innovation Network (WIIN) portal and tracking of improvement data across Wales. The second stage will focus on development of training, information and resources.

- Quality Directorate Leads are now engaged with All-Wales Safe Care Collaborative and are also participating in the associated Patient Safety Improvement Coaching Programme.

(ii) Integrating Quality Management

- The Quality and Performance Management (QPM) Steering Group has been established and includes senior leadership membership across the Strategy, Planning & Performance, Governance and Quality, Safety & Patient Experience Directorates. The Steering Group have oversight of the QPM Framework which has been updated to reflect the Duty of Quality and this document is now pivotal to the Quality Policy requirements for a robust Quality Management System.

- Work is now ongoing to review local Frameworks with self-assessment activity being undertaken by pilot areas with a third area identified for the next phase of assessment. Quality Assurance Teams are engaging with teams across the

organisation to understand the current audit and assurance activities to help support and deliver the local Quality Management Systems.

- The introduction of the QMG has strengthened the quality governance arrangements across organisational services, this integrated forum reports to CQGG providing assurance of the Quality Management System activity as well as quality improvement initiatives in place across the organisation.

- CQGG is fully established with a number of sub-groups in operation, Terms of Reference are in place or under review providing clear reporting forums for governance arrangements.

(iii) Accelerating Quality Responsiveness

- With Senior Quality Leads in place and integrated forums now in operation representatives across all Directorates have a protected space to raise quality improvement initiatives and receive support to deliver responsive Quality Management Systems. Work is ongoing to deliver reporting platforms both internally and externally to make all teams aware of the organisation's quality performance activity in line with always on reporting. As a first phase the Monthly Integrated Quality Performance Report (MIQPR) is now accessible via Siren Sharepoint as is the Quality Performance Management Framework (QPMF). Introduction of the quality improvement hub will further support quality responsiveness working collaboratively across Directorates.

C. **Integrating the Citizen Voice**

(i) People & Community Network

- Engagement with communities has continued with recruitment of citizens into the Trust's people and community network as previously reported this will be a continuous exercise to ensure appropriate representation. Network members have participated in a number of Trust activities to improve services and engagement is now commencing around the Annual Quality Report and how this can meet the community's needs.

- Internal promotion continues to ensure WAST colleagues provide opportunities for network members to be involved in projects programme activities with consideration of proactive communication and co-design forming part of QMG discussions.

(ii) Integration of Citizen Voice within Quality Cycle

- The All-Wales digital system for service user experience capture, Civica experience, is now live enabling a range of metrics to be reported against with a variety of reports demonstrating how experiences and citizens voices are being captured. These reports now form part of the standard QMG agenda helping to identify quality improvement initiatives around patient experiences and outcomes.

- The Patient Experience & Community Involvement (PECI) Team is working locally with teams to embed the sharing of Civica experience platforms with service users to ensure improved quality of patient experience is helping to drive quality improvement initiatives.

Strategic Quality Aims	Strategic Outcome	Strategic Output/Intent	Action	RAG Status	Progress Update: 2023-24 Q2
Quality Culture / Duty of Candour	Support a Learning Environment	Psychological Safety	Establish a psychological safety, through the Trust Health & Wellbeing Steering Group		In early October 2023 WAST launch the "Freedom to Speak Up" campaign. The National Guardian's Office emphasises the importance of speaking up and this year "Speak up Month" focuses on 'Breaking Barriers.' In parallel to the National campaign the Trust has initiated the digital platform "Work in Confidence" to facilitate an anonymous voice for all those staff who feel particularly vulnerable. We have enabled colleagues from across the organisation to make contact anonymously with our guardians through a generic secure email or facilitated indirectly through the digital platform. Having a digital platform will assist with the high-level collation and evaluation of concerns to guide the Trust to potential patterns/problem areas. The Guardians will be able to report anonymised trends for appropriate action or intervention will be sought as appropriate.
		Appreciation of Complex Clinical Judgements (Person Centred Care)	Embed learning & feedback from incidents and events – establishing processes for shared learning across workforce/organisation (organisational learning)		The guardians have actively engaged in communications across the organisation emphasising the significance of creating a safe environment for colleagues to voice their concerns. The benefits of this approach were reconfirmed at the leadership day, highlighting the importance of leaders being approachable and
		Openness to new approaches			
		Resources to support reflection and learning	Suite of support tools and resources supporting reflective practice, and continuous development		Not currently progressed due to capacity and absence within in the team- however this will form part of the Quality Hub development
	Enhancing Knowledge, Skills and Professionalism (Duty of Candour)	Education and Training (Duty of Candour)	**Training package** – Duty of Candour training package will be diseminated through Welsh Government as part of the quality & Engagemet Act. The pacakage will be released following conclusion of public consultation		Duty of Candour training materials have been made available to Patient Safety and Education Department. Patient Safety have shared with operations. The platform for the training is ESR but not mandatory. Currently there are issues with access to the training on ESR, which is negatively impacting on understanding compliance when running reports. Training should be is undertaken on induction and through mandatory training. Awareness raising will be undertaken on DOC at CEO Roadshows.
		Day-to-day 'Duty of Candour' implementation	*Process to capture DoC (low, medium and high level activity)*		National Patient Safety Policy June 2023 adopted and implemented. There are means to review what is listed as DoC within the OfW dashboards. QA are meeting with patient safety to develop a dashboard
	Delivering Learning & Improvements	Process and principles in which open, honest and transparent learning is undertaken	Embed enhanced learning and monitoring within quality management systems - promoting quality improvement efforts and action.		quality management meetings in place weekly to cover all elements of the QMS cycle
			Challenge current working practices and procedures in order to promote a culture of continuous improvement		
			Development of supporting processes and systems of work that focus improvement towards challenges		
Quality Management System	Quality Driven	Quality is everyone's responsibility	**Training package** – Duty of Quality training package will be diseminated through Welsh Government as part of the Quality & Engagement Act. The package will be released following conclusion of public consultation		Duty of Quality Educational Packages being finalised by NHS Executive. The platform it is being built on is 360 Articulate and it will be hosted on ESR and Learning @wales.
			An organisational evaluation will be undertaken to ascertain roles and responsibility for Quality. This will incude the requirements upon all staff, resulting from the Act; and, install the principles of responsibility towards an improvement orientated organisation		
			Statement/principle campaign		update required
			The development of an annual evalution and recognition exercise which seeks to celebrate exemplars of quality/quality improvement. **Celebrating success and exemplars**		Senior Quality Leads in post as of September 2023. Engagement Plan currently being developed in Q3 for delivery in Q3/Q4. This will ensure regular engagmenet with Clinical/Operations/Corporate functions to determine issues around Quality and highlight areas of practice.
		Empower local leaders	Quality Management system training/education will be provided additionally, wider workforce education (particularly targeting senior local leads) will be developed through a Quality Hub.		1st stage of evelopment of Quality Hub- due to be completed by December 2023. This will launch in January 2024 and will focus on WIIN Portal and Tracking of Improvement data accross Wales. 2nd Stage will focus on development of training, information and resources.
			Establish 'working together' with Senior Quality Leads		Senior Quality Leads in post as of September 2023. Currently developing an engagement plan for the wider organisation. Initially focused on Operations and Clinical Directorate. Engagement ongoing as of October 2023. Senior Quality Leads engaging with Safe Care Collaborative and 3 x members of Quality Directorate participating in the Safe Care Collaborative Coaching
	Integrating Quality Management	Systems that integrate and triangulate data	Establishment of a Quality & Performance Management Steering Group; Establishment of integrated 'governance' forums.		A Quality and Performance Management Steering Group has been established/ Furthermore, the implementation of the Quality Management Group (QMG) has strengthened the quality governance across organisational services; this group reports to CQGG.
		Collaborative forums for patient and service users			
	Strong Governance & Quality Management Structures	Integrating communication			
		Integrating reporting lines			
		Integrated Governance Group	Establish and introduce an integrated, Clinical and Quality Governance Group (CQGG)		CQGG fully established
			Develop reporting and governance channels to local level		
		Board to Floor	Development of sub-structure groups to CQGG.		
			Establishment and introduction of a integrated 'governance' forum		Sub structure to CQGG reviewed and ToR implemented
	Accelerating Quality Responsiveness	Reduce turn-around times on quality issues	Establishment of local Senior Quality Leads and local leadership 'ownership' of quality.		Senior quality leads in post and commencing engagement with wider organisational leads to embed within quality structure QMG in place and focussed around all areas of organisation to embed and develop a quality management system
		Issues locally owned and managed			update required
Integrating the Citizen Voice	People & Community Network	Inclusivity	Establish a network representational of the Citizens of Wales, inclusive to all who seeking to be involved		Engagement with communities has continued, with recruitment of citizens into the Trust People and Community Network.
		Innovation	Establish and embed work processes to enable Citizens to be contributing and co-producing Trust service development and transformation		Network members have participated in a number of Trust activities to improve services.
		Influencing	Embed the Citizen voice as an influencer in Trust decision making and planning		Internal promotion continues to ensure WAST colleagues provide opportunities for network members to be involved in projects/programme activities.
		Involvement	Provide opportunities for meaningful engagement and involvement in Trust service developments		see above.
	Integration of Citizen Voice within Quality cycle (planning)	Effective Citizen participation in service change and delivery	Defined systems and processes that enable measurable/demonstratable integration of the Citizen's voice within Trust service developments, improvements and transformation in the pursuit of enhanced quality of care & experience.		Civica is now live enabling a range of metrics to be reported against and variety of reports demonstrating how experiences and citizens voices are being captured and work to improve experiences/outcomes.

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

Focus on Clinical Indicators
Stroke

MEETING	Quality, Patient Experience and Safety Committee
DATE	8 February 2024
EXECUTIVE	Executive Director of Paramedicine
AUTHOR	Head of Clinical Intelligence & Assurance
CONTACT	Kevin Webb Kevin.webb@wales.nhs.uk

EXECUTIVE SUMMARY

1. QuEST requested a series of updates to be presented at committee meeting in relation to a focus on Clinical Indicators (CIs). A focus on Return of Spontaneous Circulation (ROSC) has previously been presented and for this meeting, the focus is on Stroke.

2. Within this update we will highlight:

   - What we measure (criteria)
   - Data quality and reporting
   - Improvements to date
   - Next steps to improvement
   - Future changes to Stroke call timing

3. Further progress has been made with improving the Clinical Indicator dashboard which now includes the time-based metric for stroke; 'Call to scene', 'Time on scene' and 'Call to hospital door'. These are now reported on as part of the Ambulance Service Indicators (ASIs) to the Emergency Ambulance Services Committee (EASC).

4. Electronic Patient Clinical Record (ePCR) user interface changes recommended from the stroke clinical audit were included in the updates implemented during December 2023. These are aimed at improving the usability for clinicians to input data and to improve compliance.

5. Work continues with the improvement plan to include further engagement and support from Senior Paramedics **RECOMMENDED: That the committee Note the PowerPoint update for the Stroke Clinical Indicator**
KEY ISSUES/IMPLICATIONS
None
REPORT APPROVAL ROUTE
Quality, Patient Experience and Safety Committee – 8 February 2024
REPORT APPENDICES
Focus on CIs – Stroke PowerPoint presentation

REPORT CHECKLIST

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

Welsh Ambulance Services NHS Trust

Clinical Indicators Focus on Stroke

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
NHS Trust

Clinical Indicators – Focus on Stroke
Version 3.0
Released: January 2024

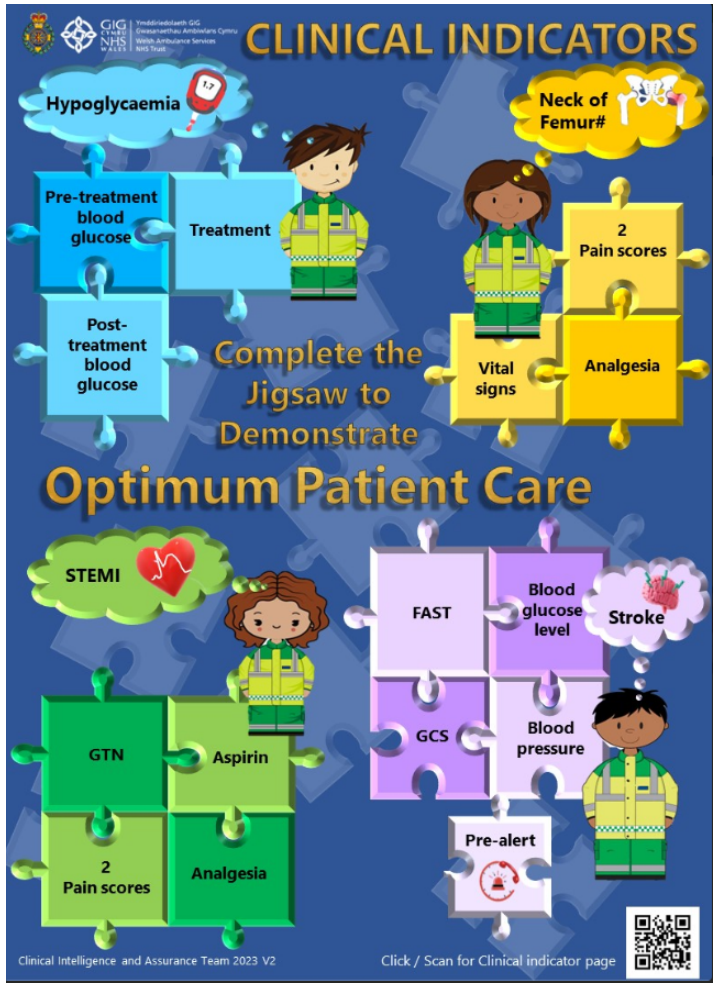
Kevin Webb
Head of Clinical Intelligence & Assurance
Kevin.webb@wales.nhs.uk

Introduction

The next Clinical Indicator (CI) in the 'Focus on CIs series' is for Stroke.

Within this we will highlight:

- ✓ **What we measure (criteria)**
- ✓ **Data quality and reporting**
- ✓ **Improvements to date**
- ✓ **Next steps to improvement**
- ✓ **Future Changes to Stroke Call Timing**

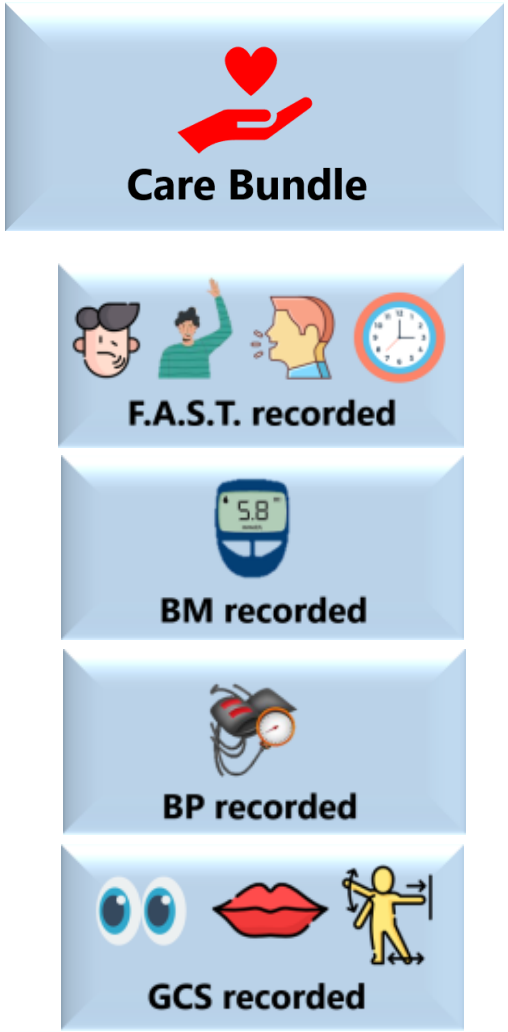


What we measure (*care bundle*)

- **Number of Stroke & FAST+ve patients attended (Diagnostic Codes for CVA or TIA) (*denominator*)**
  (excluding head trauma/cardiac arrest/inter-hospital transfers)

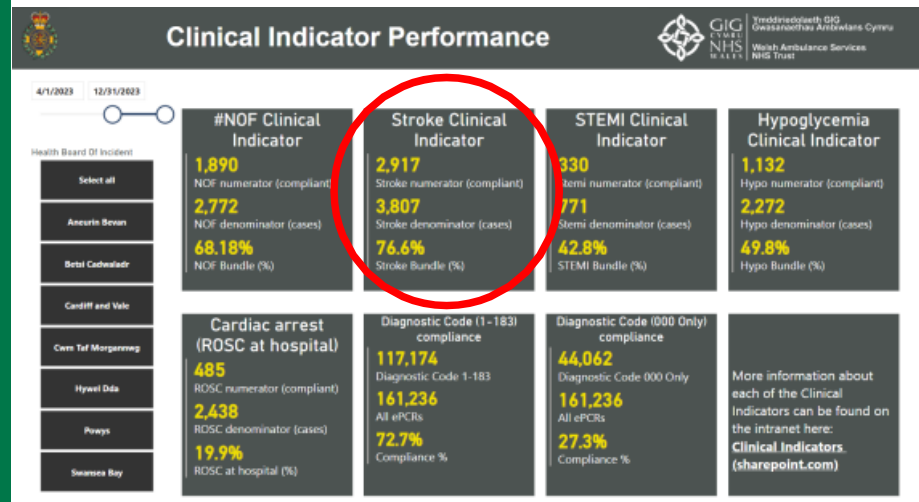
- **Compliance to the care bundle requires each criterion of care (*numerator*) to be completed:**
  - **F.A.S.T undertaken**
  - **Blood Glucose (BM)**
  - **Blood Pressure (BP)**
  - **Glasgow Coma Scale**

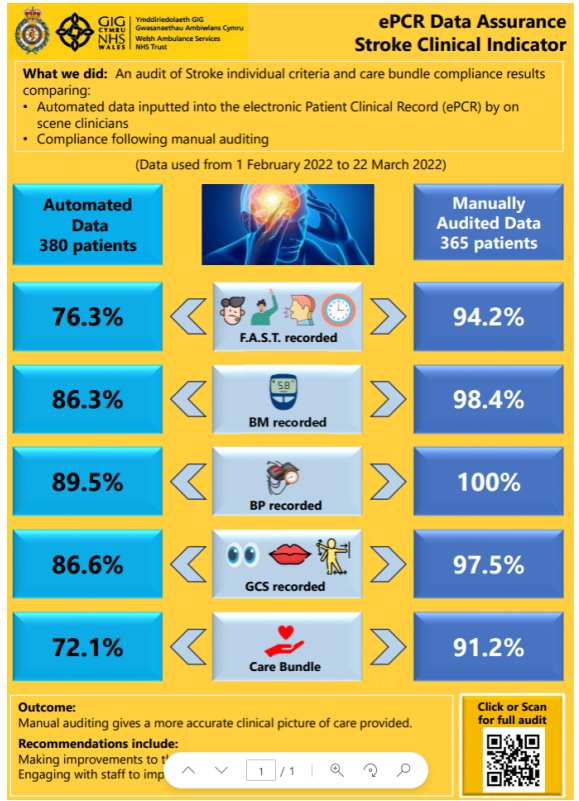
Providing a pre-alert is not part of the care bundle but is reported on as it has a positive impact on patient outcome



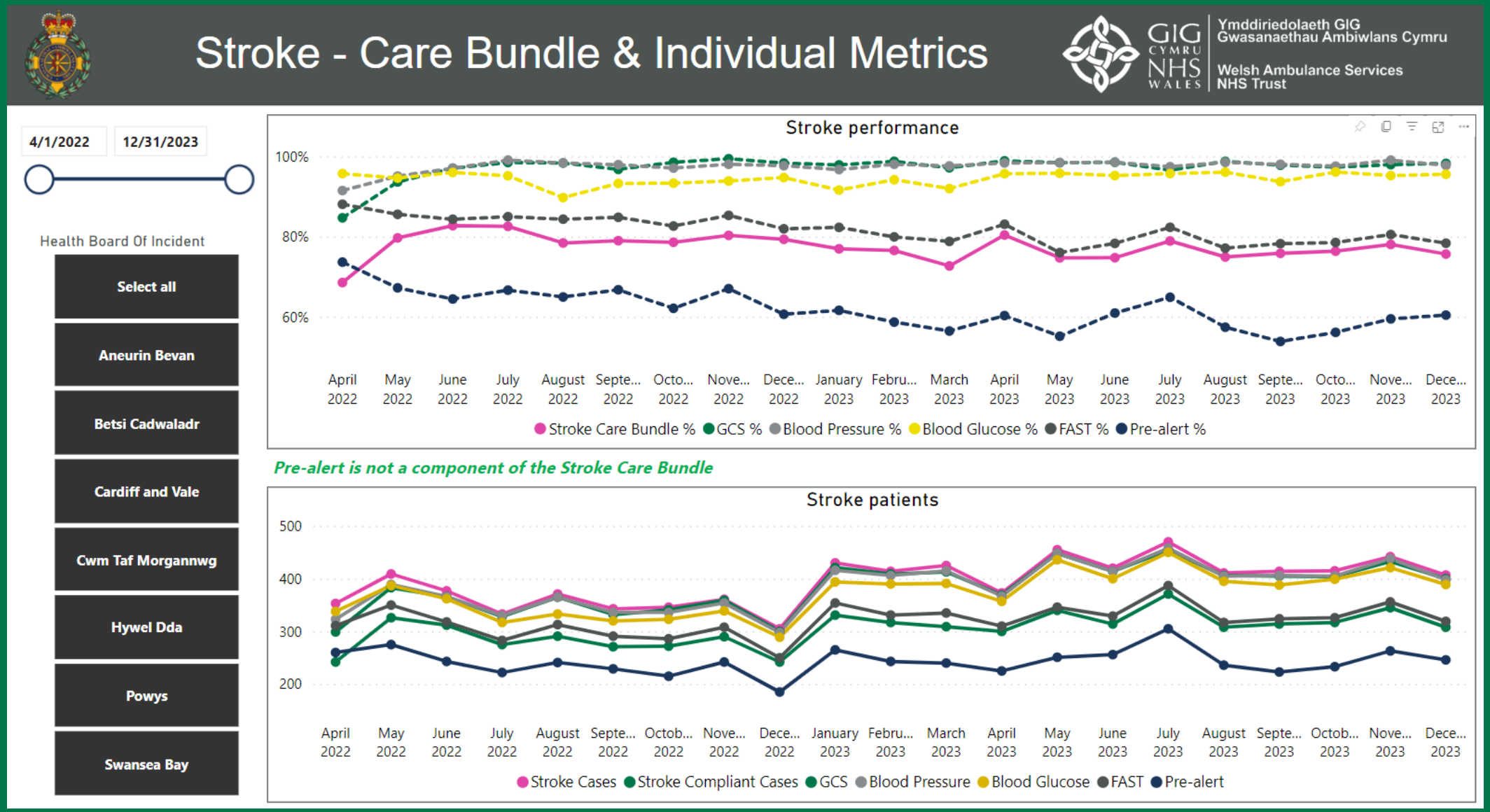
Data quality and reporting

- An ePCR technical specification was created to enable reporting
- Since the implementation of ePCR all CIs are reported on using 'raw' data inputted by clinicians (*no manual auditing prior to reporting*)
- Due to staff being unfamiliar with a new system, a reduction in CI compliance was anticipated (as in other UK Trusts), risk 535 (monitored by CIAG) was created to highlight three elements:
  - User behaviour
  - User interface
  - Scripting
- Development of a Clinical Indicator dashboard to include Stroke (*Version 2 released December 2023 includes time-based metrics*)
- The CIAT undertook a QA (deep dive) audit to:
  - Provide a more accurate clinical picture of the care delivered
  - Highlight the variation between automated and audited data
  - Help inform future reporting and caveats
  - Help inform an improvement plan and changes to the ePCR User Interface





Stroke CI compliance April 2022 – December 2023



Stroke CI compliance April 2023 – December 2023

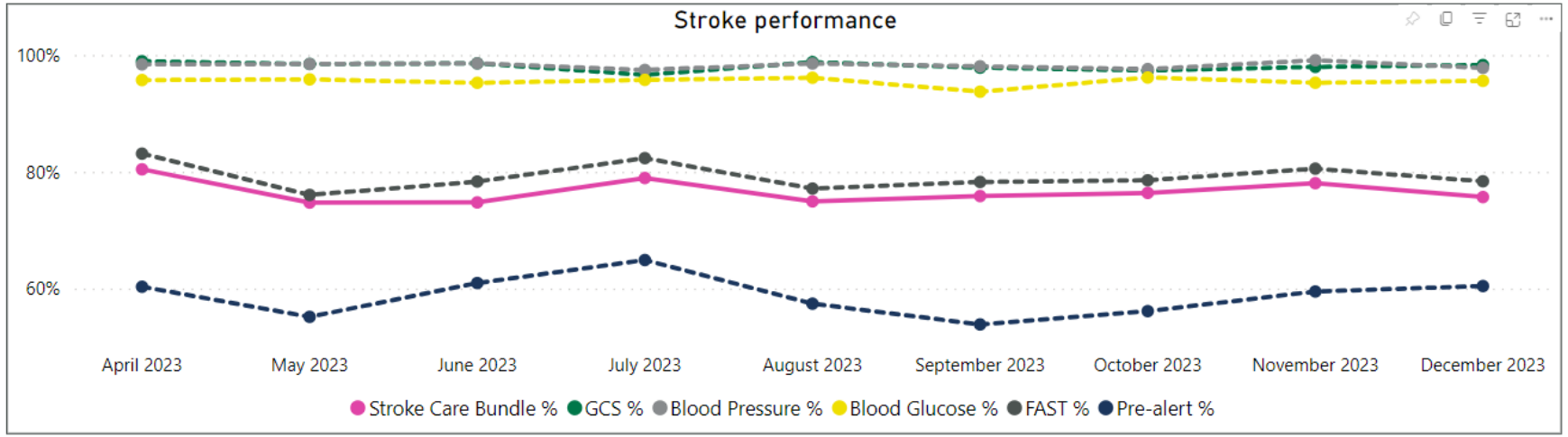
Stroke - Care Bundle & Individual Metrics

Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services NHS Trust

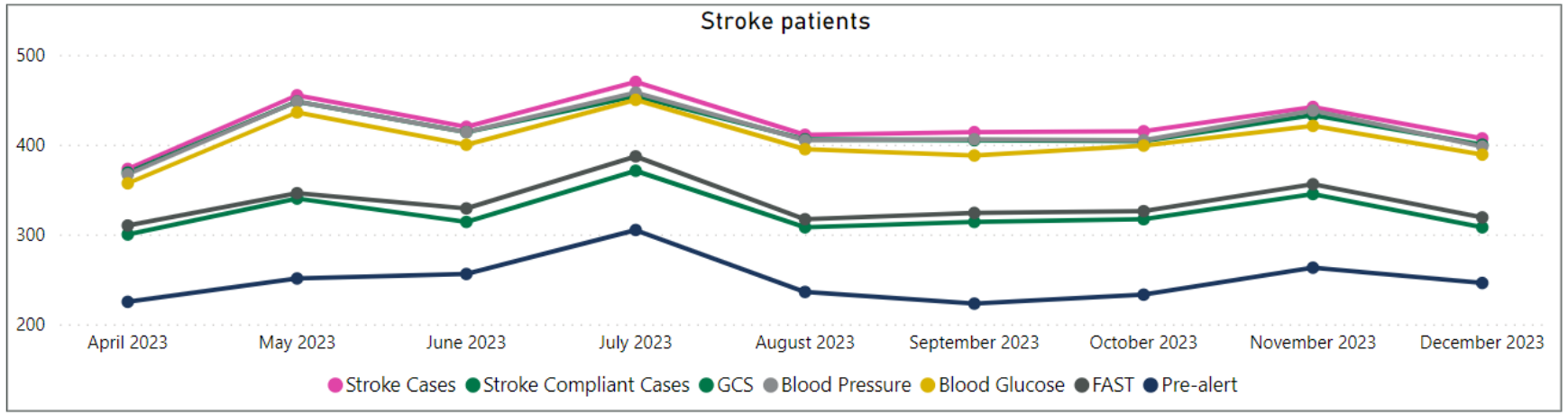
4/1/2023 12/31/2023

Health Board Of Incident

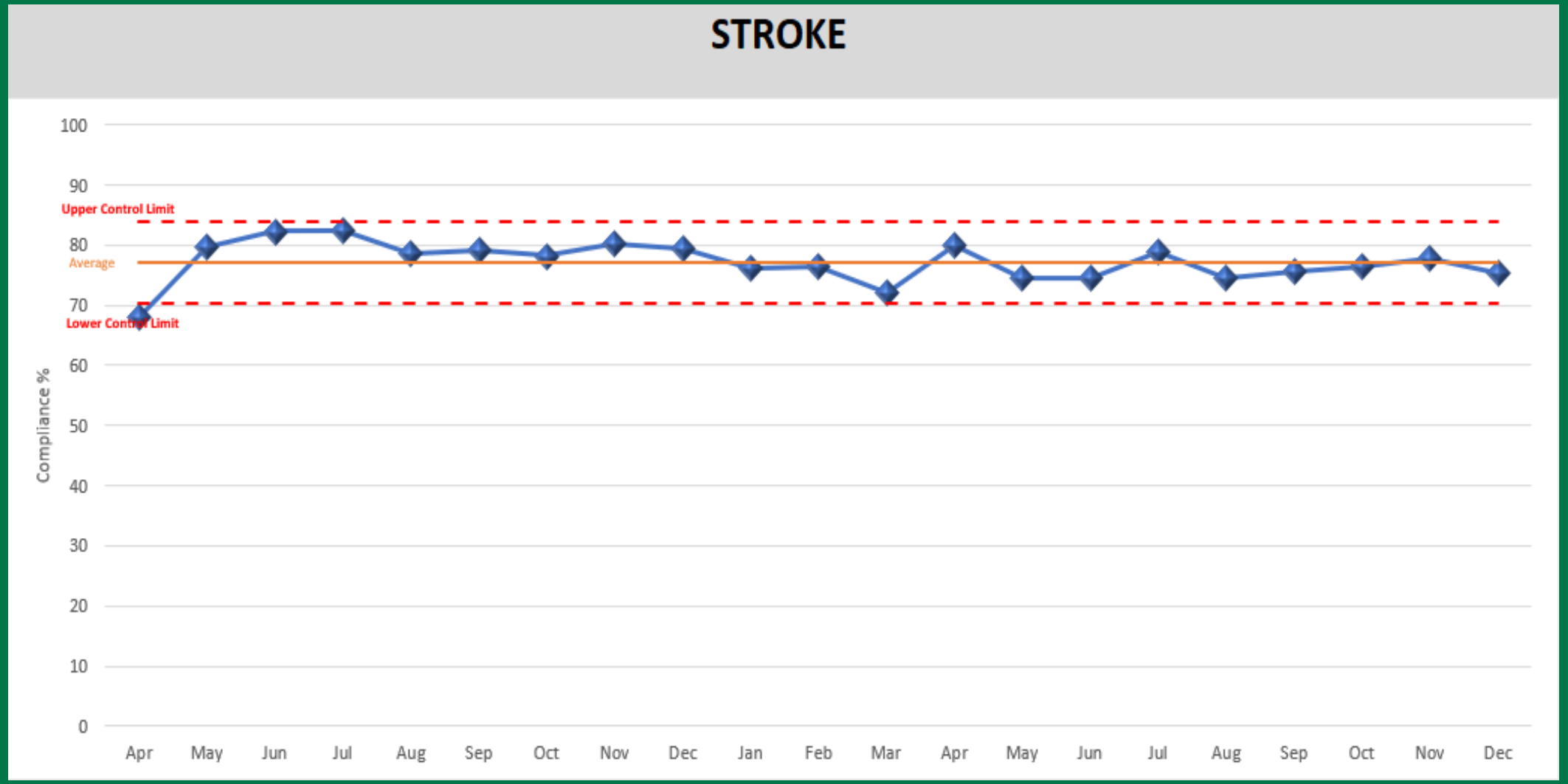
- Select all
- Aneurin Bevan
- Betsi Cadwaladr
- Cardiff and Vale
- Cwm Taf Morgannwg
- Hywel Dda
- Powys
- Swansea Bay



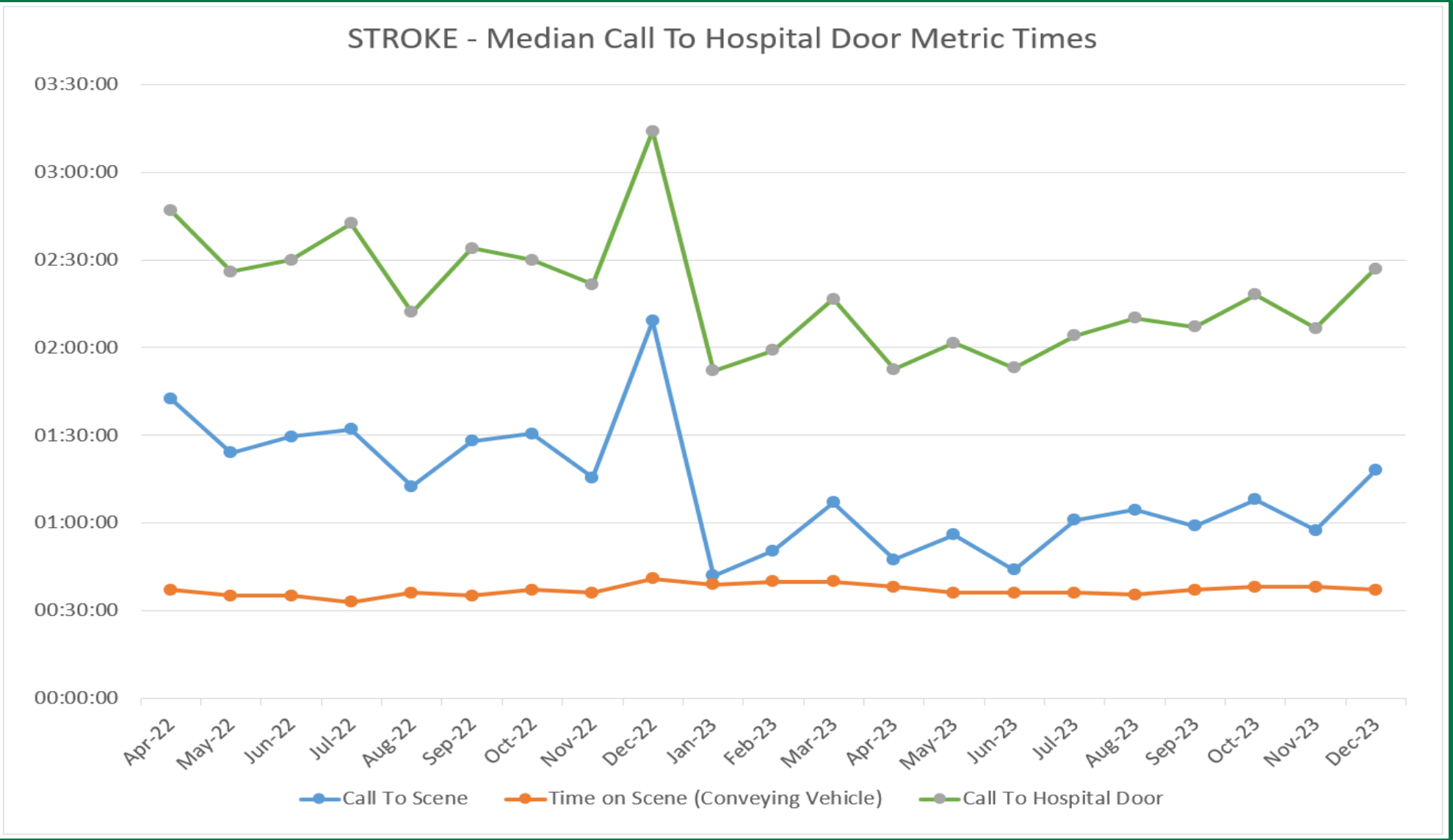
Pre-alert is not a component of the Stroke Care Bundle



Care Bundle Control Limits April 2022 – December 2023

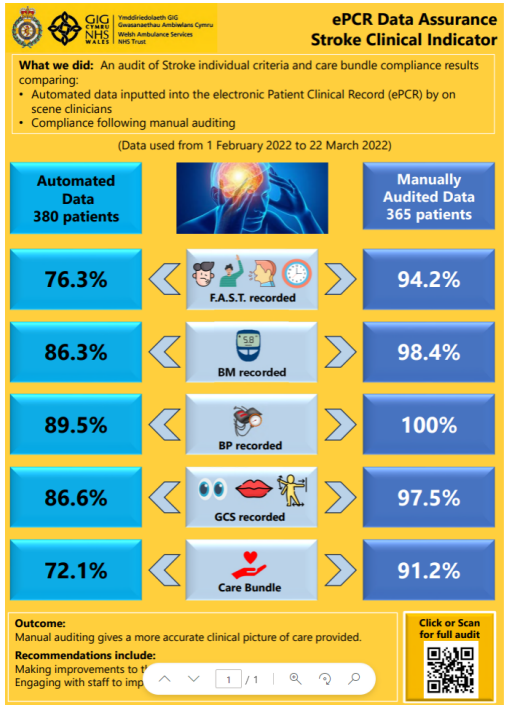


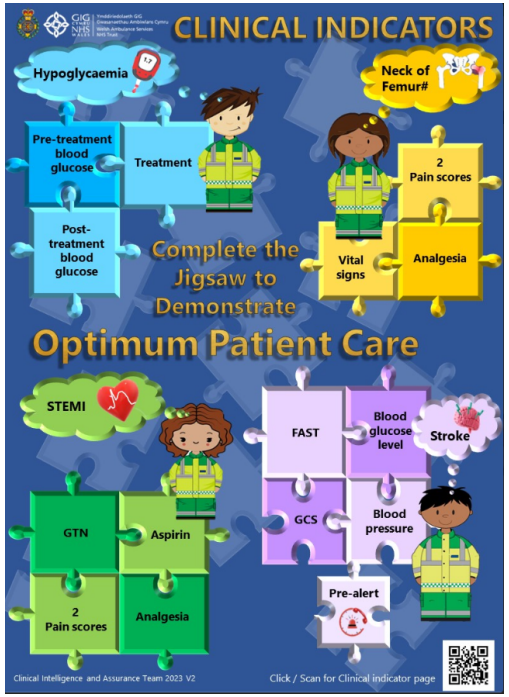
Stroke CI time-based metric April 2022 – December 2023



Improvements to date

- ePCR Clinical Data Assurance clinical audit completed to:
  - Provide a more accurate clinical picture of the care delivered
  - Highlight the variation between automated and audited data
  - Help inform future reporting and caveats
  - Help inform an improvement plan and changes to the ePCR User Interface
- User Interface changes being implemented in December 2023
- Improvement plan progressing with further engagement and support from Senior Paramedics for ePCR completion and CI compliance
- Development of a revised CI ‘Jigsaw Poster’ following requests from staff to use as an aide memoir





Next steps to improvement

- **Complete and test the User Interface changes to the ePCR**
- **User Interface changes include a facility to improve ePCR compliance for specific fields at point of ePCR closure (*changes managed by the ePCR Compliance Approval Group*)**
  - **To enable message prompts and quick access to non-compliant fields prior to closing ePCRs**
- **Continued engagement with Senior Paramedics to influence more direct clinical supervision during ride outs**
- **Complete the development of a 'Tenant Structure' to enable CIs to be reported at a range of levels (Trust wide, HB area, Locality, Team, Individual)**

Future Changes to Stroke Call Timing

- In line with most UK ambulance services, the Trust prioritises MPDS protocol 28 (Stroke) calls, in accordance with the timing of symptom onset ('t' value)

- Currently the 't' value priority assigned to Strokes is:
  - Onset of symptoms < 5 hours or unknown time = amber-1 priority
  - Onset of symptoms > 5 hours = amber-2 priority

- Recent discussions with senior clinicians from the Wales Stroke Network have indicated that:
  - New treatment opportunities exist for patients who have Stroke symptoms with an unknown onset time (often known as a 'wake up' Stroke)
  - The time window for specific therapy is now much greater – up to 12 hours

- The Trust is now working to support the clinical recommendation to change the 't' value in protocols 28 and 18, from 5 hours to 10 hours. A paper is to be submitted to the Executive Leadership Team (ELT) in January 2024

Thank you for listening

Any questions or comments?

The next in this series for focus on CIs will be #NOF

AGENDA ITEM No	**12**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**0**

HEALTH INSPECTORATE WALES NATIONAL REVIEW OF PATIENT FLOW (STROKE PATHWAY) AND IMPROVEMENT PLAN

MEETING	Quality, Patient Experience and Safety Committee
DATE	08 February 2024
EXECUTIVE	Andy Swinburn, Executive Director of Paramedicine
AUTHOR	Mike Jenkins, Regional Clinical Lead
CONTACT	mike.jenkins@wales.nhs.uk

EXECUTIVE SUMMARY

1. Following the Health Inspectorate Wales (HIW) Patient Flow Review, HIW have drawn up an Improvement Plan for WAST as part of the National Review of the Patient Flow for stroke patients in Wales.

2. The plan identifies the recommendations for WAST to deliver alongside the actions for the Health Boards.

3. The WAST actions have been transferred to the audit action tracker and updates are reported regularly by Directorates to ensure that the actions are on track. The Audit Tracker is presented to the Committee against item 18 at this meeting.

RECOMMENDATION:

4. **That the Committee receives the 'HIW National Review of Patient Flow (a journey through the Stroke pathway)' report and be assured that the improvement plan actions relevant to the Trust are being progressed accordingly.**

KEY ISSUES/IMPLICATIONS

Most of the recommendations outlined in the HIW report sit with the Health Boards.

REPORT APPROVAL ROUTE
Executive Leadership Team – 15 November 2023 Clinical Directorate Business Meeting - 27 November 2023

REPORT APPENDICES
n/a

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

SITUATION

5. A review from Health Care Inspectorate Wales (HIW) has identified 50 recommendations to improve patient flow for patients who have suffered a stroke in Wales.

6. Of the 50 recommendations, 7 apply to WAST, with the remaining recommendations sitting with other healthcare services such as the Health Boards and Public Health Wales.

7. The HIW recommendations for WAST have been captured on the all-Trust audit tracker and a management response has been prepared for each of the actions with timescales attached to the deliverables. The Audit Tracker is presented to the Committee against item 18 at this meeting.

BACKGROUND

8. In September 2023, Health Care Inspectorate Wales (HIW) published a review that took into consideration the risks and challenges facing health services in continuing recovery from the Covid-19 pandemic. The information for this report was gathered by HIW from 2022-23 on visits to several healthcare services including WAST.

9. Patient Flow was selected as the area to be reviewed with an initial focus on the stroke pathway, as the timings of treatment have a notable impact on the quality of patient outcomes for this condition.

10. The main questions that the review sought to answer included:

- How are healthcare services ensuring that timely access and treatment is provided to patients on the stroke pathway?
- What steps are healthcare services taking to ensure that safe and effective quality care is provided at each stage of care, minimising the impact of delays?
- What measures are healthcare services taking to ensure that patients are able to be discharged effectively, and safely from hospital services?

ASSESSMENT

11. WAST devised management actions in response to the review recommendations and these alongside actions for Health Boards and Public Health Wales have been included in the Patient Flow Review Improvement Plan. A copy of WAST's management actions has also been lifted to the Trust's audit tracker to hold Directorates accountable and to stay on top of progress updates for the report.

12. Of the 50 recommendations in the review, 4 sit with the Executive Director of Paramedicine (Actions 13.1, 13.2, 15, 27, 32a, 32b) and have been assigned timelines for achieving these management actions.

13. A further 1 action sits with the Executive Director of Operations and 2 actions sit with the Executive Director of Quality and Nursing. There is an action that is owned by Welsh Government (14) but WAST have identified that the organisation is ready to support delivery of this action through committing to growing the number of advanced practitioner paramedics (APPs).

RECOMMENDATION

14. **That the Committee receives the 'HIW National Review of Patient Flow (a journey through the Stroke pathway)' report and be assured that the improvement plan actions relevant to the Trust are being progressed accordingly.**

National Review of Patient Flow

a journey through the stroke pathway

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Content Page

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

We place people at the heart of what we do. We are:

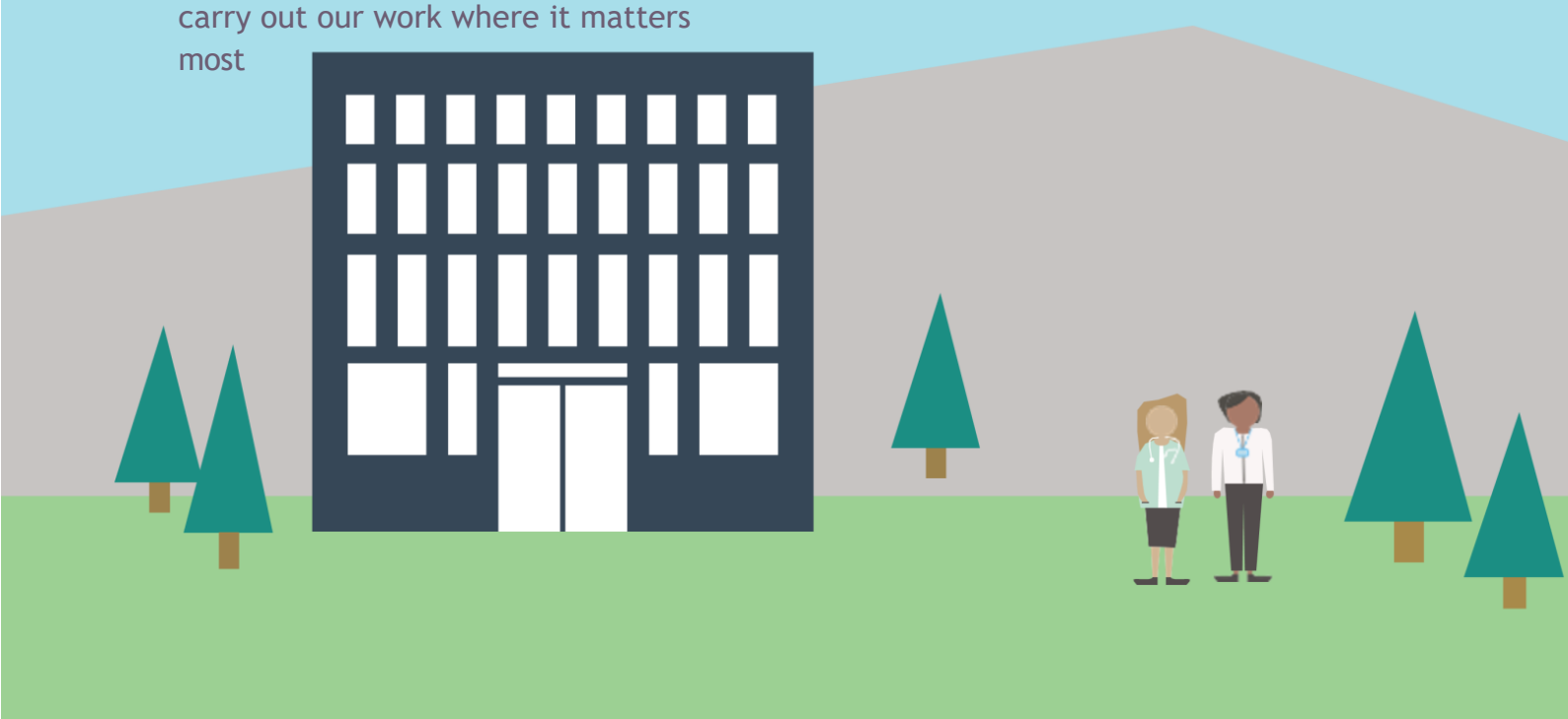
- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.



Foreword

I am pleased to be publishing this report which presents the findings from our National Review of Patient Flow: a journey through the stroke pathway. The focus of this work was to understand the risks and challenges associated with inefficient patient flow, and what impact this has on patients.

We know from our programme of assurance work that poor patient flow can have a hugely negative impact on the quality of services being provided. This has been a common factor in our inspections of Emergency Departments, and our previous review looking at ambulance handover delays to hospitals.[1] Poor flow can have a detrimental impact on the ability of staff to deliver safe and consistent standards of care and affects the experience and outcomes for patients.

It is fair to say that examples of poor patient flow are well known, and not just cited in the work of HIW. Every one of us is likely to know someone who works in a healthcare service; has been a patient who has encountered this during a hospital stay; or indeed, works in a service area where patient flow is a daily challenge.

What our review has done, however, is to highlight what these challenges mean in reality, to patients and to staff at various points on a journey from hospital admission through to discharge.

The impact of poor patient flow is ultimately felt by patients, who are not always receiving the care and treatment they need in the most timely manner. Delays in treatment can substantially impact the likelihood of developing further complications. This was particularly evident in stroke patients whom we considered as our case study. What is crucial now, is that all aspects of the health and social care system work together as effectively as possible to address poor flow and achieve better outcomes for patients in Wales.

As healthcare services continue to face unprecedented demands, and staff work tirelessly to provide safe and effective care to patients, it is clear that renewed efforts are required from the health and social care sectors, alongside Welsh Government, to tackle the issue of poor patient flow.

[1] Review of patient safety, privacy, dignity and experience whist waiting in ambulances during delayed handover

I am pleased that our work has enabled us to identify areas for improvement, and to highlight areas of good practice. Not just in relation to the stroke pathway, but also for all patients.

I want to take this opportunity to thank staff working within both health and social care sectors who endeavour to provide safe and effective care to people on a daily basis. Their dedication and commitment provide a strong and positive basis upon which to improve.

Alun Jones
Chief Executive

Healthcare Inspectorate Wales

Summary

This report sets out the findings from our National Review of Patient Flow: a journey through the stroke pathway.

The review explored the experiences of people accessing care and treatment for stroke at each stage, from calling an ambulance, transfer to hospital, assessment, inpatient treatment, through to discharge.

Patient flow is the movement of patients through a healthcare system, from the point of admission to the point of discharge. When patient flow is impeded or is inefficient, it has significant repercussions on the quality and safety of patient care.

Our review has highlighted that across Wales, there are significant challenges which are having a negative impact on the efficiency of patient flow, and this means patients are not always receiving the care they need in a timely and appropriate manner. These challenges are wide ranging; the high demand for inpatient hospital beds combined with the complexities with discharging medically fit patients from hospital, leads to the inpatient healthcare system across Wales operating under extreme pressure. This impacts on the delivery of safe and timely care.

Whilst we found a range of initiatives, different models of care, and approaches being taken within health and social care to tackle the problems arising from poor patient flow, these have not sufficiently tackled the problem. Although there is no single solution, our review identifies opportunities for the health and social care systems to make improvements across each stage of the patient pathway, which may help lessen the impact of poor patient flow. The positive initiatives and approaches identified by our review, should be considered across Wales as services attempt to tackle their challenges with poor patient flow.

We specifically examined the journey of patients through the stroke pathway. This was to understand what is being done to mitigate any harm to those awaiting care, as well as to understand how the quality and safety of care is being maintained throughout the stroke pathway.

Demand is exceeding supply in relation to the healthcare system, and during our fieldwork almost all hospitals we visited were under level four ‘extreme pressure’, as highlighted in the National Emergency Pressures Escalation and De-escalation Action Plan[2]. The demand was having a knock-on impact on Welsh Ambulance Services NHS Trust (WAST) and its timely response to emergency calls.

[2] National Emergency Pressures Escalation and De-escalation Action Plan

Despite hospital patient flow teams across Wales working tirelessly 24 hours a day seeking to manage patient flow, we found that patient flow issues were negatively impacting on every stage of stroke care. This was from the point of needing to access healthcare at home, through to discharge from hospital.

A key area requiring improvement identified by our work, relates to the need for healthcare services to engage with people, to better understand the barriers to them accessing or choosing from the range of healthcare services available in Wales. The range of healthcare services includes pharmacies, Minor Injury Units, mental health helplines, online NHS consultations, and the NHS 111 Wales service. Once the barriers are understood, this should in turn be used to influence service design. Ongoing engagement with people about the range of available services may reduce the need for people to attend their GP surgery or attend an Emergency Department (ED) when their health concern is not an emergency.

There were prolonged patient handover delays from ambulances to ED at all hospital sites we visited. These delays were significantly impacting on the ability of WAST to respond to emergency calls in the community and increase the risk to patients requiring emergency treatment and transportation into hospital.

It was positive to find that patients suspected as having had a stroke, were prioritised for ambulance handover, and transferred into ED promptly in line with the stroke pathway. However, we found that achievement of the Welsh Government 15-minute target for handover of stroke patients was challenging. This target aims to ensure that time critical investigations and treatment are undertaken promptly to ensure the best outcome for patients.

Challenges with the demand on EDs meant that some patients waited longer than expected for triage and ongoing assessment or treatment. This is a particular risk for those patients who self-present at an ED and have not had any clinical input prior to their arrival.

We found that the recognition of stroke and its prevention is a key area that needs attention across Wales. More needs to be done by NHS healthcare providers and Public Health Wales (PHW) to educate people about this debilitating condition, to help minimise their risk of developing a stroke, and to seek immediate help if symptoms arise. This is of relevance to certain population groups who are at a greater risk of having a stroke, such as those who smoke, have high blood pressure, high cholesterol, diabetes, are obese, or who excessively consume alcohol[3].

Evidence also suggest that Black and Asian people are at a higher risk of developing a stroke. Health boards and PHW should therefore work closely with these communities to understand the specific issues they face and ensure ongoing engagement with them, in support of better health outcomes.

It was disappointing to find that in 2022, the performance of most acute hospitals in Wales which provide stroke services had deteriorated since 2019.

[3] Causes of Stroke

As highlighted within the UK's Sentinel Stroke National Audit Programme (SSNAP) data, there was an increase from three, to 11 out of 14 acute hospitals who were performing poorly and were categorised as either a D or an E grade (lowest).

However, it is important to note that this period coincided with the global Covid-19 pandemic, and there was an unprecedented demand on hospital beds nationally, which was significantly impacting on patient flow in general, and throughout the stroke pathway.

As highlighted earlier, during our fieldwork almost all hospitals were under level four 'extreme pressure'. To help manage the pressure and patient flow through hospital systems, patient flow meetings were held regularly in all hospitals. They were well attended by the key staff responsible for a patient's journey through hospital. In some health boards, a Hospital Ambulance Liaison Officer (HALO) was also present during patient flow meetings, to discuss the handover delays and plans for longest wait patient handovers. We found this to have a positive impact in managing the issues associated with delayed patient handovers from ambulance crew to ED staff.

Overall, we found that patient flow teams appeared to manage meetings well, and we concluded that they had a strong understanding about which patients needed beds or moves to other wards. This included the oversight of patient specialty outliers in other service groups, such as medical patients cared for in surgical beds and vice versa.

Due to pressure on bed availability, hospitals were not always able to admit patients to the right bed or ward for their treatment. These patient outliers, as they are known, were a consistent finding across Wales. This meant that it was not always possible to move patients, which included stroke patients, to the most appropriate ward or specialty for their care and treatment. It was concerning to find that because of poor patient flow, patients are regularly being treated on a ward that would not usually care for that condition.

Patients who are not allocated to the right bed or ward, can at times experience an increased length of stay. This may lead to other complications, creating additional challenges for care teams and adding to the issue of poor flow. A stroke patient who has been admitted to hospital is likely to have a much better outcome if they are treated on a stroke ward.

During our work, it was positive to find that Improvement Cymru[4], was undertaking a pilot within three acute hospitals supporting teams to improve their patient flow systems. Together with the health boards, they implemented a Real Time Demand Capacity methodology to focus on the flow process. This focuses on discharge and improving flow in small increments.

[4] Improvement Cymru website

Whilst it does not assist with the existing flow issues which relate to social care, it supports patient flow daily, by preparing patients for earlier discharge times on the proposed discharge date. We noted that this pilot was making a positive difference to the flow process and overall management of beds, and it is an approach that should be considered nationally.

We found that in all cases, staff endeavour to achieve a brain scan for a symptomatic stroke patient within an hour of arrival at hospital. However, although infrequent, it was concerning to find in our clinical records review, that some patients were not receiving a brain scan within the one-hour target. In addition, the SSNAP data we reviewed for the period of April to June during 2019, 2021 and 2022, showed that performance had reduced in nine out of 12 sites, with an increased number of patients suspected as having a stroke waiting more than one hour for a brain scan.

Following assessment and a subsequent stroke diagnosis, it was positive to find that overall, the treatment (called thrombolysis) to help dissolve the clot in the brain, was commenced promptly in ED if there were no beds available to administer this on the acute stroke ward. Thrombolysis is used for certain categories of ischaemic stroke diagnosis and must usually be undertaken within 4.5 hours of the known onset times of stroke symptoms. However, within the updated *National Clinical Guideline for Stroke for the United Kingdom and Ireland 2023*[5], this treatment window has now been increased to nine hours in some instances, if there is specific evidence of the potential to salvage brain tissue through CT perfusion imaging[6]. Therefore, it is important that WAST works with health boards and Welsh Government to consider the protocol when sending an ambulance to stroke patients, and the increased treatment window.

An alternative procedure to thrombolysis therapy, is surgery to remove a blood clot which is known as a thrombectomy. Thrombectomy can be effective up to 24 hours from onset time of stroke symptoms and can significantly reduce the severity of disability a stroke can cause. This can result in better patient outcomes than those treated with thrombolysis. The only health board in Wales which provides a thrombectomy service is Cardiff and Vale University Health Board. This service operates Monday to Friday from 9am to 5pm, when expert interventional neuroradiology staff and radiology facilities are available to undertake this treatment.

All other health boards in Wales must refer patients for thrombectomy, either to North Bristol NHS Trust, where the service is available to patients from Wales daily between 8am and midnight, or to the Walton Centre NHS Foundation Trust in Liverpool, which offers a 24/7 service. Given the geographical challenges and the availability of ambulances across Wales due to handover delays, this can have a negative effect on the timely provision of a thrombectomy and is of particular concern when thrombolysis is not clinically appropriate.

[5] National Clinical Guideline for Stroke for UK and Ireland
[6] CT Perfusion – The Walton Centre NHS Foundation Trust

Treating stroke patients with thrombectomy can have better long-term outcomes for people. According to SSNAP data, the annual thrombectomy treatment number between April 2020 and March 2021 within England, Northern Ireland and Wales was 1,763[7].

It is concerning to find that in Wales, only 13 patients received a thrombectomy at the University Hospital of Wales, just 16 patients from other health boards received treatment in North Bristol and only four at the Walton Centre. More needs to be done to provide equitable access to thrombectomy treatment across Wales.

To give a patient the best possible chance of recovery, specialised stroke unit care must be initiated as soon as possible after the onset of stroke symptoms. Due to the range of specialist treatment they provide, acute stroke units can provide care and treatment to reduce long-term brain damage, physical disability, and healthcare costs. It was, therefore, disappointing to find several delayed admissions to acute stroke wards from ED. This was often due to a lack of available beds owing to delayed transfers to rehabilitation wards, or delayed discharges out of hospital impacted by the inability of social care providers to deliver timely social care.

To help mitigate this issue and maintain flow for stroke patients, most stroke wards aim to ring-fence a stroke beds. However, we found these beds are repeatedly used for non-stroke patients across Wales, due to the persistent issues with the demands on ED services. This is a concern since some stroke patients may not receive the most appropriate and timely care for their condition, including timely ongoing treatment needed to help with their recovery.

We considered whether organisations can provide stroke services through the Welsh language active offer, and whether patients were offered the opportunity to communicate through the medium of Welsh. We found that Welsh speakers worked within or were accessible to stroke patients in all health boards. However, this was not easily identifiable, such as staff uniforms promoting the NHS ‘Gwaith Iaith’ badge.

Across Wales, we found inconsistencies with the provision of rehabilitation to people following their stroke. Overall, we found that the health boards with stroke rehabilitation wards provided an environment that facilitated specific multidisciplinary stroke rehabilitation care, although in some hospitals both acute and rehabilitation care were undertaken in the same environment. We also found inconsistencies across Wales in the provision of the 45-minute daily target for physiotherapy, occupational therapy and speech and language therapy. This was attributed to the challenge with recruiting staff into key therapies posts, and the ability to provide timely services on wards that manage both acute and rehabilitation care to stroke patients.

HIW found good collaborative working between the stroke multidisciplinary teams

[7] Annual thrombectomy April 2020 to March 2021

in relation to patient discharge preparation.

However, a key issue which significantly impacts on patient flow and overall patient progress, is the delayed transfer of care and discharge for patients who are medically fit to leave acute care. This can be due to the availability of care home beds or social care and rehabilitation therapies provided within the home.

Unnecessarily long stays in hospital due to delayed discharge can place patients at risk of hospital acquired infections, deconditioning or deterioration whilst awaiting discharge, all of which further impact on flow. The bottleneck at the point of discharge has a knock-on impact on EDs, WAST response times, inpatient care, primary care, planned admissions and overall staff wellbeing.

It is therefore essential that Welsh Government, health boards and social care providers redouble their efforts and work collaboratively to help improve the persistent issues with discharging people from hospital.

To support us with the social care aspects of our review, we utilised the help of Care Inspectorate Wales (CIW)[8]. Through collaboration with CIW and its peer reviewer, we found several factors aligned to social care which also contributed to discharge delays. One issue was frequent delays with social worker allocation causing unnecessary discharge delays for patients who are medically fit to go home. This was identified as an issue in most health boards. Another challenge impacting timely discharge is the ability to provide timely or appropriate domiciliary care packages to people in the community, or the availability of beds in care homes. We found the most significant issue was the recruitment and retention of domiciliary carers, who are needed to provide the social care people need at home. Patients who cannot support themselves at home or who have no other means of care support, cannot be safely discharged. This in turn, increases the flow bottleneck at the hospital 'back door'.

Adding to the complexity of organising packages of care, some hospitals discharge patients to numerous local authorities within their own health board boundary, to local authorities within the boundaries of another health board, or even across the border to England. Sometimes the process in each can be different, adding to the existing challenges, which may include different referral processes or different IT systems. This makes the processes difficult to navigate and more challenging, therefore causing further unnecessary discharge delays and impacting on patient care.

It is evident that staff working within patient flow and stroke services are dedicated to helping patients move through hospital systems. However, our review indicates that health and social care services are not operating as efficiently as they could be. This inefficiency increases the risk of complications arising from delayed discharge and has a significant impact on the overall health and care system in Wales.

In our report, we have identified various areas that require improvement, and have

[8] Care Inspectorate Wales website

made recommendations for action to address these issues. We firmly believe that more can and should be done to tackle the problems highlighted by our review.

Context

In our Operational Plan for 2021-22, we committed to a programme of national reviews which considered the risks and challenges facing health services as they continue their response to, and recovery from, the pandemic.

Poor patient flow is one of the biggest challenges facing our healthcare system in Wales. This is caused by severe congestion within our hospital systems. There are ongoing pressures on the ability of healthcare systems to manage patients effectively and with minimal delays, as they move through each stage of care through to discharge or moved onto an appropriate care pathway.

Poor patient flow leads to congestion and overcrowding within our EDs, with patients waiting for admission into bed on the wards. Consequently, this also impacts on delays with patient handover from ambulances into EDs. This is consistent within several findings during previous HIW inspections of EDs across Wales, including Ysbyty Glan Clwyd[9], University Hospital of Wales[10] and Glangwili General Hospital[11] which were undertaken during 2022. In addition, patients in the community must often wait unacceptable lengths of time for an emergency response from WAST and transportation into hospital. This results in increased risks to those patients, as they have not yet been clinically assessed. Poor patient flow frequently impacts negatively on the whole of a patient's journey through the healthcare system.

Our most recent WAST review[12] highlighted how patient handover delays are a consequence of wider systemic patient flow issues through NHS healthcare systems and social care systems. The impact of inadequate bed/trolley availability in EDs is that there are occasions where multiple ambulances are waiting together outside EDs for prolonged periods of time to handover their patients.

[9] HIW Hospital Inspection Report - (Unannounced) - ED, Ysbyty Glan Clwyd - Betsi Cadwaladr University Health - 03, 04 & 05 May 2022
[10] HIW Hospital Inspection Report (Unannounced) Emergency Unit and Assessment Unit, University Hospital of Wales, Cardiff, and Vale University Health Board - Inspection date: 20, 21 and 22 June 2022
[11] HIW Hospital Inspection Report (Unannounced) Emergency Unit and Assessment Unit, University Hospital of Wales, Cardiff and Vale University Health Board, Inspection date: 20, 21 and 22 June 2022
[12] HIW WAST review: Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances

The consequences of poor patient flow are well known nationally and can include:

- Delayed ambulance response times to calls
- Delayed ambulance handover
- Overcrowding in EDs
- Patients admitted as 'outliers' to wards that are not best suited to manage their care, which may mean they have worse clinical outcomes
- Ambulatory care services, clinical decision units, even catheter labs and recovery units may be used with patients waiting for ward admission
- Inpatients are also often moved between different wards to accommodate new patients
- Staff are overstretched, and routine activities slow down dramatically
- Clinical outcomes can be measurably worse, particularly for frail older people, who suffer more harm events and may decondition due to extended periods in hospital beds.

We recognise there are pressures through the stroke pathway to deliver effective person-centred stroke care, which relate to:

- Timely access to effective care, including transfer to hospital, assessment, key diagnostic interventions, thrombolysis[13] and/or thrombectomy
- Timely admission to an acute stroke ward/unit[14] (or other relevant ward), and other acute care requirements
- Timely therapeutic assessments and treatment
- Stroke rehabilitation and preparation for life after stroke
- Discharge with social care pressures, access to required therapies and ensuring the right support.

As a result of these issues, and our intelligence and other data sources, media reports, and the issues identified through our previous ED inspections, and within both our WAST reviews in 2019-20[15] and in 2020-21[16], we decided to undertake a review of patient flow with a focus on the stroke pathway. This is because stroke is a complex condition, and timely assessment, treatment, rehabilitation, and

[13] Thrombolysis is a procedure to disperse a blood clot and return the blood supply to the brain. Some people with ischaemic stroke are eligible for thrombolysis which, for most people, needs to be given within 4 ½ hours of stroke symptoms starting.
[14] An acute stroke ward/unit is an area in the hospital that is staffed by a specialist stroke. multidisciplinary team.
[15] HIW local review report of WAST - Assessment of Patient Management Arrangements within Emergency Medical Service Clinical Contact Centres
[16] HIW review report of Welsh Ambulance Services Trust - Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during delayed handovers

recovery for patients affected by a stroke, requires support from a range of health and social care professionals, with specialist knowledge and skill.

What We Did

Focus of Review

The focus of our patient flow review was to consider the patient journey through the stroke pathway from the point of requesting an ambulance or people self-presenting at ED, through to discharge from hospital or transfer of care to other services.

The pandemic introduced unique and unprecedented pressures on the healthcare system; in view of this, our retrospective review of clinical records considered the time-period from March 2020, through to the time of our fieldwork between March and August 2022.

Throughout our review we explored the experiences of people accessing care and treatment for stroke at each stage of care, from calling for an ambulance, to assessment, inpatient treatment, and through to discharge.

Throughout, we considered the following key questions:

- How are healthcare services ensuring that timely access and treatment is provided to patients on the stroke pathway?
- What steps healthcare services are taking to ensure that safe and effective quality care is provided at each stage of care, minimising the impact of delays?
- What measures are healthcare services taking to ensure that patients are able to be discharged effectively, and safely from hospital services?

When planning our review, we were aware work was (and still is) ongoing to tackle the issue of patient flow, with various approaches and initiatives in progress at a national level.

Scope and methodology

To review the areas detailed above, we requested relevant documents and key information from health boards in Wales and WAST. This helped us to understand the degree of insight each health board has of its strengths and areas for improvement with the processes in place for patient flow on the quality and safety of stroke patients awaiting assessment and treatment. It also helped us to understand what is being done to mitigate any harm to those awaiting care, as well as understand how the quality and safety of care is being maintained throughout the stroke pathway.

We also considered local and national performance data and statistics. The Sentinel Stroke National Audit Programme[17] (SSNAP) aims to improve the quality of

[17] The Sentinel Stroke National Audit Programme

stroke care by measuring both the structure and processes of stroke care against evidence-based standards. The SSNAP targets are informed by the *National Clinical Guideline for Stroke for the United Kingdom and Ireland*, and national and local benchmarks. The SSNAP clinical audit collects a minimum dataset for stroke patients in England, Wales, and Northern Ireland in every acute hospital, and follows the pathway through recovery, rehabilitation, and outcomes at the point of six-month assessment. All patients with a stroke admitted to hospital in Wales are included on the SSNAP database, which is used to monitor and audit stroke treatment and outcomes.

Over the course of our review, we undertook interviews with a variety of health board staff across Wales. We developed and shared several staff surveys and a survey of stroke patients, or their family members or carers.

We also completed fieldwork focusing on retrospective case studies and current cases of people travelling through the stroke pathway, which included the period of the Covid-19 pandemic.

Professional staff surveys

We developed and launched a staff questionnaire to obtain views from health board staff involved throughout the stroke pathway and their patient flow within the pathway.

In addition, we designed and distributed a questionnaire to obtain views from staff at WAST to gain their opinion of the flow of stroke patients to and from hospitals.

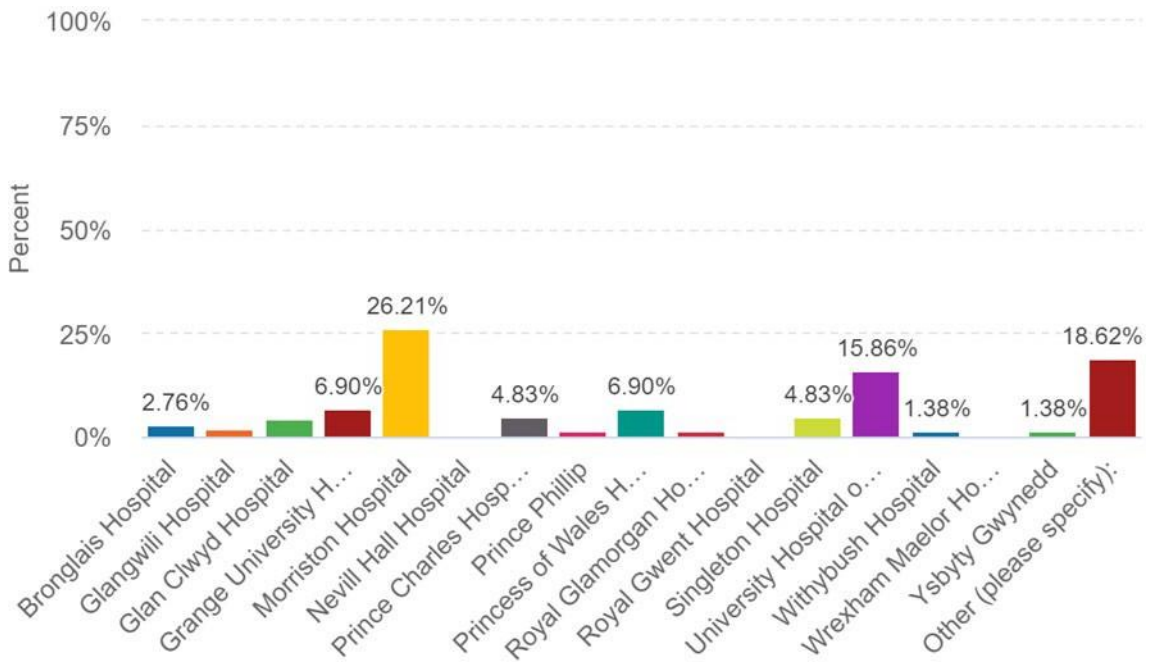
In conjunction with the Care Inspectorate Wales (CIW) we also developed and distributed two additional questionnaires. These were to obtain the views of staff working in social care and local authority staff on their opinion of the challenges faced in effective discharge of patients from hospital.

Health board staff survey

We had a total of 146 respondents who fully completed the health board staff survey.

Our survey found 75 respondents worked directly within stroke services, 20 worked within Patient Flow, 32 worked for emergency departments, 13 were senior management, 16 were site/bed management, 6 were discharge staff and the remainder were made up of various other roles.

The respondents worked within the hospitals highlighted in the chart below:



Social Care providers and Local Authority staff surveys

Both Social Services staff and Local Authority staff surveys were emailed to staff for completion in May to July 2022.

We had 26 staff respond to our social care provider survey from 16 of the 22 local authorities in Wales, which includes:

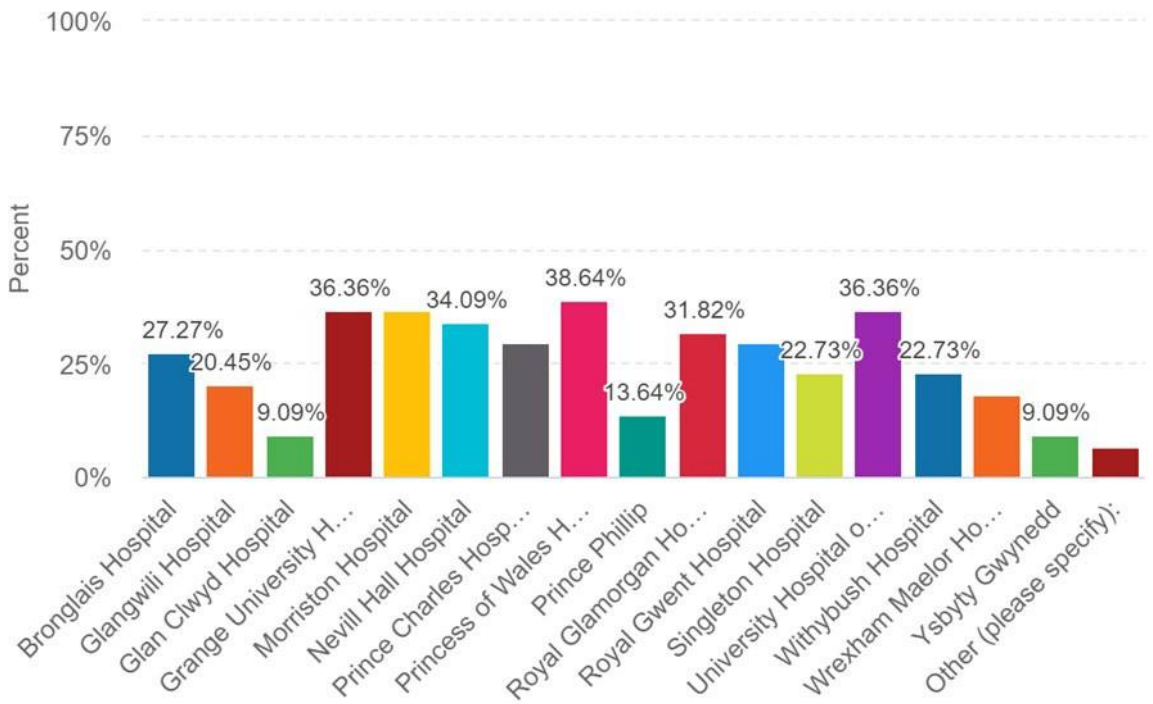
- 7 Registered Managers
- 7 Service Managers
- 6 Care Home Managers
- 3 Responsible Individuals
- 3 Other

Due to the limited number of responses, we have not undertaken a quantitative analysis, however, where applicable, we have considered comments from our qualitative analysis within the report.

WAST staff survey

The survey was emailed to staff for completion in May to October 2022.

We had 44 staff respond to our survey who worked with the following hospitals:



Public survey

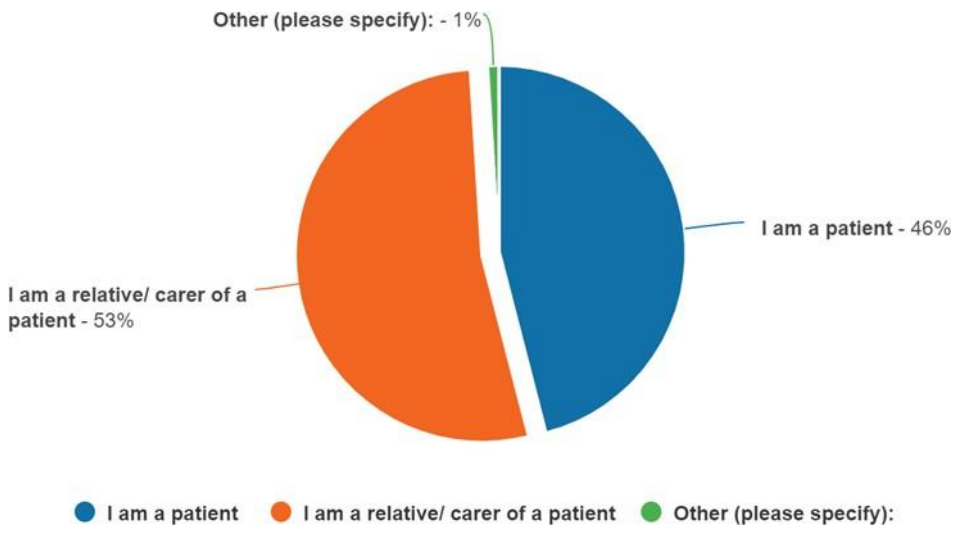
We conducted a survey to capture the views of stroke patients who had used healthcare services, or the views of their family members or carers. The patient questionnaire was designed and distributed by HIW, with the input of the Stroke Association, to obtain views from patients on the quality and safety of care throughout the stroke pathway.

The survey was promoted for completion from May to September 2022.

We received a total of 106 responses to our survey. Some partially completed or skipped some questions, but all 106 responses have been considered as part of this analysis. When asked of their gender identity, 52.5% said they identified as female, 42.5% as male and the remaining preferred not to say.

Only 81 respondents answered our multiple-choice question relating to ethnicity. 61 answered ‘white’, 29 answered ‘Welsh/English/Scottish/Northern Irish/British’, and one person answered ‘Irish’. There were zero responses to all other available options, for example, black, Asian, mixed ethnicity, gypsy/Irish travellers, or other ethnic groups.

The 106 responses were received from patients, carers or relatives, or other:



The ‘other’ response was a friend of a stroke patient. All respondents were asked to respond to questions on behalf of the patient. There was a good distribution of responses across Wales.

Fieldwork

Currently 12 hospitals across six of the seven health boards provides emergency services for stroke patients. Powys Teaching health board does not provide acute stroke services but accesses services from NHS England and Welsh health boards. All 12 sites listed below provide acute stroke services including thrombolysis treatment for patients with an acute, ischaemic stroke.

- The Grange University Hospital, Cwmbran
- Prince Charles Hospital, Merthyr
- University Hospital of Wales, Cardiff
- Princess of Wales Hospital, Bridgend
- Morriston Hospital, Swansea
- Prince Philip Hospital, Llanelli
- Withybush Hospital, Haverfordwest
- Glangwili Hospital, Carmarthen
- Bronglais Hospital, Aberystwyth
- Ysbyty Gwynedd, Bangor
- Glan Clwyd Hospital, Rhyl
- Wrexham Maelor Hospital, Wrexham

As highlighted above, we attended one acute site within every health board area during the period from March to August 2022. Most of our onsite visits were conducted over three days. Our approach to the fieldwork conducted within Powys Teaching Health Board was reduced to a two-day visit to a rehabilitation ward, given the absence of an acute stroke ward.

Our fieldwork included face to face interviews with ED staff, stroke services staff and patient flow/discharge managers. We were unable to visit all the acute sites providing stroke services within Wales; however, to understand the challenges faced with patient flow through the stroke pathway at every site, interviews were held via Microsoft Teams. We held in the region of 250 interviews with health board staff across Wales.

During our onsite visits, we also attended board rounds, multidisciplinary team meetings (MDT) or equivalent for stroke patients, bed or site management meetings and patient discharge meetings. Where we were unable to attend in person, and for sites we did not carry out fieldwork, these meetings were attended via Microsoft Teams.

Our focus during our fieldwork was on reviewing patient records and key documents within each health board, both on a retrospective review of patient clinical records from 2020 onwards, and the records of patients in hospital travelling through the stroke pathway at the time of our site visits.

The inspection team for each onsite visit consisted of:

- HIW Senior Healthcare Inspector (review lead)
- HIW Healthcare inspector (review support)
- Up to three clinical peer reviewers
- CIW peer reviewer (to interview key staff involved with the discharge of stroke patients from hospitals across Wales).

It was positive to note that during our onsite fieldwork site visits we did not identify any areas of immediate concern for patient safety, and we therefore did not need to implement our immediate assurance process.

In November 2022, we wrote to all health board Chief Executives with a summary of the initial key general findings to date. We did not require any specific action to be taken in response to these findings at that time.

Relevant guidance for patient flow and the stroke pathway

In considering the effectiveness of patient discharge, we looked at whether hospital wards follow the Welsh Government principles of ‘SAFER Patient Flow

Guidance'[18]. This guidance provides good practice to promote safe and timely discharge, improve patient flow and prevent unnecessary waiting for patients.

Throughout this report, we often refer to the NICE guideline *'Stroke and transient ischaemic attack in over 16s: diagnosis and initial management' (NG128)*[19]. In addition, the *National Clinical Guideline for Stroke for the United Kingdom and Ireland 2023*[20]. We also refer to the NICE *Stroke Rehabilitation in Adults* clinical guideline (CG162)[21]. This relates to stroke rehabilitation for adults and young people aged 16 and over who have had a stroke with continuing impairment, activity limitation or participation restriction.

Welsh language 'active offer'

We considered whether organisations can provide stroke services through the Welsh language active offer, and whether patients were offered the opportunity to communicate through the medium of Welsh.

We found that Welsh speakers worked within or were accessible to stroke patients in all health boards. However, this was not easily identifiable, such as staff uniforms promoting the NHS 'Gwaith Iaith' badge.

Within our staff survey, 22 people said their first language was Welsh, although every questionnaire was completed in English, despite the choice available to complete this in Welsh. Our patient survey identified that eight people speak Welsh, with just one who said they were offered the opportunity to speak Welsh.

In most cases during our clinical records review, we found no evidence or reference to a patient's language choice. However, in one hospital, it was recorded that patients were English speaking only within the records reviewed. We also saw in one patient record, that a patient was asked for their preferred language, as part of the Occupational Therapy cognition test.

What We Found

Patient flow: a journey through the stroke pathway

Poor patient flow is one of the biggest challenges facing our healthcare system in Wales. It is caused by severe congestion within our hospitals, and there are ongoing pressures within health and social care services to manage patient journeys effectively. The challenge within both systems can impact on timely hospital discharges, and often, people do not always receive the right care, at the right time, in the right place, which may impact on their safety.

To explore the complexities of patient flow through the healthcare system, we focussed on a patient journey through the stroke pathway. It is therefore important to highlight the significance of stroke and its prevention first.

[18] Welsh Government SAFER patient flow Guidance
[19] NICE guidance stroke-and-transient-ischaemic-attack-in-over-16s
[20] National Clinical Guideline for Stroke for the UK and Ireland
[21] NICE Stroke rehabilitation in adult's Clinical guideline

What is a stroke?

Stroke is the fourth leading cause of death in Wales and can have a significant long-term impact on survivors. The Stroke Association[22] suggests that currently, there are around 69,000 stroke survivors living in Wales, and NICE[23] suggest around 8,000 people in Wales experience a stroke each year.

As highlighted above, NICE highlights that stroke is a leading cause of death and disability, causing around 38,000 deaths each year in the UK, and in addition, in the UK there are approximately 1.3 million stroke survivors. The number of hospital admissions per year due to stroke is approximately:

- 126,000 in England
- 9900 in Scotland
- 8000 in Wales
- 5000 in Northern Ireland.

There are three different types of strokes, these include:

- **Ischaemic stroke** - caused by a blockage, such as a blood clot, cutting off the blood supply to a part of the brain
- **Haemorrhagic stroke** - caused by bleeding in or around the brain
- **Transient Ischaemic Attack (TIA)** - also known as a mini-stroke – brief blockage in supply of blood to parts of the brain.

It is critical that people know how to spot the signs and symptoms of stroke, and they should call 999 immediately, due to the time critical nature for the treatment.

The signs of stroke are highlighted below and are represented as the acronym **'FAST'**:

Face	Has their face fallen on one side? Can they smile?
Arms	Can they raise both their arms and keep them there?
Speech	Is their speech slurred?
Time	Time to call 999!

Stroke prevention

In its 2018 report, *A Healthier Wales: our Plan for Health and Social Care*[24], Welsh Government set out a long-term future vision of a 'whole system approach to health and social care'. It places a greater emphasis on preventing illness, by supporting people to manage their own health and wellbeing, and to enable people

[22] Stroke Association
[23] NICE - What is the prevalence of stroke and TIA in the UK?
[24] A Healthier Wales (gov.wales)

to live independently for as long as possible, supported by new technologies and by integrated health and social care services.

As part of our review, we considered what information is available to advise the people of Wales on the risks associated with having a stroke, and its prevention. The Royal College of Physicians[25] estimate that up to 70% of all strokes could be avoided if the risk factors were treated and people adopted healthier lifestyles.

The role of Public Health Wales in stroke awareness and prevention

Public Health Wales NHS Trust (PHW)[26] is the national public health agency in Wales. Through its work, the aim is to protect and improve the health and wellbeing of people and reduce health inequalities across Wales. As highlighted earlier, our review considered patient flow through the stroke pathway. It is, therefore, important to understand what PHW is doing to help prevent people in Wales having a stroke.

We considered how PHW were engaging with people to raise their awareness of the risk factors associated with a stroke, and their understanding of stroke symptoms. Additionally, what the Trust is doing locally or nationally to target certain groups of people who may be at the highest risk of sustaining a stroke. This may include Black and Asian people, and those living with high blood pressure, high cholesterol, diabetes, excessive alcohol intake, smokers, and those with Atrial Fibrillation (AF).

AF is a heart rhythm problem and increases the risk of a stroke due to a risk of blood clots forming in the vascular system (blood stream), which may travel to the brain causing a stroke. The Stroke Association[27] highlights that AF can happen to anyone, including people who are otherwise fit and well. It usually affects adults, and the risk increases with age, but also for people with conditions, such as heart disease, diabetes, obesity, high blood pressure, and in smokers.

In our survey, when we asked respondents about their ethnicity, there were zero responses indicating people were from Black, Asian, or other ethnic groups.

According to the Stroke Association and Different Strokes organisation[28], strokes may happen more often in people who are black or from Asian families. In addition, it is suggested that within these groups, people may need to get checked at an earlier age for diabetes, particularly if they have any risk factors, such as being overweight[29].

In 2021, Different Strokes Organisation launched a national outreach program, to raise awareness of stroke risk amongst Black and Asian communities, and to develop a longer-term plan, to break down barriers preventing Black and Asian stroke survivors from accessing its support services. Through the outreach programme, the organisation found there was lack of awareness of the risk of

[25] The Royal College of Physicians
[26] Home - Public Health Wales (nhs.wales)
[27] Stroke Association - Atrial Fibrillation
[28] Different Strokes
[29] Stroke Association - What is stroke, are you at risk of stroke

stroke at all ages, and Black and Asian people were not aware of their increased risk of stroke. They also found limited information available regarding stroke for people from Black or Asian communities, or for people whose first language is not English. Additionally, they found in UK-wide NHS campaigns, there was a limited representation for these communities, such as a lack of images of Black and Asian people, meaning that when they were looking at stroke campaigns, they would not see themselves in the images or the stories shared.

The Different Strokes Organisation has developed an engagement strategy to tackle the issues highlighted above, which plans to support and raise awareness of younger stroke amongst Black and Asian communities in the UK. The equality and diversity statics in Wales for 2018-2020 indicate that 95% of the population described their ethnic group as White, and 5% described themselves as Asian, Black, or as being from mixed or multiple ethnic groups or from another ethnic group[30]. The Different Strokes Organisation alone cannot raise the profile of stroke in Black, Asian and ethnic communities, therefore, health boards, Welsh Government and PHW must make a concerted effort with reaching out to people within these communities through stroke awareness education and campaigns.

Stroke and health inequality

Socio-economic factors also impact on the risk of stroke. Health inequalities disproportionately affect certain communities and socio-economic deprivation is linked to worse health outcomes[31]. Strokes occur more commonly in areas of deprivation, therefore, highlights the inequalities in people's health status[31]. It is therefore important that when engaging with the public on stroke awareness and stroke prevention, health boards, Welsh Government and PHW should ensure they reaches out to people affected negatively by socio-economic factors.

[30] https://www.gov.wales/review-evidence-socio-economic-disadvantage-and-inequalities-outcome-summary-html
[31] https://phw.nhs.wales/services-and-teams/local-public-health1/cwm-taf-morgannwg-public-health-team/cwm-taf-morgannwg-public-health-documents/cwm-taf-annual-report-of-the-director-of-public-health-2018-a-public-health-approach-pdf/

Recommendation 1:

Health boards should engage with each other, to learn from the good patient education practices taking place across Wales. This could help the shared learning between themselves and with GP practices in their localities, to educate patients of the risks for a stroke, to help reduce the number of strokes across Wales.

Recommendation 2:

Public Health Wales should consider the development and promotion of a national campaign to raise stroke awareness and its prevention in Wales alongside its Act FAST campaign. This should include raising awareness of stroke prevention within black and minority ethnic communities and the impact of health inequalities and socio-economic deprivation.

Recommendation 3:

Health boards and PHW should work closely with Black, and minority ethnic communities and people affected by socio-economic deprivation, to understand the specific issues they face with their increased risk of stroke and in accessing preventative care and ensure ongoing engagement with them to support better health outcomes.

Stroke management performance in NHS Wales

To demonstrate their performance in managing stroke services, hospital sites in Wales (and the UK), are graded in line with SSNAP data. Each hospital which manages stroke patients is required to regularly submit their performance data to SSNAP. The grade for performance is categorised from A (highest) to E (lowest).

In 2019, just three out of 16 hospitals in Wales who manage stroke patients, received a D or E grade. In 2022, the data reflects an increase to 11 of 14 hospitals who received a D or E score. This is concerning, not only as each hospital is graded in the lower categories, but it also highlights hospital performance has declined significantly across Wales in the past three years. However, it is important to note that this period did coincide with the COVID-19 pandemic.

The extreme and unprecedented demand for hospital beds during the pandemic had a significant impact on flow through healthcare systems, to the extent that field hospitals were implemented to cope with the overwhelming demand for beds. Health and care staff across all roles and services showed huge resilience in the face of unprecedented demands and pressures and adapted quickly with different ways of working to keep themselves and people safe. Staff worked in extremely difficult circumstances to care for people not only with COVID-19, but for others with other healthcare needs.

Despite their best efforts to protect people, tragically, many of those they cared

for died, and some staff also had to deal with the loss of colleagues.

What is Patient Flow?

Patient flow is the movement of patients through a healthcare system. It involves the clinical care, physical resources, and the internal processes and systems needed to move patients from the point of admission to the point of discharge.

Within its *Programme for Government 2021-2026*[32], Welsh Government committed to the provision of urgent and emergency care services in the right place, first time. It developed the *Six Goals for Urgent and Emergency Care*[33], which supports the health and social care system in the delivery of the programme for government commitments.

Improvement Cymru[34] is the improvement service for NHS Wales. Its aim is to support the establishment of the best quality health and care system for Wales, so that everyone has access to safe, effective, and efficient care in the right place and at the right time. During our onsite fieldwork, we found that Improvement Cymru was undertaking a pilot in three hospital sites and was supporting teams to improve their patient flow systems. Together with the health boards, they implemented a Real Time Demand Capacity (RTDC) methodology to focus on the process, using improvement methodology. This will be highlighted further, later in the report.

Managing people through the stroke pathway

In 2021, Welsh Government published its 5-year plan[35] to improve the quality of stroke services and outcomes. The new quality statement for stroke, sets out the future vision for stroke services in Wales and was developed with Wales' Stroke Implementation Group.

The Stroke Implementation Group provides guidance to the government and advice to key stakeholders and is developing a delivery plan[36] which is overseen by the National Clinical Lead for stroke in Wales. The plan will outline how services must improve the quality of stroke care and reduce variations in care across Wales. The group will also be supporting health boards to develop a network of comprehensive regional stroke centres, supported by regional operational delivery networks that work across boundaries to improve care, from acute treatment to rehabilitation.

However, to successfully achieve the above, effectively managing patient flow is pivotal.

The Senedd Health and Social Care Committee, undertook an inquiry into hospital discharge and its impact on patient flow through hospitals.

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[32] Welsh Government Programme for government: update | GOV.WALES
[33] Welsh Government - Six Goals for Urgent and Emergency Care - A policy handbook 2021-2026
[34] Improvement Cymru website
[35] New plan for Stroke care announced for Wales | GOV.WALES
[36] This a Service Specification which is being developed by a sub-group of the Stroke Implementation Group, led by the Clinical Lead for Stroke in Wales and comprises clinical, third sector and academic partners

The report[37] was published in June 2022, and highlights several challenges facing the health and social care sectors. The inquiry identified the need to take radical steps to reform health and social care systems and made 22 recommendations for improvement to Welsh Government.

We found that several of the recommendations align with the improvements needed identified as part of our review. Our review highlights that whilst work is ongoing nationally to tackle patient flow, it is not clear how effective these work streams have been to date since the complex issues with patient flow remain unchanged.

How do health boards manage patient flow?

To manage the demand for beds across Welsh hospitals, designated teams within each health board hold regular meetings to address the issues with hospital admissions and discharges.

These meetings are held several times a day, 365 days a year. They are commonly referred to as patient flow, bed management or site management meetings. In addition to these, further regular meetings take place internally with members of the executive team such as the Chief Operating Officer, to consider the movement of patients across hospital sites within health boards. In addition, external meetings are held with other health boards and WAST. These consider the wider impact on flow across health board boundaries and the impact this may have on WAST providing services to people in the community. This will be highlighted later in the report.

For ease, throughout this report, we will refer to the meetings above as 'patient flow' meetings.

Patient flow meetings

During our fieldwork, we attended several patient flow meetings across Wales, and considered how effective they were in managing flow to provide timely, safe, and effective care to patients.

Patient flow meetings were held regularly, at least three times each day across the sites visited as part of our review. They were well attended by the key staff responsible for a patient's journey through hospital, such as patient flow managers, department managers, different MDT members, senior managers, and discharge co-ordinators. The meetings enable everyone to have a collective understanding and a joint ownership of patient risk and safety across the whole hospital site.

In some health boards, a Hospital Ambulance Liaison Officer (HALO) was also present during patient flow meetings, to discuss the ambulance handover delays and plans for longest wait patient handovers.

Actions and plans were also discussed on how to off-load certain patients into ED,

[37] Welsh Parliament Health and Social Care Committee, into hospital discharge and its impact on patient flow through hospitals

to release an ambulance from the hospital. In the absence of a HALO, this input was provided by staff from ED.

Ambulance Immediate Release Protocol

To help manage the constant issue found across Wales with ambulance handover delays, in June 2022, WAST in conjunction with NHS Wales, developed its first draft of the *All-Wales Immediate Release Protocol*[38].

When a person calls 999, there is a triage process which is completed by a call handler who enters data into the Medical Priority Dispatch System (MPDS)[39]. The response provided by the caller and data entered in the MPDS, generates a WAST priority code to determine the clinical response required for the patient. The system prioritises the most urgent patients, who are categorised as Red, Amber (1 and 2), and Green. Details of call categories are highlighted on the WAST website[40].

The immediate release protocol outlines the principles and processes for managing the immediate release of ambulances when new calls are categorised as 'Red or Amber 1'. This aims to minimise safety risk for people awaiting an ambulance response in the communities. This is usually invoked when ambulance capacity is reduced, when the time for patient handover at EDs is prolonged. The handover standard is 15 minutes and is considered extended beyond 30 minutes.

Data provided by WAST for the period 1 July 2022 to 5 September 2022, reflects a high volume of Immediate Release Directions (IRDs) being made. The data reflects the pressures that EDs across Wales are experiencing, which results in patient handover delays and patients in the community experiencing long waits for an ambulance response. During this period, a total of 1,900 IRDs were made. Around 30% of these related to 'Red' priority calls and 70% for 'Amber 1'. Whilst a high percentage of IRDs relating to immediately life-threatening incidents were accepted, only 35.5% of the directions between April 2021 to June 2022, received this decision within the 8-minute response target for 'Red' calls. In addition, there remains a high percentage (62%) of declined directions for Amber 1 IRDs, despite the new protocol stating that they must not occur.

Recommendation 4:

Welsh Government, health boards and WAST must work collaboratively, to consider whether the Immediate Release Directions are effective or need improvements, given the high number of declined Immediate Release Directions occurring across Wales.

Patient flow dashboard

[38] NHS Wales Immediate Release Protocol
[39] MPDS is a unified system used to dispatch appropriate aid to medical emergencies including systematized caller interrogation and pre-arrival instructions.
[40] How WAST Responds to Emergency 999 Calls

Each acute hospital site had a patient flow dashboard (commonly known as the 'SitRep' (Situation Report)) displayed within the patient flow meeting rooms. It presents all key details for patient flow throughout the hospital, which was reviewed systematically and was referred to appropriately throughout the meetings. They were used to visualise the key areas requiring discussion, and to help plan timely management of all patients from ambulance handover, the ED and through to the wards (and operating theatres), to patient discharge.

During the patient flow meetings, we found the Chair would consider all aspects of flow systematically through the SitRep. This was from the ED ('the front door'), to discharge or transfer from hospital ('the back door'). In addition, consideration was given to the workforce requirements, such as staffing on the wards or in ED. The escalation status of the hospital was determined within the flow meetings, based on the availability of the beds available, ambulance waits, ED capacity and ability to admit people for key treatment or surgery.

Hospital escalation Status

To establish a hospital escalation status consistently across Wales, Welsh Government, health boards and WAST, jointly approved a National Emergency Pressures Escalation and De-escalation Action Plan[41]. The action plan defines the four main escalation status levels for health boards and WAST. These levels and the triggers are used to determine the appropriate response to escalating and de-escalating emergency pressures, and the actions necessary to protect core services. This is to help provide the best possible level of service with the resources available.

Levels of Escalation

The table below defines the four main escalation status levels for health boards and WAST.

Level 1 **Level 2** **Level 3**	**Steady State** **Moderate Pressure** **Severe Pressure**	Ensure all standard operating processes are functioning as efficiently as possible to maintain flow. Respond quickly to manage and resolve emerging pressures that have the potential to inhibit flow. Initiate contingencies. Escalate when applicable. Prioritise available capacity to meet immediate pressures.

[41] National Emergency Pressures Escalation and De-escalation Action Plan

		Put contingencies into action to bring pressures back within organisational control. De-escalate when applicable.
Level 4	**Extreme Pressure**	Ensure all contingencies are fully operational to recover the situation. Executive command and control of the situation. De-escalate when applicable.

Throughout our onsite fieldwork, almost all hospitals were at a level four escalation at some point during our visit, which represents extreme pressure on the hospital system overall.

Focus of flow across departments

Overall, we found that patient flow teams appeared to manage meetings well. We witnessed discussions about each ward systematically, which included bed capacity and staffing of each ward and specialty of patients within the ward beds. Concerns were highlighted and discussed appropriately during all meetings we attended, with effective communication regarding the challenges with flow through the hospital system.

Updates were given from each area which includes the following examples:

- Patient handover delays from ambulances including the longest wait and number of ambulances waiting outside ED, and plans for the handover
- Demands and risk within ED, including the number of patients awaiting admission to a ward bed
- Numbers of patients on each ward, such as medical, surgery, paediatric, critical care
- Situation on ringfenced beds, including stroke
- Department staffing and resources
- Infection prevention and control issues
- Number of patients requiring surgery that day
- Total number of patients awaiting discharge or repatriation
- Action required on patients awaiting discharge and repatriation.

Overall, we saw that patient flow teams had a good understanding of which patients needed beds or needed moves to other wards. In addition, they had knowledge of the patients requiring transfer or repatriation to other hospitals or

community settings, and discussions took place on transport requirements. This included stroke patients who were deemed appropriate for transfer from acute settings to community rehabilitation wards. It is positive to note that 87% of stroke services staff who responded to our survey said, patient flow staff were involved with the stroke patient's journey throughout their care.

Patient outliers on different specialty wards

We found adequate oversight of patient specialty outliers in other service groups or hospital areas, such as medical patients being cared for in surgical beds and vice versa. Patient outliers was a consistent finding across Wales, due to pressure on the system and the high demand for beds. It was also an issue prior to our review and is frequently evident through HIWs annual inspection process.

It was clearly not always possible to move patients, which included stroke patients, to the most appropriate ward or specialty for their care and treatment due to bed availability. Whilst this is a common occurrence across Wales, it is concerning since patients are regularly being treated on a ward that would not usually care for that specialty. Whilst it was not always possible to place people on the correct ward, staff and flow teams risk assessed the most suitable patient to place to a different specialty ward. Effective management at patient flow meetings can help to ensure this happens effectively.

When considering the stroke pathway, some healthcare staff explained issues with demand and capacity in stroke services, as there were more acute stroke beds available than rehabilitation beds. Consequently, this can have a negative impact on patient flow through stroke services because patients were waiting in acute beds longer than necessary, before being moved to a rehabilitation ward.

We also found in some health boards, wards cared for both acute stroke patients and those in their rehabilitation stage on the same ward. Within one health board, we found patients were placed in an area of a ward which was previously a rehabilitation gym. Whilst this enabled stroke care in the right ward, losing the gym area was impacting on the prompt rehabilitation of all patients. Like this finding, a staff member commented in our survey as below:

'Currently even with good MDT working and effective discharge planning, there is no step-down from acute to help flow. Patients that are no longer having active treatment then increases bed pressures in other areas of the hospital and often these patients still require input from a discharge planning point of view and reduce time spent with acute / rehab patients receiving active treatment. This then means there is increased pressures on staff and reduced available time to meet stroke guidelines and directly having a knock-on effect to patient progression and the time it takes to reach a safe level of discharge with increase length of stay and inhibits flow.'

Bed capacity pressure

We interviewed patient flow staff across Wales, who told us that pressures on the hospital patient flow system had been exacerbated by the pandemic, and the pressure continues to rise. We were told that 'winter pressures' have become an

all-year-round issue, with hospitals finding it difficult to recover during the spring and summer months due to demands on the ED and ward beds.

During the winter period, many health conditions, including respiratory diseases such as asthma, can be caused or worsened by cold weather. Those issues along with higher incidences of so-called 'seasonal illnesses, such as flu and norovirus, can mean the NHS often faces much greater pressure during winter, due to demand on healthcare services. This not only impact on hospitals, but also within community services, such as GPs, community nursing teams and pharmacy services.

During our staff interviews, we found other reasons which can affect ED capacity, therefore impacting on patient flow. This includes:

- Difficulties in people accessing primary health care, such as GP appointments, means more people are self-presenting to EDs when they do not require emergency care
- An increased demand on ED services from people needing mental health support, as adequate community support is not available when needed.

Our interviews with patient flow staff, also found consistent problems with the timely discharge of patients. This was an issue across Wales, from both acute and rehabilitation wards, and was negatively impacting on patient flow and overcrowding in ED. This includes:

- Difficulties in admitting patients to a Ward from ED, due to a lack of available ward beds, as wards cannot discharge medically fit people due to social care capacity
- Insufficient capacity for patients who require rehabilitation or intermediate care after their acute phase.

Patient flow - discharge discussions

During the patient flow meetings, the number of patients medically fit for discharge were discussed in all hospitals we visited. Staff told us that on average, approximately one third of patients on a hospital site were fit for discharge.

However, they either had no social worker allocation, set plan or date for a social care package to commence at home, or there was a lack of beds available within nursing or residential homes, if they were unable to return to their previous residence.

We found in some but not all hospitals, that when a patient was likely to be discharged on a given day, an action plan would be developed and discussed at the patient flow meetings with a view to ensure the discharge is fulfilled as planned.

This may include completing timely blood tests, ensuring take home medication was prepared in advance of discharge, and hospital non-emergency patient transport was arranged in a timely manner.

These actions would sometimes be followed up at the next meeting and addressed in subsequent meetings if incomplete. We found examples where such actions were expedited effectively and saw progress had been made by the next meeting, or the patient had been discharged or placed within the hospital's discharge lounge awaiting transport. However, there were some occasions when actions had not been delegated appropriately, which impacted on the timely discharge process.

Recommendation 5:

Health boards must communicate with each other to establish the good practices taking place in some hospitals for the robust management of patient flow. This includes the implementation of effective action plans to manage daily discharges, which remain active throughout the day, and in planning for subsequent days.

Further details relating to the challenges faced for effective discharge of patients, are highlighted later in the report.

Improving flow with Improvement Cymru

As highlighted earlier, during our onsite fieldwork we noted that an Improvement Cymru team was undertaking a pilot to support three acute hospital sites to help manage their patient flow. This was done using a Real Time Demand Capacity (RTDC) methodology. We engaged with the Improvement Cymru team, to gain an understanding of their work and any progress made since the onset of the pilot.

The goal of the RTDC tool is to improve patient flow processes by developing a situational awareness amongst staff teams within hospitals. This is to ensure staff fully understand the demand and capacity, and to establish an appropriate awareness and understanding of the bottlenecks and constraints impacting on flow. This would help structure the planning process to improve flow and to pre-empt or predict demand and capacity, and to manage flow more effectively.

The RTDC methodology focuses on discharge and improving flow in small increments, particularly in the earlier part of the day. Whilst this does not assist with the existing flow issues which relate to social care challenges impacting on discharge, it supports patient flow daily, by preparing patients for earlier discharge times on the proposed discharge date. This can result in earlier availability of ward beds, which allows for a timelier transfer of patients from ED to the wards or minimise delays with theatre list start times. This in turn, impacts positively on the timeliness of patient handovers from ambulances to ED, hence releasing ambulance crews to attend emergency calls within the community, or to repatriate or transfer patients home from hospital when applicable.

The Improvement Cymru team highlighted to us some themes found which contribute to delays in patient discharge. This included transport delays and the timely management of take-home medication. They found that often, take-home medication was not being prescribed and sent to pharmacy until the same morning that the patient is due to be discharged, which adds to unnecessary delays. This is consistent with our findings in our review of *Patient Discharge from Hospital to*

General Practice[42].

During the first week of the RTDC project at one hospital, the Improvement Cymru team found significant delays in the undertaking of blood tests and obtaining the results for these in a timely manner. An immediate action to improve this was for the health board to allocate ten priority slots with phlebotomy services to ensure patient blood tests were completed early in a timely manner, for those being discharged that day. This had a positive impact on preventing some delays with discharge.

Recommendation 6:

Health boards must review and consider processes for prescribing take home medication so that these can be obtained from pharmacy more promptly in order to minimise discharge delays. This should include planning well in advance of the scheduled time for discharge (such as the day before).

Recommendation 7:

Health boards should consider the benefits of dedicated 'discharge phlebotomy slots' for managing the necessary blood tests, to assist with effective and timely discharge.

We spoke with several staff from the three pilot sites about their engagement with the Improvement Cymru team. This was to establish what impact the RTDC methodology was having on their patient flow processes. One person said that one of the challenges they identified was the Ward Manager engagement with the RTDC process, and for them to understand how this would benefit their ward flow.

We were told by several patient flow managers that the flow processes currently in place in their hospitals had remained the same for many years, and to help change the process was a significant challenge. This would require strong leadership at both department and flow team level. The flow teams told us that to support the process, templates were developed to capture key information, and they would attend the wards in person to engage with ward managers, to support them in identifying solutions themselves, to help resolve delays in flow issues at a local level.

It was also explained to us that the RTDC methodology allows all departments across hospital sites to take ownership of the safety and risk associated with patient flow, and staff are now more engaged to share resources to help mitigate and balance the risk and safety of flow barriers across the whole hospital site.

As a result of the RTDC pilots, we also observed some positive processes implemented for improving flow discussions and the overall management of beds,

[42] HIW - Patient Discharge from Hospital to General Practice: Thematic Report 2017-2018.

which included analysis of bottlenecks and challenges with patient discharge. We heard from staff in one hospital that work was in progress to analyse data of the key flow issues. This was to support predicted planning arrangements to improve the overall flow processes. An example of this includes data analysis of ambulance attendances at the ED, both daily and weekly, to understand and predict potential patterns for demand on the service with the aim to help reduce capacity issues.

We found some disparities across Wales with directorate clinical oversight of patient flow at more senior levels, such as Senior Nurses or Lead Nurses. In some hospitals, senior nurses would be placed on a daily directorate rota for effective senior clinical oversight of patient flow for their directorate, such as one for medicine and one for surgery. They would attend the daily flow meetings, and visit the relevant wards across their directorate frequently, to ensure staff teams were making timely progress to discharge patients, consult with senior nurses from other directorates (rostered to manage flow), challenge medical staff to undertake key tasks where necessary, and help expedite any outstanding patient needs. They would also establish a plan for proposed discharges for the following or subsequent days. However, in some hospitals there was no daily senior nurse/ clinical oversight. We found that where a senior nurse oversight for flow was part of the daily process, the daily ward discharge process and planning for subsequent days was more effective. Any actions and discharges appeared to progress timelier, than hospitals without clinical flow oversight.

Recommendation 8:

Health boards must consider the benefits of Improvement Cymru's Real Time Demand Capacity methodology, and whether this would have a positive impact to implement (or to pilot) within all hospitals to help manage timely patient flow.

Recommendation 9:

Health boards should reflect on their patient flow processes and consider whether improvements can be made with predictive methodology for demand in each of their hospital sites, such as with medical and surgical admissions.

Recommendation 10:

Health boards should consider whether a daily senior nursing/ clinical oversight for each directorate could be implemented to facilitate clinical issues with flow. This may help ensure staff are making timely progress to discharge patients, challenge medical staff to undertake key tasks where necessary, and help expedite any outstanding clinical patient needs. This could also support early planning for patient discharge.

Non-emergency clinical care in the community

To help understand how people can access the most appropriate clinical support, if they have urgent, but not emergency healthcare needs, we considered what supportive measures were in place within the community.

Reducing the burden on GPs and EDs

Signposting people to other resources can help improve patient flow by reducing the burden and pressure on GPs or local EDs. Using other community services where appropriate, may reduce the overcrowding that occurs in EDs, and ensure people are getting the right care, in the right place, first time.

Welsh Government is currently promoting the '*Help Us to Help You*' campaign. This highlights to people that better health starts with them, and educates people on how to access relevant advice, support, or care for their health concern, with any new or existing condition.

The campaign and information on the *'Better Health Starts with You'* webpage[43], highlights the many ways to access healthcare in Wales. This includes using pharmacies, Minor Injury Units (MIUs) and mental health helplines, or using other online NHS consultations, to reduce the need for people to attend their GP surgery, or attending ED when their health concern is not an emergency.

Key messages relating to this campaign include advice on using the *NHS 111 Wales service*[44], which starts as a symptom checker and advises people of what steps to take prior to attending the GP or ED. There is also guidance available on accessing other local services and MIUs, and signposts support for mental health needs. We were told by Welsh Government that the reach and impact of this campaign is being measured at regular intervals; however, no data was provided to us to support this.

WAST also launched its campaign around awareness for the NHS 111 Wales service on their website[45]. It supports the *Help us to Help You* campaign by highlighting the 111-symptom checker. If a person feels their health concern is urgent, they can call 111 and speak with highly trained call handlers who will provide advice over the telephone and can arrange a call back from a clinician if needed. Using NHS 111 Wales first, can reduce pressure on the emergency 999 service and EDs.

The NHS 111 Wales service has now implemented further support for people needing help with their mental health, where they call the usual 111 number and press OPTION 2[46]. The service is available for everyone, 24 hours a day, 7 days a week to ensure those in need of mental health support can access it quickly when they need it most. The number is free to call from a landline or mobile, even to those with no credit on their phone.

When considering the *Help Us to Help You* measures in place across Wales, we explored whether it was having a positive impact on WAST and its ability to manage emergency calls in a more timely and effective way. We interviewed a senior manager within WAST who informed us that despite the promotion of the NHS 111 campaigns in Wales, the Trust continues to have multiple 999 calls for non-life-threatening emergencies. We were also told that the winter of 2022/2023

[43] Better Health Starts with You
[44] NHS 111 Wales
[45] NHS 111 Wales: Healthcare advice you can trust - Welsh Ambulance Services NHS Trust
[46] https://www.gov.wales/nhs-111-press-2

had been particularly challenging for the service, with a high number of calls, and particularly from patients with respiratory issues. WAST regularly manages the data relating to calls and categories of need.

A key area requiring improvement is for healthcare services to engage with people to better understand the barriers to them accessing, or choosing, from the range of healthcare services available in Wales. Once the barriers are understood, this should in turn be used to influence service design. Ongoing engagement with people about the range of available services may reduce the need for people to attend their GP surgery or attend an Emergency Department (ED) when their health concern is not an emergency.

Recommendation 11:

Welsh Government should consider strengthening its promotion of the *Help Us to Help You* campaign, to ensure people are appropriately educated and understand how to access healthcare in the right place, first time, by guiding them towards the most appropriate care service.

Recommendation 12:

Health boards and WAST should engage with people to better understand the barriers to them accessing, or choosing, from the range of healthcare services available in Wales. Once the barriers are understood, this in turn, could be used to influence service design.

Impact of flow on WAST

WAST patient pathway

We considered the stroke patient's journey through WAST services as the primary frontline service for emergency transport into hospitals across Wales.

In 2015, WAST introduced a framework which replaced the time-based targets for measuring response times of ambulances. The framework is a five step Ambulance Care Pathway, which focuses on the patient journey and is more aligned to the patient outcomes and experiences.

Using the Ambulance Care Pathway framework, we sought to understand how a potential stroke patient is managed from the time of calling 999 for an ambulance, the outcomes they might expect, and the impact of poor flow on WAST's ability to respond to emergency calls.

These include:

Help me to choose

We have already discussed the benefits of people in choosing the most appropriate service for their health concern through NHS 111 Wales. This is to help prevent the need to use the resource of the GP or attend ED. However, when a stroke patient

feels it necessary to call 999 for an ambulance, the data available from Stats Wales[47] shows on average, around 1400 stroke related calls can be received by WAST each month.

Answer my call

As highlighted earlier, when a person calls 999, a call handler completes a triage process and enters data into the MPDS. This allows the MPDS to generate a priority code to determine the clinical response required for the patient, as either Red, Amber, or Green.

If a caller is suggesting symptoms of a stroke, the MPDS will prompt the call handler to undertake the 'Act FAST' test. If the patient is conscious and breathing with positive stroke symptoms, and the onset of symptoms are known to be less than five hours, the call is prioritised as 'Amber 1'. If the symptom onset time is over five hours, the call will be prioritised as an 'Amber 2'. This is because the time to treat a clot in the brain must commence within four hours of known onset of symptoms, and to be considered for thrombectomy for symptoms in less than six hours.

Results from our staff survey reflected seven views on call categorisation, and a feeling that stroke callers should be categorised as 'Red' and not 'Amber', if they are to meet the therapeutic timescales for treatment. This is to help ensure a better patient outcome. One comment included:

'From a WAST perspective, strokes are categorised as an Amber 2, when they should be a red, as the quicker we can attend and recognise, the sooner we can get them to hospital'.

In HIWs previous review of WAST[48], the findings recommended that work was required to consider stroke patients as an emergency who need a 'Red' response. This is due to the time critical nature for treatment. WAST, as a commissioned service cannot make this decision to change alone; it is dependent on guidance from NHS Wales, commissioners, and Welsh Government. Discussions and votes at Senedd Cymru on 26 October 2022[49],[50] , confirmed that stroke patients will remain within the 'Amber' category.

When a patient is waiting for an ambulance, there is a process in place to monitor a patient's clinical status if necessary. If a call handler has concerns for a patient's well-being, they would 'flag' the call on the MPDS to notify the WAST clinical team that a telephone review is required. Whilst this process is in place, it was concerning to find that over the Christmas period in 2022, there were occasions when over 200 callers awaiting a WAST vehicle response, who needed clinical team's intervention.

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[47] StatsWales is the Welsh Government's free-to-use online repository for detailed statistical data for Wales.
[48] Local Review of the Patient Management Arrangements within the Welsh Ambulance Service Trust
[49] Y Senedd - Votes and Proceedings Plenary - 26 October 2022
[50] Y Senedd TV - Plenary 26 October 2022

Come to see me

The ability of WAST to send a response to a caller is dependent on the resources available at the time. This is often impacted by the number of ambulances waiting outside EDs to handover their patients. We found this was a consistent issue across Wales because of poor flow within hospital sites. WAST call handlers or the clinical team are usually aware of prolonged waits for an ambulance to attend callers in the community. Therefore, guidance with a script is available which staff use to recommend the caller makes their own way to hospital, if it is safe to do so, as opposed to losing time whilst waiting for an ambulance to arrive.

Give me treatment

When WAST staff attend a patient suffering with a stroke, they will undertake a further assessment at the scene, which follows the *Joint Royal Colleges Ambulance Liaison Committee (JRCALC) Clinical Practice Guidelines*[51]. The guidelines identify stroke as a 'time critical' medical emergency and references the time dependency for thrombolysis (clot dissolving treatment). The guidance also states that patients must be transferred to an appropriate hospital as quickly as possible, to commence treatment once the stroke diagnosis is suspected.

Take me to hospital

There are arrangements in place for ambulance crews across Wales to provide pre-alert calls to ED. WAST has guidance in place for clinicians to follow when a stroke has been confirmed during assessment. We were informed that it is the decision of the clinician at the scene of the incident to determine which is the most appropriate hospital to transport a patient, according to their condition (including stroke). On occasion, this may be a hospital across the border, such as for patients living within Powys.

We considered how patients in rural areas would access timely treatment for stroke. We were told that there are challenges with this, and during our fieldwork, we found that work was ongoing in some areas of North Wales and Powys to try to improve transfer arrangements. WAST has been working with healthcare services across the border in England to ensure that arrangements are in place to review and treat stroke patients promptly when required.

Within our staff survey, it was positive to find a good response from WAST staff who felt well equipped to undertake their role with managing a stroke patient.

Almost 85% of staff told us in the survey they had received training to support and manage stroke patients, however, only 77% of respondents said they understood the WAST stroke pathway. In addition, we found that only 49% of WAST respondents said they always allocate or take a stroke patient to a specialist stroke unit.

We recognise the challenges faced by WAST in its ability to deliver a timely response to life-threatening emergencies. This is due to increased pressures on the

[51] JRCALC Clinical Practice Guidelines - aace.org.uk

healthcare system overall, with prolonged ambulance handover delays to EDs all over Wales. It is, however, a concern that patients in the community have prolonged waits for ambulance resource, which places them at increased risk of deterioration and harm. This was also found in our two previous WAST reviews.

The impact of this is significant for stroke patients, due to the time critical nature of the investigations and treatment which are required to manage a stroke patient. Any delays to treatment will likely have life-long consequences for people.

We were told of a pilot project which is due to take place within one health board to evaluate a Pre-hospital Video Triage (PVT), which has been successful in several Trusts in England. A structured pre-hospital assessment will take place with WAST and the health board's stroke team while the patient is at home. If it is assessed that the patient is likely to have had a stroke, they will be immediately transferred to hospital and taken directly for a CT scan on arrival, bypassing the ED. In addition, when there is a pre-alert call from WAST to the ED, patients will be pre-registered within the department, which will reduce delays to thrombolysis and thrombectomy. This pilot is due to commence in August 2023.

Recommendation 13:

WAST must ensure that all relevant staff are fully aware of the WAST stroke pathway to minimise risks to patient safety.

WAST initiatives to manage patients in the community instead of hospital

During our WAST interviews, we found that the Trust is exploring a new process with the aim of reducing the number of ambulances being sent to patients by 50%. This, however, will require increased establishments of staff within the clinical desk, advanced paramedic practitioner teams, ambulance paramedics, nurses, midwives, and mental health practitioners.

The response to calls via the clinical desks will be a Multidisciplinary Team (MDT) approach, which will determine how best to respond to patients instead of inappropriately sending an ambulance. The proposed timescales to fully implement this model is three years which will need additional Welsh Government funding.

However, we were informed that funding had not yet been approved for this.

Evidence has been collated which reflects the benefits of having people treated at home via advanced paramedic practitioners.

We were provided with data which outlines the number of patients who have been managed at home or referred to other services, as well as those who are taken to hospital. It reflects that on the occasions where advanced paramedic practitioners have been sent to see patients, as opposed to ambulance paramedics, in the region of 65-70% have been treated at home without the need to go to hospital. Advanced Paramedic Practitioners can administer a greater range of medication than an ambulance paramedic, which means that more patients can be treated at home, and can be referred to ongoing services, such as their GP practice, physiotherapy

services, or healthcare clinics, such as for TIA where appropriate.

We were told that the service will need to develop and implement different types of resource to operate, such as an increased number of Advanced Paramedic Practitioners. To implement this type of service, staff need to be supported to develop their skills and knowledge, to enable them to work in these roles.

Early implementation of the new WAST model should have a positive impact on the pressures on our hospital system across Wales by reducing the number of patients being transported to EDs by ambulance. A reduction in the first bottleneck of patient flow at 'the front door' of Welsh hospitals, could lead to a reduction in pressure across the whole hospital system and an improvement in patient flow.

Recommendation 14:

Welsh Government should consider how it can support WAST to develop and implement improvements with its service delivery model, such as increasing the number of advanced paramedic practitioners across Wales, to help reduce the pressure on EDs and improve flow through healthcare systems.

Patient transfer to hospital

We explored the ways in which a patient can arrive at the ED seeking treatment, and this is highlighted below.

Patient arrival at ED

Patients can arrive at EDs in several ways, such as by ambulance, by GP or clinicians through the 111 service, or by referral from other healthcare practitioners, such as district nurses, or by people self-presenting. In our interviews with ED staff across Wales, we were told that people frequently attend ED who do not require emergency care.

There are many occasions where ED staff could redirect patients to alternative care pathways following initial clinical assessment, which would lessen the burden on ED, but also reduce waiting times at ED. The examples provided to us highlighted that people are often turned away from ED to use the services of their MIU, GP, community services, dentistry, and paediatric assessment units. However, some staff said that at times, there is a reluctance by ED staff to re-direct patients elsewhere and away from EDs, as they are risk averse and are not always confident to do so.

Stroke pre-alert calls

The stroke pre-alert call is used to notify ED staff of inbound patients that require immediate attention and is a key component in the stroke care pathway. The call enables the receiving hospital to have the specialist staff available upon the patient's arrival and aims to improve the timeliness of the treatment a patient receives.

We were informed by WAST that they have developed, in partnership with the

relevant stroke units across Wales, a standardised pathway to enable the conveyance of a patient to the appropriate hospital first time. The WAST clinician, upon suspecting a diagnosis of stroke, will pre-alert the ED of a hospital with a stroke unit capable of undertaking a scan, and when appropriate undertake thrombolysis treatment.

WAST staff told us that despite the effectiveness of the pre-alert call, issues can arise when hospital services are under extreme pressures due to poor patient flow. This can result in patients being assessed on the ambulance, then receiving their initial investigations and brain scan, and then returned to the ambulance due to pressures on ED services. This was supported by results from our WAST staff survey, which confirmed that a stroke patient is normally pre-alerted to the hospital, but often EDs are full and are unable to accept patients into the department.

During our onsite fieldwork, we found that some patients who were pre alerted or not, still showed signs of being FAST positive on arrival to ED. Some ambulance crew had documented on arrival at ED, that these patients were then a query Transient ischaemic attack (TIA)[52] as opposed to stroke, however, not all symptoms had resolved.

To support the stroke assessment process, NICE guidance for stroke, states that the diagnosis of people admitted to ED with a suspected stroke or TIA, should be established rapidly, by using a validated tool, such as ROSIER (Recognition of Stroke in the Emergency Room). The aim of the ROSIER assessment tool is to enable medical and nursing staff to differentiate patients with stroke and stroke mimics, such as TIA.

Since the use of ROSIER is a recommended tool within NICE guidelines to differentiate Stroke from TIAs, it may be beneficial for WAST to train its paramedic staff in the use of the ROSIER assessment tool, alongside the FAST assessment.

The ROSIER assessment tool is discussed later in the report.

Recommendation 15:

WAST should consider the benefits of training its paramedic staff in the use of the ROSIER stroke assessment tool, to enable staff to differentiate patients with stroke and stroke mimics, such as TIA.

It is positive to note that 94% of ED staff who responded to our survey said they were informed by a pre-alert call from ambulance services if it was a FAST positive patient. This was also supported by our interviews with ED and stroke services staff across Wales.

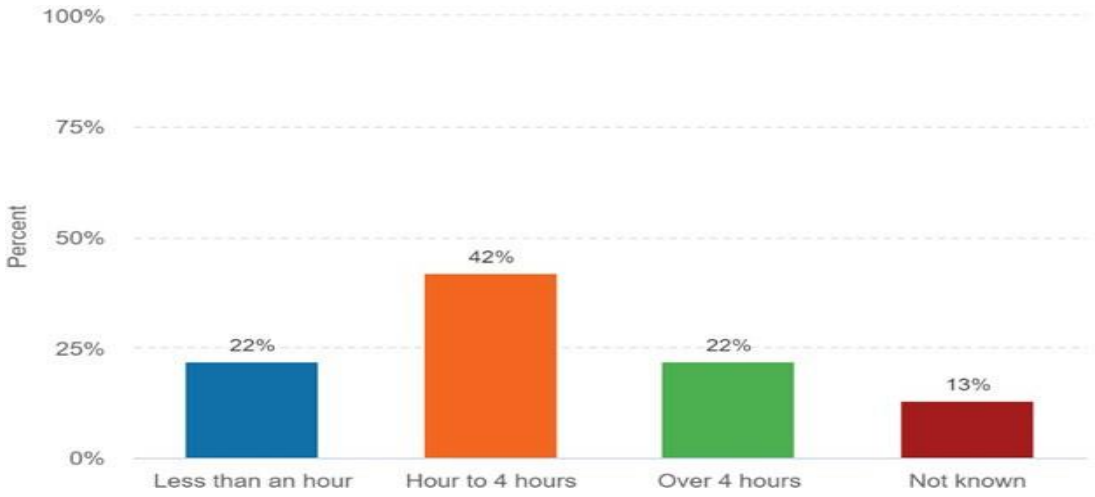
As highlighted above, we established that stroke patients arrive at EDs in different

[52] A TIA is a warning sign that you're at increased risk of having a full stroke in the near future. See: Transient ischaemic attack (TIA) - Treatment - NHS (www.nhs.uk)

ways, such as by ambulance, GP referral, or patients who self-present at EDs.

Therefore, there is a risk to some patients of missing their therapeutic window for thrombolysis treatment if there are delays in transfer or receiving timely assessments.

We asked people in our survey how long before arriving at hospital did their stroke symptoms start. The chart below highlights the times reported to us:



The above chart reflects that 64% of patients arrived at hospital within the time critical thrombolysis window.

People self-presenting at hospital

We were told by some patients and staff that due to the timely availability of an ambulance, some people self-present to ED. We were told that this can present risks to a patient if they did not clearly raise their stroke symptoms to the receptionist on arrival to ED, which consequently may impact on their triage and assessment time.

In addition, if a patient self-presents at a hospital that does not treat stroke patients, such as a MIU instead of ED, this may also present a risk for timely treatment.

This is because they may need to be transferred to a hospital that can appropriately scan and treat patients with a stroke. This in turn, may delay the time they have in the therapeutic treatment window of four and a half hours.

We considered the training provided to reception staff to help identify red flag

Recommendation 16:

Health boards should seek assurance that their MIUs and ED departments ensure all reception staff have received up to date Act FAST training, and they are competent with this. In addition, that appropriate escalation processes are in place if a receptionist is or is not sure a patient may be suffering with a stroke.

symptoms[53] of stroke, and to prioritise and escalate triage for patients if symptoms are present. We found that in general, most (but not all) reception staff had received training for this. Despite being non-clinical, they still have a vital role to play in the potential identification of stroke patients.

Impact of delayed ambulance handovers for stroke patients

We considered whether ambulance handover delays were having a negative impact on patients along the stroke pathway. In our staff survey, most ED staff said they were familiar with the hospital's handover policy to stroke services, and that the policy was easy to follow and was achievable. Whilst this finding is positive, delays in the ability of ambulance crews to hand over patients to ED staff are frequent and common.

Throughout our onsite fieldwork, we saw ambulances waiting outside EDs across Wales, waiting to handover and offload patients to the departments. Despite this, it was positive to find that patients suspected of having a stroke (and others with life threatening conditions), were prioritised and transferred into the ED promptly in line with the stroke pathway.

Timely assessment and treatment in ED for stroke patients

We observed stroke patients being assessed, investigations were undertaken, and treatment was commenced in a timely manner. We saw staff consider the risks and appropriately mobilise other lower acuity patients throughout the department, to accommodate those confirmed as stroke positive. This was to ensure timely assessment and treatment promptly.

Through our discussions with ED staff, we were told that in the event of no trolley space being available in ED to offload a stroke patient, assessment would take place onboard the ambulance if the appropriate ED staff suspected stroke.

We were told that whilst stroke patients would always be prioritised for transfer into the departments, there are occasions when this was not possible. In such instances, staff explained that investigations, such as blood tests and a CT scan would still be undertaken, although the patient may return to the ambulance until a decision on commencing treatment is made. This was to help maintain a timely response to the patient's needs. In response to our staff survey, one person said:

'At some hospitals there may be delays with handover, but assessment, and interventions are completed despite trolley or bed availability.'

In contrast to this, it was concerning to find that most respondents to our WAST survey said that ambulance offload delays are negatively impacting stroke patients. Several comments were received which included concerns with delayed

[53] Red flag symptoms of stroke may include complete paralysis of 1 side of the body, sudden loss or blurring of vision, being or feeling sick, dizziness, confusion, difficulty understanding what others are saying, problems with balance and co-ordination, difficulty swallowing (dysphagia), a sudden and very severe headache resulting in a blinding pain unlike anything experienced before, loss of consciousness.

response to those waiting in the community, timely offloading of patients to ED, and delayed patient assessment due to the bottlenecks within ED. One comment included:

'There doesn't appear to be any urgency when we pre alert a still FAST+ patient into ED. Or we are asked to take patient back onto vehicle. Not really appropriate when symptoms of a stroke have a good chance of being reversed if treatment is given promptly'.

The findings in our clinical records review were overall positive. Most FAST positive patients were taken into ED within the 15-minute Welsh Government handover target time. However, we did find instances of delays in handover and no investigations had been instigated by ED staff. This is a concern, particularly when stroke treatment is time critical, and delays may have life-long consequences.

Recommendation 17:

WAST and all health boards must work collaboratively to identify a consistent approach to ensure handover of stroke patients is made within the Welsh Government 15-minute target. This is to ensure that time critical investigations and treatment are undertaken promptly.

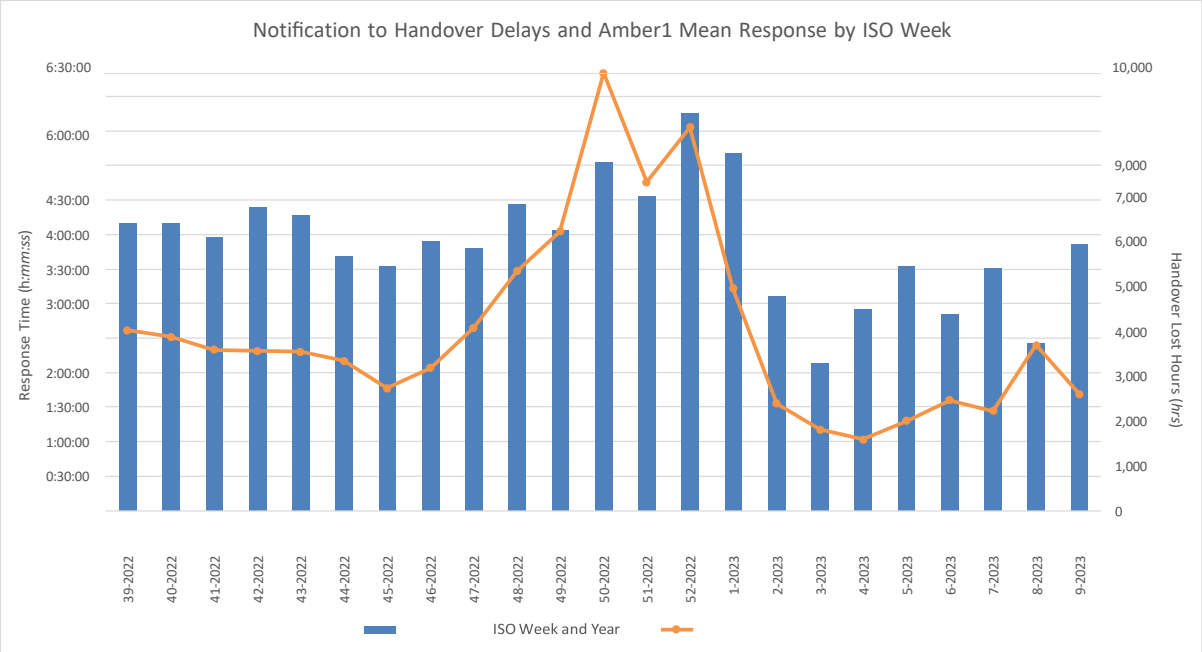
During our staff interviews, we were consistently told about the unprecedented increase in emergency care demand, impacting further on the ability to offload and handover patients from ambulances. Handover delays have been a challenge for WAST for a prolonged period, because of poor flow in hospitals. This has led to the service to re-evaluate its service delivery model, to help improve services, as highlighted earlier in the report, relating to the use of advanced paramedics in the community.

In our report, *Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover,* it is highlighted that in December 2020, 11,542 hours of ambulance crew resource was lost due to delays experienced with hospital handover.

We also found the data for this in September 2022 was significantly worse, with around 25,166 lost hours due to handover delays.

This increase is concerning and is attributed to poor patient flow. The flow is impacted further by the ability of hospitals to discharge patients in a timely manner, because of the delays with social worker allocation, availability of social care packages or placements available in care homes.

Data provided by WAST in the chart below, highlights a clear correlation between lost hours due to handover delays, and the Amber 1 response times over a six-month period.



The chart reflects that in week 52 of 2022, 8,835 hours were lost due to handover delays, and the mean time of an Amber 1 category call response (which includes most stroke calls), for that week was 5.33 hours. Given the time critical nature of potential treatment for stroke patients, the delays in the ability of WAST resources to attend patients in the community is of particular concern.

We are aware of the ongoing work nationally to improve handover delays; however, despite this, our review has found that the challenges remain. To address these issues, is not something WAST or a health board can do alone, and collaborative work is required between Welsh Government and key stakeholders in health and social care systems, to analyse the issues in order to make improvements.

Recommendation 18:

Welsh Government should work collaboratively with WAST, health boards and social care providers to evaluate and strengthen the current processes in place to improve flow through health and care systems, with a concerted focus on the analysis of flow, the bottlenecks impeding flow and the issues with achieving

Impact of flow on stroke assessment and admission to hospital

Stroke pathways

We considered whether health boards had a clear process in place for managing patients in ED with a stroke in line with NICE guidance. Overall, we found there are clear stroke pathways in place across Wales which focus on timely assessment, investigation, and ongoing treatment. All health boards follow a similar but not

identical pathway when stroke patients are admitted through ED. In general, the pathways include assessment, diagnosis, and treatment for thrombotic or haemorrhagic stroke, and for those where treatment is not a viable option, due to the extent of their stroke.

Timely assessment on arrival at hospital

We highlighted earlier that the incidences of people self-presenting at EDs with a suspected stroke is increasing. This is due to delays with the availability of ambulance resources in the community. This can prove challenging, since EDs are not pre-alerted to the arrival people self-presenting, which may present a risk in the timely assessment or diagnosis of stroke for some people.

During our onsite fieldwork, we found the challenges with the demand on ED, impacted by poor hospital flow, meant that some patients waited longer than expected for triage and ongoing assessment or treatment. Whilst this may not have impacted on FAST positive stroke patients, such delays may pose a risk to self-presenting patients who do not display easily identifiable stroke symptoms.

Stroke team assessment

When FAST positive patients are pre-alerted and arrive at hospital (and within the thrombolysis or thrombectomy treatment window), the relevant stroke team is alerted by an emergency stroke bleep of the imminent arrival of a patient. We found that all acute sites who provide stroke services have the stroke bleep system in place.

We considered the effectiveness of the relevant team response to the emergency stroke bleep. Our staff interviews found that the response to the bleep varied across Wales, according to the time and day, and who is on-call to respond.

Through the health board self-assessment responses and our interviews with staff, we found that when there is a Clinical Nurse Specialist (CNS) or Advanced Nurse Practitioner (ANP) for stroke available in acute sites across Wales, and their response is generally rapid. They will also facilitate prompt investigations and diagnosis, and the required treatment and plans for patients within the stroke pathway.

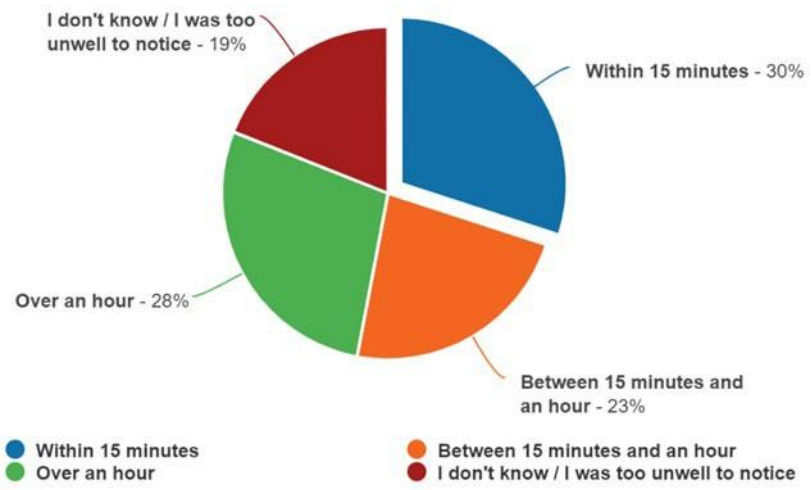
We found that during out of hours periods (such as nights or weekends), or in the absence of a Stroke CNS, ED staff and medical teams are alerted by the stroke bleep and arrange investigations and treatment for stroke patients. The medical team responders would also have access to an on-call stroke consultant.

We considered the process for those who self-present at hospital, and we found that the process was the same.

Through our clinical records review, we found positive responses from a designated on-site stroke team for attending ED. However, the timeliness of the bleep response was not always adequate. Some clinical records highlighted that triage and assessments were not always conducted in a timely manner, which may negatively impact on the ability to promptly assess and treat patients. Whilst we could not always identify the reason for this inconsistency, often the medical

teams were dealing with other in-hospital medical urgencies and emergencies on the wards.

We asked patients in our public survey how soon they were reviewed by a nurse or doctor following arrival at hospital. It was disappointing to find that over half the patients were not seen within 15 minutes, and 28% of those waited over one hour for assessment. However, it is important to note that for patients who completed the survey, their concept of time during their acute stroke episode may not have been a true reflection of their episode. Our survey findings are highlighted in the chart below:



Within our staff survey, we also found that just 28% of ED staff felt patients were assessed within 15 minutes, 60% said sometimes, and 12% said patients are not assessed in a timely manner. This again is a concern due to the time critical window for stroke patients receiving treatment.

Recommendation 19:

Health boards must ensure that ED staff undertake the triage of patients within the 15-minute target time. Where this has not been possible, it should be clearly documented 'why not' within the patient's clinical record.

Recommendation 20:

Health boards must ensure that medical staff who carry the bleep for stroke alerts recognise the urgency of both thrombolysis and non-thrombolysis stroke calls. A patient may still be symptomatic whilst out of the thrombolysis window but may still be within the thrombectomy time frame. This is particularly important if a tertiary referral centre is relatively close to the ED.

The CNS and ANP for stroke care

It is evident that prompt stroke care is essential for better patient outcomes, and the role of the CNS and ANP is beneficial in facilitating prompt progress through the stroke pathway.

We explored the CNS and ANP role further and found that it not only includes rapid assessment of patients for possible thrombolysis, but CNSs and ANPs also coordinate post-thrombolysis monitoring and acute stroke care. Their role was found to be significant in liaising between ED staff and acute stroke wards to facilitate prompt flow of stroke patients to an appropriate bed on a stroke ward, in line with national targets.

During our interviews, ED staff highlighted the benefits of the Stroke CNS and ANP to attend patients in ED. Staff reported that their presence assisted greatly in providing a prompt expert clinical opinion, and with ensuring stroke patients moved efficiently through the stroke pathway to the acute stroke ward. This also took pressure off the ED nurses and allowed them to focus on other patients requiring urgent clinical attention.

Across Wales, we interviewed staff within EDs and stroke services, and found consistently, that a key barrier to effective and timely stroke care, is the absence of a CNS or ANP for stroke service 24/7. Whilst medical teams have the appropriate knowledge and skills to manage stroke patients, there are occasions when their attendance at ED is delayed whilst they deal with other emergencies across the hospital. Such instances may negatively impact on stroke patients and their ability to be reviewed and treated in a timely manner.

Our interviews found that all hospitals aspire to have a 24/7 CNS for stroke services. However, we found inconsistencies across Wales in the provision of the CNS/ ANP service. The absence of a CNS/ ANP out of hours, such as nights and weekends, may impact negatively on patients due to the commitment of medical teams dealing with issues elsewhere across the hospital.

We found that issues with funding for the posts, or challenges in the recruitment for these key roles did not always enable a 24/7 service. Through our communication with the National Allied Health Professionals Lead for Stroke in Wales, it was highlighted that CNS or ANP for Stroke should be resourced to cover as much of the peak periods of stroke presentations to EDs as is possible, particularly during thrombectomy referral and the service availability time periods. It is therefore important that health boards regularly audit their stroke presentation and demand times on the service.

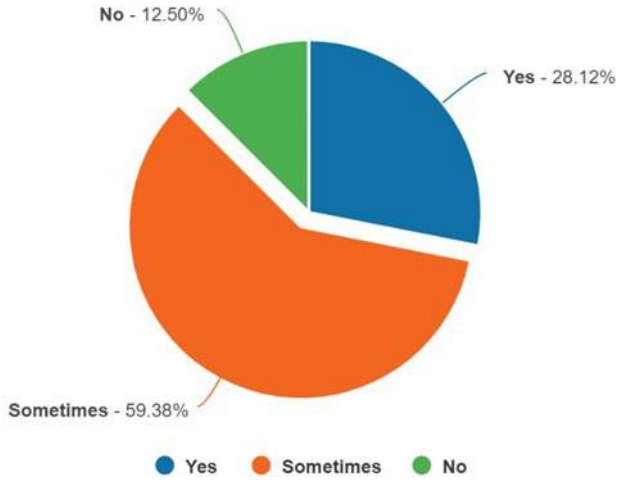
In the absence of a CNS/ ANP, we considered whether stroke patients were reviewed promptly by other stroke team members or medical teams. In our clinical records review, we found that most stroke patients arriving at EDs by ambulance were prioritised appropriately. We also saw evidence of patients who had self-presented at EDs receiving timely and appropriate assessments and investigations. However, we found that patients were not always assessed as promptly and did not

progress through the stroke pathway as effectively, in the absence of a Stroke CNS.

Recommendation 21:

Health boards should review the provision of the CNS or ANP stroke specialist service at each acute site and consider how they can maximise their availability throughout the stroke service.

In our survey, we asked staff whether they could assess stroke patients in a timely manner. Their response is highlighted in the chart below:



It is concerning that only 28% said they were able to assess people in a timely manner, and whilst 12.5% said no, the majority (60%) said they sometimes could.

The reasons highlighted to us as barriers to achieving a timely assessment include:

- Staffing issues or staff capacity
- High volume of patients to assess
- Lack of space or trolley bays in ED
- Increase of patients self-presenting at hospital

In response to our staff survey, we received the following comment which highlights the risk with people self-presenting with a stroke:

'Accident and Emergency unit staff need to be trained to pinpoint stroke pathway. Sometimes when patients have been admitted to hospital, they are not able to access the stroke pathway as efficiently as a patient attending the hospital in an Ambulance, this issue needs to be addressed. If all staff received training, it would benefit patients.'

Recommendation 22:

Health boards should ensure that EDs track and monitor all patients arriving at hospital with a suspected stroke (by ambulance and self-presenting), to drive improvement on assessment times, so people can commence on the stroke pathway in a timely manner.

Stroke assessment tools

As highlighted earlier, to support the stroke assessment process, NICE guidance for stroke states that the diagnosis of people admitted to ED with a suspected stroke or TIA, should be established rapidly, by using a validated tool, such as ROSIER. This will ensure the prompt diagnosis prior to scan of a potential stroke or TIA.

A key example of the benefits for using the ROSIER tool is; if the stroke call is put out by ED staff to alert the medical team of an imminent arrival, and a triage and ROSIER assessment is undertaken by the ED staff promptly, then a CT scan can be booked by the medical team and the patient can be taken directly to the scanner. This is to help ensure no time is lost in diagnosis, particularly when the ED is full, and ambulances are waiting outside to offload patients. Patients could then be moved directly into a space in ED to receive treatment, or placed back on board the ambulance if thrombolysis or thrombectomy is not indicated, to await the next available space in ED, if admission is needed.

The example above further questions if there is a need for WAST paramedics to be trained in ROSIER assessment as highlighted earlier in the report. This assessment could be undertaken at the scene in the community when a patient is displaying stroke symptoms, which may help with the timeliness of assessment, imaging, diagnosis, and treatment at the receiving hospital.

We found that stroke assessments and interventions were being undertaken by clinicians with appropriate expertise in neurological disability, and nursing and medical staff had the appropriate knowledge, skills, and experience to recognise and manage stroke patients. However, we considered whether an assessment tool, such as ROSIER tool was being used in EDs in all health boards.

Whilst the ROSIER tool was in use across Wales, during our fieldwork, this was not always consistent. Our clinical records review and our staff interviews found inconsistencies in the tools used across Wales. Overall, we found good examples of assessment and the use of appropriate tools, however, in some records we did not find evidence that a tool had been used to support diagnosis or treatment plan.

Recommendation 23:

Health boards must ensure that all relevant staff within EDs are trained and are competent to use the ROSIER assessment tool. In addition, that staff are consistently using a validated tool, such as ROSIER, to enable prompt differentiation with strokes or stroke mimics, such as TIA.

Recommendation 24:

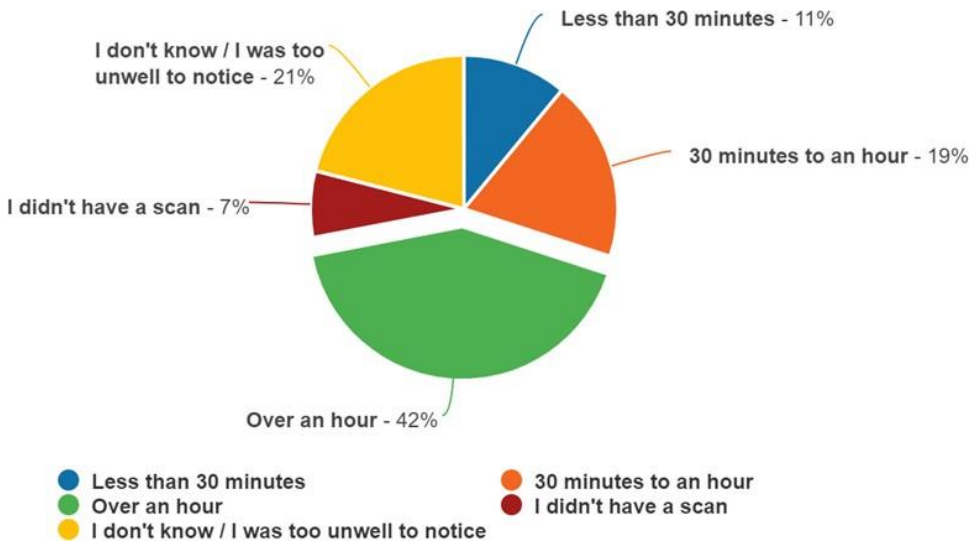
Health boards must ensure that ED staff fully and clearly complete the clinical diagnostic assessment tool for stroke.

Timely imaging

We considered whether patient flow issues through departments impact on timely brain scans. The NICE guidelines for stroke state that specific categories of suspected stroke need to receive a CT scan immediately. That is defined in the guidelines as, ideally the next slot and definitely within 1 hour of arrival at hospital, whichever is sooner. The CT scan will diagnose whether the stroke is due to a clot or a bleed on in the brain and will help determine the required treatment promptly.

In our public survey, we asked peoplehow long they waited before receiving a brain scan after they arrived at hospital. However, it is important to note that for patients who completed the survey, their concept of time during their acute stroke episode may not have been a true reflection of their episode.

Our survey findings are highlighted in the chart below:



On analysis of the survey results, it is concerning to find that 42% of patients felt that they waited over an hour for a scan after they arrived at hospital, which is beyond the recommendations within NICE guidance.

We explored this further through our interviews with staff. We found that staff

endeavour to achieve a brain scan for a patient within an hour. We found good working relationships existed between ED and stroke or medical staff and the radiology teams, which supported timely imaging for stroke diagnosis. We also found that scans are reviewed and reported on promptly by relevant radiology staff. In some health board areas, an after-hours radiology service[54] is utilised to provide interpretations of scans and ensure specialist expertise and round-the-clock support. This means that scans are sent electronically to a radiologist to obtain a rapid report of the scan.

We found a positive initiative within one acute site, where the stroke pathway facilitates symptomatic FAST positive patients (identified by ambulance paramedics), by-passing the ED, and being transported directly to the CT scanning department. This is to help mitigate against any delays with handover at ED and enables prompt diagnosis and subsequent treatment as appropriate.

We were told that the advance imaging can be supported by Artificial Intelligence (AI) for stroke imaging. The all-Wales procurement of AI stroke imaging was completed in Dec 21, and it is now in the implementation phase. This will have a positive impact on the prompt identification of patients for thrombectomy and thrombolysis through stroke imaging. Therefore, patients can access the treatment they need in a timely manner.

Recommendation 25:

All health boards should consider the prompt implementation of Artificial Intelligence for stroke imaging following the completion of the all-Wales procurement which was completed in December 2021.

As highlighted earlier, to support the diagnosis of stroke, consideration should be given to WAST paramedics training in the use of the ROSIER assessment tool for stroke patients. Health boards across Wales in conjunction with WAST, may wish to explore the benefits of direct admission by paramedic to CT scan for FAST positive stroke patients where appropriate.

Through our clinical records review, it was concerning to find that some patients were not consistently receiving a CT scan within the one-hour target. Whilst reasonable explanations were documented in the records for some patients, such as patients not presenting with typical stroke symptoms, other records provided no explanation for the delay.

We also considered SSNAP data of patients scanned within one hour of arrival at hospital. The data reviewed considered the period of April to June 2019, 2021 and 2022. Of the 12 acute sites who now deliver stroke services within Wales, the performance of nine sites dropped between 2019 and 2022 signifying that an increased number of patients waited more than one hour for a brain scan. As highlighted earlier in the report, consideration to the timing of the pandemic must be given when reviewing this data.

[54] Everlight Radiology provide immediate access to radiologists 24/7 and are often replied upon for out of hours service.

Recommendation 26:

Health boards must ensure that the reason for delayed brain imaging is monitored and analysed for possible stroke patients to ensure scans are completed in a timely manner in line with NICE guidance.

Swallow assessment

In line with NICE guidelines, patients with acute stroke should have their swallow screened by an appropriately trained healthcare professional, such as a speech and language therapist or other competently trained healthcare professional on admission or within four hours. If the screen shows signs of difficulty, the swallow should be assessed within 24-72 hours and before the person is given any oral food, fluid, or medication. We considered whether patients received a swallow screen and/or assessment within the timeframe, particularly in the event of a delay in them being transferred from ED to the stroke ward.

During our interviews with ED staff, we were told that rosters aim to ensure there are sufficient staff on duty to complete timely swallow screen and/or assessments within ED, however, this was not always possible due to high turnover of staff at some acute sites, and a high number of bank or agency staff on duty.

Staff in one health board told us that training had recently been completed for ED staff, to help further identify stroke patients and the importance of swallow assessments, which is in line with within the NICE guidance. They told us that this positive action had benefitted patients with timely assessments and demonstrated improvements in their SSNAP data.

Through our clinical records review, it was positive to find that in general, most patients had received a swallow assessment within the four-hour target as recommended by NICE. This included patients who remained in ED awaiting an inpatient bed, and for those who had been transferred to an acute stroke ward.

Impact of flow on prompt stroke treatment

Thrombolysis

People who are diagnosed with an ischaemic stroke and who are eligible for thrombolysis, should usually receive treatment within 4.5 hours of the known onset time of stroke symptoms. However, within the new *National Clinical Guideline for Stroke,* this treatment window has now been increased to nine hours in some instances, if there is specific evidence of the potential to salvage brain tissue through CT perfusion[55]. Therefore, in line with national guidance, treatment can be started between 4.5 and nine hours of known onset of symptoms, or within nine hours of the midpoint of sleep, when they have woken with symptoms[56].

We considered whether issues with flow prevented patients receiving thrombolysis

[55] Perfusion CT is an X ray examination that looks at blood flow and the amount of blood within the brain.
[56] National Clinical Guideline for Stroke for the United Kingdom and Ireland

treatment in a timely manner. Our clinical records review found that decision for thrombolysis was done on an individual patient basis, and is influenced by factors, such as pre-existing conditions and the timing of the onset of symptoms. We found the rationale for decisions were recorded in all relevant notes we reviewed, and treatment commenced in an appropriate time.

We found in some records that thrombolysis was not clinically appropriate, and the rationale for this was documented appropriately. However, it was concerning to find that some reasons for this included a delay in obtaining a CT scan, and delays in patients seeking medical assistance following onset of symptoms. Evidence in one of the records reviewed reflected that one patient who lived in a rural area had been significantly disadvantaged due to their travel time to hospital, which resulted in them missing the four-hour thrombolysis window.

We also considered which staff were trained in thrombolysis administration outside of the stroke or medical teams. Across Wales several appropriately trained ED nurses can administer thrombolysis where required, this therefore meant delays for thrombolysis treatment was minimised.

When staff were asked whether they felt they have had appropriate training to undertake their role, the majority (72%), agreed they had. For those who disagreed, the following reasons were provided:

'I have had no additional stroke training since starting my role, I have learnt on the job.'

'I have been given the opportunity to take part in training however, due to operational pressures I often do the work in my own time.'

'This is very much caseload dependent and staffing dependent. We have significant staffing issues currently therefore our priorities are mainly clinical.'

When reviewing SSNAP data, we found inconsistencies across Wales in the timeliness of thrombolysis treatment. This is not conducive to equitable treatment to people across Wales.

Recommendation 27:

Health boards and WAST must ensure that all staff associated with potential stroke patients are aware of the updated guidance for thrombolysis treatment window of between 4.5 and nine hours, as highlighted within the *National Clinical Guideline for Stroke* updated in April 2023.

Recommendation 28:

Health boards must ensure that sufficient staff in EDs across Wales are awarded time to train and are assessed as competent to administer thrombolysis treatment.

Recommendation 29:

Health boards must ensure that all possible stroke patients who are clinically appropriate for thrombolysis, receive treatment in a timely manner.

Thrombectomy

An alternative procedure to thrombolysis therapy is surgery to remove a blood clot, which is known as a thrombectomy. In the Stroke Association's publication, *What we think about: Thrombectomy*[57], it highlights evidence demonstrating that thrombectomy treatment can significantly reduce the severity of disability a stroke can cause, therefore can result in better patient outcomes.

When clinically appropriate, the NICE guidance states that a thrombectomy should be offered for people with acute ischaemic stroke as soon as possible, and within six hours of symptom onset.

We considered the provision of thrombectomy treatment across Wales. Only Cardiff and Vale University Health Board provides a thrombectomy service.

The service is available Monday to Friday from 09:00am to 5:00pm, and only when expert interventional neuroradiology staff, and the appropriate radiology facilities are available. The service is provided mainly to people who live within the health board boundary. All other health boards in Wales must refer patients for thrombectomy, either to North Bristol NHS Trust where the service is available to patients in Wales daily 8am-midnight, or to the Walton Centre NHS Foundation Trust which offers a 24/7 thrombectomy service. Given the geographical challenges and the impact of ambulance delays across Wales due to handover delays, this impacts negatively on the ability of some people receiving thrombectomy in a timely manner, particularly when thrombolysis may not be clinically appropriate for them.

According to SSNAP data, the annual thrombectomy treatment number between April 2020 and March 2021 within England, Northern Ireland and Wales was 1,763[58].

[57] https://www.stroke.org.uk/sites/default/files/new_pdfs_2019/our_policy_position/psp_-_thrombectomy.pdf
[58] Annual thrombectomy April 2020 to March 2021

It is concerning to find that in Wales, just 13 patients received a thrombectomy at the University Hospital of Wales (for those living in the locality), just 16 patients received treatment in North Bristol and only four patients at the Walton Centre.

This does not appear to be conducive to equitable access to thrombectomy treatment across Wales, and those living within the Cardiff and Vale locality are at an advantage of receiving this type of treatment for stroke to those living in other health boards across Wales.

Our clinical records review found that where appropriate, stroke teams considered thrombectomy treatment for patients, although just one patient was deemed appropriate for the procedure. Whilst it was noted clearly in some records that the patients were not considered suitable for thrombectomy treatment, in several other records there was no evidence to suggest this had even been considered when it is part of the decision-making process for treatment.

Our interviews with stroke clinicians found that there was often consideration of patients who are suitable for thrombectomy, and where referrals have been accepted, there were often challenges with timely ambulance transfers to meet the treatment window target time. This was particularly challenging for cross border transfers, despite inter-hospital transfers for thrombectomy categorised as a 'Red' response by WAST. This may be due to the geographical location of a person, or the availability of an ambulance to transfer the patient in a timely manner.

We recognise that one of the aims within the quality statement for stroke services in Wales as highlighted earlier, is to improve opportunities for patients in Wales to receive thrombectomy treatment and to develop Comprehensive Stroke Centres within a network delivering thrombectomy locally. This is a significant challenge in Wales due to resources across the country and the number of suitably trained people to undertake the procedure. Work to consider this is currently ongoing nationally.

Recommendation 30:

Welsh Government must work with the Thrombectomy Wales Oversight Group, the National Clinical Lead for Stroke, and health boards, to consider how timely and equitable access to thrombectomy treatment for stroke can be made, for all relevant people across Wales.

Recommendation 31:

Health boards must ensure clinicians consider the option of thrombectomy treatment where appropriate, and the decision either way (with rationale), should be clearly recorded within the patient's clinical records.

Recommendation 32:

WAST must consider its current response times for patients awaiting interhospital transfers for urgent thrombectomy treatment which are classified as 'Red'. This is to ensure a thrombectomy can be completed within the six-hour timescale from the onset of symptoms.

Patient flow to acute stroke wards

During our review, we considered whether people are admitted to an acute stroke ward in a timely manner. NICE Guidance (NG 128)[59] states that hospitals should admit everyone with suspected stroke directly to a specialist acute stroke unit after initial assessment, from either the community, the ED, or outpatient

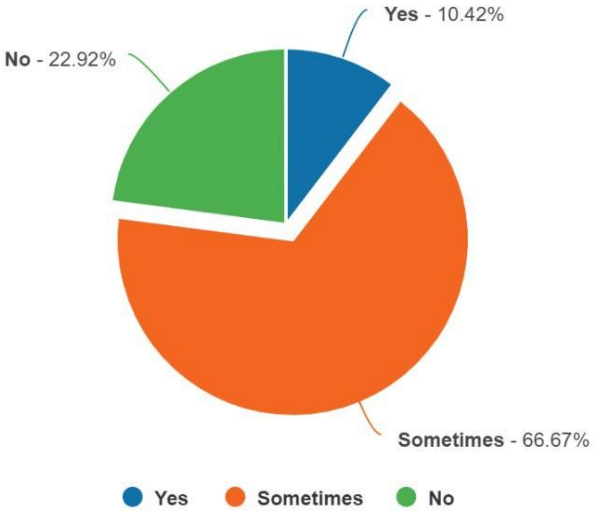
clinics. Acute stroke units can provide care and treatment to reduce long-term brain damage, physical disability, and healthcare costs due to the range of specialist treatments they provide. They are staffed by a specialist stroke multidisciplinary team and should have access to equipment for monitoring and rehabilitating stroke patients.

Acute specialist stroke units are associated with improved patient outcomes. Admission targets to these units should be within four hours of arrival at ED, so specialist treatment can begin as quickly as possible, in line with NICE guidance (NG 128). We found in all stroke pathways across Wales, that admission to a specialist stroke ward/unit, must be within four hours of arrival at ED.

We considered whether issues with poor hospital flow, impacted on the timely admission of people to acute stroke unit in line with NICE guidance. It is concerning to find that just 10% of those who responded to our staff survey said it was possible to transfer patients to a stroke ward when needed, and 23% said no.

This is highlighted in the chart below:

[59] NICE guideline [NG128] Published: 01 May 2019 Last updated: 13 April 2022



This finding was consistent with responses in our staff interviews across Wales, who suggested that poor patient flow within their hospitals prevent patients being transferred to an acute stroke ward in a timely manner.

Our interviews with ED and stroke service staff found, that every effort is made to transfer patients to the acute stroke ward within the four-hour timeframe.

However, they are consistently faced with several challenges in achieving this, which were attributed to patient flow issues.

During our fieldwork, every acute stroke ward across Wales was at full capacity. This resulted in stroke patients either remaining in ED to receive treatment and post treatment care, until a bed became available, or they were being placed as an outlier in another ward.

In our public survey, people told us of delays in their transfer to an acute stroke ward. Comments included:

'Day and a half in A&E before being admitted to ward.'

'Admission to stroke ward not possible, still waiting 13 days after admission when writing this'.

We attended patient flow meetings across Wales and witnessed discussions on how teams tried to accommodate stroke patients on the acute stroke ward. However, due to the system wide flow issues, this was not always possible. We also found in some wards that staff were proactively attempting to receive stroke patients from ED at the earliest opportunity when they had a bed available.

We explored the reason for delays entering the acute stroke ward. Several reasons were provided to us in the staff survey.

These included a lack of bed availability with delayed discharges due to social care issues and outliers of other specialties placed in stroke beds, due to flow issues

elsewhere in the hospital. We were also informed that stroke patients who required transfer to a stroke rehabilitation ward cannot be transferred due to capacity there.

Some comments in our survey from staff included:

'Often due to poor discharge flow from patients awaiting care packages and placements beds are not always readily available when a stroke patient has been identified for the pathway.'

'Bed availability on acute and rehab ward becoming an increasing problem due to the inability to step down patients from the ward and into the community. Bed availability is also taken up on stroke units by non-stroke (medical) patients/admissions.'

'Unfortunately, stroke patients are not always prioritised according to the stroke pathway, and when beds are available the decision on who fills stroke beds is not made by the stroke team.'

In our staff survey, we also asked people to comment on how the NHS could improve the service it provides to stroke patients, one respondent commented:

'Immediate availability of access to stroke ward and the specialist patient care this would provide.'

When beds were not available on the acute stroke wards, we considered whether patients were managed safely and effectively in ED. In our clinical records review, we did not find any evidence to suggest delays in transfer to a stroke ward negatively impacted on the safe and effective care to patients.

Ring-fenced stroke beds

We found that each acute site we visited had a policy to 'ring-fence[60]' stroke beds. Whilst policies are in place to ring-fence beds, this is frequently breached due to the high escalation status of the hospital site and due to overall lack of bed availability in other areas.

Staff within stroke services told us they always aim to ring-fence a stroke bed, but it is frequently not possible due to patient flow issues within the whole system, and they are made to use the bed for a different specialty patient. This frequently results in medical outliers (non-stroke patients), being placed in the ringfenced stroke bed, and stroke patients frequently being placed as outliers on other wards.

This is concerning since this may result in stroke patients not receiving the most appropriate and timely treatment for their condition, and likewise for other

[60] A ring fence bed is a method of protecting an acute bed on a stroke ward from use by patients who are not stroke patients.

specialty patients.

Our staff interviews found that ring-fencing a stroke bed was essential to maintain flow in the stroke pathway. In addition, we asked staff in our survey if they had comments on what could be improved with the flow of patients along the stroke pathway. The most common theme in the feedback related to the need to ring-fence stroke beds for stroke patients. We received 22 comments suggesting the need to maintain a ring-fenced bed.

One comment included:

'We had a ring-fenced bed for a while, but hospital pressures have meant that this is rarely available and so patients need to be moved about to get an appropriate bed on the stroke ward, that can cause delay.'

Delays in accessing stroke beds

We explored the issues around outlying patients on different wards in relation to stroke. The aim was always to transfer patients to a stroke ward as soon as a bed was available. We also found examples that at times, patients may be swapped from other wards to allow for stroke patients to be in the best environment to manage their needs.

Our clinical records review found that patients remained in ED for prolonged periods of time. Some records found overnight delays and instances where patients had remained in ED over 24 hours, prior to their admission to the stroke ward.

Whilst this is not acceptable in the appropriate management of a person within the stroke pathway, it is positive to note that evidence demonstrated that patients received the required care from other specialties, such as therapies staff, in a timely manner.

Despite the continual issues with patient flow to the stroke wards, we found some positive patient experiences for timely transfer. Several clinical records showed that patients had been transferred to the acute stroke ward within the four-hour timeframe. One record highlighted that a patient remained in ED until their condition had stabilised and were transferred to the acute stroke ward within the four-hour timeframe. Other records demonstrated that a bed on the stroke ward was ring fenced for a patient and was not used whilst they received urgent care in ED. Whilst overall, the clinical records were clear and legible, in some records it was not always clear to establish times and dates of transfer of some to the stroke ward.

It is evident from exploring the timely transfer of patient flow to the stroke wards, that there is significant pressure on the whole of the system. Patient flow is a problem across all specialties, and for stroke patients, they are not always placed in right bed in the right place at the right time, due to the high demand on beds.

Recommendation 33:

Health boards must explore the options available to improve the process for prioritising stroke patient admissions to acute stroke wards within the four-hour target, to help maximise their clinical outcome.

Recommendation 34:

Ringfenced stroke beds are frequently used for non-stroke patients, which may impact on a new stroke admission to ED. Therefore, health boards must explore how a ringfenced stroke bed can be maintained, to help ensure the best outcome for a stroke patient following their arrival at ED.

Impact of flow on stroke rehabilitation

NICE guidance (NG128), states that stroke rehabilitation is essential for better patient outcomes. Ideally, this should be provided within a dedicated stroke inpatient unit, and by a specialist stroke team within the community if required.

Across Wales, we found clear inconsistencies for the provision of rehabilitation to people following their stroke. Some hospitals provide rehabilitation within the acute stroke ward since there is no separate ward available to provide this elsewhere. Other health boards have a dedicated rehabilitation ward within the same hospital site, or stroke rehabilitation may be provided within a different hospital site, such as community hospitals.

Early Supported Discharge

Early Supported Discharge (ESD) is an intervention for adults following a stroke which allows their care to be transferred from an inpatient to a community setting[61]. ESD enables people to continue their rehabilitation therapy at home, with the same intensity that they would receive in hospital. However, this may not always be suitable for everyone following a stroke, or in all circumstances, and the decision to offer ESD is made by the stroke MDT, after discussion with the person and their family or carer if applicable.

The stroke MDT will assess whether ESD is suitable for adults who have had a stroke.

The assessment will consider the person's functional, cognitive, and social circumstances, such as the person's ability to transfer from bed to chair independently or with assistance, and whether a safe and secure environment can be provided at home.

When considering the provision of ESD for people following a stroke, we found inconsistencies with the service available across Wales. Not all health boards provide this service and for those that do, there is no standardised format in the

[61] Early Supported Discharge - NICE

provision of ESD. Access to the service across Wales is varied and there is a lot of variation in the service provided in terms of frequency of home visits and intensity of rehabilitation provision).

Our interviews with ESD staff highlighted the significant benefits and positive outcomes for patients who have received ESD. The risks associated with remaining in hospital are minimised, and the psychological impact on patients improves with the ability to be discharged from hospital. We also found that where the service was available, staff reported improvement in patient flow due to savings on patient bed days.

Despite the benefits of ESD, it was disappointing to find inconsistencies across Wales with its provision. When speaking with staff about this, it appears there is a lack of resource or funding available to provide ESD services in some health board areas. This therefore highlights the inconsistencies with equitable access to ESD for people who may benefit from this.

Recommendation 35:

Health boards should consider both the benefits and potential implementation of Early Supported Discharge to patients' physical and mental wellbeing, and to hospitals, with earlier discharge improving flow through the stroke pathway.

Stroke rehabilitation wards

Overall, we found that hospitals with stroke rehabilitation wards provide an environment which facilitates multidisciplinary stroke care, such as nursing, medical and therapies treatment. For hospitals that do not have separate rehabilitation wards, our staff survey highlighted several comments which suggested the need for a step down or rehabilitation ward for treatment to assist with the flow of patients from acute stroke wards. One member of staff commented:

'a dedicated rehabilitation area that would allow for proper dignified assessment and rehabilitation to progress people.'

In one health board, the process was ongoing to separate the stroke ward into acute and rehabilitation wards, and it was also introducing the provision of ESD.

The rehabilitation ward was re-located to community hospital sites which were also in the process of introducing ESD for all three sites. The aim is to facilitate the provision of a seven-day therapies service on the rehabilitation ward, with plans to progress to a seven-day therapies provision at the acute site. The purpose is to improve flow for stroke patients from the acute setting to the rehabilitation ward, and to facilitate earlier discharge to the community with the support of ESD.

Another health board was providing a full therapies service over seven days. Whilst this was positive in enabling earlier discharge of patients, staff told us it was having a negative impact on the weekday provision of care, due to the thin spread

of stroke speciality staff to cover seven days. Our interviews with Senior Managers found that they were considering the options of increasing the staff establishment; however, recruitment to the site was a challenge, due to complexity with discharge planning. Therefore, a high reliance on regular agency and bank staff was necessary.

We received several comments from therapies staff in our survey in relation to this issue, which included:

'Occupational therapy are involved with patients they are able to assist patients to improve ability with increased level of rehabilitation for each patient however this service is very limited. Services need to be seven-day services.'

Physiotherapy stroke service

We held discussions with staff across Wales regarding the provision of physiotherapy services. It was highlighted that it was not always possible to provide the NICE recommendation for 45-minute daily treatment, which was subsequently highlighted in SSNAP data we reviewed. This was due to the high volume of stroke patients and insufficient capacity within physiotherapy teams.

Our clinical records review found inconsistencies in the provision of the 45-minute daily physiotherapy and occupational therapy across Wales. Our staff interviews found this was attributed to the challenge with recruiting staff and several sites we visited were carrying vacancies within their therapy establishments.

We considered the physiotherapy needs of patients during our clinical records review. In some records, we found evidence of patients being assessed in a timely manner and receiving regular physiotherapy as appropriate. However, in some records the physiotherapy notes were not filed within the clinical records and were kept elsewhere. This prevented us from making a judgement on the provision of the service provided to some patients. When considering other records, some demonstrated delays in referral for physiotherapy assessment, or no evidence of physiotherapy intervention despite referral. We also found examples of stroke patients placed as outliers on other wards with no physiotherapy assessments documented. This highlights the importance of stroke patients being placed on the appropriate stroke wards to prevent any issues with not receiving the required treatment.

We received some comments in our public survey relating to physiotherapy services, which support our records review findings, these included:

'The hospital was short of physiotherapists would have liked physiotherapy on a daily basis but this was not possible. The nurses on the ward were not even allowed to help with simple arm and leg exercises.'

'No physio available cos it was a weekend.'

'Treatment/physio was not frequent enough in hospital which had an effect on recovery as the first few weeks/months are critical. No physio sessions on weekends very frustrating.'

'I was prepared to attend physio gym every day but sadly, the facilities were unavailable on weekends, which makes for a very long day with no activity.'

Occupational therapy for stroke services

When considering the records for occupational therapy input, we found similar issues to that within physiotherapy. We found inconsistencies in the patient records, with some areas demonstrating positive evidence of timely treatment, whilst several records had no documentation completed at all.

Issues were also found at times following discharge, for example, when patients were repatriated to other health boards. Patients are sometimes repatriated from acute care, and the receiving health board has not been informed of the need for referral to other services, such as occupational therapy or physiotherapy.

Therefore, delays in the provision of care are inevitable. This is clearly not appropriate for patients who are reliant on additional timely therapies services.

The issue of insufficient provision of therapies for patients was also reflected by respondents to our patient survey when asked what the NHS could do to improve the service it provides for stroke patients. One comment included:

'More physio and speech and language help [is needed] and for a much longer period.'

Speech and Language Therapy (SALT)

As highlighted earlier, a swallow screen must be completed within four hours of admission to hospital for strike patients. If the assessment identifies that a patient has problems with swallowing safely, they should receive a specialist swallow assessment. This should be undertaken within 24 hours of admission, but no longer that 72 hours, as highlighted within NICE guidelines.

Our review of clinical records reflected that most patients had passed the initial swallow screen. Where patients required a referral to SALT, this had been done within the 72 hours. In addition, there was evidence to support that a plan of care had been prescribed to support the SALT assessment.

We also considered whether patients who were unable to take oral nutrition, fluids or medication received other means of nutrition, such as tube feeding with a nasogastric tube (a small tube inserted through the nostril to the stomach), within 24 hours of admission, unless contraindicated following thrombolysis, in line with NICE guidelines.

It was positive to find that for those who may be compromised nutritionally, relevant patients had been referred to Dietetics and Nutrition teams for a nutritional assessment and were prescribed individualised feeding regimes. In addition, oral medication was reviewed to amend either the formulation or the route of administration.

When reviewing SSNAP data we considered the therapy services across Wales and found variances in the provision of therapies within stroke services for patients. Inadequate therapy services have a negative impact on patient recovery from stroke and also impact on discharge planning and patient flow within stroke services. Therefore, health boards must ensure all therapy services for stroke patients are reviewed to consider how each is meeting the needs of patients in line with national guidelines.

Recommendation 36:

Health boards must review their therapies staffing models to ensure there are sufficient resources and staff in place to adequately manage the rehabilitation and recovery of stroke patients in line with NICE guidance.

Psychology support in stroke services

Patients with stroke may suffer psychologically because of their stroke due to the significant impact it may have on their mental and physical well-being. This may include anger, frustration, depression, and anxiety. In addition, to maintain psychological wellbeing, patients should be able to speak in the language of their choice. It is important that health and social care providers maintain the Welsh language active offer for people in Wales, as highlighted earlier in the report. In addition, providers must maintain the ability to provide a translation service for people in other languages, such as Spanish, Polish, Urdu or Chinese. We found that access to a translation service was available in all health boards.

In line with NICE guidance (NG128), people who have had a stroke should have access to a clinical psychologist with expertise in stroke rehabilitation, and who is part of the core multidisciplinary stroke rehabilitation team.

Soon after a stroke, and where appropriate, patients should receive a psychological assessment to assess whether they are experiencing any early emotional problems which may have a lasting impact.

Their psychological needs may fluctuate along the stroke pathway as they recover from the acute stroke, and the reality of any disabilities may become overwhelming. The psychological support alongside physical rehabilitation, can increase a patient's opportunities to engage with rehabilitation and help maximise the outcomes.

We considered the psychological support provided to stroke survivors across Wales and found this to be inconsistent, as not all health boards provide support in this area. Our review of clinical records highlighted the lack of psychological support to patients within several health boards. This was also highlighted through our interviews with staff. We found that one health board within Wales had recently appointed three psychologists. One for each of its rehabilitation sites, along with three assistants. In addition, the staff discussed the positive work in progress, which offers education and training around the psychological needs of the patient, to all MDT members involved with the patients journey through the stroke

pathway.

We interviewed a GP who undertakes weekly ward rounds on a stroke rehabilitation ward in one health board area, which is attended by the MDT members to discuss the progress and needs of stroke patients. They supported the need for psychology input and suggested this service would be beneficial for patients. They highlighted that for stroke patients there may be a need to prescribe anti-depressants to help with their mental well-being, and that complemented by psychology support could improve the rehabilitation process for patients. In addition, having a family member with a stroke can be challenging for families or carers to deal with, and participation in the psychologically and support could also be beneficial for them.

Recommendation 37:

Health boards must consider the need for psychological support for people with stroke, and ensure that adequately trained staff are providing this support to help effectively manage patient recovery.

Overall, we found that therapy services play a key role in the patient's journey through the stroke pathway, and when preparing people for discharge. We found good collaborative working between therapy teams and others within the stroke MDT, however, as highlighted above, further investment may be required in some therapy teams for patient progress, recovery, and overall wellbeing.

In line with the inconsistencies found across Wales, not all stroke services can provide the required timely therapy services to patients. This was for several reasons, such as staff vacancies, the impact of patient flow resulting in different specialty outliers using stroke beds and vice versa and demand exceeding capacity. In addition, the overall environment to conduct therapies on the wards was problematic, relating to facilities and space for timely rehabilitation services.

A holistic approach to therapies is required across Wales, to provide patients with both physical and mental support. This approach would also benefit flow within our hospital system by enabling patients to be discharged timelier and over seven days a week.

Recommendation 38:

Health boards must consider introducing the provision of sufficient seven-day therapies services to comply with NICE guidance, to help improve patient flow by supporting a seven-day discharge for patients, and to help meet targets as highlighted within SSNAP.

Recommendation 39:

Health boards must ensure that stroke rehabilitation environments are appropriate and are adequate to meet the needs of patients.

The impact of delayed discharge on patient flow

Discharge delays for medically fit patients

As highlighted earlier, in June 2022, the Senedd Health and Social Care Committee published its *Hospital discharge and its impact on patient flow through hospitals inquiry* report[62]. The report highlights that in February 2022, there were 1,081 patients who remained in hospital who were medically fit for discharge.

During our fieldwork, staff told us that around a third of all patients in their health board area were medically fit for discharge. Some patients had remained in hospital for months until an appropriate placement or package of care was available to facilitate a safe discharge. Health boards regularly provide up-to-date numbers to Welsh Government of the medically fit people waiting in hospital beds, for a package of care, to enable them to go home, or a care home placement.

Impact of delayed discharge or Delayed Transfer of Care (DTOC) flow

To support our review in relation to patient discharge, our team included a peer reviewer from Care Inspectorate Wales (CIW), who supported our work through interviewing key staff relating to social care and those involved in the discharge planning process. This assisted our team to gain a sound understanding of the challenges related to the provision of social care.

Our report has already highlighted the challenges with the bottlenecks at the 'back door' of the healthcare system with delayed discharge, which impacts on patient flow throughout a hospital. This is felt at the 'front door' where EDs are unable to admit patients from ambulances in a timely manner.

The conclusion to the Senedd's Health and Social Care Committee's inquiry highlights the lack of social care capacity is the biggest contributor to delayed discharges and restricted patient flow through hospitals.

Unnecessary stays in hospital due to delayed discharge of care (or DTOC), can place patients at risk of hospital acquired infections and deconditioning, which can lead to further ongoing care needs following discharge. The bottleneck at the point of discharge can affect Eds, WAST, inpatient care, primary care, planned admissions and staff wellbeing.

To help support the more complex discharges, across Wales, we found teams of staff in post, who had the responsibility for the discharge of patients with complex needs and who, therefore, need detailed planning to implement ongoing support following discharge. This includes patients following a stroke. We will discuss the complexities throughout this section of the report.

Discharging stroke patients

Our review found that most stroke patients have a range of complex needs both

[62] Hospital discharge and its impact on patient flow through hospitals

physical and cognitive. This may include paralysis of limbs affecting mobility, issues with speech or swallow and cognitive impairment. Therefore, they are more likely to need ongoing packages of care at home, which are often complex to arrange. The resource is not always readily available, which may further delay a patient's discharge.

Our interviews with staff consistently found reports that discharge delays and DTOC can lead to worsening outcomes for patients and can also mean that some revert into an acute bed, and also impacts on their long-term care needs. Our staff survey also found similar, and one comment relating to this included:

'It is not good for patients' wellbeing for them to remain in hospital when they are ready to leave.'

Planning for discharge

We considered how the MDTs across Wales planned and prepared for patient discharges from hospital.

Board rounds

We attended stroke board rounds where discharge planning was central to the discussions that took place. They were led by a dedicated member of staff, and had an MDT approach, highlighting key information about each stroke patient, including diagnosis, admission date, care management plan and expected date of discharge. These meetings were consistent across Wales.

We found in most instances, a summary was made at the end of each patient discussion with the aim to highlight any daily tasks required, and the delegated person and task completion date to help ensure patient progress their journey through the stroke pathway to discharge. This also allowed for the opportunity to discuss any patients who were delayed in their discharge or DTOC.

Overall, we found board rounds were dynamic, constructive, and led to clear actions. However, some lacked effective leadership, direction, and decision-making, which in turn increased a risk to timely flow through the pathway, and out of hospital.

Recommendation 40:

Health boards must review their board rounds within stroke wards to consider their efficiency and effectiveness so that any actions identified and resolved in a timely manner to facilitate a timely patient discharge.

SAFER patient flow guidance[63].

The *SAFER Patient Flow Guidance* was published by Welsh Government, and acts as a key enabler for an overarching good practice guide to improving patient flow.

[63] SAFER patient flow guidance

The guide identifies ten areas of focus to support flow across the unscheduled care patient pathway, and *SAFER* fits into one of these ten areas, relating to transfers of care.

SAFER consists of five elements of best practice which are summarised as:

- **S** – **Senior review** of all patients before midday, informed by a multidisciplinary assessment
- **A** – **All patients** and their families involved in the setting of an Expected Discharge Date (EDD)
- **F** – **Flow of patients** at the earliest opportunity from assessment units to inpatient wards
- **E** – **Early discharge** with at least a third of patients discharged from inpatient wards by midday on their day of discharge
- **R** – **Review** of patients involving MDT, the patients, and their families for those with extended lengths of stay.

We considered whether the sites we visited used any tools to help manage flow at a ward level. During our staff interviews, we were told that wards use the principles of *SAFER Patient Flow,* however, our findings from clinical records did not fully support this. We found inconsistencies in the recording of an EDD, or the rationale of why a date had not been considered, and there were also inconsistencies in the evidence recorded relating to the use of 'Red' and 'Green' days[64]. Our attendance at stroke board rounds also found that the use of the *SAFER principles* was not consistent across Wales.

It is evident that treating patients promptly with the appropriate care in the right place at the right time, can enable a person to be supported back to their own home in a timely manner. It is pivotal that all staff work together to manage the issues that may arise through a patient's journey, to be effective. Early planning for discharge is essential, and the individual, their family, and healthcare and social care professionals must work together, to achieve a smooth and timely discharge. This, in turn will help facilitate better patient flow through healthcare systems.

Recommendation 41:

Health boards should ensure that staff are utilising the SAFER Patient Flow principles, to promote safe and timely discharge and help improve patient flow.

Multidisciplinary meetings

We considered how well teams work together to support the discharge process for

[64] The Red and Green Days approach is an example of using simple rules to help reduce delays for patients by making 'non-value' adding days (from a patient perspective) visible, and a daily topic of conversation for clinical and managerial staff. It works particularly well when it is used across inpatient wards where patients often experience significant periods of time waiting for things to happen in their plan of care.

patients. During our fieldwork, we attended several MDT meetings to observe the discharge planning process within the relevant teams. We found the discharge teams help manage the support required for stroke patients, such as arranging and referring patients to appropriate post-discharge services. The teams also consult with services to manage their discharge home from hospital, including packages of social care or transfer of care to other services.

To plan for the discharge of stroke patients from hospital, we found an MDT approach for the continuity of patient care is taken by all health boards. A patient discharge plan is developed on an individualised basis, and includes all patients' needs for their continued rehabilitation and care at home, any community services required to support them, and any equipment or other aids they will need to maintain their care and safety following discharge.

We saw effective communication through all therapy disciplines to manage the flow of a patient through to discharge. In our staff survey, 81% said that there was an effective working relationship between all Allied Health Professions. We found good examples of early planning for discharge, and for ongoing care to facilitate rehabilitation and discharge from hospital. However, there were several prolonged delays in the allocation of social workers to patients, social care packages, and delays in obtaining nursing or residential home placements. This was consistent across Wales.

In line with NICE guidelines, we observed the core multidisciplinary stroke rehabilitation teams discussing individual patients to set and follow-up on goals. The rehabilitation teams consisted of:

- Consultant physicians
- Nurses
- Physiotherapists
- Occupational therapists
- Speech and language therapists
- Rehabilitation assistants
- Pharmacy.

At some MDT meetings clinical psychologists and social workers were also in attendance, however, this varied across Wales. Through discussions with staff, we identified that prior to the COVID-19 pandemic, social workers were present at most MDT meetings to discuss and arrange the social care requirements for stroke patients who were close to the end of their rehabilitation phase and would soon be ready for discharge. Their involvement was described to us as a positive step in enabling a timely discharge. However, during our fieldwork, at most MDT meetings we attended, social workers were not present which added to the challenges of timely discharges.

Within our staff survey, all stroke services healthcare staff who responded, said

there are often delays in the discharge process, and 78% said the delays were frequent. We also received comments in our survey from local authority staff, which included:

'Poor communication between ward staff and social care staff appears to be one of the main reason for inadequate /ineffective discharge planning.

'Social Care is often inappropriately blamed as being the cause of delays when in actual fact the delays are frequently as a result of an internal issue on the ward.'

'One of the fundamental things that would see a marked improvement in discharge planning and make it a positive discharge for the patient would be evidence that a person centred/strengths based/outcome focused conversation has actually taken place with the patients themselves and health and social care staff are clear what matters to that individual. This would then help inform discharge planning and make sure we get it right.'

Communication with social care providers

When considering the perspective of staff who work within the social care system, their response to our survey highlighted issues with the communication with hospital teams. This included inaccurate or insufficient information being provided in the referral process. Only five of 17 respondents said they were given the right information about the patient to assist with discharge. Some comments included:

'Very little information provided, inaccurate most of the time.'

'Not always given correct information in terms of functional ability and rehabilitation / recovery plans.'

'We rarely get any information unless we go looking for it. We spend hours trying to contact the hospital wards and then are told different information depending on who you speak to. Its patchy and unreliable.

The staff nurses are unaware of their own discharge policy as the LA which health forms they need to complete. They ask the SW to take the lead in most meetings as they are just unsure of the process.'

'Agency nurses used to complete referrals are a massive setback as they do not know the patients well enough.'

The findings in our survey clearly highlight issues with communication between healthcare and social care teams. We also found that the view of local authority and social care staff were generally quite negative in relation to the health board's discharge policy. Just over half the respondents said that the health board had not shared their discharge policy with their teams. Ten of the 16 respondents said the health board policy was not easy to understand, and almost all said the policy wasn't followed in practice. In addition, very few said they had sight of the health board policy.

Social care providers also made comments regarding poor discharge documentation, along with the communication for patient discharge plans. These included:

'Hospital discharges are sent out without paperwork and guidelines.'

'Communication between the hospital staff and the home has been lacking at times and the information received from discharge has been wrong.'

'More effective communications between hospital and us on discharge as at times it's very difficult to get the information required until after they are home.'

In addition, nine of the 17 respondents to our local authority survey said it was not clear what was required from them, to meet the needs on discharge. The comments included:

'As information is often limited, we can only work with the information we are given. When information is missing, we do not see the full scope of needs on discharge. Following admission, we often see a higher level of need, and these are addressed when they are realised.'

These comments were supported by information received as part of our social services provider survey, with one staff member commenting:

'Better information and planning for discharge and more communication both verbal and written, from the ward.'

Our staff survey also found that health board staff reflected similar opinions, with around 50% agreeing that patients are discharged with a written and detailed discharge plan, but with insufficient information available to inform the social care teams to support the discharge process. Staff also suggested that the most common reasons for discharge delays, were challenges from family or carers and community support. Supporting the later comment, in our patient survey, only 55% said they had been included in the discharge planning process.

One respondent told us:

'There were obviously insufficient staff, my mother was left on her own feeling very confused with no one to ask about her treatment. As her next of kin, I was given no information about her post discharge care.'

The findings above, in addition to others throughout this report, highlight the need for collaborative work between health and social care services, to improve working relationships and develop a clear understanding across service teams, as to what each sector is doing to progress a discharge and improve outcomes for patients.

Recommendation 42:

Health boards should work collaboratively with local authorities and social care providers to improve the discharge processes in place. This includes the need for improved communication processes, improving the information provided for a robust referral into social care, and the sharing of and compliance with health board discharge policies.

Allocation of social workers

When patients are medically fit for discharge but have ongoing complex needs, they are referred by healthcare staff to Social Services for social worker allocation. Social workers are required for numerous patients, and their role in discharge is to assess individuals to determine the social needs, and to help achieve a safe discharge plan that is considered the best outcome for the patient. They take into consideration patient views and wishes, and often need to balance complex family dynamics.

When exploring the access to social workers, our interviews with healthcare staff highlighted frequent delays with patient social worker allocation and the required assessments. We were told that social worker vacancies across Wales are negatively impacting on timely allocation to patients. Supporting their reflections, nearly all local authority staff who responded to our survey said they were unable to meet the demands on their time at work, and there aren't enough staff to do their job properly.

To help mitigate against staffing issues, some social care teams use agency staff to bolster the service, particularly in areas where recruitment of social workers is a challenge. However, we were told that the use of social worker agency staff can result in some inconsistencies in the service provided. One local authority staff commented:

'Agency [social worker] staff have no understanding of geography or rurality.'

Through our interview process, some healthcare staff shared their frustrations around the delays in the discharge process. They explained that in some localities, the allocation of a social worker was taking up to three weeks. Once a social worker is allocated, further delays are common with their ability to attend the

hospital to undertake patient assessments.

In addition, once the assessments have been completed, and care plans developed there are challenges in obtaining the social care package in a timely manner. This prolonged process is causing unnecessary discharge delays for several patients and is consistent across most health boards.

Other examples provided to us during interviews noted that once referred to social worker teams, staff would not come to assess the patient until a full referral had been completed. The nursing staff often notify the ward or hospital based social worker that a patient will need some assistance on discharge. However, the nurses were often informed that until the referral is received by fax, they would not commence the process of allocating a social worker.

It is evident through our work, that nursing staff do not always have time to sit and complete a full referral when a patient is ready for assessment, since they have several other patients to care for during their shift, as well as arrange discharges and admissions from ED. Sometimes, the referral cannot be completed until the end of a 12-hour shift, and if this were a Friday, then it would be several days before the social worker team would receive the fax and commence the process

from their department. This would unnecessarily prolong the potential discharge of a patient.

In our staff survey, healthcare staff highlighted the challenges they face with the allocation of social workers and eight people made comments in relation to this. One included:

'Long waits for social services and packages of care and inadequate rehabilitation staffing means we can't optimise patients for their best recovery.'

We did, however, find a positive example of good engagement and cross team working with social work teams in one health board area. This was because of excellent relationships between health and social care workers. This enables timely allocation, and assessment of patients to be carried out in some localities, minimising delays with the discharge process for patients.

As highlighted earlier, delayed discharges for patients who are medically fit to leave hospital can impact on some patient's well-being. If they acquire an infection or become deconditioned whilst they are waiting to leave hospital, they may need new or additional treatment. If this does occur, we found that the process for social worker allocation and assessment is stopped if the patient is no longer medically fit for discharge. Consequently, once the patient recovers, the process of allocation and assessment must re-commence, delaying discharge further.

Recommendation 43:

Health Boards and social worker teams must work together to consider and understand the processes in place for social worker assessments and allocation to patients. The reasons for delayed assessment and allocation must also be considered to make improvements in this area.

Recommendation 44:

Welsh Government must consider the process in place for social worker teams and their role in assessment and allocation to patients in hospital, and whether the services across Wales are appropriately funded and managed to support the discharge process from hospital to improve patient flow.

Patient Best Interest Meetings

For patients with more complex needs, and who require a Best Interest Meeting[65] in line with the Mental Capacity Act[66], we considered whether there were delays in arranging these meetings. Consistently across Wales, we found delays in holding a timely meeting on several occasions. This was due to coordinating attendance for all required attendees, which could include MDT members, family members or

[65] Best Interest Meetings take place where a patient lacks mental capacity to make significant decisions for themselves and need others to make those decisions on their behalf.
[66] The Mental Capacity Act is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment.

carers and social work or care home managers. This was also highlighted in our staff interviews, and within our staff survey. One person commented:

'If a patient requires a Best Interest Meeting once clinically optimised, there are delays and difficulties in arranging the meetings to ensure all relevant stakeholders are in attendance.'

Recommendation 45:

Health boards must work collaboratively with social workers and social care providers to ensure that delays in arranging or holding Best Interest Meetings are minimised, to ensure timely and effective hospital discharge for patients to improve flow.

Whole system approach to health and social care

We considered how healthcare and social care teams are working to achieve Welsh Government's long-term future vision of a 'whole system approach to health and social care', as published in its updated plan, *A Healthier Wales: Our plan for health and social care*[67]. The vision outlines a shift over time from the reliance on traditional hospital services providing care to people, to a seamless approach of integrated care, which includes health, local authority and third sector services.

Through our staff interviews across Wales, it is positive to find that several key areas of work are effective in progressing the process of safe patient discharges, which includes stroke patients. As part of this work, some healthcare, social care and third sector teams have been developing new partnerships and implementing new models of 'Home First' and 'Hospital to Home' services in Wales, which is highlighted in the *Home First: The Discharge to Recover then Assess Model (Wales)*[68].

The model highlights the care and support offered to patients, to leave hospital and to receive ongoing assessment and recovery at home, and to limit unnecessary time in hospital settings. Since 2018 the development of Home First and Hospital to Home services and its implementation has been supported by the NHS Wales Delivery Unit, now known as NHS Wales Executive[69].

We found that Home First teams are dedicated in promoting faster discharge from hospital and provide ongoing support to people and can arrange the required packages of care for people who are medically fit for discharge. Welsh Government's long-term objective is for health and social care providers to implement and scale services from a local and regional level to a national level.

Overall, it was positive to hear from staff where the Home First model is effective, and patient discharge can happen more quickly, which in turn assists with the flow of patients through hospital. Our review has identified the benefits of Home First

[67] A Healthier Wales: Our plan for health and social care
[68] Home First: The Discharge to Recover then Assess model (Wales)
[69] NHS Wales Executive

teams, which are making the required difference in line with the set ambition of *A Healthier Wales*. It is therefore important that health and social care teams develop this service to benefit the people who need this across Wales, and to help manage the issues with patient flow through health and social care systems.

Recommendation 46:

Health boards must develop and strengthen Home First services across Wales to benefit the people who need this, and to help manage the issues with patient flow through health and social care systems.

Domiciliary care

During our interviews with discharge teams, across Wales we were told that domiciliary care-packages are difficult to obtain in most health board areas. The most significant issue highlighted, was the recruitment and retention of care workers to provide the social care people need at home. Patients who cannot support themselves at home or who have no other means of care support, cannot be safely discharged. Therefore, increasing the size of the hospital's 'back door' bottleneck.

We found that social care providers have ongoing pressures heightened since the pandemic which includes, staff sickness, low morale, and exhaustion, which impacts on recruitment and retention. It also important to highlight that the complexity of some individuals who are very frail and need higher levels of social care support, often with two carers, has placed additional pressures on social care agencies in their ability to provide care to new patients leaving hospital.

We found that healthcare staff are fully aware of the demands for domiciliary care agencies and their ability to meet demand and are always in frequent contact with them. We were told that in some health board areas, some families are encouraged to seek private domiciliary care where local authority care provision is not yet available. However, this is not always affordable to some, therefore people remain in hospital unnecessarily, which is contributing to the issues with patient flow.

Within our staff survey, most social care staff said that there were challenges of people accessing services to enable appropriate discharge. The comments included:

'Lack of care providers to meet assessed care and support needs. Lack of carers.'

'Care sector is under huge pressures for staff capacity and poor discharges are a growing issue.'

'Lack of stroke rehab services locally both in patient and community.'

Recommendation 47:

Welsh Government, health boards and local authorities must work collaboratively to consider the options of improving the accessibility to care in the community, such as domiciliary care.

Care home placements

Many patients who have sustained a stroke and others who need ongoing long-term care may need to move in to a nursing or residential home following their discharge from hospital.

Our staff interviews found that some health board staff are required to have difficult conversations with patients and their carers or families, around their care home choices. This can also include their finances and potentially paying for long term care placements. We also heard examples where due to the unavailability of domiciliary care services, patients have no choice but to move into a care home for interim periods.

We were told by healthcare staff that patients are often reluctant to enter care homes, as they want to go to their usual residence and often decline a bed when offered.

Many also decline admission to an interim bed placement for reablement, as they are worried of deteriorating and not being able to go home, or they may be faced with the need to pay high charges when their funded placement ends. In addition, for patients who require long term care home placement, many homes are long distances from their usual home and their family, and they often do not wish to move to these homes. We were told that having these conversations is challenging and can be quite upsetting at times, and most do not have experience or training for managing these difficult conversations.

We found that when people need admission to a care home in Wales, the funding process can be complex. In most cases, the person is financially means tested, and in many instances people in Wales are required to self-fund their bed if they haven more £50,000 in capital and assets. If capital and assets are less than this, then a person will likely be eligible for local authority funding. In addition, when some individuals are assessed as having long-term health needs, they may be eligible for NHS continuing healthcare funding. However, if a person does not qualify for this funding, sometimes they may be eligible for NHS funded nursing care, where the NHS will partially fund the placement, for the nursing element of the fees[70].

In our staff survey, people working within social care or local authorities shared comments with us around care home placements, with one comment including:

We have a long waiting list for both domiciliary care and residential and nursing

[70] Care Home Funding in Wales 2023.

placements.'

Reablement services

As part of its Deliver Home First[71] model, Welsh Government suggests that the process of discharge from hospital is a key factor for rehabilitation, and that the lack of support an individual receives leading up to discharge and post-discharge will impact the likelihood of them requiring care in the future.

Reablement services provided support to help people regain their independence after illness or disability, and it is usually provided for a relatively short time, such as weeks rather than months. This may include some stroke patients.

We found that the Continuing NHS Healthcare (CHC)[72] teams and complex care teams work well in their aim is to return people home quickly, however, we were told that where reablement care is needed, there have been waits for this service in some health board localities.

Variations in reablement services

There are variations to reablement services across Wales. Some health boards reported having Home First services available from all their sites.

We heard examples from staff, who said the availability of Home First for 10 days rehabilitation had a positive impact on discharging patients home promptly, and the health board approved funding to allow an extension of the daily working hours.

In other health board areas, we found waiting lists for patients to be discharged through the Hospital to Home schemes[73]; however, transition beds are available for up to six weeks, with funding agreed for up to three times a day.

We found that interim placements in care homes were available in some health boards, and patients were encouraged to utilise these when they were fit for discharge, until their home care was ready to start. These beds are funded by the health boards and at no cost to the patient but had a maximum stay of up to six weeks. Patients or their family/ carers were sometimes reluctant to utilise these beds, as they felt it would hinder their ability to return home, and if it they were not able to leave the home after the set period, they would need to pay for them after that time.

During our interviews, staff told us that the provision of interim or reablement beds in the community is often difficult to obtain. Whilst health boards can fund these beds for up to six weeks, they are associated with very high costs. During one interview, we were told that all care home beds were full within their health board and increased significant pressure on the wards to manage patient flow.

Overall, the provision of early supported discharge is inconsistent across Wales

[71] Delivering Home First. Hospital to Home Community of practice: key learning and practice examples
[72] Any adult who has complex needs and as a result might be eligible for Continuing NHS Healthcare. Continuing NHS Healthcare information booklet for individuals, families, and carers | GOV.WALES
[73] Delivering Home First - Hospital to Home Community of Practice: key learning and practice examples

with peaks and troughs being reported in these services.

Patient home equipment needs

When patients need equipment or small adjustments made at home to support their discharge, we were informed by staff across Wales that this service generally works well. This was a consistent finding across Wales. These teams, based in the community, aim to provide and install home equipment or make minor adjustments quickly to support patient discharges. Overall, we were told the waiting times for equipment assessments, delivery and/or installation was quite low. However, longer waits were reported for home adaptation which required more complex structural alterations.

Whilst health board staff were positive with this in our interviews, several comments within our staff survey of social care providers were not so positive. These included:

'Users are sent home without the necessary equipment in place and the responsibility and stress then falls on the provider to source this and ensure the safety of the users.'

'The industry is under a lot of pressure but when people are discharged unsafely without equipment, and they end up going back to hospital.'

'People are discharged without assessing the environment they are returning to. This means that in some instances people return to hospital as they are unable to live independently as they do not have access to the right equipment and services.'

It is concerning to hear the disparities in staff opinions regarding the availability of equipment. Particularly if healthcare staff suggest the service is working well, yet when social care staff attend people's homes, the required equipment is allegedly not in place. We did not visit people's homes as part of our review; therefore, we cannot establish whether the appropriate equipment was provided in line with assessment pre-discharge and whether the needs changed after a patient was home.

Positive aspects in preparing for discharge

Despite the challenges faced by health board staff across Wales for the safe and effective discharge of patients, our staff interviews highlighted several positive findings. These included the following:

- Occupational therapists and physiotherapists are available at all acute sites and as part of community reablement teams. This means that rehabilitation happens quickly and continues at home or in the community, where possible
- Where discharge coordinator posts exist in hospitals, complex discharges are managed effectively
- Partnership working at all levels is particularly good. Senior managers in both health and social care services are well informed of the issues and challenges with discharge and patient flow. Meetings occur daily and weekly

which focus on delayed discharges

- Where there is agreement for trusted assessors, assessments and care plans are carried out quickly but there is still a delay in obtaining the necessary service provision
- One health board reported operating an effective Discharge to Recover then Assess model with the aim to assess people in their own environments
- Specialist stroke rehabilitation units, with sufficient beds, and appropriate clinical support, allows people to be discharged from acute settings where appropriate
- Step-down beds are available throughout the county at the 10 Community Hospitals
- Integrated teams work well together with all professionals and the third sector playing a key part. The intermediate care teams in the community aim to keep people at home alleviating the pressure on admissions. The health board has invested in intermediate care to support people to remain at home, virtual wards, use of community hospitals for rehabilitation and GP's operate systems of case management
- There is a strong social work team in some parts of the health board, supported by students and agency staff are used where necessary
- Allocation and assessment of cases is therefore carried out speedily in those areas
- The health board has invested in Discharge Liaison Nurses who are part of the multi-disciplinary team.

Overall, we found that when patients were deemed medically fit for discharge, there were frequent lengthy delays in obtaining packages of care for patients across Wales as a whole, with minimal knowledge in some cases of when these packages could commence.

Where a patient was awaiting a placement in a nursing or residential home, we found dates were often set for transfer out, or plans were in place to cover the interim period elsewhere in reablement beds, before the placement was available, however, this was not consistent across Wales due to bed availability.

Discharge or repatriation to several localities

An additional challenge faced by several health boards is the need to discharge to several local authority areas, and the requirements in each can be different.

Whilst overall, relationships with different local authorities were described as good, we were told there are different referral routes, processes, and IT systems in place, which can make the processes difficult to navigate and more complex at times, delaying the discharge process unnecessarily. We were also informed some local authorities receive people to their homes from NHS Trusts in England, or from other health boards, where discharge processes may be different again from the usual discharging health board. This often makes discharge communication more

complex and challenging.

The day of discharge

To help facilitate daily discharges, we considered whether the hospitals we visited had a discharge lounge. A discharge lounge can help improve flow on a daily basis, as patients who are due to be discharged that day can be moved to the lounge to await transport home, or to await medication from pharmacy to take home. This can free up ward beds earlier in the day, which will help with flow across the hospital.

We found that most sites had a discharge lounge. Some lounges had flexible spaces which could be adapted according to demand and patient requirements, such as for a chair or bed. Access to the discharge lounge also varied across Wales, with some open from 8am to 6pm or 8pm, Monday to Friday with no weekend provision.

Our clinical record review found that some discharges took place late afternoon or in the evening. However, in some records reviewed, it was not clear what time of day the patient left the ward, or whether they went to a discharge lounge or other means. Therefore, it was not clear whether the wards had formally completed the timing of discharge process on the electronic patient system, therefore making them appear that they were still in the ward bed. This would make it difficult for patient flow managers to know when the bed is available (or not), which is important particularly when EDs are full, and beds are needed.

We recognise that use of the discharge lounge and accelerated discharge processes may not be clinically appropriate for all stroke patients, particularly those with complex needs, such as physical or cognitive impairments. Staff told us that some stroke wards use their day room for patients to wait for their discharge to help improve the flow through stroke services.

Recommendation 48:

Health boards must consider their discharge lounge services and whether they are utilised efficiently and effectively to support timely discharge to improve patient flow.

Recommendation 49:

Health boards must identify the hospital sites that do not have a discharge lounge service and consider the positive benefits on patient flow of implementing this service.

Recommendation 50:

Health boards must assure themselves that ward staff are promptly declaring a fully completed patient discharge within the electronic patient systems once they have left the ward. This is to enable patient flow managers to see that a bed as become available, to help manage timely patient flow.

Conclusion

It is clear from our findings that the healthcare system across Wales is frequently operating under extreme pressure, with hospitals regularly operating at the highest level of escalation. Poor patient flow is a fundamental issue causing this pressure, and our review has brought to the surface the negative impact this can, and is, having on all patients, not just those on the stroke pathway.

Whilst we have reflected in our review an intention and ambition to tackle this problem, as well as examples of good practice that have made a positive impact in alleviating flow problems, more needs to be done. It is clear that no single solution exists to solve poor flow, rather a range of approaches are required in combination to release the pressures on the health and social care system.

These solutions range from doing more to help inform and educate the public about the choices they make when accessing healthcare services, spreading the positive learning that exists from flow management initiatives within acute hospital settings, and strengthening collaboration and processes around discharge from hospitals between the health and social care sector in particular.

This review used stroke to understand the impact and dynamic nature of flow, and overall, our view is that the stroke pathway is operating effectively to some extent. People receive timely assessment, imaging, and thrombolysis treatment where appropriate. However, access to thrombectomy and the ability to progress people through their recovery and rehabilitation phase, following their stroke, is inconsistent across Wales and needs attention.

Poor patient flow is undoubtedly having a detrimental impact on aspects of the stroke pathway. We have seen the lack of timely packages of domiciliary care, and the availability of community hospital beds or care home beds, resulting in patients remaining in hospital much longer than is necessary. This can lead to patients become deconditioned with a risk that they are no longer medically fit for discharge and require further treatment.

Blockages in the discharge process can cause challenges and pressures across hospital beds, and lead to overcrowded EDs, causing significant issues in the ability of WAST to respond to patients who need emergency care in the community in a timely manner.

It is clear there is an unprecedented pressure across the whole of the health and social care systems in Wales, which has been intensified by the Covid-19 pandemic, however, this pressure is continuing to prevail. Staff are working tirelessly to help manage the flow through hospitals and out to the community. However, despite their best efforts, for a variety of reasons outlined in this report, including demand and system weaknesses this is not leading to a significant improvement in the overall position. Tackling the issue of flow is a multi-faceted challenge that needs the health and social care system, along with Welsh Government, to come together and ensure all is being done to address the issues highlighted by our review.

What Next?

We expect the health boards, Welsh Government, WAST, PHW and Local Authorities to carefully consider the findings from this review and act upon the 48 recommendations set out within the report and listed within Appendix A.

We hope this review will be used to help health boards to improve flow, by encouraging health board teams to collaborate with each other in relation to good practice and innovative practice. In addition, that this work can be a catalyst for improved relationships between health and social care teams.

All relevant stakeholders highlighted within this report are required to submit an improvement plan in response to the review's recommendations. This is to ensure that the matters raised by our review are being addressed.

The findings highlighted in our report, and the responses that we receive, will support HIW in considering whether to undertake further, local or national work.

Appendix A

Recommendations

As a result of the findings from this review, we have made the following recommendations in the table below.

	Recommendations
1	Health boards should engage with each other, to learn from the good patient education practices taking place across Wales. This could help the shared learning with themselves and with GP practices in their localities, to educate patients of the risks for a stroke, to help reduce the number of strokes across Wales.
2	Public Health Wales should consider the development and promotion of a national campaign to raise stroke awareness and its prevention in Wales alongside its Act FAST campaign. This should include raising awareness of stroke prevention within black and minority ethnic communities and the impact of health inequalities and socio-economic deprivation.
3	Health boards and PHW should work closely with Black, and minority ethnic communities and people affected by socio-economic deprivation, to understand the specific issues they face with their increased risk of stroke and in accessing preventative care and ensure ongoing engagement with them to support better health outcomes.
4	Welsh Government, health boards and WAST must work collaboratively, to consider whether the Immediate Release Directions are effective or need improvements, given the high number of declined Immediate Release Directions occurring across Wales.
5	Health boards must communicate with each other to establish the good practices taking in place in some hospitals for the robust management of patient flow. This includes the implementation of effective action plans to manage daily discharges, which remain active throughout the day, and in planning for subsequent days.
6	Health boards must review and consider timelier processes of prescribing take home medication and obtaining this promptly from pharmacy to minimise discharge delays. This should include planning well in advance of the scheduled time for discharge (such as the day before).
7	Health boards should consider the benefits of dedicated ‘discharge phlebotomy slots’ for managing the necessary blood tests, to assist with effective and timelier discharge.
8	Health boards must consider the benefits of Improvement Cymru’s Real Time Demand Capacity methodology, and whether this would have a positive impact to implement (or to pilot) within all hospitals to help manage timelier patient flow.
9	Health boards should reflect on their patient flow processes and consider whether improvements can be made with predictive methodology for demand in each of their hospital sites, such as with medical and surgical admissions.

10	Health boards should consider whether a daily senior nursing/ clinical oversight for each directorate could be implemented to facilitate clinical issues with flow. This may help ensure staff are making timely progress to discharge patients, challenge medical staff to undertake key tasks where necessary, and help expedite any outstanding clinical patient needs. In addition, to commence planning for patient discharge on subsequent days.
11	Welsh Government should consider strengthening its promotion of the *Help Us to Help You* campaign, to ensure people are appropriately educated and understand how to access healthcare in the right place, first time, by guiding them towards the most appropriate care service.
12	Health boards and WAST should engage with people to better understand the barriers to them accessing, or choosing, from the range of healthcare services available in Wales. Once the barriers are understood, this in turn, could be used to influence service design.
13	WAST must ensure that all relevant staff are fully aware of the WAST stroke pathway to minimise risks to patient safety.
14	Welsh Government should consider how it can support WAST to develop and implement improvements with its service delivery model, such as increasing the number of advanced paramedic practitioners across Wales, to help reduce the pressure on EDs and improve flow through healthcare systems.
15	WAST should consider the benefits of training its paramedic staff in the use of the ROSIER stroke assessment tool, to enable staff to differentiate patients with stroke and stroke mimics, such as TIA.
16	Health boards should seek assurance that their MIUs and ED departments ensure all reception staff have received up to date Act FAST training, and they are competent with this. In addition, that appropriate escalation process is in place if a receptionist is or is not sure a patient may be suffering with a stroke.
17	WAST and all health boards must work collaboratively to identify a consistent approach to ensure handover of stroke patients is made within the Welsh Government 15-minute target. This is to ensure that time critical investigations and treatment are undertaken promptly.
18	Welsh Government should work collaboratively with WAST, health boards and social care providers to evaluate and strengthen the current processes in place to improve flow through health and care systems, with a concerted focus on the analysis of flow, the bottlenecks impeding flow and the issues with achieving timely discharge.
19	Health boards must ensure that ED staff undertake the triage of patients within the 15-minute target time. Where this has not been possible, it should be clearly documented 'why not' within the patient's clinical record.
20	Health boards must ensure that medical staff who carry the bleep for stroke alerts recognise the urgency of both thrombolysis and non-thrombolysis stroke calls. A patient may still be symptomatic whilst out of the thrombolysis window but may still be within the thrombectomy time frame. This is particularly important if a referral tertiary centre is relatively close to the ED.

21	Health boards should review the provision of the CNS or ANP stroke specialist service at each acute site and consider how they can maximise their availability throughout the stroke service.
22	Health boards should ensure that EDs track and monitor all patients arriving at hospital with a suspected stroke (by ambulance and self-presenting), to drive improvement on assessment times, so people can commence on the stroke pathway in a timely manner.
23	Health boards must ensure that all relevant staff within EDs are trained and are competent to use the ROSIER assessment tool. In addition, that staff are consistently using a validated tool, such as ROSIER, to enable prompt differentiation with strokes or stroke mimics, such as TIA.
24	Health boards must ensure that ED staff fully and clearly complete the clinical diagnostic assessment tool for stroke.
25	All health boards should consider the prompt implementation of Artificial Intelligence for stroke imaging following the completion of the all-Wales procurement which was completed in December 2021.
26	Health boards must ensure that the reason for delayed brain imaging is monitored and analysed for possible stroke patients to ensure scans are completed in a timely manner in line with NICE guidance.
27	Health boards and WAST must ensure that all staff associated with potential stroke patients are aware of the updated guidance for thrombolysis treatment window of between 4.5 and nine hours, as highlighted within the *National Clinical Guideline for Stroke* updated in April 2023.
28	Health boards must ensure that sufficient staff in EDs across Wales are awarded time to train and are assessed as competent to administer thrombolysis treatment.
29	Health boards must ensure that all possible stroke patients who are clinically appropriate for thrombolysis, receive treatment in a timely manner.
30	Welsh Government must work with the Thrombectomy Wales Oversight Group, the National Clinical Lead for Stroke, and health boards, to consider how timely and equitable access to thrombectomy treatment for stroke can be made, for all relevant people across Wales.
31	Health boards must ensure clinicians consider the option of thrombectomy treatment where appropriate, and the decision either way (with rationale), should be clearly recorded within the patient's clinical records.
32	WAST must consider its current response times for patients awaiting interhospital transfers for urgent thrombectomy treatment which are classified as 'Red'. This is to ensure a thrombectomy can be completed within the six-hour timescale from the onset of symptoms
33	Health boards must explore the options available to improve the process for prioritising stroke patient admissions to acute stroke wards within the four-hour target, to help maximise their clinical outcome.
34	Ringfenced stroke beds are frequently used for non-stroke patients, which may impact on a new stroke admission to ED. Therefore, health boards

	must explore how a ringfenced stroke bed can be maintained, to help ensure the best outcome for a stroke patient following their arrival at ED.
35	Health boards should consider both the benefits and potential implementation of Early Supported Discharge to patients' physical and mental wellbeing, and to the hospitals, with earlier discharge therefore improving flow through the stroke pathway.
36	Health boards must review their therapies staffing models to ensure there are sufficient resources and staff in place to adequately manage the rehabilitation and recovery of stroke patients in line with NICE guidance.
37	Health boards must consider the need for psychological support for people with stroke, and that adequately trained staff can provide this support to help effectively manage patient recovery.
38	Health boards must consider introducing the provision of sufficient seven-day therapies services to comply with NICE guidance, to help improve patient flow by supporting a seven-day discharge for patients, and to help meet targets as highlighted within SSNAP.
39	Health boards must ensure that stroke rehabilitation environments are appropriate and are adequate to meet the needs of patients.
40	Health boards must review their board rounds within stroke wards to consider their efficiency and effectiveness so that any actions identified and resolved in a timely manner to facilitate a timely patient discharge.
41	Health boards should ensure that staff are utilising the SAFER Patient Flow principles, to promote safe and timely discharge and help improve patient flow.
42	Health boards should work collaboratively with local authorities and social care providers to improve the discharge processes in place. This includes the need for improved communication processes, improving the information provided for a robust referral into social care, and the sharing of and compliance with health board discharge policies.
43	Health Boards must work collaboratively with social worker teams to consider and understand the processes in place for social worker assessments and allocation to patients. The reasons for delayed assessment and allocation must also be considered to make improvements in this area.
44	Welsh Government must consider the process in place for social work teams and their role in assessment and allocation to patients in hospital, and whether the services across Wales are appropriately funded and managed to support the discharge process from hospital to improve patient flow.
45	Health boards must work collaboratively with social workers and social care providers to ensure that delays in arranging or holding Best Interest Meetings are minimised, to ensure timely and effective hospital discharge for patients to improve flow.
46	Health boards must develop and strengthen Home First services across Wales to benefit the people who need this across Wales, and to help manage the issues with patient flow through health and social care systems.

47	Welsh Government, health boards and local authorities must work collaboratively to consider the options of improving the accessibility to care in the community, such as domiciliary care.
48	Health boards must consider their discharge lounge services and whether they are utilised efficiently and effectively to support timely discharge to improve patient flow.
49	Health board must identify the hospital sites that do not have a discharge lounge service and should consider the benefits of implementing this service on improving patient flow.
50	Health boards must assure themselves that ward staff are promptly declaring a fully completed patient discharge within the electronic patient systems once they have left the ward. This is to enable patient flow managers to see that a bed as become available, to help manage timely patient flow.

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

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

WG47778

Digital ISBN 978-1-83504-616-6

Healthcare Inspectorate Wales Annual Report 2022-2023

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Healthcare Inspectorate Wales (HIW) is the independent inspectorate of the NHS and regulator of independent healthcare in Wales.

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our goal is

To be a trusted voice which influences and drives improvement in healthcare

Our values

We place people at the heart of what we do

We are

Independent
We are impartial, deciding what work we do and where we do it

Objective
We are reasoned, fair and evidence driven

Decisive
We make clear judgements and take action to improve poor standards and highlight the good practice we find

Inclusive
We value and encourage equality and diversity through our work

Proportionate
We are agile and we carry out our work where it matters most

We have set four strategic objectives through which we deliver our goal of influencing and driving improvement in healthcare.

01

We will focus on the quality of healthcare provided to people and communities as they access, use and move between services

02

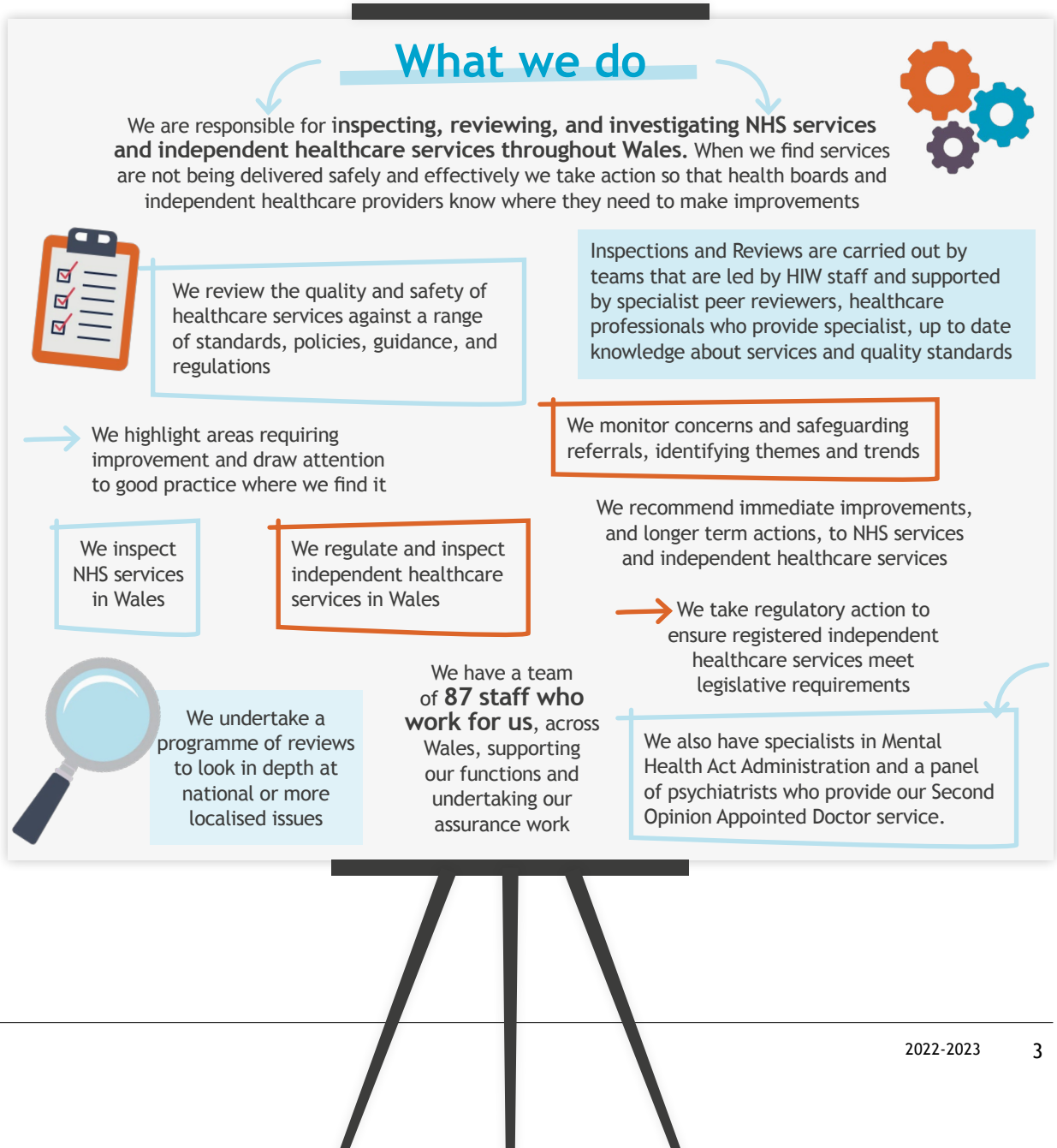
We will adapt our approach to ensure we are responsive to emerging risks to patient safety

03

We will work collaboratively to drive system and service improvement within healthcare

04

We will support and develop our workforce to enable them, and the organisation, to deliver our priorities



Contents

Foreword

Alun Jones
Chief Executive

Welcome to our Annual Report for 2022 – 2023. This Summer marked the 75th anniversary of the National Health Service (NHS), and most people living in Wales today will not have known a time without this institution.

A key milestone this year was the introduction of The Health and Social Care (Quality and Engagement) (Wales) Act 2020. The Act aims to strengthen the overall focus on delivering quality services, and improving engagement with the population across Wales, both in terms of better understanding their needs and improving openness and honesty when things do not go right. The key focus of HIW's work, is to provide an independent view and assessment of the quality and safety of healthcare services. During 2022 – 2023, we have aligned our approach to seeking assurance in preparation for taking account of how well healthcare services are embedding their responsibilities against the duties of the Act.

This report sets out our key findings from the regulation, inspection, and review of healthcare services in Wales. It outlines how we carried out our functions across Wales, seeking assurance on the quality and safety of healthcare services through a range of activities including inspections and review work in the NHS, and regulatory assurance work in the independent healthcare sector. It provides a summary of what our work has found, the main challenges within healthcare across Wales and provides our view on areas of national concern.

In providing an independent view of healthcare services, we seek to contribute to an understanding of the risks and challenges that are preventing services from operating effectively and impacting on the quality of care being delivered to patients.

This has once again been a turbulent year for healthcare services in Wales. Whilst there are initiatives in place to help support healthcare services cope with unrelenting demand,

> **"Whilst patients may well have been satisfied with the staff providing their care, they were not satisfied with the long waits and difficulty in getting treated by services in a timely manner."**

our work during this year did not find evidence of these making a clear and significant difference to services at the front line. Increasingly, we have needed to make in year changes to our programme of work to enable us to undertake inspections in the areas of highest risk. Whilst patients may well have been satisfied with the staff providing their care, they were not satisfied with the long waits and difficulty in getting treated by services in a timely manner. Whilst staff continued to describe their passion for working with people and supporting people with care, they were not satisfied with the immensely pressured environments of work they find themselves in on a daily basis.

Our role covers the regulation and inspection of independent healthcare services in Wales. These services represent an area of growing importance, where innovations in science and technology mean the frequent development of new treatment options and services, many of which are offered by the independent healthcare sector. Many of the specialist mental health care beds in Wales are provided by independent healthcare providers. The sector cares for some of the most vulnerable patients in Wales, dealing with high levels of risk and complex needs. Our work over this time has sought to challenge the sector to ensure that the standards and quality provided are in line with their regulatory responsibilities and provide a quality service to the patients they care for.

Our work within NHS acute hospitals has shown the intense daily pressure in patient admission areas and on inpatient wards. Within Emergency Departments across Wales, we have noted overcrowding, long waits for triage and long waits for treatment, plus ongoing delays in being admitted into the most appropriate beds. Our work over this period has also shown that within General Practice and Dentistry, access to NHS services remains a matter of real concern to patients. When we refer to access, we are describing the ability to source appointments and/or to be registered as a patient with either a GP or Dentist. Once patients are in direct receipt of care and treatment from the NHS, either within Primary or Secondary care services, they consistently told us how well they felt they were being cared for and recognised the professionalism of staff. Through our work we have once again seen a highly skilled and committed workforce, delivering care with compassion and innovation. The workforce of the NHS remains its biggest asset and building on the many positives, with staff, will remain central to navigating the challenges that lie ahead.

We have found one clear issue throughout our work, which is, that at any junction in the care and treatment pathway of a patient, there is huge potential for delay, a pause in treatment, and an overall introduction of risk that is not there at other times. Our work within mental health, for example, has found that this is the case when patients with a diagnosis and care and treatment plan are moving from one part of the service to another.

We have also continued to find that inefficiencies in record keeping and in record keeping systems introduce unnecessary risk into the continuity and quality of patient care.

Three key themes to have arisen from our concerns monitoring service, which takes calls and information from members of the public, are the difficulty in accessing a regular dentist and getting any dental care; difficulty in getting an appointment with a GP; and difficulty in accessing mental health services. This feedback from members of the public is highly concerning and is an early warning of future public health challenges which must be heeded.

Our objectives are ambitious and through them we aim to make a difference to the people of Wales by contributing to improvements in healthcare. In this report you will find some examples of how we have used our work to further this aim. I am proud of the organisation I lead, and the contribution we can make to healthcare in Wales.

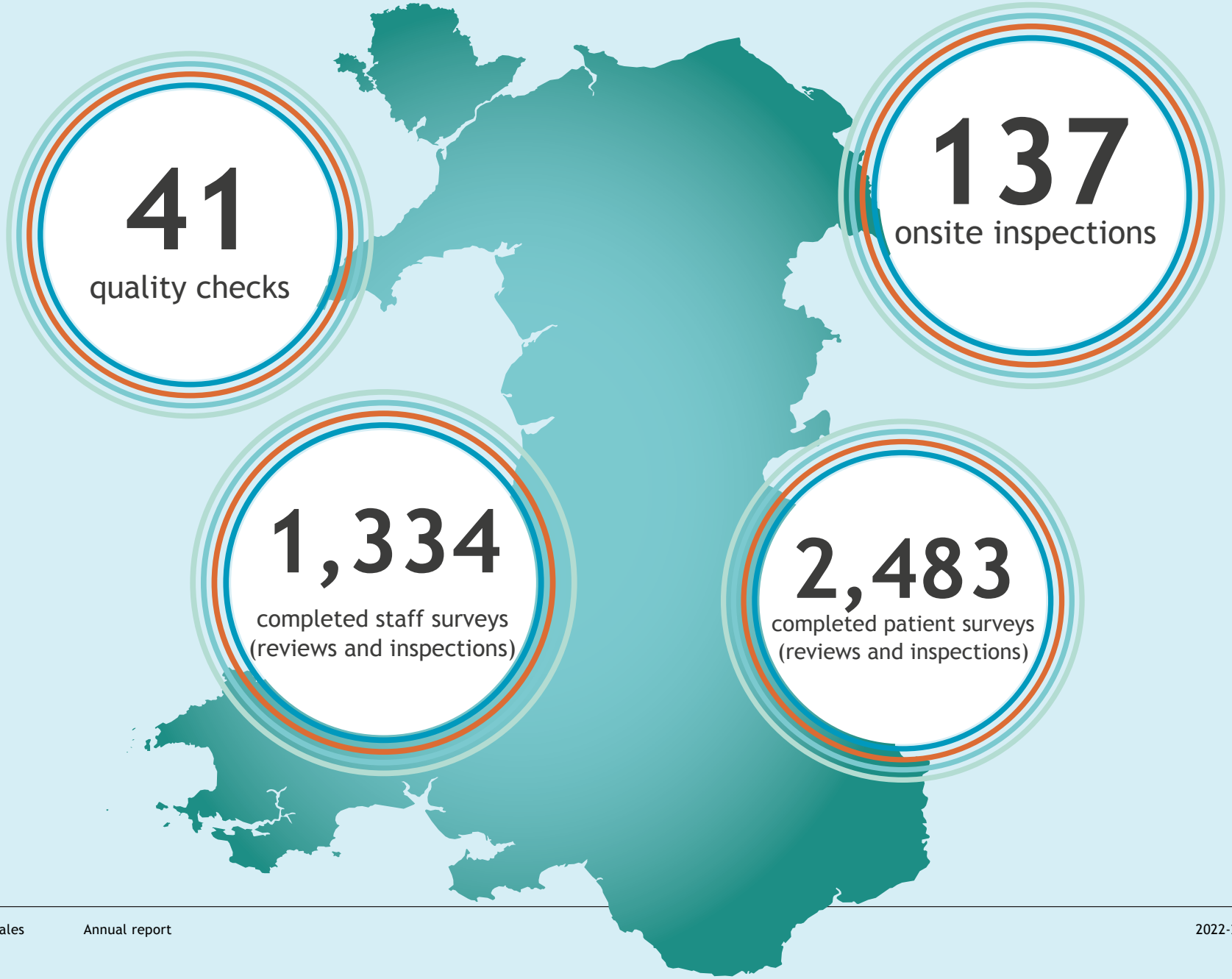
Now, more than ever, healthcare in Wales needs continued innovation, and a vision and understanding of what works and what does not. We have a clear role in illustrating, through our work, what good quality looks like within services and where we find issues with quality we will continue to shine a light on these, pushing services to put them right.

If you have any questions, comments, ideas, or feedback on our work, please do get in touch with us – we would love to hear from you.

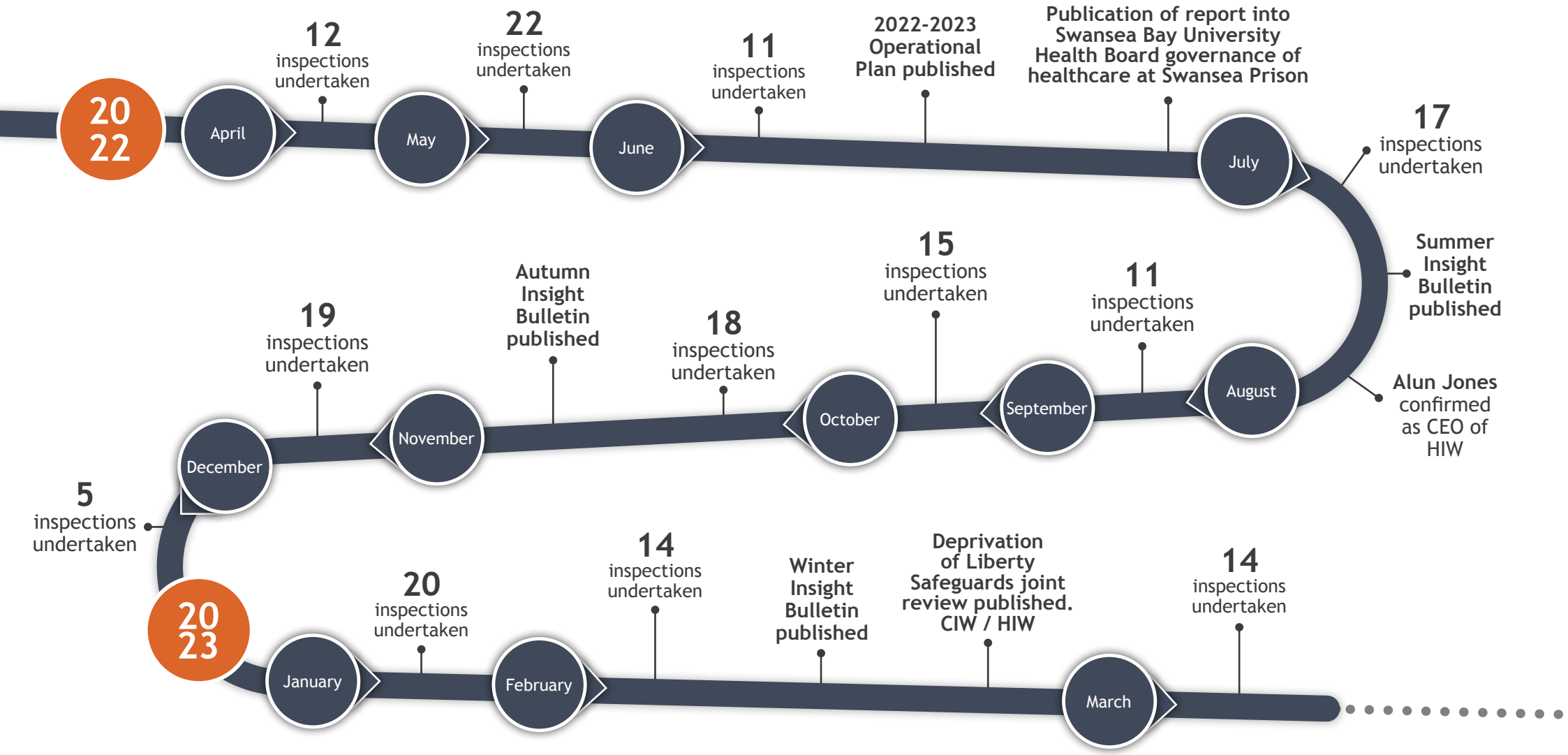
Alun Jones

Chief Executive
Healthcare Inspectorate Wales

HIW in Numbers


41
quality checks
137
onsite inspections
1,334
completed staff surveys
(reviews and inspections)
2,483
completed patient surveys
(reviews and inspections)

Timeline of our work



Engagement and Collaboration

Engagement

Speaking and listening to people who use healthcare services and who work within healthcare services is a key priority for us, and something that we are also committed to improving on. By listening to people who use and work in services, we can better understand what matters to people and can gain a greater understanding of the culture within a service and insight into the experience patients receive.

Across our inspection, quality check and review work, 4,677 people gave us their views on the care they had received, or the service they were working within.

Of the 4,677 separate responses, 4,107 related to our inspection activity and 570 related to our review work.

We heard from:

2,633 patients overall

1,826 staff overall

99 Carers / family members

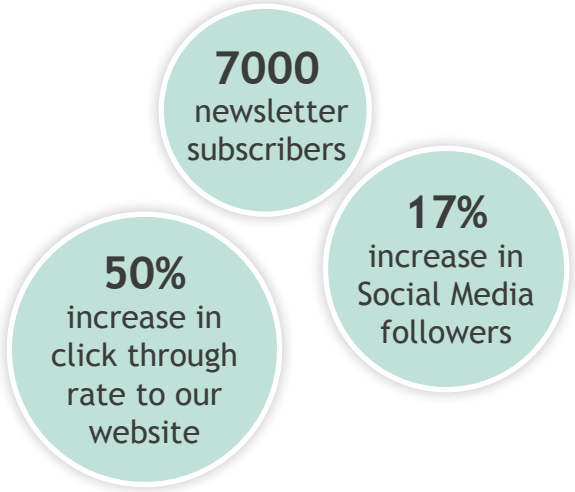
During our inspection and review work we ask patients to tell us about the care they receive by completing a short survey. When we are able to speak to patients in person during onsite visits, we gather views directly. We are also now using videos on our social media channels to help explain and promote our work.

In February 2022, we launched on LinkedIn and in our first year we have reached 7k users. This channel is providing a useful additional avenue for engagement with healthcare professionals. We have continued to use Twitter and Facebook to engage widely with social media users about our work, encouraging people to click through to our website where they can find out more about our work and role in Wales. We have seen a 50% increase in people clicking through to our website from our social media posts. We aim to post varied and interesting content across all three social media channels, posting 1.5k times during the year and seeing a 17% increase in our followers.

This is not our only means of engagement, in the spring of 2022, we launched our new Insight Bulletin. This is a quarterly update which we issue electronically to over 7000 subscribers on our mailing list. Within this we summarise our work from the quarter, and in summer 2022, added a new Learning and Insight section to the bulletin, providing us with a central area to share themes and learning emerging from our work.

We implemented a new approach to report writing in April 2022 which involves publishing a public summary and a full detailed report for the setting. We also updated our report writing style, removing duplication, and making the content easier to read.

In early 2022, we launched our HIW Stakeholder Advisory Group. Membership of the group is made up of a wide range of organisations who work with and represent people with protected characteristics. We are immensely proud of this group and it has continued to strengthen during the year. The group has influenced the way in which we ask patients for feedback during inspections and reviews and has challenged us to think more critically about the way in which our work is both designed and delivered so that we are able to capture as diverse a range of views as possible. The group is one of the ways in which we are working towards our strategic priority of better understanding the quality of healthcare being delivered to people and communities as they access, use and move between healthcare services.



Collaboration

We place considerable importance on collaboration and joint working with other organisations. The added insight and expertise we can draw on when we collaborate with others increases the impact of our work. The provision of healthcare is complex and sharing intelligence with partners enables us to gain insight and experiences that, with our organisational resources alone, we would not be able to achieve.

During 2022-2023, we hosted two Healthcare Summits, attended by regulatory and improvement bodies for healthcare across Wales. Healthcare Summit meetings take place bi-annually to enable discussion between audit, inspection, regulation, and improvement bodies.

They provide an interactive forum for sharing intelligence on the quality and safety of healthcare services provided by NHS Wales. The meetings enable us to foster close working relationships, and share intelligence between participating organisations as we all play our respective roles in driving healthcare improvement in Wales.

During the year we continued to work closely with our partner, Care Inspectorate Wales (CIW). In February 2023 we jointly published our report into the use of Deprivation of Liberty Safeguards (DoLS) in Wales. The Safeguards apply to people over the age of 18 in hospitals or care homes, who cannot consent to treatment or care.

Since 2019, we have been part of Joint Inspections of Child Protection Arrangements (JICPA), working alongside Care Inspectorate Wales (CIW) plus Estyn; Her Majesty's Inspectorate of Constabulary and Fire & Rescue Service (HMICFRS) and Her Majesty's Inspectorate of Probation (HMI Probation) to carry out this work.

In 2022-2023, we continued this work and published our findings of a review of the multi-agency arrangements in Denbighshire for responding to cases of abuse and neglect.

The report outlines our findings about the effectiveness of partnership working and the work of individual agencies in Denbighshire.

In common with many areas across Wales, we found the challenges in recruitment and retention of staff across key agencies in Denbighshire was impacting on the arrangements for safeguarding children. This is made more difficult by the high levels of demand and increasing complexity of children's needs.

We found there are systems and relationships in place to facilitate effective partnership working where a child is at risk of harm. Partners are working to a shared ethos of safeguarding children at different levels of vulnerability. Organisational leaders have a shared vision with a positive approach to regional safeguarding arrangements.

This clear strategic commitment has resulted in the commissioning of a sufficient range of effective local services to support children and families.

Assurance and Inspection Findings NHS Services

Acute Hospital Inspections

In 2022 – 2023, we carried out 19 acute hospital inspections across Wales.

We visited all Health Boards and Trusts where inpatient care is provided.

Our work showed that in general, the demand for inpatient beds and having enough staff to manage the high number of patients was a significant challenge.

The numbers show that we did more of our work in unscheduled care areas compared to scheduled care. The reason we did this was because of the complexity and overall higher risk level in these areas. Across these pieces of work, we needed to use our Immediate Assurance process in 58% of the inspections (11 out of 19). This is a highly concerning figure and demonstrates that at present, acute inpatient healthcare carries the highest level of risk in services across Wales. This figure is currently higher than we found in our inspections of mental health services, an area of healthcare which historically tends to see very high levels of patient risk. This latest finding indicates that mental health services are tackling the risks they face more successfully and strongly suggests that within inpatient acute care, more needs to be done to tackle risk, and quickly.

In the previous year, we introduced our Service of Concern process for the NHS. In 2022 – 2023, we considered 13 NHS services through this process which involves increased scrutiny of the issues identified through inspection and intelligence. In May 2022, we designated the Emergency Department at Ysbyty Glan Clwyd, Betsi Cadwaladr University Health Board as being a Service Requiring Significant Improvement (SRSI) which is a service with the most significant levels of risk.

Our findings on a national level, from our assurance and inspection activity were:

Huge demand for services continues

Compliance with mandatory training remains mixed and in general, across Wales, there are challenges in ensuring the workforce keep this up to date

The quality of the discharge planning process needs to be improved

Reducing risks within the inpatient environment is something that needs to be improved on. For example, we continue to find medicines unsecured, harmful substances not locked away and equipment not maintained as regularly as needed.

In 2021-2022, our work found evidence of significant pressures in the emergency care system. In 2022-2023, our overall summary is the same and if anything, pressures have increased. These pressures mean that we have seen overcrowded emergency departments, delays in ambulance handover of patients, long waits for triage and long waits for treatment to start. This of course, is not the finding in all instances, but the cases where we saw delay represent the majority rather than the minority. The challenge for staff working at the front line within these emergency and urgent care areas is enormous and the impact on them is equally huge.

The challenge within planned care areas differs in that there are huge challenges in getting patients discharged to more appropriate placements, or back home with support. There are often delays in this due to shortages in social care staff and social workers to assess discharge needs. Patients frequently stay in hospital beds for a long time after they are medically fit to leave because of the unavailability of support services.

When patients are able to be seen and treated by emergency and urgent care services, then admitted and cared for as inpatients, and discharged as soon as they are medically fit, the outcomes for them are far more positive then when they are delayed at each stage of their journey. The delays being experienced lead to adverse patient outcomes in the form of deconditioning, higher risk of hospital acquired infections, loss of social networks and, the initial assessment of support needs on discharge no longer being accurate and needing to be repeated due to a change in condition.

This year, once again, we found that in planned care areas, such as oncology and cardiac wards, where the staff have more control over admission and can provide more patient centred care, there were fewer areas requiring improvement.

Although responses we received to our staff questionnaires indicated low staff morale, particularly related to challenges around staffing numbers and high demand for services, this did not generally seem to impact on the experience patients had of staff. Patients told us staff were kind and compassionate.

Our inspections continued to note low levels of compliance with mandatory training for staff. Mandatory training plays a key role in ensuring staff can provide safe and effective care to patients.

The case studies demonstrate two of our pieces of work from 2022-2023 relating to acute hospitals in the NHS. This work, challenged services and health boards to look for different ways of doing things when outcomes for patients could be improved.

CASE STUDY

National Review of Patient Flow a journey through the stroke pathway

Ineffective and inefficient patient flow can have a significant impact on the quality and safety of patient care. Our national review of Patient Flow continued during 2022 – 2023 to explore this.

At a time when the NHS in Wales has continued to deal with significant pressure, staff shortages and huge demand for beds, the review explored the challenge of trying to provide timely care to confirmed stroke patients when resources are under such demand.

In order to assess the impact of patient flow challenges on the quality and safety of patients awaiting assessment and treatment, we elected to focus our review on the stroke pathway. National reviews are deep dive pieces of work which enable us to explore a service, care pathway, or department in depth.

During the period from April 2022 to the end of March 2023, we gathered evidence about the care and treatment provided to patients on the stroke pathway across Wales, undertaking nine site visits in total. The site visits involved our review team consulting with health boards in Wales including the Welsh Ambulance Service Trust (WAST), reviewing the processes in place from calling an ambulance to arrival at an emergency department, to admission when patients were receiving inpatient care and through to discharge.

The review found a high demand for inpatient beds and complexities involved in discharging medically fit patients from hospitals which led to the acute hospital system in Wales operating under extreme pressure. Unnecessarily long stays in hospital due to delayed discharge can place patients at risk of hospital acquired infections or deterioration whilst awaiting discharge. The bottleneck at the point of discharge has a knock-on impact on emergency departments, ambulance response times, inpatient care, planned admissions and overall staff wellbeing.

CASE STUDY

Inspection of Maternity Services, Glangwili Hospital, Hywel Dda University Health Board

HIW completed an unannounced, onsite inspection of the maternity unit across three consecutive days in November 2022, this included the antenatal and postnatal wards, the midwifery led unit, the labour ward and the triage assessment area. Inspectors found the maternity care provided had improved since HIW's previous inspection in 2019, but there were still some areas which required attention.

We found staff were committed to providing a high standard of care to patients. There were many examples where the inspection team witnessed staff being compassionate, kind and friendly to patients and their families. Most patients we spoke to told us they were happy and receiving good care at the hospital. Inspectors also noted that there were good arrangements in place to provide patients and families with bereavement support. We considered the quality of management and leadership, and the culture of the workforce, to be very good.

Staff were encouraged and supported to become involved in quality improvement projects to enhance the care provided, and to aid their ongoing development. Staff were positive about the support and leadership they received and described a positive culture around reporting and learning from incidents. Inspectors noted that the leadership team were visible, supportive, and very engaged with the staff. There was dedicated and passionate leadership displayed by the Head of Midwifery, who was described as energetic, approachable, supportive and visible. There was also a focus on staff wellbeing, including good welfare support and team building activities. Improvement had also been made to collaborate with other health boards effectively.

Some women on the post-natal ward indicated that when they required pain relief, it was not always given in a timely manner, or they were not given an explanation as to why they could not receive the medication. The health board must ensure that there is efficient, safe, and timely administration of pain relief for patients.

Inspectors evidenced improvements had been made regarding security measures to ensure babies were safe and fully protected within the hospital. However, on the first night of the inspection, inspectors noted that the cupboards containing patient records were unlocked and the doors were open. Inspectors immediately raised this with senior management and the cupboard doors were subsequently locked. Management must ensure staff are locking medication fridges and cupboards containing patient records when not in use. We also found that not all staff were compliant with mandatory training and that management needed to ensure rotas are reviewed to ensure there is sufficient resourcing.

Some staff we spoke with raised a concern in relation to the variance of responsiveness of consultants to an emergency when requested by junior doctors and midwives. This was also echoed by comments made in the staff survey we undertook.

We found that there had been significant improvements made since our previous inspection in 2019. There were well-defined systems and processes in place to ensure that the hospital focussed on continuously improving its services. This was achieved through a rolling programme of audit and an established governance structure, which enabled key/ nominated members of staff to meet regularly to discuss clinical outcomes associated with the delivery of patient care.

Ongoing improvements need to focus on staff compliance with the clinical room processes, such as medication fridges being consistently locked when not in use and cupboards containing patient records being always locked.

General Practice

During 2022-2023 we carried out 20 pieces of assurance work to GP practices across Wales. nine of these used our remote Quality Check methodology and 11 were onsite inspections. We needed to use our immediate assurance process in 30% of these inspections (6 out of 20 pieces of work).

This inspection year marked our first using our newly refreshed General Medical Practice (GP) methodology. The updated methodology considers the wider primary care landscape including referrals and signposting to other services.

GP practices are under significant pressure and are facing unprecedented demand. Long wait times at Emergency Departments and on long waiting lists for treatment are increasing the pressure on GP services. We used our immediate assurance process, reflecting high risk to patients, on more occasions during 2022 – 2023 compared to the previous year.

We found a range of issues such as:

- Incomplete safeguarding records and poor follow up of concerns
- Checks of emergency equipment and drugs not completed
- No DBS checks on staff including administrative and reception staff
- Medicines not safely stored
- Medication fridge temperature checks not completed
- Poor compliance with mandatory training including safeguarding, CPR and infection prevention and control
- Out of date equipment including sterile sutures, sterile gloves, urine sample collection packs, minor surgical operations packs and needles, some of which were dated 2006.

20 pieces of assurance work

11 Onsite Inspections

9 Quality Checks

Our patient experience surveys regularly conclude that staff treat patients with dignity and respect, but around a quarter of patients tell us they struggle to access an urgent appointment.

Difficulty in accessing GP appointments was one of three clear themes to come out of our HIW Concerns service during 2022-2023.

The effects of delayed appointments on patients encompass physical health, emotional well-being, and overall healthcare experiences.

Delayed access to medical care can lead to worsened health conditions. Conditions that could have been treated effectively with timely intervention might deteriorate, resulting in prolonged suffering, increased complications, and potential long-term consequences. Chronic conditions may worsen, requiring more complex interventions and leading to avoidable hospitalisations.

Patients who struggle to obtain appointments often experience heightened anxiety and stress. The uncertainty of not knowing when they can see a doctor can exacerbate existing mental health conditions or trigger new ones. This emotional toll can further impact their ability to cope with health issues and make informed decisions about their care.

Frustrated by the inability to secure timely appointments, some patients may resort to using emergency services for non-urgent issues. This strains emergency departments and diverts resources away from patients with genuine emergencies.

It is crucial that leaders within this area consider the repeated concern from patients who are unable to access the service and consider what else can be done to alleviate the pressure on GP services.

Mental Health

We look at how NHS mental health and independent mental health care services meet and comply with a range of professional standards and guidance, including the Mental Health Act 1983 and the Independent Healthcare (Wales) Regulations 2011.

During 2022 – 2023 we undertook 20 pieces of work to mental health care services across Wales. Out of these, 16 were onsite inspections to inpatient units, 3 inspections of Community Mental Health Teams (CMHT's) and one larger piece of review work to Cwm Taf Morgannwg Mental Health service. Across these 20 pieces of work, we used our immediate assurance process on seven occasions, this represents 35% of the work where issues found at inspection and review carried the most immediate risk to patients.

A positive area across the majority of our inspections was the quality of staff and patient interaction. Our staff observed patients being engaged in a positive manner with an appropriate level of explanation to ensure patients understood the care and treatment they were receiving.

Patients who are in an acute and/or challenging phase of their illness may require a degree of effective observation to ensure that their safety and the safety of others is protected. Staff must deliver a holistic plan of care in the least

restrictive way, balancing this with a risk-based approach. In four of our visits to hospitals, within health boards, we identified a lack of managing aggression/physical intervention training for staff, including bank staff. This is a significant issue because well trained staff decrease the incidents of patients and staff being injured during a restraint.

We found that patient records did not always evidence episodes of patient restraint accurately, and observational charts were not always being kept up to date.

There was also lack of staff training and guidance in this area, and during one inspection, a complete lack of any patient engagement for extended periods of time.

We found little improvement to the following areas, despite raising these in 2021-2022:

- workforce challenges – issues with recruitment and retention of staff
- medicines management – a range of issues with the storage, administration and audit
- patient observations – lack of effective recording, training of staff and the timely review of policies/procedures
- patient information – lack of information available for patients on key topics
- risk assessments and care planning documentation – including risk assessments not completed and lack of a timely review
- environment of care – a lack of audits and the management of environmental ligature risks
- governance - a lack of audit and oversight of key areas including training.

Difficulty accessing mental health services was a key theme to emerge from our HIW Concerns team which hears directly from members of the public. We repeatedly heard of the difficulty in getting support from mental health services and of the poor outcomes for patients who have not received the level of support that was needed.

The inability to access mental health services can lead to the deterioration of mental health conditions. Individuals grappling with anxiety, depression, bipolar disorder, or other mental health issues may experience worsening symptoms in the absence of proper care and support. This deterioration can impact all aspects of life, from work and relationships to physical health.

Without timely intervention, individuals facing mental health challenges are at a higher risk of experiencing crisis. Delayed access to mental health services can extend recovery times for individuals dealing with mental health disorders. Early intervention is often crucial in managing and alleviating symptoms. Protracted delays in receiving treatment may prolong suffering and hinder the individual's ability to regain stability and functioning. Mental health challenges affect not only the individual but also their families and communities.

CASE STUDY

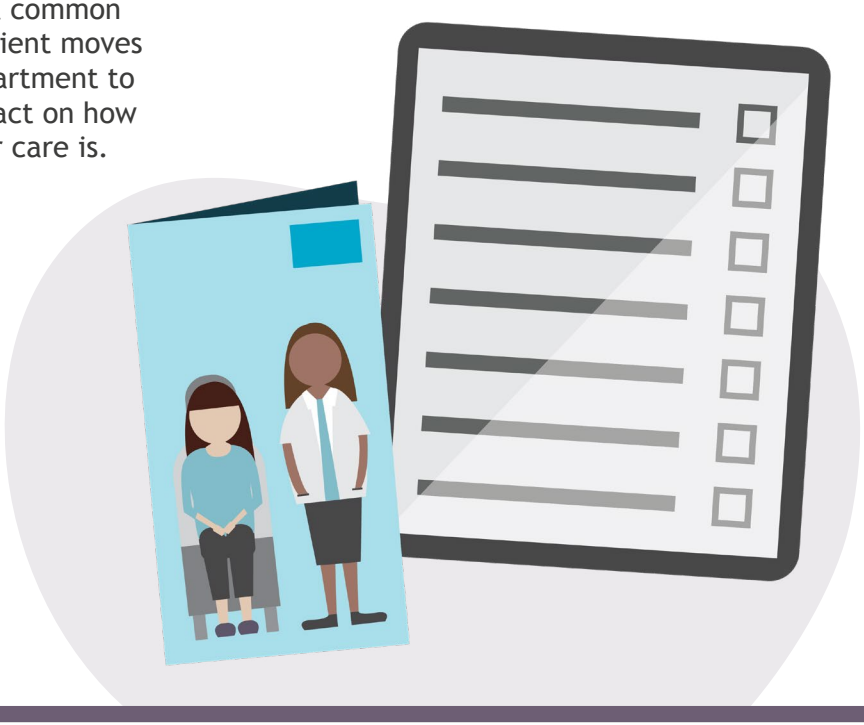
Review of Discharge Arrangements for Adult Patients from Inpatient Mental Health Services in Cwm Taf Morgannwg University Health Board

We reviewed the discharge arrangements for adult inpatients on mental health wards in Cwm Taf Morgannwg University Health Board (CTMUHB) from adult (18-65) inpatient mental health units. The decision to undertake the review was made as a result of intelligence indicating significant concerns about the health board's mental health services. This included serious incidents, issues identified through previous HIW inspections, and concerns reported to HIW by patients, the public and staff whistle-blowers.

The review focussed on the quality and safety of discharge arrangements for adults discharged from inpatient mental health units into the community. The review considered the relevant policies and procedures in place, an evaluation of patient records, and information gained through interviews with a range of staff who worked within the health board's mental health services.

As a result of the review, HIW made 40 recommendations for improvement. Some patient safety concerns were of such significance, the health board was issued with an immediate assurance letter, following which, it was required to submit an immediate improvement plan to HIW.

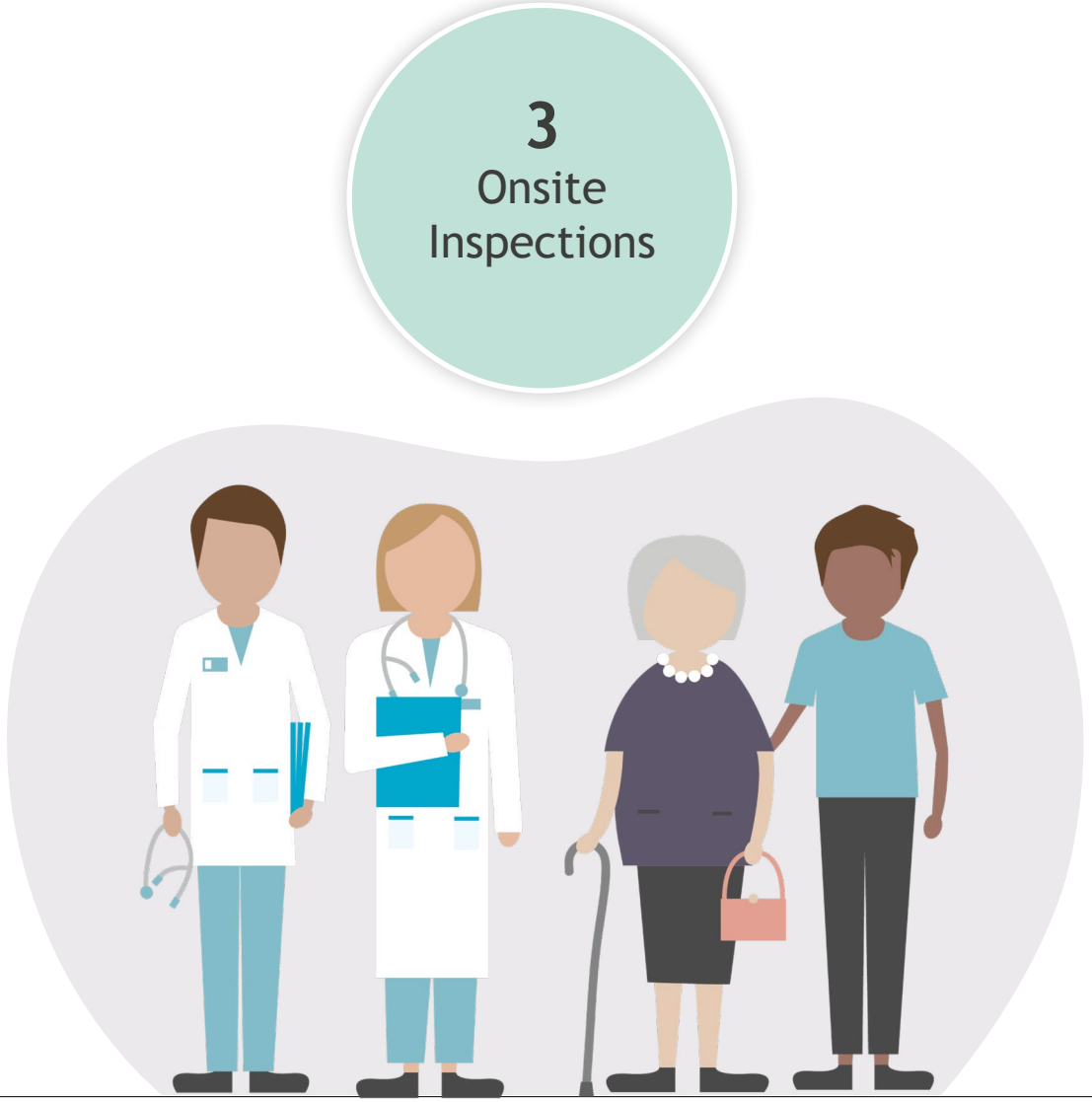
We found evidence of highly complex systems which made the delivery of timely and effective patient care more challenging. As with our National Review of Patient Flow, a common thread was that at the point a patient moves from the care of one team or department to another, there is a significant impact on how timely and well co-ordinated their care is.



Learning Disability Services

HIW undertook three inspections of facilities providing learning disability services. Within these inspections, we noted a range of positive findings including, staff interacting and engaging with patients appropriately and patients being treated with respect and dignity. In addition, there was a range of suitable community-based activities available for the patient group. However, we did find that staffing numbers were not always at a level which met patient needs.

Although this was a small number of inspection visits, we did find issues of concern in one of the three services inspected. There were risks to patient safety within this unit due to ligature risks not being managed appropriately.



Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R)

Medical ionising radiation is used in many healthcare settings, including dental practices and widely within hospital care. It is used to diagnose injuries and illnesses as well as being a form of treatment, for example x-rays and radiotherapy treatment.

It is a highly technical area of healthcare, that used carefully and in accordance with the regulations has huge benefits but there is potential for harm if it is not used safely.

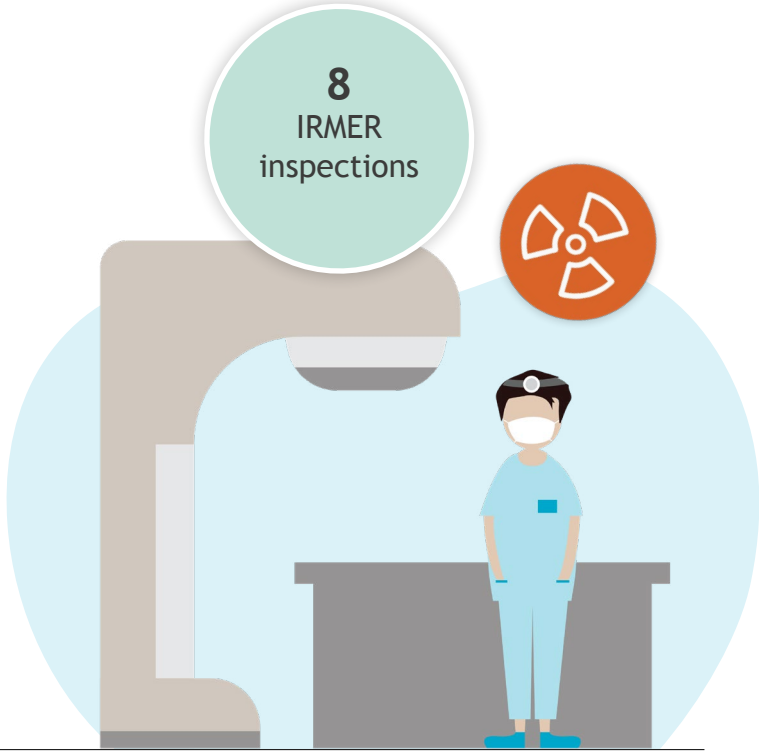
HIW is responsible for monitoring compliance against the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R). The regulations are intended to protect people from hazards associated with ionising radiation and they set out the responsibilities of those undertaking the procedures which use ionising radiation. Within the regulations, these individuals are called duty holders and will comprise of the employer, referrer, IR(ME)R practitioner and operator. Their responsibilities are to meet safety standards and ensure radiation protection, for example, minimising unintended, excessive, or incorrect medical exposures.

During 2022-2023 HIW completed eight IR(ME)R inspections, covering the three modalities of medical exposures. These inspections also covered both NHS and independent hospitals.

HIW was assisted in these inspections by a member of the Medical Exposures Group (MEG), which is part of the UK Health Security Agency (UKHSA), acting in an advisory capacity. All the inspections were undertaken onsite. As part of the process, we asked providers to undertake a full self-assessment and then we held discussions with staff about the content of the self-assessments and the supplementary evidence provided to support the self-assessment. Whilst onsite we also reviewed clinical and other relevant records as well as observing the environment in which services were delivered. We also requested patient and staff feedback through online surveys.

Feedback from patients was overwhelmingly positive with patients confirming that they had been treated with dignity and respect and had been helped to understand the risks and benefits of the procedure they were receiving. Radiology areas were good at letting patients know of waiting times and any delays in being seen, patients told us they appreciated this. During our IR(ME)R assurance activity we continued to meet experienced and committed teams of professionals, with a good team working ethos. Overall, staff we spoke with demonstrated a good awareness of their responsibilities under IR(ME)R. There was a need to improve the written procedures governing the use of ionising radiation and required against the regulations in this area.

We heard from some staff who felt there were insufficient numbers of them to do their job well and to achieve a good work-life balance. We also heard that they did not always feel listened to by management when they raised this. Although more generally, staff told us they felt very well supported in their work by senior management and the wider organisation.



Dental Practices

During 2022-2023, we undertook 74 pieces of assurance work to dental practices across Wales. Out of these, 44 pieces of work were conducted onsite at the practices, where a HIW team including a qualified dentist working as HIW dental peer reviewer, spent time examining the practices, policies and procedures which governed the way each practice was run. We also conducted 30 quality checks which are our remote method of seeking assurance, first developed at the height of the COVID-19 pandemic. The composition of work represented a huge shift back to our teams carrying out onsite inspection work. The 44 onsite pieces of work in 2022-2023 compares to just 9 undertaken onsite in 2021-2022.

Difficulty in accessing dental appointments and securing a regular dentist was one of three key themes to emerge from our HIW Concerns service this year. Securing timely access to dental care is a critical component of overall health and well-being, yet the difficulty in obtaining dental appointments has become a pressing concern with far-reaching consequences. Factors such as limited availability of dental providers, high demand for services, and changes to dental contracts have all impacted patients' ability to access timely dental care and treatment.

Evidence clearly identifies that delayed or infrequent dental appointments can lead to the progression of oral health issues. What might initially be a minor dental concern could develop into a more complex problem, requiring more invasive and costly treatments. Oral health is closely interconnected with overall health. Dental issues such as gum disease have been linked to systemic conditions like heart disease, diabetes, and respiratory problems.

Delayed access to dental care can result in prolonged discomfort and pain for patients. Toothaches, gum sensitivity, and other oral pain can significantly impact daily life, affecting eating, speaking, and even sleeping. The physical discomfort can also contribute to emotional stress and reduced quality of life.

Frustration over delayed dental appointments can lead some patients to seek relief through emergency dental services or hospital emergency departments. This not only strains healthcare resources but often also results in only temporary measures rather than comprehensive treatment.

Regular dental appointments provide opportunities for oral health education and preventive guidance. When patients are unable to access these appointments, they miss out on valuable information about maintaining proper oral hygiene, which can further contribute to deteriorating oral health.

Across all 74 pieces of work, we used our Immediate Assurance process on 6 occasions. This means that in 8% of our work to dental practices in 2022-2023, we came across concerns which had the highest level of risk to patient safety and therefore needed action to be taken and assurance of this action provided to HIW within 48 hours.

We also made a substantial number of recommendations for improvement. The key themes emerging from our dental inspections are described below:

We identified a number of key themes through our dental inspection and assurance activity:

Environmental:

- A poor standard of cleanliness in decontamination areas. In some practices HIW Inspectors uncovered ineffective decontamination processes, including inadequate cleaning of instruments and ineffective use of 'dirty/clean' pathways.
- We reported inappropriate storage of items in clinic and decontamination rooms such as food and cleaning materials, including high numbers of clinical fridges containing non-clinical items such as food and out of date medication. Practices should ensure there are procedures in place to reduce the risk of contamination and to support good standards of infection prevention and control.
- There were numerous examples of practices not undertaking audits of their work. Audits offer an opportunity to review the consistency and quality of care and treatment that is provided to patients, and they are a quality improvement tool, which can provide many benefits and support better practice.
- A number of practices did not have a system in place which ensured all risk assessments were being kept up to date. We noted that some fire risk assessments were out of date and fire drills were not being carried out and evidenced. Risk assessments are an important management tool, which help to keep patients and staff safe and should be reviewed and updated regularly to reduce risks.
- During some inspections, we highlighted the poor maintenance of first-aid kits, emergency drugs and resuscitation equipment – some included out of date items posing a significant risk to patients.

Staffing:

- The majority of dental practices needed to improve their documentation when recording staff training and evidencing that all staff had completed mandatory training sessions.
- Annual appraisals, clinical supervision and staff meetings were often overlooked. We recognise these aspects have been challenging to maintain at times during the COVID-19 pandemic, but practices must continue to prioritise this to support their staff.

General:

- Through our assurance work, inspectors did note practices had out of date or incorrect information on informative literature including patient care leaflets. Practices should conduct regular audits of materials to ensure the information available to patients and staff is relevant and accurate.

Assurance and Inspection Findings Independent Healthcare

HIW's role in the independent healthcare sector in Wales is to register and regulate independent healthcare services. The independent healthcare sector encompasses a huge variety of services, from acute hospitals, mental health hospitals, to independent clinics and laser services. Many dental practices in Wales are also independent healthcare services, providing private dental healthcare, or a mix of NHS and private dentistry.

Independent healthcare services must register with HIW, and once they are successfully registered, they will be subject to ongoing regulation which is done through inspections and checks that providers are meeting the requirements of their registration, complying with the relevant regulations and providing a safe service.

During 2022 – 2023, HIW registered 53 independent healthcare providers. This number included new dental practices and new laser clinics. In total, we had 21 additional services registered with us by the end of the year.

Once registered, any changes a service intends to make to their conditions of registration, requires an application to vary what they are registered to provide. An application to vary a registration will not automatically be approved. Each application involves scrutiny by HIW as to the appropriateness of the proposed changes. During 2022-2023, HIW processed and approved a total of 24 registration variations.

In addition to this, all independent healthcare services have a manager who goes through a registration process to enable them to run a service. In 2022-2023, HIW processed and approved 88 new managers of independent healthcare services.

Registration activity:

53 new providers registered

24 variations of registration approved

88 new registered managers approved

During the 2022-2023 period, we responded to intelligence which suggested there were 24 unregistered providers, across a range of different service types, operating services they were not registered to provide. We followed up each of these cases, requiring the provision of services was stopped until a registration with HIW had been successfully processed.

Where inspections or intelligence indicate serious concerns in registered services, we monitor them through our Service of Concern process. We monitored 26 independent healthcare services through this process during 2022-2023. Whilst not all of these were designated as a Service of Concern, they were all subject to increased scrutiny which triggered follow up assurance and inspection work as required.

In order to check that registered services are continuing to meet the requirements of their registration, and providing a safe, quality service to patients, HIW undertakes a programme of inspection work each year.

In 2022 – 2023, we undertook a total of 31 individual pieces of assurance work to independent healthcare settings. This figure can be broken down further into:

Eight inspections to independent mental health services and 74 dental practice inspections were completed. These are discussed elsewhere in the report.

Our Immediate Assurance process was used in two of seven inspections to independent clinics, a rate of 29%. Improvements required included carrying out a health and safety risk assessment; ensuring evidence of cleaning schedules is recorded, and improving infection, prevention and control arrangements. Recommendations were also made at some independent clinics to improve the feedback process with patients, ensuring that feedback is actively sought and reviewed, and ensuring that complaints procedures are up to date and readily available in the event patients need to use them.

We carried out one inspection to a non-acute independent hospital. This was to PCP Cardiff, a drug and alcohol detoxification and rehabilitation service providing residential treatment on a private basis. Patients receiving treatment there were very complimentary of the staff and the care they were receiving. We found that the service was not adequately managing the risk of ligature and needed to improve medicines management procedures. We issued a non-compliance notice, requiring remedial action within 48 hours of our inspection in order to rectify this. The service was receptive to our findings and complied with the urgent improvements required.

Hospices

Hospices provide care to adults, young people and children who have a terminal illness or a long-term condition that cannot be cured.

During 2022 – 2023, we completed:

3

Onsite inspections to hospices in Wales comprising both adult only hospices and one hospice providing care to children. All three are provided by the independent healthcare sector.

Overall, our assurance and inspection work of hospices throughout the year was positive with evidence that services provided safe and effective care.

Without exception, we found evidence of positive interactions between staff, patients and their families and carers. The care provided was tailored and clearly person centred. Care plans were updated regularly and evidenced changes in condition and any treatment changes. Families and carers who provided us with feedback were very positive about the experience of care being provided, and the support they were being given.

We did find across all three inspections, that the equipment and medication kits for dealing with medical emergencies needed to be better maintained and kept updated. These kits are used in for example, an adverse reaction to medication. All three services were highly receptive to our findings and have addressed this.

Treatment using a Class 3B/4 laser or Intense Pulsed Light (IPL)

During the year 2022-2023, we conducted 19 onsite inspections to laser and IPL registered providers across Wales.

From these 19 inspections we identified non-compliance with relevant regulations in six cases. This means that in 32% of these inspections, we found laser and IPL providers were not meeting all the requirements they need to comply with in order to meet the requirements of their registration. The issues we found required us to use our Immediate Assurance process and request urgent action.

These included, using machines which they were not registered to use, treating patients outside of the age range they were licensed to treat and having no first aider.

The regulations under which laser and IPL providers are required to operated are specific and require them to comply with a number of areas in order to demonstrate their fitness to provide these services. We found a number of areas where we were repeatedly making recommendations for improvement through these inspections. In general, these related to the governance arrangements for these services. Good governance helps to ensure services are safe for the public to receive. Laser and IPL providers should therefore ensure they are familiar with their responsibilities against the regulations. The themes from our work during this time are set out below and providers should use these as learning points, considering whether they can make any improvements based on what we have found and recommended.

In a number of cases we found that the correct documentation, such as written policies and procedures were not available, or were not kept up to date. Staff training records and recruitment records also needed improving in some cases. The provision of a first aider, appropriately trained first aiders and an up to date first aid kit were also recommendations made in a number of these inspections.

19
onsite
inspections

Findings from Concerns, Investigations and Notifications

Three key themes have come through our concerns:

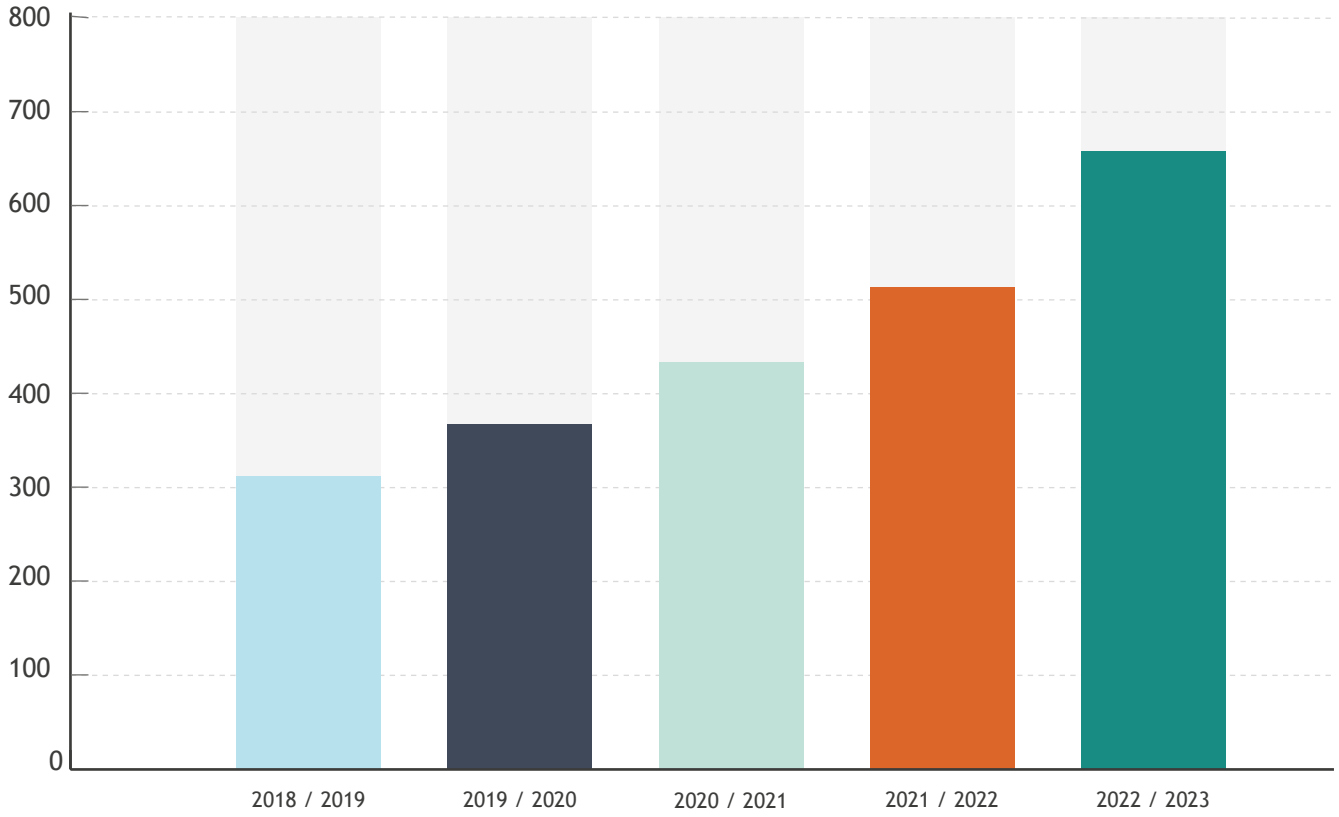
- Access to GP appointments
- Access to dental appointments / care and treatment
- Mental Health appointments and access to services

Complaints play a crucial role in identifying issues and fostering improvement within the healthcare sector. Feedback, often conveyed through complaints, provides valuable insights into areas of concern, inefficiencies, and lapses in quality. These grievances shed light on both systemic and individual problems, ranging from administrative processes to clinical care standards. By addressing and analysing complaints, healthcare organisations can pinpoint recurring patterns, root causes, and potential risks.

The concerns we receive provide an important opportunity to identify problems within a healthcare service. The intelligence received from these concerns enables an evaluation of risks to be identified and conceptualised. Consequently, HIW places significant importance on the intelligence received from concerns and uses it to drive its inspection and assurance activities.

As an organisation HIW is committed to managing concerns fairly, efficiently, and effectively. In total we received 659 concerns from 1st of April 2022 to 31st of March 2023. This represents an increase of 145 concerns compared to the previous year which equates to a 28% increase in the number of concerns received. Over the last 5 years we have seen a 111% increase in the number of concerns received.

The last 5 years of numbers of concerns

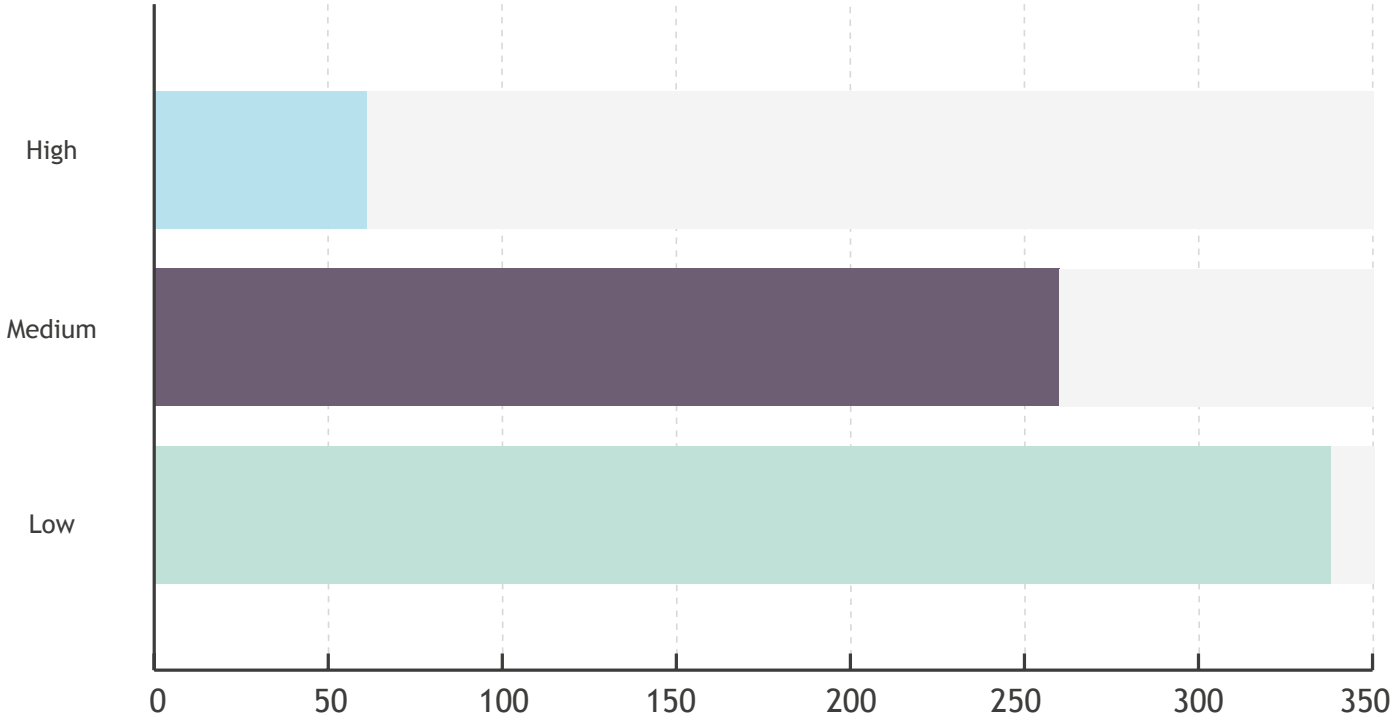


High-risk concerns require immediate action and response within 2 working days, either by HIW or another agency. Medium-risk concerns may require more direct HIW input, and responses should be actioned within 5 working days. Low-risk concerns are those concerns that are generally dealt with by way of signposting towards NHS Putting Things Right processes or the respective local complaints process for independent health providers, with responses being be actioned within 7 working days

The number of high risks concerns received has increased considerably over recent years.

We have experienced a **258%** increase in the number of high-risk concerns received compared with 2021-2022

Risk level of concerns received



HIW responds immediately to all high-risk concerns. This can be in the form of immediate escalation to the health boards / trusts or independent healthcare settings. In addition, some high-risk concerns require the immediate intervention via safeguarding structures or the police.

Abbreviations

ABUHB
Aneurin Bevan University Health Board (UHB)

BCUHB
Betsi Cadwaladr UHB

CVUHB
Cardiff and Vale UHB

CTMUHB
Cwm Taf Morgannwg UHB

HDdUHB
Hywel Dda UHB

IHC Settings
Independent Healthcare Settings

PTHB
Powys Teaching Health Board

SBUHB
Swansea Bay UHB

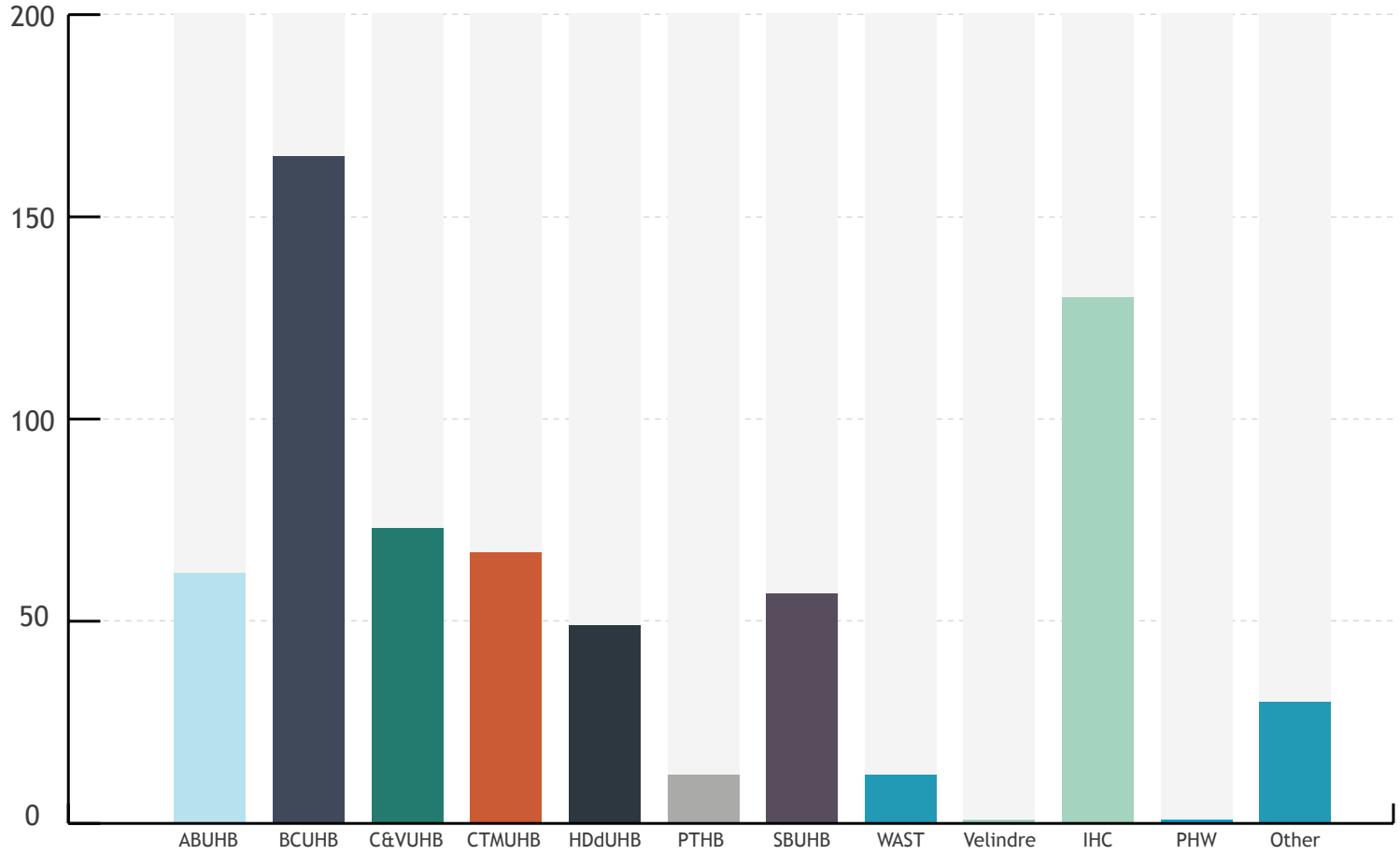
PHW
Public Health Wales

Velindre
Velindre University NHS Trust Welsh

WAST
Ambulance Services NHS Trust

IHC
Independent Healthcare

Location of concerns



Whistleblowing Concerns

25 received for 2019-2020

100 received for 2020-2021

61 received for 2021-2022

133 received for 2022-2023, an **85% increase compared** to previous year.

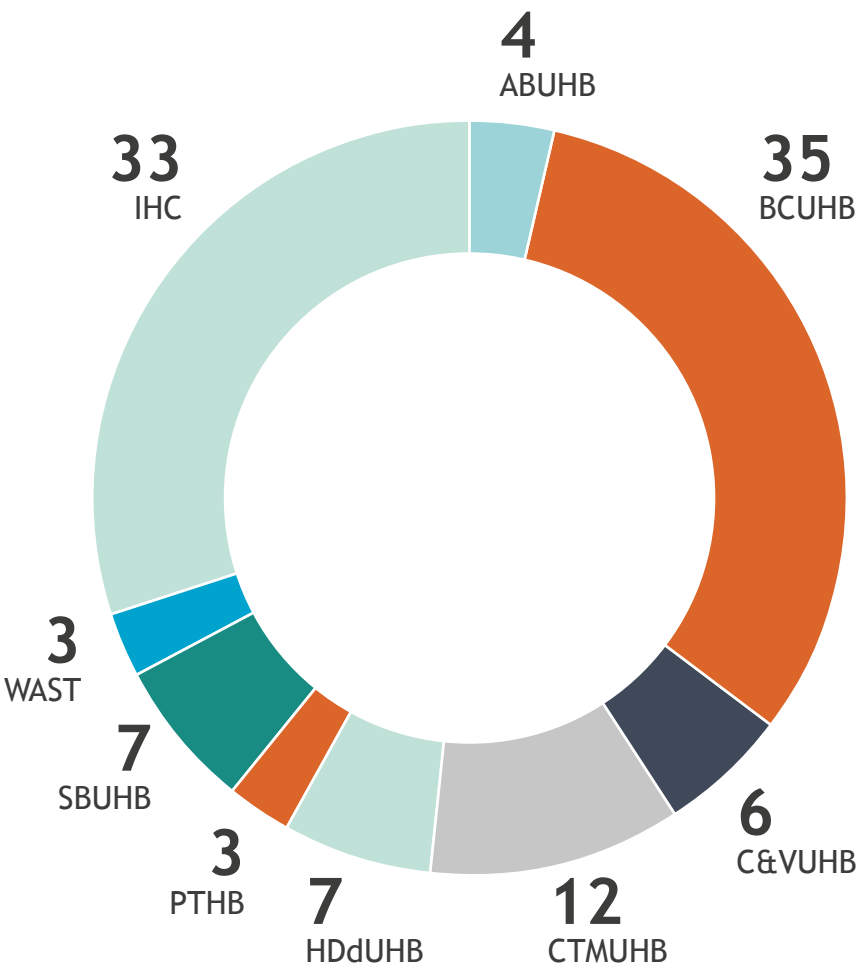
What is whistleblowing?

Whistleblowing is the term used when someone who works in or for an organisation wishes to raise concerns about malpractice, wrongdoing, illegality, or risk in the organisation. These concerns can affect patients, the public, other staff, or the organisation itself.

Whistleblowing applies to raising a concern within the organisation as well as externally, such as to a regulator like HIW. HIW has a special role for people who are thinking about "blowing the whistle" about concerns they have about wrongdoing in healthcare in Wales. HIW is a "prescribed body" under the whistleblowing laws, so employees, former employees, temporary agency staff or contractors who bring us concerns about their employer's activities can have some protection for their employment rights.

All healthcare professionals must follow their professional code of conduct and we would always recommend that they raise their concern within their own organisation first. However, if they feel unable to do this, or have already gone through this route, we will listen to the concern and explain how we can help. We may need to pass on the information they give us to another organisation or regulatory body if it is more appropriate for them to investigate the concern.

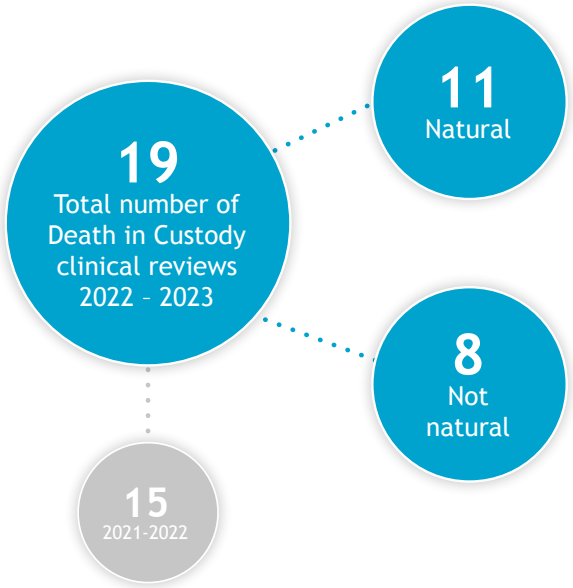
Location of Whistleblower 22/23



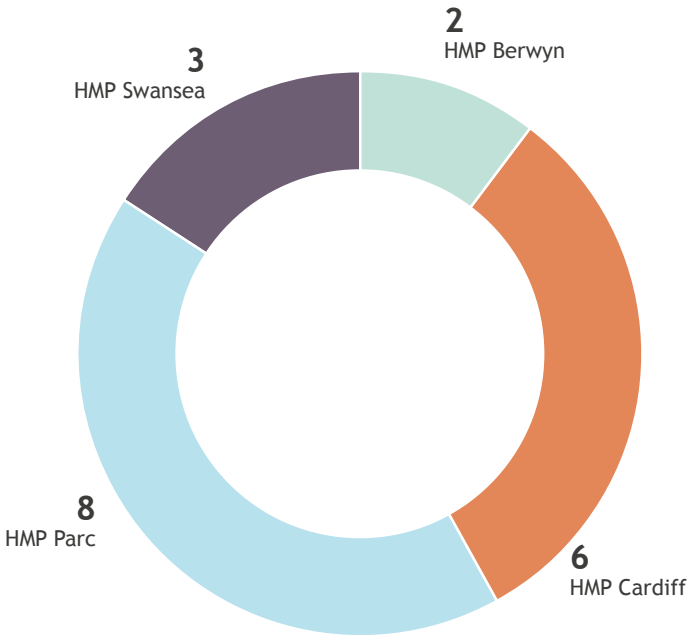
Death in Custody

Every death that takes place in a prison or other authorised location in Wales is subject to an examination by the Prisons and Probation Ombudsman (PPO). HIW assists these inquiries by conducting a clinical review of each death that occurs in a Welsh prison or other authorised location.

The fundamental goal of our clinical reviews is to assess and evaluate the level of care and medical treatment given to inmates while they in a prison or other authorised location. We aim to evaluate whether the care and treatment provided was equitable to what a person in the community could expect to receive.



Location of death:



Common Theme

A common theme identified in our reviews is the failure of prison healthcare staff to record a full set of baseline observations (vital signs) during the very early healthcare screening appointment that prisoners will have on, or shortly after arrival.

Having a comprehensive set of observations for a prisoner at the start of their incarceration is crucial. These measurements offer important insights into the body's functioning, helping healthcare professionals detect any changes. When a prisoner becomes unwell, regular clinical observations also need to be taken so that abnormalities can be spotted, and deterioration can be recognised and acted on. When this does not happen, there can be poor outcomes for patients.

Notifications

Independent healthcare providers are required to inform us of significant events and developments in their service submitting notifications against Regulation 30/31 of the Independent Healthcare (Wales) Regulations 2011.

The total number of regulatory notifications received in this reporting period is 1,847. This figure includes notifications against the following set of regulations:

- Independent Healthcare Regulations (IHC)
- Private Dentistry Regulations (DR)
- IRMER Regulations

A breakdown of the grand total shows the following number of notifications against each of the regulations:

IHC Regulations
1,713

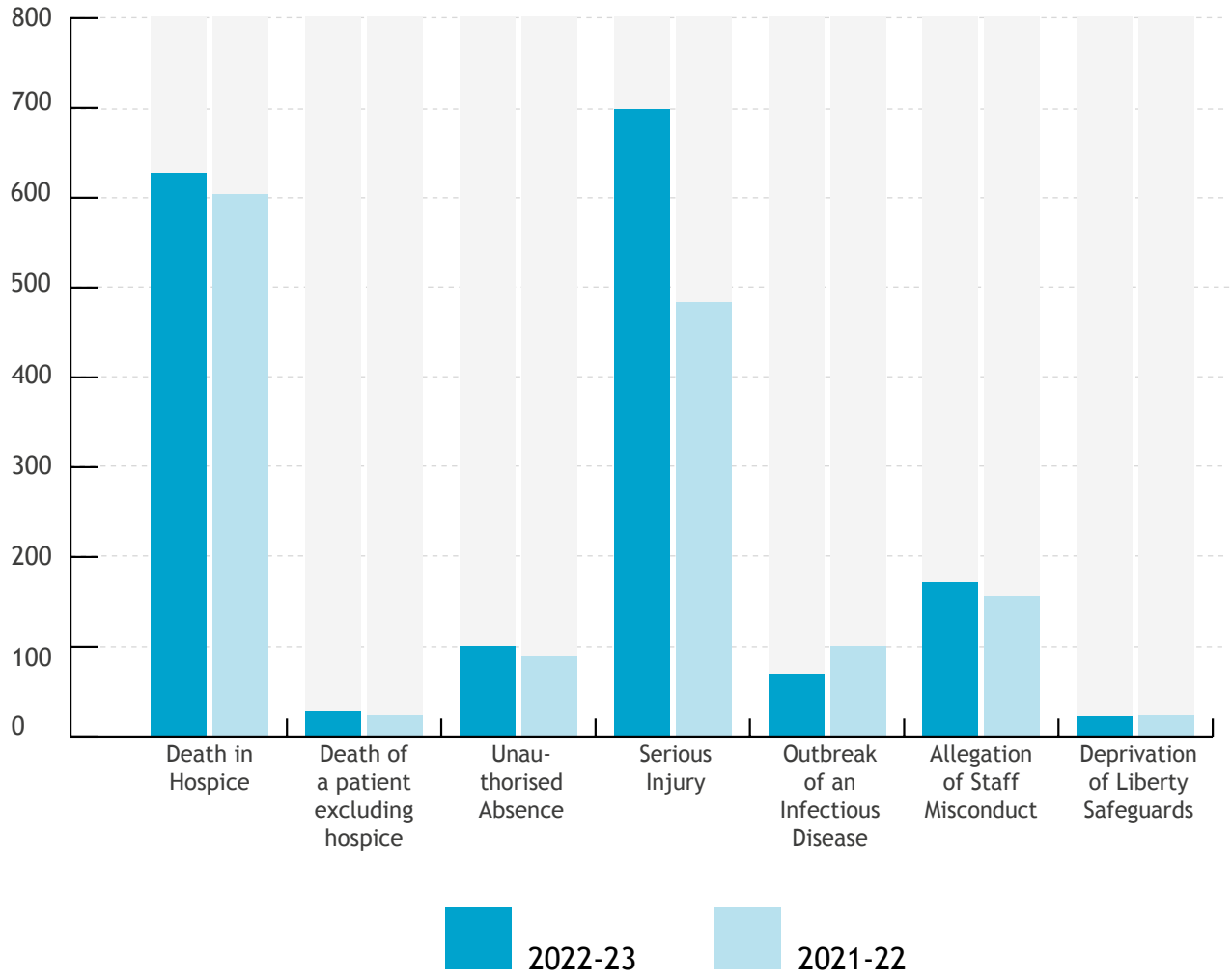
Private Dental Regulations
32

IRMER Regulations
102

Each regulation has its own reporting threshold. IHC Regulation 30/31 includes the following categories:

- **Death in Hospice**
- **Death of a patient excluding hospice**
- **Unauthorised Absence**
- **Serious Injury**
- **Outbreak of an Infectious Disease**
- **Allegation of Staff Misconduct**
- **Deprivation of Liberty Safeguards**

The graph shows a breakdown of the number of notifications received against each category and provides a comparison to the same reporting period last year.



Private Dentistry Regulation

Includes the following categories,

Serious Injury

Outbreak of Infectious Disease

Allegation of Staff Misconduct

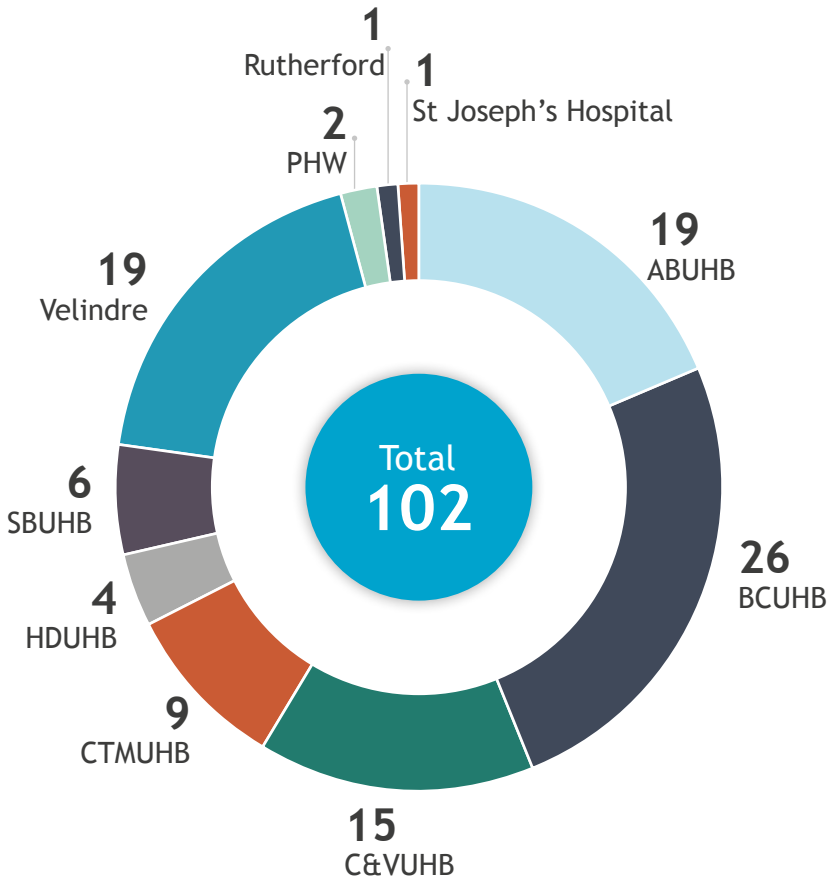
Death of a Patient

Category	2022-23	2021-22
Serious Injury	2	6
Outbreak of an infectious disease	30	147

There has been a significant reduction in the number of notifications received, mainly in the number of outbreaks of infectious diseases reported. This significant drop in the number of Outbreaks of infectious diseases is due to the COVID-19 pandemic.

IRMER

The chart below shows a breakdown of the number of notifications received against the IRMER regulations for this reporting period.



Safeguarding

256
Significant drop in the number of referrals received

In 2021/2022 we received 404 referrals

128
NHS

125
Independent Healthcare

3
Other

NHS

	Financial Abuse	Neglect	Physical Abuse	Psychological / Emotional Abuse	Sexual Abuse	Grand Total
Aneurin Bevan University Health Board		11	4			15
Betsi Cadwaladr University Health Board	2	25	13	2	3	45
Cardiff and Vale University Health Board		2				2
Cwm Taf Morgannwg University Health Board		24	8	3		35
Powys Teaching Health Board		6	7		4	17
Swansea Bay University Health Board		7	2			9
Welsh Ambulance Service NHS Trust		5				5
Total	**2**	**80**	**34**	**5**	**7**	**128**

Independent Healthcare

	Financial Abuse	Neglect	Physical Abuse	Psychological / Emotional Abuse	Sexual Abuse	Grand Total
Aberbeeg Hospital			1			1
Aderyn					1	1
Cefn Carnau Hospital		3	7			10
Coed Du Hall			2			2
Heatherwood Court Hospital		7	1	1	1	10
Hillview Hospital		4	4	3		11
Llanarth Court		11	13	6	4	34
New Hall			1	2		3
Nuffield Health The Vale Hospital		1				1
Rushcliffe Independent Hospital (Aberavon)			1			1
St Peter's Hospital		5	11	3	1	20
Ty Cwm Rhondda				2		2
Ty Grosvenor	1	14	7			22
Ty Gwyn Hall	2		4	1		7
Total	3	38	51	17	6	125

Three of the referrals were in relation to settings not regulated or inspected by HIW.

Second Opinion Appointed Doctor (SOAD) Service for Wales

HIW operates the SOAD service for Wales, employing registered medical practitioners to approve some forms of treatment for patients who are detained under the Mental Health Act. Ultimately, the role of the SOADs is to safeguard the rights of patients who are detained under the Mental Health Act and either do not consent or are considered incapable of consenting to treatment (section 58 and 58A type treatments). Individual SOADs come to their own opinion about the degree and nature of an individual patient's mental disorder and whether the patient has capacity to consent.

They must be satisfied that the patient's views and rights have been taken into consideration. After careful consideration of the patient and approved clinician's views, a SOAD has the right to change the proposed treatment. For example, a SOAD may decide to authorise only part of the proposed treatment or limit the amount of treatment which can be given.

The SOADs have a responsibility to ensure the proposed treatment is in the best interest of the patient. Approved clinicians refer cases to HIW seeking a SOAD opinion. Case reviews are requested in the following circumstances:

- liable to be detained patients on Community Treatment Orders (CTO) (Section 17A) who lack the capacity to proposed treatment or who do not consent for Part 4A patients
- serious and invasive treatments such as psychosurgery or surgical implements for the purpose of reducing male sex drive (Section 57)
- detained patients of any age who do not consent or lack the capacity to consent to Section 58 type treatments (section 58)
- patients under eighteen years of age, whether detained or informal, for whom electroconvulsive therapy (ECT) is proposed, when the patient is consenting having the competency to do so (Section 58A), and
- detained patients of any age who lack the capacity to consent to electroconvulsive therapy (ECT) (Section 58A).

Total Number of SOAD cases dealt with by HIW in 2022 - 2023:

694

Medication:
640 requests related to the certification of medication

ECT:
42 requests related to the certification of ECT

Both:
12 requests related to the certification of both medication and ECT

By comparison, during 2021-2022, HIW dealt with 759 requests for a SOAD review.

Medication:
640 requests related to the certification of medication

ECT:
42 requests related to the certification of ECT

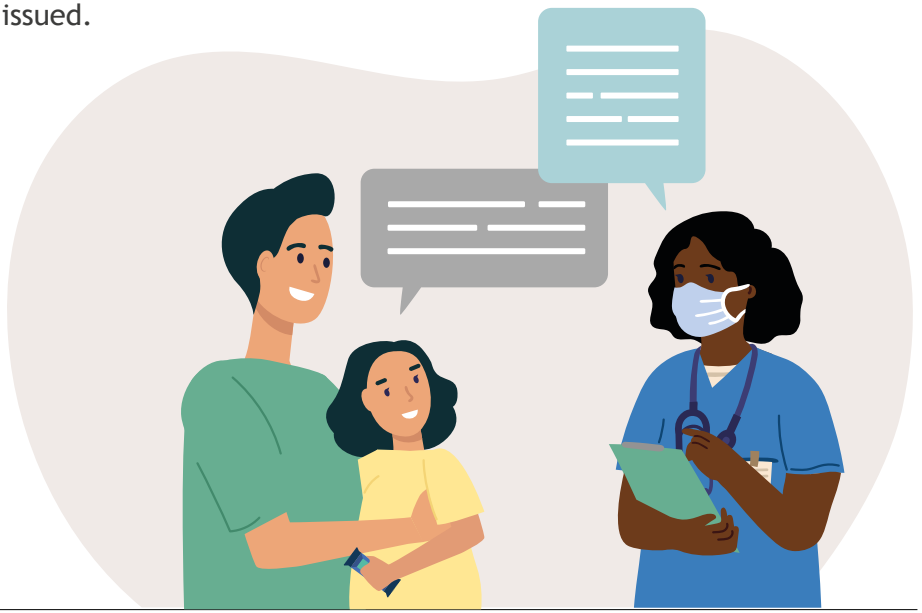
Both:
36 requests related to medication and ECT

Review of Treatment (Section 61)

Following the authorisation of a treatment plan by an authorised medical practitioner (SOAD) that has been appointed by HIW, a report on the treatment and the patient's condition must be provided by the responsible clinician in charge of the patient's treatment and given to HIW. The designated form is provided to the Mental Health Act Administrators office for all local health boards and independent settings for the Responsible Clinician to complete. For the seventh consecutive year HIW undertook an audit of these forms to ensure that adequate patient safeguards were in place. The treatments are routinely reviewed by our lead SOAD for Wales on a monthly basis. There was a delay in the timeliness of the review of treatments in 2022-23, this was due to a vacant Lead SOAD position. However, all cases have now been reviewed with appropriate action taken where applicable.

There remain very few instances where discrepancies are identified by the reviewer. Further improvements from our previous report continue in relation to the following areas:

- There continues to be minimal occasions where more medication is listed under the treatment description than is authorised on the CO3[1] form. In these instances, the reviewer highlights the need for a SOAD request to be submitted by the setting.
- There were a few instances where T3 forms were being utilised instead of the appropriate CO forms, due to temporary methodology guidance implemented during the COVID Pandemic. These have now been rectified and refreshed guidance has been issued.



1 The Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008 are the principle regulations dealing with the exercise of compulsory powers in respect of persons liable to be detained in hospital or under guardianship, together with community patients, under the Mental Health Act 1983.
The Regulations prescribe the forms that are to be used in the exercise of powers under the Act, and these are set out in Schedule 1 of the Regulations. These Regulations (and the prescribed forms) came into force on 3 November 2008 and include CO forms.

Our Resources

The table shows the number of full or part time posts in each team within HIW during 2022-2023.

Team	Posts
Senior Executive	3
Inspection, Regulation and Concerns	39
Partnerships, Intelligence and Methodology	14
Clinical Advice (including SOAD service)	6
Corporate Services (including business support)	18
Strategy, Policy and Engagement	7
Total	**87**

For 2022-2023 we had a budget of approximately £4.3m.

We have posts equivalent to approximately 87 full-time equivalent staff. We currently have a panel of over 200 specialist peer reviewers with backgrounds including specialist and general nurses, GPs, dentists, anaesthetists, and GP practice managers. We also have specialists in Mental Health Act Administration and a panel of psychiatrists who provide our Second Opinion Appointed Doctor (SOAD) service. We have 44 Patient Experience Reviewers and Experts by Experience.

Finance

The table shows how we used the financial resources available to us in the last financial year to deliver our work in 2022-2023.

HIW staff continue to be our most important resource. A programme of learning and development opportunities has once again been designed and delivered in accordance with feedback from staff. We have refreshed our internal People Forum which provides a strong and valuable source of feedback to senior HIW managers on staff matters and organisational development.

We have continued to recruit into specialist peer reviewer roles, and increased our pool of patient experience reviewers. This has strengthened our access to up to date clinical expertise and provided additional resource who can engage directly with patients during inspection work.

Our electronic Customer Relationship Management (CRM) system is now well established and providing valuable data supporting the work of all teams across HIW.

	£000'S
HIW Total Budget £	£4,372,000

Expenditure	
Staff costs	4,176,468
Travel and Subsistence	26,225
Learning & Development	29,854
Non staff costs	80,210
Translation	59,834
Reviewer costs	405,761
ICT Non CRM costs	16,810
Depreciation of assets	8,000
Total expenditure (a) £	4,803,162

Income	
Total income from Independent Healthcare (b) £	528,239
Total Net Expenditure (a-b) £	4,274,923

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

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Find us on:

WG48926
ISBN: **978-1-83577-212-6**

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

Clinical Audit Plan & Action Tracker
Q3 (update) 2023-2024

MEETING	Quality, Patient Experience and Safety Committee
DATE	8 February 2024
EXECUTIVE	Executive Director of Paramedicine
AUTHOR	Head of Clinical Intelligence & Assurance
CONTACT	Kevin Webb Kevin.webb@wales.nhs.uk

EXECUTIVE SUMMARY

Following an 'Audit Wales' review of WAST's Quality Governance Arrangements, one of the recommendations was for the Clinical Audit Plan to be submitted to QuEST for scrutiny and approval ahead of each financial year, and then monitored on a quarterly basis.

This is the Q3 2023-24 update to highlight progress with audits (the plan) and also to actions from each of the audits (action tracker).

During Q3 2023-24, a further clinical audits included in the Clinical Audit Plan for 2023-24 have been completed. These audits and associated action plans have been approved by the Clinical Intelligence & Assurance Group (CIAG). The audits that have been completed are:

- ePCR Clinical Data Assurance – End tidal carbon dioxide ($EtCO_2$) Compliance
- Non-conveyance form images in ePCR
- Recognition of Life Extinct (ROLE) form images in ePCR
- Levetiracetam (Keppra) Potential use in convulsions

Since the last update (October 2023), a further 16 actions have been completed that were aligned to 8 of the audits.

RECOMMENDED: That the committee Note the Q3 2023-24 Clinical Audit Plan and Action Tracker update.

KEY ISSUES/IMPLICATIONS
Many of the audits and re-audits can be undertaken solely by the Clinical Intelligence and Assurance (CIAT). However, support is required for some topics where subject matter experts are needed as authors, and the support of sponsors to ensure completion of the audits and subsequent actions.

REPORT APPROVAL ROUTE
Clinical Intelligence & Assurance Group – 9/01/2024 Clinical Quality Governance Group – deferred to 29/02/2024

REPORT APPENDICES
Annex 1 WAST Clinical Audit Plan (Q3) 2023-2024 Annex 2 WAST Clinical Audit Action Tracker

REPORT CHECKLIST

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

SITUATION

1. Following an 'Audit Wales' review of WAST's Quality Governance Arrangements, one of the recommendations was for the Clinical Audit Plan to be monitored on a quarterly basis at QuEST.
2. This is the Q3 2023-24 update to highlight progress with audits (the plan) and also to actions from each of the audits (action tracker).

BACKGROUND

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

4. The plan is developed in consultation with the Clinical Intelligence & Assurance Team (CIAT), and senior clinical, and non-clinical managers within the Trust. It is expected that managers will ensure there is an opportunity for staff at all levels to contribute to the development of the core plan and undertake clinical audits.

5. Care, treatment, and decision making should reflect best practice based on evidence to ensure that people receive the right care and support to meet their individual needs.

6. The Trust's annual Clinical Audit Plan allows the planning and prioritisation of clinical audits across the financial year. It is a dynamic document, updated quarterly to reflect those audits that are either planned, currently underway or have been completed. Various groups and committees receive quarterly updates against this plan of work, and it is made available on the Trust's Intranet.

7. This plan and the subsequent action tracker to monitor learning from each of the audits is monitored by the Clinical Intelligence & Assurance Group (CIAG), and an update noted at Clinical Directorate Business meetings.

ASSESSMENT

8. During Q3 2023-24, a further four of the fifteen clinical audits included in the Clinical Audit Plan for 2023-24 have been completed. These audits and associated action plans have been approved by the Clinical Intelligence & Assurance Group. The audits that have been completed are:

- ePCR Clinical Data Assurance – $EtCO_2$ Compliance
- Non-conveyance form images in ePCR
- ROLE form images in ePCR
- Levetiracetam (Keppra) Potential use in convulsions

9. Since the last update (October 2023), a further 16 actions have been completed that were aligned to 8 of the audits.

RECOMMENDED: That The committee Note the Q3 2023-24 Clinical Audit Plan and Action Tracker update.

EQUALITY IMPACT ASSESSMENT

Not required

REPORT CHECKLIST

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

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
NHS Trust

Welsh Ambulance Services NHS Trust

Clinical Audit Plan

2023/2024
Quarter 3

Version 1.0 Last Updated 27 December 2023

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

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

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

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

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

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

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

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

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

The completed clinical audit reports are available on the Clinical Audit page of the Trust's Intranet website. (https://nhswales365.sharepoint.com/sites/AMB-Intranet-Medical/SitePages/Clinical-Audit-Programme.aspx)

Kevin Webb – Head of Clinical Intelligence & Assurance

Table 1 – Summary (Full information in Table 2)

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

The topics in the section below are confirmed clinical audits

Ref	Tier	Clinical Audit Title	Clinical Audit Author	Clinical Audit Sponsor	Audit Start Date	Current Status (RAG)*				
						Q4 2022/ 2023	Q1	Q2	Q3	Q4
21_002	1	Safeguarding Adolescent Audit	Gwenan Jones-Parry Safeguarding Specialist Paramedic	Rhiannon Thomas Senior Professional Safeguarding	July 2021					
22_006	2	A review of TXA administration within the South Wales Trauma Network (SWTN)	Tim Austin Senior Trauma Paramedic	Greg Lloyd Assistant Director Clinical Delivery	March 2023					
22_007	1	Diagnostic code compliance - ePCR	Clinical Intelligence & Assurance Team	Duncan Robertson Assistant Director of Clinical Development	February 2023					
23_001a	1	Evaluation of Non-Conveyance forms within ePCR	Kevin Webb Head of Clinical Intelligence & Assurance	Duncan Robertson Assistant Director of Clinical Development	April 2023					
23_001b	1	Evaluation of ROLE forms within ePCR	Kevin Webb Head of Clinical Intelligence & Assurance	Duncan Robertson Assistant Director of Clinical Development	April 2023					
23_004	1	Re-audit ePCR clinical data assurance - #NOF	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	*To commence after ePCR changes implemented*	N/A	N/A	N/A	N/A	N/A

23_008	1	Re-audit ePCR clinical data assurance - Stroke	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	*To commence after ePCR changes implemented*	N/A	N/A	N/A	N/A	N/A
23_009	1	Re-audit ePCR clinical data assurance - STEMI	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	*To commence after ePCR changes implemented*	N/A	N/A	N/A	N/A	N/A
23_005	1	Re-audit ePCR clinical data assurance - Hypoglycaemia	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	*To commence after ePCR changes implemented*	N/A	N/A	N/A	N/A	N/A
TBC	1	Re-audit ePCR clinical data assurance – ROSC (at hospital)	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	*To commence after ePCR changes implemented*	N/A	N/A	N/A	N/A	N/A
23_002	1	Bronchiolitis Pathway Follow-up audit – Compliance to the All-Wales Guideline for Ambulance Service Management	Richard Teulon Clinical Intelligence & Assurance Co-ordinator	Greg Lloyd Assistant Director Clinical Delivery	August 2023	N/A	N/A			
23_003	1	Clinical Frailty Score (CFS) Follow-up audit in patients aged ≥ 65 years	Richard Teulon Clinical Intelligence & Assurance Co-ordinator	Duncan Robertson Assistant Director of Clinical Development	*Indicative Q4 2023/24*	N/A	N/A	N/A	N/A	
23_006	1	Appropriate administration of Methoxyflurane (Penthrox®) Clinical Audit	Andeep Chohan Project Manager	Paula Jeffery Consultant Paramedic	October 2023	N/A	N/A			
23_010	1	Morphine Administration (Recording accuracy).	Chris Moore Head of Medicines Management	Chris Moore Head of Medicines Management	October 2023	N/A	N/A	N/A		

23_011	1	Levetiracetam (Keppra) potential use in cases of multiple anti-convulsant administration	Richard Teulon Clinical Intelligence & Assurance Co-ordinator	Andy Swinburn Director of Paramedicine	October 2023	N/A	N/A	N/A		
23_007	1	ePCR clinical data assurance - $EtCO_2$ Compliance Reports	Nicola Hughes Clinical Intelligence & Assurance Supervisor	Kevin Webb Head of Clinical Intelligence & Assurance	November 2023	N/A	N/A	N/A		

Table 2 – Full Information

Ref	Clinical Audit Title	Rationale / Drivers	Clinical Audit Author	Clinical Audit Contact / Support	Audit Start Date	Comments
21_002	Safeguarding Adolescent Audit	It was agreed as part of the learning from a domestic homicide review and as part of the safeguarding team's future work plan that an audit would be completed to develop a mechanism to review this aspect of safeguarding practice.	Gwenan Jones-Parry Safeguarding Specialist Paramedic	Claire Muxworthy Clinical Intelligence & Assurance Co-ordinator	July 2021	There were 3 aspects to the data capture: PCR, MPDS & CAS. The MPDS aspect has now been removed due to difficulties with locating PCRs, this will not impact on the aims/objectives. **PCR** Data analysed. **CAS** Data capture commenced. CM – data captured Report being compiled to include both sets of results (10.02.23) CM meeting with GJP to discuss report and compile recommendations. Report approved at CIAG 14th June 2023.
22_006	A review of TXA administration within the South Wales Trauma Network (SWTN)	TXA is a key component of the package of care these major trauma patients receive to stabilise them for, or during the transfer to hospital. As such, It is important that we understand the practice of our clinicians to ensure it is administered appropriately in a timely fashion to all patients who require it.	Tim Austin Senior Trauma Paramedic	Ruth Saele Clinical Intelligence & Assurance Data Specialist	*Indicative Q4 2022/23*	A proposal form is being developed, criteria and data being identified. RT 23/2/23 – audit completed, spreadsheet data being cleansed. Some cases for TA review on his return from leave 1/3/23 Report approved at CIAG 13th April 2023.

Ref	Clinical Audit Title	Rationale / Drivers	Clinical Audit Author	Clinical Audit Contact / Support	Audit Start Date	Comments
22_007	Diagnostic code compliance - ePCR	All ePCRs should have a diagnostic code, enabling many of the clinical audits undertaken within WAST by allowing for selection by condition type. In addition, diagnostic codes are used to identify Clinical Indicators (CIs). Where ePCR records are not closed appropriately by clinicians. the TerraPACE system will automatically close the record by applying a closure code as '9999'. This audit aims to identify the ePCR diagnostic code rate, if '000' is used whether a suitable code was available, provide opportunities to revise the code list and identify why ePCRs are closed as '9999'.	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	*Indicative Q4 2022/23*	A proposal form is being developed, criteria and data being identified. CM – audit completed, results being analysed and report written (14.02.23) Report approved at CIAG 13th April 2023.
23_001a	Evaluation of Non-Conveyance forms within ePCR	In April 2022, the electronic Patient Clinical Record (ePCR) roll out was completed across Wales. For instances where patients are not conveyed or where Recognition of Life Extinct (ROLE) is documented, a paper form is completed and left at the scene as information when WAST staff have left. The ePCR has a facility to take an image through the media tab within the application and is used for taking images of the non-Conveyance and ROLE forms. This audit aims to identify that an image of the relevant form is available on the ePCR and also evaluate the quality of the information documented on form.	Kevin Webb Head of Clinical Intelligence & Assurance	Ruth Saele Clinical Intelligence & Assurance Data Specialist	April 2023	A proposal form is being developed, criteria and data being identified. Audit commenced April 2023. Records reviews completed. Scheduled for completion by the end of Q3 Final report submitted to CIAG 12/12/23 Completed

Ref	Clinical Audit Title	Rationale / Drivers	Clinical Audit Author	Clinical Audit Contact / Support	Audit Start Date	Comments
23_001b	Evaluation of ROLE forms in (ePCR).	In April 2022, the electronic Patient Clinical Record (ePCR) roll out was completed across Wales. For instances where Recognition of Life Extinct (ROLE) is documented, a paper form is completed and left at the scene as information when WAST staff have left.	Kevin Webb Head of Clinical Intelligence & Assurance	Ruth Saele Clinical Intelligence & Assurance Data Specialist	*April 2023*	Decision to evaluate 23_001 as two separate audits (a and b). Scheduled for completion in Q4.
23_004	Re-audit ePCR clinical data assurance - #NOF	To ascertain if improvements have resulted following completion of actions from the previous audit.	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	*To commence after ePCR changes implemented*	ePCR UI changes scheduled for implementation in October 2023. Changes delayed until late December 2023
23_008	Re-audit ePCR clinical data assurance - Stroke	To ascertain if improvements have resulted following completion of actions from the previous audit.	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	*To commence after ePCR changes implemented*	ePCR UI changes scheduled for implementation in October 2023 Changes delayed until late December 2023
23_009	Re-audit ePCR clinical data assurance - STEMI	To ascertain if improvements have resulted following completion of actions from the previous audit.	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	*To commence after ePCR changes implemented*	ePCR UI changes scheduled for implementation in October 2023 Changes delayed until late December 2023
23_005	Re-audit ePCR clinical data assurance - Hypoglycaemia	To ascertain if improvements have resulted following completion of actions from the previous audit.	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	*To commence after ePCR changes implemented*	ePCR UI changes scheduled for implementation in October 2023. Changes delayed until late December 2023.
TBC	Re-audit ePCR clinical data assurance – ROSC (at hospital)	To ascertain if improvements have resulted following completion of actions from the previous audit.	Clinical Intelligence & Assurance Team	Kevin Webb	*To commence after ePCR changes implemented*	ePCR change request awaiting funding approval.

Ref	Clinical Audit Title	Rationale / Drivers	Clinical Audit Author	Clinical Audit Contact / Support	Audit Start Date	Comments
				Head of Clinical Intelligence & Assurance		
23_002	Re-audit of Bronchiolitis Pathway –Compliance to the All-Wales Guideline for Ambulance Service Management	To ascertain if actions following the previous audit have led to an improvement.	Richard Teulon Clinical Intelligence & Assurance Co-ordinator	Ruth Saele Clinical Intelligence & Assurance Data Specialist	*August 2023*	Scoping ePCR data from winter 2022/23. Developing proposal and criteria. This will inform the audit for winter 2023/24. Results & analysis in early Q3 Presented to CIAG 09/11/23.
23_003	Re-audit of assurance for the recording of a Clinical Frailty Score (CFS) in patients aged ≥ 65 years	To ascertain if improvements have resulted following completion of actions from the previous audit.	Claire Muxworthy Clinical Intelligence & Assurance Co-ordinator	Ruth Saele Clinical Intelligence & Assurance Data Specialist	*Indicative Q4 2023/24*	Scoping ePCR data to inform the audit when previous actions completed.
23_006	Appropriate administration of Methoxyflurane (Penthrox®) Clinical Audit	Methoxyflurane has been introduced into WAST to enable non-registrant responders to provide analgesia. The audit aims to audit the safe and effective care of patients who self-administered Methoxyflurane (Penthrox®) analgesia.	Andeep Chohan Project Manager	Claire Muxworthy Clinical Intelligence & Assurance Co-ordinator	*September 2023*	Pilot audit commenced September 2023 to test data prior to full audit. Proceeded to full audit. Final clinical reviews undertaken in December 2023. Scheduled for completion Q4.
23_010	Morphine Administration (Recording accuracy).	Audit agreed in the Ambulance Practice Steering Group. This audit aims to test comparative accuracy between recording of morphine sulphate administered in WAST ePCR, against vehicle CD02 registers.	Chris Moore Head of Medicines Management	Claire Muxworthy Clinical Intelligence & Assurance Co-ordinator	*October 2023*	Data has been supplied in Q2 Audit commenced in Q3.

Ref	Clinical Audit Title	Rationale / Drivers	Clinical Audit Author	Clinical Audit Contact / Support	Audit Start Date	Comments
23_011	Levetiracetam (Keppra) potential use in cases of multiple anti-convulsant administration	It has been proposed that levetiracetam (Keppra) may be beneficial in the treatment of convulsions that have not been resolved with diazepam. An audit is required to consider if, when more than two doses diazepam are needed to stop convulsions, could levetiracetam be considered instead of a third dose of diazepam.	Andy Swinburn Director of Paramedicine	Richard Teulon Clinical Intelligence & Assurance Co-ordinator	October 2023	Audit commenced October 2023. Audit approved at 12/12/2023 CIAG.
23_007	ePCR clinical data assurance - $EtCO_2$ Compliance Reports	The aim of this audit is to determine if automated reporting provides an accurate picture of the clinical care provided, and its outcome will contribute to the development of the $EtCO_2$ Compliance Dashboard.	Nicola Hughes Clinical Intelligence and Assurance Supervisor	Claire Muxworthy Clinical Intelligence & Assurance Co-ordinator	November 2023	Audit completed December 2023. Submit to CIAG January 2024.

The topics in the section below need further development prior to progressing	
Exacerbation of COPD	*Initially intended as a CI, complex and time-consuming for a monthly CI due to requirement of scrutinising all PCRs. CIAG decided that this is to be an audit pending ePCR data.* *Further work needed to clarify criteria.*
Anticonvulsants - Administration in Children	*Re-audit to be undertaken to ascertain if the actions from the previous audit have resulted in improvements.*
Re-audit of clinical photographs in aiding care delivery (Consultant Connect)	*To ascertain if improvements have resulted following completion of actions from the previous audit.*
Appropriateness of Antimicrobial use by WAST Advanced Paramedic Practitioners	*An action from CAED 19_07 was to undertake a re-audit on an annual or bi-annual basis. Decided at the CIAG 19.5.2022 that consideration be given to including this on the CA Programme when ePCR data is available.*
Peripheral line Insertion bundle compliance	*Enquiry from Exec Nurse SBUHB if we report on the Insertion bundle compliance.* *PVC audits have been undertaken but the inclusion of ANTT in an audit was not completed. CIAT have contacted the requestor to support an audit.*

The topics in the section below need further consideration prior to inclusion in the clinical audit plan (*Workshops will be scheduled during the year with key stakeholders to scope these topics further*)	
Ketamine administration	*In addition to pain management audits that are planned, and an internal audit on pain management, this would demonstrate the appropriateness of administration to a specific group of patients suffering severe pain.*
Effectiveness of pain management	*Previous audit on pain scoring and the use of appropriate analgesia have been undertaking – consider re-audits too.* *Pain Management Framework presented to CIAG 12/12/23*
Re-audit of compliance to a Pain Score on PCRs for patients ≥18 years	*Should consider all ages. Consider dashboard option.* *Consider the standard, all patients, all patients in pain.* *Management of pain is more meaningful than only measuring the documentation of a pain score for all patients.*
Explore the correlation between patients presenting with stroke / TIA symptoms and UTI's / dehydration in older adults.	*When auditing clinical records, it has been observed that many elderly patients have a HPC of UTI's+/- dehydration along with their stroke/TIA symptoms.* *Would the outcome of this work add to body of knowledge and inform risk in primary care / patient. Perhaps work around potential pathway/ educational?*
Do long lie faller patients have poorer overall outcomes?	*Older adults who have fallen are a group of patients who are often vulnerable by nature of their acuity / response they can receive and their socio-economic situation.*
Undertake POPS audits within each Health Board are as the roll out continues and it becomes embedded.	*Further discussion is required to establish new criteria for POPS audit based on ePCR data.*
Major Trauma Tool	*High level topic suggestions for CIs at early CIAG meetings.*
Silver Trauma Tool	*High level topic suggestions for CIs at early CIAG meetings.*
Open Fracture (Co-amoxiclav)	*High level topic suggestions for CIs at early CIAG meetings.*
Delayed Handover.	*High level topic suggestions for CIs at early CIAG meetings*
Solo Responding	*High level topic suggestions for CIs at early CIAG meetings.*

Alternative Conveyance	*High level topic suggestions for CIs at early CIAG meetings.*
Resuscitation	*High level topic suggestions for CIs at early CIAG meetings.*
Maternity	*Welsh Government has specified that the aim of the MatNeoSSP Wales programme is to ensure we have clear and consistent improved approaches to maternity and neonatal safety within all services in Wales.*
Recording of Failed Pathways on ePCR	*Following an update to the ePCR User Interface to record the inability to refer patients onto pathways, an audit / evaluation of data would help identify areas for improvement for patient care and avoid unnecessary admission to Eds..*
Further audit topics will be considered for inclusion as new guidelines and medicines are introduced and changes to clinical practice are implemented	

Welsh Ambulance Services NHS Trust
Clinical Audit Action Tracker

Last updated 23rd January 2024

High
Medium
Low

Progress and delivery to actions key:

Red - Off track and not likely to deliver
Amber - Off track and recovery action taken
Green - On track for delivery as planned
Blue - Action complete

ID	Date Approved	Reference	Title	Action No.	Action Priority	Action	Accountable Manager	Date Due	Comments	Progress to Actions RAG-B
A	11/11/2022	CAED 22_005	ePCR Clinical Data Assurance – ROSC (at hospital) Clinical Indicator (2022)	1		This clinical audit to be shared and made available via the Trust Intranet page	Duncan Robertson	30/11/2022	Posted on the Intranet and Yammer 16/11/2022	
				2		All EMS staff using the ePCR are reminded to ensure that : • Wherever there is an out-of-hospital cardiac arrest, the OOHCA section of the ePCR is completed • The OOHCA section always has a documented outcome • Where the patent is declared as deceased, the relevant ROLE (1-4) is documented. • An appropriate condition code is assigned and the record is then closed correctly • In cases where records cannot be closed due to technical reasons, a DATIX form is completed	Duncan Robertson	31/12/2022	The Clinical Improvement Team have developed and are implementing an Improvement plan, initially linked to each of the audits for a condition specific focus each month.	
				3		Submit the change request drafted in response to the crossed records (para 41) to the ePCR Operational Change Manager for consideration by the ePCR Clinical Reference Group	Kevin Webb	31/12/2022	Included on the ePCR CRG agenda - 24/11/2022	
				4		CAED to identify and propose some UI changes of the OOHCA and ROLE sections to improve data quality - highlighting core fields in order to improve data completeness and accuracy. These should be considered through the usual routes, with a change request being submitted to the ePCR Clinical Reference Group	Kevin Webb	31/12/2022	A Change Request Form specifically relating to the cardiac arrest element of the ePCR was presented to the Clinical Reference Group (27/07/2023). Funding for the changes will need to be agreed.	
				5		CAED to report the name data quality issue (para 57) to the Principal Data Warehouse Developer and the Data Quality Lead.	Kevin Webb	31/12/2022	KC email 11/1/2023 to SG & SB	
				6		CIAG to consider the benefits of reporting internally and externally both • the full ROSC-at-hospital metric (all resuscitations) • the subset ROSC-at-hospital Utstein comparator group (patients of presumed cardiac aetiology with a bystander witnessed cardiac arrest and a shockable rhythm)	Kevin Webb	31/03/2024	Linked to action 4. When the UI changes have been made/data reviewed/internal dashboards available, CIAG can agree on what should be reported on. Due date amended to 31/03/2024 as discussions are ongoing to make the appropriate UI changes.	
				7		The Trust to evaluate alternative (more accurate) approaches for monitoring individual clinician standards of care.	Duncan Robertson	30/09/2023	To be discussed further to establish clinical performance requirements below Trust level, e.g., Locality HB etc. A request for change submitted to Terrafix to provide a facility to report at various levels.	
				8		Undertake a re-audit when TerraPACE user interface has matured and include a review of cases where justified exceptions have been documented correctly to ascertain if these have been shown as such in the raw data.	Kevin Webb	30/09/2023	Included on the Clinical Audit Plan 2023/24	
				9		Use this and the previous clinical quality assurance audits to inform an improvement plan for clinical indicators using ePCR data: • Improvements to the User Interface. • Improvement on both recording appropriately within ePCR and compliance to the individual criterion	Kevin Webb	31/12/2022	The Clinical Improvement Team have developed and are implementing an Improvement plan, initially linked to each of the audits for a condition specific focus each month.	
B	23/12/2022	CAED 20_001	Clinical audit and retrospective review of the use of Just in Case medication by Welsh Ambulance Services NHS Trust paramedics (2020/2021)	1		The results of this clinical audit to be shared with all staff via the WAST intranet.	Kevin Webb	28/02/2023	Posted on the Intranet 2nd February 2023	
				2		Suitable amendments are made to the clinical audit criteria for future audits • Advance or future care planning is not considered as a criterion of care within the inclusion criteria as it is not routinely recorded on the PCRs and currently not indicated as an EoLC prompt on ePCR. • The administration of medication via intravenous route is not included in the exclusion criteria.	Ed O'Brian & Kevin Webb	31/01/2023	These points will be taken into account for future JIC medicines audits	
				3		A single Paramedic only to complete any future clinical audits to mitigate the risk of information being interpreted inversely and to ensure consistency.	Ed O'Brian & Kevin Webb	31/03/2023	Where possible, this will be the method followed to ensure consistency of PCR reviews and data capture.	
				4		Just in case medications continue to be administered by WAST clinicians.	Ed O'Brian	28/02/2023	Approved at the Clinical Directorate meeting on 28th February 2023	

				5		Consider PGDs for just in case medications within WAST to replace the need for verbal order forms.	Chris Moore	31/03/2024	6/12/2023 - This is currently on hold, as our priority, following an internal audit, is to review and update a significant number of expired PGDs, before developing new ones. Therefore the date has been extended to 31/03/2024 Safe administration of the EOLC drugs is currently managed by verbal order from a doctor, so paramedics aren't able to administer these drugs autonomously. The Ambulance MSO Group have been preparing a guidance document/framework in relation to administration of EOLC drugs, but like everything else, its completion is dependent on priorities. To be discussed further at the Ambulance Medicines Safety Officer Group and Ambulance Pharmacists Network who are doing a wider piece of work, which is feeding into NASMed/AACE. They are pulling together a framework/guidance on level of practitioners able to administer the JIC meds, so the work is ongoing, but it will inevitably lead to the use of PGDs for the JIC drugs.	
C	12/12/2023	CIAT23_001a	Non-conveyance images in ePCR	1		The results of this clinical audit to be shared with all staff via the WAST Intranet.	Kevin Webb	31/12/2023	Clinical audit posted on Intranet 13/12/23	
				2		An updated Clinical Notice to be issued via WAST Intranet and the JRCALC plus app to reflect the audit findings.	Greg Lloyd	31/01/2024	11 01 24 Sent final CN to Sarah Campion 09.01.24 Feedback from re-draft received from GL and amended as required. 21.12.2023 Draft completed and shared with GL for comment. RS to draft a Clinical Notice for consideration by GL.	
				3		Task and Finish group to be convened to explore V2 of NC form.	Ruth Saele	31/07/2024	17.01.2024 RS has compiled a first draft of V2 for amendment/approval	
				4		NC form draft V2 to be shared with the Patient Experience & Community Involvement Team (PECI) for user feedback.	Ruth Saele	30/09/2024	Reliant on action 3 being completed with a V2 form	
				5		Consider the use of a Vlog to raise awareness of best practice in completion of the NC form.	Ruth Saele	31/07/2024	RS to discuss with DR	
D	09/01/2024	CIAT23_001b	ROLE form images in ePCR	1		The results of this clinical audit to be shared with all staff via the WAST Intranet.	Kevin Webb	10/01/2024	Clinical audit posted on Intranet 10/01/24	
				2		The findings of the audit are discussed at the Ambulance Practice Steering Group.	Kevin Webb	29/02/2024	RS to attend APSG on 19th February	
				3		An updated Clinical Notice specifically for ROLE, to be issued via WAST Intranet and the JRCALC plus app to reflect the audit findings.	Greg Lloyd	31/01/2024	15.01.2024 RS has written Clinical Notice, which has been sent to GL for approval	
				4		Follow up audit 12 months following implementation of above recommendations.	Kevin Webb	01/04/2024	Included on the 2024/2025 clinical audit plan	
				5		Feedback to be provided to staff where the ROLE form back page was not visible in ePCR images.	Keith Dorrington	29/02/2024	27.12.2023 RS has provided KD with the EPR_IDs	
E	09/01/2024	CIAT23_007	ePCR Clinical Data Assurance EtCO2 Compliance	1		The ePCR observations "$ETCO_2$ kPa" field to be added to the automatic data selection for the dashboard.	Kevin Webb	31/01/2024	Request with specification to be written by KC sent to AT & AR, for amendment of View: [dbo].[ePCR_ETCO2Compliance]	
				2		This clinical audit report to be shared and made available via the Trust intranet page.	Kevin Webb	10/01/2024	Clinical audit posted on Intranet 10/01/24	
				3		The results are shared and discussed at the Ambulance Practice Steering Group.	Kevin Webb	29/02/2024	RS to attend APSG on 19th February	
				4		The use of Quick Trach 2 to be monitored monthly by the Regional Clinical Leads.	Kevin Webb	29/02/2024	Regional Clinical Leads can access this from the ETC02 Dashboard	
				5		The Trust to explore options for improvement to maximise ePCR data inputting by on-scene clinicians, and to include prompts at point of ePCR closure to improve compliance and clinical practice.	Duncan Robertson	31/03/2024	To be managed by the ePCR compliance approval group	
				6		A Clinical Notice to be issued via WAST Intranet to clarify required ePCR documentation when EMRTS are involved in the care.	Kath Charters	31/01/2024	1601.2024 KC to wite clinical notice.	

AGENDA ITEM No	**13.3**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**1**

Clinical Audit Plan 2024-2025

MEETING	Quality, Patient Experience and Safety Committee
DATE	8 February 2024
EXECUTIVE	Director of Paramedicine
AUTHOR	Head of Clinical Intelligence & Assurance
CONTACT	Kevin Webb Kevin.webb@wales.nhs.uk

EXECUTIVE SUMMARY

Following an 'Audit Wales' review of WAST's Quality Governance Arrangements, one of the recommendations was for the Clinical Audit Plan to be submitted to QuEST for scrutiny and approval ahead of each financial year, and then monitored on a quarterly basis.

RECOMMENDED: That the committee Approve the Clinical Audit Plan 2024-2025

KEY ISSUES/IMPLICATIONS

Many of the audits and re-audits can be undertaken solely by the Clinical Intelligence & Assurance Team. However, support is required for some topics where subject matter experts are needed as authors, and the support of sponsors to ensure completion of the audits and subsequent actions.

It is not always possible to predict at the start of a financial year all of the topics that will require evaluation and therefore flexibility in setting a Clinical Audit Plan is required, resulting in the annual plan being a dynamic document, updated quarterly.

REPORT APPROVAL ROUTE

Quality, Patient Experience and Safety Committee – 8 February 2024

REPORT APPENDICES

WAST Clinical Audit Plan 2024-2025

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

SITUATION

1. Following an 'Audit Wales' review of WAST's Quality Governance Arrangements, one of the recommendations was for the Clinical Audit Plan to be submitted to QuEST for scrutiny and approval ahead of each financial year, and then monitored on a quarterly basis.

BACKGROUND

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

3. The plan is developed in consultation with the Clinical Intelligence & Assurance Team (CIAT), and senior clinical, and non-clinical managers within the Trust. It is expected that managers will ensure there is an opportunity for staff at all levels to contribute to the development of the core plan and undertake clinical audits.

4. Care, treatment, and decision making should reflect best practice based on evidence to ensure that people receive the right care and support to meet their individual needs.

5. The Trust's annual Clinical Audit Plan allows the planning and prioritisation of clinical audits across the financial year. It is a dynamic document, updated quarterly to reflect those audits that are either planned, currently underway, have been completed, or are to be considered. Various groups and committees receive quarterly updates against this plan of work, and it is made available on the Trust's Intranet.

6. This plan and the subsequent action tracker to monitor learning from each of the audits is monitored by the Clinical Intelligence & Assurance Group (CIAG), and an update noted at Clinical Directorate Business meetings.

ASSESSMENT

7. The Clinical Audit Plan 2024-2025 (attached) includes two main sections:

    a) Clinical audits that have been agreed to progress.

    b) Topics that require additional information prior to being considered for inclusion in the plan.

8. Many of the audits and re-audits can be undertaken solely by the CIAT. However, support is required for some topics where subject matter experts are needed as authors, and the of support sponsors to ensure completion of the audits and subsequent actions.

9. A further piece of work worth noting as part of this update although not part of the plan is progress to an internal audit action. One of the recommendations from an internal audit on 'Pain Management' was "To gain assurances on the completeness of pain management recorded for patients, additional pathways within the ePCR system, should be established to extract the required data; and reported to an appropriate forum with any themes or trends highlighted within the report.

10. In response, WAST agreed to set up a task and finish group to develop and design a pain management framework to support analysis and presentation of pain and analgesia related data. The framework was completed in December 2023 following four task and finish group meetings along with specific meetings with individual subject matter experts. Approval for the framework to be submitted to the February 2024 CQGG meeting was given at the December 2023 CIAG meeting.

RECOMMENDED: That the committee Approve the Clinical Audit Plan for 2024-25.

EQUALITY IMPACT ASSESSMENT

Not required

REPORT CHECKLIST

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

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
NHS Trust

Welsh Ambulance Services NHS Trust

Clinical Audit Plan

2024/2025
Quarter 1

Final Draft v0.5 Last Updated 25 January 2024

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

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

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

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

- Opportunities to improve clinical effectiveness and evidence-based practice (e.g., efficacy of treatment, new initiatives, pilot projects)
- Opportunities to quality assure clinical data (e.g., Clinical Indicator reports from electronic Patient Clinical Record (ePCR) data)
- Clinical risk management/patient safety (e.g., choosing topics in response to concerns highlighted by patient safety incidents)
- National inquiries/patient safety incidents
- Local and Trust wide priorities
- Guidance documents (e.g., National Institute for Health and Care Excellence (NICE), Association of Ambulance Chief Executives (AACE), and the Joint Royal Colleges Ambulance Liaison Committee (JRCALC).
- National Ambulance Service Clinical Quality Group
- Policy documents relating to health and healthcare
- Other benchmarking activities as appropriate

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

It is not always possible to predict at the start of a financial year all of the topics that will require evaluation and therefore flexibility in setting a Clinical Audit Plan is required, resulting in the annual plan being a dynamic document, updated quarterly.

The aim of this plan is to detail the:

- clinical audits that are either planned, currently underway or have been completed during the financial year **(Table 1 & Table 2)**
- suggested topics that need further consideration and a decision on the question being asked, availability of data etc. (**Table 3**)

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

The completed clinical audit reports are available on the Clinical Audit page of the Trust's Intranet website. (https://nhswales365.sharepoint.com/sites/AMB-Intranet-Medical/SitePages/Clinical-Audit-Programme.aspx)

Kevin Webb – Head of Clinical Intelligence & Assurance

Table 1– Summary (Full information in Table 2)

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

This section contains confirmed clinical audits

Ref	Tier	Clinical Audit Title	Clinical Audit Author	Clinical Audit Sponsor	Audit Start Date	Current Status (RAG)*				
						Q4 2023/2024	Q1	Q2	Q3	Q4
23_004	1	#NOF - ePCR Clinical Data Assurance Re-Audit.	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	*Indicative Q4 2023/24*					
23_008	1	Stroke - ePCR Clinical Data Assurance Re-Audit.	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	*To commence after ePCR changes implemented*	N/A				
23_009	1	STEMI - ePCR Clinical Data Assurance Re-Audit.	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	*To commence after ePCR changes implemented*	N/A				
23_005	1	Hypoglycaemia - ePCR Clinical Data Assurance Re-Audit.	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	*Indicative Q4 2023/24*					
TBC	1	ROSC (at hospital) - ePCR Clinical Data Assurance Re-Audit.	Clinical Intelligence & Assurance Team	Kevin Webb	*To commence after ePCR changes implemented*	N/A				

				Head of Clinical Intelligence & Assurance						
23_003	1	Clinical Frailty Scale (CFS) in Patients Aged ≥65 years Follow Up Audit.	Richard Teulon Clinical Intelligence & Assurance Co-ordinator	Duncan Robertson Assistant Director of Clinical Development	*Indicative Q4 2023/24*					
23_010	1	Morphine Administration. (Recording accuracy)	Claire Muxworthy Clinical Intelligence & Assurance Co-ordinator	Duncan Robertson Assistant Director of Clinical Development	October 2023					
TBC	1	Older Adult Fallers Discharged at Scene - ePCR Clinical Data Assurance.	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	Indicative Q1	N/A				
TBC	1	Tranexamic Acid (TXA) Administration in the South Wales Trauma Network Follow-Up Audit).	Clinical Intelligence & Assurance Team	Greg Lloyd Assistant Director of Clinical Delivery	Indicative Q1	N/A				
TBC	1	Recording of Failed Pathways on ePCR.	Jonathan Chippendale	Duncan Robertson Assistant Director of Clinical Development	Indicative Q2/3	N/A	N/A			
TBC	1	ROLE Form Images in ePCR Re-Audit.	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	Indicative Q4	N/A	N/A	N/A	N/A	
TBC	1	Major Trauma Tool.	TBC	Greg Lloyd Assistant Director of Clinical Delivery	TBC	N/A				

TBC	1	Safeguarding Adolescent Re-Audit	Gwenan Jones-Parry Safeguarding Specialist Paramedic	Rhiannon Thomas Senior Professional Safeguarding	TBC	N/A	N/A	N/A		

Table 2– Full Information

Ref	Clinical Audit Title	Rationale/Drivers	Clinical Audit Author	Clinical Audit Contact/Support	Audit Start Date	Comments
23_004	#NOF - ePCR Clinical Data Assurance Re-Audit.	To ascertain if improvements have resulted following completion of actions from the previous audit.	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	*Indicative Q4 2023/24*	ePCR UI changes implemented in December 2023.
23_008	Stroke - ePCR Clinical Data Assurance Re-Audit.	To ascertain if improvements have resulted following completion of actions from the previous audit.	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	*To commence after ePCR changes implemented*	ePCR UI changes implemented in December 2023.
23_009	STEMI - ePCR Clinical Data Assurance Re-Audit.	To ascertain if improvements have resulted following completion of actions from the previous audit.	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	*To commence after ePCR changes implemented*	ePCR UI changes implemented in December 2023.
23_005	Hypoglycaemia - ePCR Clinical Data Assurance Re-Audit.	To ascertain if improvements have resulted following completion of actions from the previous audit.	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	*Indicative Q4 2023/24*	ePCR UI changes implemented in December 2023.
TBC	ROSC (at hospital) - ePCR Clinical Data Assurance Re-Audit.	To ascertain if improvements have resulted following completion of actions from the previous audit.	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	*TBC*	Funding required for these specific changes. Potential to use 'Point of Closure' changes to improve compliance.
23_003	Clinical Frailty Scale (CFS) in Patients Aged ≥65 years Follow Up Audit.	To ascertain if improvements have resulted following completion of actions from the previous audit.	Richard Teulon Clinical Intelligence & Assurance	Ruth Saele Clinical Intelligence &	*Indicative Q4 2023/24*	Draft scripting prepared to obtain ePCR data.

Ref	Clinical Audit Title	Rationale/Drivers	Clinical Audit Author	Clinical Audit Contact/Support	Audit Start Date	Comments
			Co-ordinator	Assurance Data Specialist		
23_010	Morphine Administration (Recording accuracy).	Audit agreed in the Ambulance Practice Steering Group. This audit aims to test comparative accuracy between recording of morphine sulphate administered in WAST ePCR, against vehicle CD02 registers.	Claire Muxworthy Clinical Intelligence & Assurance Co-ordinator	Kevin Webb Head of Clinical Intelligence & Assurance	*October 2023*	Data has been supplied in Q2 (2023/24). Audit commenced in Q3.
TBC	Older Adult Fallers Discharged at Scene - ePCR Clinical Data Assurance.	To ascertain the availability and quality of raw ePCR data to inform the development of a Clinical Indicator.	Clinical Intelligence & Assurance Team	Ruth Saele Clinical Intelligence & Assurance Data Specialist	Indicative Q1	A pilot audit was undertaken in collaboration with UK Ambulance Trusts. WAST to now look at specific criteria for a Clinical Indicator.
TBC	Tranexamic Acid (TXA) Administration in the South Wales Trauma Network (follow-up audit).	To ascertain if improvements have resulted following completion of actions from the previous audit.	Clinical Intelligence & Assurance Team	Ruth Saele Clinical Intelligence & Assurance Data Specialist	Indicative Q1	Criteria may change as initial audit used digital pen data and ePCR data is now available. Therefore, this may be a follow up audit rather than a re-audit.
TBC	Recording of Failed Pathways on ePCR.	Following an update to the ePCR User Interface to record the inability to refer patients onto pathways, an audit would assist in identifying areas for improvement for patient care and avoid unnecessary admission to EDs.	Jonathan Chippendale	Clinical Intelligence & Assurance Team	Indicative Q2/3	Jonathan Chippendale (11/1/24) – confirmed audit required.
TBC	ROLE Form Images in ePCR Re-Audit.	To ascertain if improvements have resulted following completion of actions from the previous audit.	Clinical Intelligence & Assurance Team	Ruth Saele Clinical Intelligence &	Indicative Q4	

Ref	Clinical Audit Title	Rationale/Drivers	Clinical Audit Author	Clinical Audit Contact/Support	Audit Start Date	Comments
				Assurance Data Specialist		
TBC	Major Trauma Tool.	In addition to the TXA audit, this would include contact with the Trauma Desk and disposition (Trauma Unit etc).	Carl Powell Clinical Lead Acute Care	Clinical Intelligence & Assurance Team	Indicative Q2/3	Confirmed by GL that audit to progress during 2024/25.
TBC	Safeguarding Adolescent Re-Audit	To ascertain if improvements have resulted following completion of actions from the previous audit.	Gwenan Jones-Parry Safeguarding Specialist Paramedic	Claire Muxworthy Clinical Intelligence & Assurance Co-ordinator	Indicative Q3	

Table 3– Topics for consideration

The topics below need additional information prior to being considered for inclusion in the plan	
Quality Assurance on the care provided to patients with exacerbation of COPD.	*Initially intended as a CI, complex and time-consuming for a monthly CI due to requirement of scrutinising all PCRs. Clinical Intelligence and Assurance Group (CIAG) decided that this is to be an audit pending clarification of criteria and availability of ePCR data.* *To be discussed at Ambulance Practice Steering Group, potential of Task and Finish to define criteria.* *Possibly specific criteria, e.g., an intervention/Medicine, Ipratropium Bromide, Hydrocortisone.*
Appropriateness of Antimicrobial Use by WAST Advanced Paramedic Practitioners.	*An action from CAED 19_07 was to undertake a re-audit on an annual or bi-annual basis. Decided at CIAG 19.5.2022 that consideration be given to including this on the CA Programme when ePCR data is available.* *To be discussed with the Professional Development Lead and CIAT.*
Undertake POPS audits within each Health Board area as the roll out continues and it becomes embedded.	*Further discussion is required to establish new criteria for a POPS audit based on ePCR data. POPS is now incorporated in the ePCR and auto calculated.* *To be discussed with Regional Clinical Leads and CIAT. Consider what are the gaps, if no POPS on some children why not, consider the development of a dashboard.*
Peripheral Line Insertion Bundle Compliance.	*Further discussion is required with the Head of Infection Prevention & Control and CIAT to establish criteria and support.*
Ketamine Administration.	*To be discussed with Regional Clinical Lead (MJ) and CIAT. Consider as part of the pain management framework/development of a dashboard/appropriate use of Flumazenil (reverse benzodiazepines)?*
Alternative Conveyance.	*To be discussed with Bryn Thomas/Kerry Robertshaw/Jonathan Chippendale.*
End of Life Care Audit.	*To be discussed with the Clinical Lead for Palliative Care & EoLC.* *Consider an audit relating to the Palliative Care Paramedic role.*
Common Paramedic drug documentation accuracy within ePCRs.	*To be discussed at CIAG, possibly a clinical audit to include SPs/Clinical Supervision re LDP 2023/2024.*

Maternity/Newborn.	*Welsh Government has specified that the aim of the MatNeoSSP Wales programme is to ensure we have clear and consistent improved approaches to maternity and neonatal safety within all services in Wales.* *Discuss with WAST's Local Safety Champion (Midwife). A clinical audit to be considered in addition to data requests.*
Use of Quick Trach2.	Potential clinical audit identified form data included in the *ePCR Clinical Data Assurance – EtCO2 Compliance* audit (CIAT23_007). *Discussion required with DR/MJ and CIAT.*
Further audit topics will be considered for inclusion as new guidelines and medicines are introduced and changes to clinical practice are implemented	

AGENDA ITEM No	**14**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**1**

Medicines Management Assurance Report for 2023

MEETING	QuEST
DATE	8th February 2024
EXECUTIVE	Executive Director of Paramedicine
AUTHOR	Head of Medicines Management
CONTACT	Chris.Moore@wales.nhs.uk

EXECUTIVE SUMMARY

1. QUEST have requested a summary annual medicines management report.

2. This first annual report provides an overview of medicines related quality measures, drawn from monthly Medicines Management Assurance Reports (MMAR) for the 2023 calendar year.

3. A number of the measures reported, have been initiated in direct response to feedback received from Internal Audit reviews.

4. MMAR reports are presented to the Ambulance Practice Steering Group monthly, and quarterly to the Senior Operations Team.

5. Close working with Operational teams ensures compliance is monitored and local audits are completed in time.

6. Areas covered in the report include:

   - Vehicle medicines Audit
   - Omnicell Monthly Cycle Count
   - Unresolved Controlled Drug Discrepancies on the Omnicell System
   - Patient Group Directions (PGD) – Evidence of Signed Authorisations
   - Expired PGDs
   - Abloy System
   - Notification Alerts
   - Controlled Drug Quarterly Occurrence Reports
   - Medication Errors

Recommended: That

(1) Future reports for QuEST are synchronised to be delivered following closure of a financial year, therefore next report to be delivered at the May 2025 meeting covering the 2024/25 financial year; and

(2) The Committee note and discuss the content of the appended report as required.

KEY ISSUES/IMPLICATIONS
Team capacity to deliver effective medicines management within the clinical directorate is under review to assess the options for the future state. These include the hours provided by a pharmacy advisor and a Medicines Safety role to align with other UK Ambulance Services.

REPORT APPROVAL ROUTE
Clinical Directorate Business Meeting for approval (31st January 2024) QUEST for discussion, (8th February 2024)

REPORT APPENDICES
MMAR Annual Report 2023

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

Medicines Management Assurance Report

Yearly update for 2023

This first annual report provides an overview of medicines related quality measures, drawn from monthly Medicines Management Assurance Reports (MMAR) for the 2023 calendar year. A number of the measures reported, have been initiated in direct response to feedback received from Internal Audit reviews. MMAR reports are presented to the Ambulance Practice Steering Group monthly, and quarterly to the Senior Operations Team.

Vehicle Medicines Audit (CD05)

Vehicle Medicines Audits (VMAs) have been established in WAST for several years. The main purpose of the audits is to check that the stock levels of vehicle, controlled drug (CD) safes are consistent with the vehicle CD safe register, and those of the vehicle drug case consistent with the contents list and are in date. The quality measure for this audit, is for every Locality to complete at least one VMA (one vehicle) per month. Compliance against this target has been consistently high (100%), for over 24-months. However, in October 2023, several areas reported being unable to enter their audit results using the online tool. This resulted in a temporary fall in compliance in October 2023 (possibly due to a system change) but returned to 100% in November and December.

LHB	Audits Completed	Vehicles Audited	% Compliance
Aneurin Bevan	65	41	98.5%
Betsi Cadwaladr	160	76	95.0%
Cardiff and Vale	28	21	100.0%
Cwm Taf Morgannwg	70	49	95.7%
HART	5	4	100.0%
Hywel Dda	89	46	88.8%
Powys Teaching	39	23	100.0%
Swansea Bay	77	49	96.1%

Table 1: VMA Compliance by Health Board Area – January 1st to December 31st 2023

Omnicell Cabinet Monthly Cycle Count

Omnicell Cycle Counts are aimed at ensuring that stock levels within the cabinets are accurate and remain capable of supporting operational requirements at all times. When this measure was first reported, 'prescription only medicine (POM) items and CD items were combined (45 items) and reported as a single column. Responding to feedback from Internal Audit in 2023, POM and CD items are now reported separately, offering a more detailed picture of cycle count compliance. A cycle count is considered to be complete if a minimum of 36 of 41 'POM' items and all 4 'CD' items have been counted. In ***Figure 1*** below, compliant counts are represented in GREEN and non-compliant RED.

HB	Cabinet	Jan-23		Feb-23		Mar-23		Apr-23		May-23		Jun-23		Jul-23		Aug-23		Sep-23		Oct-23		Nov-23		Dec-23	
		POM	CD	POM	CD	POM	CD	POM	CD	POM	CD	POM	CD	POM	CD	POM	CD	POM	CD	POM	CD	POM	CD	POM	CD
%		80%	90%	80%	80%	70%	80%	85%	85%	80%	85%	100%	95%	90%	85%	90%	95%	90%	95%	85%	75%	85%	75%	90%	85%
AB	GUH	39	4	39	4	6	1	7	2	11	4	41	4	40	4	41	4	39	4	38	4	41	4	41	4
AB	Nev Hall	18	4	6	1	33	4	37	4	6	2	37	4	40	4	40	4	36	4	40	3	36	3	41	4
ABM	Morriston	34	4	9	4	33	2	41	4	38	4	41	4	41	4	41	4	41	4	38	3	41	4	41	4
ABM	POW	40	4	39	4	40	4	40	4	41	4	41	4	41	4	41	4	41	4	40	4	41	4	41	4
BCU	YGC	7	4	4	1	14	4	28	3	38	4	39	4	6	3	11	1	32	4	41	4	41	4	40	4
BCU	YG	38	4	39	4	8	4	40	4	9	3	41	4	41	3	39	4	40	4	15	0	9	3	9	1
BCU	Wrexham	41	4	40	0	39	4	40	4	40	4	41	4	41	4	36	4	41	4	40	4	41	4	41	4
BCU	Dobshill	41	3	41	4	41	1	38	4	38	4	39	3	41	4	41	4	41	4	41	4	41	4	41	4
C&V	UHW	37	4	37	4	39	4	40	4	40	4	40	4	41	4	41	4	39	4	41	4	41	4	39	4
C&V	UHL	39	4	40	4	38	4	40	4	40	4	41	4	41	4	41	4	41	4	41	4	41	4	40	0
CT	Prince Charles	38	4	38	4	40	4	39	4	39	4	40	4	41	4	41	4	38	4	10	1	8	2	40	4
CT	R Glam	4	3	3	1	36	4	7	3	41	4	41	4	41	4	41	4	41	4	41	4	41	4	41	4
HD	Bronglais	39	4	41	4	40	4	40	4	40	4	36	4	41	4	41	4	41	4	41	4	41	4	41	4
HD	Withybush	40	4	40	4	40	4	39	4	39	4	41	4	40	4	40	4	41	0	41	4	41	4	41	4
HD	WWG	40	4	40	4	40	4	40	4	39	4	41	4	3	1	9	4	4	4	7	1	31	1	4	1
HD	Prince Philip	40	4	40	4	8	1	39	4	6	1	40	4	41	4	41	4	39	4	38	4	41	3	38	4
POW	Newtown	40	4	41	4	40	4	40	4	41	4	41	4	41	4	41	4	41	4	41	4	41	4	41	4
POW	Welshpool	40	4	41	4	40	4	40	4	40	4	41	4	41	4	41	4	41	4	41	4	41	4	41	4
POW	Brecon	40	4	40	4	40	4	40	4	40	4	41	4	41	4	41	4	41	4	41	4	41	4	41	4
POW	Llandrindod	40	4	40	4	40	4	40	4	40	4	41	4	41	4	41	4	41	4	41	4	41	4	41	4

Figure 1. Omnicell cycle count by HB area and cabinet site – 1st January to 31st December 2023

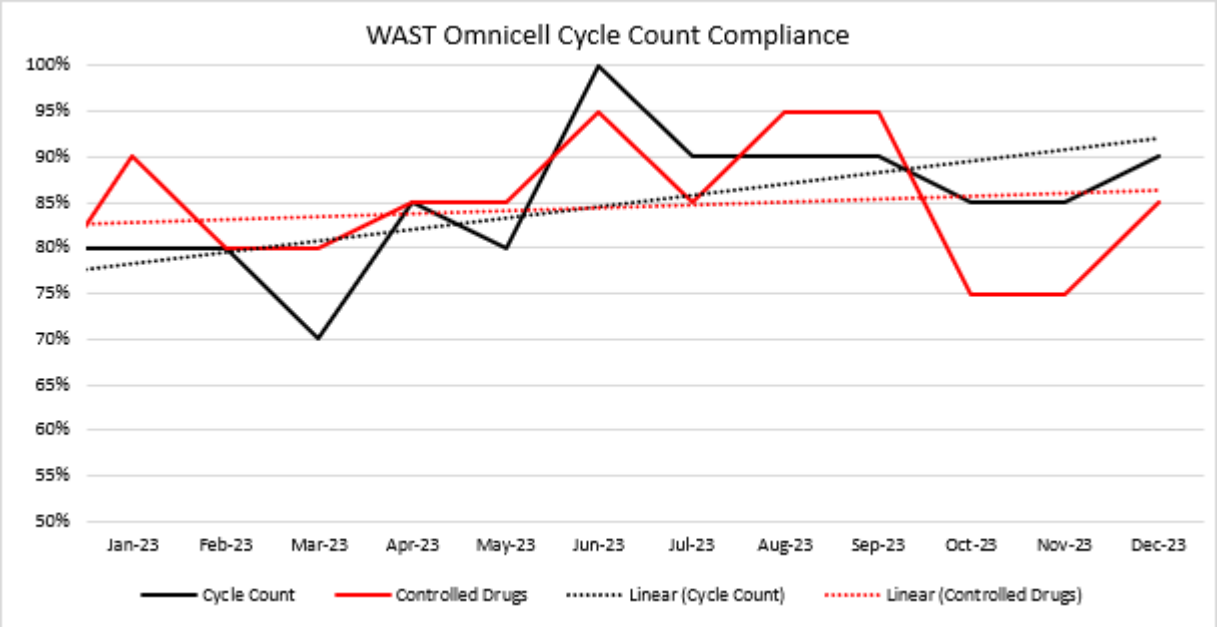


Figure 2. Linear trends of POM and CD cycle count compliance

Unresolved CD Discrepancies on Omnicell System

CD discrepancies on the Omnicell cabinet usually occur due to user error in counting the number of items in a specific area. In the CD area of the cabinet, users are required to count the number of items in a specific area (secure bin), prior to removing the required number of items. Most discrepancies occur because a user has removed an item, then counted the remaining items. If the number of items entered by the user is below that expected by the cabinet, a discrepancy alert is created and emailed directly to Duty Operations Managers (DOM)/Senior Paramedics (SP) and includes the users details. This mechanism is designed to ensure that DOMs/SPs can contact the user within minutes of the discrepancy occurring, establish the reason for the discrepancy, and resolve it at the cabinet. Omnicell discrepancies are reported by Health Board area, monthly as part of the MMAR. ***Figure 3*** below, shows the total number of CD discrepancies created across Wales by month, number resolved and unresolved. From January 2023 to December 2023 there were 275 discrepancies created, 199 of which were resolved. 76 were

unresolved at time of generating the Omnicell report. Over the reporting period there has been a steady decline in the number of discrepancies raised and the number being resolved is improving.

Month	Discrepancies	Resolved	Unresolved
Jan	14	12	2
Feb	36	29	7
Mar	30	20	10
Apr	39	29	10
May	27	19	8
Jun	34	25	9
Jul	30	24	6
Aug	16	6	10
Sep	22	12	10
Oct			
Nov	14	11	3
Dec	13	12	1

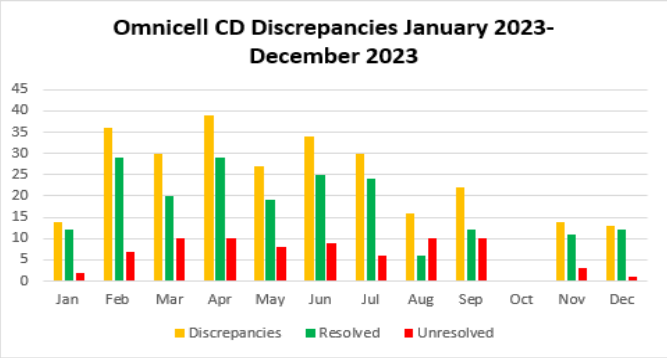


Figure 3. Omnicell CD Discrepancies 1st January to 31st December 2023

Patient Group Direction – evidence of signed authorisations

Patient Group Directions (PGDs) are a legal mechanism that permit groups of WAST clinicians (registrants), to administer drugs not currently included in Schedule 17 of the Human Medicines Regulations (2012). There are three EMS specific PGDs for intravenous use by WAST paramedics: Diazepam 10mg/2ml, Tranexamic Acid 100mg/ml and Co-amoxiclav 1200mg. Compliance is reported as the proportion of signed authorisations held on file by WAST Medicines Management, considering the number of paramedics in each Health Board area, minus abstractions (long-term sick, maternity leave, alternative duties).

Reporting of compliance against the three 'Paramedic' PGD medicines began in January 2022. At that time, national compliance for Co-amoxiclav was 82.4%, Diazepam 76.9% and Tranexamic acid 67.5%. ***Table 2*** below, shows national compliance for the 'paramedic' PGDs has improved significantly since January 2022, most likely driven by transparent reporting and a strong commitment from Operations leaders to ensure paramedics working in their health board areas are compliant with their legal requirement to be signatories to PGDs for medicines not included in the Schedule 17 exemptions.

It should be noted that the Diazepam and Tranexamic Acid PGDs have recently been revised and reissued (October 2023). Users are required to complete a new electronic authorisation form, to confirm that they have read, understood and will work within the auspices of the updated PGDs. Compliance against the new PGDs will be reported via the monthly MMAR from February 2024.

Health Board	Diazepam	TXA	Co-amoxiclav	All 3 PGDs
Aneurin Bevan	94%	91%	96%	**94%**
Betsi	99%	98%	96%	**98%**
Cardiff & Vale	100%	100%	100%	**100%**
Cwm Taf	99%	99%	100%	**99%**
HART	100%	100%	100%	**100%**
Hywel Dda	99%	96%	100%	**98%**
Powys	100%	100%	100%	**100%**
Swansea Bay	100%	99%	100%	**100%**
Overall	**99%**	**98%**	**99%**	**99%**

Table 2. PGD Compliance for 'Paramedic' medicines as of 31st December 2023

In 2022/23 NHS Wales Shared Services Partnership (NWSSP), Audit and Assurance Services conducted a 'Pain Management' audit. The purpose was to review the application of pain relief methods and their effect on pain management outcomes in terms of pain relief and patient satisfaction. Whilst not directly related to their pain management objectives, during their work, Internal Audit colleagues noted that whilst compliance to 'paramedic' PGDs was routinely reported and shared, the Trust Medicines Management Policy made reference to additional 'Advanced Paramedic Practitioner' (APP) PGDs. Internal Audit colleagues duly noted that PGD compliance for APP medicines was poor, with rates ranging from 32% to 81%, with 13 of the 20 PGDs failing to achieve a 75% level of compliance. As a result, it was recommended that APP PGD compliance be added to the monthly MMAR reports with the aim of driving up compliance. ***Table 3*** below, shows regional compliance by PGD, as of December 2023. Target compliance for all PGDs is 95%, represented as a GREEN cell.

PGD	Central & West	South East	North	Total
Amoxicillin	100%	63.6%	88.9%	**84.17%**
Cetirizine Hydrochloride	100%	90.9%	96.3%	**95.73%**
Clarithromycin	86.2%	59.1%	74.1%	**73.13%**
Co-Amoxiclav	100%	68.2%	88.9%	**85.70%**
Codeine Phosphate	89.7%	90.9%	88.9%	**89.83%**
Diazepam	89.7%	77.3%	88.9%	**85.30%**
Doxycycline	93.1%	77.3%	85.2%	**85.20%**
Flucloxacillin	100%	68.2%	88.9%	**85.70%**
Fluorescein Sodium 1%	100%	81.8%	96.3%	**92.70%**
Ibuprofen	100%	90.9%	96.3%	**95.73%**
Loperamide Hydrochloride	100%	90.9%	96.3%	**95.73%**
Nitrofurantoin	93.1%	77.3%	85.2%	**85.20%**
Oral Rehydration Salts	100%	86.4%	96.3%	**94.23%**
Paracetamol	82.8%	59.1%	81.4%	**74.43%**
Penicillin 'V	100%	68.2%	88.9%	**85.70%**
Prednisolone	100%	90.9%	96.3%	**95.73%**
Prochlorperazine	100%	81.8%	96.3%	**92.70%**
Tetracaine Hydrochloride	86.2%	68.2%	81.5%	**78.63%**
Trimethoprim	89.7%	72.7%	88.9%	**83.77%**
Salbutamol MDI	100%	77.3%	96.3%	**91.20%**
Regional Average	***95.53%***	***77.05%***	***90.01%***	***87.53%***

Table 3: 'Advanced Paramedic Practitioner' PGD Compliance December 2023

A further three PGD medicines to support the administration of 'Enhanced Analgesia' are available to a limited number of WAST SPs and paramedics working on the Cymru High Acuity Response Unit (CHARU) service. The three PGD medicines are; Flumazenil, Ketamine and Midazolam, and reporting of compliance against these PGDs via the MMAR commenced in June 2023. ***Table 4*** below, offers a 'then and now' comparison of compliance performance between June and December 2023.

Paramedic Grade	Ketamine %		Midazolam %		Flumazenil %	
	June	December	June	December	June	December
CHARU	89.2	99.1	89.2	99.1	88.3	98.2
Senior	74.5	100	74.5	100	74.5	100
HART	85	95	85	95	85	95

Table 4. 'Enhanced Analgesia' PGD compliance June/December 2023

Expired PGDs

During their 2023 'Pain Management' fieldwork, Internal Audit colleagues noted that 12 of the 26 PGDs described above had surpassed their review period. In response to their recommendation (1.2) an action plan was put in place with an immediate action to extend the 'life' of all expired PGDs to 31 January 2024. With the support of the Trust Pharmacist Advisor, review, update and approval of the 8 expired 'APP' PGDs was completed in late December 2023 and have subsequently been issued to APPs. Review of the three 'enhanced analgesia' PGDs has been scheduled for January-February 2024, subject to availability of our Pharmacist Advisor (0.125 WTE). At the time of writing, a meeting has also been scheduled with Welsh Medicines Information Service colleagues, with a view to exploring the support and expertise they are able to provide, in relation to future development and management of Trust PGDs.

Abloy System

The Trust Abloy system supports the safer management of CDs. Rollout of the system commenced in February 2020 and was completed August 2020. The system has three main components;

- individual issue keys – 1,403 issued to paramedics
- programming devices – 95 station-based units
- CD safes – 522 EMS vehicles, 44 station-based safes.
- Web-based operating system (controlled access)

At the start of their shift, paramedics are required to dock their key in the station wall mounted programming device. This action will upload CD access activity for the previous shift, before activating the key for a fixed 15-hour period. Once activated, paramedics can access all vehicle CD safes. Access to station-based CD safes is restricted to specific individuals (DOM/SP/CHARU), dependent on the access profile assigned to their keys.

Notification Alerts

The Trust receives alerts and notifications (medicines, equipment, patient safety), from a range of sources. The Trust Head of Medicines Management is responsible for reviewing all medicines related notifications to assess their impact to the organisation

and/or its clinicians. The vast majority of notifications have no implications, therefore requiring no action. Between January to December 2023, 108 medicines related notifications were received, 6 of which were considered relevant to the organisation/clinicians. Most commonly, notifications are related to medicines shortages/supply issues. Examples of relevant alerts received during 2023 include; Amiodarone 300mg pre-filled syringes, Glucagen injection and Ketamine 10mg/ml injection. Where possible, in consultation with our NHS pharmacy suppliers, the Trust will deploy alternative presentations. At the time of writing, supply of Amiodarone 300mg pre-filled syringes remains erratic, so Amiodarone 150mg ampoules are being deployed.

Controlled Drugs Quarterly Occurrence Reports

The UK Government's response to the Shipman Inquiry's Fourth Report, Safer management of controlled drugs (2008), required all healthcare and social care organisations to be accountable for the safe management of the CDs it uses. In Wales, each Health Board is responsible for organising and chairing a Local Intelligence Network (LIN). Chaired by the Health Board Accountable Officer, LIN meetings are generally held on a quarterly basis. Each organisation that uses CDs within the boundaries of a LIN, is required to submit a quarterly occurrence report, detailing the type of incident (loss/theft/discrepancy/breakage), and describing any actions taken to minimise a recurrence. In WAST, the Head of Medicines Management is responsible for reviewing all reported CD incidents and preparing the LIN report on behalf of the Trust Accountable Officer (Executive Medical Director), which is circulated to each of the 7 LIN in Wales. Table 5 below, provides an overview of the number and type of incidents reported over the four quarters of the 2023 calendar year.

2023	No. of incidents	Incident type
Q1	14	• *Accidental breakage = 5* • *Unexplained breakage = 1* • *Other =2* • *Discrepancies = 3 (1 resolved)* • *Accidental loss = 1* • *Unaccountable loss = 1* • *Lost key = 1 (found)*
Q2	13	• *Accidental breakage = 3* • *Other = 2* • *Discrepancies = 5 (all resolved)* • *Accidental loss = 1* • *Unaccountable loss = 1* • *Lost key = 1 (found)*
Q3	11	• *Accidental breakage = 2* • *Unexplained breakage = 2* • *Other = 1* • *Discrepancies = 5 (4 resolved)* • *Unaccountable loss = 1*
Q4	8	• *Accidental breakage = 1* • *Other = 3* • *Discrepancies = 3 (2 resolved, 1 open)* • *Lost key = 1*

Table 5. Summary of CD incidents reported to LIN Jan-Dec 2023

Medication Errors

Table 6 below, provides an overview of the 49 medication errors reported on DATIX up to December 19th 2023. Limited resources within the Medicines Management team limits the ability to conduct an in-depth analysis of this data in the time available to prepare this report, but it is hoped to include this in future annual MMAR.

Number of reported incidents by Harm (reporter)					
Calendar Year	**No Harm**	**Low Harm**	**Moderate Harm**	**Severe Harm**	**Total**
2023	13	28	6	2	49
Number of reported incidents by Sub-category					
Incorrect medication	**Incorrect strength/dose**	**Expired medication**	**Administration contraindicated**	**Unauthorised 3 Recording error 1 Early administration 3 Incorrect technique 3 Omitted medication 2**	**Total**
6	10	3	18	12	49

Future Plans

- To explore the potential to recruit a WTE Pharmacist Advisor to support and strengthen the work of Medicines Management, in line with other UK Ambulance services.
- Explore options to establish a Medicines Safety Officer role within WAST, in line with other UK Ambulance services.

If you require any further information following the Medicines Management Assurance Report, please contact; AMB_MedsManagement@wales.nhs.uk

This report was jointly prepared by Sarah Garrathy, Business and Systems Administrator and Dr Chris Moore, Head of Medicines Management.

AGENDA ITEM No	**15**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**3**

COMMITTEE EFFECTIVENESS REVIEW 2023/24

MEETING	QUEST Committee
DATE	8 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. As a result of the response to questionnaires completed by members and attendees a number of changes are now proposed to the Committee's operating arrangements and terms of reference.

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).

RECOMMENDATION:

4. The Committee is requested to:

   (a) Review and approve the draft Annual Report at Annex 2.
   (b) Review and approve any further changes to the terms of reference at Annex 3;
   (c) Confirm the proposed changes to operating arrangements in response to issues raised in questionnaires as set out in the draft Annual Report; and
   (d) Set priorities for the Committee for 2024/25.

REPORT APPROVAL ROUTE
Executive Management Team notified of proposed changes by email 31 December 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 2023/24

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 demonstrate the duty of quality by adopting 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.

3. The 2023/24 effectiveness reviews adopt 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. We adopted the same questionnaire as 2022/23 to see how the Committee has changed in comparison to this baseline.
Stage 2: Evaluation Process	• Questionnaires are issued to Committee members and core attendees as set out in the Terms of Reference with responses being anonymised. • 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 30 April 2024 and then to the Trust Board together with the Committee's annual report on 30 May 2024.

ASSESSMENT

4. The Committee Chair and Executive Lead met with the Corporate Governance team for stage 2 on 16th January 2024. Responses to the questionnaires were collated and reviewed and they are attached at Annex 1.

5. 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 eight responses being returned (a 50% return rate which was slightly higher than 2022/23).

6. Respondents were asked 27 questions around the themes of focus, engagement, team working, and effectiveness as well as free text on areas for development and what it should consider stopping, starting, and continuing. The standard questions also encouraged free text opportunities to explain or expand on choices.

7. The draft Annual Report attached at Annex 2 sets out in paragraphs 10 to 19 the proposed view of this Committee on its effectiveness. This is drawn from the responses to the questionnaire, a review of the Committee's adherence to its work plan during 2023/24, and the manner in which it has provided assurance to the Board. Changes to terms of reference are proposed in the draft Annual Report for review and discussion by the Committee at this meeting. Changes to the draft Annual Report will be made following this meeting and ahead of its presentation to the Audit Committee and Board.

8. 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 any new issues it may be adopting in its terms of reference; focus on areas it may not have addressed as strongly last year or which are developing; 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.

RECOMMENDATION

9. The Committee is requested to:

(a) Review and approve the draft Annual Report at Annex 2.
(b) Review and approve any further changes to the terms of reference at Annex 3;
(c) Confirm the proposed changes to operating arrangements in response to issues raised in questionnaires as set out in the draft Annual Report; and
(d) Set priorities for the Committee for 2024/5.

Welsh Ambulance Services NHS Trust

QuEST Committee Effectiveness Review 2023/24 Results

GIG CYMRU NHS WALES

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru

Welsh Ambulance Services
NHS Trust

Survey Summary

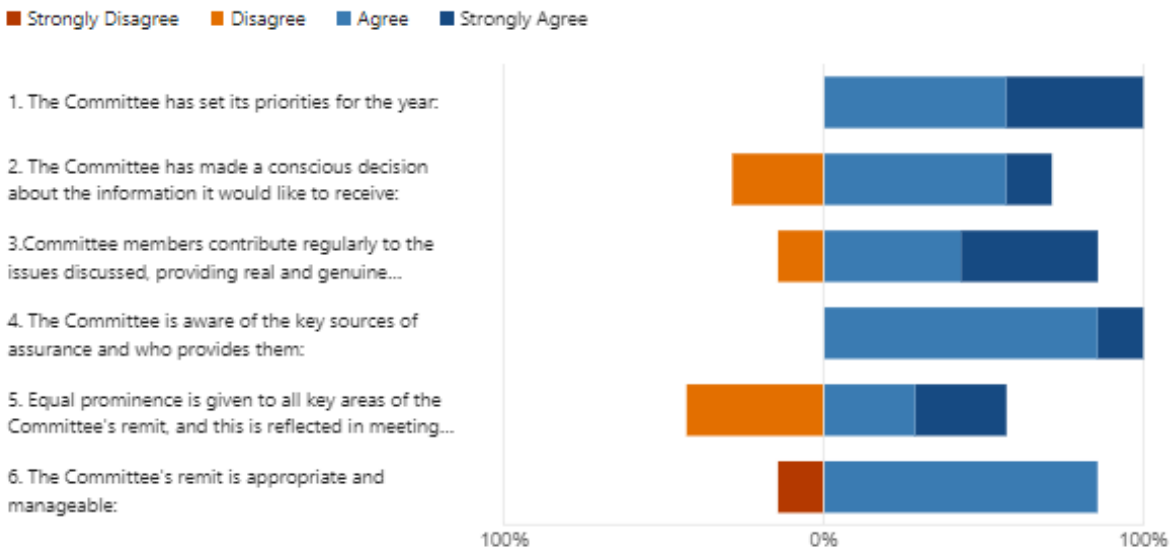
Survey Respondents included NEDs, management members, TU partners and Committee Governance Officer; **16 surveys sent with 8 returned [which is a 50% response rate, versus a 43.75% response rate 22/23]**. This PPT sets out the survey results and groups free text responses into areas of focus.

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**.

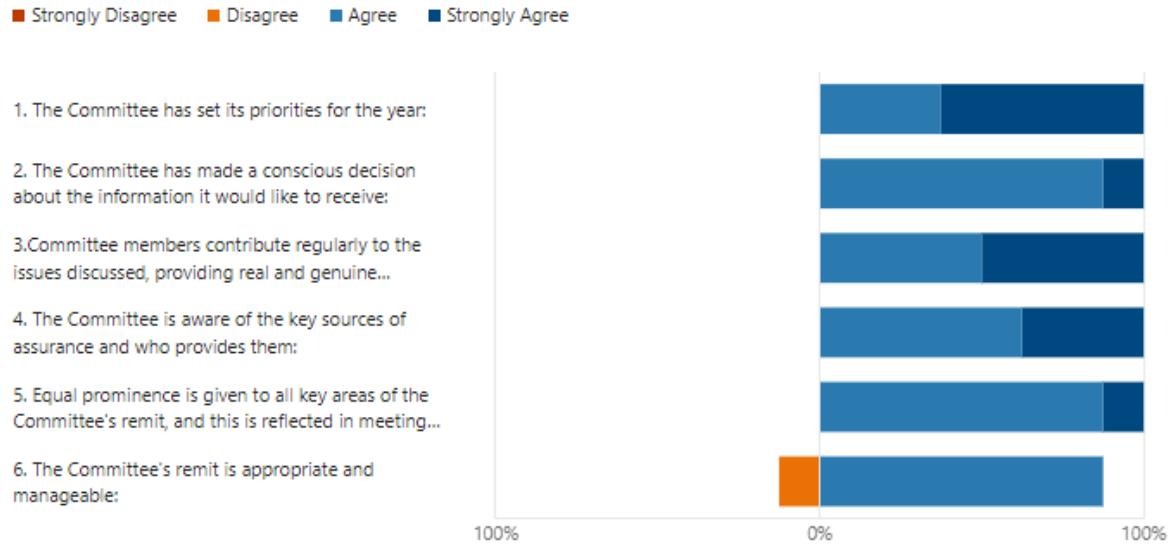
Non-Executive Director Member	3
Management Member	3
TU Partner (s)	0
Other	2

Theme 1: Committee Focus

2022/2023 Responses



2023/2024 Responses



Theme 1: Committee Focus

Management of Business

Whilst I have answered positively to Q6 I recognise the **papers are long but feel the nature of committee business requires this**. This can be **challenging to manage** but is done so effectively in my view.

The agendas are always very full and there are frequently comments about the meetings being full and difficult to manage. **The business that it taken to the Committee always seems appropriate / necessary however,** so consideration will need to be given to how this is addressed.

(5) This year, the Committee has increased its **focus on clinical indicators and the impact of these on our Patients** - which should continue to be developed.

Remit

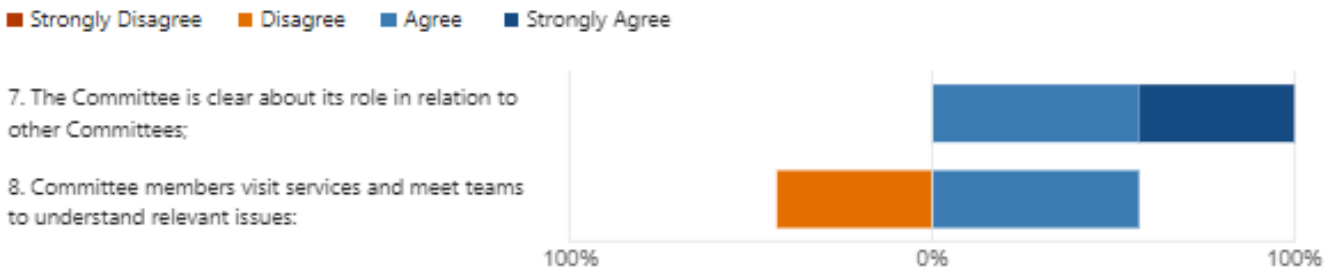
(6) The Committee's remit is **entirely appropriate albeit very broad** and includes many areas of **significant importance.**

Is there an opportunity to **extrapolate the sections of the MIQPR relevant for each committee**? Sometimes there is time pressure which can impact on the discussion of items.

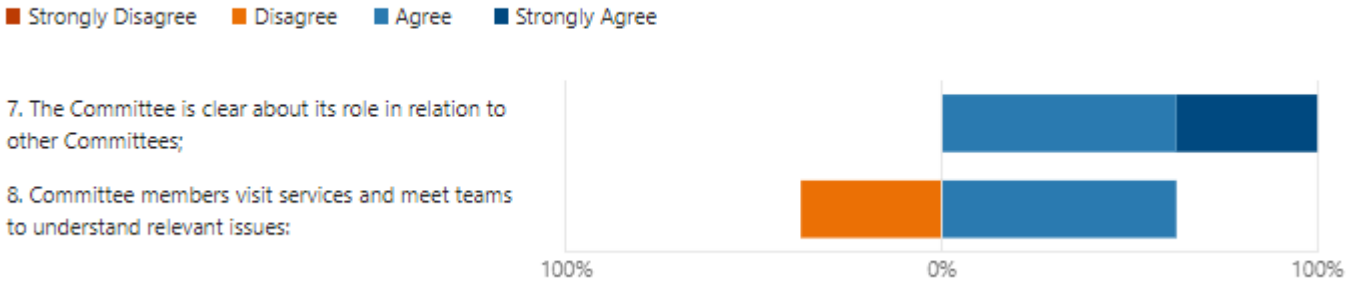
Can the **time of the meeting be extended to ensure an appropriate level of time is allowed for each item**? Appropriate focus on putting things right.

Theme 2: Committee Engagement

2022/2023 Responses



2023/2024 Responses



Theme 2: Committee Engagement

Visits

(8) whilst members do visit services/meet teams, this **can vary - depending on capacity** to do so, in light of other priorities.

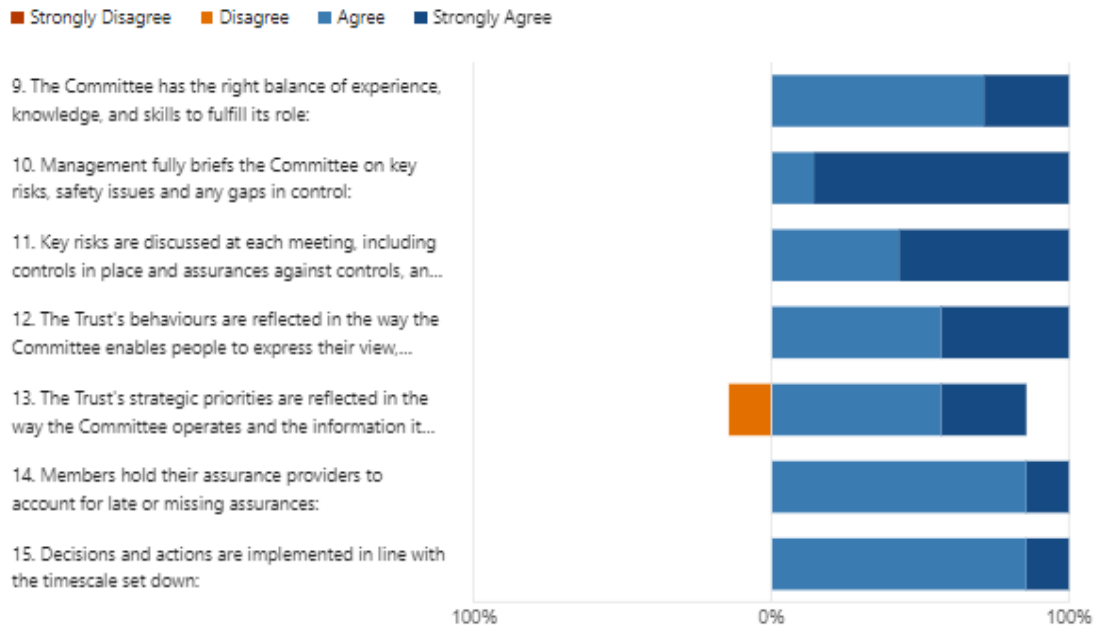
I don't know the answer to question 8 - **not aware of any formal plan around which committee members will visit which areas**.

Visiting services **has been challenging over recent years** but the newly established framework for board member visits should see this improve over time.

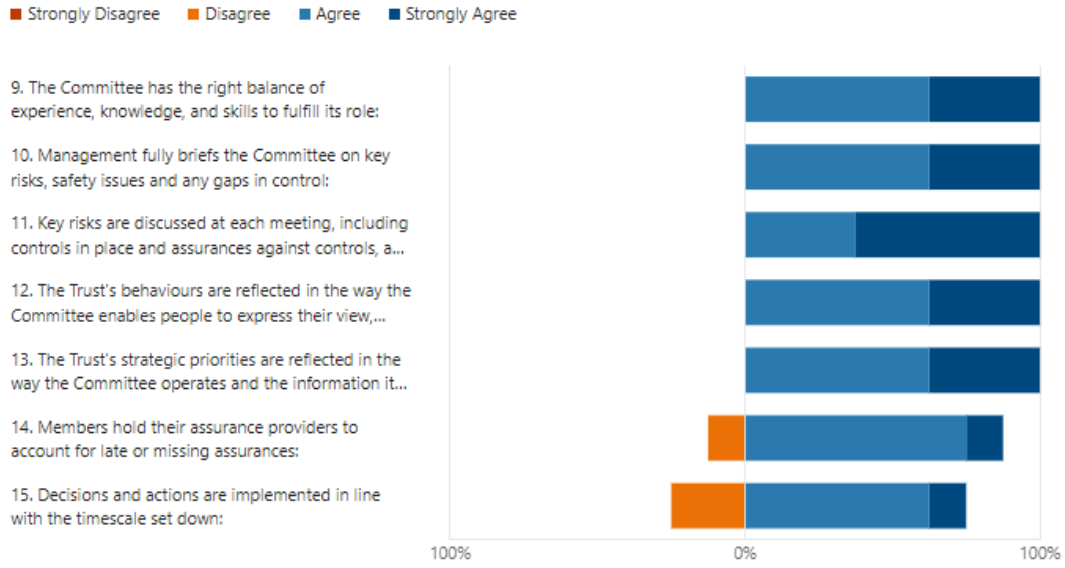
If the Committee members are making conscious visits / engagement in their capacity as members of QuEST **that's not clear (separate to their role as NEDS).** Could it be helpful to build a list of bespoke Committee activities which is appended to the Board Visits SOP?

Theme 3: Committee Team Working

2022/2023 Responses



2023/2024 Responses



Theme 3: Committee Team Working

Culture

The **culture is open and transparent**, I think all members feel they can be honest, this is fundamental particularly when discussing risk.

Risks

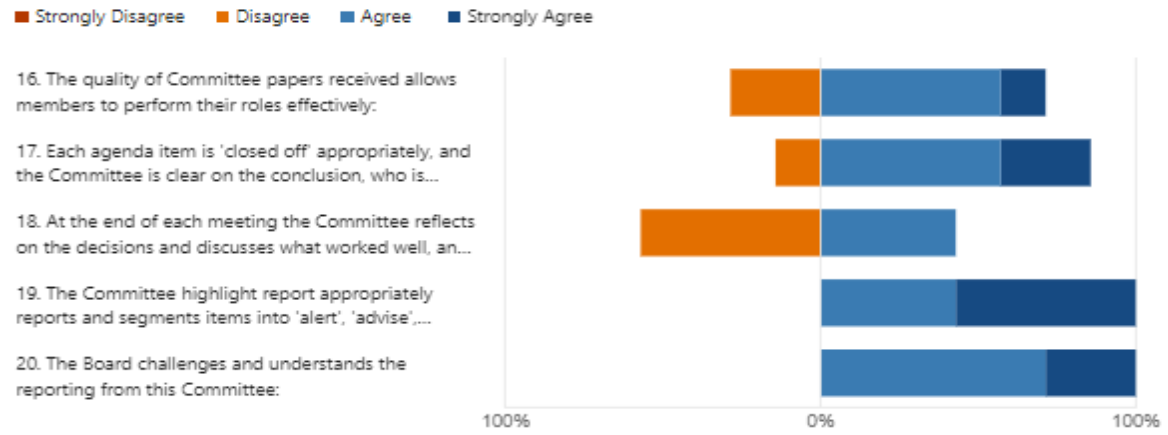
(11) **key risks are discussed robustly at each meeting** and the theme of these **permeate throughout the whole agenda.**

Decisions/Actions

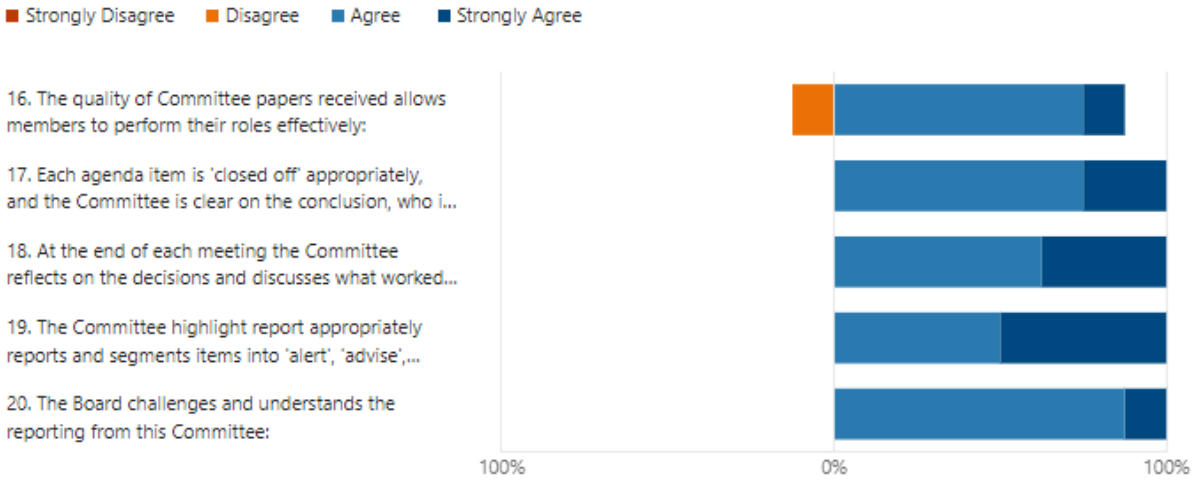
(15) there is a **commitment to achieve** this however other critical priorities can cause some delay.

Theme 4: Committee Effectiveness

2022/2023 Responses



2023/2024 Responses



Theme 4: Committee Effectiveness

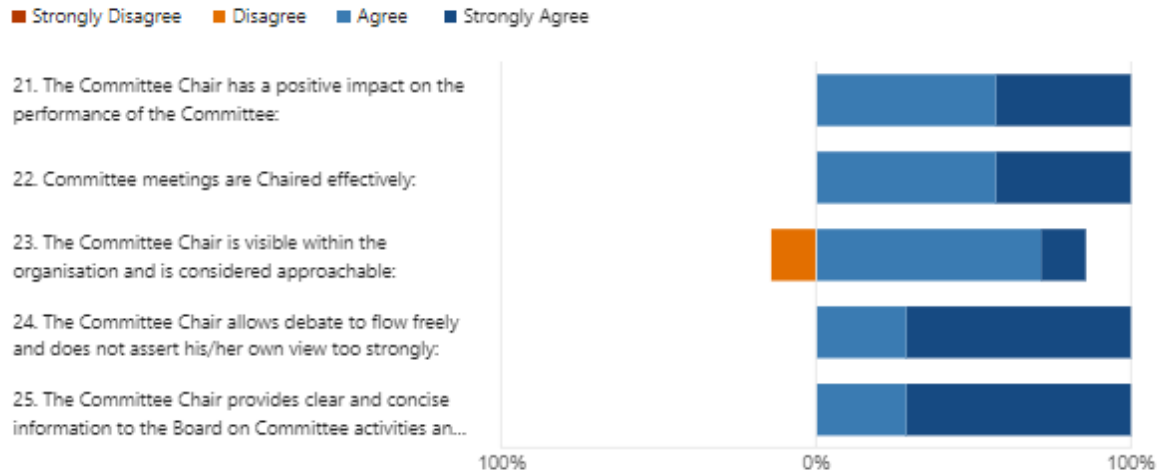
Papers are **so unbelievably long** that I fear that this does **impact on ability of committee members to undertake their role effectively.**

I think the **committee is effective, but time constraints** have the potential to impact on this.

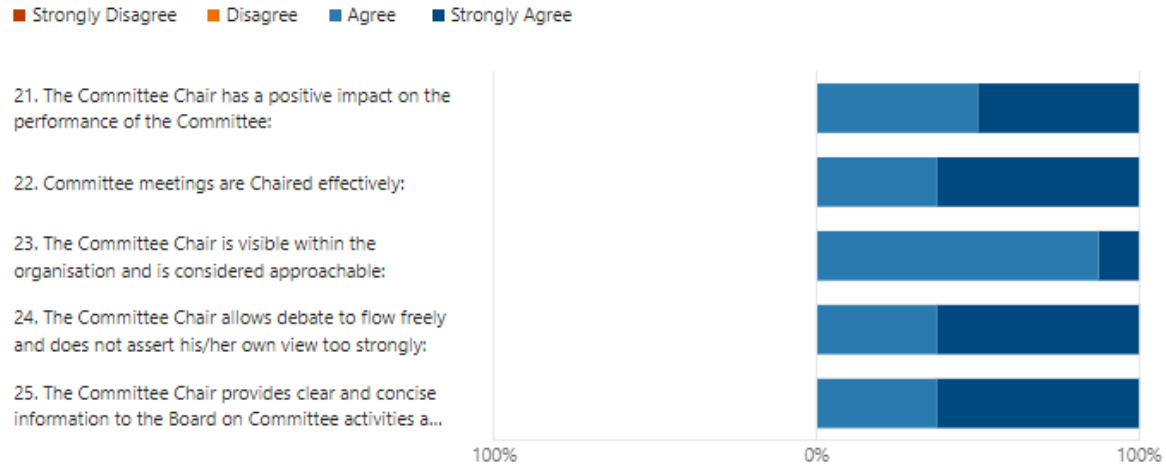
(17 & 18) - these areas have been **improved during this last year** and are now given the attention deserved.

Theme 5: Committee Leadership

2022/2023 Responses



2023/2024 Responses



Theme 5: Committee Leadership

(25) relevant information is **shared clearly and robustly with the Board;** the presentation of this at Board meetings is underpinned by clear AAA Reports.

The **Chair is highly effective** and encourages all members to contribute.

QuEST is **more visible** to the Trust **naturally by virtue of what it does** and that many more colleagues are aware of its operations.

All meetings are **Chaired effectively.**

What should the Committee stop, start or continue to do?

Start

Establish visits to service areas with specific focus on quality of service.

Improve **links of activity to the IMTP** and longer-term **strategy.**

Think about **how papers can be summarised** or reduced.

More **direct focus on the evolution of our Quality Strategy**, which underpins our approach to the Duty of Quality, would be helpful.

Continue

Continued **focus on impact assessments and QPMF.** Focus **on non-compliance with new legislation.**

Continue **the shift in emphasis on outcome reporting** as opposed to process.

Continue to **have improved focus on clinical indicators**, their **impact on Patients** and strive to identify **how performance can then be improved** in these areas.

Meetings are **run well.**

Are there any learning and development opportunities for members the Committee should consider?

Not aware of any although **new membership will require learning and development** following appointment to this Committee.

I do think **some further visits** would be good.

Continue as is - **to develop their understanding and awareness** of all aspects of operations which this Committee considers.

Deep dives to inform thinking and approach **on high risks areas.**

QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE (QUEST) ANNUAL REPORT 2023/24

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 8 February 2024 and reviewed its terms of reference, responses to questionnaires completed by members and attendees, and its operating arrangements. Discussions were also held with the Committee Chair and Executive Lead ahead of that meeting. This Annual Report reflects on the effectiveness of the Committee in 2023/24 and proposes changes to terms of reference.

ASSESSMENT

<u>Purpose of the Committee</u>

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

Membership and attendance

6. The Committee met four times as scheduled in 2023/24 and was quorate on each occasion.

7. The Committee is supported by the Chair and three Non-Executive Directors as members, and a number of core attendees. The chart below illustrates attendance of members and attendees as listed in the terms of reference for 2023/24. The Committee welcomed non prescribed attendees at various meetings as well as external guests.
[chart to be updated with 8 February attendance]

COMMITTEE ATTENDANCE				
NAME	**11 MAY 2023**	**10 AUGUST 2023**	**31 OCTOBER 2023**	**8 FEBRUARY 2024**
Bethan Evans				
Kevin Davies			In chair for meeting	
Paul Hollard				
Ceri Jackson				
Liam Williams				
Andy Swinburn		Duncan Robertson		
Lee Brooks	Steve Clinton		Sonia Thompson	
Leanne Smith	Jon Hopkins			
Jonny Sammut				
Rachel Marsh			Hugh Bennett	
Trish Mills				
Mark Marsden				
Hugh Parry				
Ian James				

8. Attendance is excellent. Leanne Smith was replaced as prescribed attendee when she completed her interim position, and Jonny Sammut joined the Committee when he commenced as Director of Digital.

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

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 and Executive Lead, and at the 8 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 eight responses being returned (a 50% return rate which is slightly better than 2022/23).

12. Respondents were asked 27 questions and were encouraged to provide free text answers to explain or expand on their choices. The responses were reviewed by the Committee on 8 February against the same questions from last year. There were a number of comments on the length of the agenda, meetings and papers. These ranged from these impacting the ability of members to undertake their role effectively, to them being appropriate given the frequency of meetings and the crucial scrutiny and oversight of patient safety, quality and patient experience. In 2024/25 meeting invitations will be extended to provide an appropriate amount of time for the meetings where that is deemed necessary at agenda setting meetings and in conjunction with the Chair.

13. Whilst the was a sense the committee needed to strengthen its timely close off of actions/holding to account for late or missing papers, it is recognised that operational pressures may mean some items are prioritised. Regular monitoring of the cycle of business, the action log and forward planner are in place to capture matters carried over.

14. There is a desire to seek to extrapolate only sections of the MIQPR which are relevant for the Committee however it was recognising this could lead to additional work and reporting. An alternative approach is the focus of members on the relevant quality, clinical, patient safety and experience indicators (in the MIQPR and the PTR report) as opposed to the full balanced scorecard (which is scrutinised at Finance and Performance Committee and Board), and the impact of that performance and improvements on patients.

15. As with other Board Committees, the question related to visibility of Committee members scored poorly. Given that there is a Board visits Standard Operating Procedure in place which illustrates members visibility, it is anticipated that this question will be omitted from the 2024/25 survey. The rationale being that it is unlikely, no matter how visible a Non-Executive or Executive Director may be, that that will always resonate with each Committee.

16. Good practice drawn out in responses included:

- The focus in 2023/24 on clinical indicators;
- Key risks are discussed and drive the agenda, with more deep dives on risks welcomes;
- Relevant information is shared clearly and robustly with the Board;

- The meetings are well chaired; and
- There is a positive and transparent culture.

17. The Committee has a cycle of business that is aligned to its terms of reference. All matters scheduled for oversight and review have been brought to the Committee and in this respect it has discharged its responsibilities in providing assurance to the Board. The Committee's business in 2023/24 included:

17.1. The Putting Things Right (PTR) (previously the Patient Safety Highlight Report) and MIQPR reports are received at each meeting. Throughout the year the focus was on:

- Pressures in the teams to respond to concerns in a timely way;
- Concerns response time improvement plans;
- Continuing number of immediate release requests refused;
- Incidents being reviewed at the Serious Case Incident Forum;
- Joint investigations being passed to Health Boards;
- National Reportable Incidents;
- The continued upward trend in Coroner's requests for information;
- Regulation 28 are brought to the attention of the Committee;
- Improvement actions under review to ensure the Electronic Patient Record (ePCR) data is correctly inputted to ensure accurate reporting on the various clinical bundles;
- Good call back time for 111 Wales calls.

17.2. [Insert detail of KPI annual review from February meeting]

17.3. A **focus on clinical indicators** was agreed at the 2022/24 effectiveness review and the first report was presented at the August meeting. The current clinical indicators and ambulance service indicators are the care bundles and individual metrics for STEMI (ST-elevation myocardial infarction), stroke, #NOF (fractured neck of femur) and hypoglycaemia, as well as the ROSC (return of spontaneous circulation) at hospital indicator. Clinical indicators in development are call to door time for STEMI and stroke. Others in consideration include older fallers, paediatric trauma/pain management, and advanced paramedic practitioner (condition specific compliance). In October the Committee focused on the clinical indicator of **Return of Spontaneous Circulation (ROSC)**, acknowledging substantial enhancements in ROSC rates since April 2022. In February the Committee focused on stroke indicators [insert].

17.4. Each meeting heard a **patient story**:

- In May the Committee heard from **Keith Jones** who is a long-standing CFR at WAST and attended a patient at their home in November 2022. Keith was with the patient and their partner for over four hours awaiting an ambulance and during that time the patient went into cardiac arrest. Despite attempts to resuscitate him, the patient unfortunately died. Members heard about the effect of this on Keith and the patient's partner who was present, and discussed the support which is available to CFRs following such an event.
- In August The Committee heard from **Beth Hews**, Palliative Care Paramedic about her experience attending a patient with metastatic bowel cancer who had been referred to Specialist Palliative Care Team (SPCT) for pain management. Through the intervention of the SPCT they were able to keep this patient in her own home rather than have her taken to hospital by ambulance, providing a holistic plan which enabled her to die with dignity and in comfort.
- In October **Steven Parsons** recounted his distressing experience of being unable to get an ambulance for his grandfather, who he thought was suffering a stroke. Steven called 999 but was told there were no ambulances available at that time because of the system pressures. Believing it was a stroke, Steven decided to transport his grandfather to the hospital himself. Upon arrival, his grandfather collapsed but was resuscitated in the Emergency Department.
- In February **Alison Cassidy** [insert]

17.5. The IMTP 2024-27 elements that related to this Committee were reviewed ahead of the IMTP's approval by Board in March.

17.6. The **Quality strategy implementation plan** was reviewed in May 2023 and February 2024. The plan was developed to support delivery of the Quality Strategy 2021-2024. Whilst progress against the plan has been slow due to resourcing challenges, there was progress in the latter half of 2022/23 in preparation for the Health and Care (Quality and Engagement) (Wales) Act 2020. [insert from February meeting]

17.7. The Patient Experience and Community Involvement (**PECI**) reports were received providing positive assurance we are meeting with and consulting with the public and out stakeholders, including with Llais (the Citizens Voice Body). Reports from PECI are now provided bi-annually.

17.8. The Trust's annual **Clinical Audit Plan**, which allows the planning and prioritisation of clinical audits across the financial year, was approved for

2023/24. It is not always possible to predict all of the topics that require evaluation and therefore this is a dynamic document which is updated quarterly with oversight by this Committee. This supports recommendations in the Audit Wales Clinical Governance Review 2022.

17.9. A **deep dive on red rural performance** was presented in August. Performance consistently tracks below pan-Wales performance and below the 65% target. By contrast however, Amber 1 performance is consistently better than more urban areas. Members recognised that whilst red rural performance remains an issue, actions are being taken to address this. The Committee was assured there was focus on this including demand led rosters, rosters that are recruited to and efficient use of that resource (in particular, handover lost hours, but also internal efficiencies like abstractions and mobilisation times). The forthcoming EMS demand and capacity review explicitly includes rurality in its terms of reference. The People and Culture Committee will look at the effect of rurality on abstractions, recruitment and retention.

17.10. The Committee reviewed the position, plans and proposed reporting for **Information Security and Information Governance** which is an area that was expanded in its remit in 2022. The comprehensive reporting provides an overview of information governance in terms of accountability, assurance and compliance and the Committee agreed a set of metrics. The Board will note that this area of oversight will transfer to the Finance and Performance Committee from 1 April 2024 so there is alignment and avoidance of duplication.

17.11. The **backlog of policies** – particularly those relevant to this Committee - was reviewed and concerns escalated to the Board. A priority order of policies for review in 2023/24 was endorsed. The following policies were approved in 2023/24:

- National Policy on Patient Safety Incident Reporting and Management;
- Aseptic Non-Touch Technique Policy;
- Medicines Management Policy;
- Information Governance Policy;
- Infection Prevention and Control Policy;
- Clinical Supervisions Policy; and
- Data Protection Policy.

17.12. The **Welsh Risk Pool Concerns Assessment** [insert update from February meeting]

17.13. **Operational** updates are received at each meeting and often generate a good deal of discussion, particularly related to system pressures.

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

- In May: noted the different approach with an afternoon start; supportive challenge and identification of further actions as a result; lived experience was important to continue to hear; papers were improved, succinct and clear and picked up on the threads of the duties of quality and candour.
- In August: The introduction of a review of the agenda and timings with the Chair closer to the meeting. This will enable the Chair to review placement and timing of items; helpfully, areas of greatest focus and where strong assurance was required were placed higher in the agenda which enabled appropriate critique and discussion to confirm assurance, however, more time could be given to some items to enable members to drill down further on performance; good succinct discussion; and the desire to reduce the volume of papers, recognising however the Committee has a substantial remit. The Board's risk appetite as to the level of assurance required could be reviewed.
- In October: clear and succinct papers and tangible progress on some longstanding issues.
- In February [insert]

17.15. The Health and Care (Quality and Engagement) (Wales) Act 2020 and hence the **duty of quality and duty of candour** came into force on 1 April 2023. The Committee noted:

- In May: The Quality and Performance Management Steering Group incorporates senior oversight and responsibility for the duty of quality and duty of candour to ensure the Quality and Performance Management Framework has an integrated approach to improving the quality of services and outcomes for patients. A quality management system digital dashboard is in progress and Trust intranet pages are available to staff to cascade messaging and enhance knowledge in this area. There was positive progress of the Trust position against the Welsh Government road map for the Act implementation, including exemplar content and ideas produced by Trust staff now being adopted at NHS Wales level. Concern was raised as to impact on

teams and resources with the increased requirements under the duty of candour as raised in the alert section.

- In August: Work is progressing regarding 'Always On' reporting with the development of a scalable digital dashboard specification based on the Quality Standards 2023 reflective of strategic, tactical, and operational quality requirements. A set of Performance and Quality Standards are currently being developed for the duty of candour to collect data and information consistently at a local and national level and create a dashboard. Progress on the Welsh Government milestones was said to be amber/green with two key outstanding areas being the 'Always-On' reporting and the ability to resource the requirements arising from the duty of candour'. It was recognised that there was a need to continue to 'hold the tone' of the duty of quality and duty of candour and that the new quality leads will play a pinnacle role in this.
- In October: The Welsh Government roadmap for August 2023 rated the Trust's progress as having identified that 'delivery is at risk but manageable' or is 'behind schedule but within tolerance'. This is in line with other NHS organisations across Wales and includes a further nine deliverables recently added to the roadmap. The appointment of the Senior Quality Governance Lead and bespoke implementation plan has increased capability and capacity to support full implementation. The current impact of this has been a review of arrangements which has led to some previously reported good progress being revised on the current WG report.
- In February: [insert]

17.16. The duty of quality requires each organisation to provide demonstrable evidence that all strategic decisions and plans have been made through a quality lens for both clinical and non-clinical aspects. A key element of demonstrating this are **Quality Impact Assessments** (QIA). The Committee were assured that the framework for QIAs was appropriate and noted that the template developed by the Trust has since been adopted by the NHS Wales Executive for use across Wales. Two QIAs were subsequently reviewed by the Committee, including the Implementation of a revised approach to the application of the Non-Emergency Patient Transport Service (NEPTS) eligibility criteria and a revised Capacity Management Plan, and The Mid and West Wales Fire and Rescue Services (M&WWF&RS) support to the Trust's emergency responses.

17.17. The Health and Care Standards (2015) have now changed to the **Health and Care Quality Standards (2023)** with six domains and five enablers.

The domains are Safe, Effective, Timely, Efficient, Equitable and Person Centred. The enablers include Leadership, Culture and Valuing People, Data to Knowledge, Learning Improvement & Research, and Whole System Perspective. Work is progressing to define quality outcome measures aligned to the Standards.

17.18. The Committee **cycle of business** was approved.

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

- Infection Prevention and Control Annual Report 2022/23
- Safeguarding Annual Report 2022/23
- Mental Health and Dementia Annual Report 2023

17.20. The Audit Wales Quality Governance Review 2022 raised the issue of the backlog of **mortality reviews** and the need to develop an action plan to reduce this backlog. The Committee saw there is evolving work to embed and strengthen the mortality review process. Learning will be shared and triangulated with information produced from other sources e.g. coroners, incidents, clinical audit programmes, and this Committee will see this in the Patient Safety Report.

17.21. **Risks** relevant to this Committee – 223 and 224 – are reviewed at each meeting and the agenda is driven by these risks. Risks to the Trust's ability to implement the duty of quality and duty of candour were also discussed with relevant mitigations, as were challenges and risks in achieving, maintaining and assurance compliance of data protection.

17.22. The **annual effectiveness review** was conducted in the January 2024 meeting.

17.23. The **medications management report** [insert discussion from February]

17.24. The revised **Audit** tracker and process was reviewed and good progress is being made to close down management recommendations.

17.25. An update was provided on the **Health Inspectorate Wales (HIW) Review: Patient Safety, Privacy, Dignity and Experience whilst waiting in ambulances during delayed handover (2021)**. There was an expectation from HIW that the recommendations made would be considered at a system level and an Emergency Ambulance Services Committee (EASC) task and finish group was established to respond to the

review. The Trust's particular management actions are reported to that group and HIW have concluded that sufficient assurance has been received in response to the findings identified within the review report for the Trust for the stage one review. A stage two review will be initiated by HIW in the latter part of 2023/24.

17.26. The **HIW national review of patient flow – a journey through the stroke pathway** and the **HIW Annual Report** were reviewed in February 2024.

17.27. **The Infection Prevention and Control (IPC) internal audit** (reasonable assurance) was presented with the Committee being assured that whilst recommendations for improvements were being made, the response and the ways we seek to support our patients with respect to IPC i.e., guidance, advice and support is appropriate.

17.28. The **Immediate Release Directions internal audit** (reasonable assurance) was presented and the need for a collaborative approach to these was apparent.

17.29. The **Data Analysis internal audit** (reasonable assurance) was also reviewed.

17.30. The limited assurance **Pain Management internal audit** was presented to this meeting following it's discussion at the Audit Committee on 25 July. The Committee reviewed the recommendations and actions, welcoming the tight timeframes within which these would be closed given the limited nature of the audit.

17.31. The **Committee's priorities for 2023/24** (implementation of the quality strategy, and the duty of quality and duty of candour) are reviewed at each meeting and a more detailed update appears later in this report.. The Committee also reviews progress against its cycle of business at each meeting.

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

19. The Committee is not currently serviced by any Sub-Committees.

Proposed Changes to the Terms of Reference

20. Extensive changes to the Terms of Reference for this Committee were made during the effectiveness reviews held in 2022. The changes this year are therefore minimal and include feedback from the Committee following the survey and the meeting on 8 February. The changes in the Terms of Reference are marked up in [Annex 1] and include:

- A change in the narrative on assurance to provide clarity on approach;
- The information governance and information security elements are proposed to transfer to the Finance and Performance Committee from 1 April. That Committee has the digital infrastructure, systems and strategy in their remit as well as cyber security and it was felt by the Caldicott Guardian (Liam Williams) and Senior Information Risk Officers (Jonny Sammut) that this move was appropriate to reduce duplication and align the approach. The Caldicott Guardian will alert the Committee to any relevant issues of patient information concerns; and
- Changes in the narrative on risk and audit to streamline responsibilities.
- [insert following February meeting discussions]

Committee priorities :

21. The Committee received an update on progress against its priorities at each meeting. The 2023/24 priorities were:

Priority	Progress
Committee will monitor implementation of the Duty of Quality and Duty of Candour following the Health and Social Care (Quality and Engagement) (Wales) Act ('Act') coming in to force in the Spring of 2023	As set out above, progress against this priority has been good throughout the year.

Priority	Progress
Implementation plan for the quality strategy.	• In May 2023 it was noted that progress with the plan had progressed faster in the second half of 2022, particularly in preparation for the Health and Social Care (Quality and Engagement) (Wales). The Committee recognised that progress was being made in embedding the quality strategy across the Trust • In February 2024 the Committee received [insert]

22. 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 2024/25:

[to be confirmed by the XXXXX meeting]

(a) [insert]
(b) [insert]

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

Next Steps

24. The next steps are to update the cycle of business with revised terms of reference

RECOMMENDATION

The Trust Board is requested to

(a) Receive and note the contents of the Committee Annual Report for 2023/24 and analysis of its effectiveness; and
(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

~~2023/24~~2024/25

1. INTRODUCTION

1.1. The Trust's Standing Orders provide that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*".

1.2. In line with Standing Orders and the Trust's Scheme of Delegation, the Board shall nominate annually a committee to be known as the Quality, Patient Experience and Safety Committee. This Committee has a key assurance role on behalf of the Board in relation to the Trust compliance with the Commissioning Core Quality Requirements, the NHS Wales Health & Care 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.

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

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

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

2. PURPOSE

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

2.2. During the ~~2023/24~~ 2024/25 financial year the Committee will continue to oversee the systems and process developed to ensure compliance with the Duty of Quality and the Duty of Candour as set out in the Health and Social Care (Quality and Engagement) (Wales) Act 2020, and ensure compliance with the Act to improve the quality of healthcare provided by the Trust.

2.3. The Committee will provide oversight of, and seek assurance on, statutory and regulatory compliance on areas within its remit.

2.4. ~~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~~ Receive assurance that the organisation has the right systems and processes in place to deliver services consistent with the six domains of quality (~~patient~~ person centred; safe; equitable; timely; effective; and efficient).

3.2. Advise the Board on a set of key indicators for quality, patient experience and clinical safety, and monitor performance against those indicators.

3.3. ~~Ensure~~ Receive assurance on compliance with the Duty of Quality and the Duty of Candour as set out in the Health and Social Care (Quality and Engagement) (Wales) Act 2020 to improve the quality of healthcare provided by the Trust and to support the delivery of an open and honest reporting and continuous learning culture.

Strategy

3.4. Oversee and contribute to the development of the Trust's strategies and plans

for the delivery of high quality and safe services, consistent with the Board's overall strategic direction and any requirements and standards set for NHS bodies in Wales.

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

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

Safe Care

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

3.8. ~~Ensure~~ Receive assurance that there is a process in place for quality impact assessments, and consider the implications for quality and safety and equitable care arising from the development of the Trust's corporate strategies and plans, or those of its stakeholders and partners, including those arising from any Committees of the Board.

3.9. Consider the implications for the Trust's quality and safety arrangements from review/investigation reports, external guidance and national reports and actions arising from the work of external regulators.

3.10. Receive assurance that ~~Monitor~~ the Trust is complian~~ct~~e with the Mental Health Act 1983, Code of Practice, and the Mental Capacity Act 2005.

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

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

3.13. Review the impact of professional standards and staffing issues on patient care, noting the People and Culture Committee has oversight of the selection, training, registration, and revalidation for staff.

3.14. Receive assurance that ~~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

3.15. Receive assurance that ~~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.

3.16. Approve the ~~annual~~ Trust's clinical audit plan that meets the standards set for the NHS in Wales; review the outcomes of clinical audits in line with the clinical audit plan and provide assurance to the Audit Committee in this respect;

3.17. Receive assurance that there ~~There~~ is an ethos of continual quality improvement and regular methods of updating the workforce in the skills needed to demonstrate quality improvement throughout the organisation.

Citizen Voice and Patient Experience

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

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

3.20. Receive assurance that ~~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.

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

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

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

~~**Information Governance and Information Security**~~

~~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.~~

~~3.25. 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.~~

~~3.26. Receive assurance on, and review effectiveness of the Trust's information security protocols.~~

~~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

~~3.28.~~3.24. Seek assurance that governance arrangements are appropriately designed and operating effectively to ensure the provision of high quality, safe healthcare and services across the whole of the Trust's activities, and that these are compliant with relevant legislation.

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

~~3.29. Recommendations made by internal audit and external reviewers are considered and acted upon on a timely basis;~~

~~3.30.~~3.26. Review and recommend to the Board the Trust's annual Duty of Candor and qQuality ~~statement~~ Report(s) ~~(as relevant)~~ and quality improvement priorities for the coming year, monitoring progress against these priorities and their impact on patient safety.

~~3.31.~~3.27. Review policies in its remit and endorse policies for Board approval that relate to complaints and incidents in line with Putting Things Right.

~~Corporate Risks and Audit Recommendation Tracker~~

~~3.32.~~3.28. Monitor the key risks relevant to its remit. ~~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~~ It will consider the controls and mitigations of ~~high level workforce~~ related risks and provide assurance to the Board that such risks are being effectively controlled and managed.

Authority

~~3.33.~~3.29. The Committee is authorised by the Trust Board to investigate, or have investigated, any activity within its terms of reference. In doing so, it will have the right to seek any information it requires from any employee or inspect any books, records, or documents relevant to its remit, ensuring patient/client and staff confidentiality as appropriate. All employees are directed to cooperate with any reasonable request made by the Committee.

~~3.34.~~3.30. The Committee is authorised by the Board to obtain outside legal advice or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Trust's procurement, budgetary and other requirements.

~~3.35.~~3.31. 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.~~3.32. The Committee may establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee business. Formal sub-committees may only be established with the agreement of the Board.

4. MEMBERSHIP

Members

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

Chair	Non Executive Director
Members	Three further Non Executive Directors of the Board.

Prescribed Attendees

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

- Executive Director of Quality and Nursing (Committee Lead)
- Executive Director of Paramedicine
- Executive Director of Operations
- Executive Director of Strategy, Planning and Performance
- Director of Digital Services ~~(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 People and Culture.

Quorum

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

Frequency of Meetings

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

Withdrawal of individuals in attendance

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

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

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

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

(a) joint planning and co-ordination of Board and Committee business; and
(b) sharing of appropriate information;

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

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

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

6. REPORTING AND ASSURANCE ARRANGEMENTS

6.1. The Committee Chair shall:

(a) report formally, regularly and on a timely basis to the Board and the Chief Executive (Accountable Officer) on the Committee's activities. This includes a written highlight report~~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	**16**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**4**

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

MEETING	Quality, Patient Experience & Safety Committee
DATE	8th February 2024
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 for oversight.

2. A summary of these risks is set out in Annex 1 with a detailed description contained within the Board Assurance Framework (BAF) in Annex 4.

3. The more detailed description contained within the BAF provides the Committee with an opportunity to review the controls in place against each principal risk and the assurance provided against those controls where applicable. This will assist Members in evaluating current risk ratings supported by the frameworks in Annex 2.

4. Each of the principal risks were presented to the Trust Board on 25th January 2024 and are updated as at 13th December 2023. These high rated risks have been reviewed during this reporting period in line with the agreed schedule detailed at Annex 3.

5. Updates are highlighted in blue on the BAF which show changes to the narrative, mitigating actions, controls, and assurances.

6. The focus for the forthcoming round of reviews will predominantly be in relation to the mitigating actions identified and taken to support risks to achieve their target score.

7. The Trust's highest rated Risks 223 *the Trust's inability to reach patients in the community causing patient harm and death*) and Risk 224 (*Significant handover of care delays outside accident and emergency departments impacts on access to*

definitive care being delayed and affects the Trust's ability to provide a safe & effective service for patients, scoring 25, remain unchanged because of sustained and extreme pressure across the Welsh NHS urgent and emergency care system which is negatively impacting on patient flow leading to avoidable patient harm and death. These risks continue to be closely monitored by management, Board Committees, and at the Trust Board meetings.

8. As reported to the November 2023 Trust Board, whilst good progress has been made on the actions that the Trust can control, the extreme pressure continues. As a result, the likelihood is that the levels of avoidable harm will continue. That does not mean that the Trust is not continually seeking additional actions to mitigate these risks and the actions are articulated in the avoidable harm paper that the Board receive at each meeting.

9. Several updates have been made to the controls and assurances in relation to Risk 223 and 224 during this period and these are highlighted on the BAF to address gaps in assurance. These two risks will be reviewed closely in conjunction with each other to ensure the synergy between them both and that they reflect the actions from the avoidable harm paper in the same way.

10. Additionally, these risks will be considered further as to how the Trust can approach them by applying the risk appetite methodology as part of the Risk Management Improvement Programme and the most efficient and effective way of managing them internally.

RECOMMENDATION: Members are asked to consider the contents of the report.

KEY ISSUES/IMPLICATIONS
11. The key issues are set out in the Executive Summary above.
REPORT APPROVAL ROUTE
• The BAF was considered by: • ADLT (04 December 2023) • EMT (13 December 2023) • Trust Board (15 January 2023)

REPORT ANNEXES
• Annex 1 - Summary table describing the Trust's Corporate Risks. • Annex 2 – Scoring Matrix • Annex 3 – Frequency of Risk review • Annex 4 - Board Assurance Framework

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

Annex 1 – Corporate Risk Register Summary

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
223 QuEST	The Trust's inability to reach patients in the community causing patient harm and death	**IF** significant internal and external system pressures continue **THEN** there is a risk of an inability and/or a delay in ambulances reaching patients in the community **RESULTING IN** patient harm and death	Director of Operations	**25 (5x5)** →
224 QuEST	Significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service	**IF** patients are significantly delayed in ambulances outside A&E departments **THEN** there is a risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised **RESULTING IN** patients potentially coming to harm and a poor patient experience	Director of Quality & Nursing	**25 (5x5)** →

Annex 2 - Risk Scoring Matrix

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

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

Annex 3 - Frequency of Risk Review

Risk Score	Review Frequency	Risk Rating
15 – 25 Red	Review monthly	High
8 – 12 Amber	Review quarterly	Medium
1 – 6 Green	Review every 6 months	Low

Annex 4 – Board Assurance Framework

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	21/11/2023	TREND	25 (5x5)
		Date of Next Review:	21/12/2023	➡	

IF	THEN	RESULTING IN
significant internal and external system pressures continue	there is a risk of an inability and/or a delay in ambulances reaching patients in the community	patient harm and death

	Likelihood	Consequence	Score
Inherent	**4**	**5**	**20**
Current	**5**	**5**	**25**
Target	**2**	**5**	**10**

IMTP Deliverable Numbers:

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

Risk Commentary Q2 2023/24

The risk score remains constant at 25 (almost certain & catastrophic). Internal and external assurances remain weak as there remains a daily risk of actual patient harm and death because of the Trust not being able to reach patients in the community. **In October 2023, over 23,232 hours were lost, equivalent to losing 25% of the Trust's conveying capacity. This is a significant increase on previous months as we approach the winter months. Only Cardiff & Vale University Health Board has demonstrated material improvement and is a positive outlier.** The impacts on patients waiting for extended periods of time both in the community and then outside emergency departments is well documented (AACE Delayed Hospital Handovers: Impact assessment of patient harm, 2021) and includes pressure damage, acute kidney injury, deconditioning, poorer outcomes, and extended recovery times. Delays across the system continue to be the focus of patient safety incidents, complaints, Coronial enquires and redress / claims. The effectiveness of our controls in many areas are dependent on external partners acknowledging and having ownership of the risk across the urgent and emergency care system. Key to moving the position is to continue to work in collaboration influencing system partners, being present and engaging in key conversations, whilst continually seeking opportunities internally to swiftly identify and mitigate the risks within our control and share those with relevant system partners that we cannot control. Of note, recent data analysis highlights the increased levels of red activity which has doubled since the pre covid period, plus an average increased on scene time of circa 10 minutes. Both measures are reflective of an increasingly challenged system with WAST crews fully exploring admission avoidance alternatives.

Improvement actions led by Welsh Government and system partners include: -

a) Audit Wales's investigation of Urgent and Emergency Care System. Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time? (E)
b) Consideration of additional WAST schemes to support risk mitigation through winter (I)
c) NHS Wales reduces emergency department handover lost hours by 25% (E)
d) NHS Wales eradicates all emergency department handover delays in excess of 4 hours (E)
e) Alterative capacity equivalent to 1000 beds (E)
f) Implement nationwide approach to emergency department 'Fit 2 Sit' (E)
g) Implementation of Same Day Emergency Care services in each Health Board (E)
h) National Six Goals programme for Urgent and Emergency Car (E)

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Regional Escalation Protocol	1. Daily conference calls to agree RE levels in conjunction with Health Boards
2. Immediate release protocol	2. The Immediate Release Protocol is a Nationally agreed NHS Wales protocol. Refusals by Health Boards are Datixed by WAST and compliance report shared weekly with the Health Board Chief Operating Officers (COOs)
3. Resource Escalation Action Plan (REAP)	3. Weekly review by Senior Operations team with assessment of action compliance. The Senior Leadership Team convenes every Tuesday as the Weekly Performance Meeting to review performance and demand data, and review/assign REAP Levels as appropriate. Dynamic escalation via Strategic Command structure. **REAP is currently undergoing annual review with an updated to be released December 2023.**
4. 24/7 Operational Delivery Unit (ODU)	4. Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end. Provides operational oversight with dynamic CSP review and system escalation as required.
5. Strategic, Tactical and Operational 24 hour/ 7 day per week system to manage escalation plans	5. Same as 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. **On Call cover is reviewed weekly at SLT Performance Meetings.**
6. Limited Alternative Care Pathways in place	6. Limited Assurance - Health Informatics reports, APP dashboard monitors, reports on app use by Consultant Connect, APP development and expansion, and bids for additional prescribing APPs.
7. Consult and Close (previously Hear and Treat)	7. **The Trust ambition is to attain 17% Consult and Close rate, with an improvement plan in place to achieve this. The Trust has however already achieved the inclusion of Mental Health Practitioners in CSD, a key contributor to the achievement of Consult and Close rates. Reported through integrated quality meeting.**
8. Advanced Paramedic Practitioner (APP) deployment model / APP Navigation	8. WAST has attempted to secure additionality within its APP numbers, as the evidence illustrates a dramatic impact upon ED avoidance with more people being managed within the community. At this stage, no additional funds have been secured.

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	21/11/2023	TREND	25 (5x5)
		Date of Next Review:	21/12/2023		

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

	However, it remains the case the prospective APPs are completing their education and could be deployed into the operational setting to mitigate the risk. ELT has therefore agreed to grow the APP numbers further this year, redirecting existing operational spend to bolster APP growth.
9. Clinical Safety Plan	9. Clinical agreement – agreeing escalation to higher levels, ODU dashboard, AACE paper through National Director of Operations group. **Clinical Safety Plan is currently under review with a release date December 2023.**
10. Recruitment and deployment of CFRs	10. **CFR numbers have grown during 2022/23 which alongside a cleanse of the volunteer database has realised 500 current active volunteers with an ambition to recruit a further 100 by end of Q4. Response data indicates that our CFRs are reaching more patients, especially those with life threatening conditions in 8 minutes compared to this time last year. Numbers of CFR's, percentage of contribution to performance a governance framework is in place. Monitoring through AD 1:1's and volunteer highlight report (IMTP).**
11. ETA scripting	11. The ETA Dashboard is a tactic that was signed off by ELT. The dashboard supports scripting analysed by comparing with real time data. **ETA performance is reviewed weekly at SLT weekly performance meeting. The effect of the ETA scripting results in cancellations of ambulances which is monitored through algorithmic review process.**
12. Clinical Contact Centre (CCC) emergency rule	12. **Emergency Rule is incorporated into CSP 999 levels.**
13. National Risk Huddle	13. This is a tactic contained in REAP ratified through SPT and EPT. Daily risk huddles are recorded, and documented actions are shared with stakeholders and progress monitored via the ODU.
14. Summer/Winter initiatives	14. Monitoring through SLT and STB. **Senior Planning Team (SPT) is now stood up for the duration of Winter 2023/24.**
15. CHARU implementation	15. **Recruitment of 153 WTE has continued; To lift further, a trial of a rotational model is due to be trialled in Aneurin Bevan Health Board area.**
16. Clinical Model and clinical review of code sets	16. Reported through **CPAS and DCR Review reporting through CQGG**
17. Remote clinical support enabling **discharge at scene**	17. Strategic Transformation Board – IMTP deliverable; **Providing support to the Community Welfare Responders (CWR) initiative and supporting CFRs to discharge at scene with current non conveyance rates for CFRs in excess of 40%**
18. Trust Board paper (28/07/22) detailing actions being taken to mitigate the risks (see actions section for details of specific work streams being progressed to mitigate this risk)	18. Formally documented action plan – actions captured are contained within and monitored via the **Mitigating avoidable harm paper from PIP.**
19. Information sharing	19. Information Sharing: Patient Safety Reports, Chief Operating Officer (COO) Data Pack, Immediate Release Declined (IRD) Reports.
20. Completed EMS Roster Review	20. Helps to ensure that we have the maximum available capacity to respond to dispatch to 999 calls received in a timely manner. **Monitor production** against **the rosters weekly at performance meeting and that provides a level of UHP as a percentage.**
21. **Delivered a reduction in the** number of multiple attendances dispatched to red calls	21. This will increase vehicle availability generally across the Trust **and is monitored through SLT weekly performance meeting.**
22. Transfer of Care	22. WAST has clearly articulated to the Health Board COOs the risk associated with delayed handovers. Consequently, work has commenced to withdraw WAST staff from portering duties on hospital premises, cease the practice of ED swaps and cease the use of WAST equipment in EDs across Wales. Please refer to the following documents: i) Letter to COO Handover Delays 30.03.2023 ii) Letter to COO Handover Delays iii) WAST – Transfer of Care Brief
	23. Multi phased approach commenced in Dec 2022 with St John Ambulance Cymru virtual ward responder, a digital and telehealth platform, and a Community Welfare Responder model to enhance community resilience. • Phase 1 delivered through St John Ambulance Cymru • Funding also obtained through external grant funding to pilot a volunteer phase. which went live mid-October with twelve teams piloting the approach. Early results look promising and the ambition to upscale is being explored with a focus on CSD capacity. Whilst the pilot tests the approach with existing CFRs, the ambition is to introduce a new volunteer role to which we will recruit new volunteers.

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	21/11/2023	TREND	25 (5x5)
		Date of Next Review:	21/12/2023	➡	

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

GAPS IN CONTROLS	GAPS IN ASSURANCE
1. Acknowledgement and acceptance of risk by Health Boards and balancing the risks across the whole system	1. Improvement in handover delays across Cardiff and Vale and more latterly across AB have led to improved handovers at Eds. This has now been sustained for some months across C&V in a phased programme of improvement with no delays in excess of 2 hours. Programme of improvement underway in AB, commencing at 4hour tolerance with a plan to reduce over time. In other Health Boards, there remains little or no controls, with variation in both handovers and risk levels across Health Boards. An extraordinary incident declared by WAST on 22 October 2023 as direct result of system risk associated with handover delays at Morrison hospital has increased focus on handover delays with external partners and across the media. Some plans are in train **(detailed in actions)** following a meeting with Swansea Bay COO to include mobile imaging, pathways to bypass ED and a pod solution ahead of winter.
2. Blockages in system e.g., internal capacity within Health Boards which affect patient flow	
3. Local delivery units mirroring WAST ODU	
4. Handover delays link to risk 224	
5. There is an ambition that no handover should exceed 4 hours and for lost hours to handover to be reduced by 25% but given the track record over last 12 months there is a low confidence in attaining this.	**The majority of Health Boards have failed to deliver on this ambition; With the exception of Cardiff and Vale University Health Board, the remaining 5 Health Boards with acute Trusts that were required to deliver on this target, have failed to do so.**
6. Handover Improvement Plans agreed between WAST and Health Boards	12. Handover Improvement Plans have been replaced by Integrated Commissioning Action Plans (ICAPS) and are subject to review with EASC; However, it is noted that previous plans did not demonstrate sufficient improvement in reducing handover delays **(see above)**
18. Access to Same Day Emergency Care (SDEC) for paramedic referrals	**18. This forms part of the handover improvement plans in place with Health Boards; however, assurance is limited given that the acceptance of paramedic referrals is low (less than 1%). There is an inconsistency in approach from Health Boards on eligibility and availability; The national Once for Wales acceptance criteria has not been uniformly deployed by Health Bards across Wales.**
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	Superseded	Rural model superseded by Action 9 below (Recruitment and deployment of CFRs)
2. Leading Change Together (forum to progress workforce related work streams jointly with TUPs)	ADLT Sub-Group	30.09.22 - Superseded	
3. Recruit and train more Advanced Paramedic Practitioners – Value Based Healthcare Fund bid for up to 50 WTE (I) [Source: Action Plan presented to Trust Board 28/07/22]	Director of Paramedicine / Director of People & Culture	Extended to March 2024	WAST has attempted to secure additionality within its APP numbers, as the evidence illustrates a dramatic impact upon ED avoidance with more people being managed within the community. At this stage, no additional funds have been secured. However, it remains the case the prospective APPs are completing their education and could be deployed into the operational setting to mitigate the risk. ELT has therefore agreed to grow the APP numbers further this year, redirecting existing operational spend to bolster APP growth.
4. 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	31.03.23 Complete	Work undertaken to map influences and progress towards each. Current % of Consult and Close increased from 12% to 15% at March 2023.
5. 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.

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	21/11/2023	TREND	25 (5x5)
		Date of Next Review:	21/12/2023		

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

6. 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.
7. 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	Complete 21.03.23	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. Volunteer team has recruited and trained 173 additional volunteers between November and March 2023.
8. Transition Plan (I) [Source: Action Plan presented to Trust Board 28/07/22]		Superseded	
9. Overnight Falls Service extension (I) [Source: Action Plan presented to Trust Board 28/07/22]	Assistant Director of Quality & Governance / Head of Quality Improvement	Ended March 2023	The temporary extension of the SJAC contract for overnight provision was evaluated, demonstrating on available evidence a positive performance impact over the period of operation (Jan-April 2023). The evaluation report was presented to EMT on 5 April 2023. The contract extension (as a temporary arrangement) ceased on 5 April 2023. Falls service enhanced day and night provision remains in place and utilisation of resources is reviewed at weekly performance meetings by Operations SLT.
10. New 2023 EMS Demand and Capacity (roster) review	**Assistant Director of Planning & Performance**	**March 2024**	**ORH modelling underway. Initial findings January 2024, full report to Trust Board and EASC in March**
11. Swansea Bay Winter actions	**Assistant Director of Operations, EMS**	**December 2023**	**Some plans are in train following a meeting with Swansea Bay COO to include mobile imaging, pathways to bypass ED and a pod solution ahead of winter.**
12. Mental Health response pilot	**Assistant Director of Operations, EMS**	**November 2023**	**Pilot to commence in Aneurin Bevan Health Board area Nov 2023**
13. Connected Support Cymru – is initially designed to utilise NHS and voluntary-sector resources and responders to enable patients to be supported in their own home whilst waiting for an urgent healthcare need to be managed. The service will employ digital health technologies to connect patients, communities and clinicals to achieve better health outcomes. The initiative will improve patient experience and safety, while supporting the healthcare system in directing patients to the right pathway at an appropriate time for their care need. It is expected this will help reduce unnecessary demand upon Emergency Departments.	**Assistant Director of Quality Governance**		**Multi phased approach commenced in Dec 2022 with St John Ambulance Cymru virtual ward responder, a digital and telehealth platform, and a Community Welfare Responder model to enhance community resilience.** **Phase 1 delivered through St John Ambulance Cymru** **Funding also obtained through external grant funding to pilot a volunteer phase. which went live mid-October with twelve teams piloting the approach. Early results look promising and the ambition to upscale is being explored with a focus on CSD capacity. Whilst the pilot tests the approach with existing CFRs, the ambition is to introduce a new volunteer role to which we will recruit new volunteers.**
14. Maximise the opportunity from Consult and Close – stretch to 17%			**Trust ambition is to attain 17% Consult and Close rate, with an improvement plan in place to achieve this. The Trust has however already achieved the inclusion of Mental Health Practitioners in CSD, a key contributor to the achievement of Consult and Close rates.**
15. Development of new model of care	**Head of Strategy Development**	**2024/25**	**Development of the model remains ongoing**
16. Development of the pathway which connects mental health users connecting via the 999 system to 111 Press 2 services	**Assistant Director of Operations, Integrated Care**	**March 2024**	**Development of the model remains ongoing**

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:	10/12/2023	TREND	25 (5x5)
		Date of Next Review:	10/01/2024	➡	

IF	THEN	RESULTING IN
patients continue to be significantly delayed in ambulances outside Accident and Emergency Departments	there is a continued risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised	patients coming to significant harm and a poor patient experience

	Likelihood	Consequence	Score
Inherent	5	5	25
Current	5	5	25
Target	3	2	6

IMTP Deliverable Numbers:

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

Risk Commentary Q2 2023/24

The risk score remains constant at 25 for quarter 2 2023/24 (almost certain & catastrophic). Internal and external assurances remain weak as there remains a daily risk of actual patient harm due to handover of care delays. **There were 1,888 patient handovers in October 2023 which were over 4 hours**. The target was originally to have zero by September 2022. In October 2023over **23,232 hours were lost, equivalent to losing 25% of the Trust's conveying capacity. Cardiff & Vale University Health Board has demonstrated material improvement and is a positive outlier.** The impacts on patients waiting for extended periods of time both in the community and then outside emergency departments is well documented (AACE Delayed Hospital Handovers: Impact assessment of patient harm, 2021) and includes pressure damage, acute kidney injury, deconditioning, poorer outcomes, and extended recovery times. Delays across the system continue to be the main focus of patient safety incidents, complaints, coronial enquires and redress / claims. The Trust received **three** Prevention of Future Death Reports (Regulation 28) during this quarter. Two reports were issued to the Trust, Betsi Cadwaladr University Health Board and the North Wales Local Authorities due to extended community response and handover of care delays. **To date (Q2 2023/24) the Trust has received 6 Prevention of Future Death Reports, 5 of which relate to delays in response and handover of care issues.**

The effectiveness of our controls in many areas are dependent on external partners acknowledging and having ownership of the risk across the urgent and emergency care system. Key to moving the position is to continue to work in collaboration influencing system partners, being present and engaging in key conversations, whilst continually seeking opportunities internally to swiftly identify and mitigate the risks within our control and share those with relevant system partners that we cannot control. WAST CEO and Directors have ensured that system safety and avoidable harm remain a live topic of discussion in all relevant forums and continue to seize opportunities as they emerge that can contribute to mitigating avoidable harm. The Joint Investigation Framework in place to review incidents across the system is now approved and included in the recently published National Policy on Patient Safety Incident Reporting & Management (May 2023). Themes from system partners following review of incidents remains the consequences of high escalation levels in acute care and crowded emergency departments.

Improvement actions led by Welsh Government and system partners include:

a) Right care, right place, first time Six Goals for Urgent and Emergency Care - A policy handbook 2021–2026. Goal 4 'Improving ambulance patient handover, ensuring no one arriving by ambulance at an Emergency Department waits more than 60 minutes from arrival to handover to a clinician – (Welsh Government) ***by the end of April 2025***
b) NHS Wales eradicates all emergency department handover delays more than 4 hours (LHB CEOs) ***revised to March 2023/24.***
c) Alternative capacity equivalent to 1,000 beds project (LHB CEOs) – 678 additional beds delivered, a significant achievement, but short of the target of 1,000.
d) Investigation of Urgent and Emergency Care System: Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time? (Audit Wales)
e) Implement nationwide approach to emergency department 'Fit 2 Sit' (Welsh Government: Chief Medical Officer and Chief Nursing Officer).

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. WAST Serious Clinical Incident Forum (SCIF) is in place to discuss patient safety incidents, learning and improvement actions to prevent future harm, working in collaboration with Health Boards / NHS Wales Executive Delivery Unit under the Joint Investigation Framework which was formalised in the National Patient Safety Policy in May 2023. Sharing of potential case of serious avoidable harm/death with Health Boards for investigation when response delay associated with system congestion is the primary cause. CNO and CMO plus peer group and COOs regularly updated on patient safety incidents.	1. Patient safety reporting and escalation through the Serious Clinical Incident Panel (SCIF), Patient Safety Highlight Reports, Health Board specific reports in place with escalation through WAST governance framework.
2. WAST membership of the working group (Executive Director of Quality & Nursing) to reform the Framework for the Investigation of Patient Safety Serious Incidents (SIs) national investigation framework with system partners. Chaired by the Deputy Chief Ambulance Commissioner and commenced in August 2022.	2. Workshop with system partners in place with executive directors of nursing attendance and to date is working well with good engagement from health board colleagues. Following the last meeting on 25.01.2023 it was agreed that sub-groups would be formed to meet more frequently to gather themes / evaluation / develop more consistency which would include aligning the outputs / outcomes with the 'Six Goals for Urgent and Emergency Care' work.
3. WAST and system compliance with National Standards - 15-minute handover (NHS Wales Hospital Handover Guidance v2 (May 2016)	3. Monthly Integrated Quality and Performance Report, Health Informatics reports, APP dashboard on app use by Consultant Connect and shared at local and corporate meetings regarding patient safety and handover of care position across NHS Wales and NHS England.
4. WAST Clinical Notice in place - Escalating a clinical concern with a deteriorating patient outside the Emergency Department (11.02.2021). National Early Warning Score (NEWS) trigger of 5 or above for escalation to hospital clinicians. NEWS data available via EPCR (electronic patient care record).	4. NEWS data now available via ePCR and escalation system in place via local managers and the Operational Delivery Unit.

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:	10/12/2023	TREND	25 (5x5)
		Date of Next Review:	10/01/2024	➡	

IF patients continue to be significantly delayed in ambulances outside Accident and Emergency Departments	**THEN** there is a continued risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised	**RESULTING IN** patients coming to significant harm and a poor patient experience

	Likelihood	Consequence	Score
Inherent	5	5	25
Current	5	5	25
Target	3	2	6

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.
7. Regional Escalation Protocol and Resource Escalation Action Plan (REAP). Proactive and forward-looking weekly review of predicted capacity and forecast demand. Deployment of predetermined actions dependant on assessed level of pressure. Consideration of any bespoke response/actions plans in the light of what is expected in the coming week. WAST has updated the REAP in advance of winter, including revised triggers (higher) for handover lost hours.	7. The Senior Leadership Team convenes every Tuesday as the Weekly Performance Meeting to review performance and demand data, and review/assign REAP Levels as appropriate. Dynamic escalation is via the Strategic Command structure.
8. Staff from WAST, Health Boards and third sector organisations assisting to meet patient's Fundamentals of Care as best they can in the circumstances.	8. Confirmed through Healthcare Inspectorate Wales (HIW) workshops and Health & Care Standards self-assessment process and Putting Things Right Quarterly Reports to Clinical Quality Governance Group and QuEST
9. 24/7 operational oversight by ODU with dynamic CSP review and system escalation as required. Realtime management and escalation of risks and harm with system partners. Triggering and escalation levels within CSP to best manage patient safety in the context of prevailing demand and available response capacity. Monitoring, escalation and reporting of extreme response or handover delays.	9. Shift reports from ODU & ODU Dashboard received by Executive Management Team (EMT), Senior Operations Team (SOT) and On-Call Team at start/end. Realtime management and escalation of risks and harm with system partners. Triggering and escalation levels within CSP to best manage patient safety in the context of prevailing demand and available response capacity. Monitoring, escalation and reporting of extreme response or handover delays
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. Monthly Integrated Quality and Performance Report (**October 2023** overall 76% - Safeguarding and dementia awareness remains over 91%.
13. Clinical audit programme in place.	13. Clinical audit programme in place (dynamic document) with oversight from the Clinical Quality Governance Group and QuEST.
14. Workshop set up by the Deputy Chief Ambulance Commissioner to respond to the findings in the Health Care Inspectorate Wales (HIW) Report *Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover* (undertaken 2021). WAST has senior representation at this meeting. – assurance is that HIW approve and sign off WAST elements and Health Board elements of recommendations.	14. Workshop set up by the Deputy Chief Ambulance Commissioner to respond to the findings in the Health Care Inspectorate Wales (HIW) Report Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover (undertaken 2021). WAST has senior representation at this meeting. A collective response from WAST and Health Boards is being overseen by EASC.
15. Escalation of patient safety concerns by Trust Board: featured in provider reports to the Emergency Ambulance Committee (EASC); been the subject of Accountable Officer correspondence to the NHS Wales Chief Executive; numerous escalations to professional peer groups initiated by WAST Directors; and coverage at Joint Executive Meetings with Welsh Government. 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	15. Monthly Integrated Quality and Performance Report, CEO Reports to Trust Board including 'Actions to Mitigate Avoidable Patient Harm Report' (last presented to Trust Board **November** 2023) and Board sub-committee oversight and escalation through 'Alert, Advise and Assure' reports.

Risk ID 224	Significant Handover of Care Delays Outside Accident and Emergency Departments Impacts on Access to Definitive Care Being Delayed and Affects the Trust's Ability to Provide a Safe & Effective Service for Patients	Date of Review:	10/12/2023	TREND	25 (5x5)
		Date of Next Review:	10/01/2024	➡	

IF patients continue to be significantly delayed in ambulances outside Accident and Emergency Departments	THEN there is a continued risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised	RESULTING IN patients coming to significant harm and a poor patient experience

	Likelihood	Consequence	Score
Inherent	5	5	25
Current	5	5	25
Target	3	2	6

lost per arrival by 25 per cent (from the October 2021 level) have been set. It should also confirm the target dates for the achievement of these targets."	
16. Implementation of Duty of Quality, Duty of Candour, and new Quality Standards requirements in April 2023.	16. Welsh Government Road Map in place (soft launch) with milestones for organisations – baseline assessment and monthly updates (RAG ratings) in place with Trust Board oversight. The current internal assessment overall as of July 2023 is 'Implementing and operationalising'. The Trust has representation on the All Wales Duty of Candor Implementation Group and is actively engaged in developing resources. **From April 2024 the Trust will publish an annual quality report and compliance with Duty of Candour. Operational oversight occurs at the Quality Management Group and Executive oversight is via the Clinical Quality Governance Group.**
17. **Clinical Support Desk First in place**	17.
	External Sources of Assurance Management (1st Line of Assurance)
	1. Monitoring and oversight of the Ambulance Quality Indicators (AQIs) including handover of care timeliness and Commissioning Framework by the Chief Ambulance Services Commissioner (CASC), the Emergency Ambulance Services Committee (EASC) including the Integrated Commissioning Action Plans (ICAPS) and Joint Executive Team (JET) meetings with Welsh Government (I&E).
	2. Healthcare Inspectorate Wales (HIW) 'Review of Patient Safety, Privacy, Dignity and Experience whilst waiting in Ambulances during Delayed Handover' Report and system wide improvement plan with working group in place with WAST senior representation. Oversight by HIW and EASC
	3. Duty of Quality and Duty of Candour readiness returns assessment by Welsh Government.
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Lack of capacity in the Putting Things Right Team to deliver across the functions due to competing priorities resulting from sustained system pressures.	1.
2.	2. Implementation of the revised Joint Investigation process remains in pilot stage with good engagement seen by system partners. Several overdue patient safety investigations remain presenting a risk to patient safety across the system. The Trust has 38 overdue nationally reportable incident investigations. Shared system learning from the Joint Investigation Framework is currently limited **with no new learning identified to date.**
3. Lack of implementation and holding to account regarding the NHS Wales of the Handover Guidance v2 and recognition of the patient safety risks pan NHS Wales*.	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. In **October** 2023, **23,232** hours were lost with 1,**888** +4 hour delayed patient handovers.
4. Variation in responsiveness at Emergency Departments to the escalating concerns regarding patients' NEWS*.	4. Strengthening of patient safety reports and audit processes as e PCR system embeds.
5. Variation pan Wales / England as position not implemented across all emergency departments*.	5.
6. Variation pan Wales / England as position not implemented across all emergency departments*.	6. New Quality Management System in development which will include monitoring of the new Quality Standards & Enablers and underpinning governance structure.
7. Variable response pan Wales / England. WAST have minimal control on this at patient level*.	7.
8. Variable response pan Wales / England. WAST have minimal control on this at patient level*.	8.
9. Transition to ePCR impacting on data temporarily	9.
10. 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*.	10. HIW approve and sign off WAST elements of recommendations.
	External Gaps in Assurance 1. Lack of escalation and response to AQIs by the wider urgent care system and regulators

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:	10/12/2023	TREND	25 (5x5)
		Date of Next Review:	10/01/2024	➡	

IF patients continue to be significantly delayed in ambulances outside Accident and Emergency Departments	**THEN** there is a continued risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised	**RESULTING IN** patients coming to significant harm and a poor patient experience

	Likelihood	Consequence	Score
Inherent	5	5	25
Current	5	5	25
Target	3	2	6

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Handover checklist implementation – Nationally WAST Quality Improvement (QI) Project	WAST QI Team (QSPE)	• TBC – Paused	• Timeframes awaited via Emergency Department Quality & Delivery Framework (EDQDF).
2. Implement patient safety dashboards (live and look back data) triangulating quality metrics / KPIs and performance data sourcing health informatics resource.	Assistant Director of Quality & Nursing	• Q4 2023/24	• Incremental improvements to quality and safety data and information to enable triangulation / collective intelligence at Trust and system level. • Access to ePCR data (NEWS) now available. Work on-going with Health Informatics regarding patient safety and health board dashboards.
3. Continued Health Board interactions – my next patient (boarding), patient safety team dialogue – proactive conversations with Health Board Directors of Quality & Nursing.	Executive Director of Quality & Nursing	• Monthly and as required.	• Monthly meetings continue to be held and networking through EDoNS.
4. Recruit and train more Advanced Paramedic Practitioners – Value Based Healthcare Fund bid for up to 50 WTE	Director of Paramedicine	• Q4 2023/24	• WAST has attempted to secure additionality within its APP numbers, as the evidence illustrates a dramatic impact upon ED avoidance with more people being managed within the community. At this stage, no additional funds have been secured. However, it remains the case the prospective APPs are completing their education and could be deployed into the operational setting to mitigate the risk. ELT has therefore agreed to grow the APP numbers further this year, redirecting existing operational spend to bolster APP growth.
5. Overnight falls service extension	Executive Director of Quality & Nursing	• 31.03.2024	• **Night Car Scheme extension agreed to 31 March 2024 (2 regional resources)** • **Utilization rates continue to be monitoring. Nighttime falls assistance 64% Utilisation (Apr 2023 -Jun 2023); Nighttime falls assistance 66% Utilisation (July – Oct 2023); Daytime utilisation sustained: July -August 58%. September- October 58% utilisation.** • **Optima modelling has now been completed. The modelling clearly identifies that the level two falls' vehicles are the more effective resource. The modelling has identified an estimated need of 48 (38 day and 10 overnight) falls vehicle level 2 12 hours shifts. The modelling is now being built into the strategic (five year) demand & capacity review.**
6. Duty of Quality, Duty of Candour and new Quality Standards implementation from April 2023 with development of a Quality Monitoring System supporting monitoring and oversight systems in place and embedded.	Executive Director of Quality & Nursing	• Q3 2023/24	• Monthly updates to progress against actions following the baseline assessment and readiness returns. • RL Datix Dashboards and KPIs under development nationally. • Key policies updated and approved. • Participation in the All Wales Duty of Candour implementation group by Patient Safety Team – monthly.
7. Connected Support Cymru is initially designed to utilise NHS and voluntary-sector resources and responders to enable patients to be supported in their own home whilst waiting for an urgent healthcare need to be managed. The service will employ digital health technologies to connect patients, communities and clinicals to achieve better health outcomes. The initiative will improve patient experience and safety, while supporting the healthcare system in directing patients to the right pathway at an appropriate time for their care need. It is expected this will help reduce unnecessary demand upon Emergency Departments.	Executive Director of Quality & Nursing	• Q3 2023/24	• Multi phased approach commenced in Dec 2022 with St John Ambulance Cymru virtual ward responder, a digital and telehealth platform, and a Community Welfare Responder model to enhance community resilience. • Phase 1 delivered through St John Ambulance Cymru • **SJAC funded ended on 31 October 2023.** • **Proof of concept using WAST CFR volunteers as CWRs is underway. Grant funding is being used to put in place roles and processes to recruit and train to new volunteer role.** • **This eyes on support to CSD clinicians, by volunteers, is producing positive results, with early data suggesting a 35% consult & close rate for the cohort of patients covered by the pilot.** • **The business case has now been completed and can be made available to key stakeholders. Now awaiting business case approval.** • **The CWR will be modelled as part of the options being considered by the current EMS demand & capacity review.**

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8. Organisational change process (OCP) of Putting Things Right Team (PTR) to enable increased capacity across all functions to manage increasing complexity and demands.	Executive Director of Quality & Nursing	• Q4 2023/24	• OCP commenced 25.09.2023 **and the consultation period has concluded with the final new structure confirmed. Next steps are to recruit to vacant positions which has commenced. It is anticipated that all positions will be filled by April 2024 (taking notice periods into account).**
9. Connect with All Wales Tissue Viability Network to explore strengthening the current investigations into harm from pressure damage across the whole patient pathway.	Assistant Director Quality & Nursing	• Q4 2023/24	• Positive meeting held in August 2023 as planned with the Chair of the TVN network. Next steps are for the Patient Safety Team to attend a TVN leads meeting to discuss opportunities for collaborative working and data / information sharing. **Date to be confirmed and there has been good engagement from Health Board Tissue Viability Nurses. Workshop date confirmed in January 2024.**
10. Audit Wales investigation of Urgent and Emergency Care System: Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time?	CEO	• Q4 2023/24	• Conducted in three phases Audit Wales will independently investigate and report on patient flow out of hospital: access to unscheduled care services and national arrangements (structure, governance, and support) • WAST will proactively support this work and offer best practice examples from other jurisdictions that can support benchmarking and improvement activities. • Expected outcomes in 2023/24.
11. Internal Audit to undertake a review of Serious Adverse Incidents & Joint Investigation Framework	Executive Director of Quality & Nursing	• Q4 2023/24	• Internal audit in progress. **Delays due to sickness in internal audit team.**

AGENDA ITEM No	**17**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**1**

Data Protection Policy

MEETING	Quality, Patient Experience & Safety Committee
DATE	8th February 2024
EXECUTIVE	Jonathan Sammut, Director of Digital Services
AUTHOR	Kelly Holding, Data Protection Compliance Manager
CONTACT	Kelly.holding@wales.nhs.uk

EXECUTIVE SUMMARY

1. This paper presents to the Quality, Patient Experience & Safety Committee, the revised Data Protection Policy.

2. The Data Protection Policy has been fully revised, redrafted and brought into alignment with the requirements of the Data Protection Act 2018 and UK General Data Protection Regulations, which are key pieces of legislation covering the handling, security, and confidentiality of personal information.

3. The Trust is legally required to have in place relevant and up-to-date data protection policies in order to meet the requirements of the 'Accountability Principle' under Article 5 UK GDPR, and the 'Responsibilities of the Controller' under Article 24 UK GDPR. In addition, all staff who use personal data must do so in accordance with data protection legislation.

4. This policy has been through the relevant stages of the policy review process, including the Information Governance Steering Group with invites for comments, followed by Trust-wide consultation. It was approved by the Policy Group on the 19th December 2023.

5. The Policy has been identified as a priority policy via the Policy Prioritisation Exercise that was undertaken in 2023 and Members are asked to approve this by Chairs Action so as not to delay publication of this important policy.

6. Members are asked to approve the Data Protection Policy.

RECOMMENDED that the QuEST Committee:

- Approve the Data Protection Policy.

KEY ISSUES/IMPLICATIONS
Key issues which are to be brought to the attention of the Committee/Board are as follows: • The Data Protection Policy was severely out-dated and was in need of a full redraft in order to be brought into line with GDPR. • The updated policy was noted in the Information Governance Steering Group with invites for comments, followed by Trust-wide consultation. This policy has been through the relevant stages of the policy review process confirmed by the policy review group.

REPORT APPROVAL ROUTE
Information Governance Steering Group – 05/09/2023 Policy Group – 19/12/2023 Executive Leadership Team – 17/01/2024

REPORT APPENDICES
Appendix 1 – Data Protection Policy

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

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
NHS Trust

GIG CYMRU NHS WALES

Data Protection Policy

Policy Number:	014	**Version No:**	2.1	**Supersedes:**	2.0
Date of Approval:	[XX/XX/XXXX]	**Review Date:**	3 years from date of approval	**Impact Assessments Completed:**	Yes
Classification of Document:	Corporate	**Type of Document:**	Policy	**Approved by:**	
Brief Summary of Document:	The purpose of this policy is to set out how the Trust aims to meets its legal obligations concerning data protection. The requirements within the Policy are primarily based on the UK General Data Protection Regulation (UK GDPR) and the Data Protection Act 2018, which are key pieces of legislation covering the processing of personal data.				
Scope:	This Data Protection Policy applies to all employees, workers, non-executive directors, students, volunteers, contractors, and any person carrying out approved work on behalf of the Trust.				
To be read in conjunction with:	• Information Governance Policy • Information Security Policy • Confidentiality Code of Conduct • Standards of Business Conduct Policy • Records Management Policy • Access to Personal Information Policy • Trust Mobile Telephony Policy • Social Media Policy • Email Policy • Internet Use Policy • CCTV Policy • Patient Privacy Notice • Staff Privacy Notice				
Owning Committee	Quality, Patient Experience & Safety Committee				
Policy Lead: **Trade Union Lead:**	Aled Williams Maldwyn Jones	**Job Title:**	Head of ICT Trade Union Partner		
Executive Director:	Jonathan Sammut	**Job Title:**	Director of Digital Services		

Version Control Sheet

Version	Date	Author	Summary of Changes
0.19	2016	Nicki Maher	
2	March 2023	Kelly Holding Charlotte Jones	This is a wholesale review of the current policy therefore this version does not have tracked changes.
2.1	18/01/24	Julie Boalch	Update to QuEST Committee as approving body
Keywords	Data Protection, Confidentiality, Information Security		

Impact Assessment Reviews

Area	Date of Review	Name of Reviewer
Training		
Counter Fraud		
Information Governance		
Records Management	25/10/2023	Judith Birkett
EqIA / Welsh Language	02/01/2024	Kathryn Cobley
Estates		
Environment		
ESMCP		

Task and Finish Group Members

Name	Job Title
Kath Charters	Clinical Data Specialist
Ruth Saele	Clinical Data Specialist
Judith Birkett	Records Service and Archive Manager
James Rowland	Senior ICT Security Specialist
Jon Hopkins	HI Information Management
Iwan Griffiths	111 Service Manager
Maldwyn Jones	Trade Union Representative
Aled Williams	Head of ICT/Data Protection Officer
Targeted for consultation: -	
Judith Bryce	Assistant Director of Operations

Policy Approval Route

Meeting Title	Meeting Date	Purpose/Outcome
Information Governance Steering Group	05/09/2023	Noted
Policy Group	18/07/2023	Review prior to consultation
Policy Group	23/10/2023	Agreed for consultation
Policy Group	19/12/2023	Review following consultation
Executive Leadership Team	17/01/2024	Noting
Quality, Patient Experience & Safety Committee – Chairs Action	18/01/2024	Approval
Quality, Patient Experience & Safety Committee	20/02/2024	Noting following approval via Chair's Action

Disclaimer
If the review date of this document has passed, please ensure that the version you are using is the most up to date either by contacting the document author or AMB_policies@wales.nhs.uk

Contents

1. INTRODUCTION

This Policy sets out how the Welsh Ambulance Services NHS Trust (the Trust) meets its legal obligations concerning data protection. The requirements within the Policy are primarily based on the UK General Data Protection Regulation (UK GDPR) and the Data Protection Act 2018, which are key pieces of legislation covering the handling, security and confidentiality of personal information.

The Data Protection Act applies to the processing of personal information relating to living individuals. The Access to Health Records Act 1990 will remain relevant for information relating to deceased persons.

The nature of the work undertaken by the Trust means that staff will manage and have access to confidential, and often highly sensitive information of both patients and staff. Therefore, it is essential that the public have confidence that the organisation as a whole maintains confidentiality of information in whatever form it is given, to whoever it is given and for whatever purpose.

Protecting the availability, confidentiality and integrity of Personal Data is a critical responsibility that must be always taken seriously. Organisations are exposed to potential fines of up to £17.5 million or 4% of total worldwide annual turnover, whichever is higher and depending on the breach, for failure to comply with the provisions of the UK GDPR.

The disclosure of personal data and confidential information needs to be both lawful and ethical. There is a range of legislation and guidance that limit or prohibit the use and disclosure of information in specific circumstances and, similarly, a range that require information to be used or disclosed. Applicable privacy laws and legislation include: -

- Data Protection Act 2018
- The UK General Data Protection Regulation 2019
- The EU General Data Protection Regulation 2016
- Access to Health Records 1990
- Freedom of Information Act 2000
- Human Rights Act 1998
- Health and Care Quality Standards 2023
- Regulation of Investigatory Powers Act 2000
- Crime and Disorder Act 1998
- Common Law Duty of Confidentiality
- The Telecommunications Regulations 2000

- Obscene Publications Act 1959 (as amended)
- Protection from Harassment Act 1997
- Equality Act 2010
- Computer Misuse Act 1990
- Public Interest Disclosure Act 1998
- Privacy and Electronic Communication Regulations 2003
- Network and Information Systems Regulations 2018

2. POLICY STATEMENT

This policy sets out how the Trust meets its legal obligations in respect of data protection to meet its operational needs and fulfil legal requirements.

3. SCOPE

This Data Protection Policy applies to all types of personal and patient identifiable data that the Trust processes, regardless of the media on which that data is stored (such as computer, paper, imaging systems, visual and audio records, photographs, CCTV and any other media), or whether it relates to past or present employees, workers, service users, patients, supplier contacts, website users, or any other Data Subject.

The Policy applies to all Trust staff. For this document, the term 'staff' refers to employees, non-executive directors, students, volunteers (Community First Responders, Ambulance Car Drivers etc.), contractors (this includes those with an honorary contract), and anyone carrying out approved work on behalf of the Trust. Related policies and guidelines are available to help staff act in accordance with this Data Protection Policy.

Other agencies, individuals and suppliers working with the Trust who have access to personal information will also be expected to have read and comply with this Policy.

4. AIM

The aim of this Policy is to set out how the Trust will meet its data protection obligations, and what the Trust expects from its staff to comply with applicable laws. Compliance with this Data Protection Policy and any associated guidance is mandatory.

The Trust is committed to a policy of protecting the rights and privacy of individuals (including patients, staff, and others) in accordance with data protection law. The Trust needs to process certain information about its staff, patients, and other individuals for administrative purposes (e.g. to recruit and pay staff and monitor performance) and to be able to provide its public task functions. To comply with the law, information about

individuals must be collected and used fairly, stored safely and securely and not disclosed to any third party unlawfully.

5. OBJECTIVES

The aims shall be achieved through regular communications, awareness, and monitoring of policies, procedures, and processes to ensure they are fit for purpose and comply with the requirements of this policy.

Additional policies, procedures and guidance shall be developed and published to ensure that all relevant parties are able to implement and follow data protection practices and legal requirements.

6. DATA PROTECTION POLICY

6.1. The UK General Data Protection Regulation

The GDPR came into force on the 25 May 2018 and formed part of the data protection regime in the UK, together with the Data Protection Act 2018.

Following the UK's exit from the European Union on 1st January 2021, the GDPR was retained in UK law by the European Union (Withdrawal) Act 2018. The Data Protection, Privacy and Electronic Communications (Amendments etc.) (EU Exit) Regulations 2019 amended the retained EU law version of the GDPR, with the amended version becoming the 'UK GDPR'. The EU GDPR will continue to apply in EU jurisdictions, and the UK GDPR will apply to the UK.

The UK GDPR outlines several principles which require that data controllers ensure personal data shall be:

- Processed lawfully, fairly and in a transparent manner; (Lawfulness, fairness, and transparency)
- Collected for specified, explicit and legitimate purposes and not further processed in a manner that is incompatible with those purposes; further processing for archiving purposes in the public interest, scientific or historical research purposes or statistical purposes shall not be incompatible with the initial purposes; (Purpose limitation)
- Adequate, relevant, and limited to what is necessary in relation to the purposes for which they are processed; (Data minimisation)
- Accurate and, where necessary, kept up to date, every reasonable step must be taken to ensure that personal data that is inaccurate (having regard to the

purposes for which they are processed), is erased or rectified without delay; (Accuracy)

- Kept in a form which permits identification of data subjects for no longer than is necessary for the purposes for which the personal data is processed. Personal data may be stored for longer periods in so far as the personal data may be processed solely for archiving purposes in the public interest, scientific or historical research purposes or statistical purposes subject to implementation of the appropriate technical and organisational measures required by the UK GDPR to safeguard the rights and freedoms of individuals; (Storage limitation)
- Processed in a manner that ensures appropriate security of the unauthorised or unlawful processing and against accidental loss, destruction, or damage, using appropriate technical or organisational measures; (Security, integrity, and confidentiality)
- Not transferred to another country without appropriate safeguards being in place; (Transfer Limitation)
- Made available to Data Subjects and allow Data Subjects to exercise certain rights in relation to their Personal Data; (Data Subject Rights and Requests) and
- Data controllers shall be responsible for and be able to demonstrate compliance with data protection. (Accountability)

6.2. Lawfulness, Fairness and Transparency

Personal data must be Processed lawfully, fairly and in a transparent manner in relation to the Data Subject.

Lawfulness

The Trust must ensure that any processing of personal data that it undertakes has a lawful basis under the UK GDPR. Article 6 of the UK GDPR sets out six legal bases for Processing which include: -

- the Data Subject has given his or her Consent.
- to meet the Trust's legal compliance obligations.
- to protect the Data Subject's vital interests.
- for the performance of a task carried out in the public interest or in the exercise of its official authority.

When processing Special Category data, an additional lawful basis under Article 9 of the UK GDPR must apply. This includes where: -

- the Data Subject has given explicit consent.
- processing is necessary to protect the vital interests of the data subject or of another natural person where the data subject is physically or legally incapable of giving consent.
- processing is necessary for the purposes of preventive or occupational medicine, for the assessment of the working capacity of the employee, medical diagnosis, the provision of health or social care or treatment or the management of health or social care systems and services.

The Trust shall identify and document the legal ground being relied on for each of its Processing activities. The Trust maintains a central Data Processing Log which shall record the legal basis for its processing activities.

Fairness

Data must also be processed fairly by the Trust. This means that personal data should only be handled in ways that people would reasonably expect and not used in ways that have unjustified adverse effects on them. Data Subjects must not be misled regarding how their data will be used.

Transparency

Data Protection laws require that specific information is provided to Data Subjects about how their data is collected and used. The information must be provided in concise, transparent, intelligible, easily accessible, clear, and plain language, and communicated in a way that is effective for the target audience. The Trust will ensure that the Staff and Patient Privacy Notices are regularly maintained and accessible in a variety of formats.

Additional privacy notices or privacy information may also be published and provided to Data Subjects in a variety of ways depending on the processing activity, for example in a leaflet, pre-recorded telephone message or website pop-up notification. The Trust will ensure that it proactively makes Data Subjects aware of privacy information using a combination of techniques, such as icons, preambles on forms and supplementary published notices for specific processing.

6.3. Purpose Limitation

Personal Data must be collected and processed only for specified, explicit and legitimate purposes. The Trust must be clear about what the purposes for processing are from the outset. Personal Data must not be further Processed in any manner incompatible with those original purposes. For example, the Trust must not collect data for the purpose of

providing care to an individual, and then use this data for additional purposes such as selling the data to direct marketing firms.

The Trust will only use Personal Data for a 'new purpose' if either this is compatible with the original stated purpose, consent is obtained, or where there is a clear obligation or function set out in law.

You shall therefore ensure that if you plan to use or disclose personal data for any purpose that is additional to or different from the original specified purpose, the new use is fair, lawful, and transparent. A Data Protection Impact Assessment will assist in determining the purposes of processing.

6.4. Data Minimisation

Personal Data must be adequate, relevant, and limited to what is necessary in relation to the purposes for which it is Processed.

You must ensure that you do not collect or use more Personal Data than is necessary for the purpose of the project/service. You must ensure that when Personal Data is no longer needed for specified purposes, it is deleted or anonymised in accordance with the Records Management Policy.

6.5. Data Accuracy

You must ensure that the Personal Data used and held is accurate, complete, kept up to date and relevant to the purpose for which it was collected. You must check the accuracy of any Personal Data at the point of collection and at regular intervals afterwards.

You must follow processes and procedures regarding the use of systems and equipment to ensure that Personal Data is recorded accurately. Failure to accurately record Personal Data, especially in relation to clinical records, can result in a data breach.

When information has been identified as having already been entered into the wrong clinical record, or incorrect information has been recorded, an incident should be raised on the Datix system. The information should not be removed, as there is a possibility that treatment or care has been given based on this incorrect information. Following notification, the Records Team, Information Governance Team, and relevant incident handler shall manage the records requirements in accordance with established procedures.

6.6. Storage Limitation

Personal Data must not be kept in an identifiable form for longer than is necessary for the purposes for which the data is processed.

The Trust maintains retention policies and procedures to ensure Personal Data is deleted after a reasonable time for the purposes for which it was being held unless a law requires that data to be kept for a minimum time. You must comply with the Trust's Records Management Policy and Retention Schedule.

You must take all reasonable steps to destroy or erase all Personal Data that we no longer require in accordance with the records retention schedules and policies. This includes requiring third parties to delete data where applicable.

The Trust will ensure Data Subjects are informed of the period for which data is stored and how that period is determined.

6.7. Security, Integrity, and Confidentiality

Personal Data must be secured by appropriate technical and organisational measures against unauthorised or unlawful Processing, and against accidental loss, destruction, or damage.

The Trust will develop, implement, and maintain safeguards to protect data. The Trust will regularly monitor, evaluate, and test the effectiveness of those safeguards to ensure security of the Processing of Personal Data. This includes through internal and external audit.

You must maintain data security by protecting the confidentiality, integrity, and availability of the Personal Data, defined as follows:

- Confidentiality means that only people who have a need to know and are authorised to use the Personal Data can access it.
- Integrity means that Personal Data is accurate and suitable for the purpose for which it is processed; and
- Availability means that authorised users can access the Personal Data when they need it for authorised purposes.

You are responsible for protecting the Personal Data we hold. You must follow all procedures and technologies we put in place to maintain the security of all Personal

Data from the point of collection to the point of destruction. Please refer to the Information Security Policy.

6.7.1. Ensuring Confidentiality

The Trust regards all identifiable personal information relating to patients as confidential and compliance with the legal and regulatory framework should be achieved, monitored, and maintained.

The Trust regards all identifiable personal information relating to staff as confidential except for where national policy or legislation on accountability and openness requires otherwise.

The Trust will establish and maintain policies and procedures to ensure compliance with the UK GDPR, Data Protection Act, Human Rights Act, the Common Law Duty of Confidentiality, Privacy and Electronic Communications Regulations, the Freedom of Information Act, Environmental Information Regulations and other related legislation and guidance.

All staff working in the NHS are bound by a legal duty of confidence to protect personal information they may encounter during their work. This is not just a contractual requirement, but also a legal obligation under the common law duty of confidence and data protection legislation.

All staff have a responsibility to access only the information which they need to know to carry out their duties. Trying to gain access to information that is not needed for the role or passing that information to someone who is not authorised to have that information is a breach of data protection and confidentiality. It is a breach of this Policy for staff to inappropriately look at any information relating to their own family, friends, or acquaintances.

It is also a criminal offence under section 170 of the Data Protection Act for an employee to knowingly or recklessly, without consent of the Trust, access, obtain or disclose personal data.

Looking at patient or staff records out of curiosity is strictly forbidden – for example a high-profile patient (celebrity). Monitoring systems and processes are in place for monitoring access to staff and patient records. Disciplinary proceedings may be instigated should abuse of access rights and privileges be discovered.

Employees are not permitted to:

- Access their own, a relative, or friend's personal data for their own purposes.
- Access any personal data where it is not a specific requirement of their job to do so.
- Ask someone who has access to personal data (where they do not) to access personal data for them, unless for an authorised Trust purpose.
- All staff agree to uphold confidentiality on signing of their contract of employment with the Trust. Non-compliance may result in disciplinary action being taken in accordance with the Trust Disciplinary Procedure, or referral to the Information Commissioner's Office (ICO) for criminal offence prosecution. This agreement extends after employment ceases.
- There may be occasions where visitors from outside of the Trust attend Trust sites. Where it is deemed that they may have access to personal / business sensitive information, they MUST sign an appropriate Confidentiality Agreement. Allowing a visitor access to personal / business sensitive information may result in a breach and therefore providing them with access to this type of information should be strictly avoided unless the access has a lawful basis. If the visitor refuses to sign, appropriate measures to ensure they do not encounter any personal / business sensitive information shall be made.

6.8. Transfer Limitation

The UK GDPR restricts data transfers to countries outside the UK to ensure that the level of data protection afforded to individuals by the UK GDPR is not undermined. You transfer Personal Data originating in one country across borders when you transmit, send, view or access that data in or to a different country. This includes when you use Data Processors that transfer or store data outside of the UK.

You may only transfer Personal Data outside the UK if an appropriate condition applies. A Data Protection Impact Assessment must be completed prior to any planned transfers of data outside of the UK to ensure applicable conditions are satisfied.

Working abroad does not qualify as a restricted data transfer. Sending personal data to someone directly employed by the sender but who is working overseas is not an international transfer requiring further specific measures for UK GDPR compliance. However, there are other information security concerns that should be considered before equipment and data should be taken abroad, and there are some high-risk countries where encrypted items must not be taken. Further advice should be sought from Cyber Security before employees take work equipment abroad.

6.9. Individual Rights

Unless subject to an exemption, individuals have the following rights with respect to their personal data:

- The right to be informed - Individuals have the right to be informed about the collection and use of their personal data. This is a key transparency requirement under the UK GDPR. This can be achieved by using a privacy notice.
- The right of access – Individuals have the right to access their personal data. This is commonly referred to as subject access request. Data subjects have a right to request access or copies of their records in line with the Data Protection Act by making a 'Subject Access Request' such as copies of 'personnel files'. Subject access requests must be completed within 30 days and provided free of charge (unless a request is "manifestly unfounded or excessive").
- The right to rectification - The right to request that the Trust corrects any data if it is found to be inaccurate or out of date.
- The right to erasure - The right to request their personal data is erased where it is no longer necessary for the Trust to retain such information (subject to exemptions).
- The right to restrict processing - The right, where there is a dispute in relation to the accuracy or processing of their personal data, to request a restriction is placed on further processing.
- The right to data portability - The right to request that the Trust provides them with their personal information and where possible, to transmit that data directly to another data controller, where their information has been processed with their consent. This only applies to information provided by the data subject, where processed on a basis of consent or where necessary for performance of a contract; and carried out by automated means. The 'Data Portability' does not apply to most 'paper' files.
- The right to object - The right to object to the processing of their data.
- The right to withdraw their consent to the processing at any time if they have previously given consent for processing.
- Rights in relation to Automated Decision-Making (ADM) and profiling - The UK GDPR applies to all automated individual decision-making and profiling. The Trust can only carry out this type of decision-making where the decision is:
    - Necessary for the entry into or performance of a contract; or
    - Required or authorised by domestic law applicable to the controller; or
    - Based on the individual's explicit consent.

In addition to the above fundamental rights, individuals can also: -

- request a copy of an agreement under which Personal Data is transferred outside of the UK.
- prevent our use of their Personal Data for direct marketing purposes.
- challenge Processing which has been justified on the basis of our legitimate interests or in the public interest.
- prevent Processing that is likely to cause damage or distress to the Data Subject or anyone else.
- object to decisions based solely on Automated Processing, including profiling (ADM).
- be notified of a Personal Data Breach which is likely to result in high risk to their rights and freedoms.
- make a complaint to the supervisory authority (ICO).

Please see Data Subject Rights Requests Procedure for more information. You can refer individual rights requests to the Information Governance Team and Records Services and Archives Team for coordination, help and advice.

6.10. Privacy by Design and Data Protection Impact Assessments (DPIA)

The UK GDPR requires the Trust to implement privacy by design measures when processing personal data. Privacy by design is achieved by putting into place appropriate technical and organisational measures (such as encryption, access controls, audit logs, training etc.)

This means that all new projects, processes, services, and systems (including software and hardware) which are introduced must be reviewed and incorporate privacy by design requirements to ensure the ongoing security and confidentiality of data as well as compliance with the data protection principles.

In addition to implementing privacy by design measures, Data Controllers are also required to conduct a Data Protection Impact Assessment for certain types of processing. DPIAs enable the Trust to address the privacy concerns and potential risks of data processing and helps to ensure that privacy by design requirements are met.

Completion of a DPIA is a mandatory legal requirement in certain circumstances. You must conduct a DPIA when implementing system or business change programs involving the Processing of Personal Data including:

- Use of new technologies (programs, systems or processes), or changing technologies (programs, systems or processes);

- Automated Processing including profiling and automated decision-making (ADM);
- large-scale Processing of Special Categories of Personal Data or Criminal Convictions Data; and
- large-scale, systematic monitoring of a publicly accessible area.

A copy of the Trust's DPIA template (with screening questions) is available on the staff intranet or can be requested directly from the Information Governance Team at AMB_infoGovernance@wales.nhs.uk. Please also refer to the Data Protection Impact Assessment Procedure.

6.11. Automated Processing (including profiling) and Automated Decision-Making

Solely automated decision-making is prohibited when an automated decision has a legal or similar significant effect on an individual unless:

a) the Data Subject has explicitly consented.
b) the Processing is authorised by law; or
c) the Processing is necessary for the performance of or entering a contract.

If certain types of Special Categories of Personal Data or Criminal Convictions Data are being processed, then grounds (b) or (c) will not be allowed but the Special Categories of Personal Data and Criminal Convictions Data can be Processed where it is necessary (unless less intrusive means can be used) for substantial public interest like fraud prevention.

If a decision is to be based solely on Automated Processing (including profiling), then Data Subjects must be informed when you first communicate with them of their right to object. This right must be explicitly brought to their attention and presented clearly and separately from other information. Suitable measures must be put in place to safeguard the Data Subject's rights and freedoms and legitimate interests.

We must also inform the Data Subject of the logic involved in the decision making or profiling, the significance and envisaged consequences and give the Data Subject the right to request human intervention, express their point of view or challenge the decision.

A DPIA must be carried out before any Automated Processing (including profiling) or Automated Decision-Making activities are undertaken.

6.12. Sharing and Disclosing Personal Data to Suppliers or Service Providers

Personal data must not be disclosed to a supplier, service provider, vendor, or contractor, unless there is a lawful basis for the processing and where certain safeguards and contractual arrangements have been put in place.

The Trust may only provide Personal Data to suppliers, service providers, vendors, or contractors if:

- they have a need to know the information for the purposes of providing the contracted services.
- sharing the Personal Data complies with the Privacy Notice provided to the Data Subject.
- the third party has agreed to comply with the required data security standards, policies and procedures and has put adequate security measures in place.
- the transfer complies with any applicable cross-border transfer restrictions.
- due diligence has been undertaken on the proposed third party, assessing their security and compliance status; and
- a fully executed written contract that contains UK GDPR-approved third party clauses has been implemented (i.e. a Data Processor Agreement).

A Data Protection Impact Assessment may be required for any processing that a third-party supplier or service provider will be undertaking on the Trust's behalf.

Data processor agreements will be required to contain the minimum provisions to comply with Article 28 of the UK GDPR, including on data retention, erasure, and security controls. Failure to have a valid Data Processing Agreement in place with a Data Processor is a breach of data protection.

6.13. Sharing and Disclosing Personal Data to other Third Parties

A Data Sharing Agreement is required where there is regular and routine data sharing with other organisations that are not acting in the capacity of a Data Processor. A DPIA MUST be completed prior to any regular or routine data sharing activity.

A Joint Data Controller Agreement is required where two or more controllers jointly determine the purposes and means of processing. This agreement shall set out the roles and responsibilities for complying with the UK GDPR. A DPIA shall be completed prior to commencing a joint-controller activity.

Data sharing agreements with third parties will be required to stipulate minimum provisions including on data retention, erasure, and security controls in accordance with

the requirements of the ICO's Data Sharing Code of Practice and the Welsh Accord on the Sharing of Personal Information.

It is recognised that ad hoc data disclosures will be required from time to time during the performance of the duties of the Trust. However, any data disclosure will be required to have at least one lawful basis for disclosing the data. In addition, any disclosing of patient data will require satisfying confidentiality rules (either implied or explicit consent, public interest or legal obligation. Please see Confidentiality Code of Conduct.)

6.14. Accountability

The Trust is responsible for, and must be able to demonstrate, compliance with the data protection principles. The Trust must have adequate resources and controls in place to ensure and to document UK GDPR compliance including:

- appointing a suitably qualified DPO (where necessary) and an executive accountable for data privacy.
- implementing Privacy by Design when Processing Personal Data and completing DPIAs where Processing presents a high risk to rights and freedoms of Data Subjects.
- integrating data protection into internal documents including this Data Protection Policy, Related Policies, guidelines or privacy notices.
- regularly training staff on the UK GDPR, this Data Protection Policy, Related Policies and guidelines and data protection matters including, for example, Data Subject rights, consent, legal basis, DPIAs and Personal Data Breaches. The Trust must maintain a record of training attendance by staff; and
- regularly testing the privacy measures implemented and conducting periodic reviews and audits to assess compliance, including using results of testing to demonstrate compliance improvement effort.

6.15. Record Keeping

The UK GDPR requires that the Trust keeps full and accurate records of all its Processing activities.

The Information Governance team will maintain a Data Processing Log which shall record at a minimum, the name and contact details of the Controller and the DPO, clear descriptions of the Personal Data types, Data Subject types, Processing activities, Processing purposes, third-party recipients of the Personal Data, Personal Data storage locations, Personal Data transfers, the Personal Data's retention period and a description of the security measures in place. To create the records, data maps should be created

and maintained by process owners that should include the detail set out above together with appropriate data flows.

Process owners have a responsibility to ensure that any changes to processing are notified to the Information Governance team to enable accurate records to be kept.

6.16. Information Assets

All types of personal data held or processed by the Trust are classed as Information Assets.

Information Assets are identifiable and definable assets owned or contracted by an organisation which are 'valuable' to the business of that organisation. These Information Assets should have Information Asset Owners who have the responsibility to ensure their assets are recorded in the Trust's Information Asset Register (IAR) together with details of their business criticality, data flow and any risk reviews carried out (via the Data Protection Impact Assessment process). Information Asset Owners must regularly review all the systems and processes under their control to ensure they comply with this Data Protection Policy and check that adequate governance controls and resources are in place to ensure proper use and protection of Personal Data.

The Information Asset may also have an Information Asset Administrator who administers the data on a day-to-day basis.

All identified Trust Information Assets must be recorded in the Trust IAR. Please refer to the Information Asset Owner Handbook and Information Governance Policy.

6.17. Data Breaches

Under the UK GDPR the Trust has a responsibility to report certain breaches of personal data to the ICO within a 72-hour time frame, and so staff must report any data protection breach concerns immediately after they become aware of them. The Trust may also be required to notify Data Subjects of high-risk data breaches.

If an employee becomes aware that they have accidentally disclosed personal data to an unauthorised person, or of any other type of potential data breach, they must raise a DATIX adverse incident. The incident will be investigated, with a view to ensuring that further incidents can be avoided, and organisational learning is in place. Please see the Adverse Incident Reporting Policy.
You should preserve all evidence relating to the potential Personal Data Breach. Incidents shall be investigated by the Information Governance team to assess the level

of risk and determine the requirement to report to the regulatory authority and / or the Data Subject.

6.18. Contacting the DPO

Please contact the DPO with any questions about the operation of this Data Protection Policy or the UK GDPR or if you have any concerns that this Data Protection Policy is not being or has not been followed. You must always contact the DPO in the following circumstances:

- if you are unsure of the lawful basis which you are relying on to process Personal Data.
- if you need to rely on Consent and/or need to capture Explicit Consent.
- if you need to draft Privacy Notices.
- if you are unsure about the retention period for the Personal Data being Processed.
- if you are unsure about what security or other measures you need to implement to protect Personal Data.
- if there has been a Personal Data Breach.
- if you are unsure on what basis to transfer Personal Data outside the UK.
- if you need any assistance dealing with any rights invoked by a Data Subject.
- whenever you are engaging in a significant new, or change in, Processing activity which is likely to require a DPIA or plan to use Personal Data for purposes other than what it was collected for.
- if you plan to undertake any activities involving Automated Processing including profiling or Automated Decision-Making.
- if you need help with any contracts or other areas in relation to sharing Personal Data with third parties.

Data protection or information governance questions and concerns can be directed to the Information Governance Team at AMB_infoGovernance@wales.nhs.uk

7. IMPACT ASSESSMENTS

7.1 Equality Impact Assessment

The Trust is committed to providing equality of opportunity, not only in its employment practices but also in the services for which it is responsible. As such, an Equality Impact Assessment initial screening and outcome report was undertaken on this policy and it was assessed not to be significant from the perspective of the application of the Equality Act 2010, and that no negative impact on the protected characteristics within the

legislation were identified. A full Equality Impact Assessment was not required.

The Trust values and respects the diversity of its employees and the communities it serves. In applying this policy, the Trust will have due regard for the need to:

- Eliminate unlawful discrimination.
- Promote equality of opportunity.
- Provide for good relation between people of diverse groups.

A copy of the EQIA screening and outcome report can be obtained from the Information Governance Team or Corporate Governance Team who received the documentation as part of the policy approval process.

7.2 Welsh Language Impact Assessment

Under the The Welsh Language (Wales) Measure 2011 the Trust's Welsh Language Scheme will be replaced by standards. This means that the Trust, when formulating new policies or reviewing or revising existing policies, will be required to assess what effect a policy decision would have on opportunities for persons to use the Welsh language and on treating the Welsh language no less favourably than the English language. The Equality Impact Assessment initial screening and outcome report took account of Welsh Language, and it was found to be neutral/no impact.

7.3 Environmental Standards and Impact Assessment

This policy will put the relevant requirements in place (such as waste management plan, reduction of CO_2 emissions & reduction of carbon footprint) to ensure that the Welsh Ambulance Services NHS Trust ongoing commitment to reduce its impact on the environment is maintained and to become a more sustainable organisation in line with Trust policy and Environmental Governance System.

7.4 Counter Fraud

The Welsh Ambulance Services NHS Trust is committed to taking all necessary steps to counter fraud, bribery, and corruption within the Trust. Staff should report suspected incidents of fraud and corruption to the Trust Local Counter Fraud Specialist, who will be happy to discuss any issues or concerns. Alternatively staff may contact the confidential NHS Counter Fraud Authority, Fraud and Corruption Reporting line on 0800 028 40 60; or the on-line reporting facility https://cfa.nhs.uk/reportfraud Fraud investigations may lead to disciplinary action and / or prosecution and civil recovery procedures.

7.5 Records Management

The Welsh Ambulance NHS Services Trust (WAST) recognises the importance of sound records management arrangements for both clinical and corporate records. The Trusts' records are its corporate memory, providing evidence of actions and decisions and representing a vital asset to support daily functions and operations. Records support policy formation and managerial decision-making, protect the interests of the Trust and the rights of patients, staff, and members of the public.

7.6 Information Governance

Information Governance (IG) is an overarching term used to describe all aspects of information management. The Trust and its staff shall ensure that they provide satisfactory assurance to stakeholders as to how the organisation fulfils its statutory and organisational responsibilities in relation to the management of information. It will enable management and staff to make correct decisions, work effectively and comply with relevant legislation and the organisations aims and objectives.

The IG framework ensures that it sets out the high-level principles for confidentiality, integrity and availability of information to promote and build a level of consistency across the Trust.

7.7 Training

All staff shall receive mandatory information governance training (in line with UK Core Skills Training Framework) on a two-yearly basis through ESR.

Staff and partners in roles which process highly confidential/sensitive information should have additional training reflected through a training needs analysis.

One-off refresher training/notification will be indicated if there is a change in legislation, production of national guidelines, protocols or new health technologies that become available.

Regular awareness training and briefings will be communicated to staff as required.

The Trust is committed to providing high quality evidence-based education to an engaged and skilled workforce operating within an organisational culture and framework that enables colleagues to work to the top of their skill set to deliver high quality care and services with competence and confidence. Staff are encouraged to

discuss any concerns or queries regarding education and training with a member of the Education and Training Team, by telephoning the Learning & Development Hub on 0300 123 2319 or via email at amb_LDHub@wales.nhs.uk

8. ROLES AND RESPONSIBILITIES

8.1 Chief Executive

The Chief Executive, as Accountable Officer, has overall responsibility for ensuring the Trust complies with all relevant legislation, including data protection. Overall responsibility for the availability, integrity and confidentiality of patient and staff information lies with the Chief Executive. Implementation of and compliance with the Data Protection Policy is delegated to the Caldicott Guardian (Executive Director of Quality and Nursing) for patient information, and Director of People and Culture for staff information.

8.2 Director of Digital Services & Senior Information Risk Owner

The Trust appoints the Director of Digital Services as the Senior Information Risk Officer (SIRO) and has delegated authority from the CEO, the SIRO is integral to the organisation's information risk management strategy and policy.

Central to the SIRO's role is the accountability for the full spectrum of information risk within the organisation. This involves ensuring a widespread understanding and acknowledgment of personal responsibilities regarding sound judgement and the appropriate safeguarding and sharing of information.

Core responsibilities of the SIRO include: -

- Policy Development and Implementation: Spearhead the creation and execution of a comprehensive Information Risk Policy.
- Risk Assessment Ownership: Direct the risk assessment process for information risks, ensuring thoroughness and accuracy.
- Risk Review and Mitigation: Collaborate with Information Asset Owners to review, evaluate, and formulate responses to identified information risks.
- Effectiveness of Risk Strategy: Validate the effectiveness of the Trust's approach to information risk, focusing on resource allocation, commitment, and practical execution.
- Issue Resolution and Discussion: Act as the primary point of contact for the resolution and discussion of information risk issues.

- Governance Structure Development: Develop a robust Information Assurance Governance structure, characterised by clear lines of information asset ownership and reporting.
- Board Engagement: Adequately brief the Trust Board on information risk issues and the state of information risk management, ensuring they are well-informed and equipped to make strategic decisions.

8.3 Executive Director of Quality and Nursing & Caldicott Guardian

The Executive Director of Quality and Nursing is the Trust's Caldicott Guardian and has the following responsibilities:

- The Caldicott Guardian should champion confidentiality issues at Board/senior management team level, should sit on an organisation's Information Governance Board/Group and act as both the 'conscience' of the organisation and as an enabler for appropriate information sharing.
- The Caldicott Guardian should develop a strong knowledge of confidentiality and data protection matters, drawing upon support staff working within an organisation's Caldicott and information governance functions, but also on external sources of advice and guidance where available.
- The Caldicott Guardian should ensure that confidentiality issues are appropriately reflected in organisational strategies, policies and working procedures for staff.
- Play a key role in helping to ensure that the organisation satisfies the highest ethical and legal standards for processing patient and service user confidential information.
- Provide leadership and informed advice on complex matters involving the use and sharing of patient and service user confidential information, especially in situations where there may be areas of legal and / or ethical ambiguity.
- The Caldicott Guardian should oversee all arrangements, protocols and procedures where confidential personal information may be shared with external bodies and others with responsibilities for social care and safeguarding. This includes flows of information to and from partner agencies, sharing through IT systems, disclosure for research, and disclosure to the police.

8.4 Data Protection Officer

The Trust's Data Protection Officer is responsible for the overall development and maintenance of data protection and confidentiality practices throughout the Trust. This includes responsibility for raising awareness of data protection, confidentiality and the Caldicott principles, and promoting compliance with this Policy to ensure compliance with applicable law. The Trust's Data Protection Officer has overall

responsibility for performing the mandatory tasks under Article 39 of the UK GDPR.

Data Controller registration and fee payment to the ICO is the responsibility of the Data Protection Officer. Details of the Trust's registration is published on the Information Commissioner's website.

8.5 Information Governance Team

The Trust's Information Governance team is responsible for providing advice on data protection issues and to provide support to the Data Protection Officer. This team is also responsible for developing, maintaining, and implementing the Data Protection Policy, and associated procedures, processes, and controls across the Trust, ensuring that they meet national and legislative requirements in relation to data protection.

8.6 Line Managers

Line managers have a responsibility to:

- Ensuring that the staff for whom they are responsible are aware of and adhere to this Policy.
- Any processes and procedures that they are responsible for adhere to the requirements of this document.
- Ensuring staff receiving training appropriate to their role and the types of personal data they may have access to.
- Investigate and take relevant action on any potential breaches of this policy supported by the Data Protection Officer and IG Team in line with existing procedures.
- Adopt and develop good information handling practices within the Trust in compliance with this Policy.

8.7 All Staff

Are responsible for ensuring that:

- They comply with the provisions of this Policy and where requested, to demonstrate such compliance. Compliance with data protection legislation is the responsibility of all individuals who process personal information and includes employees, volunteers, students, and contractors. This always applies when on and off Trust property/locations. Failure to comply will be dealt with under the Trust's Disciplinary Policy as appropriate.
- They complete any Data Protection and Information Governance training that is issued to them. This includes but is not limited to, the e-module through

the staff ESR portal upon induction, and on a two-yearly basis thereafter, as well as any additional or ad hoc training and awareness.

- Under the UK GDPR the Trust has a responsibility to report breaches of personal data that result in a risk to data subjects to the ICO within a 72-hour time frame, and so staff must report any data protection or breach concerns immediately after they become aware of them. It is the responsibility of all staff to report breaches of the data protection via the DATIX adverse incident system. (A link to this can be found via the intranet).

9. AUDIT AND MONITORING

The Trust shall have in place arrangements that enable for the monitoring of compliance with this policy. This includes through the following measures: -

- Completion of the annual IG Toolkit Assessment
- External and internal audits assessing compliance with legislation and regulations.
- Regular reporting to committees and the Information Governance Steering Group on Information Governance and Data Protection performance monitoring indicators, and data protection compliance matters.
- Regular audits into access to personal information and flagged incidents for concern through monitoring software e.g. National Integrated Intelligent Audit Solution (NIIAS) for the Welsh Demographic Service (WDS), Welsh Clinical Portal (WCP) and Cancer Information System Cymru (CANISC).

10. REFERENCES

The following reference documents are applicable: -

- Patient Privacy Notice
- Staff Privacy Notice
- CCTV Policy
- Confidentiality Code of Conduct
- Standards of Business Conduct Policy
- Disciplinary Policy
- UK Core Skills Training Framework
- Counter Fraud Policy
- Email Policy
- Internet Use Policy
- Digital Strategy
- Information Governance Policy

- Information Security Policy
- Research Strategy
- Records Management Policy
- Trust Mobile Telephony Policy
- Social Media Policy
- Access to Personal Information Policy

APPENDIX 1 - CALDICOTT PRINCIPLES

These principles apply to the use of confidential information within health and social care organisations and when such information is shared with other organisations and between individuals, both for individual care and for other purposes. The principles are intended to apply to all data collected for the provision of health and social care services where patients and service users can be identified and would expect that it will be kept private. This may include for instance, details about symptoms, diagnosis, treatment, names, and addresses. In some instances, the principles should also be applied to the processing of staff information.

Principle 1: Justify the purpose(s) for using confidential information.

Every proposed use or transfer of confidential information should be clearly defined, scrutinised, and documented, with continuing uses regularly reviewed by an appropriate guardian.

Principle 2: Use confidential information only when it is necessary.

Confidential information should not be included unless it is necessary for the specified purpose(s) for which the information is used or accessed. The need to identify individuals should be considered at each stage of satisfying the purpose(s) and alternatives used where possible.

Principle 3: Use the minimum necessary confidential information.
Where use of confidential information is necessary, each item of information must be justified so that only the minimum amount of confidential information is included as necessary for a given function.

Principle 4: Access to confidential information should be on a strict need-to-know basis.

Only those who need access to confidential information should have access to it, and then only to the items that they need to see. This may mean introducing access controls or splitting information flows where one flow is used for several purposes.

Principle 5: Everyone with access to confidential information should be aware of their responsibilities.
Action should be taken to ensure that all those handling confidential information understand their responsibilities and obligations to respect the confidentiality of patient and service users.

Principle 6: Comply with the law.

Every use of confidential information must be lawful. All those handling confidential information are responsible for ensuring that their use of and access to that information complies with legal requirements set out in statute and under the common law.

Principle 7: The duty to share information for individual care is as important as the duty to protect patient confidentiality.

Health and social care professionals should have the confidence to share confidential information in the best interests of patients and service users within the framework set out by these principles. They should be supported by the policies of their employers, regulators, and professional bodies.

Principle 8: Inform patients and service users about how their confidential information is used.

A range of steps should be taken to ensure no surprises for patients and service users, so they can have clear expectations about how and why their confidential information is used, and what choices they have about this. These steps will vary depending on the use: as a minimum, this should include providing accessible, relevant, and appropriate information - in some cases, greater engagement will be required.

APPENDIX 2 – DEFINITIONS

Automated Decision-Making: when a decision is made which is based solely on Automated Processing (including profiling) which produces legal effects or significantly affects an individual. The UK GDPR prohibits Automated Decision-Making (unless certain conditions are met) but not Automated Processing.

Automated Processing: any form of automated processing of Personal Data consisting of the use of Personal Data to evaluate certain personal aspects relating to an individual, to analyse or predict aspects concerning that individual's performance at work, economic situation, health, personal preferences, interests, reliability, behaviour, location, or movements. Profiling is an example of Automated Processing.

Staff: all employees, workers, contractors, agency workers, consultants, directors, non-executive directors, members, and others.

UK GDPR Consent: agreement which must be freely given, specific, informed and be an unambiguous indication of the Data Subject's wishes by which they, by a statement or by a clear positive action, signify agreement to the Processing of Personal Data relating to them.

Controller: the person or organisation that determines when, why and how to process Personal Data. It is responsible for establishing practices and policies in line with the UK GDPR. We are the Controller of all Personal Data relating to our staff and Personal Data used in our organisation for performing our public tasks.

Criminal Convictions Data: means personal data relating to criminal convictions and offences and includes personal data relating to criminal allegations and proceedings.

Data Subject: a living, identified or identifiable individual about whom we hold Personal Data. Data Subjects may be nationals or residents of any country.

Data Privacy Impact Assessment (DPIA): tools and assessments used to identify and reduce risks of a data processing activity. DPIA can be carried out as part of Privacy by Design and should be conducted for all system or business change programmes involving the Processing of Personal Data. DPIA template is available.

Data Protection Officer (DPO): the person required to be appointed in specific circumstances.

UK GDPR: the retained EU law version of the General Data Protection Regulation (*(EU) 2016/679*). Personal Data is subject to the legal safeguards specified in the UK GDPR.

Personal Data: any information identifying a Data Subject or information relating to a Data Subject that we can identify (directly or indirectly) from that data alone or in combination with other identifiers we possess or can reasonably access. Personal Data includes Special Categories of Personal Data and Pseudonymised Personal Data but excludes anonymous data or data that has had the identity of an individual permanently

removed. Personal data can be factual (for example, a name, email address, location, date of birth, an identification number, an online identifier or to one or more factors specific to the physical, physiological, genetic, mental, economic, cultural, or social identity of that natural person") or an opinion about that person's actions or behaviour. Personal Data specifically includes, but is not limited to: -

a) Name.

b) Date of Birth.

c) Postcode.

d) Address.

e) National Insurance Number.

f) Photographs, digital images etc.

g) NHS Number; and

h) Online Identifiers and location data (such as IP addresses, cookies data and mobile device ID's.)

Personal Data Breach: any act or omission that compromises the security, confidentiality, integrity, or availability of Personal Data or the physical, technical, administrative or organisational safeguards that we or our third-party service providers put in place to protect it. The loss, or unauthorised access, disclosure, or acquisition, of Personal Data is a Personal Data Breach.

Privacy by Design: implementing appropriate technical and organisational measures in an effective manner to ensure compliance with the UK GDPR.

Privacy Notices (also referred to as Fair Processing Notices) or Privacy Policies: separate notices setting out information that may be provided to Data Subjects when the Trust collects information about them. These notices may take the form of general privacy statements applicable to a specific group of individuals (for example, staff privacy notices or patient privacy notices) or they may be stand-alone, one-time privacy statements covering Processing related to a specific purpose.

Processing or Process means any operation or set of operations which is performed on personal data or on sets of personal data, whether by automated means, such as collection, recording, organisation, structuring, storage, adaptation or alteration, retrieval, consultation, use, disclosure by transmission, dissemination or otherwise making available, alignment or combination, restriction, erasure or destruction. Processing also includes transmitting or transferring Personal Data to third parties.

Pseudonymisation or Pseudonymised: replacing information that directly or indirectly identifies an individual with one or more artificial identifiers or pseudonyms so that the

person, to whom the data relates, cannot be identified without the use of additional information which is meant to be kept separately and secure.

Relevant filing system means any structured set of personal data which are accessible according to specific criteria. This can be either centralised, decentralised or dispersed on a functional or geographical basis. Please note that this is the definition of "filing system" in the UK GDPR. Personal data as defined, and covered, by the UK GDPR can be held in any format, electronic (including websites and emails), paper-based, photographic etc. From which the individual's information can be readily extracted.

Special Categories of Personal Data: information revealing racial or ethnic origin, political opinions, religious or similar beliefs, trade union membership, physical or mental health conditions, sexual life, sexual orientation, biometric or genetic data. This may also be known as 'sensitive personal data'. These data are subject to more stringent conditions when compared to other personal information.

Third party means a natural or legal person, public authority, agency, or body other than the data subject, controller, processor and persons who, under the direct authority of the controller or processor, are authorised to process personal data.

AGENDA ITEM No	**18**
OPEN or CLOSED	**OPEN**
No of ANNEXES	**1**

AUDIT TRACKER 2.0 – DECEMBER 2023

MEETING	Quality, Patient Experience & Safety Committee
DATE	08 February 2024
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Trish Mills, Board Secretary
CONTACT	trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. This paper provides the Committee with the current position with respect to management actions for audits within the purview of the Committee.

2. The Audit Tracker has been updated in Quarter three following its complete revision in Quarter two again there has been excellent engagement from Directorates. C.12.5% of internal audit recommendations are presented as closed in quarter in this report and there are actions with a change in date proposed (marked in blue), many of which are due to be closed in Quarter four or Quarter one of 2024/25.

3. With respect to the Committee's responsibility to scrutinise the impact of actions, in October the Committee agreed that the most effective way to improve the scrutiny of the impact of actions was by identifying actions within audits as audit reports are reviewed by the Committee, going forward.

4. The current version of the tracker is now open for Directorate review for actions due in January, February, and March. These updates will then be reported to the Committee at its meeting in May 2024.

5. Due to the timing of reporting for Committee in January 2024 there are some actions which were due in December 2023 which may not have complete updates. These updates will be incorporated into the May 2024 Committee report.

RECOMMENDATION

6. The Committee is requested to:

   (a) Receive and review any Internal Audits and Audit Wales reviews within their remit where relevant. For this meeting these are: -

      - Records Management (received by Audit Committee on 30 November)

   (b) Monitor management actions to address recommendations in the Tracker, noting any revised dates for actions (in blue); and

KEY ISSUES/IMPLICATIONS
As set out above.
REPORT APPROVAL ROUTE
Tracker presented to ADLT via email in December 2023.

REPORT APPENDICIES
Annex 1 – Tracker 2.0 October - December 2023 for Committee Reporting

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

SITUATION

7. This paper provides the Committee with the current position with respect to management actions for audits within the purview of the Committee.

BACKGROUND

8. In September 2023 the Audit Committee approved the Audit Process and Reporting Handbook. The Handbook has been further revised to include Audit Wales content.

9. The Handbook includes roles and responsibilities for the various stakeholders including:

    - The Assistant Directors Leadership Team (ADLT) as the forum to agree closure of actions, taking a check and challenge role on the Tracker.

    - Different reporting for the Audit Committee and Executive Leadership Team (ELT) to that provided to Committees, with the latter focused more on individual audits, progress and impact, and Audit Committee and ELT on the broader audit framework, progress, and exposure. This will start when Tracker 3.0 is developed which will draw the agreed reporting from the tracker via Power BI.

    - The introduction of a point of contact in Directorates for audits. This person(s) steers the audit with the Director and Assistant Directors/Deputies, ensuring internal audits feature on the directorate agenda monthly, they update the Tracker, and escalate issues as appropriate.

10. The Tracker has been updated in Quarter three following its complete revision in Quarter two. Members will receive a copy of the Tracker by email and are invited to filter the excel sheet to their particular Committee to view the relevant audit actions. A copy of the Tracker is also reproduced at Annex 1 filtered to the actions assigned to this Committee for oversight.

11. Good progress has been made on the development of the SharePoint solution for Tracker 3.0 with colleagues in Digital Health and Care Wales Centre of Excellence. It is intended that this solution will be ready to implement / use early in the 2024/25 financial year.

ASSESSMENT

12. The Handbook notes that it is the responsibility of a Board Committee (other than Audit Committee) to:

    - Receive audits in their remit;
    - Monitor management actions to address recommendations; and
    - Scrutinise impact of actions in response to audit recommendations in terms of, for example, quality improvement, the provision of more efficient and effective patient care, improved governance, better use of resources etc.

13. There has been excellent engagement with Directorates on the revised Tracker 2.0, for Quarter three, with the result that c.12.5% of internal audit recommendations are presented as closed in quarter in this report.

14. Some actions have had a change in date proposed (marked in blue), many of which are due to be closed in Quarter four.

15. Discussions have also taken place on historical actions and those where management actions may need to be amended in view of the current operating context. There has been some traction with these, and discussions will continue into Q4 with a view to closing down or revising as many as possible.

16. With respect to the Committee's responsibility to scrutinise the impact of actions, in November the Committee agreed that the most effective way to improve the scrutiny of the impact of actions was by identifying actions within audits as audit reports are reviewed by the Committee, going forward.

17. The current version of the tracker is now open for Directorate review for actions due in January, February, and March. These updates will then be reported to the Committee at its meeting in May 2024.

18. Due to the timing of reporting for Committee in January 2024 there are some actions which were due in December 2023 which may not have complete updates. These updates will be incorporated into the May 2024 Committee report.

RECOMMENDATION

19. The Committee is requested to:

(a) Receive and review any Internal Audits and Audit Wales reviews within their remit where relevant. For this meeting these are: -

- Records Management (received by Audit Committee on 30 November).

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

Points of Contact, Directors and Owners of Audit Actions - Do Not Amend Any Column With a Red Header
When proposing a revised 1st, 2nd or 3rd date, include the rationale for the movement and any progress on the action to date
ALL FINAL INTERNAL AUDIT REPORTS CAN BE FOUND ON THE CORPORATE GOVERNANCE SIREN PAGE

Trust Ref. No.	Year/ Audit Plan	Committee assigned to	Report Title	Assurance Rating	Responsible Officer	Director	Priority Level	Rec. No.in Audit	Recommendation	Response No.in Audit	Management Response	Agreed Deadline in Report	Status - met or not met agreed deadline in report	1st revised date	2nd revised date	3rd revised date	Closure Status	Where a management action has not met the agreed or revised date, Director must inlcude here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. **Please add most recent update first**
462	21/22	QSPE	Role of Advanced Paramedic Practitioner	Reasonable	Kerry Robertshaw, Jonathan Chippendale	Andy Swinburn	Medium		Formal structures should be established to ensure APPs are appropriately supported to deliver a high standard of practice. This could include a peer review network, where feedback and themes are reported to the Care Closer to Home Group.		Development of proposed standardised clinical appraisal and supervision model to ensure APPs remain up-to-date and competent within their clinical practice.	Mar-22	Not Met	Dec 22	Mar-24		Open	Last updated: 03.07.2023 APP leadership/clinical supervision rollout not supported at formal SOT in the current financial climate due to concerns around releasing APP leadership (8a) workforce from clinical duties to engage in leadership portfolio work streams. Decision to be revised in Q3. AHP funding bid against installing APP leadership infrastructure within the workforce appears unlikely to be successful. ePortfolio and curriculum development underpinned by clinical supervision framework, unable to progress until review in Q3
463	21/22	QSPE	Role of Advanced Paramedic Practitioner	Reasonable	Kerry Robertshaw, Jonathan Chippendale	Andy Swinburn	Medium		The Trust should, through an effective appraisal process, appropriately monitor APPs development in order to achieve all four pillars of advanced practice.		The creation of a 'Principles of Advanced Practice' guidance document to be created which will detail the methodology, application and monitoring of how the four pillars of advanced practice are being addressed within APP practice. Following approval, reporting against this will take place on a 6-monthly basis.	Mar-22	Not Met	Dec 22	Mar-24		Open	Last updated: 03.07.2023 Principles of advanced practice document to be written over Q2 and steered through the Advanced practice Working group (new group created within LDP) and underpinned by the All Wales national advanced and enhanced advanced practice framework.
480	21/22	QSPE	Information Management - Hear and Treat	Reasonable	Paula Jeffery	Liam Williams / Andy Swinburn	Medium		1.1 We recommend that greater use is made of referral data in the incident records to inform further developments of current and future referral pathways, including; production of reports showing more detailed analysis by stop code.		1.1.1 A new report is available with data back to January 2021 which shows the referral pathway presented to the patient once the consultation with CSD is complete. This will be able to be broken down by health board area given the nature of the patient's location information. The Ops team is also reviewing in more detail the calls into CSD and their outcome. A review of this is likely late Q4 2022.	Mar-22	Not Met	Mar-24			Open	Last Updated: 061023: Capacity building in the CSD team will enable this action to be progressed. Currently in IMTP actions for this area for delivery Q3-4 pending team expansion. Detailed analysis by stop code can be reported from a CSD perspective. Can be evidenced through Power BI dashboards and this information can be shared with the National SDEC Pathway Group on a monthly basis. All 7 HBs are cited from a community and hospital background at this group. The information is not currently provided in a report as it is live data but a functionality request for referral data to be shown by Health Board on a Power BI dashboard will be raised with Health Informatics and should be achievable by end of Q4. Update 19/10/22 Q4 2022 Update (Q3 2022-23) - Data is now available in a report in Powr BI which shows the volume of telephone triaged calls which were referred to other services and can be broken down by Health Board area. Next steps this quarter is to work with Clinical Services to review the reports and analyse.
480	21/22	QSPE	Information Management - Hear and Treat	Reasonable	Paula Jeffery	Liam Williams / Andy Swinburn	Medium		1.2 Coordinated analysis, review and scrutiny of these internally to inform quality improvement.		1.1.2. The review can be shared to inform quality improvement.	Jun-22	Not Met	Sep-24			Open	Last Updated 061023: Further investigation to be undertaken on whether this data would benefit HB partners e.g. could report into SDEC meetings as it is currently unconfirmed whether there is a forum to enable this data to be shared. Management action relevent in 2018 before work undertaken to build on pathways. Info broken down for reporting currently not done by HB level in the usual process by CSD team (see 480 1.1 above). Team to look at possibility of incorporating this filter for reporting if it will be useful to the HBs or whether this is already reported on by Operations. Development of project work (480 1.2 above) may provide more information to accompany the data which HBs may find useful. Updated: 19/10/22 See above, subsequent action.
480	21/22	QSPE	Information Management - Hear and Treat	Reasonable	Paula Jeffery	Liam Williams / Andy Swinburn	Medium		1.3 Reporting referral volumes at health board level to assist with their service provision planning		1.1.3. The detail in the new stop codes will allow for the reporting referral volumes through Consult and Close in CSD.	Jun-22	Not Met	Nov 22	Mar-24		Open	Last Updated 061023: Further investigation to be undertaken on whether this data would benefit HB partners e.g. could report into SDEC meetings as it is currently unconfirmed whether there is a forum to enable this data to be shared. Management action relevent in 2018 before work undertaken to build on pathways. Info broken down for reporting currently not done by HB level in the usual process by CSD team (see 480 1.1 above). Team to look at possibility of incorporating this filter for reporting if it will be useful to the HBs or whether this is already reported on by Operations. Development of project work (480 1.2 above) may provide more information to accompany the data which HBs may find useful. Updated: 19/10/22 See above, subsequent action.
483	21/22	QSPE	Information Management - Hear and Treat	Reasonable	Paula Jeffery	Liam Williams / Brendan Lloyd	Medium		We recommend that current analysis and sample examination of the 'Can't Send' call responses is extended to include other 'See and Treat' and 'Consult and Close' incident responses. This could be coordinated by theme and pathway type, to inform patient safety and quality improvement and should be routinely analysed and reported into the agenda of an appropriate group in the Trust's governance structure.		With the introduction of a dedicated training and audit team within the CSD more opportunity to analyse and sample Consult and close outcome will be possible. We will ensure it is part of normal audit of the activity in the CSD. Findings can be shared with other groups to ensure quality and enhanced clinical review similar to Can't Send outcomes.	Sep-22	Not Met	Dec 23			Closed in Quarter	Update 06122023: Monthy compliance audit reports are being produced where See & Treat and Consult & Close events are being reviewed. This will be covered off with individuals as part of the wider IMTP actions for CSD and from Q4 will become BAU. The team don't report on Can't Send outcomes but the findings can be shared if requested. Reports form part of the Monthly Integrated Quality Performance Reports and November report submitted as evidence for closure. Last Updated 061023: Achieved IAED/ACE accreditation in Sept 2023 and a prescribed percentage of audits for every clinician are undertaken every month and reported on compliance by PPeD. Management of staff who are not compliant with audits is stepped out within the quality assurance framework for ECNS. Consult and Close activity is reported on live in Power BI and includes several areas contribution to Consult and Close (CSD, APP NAV, PTAS, and 111 C&C) and is monitored through Operational performance meetings. The monthly audit reports are available and are reported to SLT. Updated: 19/10/22 Now that triage has moved to ECNS and reports and analysis of outcomes and audits are available this activity is more possible. The audit team are working on audit reviews and work closely with the Clinical Services team to produce this analysis. Exepcted Q3 2022-23)
524	21/22	QSPE	Respiratory Protective Equipment	Reasonable	Louise Colson	Liam Williams	Medium		4.1 We recommend the Trust refreshes the above paper in light of the challenges in meeting the requirement to quality assure all Fit testers under its current model. [the paper referred to her was a paper that went to SPT in 2021 estimating the time in hours over a 3 year period that fit testing would be required to comply with HSE legislation]		4.1 A report will be provided to the Clinical & Quality Governance Group on the output of the Quality Assurance programme recently undertaken. Furthermore, it will outline proposal for the emerging risk of sustainable fit testing across the Trust. A crossdirectorate position on a sustainable Fit Testing model will be developed.	Sep-22	Not Met	Jun-23	Dec-23		Closed in Quarter	21.11.23: Respiratory Protection Equipment Options Appraisal to be submitted to Senior Leadership Team 22.11.23 then Executive Leadership Team 29.11.23. This was seen by Board Secretary and next steps noted. Update 28.9.23 : An updated Respiratory Protection paper was presented to SOT on 28.04.23 with a recommendation that a multi-disciplinary task and finish group was established to explore a sustainable option of providing respiratory protection for staff. The first meeting took place on 22.06.23 and an options appraisal paper has been submitted to CQGG and SOT on 25.09.23. Further update will be provided once both meetings have taken place. Update 30.06.23 Issue has been discussed in IPC Strategic Group, and escalted issue to CQGG. The matter has also being rasied within Operations Senior Leadership Team, with the management of Fit Testers and associated challenges to be managed through the Senior Operations Team; a T&F group has commence led by IPC to determine a sustainable approach which includes review of PPE/RPE provision. The action related to report generation is complete, and IPC Strategic Group will monitor ongoing performance.

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506	22/23	QSPE	Infection Prevention and Control	Reasonable	Louise Colson	Liam Williams	Medium		1.1 Once the overarching IPC policy is formally approved, the supporting policies/procedures/guidance documents should be reviewed and approved in a timely manner.		1.1-1.3 The recommendations are accepted. A project of work 'IPC 3P' will be undertaken to assess policies, procedures, and other 'powers' (including guidance documents, protocols, and activity-based risk assessments). The aim of the project is to 'map' current provision, monitoring arrangements, undertake a gap analysis, and embed a RACI framework to ensure organisational 'buy-in' and accountability. This work will lead to systematic review of departmental and relevant organisational documents.	Mar-23	Not Met	Sep-23	Dec-23		Open	201223: IPC Policy will go for approval by Chair's Action in December. Propose closing this action once policy is approved. Linked actions 507 and 508 relate to the wider IPC 3P programme actions also. 21.11.23: Ongoing discussions with TU Partners on IPC Policy which will be discussed at Executive Leadership Team 22.11.23 Update 27.09.23: Both the IPC and Premise and Vehicle cleaning policies are in the policy group process still. Several meetings have been cancelled due to competing priorities involving the public enquiry. Two policies are awating final approval, the next meeting is now the 10th October. I anticiapte approval at this meeting with final approval at QUEST at the December meeting. The 3P project initial outlay is complete and incorporated into annual plan of work and was presented at the IPC strategic meeting on the 26th September. 30.06.23 (as per previous) The IPC policy has now been to the Policy group 24.04.23, a longer delay than anticipated but this was due to circumstances outside of the control of the IPC team. This will now be available for consultation. This will be a new policy which combines the AACE national policy. In the meantime work has been undertaken within the 'IPC 3P' to map out other forms of Standard Operating Procedures and Guidance and where they are aligned to. The RACI framework is being used to aid with identifyng responsibilites, risks and monitoring responsibilities. This along with the audit tracker will be presented at the next IPC strategic meeting in Q2.
507	22/23	QSPE	Infection Prevention and Control	Reasonable	Louise Colson	Liam Williams	Medium		1.2 The Trust should clarify arrangements within the Premise and Vehicle Cleaning policy to ensure cleaning instructions, responsibilities and monitoring are comprehensive and align with other related documents.		1.1-1.3 The recommendations are accepted. A project of work 'IPC 3P' will be undertaken to assess policies, procedures, and other 'powers' (including guidance documents, protocols, and activity-based risk assessments). The aim of the project is to 'map' current provision, monitoring arrangements, undertake a gap analysis, and embed a RACI framework to ensure organisational 'buy-in' and accountability. This work will lead to systematic review of departmental and relevant organisational documents.	Mar-23	Not Met	Sep-23	Feb-24		Open	21.12.23: Estates have confirmed that the section regarding the Buildings Group and Buildings Manager are to remian in the Premises and Vehicle Cleaning Policy therefore this can now progress to Policy Group Update 121023: this action will be closed once the IPC and the Premises and Vehicles Polices are approved at Committee . These Policies have been deferred to February Committee due to cancellation of Policy Group Meetings.Update 27.09.23 The Premise and Vehicle cleaning policy is awating approval vai the Policy Group pathway. There is a delay in its progress due to cancelled meetings. The nxt meeting is the 10th October and i anticiapate fianl approval at QUEST December 2023 The trust has a clear vehicle decontamination SOP. The vehilce audit tool has been redesigned, piloted and is good to go.
508	22/23	QSPE	Infection Prevention and Control	Reasonable	Louise Colson	Liam Williams	Medium		1.3 The Trust should map IPC and related policies, responsibilities, ownership, monitoring and governance arrangements to support future review and development of policies and guidance		1.1-1.3 The recommendations are accepted. A project of work 'IPC 3P' will be undertaken to assess policies, procedures, and other 'powers' (including guidance documents, protocols, and activity-based risk assessments). The aim of the project is to 'map' current provision, monitoring arrangements, undertake a gap analysis, and embed a RACI framework to ensure organisational 'buy-in' and accountability. This work will lead to systematic review of departmental and relevant organisational documents.	Mar-23	Not Met	Mar 24			Open	21.11.23: Meeting arranged with Julie Boalch for 3 January 2024 on taking the 3 Ps Project forward Update 27.09.23: The 3 P project continues, the content of which is now incorporated into the IPC annual plan. This was discussed and shared with the IPC Strategic meeting and is now at a stage for cross directorate working. All IPC related policies within the trust have been identified as the parent document, along with associated guidance, standards, SOPs, audit tools, risk assessments and training. Included is the RACI for each area of responsibility.This document has now started to identify the gaps and the work is at the stage to be shared as there are cross directorate responnsibilites. The progress has also been reported in the IPC Q1 highlight report Update 30.06.23 IPC 3P project to be reported to CQGG in Q2
517	22/23	QSPE	Infection Prevention and Control	Reasonable	Louise Colson	Liam Williams	Low		The Trust should ensure online resources contain up to date links and guidance		We accept the recommendation, future workplans will detail requirements.	Jan-23	Not Met	Sep-23	Apr-24		Open	Update 27.09.23: Proposed revised date 31.03.24. The prehospital Care ESR training resources has been updated. The ANTT Training package is in the process of being updated along with the All Wales ANTT policy. We have a plan with training school for ANTT training on the MIST training for 2024/25. This will commence April 2024. A discussion with the training school at the last IPC strategic meeting to transer some of the onclick training to the Learning Launchpad. The priority modules will be PPE, RED Level PPE training, Vehicle Cleaning and Waste management. The other modules via onlick can be incorporated into these modules as they are largely pandemic related training.. Updated 30.6.23 (as per previous 26.04.2023)
519	22/23	QSPE	Infection Prevention and Control	Reasonable	Louise Colson	Liam Williams	High		6.2 The Trust should consider longer term mechanisms for compliance which incorporate and map responsibilities of the wider IPC Strategic membership and include outline of compliance monitoring and reporting.		We accept the recommendation to standardise documentation formats. This action will be addressed through the IPC 3P Project (management response 1.1)	Jun-23	Not Met	Mar-24			Open	Update 27.09.23:The 3P project documentation was presented to the IPC strategic group in the September meeting, this will be reflected in the AAA report to CQGG and then in Q2 IPC Highlight report. Update 30.6.23: 3P project outputs to be presented to IPC Strategic Group and CQGG in Q2.
604	22/23	Quest	Pain Management	Limited	Duncan Robertson	Andy Swinburn	High	1.2(c)	The Trust should ensure all PGDs follow the Medicines Management policy, with a review undertaken every three years as a minimum.	1.2 (c)	The PGD development and review process is resource intensive, and pharmacist input is an essential requirement. Pharmacist Advisor availability is currently limited to 4-hours per month and does not currently meet the needs of the organisation, particularly given the uplift in advanced practitioners and extended skills (enhanced analgesia) of the paramedic workforce. We will develop an options appraisal to determine a costed and effective way forward to provide additional Pharmacist Advisor capacity	Mar-24	Not Yet Due				Open	
605	22/23	Quest	Pain Management	Limited	Duncan Robertson	Andy Swinburn	High	2.1	To gain assurances on the completeness of pain management recorded for patients, additional pathways within the ePCR system, should be established to extract the required data; and reported to an appropriate forum with any themes or trends highlighted within the report.	2.1	We propose to set up a task and finish group, to develop/design a pain management framework to support analysis and presentation of pain/analgesia related data. We anticipate this will enable a fuller picture of pain management, across a range of conditions, in addition to STEMI and Fractured Neck of Femur. The framework will be presented to the Clinical Intelligence and Assurance Group by the end of Q3 2023/24 and then through to CQGG and QUEST. There will be a co-dependency on some of the actions on the outcome of Matter Arising 3.	Dec-23	Not Met	Jan-24			Open	Dec 23: Update 221223 from Clinical Directorate: Agreed for implementation by CIAG (done in December) and will be passed to CQGG for approval in January. T&F group is set up, they have had 3 meetings and AAA received to November CIAG. Framework and supporting documents will be presented to the December CIAG for approval and onward communication to CQGG and upwards. AAA to be submitted for evidence. (On track for December completion).
650	22/23	Quest	Records Management	Reasonable	Jonny Sammut	Jonny Sammut	High	1.1	Management should ensure that a full review of current resources, how resource is used and time required to complete all legislative duties is undertaken, to identify gaps and risk areas upon which capacity and resilience can be measured.	1.1	Previous time & motion study showed significant variance in the tasks undertaken, and similar pressure is felt across records service community in NHS Wales with increasing complexity. A risk will be captured around legislative duties. Exploration of digital tooling to support better tracking of activity in the RM team is already being taken forward, and the ways of working of the team is under continuous review for improvement.	Dec-23	Not Met	Jan-24			Open	Taget date moved in Quarter 4 Update 18/12/23: Risk register training conducted for team in Dec, to enable creation of this risk. Digital tooling has been explored and is progressing through procurement process. A demo is to be arranged for the team in January-24. Expected risk action to be completed in January-24 (after passing through relevant governance routes within Digital).
651	22/23	Quest	Records Management	Reasonable	Judith Birkett	Jonny Sammut	High	1.2(a)	The IG reports should include a measure of the complexity of requests.	1.2(a)	Coroner requests have been identified as a process possibly suitable for automation. This process will be mapped to see if automation would create additional capacity within the team.	Jan-24	Met				Closed in Quarter	Update 18/12/23: after further discussion, the coroner request process has been determined to *not* be appropriate for automation at this stage as secure file transfer would still need to be done manually given exisiting techologies. However, as per recommendation 650, the introduction of digital tooling for tracking activity may make this feasible in future. Proposal that this Management Response action be closed - this was one of multiple ideas to address the problem. 201223 - Board Secretary noted the above comments and agreed closure on the basis that compexity will be drawn out in action 652.

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652	22/23	Quest	Records Management	Reasonable	Leanne Smith	Jonny Sammut	High	1.2(b)	The IG reports should include a measure of the complexity of requests.	1.2(b)	Additional metrics will be included in the IG & InfoSec KPI report, representing complexity of and utilisation in legislative duties.	Jan-24	Not Yet Due				Open	Update 18/12/23: to help identify and define complex cases, employee requests are now being tracked to understand effort / length of time typically required for such responses. This will inform a metric that can be built into the reporting for Information Governance Steering Group from January-24. Additional work required still to understand how a case which **becomes* * complex is logged, e.g. fire & police requests.
653	22/23	Quest	Records Management	Reasonable	Leanne Smith	Jonny Sammut	Medium	2.1(a)	A record management improvement plan should be developed, based on a formal assessment of records throughout the Trust.	2.1(a)	Additional fixed-term support will be sought to conduct the assessment and craft an improvement plan. The risk of not developing an improvement plan in 2023-24 will be included in the risk being developed as per action 1.1.	Sep-24	Not Yet Due				Open	
654	22/23	Quest	Records Management	Reasonable	Judith Birkett	Jonny Sammut	Medium	2.1(b)	A record management improvement plan should be developed, based on a formal assessment of records throughout the Trust.	2.1(b)	A Digital Notice re records management will be published on the intranet to increase awareness of individual staff responsibility.	Dec-23	Not Met	Jan-24			Open	Target date moved in Quarter 3 to January-24. Update 18/12/23: materials have been developed to help raise awareness of records management. These are being finalised, with a plan to share and put on the Records Siren page with a living FAQ sheet. Plan to release this in January-24.
655	22/23	Quest	Records Management	Reasonable	Judith Birkett	Jonny Sammut	High	3.1(a)	A formal agreement for storage of records should be developed. This should set out the responsibilities and requirements for management of health records.	3.1(a)	Additional temporary resource to be sought (from Jan-24) to conduct review of DCC stored boxes and retention schedules. A forecast of storage requirements at DCC will be created to inform a decision on if/when it will be possible to move these records into WAST-managed storage (e.g. at VPH).	Apr-24	Not Yet Due				Open	
656	22/23	Quest	Records Management	Reasonable	Judith Birkett	Jonny Sammut	High	3.1(b)	A formal agreement for storage of records should be developed. This should set out the responsibilities and requirements for management of health records.	3.1(b)	Should [following the review at 3.1a being evaluated] we still need space at Denbigh County Council then we will pursue an agreement with them for those storage, retention and disposal. In the meantime, we will ask for the policies and procedures the Council have in place for their receipt, retention and destruction of records and confirm that this is the way they treat our records. That should provide some assurance on the issues in the matter arising.	Sep-24	Not Yet Due				Open	
657	22/23	Quest	Records Management	Reasonable	Leanne Smith	Jonny Sammut	Medium	4.1	Records should be moved into the new storage area.	4.1	RSAM to review suitability of the VPH storage facility and access management arrangements. If appropriate, secure transfer of the records from Pontypool to VPH will require budget approval beyond the funds available for Records Services (to be discussed with Corporate Governance & Finance).	Jan-24	Not Yet Due				Open	
658	22/23	Quest	Records Management	Reasonable	Judith Birkett	Jonny Sammut	Medium	5.1	The records management improvement plan noted in MA2 should include a programme of identification and assessment of all records storage areas within the Trust.	5.1	The risk of not fully assessing storage areas in 2023-24 will be acknowledged in the risk being developed as per action 1.1. A Trust-wide request will be made to gather intel on what paper records are being stored across the organisation and where. This will inform the improvement plan of how to assure these storage areas.	Sep-24	Not Yet Due				Open	
659	22/23	Quest	Records Management	Reasonable	Judith Birkett	Jonny Sammut	High	6.1	The records management improvement plan noted in MA2 should include an assessment of the disposal of records (both physical and digital) and ensure that records are removed as appropriate.	6.1	Agreement that this is needed, but dependency on the assessments of MA2 and MA5, for which additional fixed-term expert support would be required. There is however an individual staff responsibility and asset owner responsibility to ensure records are disposed of correctly, which will be included in the Digital Notice of action 2.1.	Dec-23	Not Met	Feb-24			Open	Target date moved in Quarter 3 to February-24. Update 18/12/23: materials have been developed to help raise awareness of records management. These are being finalised, with a plan to share and out on the Records Management intranet page. Plan to release this in January-24. An Information Asset Owners forum is also planned to be established from February-24.

Points of Contact, Directors and Owners of Audit Actions - Do Not Amend Any Column With a Red Header

When proposing a revised 1st, 2nd or 3rd date, include the rationale for the movement and any progress on the action to date

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106	Audit Wales	22/23	QUEST	Review of Quality Governance Arrangments	Jonathan Turnbull-Ross/ Wendy Herbert/ Hugh Bennett	Liam Williams			R8 We found that the QuESt Committee is well served with quality information, but there are opportunities for improvement. The Trust should: develop a system to triangulate learning themes across its quality assurance reports. This should ensure clarity about what improvement actions have been taken as a result and how learning has been disseminated across the organisation. enhance Covid-19 reporting in the integrated quality and performance report by including information about the harm caused to patients by ongoing service pressures caused by the virus. (d) work with health bodies so that there are systems to determine the outcomes for patients who have received emergency ambulance services. This should particularly seek to understand the consequence and harm resulting from service failures such as long ambulance waits. develop patient outcome measures to support its existing quality measures.		d) The Trust will continue to share information and intelligence with partners that detail the consequences of system failures. Whilst particularly evident where experience or outcome is poor and results in complaint or adverse incident. The Trust will pursue patient outcome data through development of the ePCR over 2022/23.	Mar-23	Not Met	Dec-23	Mar-24		201223: Given the comment below Board Secretary suggests a 'check in' date of 31 March 2024. Audit Wales will be doing a further review at that time and may wish to reframe this recommendation. 11.12.23 Update from Duncan Robertson: The WAST and DHCW data-sharing agreement is with the ICO and Welsh Government as part of a consultation. This will provide the legal basis to share data. No completion date has been provided, therefore the December target date will not be met. It is completely outside of WASTs gift to propose a completion date The Putting Things Right Team are strengthening the Putting Things Right Quarterly Reports to include themes, patterns and trends. **REVISED DATE OF DECEMBER 2023** 21.11.23: Update 121023: Work Ongoing and will take a period to complete. Conversations continue with DHCW and the Ambulance Data Set (ADS) lead in England to define the ePCR definitions. Work is also continuing with DHCW to establish data sharing to enable joining up of patient records to report on outcome data. no timeline as yet and meeting with DHCW continue to clarify some of the definitions following discussions with the lead for the ADS in England. Trust Information Governance colleagues are working with DHCW for this. 26.09.23: Duty of Quality Implementation plan includes the four quadrants of quality management system as set out in the 'road map'. Quality & Performance Management Steering Group continue to monitor and review the development of 'always on' reporting in line with the requirements of the act. Additional metrics have been approved by Trust Board for inclusion in the MIQPR including PREMS/PROMS, Duty of Candour metrics. New HI post now appointed to support MIQPR move to Power BI dashboard. Proposed Revised date 31.12.23 rationale for extension is to allow BI Dashboard work to commence to allow analysts to identify how best to report 'Patient Reported Experience' measures that add value to decision making. Historic Update: We continue to work with Welsh Government colleagues and NHS Executive in the development of the 'all-Wales' Quality Management System, including how the QMS will 'join up' and detail the impact of ambulance performance on HBs/patient care. The Trust PECI Team have also continued to develop the Civiva patient experience software, alongside HBs, to enable analysis of patient experiences of services.	Open
106	Audit Wales	22/23	QUEST	Review of Quality Governance Arrangments	Jonathan Turnbull-Ross/ Wendy Herbert/ Hugh Bennett	Liam Williams			R8 We found that the QuESt Committee is well served with quality information, but there are opportunities for improvement. The Trust should: develop a system to triangulate learning themes across its quality assurance reports. This should ensure clarity about what improvement actions have been taken as a result and how learning has been disseminated across the organisation. enhance Covid-19 reporting in the integrated quality and performance report by including information about the harm caused to patients by ongoing service pressures caused by the virus. work with health bodies so that there are systems to determine the outcomes for patients who have received emergency ambulance services. This should particularly seek to understand the consequence and harm resulting from service failures such as long ambulance waits. develop patient outcome measures to support its existing quality measures.		e) The Trust is often limited by data accessibility where the patient journey extends beyond the organisational boundary. The Trust will pursue patient outcome data through development of the ePCR over 2022/23, which will enable 'joining up' of patient records. Furthermore, the Trust will further consider accessibility and governance matters for wider adoption of Patient Reported Outcome Measures, and Patient Reported Experience Measures.	Mar-23	Not Met	Mar-24			201223: Given the comment below Board Secretary suggests a 'check in' date of 31 March 2024. Audit Wales will be doing a further review at that time and may wish to reframe this recommendation. Update: 11.12.23 DEVELOPMENT OF EPCR: Update will be provided by Duncan Robertson via update of item d) PATIENT REPORTED OUTCOME MEASURES: The Trust has defined standardised data to measure. Minimum dataset of approximately 600 definitions to agree with DHCW. Currently linking with England to assess available datasets and definitions. Data sharing agreements currently sit with DHCW and Welsh Government for approval. Instruction letters shared and awaiting response. (Leanne Hawker liaising with Alex Crawford on completion date) PATIENT REPORTED EXPERIENCE MEASURES: Data survey and narrative for generalised PREMs has been standardised and feeds into the MIQPR. A bespoke PREM is being developed in relation to Pain Management and Learning Disability (should be completed by end January 2024) REVISED DATE OF MARCH 2024 Update 121023: PREMS live, but in development. PLICS is due to come on stream in Mar-24. PROMS is in development and dependent on DCHW. Business Care Process and Project Management Pathway are relevant considerations.	Open
130	HIW	23/24	Quest	National Review of Patient Flow – a journey through the stroke pathway	Lee Brooks			4	Welsh Government, health boards and WAST must work collaboratively, to consider whether the Immediate Release Directions are effective or need improvements, given the high number of declined Immediate Release Directions occurring across Wales.	4	It is imperative to acknowledge that Immediate Release Directions are required when there is no ambulance to send to the patient. The inability to respond in a timely way is the lost capacity due to extended emergency department handover delays that in recent months absorbs between 20% to 33% of WAST conveying resource capacity. There is an argument that relying on immediate release to respond to patients is too late, as capacity is needed to respond in a timely way without relying on this mechanism. The All-Wales Immediate Release Protocol is approved by the NHS Wales Chief Executive group and used by WAST when directing immediate release. Its next review is due in January. The existing script used by WAST when entering the direction to health boards includes the age and chief complaint for the patient. In a recent meeting, led by EASC representatives with health board colleagues, it was suggested that the reason for the release direction should not have to be justified by WAST, and this helps to decrease the length of the script. This would be achieved by removing the age and chief complaint for the patient. It is posited this reduces moral injury for ED staff receiving the direction (sought by health board representatives) who may then be unable to accommodate. Considering this position and if required, it would not be possible for WAST to differentiate stroke patients from others when submitting the direction to health boards and arguably inhibits clinical prioritisation. WAST continues to validate immediate release directions, including providing health boards with data outputs following this process. WAST has been audited on its application of the protocol and recommendations appear in the WAST audit tracker. At this stage, there is nothing more that WAST can do to progress this recommendation. Accommodating immediate release directions is a matter for health board partners whilst WAST continues with its strategy to resolve more episodes of care closer to home (as per IMTP).	N/A						

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131	HIW	23/24	Quest	National Review of Patient Flow – a journey through the stroke pathway	Liam Williams			12	Health boards and WAST should engage with people to better understand the barriers to them accessing, or choosing, from the range of healthcare services available in Wales. Once the barriers are understood, this in turn, could be used to influence service design.	12	The Welsh Ambulance Service's Patient Experience & Community Involvement Team (PECI) operate a model of continuous engagement with patients, carers, service users, organisations, including the Stroke Association and Age Alliance Wales, stakeholders and the general public across Wales,. Meeting, listening to, capturing and acting on people's experiences of using the Welsh Ambulance Service, including Emergency Medical Services, Non-Emergency Patient Transport Services and NHS 111 Wales. WAST consistently aspire to work in partnership to develop services which are safe and appropriate, and to improve people's experiences and outcomes. In 2023, the PECI Team also established a People & Community Network for the Welsh Ambulance Service. Aligned to our Quality Strategy 2021-2024 and informed by the Health and Social Care (Quality & Engagement) (Wales) Act 2020; the People & Community Network is a group of people with a shared goal: to help develop and improve the services provided by Welsh Ambulance Services NHS Trust. The Network represents the voices and opinions of patients, service users, carers, staff and wider stakeholders from across Wales, in respect of services we provide. The Network will also work with Llais, the Welsh Government's new citizen voice body, to understand people's views and experiences of health and social care, and to make sure feedback is used by decision-makers to shape services and support the continuous improvement of person-centered services. WAST has a long-term aspiration to enhance its service offer managing more patients in the community. In delivering this, we aim to ensure greater emergency ambulance availability by supporting patients through the most appropriate part of the system in their times of crisis.	12 months						
132	HIW	23/24	Quest	National Review of Patient Flow – a journey through the stroke pathway	Andy Swinburn			13.1	WAST must ensure that all relevant staff are fully aware of the WAST stroke pathway to minimise risks to patient safety.	13.1	It is noted that within the report 85% of the 44 staff involved in the survey undertaken by Health Inspectorate Wales (HIW) stated that they have received training to support and manage stroke patients. 77% of staff understood the stroke pathway however, only 49% of WAST respondents said that they always allocate or take a stroke patient to a specialist stroke unit. Considering the relatively low numbers of staff involved in this survey WAST will undertake its own clinical audit to ascertain as to widespread any short fall in adherence to the stroke pathway there may be. Paramedic and Emergency Medical Technician (EMT) education is underpinned by the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) Clinical Guidelines, these are available to all EMTs and Paramedics via an app on their individually issued I-Pads. These guidelines provided comprehensive guidance to Paramedics and EMTs on the pathophysiology, signs and symptoms, assessment and management of both stroke and TIA. Included in these guidelines is recognition that acute stroke is a 'time critical' condition and that patients should be conveyed to an appropriate stroke unit. WAST has for many years had in place a pathway for patients suffering an acute stroke, this includes a pre-alert which informs the receiving unit, preparing them to receive a possible stroke patient enabling the relevant stroke teams to be ready for their arrival. It is worth noting that the only hospital with an accident and emergency department where there is not a stroke unit is the Royal Glamorgan hospital. Clearly the WAST pathway for stroke does not include this hospital.	6 months						
133	HIW	23/24	Quest	National Review of Patient Flow – a journey through the stroke pathway	Andy Swinburn			13.2	WAST must ensure that all relevant staff are fully aware of the WAST stroke pathway to minimise risks to patient safety.	13.2	WAST is currently working with the stroke networks in Wales in relation to the upcoming reconfiguration of stroke services and the development of Hyper Acute Stroke Units (HASU), this will potentially result in a change to the existing stroke pathways that are in place. However, to ensure that the current stroke pathway is clearly understood by WAST staff, a clinical bulletin will be circulated updating staff on the current pathways that are in place across Wales relating to stroke, this will then be updated the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) app that is available to all Paramedics and EMTs via their personal issue I-Pads.`	1 month						
134	HIW	23/24	Quest	National Review of Patient Flow – a journey through the stroke pathway				14	Welsh Government should consider how it can support WAST to develop and implement improvements with its service delivery model, such as increasing the number of advanced paramedic practitioners across Wales, to help reduce the pressure on EDs and improve flow through healthcare systems.	14	While WAST recognises that this is not a recommendation for WAST, we wholly endorse this recommendation and remain ready to play our part in growing the number of APPs.							
135	HIW	23/24	Quest	National Review of Patient Flow – a journey through the stroke pathway	Andy Swinburn			15	WAST should consider the benefits of training its paramedic staff in the use of the ROSIER stroke assessment tool, to enable staff to differentiate patients with stroke and stroke mimics, such as TIA.	15	WAST has previously considered the implementation of ROSIER, however the decision not to adopt was informed by a study undertaken by a large ambulance service in England that demonstrated that ROSIER was no better than the Face Arm Speech Test (FAST) in the prehospital setting. As stated above clinical practice is underpinned by JRCALC, these guidelines inform the attending EMT/Paramedic to the level of assessment that should be undertaken. JRCALC does not include ROSIER as part of the recommended assessment, it does however suggest that clinician may consider using the PASTA (Paramedic Acute Stroke Treatments Assessment) structured assessment and handover as per local agreement. To further inform the debate around prehospital stroke assessment, the HIW report will be presented to the WAST 'Ambulance Practice Steering Group' for consideration. As part of that consideration WAST will undertake an up-to-date literature review to ascertain to whether the previous study has been superseded. To further inform this point WAST will consult the Welsh Stroke Network for a expert view on the use of ROSSIER or indeed any other stroke tool for the pre hospital setting. In addition, within the above-mentioned clinical bulletin all EMTs and Paramedics will be reminded that if a patient remains FAST positive despite some evidence of improvement, stroke should be considered as the primary differential diagnosis, TIA should only be consider following a complete recovery, this latter point is highlighted within JRCALC Practice Guidelines. To support ongoing education to all future Paramedics, WAST will seek to work further in partnership with both universities in Wales who deliver pre-registration education in developing an up-to-date syllabus for stroke education, supported by senior stroke specialists from across Wales.	6 months						

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136	HIW	23/24	Quest	National Review of Patient Flow – a journey through the stroke pathway	Liam Williams			17	WAST and all health boards must work collaboratively to identify a consistent approach to ensure handover of stroke patients is made within the Welsh Government 15-minute target. This is to ensure that time critical investigations and treatment are undertaken promptly.	17	WAST recognises that it has a responsibility to undertake an appropriate clinical assessment of patients presenting with stroke symptoms. Where stroke is considered a potential diagnosis a pre alert should be provided to the appropriate unit to inform stroke teams of the patients' imminent arrival enabling them to be prepared for a rapid handover of care for that patient. It is recognised that system pressures that exist has a direct impact on the 15-minute handover period. WAST continues to work with the health boards to minimise the impact upon service delivery to all its patients. It is worth noting that there does exist improvements across some health boards in Wales, while still accepting that there are further improvements required across all health board areas. WAST will seek to work with Executive Directors of Nursing in the development of a handover standardised pathway.	6 months						
137	HIW	23/24	Quest	National Review of Patient Flow – a journey through the stroke pathway	Andy Swinburn			27	Health boards and WAST must ensure that all staff associated with potential stroke patients are aware of the updated guidance for thrombolysis treatment window of between 4.5 and nine hours, as highlighted within the National Clinical Guideline for Stroke updated in April 2023.	27	WAST recognises that the 'National Clinical Guideline for Stroke (2023) recommends that patients suffering with an acute stroke may be treated with alteplase or tenecteplase if that treatment can be started within 9 hours of known onset, or within 9 hours of the midpoint of sleep when they have woken with symptoms. In recognising this WAST will work with stroke networks to coordinate the dissemination of this information to all staff involved in the management of patients suffering an acute stroke to ensure a consistent approach across the NHS in Wales. It should be recognised that extending the time window from a 4.5 to a 9-hour window has a potential resource implication for WAST. Following the clarity from the stroke network further engagement with our commissioners will take place if necessary.	6 months						
138	HIW	23/24	Quest	National Review of Patient Flow – a journey through the stroke pathway	Andy Swinburn			32(a)	WAST must consider its current response times for patients awaiting interhospital transfers for urgent thrombectomy treatment which are classified as 'Red'. This is to ensure a thrombectomy can be completed within the six-hour timescale from the onset of symptoms.	32(a)	WAST has been working with the stroke leads and the South Wales Major Trauma Network to implement a process that supports the interhospital process for patients referred for thrombectomy outside of Wales. Patients identified for thrombectomy have their transfer arranged through the trauma desk which is situated in a WAST contact centre. The trauma desk team are contacted directly to discuss the transfer requirements of the patient and ensure we have the correct level of clinical support during the transfer and that the transfer is correctly prioritised. Red prioritisation is the highest level of response in our clinical response model, other examples in this group are cardiac arrest, choking and catastrophic haemorrhage. Welsh Government has set ambulance response targets at 65% of all calls categorised as immediately life threatening (red) to receive an emergency response within eight minutes, these standards are reported monthly by Local Health Board.	Complete						
139	HIW	23/24	Quest	National Review of Patient Flow – a journey through the stroke pathway	Andy Swinburn			32(b)	WAST must consider its current response times for patients awaiting interhospital transfers for urgent thrombectomy treatment which are classified as 'Red'. This is to ensure a thrombectomy can be completed within the six-hour timescale from the onset of symptoms.	32(b)	WAST will review this process in due course and ascertain its success and determine if any further actions are required	6 months						

Records Management

Final Internal Audit Report

October 2023

Welsh Ambulance Service NHS Trust

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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

Contents

Review reference:	WAST-2324-13
Report status:	Final
Fieldwork commencement:	14 June 2023
Fieldwork completion:	13 September 2023
Debrief meeting:	20 September 2023
Draft report issued:	20 September 2023 & 11 October 2023
Management response received:	27 October 2023
Final report issued:	27 October 2023
Auditors:	Osian Lloyd, Head of Internal Audit. Martyn Lewis, Senior IM&T Audit Manager. Kevin Bridgman, IT Audit Manager.
Executive sign-off:	Jonny Sammut, Director of Digital
Distribution:	Leanne Smith, Assistant Director of Digital Services Judith Birkett, Records Services and Archives Manager
Committee:	Audit Committee.

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement

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

Disclaimer notice - please note

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

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

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with the Welsh Ambulance Services NHS Trust. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Executive Summary

Purpose

To review the arrangements and processes in place to enable the effective management of records.

Overview

We have issued a reasonable assurance. on this area.

There is guidance in place that cover the records management lifecycle, and includes retention period for different record types.

The Records Management Department focuses on the provision of records under legislative requirements and is complying with the defined timescales for this. However, we note that due to a lack of resource, there has been no structured assessment of records management across the Trust, and no associated improvement plan.

The majority of records in use, particularly patient records, are in digital form. Records are generally stored appropriately, with recent improvements being made. However, the main storage of physical records is with an external provider, for which no formal agreement exists.

The main points which require management action are:

- Reviewing the resource available to the Records Management Team.
- Defining an improvement plan for the organisation.
- Ensuring records held with third parties are subject to formal agreement.
- Identification and assessment of storage sites.
- Ensuring all records are disposed of according to schedules.

Report Opinion

		Trend
Reasonable. 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	None

Assurance summary[1]

Objectives		Assurance
1	Guidance	Reasonable
2	Capacity and Resilience	Limited
3	Availability	Substantial
4	Storage	Limited
5	Digitisation	Reasonable
6	Disposal	Limited

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Capacity of RSA Team	2	Design	High
3	Records Storage Contract	4	Operation	High
5	Retention and Destruction of Records	6	Operation	High

1. Introduction

1.1 The Information Commissioners Office (ICO) Records Management Code of Practice 2021 (Section 46) provides guidance to public authorities (and any other organisations whose administrative and departmental records are subject to the Public Records Act) on their obligations in relation to good records management, including keeping, managing and destroying records. Following the code of practice will help the Welsh Ambulance NHS Trust (the 'Trust' or 'organisation') to comply with the legislation.

1.2 The risks considered as part of this audit are:

- Inappropriate access to confidential information.
- Inaccessibility of records impacts on patient care; and
- Inefficient processes lead to increased costs.

1.3 We note that this audit did not include an assessment of the quality of the contents of records nor the delivery and completion of Information Governance training across the Trust, as the responsibility for this lies outside of the Records Management Team. As such, the audit does not provide assurance that documentation and records are kept to an appropriate standard.

2. Detailed Audit Findings

2.1 The table below summarises the recommendations raised by priority rating:

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	1	2	-	3
Operating Effectiveness	2	1	-	3
Total	3	3	-	6

2.2 Our detailed audit findings are set out below. All matters arising and the related recommendations and management actions are detailed in Appendix A.

Objective 1: Guidance - appropriate policies, procedures and guidelines are in place for records management that cover the full records lifecycle and ensure standardisation of processes and record content.

2.3 The Welsh Ambulance Services NHS Trust (WAST) recognises the importance of sound records management arrangements, for both clinical and corporate records produced by the Trust. To this end the WAST Record Management Team has a number of policies, procedures and guidelines in place for the organisation, which cover records management and the lifecycle of individual records to ensure a

consistent approach to the standardisation and management of records. These include but not limited to:

- Access to Personal Information Policy (2019);
- Police Records Request Guide V3;
- Call Recording User Guide V3;
- Redacting a Call Recording Guide V2;
- Records Retention Schedule;
- Records-Management-Policy (2018).

2.4 The Trust has a structured process for the creation and approval of Policies. This is managed by the Trust's Corporate Governance Team. Recent Audit Wales and internal audit reports have highlighted a wider issue across the Trust with policy reviews being impacted by the Covid-19 pandemic and the capacity of the Office of the Board Secretary. This meant that most policies, including those highlighted above, whilst remaining extant and in use have passed their review date. A prioritisation exercise has recently been undertaken to fully assess the Trust's position, which has resulted in a programme of work being established to bring key policies up to date. We have not therefore raised a recommendation on this basis.

2.5 Guidance documents produced 'internally' have a version number and are managed by the Records Services and Archives Manager (RSAM), and we note that these documents have recently been updated to incorporate changes in processes. The guidance is available for staff on a shared drive stored on the local server. However, we note that due to the workload for the department which has a small team, the RSAM has not been able to actively disseminate the information throughout the organisation to ensure standardisation.

2.6 As part of our testing, using the Information Asset Register (IAR), a number of information assets were selected and key staff contacted to assess awareness of guidance and records management good practices. All parties contacted were aware of the Records Services & Archives (RSA) Team but only contacted the RSA Team for storage issues or document requests. All the asset owners contacted were aware of the requirements and regulations for records management.

Conclusion:

2.7 There are a number of policies and procedure in place which cover the lifecycle of the records stored within WAST. Although there is no programme for dissemination of these, our discussions with staff noted that staff in charge of information do comply with good practice and legislative requirements. We note that the policies are passed their review date however. Accordingly, we have provided **Reasonable** assurance over this objective.

Objective 2: Capacity - the capacity, resilience and succession planning for the records function is appropriate to ensure continued compliance, recognising the continuing trend of increasing requests for support.

2.8 The RSA Team is a small unit consisting of the manager, one business support officer for 18.75 hours per week and 1.6 WTE information governance officers (of which 1.0 is vacant), with additional help provided by one full time light duties staff member as and when available. We note that there is an advertised vacancy currently in place for the vacant full time role.

2.9 Light duty staff are utilised when available and are provided with basic training in relation to records management. However, there is a regular turnover of light duty staff and providing in depth training for them would be time consuming and would not provide a good return on the time invested. We note however, that there are internal guidelines available for reference thus ensuring compliance with current records management procedures.

2.10 The RSA Team has responsibility for various aspects of records management within the Trust. These include core records management, provision of advice and dealing with requests for information, including in relation to subject access requests (SARs) made under the General Data Protection Regulation (GDPR). The team also assists in the provision of information requested under Freedom of Information (FoI), with that process being managed by the Corporate Governance Team.

2.11 Due to the small size of the Records Management Team, nearly all the working time is taken up dealing with information requests from the police and subject access requests received by the Trust. The timescales for provision of this information are set out under GDPR and as such this is a legislative requirement for the Trust.

2.12 Information gathered through our testing process showed that the RSA Team follow a clear and defined set of processes for handling subject access requests. This involves a high level of scrutiny of the data to ensure that only data requested is passed on to the requesting parties and includes redacting data where necessary. We note that the collation and preparation of the documentation can be time consuming.

2.13 We note that both the number of requests, and the complexity requests have been increasing on a year by year basis, with employee requests in 2022 accounting for 2.5K pages of information, and a total of around 3,500 requests made to the Team. This would equate, for 2.5 WTEs, working 45 weeks a year to more than 30 requests a week each.

2.14 From our testing of the process, from January 2023 to March 2023, the Team processed 1,472 requests of which 1,442 (98%) where completed on time. Currently the RSA Team are complying with the majority of deadlines for provision of information, however as the team only consists of 1.5 full time members of staff, there is a risk that this compliance will drop in the future, particularly if the trend of increasing requests and their complexity continues. We also note that the size

of the team make succession planning difficult and leads to limited resilience in the case of staff absence, with a single point of failure. **Matter Arising 1**

2.15 We note that the activity on access requests is reported as part of the information governance reporting framework, within the highlight report to the Information Governance Steering Group. However, this only provides the compliance KPIs and does not provide any detail on trends of complexity, or time taken to resolve. As such the activity of the RSA department is not fully reported and this may mean that the resourcing risks are not highlighted. **Matter Arising 1**

2.16 Due to the lack of resource, currently there is no wider work on improving records management throughout the organisation, with no records management assessment or improvement plan in place. The RSAM has made attempts to develop this, however the lack of resource available has meant that this has not be possible at present. As such there may be an inconsistent approach to records management across the organisation. **Matter Arising 2**

Conclusion:

2.17 The RSA Team is small, and makes use of staff being rotated in on a temporary basis. The Team is responsible for all areas of records management, including the provision of information to the police, under FOI and for subject access requests under GDPR. Whilst there is compliance with required timescales at present, the number of requests has increased and become more complex, taking longer to process and the small size of the team leads to limited resilience which presents a risk that compliance may drop. The lack of resource also means that there is no capacity to monitor records management throughout the Trust and develop an improvement plan. Accordingly, we have provided **limited** assurance over this objective.

Objective 3: Availability - records are available when and where needed by operational staff and for any disclosure requirements.

2.18 WAST has transitioned to a largely digital based organisation, with all the key patient management systems in use being digital, such as the electronic patient clinical record (ePCR), and the computer aided dispatch (CAD) system. As such records are available to staff within the organisation as needed, and access is controlled to the systems as appropriate. Access is controlled by the IT Department with authorisation from RSAM, although we have not fully tested system access controls as part of this audit.

2.19 There are still some physical records in use, as an example the Pontypool site contains records relating to staff disciplinaries, work related incidents and various HR records.

2.20 As noted under objective 2 above, the RSA Team comply with the procedures and requirements relating to time constraints for disclosure requests. We note that physical records are more of a challenge due the location of some, as these would need to be transported to North Wales where the RSA Team is based, which could lead to delays in fulfilling the request.

2.21 There is a process for tracking of records, which is included within ePCR. In respect of call recordings, the Telecoms Team will investigate if they cannot be located in the first instance. If a record cannot be found, then an incident is logged within DATIX.

2.22 Request for records and documentation can be received from a number of different sources, including the police, health care professionals, the Medical Examiner, the DVLA, patients and professional Councils such as the GMB. The nature and extent of documentation requested can vary and include patient notes, emails and call recordings. We note that call recordings may need to be redacted which is time consuming. Requests are prioritised for time and complexity, with some requests having defined response times:

- Response to Coroner in 24-48 hour turn around.
- Subject Access is 30-day response.
- Access to health is 40-day response.

2.23 There is a robust process in place to enable the RSA Team to track requests for records in order to ensure timescales are met. This process uses multiple spreadsheets which capture key information relating to the requests, such as the date received, regulatory time allowed, target date and escalation dates.

2.24 In order to provide information as requested, the RSA Team has full access to all the digital records used within the organisation.

Conclusion:

2.25 The move to a digital organisation has meant that, in general, records are available as needed throughout the Trust. There are good processes in place within the RSA Team for handling requests for information and this ensures that records are provided within the required timescales. Accordingly, we have provided **substantial** assurance for this objective.

Objective 4: Storage - records storage facilities ensure that records are protected from unauthorised access, destruction or theft, and from accidental damage from environmental hazards.

2.26 Digital records are stored within the WAST architecture and as such are subject to standard protections. Our previous work on cyber security noted reasonable assurance over the processes in place to protect digital systems from unauthorised access or loss.

2.27 The main storage location for physical records is a facility operated by Denbigh County Council (DCC), where more than 1.5 million archived records are being stored. These records, in the main, were produced prior to the introduction of digital records. There is no contract or formal agreement between WAST and DCC regarding the transfer and storage of the records, and nothing that defines the responsibilities of DCC in relation to the management of health records, as such this may be breaching GDPR. **Matter Arising 3.**

2.28 Access to the records at DCC is arranged by the RSAM, who maintains a record of what has been passed for storage, via a contact in DCC. DCC staff will collect the

requested records and provide them to the requesting department within the Trust, who will return them back to DCC to be filed back into storage. The RSAM has visited the DCC location to review the arrangements in place to ensure records are held securely and in a good condition and protected from environmental damage. The RSAM has also given assurance that the transportation of any physical records is done in a secure manner by NHS staff.

2.29 There are additional records storage facilities at the Pontypool ambulance station. This being a small purpose-built room which has been partitioned off from an old maintenance bay on the ground floor. There are live water pipes traversing the area where records are stored and the area is subject to flooding, of which there was recent evidence. All racking is full, and boxes are being stored on the floor of the room. There is no water detection system on the floor, nor is there any fire/smoke detection or suppression in the area.

2.30 Access to the room is via a digital door lock mounted on a not very robust door frame. The unused maintenance bay which has been partitioned off to create a storge room is closed by a roller shutter which is damaged and could be prised open.

2.31 Additional storage has been provisioned at Vantage Point House (VPH) Cwmbran. This is a shared building with South Wales Police. The basement area in VPH has recently been renovated and has several rolling racks to store records. The basement area allocated to WAST will also be used by various NHS departments for their storage, which will also include the relocation of documents currently in the Pontypool Ambulance Station basement noted above. WAST has access to racks 6 to 9 which are currently empty. The renovated basement was completed in March 2023, however as yet no records have been moved. **Matter Arising 4**

2.32 As noted previously, the lack of resources within the RSA Team has meant that there has been no full programme of identification and assessment of all areas where records are held. As such it is likely that there are physical records of which the RSAM is unaware, and no associated plan to ensure that all records are held appropriately. **Matter Arising 5**

Conclusion:

2.33 The majority of records in use, particularly patient records, are in digital form. Archived physical records are stored in an offsite secure location based at DCC. There are additional storage areas within the Trust, and a new, improved area has been recently created. However, no records have yet moved into the new area and the DCC facility lacks any formal agreement or underpinning basis for the transfer and storage of records outside the Trust. Accordingly, we have provided **limited** assurance over this objective.

Objective 5: Digitisation – the records management function has transitioned from enabling a paper-based service to a digital service.

2.34 Whilst paper records still exist, the majority of these are held at DCC as noted above. They are accessed infrequently and therefore are not planned for digitisation at the present time. The majority of the records are now digital and

stored electronically, such as on the CAD system and ePCR. Records, in particular patient records relating to emergency services may be required to be held for a significant time, with some needing to be held for 25 years.

2.35 The procedures for handling digital records in relation to availability and storage follow the same process as paper, with a secure environment and restricted access. The major difference is that digital records are backed up via an IT policy which does not form part of this audit.

2.36 The RSA Team has transitioned into managing the requests from electronic information, with guidelines and procedures for this being updated.

Conclusion:

2.37 The move of the Trust to a digital organisation has led the Records Management Team to amend their processes in order to manage requests for information. The processes have changed, however we note that the updating of procedures is not yet finalised. Accordingly, we have provided **Reasonable** assurance over this objective.

Objective 6: Disposal – an appropriate process is in place to archive and dispose of records appropriately, both physical and digital.

2.38 Guidance in place states that the Trust will only retain records if there is a legal obligation to do so. Unless agreed for extended preservation, all records will be securely destroyed on expiry of minimum retention periods as listed in the retention schedules which have been provided by the RSAM, and which are available to all staff. Our discussions with individual asset owners confirmed that they were aware of the retention policy and requirements for disposal and referred back to RSAM for any additional guidance.

2.39 As noted previously, a large number of physical records are stored by DCC. The RSAM has a comprehensive list of what is stored there and when it should be destroyed. There is a process in operation for disposal of records from this site, with the WAST Record manager contacting DCC via email and providing a 'list' of what can be removed for destruction. DCC has a large secure destruction container which is used for both WAST and DCC records. However, as there is no WAST staff present who can physically verify the correct records are destroyed, there is a heavy reliance on DCC staff to comply with the list provided by the WAST Record manager. We note that DCC provide email confirmation of destruction to the RSA Team.

2.40 The removal of digital records will enable easier deletion going forwards. Digital records are the 'property' of the individual asset owners. The retention schedule relates to all records, including digital records. However, there is no structured process to ensure that digital records are deleted as per the schedule. As noted previously there is no records management improvement plan and so no process to ensure that all records are deleted appropriately. As such the Trust is likely to be holding records for longer than the required period. **Matter Arising 6.**

Conclusion:

2.41 Guidance is in place which sets out the retention periods for records, and staff were aware of this. There is a process for appropriate disposal of physical records which is managed by the RSA. However, there is no structured process to ensure that all records, including digital, are appropriately disposed of throughout the Trust. Accordingly, we have provided **limited** assurance over this objective.

Appendix A: Management Action Plan

Matter Arising 1: RSA Team Resilience (Design)			Impact
The RSA Team only consists of 2.6 full time members of staff of which 1.0 has been vacant since June, and is having to deal with an increasing number of requests for information of increasing complexity. Although the team is complying with required timescales at present there is a risk that this compliance will drop in the future, particularly if the trend of increasing requests continues. We also note that the size of the team make succession planning difficult and leads to limited resilience in the case of staff absence, with a single point of failure. We note that the activity on access requests is reported within the information governance reporting framework. However, this only provides the compliance KPIs and does not provide any detail on trends of complexity, or time take to resolve. As such the activity of the RSA department is not fully reported and this may mean that the resourcing risks are not highlighted.			Potential risk of: • Inadequate records management arrangements, resulting in non-compliance with legislative requirements and potential reputational damage and financial loss.
Recommendations			**Priority**
1.1	Management should ensure that a full review of current resources, how resource is used and time required to complete all legislative duties is undertaken, to identify gaps and risk areas upon which capacity and resilience can be measured.		High
1.2	The IG reports should include a measure of the complexity of requests.		
Agreed Management Action		**Target Date**	Responsible Officer
1.1	Previous time & motion study showed significant variance in the tasks undertaken, and similar pressure is felt across records service community in NHS Wales with increasing complexity. A risk will be captured around legislative duties. Exploration of digital tooling to support better tracking of activity in the RM team	Dec-23 for a risk to be developed and logged	Director of Digital

	is already being taken forward, and the ways of working of the team is under continuous review for improvement.		
1.2a	Coroner requests have been identified as a process possibly suitable for automation. This process will be mapped to see if automation would create additional capacity within the team.	Jan-24 for process mapping	Records Services & Archives Manager
1.2b	Additional metrics will be included in the IG & InfoSec KPI report, representing complexity of and utilisation in legislative duties.	Jan-24 for new metrics	Assistant Director of Digital Services

Matter Arising 2: Records Management Improvement Plan (Design)			Impact
Due to the lack of resource, currently there is no wider work on improving records management throughout the organisation, with no records management assessment or improvement plan in place. The RSAM manager has made attempts to develop this, however the lack of resource available has meant that this has not be possible at present. As such there may be an inconsistent approach to records management across the organisation.			Potential risk of: • Inadequate records management arrangements, resulting in non-compliance with legislative requirements and potential
Recommendations			**Priority**
2.1	A record management improvement plan should be developed, based on a formal assessment of records throughout the Trust.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
2.1a	Additional fixed-term support will be sought to conduct the assessment and craft an improvement plan. The risk of not developing an improvement plan in 2023-24 will be included in the risk being developed as per action 1.1.	Sept-24 (due to current resourcing constraints)	Assistant Director of Digital Services
2.1b	A Digital Notice re records management will be published on the intranet to increase awareness of individual staff responsibility.	Dec-23 for Digital Notice	Records Services & Archives Manager

Matter Arising 3: DCC Records Storage Contract (Operation)			Impact
The main storage location for physical records is a facility operated by Denbigh County Council (DCC), where more than 1.5 million archived records are being stored. There is no contract or formal agreement between WAST and DCC regarding the transfer and storage of the records, and nothing that defines the responsibilities of DCC in relation to the management of health records, as such this may breaching GDPR			Potential risk of: • Non compliance with legislative requirements.
Recommendations			**Priority**
3.1	A formal agreement for storage of records should be developed. This should set out the responsibilities and requirements for management of health records.		**High**
Agreed Management Action		**Target Date**	**Responsible Officer**
3.1a	Additional temporary resource to be sought (from Jan-24) to conduct review of DCC stored boxes and retention schedules. A forecast of storage requirements at DCC will be created to inform a decision on if/when it will be possible to move these records into WAST-managed storage (e.g. at VPH).	April -24	Records Services & Archives Manager
3.1b	Should [following the review at 3.1a being evaluated] we still need space at Denbigh County Council then we will pursue an agreement with them for those storage, retention and disposal. In the meantime, we will ask for the policies and procedures the Council have in place for their receipt, retention and destruction of records and confirm that this is the way they treat our records. That should provide some assurance on the issues in the matter arising.	September-24	Records Services & Archives Manager

Matter Arising 4: Appropriateness of Records Storage Environment (Operation)			Impact
The records storage facilities at the Pontypool ambulance station is full, with records stored on the floor, evidence of water ingress and no fire/smoke detection or suppression in the area. Additional storage has been provisioned at Vantage Point House (VPH) Cwmbran. This is a shared building with South Wales Police. The renovated basement was completed in March 2023, however as yet no records have been moved.			Potential risk of: • Loss, damage, or inappropriate access to records.
Recommendations			**Priority**
4.1	Records should be moved into the new storage area.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	RSAM to review suitability of the VPH storage facility and access management arrangements. If appropriate, secure transfer of the records from Pontypool to VPH will require budget approval beyond the funds available for Records Services (to be discussed with Corporate Governance & Finance).	Jan-24	Assistant Director of Digital Services

Matter Arising 5: Identification and Assessment of Records Storage Areas (Design)			Impact
As noted previously, the lack of resources within the RSA Team has meant that there has been no full programme of identification and assessment of all areas where records are held. As such it is likely that there are physical records of which the RSAM is unaware, and no associated plan to ensure that all records are held appropriately.			Potential risk of: • Loss, damage, or inappropriate access to records. • Non compliance with legislation.
Recommendations			**Priority**
5.1	The records management improvement plan noted in MA2 should include a programme of identification and assessment of all records storage areas within the Trust.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
5.1	The risk of not fully assessing storage areas in 2023-24 will be acknowledged in the risk being developed as per action 1.1. A Trust-wide request will be made to gather intel on what paper records are being stored across the organisation and where. This will inform the improvement plan of how to assure these storage areas.	Sept-24	Records Services & Archives Manager

Matter Arising 6: Retention and Destruction of Records (Operation)			Impact
Digital records are the 'property' of the individual asset owners. The retention schedule relates to all records, including digital records. However, there is no structured process to ensure that digital records are deleted as per the schedule. As noted previously there is no records management improvement plan and so no process to ensure that all records are deleted appropriately. As such the Trust is likely to be holding records for longer than the required period.			Potential risk of: • Inadequate records management arrangements, resulting in non-compliance with legislative requirements and potential reputational damage and financial loss.
Recommendations			**Priority**
6.1	The records management improvement plan noted in MA2 should include an assessment of the disposal of records (both physical and digital) and ensure that records are removed as appropriate.		**High**
Agreed Management Action		**Target Date**	**Responsible Officer**
6.1	Agreement that this is needed, but dependency on the assessments of MA2 and MA5, for which additional fixed-term expert support would be required. There is however an individual staff responsibility and asset owner responsibility to ensure records are disposed of correctly, which will be included in the Digital Notice of action 2.1.	Dec-23 for Digital Notice	Records Services & Archives Manager

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

AGENDA ITEM No	**19**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**1**

INFORMATION GOVERNANCE & INFORMATION SECURITY KPI REPORTING

MEETING	Quality, Patient Experience and Safety Committee
DATE	8th February 2024
EXECUTIVE	Jonny Sammut, Director of Digital
AUTHOR	Leanne Smith, Assistant Director of Digital
CONTACT	leanne.smith4@wales.nhs.uk

EXECUTIVE SUMMARY

1. This report brings to the committee Information Governance and Information Security Key Performance Indicators (KPIs) relating to elements of compliance, areas of risk, and our progress against improvement plans.

2. The data in this report refers to the period of 1st April 2023 to 31st December 2023 unless otherwise indicated. Note that some metrics are still in development, and will continue to evolve as new systems come online, risks are identified, and internal audits identify recommended areas of focus.

3. Key points of note from this report include:

   a. **Data Protection Impact Assessments (DPIA)**: DPIAs are required when new systems, processes or projects, or changes to existing ones, may result in a risk to the rights and freedoms of individuals and their personal information. Although progress has been steady over the year, a large number of DPIAs are still awaiting review or have not yet been started due to lack of engagement from teams around the organisation, and limited capacity in the IG team to support the completion and approval of DPIAs.
   b. **Records Requests:** despite a significant increasing trend requests for records received annually, the small team have managed to increase compliance rates since the October reporting where compliance was at 86%. This is through improved processes and support from individuals performing alternative duties within the Trust.
   c. **Freedom of Information Requests:** an increase in the volume and complexity of FOI requests compared to 2022/23 has led to months in 2023/24 seeing poor performance against the target (of responding to 90% of requests within 20 working days). Guidance is being developed,

processes mapped, and a new management system being scoped to support streamlining and automation in this area where possible.

d. **IG Training Compliance:** following a recent update to ELT and targeted messages across the Trust regarding mandatory IG training, there was an increase in Directorate level compliance rates in December; however, the overall compliance rate for the Trust is <72% (as of 9th January 2024), below the 'minimum expectation' requirement of 75%. It should be noted that this minimum requirement will be increasing to 85% from next financial year, in line with Welsh Government recommendations.

Recommended: The Committee are asked to NOTE the contents of the accompanying report and the trends in metrics presented.

KEY ISSUES/IMPLICATIONS

4. A risk is in development for WAST compliance with **Data Protection** law and regulation; increased awareness of individual information security & data protection responsibilities by staff across the Trust is also required, and a comms plan is in development.
5. **Records Services** is progressing a number of recommendations following a recent internal audit resulting in a 'reasonable' score, including the development of a risk around legislative duties and finding ways to increase capacity within the function.
6. Failure to meet statutory and legal requirements for **Freedom of Information** requests appears on the Corporate Governance Directorate risk register (ID 183) and is currently assessed as a moderate risk.

REPORT APPROVAL ROUTE

Digital Leadership Group – noted at 10th January 2024 meeting
Information Governance Steering Group – 23rd January 2024

REPORT APPENDICES

Main report – 'IG and InfoSec KPI Reporting Jan24'

REPORT CHECKLIST

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

INFORMATION SECURITY & GOVERNANCE KPI REPORTING

Reporting period:
Apr-23 to Dec-23

IG TOOLKIT & IMPROVEMENT

2023-24 IG Toolkit saw significant change from 2022-23 set. Completion of Minimum Expectation requirements:

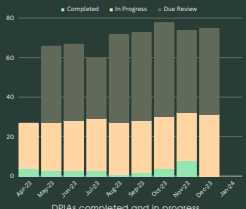
Escalation process in place for outstanding response

Minimum expectations were NOT met across all categories in 2022-23 toolkit.

- Leadership & Oversight
- Policies & Procedures
- Training & Awareness
- Individual Rights
- Transparency
- Records of Processing Activity
- Contracts & Info Sharing
- Risks & DPIAs
- RM & Security
- Breach & Monitoring
- FOI & EIR
- Information Security
- Business Continuity

2023-24 categories differ from this list, but our focus remains.

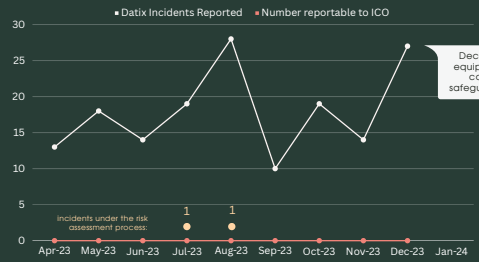
The **DPIA log** continues to be reviewed and updated weekly, including cloud security assessments.



DPIAs completed and in progress

Difficult getting engagement from other teams to progress

DATA PROTECTION BREACHES



IG related incidents reported on Datix

Dec-23 peaks across equipment/devices, IT, confidentiality & safeguarding categories

INFO SECURITY

Reporting relates to cyber incidents, but recent threshold changes include confidentiality, integrity and availability of systems.

2 cyber incident reported to CRU under NIS regulations in 2023/24 to date

1) UK wide 999 outage (June 23)
2) 999 outage in SE (July 23)

>1000 weak user passwords across the Trust

Enforced reset in progress

RECORDS MANAGEMENT

Subject Access Requests

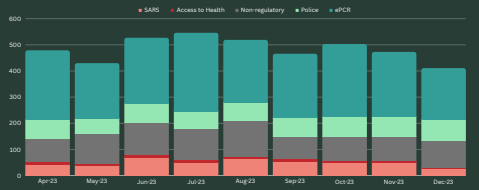
Must be responded to within 30 calendar days from receipt in line with GDPR.

Access to Health

Requests for personal information which fall under the Access to Health Records Act 1990 require response within 40 calendar days.

Other Requests

Requests which do not fall under either of the 2 other regulations must have a legal basis. These include requests from Police, Coroner etc.



Sep-23 saw 26% growth compared to Sep-22 requests

Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
95%	100%	100%	95%	90%	92%	86%	95%	100%
2			3	7	5	8	3	

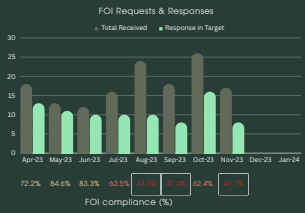
Compliance (%)
Breaches (#)

Internal processing issues and capacity constraints led to breach of the regulatory time.

DATA QUALITY

MEASURES OF DQ TO BE ESTABLISHED

FREEDOM OF INFORMATION



Freedom of Information

The FOI Act gives the public the right to access information held by public authorities. ICO target is for organisations to respond to **90%** within 20 working days.

Aug-Sept23 saw an increase in requests & their complexity compared to 22/23. Trust's FOI lead was on leave in August. Guidance being developed + plan for processes to be mapped, streamlined & automated.

AWARENESS & TRAINING

Mandatory ESR **Data Protection & IG training compliance** is below the 75% threshold

INCREASE IN ALL NOTED DIRECTORATES

"Our people are our last line of defence."

Typical adoption rate of the 7 available cyber training packages on MetaLearn platform (increase on July)

User acceptance rate of the **InfoSec Policy** (distributed & monitored via MetaPolicy tooling)

Phishing campaign Oct 23

4867 users targeted by simulator Oct-23

39% (1909) deleted the email ✓

14% (683) reported the email ✓

June campaign saw only **5%** reported

June campaign saw **>22%** click the link

6% (276) clicked the links ✗

2% (89) supplied credentials ✗

26% of the 276 (47 who clicked + 22 who gave details) completed training ✓

In June only **10%** completed training

AGENDA ITEM No	**20**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**3**

WELSH RISK POOL CONCERNS ASSESSMENT

MEETING	Quality, Patient Experience and Safety Committee
DATE	8 February 2024
EXECUTIVE	Liam Williams, Executive Director of Quality & Nursing
AUTHOR	Steven Johnson - Head of Patient Safety, Concerns & Learning Caroline Miftari - Head of Quality Assurance
CONTACT	Stephen.johnson2@wales.nhs.uk Caroline.miftari@wales.nhs.uk

EXECUTIVE SUMMARY

The Report outlines the current progress against the Welsh Risk Pool (WRP) Concerns Assessment as of December 2023.

The WRP Concerns Assessment (**Annex 2**) is intended to support health bodies within NHS Wales to continuously improve the operation of its Putting Things Right processes and provide assurance in relation to current policies, procedures and practice. The Trust's Assessment Report provides findings following a review conducted by independent assessors from the WRP Safety & Learning Team. The Report has previously been circulated in draft form by the Assessment Team for comments and factual accuracy considerations.

The Report identifies a number of recommendations. Each Health Board and Trust has been asked to develop an Improvement Plan which addresses the findings and supports the prioritisation of improvement activity in this area.

RECOMMENDED that the Committee notes the report.

KEY ISSUES/IMPLICATIONS

Revision to improvement actions timescales for one of the recommendations.

REPORT APPROVAL ROUTE

Clinical and Quality Governance Group	24 January 2024
Quality, Patient Experience & Safety Committee	8 February 2024

REPORT APPENDICES
ANNEX 1 - SBAR providing background information **ANNEX 2** - Final Welsh Risk Pool Assessment **ANNEX 3** - Welsh Risk Pool Assessment Improvement Plan December 2023 Update

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

ANNEX 1

SITUATION

1. This Report outlines the progress up to December 2023 against the Welsh Risk Pool Concerns Assessment improvement actions.

BACKGROUND

2. The Welsh Risk Pool Assessment (**Annex 2**) is intended to support health bodies within NHS Wales to continuously improve the operation of its Putting Things Right processes and provide assurance in relation to current policies, procedures, and practice.

3. This Report provides findings for the Trust following a review conducted by an independent Assessment Team. The Report has previously been circulated for comments and factual accuracy considerations.

4. The Report identifies a number of recommendations. Each organisation in Wales has been asked to develop an Improvement Plan which addresses the findings and supports the prioritisation of improvement activity in this area.

5. The Report focuses on 10 areas for improvement for the Welsh Ambulance Services NHS Trust as documented in detail in **Annex 2** of this Report. An overview is provided below:

<u>WRP1</u>

- Ensure that investigation outcomes for incidents are recorded accurately on Datix Cymru.

<u>WRP2</u>

- Introduce a Key Performance Indicator (KPI) for incident reporting and regularly review and scrutinise cases to ensure that they are closed efficiently and do not remain open on the system longer than necessary.

<u>WRP3</u>

- Ensure that all Datix Cymru records are the subject of a validation process, as a minimum of closure of the record, to ensure all information and data fields are completed comprehensively.

WRP 4

- The process for obtaining consent for release of information arising from a concern should be reviewed and produced in a structured procedure, with arrangements for recording circumstances where consent is not required or appropriate.

WRP 5

- Ensure all documents including staff statements and detailed investigation reports are uploaded to the Datix Cymru system.

WRP 6a

- It is expected that the Actions Module in Datix Cymru is utilised and applied efficiently and correctly.

WRP 6b

- It is expected that the Yorkshire Contributory Framework is utilised and applied efficiently and correctly to ensure appropriate review of investigations in accordance with the All-Wales approach.

WRP 7

- Train and skill the Investigating Officers in considering Breach of Duty and Qualifying Liability as part of their investigation process.

WRP 8

- Consider issuing an Interim Regulation 26 response to avoid delays when the investigation has concluded that there is a Breach of Duty.

WRP 9

- Ensure subject and sub-subject codes for all records in the Datix Cymru systems are completed consistently and comprehensively and are subject to validation checks.

WRP 10

- Ensure the description field is completed correctly on the Datix Cymru system and that these are subject to validation checks.

ASSESSMENT

6. **WRP01** will need to be extended to 31 March 2024. Reports have been developed and posted on the Quality Dashboard for the Patient and Health and Safety Teams to review and identify incidents where no Management Review has taken place. Also, a closure guidance process is being developed for all Managers to have the responsibility to close incidents and a draft process will be completed by January 2024 in readiness for approval.

7. The development of training packages for staff is essential in order for cultural change. Training packages will need to be further reviewed in light of a Once for Wales update to the Datix Cymru system in December 2023. Therefore, realistically the completion date should be extended to 31 March 2024.

8. As of the end of December 2023 the Trust is on target for implementing the other 9 areas of improvement (**Annex 3**) due for completion between 31 January 2023 and 31 March 2023.

9. The Trust will need to consider informing the WRP of the amended timescale for WRP01 if approved.

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Cronfa Risg Cymru
Shared Services Partnership
Welsh Risk Pool Services

WRP Concerns Assessment

A Report by the Welsh Risk Pool Safety and Learning Team

Welsh Ambulance Service Trust

Final Report November 2023

Gwella Diogelwch Cleifion Trwy Ddysgu
Improving Patient Safety Through Learning

WRP Concerns Assessment

A Report by the Welsh Risk Pool Safety and Learning Team

November 2023

About this Report

This report is intended to support health bodies within NHS Wales to continuously improve the operation of its Putting Things Right processes and provide assurance in relation to current policies, procedures, and practice.

This report provides findings for the health body following a review conducted by an independent assessment team. It has previously been circulated for comments and factual accuracy considerations.

The report identifies a number of recommendations. Each organisation has been asked to develop an action plan which addresses the findings and supports the prioritisation of improvement activity in this area. A copy of the organisation's action plan is included in the final report to enable tracking of information and to support future reviews.

In addition to the report, the health body has been provided with a summary of the fieldwork analysis of the matters scrutinised. This enables the organisation to consider the comments in the context of the information that the reviewers analysed.

Assessment Visits	January 2023-March 2023
Draft Findings shared	July 2023
Action Plans Received	November 2023
Final Report Published	November 2023
All-Wales Summary Report Published	November 2023

Version
Welsh Ambulance Trust WRP Concerns Assessment Report VFinal2

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1.0 Outline of Review

1.1 The Welsh Risk Pool undertakes assessments of member organisations' policies, procedures, and practice as part of its oversight duties – with the aim of gathering assurance on local processes for the Welsh Risk Pool Committee and Welsh Government, and to provide recommendations to support organisations in continuous improvement in this area.

1.2 The WRP Assessment is used by the Welsh Risk Pool Committee when determining members' contributions to the fund as part of the risk sharing agreement. For the 2022-23 programme of assessments, the outputs will be advisory in nature and will not affect the individual contributions already established for the 2023-24 financial year.

1.3 The WRP Assessment process provides a framework for the analysis an organisation's compliance with the WRP Reimbursement Procedures, the requirements of the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 and other national policies & procedures related to the Putting Things Right sector.

1.4 The review involves analysis of individual case management against both legal requirements and policy criteria. It also examines compliance with the application of the Once for Wales Concerns Management System workflows and essential data fields.

1.5 The review further facilitates analysis of the efficacy of the Learning from Events process within the organisation and examines how a health body shares and implements good practice between organisations.

1.6 The methodology for assessment has evolved during the last few years in line with national policies. The approach is focussed on peer-review, with senior leaders within the Putting Things Right sector in other organisations joining staff from the Welsh Risk Pool in conducting the assessment. Specialist advisors, in legal specialists, join the assessment team as required. This approach is considered to promote sharing of best practice and enable the assessment team to recognise the application of the areas for assessment in operational practice.

1.7 For each area for assessment, the Assessment Team consider the available evidence and report assurance to the organisation using the NHS Wales Internal Audit Assurance Framework. Details of the framework are shown in Appendix 1.

2.0 Scope of Review

2.1 The review considers a number of areas for assessment, each focussed on a different aspect of the Putting Things Right process.

- Management of Concerns (Incidents)
- Management of Concerns (Complaints & Enquiries)
- Redress Case Management
- Claims Case Management
- Learning from Events
- WRP Reimbursement Process

2.2 The period used for the assessment related to policies and procedures in force and matters opened, under investigation, or closed between 1st January 2022 to 31st March 2022. This period was selected and agreed with senior leaders from the Putting Things Right sector, as it is considered that cases would be sufficiently progressed from initial report and commencement of investigations to facilitate a thorough review. This period was selected for all organisations to allow a fair comparison between organisations where the outputs of the assessment are used as part of the risk sharing agreement. Where an organisation had not commenced live use of the Once for Wales Concerns Management System during the intended period, the first three months of live use of the system was selected as an alternative period. For the WAST Assessment, the period of 1st March 2022 to 31st May 2022 was used for the incidents. Due to the limited volume of claims and the recent transition to using Datix Cymru, the period used for this part of the assessment was 1st December 2022 to 31st January 2023.

2.3 The clinical specialities selected as an area for focus in organisations which provide acute care were chosen as they represent the greatest proportion of the litigation profile across NHS Wales. The clinical specialties selected for the focus of the assessment in acute organisations were:

- Maternity Services
- Emergency Department Care
- Orthopaedics

3.0 Assessment Team

3.1 The WRP Assessments are conducted by a small group of specialist practitioners who are drawn from the Putting Things Right sector.

3.2 The Coordinator for each Assessment is a member of the Welsh Risk Pool team, with the Chair of the Assessment Team drawn from a member of the Heads of Patient Experience Safety & Learning Network – providing realistic advice on the practicalities in achieving the standards in practice.

3.3 To ensure compliance with the legislation, a lawyer from the Legal & Risk Service is included in the Assessment Team and this colleague focusses on compliance with redress case handling and legal compliance in relation to claims.

3.4 As the assessment process focussing greatly on the use of the Datix Cymru system, a member of the Once for Wales Concerns Management System central team is included in the Assessment Team.

3.4 The Assessment Sponsor coordinates the formation of fieldwork teams and oversees any queries which arise along with signing off the Assessment Report.

3.5 The Assessment Team for this review was:

Sponsor:	Jonathan Webb, Head of Safety & Learning *Welsh Risk Pool*
Field Work:	Kath Clarke, Head of Quality *Betsi Cadwaladr University Health Board*
	Gemma Cooper, Senior Solicitor *Shared Services Partnership, Legal & Risk Services*
	Christine Buckland, Safety & Learning Advisor *Once for Wales Concerns Management System Team*
	Eleri Wright, Safety & Learning Advisor *Welsh Risk Pool*

4.0 Review Findings

4.1 Management of Concerns (Incidents)

4.1.1 The Assessment Team noted that there were 1602 incidents reported in the period 1st March 2022 to 31st May 2022. The transition to using Datix Cymru had occurred on 4th May 2022, but cases had been retrospectively entered into the new system to facilitate good data management.

4.1.2 In considering the application of policy, the Assessment Team found that there was an Adverse Incident Policy in place which was approved by the Quality, Safety & Patient Experience Committee in 2021 and was currently in the process of being reviewed and updated as part of its natural review cycle.

4.1.3 The Assessment Team reviewed twenty case records for the relevant period and noted good practice in terms of safeguarding involvement. Joint working with Health Boards and other services was reported as complex and currently the subject of a review at a national level.

4.1.4 The Assessors reviewed a case where abuse was mentioned but the name of the perpetrator had not been provided and in another similar case the name of the patient had not been included. It is considered important to capture identities where they are known at an early stage as missing information of this nature can lead to difficulties in progressing investigations. The Assessment Team would recommend that matters are reviewed periodically and upon closure to ensure all relevant information has been provided and all essential fields have been completed appropriately.

4.1.5 From the cases reviewed the Assessors did not see evidence of an investigation report, however within the catastrophic incidents there were Significant Clinical Incident Forum (SCIF) briefs. These briefs, however, do not contain any investigation analysis but provide information on the capacity and resources at the time. The Assessment Team would recommend that detailed investigation reports are adopted and uploaded appropriately to ensure there is appropriate analysis of the investigation and action taken as a result. This would also ensure that issues identified as part of the management review or SCIF are captured as learning or actions for improvement.

4.1.6 The Assessment Team did not see any evidence of the Action module being used. The Yorkshire contributory framework does not appear to be used correctly in any grade of incident. In most assessments, the fields are ticked as “none” or “no” with no further narrative included. It is expected practice that both the Actions Module and the Yorkshire contributory framework is used efficiently and correctly to ensure appropriate review of investigations and to align WAST investigations with other health services in NHS Wales. Training to support this can be access via the OfWCMS national team.

Management of Concerns (Incidents)		
LIMITED ASSURANCE		The organisation can take **limited assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. More significant matters require management attention with moderate impact on residual risk exposure until resolved.

4.2 Management of Concerns (Complaint and Enquiries)

4.2.1 The Assessment Team noted that there were 130 complaints reported in the period 1st January 2022 to 31st March 2022. The transition to using Datix Cymru had concluded prior to this period.

4.2.2 The Assessment Team reviewed the current Putting Things Right Policy in place which was due for review in September 2019. This was discussed with colleagues who assured the Assessors that it was currently under review and would be updated shortly.

4.2.3 The Assessment Team scrutinised the detail of twelve complaint records within the Datix Cymru system and found that further use of system is required to ensure appropriate data is captured and matters are completed appropriately.

4.2.4 Statements taken from staff as part of the investigation should be uploaded to the Complaint record as supporting documentation. Staff involved in complaints investigations should also be added as contacts on the record. This ensures that a comprehensive record of the matter is available and will enable accurate reports to be produced.

4.2.5 The Assessors noted that mandatory fields on the Datix Cymru System were not completed in many cases and the investigation panel was not completed which meant it was not possible to identify causative issues and lessons learned from matters.

4.2.6 It is acknowledged that there was a period when WAST were experiencing some challenges in coding complaints due to the sub-subjects not being similar to the traditional codes using in legacy systems. The assessment found that subjects and sub-subjects were not adequately completed on many occasions and in a number of instances where suitable & appropriate codes were available but not used. Appropriate completion of the coding framework ensures that valuable reports on themes and trends are able to be produced from the system. A process of case validation, ultimately on closure of the record, must be introduced to ensure data quality.

4.2.7 Evidence was seen in multiple cases in which the description of the complaint was entered in the 'Details of complaint raised'. Details of complaint is to record main points/questions to be addressed. The main body of the complaint should be

documented in the description field with 'Details of complaint raised' being used to precis the points to be investigated. The system is provided with a comprehensive user guide and the assessors could not see that this had been cascaded.

4.2.8 The Assessors noted from the cases reviewed that it was not always clear if qualifying liability had been considered when the complaint contains allegations of harm. This is a statutory requirement and should be explicitly recorded.

4.2.9 It is important that no concerns are responded to with details of patient care without appropriate consent from the person affected being held. If consent is not required, the rationale for not needing consent from the person affected should be documented (e.g., patient lacks capacity) and evidence that sharing confidential information relating to a person affected with the complainant is appropriate. Following the assessment period, discussions were held with Senior colleagues from the WAST PTR Team to explore this further and it was clear that usual practice has been to release information to a caller raising concerns without appropriate consent. The Assessment Team consider that it is possible that the amount of information provided in such cases could be considered a breach of confidentiality. It is recommended that the process for obtaining consent and releasing information, with governance of decisions where consent is not required, is reviewed to ensure a robust procedure is in place.

Management of Concerns (Complaints & Enquiries)		
LIMITED ASSURANCE		The organisation can take **limited assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. More significant matters require management attention with moderate impact on residual risk exposure until resolved.

4.3 Redress Case Management

4.3.1 The Assessment Team scrutinised the detail of nine cases on the Datix Cymru system which included some follow up work by way of review of hard copies of responses received following the assessment date as they had not been available initially on the Datix Cymru system.

4.3.2 The Welsh Ambulance Services NHS Trust currently has one Redress Lead whose role also includes the management of Inquests as well as Ombudsman cases. The Assessment Team notes that on the older and closed files, there was a very limited amount of information contained within the Datix Cymru system and the cases were, as a result, very difficult to review. The team also use a shared folder in which documentation is stored. This was not reviewed for the purposes of the assessment, although (as above) hard copies of R26/33/24 response letters were provided by email to enable the reviews to be completed. From review of more recent files, it was apparent that there was better use of Datix Cymru and to ensure that all documents are uploaded appropriately and labelled correctly to ensure ease of review.

4.3.3 Following discussion, the Assessment Team did note that efforts are being made to ensure documentation is uploaded and it is recognised that there is a need to continue to improve but that this was affected by the capacity issues and need to prioritise. The Assessment Team are confident that the aim of full migration and uploading of data will be sustained from 2023/24 onwards.

4.3.4 The Trust has good processes whereby cases are investigated by an Investigating Officer and then either responded to as Reg 24 (drafted by Investigating Officer and reviewed by Redress Lead), or a Reg 26 or 33. Cases where there is potentially a QL/Redress are identified for the Complex Case Panel ('CCP') and opened in Datix Cymru as 'Potential Redress'.

4.3.4 It was noted by the Assessment Team that the Investigating Officers do not appear to make decisions with regards to breach of duty or Qualifying liability during the initial investigation, with these decisions being made by the CCP. This has clearly led to some delays and longer delays only avoided by the efforts of the corporate team. The Assessment Team recommend the approach as outlined in the regulations, to train and provide support to the Investigating Officers in considering issues of breach of Duty and Qualifying Liability as part of their investigation.

4.3.5 A number of the cases reviewed proceeded straight to issuing a Regulation 33 response, where the Trust had conclusions regarding both breach of duty and causation. Whilst this is acceptable practice under the Regulations, it meant that complainants were not receiving a response within 30 days, and there was some delay in reaching the Regulation 33 response, albeit in some cases this was still under the 12-month point. It should therefore be considered by the Trust whether an Interim Regulation 26 response should be sent in investigations where conclusions as to breach of duty were reached at an earlier stage. This could be a

simply constructed interim response which is scheduled after a specified period and would not add a significant administrative burden but would address potential concerns from the Complaints Standards Authority regarding timescales.

4.3.6 The Assessment Team noted that the PTR responses reviewed were well written and tailored specifically to the cases and the issues raised within them. There is also evidence of good engagement by the Redress Lead with complainants once cases are within that team.

4.3.7 The Redress Lead explained that a number of Incident cases also filter to the CCP which was noted as a good process although it was recognised that further improvements could be made. The Assessment Team recognised that the Trust was reviewing its procedures in light of the introduction of the Duty of Candour in Wales.

4.3.8 The Trust also confirmed that improvements could be made in the joint cases with Health Boards and assurance should be sought that cases are being managed in line with the Putting Things Right Regulations.

4.3.9 Overall, the Assessors noted that the Health Board has a good structure in place to manage redress cases with minimal input required from Legal & Risk Services. There is a clear process for complaints to move to the Redress Team however there is a slightly less defined process with regards to incidents. The Health Board assured the Assessment Team that this is being considered and they are aware of the need to strengthen this process.

Redress Case Management		
SUBSTANTIAL ASSURANCE		The organisation can take **substantial assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Few matters require attention and are compliance or advisory in nature with low impact on residual risk exposure.

4.4 Claims Case Management

4.4.1 The Assessment Team noted that there were 14 claims opened in the period 1st January 2022 to 31st March 2022.

4.4.2 There were limited cases available for review within the relevant period. Of the cases which had been migrated over no documents had been uploaded and there was limited information on Datix Cymru including on progress notes which made it difficult to review the current position of the claims.

4.4.3 Cases received in January to March 2022 and migrated over to Datix Cymru in December 2022 were reviewed and it was recognised by the Team that further review of Datix Cymru to ensure complete migration is required. The corporate team assured the Assessment Team that a plan is in place to fully migrate the cases and a review of this work by the WRP team will be undertaken during the autumn of 2023.

4.4.4 The period therefore selected for the review, in relation to claims, consisted of cases which were opened, open or closed between Dec 2022 and Jan 2023.

4.4.5 There was good evidence of clear claims management processes in place for both Clinical Negligence and Personal Injury Claims. The Assessment Team noted that there was a policy in place, but it was in the process of being reviewed and updated in line with changes in process and introduction of Datix Cymru.

4.4.6 The Assessment Team noted that the Trust's process for the application of Standing Financial Instructions was reviewed in 2022. The Trust's Solicitor can agree damages and costs up to £10,000 however most claims require authority from the Board and a detailed report is submitted for each matter.

4.4.7 It was explained that a Significant Claims Report is prepared and submitted by the Trust's Solicitor to the Executive Management Team on a quarterly basis which highlights any issues raised with Clinical Negligence and Personal Injury Claims. The Assessment Team were also advised that a Quarterly Quality Report is prepared by the Head of Patient Safety, Concerns & Learning which both Claims and Redress feed into. The Trust's Solicitor attends the Board meeting and provides a summary on all ongoing claims and highlights any significant issues.

4.4.8 The Assessment Team were pleased to note that PTR training is provided for new entrants which includes claims, complaints, and incidents. Statement writing is also included with this training which was noted as good practice.

4.4.9 A small cohort of claims, predominantly relating to road traffic and personal injury matters, are handled directly by WAST in-house teams. These cases were not the subject of this review, as the legal case management is overseen by the Managing Solicitor for Wales. However, the Assessment Team noted the good practice in ensuring lessons learned are included as a single set of outcomes – whether a claim is handled on behalf of the Trust by the Legal & Risk Services or is handled internally by the Solicitor-led team. The Assessment Team also noted the introduction of a process for aggregation of claims information.

4.4.10 There is a clear process in place for referral of relevant matters to Legal and Risk Services and for receipt of advice in a matter from Legal and Risk Services which are actioned in a timely manner following receipt and in accordance with requests of the protocol.

Claims Case Management		
SUBSTANTIAL ASSURANCE		The organisation can take **substantial assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Few matters require attention and are compliance or advisory in nature with low impact on residual risk exposure.

4.5 Learning from Events

4.5.1 The Trust explained that Learning From Events Reports are taken to the Patient Safety Managers' Learning Group on a quarterly basis. The Redress Lead is also in the process of establishing a themes and trends report to be presented at this meeting.

4.5.2 The Claims Teams draft the LFER's, and they are signed off by the Trust Solicitor with the involvement of the Executive Management Team and senior staff are involved in all claims and the learning process from the outset. This assured the Assessment Team that learning from claims is a priority to the Trust.

4.5.3 The Assessment Team were pleased to note that a quarterly report is provided the Board on lessons learnt which was highlighted as good practice. LFER's for Personal Injury Cases are presented at the Health and Safety meeting with clinical LFER's being presented at QuEST.

4.5.4 The Assessment Team were pleased to note that all LFER's are submitted on time as they are tracked efficiently, and local services are contacted as necessary. However, to avoid the process being person-dependant, the Trust would benefit from using the Datix Cymru System by inputting the relevant trigger dates.

4.5.5 In summary, the Assessment Team were impressed with the corporate arrangements for capturing, reviewing, and presenting learning. However, there is also clear evidence of escalation and chasing of local teams which could lead to delays in submission of appropriate learning and may incur penalties in the future. This could be assisted by a reminder of the importance of learning from events by the executive team to all tiers of leadership throughout the organisation.

Learning from Events		
SUBSTANTIAL ASSURANCE		The organisation can take **substantial assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Few matters require attention and are compliance or advisory in nature with low impact on residual risk exposure.

4.6 Reimbursement Process

4.6.1 The Assessment Team were assured that there is a close working relationship with the Finance Department who support the reimbursement process. There is an efficient and robust process in place with all cases being submitted on time and within the Welsh Risk Pool deadlines.

4.6.2 Staff use their own spreadsheet and calendars for monitoring cases and submission deadlines. The Assessment Team would recommend that Datix Cymru is utilised for CMR trigger dates to enable a report to be run for the monitoring of cases to avoid being solely person dependant.

4.6.3 The number of U5 request for reimbursement in closed matters, which would be an indicator for poor case and payment tracking, was noted to be very low for WAST and therefore a very good exemplar for other organisations to follow.

Reimbursement Process		
SUBSTANTIAL ASSURANCE		The organisation can take **substantial assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Few matters require attention and are compliance or advisory in nature with low impact on residual risk exposure.

5.0 Main Themes

The Assessment has identified a number of themes:

5.1 Good evidence of clear Redress management.

5.2 Effective communication channels with Executive Team to maintain awareness and provide escalation where necessary.

5.3 Good Claims management structure in place with effective in-house leadership.

5.4 Areas of Good Practice

A number of areas of good practice have been identified:

5.4.1 The Assessment Team noted good practice in terms of safeguarding involvement with incidents and joint working with Health Boards.

5.4.2 The Trust has good processes whereby cases are investigated by the Investigating Officer and then either responded to as Regulation 24 or a Reg 26 or 33.

5.4.3 Response Letters are well written and there is evidence of good engagement by the Redress Lead with complainants once cases are within that team.

5.4.4 A quarterly report is provided the Board on lessons learnt which was highlighted as good practice.

6.0 Assurance Summary

Welsh Ambulance Services NHS Trust		
Management of Concerns (Incidents)	LIMITED ASSURANCE	
Management of Concerns (Complaints & Enquiries)	LIMITED ASSURANCE	
Redress Case Management	SUBSTANTIAL ASSURANCE	
Claims Case Management	SUBSTANTIAL ASSURANCE	
Learning from Events	SUBSTANTIAL ASSURANCE	
WRP Reimbursement Process	SUBSTANTIAL ASSURANCE	
NOTES		

7.0 Recommendations

R01 WAST should ensure that investigation outcomes for incidents are recorded accurately on Datix Cymru.

R02 WAST should introduce a KPI for incident reporting and regularly review and scrutinise cases to ensure that they are closed efficiently and do not remain open on the system longer than necessary.

R03 WAST should ensure that all Datix Cymru records are the subject of a validation process, as a minimum of closure of the record, to ensure all information and data fields are completed comprehensively.

R04 The process for obtaining consent for release of information arising from a concern should be reviewed and produced in a structured procedure, with arrangements for recording circumstances where consent is not required or appropriate.

R05 WAST should ensure all documents including staff statements and detailed investigation reports are uploaded to the Datix Cymru system.

R06 It is expected that both the Actions Module in Datix Cymru and the Yorkshire Contributory Framework is utilised and applied efficiently and correctly to ensure appropriate review of investigations in accordance with the all-Wales approach.

R07 WAST should train and skill the cadre of Investigating Officers in considering Breach of Duty and Qualifying Liability as part of their investigation process.

R08 WAST should consider issuing an Interim Regulation 26 response to avoid delays when the investigation has concluded that there is a Breach of Duty.

R09 WAST should ensure subject and sub-subject codes for all records in the Datix Cymru systems are completed consistently and comprehensively and are subject to validation checks.

R10 WAST should ensure the description field is completed correctly on the Datix Cymru system and that these are subject to validation checks.

8.0 Health Body Action Plan

The Welsh Ambulance Service Trust has developed an action plan which addresses the recommendations made in this report. The action plan was received by the Welsh Risk Pool on 1st November 2023.

WELSH RISK POOL (WRP) ASSESSMENT VERSION 1

IMPROVEMENT PLAN & DECISIONS TRACKER

Ref	Date	Action Note	Responsible	Due Date	Progress/ Comment	Status	Action List	Owner
WRP01	Jul-23	Ensure that investigation outcomes for incidents are recorded accurately on Datix Cymru.	Head of Patient Safety & Concerns Service Manager, Operations Quality Head of Health & Safety Datix Cymru Local System Lead	31.01.2024 Retrospective records 31.03.2024	Capacity in the PTR Team has been limited due to sustained pressures and staff absence. The PTR OCP is currently in progress with the proposal that the Patient Safety functions are strengthened which will release capacity to ensure appropriate recording on the system retrospectively (NRIs) and on an ongoing basis. Currently records & files are held on the Shared Drive. Datix Cymru Local Team will assist in identifying retrospective records.	On target	Implementation plan and SOP to be developed and monitored.	Head of Patient Safety & Concerns Service Manager, Operations Quality Head of Health & Safety Datix Cymru Local System Lead
WRP02	Jul-23	Introduce a KPI for incident reporting and regularly review and scrutinise cases to ensure that they are closed efficiently and do not remain open on the system	Head of Quality Assurance & Datix Cymru	28.02.2024	Thresholds / KPIs to be developed and monitored via senior operations meetings and Clinical Quality Governance Group (Executive Group).	On target	Develop KPIs for reporting of incidents on Datix Cymru.	Head of Quality Assurance & Datix Cymru

WELSH RISK POOL (WRP) ASSESSMENT VERSION 1

IMPROVEMENT PLAN & DECISIONS TRACKER

Ref	Date	Action Note	Responsible	Due Date	Progress/ Comment	Status	Action List	Owner
		longer than necessary.						
WRP03	Jul-23	Ensure that all Datix Cymru records are the subject of a validation process, as a minimum of closure of the record, to ensure all information and data fields are completed comprehensively .	Datix Cymru Local System Lead	31.01.2024	Datix Cymru Local System Lead will work with key stakeholders to develop a governance process to identify the correct information to be entered into the correct fields within Datix Cymru which are dependent on the nature of the investigation. Each team i.e., Patient Safety, Health & Safety, Safeguarding, Operations, Information Governance, Estates etc will need to provide the Datix Team with a list of what fields within Datix they require in a data listing report and the system lead will create a data report. This will enable each team to draw	On target	The Patient Safety Team to identify within Datix Cymru what fields require completion on closure for all modules and provide a list to the Datix system lead to allow them to create appropriate listing reports. There will be the need for multiple lists depending on the area of business, i.e. feedback, incidents, NRIs.	Datix Cymru Local System Lead

WELSH RISK POOL (WRP) ASSESSMENT VERSION 1

IMPROVEMENT PLAN & DECISIONS TRACKER

Ref	Date	Action Note	Responsible	Due Date	Progress/ Comment	Status	Action List	Owner
WRP03 continued	Jul-23				down their own validation report. The Datix Cymru System Lead can then produce a validation report. Training is being arranged in collaboration with the Once for Wales Datix Cymru Team.	On target	The Health & Safety Team to identify within Datix Cymru what fields require completion on closure for all modules, and provide a list to the Datix system lead to allow them to create appropriate listing reports. There will be the need for multiple lists depending on the area of business, i.e. incidents, RIDDOR.	Head of Health and Safety

WELSH RISK POOL (WRP) ASSESSMENT VERSION 1

IMPROVEMENT PLAN & DECISIONS TRACKER

Ref	Date	Action Note	Responsible	Due Date	Progress/ Comment	Status	Action List	Owner
WRP03 continued	Jul-23					On target	The Datix Cymru Local System lead is required to create listing reports following receipt of the relevant information from the Patient Safety Team and the Health and Safety Team. These reports will be pinned to the relevant staff dashboards to enable those staff members to validate the data within those report.	Datix Cymru Local System Lead
						On target	The Datix Cymru Local System Lead will bi-monthly run reports highlighting incomplete areas and will highlight these	Datix Cymru Local System Lead

WELSH RISK POOL (WRP) ASSESSMENT VERSION 1

IMPROVEMENT PLAN & DECISIONS TRACKER

Ref	Date	Action Note	Responsible	Due Date	Progress/ Comment	Status	Action List	Owner
							to the relevant departments.	
WRP04	Jul-23	The process for obtaining consent for release of information arising from a concern should be reviewed and produced in a structured procedure, with arrangements for recording circumstances where consent is not required or appropriate.	Head of Patient Safety & Concerns	31.03.2024		On target	Process to be reviewed and SOP produced.	Head of Patient Safety & Concerns
WRP05	Jul-23	Ensure all documents including staff statements and detailed investigation reports are uploaded to the Datix Cymru system.	Head of Patient Safety & Concerns Service Manager, Operations Quality Head of Health & Safety	31.01.2024 NRI Retrospective records 31.03.2024		On target	Staged implementation with monitoring process to be implemented.	Head of Patient Safety & Concerns Service Manager, Operations Quality Head of Health & Safety

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NHS Trust

WELSH RISK POOL (WRP) ASSESSMENT VERSION 1

IMPROVEMENT PLAN & DECISIONS TRACKER

Ref	Date	Action Note	Responsible	Due Date	Progress/ Comment	Status	Action List	Owner
WRP06a	Jul-23	It is expected that the Actions Module in Datix Cymru is utilised and applied efficiently and correctly.	Datix Cymru Local System Lead	01.03.2024	The Datix System lead will work with key stakeholders to ensure the investigator and incident manager understand how to utilise the actions functionality if required within the incident module.	On target	The Datix Cymru Local System Lead will liaise with the Once for Wales Team and provide an update to Patient Safety Team and Health and Safety Team on the functionality of the Actions Module. The Datix Cymru Local System Lead will also investigate the governance around this module and requirement for security groups.	Datix Cymru Local System Lead

WELSH RISK POOL (WRP) ASSESSMENT VERSION 1

IMPROVEMENT PLAN & DECISIONS TRACKER

Ref	Date	Action Note	Responsible	Due Date	Progress/ Comment	Status	Action List	Owner
WRP06a continued	Jul-23					On target	The Datix Cymru Local System Lead, Patient Safety Team and the Health and Safety Team will create bite size educational material for staff outlining how to use the Action module.	Datix Cymru Local System Lead Head of Patient Safety & Concerns Head of Health & Safety
WRP06b	Jul-23	It is expected that the Yorkshire Contributory Framework is utilised and applied efficiently and correctly to ensure appropriate review of investigations in accordance with the All-Wales approach.	Datix Cymru Local System Lead	31.03.2024	The Datix Cymru Local System Lead will work with key stakeholders i.e. Patient Safety and Health & Safety to develop in collaboration guidance for the Yorkshire Contributory Framework for the investigator/ incident manager.	On target	Training to be provided for end users on how to complete the Yorkshire Contributory Framework within the Incident Module.	Datix Cymru Local System Lead Head of Patient Safety & Concerns Head of Health & Safety
						On target	The Datix Cymru Local System Lead to generate monthly reports to allow the	Datix Cymru Local System Lead

WELSH RISK POOL (WRP) ASSESSMENT VERSION 1

IMPROVEMENT PLAN & DECISIONS TRACKER

Ref	Date	Action Note	Responsible	Due Date	Progress/ Comment	Status	Action List	Owner
WRP06b continued	Jul-23						Patient Safety and Health & Safety teams to validate the content of information within the Yorkshire Contributory Framework.	Datix Cymru Local System Lead
						On target	Patient Safety and Health & Safety Teams to undertake monthly validation on the content of information within the Yorkshire Contributory Framework.	Head of Patient Safety & Concerns Head of Health & Safety
WRP07	Jul-23	Train and skill the Investigating Officers in considering Breach of Duty and Qualifying Liability as part of their investigation process.	Trust Solicitor	31.03.2024		On target	Training plan post Organisational Change Process in PTR Team.	Trust Solicitor

WELSH RISK POOL (WRP) ASSESSMENT VERSION 1

IMPROVEMENT PLAN & DECISIONS TRACKER

Ref	Date	Action Note	Responsible	Due Date	Progress/ Comment	Status	Action List	Owner
WRP08	Jul-23	Consider issuing an Interim Regulation 26 response to avoid delays when the investigation has concluded that there is a Breach of Duty.	Head of Patient Safety & Concerns / Trust Solicitor	31.03.2024		On target	Process to undergo review and SOPs developed.	Head of Patient Safety & Concerns / Trust Solicitor
WRP09	Jul-23	Ensure subject and sub-subject codes for all records in the Datix Cymru systems are completed consistently and comprehensively and are subject to validation checks.	Datix Cymru Local System Lead	31.03.2024	Datix Cymru Team to quality assure the subject & sub subject codes. Since the period of the report, the fields referred to are now mandatory.	Complete	The Datix Cymru Local Team carry out regular validation checks on the Classification, Category and sub-category fields within Datix Cymru.	Datix Cymru Local System Lead

WELSH RISK POOL (WRP) ASSESSMENT VERSION 1

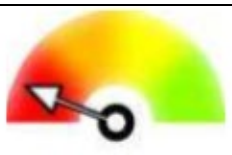
IMPROVEMENT PLAN & DECISIONS TRACKER

Ref	Date	Action Note	Responsible	Due Date	Progress/ Comment	Status	Action List	Owner
WRP10	Jul-23	Ensure the description field is completed correctly on the Datix Cymru system and that these are subject to validation checks.	Datix Cymru Local System Lead	31.03.2024	The system lead together with PTR and H&S colleagues will develop and implement a training package for staff to outline to staff completing/reporting an incident how to complete the description field on data and what information is expected and codes(free text). the Datix on QA will remove patient identifiable information and update the codes if required.	On target	The Patient Safety Team and Health & Safety Team to create bite size training content for end users and make these available to staff, on how to complete the description fields.	Head of Patient Safety & Concerns Head of Health & Safety
						Complete	The Datix Cymru Local System Lead will identify through QA checks if there has been any patient identifiable information entered within these fields.	Datix Cymru Local System Lead

Appendix 1

NHS Wales Assurance Framework

The WRP Assessment Programme utilises the NHS Wales Internal Audit Framework for Assurance:

SUBSTANTIAL ASSURANCE		The organisation can take **substantial assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Few matters require attention and are compliance or advisory in nature with low impact on residual risk exposure.
REASONABLE ASSURANCE		The organisation can take **reasonable assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.
LIMITED ASSURANCE		The organisation can take **limited assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. More significant matters require management attention with moderate impact on residual risk exposure until resolved.
NO ASSURANCE		The organisation has **no assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Action is required to address the whole control framework in this area with high impact on residual risk exposure until resolved.

Appendix 2

WRP Concerns Assessment – Areas for Assessment

The WRP Assessment Programme uses a series of Areas for Assessment to guide the Assessment Team in the aspects and criteria to be examined. These cover the areas of activity which directly impact on matters which may cause a request for reimbursement from the Welsh Risk Pool.

The Areas for Assessment provide a framework for the Assessment Team to gather information, evidence and collate data to support the identification of findings and the establishment of recommendations.

Assessment Criterion

AREA FOR ASSESSMENT	
A	Management of Concerns (Incidents)
B	Management of Concerns (Complaint and Enquiries)
C	Redress Case Management
D	Claims Case Management
E	Lessons Learned
F	Reimbursement Process

Area for Assessment A: Management of Concerns (Incidents)	
A1-01	Is the timescale between index events and incident reporting reasonable?
A1-02	Did the incident have an initial review, where appropriate?
A1-03	Is the timescale between reporting and initial review, where appropriate, reasonable?
A1-04	Did the incident have a management review completed, where appropriate?
A1-05	Did the incident have a proportionate investigation completed, where appropriate
A1-06	Is the timescale between reporting and investigations reasonable?
A1-07	Have all the essential data fields been completed correctly on Datix Cymru?
A1-08	Was the incident record closed within 30 days? Where this is not possible, is there information to explain the reason for any delays or actions being taken?
A1-09	Was the incident reportable as a Nationally Reportable Incident? Was the timeliness of any notifications reasonable?
A1-10	Was there a consideration whether the incident met the requirements for a Qualifying Liability?

Policy and Procedure	
A2-01	Is there a policy or procedure in place for Incident Management within the Health Body? Is it in date? Is there a review date? How is it reviewed/ratified?
A2-02	Does the policy or procedure cover the requirements as set out in PTR guidance and associated national policy?

Information, Reporting & Governance Arrangements	
A3-01	Are there effective governance arrangements for the management of incidents?
A3-02	Is there a screening process in place for monitoring accuracy of information submitted in incident reports? Is it timely?
A3-03	How are incidents reported within the Health Body and to what meetings or committees are they reported? Are they reported at Board level or Sub-Committee? Are these arrangements proportionate?
A3-04	Is there training in place for staff for reporting incidents?
A3-05	Is there training in place for staff for investigating incidents?

Area for Assessment B: Management of Concerns (Complaint and Enquiries)	
B1-01	Is the complaint record complete? Is all correspondence, advice and supporting information available for review?
B1-02	Does the complaint investigation consider all relevant points raised in the complaint received?
B1-03	Does the complaint response comply with the content requirement as set out within the guidance?
B1-04	Did the concern conclude with the final response? If not why? How was the concern resolved if not with the final response?
B1-05	Are the essential data fields in Datix Cymru completed accurately and up to date?
B1-06	Has a response been prepared for every concern notified and investigated?
B1-07	Has a report been provided to the person notifying the concern within 30 days
B1-08	Where it has not been possible to provide the report within 30 days, has the person notifying the concern been advised within 30 working days, and an explanation provided, and proposed timescale agreed?
B1-09	Where a complaint is dealt with ‘on the spot’ / via early resolution, is this recorded appropriately? Is the timescale for early resolution matters recorded accurately and is it appropriate?
B1-10	How many concerns were answered within the 30-day period?

Area for Assessment B:	
Policy and Procedure	
B2-01	Is there a policy or procedure in place for Complaint Management within the Health Board? Is it in date? Is there a review date? How is it reviewed/ratified?

Information, Reporting & Governance Arrangements	
B3-01	What are the governance arrangements for the management of complaints and enquiries?
B3-02	How are complaints reported and monitored within the Health Body and to what meetings/Committees are they reported? Are they reported at Board level or Sub-Committee?
B3-03	Is there a training package in place for staff for complaints handling?

Area for Assessment C: Redress Case Management	
C1-01	Is there an appropriate process for determining when a matter should be handled by Redress specialists? Is there a clear process for transition from incident teams and complaints teams?
C1-02	Is the redress record complete? Is all correspondence, advice and supporting information available for review?
C1-03	Has an interim report (Reg 26 letter) for the concern reviewed and investigated been prepared where the Health Body considers there may be a Qualifying Liability?
C1-04	Has the interim report been provided to the person notifying the concern within 30 days?
C1-05	Does the response letter comply with the content requirement set out in the Regulations & associated Guidance? E.g., explaining QL, advice re Solicitors, addresses all concerns raised etc
C1-06	Has a Reg 24 response been prepared for the concern reviewed which has been investigated and in respect of which the Responsible Body considers there is no QL in tort?
C1-07	Has a Reg 24 been prepared for the concern which has been investigated and in respect of which the Health Board considers the claim to be over £25,000 in value?
C1-08	Has a Reg 24 letter been provided to the person notifying the concern within 30 days?
C1-09	Where it has not been possible to provide the Reg 24 letter within 30 days, has the person notifying the concern been advised within 30 working days, with an explanation provided and proposed timescale agreed?

C1-10	Does the Reg 24 letter comply with the requirements as set out in the guidance? E.g., no reference to BOD and QL if considered over £25,000 and advice re Solicitors etc?
C1-11	In circumstances where a Reg 26 interim response was provided, have independent experts been instructed? Has this been done in line with the requirements in the Regulations (i.e., jointly) and appropriately?
C1-12	Has a Regulation 33 report been sent for every concern reviewed and investigated in respect of which the Responsible Body has not sent a Regulation 24 response?
C1-13	Has the Regulation 33 report been provided within a maximum of 12 months of the concern being notified to it?
C1-14	Does the Regulation 33 Response comply with the requirements of the Guidance? E.g., clearly sets out the basis for the final decision as to QL and the offer made.
C1-15	Where financial compensation has been paid, has an appropriate contract been entered into between the recipient of the financial compensation and the Organisation?
C1-16	Has Legal and Risk Advice been requested? Was this request proportionate?
C1-17	Who authorised QL and on what basis? Was this appropriate?
C1-18	Have all essential data fields been completed correctly within the case management record?
C1-19	How many LFER's submitted in relevant period?
C1-20	How many requests for reimbursement submitted to WRP?
C1-21	What is the performance for WRP submission deadlines?
C1-22	How many extensions were requested for submission to WRP?
C1-23	How many cases were approved at the first Learning Advisory Panel?

Policy and Procedure	
C2-01	Is there a policy or procedure in place for Redress Case Management within the Health Body? Is it in date? Is there a review date? How is it reviewed/ratified?
C2-02	Is there a clear process for the application of Standing Financial Instructions and authorisation of admissions & settlement of matters?
C2-03	Is there a process in place to review admission/denial decisions?

Area for Assessment C: Redress Case Management	
Information, Reporting & Governance Arrangements	
C3-01	What are the governance arrangements for the management of redress cases?
C3-02	How are they reported within the Health Board and to what meetings/Committees are they reported? Are they reported at Board level or Sub-Committee?
C3-03	Is there a training package in place for staff?
C3-04	There is a system for learning lessons from events including concerns (incidents, complaints, claims under redress) compensation claims, claims reviews etc which are used to improve services

Area for Assessment D:	
Claims Case Management	
D1-01	Is there an effective process for receiving and processing requests for disclosure of medical records in matters where a claim is being considered against the health body?
D1-02	Where disclosure of records is requested, is there a process to ensure appropriate release of information is managed and redaction of relevant information undertaken as required?
D1-03	Is there an effective process for the oversight of disclosure of information in matters where a claim is being considered against the health body?
D1-04	Is there a clear process for referral of relevant matters to Legal & Risk? Is the referral to Legal & Risk being utilised? Is the timescale for referral of claims to Legal & Risk appropriate?
D1-05	Is there a clear process for receipt of advice in a matter and analysis of requests for instructions? Are the timescales for receiving advice and providing instructions appropriate and proportionate?

Area for Assessment D:	
Policy and Procedure	
D2-01	Is there a policy or procedure in place for Claims Case Management within the Health Board? Is it in date? Is there a review date? How is it reviewed/ratified?
D2-02	Is there a clear process for the application of Standing Financial Instructions and authorisation of admissions & settlement of matters?

Area for Assessment D: Information, Reporting & Governance Arrangements	
D3-01	What are the governance arrangements for the management of claims cases?
D3-02	How are they reported within the Health Board and to what meetings/Committees are they reported?
D3-03	Are they reported at Board level or Sub-Committee?
D3-04	Is there a training package in place for staff responsible for managing claims?

Area for Assessment E: Lessons Learned	
E1-01	Does the Health Body have in place a defined and formalised process or procedure through which it sets out its objectives and demonstrates practically how it learns lessons from events?
E1-02	Is there a clear process relating to the approval of Learning from Events Reports prior to submission to WRP
E1-03	Is there an assurance process relating to lessons learned from the Operational level to Board level? E.g., Flowchart, Terms of Reference for meetings, Reports?
E1-04	What proportion of LFER reports were submitted in accordance with the WRP Reimbursement Procedures? E.g., timeless, completeness, extension requirements?
E1-05	What proportion of LFER reports were approved by the Learning Advisory Panel?

Area for Assessment F: Reimbursement Process	
F1-01	Does the Health Body have in place a defined and formalised process or procedure through which it sets out its objectives and provides assurance for the accounting of losses & special payments which are subject to WRP Reimbursement?
F1-02	Does the Health Body have a process for tracking and ensuring submission to WRP for reimbursement? E.g., timeliness?
F1-03	Does the Health Body have a process for identifying and submitting post-closure reimbursement requests in a timely manner?

WELSH RISK POOL (WRP) ASSESSMENT VERSION 1
IMPROVEMENT PLAN & DECISIONS TRACKER

									Progress Update		
Ref	**Date**	**Action Note**	**Responsible**	**Due Date**	**Progress/Comment**	**Status**	**Action List**	**Owner**	**Timeframe**	**November Update**	**December Update**	**January Update**
WRP01	Jul-23	Ensure that investigation outcomes for incidents are recorded accurately on Datix Cymru.	Head of Patient Safety & Concerns Service Manager, Operations Quality Head of Health & Safety Datix Cymru Local System Lead	31.01.2024 Retrospective records 31.03.2024	Capacity in the PTR Team has been limited due to sustained pressures and staff absence. The PTR OCP is currently in progress with the proposal that the Patient Safety functions are strengthened which will release capacity to ensure appropriate recording on the system retrospectively (NRIs) and on an ongoing basis. Currently records & files are held on the Shared Drive. Datix Cymru Local Team will assist in identifying retrospective records.	On target		Head of Patient Safety & Concerns Service Manager, Operations Quality Head of Health & Safety Datix Cymru Local System Lead	Milestone Jan-24	We will develop a report to Identify missing outcomes & ensure completion by the responsible managers going forward e.g Training. A group has been established to develop a training package.	Reports have been developed and posted on a Quality Dashboard for the Patient and Health and Safety teams to review and identify any incidents with no management reviews. A Closure Guidance process is being developed for all managers to have the responsibility to close incidents. A draft process will be completed by Jan in readiness for approval.	
WRP02	Jul-23	Introduce a KPI for incident reporting and regularly review and scrutinise cases to ensure that they are closed efficiently and do not remain open on the system longer than necessary.	Head of Quality Assurance & Datix Cymru	31.12.2023	Thresholds / KPIs to be developed and monitored via senior operations meetings and Clinical Quality Governance Group (Executive Group).	On target	Develop KPIs for reporting of incidents on Datix Cymru	Head of Quality Assurance & Datix Cymru	Feb-24		The KPIs have been incorporated into the draft SOP for the Management of Incidents reported over Datix.	
WRP03	Jul-23	Ensure that all Datix Cymru records are the subject of a validation process, as a minimum of closure of the record, to ensure all information and data fields are completed comprehensively	Datix Cymru Local System Lead	31.01.2024	Datix Cymru Local System Lead will work with key stakeholders to develop a governance process to identify the correct information to be entered into the correct fields within Datix Cymru which are dependant on the nature of the investigation. Each team i.e. Patient Safety, Health & Safety, Safeguarding, Operations, Information Governance, Estates etc will need to provide the Datix Team with a list of what fields within Datix they require in a data listing report and the system lead will create a data report. This will enable each team to draw down their own validation report. The Datix Cymru System Lead can then produce a validation report. Training is being arranged in collaboration with the Once for Wales Datix Cymru Team.	On target	The Patient Safety Team to identify within Datix Cymru what fields require completion on closure for all modules, and provide a list to the Datix system lead to allow them to create appropriate listing reports. There will be the need for multiple lists depending on the area of business, i.e. feedback, incidents, NRIs.	Head of Patient Safety & Concerns	Jan-24	PST Feedback, Incidents & NRIs: - will develop a checklist for NRI & Patient Safety incidents with a Severity of Moderate+	Development ongoing - waiting on the new form design due to be implemented on 22 December 2023.	
						On target	The Health & Safety Team to identify within Datix Cymru what fields require completion on closure for all modules, and provide a list to the Datix system lead to allow them to create appropriate listing reports. There will be the need for multiple lists depending on the area of business, i.e. incidents, RIDDOR.	Head of Health and Safety	Jan-24	H&S Team are reviewing the required fields to aid the creation of suitable listing reports.	Ongoing	
						On target	The Datix Cymru Local System lead is required to create listing reports following receipt of the relevant information from the Patient Safety Team and the Health and Safety Team. These reports will be pinned to the relevant staff dashboards to enable those staff members to validate the data within those report.	Datix Cymru Local System Lead	Jan-24	Patient Safety Incident reports relating to moderate harm & above are in the process of being developed. In readiness for comment and review by PST.	Ongoing	
						On target	The Datix Cymru Local System Lead will bi-monthly run reports highlighting incomplete areas and will highlight these to the relevant departments	Datix Cymru Local System Lead	Jan-24	To be completed once items identifed in Action 24 have agreed	Ongoing	
WRP04	Jul-23	The process for obtaining consent for release of information arising from a concern should be reviewed and produced in a structured procedure, with arrangements for recording circumstances where consent is not required or appropriate.	Head of Patient Safety & Concerns	31.03.2024		On target		Head of Patient Safety & Concerns	Mar-24	PST will liaise with the Legal Team and IG Team to review what is currently in place	Ongoing	
WRP05	Jul-23	Ensure all documents including staff statements and detailed investigation reports are uploaded to the Datix Cymru system.	Head of Patient Safety & Concerns Service Manager, Operations Quality Head of Health & Safety	31.01.2024 NRI Retrospective records 31.03.2024		On target		Head of Patient Safety & Concerns Service Manager, Operations Quality Head of Health & Safety	Jan-24	PST NRI checklist: - will be developed for the closure for all NRI's to ensure all information relating to the incident has been captured and uploaded. H&S Team will develop a form for incidents where harm levels are medium and above to ensure related documents are uploaded to Datix	Ongoing - Discussions ongoing ref various reports to capture the information.	
WRP06a	Jul-23	It is expected that the Actions Module in Datix Cymru is utilised and applied efficiently and correctly.	Datix Cymru Local System Lead	01.03.2024	The Datix System lead will work with key stakeholders to ensure the investigator and incident manager understand how to utilise the actions functionality if required within the incident module.	On target	The Datix Cymru Local System Lead will liaise with the Once for Wales Team and provide an update to Patient Safety Team and Health and Safety Team on the functionality of the Actions Module. The Datix Cymru Local System Lead will also investigate the governance around this module and requirement for security groups.	Datix Cymru Local System Lead	Feb-24	Work has commenced on the implementation of the Actions Module for high level patient safety incidents i.e. NRI's, SCIF complex case panel in the first instance.	Ongoing	
						On target	The Datix Cymru Local System Lead, Patient Safety Team and the Health and Safety Team will create bite size educational material for staff outlining how to use the Action module.	Datix Cymru Local System Lead Head of Patient Safety & Concerns Head of Health & Safety	Feb-24	This will be developed once the Actions module has been implemented & any issues identified. NPSI bitesize training modules identified scripts and storyboards under development.	Ongoing	

WRP06b	Jul-23	It is expected that the Yorkshire Contributory Framework is utilised and applied efficiently and correctly to ensure appropriate review of investigations in accordance with the All-Wales approach.	Datix Cymru Local System Lead	31.03.2024	The Datix Cymru Local System Lead will work with key stakeholders i.e. Patient Safety and Health & Safety to develop in collaboration guidance for the Yorkshire Contributory Framework for the investigator/ incident manager.	On target	Training to be provided for end users on how to complete the Yorkshire Contributory Framework within the Incident Module.	Datix Cymru Local System Lead Head of Patient Safety & Concerns Head of Health & Safety	Mar-24	Patient Safety Managers are developing guidance to support the managers in completing the YCF. Head of H&S in discussion with All Wales H&S Manager Group to identify synergies with non-patient safety root cause analysis tools already in place.	The Yorkshire Framework will be included in the Closures guidance mentioned above. Discussions ongoing for report to capture information.	
						On target	The Datix Cymru Local System Lead to generate monthly reports to allow the Patient Safety and Health & Safety teams to validate the content of information within the Yorkshire Contributory Framework.	Datix Cymru Local System Lead	Jan-23	This will follow on from the above point. A report will be developed by the system lead to identify incomplete fields. And the PST and HS teams will do a sample audit to ensure the information given is appropriate. A manageable sample size is to be agreed.	Ongoing - Discussions ongoing ref various reports to capture the information.	
						On target	Patient Safety and Health & Safety Teams to undertake monthly validation on the content of information within the Yorkshire Contributory Framework.	Head of Patient Safety & Concerns Head of Health & Safety	Mar-24		Ongoing - Discussions ongoing ref various reports to capture the information.	
WRP07	Jul-23	Train and skill the Investigating Officers in considering Breach of Duty and Qualifying Liability as part of their investigation process.	Trust Solicitor	31.03.2024		On target		Trust Solicitor	Mar-24	Consultation with the Legal Team is required to establish what is currently in place.	Liaise with Legal Team. Ongoing	
WRP08	Jul-23	Consider issuing an Interim Regulation 26 response to avoid delays when the investigation has concluded that there is a Breach of Duty.	Head of Patient Safety & Concerns / Trust Solicitor	31.03.2024		On target		Head of Patient Safety & Concerns / Trust Solicitor	Mar-24	Consultation with the Trust Solicitor is required prior to agreeing adoption of interim 26 responses.	Liaise with Legal Team. Ongoing	
WRP09	Jul-23	Ensure subject and sub-subject codes for all records in the Datix Cymru systems are completed consistently and comprehensively and are subject to validation checks.	Datix Cymru Local System Lead	31.03.2024	Datix Cymru Team to quality assure the subject & sub subject codes. Since the period of the report, the fields referred to are now mandatory.	Complete	The Datix Cymru Local Team carry out regular validation checks on the Classification, Category and sub-category fields within Datix Cymru.	Datix Cymru Local System Lead	Sep-23	This will form part of the closure checklist	A Closure checklist will be developed and implemented to ensure completion. Dashboard report to be developed. Validation checks will be included as part of the process.	
WRP10	Jul-23	Ensure the description field is completed correctly on the Datix Cymru system and that these are subject to validation checks.	Datix Cymru Local System Lead	31.03.2024	The system lead together with PTR and H&S colleagues will develop and implement a training package for staff to outline to staff completing/reporting an incident how to complete the description field on data and what information is expected and codes(free text). the Datix on QA will remove patient identifiable information and update the codes if required.	On target	The Patient Safety Team and Health & Safety Team to create bite size training content for end users and make these available to staff, on how to complete the description fields.	Head of Patient Safety & Concerns Head of Health & Safety	Mar-24	A group has been established to develop a training package. NPSI bitesize training modules identified scripts and storyboards under development.	A suite of training videos have been developed in Q3. However, following the system changes on the 22 Dec affecting the layout of DATIX forms, some videos may require re-doing and potential amendments.	
						Complete	The Datix Cymru Local System Lead will identify through QA checks if there has been any patient identifiable information entered within these fields.	Datix Cymru Local System Lead	Sep-23			

AGENDA ITEM No	**21**
OPEN or CLOSED	**Open**
No of ANNEXES	**1**

Committee Cycle of Business Monitoring Report

MEETING	Quality, Patient Experience and Safety Committee
DATE	08 February 2024
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Trish Mills, Board Secretary
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. This report updates the Committee on progress against the agreed cycle of business for the Committee. There is an update regarding the receipt of the Quality Strategy Implementation Plan.

2. The usual Committee update regarding progress against priorities for 2023/24 has been included in the annual Committee effectiveness review paper received separately at this meeting.

RECOMMENDATION: The Committee is asked to note the update.

KEY ISSUES/IMPLICATIONS

No issues to raise.

REPORT APPROVAL ROUTE

Not applicable

REPORT APPENDICES

Annex 1 – QuEST Committee Cycle of Business Monitoring Report

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

COMMITTEE CYCLE MONITORING REPORT

SITUATION

3. This report updates the Committee on progress against the agreed cycles of business. The usual Committee update regarding progress against priorities for 2023/24 has been included the annual Committee effectiveness review paper received separately at this meeting.

BACKGROUND

4. The Committee's cycle of business was approved by the Committee in May 2023. The agenda is set with reference to that cycle, together with the forward planner, action log and highest rated principal risks.

5. The monitoring report is at Annex 1. Items in green show they are cycled for a particular meeting. Items in beige indicate they are a prompt at agenda setting as they may be ad hoc items such as business cases or external reports. The blue indicates that the item is either on the agenda as scheduled or is an ad hoc item which was discussed in agenda setting.

ASSESSMENT

6. The Committee's attention is drawn to the scheduled receipt of the Quality Strategy Implementation Plan. The plan was developed to support delivery of the Quality Strategy 2021-2024. Whilst progress against the plan has been slow due to resourcing challenges, there has been progress in the latter half of 2022/23 in preparation for the Health and Care (Quality and Engagement) (Wales) Act 2020. An update has been programmed for its meeting in February 2024.

RECOMMENDATION: The Committee is asked to note the update.

PAPER	PRE C'EE FORUM	FREQUENCY	Q1	Q2	Q3	Q4	LEAD	PURPOSE	
QUEST COMMITTEE - CYCLE OF BUSINESS 2023/24									
See full cycle of business for reference to the duties in the terms of reference as they relate to Committee reports below									
MAIN ELEMENTS									
MIQPR review of metrics	EMT	Annually					EDSPP	Approval	Programmed for Q4.
Committee QPSE review of metrics	TBC	Annually					EDQN	Approval	Programmed for Q4.
MIQPR	EMT	Quarterly					EDSPP	Assurance	
Putting Things Right Report	CQGG	Quarterly					EDQN/DP	Assurance	
Quality Report	CQGG	Annually					EDQN	Approval	First report Q1 24/25
Duty of Candour Report	CQGG	Annually					EDQN	Approval	First report Q1 24/25
Quality Strategy/Plan	CQGG	Initial and cyclical review					EDQN	Approval	Agreed to programme for Q4; Committee priority.
Clinical Strategy/Plan	CQGG	Initial and cyclical review				→	DP	Approval	Not required for Q4; will be brought in 2024/25.
Dementia standards report	CQGG	Annually					EDQN	Assurance	
Committee elements of IMTP	STB	Annually			→		EDSPP	Endorsement	Commissioned for 31.10, then agreed to defer to Feb 2024.
IMTP exception reporting	STB	Ad Hoc					Relevant Director	Assurance	Programmed for Q4.
Health and care standards	CQGG	TBC					EDQN	Assurance	Reporting developing 23/24
Quality Impact Assessments	CQGG	Ad Hoc					EDQN/DP	Assurance	QIAs on NEPTS eligibility & Decommissioning of F&R service first responders Oct
External and/or peer reports	Various	Ad Hoc					Relevant Director	Assurance	Two HIW updates in August; HIW Stroke report in Q4.
Annual Mental Health Report	CQGG	Annually					EDQN	Assurance	Annual report in October meeting
Annual IPC report	CQGG	Annually	→				EDQN	Assurance	Deferred from May and presented in August
Annual safeguarding reports	CQGG	Annually	→				EDQN	Assurance	Deferred from May and presented in August
Referrals from PCC	PCC	Ad Hoc					Relevant Director	Discuss/Assure	
Clinical audit plan	CQGG	Annually					DP	Approval	Approved in May; agreed to be quarterly updates not annual. Not req. for Q4.
Monitoring report on clinical audit	CQGG	Quarterly					DP	Assurance	
Spotlight On clinical indicators	CQGG	Quarterly					DP	Assurance	Started in August 2023 and programmed at each subsequent mtg.
Mortality Report	CQGG	Bi-annually					EDQN	Assurance	Reported in May as cycled
Meds management report	CQGG	Annually					DP	Assurance	
PECI report	TBC	Bi-annually					EDQN	Assurance	Reported in May as cycled
Patient story	N/A	Quarterly					EDQN	Assurance	Q4: Staff Story (TBC)
Patient story updates	N/A	Quarterly					EDQN	Assurance	
Information Governance Toolkit	IGSC	Annually	→				DD	Assurance	Reported in August
Information governance report	IGSG	Quarterly					DD	Assurance	Reporting started in August; programmed for every mtg.
Audit recommendation tracker	EMT	Quarterly					BS	Assurance	
Audits within purview of Committee	Audit/Board	Ad Hoc					Relevant Director	Assurance	
Report from policy group	Policy Group	Annually	→				BS	Assurance	Reported in August; Q4 policies for approval only.
Policies for review and approval	Policy Group	Ad Hoc					BS	Approval	
Board Assurance Framework	EMT	Quarterly					BS	Assurance	
Corporate Risk Register	EMT	Quarterly					BS	Assurance	
SUB-GROUPS									
Where applicable	N/A	Ad Hoc					N/A	N/A	
GOVERNANCE									
Committee effectiveness review annual report	Audit/Board	Annually					BS	Approval	
Review of Terms of Reference	Audit/Board	Annually					BS	Approval	
Committee Cycle of Business annual refresh	N/A	Annually					BS	Approval	Reported in May as cycled
Committee Cycle of Business monthly review	N/A	Quarterly					BS	Review	
Committee Review of Annual Priorities	N/A	Quarterly					BS	Review	Started in August as cycled
PROMPTS									
External Reports	N/A	Ad Hoc					Relevant Director	Varies	Ombudsman report in August; Q4 - HIW Report (Stroke)
OTHER									
Operations Directorate Update	N/A	Quarterly					EDO	Information	

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

Cycled for each meeting
Ad hoc item - prompt for agenda setting
Reporting developing
Presented as cycled/ad hoc item considered at agenda setting
Deferred - see comment

Patient story tracker steven parsons

Steven's grandfather collapsed at home, rang 999, fearing he might have had a stroke. Was advised there were no ambulances available and to take his grandfather to hospital. Steven decided to take him to A&E at the Grange Hospital himself by car. Although still conscious and breathing his condition was deteriorating, he collapsed while Steven was trying to get him across the car park to the A&E. A&E staff quickly admitted him and informed Steven that his grandfather had gone into cardiac arrest. Fortunately, he pulled through. However, Steven remains traumatised by the experience of helplessness and anxiety he felt, particularly re-living the moment his grandfather collapsed as he carried him to A&E. Steven feels that if an ambulance had been sent in time that it might have prevented the cardiac arrest and would have spared him and his grandfather the anxiety and helplessness which contributed to the traumatic experience.

Themes identified

- Hospital handover delays.
- Use of 'can't send'.
- PTSD/Harm caused to patients/families/carers
- **Awareness amongst Health Boards of the harm in the community because of hand over delays.**
- **Poor wording of Trust response letter to a complaint addressing reason for delayed response.**
- **Trauma families experience when there are no resources to send in response to their call.**

goal	Primary drivers	secondary	actions	RESPONSIBILITY FOR ACTIONS	progress	outcome
• Deliver an emergency service to patients in times of need. • Support families following a traumatic event. • Review how Trust explains wider pressure system impacting on ability to send emergency respond because of hand over delays.	• Reduce and eliminate hospital handover delays in ABUHB area. • Patients coming to harm whilst waiting in the community • Pressure on ambulance service to provide ambulance response. • Manage reputation risk/harm with public on ambulance delays and 'can't send' outcomes. • Appropriate/timely declaration of incidents at hospital • Track patient mortality and morbidity through their journey and healthcare system.	• Raise awareness with Health Boards the harm to patients in the community due to hand over delays. • Articulate clearly work from patient harm/harm avoided in the Demand & Capacity Review. • Audit Wales – looking at whole system approach. • Public perception of Welsh Ambulance Service and experience rating. • Psychological trauma/harm on public/ patients and their families/carers	• Continue to work with Health Board to reduce and eliminate hospital delays. • Share story with EASC & Audit Wales. • Review complaint response with attention at how we present explain wider system pressures on the Trust. • Public messaging on appropriate use of services. • Review Clinical Safety Plan. • Share story with ABUHB and explore how we support patients/families with PTSD and signposting for help	• Executive Management Team • Quality Improvement • Communications • Patient Safety/PTR • PECI share story/learning with National Patient Experience leads		

Story action timeline

Dec 2022	Jan 2023	Feb 2023	Apr 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023
Date of incident	Story appears in BBC News	Start of PTR process	Investigation outcome letter sent	Meeting with Jason and Wendy	Video recorded	Video Played at QMG	Video Played at Trust Board

RISKS

- Financial Savings:
  - Removal of taxi provision
  - Shifts not covered by OT
- Continued system pressures
- Declaration of incident – getting hospitals to call it

Updated 20 November 2023 v3