

# Bundle Quality, Patient Experience and Safety Committee 10 August 2023

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- 16 Clinical Audit Plan – Update  
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ITEM 17.7 Adopted National Policy on Patient Safety Incident Reporting & Management Supporting Section 3 – Guidance on Specific Incident Types June 2023  
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- 17.1 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.*
- 18 Committee Priorities and Cycle of Business Monitoring Report  
ITEM 18 QuEST Priorities and Cycle Monitoring Report  
ITEM 18.1 Quest Committee Cycle of Business 2023-24 – Monitoring Report
- 19 Groundhog Day 2: An opportunity for cultural change in complaint handling  
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- 20 Reflections and Summary of Decisions & Actions
- 21 Key Messages for Board
- 22 Any Other Business
- 23 Date and Time of Next Meeting: – 31 October 2023 at 09:00



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

Held on **10 August 2023** from **09:30 – 13:20**

Meeting held virtually via Microsoft Teams

### AGENDA

No	Agenda Item	Purpose	Lead	Format	Time
<b>OPENING ITEMS</b>					
1.	Chair's welcome, apologies, and confirmation of quorum	Information	Bethan Evans	Verbal	10 Mins
2.	<a href="#">Declarations of Interest</a>	Information	Bethan Evans	Verbal	
3.	Minutes of the Previous Meeting - 11 May 2023	Approval	Bethan Evans	Paper	
4.	Action Log and Matters Arising	Discussion	Bethan Evans	Paper	
<b>ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION</b>					
5.	Operations Directorate Quarterly Report Q1 2023/24	Discussion	Lee Brooks	Paper	10 Mins
6.	Staff Experience – Beth Hews, Palliative Care Paramedic, Ty Olwen and WAST	Discussion	Liam Williams	Video	30 Mins
7.	Monthly Integrated Quality Performance Report	Assurance	Rachel Marsh	Paper	20 Mins
	7.1 Deep Dive into Red rural Calls	Assurance	Rachel Marsh	Presentation	
8.	Putting Things Right Report Q1 2023/24	Assurance	Liam Williams	Paper	20 Mins
	8.1 Spotlight on Clinical Indicators	Assurance	Duncan Robertson	Presentation	
9.	Duty of Quality/Duty of Candour Implementation	Assurance	Liam Williams	Paper	15 Mins
10.	Information Governance Report	Assurance	Leanne Smith	Paper	10 Mins



11.	Risk Management and Board Assurance Framework Report	Assurance	Julie Boalch	Paper	10 Mins
<b>BREAK – 10 MINUTES</b>					
12.	Internal Audit Tracker Update and Internal Audits: 12.1 Pain Management Report	Assurance	Trish Mills Duncan Robertson	Paper	15 Mins
13.	Health Inspectorate Wales (HIW) – Update on Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover	Assurance	Liam Williams	Paper	15 Mins
	13. HIW Emergency Medical Services Clinical Contact Centre, Patient Safety Review	Assurance	Lee Brooks	Paper	
14.	Annual Infection Prevention and Control Report	Assurance	Liam Williams	Paper	15 Mins
15.	Annual Safeguarding Report	Assurance	Liam Williams	Paper	15 Mins
16.	Clinical Audit Plan – Update	Assurance	Duncan Robertson	Paper	5 Mins
17.	17.1 Policy Report	Assurance	Julie Boalch	Paper	15 Mins
	17.2 National Policy on Patient Safety Incident Reporting and Management	Approval	Liam Williams		
<b>CONSENT ITEMS</b>					
<b>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.</b>					
18.	Committee Priorities and Cycle of Business Monitoring Report	Information	Trish Mills	Paper	5 Mins
19.	Groundhog Day 2: An opportunity for cultural change in complaint handling	Information	Liam Williams	Paper	
<b>CLOSING ITEMS</b>					
20.	Reflections and	Discussion	Bethan Evans	Verbal	10 Mins



	Summary of Decisions & Actions				
21.	Key Messages for Board	Discussion	Bethan Evans	Verbal	
22.	Any Other Business	Discussion	Bethan Evans	Verbal	
23.	Date and Time of Next Meeting: - 31 October 2023 at 09:00	Information	Bethan Evans	Verbal	

## Lead Presenters

Name	Position
Julie Boalch	Head of Risk/Deputy Board Secretary
Lee Brooks	Executive Director of Operations
Bethan Evans	Non-Executive Director and Committee Chair
Nikki Harvey	Head of Safeguarding
Leanne Hawker	Head of Patient Experience & Community Involvement
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Trish Mills	Board Secretary
Duncan Robertson	Assistant Director of Clinical Development
Leanne Smith	Interim Director of Digital Services
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 11 MAY 2023 VIA TEAMS

#### Meeting started at 13:30

#### PRESENT:

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

#### IN ATTENDANCE:

Andrew Clement	Partners in Healthcare, Resource Development Coordinator (left after item 015/23)
Stephen Clinton	Assistant Director of Operations
Lisa Harte	Internal Audit
Leanne Hawker	Head of Patient Experience and Community Involvement
Wendy Herbert	Assistant Director of Quality and Nursing
Jon Hopkins	Health Informatics Management
Fflur Jones	Audit Wales
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Trish Mills	Board Secretary
Steve Owen	Corporate Governance Officer
Jane Palin	Assistant Director of Quality and Nursing
Gareth Parry	Operations Assistant Community Support ((left after item 015/23)
Hugh Parry	Trade Union Partner
Alex Payne	Corporate Governance Manager
Duncan Robertson	Assistant Director of Clinical Development
Andy Swinburn	Director of Paramedicine
Gareth Thomas	Patient Experience and Community Involvement Manager
Jonathan Turnbull-Ross	Assistant Director of Quality Governance
Liam Williams	Executive Director of Quality and Nursing
Jennifer Wilson	National Volunteer Manager (left after item 015/23)

#### Apologies:

Lee Brooks  
Cheryl Merrick  
Hannah Rowan  
Leanne Smith

Executive Director of Operations  
Llais Wales (formerly Community Health Council)  
Non Executive Director  
Interim Director of Digital Services

## **013/23 PROCEDURAL MATTERS**

The Chair extended a warm welcome to everyone advising that the meeting was being recorded. Apologies had been received from Lee Brooks, Cheryl Merrick, Leanne Smith and Hannah Rowan.

### **Declarations of Interest**

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

### **Minutes**

The Minutes of the meeting held on 9 February 2023 were confirmed as a correct record subject to amending the wording under Minute 11/23, bullet point 2 regarding WISH ambulance; it was agreed that Ceri Jackson would provide the amended wording.

### **Action Log**

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

Action 002/23: Operations update, future reports to include an update on the Intelligent Routing Platform pilot. Details contained in update, action closed.

Action 004/23a: Patient safety report, backlog of National Reportable Incidents; the Committee requested an update to be given at the next meeting. Verbal update provided with a further update to be given at the 10 August meeting. Action to remain open.

Action 005/23: Patient safety report, next report to contain details of how many Serious Case Incident Forums were linked to Immediate Release Directives being declined. Detail contained in report. Action closed.

Action 007/23a: Patient Experience and Community Involvement (PECI) highlight report; Consider how to re-frame the questions for patient surveys to improve services from the feedback given. Update include on action log. Action closed.

Action 008/23: Duty of Quality/Candour preparedness. It was asked that a risk be generated/articulated to consider the impact of implementation of non-compliance with the introduction the Health and Social Care (Quality and Engagement) (Wales) Act 2020 ("the Act"). Action to be discussed alter in the agenda. Action closed.

Action 008/23a: Duty of Quality/Candour preparedness; clarity on the Implementation of the Quality strategy. An update was requested in respect of how this would be delivered in the next report. Item will be discussed later in the agenda. Action closed.

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 9 February 2023.

Comments:

Kevin Davies updated the Committee following the last Vice Chairs of Health Board's meeting in which it was acknowledged there was still issues with handover delays and the work of Health Boards to address this.

**RESOLVED: That**

- (1) the Minutes of the Open meeting held on 9 February 2023 were confirmed as a correct record subject to the revised wording under Minute 11/23; and**
- (2) consideration was given to the Action Log and AAA report as described above.**

#### **014/23 OPERATIONS DIRECTORATE QUARTERLY REPORT – 2022-23 Q4**

Steve Clinton introduced the Operations Quarterly Report as read, conscious that some colleagues would have already had sight of it at other meetings. He drew attention to the following areas:

Intelligent Routing Platform (IRP). The IRP was an NHS England procured solution that automated some of the manual BT call handling processes for 999 calls. The Trust was now more comfortable with the level of call volume following changes to the IRP.

Hand over delays remained significantly high during this reporting period however there has been, over the last fortnight, an element of improvement in Health Boards across Wales. It was of particular note that Cardiff and Vale University Health Board had considerably improved their hand over delays.

Consult and close rates continue to improve edging towards a 15% rate for the month.

The roster review for clinicians on the Clinical Service Desk (CSD) has now been completed and should improve the situation in CSD.

Work was shortly to commence on the 111 Integrated Information Solution (AKA Salus), implementation, which was expected to be rolled out in November 2023.

Comments:

Whilst the Committee noted there had been some positive improvement with hand over delays in the Cardiff and Vale University Health Board area, it was pleasing to note there had been improvements elsewhere in Wales.

Members were encouraged by the update on the Salus programme recognising the situation had been, in the past, problematic.

The Committee expressed their delight with the rollout of Pentrox which was now able to be administered by volunteers.

In terms of the Manchester Arena Inquiry (MAI) an update was sought on progress against the recommendations from the inquiry. Ceri Jackson agreed to seek an update on the MAI following the meeting.

Also a query arose in terms of an update regarding rural response and the challenges faced by the Trust in meeting the Red performance target. In respect of the rural response, Rachel Marsh advised that work had been undertaken to consider the variation between rural and urban Red response, however this had been paused due to other ongoing system pressures. Following further discussion it was agreed that a deep dive on the Trust's Red response in rural areas would be provided at the next meeting through the MIQPR. Andy Swinburn added that the Trust has specifically targeted and bolstered some of the rural areas with the addition of Newly Qualified Paramedics (NQP).

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

## **015/23 STAFF EXPERIENCE**

The Committee heard from Keith Jones who was a long-standing Community First Responder (CFR) at WAST and attended a patient at their home in November 2022. When Keith arrived he was met by the patient's partner who advised him that their partner had been lying on the sofa in the living room for about three weeks. The patient explained that he was finding it difficult to breathe and Keith gave him oxygen. Furthermore the patient advised Keith that they had tried to call the GP on several occasions and in the end through lack of response just gave up.

Keith continued to monitor the patient for over four hours awaiting an ambulance and during that time the patient went into cardiac arrest. Despite attempts to resuscitate him, the patient died.

Comments:

Leanne Hawker explained that following a patient survey, 33% of those that responded had found it difficult to book a GP appointment.

Members were moved by Keith's story and felt the distress in his voice when he was recalling the events of that day. They acknowledged the very important and key role CFR's played throughout the Community. Members were aware however that this

anguish would not have been experienced had the handover delays not been so extreme.

In terms of the coroner's report, it was queried if this had taken place and if there were any implications for the Trust. Wendy Herbert advised at this stage it was not known if a coroner's inquiry would be taking place.

Following a question regarding support for CFRs, Jennifer Wilson commented that the CFR team have supported Keith throughout and the CFRs end of shift form would capture any potential debrief requirements. Gareth Parry added that the CFR team would follow up on any support they need, any links with CFR champions, occupational health, or Trauma risk Management (TRiM) referrals. Jennifer Wilson added that all the benefits of employee assistance programme was also now being offered to CFRs.

A question arose seeking clarity on whether the role of the CFR had changed as a result of ongoing system pressures. Jennifer Wilson explained that whilst all CFRs have the same level of training they are able to select which type of call they want to respond to. Clearly the roll out of CFRs being able to administer pain relief will see further changes to the role going forward. She added that these and any further changes to the role should be discussed at People and Culture Committee (PCC) meetings. The Chair of PCC agreed this would be discussed at a date to be determined.

The Committee were updated by Duncan Robertson on the roll out of the ePCR for CFR's and how this would enhance their portfolio.

The Committee discussed in detail the issue of deploying a CFR when ambulance back up may not be readily available which this story had highlighted.

Liam Williams added that whilst the Trust played its part in emergency and urgent care it should also assist where it can with other partners across the health system in ensuring patients have access to primary care. He further commented that this particular patient from an overall NHS perspective was not supported at the time of identified need. This cascaded into a trajectory of deterioration which resulted in the CFR being left in that position. He reiterated the value of CFRs and how they have integrated successfully into the Trust, recognising their training continued to develop.

The Chair thanked the team involved and in particular to Keith for sharing this difficult story.

**RESOLVED: That the STAFF story was noted recognising that the Trust continued to develop the CFR training.**

## 016/23 MONTHLY INTEGRATED QUALITY PERFORMANCE REPORT

Rachel Marsh presented the latest Monthly Integrated Performance Report (MIQPR) and highlighted the following:

In terms of the 999 service, there had been an improvement in April recognising the work into improving performance had started to have an impact.

With regards to National Reportable Incidents (NRI). The Trust reported three NRIs to the delivery Unit in March, even though these were lower than February (12) they were still of concern.

In terms of patient harm, there had been a reduction in the number of times these required escalation to the highest levels of the Clinical Safety Plan (CSP)

Clinical Indicators, the Trust continued to work on the improvement actions in order to ensure the data being captured through the Electronic Patient Clinical record (ePCR) was accurate and complied with the various clinical bundles.

It was noted that response times to concerns continued to fall below the required performance level and work was underway implementing several measures to address this. The impact on the Putting Things Right (PTR) team and their ability to meet targets during this challenging period was recognised, and a brief update on the measures in place to address this was provided.

Hours Produced: The Trust produced 118,141 Ambulance Response ambulance unit hours in April 2023. Emergency ambulance unit hours production (UHP) was 98% in April 2023, thus achieving the 95% target. It was noted there was a 1% staff vacancy factor in EMS and when comparing this with other organisations in Wales it was quite remarkable and was a credit to all those involved in with recruitment and retention of staff.

Staff training and Personal Annual Development Review (PADR): PADR rates did not achieve the 85% target in March 2023 (72.1%), compliance for Statutory and Mandatory training also dropped significantly below the target achieving 73.69%. The reasons for this decline in Statutory & Mandatory training were being reviewed.

In respect of the funding for 100 Whole Time Equivalents, the Trust was expectant this would be forthcoming in the very near future.

Comments:

In terms of the new clinical outcome indicators for call to door time for strokes it was queried if these would be available in June. Duncan Robertson confirmed that the data was ready and would be reviewed by the Clinical Intelligence Assurance Group at which it would be decided how the data will be presented as an indicator.

Following the roll out of ePCR it was questioned if there had been any feedback. Duncan Robertson advised that ePCR had been rolled out across the Trust; staff were able to provide feedback through various channels, adding that any issues were resolved as soon as possible.

A discussion ensued in which Members considered any other measures to support the PTR Team, and also expressed their apprehension for the Team's welfare and the backlog of concerns. It was agreed that going forward, Trish Mills would consider with other colleagues how this issue could be addressed. Liam Williams outlined the challenges involved in improving performance. Wendy Herbert re-emphasised the difficulty in clearing the backlog which going forward would become more difficult due to the implementation of the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

Whilst there were some positive aspects within the report, the Chair commented that the challenges continued and the level of patient harm and the impact was substantial due to excessive amongst other things, handover delays. In terms of 111 call answering it was acknowledged there was a priority to re-roster the 111 team; and it was queried if there was a timeline for this. Rachel Marsh advised this was still being evaluated with the Chief Ambulance Services Commissioner, and advised that December 2023 was the proposed date.

**RESOLVED: The Committee considered the March 2023 Integrated Quality and Performance report and remained concerned on performance, noting there were some improvements in some areas.**

### **017/23 PATIENT SAFETY REPORT Q4 2022/23**

Jane Palin gave an outline of the report and drew the Committee's attention to the following areas, noting that several areas of the report had been discussed in the previous item:

There was a decrease in the in the number of concerns being received but a backlog remained.

Patients waiting for extended periods of time in the community continued. During quarter four 1690 patients received a response or wait over 12 hours.

There continued to be a number of incidents being reviewed at the Serious Case Incident Forum (SCIF). During this reporting period there were 21 SCIF Meetings held, with 157 incidents discussed. 20 incidents have been reported as NRIs to the Delivery Unit (DU) and 66 incidents were referred under the Joint Incident Framework to the respective Health Board.

During the periods of industrial action, patient safety incidents were monitored with oversight from the Operational Delivery Unit and the Patient Safety Team. Additionally, recognising that there was reduced capacity for teams to report

incidents during these periods, the Patient Safety Team worked alongside colleagues in EMS Coordination to identify actual and potential patient safety incidents.

During the reporting period the Trust received two Regulation 28 (Prevention of Future Deaths) Reports and issued both responses within the 56-day target. Both were broadly related to timeliness.

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 originated from delayed responses to patients at a time of escalation. The number of open clinical claims being investigated and litigated was now at an unprecedented level in the Trust's history.

Comments:

Members were keen to ascertain the impact the Health and Social Care (Quality and Engagement) (Wales) Act 2020 had on the Trust thus far. Jane Palin explained there would be a 12 month settling in period and the Trust was very clear on the responsibilities of the Act and continued to prepare for it. Liam Williams added that one of the main impacts would be the increased volume of concerns and being able to manage them.

In terms of patients waiting for extended periods of time in the community, in particular the 166 patients who had waited over 12 hours having experienced a fall, assurance was sought whether further details on patients was captured. Liam Williams commented that the highest number of handover delays correlated directly with the longest waits for ambulances. Thematic analysis emanating from the SCIF process articulated lessons learned progressed through the Clinical Quality Governance Group. Further to those patients who had experienced a fall, the Chair queried if there was an opportunity to develop the falls model. Rachel Marsh explained that any further expansion of the falls service was subject to local discussion at each Health Board commenting that funding was currently not available. Jonathan Turnbull-Ross advised that work was ongoing to advise Health Boards on the positive impact of improving the falls service.

Further clarity was sought on the decision-making for derogations (a method of maintaining safe staffing levels on strike days by agreement, and are achieved when the Union and the employer agree that a member or service shall be exempt from taking part in industrial action) and whether this would be taken into account by the NHS Wales Executive (Delivery Unit) who were leading a national overview of patient safety incidents related to industrial action to understand the effect of strike action across NHS Wales. Liam Williams advised that where it had been identified industrial action has been a direct contributor to patient harm this has been shared with the Delivery Unit. Whilst the Trust can escalate concerns and highlight the risk, ultimately the derogations are negotiated between the employer and the Trade Unions. He added that the

learning for industrial action to date, will directly inform how future industrial action negotiations were conducted. Hugh Parry outlined the negotiation process and the challenges encountered during them.

The Chair commented on Patient Safety Investigations and the number of overdue NRI investigations querying why Cwm Taf Morgannwg University Health Board's figures were much higher than other Health Board areas. Liam Williams explained that some Health Boards had implemented the joint investigation framework earlier than others and it was agreed the Chair would seek this information after the meeting.

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

### **018/23 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK REPORT (BAF)**

Trish Mills explained that the purpose of the report was to provide assurance in respect of the management of the Trust's principal risks, specifically risk 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).

The Committee were advised that detail of the actions of system partners remained in the BAF, however they were now included within a context box rather than within the 'actions' section. This will allow the Board and Committees to focus on scrutiny of the mitigating actions which the Trust was taking, whilst noting the context within which these risks remain at a score of 25.

#### Comments

The Committee welcomed the additional narrative in the commentary box which helped to contextualise the risks and found the guidance document on interpreting the BAF very useful.

Members sought to understand at which point, when the Trust has done everything in its gift to mitigate the risk, it no longer gives the risk a score of 25. Trish Mills explained that the context box explained the rationale of what was in the Trust's control.

Going forward, when the BAF matures further, there may be an opportunity to look at the risks differently. Liam Williams added that had the Trust reviewed the risk over the last two years, actions for the Trust and Health Boards may have evolved differently.

**RESOLVED: The Committee accepted the status of the two corporate risks which it has been assigned to oversee the management of – risks 223, 224. The Committee received the relevant sections of the Board Assurance Framework and noted the ongoing mitigating controls.**

## **019/23 PATIENT EXPERIENCE AND COMMUNITY INVOLVEMENT (PECI) QUARTERLY REPORT**

Leanne Hawker explained that the report provide assurances and, an update, on the work delivered by the Peci team on how it was 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 met the differing needs of each of our communities we serve without prejudice or discrimination.

The main focus of the report was to highlight how the Trust was engaging with service users and to increase the number of patient experience returns. A significant amount of work has been carried out in preparation for using the Civica system to capture patient and staff feedback. Liam Williams advised that going forward this report would be presented on a six- monthly basis.

Comments:

The Committee welcomed that reports would be presented on a six-monthly basis and queried if this approach would be shared with Health Boards. Leanne Hawker explained that the Trust was part of the all-Wales patient experience group and shared information on a reciprocal basis.

**RESOLVED: That**

- (1) The Committee noted the activities to date and acknowledge that Peci reports will be presented bi-annually to Committee;**
- (2) That the Committee received the report and accepted the assurances that the Trust was meetings its statutory duties/responsibilities to consult; engage and involve the public/patients in its work.**

## **020/23 DUTY OF QUALITY/ DUTY OF CANDOUR PREPAREDNESS**

Jonathan Turnbull-Ross reminded the Committee that The Health & Social Care (Quality and Engagement) Act 2020 came into force on 1 April 2023. This update outlines the implementation of the two aspects falling out of the Act, the Duty of Candour (DoC) and the Duty of Quality (DoQ).

The Trust's quality governance infrastructure was being reviewed, in relation to the new legislation, ensuring systems and processes within its governance structure assists in capturing and recording all strategic decisions to provide noticeable evidence that all strategic decisions and plans have been made through a quality lens.

In terms of informing and educating staff regarding the new legislation, tailor made pages have been created on the intranet. There will be further training and education through information resources which will be included as part of the Trust's 'Quality Hub' as outlined in the 2023/23 Integrated Medium Term Plan (IMTP) deliverables. This

will enable staff to learn further about quality impact assessments and how to access support.

Recruitment to a key leadership position 'Senior Quality Governance Lead' was in progress; while recruitment of the Senior Quality Lead role was due to be fulfilled by Summer 2023. These roles will provide additional strategic capacity, and local expertise and capabilities to support the Trust in delivering the DoC and DoQ.

Comments:

The Committee welcomed the update and felt more assured that sufficient preparedness was in place to deal with the new legislation.

It was queried whether there had been any joint preparedness between the Trust and Health Boards. Jonathan Turnbull-Ross explained there had been positive liaison with Health Boards which would continue through the coming months.

Liam Williams commented there was still further work to ensure that the Trust focused on capturing internal data through the Quality Performance Management Framework was consistent with NHS Wales wide reporting.

It was asked if there was completion date for the Quality Management Systems dashboard. Jonathan Turnbull-Ross explained that the digital infrastructure was in place to capture the appropriate metrics and that more clarity would follow after an upcoming workshop which would consider a possible go live date.

Members recognised and acknowledged the challenges and risks around the implementation of the Duty of Candour which were likely to further exacerbate the issues already being experienced by the Putting Things Right team.

**RESOLVED: The Committee reviewed the report, considered the next steps and, supported the continued prioritisation of work to ensure appropriate levels of compliance in line with Welsh Government expectations from April 2023.**

## **021/23 QUALITY STRATEGY IMPLEMENTATION PLAN**

Jonathan Turnbull-Ross explained that the report outlined progress in developing the plan which was to support the realisation of the Quality Strategy 2021-24.

He added that progress against the implementation plan had been particularly challenged due to operational demands resulting from the pandemic, pandemic recovery, winter and more recently, industrial action.

He advised the Committee that implementation remained a priority for delivery over 2023/24, noting that several areas of the plan required investment in resources to achieve success.

He asked the Committee to consider the positive progress of the Trust's position against the Welsh Government road map for the Act implementation previously reported,

including exemplar content and ideas produced by Trust staff now being adopted at NHS Wales level.

Comments:

The Committee held a discussion which considered the role of the Patient Experience Community Involvement team in terms of integrating the Citizens of Wales' voice and engaging with people to ensure inclusivity. Liam Williams stressed the importance of ensuring the Trust was coordinating and sharing information reciprocally with the relevant clinical networks going forward.

The Committee queried if there was progress in terms of embedding the quality strategy across the Trust. Jonathan Turnbull- Ross explained there had been reasonable progress adding that the infrastructure to improve quality was developing satisfactorily.

**RESOLVED: The Committee noted the progress against the implementation action plan.**

## **022/23 QUALITY IMPACT ASSESSMENT GOVERNANCE**

Liam Williams explained that the duty of quality required each organisation to provide palpable 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 were Quality Impact Assessments (QIA).

The Trust has developed a QIA Framework and template, which was agreed at the Clinical Quality Governance Group (CQGG) in November 2022. The framework and template have been updated to reflect the new Health Care Standards 2023.

Roles and responsibilities were outlined in the Trust's QIA framework which identified governance and assurance processes for the development, accountability, and monitoring of QIAs.

The CQGG will provide the necessary scrutiny and governance to ensure that the appropriate QIA process was carried out for all new and existing Trust wide service redesign/transformation, projects and cost improvements.

Comments:

Members queried how QIAs would relate to the Trust's socio-economic duty and potentially any Equality Impact Assessments (EQIA). Liam Williams explained there was a requirement to keep QIAs separate from EQIAs and outlined the reasoning behind it. He added they were separate processes with separate expectations. Trish Mills added that the EQIA had been revised to merge different impact assessments and this will include information relating to socio-economic and well-being of future generations.

The Committee recognised that going forward it would provide an evidence base of the decisions being made.

Members sought assurance that the appropriate training would be provided to staff. Jonathan Turnbull-Ross gave assurance that the relevant instinctive and user friendly training would be given and widely available. Wendy Herbert informed Members that WAST had been acknowledged as the exemplar in the QIA process across Wales with Health Board colleagues taking an interest in WAST's progress.

**RESOLVED: The report was noted.**

#### **023/23 CLINICAL AUDIT PLAN 2023/24**

Andy Swinburn reminded the Committee that 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.

Duncan Robertson explained that the clinical audit plan had been scrutinised and monitored by the Clinical Intelligence & Assurance Group (CIAG), and the action plan noted at Clinical Directorate Business meetings. The Clinical Intelligence and Assurance Team (CIAT) continued to review and improve on the quality of the data available.

The clinical audit plan includes three main sections:

- a) Clinical audits that have been agreed by the CIAG to progress, considering the potential of the relevant ePCR data being available during the financial year.
- b) Suggested topics that need further development before progressing, e.g., specifying the requirements to be audited.
- c) Topics that require further consideration of their need, available data, and resources prior to inclusion in the plan.

He added that clinical audits may be linked into any themes arising from the concerns team and also for future audits to be linked in with other teams to present a wider range of audit activity going forward. Furthermore it was noted that this plan would be taken to the Audit Committee for assurance.

Comments:

The Committee welcomed the report and were pleased to see a more formal structured approach to clinical audits and looked forward to receiving any future feedback.

**RESOLVED: The Clinical Audit Plan 2023/24 was approved.**

#### **024/23 UPDATE ON MORTALITY REVIEWS**

Mike Jenkins informed the Committee that Welsh Government required all Health Boards and Trusts, including WAST, to undertake Mortality Reviews. In 2015 WAST Executive Medical Director supported the development of a Trust Mortality Review Group. The purpose of this group was to provide assurance that the care provided to

patients who suffered a cardiac arrest between point of contact (999 call) and arrival at hospital, was in line with resuscitation guidelines.

This method of undertaking mortality reviews identified the necessity to download Corpuls Records, this significantly increased the time taken to complete a review resulting in an increasing backlog of records awaiting a review. By January 2022 there were 740 mortality reviews waiting for review.

Following recommendations from the Delivery Unit, the Trust carried out a 10% review of the mortality review backlog. The date range of incidents reviewed were from May 2020 through to February 2022 (introduction of the electronic Patient Clinical Record). All incidents related to patients who had suffered a cardiac arrest in WAST care. Of the 74 cases reviewed several themes arose which included; poor documentation and Inappropriate Cardiopulmonary Resuscitation (CPR) due to the presence of Do Not Attempt CPR.

As part of the approach to mitigate the recommendations from the Delivery Unit, the Trust has introduced the role of Senior Paramedic (SP) with the aim of promoting clinical excellence. SP's accompanied Emergency Ambulance crew during their shift and fed back on several areas including quality of care, completions of documentation and airway logs. It has been noted that since the introduction of SP's the documentation quality has improved significantly.

Comments:

Members questioned if the sample of 10% was random or whether any criteria had been applied. Mike Jenkins commented it was purely a 10% random sample.

It was queried if any of the learning had already happened, i.e., was there a connection to Datix. As part of the mortality review, Mike Jenkins explained for the 10%, these were not Datix related; however, the Trust had already completed the learning process for staff if it was on Datix.

Liam Williams added that going forward with the introduction of SPs the Trust will have a richer understanding of any future deep dives on mortality reviews, and also more quality data can be captured from ePCRs. He further commented that having the SP's in place and the Cymru High Acuity Response (CHARU) paramedics was an excellent enabler to provide expertise to other staff.

**RESOLVED: The Committee received the report and noted it for assurance.**

## **025/23 COMMITTEE CYCLE OF BUSINESS**

Trish Mills in updating the Committee advised that the cycle had been developed with direct correlation to the duties in the Committee's terms of reference. This allows the Committee to review the appropriateness of the proposed reports and their frequency.

The cycle for the Committee is a maturing document which will grow organically over the next 12 months.

The cycle of business will be used to build the quarterly Committee agenda. A monitoring report will also be provided to each meeting under the consent item, and where issues of escalation were required i.e., where cycle needs to be adjusted or reporting was overdue, these will be drawn out in a short paper by the Board Secretary.

**RESOLVED: The Committee:**

**(1) Reviewed and approved the 2023-24 cycle of business; and**

**(2) Noted the cycle of business monitoring document.**

## **026/23 INTERNAL AUDIT TRACKER UPDATE AND INTERNAL AUDITS**

Trish Mills advised the Committee that the audit tracker was currently undergoing a full review and will be available for the next Audit Committee for scrutiny. In addition, Internal Audit were undertaking their annual review of the tracker.

The Committee recognised some audit recommendation had surpassed their revised date, however within the narrative there was an explanation to mitigate this.

In terms of the Audit Wales tab, those marked as overdue were either complete or close to completion.

Comments:

Liam Williams updated the Committee on the work being undertaken to respond to the recommendations as outlined in the Infection Prevention and Control audit. He added that a large focus of WAST was to consider the use of Personal Protective Equipment both now and for any future pandemic.

The Committee held a discussion in which they considered how to strengthen management responses to audits, especially in relation to the Immediate Release Directions audit in which a collaborative approach with Health Boards was required.

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

## **027/23 REFLECTIONS & SUMMARY OF DECISIONS & ACTIONS**

- The supportive challenge had been relay useful.
- Always welcome the lived experience, especially the patient/staff stories.
- Assured by the update on the Duty of Candour/Quality.
- There has been an improvement in the report writing making them more streamlined.

### **Actions**

- Deep dive on red calls in rural areas to be included Operations quarterly report.
- Further conversation to be taken offline regarding the changing role of CFR's and discussed at the People and Culture Committee going forward.

- Agreed that a meeting be coordinated with Quest and People and Culture Committee to discuss the situation regarding the challenges faced by the PTR team.
- PEGI reports would be received on a 6 monthly basis.
- Quality strategy, important to get the connections across our networks, right, and make sure that The Citizens' Voice is used to inform what we are doing. So part of the action is to make sure that we do capture that and we move forward implementing actions as necessary.

**028/23 KEY MESSAGES FOR BOARD**

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

**029/23 ANY OTHER BUSINESS**

None.

**Date of Next meeting: 10 August 2023**

**Meeting concluded at 17:25**

DRAFT

**ACTION LOG - UPDATE FOR MAY 2023**  
**QUEST COMMITTEE**

Minute Ref	Date	Agenda Item	Action Note	Responsible	Due Date	Progress/Comment	Status
004/23a	9 February 2023	Patient safety report	Backlog of National Reportable Incidents; the Committee requested an update to be given at the next meeting.	Liam Williams	10 August 2023	Update for 11 May 2023 Meeting has been held with NHS Wales Executive who have received assurance from Health Boards that the back log would be cleared by April 30th. The next all-Wales meeting will confirm the position. <b>Defer until 10 August 2023</b>	Open
14/23	11 May 2023	Operations Update	Red calls Rural Response Deep Dive - response and impact on patients plan to build into future reports, Agreed to include details within the MIOPR	Rachel Marsh	10 August 2023	Update for 10 August 2023 See Item 7.1 (Presentation)	Open
16/23	11 May 2023	MIQPR	Agreed that a meeting be coordinated with quest and PCC to discuss the situation regarding the challenges faced by the PTR team	Liam Williams	10 August 2023	Update for 10 August 2023 Verbal update to be provided at the meeting	Open
021/23	11 May 2023	Quality Strategy Progress report	Quality strategy, important to get the Connections across our networks, right, and ensure The Citizens' Voice is used to inform what we are doing. Part of the action is to make sure that we do capture that and we move forward implementing actions as necessary.	Jonathan Turnbull-Ross	10 August 2023	Update for 10 August 2023 The Quality & Performance Management Steering Group is continuing to work on the Quality Management System, including the digital requirements/build for the always on system. Engagement continues to take place with NHS Executive colleagues on integration and 'sharing' of data and information flow across system partners.	Open



## QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE HIGHLIGHT REPORT TO BOARD

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

<b>Trust Board Meeting Date</b>	25 May 2023
<b>Committee Meeting Date</b>	11 May 2023
<b>Chair</b>	Bethan Evans

### KEY ESCALATION AND DISCUSSION POINTS

#### ALERT

(Alert the Board to areas of attention)

1. Whilst there were improvements in handover delays with 23,000 hours lost in April, this was still far in excess of what was acceptable, as was 2,700 patients waiting more than 4 hours to be seen in an Emergency Department, and **this continues to present patient safety risks and extended waits in the community**. The patient story, told by Keith Jones, Community First Responder (CFR) further illustrated this.

The Committee is aware of the actions being taken by WAST to mitigate harm and of the escalations and actions in the system, including targets introduced by Welsh Government to reduce handover delays in 2023/24. Progress against these actions is a focus at each Public Board meeting, however a continued high number of concerns raised, immediate release direction refusals, and incidents linked to timeliness of response demonstrates that more pace is required to address the issue at a system and strategic level.

The very poor patient experience and risk of continued harm ran through most of the items discussed at this meeting and is the focus of **risks 223 and 224**. The detail of the actions of system partners remains in the BAF however they are now included within a commentary box rather than within the 'actions' section. This allows the Board to focus on scrutiny of the actions which the Trust is taking, whilst noting the context within which these risks remain at a score of 25. The Committee were of the view that whilst the risk score had not moved for some time there has been evolution of the actions and not a standing still of mitigations.

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



2. There have not been improvements in the **Putting Things Right response times**, despite additional resources being provided, which highlights the increasing volumes and complexity of concerns being raised. The Committee voiced their concerns over the effect of this, not only on timeliness of responses but more particularly on the teams who deal with the backlog, the inability to improve response rates, and the very difficult nature of the work. The duty of candour will place additional strains on these colleagues. Whilst changes to the approach are in train, a joint session for the People and Culture Committee and this Committee was proposed, to explore this further in terms of the impact on our Patients and Staff alike and this session will be scoped.

## ADVISE

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

3. 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 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. The CFR team have supported Keith throughout and the CFR's end of shift form captures any potential debrief requirements. The CFR team follow up on any support they need, any links with CFR champions, occupational health, or TRiM referrals. The employee assistance programme is also now being offered to CFRs. Members were aware however that this anguish would not have been experienced had the handover delays not been so extreme.

The People and Culture Committee will look at the changing face of our volunteers at a forthcoming meeting. Members thanked Keith and the patient's family for sharing this story with them.

4. The **Quality Strategy** implementation plan, developed to support the delivery of the Quality Strategy 2021-2024 was reviewed. Whilst progress against the plan has been slow due to resourcing challenges, as was raised in the Committee's last AAA report, there has been accelerated progress in the latter half of 2022/23 in preparation for the Health and Care (Quality and Engagement) (Wales) Act 2020. This remains a priority of the Committee.
5. 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 will be updated quarterly with oversight by this Committee. This supports recommendations in the Audit Wales Clinical Governance Review 2022.
6. The Committee received the quarterly **Operational Update** as a standing agenda item. Improvements in handover at Cardiff and the Vale University Health Board were noted as was the adoption of that learning to other hospital sites such as the Princess of Wales Hospital. In considering the improvement seen in handover delays in some areas, Members queried whether or not this information could be triangulated; i.e. in comparing with other data to better



understand the reasons behind these improvements; e.g. how did improvements in handover delays correspond with demand levels at that time. Officers will consider this request and feedback will be provided to Committee in due course.

Further, and in discussing the ongoing deep dive of Red calls, Members requested that this review incorporates a focus on how this plays out in more rural areas. This will be considered whilst at the same time accepting the limitations and challenges presented by the significantly lower numbers in rural areas.

7. The new **cycle of business** was approved by Members, who welcomed the structure this will provide in terms of managing the business of the Committee over the next year.
8. Members' **reflections** on the meeting included the 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.

## ASSURE

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

9. 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 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 reported previously to QUEST, 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.
10. 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.
11. The Health and Care Standards (2015) have now changed to **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.
12. 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 Clinical Quality



Governance Group agreed an approach to the backlog which saw a sample of 10% being reviewed spanning May 2020 to February 2022 when ePCR was introduced. Cases reviewed identified requiring learning and feedback to staff and one was recognised as a national reportable incident. One of the common themes from the reviews is the quality of documentation, with feedback and learning provided by the Senior Paramedics having improved this. 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.

13. The Committee receives assurance reporting by way of the **Monthly Integrated Performance Report** (MIQPR) for March/April and the **Q4 Patient Safety Highlight Report**. It was recognised that the duplication and overlap in the reports is being addressed and future reports will reflect a more streamlined approach. The MIQPR had been discussed in detail at Trust Board shortly before this meeting therefore the Committee focused on and noted the 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; and a continued upward trend in Coroner's requests for information. Two regulation 28 notices have been received and responses submitted within the prescribed timescales.

Improvement actions are still under review to ensure the Electronic Patient Record (ePCR) data is correctly inputted to ensure accurate reporting on the various clinical bundles. Call to door times for STEMI/stroke will be in place by Q2 and the spotlights on the clinical indicators will be a regular feature at future meetings.

The Trust Board will note the escalations made in this report concerning continued patient harm as a result of prolonged handover delays.

14. The **Patient Experience and Community Involvement (PECI) Q4 report** was received providing positive assurance we are meeting with and consulting with the public and out stakeholders, including with Llais (the Citizens Voice Body).
15. The **Audit tracker** was reviewed, noting some overdue actions with revised dates, some of which are partially complete. Progress on actions has been affected by the tremendous pressures faced over the last quarter and two consecutive bank holidays. The Committee noted there is a review of the tracker planned to go to the Audit Committee in September. 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. The Immediate Release Directions internal audit (reasonable assurance) was presented and the need for a collaborative approach to these was apparent. The Data Analysis internal audit (reasonable assurance) was also reviewed.

## 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. The theme of these risks arose throughout the agenda items discussed at this meeting and are part of the escalation section of this report.

**New Risks Identified:** Risks to the Trust's ability to implement the duty of quality and duty of candour was raised, and it was accepted that management would review early data that is being collected on this and changes to approach in dealing with concerns ahead of raising a formal risk.

COMMITTEE AGENDA FOR MEETING		
Feedback from Chair on escalations from Committee to Board in March	Operations Directorate Quarterly Report for Q4	Patient experience
Monthly Integrated Quality Performance Report	Patient Safety Report Q4 2022/23	Patient Safety Report Q4 2022/23
Patient Experience and Community Involvement Report Q4 2022/23	Risk Management and BAF	Duty of Quality and Duty of Candour Implementation
Quality Strategy Implementation Plan	Quality Impact Assessment Governance	Clinical Audit Plan 2023/24
Update on Mortality Reviews	Committee Cycle of Business 2023/24	Internal Audit Tracker and Audits (IPC review; Immediate Release Directions; Data Analysis)

COMMITTEE ATTENDANCE				
NAME	11 MAY 2023	10 AUGUST 2023	9 NOVEMBER 2023	8 FEBRUARY 2024
Bethan Evans				
Kevin Davies				
Paul Hollard				
Ceri Jackson				
Liam Williams				
Andy Swinburn				
Lee Brooks	Steve Clinton			
Leanne Smith	Jon Hopkins			
Rachel Marsh				
Trish Mills				
Mark Marsden				
Hugh Parry				
Ian James				

	Attended
	Deputy attended
	Apologies received
	No longer member



## OPERATIONS DIRECTORATE QUARTERLY REPORT FOR COMMITTEES 2023-24 Q1 (Apr – Jun 2023)

### National Operations & Support

#### Challenges

##### EPRR Manchester Arena Inquiry Report (MAI)

The EPRR team has now recruited into the Operations Support Manager (MAI) role. Since this member of staff has been in post the 149 recommendations within Volume 2 of the report have been reviewed. WAST is currently progressing 71 of the recommendations, as these recommendations have been assessed as being relevant to the Trust. WAST is working closely with a number of groups to ensure the recommendations are implemented within the Trust; this includes UK health subgroups who report into Department of Health and Social Care, subgroup of the UK National Director of Operations Group (NDOG), subgroup of the Joint Emergency Services Group (JESG) within Wales, all four Local Resilience Forums (LRFs) within Wales and the UK Heads of EPRR group.

#### IMTP

##### EPRR

A programme of work is in place across EPRR to quantify and improve our culture, and make our work environment the best it can possibly be; to date, this has included allyship training, drop in EDI sessions and manager training. In order to raise awareness of the functionality of HART and promote opportunities, two open days for HART have taken place in June, including a women's open day.

#### General Update

##### EPRR

**Exercise Dollhouse.** Exercise Dollhouse is a Tier One national Counter Terrorism exercise that is being undertaken in July. This exercise will allow the Trust to test and exercise our multiagency response to a Manchester Arena style incident. We will have members of staff from our frontline and from our specialist assets taking part in the exercise. The exercise is affording the Trust an opportunity to test the new patient triage system, which is a direct outcome from the Manchester Arena Inquiry recommendations.

**Annual Report.** The EPRR annual report is being submitted to the Finance and Performance Committee in July. This report provides Committee with a strategic update on the main areas of work that the Trust's EPRR team are undertaking. Content includes the Review of the Civil Contingencies in Wales report where the team has been working with partners, including Welsh Government, to look at the future of Civil Contingencies within Wales. The UK Resilience Framework which describes the vision the UK government has for Civil Contingencies. The report highlights the annual HART/SORT Key Performance Indicators Report and the Welsh Government Annual Emergency Planning Report that have been submitted to Welsh Government and give assurance on the Trust's preparedness for and ability to respond to incidents. The report describes the updates that have

been made to the Trust Incident Response Plan and the areas that will be updated within the plan. Lastly the report introduces the intension to review the Trust's business continuity structures with the aim to strengthen business continuity within the organisation.

## **Volunteering**

A grant of £315,000 across two years has been secured from NHS Charities Together. This funding will be used to develop a Community Welfare Responder role within phase one of the Connected Support Cymru project. An adaptation form will be submitted to NHSCT with slight amendments to proposed spends.

Roll-out of analgesia (paracetamol and Pentrox) to CFR volunteers is on track. All volunteer training has now been completed and volunteers are able to go live within their respective locality.

Community First Responder numbers are currently around 600 volunteers. The number of active CFRs is currently circa 450. The newly appointed Support Officer (Compliance) is working with colleagues to ensure swift re-activation. However, Volunteer Car Service recruitment has remained flat during 2023. The current recruitment for the Operations Manager (VCS) post will develop this service and grow VCS volunteers by 25% across Q2-4.

## **Resourcing & EMS Coordination**

### **Challenges**

#### **EMSC**

Recruitment and Retention within EMS Coordination remains a concern with the attrition rate for the rolling 12-month period (July 22 to June 23) at 17.54% peaking at 24.16% in September 22 and remaining above 22% until May 23. This attrition figure only relates to external attrition and does not account for internal moves to other departments, which account for a further 31 staff moves during the same period. Significant recruitment initiatives have been implemented since September 2022 with 100 staff being recruited in the last 12 months (29% of the total workforce for EMSC). Despite this we continue to see withdrawals during the recruitment process, during induction and during training which further impacts our establishment position. Workforce plans are in place for the year based on our attrition rate, however due to the 3-month lead in time for recruitment and 1 month notice period for these staff groups we are often in an under-established position. Intentions to recruit to levels above attrition rates have not been realised due to high levels of attrition, withdrawals from cohorts and new recruits being unable to meet the appropriate standard leading to redeployment and/or resignation. This continues to be an area of focus but remains a risk and challenge.

#### **Concerns**

The workload for the Operations Quality Concerns Team remains high at 257 outstanding tasks. This is however a reduction from 283 at end of Q4. The Operations Quality Team continues to work closely with the Putting Things Right (PTR) Team to prioritise work to meet deadlines and requests. There continues to be sustained improvement in the status of outstanding concerns investigations, with 68% of concerns within the agreed timeframe to return to PTR. The outstanding coroner statements remain high at 29, however, 7 of these have been delegated to wider Ops to complete and 17 remain unallocated. It is anticipated that more outstanding statements will be delegated outside of Operations Quality and EMS Coordination in Q2.

## **Resourcing**

The workload for the Resourcing function remains high, although abstraction trajectory (sickness) is reducing across ADO portfolios. Abstractions overall remain above funded relief capacity. Operations establishment (vacancies) and skill mix also a contributing factor to production. This in turn reduces capacity within the resource function to develop and improve aligned with IMTP ambitions.

Resource team are pivotal in the trust financial savings plan for pay and workload for the team is envisaged to increase further whilst overseeing the overtime considerations process aligned to the financial savings plan, with the introduction of daily overtime time considerations meetings.

## **IMTP**

### **EMSC**

On 25<sup>th</sup> April 2023 WAST implemented a new national Control Room Solution for Integrated Communications Control Systems (ICCS). The Control Room Solution (CRS) project is a UK wide programme, overseen by the UK Ambulance Radio Programme (ARP) which started in 2018 to replace the current DS2000 ICCS with a new solution developed by software designer Frequentis and known as LifeX. The Emergency Services Network (ESN) will replace the current Airwave network and once fully built all Emergency Services in the UK will transition onto ESN. LifeX is compatible with both the current Airwave network and ESN. Transition to the LifeX system now is a step towards full ESN transition.

The new Life X system is now in operation across all EMS Coordination Centres (ECCs), NEPTS Journey Coordination Centres (JCC) as well as Emergency Medical Retrieval and Transfer Service (EMRTS) Critical Care Hub (ECCH). Following extensive development, testing and training collaboratively across multiple directorates and organisations WAST was the first large scale Ambulance Service to implement the new LifeX solution sharing knowledge and strategic approaches with other UK ambulance services to support future transitions successfully.

## **Resourcing**

Resourcing continues to support discussions and data requests in support of “inverting the triangle”, EMT3 expansion, CHARU expansion, APP expansion and subsequent skill mix and rightsizing requirements aligned to funding.

Engagement with trade union partners on 6-week relief planning continues with an options appraisal shared with partners and regular meetings taking place to work through a mutually agreeable way forward.

## **General Update**

### **MPDS Audits**

WAST is required to reaccredit with the International Academy of Emergency Dispatch (IAED) every 3 years, and this is due in September 2023. To do this, the Trust must follow the reaccreditation process set out by the IAED. Work is ongoing to meet deadlines and the required standards to reaccredit as a recognised centre of excellence.

## Emergency Medical Service

### Challenges

#### **Industrial Action and WAST Non-Pay Annex**

Three of our four unions have voted to accept the revised pay offer from Welsh Government in response to the dispute over pay and conditions which has led to the industrial action which started last year. The RCN has rejected the offer, and two industrial action days took place on 6<sup>th</sup> and 7<sup>th</sup> June. The industrial action planning team reconvened and planned sufficient mitigation across the Trust. Consequently, there were no adverse impacts on patient safety across these two days. The further two days of industrial action at the time of preparing this report are expected not to take place as discussions continue.

Relevant unions have also accepted the terms of the WAST specific non pay annex as part of the pay dispute and specific action relating to EMS: -

- **Start and End of Shift arrangements to reduce overruns** – this amendment to the Standard Operating Procedure sets out that relieving off going crews is to be a high priority. EMS and UCS crews in the last hour of their shift that are not already deployed to an incident will begin to return to base as a matter of course. The nature of calls they can be despatched to in this last hour is also set out, thus reducing the likelihood of an overrun occurring. Two pilot schemes for handover crews at Morriston Hospital and Ysbyty Glan Clwyd will also commence. We have agreed this position for so long as more than 9,000 hours a month are lost to extended handover delays as these delays inhibit our people from ending work on time.

#### **WAST Facilitation of Extended Transfer of Care**

As reported at the WAST Trust Board in March, the Executive Director of Operations raised concerns focussed on two risks being exacerbated by a worsening position on the time taken for transfer of care at emergency departments with Chief Operating Officers. At the face-to-face COO Peer Group meeting in April, the Executive Director of Operations spoke about several issues emanating because of extended transfer of care times (including WAST staff exposure to diesel fumes) and informed COO colleagues that local management teams would be mobilised to discuss with local emergency department teams. Local WAST management teams were mobilised on the issues of ED Swaps (the practice of one patient taken into the ED provided one patient is taken out and returned home – discharge transport), the use of WAST equipment inside the ED and the use of WAST staff for the purpose of portering. The purpose being to achieve an improved transfer of care time so that emergency crews can respond to undifferentiated patients at greatest clinical risk in the community. Following local engagement, the Executive Director of Operations wrote again to health board colleagues in June to share the dates of the cessation of these issues. The response across the system has been mixed. There has been no response from some health boards, where others have lodged reports with external partners without engaging with the author of correspondence.

WAST has never supported its staff being used for portering and neither have health boards engaged WAST on pre-hospital clinicians undertaking extended duties following arrival at the emergency department. WAST has facilitated some patients requiring diagnostics by allowing the pre-hospital ambulance paramedic/EMT to provide clinical escort to a

diagnostic test with a hospital porter, particularly where the diagnostic is time critical to the patient outcome. With regret, this position has been taken advantage of, and it appears that the pathway has systematised use of WAST staff not only to provide clinical escort for a broader range of diagnostic tests, but also to fulfil the portering role. It is of concern that transfer of care improvements at some hospital sites appear to depend on this being done by WAST, without engaging us first or fully assessing the broader consequences. This is said in the context of feedback that WAST not undertaking these in-hospital tasks will extend the transfer of care time.

In coming to this position, the following points have also been considered:

- WAST is not licensed for systematic care delivery inside the hospital and while the Welsh Risk Pool would likely support WAST where there was an exceptional clinical requirement for us to act, the current situation is not exceptional any longer.
- We must also be cognisant of the recent challenging period of industrial action. The use of WAST staff in a way for which they are not trained or commissioned specifically creates bad will and this has come through from our people during picket line visits by members of the WAST Executive. The WAST staff experience has been negatively impacted due to hospital handover delays including prolonged exposure to vehicle diesel fumes outside the emergency department (for which health boards have been asked to consider the health and safety implications and mitigations that can be put in place), late shift finishes, delayed access to periods of rest, and skill degradation as patient contact reduces for which there is additional clinical risk.
- From a safeguarding perspective there are two considerations; first for the patient waiting outside the emergency department and secondly, for the patient seeking WAST care but to whom we are unable to respond. As already stated, the latter patient is at highest risk as no healthcare is being made available to them and so action that promotes an earlier transfer of care for patients from an ambulance would improve the quality, safety, and safeguarding risks for all patients within our care, or to whom we have a duty of care. It is important to note that an inhibited emergency ambulance response to patients with acute medical conditions has led to self-conveyance and patients dying en-route, in hospital car parks, or waiting for ambulance attendance. Not to mention the unknown consequences for patients we do not attend either due to the Clinical Safety Plan or those who cancel the ambulance in favour of making their own arrangements.
- The ratio of two WAST pre-hospital clinicians to one patient demonstrates poor value for money. In staff cost alone, in December 2022 and March 2023, more than £4.5m of staff cost was lost to extended transfer of care times.

## IMTP

### EMT2/EMT 3

There are currently 55 WTE staff (64 people) who are Band 5 out of a current total EMT funded establishment of around 660 WTEs. At present, the EMT3 role is a closed role which means that as these staff leave their position, they are not replaced on a like for like basis. We have previously given a commitment to change this as part of the agreement on the UCA role (later known as ACA2). We have been in discussion with lead Trade Union Partner reps over the last few months to discuss how this could be taken forward, and a proposal has been shaped through these positive and progressive collective discussions.

In broad terms, the proposal we have been working closely with our Trade Union partners is:

- EMT3s will continue to be recognised as a valued and important part of the workforce
- The EMT3 role will be part of a broader career offer and opportunity for staff, continuing to strengthen and grow the career structure we offer for our people beyond other roles we have added in the last couple of years such as Senior Paramedics
- We will initially grow the number of EMT3s from the current number to a total of around 255 WTEs. This will mean that around 35% (a little more than 1 in 3) of the technician workforce will then be an EMT3 at band 5.

A Task and Finish Group has been established to take forward this piece of work which has focused on developing: -

- Scope of Practice for the EMT3 role
- Recruitment and selection process
- Frequently Asked Questions

The position currently is that Trade Union Partners have declared that they intend to consult with their members on the package and have offered to advise Management on the associated timelines. Unfortunately, that does push back the selection process with the first cohort scheduled to enter training in October 23.

## General Update

### Mobile Data Vehicle Solution

Emergency Services Mobile Communication Programme (ESMCP) is a Home Office led cross-government programme delivering a new critical communication system for Great Britain's emergency responders; the Emergency Services Network (ESN).

ESN will transmit fast, safe and secure voice, video and data across the 4G network and give first responders immediate access to life-saving data, images and information in live situations and emergencies. It will provide total end to end critical communication system for UK Ambulance Services; the Ambulance Radio Programme (ARP) are working with Trusts to deliver the total solution.

A project Board has been established since February 2022 will oversee the delivery of the Mobile Data Vehicle Solution (MDVS) project in accordance with the agreed project documentation and plans.

On the 29<sup>th</sup> July 2023 the Project Board sanctioned the commencement the MDVS Pilot is due to begin w/c 3<sup>rd</sup> July 2023 using 3 EMS vehicles in North Wales.

## Ambulance Care

### Challenges

#### **Performance Standards Refresh**

The service has implemented a refreshed set of performance standards from April 23. These were agreed in conjunction with the commissioner and all Health Boards. The new standards reflect our funded capacity much more accurately, in particular on oncology transport where ORH, in the NEPTS demand and Capacity review, identified a funding gap equivalent to 148 WTE .

To support the roll out of the new standards, an implementation plan has been developed focusing on improving process, data, reporting, performance management and most importantly the culture of the service.

### IMTP

#### **NEPTS Eligibility**

A review of how the service applies national eligibility criteria has begun and a proposal has been developed for an improved process, which should improve patient experience and reduce late notice cancellations of transport. These improvements will be supported by a review of alternative options available to patients across Wales.

#### **Quality Assurance**

The service continues to drive through the quality assurance agenda as per the IMTP. A revised patient survey is now live with QR codes to link to it being rolled out across the NEPTS fleet and hospital based estate. The results of the survey support the service's move to a balanced scorecard of reporting on service delivery. They also inform the NEPTS QA dashboard, elements of which are reported onward to trust committees.

#### **CAD Upgrade**

Following the upgrade of the NEPTS CAD in Quarter 4 22/23, work has begun on implementing the additional functionality that the new hosted platform allows. The first step on this journey will be the launch of a 'Patient Zone' which will allow patients to initially check and cancel journeys as well as see online where their transport is. The next phase of this rollout will be online booking functionality. It is anticipated that the patient zone will be active in late 2023.

### General Update

#### **Urgent Care Service Strategic Review**

The service has been conducting a review of the Urgent Care Service, focusing on identifying the current case mix for the service and developing options for a tighter case mix in the future.

The review has been supported by modelling from ORH and the final meeting of the steering group is planned for July 2023. The outcomes of the review, once agreed, will then be discussed with colleagues within their team prior to being presented for formal approval.

## Integrated Care

### Challenges

#### 111 SALUS Operations Implementation

The teams have started to prepare to implement SALUS into the 111 operation. Following product specification testing scheduled in July we can begin to train trainers and later staff. There are several groups within WAST and with the 111 Programme team to understand more about the new bespoke system and to prepare for its implementation in November.

### IMTP

#### CSD Community Welfare Responder / Connected Support Cymru

The CSD Operations and Clinical team have been busy working on supporting the pilot scheme for the Community Welfare Responder and have created new processes and working practices to enable the efficient use of the available St John CWR crews. Positive results have been returned where the crews have been able to be on scene and take observations for the CSD Clinicians, enabling consult and close, protection of vulnerable callers, welfare checks and calling on failed contacts. The pilot continues for several more weeks and more positive results are expected.

#### Red Review in CSD

The existing process of remotely reviewing calls continues and the SOP has been updated to refresh and make the process more robust. This will also include tracking to identify where the red call has been reviewed but was not able to be downgraded allowing for improved reporting.

### General Update

#### Industrial Activity in 111 and CSD

The Royal College of Nursing staged two days of action in June. Collaborative discussions took place with the RCN industrial action management team on derogations and cover for the two days which allowed for measured action in WAST with little or no impact on service delivery across the two days. Both days were managed within the Integrated Care leadership team without need for wider operational structures.



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<b>AGENDA ITEM No</b>	7
<b>OPEN or CLOSED</b>	OPEN
<b>No of ANNEXES ATTACHED</b>	1

**MONTHLY INTEGRATED QUALITY & PERFORMANCE DASHBOARD –  
June/July 2023**

<b>MEETING</b>	Quality Safety Patient Experience Committee (QUEST)
<b>DATE</b>	10 <sup>th</sup> August 2023
<b>EXECUTIVE</b>	Rachel Marsh – Executive Director of Strategy, Planning & Performance
<b>AUTHOR</b>	Hugh Bennett – Assistant Director of Commissioning & Performance Mark Thomas – Commissioning & Performance Manager
<b>CONTACT</b>	<a href="mailto:Hugh.bennett2@wales.nhs.uk">Hugh.bennett2@wales.nhs.uk</a> <a href="mailto:Mark.Thomas12@wales.nhs.uk">Mark.Thomas12@wales.nhs.uk</a>

**EXECUTIVE SUMMARY**

The purpose of this report is to provide senior decision makers in the Trust with an integrated dashboard (Our Patients, Our People, Value and Partnerships/System Contribution) focused on the “vital few” key metrics. This report is for **June/July 2023**. The report puts forward a revised set of metrics for 2023/24 for agreement.

The indicators used at this high-level show an easing of system pressure, in particular, handover lost hours and therefore improved quality and performance for the Emergency Medical Service (EMS), but the operating context remains very challenging. 111 is showing continuous improvement throughout 2023 with abandonment rates and call answer times achieving the best performance since February 2022. Ambulance Care, in particular, Non-Emergency Patient Transport Service’s (NEPTS) performance has been stable, but with demand increasing to pre-Covid levels, performance has dipped slightly over the past two months. Overall the picture remains one in which the Trust can demonstrate clear improvement over things it controls, but a more mixed picture where there are system dependencies e.g. handover lost hours.

**RECOMMENDATION**

The Committee is asked to: -

- **Consider** the June/July 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.
- **Agree** the new metrics for 2023/24.

## 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 **June/July 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 will be 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.

## ASSESSMENT

### Our Patients – Quality, Safety and Patient Experience

5. **Call answering** (safety): the speed at which the Trust is able to answer a 999 or 111 call is a key patient safety measure.
6. **999** call answering times, having been challenging across the winter, have now been on target for the last 7 months, although the 95<sup>th</sup> percentile did worsen in July 2023.
7. **111 call answering is improving**, with the call abandonment target of 5% being achieved in July (4.1%) and 62.2% of calls being answered within 60 seconds, although this remains significantly off target (95%). Negotiations with commissioners have indicated that funding is available for 198 call handlers and recruitment has been underway to secure this number, but there remain a number of vacancies. The number of vacancies will increase as we move through the year with limited opportunity to recruit as a result of the SALUS implementation and urgent consideration is being given internally to how this risk can be mitigated. It has recently been agreed to recruit another cohort in November, with the aim of

delivering the 198 level. Further work is required to reduce capacity lost through sickness absence (particular improvement now being seen in call handlers), aligning capacity with demand and improving the efficient use of resource. A priority is now re-rostering 111, which is dependent on commissioners initiating the procurement process (currently out to tender).

8. **111 Clinical response:** the Trust continues to see achievement of the clinical call back time target for the highest priority 111 calls (P1CT – 99.2%) , while the P2 and P3 call back times also achieved the 90% performance target in July 2023, with the respective figures for being 95% and 92.5%. Numbers of clinicians are now broadly at agreed establishment levels (recently agreed as 100 WTE).
9. **Ambulance Response** (safety / patient experience): the Red 8-minute response performance for July 2023 was 52.60%, a slight drop when compared to June 2023, and still below the 65% target. The Amber 1 median was 1 hour 7 minutes (ideal 18 minutes) and the Amber 1 95<sup>th</sup> percentile was 4 hours 46 minutes. These long response times have a direct impact on outcomes for many patients. Actions within the Trust’s control include:

#### Capacity:

- Recruitment: Confirmation has been received of further non recurrent funding in 2023/24 to support the 100 WTE staff recruited in 2022/23. Work will continue through the year to ensure that establishment remains at commissioned levels.
- Some additional funding has also been made available to pilot the new Connected Support Cymru service in partnership with St John Cymru.

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

- The Managing Attendance Programme continues, which includes seven work-streams. This has reduced overall sickness levels, with further work to reduce to 6% during 2023/24. There remain risks associated with delivery of this level of improvement.

#### Demand Management

- The increase in Clinical Support Desk capacity has meant that the Trust has been able to increase its consult and close rate, achieving 13.9% in June 2023, with an increased ambition of 17% in 2023/24 (quarter 4).

#### Red Improvement Actions

- The full roll out of the Cymru High Acuity Response Units (CHARUs). Recruitment and training is being undertaken at pace with the aim to fully populate the CHARU rosters keys (153 full time equivalents). The Trust is commissioned for 52 FTEs plus the Senior Paramedic contribution currently, so 89.5 FTEs will be required via an internal movement between the emergency ambulance roster and the CHARU rosters.

- Red review. This is being undertaken within additional resource, when possible, but ideally, as previously modelled, would require additional FTEs. A further request to model the balance between consult & close v red review is currently being actioned.
  - A more efficient response logic, which went live on 19 June 2023.
10. One of the key factors in relation to response times is the capacity lost to **handover outside Emergency Departments**. 19,118 hours were lost during July 2023, an increase compared to the 18,548 hours lost in June 2023. These levels remain so extreme that all the actions within the Trust's control cannot mitigate or offset this level of loss. 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. Immediate Release figures for July 2023 were: Red 139 accepted and 7 declined; and Amber 1 178 accepted and 338 declined.
  11. Modelling has indicated that red performance could improve by 7% to around 58% as a result of the CHARU implementation, red logic changes and a reduction to 15,000 lost hours. Further modelling is currently being undertaken to determine the further potential improvements in line with a reduction to 12,000 hours, an improvement to 6% sickness and the increase in consult and close rates.
  12. **Ambulance Care (formally NEPTS) (Patient Experience):** Oncology performance achieved the 70% target in June 2023 (69.6%). Discharge performance also declined slightly to 78% (target 90%). Overall demand for the service continues to increase, and in June 2023 demand was at levels not seen since 2019. The Trust has a comprehensive Ambulance Care Transformation Programme in place, which includes delivering a range of efficiencies and improvements, for example: improved procurement through the plurality model, aligning clinic patient ready times to ambulance availability, re-rostering (NET Centre and NEPTS transport) and addressing oncology performance.
  13. **National Reportable Incidents (NRIs) / Concerns Response:** The Trust reported 8 NRIs to the NHS Executive in June 2023, an increase of 2 from the 6 reported in May 2023; and 17 serious patient safety incidents were referred to health boards under the Joint Investigation Framework, which has now been adopted NHS Wales wide. In June 2023 complaint response times increased to 43%, although still failed to meet the 75% target with cases remaining complex. Reviews of lower graded concerns are being undertaken to ensure proportionate investigations are undertaken. The Trust has put more capacity into the Putting Things Right (PTR) team, which has had a positive impact for the Legal Team until periods of long-term sickness absence. The Concerns Administrators responding to patients and families continue to have lengthy and repeated calls due to protracted response times in the community, compounded by an inability to always respond in a timely manner to their concerns and questions. The Trust is concerned for the welfare of

the team, given the nature and volume of the PTR work across all functions and a number of supportive actions are progressing/planned for both the corporate team and EMS Coordination & Resourcing.

14. **Clinical outcomes:** The percentage of suspected stroke patients who are documented as receiving an appropriate stroke care bundle was 74.6% in June 2023, remaining below the 95% performance target. Work is ongoing to improve reporting and compliance through the ePCR system. The return to spontaneous circulation (ROSC) rate continued to increase to 22.2% in June 2023, the highest figure recorded by the Trust.

#### Our People (workforce resourcing, experience, and safety)

15. **Hours Produced:** The Trust produced 117,574 Ambulance Response unit hours in June 2023, a decrease from the 124,692 produced in May 2023. Emergency ambulance unit hours production (UHP) was 92% in June 2023, thus failing to achieve the 95% target. CHARU UHP also increased month on month to 139% in May (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.
16. **Response Abstractions:** EMS abstraction levels decreased to 34.02% in June 2023, but remaining above the 30% benchmark. An initial deep dive meeting has been held, with further work planned. EMS Response sickness abstractions stood at 8.47% in June 2023 (benchmark 5.99%).
17. **Trust sickness absence:** the Trust's overall sickness percentage was 7.51% in June 2023, a further improvement from the 7.60% recorded in May 2023. Actions within the IMTP concentrate on staff well-being with an aim to start to reduce this level.
18. **Staff training and PADRs:** PADR rates did not achieve the 85% target in June 2023 (73.14%), compliance for Statutory and Mandatory training increased slightly to 77.53%.

#### Finance and Value

19. **Financial Balance:** The reported outturn performance at Month 3 is a deficit of £33k, with a forecast to the yearend of breakeven.

#### Partnerships/ System Contribution

20. **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 13.9% in June 2023, close to the Trust's 2022/23 IMTP ambition of 15%.

21. The Trust **conveyed** 39.7% of patients to emergency departments in June 2023. This figure needs to be treated with caution as analysis shows that conveyance rates are linked to pressures within the system and the application of the Clinical Safety Plan (CSP), which will trigger the Trust being unable to send ambulances to lower acuity calls, with many patients cancelling the ambulance due to the long response times. In July 2023, 8,533 patients cancelled their ambulance, and the Trust was unable to send an ambulance due to application of CSP levels to approximately 308 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" and a stakeholder engagement process.

#### Summary

22. The indicators used at this high-level showed an easing of system pressure, in particular, handover lost hours and therefore improved quality and performance for the Emergency Medical Service (EMS) during June 2023. However, July 2023 shows signs of some of those pressures increasing slightly again, meaning the operating context remains very challenging. 111 is continuing to show improvement throughout 2023 with abandonment rates and call answer times achieving the best performance since February 2022. Ambulance Care, in particular, Non-Emergency Patient Transport Service's (NEPTS) performance has been stable, but with demand increasing to pre-Covid levels, performance has dipped slightly over the past two months. Overall the picture remains one in which the Trust can demonstrate clear improvement over things it controls, but a more mixed picture where there are system dependencies e.g. handover lost hours.

#### Review of metrics

23. Each year a review of Board level metrics is undertaken. A presentation was provided to Finance and Performance Committee in May 2023 setting out some proposed changes. These were discussed further at EMT and at a Board development meeting in June 2023 and again at Finance & Performance Committee this month. As a result of these discussions a number of changes have been made and the final set of metrics is set out in Appendix 2 attached to this report. A total of 43 metrics are proposed, which is a slight increase on those which have been reported this year.
24. At the Board development session, there was a discussion about further iterations and considerations. In particular, it was felt that it would be helpful to be able to pull out and visualise those metrics which linked specifically to our long-term ambition and the inverting the triangle strategy and some initial ideas were

presented which will be developed further. In addition, board members discussed the potential, over time, to develop a more tiered approach, with a smaller set of metrics at Board and a more detailed set for each of the sub committees. It was noted that the one set enabled a reduction in workload and also ensured that each sub-committee continued to review metrics in an integrated way. Further thinking will be undertaken through the year.

## RECOMMENDATIONS

The Committee is asked to: -

- **Consider** the June/July 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.
  
- Agree the new metrics for 2023/24.

REPORT APPROVAL ROUTE	
<b>Date</b>	<b>Meeting</b>
<b>09 August-23</b>	<b>Executive Management Team</b>
<b>10 August-23</b>	<b>QUEST</b>

REPORT APPENDICES
<b>Appendix 1 – Top Indicator Dashboard</b>
<b>Appendix 2 – Review of Board Level Metrics <a href="#">Appendix 2 Metrics Review FPC July 2023</a></b>

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

Welsh Ambulance Services NHS Trust

# Monthly Integrated Quality & Performance Report

June/July 2023

Annex 1 – Top Indicator Dashboard



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Gwasanaethau Ambiwylans Cymru  
Welsh Ambulance Services  
NHS Trust

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Annex 1 – Top Indicator Dashboard  
Version 1.0  
Released: June 2023

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by Commissioning & Performance Department

# Section 1: Monthly Indicators / Top Indicator Dashboard



Top Monthly Indicators	Target 2023/24	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	2 Year Trend	RAG
<b>Timeliness Indicators</b>															
NHS111 Call Handling Abandonment Rates	< 5%	13.3%	11.2%	14.8%	13.6%	49.5%	16.0%	14.9%	15.4%	11.8%	7.9%	3.8%	4.1%		G
111 Clinical Triage Call Back Time (P1)	90%	98.5%	97.9%	98.3%	97.2%	94.9%	99.0%	99.3%	98.5%	98.9%	98.9%	99.3%	99.2%		G
999 Call Answer Times 95th Percentile	95% in 00:00:06	00:36	00:52	01:03	01:11	01:34	00:03	00:03	00:06	00:03	00:03	00:15	N/A		A
NEPTS Call Answering	Improvement Trend	08:28	05:36	03:22	03:32	02:38	01:47	02:08	01:08	01:43	01:18	00:46	N/A		G
999 Red Response within 8 minutes	65%	50.7%	50.0%	48.0%	48.0%	39.5%	48.9%	50.9%	47.5%	53.0%	54.4%	54.6%	52.6%		R
999 Amber 1 Median	00:18	01:16	01:30	01:42	01:34	03:30	00:50	00:55	01:35	00:59	00:55	00:55	01:07		R
Oncology Journeys arriving within 45 mins and up to 15 minutes after appointment time	70%	73.1%	70.5%	71.3%	72.4%	71.7%	76.6%	75.5%	73.4%	76.5%	69.9%	69.6%	N/A		G
Discharge & Transfer journeys collected less than 60 minutes after booked time (NEPTS)	90%	86.0%	88.0%	85.0%	90.0%	90.0%	90.0%	78.5%	82.7%	82.2%	83.0%	78.0%	N/A		R
<b>Clinical Outcomes / Quality Indicators</b>															
Return of Spontaneous Circulation (ROSC)	Improvement Trend	-	-	-	15.9%	14.2%	17.8%	15.9%	14.0%	16.0%	20.7%	22.3%	N/A		A
Stroke Patients with Appropriate Care	95%	78.6%	79.1%	78.2%	80.2%	79.4%	76.2%	76.6%	72.2%	80.1%	74.5%	74.6%	N/A		R
Acute Coronary Syndrome Patients with Appropriate Care	95%	43.9%	51.0%	44.0%	51.3%	37.9%	49.4%	42.1%	46.3%	38.3%	47.5%	34.8%	N/A		R
National Reportable Incidents reports (NRI)	Reduction Trend	10	7	8	2	0	5	12	3	8	8	8	N/A		A
Can't Send & Cancelled by Patient Volumes	Reduction Trend	11,073	10,605	11,482	10,087	13,556	7,086	6,938	10,124	7,694	8,105	8,044	N/A		R
Concerns Response within 30 Days	75%	24%	28%	28%	24%	27.0%	21.0%	24.0%	33.0%	35.0%	29.0%	43.0%	N/A		R
<b>Our People</b>															
<b>Capacity</b>															
Hours Produced for Emergency Ambulances	95-100%	95%	96%	90%	92%	91%	97%	95%	95%	98%	97%	92%	N/A		A

Top Monthly Indicators	Target 2023/24	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	2 Year Trend	RAG
<b>Health &amp; Well-being</b>															
Sickness Absence (all staff)	6.0%	8.72%	8.68%	9.48%	8.77%	10.65%	8.92%	8.06%	8.33%	8.04%	7.76%	7.51%	N/A		A
Mental Health Absence Rates	Reduction Trend	2.33%	2.30%	2.30%	2.44%	2.41%	2.36%	2.04%	2.12%	2.08%	2.24%	2.08%	N/A		A
Staff Turnover Rate	Reduction Trend	11.50%	11.35%	11.11%	10.70%	10.64%	10.69%	10.86%	10.38%	10.28%	9.89%	9.79%	N/A		G
Statutory & Mandatory Training	>85%	85.44%	85.60%	85.58%	85.40%	84.63%	76.51%	60.10%	65.05%	75.55%	76.32%	77.53%	N/A		A
PADR/Medical Appraisal	>85%	73.66%	78.75%	80.49%	80.75%	87.89%	79.12%	78.71%	72.10%	73.0%	72.0%	73.1%	N/A		A
Number of Shift Overtimes	Reduction Trend	3,785	3,786	3,901	3,758	3,799	3,720	3,431	4,064	3,839	4,087	2,053	N/A		A
<b>Inclusion &amp; Engagement / Culture</b>															
NHS111 % of Total Calls Answered in Welsh	TBD	0.28%	0.37%	0.30%	0.35%	0.03%	0.48%	0.28%	0.31%	0.44%	0.59%	0.74%	N/A		TBD
NEPTS % of Total Calls Answered in Welsh	TBD	0.6%	0.7%	1.2%	1.3%	0.8%	0.7%	0.9%	1.1%	1.4%	1.8%	1.7%	N/A		TBD
<b>Value</b>															
Financial balance - annual expenditure YTD as % of budget expenditure YTD	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	N/A		G
EMS Utilisation Metric (All Vehicles)	Improvement Trend	61.6%	61.8%	62.6%	61.2%	64.6%	56.0%	56.6%	61.4%	58.8%	56.3%	55.3%	55.9%		A
Average Jobs per Shift (All Vehicles)	Increasing Trend	2.46	2.43	2.46	2.48	2.38	2.23	2.32	2.28	2.39	2.45	2.43	N/A		A
NEPTS on the Day Cancellations	Reduction Trend	18.9%	19.9%	19.7%	18.3%	23.2%	19.4%	20.4%	21.6%	18.3%	17.8%	18.7%	N/A		A
<b>Partnerships / System Contribution</b>															
<b>Inverting the Traingle</b>															
Successful Consult & Close Outcome	17.0%	11.7%	12.2%	12.8%	12.6%	14.6%	14.9%	14.2%	13.8%	14.7%	14.1%	13.9%	N/A		R
% Of Total Conveyances taken to a Service Other Than a Type One Emergency Department	Improvement Trend	11.99%	11.14%	10.65%	11.04%	11.18%	10.72%	10.05%	11.1%	10.7%	11.8%	11.7%	N/A		A
Number of Handover Lost Hours	15,000	24,295	25,174	28,038	25,020	32,098	23,525	19,110	28,620	23,082	20,392	18,548	19,118		R
<b>NHS111</b>															
NHS111 Dental Calls	-	6,038	5,913	6,051	5,829	4,657	6,063	5,746	6,668	6,723	6,865	6,515	N/A		TBD
Consult & Close Volumes by NHS111	Increasing Trend	1,283	1,180	1,287	1,196	1,338	811	949	956	985	1,015	1,031	N/A		A

## 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))

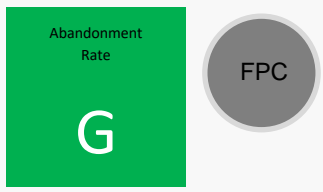
Red: Performance is less than 10% of target (Indicates close monitoring or significant action is required)

TBD: Status cannot be calculated (To Be Determined)

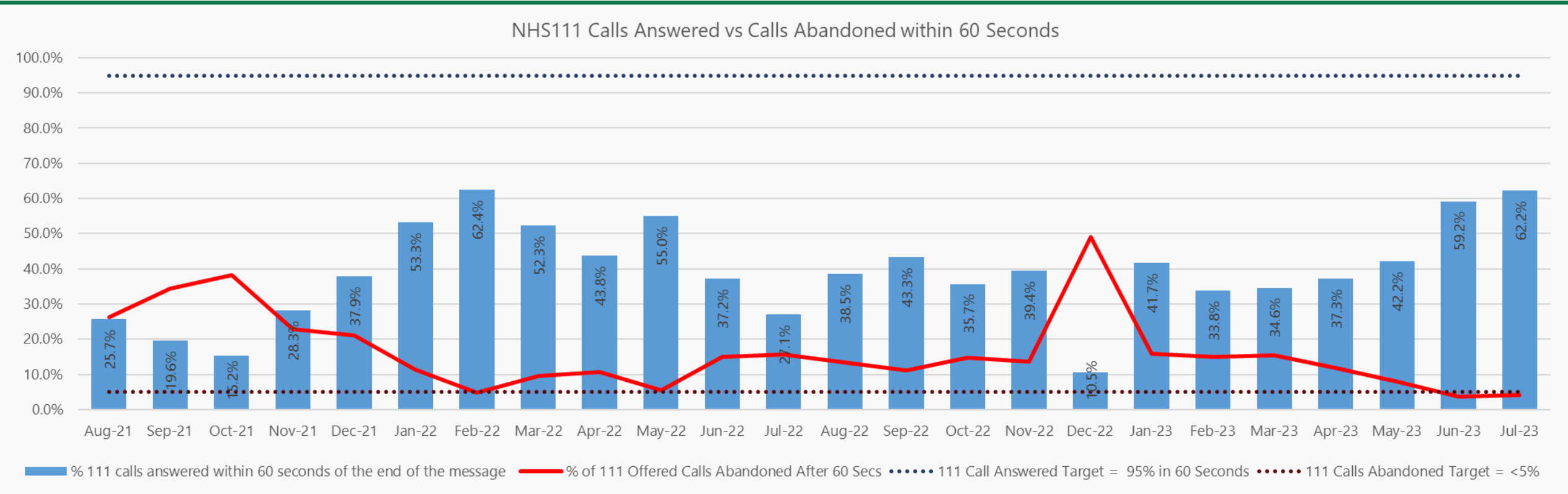
# Our Patients: Quality, Patient Safety & Experience

## 111 Call Answering/Abandoned Performance Indicators

(Responsible Officer: Lee Brooks)



### Influencing Factors – Demand and Call Handling Hours Produced



**Analysis**  
 111 call abandonment is a key patient safety indicator for the service. July 2023 saw an **abandonment rate of 4.1%**, a slight increase compared to the 3.8% figure seen in June 2023, but remaining below the 5% target. It is also the second lowest monthly figure recorded during the 2-year recording period.

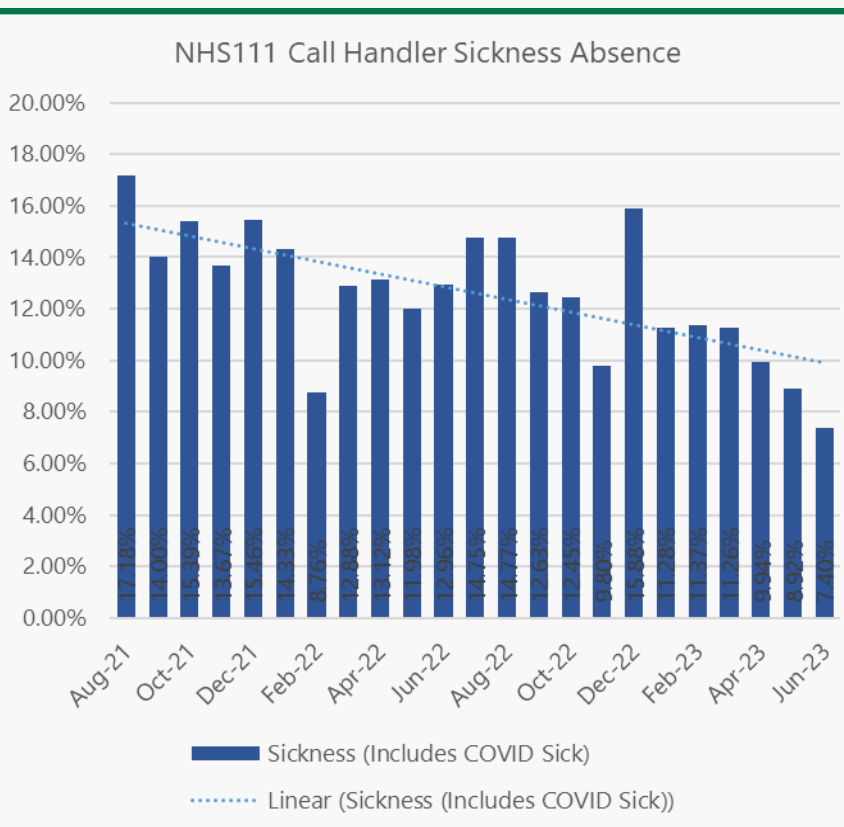
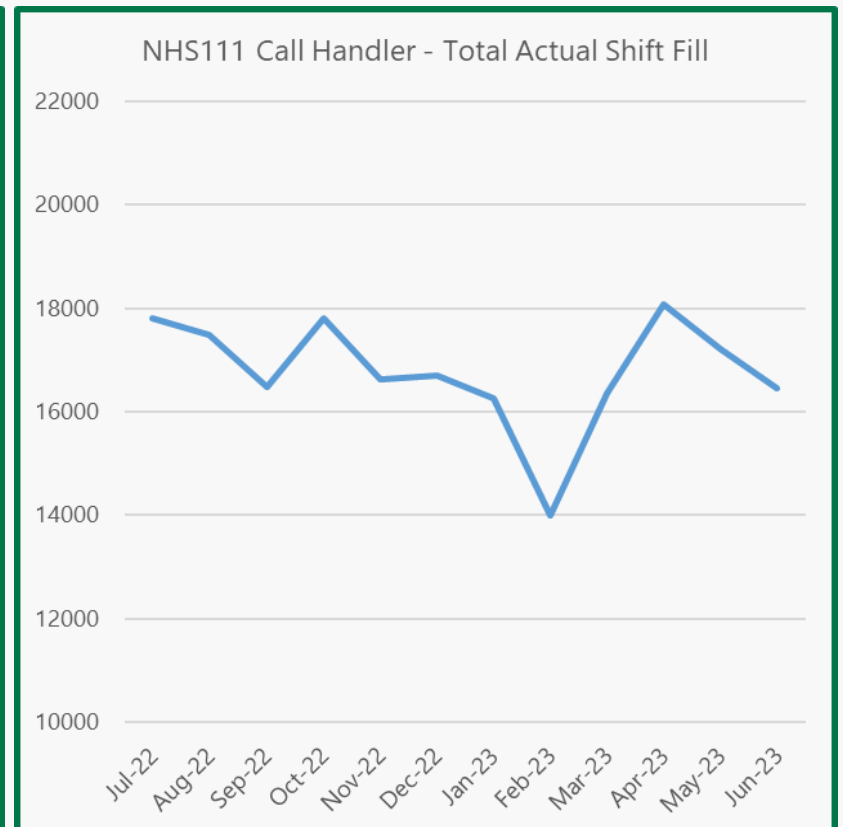
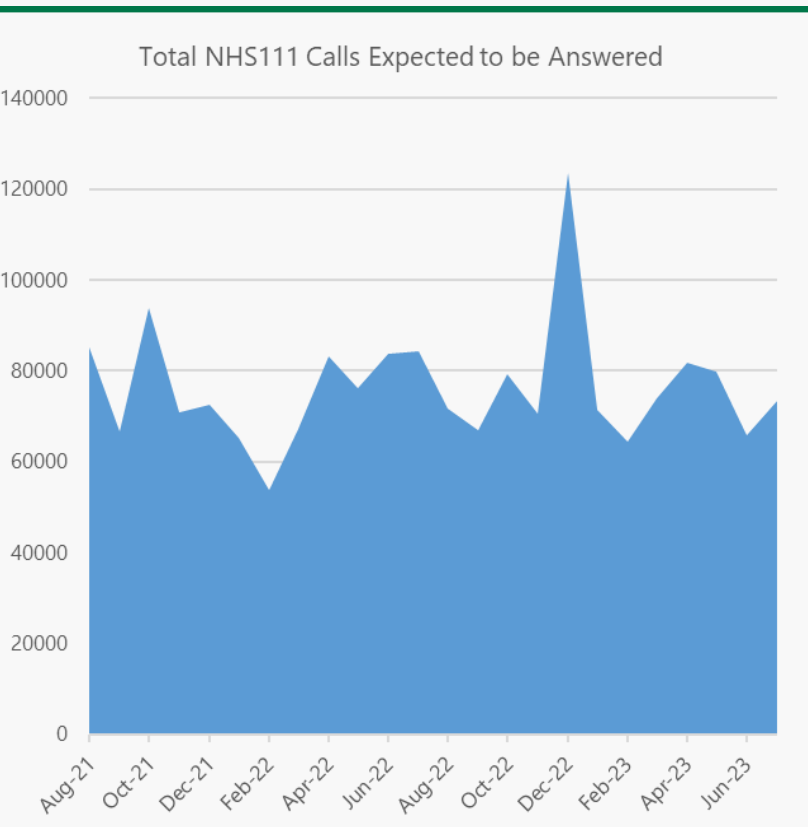
The percentage of 111 calls answered within 60 seconds of the end of the message also increased again in July 2023 to 62.2%, the fifth consecutive month in which an improvement has been seen.

Total capacity measured through shift fill decreased in June to just below the 12-month average.

**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. The Trust is currently 21.25 FTE short of establishment. The Trust is aiming to address this in quarter three.
- Work continues on sickness absence in line with the Trust's managing absence work programme with an IMTP aim to get organisational sickness down to 6%
- A roster review in three parts is due to start, in collaboration with the 111 commissioners to review rosters and ensure that capacity is aligned to demand, and to try and even out performance through the week. Currently out to tender.
- Work also continues in reviewing the use of the Clinical Advice Line which is available to call handlers who want some clinical advice whilst on call with the patient. The call handler has to wait for a clinician to answer the call and therefore call times are related to clinician availability. In May, the % of calls passed to the CAL was 24%, a reduction from 34% in recent months.

**Expected Performance Trajectory**  
 As call handler numbers reduce through the SALUS implementation phase and additional abstractions for SALUS training are accommodated performance is expected to deteriorate month on month until Q4. Agreed further action to address this.



# Our Patients: Quality, Safety & Patient Experience

## 111 Clinical Assessment Start Time Performance Indicators

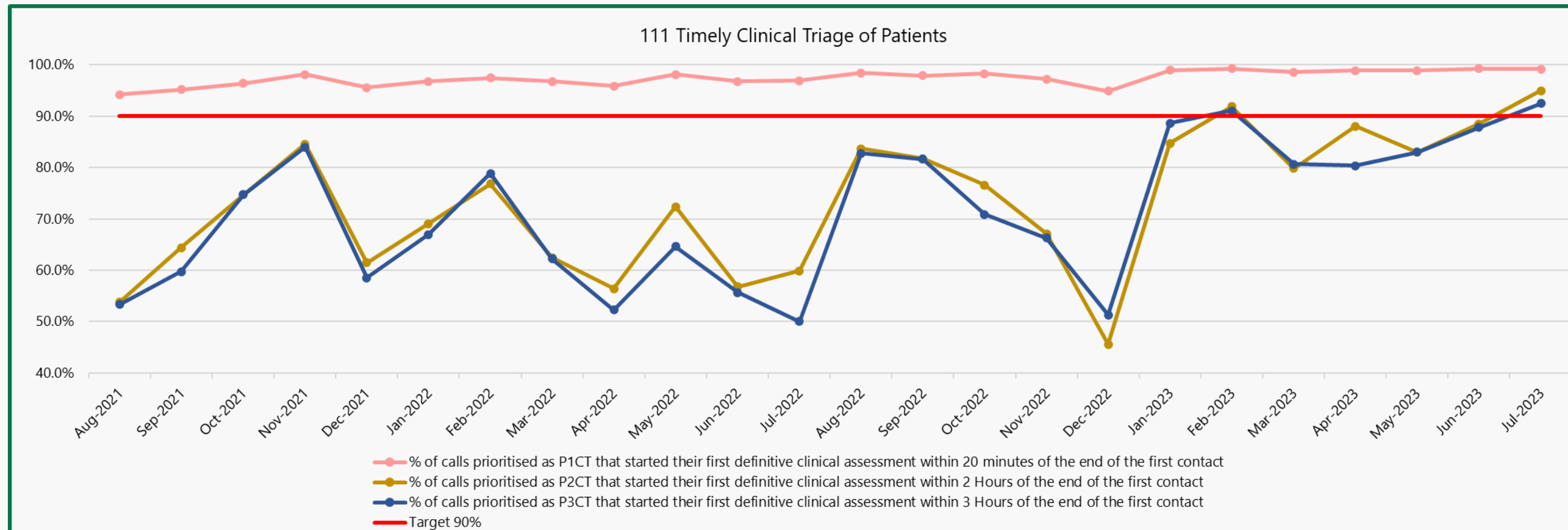
(Responsible Officer: Lee Brooks)

P1CT

G

FPC

### Influencing Factors – Demand and Clinical Hours Produced



#### Analysis

The highest priority calls, P1CT, continues to achieve the 90% target (99.2%).

For lower category calls P2CT increased to 95% in July 2023 when compared to 88.5% in June 2023, while P3CT also rose to 92.5% in July 2023 compared to 87.8% in June 2023.

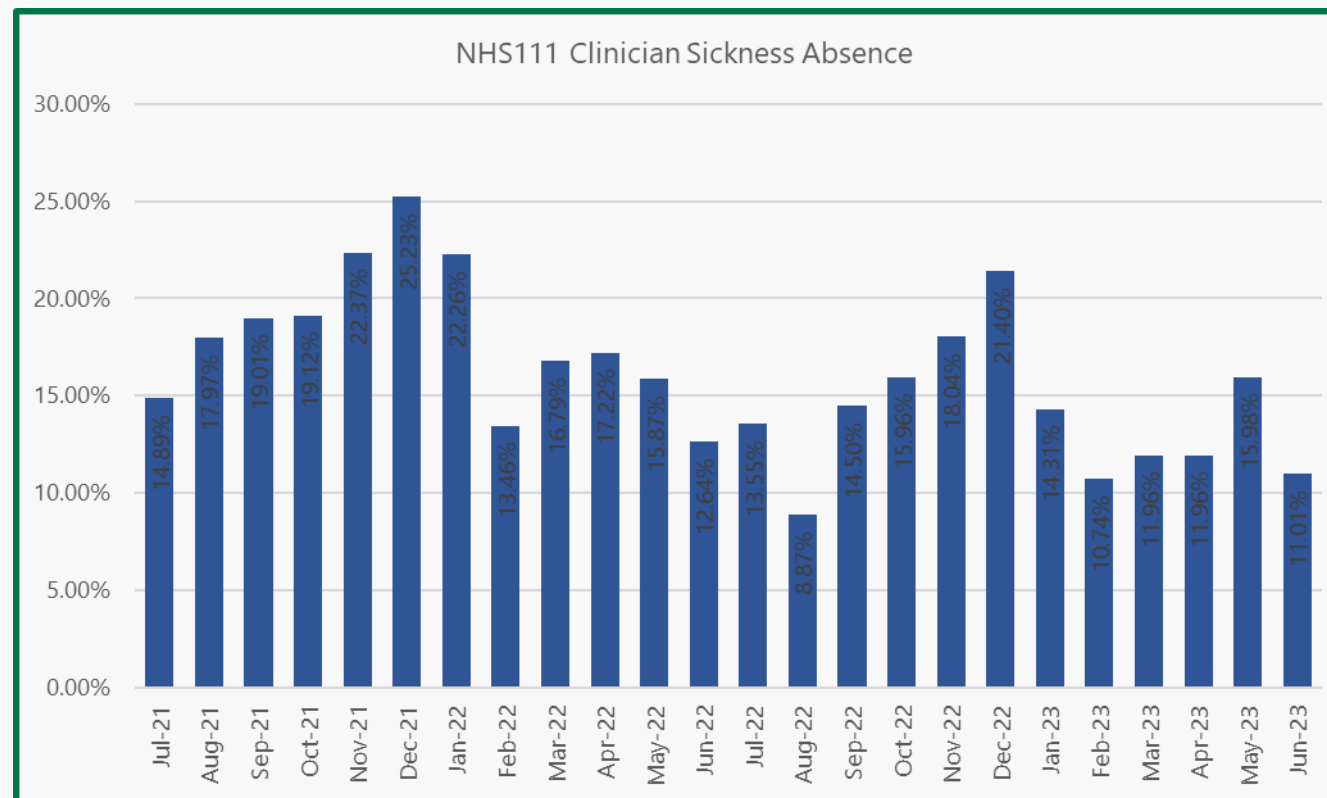
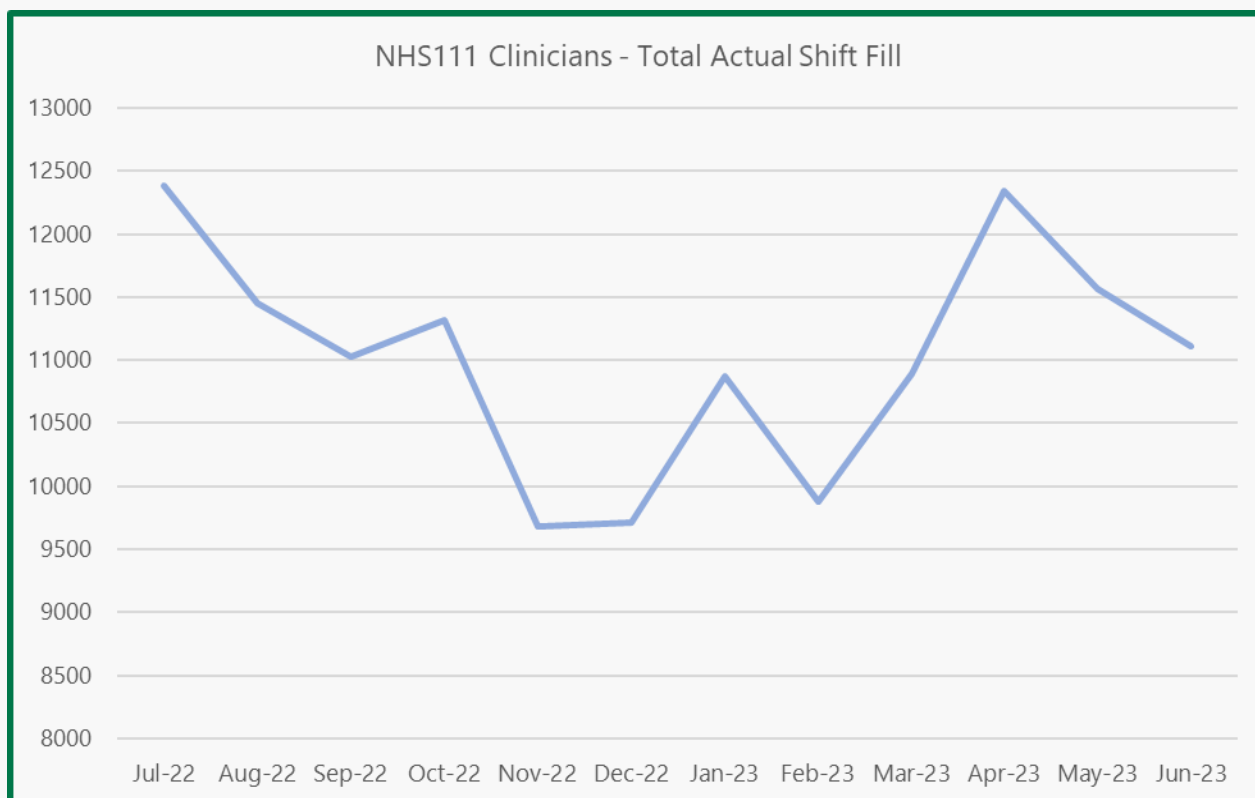
Clinical staff capacity is the key issue. 11,106 hours were filled by clinicians during June 2023, a decrease of 455 when compared to May 2023. Clinician sickness absence decreased to 11.01% in June 2023, from the 15.98% reported in May 2023.

#### 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. At present 103.71 FTE nurses and paramedics are in post, and commissioners have indicated that they have funding available for 100 WTE. Additional staff have been recruited recently which will help the service through the SALUS implementation, with numbers expected to fall to around the 87 WTE mark by the end of the year.

#### Expected Performance Trajectory

Clinical performance, whilst much improved, is expected to decline due to attrition and abstractions arising as a result of SALUS. Further demand & capacity work to determine the correct number of clinicians with the correct level of abstractions is also an area of future development.

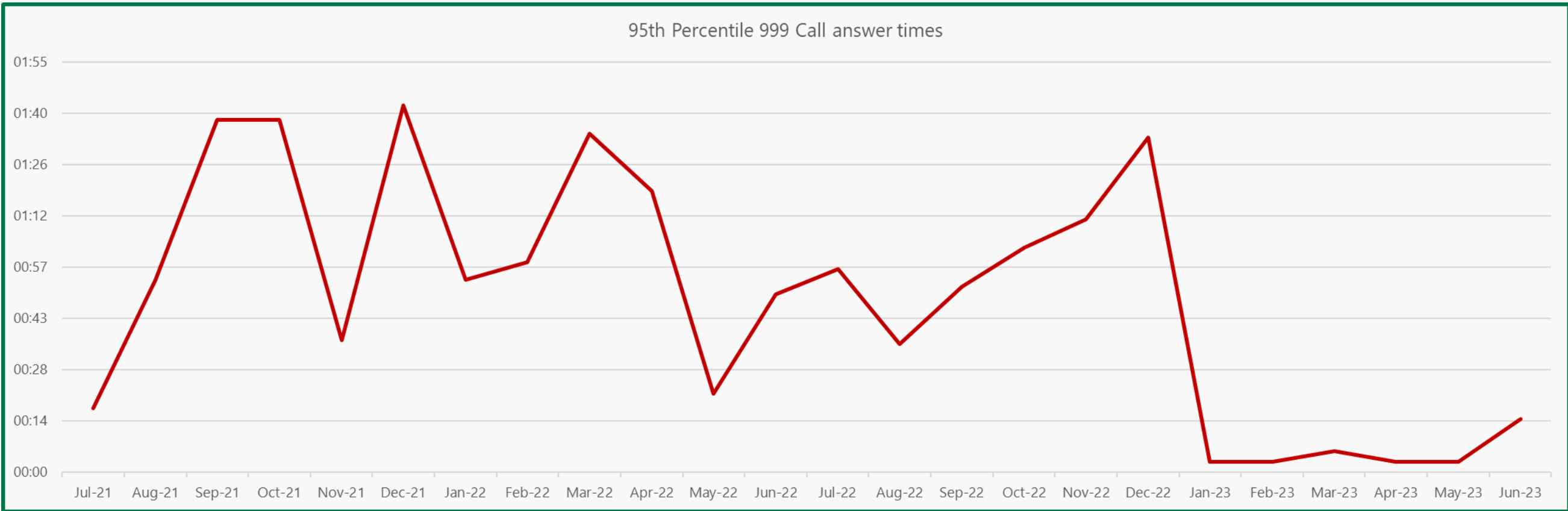
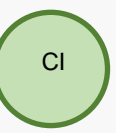


# Our Patients: Quality, Safety & Patient Experience

## 999 Call Performance Indicators

### Influencing Factors – Demand and Hours Produced

(Responsible Officer: Lee Brooks)



**Analysis**  
**The 95<sup>th</sup> percentile 999 call answering performance increased to 15 seconds in June 2023, above the 6 second target for the first time since December 2022.**

The median call answer time for the 999 service remains consistent at 2 seconds.

The Trust received 41,973 emergency 999 calls in June 2023, a decrease from the 43,563 calls received during May 2023.

Overall sickness abstractions within the CCC have risen slightly the past two months, after being on a downward trajectory since March 2022 rising to 8.47% in June 2023. This means they have been above the 8% target in the past two months.

**Remedial Plans and Actions**

- EMS Coordination meet twice weekly to review demand profiles and design tactics for service delivery based on demand, staffing levels and business continuity plans.
- EMD FTE is currently 119.89 against a funded establishment of 111.76; however, this includes new starters still in the sign off period. Once qualified, experienced staff will be re-aligned to vacant dispatcher posts.
- Intelligent Routing Platform is now in operation following configuration changes.
- Five new EMD cohorts were trained during May and June across 3 EMS co-ordination centres. 19 new EMDs are already live call handling from these cohorts with another 11 currently training and due to go live in the next 2 weeks. A further cohort was agreed for North CCC, which will begin training in the next couple of weeks.
- Three workstreams are currently 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 EMT).

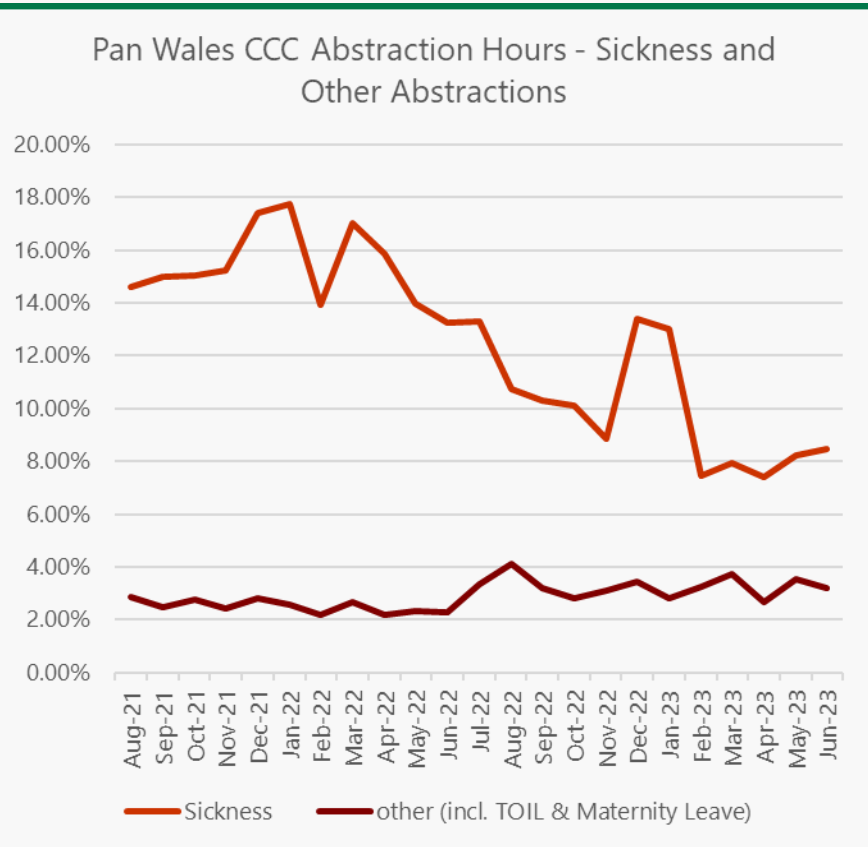
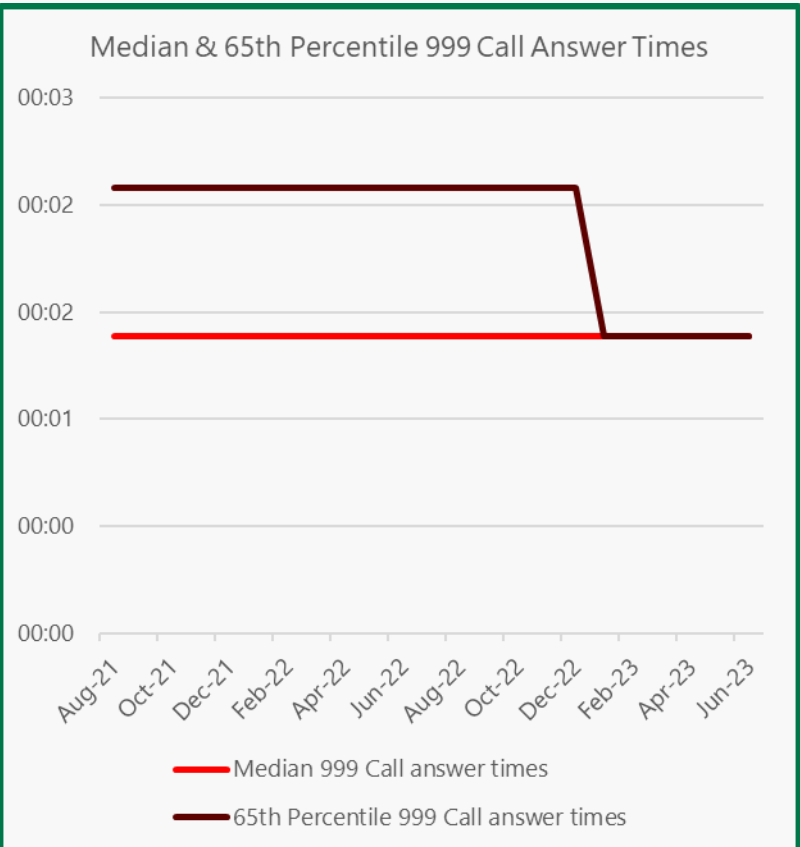
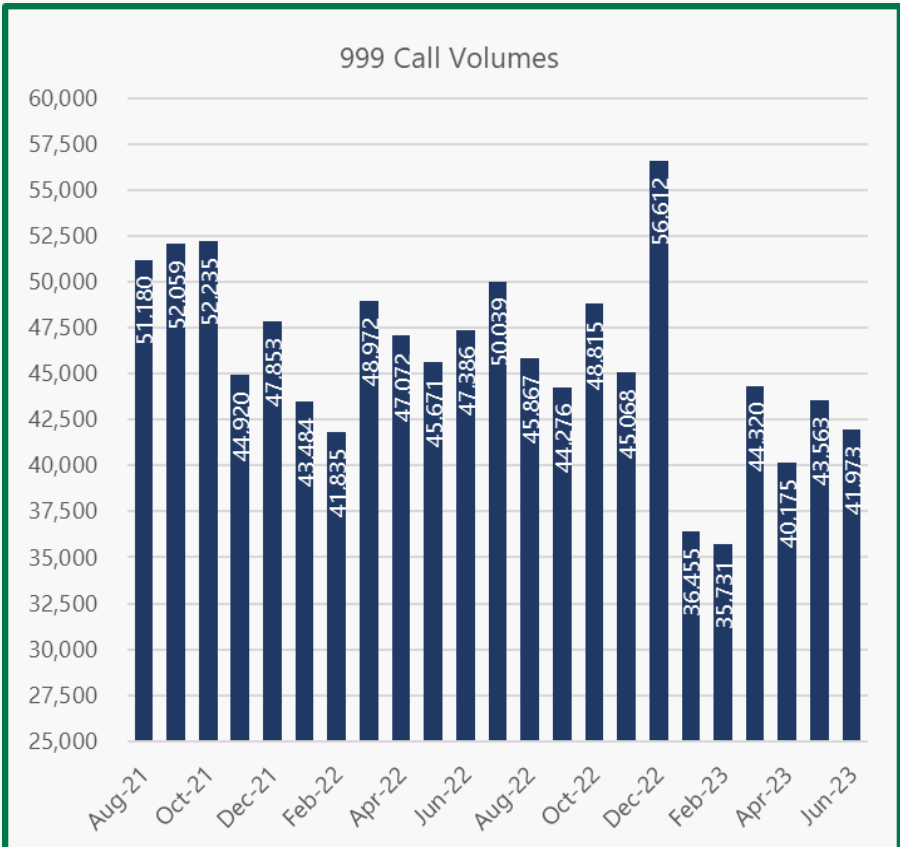
**Roster Review.** Having successfully implemented an EMD roster review in February 23 the project has now progressed to commencing a dispatch Roster review for Allocators and Dispatchers however this is currently on pause while negotiations continue with TUP

**Boundary changes.** In line with ORH recommendations in the Demand & Capacity Review of 2019 EMS Coordination intend to realign dispatch boundaries to balance workload and pressures for individual dispatch teams.

**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.

**Expected Performance Trajectory**

Performance is expected to remain on track, subject to continued good work around capacity management.



# Our Patients: Quality, Safety & Patient Experience

## Red Performance Indicators

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

(Responsible Officer: Lee Brooks)

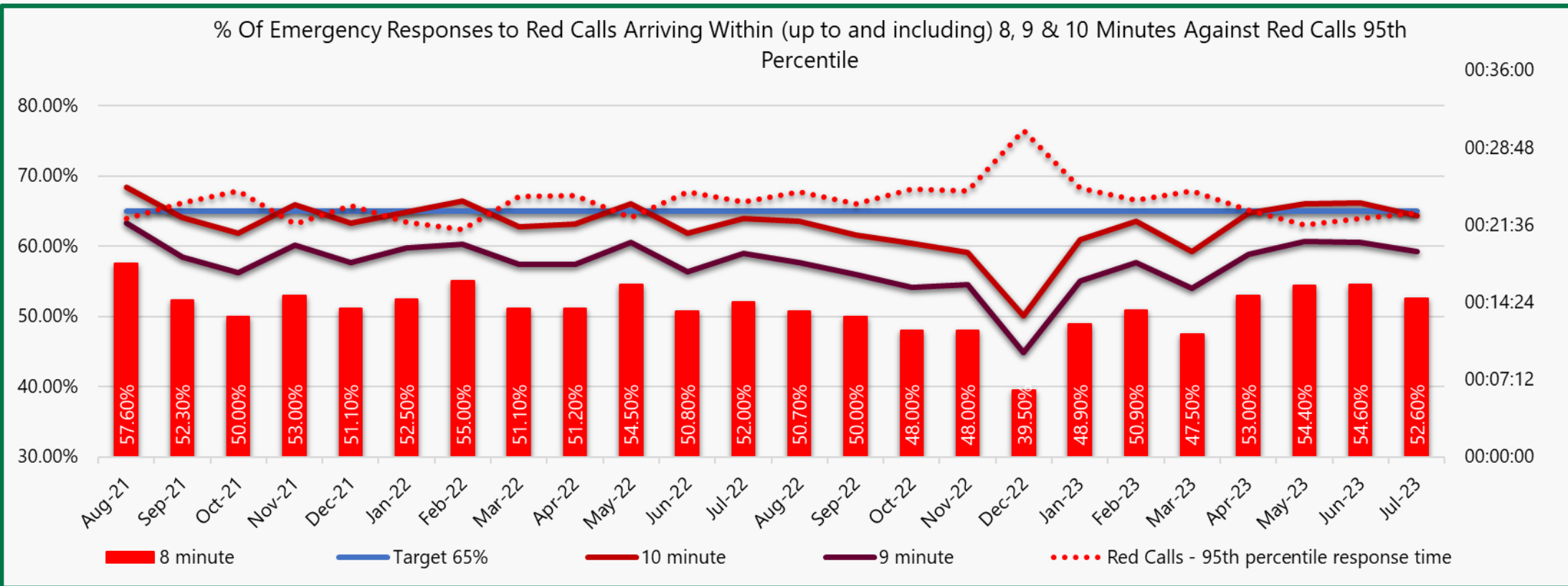
65%  
**R**

95%  
**R**

QUEST

FPC

CI



#### Analysis

Red performance declined slightly in July 2023, with Red 8-minute performance decreasing to 52.60% and continues to remain below the 65% target. Although there was variation, none of the seven health boards achieved this target. Red 10-minute performance was 64.4% for July 2023, down from 66.2% in June 2023.

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

Red demand has generally been increasing over the past two years, reaching a peak in December 2022. Demand has remained fairly consistent since that spike but remains slightly higher than the same period last year.

Hours produced have decreased slightly to 117,574 hours in June, although this remains above the 2-year monthly average.

The lower centre graph demonstrates the correlation between overall Red performance and hospital handover lost hours. Lost hours are now lower than their peak in December, but July 2023 did see an increase to 19,118 lost hours compared to a figure of 18,848 in June 2023. These levels continue to remain significantly above where they need to be.

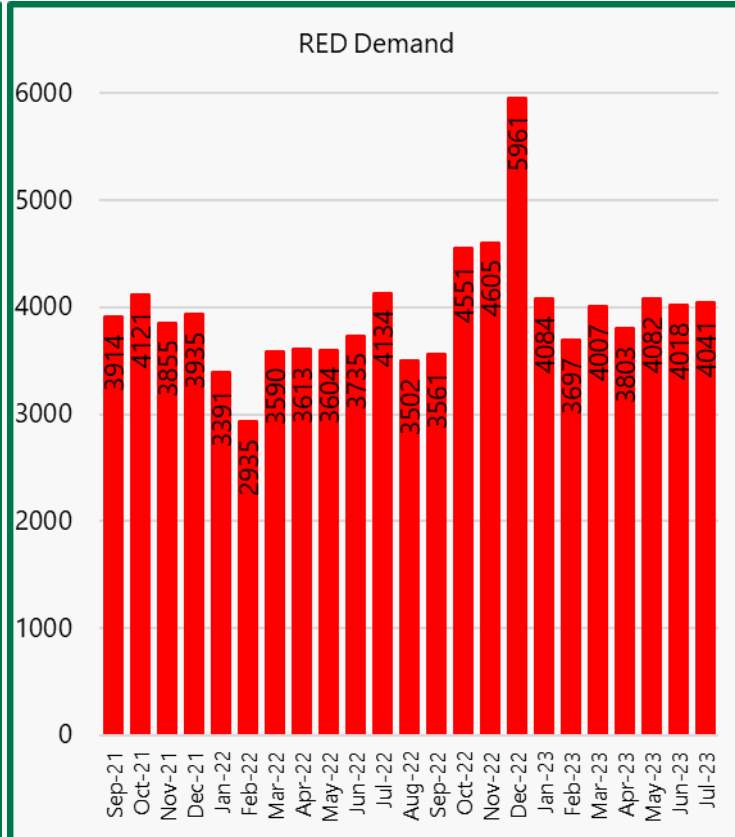
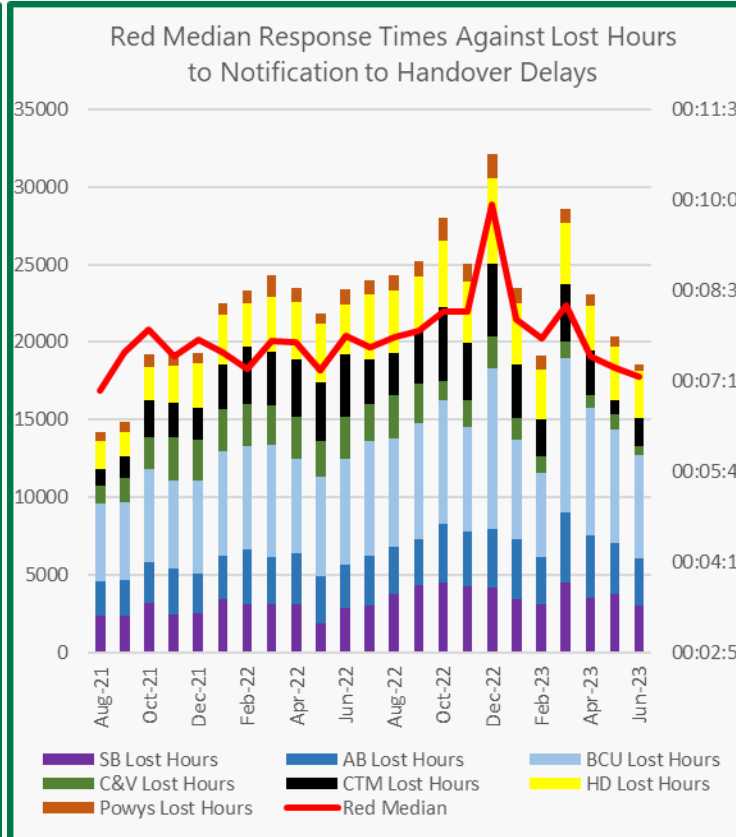
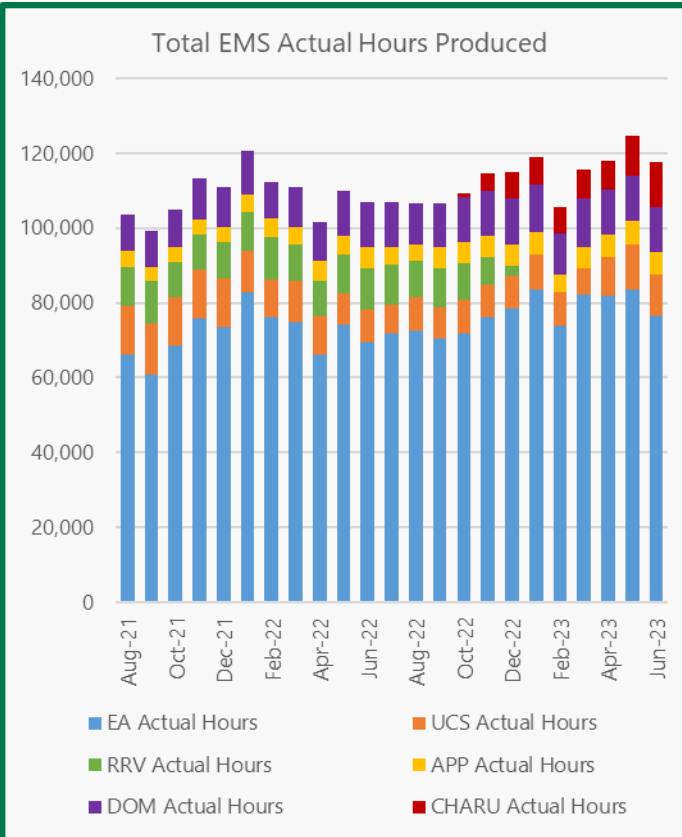
#### Remedial Plans and Actions

- 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 with the exception of some hard-to-reach areas. Further actions to address;
  - Potential 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 Integrated Medium-Term Plan (IMTP) (8% by Mar-23/6% 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

The Red modelling estimates a 7%-point improvement in Red 8-minute performance if CHARUs are fully rolled out, and associated Red improvement actions are delivered. Including a reduction in lost hours to 15,000.

\*NB: Data correct at time of abstraction

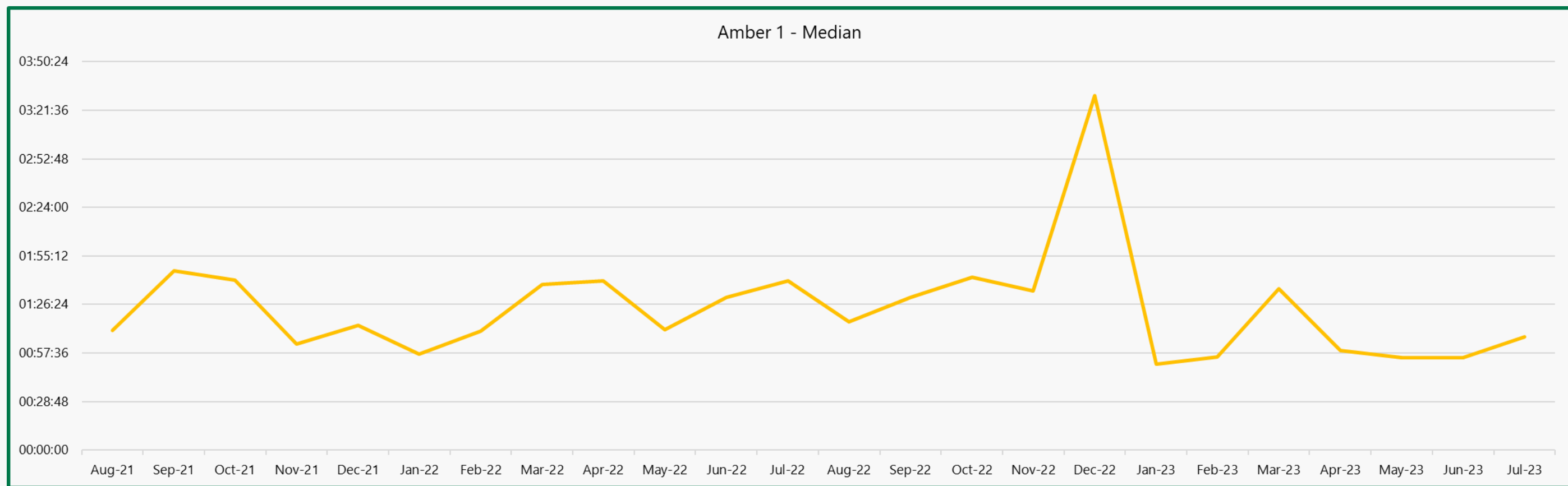
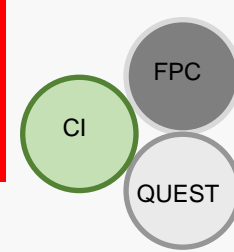
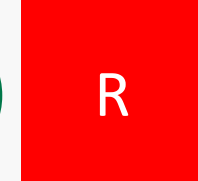


# Our Patients: Quality, Safety & Patient Experience

## Amber Performance Indicators

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

(Responsible Officer: Lee Brooks)



**Analysis**  
 Amber 1 median performance declined during July 2023 to 1 hour seven minutes, from the 54 minutes 43 seconds recorded in June 2023. The ideal Amber 1 median response time is 18 minutes. The 95<sup>th</sup> percentile also rose to 4 hours and 46 minutes.

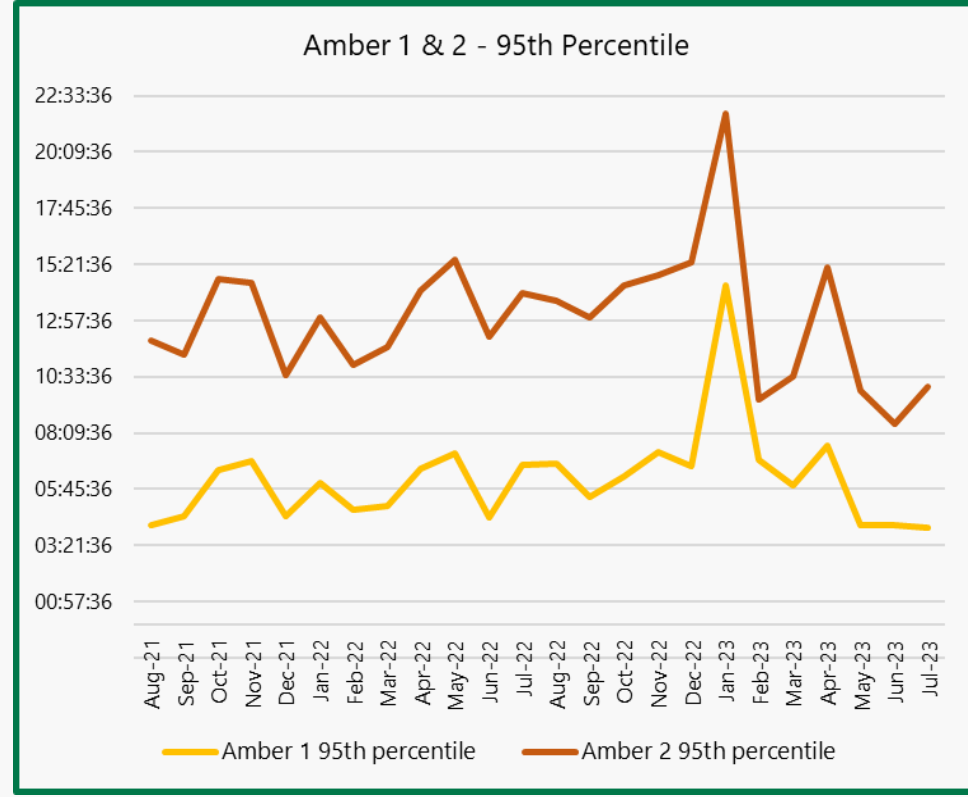
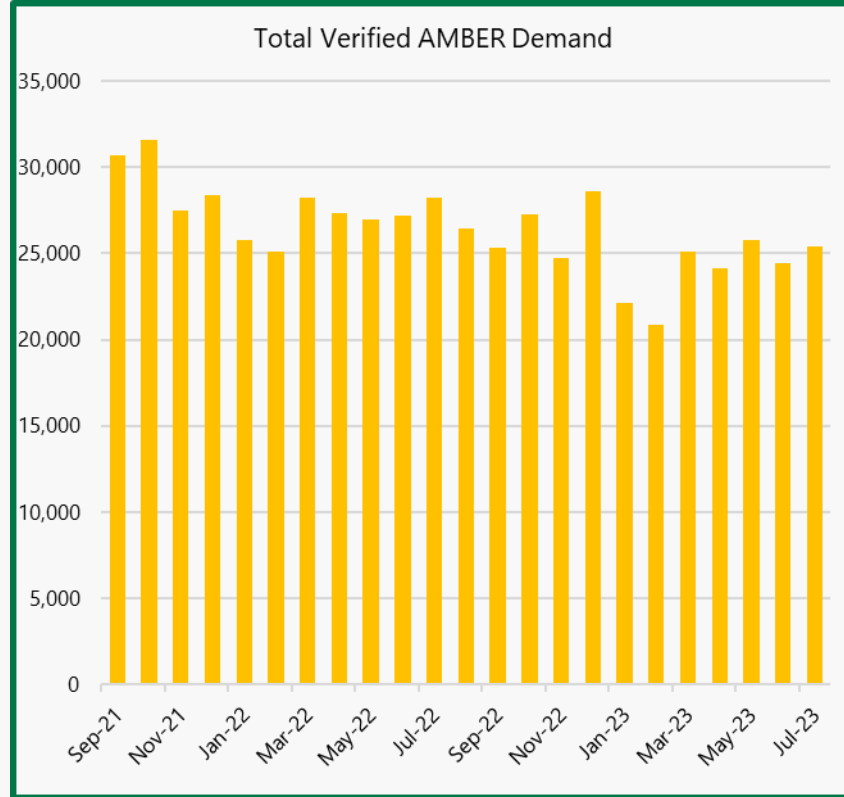
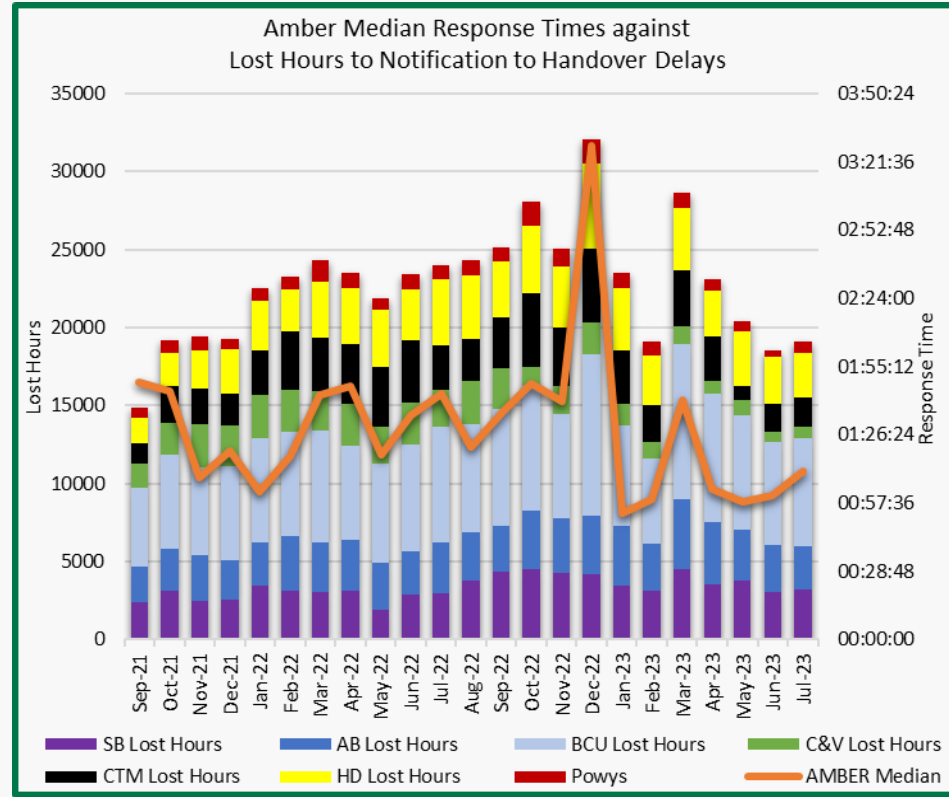
There were still some long patient waits in June 2023, with 1,440 patients (all categories, not just Amber) waiting over 4 hours. This is however a decrease from the 1,625 recorded in May 2023.

Amber demand increased in July 2023 to 25,384 verified incidents.

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.



# Our Patients: Quality, Safety & Patient Experience

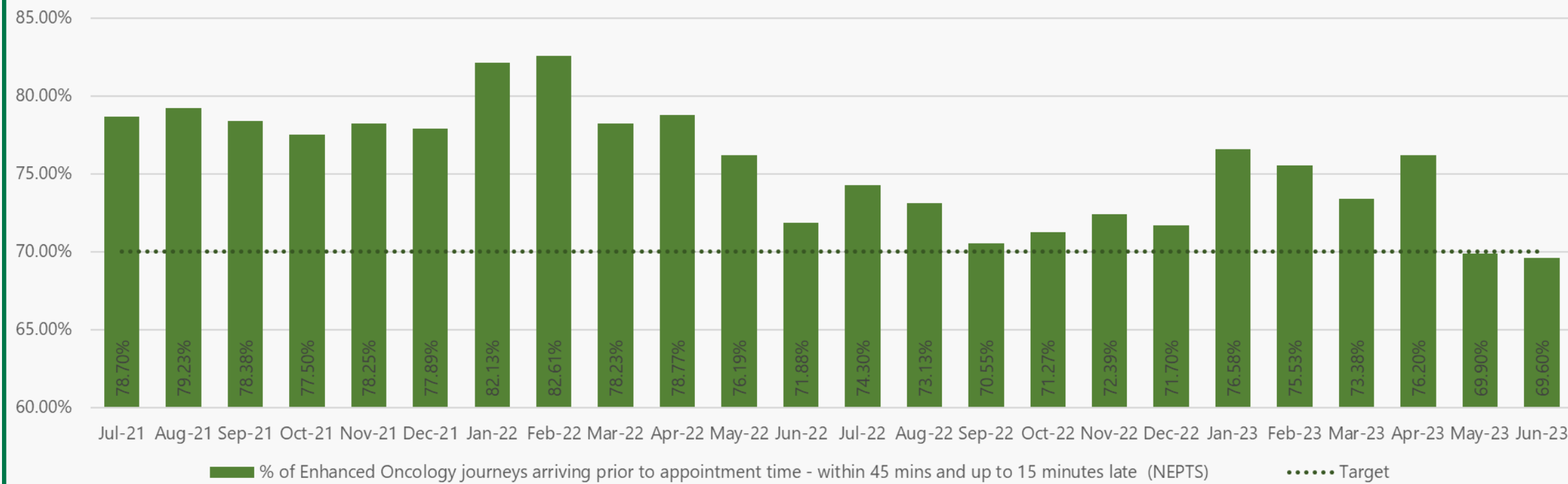
## Ambulance Care Indicators

### Patient Experience

(Responsible Officer: Lee Brooks)

Oncology **G** D&T **R** FPC CI

% of Enhanced Oncology journeys arriving prior to appointment time - within 45 mins and up to 15 minutes late



#### Analysis

**Ambulance Care (NEPTS element) performance declined slightly during June 2023.** 69.6% of enhanced oncology journeys arrived within 45 minutes prior and up to 15 minutes late to their appointment time, down from 69.9% in May 2023, achieving the 70% target.

78% of discharge & transfer journeys were collected within 60 minutes of their booked ready time, a decrease compared to May 2023 (83%), and the fifth consecutive month where the 90% target has not been achieved.

Same day cancellations increased slightly from 17.8% in May 2023 to 18.7% in June 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.
- Oncology journeys in particular have increased significantly since April 2023 and in June 2023 were at levels not seen since 2019.
- There has been a notable increase in requests for discharges from the ED. This correlates with EMS no longer facilitating these requests.

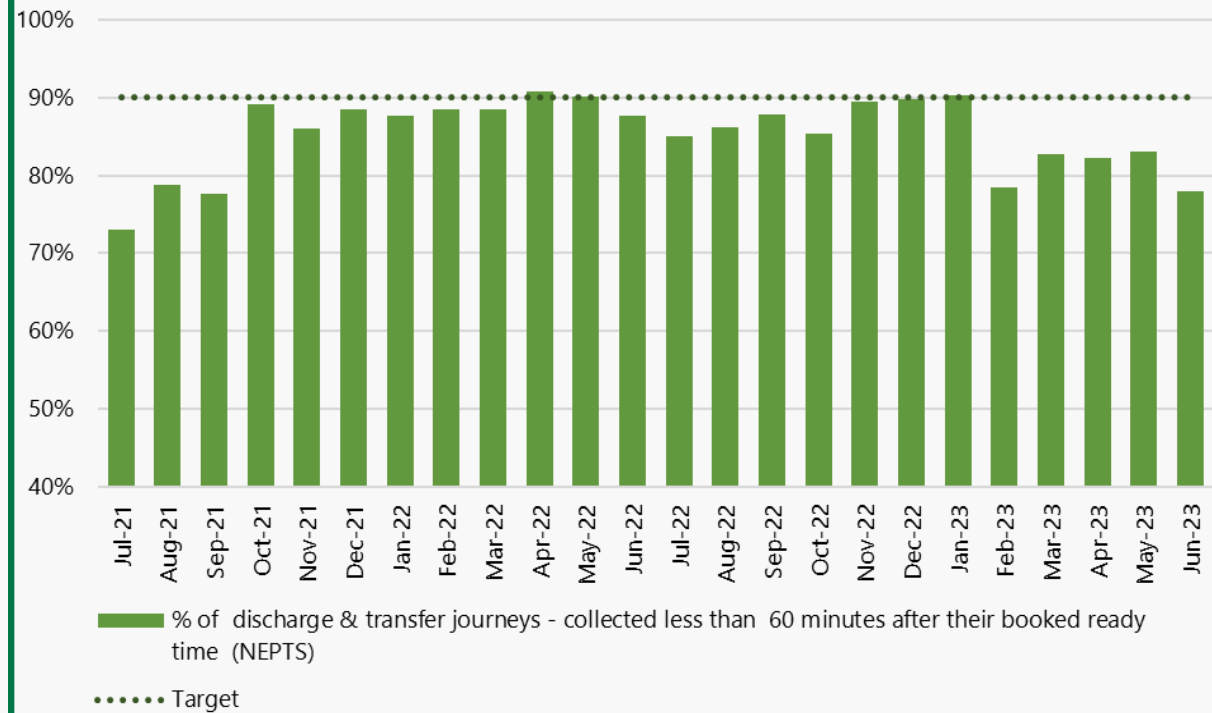
#### Remedial Plans and Actions

- D&C Project: roster review of NEPTS transport paused as part of IMTP prioritisation exercise.
- Transfer and Discharge Service: work is in progress with regards to the modelling (initial results received, almost complete).
- The service has implemented a performance standard implementation plan to support the roll out of the new parameters. This plan is focused on ensuring the entire team are aware of the standards and their role in delivering them.
- Updated NEPTS performance parameters went live in April 2023, these will separate out on the day and advance booked journeys. At present most bookings are made on the day, which makes it difficult to respond to within the times allowed. A focus on pre-planned discharge should support work being completed by working groups 5&6 of the 6 goals programme board

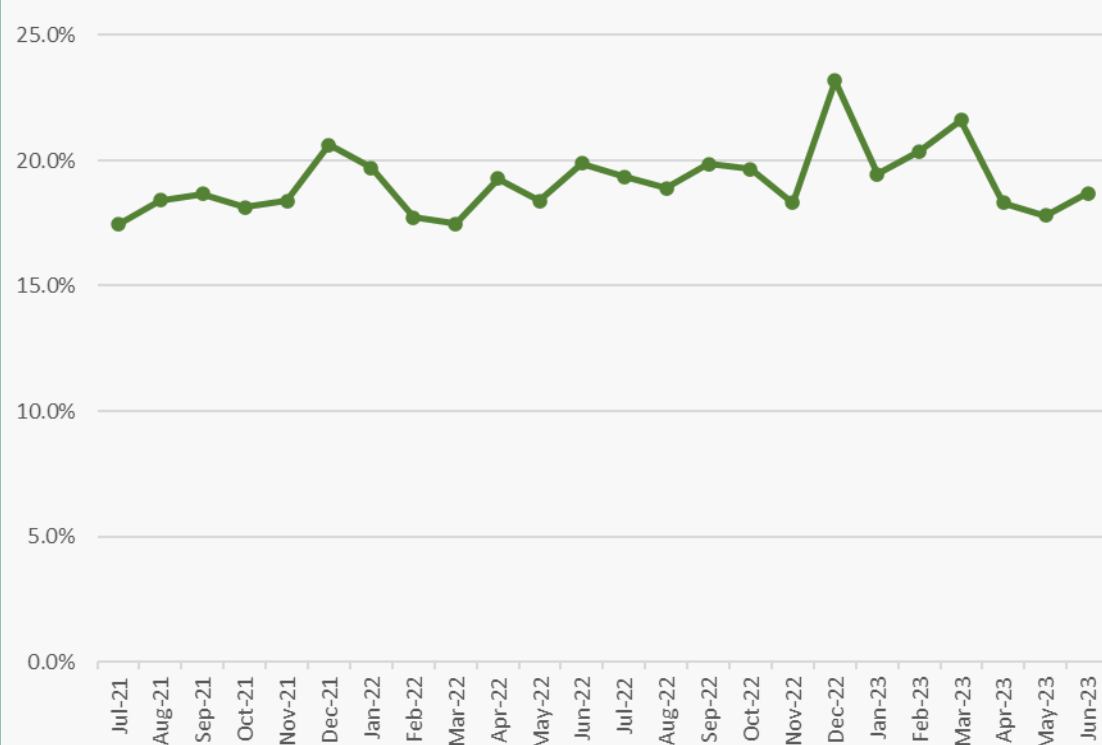
#### Expected Performance Trajectory

At present, the uncertainty around demand as health boards move through system recovery following the pandemic, with the potential addition of austerity and a move to different performance parameters, means that it is difficult to forecast performance. WAST will continue to work with the HBs through the commissioning DAG (NCCU) to deliver the best performance possible for the patient.

% of Discharge & Transfer Journeys - Collected less than 60 minutes after their booked ready time (NEPTS)



Volume of on the Day Cancellations



# Our Patients: Quality, Safety & Patient Experience

## Clinical Outcomes Indicators

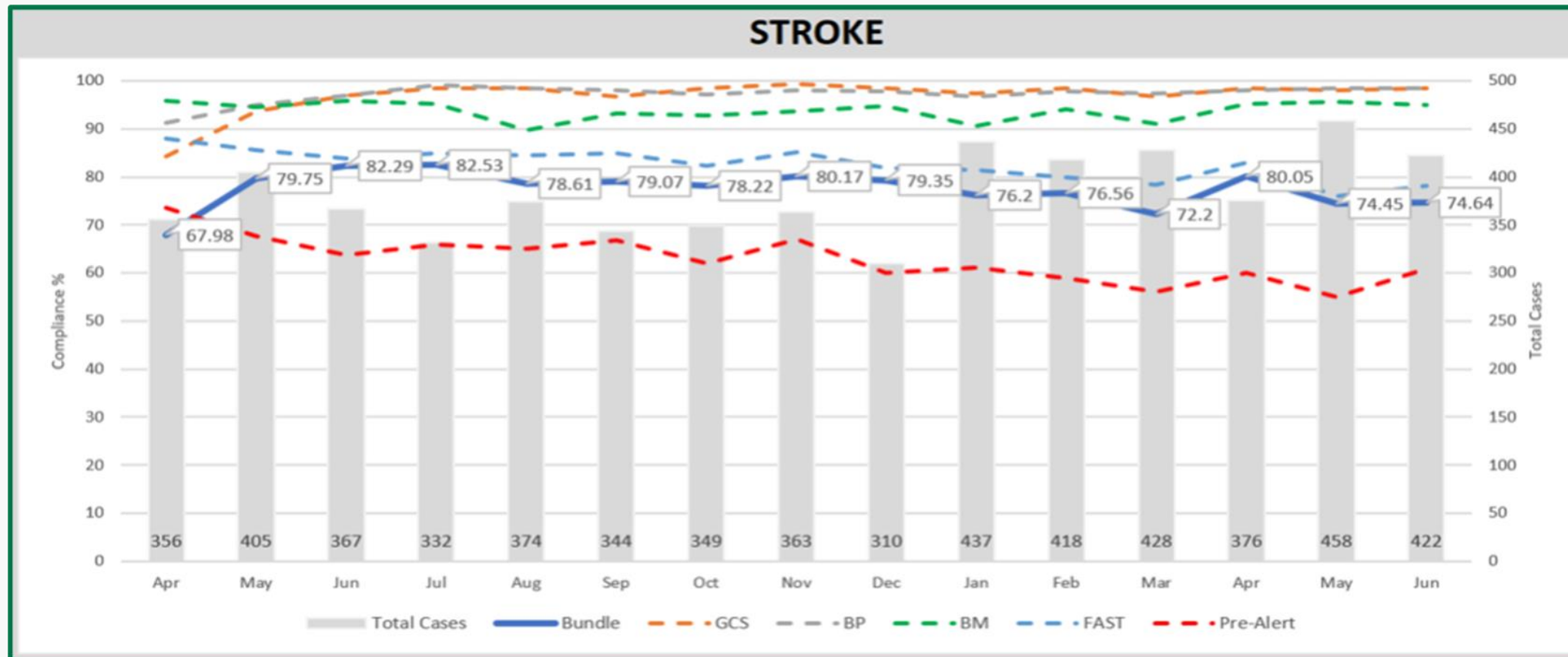
(Responsible Officer: Andy Swinburn)

Stroke/Hip Fracture/Hypoglycaemic  
**R**

Self Assessment:  
Strength of Internal Control: Moderate

QUEST

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



### Analysis

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

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

### Remedial Plans and Actions

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

### New agreed indicators (commissioning intention) include:

- (1) Call to door time for STEMI and Stroke and;
- (2) Reporting on Outcomes (by response type).

There is a lot of work required to agree and then report on these indicators:

### Q3 (Oct – Dec 2022)

- (1) Discussions commenced between the CIAT/Hi/NCCU to define 'call to door' and 'at hospital' for the STEMI & Stroke time-based metrics. The various data points available are not always consistently available for all calls so options on the best approach will be discussed and decided on at the CIAG.
- (2) Establish initial requirements with the NCCU for Reporting on Outcomes (by response type), this may be by staff grade, patients conveyed or not conveyed. Initial consideration is to use Stroke and #NOF data.

### Q4 (Jan – Mar 2023)

- (1) Work continued with CIAT/Hi/NCCU to decide on the most appropriate data points, taking into consideration those used by English Ambulance Trusts to look at potentially comparing like-for-like data. HI have produced sample data (December 2022) for discussion at CIAG which has representation from the NCCU. Review potential data points for use as test data/discussed with NCCU. Test reporting with initial data points/discussed with NCCU.

### April - June 2023

- (1) The criteria and reporting format for STEMI and Stroke time-based metrics were agreed, and the dashboard was presented to CIAG with data from April 2022. Approve time-based metrics for ASI reporting, this will be via CIAG when presented.
- (2) Submit sample data (December 2022) to CIAG for the Reporting on Outcomes (by response type). Due to various priorities, this work is ongoing.

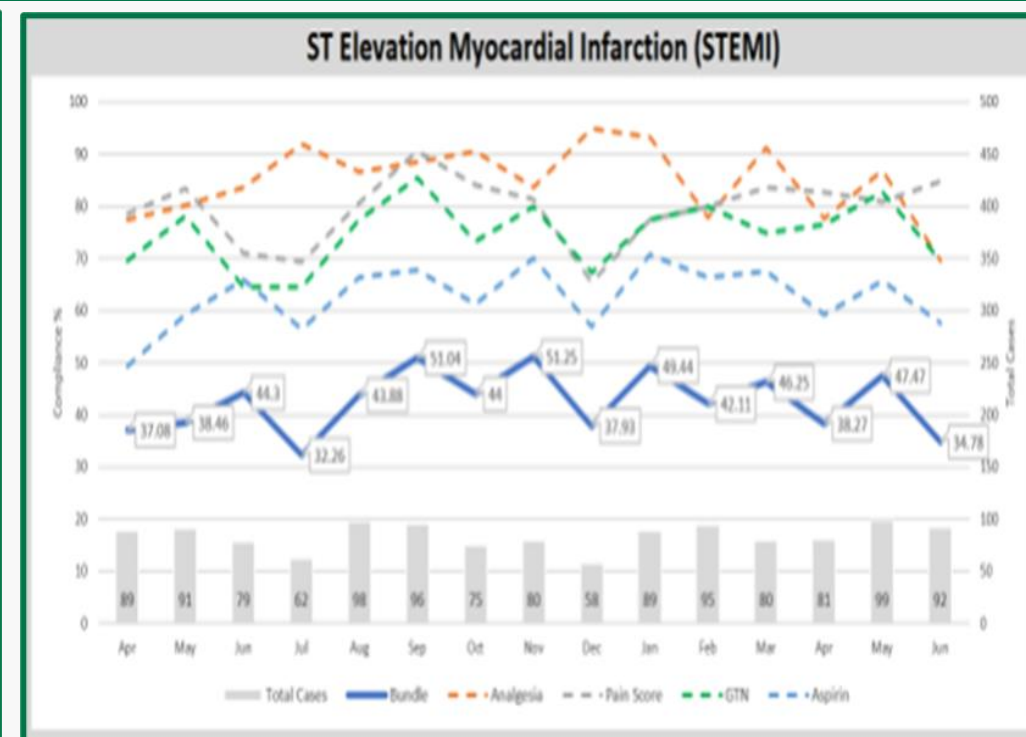
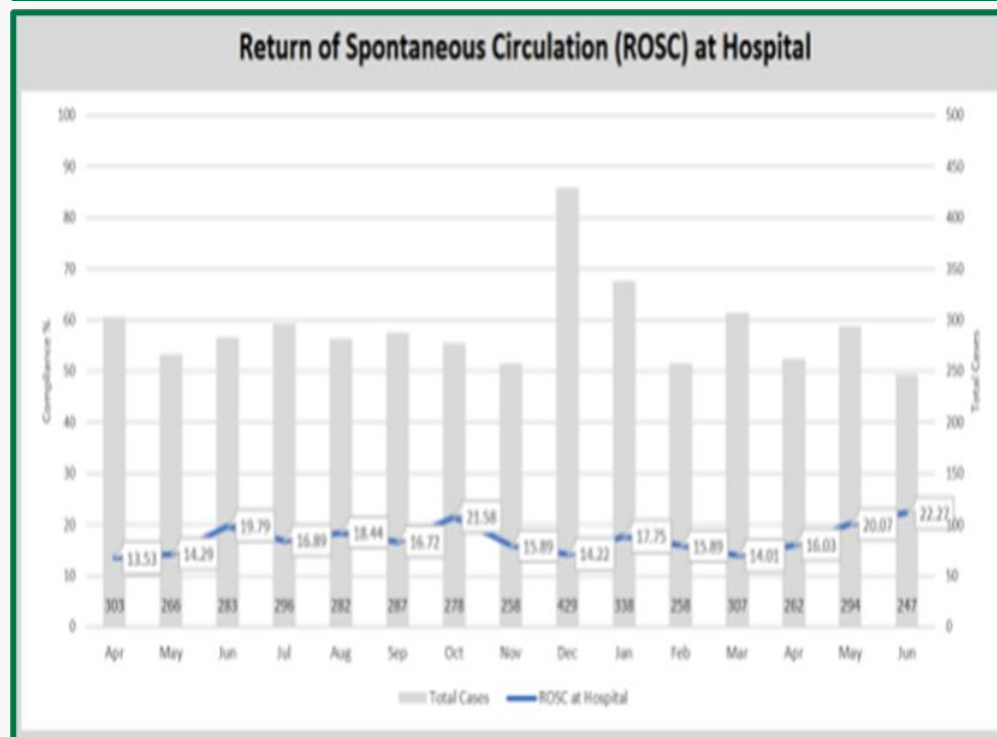
### July - September 2023

- (1) The data points are being reviewed for v2 to consider the '1st available time'. This may ensure more incidents are included.
- (2) This work is ongoing due to various priorities and capacity.

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

### Expected Performance Trajectory

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



# Our Patients: Quality, Safety & Patient Experience

## Patient National Reportable Incidents & Patient Concerns Responses Indicators

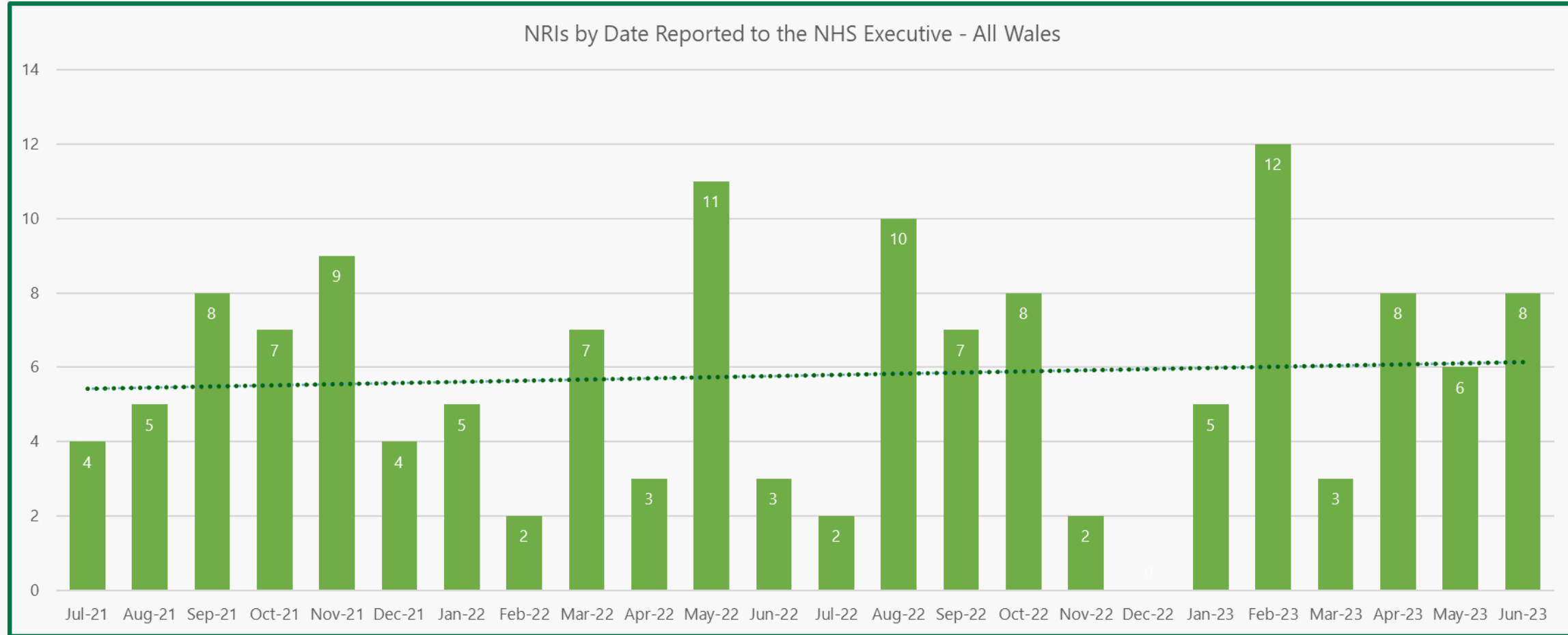
(Responsible Officer: Liam Williams)

NRI.  
**A**

Self-Assessment:  
Strength of Internal Control:  
Moderate

QUEST

Health & Care Standard  
Health - Safe Care / Timely Care



### Analysis

The percentage of responses to concerns in June 2023 is 43% against a 75% target (30-day response) which is a slightly improved 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 is now increasing again with 88 complaints being received in June 2023. These complaints are frequently complex with our concerns administrators frequently taking lengthy calls from distressed patients or family members for up to one hour per call. From April 2023 the 2-day acknowledgment measure for complaints has been revised to a 5-day acknowledgement measure (98% compliance May 2023). This is to bring the Putting Things Right Regulations in line with Duty of Candour. The 2-day measure will continue to be monitored internally due to the fragile position currently.

Six Serious Case Incident Forums (SCIF) were held during the month and 27 cases were discussed. Following discussion eight serious patient safety incidents were reported to the NHS Wales Executive (Delivery Unit) and seventeen 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.

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.

In June 2023, 351 patients waited over 12 hours for an ambulance response, which is an increase on the 264 reported in May.

66 Compliments were received from patients and/or their families in June 2023.

### 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 EMS Coordination Team. An organisational change process is planned across the Putting Things Right functions in quarter three 2023/24. Additionally, we are working closely with the Trust's Wellbeing Team to understand what additional support can be provided to staff across the Putting Things Right functions.

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 and are considered at both Board sub-committee level and at Trust Board.

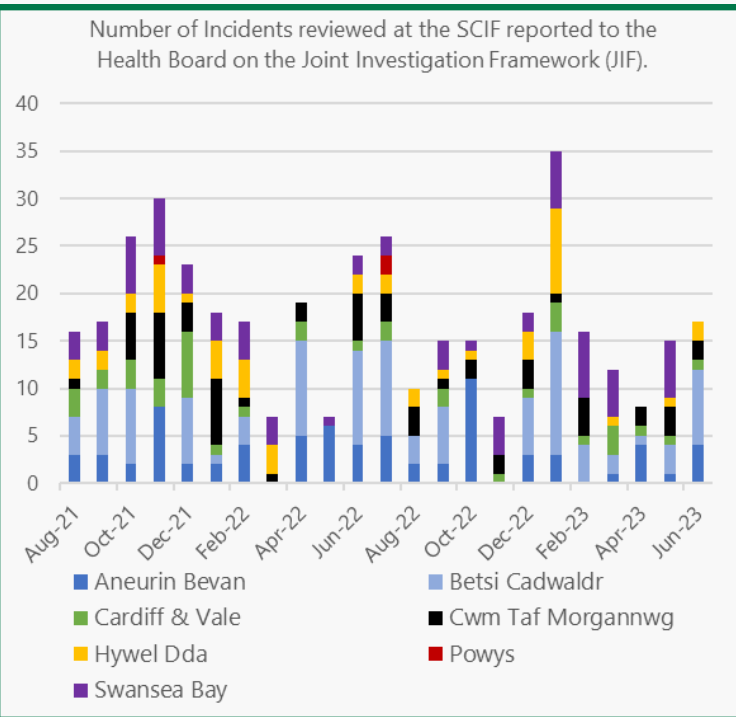
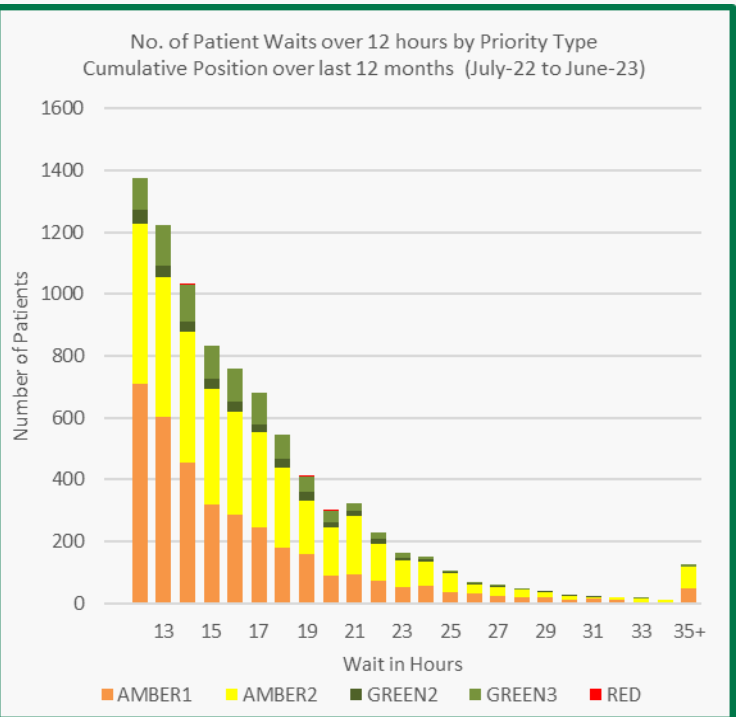
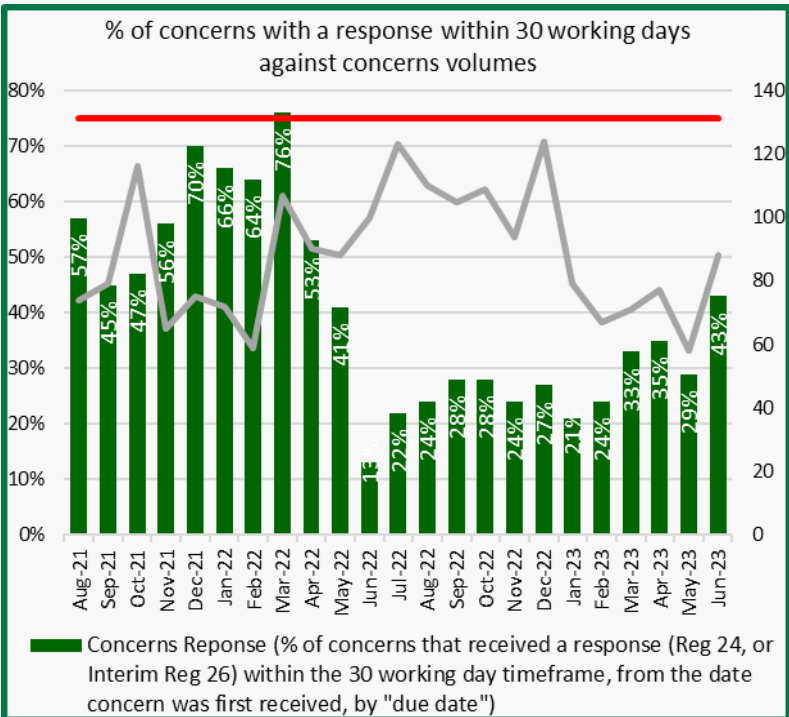
The Joint Investigation Framework is now formally in place across NHS Wales and is referenced in the recently published NHS Wales National Policy on Patient Safety Incident Reporting & Management (May 2023) which has been formally adopted by the Trust.

Immediate improvement actions following the Serious Case Incident Forum (SCIF) include education and training for individual staff, updates to operating procedures and circulation of bulletins to share learning and provide updates.

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

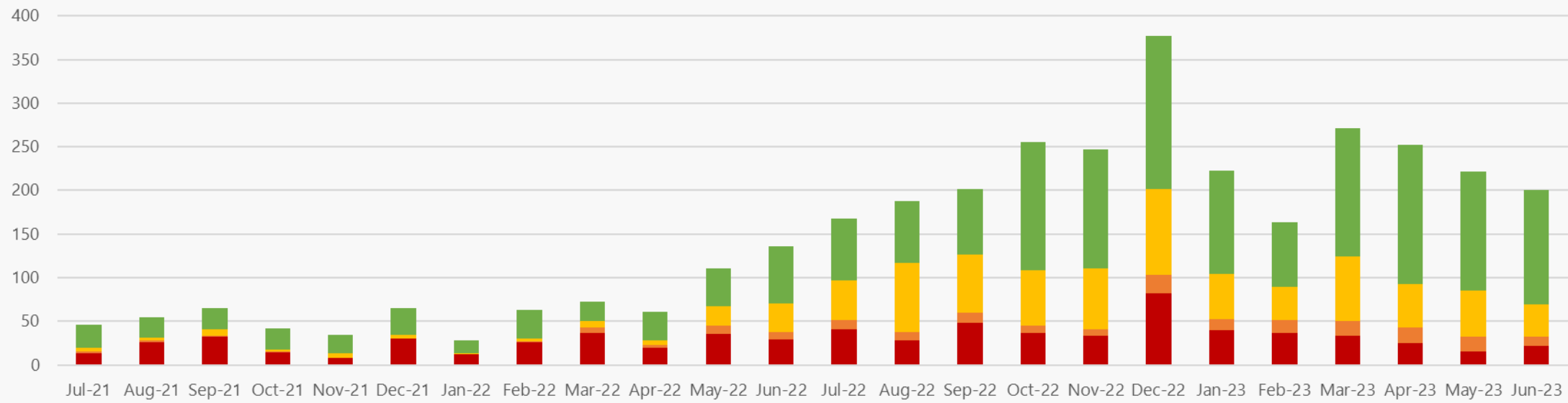
(Responsible Officer: Liam Williams)

Self-Assessment:  
Strength of  
Internal Control:  
Moderate

PCC

Health & Care  
Standard  
Health – Safe Care

Number of incidents Closed on Datix system within the reporting month, by Harm grading (Volumes Received)



	Jul-21	Aug-21	Sep-21	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
Minor	26	24	24	24	22	30	15	33	23	33	44	66	71	71	75	146	136	175	119	74	147	159	137	132
Moderate	5	3	8	2	5	5	1	3	7	5	22	32	46	79	67	64	70	99	52	38	74	50	53	37
Severe	2	2	1	2	0	0	0	1	6	3	9	9	10	10	12	8	7	21	12	14	17	18	17	10
Catastrophic	13	26	32	14	8	30	12	26	37	20	36	29	41	28	48	37	34	82	40	37	33	25	15	22

### 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 – 115
- Minor harm – 132
- Moderate harm - 37
- Severe Outcomes - 10
- Catastrophic - 22

(\*NB: Volumes received).

The bottom graph highlights the 332 Incidents that were closed on the Datix system in June 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. It is expected that the combination of the implementation of the Duty of Candour, Duty of Quality and the Medical Examiner Service will involve additional activity for the Putting Things Right team.

Early informal engagement on the structure of the Putting Things Right team has begun ahead of the formal organisational change process planned for quarter 2 2023/24 which will consider our local and national priorities and resources to meet the needs of our patients and families.

The Trust is represented at national networks including Duty of Candour, Complaints, Mortality, Claims and Redress and Datix Cymru development groups as resources allow.

Work is progressing in respect of the development of dashboards to inform reporting and oversight internally with Health Informatics and through the national Once for Wales team (Datix Cymru).

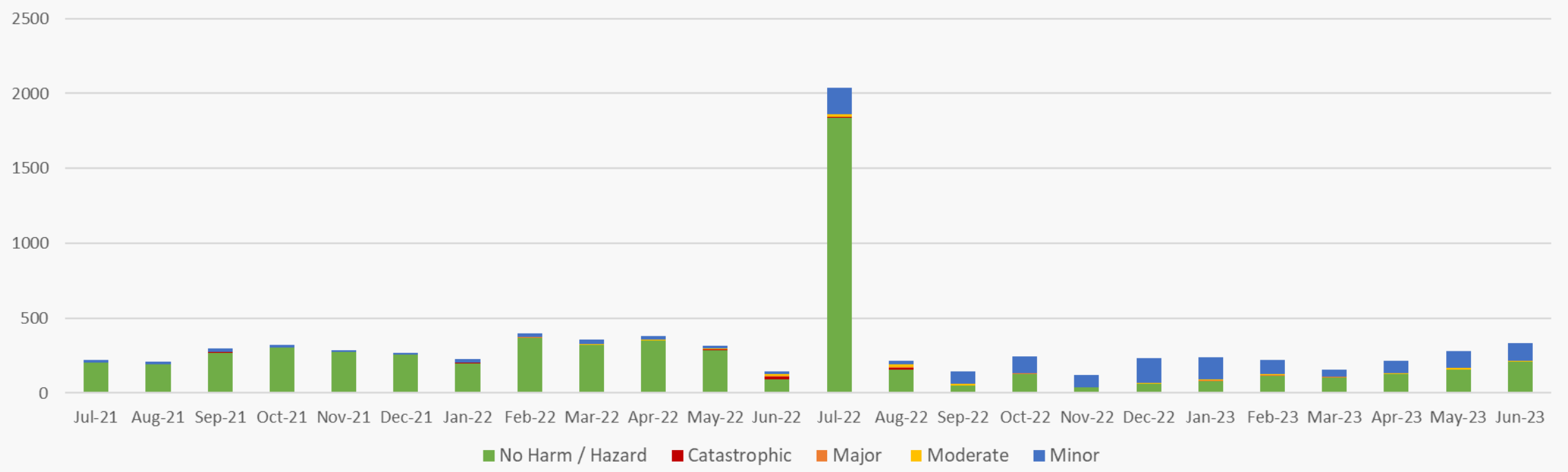
### Expected Performance Trajectory

The Trust will continue to identify quality and safety improvements through the PTR processes.

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

Data source: Datix

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



# Our Patients: Quality, Safety & Patient Experience

## Coroners, Mortality and Ombudsmen Indicators

(Responsible Officer: Liam Williams)

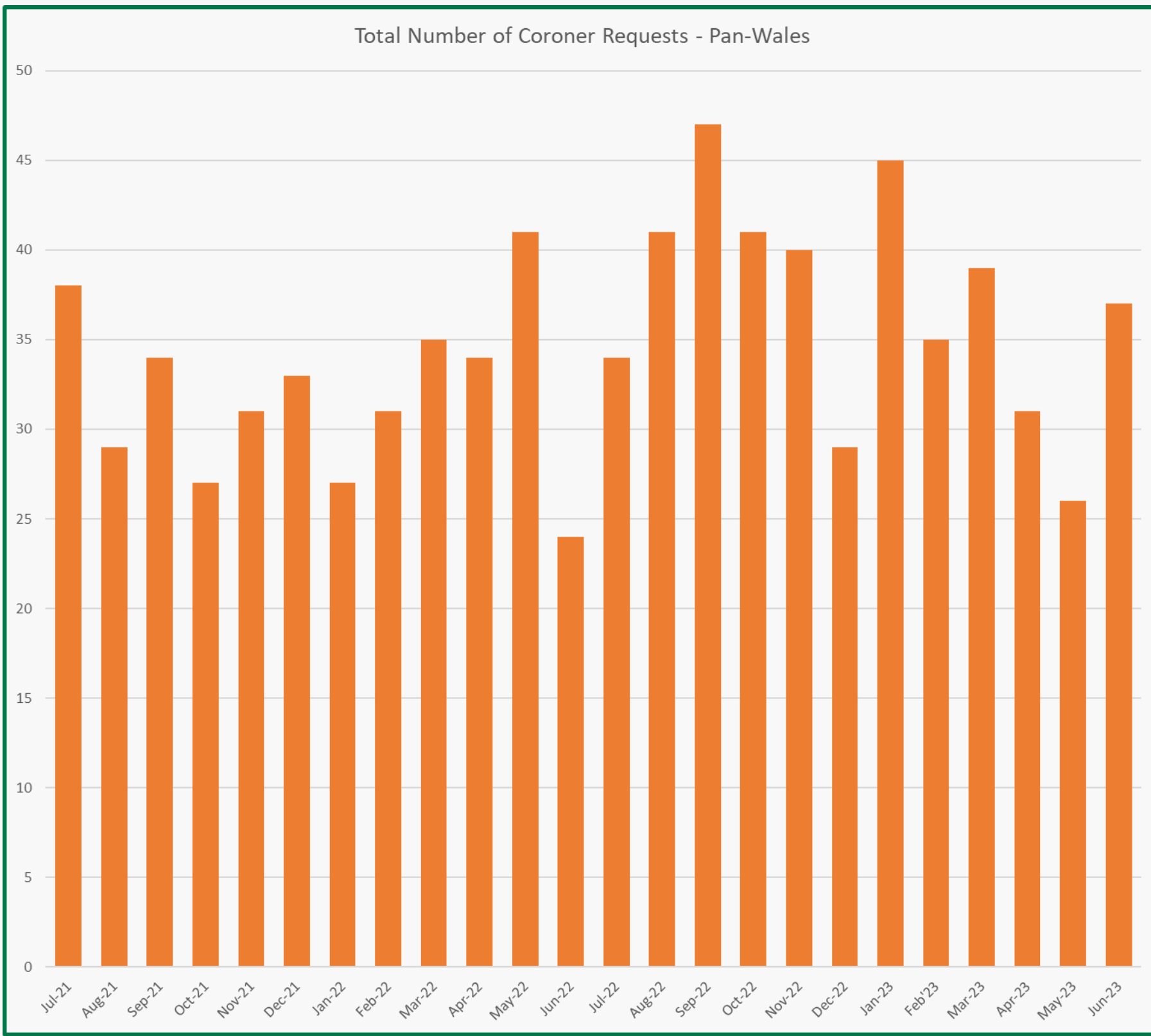
**Coroners**  
Self-Assessment:  
Strength of  
Internal Control:  
Moderate

**Mortality**  
Self-Assessment:  
Strength of  
Internal Control:  
Moderate

QUEST

Health & Care  
Standard  
Health – Safe Care

Total Number of Coroner Requests - Pan-Wales



### Analysis

**Coroners:** The number of in month request continues to be higher than pre pandemic. This increased number of approaches is now the norm, rather than the exception. The complexity remains high, with multiple statements per approach. The Trust is moving the cases from the Datix web system (legacy) to the new Datix Cymru system. This will affect how we record our data and what we will be able to report on, as we come in line with an all-Wales format. Additionally, 50% of the staff managing coroner and Road Traffic accident cases have not been in work this financial year.

At the end of June 2023 there were 506 claims open; these relate to Personal Injury (70 Claims); Personal Injury - Road Traffic Accidents (61 Claims), Clinical negligence (131 claims); Road Traffic Accident (223 claims) and Damage to Property (21 claims).

**Ombudsman:** There are currently 10 open Ombudsman cases in June 2023. At present cases are not being investigated, which supports the Trust's actions. Intermediate actions are being agreed to close without full investigations by the Ombudsman.

**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. 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. To date the Trust have received over 500 requests for information from the Medical Examiner Service.

To date the Trust has not received any requests to undertake a Level 2 mortality review of patients in our care under the new processes in place across NHS Wales. 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 from September 2023 when an increase in activity for requests / reviews for the Trust is expected..

The NHS Wales Executive (Delivery Unit) is leading a thematic review of 'do not attempt cardiopulmonary resuscitation' (DNACPR) processes across Wales with an initial workshop held on 23 May 2023 with WAST representation. The outcomes and learning from the day are being collated to inform next steps.

### Remedial Plans and Actions

**Coroners:** Cases continue to be registered and distributed and the Team has had to introduce a new process surrounding the notification of summons to inquest. This has affected the timeliness of our case registration and distribution. The number of cases where staff are giving evidence for continuity purposes has reduced and the number where staff are giving evidence as the Trust is an IP has increased significantly, representing a quarter of all open cases. This also has a significant impact on the capacity of the Team, as these cases require considerably more management.

**Ombudsmen:** The Trust is in the process of transferring all Ombudsmen cases from the Old Datix system to the new system

**Mortality Review:** The Trust is in the process of developing the internal mechanisms in order to facilitate mortality reviews under the new approach and our internal framework has been approved at the Clinical Quality Governance Group and an internal mortality group (learning from deaths) is being established, closely aligning to the Serious Case Incident Forum.

Representation and contribution by the Trust at the All-Wales Mortality Working Group will continue and a task and finish group has been established to review the process for contacting families following their meetings with the medical examiners. Additionally, the Trust are engaged in the meetings lead by the Once for Wales Datix Cymru team who are developing the Datix Cymru Mortality Module currently.

### Expected Performance Trajectory

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

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

Data source: Datix

Mortality Reviews Data source: Internal Web Application

# Our Patients: Quality, Safety & Patient Experience

## Safeguarding, Data Governance & Public Engagement Indicators

(Responsible Officer: Liam Williams)

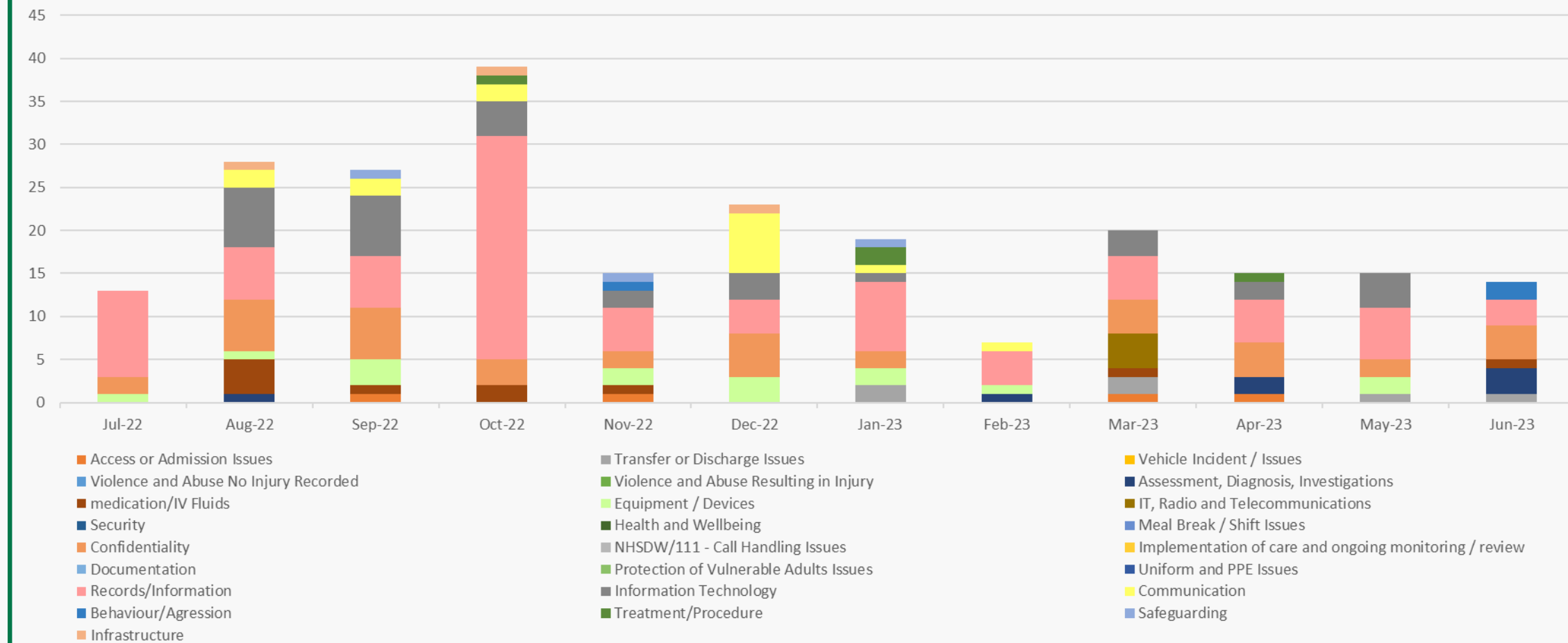
Self-Assessment:  
Strength of  
Internal Control:  
Strong

QUEST

Safeguarding Data source: Doc Works

Health & Care  
Standard  
Health – Safe Care

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



### Analysis

**Safeguarding:** In June 2023 staff completed a total of 155 Adult at Risk Reports, 94% of these were processed within 24 hours. Whilst the Trust does not report on Adult Social Need reports, 476 referrals were received and processed to the local authority during this reporting period.

There have been 236 Child Safeguarding Reports in June 2023, 92% of these were processed within 24 hours.

**Data Governance:** In June 2023 there were 14 information governance (IG) related incidents reported on Datix Cymru categorised as an Information Governance (IG) breach. Of these 14 breaches, 5 related to information governance/confidentiality, 3 records/information, 3 assessment/diagnosis, 2 behaviour/aggression and 1 medication/IV/fluids.

**Public Engagement:** During June, the Patient Experience and Community Involvement Team attended 17 community engagement opportunities, engaging with 1,600 people. This month our engagement has incorporated attendance at several large-scale equality and diversity events including Cardiff Mela and Pride Cymru. At engagement events throughout the month, we continued to use engagement opportunities to listen to people's experiences of using our services and to recruit people to join our People & Community Network. During June we also continued to promote series of Patient Reported Experience Survey's (PREMS), asking people to provide feedback about their interactions with our services. Outcomes of our engagement results collected from surveys remain 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. 111 callers have told us that they experienced long waits for their calls to be answered and reported long waits for call backs. NEPTS users told us that overall, they continue to be happy with the transport they receive but experience long delays when making their initial telephone booking.

### Remedial Plans and Actions

**Safeguarding:** The Trust primarily manages all safeguarding reports digitally via Docworks 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 which is seeing a steady improvement.

**Data Governance:** During the reporting period, of the 14-information governance related incidents reported on Datix, 0 incidents were deemed to meet the risk threshold for reporting to the Information Commissioner's Office (ICO). 1 incident is in the process of assessment of risk for ICO notification reporting. The IG team has provided advice and determined remedial actions for other relevant incidents where appropriate.

**Public Engagement:** Community involvement and engagement with patients/public will form 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 PECEI 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 PECEI 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. The new 'Once for Wales' Patient Experience Recording solution Civica is now slowly being embedded across the Trust and reporting on feedback received through the system will become central to a new Welsh Government reporting framework. Monitoring feedback received and satisfaction scores given by service users will also become a KPI used by the PECEI Team.

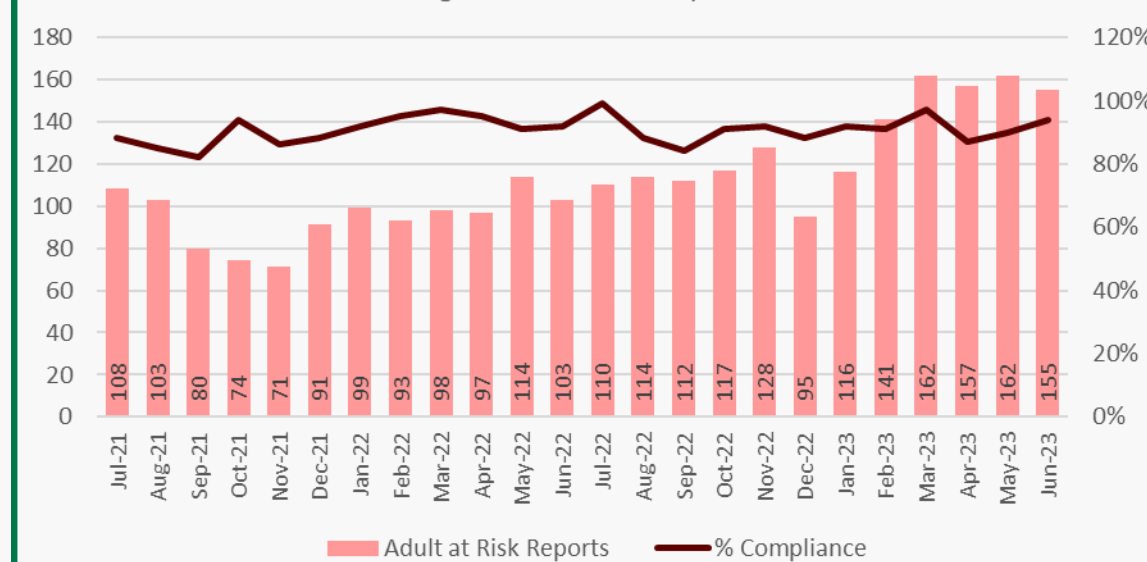
### Expected Performance Trajectory

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

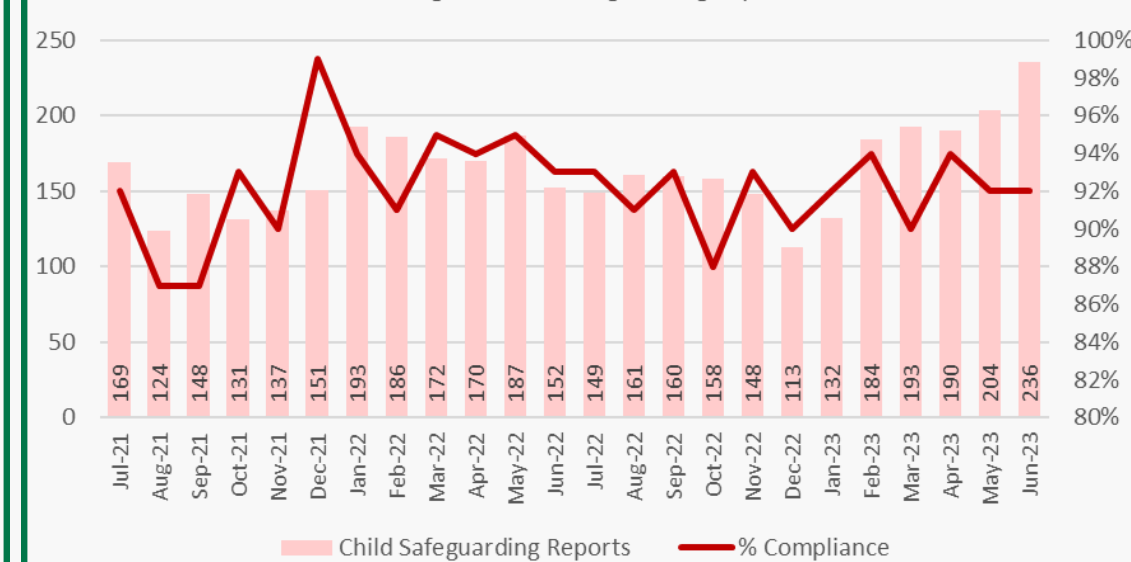
**Data Governance:** The submission for the FY22-23 IG Toolkit closed on 30th June 2023.

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

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



Number and Percentage of Child Safeguarding Reports sent within 24 Hours



\*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

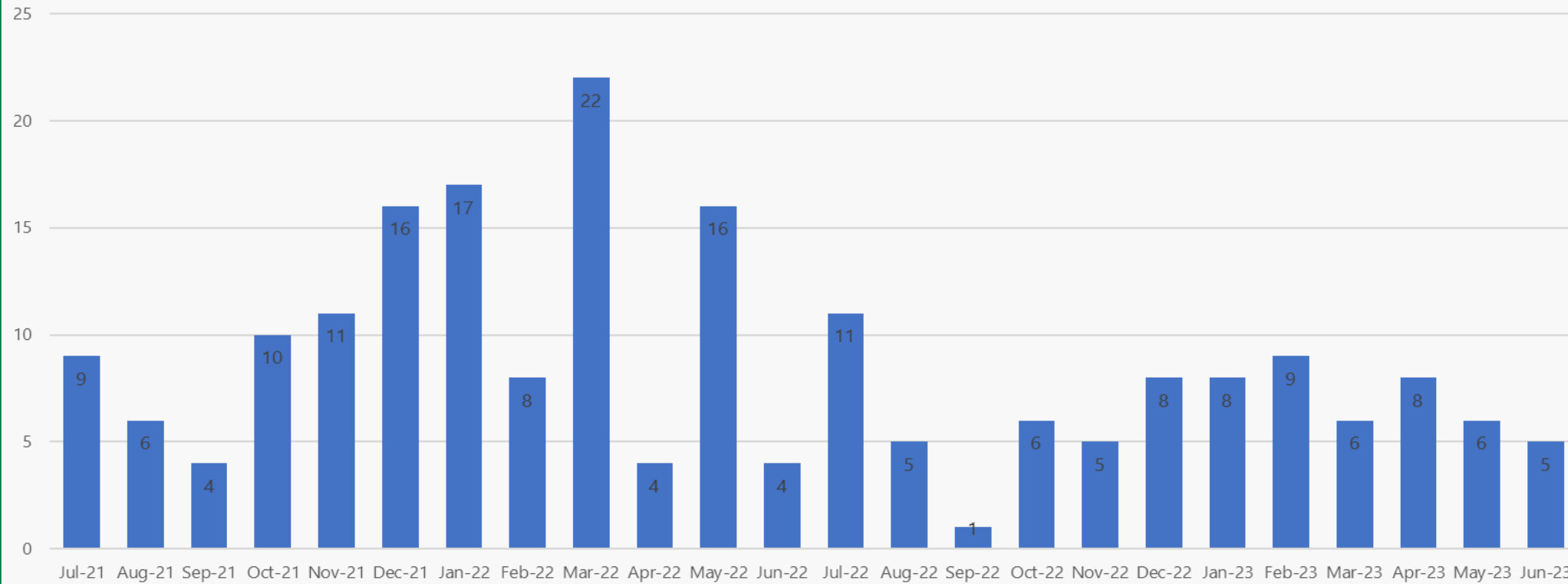
(Responsible Officer: Liam Williams)

Self-Assessment:  
Strength of  
Internal Control:  
Moderate

PCC

Health & Care  
Standard  
Health – Safe Care

Volume of RIDDOR Reports by Month



### Analysis

**RIDDOR:** There were 5 incidents requiring reporting und RIDDOR during June 2023. All were due to staff being absent from work for over 7 days as a result of their injury. 3 of the RIDDOR reports were as a result of Manual Handling whilst moving patients, 1 was a Slip/trip incident and 1 was from contact with an object. Four of the incidents occurred at the patient's property where we have little control over the environment, 2 were whilst using vacuum mattress where greater control of the manual handling method used may have prevented the incident.

80% of the reports were completed within the reporting required timeframes the reduction in reporting on time percentage was due to late notification of the injured person being absent form work for over 7 days to the Health and Safety team. Communication between the Health and Safety Team and the incident investigators continues to provide high levels or reporting performance.

Risk 199 remains rated 15. The revised Health and Safety Policy and Safety Annual Improvement Plan has articulated actions required to implement the controls identified in the risk that will beneficially impact the risk rating during this financial year.

**Violence and Aggression:** The number of V&A incidents reported in June 2023 increased to 63 for the month. Physical Assaults on staff increased to 4 in this reporting period with incidents of verbal abuse increasing to 9.

There was 1 incident recorded of sexual assault with a harm rating of severe.

### Remedial Plans and Actions

**RIDDOR:** The importance of good manual handling techniques in the prevention of muscular skeletal injuries is of vital importance a deep dive of manual handling incidents is ongoing to identify common causation and propose a suitable action plan.

RIDDOR performance continues to be presented in monthly reports and service units business meetings.

**Violence and Aggression:** Collaborative working with AACE regarding V&A training is continuing with the aim of improving the current training to better support staff. Particularly around clinical restrictive physical intervention.

Reestablishment of the Strategic Anti-Violence Collaborative will commence next month continuing to improve working relationships with all four Welsh police forces and Crown Prosecution service and the Trust

Toolbox talks , raising awareness of case management support are taking place across the Region by the Case Manager & V&A Manager to support staff and raise awareness, it is planned to establish regular interaction with staff directly affected by incidents of V&A.

### Expected Performance Trajectory

**RIDDOR:** The reporting of Trust-wide incident statistics has seen an increase in reporting in a number of areas. This is to be encouraged as it provides valuable data that can be trended to identify immediate and underlying causes that can be address by the Health and Safety Team.

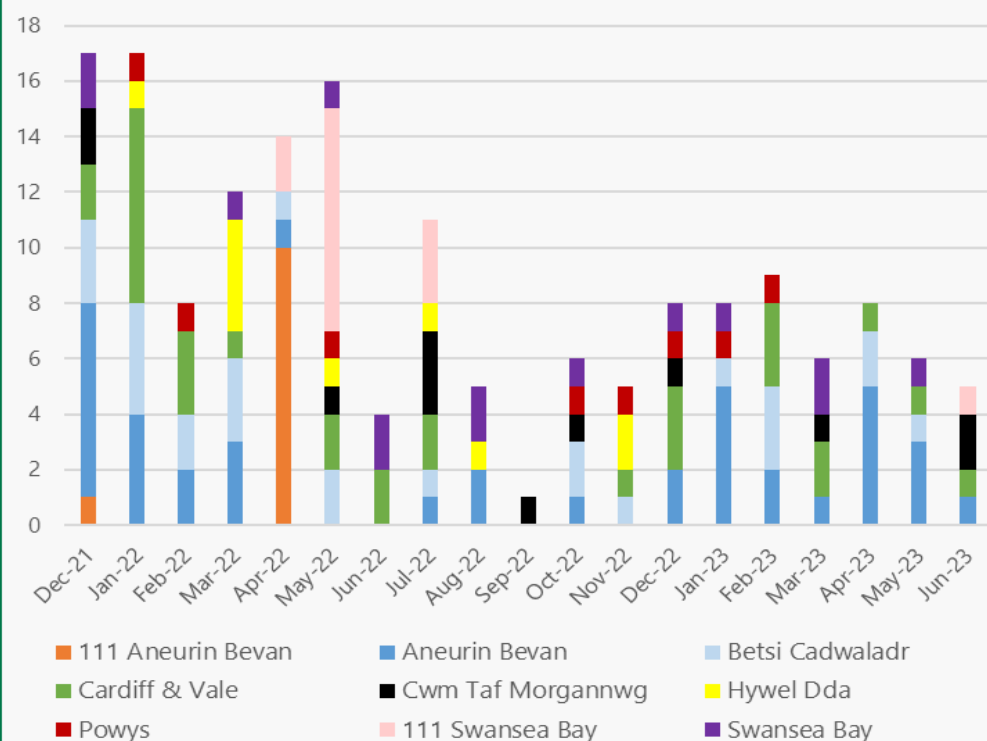
**Violence and Aggression:** Work is continuing in the development of further DATIX dashboards to allow for further scrutiny into V&A incidents by both operational area and Health Board Area with the aim of influencing local interventions where required.

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

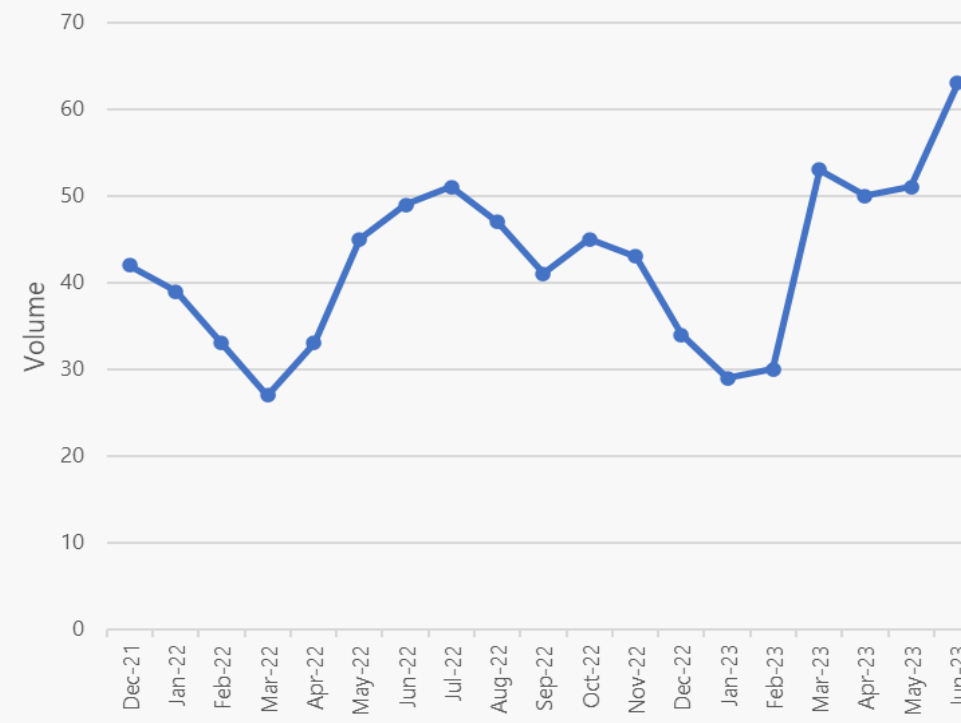
Data source: Datix

Welsh Ambulance Services NHS Trust

Volume of Riddor Reports by Health Board



Total Violence & Agression Reports by Month



# Our Patients: Quality, Safety & Patient Experience

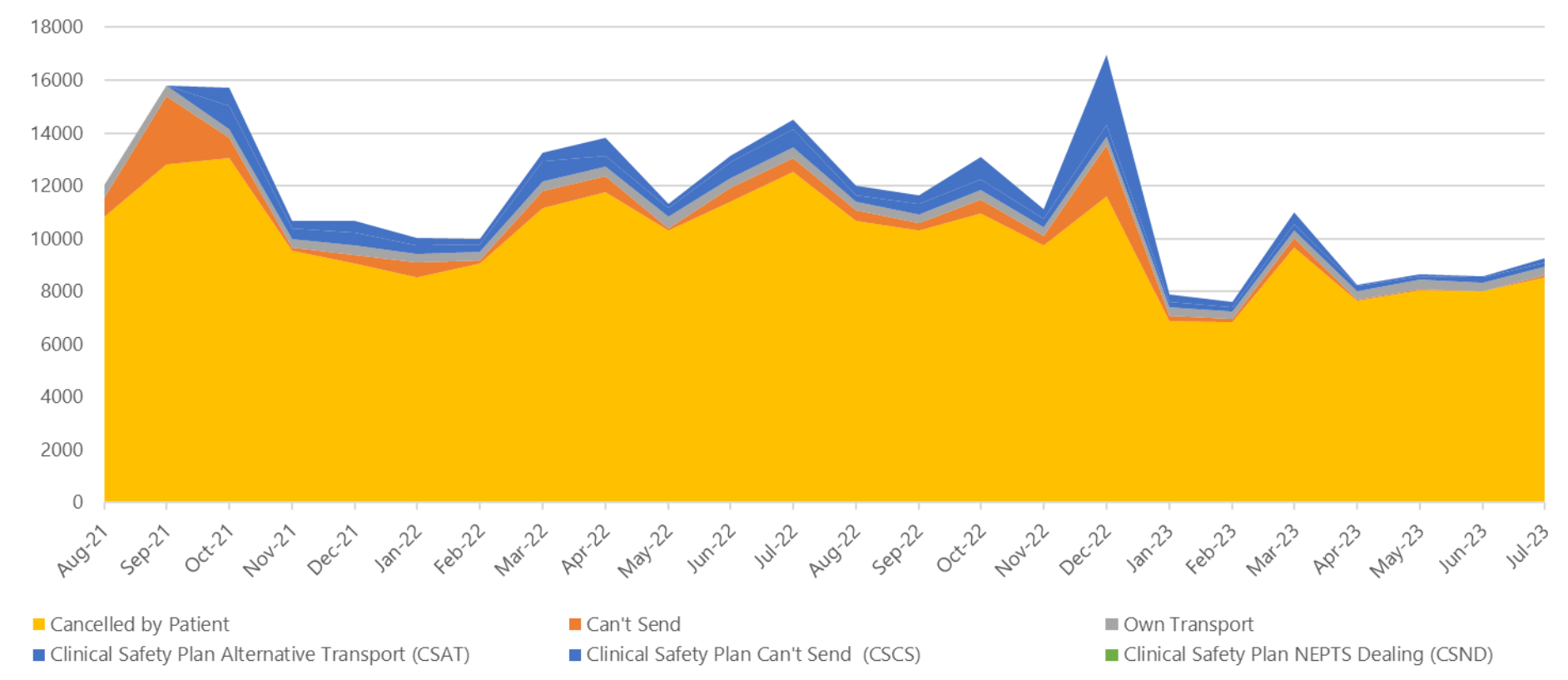
## Escalation and Patient Experience

(Responsible Officer: Andy Swinburn)

TBD

FPC

Numbers of Patients with No Send or Cancelling Ambulance



### Analysis

In July 2023, 153 ambulances were stopped due to Clinical Safety Plan (CSP) alternative transport and 154 were stopped as a result of CSP 'Can't Send' options. In addition, 8,533 ambulances were cancelled by patients (including patients refusing treatment at scene) and 332 patients made their way to hospital using their own transport.

There were 662 requests made to Health Board EDs for immediate release of Red or Amber 1 calls in July 2023. Of these 139 were accepted and released in the Red category, with 7 not being accepted. Further to this, 178 ambulances were released to respond to Amber 1 calls, but 338 were not.

The graph in the bottom left shows that in June 2023 of the 5,311 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% (797 patients) would experience no harm, 53% (2,815 patients) would experience low harm, 23% (1,221 patients) would experience moderate harm and 9% (478 patients) would experience severe harm.

In June 2023 CSP levels for the Trust were:



CSP Level	RED	AMBER 1	AMBER 2	GREEN	HCP
0	Business As Usual				
1	Respond	Respond	ETA - ALT Transport		
			Respond to Exceptions		
2a	Respond	Respond	ETA - ALT Transport		
			Respond to Exceptions		
2b	Respond	65th ETA Script			
		ALT Transport			
		Respond to Exceptions			
2c	Respond	65th ETA Script		Can't Send	
		ALT Transport		Can't Send	Pass to ROU or EMG
		Respond to Exceptions			
3a	Respond	90th ETA Script		Clinical Screening	Can't Send
		ALT Transport			
		Respond to Exceptions			
3b	Respond	Clinical Screening		Can't Send	
4a	Clinical Screening		Can't Send		
4b	Clinical Screening		Can't Send		

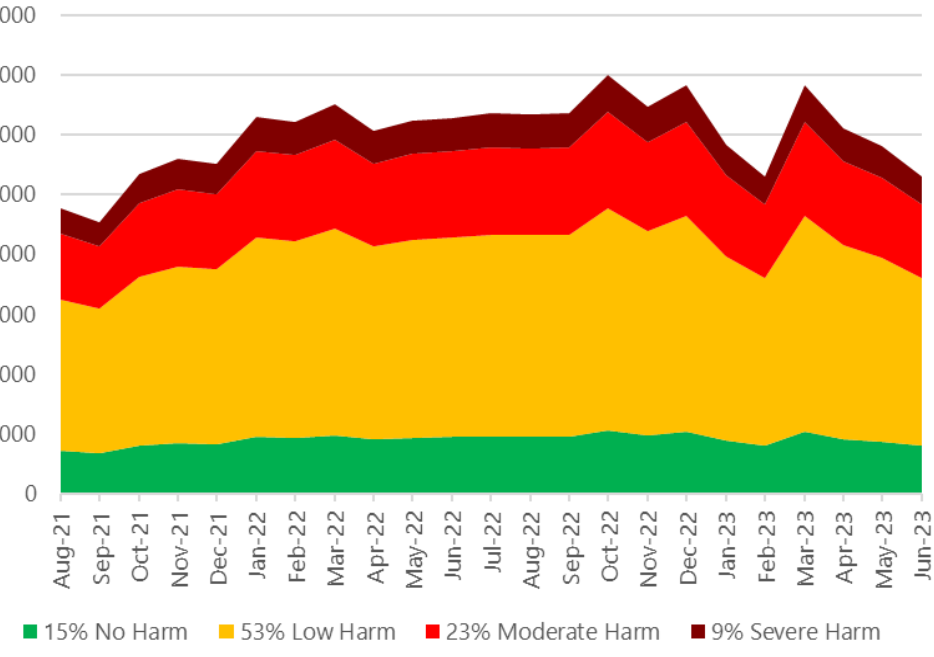
### Remedial Plans and Actions

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.

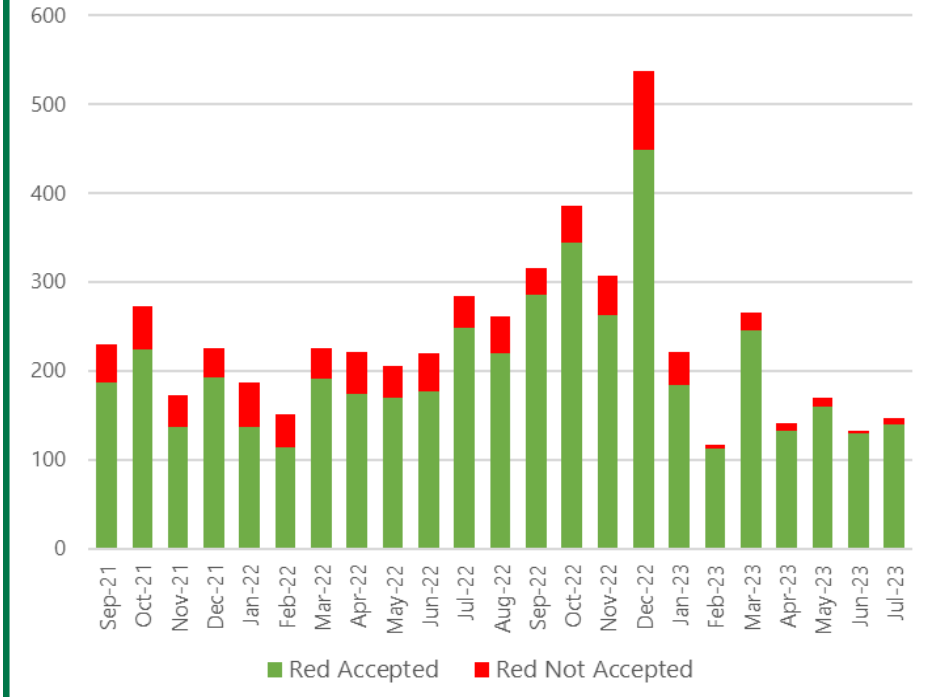
### Expected Performance Trajectory

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.

Modelled Harm Coming to Patients Who Wait Over 60 Minutes for a Hospital Handover



Pan-Wales Immediate Red Release



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

# Our People Capacity - Ambulance Abstractions and Production Indicators

(Responsible Officer: Lee Brooks)

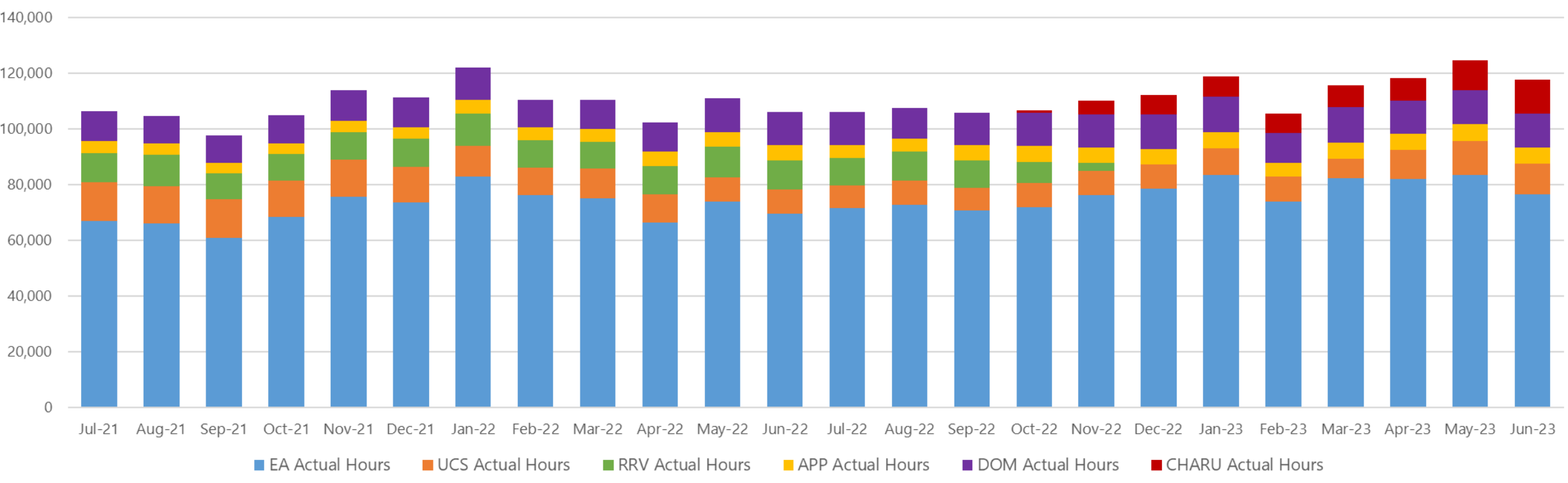
EA Production Abstractions

G R

CI PCC

FPC

Total EMS Actual Hours Produced



### Analysis

As shown in the bottom graph, monthly abstractions from the rosters are key to managing the number of hours the Trust has produced. In June 2023, total EMS abstractions (excluding Induction Training) stood at 34.02%. This was a slight decrease from the 34.28% recorded in May 2023. However, this percentage remains above the 30% benchmark figure set in the Demand & Capacity Review. The highest proportion of abstractions was due to annual leave at 15.69% followed by sickness at 8.47%. This figure for sickness abstractions for June 2023 was lower when compared to the same month last year (10.07%).

**Emergency Ambulance Unit Hours Production (UHP) was 92% in June 2023** (76,577 Actual Hours). CHARU UHP achieved 139% (11,996 Actual Hours) compared to 121% in May 2023 (this is the commissioned level not the modelled level). The total hours produced is a key metric for patient safety. The Trust produced 117,574 hours in June 2023, which is higher than the 124,692 hours produced in May 2023.

### Remedial Plans and Actions

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

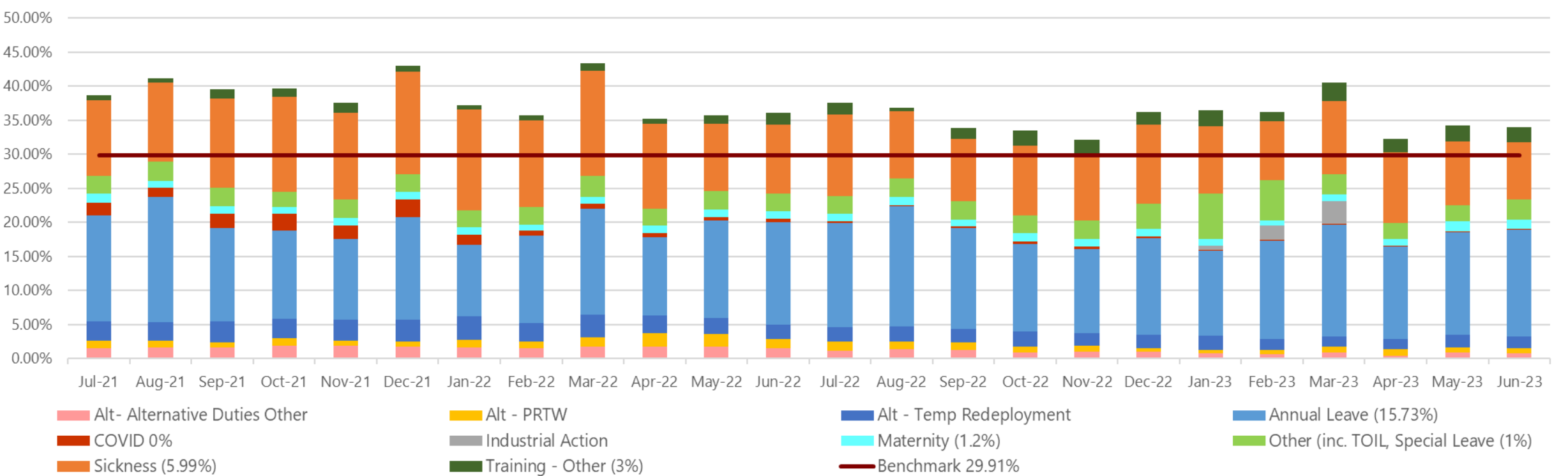
The Trust has a budgeted establishment of 1,761 FTEs for 2022-23. This is changing due to internal movements e.g., new APPs, EMT3s, maximising the inflow of NQPs. The vacancy factor has been very low with a prediction to widen to 5% by August, which will be reviewed.

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 EMT.

Pan Wales EMS Total Rota Abstraction Hours

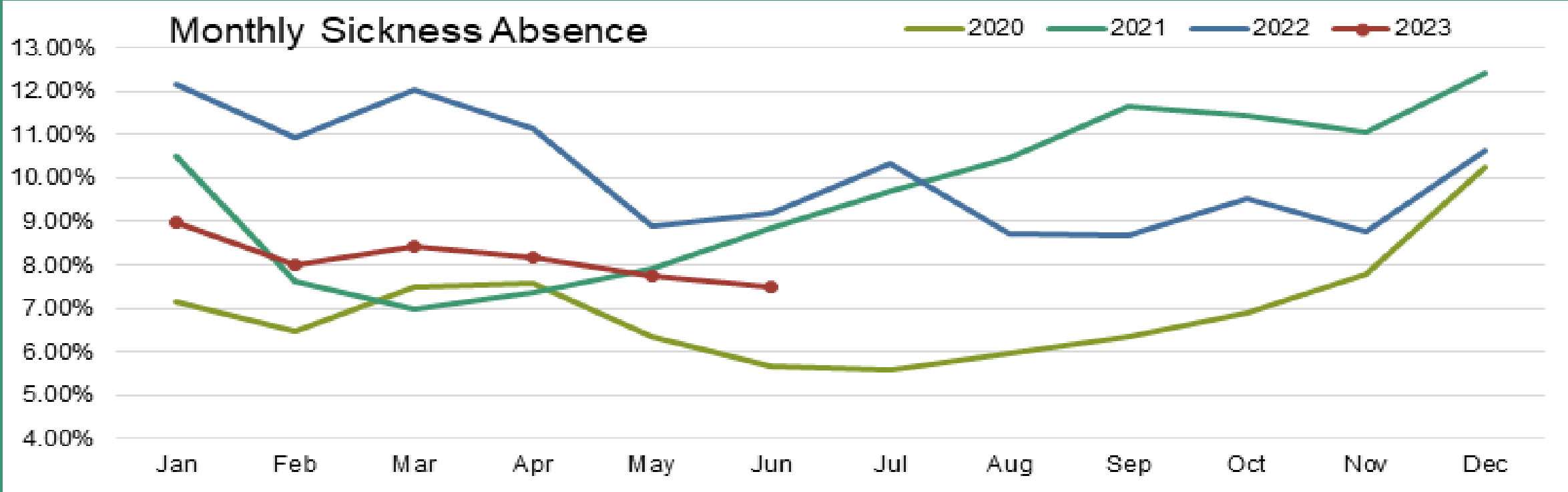


# Our People Capacity - Sickness Absence Indicators

(Responsible Officer: Angela Lewis)



NB: Sickness data will always be reported one month in arrears.



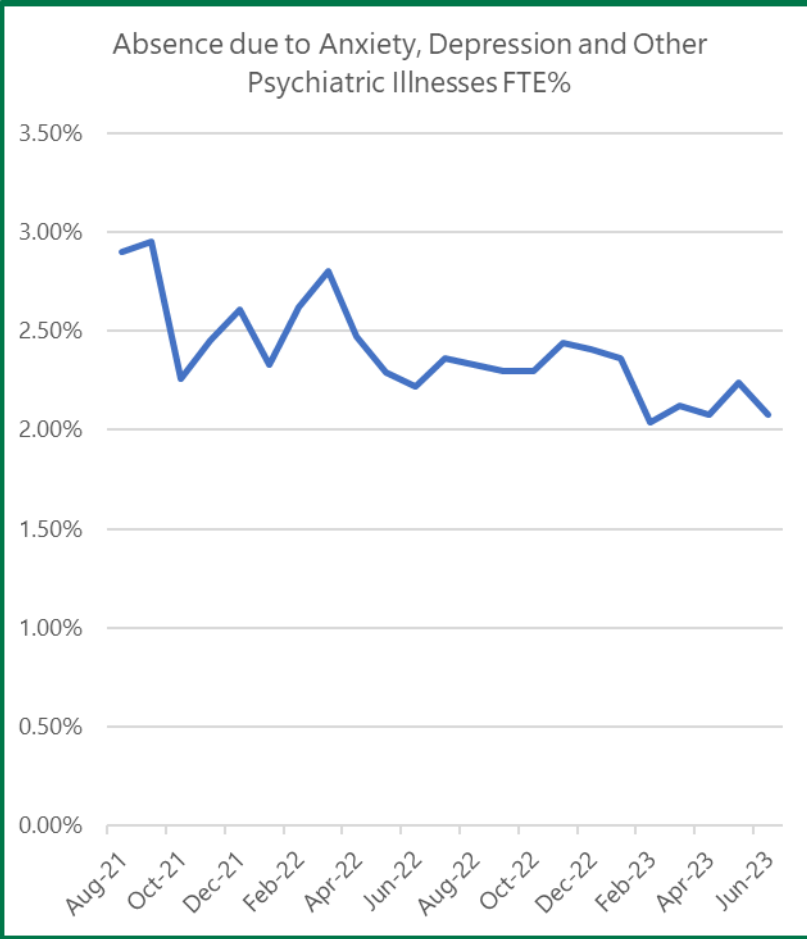
**Analysis**  
 There was a decrease in sickness absence in June 2023, decreasing from 7.76% in May 2023 to 7.51% in June 2023. Short-term absence increased slightly from 2.05% in May to 2.70% in June, while long-term absence, decreased from 5.71% in May to 4.81% in June.

Indicative figures (as of 24.07.2023) show an increase in sickness absence in July 2023 to 8.06%, with long term absence increasing to 5.18% and short-term absence to 2.88%.

**Remedial Plans and Actions**

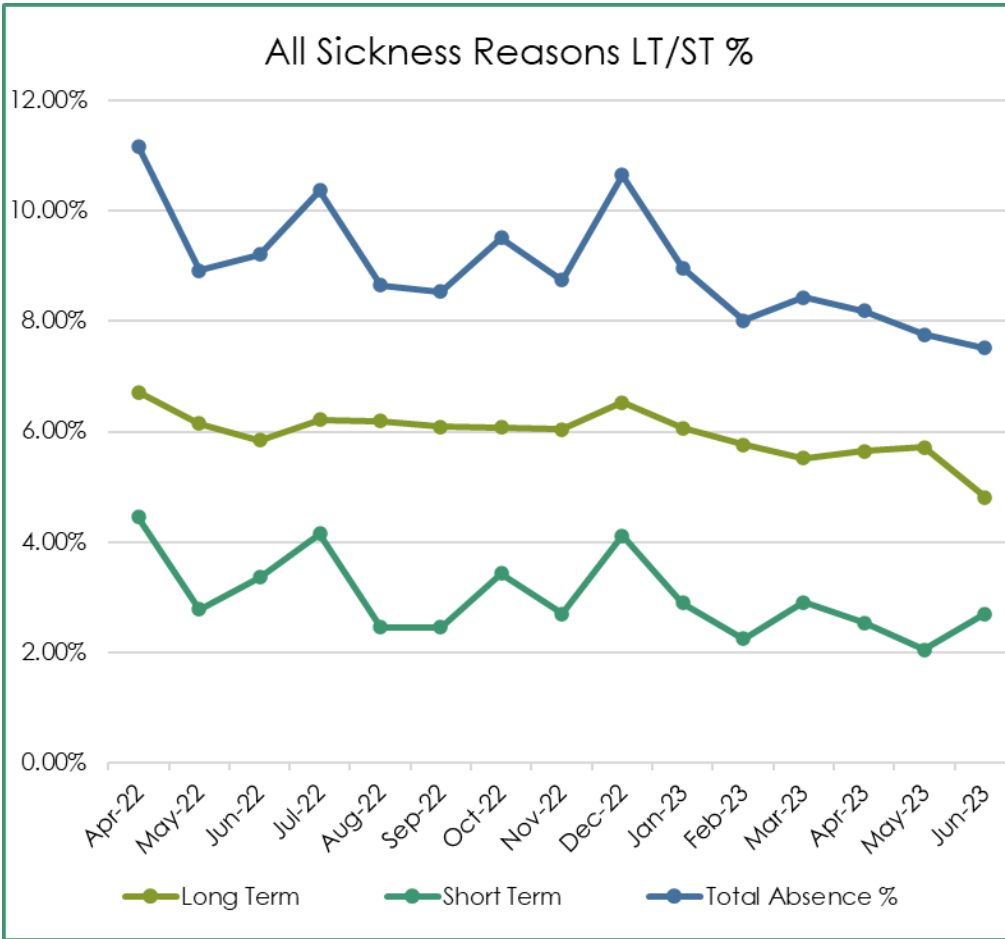
- MAAW training and bitesize training sessions continue to be scheduled on a bi-monthly (MAAW) and monthly basis (Bitesize sessions).
- In line with the Improving Attendance Action Plan, the People Services Advisors have undertaken audits on short term absence occurrences within the Operations Directorate.
  - 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.
- Indicative figures for short term absence in June 2023 shows an increase to 2.85% from 2.67% in May. The highest reasons for short term absence in May & June 2023 are Anxiety/ Stress/ Depression, Musculoskeletal, Cough/ Cold/ Flu, Headache/ Migraine and Gastrointestinal problems.
- Physiotherapy: 38 referrals were received in May 2023; this was 7 less than April 2023.

**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.



Average working days lost per FTE (Annual)	
20.03 days	
Single month Absence %	
7.51%	
Long Term	Short Term
5.59%	1.91%
Mental Health	Other MSK
(S10 Stress/Anxiety)	(excluding Back)
2.08%	1.13%

June 2023

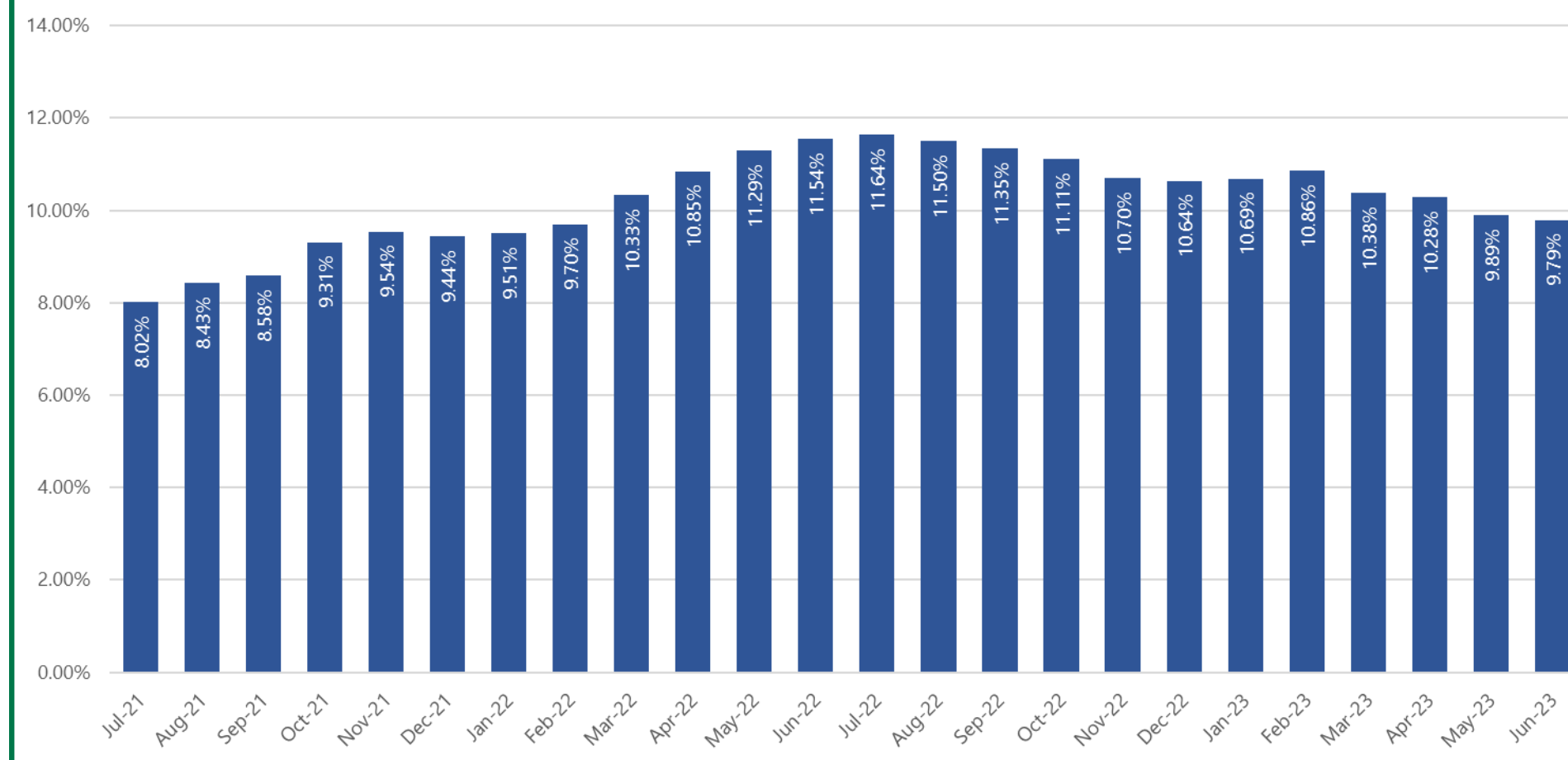


# Our People Capacity - Turnover

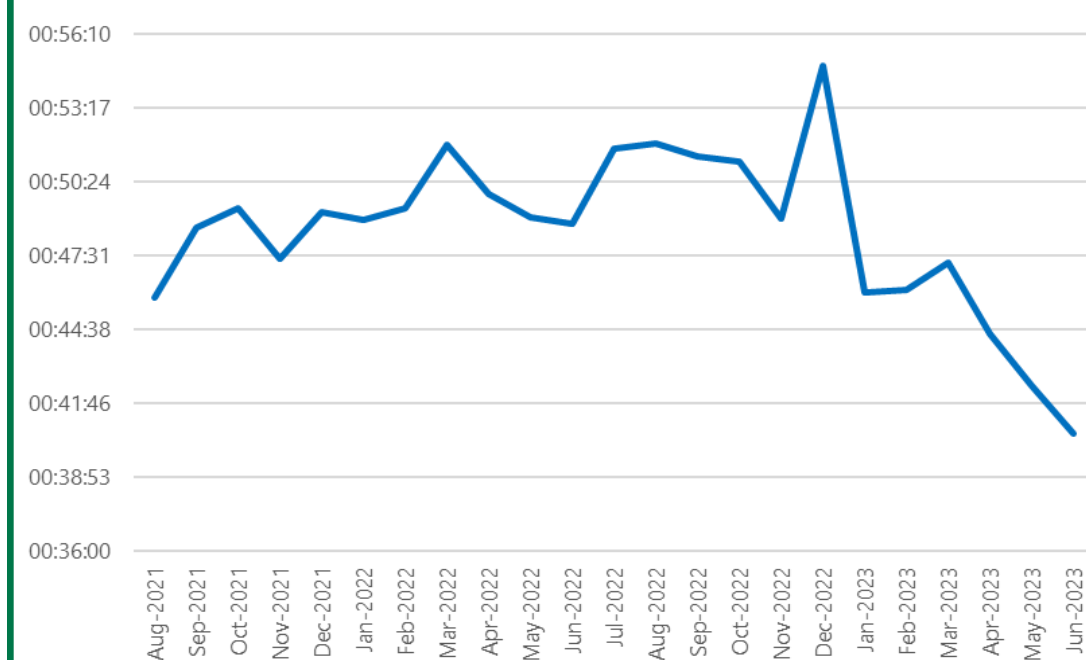
(Responsible Officer: Angela Lewis)

A

Staff Turnover Rate FTE (% Employees leaving the Organisation) (12m)



Average Shift Overrun Time (All Resource Types)



May-23	FTE by Post
Org L4	
020 Ambulance Care L4 (NX10)	908.09
020 Emergency Medical Services L4 (DX04)	1,785.90
020 Integrated Care L4 (DX03)	435.19
020 National Operations & Support L4 (DX02)	134.57
020 Resourcing & EMS Coordination L4 (DX05)	347.03
<b>Grand Total</b>	<b>3,610.78</b>
<b>Ambulance Response</b>	<b>1536.81</b>
<b>020 Ambulance Care L4 (NX10) ACA2/Team Leaders</b>	<b>281.2</b>

## Analysis

Staff turnover rates in June 2023 were 9.79%. However, rates have gradually been declining since they peaked in July 2022, with the current monthly rate being the lowest reported since February 2022. Staff leave the Trust for a variety of reasons including promotions, relocations, culture and due to the pressures of NHS working.

WAST remains committed to colleague wellbeing, and ensuring appropriate provisions are in place to support colleagues. We have an EAP which enables our people to access support 24/7, with access to counselling. We continue to deliver workshops for colleagues on stress, and wellbeing and resilience to support them in their roles. We have had guest speakers join our Circle of Support and Women's Health Group this month, delivering talks on cold water swimming and how to deal with chronic pain. We continue to run health promotion, having focused on mental health awareness week and men's health more recently.

## Remedial Plans and Actions

Accessible financial wellbeing support is available to colleagues through a dedicated page on Siren. The page links to a short video presentation outlining available support, ideas shared through the digital suggestion box which remains open to all colleagues (including our volunteers) and broader employee benefits information. A podcast has been recorded with the Money & Pensions Service and will be shared through communications platforms in April 2023.

The WAST Voices Network held its first Advocate meeting in March 2023 and activity continues relating to themes of misogyny and sexual safety within the organisation. Reverse mentoring relationships have been established and the impact of these will be measured after 2 sessions of Senior Leaders hearing from lived experience of these issues.

Work around improving the preparedness of new colleagues has begun and we now facilitate group discussions around anti racism and sexual safety at all welcome sessions. We are also capturing organisational culture experiences through the 3 months check in carried out with all new colleagues. The allyship programme continues to be rolled out for current colleagues and where required, team interventions taking place.

A volunteer wellbeing package has been put together and the OD Team are running monthly evening Warm WAST Welcome sessions for new volunteers.

WAST Outdoors initiatives being trialled.

## Expected Performance Trajectory

The situation regarding wellbeing of staff remains challenging, many of the difficulties and frustrations are difficult to influence and change. Management development will continue with a focus on people skills and support with robust wellbeing offers so colleagues know where to get support. The People and Culture Plan will continue to highlight that employee experience and culture contribute to overall wellbeing.

The wellbeing offer is regularly reviewed and fully described on SharePoint.

# Our People Culture - Staff Vaccination Indicators

(Responsible Officer: Angela Lewis)

Self Assessment:  
Strength of Internal  
Control: Moderate

Flu  
**R**

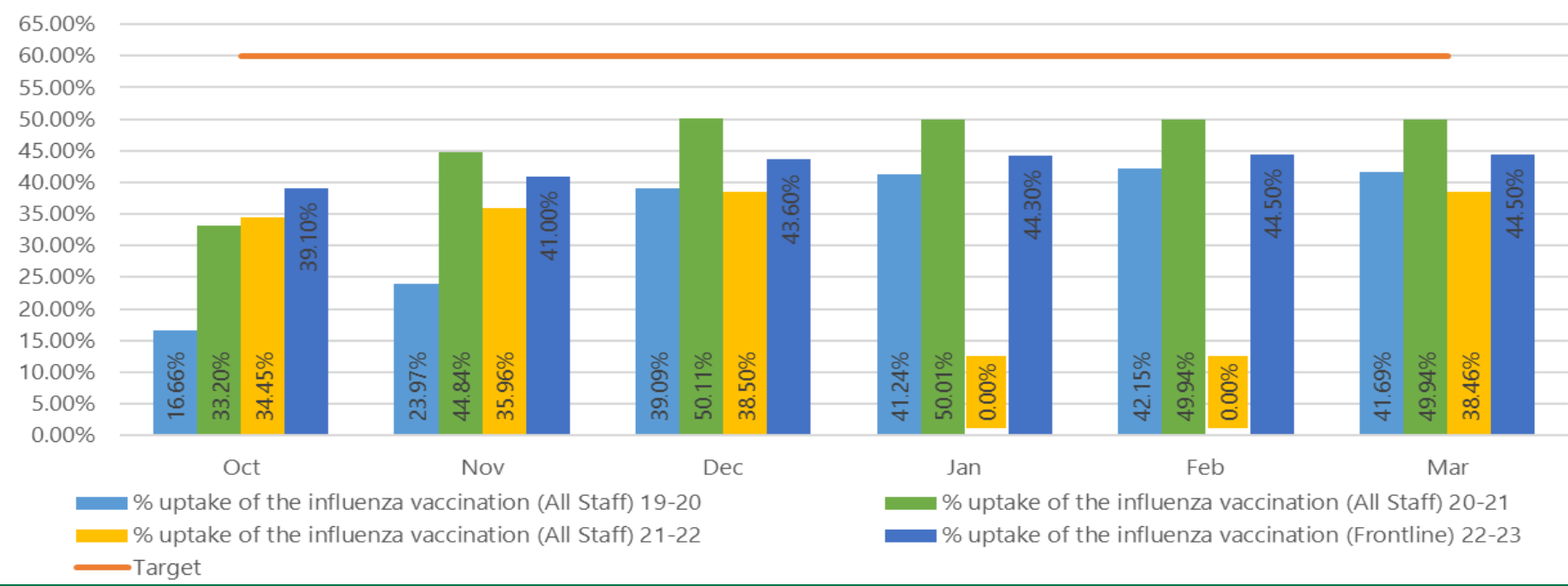
PCC

CI

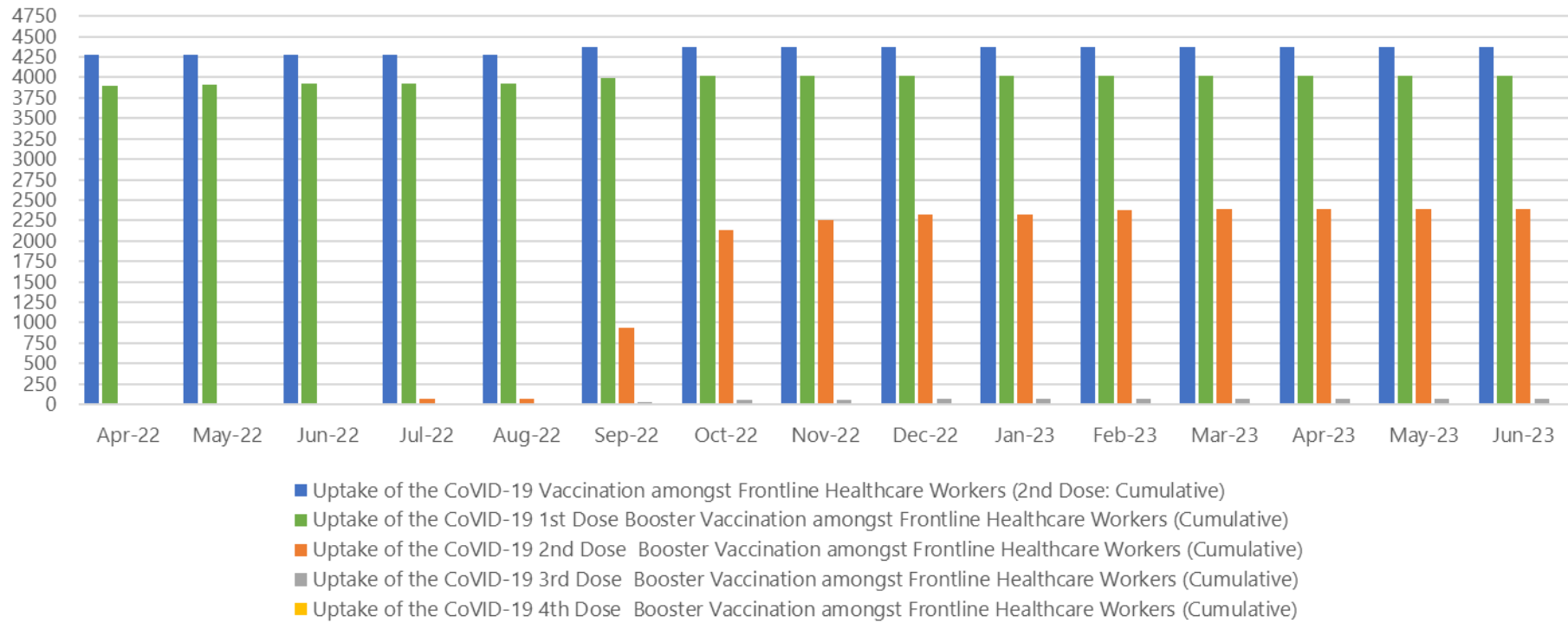
Health & Care  
Standard  
- Health (PPI)

NB: Flu – Next reporting schedule is October 2023

% Uptake of the Influenza Vaccination amongst WAST Frontline Healthcare Workers



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



## Analysis

**Flu:** The 2022-23 Flu Campaign has officially come to an end, concluding data collection as of 28<sup>th</sup> February 2023. During the campaign 1,813 flu vaccines administered by Occupational Health Vaccinators and Peer Vaccinators (including flu vaccines administered to PHW staff / Students / HCS staff etc.) Of these vaccines administered within the Trust, 1,601 were received by WAST staff. There was a further 289 given to staff elsewhere (i.e., GP surgery, COVID Booster setting) therefore a total of 1,890 WAST staff received the vaccination against flu, equating to 44.5% of the overall workforce. Additional engagement was received from 247 WAST staff completing the Microsoft Form indicating that they have chosen to opt-out of having the flu vaccine, concluding the campaign with 50.3% engagement rate.

Both the vaccine uptake and Microsoft Form engagement surpassed that experienced in the previous campaign last year, 2021-22. There was a 6% increase on vaccinations and a 9.6% increase in engagement. Patient facing staff specifically saw a 46.3% uptake of the vaccine this year (a 5.2% increase from last year).

**COVID-19:** As of end of June 2023, front line (Patient Facing and Non-Patient Facing staff), 94% (4,404) of staff have received a first dose COVID-19 vaccination, 94% (4,377) have received a second dose, 86% (4,026 Staff) have received the Booster 1 vaccination and 51.2% (2,389) have received the Booster 2 vaccination.

## Remedial Plans and Actions

**Flu:** Following a full review of this year's campaign, recommendations have been devised based on some of the key areas of learning and development. The aim is to streamline current processes, remove duplication of effort and improve engagement with the workforce. It is evident that positive steps have been made, and a number of the lessons learnt from the previous campaign have been implemented. However, there is a range of areas that require continued development for future campaigns. Planning for the next Flu Campaign is expected to start shortly, earlier than ever before.

**COVID-19:** Welsh Government have been involved in discussions between the four UK Chief Medical Officers (CMOs) regarding the UK Covid-19 alert level. This alert level system has been in operation since May 2020. Its function is to clearly communicate, to the public and across governments, the current level of direct Covid-19 risk. Since September 2022, we have been at level 2. The four UK CMOs have agreed it is appropriate to pause the alert level system. It was suspended on 30 March.

Routine testing will be paused for all symptomatic health and social care workers, care home residents, prisoners and staff and residents in special schools over the (2023) spring and summer.

## Expected Performance Trajectory

The 2022-23 Flu campaign has now concluded. The Trust will continue to monitor influenza and COVID-19 through intelligence gathered by the Forecasting & Modelling Group on a weekly basis. Any learning from southern hemisphere countries will be shared and used for modelling purposes for the 2023-24 winter flu season.

*\*NB: Due to a technical error in the downloading of data for the Trust are unable to report monthly flu data for January & February 2022.*

*\*\*NB: COVID Vaccinations are reported using the WAST definition of Frontline Patient Facing employees and therefore includes those employed within Clinical Contact Centres.*

*\*\*\*NB: Flu data accurate at time of publication and subject to change / Spikevax vaccination data correct at time of publication and subject to change.*

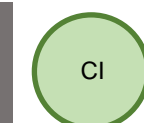
Date source: Cohort Electronic System / Welsh Immunisation System (WIS)

# Our People Capability - PADR and Training Rates Indicators

(Responsible Officer: Angela Lewis)

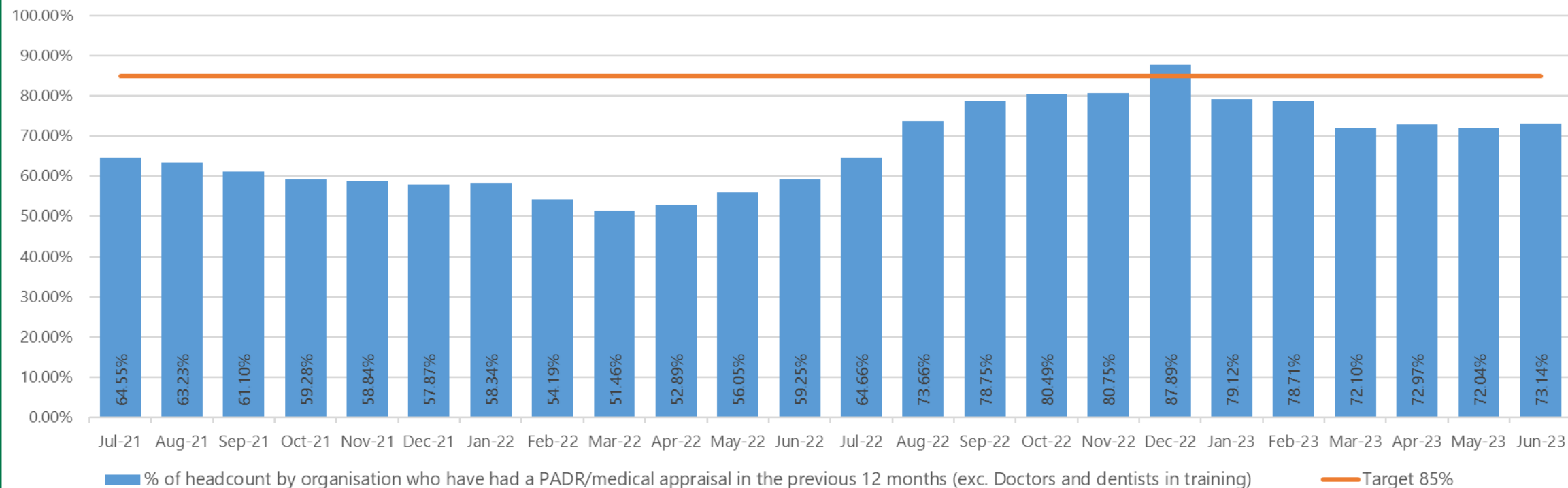


Self-Assessment:  
Strength of Internal  
Control: Strong



Health & Care  
Standard  
Health – Staff &  
Resources

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



## Analysis

PADR rates for June 2023 increased slightly when compared to the previous month to 73.14% but remains below the 85% target. Over the reporting period this target has only been achieved once, in December 2022, although current rates are significantly higher than during the same period last year.

In June 2023 Statutory & Mandatory Training rates reported a combined compliance of 77.53%; with Safeguarding Adults (92.1%), Dementia Awareness (91.3%) and Violence Against Women, Domestic Abuse & Sexual Violence (85.8%) all achieving the 85% target. Moving & Handling (78.3%), Fire Safety (75.2%), Equality & Diversity (76.2%), Information Governance (69.5%), and Paul Ridd (50%) all remain below this target. The Paul Ridd course is new and is the reason for a reduction in overall compliance.

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

At the time of reporting, 1200 of 1,836 EMS colleagues (65.3%), 94 of 284 ACA2 (33%) and 240 of 540 ACA1 colleagues (44.8%) have completed MIST Training days. Sessions continue to be facilitated Pan-Wales through the Education and Training Team, who Continue to manage and monitor these via the online booking system accordingly. Sessions have now completed for the training year 2022/2023, although we may have a small number of colleagues who complete it as a part of their return to work if they have been absent from patient facing duties for more than 6 months.

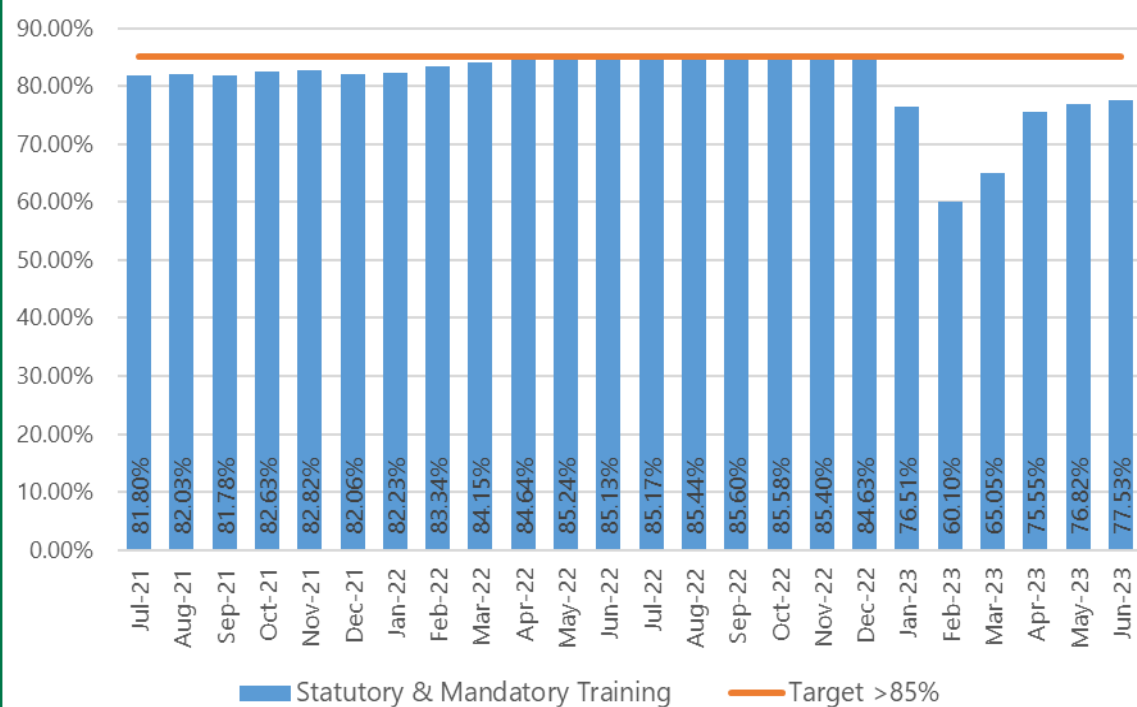
From the 01 April 2023 e-learning mandated by Welsh Government in relation to Welsh Language will be added to all colleagues' compulsory competencies via ESR. Communication to ensure colleagues are prepared and aware of this continues to be circulated via Siren and Yammer.

## Expected Performance Trajectory

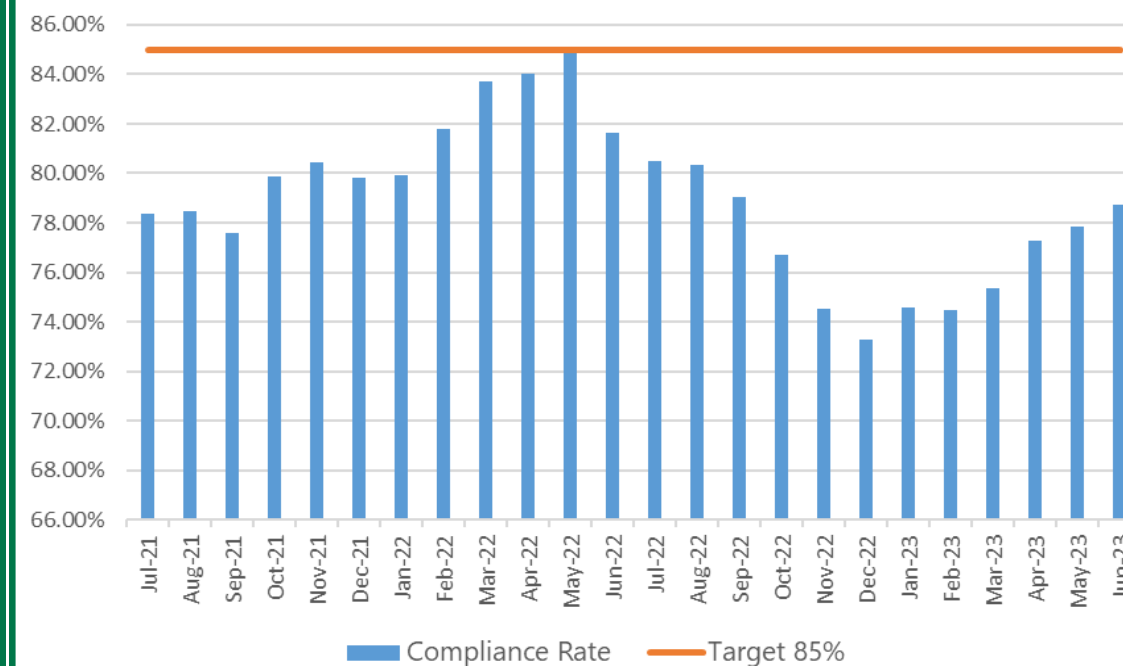
Performance is improving as compliance Has risen in relation to Paul Ridd

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
<b>Mandatory Courses</b>	
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

% Compliance Statutory and Mandatory Training (10 CSTF Modules)



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

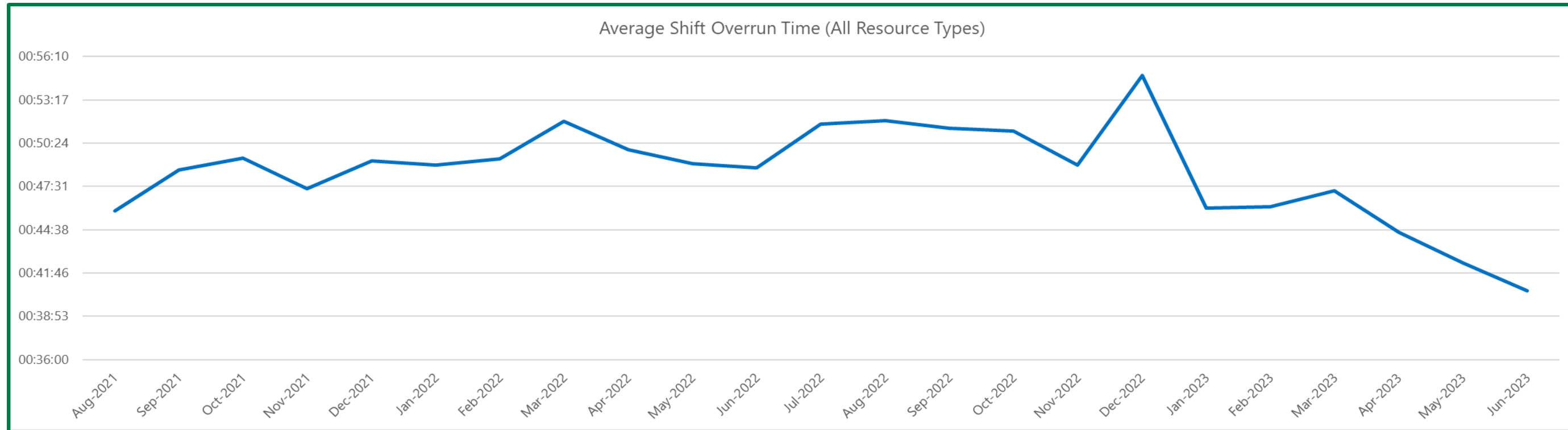
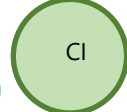


Data source: ESR

# Our People

## Health and Well-being – Shift OVERRUNS

(Responsible Officer: Angela Lewis)

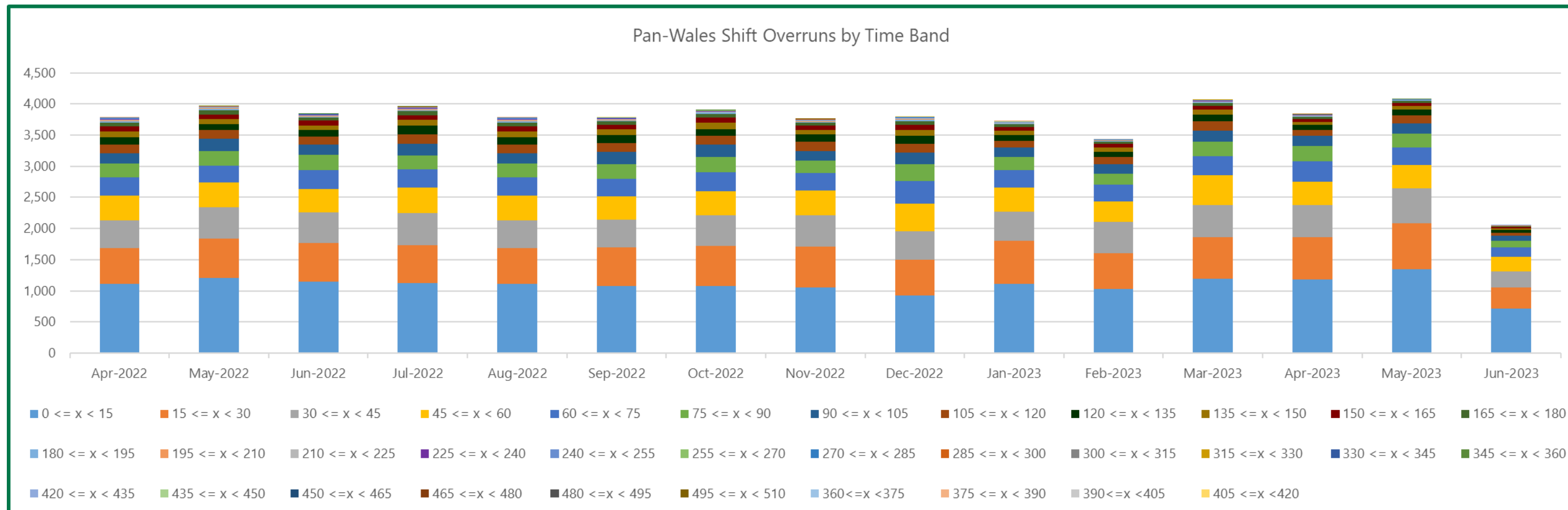


**Analysis**  
 The average shift overrun (for all resource types) in June 2023 was 40 minutes and 36 seconds, a decrease when compared to the previous month (42 minutes and 26 seconds).

The highest volume of shift overruns occur within the 0 to 60-minute category, accounting for 69.1% of the total. 21.6% fall within the 61 to 120-minute category, 7.8% in the 121 to 180-minute category, 1% in the 181 to 240-minute category and 0.5% 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.

**Expected Performance Trajectory**  
 A new People and Culture Plan is due to be launched in the coming months along with an accompanying enabling framework that covers People and Culture Directorate Plans that focus on our people.



# Finance, Resources and Value

## Value - Finance Indicators

(Responsible Officer: Chris Turley)

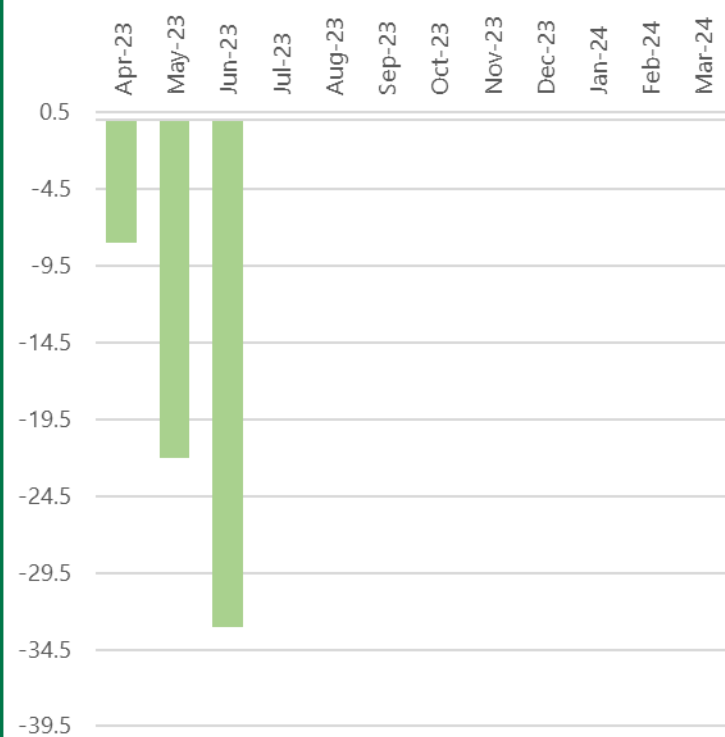
G

FPC

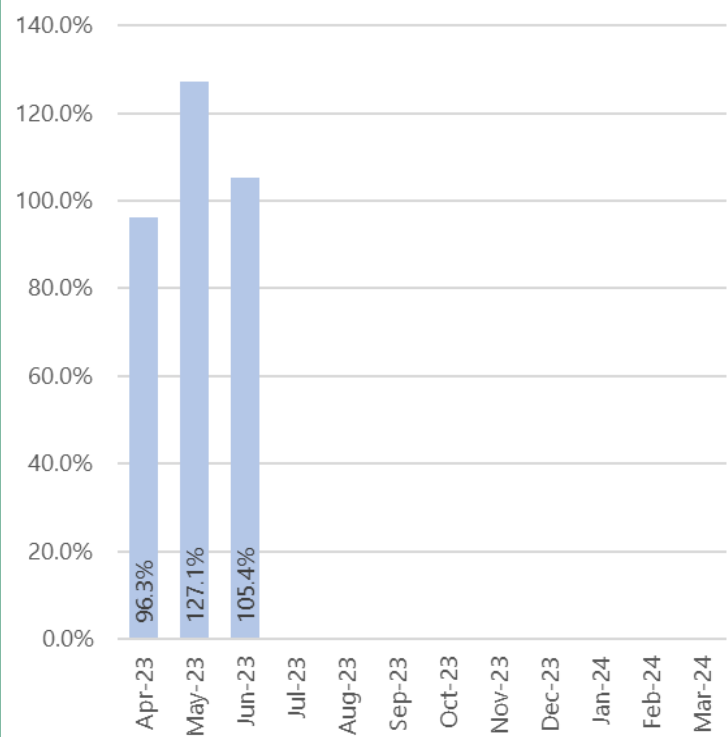
Financial balance - annual expenditure YTD as % of budget expenditure YTD



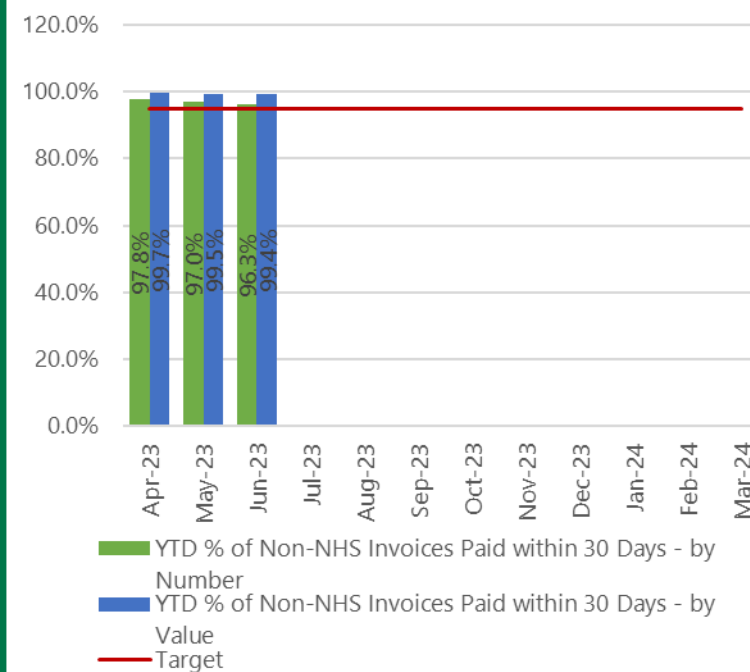
Actual Trust Surplus/(Deficit) YTD - £000



Actual Savings YTD as % of Planned Savings YTD



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



### Analysis

The reported outturn performance at Month 3 is a deficit of £33k, with a forecast to the year end of breakeven.

For Month 3 the Trust is reporting planned savings of £1.727m and actual savings of £1.820m.

The Trust's cumulative performance against PSPP as at Month 3 is 96.3% against a target of 95%.

At Month 3 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 31<sup>st</sup> 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 2022/23 financial plan and beyond include:

- 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.

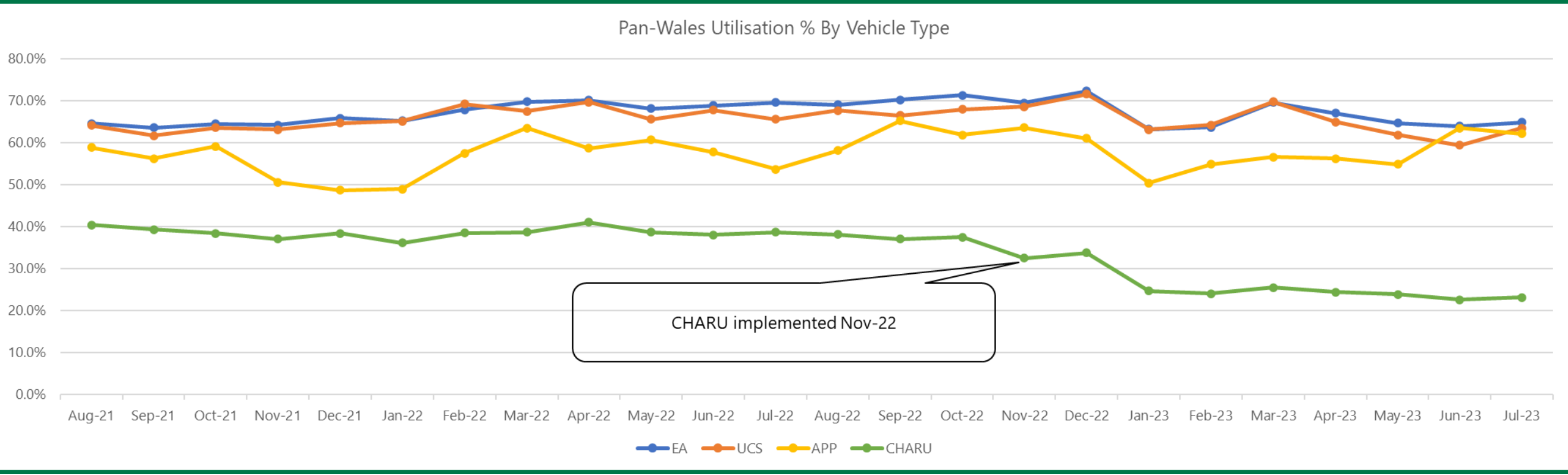
# Value / Partnerships & System Contribution

## EMS Utilisation & Postproduction Lost Hours Indicators

(Responsible Officer: Lee Brooks)

Utilisation  
**A**

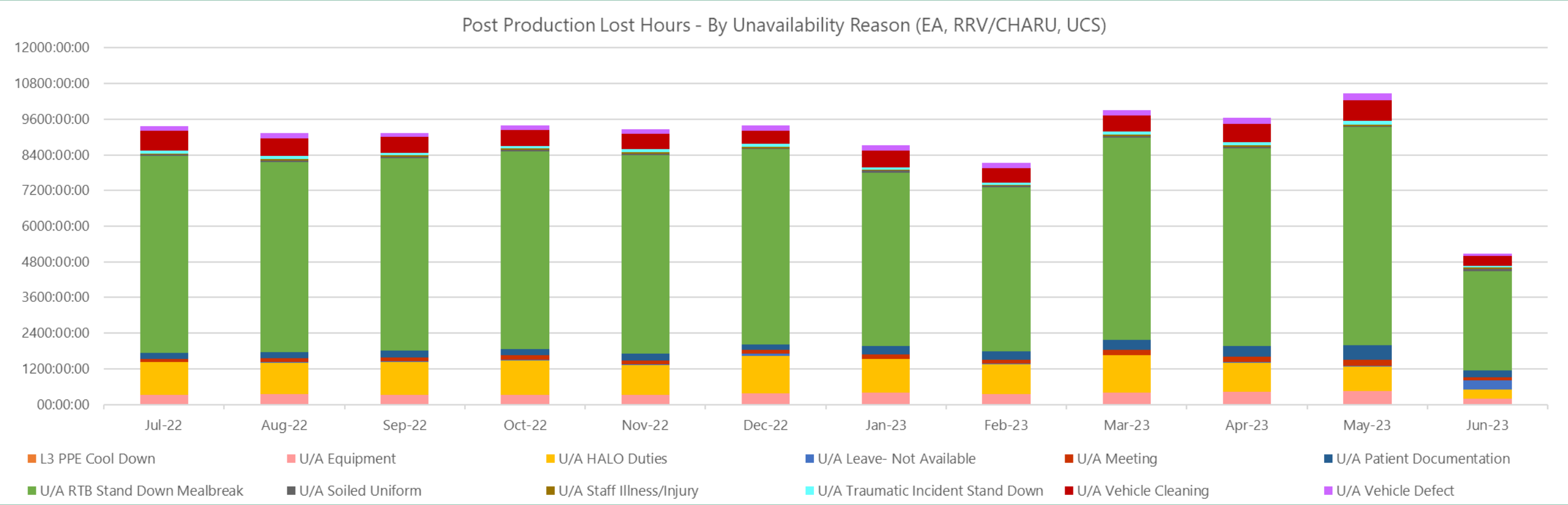
FPC



**Analysis**  
**Pan Wales Utilisation metrics in July 2023 was 55.9% for all vehicles types, a slight increase from 55.3% in June 2023.** EA achieved the highest rate during the month at 64.9% while UCS was at 63.5%. Both have seen a generally increasing trend over the past two years before dropping off slightly between March and June 2023. The optimal utilisation rate for EAs needs to lower so that they are free to respond to incoming calls.

There were 5,035 post-production lost hours (PPLH) across EA, RRV/CHARU, APP & UCS vehicles in June 2023; which is considerably lower than in May 2023 (10,505) and lower than all months in the past year. However, it has been identified that this low figure is due to no data being available between the 14<sup>th</sup> and 26<sup>th</sup> June following the CCM update. Unfortunately, it is unlikely that this data will be recoverable and therefore the June figure will remain low.

PPLH are due to numerous factors, as outlined in the bar chart, which demonstrates they remained relatively consistent since May 2022 (the month a retrospective fix was undertaken for the under-reporting of U/A RTB Stand Down Meal-break code).



**Remedial Plans and Actions**  
 The Trust will not be able to eliminate PPLH, however, efficiency options continue to be worked through, and PPLH are monitored and scrutinised closely, forming part of the weekly performance meeting. In relation to the U/A RTB Stand Down Meal-break reason, the rest break automation initiative has been paused due to industrial relations. The Trust plans to revisit this once the industrial dispute with Welsh Government has concluded. Good progress has been made on other areas of PPLH.

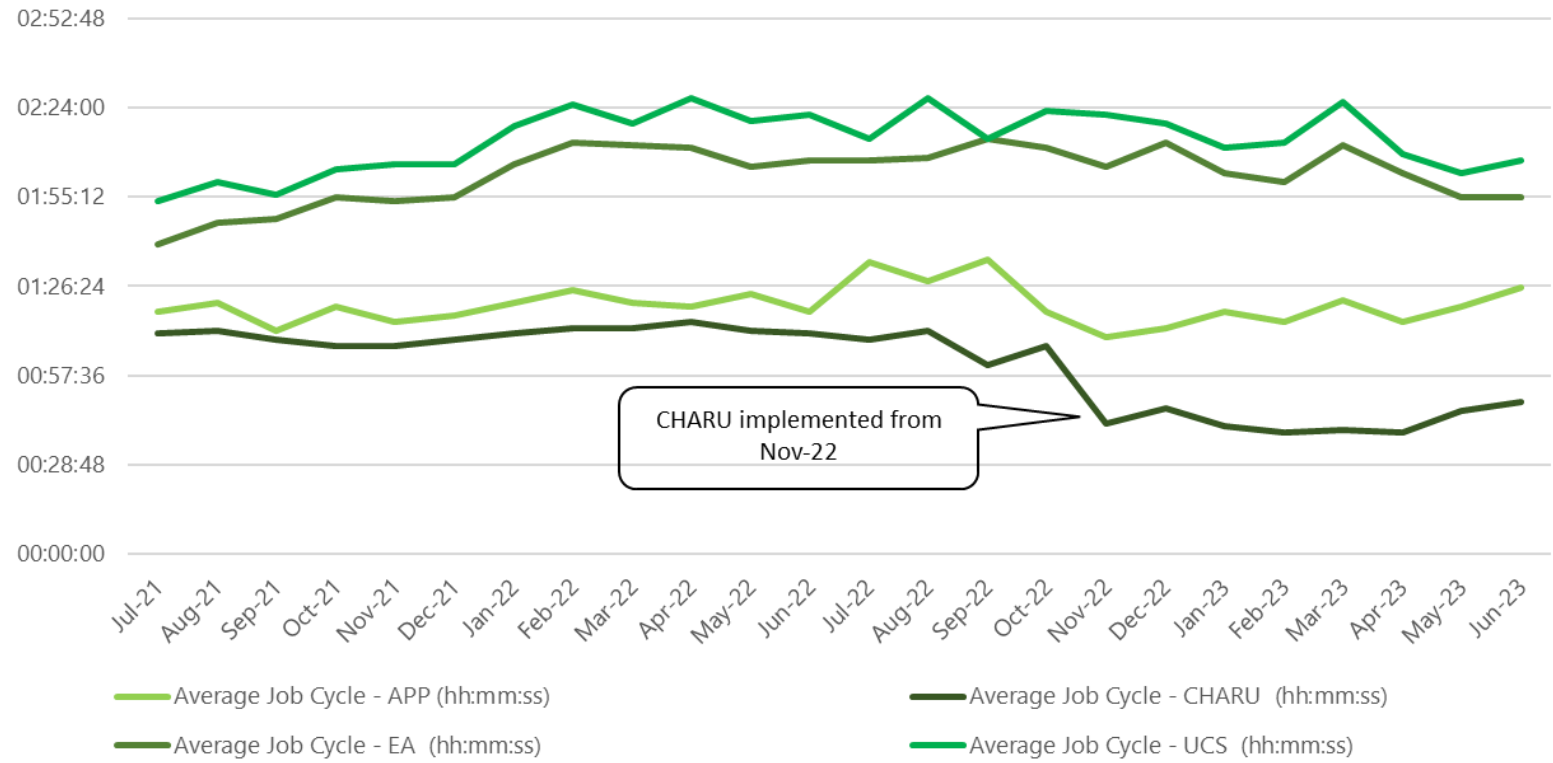
**Expected Performance Trajectory**  
 The current data needs to be treated with a degree of caution. As stated above, the Trust will not be able to eliminate PPLH. Although delayed handover hours outside EDs have improved slightly from December 2022, the lost hours for March 2023 were extreme, meaning resources are returning to base for rest predominantly outside of the rest break window, resulting in an unavailable status being assigned.

# Finance, Resources and Value

## Resource and Value Indicators

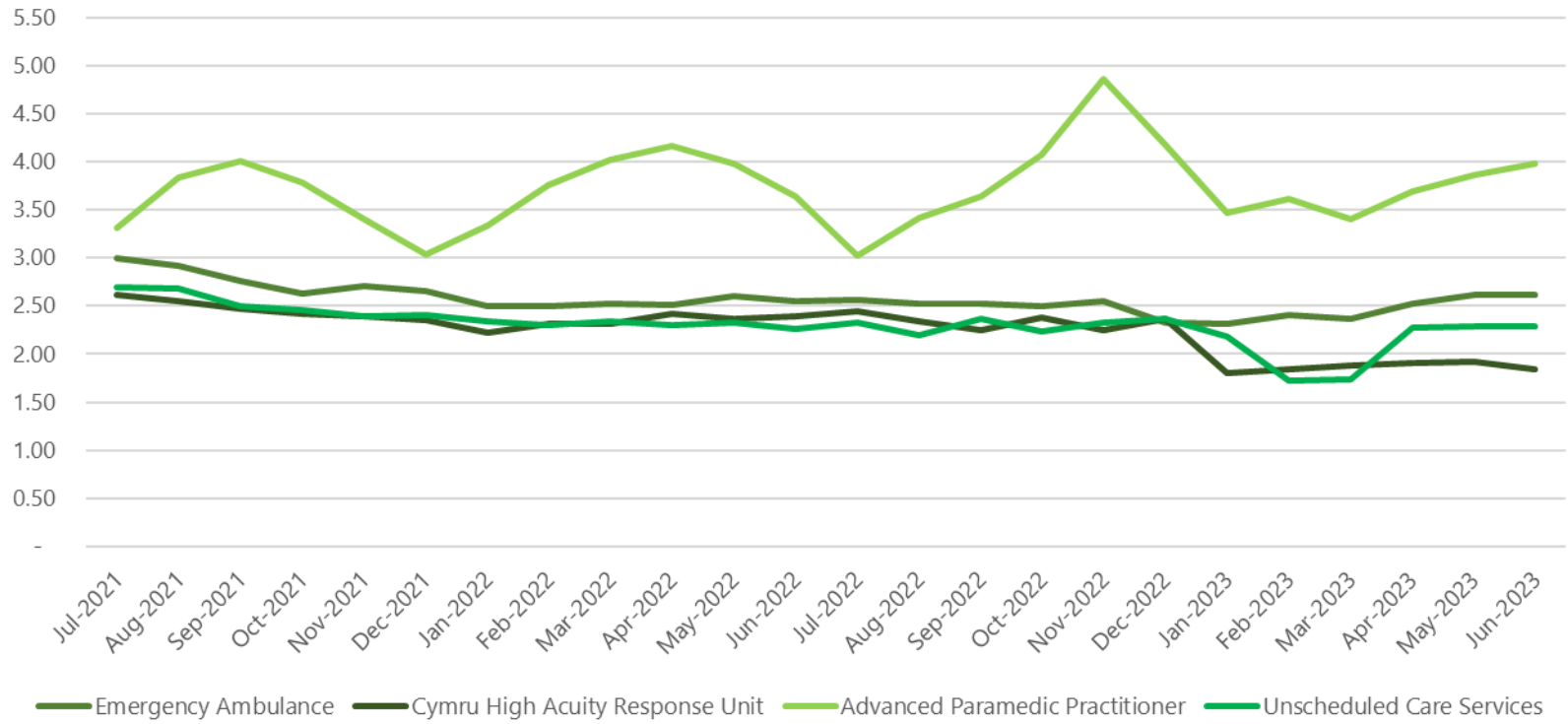
(Responsible Officer: Chris Turley)

Average Job Cycle by Vehicle Type (EA, CHARU, APP & UCS)



CHARU implemented from Nov-22

Average Jobs per Shift by Vehicle Type (EA, CHARU, APP & UCS)



### Value – Job Cycle and Volume

**Analysis**  
As demonstrated in the top graph, the average job cycle in June 2023 remained static at 1 hour 55 minutes for EA but increased for UCS, APP and CHARU. EA calls UCS crews saw their average increase to 2 hours 7 minutes, APPs rose from 1 hour 20 minutes to 1 hour 26 minutes and CHARUs increased from 46 minutes to 49 minutes.

Overall average jobs per shift was 2.43 in June 2023, a slight decline from the 2.45 recorded in May 2023. APPs attended on average 3.98 jobs per shift, EAs 2.62 jobs per shift, UCS crews 2.28 jobs per shift and CHARU's 1.84 jobs per shift.

Overall average jobs per shift has remained relatively static for EA, CHARU and UCS throughout the past year, while in comparison average jobs per shift for APPs is on a fluctuating, but generally increasing, trajectory.

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

**Expected Performance Trajectory**  
The increase in job cycle time since 2021 is caused by numerous complex factors. As ePCR embeds, a decrease may be seen, but with the factors outside of WAST's control a reduction to pre pandemic levels may not be seen.

*\*NB: Average jobs per shift only includes data where the full shift worked is less than 20 hours.*

*Total shift hours currently includes the meal break for the shift. Total shift hours also includes Postproduction Lost Hours*

### Resource - Decarbonisation

**Analysis**  
Delivery of the capital programme in 2023/24 sought to maximise decarbonisation aspects associated with investment. Examples include PV panels and battery storage at Bridgend Ambulance Hub, PV panels, battery storage and installation of air source heat pump within the development of the SE Fleet Workshop, and other energy saving schemes such as LED lighting, glazing and building management systems where possible during the last quarter of 2023/24. The Trust's EV charging network (initially to support implementation of 23 PHEV car-based response vehicles) developed from minimal provision to 67 chargers over 54 sites.

**Remedial Plans and Actions**  
WAST Decarbonisation Action Plan is currently reporting internally as Amber. Estates and Facilities Advisory Board funding in 2023/24 and 2-24/25 will allow for investment in further infrastructure and decarbonisation schemes across a range of sites. Plans for Building Management Systems, and a design guide for retrofit of estate continue to be developed. However, further funding will be required. The Trust has completed a scoping exercise for electrical capacity requirements across the WAST estate and work is ongoing with Welsh Government Energy Services on rapid EV charging. The first Programme Board meeting held on 30<sup>th</sup> January 2023 with Executive level chair. The Board will oversee the delivery of the DAP and all associated underpinning programme management elements such as workstreams, management of risks, identification of benefits and supporting ongoing programme lessons. The programme board then met again on 24<sup>th</sup> April 2023, and continues to develop its work programme and risk management approach with meetings every quarter.

The first meeting of the Transport Group took place on 29<sup>th</sup> March 2023 chaired by the Head of Capital Development. This group follows on from the small group (comprised of Fleet and Capital and Estates colleagues) which has overseen the EV charging network development in 2022/23 but looks to widen the scope of works to encompass all transport elements of the DAP including EV, other low emission vehicles, charging, staff EV charging, cycle and other transport initiatives and the grey fleet/staff vehicles aspects. The group will also be responsible for delivering associated policies and procedures underpinning the safe use of the network.

**Expected Performance Trajectory**  
The Welsh Government targets of a net-zero position by 2030 pose real and complex challenges for WAST. In response to this, a key action over the next year will be to develop our Sustainability and Infrastructure Strategic Outline Programme, which will outline the financial and resource implications for the move to a carbon-neutral ambulance Trust. This will need significant input from our colleagues across the Trust and will require additional investment within the Finance and Corporate Resources

Directorate to manage this. The relevant business cases in support of Estates and Fleet developments will continue to reinforce the importance of this agenda, and to push us towards a position of carbon neutrality, maximising our use of new technology and responding in a flexible and agile way to the changing external environment. However, it should be noted that there continues to be global issues with motor vehicle supply chains which is hindering the progress of electric emergency ambulances, alongside limited funding.

# Partnerships / System Contribution

## NHS111 Hand Off Metrics and NHS111 Consult & Close Indicators

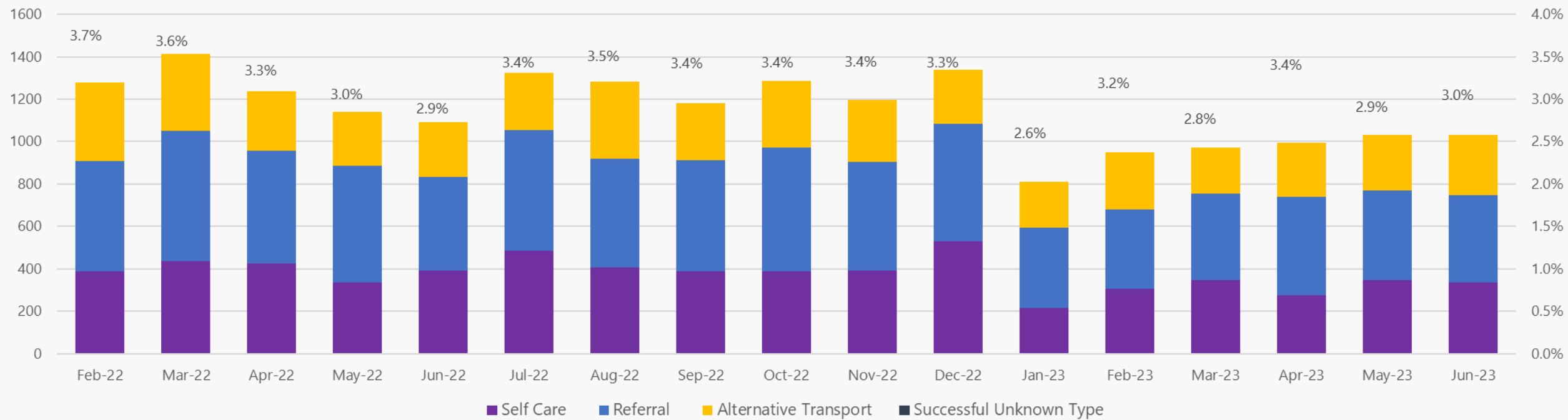
### Influencing Factors – Demand and Clinical Hours Produced

(Responsible Officer: Lee Brooks)

A

FPC

Outcomes against 999 calls where secondary triage is performed by NHS111 Consult and Close.



#### Analysis

The top graph depicts the outcomes against 999 calls where secondary triage is performed by NHS111 Consult and Close. As demonstrated in the graph, in May 2023, referral was the top outcome for calls handled by NHS111 followed by self-care and alternative transport.

71,646 calls were received into the 9 categories displayed in the bottom graph during July 2023, an increase compared to the 65,611 received during June 2023. This was above the average volume of calls seen over the past 12 months (65,905).

In June 2023, calls Referred to a General Practitioner (handover of care) continued to be the top outcome for NHS111 accounting for 41% of all calls.

#### Remedial Plans and Actions

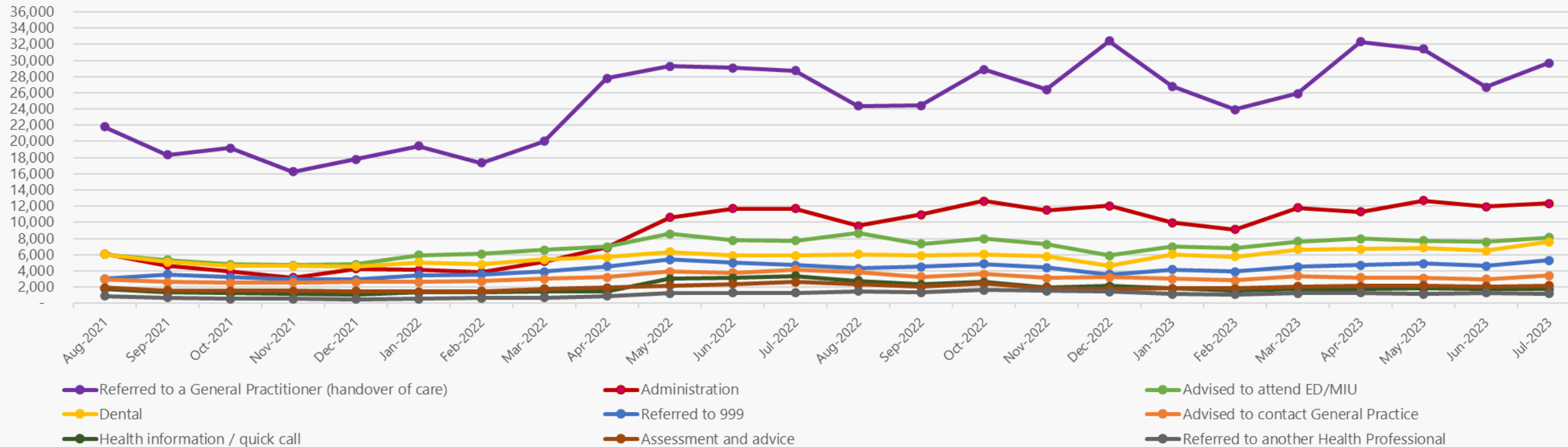
The new Consult and Close dashboard is now complete and live, enabling the Trust to report more meaningful and specific data in relation to calls ending in alternative transport, referral and self-care.

The use of video consultation has been implemented and is now live, early indications show this to be a useful tool.

#### Expected Performance Trajectory

The Trust currently have a target to consult and close 15% of calls and are ambitious in aims to increase the proportion of activity resolved at step 2 by increasing the current target to 17% by the end of Quarter 1 2023/24 through internal efficiencies. The IMTP aspiration is to advance this to 20% but will require further investment of FTEs in the Clinical Support Desk (CSD).

111 Calls By Final Outcome



# Partnerships / System Contribution Consult & Close Indicators

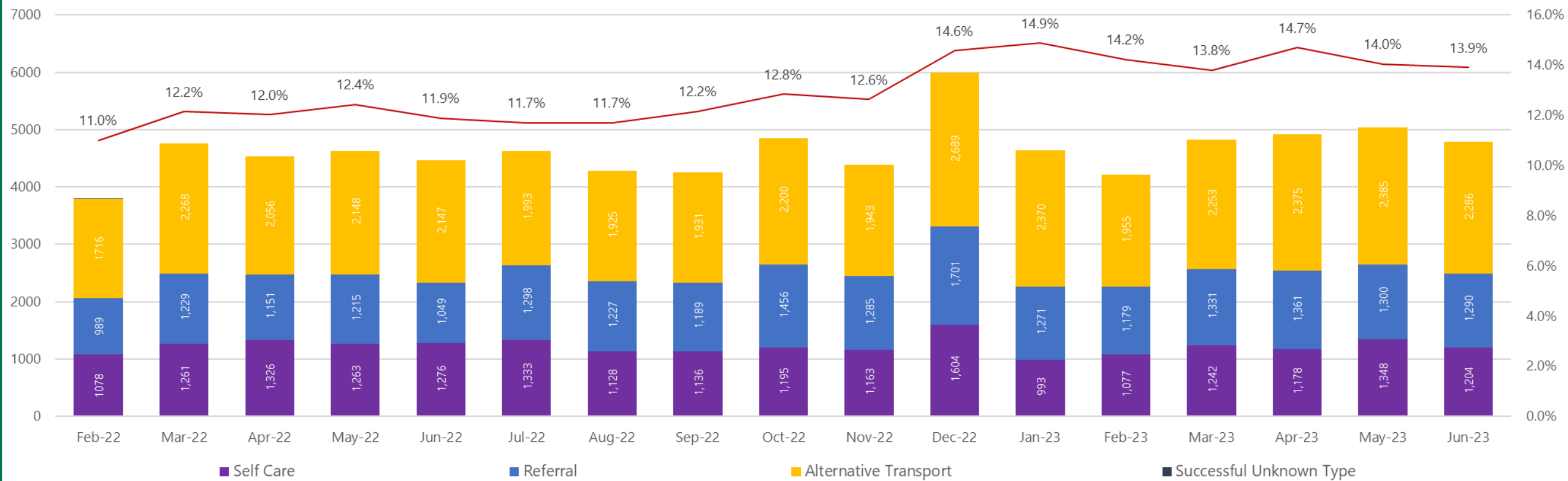
(Responsible Officer: Lee Brooks)

C&C

R

FPC

Successful Consult and Close Outcomes (By Type)



## Analysis

**Consult and Close**, with contributions from Clinical Support Desk (CSD) (10.2%), NHS111 (3.0%), WAST APP (0.5%) and the Health Boards using Physician Triage and Streaming Service (PTAS) (0.2%) achieved 13.9% in June 2023. This was a decrease on the 14.1% seen during May 2023 and remained short of the new 17% target figure. In May 2023, the number of 999 calls resulting in a Consult and Close outcome was 4,780, down from 5,033 in May 2023.

Of the calls successfully closed in June 2023, 1,204 patients received an outcome of self-care; 1,290 patients were referred to other services (including to Minor Injury Units and SDEC) and 2,286 were advised to seek alternative transport services in order to acquire treatment.

Re-contact rates in June 2023 were 16.3%, a further increase compared to 15% seen in May 2023, and the 9.7% in April 2023, although this rise in May can in part be attributed to one caller re-contacting the service on 74 occasions over the space of a few hours.

## Remedial Plans and Actions

- The team are undertaking process maps of the work that they do in order to identify where improvements can be made.
- Red Review of 999 calls to confirm appropriate category selection continues to be a high priority for CSD in addition to Consult and Close activity.
- Discussions are ongoing to identify additional resources required on top of Consult & Close priorities.

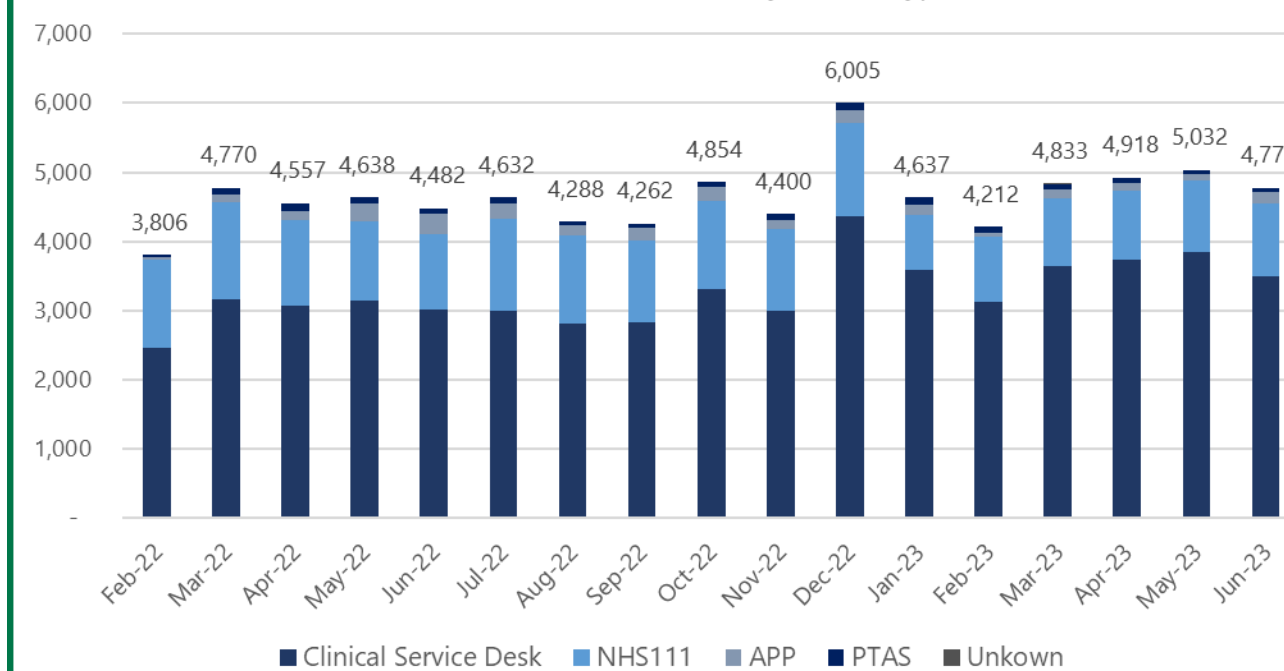
## Expected Performance Trajectory

The Trust currently have a target to consult and close 15% of calls and are ambitious in aims to increase the proportion of activity resolved at step 2 by increasing the current target to 17% by the end of Quarter 1 2023/24 through internal efficiencies. The IMTP aspiration is to advance this to 20% but will require further investment of FTEs in the Clinical Support Desk (CSD).

Re-Contact % within 24hrs of Telephone Triage (Consult and Close)



Consult and Close Volumes by Service Type



# Partnerships / System Contribution Conveyance to ED Indicators

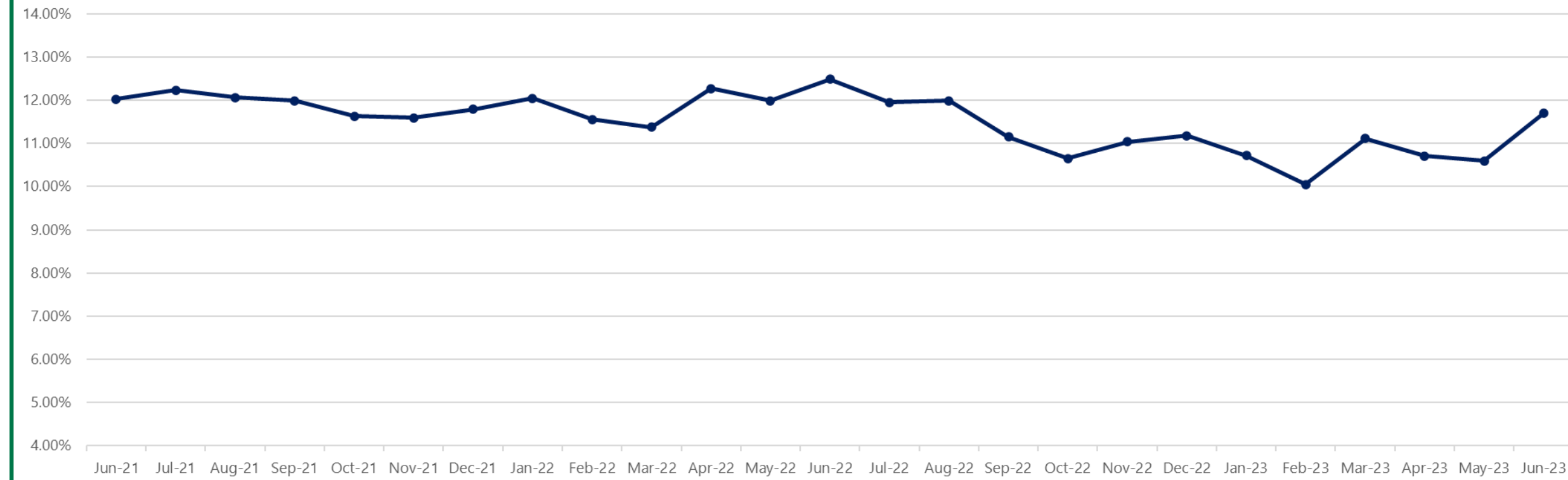
(Responsible Officer: Andy Swinburn)

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Ministerial Measure

% of Total Conveyances taken to a service other than a Type One Emergency Department



## Analysis

**In June 2023 11.7% of patients (1,806) were conveyed to a service other than a Type One ED.** Although not shown here, the percentage of patients conveyed to EDs has decreased compared to the same month last year by 1.48 percentage points. In June 2023 conveyance to EDs as a proportion of total verified incidents was 39.65% (compared to 35.99% in June 2022).

The combined number of incidents treated at scene or referred to alternate providers decreased, from 4,080 in May 2023 to 3,748 in June 2023.

There has been a general increase in APP conveyance rates in recent months, due to several factors: -

- CSP means the right jobs are not always there for APPs to alter or influence the disposition.
- The tasking of APPs has changed, moving away from APPs reviewing the stack to mandatory code sets.
- There has been an increase in respiratory patients of all ages over the last quarter who have been poorly and required hospital admission.

The volume of patients conveyed to Same Day Emergency Care (SDEC) Units remains low, at 0.17% during June 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%. This modelling has been provided to both EASC and WG. 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, for example, SDECs.

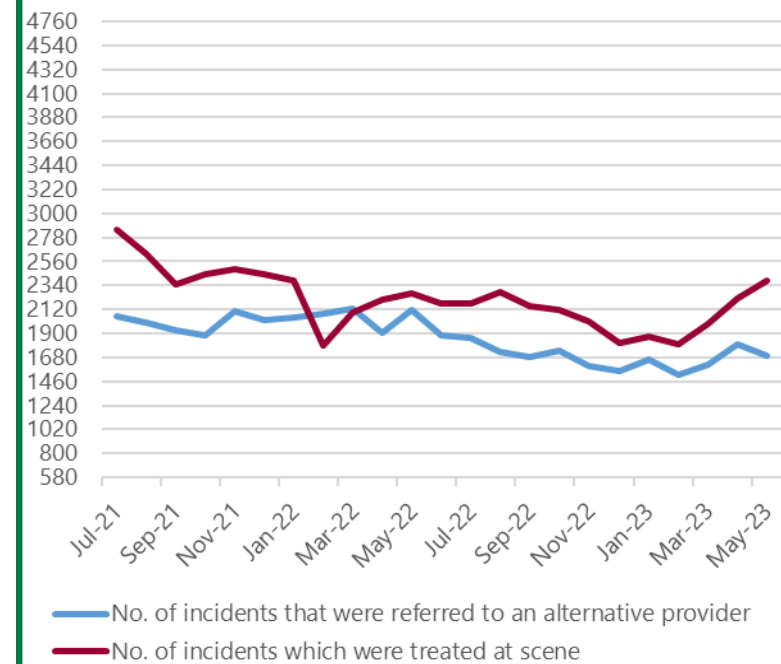
Utilisation of APP resources will continue to be monitored as part of weekly performance reviews and evaluation of the appropriate APP code-set will be undertaken through the Clinical Prioritisation and Assessment Software (CPAS) group.

## Expected Performance Trajectory

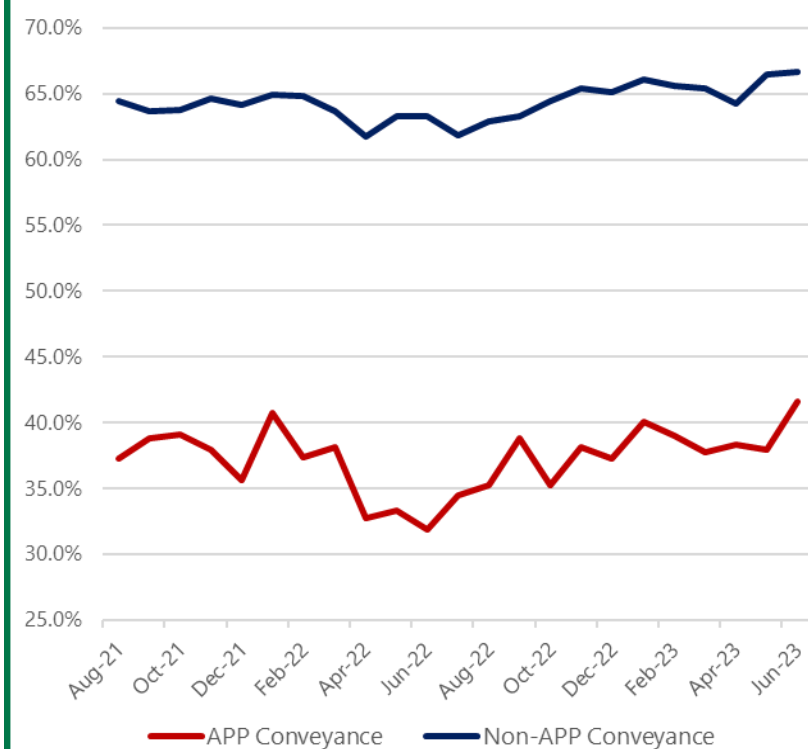
The Trust has completed modelling on a full strategic shift left, which identifies that the Trust could reduce handover levels by c.7,000 hours per month, with investment in APPs and the CSD; however, the modelling indicates that handover would still be at 10,000 hours per month. Health Board changes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

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

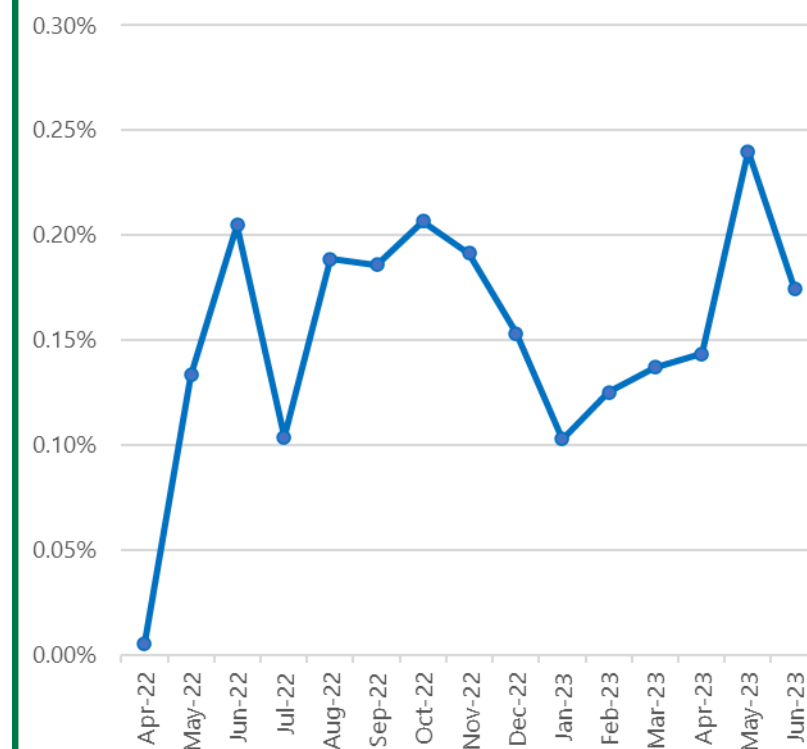
Incidents Treated at Scene VS Incidents Referred to Alternative Providers (Ambulances Stopped)



APP vs Non-APP Conveyance Rates



% Patients Conveyed to SDEC Units Pan-Wales



# Partnerships / System Contribution Handover Indicators

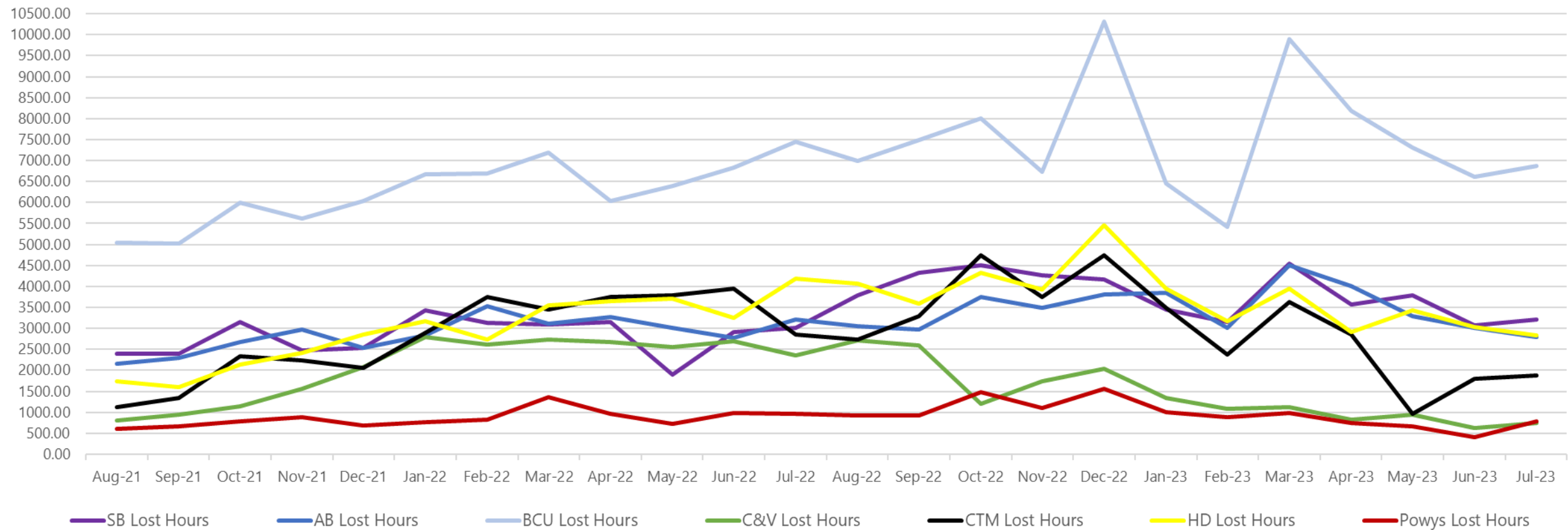
(Responsible Officer: Health Boards)

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Notification to Handover Lost Hours by Health Board



## Analysis

**287,912 hours were lost to Notification to Handover, i.e., hospital handover delays, over the last 12 months (Aug-22 to Jul-23), compared to 246,393 over the same timeframe the previous year.** 19,118 hours were lost in July 2023, an increase from the 18,548 lost in June 2023. This is the first time the figure has increased in four months.

The hospitals with the highest levels of handover delays during July 2023 were:

- Morriston Hospital (SBUHB) at 3,412 lost hours
- Wrexham Maelor Hospital (BCUHB) at 2,429 lost hours
- The Grange University Hospital (ABUHB) at 2,625 lost hours
- Ysbyty Glan Clwyd Hospital (BCUHB) at 2,792 lost hours

Notification to handover lost hours averaged 617 hours per day during July 2023 compared to 618 hours a day in June 2023.

In July 2023, the Trust could have responded to approximately 6,030 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.

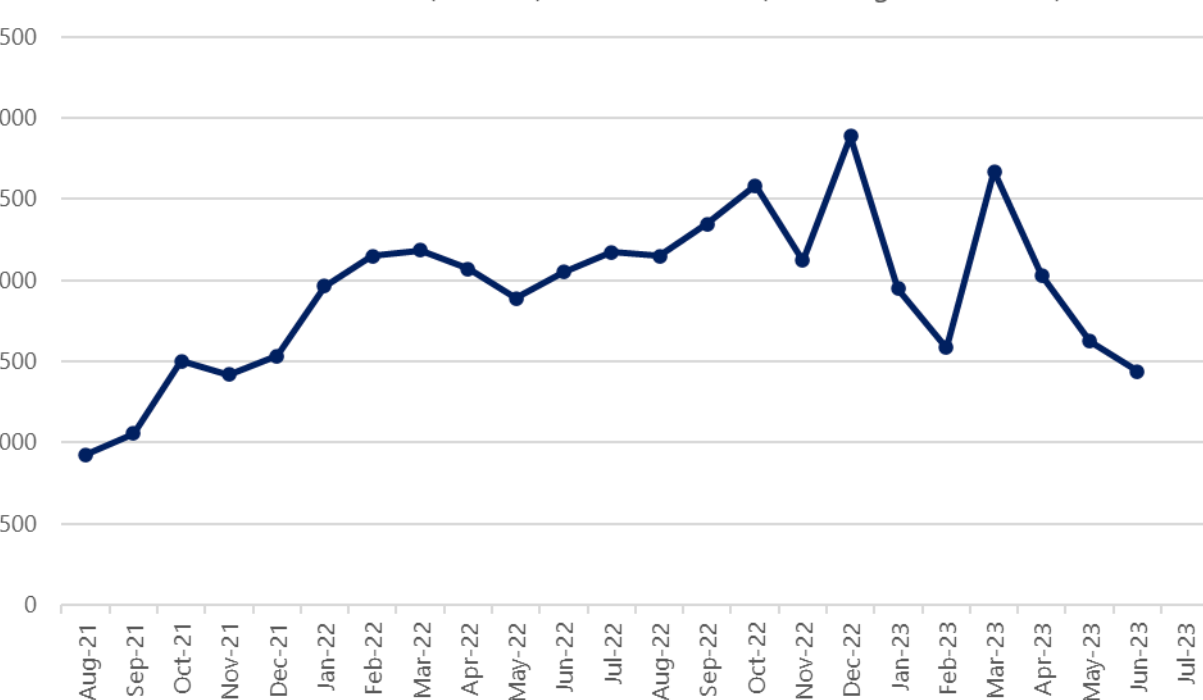
The WIIN platform continues to focus on patient handover delays at hospital and Electronic Patient Care Record (ePCR).

## Expected Performance Trajectory

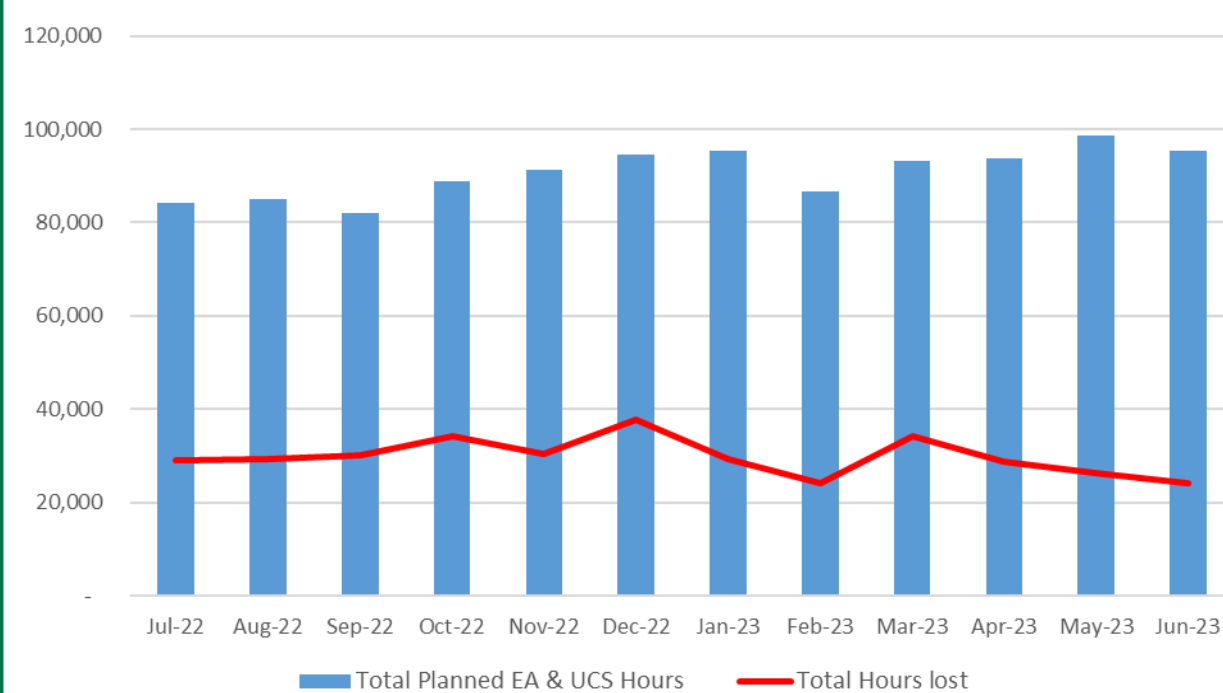
The Commissioning intention for 2023/24 is that handover lost hours should reduce to 15,000 hours per month, the same seen levels seen in the winter of 2019/20, which were considered extremely high, 12,000 hours by the end of Quarter 2 and sustained and incremental improvement in quarters 3 and 4. The 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.*

Handover Rates Over (4 Hours) 240.01 minutes (including first 15 mins)



Total Planned hours VS Total Hours Lost



Term	Definition	Term	Definition	Term	Definition	Term	Definition	Term	Definition
AB / ABHB	Aneurin Bevan / Aneurin Bevan Health Board	CTM / CTMHB	Cwm Taf Morgannwg Health Board	HD / HDHB	Hywel Dda / Hywel Dda Health Board	NHS	National Health Service	ROSC	Return Of Spontaneous Circulation
AOM	Area Operations Manager	C&V / C&VHB	Cardiff & Vale / Cardiff & Vale Health Board	HIW	Health Inspectorate Wales	NHSDW	National Health Service Direct Wales	RRV	Rapid Response Vehicle
APP	Advanced Paramedic Practitioner	D&T	Discharge & Transfer	HI	Health Informatics	NPUC	National Programme for Unscheduled Care	SB / SBUHB	Swansea Bay / Swansea Bay Health Board
AQI	Ambulance Quality Indicator	DU	Delivery Unit	H&W	Health & Wellbeing	NQPs	Newly Qualified Paramedic	SCIF	Serious Concerns Incident Forum
BCU / BCUHB	Betsi Cadwaladr / Betsi Cadwaladr university Health Board	EASC	Emergency Ambulance Service Committee	HR	Human resources	NRI	Nationally Reportable Incident	SPT	Senior Pandemic Team
CASC	Chief Ambulance Services Commissioner	EAP	Employee Assistance Provider	HSE	Heath and Safety Executive	OBC	Outline Business Case	STEMI	ST segment Evaluation Myocardial Infarction
CC	Consultant Connect	ED	Emergency Department	IG	Information Governance	OD	Organisational Development	TPT	Tactical Pandemic Team
CCC	Clinical Contact Centre	EMD	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
<b>111 Abandoned Calls</b>	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	<b>Hours Produced for Emergency Ambulances</b>	Proportion of hours produced within the calendar month for Emergency Ambulance Vehicles (Target 95%).
<b>111 Patients Called back within 1 hours (P1)</b>	(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.	<b>Sickness Absence (all staff)</b>	Staff sickness volumes as a percentage for all staff employed within the Welsh Ambulance Services NHS Trust.
<b>999 Call Answer Times 95<sup>th</sup> Percentile</b>	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.	<b>Frontline COVID-19 Vaccination Rates</b>	Volume of frontline (patient facing and non-patient facing) who have received a second COVID-19 vaccination.
<b>999 Red Response within 8 Minutes</b>	Percentage of 999 incidents within the Red (immediately life-threatening) category which received an emergency response at scene within 8 minutes.	<b>Statutory and Mandatory Training</b>	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).
<b>Red 95<sup>th</sup> Percentile</b>	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).	<b>PADR/Medical Appraisal</b>	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.
<b>999 Amber 1 95<sup>th</sup> Percentile</b>	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).	<b>Ambulance Response FTEs in Post</b>	Number of Emergency Medical Services, Full Time Equivalent (FTE) staff working for the Welsh Ambulance Services NHS Trust.
<b>Return of Spontaneous Circulation (ROSC)</b>	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.	<b>Ambulance Care, Integrated Care, Resourcing &amp; EMS Coordination FTEs in Post</b>	Number of Ambulance Care, Integrated Care, Resourcing & EMS Coordination Full Time Equivalent (FTE) staff working for the Welsh Ambulance Services NHS Trust.
<b>Stroke Patients with Appropriate Care</b>	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 care that have a greater effect on patient outcomes if done together in a time-limited way, rather than separately).	<b>Financial Balance – Annual Expenditure YTD as % of budget Expenditure</b>	Annual expenditure (Year to Date) as a proportion of budget expenditure.
<b>Acute Coronary Syndrome Patients with Appropriate Care</b>	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.	<b>Post Production Lost Hours</b>	Number of hours lost due to ambulance vehicles being unavailable due to a variety of reasons (A detailed list of these is show in the graph on slide 22).
<b>Renal Journeys arriving within 30 minutes of their appointment (NEPTS)</b>	Proportion of renal journeys which arrive at hospital appointments within 30 minutes (+/-) of their appointment time.	<b>111 Consult and Close</b>	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.
<b>Discharge &amp; Transfer journeys collected less than 60 minutes after booked ready time (NEPTS)</b>	Proportion of journeys being discharged from and/or transferred between hospitals which were collected within 60 minutes of the hospital booked ready time.	<b>999 / 111 Hear and Treat</b>	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.
<b>National reportable Incidents (NRI)</b>	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.	<b>% Incidents Conveyed to Major EDs</b>	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).
<b>Concerns Response within 30 Days</b>	Proportion of concerns responded to by the complaints team within 30 working days of receiving the concern.	<b>Number of Handover Lost hours</b>	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.
<b>EMS Abstraction Rate</b>	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.	<b>Immediate Release requests</b>	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

Welsh Ambulance Services NHS Trust

# QUEST: Red Rural Deep Dive - August 2023



GIG  
CYMRU  
NHS  
WALES

Ymddiriedolaeth GIG  
Gwasanaethau Ambiwylans Cymru  
Welsh Ambulance Services  
NHS Trust

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Version 1.0  
Meeting: 09 August 2023

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by Strategy, Planning & Performance



## Key Messages

- A lot of work has been undertaken in the Red rural performance space.
- Whilst Red rural performance remains an issue, actions are being taken to address rural performance, based on the work undertaken.
- The level of work undertaken (and on-going actions) should provide QUEST with assurance that the Trust is focused on this issue.
- The following slides provide a chronological narrative of the work so far and current actions being undertaken.

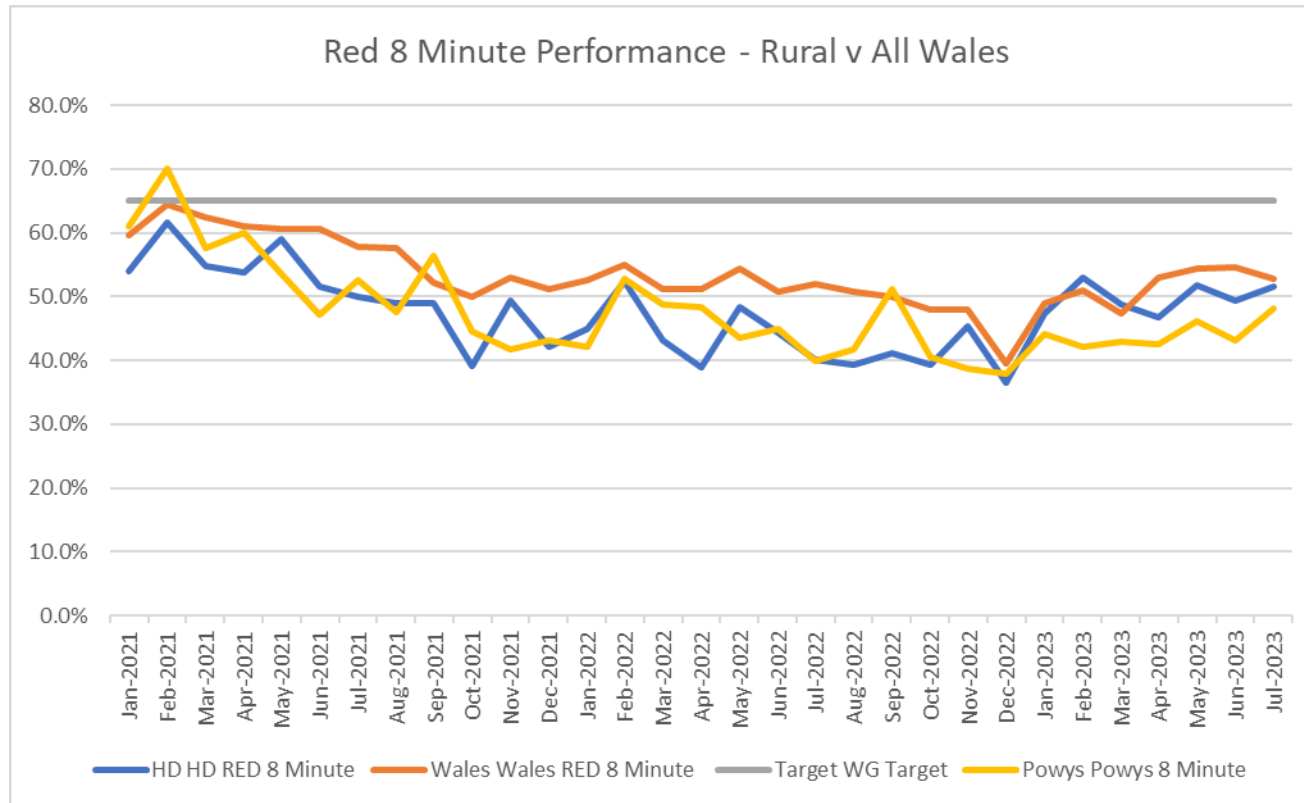


# Chronology

1. Rural Red performance: a long term issue for the Trust.
2. Welsh Government targets and commissioning requirements.
3. 2019 Demand & Capacity Review.
4. Previous deep dives.
5. EMS Transformation Programme.
6. Rural Impact Assessment
7. CHARUs
8. Recruitment, Retention & CHARU latest.
9. Handover and Out of Area.
10. 2023 Demand & Capacity Review.



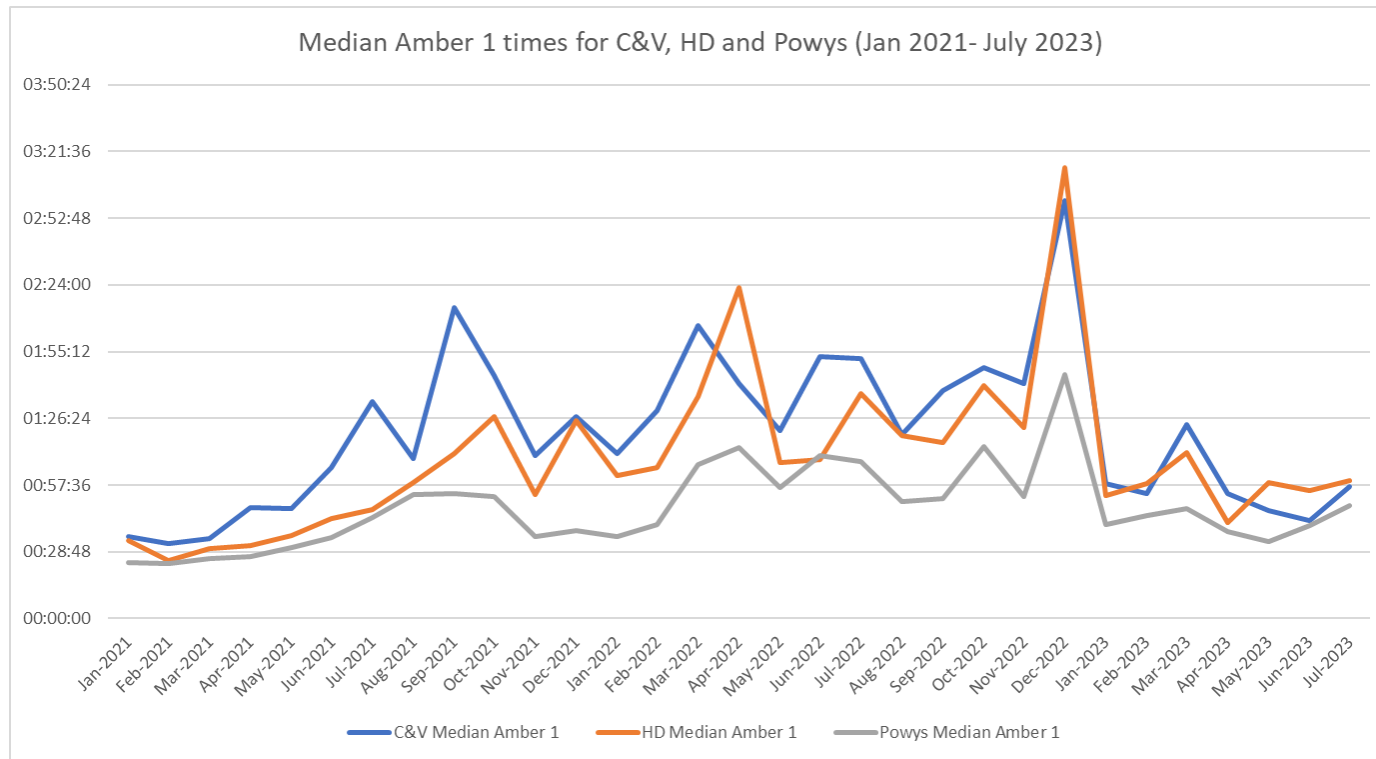
## Red Performance



- Rural Red performance, illustrated here as Hywel Dda and Powys, has been a consistent issue for the Trust.
- Rural Red performance consistently tracks below pan-Wales performance (and below the 65% target).



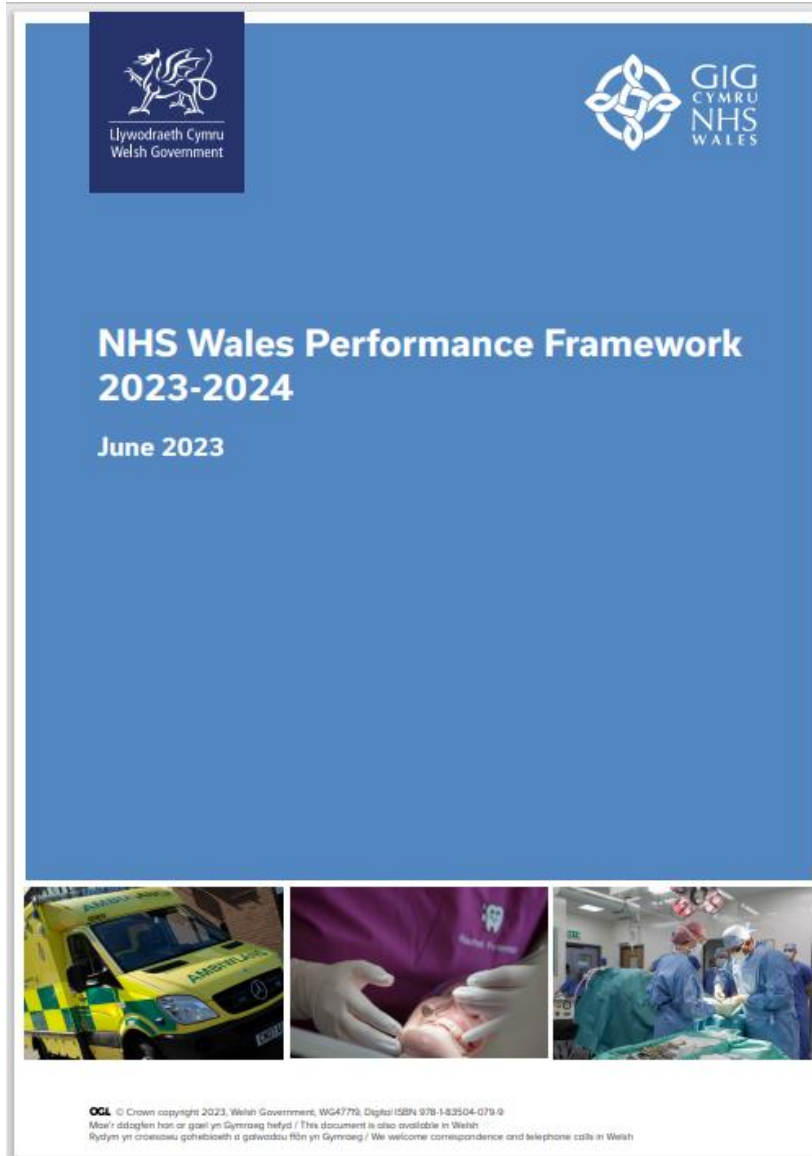
# Amber Performance



- By contrast rural Amber 1 performance is consistently better than more urban areas (illustrated here as Cardiff & the Vale).
- Chart uses median, the 95<sup>th</sup> percentile would show a wider disparity.
- Benchmarking data from EASC indicates that for every £1 spent per head of population on emergency ambulances in Cardiff & the Vale, £9 is spent in Powys.



# WG Targets & Commissioning Framework



- The NHS Wales Performance Framework 2023-24 identifies the following performance measure for Red “percentage of emergency responses to Red calls arriving within (up to and including) 8 minutes.
- It does not actually define the target, but the EASC performance reporting identifies it is 65% for Red (and 60% per health board).
- Performance is commissioned at a health board level, not locality or local authority level.
- There are no explicit targets for rural emergency ambulance performance in either the WG documentation or EASC documentation.



# 2019 EMS D&C Review

## Final December 21 Position Performance and Utilisation Summary

### 2021 Position with Planned Shifts (10% H&T)

Health Board	Red	Red	Amber 1	Amber 2	Red	Amber 1	Amber 2
	%	Mean	Mean		90th Percentile		
Abertawe Bro Morgannwg University LHB	77.6%	05:25	81:20	179:34	10:34	224:56	-
Aneurin Bevan LHB	81.1%	05:01	46:29	105:53	09:54	106:42	270:00
Betsi Cadwaladr University LHB	75.6%	05:34	29:57	69:48	11:12	64:43	173:31
Cardiff & Vale University LHB	80.3%	05:29	43:39	122:36	10:02	99:03	315:16
Cwm Taf LHB	75.2%	05:44	36:12	71:05	10:53	80:41	172:35
Hywel Dda LHB	64.0%	06:59	65:25	144:06	15:14	177:25	-
Powys LHB	65.4%	07:06	62:27	141:39	17:02	166:25	-
<b>Wales-wide</b>	<b>76.0%</b>	<b>05:40</b>	<b>49:45</b>	<b>112:29</b>	<b>11:19</b>	<b>123:39</b>	<b>145:25</b>

### Final 2021 Position with CTL RRVs (Re-roster planned + relief, 10% H&T)

Health Board	Red	Red	Amber 1	Amber 2	Red	Amber 1	Amber 2
	%	Mean	Mean		90th Percentile		
Abertawe Bro Morgannwg University LHB	66.7%	06:56	61:23	171:31	14:11	150:50	-
Aneurin Bevan LHB	66.3%	06:56	30:21	64:14	14:25	62:37	144:42
Betsi Cadwaladr University LHB	69.0%	06:18	21:17	47:26	13:04	45:08	106:03
Cardiff & Vale University LHB	67.9%	06:45	26:47	70:11	13:20	54:36	161:47
Cwm Taf LHB	66.9%	06:43	24:14	42:59	13:19	49:17	91:09
Hywel Dda LHB	65.8%	07:12	48:04	123:55	16:26	111:37	-
Powys LHB	67.9%	06:26	42:48	118:54	15:57	102:13	-
<b>Wales-wide</b>	<b>67.3%</b>	<b>06:46</b>	<b>34:55</b>	<b>85:27</b>	<b>14:06</b>	<b>78:26</b>	<b>80:44</b>

### Difference

Health Board	Red	Red	Amber 1	Amber 2	Red	Amber 1	Amber 2
	%	Mean	Mean		90th Percentile		
Abertawe Bro Morgannwg University LHB	-10.9%	01:30	-19:57	-08:04	03:37	-74:06	-
Aneurin Bevan LHB	-14.8%	01:54	-16:08	-41:39	04:31	-44:05	-125:17
Betsi Cadwaladr University LHB	-6.6%	00:44	-08:40	-22:22	01:53	-19:36	-67:28
Cardiff & Vale University LHB	-12.4%	01:16	-16:52	-52:25	03:18	-44:27	-153:28
Cwm Taf LHB	-8.3%	00:59	-11:58	-28:06	02:25	-31:25	-81:26
Hywel Dda LHB	1.9%	00:13	-17:21	-20:11	01:12	-65:48	-
Powys LHB	2.5%	-00:40	-19:39	-22:45	-01:05	-64:12	-
<b>Wales-wide</b>	<b>-8.7%</b>	<b>01:05</b>	<b>-14:50</b>	<b>-27:01</b>	<b>02:47</b>	<b>-45:13</b>	<b>-64:42</b>

### Utilisation

CCC Area	EA	RRV	UCS
Central & West	49.3%	33.2%	54.1%
North	53.1%	31.8%	55.7%
South East	61.3%	31.9%	62.3%
<b>Overall</b>	<b>54.1%</b>	<b>32.2%</b>	<b>58.0%</b>

### Utilisation

CCC Area	EA	RRV	UCS
Central & West	49.1%	36.1%	52.2%
North	50.6%	33.6%	50.5%
South East	56.4%	38.1%	48.2%
<b>Overall</b>	<b>52.0%</b>	<b>36.4%</b>	<b>50.0%</b>

- The 2019 Demand & Capacity Review modelled Red above 65% in every health board (note this is above what is required by the Commissioning Framework).
- The Review did squeeze Red performance with the aim of improving Amber performance.
- In this modelling there were no RRVs in North, five at peak in South East and 6 at peak in Central & West. A reduction in RRVs, but with more EAs focused on Amber.

## Summary - Powys Red Performance

- Powys RED performance was 51.6% in Jun-20, the lowest it has been in the last 2 years.
- The RED A8 65% has been missed in Powys for 9 out of 12 months in the last year i.e. there is an underlying RED performance issue that was particularly acute in Jun-20. This changes to 3 out of 12 months for RED A10 65% performance.
- Verified RED demand was its lowest in Jun-20 (62 Incidents) in the last 2 years. Each missed RED reduced RED performance by -1.6% in Jun-20.
- EA Unit Hours Production in Jun-20 was 96%, but 757 less EA hours were produced in Jun-20 compared to May-20 (-10%) and the EA contribution to RED A8 was down from 46.8% in May-20 to 25.8% in Jun-20 (abstractions were higher in Jun-20, a combination of annual leave, sickness (5.86%, target is 5.99%) and reduced overtime take up (2,793 hours in Jun-20 compared to 4,036 hours in May-20)).
- With the exception of Activation Input, the Response Duration (Activation Input, Dispatch, Mobilisation and Travel Duration) was longer in Q1 2020/21, compared to the Q2-Q4 2019/20.
- Missed REDs are evenly spread across Powys, but data suggests a focus on Newtown and Welshpool and evenings.
- The relief gap in Powys is 26% which is the highest (average is 18%). The EMS Demand & Capacity Programme will see the relief gap close in 2021/22 (subject to EASC agreeing to this). This should help, but the NCCU are currently considering whether we need to look at a difference response model for more rural areas, given 57% of the missed REDS in Powys in Jun-20 were outside national deployment plan.
- There are no obvious “low hanging fruit”, but an initial focus on dispatch and mobilisation would help, whilst the relief gap is closed and further work on rurality is undertaken (expected to be via the Ministerial Taskforce).



Extract from  
Deep Dive  
presented  
to Powys  
CEO by  
WAST CEO

## Further Analysis

The EMS Demand & Capacity Programme is making a fundamental shift away from RRVs towards EAs. This will mean we have more conveying resource i.e. the ideal resource.

This will deliver the performance parameters as per the EMS Demand & Capacity Review, however, recent analysis in Hywel Dda has shown disproportionate modelled performance gains in urban v rural areas.

The NCCU has indicated that as part of the Ministerial Ambulance Taskforce there may be further review and agreement on a specific response model for more rural localities e.g. Ceredigion, South Gwynedd, North Powys and South Powys.

Further modelling could be undertaken to look at moving existing resource, but care needs to be taken on the benefits of doing this.

The fundamentals are low RED demand, the resource to respond to this (relief gap) and the response model required for more rural localities.

Initial analysis indicates that the change in service configurations at Neville Hall has had some impact on resource travelling to Prince Charles, but is not the key reason for the change in performance in Jun-20 (low demand, reduction in EA hours, underlying performance issue driven by relief gap and rurality).

The following slides contain background information in support of the Summary and Further Analysis slides

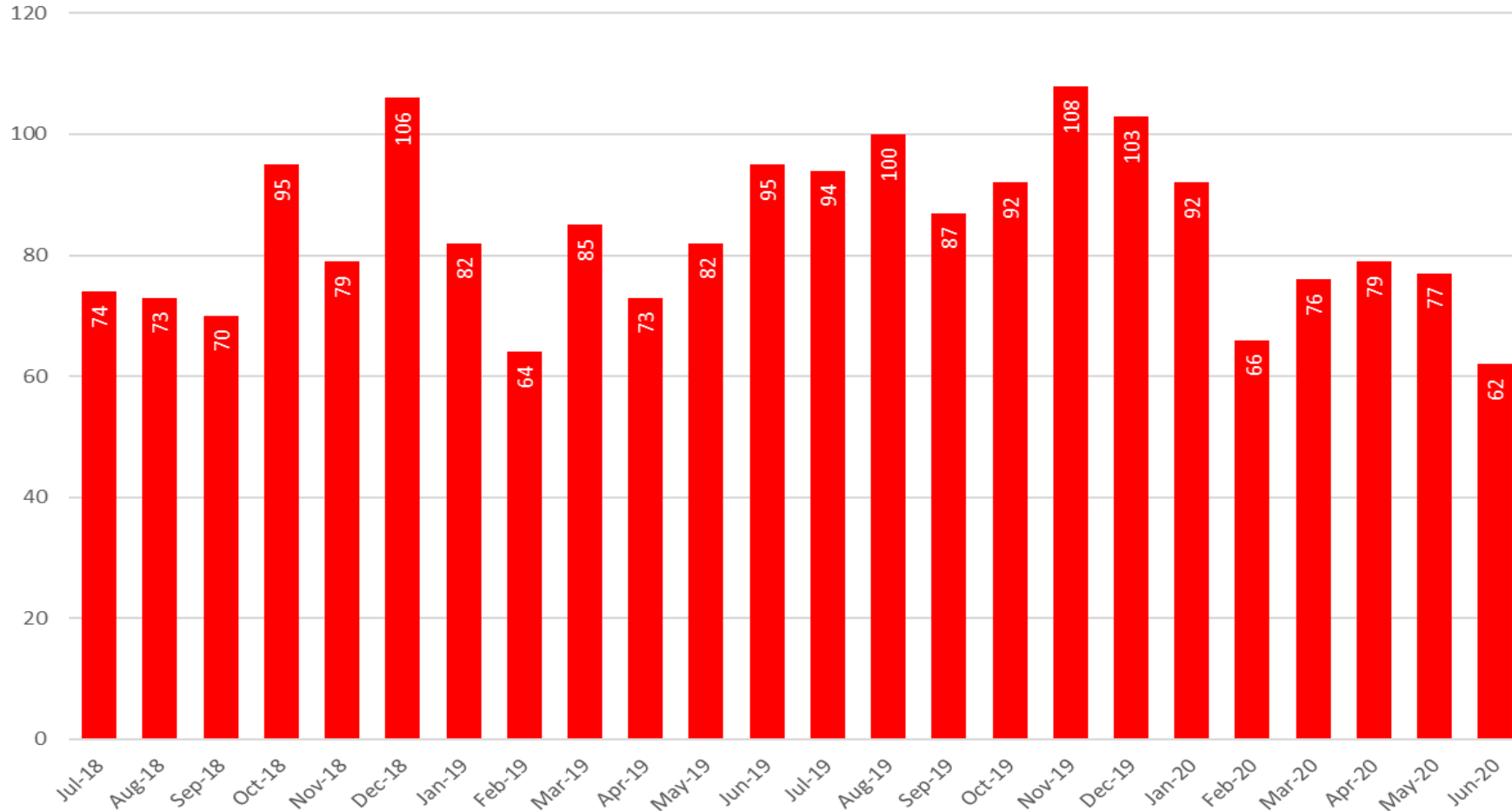


Extract from  
Deep Dive  
presented  
to Powys  
CEO by  
WAST CEO

# Demand

## Red Responded Demand

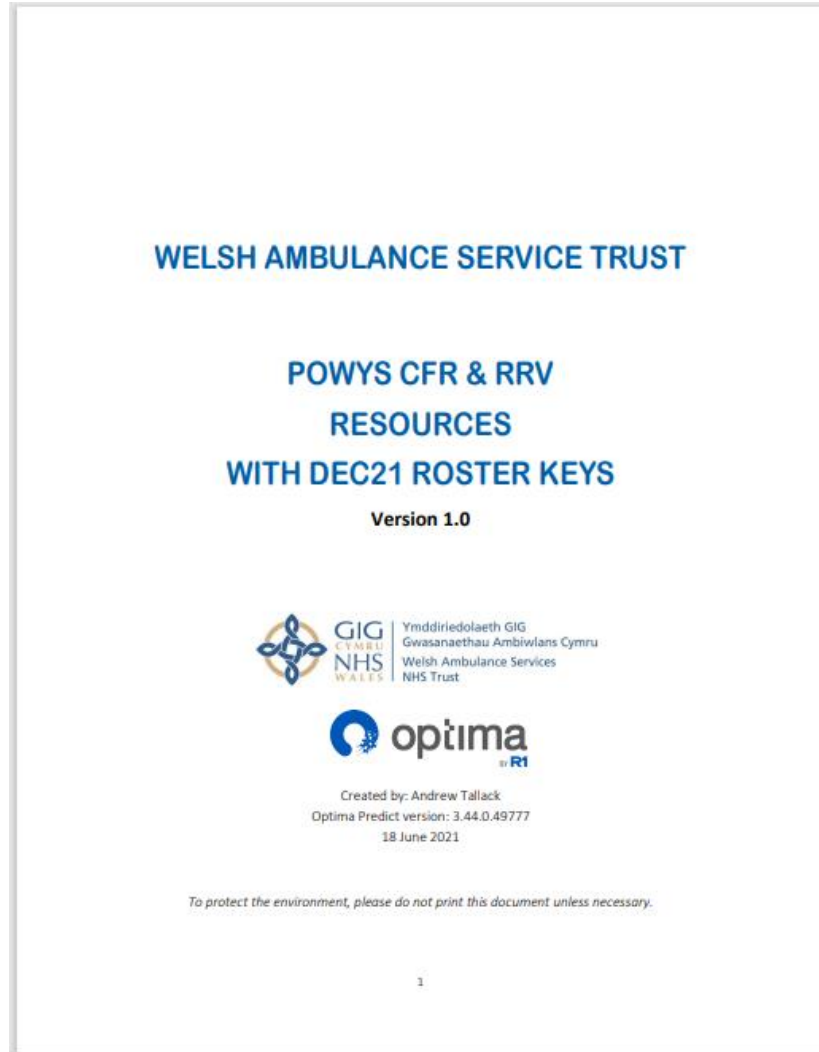
Total Verified Red Demand Calls - Powys



Extract from Deep Dive presented to Powys CEO by WAST CEO

Note the very low Red demand, so for June 2020, 2 Red calls per day or one per locality. One miss and performance is 50%.

# EMS Transformation Programme



- The EMS Operational Transformation Programme (the delivery mechanism for the demand & capacity review) looked more closely at rurality, in particular, Powys.
- EASC were interested in whether a specific rural model was required.
- The modelling identified the need for two RRVs (see slides on CHARU), but the programme did not conclude that a rural model was required.
- The programme concluded that there were three key requirements: rosters that reflect demand, rosters that are recruited to and reduced handover lost hours.



# CHARUs

CHARU Only Position: CHARU Shifts					
Station		Hours	Days	Rostered Hours per Week	FTE (42.67% relief)
Cwmbran	AB	24 hours	7	168	6.3
Cwmbran	AB	24 hours	7	168	6.3
Newport	AB	0800-2000/2000-0600	7	154	5.7
Pontypool	AB	0800-2000	7	84	3.1
Newport	AD	24 hours	7	168	6.3
Bangor	BCU	24 hours	7	168	6.3
Colwyn Bay	BCU	24 hours	7	168	6.3
Dobshell	BCU	24 hours	7	168	6.3
Porthmadog	BCU	0930-2130	7	84	3.1
Wrexham	BCU	0900-2100	7	84	3.1
Blackweir	C&V	24 hours	7	168	6.3
Bryncethin	CTM	0800-2000	7	84	3.1
Aberdare	CTM	0800-2000	7	84	3.1
Blackwood	CTM	0900-2100	7	84	3.1
Hawthorn	CTM	1000-2200	7	84	3.1
Hawthorn	CTM	0800-2000	7	84	3.1
Merthyr	CTM	24 hours	7	168	6.3
Pontyclun	CTM	0900-2100	7	84	3.1
Aberystwyth	HD	0800-2000	7	84	3.1
Ammanford	HD	24 hours	7	168	6.3
Camarthen	HD	24 hours	7	168	6.3
Cardigan	HD	0800-2000	7	84	3.1
Haverfordwest	HD	24 hours	7	168	6.3
Llanelli	HD	24 hours	7	168	6.3
New Quay	HD	0800-2000	7	84	3.1
Pembroke Dock	HD	24 hours	7	168	6.3
Tumble	HD	0900-2100	7	84	3.1
Builth Wells Fire Station	P	24 hours	7	168	6.3
Welshpool	P	0800-2000	7	84	3.1
Morrison	SB	24 hours	7	168	6.3
Port Talbot	SB	0900-2100	7	84	3.1
Swansea	SB	0700-1900/1400-0200	7	168	6.3
<b>Total</b>				<b>4,102</b>	<b>153.48</b>

- The 2019 Demand & Capacity Review was revisited in 2021 to consider the increase in Red demand.
- At the same time CHARUs, rather than RRVs were modelled.
- The table sets out the recommended CHARU resource, which is what the Trust is currently recruiting and rostering to.
- Note the extensive level of CHARU resource into HD.
- The lowest CHARU utilisation modelled to was 17%. This is very low, with lower levels of utilisation being prohibitively expensive and poor value.



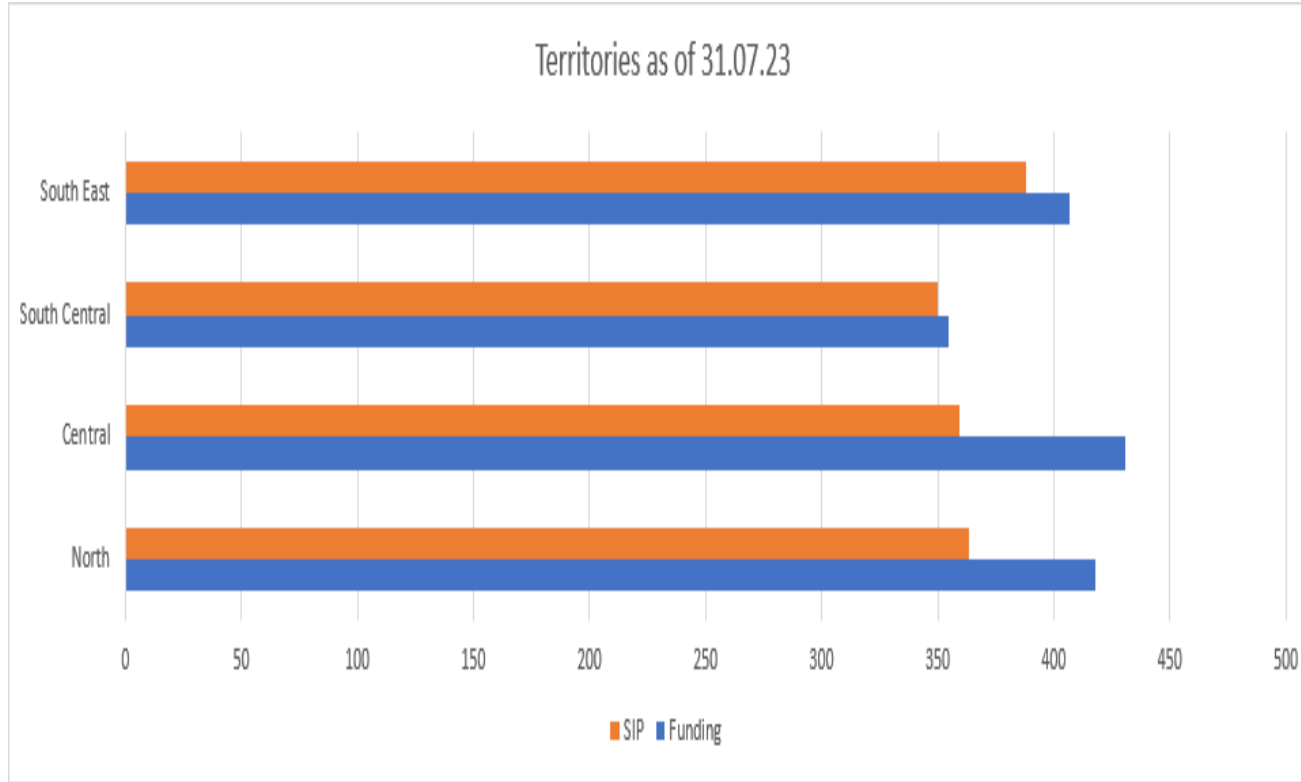
# Rural Impact Assessment

- As part of the recent EMS roster review, the Trust undertook a rural impact assessment. Rurality is defined as follows by WG:-

12. The Welsh Government statistics Bulletin SB 10/2008 identifies the following areas of Wales as rural: -

- Rural authorities - Isle of Anglesey; Gwynedd; Conwy; Denbighshire; Powys; Ceredigion; Pembrokeshire; Carmarthenshire; and Monmouthshire. Often referred to as the nine "broadly rural" local authorities.
- It is interesting to note that the areas identified as rural are not all in Hywel Dda and Powys.
- The reported identified the impact was overall positive for rural areas (on the assumption that the Trust could recruit to the proposed rosters). Further options were looked at in some cases, but were rejected by EMT.
- As per previous slides it must be remembered that the Trust is commissioned at a health board level and that spending per head of population is much higher in rural settings than urban.

# Recruitment, Retention & CHARU Latest

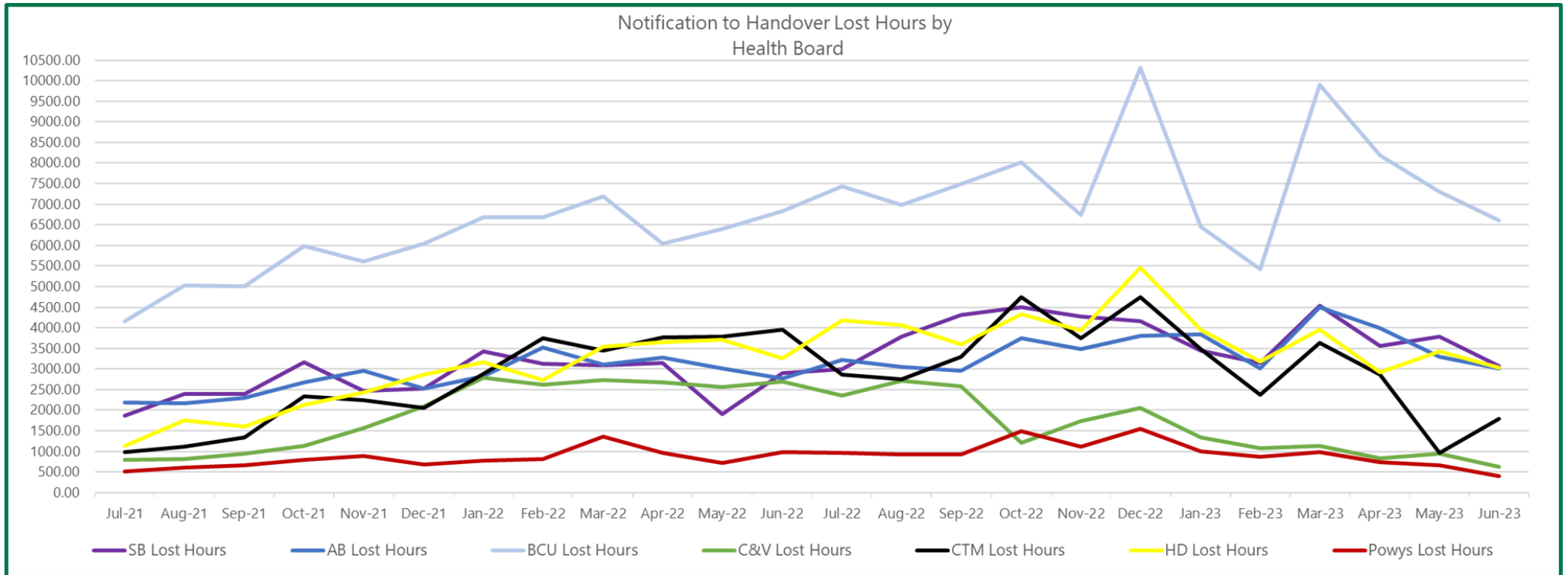


The above graph shows station in post v funded establishment, which shows that central (Hywel Dda and Powys) has the biggest gap.

- The current position against the CHARU 153 FTEs is 97 staff in post and 11 SP contribution (modelled contribution is 11.5), so vacancies of 45 FTEs.
- The vacancies approved are predominantly in the more rural areas: BCU -5.85, HD -14.15 and Powys at -8.65 FTEs.
- There are also vacancies on the EA lines.
- Further recruitment is planned, including external recruitment of fully qualified Paramedics (paused whilst the current funding pressures are worked through) and also more innovation to aid recruitment e.g. combined EA/CHARU rosters etc.



# Handover & Out of Area

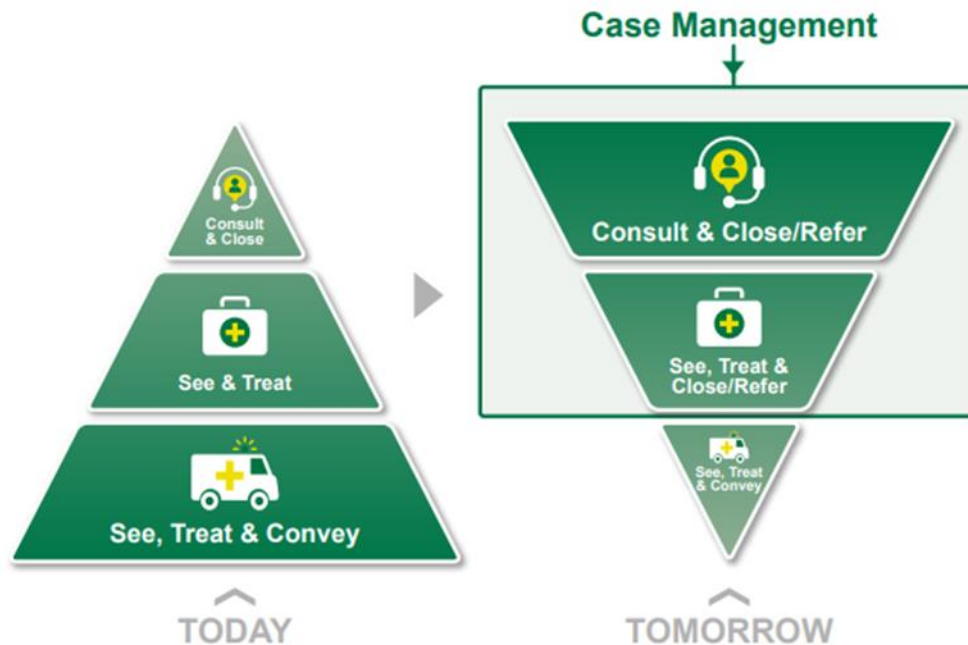


- The Trust lost 18,548 hours to handover delays in June 2023, more than three times the level modelled in the 2019 Demand & Capacity Review (considered high at the time). This equates to 1,613 lost 11.5 hour shifts.
- Handover causes ambulance resource to be pulled out of area. This is often cited as an issue in rural areas, what is sometimes referred to as “urban drift”. Modelling data does indicate a need to enable resource from areas like Hywel Dda and Powys to return into their area.
- Out of area is not exclusive to rural areas, for example, C&V is currently experiencing a pull into AB and CTM.
- The key issue is to reduce handover, not ring fencing, ring fencing is fundamentally inefficient and divisive





# 2023 EMS Demand & Capacity Review



- CEO and CASC requirement for independent collaborative strategic (five year) EMS demand & capacity review.
- It should be (and is) BAU to repeat a strategic review before the previous one runs out.
- It will rebase the EMS taking into account system changes, in particular, the change in demand (higher red), much higher handover etc.
- It will be very different to the last one due to “inverting the triangle”.
- It should provide a quantified future state of the resource (cost) and benefit of the inversion. Will be more complex.
- It explicitly includes rurality.
- An option may be to model a “floor parameter” for locality performance.



## Conclusions

- A lot of work has been undertaken in the Red rural performance space.
- Whilst Red rural performance remains an issue, actions are being taken to address rural performance, in particular, the full roll out of CHARUs.
- Population sparsity and associated demand will always be an issue, with the Trust spending significantly more on rural communities (per head of population) than it does on urban, because you need more resource to hit the sparse demand.
- The work undertaken indicates the key areas of focus are: 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 & Capacity Review explicitly includes rurality in its terms of reference.

Welsh Ambulance Services NHS Trust

# Clinical Indicators The Journey & Assurance



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NHS  
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Ymddiriedolaeth GIG  
Gwasanaethau Ambiwylans Cymru  
Welsh Ambulance Services  
NHS Trust

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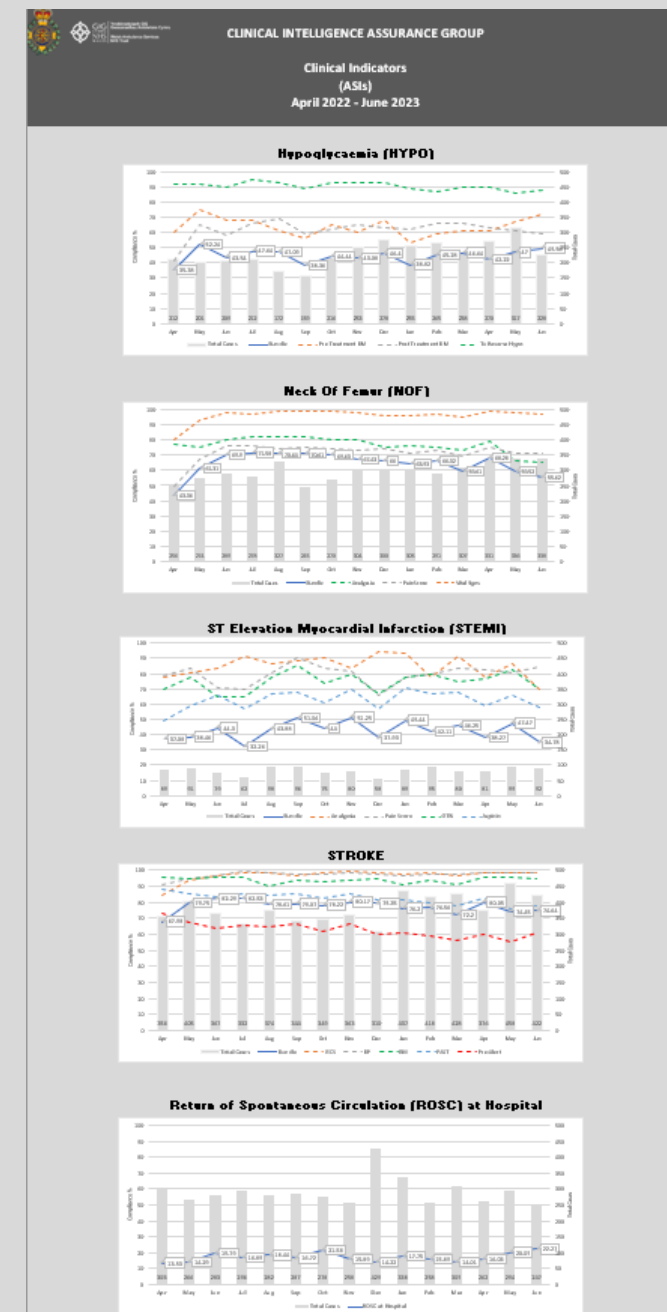
Clinical Indicators – The Journey & Assurance  
Version 1.0  
Released: July 2023

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Kevin Webb  
Head of Clinical Intelligence & Assurance  
Kevin.webb@wales.nhs.uk

Clinical Indicators (CI) have been reported on internally to monitor and improve on condition specific compliance for around 20 years and form part of the Ambulance Service Indicators (ASIs) published by the Emergency Ambulance Services Committee (EASC).

In the main, only 5 condition specific CIs have been reported on due to the availability of clinical data. There have been requests for a suite of CIs to be developed, to report on **time-based metrics** for some CIs (e.g., STEMI & stroke) and to link CIs to the wider NHS for **outcome data**.



# Patient Clinical Records

Prior to 2015, CI data was taken from paper Patient Clinical Records (PCRs). These were a single sided A3 form, handwritten with limited clinical data being documented.

As the PCRs were transported from each ambulance station to a single point in the Trust for processing, there was often up to a 6-week delay from a PCR being completed to the data being available for reporting.

PCRs were scanned and manually audited to ensure a more accurate clinical picture of the care delivered as information contained in the narrative contributed to compliance. This was a time-consuming process and added to the limitations of the numbers of CIs that could be produced.

The image shows a complex, multi-sectioned form titled 'CLINICAL RECORD IN CONFIDENCE' from the 'WELSH AMBULANCE SERVICES NHS TRUST'. The form is organized into several numbered sections:

- 1. PATIENT DETAILS:** Includes fields for date, time, location, and patient name.
- 2. RESPONSE DETAILS:** Contains a grid for recording vital signs (HR, RR, SpO2, BP, Temp) and other parameters.
- 3. CONDITION CODE:** A grid for recording various clinical conditions.
- 4. PRIMARY SURVEY:** A section for recording initial assessment findings.
- 5. OBSERVATIONS:** A large grid for recording ongoing patient observations.
- 6. OBSTETRICS:** A section for recording obstetric-related information.
- 7. RELEVANT MEDICAL INFORMATION:** A section for recording patient history and medical background.
- 8. REFERRAL POINT:** A section for recording the reason for the ambulance call.
- 9. REFERRAL OF TREATMENT:** A section for recording the treatment provided.
- 10. RNA INFORMATION:** A section for recording ambulance arrival and response times.
- 11. MONITOR:** A section for recording vital signs and other monitoring data.
- 12. AIRWAY & BREATHING:** A section for recording airway management and breathing support.
- 13. CARDIAC ARREST:** A section for recording cardiac arrest details.
- 14. CANNULATION:** A section for recording cannulation details.
- 15. INJURY INFORMATION:** A section for recording injury details, including a body diagram.
- 16. OTHER INTERVENTIONS:** A section for recording other medical interventions.

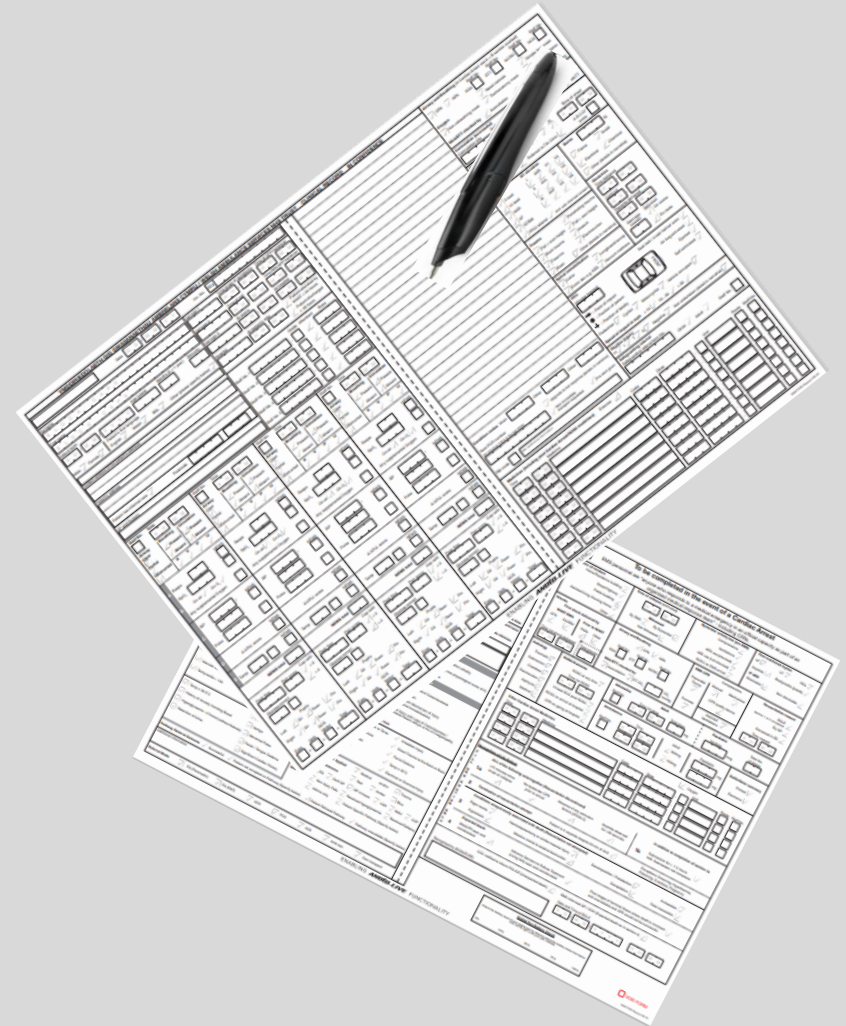
A pen is resting diagonally across the bottom right portion of the form.

# Patient Clinical Records

From October 2015 – March 2022, Digital Pens were used to complete PCR. A double-sided A3 form was designed which allowed a wider range of data to be documented.

The PCR image and data was available as soon as the digital pens were docked which was a significant improvement on the paper-based process.

Even though a wider range of clinical data was now available and used for clinical audits, there was still a requirement to manually audit the PCRs for the CIs so limited increasing the number we could produce.

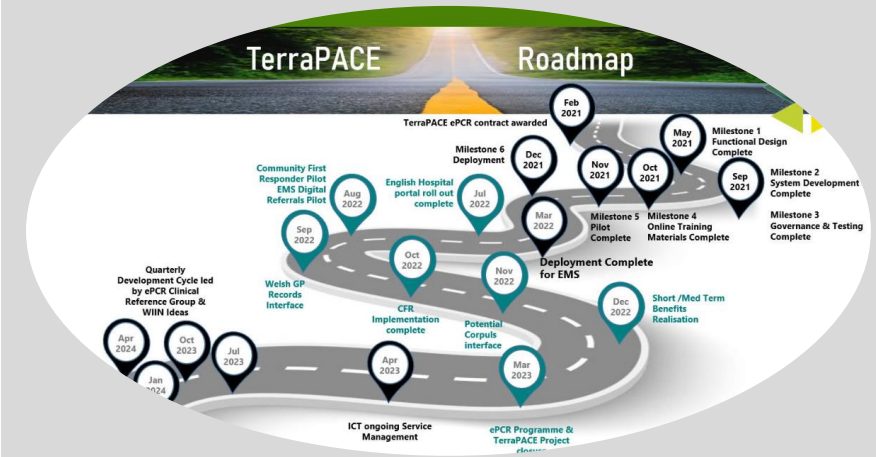


# electronic Patient Clinical Records

In April 2022, the electronic Patient Clinical Record (ePCR) was implemented Trust wide.

This provided opportunities to capture a much wider range of data and for it to be available almost instantly.

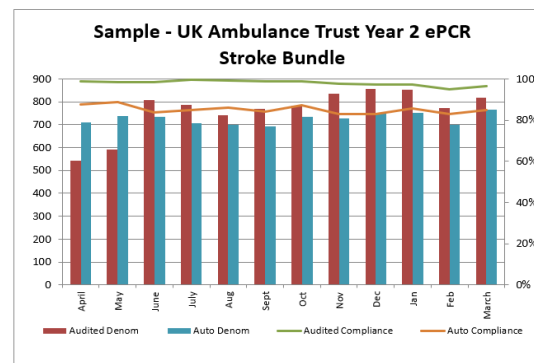
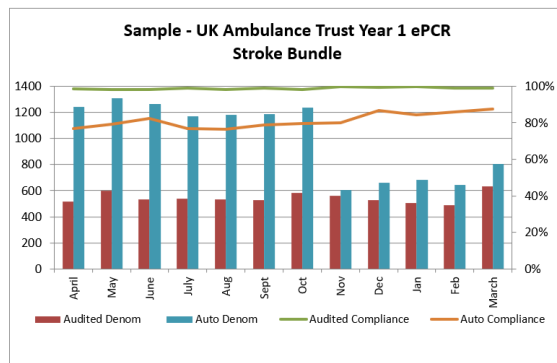
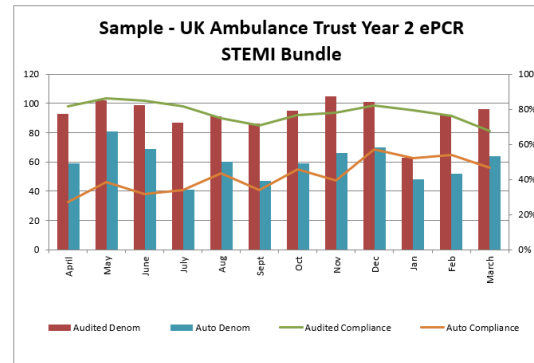
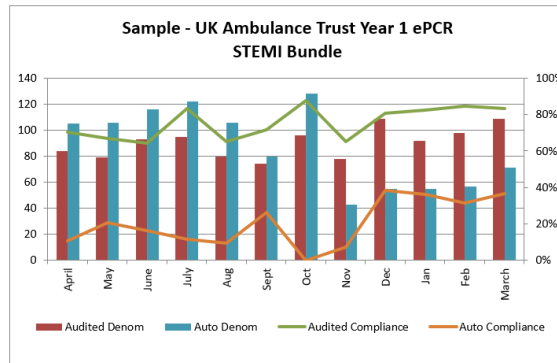
A decision was made not to audit the data required for CIs and instead to report on the 'raw' data as inputted by clinicians.



# CI compliance (anticipated reduction)

Feedback from English Trusts who had implemented ePCRs highlighted a significant reduction in their CI compliance prior to auditing.

English Ambulance Trusts continue to manually audit their CIs before release (1 month in 3 and first 300 records).



Due to staff being unfamiliar with a new system, a reduction in CI compliance was anticipated to be the same for WAST, risk 535 was created to highlight 3 elements:

- User behaviour
  - Narrative completed instead of specific fields
  
- User Interface
  - Some areas need improving to facilitate accurate completion, justified exceptions and timestamps
  
- Scripting
  - Some scripting (e.g., STEMI) required changing to minimise false positives, ASI data rerun

Risk 535 is monitored by the Clinical Intelligence & Assurance Group (CIAG)

Likelihood score		1	2	3	4	5
Severity	5	Rare	Unlikely	Possible	Likely	Almost certain
	4	1	2	3	4	5
	3	2	3	4	5	6
	2	3	4	5	6	7
	1	4	5	6	7	8
Risk level		1-3	4-6	7-9	10-12	13-15
		Low risk	Moderate risk	High risk	Extreme risk	Extreme risk

**Risk Scoring Matrix:**

Severity	1	2	3	4	5
5 Catastrophic	15	20	25	30	35
4 Major	10	15	20	25	30
3 Moderate	5	10	15	20	25
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

**Severity Descriptions:**






- 5 Catastrophic: An event which results in a total loss of life, or a total loss of the ability of the system to perform its function.
- 4 Major: An event which results in a total loss of the system's ability to perform its function, or a total loss of the system's ability to perform its function.
- 3 Moderate: An event which results in a total loss of the system's ability to perform its function, or a total loss of the system's ability to perform its function.
- 2 Minor: An event which results in a total loss of the system's ability to perform its function, or a total loss of the system's ability to perform its function.
- 1 Negligible: An event which results in a total loss of the system's ability to perform its function, or a total loss of the system's ability to perform its function.

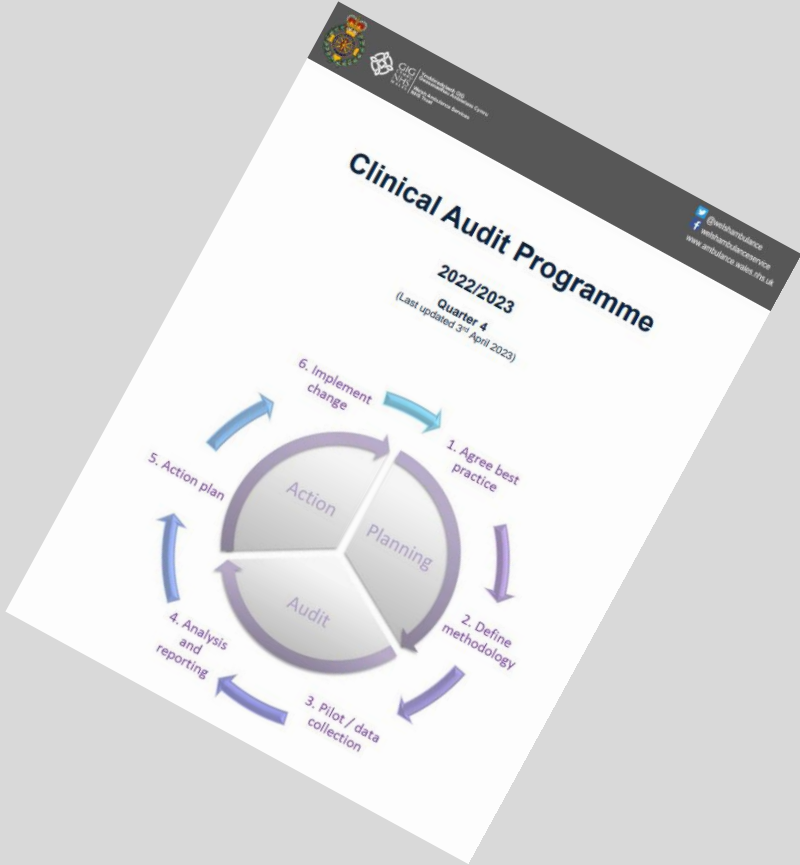
**Likelihood Descriptions:**

- 1 Rare: This will probably never happen.
- 2 Unlikely: This will probably happen once in a while.
- 3 Possible: This will probably happen occasionally.
- 4 Likely: This will probably happen frequently.
- 5 Almost certain: This will probably happen every time.

The Clinical Intelligence & Assurance Team undertook QA (deep-dive) audits for each of the CIs to provide:

- A more accurate clinical picture of the care delivered
- Highlight the variation between automated data and audited data
- Help inform future reporting and caveats

Scan the QR codes for the QA (deep-dive) audits				
Stroke	STEMI	Hypoglycaemia	#NOF	ROSC (at hospital)
				



As a result of the audits, many lessons were learned, these included:

- ✓ Ensuring the CIAT sense check SQL scripts when developing future CIs
- ✓ Change request for the ePCR UI to assist staff in documenting the care delivered and improve CI compliance
- ✓ For hypoglycaemia, the changes being progressed include clearer terminology for justified exceptions and resolved hypoglycaemia on EMS arrival
- ✓ Change request for observations and pain score to be saved in the observations section and mirrored elsewhere, pain score to have a time stamp
- ✓ Change request for stroke submitted for improved terminology for justified exceptions
- ✓ For ROSC, suggested changes will include highlighting core fields to improve accuracy



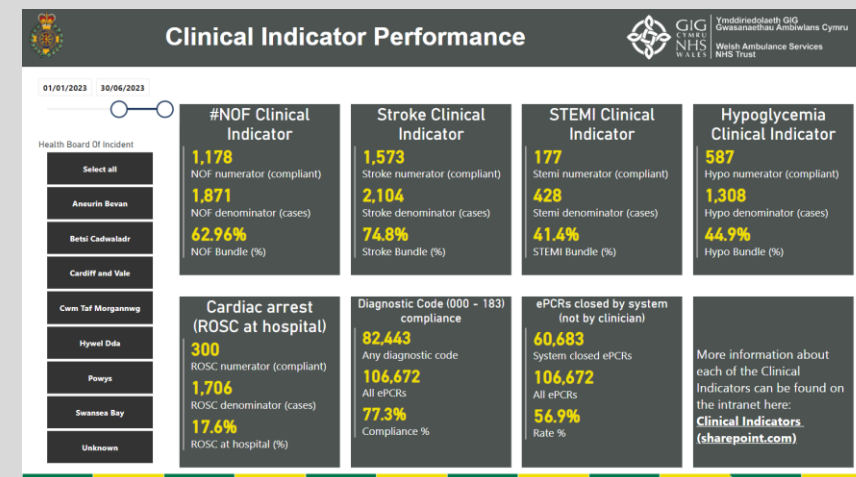
- As a result of the audits, an improvement plan was developed which included:
  - Issuing 'Tops Tips' for staff in completing CI aspects of the ePCR
  - Recommending changes to the ePCR UI (being progressed)

- Some improvement work paused due to higher priorities
- CI compliance and ePCR completion discussed during Senior Paramedic 'ride outs'
- CIAG review and approve the CIs and caveats for release as ASIs to EASC (NCCU part of CIAG)



➤ A CI dashboard has been developed by Health Informatics and is available on the Trust's Power BI app

- This is version 1 and continues to be developed following feedback
- Reports needed to demonstrate clinical performance and facilitate improvement
- Staff and managers can monitor compliance from April 2022 (ePCRs)
- Reports by patient location (not by team)
- A tenant structure being developed (to report by team)



STEMI - Care Bundle & Individual Metrics

Stroke - Care Bundle & Individual Metrics

#NOF - Care Bundle & Individual Metrics

Hypoglycemia - Care Bundle & Individual Metrics

ROSC - At Hospital Indicator

Current  
Clinical Indicators  
(WAST Dashboard)

&

Ambulance Service Indicators  
(Emergency Ambulance Services Committee)

Stroke - Care Bundle & Individual Metrics

#NOF - Care Bundle & Individual Metrics

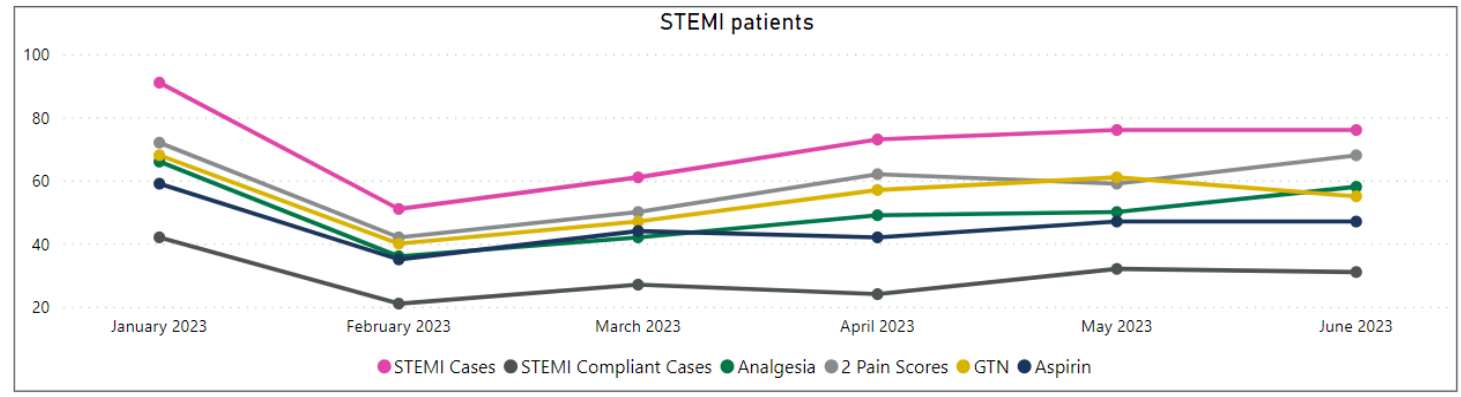
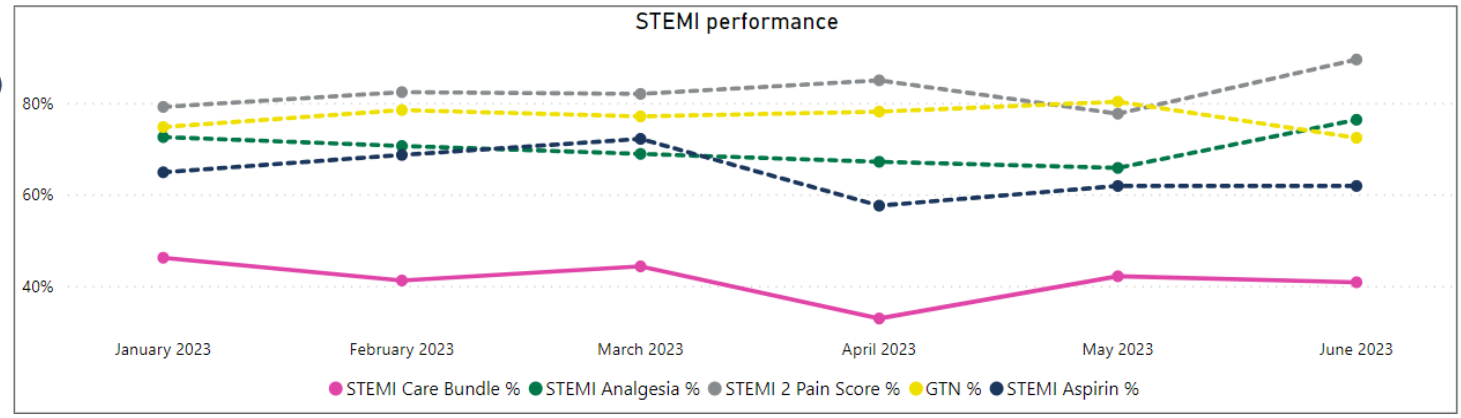
Hypoglycemia - Care Bundle & Individual Metrics

ROSC - At Hospital Indicator

01/01/2023 30/06/2023

Health Board Of Incident

- Select all
- Aneurin Bevan
- Betsi Cadwaladr
- Cardiff and Vale
- Cwm Taf Morgannwg
- Hywel Dda
- Powys
- Swansea Bay
- Unknown




STEMI - Care Bundle & Individual Metrics

#NOF - Care Bundle & Individual Metrics

Hypoglycemia - Care Bundle & Individual Metrics

ROSC - At Hospital Indicator



## Stroke - Care Bundle & Individual Metrics



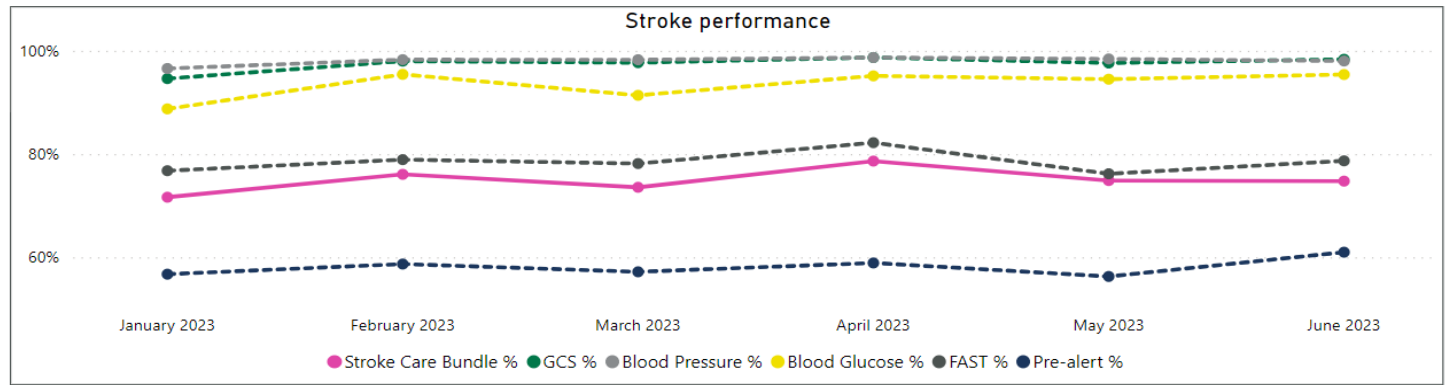
Ymddiriedolaeth GIG  
Gwasanaethau Ambiwylans Cymru  
Welsh Ambulance Services  
NHS Trust

01/01/2023    30/06/2023

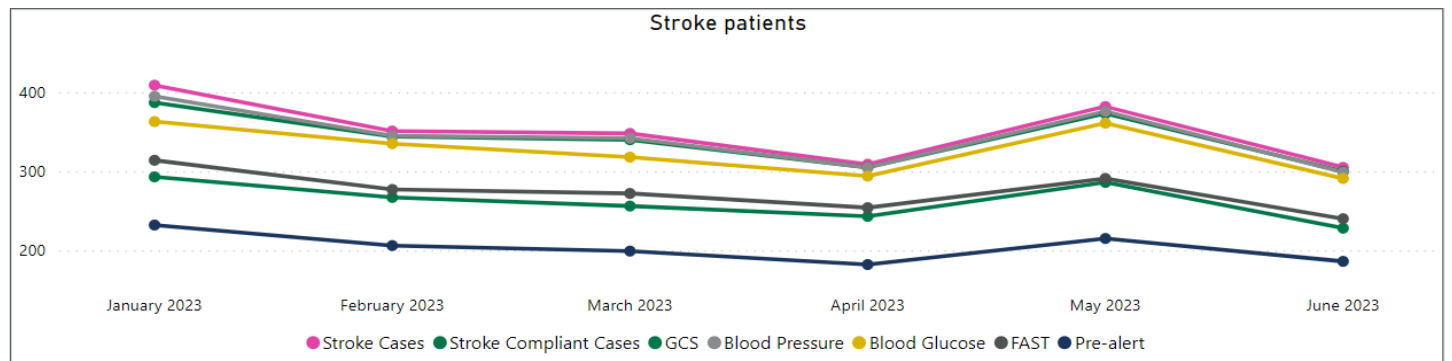


Health Board Of Incident

- Select all
- Aneurin Bevan
- Betsi Cadwaladr
- Cardiff and Vale
- Cwm Taf Morgannwg
- Hywel Dda
- Powys
- Swansea Bay
- Unknown



*Pre-alert is not a component of the Stroke Care Bundle*



STEMI - Care Bundle & Individual Metrics

Stroke - Care Bundle & Individual Metrics

Hypoglycemia - Care Bundle & Individual Metrics

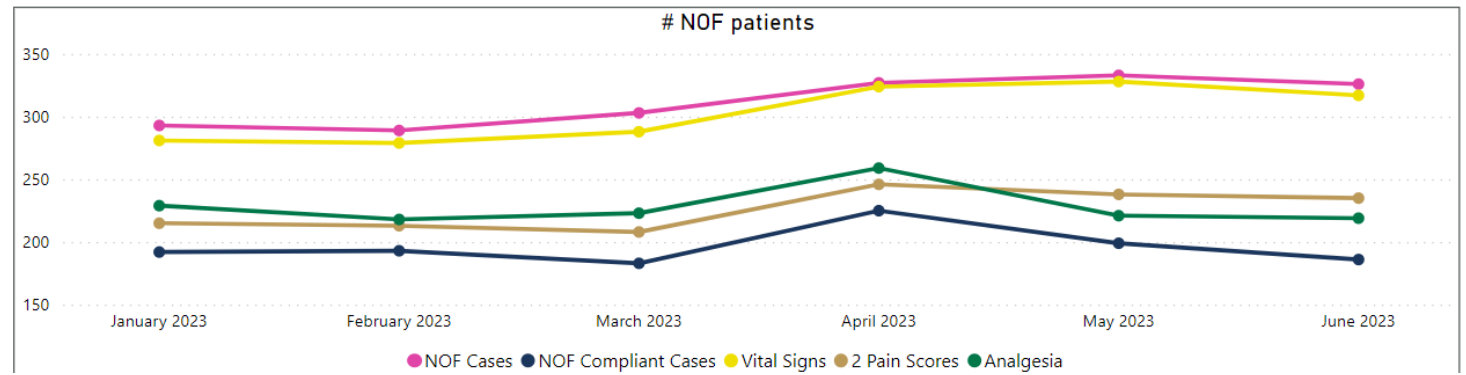
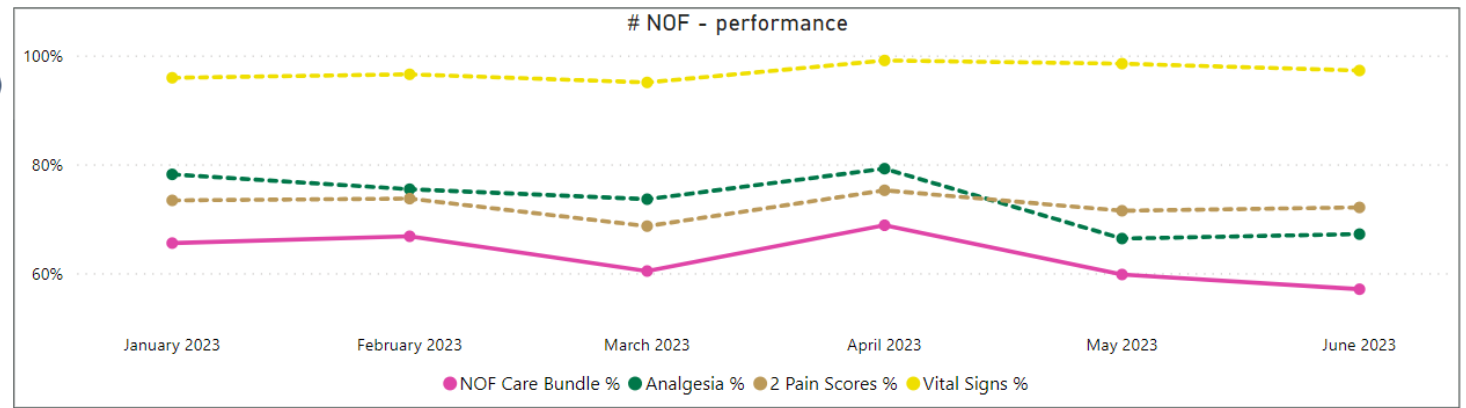
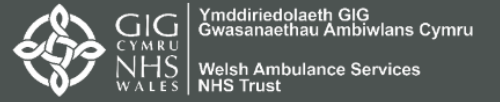
ROSC - At Hospital Indicator

# #NOF - Care Bundle & Individual Metrics

01/01/2023 30/06/2023

Health Board Of Incident

- Select all
- Aneurin Bevan
- Betsi Cadwaladr
- Cardiff and Vale
- Cwm Taf Morgannwg
- Hywel Dda
- Powys
- Swansea Bay
- Unknown

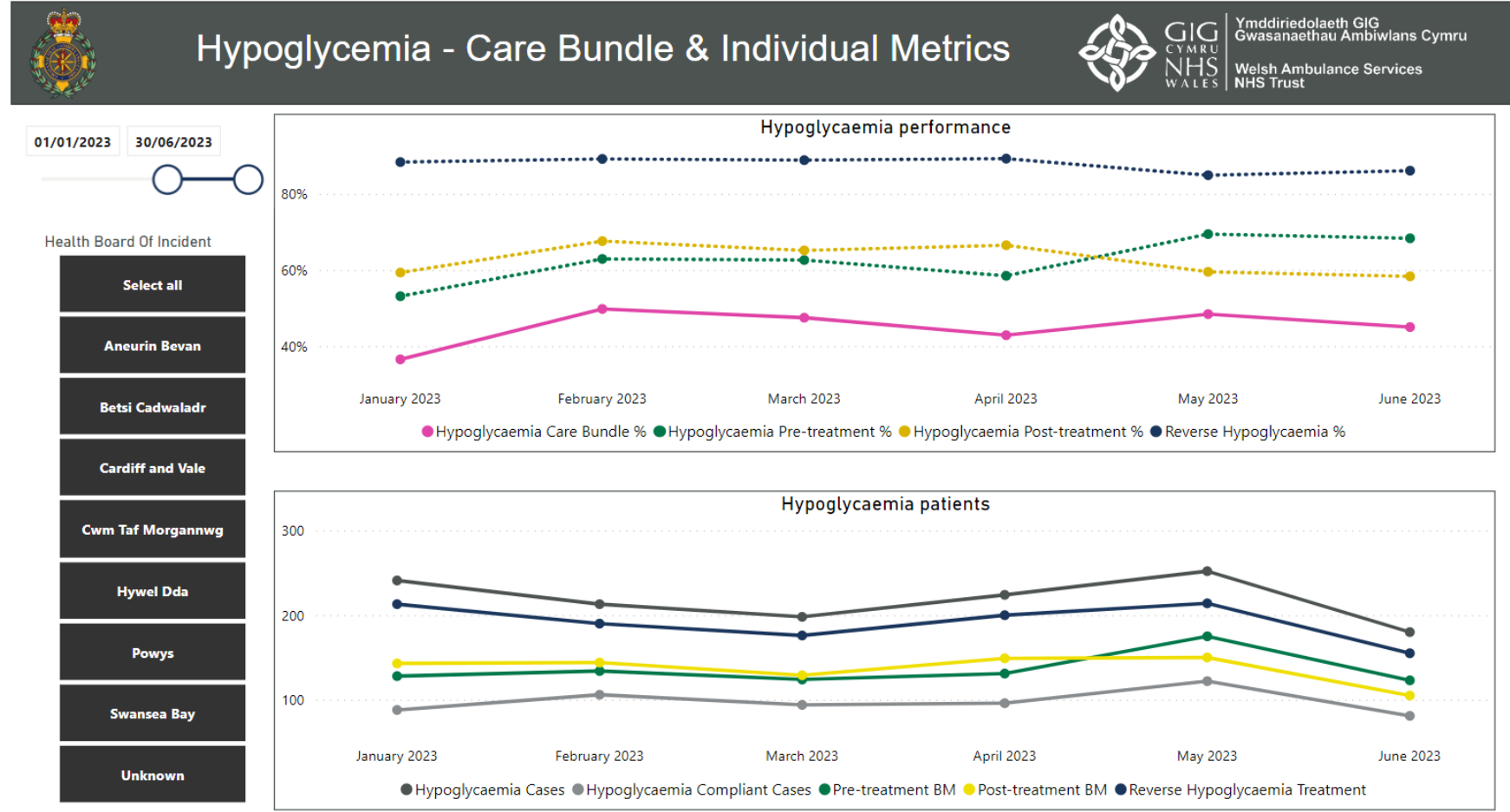


STEMI - Care Bundle & Individual Metrics

Stroke - Care Bundle & Individual Metrics

#NOF - Care Bundle & Individual Metrics

ROSC - At Hospital Indicator



STEMI - Care Bundle & Individual Metrics

Stroke - Care Bundle & Individual Metrics

#NOF - Care Bundle & Individual Metrics

Hypoglycemia - Care Bundle & Individual Metrics



# ROSC - At Hospital Indicator



Ymddiriedolaeth GIG  
Gwasanaethau Ambiwians Cymru  
Welsh Ambulance Services  
NHS Trust

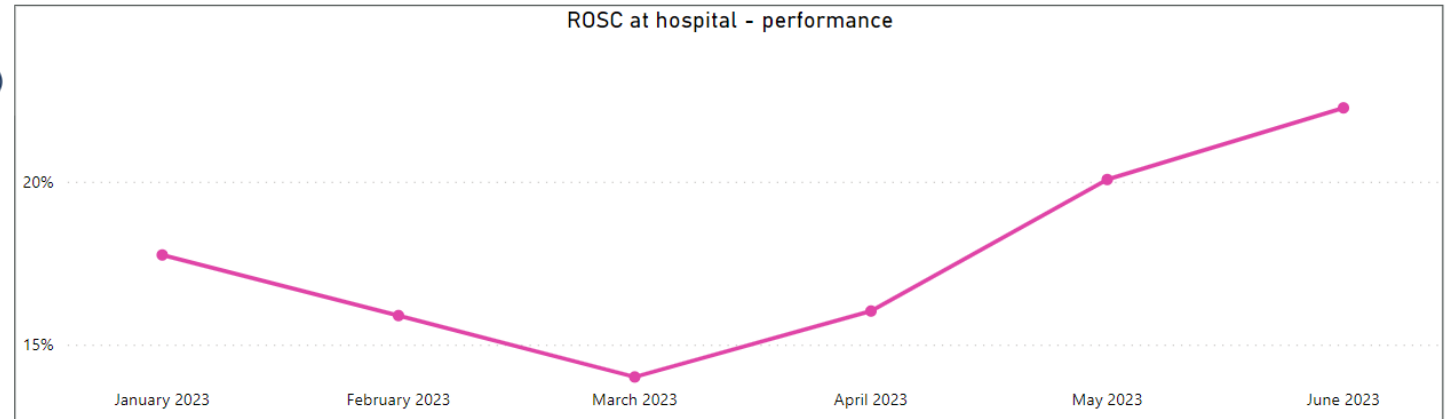
01/01/2023 30/06/2023



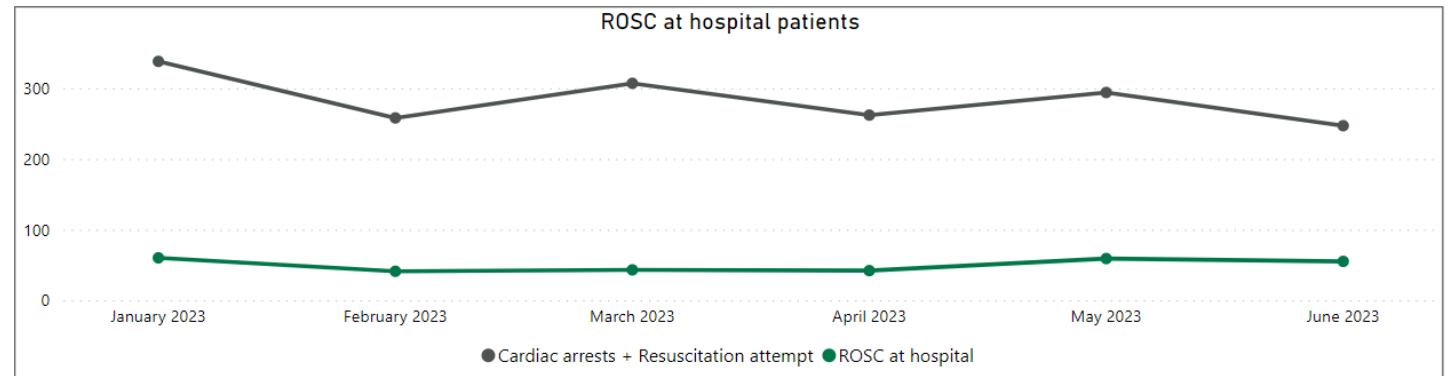
Health Board Of Incident

- Select all
- Aneurin Bevan
- Betsi Cadwaladr
- Cardiff and Vale
- Cwm Taf Morgannwg
- Hywel Dda
- Powys
- Swansea Bay
- Unknown

ROSC at hospital - performance



ROSC at hospital patients



- CIAG have a CI plan to develop new CIs (considering commissioning intentions) and to review the evidence base for existing CIs
- The CIAT will undertake and audit for all newly proposed CIs to help inform their suitability as a CI
  - Be evidence based
  - Have impact, meaning, and make a difference to our patients
  - Lead to quality improvement
  - Be automated as much as possible
  - Be more than a simple count
- New CIs in development are:



STEMI - Median Call To Door Metric Times



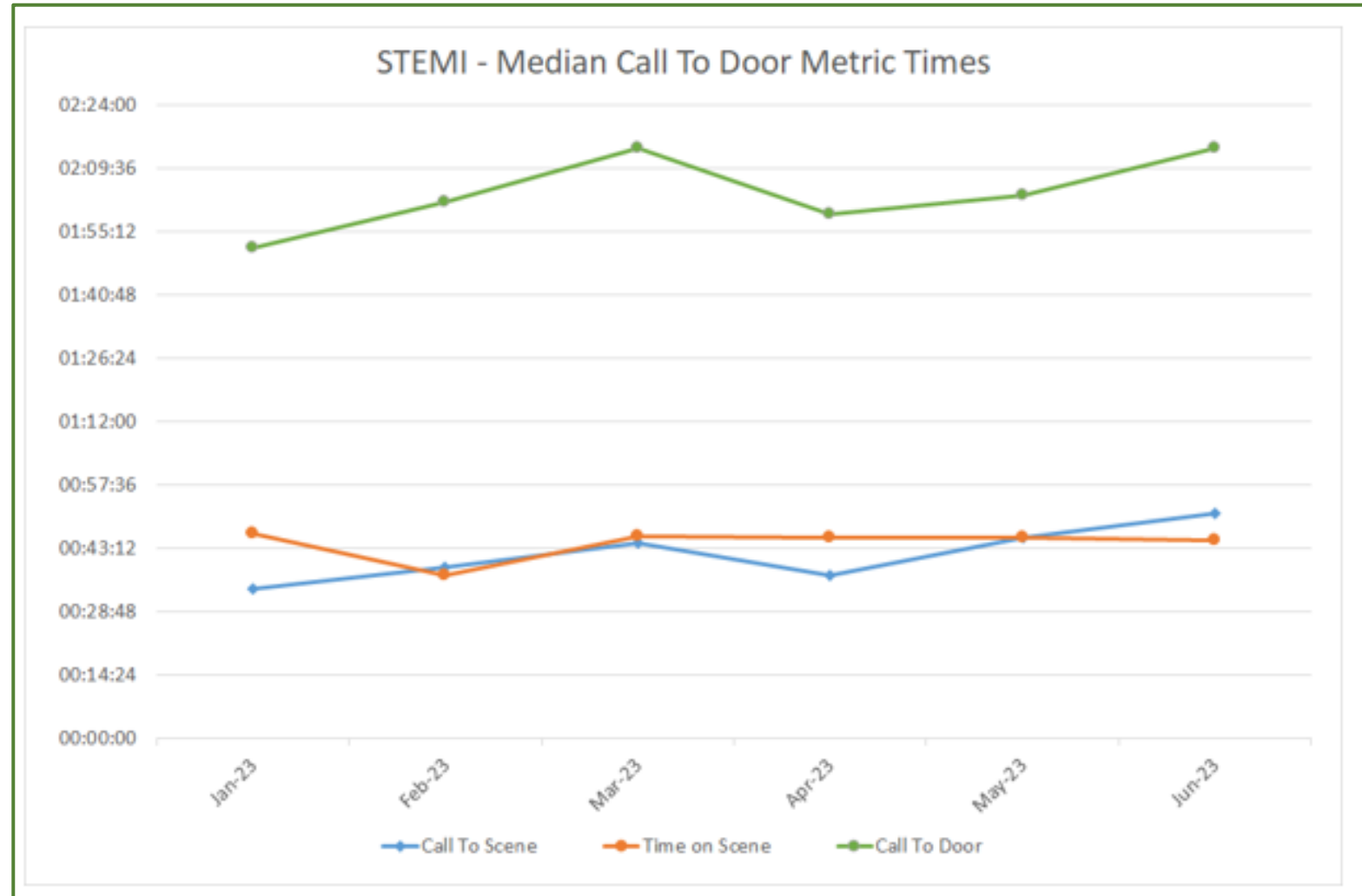
STROKE - Median Call To Door Metric Times

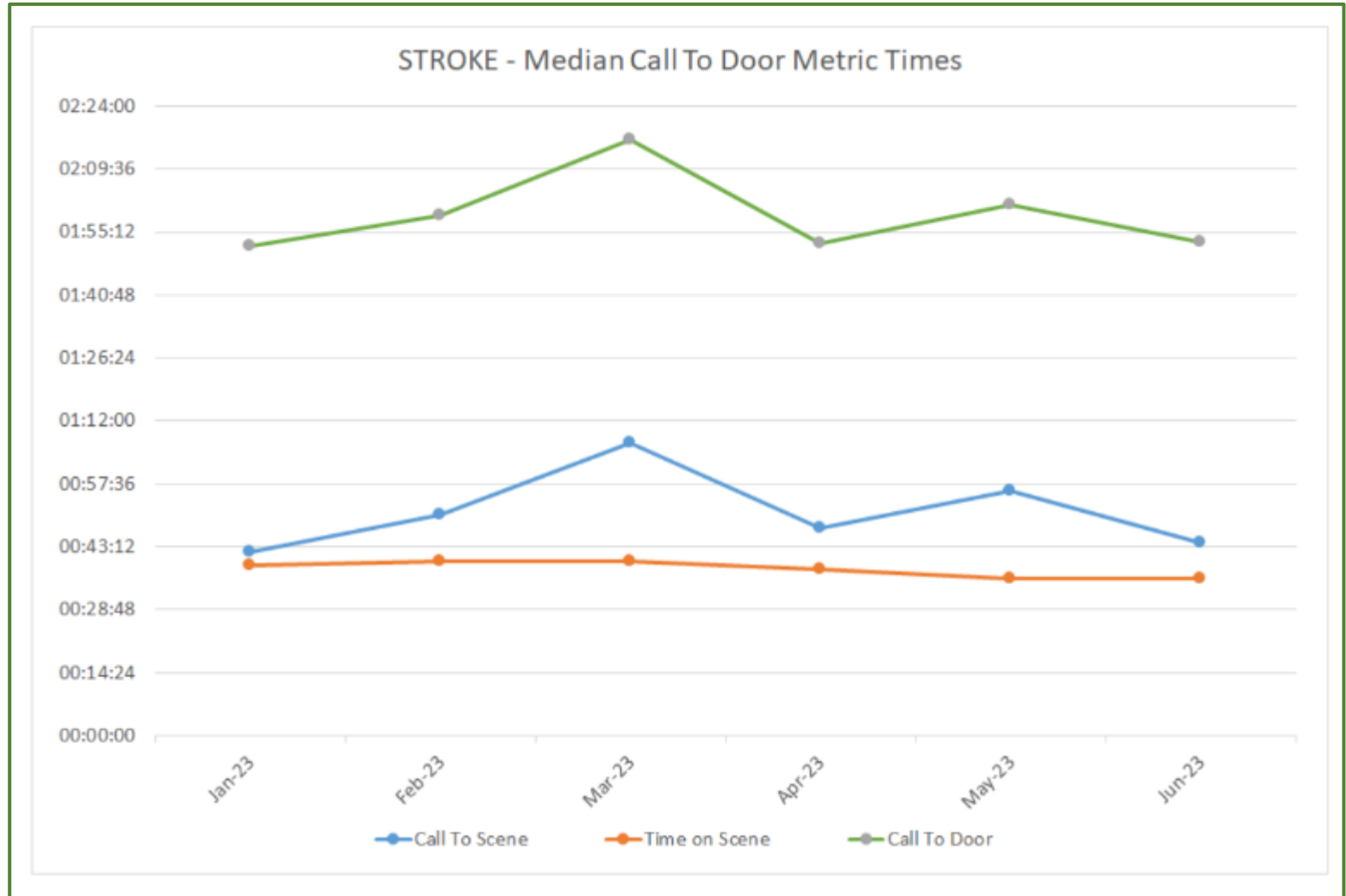
## Clinical Indicators in Development:

- ✓ Call to door time – STEMI
- ✓ Call door time – Stroke

## Clinical Indicators being considered:

- ❖ Older Fallers (Pilot – English Ambulance Trusts)
- ❖ Paediatric trauma / pain management
- ❖ Advanced Paramedic Practitioner (Condition specific compliance)





# Next steps on this journey

- Complete the User Interface (UI) changes to the ePCR software (from clinical audits)
- Improve communication channels with staff; bulletins, Top Tips posters, changes updates
- Further involvement of SPs to instigate change and improve understanding / compliance
- Update the online ePCR training module to reflect UI changes and be more WAST specific
- Work closely with 'champions' in each locality on data interpretation and improvement
- Continue to work with DHCW to clarify ePCR definitions for the Ambulance Data Set
- Work with DHCW and the wider NHS to link outcome data

# Next steps on this journey

## Closure of ePCRs

Add prompts to the UI so that staff are made aware of incomplete fields when a CI condition specific record is being closed. This is being progressed via the ePCR Clinical Reference Group.

The screenshot shows a web interface titled "Select Diagnostic Code" with a "Close" button in the top right. Below the title is a table with columns: Closure Time, Closure Type, Closure Code, Closure Reason, Edit, and Remove. The table contains one row with the following data: Closure Time: 11/07/2023 4:37:00 PM, Closure Type: Primary, Closure Code: 35, Closure Reason: Hypoglycaemia. The "Hypoglycaemia" text is circled in red. Below the table are two "Add Closure Entry" input fields and a green "Close Record" button. A callout box points to the "Close Record" button with the text: "When the 'Close Record' button is chosen, it alerts the clinician to any CI fields that have not been completed. Clicking that will return to the relevant section for completion, the ePCR can then be closed." To the right of the "Close Record" button is a red-bordered box containing the text: "Incomplete Clinical Indicator Care Bundle Before the ePCR can be closed, please click on the red elements(s) below to return to the relevant section(s)". Below this box are three buttons: "Pre-treatment BM" (green), "Treatment" (green), and "Post treatment BM" (red).

Closure Time	Closure Type	Closure Code	Closure Reason	Edit	Remove
11/07/2023 4:37:00 PM	Primary	35	Hypoglycaemia		

When the 'Close Record' button is chosen, it alerts the clinician to any CI fields that have not been completed. Clicking that will return to the relevant section for completion, the ePCR can then be closed.

**Incomplete Clinical Indicator Care Bundle**  
Before the ePCR can be closed, please click on the red elements(s) below to return to the relevant section(s)

- Pre-treatment BM
- Treatment
- Post treatment BM

# Next steps on this journey

## Develop new CIs

- Work with our commissioners, staff, managers and other ambulance services to identify and test specific areas to be considered as CIs. Currently, these are:
  - Older Fallers
  - Paediatric trauma / pain management
  - APP (condition specific)

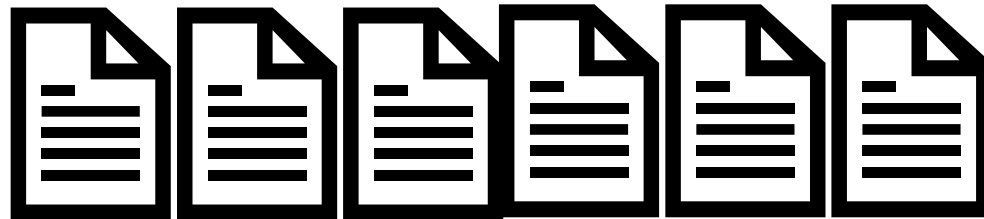
## Review existing CIs

- Review the evidence base and criteria for existing CIs
- Consider the work of English Ambulance Trusts

# Next steps on this journey

## Artificial Intelligence

- Explore Artificial Intelligence and Machine Learning to support scrutiny of narratives to improve compliance
- Text analysis to automate processes of classifying and extracting text data



# Thank you for listening

## Any questions or comments ?



GIG  
CYMRU  
NHS  
WALES

Ymddiriedolaeth GIG  
Gwasanaethau Ambiwylans Cymru  
Welsh Ambulance Services  
NHS Trust

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Clinical Indicators The Journey and Assurance



<b>AGENDA ITEM No</b>	
<b>OPEN or CLOSED</b>	<b>OPEN</b>
<b>No of ANNEXES ATTACHED</b>	<b>1</b>

**PUTTING THINGS RIGHT REPORT  
QUARTER 1, APRIL - JUNE 2023**

<b>MEETING</b>	Quality, Patient Experience & Safety Committee
<b>DATE</b>	10 August 2023
<b>EXECUTIVE</b>	Liam Williams, Executive Director of Quality & Nursing
<b>AUTHOR</b>	Wendy Herbert, Assistant Director of Quality & Nursing
<b>CONTACT</b>	07966 205399 <a href="mailto:Wendy.herbert@wales.nhs.uk">Wendy.herbert@wales.nhs.uk</a>

<b>EXECUTIVE SUMMARY</b>
<p>This report provides an update to The Quality, Patient Experience &amp; Safety Committee (QuEst) on the key information from the Patient Safety and Putting Things Right (PTR) functions.</p> <p>In summary the Report for this quarter identifies:</p> <ul style="list-style-type: none"> <li>• Continued high level of risk of harm to our patients in community (Risk 223) and patients delayed outside of Emergency Departments (Risk 224).</li> <li>• An increase in the number of concerns, and a backlog remains.</li> <li>• A continuing number of incidents being reviewed at the Serious Case Incident Forum (SCIF).</li> <li>• A continuing number of Joint Investigations passed to Health Boards.</li> <li>• A continuing number of Nationally Reportable Incidents (NRIs) identified.</li> <li>• A continued upward trend in Coroner’s requests for information.</li> <li>• An increase in the number of Road Traffic Incident claims.</li> <li>• The Trust received two Regulation 28 Reports during this period and responses are due in August 2023.</li> <li>• Periods of industrial action took place during this quarter by the Royal College of Nursing.</li> </ul> <p><b>RECOMMENDED that the Committee receives the report for discussion.</b></p>

<b>KEY ISSUES/IMPLICATIONS</b>	
(i)	There continues to be an increase in activity in the majority of areas across PTR.
(ii)	There continues to be a high-level volume of concerns being received.
(iii)	A significant improvement in our two-day acknowledgement of concerns has been sustained overall, but our thirty-day compliance remains lower.
(iv)	Delivery of functions remains a significant challenge due to capacity, demand and competing priorities.

<b>REPORT APPROVAL ROUTE</b>	
Clinical Quality Governance Group	24 July 2023
Quality, Patient Experience & Safety Committee	10 August 2023

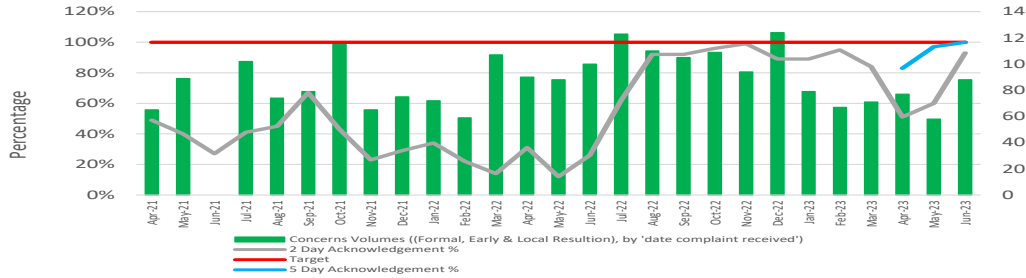
<b>REPORT APPENDICES</b>
<b>ANNEX 1</b> - Putting Things Right Report

<b>REPORT CHECKLIST</b>			
<b>Confirm that the issues below have been considered and addressed</b>		<b>Confirm that the issues below have been considered and addressed</b>	
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

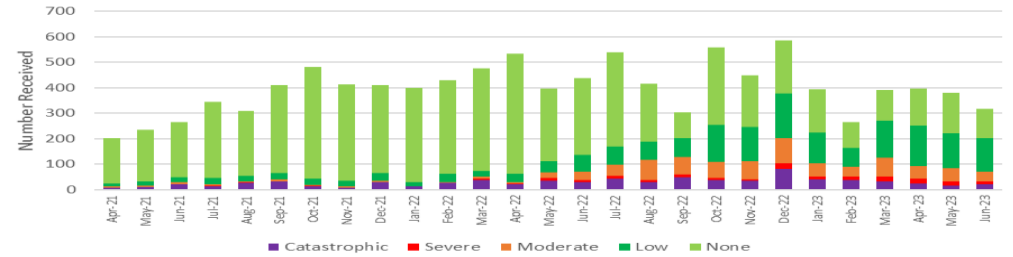
<b>PUTTING THINGS RIGHT</b>						
Comparison of Data Quarter / Year	Quarter 1, 2022-23			Quarter 1, 2023-24		
	April 2022	May 2022	June 2022	April 2023	May 2023	June 2023
<b>Patient Safety Incidents (Reporters view of harm)</b>						
Catastrophic	20	36	29	25	15	22
Severe	3	9	9	18	17	10
Moderate	5	22	32	50	53	37
Low	33	44	66	159	137	132
None	474	285	301	146	158	115
<b>Total</b>	<b>535</b>	<b>396</b>	<b>437</b>	<b>398</b>	<b>380</b>	<b>316</b>
<b>Concerns</b>						
Total Received	90	88	100	77	58	88
Political Concerns	5	10	2	6	2	3
2 Day Acknowledgment %	31%	12%	26%	63%	67%	94%
5 Day Acknowledgement % (new April 2023)	-	-	-	88%	96%	99%
30 Day Response due %	53%	41%	13%	35%	29%	43%
<b>Ombudsman</b>						
Cases Received	7	5	3	2	1	3
Cases Closed	3	5	4	2	5	0
Reports Received	0	1	1	0	0	0
<b>Coroners</b>						
Information Requests	115	112	116	141	149	139
Identified as Interested Party	19	20	19	32	35	45
Staff Attending	5	5	6	11	7	5
Regulation 28 Issued	0	1	1	0	0	2
Response to Regulation 28 outside 56 working days	0	0	0	0	0	0
<b>Nationally Reportable Incidents (NRIs) to NHS Wales Executive (Reporting date)</b>						
Serious Case Incident Forums held	7	8	8	8	6	8
Serious Case Incident Forums Cases	26	44	47	30	46	27
WAST NRIs reportable to Delivery Unit	3	11	3	8	6	8
Joint Investigation Framework - Passed	19	7	24	8	15	17
Joint Investigation Framework - Received	0	0	0	0	0	0
NRI Closures Submitted - Total	5	8	20	4	1	19
<b>Claims</b>						
Personal Injury – Received	3	1	0	4	0	1
Personal Injury – Closed	3	0	1	3	0	7
Clinical Negligence - Received	4	1	2	2	3	3
Clinical Negligence - Closed	3	0	0	0	0	1
Road Traffic Collision & Damage to Property – Received	15	17	25	33	18	29
Road Traffic Collision & Damage to Property – Closed	6	19	10	12	4	14

# Putting Things Right Overview

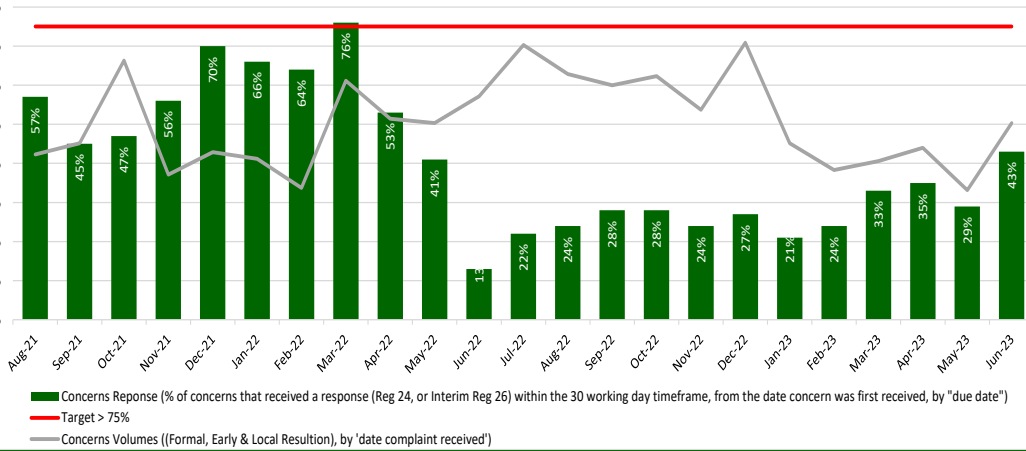
## Concerns Acknowledgement %



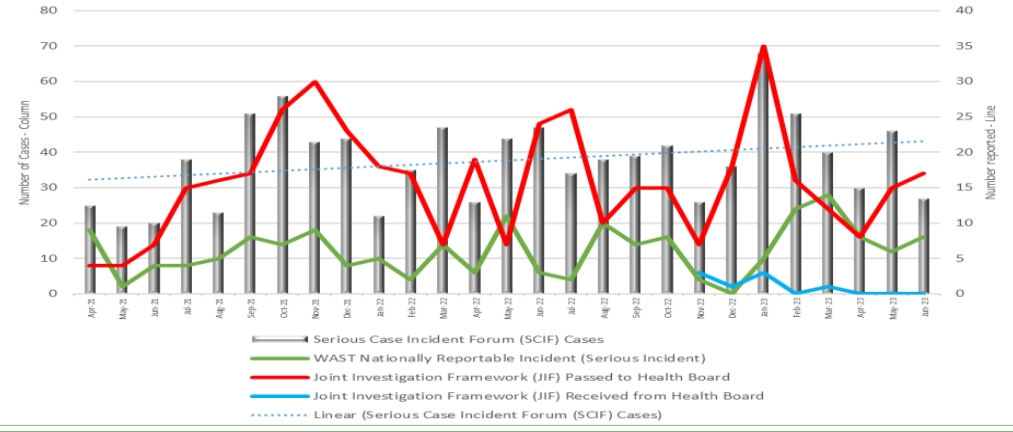
## Patient Safety Incidents (by reporters view of harm)



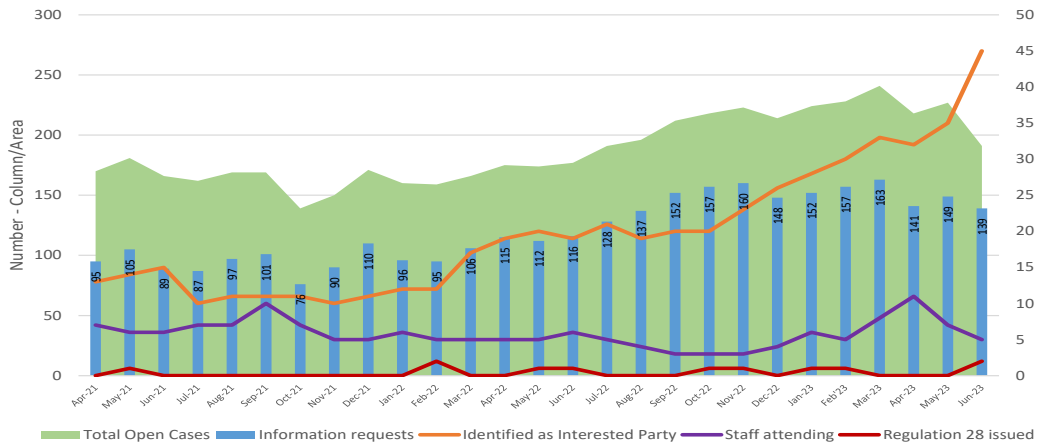
## % of concerns with a response within 30 working days against concerns volumes



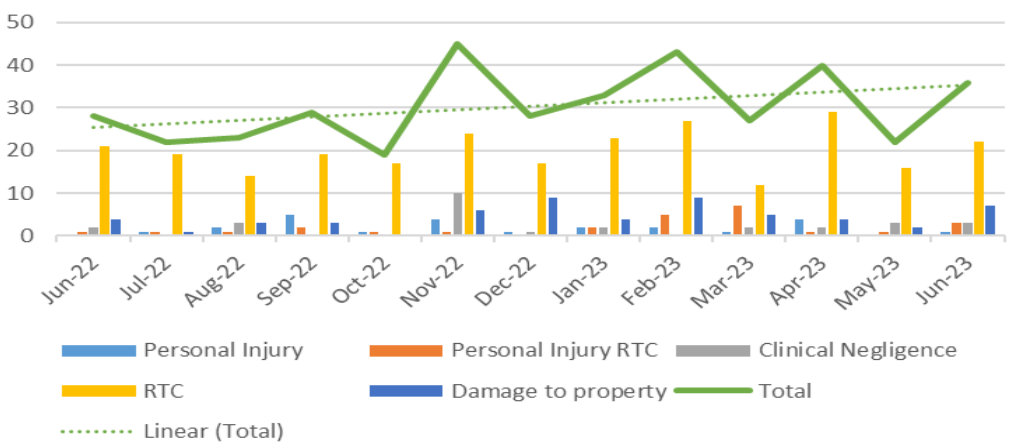
## Serious Case Incident Forum Cases WAST NRI / Joint Investigations (by date reported)



## Coroners Activity



## Legal Cases Received During The Month



## BACKGROUND

1. The purpose of this Patient Safety Highlight & Putting Things Right Report is to provide an update to the Quality, Patient Experience & Safety Committee, with onward reporting to Trust Board as required on the key information, areas of concerns and assurances.

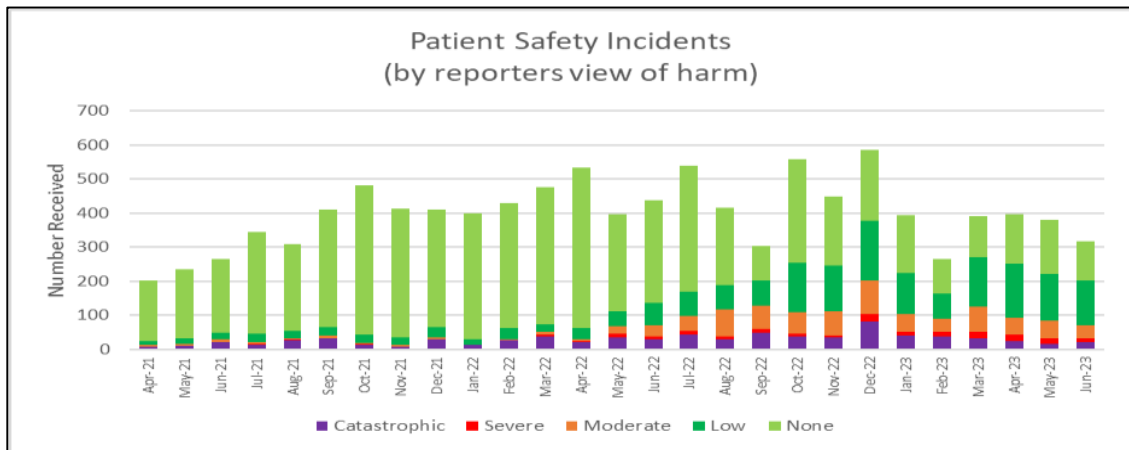
This Report provides key information on:

- Patient Safety Incidents including Duty of Candour
  - Nationally Reportable Incidents (NRIs) (previously Serious Adverse Incidents)
  - Patient Safety Alerts/Notices
  - Learning from Deaths - Mortality Reviews
  - Concerns (including political)
  - Ombudsman Cases
  - Coroners
  - Redress
  - Claims
  - Organisational Learning
  - Horizon Scanning
2. Please note that the data contained within this Report is accurate at the time of reporting. **Data may be subject to change as incident case types may be regraded during the investigation process.**

## ASSESSMENT

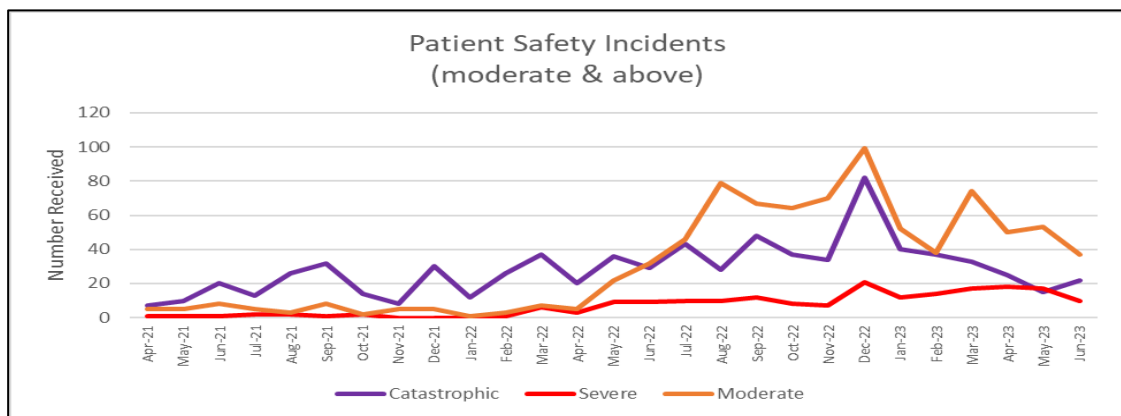
### Patient Safety Incidents

3. Patient Safety Incidents (PSI) reported as catastrophic are usually related to patient outcome. In all cases an investigation is pending, and it has not been established whether the outcome was due to any act or omission by The Welsh Ambulance Services NHS Trust (WAST) or whether it was due to the patient's underlying medical condition.
4. During this period a total of **1,094** patient safety incidents were reported, **398** in April, **380** in May and **316** in June. All incidents with an initial harm grading of moderate, severe or catastrophic are reviewed weekly by the Patient Safety Team. It must be noted that the harm grading may change subject to the conclusion or outcome of any investigation.
5. Graph 1 below illustrates the number of PSIs reported on a rolling basis from April 2021 by initial grading. Themes continue to be timeliness to response.



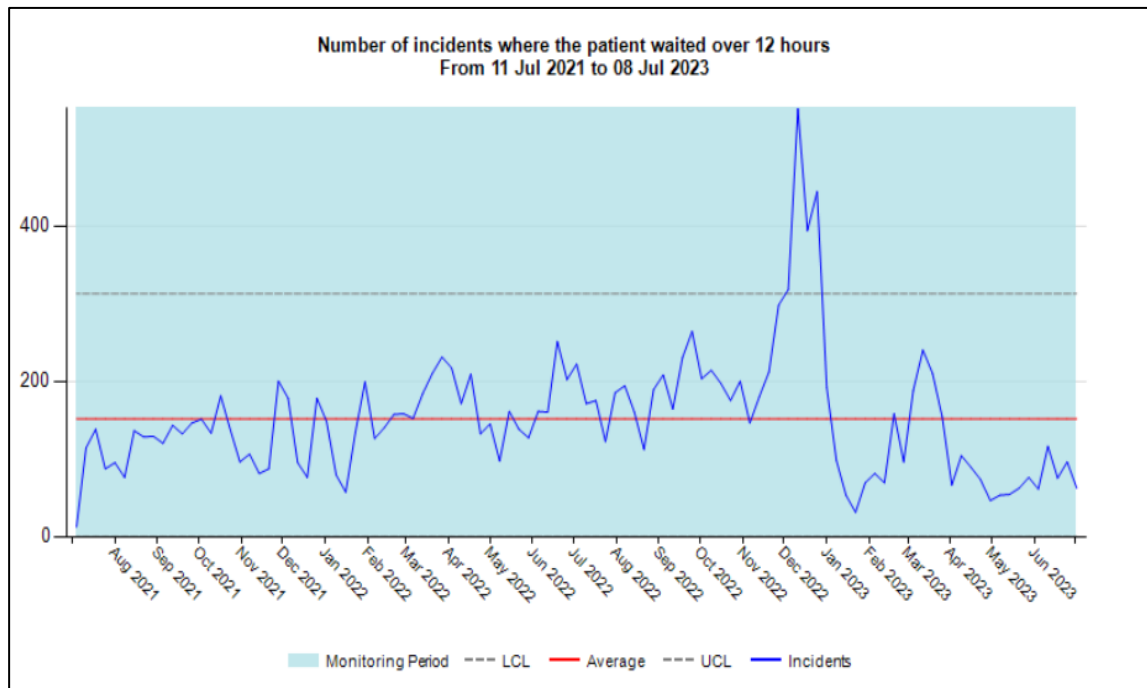
Graph 1

6. The graph below details the number of PSIs rated moderate and above. From April 2023 all PSIs graded moderate or above following review by the Patient Safety Team/SCIF Panel triggers the Duty of Candour. Compliance with the Duty is monitored by the Patient Safety Team.



Graph 2

7. Patients waiting for extended periods of time in the community continues as detailed in Graph 3 below. During Quarter 1 of 2023/24, **959** patients received a response or wait over 12 hours.
8. **76** of the patients waiting over 12 hours had experienced a fall, with the longest waiting patient being **24 hours and 04 minutes**. **64** of the patients were in the Amber2 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.

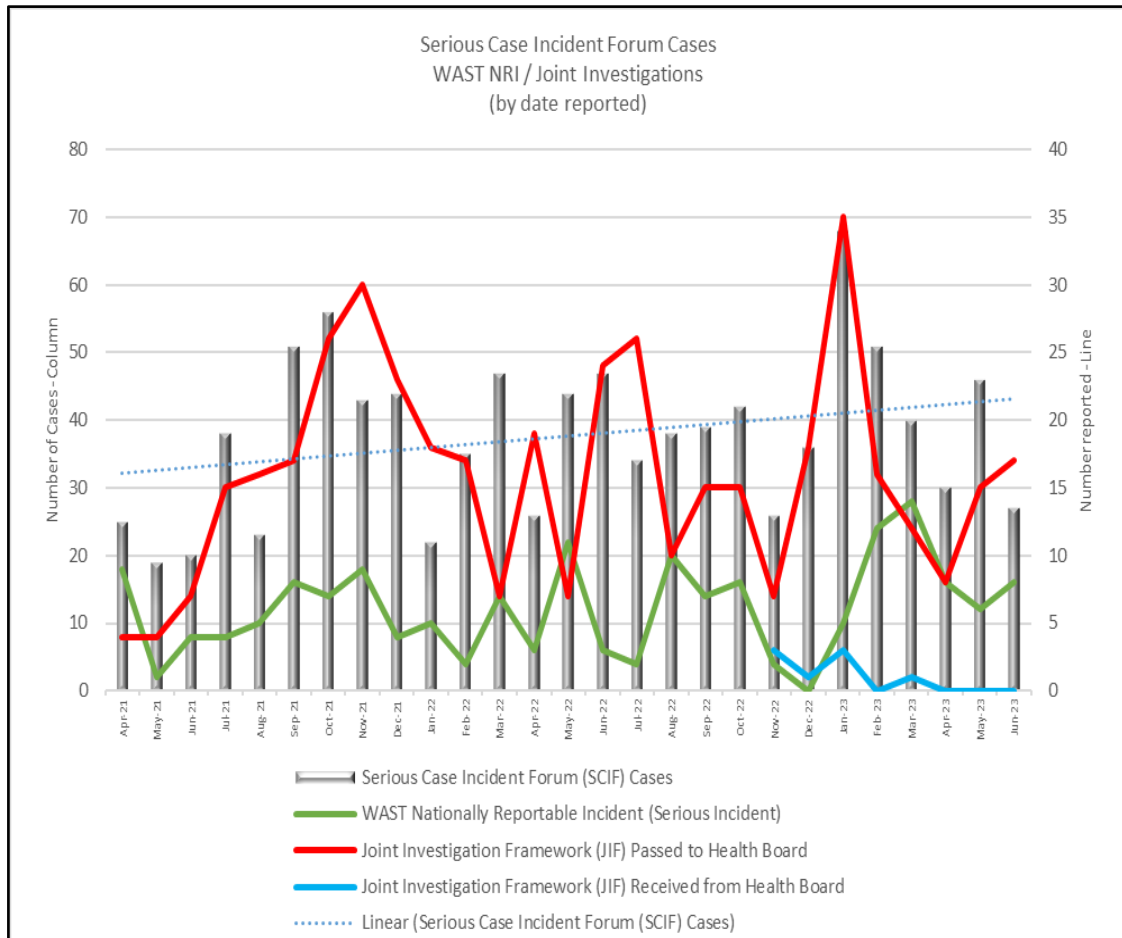


Graph 3

9. 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 across the system to explore the WAST contribution to pressure area damage reviews held in Health Boards to ensure the whole patient journey is considered. A meeting with the Chair of the All-Wales Tissue Viability Network is scheduled in early August 2023.
10. Additionally Welsh Risk Pool have been contacted regarding data and information nationally in respect of Redress and Claims and pressure damage. Data and information are expected by the end of August 2023. Consideration is also being given to any additional and appropriate actions the Trust could take to mitigate some of the harm occurring as a result of delays in handovers outside hospitals.

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

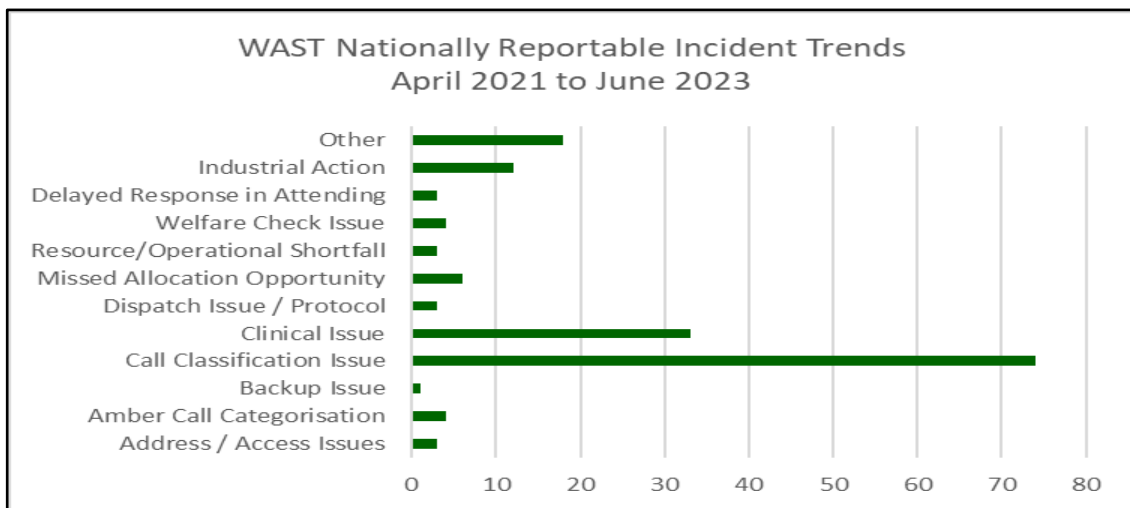
11. Graph 4 below details the number of cases discussed at the SCIF and those reported either to the Health Boards for further investigation under the Joint Investigation Framework and those reported and investigated internally. Incidents not reaching the threshold are managed as lower graded PSIs.



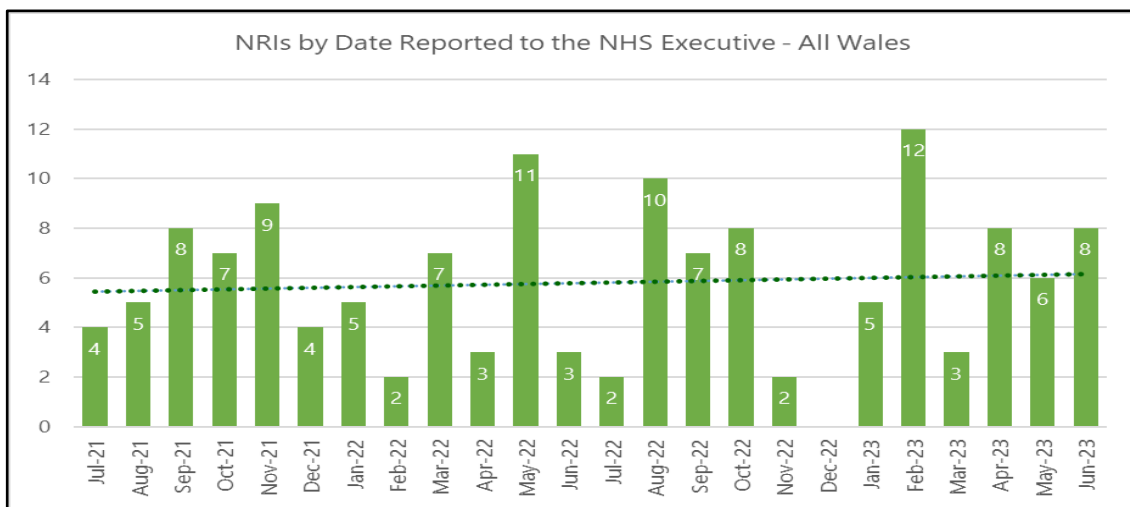
Graph 4

12. During this reporting period there were **20** SCIF Meetings held, with 103 incidents discussed. **22** incidents have been reported as NRIs to the NHS Executive and **40** incidents were referred under the Joint Incident Framework to the respective Health Board.
13. Feedback from Health Boards following joint investigations is variable with different approaches to investigations noted. No specific themes have been identified to date. General themes are over-crowded Emergency Departments and wider system pressures resulting in hospitals being in very high levels of escalation.
14. The Datix Cymru Incident Reporting and Management Group is currently reviewing the Investigation Module on Datix Cymru to support a consistent approach.

15. The Yorkshire Contributory Factors Framework is included in the Datix Cymru system enabling themes and trends to be extracted from the module for local and national use. The Framework is an evidence-based Conceptual Framework of 20 domains with a definition for each that may contribute to PSIs. The Framework is acute focused and was designed for use in hospital patient safety investigations. The Patient Safety Team plan to discuss the use of the Framework at the National Meeting following an analysis of the use of the Framework internally to date.



Graph 5



Graph 6

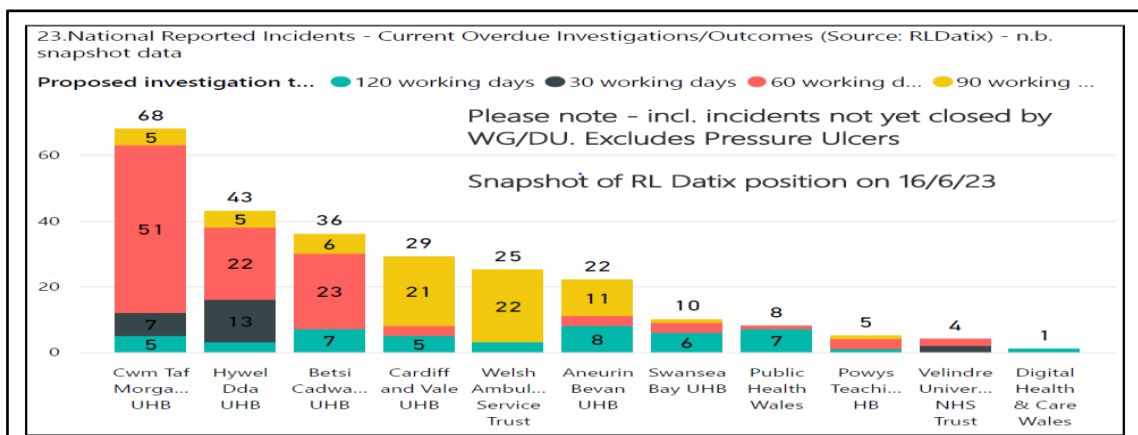
16. Graph 5 provides an overview of the themes of NRIs from April 2021. Graph 6 provides the numbers reported over time. During this quarter **22** NRIs were reported to the NHS Executive and the themes remain similar:

- Call Classification Issue (**13**) (**6** of which were missed ineffective breathing)
- Clinical Issue (**6**)
- Other - 111 Clinical Triage (**1**)
- Other - Clinical Support Desk (CSD) Downgrade (**1**)
- Industrial Action (**1**) (Occurred February 2023, reported April 2023)

- 17. Graph 5 includes incidents categorised as 'Other' on the Datix Web System (pre-May 2022). 7 of the incidents are still under investigation and the categorisation will be updated following completion.
- 18. The Emergency Medical Service (EMS) Co-ordination and Resourcing Operations Quality Team continue to review cases relating to ineffective breathing and this is also being discussed at National Ambulance Forums as a reoccurring national theme.
- 19. No incidents linked to a declined immediate release request.

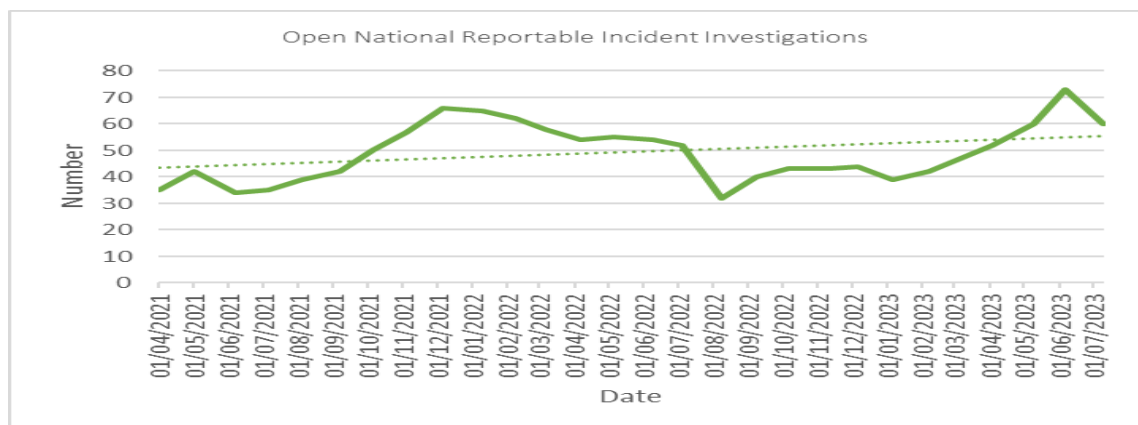
### Patient Safety Investigations

- 20. The Trust currently have a number of overdue NRI investigations (n=25), however there is an improved position on last quarter (n=30). There are multiple factors but predominately these are due to capacity, demand and competing pressures.
- 21. Graph 7 is extracted from the 'NHS Wales Dashboard (March 2023)' and provides details on the Trust's position in relation to overdue investigations, with a comparison to other NHS organisations.



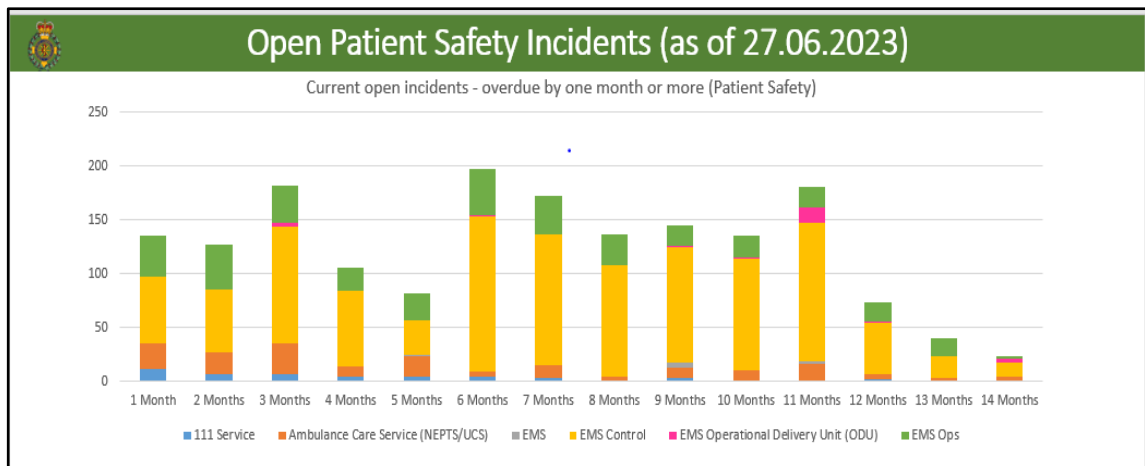
Graph 7

- 22. The Trust currently have a total of **60** open NRI investigations. Graph 8 below details the number of open NRI cases over time, with a rising trajectory overall.

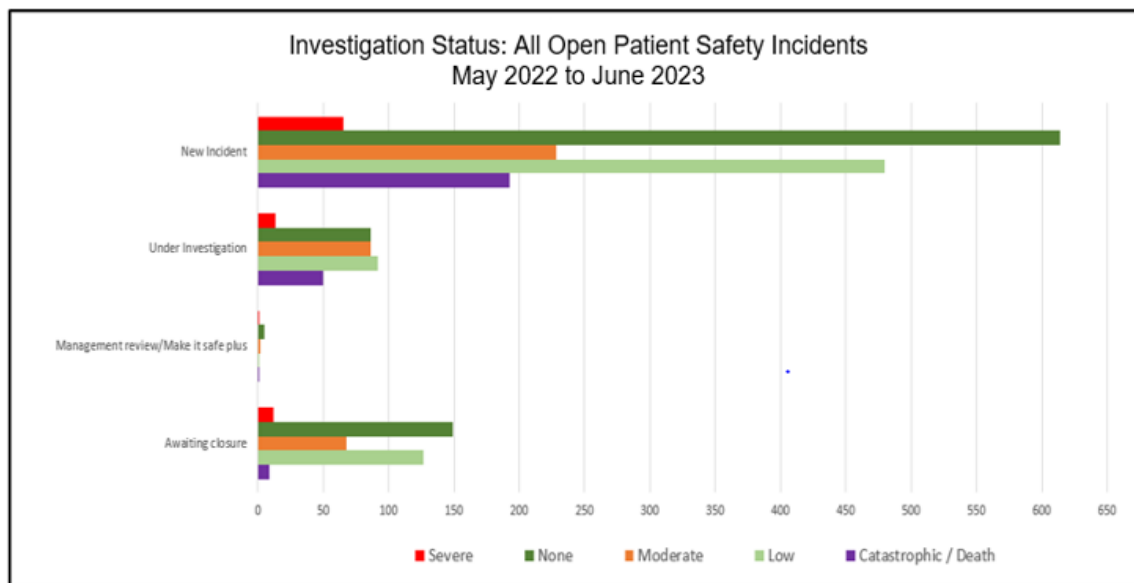


Graph 8

- 23. Organisational pressures are also impacting on teams' capacity to undertake investigations of incidents graded as no harm, low harm and moderate harm. A number of investigations are past the timescales set out in Trust Policies and Procedures.
- 24. Graph 9 provides a breakdown of the current position in respect of investigations overdue by one month or more. This has been discussed at Clinical Quality Governance Group and reports to enable oversight of progress with investigation completion at operational meetings on a monthly basis have been developed.



Graph 9



Graph 10

- 25. Graph 10 provides an overview of the investigation status of all patient safety incidents May 2022 (new Datix Cymru System) to June 2023 by incident category. Work is underway to develop live dashboards collating patient safety data and information from a number of Trust systems to enable a triangulated approach and improved oversight by the Patient Safety Team and provide efficiencies.

## Duty Of Candour

26. The Duty of Quality and Duty of Candour (DoC) Welsh Government Roadmap is updated on a monthly basis with oversight from the Quality, Patient Experience and Safety Committee. The Trust is represented on the NHS Wales DoC Network which meets monthly. At this meeting a set of Performance and Quality Standards are currently being developed to form a dashboard to collect data and information consistently at a local and national level.

The performance standards proposed include:

- 1) How many Candour triggers are there
- 2) Timeframe between Candour trigger and in person notification
- 3) Five working day written notification
- 4) How many cases have been re-graded. Be able to evidence a reduction in cases following targeted training
- 5) How many cases escalate to complaint in relation to the non-compliance of the Candour Procedure Regulations and/or the management of the Candour Statutory Guidance
- 6) How many cases escalate to Ombudsman in relation to the non-compliance of the Candour Procedure Regulations and/or the management of the Candour Statutory Guidance

The proposed quality standards include:

- 1) Key things included in the written notification letter as prescribed in the Candour Statutory Guidance
- 2) How many cases have been re-graded - enable targeted training - would expect to see a reduction in cases being re-graded
- 3) Review of cases escalating to Redress - levels of harm, incident type, redress outcome, learning
- 4) Evidence of Thematical Review - Evidence of reduction same type incidents causing harm
- 5) Evidence of learning from Candour cases
- 6) Feedback questionnaire capturing experience of Candour process
- 7) Evidence of learning from feedback
- 8) How many cases have been notified by another organisation

27. The Trust's Patient Safety Team has suggested a quality standard is added to include that patients and families have been provided with signposting information for additional support as required.

## Patient Safety During Industrial Action

28. During the periods of industrial action patient safety incidents were monitored with oversight from the Operational Delivery Unit and the Patient Safety Team.
29. No serious incidents were identified in the Trust during the industrial action taken by the Royal College of Nursing in June 2023.

30. The NHS Wales Executive are leading a national overview of patient safety incidents related to all industrial action to understand the effect of strike action across NHS Wales.

### NHS Wales Patient Safety Alerts/Notices - Trust Position

31. As of 12 July 2023, the Trust has one Patient Safety Alert outstanding on the NHS Executive Delivery Unit UHB Dashboard:

**Alert: PSA015:** Safe use of oxygen cylinders in areas without medical gas pipeline (requires review of recently published NHSE Guidance and Risk Assessment to be undertaken which includes preserving oxygen supplies).

Actions taken/planned:

- A Clinical Notice covering the alert was issued in January 2023 by the Clinical Directorate. The alert will be discussed again at the next All Wales Patient Safety Solutions Review Group (AWPSSRG) in July 2023 by the Head of Patient Safety in respect of any combined WAST and Health Board actions. Oversight of the alerts occurs in the Clinical Quality Governance Group.

**Notice: PSN065:** The safe use of ultrasound gel to reduce infection risk.

Actions taken/planned:

- Head of Patient Safety to confirm that this is not used in the organization, and mark as non-applicable at the next meeting of the AWPSSRG in May 2023.

**Outcome: CLOSED**

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

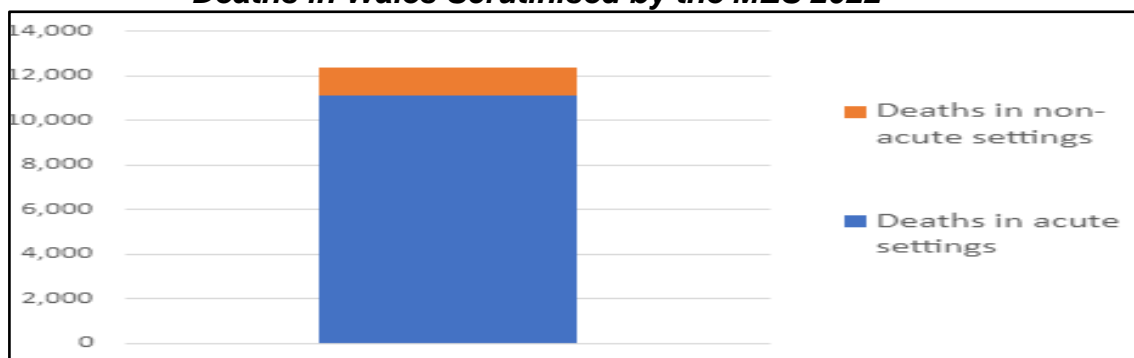
32. The Trust continues to participate in Health Board led Mortality Reviews as appropriate, with attendance from the Patient Safety and Clinical Teams. Data and information is also provided by the Trust as required to the Medical Examiner Service (MES) to inform their reviews of deaths in acute care. To date over **500** referrals have been received from the MES for information or to feedback concerns. To date **298** referrals are awaiting review due resources and competing PTR functions.

33. Concerns raised through the MES include:

- Extended waiting times for an ambulance
- Handover of care delays
- Pressure damage due to delays
- Call categorisation
- Family concerns over the hospital the patient was taken to
- Implementation of the End of Life Care Pathway

- Families taking sick relatives by car
34. A Learning from Deaths Group is to be established internally reporting to the Clinical Quality Governance Group to review requests and enact any Level 2 Mortality Review requests.
  35. To date the Trust has not received any requests to undertake a Level 2 Mortality Review of patients in our care under the new processes in place across NHS Wales. Currently the focus of the Medical Examiner Service is undertaking Mortality Reviews in the acute care setting. From September 2023 all non-coronial deaths, including community deaths will be reviewed and a significant increase in activity is expected by the Trust.
  36. The Medical Examiner Service also signpost families to health bodies if they have any queries or concerns so this may also result in an increase in concerns activity.
  37. The National Medical Examiner's Report 2022 was published in May 2023 and Graph 11 details the number of deaths scrutinised by Medical Examiners in Wales in non-acute and acute settings in 2022.

**Deaths in Wales Scrutinised by the MES 2022**



Graph 11

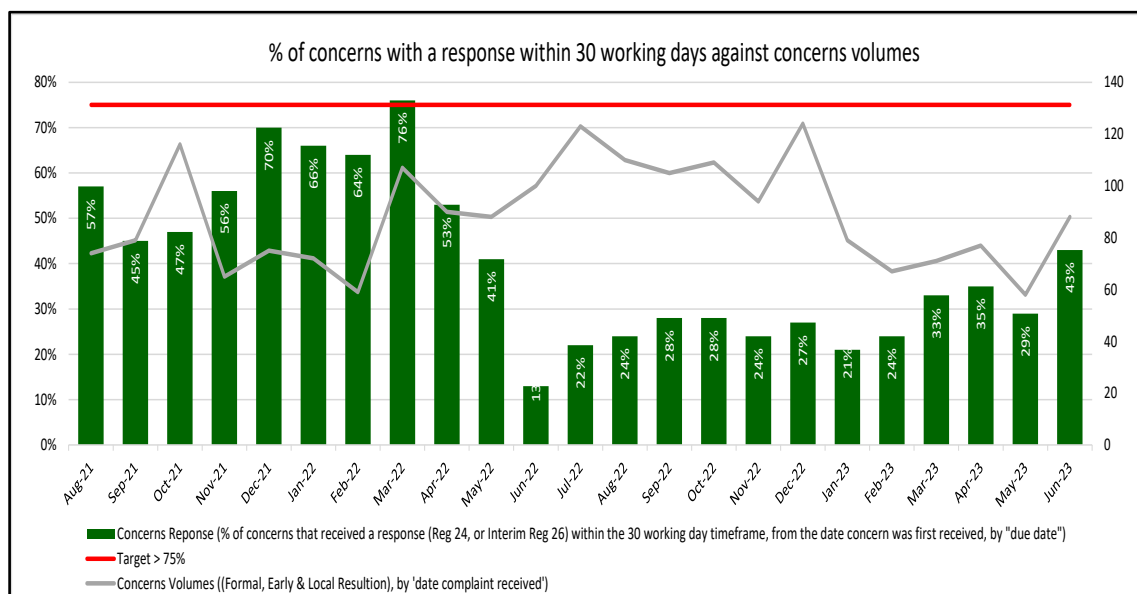
38. Common themes or patterns identified by Medical Examiners in the Annual Report that generally required action at provider, local or system level included:
  - Deaths related to sepsis, and in the winter period, high numbers of deaths linked to COVID-19 and influenza.
  - Difficulties achieving timely medical certificate of cause of death (MCCD) completion, often as a result of post-pandemic pressures, along with reversion to standard death certification processes after the emergency Coronavirus Act measures ended in March 2022.
  - Deficiencies in end-of-life care in the community, resulting in inappropriate admissions.
  - Staff vacancies, sickness and absence, including of junior doctors impacting service delivery.
  - Deaths featuring delays in care have been highlighted across a number of Medical Examiner offices.

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

### 39. 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.

### 40. Graph 12 below the Trust continues to receive a steady number of concerns overall with **223** being received during this reporting period.



Graph 12

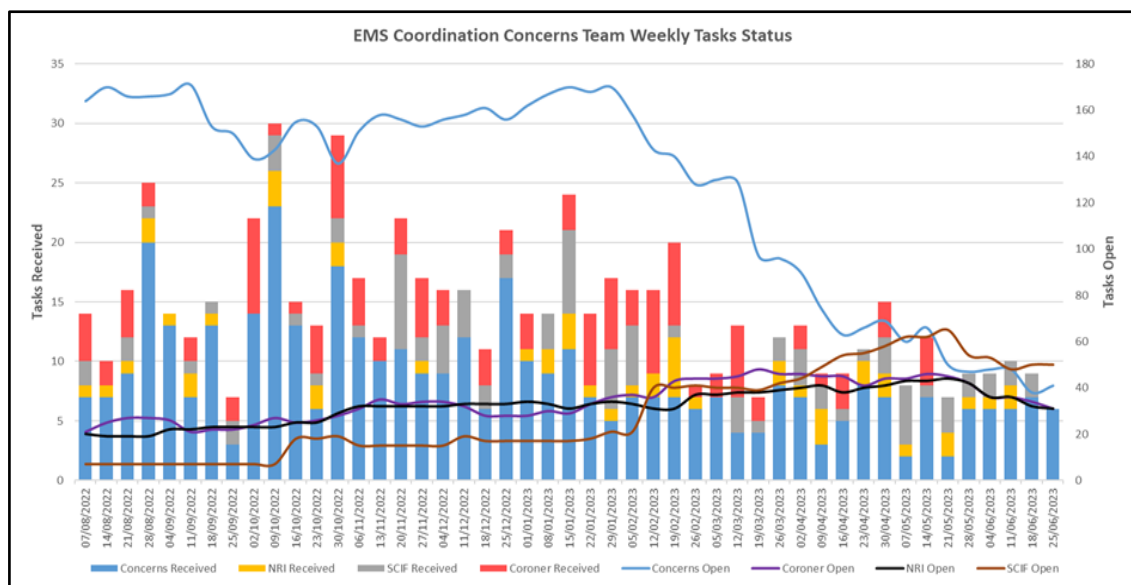
### 41. The acknowledgement date has been amended nationally to five working days. Due to the fragile position the two-day target will be retained as an internal measure until compliance is sustained. During this reporting period the five-day acknowledgement performance was 88%, 96% and 99% (100% target) with the 30-day target achieving 35%, 29% and 43% respectively (75% target).

### 42. Following on from the unprecedented pressures in late 2022 and early 2023, this reporting period has remained busy with the volume and complexity of concerns increasing again. PTR Administrators taking calls from patients and families can be on calls for over an hour in some circumstances due to the complexity and content of the calls with many complainants recontacting due to delays in our responses.

### 43. The overwhelming theme and trend through the majority of concerns remains timeliness to responding to calls in the community. Themes are emerging in respect of Ambulance Care regarding cancellation of transport. The Patient Safety Team are meeting with Ambulance Care colleagues to review the data and information.

## EMS Co-ordination and Resourcing Centre (EMSC&R) Concerns & Coroners Activity

44. The number of open concerns coming into the EMS Co-ordination and Resourcing Centre has reduced, a new process to review and investigate grade 1 & 2 concerns enables a timelier response for the complainant focusing on their questions and concerns. The overall total of open concerns remains high.
45. The Operations Quality (OQ) Concerns Team has made significant improvements on the outstanding backlog of work from 2022. The Team currently has an additional 2 Investigation Supervising Officers (ISOs) funded from PTR winter pressure monies. These are fixed term until the end 2023. A new Service Manager, Operations Quality (SMOQ) was also appointed in March 2023.



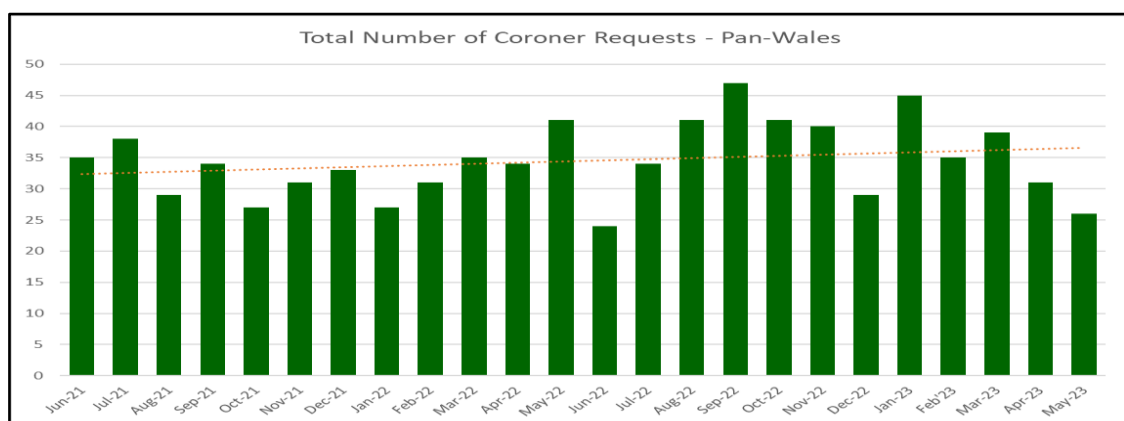
Graph 13

46. All outstanding concerns are now within the timeframe for return to PTR. There are 41 outstanding concerns down from circa 170 in January 2023. There has been a concerted effort by the team to prioritise concerns work, the implementation of automation using Blue Prysm has streamlined processes, and a Review Meeting which identifies concerns suitable for concise investigations happens weekly. The Team continues to focus on formal concerns work and outstanding NRIs. The Team has also been making improvements in the NRI position over recent weeks.
47. Identified learning from concerns investigations is shared with the OQ Learning & Development Team to cascade to EMS Coordination Teams via appropriate methods including bulletins, as well as amongst the EMS Coordination and OQ Senior Teams during the EMS Coordination Quality Meeting. The OQ Team meets weekly to identify themes and trends to ensure learning is being actioned, and the MPDS Audit Team is currently reviewing the EMD and MPDS Standard Operating Procedures (SOPs).

48. It has been identified that additional capacity within the OQ Concerns Team is required to effectively address the backlog of work sitting with the team and sustain an acceptable position. Appropriate escalations are being made by the SMOQ.
49. There remains a high number of outstanding coroner statements sitting with the Operations Quality Team. There are currently **30** outstanding down from **48** in March 2023. The team is receiving more and more update requests from HMC due to upcoming inquest dates. As the majority of outstanding statements are already far outside of the request date, extension requests have been more difficult to secure. Circa 50% of these outstanding requests have been identified as relating solely to hospital handover delays.
50. The SMOQ has escalated this to Senior Operations Team (SOT) and Senior Leadership Team (SLT), and approval for these outstanding statements to be allocated to Senior Managers within Operations but outside of OQ has been confirmed.
51. The OQ Concerns Team is working on Briefing Reports for these coroner cases to support those writing statements. The SMOQ will support SOT colleagues to ensure they are completed to a satisfactory standard. A Statement Template has also been created for use. It is anticipated that this will significantly reduce the number of outstanding Coroner's statements over the next few months.

### Organisational Legal Activity and Coroners

52. The number of approaches received from Coroners has remained constant 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.
53. Activity has increased month on month due to the delay in receiving statements. Many of the statements rely upon MPDS audits and there have been delays in the Audits being undertaken. Graph 14 illustrates the continuing pattern up until May 2023:



Graph 14

## Prevention of Future Death Reports (Regulation 28)

54. During the reporting period the Trust received 2 Regulation 28 (Prevention of Future Deaths) Reports. Both were received in June with responses due by 14 and 15 August 2023.
  55. The specific issues to be addressed have been shared with the appropriate Managers. With a timescale incorporated, to ensure that the Trust responds in a timely manner.
  56. Both Regulation 28 Reports were issued by the same Coroner in North Wales and relate to delays in responding to patients in the community, including a case where the patient was also significantly delayed outside of the hospital on arrival.
  57. Both Regulation 28 reports were issued to this Trust, Betsi Cadwaladr Health Board and the North Wales Local Authorities
- **Ref 1: LCH** - *"Whilst the time it took for the ambulance to arrive to Mr H's home and the time it took for Mr H to be handed over to nursing staff at hospital did not cause or contribute to Mr H's death, the delays experienced are significant. It is understood that the matter of ambulance delays is not solely a matter for WAST hence this report being sent to those organisations involved in its impact across the Health Board area (to include the provision of social care where patients are medical fit for discharge from hospitals but without adequate placements / care in the community).*

*I have previously issued Prevention of Future Death Reports to BCUHB and WAST pertaining to the length of time it is taking for ambulances to arrive to patients and handover at hospitals.*

*I remain significantly concerned that delays are continuing and that deaths will continue to occur into the future."*

- **Ref 2: JF** - *"There was evidence from WAST and BCUHB that improvements had been made internally within their organisations. It seems that patient flow i.e. those patients who are ready to be discharged from hospital but are unable to be discharged due to insufficiencies in social care means that ambulances are unable to offload patients into the Emergency Department which then causes the community delays as ambulances are not readily available. I have not been presented with any meaningful evidence on the involvement of Local Authorities in the considerations by WAST and BCUHB of lack of patient flow due to social care deficiencies.*

*I have previously issued Prevention of Future Death Reports to BCUHB and WAST pertaining to the length of time it is taking for ambulances to arrive to patients (as well as handover at hospitals).*

*I remain significantly concerned that delays are continuing and that deaths will continue to occur into the future.*

Specifically, I require responses to the following: -

1. *Extent of working relationship between WAST, BCU and North Wales Local Authorities to address the above issues; and*
2. *Extent of progress between WAST, BCU and North Wales Local Authorities in addressing the above issues; and*
3. *Extent of Strategic plan of action/improvement plan to address the above issues.”*

58. Regulation 28 improvement actions are discussed at the Assistant Directors Leadership Team meeting, with monitoring and oversight of closure reports by the Executive Management Team and Quality, Patient Experience & Safety Committee.

59. Below is a table showing the receipt of Regulation 28 reports by the Trust over that last three financial years and a brief description of the subject of the report.

Year	April	May	June	July	August	September	October	November	December	January	February	March	TOTAL
2020/21	0	0	0	0	0	2	0	0	0	0	0	0	2
2021/22	0	1	0	0	0	0	0	0	0	0	2	0	3
2022/23	0	1	1	0	0	0	1	1	0	1	1	0	6
													11

### 2020/21

- Providing callers with expected response times during escalation - ambulance delays
- Delay responding to a Stroke patient, including reducing hospital delays and the appropriateness of current stroke coding and priorities

### 2021/22

- Delayed response to a Propranolol overdose, including reduce hospital delays and appropriateness of our coding and priorities in such cases.
- Delay in the Trust responding to patients in the community.
- Delay in responding to a patient in the community.

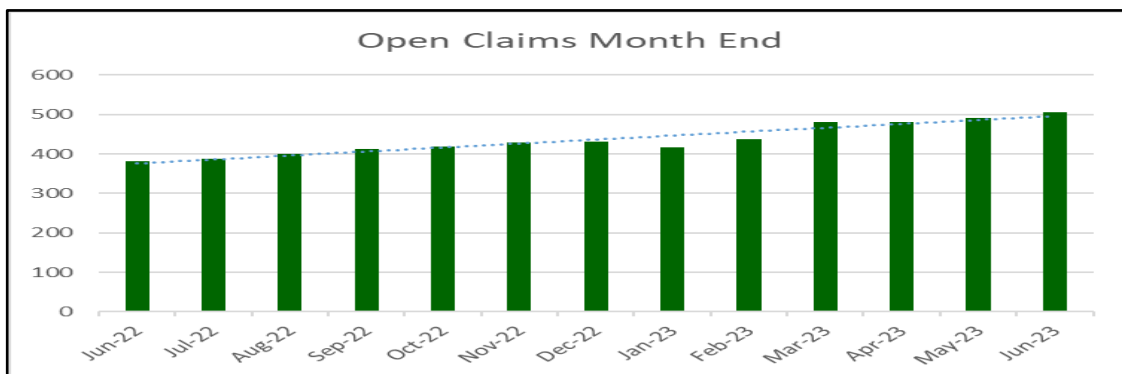
### 2022/23

- Delay in responding to a patient in the community.
- Delay in responding to a patient in the community.
- Delay in responding to a patient in the community, deterioration due to long lie.
- Delay in responding to a patient in the community, whose condition deteriorated.
- Delay in the Trust responding to patients in the community.
- Delay in responding to a request for a transfer in relation to the vascular pathway.

## Legal Claims

Legal Claims Overview		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
Claims opened	Personal Injury (PI)	0	1	2	5	1	4	1	2	2	1	4	0	1
	PI Road RTC	1	1	1	2	1	1	0	2	5	7	1	1	3
	Clinical Negligence	2	0	3	0	0	0	1	2	0	2	2	3	3
	RTC	21	19	14	19	17	24	17	23	27	12	29	16	22
	Damage to property	4	1	3	3	0	6	9	4	9	5	4	2	7
Claims closed	Personal Injury (PI)	1	1	0	2	0	0	4	1	0	6	3	0	7
	PI Road RTC	1	0	0	0	0	0	1	1	1	0	1	0	2
	Clinical Negligence	0	0	1	0	4	0	0	0	0	0	0	0	1
	RTC	10	14	10	11	15	22	11	47	17	11	8	3	11
	Damage to property	0	3	0	4	1	15	9	4	5	2	4	1	3
Claims open at the end of the month	Personal Injury (PI)	70	70	72	75	76	80	77	78	80	75	76	76	70
	PI Road RTC	43	44	45	47	47	48	47	48	52	59	59	60	61
	Clinical Negligence	105	105	107	105	109	119	120	122	122	124	126	129	131
	RTC	141	147	151	163	165	173	180	159	170	177	203	210	223
	Damage to property	22	21	24	23	22	8	8	9	13	16	16	17	21
		<b>381</b>	<b>387</b>	<b>399</b>	<b>413</b>	<b>419</b>	<b>428</b>	<b>432</b>	<b>416</b>	<b>437</b>	<b>451</b>	<b>480</b>	<b>492</b>	<b>506</b>

60. 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. 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.
61. Graph 15 details the current position in respect of open claims which continues on an upward trajectory.



Graph 15

## Ombudsman and Political Investigations

62. There are currently **7** open Ombudsman cases. The Trust has submitted all documentation to the Public Service Ombudsman for Wales (PSOW) and are one case, that has recently been notified to the Trust.
63. There has been an issue in providing the Ombudsman's office with the supporting documentation in relation to one investigation. This resulted in the matter being escalated to CEO level by the Ombudsman. The specific case revolved around the Trust's data in relation to the early stages of the COVID-19 pandemic. This information was subject to the ongoing inquiry and required input from Barristers representing the Trust.
64. During the reporting period there have been no final reports received. However, the Public Service Ombudsman for Wales has produced a report 'Groundhog Day 2', which looks specifically at the handling of concerns within the NHS.

## Organisational Learning

65. Organisational learning occurs through several routes. Examples of learning and improvement actions are detailed throughout this section.
66. 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.
67. Learning from investigations - the following notices have been issued this period:

### **Clinical Notices Issued April 2023**

- CN 08/23 Methoxyflurane (Pentrox) Introduction

### **Clinical Notices Issued May 2023**

- CN 09/23 Amiodarone Shortage
- CN 10/23 Royal Shrewsbury Acute Medical Assessment Area
- CN 11/23 Medicine Supply Notification - Glucagon 1mg Powder for Injection Kit (Glucagon)
- CN 12/23 Clinical Indicator ePCR Reporting
- CN 13/23 Diagnostic Code Clinical Audit
- CN 14/23 P4 Four-Hour Pick-Up Window and Removal of Card 35 Option

### **Clinical Notices Issued June 2023**

- CN 15/2023 Glan Clwyd Paramedic - SDEC Referral Pathway Update for 2023
- CN 16/2023 South Wales Trauma Desk
- CN 17/23 University of Wales Paramedic - Medical SDEC Referral Pathway

68. Learning from clinical reviews are detailed overleaf.

## Learning from Clinical Reviews by Health Board Area

Clinical Reviews by Health Board	No	Brief Description of Review	Themes	Learning Opportunities and Improvements
<b>Aneurin Bevan</b>	2	<ul style="list-style-type: none"> <li>Concern from relative regarding a patient not being conveyed to hospital following a fall</li> <li>Poor patient care</li> </ul>	<ul style="list-style-type: none"> <li>No concerns found</li> <li>Failure to identify a deteriorating patient</li> </ul>	<ul style="list-style-type: none"> <li>Appropriate care was provided by all clinicians who attended the patient</li> <li>Improved identification of a patient's condition</li> </ul>
<b>Betsi Cadwaladr</b>	3	<ul style="list-style-type: none"> <li>Registrant shared details of wife's home birth on social media alongside alluding he was prepared with paramedic kit. Behaviours concerns reported by the HB whilst staff member interacted with them in antenatal.</li> <li>Paramedic self-down-graded A1 call and responded on normal driving conditions (involved in RTC but not reported by crew) and poor patient care</li> <li>Inappropriate discharge and poor documentation. Call later received as a red call, ineffective breathing.</li> </ul>	<ul style="list-style-type: none"> <li>Obstetrics</li> <li>Social Media</li> <li>Delayed response</li> <li>Failure to identify deteriorating patient</li> <li>Lack of observations</li> <li>Inappropriate discharge</li> <li>Poor documentation</li> </ul>	<ul style="list-style-type: none"> <li>Trust social media guidance &amp; core paramedic knowledge in regard to management of PPH – Paramedic Scope of Practice and internal procedures.</li> <li>Need for timely observations</li> <li>Understanding scope of practice and can't downgrade A1 calls based purely on details provided on MDT/ePCR whilst en route to incident</li> <li>Improved ePCR completion</li> <li>Following correct process for non-registrant discharge</li> </ul>

## Learning from Clinical Reviews by Health Board Area

<b>Cardiff and Vale</b>	4	<ul style="list-style-type: none"> <li>Decision making and failure to admit patient with NEWS of 12</li> <li>Formal complaint from a patient's mother around treatment and compassion of crew shown to patient</li> <li>Crew failed to identify STEMI and brought the patient to UHL instead of PPCI in UHW. Patient later transferred to PPCI by another crew as blue light transfer. Concern raised by this crew as initial ECG was showing obvious STEMI.</li> <li>Staff member self-reported due to mismanagement of a cardiac arrest. Delay in shocking VF and ROLE implemented outside policy. Patient was in fine VF.</li> </ul>	<ul style="list-style-type: none"> <li>Failure to identify deteriorating patient</li> <li>Poor documentation</li> <li>Behaviour on Scene</li> <li>Failure to identify STEMI</li> <li>Poor Management of Cardiac Arrest</li> <li>ROLE Guidance not adhered to</li> </ul>	<ul style="list-style-type: none"> <li>Improved decision making</li> <li>Review of Sepsis</li> <li>Improved ePCR documentation</li> <li>Reflection by crew</li> <li>STEMI identification</li> <li>ECG refresher training</li> <li>Improved Cardiac Arrest Management</li> <li>Retraining and refresher</li> </ul>
<b>Cwm Taf</b>	0	No clinical reviews to report with some currently ongoing		
<b>Hywel Dda</b>	1	<ul style="list-style-type: none"> <li>Incorrect management of VF cardiac arrest, failure to shock VF</li> </ul>	<ul style="list-style-type: none"> <li>Poor documentation</li> <li>Poor Management of Cardiac Arrest</li> </ul>	<ul style="list-style-type: none"> <li>Opportunity for critical analysis of incident with crew members</li> <li>Improved management of cardiac arrest and rapid defibrillation</li> <li>Effective crew resource management</li> </ul>

## Learning from Clinical Reviews by Health Board Area

<p><b>Powys</b></p>	<p>5</p>	<ul style="list-style-type: none"> <li>• EMT crew failed to shock VF during cardiac arrest</li> <li>• Suspected open fracture was not exposed and examined. No co-amoxiclav administered.</li> <li>• Paramedic back up requested by paramedic on scene. However, after first paramedic cleared the second paramedic downgraded the call for a UCS call. On arrival at ED, the doctor queried why the patient was not being as in AF with ST depression.</li> <li>• Concern from OOH GP with regards to referral of patient with back pain</li> <li>• Inappropriate discharge of patient resulting in later admission. Under review for accuracy of documentation.</li> </ul>	<ul style="list-style-type: none"> <li>• Poor management of a Cardiac Arrest</li> <li>• Failure to examine patient adequately</li> <li>• Inappropriate downgrade for UCS</li> <li>• Inappropriate discharge of patient</li> <li>• Inappropriate discharge</li> <li>• Poor documentation</li> </ul>	<ul style="list-style-type: none"> <li>• Further training surrounding cardiac arrest management</li> <li>• Requirement to expose and examine and initiate timely antibiotic therapy in this cohort of patients</li> <li>• Importance of understanding: <ul style="list-style-type: none"> <li>- Scope of practice of different clinical grades</li> <li>- All Wales delegation policy</li> <li>- ECG interpretation</li> </ul> </li> <li>• Holistic approach required, taking into account all facts and information available and reviewing of JRCALC guidelines</li> <li>• Improved ePCR documentation</li> </ul>
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## Learning from Clinical Reviews by Health Board Area

Swansea Bay	5	<ul style="list-style-type: none"> <li>• Concern around pre-alert</li> <li>• Non-Immobilisation of patient and failure to use trauma tool</li> <li>• Poor documentation</li> <li>• Feedback to HB regarding IV cannulation</li> <li>• Medical Examiner request for information</li> </ul>	<ul style="list-style-type: none"> <li>• PRE-alert guidance</li> <li>• Spinal immobilisation</li> <li>• No use of Major Trauma Tool</li> <li>• Poor documentation</li> <li>• IV cannulation</li> <li>• Poor documentation</li> </ul>	<ul style="list-style-type: none"> <li>• Improved awareness of pre-alert guidance</li> <li>• Awareness of Major Trauma Tool</li> <li>• Referral to spinal immobilization guidance</li> <li>• Improved ePCR completion</li> <li>• Feedback re: IV cannulation</li> <li>• Improved ePCR documentation</li> </ul>
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## Welsh Risk Pool Learning from Events Reports: Welsh Risk Pool Committee Outcomes

69. 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.
70. 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.
71. WRP have started to apply financial penalties to organisations that do not provide the requested learning within the 6-month period.

### WRP Committee Outcomes (23 May 2023) & Current Position of Cases Overall

Learning from Events	Number approved	Number Amber Deferred (requesting some additional information minutes etc. to be provided within 6 months of the request)	Number Red Deferred (to be represented to the LAP within 6 months with evidence)
Claims	13	0	0
Redress	0	1*	0
Previously Deferred Claims	0	0	0
Previously Deferred Redress	0	0	0
Total	0	1	0

\*confirmation of staff reflections and sharing of the learning has been requested.

72. Oversight of the WRP Tracker and evidence will be undertaken at the new formed Quality Management Group.

### Horizon Scanning & Key Documents

73. During the period the following key documents have been published:
  - NHS Wales National Patient Safety Reporting and Investigation Policy (2023) - adopted by the Trust in June 2023 by the Clinical Quality Governance Group and QuEST August 2023.
  - National Medical Examiner's Report 2022 (May 2023) included on Clinical Quality Governance Group agenda July 2023.
  - NHS Wales Ombudsman 'Groundhog Day 2' (June 2023) publication - Trust review and report commissioned by the Executive Director of Quality & Nursing.



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Ymddiriedolaeth GIG  
Gwasanaethau Ambiwylans Cymru  
Welsh Ambulance Services  
NHS Trust

<b>AGENDA ITEM No</b>	<b>9</b>
<b>OPEN or CLOSED</b>	<b>OPEN</b>
<b>No of ANNEXES ATTACHED</b>	<b>1</b>

<b>DUTY OF QUALITY/DUTY OF CANDOUR IMPLEMENTATION</b>
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<b>MEETING</b>	Quality, Patient Experience & Safety Committee
<b>DATE</b>	10 August 2023
<b>EXECUTIVE</b>	Liam Williams, Executive Director of Quality & Nursing
<b>AUTHOR</b>	Caroline Miftari, Head of Quality Assurance
<b>CONTACT</b>	07970 406447 <a href="mailto:Caroline.miftari@wales.nhs.uk">Caroline.miftari@wales.nhs.uk</a>

<b>EXECUTIVE SUMMARY</b>
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1. The report considers the Trust implementation of the Duty of Candour and Duty of Quality aligned to the Welsh Government Road Map, the next milestone is September 2023.
2. The Quality and Performance Steering Group (QPSG) continues to monitor the progress of Duty of Quality and Duty of Candour requirements. 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 technical specification template is being designed by key stakeholders to ensure compliance and consistent approach to data quality standards for current and future quality measures.
3. A Quality Management Group has been established to assist the Trust in embedding and administering an effective quality management system, providing assurance against the quality requirements of Health & Social Care (Quality & Engagement) (Wales) Act 2020. The Group will be chaired by the new Senior Quality Governance Lead and will report to the Clinical & Quality Governance Group via an Alert, Advise and Assure Report on a monthly basis.
4. The Trust quality governance arrangements have been reviewed in relation to the new legislation, ensuring systems and processes capture and record decisions to provide evidence that plans have been made through a quality lens. One element of this is the Quality Impact Assessment (QIA) that has been developed in conjunction with the Delivery Unit/NHS Executive. Quality Impact Assessments provide a mechanism to identify, mitigate and monitor impacts

on quality resulting from service redesign/transformation, projects and cost improvements. The Trust QIA Framework agreed at CQGG in November 2022 has subsequently been updated to reflect the new Quality Health Care Standards 2023. The new Trust QIA Framework has been shared with NHS Executive, who have requested that it is used Pan Wales by all Health Boards and Trusts.

5. The Trust is also considering implementation of the new Quality Decision Tool Template designed by the NHS Executive as part of the governance process, supplementary to the QIA. This is a Tool to help NHS bodies ensure they have considered the broad quality perspective in the strategic decisions they are making by considering the 12 Health and Care Quality Standards. The decision-making tool supports the operationalisation of the duty of quality. Use of the Tool is not mandated in its current format. The Trust is awaiting guidelines on its application which are due end of July.

i.

**RECOMMENDED: That**

- (1) the Committee Receives and notes the report; and**
- (2) notes that the Trust is working towards the baseline assessment criteria as set by the Welsh Government Road Map, with a forthcoming milestone in September 2023**

**KEY ISSUES/IMPLICATIONS**

Resourcing requirements - the digital infrastructure is a key consideration in the Trust delivering against the 'always on' requirement.

**REPORT APPROVAL ROUTE**

Clinical & Quality Governance Group	24 July 2023
Quality, Patient Experience & Safety Committee	10 August 2023

**REPORT APPENDICES**

**ANNEX 1** - SBAR provides an overview of the implementation of the Duty of Quality/Duty of Candour

**REPORT CHECKLIST**

Confirm that the issues below have been considered and addressed		Confirm that the issues below have been considered and addressed	
EQIA (Inc. Welsh language)	NA	Financial Implications	YES
Environmental/Sustainability	NA	Legal Implications	YES

Estate	NA	Patient Safety/Safeguarding	YES
Ethical Matters	YES	Risks (Inc. Reputational)	YES
Health Improvement	YES	Socio Economic Duty	YES
Health and Safety	YES	TU Partner Consultation	N/A

**SITUATION**

1. The report considers the implementation of the Duty of Candour and Duty of Quality aligned to the Welsh Government Road Map.

**BACKGROUND**

2. The Health & Social Care (Quality and Engagement) Act 2020 came into force on 1 April 2023. There are four key components to the Act: Duty of Quality, Duty of Candour, Citizens Voice and Vice Chairs.
3. The Welsh Government (WG) implementation 'road map' has been used to assess Duty of Quality (DoQ) and Duty of Candour (DoC) progress against expected outcomes, the next milestone is September 2023.
4. The revised legislation will change the basis upon which Health Inspectorate Wales (HIW), as our regulator, assesses organisation compliance to legislation.

**ASSESSMENT**

5. The Quality and Performance Steering Group (QPSG) continues to monitor the progress of Duty of Quality and Duty of Candour requirements. A revised Terms of Reference is awaiting sign off in addition to a review of the Quality and Performance Framework.
6. Key considerations of the group include the development of a quality environment and infrastructure to attain legislative requirements, to include:
  - Outline Trust evidence and publication schedules for sharing DoQ intelligence with stakeholders
  - Define the specification for quality intelligence - including how information is escalated through the organisation using a digital architecture
  - Develop and assess the effectiveness of the Trust's Quality Management System and Implementation Plan, linking with the Digital and Data Strategy, to include quality planning, control, improvement and assurance
  - Ensure Trust commissioning and hosting arrangements are aligned for the service providers working with the Trust
  - Develop opportunities for system-wide learning - to share learning across the patient journey and population
  - Agree strategic quality improvement requirements based on intelligence emerging from the quality management system

- Oversee the Trust training needs analysis and associated plan to enable all staff to apply the DoQ and DoC into practice.
7. Work is progressing regarding 'Always On' reporting led by the QPSG. Development of a scalable Digital Dashboard specification based on the Quality Standards 2023 reflective of strategic, tactical and operational quality requirements is in progress. A technical specification template is being designed by key stakeholders to ensure compliance with data quality standards for current and future quality measure.
  8. A Quality Management Group has been established to assist the Trust in embedding and administering an effective Quality Management System, providing assurance against the quality requirements of Health & Social Care (Quality & Engagement) (Wales) Act 2020. The Group will be chaired by the new Senior Quality Governance Lead and will report to the Clinical & Quality Governance Group via an Alert, Advise and Assure Report on a monthly basis.
  9. The Group will outline a systemic approach incorporating planning, improvement, control and assurance elements, providing the internal structure and process reflective of:
    - Continuous requirement to understand and secure the improvements in outcomes for the population served by the commissioned services
    - Strengthen quality governance, improve responsiveness to quality matters and promote clinical and quality excellence in Trust activities and initiatives
    - Monitoring progress and evidence on the improvement of quality services and outcomes aligned to the Quality Healthcare Standards 2023
    - Regular assessments, investigations and measurement over time to identify areas to improve quality and recognition and sharing of good practice and early escalation and intervention in response to signals
  10. The DoQ and DoC intranet pages are now available to all staff cascading NHS Executive education material to enhance knowledge on the quality vision and Welsh Government communications. Further work is required to ensure all staff recognise and understand the organisation's quality vision and their roles within it.
  11. The Trust quality governance infrastructure has been reviewed in relation to the new legislation, ensuring systems and processes capture and record decisions to provide evidence that plans have been made through a quality lens. One element of this is the Quality Impact Assessment (QIA) that has been developed in conjunction with the Delivery Unit/NHS Executive. Quality Impact Assessments

provide a mechanism to identify, mitigate and monitor impacts on quality resulting from service redesign/transformation, projects and cost improvements. The Trust QIA Framework agreed at CQGG in November 2022 has subsequently been updated to reflect the new Quality Health Care Standards 2023. The new QIA Framework has been shared with NHS Executive, who have requested that it is used Pan Wales by all Health Boards and Trusts.

12. The Trust is also considering implementation of the new Quality Decision Tool Template designed by the NHS Executive as part of the governance process, which is supplementary to the QIA. This is a tool to help NHS bodies ensure they have considered the broad quality perspective in the strategic decisions they are making by considering the 12 Health and Care Quality Standards. The decision-making tool supports the operationalisation of the duty of quality. Use of the tool is not mandated in its current format. The Trust is awaiting guidelines on its application due end of July.
13. A Trust wide Training Needs Analysis and Training Plan is required and forms part of the proposed work streams to support the cascade of Welsh Government education packages (awareness videos and e-learning package) as they become available. It is anticipated that the Trust will use existing Forums/Education Programmes to ensure staff understanding of the duty of quality and duty of candour and their roles within it.
14. The Trust has representation on the Duty of Candour Implementation Network, hosted by NHS Wales Shared Services Partnership (NWSSP) Welsh Risk Pool. This Group is currently developing a suite of standards and a consistent approach in the Datix Cymru system to collate both local and national data on duty of candour.
15. Following conversations with the Duty of Candour Implementation Network Chair it has been agreed that Welsh Ambulance Services NHS Trust (WAST) case studies will be developed, discussed and shared via the network. Currently the suite of case studies are acute focussed.
16. DoQ and DoC requirements are being incorporated into the Trust commissioning and hosting arrangements through the ongoing reviews taking place reflective of any associated contracts and agreements held by the Trust.
17. All related policies and procedures to be reviewed, in particular: Putting Things Right Policy (in line with Duty of Candour) and Adverse Incident Policy on receipt of the final policy guidance and Quality Impact Assessments.

## **NEXT STEPS**

18. The Trust will continue to work towards the Welsh Government Baseline Road Map, regularly reporting through the Trust Quality and Performance Steering Group, and the Clinical & Quality Governance Group.



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Ymddiriedolaeth GIG  
Gwasanaethau Ambiwylans Cymru  
Welsh Ambulance Services  
NHS Trust

<b>AGENDA ITEM No</b>	<b>10</b>
<b>OPEN or CLOSED</b>	<b>OPEN</b>
<b>No of ANNEXES ATTACHED</b>	<b>2</b>

**Information Security & Information Governance: position, plans and reporting**

<b>MEETING</b>	<b>QUEST</b>
<b>DATE</b>	<b>10<sup>th</sup> August 2023</b>
<b>EXECUTIVE</b>	<b>Director of Digital Services</b>
<b>AUTHORS</b>	Charlotte Jones, Kelly Holding, Leanne Smith
<b>CONTACT</b>	Leanne.smith4@wales.nhs.uk

**EXECUTIVE SUMMARY**

The Terms of Reference for QUEST sets out how the committee expects to provide oversight and seek assurance on statutory and regulatory compliance, and oversee the quality and integrity, safety and security, and appropriate access and use of information. This oversight and assurance therefore refers to the Trust’s Information Governance (IG) and Information Security (InfoSec) arrangements and design.

It is proposed that this paper form the first report to the QUEST committee, explaining context and accountabilities, WAST’s IG framework, and offering key compliance metrics as per the accompanying report.

The following questions are answered in sequence by this paper:

- What is information governance?
- Why is this planned for QUEST?
- What does the law require?
- How are those laws met?
- What is the accountability framework?
- What mechanisms do we have to support assurance?
- What is our current position?
- What will we report to QUEST?

**RECOMMENDATION:**

**The committee is asked to CONSIDER the proposed metrics in the KPI report (as per Annex 1) against the context supplied in this paper, and DECIDE if quarterly reporting in this form meets the assurance needs of QUEST.**

### KEY ISSUES/IMPLICATIONS

Caldicott and SIRO and DPO responsibilities

Risk re IG team capacity in development

Related to Cyber Security risk - 260

### REPORT APPROVAL ROUTE

Digital Leadership Group – reviewed 3<sup>rd</sup> July 2023

Information Governance Steering Group - async review

EMT – reviewed 2<sup>nd</sup> August

QUEST – 10<sup>th</sup> August

### REPORT APPENDICES

**Annex 1 – IG and InfoSec KPI Reporting (June23)**

**Annex 2 – IG Toolkit 2022-23 Submission (June23)**

### REPORT CHECKLIST

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

## SITUATION

### What is Information Governance?

1. Through our day-to-day operations, WAST obtains a breadth of patient and staff information – it is crucial that we maintain public trust in our ability to protect this data, our reputation with partners, as well as meet the law.
2. As such, we must assure the processes and governance around our data and its protection throughout the entire data lifecycle.
3. Key descriptions:
  - a. **Information Governance (IG)** is a framework for managing information processes in accordance with the law and associated standards. It describes the approach within which accountability, standards, policies and procedures are developed, implemented and maintained, to ensure that all types of information used are sourced, stored, and used appropriately, legally and securely.
  - b. **Information Security (InfoSec)** includes all the processes and tools for protecting information in general (regardless of source or type) from unauthorised activities, including inspection, modification, recording, and disruption / destruction. The goal is to ensure the safety and privacy of critical personal and organisational data, following three principles: confidentiality (the technical security), integrity (that the data held is of high quality), and availability (that access is controlled appropriately).
  - c. IG & InfoSec apply to confidential patient data, but also to staff, organisational and commercial data held by the Trust. **Data Protection** is the act of securing the private, personal information.
  - d. In this digital age, it is increasingly important to consider information security in the context of **cyber security**. However, it should also be remembered that not all information is digital, and it remains important to secure it in a physical way too.
4. Data-informed decision-making is important for any organisation; and with WAST's practice and ambition of using data to inform service improvement and drive innovation, we have a duty to ensure any information we hold is used lawfully and safely; and that we keep up to date with a regulatory landscape that is adapting for advances in technology, data science and AI.

## Why is this paper planned for QUEST?

5. As per the Terms of Reference, the QUEST committee's **purpose** is to:

*2.3 provide oversight of, and see assurance on, statutory and regulatory compliance*

*2.4 oversee the quality and integrity, safety and security, and appropriate access and use of information (including patient and personal information).*

6. QUEST's delegated powers and authority cover the following duties for 2023-24 which and so seek updates on Information Governance and Information Security throughout the year:

*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 (FOI) requests, data breaches, police requests and Subject Access Requests (SARS).*

7. There has been limited visible **reporting** previously, and no formal frequency to this (although longstanding local monitoring is in place); however:

- a. The Information Governance Steering Group (IGSG) was reignited in 2022-23 with a regular 'IG highlight report' including qualitative intel and quantitative metrics for discussion. The TOR are being revised in line with requirements, and this group will report directly to EMT.
- b. Improvement plans across both IG and InfoSec are in development.
- c. An internal audit on data analysis in 2022-23 highlighted further areas for improvement which are being worked towards this financial year, reporting through the Audit committee.
- d. In previous years subject matter experts have contributed to the Annual Report with information on IG, Records, Data Quality & Cyber.

- e. Additionally, WAST are required to report externally on an annual basis via various mechanisms, including the IG Toolkit – a self-assessment of our compliance with IG standards.
8. This paper intends to provide context and an update on the status of IG and InfoSec within the Trust, highlight areas for improvement, and describe high-level risks. A compliance performance report accompanies this paper (Annex 1) and will be presented as a regular item at future meetings for oversight by the QUEST committee. The suitability of an overarching annual reporting mechanism is also being considered.

## BACKGROUND

### What does the law require?

9. This section defines and describes the various overarching legislation, regulations and directions any UK public body must consider with regards to information governance and security:
  - a. **Data Protection Act & UK GDPR:** the Data Protection Act 2018 is a national law that complements the UK General Data Protection Regulation (UK GDPR<sup>1</sup>).

Article 5 of the UK GDPR sets out seven key principles which lie at the heart of the general data protection regime which must be complied with. Failure to comply with the principles may leave organisations open to substantial fines (see Appendix for examples). The principles require that personal data is:

- used fairly, lawfully, and transparently.
- used for specified, explicit purposes.
- used in a way that is adequate, relevant and limited to only what is necessary.
- accurate and, where necessary, kept up to date.
- kept for no longer than is necessary.
- handled in a way that ensures appropriate security, including protection against unlawful or unauthorised processing, access, loss, destruction or damage.
- and that the controller shall be responsible for, and be able to demonstrate compliance with these principles ('accountability').

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<sup>1</sup> The UK GDPR is the retained EU law version of the General Data Protection Regulation ((EU) 2016/679) (EU GDPR) as it forms part of the law of England and Wales, Scotland and Northern Ireland by virtue of section 3 of the European Union (Withdrawal) Act 2018 and as amended by Schedule 1 to the Data Protection, Privacy and Electronic Communications (Amendments etc) (EU Exit) Regulations 2019 (SI 2019/419).

b. **Common Law Duty of Confidentiality:** the Common Law Duty of Confidentiality (CLDC) requires that information that has been provided in confidence may be disclosed only for the purposes which the subject has been informed and has consented to. This means there should be no use or disclosure of any confidential patient information for any purpose other than the direct clinical care of the patient to whom it relates; however, there are some broad exceptions:

- The patient explicitly consents to the use or disclosure.
- The disclosure is required by law or court order, or the disclosure is permitted under a statutory process that sets aside the duty of confidentiality.
- The disclosure can be justified in the public interest.

All employees working in the NHS are bound by a legal duty of confidentiality and are obliged to keep strictly confidential any personal / patient identifiable information (PII), commercially sensitive, and business-in-confidence information they become party to. The consequence of not is possible legal action against the organisation, but also against the individual responsible for the breach.

c. Under the UK GDPR, **individuals have various rights** over their personal data (a breach may result in an enforcement notice, where failure to comply is a criminal offence). An individual has the right:

- To be informed
- To access
- To rectification
- To erasure
- To restrict processing
- To object
- In relation to automated decision making and profiling.

d. **NIS Directive:** the EU's Network and Information System (NIS) Directive<sup>2</sup> is the first piece of EU-wide cyber security legislation. It aims to achieve a high common level of network and information system security across the EU's critical infrastructure. The regulations require that appropriate and proportionate measures are taken to:

- Manage risks posed to the security of the network and information systems on which our essential services rely

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<sup>2</sup> The aim of the NIS Directive is to install a culture of security across sectors which are vital for our economy and society, for example: healthcare, energy and transport. These are seen as operators of essential services (OES). The competent authority within Wales is the Welsh Assembly Government, which requires OES to take appropriate and proportionate measures.

- Prevent and minimise the impact of security incidents on the delivery of essential services and
- Report serious network and information incidents that impact on provision of the essential service.

Any security incident refers to the initial intrusion or attack that disrupts the service; whilst a personal data breach could follow as a result of that intrusion. A competent authority for NIS (e.g. Welsh Government) will use information notices, enforcement notices and financial penalties to any operator of essential services that fails to meet NIS requirements.

- e. **Caldicott Principles:** there are 8 Caldicott Principles that apply to the use of confidential information within health and social care organisations, and when sharing information 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.
1. Justify the purpose(s) for using confidential information.
  2. Use confidential information only when necessary.
  3. Use the minimum necessary confidential information.
  4. Access to confidential information should be on a strict need to know basis.
  5. Everyone with access to confidential information should be aware of their responsibilities.
  6. Comply with the law.
  7. The duty to share information for individual care is as important as the duty to protect confidentiality.
  8. Inform patients and service users about their how their confidential information is used.

### **How are those laws met?**

10. In order to meet these laws, the organisation, and individuals within it, carry a number of responsibilities and duties:
  - a. A **Data Protection Impact Assessment (DPIA)** is a process which helps assess privacy risks to individuals in the collection, use and disclosure of personal information. A failure to properly embed appropriate data and privacy protection measures may result in a breach of data protection law, a declaration of incompatibility with the Human Rights Act, or prohibitive costs in retro-fitting a system to

ensure legal compliance or address community concerns about privacy. A DPIA is a mandatory legal requirement in certain cases<sup>3</sup>.

- b. **Data Sharing Agreements (DSA)** set out the purpose of the data sharing, cover what happens to the data at each stage, set standards and help all the parties involved in sharing to be clear about their roles and responsibilities. DSAs are not a legal requirement<sup>4</sup>.
- c. **Subject Access Requests (SAR)** allows individuals the right to see what personal data is held about them. Under Subject Access an organisation has 30 calendar days in which to respond to a request. Failure to do so is a breach of the DPA / UK GDPR law and the requestor has the right to lodge a complaint with the Information Commissioner's Office as a result. The disclosure of records of deceased persons is dealt with under the Access to Health Records Act 1990 and the response time for a request under this legislation is 40 calendar days.
- d. **Freedom of Information (FOI)** requests provide public access to information held by public authorities. It does this in two ways: public authorities are obliged to publish certain information about their activities; and members of the public are entitled to request information from public authorities. (Note: generally this will not include personal data, and breaches of the FOI Act are unlawful, but not criminal.)
- e. The need to identify, assess and manage privacy risks is an integral part of the accountability principle. The Information Commissioner's Office expects organisations to use a risk management tool to do this. (As a data controller, WAST use Datix as the **Risk Management Information System**, allowing us to capture and review risks associated with data processing operations.)
- f. The UK GDPR states that when a security incident takes place, it must be quickly established whether a personal data breach has occurred, and requires that any personal data breach is reported to the **Information Commissioner's Office (ICO)** within 72 hours of the controller becoming aware of it, unless the breach is unlikely to result in a risk to the rights of freedoms of the data subject.

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<sup>3</sup> Article 35 of UK GDPR makes completing a DPIA a mandatory legal requirement where the processing is likely to result in a 'high risk' to the rights and freedoms of individuals. The Article 35 and complementary regulatory guidance has been issued on what kind of processing could trigger a legal requirement to complete a DPIA. In all other cases, it is recommended for good practice.

<sup>4</sup> However, they are a recommended tool for documenting sharing and are also used to demonstrate the 'accountability' principle. The WASPI Framework and NHS Policy requires that DSAs are put into place. Data Processor agreements and joint-controller agreements are a legal requirement.

## What is the accountability framework?

11. Although IG and InfoSec is a matter for everyone within a healthcare organisation, there are also a number of **named individuals** who will be accountable overall for managing and assuring against the range of regulations and laws described above. (Further information for each is in Appendix 1.)
  - a. The strategic management of IG forms part of the Digital Directorate under the leadership of the Director of Digital Services, who holds the position of the **Senior Information Risk Owen (SIRO)**. Responsibilities include the development of an Information Risk Policy, and ownership of the process for information risk, ensuring the process is up to date, and it has a managed structure for reporting
  - b. The main responsibility of the **Caldicott Guardian** (in WAST this sits with the Executive Director of Quality & Nursing) is to uphold the Caldicott Principles. This predominantly includes protection of the confidentiality principle whilst also ensuring personal information can be used for improving care and patient outcomes with a legal and ethical lens.
  - c. The final part of the triad is the **Data Protection Office (DPO)**. The role of DPO (currently held by the Head of ICT due to a vacancy), should work at a tactical level with the subject matter experts, and has responsibilities around development and implementation of templates and frameworks to support the governance structures, reviewing data arrangements for projects in line with laws, and managing any issues associated, and monitoring compliance.
12. There are also **external agencies** which provide scrutiny and additional support to an organisation's data protection, security and governance arrangements, including:
  - a. The **Information Commissioner's Office (ICO)** monitors compliance with key legislation (DPA 2018, UK GDPR and FOI act) on behalf of the UK Government as an arms-length body. The ICO also keep a watching eye on media and publications; for example a recent BBC article about the introduction of new healthcare apps in two Health Boards sparked a query by the ICO to the NHS Wales IG leads group.
  - b. **UK Government departments** offer guidance on security / cyber, Data Protection and AI. Although there is no formal governance and regulation around AI in healthcare at this stage, the Centre for Data

Ethics and Innovation (CDEI) held within the UK Government's Central Digital & Data Office has recently developed an 'Algorithmic Transparency Recording Standard'. This helps address the difficulty of providing information for use in data-driven tech in a trusted, accessible and effective way, and how to share the benefits.

- c. In Wales, DHCW's **Cyber Resilience Unit** (CRU) act on behalf of NHS Wales to ensure organisations meet the NIS regulations, by monitoring against the Cyber Assurance Framework (CAF).

## ASSESSMENT

### What mechanisms do we have to support assurance?

13. The following demonstrates mechanisms already in place **within WAST** that can inform an assessment of assurance regarding the Trust's management and governance of IG and InfoSec:
  - a. The **Information Governance Steering Group (IGSG)** which oversees the Information Governance and Security strategy, policies, systems, processes and practices across the Trust, providing assurance that the organisation is compliant, and managing any risk to compliance. (Members of the IGSG include the SIRO, DPO and Caldicott Guardian; Terms of Reference are currently being revised.)
  - b. WAST have several different internal **policies & procedures** in place for Information Governance overlapping into Information Security, with 9 currently due for review. After a prioritisation exercise, we have committed to complete review of 2 policies this year, with a 3<sup>rd</sup> already out for consultation.
  - c. In previous years, the various local subject matter experts of IG and InfoSec have added a submission to the **WAST annual report**. This will be managed as part of the IGSG cycles of business this year.
  - d. Through the 2022-23 **internal audit** for data & analytics, we received a recommendation to enhance our Data Sharing Agreements register to capture more details on each request. Also, the register should be reviewed regularly to ensure it is kept up to date. Additionally, a Cyber Security Audit internal audit report has just been published, and a Records Management internal audit is in progress.
  - e. All personal data **breaches** are reported through Datix. Here they are investigated and where appropriate will be reported to the Information

Commissioners Office (ICO). Where there is a 'high risk' to the data subject, the individual must be notified.

14. Additionally, **within NHS Wales**, there are other activities which help assess the design and operation of IG and InfoSec arrangements within the Trust:

a. The Welsh **IG Toolkit** for the NHS is an assessment that allows organisations to measure their performance against agreed national information governance standards and legislation. All organisations that have access to NHS Wales patient data and systems must use the toolkit to demonstrate compliance with:

1. UK GDPR and DPA 2018
2. expected data security standards for health & social care for processing personal data
3. readiness to access secure health and digital methods of information sharing such as NHS email, Welsh healthcare records and systems and location information sharing solutions and agreements

The IG Toolkit is separated into 13 categories. In each category, there are two standards which are assessed - Minimum Expectations Met and Expectation Exceeded. The Trust is required to meet the Minimum Expectations of each category to demonstrate minimum compliance standards. Documents are uploaded to the IG Toolkit to provide evidence of achieving the expectations.

b. The **National Intelligent Integrated Audit Solution (NIAS)** is a proactive audit monitoring system utilised by NHS Wales to protect patient confidentiality. NIIAS detects potential instances of unauthorised access to patient information held within certain national electronic information systems, including the Welsh Demographics Service and the Welsh Clinical Portal. WAST uses NIIAS to monitor access, receive alerts, and produce automated reports highlighting unusual or suspicious activity where further investigation may be required.

c. The **Cyber Assessment Framework (CAF)** provides a systematic and comprehensive approach to assessing the extent to which cyber risks to essential functions are being managed by the organisation responsible. It is intended to be used either by the responsible organisation itself (self-assessment) or by an independent external entity, possibly a regulator or a suitably qualified organisation acting on behalf of a regulator. From this assessment, we are able to identify areas for improvement to ensure increased information security.

- d. The **Information Government Management Advisory Group (IGMAG)** provides a forum to consider IG requirements within NHS Wales, and provide direction and consistency in how IG is managed. The group also works collaboratively to influence policy and practice.
15. **External reporting** is largely through the ICO:
- a. The Trust has a legal obligation to notify the ICO within 72 hours of becoming aware of a breach where a certain risk threshold has been met. This time period begins as soon as the organisation is made aware that an incident has occurred, regardless of whether it has been reported to Information Governance team or even if all the details are not yet known. Where there is a high risk to the Data Subject, for example when confidential medical information has been disclosed to a member of the public, the Trust is also required to notify the Data Subject without undue delay. Therefore, early reporting of incidents on Datix is vital to enable early assessment of risk threshold, required mitigation actions, and ICO notification requirements.

### **What is our current IG & InfoSec position?**

16. **IG Toolkit:** the annual Welsh IG Toolkit compliance assessment for 2023/23 was submitted in June 2023. We are awaiting confirmation of successful submission, but the Trust did not meet the Minimum Expectations for all categories. Upon receipt of official results, an improvement plan will be developed. See Annex 2 for the IG Toolkit status.
17. **Records Management & Requests:** an internal audit of records management was conducted in Q1 2023-24, with results expected August 2023.
18. **FOIs:** in 2022-23, WAST made 172 FOI responses regarding information requests. Metrics are in development to ensure ease of trend analysis in future, and to demonstrate compliance with the requirements of the Act.
19. **Info Security:** NIS regulation assurance work by the CRU has recently been completed with an improvement plan in development for WAST. In Q1 2023-24, an internal audit paper on cyber security was received which gave 'reasonable' assurance, offering some recommendations around InfoSec.
20. Themes around current **challenges and risks** in achieving, maintaining and assuring compliance of data protection can be summarised as:

- a. **Data breach:** there is a significant risk of breach arising from inappropriate staff behaviour and system access in a variety of scenarios, for example:
  - Accessing your own personal records
  - Accessing a family member or a friend's personal records
  - Accessing colleagues' personal records
  - Accessing the records of celebrities or people who are in the media spotlight
  - Accessing any record which the user has no valid work reason to be viewing
- b. **Data Protection expertise and capacity:** the teams supporting this breadth of activity is small and has received little or no investment despite a growth in data and technology-led ambitions across NHS Wales (e.g. improvement initiatives / tests of change etc).
- c. **Demand:** a risk is being developed around the increase in demand related to concerns, investigations, and Nationally Reportable Incidents due to system-wide pressure. This results in more records requests and media attention (for information) as well as FOIs.
- d. **Cyber Security:** the InfoSec element of this relies on WAST people as the last line of defence (cyber awareness is now part of the ESR mandatory IG training module). This is on the corporate risk register, and although refers to activities broader than InfoSec, malicious actors are often driven by the value in obtaining sensitive, personal data.
- e. **Tooling:** access to NIIAS requires training and approval by DHCW which can take time. Additionally, any new systems we implement that store personal data are required to be auditable (e.g. ECNS, ePCR, SALUS).

### What will we report to QUEST?

21. **Performance Metrics** - Annex 1 presents the first version of a report of key metrics. It is proposed that the metrics included be the basis for regular reporting internally, at IGSG, and reported through to EMT, whilst also brought forward on a regular basis to QUEST to assure of internal processes and progress of improvement plans surrounding IG and InfoSec.
22. **IG Toolkit** – Annex 2 provides the status of WAST's IG Toolkit submission for 2022-23. The IG Toolkit status and results will also be brought forward to QUEST annually.
23. Statutory and mandatory IG training compliance may wish to be reported more regularly though other routes (e.g. MIQPR) in future.
24. The Trust may wish to include an overarching SIRO or Data Protection statement in its Annual Report.

## **RECOMMENDATION**

**The committee is asked to CONSIDER the proposed metrics in the KPI report (as per Annex 1) against the context supplied in this paper, and DECIDE if quarterly reporting in this form meets the assurance needs of WAST.**

## **APPENDICES**

### **Appendix 1a: Responsibilities of the Senior Information Risk Officer**

- Oversee the development of an Information Risk Policy. This should include a Strategy for implementing the policy within the existing Information Governance Assurance Framework and be compliant with NHS IG policy, standards and methods.
- Take ownership of the assessment processes for information risk, including prioritisation of risks and review of the annual information risk assessment to support and inform the annual statement.
- Ensure that the Board are kept up to date and briefed on all information risk issues affecting the organisation and its business partners.
- Review and agree actions in respect of identified information risks.
- Ensure that the Organisation's approach to information risk is effective in terms of resource, commitment, and execution, being appropriately communicated to all staff.
- Provide a focal point for the escalation, resolution and/or discussion of information risk issues.
- Ensure that an effective infrastructure is in place to support the role by developing a simple Information Assurance governance structure, with clear lines of Information Asset ownership and reporting with well-defined roles and responsibilities.
- Ensure that identified information threats and vulnerabilities are followed up for risk mitigation, and that perceived or actual information incidents are managed in accordance with NHS IG requirements.
- To ensure that there are effective mechanisms in place for reporting and managing Serious Untoward Incidents (SUIs) relating to the information of the Organisation. These mechanisms should accommodate technical, operational or procedural improvements arising from lessons learnt.
- Provide leadership for Information Asset Owners (IAOs) of the Organisation through effective networking structures, sharing of relevant experience, provision of training and creation of information risk reporting structures.
- Advise the Board on the level of Information Risk Management performance within the Organisation, including potential cost reductions and process improvements arising etc

### **Appendix 1b: Responsibilities of the Caldicott Guardian**

- 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.

### **Appendix 1c: Responsibilities of the Data Protection Officer**

- Implementing measures and a privacy governance framework to manage data use in compliance with the UK GDPR and other relevant legislation, including developing templates for data collection, advising on and assisting with data mapping and records of data processing, and management reviews.
- Working with key internal stakeholders in the review of operations and projects and related data processing to ensure compliance with data privacy laws and advising on and monitoring data protection privacy impact assessments pursuant to Article 35 of the UK GDPR.
- Involved, properly and in a timely manner, in all issues which relate to the protection of personal data and have due regard to the risk associated with processing operations, taking into account the nature, scope, context and purposes of processing.
- To inform and advise the Trust and employees of their obligations pursuant to the UK GDPR and data protection provisions.

- Serving as the primary point of contact and liaison for the Information Commissioner on all data protection related matters under the UK GDPR and other relevant legislation and cooperate and consult with the Information Commissioner as necessary.
- Serving as the primary point of contact for data protection queries in the Trust.
- Monitor compliance with the UK GDPR and other data protection provisions, and with the policies Trust in relation to the protection of personal data, including the assignment of responsibilities, awareness-raising and training of staff involved in processing operations, and the related audits.
- Reviewing vendor contracts (including relevant standard contractual clauses for international data transfers) and other third-party data processing and data sharing arrangements in partnership with the organisation's Procurement and Information Security functions.
- Ensuring filing and fee requirements with the Information Commissioner are achieved.
- Managing and conducting ongoing reviews of the Trust's privacy governance framework and regular and ad hoc reporting on data privacy compliance within the organisation
- Monitoring changes to relevant privacy laws and making recommendations when appropriate.
- Setting standards and reviewing policies and procedures globally that meet the requirements under the UK GDPR.
- Developing and delivering privacy training to various business functions and collaborating with the Information Security function(s) to raise employee awareness of data privacy and security issues.
- Developing strategies and initiatives to ensure engagement with key internal and external stakeholders.
- Coordinating, conducting, and monitoring data privacy audits.
- Collaborating with the Information Security function(s) to maintain records of all data assets and exports and maintaining a personal data security incident management plan to ensure timely remediation of incidents impacting personal data including impact assessments, breach response, complaints, claims or notifications.
- Responding to and advising on data subject rights requests, including data subject access requests (SARs) and other requests from individuals. Data subjects may contact the DPO with regard to all issues related to processing of their personal data and to the exercise of their rights.
- Ensuring that the Trust's IT systems and procedures comply with all relevant data privacy and protection law, regulation and policy (including in relation to the retention and destruction of data).

- Working with designated subject matter experts or champions across the Trust's offices and, where necessary, outside legal advisers to help advise on data privacy law issues.
- The DPO shall be bound by secrecy or confidentiality concerning the performance of his or her tasks, in accordance with the law.

## **Appendix 2: Examples of substantial fines**

<https://www.enforcementtracker.com/ETid-1730>

<https://www.enforcementtracker.com/ETid-1190>

<https://www.enforcementtracker.com/ETid-1188>

# INFORMATION SECURITY & GOVERNANCE KPI REPORTING

Reporting period:  
June 2023

## IG TOOLKIT & IMPROVEMENT

2022-23 IG Toolkit is complete, although a technical glitch has prevented the submission.



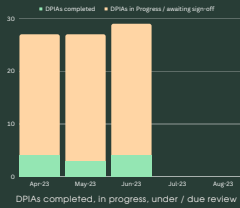
An IG Improvement plan is in development.



Minimum expectations have NOT been met across all categories.



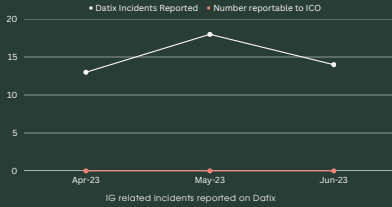
The DPIA log continues to be reviewed and updated weekly, including cloud security assessments.



## DATA PROTECTION BREACHES

0 incidents meeting the threshold for reporting to the ICO in June 2023

1 incidents currently under the risk assessment process



## INFO SECURITY

1 cyber incident reported to CRU under NIS regulations during June 2023

> 1000

to later include number of security breaches, incidents and near misses

weak user passwords across the Trust

## RECORDS MANAGEMENT

### Subject Access Requests

Must be responded to within 30 calendar days from receipt.

### 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.

	SARS	Access to Health	Non Regulatory Requests	Police DPA Requests	ePCR Requests	Total Cases Processed	Previous Year	% Increase on Previous Year	Breaches	Compliance
Apr	42	11	90	71	265	479	399	20%	2	95%
May	37	9	115	56	213	430	518	-15%	0	100%
Jun	69	11	123	71	253	527	416	27%	0	100%
Q1	148	31	328	198	731				2	

2 breaches of the regulatory time period in April 2023

to later include file retrieval statistics, adherence to disposal schedules and tracking of paper files

MEASURES OF DQ TO BE ESTABLISHED

172 FOI responses in 2022/23

FURTHER FOI MEASURES TO BE INCLUDED



Mandatory ESR Data Protection & IG training compliance is below the 75% threshold



Optional ESR Cyber training module completed

“Our people are our last line of defence.”



Pass rate for phishing exercise (MS Defender Attack Simulator) - April 2023 results

Completion rate for targeted Executive Training (this is the highest uptake of all modules)

Phishing campaign



4793 users targeted by simulator Jun-23



3163 (66%) of the emails were opened



253 (5%) reported the email



1080 (22.5%) opened the links



325 (6.7%) supplied credentials



489 (10%) finished the training



## IG Toolkit Submission – Status Report as of 30<sup>th</sup> June 2023

The IG Toolkit submission was due 30<sup>th</sup> June 2023. Below is a status report of each section.

Section	Provisional Status	Notes
Leadership and Oversight	Minimum Expectations Met	Pending completion of DPO training, it is expected that 'Expectations Exceeded' will then be met.
Policies and Procedures	Minimum Expectations Not Met	<p>Requirements not met: -</p> <ol style="list-style-type: none"> <li>The Trust's DP Policy, Info Sec Policy, and RM Policy have not been reviewed and updated by the review date.</li> </ol> <p>*Note: It was previously a toolkit requirement for the organisation to have approved and adopted the All Wales IG policy set. WAST has not formally adopted the All Wales IG Policy, and All Wales Information Security Policy, however this requirement has since been removed from the Toolkit.</p>
Training and Awareness	Minimum Expectations Not Met	<p>Requirements not met: -</p> <ol style="list-style-type: none"> <li>The organisation is not currently meeting or exceeding compliance of 75% for mandatory IG training. Reminders have been issued on Yammer.</li> </ol>
Individual Rights	Expectations Exceeded	
Transparency	Minimum Expectations Met	
Records of Processing Activity	Minimum Expectations Not Met	<p>Requirements not met: -</p> <ol style="list-style-type: none"> <li><a href="#">'Appropriate Policy Document'</a> required. (IT has been queried with the IG toolkit team to confirm that it is an 'Appropriate Policy Document' which covers specific criteria, rather than a general policy covering data processing and is pending a response).</li> </ol>
Contracts and Information Sharing	Minimum Expectations Met	
Risks and DPIAs	Minimum Expectations Met	

RM and Security	Minimum Expectations Met	
Breach and Monitoring	Minimum Expectations Met	
FOI and EIR	Minimum Expectations Not Met	Requirements not met: - 1. Documented procedure or guidance procedure and guidance outlining FOI and EIR high level responsibilities – No documented procedure available.
Information Security	Minimum Expectations Not Met	Requirements not met: - 1. BYOD Policy is not in place in the Trust.
Business Continuity	Minimum Expectations Met	



<b>AGENDA ITEM No</b>	<b>11</b>
<b>OPEN or CLOSED</b>	<b>Open</b>
<b>No of ANNEXES ATTACHED</b>	<b>5</b>

<b>RISK MANAGEMENT &amp; BOARD ASSURANCE FRAMEWORK REPORT</b>
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<b>MEETING</b>	Quality, Patient Experience & Safety Committee
<b>DATE</b>	10 <sup>th</sup> August 2023
<b>EXECUTIVE</b>	Trish Mills, Board Secretary
<b>AUTHOR</b>	Julie Boalch, Head of Risk/Deputy Board Secretary
<b>CONTACT</b>	<a href="mailto:Julie.Boalch@wales.nhs.uk">Julie.Boalch@wales.nhs.uk</a>

<b>EXECUTIVE SUMMARY</b>
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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. The principal risks were presented to the Trust Board on 25<sup>th</sup> May 2023 and are updated as at 6<sup>th</sup> July 2023. The high rated risks have been reviewed during this reporting period in line with the agreed schedule detailed at Annex 3. Focus has been given to the risk ratings and the mitigating actions identified and taken to ensure risks achieve their target score. This is in addition to the review of controls, assurances, and any gaps.
5. Specifically, The Trust’s highest rated Risks 223 and ID 224, scoring 25, remain unchanged despite a series of mitigating actions being in place. These risks continue to be closely monitored by management, Board Committees, and the Trust Board.
6. All current mitigating actions within WAST’s control have been completed or superseded in relation to Risk 223 and remain on the BAF for review. The Trust will continue to challenge itself that all possible mitigations are in place or planned,

this includes considering a potential breakdown of risk score by Health Board; however, at this stage it was felt to be too early for that to reduce the overall score of this risk.

7. A deep dive in relation to Risk 224 was undertaken by the Quality & Nursing Directorate and it was agreed that the score should remain at 25 (5x5) given recent cases of patients deteriorating outside of Emergency Departments.
8. Updates made in respect of actions, controls and assurances are highlighted in blue on the BAF.

**RECOMMENDATION:**

9. **Members are asked to consider the contents of the report.**

**KEY ISSUES/IMPLICATIONS**

10. The key issues are set out in the Executive Summary above.

**REPORT APPROVAL ROUTE**

11. The BAF was considered by:

- EMT – 5<sup>th</sup> July 2023
- ADLT – 26<sup>th</sup> June 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
- Appendix 1 - Guidance on Interpreting the Board Assurance Framework

**REPORT CHECKLIST**

<b>Confirm that the issues below have been considered and addressed</b>		<b>Confirm that the issues below have been considered and addressed</b>	
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**

<b>CORPORATE RISK REGISTER</b>				
<b>RISK ID</b>	<b>NEW RISK TITLE</b>	<b>NEW SUMMARY DESCRIPTION</b>	<b>EXECUTIVE OWNER</b>	<b>RISK SCORE</b>
223 QuEST	The Trust’s inability to reach patients in the community causing patient harm and death	<p><b>IF</b> significant internal and external system pressures continue</p> <p><b>THEN</b> there is a risk of an inability and/or a delay in ambulances reaching patients in the community</p> <p><b>RESULTING IN</b> patient harm and death</p>	Director of Operations	<p><b>25</b> <b>(5x5)</b></p> <p><b>➔</b></p>
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	<p><b>IF</b> patients are significantly delayed in ambulances outside A&amp;E departments</p> <p><b>THEN</b> there is a risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised</p> <p><b>RESULTING IN</b> patients potentially coming to harm and a poor patient experience</p>	Director of Quality & Nursing	<p><b>25</b> <b>(5x5)</b></p> <p><b>➔</b></p>

## Annex 2 - Risk Scoring Matrix

Consequence:	1 Negligible	2 Minor	3 Moderate	4 Major	Catastrophic
<b>Safety &amp; Well-being - Patients/ Staff/Public</b>	Minimal injury requiring no/minimal intervention or treatment. No time off work. Physical injury to self/others that requires no treatment or first aid. Minimum psychological impact requiring no support. Low vulnerability to abuse or exploitation - needs no intervention. Category 1 pressure ulcer.	Minor injury or illness, requiring minor intervention. Requires time off work for >3 days. Increased hospital stay 1-3 days. Slight physical injury to self/others that may require first aid. Emotional distress requiring minimal intervention. Increased vulnerability to abuse or exploitation, low level intervention. Category 2 pressure ulcer.	Moderate injury/professional intervention. Requires time off work 4-14 days. Increased hospital stay 4-15 days. RIDDOR/Agency reportable incident. Impacts on a small number of patients. Physical injury to self/others requiring medical treatment. Psychological distress requiring formal intervention by MH professionals. Vulnerability to abuse or exploitation requiring increased intervention. Category 3 pressure ulcer.	Major injury leading to long-term disability. Requires time off work >14 days. Increased hospital stay >15 days. RIDDOR Reportable. Regulation 4 Specified Injuries to Workers. Patient mismanagement, long-term effects. Significant physical harm to self or others. Significant psychological distress needing specialist intervention. Vulnerability to abuse or exploitation requiring high levels of intervention. Category 4 pressure ulcer.	Incident leading to death. RIDDOR Reportable. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients.
<b>Quality/ Complaints/ Assurance/ Patient Outcomes</b>	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.
<b>Workforce/ Organisational Development/ Staffing/ Competence</b>	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.
<b>Statutory Duty, Regulation, Mandatory Requirements</b>	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.
<b>Adverse Publicity or Reputation</b>	Rumours. Low level negative social media. Potential for public concern.	Local media coverage - short-term reduction in public confidence/trust. Short-term negative social media. Public expectations not met.	Local media coverage - long-term reduction in public confidence & trust. Prolonged negative social media. Reported in local media.	National media coverage <3 days, service well below reasonable public expectation. Prolonged negative social media, reported in national media, long-term reduction in public confidence & trust. Increased scrutiny: inspectorates, regulatory bodies and WG.	National/social media coverage >3 days, service well below reasonable public expectation. Extensive, prolonged social media. MP/MS questions in House/Senedd. Total loss of public confidence/trust. Escalation of scrutiny status by WG.
<b>Business Objectives or Projects</b>	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.
<b>Financial Stability &amp; Impact of Litigation</b>	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.
<b>Service/ Business Interruption</b>	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.
<b>Environment/Estate/ Infrastructure</b>	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.
<b>Health Inequalities/ Equity</b>	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	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

<b>Risk ID</b> 223	<b>The Trust's inability to reach patients in the community causing patient harm and death</b>			<b>Date of Review:</b>	26/06/2023	<b>TREND</b>	25 (5x5)
				<b>Date of Next Review:</b>	25/07/2023		
<b>IF</b> significant internal and external system pressures continue	<b>THEN</b> there is a risk of an inability and/or a delay in ambulances reaching patients in the community	<b>RESULTING IN</b> patient harm and death		<b>Likelihood</b>	<b>Consequence</b>	<b>Score</b>	
			<b>Inherent</b>	4	5	20	
			<b>Current</b>	5	5	25	
			<b>Target</b>	2	5	10	
IMTP Deliverable Numbers: 3, 7,9,11, 12, 14,16, 18, 21, 22, 26							
<b>EXECUTIVE OWNER</b>		Director of Operations	<b>ASSURANCE COMMITTEE</b>		Quality, Safety and Patient Experience Committee		
<b>Risk Commentary Q4 2022/23</b>							
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 as a result of the Trust not being able to reach patients in the community.							
There were over 28,000 hours lost outside EDs in March 2023, a comparable figure to the pre Christmas delays. Whilst there has been improvement in some Health Board areas (Cardiff and Vale where there has been a corresponding improvement in red performance), other Health Board continue to experience protracted delays. 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 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.							
Improvement actions led by Welsh Government and system partners include: -							
<ul style="list-style-type: none"> <li>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)</li> <li>b) Consideration of additional WAST schemes to support risk mitigation through winter (I)</li> <li>c) NHS Wales educes emergency department handover lost hours by 25% (E)</li> <li>d) NHS Wales eradicates all emergency department handover delays in excess of 4 hours (E)</li> <li>e) Alterative capacity equivalent to 1000 beds (E)</li> <li>f) Implement nationwide approach to emergency department 'Fit 2 Sit' (E)</li> <li>g) Implementation of Same Day Emergency Care services in each Health Board (E)</li> <li>h) National Six Goals programme for Urgent and Emergency Car (E)</li> </ul>							
<b>CONTROLS</b>				<b>ASSURANCES</b>			
				<b>Internal Management (1<sup>st</sup> Line of Assurance)</b>			
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.			
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. Gold/Strategic, Silver/Tactical and Bronze/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.			
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. Monitoring CSD rates through AQIs. Consult and Close volumes form part of EMS CCC weekly reports to SLT. Regular reporting of incident volumes to Operational Review Groups. Summary level information about Consult and Close volumes, targets, trends and recontact rates reported to TB and sub-committees. Metrics relating to Ambulance Quality Indicators (AQI) published on a quarterly basis by EASC. Bi-monthly EASC Provider reports. Consult and Close performance reported in Joint Executive Team meeting every 6 months with Welsh Government. NWSSP Information			

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death		Date of Review:	26/06/2023		TREND	25 (5x5)
			Date of Next Review:	25/07/2023		→	
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	
		Management Internal Audit report February 2022 (External Assurance). Consult and Close rate has increased from 12% to circa 15% March 2023.					
8. Advanced Paramedic Practitioner (APP) deployment model / APP Navigation		8. Qlik sense APP dashboard monitors performance and provides assurance that APPs are flowing patients into alternatives to emergency department. Qlik sense is a national report and can drill down into regional, local and individual performance as required. APP Navigation – Test of Change Framework (Swansea Bay & Hywel Dda). Review of despatch criteria for APPs. <b>EMT have agreed to offer contracts to the 22 APPs who are about to complete their Masters programme. This will take our APP headcount to 88.7FTE.</b> <b>An investment proposal has been submitted to Welsh Government AHP in primary and community care pot. I think that there is low expectation that the bid will be successful. We are currently workforce planning to increase our APP headcount by 40 per year.</b>					
9. Clinical Safety Plan		9. Clinical agreement – agreeing escalation to higher levels, ODU dashboard, AACE paper through National Director of Operations group					
10. Recruitment and deployment of CFRs		10. Volunteers are another resource for response, Volunteer					
11. ETA scripting		11. The ETA Dashboard is a tactic that was signed off by EMT – there is a dashboard that supports scripting analysed by comparing with real time data					
12. Clinical Contact Centre (CCC) emergency rule		12. CCC Emergency Rule is policy that has been signed off by Execs.					
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.		14.					
15. Summer/Winter initiatives		15. Monitoring through SLT and STB					
16. CHARU implementation		16. Monitored via the EMS project Board					
17. National Transfer & Discharge Model		17.					
18. Conveyance Reduction		18. This is part of the weekly performance review and aligned to Care Closer to Home Programme					
19. Access to Same Day Emergency Care (SDEC) for paramedic referrals		19. 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%) and inconsistent.					
20. Mental Health Practitioners in cars		20.					
21. Roll out of ECNS		21. Reported through QuEST					
22. Clinical Model and clinical review of code sets		22. Reported through QuEST					
23. Remote Clinical Support Strategy		23. Strategic Transformation Board – IMTP deliverable					
24. 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)		24. Formally documented action plan – actions captured are contained within and monitored via the Performance Improvement Plan (PIP)					
25. Information sharing		25. Information Sharing: Patient Safety Reports, Chief Operating Officer (COO) Data Pack, Immediate Release Declined (IRD) Reports.					
<b>26. Completed EMS Roster Review</b>		<b>26. Helps to ensure that we have the maximum available capacity to respond to dispatch to 999 calls received in a timely manner</b>					
<b>27. Work underway to reduce the number of multiple attendances dispatched to red calls</b>		<b>27. This will increase vehicle availability generally across the Trust</b>					
<b>28. Transfer of Care</b>		<b>28. 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</b>					

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			Date of Next Review:	25/07/2023		
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	4	5	20
			Inherent	4	5	20
			Current	5	5	25
			Target	2	5	10
		<p>the practice of ED swaps and cease the use of WAST equipment in EDs across Wales. Please refer to the following documents:</p> <ul style="list-style-type: none"> <li>i) Letter to COO Handover Delays 30.03.2023</li> <li>ii) Letter to COO Handover Delays</li> <li>iii) WAST – Transfer of Care Brief</li> </ul>				
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				
2. Blockages in system e.g. internal capacity within Health Boards which affect patient flow						
3. Covid capacity streaming						
4. Transition Plan/Inverted Triangle – bid for transition plan has been put in and is now subject to funding						
5. Local delivery units mirroring WAST ODU						
6. Handover delays link to risk 224						
7.						
8. During industrial action days, Health Boards demonstrated compliance with reducing handover delays in order to maximise WAST resources. Despite a reduced volume of conveyance as a result of the industrial action, there is however a demonstration that reduced handover delays are achievable, and this therefore warrants a triangulation of data.						
9. There is an ambition that no handover should exceed 4 hours and for lost hours to handover to be reduced by 25% but given the track record over last 6 months there is a low confidence in attaining this.						
10. Outputs from the NHS System Reset – it is a closer collaboration to address some of the system blockages and reduce system pressures. This is the aspiration						
11.						
12. 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				
18. National Transfer & Discharge Model		18. National Transfer & Discharge model is yet to be determined. A task and finish has been established to progress this piece of work				
21. Mental Health Practitioners		21. Mental Health Practitioners – not yet implemented but part of the Care Closer to Home workstream				
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. EMS Demand & Capacity i.e. review and implementation of new EMS rosters		Assistant Director of Operations EMS	Complete	Majority of EMS rosters complete and implemented		

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death		Date of Review:	26/06/2023	TREND	25 (5x5)
			Date of Next Review:	25/07/2023		
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
4. Transition arrangements post pandemic		Executive Pandemic Team / Assistant Director of Strategic Planning (BCRT Chair)	Complete 30/08/22	Transition complete		
5. Recruit and train more Advanced Paramedic Practitioners – Value Based Healthcare Fund bid for up to 50 WTE (I) [Source: Action Plan presented to Trust Board 28/07/22]		Director of Paramedicine / Director of Workforce & OD	30.07.23 Checkpoint	Offers to 22 in July 2023. 13.33 FTE uplift. Continue to seek opportunities for funding APPs to improve service delivery.		
6. Maximise the opportunity from Consult and Close – stretch to 15% and beyond (I) [Source: Action Plan presented to Trust Board 28/07/22]		Assistant Director of Operations, Integrated Care	31.03.23 Complete	Work undertaken to map influences and progress towards each. Current % of Consult and Close increased from 12% to 15% at March 2023.		
7. 24/7 operational oversight by ODU with dynamic CSP review and system escalation as required (I) [Source: Action Plan presented to Trust Board 28/07/22]		Assistant Director of Operations, National Operations & Support	Complete	System in place and ongoing.		
8. Weekly REAP review by senior Operations Directorate team with assessment of action compliance (I) Source: Action Plan presented to Trust Board 28/07/22]		Director of Operations / Operations Senior Leadership Team	Complete	In place and ongoing - Weekly Performance Meetings occur every Tuesday lunchtime to review performance, etc. and determine REAP level.		
9. Recruitment and deployment of new CFRs (I) [Source: Action Plan presented to Trust Board 28/07/22]		Assistant Director of Operations, National Operations & Support / National Volunteer Manager	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.		
10. Transition Plan (I) [Source: Action Plan presented to Trust Board 28/07/22]			Superseded			
11. Overnight Falls Service extension (I) [Source: Action Plan presented to Trust Board 28/07/22]		Assistant Director of Quality & Governance / Head of Quality Improvement	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.		

<b>Risk ID</b> 224	<b>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 &amp; Effective Service for Patients</b>		<b>Date of Review:</b>	27/06/2023	<b>TREND</b>	25 (5x5)
			<b>Date of Next Review:</b>	27/07/2023		
<b>IF</b> patients continue to be significantly delayed in ambulances outside Accident and Emergency Departments	<b>THEN</b> 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	<b>RESULTING IN</b> patients coming to significant harm and a poor patient experience	<b>Likelihood</b>	<b>Consequence</b>	<b>Score</b>	
			<b>Inherent</b>	5	5	25
			<b>Current</b>	5	5	25
			<b>Target</b>	3	2	6
IMTP Deliverable Numbers: 7,9, 10, 11, 12, 13, 14, 15, 16, 23, 24, 25, 26, 33, 35						
<b>EXECUTIVE OWNER</b>		Director of Quality & Nursing	<b>ASSURANCE COMMITTEE</b>		Quality, Safety and Patient Experience Committee	
<b>Risk Commentary Q1 2023/24</b>						
<p>The risk score remains constant at 25 (almost certain &amp; 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 over <b>2,000</b> +4 hour patient handovers in <b>April 2023</b>; the target being 0 from September 2022 <b>has now moved to the end of 2023/24</b>. Currently &lt; 0.014% of the Trust's demand is going into Same Day Emergency Care currently is &lt;0.025% (modelling 4%). 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 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. <b>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.</b> The Joint Investigation Framework <b>in place to review incidents across the system is now approved and included in the recently published National Policy on Patient Safety Incident Reporting &amp; Management (May 2023).</b></p> <p>Improvement actions led by Welsh Government and system partners include:</p> <ol style="list-style-type: none"> <li>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) <b>by the end of April 2025</b></li> <li>NHS Wales eradicates all emergency department handover delays in excess of 4 hours (LHB CEOs) <b>by revised to March 2023/24.</b></li> <li>Alternative capacity equivalent to 1,000 beds project (LHB CEOs)</li> <li>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)</li> <li>Implement nationwide approach to emergency department 'Fit 2 Sit' (Welsh Government: Chief Medical Officer and Chief Nursing Officer)</li> </ol>						
<b>CONTROLS</b>			<b>ASSURANCES</b>			
			<b>Internal Management (1<sup>st</sup> Line of Assurance)</b>			
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 is currently in pilot phase and an evaluation is to be undertaken in quarter 1 2023/24 by EASC. 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 monitors, reports on app use by Consultant Connect and shared at local and corporate meetings regarding patient safety and handover of care position across NHS Wales and NHS England.			
4. WAST Clinical Notice in place - Escalating a clinical concern with a deteriorating patient outside the Emergency Department (11.02.2021). National Early Warning Score (NEWS) trigger of 5 or above for escalation to hospital clinicians. NEWS data available via EPCR (electronic patient care record).			4. NEWS data now available via ePCR and escalation system in place via local managers and the Operational Delivery Unit.			

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		Date of Next Review:	27/07/2023			
IF patients continue to be significantly delayed in ambulances outside Accident and Emergency Departments	THEN there is a continued risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised	RESULTING IN patients coming to significant harm and a poor patient experience	Likelihood	Consequence	Score	
			Inherent	5	5	25
			Current	5	5	25
			Target	3	2	6
5. Workstreams put in place to meet requirements of <i>Right care, right place, first time Six Goals for Urgent and Emergency Care A policy handbook 2021–2026</i> . 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 NWS 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.				
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 ( <b>April 2023 overall 75% - Safeguarding and dementia over 90%</b> ).				
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 <i>Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover</i> (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 <i>Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover</i> (undertaken 2021). WAST has senior representation at this meeting. A collective response from WAST and Health Boards is being overseen by EASC.				
15. Escalation of patient safety concerns by Trust Board: featured in provider reports to the Emergency Ambulance Committee (EASC); been the subject of Accountable Officer correspondence to the NHS Wales Chief Executive; numerous escalations to professional peer groups initiated by WAST Directors; and coverage at Joint Executive Meetings with Welsh Government.  Evidence submission to Senedd Health and Social Care Committee. Written evidence submitted during Q4 21/22 to the committee to assist their inquiry into Hospital Discharge and its impact on patient flow through hospitals Report published in June 2022 containing 25 recommendations with recommendation six specifically WAST related stating "The Welsh Government should explain how the targets outlined in the Minister for Health and Social Service's statement of 19 May 2022 on urgent and emergency care and the Six Goals Programme to eradicate ambulance patient handover delays of more than four hours and reduce the average ambulance time lost per arrival by 25 per cent (from the October 2021 level) have been set. It should also confirm the target dates for the achievement of these targets."		15. Monthly Integrated Quality and Performance Report, CEO Reports to Trust Board including 'Actions to Mitigate Avoidable Patient Harm Report' (last presented to Trust Board May 2023 and Board sub-committee oversight and escalation through 'Alert, Advise and Assure' reports.				

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			Inherent	5	5	25
			Current	5	5	25
			Target	3	2	6
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 February 2023 is 'Implementing and operationalising'. The Trust has representation on the All Wales Duty of Candour Implementation Group and is actively engaged in developing resources.				
		<b>External Sources of Assurance Management (1<sup>st</sup> Line of Assurance)</b>				
		1. Monitoring and oversight of the Ambulance Quality Indicators (AQIs) including handover of care timeliness and Commissioning Framework by the Chief Ambulance Services Commissioner (CASC) and Joint Executive Team (JET) meeting Welsh Government (I&E).				
		2. Healthcare Inspectorate Wales (HIW) 'Review of Patient Safety, Privacy, Dignity and Experience whilst waiting in Ambulances during Delayed Handover' Report and system wide improvement plan with working group in place with WAST senior representation. Oversight by HIW and EASC				
		3. Duty of Quality and Duty of Candour readiness returns assessment by Welsh Government.				
<b>GAPS IN CONTROLS</b>		<b>GAPS IN ASSURANCE</b>				
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. A number of overdue patient safety investigations remain presenting a risk to patient safety across the system. The Trust has 30 (as of 07.03.2023) overdue nationally reportable incident investigations.				
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. <b>23,082</b> hours were lost in <b>April 2023 with 2021 +4 hour patient handovers in April 2023.</b>				
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.		5.				
6. Variation pan Wales / England as position not implemented across all emergency departments*.		6.				
7.		7.				
8. Variation pan Wales / England as position not implemented across all emergency departments*.		8. <b>New Quality Management System in development which will include monitoring of the new Quality Standards &amp; Enablers and underpinning governance structure.</b>				
9. Variable response pan Wales / England. WAST have minimal control on this at patient level*.		9.				
10.		10.				
11. Variable response pan Wales / England. WAST have minimal control on this at patient level*.		11.				
12.		12.				
13. Transition to ePCR impacting on data temporarily		13.				
14. National steer required to confirm the accountability arrangements regarding patients in ambulances outside of the emergency departments. The seven Local Health Boards (LHBs) in Wales are responsible for planning and securing delivery of primary, community, secondary care services, and also the specialist services for their areas*.		14. HIW approve and sign off WAST elements of recommendations.				
15.		15.				
		<b>External Gaps in Assurance</b>				
		1. Lack of escalation and response to AQIs by the wider urgent care system and regulators				

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			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	<ul style="list-style-type: none"> <li>Incremental improvements to quality and safety data and information to enable triangulation / collective intelligence at Trust and system level.</li> <li>Access to ePCR data (NEWS) now available. Work on-going with Health Informatics regarding patient safety dashboards.</li> </ul>		
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	<ul style="list-style-type: none"> <li>Bid not successful. However, Trust decision to proceed with 18 MSC places. 10 started in September (North) with the balance (eight) on target for March 2023 start.</li> <li>22 trainee APPs expected to complete training in Jun-23.</li> <li>EMT has agreed to offer places to these 22 trainee APPs funded from a reduction in technician posts 1/2s i.e. internal movement.</li> <li>The Trust has recently submitted a bid to increase AHPs in Primary and Community Care (WG fund) for more APPs.</li> </ul>		
5. Overnight falls service extension		Executive Director of Quality & Nursing	• June 2023	<ul style="list-style-type: none"> <li>Night Car Scheme extension agreed to 31 March 2023 (2 regional resources)</li> <li>Aim to achieve 60% utilisation of Falls Assistant resources, by December 2022 and achieve consistent utilisation of 60% + through Jan-Mar 2023. Good progress has been made on this.</li> <li>Falls level 1 and 2 impact evaluation report completed - presenting to Clinical Quality Governance Group (CQGG) 18 Jan-2023.</li> </ul>		
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	<ul style="list-style-type: none"> <li>Monthly updates to progress against actions following the baseline assessment and readiness returns.</li> <li>Key policies updated and approved.</li> <li>Participation in the All Wales Duty of Candour implementation group by Patient Safety Team – monthly.</li> <li><b>Quality Management System workshop to be held 12 June 2023.</b></li> </ul>		
7. Virtual Ward <b>now Connected Support Cymru</b>		Executive Director of Quality & Nursing	• Q2 2023/24	<ul style="list-style-type: none"> <li><b>Commencing Test of Change deployments with SJAC – two vehicles at present have been utilised, 2 to follow.</b></li> <li><b>Arrangements – CSD selecting cases for SJAC to respond and take patient observation. To date, the small number of cases have negated any EA attendance to the scene.</b></li> <li><b>Funding – CASC have awarded SJAC a direct commission for circa 20 weeks provision.</b></li> <li><b>Small Business Research Initiative – has 'kicked off' phase one, with a virtual warding technology platform in development for the pre-hospital/community used (within WAST).</b></li> </ul>		
8. Organisational change process of Putting Things Right Team (PTR) to enable increased capacity across all functions to manage increasing complexity and demands.		Executive Director of Quality & Nursing	• Q2 2023/24	• Informal consultation phase <b>commenced</b> May 2023.		
9. <b>Connect with All Wales Tissue Viability Network to explore strengthening the current investigations into harm from pressure damage across the whole patient pathway.</b>		<b>Assistant Director Quality &amp; Nursing</b>	• <b>Q2 2023/24</b>			
10. <b>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?</b>		<b>CEO</b>	• <b>Q4 2023/24</b>	• <b>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)</b>		

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				Inherent	5	5
				Current	5	25
				Target	3	2
			<ul style="list-style-type: none"> <li>WAST will proactively support this work and offer best practice examples from other jurisdictions that can support benchmarking and improvement activities.</li> <li>Expected outcomes in 2023/24.</li> </ul>			
Completed Actions		Action Owner	When /Milestone	Progress Notes:		
1. HIW Improvement Plan / Workshop – WAST inputs / influencing improvements. Response and improvement actions to Healthcare Inspectorate Wales Inspection report (2021) 'Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover' which links to Fundamentals of Care.		Assistant Director of Quality & Nursing	Completed			
2. Representation at the Right care, right place, first time Six Goals for Urgent and Emergency Care Delivery Boards and Clinical Advisory Board.		Chief Executive Officer	Completed	<ul style="list-style-type: none"> <li>Led by the NHS Wales Deputy Chief Executive this programme seeks to modernise access to and the provision of Urgent and Emergency Care across Wales</li> <li>WAST will be represented on the Clinical Reference Group by Andy Swinburn with first meeting now held.</li> <li>The Trust recently reported to EASC that it has further updated how it maps into six goals programmes. The programme structure nationally is being embedded and the Trust now has presence on goals 2, 5 &amp; 6 at delivery board level and on the clinical advisory board.</li> </ul>		
3. Participation in the CASC led workshop to reform the Framework for the Investigation of Patient Safety Serious Incidents (SIs) V2.2, dated July 2019.		Executive Director of Quality & Nursing	Completed	<ul style="list-style-type: none"> <li>Revised joint investigation approach agreed and now formalised.</li> </ul>		
4. Recruit additional frontline capacity – additional £3m non recurrent 22/23 allocation		Director of Workforce & Organisational Development	Completed	<ul style="list-style-type: none"> <li>Strong focus from Executives with detailed updates to EMT every two weeks.</li> <li>Year-end position is +85 FTEs, with a vacancy factor of just 1%, rather than the often used 5%, which would produce a figure of -88 FTEs rather than the estimated - 15 FTEs.</li> <li>Further non recurrent funding has been secured for 2023/24</li> </ul>		
5. Transition Plan		Chief Executive Officer	Completed	<ul style="list-style-type: none"> <li>Action complete, but the Trust will continue to undertake strategic and technical workforce planning in support of the Trust's ambition e.g. inverting the triangle etc.</li> </ul>		
6. Consideration of additional WAST schemes to support overall risk mitigation through winter		Director of Operations	Completed	<ul style="list-style-type: none"> <li>Winter ended. Focus now on forecasting and modelling for the summer, but Trust not aiming to produce specific Summer Plan (the Trust did during the pandemic linked to travel restrictions).</li> <li>The Trust needs to determine whether there is value in producing a specific winter plan, particularly, within the context of the financial constraints NHS Wales is not operating in.</li> </ul>		
7. National 111 awareness campaign		Director of Partnerships and Engagement Director of Digital	Completed	<ul style="list-style-type: none"> <li>The national awareness campaign was undertaken as planned and ended in March 2023. An evaluation will be provided to the 111 Board.</li> </ul>		

## IMTP Deliverable Key

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



Welsh Ambulance Services NHS Trust

# **Guidance on Interpreting the Board Assurance Framework**

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Version 1.1

April 2023

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# Board Assurance Framework

The Board Assurance Framework (BAF) provides assurance to the Board on the Trust’s delivery of its strategic aims, outlined in its 3 Year Integrated Medium Term Plan (IMTP) and through its risk management framework.

An element of the Trust’s Risk Transformation Programme was to develop a transitional BAF that focussed the Board on the key risks that might compromise the achievement of those strategic aims.

The BAF currently draws its principal risks from the Corporate Risk Register and maps them to the Integrated Medium-Term Plan deliverables and therefore, by extension, are the Trust’s strategic risks.

As the Trust’s risk maturity advances the current BAF template will be used to capture risks to the strategic objectives and will be cross-referenced to the principal corporate risks.

The BAF aligns principal risks, drawn from the Corporate Risk Register, the key controls, and the assurances on those controls. Gaps are identified where key controls and assurances are insufficient to mitigate the risk and subsequent actions are identified. The Board should monitor these actions as intended to close the gaps and mitigate the risks.

## COMPONENTS OF THE BAF

Elements for the Board to consider when scrutinising the BAF:

### 1. REVIEW DATE

Risks scored high (15-25) are reviewed monthly, medium risks (8-12) are reviewed quarterly, and low risks (1-6) are reviewed every 6 months.

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



The Board should consider whether the risk has been reviewed on time and in accordance with the governance routes agreed by the Audit Committee.

## 2. RISK ARTICULATION

An *If, Then, Resulting In* approach is used to provide a more detailed description of the risk. The Board should consider whether the cause and effect of the risk clear.

## 3. SCORING

The risk score uses the likelihood x consequence mechanism. A guide on how likelihood and consequence scores are arrived at to gauge if the score is appropriate is included in the tables in annex 1.

## 4. CONTROLS

A control is a measure that is already in place to mitigate a risk. Controls may change or be added to through regular updates. The Board will need to assure itself that these controls are effective to manage the principal risks.

## 5. ASSURANCE

Assurance provides confidence, evidence, and certainty that controls are effective. The Board should look at the control and the assurance related to that specific control to judge its effectiveness in managing the risk. As the BAF matures future iterations could include an assurance rating to support the assessment of effectiveness of controls.

## 6. GAPS

A gap in control or assurance occurs when either of these elements do not exist or that they do not effectively mitigate the risk. It may be that the control is not operating effectively to mitigate the risk. The Board should consider whether gaps are comprehensive with what is known in the current environment and whether the BAF supports the identification of the gaps or weaknesses in controls.

## 7. ACTIONS

An action is something which is intended to be done and which will limit the impact of a risk in the future. It may reduce the likelihood of the risk occurring at all. Once complete an action may become a new control. The Board should consider whether there is an associated action for each gap; are those actions on track according to their dates; and will these actions support the reduction of the risk when completed and become controls.

## RISK SCORING MATRIX

## Annex 1

Consequence:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
<b>Safety &amp; Well-being - Patients/ Staff/Public</b>	<p>Minimal injury requiring no/minimal intervention or treatment. No time off work.</p> <p>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.</p>	<p>Minor injury or illness, requiring minor intervention. Requires time off work for &gt;3 days Increased hospital stay 1-3 days.</p> <p>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.</p>	<p>Moderate injury/professional intervention Requires time off work 4-14 days. Increased hospital stay 4-15 days. RIDDOR/Agency reportable incident. Impacts on a small number of patients. Physical injury to self/others requiring medical treatment. Psychological distress requiring formal intervention by MH professionals. Vulnerability to abuse or exploitation requiring increased intervention. Category 3 pressure ulcer.</p>	<p>Major injury leading to long-term disability. Requires time off work &gt;14 days. Increased hospital stay &gt;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.</p>	<p>Incident leading to death. RIDDOR Reportable. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients.</p>
<b>Quality/ Complaints/ Assurance/ Patient Outcomes</b>	<p>Peripheral element of treatment or service suboptimal. Informal complaint/inquiry.</p>	<p>Overall treatment/service suboptimal. Formal complaint (Stage 1). Local resolution. Single failure of internal standards. Minor implications for patient safety. Reduced performance.</p>	<p>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.</p>	<p>Non-compliance with national standards with significant risk to patients. Multiple complaints/independent review. Low achievement of performance/delivery requirements. Critical report.</p>	<p>Totally unacceptable level or quality of treatment/service. Gross failure of patient safety. Inquest/ombudsman/inquiry. Gross failure to meet national standards/requirements.</p>
<b>Workforce/ Organisational Development/ Staffing/ Competence</b>	<p>Short-term low staffing level that temporarily reduces service quality (&lt; 1 day).</p>	<p>Low staffing level that reduces the service quality.</p>	<p>Late delivery of key objective/service due to lack of staff. Unsafe staffing level (&gt;1 day)/competence. Low staff morale. Poor staff attendance for mandatory/key professional training.</p>	<p>Uncertain delivery of key objective/service due to lack/loss of staff. Unsafe staffing level (&gt;5 days)/competence. Very low staff morale. Significant numbers of staff not attending mandatory/key professional training.</p>	<p>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.</p>
<b>Statutory Duty, Regulation, Mandatory Requirements</b>	<p>No or minimal impact or breach of guidance/statutory duty.</p>	<p>Breach of statutory legislation. Reduced performance levels if unresolved.</p>	<p>Single breach in statutory duty. Challenging external recommendations/improvement notice.</p>	<p>Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low achievement of performance/delivery requirements. Critical report.</p>	<p>Multiple breaches in statutory duty. Zero performance rating. Prosecution. Severely critical report. Total system change needed.</p>
<b>Adverse Publicity or Reputation</b>	<p>Rumours. Low level negative social media. Potential for public concern.</p>	<p>Local media coverage - short-term reduction in public confidence/trust. Short-term negative social media. Public expectations not met.</p>	<p>Local media coverage - long-term reduction in public confidence &amp; trust. Prolonged negative social media. Reported in local media.</p>	<p>National media coverage &lt;3 days, service well below reasonable public expectation. Prolonged negative social media, reported in national media, long-term reduction in public confidence &amp; trust. Increased scrutiny: inspectorates, regulatory bodies and WG.</p>	<p>National/social media coverage &gt;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.</p>



Consequence:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
<b>Business Objectives or Projects</b>	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.
<b>Financial Stability &amp; Impact of Litigation</b>	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.
<b>Service/ Business Interruption</b>	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.
<b>Environment/Estate/ Infrastructure</b>	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.
<b>Health Inequalities/ Equity</b>	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



**GIG**  
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Ymddiriedolaeth GIG  
Gwasanaethau Ambiwylans Cymru  
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NHS Trust

<b>AGENDA ITEM No</b>	<b>12</b>
<b>OPEN or CLOSED</b>	<b>OPEN</b>
<b>No of ANNEXES</b>	<b>1</b>

## AUDIT REPORT

<b>MEETING</b>	Quality, Patient Experience & Safety Committee
<b>DATE</b>	10 August 2023
<b>EXECUTIVE</b>	Trish Mills, Board Secretary
<b>AUTHOR</b>	Trish Mills, Board Secretary
<b>CONTACT</b>	<a href="mailto:trish.mills@wales.nhs.uk">trish.mills@wales.nhs.uk</a>

### EXECUTIVE SUMMARY

1. The audit tracker is currently undergoing a full review and, together with audit guidance for the organisation, will be available for the 14 September Audit Committee for scrutiny.
2. This report updates the Committee on progress of the review and sets out the audits which are open and past their initial review date for scrutiny by the Committee.
3. Also before the Committee at this meeting is the limited assurance internal audit report on Pain Management. Duncan Robertson (Assistant Director for Clinical Development) will be available to discuss any finding, recommendations, and planned actions, in place of Andy Swinburn (Director of Paramedicine).
4. The Committee is requested to:
  - (a) Note the work planned and in train for the audit tracker and guidance document which the Audit Committee will review on 14 September; and
  - (b) Advise of any further action required with respect to the open actions under the oversight of this Committee.

### KEY ISSUES/IMPLICATIONS

As set out above.

<b>REPORT APPROVAL ROUTE</b>
Not applicable.

<b>REPORT APPENDICIES</b>
None.

<b>REPORT CHECKLIST</b>			
<b>Confirm that the issues below have been considered and addressed</b>		<b>Confirm that the issues below have been considered and addressed</b>	
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

## **AUDIT TRACKER**

### **SITUATION**

1. This paper updates the Committee on the changes to the audit tracker and approach to its reporting.

### **BACKGROUND**

2. The audit recommendation and action tracker is in place for the purpose of tracking progress across the Trust to ensure that recommendations contained in internal and external audit review reports are actioned in a timely manner.
3. The manual nature of the tracker means a significant amount of time is required in its maintenance. This includes the transposing of the information from PDF copies of internal audit reports, and dialogue with the owners of management actions to obtain updates on closures of actions. A new approach is therefore being developed to bring automation and clearer reporting to the tracker and to embed ownership of the actions within already existing directorate processes. We are working with Internal Audit in the development of the new process and tracker.

### **ASSESSMENT**

4. Guidance has been drafted to provide the organisation with information on why we conduct audits, both internal audits and structured assessments in particular, and the roles of individuals involved in those audits. This will be reviewed by the Audit Committee at its 14 September meeting.
5. The audit tracker, which includes both Internal Audit and Audit Wales recommendations and management actions, enables the Executive Management Team and the Board through its Audit and other Committees to see where recommendations have been completed, therefore positioning them to see the impact of changes to systems or processes. Likewise, it provides a mechanism to see where actions have been delayed and to discuss the risks to such delayed actions and gain assurance on any remedial action.
6. However, the tracker is highly manual and, as it currently stands, requires a significant amount of input from the Corporate Governance Team. With limited resources in the team, new and automated solutions for tracking the progress of audits are being investigated, together with improvements to the end to end process and cycle of an audit. This includes embedding a regular review of audit

recommendations and actions in directorate meetings and enabling an audit point of contact to update the tracker directly.

7. A new form of manual excel tracker has been developed pending a potential Microsoft 365 solution. The Corporate Governance Team will work with Internal Audit and Audit Wales to ensure they are comfortable with the changes with the intention of transposing any open audit actions to that tracker over the course of the coming weeks and close down the current tracker. Because of this, the audit tracker is not before the Committee for review today.
8. A number of actions have *revised dates* for completion from the *original due date* in the audit report, however this Committee has been aware of this from previous reports and the Audit Committee reviewed the full tracker as at 5 July at their 25 July meeting. There are four historical recommendations related to the Information Management Hear and Treat audit of 2021/22 (see Annex 1) where are overdue from their original and revised dates. A meeting is being held on 11 August with Internal Audit to review these in light of the current operational and clinical structures in CSD compared to the time when these recommendations and actions were finalised.
9. In addition to Annex 1 there are three actions related to the Audit Wales Review of Quality Governance Arrangements 2022 where updates are in progress related to the joint investigation process and an all-Wales quality management system.
10. For completeness, audits planned for 2023/24 relevant to this Committee include the following:
  - (a) Senior Paramedic Role (fieldwork started)
  - (b) Records management (Q1)
  - (c) Serious adverse incidents Joint Investigation Framework (Q1/2)
  - (d) Seatbelt action plan (Q2)
  - (e) Clinical handover (Q3)
  - (f) Clinical audit (Q3)

## **RECOMMENDATION**

11. The Committee is requested to:
  - (a) Note the work planned and in train for the audit tracker and guidance document which the Audit Committee will review on 14 September; and
  - (b) Advise of any further action required with respect to the open actions under the oversight of this Committee.

Trust Ref. No.	Year/ Audit Plan	Committee assigned to	Report Title	Assurance Rating	Responsible Officer	Director	Priority Level	Recommendation	Management Response	Agreed Deadline in Report	Status	Due	1st revised date	2nd revised date	3rd revised date	Closed/Open	Reason overdue / Reason complete If closed and not complete, please provide justification	Note for QUEST Committee 10 August 2023
480	21/22	QSPE	<a href="#">Information Management - Hear and Treat</a>	Reasonable	Paula Jeffery	Liam Williams / Brendan Lloyd	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	Partially complete	Overdue original date				Open	Last Updated: 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.	Historical recommendations - meeting with Internal Audit planned for 110823.
480	21/22	QSPE	<a href="#">Information Management - Hear and Treat</a>	Reasonable	Paula Jeffery	Liam Williams / Brendan Lloyd	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		Overdue original date				Open	Last Updated: 19/10/22 See above, subsequent action.	Historical recommendations - meeting with Internal Audit planned for 110823.
480	21/22	QSPE	<a href="#">Information Management - Hear and Treat</a>	Reasonable	Paula Jeffery	Liam Williams / Brendan Lloyd	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		Overdue original date	Nov 22			Open	Last Updated: 19/10/22 See above, subsequent action.	Historical recommendations - meeting with Internal Audit planned for 110823.
483	21/22	QSPE	<a href="#">Information Management - Hear and Treat</a>	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		Overdue original date	Dec 22			Open	Last Updated: 19/10/22 Now that triage has moved to ENCS 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. Exepected Q3 2022-23)	Historical recommendations - meeting with Internal Audit planned for 110823.

# Pain Management Final Internal Audit Report July 2023

Welsh Ambulance Services NHS Trust



Partneriaeth  
Cydwasaethau  
Gwasanaethau Archwilio a Sicrwydd  
Shared Services  
Partnership  
Audit and Assurance Services



Ymddiriedolaeth GIG  
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Welsh Ambulance Services  
NHS Trust



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Review reference:	WAST-2223-012
Report status:	Final
Fieldwork commencement:	23 November 2022
Fieldwork completion:	12 June 2023
Debrief meeting:	17 May 2023
Draft report issued:	15 June 2023
Management response received:	7 July 2023
Final report issued:	10 July 2023
Auditors:	Osian Lloyd, Head of Internal Audit Felicity Quance, Deputy Head of Internal Audit Ross Hughes, Principal Auditor
Executive sign-off:	Andy Swinburn, Director of Paramedicine
Distribution:	Kevin Webb, Head of Clinical Intelligence and Assurance Chris Moore, Head of Medicines Management Duncan Robertson, Assistant Director of Clinical Development Greg Lloyd, Assistant Director of Clinical Delivery
Committee:	Audit Committee



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

### Acknowledgement

NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

### Disclaimer notice – please note

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

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## Executive Summary

### Purpose

To review the application of pain relief methods and their effect on patient outcomes in terms of pain relief and patient satisfaction.


### Overview

We have issued limited assurance on this area.

The matters requiring management attention include:

- Poor compliance rates in Patient Group Direction completion for Advanced Paramedic Practitioners, with no monitoring at group/ Committee level. Whilst it is recognised that not all are specific to analgesia, for the four that are, only one has achieved the target compliance rate of 75%.
- Patient Group Directions not reviewed on a regular basis, noting that of those that have surpassed their review date, two are in relation to analgesia.
- Lack of oversight into pain scores and administration of analgesia.
- Administration of analgesia by appropriately qualified clinicians.

### Report Classification

		Trend
Limited	More significant matters require management attention.	N/A
	<b>Moderate impact</b> on residual risk exposure until resolved.	

### Assurance summary<sup>1</sup>

Assurance objectives	Assurance
1 Policy and procedures	Reasonable
2 Patient Group Directions	Limited
3 Administration of analgesia	Limited
4 Management information	Limited
5 Monitoring and reporting	Reasonable

### Key matters arising

	Assurance Objectives	Control Design or Operation	Recommendation Priority
1 Patient Group Directions	2	0	High
2 Lack of oversight for pain scoring and administration of analgesia	3,4	0	High
3 Administration of Analgesia	3	0	Medium

<sup>1</sup> The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

## 1. Introduction

- 1.1 Assessment and documentation of a patient's pain experience is a crucial component in providing effective pain management. Accurate and systematic documentation of pain, pre and post pain relief medication (analgesia), supports the Paramedic's clinical decision relating to the administration of an appropriate analgesic, and the following evaluation of its efficacy. It also demonstrates the ability to achieve, for the patient: a reduced experience of pain; increased comfort; improved physiological, psychological and physical function; and increased satisfaction with pain management.
- 1.2 The Joint Royal College Ambulance Liaison Committee (JRCALC) Clinical Practice Guidelines state:
- *Analgesia should be administered as soon as clinically possible after arriving on scene, although this can be done en-route so as not to delay time critical patients.*
  - *There is no reason to delay relief of pain because of uncertainty with definitive diagnosis. It does not affect later diagnostics efficacy.*
  - *All patients with pain must have a pain severity score undertaken and should be repeated after each intervention.*
- 1.3 In addition to the above, the Trust must adhere to national legislation, including The Misuse of Drugs Act 1971 and The Human Medicines Regulations 2012, when administering pain relief. Further, to support Paramedics in administering analgesia, the Trust will issue Patient Group Directions (PGDs) which are written instructions to help the user supply or administer medicines to patients if they believe there is an advantage to the patient without compromising their safety.
- 1.4 The risks considered during the review were as follows:
- i. Breach of legislation due to non-compliance with policies and procedures;
  - ii. Controlled drugs are not being managed / used safely resulting in patient harm; and
  - iii. Lack of oversight of incidents / issues relating to pain management within the Trust
- 1.5 The review did not assess the clinical outcomes of drugs administered or the cost effectiveness of drugs in use / looking to be introduced into the Trust.

## 2. Detailed Audit Findings

2.1 The table below summarises the recommendations raised by priority rating:

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	-	-	-	-
Operating Effectiveness	2	1	-	3
<b>Total</b>	<b>2</b>	<b>1</b>	<b>-</b>	<b>3</b>

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](#).

### **Audit objective 1: There are policies and procedures in place outlining the Trust's approach to pain management.**

2.3 Management confirmed that there is no Trust policy specific to pain management. However, the following policies, which are available to all staff via the Siren SharePoint policy library (Medical and Clinical Services section), include reference to pain management:

	Medicines Management Policy	Management of Controlled Drugs policy
Approved By	Quality Patient Experience & Safety (QuEST) Committee	QuEST & Policy Group
Date of Approval	25/02/2020	27/07/2021
Review Date	3 years from approval date (25/02/2023)	3 years from approval date (27/07/2024)

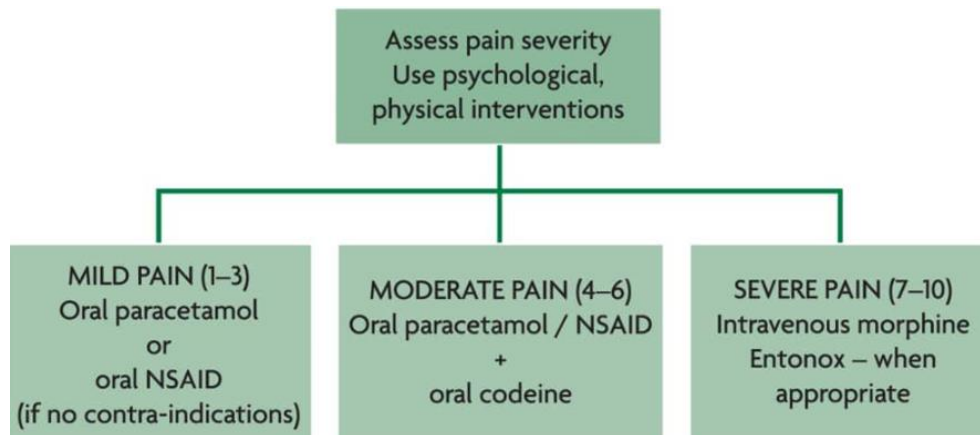
2.4 The Medicines Management Policy (Appendix 3) details a comprehensive table of drugs available within the Trust, with the relevant clinical situations in which the drugs may be required to manage pain; and which staff group are permitted to administer them. It is noted that, at the date of fieldwork, the policy was due for review. Management confirmed that the updates required have been made and are currently out to consultation; therefore, noting the review process is underway no recommendation has been raised at this report.

2.5 The Management of Controlled Drugs Policy provides the user information on how to use analgesia (e.g., Morphine Sulphate, Ketamine and Midazolam) whilst also informing how to record its use.

2.6 In addition to these policies, the Trust follows the guidelines set out within the Joint Royal Colleges Ambulance Liaison Committee Guidance (JRCALC), which are available via an electronic application. The Trust issues its Clinical Staff with an electronic tablet – each one has the JRCALC app embedded within it; and we

understand from discussions with management that the tablets are automatically updated ensuring current JRCALC guidance is available at all times. A review of the JRCALC noted that there are specific sections with the guidelines around Pain Management in adults (see diagram 1) and in children (use of the Wong-Baker 'faces' scale or the FLACC scale). For compliance with these guidelines, refer to audit objective 3.

Diagram 1



### Conclusion:

2.7 Whilst it is noted that the Trust have policies in place which incorporate reference to pain management the overarching guidance is via the JRCALC. Updates to drugs details, and expectations for the administering of such, have been confirmed through this application. Noting this, **Reasonable** assurance has been determined.

### **Audit objective 2: There are appropriate processes in place for the communication, approval and acceptance of Patient Group Directions in place for the administration of analgesia.**

2.8 Patient Group Directions (PGDs) are legal mechanisms that permit paramedics to administer drugs that are not currently included in Schedule 17 of the Human Medicines Regulations (2012).

2.9 Section 14 of the Medicines Management Policy sets out the process for the development of PGDs including:

- *'review every three-years to ensure they remain up to date and fit for purpose...undertaken by the Medicines Management Lead, Pharmacist Advisor and at least one Advanced Practitioner'; and*
- *'When a justifiable case is made by a practitioner for a specific medicine to enhance their practice, or a change is driven by national guidance, the practitioner will be provided with the necessary support to develop a draft version of their PGD. The draft will then be refined by the Medicines Management Lead, before being shared with relevant professionals*

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*including the Trust Pharmacy Advisor and Executive Medical Director, before final sign off'.*

- 2.10 The Medicines Management Policy (Appendices 3 and 4) lists PDGs which have been approved by the Trust – ‘Advanced Practice’ PDGs (19) and ‘Additional Miscellaneous’ PDGs (7) respectively. The ‘Advanced Practice’ drugs are specifically for use by Advanced Paramedic Practitioners (APP). The miscellaneous PDGs include enhanced analgesia drugs to which access is restricted to Senior Paramedics that have been granted a profile with their Abloy key (access to Abloy protected controlled drugs safe / cabinets); ‘paramedic’ PDG drugs (see para 2.12); and drugs which are managed by Occupational Health e.g. flu and MMR vaccines.
- 2.11 To confirm adherence with the expected review process, we reviewed all PDGs that are currently in use within the Trust. It was noted that 12 of the 26 PDGs have surpassed their review period (**See MA1**). Of the 26 PDGs, five relate to analgesia (Codeine phosphate, Diazepam, Paracetamol, Ibuprofen and Ketamine), with the latter two having surpassed their review period (11 months and 3 months respectively).
- 2.12 As part of the Medicines Management process, a database is maintained for signed and authorised PDGs within the Trust, which confirms that individual paramedics have signed the required form to allow them to administer the drugs. The compliance levels for the following Emergency Medical Service (EMS) specific PDGs are reported via the Medicines Management Assurance Report, which is issued monthly to the Ambulance Practice Steering Group:
- Co-amoxiclav;
  - Tranexamic Acid; and
  - Diazepam (*note: when administered by EMS, is used as an anticonvulsant rather than analgesia. The drug is only administered as analgesia by APP’s (see Appendix C)*).

Management confirmed monitoring is undertaken of these as they are deemed high risk as are applicable for use by all Paramedics; and is also recognised that none are administered as an analgesia.

- 2.13 During discussion with the Head of Medicines Management it was noted that EMS PDGs compliance levels, at January 2022, were below the expected level. This was discussed with the Local Duty Operations Managers with a goal set of achieving an overall 95% compliance rate within the Trust. A review of the Medicines Management Assurance Reports highlighted a gradual increase in compliance month on month with the March 2023 report noting all three exceeding the target:

*Table 1 (improvement since January 2022)*

Month	Diazepam	Tranexamic Acid	Co-amoxiclav
January 2022	76%	67%	82%
November 2022	97%	94%	98%
March 2023	99%	97%	99%

*Table 2 (Compliance levels per health board locality)*

Health Board Locality	Diazepam	Tranexamic Acid	Co-amoxiclav	Total (All 3 PGDs)
Aneurin Bevan	94%	91%	96%	<b>94%</b>
Betsi Cadwaladr	98%	94%	94%	<b>95%</b>
Cardiff & Vale	100%	100%	100%	<b>100%</b>
Cwm Taf	99%	99%	100%	<b>99%</b>
HART	100%	100%	100%	<b>100%</b>
Hywel Dda	99%	96%	100%	<b>98%</b>
Powys	100%	100%	100%	<b>100%</b>
Swansea Bay	100%	99%	100%	<b>100%</b>
<b>Overall</b>	<b>99%</b>	<b>97%</b>	<b>99%</b>	<b>98%</b>

- 2.14 Whilst we note the Head of Medicines Management monitors compliance of the APP specific PGDs, no formal reporting is undertaken. A review of the APP PGD compliance rates noted poor compliance, with rates ranging from 32% to 81% across the Trust and with 13 of the 19 PGDs failing to achieve a 75% compliance rate. It is also noted that in the South East locality, compliance rates for Co-Amoxiclav, Flucloxacillin and Penicillin V are currently at 0%. Management further confirmed that four of these APP PGDs relate to analgesia; of which only one (ibuprofen) has achieved the compliance rate and the remaining three (codeine-phosphate; diazepam and paracetamol) achieving a 52% compliance rate at the date of fieldwork. (**See MA1 and Appendix C**). We recognise that further work has been undertaken to improve the compliance rates with 62%, 62% and 54% respectively being reported.
- 2.15 At the outset of our review, management confirmed that discussions were ongoing as to the potential introduction of a new type of emergency pain relief (Penthrox). At the date of reporting, it is noted that such discussions had suitably progressed with the introduction of the drug (3 May 2023) into the Trust's suite of pain-relieving drugs; and to be used by all clinicians, including Community First Responders. A clinical notice was issued to all staff via the May 11<sup>th</sup> Siren newsletter.
- 2.16 A PGD was not required for the new drug, however a protocol for the use of Penthrox has been prepared by the Health Board Clinical Leads, supported by the Head of Medicines Management and Regional Clinical Lead (Consultant

Paramedic). The protocol was approved by the Executive Medical Director and Pharmacist Advisor prior to approval by the Ambulance Practice Steering Group (APSG) in February 2023. The minutes for APSG note submission of the protocol for approval from the Clinical & Quality Governance Group (CQGG); and this confirmed as submitted to the March 2023 meeting.

### Conclusion:

2.17 The Trust monitors and formally reports to the APSG on the compliance levels, for which target compliance has been met, for only the three EMS PGDs. Whilst compliance for the remaining PGDs is monitored, and noting compliance rates are below target, there is no evidence of formal reporting of the same. Further, a number of the PGDs have not been reviewed within the required three-year period.. It is recognised, that not all of the PGDs are specific to analgesia and, therefore, are outside the scope of this review. However, improvements to the compliance and monitoring process is required for those specific to analgesia, therefore **limited** assurance has been determined.

### **Audit objective 3: The administering of pain management is carried out in accordance with the policy and operating procedures.**

2.18 As per para 2.6, the Trust follows the guidance set out by the JRCALC, which is readily available on the tablets issued to each clinician. To confirm compliance, sample testing was undertaken to ensure:

- There was a pain score recorded prior to the administration of analgesia;
- There was a pain score recorded post analgesia to determine its effectiveness; and
- An appropriately qualified clinician administered the analgesia.

2.19 We requested the data for September and November 2022 on all callouts for the following conditions:

- Head injury (64);
- Upper Limbs (93);
- General back injury (69);
- Dislocation of joint (101); and
- Any call out to a child receiving analgesia.

We were informed that the Trust does not routinely produce reports for these clinical codes, noting it would take a considerable amount of time and resource to create the required pathways within the ePCR software (**see MA2**). It was, however, highlighted that pathways to extract similar information on Fractured Neck of Femur (NOF) and ST Elevation Myocardial Infraction (STEMI) were already in place. Due to this our sample testing consisted of call outs undertaken in September 2023 for NOF (5), STEMI (5) and Children receiving analgesia (5).

2.20 From review of the ePCR form provided for each of our sample, the following was noted (refer to Appendix B for full details of testing):

NOF	STEMI	Children
Three patients received multiple administration of analgesia during the care provided (total of 12 administrations).	Pain scores taken prior to the administration of analgesia (3 of the 4 administrations).	Two patients received multiple administration of analgesia during the care provided (total of 7 administrations).
Pain scores taken prior to administration of analgesia (9 of the 12 administrations).	Pain scores taken post administration of analgesia (2 of the 4 administrations).	Pain scores taken prior to administration of analgesia (6 of the 7 administrations). Noting the exception was a toddler
Pain scores taken post administration of analgesia (8 of the 12 administrations).	Where both pain scores recorded, analgesia deemed effective (2 of the sample of 4 – noting that analgesia was not required for 1 patient).	Pain scores taken post administration of analgesia (4 of the 7 administrations).
Where pain scores recorded, analgesia deemed effective (3 of the 4 sampled – noting that analgesia was not required for 1 patient).		Analgesia deemed effective for 3 of the 5 sample, due to the lower pain score recorded.

2.21 The ePCR forms had elements of information redacted i.e. patients details, but also the name of the paramedic completing the ePCR form. Therefore, we were unable to identify the crew member administering the analgesia to ensure it was in line with protocol. On request for this information, we were informed that, the most senior level of clinician who is involved in the callout assumes responsibility for the overall care of the patient. Management noted that it is assumed the senior clinician will have administered the analgesic even if it is documented by a lower grade of staff, whose scope of practice does not allow administration of a particular analgesia. **(See MA3)**. This is because the senior clinician is deemed responsible for the administration under their supervision. It is, however, noted that there was only instance in our sample testing where the analgesia administered would have fallen to the remit of a senior clinician.

#### Conclusion:

2.22 We were unable to test a wider sample of clinical codes, as the Trust currently only extracts and monitors pain score data for two clinical codes (STEMI and NOF). Sample testing undertaken noted that pain scores, both pre and post analgesia not routinely recorded for patients. Where both have been recorded (66% of the sample tested), however, the analgesia was determined to be effective. Whilst the ePCR forms don't categorically confirm the member of staff administering the pain relief, for the sample reviewed, the analgesia (bar one) could be administered by all clinicians. Enhancement to the recording mechanisms of this data is recommended. **Limited** assurance has therefore been determined.

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**Audit objective 4: Management information relating to the appropriate use of analgesia and its efficacy is regularly monitored, and themes / trends are identified.**

2.23 The Trust reports on care bundle compliance to the Clinical Intelligence Assurance Group (CIAG) for the following five clinical indicators (CI):

- Hypoglycaemia
- Neck of Femur (NOF)
- ST Elevation Myocardial Infarctions (STEMI)
- Stroke
- Return of Spontaneous Circulation (ROSC) at Hospital

Management confirmed that, historically, the information has been derived from validated data (including manual audit of non-compliant cases) to determine overall compliance. However, since the introduction of the new ePCR system from March 2022, the information consists of raw (unvalidated) data. **(See MA2)**

2.24 A review of the data contained in the CI reports noted that only the NOF and STEMI indicators report on pain scores (noting compliance is for one or more scores recorded) and compliance with administration of analgesia. As noted in objective 3, reports into compliance figures for other clinical codes are not currently undertaken. **(See MA2)**. There are no themes / trends reported either, however, we do acknowledge that the clinical team will be reviewing the format of reporting to ensure good clinical practice is captured and reported.

2.25 The Clinical Audit and Effectiveness department informed us that they undertake general pain score reviews within the Trust, however the last audit undertaken in the subject was a follow up review in 2019. There is the expectation that pain scores are recorded twice – pre and post analgesia; however management confirmed that if only one has been recorded, this will still be recorded as compliant. A review of the pain score compliance levels from this review highlighted a 83.9% compliance rate for one or more pain scores recorded, an increase on the 77% recorded in 2016, but still short of the 100% expected level..

2.26 The team have informed us that they are in the process of undertaking deep dives into the clinical indicators to ensure information coming through from the ePCR system is accurate. The team supplied us with reports on recently undertaken reviews into ePCR Clinical Data Assurance for NOF and STEMI, noting that there is a discrepancy between information manually reviewed to the raw data extracted from ePCR system. Due to these discrepancies, only STEMI compliance rates are reported to QuEST, with May's pain score compliance reported at 73%.

**Conclusion:**

2.27 Management information on the appropriate use and efficacy of pain management, reporting to the CIAG, is only in relation to STEMI and NOF. There is no other reporting to ensure the management of other clinical code areas is appropriate and compliant with guidance; and there is no analysis of

themes/trends included in the reports either. Therefore, we have determined **limited** assurance.

**Audit objective 5: There are appropriate governance and reporting arrangements in place.**

- 2.28 As per para 2.11 the Ambulance Practice Steering Group receives monthly Medicines Management Assurance reports for which the pain management focus is in relation to the compliance levels for the three EMS PGDs (see Objective 2). Review of the terms of reference for the Group confirms the reporting lines to the Quality Patient Experience & Safety (QuEST) Committee, via the Clinical and Quality Governance Group (CQGG).
- 2.29 As per para 2.17, the Clinical Intelligence Assurance Group receives monthly updates on the Trusts Clinical Indicators, highlighting the bundle compliance rates for five clinical codes. This includes pain scores and administration of analgesia for NOF & STEMI only, noting that only STEMI compliance rates are reported to QuEST currently due the discrepancy between information manually reviewed to the raw data extracted from ePCR system. Review of the terms of reference for this group confirms reporting into the QuEST Committee via the CQGG.
- 2.30 A review of the QuEST papers for 2022/23 failed to note any reporting on PGDs compliance rates. In respect of the Clinical Indicators, at the November 2022 meeting, it was reported that *'The Trust is unable to fully report on the performance of all clinical indicators whilst work continues to link ePCR with the CAD and quality assure metrics.'* However, it was noted that three of the four meetings did report on STEMI, Stroke and ROSC at Hospital care bundles compliance.
- 2.31 Review of the February 2023 meeting minutes noted that the proposed changes to the terms of reference for the Committee includes *'a quarterly 'spotlight' on clinical indicators via the CQGG to provide more focus on clinical care'*

**Conclusion:**

- 2.32 Ambulance Service Indicators and Medicine Management assurance reports are issued regularly to the CIAG and APSG respectively. Both groups have clear reporting lines to the QuEST Committee, via the Clinical Quality Governance Group, to escalate issues when required. However, it is noted that the Trust is currently reporting what they can to Committee with the caveat of the infancy of ePCR, but enhancement of assurance reporting in respect of pain management is required. **Reasonable** assurance, therefore, has been determined.

## Appendix A: Management Action Plan

### Matter arising 1: Patient Group Directions (Operation)

### Impact

The Trust currently reports on the compliance levels of three EMS Patient Group Directions on a regular basis; and it is noted that these are not administered as an analgesia. Based on Appendix 3 and 4 of the Medicines Management Policy, it was identified that the Trust have a further 19 PGDs in place relating to Advanced Paramedic Practitioners (APP), 3 PGDs relating to enhanced analgesia and 4 PGDs in place for Occupational Health staff.

Whilst review of compliance for these is undertaken by the Head of Medicines Management, there is no formal reporting of compliance levels with APP PGDs. At the date of reporting, compliance rates varied between 32% and 81% across the Trust, with 13 not achieving the 75% target (refer to Appendix C for full details of compliance rates across localities). It is also recognised that only four of the APP PGDs are for analgesia with one reaching the compliance level (Ibuprofen) and the remaining three (codeine-phosphate; diazepam and paracetamol) achieving a 52% compliance rate (which has increased to 62%, 62% and 54% respectively at the date of reporting)

Each PGD is given a three-year cycle for review. At present, 12 of the PGDs have surpassed their review date (7 APP PGDs, 3 enhanced analgesia PGDs and 2 EMS paramedic PGDs). Of these, two are in relation to analgesia – Ibuprofen: circa 12 months; and Ketamine, circa 3 months.

Potential risk of:

- Controlled drugs are not being managed / used safely resulting in patient harm

### Recommendations

### Priority

- 1.1 Whilst recognised not all PGD's are in relation to analgesia, the current data maintained for compliance for all, should be formally reported to an appropriate forum and action taken to address areas of non-compliance.
- 1.2 The Trust should ensure all PGDs follow the Medicines Management policy, with a review undertaken every three years as a minimum.

**High**

### Management response

### Target Date

### Responsible Officer

- 1.1 From the July reporting period, we will include compliance for 'Paramedic', 'Advanced Practice' and 'Enhanced Analgesia' PGDs in the monthly Medicines Management Assurance Report (MMAR). These reports are routinely shared with the Ambulance Practice Steering Group (APSG), Senior Operations Team (SOT) and highlights to CQGG via triple A (Advise/Assure/Alert) reports.

July 2023

Head of Medicines Management

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1.2	As an immediate action, with the support of our Pharmacist Advisor, we propose to 'extend' the current expiry dates of our out of date PGDs. This will be a limited time action to allow us time to catch-up with the backlog.	30 September 2023	Head of Medicines Management
	We will prepare and agree a prioritisation plan, to manage the expired status backlog which will be presented to APSG and through to CQGG.	30 September 2023	Head of Medicines Management
	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	30 March 2024	Assistant Director of Clinical Development

**Matter arising 2: Lack of oversight for pain scoring and administration of analgesia (Operation)****Impact**

To undertake sample testing during the review, to confirm completeness of pain score recording and effectiveness of analgesia administered, we requested the data for a number of clinical codes within the Trust. However, due to the infancy of the ePCR system management advised that it would be difficult to extract the required data in a timely manner. Noting that NOF and STEMI pathways are currently subject to regular reporting through the clinical indicators, this data had to be used. Data for children, however, was extracted for our use. This limitation to data reduced the scope of testing to be performed to assess the compliance with guidance for completion of the ePCR records and the recorded effectiveness of the pain relief administered.

It was also noted that the data extracted from ePCR is raw (unvalidated) data when, previously, the compliance data was determined manually from validated data.

There are no themes / trends reported either, however, we do acknowledge that the clinical team will be reviewing the format of reporting to ensure good clinical practice is captured and reported.

Potential risk of:

- Lack of oversight of incidents / issues relating to pain management within the Trust

**Recommendations****Priority**

- 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.

**High****Management response****Target Date****Responsible Officer**

- 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.

30 Dec 2023

Assistant Director of Clinical Development

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.

**Matter arising 3: Administration of Analgesia (Operation)****Impact**

From review of the ePCR records provided, we were unable to identify the Trust member administering the analgesia. Management advised that any Trust member can complete the form, even if their grade is below that required to administer the analgesia, with the assumption it would have been the most senior member of staff responsible for administering the analgesia.

However, in the event of any patient recourse, this does not provide the required assurances as to the qualifications / experience of the actual member of staff providing the pain relief.

Potential risk of:

- Controlled drugs are not being managed / used safely resulting in patient harm

**Recommendations****Priority**

- 3.1 The functionality of the ePCR system should be reviewed for the inclusion of a field to track the details of the member of staff who administered the analgesia to the patient.

**Medium****Management response****Target Date****Responsible Officer**

- 3.1 The ePCR team will prepare a change request specification and work with our TerraPACE suppliers, to enable the identification of clinicians who have administered analgesia before the end of Q2. The change request will be submitted to the ePCR Clinical Reference Group who report to the CQGG. Note that delivering any change to the ePCR will have a cost associated with it, meaning that it may not be able to be delivered in practice until the funds have been identified.

30 September 2023

Assistant Director of Clinical Development  
Health Board Clinical Lead (ePCR)

## Appendix B: Administration of Pain Management: results of testing

Audit ref	Callout category	Pain Score 1	Pain Score 2	Analgesia Administered	Pain levels reduced
1	Child	9	9	Entonox	X
2	Child	10	2	Entonox	✓
3	Child	Not taken – patient too young	N/A	Morphine Sulphate	Recorded that patient became more settled following analgesia
4	Child	9	9	Entonox	X
		9	Not taken	Paracetamol	Unknown
		9	Not taken	Ibuprofen <b>Note 1</b>	Unknown
5	Child	8	6	Paracetamol	✓
6	NOF	Not taken	Not taken	Paracetamol	Unknown
		9	8	Morphine Sulphate	✓
		8	5	Morphine Sulphate	✓
		5	4	Morphine Sulphate	✓
7	NOF	7	4	Paracetamol	✓
8	NOF	-	-	No analgesia administered <b>Note 2</b>	-
9	NOF	Not taken	Not taken	Paracetamol	Unknown
		Not taken	Not taken	Entonox	Unknown
		9	8	Morphine Sulphate	✓
		7	6	Morphine Sulphate	✓
		7	Not taken	Paracetamol	Unknown
10	NOF	10	10	Paracetamol	X
		10	7	Morphine Sulphate	✓

Audit ref	Callout category	Pain Score 1	Pain Score 2	Analgesia Administered	Pain levels reduced
11	STEMI	6	Not taken	Paracetamol	Unknown
12	STEMI	6	1	Morphine Sulphate	✓
13	STEMI	6	4	Paracetamol	✓
14	STEMI	Not taken	Not taken	Morphine Sulphate	Unknown
15	STEMI	-	-	No analgesia administered <b>Note 3</b>	-

**Note 1** Within our sample, this is the only analgesia that needs to be administered by an Advanced Paramedic Practitioner. From review of the ePCR form, we were unable to determine if this had been administered appropriately.

**Note 2** As per ePCR form, patient took own pain relief prior to paramedic's arrival, stated no pain on crews' arrival

**Note 3** As per ePCR form, patient stated they were not in pain, no analgesia administered

## Appendix C: Advanced Paramedic Practitioner PGD Compliance Rate

PGD	Central and West		South East		North		Total	
Amoxicillin	83.87%		4%		10.71%		<b>32.86%</b>	
Cetirizine Hydrochloride	100%		60.87%		82.14%		<b>81%</b>	
Clarithromycin	54.84%		34.78%		53.57%		<b>47.73%</b>	
Co-Amoxiclav	83.87%		0%		14.29%		<b>32.72%</b>	
Codeine Phosphate (A)	48.38%	50%	52.17%	78.95%	57.14%	58.33%	<b>52.56%</b>	<b>62.42%</b>
Diazepam (A)	45.16%	46.67%	56.52%	68.42%	57.14%	70.83%	<b>52.85%</b>	<b>61.97%</b>
Doxycycline	54.84%		30.43%		57.14%		<b>47.47%</b>	
Flucloxacillin	83.87%		0%		10.71%		<b>31.53%</b>	
Fluorescein Sodium 1%	100%		56.52%		85.71%		<b>80.74%</b>	
Ibuprofen (A)	96.77%	96.67%	47.83%	78.95%	82.14%	83.33%	<b>75.58%</b>	<b>86.31%</b>
Loperamide Hydrochloride	100%		52.17%		85.71%		<b>77.85%</b>	
Nitrofurantoin	54.84%		30.43%		50%		<b>45.09%</b>	
Oral Rehydration Salts	100%		47.83%		82.14%		<b>76.66%</b>	
Paracetamol (A)	45.16%	46.67%	56.52%	47.37%	57.14%	66.67%	<b>52.94%</b>	<b>53.57%</b>
Penicillin 'V	83.87%		0%		7.14%		<b>30.34%</b>	
Prednisolone	100%		52.17%		85.71%		<b>79.29%</b>	
Prochlorperazine	100%		52.17%		82.14%		<b>78.10%</b>	
Tetracaine Hydrochloride	45.16%		39.13%		50%		<b>44.76%</b>	
Trimethoprim	54.84%		30.43%		57.14%		<b>29.52%</b>	
Salbutamol MDI	100%		34.78%		60.71%		<b>65.16%</b>	

A: PGD is in respect of an analgesia and additional information has been provided regarding compliance rates both at the date of fieldwork (May 2023); and at the date of reporting (June 2023).

## Appendix D: 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:

	<p><b>Substantial assurance</b></p>	<p>Few matters require attention and are compliance or advisory in nature.  <b>Low impact</b> on residual risk exposure.</p>
	<p><b>Reasonable assurance</b></p>	<p>Some matters require management attention in control design or compliance.  <b>Low to moderate impact</b> on residual risk exposure until resolved.</p>
	<p><b>Limited assurance</b></p>	<p>More significant matters require management attention.  <b>Moderate impact</b> on residual risk exposure until resolved.</p>
	<p><b>No assurance</b></p>	<p>Action is required to address the whole control framework in this area.  <b>High impact</b> on residual risk exposure until resolved.</p>
	<p><b>Assurance not applicable</b></p>	<p>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.</p>

### 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.



NHS Wales Shared Services Partnership  
4-5 Charnwood Court  
Heol Billingsley  
Parc Nantgarw  
Cardiff  
CF15 7QZ

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)



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

<b>AGENDA ITEM No</b>	<b>13</b>
<b>OPEN or CLOSED</b>	<b>OPEN</b>
<b>No of ANNEXES ATTACHED</b>	<b>2</b>

**HEALTH INSPECTORATE WALES (HIW) REPORT: PATIENT SAFETY, PRIVACY,  
DIGNITY AND EXPERIENCE WHILST WAITING IN AMBULANCES DURING  
DELAYED HANDOVER (2021)  
STAGE ONE CLOSURE REPORT**

<b>MEETING</b>	Quality, Patient Experience & Safety Committee
<b>DATE</b>	10 August 2023
<b>EXECUTIVE</b>	Liam Williams, Executive Director of Quality and Nursing
<b>AUTHOR</b>	Caroline Miftari, Head of Quality Assurance
<b>CONTACT</b>	07970 406447 <a href="mailto:Caroline.miftari@wales.nhs.uk">Caroline.miftari@wales.nhs.uk</a>

**EXECUTIVE SUMMARY**

1. The HIW Review: Patient Safety, Privacy, Dignity and Experience whilst waiting in ambulances during delayed handover (2021) set out specifically to consider what the impact of ambulance waits outside of Emergency Departments is having on the overall experience of patients, which included their safety, care, privacy and dignity during the period between 1 April 2020 and 31 March 2021.
2. The focus of review was patient safety, privacy, dignity and how the overall experience was managed by the Welsh Ambulance Services NHS Trust (WAST) ambulance crews and Health Board Emergency Department (ED) staff.
3. The review identified that the issue of prolonged handover delays is a regular occurrence outside ED across Wales. Whilst patients were positive about their experience with ambulance crews, it was clear that handover delays are having a detrimental impact upon the ability of the healthcare system to provide responsive, safe, effective and dignified care to patients.
4. The report sets out HIW findings and recommendations for improvement, with an expectation that recommendations are considered at a system level and are taken forward in the context of broader improvement work underway to tackle the challenges faced in this area over recent years.

5. The HIW Review outlined 20 recommendations of which recommendation 8 was not accepted by the Trust. HIW approved the Trust Action Plan and management response in February 2022.
6. An Emergency Ambulance Services Committee (EASC) Task and Finish Group was established in response to the HIW Review at the request of the EASC Management Group. The Group included representatives from Health Boards, WAST and chaired by the National Collaborative Commissioning Unit (NCCU). The Trust were represented by the Assistant Director of Quality and Nursing, Assistant Director of Quality and Safety (Interim), Director of Operations and the Assistant Director of Clinical Development.
7. In addition to the EASC Task and Finish Group the Assistant Director of Planning and Performance provided regular progress updates to Chief Ambulance Service Commissioner (CASC) against the Trust Action Plan.
8. The NCCU Team met with key members of the Trust to discuss progress outside of the Task and Finish Group. All responses to HIW regarding the recommendations and progress were submitted by the Deputy Chief Ambulance Services Commissioner.
9. On 22 December 2022, HIW confirmed to the Deputy Chief Ambulance Services Commissioner that the Action Plan and supporting information submitted on 30 September and 16 November 2022 provided the improvements HIW identified as having either been addressed and/or progress is being made to ensure that patient safety is maintained and improved as part of HIW's stage one reviews follow-up process. This concluded that sufficient assurance in response to the findings identified within the review report for WAST had been received and this paper is the final element of the assurance process.
10. The NCCU have outlined that they anticipate HIW requesting a further update on the current situation relating to patient safety, privacy, dignity and experience whilst waiting in ambulances during delayed handover in the next few weeks. On receipt of the request from HIW, NCCU will write to the Trust to initiate stage two reviews.

**RECOMMENDED that the Quality, Patient Experience & Safety Committee notes the report and confirms agreement with the assurance provided and closure of the action plan.**

## KEY ISSUES/IMPLICATIONS

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<b>REPORT APPROVAL ROUTE</b>	
Clinical Quality Governance Group	24 July 2023
Quality, Patient Experience & Safety Committee	10 August 2023

<b>REPORT APPENDICES</b>
<p><b>ANNEX 1</b> - SBAR Report concludes the Trust stage one response to the HIW Report Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover (2021)</p> <p><b>APPENDIX 1</b> - Trust Action Plan: HIW Report Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover (2021) which provides supporting information and background.</p>

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

### SITUATION

1. The report concludes the Trust stage one response to the HIW Report: Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover (2021)

### BACKGROUND

2. Health Inspectorate Wales (HIW) committed to undertake a local review of the Welsh Ambulance Services NHS Trust (WAST) due to concerns identified with long handover delays during a previous WAST local review carried out in 2019-20, where HIW explored how the risks to patients' health, safety and well-being were being managed, whilst they were waiting for an ambulance to arrive.
3. The review set out specifically to consider what the impact of ambulance waits outside of Emergency Departments is having on the overall experience of patients, which included their safety, care, privacy and dignity during the period between 1 April 2020 and 31 March 2021.
4. The focus of review was patient safety, privacy, dignity and how the overall experience was managed by WAST ambulance crews and Health Board Emergency Department (ED) staff, whilst they waited on-board ambulances during delayed handover to ED staff. To achieve this, five areas were explored:
  - Patient handover - to consider the procedures in place between the WAST and each acute hospital ED for accepting patients from ambulances into the care of Health Board staff.
  - Patient experience - to assess the overall experience of patients whilst waiting in an ambulance to include their safety, care and any impact on their wellbeing. We also considered how patient dignity is maintained and needs are met, to include nutritional, hydration and toilet needs.
  - Workforce - to consider the impact of handover delays on ambulance crew to include their welfare and support.
  - Escalation processes - to consider the risk management and escalation arrangements of WAST during periods of high pressure as a result of delayed handovers.

- Governance arrangements - to consider incident reporting, investigation of incidents of patient harm due to delayed handovers and learning from incidents.

## **ASSESSMENT**

5. The HIW Review sets out its findings and recommendations for improvement, with an expectation that recommendations are considered at a system level and are taken forward in the context of broader improvement work underway to tackle the challenges faced in this area over recent years.
6. The Review identified that the issue of prolonged handover delays is a regular occurrence outside EDs across Wales. Whilst patients were positive about their experience with ambulance crews, it is clear that handover delays are having a detrimental impact upon the ability of the healthcare system to provide responsive, safe, effective and dignified care to patients.
7. Whilst there are clear expectations and guidance for NHS Wales in relation to hospital handovers, and a clear and apparent will to meet and achieve these, there are substantial challenges inhibiting the ability of the NHS in Wales to do so.
8. The problem of delayed handovers is symptomatic of the wider issue of patient flow throughout the NHS, with consequent increased risks to patients associated with prolonged waits on ambulance vehicles outside EDs, impacting the ability of WAST to coordinate responses for patients waiting in the community for an ambulance.
9. The review has noted that whilst work is ongoing to try and tackle this issue, with various approaches and initiatives in progress at a national level, such as the development of a National Quality and Delivery Framework for Emergency Departments in Wales, which commenced in 2018, it is unclear how effective these activities have been to date.
10. This is not a problem that WAST can resolve by itself, it is a challenge that requires WAST, Health Boards, and Welsh Government to work together and consider whether a different approach is required to ensure reinvigorated, strengthened and concerted action is taken to make sure that these issues are overcome.
11. Patients were generally positive about their experiences and provided good feedback about ambulance crews, particularly in relation to their kindness, overall communication and management of distressing situations. Patients reported that they were treated with dignity and respect by ambulance crews and felt safe and

cared for. Patients also indicated that they were satisfied with the care and treatment from ED staff.

12. Overall, HIW findings indicate that the severe impact of the pandemic did not negatively affect the experience of patients who used Emergency Ambulances Services across Wales, and that on the whole patients were satisfied with the care provided.
13. Whilst patient feedback has been positive, this should not detract from the issues associated with delayed handover. It is clear that there are genuine frustrations held by WAST and Health Board staff regarding their inability to effectively carry out their roles as a consequence of this issue.
14. The positive experiences shared by patients should also not detract from areas of concern regarding patient care, including the difficulties in facilitating patients to access a toilet during their wait, the risk to patients of sustaining skin tissue pressure damage, and the problems faced in providing them with food and drink. In addition, a number of staff raised concerns about their ability to appropriately achieve and appropriately maintain high standards of hygiene and infection, prevention and control measures on board the ambulance.

## **RECOMMENDATIONS**

15. The HIW Review outlined 20 recommendations of which recommendation 8 was not accepted by the Trust. HIW approved the Trust Action Plan and management response February 2022 (**Appendix 1**).
16. The recommendations and relationship to WAST and Health Boards is outlined below:
  - Recommendation 3 related to Health Boards
  - Recommendations (2, 4, 5, 6, 7, 14) joint actions between the Health Boards and WAST
  - Recommendations (15, 16, 18, 19 & 20) WAST actions
17. An Emergency Ambulance Services Committee (EASC) Task and Finish Group was established in response to the HIW Review at the request of the EASC Management Group. The Group included representatives from Health Boards, WAST and chaired by the National Collaborative Commissioning Unit (NCCU). The Trust were represented by Assistant Director of Quality and Nursing, Assistant Director of Quality and Safety (Interim), Director of Operations and the Assistant Director of Clinical Development.

18. The Assistant Director of Planning and Performance provided regular progress updates to Chief Ambulance Service Commissioner (CASC) against the Trust Action Plan.
19. The National Collaborative Commissioning Unit Team met with key members of the Trust to discuss progress outside of the Task and Finish Group. All responses to HIW regarding the recommendations were submitted by the Deputy Chief Ambulance Services Commissioner.

## **CONCLUSION**

20. On 22 December 2022 HIW confirmed to the Deputy Chief Ambulance Services Commissioner that the Action Plan and supporting information submitted on 30 September and 16 November 2022 provided the improvements HIW identified as having either been addressed and/or progress is being made to ensure that patient safety is maintained and improved as part of HIWs stage one reviews follow-up process. This concluded that sufficient assurance in response to the findings identified within the review report for WAST had been received.
21. The NCCU have outlined that they anticipate HIW requesting a further update on the current situation relating to patient safety, privacy, dignity and experience whilst waiting in ambulances during delayed handover in the next few weeks. On receipt of the request from HIW, NCCU will write to the Trust to initiate stage two reviews.

# Appendix 1

## Action Plan 2021/22

Ref	HIW Recommendation	WAST Management Action Response	Timescales	whom	Action Status
1	Health boards, and Welsh Government should consider what further actions are required to make improvements regarding the patient flow issues impacting on delayed patient handover. This may include consideration of whether a different approach is required by WAST, health boards, and social care services within Wales, to that taken to date in tackling this system-wide problem.	WAST welcome any opportunity to work with Health Boards and Welsh Government to improve patient flow and will respond positively to any request to do so.	N/A	N/A (Health Boards/ WG action)	N/A
2.	WAST should engage with health board representatives to ensure there is improvement in practice between ambulance crew and emergency department staff to ensure the dual pin process is consistently followed, and ensure Welsh Government reporting data is accurate.	The Trust recognise the importance of an effective hospital handover in ensuring reporting data is accurate. The Trust will review the current dual PIN handover process, seeking to identify inconsistent practices across Health Boards. The Trust will explore alternative approaches, including opportunities arising from the commencement of the electronic patient care record (ePCR). A Trust wide standard operating procedure will be developed, articulating the standard expects of staff involved in a handover process.	Q1 2022/23	Sonia Thompson: Assistant Director - EMS	Complete  Discussed at; Emergency Ambulance Services Committee EASC Management Group Healthcare Inspectorate Wales (HIW) Task & Finish Group
3.	Health boards should consider the benefits of the introduction of specific roles within their EDs that have the aim of improving process of the handover of patients from ambulances.	The Trust welcome Health Board consideration on this matter. We recognise the importance of systems thinking on this issue and seek to support Health Boards in the development of roles that support patients and staff at the interface of our organisations. This will assist the	N/A	N/A (Health Boards)	N/A

		ensure consistency and equality in experience of care during handover across Health Boards			
4.	Health boards must ensure that appropriate representation is present at WAST Serious Clinical Incident Forum meetings, to aid with the timely management of concerns and service improvement.	<p>The Trust's Head of Patient Safety, Concerns and Learning will liaise with all Health Boards and Velindre NHS Trust to review and update the key roles and names of key people in Health Boards that will be single points of access for WAST. This will ensure that there is clarity of who to contact within organisations, and that there is appropriate and consistent attendance from Health Boards at meetings related to patient safety, concerns and learning, including the Serious Case Incident Forums (SCIF).</p> <p>Whilst the Trust welcome attendance from Health Boards at SCIF, in some circumstances the practicalities of doing so must be recognised. Occasionally, the Trust may convene an additional SCIF at short notice when it is assessed as necessary. It should also be recognised that cases are discussed from across Wales and not limited to individual Health Board areas. The Trust will engage and propose that all Health Boards commit to regular monthly meetings with the Trust Patient Safety Team to review cases; whilst this currently happens in some Health Boards, this is not standardised across all Health Boards.</p>	Q3 2021/22	Wendy Hebert Assistant Director of Quality Nursing and Patient Experience (WAST)	<b>Complete</b>  <b>Discussed at;</b> <b>Emergency Ambulance Services Committee</b> <b>EASC Management Group</b> <b>Healthcare Inspectorate Wales (HIW) Task &amp; Finish Group</b>
5.	If and where local standard operating procedures are absolutely necessary, WAST and health boards must together ensure that ambulance crew are familiar with the handover policy for that ED.	<p>The Trust support a national, standardised approach for hospital handover; local standard operating procedures should be utilised only where a local factor has been identified, clearly defined, and communicated effectively across the system.</p> <p>The national adoption of a standardised method of handover will</p>	Q2 2021/22	Jonathan Turnbull-Ross: Assistant Director of Quality Governance	<b>Complete</b>  <b>Discussed at;</b> <b>Emergency Ambulance Services Committee</b> <b>EASC Management Group</b>

		ensure consistency. The Trust propose adopting a standard SBAR handover approach and accompanying tools, that enable effective, un-interrupted patient handovers. The Trust are willing to develop and lead on this work in partnership with Health Boards.			<b>Healthcare Inspectorate Wales (HIW) Task &amp; Finish Group</b>
6.	<p>WAST and health boards need to ensure that when delays occur, patients and their relatives or carers should be kept fully informed of the reasons and the progress being made in resolving them.</p> <p><i>'How are WAST and HBs 'currently making sure' that a patient (+/- relative) on board ambulance is being updated during lengthy handover delays? How do WAST and HBs plan to work collaboratively to ensure a consistent approach to improve communication methods (to patient on board)'</i></p>	All Trust staff will be reminded that any patient delayed in an ambulance at ED must have a Nurse assessment every 30 minutes (fundamentals of care assessment: previously agreed at the all Wales Executive Director of Nursing Peer Group) and regular medical assessments. Trust staff will be reminded and encouraged to ensure that both the patient and the family is informed of the reason for the delay and updated on progress to resolve the situation.	Q3 2021/22	Wendy Herbert: Assistant Director of Quality and Nursing.	<b>Complete</b>  <b>Discussed at; Emergency Ambulance Services Committee EASC Management Group Healthcare Inspectorate Wales (HIW) Task &amp; Finish Group</b>
7.	WAST and health boards across Wales should ensure patient feedback is obtained regularly to understand their experiences of long waits on board an ambulance, in order to inform improvement.	The Trust operates a continuous engagement model with patients, families and communities. To date, we have frequently captured patient stories on the effect of handover delay on patients, which have been shared within the Trust and with Health Board partners. We will continue to capture such patient feedback and stories, seeking to influence improvement efforts from system partners, in relation to hospital handover delays. The Health Board Reports provided by WAST contain patient feedback and are developed on a monthly basis. The Patient Experience and Community	Q3 2021/22	Wendy Herbert: Assistant Director of Quality and Nursing	<b>Complete</b>  <b>Discussed at; Emergency Ambulance Services Committee EASC Management Group Healthcare Inspectorate Wales (HIW) Task &amp; Finish Group</b>

		Involvement Team continue to produce a quarterly report which details patient feedback and engagement activities.			
8.	WAST and all health boards across Wales must work together to identify a consistent approach in providing timely investigations and treatment for patients on board ambulances, to enable ambulance crews to be released quickly.	<p>WAST do not accept this recommendation as it renders the ambulance unavailable for patients waiting in the community, leading to significant concerns for those patient's safety and experience.</p> <p>The primary aim must be to admit the patient to the Emergency Department, which is a suitable environment for those investigations and treatments pertinent to Secondary Care. The Trust continue to advocate that an ambulance is not a suitable environment of care consistent with dignity and privacy and therefore, the focus for improvement must be that timely handovers of care are expedited. An ambulance vehicle is not designed for prolonged occupancy, is not conducive to positive patient and staff wellbeing/experience.</p> <p>Delayed release of ambulance crews from hospitals due to handover delays is increasing clinical safety risks, and actual patient harm, to patients awaiting an emergency ambulance response in the community.</p>		Not applicable: recommendation not accepted.	<b>Complete</b> <b>Discussed at;</b> <b>Emergency Ambulance Services Committee</b> <b>EASC</b> <b>Management Group</b> <b>Healthcare Inspectorate Wales (HIW)</b> <b>Task &amp; Finish Group</b>
9.	Both WAST and health boards must ensure that ambulance crew and ED staff work collaboratively to ensure patient privacy and dignity is maintained, and patients are always provided with the opportunity to use private toilet facilities where appropriate, in a	<p>All Trust staff will be reminded that any patient delayed in an ambulance at ED must have a Nurse assessment every 30 minutes (fundamentals of care assessment: previously agreed at the all Wales Executive Director of Nursing Peer Group).</p> <p>The Trust continue to advocate that an ambulance is not a suitable environment of care consistent with dignity and privacy and therefore, the focus for improvement must be that</p>	Q3 2021/22	Wendy Herbert: Assistant Director of Quality and Nursing	<b>Complete</b> <b>Discussed at;</b> <b>Emergency Ambulance Services Committee</b> <b>EASC</b> <b>Management Group</b> <b>Healthcare Inspectorate Wales (HIW)</b>

	dignified manner whilst waiting on board an ambulance during delayed handovers.	timely handovers of care are expedited.			<b>Task &amp; Finish Group</b>
<b>10.</b>	During prolonged handover delays, WAST and health boards must work collaboratively and consistently, to minimise the risk of skin tissue damage for patients.	<p>All Trust staff will be reminded that any patient delayed in an ambulance at ED must have a Nurse assessment every 30 minutes (fundamentals of care assessment: previously agreed at the all Wales Executive Director of Nursing Peer Group). This assessment should include a risk assessment of skin tissue damage. Any patient at high risk of skin pressure damage should have access to a suitable environment within the hospital expedited.</p> <p>The Trust continue to advocate that an ambulance is not a suitable environment for prolonged episodes of care, particularly in regard to caring for patient skin tissue where access to specialist equipment is required. Therefore, the focus for improvement must be that timely handovers of care are expedited.</p>	Q3 2021/22	Wendy Herbert: Assistant Director of Quality and Nursing	<b>Complete</b> <b>Internal to WAST</b>
<b>11</b>	WAST should work with health boards to ensure that patients nutritional and hydration needs are consistently met whilst waiting in the back of an ambulance due to delayed handovers.	<p>All Trust staff will be reminded that any patient delayed in an ambulance at ED must have a Nurse assessment every 30 minutes (fundamentals of care assessment: previously agreed at the all Wales Executive Director of Nursing Peer Group). This should include a Nutrition and hydration assessment.</p> <p>The Trust continue to advocate that an ambulance is not a suitable environment for prolonged care of patients' nutritional and hydration needs. Therefore, the focus for improvement must be that timely handovers of care are expedited.</p>	Q3 2021/22	Wendy Herbert: Assistant Director of Quality and Nursing	<b>Complete</b> <b>Discussed at; Emergency Ambulance Services Committee EASC Management Group Healthcare Inspectorate Wales (HIW) Task &amp; Finish Group</b>
<b>12</b>	WAST should consider how ambulance crew and patients can be	All Trust staff will be reminded that any patient delayed in an ambulance at ED must have a Nurse assessment every	Q3 2021/22	Jonathan Turnbull-Ross:	<b>Complete</b> <b>Discussed at;</b>

	supported to achieve and maintain high standards of hygiene and IPC, in particular during periods of delayed handovers for patients on board an ambulance.	<p>30 minutes (fundamentals of care assessment) This should include an opportunity for an IPC assessment of the patient.</p> <p>Trust staff undertake IPC education updates and the importance of hand washing is a key message. As there are no hand washing facilities on board an ambulance, the Trust will continue to advocate that an ambulance is not a suitable environment of care consistent with prolonged periods of care. Therefore, the focus for improvement must be that timely handovers of care are expedited.</p>		Assistant Director Quality Governance	<b>Emergency Ambulance Services Committee</b> <b>EASC Management Group</b> <b>Healthcare Inspectorate Wales (HIW) Task &amp; Finish Group</b>
13.	WAST and health boards must ensure there is absolute clarity, consistency and understanding between both ambulance crew and ED staff, as to where the responsibility and accountability lies for patient care on board an ambulance following triage, until transferred into the ED.	<p>All Trust staff will be reminded that the responsibility and accountability for a patient delayed in an ambulance at ED lies with the Health Board, hence patients must have a Nurse assessment every 30 minutes (fundamentals of care assessment: previously agreed at the all Wales Executive Director of Nursing Peer Group) and regular medical assessments.</p> <p>Trust Staff will be reminded of the importance of their role in advocating for the needs of their patient and escalating clinical concerns to Health Board staff, in line with the expectations of the Trust, moral obligation and professional registrant requirements (Health and Care Professions Council (HCPC) Standards of conduct, performance and ethics) where applicable. Trust staff have an obligation to provide care to patients within the scope of their practice, training, and provision of equipment. Specifically, the HCPC state “You must keep within your scope of practice by only practising in the areas you have</p>	Q3 2021/22	Andy Swinburn: Associate Director of Paramedicin e	<b>Complete</b> <b>Discussed at; Emergency Ambulance Services Committee</b> <b>EASC Management Group</b> <b>Healthcare Inspectorate Wales (HIW) Task &amp; Finish Group</b>

		<p>appropriate knowledge, skills and experience for”.</p> <p>Our clinical workforce are predominantly out of hospital clinicians with limited capability to provide care akin to Secondary Care over prolonged period of time; this falls outside of the scope of practice for Paramedics, Emergency Medical Technicians, and Urgent Care Service staff. Trust staff must escalate concerns to Health Board staff to promote safe and positive experience of care.</p>			
14.	<p>WAST and health boards must review and continuously monitor their staff establishments, in order to ensure appropriate levels of staff are maintained at all times.</p>	<p>The Trust’s demand and capacity review from 2019 has informed our staff establishment and we are currently re-visiting that review. Additionally, the Trust is currently developing utilisation reporting to enhance information and intelligence.</p> <p>On a monthly frequency, a workforce paper is reviewed at the Trust’s Senior Operational Team meeting to track the establishment matters. In addition to this, the Trust Emergency Medical Services Operational Transformation Programme Board is currently scrutinising establishment and developing the plans against the demand and capacity review.</p> <p>The Trusts continued efforts against establishment review activity is such that this recommendation for should be considered complete.</p>		<p>Lee Brooks: Director of Operations</p>	<p><b>Complete</b></p> <p><b>Discussed at;</b> <b>Emergency Ambulance Services Committee</b> <b>EASC Management Group</b> <b>Healthcare Inspectorate Wales (HIW) Task &amp; Finish Group</b></p>
15	<p>WAST should consider how initiatives already introduced can be made consistently available to all ambulance crew across Wales. In addition, consideration should be given to how</p>	<p>The Trust pro-actively plan in developing and deploying initiatives to support staff and patients during periods of high demand that exacerbate unacceptable, prolonged hospital handover delays. The general intent is for initiatives to reach all staff;</p>	<p>Q3 2021/22</p>	<p>Sonia Thompson: Assistant Director - EMS</p>	<p><b>Complete</b></p> <p><b>Discussed at;</b> <b>Emergency Ambulance Services Committee</b></p>

	the welfare and support available to ambulance crews can be further improved	<p>the Trust to commit to seek deployment of initiatives across Wales.</p> <p>The Trust continue to advocate that an ambulance handover delays are an unacceptable practice. Whilst the Trust commits to undertaking initiatives to support the health and wellbeing of staff and patients, the focus for improvement must be that timely handovers of care are expedited.</p>			<b>EASC Management Group Healthcare Inspectorate Wales (HIW) Task &amp; Finish Group</b>
<b>16.</b>	WAST must ensure that the support for staff mental well-being is consistent across Wales, and that staff are routinely referred when appropriate and aware of how to access support if required.	<p>The Trust have a number of support mechanisms in place currently, with further initiatives planned. For this winter pool cars to assist staff during end of shift changeover, our hospital concession scheme will enable staff to have access to food and beverages, as well as the provision of welfare vehicles (and access to facilities inside the hospital) at sites where staff are delayed at handover. Furthermore, the Trust provides all staff support through the Employee Assistance Programme, and offer traumatic incident management and support through our TRiM programme.</p> <p>The Trust is particularly concerned about the need to reduce moral injury through a reduction in the time staff spent feeling a sense of helplessness through being delayed at hospitals rather than responding in the community. Addressing the core issue of ambulance handover delays and enabling our staff to undertake the role they are trained for is a pivotal improvement required to ensure the well-being of our staff.</p>	Q3 2021/22	Claire Vaughan, Executive Director of Workforce and OD	<b>Complete</b> <b>Discussed at; Emergency Ambulance Services Committee</b> <b>EASC Management Group Healthcare Inspectorate Wales (HIW) Task &amp; Finish Group</b>
<b>17.</b>	WAST should ensure that appropriate training is provided to ambulance crew in providing care to patients on board an ambulance, during	Paramedic, EMT and UCS scope of practice is clearly defined and the training requirements are appropriate and relevant to the scope of practice. Paramedic pre-registration courses are intended for out of hospital care and		N/A	

	prolonged periods of handover delays.	therefore the fundamentals of care education provided in a pre-registration Nursing degree are not included. Likewise, EMTs and UCS will not have these skills as both receive short vocational courses (12 weeks and 4 weeks respectively) In order to do this, significant changes would need to take place in curriculums and this would fundamentally shift the scope of practice. The HCPC Standards of conduct, performance and ethics (item 3.1) states “you must keep within your scope of practice by only practising in the areas you have appropriate knowledge, skills and experience for.” The Trust does not accept this recommendation and will continue to advocate that an ambulance is not a suitable environment of care consistent with dignity and privacy. Therefore, the focus for improvement must be that timely handovers of care are expedited.			
18.	WAST must ensure all relevant staff are fully aware of the escalation process in place should a patient’s health deteriorate, in order to minimise risks to patient safety.	The Trust has a clinical escalation standard operating procedure (SOP) in place.  The Trust will commit to communicating and promoting awareness of the SOP.	Q3 2021/22	Duncan Robertson, Interim Assistant Director of Research, Audit and Service Improvement	<b>Complete Discussed at; Emergency Ambulance Services Committee EASC Management Group Healthcare Inspectorate Wales (HIW) Task &amp; Finish Group</b>
19	WAST must provide HIW with evidence of its assessment of the effectiveness of the escalation process.	The Trust will provide evidence of the SOP and provide information relating to its use. Furthermore, the Trust will explore how such activity is captured and reported through the introduction of the ePCR.	Q4 2021/22	Duncan Robertson, Interim Assistant Director	<b>Complete Discussed at; Emergency Ambulance Services Committee EASC Management Group</b>

					<b>Healthcare Inspectorate Wales (HIW) Task &amp; Finish Group</b>
<b>20.</b>	WAST must do more to ensure that its staff feel able to, and are confident in raising concerns. It must also ensure that robust processes are in place to share the learning with staff following incident investigations, in order to improve quality and safety of patient care.	The Trust has established the role of the Senior Paramedic and Duty Operational Manager. There has been significant investment in strengthening front-line supervision. These roles will be the conduit through which dissemination of learning will be shared and a culture of candour and learning is facilitated.	Q2 2022/23	Andy Swinburn, Associate Director of Paramedicin e	<b>Complete</b>  <b>Discussed at;</b> <b>Emergency Ambulance Services Committee</b> <b>EASC Management Group</b> <b>Healthcare Inspectorate Wales (HIW) Task &amp; Finish Group</b>



GIG  
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NHS  
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Gwasanaethau Ambwlans Cymru  
Welsh Ambulance Services  
NHS Trust

<b>AGENDA ITEM No</b>	13.2
<b>OPEN or CLOSED</b>	
<b>No of ANNEXES ATTACHED</b>	1

**Health Inspectorate Wales (HIW)  
Emergency Medical Services Clinical  
Contact Centre (EMSCCC) Patient  
Safety Review**

<b>MEETING</b>	Quality, Patient Experience and Safety Committee
<b>DATE</b>	10 August 2023
<b>EXECUTIVE</b>	Lee Brooks, Executive Director of Operations
<b>AUTHOR</b>	Alessandro Di Ronato – Operations Business Manager
<b>CONTACT DETAILS</b>	Alessandro.DiRonato2@wales.nhs.uk

<b>EXECUTIVE SUMMARY</b>
<p>1. The purpose of the report is to provide a summary and overview of the progress made on the actions agreed in response to HIW EMSCCC Patient Safety Review.</p> <p>2. A summary of the key findings are contained in the report.</p> <p><b>RECOMMENDATION:</b></p> <p>1. <b>The Committee note the update provided and agree to the status update of the actions detailed in this paper and in the appended tracker.</b></p> <p>2. <b>The Committee notes actions 12.1 and 21.1 are overdue however work continues toward completion.</b></p>

**REPORT APPROVAL ROUTE**

<b>WHERE</b>	<b>WHEN</b>	<b>WHY</b>
<b>SLT</b>	<b>11/07/2023</b>	<b>Noting</b>
<b>EMT</b>	<b>26/07/2023</b>	<b>Noting</b>
<b>QuEst</b>	<b>10/08/23</b>	<b>Noting</b>

## **SITUATION**

1. Following concerns raised regarding the potential impacts of extended and deteriorating handover times at emergency departments across Wales, a review by Health Inspectorate Wales (HIW) was undertaken during Q3 & Q4 of 2019/20.
2. An action plan update was presented to Executive Management Team (EMT) on the 03/08/22 and Quality Patient Experience and Safety Committee (QuEST) on 11/08/22.
3. The purpose of this paper is to provide a summary and overview of the progress made against the action plan since the last update.

## **BACKGROUND**

4. The principal objective of the review was to assess how patients are managed by EMS Coordination (EMSC) encompassing the period from the time the call is received through to an operational response arriving with the patient.
5. As a secondary objective the review considered how staff working in EMSC are resourced and supported.
6. HIW conducted the field work between November 2019 and January 2020 using a mixed methods approach including staff surveys, document reviews and semi-structure interviews.
7. The key findings of the review were:
  - i. The review found a 'strong team ethos' through the EMSC despite often having to work in challenging circumstances relating to limited resources.
  - ii. Pressures arising from lost hours at hospital as a consequence of delayed handovers of care at Emergency Departments was a consistent and 'significant' theme which was driving the negative staff and patient experiences.
  - iii. Management, leadership and accountability structures are clear however the review found that more could be done to increase the visibility of this leadership.
  - iv. The review found that sound risk management processes were in place although opportunities for improvement were identified.

- v. Further organisational focus is required to ensure that EMSC have the correct resources, training, and development.

**ASSESSMENT**

- 8. The action plan contained 44 actions, 8 of which were deemed complete prior to the publication of the action plan based on developmental and improvement work already undertaken.
- 9. 18 have actions against them which are predominantly for EMS Coordination but also include support/lead from other areas namely, People and Culture and Clinical Directorates.
- 10. An update was requested by HIW in Q2 2022 which involved submission of an updated response including the updated action plan.
- 11. The table below sets out the status of recommendations by quarter & financial year at the time of preparing this paper.

	<b>Year (19/20)</b>	<b>Year (20/21)</b>	<b>Quarter 1 (21/22)</b>	<b>Quarter 2 (21/22)</b>	<b>Quarter 3 (21/22)</b>	<b>Quarter 4 (21/22)</b>
<b>Actions Due</b>	7	30	4	1	0	2
<b>Complete (Nov 21)</b>	7	25	3	0	n/a	0
<b>Complete (Jun 22)</b>	7	27	3	0	n/a	1
<b>% Complete (Aug 23)</b>	100%	93%	100%	100%	n/a	50%
<b>Outstanding</b>	0	1	0	0	0	1

- 12. Since the last update to QuEST the following actions have been complete:

<b>Action</b>
<b>Action 18.1</b> Work with DCMs to ensure existing time for protected appraisal discussions is utilised effectively and scheduled in advance or look for a more appropriate way that appraisals can be carried out.
<b>Action 19.2</b> Workforce & Organisational Development team to assess the training needs of first line managers within EMSC to support their delivery of effective and meaningful PADRs
<b>Action 21.2</b> Complete the return to the workplace review to ensure the maximum space is still provided in the medium term for clinicians to work remotely from the EMSCCC main spaces.
<b>Action 17.3</b> continue to engage with HEIW to develop an accredited programme of education focussed on clinical and non-clinical remote decision making

**Action 19.1** Develop and trial an EMS CCC specific appraisal process to ensure that staff receive the appropriate developmental discussion

13. The two outstanding actions continue to be reviewed and assessed. Outlined below are the two remaining actions:

14. The outstanding action from the 2020/21 is:

<b>Action</b>	<b>Progress &amp; Anticipated Completion</b>
<b>Action 21.1:</b> Complete the North Wales EMS CCC estate strategy and identify opportunities for improvements.	Some discretionary capital funding for this financial year has been allocated to support progress in this area. It should be noted that WAST has completed and rolled out the estate's strategy in VPH with a view to progress plans with Dyfed Powys Police for Llangunmor now to progress with the redevelopment of the ground floor. This is at design stage currently, but funding has been allocated from this year's discretionary capital budget to support this.

15. The outstanding action from the 2021/22 is:

<b>Action</b>	<b>Progress &amp; Anticipated Completion</b>
<b>Action 12.1</b> Continue with the work of the CAD Phase 3 project to realign workloads within the EMSCCC for more efficient operation.	The EMS Configuration Programme recommenced in Q1 2023 following being paused due to Industrial Action and Operational Pressures. Roster Review of call takers is complete. The realignment of boundaries aspect of this work, which provides the necessary re-alignment of workloads, has commenced and engagement with staff had taken place prior to the pause. This work has re-commenced and is currently waiting on a refresh of the data to finalise discussions with staff and Trade Union Partners.

16. Action 21.1 - The project will likely span two years. In terms of the North Wales Estate (Bryntirion) initial work has started across departments to ensure that all

elements of the work are mapped out and options are considered. The existing site requires remedial work which is considered poor investment given the site is not WAST owned. There is a technological development (Airwave replacement) required that enables a full move out of Bryntirion; early indication from the Ambulance Radio Programme (ARP) is that the roll-out of this technology is likely to be Q1 2024. A capital budget (discretionary) has been identified and allocated.

17. Action 12.1 - The realignment of desks is currently being paused due to awaiting data. It is anticipated that this will be available in Q2 2023 and that this aspect of the project will be completed end of Q3, subject to management capacity. In addition, we continue to pursue the changes identified above that require a £750k investment however funding support for this is contingent on external investment which in the current economic climate is difficult to secure.

18. On the 11 July 2023 the Senior Leadership Team endorsed the recommendations and approved the paper for submission to EMT who in turn did the same on 2 August 2023.

**RECOMMENDED: That**

1. The Committee note the update provided and agree to the status update of the actions detailed in this paper and in the appended tracker.
2. The Committee notes actions 12.1 and 21.1 are overdue however work continues toward completion.

## Action Plan: Welsh Ambulance Service Trust - Local Review 2019-2020

Ref	Recommendation	Setting action	Timeframe	Responsible person	Action Status (Complete/In Progress/Not Actioned)
1	Consider how the service can maximise the opportunity to respond to patients who have specific therapeutic window timescales.	<p><b>Action 1.1: The trust will consider a review of response time standards and methodology for therapeutic conditions with commissioners</b></p> <p><i>Response time standards of this nature are subject to NHS Wales and commissioners' guidance as the trust is a commissioned service. The trust can consider timelines and response standards for various therapeutic windows which are outside the current response time standards in Wales with our Commissioner.</i></p>	Q3 20/21 <b>Completed: Q3 20/21</b>	Lee Brooks	Complete
2	Review and consider other viable options for managing patients on the call waiting queue in each of the three EMSCCs.	<p><b>Action 2.1: In line with the Trusts Integrated Medium Term Plan (IMTP) deliver the recommendations in the Trust's Clinical Review.</b></p> <p><i>The Trust has undertaken a clinically led, operationally supported review of the clinical functions within the EMS Clinical Contact Centre. The review explores the utilisation of clinicians and how they can be used to best effect. The review makes a number of recommendations for change and development which will significantly contribute to the delivery of this recommendation including reviewing the other functions of the Clinical Support Desk (CSD) to ensure they are required and to assess if they could be delivered in a different way to support patient care.</i></p> <p><i>The Demand Management Plan (DMP) has been revised and re-published since the completion of the HIW review. This plan sets out additional measures that are to be taken for patients with long waits including clinical case reviews, enhanced cross-border resource utilisation and engagement with ambulance response leadership teams to consider alternative operational solutions. We believe this will provide clarity of actions</i></p>	Q2 20/21 <b>Completed: Q3 20/21</b>	Lee Brooks	Complete

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		<p><i>and realignment of roles to support increasing demand and patient safety management.</i></p> <p><b>Updated 24/10/22: DMP has been superseded by Clinical Safety Plan (CSP), which provides ongoing strategic oversight of demand and capacity. CSP continues to be reviewed with latest clinical and operational updates. The Trust is imminently publishing our most recent revision of the plan.</b></p>			
3	<p>Review SICAT to determine the benefits in rolling this service out across Wales into all EMSCCCs.</p>	<p><b>Action 3.1: Continue to engage with Health Board stakeholders regarding availability and expansion of (PTAS) opportunities.</b></p> <p><b>Action 3.2: Explore opportunities and funding for improved technical solutions to enable PTAS models to operate remote from the EMSCCC.</b></p> <p><i>The EMSCCC currently operates a small number of Physician Triage and Streaming (PTAS) models across Wales, one of which is the SICAT model in place in conjunction with Betsi Cadwallader University (BCU) Health Board.</i></p> <p><i>The Trust has worked alongside other Health Boards to explore the PTAS opportunities reflecting the patient and staff benefits derived from these schemes including Swansea Bay (SB) Health Board and Aneurin Bevan (AB) Health Board who have both trialled or put in place similar schemes.</i></p> <p><i>The CCC Clinical Review project has a work stream which is actively evaluating the current models and exploring additional opportunities with other Health Boards and this will continue as part of the review work.</i></p> <p><i>To overcome the challenges of co-locating the Trust is reviewing a version of the Computer Aided Dispatch system (CAD) which allows remote Health Board physicians to review the ongoing 999 calls to review opportunities for intervention to avoid the</i></p>	<p>Q4 20/21</p> <p><b>Completed Q1 22/23</b></p>	<p>Jonathan Edwards</p>	<p>Complete</p>

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		<p><i>need for a patient to attend hospital. This will allow for more opportunities for PTAS across all Health Boards.</i></p> <p><b><i>Update 25/10/22: To date, three HB's are live with PTaS (HDUHB, BCUHB &amp; ABUHB). Most HB's have had initial engagement, but some are awaiting documentation sign off by MoU and a Joint Commissioner Agreement. There is an ongoing review of the PTaS data and will undergo internal review before further engagement with HB leads.</i></b></p> <p><b><i>Further work is ongoing regarding the formal handover to the remaining HB's to be live with PTaS with continued engagement and reporting to NCCU. The most recent positions</i></b></p>			
4	<p>Consider including more realistic expected waiting times to DMP scripts, to allow patients to make informed decisions about their wait.</p>	<p><b>Action 4.1: Expected waiting times are currently included within the Demand Management Plan (DMP). These are provided in time bands which represent the time the caller can reasonably expect to wait for a response to arrive at their location, given the current volume of 999 and urgent responses being managed by the service.</b></p> <p><b>Action 4.2: In order to further improve patient experience and to enable patient's to make informed decisions regarding their care the Trust will review the existing approach with a view to providing more realistic waiting times.</b></p> <p><i>Consideration has been given to the presentation of actual or more precise expected waiting times but this is not possible due to the complexity and dynamic nature of the operational environment.</i></p> <p><b><i>Update 24/10/22 – Since September / October 2021 an Estimate Time of Arrival (ETA) dashboard and Scripting has been fully functional across Wales that provides patients with a guide as to the likely waiting times for Ambulances in their area, based on the CSP level (demand &amp; Capacity) in their area.</i></b></p>	<p>Q4 19/20  <b>Completed</b>          Q4 19/20</p>	<p>Lee Brooks</p>	<p>Complete</p>

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5	<p>Undertake a review of the REAP and DMP escalation arrangements to ensure they are being applied consistently.</p>	<p><b>Action 5.1: We will pursue with our Health Informatics (HI) colleagues an improved Ambulance Dispatch Operations Log (ADOL) report so that actions taken as a result of REAP and DMP levels are more visible and able to be reported on more easily.</b></p> <p><b>Action 5.2: The Trust will review the process of increasing DMP levels by the DCM to ensure the process is being followed and will review the findings to see if improvements can be made.</b></p> <p><i>The Resource Escalation and Action Plan (REAP) arrangements are reviewed annually by the Trust and will be reviewed again in August 2020. They are consistent with the Association of Ambulance Chief Executives (AACE) guidance and are especially geared towards activity in Wales.</i></p> <p><i>A REAP level assessment is undertaken at weekly performance meetings by the Director of Operations. Decision making is documented and held on record. This takes a current and future view of staffing levels, expected demand and other external factors such as events in the community or external pressures such as seasonal increases (winter) or pandemics. This process is consistent with other UK Ambulance Services.</i></p> <p><i>At the end of each session the REAP level is communicated to Trust staff through the usual communication routes and out to Health Boards through regular daily meetings. The REAP level is recorded in the Computer Aided Dispatch system to ensure that the level is known at all times.</i></p> <p><i>Each REAP level has certain actions associated with it and when these actions are carried out by commanders, managers and staff they are recorded in the Ambulance Dispatch Operations Log (ADOL) by the respective individuals. Reporting for this system is a manual process and quite complex and would benefit from improvement so that the entries in the log can more easily be reported to ensure compliance to the plans.</i></p>	<p>Q3 20/21          Completed          Q3 21/22</p>	<p>Lee Brooks</p>	<p>Complete</p>
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		<p>Since the review took place the Demand Management Plan (DMP) has been updated and now includes more narrative and improved action cards for 999 Call Handlers, Dispatchers and Allocators and Clinicians working in the CSD. There are more distinct levels of DMP; DMP levels are managed through triggers by the Duty Control Manager (DCM) up to Level 3 and any level above by the Strategic Commander on duty. Higher levels require the information / approval of the Chief Executive Officer. Strategic Commanders, EMSCCC staff and CSD Clinicians were provided with familiarisation sessions on the new DMP.</p> <p>Call Supervisors at each centre communicate the levels to the centre staff and to the other EMSCCCs and record the levels in the Ambulance Daily Occurrence Log (ADOL) for reference. The level is also recorded in a new web based system (this was not in place at the time of the review) so that it is available in real time for others to see the levels in each Centre (e.g. the Operational Delivery Unit) and so that it can be more easily reported and reviewed for past incidents.</p> <p>Similarly to REAP the DMP levels have actions associated with them and when these actions are carried out they should be recorded in the ADOL. Reporting for this system is a manual process and quite complex and would benefit from improvement so that the entries in the log can more easily be reported to ensure compliance to the plans.</p> <p><b>Update 24/10/22 – REAP is subject to an annual review to ensure that it continues to meet the needs of the Trust and patient safety. REAP continues to be tested annually pre-winter. As noted above DMP has morphed into CSP and is subject to periodical reviews to ensure that it continues to meet the needs of patients. The CSP levels have been standardised across the UK.</b></p>			
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6	<p>Ensure Senior Management Staff routinely attend EMSCCCs as directed within the DMP escalation process where required.</p>	<p><b>Action 6.1: We will review the current arrangements for managers attending the EMSCCC to ensure that this is taking place.</b></p> <p><b>Action 6.2: We will work with the ODU on support for EMSCCC and service delivery and review a need to adjust the requirement for operational managers to report to the EMSCCC.</b></p> <p><i>Occasionally the Locality Managers or on-call Tactical Commander (Silver) are requested to attend the EMSCCC to support the Duty Control Manager (DCM) in and out of hours. The EMSCCC Managers routinely attend the EMSCCC during significant escalation periods when they are on duty in hours. Out of hours the on call senior managers for EMSCCC and Ambulance Response are not mandated to attend the EMSCCC and remain on-call and available 24/7 for support and intervention where necessary.</i></p> <p><i>On the extremely rare occasions that any of these managers do not respond in or out of hours, there is a command structure available at all times within the Trust for escalation at the time to the next more senior commander. Any absence of a response is reported to the relevant member of the Senior Operations Team who will follow up with the individual involved.</i></p> <p><i>Since the review took place the pilot of the Operational Delivery Unit (ODU) commenced which provides extended hours of support for service delivery within the Trust and across the broader health system. It has been able to support the EMSCCC in some of the activities which previously needed a Tactical Commander to enable. This reduced the reliance on in and out of hour's commanders.</i></p> <p><b>Updated 24/10/22: The ODU have operated on a 24/7 365 basis for the last 12 months and provides tactical coverage for the Trust across Wales supported where required</b></p>	<p>Q3 20/21  <b>Completed          20/21</b></p>	<p>Jonathan          Edwards</p>	<p>Complete</p>
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		<i>by tactical Commander for operational areas and supporting the 24/7 Strategic Commander. Commissioners have committed on permanent funding of the ODU.</i>			
7	Continue discussions with Welsh Government to agree an appropriate Non-Send process, for low acuity patients during times of high demand on the service.	<p><b>Non-Send processes are now included with the DMP Action cards in place within WAST.</b></p> <p><i>Since the review took place, and as part of our preparations for the Covid-19 response, a revised Demand Management Plan (DMP) was introduced to include a non-send process. The plan has been extended from 4 to 8 levels with a scale of non-send commensurate with the demand and capacity presenting. It commences with a non-send process for the lowest of acuity, extending through to a process where ambulances might be reserved for only confirmed life threatening cases. Whilst a patient might not receive an ambulance response if non-send was invoked, we would signpost a caller according to their presentation. This was approved by Trust Board and was shared with Welsh Government.</i></p> <p><i>A key enabler for non-send are alternative patient focussed pathways. The Trust will continue to work with Health Boards to mobilise such pathways and pathway opportunities, for example through the recent release of the Consultant Connect technology.</i></p> <p><b>Update 24/10/22: The CSP has changed the nomenclature from No Send to Can't Send reflecting that this is not a Trust decision not to send, but moreover reflective of the demand and capacity pressures, which means that difficult decisions have to be made around prioritisation based on the current system pressures.</b></p>	Q4 19/20 <b>Completed</b> Q4 19/20	Lee Brooks	Complete
8	Consider how it can engage further with the public to provide additional education and awareness on the	<b>Action 8.1: Further develop alongside Welsh government a national campaign to influence behaviour change.</b>	Q3 20/21 <b>Completed</b> Q1 21/22	Lee Brooks	Complete

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	appropriate use of the emergency ambulance service.	<p><b>Action 8.2: Deliver further online events with the public which describe how we operate and appropriate use of the EMS service. Encouraging use of other services which can support people, including NHS 111 Wales, its website and online symptom checkers.</b></p> <p><b>Action 8.3: Launch a community participation network which will receive and disseminate information on key information and updates from the service. This network will receive and disseminate information on key information and updates from the service, as well as allowing members of the public to have their voices heard and be involved in shaping future service design and delivery.</b></p> <p><b>Action 8.4: Develop and disseminate an educational video aimed at a younger audience regarding the EMS service and appropriate use of it.</b></p> <p><i>Educating the public about the appropriate use of the ambulance service is a year-round objective for the Communications Team and Patient Experience and Community Involvement Team. A concerted effort to engage with the public on this subject is made over the busy winter months, and the Trust is working with Welsh Government to influence and develop a new, national campaign to effect behaviour change in this area.</i></p>			
9	Work with EMSCCC staff to explore well-being initiatives which could provide on duty support to staff and processes to improve attendance at work.	<p><b>Action 9.1: Wellbeing workshops are to be arranged for EMSCCC teams. These will focus on developing resilience in terms of sound foundations of good mental health.</b></p> <p><b>Action 9.2: The Health and Wellbeing Strategy is currently in consultation phase and a EMSCCC specific focus group will be convened to further develop the EMSCCC contribution to that strategy</b></p> <p><b>Action 9.3: Provide an awareness film for EMSCCC colleagues on muscular-skeletal injuries and how best to prevent them in the workplace.</b></p>	Q4 20/21 <b>Completed</b> Q3 20/21	Jonathan Edwards	Complete

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		<p><i>The Trust places a significant emphasis on the well-being of our colleagues. The following initiatives and actions are already in place and will continue:</i></p> <ul style="list-style-type: none"> <li>• <i>Provision of counselling during periods of high pressure.</i></li> <li>• <i>Trauma Risk Incident Management (TRIM) referrals following complex and / or traumatic incidents.</i></li> <li>• <i>Virtual and face-to-face drop in sessions to offer sign posting and awareness of the full organisational wellbeing offer. When and/ or if it becomes possible to conduct face to face drop in sessions then the plan is that this will be provided on site.</i></li> <li>• <i>Mental health awareness training has been made available across the organisation and further training is planned in line with the strategy proposals and this will be included at induction for new members of staff following a review of the induction period.</i></li> <li>• <i>In relation to physical wellbeing then health surveillance has commenced with skin surveillance and will expand to other areas including hearing checks in the near future.</i></li> <li>• <i>The Trust have two physio providers and can fast track physiotherapy appointments and advice. Video guides for stretch and movement breaks to reduce MSK tensions and stresses are also available and wellbeing are able to signpost to these.</i></li> </ul> <p><b>Updated 24.10.22: The Trust have commissioned a range of wellbeing activities to support staff, including the provision of 'Zen rooms' that provide a safe space for EMS CC staff to come out of the Operational environment and relax. This is just one of many initiatives the Trust have invested in recent years, alongside the Occupational Health Unit proactive activity.</b></p>			
10	Ensure robust workforce planning arrangements are in place which set out to mitigate against under resourced shifts, as well as	<b>Action 10.1: A CCC workforce plan is to be developed and maintained to align the needs and priorities of the organisation with those of our workforce to ensure we can meet service and production requirements and organisational objectives.</b>	Q3 20/21 <b>Completed</b> Q3 20/21	Jonathan Edwards	Complete

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	<p>to reduce the reliance on overtime.</p>	<p><b>Action 10.2: We will ensure that there are sufficient plans in place for recruitment of staff to meet expected attrition and to ensure that the staffing levels do not drop to those which were being experienced during the review period.</b></p> <p><i>Since the review took place the Trust has completed a recruitment process which has provided sufficient staff to meet establishment levels. This has removed the vacancies which were impacting on the positions noted and reduced much of the reliance on overtime.</i></p> <p><i>As part of regular weekly operations the Area Manager, EMSCCC conduct twice weekly reviews of staffing levels in each of the EMSCCCs with the EMSCCC Centre Mangers in order to optimise staffing levels for each role and ensure as far as possible each position is covered by regular or relief staff.</i></p> <p><i>Since the Pandemic has required additional resource to meet the surge in demand a large number of bank staff are more readily available to meet any further temporary decreases in staffing levels for 999 Call Handlers and these can be called upon to fill gaps. The organisation's approach to covering vacant shifts however supports overtime being used before bank staff so this will not reduce the reliance on overtime.</i></p> <p><b>Update 24.10.22: A formal establishment monthly review of recruitment is carried out by the Head of Service with the Assistant Director of Operations to review the workforce plan. This is also escalated on a monthly basis to the Executive Director of Operations. Any specific issues are fed through to Executive Management Team through the Senior Leadership Team meetings. This factors in internal and external attrition are assessed and People Services support with external recruitment campaigns.</b></p>			
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11	<p>Complete its review of the welfare call process and consider how funding can be made available to increase staffing to support this.</p>	<p><b>Action 11.1: Work with Health Informatics (HI) colleagues to refresh analysis around welfare call demand based on new guidelines and utilise data to inform future workforce planning considerations.</b></p> <p><i>Since the review took place the requirement for welfare calls was reviewed by the Trust and updated to adjust the frequency of calls in line with the acuity of the patient. As such the requirement for the number of staff to complete welfare calls has reduced since it was earlier evaluated.</i></p> <p><i>Dispatchers and 999 Call Handlers (both staff are qualified as Emergency Medical Dispatchers, which is the qualification required to handle 999 calls and therefore carry out welfare checks) both perform welfare checks, though the Call Supervisors now monitor the waiting queue and allocate welfare calls to Call Handlers whenever available reducing the demand on Dispatchers to undertake this role.</i></p> <p><i>As part of the CAD Phase 3 project, which also supports the outcomes of the broader Emergency Medical Service Demand and Capacity Review, we are looking at the roles of all staff and we will calculate the amount of time required to perform welfare checks and at which times they are required (as they fluctuate increasing during period of longer patient waiting times) in order to be better prepared to request funding for the welfare check calls to be carried out in line with the recommendation.</i></p> <p><b>Update 24.10.22: Welfare checks are part of the role of Dispatcher. Within the EMS Coordination Reconfiguration Project the need to maintain additional capacity to carry out tasks such as welfare calls to patients have been factored into the long term structures.</b></p>	<p>Q3 20/21  <b>Completed</b>  <b>Q3 20/21</b></p>	<p>Lee Brooks</p>	<p>Complete</p>
12	<p>Review current duties of EMSCCC staff to determine where responsibilities can be streamlined.</p>	<p><b>Action 12.1: Continue with the work of the CAD Phase 3 project to realign workloads within the EMSCCC for more efficient operation.</b></p>	<p>Q4 20/21</p>	<p>Jonathan Edwards</p>	<p><b>In Progress</b></p>

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		<p><i>CAD Phase 3 was renamed CCC Reconfiguration and recommenced following response to Wave 2 of the Covid 19 pandemic. The model agreed by SOT in December 2019 was progressed with Job Evaluation work completed in Qtr 1 21/22 and review of these evaluations following engagement with EMT in Qtr 2 21/22 was completed. EMT supported the proposal but a financial investment of circa £750k recurring was required to deliver.</i></p> <p><i>As a result of a challenging financial position a funding stream for this investment has not yet been identified and this remains a cost pressure for the organisation. As a result CCC reconfiguration cannot be delivered in it's entirety and instead the Project Board are now reviewing the PID and TOR to review was modernisation actions can be achieved without a revised structure.</i></p> <p><i>This action is tracked through the EMS Transformational Change board. The Operational Delivery Unit (ODU) has commenced internal discussions on which responsibilities may move to the ODU remit and away from the EMSCCC, however its continuation is subject to business case approval and financial resources.</i></p> <p><i>A trial has been conducted of a fleet and logistics desk within the EMSCCC environment to manage vehicle movements, breakdowns and other general logistics which is currently being evaluated for its effectiveness.</i></p> <p><b>Update 24.10.22:</b> <i>As noted above, the EMS Coordination Reconfiguration project has restarted and in this financial year (2022/2023) focuses on three distinct areas; 1. Roster Review for EMDs, 2. Boundary Changes (for dispatch), 3. Better ways of working. In addition, we continue to pursue the changes identified above that require a £750k investment however funding support for this is contingent on external investment which in the current economic climate is difficult to secure.</i></p> <p><b>Update 19.06.23:</b> <i>The EMS Configuration Programme recommenced in Q1 2023 following being paused due to Industrial Action and Operational Pressures. Roster</i></p>			
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		<p><i>Review of call takers is complete. The realignment of boundaries aspect of this work, which provides the necessary re-alignment of workloads has commenced and engagement with staff had taken place prior to the pause. This work has re-commenced and is currently waiting on a refresh of the data to finalise discussions with staff and Trade Union Partners.</i></p>			
13	<p>Explore other options available for a sustainable process for welfare check calls.</p>	<p><b>A review of the triggers and actions associated with Welfare checks were undertaken with supported timescales agreed with CPAS</b></p> <p><i>As the welfare check call may require a re-triage of the patient, only qualified Emergency Medical Dispatchers (EMD) licensed to use the MPDS triage system can make the calls (999 Call Handlers and most Dispatchers are qualified). Call Handling Supervisors now monitor the waiting queue and allocate welfare calls to call handlers whenever available reducing the demand on Dispatchers to undertake this role.</i></p> <p><i>Reducing patient waiting times has the most significant impact on the requirement to make welfare calls and the Trust continues to work with Health Boards to examine ways in which delays handing over patients at hospital can be reduced which frees up resources to respond in a timely manner. See other action items.</i></p> <p><b>Update 24.10.22: As noted above Dispatchers are carrying out the welfare callers, which is overseen by Call Taking Supervisors.</b></p>	<p>Q4 19/20 <b>Completed</b> Q4 19/20</p>	Lee Brooks	Complete
14	<p>Review the process in place to allow staff to submit views and suggestions relating to the service. The process should consider and acknowledge suggestions received by providing feedback to staff.</p>	<p><b>Action 14.1: The Trust has a mature and developed approach to enabling colleagues to share suggestions and views. Local measures in place include a dedicated email address for suggestions and quarterly open forums with senior managers.</b></p> <p><i>Additionally the EMSCCC actively utilises and supports the WAST Improvement and Innovation Network (WIIN). This is a cross-directorate network, with a Trust-wide membership supported by a steering group whose remit includes, but is not limited to, improvement and innovation, change management, service improvement and quality</i></p>	<p>Q4 20/21 <b>Completed</b> Q4 20/21</p>	Jonathan Edwards	Complete

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		<p><i>improvement. The purpose of the WIIN is to support colleagues with their ideas to make improvements and be innovative, offering guidance and support with Clinical Audit, Research, Quality Improvement and projects that require a more 'formal' approach which sit within the Project and Programme Management Framework.</i></p> <p><i>The existing process will be reviewed on a cross-Directorate basis to ensure that that the arrangements give due consideration to all suggestions and provide staff feedback.</i></p>			
15	<p>Ensure that staff are provided with the opportunity to contribute their opinions into the ongoing structure and resource review, and that these reviews are considered.</p>	<p><b>Engagement and co-design was built into the CAD Phase 3 project and evidence of engagement sessions recorded</b></p> <p><i>The engagement and co-design phase of the structure and resource review (part of CAD Phase 3) concluded in December 2019. This phase of the project involved 9 virtual engagement sessions and 18 face-to-face roadshows and workshop sessions. This was supplemented by a dedicated Facebook group, letters to individual staff members, dedicated noticeboards and video messages.</i></p> <p><i>The dedicated email group and Facebook site continue to be available for staff to contribute views, opinions and ideas. This is of course supplemented by engagement and dialogue locally through management teams.</i></p> <p><i>The Organisational Change Policy shall be applied at the necessary times requiring consultation with staff about structural change.</i></p> <p><b>Update 24.10.22: Staff are provided with an opportunity to engage with change processes and representatives from each centre sit on the EMS Coordination Reconfiguration Project Board as well as Trade Union Partners. For the Roster Review for example, Staff will be engaged with engagement events to ensure they understand the options being put forward and have a say in selecting (voting) for the roster they want to work on.</b></p>	<p>Q3 19/20  <b>Completed</b>  <b>Q3 19/20</b></p>	Lee Brooks	Complete

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16	<p>Consider a holistic review with stakeholder engagement, of the current handover arrangements in place, which should include current escalation arrangements during periods of high demand.</p>	<p><b>Action 16.1: Continue to support local improvement initiatives such as the POD within Aneurin Bevan.</b></p> <p><b>Action 16.2: Continue to develop the Operational Delivery Unit business case to ensure support from the Commissioner and Welsh Government to address the flow concerns on a 24/7/365 basis.</b></p> <p><b>Action 16.3: Develop a communications plan to share with staff what actions are being undertaken to address the issue.</b></p> <p><i>The Trust continues to work with Health Boards and other stakeholders to address the concerning number of resource hours lost to delayed handovers at emergency departments in a collaborative fashion recognising this issue as a system wide concern.</i></p> <p><i>Specific actions include regular engagement at the most senior levels and the Emergency Ambulance Service Commissioner to discuss the impact of delays and a collaborative approach to their reduction.</i></p> <p><i>The Trust continues to work locally with Health Boards on unique approaches to resolve flow concerns at Emergency Departments (ED) for instance with Aneurin Bevan in staffing a patient care department (the POD) outside the ED.</i></p> <p><i>The Trust continues to pursue the funding for the Operational Delivery Unit (ODU), a hosted, all systems approach to ensuring flow of patients to and through emergency departments. In March 2020, WAST commenced a pilot of the Operational Delivery Unit (ODU) with two clear operating functions:</i></p> <ul style="list-style-type: none"> <li><i>• To provide senior leadership capacity to effectively manage and mitigate the pressure and risk across the Unscheduled Care System; and</i></li> <li><i>• To provide robust senior operational management support to mitigate on the day performance or service delivery challenges (including hospital handover issues).</i></li> </ul>	<p>Q3 20/21  <b>Completed</b>          Q3 20/21</p>	<p>Lee Brooks</p>	<p>Complete</p>
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		<p><i>The pilot has been achieved through a hybrid of seconded and redeployed staff, neither of which is unfortunately sustainable beyond August 2020. A business case has been prepared to fund the ODU on a permanent basis.</i></p> <p><b><i>Update 24/10/22: The ODU has been successfully operating on a 24/7 365 basis for the last 12 months and provides that constant link between HB and hospital sites to ensure that patient flow and Ambulance demand is factored into the movement of patients. The POD at Aneurin Bevan is no longer provided. The Trust has instead deployed alternative cohorting models at The Grange Hospital and Morrison Hospital. Following evaluation this model was discontinued as it was not proven to be effective. The organisation continues to provide a monthly WAST Live. This allows any staff members to ask questions of the Executive Management Team and the session includes the opportunity for key messages to be shared with staff. The Trust has also just completed its third round of CEO Roadshows. This occur six monthly and are staff engagement sessions. The issue of hospital handover delays and the actions the Trust is taking are routinely covered, however additional information was shared in the October 2022 series of roadshows.</i></b></p>			
17	<p>Implement a training strategy which ensures that staff are provided with the appropriate training and development, to enable them to undertake their relevant roles effectively. Progress against the strategy should also receive Trust Board oversight.</p>	<p><b>Action 17.1: Continue to pursue the formalisation of the two EMSCCC training roles to further deliver the Dispatcher and Allocator role training courses.</b></p> <p><b>Action 17.2: Introduce dispatch training course for all new appointments into dispatch and allocation roles and schedule any update training for all dispatchers and allocators currently in post.</b></p> <p><i>Initial induction and training for entry into EMSCCC forms part of an existing and established scheme of work with signed off competencies and assessment in line with corporate induction, mandatory training and International Academy of Emergency Dispatch (IAED) requirements in 999 Call Handling.</i></p>	<p>Q4 20/21 <b>Completed</b> Q2 22/23</p>	<p>Jonathan Edwards</p>	<p>Complete</p>

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		<p><i>Prior to the HIW review being undertaken a member of the EMSCCC team was seconded into the role of Training Manager and over the subsequent months (finalised after the review) has created a formal Dispatcher and Allocator training programme with a record of competencies. The classroom based course has been created and piloted and includes live exposure with a mentor with sign off to agreed competencies and assessment.</i></p> <p><i>Internal funding has been previously realigned to provide 2 FTE positions to deliver training courses, specifically dispatching and allocating. EMSCCC is progressing the job descriptions through internal evaluation and consistency checking processes and once complete intends to recruit into these positions to support the delivery of the standard dispatcher and allocator training course.</i></p> <p><i>Each of the Duty Control Managers (DCM) has been enrolled on an Institute of Leadership and Management (ILM) training course and we will continue to provide this opportunity to all future staff in this role.</i></p> <p><i>Finally across the CCC environment (EMS and 111), in conjunction with Health Education and Improvement Wales (HEIW), CCC has explored opportunities for education and accreditation against competencies, specifically focussed on remote clinical decision making and telephone triage for clinical and non-clinical roles.</i></p> <p><b>Action 17.3: Continue to engage with HEIW to develop an accredited programme of education focussed on clinical and non-clinical remote decision making.</b></p> <p><i>WAST continue to engage with HEIW around this programme which was paused during response to the Covid 19 Pandemic. Quest approved an extension until Qtr 2 21/22 however this work is now being tracked under the Gateway to Care programme. Given that the action was to engage the recommendation is to close this action and cross reference to the gateway to care programme for future monitoring.</i></p>			
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## Action Plan: Welsh Ambulance Service Trust - Local Review 2019-2020

		<p><b>Update 24.10.22: As noted there has been significant progress on the first two actions with a Training Manager and 2 trainers appointed. Dispatch Training is now offered. 17.3 is now reinstated and will be owned by the 'Gateway to Care' programme.</b></p>			
18	Ensure sufficient time is permitted to allow for appraisal discussions between managers and their staff to take place.	<p><b>Action 18.1: Work with DCMs to ensure existing time for protected appraisal discussions is utilised effectively and scheduled in advance or look for a more appropriate way that appraisals can be carried out.</b></p> <p><i>Existing time was already available within rostered training provision. There is ongoing work on an EMS-C roster review that could incorporate protected time to undertake PADR's. Due to the operational pressure and high level of escalation in operation between August 21 and Jun 22 this time was realigned to support operational service delivery. This has impacted on the capacity to undertake PADR. An action plan is now in place to ensure all EMS Coordination teams have received a quality PADR in the next 6 months. Administrative support teams are now tasked with scheduling these appointments to ensure timely PADR and 6 monthly reviews are completed. PADR compliance is currently 59.61% (excluding those with open sickness absence) having improved from 27.27% as of 1st April 2022 with a trajectory for completion by September 2022.</i></p>	Q3 20/21 <b>Completed</b> Q3 22/23	Jonathan Edwards	Complete
19	Ensure training is provided to relevant staff in regards to the annual appraisal process.	<p><b>Action 19.1: Develop and trial an EMSCCC specific appraisal process to ensure that staff receive the appropriate developmental discussion.</b></p> <p><i>Development of the EMSC trial has been completed with support from WOD and appropriate templates and training provided. Learning from this pilot is now informing a wider organisational review of PADR processes.</i></p>	Q4 20/21 <b>Completed</b> Q2 22/23	Jonathan Edwards	Complete

## Action Plan: Welsh Ambulance Service Trust - Local Review 2019-2020

		<p><b>Action 19.2: Workforce &amp; Organisational Development team to assess the training needs of first line managers within EMSCCC to support their delivery of effective and meaningful PADR.</b></p> <p><i>A training needs assessment has been carried out through engagement with the Workforce and Organisational Development team, which resulted in a bespoke training package that has been developed and completed. Through this work in EMS-C wider change across the organisation has also taken place in terms of PADR delivery.</i></p>			
20	<p>Consider benchmarking with the International Academy of Emergency Dispatch, to identify best practice for supporting and monitoring EMSCCC staff to explore options of improving the existing arrangements.</p>	<p><b>WAST is an ACE accredited centre and regular benchmarking exercises are undertaken to support and maintain this position.</b></p> <p><i>In line with the IAED requirements to maintain Accredited Centre of Excellence (ACE) status in 999 call handling and triage, which the Trust holds nationally across all three EMS Clinical Contact Centres, a percentage of all 999 calls are audited routinely. To attain accreditation as an ACE centre the Trust must provide evidence of compliance scores monthly and provide 6 months of audits for quality assurance by the IAED to recertify every 2 years. Both the quantity and quality arrangements are set down by the IAED.</i></p> <p><i>In addition to the routine audits, additional calls associated with patient care concerns or areas of focused improvement for call handlers are also audited. All EMDs receive a minimum of 5 call audits a month and receive feedback on all those audits in various media with feedback documents being provided by email. Where evidence of required learning is identified feedback is provided face to face as are any audits related to concerns investigations. Our auditors undergo regular exercises supported by IAED to ensure consistency and best practice in audit.</i></p> <p><i>EMSCCC has an embedded and established process of recognition for high compliance to protocol standards as well as great customer service for 999 call handlers. In addition we monitor exemplary performance for nomination to national and</i></p>	<p>Q4 20/21  <b>Completed</b>  <b>Q4 19/20</b></p>	Lee Brooks	Complete

## Action Plan: Welsh Ambulance Service Trust - Local Review 2019-2020

		<p><i>international award ceremonies and have recognised several finalists for IAEDs 999 Ambulance Call Handler of the Year.</i></p> <p><b>Update 24.10.22:</b> <i>WAST continued to secure IAED accreditation and have a strong programme of audit in place to ensure that the quality and learning opportunities for EMDs are constantly available. The Audit and Training Units sit within the Service Manager Operations Quality portfolio that sits within the Resourcing and EMS Coordination Assistant Directorate Portfolio. There is daily interaction between the teams to ensure ongoing learning and support.</i></p>			
21	<p>Consider how the EMSCCC working environments and IT equipment available can be improved to assist staff in carrying out their relevant roles as well as to improve staff well-being.</p>	<p><b>Action 21.1: Complete the North Wales EMS CCC estate strategy and identify opportunities for improvements.</b></p> <p><i>Estates project reprioritised to focus on covid secure workplaces during Pandemic response. Whilst included within the Estates SOP this strategy work has not yet recommenced. This issue has been escalated and supported by the Operations Directorate Senior Leadership team and is currently supported by two corporate risks</i></p> <p><b>Update 24.10.22:</b> <i>A paper has progressed through Governance that sets out the Requirements for each of the EMS Coordination Centres. This now forms part of the Estates SOP. Progress has been made in Vantage Point House and Carmarthen to provide further space, which has proven effective. The North Centre remains at Bryntirion with options being explored across other parts of North Wales with the introduction of new ICT options that may provide a cost effective solution to moving staff from the existing site while retaining the network (Airwave) coverage. This is likely to be within the next 12-18 months.</i></p> <p><b>Update 19.06.23:</b> <i>The Bryntirion site for EMSC in the North has been allocated some discretionary capital funding for this financial year to support some progress in this area. The project will likely span two years. In terms of the North Wales Estate (Bryntirion) initial work has started across departments to ensure that all elements of</i></p>	Q4 20/21	Jonathan Edwards	<p>21.1 Not Actioned</p> <p>21.2 Complete</p> <p>21.3 Complete</p>

## Action Plan: Welsh Ambulance Service Trust - Local Review 2019-2020

		<p><i>the work are mapped out and options are considered. There is a technological development (Airwave replacement) required to enable a full move out of Bryntirion. Early indication from the Ambulance Radio Programme (ARP) is that the roll-out of this technology is likely to be Q1 2024. In the interim senior managers are exploring the options to move those staff that can move out of Bryntirion.</i></p> <p><i>It should be noted that WAST have completed and rolled out the estates strategy in VPH with a view to progress plans with DPP for Llangunnor now to progress with the redevelopment of the ground floor. This is at design stage currently, but funding has been allocated from this year's discretionary capital budget to support this.</i></p> <p><b>Action 21.2: Complete the return to the workplace review to ensure the maximum space is still provided in the medium term for clinicians to work remotely from the EMSCCC main spaces.</b></p> <p><i>A paper was approved through Senior Leadership Team and now forms part of the Estates Strategic Outline Plan. This focuses on increasing the capacity of all three sites to provide sufficient space to work from EMS Coordination Centres. Stephen Clinton as the ADO for Integrated Care is working with the Team to ensure that there is sufficient capacity for Clinicians to work at the three Centres. In addition, it is acknowledged that other facilities have also been created across the Estate to accommodate staff who want to work from WAST premises together with the capability of remote working that was expedited as part of the response to covid.</i></p> <p><b>Action 21.3: Undertake a review of opportunities to enhance the ICT equipment available to EMSCCC staff in order to assist colleagues to discharge their roles with greater efficacy and to enhance their wellbeing.</b></p> <p><i>The EMSCCC estate has seen some improvements since the review took pace including new staff rest and kitchen areas being provided in the North Wales EMSCCC. Additionally, motivated by the response to the pandemic the Trust has provided a</i></p>			
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## Action Plan: Welsh Ambulance Service Trust - Local Review 2019-2020

		<p><i>significant number of laptops to enable CSD clinicians to work remotely including at home and in other areas of the Trust estate, including North Headquarters building. This has created space within all three EMSCCCs.</i></p> <p><i>In response to the pandemic a new area in the Vantage Point House (VPH) building has been created for call taking capacity which allows all 999 and 111 Call Handlers to work away from the main joint CCC. This has created a significant amount of space in the main CCC. The team are currently reviewing the essential and non-essential activity that takes place in the main CCC to enable a more efficient layout which provides 2m distancing between each desk.</i></p> <p><i>Central and West EMSCCC has also acquired additional space in the building and desks have been removed from the main floor with 999 call handling staff working out of the room. This has created capacity and shortly the remaining desks will be moved to a new layout to facilitate 2m distancing. All changes to layout are intended to be permanent.</i></p> <p><i>In the longer term the Trust is reviewing an ongoing Estates Strategy which relates to the provision of a long term approach to housing current and future needs of the CCCs (EMS and 111).</i></p>			
22	<p>Ensure that consideration is given to improving senior management availability and presence within the EMSCCC 24 hours a day.</p>	<p><b>It is not possible to provide senior management availability across 3 sites within the existing management team but on call arrangements supported by development of the ODU provide escalation and support pathways for EMSCCC 24 hours a day.</b></p> <p><i>EMSCCC operate a CCC Tactical Advisor on-call to provide senior leadership support and guidance to EMSCCC remotely outside of normal operational hours. EMSCCC managers are situated on site during the in hours period.</i></p> <p><i>The Trust continues to pursue the funding for the Operational Delivery Unit, a hosted all systems approach to ensuring flow of patients to and through emergency</i></p>	<p>Q4 19/20 <b>Completed</b> Q4 19/20</p>	<p>Jonathan Edwards</p>	<p>Complete</p>

## Action Plan: Welsh Ambulance Service Trust - Local Review 2019-2020

		<p>departments with the ultimate aim of ensuring ambulance availability for calls in the community. (This action is included in another section of this response).</p> <p><b>Update 24/10/22:</b> As noted above, the ODU has been successfully operating on a 24/7 365 basis for the last 12 months and provides that constant link between HB and hospital sites to ensure that patient flow and Ambulance demand is factored into the movement of patients.</p>			
23	<p>Ensure adequate arrangements are in place to encourage staff where required to speak up regarding their personal concerns, particularly in relation to bullying, harassment or abuse.</p>	<p><b>Action 23.1: Develop in collaboration with Board Secretary, Workforce and Organisational Development (WOD) and Trade Union Partners a poster campaign promoting the All Wales Raising a Concern policy to further reinforce the position.</b></p> <p><i>EMSCCC senior managers are committed to a programme of work to establish an open culture of dignity and respect within the CCC environment. Annual HSE stress risk assessments allow staff to identify any issues through anonymous surveys and access to senior managers. During 2019 a programme of engagement was completed with support from WOD experts and an external clinical psychologist to allow staff to identify issues around these factors and other stressors in the workplace environment.</i></p> <p><i>The Trust utilises the All Wales Raising a Concern Policy for reporting of issues of concerns including bullying and supports anonymous reporting ‘whistleblowing’ through this policy and this was recently promoted within the Trust. Staff have already been provided with a refreshed copy of the EMSCCC Code of Conduct including specific reference to Dignity at Work and descriptors of bullying and harassment as indicated in the All Wales policy.</i></p> <p><b>Update 24.10.22:</b> the Trust carried out its Culture and Behaviours work over the last 12 months with Honne. A EMS Coordination Action plan has been constructed with buy in from managers across the centres to ‘own’ the plan and the actions therein.</p>	<p>Q3 2020-21 <b>Completed Q3 20/21</b></p>	Lee Brooks	Complete

## Action Plan: Welsh Ambulance Service Trust - Local Review 2019-2020

		<b>Workshops have been carried out with Workforce and Organisational Development on a Pan Wales and Localised (Centre) basis to support the work.</b>			
24	Ensure that engagement is improved between operational staff and the Trust senior management team working within the organisation.	<p><b>Action 24.1: Communicate schedule of engagement events for the coming year and review opportunities to engage through digital formats in the Covid environment.</b></p> <p><i>EMSCCC have an action plan of engagement with staff to improve visibility including a programme of workshops specifically designed to maximise exposure across the pan-Wales staff group with the senior management team. The first of these engagement sessions was completed in October 2019 and the second, which was due to take place in April 2020, was postponed due to the pandemic.</i></p> <p><i>The Area Manager for EMSCCC completes quarterly open forums for staff to engage directly about issues and concerns and to allow an opportunity to communicate current strategies for development within EMSCCC. The action plan also includes actions for the EMSCCC management team to schedule operational duties within EMSCCC to allow informal engagement and access to the management team. In addition the Trust operates a closed Facebook group where staff can share information with managers and raise questions and concerns, as well as opportunities to engage with the executive team via Facebook Live/Zoom engagement events chaired by the Chief Executive.</i></p>	Q2 2020-21 <b>Completed</b>	Jonathan Edwards	Complete
25	Reassess current risk assessment documentation in relation to EMSCCC staff training, to ensure sufficient actions and mitigations have been implemented.	<p><b>Action 25.1: A review of the risk relating to staff training (E-risk ID 119) will be undertaken to ensure the mitigating actions are sufficient and are progressed.</b></p> <p><i>EMSCCC utilises the Datix system in the Trust for reporting, reviewing and escalating risks at a departmental, directorate and organisational level. The EMSCCC leadership team undertake a review of any new or emerging risks as well as the highest rated risks during monthly business meetings and the senior leadership team undertake a</i></p>	Q3 2020-21 <b>Completed</b> Q3 20/21	Jonathan Edwards	Complete

## Action Plan: Welsh Ambulance Service Trust - Local Review 2019-2020

		<p><i>review with the Assistant Director of Operations (Resourcing and EMS Coordination) as part of regular business meetings.</i></p> <p><i>The Assistant Director Leadership Team (ADLT) review organisational risks and recommend inclusion on the corporate risk register prior to approval by the Executive Management Team.</i></p> <p><i>The risk register in place contains a detailed description of the risks identified, an assessment of the risk and an initial risk rating as well as considering the level of assurance of internal controls related to the risk and monitoring arrangements. In order to provide a high level summary EMSCCC also have a dashboard to graphically represent the status of current risks and the register (corporate, directorate or local) in which they sit.</i></p>			
26	Ensure that clear guidance and training is provided to staff for reporting incidents.	<p><b>Action 26.1: Develop and issue guidance specifically focussed at EMSCCC staff about what, when and how to report an adverse incident including guidance for managers on ensuring feedback is completed.</b></p> <p><i>Staff within the EMSCCC compete Datix incident reports regularly on a wide variety of topics however there are some instances where it has been identified that there may not be enough clarity on when to submit a Datix report. We will review the process and documentation to ensure there is more clarity. In particular we will expand that guidance to the management team to ensure feedback is provided to individual staff members</i></p>	Q2 2020-21 <b>Completed Q2 20/21</b>	Jonathan Edwards	Complete
27	Ensure that there is a suitable process in place to enable consistent incident reporting which includes feedback to staff.	<p>The existing Datix system provides a suitable reporting system which includes a feedback route for staff.</p> <p><i>Staff within the EMSCCC compete Datix incident reports regularly on a wide variety of topics however there are some instances where it has been identified that there may not be enough clarity on when to submit a Datix report. We will review the process</i></p>	Q3 2019-20 <b>Completed Q3 19/20</b>	Lee Brooks	Complete

## Action Plan: Welsh Ambulance Service Trust - Local Review 2019-2020

		<p><i>and documentation to ensure there is more clarity. In particular we will expand that guidance to the management team to ensure feedback is provided to individual staff members</i></p>			
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<b>AGENDA ITEM No</b>	<b>14</b>
<b>OPEN or CLOSED</b>	<b>OPEN</b>
<b>No of ANNEXES ATTACHED</b>	<b>3</b>

**INFECTION PREVENTION AND CONTROL ANNUAL REPORT 1 APRIL 2022 - 31 MARCH 2023**

<b>MEETING</b>	Quality, Patient Experience & Safety Committee
<b>DATE</b>	10 August 2023
<b>EXECUTIVE</b>	Liam Williams, Executive Director of Quality and Nursing
<b>AUTHOR</b>	Louise Colson, Health of Infection, Prevention & Control
<b>CONTACT</b>	07712003134 <a href="mailto:Louise.colson@wales.nhs.uk">Louise.colson@wales.nhs.uk</a>

**EXECUTIVE SUMMARY**

1. This report provides analysis of Infection Prevention and Control (IPC) performance throughout the organisation from 1 April 2022 - 31 March 2023.
2. The period that this report covers includes the transition from the COVID-19 pandemic, to, Business as Usual (BAU), in addition this report will contain the IPC Work Plan for 2023-24.
3. BAU Guidance will be based on the National IPC Manual ([NIPCM Wales](#)). All guidelines for IPC within Healthcare Services will be based on this manual.
4. On 5 May 2023, the Head of the UN World Health Organisation (WHO) declared 'with great hope' and end to COVID-19 as a public health emergency.
5. In August 2022, the pandemic structures within the Trust were closed with a final SBAR from the Business Continuity and Recovery Cell (BCRC).
6. In addition to managing COVID-19 during this time, there was also an outbreak of Monkeypox, initially categorised as a High Consequence Infectious Disease (HCID), affecting certain demographics of society, this demonstrates that we must remain vigilant in our preparedness for infectious diseases.
7. From 1 September 2022 until 8 February 2023, Public Health Wales was notified of five deaths in children under the age of 15 who had contracted Invasive Streptococcus A, otherwise known as iGAS, these are rare side effects with many children having made full recoveries from Strep A.
8. From 7 September 2022 to 25 October 2022, shared services began fieldwork for the IPC Internal Audit. The final report was submitted on 5 January 2023, (Appendix 1). On completion of the Audit the Trust was issued with 'reasonable assurance' with recommendations which is documented and managed via the Trust's 'Audit Tracker'.
9. Based on the above recommendations a 3P Project (Power, Policies and Procedures) has commenced within the IPC Team. This is to ensure that parent

documents (Policies) are appropriately linked with associated Standard Operating Procedures, Standards of Practice, Risk Assessments and Monitoring Arrangements. The reporting of this is done via the IPC Strategic Group and Alert, Advise and Action (AAA) reporting to the Clinical & Quality Governance Group (CQGG).

10. Updated IPC Guidance is in development and will be published Autumn 2023 and will be based on the National IPC Manual, initially developed by NHS Scotland, and adopted by all 4 government administrations. This will be approved by the CQGG once complete.

**RECOMMENDED that the Quality, Patient Experience & Safety Committee notes the information within this paper and receive assurance that the Trust is actively driving towards a consistent IPC culture, one in which we maintain high standards of patient care and staff safety and that the focus for the next year will be on monitoring, audit and assurance.**

#### KEY ISSUES/IMPLICATIONS

Key areas for 2023/24 are to source a sustainable model to provide staff with appropriate respiratory protection for both Business-as-Usual activities and any future pandemic requirements. This is currently being worked through via a multidisciplinary Task and Finish Group. Once complete a report will be presented with an options appraisal for the Executive Management Team to consider.

#### REPORT APPROVAL ROUTE

Clinical Quality Governance Group	24 July 2023
Quality, Patient Experience & Safety Committee	10 August 2023

#### REPORT APPENDICES

**ANNEX 1** - SBAR  
**APPENDIX 1** - WAST IPC Final Audit Report (January 2023)  
**APPENDIX 2** - IPC Work Plan 2023-2024

#### REPORT CHECKLIST

Confirm that the issues below have been considered and addressed		Confirm that the issues below have been considered and addressed	
EQIA (Inc. Welsh language)	NA	Financial Implications	YES
Environmental/Sustainability	NA	Legal Implications	YES
Estate	YES	Patient Safety/Safeguarding	YES
Ethical Matters	YES	Risks (Inc. Reputational)	YES

Health Improvement	YES	Socio Economic Duty	YES
Health and Safety	YES	TU Partner Consultation	NA

### SITUATION

1. This report provides analysis of Infection Prevention and Control (IPC) performance throughout the organisation from 1 April 2022- 31 March 2023.
2. This report is presented to provide assurance to patients, service users and the Welsh Ambulance Services NHS Trust (WAST) Trust Board on how we are continuing to provide quality and safety in the care that we deliver for IPC.
3. The Team embraces the Welsh Government Code of Practice on Prevention and Control of Healthcare Associated Infections (these are currently being updated, the expected release date for the updated Code of Practice is September 2023), this enhances and supports our working practices detailed in the [Health and Care Quality Standards 2023](#).
4. Standard IPC precautions are the basic infection prevention practices that, when used consistently and diligently, reduce the transmission of potentially pathogenic organisms from both recognised and unrecognised sources, ultimately protecting patients, staff, and visitors. These include correct hand hygiene, safe cleaning and decontamination, safe handling and disposal of waste and linen, sharps safety, correct use of personal protective clothing, safe handling of blood and body fluids and respiratory hygiene. This portion remains unchanged in the basic standards of practice for IPC.
5. The period that this report covers includes the transition from the COVID-19 pandemic, to, Business as Usual (BAU), in addition this report will contain the IPC Work Plan for 2023-24.
6. BAU Guidance will be based on the National IPC Manual ([NIPCM Wales](#)). All guidelines for IPC within Healthcare Services will be based on this manual.
7. On 5 May 2023, the Head of the UN World Health Organisation (WHO) declared 'with great hope' an end to COVID-19 as a public health emergency, stressing that it does not 'mean the disease is no longer a global threat'. COVID-19 will still be tracked to better understand its endemic pattern, transmission, and pathogenicity. It is expected that COVID-19 will become one of many seasonal respiratory infections to manage in healthcare, the response to COVID-19 needs to form part of BAU activities.
8. In August 2022, the pandemic structures within the Trust were closed with a final SBAR from the Business Continuity and Recovery Cell (BCRC). This document set out reporting structures and governance routes to replace the Pandemic cell

structures. For IPC this will be largely managed by the IPC Strategic Group (IPC SG) along with the Clinical & Quality Governance Group (CQGG) and the Quality, Patient Experience & Safety Committee (QuEST).

9. In addition to managing COVID-19 during this time frame, there was also an outbreak of Monkeypox, initially categorised as a High Consequence Disease (HCID), affecting certain demographics of society.
10. The first reported case in Wales was 6 May 2022, 47 cases were confirmed, with the outbreak officially declared closed on 22 November 2022 with no new confirmed cases for several weeks. The total confirmed cases within the UK by this point was 3,580, there were no fatalities recorded.
11. From 1 September 2022 until 8 February 2023, Public Health Wales was notified of 5 deaths in children under the age of 15 who had contracted Invasive Streptococcus A, otherwise known as iGAS, or more commonly known as Scarlet Fever. Some theories for the increase were isolation during the COVID-19 pandemic with a return to social settings more frequently.

## **BACKGROUND**

12. The IPC All Wales Code of Practice builds on the 2011 Welsh Government Commitment to Purpose, Eliminating Preventable Healthcare Associated Infections (HCAIs). It sets out the minimum necessary infection prevention and control arrangements for NHS Healthcare providers in Wales. The code is based on 9 standards of practice [Welsh Government IPC Codes of Practice](#). These standards have recently been reviewed by Public Health Wales and are due to be published Autumn 2023. No exact date has been given at the time of completing this report.
13. The Health and Care Quality Standards (Welsh Government April 2023) have now replaced the previous Health and Care Standards (2015). The Duty of Quality Statutory Guidance 2023 and Health and Care Quality Standards 2023 have been based on The Health and Social Care (Quality and Engagement) (Wales) Act 2020.

## **ASSESSMENT**

### **IPC Governance**

14. IPC Governance within the Trust continues to be managed in the first instance via the IPC SG. The Terms of Reference for this group have been reviewed regularly to ensure that the membership and frequency of meetings are appropriately distributed. There have been some disruptions during the last financial year, this has necessitated some meetings being cancelled and or

rearranged. This was largely due to industrial action, increasing demand and activity leading resources being prioritised.

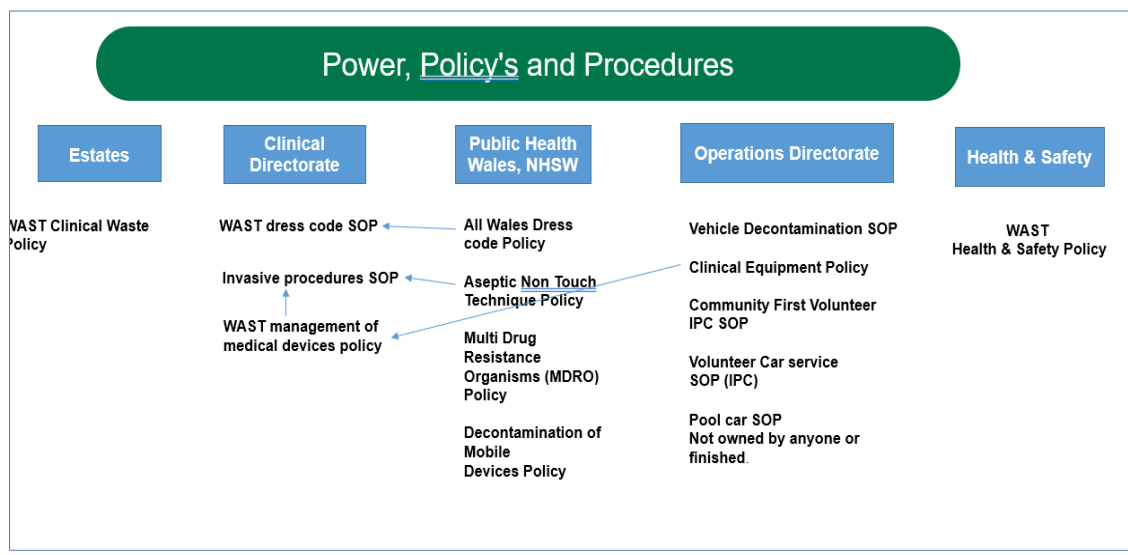
15. From 7 September 2022 to 25 October 2022, shared services began fieldwork for the IPC Internal Audit. The final report was submitted on 5 January 2023 (Appendix 1).
16. The purpose of the Audit, 'to assess adherence to organisational policies and the Standards for Health Services in Wales and consider progress to implement recommendations raised in the 2019/20 'limited' assurance Cleaning Standards Report.'
17. On completion of the Audit the Trust was issued with 'reasonable assurance' on this area. The matters which required management attention were:
  - IPC audits and audits tools
  - Continued issues in operation and membership of the IPC Strategic Group
  - Clarity required for ongoing performance monitoring and reporting arrangements
  - Arrangements for formal monitoring of the IPC Action (Work) Plan (Appendix 2)
  - Inconsistencies identified in roles and responsibilities within draft policies and procedures.
18. The management response to the Audit Report is managed via the Trust's Audit Tracker.

### **IPC Policy and Document Progress**

#### Policy documents

19. The IPC Policy has been reviewed and updated, it now reflects the National IPC Policy, (written by the National Ambulance IPC Group, overseen by the Association of Ambulance Chief Executives (AACE)), the Welsh Code of Practice for IPC and the Health and Care Quality Standards (2023). The progress of this updated Policy is via the Trust's Policy Group and is now at the consultation phase due to the many changes that have been made to the original Policy.
20. The Trust's Premise and Vehicle Cleaning Policy has also been reviewed and updated, the Policy Group has reviewed the changes and deemed them as minor and has approved the updates for publication. This will be sent to the CQGG and QuEST for final approval and this too is being managed via the Trust Policy Group. This updated version required minimal updating and was therefore approved by the Policy Group members.

21. Both Policies have been delayed in their progress due to the exceptional workload of the Governance Team, in particular the work required for the COVID-19 public enquiry and several Coroner inquests which have taken priority. They are now on track for completion.
22. The IPC Team has developed many documents pre COVID-19, during and now as we resume to normal activities, to that end and in response to the Internal Audit the IPC Team is now undertaking a mapping process to align IPC and related policies, responsibilities, ownership, monitoring, and governance arrangements to support future review and development of policies and guidance. This has been called 'The 3P Project'. Progress and monitoring of this project and resulting documents is being done via the IPCSG and Alert, Advise and Action (AAA) Reports to the Clinical & Quality Governance Group.



23. The All-Wales Aseptic Non-Touch Technique (ANTT) Policy has been reviewed by Public Health Wales and will also be presented to the Policy Group for approval.

**Standard Operating Procedures (SOPs)**

24. Below are the current SOPs in various stages of completion. Not all are owned by the IPC function however, they will require IPC support in their construction.

Completed and Approved SOPs	SOPs awaiting approval	SOPs in development
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<ul style="list-style-type: none"> <li>• High Consequence Infectious Diseases (HCID) Standard Operating Procedure</li> <li>• Infectious Disease Outbreak Management (Non COVID -19) Standard Operating Procedures.</li> <li>• Vehicle Decontamination SOP</li> <li>• Respiratory Protection SOP</li> <li>• Fit Testing SOP</li> </ul>	<ul style="list-style-type: none"> <li>• Hand Hygiene and Bare Below the Elbow SOP</li> <li>• Linen SOP</li> <li>• Adenosine Triphosphate SOP</li> <li>• Decontamination of Mobile Devices SOP</li> </ul>	<ul style="list-style-type: none"> <li>• Sharps Standard Operating Procedure (this replaces the previous Invasive Procedure SOP)</li> <li>• Decontamination of Medical Devices</li> <li>• Multi Drug Resistance Organisms (formerly AMR Delivery Plan)</li> <li>• Volunteer Car Services SOP</li> <li>• Pool Car SOP</li> <li>• Community First Responder SOP</li> </ul>
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### **Guidance Documents**

25. The current IPC Personal Protective Equipment (PPE) Guidance Version 3 is the transition guidance from COVID-19 to BAU activity. This Guidance will be replaced by the Safe Clean Care Guidance document currently in draft with the anticipated publication of Autumn 2023. Public Health Wales has teamed with NHS Scotland to host and utilise their electronic National Infection Control Manual (NICM). This is to ensure that Wales has access to consistent, current, and standardised policies to support practice. All previous guidance documents for IPC developed by Public Health Wales has been superseded by the adoption of the NIPCM ([NIPCM Wales](#)).

### **Standards**

26. Standards of Practice that govern IPC in Wales are set by Welsh Government and Public Health Wales.

<b>Completed Standards</b>	<b>Standards For Approval</b>	<b>Standards in development</b>
Vehicle Cleaning Standards	*Welsh Ambulance Key Standards for Environment Cleanliness	<ul style="list-style-type: none"> <li>• of Practice Hand Hygiene and Bare Below the Elbow</li> <li>• Standard Infection Prevention and Control (SIPCS).</li> </ul>

		<ul style="list-style-type: none"> <li>• Transmission Based Precautions (TBPs) Standards</li> </ul>
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**\*NB** The current National Cleaning Standards published by NHS England in 2021 do not cover Ambulance Trusts and Emergency Services. In addition to this Wales has decided to produce its own set of Standards and there is a current Task and Finish Group involved with this (Head of IPC, WAST a member). In addition to this there are Standards that are being written by the National Ambulance IPC Group, supported by AACE. To that end what these Standards will consist of is unclear at this time.

### **Audits**

27. One Internal Audit performed by Shared Services was completed, with field work starting on 7 September, concluding on 25 October and the final report published on 5 January. It is important to note that this Audit took place six weeks into BAU following the closure of the Pandemic Cell structures. Reasonable assurance was given with recommendations moving forward (full report attached in **Appendix 1**).
  
28. The IPC Team has developed 2 new Audit Tools, 1 for vehicle cleaning and the second for environmental cleaning. There are currently no nationally used Audit Tools available to the IPC Team therefore these Audit Tools have been developed using Microsoft Forms. The Audit Plan for 2023/2024 is included within the IPC Work Plan (**Appendix 2**). Audit progress once again has been delayed, this has been due to continued COVID-19 priorities at the beginning of 2022, fit test training and quality assurance processes, along with industrial action and significant system pressures. In addition to this the team establishment has been reduced due to both sickness and a vacancy. Audit is a priority for the 2023/2024 financial year, this is also clear in the IPC Work and Audit Plan.

### **Risk Management**

29. As the work has progressed with the 3P Project following the Internal Audit, a suite of Risk Assessments has been developed, each of these Risk Assessments that have been completed are in alignment with recently developed SOPs and are part of the 3P Project. These will be processed via the IPCSG, the CQGG and Trade Union Partners. In terms of monitoring when each new Audit Tool is developed, we will ensure that they are based on Standards, Risk Assessments, and best practice.
  
30. Risk Assessments work in progress:

<b>Completed</b>	<b>Comments</b>	<b>To be completed</b>
Hand Hygiene	For Approval at IPCSG and CQGG	The use of Twiddle Mitts
Management of Linen	For Approval at IPCSG and CQGG	Revisit Pandemic Preparedness
The use of patient friendly wipes	For Approval at IPCSG and CQGG	Needlestick injuries
Corpro valve replacement	For Approval at IPCSG and CQGG	Contamination from blood and bodily fluids
Fit Testing	For Approval at IPCSG and CQGG	IPC Training and Education appropriate for all staff levels and grades
Red level PPE and Versaflo training	For Approval at IPCSG and CQGG	Compliance with Waste Management
The removal of general waste	For Approval at IPCSG and CQGG	Compliance with Vehicle Cleaning Standards
RPE filter change on Versaflo hood units	For Approval at IPCSG and CQGG	Effective Premise Cleaning
Cleaning of Versaflo Hoods	For Approval at IPCSG and CQGG	
Decontamination of mobile devices	For Approval at IPCSG and CQGG	
How to clean a vehicle contaminated by faeces	For Approval at IPCSG and CQGG	
Removal of clinical waste PPE	For Approval at IPCSG and CQGG	

### 31. Fit Testing:

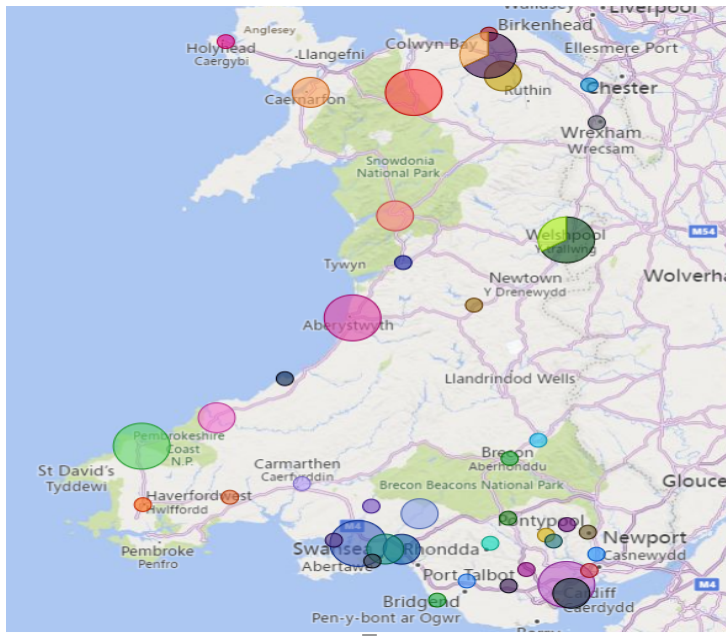
- 95% of Emergency Medical Services (EMS) staff are recorded as having been fit tested within the last three years.

- 82% of Non-Emergency Patient Transport Service (NEPTs) staff are recorded as having been fit tested within the last three years.
- FP3 protection is required for more than just COVID and respiratory infections, staff should always check in the A-Z of common diseases for further guidance ([A-Z Common Diseases](#))
- Fit Testing updates are sent via Electronic Staff Record (ESR) reporting and can be accessed by all Managers within their own localities.
- Staff will require re-fit testing every three years and for many this will be required during 2023.
- Simultaneously a Task and Finish Group has been established to determine future Respiratory Protective Equipment (RPE) and Fit testing options.

### 32. Fit Testers:

- There are currently, at the time of writing this report, 89 members of staff across the Trust that have been trained as a Fit Tester by the IPC Team.
- Two members of the team achieved British Standard Institute (BSIF) fit testing certification in 2021. One member has since left the team and is still employed by the Trust in a different role. This ensures the Trust is compliant with Health and Safety Regulations and fit testing is done by staff identified as competent to do so.
- There is a comprehensive training package to train new Fit Testers with a record of competencies and up to date documentation.
- Each trained Fit Tester requires an annual quality assurance check to ensure ongoing competencies, required annually due to the infrequency of testing, this is currently done by the IPC Team
- Currently staff that are on alternative duties are put forward as Fit Testers, rarely are they available once they return to their substantive roles.
- All current trained Fit Testers are registered on Everbridge.
- All guidance for fit testing and RPE for the Trust can be found in the Trust's Fit Testing Standard Operating Procedure (SOP) ([Fit Testing SOP](#)) and the Respiratory Protection SOP ([Respiratory Protection SOP](#)).

Figure 1: Current Fit Testers demographically:



33. Key Challenges for 2023:

- A key challenge for the Trust is the sustainability of the current Fit Testing Model and the future RPE provision for staff. We must remain pandemic prepared, learn from the last three years and be efficient and cost effective moving forward.
- An RPE Task and Finish Group has been established to investigate these challenges further and to seek a long-term sustainable option to maintain appropriate respiratory protection for staff. The progress of this work will be reporting to the Senior Operations Team (SOT) and the Clinical Quality Governance Group (CQGG).
- The Trust should maintain its British Safety Industry Federation (BSIF) accreditation, and more staff should achieve this.
- The Health and Safety Executive (HSE) requires the Trust to keep records of maintenance and cleaning of reusable RPE and fit testing details. These should be available for inspection if requested. The maintenance and cleaning records are not a requirement for single use RPE or elements that are single use.

34. Training and Education:

Current IPC training available for staff within the trust	Comments	IPC Team Training

WAST Learning Zone On click 6 modules available.	Requires updating which requires finance	<ul style="list-style-type: none"> <li>• IPC specialist education/Training</li> <li>• PADR's</li> <li>• CPD Activity</li> <li>• BSIF Accreditation</li> <li>• Statutory and Mandatory Training</li> <li>• National IPC Group membership</li> <li>• National IPC Conference</li> </ul>
ESR Level 1 and 2 IPC training mandatory training via ESR	Level 2 for WAST staff is the Pre-Hospital Care Level 2 Training	
Emergency ANTT	Currently being migrated onto ESR to replace the All-Wales ANTT training package, agreement for this from PW and ANTT.org	

35. The IPC Team and the Training School have worked closely over the past year to both standardise the training provided to staff ensuring that we stay within all Wales Infection Prevention and Control Training Framework. This has included the production of training videos, scenarios, practical demonstrations, and online resources.
36. The IPC Team, wherever possible, attend in person for any training requests. The training material is available to the Training School should there be limited support for face-to-face attendance necessitating the Training School staff to attend on our behalf.
37. Internal Training Reports:

<b>EMS IPC Onclick Module Compliance - as of 24.04.2023</b>			
<b>020 Ambulance Response - ABM L6 (DZ51)</b>			
	<b>No. of Completions</b>	<b>Headcount</b>	<b>Compliance</b>
020 ABM Bridgend Locality L8 (DD30)	235	282	83.33%
020 ABM Neath Locality L8 (DD40)	51	64	79.69%
020 ABM Swansea Locality L8 (DD50)	79	95	83.16%
<b>020 Ambulance Response - Aneurin Bevan L6 (DZ71)</b>			
020 Area Management - Aneurin Bevan L8 (DE10)	105	123	85.37%
020 Caerphilly Locality Management (DE40)	232	303	76.57%
020 Gwent/Torfaen Locality Management (DE30)	0	1	0.00%
020 Newport/Monmouth Locality Management (DE20)	51	72	70.83%
<b>020 Ambulance Response - BCU L6 (DZ61)</b>			
020 Area Management - BCU L8 (DF10)	91	104	87.50%
020 BCU-E Conwy & Denbighshire Locality L8 (DF30)	292	449	65.03%
020 BCU-E Flintshire & Wrexham Locality L8 (DF40)	12	22	54.55%
020 BCU-W South Gwynedd Locality L8 (DF50)	109	142	76.76%
020 BCU-W Ynys Mon Locality L8 (DF60)	64	120	53.33%
<b>020 Ambulance Response - C&amp;V L6 (DZ72)</b>			
020 C&V Cardiff Locality L8 (DG20)	62	98	63.27%
020 C&V Vale Locality L8 (DG30)	146	182	80.22%
<b>020 Ambulance Response - Cwm Taf L6 (DZ73)</b>			
020 Merthyr Locality L8 (DH40)	47	56	83.93%
020 RCT Locality L8 (DH30)	109	154	70.78%
<b>020 Ambulance Response - Hywel Dda L6 (DZ52)</b>			
020 Carmarthen Locality L8 (DJ20)	64	75	85.33%
020 Ceredigion Locality L8 (DJ30)	45	79	56.96%
020 Ceredigion Locality L8 (DJ30)	244	290	84.14%
020 Pembroke Locality L8 (DJ40)	101	119	84.87%
<b>020 Ambulance Response - Powys L6 (DZ53)</b>			
020 North Powys Locality L8 (DK20)	62	65	95.38%
020 North Powys Locality L8 (DK20)	81	106	76.42%
020 South Powys Locality L8 (DK30)	101	145	69.66%
<b>020 Operations Directorate - Resilience L6 (DZ03) (HART Only)</b>			
020 Hazardous Area Response Team L8 (DA20)	43	58	74.14%
020 Hazardous Area Response Team L8 (DA20)	58	89	65.17%
<b>Grand Total</b>	<b>38</b>	<b>42</b>	<b>90.48%</b>
	38	42	90.48%
	<b>1397</b>	<b>1847</b>	<b>75.64%</b>

<b>NEPTS IPC Onclick Module Compliance - as of 24.04.2023</b>			
<b>Row Labels</b>	<b>No. of Completions</b>	<b>Headcount</b>	<b>Compliance</b>
020 NEPTS C&W ABM L6	102	120	85.00%
020 NEPTS C&W Hywel Dda Area L6	81	91	89.01%
020 NEPTS C&W Powys Area L6	39	43	90.70%
020 NEPTS NR BCU Area L6	94	168	55.95%
020 NEPTS SE Aneurin Bevan Area L6	122	212	57.55%
020 NEPTS SE C&V Area L6	68	100	68.00%
020 NEPTS SE Cwm Taf Area L6	59	88	67.05%
<b>Grand Total</b>	<b>565</b>	<b>822</b>	<b>68.73%</b>

<b>Infection Control Level 1 - as of 31.03.23</b>				
Assignment Count	Required	Achieved	Compliance %	
4372	4372	3117	71.29%	
Org L4	Assignment Count	Required	Achieved	Compliance %
O20 Ambulance Care L4 (NX10)	989	989	732	74.01%
O20 Capital & Estates L4 (HX15)	26	26	17	65.38%
O20 Chief Executive Directorate L4 (BX11)	19	19	9	47.37%
O20 Clinical Division L4 (UX14)	51	51	40	78.43%
O20 Complaints Claims & Litigation L4 (UX12)	23	23	20	86.96%
O20 Corporate Governance L4 (BX81)	7	7	6	85.71%
O20 Education & Development L4 (PX12)	28	28	26	92.86%
O20 Emergency Medical Services L4 (DX04)	1852	1852	1147	61.93%
O20 Finance Division L4 (FX11)	34	34	27	79.41%
O20 Health & Safety L4 (PX13)	12	12	11	91.67%
O20 Health Informatics L4 (HX13)	20	20	16	80.00%
O20 ICT Division L4 (IX12)	32	32	23	71.88%
O20 Integrated Care L4 (DX03)	537	537	443	82.50%
O20 Medical Division L4 (UX13)	1	1	1	100.00%
O20 National Fleet Services L4(DZ41)	47	47	42	89.36%
O20 National Operations & Support L4 (DX02)	150	150	84	56.00%
O20 Partnerships & Engagement L4 (CX11)	12	12	7	58.33%
O20 People & Culture L4 (PX11)	64	64	57	89.06%
O20 Quality & Nursing L4 (JX11)	94	94	88	93.62%
O20 Research & Development Division L4 (UX11)	5	5	2	40.00%
O20 Resourcing & EMS Coordination L4 (DX05)	352	352	308	87.50%
O20 Strategy, Planning & Performance L4 (HX17)	17	17	11	64.71%

<b>Infection Control Level 2 - as of 31.03.23</b>				
Assignment Count	Required	Achieved	Compliance %	
2732	2732	1334	48.83%	
Org L4	Assignment Count	Required	Achieved	Compliance %
O20 Ambulance Care L4 (NX10)	829	829	499	60.19%
O20 Clinical Division L4 (UX14)	10	10	5	50.00%
O20 Education & Development L4 (PX12)	16	16	15	93.75%
O20 Emergency Medical Services L4 (DX04)	1796	1796	785	43.71%
O20 Health & Safety L4 (PX13)	1	1	1	100.00%
O20 Integrated Care L4 (DX03)	9	9	8	88.89%
O20 National Operations & Support L4 (DX02)	61	61	13	21.31%
O20 People & Culture L4 (PX11)	10	10	8	80.00%

<b>ANTT Compliance - as of 31.03.2023</b>				
Assignment Count	Required	Achieved	Compliance %	
1951	1951	847	43.41%	
Org L6	Assignment Count	Required	Achieved	Compliance %
O20 Clinical Division L6 (UZ03)	11	11	8	72.73%
O20 Complaints Claims & Litigation L6 (JZ02)	1	1	1	100.00%
O20 EMS - ABM L6 (DZ51)	283	283	101	35.69%
O20 EMS - Aneurin Bevan L6 (DZ71)	302	302	142	47.02%
O20 EMS - BCU L6 (DZ61)	452	452	154	34.07%
O20 EMS - C&V L6 (DZ72)	183	183	69	37.70%
O20 EMS - Cwm Taf L6 (DZ73)	152	152	95	62.50%
O20 EMS - Hywel Dda L6 (DZ52)	290	290	133	45.86%
O20 EMS - Powys L6 (DZ53)	146	146	87	59.59%
O20 Education & Development L6 (PZ02)	16	16	16	100.00%
O20 Integrated Care L6 (DZ90)	58	58	26	44.83%
O20 National Operations & Support - Volunteer Management L6 (DZ05)	9	9	3	33.33%
O20 Quality & Nursing L6 (JZ01)	5	5	5	100.00%
O20 Resilience/Business Continuity L6 (DZ03)	43	43	7	16.28%

38. Many staff have now come out of compliance for the practical assessment of their Aseptic Non-Touch Technique (ANTT). This is planned for the Mandatory in Service Training (MIST) on 2024/2025. This is largely down to the lack of ANTT Assessor Training. Between now and March 2023, trainers within the Training School will be identified as ANTT Assessors, training will be supplied by ANTT.org.
39. Any staff that require the theory for their compliance will be able to access the Emergency ANTT training that was a bespoke training module for WAST devised by ANTT.org. This training was purchased from ANTT.org and therefore can be uploaded to ESR to replace All Wales training. This has been agreed by Public Health Wales to recognise the different challenges faced by our Emergency Services as opposed to a more controlled secondary care environment.

### **WAST IPC Team Representation**

40. It is encouraging to note below the meetings, Working and Advisory Groups that members of the IPC have working relationships with and are able to represent the service, ensuring that the service and the out of hospital environment for IPC considerations and communication. It is essential that these relationships are strengthened, and IPC remains a focus for good standards and practices:

<b>Internal</b>	<b>External</b>
<ul style="list-style-type: none"> <li>• IPC Strategic Group</li> <li>• Estates working group.</li> <li>• Fleet working group.</li> <li>• Working safely dynamic delivery group.</li> <li>• IPC team meetings.</li> <li>• Quality Live.</li> <li>• Outbreak Management Teams</li> <li>• High Consequence Disease Task and Finish Group</li> <li>• Senior Pandemic Team</li> <li>• Quality Safety, Wellbeing Advisory Cell</li> <li>• Business Continuity and Recovery Cell</li> <li>• National Health &amp; Safety Committee</li> <li>• Pandemic Governance Group</li> <li>• Senior Operational Team Meetings as required.</li> <li>• Clinical Quality Governance Group as required.</li> <li>• ADLT as required</li> </ul>	<ul style="list-style-type: none"> <li>• National Ambulance IP&amp;C group.</li> <li>• Public Health Wales working and advisory groups. (e.g., HCAIs and IP&amp;C working group)</li> <li>• Infection Prevention Society working groups and branch meetings.</li> <li>• National Framework Operational Delivery Group for the investigations of COVID related HCAI's</li> <li>• Wales IPC Code of Practice refresh working group.</li> <li>• Wales Environmental Cleaning Standards Tasks and Finish Group</li> </ul>

### **Datix Reviews**

41. Any Datix that is submitted which generates an IPC code within the submission is emailed directly to the IPC Team. These submissions are reviewed on a weekly to two weekly bases (dependent on weekly activity). The datix date, number, details, and handlers are recorded and contact is made to offer support for any investigations. Notes are kept on the progress of the recorded datix and when they are closed, or if no action is required. Reporting from Datix is now quite complicated with many different codes for IPC.

### **Horizon Scanning**

42. Dedicated time within the IPC Team is allocated to horizon scanning and the team publish monthly on national and global activity, this can be accessed on the

IPC homepage on the intranet. It is imperative that any relevant or emerging threats are disseminated immediately to all relevant parties and to reinforce continued pandemic preparedness.

### **Notifications of Infectious Diseases (NOIDS)**

43. Notification of infectious diseases is the term used to refer to the statutory duties for reporting notifiable diseases in the Public Health (Control of Disease) Act 1984 and the Health Protection (Notification) Regulations 2010 ([Notifiable Diseases weekly reports](#)).

### **High Consequence Infectious Disease (HCIDs)**

44. This term is used to refer to infections which are acute, have a high case-fatality rate and may not have effective prophylaxis or treatment. They are often difficult to recognise and detect rapidly, they can spread rapidly in the community and within healthcare settings. Management requires an enhanced individual, population, and system response to ensure it is managed effectively, efficiently, and safely.

### **Global Hazards**

45. HCIDs including Viral Haemorrhagic Fevers (VHFs), are rare in the UK however they do have the ability to cross border, land, and sea. When cases do occur, they tend to be sporadic and are typically associated with recent travel to an area where the infection is known to be endemic or where an outbreak is occurring. None of the HCIDs listed are endemic in the UK and the known animal reservoirs are not found in the UK ([High consequence infectious disease: country specific risk - GOV.UK \(www.gov.uk\)](#)).

# Infection Prevention and Control Final Internal Audit Report

January 2023

Welsh Ambulance Services NHS Trust



GIG  
CYMRU  
NHS  
WALES

Partneriaeth  
Cydwasaethau  
Gwasanaethau Archwilio a Sicrwydd  
Shared Services  
Partnership  
Audit and Assurance Services



GIG  
CYMRU  
NHS  
WALES

Ymddiriedolaeth GIG  
Gwasanaethau Ambiwllans Cymru  
Welsh Ambulance Services  
NHS Trust



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Review reference:	WAST-2223-03
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Final report issued:	5 <sup>th</sup> January 2023
Auditors:	Osian Lloyd, Head of Internal Audit Jonathan Jones, Audit Manager
Executive sign-off:	Liam Williams, Executive Director of Quality & Nursing
Distribution:	Jonathan Turnbull-Ross, Assistant Director of Quality Governance, Louise Colson, Head of Infection Prevention and Control
Committee:	Audit Committee



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

### Acknowledgement

NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

### Disclaimer notice - please note

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of 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.

## Executive Summary

### Purpose

To assess adherence to organisational policies and the Standards for Health Services in Wales and consider progress to implement recommendations raised in the 2019/20 'limited' assurance Cleaning Standards report.

### Overview

We have issued reasonable assurance on this area. The matters which require management attention include:

- IPC audits are not yet underway with audit tools yet to be finalised.
- Continued issues in operation and membership of the IPC Strategic group.
- Clarity required for ongoing performance monitoring and reporting arrangements.
- Arrangements for formal monitoring of the IPC Action Plan are unclear.
- Inconsistencies identified in roles and responsibilities within draft policies and procedures.

### Report Classification

Reasonable



Some matters require management attention in control design or compliance.

**Low to moderate impact** on residual risk exposure until resolved.

Trend



Cleaning Standards 2019/20

### Assurance summary<sup>1</sup>

Assurance objectives	Assurance
1 Policies and procedures	Reasonable
2 Trust structure and responsibilities	Reasonable
3 IPC Programme	Limited
4 Guidance and training	Reasonable
5 Mechanisms for assurance	Limited
6 Performance and oversight	Reasonable

### Key matters arising

	Assurance Objectives	Control Design or Operation	Recommendation Priority
1 IPC Policies and related procedures	1	Design	Medium
2 IPC Strategic Group operation	2	Operation	Medium
3 Roles and responsibilities	1, 2	Design	Medium
4 IPC Work Plan content, monitoring and approval	3	Operation	Medium
5 'Onclick' Resources	4	Operation	Low
6 Trust IPC assurance mechanisms	5	Design	High
7 Performance reporting	4, 6	Operation	Medium

<sup>1</sup> The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

## 1. Introduction

- 1.1 The Welsh Ambulance Services NHS Trust ('the Trust') is committed to a zero tolerance of preventable healthcare associated infections (HCAI's). The Trust aims to work in partnership with all staff, service users and key stakeholders, to reduce the risk of transfer of community acquired infections in the pre-hospital care environment to secondary care and wider community environments.
- 1.2 The Infection Prevention and Control Annual Report 2021 – 2022, presented to the Trust's Quality, Patient Experience and Safety (QUEST) Committee in August 2022, outlined that the Infection Prevention and Control (IPC) team has necessarily had a COVID-19 focus in the past two years. The report outlined that the team was now looking to return to a business-as-usual approach, whilst retaining the improvements and IPC related behaviours gained through experience of the pandemic.
- 1.3 The Annual Report also provided a summary of IPC team priorities to be taken forward in 2022/23, including review of the Trust IPC Policy and a number of standard operating procedures, guidance and standards documents, alongside recommencing IPC audits which were suspended during the pandemic.
- 1.4 This review will also consider progress made to implement recommendations raised in the 2019/20 'limited' assurance Cleaning Standards report.
- 1.5 The risks considered during the review were as follows:
- i. Patient or staff harm where infection prevention and control guidance and practice are not aligned to national standards.
  - ii. Financial loss or reputational damage to the Trust as a result of poor performance.

## 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	0	3
Operating Effectiveness	0	3	1	4
<b>Total</b>	<b>1</b>	<b>5</b>	<b>1</b>	<b>7</b>

- 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](#).

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**Audit objective 1: The Trust has an infection prevention and control policy that provides clear direction, aligns with national standards, and is supported by appropriate operational policies and procedures.**

- 2.3 The Trust has an overarching Infection Prevention and Control policy: '*Infection Prevention & Control Policy: Elimination of Healthcare Associated Infections*' ('the policy'), which was due for review in May 2021. Updates were made in September 2022, by the Head of Infection Prevention and Control (IPC), to align it with the Association of Ambulance Chief Executives (AACE) model national IPC policy. At the time of fieldwork closing the policy was to be submitted to the October 2022 meeting of the Trust Policy Review Group.
- 2.4 Whilst incorporating content from the AACE national policy, the Trust needs to ensure there remains alignment to the Welsh Government standards (*Code of Practice for the Prevention and Control of Healthcare Associated Infections*). We were also informed that the policy would retain guidance on Personal Protective Equipment provided by the Health and Safety Executive (HSE) that featured in previous revisions.
- 2.5 Review of the draft policy has identified a number of key revisions and updates. These include revised scope, aim and objectives and, in particular, reference to the previous IPC improvement plan has been replaced with a commitment to the prevention and control of infection and to set the strategic direction for IPC initiatives.
- 2.6 The draft revised policy expands on roles and responsibilities, including the addition of the Trust Board, Head of IPC and wider IPC team. Roles and responsibilities for managers and staff have also been refreshed and it provides further clarity on the need to ensure all staff and contractors receive sufficient training, information and supervision, with responsibility for developing training content assigned to the IPC team.
- 2.7 There is also outline of IPC audit arrangements, with audit subjects including vehicles, premises, equipment, clinical waste, sharps, linen and reference to 'local ownership of IPC standards by local management teams.' These are to be undertaken in line with the Trust's IPC audit programme. We discuss IPC audit arrangements in more detail at 2.46.
- 2.8 The overarching policy is supported by subject specific policies, standard operating procedures (SOPs) and guidance documents, although we note not all of these are owned or maintained by the IPC team. Following the move from Covid-19 response to business as usual in July 2022, there is currently a focus on updating those which have passed their review date, or those previously paused due to the pandemic.
- 2.9 At the time of fieldwork there were seven documents which were at various stages of draft or pending approval, these included the *Premises and Vehicle Cleanliness Policy*, *Safe Clean Care (IPC Handbook)*, *Key Standards for Environmental*

*Cleanliness*, and SOPs for hand hygiene, management of linen, mobile device decontamination and invasive procedures.

- 2.10 The *Premises and Vehicle Cleanliness* policy will be presented to the Trust Policy Review Group in October 2022. It contains detail on cleaning of premises, and outline of staff, management and reporting responsibilities. However, the cleaning instructions will require updating in line with the *Key Standards for Environmental Cleanliness* document which remains in draft, and monitoring arrangements detailed do not mention vehicles currently. We also note the Operations Directorate has issued a *Vehicle Decontamination SOP*, which provides instruction on vehicle cleaning for those which do not have access to regular cleaning at Trust Make Ready Depots (MRD). There is variation in cleaning instructions between these documents, the SOP also lacks detail on audit or other assurance arrangements. **See MA1 & MA3**
- 2.11 Throughout the pandemic the IPC team has produced a number of updates to Covid-19/PPE guidance documents, to ensure they remained in line with nationally issued guidance. Updates reflected changes in PPE, risk assessments, action cards and isolation/distancing requirements. In line with the movement from transition to business as usual, the team are now developing the next iteration of the IPC handbook: '*Safe Clean Care*'. The handbook combines content from a number of individual SOPs and national guidance, comments provided at the September IPC Strategic group, whilst positive, highlighted the requirement to ensure alignment and consistency. **See MA1**
- 2.12 There has also been focus on emerging risks with the co-production by IPC Team and Operations Directorate of an *Outbreak Management SOP*. This features trigger action cards for escalation, local management team processes, terms of reference and standard meeting agendas. Additionally, guidance has been issued for PPE and IPC management of Monkeypox.

#### Conclusion:

- 2.13 The Trust's IPC Policy has been updated, subject to formal review and approval, and aligns to national practice. A number of policies, SOPs and guidance documents are being reviewed, and the team has continued to address pandemic and other risk areas. However, there are a number of key documents remain in draft with inconsistencies that need to be addressed to ensure alignment. We assign this objective **reasonable** assurance.

#### **Audit objective 2: The Trust has a clear infection prevention and control structure, and Operational and Executive responsibilities are clearly outlined.**

- 2.14 The Trust established a pandemic structure in 2020, which transitioned through response and recovery to a return to business as usual in 2022. The IPC team engaged and contributed to a number of groups within the structure, particularly the Quality, Safety and Wellbeing Advisory and the Business Continuity and Recovery Cells.

- 2.15 During the pandemic, the IPC Team engaged with the cell structure established across the Trust, including the Quality, Safety and Wellbeing Cell, Health and Safety Advisory Cell, Clinical Advisory Cell, Trade Union Partnership Cell, and Senior Pandemic Team meetings. Example documents were provided supporting IPC team attendance and the sharing of guidance, training compliance, number and locations of positive Covid-19 tests and Covid outbreak team incident reports.
- 2.16 As the pandemic structure was stood down on 20<sup>th</sup> July 2022, the Chair of the Business Continuity and Recovery Team (BCRT) produced an SBAR to set out the governance arrangements proposed for those areas which had been included within the remit of the BCRT, and previous Senior Pandemic and Executive Pandemic teams. IPC features within this, with reference to the IPC Strategic Group for development of guidance, and the Clinical Quality Governance Group (CQGG) as the approving forum.
- 2.17 The IPC Strategic Group met infrequently during the pandemic period, as would be expected with the need to focus on Covid-19 response. The Terms of Reference (ToR) is in the process of being revisited and has been shared with the Executive Management Team (EMT) and the IPC Strategic group for review. The membership of the Group needs to be confirmed before the revised version can be finalised.
- 2.18 We reviewed agendas, papers and minutes for the three IPC Strategic meetings held in 2022 (January, April and September 2022), and compared these to the contents of the group's ToR and monitoring requirements in line with the updated IPC policy. Acknowledging that only the September meeting would have been held under a business-as-usual heading, the review suggests there are gaps in its operation. All three meetings were quorate.
- 2.19 The group's ToR includes a requirement '*to provide assurance on performance and the implementation of work programmes*'. However, it has not received the IPC work plan which was developed in 2021. The group is to provide a '*senior cross directorate forum*', but as noted above Senior Operations membership has not been confirmed. There is also a requirement to '*receive and disseminate information pertinent to IPC, monitoring and measuring performance at local, regional and Trust wide levels.*' Whilst the group has met only once since the return to business as usual, our review of meeting agendas does highlight limited performance information being presented. It is important that the Trust take the opportunity to address this for future meetings. **See MA2 & MA7.**
- 2.20 The IPC Strategic group attendance has included members from Estates, Fleet, and the Make Ready Depot Lead. However, review of agendas indicate that papers and reports are only produced by the IPC team, which suggests there could be more emphasis placed on membership responsibilities and contribution to support the group's operation. **See MA2**
- 2.21 We also reviewed the group's minutes and action logs, to identify if actions are identified, tracked, and monitored appropriately. Whilst there have been longstanding actions held within the action log, we observed the September meeting and can confirm each action was subject to discussion and review.
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However, we do note that the most recent minutes for that meeting did not include specific capture of actions, and so consideration should be given to correct this for future meetings.

- 2.22 Operating alongside the pandemic cell structure, the CQGG was responsible for non-Covid related business. Review of CQGG minutes identified that it has received the IPC Annual Report 2021/22, circulation of and subsequent approval of Monkeypox guidance at an extraordinary meeting of the group in June 2022. We note the CQGG has also approved updates for a number of SOPs and SBARs, which suggest that there is a clear route for discussion and approval of IPC documents.
- 2.23 Our recent review of Respiratory Protective Equipment (RPE) included positive reflection of the RPE and Fit Testing SOPs, noting clear outline of both Executive, and operational roles and responsibilities. In particular we noted the IPC team responsibilities for designing policy and process documentation, and as subject experts ensuring these complied with required legislation. This also included consideration of the ability of the Trust to deliver the systems within resources available, while retaining responsibility for implementation through the Operations Directorate. As noted above, the team are progressing and prioritising a number of draft SOPs, and four of these were shared at the September meeting of the IPC Strategic Group for review.
- 2.24 We compared the outline of roles and responsibilities within those four draft SOPs, and the '*Key Standards for Environmental Cleanliness*' which was also submitted for comment at that meeting. Whilst acknowledging they are still in draft, we note variation in how responsibilities are outlined and so there is opportunity to consider further standardisation in format and terminology to support the good practice identified in our earlier review. **See MA3**

#### Conclusion:

- 2.25 There is a clear structure to support IPC within the Trust, with evidence of its use, including across a number of pandemic cells, to discuss and approve SOPs and guidance documents. In the return to business as usual it is important to improve the operation of the IPC Strategic group and its membership. We have also highlighted further opportunities to clarify roles and responsibilities. We assign this objective **reasonable** assurance.

### **Audit objective 3: A programme is in place to direct and deliver infection prevention and control improvements across the Trust.**

- 2.26 We understand from discussion with the Head of IPC that a post pandemic IPC workplan was requested to support the delivery of the 2021-2024 IMTP, and were informed that this was approved through the Trust Pandemic structure.
- 2.27 The 2021 IMTP included reference to developing and implementing a sustainable health and safety transformation plan incorporating health and safety and infection prevention and control. The 2022-25 IMTP highlights key areas for

recovery, including how IPC measures continue to apply in a post-pandemic phase, and ensuring the lessons learnt and systems put in place during Covid-19 continue within business as usual.

- 2.28 The IPC work plan includes that the 2021 IMTP deliverable will be progressed through an IPC action plan, but the document has not been updated to capture the same link to the more recent IMTP.
- 2.29 The work plan is comprised of 10 IPC team deliverables, each with supporting actions, responsible officer, priority, status, and target implementation dates. There is also a column for progress updates and an outline of specific risks to delivery which are RAG rated.
- 2.30 In reviewing the priority areas we considered the deliverables listed above, the requirements of the updated IPC policy, and the priorities listed within the IPC Annual Report 2021-22. Overall, we note there is good coverage, although we did identify omissions. For example, the IPC Annual Report includes reference to actions to address audit recommendations, which is not reflected within the IPC work plan. Additionally, we note the plan does not include actions related to the sustainability of Fit Testing, which is currently a risk held by the team and highlighted as a major focus of team capacity. We also note the plan does not include the work to be undertaken in developing training in line with the HEIW national IPC training framework. **See MA4**
- 2.31 We also reviewed the work plan to consider if it demonstrated consideration of resource requirements, noting that at present it does not with all actions assigned to the Head of IPC. The work plan currently lists two of the ten actions as complete, and whilst a further six have target dates listed for November or December 2022, these include actions yet to be started (Action 10 – Safe Clean Care Campaign), reliant on external support (Action 6 – Audit tools/programme) and progressing of documents out for comment which will likely require approval outside of the group (Action 4 – SOPs, Action 5 IPC Standards). **See MA4**
- 2.32 Review of the IPC plan confirmed that each action has received at least one status review, with the majority having 2-3 narrative progress updates between June 2021 to September 2022. We have noted that priorities within the work plan have been discussed at the various cells within the pandemic structure, although we note this has been ad-hoc rather than on a regularly scheduled basis.
- 2.33 The work plan was initially shared at the IPC Strategic group in July 2021, and we are informed the priorities within the plan was also shared within presentations to the Clinical Advisory and Trade Union Partnership Cells. The plan has not returned to the IPC Strategic group or shared at the CQGG, which will have impacted on their ability to review and monitor progress across the priority areas. The QUEST committee terms of reference were revised this year to include '*Review the annual infection prevention and control plan and monitor its implementation*'. However, the IPC work plan has not been shared at that forum.
- 2.34 We also recognise that the work plan was intended to address post pandemic priorities, but that there has also been a need to tackle other pressing issues,

such as the Fit testing and subsequent quality assurance programme, which has impacted the team's capacity to achieve this.

- 2.35 Additional resource has been secured for the IPC team, including substantive appointments of a Senior and Assistant IPC Practitioner(s) and shared administrative resource with the Health and Safety team. This has primarily been directed to support the establishment of Fit testers and quality assurance arrangements. The majority of quality assurance assessments were undertaken in November and December 2021 and the Trust is committed to a 12-month review of QA Fit Testers by the accredited IPC team members.

#### Conclusion:

- 2.36 The Trust has an established IPC work plan which contains priorities linked to the IMTP and IPC policy. The work plan was shared at the IPC Strategic group but has not returned for further monitoring. It has not been presented to the CQGG, or QUEST committee, and we note there are delays in delivery of identified actions. We have outlined areas that could strengthen the plan content and monitoring. We assign this objective **limited** assurance.

#### **Audit objective 4: There is awareness of infection prevention and control guidance and staff have undertaken appropriate training.**

- 2.37 Outside of the statutory and mandatory IPC training requirements, the Trust has commissioned a supplementary suite of online training materials through the provider 'Onclick'. The additional modules are available to all staff and volunteers through the Trust Learning Zone site and whilst completion is optional, it is recognised as contributing to Continuous Professional Development (CPD).
- 2.38 Guidance on the access and use of both statutory and mandatory training and the onclick modules is available through the IPC SharePoint site, under its training and education page.
- 2.39 Subject areas covered within the online modules include *transmission of infectious diseases, evolution of a pandemic, day in the life on the frontline, PPE Part A, Powered Respiratory Hood Part A, and vehicle cleaning, sharps and waste management.*
- 2.40 We reviewed the *vehicle cleaning, sharps and waste management* module. The module also refers to additional resources such as legislation, policies, and key documents, although we noted instances where the use of links directed the user to incorrect versions and the omission of the *Vehicle Decontamination SOP*. **See MA5**
- 2.41 Health Education Improvement Wales, at the request of Welsh Government, have developed a national framework for IPC Training. The framework outlines expectation across four levels, ranging from entry level: '*introductory awareness*' to Level 4: '*specialist knowledge understanding and application*'. The IPC team are working with the Trust's Training college to map the levels across staffing groups and specialised roles, and we were provided with an initial training needs

analysis. Further work is being undertaken to develop competency booklets to support these requirements. **See MA5**

- 2.42 Training compliance rates for statutory and mandatory IPC training and the Onclick modules were included within the IPC Annual Report 2021/22. Whilst this information is not currently reported to the IPC Strategic group, this has been identified as an area to address and capture in reporting going forward. At the time of fieldwork current performance is as below, noting the national target for IPC Level 1 and 2 is 85%:

Training Course	May 2022	October 2022
IPC Level 1	88.23%	75.63%
IPC Level 2	48.51%	45.46%
Onclick – EMS	72.73%	75.50%
Onclick - NEPTS	79.20%	72.34%

- 2.43 Review of QUEST and People and Culture Committee papers identified that they are provided with an overall combined training compliance figure, rather than a breakdown of performance for each subject area which was previously captured within a Quarterly Assurance Report. We understand that the report is currently under review. **See MA7**
- 2.44 The IPC team are actively supporting face to face training, and in observing the IPC Strategic group meeting in September it was clear that the team have good working relationships with the Learning and Development team. An action was agreed at that meeting to support the development of 'behavioural IPC champions' and to develop resources to highlight the risks of transmissibility within contact centres.
- 2.45 There is also awareness raising through the use of Quality & Nursing Directorate notices which are distributed throughout the Trust. We identified a number have been issued this year, including to promote awareness of infectious diseases, cleaning guidance, and fit test expiry dates.

#### Conclusion:

- 2.46 The Trust provides additional training and guidance materials to support staff, but links to key documents do require updating. Training compliance figures have been reported to QUEST, but we are unable to identify ongoing monitoring or reporting of these where focus is required to improve IPC Level 2 compliance. The team has undertaken an initial training needs analysis against the national framework, with further actions with the Learning and Development team planned. We assign the objective **reasonable** assurance.

#### **Audit objective 5: Mechanisms in place to ensure compliance with Trust policies and procedures are appropriate.**

- 2.47 Our previous review of Cleaning Standards, which was issued at the beginning of the pandemic in 2020, highlighted the need to develop more effective audit

methods to monitor compliance. The IPC Annual Report 2021/22 outlined that no audits were undertaken for 2021/22 due to the need to focus team resource and capacity on the pandemic response and any emerging variants of concern. The report included that a Trust IPC audit programme would be reintroduced in 2022-23 which would include:

- Corpro mask use, filter and maintenance logs and ESR Records;
- Versaflo usage, filter and maintenance logs;
- Peripheral cannulation and ANTT Compliance;
- On Click and eLearning compliance;
- Premise and Vehicle Cleaning;
- Hand Hygiene and Bare Below the elbow.

- 2.48 Discussion with the Head of IPC confirmed that at present the audit programme has not commenced, as there was a need to develop appropriate audit tools which utilised current software applications. The team does not have this capability and so both internal and external assistance had been sought. **See MA6**
- 2.49 The revised IPC policy references a number of additional subject areas which should feature within audit programmes, including staff competency at point of care, storage of medical consumables and equipment, handling and disposal of clinical waste and sharps, management and handling of linen, antimicrobial supply and administration, and local ownership of IPC standards by local management teams. In the previous iteration of the IPC policy some of the above were included but assigned to the Operations and Medical Directorates to undertake. **See MA6**
- 2.50 For the full benefit of the IPC audit programme, it would also require all subject areas having established criteria to be audited against. At the time of fieldwork, the *Premises and Vehicle Cleanliness* policy, *Key Standards for Environmental Cleaning*, and *Hand Hygiene and bare below the elbows* SOP were at draft stage.
- 2.51 With IPC audits not in operation, we queried if there were alternative mechanisms for assurance across key areas of premises and vehicles. Since our previous internal audit review of Cleaning Standards in 2019/20, and in response to the pandemic, the Trust has secured cleaning services for all Trust premises. Additionally, we note the health and safety team have undertaken a programme of Covid-19 risk assessments, which include elements of IPC, across Trust premises in 2021.
- 2.52 Vehicle arrangements have also been strengthened following the opening in 2022 of an additional Make Ready Depot (MRD) in Cardiff. The Trust has an ambition to increase the number of such facilities, to expand this model and approach across Wales. The MRD sites provide dedicated cleaning across three levels, which range from surface clean, a six weekly deep clean, and ad-hoc cleaning where contamination has occurred. As was the case at the time of our previous review of Cleaning Standards, the majority of Trust vehicles are not cleaned at MRD sites,

and so there remains a need to demonstrate and provide assurance for those vehicles.

- 2.53 Our previous review of cleaning standards identified that Adenosine Triphosphate (ATP) swab testing was being considered as a method for assessing cleaning standard compliance. We are informed that MRDs had used ATP during the pandemic, and was particularly useful as a source of assurance for staff. However, in the return to business as usual the process is currently retained for quality assurance purposes only, with future use to be determined through review of policies and procedures which is currently underway. MRD reporting of activity has continued, but as our previous review identified there is no reporting which captures cleaning status for the entire Trust fleet.
- 2.54 Included within the IPC Annual Report 21/22 was detailed outline of IPC related datix reporting, which was broken down by theme and health board area. Whilst the report highlighted an increase in needlestick injuries within the Swansea Bay University Health Board area, and we note a consistent number of returns related to IPC policy or procedural issues, these have not resulted in further action. The team has recently introduced a weekly review of datix reports and began to collate responses and actions. The intention will then be to map themes and actions, which can be incorporated into the ongoing highlight and dashboard reporting.  
**See MA6**

#### Conclusion:

- 2.55 The Trust IPC audit programme requirements are outlined within the IPC policy and included within the IPC work plan. Following suspension due to pandemic pressures audits are yet to be restarted. The Trust has some mitigating measures around MRD vehicle cleaning and premise cleaning, however the previous development of ATP swab testing, which provided a method for assessing cleaning standard compliance, has not been implemented fully resulting in an absence of assurance reporting. We assign this objective **limited** assurance.

#### **Audit objective 6: There is regular reporting on Trust performance with clear oversight arrangements to support escalation of risks and issues.**

- 2.56 Prior to the return to business as usual, the route for oversight and reporting remained through the pandemic structure for Covid-19 related activity. Senior Pandemic Team agendas and papers demonstrate the heightened profile of IPC during this period. Covid related incidents, risk assessments and IPC/'on click' training summaries were presented to cells across the structure.
- 2.57 The IPC Team also provided quarterly highlight reports to both the Assistant Directors Leadership Team, and the Trust's National Health and Safety Committee. These provide a narrative outline of team progress and developments, and a summary of key areas in the alert/advise/assure/inform format. Review of report content, alongside the reporting within the pandemic structure, provides coverage against priorities contained within the IPC work plan,

although only at a high level for some these suggesting therefore more focused monitoring arrangements would be beneficial in the return to business as usual.

- 2.58 With the pandemic structure now stood down, we considered the arrangements in place to support ongoing monitoring and reporting of risks in the return to business as usual. The IPC Strategic group meets on a quarterly basis and is a subgroup of the CQGG. Its ToR includes that it will provide a highlight report to the CQGG following each meeting. The CQGG holds monthly meetings and in turn provides a 'Quality Highlight Report' summarising its key activities the QUEST Committee, which meets on a quarterly basis.
- 2.59 We reviewed CQGG papers and minutes for the period January 2022 and August 2022 to identify the frequency and content of reporting in place. In that period the CQGG received and approved a number of IPC SOPs and guidance documents, and the IPC Annual Report 2021-22. The Annual Report provides summary of training compliance, datix incidents, and overview of IPC risks, alongside outline of the team's priorities for 2022/23. We could not identify use of highlight reports from the IPC group to the CQGG, suggesting there is opportunity to enhance future reporting of current performance, or the key activities of the group. **See MA7**
- 2.60 Review of the Quality Highlight Report from CQGG to QUEST identified that information provided varied. For example, the report provided in May 2022 included outline of the group's purpose, but little on its activity. The second, provided in August 2022, contained further detail including approval of IPC SOP for *High Consequence Infectious Diseases*, and this indicates that the structure for discussion and approval outlined within objective two is in place.
- 2.61 The Quality Highlight Report did not however contain indicators on performance or detail on progress against the IPC work plan. Our previous review of Cleaning Standards in 2019/20 had identified that the previous Quarterly Quality Assurance Reports, presented at the CQGG predecessor group (the Quality Steering Group), included detail on IPC statutory and mandatory training compliance, datix incidents and cleanliness audits. This, in turn, was reported to the QUEST Committee. Discussion with the Assistant Director of Quality Governance outlined that the reporting requirements from CQGG to QUEST are being considered. The Audit Wales Review of Quality Governance issued in 2022 highlighted that whilst current reporting provides a *'good high-level summary, some of the quality focus and detail in the original Quality Assurance Report has been lost.'* A highlight report aligned to key indicators is planned for November 2022 onwards. **See MA7**
- 2.62 The QUEST Committee provides a highlight report to Trust Board following each meeting. This is formatted around an alert (escalation), advise (developments, monitoring, approval), and assure format. We note that receipt of the IPC Annual report at the August QUEST Committee meeting was included within the subsequent report to Board under the assure heading. **See MA7**
- 2.63 There has been a number of IPC related risks that were included within the Trust's Corporate Risk Register during the pandemic which have been subsequently de-escalated. The IPC Annual Report 2021/22 includes outline of six individual risks

that the team closed during the year, relating to team structure, PPE, and lack of compliance with HSE regulations for Fit testing. The September IPC Strategic group received and discussed a risk opened in May 2022 relating to the sustainability of the Fit testing programme within the Trust, a challenge highlighted within our review of RPE earlier this year. The group agreed that the risk required organisational awareness and that it should be escalated.

#### Conclusion:

- 2.64 There is a clear reporting structure from the IPC Strategic Group to the CQGG and onwards to the QUEST Committee and Trust Board. During the pandemic, there has been use of the Trust's cell structure to escalate risks and monitor training levels. We've considered the initial arrangements supporting the return to business as usual, which has identified the need to enhance the flow of reporting, in line with Audit Wales recommendations. We assign this objective **reasonable** assurance.

## Appendix A: Management Action Plan

### Matter arising 1: IPC Policies and related procedures (Design)

### Impact

In returning to business as usual the IPC team are reviewing and updating policies, procedures, and guidance documents. This includes the overarching IPC policy, which has been updated, but is awaiting approval from the Trust Policy Group.

A number of supporting policies and procedures were also in development or pending approval at the time of fieldwork. The *Premise and Vehicle Cleanliness* policy is in draft we reviewed its content noting:

- The adapting of *Key Standards for Environmental Cleanliness* for use within the Trust is still to be completed and these will need to be incorporated within the above policy once finalised.
- Monitoring arrangements within the policy include IPC audits, however under responsibilities Health and Safety Managers are listed as responsible for audit of the policies operation.
- Reporting is to be to a Building Cleaning Group yet to be established and there is no mention of the role of the IPC Strategic group.
- The document includes cleaning instructions on premise cleaning, but information on vehicle cleaning does not replicate content from the *Vehicle Decontamination SOP* which does provide vehicle cleaning instructions. The SOP contains no outline of audit or other assurance arrangements.

Alongside the current policies and SOPs there will shortly be an updated IPC handbook. Discussion at the IPC Strategic group, and our own review of the draft document, notes that handbook duplicates content from a number of other documents and will require ongoing maintenance to ensure content remains current.

Potential risk of:

- Policies and procedures do not provide comprehensive coverage of related areas.
- Lack of clarity across responsibilities and ownership.

### Recommendations

### Priority

- 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.
- 1.2 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.

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.
- 1.4 Consideration should be given to modifying the IPC handbook to direct users to relevant content, this could also contain the outcome of mapping recommended above.

Management response	Target Date	Responsible Officer
1.1 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.	March 2023	Louise Colson, Head of IPC
1.3 – 1.4 Consideration will be given to modifying the IPC Handbook following the IPC 3P Project. The aim of this action is to ensure staff are able to navigate to relevant and important content, as and when required.	June 2023	Louise Colson, Head of IPC

Matter arising 2: IPC Strategic Group (Operation)

Impact

Our previous review of Cleaning Standards in 2019/20 identified that the IPC Strategic group was not operating effectively. Since then there has been review of the group’s terms of reference, however membership is still to be finalised. The group has met a number of times during the pandemic, transition period, and once during business as usual.

Review of group agendas, papers and minutes identified the following gaps against its terms of reference;

- *‘The purpose of the IPC Strategic Group is to provide strategic expertise, assurance on performance, and implementation of work programmes within the organisation of matters relating to IPC.’* - We note the group has not received, approved, or discussed the IPC work plan which was developed in 2021.
- *‘The Group will provide a senior cross-directorate forum, in which IPC matters will be considered to ensure successful operationalisation and positive implementation into Trust policies, procedures and practices.’* – There is currently no attendance from senior Operations management and membership from that group is yet to be confirmed.
- *‘Receive and disseminate information pertinent to IPC, monitoring and measuring performance at local, regional and Trust-wide levels;’* – The group received narrative updates on development of policies/plans and guidance, however currently there are no IPC audits underway and limited input from non-IPC members on their areas of responsibility.
- *‘Contribute to and influence prudent antimicrobial prescribing into routine practice.’* – We did not identify discussion of this subject area within minutes reviewed.

The gaps identified above would also impact the achievement of objectives listed within the updated IPC Policy.

Draft minutes circulated following the group’s September meeting did not include use of an action column. There would be benefit in a consistent approach and format used to identify and capture actions raised within the meeting.

Potential risk of:

- Trust IPC priorities not delivered.
- Effectiveness of group operation impacted by gaps in membership and subject coverage.

Recommendations

Priority

- 2.1 The Terms of Reference for the IPC Strategic group, including membership, should be finalised, and submitted for approval from the CQGG.
- 2.2 The format and agenda of the IPC Strategic group should be reviewed to align with the IPC Work Plan priorities.

**Medium**

- 2.3 In undertaking the above the Trust should consider the information, monitoring, and reporting contributions from each which could contribute to the progressing of the IPC priorities within the work plan.

Management response	Target Date	Responsible Officer
2.1 The Terms of Reference for the IPC Strategic group, including membership, will be finalised, and submitted for approval from the CQGG. Additionally, a revised Agenda and group work programme will be implemented.	March 2023	J Turnbull-Ross, Asst. Director
2.2 The Terms of Reference, group work programme/agenda will include routine monitoring of performance, and review of documentation in a timely manner.	March 2023	J Turnbull-Ross, Asst. Director
2.3 Management response 1.1 will inform the content of the group's monitoring requirements.		

Matter arising 3: Roles and Responsibilities (Design)	Impact
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Our recent review of Respiratory Protective Equipment (RPE) included positive reflection of the RPE and Fit Testing SOPs which contained clear outline roles and responsibilities across both Executive and operational staff and management. We have also noted the alignment within the overarching IPC policy to the content held in the AACE national IPC policy which itself includes outline of roles and responsibilities.

Potential risk of:

- Inconsistent outline of roles and responsibilities.

We compared the outline of roles and responsibilities within four draft SOPs, and the *Key Standards for Environmental Cleanliness* presented to the IPC Strategic group in September. Whilst acknowledging they are still under development there is variation in frequency and terminology.

We noted;

- The *Decontamination of Mobile Devices* and *Invasive Procedure* SOPs did not include reference to Executive Director responsibilities. The *Key Standards for Environmental Cleanliness* refer to the Director responsible for IPC rather than the Director of Nursing and Quality.
- The *Invasive Procedure*, *Management of Linen*, and *Decontamination of Mobile Devices* SOPs, and the draft Key Standards do not have clear outline of the responsibilities of the IPC team.
- The *Invasive Procedure*, *Management of Linen*, and the draft *Key Standards for Environmental Cleanliness* do not have managers responsibilities clearly outlined.

Recommendations	Priority
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3.1 The Trust should consider further standardisation of roles and responsibilities outlined across executives, managers and staff which can be included within the development of future SOP, policies, and guidance documents. This could be drawn from the content within the updated IPC policy.

Medium

Management response	Target Date	Responsible Officer
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3.1 We accept the recommendation to standardise documentation formats. This action will be addressed through the IPC 3P Project (management response 1.1)

March 2023

Louise Colson, Head of IPC

**Matter arising 4: IPC Work Plan, monitoring and approval (Operation)** **Impact**

The work plan is comprised of 10 IPC team deliverables each with supporting actions, responsible officer, priority, status, and target implementation date. There is also a column for progress updates and an outline of specific risks to delivery which are RAG rated. Our review noted priorities matched with the requirements of the updated IPC policy and priorities within the IPC Annual Report 2021/22.

We noted some small gaps against ongoing delivery including, action to address NWSSP Audit and Assurance reports, inclusion of the Fit testing Quality Assurance programme, and action to address the HEIW national IPC training framework.

Review of actions outlined that two of the ten actions are currently complete, with a further six contain target dates of November/December 2022 these include actions yet to be started (Action 10 – Safe Clean Care Campaign), reliant on external support (Action 6 – Audit tools/programme) and progressing of documents out for comment which will likely require approval outside of the group (Action 4 – SOPs, Action 5 IPC Standards). All actions within the IPC work plan are assigned to the Head of IPC.

Additional resource secured for the team has been directed towards the establishment of a Fit tester programme, followed by the need to provide ongoing quality assurance. These actions are not included within the plan. The IPC work plan has not been shared at the CQGG or QUEST Committee.

Potential risk of:

- IPC performance and delivery of priorities may not be adequately scrutinised.

**Recommendations** **Priority**

- 4.1 The IPC Work Plan and content should be reviewed to ensure it contains both the Trusts overall IPC priorities but also those areas which have greatest impact on the IPC team capacity and resource. It should then be submitted for approval from the CQGG.
- 4.2 Resource requirements and target dates should be reviewed with changes in timescales or actions included at IPC Strategic group and CQGG meetings.
- 4.3 The ongoing delivery of the IPC work plan should be regularly monitored at the IPC Strategic group.

Medium

**Management response** **Target Date** **Responsible Officer**

- 4.1 The IPC Work Plan will be reviewed and submitted to CQGG for approval. March 2023 Louise Colson, Head of IPC

---

4.2	We accept the recommendation, future workplans will detail requirements.	March 2023	Louise Colson, Head of IPC
4.3	The IPC Strategic Group's Terms of Reference, group agenda and work programme will include monitoring of deliverables against the IPC Work Programme	March 2023	Louise Colson, Head of IPC

Matter arising 5: 'Onclick' Training resources (Operation)

Impact

Outside of the statutory and mandatory IPC training requirements the Trust has commissioned a supplementary suite of online training materials through the provider 'Onclick'. Subject areas covered within the online modules include *transmission of infectious diseases, evolution of a pandemic, day in the life on the frontline, PPE Part A, Powered Respiratory Hood Part A, and vehicle cleaning, sharps and waste management*. The modules are also supported by links to additional resources such as legislation, policies, and key documents.

Potential risk of:

- Access and use of out-of-date guidance.

Review of the vehicle cleaning, sharps and waste management module The IPC documents linked to within the module were to previous out of date versions;

- All things IPC - Version 1.3, current version is 3.0
- A-Z of Common Disease – Version 1.3, current version is 8.2

it did not include the Vehicle Decontamination SOP which provides the Trust's approach to non MRD cleaning instructions.

Recommendations

Priority

5.1 The Trust should ensure online resources contain up to date links and guidance.

Low

Management response

Target Date

Responsible Officer

5.1 Immediate action will be undertaken on those identified. The IPC 3P Project will systematically review documentation for outdated links/information.

January 2023

Louise Colson, Head of IPC

Matter arising 6: Trust IPC Assurance Mechanisms (Design)

Impact

Our previous review of Cleaning Standards in 2019/20 highlighted that vehicle and premise checks undertaken were 'subjective and therefore provide only limited assurance'. Alternative methods of audit, such as the use of ATP swab testing, which did provide some assurance on the effectiveness of cleaning methods, were being considered at that point but these have not been continued.

Potential risk of:

- Lack of assurance on compliance with policies.

As outlined within the IPC Annual Report 2021-22 IPC audits were paused as team resource and capacity was directed to support the Trust's pandemic response. The report included intention to reintroduce an audit programme in 2022/23, and we're informed the team has allocated dedicated time to undertake these, however the audit tools to support the programme are yet to be finalised.

The previous IPC policy included outline of those responsible for IPC related audits, including those outside of the IPC team itself. Review of IPC Strategic group papers has identified no reporting of any checks made by alternative parties.

With the *Key Standards for Environmental Cleanliness* still in draft there will also need to be clear circulation of these once finalised to ensure staff are aware of the criteria being measured against.

The IPC team has recently established regular review arrangements for datix incidents to capture related actions and themes, at present this only relates to August and September 2022.

Recommendations

Priority

- 6.1 Whilst continuing to progress the updating of IPC audit tools the Trust should develop a prioritised schedule of audits which can be delivered by the IPC team for the remainder of 2022/23. This should be alongside finalising and communicating expected criteria and standards.
- 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.
- 6.3 To support both of the above actions the IPC team should incorporate analysis of datix incidents for 2022/23 so that the targeting of audits is risk based.

**High**

Management response

Target Date

Responsible Officer

---

6.1	A prioritisation assessment will be undertaken to audit higher risk focus areas.	March 2023	Louise Colson, Head of IPC
6.2	IPC 3P Project will provide a comprehensive assessment of monitoring and audit arrangements. Additionally, responsibilities will be articulated through a RACI framework	June 2023	Louise Colson, Head of IPC
6.3	The recommendation is supported. An analysis of the data will be undertaken to determine priorities for the IPC Work Plan for 2023/24, including auditing.	March 2023	Louise Colson, Head of IPC

## Matter arising 7: Performance Reporting (Operation)

## Impact

The IPC Annual Report 2021-22 was provided to the Clinical Quality Governance Group (CQGG) in May 2022, Executive Management Team in June 2022, and presented to the QUEST Committee in August 2022. This provided a good summary of training compliance, datix incidents, and overview of IPC risks, alongside outline of the team's priorities for 2022/23. There has been use of the Trust pandemic cell structure to report Covid-19 incidents, IPC training compliance, and use of SBARs for risks across a number of cells and the Senior Pandemic Team.

Review of CQGG minutes and papers confirms that the group receives and approves guidance and procedure documents from the IPC Strategic group on a regular basis.

In the return to business-as-usual arrangements to support ongoing performance monitoring and escalation is not as clear with no highlight reports from the IPC Strategic group to CQGG identified within the period reviewed.

Our previous review of Cleaning Standards identified that whilst there were opportunities to strengthen the monitoring at the IPC Strategic Group, there had been consistent reporting of key indicators such as statutory and mandatory training compliance, datix incidents and audit outcomes featured within the Quarterly Assurance Reports to the QUEST Committee. Audit Wales in their review of Quality Governance highlighted that whilst current reporting provides a 'good high-level summary, some of the quality focus and detail in the original Quality Assurance Report has been lost.'

Potential risk of:

- Gaps in performance reporting.

## Recommendations

## Priority

- 7.1 We support the review of key indicators to be reported from CCQG to the QUEST Committee. This review should also determine the key indicators to be reported and monitored at the IPC Strategic Group.

**Medium**

## Management response

## Target Date

## Responsible Officer

- 7.1 A review of performance indicators will be undertaken for the IPC function. Routinely, these will be reported by exception to CQGG. Further consideration will be undertaken to ensure Board committee oversight of key IPC measures.




March 2023

Louise Colson, Head of IPC

## 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:

	<p><b>Substantial assurance</b></p>	<p>Few matters require attention and are compliance or advisory in nature.  <b>Low impact</b> on residual risk exposure.</p>
	<p><b>Reasonable assurance</b></p>	<p>Some matters require management attention in control design or compliance.  <b>Low to moderate impact</b> on residual risk exposure until resolved.</p>
	<p><b>Limited assurance</b></p>	<p>More significant matters require management attention.  <b>Moderate impact</b> on residual risk exposure until resolved.</p>
	<p><b>No assurance</b></p>	<p>Action is required to address the whole control framework in this area.  <b>High impact</b> on residual risk exposure until resolved.</p>
	<p><b>Assurance not applicable</b></p>	<p>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.</p>

### 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.



NHS Wales Shared Services Partnership  
4-5 Charnwood Court  
Heol Billingsley  
Parc Nantgarw  
Cardiff  
CF15 7QZ

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)



GIG  
CYMRU  
NHS  
WALES

Ymddiriedolaeth GIG  
Gwasanaethau Ambiwylans Cymru  
Welsh Ambulance Services  
NHS Trust

<b>AGENDA ITEM No</b>	<b>15</b>
<b>OPEN or CLOSED</b>	<b>OPEN</b>
<b>No of ANNEXES ATTACHED</b>	<b>2</b>

**WELSH AMBULANCE SERVICES NHS TRUST  
SAFEGUARDING ANNUAL REPORT 2022-2023**

<b>MEETING</b>	Quality, Patient Experience & Safety Committee
<b>DATE</b>	10 August 2023
<b>EXECUTIVE</b>	Liam Williams, Executive Director of Quality and Nursing
<b>AUTHOR</b>	Rhiannon Thomas, Safeguarding Specialist
<b>CONTACT</b>	01792 315884 <a href="mailto:Rhiannon.Thomas@wales.nhs.uk">Rhiannon.Thomas@wales.nhs.uk</a>

**EXECUTIVE SUMMARY**

1. This report will provide information to the Quality, Patient Experience & Safety Committee on how the Trust has met its statutory duties during 2022-2023 under the Children Act 2004, the Social Services and Well-being (Wales) Act 2014, the Violence Against Women Domestic Abuse and Sexual Violence (Wales) Act 2015 and that compliance with the Welsh Government Adult and Child Protection Guidance are being fulfilled.

**RECOMMENDED that the Quality, Patient Experience & Safety Committee receives and approves the Safeguarding Annual Report.**

**KEY ISSUES/IMPLICATIONS**

2. The Safeguarding Annual Report (**Annex 2**) provides evidence on how the Trust has performed during the 2022-2023 period in relation to safeguarding people in our care. It aims to give the Trust Board information on Welsh Ambulance Services NHS Trust safeguarding activities, engagement and collaborative working with our partner agencies; as well as the necessary assurances that the statutory duties under the relevant safeguarding legislation and guidance are being fulfilled.
3. The Public Health Wales Safeguarding Maturity Matrix (SMM) was completed in July 2023 and an associated Work Plan has been developed and will be monitored through the Strategic Safeguarding Group.

4. Committee members can view the SMM submission on request, and updates will be offered to the Committee through the Monthly Integrated Quality Performance Report.

#### REPORT APPROVAL ROUTE

Clinical Quality Governance Group	24 July 2023
Quality, Patient Experience & Safety Committee	10 August 2023

#### REPORT APPENDICES

**ANNEX 1** - SBAR providing supporting background information

**ANNEX 2** - Safeguarding Annual Report 2022-2023

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

## **ANNEX 1**

### **SITUATION**

1. The purpose of this report is to provide information on the Safeguarding Annual report to members of the Quality, Patient Experience & Safety Committee (QuESt).

### **BACKGROUND**

2. The Safeguarding Annual Report provides an overview of how the Trust has performed during this reporting period in relation to safeguarding people in our care. It aims to give the Trust Board information on the continued effect of the pandemic in relation to Welsh Ambulance Services NHS Trust (WAST) safeguarding activities as well as the necessary assurances that the statutory duties under the relevant Safeguarding legislation and guidance are being fulfilled.

### **ASSESSMENT**

3. The Safeguarding Governance Frameworks have continued to be part of everyday practices within WAST during a continued challenging reporting period.
4. The data evidenced within this year's report demonstrates a further year on increase in the total number of reports submitted by WAST staff since the initial launch of Doc Works. Feedback from WAST staff as well as our partner agencies acknowledge that this is an improved mechanism for submitting reports to Local Authorities across Wales.
5. DocWorks digitalised system has been supported by the implementation of the DocWorks/TerraPace electronic Patient Care record (ePCR) interface during this reporting period. This implementation aims to ease user ability between the two applications within WAST.
6. The Trust's Annual Training Plan continues to support statutory safeguarding requirements, ensuring that staff are provided with the right level of training commensurate with their role. This report illustrates compliance of 86% for Level 2 Safeguarding Children and 92% Level 2 adult safeguarding training (target set at 85%) and 85% for Group 1 training as required under the Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) National Training Framework (NTF).

7. ***Violence against women, domestic abuse and sexual violence:*** This section of the Safeguarding Annual Report outlines the VAWDASV National Training Framework Training Plan for the Trust. The Plan for WAST was reviewed and updated following consultation with the Welsh Government VAWDASV Team. WAST compliance with the NTF is included in an Annual NTF Report to Welsh Government in 2023.
8. There is a fundamental obligation for all agencies involved in the care, support, and protection of those at risk to ensure the highest possible standards are provided and maintained at all times. Part of this obligation is a requirement to learn from mistakes, especially those resulting in the death or serious injury of an individual at risk.
9. This report includes information on WAST activity generated by our 'duty to cooperate'. WAST Safeguarding Team has worked in partnership with other agencies as required in all safeguarding activities including Procedural Response to Unexplained Deaths in Childhood (PRUDiC), Practice and Domestic Homicide Reviews and Safeguarding Strategy Meetings. There has been a noticeable increase in WAST collaborative safeguarding activity associated with our core business.

Welsh Ambulance Services NHS Trust

# Safeguarding Annual Report 2022-2023



GIG  
CYMRU  
NHS  
WALES

Ymddiriedolaeth GIG  
Gwasanaethau Ambiwylans Cymru  
Welsh Ambulance Services  
NHS Trust

---

[Amb\\_wastsafeguarding@wales.nhs.uk](mailto:Amb_wastsafeguarding@wales.nhs.uk)

01792 315884

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3. Partnership Working	11
4. Quality Improvement	18
5. Support, Advice and Guidance	21
Conclusion	
Moving Forward	



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[Amb\\_wastsafeguarding@wales.nhs.uk](mailto:Amb_wastsafeguarding@wales.nhs.uk)

01792 315884

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# Introduction

The Welsh Ambulance Services NHS Trust's (WAST) success in safeguarding is driven by an effective organisational culture; one with values and behaviours which foster professional curiosity, encourages scrutiny and supports the actions required to protect those at risk of abuse or in need of care and support.

The safeguarding annual report provides the Trust Board with the necessary assurances that the organisation is compliant with statutory duties under the Social Services and Well-being (Wales) Act 2014, the Violence Against Women Domestic Abuse and Sexual Violence (Wales) Act 2015, the Children Act 2004, and the Wales Safeguarding Procedures.

It provides an overview on how the Trust has performed over this reporting period in relation to safeguarding people in our care. Priority is given within the report to evidence the significant increase in safeguarding activity within the organisation, to celebrate the success and achievements of the dedicated Safeguarding Team as well as sharing the good practice of WAST colleagues; our improved safeguarding systems and processes and how we have learned from our experiences.

The Executive Director of Quality & Nursing is the executive lead for safeguarding within WAST. The Head of Safeguarding has responsibility as Named Professional for Safeguarding Children as well as Adults at Risk. This role ensures the Trust's compliance with Statutory Legislation and Guidance above. The Head of Safeguarding takes the organisational strategic lead on all safeguarding related matters.

The Safeguarding Team works collaboratively with senior managers and colleagues within WAST to promote an unequivocal safeguarding culture, both articulated and lived at each level in the organisation. External partnership working is also integral to the team's role, WAST contribution to the work of our partner agencies will be highlighted in this report.



# 1. Safeguarding People

**Safeguarding People** within this report for 2022-2023 relates to the Welsh Ambulance Services NHS Trust's Safeguarding activity. The Safeguarding Team's priority is to ensure that WAST colleagues provide safe and effective care which protects people at risk of abuse and neglect as well as those in need of care and support. This involves reporting concerns appropriately to the relevant agencies and utilising appropriate pathways which further support victims of domestic abuse and sexual violence following contact with our service.

## Reporting Rates

The number of reports submitted by WAST has continually increased since the initial launch of Doc Works in 2019. This reporting period illustrates a 20% increase as shown in Table 1. This data provides a further breakdown of the report types submitted over the last three reporting periods. The figures demonstrate the increase relates mainly to concerns for adults, the Safeguarding Team plan to scrutinise the disparity between adult and child reporting rates.

Table 1

Report Type	2020/21	2021/22	2022/23
Child at Risk	1,461	1,303	1,138
Child in Need	754	853	775
Adult at Risk	1,149	1,106	1,419
Adult social care need	3,291	3,785	4,605
<b>Total</b>	<b>6,655</b>	<b>7,047</b>	<b>7,937</b>

The following graphs illustrate the number of reports made per health board:



In addition to the reports made to Local Authorities within Wales, WAST colleagues also reported 12 concerns for children and 9 for Adults to the other relevant Authorities in the UK.

# WAST Safeguarding Reports

The Safeguarding team has continued to progress WAST colleagues' skills and understanding of the Safeguarding thresholds met, to ensure that the reports made to Social Services are appropriate and in accordance with the required standard. The digital mechanism for submitting WAST safeguarding reports has been promoted throughout the Trust since the initial launch of DocWorks in 2019. This initiative has received recognition both internally and externally in the wider safeguarding arena.

To celebrate NHS Wales Safeguarding Network's 10<sup>th</sup> Anniversary, the National team hosted the "NHS Wales Safeguarding Together: Then, Now, Next Conference" in March 2023. Safeguarding teams across the Principality were asked to submit an abstract for a poster presentation that were exhibited on the day. WAST Safeguarding Team is pleased to report that our application was successful and our poster presentation "Revolutionising safeguarding reporting" will promote the innovative safeguarding work taking place within our organisation.

## Feedback



"Thank you for keeping me informed it's good to know we can make a difference"

"Having the forms on my iPad makes it so much easier to complete a report"

The Safeguarding team also received a commendation at the Cardiff and Vale Safeguarding Board's annual awards ceremony for the development of the DocWorks reporting process in November 2022.

## Revolutionising Safeguarding Reporting Chwyldroi Adroddi Diogelu

**The Aim?** Modernise the way in which WAST colleagues report safeguarding concerns

### THEN

The old processes to report safeguarding concerns within WAST were outdated. There were two different reporting systems within WAST. Clinical contact centre (CCC) and NHS 111 Wales colleagues used a simple form to note their concerns which then required the safeguarding team e-mailing them to the relevant Local Authority. Frontline colleagues hand wrote on paper, faxed to the CCC, who then scanned and e-mailed the relevant Local Authority. Both systems relied upon a multi-step process which was fraught with issues at each stage.

### NOW

We listened to staff concerns and wanted to move away from paper reports to improve access, efficiency, legibility and reflect updated legislation. **Safeguarding Reports** DocWorks Scribe is a programme to digitally submit safeguarding reports. Operational staff can use an App on their iPads and office-based staff can utilise the same system on desktop computers. All colleagues complete online safeguarding forms, click submit and the forms are automatically sent to the relevant Local Authority at the time of submission.

### NEXT

WAST Safeguarding Team are proud to have implemented a new process during the pandemic. The organisation supported the Safeguarding Team by committing resources and finance in order to implement and maintain the system. Since its introduction the Safeguarding Team have noticed a marked increase in the number of safeguarding reports submitted. It has also had a positive impact on time and resources as the submission process has been simplified. The opportunities that digital reporting via DocWorks Scribe affords us are invaluable in ensuring we make every contact count to safeguard the most vulnerable across Wales.

### THE ISSUES

- Forms not reflective of current legislative language
- NHS 111 Wales forms restrictive in current format with character limits
- Colleagues often had to return to station to fax
- Hand written reports often illegible
- Finding a working fax machine
- CCC colleagues had to find and select correct Local Authority
- Issues Faxing
- Delays reporting safeguarding concerns
- Laborious process taking up resources and time

### Fire Risk Referrals

We now use DocWorks Scribe to refer directly to our Fire & Rescue Service colleagues throughout Wales. These referrals are when fire risk concerns are identified and a home safety check is requested. There are a variety of different fire risk hazards that can be referred (e.g. hoarding, poor electrical safety). There have been 148 referrals since the introduction of this pathway which has resulted in individuals being provided with smoke alarms, carbon monoxide alarms and fire retardant bedding.

### Live Fear Free Referrals

We now use DocWorks Scribe to refer digitally to the Live Fear Free Helpline where there are concerns for an adult and/or their families regarding domestic abuse and/or sexual violence. Live Fear Free is a free, 24/7 confidential helpline for domestic abuse and sexual violence in Wales.

### Dementia Concern Referrals

A new bespoke referral pathway to Dementia Connect (part of Alzheimer's Society) for any dementia related concern (confusion, memory loss, or issues with communication or daily routines). Carers who may need additional support can also be referred.

### PREVENT Referrals

To digitalise the 'All Wales PREVENT Partners Referral' form to enable WAST colleagues to share information where they have concerns of radicalisation.

Authors: Welsh Ambulance Services NHS Trust (WAST) Safeguarding Team  
Many Thanks/Gyda Diolch to all colleagues involved in successfully developing, implementing, using, reviewing and evolving the WAST & DocWorks Scribe partnership

# WAST Pathway to Protect Victims and Survivors of Domestic Abuse

The Social Services and Wellbeing (Wales) Act 2014, the Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015, along with key guidance within 10,000 Safer Lives – Domestic Abuse Project and NICE (2014); recommended an improved multi-agency service delivery with integrated care pathways for identifying, referring and providing interventions to support people who experience forms of domestic abuse and sexual violence. WAST Safeguarding team initiated an appropriate pathway for facilitating contact with the specialist services of the Live Fear Free helpline with support from both the helpline manager and the projects and innovations manager from Welsh Womens Aid. The pathway has now been digitalised for WAST iPad users and provides an additional mechanism for front line colleagues to support victims and survivors who may have suffered from these issues.

## Live Fear Free Helpline



*"In my capacity as the Live Fear Free Helpline Manager, I liaise closely with the Safeguarding Team in partnership to offer support to victims of domestic abuse and sexual violence.*

*I have found WAST to be passionate about making a difference to the lives of vulnerable people such as those who experience domestic and sexual abuse. The Safeguarding Team has worked tirelessly to ensure that the pathway is as robust as possible and that the patient's welfare is at the heart of the process.*

*I can truly say that it has been a pleasure, the Teams positivity and optimism are infectious and have made developing our partnership an extremely enjoyable experience. The pathway has been set up and developed to be a successful project that supports survivors of abuse at the earliest possible stage.*

*Because of the excellent and ongoing success of the pathway, we are looking to further develop additional resources. In summing up, the Safeguarding Team has been a lynchpin in ensuring the success of a most valuable partnership. It is thanks to their determination and 'can do' attitude, that we have been able to make the pathway so successful and, ultimately, offer support, safety and vital information to some of the most vulnerable people in Wales".*

**Ann Williams, Live Fear Free Helpline Manager**



Welsh Ambulance Services NHS Trust

# Live Fear Free Pathway



Llinell Gymorth Live Fear  
Byw Heb Ofn Free Helpline

**0808 80 10 800**

ffôn • teict • sgwrsio byw • ebost  
call • text • live chat • email



- Free 24/7 helpline for anyone in Wales who is experiencing Domestic Abuse or Sexual Violence.
- WAST have a bespoke pathway in place.
- **18/11/2021 – 31/03/2022 = 8**
- **01/04/2022 – 31/03/2023 = 41**
- These figures cannot capture the contacts where WAST colleagues provide service users with the helpline number.
- Helpline is available to all WAST colleagues and volunteers for specialist advice and support.
- Colleagues are reminded that an adult or child at Risk report may also be required.

**41** digital reports to **Live Fear Free** this year





Gwasanaeth Tân ac Achub  
Canolbarth a Gorllewin Cymru  
Mid and West Wales  
Fire and Rescue Service



Gwasanaeth Tân ac Achub  
De Cymru  
South Wales  
Fire and Rescue Service



Gwasanaeth Tân ac Achub  
Fire and Rescue Service

**150 Fire Risk Referrals**  
Shared with our Fire &  
Rescue Services Partners  
(FRS)

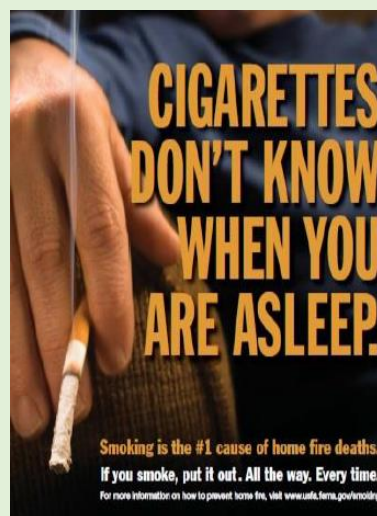


Table 2

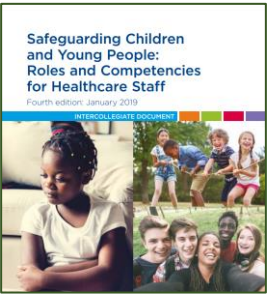
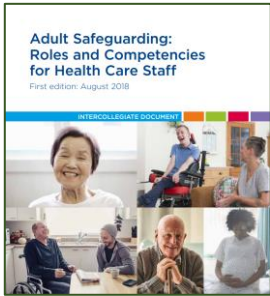
	North Wales FRS	Mid & West Wales FRS	South Wales FRS	Total
18/11/21 – 31/03/22	15	12	11	<b>38</b>
01/04/22 – 31/03/23	33	29	93	<b>155</b>

- Significant increase in the submission of fire risk referrals this year, evidenced in Table 2
- The referral process allows WAST colleagues request that the local FRS get in contact to **offer support** or conduct a **home safety check**
- Colleagues complete a referral on Docworks and it is e-mailed directly to the relevant FRS
- Streamlined and time-efficient collaborative referral process to protect some of the most vulnerable of our communities in Wales



# 2. Education and Training

The Trust's annual training plan continues to support statutory safeguarding requirements. Working in partnership with our dedicated training teams across WAST to establish a robust training program for all aspects of safeguarding.



## Level 2 Safeguarding Training

The Safeguarding Team continue to provide face to face or virtual sessions to all CCC, ACA, EMS and NHS111 colleagues across the Trust. We delivered 54 induction sessions in the last reporting year providing assurances to the Trust that staff are trained commensurate to their roles as designated within the Inter Collegiate Documents for Adults and Children.

**Level 2 compliance**  
WAST has achieved 86% compliance for child safeguarding and 92% for adult safeguarding training during this reporting period.

## NHS111 CPD

The Team also developed their first recorded session which was accessed by over 280 Clinicians, Call Takers, Dental Nurses and Health Information Advisers. The video explored emerging safeguarding themes such as Contextual Safeguarding and embedded learning from Adult and Child Practice Reviews such as **Professional Curiosity** and **Disguised Compliance**.



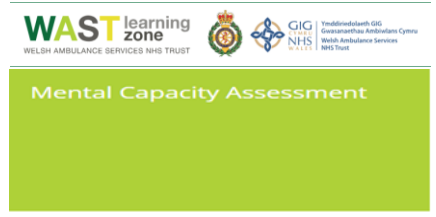
## Quotes from staff on themes they took from the session

## MIST Training

During this reporting period the team also worked collaboratively with the National Ambulance Training College (NATC), integrating safeguarding concerns into clinical scenarios as part of the Mandatory In Service Training. This provided an opportunity to deliver safeguarding in a particularly meaningful and realistic format. We were able to further embed learning from APR's, CPR's and DHR's. The Live Fear Free and Fire Service Pathways were also promoted during these sessions. The sessions were well received and recommendations were made for this to continue in future MIST training.

*"This is a good idea, every scenario could have this incorporated, it is easier to remember than reading in a textbook".*

*"This was an excellent addition- safeguarding discussions have carried on throughout the day"*



**In addition, 466 WAST staff have accessed the MCA training via WAST Learning Zone**

# Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV)



This section of the Safeguarding Annual report outlines the VAWDASV National Training Framework Training Plan for the Welsh Ambulance Service NHS Trust (WAST). Under Section 15 of the VAWDASV (Wales) Act 2015, WAST *“is required to incorporate training for Groups 1, 2, 3 and 6 into their existing learning and development framework and submit to the Welsh Ministers their own training plan, training needs analysis and annual plan based on this”*.

The Plan for WAST will be reviewed and updated in April 2023 and subsequently be included in an Annual NTF Report to Welsh Government in May 2023.

## Group 1 of the National Training Framework (NTF)

Table 3 illustrates the number of colleagues who have completed Group 1 training has been determined by the WAST Online Learning Management and training department records which are recorded on WAST electronic staff records (Target 100% compliance).

Table 3

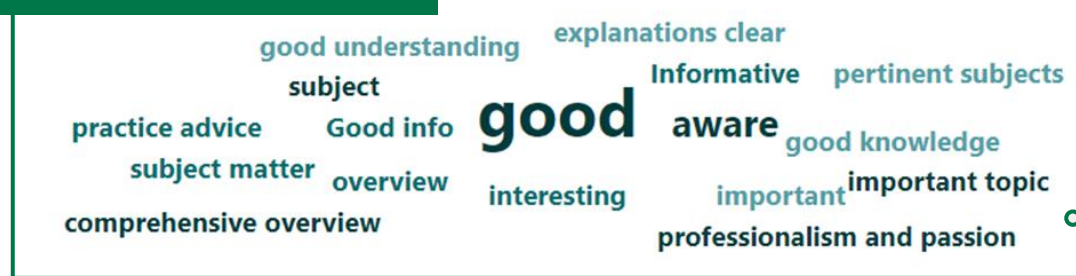
Total per Group	Total completed	% compliance
4,383	3,719	85%

## Group 2 of the National Training Framework (NTF)

Group 2 training under the NTF focusses on “Ask and Act”- a principles based approach of targeted enquiry.

The objective of this is to enable practitioners to “Ask” potential victims and survivors when concerns relating to VAWDASV are identified; and “Act” so that suffering and harm is prevented or reduced.

## Learner Feedback



“Can happen to anyone”

“I feel more confident to deal with this now”

“fundamental part of our role”

### 3. Partnership Working



The Safeguarding Team sits within the Quality, Safety and Patient Experience Directorate to carry out a necessary corporate function as well as supporting the specific work of the Directorate. Our commitment to delivering high quality care in safeguarding has been clearly demonstrated by achievements highlighted in previous reporting periods. Effective, compassionate leadership, courageous management and innovation have been integral to our success.

The Safeguarding Team achieve our safeguarding objectives by effectively working together with a wide range of services and professionals, ensuring good outcomes for people who have contact with our service.

This requires the Safeguarding Team to establish strong relationships with all departments in our organisation as well as within the wider safeguarding arena across Wales.

Our achievements obtained through improved knowledge, skills and attitudes as well as the promotion of our engagement with safeguarding multiagency activity has fortified our working relationships both at an operational and strategic level.

# The Wider Safeguarding Arena

## National Ambulance Safeguarding Advisory Group (NASAG)

The purpose of this group is to promote a consistent approach to safeguarding across the UK ambulance services. To connect, support and guide the safeguarding practice of its practitioners across the UK.

The Head of Safeguarding for WAST was Vice Chair of this group during this reporting period.

WAST Safeguarding Team contribute to the work of the group and participate in an annual benchmarking exercise to assess and analyse safeguarding activity as well as to identify areas of improvement.



## Social Care Wales

In June 2022 Social Care Wales launched the **National Safeguarding Training Standards Consultation**.

The aim of the standard is to provide a framework for organisations to provide training which is commensurate with their role and responsibilities. A Senior Professional from the Safeguarding Team was part of the task and finish group for this consultation. The task and finish group ensured that the standards aligned with the Intercollegiate Document 2018.



## Public Health Wales Procedural Response to Unexpected Deaths in Childhood (PRUDiC)

The aim of the PRUDiC process is to ensure that the response is safe, consistent, sensitive and supportive to all concerned. It promotes uniformity across Wales in the multi-agency response to unexpected child deaths.

WAST plays a significant role in the PRUDiC process from the initial alert to Police through to attendance at the phase 1 multi-agency meeting.

The Safeguarding Team contributed to the review of this procedure in February 2023.



## Welsh Government Single Unified Safeguarding Review (SUSR)



Following the findings from a thematic review of adult and domestic homicide reviews conducted in Wales in 2018, Welsh Government initiated work relating to the SUSR consultation.

The aim was to establish a more efficient review process to improve the governance arrangements of reviews and share learning across Wales via a safeguarding repository.

WAST Safeguarding Team took an active role in the work of the task and finish groups across Wales.



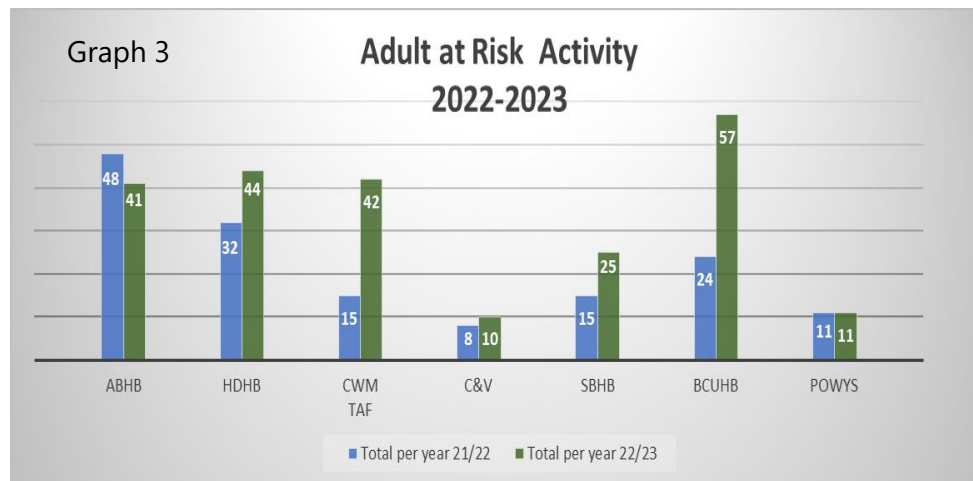
# Protecting Adults at Risk

Following a report, social services have a duty to make enquiries under s126 of the Social Services and Wellbeing (Wales) Act 2014. As a recognised “relevant partner” of the Local Authority WAST has a legislative responsibility to participate in any enquiries or strategy meetings/discussions that may be undertaken.

The aim of the process is to focus on the needs of the vulnerable person and allow agencies to appropriately share information, identify risks and take specific action.

The Safeguarding Team may need to access a variety of WAST systems and work collectively with many directorates within WAST to gather the appropriate information to support the process.

This activity has increased during this reporting period, demonstrated in Graph 3.



The 7-minute briefing relates to specific learning for WAST as a result of s126 Adult at Risk enquiries in one area of Wales. Whilst the concerns were raised in one Local Authority area, the Team used the opportunity to share the learning internally and externally (to Health Board colleagues) pan-Wales.

**WAST Specific Learning from an Adult at Risk Strategy Meeting**

**1 Background**  
Duty to report raised regarding concerns that an elderly female patient was left in clothing that was saturated in urine whilst in the care of WAST and waiting to be admitted into Hospital. This led to the Local Authority making enquiries under s126 of the Social Services & Wellbeing (Wales) Act 2014, which resulted in an Adult at Risk strategy meeting.

**2 Definition of an Adult at Risk**  
An Adult at Risk is:  
• An Adult who is experiencing or is at risk of ABUSE or NEGLECT  
• Has Needs for Care and Support (whether or the authority are meeting any of those needs)  
And  
• As a result of those needs is unable to protect himself or herself against the ABUSE or NEGLECT, or the risk of it.

**3 Adult at Risk Strategy Meeting**  
This meeting is attended by Multi Agency representatives and chaired by a member of the Local Authority's adult safeguarding team. The aim of the meeting is:  
• Identify the concern  
• Gather information  
• Assessment and analysis of early help, care and support or care and support protection needs  
• Decision making and planning the most appropriate intervention  
• Actions and interventions  
• Evaluating effectiveness of the actions and interventions

**4 Good Practice**  
Whilst there was learning for WAST the agencies were keen to highlight good practice that they identified. Key areas of note were:  
• Crew ensured that female patient and escort were provided with food and water whilst waiting outside ED  
• Pressure areas were checked  
• It was commented that the female patient received good clinical care whilst on board the Ambulance

**5 Outcome from meeting**  
As previously mentioned the concern was raised in relation to the handover of a female patient who was found to be in soiled clothes and saturated in urine. The outcome of the meeting stated that the female patient's dignity was compromised. However the attendees at the meeting recognised that this was not a deliberate omission from the crew and were compounded by significant handover delays.

**6 WAST Learning**  
These recommendations were developed following the information gathered at the meeting which included the wishes and feelings of the female patient involved in the process.  
• Ensuring ALL basic care needs are met, this includes offering or asking patient if they require toileting  
• Due to an individual's cognitive ability we may need to prompt patients rather than ask if they need the toilet  
• Document when the patient was asked or prompted and record outcome  
• Be mindful that female patients may feel more at ease to ask to use the toilet if there is a female present (WAST or ED staff)

**7 Recommendations**  
A recent Health Inspectorate Wales (HIW) report into Patient Experience during handover delays identified a number of actions for both Health Boards and WAST. Three of the actions were in relation to WAST and Health Boards working collaboratively to ensure that;  
• Privacy and Dignity is maintained, and patients are always provided with an opportunity to use toilet facilities where appropriate  
• Minimise the risk of skin tissue damage for patients  
• Patients nutritional and hydration needs are met  
If WAST requests to achieve the above are declined, then this must be documented within the ePCR, escalate to Nurse in Charge at ED and complete a DATIX.

**Dignity & Respect**

**Remember DOCUMENT & ESCALATE Issues**

**Welsh Ambulance Services NHS Trust**  
Email: [Amb\\_wastsafeguarding@wales.nhs.uk](mailto:Amb_wastsafeguarding@wales.nhs.uk)  
Phone: 01792 315884

# Regional Safeguarding Board's Activity

The amount of activity generated by our duty to cooperate with Adult/Child Practice Reviews and Domestic Homicide Reviews has continued to progress during this reporting period. The Head of Safeguarding and Senior Professionals have ensured strategic engagement at the board level, whilst panel membership on reviews has regained momentum as anticipated following the impact of the Covid-19 pandemic.

The following tables demonstrates WAST's engagement with APR, CPR, and DHR processes:

Adult Practice Reviews		
2020/2021	2021/2022	2022/2023
2	3	4

Table 4

Child Practice Reviews		
2020/2021	2021/2022	2022/2023
3	5	5

Table 5

Domestic Homicide Reviews		
2020/2021	2021/2022	2022/2023
0	4	6

Table 6

## Learning from Reviews

Learning Events are an integral part of the review process as the information gathered from attending practitioners within this forum will often identify key learning themes and help shape the published report and action plan. The Safeguarding Team has continued to support WAST staff required to attend these events during 2022-23.

*"I really appreciated the support provided by the safeguarding team during the review process. I have gained valuable insight into the events leading up to time we attended the call"*

The Safeguarding Team also has responsibility for sharing the learning generated from the review process across the organisation.

This is achieved through a variety of different methods such as 7-minute briefings, Newsletters, or inclusion of relevant themes into training packages and on the safeguarding SharePoint pages.



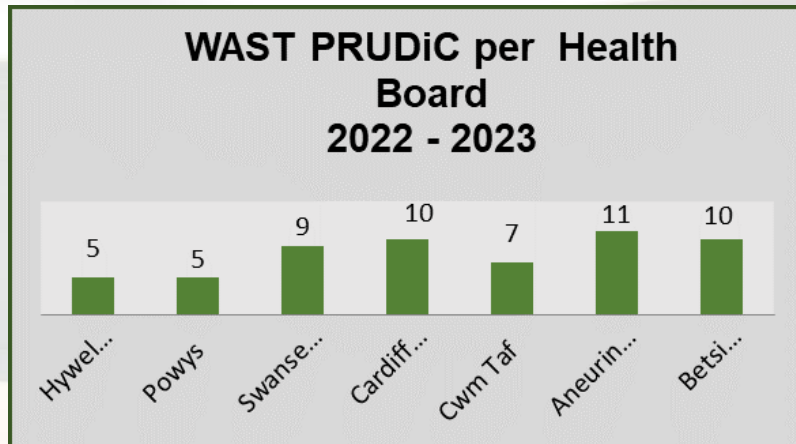
# Procedural Response to Unexpected Deaths in Childhood (PRUDiC)

The aim of the PRUDiC is to ensure that the response is safe, consistent and sensitive to those concerned, and that there is uniformity across Wales in the multi-agency response to unexpected child deaths.

During this reporting period WAST has contributed to **57** information and planning meetings held under the PRUDiC process.

The graphs and chart below highlight WAST data relating to unexpected child deaths during 2022-2023. This includes the numbers of PRUDiC incidents per WAST Health Board, monthly occurrence and also age range.

Graph 4



Graph 5

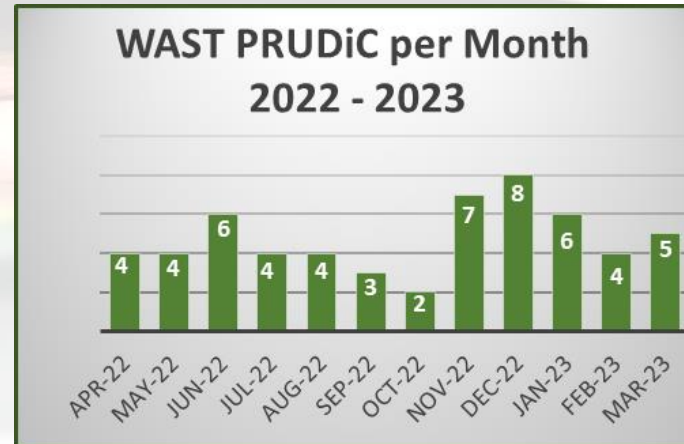
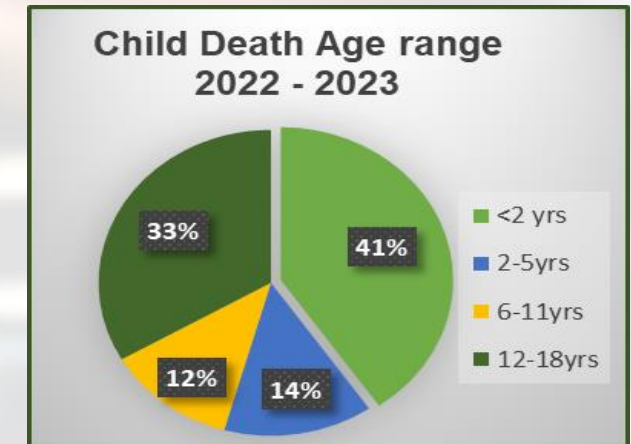


Chart 1



The highest percentage age range was for the under 2 years of age (**41%**) this includes babies found unresponsive and 12-18yrs (**33%**) which included death by suicide. These age ranges for such tragic events are consistent with previous annual figures.

The highest number of child deaths were seen during the winter months. It is worthy to note that cases of Streptococcus A related mortality figures increased during the winter months nationally. This was likely to be as a result of children being more isolated during the pandemic and resuming social interactions. This also impacted on NHS111 Wales service who reported one of the busiest weekends ever with huge numbers of calls from worried parents and carers (PHW, 2023).

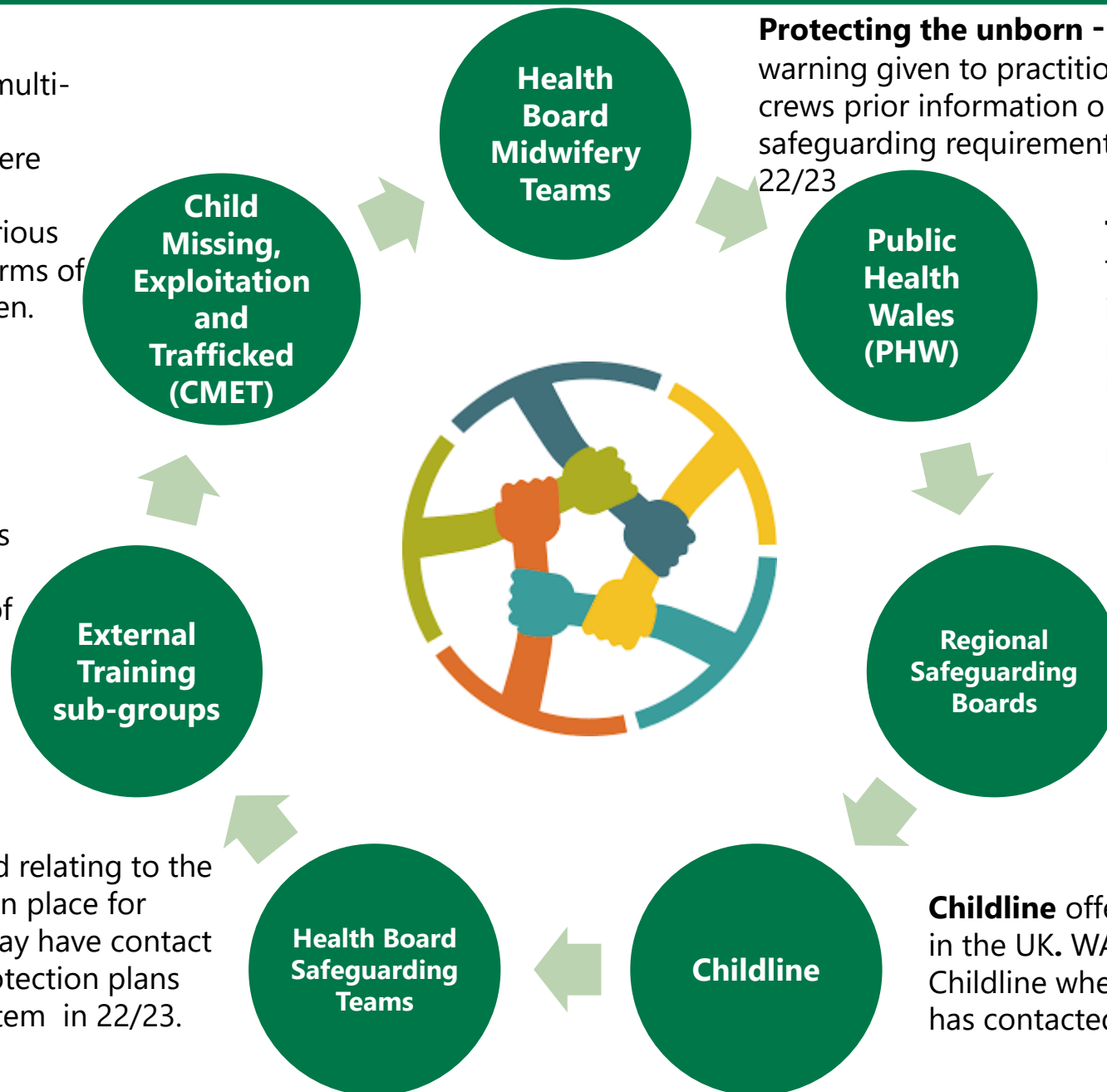
Themes and trends are collated by the Public Health Wales child death review panel who provide annual reports from a national perspective. Data collated is then used to promote good practices which reduce harm. As a team we have also identified themes of unsafe sleep practices that may have contributed to a child's death. Learning resources are being considered to support staff across the organisation.

# WAST Additional Partnership Working

**The CMET group** work in partnership to formulate a multi-agency, multi-disciplinary response to issues where there are contextual safeguarding concerns of exploitation, serious youth violence and other forms of extra familial harm to children.

**WAST Safeguarding Team** contribute to the work of various regions across Wales by participating in the development and delivery of safeguarding training to external partner agencies.

**Child Protection Plans** Specific information is shared relating to the safeguarding arrangements in place for families with children who may have contact with our service. **12** child protection plans were placed on our alert system in 22/23.



**Protecting the unborn** - Specific information is shared and a pre-warning given to practitioners the aim of which is to give responding crews prior information on the existence of an agreed plan of care or safeguarding requirement. **65** midwifery alerts actioned by WAST in 22/23

**Thematic Reviews** — WAST Safeguarding Team engage with the thematic reviews instigated by the PHW child death review panel. The information obtained from each review is then utilised to formulate National health or safety campaigns to help protect the public.

**Annual Partnership Reports** — WAST Safeguarding Team contribute to the Partnership Reports to all Boards across Wales as requested. This ensures wider understanding of the safeguarding activity and experiences of our organisation.

**Childline** offers a unique service to help young people in the UK. WAST Safeguarding Team works with Childline when we have provided care for a child who has contacted them.

## Partnership Working in Practice

### GOOD NEWS STORY

WAST Safeguarding Team were invited to a section 126 strategy discussion for an adult at risk. This adult was bed bound living at home being cared for by family members and there were neglect concerns. These concerns included poor personal hygiene, family smoking in enclosed environment with burns to the bedding, inappropriate manual handling and not acting on medical advice.

The result of the discussions were the application to the courts to remove this adult at risk from the property.

Removal arrangements were a multi-organisational task with Police, Social Services and WAST NEPTS in attendance.

This adult was successfully removed from the property and taken to a care home where within hours they were cleaned, sat up in bed eating fish and chips for the first time in years.



**Diolch yn Fawr**

This story demonstrates the value of identification, reporting and the sharing of information with Local Authorities that is seen, heard and experienced during our contacts with services users to ensure the protection of vulnerable adults and children and promote positive outcomes.

***"The crew were commended on their professionalism, the way they made the lady feel at ease during what could have been a traumatic conveyance for she had not left the house in years and they treated her in a very respectful and dignified way"***

***Local Authority, Central and West Region***

**Thank you to all WAST colleagues involved in safeguarding this adult at risk.**

# 4. Quality Improvement



The Safeguarding team’s approach to quality and quality improvement for this reporting period has been to focus on achieving the requirements set within the Safeguarding work plan 2022/23. This aims to achieve our targets within the WAST Quality Strategy (2021-24) and prioritises our contribution in delivering the Integrated Medium Term Plan; as well as to identify any actual or potential risks to deliverables during this reporting period and beyond.

WAST is required to report on the Safeguarding position of the organisation both internally and externally. The Safeguarding work plan provides the focus for improving quality as part of the organisation’s internal strategy but also incorporates the requirements included in standards and outcomes set by external reporting mechanisms. The Safeguarding work plan & assurance framework is mapped to the Health & Care Standards (2015) specifically standard 2.7; safeguarding children and adults at risk. Safeguarding sits within the Quality Theme: Safe Care and Prudent Healthcare. The outcome of which is to ensure *our service users are protected from harm and protect themselves from harm.*

The principles of Prudent Healthcare are considered throughout, recognising continued progress is always required to integrate the principles into our safeguarding operational framework.

The following table illustrates the priority areas for achieving this by focussing on the key deliverables specified within the Safeguarding work plan for 2022/23. (Ref kd19 IMTP 4 CR 1-6)

Safe Care and Prudent Healthcare			
Safeguarding Reporting Process	Training and Education	Policy and Procedure	National Collaboration

Progress 2022/23

- Safeguarding Reporting Process**
  - DocWorks and TerraPace ePCR interface implemented.
- Training**
  - Safeguarding Training level 2 delivered as required. (86% for Level 2 Safeguarding Children and 92% for Adult Safeguarding training).
  - Recorded sessions created and launched for NHS 111 CPD
  - MIST sessions launched and well received
- Policies and Procedures**
  - Required review and updates ongoing
- National Collaboration**
  - Significant increase during this reporting period.

## “Putting things right” and improving the quality of service we provide

The Safeguarding Team within WAST is fully committed to supporting the Trust’s legislative responsibility regarding Duty of Candour. Therefore, we fully embrace “Putting Things Right” as a process for highlighting, investigating and learning from concerns.

A close and collaborative working relationship exists between the Safeguarding and Patient Safety Teams. This ensures an effective interface in the considerations of concerns, adverse incidents and the safeguarding issues highlighted within them. Our working together ensures that any incidents that involve adult or child safeguarding issues are responded to correctly.

The aim is to provide a supportive framework for people to highlight issues. Support is offered by the Team for all staff involved to learn from adverse incidents raised within WAST that have an element of safeguarding attached to them.

Safeguarding regularly attend the WAST Serious Case Incident Forum (SCIF). This ensures all aspects are addressed internally and externally with our partner agencies.



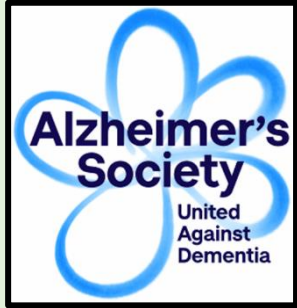
## Safeguarding Maturity Matrix

The Safeguarding Maturity Matrix (SMM) is a self- assessment tool developed and managed by the National Safeguarding Service for Public Health Wales. It addresses the interdependent strands regarding Safeguarding, service quality improvement, compliance against agreed standards as well as learning from incidents and reviews.

The focus of the SMM is then for each Organisation to develop improvement plans which support a consistent approach to Safeguarding across Wales. Members from WAST Safeguarding team participate in the peer review process with 9 other NHS organisations. Utilising a facilitated approach Organisations were able to consider and discuss individual self-assessment improvement plans in a collaborative and transparent system of learning.

WAST improvement plan forms part of the Safeguarding priorities set for 2022-2023 and beyond.





### Dementia Concern Referral

A new bespoke referral pathway to Dementia Connect (part of Alzheimer's Society) for any dementia related concern (confusion, memory loss or issues with communication or daily routine). Carers who may need additional support can also be referred.



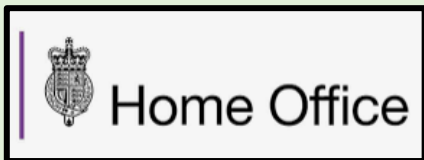
### Live Fear Free Referrals

Following the success of the digital referral pathway for colleagues who use iPads, the pathway will soon be fully digitalised.

Colleagues in NHS 111 Wales and CSD will soon be able to complete digital referrals to Live Fear Free.

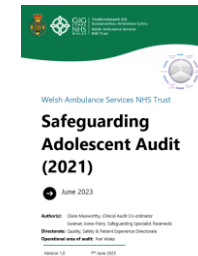
### PREVENT

Digitalising the 'All Wales PREVENT Partners Referral' form to enable WAST colleagues to share information where they have radicalisation concerns.



# Safeguarding Adolescent Audit

- Missed opportunities to safeguard identified during a Domestic Homicide Review and while completing searches for a Local Authority
- 11–17-year-olds who self-harm, overdose, have suicidal thought or die by suicide
- Looked at all 111 and 999 incidents which met criteria between 1<sup>st</sup> October 2020 and 31<sup>st</sup> December 2020
- 386 total incidences audited and 109 excluded as they did not match the inclusion criteria
- It was checked whether a safeguarding report was submitted for all 277 incidents which met inclusion criteria
- Audit Report will be finalised, any learning will be shared during 2023/2024



## 5. Support, Advice and Guidance

The Safeguarding Team within WAST appreciates that working to ensure good outcomes for children and adults at risk, and also victims of domestic abuse/sexual violence can be demanding and distressing work.

Supporting colleagues requires a collaborative approach which facilitates the promotion of good standards and ensures confident and competent practitioners who are able to make sound professional judgements.

### Feedback

#### Local Authority

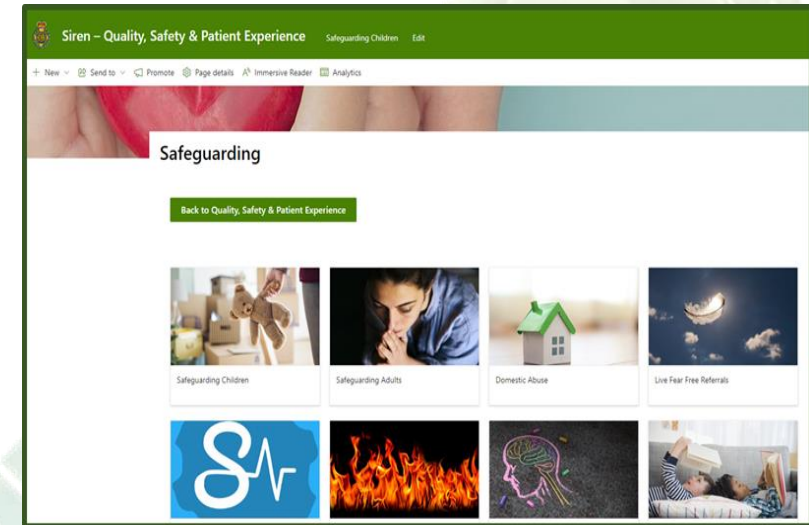


**Obtaining feedback** from social services in relation to safeguarding reports has been improved since the digitalised DocWorks process. The feedback received facilitates WAST practitioners learning to improve future practice.

### What do we offer

- Safeguarding Advice
- Bespoke 1:1 training
- Safeguarding/Restorative Supervision
- Shadowing Experience
- Central Resources
- 7 minute briefings

*“Following your report for this gentleman. He has consented to support and all referrals have been completed. Many thanks for highlighting his circumstances, the case will now be closed to Adult Safeguarding”*



### Safeguarding SharePoint Page

**Modernised & Updated**

*"I worked as a Paramedic within the Welsh Ambulance Service NHS Trust for 5 years prior to joining the Safeguarding Team.*

*The transition from a face to face clinical role to a non-clinical role within the team took a little time for me to adjust. I've settled in more now and have found that my previous experience; understanding of the demands faced by crews for both clinical and safeguarding situations, has proved invaluable.*

*My new team has been very supportive and given me plenty of opportunities to shadow experienced members whilst developing my safeguarding knowledge, skills and understanding of the specialists' role.*

*I am aligned with the WAST safeguarding activity in the SE Region and will often work from various ambulance stations in that area. This gives me a great opportunity to engage with colleagues and support with any safeguarding queries, DocWorks issues or MIST sessions"*

*Charlotte Wilcockson  
Safeguarding Specialist*



*"My background is in Paediatric Nursing within the acute and community setting as well as working on the Clinical Support Desk within WAST in more recent years.*

*I joined the Safeguarding Team in 2020. Since becoming a safeguarding specialist, I have experienced continued support and guidance from the team.*

*This has provided me with the opportunity to improve my IT skills and drive forward the development of safeguarding resources"*

This work has included:

- Revamping the child safeguarding SharePoint page
- Creation of 7 minute briefings on Contextual Safeguarding, Cannabis & Parenting and Professional Curiosity.
- Modernising the VAWDASV Group 2

*Jane Rees  
Safeguarding Specialist*



## Conclusion

In conclusion the Safeguarding Annual report reflects the significant contribution which the Trust, Safeguarding Team and WAST colleagues have made in ensuring people are safeguarded from harm. There is much to celebrate in the achievements highlighted throughout the report.

The Safeguarding Team's collaborative partnership working continues to be significant. This contributes to the assurance that the Trust is fulfilling all of its safeguarding responsibilities. Our achievements obtained through improved knowledge, skills, attitudes and systems have promoted WAST's ability to utilise professional curiosity and act on the safeguarding concerns identified. The team's proactive engagement with safeguarding multiagency activity has strengthened our working relationships and reputation; both internally and externally with our partner agencies.

Safeguarding within WAST is dedicated to providing continual advice, guidance and support to colleagues at all levels. This is reflected in our daily activity; providing 'on scene' and retrospective safeguarding advice. In view of this important element of the team's role within WAST, work has commenced to capture this engagement data for 2023/24. Positive feedback has been received on the provision of safeguarding supervision, additional support sessions held for operational practitioners and the opportunity for shadowing experience to learn from a dedicated specialist team.

The work streams commenced during this reporting period provide focus for the team to continue to progress in 2023-24.



Amb\_wastsafeguarding@wales.nhs.uk  
01792 315884



# Moving Forward 2023/2024

Building on the Safeguarding Team achievements during 2022-23 the following priorities have been identified for future progress.

**To continue to progress DocWorks capabilities**

**To continue to promote WAST Safeguarding National Collaboration**

**To continue to update safeguarding training and methods of delivery**

**To ensure the resilience and required resources for the WAST Safeguarding Team**





GIG  
CYMRU  
NHS  
WALES

Ymddiriedolaeth GIG  
Gwasanaethau Ambiwylans Cymru  
Welsh Ambulance Services  
NHS Trust

Welsh Ambulance Services NHS Trust

# Clinical Audit Plan



2023/2024  
Quarter 1

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_001	1	Evaluation of Non-Conveyance & ROLE forms with ePCR	Kevin Webb Head of Clinical Intelligence & Assurance	Duncan Robertson Assistant Director of Clinical Development	April 2023					
TBC	1	Re-audit ePCR clinical data assurance - #NOF	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	<i>To commence after ePCR changes implemented</i>	N/A	N/A	N/A	N/A	N/A
TBC	1	Re-audit ePCR clinical data assurance - Stroke	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	<i>To commence after ePCR changes implemented</i>	N/A	N/A	N/A	N/A	N/A

<b>TBC</b>	1	Re-audit ePCR clinical data assurance - STEMI	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	<i>To commence after ePCR changes implemented</i>	N/A	N/A	N/A	N/A	N/A
<b>TBC</b>	1	Re-audit ePCR clinical data assurance - Hypoglycaemia	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	<i>To commence after ePCR changes implemented</i>	N/A	N/A	N/A	N/A	N/A
<b>TBC</b>	1	Re-audit ePCR clinical data assurance – ROSC(at hospital)	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	<i>To commence after ePCR changes implemented</i>	N/A	N/A	N/A	N/A	N/A
<b>TBC</b>	1	Re-audit of Bronchiolitis Pathway – Compliance to the All-Wales Guideline for Ambulance Service Management	Ruth Saele Clinical Data Specialist	Greg Lloyd Assistant Director Clinical Delivery	<i>Indicative Q2 2023/24</i>	N/A	N/A			
<b>TBC</b>	1	Re-audit of assurance for the recording of a Clinical Frailty Score (CFS) in patients aged ≥ 65 years	Claire Muxworthy Clinical Audit Coordinator	Duncan Robertson Assistant Director of Clinical Development	<i>Indicative Q3 2023/24</i>	N/A	N/A			
<b>TBC</b>	1	Appropriate administration of Methoxyflurane (Penthrox®) Clinical Audit	Andeep- Chohan Project Manager	Paula Jeffery, Consultant Paramedic,	<i>Indicative Q3 2023/24</i>	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 Audit Coordinator	July 2021	<p>There were 3 aspects to the data capture: PCR, MPDS &amp; CAS. The MPDS aspect has now been removed due to difficulties with locating PCRs, this will not impact on the aims/objectives.</p> <p><b>PCR</b> Data analysed.</p> <p><b>CAS</b> Data capture commenced. CM – data captured</p> <p>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 14<sup>th</sup> June 2023.</p>
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 Data Specialist	<i>Indicative Q4 2022/23</i>	<p>A proposal form is being developed, criteria and data being identified.</p> <p>RT 23/2/23 – audit completed, spreadsheet data being cleansed. Some cases for TA review on his return from leave 1/3/23</p> <p>Report approved at CIAG 13<sup>th</sup> April 2023.</p>

Ref	Clinical Audit Title	Rationale / Drivers	Clinical Audit Author	Clinical Audit Contact / Support	Audit Start Date	Comments
22_007	Diagnostic code compliance - ePCR	<p>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).</p> <p>Where ePCR records are not closed appropriately by clinicians. the TerraPACE system will automatically close the record by applying a closure code as '9999'.</p> <p>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'.</p>	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	<i>Indicative Q4 2022/23</i>	<p>A proposal form is being developed, criteria and data being identified.</p> <p>CM – audit completed, results being analysed and report written (14.02.23)</p> <p>Report approved at CIAG 13<sup>th</sup> April 2023.</p>
23_001	Evaluation of Non-Conveyance & ROLE forms (ePCR)	<p>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.</p> <p>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.</p> <p>This audit aims to identify that an image of the relevant form is available</p>	Kevin Webb Head of Clinical Intelligence & Assurance	Ruth Saele Clinical Data Specialist	April 2023	<p>A proposal form is being developed, criteria and data being identified.</p> <p>Audit commenced April 2023.</p>

Ref	Clinical Audit Title	Rationale / Drivers	Clinical Audit Author	Clinical Audit Contact / Support	Audit Start Date	Comments
		on the ePCR and also evaluate the quality of the information documented on form.				
<b>TBC</b>	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	<i>To commence after ePCR changes implemented</i>	Change request approved, funding being sought prior to submission to Terrafix.
<b>TBC</b>	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	<i>To commence after ePCR changes implemented</i>	Change request approved, funding being sought prior to submission to Terrafix.
<b>TBC</b>	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	<i>To commence after ePCR changes implemented</i>	Change request approved, funding being sought prior to submission to Terrafix.
<b>TBC</b>	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	<i>To commence after ePCR changes implemented</i>	Change request approved with funding and being progressed by Terrafix.
<b>TBC</b>	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 Head of Clinical Intelligence & Assurance	<i>To commence after ePCR changes implemented</i>	Change request to be developed.
<b>TBC</b>	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.	Ruth Saele Clinical Data Specialist	Kath Charters Principal Clinical Information Officer	<i>Indicative Q2 2023/24</i>	Scoping ePCR data from winter 2022/23. Developing proposal and criteria. This will inform the audit for winter 2023/24.

Ref	Clinical Audit Title	Rationale / Drivers	Clinical Audit Author	Clinical Audit Contact / Support	Audit Start Date	Comments
TBC	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 Audit Coordinator	Ruth Saele Clinical Data Specialist	<i>Indicative Q3 2023/24</i>	Scoping ePCR data to inform the audit when previous actions completed.
TBC	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 Audit Coordinator	<i>Indicative Q3 2023/24</i>	To commence once sufficient administrations Trust-wide have been documented.

## The topics in the section below need further development prior to progressing

Exacerbation of COPD	<p><i>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</i></p> <p><i>Further work needed to clarify criteria.</i></p>
Anticonvulsants - Administration in Children	<p><i>Re-audit to be undertaken to ascertain if the actions from the previous audit have resulted in improvements.</i></p>
Re-audit of clinical photographs in aiding care delivery (Consultant Connect)	<p><i>To ascertain if improvements have resulted following completion of actions from the previous audit.</i></p>
Appropriateness of Antimicrobial use by WAST Advanced Paramedic Practitioners	<p><i>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.</i></p>
Peripheral line Insertion bundle compliance	<p><i>Enquiry from Exec Nurse SBUHB if we report on the Insertion bundle compliance.</i></p> <p><i>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.</i></p>

## 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	<i>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.</i>
Effectiveness of pain management	<i>Previous audit on pain scoring and the use of appropriate analgesia have been undertaken – consider re-audits too.</i>
Re-audit of compliance to a Pain Score on PCRs for patients ≥18 years	<i>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.</i>
Explore the correlation between patients presenting with stroke / TIA symptoms and UTI's / dehydration in older adults.	<i>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?</i>
Do long lie faller patients have poorer overall outcomes?	<i>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.</i>
Undertake POPS audits within each Health Board as the roll out continues and it becomes embedded.	<i>Further discussion is required to establish new criteria for POPS audit based on ePCR data.</i>
Major Trauma Tool	<i>High level topic suggestions for CIs at early CIAG meetings.</i>
Silver Trauma Tool	<i>High level topic suggestions for CIs at early CIAG meetings.</i>
Open Fracture (Co-amoxiclav)	<i>High level topic suggestions for CIs at early CIAG meetings.</i>
Delayed Handover.	<i>High level topic suggestions for CIs at early CIAG meetings</i>
Solo Responding	<i>High level topic suggestions for CIs at early CIAG meetings.</i>

Alternative Conveyance	<i>High level topic suggestions for CIs at early CIAG meetings.</i>
Resuscitation	<i>High level topic suggestions for CIs at early CIAG meetings.</i>
Maternity	<i>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.</i>
Recording of Failed Pathways on ePCR	<i>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.</i>

**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

High  
Medium  
Low

Last updated 2nd August 2023

**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	21/01/2022	CAED 20_002	Baseline assurance audit for the recording of a Clinical Frailty Score (CFS) in patients aged ≥ 65 years (2020)	1	High	Include the Clinical Frailty Score on the ePCR in the falls and social history sections for ease of access to support clinicians.	Duncan Robertson	31/01/2022	Included on the ePCR app during the pilot phase and prior to full ePCR rollout	Blue
				2	Medium	Promote staff use of the JRCALC Plus app via Health Board Clinical Leads and Senior Paramedics for reading and acknowledging Clinical Notices.	Duncan Robertson	31/03/2022	email from DR to HBCLs	Blue
				3	Medium	Work with the Older Person's Lead to develop further educational materials and approaches to embed the application of the Clinical Frailty Scale into practice.	Duncan Robertson	30/09/2023	Work has commenced and this involves a variety of educational materials to be developed throughout the year. This work will continue into Q4 and the due date extended until 31/03/2023. Due to the absence of the Older Person's Lead this work will be picked up later in the year, due date amended to 30/09/2023. It is reassuring to see an increased use of frailty scores being documented since the implementation of the ePCR.	Green
				4	High	Undertake a re-audit using ePCR data once the system is rolled out across WAST and when sufficient ePCR data for frailty is available.	Kevin Webb	31/12/2022	Included on the Clinical Audit Plan 2023/24	Blue
B	11/11/2022	CAED 22_005	ePCR Clinical Data Assurance – ROSC (at hospital) Clinical Indicator (2022)	1	Medium	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	Blue
				2	Medium	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 patient 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.	Blue
				3	Medium	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	Blue
				4	Medium	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.	Amber
				5	High	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	Blue
				6	Medium	CIAG to consider the benefits of reporting internally and externally both • the full ROSC-at-hospital metric (all resuscitations) • the subset ROSC-at-hospital Ulstein comparator group (patients of presumed cardiac aetiology with a bystander witnessed cardiac arrest and a shockable rhythm)	Kevin Webb	30/09/2023	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 30/09/2023.	Green
				7	Medium	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.	Blue
				8	High	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	Blue
				9	High	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.	Blue
	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	Medium	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	Blue

C				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 PGD's for just in case medications within WAST to replace the need for verbal order forms.	Chris Moore	31/12/2023	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.	
D	13/04/2023	CAED22_006	Tranexamic Acid Administration in the South Wales Trauma Network (2020-21)	1	The results of this clinical audit to be shared with all staff via the WAST intranet.	Kevin Webb	30/04/2023	<a href="#">Siren – Clinical - 2020-21 Tranexamic Acid (CAED22_006).pdf - All Documents (sharepoint.com)</a>	
				2	Clinical Notice to be issued via WAST intranet and JRCALC app.	Greg Lloyd	31/07/2023	RT to discuss with KW re draft notice for consideration by GL 15/05/23 Draft notice shared with GL Clinical Notice 19/2023 approved by GL, posted on the Intranet 07/07/2023	
				3	WAST to consider reviewing the TXA PGD in line with the South Wales Trauma Network guidelines for both in-hospital and pre-hospital cases (initial dose as bolus NOT over 10 minutes).	Chris Moore	30/09/2023	It has been decided to continue with current PGD guidance as JRCALC, the SPS National TXA PGD template, Electronic Medicines Compendium and BNF all advocate administration by slow intravenous injection.	
				4	Guidance to be provided to WAST clinicians on the expected standards of documentation for the administration of 0.9% Sodium Chloride, for the purpose of a flush.	Chris Moore	30/09/2023	Guidance included in Clinical Notice in line with JRCALC.	
				5	Follow-up audit to be undertaken using ePCR data, 12 months post-publication of this audit.	Kevin Webb	01/04/2024	To be added to the Clinical Audit Plan 2024/25	
E	13/04/2023	CAED22_007	Diagnostic Code Compliance - ePCR	1	The results of this clinical audit to be shared with all staff via the WAST intranet.	Kevin Webb	30/04/2023	<a href="#">Siren – Clinical - 2022 Diagnostic Codes (CAED22_007).pdf - All Documents (sharepoint.com)</a>	
				2	Clinical Notice to be issued via WAST intranet and JRCALC app.	Duncan Robertson	31/07/2023	Clinical Notice 13/2023 posted on the Intranet 26/5/23	
				3	Further engagement with clinical and operational staff to improve the documentation of specific codes 1- 183	Duncan Robertson	31/10/2023		
				4	CIAT to provide details of ePCRs of the three ePCRs which had diagnostic code anomalies.	Kevin Webb	30/04/2023	ePCR IDs where differing closure code seen to be provided to SG Any other records identified please advise SG	
				5	Health Informatics to investigate the reason why the three ePCRs which had diagnostic code anomalies.	Stewart Griffiths	31/05/2023	SG logged support call to TFX, resulting in the import from TFX to WAST DB frequency change from every 10 minutes to hourly for the foreseeable future. Import change made 05/04/2023. We need to confirm that since the DB frequency change this is not continuing to happen. HI now have daily reports for review and will reimport data if this recurs.	
				6	Undertake further work to minimise the auto closure of ePCRs with a code of 9999.	Duncan Robertson	31/10/2023		
				7	Develop a dashboard to monitor compliance with documentation of diagnostic / 9999 closure codes.	Abby Townsend	31/12/2023		
F	14/06/2023	CAED21_002	Safeguarding Adolescent Audit (2021)	1	The results of this safeguarding audit to be shared with all colleagues via WAST SharePoint as soon as possible.	Gwenan Jones-Parry	01/10/2023	Clinical audit posted on Intranet 5/7/23	
				2	Create a bespoke webinar to share the results of this audit. This webinar to be held at least twice before 1st October 2023.	Gwenan Jones-Parry	01/10/2023		
				3	Include the identified learning from this audit within the 2023/2024 safeguarding induction training delivered to new WAST colleagues.	Fiona Davies & Rhiannon Thomas	31/07/2023	The learning has been implemented into safeguarding induction training, with team members knowing to include the requirement for safeguarding reports in situations that meet the audit criteria.	
				4	Create a 7-minute briefing, published by the end of July 2023, which emphasises to WAST colleagues that child safeguarding includes all individuals under 18 years of age and there is a legislative duty to report safeguarding concerns directly with the Local Authority.	Gwenan Jones-Parry	31/07/2023	The 7-minute briefing has been created, shared and published on 17th July 2023	
				5	Within 4 months of publication, the relevant practice educators for Localities, CSD and NHS 111 Wales to ensure the results of this audit are disseminated within their respective teams.	Regional Clinical Leads CSD Practice Educators NHS 111 Wales Practice Coach Team	01/01/2024		
				6	Re-audit to be undertaken to ascertain if the above actions have resulted in improvements.	Fiona Davies & Rhiannon Thomas	31/03/2024	To be included on the 2024/25 Clinical Audit Plan	



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

<b>AGENDA ITEM No</b>	<b>17</b>
<b>OPEN or CLOSED</b>	<b>Open</b>
<b>No of ANNEXES ATTACHED</b>	<b>1</b>

## TRUST POLICY REPORT

<b>MEETING</b>	Quality, Patient Experience & Safety Committee
<b>DATE</b>	10 <sup>th</sup> August 2023
<b>EXECUTIVE</b>	Trish Mills, Board Secretary
<b>AUTHOR</b>	Julie Boalch, Head of Risk/Deputy Board Secretary
<b>CONTACT</b>	<a href="mailto:Julie.Boalch@wales.nhs.uk">Julie.Boalch@wales.nhs.uk</a>

### EXECUTIVE SUMMARY

1. The purpose of the report is to provide an update to the Committee on the status of the Trust's Policies.
2. The number of Policies within their review date fell below reasonable levels during the Covid-19 pandemic as the policy work plan was largely paused and efforts directed to support the response. This means that most policies have now past their review date; however, it is important to note that these remain our extant policies, they are in use and have not expired. The majority of policies will only require minor changes during the review process as they have already been through robust governance.
3. Whilst it is not possible to provide assurance that all Trust policies comply with current legislation, or that they discharge the Trust's statutory duties; Members can be assured that professionals across the organisation are proactive in identifying legislation or practice changes and updating policies as and when necessary to reflect any significant changes.
4. It is, of course, good practice to review, improve and update our policies in a timely manner and a policy prioritisation exercise is underway to fully assess the Trust's position and outline a priority programme of work to bring the organisation's key policies up to date during 2023/24 and schedule a further work plan over 2024-2026.
5. By way of additional assurance, the Trust's internal controls and policies are tested by the Audit Wales Structured Assessment and through the Internal Audit annual audit plan, both of which are aligned to areas of identified risk within the Trust. Additionally, there is a robust programme of risk management in place that will identify any specific areas that need to be addressed outside of the standard process for the review of policies.

6. The Corporate Governance Team hold a policy risk on the Directorate Register which will be reassessed given the that the Trust has several policies that are past their review date. This risk is partially mitigated given that these are the Trust’s extant policies and will be further mitigated as any required amendments are made, and these are brought through the policy governance process.
7. The Trust’s policy governance process is being refreshed in partnership with Trade Union colleagues and includes the review of the Policy on Policies and the process for other documents such as Standard Operating Procedures. It is expected that proposals will be submitted to the Executive Management Team (EMT) for endorsement in late August 2023 and a report submitted to Audit Committee and Trust Board in December 2023 for approval.
8. The EMT agreed proposals to consider extending the current review dates for several non-critical policies that have already been through a robust review process and this will be included in the report for Audit Committee and Trust Board in December 2023 which will also include an overview of the process in selecting these non-critical policies for extension and the 3 year policy work plan for approval.

**RECOMMENDATION:**

9. **Members are asked to:**
  - a) **Consider the contents of the report and the programme of work in development to mitigate risk and bring policies in line with appropriate review dates.**
  - b) **Provide a view on any of the policies within Committee’s remit that should be included on the priority work plan.**

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

<b>REPORT APPROVAL ROUTE</b>
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11. The report and associated policy tracker were considered by:

- Policy Group – 20<sup>th</sup> June 2023
- ADLT – 26<sup>th</sup> June 2023
- EMT – 28<sup>th</sup> June 2023
- Audit Committee – 25<sup>th</sup> July 2023

<b>REPORT ANNEXES</b>
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SBAR Report  
Annex 1 – Trust Policy List

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

## **SITUATION**

1. This paper provides an update to the Committee on the status of Trust Policies as of 20<sup>th</sup> June 2023 along with proposals to bring them up to date.

## **BACKGROUND**

2. The Policy Group was set up in 2017 to ensure appropriate governance, process and partnership working was applied to the review of existing policies, the development of new policies and to ensure that all policies were dealt with in agreed timelines.
3. Since the Trust's revised policy process was implemented in 2017 there was a significant improvement in the number of policies within their review date. However, the rate of review fell below reasonable levels during the Covid-19 pandemic as policy work was largely paused and efforts directed to support the response. This means that most policies are now past their review date and are overdue for review.
4. Whilst it is not possible to provide assurance that all Trust policies comply with current legislation, or that they discharge the Trust's statutory duties; the Trust can be assured that professionals across the organisation are proactive in identifying legislation or practice changes and updating policies as and when necessary to reflect any significant changes.

## **ASSESSMENT**

5. The Corporate Governance Team has maintained a policy tracker contained at Annex 1. This has been specifically designed to facilitate dynamic reporting dependent on the areas which are of most interest to users, for example reports can be produced by Directorate, type of policy, review date or Policy Lead.
6. The tracker describes the status of all policies and lists those which have been identified as a priority for review to date by working with Directors and their teams as well as reviewing Committee Terms of Reference and cycles of business.
7. In terms of a breakdown of the numbers; the Trust holds 93 policies and, for the reasons set out in this paper, only 13 of those are within their review date – this equates to 14% overall.
8. Additionally, there are 19 all Wales NHS Policies that the Trust has adopted from the NHS Employers Unit and only 1 of these is within its review date - equating to 5%. These figures and policy reviews are out of the Trust's control as the programme of policy review work sits with NHS Wales. The Trust has received a review schedule from the NHS

Employers Unit and whilst 5 policies are under review, all NHS Wales employment policies remain extant.

9. There are 13 new policies which have been identified for development along with 2 new policies expected from the NHS Employers Unit. This brings the total number of policies on the policy tracker to 127.
10. There were 49 policies that became due for review during the pandemic; however, there are a number that fell due just before and just after this which will naturally have been postponed given the response to the pandemic.
11. The policy prioritisation exercise which is underway will fully assess the Trust's position and outline a priority work plan to review the organisation's key policies during 2023/24 and schedule a further work plan over 2024-2026.

### **Policy Work Plan**

12. Colleagues have reviewed their directorate lists within the tracker to support the development of a priority schedule and workplan for 2023/24. The Corporate Governance Team will continue to work across the Trust to develop a 3 year work plan to ensure the necessary work is undertaken to enable the Trust to maintain a suite of up to date policies.
13. There is an additional piece of work to be done to review policies in terms of their status and whether these are better suited as Standard Operating Procedures rather than Policy. This will be drawn out in the revised policy governance process.
14. Key Policies identified for priority review in 2023/24 so far are described below; however, this is not a definitive list and others will be included as the work programme is fully established by the Policy Group in August 2023. The list consists of those policies that sit under the Audit Committee's remit as well as specific policies that sit within Safeguarding and Health & Safety for example. The EMT reviewed this draft list at its meeting on 28<sup>th</sup> June 2023.
  1. Assessment, Failure Referral and Appeals Policy
  2. CCTV Policy
  3. Children in Special Circumstances Policy
  4. Counter Fraud, Corruption and Bribery Policy
  5. Data Protection Policy
  6. Driving at Work Policy
  7. Education Programme Policy
  8. Environmental, Estates and Facilities Policy
  9. Equality Policy

10. Fire Safety Policy
11. Flexible Working Policy
12. Health and Safety Policy
13. Home Working Policy
14. HR Starting Policy
15. Information Governance Policy
16. NHS Wales Raising Concerns Policy
17. Occupational Health Policy
18. People Development Policy
19. Policy for the Development and Review of Policies
20. Recruitment and Selection Policy
21. Relocation Expenses Policy
22. Risk Management Policy (new)
23. Safeguarding Children and Adults Policy
24. Staff Immunisation Policy
25. Violence and Aggression Policy

15. It is worthy of note that several policies are already at various stages of the review and development process, as described in the list below, and have been included on the Policy Group Agenda in recent months.

1. Information Security Policy
2. Waste Management Policy (New)
3. Management of High Intensity Service Users (Previous Frequent Caller)
4. Medicines Management Policy
5. Infection Prevention and Control Policy
6. Premises and Vehicle Cleaning Policy
7. NHS Pay Progression Policy
8. NHS Wales Lease Car/Pool Car Policy
9. NHS Wales Executive National Policy on Patient Safety Incident Reporting and Management
10. Clinical Supervision Policy (New)
11. Management of Medical Devices Policy
12. Standards of Business Conduct Policy

16. The EMT agreed proposals to consider extending the current review dates for several non-critical policies that have already been through a robust review process. An extension could be between 6-12 months to support a manageable work plan over the next 3 years and could be applied to policies that fell due just before, during and just after the pandemic period. Work is underway to carry out an assessment of which policies this extension could be applied to facilitate a manageable work plan.

17. A workshop is in the early planning stages and due to be held on the 19<sup>th</sup> September 2023 to launch the revised policy governance process, which is currently under review, along with a series of communications to support colleagues to undertake the review of existing policies or develop new policies.

## **RECOMMENDED**

18. **Members are asked to:**
  - a) **Consider the contents of the report and the programme of work in development to mitigate risk and bring policies in line with appropriate review dates.**
  - b) **Provide a view on any of the policies within Committee's remit that should be included on the priority work plan.**

Policy Title	Priority Number 1 High 10 Low	Directorate	Policy Lead	Policy Type	Issue Date	Review Date
Gifts and Hospitality and Declaration of Interest Policy Standards of Business Conduct Policy	1	CORPORATE GOVERNANCE	Trish Mills	Corporate	04/09/18	04/09/21
Policy for the Development, Review and Approval of Policies	1	CORPORATE GOVERNANCE	Julie Boalch	Corporate	28/03/19	28/03/21
Risk Management Policy	1	CORPORATE GOVERNANCE	Julie Boalch	Corporate	01/02/13	01/01/14
Data Protection Policy	1	DIGITAL	Aled Williams (DPO)	Corporate	15/12/16	15/12/19
Environmental, Estates and Facilities Policy	1	FINANCE & CORPORATE RESOURCES	Susan Woodham	Corporate	16/07/14	16/02/17
Management of Medical Devices Policy	1	MEDICAL & CLINICAL	Jon Wilson	Corporate	22/05/18	22/07/18
Professional Regulation Policy	1	MEDICAL & CLINICAL	Greg Lloyd	Employment	10/01/19	10/01/21
Health and Safety Policy	1	QS&PE	Nicola White	Corporate	28/11/17	28/11/20
Infection Prevention & Control Policy	1	QS&PE	Louise Coulson	Clinical	08/09/20	22/05/21
Premises and Vehicle Cleanliness Policy	1	QS&PE	Louise Coulson	Clinical	26/11/19	26/11/21
CCTV Policy	2	DIGITAL	Kelly Holding	Corporate	25/04/19	25/04/21
Information Security Policy	2	DIGITAL	James Rowlands	Corporate	25/04/19	25/04/22
Non Medical Prescribing Policy	2	MEDICAL & CLINICAL	Kerry Robertshaw	Clinical	25/02/20	25/02/23
Alternatives to Conveyance Policy	3	MEDICAL & CLINICAL	Bryn Thomas	Clinical	01/11/10	01/11/11
Consent to Examination and Treatment Policy	3	MEDICAL & CLINICAL	Bryn Thomas	Clinical	25/02/20	25/02/21
Fire Safety Policy	4	FINANCE & CORPORATE RESOURCES	Susan Woodham	Corporate	17/03/22	17/03/25
Dispatch Cross Reference (DCR) Table Policy	4	MEDICAL & CLINICAL	Grayham McLean	Corporate	23/02/21	23/02/24
Data Quality Policy	5	DIGITAL	Jon Hopkins / Sue Brown	Corporate	16/07/19	16/07/22
Management of Frequent Callers High Intensity Users Policy	5	MEDICAL & CLINICAL	Sarah Woods	Clinical	04/09/18	04/09/21
Medicines Management Policy	5	MEDICAL & CLINICAL	Chris Moore	Clinical	25/02/20	25/02/23
Information Governance Policy	6	DIGITAL	Kelly Holding	Corporate	25/10/18	25/10/21
Information Sharing Policy	6	DIGITAL	Kelly Holding	Corporate	New	New
Counter Fraud, Corruption and Bribery Policy	6	FINANCE & CORPORATE RESOURCES	Carl Window	Corporate	24/05/18	24/05/21
Management of Controlled Drugs Policy	6	MEDICAL & CLINICAL	Chris Moore	Clinical	27/07/21	27/07/24
Access to Personal Information Policy	7	DIGITAL	Judith Birkett	Corporate	25/04/19	25/04/21

Forensic / Digital Evidence Policy	7	DIGITAL	Aled Williams / James Rowlands	Corporate	New	New
Patient Clinical Record Policy	7	MEDICAL & CLINICAL	Kevin Webb	Clinical	New	New
Access Control Policy	8	DIGITAL	Kelly Holding	Corporate	25/10/18	25/04/20
Records Management Policy	8	DIGITAL	Judith Birkett	Corporate	25/10/18	25/10/21
Vehicle Disposal Policy	8	FINANCE & CORPORATE RESOURCES	Gavin Lane	Corporate	11/03/21	11/03/24
Information Classification Policy	9	DIGITAL	Aled Williams	Corporate	No dates	No dates
Mobile Computing Policy	9	DIGITAL	Aled Williams / James Rowlands	Corporate	No dates	No dates
Trust Mobile Phone Policy	9	DIGITAL	Aled Williams / Tony Raine	Corporate	01/11/09	01/11/12
Fuel Card Policy	9	FINANCE & CORPORATE RESOURCES	Gavin Lane	Corporate	25/04/19	25/04/21
Confidentiality and Code of Conduct	10	DIGITAL	Kelly Holding	Corporate	23/02/21	23/02/24
Information Risk Policy	10	DIGITAL	Kelly Holding	Corporate	23/02/21	23/02/24
Tyres and Wheels	10	FINANCE & CORPORATE RESOURCES	Gavin Lane	Corporate	16/07/19	16/07/20
NHS Wales Lease Car Policy	10	FINANCE & CORPORATE RESOURCES	Angie Evans	Corporate	30/10/19	30/10/22
Charitable Funds Investment Policy	10	FINANCE & CORPORATE RESOURCES	Jill Gill	Corporate	13/02/20	13/02/23
Purchase Card Policy	10	FINANCE & CORPORATE RESOURCES	Jill Gill	Corporate	New	New
Pubic Sector Payment Policy - WG	N/A	FINANCE & CORPORATE RESOURCES	TBC	Corporate	01/01/21	NRS
Overpayments Policy	N/A	FINANCE & CORPORATE RESOURCES	NWSSP / Jill Gill	Corporate	New	New
NHS Wales No PO No Pay (No Purchase Order No Payment) Policy	N/A	FINANCE & CORPORATE RESOURCES	NHS Employers Unit	Corporate	No dates	No dates
NHS Wales Research and Development Policy NHS Wales	See comments	MEDICAL & CLINICAL	Nigel Rees	Corporate	10/05/18	10/05/21
Intellectual Rights Policy	x	MEDICAL & CLINICAL	Nigel Rees	Clinical	01/01/17	01/11/18
NHS Wales Do Not Attempt CPR for Adults in Wales	x	MEDICAL & CLINICAL	Dr Paul Buss	Clinical	30/10/18	NRS
Decontamination of Medical Devices Policy (SOP)	x	QS&PE	Louise Coulson	Clinical	New	New
Vehicle Telematics Policy		FINANCE & CORPORATE RESOURCES	Gavin Lane	Corporate	10/05/18	10/05/21
Business Continuity Management Policy		OPERATIONS	TBC	Corporate	24/10/19	24/10/22
Command Policy		OPERATIONS	Clare Langshaw	Corporate	25/04/23	25/04/26
<del>Emergency Operations Demand Management Policy superseded by Clinical Safety Plan</del>		OPERATIONS	Kate Blackmore	Corporate	19/11/20	19/05/21
High Risk Record Policy		OPERATIONS	Katie Blackmore	Corporate	16/07/20	16/07/23
MPDS QA Policy		OPERATIONS	TBC	Clinical	10/01/19	10/01/21

Quality Assurance Framework for the Clinical Desk		OPERATIONS	TBC	Clinical	01/06/15	NRS
Adverse Incident/Hazard Reporting Policy		QS&PE	Jane Palin	Clinical	25/04/23	25/04/26
Children in Special Circumstances Policy & Procedure		QS&PE	Fiona Davies	Clinical	28/11/17	28/11/20
Domestic Abuse, Gender Based Violence and Sexual Violence "Ask and Act" Policy		QS&PE	Rhiannon Thomas	Clinical	26/11/19	26/11/21
Infection Prevention & Control: Sharps Policy		QS&PE	Louise Coulson	Clinical	01/12/20	01/12/23
Lone Worker Policy		QS&PE	Nicola White	Employment	No dates	No dates

Date Review due to Commence (within 3 months)	Comments
04/06/21	In the process now
28/12/20	Under review
01/10/13	Under review
15/09/19	Working with Kelly on a timeline for review
16/11/16	
22/04/18	Out to consultation. Back at PG 29 Aug, QuEST 9 Nov
10/10/20	
28/08/20	In process now
08/02/21	In process now
26/08/21	In process now
25/01/21	
25/01/22	Currently in review (Feb 2023)
25/11/22	
01/08/11	
25/11/20	
17/12/24	A fire safety policy exists and is reviewed, however recent changes to their team does mean elements
23/11/23	
16/04/22	Likely to be a recommendation from the 2023 internal audit for data analysis
04/06/21	T&F group reviewing changes and then back to PG
25/11/22	In process now
25/07/21	
New	
24/02/21	scheduled within 2023 work plan
27/04/24	In process now
25/01/21	

New	Not yet written - no systems in place yet for forensics
New	
25/01/20	
25/07/21	Needs updating to latest GDPR references
11/12/23	
	Drafted - but most remote working aspects now covered under Info Security Policy
01/08/12	Possibly obsolete
25/01/21	
23/11/23	
23/11/23	
16/04/20	
30/07/22	New All-Wales policy only recently provided and approved by AC in Nov 22 - would assume no
13/11/22	This policy was approved at policy group in June and will go to the July CFC meeting
New	Purchase card process in place on a trial basis which will help to inform the final purchase card policy
	All Wales Policy - Shared Services Procurement team asked to provide any review dates
New	All Wales Overpayments Policy review group has been set up with a second meeting taking place on
	All Wales Policy - T&F group set up across Wales to review start of Sept 23
10/02/21	
01/08/18	Will be superseded by all Wales Policy
New	IPC owned SOP, not Clinical Directorate policy
10/02/21	
24/07/22	
25/01/26	In process now
19/02/21	
16/04/23	
10/10/20	

25/01/26	
28/08/20	
26/08/21	
01/09/23	



Ymddiriedolaeth GIG  
Gwasanaethau Ambiwylans Cymru  
Welsh Ambulance Services  
NHS Trust

<b>AGENDA ITEM No</b>	17.2
<b>OPEN or CLOSED</b>	OPEN
<b>No of ANNEXES ATTACHED</b>	9

<b>National Policy on Patient Safety Incident Reporting &amp; Management - May 2023</b>	
<b>MEETING</b>	Quality, Patient Safety and Experience Committee
<b>DATE</b>	10 August 2023
<b>EXECUTIVE</b>	Executive Director of Quality & Nursing
<b>AUTHOR</b>	Jane Palin, Assistant Director (interim)
<b>CONTACT</b>	<a href="mailto:jane.palin@wales.nhs.uk">jane.palin@wales.nhs.uk</a>
<b>EXECUTIVE SUMMARY</b>	
<ol style="list-style-type: none"> <li>1. A Welsh Health Circular (issued 10 May 2023) has been received from Professor Chris Jones, National Clinical Director, NHS Wales and Deputy Chief Medical Officer, Welsh Government in respect of the NHS Wales Executive National Policy on Patient Safety Incident Reporting and Management Policy.</li> <li>2. The Policy has been developed by the former NHS Wales Delivery Unit (now part of the NHS Wales Executive) through a series of consultation workshops held in late 2022 and fulfils action 4 of the Welsh Government Quality and Safety Framework: learning and improving (2021).</li> <li>3. As a result of feedback provided during consultation the new policy merges Welsh Government policy and Delivery Unit implementation guidance. It replaces the interim Welsh Government Patient Safety Incidents Policy of May 2021 and the Delivery Unit implementation guidance of June 2021. The Policy sets out several key changes, for example the establishment of a system to thematically analyse incident data has been superseded by plans to undertake thematic analysis at a national level using the Once for Wales Concerns Management System (Datix Cymru).</li> <li>4. Incident reporting and shared learning go hand in hand to help improve the quality and safety of patient care, one of the aspirations of A Healthier Wales. This updated Policy 'empowers organisations to take ownership and accountability for incident reporting and management and sets out clear expectations for patient safety incident reporting across NHS Wales'.</li> <li>5. All NHS organisations are required to adopt the revised national policy through their internal governance processes during Q1 2023/24. The updated Policy and supporting documents are to be implemented with immediate effect.</li> <li>6. This Policy formalises the adoption of the Joint Investigation Framework following the</li> </ol>	

- pilot undertaken in 2022/23 to replace the 'Appendix B' process.
7. Six supporting documents have been published in addition to the Policy – also for adoption by all NHS organisations:
    - a) Supporting Section 1 – Never Events
    - b) Supporting Section 2 – Nationally Reportable Incidents Reporting Processes
    - c) Supporting Section 3 – Guidance of Specific Type Incidents
    - d) Supporting Section 4 – Joint Investigation Process
    - e) Supporting Section 5 - Safety II Guidance
    - f) Supporting Section 6 – Commissioned Services Flowchart
  8. The adoption of the Policy does not materially change the processes in place internally currently as the Policy and Datix Cymru System have evolved overtime with engagement from all Trusts and Health Boards.
  9. A review of existing key linking trust policies and procedures is planned to reflect the adoption of this Policy and the revised Putting Things Right Regulations.

**RECOMMENDATION: That the Committee,**

- (1) **Discuss the policy and supporting documents.**
- (2) **Approve the adoption of the policy and supporting documents.**

**KEY ISSUES/IMPLICATIONS**

- Adoption of the Policy and supporting documents is mandated by Welsh Government.

**REPORT APPROVAL ROUTE**

Quality, Safety & Patient Experience Directorate Meeting – 23 June 2023  
 Clinical & Quality Governance Group – 29 June 2023  
 Quality, Patient Experience and Safety Committee – 10 August 2023

**REPORT ANNEXES**

1. Letters from Welsh Government
2. National Policy
3. Supporting Sections 1-6

**REPORT CHECKLIST**

<b>Confirm that the issues below have been considered and addressed</b>		<b>Confirm that the issues below have been considered and addressed</b>	
EQIA (Inc. Welsh language)	NA	Financial Implications	NA
Environmental/Sustainability	NA	Legal Implications	NA
Estate	NA	Patient Safety/Safeguarding	YES
Ethical Matters	NA	Risks (Inc. Reputational)	NA

Health Improvement	NA	Socio Economic Duty	NA
Health and Safety	NA	TU Partner Consultation	NA

# WELSH HEALTH CIRCULAR



Llywodraeth Cymru  
Welsh Government

**Issue Date:** 10 May 2023

**STATUS: ACTION**

**CATEGORY: QUALITY & SAFETY**

**Title:** NHS Wales Executive National Policy on Patient Safety Incident Reporting and Management

**Date of Expiry / Review** 31 March 2024

**For Action by:**

Local health boards and NHS trusts, special health authorities, primary care providers.

**Action required by:** 11 May 2023

**Sender:**

Professor Chris Jones, National Clinical Director, NHS Wales and Deputy Chief Medical Officer

**HSSG Welsh Government Contact(s) :**

Teresa Bridge, Quality and Safety, Quality and Nursing Directorate. Tel: 03000 256797 Email:

[QualityAndNursing@gov.wales](mailto:QualityAndNursing@gov.wales)

**Enclosure(s):** None

**Yr Athro/Professor Chris Jones**

Cyfarwyddwr Clinigol Cenedlaethol, GIG Cymru

a Dirprwy Brif Swyddog Meddygol

National Clinical Director, NHS Wales and Deputy Chief Medical Officer

10 May 2023



Llywodraeth Cymru  
Welsh Government

Dear Colleagues

I would like to draw your attention to the new national policy on patient safety incident reporting and management.

This has been developed by the former NHS Wales Delivery Unit (now part of the NHS Wales Executive) through a series of consultation workshops held in late 2022 and fulfils action 4 of the [Quality and Safety Framework: learning and improving](#).

As a result of feedback provided during consultation the new policy merges Welsh Government policy and Delivery Unit implementation guidance. It replaces the interim Welsh Government Patient Safety Incidents policy of May 2021 and the Delivery Unit implementation guidance of June 2021. The policy sets out several key changes, for example the establishment of a system to thematically analyse incident data has been superseded by plans to undertake thematic analysis at a national level using the Once for Wales Concerns Management System.

Incident reporting and shared learning go hand in hand to help improve the quality and safety of patient care, one of the aspirations of *A Healthier Wales*. This updated policy empowers organisations to take ownership and accountability for incident reporting and management and sets out clear expectations for patient safety incident reporting across NHS Wales.

I expect NHS organisations to ratify this revised national policy through their internal governance processes during Q1 2023/24. The updated policy and supporting documents can be accessed through at the following link and should be used with immediate effect.

[Performance and Assurance - NHS Wales Executive](#)

The Nationally Reportable Incident (NRI) forms will be updated to help improve the quality of information received by the NHS Wales Executive and support more thematic analysis of investigation outcomes.

I extend my thanks to all key stakeholders and NHS Wales Executive colleagues involved in the development of the policy and supporting documents.



---

Llywodraeth Cymru  
Welsh Government

Yn gywir/Yours sincerely

A handwritten signature in black ink, which appears to read "Chris Jones". The signature is written in a cursive, flowing style.

**YR ATHRO/PROFESSOR CHRIS JONES**

# CYLCHLYTHYR IECHYD CYMRU



Llywodraeth Cymru  
Welsh Government

Dyddiad cyhoeddi: 10 Mai 2023

## STATWS: GWEITHREDU

## CATEGORI: ANSAWDD A DIOGELWCH

**Teitl:** Polisi Cenedlaethol Gweithrediaeth GIG Cymru ar Adrodd a Rheoli Digwyddiadau Diogelwch Cleifion

**Dyddiad dod i ben / Dyddiad yr adolygiad** 31 Mawrth 2024

### **I'w weithredu gan:**

Byrddau iechyd lleol ac ymddiriedolaethau'r GIG, awdurdodau iechyd arbennig, darparwyr gofal sylfaenol.

**Angen gweithredu erbyn:** 11 Mai 2023

### **Anfonwr:**

Yr Athro Chris Jones, Cyfarwyddwr Clinigol Cenedlaethol, GIG Cymru a'r Dirprwy Brif Swyddog Meddygol

### **Enw(au) cyswllt Grŵp Iechyd a Gofal Cymdeithasol Llywodraeth Cymru:**

Teresa Bridge, Ansawdd a Diogelwch, Cyfarwyddiaeth Ansawdd a Nyrsio. Rhif ffôn: 03000 256797 E-bost:

[AnsawddANyrsio@llyw.cymru](mailto:AnsawddANyrsio@llyw.cymru)

**Dogfennau amgaeedig:** Dim

### **Yr Athro/Professor Chris Jones**

Cyfarwyddwr Clinigol Cenedlaethol, GIG Cymru  
a Dirprwy Brif Swyddog Meddygol

National Clinical Director, NHS Wales and Deputy Chief Medical Officer



10 Mai 2023

Llywodraeth Cymru  
Welsh Government

Annwyl Gydweithwyr

Hoffwn dynnu eich sylw at y polisi cenedlaethol newydd ar adrodd a rheoli digwyddiadau diogelwch cleifion.

Cafodd y polisi hwn ei ddatblygu gan gyn Uned Gyflawni GIG Cymru (sydd bellach yn rhan o Weithrediaeth GIG Cymru) drwy gyfres o weithdai ymgynghori ar ddiwedd 2022, ac mae'n cyflawni cam gweithredu 4 o [Fframwaith Ansawdd a Diogelwch y GIG | LLYW.CYMRU](#).

O ganlyniad i adborth a gafwyd yn ystod yr ymgynghoriad, mae'r polisi newydd yn uno polisi Llywodraeth Cymru a chanllawiau gweithredu'r Uned Gyflawni. Mae'n disodli polisi Digwyddiadau Diogelwch Cleifion Llywodraeth Cymru, Mai 2021, a chanllawiau gweithredu'r Uned Gyflawni, Mehefin 2021. Mae'r polisi'n amlinellu sawl newid allweddol, er enghraifft mae sefydlu system i ddadansoddi data digwyddiadau fesul thema wedi'i ddisodli gan gynlluniau i gyflawni dadansoddiad thematig ar lefel genedlaethol gan ddefnyddio'r System Rheoli Pryderon Unwaith i Gymru.

Mae adrodd am ddigwyddiadau a rhannu'r hyn a ddysgwyd yn mynd law yn llaw i helpu i wella ansawdd a diogelwch gofal cleifion, sef un o ddyheadau *Cymru Iachach*. Mae'r polisi diwygiedig hwn yn grymuso sefydliadau i gymryd perchnogaeth a bod yn atebol am roi gwybod am ddigwyddiadau a'u rheoli, ac yn amlinellu disgwyliadau clir ar gyfer adrodd am ddigwyddiadau diogelwch cleifion ar draws GIG Cymru.

Rwy'n disgwyl i sefydliadau GIG Cymru gadarnhau'r polisi cenedlaethol diwygiedig hwn drwy eu prosesau llywodraethu mewnol yn ystod Ch1 2023/24. Gallwch weld y polisi diwygiedig a'r dogfennau ategol drwy ddilyn y ddolen isod, a dylid eu defnyddio yn syth.

[Perfformiad a Sicrwydd – Gweithrediaeth GIG Cymru](#)

Bydd y ffurflenni Digwyddiad Adroddadwy Cenedlaethol (NRI) yn cael eu diweddarau i helpu i wella ansawdd yr wybodaeth sy'n cael ei derbyn gan Weithrediaeth GIG Cymru a chefnogi dadansoddiad mwy thematig o ganlyniadau'r ymchwiliad.



Llywodraeth Cymru  
Welsh Government

Hoffwn ddiolch i'r holl randdeiliaid allweddol a chydweithwyr Gweithrediaeth GIG Cymru sydd wedi bod yn rhan o ddatblygu'r polisi a'r dogfennau ategol.

Yn gywir

A handwritten signature in black ink, which appears to read "Chris Jones". The signature is written in a cursive, flowing style.

**YR ATHRO/PROFESSOR CHRIS JONES**



# NHS Wales

## National Policy on Patient Safety Incident Reporting & Management

<b>Policy Number:</b>	TBC	<b>Version No:</b>	2.0	<b>Supersedes:</b>	New national policy.
<b>Date of Approval:</b>	June 2023	<b>Review Date:</b>	March 2024	<b>Impact Assessments Completed:</b>	Yes
<b>Classification of Document:</b>	Policy	<b>Type of Document:</b>	Corporate	<b>Approved by:</b>	Clinical Quality Governance Group Quality (June 2023) Quality, Patient Experience and Safety Committee (August 2023)
<b>Brief Summary of Document:</b>	<p>A National Welsh Government Policy developed by the former NHS Wales Delivery Unit (now part of the NHS Wales Executive) through a series of consultation workshops held in late 2022 and fulfils action 4 of the Quality and Safety Framework: Learning and Improving.</p> <p>The policy sets out several key changes, for example the establishment of a system to thematically analyse incident data has been superseded by plans to undertake thematic analysis at a national level using the Once for Wales Concerns Management System. Incident reporting and shared learning go hand in hand to help improve the quality and safety of patient care, one of the aspirations of A Healthier Wales. This policy empowers organisations to take ownership and accountability for incident reporting and management and sets out clear expectations for patient safety incident reporting across NHS Wales.</p>				
<b>Scope:</b>	This policy is aimed at all staff, volunteers, and contractors across the Trust, and should be read in conjunction with the relevant documentation.				
<b>To be read in conjunction with:</b>	<ul style="list-style-type: none"><li>• Safeguarding Children &amp; Adults at Risk of Harm Policy</li><li>• Management of Allegations Policy</li><li>• Duty to Report Guidance</li><li>• Health and Safety Policy (including RIDDOR reporting)</li><li>• Disciplinary Policy</li><li>• Capability Policy</li><li>• Dignity at Work process</li><li>• Putting Things Right Policy (pending review)</li><li>• Adverse Incident Reporting Policy and Procedure (pending review)</li><li>• National documents referenced and linked in this Policy.</li></ul>				
<b>Owning Committee</b>	Quality, Safety & Patient Experience Committee				
<b>Policy Lead:</b>	Stephen Johnson	<b>Job Title:</b>	Head of Patient Safety, Concerns and Learning (interim)		
<b>Trade Union Lead:</b>	TBC	<b>Job Title:</b>	Trade Union Partner		
<b>Executive Director:</b>	Liam Williams	<b>Job Title:</b>	Executive Director of Quality and Nursing		



## NHS Wales

# National Policy on Patient Safety Incident Reporting & Management

<b>Date to be reviewed:</b>	31 March 2024	<b>No of pages:</b>	23
<b>Document author &amp; owner:</b>	NHS Wales Executive		
<b>Contact email:</b>	PatientSafety.Wales@wales.nhs.uk		
<b>Approved by:</b>	Welsh Government		
<b>Approval date:</b>	4 May 2023		
<b>Effective date (live):</b>	11 May 2023		
<b>Version:</b>	v2.0		

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### Supporting sections include:

1. NHS Wales Never Events list
2. Nationally Reportable Incident (NRI) reporting processes & flow chart
3. Guidance on nationally reporting specific incident types
4. Joint investigation process
5. Guidance on Safety-II principles
6. Commissioned Services flowchart

## 1. Changes from previous version

- Merged the content of the policy and the guidance document into a single document
- Removed references to “Phase 1” and “Phase 2” of policy implementation. Phase 2 related to the establishment of systems to thematically analyse incident data, this work has been superseded by the plans to undertake thematic analysis at a national level through the use of the Once for Wales Concerns Management system (Datix Cymru)
- Clarification of the scope of applicability of the policy, particularly with regard to independent service providers
- Improved clarity of roles & responsibilities of all organisations involved in policy delivery, alongside use of more inclusive terminology throughout the document
- Improved clarity on the requirements of the initial assessment process following identification of a patient safety incident
- Strengthened references to the use of Datix Cymru for the reporting and management of patient safety incidents, including the use of the in-built Yorkshire Contributory Factors Framework tool
- Clarified the principles for NHS organisations to consider in determining whether an incident should be nationally reported
- Incorporated the NHS Wales Never Events list
- Endorsement of the just culture guide as a supporting tool
- New/strengthened sections on:
  - Duty of Candour, including alignment of harm definitions
  - Joint safety incident investigations
  - Incidents occurring in relation to commissioned services
- Clarification of accountability for completion (closure) of an incident investigation
- Provision of introductory guidance relating to the use of Safety-II thinking into current incident management processes
- Updated guidance and definitions in relation to specific incident types based on feedback throughout 2021/22 including:
  - patient & service user falls to be retrospectively reported where the investigation has determined the fall was avoidable
  - alignment of reporting requirements associated with maternal & perinatal and infant deaths to National Confidential Enquiry (MMBRACE-UK) definitions
- Clarity on the relationship between Nationally Reportable Incident (NRI) reporting and Welsh Government (WG) Early Warning Notifications

## 2. Introduction

Patient safety incident reporting is changing across Wales. Historically, incident reporting has been used as a key safety indicator in healthcare to attempt to understand where things go wrong to learn and improve safety, experience and outcomes for future patients and service users. As a nation, our understanding of how to best use intelligence from incident data is continuing to evolve. New conceptual approaches to safety, such as Safety-II, will help us shift the narrative from focussing purely on “what went wrong?” and balance this line of inquiry alongside “what goes right, and how can we learn from that as well?” (see Supporting Section 5 for more information on Safety-II). These new approaches require us to think differently and consider how incident reporting is one component of a whole safe system of care. We must continue to ensure our national processes and approaches to this complex and sensitive area of healthcare are aligned to maximise learning opportunities for the benefit of patients, service users, their families, carers and loved ones, staff and our NHS organisations.

To achieve these ambitions, our national processes must support a just culture for organisations and staff to feel supported to identify, report and learn from patient safety incidents, without the fear of punitive response or action throughout all levels of NHS Wales.

The previous version of this policy (in effect from 14 June 2021) aimed to empower organisations to think differently about what should be reported, taking more ownership and accountability for incident reporting and management. Through this updated version of the Policy, the NHS Wales Executive will take these aims further and continue to work collaboratively with NHS Wales organisations and other key stakeholders in delivering a new system for collecting and analysing incident data which is for the NHS, by the NHS.

## 3. Purpose of this policy

A patient safety incident occurs when an unintended or unexpected incident could have or did lead to harm for one or more patients or service users receiving NHS-funded healthcare.

While many incidents will not result in significant harm to an individual, the exploration of incident reports can help provide a source of intelligence which can be used by healthcare providers for a variety of purposes, including:

- to **learn** from what has gone wrong and what could have been done differently, by using the incident as a prompt to undertake an investigation and take action in order to make changes to improve the safety of patients;
- to identify and address **emerging risks** by looking for trends, themes and patterns of incident reports; and
- as a mechanism for oversight and **assurance** particularly where significant harm has occurred in the delivery of healthcare, in line with *The National Health Services*

*(Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011*- also known as ‘Putting Things Right’ (referred to forthwith as ‘the Regulations’).

Incident reports can be a valuable signal to healthcare providers about where to focus resource and attention to improve patient safety. However, they are only one part of the puzzle and should be examined in the wider context of other sources of safety intelligence. This includes triangulation with other data sources (for example, patient experience and complaint data) as well as looking at what goes well the majority of the time, and what we can learn from that (e.g. Safety-II). Throughout 2023 and beyond, the NHS Wales Executive will be working to improve how this triangulation of multiple data sources is undertaken at a national level.

The purpose of this Policy is to set out clear expectations for patient safety incident reporting and management across NHS Wales. It supersedes and replaces the section on “Serious Incidents” within the 2013 ‘Putting Things Right’ (PTR) guidance document.

#### 4. Strategic policy context

The following national programmes and concepts provide context to this Policy:

- [Health and Social Care \(Quality and Engagement\) \(Wales\) Act 2020](#), which underpin the statutory **Duties of Candour and Quality**:
  - The [Duty of Candour](#) is intrinsically linked to incident management. The Duty focusses on the need to be open with patients and service users and anyone acting on their behalf when things go wrong, building on the requirements already set out in the Regulations.
  - The [Duty of Quality](#) has two aims – to improve the quality of services, and to improve outcomes for people in Wales.
- [Quality & Safety Framework: learning and improving](#): the overarching national Framework setting out the national ambitions for Wales in relation to quality and safety in the NHS. In particular, this Policy relates to Action 4 – **the development of a new National Incident Reporting Framework focussing on maximising and sharing learning from incidents**.
- [National Clinical Framework: A Learning Health and Care System](#): the overarching national Framework setting out the national ambitions for Wales in relation to the development of clinical services across NHS Wales.
- [NHS Wales Executive](#): in fulfilment of an objective set down in A Healthier Wales, a number of organisations have brought together under the banner of the NHS Wales Executive from 1 April 2023. National systems for incident reporting will be established, maintained and developed by the NHS Wales Executive.

- **National Quality Management System (NQMS)**: a visionary system for NHS Wales which will ultimately bring together data from a number of sources, including patient safety incidents, for triangulation and to inform a range of activities in relation to learning and assurance.
- **[Once for Wales Concerns Management System](#)**: the national IT system enabling consistent approaches to a range of processes across NHS Wales. In relation to incident reporting and management, this system is also known as **Datix Cymru**.
- **COVID-19 pandemic & the [National Nosocomial COVID-19 Programme \(NNCP\)](#)**: NHS Wales is still recovering from the effects of the COVID-19 pandemic and this must continue to be taken into consideration in relation to patient safety incident reporting and management. Importantly, learning and changes to process which were brought about by the pandemic must be capitalised on, including in particular learning from the NNCP, which will be incorporated into this and future versions of the policy as applicable.

## 5. Scope of Policy

This Policy applies to **all** services directly provided or managed by a Health Board, Trust or Special Health Authority in NHS Wales.

NHS Wales organisations that contract, agree or arrange for care to be provided by a non-NHS Wales provider (independent provider) on their behalf, retain responsibility for national incident reporting. This is in keeping with position outlined in the *Health and Social Care (Quality and Engagement) (Wales) Act 2020* for Duty of Candour reporting. The requirement to report extends to Primary Care services providing care as part of NHS Wales.

## 6. References and related documents

- [Health and Social Care \(Quality and Engagement\) \(Wales\) Act 2020](#)
- [The National Health Services \(Concerns, Complaints and Redress Arrangements\) \(Wales\) Regulations 2011](#) as amended by [National Health Service \(Concerns, Complaints and Redress Arrangements\) \(Wales\) \(Amendment\) Regulations 2023](#)
- [The Duty of Candour Procedure \(Wales\) Regulations 2023](#)
- [The Duty of Candour Statutory Guidance 2023](#)
- [Putting Things Right guidance document \(v3, 2013\)](#)

## 7. Aims and objectives of this policy

- Provide a clear and consistent national approach to incident reporting, management and investigation across NHS Wales.
- Provide clear guidance on what types of incident should be nationally reported, and how this should occur.

## 8. Responsibilities in relation to this policy

### Welsh Government:

- Setting legislation, statutory guidance and government policy.
- Ensuring that intelligence and learning derived from the outputs of this policy are taken into account in setting legislation, statutory guidance and government policy.
- Publishing official statistics based on reported incidents.

### NHS Wales Executive:

- Oversee and deliver national policy and processes in relation to reporting, management and investigation of safety incidents.
- Identification of cross-system learning, ensuring that learning is disseminated.
- Ensuring consistency of application of this policy, including provision of assurance mechanisms in relation to incident reporting, management and investigation.
- Provide national analysis on nationally reported incident data.
- Provide advice, guidance and support to organisations in relation to implementation of this policy, including the reporting, management and investigation of safety incidents.

### Health Boards, NHS Trusts and Special Health Authorities

- Accountable for the quality and safety of care and services provided to their respective populations, including care that they contract, agree or arrange for their populations.
- Implementing this policy including endorsement through their Quality & Safety governance framework.
- Ensuring there are appropriate governance and assurance mechanisms in place, facilitating a flow of information across all parts of the organisation.

- Ensuring local systems and processes for incident reporting are in place and embedded.
- Ensuring that there are systems and processes for incident reporting, management and learning for any health care they contract, agree or arrange on behalf of their populations.
- Undertaking analysis of locally reported incidents, including identifying trends and themes from incident data.
- Establishing mechanisms to extract and share learning from incidents, and taking action to reduce the risk of recurrence and improve patient and service user safety, experience and outcomes.
- Ensuring staff are familiar with the requirements of this Policy.

#### **Primary Care (General Medical Services) contractors in NHS Wales**

- Accountable for the quality and safety of care and services provided to their respective populations
- Required to locally report incidents that have occurred within their organisations using the Datix Cymru system. The Health Body whose system they report into is responsible for assessing whether incidents have met the NRI threshold and undertaking any subsequent reporting.
- Primary Care Contractors must notify the relevant Health Board of occurrences where the Duty of Candour is triggered in respect of the health care they provide under a contract or other arrangement.
- Establishing mechanisms to extract and share learning from incidents, and taking action to reduce the risk of recurrence and improve patient and service user safety, experience and outcomes.

#### **Once for Wales Concerns Management System programme:**

- Responsible for overseeing the development and delivery of relevant Datix Cymru modules to support the implementation of this Policy.

## 9. Key Definitions

### General definitions:

Policy Term	Applicable Definition
Concern	As defined in the <i>NHS Wales (Concerns, Complaints and Redress Arrangements) (Wales) (Amendment) Regulations 2011</i> , a concern is any complaint, claim or reported patient safety incident
Patient Safety Incident	An unintended or unexpected incident that could have or did lead to harm for one or more patients or service users receiving NHS-funded healthcare Note: the term “patient safety incident” refers to an incident occurring in the course of the delivery of healthcare. It is recognised that this may not always be to a patient but can also affect other service users in receipt of NHS-funded healthcare. The language throughout this document has been updated where possible to reflect this but for the avoidance of doubt, the definition of a patient safety incident applies equally to a service user in receipt of NHS funded healthcare even if they are not classified as a patient.
Patient or Service user	A person to whom healthcare is or has been provided Healthcare includes services for the prevention, diagnosis or treatment of illness as well as the promotion and protection of public health. It also includes NHS staff accessing treatment and care through wellbeing/occupational health services
Action	Something done intentionally or unintentionally
Inaction	Something <b>not</b> done intentionally or unintentionally including as a result of indecision, unnecessary delay, failure to act
Nationally Reported Incident (NRI)	A patient safety incident which is nationally reportable in line with this policy
“Must report”	A sub-set of Nationally Reportable Incidents where national reporting is mandated through this Policy

## Harm definitions

The following definitions align with the definitions set out in the [Duty of Candour Statutory Guidance](#)

No harm	Any patient safety incident that had the potential to cause harm but impact resulted in no harm having arisen
Low harm	Any patient safety incident that resulted in a minor increase in treatment and which caused minimal harm to one or more persons receiving NHS-funded care
Moderate harm	Any significant but not permanent harm, or harm that requires a 'moderate increase in treatment' relating to the incident.  A 'moderate increase in treatment' is further defined as an unplanned return to surgery, an unplanned readmission, a prolonged episode of care, extra time in hospital or as an outpatient or transfer to another treatment area such as intensive care
Severe Harm	The permanent lessening of the bodily, sensory, motor, physiologic or intellectual functions, including the removal of the wrong limb or organ or brain damage, which is related directly to the incident and not related to a natural course of the service user's illness or underlying condition
Death	A death caused or contributed to by a patient safety incident, as opposed to a death which occurs as a direct result of the natural course of the patient or service user's illness or underlying condition

## 10. Governance & assurance requirements

Organisations must ensure they have robust systems and processes in place in relation to local and national incident reporting, including:

- systems and processes to enact this policy in all areas of the organisation;
- all incidents should be reviewed within an appropriate governance framework to determine required risk management activities as well as any national reporting requirement. Whilst advice and support can be sought from the NHS Wales Executive, it will be expected that organisations are responsible and accountable for their judgements and decisions in line with the policy;
- integration with other relevant clinical and corporate governance processes e.g. management of complaints and claims, mortality review processes etc.;
- internal oversight, scrutiny and quality assurance of all incident reporting and investigation processes, including Executive level sign off on national incident notification and investigation outcome forms;
- clear and demonstrable lines of reporting across all parts of the organisation, including through relevant Committees of the Board;

- mechanisms for ensuring joint investigations with other responsible bodies and external agencies where applicable and appropriate;
- mechanisms for recording the outcomes of decisions around national reporting and investigation, including decisions on appropriate investigation methodology. In particular, organisations must ensure they keep robust records around the decisions not to report/investigate incidents as this will be needed for quality assurance purposes;
- mechanisms for capturing and demonstrating shared learning;
- mechanisms for ensuring engagement with any affected patient or service user or anyone acting on their behalf, in line with the legal Duty of Candour.

## **11. Local incident reporting, management & investigation requirements**

### **11.1. Context**

Patient safety incidents can be single isolated events, or multiple recurring events which can signal more systemic failures in care or demonstrate system weaknesses. They can also include events which indirectly impact patient safety or an organisation's ability to deliver a service, such as a failure of an IT system. Consequently, there is no definitive list of what constitutes a patient safety incident and accordingly NHS organisations will need to apply judgment when considering what should be reported, both at a local and a national level.

### **11.2. Systems and processes**

All organisations are required to ensure that they have systems and processes for local incident reporting, management and investigation in line with this Policy. This must include systems and processes to analyse incident data, extract learning and disseminate it throughout the organisation, with relevant actions taken to improve patient and service user safety, outcomes and experience.

Organisations should also have systems in place for monitoring and nationally reporting incidents that occur within services that are provided on their behalf by non-NHS Wales providers.

These processes must include the use of Datix Cymru where available to ensure a consistent national approach to data collection and analysis. These processes should be sufficient to capture and analyse data from across all parts of the patient or service user pathway, including (but not limited to):

- secondary and acute care settings
- primary and community care, including community pharmacy, optometry, dentistry services

- urgent and emergency services including emergency departments & ambulance services
- out of hours' services
- public health services
- relevant IT services
- prisons
- commissioned services, and
- incidents identified through the course of other clinical and corporate governance processes, for example Medical Examiner and Mortality Reviews.

The systems and processes must fully align with the organisation's governance and assurance mechanisms, ensuring clear reporting across the entire organisation for relevant information.

Organisations must ensure local processes are reviewed, amended and/or adapted to incorporate the requirements of this Policy.

### **11.3. Initial assessment to determine risk management activities and next steps**

All patient safety incidents will require an initial assessment in order to assess the circumstances, identify the relevant make safe actions required, and determine the next steps to manage the incident. This initial assessment should take place as soon as practicable after the incident has occurred or otherwise been identified.

This initial assessment must include:

- review of known information about the incident and consideration of further information to be obtained to inform the next steps;
- assessment of risk and determination of make safe actions in relation to:
  - all patient(s) or service user(s) affected by the incident, and
  - the organisation, or other safety systems, to prevent recurrence in similar circumstances;
- determination of the depth and parameters of an appropriate investigation;
- consideration of engagement with the patient or service user and anyone acting on their behalf as appropriate. This assessment will need to balance the desire to engage transparently and compassionately with all affected by the incident whilst having due regard for legal matters of consent and capacity.

- consideration and, where required, escalation e.g.:
  - as a Nationally Reported Incident (NRI);
  - through to relevant national frameworks (e.g. multiagency safeguarding processes); and/or
  - through to relevant external bodies;
- any relevant communications handling required;
- next steps in terms of incident management.

The depth of the initial assessment will vary depending on the circumstances of the incident. The initial assessment must be undertaken by someone of sufficient seniority and experience in incident management proportionate to the circumstances of the incident, and in many cases will require a multi-disciplinary approach. In some cases, including where the incident requires reporting as an NRI, this may require Executive level oversight.

Depending on the circumstances of the incident, this may be the point at which the organisation considers whether the Duty of Candour has been triggered and if so, who should make the initial “in person” notification – see Section 4 of the Statutory Guidance.

#### **11.4. Use of Datix Cymru**

All patient safety incidents should be reported through Datix Cymru (part of the Once for Wales Concerns Management System) in line with the applicable User Guide operational at the date of reporting.

Employees of Health Boards, Trusts and Special Health Authorities should have access to report directly into their employer’s Datix Cymru system.

Primary Care Contractors in NHS Wales are required to report incidents that have occurred within their organisations. More information can be obtained from the [Primary Care Wales Incident Reporting - NHS Wales Shared Services Partnership](#) website.

#### **11.5. Welsh Government Early Warning Notifications (EWN)**

Early Warning Notifications (EWN) (previously No Surprise Reporting) is a communication function established by Welsh Government. Its purpose is to provide rapid information to Welsh Government on a range of issues, which may or may not relate to patient safety incidents.

The EWN process is independent of the incident reporting systems described in this Policy, which are overseen and managed by the NHS Wales Executive.

For clarity, where a patient safety incident meets both the requirements of a EWN and a NRI, then both processes must be followed.

## 12. National incident reporting requirements

### 12.1. Context

A subset of patient safety incidents will require national reporting to the NHS Wales Executive. The reporting of patient safety incidents at a national level:

- provides oversight and assurance relating to incidents that cause the most harm to patients and service users during healthcare;
- provides oversight and assurance relating to incidents that cause high levels of service impact, disruption or risk;
- enables the identification of organisational and/or system risks; and
- informs learning and action, including e.g. development of patient safety alerts and notices, policies and improvement programmes, national priorities, outcome measures and potential service reforms.

Building on the foundation of the previous version of the Policy, there is a need to move away from prescriptive “trigger list” approaches to determining what incidents require national reporting. This is because of the complexity of healthcare and the incidents that can occur, it would never be possible to determine and list all the types of incidents which should be reported.

Accordingly, NHS organisations must have systems and processes in place to review all incidents on an individual basis and apply judgement to determine what should be reported nationally.

### 12.2. Nationally Reportable Incidents (NRIs)

As part of the initial assessment process described above, NHS organisations will need to consider whether an incident requires reporting nationally, taking the following principles into account:

#### *Principle 1 - ‘Must reports’*

Incidents related to the following are always nationally reportable (please see Supporting Section 3 for more guidance on definitions):

- Never Events, as specified within this Policy, even where no harm has occurred. The current NHS Wales Never Event list can be found in Supporting Section 1 of this Policy;
- suspected mental health homicides;
- suspected suicide or self-inflicted death
  - in any clinical setting; or

- during authorised/agreed leave, following recent planned discharge, or following unplanned leave/discharge; and
- maternal, perinatal and infant deaths.

#### *Principle 2 - outcome/harm*

A safety incident should be nationally reported if it is **assessed or suspected** an **action or inaction** in the course of a patient or service user's treatment or care, in any healthcare setting, **has, or could have caused or contributed** to their **severe harm or death**.

It will not always be possible to rapidly determine the extent to which a safety incident caused or contributed to the harm or death of a patient or service user within seven working days. In this case, organisations should nationally report the incident, specifying that the position is unclear and/or investigations are ongoing. Incidents can be downgraded at a later date.

Acts and inactions can relate equally to human interactions, technical failures and/or delays in systems and processes.

#### *Principle 3 - number of patients or service users involved*

Special consideration must be given to incidents where the numbers of patients or service users affected is significant, even where direct harm has not been, or is difficult to, identify. This includes but is not limited to incidents involving significant:

- screening services;
- IT failures;
- data breaches;
- national system failures; and/or
- service disruptions.

#### *Principle 4 - learning opportunities*

Incidents should be nationally reported where they present new learning opportunities, particularly where a similar risk may be present in other NHS organisations. This may include:

- near misses and/or no or low harm incidents where the learning would be beneficial to be shared nationally with other organisations to help raise awareness and mitigate risks for other patients or service users; and/or

- incidents may present which are unusual, unexpected or surprising, where seriousness of the incident requires it to be nationally reported and the learning would be beneficial for others.

#### *Principle 5 - joint decision making around reporting and investigation*

Some patient safety incidents will require joint investigation with another organisation. Early consideration must be given to involving relevant stakeholders in any discussions around incidents potentially requiring joint investigation, to ensure relevant information is obtained from all sources in order to inform the discussion. Guidance on the joint investigation process can be found in Supporting Section 4.

### **12.3. Reporting process**

A patient safety incident will be nationally reported to the NHS Wales Executive within seven working days from the date of knowledge of the incident.

The reporting process is set out in Supporting Section 2.

## **13. Duty of Candour**

The provisions of the statutory Duty of Candour, as set out in the [Health and Social Care \(Quality and Engagement\) \(Wales\) Act 2020](#) came into effect on 1 April 2023. This is an organisational duty on all NHS bodies and primary care providers. More information on the Duty of Candour, including the [statutory guidance](#), can be found on the [Welsh Government website](#).

Incident reporting, management and investigation is intertwined with the principles of [Being open: communicating patient safety incidents with patients and their carers](#) and must adhere to the Duty of Candour, so in practice these activities should be fully integrated. In preparation for the Duty of Candour, NHS organisations have been reviewing their systems and processes in relation to concerns and incident reporting, investigation, and management to ensure that they are aligned as far as possible, in order to provide a seamless patient or service user experience.

The Duty of Candour is triggered when:

- an adverse patient safety event (usually an incident) occurs, and the service user sustains or could sustain harm which is
  - unintended or unexpected, and
  - more than minimal e.g., moderate, severe or death, and
- the provision of healthcare was or could have been a factor in that harm occurring.

At the point the incident is reviewed, and it is recognised that the above triggers for the Duty of Candour have been met, the organisation becomes 'aware'. It is at this point that the Duty of Candour procedure should be initiated.

The Duty of Candour is not intended to operate retrospectively and therefore will only apply where the conditions triggering the Duty of Candour as set out in Section 3 of the [Health and Social Care \(Quality and Engagement\) \(Wales\) Act 2020](#) occur after the date on which Section 3 was brought into force (i.e. 1 April 2023). In practical terms, this means that the provision of health care and the harm which ensued, must have taken place after 1 April 2023.

For the avoidance of doubt, the Duty of Candour may be triggered following a retrospective case review but that the conditions which gave rise to the notifiable adverse outcome must have occurred after Section 3 was brought into force.

## **14. Patient safety incident investigations**

### **14.1. Legislation**

All concerns reported in NHS Wales, including patient safety incidents, must be subject to an appropriate and proportionate investigation in line with the *NHS Wales (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011*. In particular, [Regulation 23](#) outlines the requirements of the investigation to be undertaken and requires the organisation to undertake the investigation in the manner that appears, to that organisation, to be most appropriate to reach a conclusion in respect of those matters thoroughly, speedily and efficiently.

### **14.2. Methodologies**

NHS organisations must have systems and processes for determining the appropriate and proportionate investigation to be undertaken in response to each reported safety incident, taking into account considerations such as scale, complexity and type of incident.

Organisations should therefore ensure they have access to a range of suitable investigation approaches/tools to support a proportionate approach across a range of outcomes. It will not be appropriate to conduct in-depth investigations for all incidents, and so it is important to determine as accurately as possible from the outset what will be proportionate in the circumstances.

Methodologies in use by an organisation should ensure the involvement throughout the investigation of appropriate staff and patient, service user or a person acting on their behalf.

For certain incident types, to support a consistent national approach there are a number of focussed review tools built into Datix Cymru, which should be used where they are available. This includes safety incidents relating to:

- Falls
- Pressure damage
- Extravasation

This section will be expanded during 2023 in line with the NHS Wales Executive's work.

### **14.3. Use of Yorkshire Contributory Factors Framework**

The Yorkshire Contributory Factors Framework (YCFF) has been built into Datix Cymru to support a consistent approach to the analysis of incidents, including the identification of cross-cutting themes to enable targeting of improvement activities.

Accordingly, the use of the YCFF is required for NRIs and encouraged for other patient safety incidents.

### **14.4. Just culture guide**

Staff who have been involved in a patient safety incident should be treated in a consistent, constructive and fair way.

NHS Wales endorses the use of the NHS England just culture guide as a tool to support the fair treatment of staff who have been involved in an incident. It supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely.

The just culture guide should **not** be used as a routine or integral part of a patient safety investigation – it should only be used when consideration needs to be given to whether an individual member of staff requires support or management to work safely.

The just culture guide, along with supporting reference materials, can be found on the NHS England website - <https://www.england.nhs.uk/patient-safety/a-just-culture-guide/>

### **14.5. Joint investigations**

Some safety incidents will require joint investigations, including between:

- different departments within the same organisation;
- where patients have been moved between organisations, including patient handovers at emergency departments; and

- where services have been commissioned, including relating to social care.

NHS organisations should have systems and processes in place to manage these types of investigations.

For joint investigations involving multiple organisations, please refer to the joint investigation process in Supporting Section 4.

## **15. Investigation of incidents occurring to a patient or service user while in receipt of commissioned services**

Whilst the reporting of patient safety incidents at a national level remains the responsibility of the NHS Wales organisations that provided, managed or commissioned the care at the time of the incident, guidance on the investigation of such incidents is provided within the *The National Health Services (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011* (“the Regulations”). The Regulations require all ‘responsible bodies’ to investigate incidents which occur to services users in receipt of NHS funded care.

A responsible body is defined under the Regulations as:

- a Welsh NHS body:
  - a Health Board;
  - an NHS Trust managing a hospital or other establishment or facility wholly or mainly in Wales;
  - a Special Health Authority
- a primary care provider; or
- an independent provider:
  - a person or body who provides healthcare in Wales under arrangements made with a Welsh NHS body; and is not an NHS body or a primary care provider.

When a patient safety incident occurs, [Regulation 23](#) states that “the responsible body must investigate the matters raised in the notification of a concern in the manner which appears to that body to be most appropriate to reach a conclusion in respect of those matters thoroughly, speedily and efficiently, having particular regard to additional criteria set out in the Regulations”. The Regulations also detail what actions responsible bodies must take in terms of *redress*<sup>1</sup>, when harm is deemed to have been ‘caused’ to a patient or service user through a ‘breach in duty of care’ to that patient or service user.

When healthcare is funded by another Welsh NHS body (Health Board or Trust), the Regulations require a full investigation up to and including consideration of qualifying

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<sup>1</sup> Redress is a range of actions which include an apology, learning lessons, and/or in certain circumstances, financial compensation.

liability (QL). Organisations are required to undertake a joint investigation with a lead organisation agreed.

There are however distinct differences in how the Regulations are applied when healthcare provision has not been provided by a 'Welsh NHS body' (Health Board or Trust) through NHS funding arrangements. The degree in variation is predicated on which other type of 'responsible body' provided the healthcare, and particularly when the healthcare has been provided outside of Wales.

The way in which the Regulations vary can be divided into two categories;

1. NHS Wales funded healthcare provided by another UK NHS provider, i.e.:
  - NHS England; or
  - NHS Scotland; or
  - NHS Northern Ireland; and
2. NHS Wales funded healthcare provided by an 'independent provider', either:
  - provided in Wales under arrangements made with a Welsh NHS body and is not an NHS body or a primary care provider; or
  - provided outside of Wales.

### **NHS Wales funded healthcare provided by another UK NHS provider**

When the Regulatory duty is applied to other UK NHS organisations through cross-border and other commissioning arrangements, it is anticipated that local procedures for managing concerns and investigations will be of a sufficient standard to support investigations in keeping with the Regulations. The Regulations require other UK nations to consider a qualifying liability (QL) and refer the matter back to the NHS Wales commissioning organisation where they consider a QL **does**, or **may** exist. However, there is no requirement on other UK NHS organisations to inform an NHS Wales commissioning organisation where they **do not** consider a QL exists.

### **NHS Wales funded healthcare provided by an 'independent provider'**

The Regulations state any responsible body, who provides healthcare **in Wales** under arrangements made with a Welsh NHS organisation, and who is not an NHS Wales Health Board or Trust, must have arrangements in place to manage and undertake investigations when a concern, including a patient safety incident, is raised.

The first element to highlight is that the Regulations do not apply to private provision of healthcare *outside* of Wales.

The second element relates to private provision *within* Wales. In this regard, this will include healthcare provision in care and residential home settings through continuing healthcare

(CHC) and funded nursing care (FNC) arrangements, including local authority managed, third sector/charitable/not for profit sector, and private business. This also extends to any other privately provided healthcare which is NHS funded.

### **Responsibility to Investigate**

Whilst the Regulations require an investigation to be undertaken when a patient or service user is subject of a concern during funded provision of healthcare, there are two key differences when a concern is raised in this regard:

1. the investigation is to be **undertaken by the provider** and not the NHS commissioning organisation, in keeping with the requirement on them to have arrangements in place to do so; and
2. there is no requirement on the provider to consider a QL as part of the investigation process.

### **Joint investigations in relation to commissioned services**

Although the Regulations require the provider to undertake investigations when a concern is raised (including a patient safety incident), it is envisaged that when a concern is raised both in respect of the commissioned healthcare provider, and the commissioning organisation, it will be for the NHS Wales organisation to lead a joint investigation. The Regulations still however limit the independent provider element of the investigation to a factual response and not as far as considering QL, but the NHS element of the investigation is required to consider QL.

### **Post discharge**

Concerns which occur during healthcare provision by an NHS Wales body prior to, or during a transfer of care to an independent provider through NHS funding arrangements, will remain the responsibility of NHS commissioning organisation to manage and investigate, fully in keeping with the Regulations up to and including consideration or QL.

## **16. Investigation outcomes**

### **16.1. Learning from incident investigations**

A fundamental part of undertaking incident investigations is to learn from previous experience in order to identify areas for improvement to reduce the risk of similar incidents occurring in the future.

NHS organisations should ensure they have robust systems and processes in place to support the extraction and dissemination of learning from incident investigations throughout the organisation, and include key learning as part of sharing investigation outcomes with the NHS Wales Executive.

This section will be expanded during 2023 in line with the NHS Wales Executive's work.

## **16.2. Completing (closing) an incident investigation**

The accountability for completing (closing) an incident investigation sits with the NHS organisation who undertook the investigation.

NHS organisations must ensure there are robust processes in place to ensure the timely completion of incident investigations in line with this policy, which incorporate processes for patient or service user involvement, quality assurance, and Executive sign off.

To allow Boards to be assured that incidents within their organisation have been dealt with appropriately, all NHS organisations must ensure robust processes are in place to inform and assure their Boards that:

- the quality of their investigation processes is of a high standard;
- investigations are being undertaken and completed in a timely manner;
- patients or service users or anyone acting on their behalf are being engaged and supported during the investigation process and the findings and outcomes of the investigation are shared with them; and
- appropriate actions are being taken and learning is being shared across the organisation.

## **16.3. Process for reporting outcomes of an investigation into an NRI**

Detailed guidance on the process for reporting NRI investigation outcomes to the NHS Wales Executive is in Supporting Section 2.

## **16.4. NHS Wales Executive's role in relation to investigation outcomes**

The NHS Wales Executive does not "close" incident investigations related to NRIs. As stated above, the completion of an incident investigation is the responsibility and accountability of the NHS organisation who undertook the investigation.

The NHS Wales Executive has an assurance function to ensure that the information shared in relation to the investigation outcomes is of good quality, using a suitable approach, and undertaken in a timely manner. This is to support a patient or service user focused approach, as patients or service users affected by safety incidents and people acting on their behalf require good quality information to be provided to them in a timely manner. Where gaps in assurance are identified, the NHS Wales Executive will liaise with the relevant NHS organisation to seek further assurance.

In addition to the extraction and utilisation of learning from incidents, data and intelligence from NRIs will be used to inform local and national assurance activities.

## **17. Future thinking in relation to incident reporting and analysis**

As described in the introduction section, new conceptual approaches to safety including resilience in healthcare and Safety-II, will be increasingly considered by the NHS Wales Executive to determine how these new ways of thinking can help support continual improvement and evolution of our safety management systems in healthcare.

Some preliminary guidance on how to incorporate elements of Safety-II thinking into current incident management practices is included in Supporting Section 5.

This section will be expanded during 2023 in line with the NHS Wales Executive's work.

## **18. Getting Help**

Please contact [PatientSafety.Wales@wales.nhs.uk](mailto:PatientSafety.Wales@wales.nhs.uk) if help and support in application of this policy is required.

Welsh Ambulance Services NHS Trust email contact: [amb\\_PTR\\_admin@wales.nhs.uk](mailto:amb_PTR_admin@wales.nhs.uk)

## **19. Supporting documents**

1. NHS Wales Never Events list
2. Nationally Reportable Incident (NRI) reporting processes & flow chart
3. Guidance on nationally reporting specific incident types
4. Joint investigation process
5. Guidance on Safety-II principles
6. Commissioned Services flowchart

Please refer to separate documents on the intranet site (Policies) or contact the Patient Safety Team [amb\\_PTR\\_admin@wales.nhs.uk](mailto:amb_PTR_admin@wales.nhs.uk)



## NHS Wales Executive National Policy on Patient Safety Incident Reporting and Management

### Supporting Section 1 – NHS Wales Never Events list (as at 1 July 2022)

This document confirms the revised list of reportable patient safety incidents to be classed as Never Events in NHS Wales from 1 July 2022. This updates the previous list published in 2018 and applies to all NHS Wales' Health Boards and Trusts.

This list has been adapted with thanks, from the NHS England Never Events list.

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## NEVER EVENTS LIST

Never Events are defined as “Serious Incidents that are wholly preventable because guidance or safety recommendations are available at a national level and should have been implemented by all healthcare providers”<sup>1</sup>.

Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death does not need to have happened as a result of a specific incident for that incident to be categorised as a Never Event.

Never Events require full investigation under the National Policy on Patient Safety Incident Reporting. This includes the need to fully and meaningfully engage patients, families and carers at the beginning of and throughout any investigation.

Learning from what goes wrong in healthcare is crucial to preventing future harm.

## Surgical

### 1. Wrong site surgery

An invasive procedure<sup>2</sup> performed on the wrong patient or at the wrong site (e.g. wrong knee, eye, limb). The incident is detected at any time after the start of the procedure.

**Includes:** Interventions that are considered to be surgical but may be done outside a surgical environment – for example, wrong site block (including blocks for pain relief), biopsy, interventional radiology procedure, cardiology procedure, drain insertion and line insertion (e.g. peripherally inserted central catheter (PICC)/ Hickman lines).

**Excludes:**

- Removal of wrong teeth.
- Local anaesthetic blocks for dental procedures.
- Interventions where the wrong site is selected because the patient has unknown/unexpected anatomical abnormalities; these should be documented in the patient’s notes.
- Wrong level spinal surgery\*.
- Wrong site surgery due to incorrect laboratory reports/results or incorrect referral letters.
- Contraceptive hormone implant in the wrong arm.

\* Excluded from the current list while work is underway with NHS Improvement and the relevant professional organisations to ensure development of robust national barriers to prevent this incident.

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<sup>1</sup> [NHS England Never Events list](#)

<sup>2</sup> The start of an invasive procedure is when a patient’s anatomy begins to be permanently altered. For example, this is when the first incision is made that will scar the patient and take time to heal and recover from.

**Setting:** All settings providing NHS-funded care.

**National safety requirement:**

- Safer Practice Notice – Wristbands for hospital inpatients improves safety (2005). The key points are summarised in [Recommendations from National Patient Safety Agency alerts that remain relevant to the Never Events list](#).
- Safer Practice Notice – Standardising wristbands improves patient safety (2007). The key points are summarised in [Recommendations from National Patient Safety Agency alerts that remain relevant to the Never Events list](#).
- Patient Safety Alert – WHO surgical safety checklist (2009). The key points in the alert are summarised in [Recommendations from National Patient Safety Agency alerts that remain relevant to the Never Events list](#).
- Safe Anaesthesia Liaison Group – [Stop before you block](#) (2011).
- The Royal College of Radiologists – [Standards for providing a 24 hour interventional radiology service](#) (2008).
- Faculty of Pain Medicine – [Safety checklist for interventional pain procedures under local anaesthesia or sedation](#) (2017).
- Royal College of Surgeons (Faculty of General Dental Practice) – [Toolkit for the prevention of wrong tooth extraction](#) (2017).
- Wales Deanery (Dental Section) – [Mouthcare pre-extraction checklist](#) (2017).
- [National safety standards for invasive procedures](#) (NatSSIPs) (2016).
- Patient Safety Notice – [Supporting the introduction of the National Safety Standards for Invasive Procedures](#) (2016).

## 2. Wrong implant/prosthesis

Placement of an implant/prosthesis different from that specified in the procedural plan, either before or during the procedure. The incident is detected any time after the implant/prosthesis is placed in the patient.

**Excludes:**

- Placed implant/prosthesis is intentionally different from that specified in the surgical plan, based on clinical judgement at the time of the procedure.
- Specified implant/prosthesis is placed as planned but later found to be suboptimal.
- Implant/prosthesis is different from the one specified due to incorrect pre-procedural measurements or incorrect interpretation of the pre-procedural data (e.g. wrong intraocular lens placed due to wrong biometry or using wrong dataset from correct biometry.)

**Includes:**

- Implantation of an intrauterine contraceptive device different from the one in the procedural plan.

See **Appendix A** for examples of correct application of this Never Event definition.

**Setting:** All settings providing NHS-funded care.

**National safety requirement:**

- Safer Practice Notice – Wristbands for hospital inpatients improves safety (2005). Key points are summarised in [Recommendations from National Patient Safety Agency alerts that remain relevant to the Never Events list](#).
- Safer Practice Notice – Standardising wristbands improves patient safety (2007). Key points are summarised in [Recommendations from National Patient Safety Agency alerts that remain relevant to the Never Events list](#).
- Patient Safety Alert – WHO surgical safety checklist (2009). Key points are summarised in [Recommendations from National Patient Safety Agency alerts that remain relevant to the Never Events list](#).
- [National safety standards for invasive procedures](#) (NatSSIPs) (2016).
- Patient Safety Notice – [Supporting the introduction of the National Safety Standards for Invasive Procedures](#) (2016).

### 3. Retained foreign object post procedure

Retention of a foreign object in a patient after a surgical/invasive procedure.

‘Surgical/invasive procedure’ includes interventional radiology, cardiology, interventions related to vaginal birth and interventions performed outside the surgical environment – for example, central line placement in ward areas.

‘Foreign object’ includes any items subject to a formal counting/checking process at the start of the procedure and before its completion (such as for swabs, needles, instruments and guidewires) except where items:

- Not subject to the formal counting/checking process are inserted any time before the procedure, with the intention of removing them during the procedure but they are not removed.
- Subject to the counting/checking process are inserted during the procedure and then intentionally retained after its completion, with removal planned for a later time or date as clearly recorded in the patient’s notes.
- Are known to be missing before completion of the procedure and may be inside the patient (e.g. screw fragments, drill bits) but action to locate and/or retrieve them is impossible or more damaging than retention.

See **Appendix B** for examples of correct application of this Never Event definition.

**Setting:** All settings providing NHS-funded care.

**National safety requirement:**

- Patient Safety Alert – WHO surgical safety checklist (2009). Key points are summarised in [Recommendations from National Patient Safety Agency alerts that remain relevant to the Never Events list](#).

- Safer Practice Notice – Reducing the risk of retained throat packs after surgery (2009). Key points are summarised in [Recommendations from National Patient Safety Agency alerts that remain relevant to the Never Events list](#).
- Patient Safety Alert – Reducing the risk of retained swabs after vaginal birth and perineal suturing (2010). Key points are summarised in [Recommendations from National Patient Safety Agency alerts that remain relevant to the Never Events list](#).
- [National safety standards for invasive procedures](#) (NatSSIPs) (2016).
- Patient Safety Notice – [Supporting the introduction of the National Safety Standards for Invasive Procedures](#) (2016).

## Medication

### 4. Mis-selection of a strong potassium solution

Mis-selection refers to:

- When a patient is intravenously given a strong<sup>3</sup> potassium solution rather than the intended medication.

**Setting:** All settings providing NHS-funded care.

**National safety requirement:**

- Patient Safety Alert – Potassium chloride concentrate solutions (2002; updated 2003). Key points are summarised in [Recommendations from National Patient Safety Agency alerts that remain relevant to the Never Events list](#).

### 5. Administration of medication by the wrong route

The patient is given one of the following:

- Intravenous chemotherapy by the intrathecal route.
- Oral/enteral medication or feed/flush by any parenteral route.
- Intravenous administration of an epidural medication that was not intended to be administered by the intravenous route\*.

\*During the transition period for the introduction of NRFit™ devices, the 'intravenous administration of a medicine intended to be administered by the epidural route' cannot be considered a Never Event. An update will be provided when this period ends

**Setting:** All settings providing NHS-funded care.

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<sup>3</sup> ≥10% potassium w/v (e.g. ≥0.1 g/mL potassium chloride, 1.3 mmol/mL potassium chloride).

**National safety requirement:**

- Patient Safety Alert – Promoting safer measurement and administration of liquid medicines via oral and other enteral routes (2007). Key points are summarised in [Recommendations from National Patient Safety Agency alerts that remain relevant to the Never Events list](#).
- Patient Safety Alert – Safer practice with epidural injections and infusions (2007). Key points are summarised in [Recommendations from National Patient Safety Agency alerts that remain relevant to the Never Events list](#).
- Patient Safety Alert – [Update to National Patient Safety Agency \(NPSA\) alert for safer spinal \(intrathecal\), epidural and regional devices](#) (2016).
- Patient Safety Notice – [Managing risks during the transition period to new ISO connectors for medical devices used for enteral feeding and neuraxial procedures](#) (2015).

**6. Overdose of insulin due to abbreviations or incorrect device**

Overdose refers to when:

- A patient is given a 10-fold or greater overdose of insulin because the words ‘unit’ or ‘international units’ are abbreviated; such an overdose was given in a care setting with an electronic prescribing system<sup>4</sup>.
- A healthcare professional fails to use a specific insulin administration device – that is, an insulin syringe or pen is not used to measure the insulin.
- A healthcare professional withdraws insulin from an insulin pen or pen refill and then administers this using a syringe and needle.

**Setting:** All settings providing NHS-funded care.

**National safety requirement:**

- Rapid Response Report – Safer administration of insulin (2010). Key points are summarised in Recommendations from [Recommendations from National Patient Safety Agency alerts that remain relevant to the Never Events list](#).
- Patient Safety Alert – [Ensuring the Safe Administration of Insulin](#) (2016).

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<sup>4</sup> Electronic prescribing, dispensing and administration systems are an evidence-based method to reduce patient harm from medicines. All NHS organisations should introduce them as soon as possible. When the definitions for the insulin and methotrexate overdose Never Events were revised in 2015, it was agreed that those for insulin given in overdose because of the use of abbreviations for ‘unit’ and for all methotrexate overdose incidents would only apply to care settings with electronic prescribing systems as indicated. The systemic protective barriers for these two types of Never Event were found not to be strong enough in care settings where electronic barriers do not exist. For example, even though most acute hospitals do use a pre-printed insulin prescription to try and prevent prescribers using the abbreviations ‘iu’ or ‘u’, this is not the case in all care settings. Also, pre-printed prescriptions on their own are not a reliably strong enough barrier to prevent a potential 10-fold dosing error as prescribers can still prescribe insulin on general prescriptions.

## 7. Overdose of methotrexate for non-cancer treatment

Overdose refers to when:

- A patient is given a dose of methotrexate, by any route, for non-cancer treatment that is more than the intended weekly dose; such an overdose was given in a care setting with an electronic prescribing system (see footnote 3 on previous page).<sup>3</sup>

**Setting:** All settings providing NHS-funded care.

### National safety requirement:

- Patient Safety Alert – Improving compliance with oral methotrexate guidelines (2006). Key points are summarised in [Recommendations from National Patient Safety Agency alerts that remain relevant to the Never Events list](#).

## 8. Mis-selection of high strength midazolam during conscious sedation

Mis-selection refers to when:

- A patient is given an overdose of midazolam due to the selection of a high strength preparation (5 mg/mL or 2 mg/mL) instead of the 1 mg/mL preparation, in a clinical area performing conscious sedation.
- Excludes clinical areas where the use of high strength midazolam is appropriate; these are generally only those performing general anaesthesia, intensive care, palliative care, or areas where its use has been formally risk assessed in the organisation.

**Setting:** All settings providing NHS-funded care.

### National safety requirement:

- Rapid Response Report – Reducing risk of overdose with midazolam injection in adults (2008). Key points are summarised in [Recommendations from National Patient Safety Agency alerts that remain relevant to the Never Events list](#).

## Mental health

### 9. Failure to install functional collapsible shower or curtain rails

Involves either:

- Failure of collapsible curtain or shower rails to collapse when an inpatient attempts or completes a suicide.
- Failure to install collapsible rails and an inpatient attempts or completes a suicide using non-collapsible rails.

**Setting:** All settings providing NHS-funded mental health inpatient care.

**National safety requirement:***Health building notes:*

- Welsh Health building note 03-01 – Adult acute mental health units (2016).
- Health building note 03-02 – Facilities for child and adolescent mental health services (CAMHS) (2017).

*Estates and facilities alerts:*

- NAFW Safety Action Bulletin (2002) 02 – Cubicle rail suspension system with load release support systems (2002).
- NHS Estates Alert (2004)03 – G-rail 2301, window curtain tracking system (2004).
- NHS Estates Hazard Notice (2004)06 – Cubicle rail tracking and PVC dustcovers (2004).
- NHS Estates Hazard Notice (2004) 08 – Bed cubicle rails, shower curtains rails, and curtain rails in psychiatric in-patient settings (2004).
- WAG DH Estates & Facilities Alert (2007)08 – Cubicle curtain track rail (2007).
- EFA/2010/003 – Anti-ligature curtain rails (including shower curtains): Risks from incorrect installation or modification (2010).
- EFA/2010/10 – Flush fitting anti-ligature curtain rails: ensuring correct installation (2010).

**General****10. Falls from poorly restricted windows**

A patient falling from a poorly restricted window<sup>5</sup>. This applies to:

- windows ‘within reach’ of patients; this means windows (including the window sills) that are within reach of someone standing at floor level and that can be exited/fallen from without needing to move furniture or use tools to climb out of the window.
- windows located in facilities/areas where healthcare is provided and that patients can and do access.
- where patients deliberately or accidentally fall from a window where a fitted restrictor is damaged or disabled, but not where a patient deliberately disables a restrictor or breaks the window immediately before they fall.
- where patients can deliberately overcome a window restrictor using their hands or commonly available flat-bladed instruments as well as the ‘key’ provided.

**Setting:** All settings providing NHS-funded care.

<sup>5</sup> This includes windows where the provider has not put a restrictor in place in accordance with guidance.

**National safety requirement:**

- Welsh Health Building Note 00-10 Part D – Windows and associated hardware (2014).
- Department of Health Estates and Facilities Alert – Window restrictors of cable and socket design (2014).
- Health and Safety Executive Risk of falling from windows (2016).

**11. Chest or neck entrapment in bed rails**

Entrapment of a patient's chest or neck between bedrails or in the bedframe or mattress, where the bedrail dimensions or the combined bedrail, bedframe and mattress dimensions do not comply with Medicines and Healthcare products Regulatory Agency (MHRA) guidance.

**Setting:** All settings providing NHS-funded care including care homes, and patients' own homes where equipment for their use has been provided by the NHS.

**National safety requirement:**

- Medicines and Healthcare products Regulatory Agency – [Safe use of bed rails](#) (2013).

**12. Transfusion or transplantation of ABO-incompatible blood components or organs**

Unintentional transfusion of ABO-incompatible blood components.

**Excludes:**

- where ABO-incompatible blood components are deliberately transfused with appropriate management.

Unintentional ABO-mismatched solid organ transplantation.

**Excludes:**

- situations in which clinically appropriate ABO-incompatible solid organs are deliberately transplanted.

In this context, 'incompatible' antibodies must be clinically significant. If the recipient has donor-specific anti-ABO antibodies and is therefore likely to have an immune reaction to a specific ABO-compatible organ, the inadvertent transplantation of that organ without appropriate management is a Never Event.

**Setting:** All settings providing NHS-funded care.

**National safety requirement:**

- Patient Safety Notice – [Safe transfusion practice: use a bedside checklist](#) (2018).
- British Society for Histocompatibility and Immunogenetics and British Transplantation Society – [Guidelines for the detection and characterisation of clinically relevant antibodies in allotransplantation](#) (2014).
- British Transplantation Society – [Guidelines for antibody incompatible transplantation](#) (2015).

- Safer Practice Notice – Wristbands for hospital inpatients improves safety (2005). Key points are summarised in [Recommendations from National Patient Safety Agency alerts that remain relevant to the Never Events list](#).
- Safer Practice Notice – Standardising wristbands improves patient safety (2007). Key points are summarised in [Recommendations from National Patient Safety Agency alerts that remain relevant to the Never Events list](#).

### 13. Misplaced naso or oro-gastric tubes

Misplacement of a naso or oro-gastric tube in the pleura or respiratory tract that is not detected before starting a feed, flush or medication administration.

**Setting:** All settings providing NHS-funded care.

**National safety requirement:**

- Patient Safety Alert – [Nasogastric tube misplacement: continuing risk of death and severe harm](#) (2017).
- NHS Improvement – [Initial placement checks for nasogastric and orogastric tubes: resource set](#) (2016).
- Patient Safety Notice – [Placement devices for nasogastric tube insertion DO NOT replace initial position checks](#) (2014).

### 14. Scalding of patients

Patient scalded by water used for washing/bathing.

**Excludes:**

- Scalds from water being used for purposes other than washing/bathing (e.g. from kettles).

**Setting:** All settings providing NHS-funded care.

**National safety requirement:**

- WHTM 04-01 – Safe water in healthcare premises (2006, updated 2016).
- WHealth Building Note 00-10 Part C – Sanitary assemblies (2014).
- Health and Safety Executive – Managing the risks from hot water and surfaces in health and social care (2012).
- Health and Safety Executive – Scalding and burning (2012).

### 15. Unintentional connection of a patient requiring oxygen to an air flowmeter

This applies when a patient who requires oxygen is connected to an air flowmeter when the intention was to connect them to an oxygen flowmeter.

**Excludes:**

- Unintentional connection to an air cylinder instead of an oxygen cylinder as robust barriers to prevent this have not yet been identified.

**Setting:** All settings providing NHS-funded care.

**National safety requirement:**

- Patient Safety Notice – [Reducing the risk of oxygen tubing being connected to air flowmeters](#) (2016).

### **16. Suspended - undetected oesophageal intubation**

Ventilation of a patient following oesophageal intubation instead of the intended tracheal intubation, which is not identified because capnography is not used or capnography readings indicating the need for tracheal intubation are not acted on.

See Appendix C for further guidance on the reasons for suspension of this type of Never Event.

## Appendix A: Wrong implant/prosthesis

Earlier definitions of the Never Event type ‘wrong implant/ prosthesis’ were not consistently applied with regard to wrong intraocular lenses (IOL). The examples below assist with consistent application of the current clarified definition. They are intended solely as examples of the principles of the definition, and are not a complete list of circumstances where the definition applies.

Circumstances	Does this fit the Never Event definition?
<p>A patient attended hospital for a right phacoemulsification and IOL procedure. The surgeon, a senior trainee, discussed the risks and benefits of right cataract surgery and the target refractive outcome with the patient, who consented to the procedure with the aim of achieving an emmetropic (no distance glasses) outcome. A +20.5 dioptre (D) IOL was chosen and the IOL selection sheet was completed accordingly. At the WHO sign in the surgeon confirmed with the team he wanted a +20.5D IOL.</p> <p>A +20.0D IOL was presented during the time out section of the WHO checklist, which was completed by the consultant (not the surgeon), scrub nurse and operating department practitioner. The team did not identify that the lens power did not match that selected on the biometry and IOL selection sheet, and previously stated at the sign in. The senior trainee continued with surgery supervised by the consultant and a +20.0D IOL was implanted in error.</p>	<p>This is a Never Event. The surgeon clearly stated the surgical plan for a +20.5D IOL to the team. A different IOL was inserted.</p>

Circumstances	Does this fit the Never Event definition?
<p>A patient was admitted for right phacoemulsification and IOL. A toric IOL was planned to correct astigmatism. The IOL power was circled correctly on the biometry sheet and this was also correctly transcribed onto an IOL selection sheet. The operation was cancelled as the list was running late and the patient was admitted a few days later for surgery by a different consultant. This surgeon confirmed at sign in and again at time out with the surgical team that a 19D model SN6AT (toric) lens was required as detailed in the notes, but did not confirm that a toric lens was required as planned. The lens presented to the surgeon was a 19D SA60AT (non-toric) and this was opened and inserted into the patient's eye.</p>	<p>This is a Never Event. The surgeon stated in the surgical plan the wish to implant a certain model of lens but implanted a different model, which could not correct the astigmatism.</p>
<p>A patient attended hospital for a left phacoemulsification and IOL procedure. The surgeon confirmed with the patient that the aim of the procedure was emmetropia and circled a +17.5D IOL on the biometry sheet. The sheet had unexpectedly been printed in a different format, moving the data for the most commonly used IOL from where it normally appeared. This meant the wrong type of IOL was circled, an anterior chamber not a posterior chamber lens. All WHO checks were appropriately completed by the surgeon and the team, and a lens power of +17.5D was confirmed verbally by the surgeon to the team as the surgical plan. A +17.5D posterior chamber lens was inserted. At the postoperative review the patient was noted to be 3.5D hypermetropic and not emmetropic.</p>	<p>This is not a never event. The IOL inserted was the one stated in the surgical plan by the consultant. However, this surgical plan was wrong because the surgeon had chosen the power for a posterior chamber lens using data pertaining to an anterior chamber lens.</p>

Circumstances	Does this fit the Never Event definition?
<p>A patient was admitted for left phacoemulsification and IOL. The surgeon discussed the refractive aim with the patient; emmetropia was agreed and a +22D lens was circled on the biometry sheet. The IOL power was then unclearly transcribed onto an IOL selection sheet and later misread as 27D, not 22D.</p> <p>The surgeon confirmed the IOL as 27D to the team and all checks were completed. It was not noted that the original biometry sheet indicated a 22D IOL. A 27D lens was inserted. The patient was noted postoperatively to be myopic rather than emmetropic.</p>	<p>This is not a never event. The IOL inserted was that stated in the surgical plan by the consultant, but the surgical plan was based on information incorrectly transcribed from a poorly written document.</p>

## Appendix B: Retained foreign object post procedure

Earlier definitions of the Never Event type 'retained foreign object post operation' were not consistently applied. The examples below assist with consistent application of the current clarified definition. They are intended solely as examples of the principles of the definition, and are not a complete list of circumstances where the definition applies.

Note that the principles of the definition relate to items that should be subject to a formal counting or checking process at the start of the procedure and before its completion. The size of the retained foreign object and the potential for harm from the retained foreign object are irrelevant to the incident's designation as a Never Event.

Circumstances	Does this fit the Never Event definition?
<p>A patient underwent gynaecological surgery and a vaginal pack/vaginal tampon was intentionally left in place at the end of surgery, with removal planned for 48 hours after surgery. Unfortunately, the pack was not removed as planned and the patient was sent home with the pack still in place. She went to her GP complaining of vaginal discomfort and discharge. He examined her and found the pack.</p>	<p>This does not meet the definition of a Never Event as the vaginal pack was intentionally retained after the procedure. Once outside the controlled counting processes in theatre, the Never Event principle of being eminently preventable if existing guidance is followed does not apply. This incident is still likely to fit the definition of a Nationally Reportable Incident and should be reported to the NHS Executive, with all possible steps taken to prevent similar events in future.</p>
<p>A patient needed suturing after an episiotomy during a vaginal delivery. To create a clear view for the suturing procedure, three swabs were placed in the patient's vagina, to be removed as soon as suturing was complete. Only two swabs were removed. This error was realised when the swab fell out a few days after the patient and her baby went home.</p>	<p>This meets the definition of a Never Event. The swab was not intentionally retained. The number of swabs inserted and removed should have been counted at the time of the procedure.</p>

Circumstances	Does this fit the Never Event definition?
<p>A patient undergoing eye surgery as a day case had a pledget (a small swab) inserted under her eyelid an hour preoperatively to deliver topical medication. The pledget should have been removed during surgery but was not. The patient telephoned for advice about her painful eye the day after her procedure. When she returned to the unit to be examined the pledget was found and removed.</p>	<p>This does not meet the definition of a Never Event as the pledget was inserted outside the controlled counting processes in theatre. The Never Event principle of being eminently preventable if existing guidance is followed does not apply.</p> <p>This incident is still likely to fit the definition of a Nationally Reportable Incident and should be reported to the NHS Executive with all possible steps taken to prevent similar events in future.</p>
<p>A patient undergoing eye surgery as a day case had a pledget inserted under her eyelid at the beginning of the procedure. The pledget should have been removed at the end of the surgery but was not. The patient telephoned for advice the day after her procedure because her eye was painful. When she returned to the unit to be examined the pledget was found and removed.</p>	<p>This meets the definition of a Never Event. The pledget was not intentionally retained and the number of pledgets inserted and removed should have been counted at the time of the procedure.</p>
<p>A patient had an interventional cardiology procedure using a guidewire. When the doctor tried to withdraw the guidewire, it appeared to be stuck. It was left in place so that X-rays could be taken and expert advice sought before attempting to remove it.</p>	<p>This does not meet the definition of a Never Event as the guidewire was known to be retained before the procedure was completed, and immediate action to retrieve it was impossible or more damaging than retention. This incident is still likely to fit the definition of a Nationally Reportable Incident and should be reported to the NHS Executive, with all possible steps taken to prevent similar events occurring in future. If an equipment fault is likely to be responsible, the incident should also be reported to the MHRA.</p>
<p>A patient had an interventional cardiology procedure using a guidewire. No problems with the procedure were noticed at the time, but an X-ray taken for another reason several days later revealed a broken-off guidewire tip lodged in a blood vessel.</p>	<p>This meets the definition of a Never Event as the guidewire should have been checked for completeness when it was withdrawn at the end of the procedure.</p>

## Appendix C: Rationale for amendments to the Never Events list

The revised list includes changes to three previous Never Events. These are:

1. **Wrong Site Surgery tooth extraction** is removed from the list ([per Welsh Government letter dated 21 July 2021](#))
2. **Undetected oesophageal intubation** is suspended pending further guidance
3. **Administration of medication by the wrong route** - the 'intravenous administration of a medicine intended to be administered by the epidural route' cannot be considered a Never Event during the transition period for NRFit™ devices.

Never Event	Amendment	Rationale
<b>Wrong Site Surgery</b>	Exclude the removal of wrong teeth	The systemic barriers to prevent the removal of wrong teeth are considered not to be strong enough to prevent these from occurring e.g. lack of standardisation in types of tooth notation and difficulties with site marking. (July 2021)
<b>Undetected oesophageal intubation</b>	Suspended	Pending further guidance for neonates/paediatrics
<b>Administration of medication by the wrong route</b>	Intravenous administration of an epidural medication that was intended to be administered by the intravenous route*.	*During the transition period for the introduction of NRFit™ devices, the 'intravenous administration of a medicine intended to be administered by the epidural route' cannot be considered a Never Event. An update will be provided when this period ends



## NHS Wales Executive National Policy on Patient Safety Incident Reporting and Management

### Supporting section 2 – NRI reporting processes

#### Guidance for submission of any NRI forms to the NHS Wales Executive

- All submissions must take place on the approved forms for the designated purpose. Updated forms will be accessible from within each NHS organisation's local Datix Cymru system for use from 1 May 2023.
- All submissions should be made via the NHS organisation's corporate team with responsibility for overseeing incident management processes.
- All forms should be subject to a quality assurance process within the reporting NHS organisation and must receive Executive sign-off prior to submission.
- Forms with mandatory fields incomplete will be returned to the submitting organisation, who will be required to update the forms and re-submit prior to acceptance for processing. It is the responsibility of the reporting organisation to ensure that returned forms are updated and re-submitted as promptly as possible.
- All forms will continue to be submitted via email to [NationalSIreports@wales.nhs.uk](mailto:NationalSIreports@wales.nhs.uk) until such time the Once for Wales Concerns Management System processes allow for electronic submission.

#### Notification of new Nationally Reportable Incidents

All organisations will submit Nationally Reportable Incidents to the NHS Wales Executive at the earliest opportunity, but no later than seven working days following occurrence or point of knowledge of the incident.

The NHS organisation must complete all mandatory fields on the notification form, including setting out how long they anticipate the investigation will take.

Following receipt and processing of a completed notification form, the NHS Wales Executive will confirm the NHS Wales Executive NRI reference number associated with that incident.



## **Timescales for completion of an investigation into an NRI**

NHS organisations are responsible for selecting the anticipated timescale for investigating an NRI, from 30, 60, 90 or 120 working days. This timeframe incorporates the whole process from the date of NRI notification to the NHS Wales Executive through to the submission of the investigation outcomes form to the NHS Wales Executive.

At the time of processing the NRI, the NHS Wales Executive will provide confirmation of the date the investigation outcomes form is due, based on the timescale selected by the NHS organisation.

NHS organisations must ensure they are choosing appropriate and realistic timescales for the investigation to be carried out, putting the patient or service user or the person(s) acting on their behalf at the heart of this decision to ensure that they receive relevant information in a timely manner.

Where an NHS organisation is unable to meet the timescale originally anticipated for completion, the reasons why this has been unable to be achieved should be examined by the organisation and also reported to the NHS Wales Executive at the time of submitting the NRI outcomes form. The NHS Wales Executive does not extend timescales chosen by NHS organisations but will work with NHS organisations to understand why delays occur and offer support where appropriate.

## **Retrospective reporting of certain types of patient safety incidents as Nationally Reportable Incidents**

There are a small number of designated incident types that are acceptable to be retrospectively reported following the completion of the investigation. These are:

- avoidable pressure damage
- avoidable falls resulting in any fracture or significant injury
- medically unexpected deaths in the community of patients who have been in contact with Mental Health and/or Learning Disability Services in the last year

Retrospective reporting means that these incidents require reporting as a Nationally Reported Incident where the local investigation has identified a causal or contributory factor in line with the definitions set out in this Policy.



The following forms and timescales apply to the retrospective reporting of these incidents:

Incident type	Timescales for submission	NRI form(s) to use
Avoidable pressure damage	Submission within 60 days from the date of identification of the incident	Combined notification & investigation outcomes form
Avoidable falls resulting in any fracture or significant injury	Submission within 60 days from the date of identification of the incident	
Medically unexpected deaths in the community of patients who have been in contact with Mental Health and/or Learning Disability services in the last year	Submission within 120 days from the date of identification of the incident	

These incident types are the only NRIs permitted to be submitted on the combined notification & investigation outcomes form.

### **Notifications of new Nationally Reportable Incidents involving multiple organisations**

Where an incident is to be jointly investigated between multiple organisations, only one national notification in relation to the incident needs to be made. The organisations involved in the joint investigation should agree the lead organisation for reporting purposes as part of their initial discussions.

### **Sharing investigation outcomes**

Once the investigation for an NRI has been completed by the NHS organisation, the outcomes and learning from the investigation must be shared with the NHS Wales Executive on or before the specified date, using the approved investigation outcomes form (available within the local Datix Cymru system for use from 1 May 2023).

The NHS Wales Executive does not “close” incidents (as this is the responsibility of the NHS organisation) so will provide confirmation of safe receipt of the incident outcomes form only.



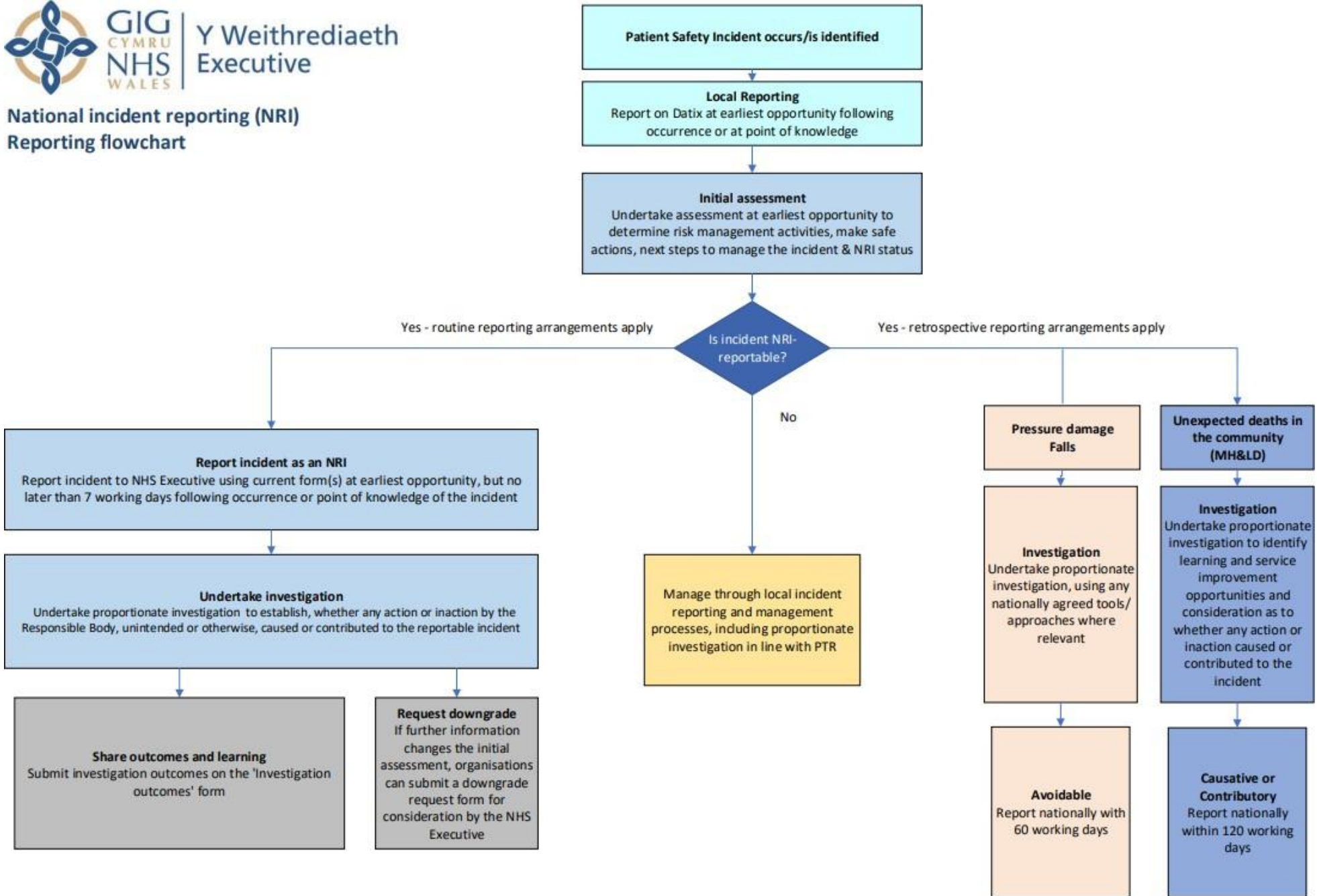
### **Downgrading a previously reported NRI**

On occasion, a patient safety incident may initially appear to meet NRI threshold and following investigation, the NHS organisation may determine that it did not meet the threshold for reporting. For example, an unexpected death of a patient which was subsequently found by HM Coroner to have been unrelated to provision of healthcare.

On these occasions, the NHS organisation may submit a downgrade request form to the NHS Wales Executive who will support organisations in consistent application of the downgrade criteria. The downgrade form is available within the local Datix Cymru system for use from 1 May 2023.



**National incident reporting (NRI)  
Reporting flowchart**





## Supporting Section 3 – guidance on nationally reporting specific incident types

This section aims to provide clarity around some particular types of incidents which may require national reporting. It is not intended to be an exhaustive or even illustrative list of patient safety incidents which require national reporting.

As set out in the Policy, organisations are responsible for ensuring that they are considering **all** patient safety incidents widely, and making informed decisions on whether or not they think they should be nationally reported, in line with the principles set down in the Policy.

### Contents:

1. Guidance on 'must reports'
  - 1.1. Never Events
  - 1.2. Suspected mental health homicides
  - 1.3. Suspected suicide or self-inflicted death
    - in any clinical setting; or
    - during authorised/agreed leave; following recent planned discharge; following unplanned leave/discharge
  - 1.4. Maternal, perinatal and infant deaths
2. Incidents reportable to other external organisations
3. Safeguarding incidents, including Procedural Response to Unexpected Death in Childhood (PRUDiC)
4. Healthcare Acquired Infections (HCAIs)
5. Retrospective reporting of certain types of patient safety incidents
  - 5.1. Avoidable pressure damage
  - 5.2. Avoidable falls resulting in harm
  - 5.3. Medically unexpected deaths in the community of patients known to MH&LD services
6. Incidents where the number of patients affected is significant
7. Unusual, unexpected or surprising incidents where the seriousness of the incident
8. requires it to be nationally reported and the learning would be beneficial

## 1. Guidance on 'must reports'

### 1.1. Never Events

Never Events are defined as “serious incidents that are wholly preventable because guidance or safety recommendations are available at a national level and should have been implemented by all healthcare providers”.

The NHS Wales Never Event list is maintained by the NHS Wales Executive and is issued as part of this Policy (Supporting Section 1).

All Never Events are reportable regardless of harm caused.

When reporting a Never Event, the list in effect at the time the incident was identified should be used.

### 1.2. Suspected mental health homicides

In line with the proposed definition in the draft statutory guidance for the Single Unified Safeguarding Review process (consultation version launched 6 March 2023), a mental health homicide is when a homicide is committed, and the alleged perpetrator has been in contact with primary, secondary or tertiary Mental Health Services within the last year. In this criteria, 'contact' may include an assessment or intervention.

This definition will be reviewed on completion of the SUSR statutory guidance consultation to ensure alignment as far as possible.

### 1.3. Suspected suicide or self-inflicted death

- **in any clinical setting; or**
- **during authorised/agreed leave, following recent planned discharge, or following unplanned leave/discharge**

#### *In any clinical setting*

All completed suspected suicides and any self-inflicted death, regardless of apparent intent in any NHS Wales Health Board or Trust premises, are reportable. This applies across all NHS Wales healthcare provider inpatient and outpatient environments.

The requirement extends to all service users, not just those being treated for mental health needs, either within a Mental Health setting or otherwise.

#### *During authorised/agreed leave, following recent planned discharge, or following unplanned leave/discharge*

The suspected suicide or self-inflicted death of any patient during an episode of authorised/agreed leave from hospital OR following recent planned discharge OR following

a recent unplanned/unauthorised discharge from in-patient care. The definition of 'recent' will depend on individual circumstances, including the clinical condition that the patient was being assessed or treated for.

This includes:

- patients who are legally detained (e.g. under the Mental Health Act) and die unexpectedly whilst on authorised leave
- patients who are not legally detained and die unexpectedly whilst on agreed leave
- patients who knowingly discharge themselves against medical advice
- patients who leave hospital care of their own volition without prior notification (e.g. without signing a Discharge Against Medical Advice form)
- patients who are discharged from hospital without the care team having full assurance of safe discharge arrangements (possibly at times of high operational pressures)

The requirement extends to all service users, not just those being treated for mental health needs, either within a Mental Health setting or otherwise.

#### **1.4. Maternal, perinatal and infant deaths**

The requirement to report maternal, perinatal and infant deaths as an NRI will be aligned with the current reporting definitions as set out by MMBRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) - <https://www.npeu.ox.ac.uk/mbrance-uk/data-collection>.

Where the MMBRACE-UK reporting definition is met, the underlying incident should also be reported as an NRI.

Some neonatal deaths meet the criteria for PRUDiC and will also need to be managed through this pathway (see also section 3 below).

## **2. Incidents reportable to other external organisations**

There is already a requirement for certain incidents to be reported to external organisations and where these requirements exist, they must be followed. These include (but are not limited to):-

- Human Tissue Authority (HTA) and the Human Fertilisation and Embryology Authority (HFEA)
- Ionising Radiation (Medical Exposure) Regulations (IRMER) – incidents of accidental or unintended radiation exposure reportable to HIW
- Health and Safety Executive (HSE) - incidents including Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR)

- Medicines and Healthcare products Regulatory Agency (MHRA), including Serious Adverse Blood Reactions and Events (SABRE)
- National audit programmes and Confidential Enquiries for example: Joint Registry, National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) etc.
- Professional regulators including General Medical Council, Nursing & Midwifery Council etc.

Except in the case of MMBRACE-UK, there is no requirement within the Policy for responsible bodies to routinely generate a National Incident Report by virtue of the incident being reportable to an external organisation.

However, each incident must be assessed on the basis of the principles set out in the policy to determine if it requires NRI reporting in addition to any other external reporting. Where the responsible body determines that the NRI threshold is met, then the incident must be reported an NRI in addition to the external organisation.

### **3. Safeguarding incidents, including Procedural Response to Unexpected Death in Childhood (PRUDiC)**

#### *Reporting*

Safeguarding incidents must be reported and managed in keeping with current national safeguarding procedures and requirements.

Where a safeguarding incident **also** meets the definitions and thresholds in this policy, then it will **also** need to be reported nationally as an NRI. The requirements of both processes will need to be met.

For clarity, there is no routine requirement to report PRUDiC cases as a NRI. Where there is an element associated with the unexpected death related to the provision of healthcare that meets the definitions described in this policy, this must be considered in line with this policy and where the principles of this policy are met, reported as an NRI.

#### *Investigation*

Wherever possible, the investigation into an incident which is both (a) a safeguarding incident and (b) a patient safety incident, should be as cohesive as possible i.e. ideally a single investigation covering all relevant aspects, although it is recognised that this may not always be possible.

At the outset of a safeguarding review/investigation (including e.g. an adult/child practice review), consideration should be given at the earliest opportunity to ensuring that the Terms of Reference for the investigation meets the requirements of an investigation under PTR.

## 4. Healthcare Acquired Infections (HCAIs)

### *Context*

The COVID-19 pandemic has seen a shift in national reporting of HCAIs across Wales, in particular given the establishment of the National Nosocomial COVID-19 Programme (NNCP) through which all cases of nosocomial COVID-19 were reported. As we transition from the NNCP into Business-as-Usual reporting processes, this policy will set out the new reporting requirements for any new cases of nosocomial COVID-19.

Additionally, throughout the pandemic period, national reporting of non-COVID-19 HCAIs has been inconsistent.

The detail below aims to provide clarity of expectation around national reporting requirements of all HCAIs.

### *Reporting requirement*

**Local reporting, management & investigation:** All HCAIs (including nosocomial COVID-19) and increased incidences of HCAIs (formerly known as outbreaks) are patient safety incidents. They should therefore be locally reported, managed and investigated in line with the Policy and the Duty of Candour once it has come into effect.

**National reporting:** National reporting in relation to HCAIs should take place in line with this policy, with individual cases and increased incidences assessed in line with the principles set down in the policy to determine whether the national reporting thresholds have been met.

- Individual cases – at a minimum, where a patient or service user has acquired an infection that has caused or contributed to severe harm or their death would be reportable in line with the “outcomes” principles described in the Policy.
- Increased incidences - at a minimum, where an increased incidence of HCAIs has been identified and has caused a significant service disruption (e.g. a ward closure, inability to deliver expected services etc.), this would be reportable in line with the “number of people involved” principle described in the Policy.

### *National Nosocomial COVID-19 Programme*

The requirements of the NHS Wales national framework – Management of patient safety incidents following nosocomial transmission of COVID-19 (accessible from [Health in Wales | COVID-19 Essential Services Guidance](#)) still apply for all cases of nosocomial COVID-19 contracted prior to 01 May 2022.

## **5. Retrospective reporting of certain types of patient safety incidents**

Some incident types are designated as acceptable for retrospective reporting, in order to allow the NHS organisation to undertake a fuller local investigation to determine the national reporting requirement.

In these cases, the expectation is that these will be locally reported as soon as possible, consistent with local reporting of all other incident types. An appropriate investigation must then be undertaken in a timely manner.

Where the local investigation identifies a causal or contributory factor in line with the definitions set out in this policy, it must be retrospectively reported in line with Supporting Section 2 of this policy.

The relevant incident types which can be retrospectively reported are detailed below:

### **5.1. Avoidable pressure damage**

The detail of what types of pressure damage should be reported nationally are set out in the version of the All Wales Pressure Ulcer Reporting and Investigation guidance document in effect at the time the incident was identified.

Incidents relating to pressure damage are retrospectively reported following the process set out in Supporting Section 2 of this policy.

### **5.2. Avoidable falls resulting in harm**

Feedback from across NHS Wales during 2021/22 is that there is significant difficulty in determining the severity of harm from falls at the outset of the incident, particularly where it will take some time to determine the permanence of harm from a fall in an elderly patient.

Accordingly, to provide national clarity, patient falls which result in any fracture or significant injury, where the investigation has identified causative or contributory factors, will be reportable as an NRI.

NHS organisations will need to consider other falls resulting in harm to determine whether they require reporting nationally in line with the principles set out in the policy.

### **5.3. Medically unexpected deaths in the community of patients known to MH&LD services**

It is not possible to provide guidance for all eventualities of unexpected deaths in the community of service users known to Mental Health & Learning Disabilities (MH&LD) services. Accordingly the following is provided as broad guidance for organisations.

The cohort of patients and service users relevant to this section are those individuals who have been in contact with primary, secondary or tertiary Mental Health or

Learning Disability Services within the last year. In this criteria, 'contact' may include an assessment or intervention.

MH&LD services include:

- substance misuse services e.g. community drug and alcohol teams
- neurodevelopmental services

It does NOT include deaths of service users where the cause of death is immediately known and not relevant to the healthcare being provided (e.g. the service user dies unexpectedly in a car accident, or as the result of a diagnosed terminal illness).

## **6. Incidents where the number of patients affected is significant**

The key wording in this reporting requirement is “the number of patients affected is significant”. The word ‘is’ has been purposely included to prevent unnecessary reporting where emerging issues, which could have resulted in harm, were avoided through corrective action or risk mitigation.

Where any incident has, or is likely to have caused an unexpected or avoidable death, and/or severe harm, this should be reported as a national incident within seven days from the point of knowledge that harm has been caused (regardless of timeframe). It should be reported by the organisation responsible for coordinating the care and treatment of the affected patient(s) or service user(s), regardless of whether the underlying incident was within that organisation’s control. Reporting organisations can identify at the time of reporting who the appropriate investigating organisation should be where the incident is considered beyond their control.

## **7. Unusual, unexpected or surprising incidents, where the seriousness of the incident requires it to be nationally reported and the learning would be beneficial**

The nature of patient safety incidents makes it impossible to define a list to which all reportable incidents would comply – this is one of the problems observed with traditional ‘category based’ or ‘trigger list’ reporting methods. All organisations will have incidents occur that do not strictly meet the criteria set out in the policy or this guidance, but should still be reported. This may be because the incident was a significant near miss or because the circumstances of the incident make it impossible to determine a level of harm with any certainty.

The purpose of including this category within the policy was to help make it clear that organisations should be reporting any incident they consider should be reported, even where the national reporting criteria are not met. This is in keeping with the spirit of the policy that a mature approach to assessing and reporting incidents should allow organisations to make decisions and, following assessment, report any such incidents they feel should be reported.

There is therefore an expectation that, as part of the systems and processes specified above, responsible bodies will consider all incidents, and where an incident of significant concern occurs, will report those incidents nationally even if they do not strictly meet the criteria set out in the Policy. Whilst it is a decision for each organisation about serious patient safety incidents reported in this way, advice can be sought from the NHS Wales Executive to support decision making.



## Supporting Section 4 – joint investigation process

Where multiple organisations are involved in a single patient safety incident, a joint investigation in line with section 17 of the [Regulations](#) may be required. While a joint investigation should meet the same standards and requirements of any patient safety incident investigation as described in the Policy, there may be logistical differences in terms of how a joint investigation is conducted in practice.

This section, developed collaboratively by an All-Wales NHS Task & Finish Group, provides guidance and a structure for joint investigations involving multiple organisations although it is recognised that the process may need to be tailored to meet the needs of the patient or service user, organisations and/or depending on the complexity of the incident.

### Joint incident management meetings

Joint incident management meetings are considered to be an essential element of the early process of starting to investigate a patient safety incident, to facilitate discussion and joint decision-making as soon as practicable after an incident has been identified.

Where possible, the format and membership of this meeting should be considered and understood ahead of time to enable meetings to be quickly established as required.

The below principles may help Health Boards and Trusts in establishing joint incident management meetings:

Relevant membership, which may include:

- Health Board/Trust representatives – while information from all relevant aspects of the patient's care should be captured (including emergency care, primary & community care, flow management etc.). Note: this may not necessarily require multiple Health Board/Trust representatives at the meeting, within the organisation there may need to be a process for information sharing and delegation to a single or small number of Health Board representatives in order to facilitate a timely meeting;
- Relevant social care/Local Authority engagement;
- Relevant independent/private providers;
- Other stakeholders engaged in commissioned services related to the incident.

Consideration should be given to:

- Whether meetings are established on a local or regional basis;
- The frequency of meetings, noting the expected timescales set out in the process below;
- Whether meetings are set up as routine (e.g. each fortnight) and/or in response to individual incidents.

## Standard data set

As the purpose of the meeting is to have a rapid, informed discussion to support joint decision making, it is important that appropriate information is available to all members ahead of the meeting.

This could include:

- a list of incidents requiring joint discussion, and
- for each incident under discussion, a standard set of data including, where relevant and applicable:
  - Patient notes from the relevant episode(s) of care
  - Any relevant recent patient history including related to episodes of care, relevant discharges, outpatient appointments, primary and community care etc.
  - Operational position of relevant organisations
  - Any records of communication between relevant organisations
  - Mortality Review and Medical Examiner records
  - Information on any other concerns linked to the same patient

## Investigation methodology

Consideration should be given to the use of the appropriate investigation methodology/ tools depending on the circumstances of the incident.

Although relevant for all incident investigations, the concept of systems thinking and taking systems-based approaches will be of particular importance to joint investigations, in order to study and understand the interfaces and interactions between different component parts of the healthcare system and community.

Regardless of the methodology used, the use of the Yorkshire Contributory Factors Framework is required as part of the investigation analysis, to facilitate local, regional and national collation and analysis of data.

## Overview of joint investigation process:

1. The organisation who identifies that an incident has occurred is responsible for reporting the incident on their local Datix Cymru system in line with local requirements. This should be within one working day of identification of the incident.
2. In line with the organisation's local processes, the incident will be reviewed in a timely manner to assess the circumstances and determine next steps. It is expected that this review will take place within two working days of the report being made. A routine part of this review will be to consider if a joint incident management meeting is indicated.

Where a joint incident management meeting is indicated, the identifying organisation will initiate the joint review process with organisations relevant to the incident. This includes:

- identifying potential stakeholder organisations required for the joint incident management meeting;
  - making stakeholder organisations aware of the circumstances of the incident, and of the indication for joint review and requesting relevant data to be collated ahead of the joint incident management meeting; and
  - ensuring that the incident is discussed at a joint incident management meeting in a timely manner. This is expected to take place as soon as possible and usually within two weeks of identification of the incident, recognising that there may be occasions where this timescale is exceeded due to complexity.
3. To support discussions in relation to the incident, the data described in the standard dataset should be made available, where possible, to all parties involved in the joint incident management meeting. However, not having all the data should not prevent the discussion taking place.
4. The incident should be discussed at the joint incident management meeting to make a joint decision on whether it requires a joint investigation.
- If the decision is that the incident does not require a joint investigation, then the rationale for this decision should be documented as part of the minutes for the joint incident management meeting. Consideration must be given to whether an individual organisation should carry out an investigation under PTR.
  - If the decision is that the incident does require a joint investigation, then the following points should be discussed and agreed (the below may be used as the template for an agenda, if helpful):
    - Clarity on what the incident is, as well as the outcome
    - Consideration of the level of harm arising from the incident (using the current knowledge available) as this will inform and influence actions under PTR
    - Scope and Terms of Reference for the joint investigation
    - Investigation methodology to be used and expected timescales for completion (30, 60, 90 or 120 days)
    - Roles and responsibilities of all organisations involved in joint investigation
    - Agreement of who will be the lead organisation, with responsibility for acting as the Single Point of Contact for the patient, service user or person acting on their behalf
    - Decision on any national reporting requirement (NRI)
    - Decision on any other external reporting that may be required
    - Plan to support staff who have been involved in the incident

- Governance and sign off arrangements for the final investigation report
  - (if needed) plan for coordination with other concerns processes e.g. complaints, inquest
  - Safeguarding considerations
  - Media and communications considerations
5. Consideration of the lead organisation should be taken on a case by case basis. When deciding the lead organisation, consideration should be given to factors such as:
- the patient must be put at the centre of the investigation so the primary consideration needs to be, which organisation will be best placed *for the benefit of the patient or service user and any person acting on their behalf* to undertake the lead role which will include acting as the single point of contact for the patient/family;
  - what the actual incident is and where it occurred, which may be different to where harm and/or the incident was identified.
6. All NHS Wales organisations involved in the joint investigation will raise an incident on their local Datix Cymru system, clearly coding this as a joint investigation with the relevant reference details for the other organisations for cross-matching purposes.
- Non-NHS Wales organisations should give consideration to their own local recording requirements.
7. Should the incident meet the threshold for national safety incident reporting, the lead NHS Wales organisation will undertake any national reporting requirement, taking into account the guidance provided in Section 15 of the Policy on incidents occurring in commissioned services.
8. The lead organisation will engage the patient, service user or person acting on their behalf in line with the requirements of PTR and the Duty of Candour. For incidents where moderate harm or above has resulted, this will include proactively making contact with the patient, service user or person acting on their behalf at the earliest appropriate opportunity, and engaging them in the investigation process, including understanding events from their perspective and ensuring any of their questions are taken into consideration as part of the investigation. Involvement of the patient, service user or person acting on their behalf should be undertaken throughout the investigation process.
9. Following the joint decision to undertake a joint investigation, a proportionate investigation will be jointly undertaken by the relevant stakeholders utilising the chosen methodology and within the stipulated timescale. Regardless of the methodology chosen, the joint investigation must include analysis in line with the Yorkshire Contributory Factors Framework (YCF).

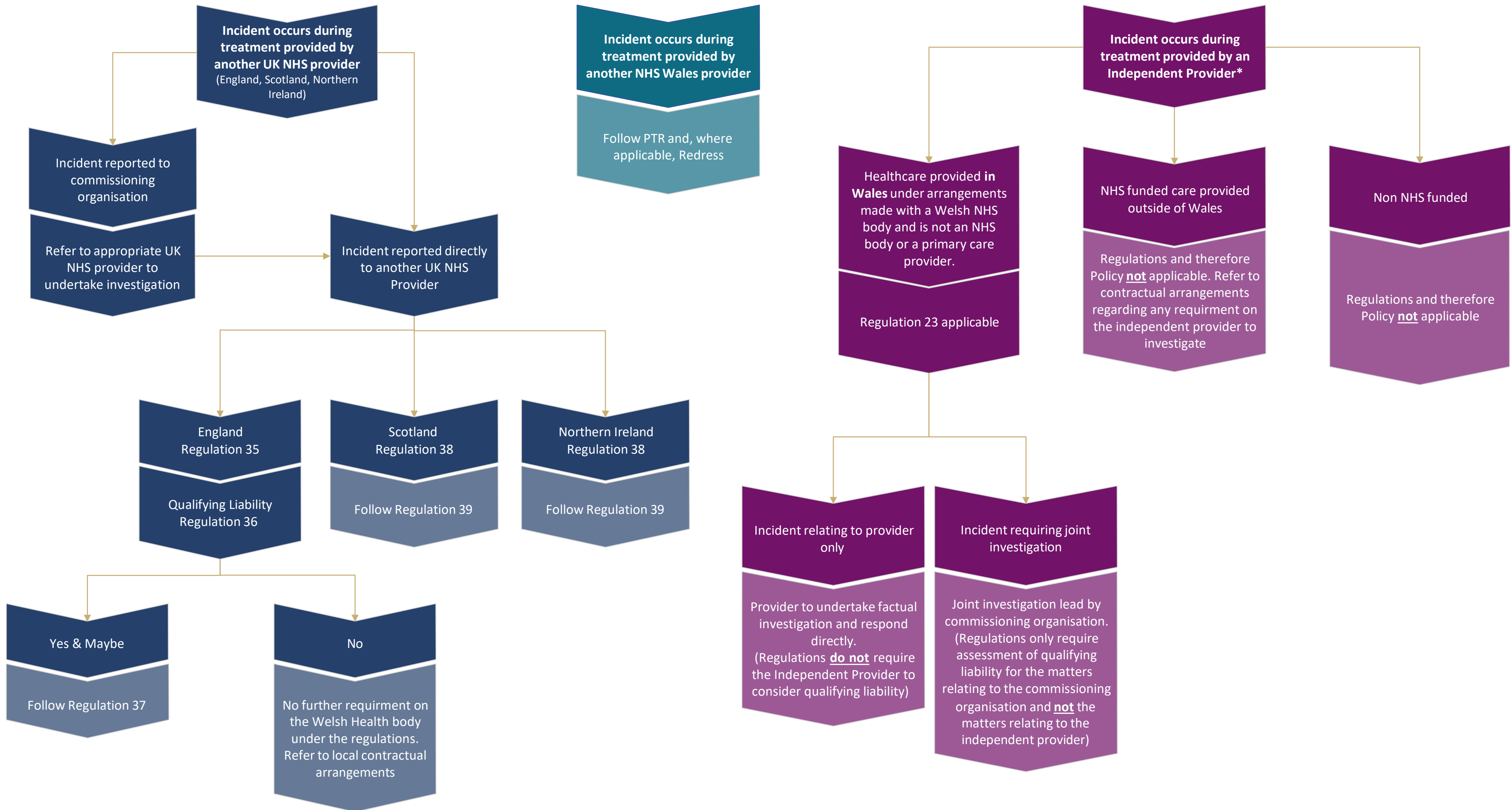
10. The end product of the joint investigation will be one investigation report which covers all parts of the patient's journey relevant to the incident, incorporating the YCFF analysis, along with identified areas for improvement.
  - It is essential that action is taken to address the identified areas for improvement, consideration should be given to whether this is best addressed through a stand-alone action plan or via a thematic action plan.
11. The joint investigation report will be submitted through the governance and quality assurance mechanisms for sign off as agreed at the strategy meeting.
12. Once the joint investigation report has been finalised, each NHS Wales stakeholder organisation will:
  - update their Datix Cymru record with the investigation outcomes and contributory factor analysis; and
  - share the outcomes and learning from the investigation within their organisation.
13. In addition to the above, the lead organisation will:
  - if the incident was nationally reported, complete any outcome requirements associated with the notification, including sharing the contributory factor analysis at a national level; and
  - complete any relevant PTR requirements in line with the organisation's governance processes, including engaging with the patient, service user or person acting on their behalf about the final investigation report.



# COMMISSIONED SERVICES FLOWCHART

APPLICATION OF THE POLICY WITHIN COMMISSIONED SERVICES

Ymddiriedolaeth GIG  
Gwasanaethau Ambiwylans Cymru  
Welsh Ambulance Services  
NHS Trust



## DEFINITIONS

\*Independent provider means a person or body who provides health care in Wales under arrangements made with a Welsh NHS body; and is not an NHS body or a primary care provider.



<b>AGENDA ITEM No</b>	<b>18</b>
<b>OPEN or CLOSED</b>	<b>Open</b>
<b>No of APPENDIX</b>	<b>1</b>

## Committee Priorities and Cycle Monitoring Report

<b>MEETING</b>	Quality, Patient Experience and Safety Committee
<b>DATE</b>	10 August 2023
<b>EXECUTIVE</b>	Trish Mills, Board Secretary
<b>AUTHOR</b>	Trish Mills, Board Secretary
<b>CONTACT</b>	<a href="mailto:Trish.mills@wales.nhs.uk">Trish.mills@wales.nhs.uk</a>

### EXECUTIVE SUMMARY

1. This report updates the Committee on progress against the priorities it set for 2023/24 and progress against the agreed Cycle of Business for the Committee.
2. Progress is steady across all priorities and there is nothing to escalate on the cycle of business progress.

### RECOMMENDATION

3. The Committee is asked to note the update.

### KEY ISSUES/IMPLICATIONS

No issues to raise.

### REPORT APPROVAL ROUTE

Not applicable

### REPORT APPENDICES

None

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

## COMMITTEE PRIORITIES & CYCLE OF BUSINESS MONITORING REPORT

### SITUATION

4. This report updates the Committee on progress against the priorities it set for 2023/24 and progress against the agreed Cycle of Business.

### BACKGROUND

5. During the course of the effectiveness reviews, it was agreed that it is good practice for Committees to set priorities for the forthcoming year. The Committee's priorities, which are set out below, were agreed by the Trust Board in May 2023 and will be tracked quarterly.
6. 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.
7. 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

8. The Committee priorities, and progress against them is as follows:

Priority	Progress
a) 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; and	<ul style="list-style-type: none"><li>• An update report is scheduled for receipt and discussion at the August meeting of the Committee. This will be cycled into each meeting of the Committee as required.</li></ul>
b) Implementation plan for the quality strategy.	<ul style="list-style-type: none"><li>• The Quality Strategy Implementation Strategy will be received in Q3 (the November 2023 Committee meeting).</li></ul>

9. The Committee is reminded that work is going to address potentially duplicative reporting in the monthly MIQPR and quarterly patient safety and quality assurance reports, and work is ongoing throughout 2023.
10. Additionally, a quarterly 'spotlight' on clinical indicators via the Clinical Quality Governance Group (CQGG) has been incorporated into the Cycle of Business (and commenced from this meeting) and will be brought quarterly.

## **RECOMMENDATION**

11. The Committee is asked to note the update.

PAPER	PRE C'EE FORUM	FREQUENCY	Q1	Q2	Q3	Q4	LEAD	PURPOSE	
<b>QUEST COMMITTEE - CYCLE OF BUSINESS 2023/24</b>									
<b>See full cycle of business for reference to the duties in the terms of reference as they relate to Committee reports below</b>									
<b>MAIN ELEMENTS</b>									
MIQPR review of metrics	EMT	Annually					EDSPP	Approval	
Committee QPSE review of metrics	TBC	Annually					EDQN	Approval	
MIQPR	EMT	Quarterly					EDSPP	Assurance	
Patient Safety 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	Implementation plan in month Q3
Clinical Strategy/Plan	CQGG	Initial and cyclical review					DP	Approval	
Dementia standards report	CQGG	Annually					EDQN	Assurance	
Committee elements of IMTP	STB	Annually					EDSPP	Endorsement	
IMTP exception reporting	STB	Ad Hoc					Relevant Director	Assurance	
Health and care standards	CQGG	TBC					EDQN	Assurance	Reporting developing 23/24
Quality Impact Assessments	CQGG	Ad Hoc					EDQN/DP	Assurance	
External and/or peer reports	Various	Ad Hoc					Relevant Director	Assurance	Potentially update on HIW report on dignity
Annual Mental Health Report	CQGG	Annually					EDQN	Assurance	
Annual IPC report	CQGG	Annually					EDQN	Assurance	
Annual safeguarding reports	CQGG	Annually					EDQN	Assurance	
Referrals from PCC	PCC	Ad Hoc					Relevant Director	Discuss/Assure	
Clinical audit plan	CQGG	Annually					DP	Approval	
Monitoring report on clinical audit	CQGG	Quarterly					DP	Assurance	
Spotlight On clinical indicators	CQGG	Quarterly					DP	Assurance	
Mortality Report	CQGG	Bi-annually					EDQN	Assurance	
Meds management report	CQGG	Annually					DP	Assurance	
PECI report	TBC	Bi-annually					EDQN	Assurance	
Patient story	N/A	Quarterly					EDQN	Assurance	
Patient story updates	N/A	Quarterly					EDQN	Assurance	
Information Governance Toolkit	IGSC	Annually					DD	Assurance	Reported in Q2
Information governance report	IGSG	Quarterly					DD	Assurance	Reporting developing 23/24
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	
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	
<b>SUB-GROUPS</b>									
Where applicable	N/A	Ad Hoc					N/A	N/A	
<b>GOVERNANCE</b>									
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	
Committee Cycle of Business monthly review	N/A	Quarterly					BS	Review	
Committee Review of Annual Priorities	N/A	Quarterly					BS	Review	
<b>PROMPTS</b>									
External Reports	N/A	Ad Hoc					Relevant Director	Varies	
<b>OTHER</b>									
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

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



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# Groundhog Day 2: An opportunity for cultural change in complaint handling?

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June 2023



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Public Services Ombudsman for Wales  
1 Ffordd yr Hen Gae  
Pencoed  
CF35 5LJ

Tel: 0300 790 0203

Email: [communications@ombudsman.wales](mailto:communications@ombudsman.wales)

**Mae'r ddogfen hon hefyd ar gael yn y Gymraeg.**

**This document is also available in Welsh.**



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## **Groundhog Day 2: An opportunity for cultural change in complaint handling?**

The Ombudsman is publishing this report as an extraordinary report in accordance with paragraph 15 of Schedule 1 of the Public Services Ombudsman (Wales) Act 2019.

# Foreword

This is the first Thematic Report I have issued since being appointed as the Public Services Ombudsman for Wales in April 2022.

During my first year as Ombudsman, I have been struck by the similar pattern of complaint handling failings which my office has identified in cases involving Health Boards across Wales.

In March 2017, my predecessor issued a Thematic Report '[Ending Groundhog Day: Lessons from Poor Complaint Handling.](#)'

The lessons highlighted in that report remain relevant today. All too often, public bodies respond to complaints defensively rather than seeing them as an opportunity for learning and improving the services they deliver. This report focusses on cases involving Health Boards in Wales, which represent a significant proportion of the complaints made to my office.

The new 'Duty of Candour' on health organisations in Wales, which was introduced on 1 April 2023, requires them to be open and transparent with service users when they experience harm whilst receiving health care. This duty provides a fresh opportunity for cultural change - to promote candour and openness with service users and ensure there is systemic learning when things have gone wrong.

Although most health care across Wales is delivered in an excellent and professional manner, inevitably, sometimes organisations make mistakes. When mistakes happen, we expect health bodies to respond openly and honestly to patients and their families.

This ethos underpins our work as [Complaints Standards Authority](#) for Wales. Our statutory Guidance to public bodies in Wales: '[Principles of Good Administration](#)' outlines that "putting things right" is a key principle of good administration, which includes investigating complaints thoroughly and acknowledging when things go wrong.



Our complaints standards training to Health Boards and the requirements of the Duty of Candour provide a fresh opportunity for changes to the ways in which health bodies engage with their patients and respond to complaints.

I hope that the guidance and lessons highlighted in this Report will be helpful and will remind Health Boards why honesty and openness is so important when responding to complaints.

**Michelle Morris**

Public Services  
Ombudsman for Wales

15 June 2023



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and Quality and NHS  
Complaints Process



## Our role



As the Public Services Ombudsman for Wales, we have legal powers to look at complaints about public services.

We can look at complaints about all health care providers and independent care providers in Wales, including Health Boards, Trusts, GPs and dentists.

We have a team of people who consider and investigate complaints.

We are independent of all government bodies and our service is impartial and free of charge.



# Background

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# Introduction

When we issued the first 'Groundhog Day' report, our aim was to highlight to public bodies in Wales that the complaints they receive provide an opportunity for learning and improvement. We also wanted to show that, all too often, we have seen that public bodies have been overly defensive and not objective enough when responding to complaints.

We also highlighted that, in too many cases, when organisations made mistakes, they made the situation worse by not looking into complaints correctly. We urged public bodies to embrace the cultural change which was needed to ensure that they learned from complaints and improved services. Although we see many examples of good practice in complaint handling, evidence from our casework suggests that more needs to be done. This is especially true in relation to health complaints which are handled by Health Boards.

The 'Duty of Candour' was introduced in addition to the 'Duty of Quality', which requires NHS organisations (and Welsh Ministers) to take new steps to improve the quality of health services.<sup>1</sup> The overarching aim of the Duty of Candour is to ensure that a person

receiving care from the NHS (or from a regulated provider of health care services) can have confidence that they will be dealt with in an open, transparent and honest way. If something goes wrong, they should be told about it, receive an apology, offered support and be assured that their issue will be investigated properly, under the Putting Things Right scheme.<sup>2</sup>

Under the Duties of Quality and Candour, Health Boards must report every year on how they comply with these duties. Quality and Patient Safety Committees within Health Boards also have a role in ensuring that the Health Boards discharge these duties, learn lessons and escalate concerns to the Board, if appropriate.

The learning from our cases should also inform NHS bodies' assessments of how effectively they are complying with the Duty of Candour. If, for example, we find that an NHS body has not complied with the Duty of Candour in relation to any individual complaint, this should form part of the Board's monitoring and assurance processes.

This is what we would like to see when we consider how public bodies have handled complaints.

1 Appendix 2 – explanation of Duties of Candour and Quality

2 Appendix 2 – explanation of the NHS Complaints Process: the Putting Things Right scheme



People who contact us want organisations to put things right for them; however, sometimes, even more importantly, they also want to make sure that the same issue will not affect someone else in the future.

When public bodies respond to complaints poorly and defensively, sometimes after a lengthy complaints process, they compound the feeling of injustice that prompted people to complain in the first place. It is also exhausting for complainants to have to escalate their concerns to us. The way in which organisations deal with complaints is very important and can make a huge difference to people's experiences and to their ongoing relationship with, and trust in, their care provider and public services.

# Our work as Complaints Standard Authority

Since our original 'Groundhog Day' report, we have used our proactive powers under the Public Services Ombudsman (Wales) Act 2019, to publish our [Statement of Principles](#) for complaints handling by public bodies. These include our expectation that effective complaints handling processes should be fair and objective, accountable and committed to continuous improvement.

We have also supported Health Boards by providing extensive training in complaint handling for their staff and begun capturing data from organisations about the complaints they deal with under the NHS complaints procedure: the 'Putting Things Right scheme' ('PTR'). By publishing this data, we have introduced more transparency and accountability for Health Boards handling complaints.

Since February 2021, we have provided over 120 training sessions for Health Boards on Complaint Handling, Investigation Skills and Communications Skills. We now expect health bodies to reflect upon and implement this good practice.

When we uphold complaints, we may make recommendations to the relevant organisation to put things right for the person who has suffered injustice - and to ensure that the body learns from what went wrong. The case examples included in this report demonstrate how things can go wrong and why a cultural change in approach to complaint handling is needed.



**Capturing data  
from organisations  
about the  
complaints they deal with.**



**Over 120 training  
sessions provided  
on Complaint  
Handling, Investigation  
Skills and Communication  
Skills.**



# Complaints about Health Boards

Complaints about health services continue to represent a large part of our work. During 2022/23, 37% of all complaints about public bodies made to us were health cases, of which 75% were about Health Boards. They accounted for 81% of the cases we investigated. This is because we often need to obtain clinical records and independent clinical advice to inform our decisions on these cases. Even on health cases that we do not fully investigate, we often agree to resolve things early.

We continue to see increases in complaints about poor complaint handling by Health Boards. For example, when complaints responses are delayed or inadequate, we can recommend that a full and reasoned response is provided to the complainant. Overall, our intervention rate<sup>3</sup> on complaints about Health Boards we receive ranges from between 22% and 41%, depending on the Health Board area.<sup>4</sup>

We uphold complaints when we decide the organisation made mistakes which had a negative impact on the person who received care. We apply our [Clinical Standard](#) and consider whether the care and treatment were appropriate. We also consider the facts of the case, relevant clinical guidance or other codes of practice or policies in place at the time, as well as explanations provided by the clinician or organisation delivering the care.

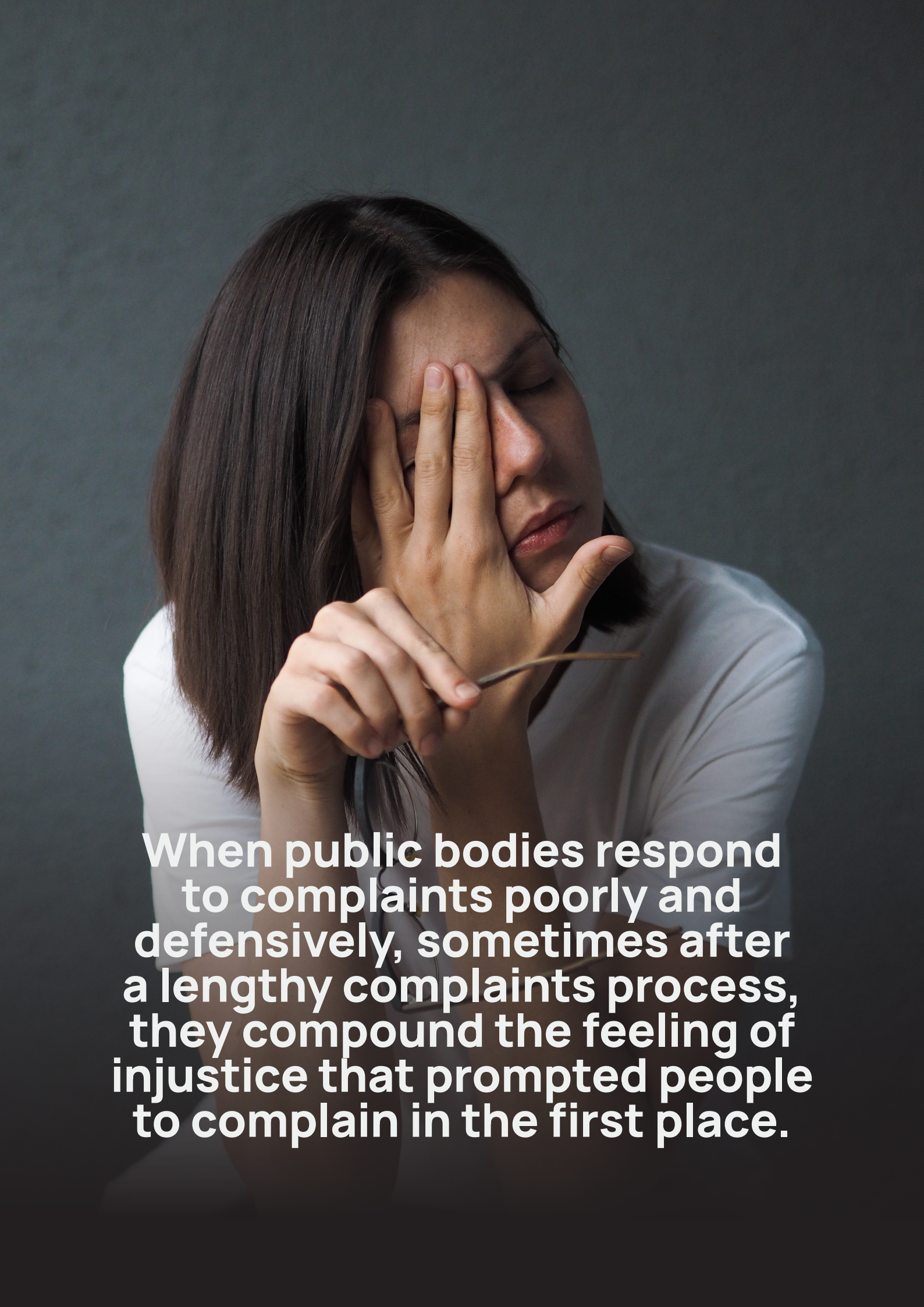
The case examples (set out in full in Appendix 1) included in this report are recent cases we have determined over the last 12 months. This is a small, but representative, sample of cases which highlight the apparent lack of rigour and openness in complaints investigations. It reflects the pattern of failings we see in local investigations which are undertaken in Health Boards under the PTR scheme.

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<sup>3</sup> Our 'intervention' rate reflects an outcome in complaints in public services when we decide that something has gone wrong, and things must be put right. This could be by making recommendations or agreeing early resolution or settlement of a complaint.

<sup>4</sup> Data on our intervention rates, early resolutions and upheld complaints per health board is in our Annual Report 2022/23.



A woman with long dark hair, wearing a white shirt, is shown from the chest up. She has her eyes closed and her right hand is pressed against her face, covering her eyes and nose. Her expression is one of distress or frustration. The background is a dark, solid color.

**When public bodies respond to complaints poorly and defensively, sometimes after a lengthy complaints process, they compound the feeling of injustice that prompted people to complain in the first place.**

# Themes & learning points

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## A lack of openness and candour - clear evidence of maladministration or service failure not identified during local investigations

Even when, following investigation, the facts of a case clearly show that the Health Board made a mistake, we see that organisations do not acknowledge this in their complaint responses. This should be an obvious step. That it often does not happen suggests that there is a need for cultural change for staff investigating complaints, so that they feel they can respond to and uphold complaints when the evidence supports this, in an honest and open way.

Mrs A's complaint concerned this kind of failing (**case example 2**). Even when the Betsi Cadwaladr University Health Board had acknowledged that it had not offered Mrs A's relative the bowel care she needed and had discharged her too soon, its initial response supported the discharge decision. Even when it issued a second response to the complaint, the Health Board did not acknowledge the failings fully. We considered that the initial review of the patient's care was not detailed, rigorous, open and transparent enough. This contributed to a lack of candour on the part of the Health Board.

In Mr D's complaint (**case example 3**), the Swansea Bay University Health Board acknowledged in its complaints response that there was no record of Mr D being given an appropriate discharge letter. Still, even after agreeing to our proposal for settlement, it took detailed discussions with the Health Board and its legal department for it to finally accept the modest settlement we proposed in recognition of this failure.



In Mr J's case (**case example 4**), we found that the Aneurin Bevan University Health Board had mishandled arrangements for the surgery Mr J needed. This resulted in an avoidable 5 week delay until the surgery took place (which breached the National Pathway guidelines for colorectal cancer). This had a very negative impact on Mr J. Rather than accept that it had made this mistake, the Health Board's complaint response lacked candour and openness. It was only in response to our investigation that the Health Board acknowledged that the surgery had not been booked. The Health Board should have been open with Mr J about this from the start, when it responded to his complaint.

## A lack of objective review of clinical care and treatment

When we consider health complaints, we rely on advice from our clinical advisers, apply our [Clinical Standard](#) and decide whether the care and treatment provided to any individual was appropriate.

We often find that, when Health Boards respond to complaints, they have not objectively assessed the care and treatment provided. Sometimes, the individual clinicians who have delivered the care are involved in complaints responses. However, even when there has been a review of the care and treatment by other clinicians within the body, failings which are immediately apparent to our own clinical advisers were not identified during the local peer review.

When we share the clinical advice we have received with Health Boards, we find that, in most cases, our recommendations are accepted. Although we welcome this, we are concerned that this pattern suggests that the care and treatment is not reviewed openly and objectively during local investigations.

For example, despite us finding that the Cwm Taf University Health Board made serious mistakes in the case of Mrs V's relative (**case example 5**), its own investigation of Ms V's complaint did not find any failings. This was despite the case being discussed "at length" at a Surgical Clinical Governance meeting. The view at the meeting was that the patient had received "...the standard treatment, as the other surgeons would have provided..."

We found that the Health Board missed opportunities during the complaint response process to identify failings at an earlier stage and avoid the need for the patient's family to escalate their complaint to us. However, when we shared our draft report and clinical advice with the Health Board, it accepted our recommendations.

Likewise, in **case example 6**, the Cardiff and Vale University Health Board's response to Miss X's original complaint only acknowledged that the Health Board did not communicate with Miss X's family as it should have. However, its own investigation did not identify that it missed several opportunities to treat Miss X's father and that his care was not good enough – all identified by our clinical adviser. This meant that the family had to

pursue their complaint through our office, causing them additional time and distress.

It is worth pointing out that we very rarely, if ever, see evidence of Health Boards considering if the person investigating the matter on their behalf requires independent medical advice to assist them during their investigation. This option is available to NHS bodies as specified in the PTR Scheme.



**Sometimes, the individual clinicians who have delivered the care are involved in complaints responses.**



**We are concerned that the care and treatment is not always reviewed openly and objectively during local investigations.**



## Importance of timeliness and good communications

Good communication is key to ensuring that complainants do not lose trust and confidence in the complaints process. Complainants should be kept well informed throughout the complaints process and Health Boards should ensure that staff throughout the organisation understand the importance of meeting the PTR or agreed timescales for responding to complaints – staff within their complaints teams need to be well informed by their colleagues, have the support of the Health Board as a whole and have the capacity and resources to respond in a timely way.

In Mr T's case (**case example 1**), it took our intervention and over 16 months for the Hywel Dda University Health Board to respond to Mr T's complaint about the care his late mother received. This delay was well beyond the 30 day time limit, or 6-month time scale (for complex cases), set out in the PTR Scheme. This was wholly unacceptable and distressing for Mr T at a time when he was also grieving for the loss of his mother. Mr T explained to us how the ongoing delay had affected him personally and his family.

Such delays are especially concerning when complaints raise concerns about the care provided to a family member before they died. Families are entitled to receive answers to their concerns and sufficient resource should be dedicated to complaint handling within Health Boards.

In Mr T's case, and in many others we see, even after we have intervened in cases, Health Boards do not respond to complaints in line with the timescales agreed with us and complainants are not kept well informed about the reasons for this.



**Complainants should be kept well informed throughout the complaints process.**



**Health Boards should ensure that staff throughout the organisation understand the importance of meeting the PTR or agreed timescales.**

# Acting fairly and proportionately – the need for robust investigations

Health Boards should give complainants a reasoned explanation, so that it is clear why they made a decision and on what facts they drew their conclusions. All of the case examples included in this report provide examples of Health Boards failing to ensure that they robustly investigated complaints and delivered fair outcomes for complainants, in line with the PTR scheme.

Health Boards should always carefully establish the facts of any case. Before coming to a decision, they should consider the evidence from the complainant and the accounts of staff members who delivered the care. This is especially important in cases when there has been a loss of life. Otherwise, complainants may completely lose trust in the investigation process and the outcome of their complaint.



# Future considerations

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As Health Boards across Wales embrace and implement their organisational Duty of Candour, we trust that the themes outlined in this report will provide a timely reminder of lessons which they should learn from our recent complaints.

The organisational Duty of Candour on Health Boards should also bring a cultural change to the way in which Health Boards respond to complaints and concerns. If we see that a Health Board made an error that had a negative impact on the complainant, we can recommend that it reviews how it has handled the complaint, in line with the Duty.

Also, when Health Boards' Quality and Patient Safety Committees review how effectively they have complied with the Duty, we expect them to consider details of any cases we have settled or upheld when we consider the Duty of Candour should have been engaged. Learning from our cases should also be included in Health Boards' annual reports on how effectively they have complied with the Duty of Candour and form part of Health Boards' wider monitoring and assurance processes.


### **Consideration of the Duty of Candour may be appropriate at all stages of our process:**

- **at assessment stage**, when we are agreeing an early resolution of a complaint
- **when we have started an investigation** and we are agreeing a voluntary settlement with the body and discontinuing our investigation
- **when we have fully investigated a complaint** and we are issuing a public interest or non-public interest report.



**We recommend that this report is shared with Quality & Patient Safety Committees in Health Boards and that they:**

- **review the resources available to complaints teams in their Health Board**
- **consider whether the option to provide staff investigating complaints with independent medical advice, is considered on a case by case basis**
- **reflect upon the lessons highlighted in this report when scrutinising their performance on complaint handling**
- **ensure that lessons learned from the PSOW's findings and recommendations are included in their Health Board's annual report on the Duty of Candour and Quality.**

A photograph showing a male doctor in a white coat and stethoscope on the left, looking towards a young child on the right. The child is smiling and looking up. A woman, presumably the mother, is standing behind the child, looking on with a gentle expression. The background is a blurred clinical setting with shelves and a plant.

**We trust that the Duty of Candour will have a positive and transformational impact on the way in which complaints are handled within Health Boards.**

# Appendix 1

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# Case example 1

## Mr T's complaint (202206990 & 20230420)

Hywel Dda University Health Board

In December 2021, Mr T complained to the Hywel Dda University Health Board about the treatment his late mother received when in hospital. In his complaint to us, Mr T explained how the loss of his mother had affected him and that it was unacceptable that the Health Board had not responded to his complaint. He had been waiting for a response for 13 months before he first contacted us in February 2023.

Because of that significant delay, we agreed an early settlement of the complaint with the Health Board. The Health Board agreed to pay Mr T £250 in recognition of the delay and to respond to his complaint within four weeks (by 20 March).

The Health Board then contacted us requesting more time because a senior member of staff had identified an issue which needed to be resolved before the Health Board could respond. We agreed that the Health Board could have 3 more weeks (by 7 April), if it apologised again to Mr T and explained the reason for the further delay.

On 5 April, the Health Board contacted us again to say that it still could not issue its complaint response to Mr T.

The Health Board agreed to make a further payment of £100 to Mr T in recognition of the ongoing unacceptable delay and to issue its complaint response to Mr T by 28 April, which it then complied with.



## Case example 2

### Mrs A's complaint (202101000)

Betsi Cadwaladr University Health Board

Mrs A complained about the care her late sister, Ms B, received at Ysbyty Glan Clwyd ("the Hospital", within Betsi Cadwaladr University Health Board) between May 2019 and May 2020.

Mrs A was concerned that her sister did not receive appropriate bowel care when she was in the Hospital in April and May 2020. Ms B needed a specific type of bowel care but did not receive it, as no skilled staff were available to provide it. Nurses did not update doctors that it had not been done.

Ms B then developed some new symptoms. These new symptoms may have meant that Ms B had a bowel blockage, but this was not considered. She was discharged from the Hospital on 5 May without being seen by a doctor and sadly died.

We could not be sure that the inadequate bowel care, or poor communication about this, contributed to Ms B's death, as she was very unwell with other problems. However, these failings meant that

there was a loss of dignity for Ms B. We also identified that the Health Board should have considered Ms B and Mrs A's rights under the Human Rights Act – Article 8, the right to respect for private and family life. In our investigation, we also saw that record keeping fell short of the requirements expected for both doctors and nurses.

Concerningly, we saw similar failings in basic nursing care, in record keeping and in communication in previous cases we have investigated about this Hospital.

We acknowledged that Ms B was in hospital during the early days of the COVID-19 pandemic. Still, Ms B's care should have been better.

We were concerned that the Health Board did not respond to Mrs A's complaint well and robustly enough. Its first response did not identify everything that the Health Board did wrong. Its second response also did not fully acknowledge all the failings. Overall, we decided



that the Health Board did not review Ms B's care in a detailed, rigorous, open and transparent way. The way it handled the complaint put Mrs A to unnecessary additional time and trouble in pursuing her concerns, at a time of bereavement. This contributed to a lack of candour on the part of the Health Board.

To remedy the injustice to Mrs A, and ensure that lessons were learned, we recommended that the Health Board reviewed its complaint handling and responses, in light of the Duty of Candour.

## Case example 3

### Mr D's complaint (202205762)

Swansea Bay University Health Board

Mr D complained that he was not informed of his positive COVID-19 test when he was a patient at X Hospital. He also said that he was not given the right discharge advice about self-isolation.

Shortly after Mr D was discharged, his wife, Mrs A, caught COVID-19 and sadly died. We could not be sure how Mrs A caught COVID-19; we focussed only on whether the ward procedures which were in place at the time of Mr A's discharge were followed.

The Health Board acknowledged in its complaints response that there was no record of Mr D being given information in an appropriate discharge letter.

We were concerned that Swansea Bay University Health Board could not provide us with evidence to show that it told Mr D about the positive COVID-19 test or gave him information and advice about the self-isolation period, as it should have done, according to its ward policy at the time.



We recommended that the Health Board should apologise to Mr D and pay him £750 in recognition of these failings. The Health Board agreed to this as an alternative to our investigation.

However, although the Health

Board accepted that its records were incomplete and agreed to our recommendations, it took further detailed discussions (also with its legal department) before the full settlement, including the modest financial payment, was finally accepted.

## Case example 4

### Mrs H's complaint (202203723)

Aneurin Bevan University Health Board

We investigated Mrs H's complaint, on behalf of her brother (Mr J), that the Health Board had unreasonably delayed Mr J's treatment for colorectal cancer.

We found that, although the Health Board had informed Mr J on 1 February 2022 that he would have surgery on 21 March, it did not schedule the surgery, as it had indicated. Mr J only found this out when he contacted the ward the day before he was due to be admitted to hospital. The Health Board then took no action to resolve the matter until it was prompted to reschedule the surgery, after telephone calls and a complaint from Mr J's family.

This resulted in an avoidable 5-week delay until the surgery took place. The overall time between suspected cancer referral to the start of the treatment was outside the National Pathway guidelines for colorectal cancer. This caused injustice to Mr J. For him to find out the day before that the surgery he was expecting to take place, and for which he had prepared, was not in fact going ahead, must have been devastating, particularly as it turned out that this was due to an error by the Health Board in not booking the surgery in the first place.

Although the records clearly indicated that the Health Board made a mistake, its complaint response to Mr J was not candid and was contrary to the Putting

Things Right (PTR) scheme, which places a “duty to be open” on the Health Board.

It was only in response to our investigation that the Health Board acknowledged that the surgery had not been booked. It should have been

open with Mr J about this from the start, when it responded to his complaint.

The Health Board agreed to our recommendation that it should apologise for the failings and complete an audit of its colorectal scheduling processes and controls.

## Case example 5

### Mrs Vs complaint (202006310)

Cwm Taf University Health Board

Mrs V complained to us about the care and treatment provided to her cousin, Ms F, by Cwm Taf Morgannwg University Health Board.

We found that the Health Board missed opportunities to identify and treat the appendicitis that caused Ms F’s ruptured appendix. When Ms F attended the Ambulatory Emergency Surgical Unit at Princess of Wales Hospital on 17 July, appendicitis was not suspected, despite symptoms including severe abdominal pain, unusually low blood pressure and blood test results which indicated the presence of a significant infection. Instead of being admitted to hospital, Ms F was sent home without being prescribed antibiotics and without the

Health Board arranging appropriate and timely investigations, including scans.

When Ms F returned for a review and further investigations on 20 July, the scan ruled out gallstones as the cause of her symptoms, but again she was not admitted to hospital, and told to return 2 days later.

Sadly, Ms F did not return for further review, and she died at home on 1 August 2020.

We found that, on the balance of probabilities, if the Health Board had provided appropriate care on 17 or 20 July, Ms F’s appendicitis would have been identified and treated and her



death would have been avoided.

Although we found serious failings in this case, we were concerned that the Health Board's own investigation into Ms V's complaint did not find that it had done anything wrong, despite the case being discussed "at length" at a Surgical Clinical Governance meeting. On the contrary, the view at the meeting was that Ms F had received, " ...the standard treatment, as the other surgeons would have provided...". In our view, the Health Board missed clear opportunities during the complaints response

process to identify failings at an earlier stage and avoid the need for Ms F's family to escalate their complaint to us. However, when we shared the draft version of our report and our clinical advice with the Health Board, it accepted our recommendations.

We recommended that the Health Board should apologise and provide legal support to secure appropriate financial redress for Ms F's family. We also recommended that our findings should be reviewed by the Surgical Clinical Governance Team. The Health Board agreed to comply with our recommendations.

## Case example 6

### Miss X's complaint (202102028)

Cardiff & Vale University Health Board

Miss X complained about the care and treatment her late father, Mr Y, received at Cardiff and Vale University Hospital of Wales ("the Hospital") in March 2020.

He went to the Emergency Department ("the ED") but was sent home. Two days later, he was admitted to the Hospital but sadly died a few days later, after emergency surgery.

We found that Mr Y should not have been discharged from the ED as he was, because his clinical history had not been assessed. Also, the Health Board did not take enough information about Mr Y's bladder symptoms, constipation and new large groin lump. These symptoms pointed to an obstructed hernia which needed treatment, but Mr Y was discharged without adequate assessment. If the



Health Board assessed and admitted him at the time, the outcome for him might have been different.

Mr Y was admitted to the Hospital 2 days later. We found that his symptoms were again not promptly examined and recognised. This led to a delay before Mr Y underwent surgery, which meant that his condition worsened. When a delayed scan led to the diagnosis of a strangulated hernia, Mr Y needed emergency surgery.

Mr Y was very ill following surgery, but we found that he was not moved to the Intensive Care Unit (“ICU”), as it was determined that he would not benefit from this. We found that this decision reduced his chances of survival. Had the clinical failings not occurred, and had Mr Y received ICU care following surgery, his deterioration and death might have been prevented.

We acknowledged that the COVID-19 pandemic was beginning at the time Mr Y was admitted. This was creating extreme pressure for the Hospital

staff. Even so, Mr Y was an emergency case and he did not receive the appropriate standard of care.

We made several recommendations, which the Health Board accepted, including an apology and carrying out a case review to discuss assessment and diagnosis of strangulated hernias.

The Health Board’s response to the original complaint accepted that communication with Mr Y’s family was poor. However, we were concerned that its investigation did not identify that there were several missed opportunities to treat Mr Y and that there were therefore failings in the care provided to him.

The Health Board could have identified actions to remedy these failings sooner. Instead, the family had to pursue their complaint through our office, costing them additional time and causing more distress. Overall, we questioned the robustness of the Health Board’s investigation.



# Appendix 2

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# Duty of Candour and Quality

The [Health and Social Care \(Quality and Engagement\) \(Wales\) Act 2020](#) includes the Duties of Candour and Quality, provisions in the Act aim to:

- strengthen the existing Duty of Quality on NHS bodies and extend this to the Welsh Ministers in relation to their health service functions.
- establish an organisational Duty of Candour on providers of NHS services, requiring them to be open and honest with patients and service users when things go wrong.

The Act:

- places an overarching Duty of Quality on the Welsh Ministers; and
- reframes and broadens the existing Duty on NHS bodies.

The Duty seeks to strengthen governance arrangements by requiring the Welsh Ministers and NHS bodies to report annually on the steps they have taken to comply with the Duty and assess the extent of any improvement in outcomes.

The Act also places a Duty of Candour on providers of NHS services (NHS bodies and primary care) - supporting existing professional duties.

The Duty requires NHS providers to follow a process – set out in [Regulations](#) – when a service user suffers an adverse outcome which has or could result in unexpected or unintended harm that is more than minimal and the provision of health care was or may have been a factor. There is no element of fault, enabling a focus on learning and improvement, not blame.

Welsh Ministers have issued [statutory guidance](#) in relation to the Duty of Candour.

The Duty seeks to promote a culture of openness and improves the quality of care within the health service by encouraging organisational learning, avoiding future incidents.

The Act requires NHS providers to report annually about when the Duty has come into effect - how often the Duty has been triggered, a description of the circumstances leading to the event and the steps taken by the provider with view to preventing any further occurrence.



# NHS Complaints Process

The [National Health Service \(Concerns, Complaints and Redress Arrangements\) \(Wales\) Regulations 2011](#) came into force in April 2011. They prescribe arrangements for complaint handling in all NHS bodies in Wales and were supplemented by guidance entitled “Putting Things Right”. Complaints must be investigated properly and appropriately and details of complaints should be shared with the staff member involved “where appropriate”. A complainant should generally receive a response within 30 working days; if this is not possible, the response should be sent within six months and the complainant kept informed of the delay and the reason for it. Lessons should be learned from complaints and complainants informed of action which has been taken as a result of the complaint.

An NHS body must investigate matters raised in a concern in the manner which appears to the body to be most appropriate to reach a conclusion in respect of those matters thoroughly, speedily and efficiently, having particular regard to the matters listed in Regulation 23 of the Regulations, including whether the person investigating the matters raised required independent medical or other advice.

The Regulations contain provision for the payment of redress in certain circumstances if the investigation concludes that harm may have been caused to the complainant through the fault of the organisation. Further investigation may be necessary if the initial investigation concludes that this may be the case and extended timescales apply to the consideration of redress.





**Ombwdsmon**  
**Ombudsman**  
Cymru · Wales

**Public Services Ombudsman for Wales**

**1 Ffordd yr Hen Gae**

**Pencoed**

**CF35 5LJ**

**Tel: 0300 790 0203**

**Fax: 01656 641199**

**Email: [ask@ombudsman.wales](mailto:ask@ombudsman.wales)**

**Follow us on Twitter: [@OmbudsmanWales](https://twitter.com/OmbudsmanWales)**