Bundle Quality, Patient Experience and Safety Committee 7 May 2024

Agenda attachments

ITEM 0 Open Quest Agenda - 7 May 2024

0 09:30 - OPENING ITEMS

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

2 Board Member Register of Interests
Board Member Register of Interests

3 Minutes of the Previous Meeting 8 February 2024
2024-02-08 QUEST OPEN MINUTES

4 Action Log & Matters Arising
4.1 Committee Highlight Report
ITEM 04 Action Log
ITEM 04.1 Quest Committee Highlight Report February 2024

5 09:40 - Operations Directorate Quarterly Report Q4 2023/24
ITEM 05 Operations Quarterly Report for Committees 23-24 Q4 FINAL

5.1 ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION

6 10:00 - Staff Story
Staff Story - Fiona Maclean, Patient Experience Community Involvement Team and Julie Starling, Save a Life Cymru
6.1 Patient story update – Alison Cassidy
ITEM 06.1 Tracker Alison Cassidy

7 10:40 - Putting Things Right Report Quarter 4, January – March 2024
ITEM 07 Putting Things Right Report Quarter 4 (January - March 2024)

8 11:00 - Putting Things Right Recovery Plan
ITEM 08 Putting Things Right Recovery Plan
ITEM 08.1 Putting Thing Right Recovery Plan - Annex 2

8.1 11:10 - COMFORT BREAK

9 11:25 - Patient Experience Community Involvement Bi-annual Report
ITEM 09 Patient Experience Community Involvement Bi-Annual Report October-March 2023-2024
ITEM 09.1 PECI Report October 2023 - March 2024 Final

10 11:45 - Monthly Integrated Quality Performance Report
ITEM 10 MIQPR SBAR QUEST February March 2024
ITEM 10.1 Annex 1 MIQPR QUEST February March 2024

11 12:00 - Annual Quality Report 2023/24
ITEM 11 Executive Summary Duty of Quality Annual Report 2023-24
ITEM 11.1 Annex 2 DRAFT Duty of Quality Annual Report v1
ITEM 11.2 Executive Summary Duty of Quality Annual Report 2023-24 - Annex 3

11.1 12:30 - LUNCH

12 13:00 - Update on Clinical Plan
ITEM 12 Our Clinical Plan SBAR - QUEST May 2024
ITEM 12.1 Our Clinical Plan 2025-2030

13 13:10 - Clinical Audit Plan and Action Tracker Q4 (update) 2023-2024
ITEM 13 SBAR - Clinical Audit Plan & Action Tracker Q4 2023-24
ITEM 13.1 Clinical Audit Plan Q4 2023 - 24 Final

14 13:20 - Spotlight on Clinical Indicators:
Fractured Neck of Femur
ITEM 14 SBAR - Focus on CIs - #NoF 19.4.2024
ITEM 14.1 Focus on CIs - Fractured NoF v0.3 - 19.4.2024

15 13:40 - Audit Tracker

15 Audit Tracker
15A - Quest and QSPE
15B - Audit Wasles and HIW
Internal Audit Reports:
15.1 Serious Adverse Incidents – Joint Investigation Framework
15.2 Electronic Patient Clinical Record: Clinical Compliance
15.3 Seatbelt Action Plan

ITEM 15 SBAR Audit Tracker to Committees - Q4 Reporting - May-June Reporting - QuEST
ITEM 15A Quest Tracker
ITEM 15B Audit Wales HIW
ITEM 15.1 WAST_2324-007_Serious Adverse Incidents Joint Investigation Framework_Final Internal Audit Report
ITEM 15.2 WAST_2324-008_ePCR Clinical Compliance_Final Internal Audit Report
ITEM 15.3 WAST_2324-012_Seatbelt Action Plan_Final Internal Audit Report

16 13:50 - Risk Management and Board Assurance Framework Report

ITEM 16 Executive Summary Risk Management Report QuEST 070524

17 14:00 - Policies for Approval/Adoption:
17.1 Consent to Examination and Treatment Policy
17.2 Management of Controlled Drugs Policy
17.3 Non Medical Prescribing Policy
17.4 Premises and Vehicle Cleaning Policy
17.5 Clinical Supervision Policy
17.5B,17.5C and 17.5D (Clinical Supervision Implementation Plan)
17.6 Dispatch Cross Reference (DCR) Table Policy

ITEM 17 Policies for Committee Approval - QuEST 070524
ITEM 17.1 Consent to Examination and Treatment Policy V2.8 250424
ITEM 17.2 Management of CD Policy 2024 v5.10 250424
ITEM 17.3 Non-Medical Prescribing Policy v2.4 160424
ITEM 17.4 Premises and Vehicle Cleanliness Policy v1.13
ITEM 17.5 Clinical Supervision Policy Implementation SBAR - QUEST May 2024
ITEM 17.5A Executive Summary Clinical Supervision policy 4722
ITEM 17.5B Clinical Supervision Implementation TF Group ToR v2
ITEM 17.5C Clinical Supervision Policy v1.6 290424
ITEM 17.5D CS ELT paper KRJC
ITEM 17.6 DCR Table Management Policy V1.10 010524

18 14:15 - Committee Cycle of Business (CoB) 2024-25 and Monitoring Report

ITEM 18 SBAR for QUEST on Cycles of Business 24-25
ITEM 18.1 Cycle of Business
ITEM 18.1a Notes
ITEM 18.2 Monitoring report

18.1 14:25 - CLOSING ITEMS

19 Key Messages for Board Decisions & Actions

20 Reflections of the Meeting

21 Any Other Business

22 Date and Time of Next Meeting: 13 August 2024 at 09:30

MEETING OF THE OPEN QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE

Held on **7 May 2024** from **09:30 to 14:35**
Meeting held virtually via Microsoft Teams

Comfort Break: 15 Minutes
Lunch Break: 30 Minutes

AGENDA

No.	Agenda Item	Purpose	Lead	Format	Time
OPENING ITEMS					
1.	Chair's welcome, apologies, and confirmation of quorum	Information	Bethan Evans	Verbal	10 Mins
2.	Board Member Register of Interests	To State Conflicts	Bethan Evans	Verbal	
3.	Minutes of the Previous Meeting 8 February 2024	Approval	Bethan Evans	Paper	
4.	Action Log & Matters Arising 4.1 Committee Highlight Report from 8 February 2024	Review	Bethan Evans	Paper	
5.	Operations Directorate Quarterly Report Q4 2023/24	Information	Jonathan Edwards	Paper	20 Mins
ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION					
6.	Staff Story Fiona Maclean, Patient Experience Community Involvement Team and Julie Starling, Save a Life Cymru 6.1 Patient story Update – Alison Cassidy	Discussion Assurance	 Liam Williams	Presentation Paper	40 Mins
7.	Putting Things Right Report Quarter 4, January – March 2024	Assurance	Liam Williams Claire Appleton	Paper	20 Mins
8.	Putting Things Right Recovery Plan	Assurance	Liam Williams Claire Appleton	Paper	10 Mins

No.	Agenda Item	Purpose	Lead	Format	Time
COMFORT BREAK – 15 Minutes					
9.	Patient Experience Community Involvement Bi-annual Report	Assurance	Liam Williams	Paper	20 Mins
10.	Monthly Integrated Quality Performance Report	Assurance	Rachel Marsh	Paper	15 Mins
11.	Annual Quality Report 2023/24	Endorsement	Liam Williams	Paper	30 Mins
LUNCH BREAK – 30 Minutes					
12.	Update on Clinical Plan	Discussion	Andy Swinburn	Presentation	10 Mins
13.	Clinical Audit Plan & Action Tracker Q4 (Update) 2023-2024	Assurance	Andy Swinburn	Paper	10 Mins
14.	Spotlight on Clinical Indicators: Fractured Neck of Femur	Assurance	Duncan Robertson	Presentation	20 Mins
15.	Audit Tracker 15A - Quest and QSPE 15B - Audit Wales and HIW *Internal Audit Reports:* 15.1 Serious Adverse Incidents – Joint Investigation Framework 15.2 Electronic Patient Clinical Record: Clinical Compliance 15.3 Seatbelt Action Plan	Assurance Assurance Assurance Assurance	Alex Payne Liam Williams Andy Swinburn Jonathan Edwards	Paper	10 Mins
16.	Risk Management and Board Assurance Framework Report	Assurance	Julie Boalch	Paper	10 Mins
17.	Policies for Approval/Adoption: 17.1 Consent to Examination and Treatment Policy 17.2 Management of Controlled Drugs Policy	Assurance Approval Approval	Julie Boalch Andy Swinburn Andy Swinburn	Papers	15 Mins

No.	Agenda Item	Purpose	Lead	Format	Time
	17.3 Non Medical Prescribing Policy	Approval	Andy Swinburn		
	17.4 Premises and Vehicle Cleaning Policy	Approval	Liam Williams		
	17.5 Clinical Supervision Policy (To include Implementation Plan)	Approval	Andy Swinburn		
	17.6 Dispatch Cross Reference (DCR) Table Policy	Approval	Andy Swinburn		
18.	Committee Cycle of Business (CoB) and Monitoring Report	Approval	Julie Boalch	Paper	10 Mins
CLOSING ITEMS					
19.	Key Messages for Board Decisions & Actions	Discussion	Bethan Evans	Verbal	10 Mins
20.	Reflections of the Meeting	Discussion	Bethan Evans	Verbal	
21.	Any Other Business	Discussion	Bethan Evans	Verbal	
22.	Date and Time of Next Meeting: 13 August 2024 at 09:30	Information	Bethan Evans	Verbal	

Lead Presenters

Name	Position
Julie Boalch	Head of Risk/Deputy Board Secretary
Jonathan Edwards	Assistant Director of Operations
Bethan Evans	Non-Executive Director and Committee Chair
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Andy Swinburn	Executive Director of Paramedicine
Duncan Robertson	Assistant Director of Clinical Development
Liam Williams	Executive Director of Quality and Nursing
Claire Appleton	Head of Putting Things Right
Alex Payne	Corporate Governance Manager

WELSH AMBULANCE SERVICES NHS TRUST

UNCONFIRMED MINUTES OF THE OPEN SESSION OF THE MEETING OF THE QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE HELD ON 8 FEBRUARY 2024 VIA TEAMS

Meeting started at 09:30

PRESENT:

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

IN ATTENDANCE:

Julie Boalch	Head of Risk/Deputy Board Secretary
Louise Colson	Head of Infection Prevention and Control
Mark Harris	Assistant Director of Operations (Deputy for Lee Brooks)
Leanne Hawker	Head of Patient Experience and Community Involvement
Fflur Jones	Audit Wales, Performance Auditor (left after Minute11/24)
Alison Kelly	Business and Quality Manager
Osian Lloyd	Head of Internal Audit, NWSSP
Mark Marsden	Trade Union Partner
Trish Mills	Board Secretary
Hugh Parry	Trade Union Partner
Alex Payne	Corporate Governance Manager
Duncan Robertson	Assistant Director of Clinical Development (Left after Minute 16/24)
Leanne Smith	Assistant Director of Digital (Data) (Deputy for Jonny Sammut)
Andy Swinburn	Director of Paramedicine (Joined at Minute 05/24 and left after Minute 11/24)
Mark Thomas	Commissioning and Performance Manager
Jonathan Turnbull-Ross	Assistant Director of Quality Governance (left after Minute 11/24)
Liam Williams	Executive Director of Quality and Nursing
Debbie Young	Executive Assistant to the Executive Director of Quality and Nursing

Apologies:

Lee Brooks	Executive Director of Operations
Ian James	Trade Union Partner
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Jonny Sammut	Director of Digital Services

01/24 PROCEDURAL MATTERS

The Chair extended a warm welcome to everyone advising that the meeting was being recorded. Apologies were noted from Lee Brooks, Ian James, Rachel Marsh and Jonny Sammut.

Declarations of Interest

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

Minutes

The Minutes of the meeting held on 31 October 2023 were confirmed as a correct record.

Ratification of Chair's Action

The QuEST Committee ratified the Chair's Action made on 30 January 2024 to approve the Infection, Prevention and Control Policy (v.2.4) which was presented to the Committee for the formal record.

Action Log

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

Action Number: 50/23: Update on EMS CSD reconfiguration. Action to remain open, final paper will be shared with colleagues once ready.

Action Number 50/23a: NEPTS Eligibility matrix update. Mark Harris advised the Committee that no formal challenge had been received from Local Authorities or Welsh Government in respect of the changes made. There may be occasions when the Trust was unable to offer transport to those patients who were ineligible but would try their utmost to arrange it, however all eligible patients who required transport would receive it. Action Closed.

Action Number 51/23: It was highlighted that the Operational Delivery Unit have informed the Stroke Association that they are conducting an Audit on self-presentation to A&E. Liam Williams agreed this would be reported through to Quest if there was a material consideration. Liam Williams was engaging with Ceri Jackson to obtain further information on Lead within Operational Delivery Unit. Action Closed.

Action Number 52/23: In terms of the longest waiting patient (39 hours and 59 Minutes) it was requested that context be provided. The context was included in the Quarter 3 Putting Things Right report. Action Closed.

Action Number 54/23: Clarity on utilisation rates of Cymru High Acuity Response Unit (CHARU) activated at call centres. Work continues to define this action. It is recognised that CHARU dispatch requires further development to ensure an appropriate balance between clinical performance/ clinical outcomes/ response time performance and old despatching multi-resources when clinically appropriate. To this end, the CHARU Task and Finish Group will now be converted in a CHARU Delivery Group which will work with several teams across the organisation to continue to hone the delivery of the CHARU service. Action Closed.

Committee AAA report dated 31 October 2023

The Chair drew the Committee's attention to the contents of the AAA report for their information; this highlighted the key points from the Committee's last meeting on 31 October 2023.

RESOLVED: That

(1) Apologies were recorded for Lee Brooks, Ian James, Rachel Marsh and Jonny Sammut;

(2) The Minutes of the Open meeting held on 31 October 2023 were confirmed as a correct record;

(3) The Committee ratified the decision made by Chair's Action dated 30 January 2024 to approve the Infection Control Policy v.24; and

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

02/24 OPERATIONS DIRECTORATE QUARTERLY REPORT – 2023/24 Q3

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

The work on the Manchester Arena Inquiry (MAI) recommendations has now been ongoing for 6 months, and a mid-year review was completed in December. An update on the 68 recommendations that the Trust was working on was given. One of the recommendations from the MAI is the introduction of two new triage tools for mass casualty incidents. Ten Second Triage (TST) is designed to be used by anyone responding to a major incident to provide care to casualties prior to the arrival of clinicians on scene, and the Major Incident Triage Tool (MITT) is for use by NHS Responders at scene. Work has been ongoing to introduce this new tool within the Trust with the UK Ambulance Services go-live date set for 1 April 2024.

The outstanding tasks sitting with the Operations Quality (OQ) Concerns Team is at 168. This is down from 209 in Q2. The OQ Team continues to work closely with the Putting Things Right (PTR) Team to prioritise work to meet deadlines and requests.

In terms of NEPTS, the team has reviewed the current Capacity Management Plan, which sets out how the service applies the Welsh Government WHC 2007(005) eligibility criteria for non-emergency transport and the process for managing scenarios where demand for transport exceeds available capacity. The revised plan, which has been through an Equality Impact Assessment (EQIA) and Quality Impact Assessment (QIA) process, modifies the approach to a position where the service will only take bookings from patients that meet the criteria as per the Welsh Health Circular. Patients who do not meet the eligibility criteria will not be entitled to Non-Emergency Patient Transport and will be signposted to alternative transport solutions only. This plan has been shared with the Chief Ambulance Services Commissioner (CASC) and supported at the Delivery Assurance Group (DAG) meeting.

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

Comments:

Members were keen to understand if there had been any business continuity incidents (BCI) for 111 in the last 12 months. Mark Harris was not aware of any however agreed to confirm the position and report back to the Committee. He added there were a number of different scenarios that would trigger a BCI, and in terms of 111, there may be times when it is out of the Trust's control; for example, the issue with the Adastra system which was a Health Board system issue which occurred in 2022.

With respect to the Joint Emergency Services Interoperability Programme (JESIP) assurance visit noted in the report, the Committee asked what the position was with the report reference. Mark Harris advised that he would ascertain if there were any further details in respect of the visit and report back to the Committee.

RESOLVED: That the report was received.

03/24 PATIENT STORY

Liam Williams introduced the patient story in relation to Alison Cassidy and what has been a challenging family life for both mother and daughter. Whilst the Trust's response was compliant and in line with policies and procedures, it might not have been as sensitive or supportive as desired given the personal nature of the circumstances.

Leanne Hawker provided assurance to the Committee that the Trust was collaborating with colleagues at the Betsi Cadwaladr University Health Board (BCUHB) to extract

shared insights and plans of action from this story. Additionally, the story was being shared with BCUHB and any decisions regarding the next steps will be made collaboratively.

Alison Cassidy recounted the experience of her daughter Emma, who has a rare genetic disorder, Angelman Syndrome. Most people with this syndrome will have limited speech and will need support throughout their life and have severe learning disabilities and epilepsy.

In August 2021 Emma needed urgent dental care which required her to attend Ysbyty Glan Clwyd Hospital for treatment under general anesthetic and was advised by Health Care Professionals in the Health Board to access the Non-Emergency Patient Transport Service (NEPTS) to take Emma to her appointment (as she was unable to be transported safely due to seizure risk being elevated by the dental pain). NEPTS advised that at least 24 hours' notice was needed, and Alison was advised to ring 999; however, due to system pressures at that time a 999 response was unavailable. A further six 999 calls were made during the next 24 hours in an attempt to secure an emergency ambulance response.

After 28 hours Emma was sedated by Learning Disability Liaison nurses in the garden at her home, supervised by two North Wales Police officers, who arranged a taxi to take Emma with her siblings to hospital.

In Emma's escalating distress, she began exhibiting self-harming behaviour, this triggered an "attempted suicide" script from the Clinical Contact Centre call-taker. Alison believes it was entirely inappropriate and indicative of how the Advanced Medical Priority Dispatch System (AMPDS) scripts do not have capacity to effectively assess people with learning disabilities.

Comment:

Leanne Hawker advised that this story has been shared with BCUHB colleagues who identified the need for further education on staff protocols for ordering ambulances and their appropriate utilisation. They are eager to engage with Alison Cassidy to discuss her experience and collaborate on enhancing existing initiatives for individuals with specific needs. A patient story tracker specific to this case will be presented at the May 2024 Quest Committee meeting to ensure ongoing monitoring and improvement.

The Committee agreed there was learning required across the Health Board, but also within the ambulance service. Whilst the AMPDS was a robust system there were occasions when it did not work for every patient, and situations like this need to be challenged going forward.

Liam Williams explained that under most circumstances the Clinical Support Desk (CSD) clinicians would normally be reviewing the call stack would be able to intervene directly. It is not necessarily clear from the Story that this was a period of high demand and the Trust faced challenges in responding to Amber calls.

Due to a lack of available resources the CSD was under considerable pressure, meaning that focus would be on Red calls in addition to reducing the number of Ambers. The challenge was to ensure that people with long term complex needs have the appropriate care plan escalations in place; with these plans documented and digitally accessible across the system given to the patients and their carers. Furthermore, the CSD must be informed of these plans on a case-by-case basis. The Committee noted that since this incident recruitment into the CSD had increased and were interested to see if improvements will be made going forward.

Liam Wiliams added that Digital Health and Care Wales (DHCW) were working on increasing accessibility for flagged patients allowing clinicians in CSD to access this through the Welsh clinical portal to indent where a flag exists. Using this portal clinicians can inform the correct response. Leanne Hawker added that the Trust does have a flagging policy and has recently completed a consultation with the public for people with learning disabilities and learning difficulties around the priorities for the Trust with regards to quality improvement. Overwhelmingly the feedback was that a system where they can be assured that the Trust was using flags against individual patients (as currently the system flags addresses), was desired.

The Committee recognised that joint working would include that the relevant care plan was in place. Health Boards will be accountable to ensure the equity of access to services for an individual with complex healthcare needs.

Mark Harris added that whilst NEPTS was a planned routine service there was some flexibility in the system. He welcomed the ongoing work particularly with BCUHB to try and prevent similar incidents occurring in the future. Liam Williams added that the Trust's priortisation system was built for a response model which has timelines far more than what can be achieved. It is acknowledged that a cohort priortisation system is not designed to and does not meet the needs of some people. The system was designed for a whole system response in a timely manner and was not a priortisation system for long term care. He added that the collaborative work highlighted by Leanne Hawker was critical going forward.

Members held a discussion in which they acknowledged it was an overall system issue and that services should be working hard to ensure this does not happen again. In this particular case the Trust was unable to meet Emma's needs. The Committee also asked that going forward, progress with patient stories (patient story diagram) be included as a substantive item on agendas.

The Committee recognised that whilst the video was being shared at the Health Board it was felt that wider distribution to staff would be of great benefit. Liam Williams explained that when the service was under considerable pressure the Trust and other partners will always want to do better.

Leanne Hawker emphasised the extensive sharing and dissemination of patient stories across various platforms and stakeholders in Wales, including through networks, forums, podcasts, and organisational channels. This also included the development of

a national repository for patient stories to enable wider access and the ability to learn lessons.

The Chair expressed gratitude to Liam Wiliams and Leanne Hawker for bringing this story to the Committee's attention. Sharing the story with BCUHB and collaborating on implementing actions was crucial in preventing similar incidents. The comment made by Alison about the system not working for everyone, especially for those with complex needs, was very prominent to the Committee. The Trust must take control and improve itself, focusing on what it can control and collaborating with partners to do the same. The Chair stated that the system wide pressures and risks are readily discussed at every Committee meeting. There must be a commitment to learning from these experiences to ensure prompt support for individuals with complex needs in the future.

RESOLVED: The Committee noted the update.

04/24 PUTTING THINGS RIGHT (PTR) REPORT QUARTER 3, OCTOBER – DECEMBER 2023

Liam Williams presented the report to the Committee focusing on the specific points below for their attention which should be taken into context against the backdrop of ongoing pressures and challenges within the system being experienced:

1. There continues to be a high volume of incidents being reviewed at the Serious Case Incident Forum (SCIF).

2. The PTR Organisational Change Process has concluded and recruitment to posts is in progress. The new structure is expected to be fully established by April 2024.

3. There continues to be progress in the two and five day acknowledgement in respect of concerns; however, the acknowledgement of the 30 days responses remains a challenge to meet.

Patient waiting times in the community continue to impact on patient safety and during December 2022, 1.180 patients waited over 12 hours. During this period 231 of the patients waiting over 12 hours had experienced a fall, with the longest waiting patient being 45 hours and 04 minutes. A review of this case has been requested following an initial screen of the sequence of events. Liam Wiliams planned to conduct roundtable discussions with colleagues across the Trust to explore additional improvements in this area. Liam Williams also raised the question of whether there were additional measures that could be implemented through the clinical support desk for patients who had fallen and been assessed, and to explore alternatives to help alleviate system pressures.

Six incidents have been reported as National Reportable Incidents (NRIs) to the NHS Wales Executive and included clinical practice issues, delayed diagnosis and patient injury whilst being conveyed. The Trust currently has a total of 59 open NRI investigations with 56 of them overdue.

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

Following the detailed update to the Committee at the last meeting on Learning from Deaths (Mortality reviews and the Medical Examiner Service) a plan is in place to fully review the backlog of cases (800 cases) forwarded by the Medical Examiner Service, map the cases to incidents and complaints as relevant, and update the Datix Cymru Mortality Module.

All referrals have been screened on receipt by a member of the Patient Safety Team and escalated as required. Following collaboration with various teams within the Trust there has been an improvement in clearing the backlog.

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

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

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.

Comments:

It was observed that the data captured for those patients waiting for a response after a fall varied across Wales. The Committee acknowledged that ensuring a representative boundary for data capture was crucial for accurate analysis.

Following a query regarding the public service ombudsman work in terms of collecting data across the system regarding investigations which was clearly very pertinent to patient outcomes, Members sought an update and any timelines. Liam Williams advised that the Trust's aspiration was to look at these cases beyond the ambulance/hospital interface.

Liam Williams added that that future PTR reports will include presentation of the data from a population point of view per Health Board area, as opposed to simply by Health Board - to put the numbers in context across Health Board. The Trust was also working with colleagues to have a better understanding of how we can present this more clearly.

The Committee recognised there had been issues with Residential and Nursing Homes; and queried if the Trust could do more, particularly around remote and/or video assessment of patients. Especially in cases where patients are lying on the floor for a lengthy period to await a paramedic to make the assessment. Jonathan Turnbull-Ross advised that the Trust continues to consider more and more remote consultation but would require the appropriate infrastructure, investment and resource going forward to develop it. In terms of falls cases, he added that work was ongoing to ascertain the correct model and the scale of resource required.

Members discussed what initiatives could be done to support Care Homes more widely going forward and were very supportive.

In terms of clinical reviews, and particularly the concern raised by a patient regarding the attitude of a crew member, the Committee sought whether the Trust had an update on any learning from this. Liam Williams acknowledged there was more work to do in terms of the guidance regarding compassion moving forward.

RESOLVED: The Quality, Patient Experience & Safety Committee received the report for discussion and were satisfied with the assurance given regarding the Trust's Putting Things Right function.

05/24 MONTHLY INTEGRATED QUALITY PERFORMANCE REPORT – DECEMBER 2023

Mark Thomas presented the report and highlighted the following areas for the Committee's attention:

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

111 call answering decreased, as expected over the holiday period, with the call abandonment target of <5% not being achieved in December 2023 for the first time in seven months (13.1%).

111 Clinical response saw the highest priority 111 calls (P1CT) remain stable and above target at 98.3%. Priority 2 and Priority 3 fell further below the 90% performance target in December 2023, with the respective figures being 63.2% and 62.3%.

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

One of the key factors in relation to response times is the capacity lost to handover outside Emergency Departments. 22,756 hours were lost during December 2023, which is a material improvement on the 32,098 hours lost in December 2022.

Ambulance Care (formally NEPTS) (Patient Experience): Oncology performance dropped below the 70% target in December 2023 to 68.16%. Renal performance increased in December 2023, and remained above target at 74.08%. Advanced discharge & transfer journey booked in advance performance decreased compared to the previous month to 78%; remaining below the 95% target. Overall demand for NEPTS continues to increase, but remains below pre-pandemic levels.

The percentage of suspected stroke patients who are documented as receiving an appropriate stroke care bundle was 75.3% in December 2023, a slight decrease from the 77.9% seen in November 2023, and remaining below the 95% performance target.

The return to spontaneous circulation (ROSC) compliance rate decreased to 17.6% in December compared to 22.2% in November 2023.

National Reportable Incidents (NRIs) / Concerns Response: the Trust reported one NRI to the NHS Executive in December 2023, a slight decrease from the three reported in November 2023; and 16 serious patient safety incidents were referred to health boards under the Joint Investigation Framework, which has now been adopted NHS Wales wide.

In December 2023 complaint response times increased to 58%, a significant improvement on November 2023's 38%, but remains below the 75% target, with cases remaining complex.

The Trust produced 123,727 Ambulance Response unit hours in December 2023, an increase from the 121,349 produced in November 2023.

Good progress has been made through the year in increasing Consult and Close rates after 999 calls; and the Trust achieved 14.1% in December 2023, a slight increase from the 14% seen in November 2023, but below the Trust's 2023/24 IMTP ambition of 17%.

The indicators used highlighted that even though demand, and subsequently, system pressures increased during December 2023, performance remained relatively stable, across all areas, and significantly exceeded the levels achieved during December 2022.

Comments:

It was noted by the Committee there had been significant improvement in performance in some areas since December 2022; however, current performance in some areas was still below target.

In terms of the issues in meeting the targets regarding staff sickness and Personal Appraisal Development Reviews (PADRs), it was agreed this would be discussed at the next People and Culture Committee (PCC). The Chair of the PCC, Paul Hollard, agreed that the Committee would consider the action plan for reducing sickness and would look at the areas where PADR rates were low.

In respect of the presentation of the MIQPR and the phrase '*holding in the community*' particularly around immediate release, it was suggested that it could be prudent for the Trust to re-consider the use of language to ensure transparency of this term.

The Committee acknowledged that around 9900 patients cancelled their ambulance and that we were unable to respond to 793 calls. From a presentation perspective it was queried whether the placement of this data under 'Partnership & System Contribution' was correct. It was agreed that Mark Thomas would feed this back to his Directorate for clarification.

In terms of Immediate Release Directives, the Committee sought clarity at what level such Directives are made. Andy Swinburn explained that the request was made from the Operational Delivery Unit who would ask the nurse in charge of the department.

In respect of those patients that were delayed at handover, it was queried if it was possible to identify what type of cases they were. Andy Swinburn advised that the majority were likely to be frail older people who had a mixture of presentations. Liam Wiliams advised there was further work required in terms of clinical audits for the Trust to understand further the presentation and the clinical decision making that inform the decision to convey. Prior to conveyance, the ambulance crew will consider the presentation of the patient, their existing identified clinical need, and any potential clinical need. It was important that the Trust should build the clinical pathway in collaboration with Health Boards to understand what could be done differently.

Liam Williams assured the Committee that the Executive Leadership Team were well sighted on the pending political changes that may affect the Trust going forward.

RESOLVED: The Committee received the Monthly Integrated Quality and Performance report for December 2023 and actions being taken and determined that the report provided sufficient assurance

06/24 INTEGRATED MEDIUM TERM PLAN (IMTP) – QUEST COMMITTEE ELEMENTS

Trish Mills gave a verbal update in which she advised at this stage there was no written update due to the IMTP development timeline, but that the Board would have an opportunity to review the document so far as its Development Day on 22 February 2024. Going forward this item will need to be considered in the terms of the Committee's cycle of business.

RESOLVED: The Committee noted the update.

07/24 QUALITY STRATEGY IMPLEMENTATION PLAN UPDATE

Jonathan Turnbull-Ross presented the report and updated the Committee on the following points:

Following the internal Organuisational Change Process (OCP), the Senior Quality Leads have been appointed and took post as of September 2023. An Engagement Plan has been developed with delivery continuing in Quarter 4. This will ensure regular engagement with clinical, operational, and corporate functions to support quality improvement and provide specialist advice.

The first stage of development for the quality hub is due to be completed by the end of December 2023 with a proposed launch in early 2024. The first phase will focus on the Welsh Ambulance Services NHS Trust Improvement and Innovation Network (WIIN) portal and tracking of improvement data across Wales. The second stage will focus on development of training, information, and resources.

Careful consideration has been taken with the Operations Directorate in assessing the alignment of operational governance structures. Continued collaborative working through the two Directorates has allowed the Quality Management Group (QMG) to establish a growingly effective forum, embedding patient safety and learning into this agenda with a revised TOR tabled for CQGG on 24 January 2024.

Engagement with communities has continued with recruitment of citizens into the Trust's people and community network, and as previously reported this will be a continuous exercise to ensure appropriate representation.

Comments:

Members noted the ongoing work in engaging with communities especially with the Citizen's Voice and the challenges in managing their expectations; and it will be interesting to understand how this develops.

The Committee asked that for the next update it would be useful have some timelines, in respect of the actions being undertaken, particularly in the red areas.

The Committee were keen to understand how the Senior Quality Lead was settling into their roles. Jonathan Turnbull-Ross assured the Committee they were settling in well, however the Trust still required further resource to ensure the full effectiveness of implementing the strategy.

Members queried if the Duty of Quality report for 2024 would be presented in a consistent format across all Health Boards. Jonathan Turnbull-Ross commented that following guidance, that was the intention going forward, however there may be slight nuances with every Health Board.

The Committee sought an update on any future engagement events following the implementation of the strategy. There has been some extensive engagement already and agreed to update the Committee on future timelines. Liam Williams updated the Committee on the work in terms of how the Trust was engaging at Health Board level. He added that he was keen for the Trust to have an approach that aligned quality improvement and quality and safety into a single operating environment with a defined set of metrics.

Members thanked all those involved in the progress they had made despite the ongoing challenges.

RESOLVED: The Quality, Patient Experience & Safety Committee noted the progress against the Implementation Action Plan.

08/24 SPOTLIGHT ON CLINICAL INDICATORS (CI) - STROKE

Duncan Robertson gave the Committee a PowerPoint presentation which outlined the following details:

An ePCR technical specification was created to enable reporting and since the implementation of ePCR all Clinical Indicators (Cis) are reported on using 'raw' data inputted by clinicians (*no manual auditing prior to reporting*)

Due to staff being unfamiliar with a new system, a reduction in CI compliance was anticipated (as in other UK Trusts), risk 535 (monitored by CIAG) was created to highlight three elements: User behaviour, User interface and Scripting.

A Clinical Indicator dashboard has been developed to include Stroke (*Version 2 released December 2023 includes time-based metrics*). A deep dive audit had been conducted by the Clinical Intelligence and Assurance Team to:

- Provide a more accurate clinical picture of the care delivered
- Highlight the variation between automated and audited data
- Help inform future reporting and caveats
- Help inform an improvement plan and changes to the ePCR User Interface

By and large through March of 2023 the Trust performed better than it did in March 2022, in terms of getting the resource to the to the patient. There have been several improvements to date following the ePCR Clinical Data Assurance clinical audit which included:

- A more accurate clinical picture of the care delivered is provided
- The variation between automated and audited data is highlighted
- It has helped to inform future reporting and caveats and inform an improvement plan and changes to the ePCR User Interface

The User Interface changes were being implemented in December 2023 and the

improvement plan was progressing with further engagement and support from Senior Paramedics for ePCR completion and CI compliance. Furthermore, the development of a revised CI 'Jigsaw Poster' following requests from staff to use as an *aide memoire*.

Future Changes to Stroke Call Timing:

In line with most UK ambulance services, the Trust prioritises MPDS protocol 28 (Stroke) calls, in accordance with the timing of symptom onset ('t' value)
Currently the 't' value priority assigned to Strokes is:
Onset of symptoms < 5 hours or unknown time = amber-1 priority
Onset of symptoms > 5 hours = amber-2 priority

Recent discussions with senior clinicians from the Wales Stroke Network have indicated that:
New treatment opportunities exist for patients who have Stroke symptoms with an unknown onset time (often known as a 'wake up' Stroke)
The time window for specific therapy is now much greater – up to 12 hours.
The Trust is now working to support the clinical recommendation to change the 't' value in protocols 28 and 18, from five hours to ten hours. A paper is to be submitted to the Executive Leadership Team (ELT) in January 2024.

Comments:

The Committee welcomed the presentation and recorded a note of thanks for those involved in its production, notably Kevin Webb. The Committee expressed their concern about potential variations in access to treatment across Health Boards, especially with the extended therapeutic window switching from five hours to ten hours. Data collection will be crucial for providing feedback and addressing any disparities in access to treatment within this context.

Duncan Robertson commented that Patients who wake up with stroke symptoms but with a very narrow therapeutic window are missing opportunities. It may be that they had their stroke an hour before they woke up or 10 minutes before they woke up and are being disadvantaged through this approach. There has been a lot of work done in the background in terms of modelling the numbers through this as well and working with colleagues within Operations in relation to making sure they're not being inundated with a lot of what might be false positives in terms of stroke. The other piece of work involves the Clinical Prioritisation Assessment Software (CPAS) team who look after the tables that indicate how the Trust responds to each of the codes that it goes to. There was also some work involved moving amber one into amber two calls so from an organisational perspective it is not increasing the number of amber one calls because of the strokes but what that does mean is there is space there for the additional amber one stroke coding to go through that way and doesn't have any additional burden.

Andy Swinburn explained in terms of the CI there was only one element that fundamentally contributes to the outcome of the patient and that was recognising that the person is having a stroke through a Face, Arms, Speech, Time(FAST) test. While

assessing blood pressure and using the Glasgow Coma Scale were important and useful, they don't directly alter patient outcomes. Instead, factors like pre alerts, shorter time on scene and call to door time are more impactful in improving patient outcomes.

Following further discussion, it was noted that a deep dive audit was scheduled to be conducted on the Stroke CI, and once this had completed the Committee would be updated.

The Committee were keen to understand more detail around when the FAST assessment was completed, unless there was a justified exception and how is the justified exception being documented and then evaluated. Duncan Robertson explained this was being updated with the user interface changes in ePCR, as some of the justified exceptions were not as clear as they were with the documentation to support the digital pen and paper-based Patient Clinical Record (PCR)s. Every CI has its own separate section on the ePCR, and these sections have been streamlined so that the indications for doing something are included and what they've done and if medication is involved this can be updated accordingly.

Liam Williams added it was important to note that the changes that are being made were made by the stroke network on behalf of Wales.

RESOLVED: The Committee noted the PowerPoint update for the Stroke Clinical Indicator.

09/24 HEALTHCARE INSPECTORATE WALES (HIW) NATIONAL REVIEW OF PATIENT FLOW – A JOURNEY THROUGH THE STROKE PATHWAY (AND TRUST ACTIONS) & IMPROVEMENT PLAN

Andy Swinburn presented the report advising the Committee that a review from Health Care Inspectorate Wales (HIW) had identified 50 recommendations to improve patient flow for patients who have suffered a stroke in Wales.

Of the 50 recommendations, seven were specific to the Trust, with the remaining recommendations sitting with other healthcare services such as the Health Boards and Public Health Wales.

The Trust has devised management actions in response to the review recommendations and these alongside actions for Health Boards and Public Health Wales have been included in the Patient Flow Review Improvement Plan. A copy of the Trust's management actions has also been lifted to the Trust's audit tracker to hold Directorates to account and to monitor progress the actions relevant to the Trust.

Comments:

In terms of the Immediate Release Directives protocol and how the process worked in Emergency Departments, it was asked whether this was being reviewed and whether it

would be appropriate for the Committee to have sight of this work. Andy Swinburn explained that this was not within the Trust's control.

As part of addressing the actions the Committee asked whether the increase of Advanced Paramedic Practitioners (APP) played an important part. Andy Swinburn explained the ultimate goal was to create the capacity to reduce the usage of ambulances to ensure there was always one available to respond to patient who present as a stroke.

2022/23HIW Annual Report

Liam Williams presented the report as read and highlighted the key areas as follows:

Outlined the work undertaken by HIW in relation to the Stroke pathway.

The work carried forward from 2021/22 and into 2022/23 in relation to systems pressures and understanding the pathway issues for offering care, particularly around handover delays and the consequences this had on the Trust's ability to provide care.

Safeguarding, the Committee had previously received the annual report which set out all the work the Trust had undertaken to highlight safeguarding as a critical part of practice.

Comments:

The Chair advised there had been an increase in the number of safeguarding alerts raised in the Trust, whilst the report states a significant drop, Liam Williams explained that some of the alerts are coded to the Health Boards and were picked up at Local Authority level. He agreed to clarify this point and update the Committee.

RESOLVED: The Committee

(1) Received the 'HIW National Review of Patient Flow (a journey through the Stroke pathway)' report and were assured that the improvement plan actions relevant to the Trust were being progressed accordingly; and

(2) Noted the 2022/23 HIW Annual Report.

10/24 CLINICAL AUDIT PLAN AND ACTION TRACKER QUARTER 3 UPDATE AND CLINICAL AUDIT PLAN Q1 2024/25

Duncan Robertson presented the report highlighting for the Committee's attention:

During Q3 2023-24, a further four of the 15 clinical audits included in the Clinical Audit Plan for 2023-24 have been completed. These audits and associated action plans have been approved by the Clinical Intelligence & Assurance Group. The audits that have been completed are:

- ePCR Clinical Data Assurance – $EtCO_2$ Compliance
- Non-conveyance form images in ePCR
- ROLE form images in ePCR
- Levetiracetam (Keppra) Potential use in convulsions

Since the last update (October 2023), a further 16 actions have been completed that were aligned to eight of the audits.

Clinical Audit Plan Q1 2024/25

The plan was presented by Duncan Roberston who advised that its development had been in consultation with eh Clinical Intelligence and Assurance Team (CIAT).

The development of this Annual Plan takes into consideration several aspects including the resources available both in terms of funding and skills.

This plan and the subsequent action tracker to monitor learning from each of the audits is monitored by the Clinical Intelligence & Assurance Group (CIAG), and an update noted at Clinical Directorate Business meetings.

Comments:

The Committee welcomed the reports, noting the good progress and recorded a note of thanks for those involved in its production, notably Kevin Webb.

It was also noted that the Chair of the Committee would prepare a report to advise the Audit Committee that the Quest Committee had received the plan, in accordance with the Audit Committee's Terms of Reference.

RESOLVED: The Committee

(1) Noted the Q3 2023-24 Clinical Audit Pan and Action Tracker Update; and

(2) Approved the Clinical Audit Plan Q1 2024/25 as set out with the caveat that additional items may be added as the year progressed.

11/24 MEDICINES MANAGEMENT ASSURANCE REPORT FOR 2023

Duncan Robertson presented the report adding it was the first time a Medicines Management Annual Report had been provided. Areas within the report included the following:

Vehicle medicines Audit
Omnicell Monthly Cycle Count
Unresolved Controlled Drug Discrepancies on the Omnicell System
Patient Group Directions (PGD) – Evidence of Signed Authorisations
Expired PGDs
Abloy (controlled drug key) System

Notification Alerts
Controlled Drug Quarterly Occurrence Reports
Medication Errors

The report had identified that in terms of any controlled drug discrepancies within the Omnicell system, this had improved with less discrepancies being reported.

The Committee were given assurance that additional work was ongoing with the Patient Group Directions as directed via an Internal Audit report.

Medication Errors were currently based in table form and was based on reports received from Datix administrators; the Trust was looking to expand and include more information.

Comments:

The Committee noted that a plan was being worked on to expand capacity and resource within the Medicines Management Team.

Members recognised this report had been subject to an Internal Audit and the progress has been significant and positive, demonstrating the actions being taken.

Members discussed whether this report should be appended to the Committee Highlight report being presented to the Board next month. It was agreed that the report should be presented in the Closed session of the Board.

RESOLVED: The Committee:

(1) Agreed that future reports for QuEST are synchronised to be delivered following closure of a financial year, therefore next report to be delivered at the May 2025 meeting covering the 2024/25 financial year; and

(2) Noted and discussed the content of the appended report as required.

12/24 COMMITTEE ANNUAL EFFECTIVENESS REVIEW 2023/24

Trish Mills explained that the Annual Effectiveness Reviews are designed to evaluate the effectiveness of the Board and its Committees, review its operating arrangements, and propose changes to improve its support, challenge, scrutiny, and oversight responsibilities.

Questionnaires were sent to members and attendees provided an opportunity to gauge opinion on areas of good practice and areas that require improvement. Sixteen questionnaires were sent out with eight responses being returned (a 50% return rate which was slightly higher than 2022/23).

It is good practice for Committees to set priorities for the forthcoming year when they review their effectiveness. Such priorities may include a particular focus throughout the year, or in particular quarters. For example, the Committee may wish to prioritise more agenda time to any new issues it may be adopting in its terms of reference; focus on areas it may not have addressed as strongly last year or which are developing; or review of the Committee's risks, both operational and strategic.

It was noted that due to operational pressures, this has sometimes meant that information was presented at different times. However, the cycle of business and monitoring report presented at each meeting indicates the reasons for this.

The Committee noted from the Annual Report the significant amount and varied issues of business discussed during the year. There were several proposed minor changes to the Committee's terms of reference. The main change was moving the Information Governance, and the Information Security sections over to the Finance and Performance Committee.

In terms of membership there will be a change to the Members with a new NED arriving and one leaving, with no changes to the Prescribed Attendees list.

Comments:

The Committee discussed the issues around clinical indicators and the data aligned to that and how that along with the Duty of Quality and Candour would develop going forward.

Trish Mills commented that Committee would focus on the quality strategy or quality plan the development of it as it comes through next year and maybe also with the new health and care quality standards being introduced with the new act is how the Trust was moving towards providing assurance to the Board on those standards. Liam Williams added that the Quality Management Group was addressing the standards with updates, through the Clinical Quality and Governance Group (CQGG) coming to the Committee.

Liam Williams added that the Chief Nursing Officer will have a focus on Infection Prevention and Safeguarding.

The Committee must continue to focus on the two main risks, 223 (the Trust's inability to reach patients in the community causing patient harm and death) and Risk 224 (Significant handover of care delays outside accident and emergency departments impacts on access to definitive care being delayed and affects the Trust's ability to provide a safe & effective service for patients), and their impact. Liam Wiliams added that the Committee could weave its agenda items into these risks and align the work of the Committee to support the mitigation of these risks.

Members appreciated that the focus of the Trust was on those areas of high risk and queried if there was enough focus on the other services, i.e. NEPTS. It was

suggested if there were ways in which the Committee could have more visibility on some of the lower risk areas.

In setting its priorities for 2024/25, the Chair emphasised the importance of recognising the duty of quality and duty of candour as a priority highlighting the role of the quality strategy in fulfilling this duty additionally as a sub section of this priority. Addressing risks 223 to 224 too should be noted as another priority alongside innovations in care. The many comments made during this discussion have aligned with these three overarching priorities. Members were content and agreed with these priorities.

RESOLVED: The Committee:

(1) Reviewed and approved the draft Annual Report.
(2) Reviewed and endorsed any further changes to the terms of reference;
(3) Confirmed the proposed changes to operating arrangements in response to issues raised in questionnaires as set out in the draft Annual Report; and
(4) Set its priorities for the Committee for 2024/5.

13/24 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK (BAF)

Trish Mills presented the report advising that the same information was presented to the Board last month.

The Trust's highest rated Risks 223 and Risk 224 scoring 25, remain unchanged because of sustained and extreme pressure across the Welsh NHS urgent and emergency care system which is negatively impacting on patient flow leading to avoidable patient harm and death. These risks continue to be closely monitored by management, Board Committees, and at the Trust Board meetings.

Several updates have been made to the controls and assurances in relation to Risk 223 and 224 during this period and these are highlighted on the BAF to address gaps in assurance. These two risks will be reviewed closely in conjunction with each other to ensure the synergy between them both and that they reflect the actions from the avoidable harm paper in the same way.

Comments:

Members welcomed the reviewing of the two highest scoring risks, noting that the Trust continued to do everything it could to reduce the score.

RESOLVED: The Committee noted the report.

14/24 POLICIES FOR APPROVAL/ADOPTION

Leanne Smith explained that the Data Protection Policy has been fully revised, redrafted and brought into alignment with the requirements of the Data Protection Act 2018 and UK General Data Protection Regulations, which are key pieces of legislation covering the handling, security, and confidentiality of personal information.

This policy has been through the relevant stages of the policy review process, including the Information Governance Steering Group with invites for comments, followed by Trust-wide consultation. It was approved by the Policy Group on 19 December 2023.

The Committee were advised that the Trust employed Kelly Holding as the data protection expert who's responsible for helping ensure the Trust's legal obligations as a collective were met. Her work and others involved in the Trust who have developed the policy should be recognised.

RESOLVED: The Data Protection Policy was approved.

15/24 AUDIT TRACKER AND AUDIT REPORTS

Trish Mills advised the Committee that the Audit Tracker has been updated in Quarter three following its complete revision in Quarter two; again, there has been excellent engagement from Directorates. Around12.5% of internal audit recommendations are presented as closed in quarter in this report and there are actions with a change in date proposed, many of which are due to be closed in Quarter four or Quarter one of 2024/25.

The current version of the tracker is now open for Directorate review for actions due in January, February, and March. These updates will then be reported to the Committee at its meeting in May 2024.

Discussions have taken place on historical actions and those where management actions may need to be amended in view of the current operating context. There has been some traction with these, and discussions will continue into Q4 with a view to closing or revising as many as possible.

Records Management Internal Audit Report – Reasonable Assurance

Leanne Smith presented the report and thanked the Internal Auditors for their assistance in developing this report.

Leanne Smith clarified that the records team comprises only three permanent members who covered two essential services; handling requests for personal and Trust records and managing Trust records which was the focus of the audit.

The Trust has experienced a notable rise in records requests over the past decade with a 40% increase in 2022-2023 compared to the previous year. This year the increase is projected to be around 7% however the capacity to focus on records management as highlighted in the audit is diminishing. The team has prioritised not breaching any individual rights and subject access requests, but this focus has led to challenges in implementing records management improvement plans.

Progress was being made on the action listed in the report which is illustrated in the Audit Tracker.

Comments:

Members queried whether the storage of physical records, which were currently being held in a premises owned by Denbighshire County Council, as the Trust moved towards digitisation, would decrease over time. Leanne Smith commented that the risk of paper records being held outside Trust premises and the cost would decrease over time. She added that the Trust was looking to see if there was unused space on Trust premises that could be used as storage in the meantime.

Osin Lloyd added that some of the high priority findings in the audit related to the paper records and storage.

Given the resources in the Team, the Committee queried whether the timelines reflected in completing the actions were realistic. Leanne Smith accepted there would be challenges but plans were currently on track to meet the timelines for the current quarter.

RESOLVED: The Committee:

(1) Received and reviewed any Internal Audits and Audit Wales reviews within their remit where relevant. For this meeting these were: -

(2) Records Management (received by Audit Committee on 30 November); and

(3) Monitored management actions to address recommendations in the Tracker, noting any revised dates for actions and were assured by the update received.

16/24 INFORMATION GOVERNANCE REPORT AND INFORMATION SECURITY KEY PERFORMANCE INDICATORS (KPI) REPORTING

Leanne Smith presented the report and highlighted the following areas for the Committee's attention:

Data Protection Impact Assessments (DPIA): DPIAs are required when new systems, processes or projects, or changes to existing ones, may result in a risk to the rights and freedoms of individuals and their personal information. Although progress has been steady over the year, many DPIAs are still awaiting review or have not yet been started due to lack of engagement from teams around the organisation, and limited capacity in the IG team to support the completion and approval of DPIAs. The Information Governance Steering Group was now assisting in the prioritisation of reducing the current backlog.

Records Requests: despite a significant increasing trend requests for records received annually, the small team have managed to increase compliance rates since the October reporting where compliance was at 86%. This is through improved processes and support from individuals performing alternative duties within the Trust.

Information Governance Toolkit – This is the top section of the dashboard and has seen a significant change from the 2022/23 set of minimum expectation requirements. The questions set in the categories for this year have changed which means that some of the evidence to be collected will be different. In terms of progress against the 2023/24 IG Toolkit submission, there was still around 28% of requirements with outstanding evidence against them.

Work was ongoing to improve the strength of passwords within the Trust; the challenge being for front line staff.

Comments:

Freedom of Information Requests: There has been an increase in the volume and complexity of FOI requests compared to 2022/23 which has led to months in 2023/24 seeing poor performance against the target (of responding to 90% of requests within 20 working days). Trish Mills explained the challenges in resources which has been the cause of this issue; adding that the Trust was looking at ways to improve the situation which included automation.

RESOLVED: The Committee noted the contents of the report and the tends in the metrics.

17/24 WELSH RISK POOL CONCERNS ASSESSMENT

Liam Williams advised the Committee that the report outlined the progress against the Welsh risk Pool (WRP) Concerns Assessment as of December 2023.

The Report identified several recommendations. Each organisation in Wales has been asked to develop an Improvement Plan which addresses the findings and supports the prioritisation of improvement activity in this area. There were 10 areas earmarked for improvement, one of the recommendations (WRP01) required Committee support to be extended to 31 March 2024, the remaining nine actions were on target to be completed by then.

The Committee noted and supported the extension of the action WRP01 to 31 March 2024.

RESOLVED: The Committee noted the report and agreed that WRP01 completion date be extended to 31 March 2024:

18/24 CYCLE OF BUSINESS MONITORING REPORT

The report was presented for information.

RESOLVED: The Committee noted the report.

19/24 PATIENT STORY UPDATES

The report was presented for noting.

RESOLVED: The update was noted.

20/24 KEY MESSAGES FOR BOARD

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

21/24 REFLECTIONS & SUMMARY OF DECISIONS & ACTIONS

The following actions were captured during the meeting:

The driver diagram now will be a substantive item on the next meeting agenda rather than in the consent items.

The PTR report discussed how data could be presented differently and considered how to have different approaches to remote consultation and involve care homes.

MIQPR, PCC would consider more closely the staff sickness and PADR. There were also questions raised on the content regarding the number of patients where ambulances were cancelled or where it was not possible to provide a response, it was queried whether the placement of this under 'Partnership & System Contribution' was correct.

The Committee asked that a timeline/timetable of how the revised Quality Strategy would be delivered.

Healthcare Inspectorate Wales Annual Report 22-23, it was agreed this would be appended to the AAA report going to the Board.

Medicines Management Assurance report, it was agreed this would be added to the Trust Board closed meeting.

In respect of the Committee's effectiveness, Members reviewed and approved the draft Annual Report. Reviewed and approved any further changes to the terms of reference. Confirmed the proposed changes to operating arrangements in response to issues raised in questionnaires as set out in the draft Annual Report and set its priorities for the Committee for 2024/5.

Agreed to review Risks 223 and 224 noting the position has been the same for several years.

The Committee approved the new Data protection policy.

Welsh Risk Pool Concerns, the Committee noted and supported the extension of the action WRP01 to 31 March 2024.

The patient story was challenging and led to a very constructive discussion, but it was important to continue to hear from patients.

It was recognised that the lack of capacity in some areas of the workforce added to the already significant and challenging workloads of staff.

The meeting, with a lunch break did not feel rushed and each item was afforded the appropriate time allowing for effective discussion.

22/24 ANY OTHER BUSINESS

The Chair of the Committee, recognising this was Paul Hollard's last meeting thanked him for his support and valued contribution over the past several years.

Paul Hollard thanked the Chair adding that he had seen over the years how the Quest Committee had grown positively and improved.

Date of Next meeting: 7 May 2024

Meeting concluded at 14:30

ACTION LOG - UPDATE
QUEST COMMITTEE

Date+B1:H62	Agenda Item	Action Note	Responsible	Due Date	Progress/Comment	Status
31 October 2023	Operations Update	Update on the EMS CSD reconfiguration following the outcome of the new Demand and capacity review currently underway. The EMSC reconfiguration (connected to the 2019 D&C) has been delayed due to the pandemic, it is now restarted using data from the new review, that is now live. Further information was sought on the EMSC boundaries and what desks are working in each boundary. Suggested that QuEST receive a copy of the entire review once complete (which is the Trust's strategic response to patient safety and will include CSD). It's a key document (inc. slides and a summary). Final draft is expected in January 2024 and suggest inclusion in February 24 meeting.	Rachel Marsh Hugh Bennett	1 May 2024	Update for 8 February 2024 Details contained in the Ops update report: The current IMTP (legacy) deliverable of reconfiguring EMSC has now been replaced by a proposal for a revised leadership structure, which will also incorporate the original single allocator model and dispatch boundaries recommendations. Initial work was carried out to progress the boundaries recommendation in early 2023 and it became clear that Project Board were keen to refresh the data to ensure that the original (2017) paper and therefore data remained valid in the current context. As a result, further modelling was carried out by ORH in September 2023 that considered more recent and up to date data (Sept 2022 to May 2023). The revised D&C recommendations (Sept 2023) were considered as part of the wider EMS Coordination Reconfiguration Project and an initial paper has set out a proposed structure that will provide a leadership structure that is fit for purpose but will also address the two outstanding recommendations from the original ORH Report in 2017. The final paper, once ready, will be submitted to colleagues and will be shared with Trade Union partners and all elements will feature as part of the Organisational Change Process (OCP). 08022024: The Committee noted that an update would be received within the Operations report, however the summary document is not yet available. Action to remain open until document made available to the Committee.	Open
8 February 2024	Putting Things Right Report	That future PTR reports include presentation of the data from a population point of view per Health Board area, as opposed to simply by Health Board - to put the numbers in context across Health Board. This will be considered by the PTR Team for future reporting.	Liam Williams	1 May 2024	Update for 7 May 2024 A meeting has taken place with the NHS Wales Executive Digital Team to discuss the metrics used in the national Beacon Dashboard (Quality Measures) which is under development. The Beacon Dashboard now reports NRI data in this format. Information in respect of WAST NRIs will be included from a population perspective in the Quarter 4 Putting Things Right Report. Support from Health Informatics will be sourced when feasible to incorporate this approach in all relevant PTR measures, ensuring this aligns to the data sources used nationally. This has been added to the PTR Recovery Plan to include as part of the requests for live BI dashboards drawing from Datix Cymru and Trust systems. Currently the PTR are pulling a significant amount of core data manually which is extremely time consuming.	Open
8 February 2024	MIQPR	On the content regarding the number of patients where ambulances were cancelled or where it was not possible to provide a response, it was queried whether the placement of this under 'Partnership & System Contribution' was correct. This will be fed back to Hugh Bennett; Andy Swinburn will support as required. For consideration for future reporting.	Mark Thomas, Hugh Bennett (Rachel Marsh)	1 May 2024	Update for 7 May 2024	Open
8 February 2024	Quality Strategy Implementation Update	The Committee asked that a timeline/timetable of how the revised Quality Strategy would be delivered be provided to the Committee.	Liam Williams	1 May 2024	Update for 7 May 2024 An high level outline plan has been developed, with intention to share the proposal with Committee members by June 2024	Open
8 February 2024	Healthcare Inspectorate Wales Annual Report 22-23	The Chair advised there had been an increase in the number of safeguarding alerts raised, whilst the report states a significant drop, Liam Williams explained that some of the alerts are coded to the Health Boards and were picked up at Local Authority level. Liam Williams agreed to clarify this point.	Liam Williams	1 May 2024	Update for 7 May 2024	Open

QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE
HIGHLIGHT REPORT TO BOARD

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

Trust Board Meeting Date	28 March 2024
Committee Meeting Date	8 February 2024
Chair	Bethan Evans

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. Lost hours due to handover delays were just under 27,000 hours in January and far in excess of what is acceptable. System pressures **continue to present patient safety risks and extended waits in the community.** The experience of Alison Cassidy in the patient story was a stark illustration of this. Themes from patient safety incidents continue to be timeliness to respond and handover of care delays, with 1,880 patients receiving a response or wait of over 12 hours in Quarter 3, with one patient waiting 45 hours. 231 of those waiting over 12 hours were for falls and the Committee heard of further work underway to look at clinical solutions and risk mitigations for this group of patients and engagement with care homes.

   The ways in which the Trust is continually working with partners to influence system change ran through the agenda and the Trust Board will receive an update to the paper on the system actions to mitigate avoidable harm at its March meeting. Whilst risks 223 and 224 have not changed their risk rating, the Committee was assured that they are regularly reviewed, monitored, and updated to introduce mitigations wherever possible.

   Members continue to challenge on any further actions that can be put in place by the Trust and its influence on system partner actions and raise the Trust's ongoing concerns in their respective forums.

2. The Committee raised an alert following their April meeting as to effect of the backlog and volume of concerns on the **Putting Things Right and Operational Quality teams**. The volume and breadth of issues ranging from concerns, national reportable incidents, joint investigations, policy and Coroner requests that the teams deal with remains substantial as set out in the assure section. Performance is concerning; however members were assured that good progress is being made on the appointment to key roles to drive and embed the improvement plan. The Committee will continue to monitor this until the teams are up to full establishment. Members also raised concerns over other teams where resourcing for important compliance and specialist functions is limited, and

discussed mitigations.

3. The **Chair's Action** taken between meetings to approve the Infection Prevention and Control Policy was ratified.

4. Excellent focus on **Clinical Indicators** with the deep dive on Stroke, the HIW Stroke Pathways Report and Clinical Audit Plan.

ADVISE

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

5. **Alison Cassidy** recounted the experience of her daughter Emma, who has a rare genetic disorder, severe learning disabilities and epilepsy. She needed urgent dental care requiring general anesthetic at Glan Clwyd Hospital and was advised by Health Care Professionals in the Health Board to access the Non-Emergency Patient Transport Service (NEPTS) to take Emma to her appointment (she was unable to be transported safely due to seizure risk being elevated by the dental pain). NEPTS advised that at least 24 hours' notice was needed, and Alison was advised to ring 999 however due to system pressures at that time a 999 response was unavailable. After 28 hours Emma was sedated by LD Liaison nurses in the garden at her home, supervised by two North Wales Police officers who arranged a taxi to take Emma with her siblings to hospital.

   During Emma's escalating distress she began exhibiting self-harming behaviour, and as such the call to 999 triggered an "attempted suicide" script from clinical contact center call-taker. Alison could not say that Emma was going to deliberately kill herself, but she may have taken a deliberate action but not mean to kill herself. Alison felt that the MPDS script does not effectively assess people with severe learning disabilities. Liam Williams noted that ordinarily the clinical support desk would review the calls and be able to intervene, however the service was under considerable demand pressure at the time of the call.

   Members heard that Emma and her family's experience would be shown at the Betsi Cadwaladr University Health Board (BCUHB) Organisational Learning Forum and that actions to try and avoid this occurring again will be agreed in partnership with BCUHB including information on ordering and availability of vehicles. Mitigations discussed included the flagging on the record of complex cases coming through 999 not only for the address but also for the individual.

   Members expressed their thanks to Alison for sharing her experience. The next steps, lessons learned, and mitigations will remain on the substantive agenda for forthcoming meetings so that the Committee is able to monitor resolutions.

6. The Committee received the **Quarter 2 Operational Update**, and the continued positive progress on the Manchester Arena Inquiry actions was noted, as was the focus and improvements on 111 and NEPTS calls being answered in Welsh.

7. The Committee reviewed progress on implementation of the **Quality Strategy**. The Board will recall that the strategy covers quality culture/duty of candour; quality management system; and integrating

the citizen's voice. Whilst it was recognised that there were some areas where progress has been slower, a tremendous amount of work was acknowledged, and the newly appointed Quality Leads are central to taking this forward. The planning and engagement for a new Quality Plan will be developed during 2024/25 with the 2023/24 Quality Report informing some of this.

8. The **Healthcare Inspectorate Wales (HIW) Annual Report 2022-23** was reviewed and is attached at Annex 1. The Committee noted that the issues raised, including system pressures and safeguarding, are frequent areas of discussion and oversight at QUEST.

9. The **Data Protection Policy was approved**. This policy aligns to the requirements of the Data Protection Act 2018 and the UK General Data Protection Regulations. These cover the handling, security and confidentiality of personal information.

10. This was the last meeting for **Paul Hollard** whose tenure as a Non-Executive Director comes to an end on 31st March. Paul was thanked by the chair for his contribution to Quest where he consistently champions matters of patient safety, patient experience and quality. Paul commented that the Committee is valued for raising and discussing difficult issues with a focus on outcomes for patients.

11. Members' **reflections** on the meeting included that more time and a lunch break meant the meeting did not feel rushed; the patient story provoked both challenging and constructive discussion and it is important to continue to hear these and to allow time to do so.

ASSURE

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

12. The **2023 Medicines Management Assurance Report** was reviewed by the Committee. This is the first report of its kind and content on future reports was discussed. Assurance was taken on this report, and it was good to see that the previous internal audit on medicines management was a good lever for change.

13. The Committee received assurance by way of the **Monthly Integrated Performance Report** (MIQPR) for December 2023 and the **Quarter 3 Putting Things Right (PTR) Report**. The organisational learning from clinical reviews was set out in the latter report. The Trust Board will note the escalation in the alert section regarding continued system pressures. The Committee noted that as follows:

- 111 Calls answered within 60 seconds increased in January to 63%.
- 111 Abandonment rates decreased in January to 4.4%.
- Red 8-minute response times remained stable in January at 48.8%, even though demand decreased compared with December. The actual number of red 8-minute responses improved year-on-year, as they averaged 2,115 a month in 2023 compared with 1,921 a month in 2022.
- Return of Spontaneous Circulation (ROSC) rates dropped after achieving over 22% in 3 of the past 4 months.
- In the quarter the Trust received one (joint) Regulation 28 Report from a Coroner in South Wales Central and related to the causal significance, if any, of a delay of thirteen hours in the provision of an ambulance. The report was also sent to the Cardiff and Vale University Health Board and the

Minister for Health and Social Services. The Trust is engaging with the Coroner on the initiatives it has in place and will continue to do so.

- 1,212 patient safety incidents were reported in Q3 with themes continuing to be timeliness to respond and handover of care delays. Whilst lower than the same time period in the previous 12 months, they remain extreme.
- There continues to be a number of overdue National Reportable Incidents investigations, with capacity the main reason and this is a focus at the Clinical Quality Governance Group and Senior Operations Team.
- With respect to concerns, 253 were received in Q3 with the five-day acknowledgement performance over the October to December period at 71%, 99% and 100% (100% target) which was a rise from the last quarter. The 30-day target achieved 21%, 38% and 58% respectively (75% target) which overall was a reduction from the previous quarter. The overwhelming themes and trends through the majority of concerns remains timeliness to responding to calls in the community. Themes related to Ambulance Care include those related to cancellation of transport.
- A continuing number of incidents are being reviewed at the Serious Case Incident Forum (SCIF) and Joint Investigations passed to Health Boards. General themes received from Health Boards following joint investigations are over-crowded emergency departments and wider system pressures resulting in hospitals being in very high levels of escalation.
- 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.
- The Public Service Ombudsman responses are positive and of those that go on to and investigation the majority are upheld.

14. Organisational learning and improvement actions were reviewed as part of the PTR report and are drawn from a range of areas including clinical reviews and Welsh Risk Pool Learning from Events reports. These inform MIST training, discretionary training, and changes in clinical ways of working. The **Welsh Risk Pool Concerns Assessment** was also received and themes such as the PTR capacity and Datix Cymru were discussed.

15. During this meeting, the Committee focused on the **clinical indicator of Stroke.** Further progress has been made with improving the Clinical Indicator dashboard which now includes the time-based metric for stroke; 'call to scene', 'time on scene' and 'call to hospital door'. These are now reported on as part of the Ambulance Service Indicators to the Emergency Ambulance Services Committee. Electronic Patient Clinical Record (ePCR) user interface changes recommended from the stroke clinical audit were included in the updates implemented during December 2023. These are aimed at improving the usability for clinicians to input data and to improve compliance.

    The importance of pre-alert reporting was emphasised, particularly given the changes to stroke call timing for specific therapies from five to twelve hours. A deep dive into the call to door metrics and pre-alerts will be included in the 2024/25 clinical audit plan and returned to the Committee. This was a clear presentation with improvement plans to include further engagement and support from Senior Paramedics. Excellent engagement was noted with the Stroke Network. The **HIW Review of Stroke Pathway report** was also provided, and the Committee was assured on the actions being taken by WAST in response to that report which they will monitor via the Audit Tracker.

16. The **Clinical Audit Plan update for Q3** was received with no escalations. Audits completed in quarter include:

    - ePCR clinical data assurance – end tidal carbon dioxide ($EtCO_2$) Compliance
    - Non-conveyance form images in ePCR
    - Recognition of Life Extinct (ROLE) form images in ePCR
    - Levetiracetam (Keppra) Potential use in convulsions

17. The 2024**/25 (Q1) Clinical Audit Plan** was also agreed. The Board will note that it is not always possible to predict at the start of a financial year all of the topics that will require evaluation and therefore flexibility in setting a clinical audit plan was agreed, resulting in the annual plan being a dynamic document, updated quarterly.

18. The Committee was presented with the **Information Security and Information Governance Key Performance Indicators (KPIs)** and noted:

    - Information Governance training compliance is at <72% which is an increase but remains below the 75% minimum expectation, which will rise to 85% for 2024/25.
    - Despite steady progress there are a large number of Data Protection Impact Assessments for review
    - Despite a significant increase in requests for records compliance rates are increasing due to individual support and improved processes.
    - Compliance with the Freedom of Information Act remains challenging, recording rates of 47.1% in November against a target of 90%. A review of process including digital support is underway.

    Members recognised the work being done by small teams which is raised in the alert section. The reasonable assurance **Records Management Internal Audit** reflected this in that some of the actions have longer lead times to ensure they are closed off appropriately.

19. An update was received on a revised **Audit tracker** with 12% of QUEST related management actions closed in the quarter and a number of historical actions revisited to open up discussions on potential revisions of management actions due to the passage of time.

20. The Committee's **annual effectiveness review** was conducted and the draft annual report and changes to terms of reference agreed. Priorities for 2024/25 were also agreed. Final reports will be presented to the Board in May 2024.

21. The Committee's **priorities for 2023/24** (implementation of the quality strategy, and the duty of quality and duty of candour) are progressing well. The Committee also reviewed its progress against its cycle of business and other than the QUEST related elements of the Integrated Medium Term Plan 2024-27 all is on track. It was agreed that the appropriateness of this coming to this Committee and the People and Culture Committee due to timing would be reviewed in the cycle for 2024/25.

RISKS

Risks Discussed: There are two corporate risks assigned to the Committee which are rated as high risks with no changes to scores since the last review. **Risk 223:** the Trust's inability to reach patients in the

community causing patient harm and death and **risk 224:** significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service are both rated at 25. Both have been reviewed in accordance with their schedules and the scores remain static. The theme of these risks arose throughout the agenda items discussed at this meeting and are part of the escalation section of this report.

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

New Risks Identified: Risks with respect to information governance and information security are being developed. These include Data Protection, records services and freedom of information requests.

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

COMMITTEE AGENDA FOR MEETING		
Operations Directorate Quarterly Report for Q3	Patient story	Putting Things Right Report Q3
Monthly Integrated Quality and Performance Report	IMTP QUEST elements	Quality Strategy Implementation
Spotlight on clinical indictors: Stroke	HIW National Review of Patient Flow (a journey through stroke the pathway) HIW Annual Report	Clinical Audit
Medicines Management Assurance Report 2023	Committee Annual Effectiveness Review	Risk Management and Board Assurance Framework Report
Policies for approval	Audit tracker and audit reports (Records Management audit)	Information Governance Report
Welsh Risk Pool Concerns Assessment		

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

Andy Swinburn in meeting between 11am and 1pm

	Attended
	Deputy attended

	Apologies received
	No longer member

OPERATIONS DIRECTORATE
QUARTERLY REPORT FOR COMMITTEES
2023-24 Q3 (Jan – March 2024)

National Operations & Support

Manchester Arena Inquiry (MAI)

Progress on the MAI workstream continues toward completion of the outcome. The Chairman of the Inquiry has set out that each organisation including all ambulance Trusts should review their capacity to respond to a mass casualty incident, make recommendations to their NHS commissioners relating to additional resources and that commissioners must then give urgent and close consideration to these recommendations. Having undertaken a series of workshops and evidence gathering exercises, including data modelling, three reports will be produced which will detail:

- Our Capability to Prepare
- Our Capability to Respond
- Capability of Specialist Assets

These three reports will recommend what additional resources are required to effectively plan and respond to a mass casualty incident in Wales. This will form a financial submission which will then work through the governance route between May and July 2024. This will include Operations Senior Leadership Team, the Executive, Board Development, Finance and Performance Committee and finally Trust Board. All of these will be held in closed sessions. To aid familiarisation for trade unions partners prior to Board Development and Committee meetings, colleagues will be invited to attend the Operations Senior Leader Team consideration of papers.

Welsh Government and EASC have been briefed during the process and are set to receive the final submission on completion of the internal governance route.

Community Welfare Responders (CWR)

There are currently 8 active teams of CWRs across Wales, operating as part of the Connected Support Cymru (CSC) initiative. We held our first CWR onboarding event in February with a number of volunteers invited to attend the recruitment courses in February and March in Cardiff and Swansea respectively.

January saw the first webinar for CSC reaching out to stakeholders for recruiting partner organisations. This was well attended, and a list of over 180 expressions of interest has been collated

with some of these volunteers offered places on the Cardiff and Swansea training courses. The initial phase of CSC will focus on growing numbers of CWR responders. Support Officers are also supporting the awareness courses for the role out of LUSCII technology in care homes across North Wales.

NHSCT Grant Award

Following the funding from NHSCT in June 2023, the Volunteering team was able to recruit Support Officer posts to support the on-boarding and operational support for CWR responders. These posts were recruited to in January 2024 and will undertake stakeholder engagement as well as being involved in LUSCII projects in Care homes. As part of the NHSCT bid, observation kits for volunteers have been funded to enable this new role to become operational.

Resourcing, EMS Coordination and Quality

Accredited Centre of Excellence (ACE) status with the International Academies of Emergency Dispatch (IAED)

The Trust has fallen below the standard for centre of excellence accreditation set by the IAED for the last reporting period (quarter). This is because the non-compliance of random 999 call audits finalised at 8.7% for the quarter which is above the 7% threshold set by the IAED. Broken down by month between January and March 2024, this equated to 7%, 10% and 9% non-compliance respectively. An analysis of the issues impacting compliance, and an accompanying action plan has been developed between Operations Quality and EMS Coordination, and this is being considered at Senior Operations Team (SOT) on 23 April 2024 before formal escalation to Senior Leadership Team (SLT). Colleagues should further anticipate these outputs also being shared within our quality meeting structures. The Operations Quality department has been working closely with the IAED to identify the issues and develop actions to make improvements. Following approval, the action log will be submitted to the IAED as part of the requirement set by the IAED Remediation & Revocation Policy. The process allows the Trust 3 months to return to compliance and a further 3 months if not achieved within the first 3 months.

HM Coroners

EMS Coordination/Operations Quality received an influx of coroner request during Q4 which has resulted in an increased backlog of statements. Capacity within Operations Quality (OQ) has been realigned where possible to support with the construction of statements and a robust QA process is in place to ensure that accurate statements can be reviewed and signed by the Service Managers/Head of Service for serving to HMC. Whilst 9 of the outstanding 30 coroner statements have breached the requested return date, these are all at some point in the QA process. All other outstanding statements are not yet due, and the OQ team is completing these alongside other investigations (concerns and nationally reportable incidents (NRIs) etc.).

Resource - Relief Planning Pilot

During Q4, relief planning pilot progressed to a 5 week notice period for shift allocation across all areas of operations. The group have met to review the impact and are pleased to report that annual leave compliance in line with resourcing policy has improved in comparison to the same position last year. To further support the pilot and staff it was agreed that the remaining staff would be afforded an extended deadline of last week in April to increase compliance or discuss mitigating circumstances with line manager. The agreement in partnership is to commence allocating leave to the remaining non-compliant staff by resourcing prior to publication of rosters which will align with the next phase of the pilot during Q1 to provide a 6 week notice period for shift allocation.

MIST Booking contractual hours (CPD) monitoring.

During Q4, the MIST booking process has been reviewed in collaboration with Education and Development, EMS and Ambulance Care. The process now incorporates Resourcing approving bookings to ensure compliance with working time regulations and resourcing policy as well as capturing MIST hours contribution to contractual hours monitoring (CPD hours). Further work is ongoing to expand the process to capture the remaining CPD hours afforded to EMS and ACA2 colleagues.

Work Management Portal

Workflow/Request system (Work Management Portal) is in early stages of development utilising O365 as a platform. Once development and testing is complete in Q1/2, this will introduce a centralised web based work request system that will enable staff and management to track progress on resourcing work/information requests (replace emails). It will also provide insight, data, and intelligence on resourcing departmental demand to identify areas for both system and service improvement, automation, and quality. It will promote the Resourcing brand as one team servicing four operational functions and will be a move forward in providing resilience and equity of service across the functions.

Estates

Plans for Estate work in Llangunnor were signed off in March 2024 with a view to complete the estates strategy in Q2 of 24/25. The estates plan in the North was also signed off in March 2024 with a delivery quarter of Q3 following the feedback from capital management colleagues. We do however stay alert to lesser contractor availability in North Wales which we understand could impact the timeline.

Call Handler Recruitment

As part of the recruitment process, a total number of 29 staff members were recruited in January 2024 with a plan to further recruit in Q2 24/25. This additional capacity within EMSC has resulted in capacity being over established in our EMD function rectifying the position previously reported.

Culture

Culture initiatives including regular drop-in sessions for staff are now regularly offered. The engagement with staff offers the opportunity to engage with Service Managers and Head of Service directly with the intention of promoting a positive culture within the CCC and EMS Coordination.

Demand and Capacity

The restructure of the EMSC leadership was agreed in principle at ELT in January 2024. The restructure will bring EMSC in line with other Directorates within Operations. The new leadership model will also support the delivery of the demand and capacity recommendations from ORH. The recommendations include a Single Allocator Model, Boundary changes and Roster review for the DCM's and Dispatcher teams. The OCP is expected to commence in Q1 and it is exciting to see, for the first time in WAST, the potential for a management and support structure with role opportunities at all levels offering a career pathway within EMSC.

Operations Quality OCP

The Operations Quality (OQ) OCP has concluded, and final job evaluations and recruitment have begun. Interviews have been scheduled for the Locality Manager, OQ post which will have some of the coroner responsibility for the department/directorate alongside the Service Manager, OQ. The Support Officer and third Learning & Development Coordinator posts are awaiting approval on Trac, and the Quality Improvement Manager and Quality Audit Manager posts are awaiting job evaluation. It is anticipated that once these posts are in place, the department will have the capacity to push forward with the required SOP reviews.

Emergency Medical Service

Challenges

Lost Hours to Handover

Delayed transfer of care at Emergency Departments across Wales remains a significant challenge in being able to provide a safe level of emergency service with timely response to calls. The total amount of lost hours in January 2024 were 26,985, February 2024 at 23,896 and March 2024 at 23,403. The impacts of these delays and associated system pressures are regularly discussed at Committee and Trust Board.

Red and Amber Performance

As we notice a continued very poor position in transfer of care delays, this is ultimately being translated into a deteriorating Red performance and delayed response to our most critical patients. On the whole, the Red performance continues to fall well short of 65% in all Health Board areas. This is under constant scrutiny within the EMS Response and EMS Coordination teams to improve the level of response in this area.

The Amber median trend has remained relatively constant; however, recent deterioration has been evident. A reduction in handover delays would support our response to these patients and prevent escalating through the Clinical safety Plan (CSP) with further response implications to this category of patients, especially amber 2 patients.

General Update

Quality & Support Days

These days have proven invaluable in supporting operational staff in the promotion of key indicators and expectations relating to many elements of quality behaviour within Trust premises, on ambulance vehicles, and relating to the member of staff personally.

The subject areas covered include seat belt and safety harness use, Dress Code Policy, IP&C, and cultural awareness. These days are supported by all grades of operational manager/leader and further promote visibility to staff.

An MS Form is completed for each interaction with an operational crew or station visit during the support day which serves to provide assurance of compliance against the requirements.

Three Q&S days have been held so far, with all aspects of the Operations leadership teams involved. Themes and trends are to be collated and fed back through the senior leadership team.

End of Shift Overruns

While it is noted that the level of investigation of over 2 hour end of shift overruns have improved, along with the uptake of utilising the options available to reduce the end of shift overrun, work progresses on a number of initiatives to further reduce end of shift overruns to support the wellbeing of staff. Despite rising handover delays in recent months, the average length of overrun has remained a levels lower than 12-15 months ago.

Financial Savings Plan 2024/25 Overtime Allocation

The 2023/24 FSP concluded successfully with original savings assumptions mainly achieved and overtime allocation following suit. The new savings requirements have been announced for the 2024/25 period with similar savings assumptions modelling almost complete. To support the routine day-to-day overtime allocation an 'Overtime Allocation SOP' has been approved and currently in use to support this now business-as-usual process.

Ambulance Care

IMTP

UCS Transformation Plan

An action plan was implemented in March 2024 to oversee delivery, numbers, and the development of rosters for consultation and work was completed to develop a new code set for Urgent Care Service. Communications were completed and issued alongside engagement sessions. The recommendations will be presented to ELT in April 2024.

General Update

Recruitment

The Ambulance Care OCP which commenced in 2023 has recently seen all the positions recruited into. This will allow Ambulance Care to now progress with the service improvements the new structure was designed to achieve.

CMP (Capacity Management Plan)

An updated Capacity Management Plan has recently been approved by the Executive (following engagement with commissioners) enabling greater capability to manage the thousands of patient journey requests. Go live is scheduled for May 2024.

Integrated Care - CSD

Challenges

Integration of Systems

The integration of the telephony system within CSD involved various complexities, including ensuring smooth integration with existing systems, providing adequate training to staff, adjusting operational procedures, and ensuring accuracy in reporting. These challenges likely arose due to the intricacies involved in transitioning to a new system while maintaining uninterrupted service and data accuracy. Despite the overall challenges faced by the service, additional BI reporting has given additional metrics to support intelligence and reporting.

Capacity and Leadership support

Sufficient leadership support for operational activities has posed some challenges due to a high volume of staff on sickness absence and/or those on supported return to the workplace. To bridge this gap and to offer members of the wider team an opportunity for professional growth we have implemented an Operation Manager development programme which has been well received.

Inbound Contact Centre Concept

Traditionally focused on outbound calling, the solidification of an inbound contact centre concept in CSD has grown significantly in this quarter. CSDs Remote Clinical Support for Newly Qualified Paramedic crews, Community Responders, as well as the pilot to support Police colleagues potentially facing long waits on scene has taken considerable reorganisation of "on duty" activity. Focus on managing call answering in a timely manner has led to the creation of a specialist desk to deal with this inbound work. However, this has taken core staff away from the traditional role of Consult and Close and with other roles such as Screening and Enhanced Screening in escalation alongside the commitment to 24/7 Red Review provision has meant that our ability to significantly improve on our Consult and Close percentage has been challenged.

IMTP

Consult and Close

The Consult and Close rate rose in the quarter but did not exceed 14.3%. Work continues with staff and teams to focus on activity levels to improve triage rates. Work continues on the use of ECNS to reduce triage durations. The service is also committed to offering the provision of a 24/7 Red Review and Remote Clinical Screening during high levels of escalation.

ECNS

The process to improve clinical outcomes in ECNS is in place with auditors and practice educators to identify and support those whose outcomes/conversions are comparatively lower. Guidance was released in Q4 to improve the efficiency of the ECNS triage process to optimise time taken per triage.

General Update

PTAS

A video was completed in collaboration with ABUHB and CVUHB health boards to increase the use of PTAS to consult and close. As part of the strategy to move away from a local SOP to a guidance document used by Health Boards, The SOP has been removed with a view to be updated and circulated as a Guidance document to disseminate.

Integrated Care – NHS 111 Wales

Challenges

Demand Levels & Operational Productivity

NHS 111 Wales call demand in Q4 was 10% up on Q3. Recent weeks have continued to see higher demand than we saw for much of December. This level of demand is 14.6% above the level the service is resourced to answer.

Through Q4 we have seen 9-10% of our staff abstracted consistently for CAS replacement training. Despite those abstractions we answered 9% more calls in Q4 than we did in Q3. The increase in calls answered despite higher abstractions can be attributed to the use of agency call handling resources and the introduction of virtual queuing. The level of calls answered in Q4 was 5.6% above funded levels.

Workforce capacity

Recruitment was curtailed during the SALUS implementation period and again during the CAS replacement project. Consequently 111 is under established and this is impacting operational production. Plans are in place to return to full establishment through Q1 and Q2.

IMTP

Dental Services Transformation

The funded operating model for four health boards has been built and is confirmed following work with Health Boards, Six Goals Programme and the Chief Dental Officer for Wales. This model will be going live on the 30th April 2024 along with the replacement CAS. Unfunded activity for the remaining health boards has now been ended following a phased and agreed roll back of those services.. The development of "Once for Wales" options in the unfunded areas continues with Health Boards and the Six Goals Team. This work is included as part of the Operations Transformation work outlined in the 24-27 IMTP.

Increased Available Pathways

A pathway to enable WAST 111 staff to pass calls to 111 Press 2 teams was will go live as part of the rollout of the new CAS system at the end of April 2024.

A trial of direct booking from 111 to Urgent Primary Care Centres in two Health Boards commenced in this quarter. Referral volumes have been lower than expected however this has been predominantly attributed to a very narrow inclusion criteria. In the next quarter we will work with HBs and other stakeholders to broaden the criteria.

General Update

CAS Replacement Project

Significant focus and effort has been focussed on the replacement CAS solution. The solution remains on track for go live on the 30th of April 2024.

Considerable activity has taken place across Operations, Digital and QSPE Directorates to ready the technical infrastructure, train our people and re-design every process within 111.

Patient story Tracker
Alison Cassidy – Part

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

Themes identified

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

goal

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

Primary drivers

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

secondary

Local Learning:

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

actions

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

RESPONSIBILITY FOR ACTIONS

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

progress

- Change request submitted to make improvements to EPCR to record; patients having additional needs and a prompt to record reasonable adjustments that are made on scene.
- Funding application submitted to RCN Wales for creation of a video to train staff on best practice during observations and inform patients.
- Continued promotion of the Paul Ridd online training and WAST LD module through Siren and Yammer.

outcome

- Protype solution in development, funded by Improvement Cymru LD Team, who are also collaborating to explore funding opportunities to make improvements for LD on telephony systems.
- 67.8% of staff have completed the mandatory and statutory Paul Ridd LD training
- The LD module on WAST's OnClick page has been completed by over 642 participants and compliments the mandatory Paul Ridd foundation training on ESR.

Story action timeline

Date of incident	Start of PTR process	Investigation outcome letter sent	PTR/CHC meeting with Alison	CHC request to record story	Video recorded	Story played to QMG	Story played shared with BCUHB	Story shared with QUEST Committee	Story shared with Quality management Group	Story shared with LLFG
August 2021	September 2021	December 2021	October 2022	April 2023	July 2023	October 2023	October 2023	February 2024	February 2024	March 2024

Updated
22 March 2024
v5

Patient story Tracker
Alison Cassidy – Part

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

Following presentation to QUEST Committee and subsequent Quality management Group a possible adverse impact upon individuals with a protected characteristic has been identified

goal	Primary drivers	secondary	actions	RESPONSIBILITY FOR ACTIONS	progress	outcome
• Demonstrate due regard and consideration to individuals with protected characteristics and any actual or potential negative impact is acknowledged, eliminated, or minimised.	• Equality Act • Public Sector Duties • Health Board/WAST – ensuring individual patients has equitable access to services	• 999 environment challenging – timeliness in responding • Patient Experiences • Patient Outcomes	• Undertake further review/discussion to ensure opportunities for promoting equality and human rights for people with protected characteristics is recorded. • Continue engagement with BCUHB to action identified learning • Undertake an options appraisal with view to improving ability to flag records that patients have additional needs (LD, autistic and neurodiverse) on telephony systems and patient records/addresses.	• Quality Assurance, Operations, PECI teams • PECI and BCUHB Patient Experience team. • PECI team	• Option appraisal identified short and longer-term potential options, with support from Improvement Cymru worked is earmarked for 3rd quarter of 2024.	

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

PUTTING THINGS RIGHT REPORT
QUARTER 4, JANUARY - MARCH 2024

MEETING	Quality, Patient Experience & Safety Committee
DATE	7 May 2024
EXECUTIVE	Liam Williams, Executive Director of Quality & Nursing
AUTHOR	Jane Palin, Assistant Director (interim)
CONTACT	Jane.Palin@wales.nhs.uk

EXECUTIVE SUMMARY

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

In summary the Report for Quarter 4 2023/24 highlights:

- Continued high level of risk of harm to our patients in community (Corporate Risk 223 rated 25) and patients delayed outside of Emergency Departments (Corporate Risk 224 rated 25)
- A sustained increase in the number of concerns received
- A continuing high volume of incidents being reviewed at the Serious Case Incident Forum (SCIF)
- A continuing number of serious incidents shared with Health Boards colleagues to investigate under the Joint Investigation Framework
- A rising trend in the number of Nationally Reportable Incidents (NRIs) identified
- Incidents identified as notifiable under the Duty of Candour Regulations
- A continued upward trend in Coroner's requests for information
- The Trust received three Prevention of Future Deaths Regulation 28 Reports
- A PTR Recovery Plan has been developed to move to a sustained improvement position in our responses to patients and families

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

KEY ISSUES/IMPLICATIONS

(i) There continues to be an increase in activity in the majority of areas across PTR.
(ii) There continues to be a high-level volume of concerns being received.
(iii) Our five-day compliance remains below the 100% Welsh Government target.
(iv) Our thirty-day compliance remains below the 75% Welsh Government target.

REPORT APPROVAL ROUTE	
Clinical and Quality Governance Group	30 April 2024
Quality, Patient Experience & Safety Committee	7 May 2024

REPORT APPENDICES
ANNEX 1 SBAR Report

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

ANNEX 1

SITUATION

1. This Putting Things Right (PTR) Report covers the period from 1 January to 31 March 2024. Table 1 and the 'PTR Overview' overleaf provide a 'at a glance brief' of comparison data quarter on quarter and over on a twelve-month rolling period across each of the functions.

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

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

3. Please note that the data contained within this report is accurate at the time of reporting. Data may be subject to change following the investigation process including regrading of incidents.

BACKGROUND

4. The PTR Team Organisational Change Process to provide additional leadership and capacity across the functions has completed and recruitment to vacant positions continues.

5. It is anticipated that the structure will be fully established by July 2024 with the Deputy Head of Patient Safety due to start in June 2024. The Deputy Patient Safety Manager and administrative support post in Legal Services are currently out for recruitment; these vacancies have occurred due to internal promotions.

6. The ambition in future reports is to move to Aggregated Thematic Reviews, in order to determine patterns and trends corporately and at service and Health Board levels when data from Datix Cymru can be extracted into Trust systems to create live dashboards.

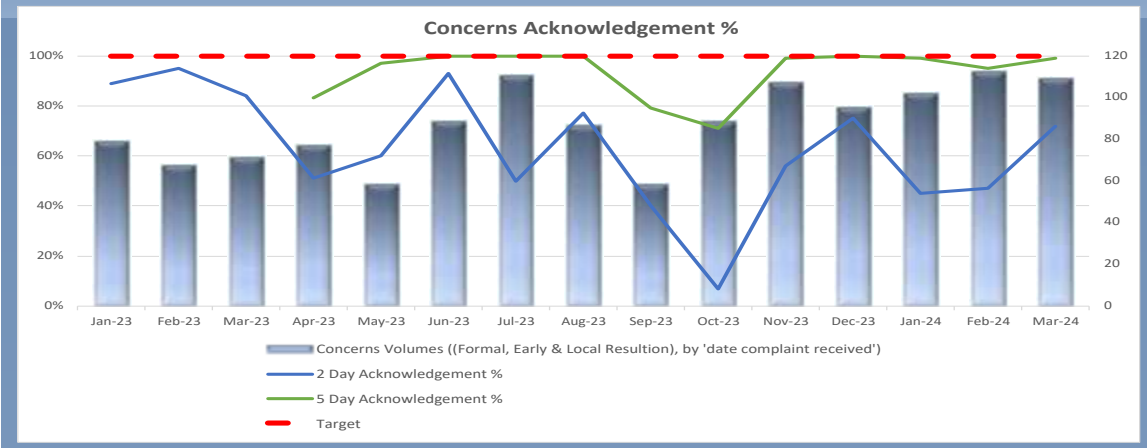
ASSESSMENT

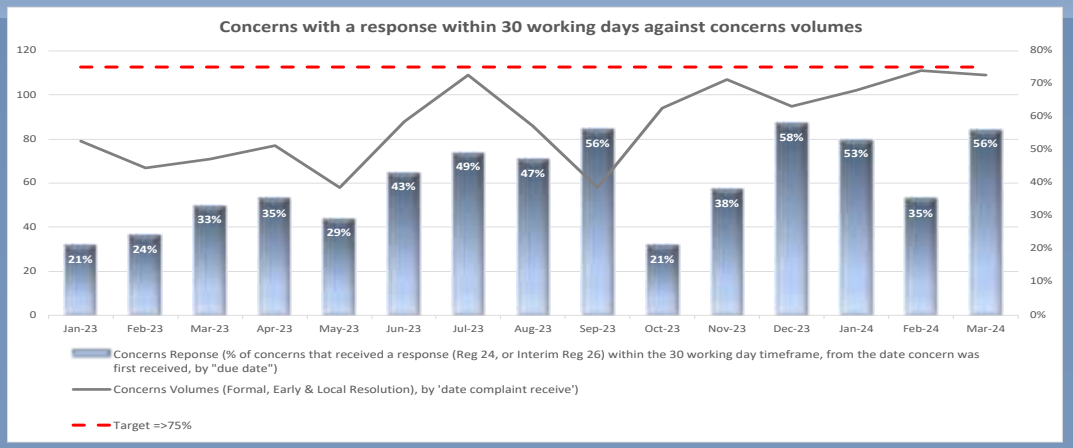
Table 1

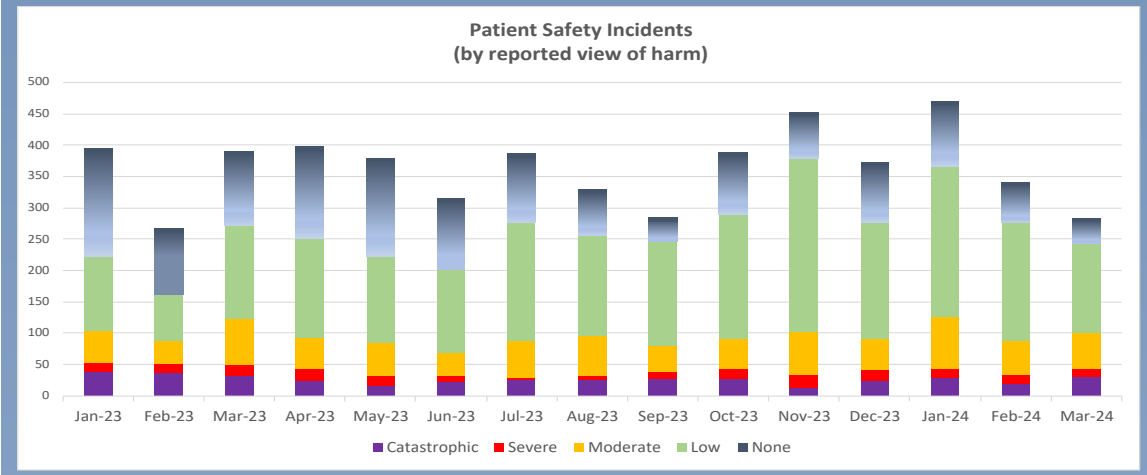
PUTTING THINGS RIGHT						
Comparison of Data Quarter / Year	Quarter 4, 2022 - 2023			Quarter 4, 2023 - 2024		
	January 2023	February 2023	March 2023	January 2024	February 2024	March 2024
Patient Safety Incidents (Reporters view of harm)						
Catastrophic	40	37	33	29	19	31
Severe	12	14	17	14	16	11
Moderate	52	38	74	83	54	58
Low	119	74	147	240	187	143
None	171	103	119	105	64	40
Total	394	266	390	471	340	283
Concerns						
Total Received	79	67	71	102	111	109
Political Concerns	10	7	2	3	4	7
2 Day Acknowledgement %	89%	95%	84%	45%	47%	72%
5 Day Acknowledgement %	-	-	-	99%	95%	99%
30 Day Response due %	21%	24%	33%	53%	35%	56%
Ombudsman						
Cases Received	8	1	5	3	1	3
Cases Closed	4	2	7	0	4	4
Reports Received	0	0	1	2	0	0
Coroners						
Information Requests	152	157	163	225	241	250
Identified as Interested Party	28	30	33	43	49	42
Staff Attending	6	5	8	5	5	8
Regulation 28 Issued	1	1	0	0	1	1
Response to Regulation 28 outside 56 working days	0	0	0	0	0	0
Nationally Reportable Incidents (NRIs) to NHS Wales Executive Reporting Date						
Serious Case Incident Forums held	8	6	7	5	7	5
Serious Case Incident Forums Cases	68	51	40	31	35	34
WAST NRI's reportable to NHS WE	5	12	14	3	7	4
Joint Investigation Framework - Shared	35	16	12	16	14	21
Joint Investigation Framework - Received	3	0	1	2	2	1
NRI Closures Submitted - Total	1	3	4	3	1	1
Claims						
Personal Injury - Received	2	2	1	9		
Personal Injury - Closed	1	0	6			
Clinical Negligence - Received	2	0	2	7	5	5
Clinical Negligence - Closed	0	0	0	0	1	0
Road Traffic Collision & Damage to Property - Received	23	27	12			
Road Traffic Collision & Damage to Property - Closed	47	17	11			

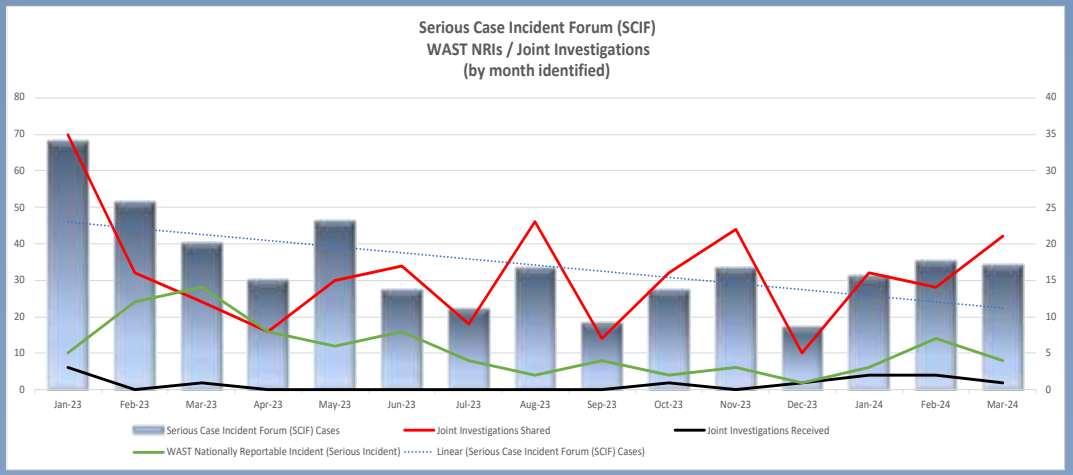
Claims management moved from Datix Cymru to the Welsh Risk Pool System in Quarter 4 and data validation is in progress. Therefore, some data is not present in Quarter 4 and will be reflected in the Quarter 1, 2024/25 Report.

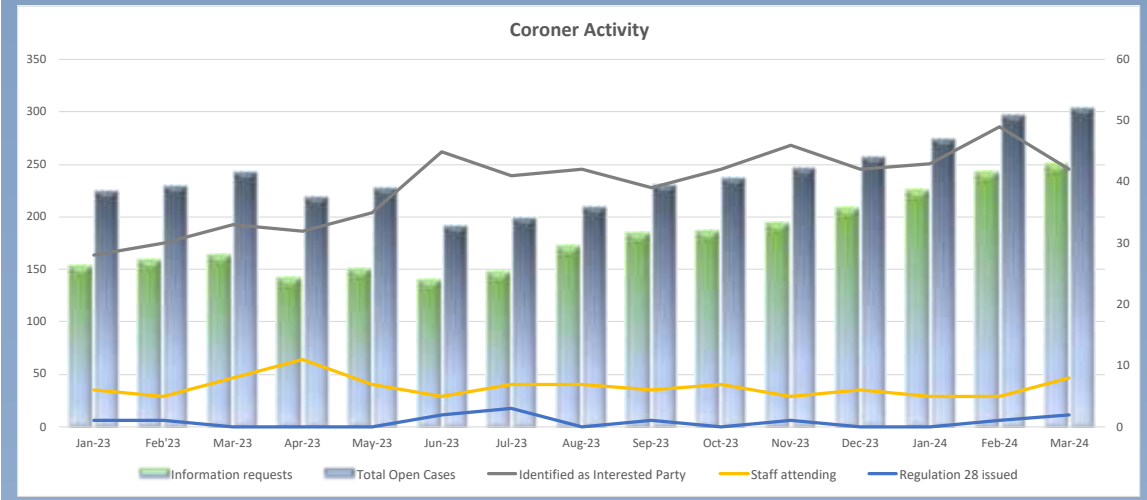
Putting Things Right Overview

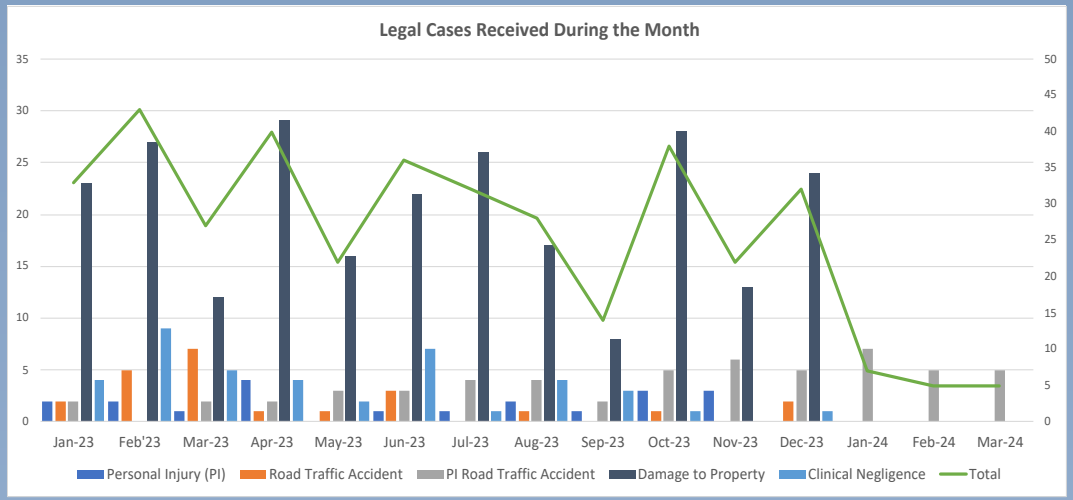












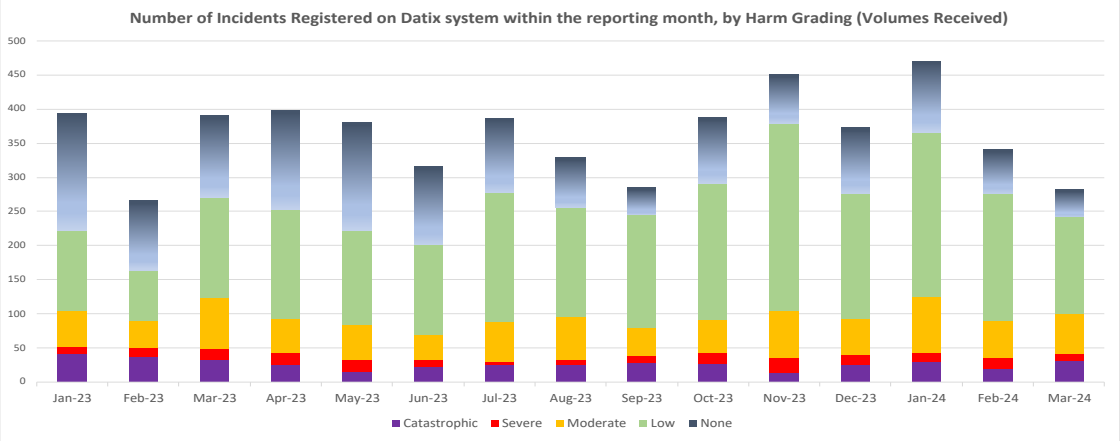
Patient Safety Incidents

7. 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 University NHS Trust.

8. During this period a total of 1,094 PSIs were reported, 471 in January, 340 in February and 283 in March. It must be noted that the harm grading may change subject to the outcome of any investigation.

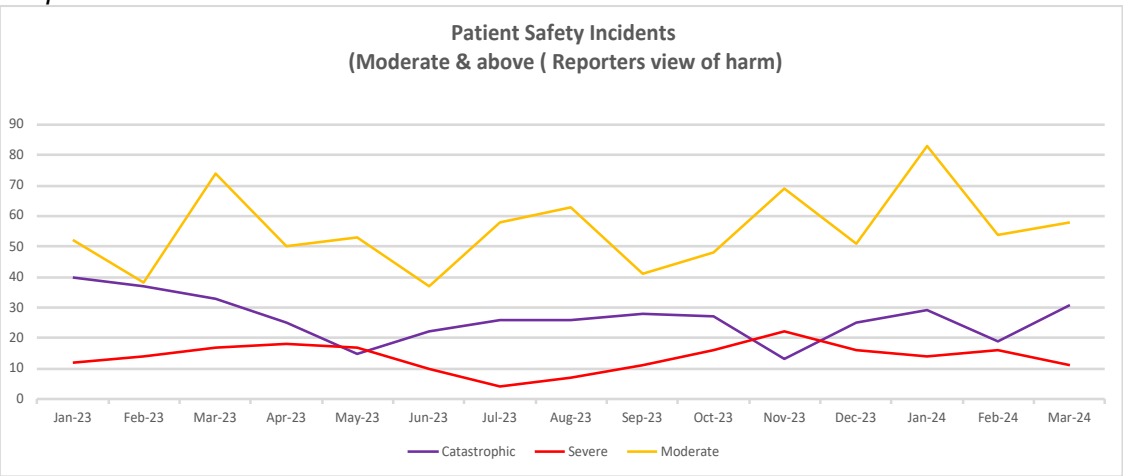
9. The graph below illustrates the number of PSIs reported on a rolling basis from January 2023 by initial grading (reporters view of harm). Themes continue to be timeliness to response and handover of care delays.

Graph 1



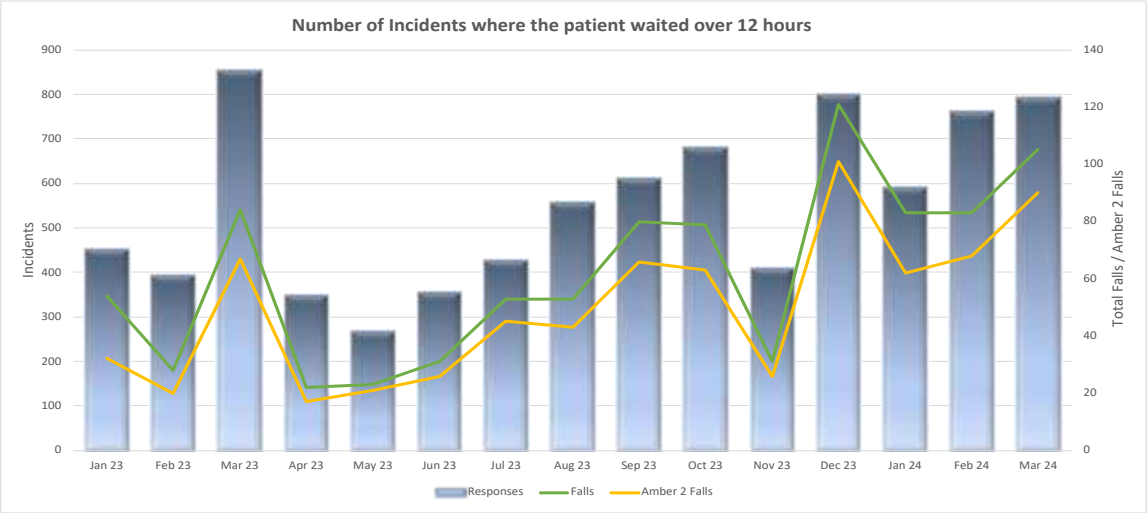
10. Graph 2 below details the number of PSIs rated moderate and above. The Patient Safety Team continue to review incidents graded moderate and above to determine any Duty of Candour (DoC) requirements. Data and information on the enactment of DoC is included later in this Report.

Graph 2



11. Patients waiting for extended periods of time in the community continues to impact on patient safety as detailed in Graph 3 below. During this period 2,137 patients received a response or wait over 12 hours.

Graph 3



12. 271 of the patients waiting over 12 hours had experienced a fall, with the longest waiting patient being 46 hours and 46 minutes. This patient was being cared for in a nursing home and no concern has been formally raised to date.

13. 220 of the 271 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. Table 2 provides a breakdown of where patients waited by Health Board area.

14. The Trust received the first Prevention of Future Deaths Report (Regulation 28) in March 2024 raising concerns about patients developing pressure damage jointly with Swansea Bay University Health Board.

Table 2

Health Board Area *Plans are in place to provide future data by population.*	Number of Patients who have fallen and waited over 12 hours for a response. January to March 2024
Aneurin Bevan UHB	21
Betsi Cadwaladr UHB	94
Cardiff & Vale UHB	13
Cwm Taf Morgannwg UHB	52
Hywel Dda UHB	34
Powys Teaching HB	8
Swansea Bay UHB	49
Total	271

15. Identification of patient harm across the whole Urgent Care Pathway is challenging, as impacts are not always immediately apparent.

16. The Patient Safety Team continue to work with tissue viability colleagues nationally. A meeting was held in January 2024 with colleagues from the All-Wales Tissue Viability Network to determine next steps in identifying avoidable harm across the system in respect of pressure damage, including information sharing and the Welsh Ambulance Services University NHS Trust's role in Health Board Pressure Damage Panels and incident reporting.

17. Graph 4 below details the number of cases discussed at the SCIF and those shared with 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

18. During this reporting period there were 17 SCIF Meetings held, with 100 incidents discussed. Fourteen incidents have been reported as Nationally Reportable Incidents (NRIs) to the NHS Wales Executive; key areas of concern identified include call categorisation, missed ineffective breathing descriptor, allocation issues and a missed appointment (Ambulance Care).

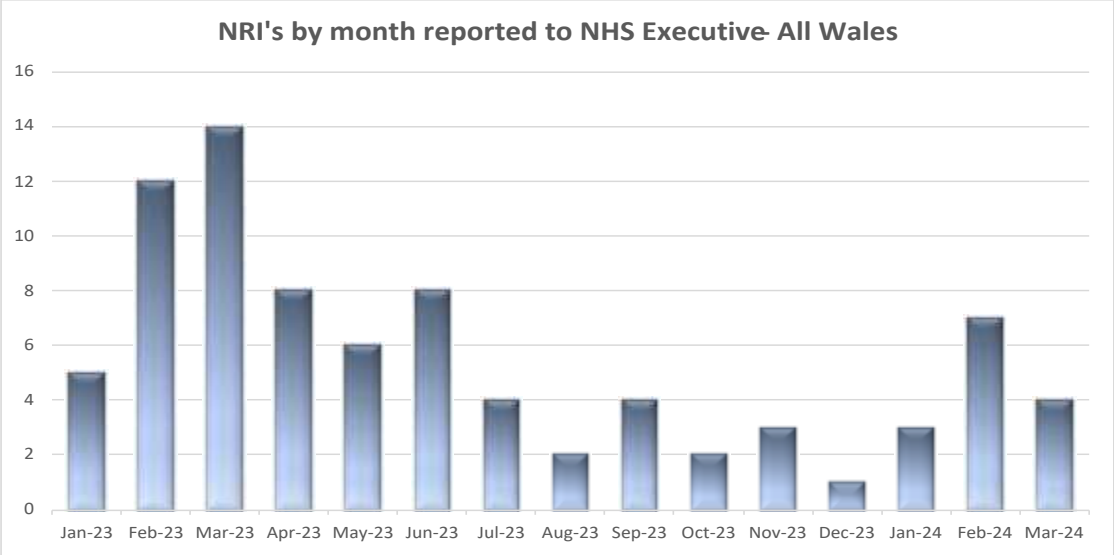
19. 51 incidents were shared under the Joint Investigation Framework to the respective Health Boards following a review internally. No recorded incidents linked directly to immediate release requests were identified.

20. General themes following joint investigations remain the same with over-crowded Emergency Departments and wider system pressures resulting in high levels of escalation, lack of end-of-life care or ceilings of care planning and discharge delays.

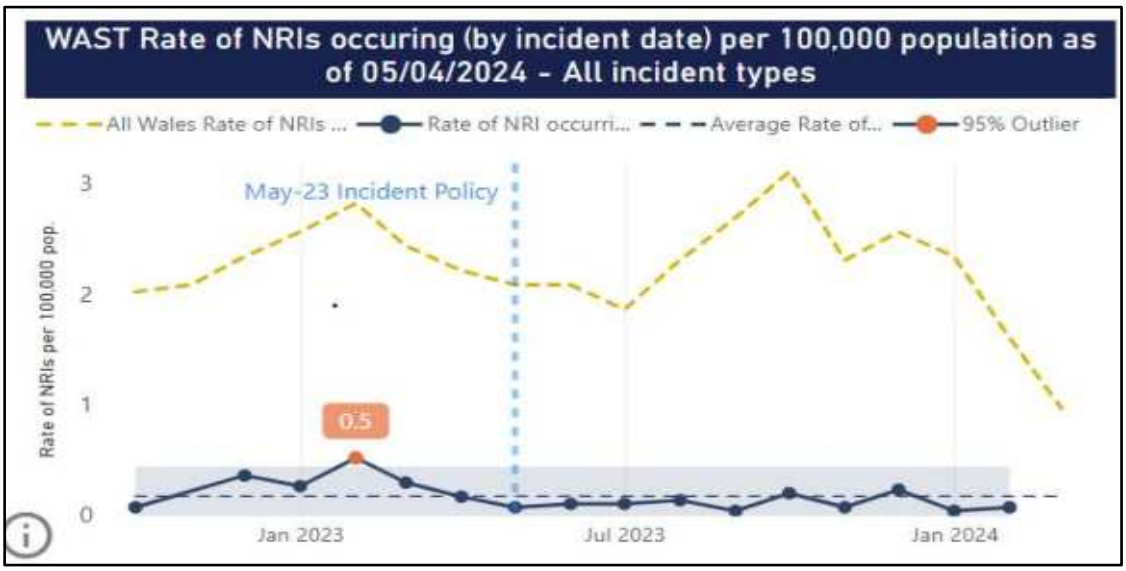
21. One of the Patient Safety Team's priorities following the recruitment to the new structure is to work with system colleagues to identify more meaningful patterns, themes and trends and associated learning opportunities from the Joint Investigation Process.

22. Graph 5 below provides an overview of the themes of NRIs from April 2021. Graph 6 provides the numbers of NRIs by population health (NHS Wales Beacon Dashboard updated 16.4.2024).

Graph 5



Graph 6



23. Table 3 and 4 provide a breakdown of the current open NRIs (n=58). A high proportion of frequently used Welsh Ambulance Services University NHS Trust codes sit under 'Access, Admission' to Services detailed in Table 3. The subcategory codes provide better analysis and as such the plan is to use these for reporting purposes (Table 4).

Table 3

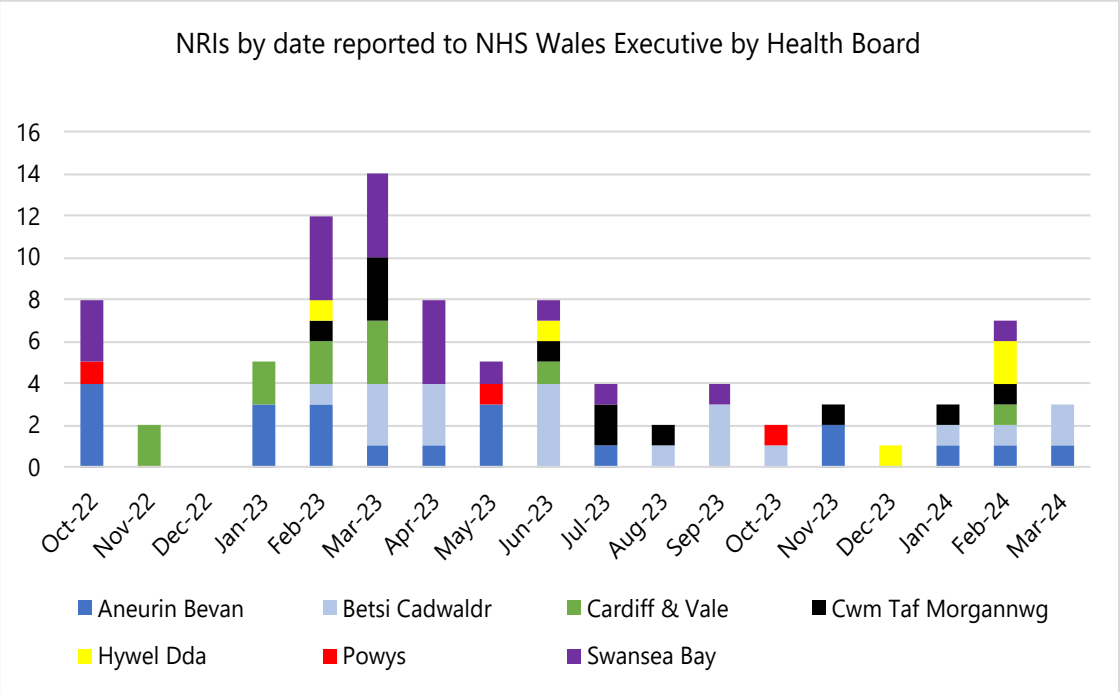
Classification of Open NRI's as of 15/04/2024	ABUHB	BCUHB	CTMUHB	CVUHB	HDUHB	Powys	SBUHB	Grand Total
Access, Admission	9	6	6	5	2	1	1	30
Accident, Injury	1		1					2
Assessment, Investigation, Diagnosis	3	2					1	6
Assessment, investigation, diagnosis (clinical care)		1						1
Behavior (including violence and aggression)	1							1
Consent process for examination or treatment not / inadequately followed		1						1
Infrastructure (including staffing, facilities, environment)		1						1
Maternity adverse occurrence	1							1
Patient/service user death	1		3	1	4	1		10
Patient/Service User Death (RTC)		1						1
Pressure Damage, Moisture Damage		1						1
Treatment, Procedure	2			1				3
Grand Total	**18**	**13**	**10**	**7**	**6**	**2**	**2**	**58**

Table 4

Datix Sub Category	ABUHB	BCUHB	CTMUHB	CVUHB	HDUHB	Powys	SBUHB	Grand Total
Access to admission delayed	3	1		1	1	1		7
Access to Services delayed	1				1			2
Access to services denied		1						1
Adult (not known to mental health services)	1		2	1	3	1		8
Allocation delay - No / lack of available resources	2	4	4	3			1	14
Care not as directed / clinical practice guidelines not followed	1			1				2
Delay - nearest available resource not allocated			1					1
Delay / difficulty in obtaining clinical information		1						1
Delay due to escalation Deployment Management Plan (DMP)	1			1				2
Delay in accessing location/address			1					1
Delivery of baby with no professional in attendance (e.g. Born before admission (BBA))	1							1
Diagnosis delayed	1							1
Failure to resource service adequately		1						1
Inadequate clinical assessment	1	1						2
Injury of unknown origin / unwitnessed	1							1
Involving ambulance (patient on board)			1					1
Medical Priority Dispatch System (MPDS) - Call audit errors identified	1							1
Medical Priority Dispatch System (MPDS) - delay - incorrect prioritisation	1							1
Medical Priority Dispatch System (MPDS) - Incorrect determinant coding		1					1	2
Missed appointment - Transport issues	1							1
Neonatal death					1			1
Pressure ulcer developed or worsened during care in this clinical care area/caseload		1						1
Staff attitude to patient/service user, visitor, public	1							1
Sub CategoryChild/adolescent (not known to mental health services)			1					1
Treatment or procedure wrong or inappropriate	1							1
(blank)		2						2
Grand Total	**18**	**13**	**10**	**7**	**6**	**2**	**2**	**58**

24. Graph 7 below details the number of NRIs reported to the NHS Wales Executive by Health Board area.

Graph 7



Duty of Candour

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

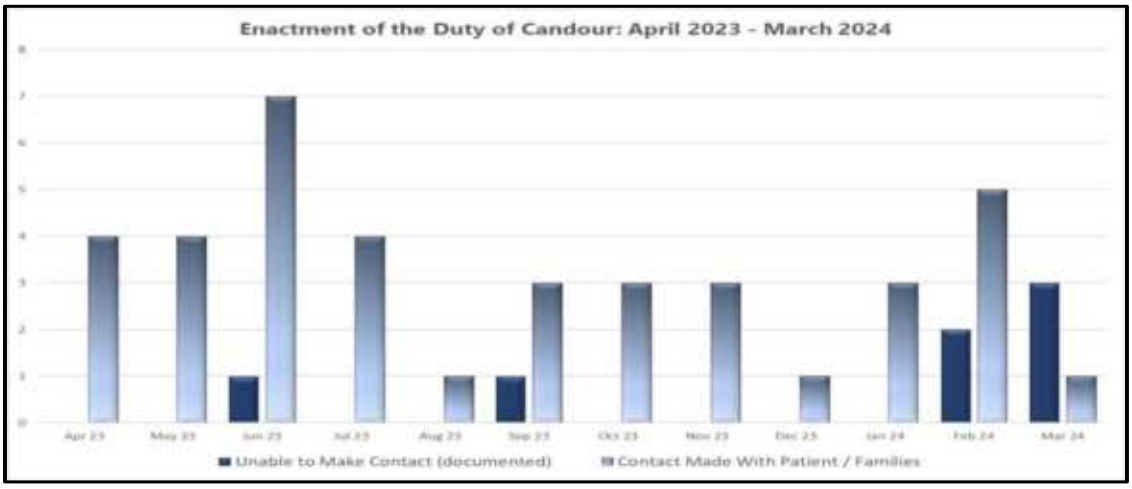
26. The Datix Cymru system has a dedicated Panel for DoC to ensure an audit trail is in place to record the enactment of the DoC or when this has not been possible and the rationale. Coding fields for reasons the DoC is not enacted will be developed on the system nationally to aid analysis in future.

27. The Trust identified 46 PSIs at the SCIF which were notifiable and triggered the DoC threshold from April 2023 to March 2024.

28. A notifiable adverse outcome is any incident whereby harm (moderate harm, severe harm and death) is caused, which is unintended or unexpected and that the provision of the health care was or may have been a factor in the service user suffering that outcome.

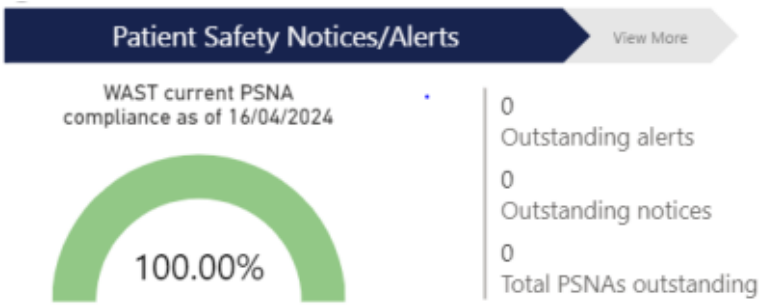
29. The Duty was enacted on all 46 occasions, although we were unfortunately unable to make contact with seven patients or families, despite exhausting a number of routes, including contacting Health Board colleagues for contact details and attempting to make contact on multiple occasions as detailed in Graph 8.

Graph 8



NHS Wales Patient Safety Alerts/Notices

30. The Trust has no outstanding alerts (NHS Wales Beacon Dashboard updated 16.4.2024) as detailed below.



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

31. The Medical Examiner Service becomes a statutory body from September 2024 and all non-coronial deaths will be included in the reviews, including community deaths.

32. A review of the backlog of cases (approximately 600 cases) forwarded by the Medical Examiner Service is in progress. All Referrals have been screened on receipt by a member of the Patient Safety Team and escalated as required to the

SCIF. A multidisciplinary Scrutiny Panel to sift the Referrals is to be established, reporting to the Learning from Deaths Forum.

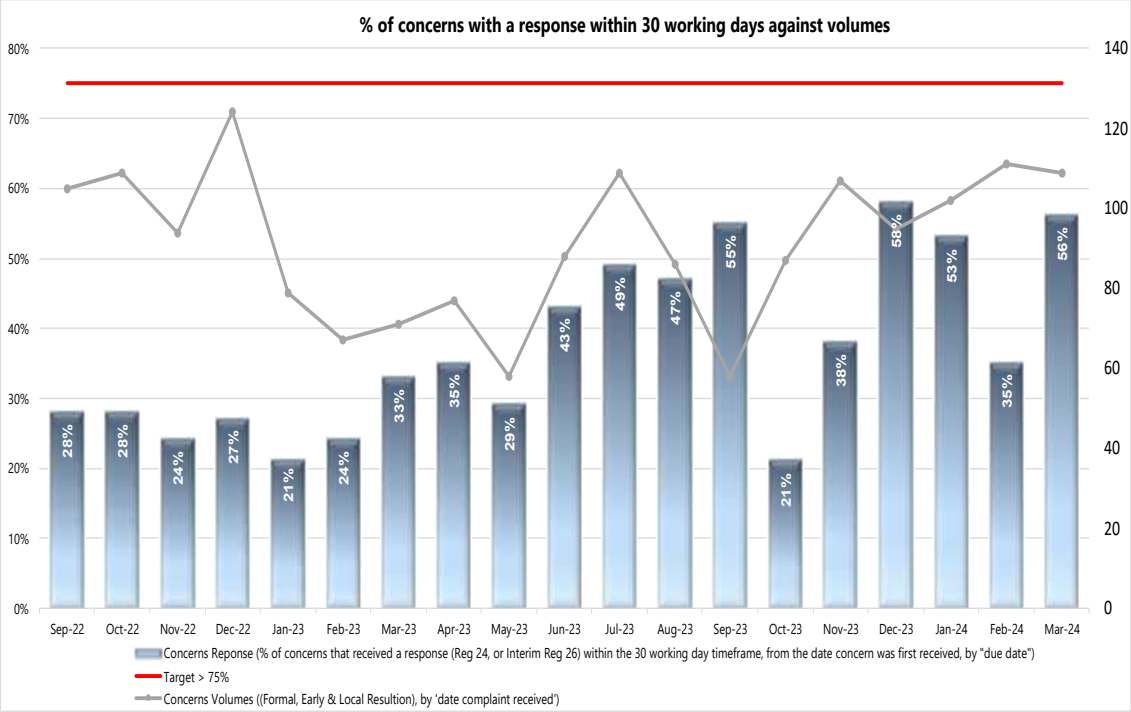
Early Resolution (ER), Local Resolution (LR) and Formal Concerns

33. 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.

34. Graph 9 below provides the complaints position over time. The Trust continues to receive a steady number of complaints with 336 being received during this reporting period.

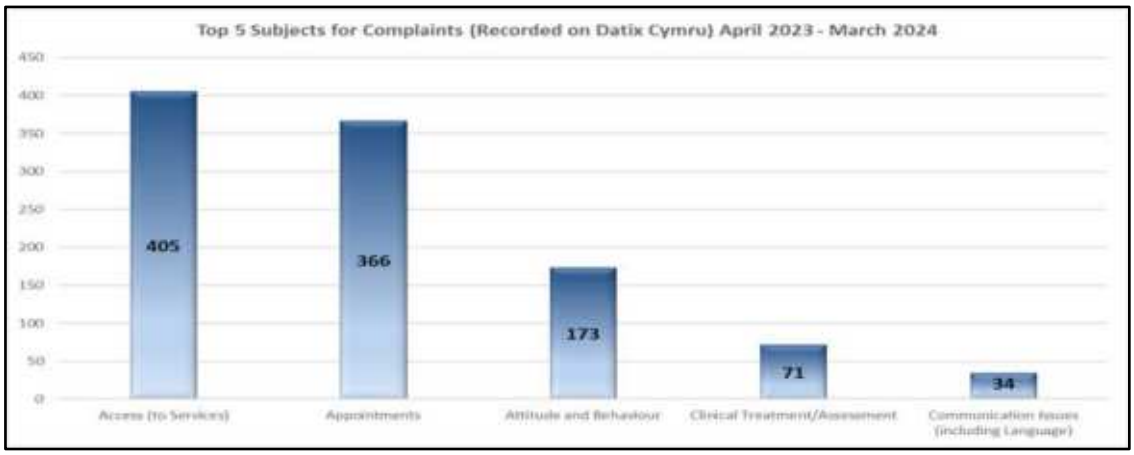
Graph 9



35. The acknowledgement date target has been amended nationally to five working days. During this reporting period the five-day acknowledgement performance was 99%, 95% and 99% (100% target) with the 30-day target achieving 53%, 35% and 56% respectively (75% target).

36. A breakdown is provided of our top five complaint categories. The majority of complaints in access relate to a delayed response in the community following calls made to the 999 service. Complaints relating to appointments are predominately in relation to our Non-Emergency Patient Transport Service (Ambulance Care) detailed in Graph 10.

Graph 10



37. A PTR Recovery Plan has been developed to move to a sustained improvement position in our responses to patients and families. This details the predicted reduction in both the 5 day and 30-day response times whilst three new staff who started in April 2024 undergo induction, training on Trust systems and a mentoring period.

38. In relation to the Ambulance Care Service, there remains a challenge with regards to the backlog of concerns. These concerns are mainly in the Aneurin Bevan University Health Board area and predominately relate to appointments.

39. The Patient and Family Relations Team have undertaken training with staff from the Ambulance Care Team in order to reinforce the process and provide advice and guidance on managing complaints.

40. Next steps are for the Patient and Family Relations Team to work more closely with Ambulance Care in order to expedite those concerns that can be resolved relatively quickly (early resolution).

41. Feedback is provided to staff regarding concerns relating to attitude and behaviour and our Clinical Leads undertake Clinical Reviews of incidents and complaints relating to clinical care and actions/improvements frequently include additional education, training and mentoring.

EMS Co-ordination and Resourcing Centre Concerns & Coroners Activity

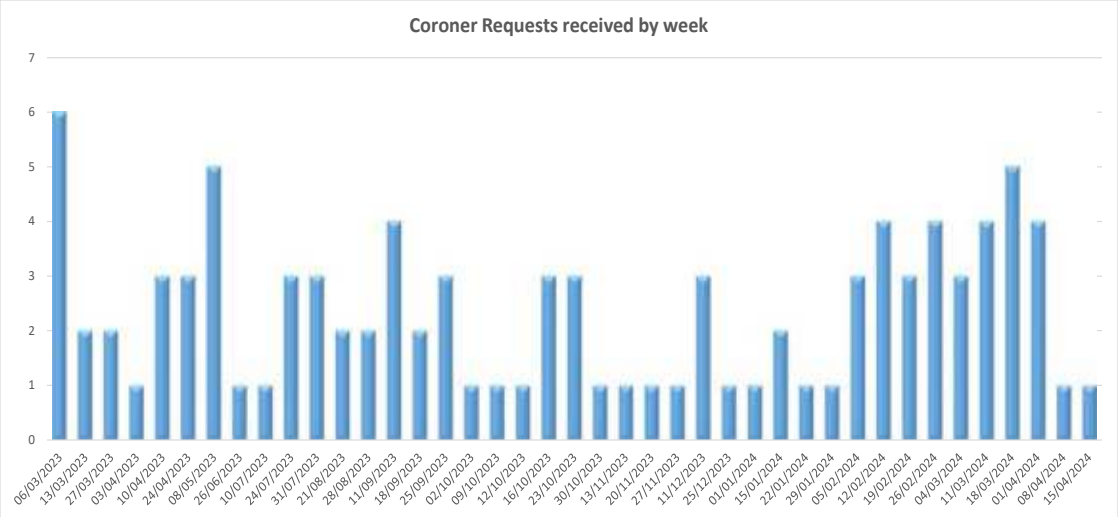
Prepared by the Service Manager, Operations Quality:

42. There are 32 outstanding concerns sitting with Operations Quality (OQ). From January 2024, the OQ Department is investigating all concerns whether consent has been gained or not. A review of previous concerns from 2023 which were never investigated due to no consent gained is being planned but has not yet been undertaken.

43. There are fourteen outstanding NRIs sitting with the Department. This is a reduction from 24 at the end of December 2023. Three are overdue. These are at the quality assurance stage and are relating to ineffective breathing, which the International Academies of Emergency Dispatch supported the Trust to identify learning and review these cases.

44. There are 34 coroner's statements outstanding with the Department. This is an increase from 18 at the end of December 2023. The Department has seen an influx of statement requests since February 2024 which is outlined in Graph 11 below. The Department has aligned capacity to address the backlog and recruitment into a new post which includes responsibilities for coroners is ongoing as part of an approved Organisational Change Process.

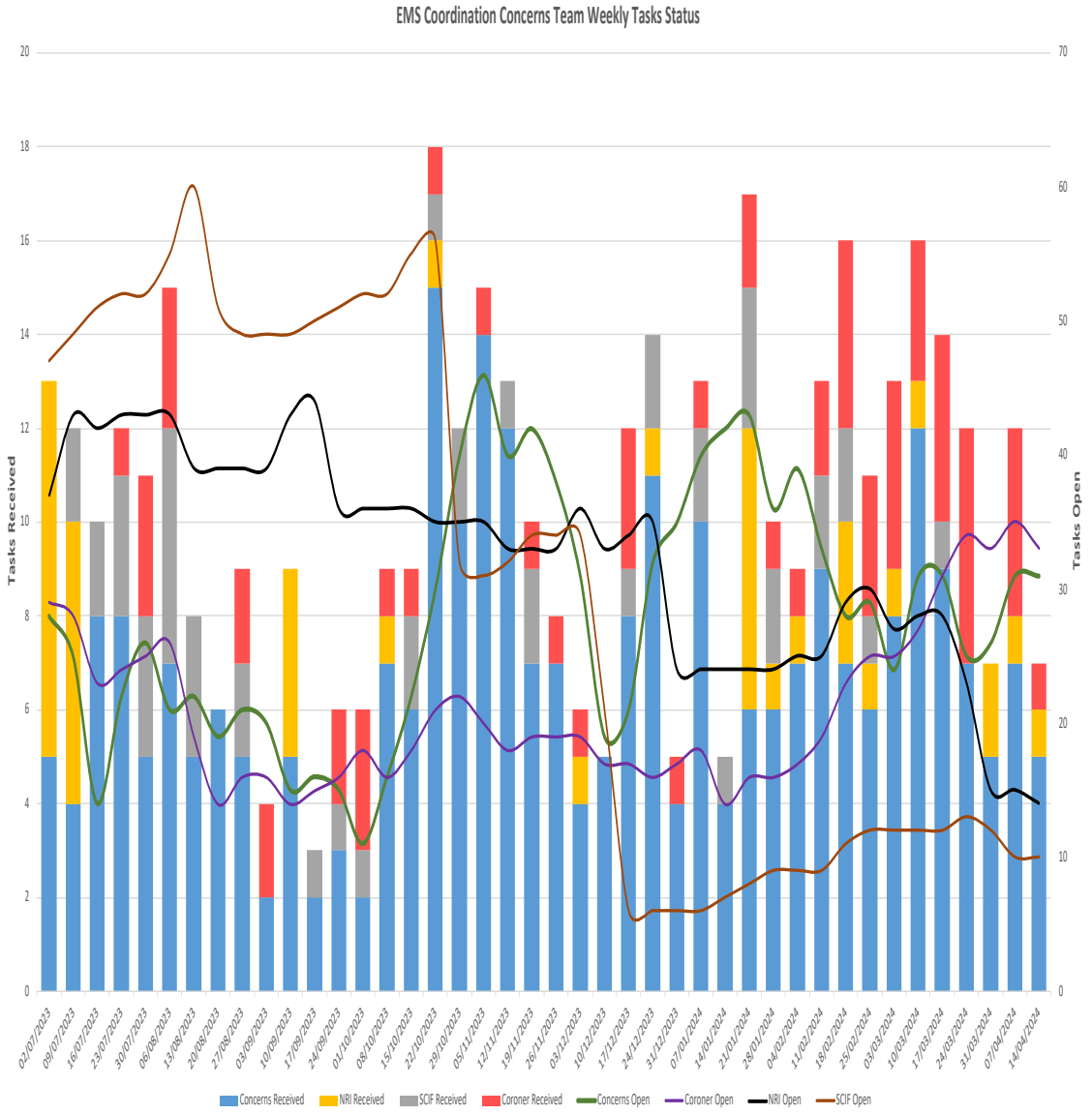
Graph 11



45. There are 18 SCIF actions continue to be reviewed monthly to ensure they are being progressed and completed. There are eight outstanding SCIF actions.

46. Graph 12 provides an overview of the activity of the Team up until 31 March 2024.

Graph 12



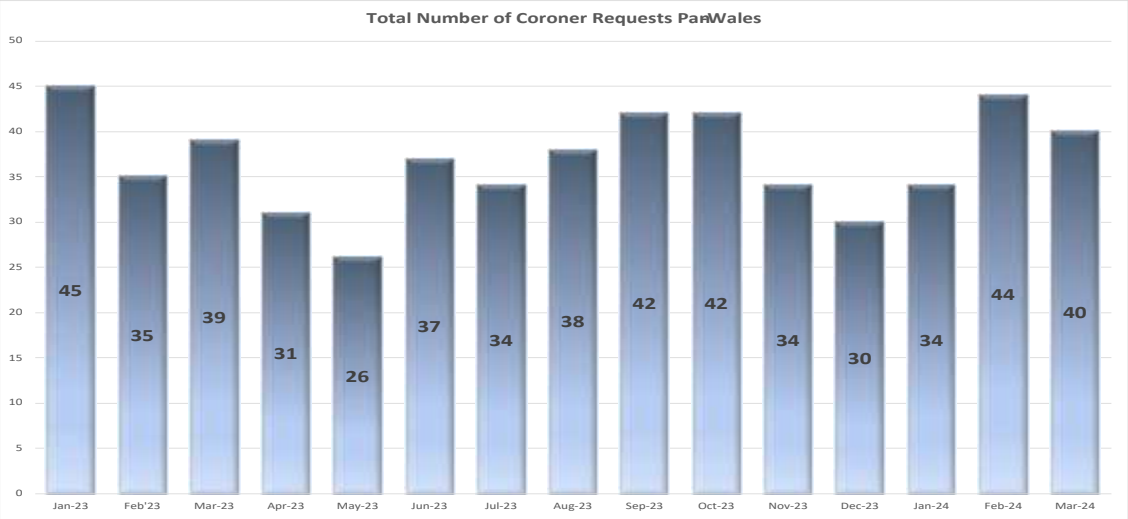
47. Learning from concerns investigations, coroners and SCIF continues to be shared with Emergency Medical Services (EMS) Coordination Teams by OQ via coaching bulletins, competency sign offs and face-to-face where required.

48. Themes and trends are also considered and discussed at the monthly EMS Coordination Quality Meeting, which is chaired by the Service Manager, Operations Quality.

Organisational Legal Activity and Coroners

49. The number of approaches received from Coroners has increased during the reporting period. The complexity of the requests being received continues to be high, resulting in more statements per approach, together with increased legal complexity, requiring extensive disclosure, attendance at Pre-Inquest Hearings and multiple witnesses, Interested Parties and day inquest hearings. Activity has increased overall as detailed in Graph 13.

Graph 13



Prevention of Future Death Reports (Regulation 28)

50. During the reporting period the Trust received two Prevention of Future Deaths Reports (Regulation 28).

51. A Report was received from the Area Coroner, for the coroner area of South Wales Central on 7.2.2024 in respect of the script and information provided to callers as part of the Clinical Safety Plan which inform callers not to call back for an estimated time of arrival of the ambulance. They are told to only call back if there is a deterioration in the patient's condition.

52. A Report was received from the Assistant Coroner, for the coroner area of Swansea Neath & Port Talbot on 4.3.2024. The Report was sent to the Trust & Swansea Bay University Health Board in respect of concerns where vulnerable patients are left waiting for an ambulance then pressure sores can develop due to a long lie.

53. Two Prevention of Future Deaths Reports (PFD) (Regulation 28) linked to the Trust but not sent to the Trust directly to respond were received.

54. A Report was sent to the Minister for Health and Social Services, Welsh Government on 22.2.2024 in respect of delays responding to a patient (Amber 1) by Assistant Coroner for the coroner area of South Wales Central.

55. A Report was sent to The Rt Honourable James Cleverly, Secretary of State for the Home Office by the Senior Coroner for North West Wales on 13.3.2024. This was in respect of alternative analgesics which can be administered much more quickly, have a much quicker impact and can be easier to remove when required. Example of such is mucosal fentanyl lozenge. There were concerns regarding the unavailability of such analgesics to paramedics (in England as well as Wales) to assist patients who require immediate pain relief in the context of it reducing stress on the body, providing easier and potentially faster extrication and patient handling, and improving breathing, where time is of the essence for medical treatment, to reflect a risk of deaths into the future.

56. The Legal Services Team coordinate the responses to the coroner's, ensuring information is submitted with in the defined timescales.

Legal Claims

Table 5

Legal Claims Overview		Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Claims opened	Personal Injury (PI)	2	2	1	4	0	1	1	2	1	3	3	0	*		
	PI Road Traffic Accident	2	5	7	1	1	3	0	1	0	1	0	2	*		
	Clinical Negligence	2	0	2	2	3	3	4	4	2	5	6	5	7	5	5
	Road Traffic Accident	23	27	12	29	16	22	26	17	8	28	13	24	*		
	Damage to property	4	9	5	4	2	7	1	4	3	1	0	1	*		
Claims closed	Personal Injury (PI)	1	0	6	3	0	7	1	0	6	0	0	0	*		
	PI Road Traffic Accident	1	1	0	1	0	2	0	0	5	0	1	0	*		
	Clinical Negligence	0	0	0	0	0	1	1	0	0	0	1	1	0	1	0
	Road Traffic Accident	47	17	11	8	3	11	5	8	4	4	14	19	*		
	Damage to property	4	5	2	4	1	3	2	1	5	1	1	3	*		
Claims open at the end of the month	Personal Injury (PI)	78	80	75	76	76	70	70	72	67	70	73	73	*		84
	PI Road Traffic Accident	48	52	59	59	60	61	61	62	56	57	56	58	*		63
	Clinical Negligence	122	122	124	126	129	131	134	138	140	145	150	154	161	162	167
	Road Traffic Accident	159	170	177	203	210	223	244	253	269	293	292	297	*		228
	Damage to property	9	13	16	16	17	21	20	23	21	21	20	18	*		29
		416	437	451	480	492	506	529	548	553	586	591	600			571

*In Jan 2024 the PI/PIRTC and RTC data was downloaded from Datix web (historic) and placed on the Legal & Risk Services system. The Team are currently undertaking the work of cross referencing the cases and entering the details of the cases held on an excel spreadsheet. Until this work is completed (by end of the financial year at the latest) it will not be possible to report on these cases.

57. Table 5 provides an overview of the activity in Legal Services. There has been a significant ongoing increase in the number of clinical negligence claims (actual and potential) being received by the Trust, many of which stem from delayed responses to patients at a time of escalation.

58. 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.

59. Graph 14 details the current position in respect of open claims which continues on an upward trajectory. Data for Q4 is awaited following a move in information systems.

Graph 14

Organisational Learning

60. Organisational learning plays a vital role in the continuous improvement and development of healthcare organisations. Creating a culture of learning within the NHS is crucial for organisational improvement and the delivery of person-centred, high-quality services, whilst supporting staff wellbeing.

61. Learning occurs through a variety of routes both across the Trust and across the health system, but we know this can be improved and in September 2023 we joined the All Wales Enhancing Learning Programme. A Framework for Learning from Events has been developed by the programme members to provide a consistent, but adaptable approach.

62. The Trust's version of the Learning from Events Framework is now in development and will be implemented by Quarter 4, 2024/25.

63. Organisational learning includes:

- Implementation/changes in Education and Training Programmes for example maternity care led by our Midwife Safety Champion
- Thermoregulation training and improved awareness of the importance of recording the temperature of a newborn and use of relevant equipment
- Improving clinical documentation on ePCRs
- Improved awareness of available patient pathways
- Importance of pre-alert in patients with a reduced Glasgow Coma Scale and high National Early Warning Score (NEWS).
- Learning around criteria for referring patients to Minor Injury Units
- Awareness of Major Trauma Tool and referral to spinal immobilization guidance
- Sharing of learning occurs through education & training, dedicated intranet sites and bulletins and notices

64. The following notices have been issued this period:

- CN 02/2024 Increase in Whooping Cough
- CN 03/2024 Non-conveyance Form Images in ePCR
- CN04/2024 ROLE Form images in ePCR
- CN05/2024 Changes to the Dispatch Cross Reference Table
- CN06/2024 Medicines Shortage - Salbutamol 2.5mg/2.5ml and 5mg/2.5ml nebuliser liquid unit does vials

65. Examples of learning from Clinical Reviews are detailed overleaf in Table 6.

Table 6 **- Examples of learning from clinical reviews**

	Number	**Brief Description**	Themes	Learning Opportunities
Aneurin Bevan	1	• Failure to monitor patient who then deteriorated whilst in crew's care.	• Failure to identify deteriorating patient. • Lack of observations	
Betsi Cadwaladr	1	• CFR auto-back (timeliness in requesting EMS back up).	• Delayed response	• Improved CFR awareness of 02 therapy and COPD patients
Cardiff and Vale	4	• Baby born in the community, no temperature recorded, and concern raised by C&V midwifery team on arrival at hospital. • Family felt that the decision making, and management was not appropriate but the ePCR showed that crew engaged with patient, discussed options and contacted hospital to arrange admission. Patient did not travel with crew against advice. Non-conveyance form completed and left with patient. • Patient has stated that they were left in the back of the ambulance with a student. Upon review, behavioural issues have been identified and referred to operational manager. • Paramedic administered 1mg of Adrenaline for asthma instead of 0.5mg. Realised immediately and self-reported. •	• Obstetrics • Appropriate action taken by crew. • Scope of student paramedics • Drug administration error	• Thermoregulation training available on LMS 365 and improved awareness of the importance of recording the temperature of a newborn and use of relevant equipment. • Minor improvements to ePCR to support non-conveyance. • Behavioural concerns • Actions of self-reporting and handing over error to hospital staff illustrates insight.

	Number	Brief Description	Themes	Learning Opportunities
Hywel Dda	2	• Double EMT crew inappropriately used P4 for a patient who required hospital admission, via GP admission. • UCS backed up a CHARU paramedic who was bradycardic. The CHARU paramedic insisted on not travelling to hospital with the crew and the patient become unwell on route to hospital. Experienced UCS crew identified the deterioration and pre-alerted the hospital.	• EMT Scope of Practice • Poor documentation • Failure to identify deteriorating patient	• Obstetrics • Appropriate action taken by crew. • Scope of student paramedics • Drug administration error.
Powys	1	• Patient attended by CHARU and discharged at scene. Second 999 call received shortly after, delayed response and patient in cardiac arrest on arrival of second crew (ROLE) implemented	• Poor documentation • Poor management of cardiac arrest	• The need for accurate and comprehensive documentation. • Correct recognition and management of shockable and non-shockable rhythms in cardiac arrest.
Swansea Bay	2	• Intubation and lack of ETCO2 monitoring • Referred to incorrect pathway and sent to MIU instead of ED	• Poor management of cardiac arrest • Oesophageal intubation • Incorrect pathway followed	• Cardiac arrest management • Improved awareness of available pathways

Welsh Risk Pool (WRP)Learning from Events Reports & WRP Committee Outcomes

66. The 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.

67. 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.

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

69. The Trust has not received any financial penalties to date.

WRP Committee Outcomes (as of 5.4.2024) & Current Position Overall

Table 7

Learning from Events	Number Amber Deferred (requesting some additional information minutes, confirmation of sharing learning, training etc.)	Number Red Deferred (to be represented to the LAP with additional evidence, answers to questions etc.)	Total
Deferred Claims	2	0	2
Deferred Redress	3	3	6
Overall position	5	3	8

70. Table 7 provides an overview of the current position with the Trust having five amber deferred cases and three red deferred cases awaiting evidence of learning.

71. Learning from a recent case (LFER 7909) included feedback to call takers and Clinical Support Desk (CSD) clinicians regarding categorisation and ectopic pregnancy. A maternity education session is now available on the CSD Hub.

72. Oversight of the status of cases is undertaken by the Legal Services Team and additional supporting evidence is currently being gathered.

Horizon Scanning & Key Documents

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

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

- The Medical Examiners (Wales) Regulations 2024 are being laid in April in England and Wales, which will establish the legal Framework for a statutory, unified system of scrutiny by independent Medical Examiners for all deaths in England and Wales, which are not investigated by a Coroner and will come into force on 9 September 2024.

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

PUTTING THINGS RIGHT TEAM RECOVERY PLAN

MEETING	Quality, Patient Experience and Safety Committee
DATE	7 May 2024
EXECUTIVE	Liam Williams, Executive Director of Quality & Nursing
AUTHOR	Jane Palin, Assistant Director (interim)
CONTACT	Jane.Palin@wales.nhs.uk

EXECUTIVE SUMMARY

1. The Putting Things Right Team underwent a comprehensive organisational change process which completed in December 2023. This involved a restructure of the delivery of the key functions, additional posts and strengthened leadership.

2. The attached Putting Things Right (PTR) Recovery Plan (**ANNEX 2**) outlines the five key priority areas and actions across the functions over the next twelve months to ensure recovery which includes:

- Team wellbeing
- Complaints
- Nationally Reportable Incident (NRI) investigations
- Learning from Events including Welsh Risk Pool
- Learning from Deaths & Medical Examiner Service Referrals

3. The Plan includes the current position, key improvement actions, key dependencies for delivery, metrics and oversight and current mitigations.

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

KEY ISSUES/IMPLICATIONS

(i) Failure to deliver the Plan following investment will result in continued non-compliance with the Putting Things Right Regulations and Welsh Government targets, impacting negatively on our patients and families and our teams.

REPORT APPROVAL ROUTE	
Clinical and Quality Governance Group	30 April 2024 (direct request)
Quality, Patient Experience & Safety Committee	7 May 2024

REPORT APPENDICES	
ANNEX 1	SBAR Report
ANNEX 2	Putting Things Right Recovery Plan

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

ANNEX 1

SITUATION

1. The Putting Things Right Team (PTR) are in a period of transition following significant investment and the completion of the organisational change process, recruiting to brand new posts and current posts which have become vacant following promotions or moves to different roles.

2. At least five of the staff recruited (potentially seven) are brand new to the Trust and will require comprehensive induction, education and training.

3. Three new staff in the PTR administration hub will require intense education and training on Trust systems, including Datix Cymru. Additionally, mentoring and supervision is required to ensure these staff are fully skilled up and supported to engage with patients and families who are raising concerns.

4. Current team members are being released to undertake Induction and Education Programmes leaving a gap in day-to-day functions on a temporary basis.

5. The Trust is not meeting key targets/timeframes set externally resulting in a suboptimal service for our patients and families which brings continued pressures across our teams.

BACKGROUND

6. Following a review of the increasing demand across all of the PTR functions, and additional requirements including Duty of Candour, Duty of Quality, Medical Examiner Service and Welsh Risk Pool Learning from Events, the PTR Team received significant investment.

ASSESSMENT

7. The attached PTR Recovery Plan outlines the five key priorities across the functions over the next twelve months which includes:

- Team wellbeing
- Complaints
- Nationally Reportable Incident (NRI) investigations
- Learning from Events, including Welsh Risk Pool
- Learning from Deaths, including the Medical Examiner Service

8. The Plan includes the current position, key improvement actions, key dependencies for delivery, metrics and oversight and current mitigations.

9. The Plan links across to the outputs of the recent Internal Audit of the Joint Investigation Framework and subsequent actions detailed in the Trust's Tracker.

10. The new Head of Putting Things Right will own the Plan and local oversight will occur at the PTR Meeting and through the Quality, Safety & Patient Experience Directorate governance routes.

Welsh Ambulance Services NHS Trust

Putting Things Right Team

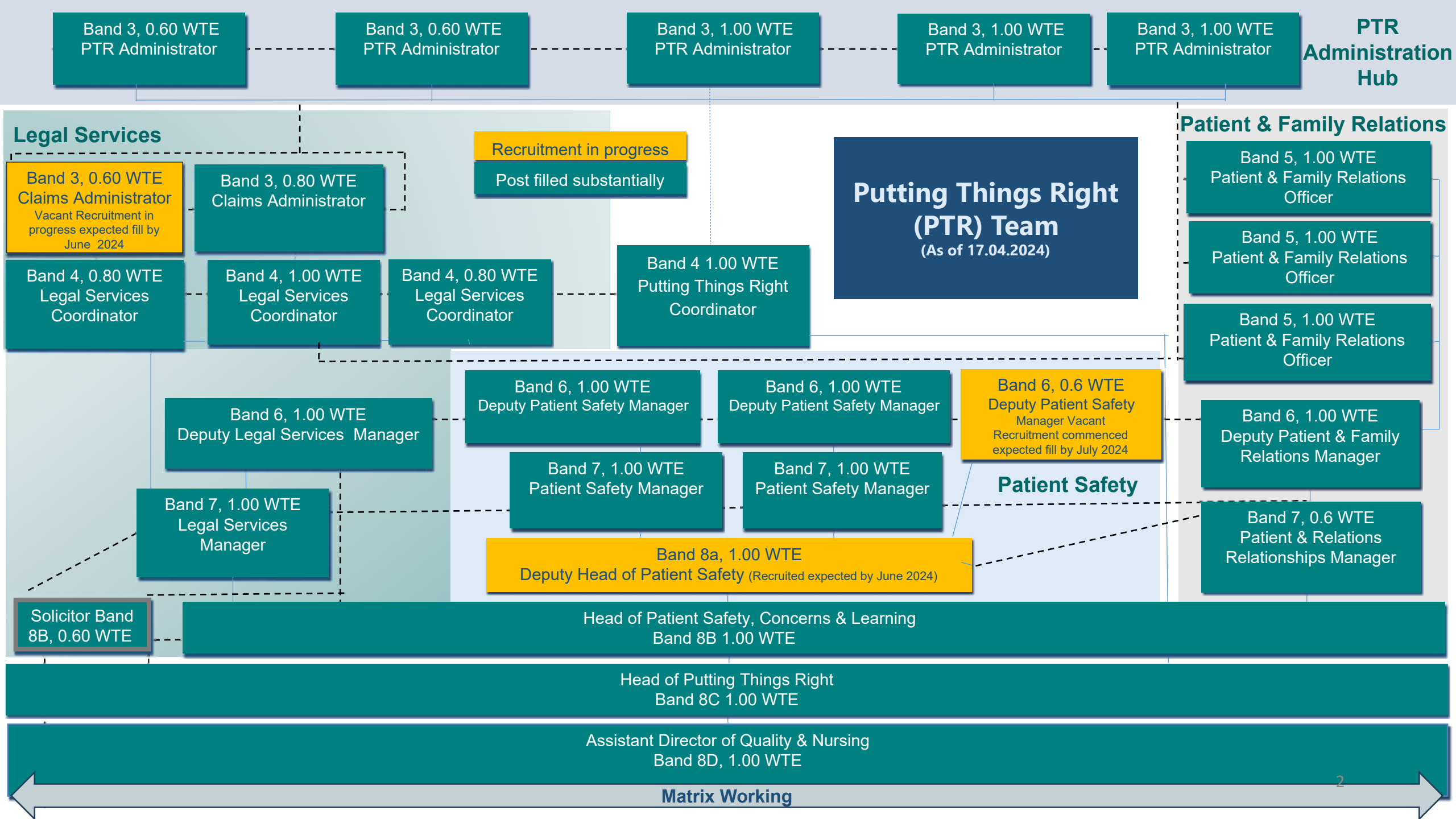
Recovery Plan

Version 1

18 April 2024

GIG CYMRU NHS WALES

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


Band 3, 0.60 WTE PTR Administrator
Band 3, 0.60 WTE PTR Administrator
Band 3, 1.00 WTE PTR Administrator
Band 3, 1.00 WTE PTR Administrator
Band 3, 1.00 WTE PTR Administrator
PTR Administration Hub
Legal Services
Recruitment in progress
Post filled substantially
Putting Things Right (PTR) Team
(As of 17.04.2024)
Patient & Family Relations
Band 3, 0.60 WTE Claims Administrator
Vacant Recruitment in progress expected fill by June 2024
Band 3, 0.80 WTE Claims Administrator
Band 5, 1.00 WTE Patient & Family Relations Officer
Band 5, 1.00 WTE Patient & Family Relations Officer
Band 5, 1.00 WTE Patient & Family Relations Officer
Band 4, 0.80 WTE Legal Services Coordinator
Band 4, 1.00 WTE Legal Services Coordinator
Band 4, 0.80 WTE Legal Services Coordinator
Band 4 1.00 WTE Putting Things Right Coordinator
Band 6, 1.00 WTE Deputy Patient Safety Manager
Band 6, 1.00 WTE Deputy Patient Safety Manager
Band 6, 0.6 WTE Deputy Patient Safety Manager Vacant Recruitment commenced expected fill by July 2024
Band 6, 1.00 WTE Deputy Legal Services Manager
Band 6, 1.00 WTE Deputy Patient & Family Relations Manager
Band 7, 1.00 WTE Patient Safety Manager
Band 7, 1.00 WTE Patient Safety Manager
Patient Safety
Band 7, 1.00 WTE Legal Services Manager
Band 7, 0.6 WTE Patient & Relations Relationships Manager
Band 8a, 1.00 WTE Deputy Head of Patient Safety (Recruited expected by June 2024)
Solicitor Band 8B, 0.60 WTE
Head of Patient Safety, Concerns & Learning Band 8B 1.00 WTE
Head of Putting Things Right Band 8C 1.00 WTE
Assistant Director of Quality & Nursing Band 8D, 1.00 WTE
Matrix Working

Recovery Plan:
Team Well-being

Putting Things Right Team (PTR) Well-being

Current position	• Organisational change process completed with good staff engagement and overall positive outputs. • Team education and development requirements to deliver immediate & medium / long-term priorities. • Posts in the structure still to recruit to or start. • 5 (potentially 7) new staff from outside of the Trust to start in the team.
Key actions by managers	• Induction, education & training programmes for new staff. • Development programme for new & existing staff in new roles. • Away Days 14 & 15 May 2024 to form new operating plan. • Staff awareness of well-being support mechanisms.
Engagement / key dependencies	• People & culture support at Away Days ('Colours' work) – engaged & booked. • People & culture management & leadership develop programmes. • Develop key relationships and operating framework across PTR Team and Operations Quality (currently going through OCP). • Engagement and response from WAST teams. • Engagement and response from system colleagues.
Metrics & oversight by Head of PTR	• Sickness absence & turnover. • Staff engagement & feedback through PTR meeting, team meetings & 1:1s. • Uptake of development opportunities. • Staff 1:1 meetings in place as business as usual. • Staff surveys including work / life balance.
Current issues & mitigations	**Issues include:** • The PTR Team currently has gaps in a number of roles due to sickness / absence including key leadership roles. • Three posts are pending recruitment (progressing). • New staff require comprehensive induction, education and training and mentorship. The administrators handling patient and family relations in particular require a significant amount of resource initially. **Mitigations include:** • Temporary bank staff cover to back fill gaps in some roles with experienced staff to cover day to day functions and develop new staff whilst recruitment processes progress. • Temporary acting up to cover leadership roles. • Cross cover / matrix working across the PTR functions.

Recovery Plan: Patient & Family Relations (complaints)

Patient & Family Relations: Complaints

Current position

- Patient & Family Relations Team recruited to. 3 new administrators in PTR Hub starting April 2024 who cover patient & family calls and emails, referring & escalation of complaints and logging on Datix Cymru.
- Improved position on the 5-day complaints response time from 71% to 95% but not consistently maintained.
- Consistently underperforming on the 30-day response.
- Dedicated part time (0.6wte) B7 Patient & Family Relations Manager in place from April 2024.

Key actions

	Lead	Timescale	Position
1. Trajectories covering complaints handling process.	JP/JW	16.04.2024	Complete
2. Development of KPIs at each stage of the process to identify blockers to achieving timely responses. Need to include interim response and quality assurance measures as no function in Datix Cymru currently to record these metrics, so internal Microsoft form to be developed.	CA/SJ	30.06.2024	On track
3. Development of dashboards with volume of cases and handlers to be refreshed initially weekly (as part of a wider PTR Performance Dashboard) which currently will be manually produced and then develop an automated process with Health Informatics support when available.	JP/JW	31.03.2024	Complete
	LJ/JW	Live data TBC	Not yet started
4. Implement rota system for PTR administrators to avoid constant complaint handling.	SJ/EGY	31.07.2024	On track
5. Daily, weekly and monthly performance meetings with team with dedicated manager in post.	SJ	April 2024	Complete
6. Implement the recommendations from the WRP Concerns Assessment 2023/4 (includes SOPs).	CA/SJ	30.06.2024	On track
7. Establish a suitable central hub for administrators to undertake calls at Beacon House (estates).	SJ/RD	TBC	Scoping
8. Complaints data quality: Quality assure the feedback data and review the coding to ensure minimal usage of the 'other' code to improve analysis.	SJ/JW	31.07.2024	On track
9. Develop an escalation process for the PTR inbox and complaints response with clear actions to be taken and focused support and process map the whole complaints process.	SJ	Away Days & 31.07.2024	On track
10. Determine alternative arrangements for handling general Trust enquiries. The PTR email / number is used as the 'catch all' for all queries and advice which impacts on PTR functions. The Trust should have a general enquiries inbox and telephone line to handle non-PTR business e.g. lost property, road traffic accidents and general requests.	LW/AK	Q3 2024/25	Not yet started
11. Adoption and implementation of new PTR Regulations (Autumn) and refresh documents*.	CA	Q4 2024/25	Not yet started

* Linked to Internal Audit Tracker Joint Investigation Framework

Recovery Plan: Patient & Family Relations (complaints)

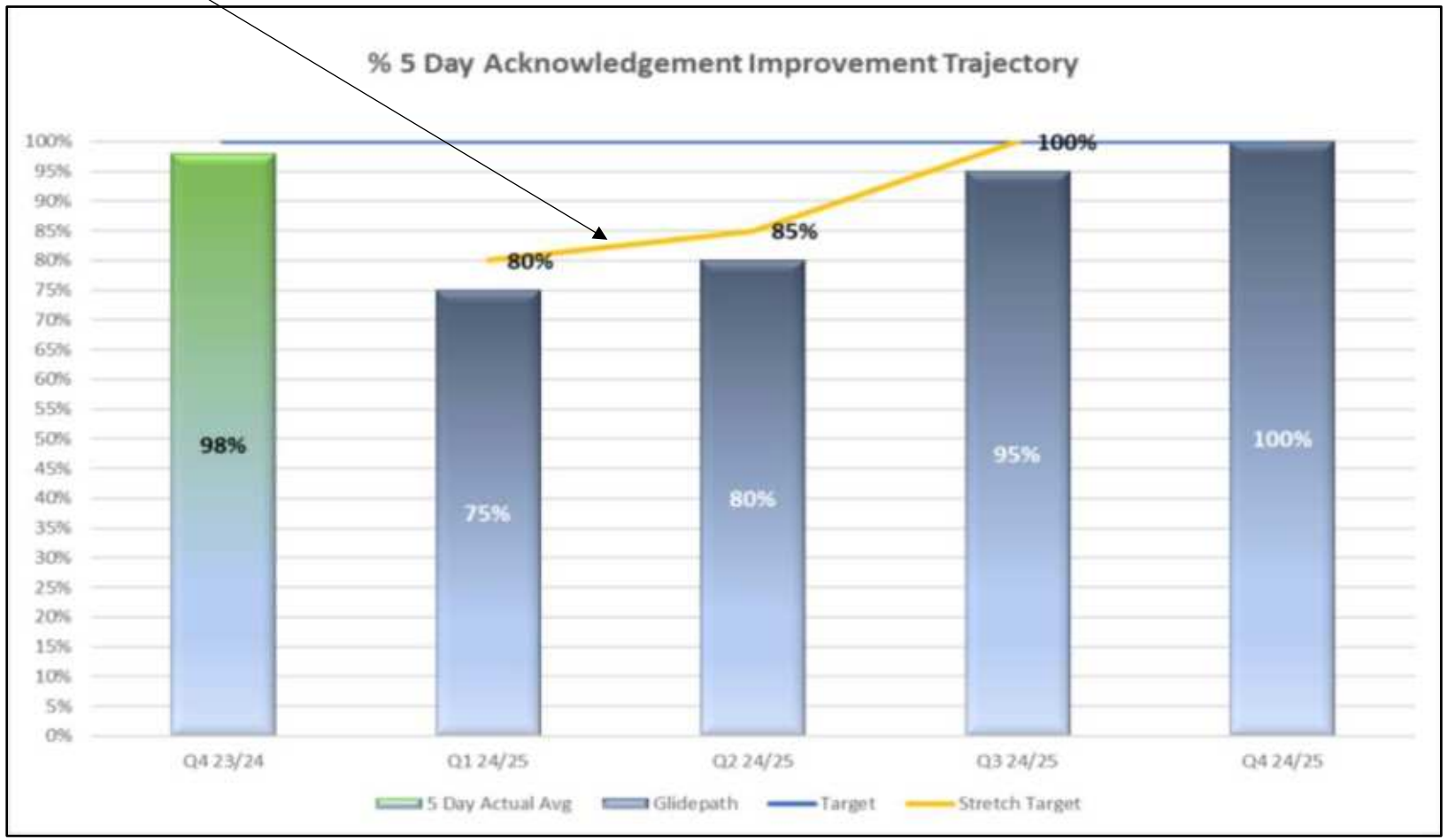
Patient & Family Relations: Complaints

Engagement / key dependencies	• Operations Quality delivery including audits and investigations. Team undergoing organisational changes process currently. • Engagement and response from WAST teams. • Engagement and response from system colleagues. • Implementation of general enquiries access into the Trust. • Datix Cymru functionality – automated reminders for response due dates. • Datix Cymru capacity locally. • Support from Health Informatics regarding live data feeds from Datix Cymru and BI functionality. • Continued engagement at Once for Wales networks and system meetings to ensure WAST can influence system changes and improvements. • Awaiting revised PTR Regulations planned Autumn 2024 by Welsh Government.
Metrics & oversight	• Welsh Government 5-day response – 100% - trajectories detailed on slide 6. • Welsh government 30 – day response 75% (with stretch to 85% for resilience) - trajectories are detailed on slide 7. • Monthly Integrated Quality & Performance Report and Quarterly PTR Report presented to Clinical Quality Governance Group & the Quality, Patient Experience & Safety Committee.
Current issues & mitigations	**Issues include:** • A live BI dashboard was developed with Health Informatics (HI) for complaints providing oversight of initial and 30-day responses by health board area, however the data cannot be validated due to issues between Datix Cymru and WAST systems. This is now on hold. HI are challenged in respect of capacity currently. • The volume of Once for Wales meetings and national Networks whilst extremely helpful are challenging to service, but WAST needs to have a presence to influence system changes and to be sighted on national issues. • 3 new staff PTR administrators started April 2024 need education, training & mentorship which the existing team members need to undertake. Sickness / absence in the Patient & Family Relations team. **Mitigations include:** • Manual data extraction being undertaken. Work with Health Informatics when capacity allows. • National Once for Wales meetings are prioritised across the Directorate as capacity allows. • Flex and cover across roles as much as possible in short term whilst education and training period completed.

Patient & Family Relations: Complaints Response Trajectories

Recovery Plan: Patient & Family Relations (complaints)

Three new PTR administrators started in post early April 2024. These staff are new to the Trust and require education and training on Trust systems. Some existing staff members covering complaints functions have been released to undertake this. As such a reduction in compliance against the target is predicted.

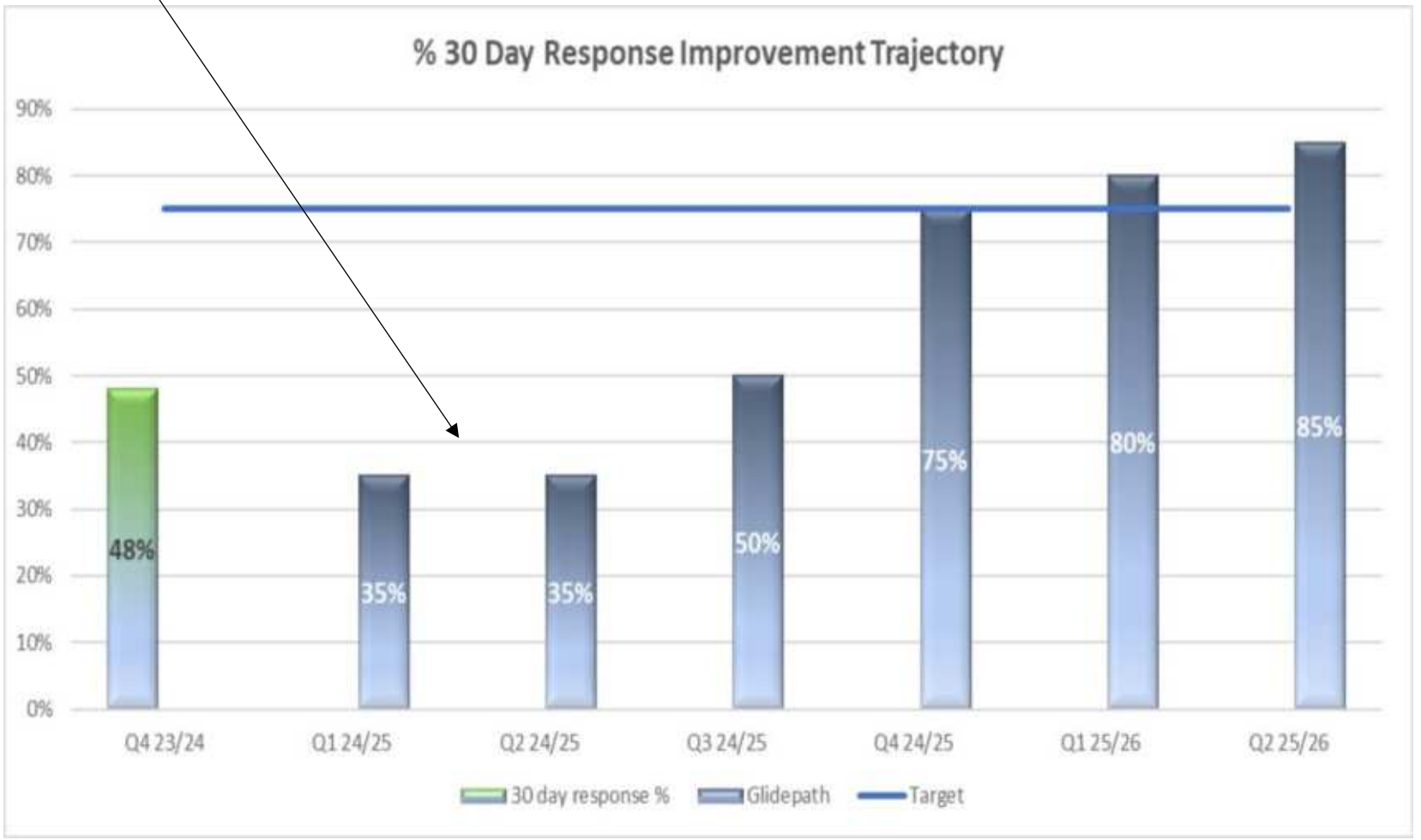


5 Day Response

Patient & Family Relations: Complaints Response Trajectories

Recovery Plan: Patient & Family Relations (complaints)

The 5-day response directly impacts on the 30-day response in respect of the time available to investigate and respond to patients and families. Additionally, the way in which the target is calculated results in a 'tail' as the out of timescale complaints are closed. The Patient & Family Relation Officers are also training & educating staff during April & May resulting in additional impacts ahead of sustained improvements.



5 Day Response

Patient & Family Relations: Complaints

Recently Developed Interactive Dashboards for Complaints Monitoring (currently manual extraction)

Count of Primary Location - H	Column Lab						
Health Board	Aneurin Bevan	Betsi Cadwaladr	Cardiff & Vale	Cwm Taf Morgannwg	Hywel Dda	Powys	Swansea Bay
Jun 22					2		
Jul 22		1					
Aug 22		1			2		
Sep 22							1
Dec 22					1		
Feb 23		1					
Mar 23	1						
May 23	1						
Jul 23		2					
Aug 23	1					1	
Sep 23	1				2		
Oct 23	2	1			2	1	
Nov 23	3					1	1
Dec 23	4	1				1	4
Jan 24	6	5		1			5
Feb 24	8	9	2	3	1		4
Mar 24	14	10	9	7	5	4	6
Apr 24	4	3		1	2		3
Grand Total	45	34	11	12	17	8	24

Count of Pr	Colur				
Service	111	CSD	EMS Control / CCC	EMS Ops	NEPTS / UCS
Jun 22			1	1	
Jul 22			1		
Aug 22			2	1	
Sep 22			1		
Dec 22			1		
Feb 23			1		
Mar 23	1				
May 23					1
Jul 23			2		
Aug 23	1	1			
Sep 23		1	2		
Oct 23			3	1	2
Nov 23			1	2	2
Dec 23			7		3
Jan 24	1		6	6	4
Feb 24	2	1	5	6	13
Mar 24	2		27	12	14
Apr 24	1		7	1	4
Grand Total	8	3	67	30	43

Count of Curre	Colur				
Current Sta	Advice/Approval from Redress	Awaiting comments from Service	Investigation complete	Opened	Quality Assurance
Jun 22	2				
Jul 22	1				
Aug 22	1			2	
Sep 22					1
Dec 22	1				
Feb 23	1				
Mar 23				1	
May 23				1	
Jul 23	2				
Aug 23				2	
Sep 23				3	
Oct 23	2		1	3	
Nov 23	1	1		3	
Dec 23	1			9	
Jan 24	1		3	12	1
Feb 24				25	2
Mar 24			1	51	3
Apr 24			1	12	
Grand Total	13	1	6	124	7

Response %	In Date Final Response Date Total	In Date Final Response Date %
In Date response due da	50	33%
Out of date response du	101	67%
Grand Total	151	

Primary Serv...
- 111
- CSD
- EMS Control / CCC
- EMS Ops
- NEPTS / UCS

In Date Final Resp...
- In Date response due date
- Out of date response due date

Current Stage
- Advice/Approval from Redr...
- Awaiting comments from Se...
- Investigation complete
- Opened
- Quality Assurance

Initial Complaint Gr...
- Grade 1
- Grade 2
- Grade 3
- Grade 4

Count of In Date Final Respor	Column Lal		
Service	In Date response due date	Out of date response	rand Total
111	1	7	8
CSD		3	3
EMS Control / CCC	35	32	67
EMS Ops	9	21	30
NEPTS / UCS	5	38	43
Grand Total	50	101	151

Recovery Plan:
Nationally Reportable Incidents

Patient Safety: Nationally Reportable Incidents (NRIs)

Current position

- Consistently breaching the investigation timeframes for Nationally Reportable Incidents. 58 remain open, with 38 being overdue.
- Limited feedback / learning from the Joint Investigation Framework process.
- Improve processes to ensure patient safety incidents graded as moderate incidents are detected.

Key actions

	Lead	Timescales	Current Position
1. Deep dive on all currently open NRIs.	CA	23.04.2024	On track
2. Process map incident investigation process and then determine improvement trajectories.	CA/JW	31.08.2024	On track
3. Development of KPIs at each stage of the process to identify blockers / challenges.	CA/LJ	31.08.2024	On track
4. Development of dashboards with volume of cases and handlers to be refreshed initially weekly (manually) and devise trajectories for recovery.	CA/JW	31.08.2024	On track
5. Work towards an automated live system with Health Informatics.	CA/JW	TBC	Not yet started
6. Commence tri weekly and monthly support meetings with team.	CA/LJ	12.04.2024	Complete
7. Determine realistic timeframes e.g. internal 90 day / external 120 day.	CA/LJ	30.04.2024	On track
8. Commence Monday / Wednesday / Friday Patient Safety Team additional scrutiny of incidents triggering to prioritise cases for SCIF / audits. 72-hour review.	CA/LJ	12.04.2024	Complete
9. Redesign and review of the Serious Case Incident Log to enable improved tracking and analysis and on at least at monthly basis.*	CA/JW	31.07.2024	On track
10. Introduction of a tracker and underpinning process for the incidents referred as part of the Joint Investigation Framework to capture learning and any subsequent actions e.g. Duty of Candour / national reporting by health boards.*	CA/JW	30.06.2024	On track
11. Refresh of Trust versions of the National Patient Safety Incident Reporting & Management Policy and Putting Things Right Policy (& SOPS) when national documents released by Welsh Government.	CA/LJ	TBC (WG)	Not yet started
12. In consultation with relevant teams determine the Trust's investigation tools (e.g. SEIPS) and output and quality measures for investigations (including patient & family engagement).	CA/LJ	Q4 2024/25	Not yet started

* Linked to Internal Audit Tracker Joint Investigation Framework

Recovery Plan: Nationally Reportable Incidents (NRIs)

Patient Safety: Nationally Reportable Incidents (NRIs)

Engagement / key dependencies	• Operations Quality delivery including audits and investigations. Team undergoing organisational changes process currently. • Engagement and response from WAST teams. • Engagement and response from system colleagues. • Backlog of incident investigations in Operations. • Once for Wales pilot of Joint Investigation Framework Module on Datix Cymru (Cardiff & Vale UHB) • Health Informatics support with live data feeds and dashboards.
Metrics & oversight	• NHS Executive 60/90/120-day completion of investigations. • Monthly Integrated Quality & Performance Report and Quarterly PTR Report @ Clinical Quality Governance Group & Quality, Patient Experience & Safety Committee.
Current issues & mitigations	**Issues** • All Wales mandate on investigation methodology is RCA – newer approaches should be considered by the Trust. • No facility in Datix Cymru to record investigation internally or flag Joint Investigation Framework. • The volume of Once for Wales meetings and networks is challenging to service. **Mitigations** • Once for Wales piloting a module for the Joint Investigation Framework process in Cardiff & Vale University Health Board. • Directorate colleagues prioritising Once for Wales & network meetings to ensure WAST is engaged and influences developments.

Recovery Plan:
Learning from Events

Patient Safety: Learning from Events (including Welsh Risk Pool)

Current position

- Learning processes need strengthening across the Trust.
- The Trust are engaged in the All Wales Enhancing Learning Programme.
- Welsh Risk Pool are now applying penalties for delays in evidencing learning improvements (no penalties to date).
- The Trust participant on the All Wales Learning Advisory Panel.
- WRP updates from WRP Committee are included in the Quarterly Putting Things Right Report.
- Current position: 7 Amber Deferred (5 x Redress and 2 x Claims) and & 3 Red Deferred cases (Redress)– due approval by July 2024 WRP Committee.
- Risk of financial penalties for not meeting reimbursement procedures form Welsh Risk Pool.
- In the new PTR Structure, the Learning from Events Reports sit in the Patient Safety Team. (previously Legal Services).

Key actions

	Lead	Timescales	Current Position
1. Implementation of the All-Wales Learning from Events Framework (WAST version) (includes WAST Learning Hub & interactive PTR Intranet site)	LJ	Q4 2024/5	Not yet started
2. Skill up the Patient & Family Relations Team and Patient Safety Team to complete the WRP Learning from Events Reports & underpinning evidence provision to reduce duplication.	CA/LJ	30.08.2024	Not yet started
3. Process map the WRP LFER handling process.	CA/LJ	31.08.2024	On track
4. Development of KPIs at each stage of the process to identify blockers to achieving timely responses including corporate and operational team responsibilities (national work).	CA/LJ	31.08.2024	On track
5. Development of dashboards with volume of cases and leads to be refreshed initially weekly (manually) and then develop an automated process with Health Informatics support.	CA/JW	31.07.2024	On track
	CA/JW	Live TBC	Not yet started
6. WRP position and escalation of issues in evidence provision to be included on the Complex Case Panel AAA Report to CQGG.	CA/CP	31.07.2024	On track
7. Interim focussed meeting to review the current amber & deferred cases and evidence.	JP/CP	18.04.2024	Completed
8. External education session with WRP Principal Safety & Learning Advisor for WAST.	LJ	TBC	Date to be confirmed
9. Support Clinical Support Desk to set up a process to respond to WRP requests.	CP	30.06.2024	On track
10. Review of Learning from Events Report & evidence at Patient Safety Team meeting prior to Head of Putting Things Right QA & approval.	CA/LJ	31.05.2024	On track

Recovery Plan:
Learning from Events

Patient Safety: Learning from Events (including Welsh Risk Pool)

Engagement / key dependencies	• Engagement and response from WAST teams for LFER development and evidence. • Engagement in the development & implementation of the Learning from Events Framework by WAST teams.. • Support from Digital Directorate in respect of proposed PTR Learning Hub and intranet site.
Metrics & oversight	• Welsh Risk Pool 12-month timeframe from trigger of Redress or Claim to approval of learning. • Number of cases approved with the 12-month period – indicates commitment to organisational learning. • Complex Case Panel AAA, Quarterly PTR Report at Clinical Quality Governance Group & QuESt. • WRP will be requesting an implementation plan for the Learning from Events Framework.
Current issues & mitigations	**Issues** • Challenges obtaining evidence from teams with competing priorities across the Trust. This can include evidence spanning a number of years. **Mitigations** • WAST Learning from Events Framework implementation will support the process through reviewing systems in each service and corporate departments for identifying and sharing learning and knowledge management. • Current actions include review meetings to target cases which may be at risk from penalties.

Patient Safety & Legal Services: Learning from Deaths

Recovery Plan: Learning from Deaths

Current position

- PTR Legal Services Manager now in place.
- Funding for Operations Quality part time post to support the Operations Directorate to ensure Coroners requirements are met e.g. statements & evidence gathering. OCP in progress in Operations Quality.
- Continued significant number of coroners' requests & Regulation 28 Reports received.
- Backlog of Medical Examiner referrals to review and theme. An initial screen and escalation to SCIF has occurred as appropriate.
- Learning from Deaths Forum established.

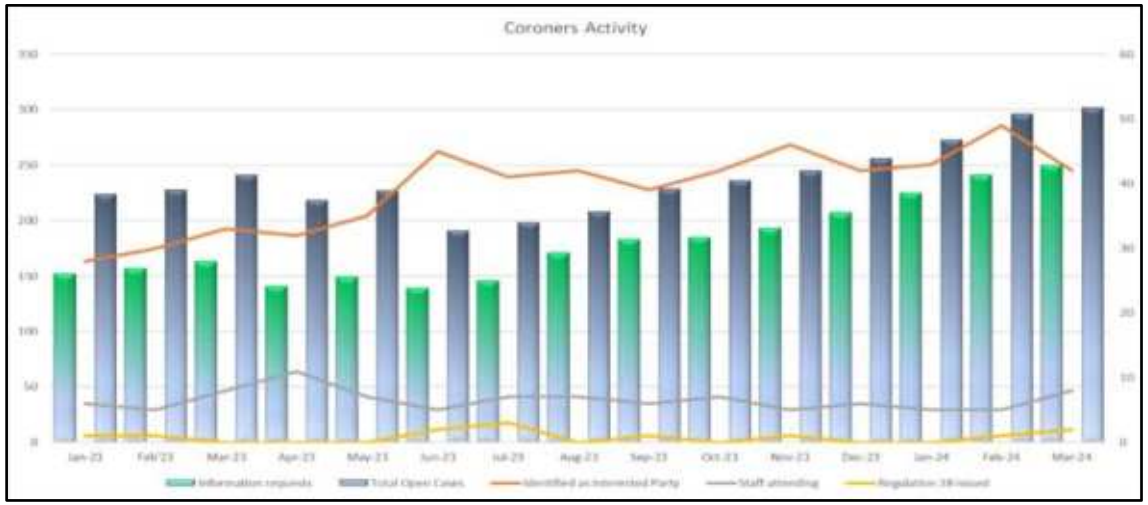
Key actions

	Lead	Timescales	Current Position
1. Process map the Medical Examiner Referral process.	JP/JW	31.07.2024	On track
2. Development of KPIs at each stage of the process to identify blockers to achieving timely reviews of the ME referrals and sift and sort scrutiny process.	CA/LJ	31.07.2024	On track
3. Development of dashboards with volume of Medical Examiner referrals cases and leads to be refreshed initially weekly (manually) – as part of PTR performance dashboard.	CA/LJ	31.07.2024	On track
4. Work towards an automated live system of Medical Examiner referrals with HI support.	CA/LJ	TBC	Not yet started
5. Refresh the WAST Learning from Deaths Framework following publication of the second version of the national framework and primary care guidance.	JP/LJ	30.08.2024	Not yet started
6. Review all Medical Examiner referrals up until 31.03.2024 and undertake a mapping exercise against incidents, complaints, inquests and claims. Produce a report to include with themes / patterns and trends and align to current work programmes.	JP/LJ	30.08.2024	On track
7. Medical Examiner referrals to be considered as part of the Patient Safety Team meetings (from April 2024) and trigger to SCIF or the Learning from Deaths Forum.	CA/LJ	30.04.2024	On track
8. Ensure continued representation at national Mortality Review Working Group and Once for Wales Mortality Datix Cymru System meetings to ensure WAST can influence.	CA/LJ	From April 2024	Complete
9. Develop an escalation process for the Medical Examiner inbox with clear actions.	CA/LJ	31.07.2024	On track
10. Develop a process to capture involvement and learning from health board mortality reviews (links to the Learning from Events Framework development & implementation).	CA/LJ	Q4 2024/5	Not yet started
11. Development of natural language process programme to theme the qualitative information provided by the Medical Examiner Service by Health Informatics.	LS (HI)	Q2 2024/5	Not yet started

Recovery Plan:
Learning from Deaths

Patient Safety & Legal Services: Learning from Deaths

Engagement / key dependencies	• Operations Quality delivery including audits and investigations. Team undergoing organisational changes process currently. • Engagement and response from WAST teams. • Engagement and response from system colleagues.
Metrics & oversight	• Regulation 28 Reports – timeframe 56 days. • Medical Examiner Service referrals – no metrics / oversight currently. Internal metrics to be developed. • Quarterly PTR Report @ Clinical Quality Governance Group & QuESt
Current issues & mitigations	**Issues** • Backlog of referrals from Medical Examiner Service and plan in place to undertake a thematic review and mapping exercise of all cases for review at the Learning from Deaths Forum in Q2 2024/25. **Mitigation** • Screening of cases in place. • Current cases to form part of the Patient Safety Team's scrutiny meetings and sifting panel to be established.



Medical Examiner Referrals As of 17.04.2024	Total Records	Overdue
New	4	1
Pending Level 1 Lead Clinician Review	526	484
Pending Level 2 Scrutiny Panel	0	0
Further Information / Action Required	0	0
Closed by Panel - Pending Feedback to ME	1	1
Process Completed - Closed	326	

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

PATIENT EXPERIENCE & COMMUNITY INVOLVEMENT BI-ANNUAL REPORT (OCTOBER - MARCH 2023/2024)

MEETING	Quality, Patient Experience & Safety Committee
DATE	7 May 2024
EXECUTIVE	Liam Williams, Executive Director of Quality & Nursing
AUTHOR	Leanne Hawker, Head of Patient Experience & Community Involvement
CONTACT	Leanne.Hawker@wales.nhs.uk

EXECUTIVE SUMMARY

1. This report provides an overview of the work undertaken over the last six months in capturing peoples feedback and experiences as well engaging with people to provide a platform for their voices to be heard as required in the Citizens voice component of the Health and Social Care (Quality and Engagement) (Wales) Act 2020-21.
2. Patient experience is a 'golden thread' that runs throughout the Trust's Integrated Medium-Term Plan (IMTP) and is at the heart of our services. The Patient Experience & Community Involvement (PECI) Team continues to engage in an ongoing dialogue with the public on what they think are important developments the Trust could make to improve quality and how it feels to be user/patient of it services.

RECOMMENDATION: That the Committee

(1) Receives the report and accept the assurances that the Trust is meeting its statutory duties/responsibilities to consult, engage and involve the public/patients in its work, and

(2) Is requested to note the activities to date and acknowledge that PECI Reports will be shared publicly through the Trust's People & Community Network.

KEY ISSUES/IMPLICATIONS
(i) We have been required to submit our Patient Experience Civica Performance Report for Quarters 1, 2 and 3 of 2023/24 for validation and onward reporting to Welsh Government as part of the new Reporting Framework. The Civica Performance Reports are currently reporting low numbers. (ii) The information governance arrangements pertaining to contacting service users for Surveys is ongoing. A Data Protection Impact Assessment (DPIA) covering 999, 111 and any other methods for Surveys is in the process of being drafted and will be submitted for formal consultation with the Information Commissioner's Office (ICO). The DPIA will identify and address risks and issues including what are the reasonable expectations of callers/patients to be contacted (this would be the first time in our Trust history that 999 callers would be contacted in this way), on the lawful basis and opt-in/opt-out process. (iii) While we work to resolve this issue and to be able to meaningfully use the system to upscale the feedback we are receiving to inform service improvement and partnership working, we continue to signpost people to our Trust website where they can complete and submit a Patient Experience Survey online. We are also exploring the use of QR codes on ambulance vehicles and via Putting Things Right materials/responses.

REPORT APPROVAL ROUTE	
Clinical and Quality Governance Group	30 April 2024
Quality, Patient Experience & Safety Committee	7 May 2024

REPORT APPENDICES	
ANNEX 1	SBAR Providing an overview of patient experience and community involvement
ANNEX 2	Patient Experience & Community Involvement Bi-Annual Report

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

ANNEX 1

SITUATION

1. The team has continued engaging, capturing experiences, and listening to public, patients, and carers throughout the last six months.

2. Key themes from service-user feedback continue to be around anxiety and frustrations associated with emergency ambulance response delays, which is well documented. For Ambulance Care the key themes are associated with the length of time people wait to be transported home after their hospital appointment. However, feedback is also reflecting how reassured people feel by the professional and compassionate behaviour of staff which is instilling confidence with patients and their families in the care and treatment they are receiving.

3. The PECI Work Programme during this period has been primarily focused on promoting Civica, identifying opportunities to extend the reach of Patient Experience Surveys and returns as well as applying for external funding opportunities to support key pieces of work associated with improving the experiences and outcomes for people with a learning disability.

4. All PECI activity is mapped against the Quality Standards to provide assurance against the Duty of Quality and improvement in outcomes by using:

- Patient Reported Experience Measures (PREMs)
- Once for Wales CIVICA System for patient experience
- Patient stories
- People & Community Voices Network
- Community involvement using a co-creative and production approach.

5. PREMs for this period are included within the PECI Bi-Annual Report (**ANNEX 2**).

BACKGROUND

6. The Trust has a legal duty to engage with service users and communities to listen and capture their experiences and involve them in influencing, designing, and delivering services as set out in:

- Framework for Assuring Service User Experience
- NHS Wales Performance Framework
- Social Services and Well-being (Wales) Act 2014-18
- Well-being of Future Generations (Wales) Act 2015-19
- The National Principles for Public Engagement in Wales (2011)20

- Health and Social Care (Quality and Engagement) (Wales) Act 2020-21

- Health and Care Standards to be replaced by 'The Quality Standards' - April 2023
- A Healthier Wales 2022

ASSESSMENT

7. The contribution and key deliverables of the PECI Team towards improving patient experiences, quality of services and enhancing the reputation of the Trust across communities is included within the Bi-Annual Report (**ANNEX 2**).

Patient Experience & Community Involvement (PECI)

Bi-annual report October – March 2023/24

GIG CYMRU NHS WALES

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

PECI.TEAM@Wales.nhs.uk

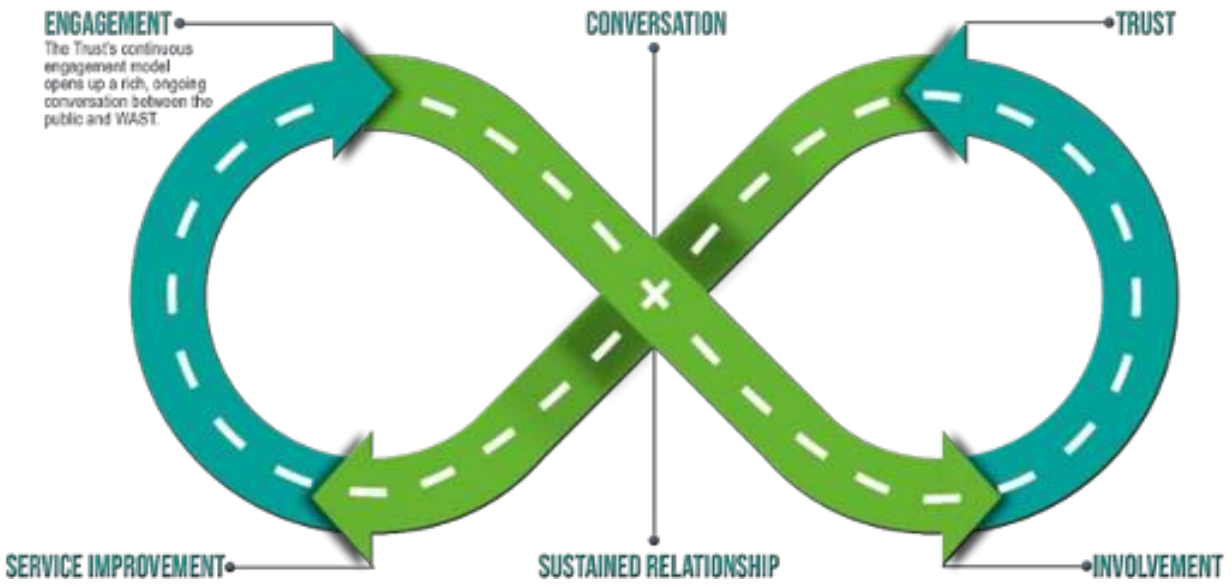
Contents

Patient Experience within the Welsh Ambulance Service

Patient experience at the Welsh Ambulance Service (WAST) is influenced by the many interactions people have with our staff, their expectations when in need, and their first and lasting impressions of those interactions.

The patient experience within this report is defined by what it feels like for people to access and receive care from WAST, it is based on their perceptions of their care and treatment.

Experience has been captured and reported directly by patients, their families and carers using our continuous engagement model and various channels for experience feedback. Though this may be seen as a subjective indicator of quality, experiences and feedback are essential components for monitoring and serving as quality indicators.



"If quality is to be at the heart of everything we do, it must be understood from the perspective of patients." *Lord Darzi*

NHS Wales Performance Framework (Learning Disabilities)

Performance Measure Learning Disabilities (LD) – Improving the lives of people with learning disabilities.

- A change request to make improvements to EPCR to record; patients having additional needs (LD, Autistic and Neurodiverse) and a prompt to record reasonable adjustments that are made on scene, was submitted and a prototype solution is in development. The change was funded by Improvement Cymru LD Team, who are also collaborating to explore funding opportunities to make improvements for LD on telephony systems.
- An options appraisal was compiled to improve ability to flag records that patients have additional needs (LD, autistic and neurodiverse) on telephony systems and patient records/addresses. The appraisal identified some short and longer-term potential options, with support from Improvement Cymru earmarked for this year.
- In preparation for the call for applications for funding with the Royal College of Nursing Foundation. PECI attended 7 engagement sessions nationally to canvas the community and professionals on 3 potential projects, the development of our pre-hospital communication app, flagging (as above) and a video on basic observations. PECI submitted a bid for the video to train staff on best practice during observations and inform patients.

Future Generations Commissioner & Children's Commissioner

Future Generation's Commissioner Well-being goal (A Healthier Wales)

Shoctober (Campaign held throughout October)
A WAST led primary education campaign aligned to the well-being goal of a Healthier Wales; NHS Wales out of Hospital Cardiac Arrest Plan (June 2017) and Save a Life Cymru. Also working towards long term achievement of developing well informed adults. The campaign encourages pupils to become future lifesavers and resilient members of the community.

Expressions of interest from schools this year were up by 194% (highest level recorded since its launch in 2016) also;

- 83 volunteers who attended sessions, highest to date.
- 68 schools attended across Wales, including 11 Welsh medium schools with 4 sessions being delivered in Welsh.

For 2024 we will include new health scenarios to enable pupils to consider when 999 is appropriate and record an emergency 999 simulation call with a younger caller not knowing their home address.

Children's Commissioner 'The Right Way' a children's rights approach

'7 Important checks' is the latest feature developed and added to our WAST 'Blue Light Hub' gaming app.

The bilingual gaming app, aimed at 7–12-year-olds is designed to assist children & young people in understanding what happens when they call 999 and how we prioritise patients. It also aims to familiarise players with equipment emergency crews use, and why they use them, alleviating any fears young patients may have and promote a positive experience.

The app is available on all staff iPads. Under strict supervision and parental consent, staff have the option us the app for play and distraction technique purposes. The app is also free to download at Google Play and Apple.

Framework for Assuring Service User Experience

CIVICA – WAST Patient Experience Surveys

We continue to promote 4 core Patient Experience Surveys covering WAST's main service delivery areas:

999 EMS Experience Survey

This survey is currently made available to members of the public online through the WAST website and social media channels. We do not have a governance process in place allowing us to directly contact 999 users to ask for feedback, as a result service users must use their own initiative and seek out the survey themselves to provide feedback.

This means that responses to the survey remains lower than we would like. We are continuing to work closely with colleagues in the Information Governance Team to find a resolution to this problem and will be submitting a paper and updated Data Protect Impact Assessment (DPIA) to the Information Commissioner's Office to seek their guidance.

Over the past few months, we have worked closer with the Corporate Communication's Team to increase visibility of this survey across the Trust's social media platforms, which has resulted in a slight increase in engagement with the survey.

We have also connected with other ambulance services across the UK to learn more about what they are doing to capture experiences of their 999 service users. Colleagues at the South-East Coast Ambulance Service have shared with us information about a new campaign they have launched to capture experiences, using QR codes placed in the back of all their emergency vehicles, linking to an experience survey. We plan to explore options for rolling out a similar campaign across WAST over the coming months.

A full breakdown of EMS Experience Surveys completed can be found in Appendix 1.

Framework for Assuring Service User Experience

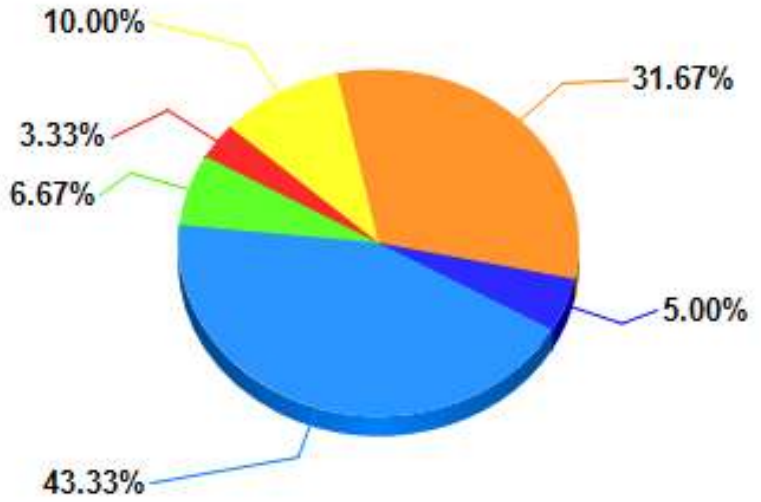
NHS 111 Wales Experience Survey
There are two surveys in place for NHS 111 Wales, separately collecting feedback about people's online experience and telephony experience.

We expect that the implementation of the new CPSS system in NHS 111 Wales will offer future opportunities to increase the number of patient experience feedback on the service. We are currently reliant on people using their initiative and accessing the survey online themselves to provide feedback.

The online experience survey is available through the NHS 111 Wales website, users are prompted to leave feedback using a pop up that appears on screen.

In this reporting period **100** responses to the Telephony survey were received; and **228** to the Online survey. A full breakdown can be found in Appendix 1.

Thinking about the NHS 111 Wales service, how was your overall experience of our service today?



Available Answers	Responses	Score
Very Good	26	43.33%
Good	4	6.67%
Neither Good nor Poor	2	3.33%
Poor	6	10.00%
Very poor	19	31.67%
Don't Know	3	5.00%
Total	**60**	**100%**

Framework for Assuring Service User Experience

NEPTS Experience Survey

An established governance process is in place which allows us to contact people who have received transport to their appointment and ask for feedback. Responses to this survey continue to show us that overall NEPTS users are broadly satisfied with the service they receive. With negative comments tending to focus on timeliness.

Survey results show that wait time for transport home following an appointment is an ongoing area on concern for patients. Results also indicate that not all patients are being reminded to wear their seatbelt during their journey. To help us understand these areas of concern better, from 1st April 2024 we will ask more probing questions about these two areas of concern and will provide an update in our next report.

In this reporting period **702** responses were received. A full breakdown can be found in Appendix 1.

Thinking about the Non-Emergency Patient Transport Service, how was your overall experience of our service the last time you used it?

Available Answers	Responses	Score
Very Good	463	76.91%
Good	52	8.64%
Neither Good nor Poor	18	2.99%
Poor	20	3.32%
Very poor	43	7.14%
Don't Know	6	1.00%
Total	**602**	**100%**

Framework for Assuring Service User Experience

New & Developing PREMS Surveys

Falls Assistant & Falls Responder Surveys

Working with the WAST Falls Improvement Lead we have developed two Falls Experience surveys. One for Level 1 Falls Assistants and one for Level 2 Falls Responders. Patients attended to by either a Falls Assistant or Falls Responder who are treated and left at home are being left an invitation to complete a survey to share their experience. The invitation contains a QR code that can be scanned to complete a survey online; as well as the phone number and email address for the PECI Team for anyone who would like a hard copy survey sent out to them.

RITA Experience Surveys

Working with the Trust's Programme Manager for Dementia, we have developed a patient and staff survey to help us better understand the experiences of both parties when using RITA reminiscence tablets available in select vehicles across Hywel Dda.

Oncology Volunteer Car Transport Survey

Working with colleagues in Ambulance Care, we have developed a bespoke survey to look specifically at the experiences of oncology patients who travel top their hospital appointments using the Volunteer Car Service. Patients are being left an invitation to complete a survey following their transport when being dropped off at home. Copies of the survey are also being made available at hospital transport liaison desks.

Mental Health Survey

We are in the early stages of developing a survey for mental health callers. This would complement a national piece of work being done to look at the experiences of people using the NHS 111 Wales Press 2 service.

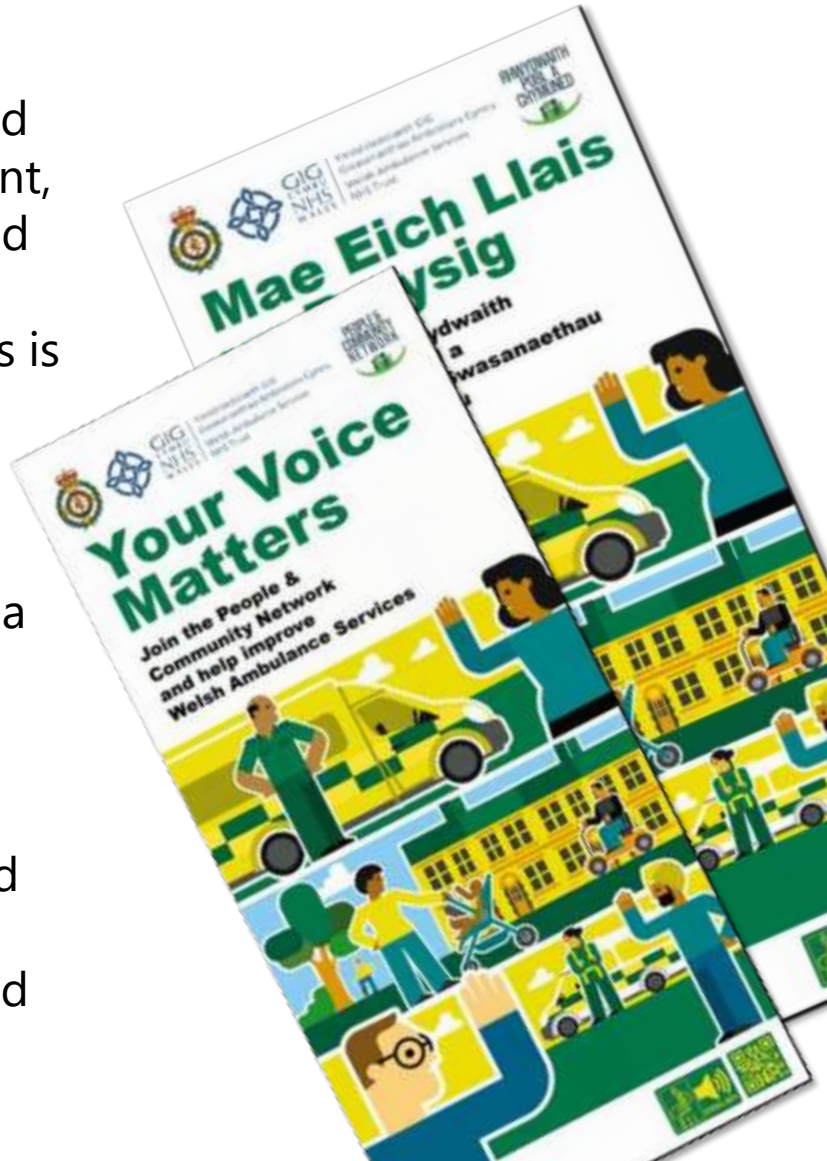
Citizens Voice- People & Community Network

The number of network members currently stands at 97. Network activities in the last 6 months have included:

- **People & Community Voice Group (PCVG) -** In February, 4 members joined the PCVG - a multi-stakeholder network to support the collective development, awareness and promotion of positive service user experience, accessibility and inclusion within the services we provide. Members have signed relevant governance documents to allow them to attend these internal meetings. This is a first for the Trust and indicates a formal step on our journey towards co-designing and co-producing Welsh Ambulance Services.

- **Research & Innovation – Patient and Public Involvement -**
  A selection of Network members have offered their time and efforts towards a funding bid for a research project with Health and Care Research Wales to Help Welsh Ambulance Service reduce violence and aggression faced by their staff.

- **Connected Support Cymru -** We have been approached by the team behind the Connected Support Cymru project to involve Network members in the development of the project. The PECI Team have joined their project team and will work to facilitate meaningful involvement with Network members and members of the public.



Citizens Voice - Llais

Llais is the new citizen's voice body for Wales, established in 2023 Llais will replace Community Health Councils (CHCs), and will represent the citizen voice across health & social care in Wales.

Llais are there to understand people's views and experiences of health and social care, and to make sure feedback is used by decision-makers to shape services.

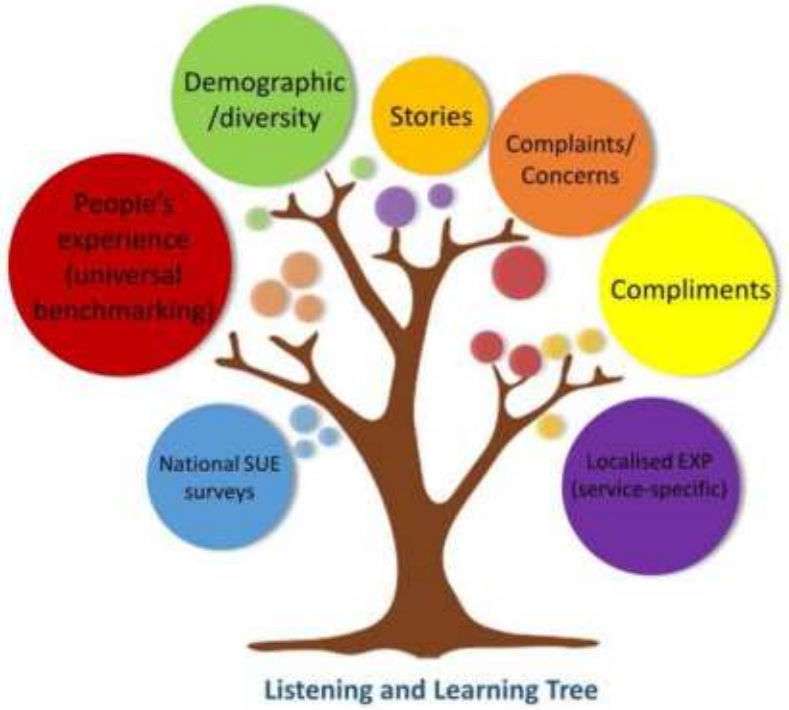
They seek out both good and bad stories to understand what works well and how services may need to get better. **They look to particularly talk to those whose voices are not often heard.**

Over the past six months the PECI Team has continued build relationships with Llais as they establish themselves as the overarching citizen's voice body for Wales. We have met with representatives from each of the regional Llais bodies to ensure we are, wherever possible, working co-productively when listening to people's experiences of using services delivered by the Welsh Ambulance Service.

Health and Social Care (Quality and Engagement) (Wales) Act 2020-21

Peoples Experience Framework (PEF)

- The Peoples and Communities Experience Framework, originally developed through collaborative efforts across Wales three years ago, has been revamped.
- Now rebranded as the People Experience Framework (PEF), it has been realigned to meet the standards of the Duties of Candour and Quality.
- The production of the framework has been a collective effort contributed to by representatives from across NHS Wales, Health Boards/Trusts. PECI represented WAST in the development of this cohesive framework.



People & Community Experience Framework

Patient Stories & Digital Storytelling

Patient Stories

- We have continued to work with patients their families and carers, along with healthcare professionals, WAST staff and volunteers to record their experiences as patient story videos, with actions mapped on story trackers.
- Common themes include delayed 999 response times/hospital handovers, and the ongoing psychological impact these issues have for patients and their families or carers.

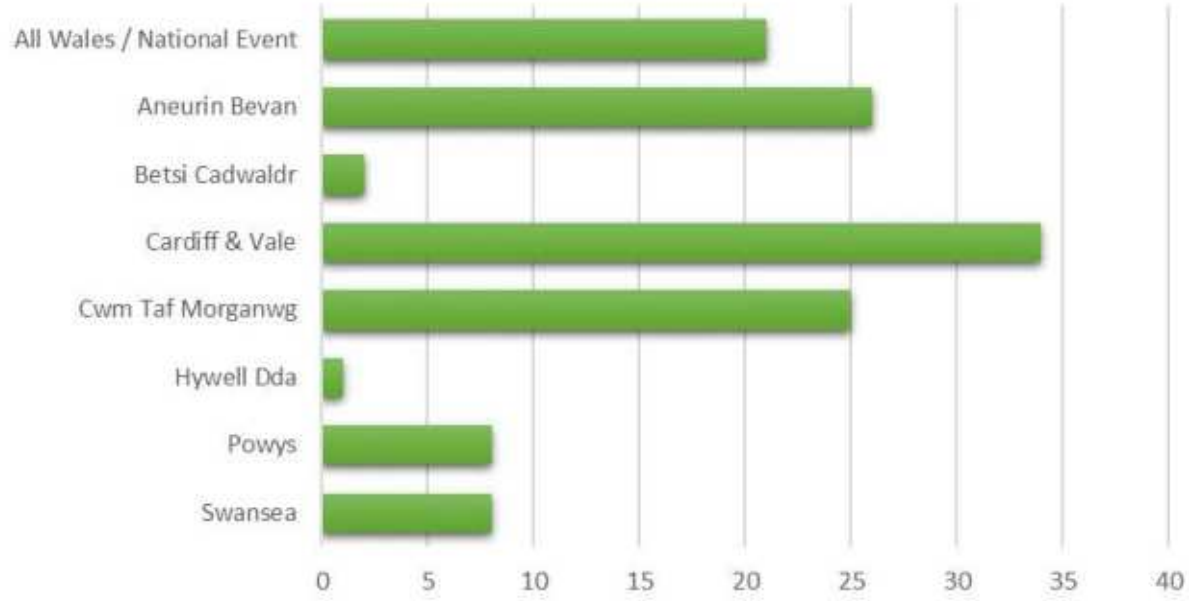
All Wales Digital Stories Network

- We represent WAST on the Network, where our innovative practice in patient storytelling through video and using our online Videobooth are acknowledged as exemplars.
- We are currently researching opportunities for presenting extended patient experience stories through podcasting to extend the digital reach, particularly for WAST staff.
- We are also in the process of launching a Patient Stories Page on the WAST Learning Launchpad staff training portal.

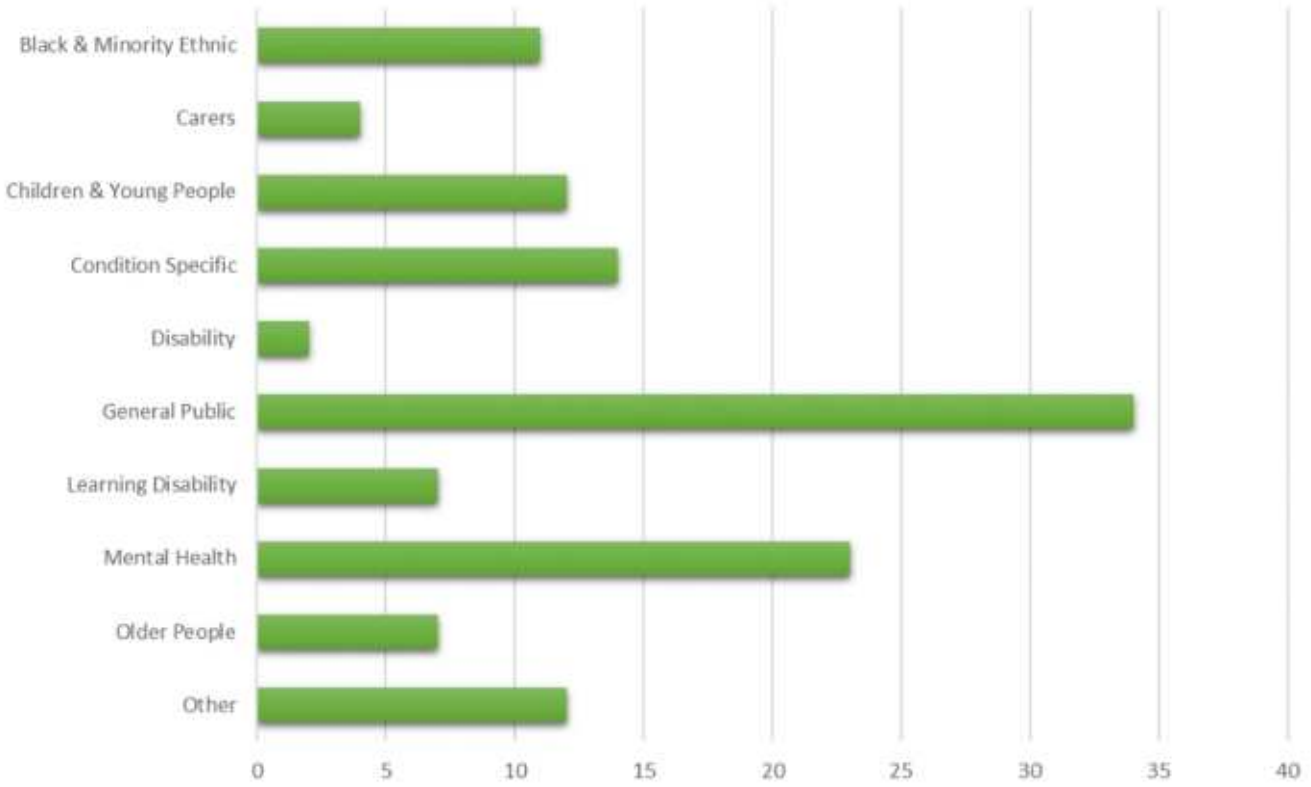
Community Involvement & Co-production

During this reporting period the PECI Team attended 126 engagement opportunities. Engaging with 9,059 people across Wales.

Engagement opportunities were attended in all Health Board areas, though a majority of these were focused across the south. Over the next six months we will make a greater effort to target engagement opportunities in North and West Wales to ensure people right across Wales have opportunity to engage with us, learn about our services and share their experiences.



Community Involvement
Who we engaged with



Experiences and feedback, captured through our engagement with communities covers a large cross section of the population.

There has been continued 'targeted' engagement with groups known to have the least positive experiences of accessing and receiving care such as Learning Disability, Black & Minority Ethnic, older people and Carers, this feedback has been used to identify areas for improvement.

Engagement with children and young people is linked to the ambitions of creating stronger/resilient future generations and supports our annual school education campaigns.

General population engagement is enabling us to develop ways to align our work with their needs and by understanding their expectations.

Community Involvement & Co-production

Integrated Medium Term Plan (IMTP)

- The team have shared public feedback, experiences and expectations to help shape the Trusts latest IMTP.
- We will be adapting our continuous engagement model by including a continuous feedback process to help shape future IMTP development.
- We will continue to share relevant information about the IMTP as part of our community engagement.

Minority Communities

- The Welsh Ambulance Service 'Welcome Pack' was successfully launched with partners at Ethnic Youth Support Team (EYST)
- Engagement trials showed that accessing the pack was problematic, and an improvement project successfully reduced the number of steps to access it.
- An online translation tool has been built into the pack to allow users to feedback in 'real time' and a new set of pictorial instructions for inclusion is in development, to be rolled out from April 2024.

Recognition

WAST Staff Award

At the WAST Staff Awards in October 2023, the PECI Team were pleased to be awarded the ‘Support Service Team of the Year’ award.

Welsh Experience National Awards (WENA)

At the inaugural WENA awards held in March 2024, the Welsh Ambulance Service was presented with the award for ‘Excellence in Collaboration & Partnerships’.

Bi-annual report
October 2023 – March 2024

APPENDIX 2, PREMs DATA

GIG CYMRU NHS WALES

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
NHS Trust

PECI.TEAM@Wales.nhs.uk

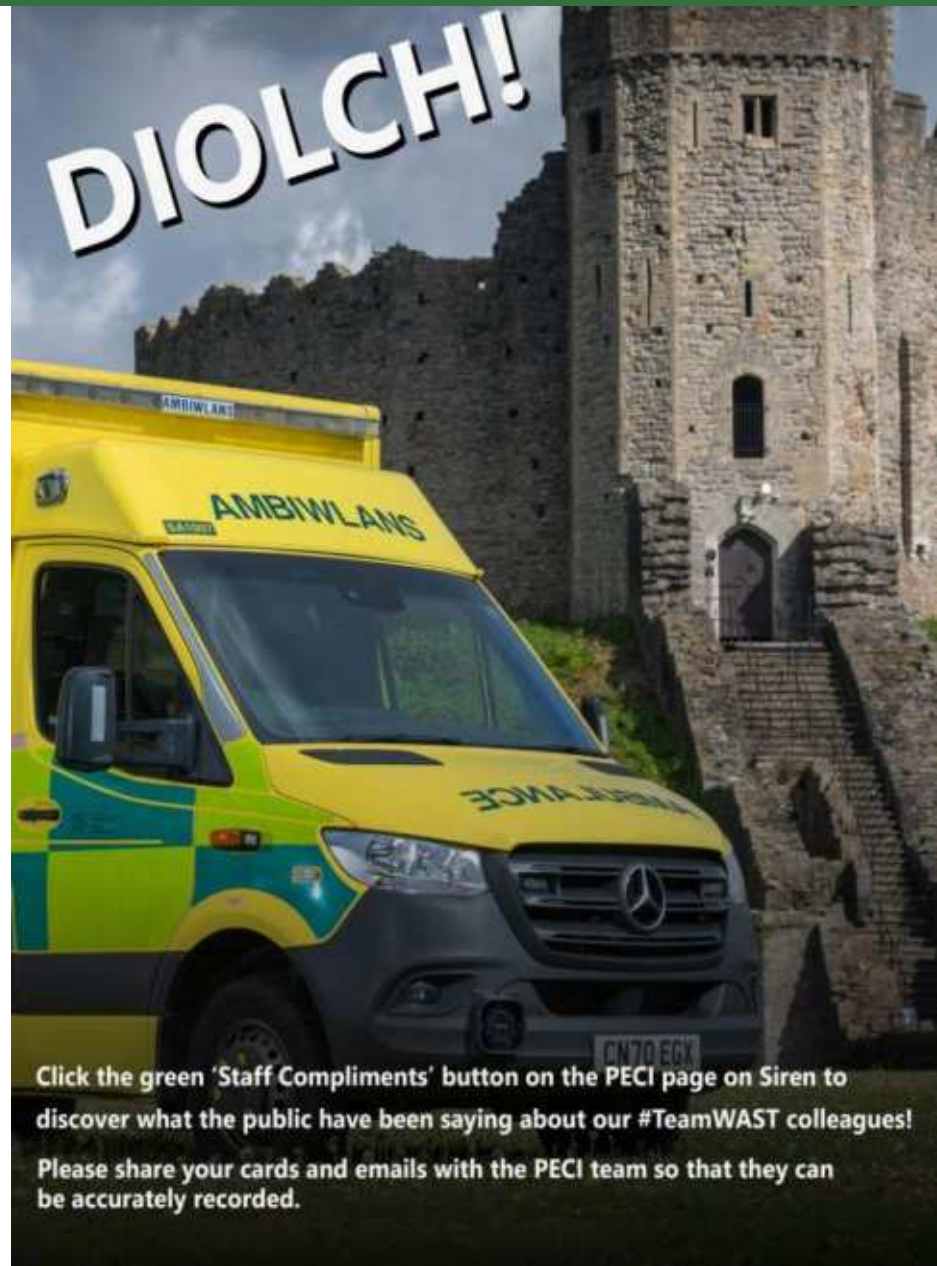
Compliments Received

October 2023	**39**	**January 2024**	**64**
November 2023	**52**	**February 2024**	**51**
December 2023	**45**	**March 2024**	**63**

General themes from compliments reported reflect how, reassured people feel by the professional and compassionate behaviour of staff which is instilling confidence with patients in the care/treatment they are receiving.

Compliments are submitted to teams across the Trust. In our attempt to accurately report on the volume of compliments we have been raising awareness amongst colleagues on the volume of compliments formally captured through the Trusts 'Have your say' facility. Colleagues are being encouraged to share compliments they may receive via cards posted to stations/ccc or emailed. We can include them as part of the reporting of Patient experience requirements into Welsh Government.

With support from Communications team, we are promoting themes/trends from compliments via a new dedicated page via Siren and station posters shown here.



Information Governance & PREMs Development

Information Governance – 999 /111 Patient Consent and Patient Experience Capture

The team have been trying to implement a patient experience capture process across all WAST's services, consent to contact the patient has been the main sticking point.

A Data Protection Impact Assessment (DPIA) covering 999, 111 and any other methods for surveys is being finalised ahead of a formal consultation with the Information Commissioner's Office.

This action will need approval of the Information Governance Steering Group. Final elements of the DPIA are being completed by the PECI and IG Teams and will be submitted to the ICO and shared with colleagues by end of the April.

PREMs
A Pre-Hospital PREM – Pain Management

An NWSSP Internal Audit action recommended that 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 form with any themes or trends highlighted within the report.

In response WAST set up a task and finish group to develop/design a pain management framework to support analysis and presentation of pain/analgesia related data and invited PECI representatives to be part of the group.

As a result, a bespoke PREM for pain is in development with routine questions, and establishment of appropriate benchmarks.

Your experience of calling 999

From October 2023 to March 2024 a total of 69 people used the 999 survey to provide feedback.

Over recent months we have been more proactive in promoting surveys to the public, working closely with colleagues in the Communications Team to make better use of available social media channels.

However, the overall response rate remains low, and we acknowledge that responses received do not provide a truly representative picture of what it feels like to be an EMS service user across Wales. Responses were received from all Health Board areas across Wales over the past 6 months.

- **70% of respondents said they felt confident in the ability of the person who answered their call to manage the call and provide appropriate advice.**
- **76% of respondents said they did not receive a call back from a clinical advisor.**
- **Of those who did receive a call back from a clinical advisor, 50% said they felt they were given enough advice about what to do next.**
- **Of those who said an ambulance was sent, 76% said they felt safe whilst in the care of the ambulance crew.**
- **45% of people who completed the survey rated their overall experience as 'Good' or 'Very Good'.**

Your experience of calling 999

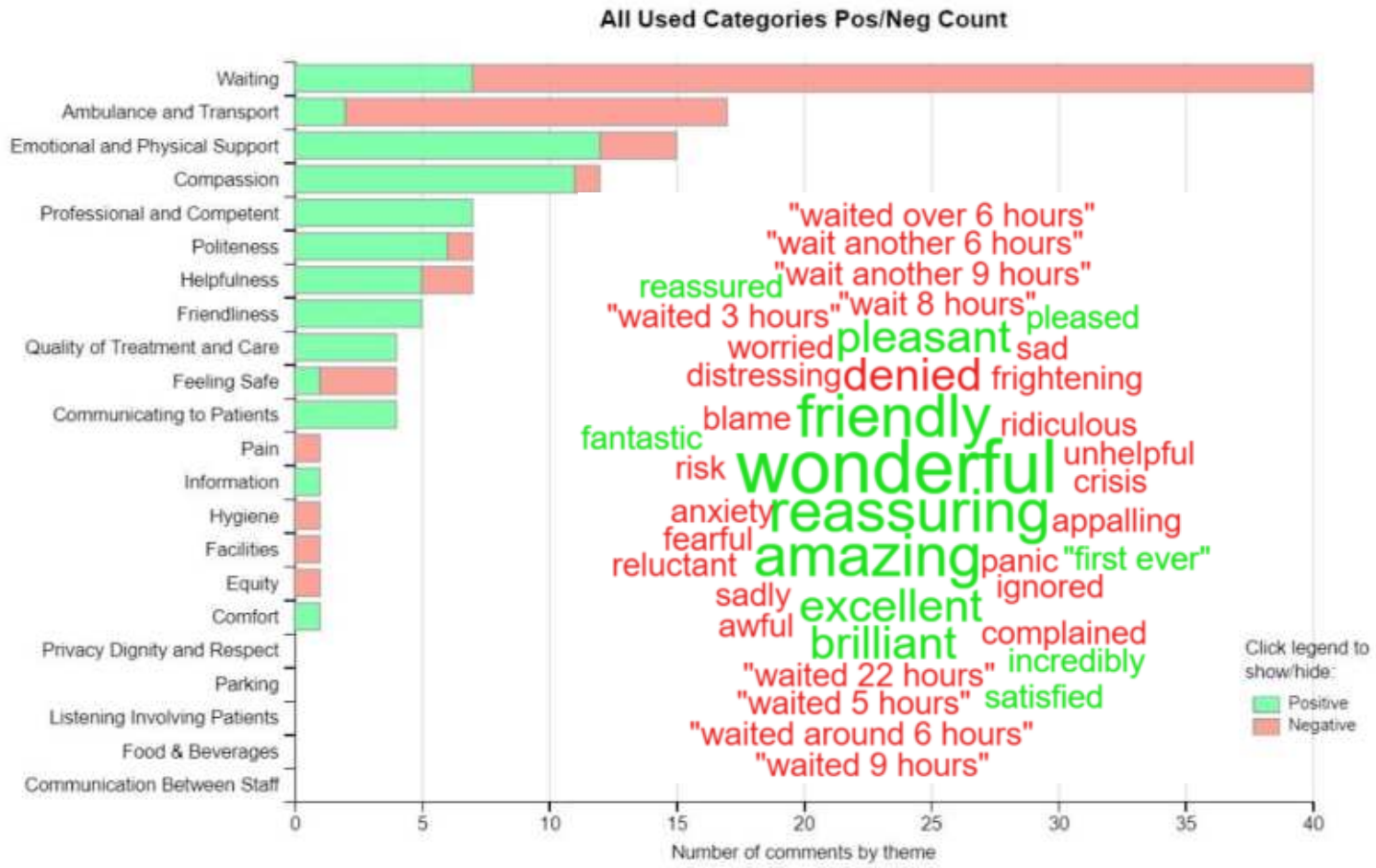
The Civica Experience platform provides us with some enhanced reporting facilities, including the ability to weight questions and produce 'Heat Maps' based on responses. We set a benchmark of 85, with aggregated scores of 85 and above representing a positive response. From the Heat Maps below we can see that the benchmark set was not met in most areas, suggesting that a majority of the people who chose to complete an experience survey had an experience they were unhappy with overall.

	Overall Experience	EMS Coordination				Clinical Support Desk				
Responses	Thinking of the last time you called 999. Overall, how would you rate your experience of the service	The 999 call taker who answered your call listened carefully	The 999 call taker who answered your call was reassuring	The 999 call taker who answered your call explained what was going to happen next	You felt confident in the 999 call takers ability to manage your call and provide appropriate advice	Was the Clinical Advisor you spoke with polite?	Did you feel that you were listened to by the Clinical Advisor?	Did the Clinical Advisor explain why an ambulance would or would not be sent to you on this occasion	Do you feel you were given enough advice on the telephone about what to do next?	Did you follow the advice given to you by the Clinical Advisor?
58	45	81	73	76	69	92	75	75	57	79
Benchmark	85	85	85	85	85	85	85	85	85	85

EMS Response								
The length of time I waited for the ambulance to arrive was acceptable	I understood the explanation of the care and treatment provided	I felt safe whilst in the care of the ambulance staff	The ambulance staff were professional and reassuring	The ambulance journey was comfortable	Overall, I was happy with the service received from Welsh Ambulance Service	Overall, I felt that I was treated with dignity and respect	Did the Paramedic or ambulance service staff clearly explain why you were not being taken to hospita	Before leaving you at home, did the Paramedic or ambulance service staff provide you with enough inf
47	72	79	78	76	61	80	60	60
85	85	85	85	85	85	85	85	85

Your experience of calling 999

The Civica Experience platform also uses Akumen pansensic text analysis. This uses advanced emotion analytics to scan text-data, identifying emotions, sentiment, themes and behavioural indicators to provide a previously unavailable level of understanding about our feedback.



What people said:

"The two ambulance staff from Neath station were both wonderful people and kept up our spirits up at this worrying time. Their job is so hard when they are sat outside a hospital for hours waiting for their patients to be admitted. I cannot praise them enough. They were wonderful"

"Transferred from 111 to 999. I had to provide all my personal details twice which was incredibly difficult with breathing difficulties. They could have just exchanged info and asked me to confirm if necessary. Call handlers both courteous, clear and helpful though"

"Waited over 6 hours for an ambulance for my elderly and house bound severely unwell dad. Then had to wait for over 24 hours in the ambulance outside of A&E"

Your NEPTS experience

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

Between October 2023 and March 2024, a total of 702 NEPTS patient experience surveys were completed. The responses received come from people who were sent a text message asking them to complete a survey, people who asked to receive a postal survey or NEPTS users who visited the Welsh Ambulance Service website to complete an online survey. Stickers asking patients to provide feedback are now also displayed in all NEPTS vehicles, the stickers contain show a QR code which people can use to access the survey online, alternatively the phone number for the Patient Experience & Community Involvement Team is displayed for people who prefer to use this method.

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

- **96% found the booking process easy. Those who answered negatively here said it was because of long delays for booking calls to be answered.**
- **89% said they were happy with the transport they received.**
- **Majority of people (84%) scored their NEPTS experience 8 out of 10 or higher.**

The NEPTS patient experience survey results continue to be positive and offer good levels of assurance that NEPTS users are generally satisfied with the service. Less positive responses continue to follow historical trends and focus on timeliness and wait times. Over the past six months we also noted a number of concerns raised from patients who were told they could not travel with their walking aid. Patients told us this didn't work for them as their walking aid provides independence and is a 'life-line'. This feedback has been shared with NEPTS service managers and we will continue to monitor for further feedback around this issue.

Your NEPTS experience

The NEPTS Patient Experience survey also contains a number of weighted questions, allowing us to produce Heat Map reports. These heat maps use a benchmark of 85 to indicate a positive response.

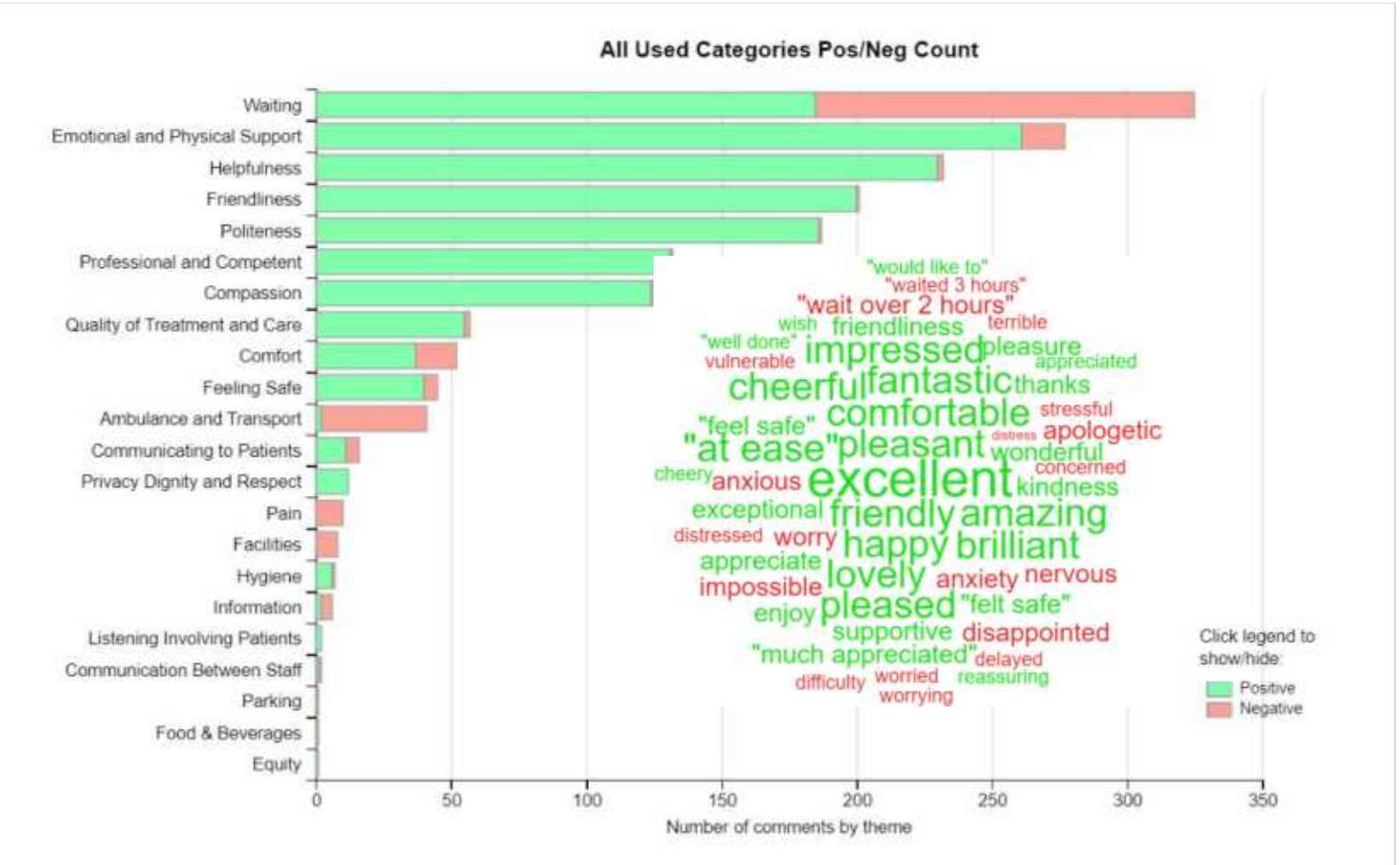
From the heat map below, we can see the benchmark has been reached in most areas. In some areas, the benchmark has just been reached or has narrowly been missed. For a second reporting period in a row, being reminded about wearing a seatbelt has just achieved the benchmark, suggesting more can be done to ensure staff are consistently delivering this message. Especially as we know in recent months there have been numerous reported patient safety incidents relating to appropriate use of seat belts and restraints. It has been suggested that some patients are answering 'No' to this question as they had put on their seatbelt independently and didn't need to be reminded. Therefore, we have amended this question to allow more indepth understanding. We have also included a supplemental question asking if patients felt safe during their journey.

Satisfaction with wait times for transport home following an appointment also misses its benchmark for a second reporting period in a row. We have amended this question in the survey to ask patients who feel they waited too long for transport home why the wait was too long and if there is anything we could have done to make the wait time more comfortable / acceptable to them. We will be able to report on the findings of these two amended question in our next six-monthly report.

	Booking			Transport & Journey							Overall Experience	
Responses	Did you find your booking experience easy?	Was our call handler polite and courteous during the call?	Do you feel you were given all of the information you required prior to your journey?	Were you happy with the transport you received?	Did you feel that the crew were polite and helpful towards you?	Were you given support to meet any additional needs you have? For example: communication; mobility;	If you asked for assistance, did you get it when you needed it?	How clean was the vehicle you travelled on?	During your journey, were you reminded/prompted about wearing your seatbelt?	How long did you wait for your transport to take you home after your appointment?	Thinking about the Non-Emergency Patient Transport Service, how was your overall experience of our s	Using a scale of 0-10 (0 being bad and 10 being excellent), how would you rate your overall experien
691	96	99	95	89	96	95	95	96	87	80	86	87
Benchmarks	85	85	85	85	85	85	85	85	85	85	85	85

Your NEPTS experience

Akumen pansesic text analysis of comments left shows us that people spoke about waiting times, emotional & physical support, helpfulness and friendliness in positive tones.
Waiting, comfort and overall transport were areas where people left comments which had a more negative sentiment behind them.



What people said:

"My husband's appointment was for 8.30 am we got there at 11.50 am. When I booked, I told them that I needed a 4-person crew because my husband is bed ridden, I also reminded them when I rang twice to see where the ambulance was. Just 2 crew members turned up and then my husband had to wait in the ambulance outside the house because they hadn't arranged 4 crew on the way back. My husband is a very sick man 86, and he was there all day lying on an ambulance trolly"

"My driver was so kind and supportive. Determined to make my journey there and back comfortable for me and the disabling pain I live with on a daily basis. Not at all phased by my ongoing tearful distress. I consider her perfect for her job. She even had me laughing - a rarity".

Your NHS 111 Wales experience

In our last report we were unable to provide any update on NHS 111 Wales patient experience, as response rates to the survey were too low to report. Over the past six months we have increased our efforts to promote this survey and make it more visible to NHS 111 Wales service users.

Between October 2023 and March 2024, a total of 100 NHS 111 Wales patient experience surveys were completed. We acknowledge that this is still a relatively low response in comparison to overall call volumes. However, it is a sufficient response to be able to report against. The responses received come from all Health Board areas.

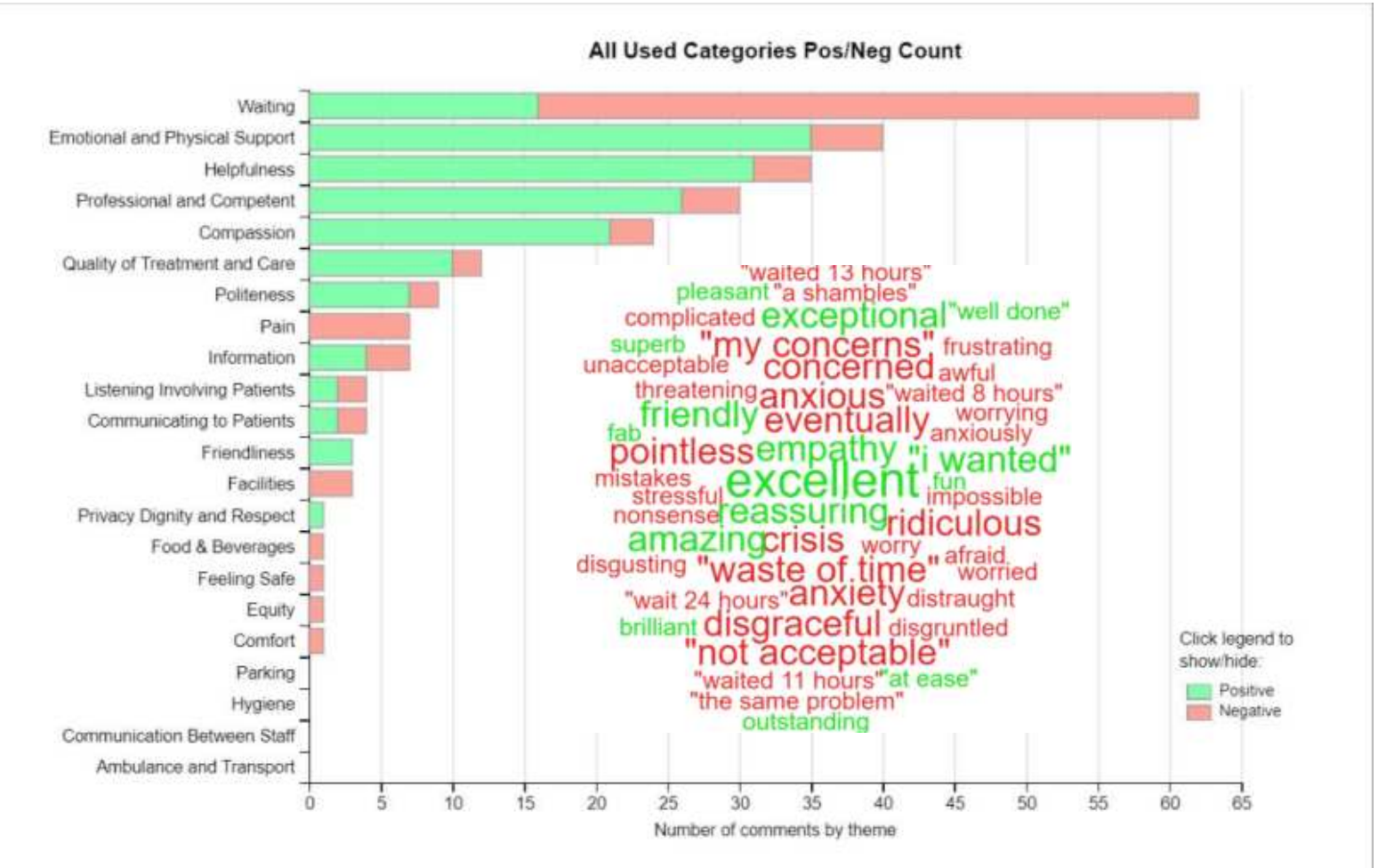
- **71% of respondents told us that NHS 111 Wales had been their first port of call and that they had not been referred on from another service.**
- **65% of people told us they called 111 looking for health information or advice for themselves.**
- **46% of people told us they found their call to NHS 111 Wales 'Very Helpful' or 'Helpful'.**
- **85% of people said they went on to follow the advice given to them by NHS 111 Wales.**

	Access and Information Provided			Overall Experience			
Responses	How satisfied were you with how long it took for your call to NHS 111 Wales to be answered?	Do you feel that your call to NHS 111 Wales was helpful?	Did you follow the advice given to you by NHS 111 Wales?	Thinking about the NHS 111 Wales service, how was your overall experience of our service today?	Using a scale of 0 – 10 where 0 is very bad and 10 is very good, please rate your overall experience	Would you consider using the NHS 111 Wales service again?	Overall
100	61	54	85	50	59	71	63
Benchmarks	**85**	**85**	**85**	**85**	**85**	**85**	85

Your NHS 111 Wales experience

Akumen pansesic text analysis of comments left shows us that people spoke about waiting times, emotional & physical support, helpfulness and friendliness in positive tones.

Waiting, was an area where people left comments which had a more negative sentiment behind them. Helpfulness and Support were spoken about positively.



What people said:

"As above. The call handler was brilliant in dealing with my call. I have nothing but good things to say. As you can imagine we were quite distressed as our son is only 2.5 but the call handler made us feel at ease and all the processes that followed made us feel like a priority"

"Felt I was just a number, seemed anxious to get me off phone asap"

"Really friendly and wasn't made to feel a nuisance for an ear infection"

"It took 55 minutes to get a reply, another 2 hours for a clinician to phone back to be told to call an ambulance which took another 4 hours"

Your experience of NHS 111 Wales Online

Throughout this reporting period we have continued to make available a patient experience survey asking people to share their views with us about accessing health information and advice through the NHS 111 Wales website. **Between October 2023 and March 2024 228 people completed a website experience survey.**

- 32% told us that they didn't find it easy to find the information they were looking for on the website
- In contrast, 55% of respondents said they found it either 'Extremely' or 'Very' easy to find the information they needed
- 56% of people said they intended to follow the follow the advice they found on the website.
- 56% of respondents rated their overall experience of using the website as 'Good' or 'Very Good'. When asked to explain why they gave that rating, people said:
  - ***"Good advice given in understandable non-technical terms"***
  - ***"Had a question on prostate cancer. Found the topic easily. Read the symptoms easily. Now know that I need speak to my doctor"***
- 27% of respondents rated their overall experience of using the website as 'Poor' or 'Very Poor'. When asked to explain why they gave that rating, people said:
  - ***"I tried several different searches using various key words. It took quite a few to get where I needed to be "***
  - ***"I was advised to go on website to help 89 year-old parent find out about having vaccine. Very difficult to go around site and not resolved when I did. No further in getting answer!"***

AGENDA ITEM No	10
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	1

MONTHLY INTEGRATED QUALITY & PERFORMANCE DASHBOARD – February/March 2024

MEETING	QUEST
DATE	7th May 2024
EXECUTIVE	Rachel Marsh – Executive Director of Strategy, Planning & Performance
AUTHOR	Hugh Bennett - Assistant Director, Commissioning & Performance Mark Thomas – Commissioning & Performance Manager Melanie O'Connor - Commissioning & Performance Officer
CONTACT	Hugh.Bennett2@wales.nhs.uk Mark.Thomas12@wales.nhs.uk Melanie.O'Connor@wales.nhs.uk

EXECUTIVE SUMMARY

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 **February/ March 2024.**

Our response times to 999 callers remains of concern with red 8-minute performance at 48.9% in March 2024 and Amber 1 median at 1 hour and 22 minutes, which the Trust knows leads to avoidable patient harm. The Trust continues to work on actions within its control to mitigate this risk including, for example, maintaining high levels of EA production and fully rolling out the CHARU service. Work continues on an action plan to increase the consult and close rates to the target 17%, as this is modelled to have a significant impact on response times. The Trust lost nearly 23,500 hours to handover in March 2024, and this level of lost capacity is difficult to compensate for, despite all the actions being taken. The 2024/25 budget includes further investment in activities designed to shift demand left and mitigate the impact of handover lost hours.

111 performance is broadly stabilised, but patient demand was 24% higher in March 2024, compared to March 2023, with a commissioned 4% reduction in call handlers in 2024/25. The service is in a more resilient place, but if demand continues to remain at these levels future performance may become a concern. The immediate focus for 111 is the delivery of the new 111CAS by 30 April 2024, which is on target at this time.

Ambulance Care, in particular, Non-Emergency Patient Transport Service's (NEPTS) performance has been stable, with oncology remaining above target and renal performance achieving its target. Both the NET Centre and NEPTS transport are due to be re-rostered in 2024/25, a key efficiency.

The Trust continues to focus on its people, with a range of actions in place to improve workplace experience including, for example, reducing shift overruns, whilst also continuing with the more strategic focus on the People & Culture Plan. Sickness absence was 7.67% in March 2024 compared to 8.50% in February 2024. The 23/24 IMTP ambition is to reach 6%, but it is unlikely that this will be achieved. The Trust will continue its focus on sickness absence. It is of note that the EMS abstractions have hit the 30% benchmark in January and February respectively, however this has increased slightly in March 2024.

The Trust continues with its programme of transformation as detailed in its 2024-27 IMTP, which is required in order to ensure that patients receive the right care in the right place every time.

RECOMMENDATION: QUEST is asked to: -

- **Consider the February/ March 2024 Integrated Quality and Performance Report and actions being taken and determine whether:**
  - **a) The report provides sufficient assurance.**
  - **b) Whether further information, scrutiny or assurance is required, or**
  - **c) Further remedial actions are to be undertaken through Executives.**

REPORT APPROVAL ROUTE	
Date	**Meeting**
30th April 2024	**Assistant Director, Commissioning & Performance**
7th May 2024	**QUEST**

REPORT APPENDICES
Appendix 1 – Top Indicator Dashboard

REPORT CHECKLIST			
Confirm that the issues below have been considered and addressed		**Confirm that the issues below have been considered and addressed**	
EQIA (Inc. Welsh language)	x	Financial Implications	x
Environmental/Sustainability	x	Legal Implications	x

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

SITUATION

1. The purpose of this report is to provide senior decision makers in the Trust with an integrated dashboard (Our Patients, Our People, Value and Partnerships/System Contribution) focused on the "vital few" key metrics. This report is for **February/March 2024.**

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. As previously agreed, the metrics which form part of this committee/Board report are updated on an annual basis, to ensure that they continue to represent the best way of tracking progress against the Trust's plans (IMTP) and strategies. A revised set were agreed for 2023/24. All the updates for the revised set have now been completed, with the exception of: a metric on the duty of candour where we will need to determine our own metric whilst national reporting is agreed; completed symptom checkers; and value indicators for 111/CSD – it is likely that this one will be difficult to determine.

ASSESSMENT

Our Patients – Quality, Safety and Patient Experience

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

5. **999** call answering times have declined to 34 seconds in March 2024 from 15 seconds in February 2024, not achieving the 6 second target. The 65th percentile and median performance remain very good.

6. **111 call answering performance remains broadly stable,** although the call abandonment performance at 11.8% in March and off target. The Trust had almost recruited up to the 198 FTE call handler commissioning control total for 2023/24 with very good levels of production. It should be noted that the Trust is anticipating a reduction in the commissioned level of call handler FTEs next year (-4%). Demand in March 2024 was 24% higher than March 2023. If this level of demand is sustained, alongside a reduction in capacity, then future call

abandonment performance could start to be a concern. In the short term, there will also be a planned short term dip in staffing numbers linked to the imminent 111 CAS go live and the need to re-programme training capacity away from new recruits and towards the existing workforce on the new system. This will have some short term impact on performance.

7. **111 Clinical response:** clinical ring back times for patients with the highest priority remained above target at 98%. Unfortunately, response times for lower priority calls remain some way below target. This drop in performance has been affected by a rise in call demand, but also high clinician sickness absence. Clinician sickness has seen a material deterioration in March, rising to 11.8% compared to 11.3% in February. As with call handling performance, there is likely to be some further deterioration linked to staff abstracted to undertake training for the new system.

8. **Ambulance Response** (safety / patient experience): the red 8-minute response performance for March 2024 was 48.9%, remaining below the 65% target. However, as total red demand has increased, so has the actual number of red incidents attended within 8-minutes. The Amber 1 median in March was 1 hour 22 minutes and the Amber 1 95th percentile was 7 hours 35 minutes. These long response times have a direct impact on outcomes for many patients.

9. Traditionally the factors which affect response times are demand and capacity (recruitment and lost hours). Recruitment is good, see slide 20 for information on staff in post v establishment, but the lost capacity through handover at hospital remains extremely challenging. The Trust's main focus in the first half of 2024/25 is to implement a material element of the "inverting the triangle" transformation programme, before winter. This is a radical move away from a traditional conveyance model. A series of workshops are planned in early May 2024, with additional leadership capacity also being put into this area: both designed to move this at pace. Areas of focus include:-

    - Further investment into the Clinical Support Desk (+23 FTEs);
    - Further investment in APPs (+32 APPs);
    - An updated clinical model that places more emphasis on telephone triage e.g. clinical screening, further work on timebound and planned responses e.g. , "Amber Hot" and "Amber Cold";
    - Development of the integrated care model (111 clinicians and CSD clinicians);
    - Continued focus on a range of responses that support non-conveyance, where it is clinically safe and appropriate to do so: Connecting Support Cymru, mental health response pilot, Falls response etc.;
    - Formal reporting of the 2023 collaborative and independent EMS Demand & Capacity review.

10. The one area of particular focus for recruitment is CHARU: with the Trust recruiting up to the modelled 153 FTEs; and connected to this a focus on CHARU productivity, with on-going analysis work on their contribution (findings positive) etc.
11. As above, the extreme level of lost hours to **handover outside Emergency Departments** remains the critical component of long waiting times and patient safety incidents. 23,403 hours were lost during March 2024. 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. Performance into April has remained very challenging with days where over 1,000 hours are lost.

12. **Ambulance Care (Patient Experience)**: Oncology performance in March 2024 was 74.20%, hitting the 70% target. Renal performance also remains above target at 75.70%. Advanced discharge & transfer journey booked in advance performance increased compared to the previous month to 86%; however, remains below the 95% target. Overall demand for NEPTS continues to increase but remains below pre-pandemic levels. The Trust has a comprehensive Ambulance Care Transformation Programme in place, which includes delivering a range of efficiencies and improvements, for example: aligning clinic patient ready times to ambulance availability and addressing oncology performance. The Trust is expecting to re-roster NEPTS transport in 2024/25 which will better align capacity with demand patterns.

13. **National Reportable Incidents (NRIs) / Concerns Response**: the Trust reported four NRI's to the NHS Executive in March 2024, a slight decrease from the seven reported in February 2024; and 21 serious patient safety incidents were referred to health boards under the Joint Investigation Framework, which has now been adopted NHS Wales wide. In February 2024 complaint response times improved to 56%, a significant improvement on the 35% recorded in February 2024, but remaining below the 75% target, with cases remaining complex. Reviews of lower graded concerns are being undertaken to ensure proportionate investigations are undertaken. The Trust is currently recruiting to a new structure for the Putting Things Right (PTR) team, which will increase capacity and leadership, including a new Head of Service, appointed and arriving shortly.

14. **Clinical outcomes**: The percentage of suspected stroke patients who are documented as receiving an appropriate stroke care bundle was 72.85% in March 2024, remaining below the 95% performance target. Work is ongoing to improve reporting and compliance through the ePCR system. The return to spontaneous circulation (ROSC) compliance rate increased to 21% in March 2024 compared to 14.7% in February 2024.

15. The Trust is now able to report on call to door times for Stroke and STEMI patients. For March 2024 these highlight call to hospital door times of two hours and 25 minutes for stroke patients and two hours and seventeen minutes for STEMI. Clearly these times are too long and are representative of the longer response times for all calls as a result of the pressures and issues outlined in this report.

16. In March 2024, 9,605 patients **cancelled** their ambulance, and the Trust was unable to send an ambulance due to application of CSP levels to approximately 552 callers. The Trust believes that 50% of this combined number is unmet demand and is likely to be popping up elsewhere in the system. Anecdotal evidence from health boards supports this view, but data linking planned for 2024/25 is a key enabler to properly evidence this.

Our People (workforce resourcing, experience, and safety)

17. **Hours Produced**: The Trust produced 121,069 Ambulance Response unit hours in March 2024 and delivered an emergency ambulance unit hours production (UHP) of 93%, just short of the 95% target. Key to the number of hours produced are roster abstractions.

18. **Response Abstractions:** EMS abstraction levels increased to 33.49% in March 2024, returning just above the 30% benchmark figure. EMS Response sickness abstractions stood at 8.17% (benchmark 5.99%).

19. **Trust sickness absence:** the Trust's overall sickness percentage was 7.67% in March 2024, a decrease on the 8.50% recorded in February 2024. Actions within the IMTP concentrate on staff well-being with an aim to continue to reduce this level supported by the ten-point plan.

20. **Staff training and PADRs:** PADR rates did not achieve the 85% target in February 2024, but have been steadily improving (78.80%). Compliance for Statutory and Mandatory training increased to 81.89%.

21. **People & Culture Plan**: The Trust launched its People & Culture Plan in April 2023 and workstreams are being delivered around behaviours, in particular, sexual safety, Freedom to Speak Up, 111 culture review, flexible working and the introduction of a staff pulse survey tool. The Executive Leadership Team undertook a pan-Wales round of CEO Roadshows in April 2024. Feedback from attendees will be reviewed.

Finance and Value

22. **Financial Balance**: The reported outturn performance at Month 12 is a surplus of £85k and the Trust achieved both its External Financing Limit and its Capital Resource Limit.

Summary

23. The indicators used at this high-level highlight that the 111, EMS and Ambulance Care performance are stable; however, 111 and EMS performance are not where the Trust would want them to be.

24. 111 has seen a clear improvement in performance over the past 12 months and the service is undoubtedly more resilient, however, the current high levels of demand plus a commissioned reduction in call handlers and clinicians may mean that the improved performance comes under pressure in 2024/25. The Trust and commissioners will need to keep the level of demand under review and determine whether a reduction in capacity will affect performance into this year.

25. EMS performance has been recognised as challenging for a long time. Transformation of our service offer is a necessity (not an option) for reducing handover lost hours along with handover reduction by health boards. The Trust also needs to continue its focus on core activities like abstractions, production and utilisation.

RECOMMENDATIONS: QUEST is asked to: -

- **Consider the February/ March 2024 Integrated Quality and Performance Report and actions being taken and determine whether:**

  a) The report provides sufficient assurance.
  b) Whether further information, scrutiny or assurance is required, or
  c) Further remedial actions are to be undertaken through Executives.

Welsh Ambulance Services University NHS Trust

Monthly Integrated Quality & Performance Report

February/March 2024

Annex 1 – Top Indicator Dashboard

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

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

by Commissioning & Performance Team

Section 1: Monthly Indicators / Top Indicator Dashboard

Top Monthly Indicators	Target 2023/24	2 Year Average	Feb-24	Mar-24	RAG
Our Patients					
Timeliness Indicators					
NHS111 Call Handling Abandonment Rates	< 5%	11.4%	6.2%	11.8%	R
111 Clinical Triage Call Back Time (P1)	90%	97.9%	95.8%	98.0%	G
999 Call Answer Times 95th Percentile	00:06	00:30	00:15	00:34	R
999 Red Response within 8 minutes	65%	50.0%	49.9%	48.9%	R
999 Amber 1 Median	00:18	01:24	01:27	01:22	R
Oncology Journeys arriving within 45 mins and up to 15 minutes after appointment time	70%	72.1%	71.3%	74.2%	G
Advanced Discharge & Transfer journeys collected less than 60 minutes after booked time (NEPTS)	90%	84.2%	85.4%	86.5%	A
Clinical Outcomes / Quality Indicators					
Return of Spontaneous Circulation (ROSC)	Increasing Trend	18.1%	14.70%	21.00%	A
Stroke Patients with Appropriate Care	95%	76.9%	73.50%	72.80%	R
Stroke Call to Hospital Door Times	Reduction Trend	02:24	2:19	2:25	R
ST-Elevation Myocardial Infarction (STEMI) with Appropriate Care	95%	42.7%	45.10%	40.90%	R
National Reportable Incidents reports (NRI)		5	7	4	
Can't Send & Cancelled by Patient Volumes	Reduction Trend	10,888	10,065	11,115	R
Concerns Response within 30 Days	75%	35.7%	35%	56%	A
Our People					
Capacity					
Hours Produced for Emergency Ambulances	95-100%	94%	95%	93%	A

Top Monthly Indicators	Target 2023/24	2 Year Average	Feb-24	Mar-24	RAG
Health & Well-being					
Sickness Absence *(all staff)*	6.0%	8.88%	8.50%	7.67%	R
Mental Health Absence Rates	Reduction Trend	2.31%	2.07%	N/A	R
Staff Turnover Rate	Reduction Trend	10.22%	8.83%	8.73%	A
Statutory & Mandatory Training	>85%	79.06%	81.00%	81.89%	A
PADR/Medical Appraisal	>85%	73.18%	79.25%	78.80%	A
Number of Shift Overruns	Reduction Trend	3830	3944	4010	R
Inclusion & Engagement / Culture					
NEPTS % of Total Calls Answered in Welsh	Increasing Trend	1.2%	1.7%	0.6%	R
Value					
Financial balance - annual expenditure YTD as % of budget expenditure YTD	100%	100%	100%	100%	G
EMS Utilisation Metric (CHARU)	Increasing Trend	30%	28.0%	28.5%	R
Average Jobs per Shift (All Vehicles)	Increasing Trend	2.39	2.22	2.27	A
NEPTS on the Day Cancellations	Reduction Trend	19.8%	19.6%	19.8%	A
Partnerships / System Contribution					
Inverting the Triangle					
Successful Consult & Close Outcome	17.0%	13.4%	13.9%	14.0%	A
% Of Total Conveyances taken to a Service Other Than a Type One Emergency Department	Increasing Trend	11.4%	11.62%	11.46%	A
Number of Handover Lost Hours	15,000	23,296	23,896	23,403	R
NHS111					
NHS111 Dental Calls	Increasing Trend	6,488	6,995	7,277	A
Consult & Close Volumes by NHS111	Increasing Trend	1,064	800	946	G

In-Month RAG Indicates =

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

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

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

TBD: Status cannot be calculated (To Be Determined)

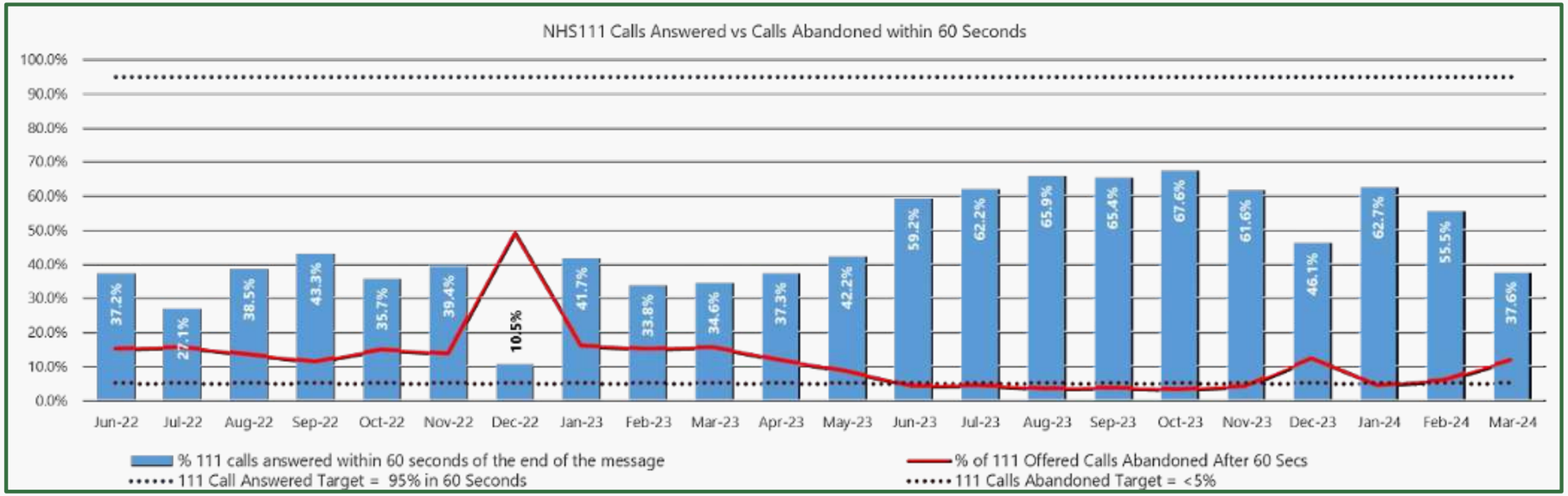
Our Patients: Quality, Patient Safety & Experience
111 Call Answering/Abandoned Performance Indicators

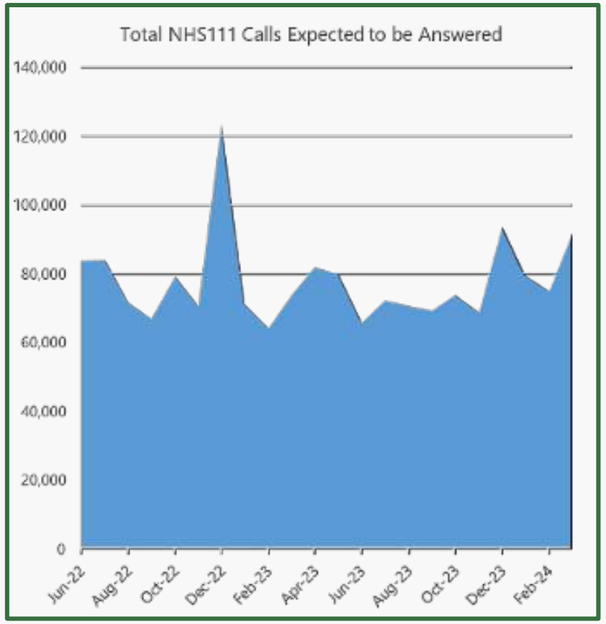
(Responsible Officer: Lee Brooks)

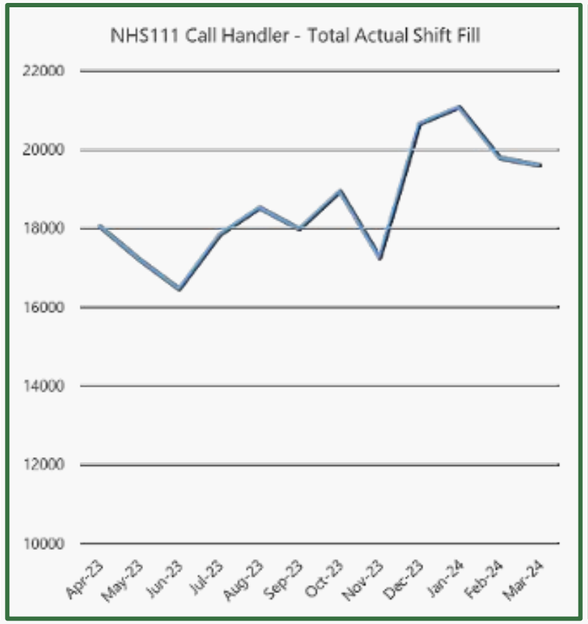
Abandonment Rate R

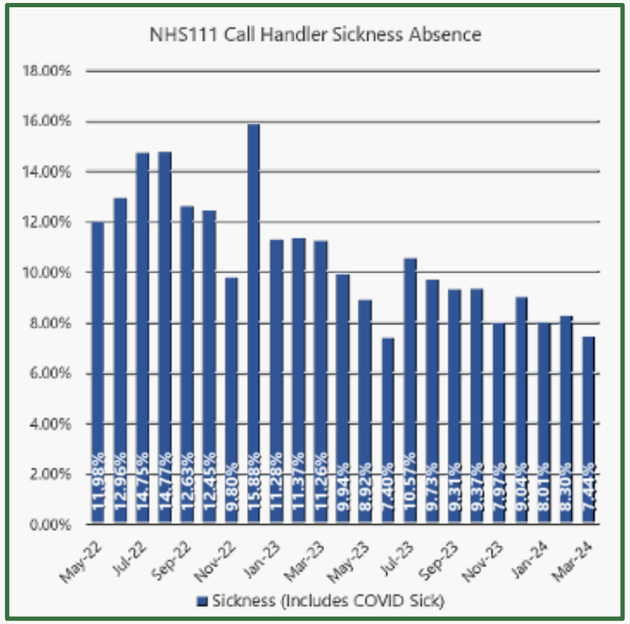
FPC

Influencing Factors – Demand and Call Handling Hours Produced









Analysis

The 111-call abandonment rate declined from 5.9% in February 2024 to 11.8% in March 2024 and failed to achieve the 5% target. However, this figure remains lower than the 15.4% abandonment rate seen in March 2023. This is also despite demand in March 2024 being 24% higher than in March 2023.

The percentage of 111 calls answered within 60 seconds decreased, from 55.5% in February 2024 to 37.6 % in March 2024, and continues to be below the 95% target. However, once again it is an improvement on the 34.6% figure recorded in March 2023. The drop in performance during March 2024 was due to a spike in demand, to its third highest level over the past two years, but due to increased staffing levels now in place the impact on performance was far less significant than seen during previous months of higher demand.

Abstractions due to sickness absence decreased, reaffirming the longer-term downward trend, and overall, 111 abstractions remain lower (better) than benchmark.

Remedial Plans and Actions

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

- However, less call handlers will be commissioned in 2024/25 (-4%).
- Work continues sickness absence in line with the Trust's managing absence work programme with an IMTP aim to get organisational sickness down to 6% by the end of 23/24.
- A roster review was planned in collaboration with the 111 commissioners to review rosters and ensure that capacity was aligned to demand, and to try and even out performance through the week. However, funding has been withdrawn, so this project is now paused. The Trust continues to press for this.

Expected Performance Trajectory

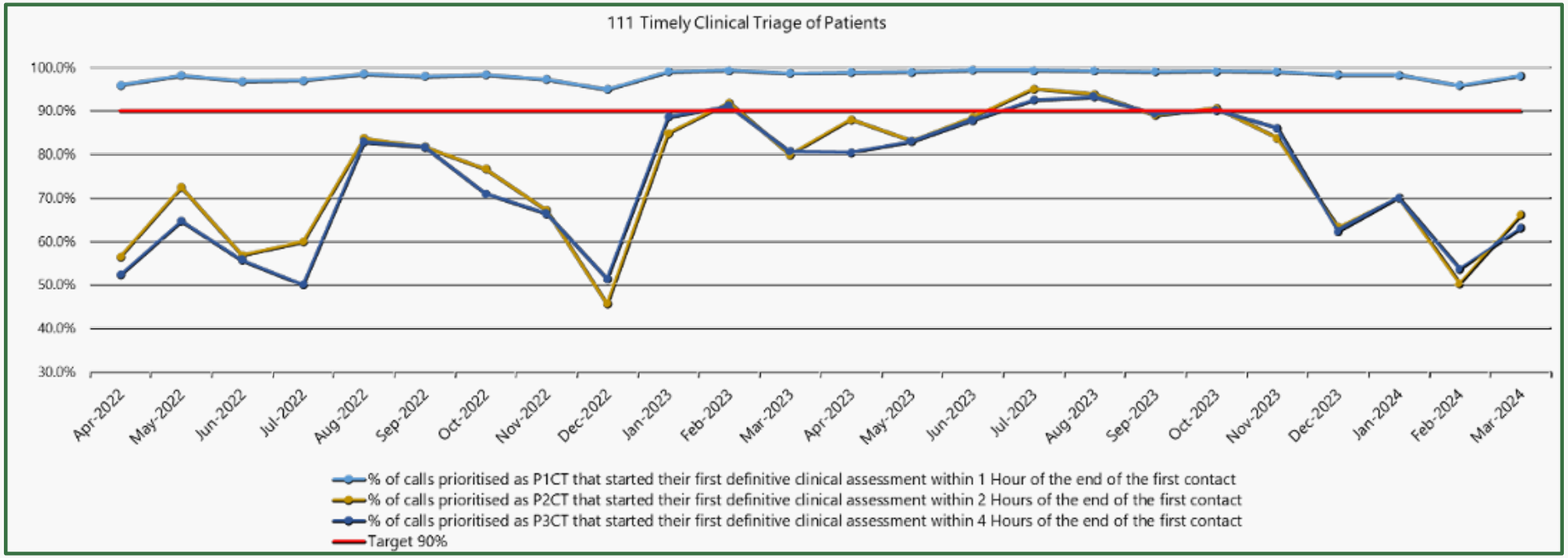
The service is much improved, but with demand increasing in the way it is and the call handlers reducing next year performance is unlikely to improve or hit the commissioned targets.

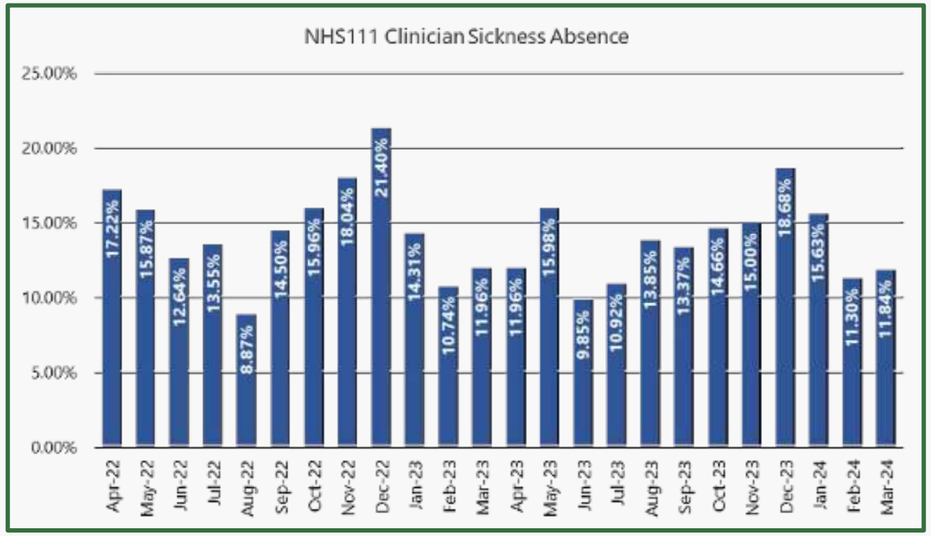
Our Patients: Quality, Safety & Patient Experience
111 Clinical Assessment Start Time Performance Indicators

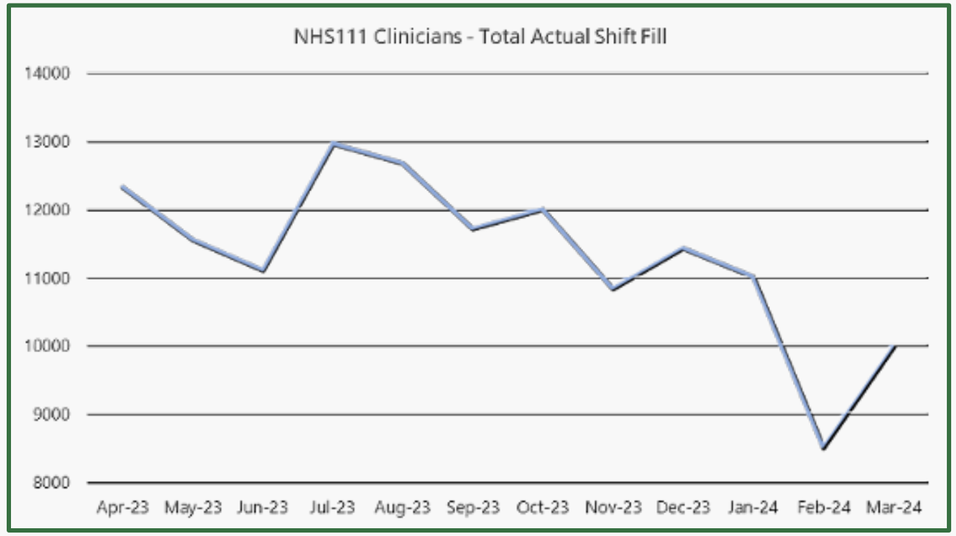
(Responsible Officer: Lee Brooks)

P1CT G FPC

Influencing Factors – Demand and Clinical Hours Produced







Analysis

The highest priority calls, P1CT, achieved the 90% target once again, recording 98% in March 2024.

Lower category calls both improved during March 2024, reversing a previous deterioration in performance, which was primarily due to an uplift in demand but was also compounded by staff abstractions for new systems training.

P2CT increased from 50.2% in February 2024 to 66% in March 2024, while P3CT increased from 53.6% to 63.1%.

Clinical staff capacity decreased to 9,990 hours during March 2024, a decrease of 904 hours when compared to March 2023. Clinician sickness absence also increased slightly to 11.84% in March 2024 from the 11.30% reported in February 2024.

Sickness absence management is another core component of capacity and workforce. Current levels within the 111 service, indicate that clinician absence remains higher than target in Mar-24 and further work is required.

Remedial Plans and Actions

The main focus is the new 111CAS with a go live date of 30 April 2024. This is being implemented at very high pace to mitigate the non-delivery of SALUS.

The new system should deliver a range of benefits for service users and staff and improved performance, but this is not modelled currently.

Sickness levels amongst clinicians remains higher than the Trust would want, but there was a significant improvement in February.
As per the previous slide a demand & capacity review that quantifies the number of clinicians required to meet forecast demand (net of efficiencies) remains key.

Expected Performance Trajectory

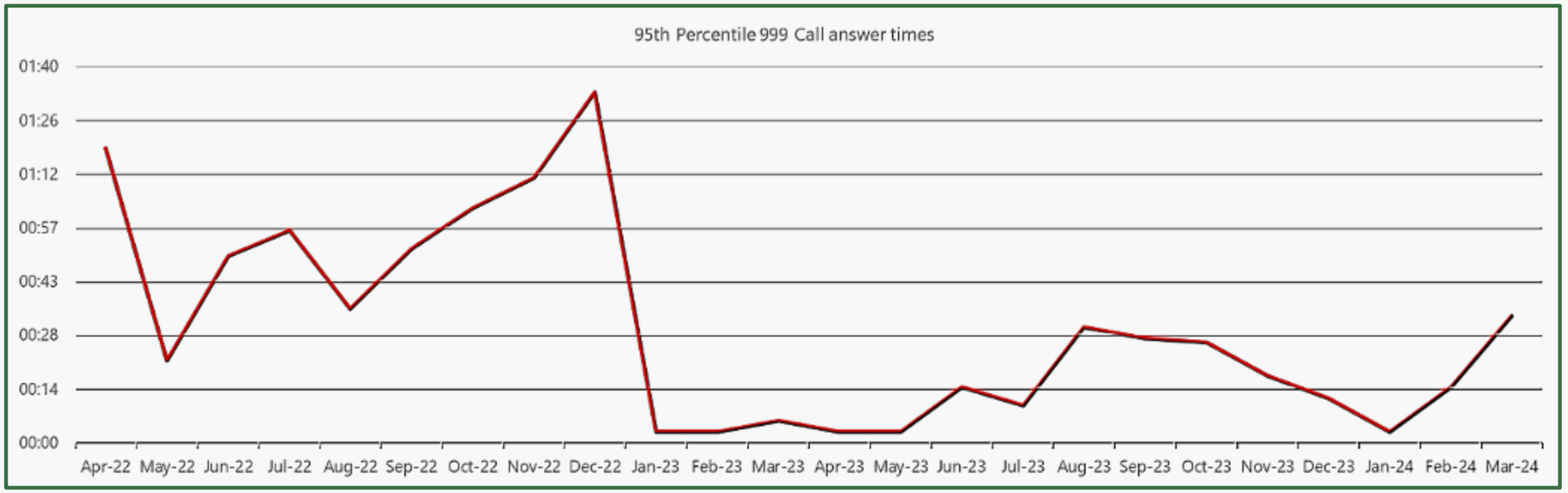
The new 111CAS will bring performance benefits, however, demand is increasing materially, and the number of commissioned clinicians will be lower next year.

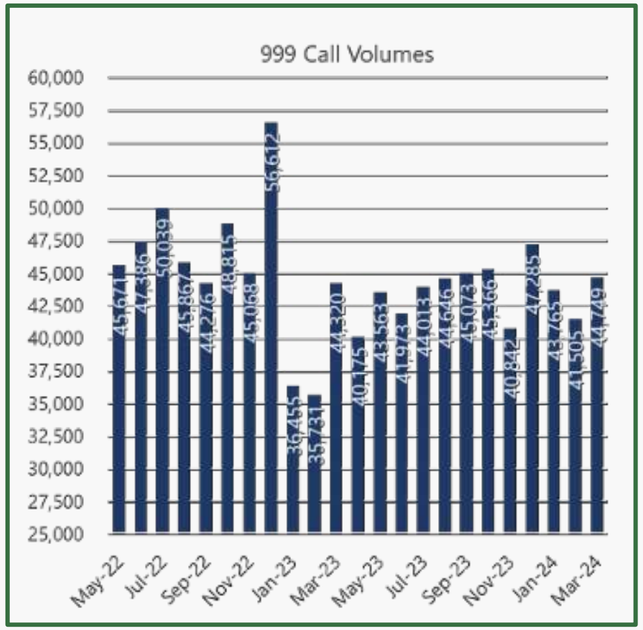
Our Patients: Quality, Safety & Patient Experience
999 Call Performance Indicators

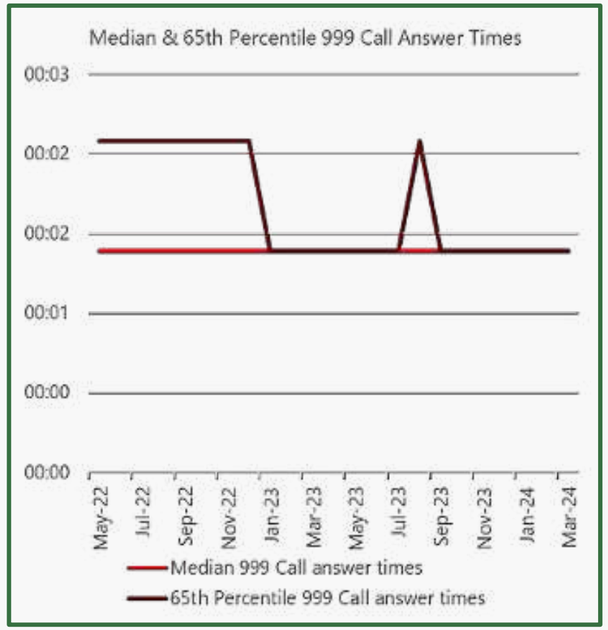
(Responsible Officer: Lee Brooks)

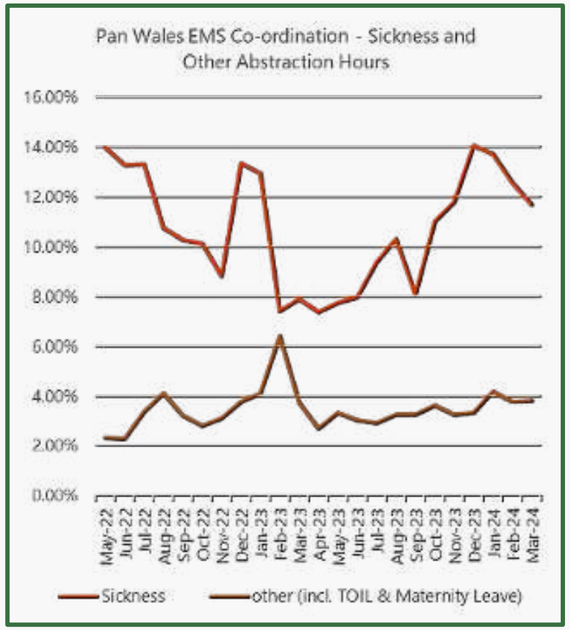
95th R FPC CI

Influencing Factors – Demand and Hours Produced









Analysis

The 95th percentile 999 call answering performance increased to 34 seconds in March 2024, up from 15 seconds in February 2024, and not achieving the 6 second target for the second month in a row. The median call answer time for the 999-service remained consistent at 2 seconds.

The Trust received 44,749 emergency 999 calls in March 2024, an increase on the 41,505 calls received during February 2024.

Overall sickness abstractions within EMS Coordination has returned to a downward trajectory after a three month increase at the end of 2023. Sickness decreased to 11.68% in March 2024 from 12.59% in February 2024.

Remedial Plans and Actions

- Currently call taker are over established by 15.93 FTE.
- There is a future recruitment drive planned for April to August which should provide an additional 36 (if successful in recruiting) which would mitigate against attrition.
- Over establishment has been approved for EMSC by the Executive Director of Operations
- Intelligent Routing Platform is now in operation following configuration changes.
- Three workstreams are being progressed through the EMS Reconfiguration project (the complete reconfiguration has not commenced due to cost pressures required to fund the agreed model approved by ELT). This is on hold currently but will re commence in the next few weeks pending outcome and approval of a proposed new Structure for EMSC. This will require consultation.

Roster Review. Having successfully implemented an EMD roster review in February 23 the project has now progressed to commencing a dispatch roster review for Allocators and Dispatchers. The workstream is now being progressed.

Boundary changes. EMS Coordination intend to realign dispatch. boundaries to balance workload and pressures for individual dispatch teams. The work-stream is now being progressed.

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. This workstream is now being progressed.

Expected Performance Trajectory

The median and 65th percentile are performing very well and are stable. The above changes should provide further resilience. There is some resilience to demand increases, but this needs to be kept under review.

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

Influencing Factors – Demand, Hours Produced and Hours Lost

(Responsible Officer: Lee Brooks)

8 Min
R

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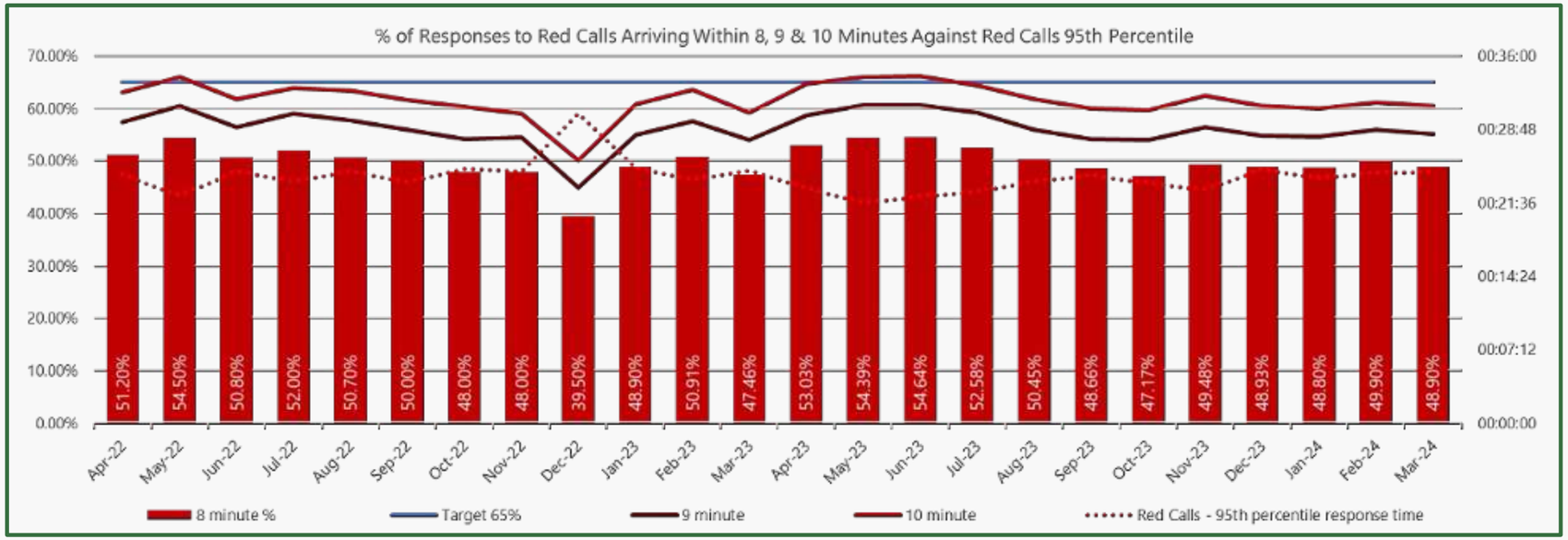

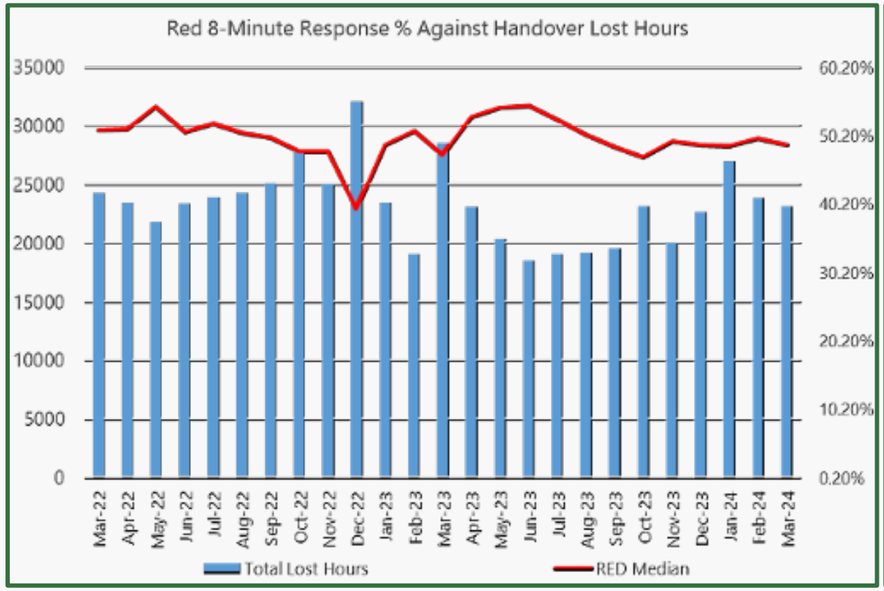

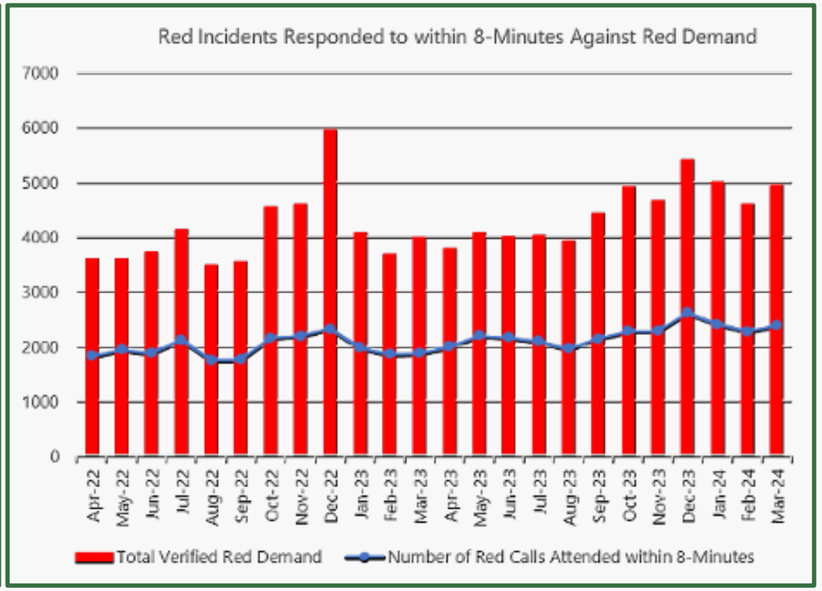

Analysis

Red 8-minute performance continues to remain below the 65% target and decreased marginally during March 2024 to 48.9%.

Red 10-minute performance for March 2024 was 60.7%, a slight reduction from 61.2% in February 2024.

The bottom right graph shows that as demand has increased, so too has the number of red incidents responded to within 8-minutes, with the figure for March 2024 being 2,374. This is above the 12-month average (2,227) and would indicate that performance in this area is mirroring the rise experienced in demand during the month.

The lower left graph demonstrates the correlation between overall Red performance and hospital handover lost hours. March 2024 (23,176) saw a decrease on the 28,620 recorded in March 2023, and this is despite a significant rise in the number of red incidents this March compared to last.

Remedial Plans and Actions

The main improvement actions are:

- To maintain commissioned establishment levels overall. Funding for the +100 now secure.
- Full roll out of the Cymru High Acuity Response Unit (CHARU), now largely complete (127 FTEs v target of 153 FTEs) with the exception of some hard-to-reach areas. Further actions to address;
- Continued focus on production and abstractions);
- The rapid deployment, before winter 2024/25, of the inverting the updated clinical model (triangle inversion) e.g. red screening, Amber Hot, Amber Cold etc.

Expected Performance Trajectory

Modelling has been completed for Spring 2024. This continues to indicate a level of Red performance below target (most likely scenario 52%) and Amber 1 (one hour and 12 minutes). This modelling includes changes already operationalised and some further improvements but does not include the major change to the clinical model i.e. this will not come on stream in Q1.

*NB: Data correct at time of abstraction

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

(Responsible Officer: Lee Brooks)

R

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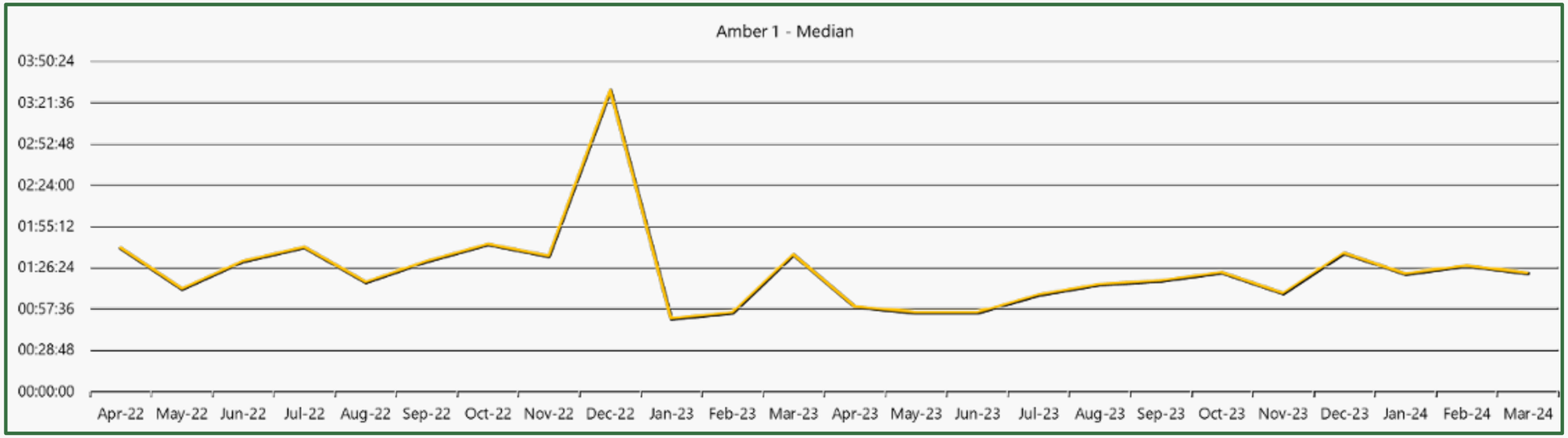
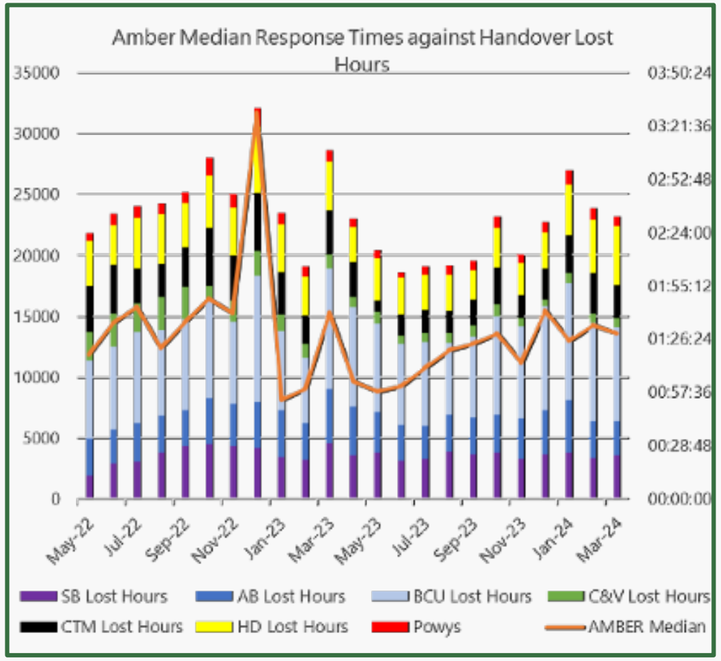
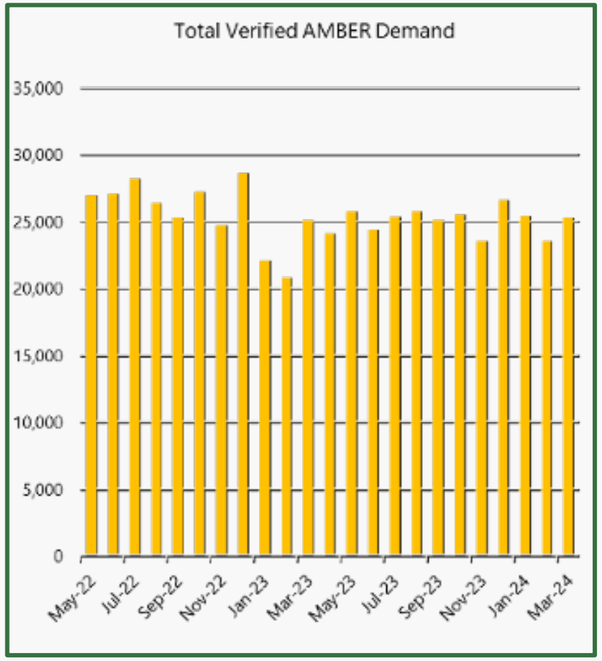
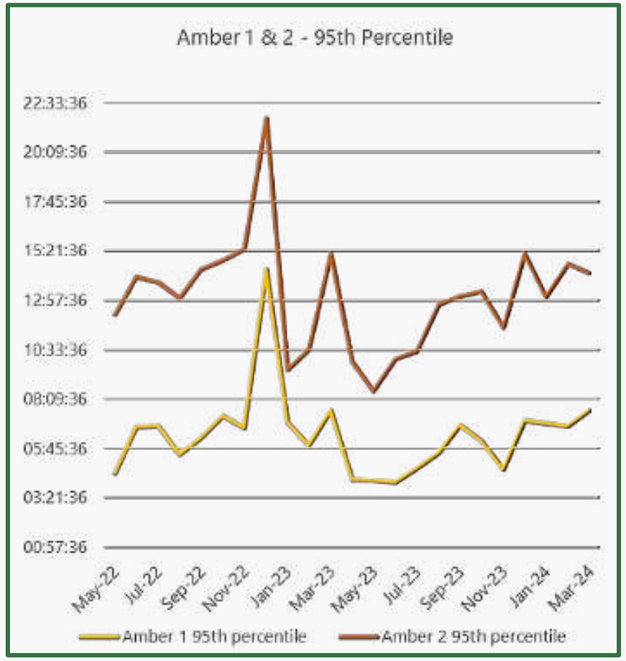
Influencing Factors – Demand, Hours Produced and Hours Lost









Analysis

Amber 1 median performance time improved slightly during March 2024 to 1 hour 22 minutes, from the 1 hour 27 minutes recorded in February 2024. Although this figure is lower than the 1 hour 35 minutes recorded for March 2023, it is against a month of higher Amber demand (+187) and an unprecedented level of hours lost to handover at hospitals. The ideal Amber 1 median response time remains at 18 minutes, although this has yet to be achieved during the 3-year reporting period.

The Amber 1 95th percentile decreased slightly during March 2024 to 7 hours and 35 minutes from 6 hours 51 minutes in February 2024.

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

Remedial Plans and Actions

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

Expected Performance Trajectory

The EMS Operational Transformation Programme is the Trust's key strategic response to Amber. As per the commentary on Red performance delivering these benchmarks is dependent on a range of investments and system efficiencies, not all of which are within the Trust's control. This programme is now coming to an end, but the Trust is now well advanced with the strategic EMS Demand & Capacity Review.

Our Patients: Quality, Safety & Patient Experience

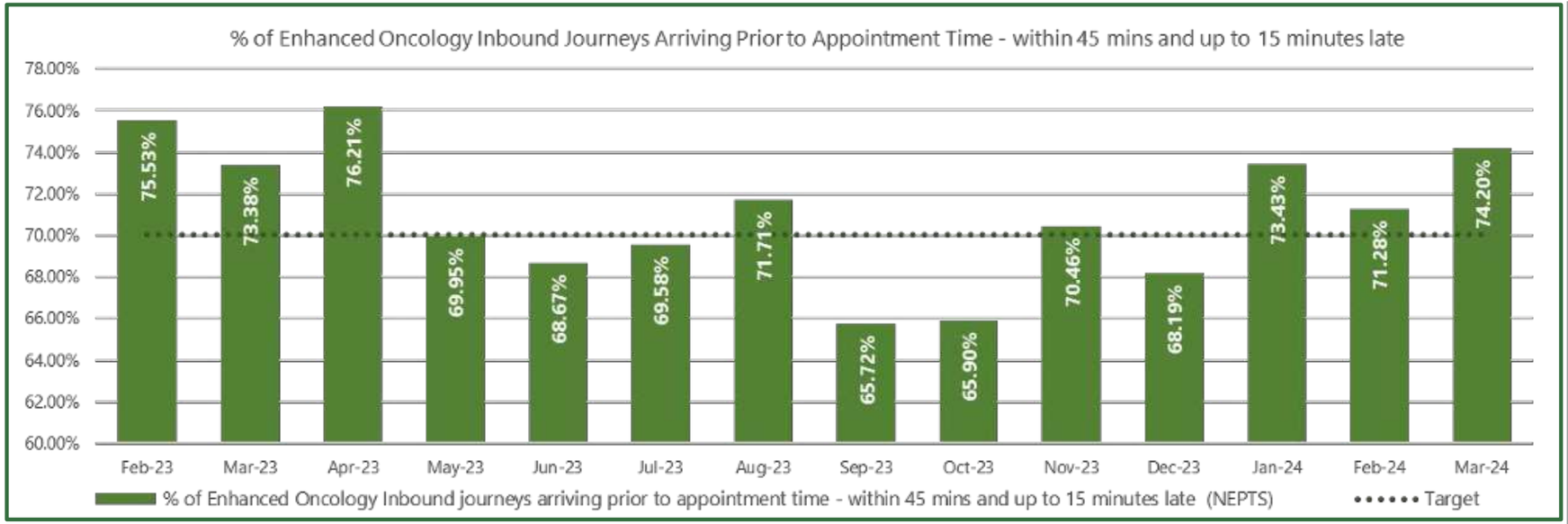
Patient Experience – Influencing Ambulance Care Indicators

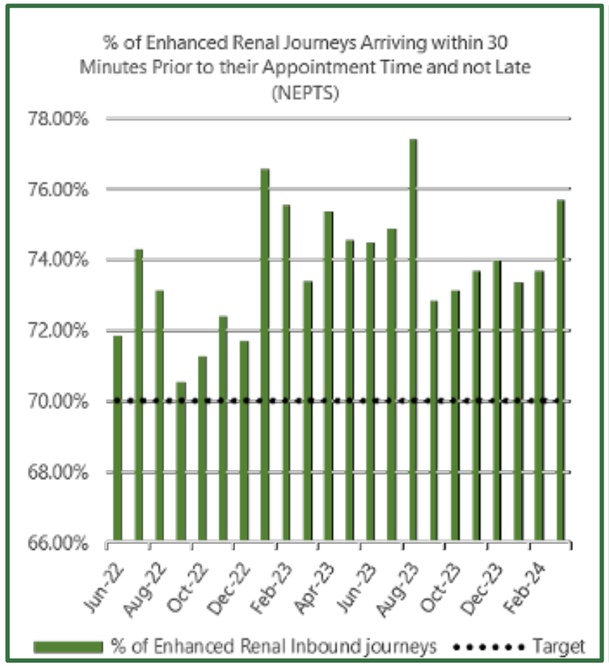
(Responsible Officer: Lee Brooks)

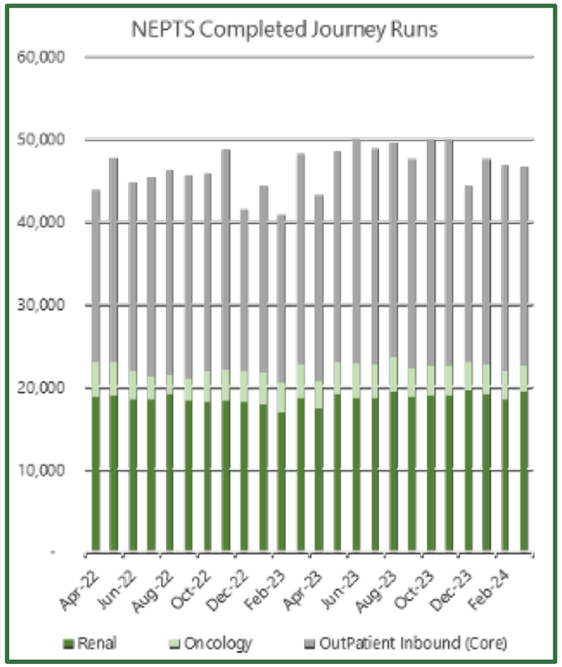
Oncology	Welsh Calls
G	R

FPC

CI







Analysis

Ambulance Care (NEPTS element) performance increased during March 2024. 74.20% of enhanced oncology journeys arrived within 45 minutes prior and up to 15 minutes late to their appointment time, an increase from 71.28% in February 2024, still achieving the 70% target. Enhanced Renal journeys, saw a slight increase, from 73.69% in February 2024 to 75.70% in March 2024 and continues the pattern of the last two years of exceeding the agreed performance standard.

The recent good performance of the enhanced service has been achieved despite continual growth in the sector, mainly driven by renal activity increasing.

The NEPTS service continues to be completely committed and focused on improving both timeliness and service quality and is currently trialling a focused service matching oncology patients up with dedicated drivers which has returned an initially positive set of outcomes. In addition, investment has been made in Oncology transport within areas of traditional poor performance,

Call volumes answered decreased in March 2024 (16,939) compared to February 2024 (18,067). The average speed of call answering improved slightly in March 2024 (00:03:01) for the second consecutive month compared to February 2024 (00:03:59).

ACA1 (NEPTS) sickness decreased slightly in March 2024 to 11.37% compared to 12.65% in February 2024. However, ACA2 (UCS) sickness increased to 10.06% in March 2024 compared to 9.73% in February 2024.

Remedial Plans and Actions

- The journey booking team are reviewing both the existing service standards, which are uncontracted historical measures and not fully funded. This has already been discussed with the NEPTS DAG.
- Opening hours and delivery methodology are also being reviewed to establish a more focused resource profile compared to demand.
- Sickness is a particular area of focus and enhanced monitoring processes have been implemented.

Expected Performance Trajectory

It is anticipated that, as we work through the attendance at work policy actions, sickness will begin to improve.

Our Patients: Quality, Safety & Patient Experience
Clinical Indicators

(Responsible Officer: Andy Swinburn)

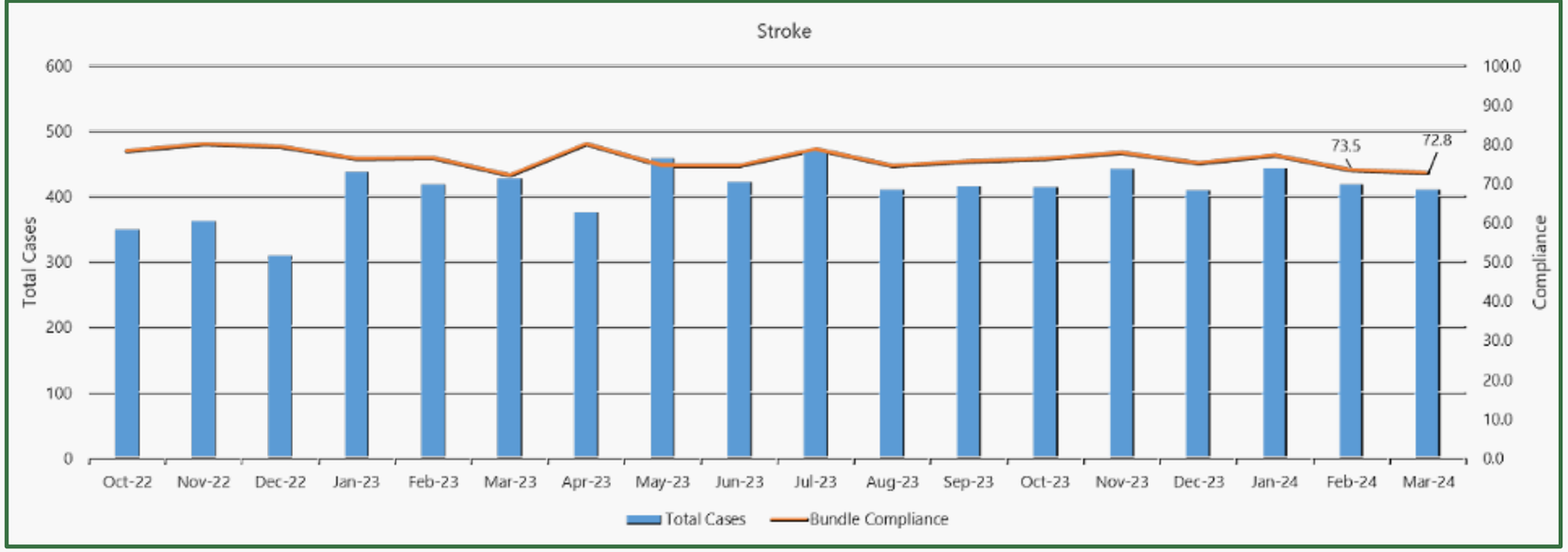
ROSC/Stroke/STEMI

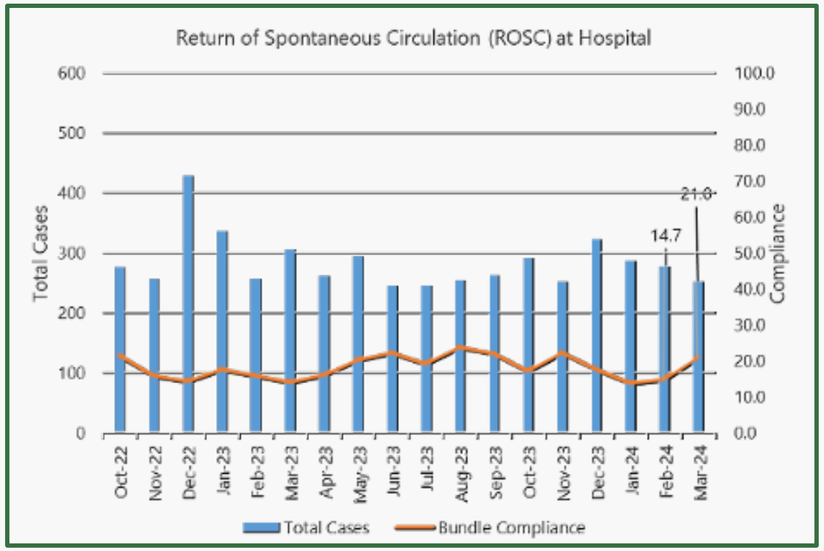
A

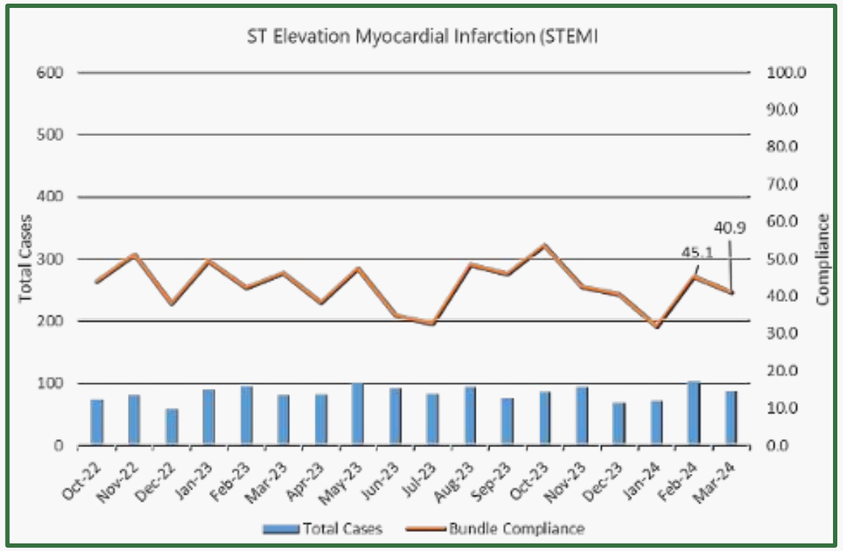
Self-Assessment: Strength of Internal Control: Moderate

QUEST

Return of Spontaneous Circulation, Suspected Stroke Patients with Appropriate Care, ST-elevation myocardial infarction (STEMI) with Appropriate Care







Analysis

The percentage of suspected stroke patients receiving an appropriate care bundle in March 2024 was 72.8%, a decrease from the 73.5% recorded in February 2024. This was against a total case number of 411 during the month of March. There is a correlation between documenting FAST and the care bundle, this will inform the improvement plan.

The ROSC rate for March 2024 was 21% an increase from 14.7% in February 2024. This was against a total case number of 253 during the month of March. The highest rate recorded since the implementation of ePCR was seen in August 2023, achieving 23.8%.

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

As a result of the recent decline in ROSC at hospital, the Clinical Intelligence & Assurance Team undertook work to understand the reason. This so far has identified an improved clinical picture as information is documented in the narrative and not the specific ePCR fields for CIs reported on using raw data. Draft data was presented at CIAG in April 2024 and a further update and option appraisal will be presented at CIAG in May 2024.

The percentage of suspected STEMI patients receiving an appropriate care bundle in March 2024 was 40.9%, a decrease from 45.1% in February 2024. This was against a total case number of 88 during the month of March. There is a correlation between documenting of analgesia and the care bundle, this will inform the improvement plan.

All Clinical Indicators remain within the normal bundle control limits

Updates to the User Interface for the ePCR were rolled out in December 2023, including some of those that affect the CIs. We continue to work with the suppliers for the remaining changes.

Following the switch to ePCR, the way data is collected when with the patient has changed. Automated Clinical Indicator reports are generated from data directly inputted onto ePCRs by clinicians. There are theoretical advantages to the new process, however this has not yet been realised with the monthly results. A recovery plan has been implemented to improve compliance to the reports.

As a result of the anticipated low compliance, risk 535 was generated with three key mitigations to work on:
Design of the User Interface
Clinician interaction with the ePCR
Accuracy of the scripting to extract the data from the data warehouse to create the report

Our Patients: Quality, Safety & Patient Experience
Clinical Indicators

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

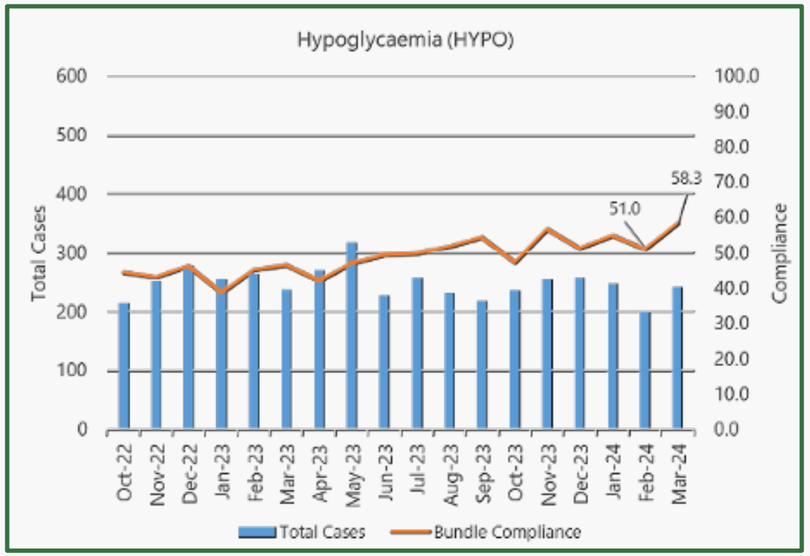
(Responsible Officer: Andy Swinburn)

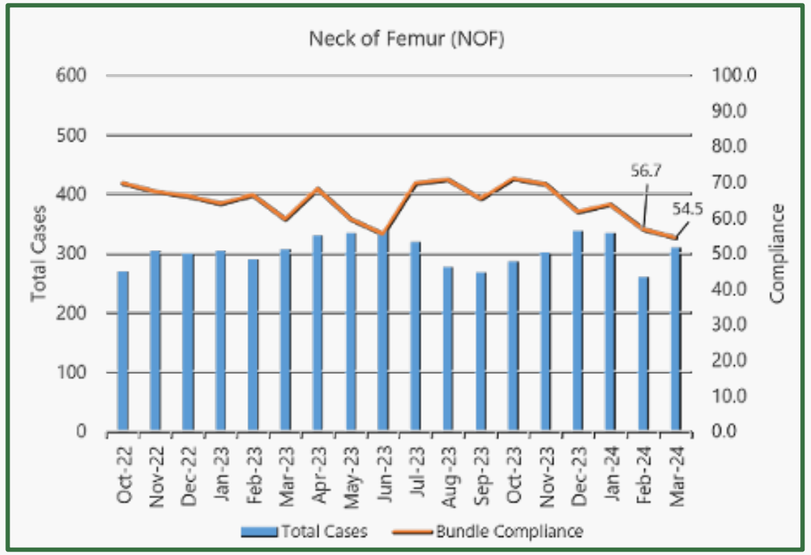
Door to Door

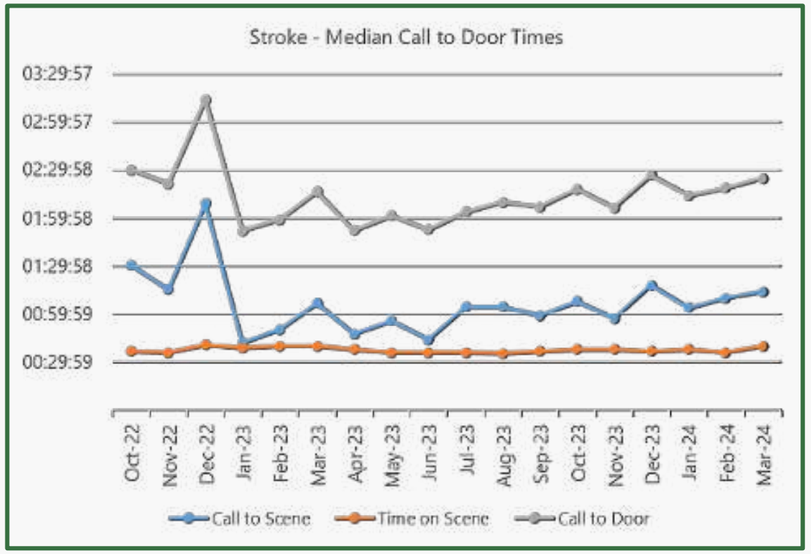
A

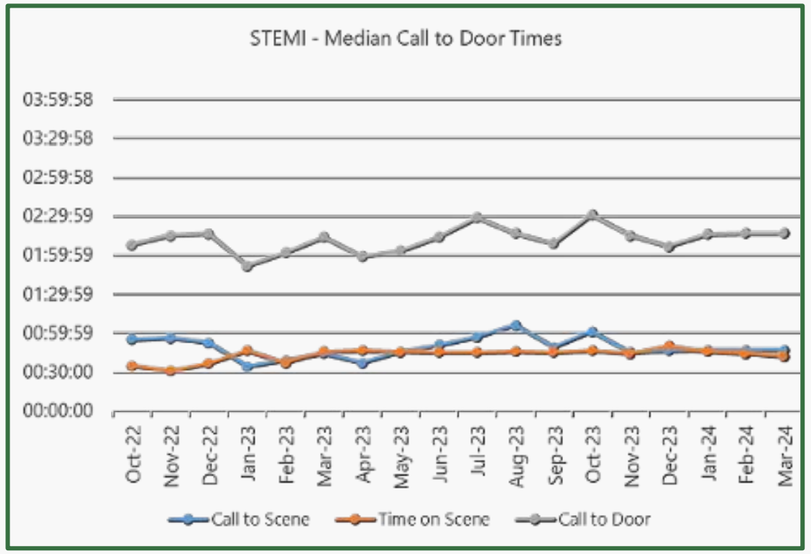
Self-Assessment: Strength of Internal Control: Moderate

QUEST









Analysis

The percentage of hypoglycaemic patients receiving an appropriate care bundle in March 2024 was 58.3%, an increase from 51% in February 2024. This was against a total case number of 242 in March. There is a correlation between documenting BM readings and the care bundle, this will inform the improvement plan.

The percentage of #NOF patients receiving an appropriate care bundle in March 2024 was 54.5%, a decrease from 56.7% in February. There is a correlation between documenting pain score and analgesia and the care bundle which will inform the improvement plan.

Clinical Indicators relating to call to door times for STEMI and Stroke are now reported on as part of the Ambulance Service Indicators reported to EASC. These show the breakdown for:
Time the call started to time of arrival at scene
Time on scene of the conveying vehicle
Time the call started to time of arrival at hospital

Remedial Plans and Actions

A recovery plan has been implemented to improve the CI compliance; actions include:

Full deployment at pace of the CI Improvement Plan
Focussed communication with WAST clinicians to use the bespoke ePCR boxes for CIs
Supporting Senior Paramedics to have conversations about CIs
Health Board focussed clinical workshops to promote understanding of CIs and care bundles
Invest in resources to utilise Natural language Processing, a form of AI to interrogate clinical narrative
Review scripting in a structured way for each CI bundle, monitor and repeat annually
Implementation of the clinical supervision policy to embed CIs
Plan resources required to provide clinical data at an individual level to all clinicians

The Trust's introduction of the Cymru High Acuity Response Unit model, based on improved clinical leadership and enhanced training, will further improve outcomes for patients and is our main response to improve Return of Spontaneous Circulation (ROSC) rates. Since May 2023 there has been an increase in numbers and availability.

Expected Performance Trajectory

The ePCR Compliance Approval Group are exploring options to improve ePCR completion and compliance to CIs with prompts when an ePCR is being closed to enable clinicians to easily return to the required filed for completion. This will be implemented in a stepwise approach.

This, along with continuing improvements in clinical supervision and the support of SPs working with the Clinical Improvement and Clinical Intelligence and Assurance Teams should increase compliance rates.

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

(Responsible Officer: Liam Williams)

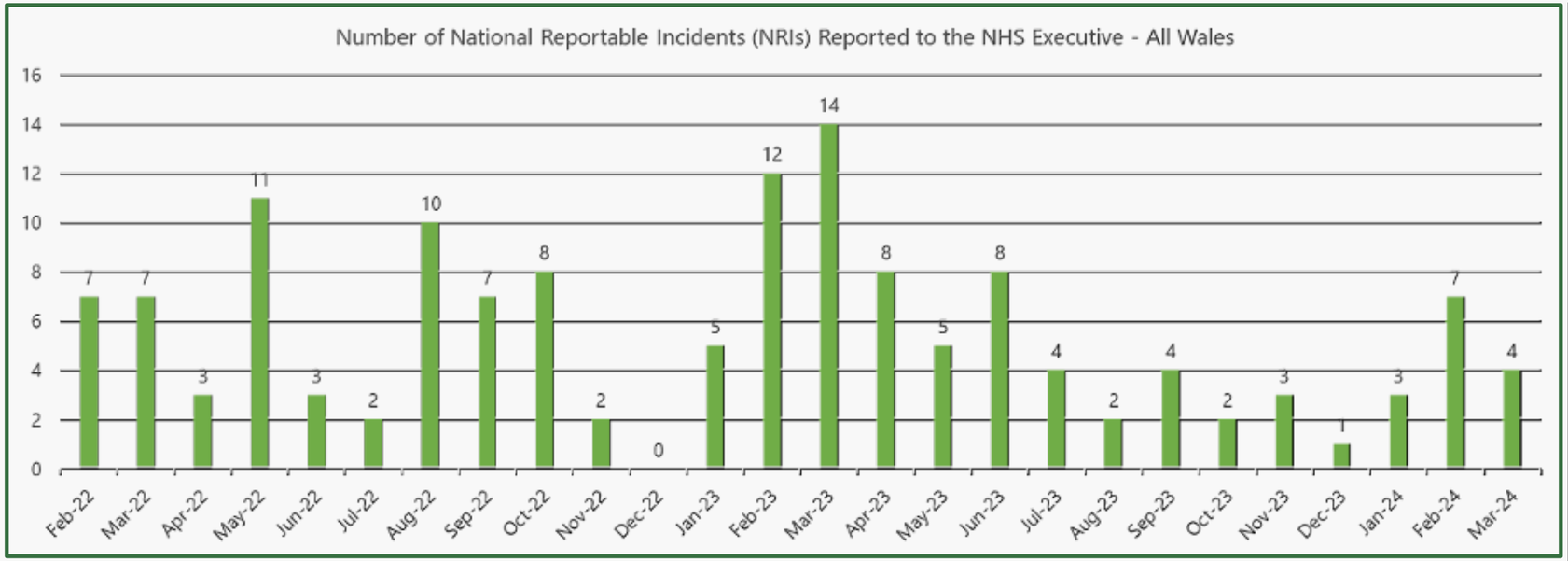
Concerns.

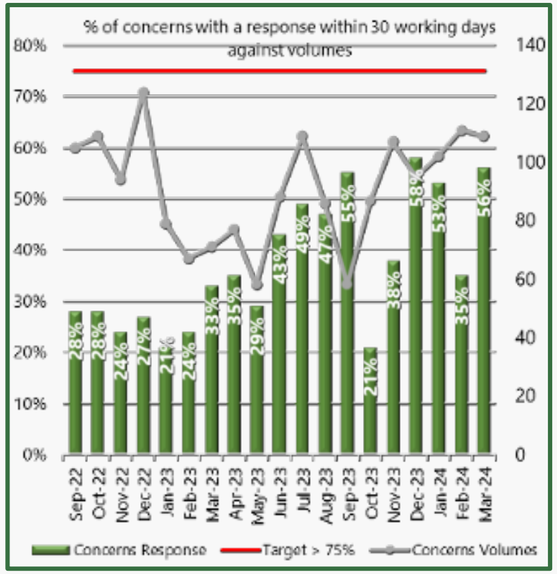
A

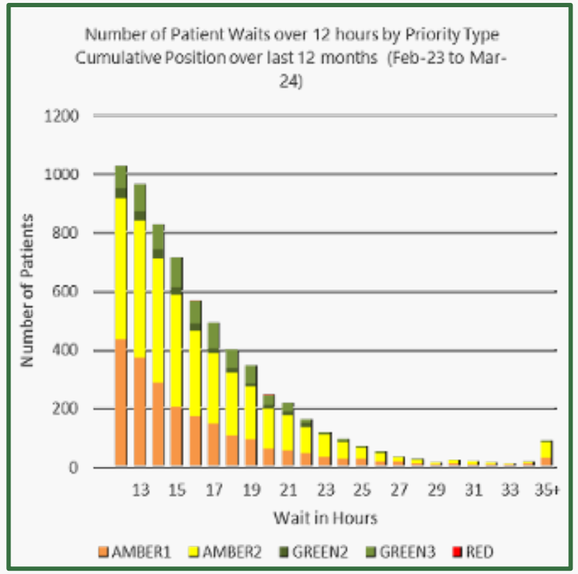
Self-Assessment: Strength of Internal Control: Moderate

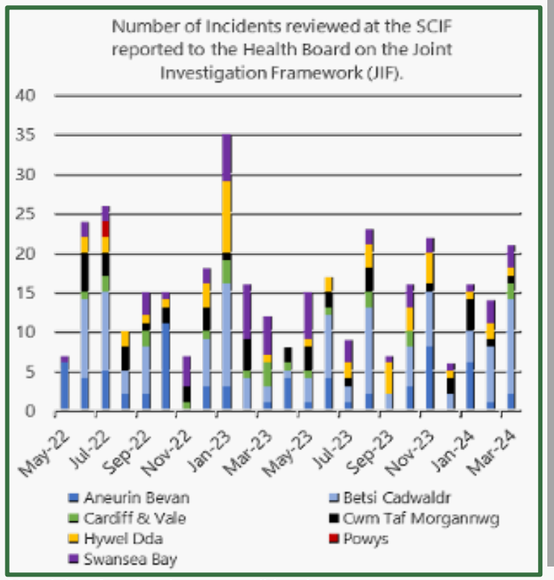
QUEST

Health & Care Standard
Health - Safe Care / Timely Care









Analysis

The percentage of responses to concerns in March 2024 is 56% against a 75% target (30-day response) which is an increased position but is expected to reduce ahead of stabilising by quarter 3 due to new staff education and training. Several factors continue to affect the Trust's ability to respond to concerns, including, overall increased demand, a rise in the number of inquests, continuing volumes of Nationally Reportable Incident's (NRIs) and timely response to requests for information from key parties. The number of total concerns has slightly decreased with 109 complaints being received and processed in March 2024. These complaints are frequently complex with our concerns administrators taking lengthy calls from distressed patients or family members for up to one hour per call. Five (5) Serious Case Incident Forums (SCIF) were held during the month and 34 cases were discussed. Following discussion 4 serious patient safety incidents were reported to the NHS Wales Executive and 21 serious cases were referred to Health Boards for investigation under the Joint Investigation Framework. The Trust received 1 referral from a Health Board under the Joint Investigation Framework during the period. Learning from the Joint Investigation Framework process remains limited with Health Boards citing high levels of escalation as causal factors.

All patient safety incidents graded moderate or above will continue to be reviewed by the Patient Safety Team, who will consider the requirement to enact the Duty of Candour and contact patients and families as appropriate and metrics will be included in the MIQPR from April 2024.

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

In March 2024, 787 patients waited over 12 hours for an ambulance response and 63 compliments were received from patients and/or their families.

Remedial Plans and Actions

A range of actions are in place:-

Good progress is being made in recruitment to posts following the Putting Things Right organisational change process. New staff require induction, education and training which takes existing resource. A recovery plan will be presented at the Clinical Quality Governance Group in April 2024.

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

The key strategic action is the EMS Operational Transformation Programme.

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.

**NB: Data correct on the date and time it was extracted; therefore, these figures are subject to change **NB: 30 Day Compliance reported from Power BI and therefore data is not yet validated*

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

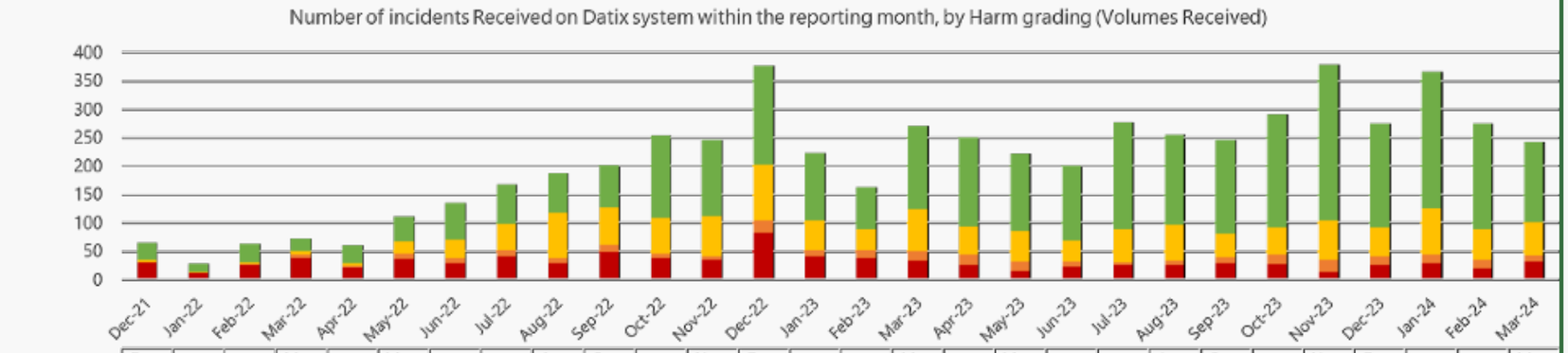
Our Patients: Quality, Safety & Patient Experience
Patient & People Safety Indicators

Self-Assessment: Strength of Internal Control: Moderate

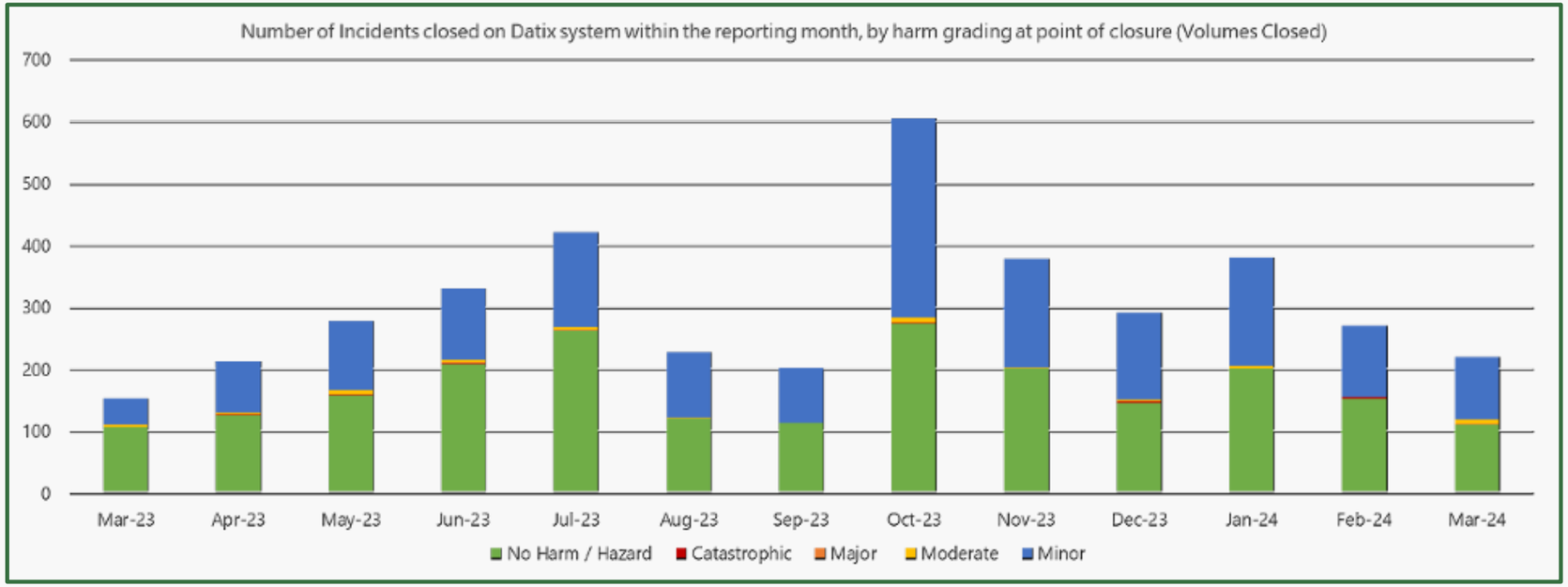
PCC

(Responsible Officer: Liam Williams)

Health & Care Standard
Health – Safe Care



	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Minor	30	15	33	23	33	44	66	71	71	75	146	136	175	119	74	147	159	137	132	189	160	166	200	275	184	240	187	143
Moderate	5	1	3	7	5	22	32	46	79	67	64	70	99	52	38	74	50	53	37	58	63	41	48	69	51	83	54	58
Severe	0	0	1	6	3	9	9	10	10	12	8	7	21	12	14	17	18	17	10	4	7	11	16	22	16	14	16	11
Catastrophic	30	12	26	37	20	36	29	41	28	48	37	34	82	40	37	33	25	15	22	26	26	28	27	13	25	29	19	31



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 – 40
- Minor harm – 143
- Moderate harm -58
- Severe Outcomes - 11
- Catastrophic - 31

(*NB: Volumes received).

The bottom graph highlights the 222 Incidents that were closed on the Datix system in March 2024. Monthly volumes should be interpreted with caution as incidents can be duplicated on the system (for example two crews submitting the same incident).

Remedial Plans and Actions

Workload for all members of the team continues to be high due to continued system pressures resulting in a backlog of Putting Things Right concerns which are frequently complex. The combination of the implementation of the Duty of Candour, Duty of Quality and the Medical Examiner Service has meant additional activity for the Putting Things Right Team. There is also a backlog of MPDS audits currently. The EMSC team are working hard to conclude these as soon as possible.

The Putting Things Right Team organisational change process is progressing, and final posts will be recruited to by July 2024. This new structure has taken into consideration the Trust's local and national priorities and resources to meet the needs of patients and families. It is envisaged that the new structure will take some time to become established. A recovery plan will be presented to Clinical Quality Governance Group at the April 2024 meeting.

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

Expected Performance Trajectory

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

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

Data source: Datix

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

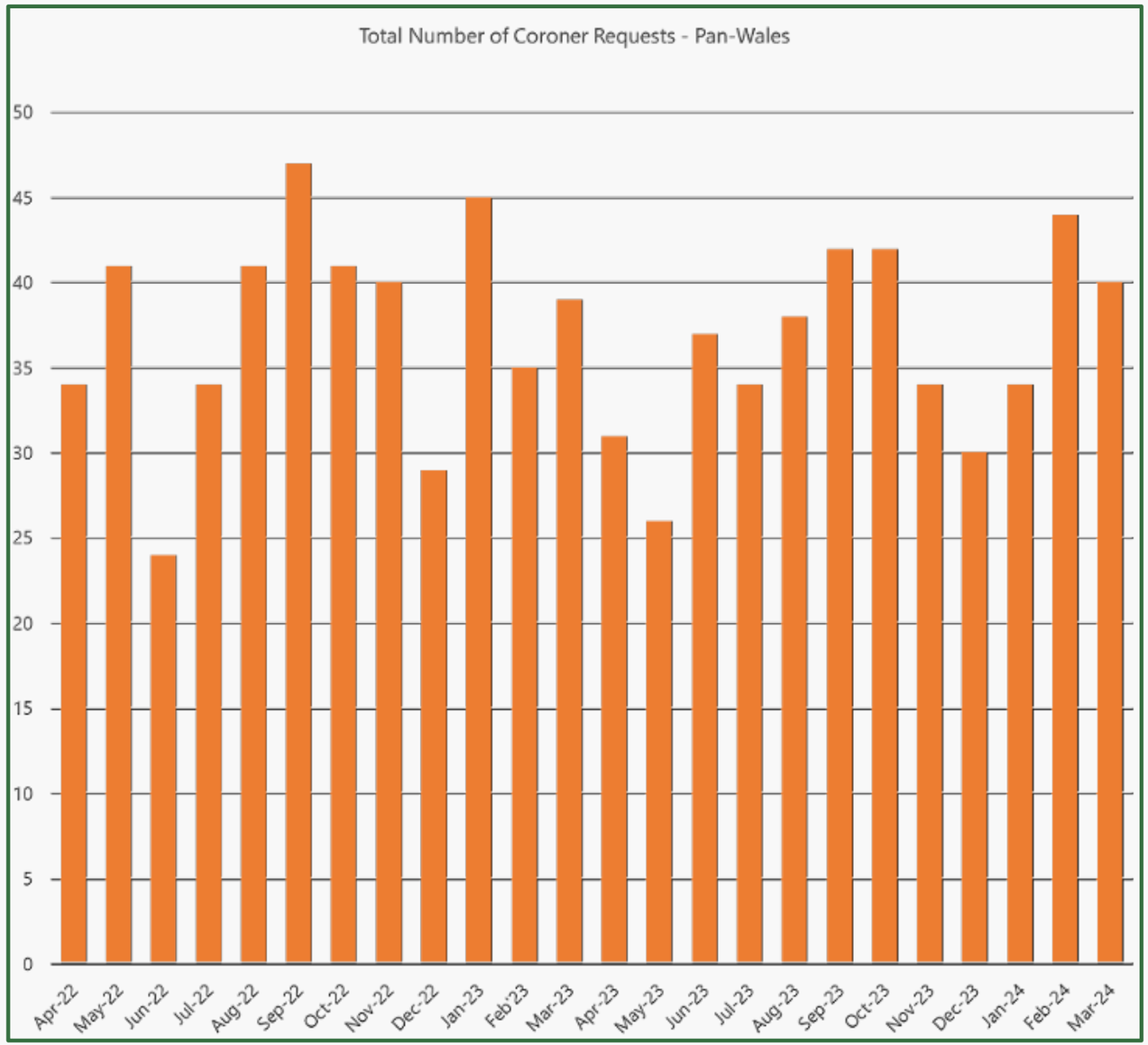
(Responsible Officer: Liam Williams)

Coroners Self-Assessment: Strength of Internal Control: Moderate

Mortality Self-Assessment: Strength of Internal Control: Moderate

QUEST

Health & Care Standard
Health – Safe Care



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

Analysis

Coroners: The complexity of the cases remains high, with multiple statements and actions per approach. This is in addition to the work required to manage cases where the Trust has been given IP status. The number of cases in which the Trust is an IP raised in April 2023 and continues higher, we now consider this to be the new normal. Cases continue to be registered and distributed. Delayed statement requests are escalated to ensure that the Trust does not receive a Schedule 5 summons.

Ombudsman: There has been a reduction in initial approaches to the Trust by the PSOW. All PSOW cases are now being managed via Datix Cymru. A deeper dive into the cases has been undertaken and will be reported as part of the next quarter report. The Ombudsman is considering issues surrounding joint investigations and the issues of elderly patients laying on floors waiting for ambulances.

Mortality Review: The Trust continues to participate in Health Board led mortality reviews as appropriate, with attendance from the Patient Safety Team and clinical colleagues as available. Data and information is also provided by the Trust as required to the Medical Examiner Service to inform their reviews of deaths in acute care. Feedback from the Medical Examiner Service in respect of themes and trends include timeliness in response to patients in the community, handover of care delays and patients on the end-of-life care pathway being conveyed to acute care.
Currently the focus of the Medical Examiner Service is undertaking mortality reviews in the acute care setting and the plan is for all non-coronial deaths, including community deaths to be reviewed by the Medical Examiner Service from April 2024. An increase in activity for requests / reviews for the Trust is expected when this occurs.

Remedial Plans and Actions

Coroners: There continues to be additional work due to the ongoing recovery of the Trust solicitor/claims manager, who is unable to travel for long distances. A temporary staff member's contract has been extended to the end of April 2024 to try and minimise the impact of the additional work. The Legal Services Team is not yet fully staffed following OCP, and work continues to ensure that the Team is fully formed as soon as possible.

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

Mortality Review: The Trust is in the process of developing the internal mechanisms in order to facilitate mortality reviews aligning to the national approach. This includes consideration of the resources required in the new Putting Things Right (PTR) Team structure with additional roles included in the Patient Safety Team. Recruitment to the new structure is expected to be completed by July 2024. Representation and contribution by the Trust at the All-Wales Mortality Working Group continues. The Patient Safety Team are engaged in the meetings lead by the Once for Wales Datix Cymru Team who are developing the Datix Cymru Mortality Module. The Learning from Deaths Forum, chaired by the Assistant Director of Quality & Nursing is established and is currently meeting on at least a quarterly basis, with oversight and reporting to the Clinical Quality Governance Group. Following the finalisation of the All-Wales National Mortality Framework which will include the processes in primary care, the Learning from Deaths Forum will oversee the updates to the Trust's Framework.

Expected Performance Trajectory

Coroners: This level of activity seems to be the new normal and will continue to be monitored.

Ombudsmen: Learning has been placed in a PTR, for sharing pan Wales.

Mortality Review: Whilst the multiple benefits of the Medical Examiner Service are recognised there will undoubtedly be significant resource implications for the Trust, particularly as the process expands to every non-coronial death in NHS Wales by the end of April 2024 and the Health Boards (who are at different levels of maturity regarding mortality reviews) start to develop and embed their processes. It is recognised that some cases will have already been escalated following screening and reviewed via PTR processes internally through the Serious Case Incident Forum. Following the recruitment to the new PTR Structure (expected by May 2024) improvements in the timely review of MES referrals is expected.

Mortality Reviews Data source: Internal Web Application

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

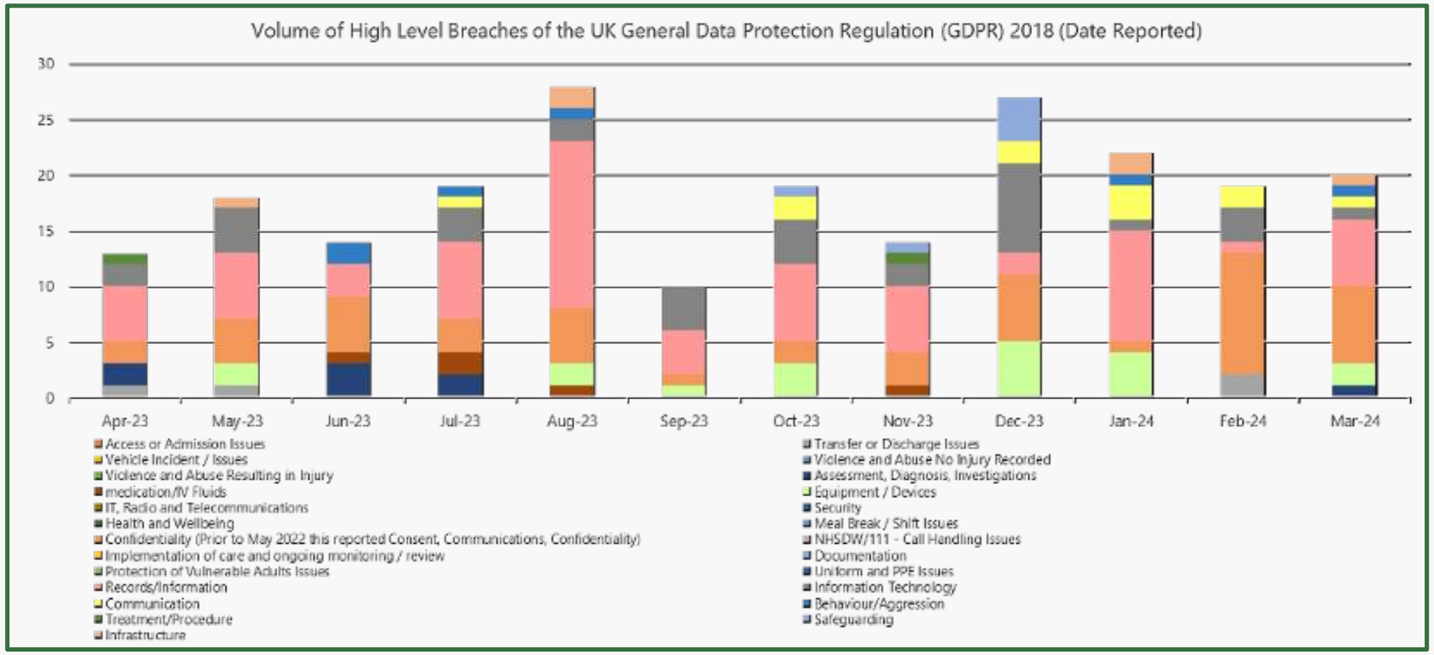
(Responsible Officers: Jonny Sammut & Liam Williams)

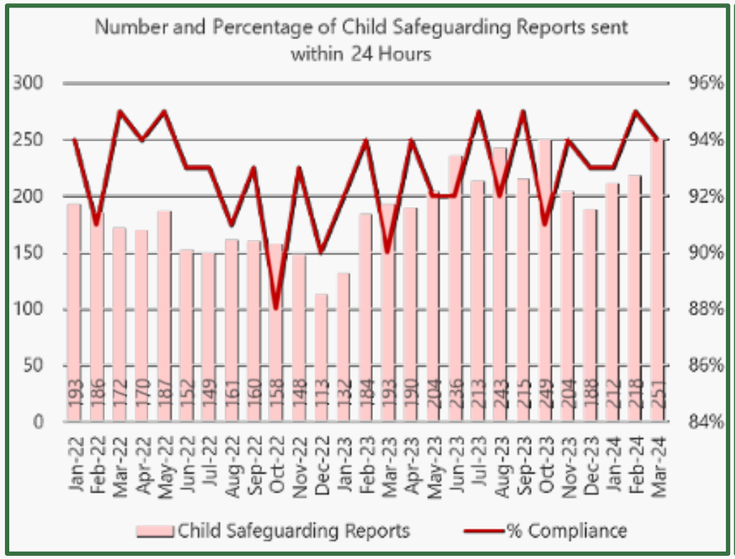
Self-Assessment: Strength of Internal Control: Strong

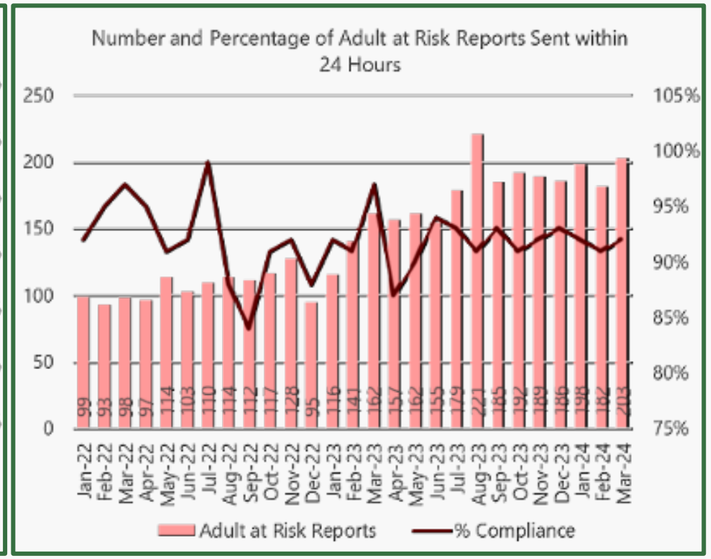
QUEST

Health & Care Standard
Health – Safe Care

Safeguarding Data source: Doc Works







Analysis

Safeguarding: In March 2024 staff completed a total of 203 Adult at Risk Reports, 92% of these were processed within 24 hours. Whilst the Trust does not report on Adult Social Need reports, 565 referrals were received and processed to the local authority during this reporting period. There have been 251 Child Safeguarding Reports in March 2024, 94% of these were processed within 24 hours.

Data Governance: In March 2024, there were 20 information governance (IG) related incidents reported on Datix Cymru categorised as an Information Governance (IG) breach. Of these 20 breaches, 7 related to IG/Confidentiality, 6 Records/Information, 2 equipment/devices, 1 Communication, 1 Information Technology, 1 behaviour, 1 Infrastructure, and 1 Assessment Investigation and Diagnosis.

Public Engagement: During March, the Patient Experience and Community Involvement Team attended 24 community engagement opportunities, engaging with approximately 652 people. This month engagement has included attendance at an Aneurin Bevan University Health Board led 'Big Conversation' event talking to members of the public about their experiences of grief, bereavement, death and dying. We celebrated International Women's Day at a community event in Newport with a focus on building resilience and confidence in women. We attended an event in support of the UN International Day for the Elimination of Racial Discrimination where we promoted the new WAST Welcome Pack for people whose first language isn't English or Welsh. In addition, we continued to meet and engage with colleagues from Llais and have had introductory meetings with Care & Repair Cymru to explore ways of future partnership working. We have also continued on our co-production journey by attending workshops led by Co-Production Wales, sharing emergent practice and learning from real-life examples. Through the month we also continued to use engagement events as an opportunity to promote Patient Experience Surveys, asking people to provide feedback about their interactions with our services. We acknowledge that response rates to some of these surveys remains low and isn't truly reflective of all patient's experience, though we are working with colleagues to try and increase return rates. Engagement and survey outcomes remain largely consistent and tell us that people find calling 999 a stressful experience, our questioning is repetitive, and people don't understand why they need to repeat the process if they re-dial 999 to check on an ETA. But people continue to tell us that they are generally happy with the clinical care they eventually receive and that our staff are reassuring and professional. 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 longer than wanted delays when waiting for their transport home following their appointment. We have also seen an increase in people complaining about short notice cancellation of transport, leaving some with no option but to miss their much-needed hospital appointment.

Remedial Plans and Actions

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

Data Governance: During the reporting period, of the 20-information governance related incidents reported on Datix, 0 incidents were reported to the Information Commissioner's Office (ICO). The IG Team continues to review and provide advice on reported incidents.

Public Engagement: Community involvement and engagement with patients/public forms an integral part of the Trust's ambition to 'invert the triangle' and deliver value-based healthcare evaluated against service users' experiences and health outcomes. The work delivered by the PECI Team is supporting the Trust's principles of providing the highest quality of care and service user experience as a driver for change and delivering services which meet the differing needs of communities we serve without prejudice or discrimination. The PECI Team will continue to engage in an ongoing dialogue with the public on what they think are important developments the Trust could make to improve services they receive. Response rates to some of our PREM's surveys is disappointingly low and we acknowledge that this means we cannot report a truly reflective picture of what it feels like to be a user of some of our services. We are actively working with colleagues across the Trust in a number of different departments to try and agree on solutions that would allow us to directly contact more patients to ask for feedback about their experiences with us. We have escalated our concerns to barriers which are preventing us from directly contacting patients to colleagues at the Welsh Risk Pool who oversee implementation of the Once for Wales Civica & Datix systems. We are seeking their advice on a way forward. WAST's Information Governance Team has also contact the Information Commissioner's office who are reviewing the situation for us and will provide further guidance.

Expected Performance Trajectory

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

Data Governance: The IG Toolkit submission for FY23/24 was submitted end of March. An Improvement Action Plan will be developed in readiness for the next submission in March 2025.

Public Engagement: All feedback received is shared with relevant Teams and Managers and continues to be used to influence ongoing service improvement. Patient experience and community engagement information is now shared weekly at the Senior Quality Team meeting.

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

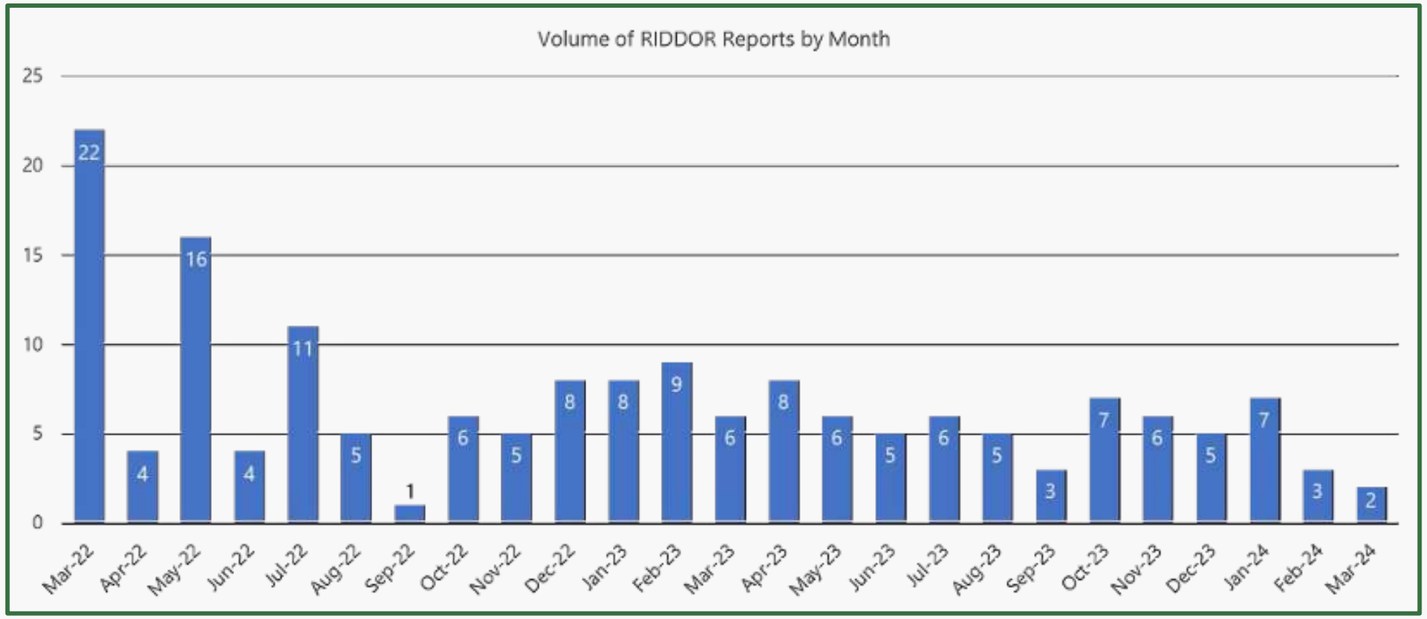
Our Patients: Quality, Safety & Patient Experience
Health & Safety (RIDDORS) Indicators

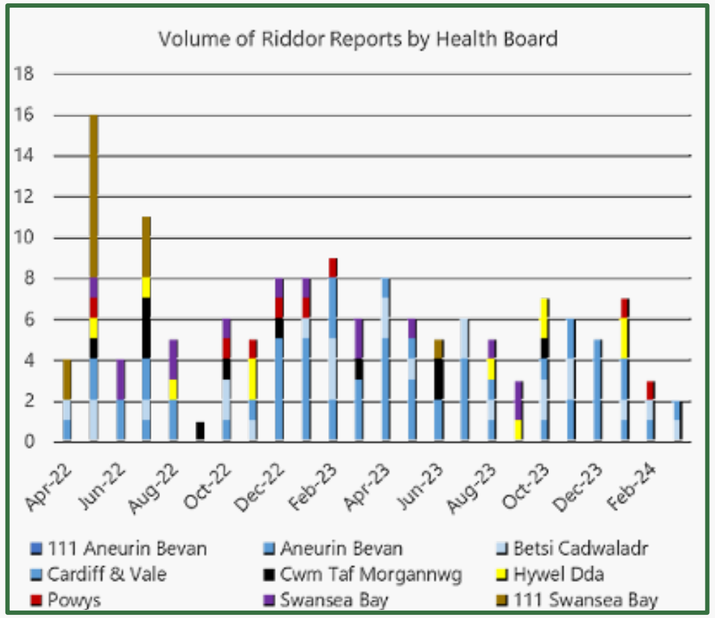
(Responsible Officer: Liam Williams)

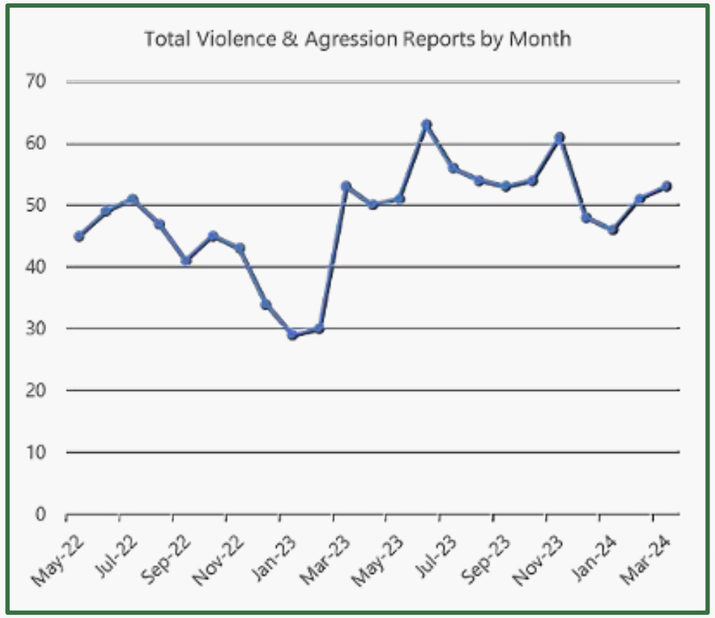
Self-Assessment: Strength of Internal Control: Moderate

PCC

Health & Care Standard
Health – Safe Care







Analysis

RIDDOR: There were 2 incidents requiring reporting under RIDDOR during March.
All were related to staff being absent from work for over 7 days because of their injury that resulted from manual handling activities.

100% of the reports were completed within the reporting required time frames. Health and Safety team will continue to work with Incident Handlers to ensure reports are submitted within the required timescales.
Manual handling continues to be the highest category of incidents reported under RIDDOR.

Violence and Aggression: A total of 53 incidents have been reported of V&A in March.
6 Physical Assaults on staff were reported during the month with incidents of verbal abuse amounting to 47for the month.

There were 3 reports for inappropriate sexual behaviour 1 verbal and another behavioural.
14 incidents were reported as Moderate in harm and 23 noted as low harm which continues the higher trend seen since August 2023.

Verbal abuse continues to be the major category of reporting received with aggressive and threatening behaviour toward staff still at high levels.
Several Individuals convicted of violence an aggression toward staff from previous incidents have been convicted and sentenced in March.

No fines, prosecutions or notices were issued from the Health and Safety Executive (HSE) during March.

Remedial Plans and Actions

RIDDOR: A new DSE/Manual Handling Advisor has been appointed and they are undertaking an analysis of the manual handling incidents within the Trust to identify areas for continuous improvements.

Violence and Aggression: The V&A Team have visited the 111 call centres and completed visit to the CCC areas to gain a better understanding of the incidents of verbal abuse received and the challenges of reporting the incidents on Datix. The aim is to ensure more consistent reporting and investigation to ensure the physical and mental safety of our staff.
We are assisting EMS – Mental Health to RA The impact of RCRP

Expected Performance Trajectory

RIDDOR: As recommendations from the manual handling review are implements the number of incidents are projected to fall.

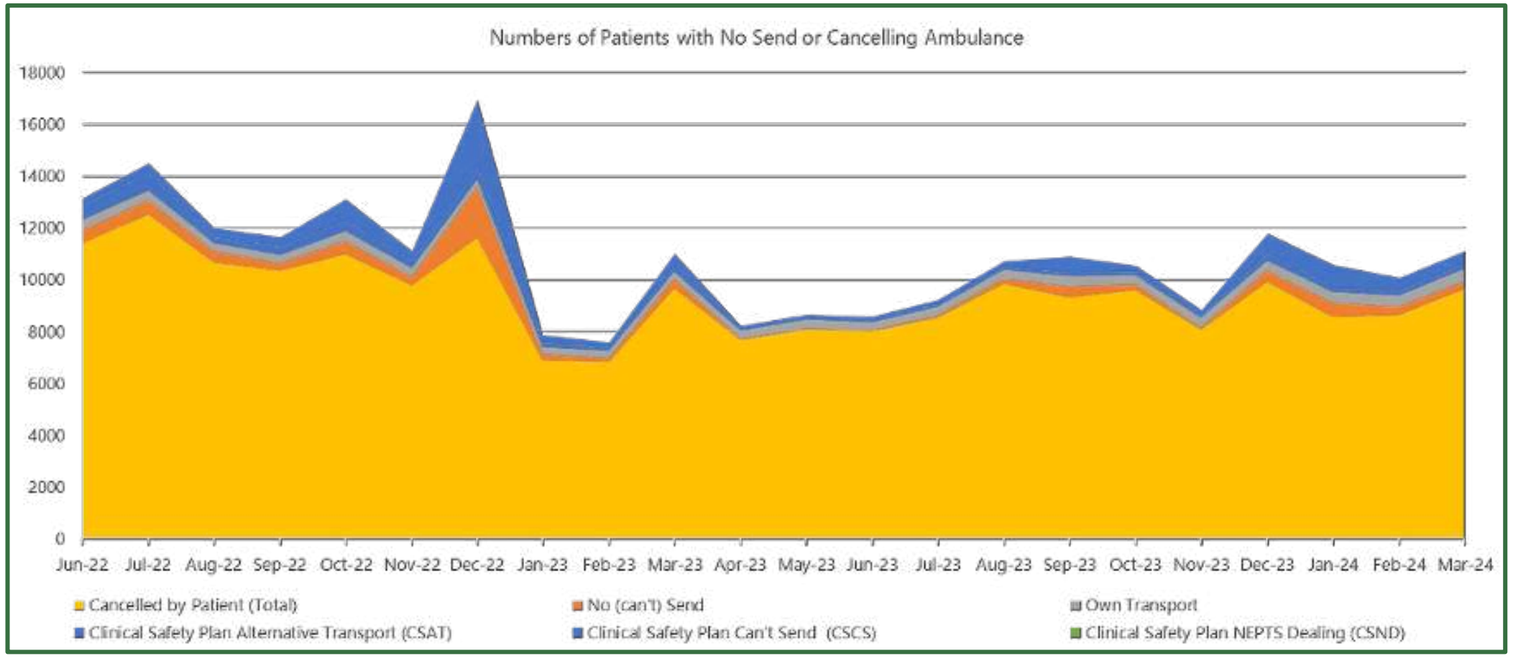
Violence and Aggression: The impact of RCRP Police attendance at welfare/mental health calls may result in an increase reporting of V&A incidents as staff try to deal with unstable patients. This is a national concern and has been raised at NAVSEG. All Police forces are implementing a phase approach to not attending calls as previously experienced .. only if there is immediate threat to life.

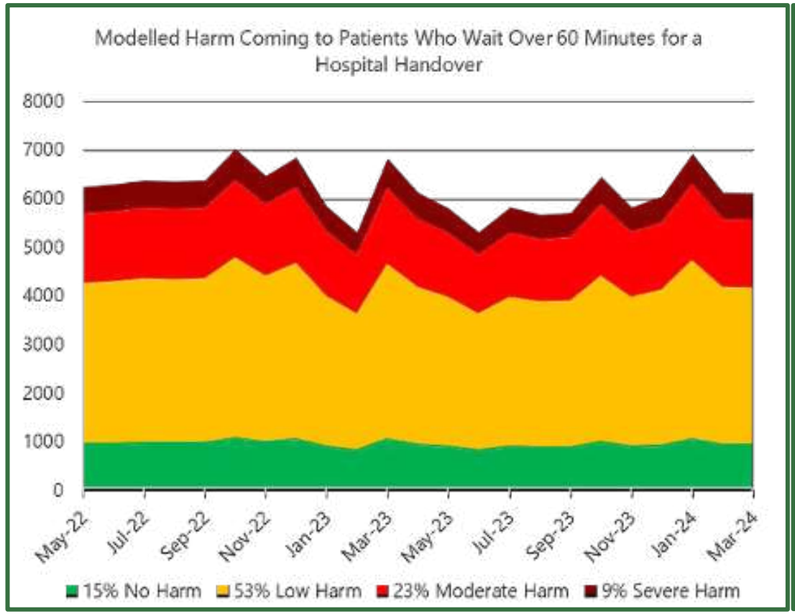
**NB: Data correct on the date and time it was extracted; therefore, these figures are subject to change*

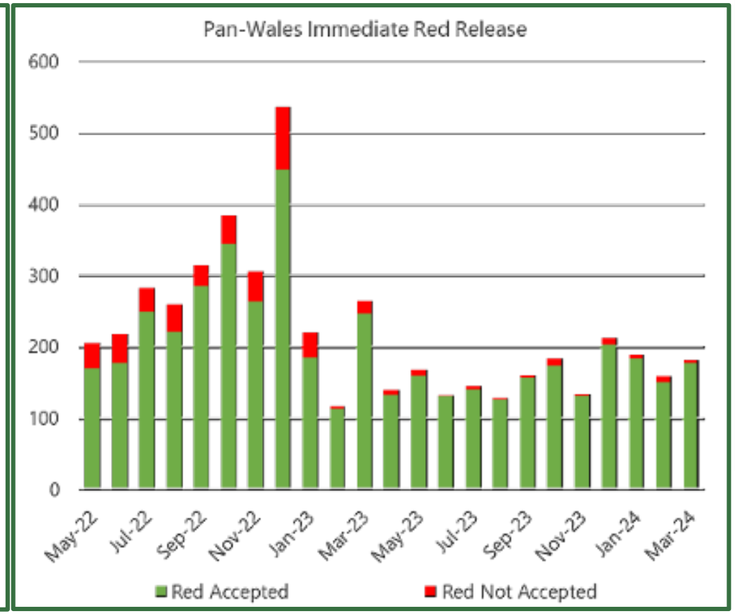
Data source: Datix

Our Patients: Quality, Safety & Patient Experience
Potential Patient Harm Indicators

(Responsible Officer: Andy Swinburn) R FPC







Analysis

In March 2024, 169 ambulances were stopped due to Clinical Safety Plan (CSP) alternative transport and 552 were stopped due to CSP 'Can't Send' options. In addition, 9,605 ambulances were cancelled by patients (including patients refusing treatment at scene) an increase from 8,623 in February 2024 and 479 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 March 2024. Of these 177 were accepted and released in the Red category, with 5 not being accepted. Further to this, 152 ambulances were released to respond to Amber 1 calls, but 328 were not.

The graph in the bottom left shows that in March 2024 of the 6,105 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% (915 patients) would experience no harm, 53% (3,235 patients) would experience low harm, 23% (1,404 patients) would experience moderate harm and 9% (549 patients) would experience severe harm.

In March 2024 CSP levels for the Trust were:

Remedial Plans and Actions

Red immediate release is monitored weekly by the Chief Executive and reported through to Health Board CEOs with the expectation that there are no declines for Red Release from any of the 7 Health Boards. All health boards have agreed to this measure. Integrated Commissioning Action Plan (ICAP) meetings have commenced with Health Boards, the Commissioner and the Trust and performance is reviewed monthly with questions posed to Health Boards regarding immediate release and handover reduction plans and actions.

Expected Performance Trajectory

The Trust continues to monitor CSP levels both daily through the ODU and weekly through the Weekly Operations Performance Meeting and mitigations are actioned to reduce the impact on the Trusts ability to respond to demand. Seasonal pressures impact the Trust and planning is being used to prepare for this through a range of measures including the use of forecasting and modelling.

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

Our Patients: Quality, Safety & Patient Experience
Patient Experience Surveys

(Responsible Officer: Liam Williams)

Self-Assessment: Strength of Internal Control: Moderate

PCC

Health & Care Standard
Health – Safe Care

March 2024		
NEPTS (132 responses)	Benchmark	Score
How long did you wait for your transport to take you home after your appointment.	85	82
Were you happy with the transport you received?	85	85
999 (39 responses)	Benchmark	Score
The 999-call taker who answered your call was reassuring.	85	69
The 999-call taker who answered your call explained what was going to happen next.	85	74
You felt confident in the call taker ability to manage your call and provide appropriate advice.	85	65
The length of time I waited for an ambulance to arrive was acceptable.	85	43
111 (38 responses)	Benchmark	Score
Do you feel your call to 111 Wales was helpful?	85	55
Did you follow the advice given to you by NHS 111 Wales?	85	92
Would you consider using NHS 111 Wales again?	85	67
WAST Overall - Friends & Family Test How was your overall experience with the service today?	Ranked from very poor to very good.	
o Ambulance care	81.58% Good	12.28% Poor
o Integrated Care (NHS 111 Wales Telephone line only)	50.00% Good	27.78% Poor
o EMS (including CSD and Falls Response)	61.70% Good	21.79% Poor
o NHS 111 Wales Online	58.06% Good	29.03% Poor
	* Where totals above do not add up to 100%, this is because a 'Do Not Know' answer was given, these are excluded from overall total.	

Analysis
Within the NEPTs survey the responses provided did not hit the benchmark in relation to the questions 'How long did you wait for your transport to take you home after your appointment and 'Were you happy with the transport your received', therefore not providing the level of service the patient expected. However, 92% in the 111-survey confirmed they took the advice given by NHS 111 Wales.

It is acknowledged that the small number of respondents for the 999 and 111 surveys does not provide a great enough response to reflect a true patient experience picture, but work is currently underway to develop a process that will increase response rates and make them more meaningful.

Remedial Plans and Actions
We continue to make available 4 core Patient Experience surveys, covering the Trust's main service delivery areas:

- 999 EMS Response (incorporating CSD)
- Ambulance Care (NEPTS)
- NHS 111 Wales Telephony
- NHS 111 Wales Online

Response rates to the 999 and 111 surveys are low and it's acknowledged that these do not reflect an entirely representative picture based on overall call volumes, but we are working consistently to develop a process that will help increase these response rates. An updated DPIA is nearing completion and will soon be submitted to the ICO for their consideration and advice about a way forward around us of SMS text messages to distribute survey requests to service users. However, we are not completely relying on this approach and have been looking at alternative methods of distribution also. We have met with colleagues at South East Coast Ambulance Service who have successfully placed QR codes in the back of all their EMS vehicles to increase patient feedback and we plan to explore use of the same model here at WAST.
We have been working closely with the Trust's Falls Improvement Lead, and in March we launched a targeted survey looking at the experiences of people who are responded to by either a Level 1 or Level 2 falls responder. Patients who are left at home with no further intervention required are left an invitation to share their experience with us by completing a survey. The invitation contains a QR code that can be scanned to access an online survey, contact details for the PECI Team are also included allowing people to request a hard copy survey is sent to them. So far just over 20 people have completed a survey with all respondents rating their experience with the Falls service as 'Very Good'. Capturing service user experience through the use of surveys is a mandatory requirement and a new reporting framework is submitted to the NHS Executive and Welsh Government on a monthly basis outlining how many surveys have been completed.

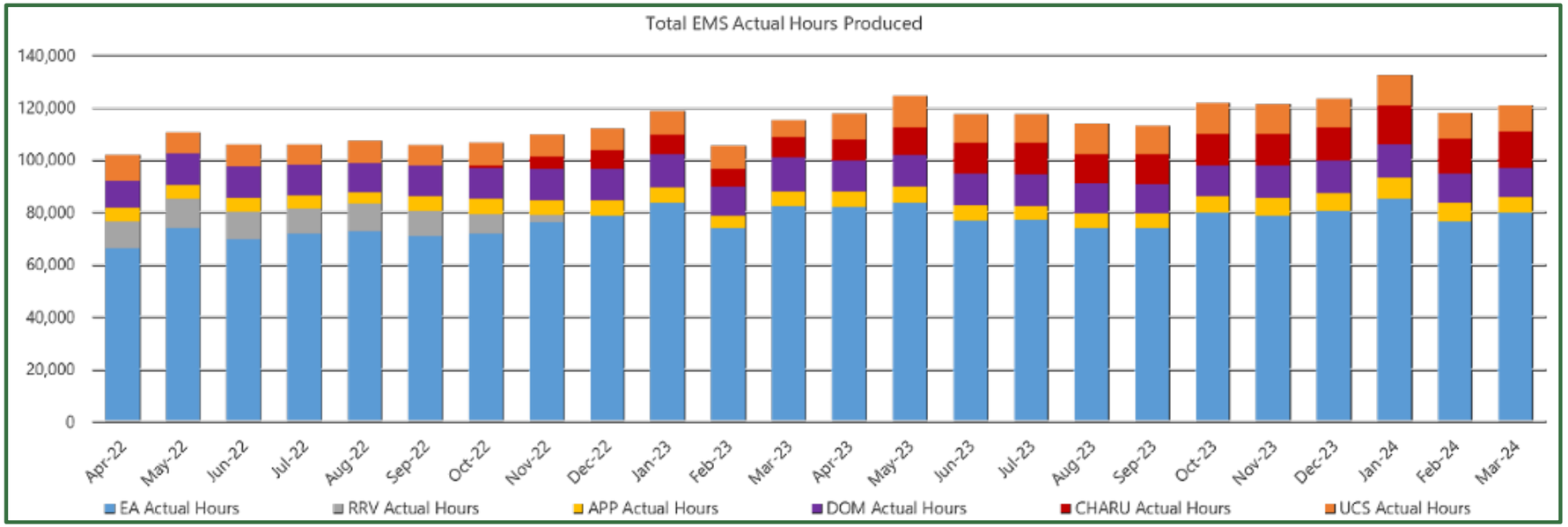
Expected Performance Trajectory
Work to further integrate our systems with Civica to push email/text surveys to patients. Using Other methods of survey delivery such as QR codes in EMS vehicles to compliment this, with an overall aim of increasing visibly of experience surveys and maximising opportunities to capture patient experience data through experience surveys.

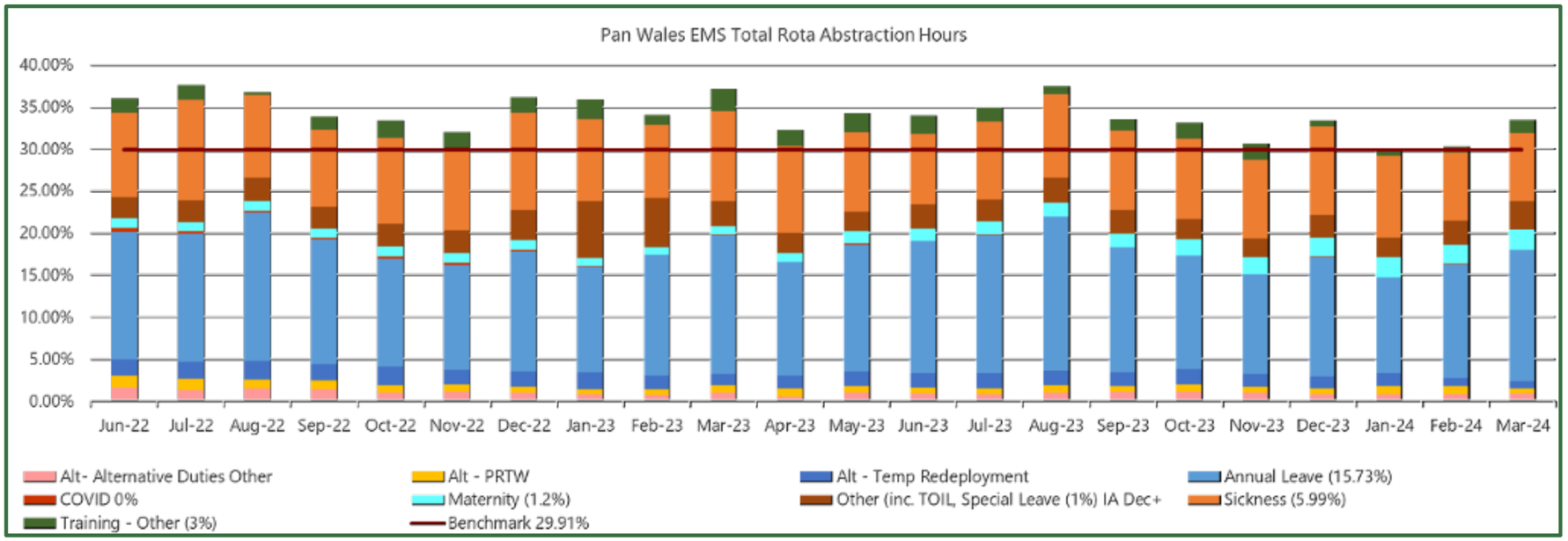
Our People
Capacity - Ambulance Abstractions and Production Indicators

(Responsible Officer: Lee Brooks)

EA Production	Abstractions
A	R

CI PCC FPC





Analysis

The total hours produced is a key metric for patient safety. The Trust produced 121,069 hours in March 2024, compared to the 115,647 hours produced during March 2023 (2024 a leap year). The Trust is delivering good levels of production.

As shown in the bottom graph, monthly abstractions from the rosters are key to managing the number of hours the Trust has produced, as are the total number of staff in post. In March 2024, total EMS abstractions (excluding Induction Training) stood at 33.49%. This was an increase from the 30.33% recorded in February 2024 meaning the Trust remains above 30% (which is the benchmark figure). The highest proportion of abstractions was due to annual leave at 15.62% followed by sickness at 8.17%. This figure for sickness abstractions for March 2024 was a decrease when compared to the same month last year (10.75%).

Emergency Ambulance Unit Hours Production (UHP) achieved 93% in March 2024 which equated to 79,699 Actual Hours. This is a 3% decrease on the Actual Hours produced during March 2023.

CHARU UHP achieved 154% (13,744 Actual Hours) compared to 160% in February 2024 (this is the commissioned level not the modelled level). This equates to 76% UHP of the full roll out requirement against the agrees rosters.

Remedial Plans and Actions

Continued focus on managing attendance across the Trust and managing abstractions from rosters.
Full roll out of CHARUs.
Continued focus on staff in post to establishment, aiming for 95% benchmark.
Smoothing of staff between urban and rural areas.

Expected Performance Trajectory

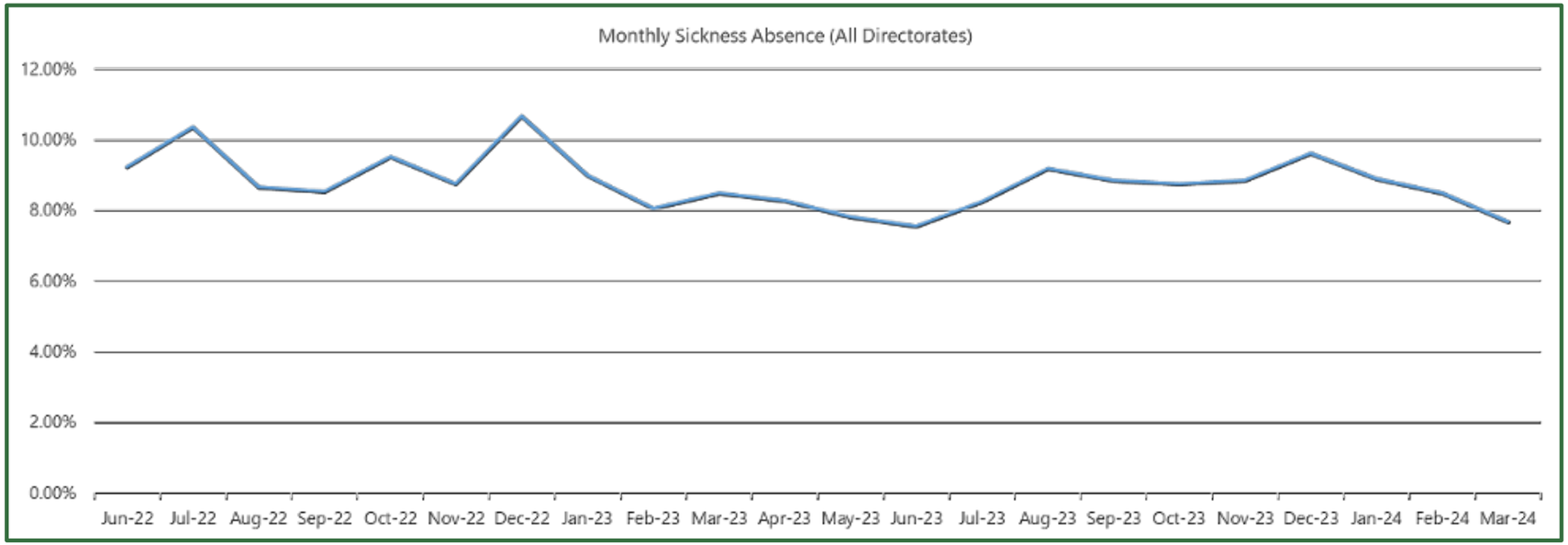
UHP estimates, based on recruitment levels, estimated abstractions and overtime have been provided to ELT. Production is good. The Trust has an ambition to reduce sickness to 6% and abstractions to 30% by March 2024, which would further boost production; however, the handover levels are extreme, and the rosters are simply not designed to cope with over 23,000 lost hours; they were predicated on 6,000 hours.

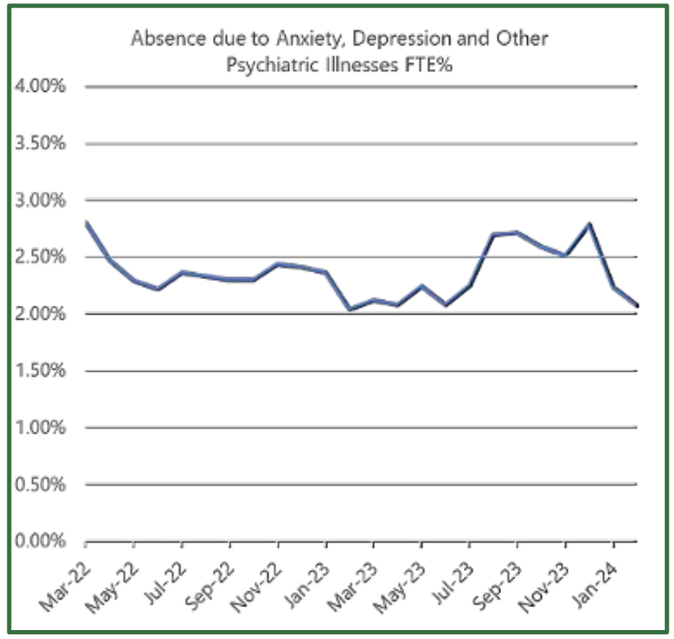
Our People
Capacity - Sickness Absence Indicators

(Responsible Officer: Angela Lewis)

Mental Health
R

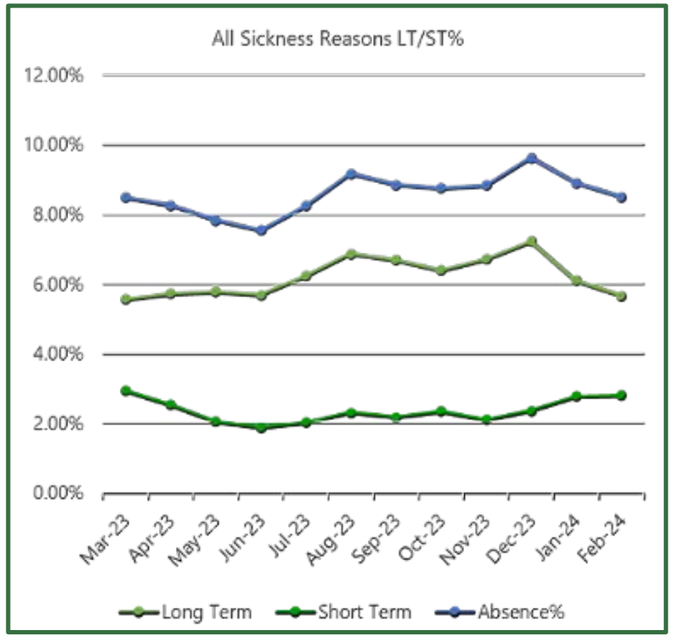
CI





Average working days lost per FTE (Annual)	
19.56 days	
Single Month Absence %	
8.46%	
Long Term	Short Term
5.66%	**2.80%**
Mental Health (S10 Stress/Anxiety)	Other MSK (excluding back)
2.07%	**0.97%**

February 2024



Analysis

There was a decrease in overall sickness absence rates between February 2024 and March 2024, dropping from 8.50% to 7.67%.

Long term absence decreased from 6.10% in January 2024 to 5.66% in February 2024, however short-term absence increased marginally from 2.78% in January 2024 to 2.80% in February 2024.

The highest reason for short term absence in February 2024 was Anxiety/ Stress/ Depression, other musculoskeletal problems and cold, cough, flu-influenza.

Absence due to Mental Health has had an upwards trajectory since June 23, however, is now at 2.07%, which is back in line with figures seen during the early part of 2023.

Remedial Plans and Actions

- Monitoring continues with ongoing reviews in both long term and short-term absences with monthly meetings to track sickness and provide support. Three MAAW training sessions have been scheduled for April, June & September 2024.
- Three bitesize training sessions have been scheduled for March 2024 whilst we continue to develop the use of e-learning for the sessions through the use of LMS365.
- In line with the Improving Attendance Action Plan, the People Services Advisors have undertaken audits on short term absence occurrences within the Operations Directorate.
- Audits for all Directorates, will be undertaken on a monthly basis over the next 6 months and the People Services Team will provide targeted support to line managers on reasonable adjustments and the appropriate use of discretion in areas identified as hot spots.

Expected Performance Trajectory

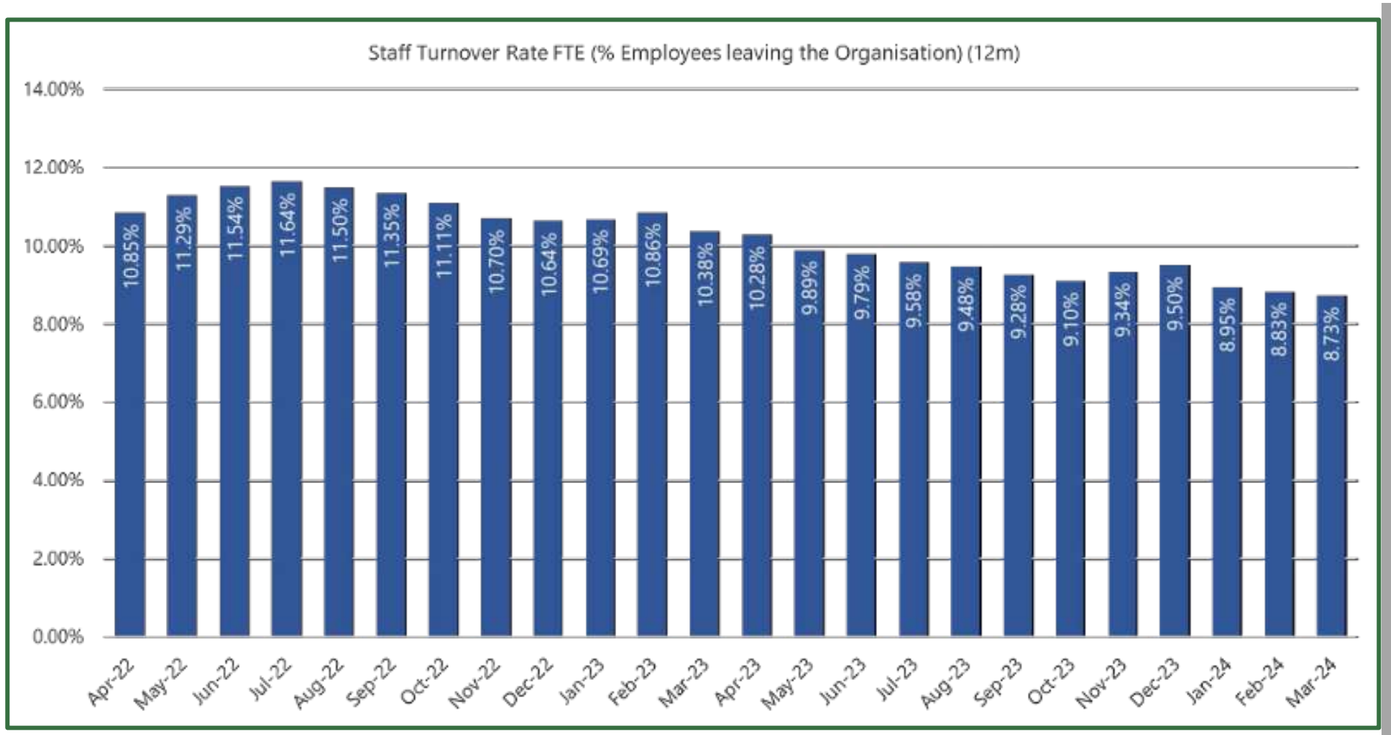
The Trust has indicated through its IMTP that sickness levels will fall in this financial year, but that there remain risks to delivery.

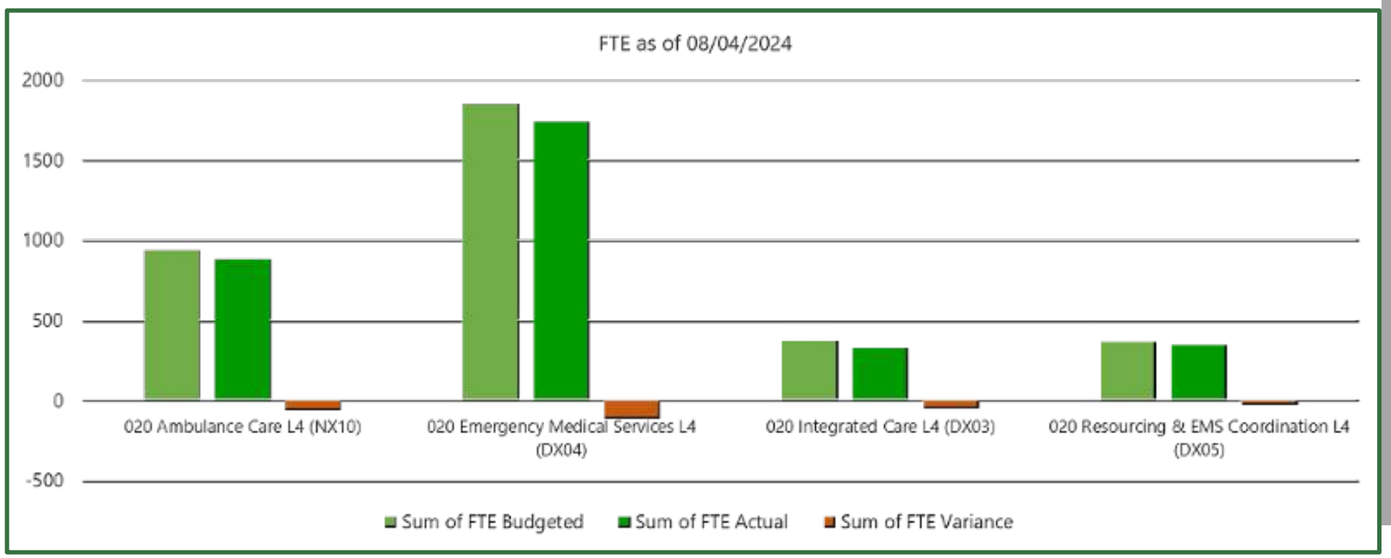
NB: Sickness data will always be reported one month in arrears.

Our People
Capacity - Turnover

(Responsible Officer: Angela Lewis)

Turnover
A





Analysis

Staff turnover rates in March 2024 were 8.73%, which is a slight decrease from the 8.83% recorded in February 2024, and rates have generally been declining since they peaked in July 2022. March saw 35 leavers (29.35 FTE) from WAST compared to 26 in February and 27 in January. (Turnover in months at the end of the quarter are generally higher). This was unbalanced with 16 joiners (14.35 FTE) in March. Of those leaving, the majority were from Ambulance Care (5 people) and Emergency Dispatchers (5 people). 9 leavers were due to retirement, 3 were granted flexible retirement, 5 were dismissals, 1 due to the end of a fixed term contract and 17 were resignations

Shift overrun average times have been steadily increasing again following a two year low recorded in June 2023, however, the average figure for March 2024 was 41 minutes compared to 43 minutes and 13 seconds in February 2024. 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.

Our occupational health waiting times have greatly improved, our KPI of 10 working days from receipt of management referral to first offer of appointment is met and currently colleagues are waiting for approximately 5 working days. From receipt of Wellbeing referrals to first call (from one of our Wellbeing Practitioners), the waiting time is currently 2 days. All referrals and enquiries are triaged to ensure prioritisation of anything that requires urgent attention. We have welcomed 2 new colleagues to the Occupational Health and Wellbeing Team, Janice Shawcross, Office Manager and Amanda Fletcher-Brown, Administrator.

Remedial Plans and Actions

We continue to improve our data collection through Our MI system (Opas G2), so that we can produce accurate and reliable data. We have defined our standard reports, I.e. which reports need to be run regularly, on a daily, weekly or monthly basis, etc. Also, building our own customised reports for which we can report on themes and trends and identify areas that may require additional support. From this information we can complete appropriate analyses and target our Occupational Health and Wellbeing provision (including themes/promotional events) in an appropriate way. Our MI reports can be used to support strategic decision-making regarding the service, also to provide impact analysis and highlight value for money. We are still working closely with the Welsh health boards to standardise our reporting. The Wellbeing team continue to support colleagues and managers who are facing large-scale changes through holding regular meetings and facilitating drop-in sessions for colleagues.
We are currently offering support to managers through scheduled events; Occupational Health - Guidance on Management Referrals. We have facilitated two events already; attendance has been good at both.
Our provider for our Employee Assistance Programme has now been appointed and a launch will be conducted in May/June.
Our self-booking option for Occupational Health referrals has proved extremely popular and has improved the service for everyone whilst streamlining processes for the team, creating capacity to address other projects.
We continue to evaluate the service through gathering feedback from our colleagues, we are improving this process by updating our questionnaire and will be circulating this through Opas G2.
The clinical team continue to support People Services and managers through sickness absence meetings. Team members from OH/Wellbeing/TRiM continue to promote the service using our Occupational Health & Wellbeing vehicles, also through presenting to new starters within WAST and through attendance at managers' meetings. The team continue to deliver Drop-in sessions across all our Clinical Contact Centres, (CCCs) dates for 2024 have been advertised. These are delivered in person at the CCCs and online via Teams.
The REACT (Recognise, Engage, Actively Listen, Check Risk, Talk) training is still proving popular, new dates have been advertised on Siren.
The Wellbeing team will be present at each of the CEO roadshows in April, promoting the service and providing advice and guidance to colleagues.
We are still in the process of writing the Health and Wellbeing strategy for 2025/29. The team has implemented outcome measures and integrated them into OPAS G2, our MI system, this means that we will be sending questionnaires to colleagues around mental health assessment measures. The Health Surveillance programme is starting with HAVS at the fleet workshops – H&S are beginning a scoping exercise on the equipment used.
We continue to plan for the pilot Health Check Programme Health Diagnostics, which is still in process to look at reducing risk of cardiac ill health in our older workforce, by implementing a screening programme. We are continuing MMR audits for frontline staff.

Expected Performance Trajectory

The People and Culture Strategy will continue with its wellbeing focus. We are currently in the process of writing the WAST Health and Wellbeing strategy for 2025/29.
The wellbeing provision is regularly reviewed to ensure that services/interventions offered are relevant, appropriate, and up to date, our focus is on continuous improvement.
Our tender process for an EAP has been successful and a provider will be appointed. The contract will be in place for 2 years.
The team are currently evaluating the In Work Support programme, (currently funded by Welsh Government), to which the team have been referring colleagues for physiotherapy. We are monitoring turnaround times/general quality of service for our colleagues.
The team will be promoting the service and raising awareness of the OH and Wellbeing offer at each of the CEO roadshows in April.

Our People
Culture - Staff Vaccination Indicators

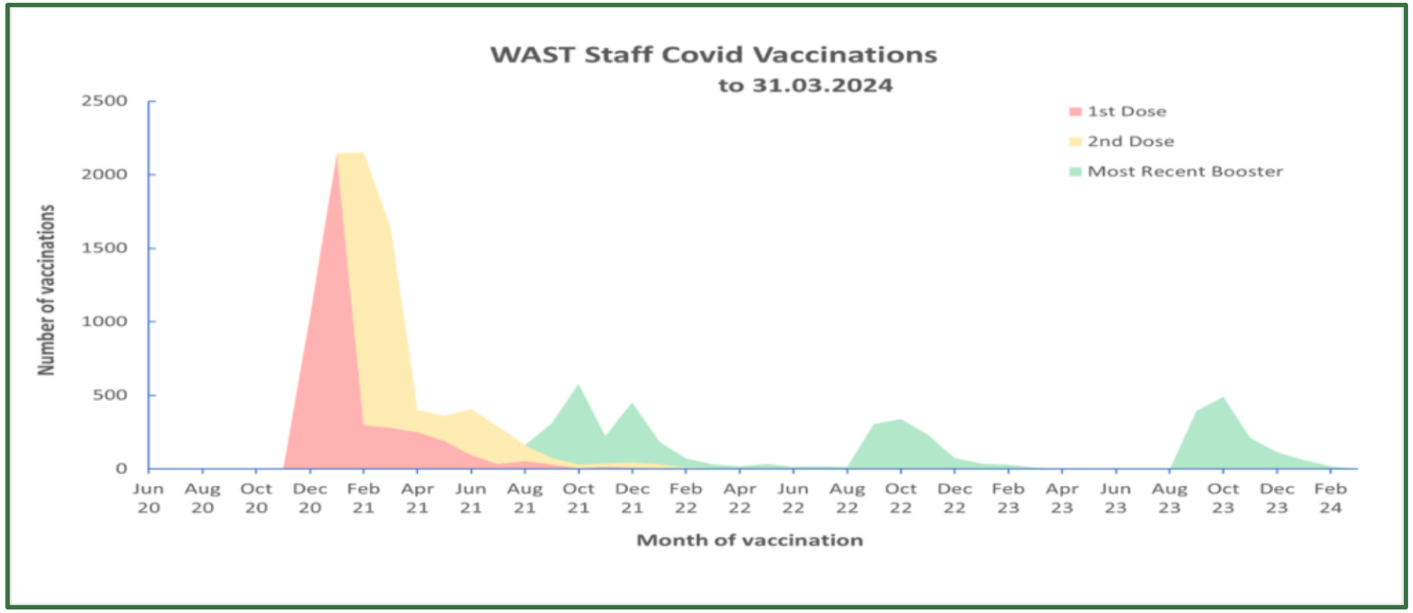
(Responsible Officer: Angela Lewis)

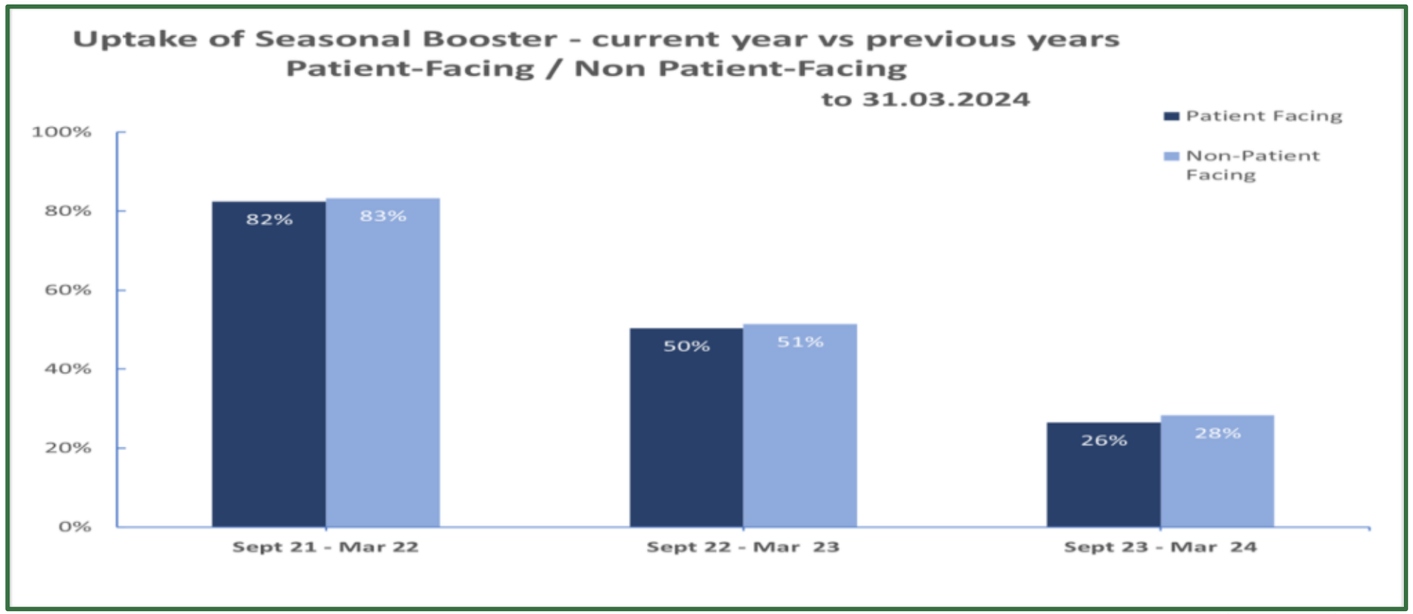
Self-Assessment: Strength of Internal Control: Moderate

PCC

CI

Health & Care Standard - Health (PPI)





Analysis

Flu: The target set out by Welsh Government is to improve on last year's flu vaccination uptake. However, this was unfortunately not met during this year's campaign.

The Trust's final uptake of staff vaccinated was 36.5% of WAST staff, which is a decrease of 8% from last year's campaign. The number of patient facing staff that are recorded as receiving the vaccine for the 2023-24 campaign has also noticeably decreased by 15.2%, reporting 31.1% at the end of the campaign. This equates to 820 out of 2639 being recorded as having the flu vaccine during this campaign, in comparison to 1171 out of 2527 during the previous campaign.

This is reported alongside a 44.2% engagement rate for the organisation and for those that engaged via Microsoft Form, 36.5% decided to receive the vaccination this year. The remaining 7.7% decided to decline the flu vaccine and opt-out

The Charitable bid for an incentive of vouchers has had a positive effect on the engagement rate of staff completing the form. 11.3% (491 WAST staff) completed the form to state they have had the vaccine elsewhere during this campaign, in comparison to 6.8% (289 WAST staff) in the previous campaign, therefore, a 4.5% increase.

COVID-19: As of the end of March 2024, 93% of Patient-Facing staff have received both the first and second COVID-19 vaccination dose.

As of the end of March 2024, 93% of Patient-Facing, and 92% of Non-Patient-Facing, staff have received the second COVID-19 vaccination dose.

85% of Patient-Facing, and 84% of Non-Patient-Facing, staff have received at least one of the Covid-19 boosters offered in the last 3 years

As of the end of March 2024, 26% of Patient-Facing, and 28% of Non-Patient-Facing, staff have received this season's Covid-19 Booster. The season started in September 2023

This is compared to 50%/51%, respectively, for the equivalent time period in 22/23 and 82%/83%, respectively, for the equivalent time period in 21/22.

Remedial Plans and Actions

Flu: The 202/24 WAST Flu campaign ended at the end of February 2024. The end of season report has been shared and discussed at the Clinical Directorate Business meeting and ELT.

COVID-19: The four UK CMOs agreed it was appropriate to pause the alert level system, which was suspended on 30th March 2023.

Routine testing was also paused for all symptomatic health and social care workers, care home residents, prisoners and staff and residents in special schools during the spring of 2023.

Expected Performance Trajectory

It is evident via the report that lessons have been learnt from this campaign and consequently, there is an extensive list of areas that require continued development for future flu campaigns.

***NB: COVID Vaccinations for the past 2 years have only reported using the WAST definition of Frontline Patient Facing employees and therefore only includes those employed within Emergency Services, and Patient Transport Services..*

****NB: Flu data accurate at time of publication and subject to change / COVID-19 vaccination data correct at time of publication and subject to change.*

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

Our People
Capability - PADR and Training Rates Indicators

(Responsible Officer: Angela Lewis)

PADR: A

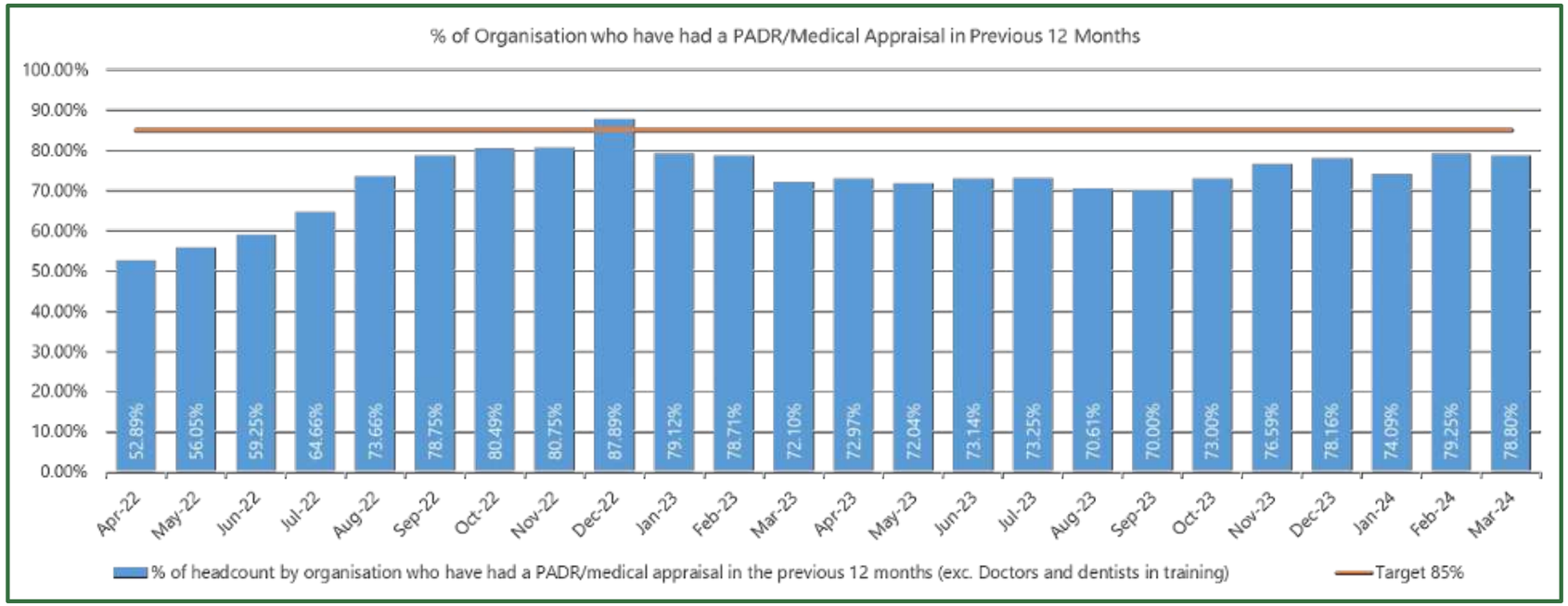
Stat & Mand: A

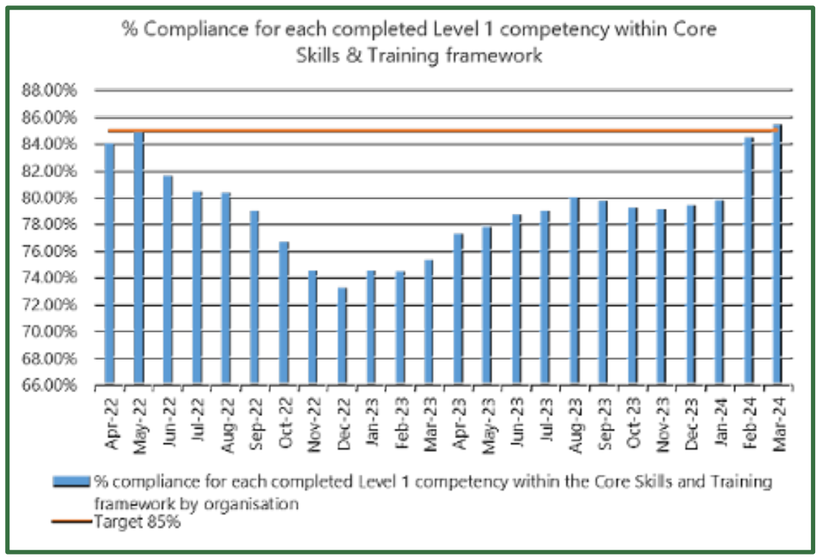
CI

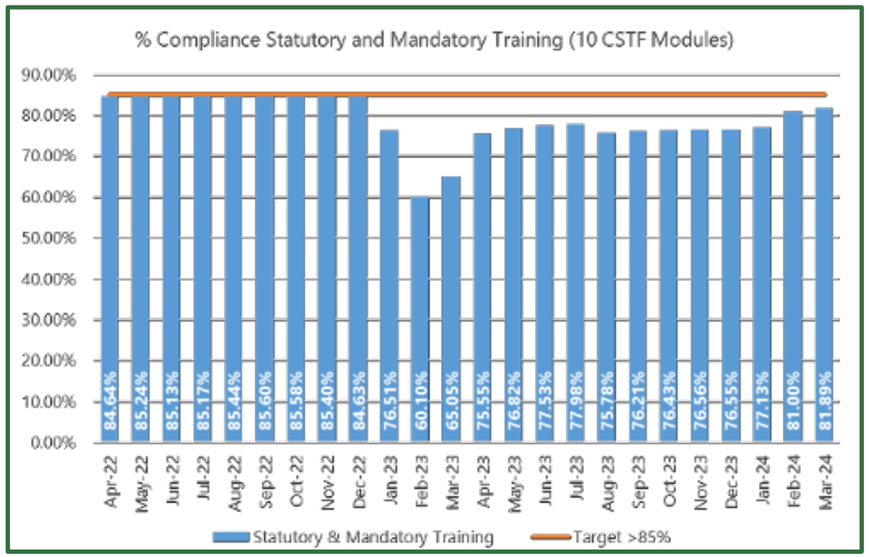
PCC

Health & Care Standard Health – Staff & Resources

Self-Assessment: Strength of Internal Control: Strong







Analysis

PADR rates for March 2024 78.80% decreased slightly when compared to the previous month to 79.25% and remains below the 85% target. Over the reporting period this target has only been achieved once, in December 2022, but the current rates are 9.2% higher than the same month last year.

In March 2024 Statutory & Mandatory Training rates reported a combined compliance of 81.89%; with only Dementia Awareness (93.34%) and Moving & Handling (92.25%), achieving the 85% target. Equality & Diversity (82.69%), Fire Safety (77.26%), Safeguarding Adults (76.96%). Violence Against Women, Domestic Abuse & Sexual Violence (74.99%), Information Governance (73.46%), Paul Ridd (68.58%), Welsh Language Awareness (61.01%) and Fraud Awareness (58.86%), all remain below this target.

There are currently 15 Statutory and Mandatory courses that NHS employees must complete in their employment. These are listed in the table below:

Remedial Plans and Actions

At time of reporting, annual Mandatory In-Service update programmes have been accessed by 88% of colleagues across ACA, EMT and Paramedic roles. Those absent from work access this programme on their return to practice providing assurance of their up-to-date knowledge and skills.

Progress toward 85% target for mandatory competencies introduced in 2023/24, namely Welsh Language Awareness, Fraud Awareness and the Paul Ridd Learning Disability awareness is falling short on the first anniversary of their reporting; this is a disappointing position and targeted focus will be applied to these 3 competencies in the early part of 2024/25.

There has been a continuation of the climb toward achievement of the 85% target across the remainder of the Core Skills Training Framework competencies which is projected to continue to increase as more learning content is moved to the user friendly LMS365 environment enabling easier access to these reportable competencies and the wider suite of Ambulance Service specific learning hosted outside ESR.

Expected Performance Trajectory

Performance is improving as compliance has risen.

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

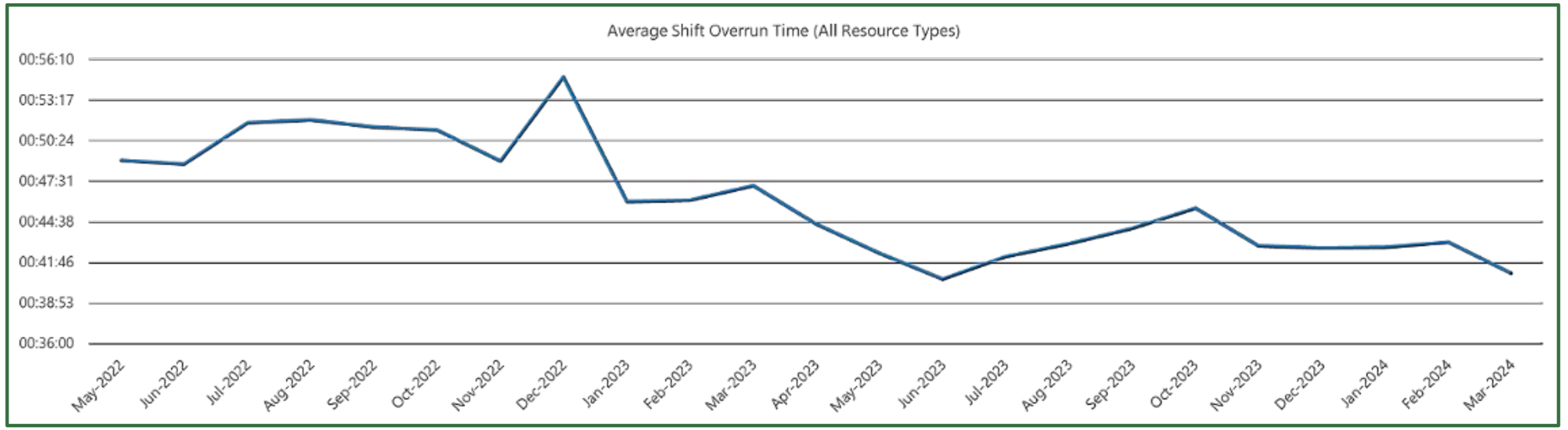
Data source: ESR

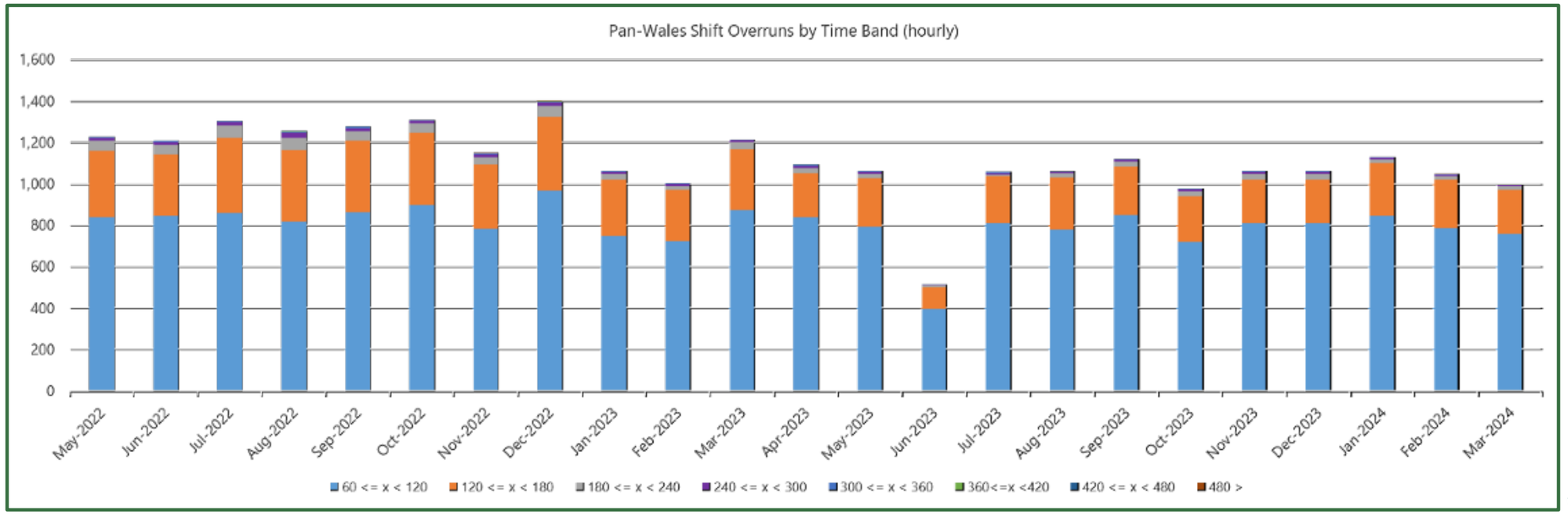
Our People
Health and Well-being – Shift Overruns

(Responsible Officer: Angela Lewis)

Overruns
R

CI





Analysis

Shift overrun average times have been steadily increased between June and October 2023, but have since varied. The average figure for March 2024 was 41 minutes compared to 43 minutes and 13 seconds in February 2024.

The highest volume of shift overruns occur within the 0 to 60-minute category, accounting for 73.2% of the total. 20.2% fall within the 61 to 120-minute category, 5.7% in the 121 to 180-minute category, 0.5% in the 181 to 240-minute category and 0.3% in the 241 minutes and over category.

Remedial Plans and Actions

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

As part of the Trust's winter resilience planning, it is introducing "pods" at some hospital locations to aid staff finishing on time. These are continuing, at this time, into 2024/25.

Expected Performance Trajectory

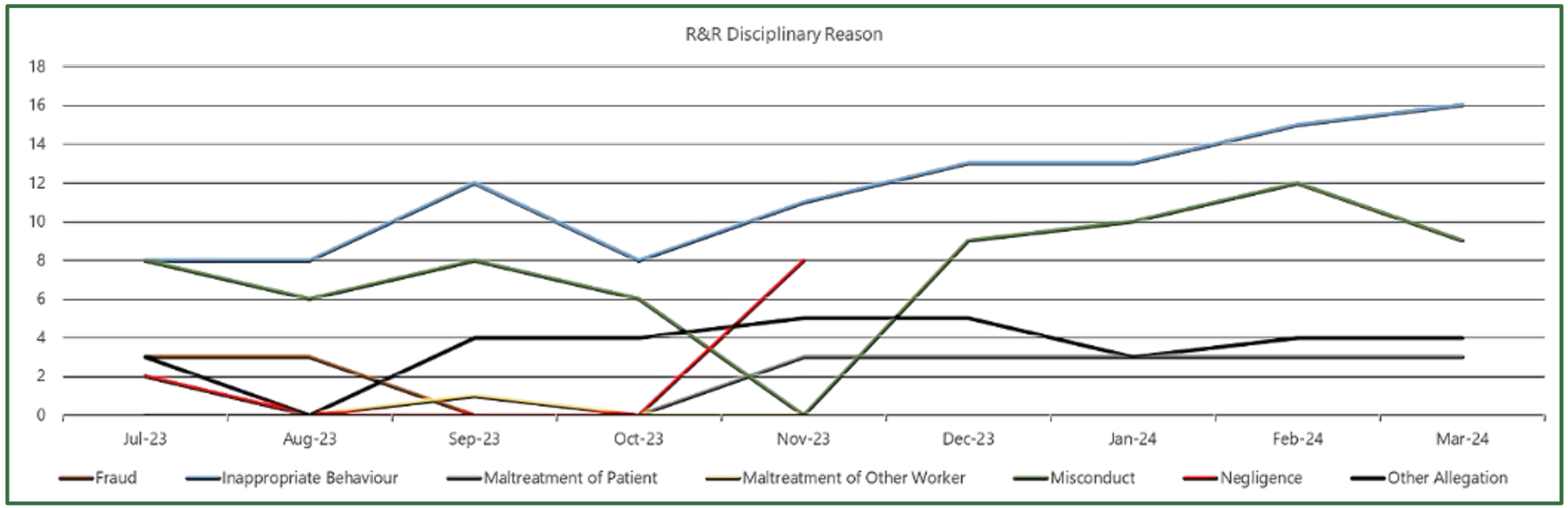
Overruns correlate with handover lost hours. As we have moved out of winter both levels had started to drop. We may expect this to stabilise before moving into higher levels again next winter.

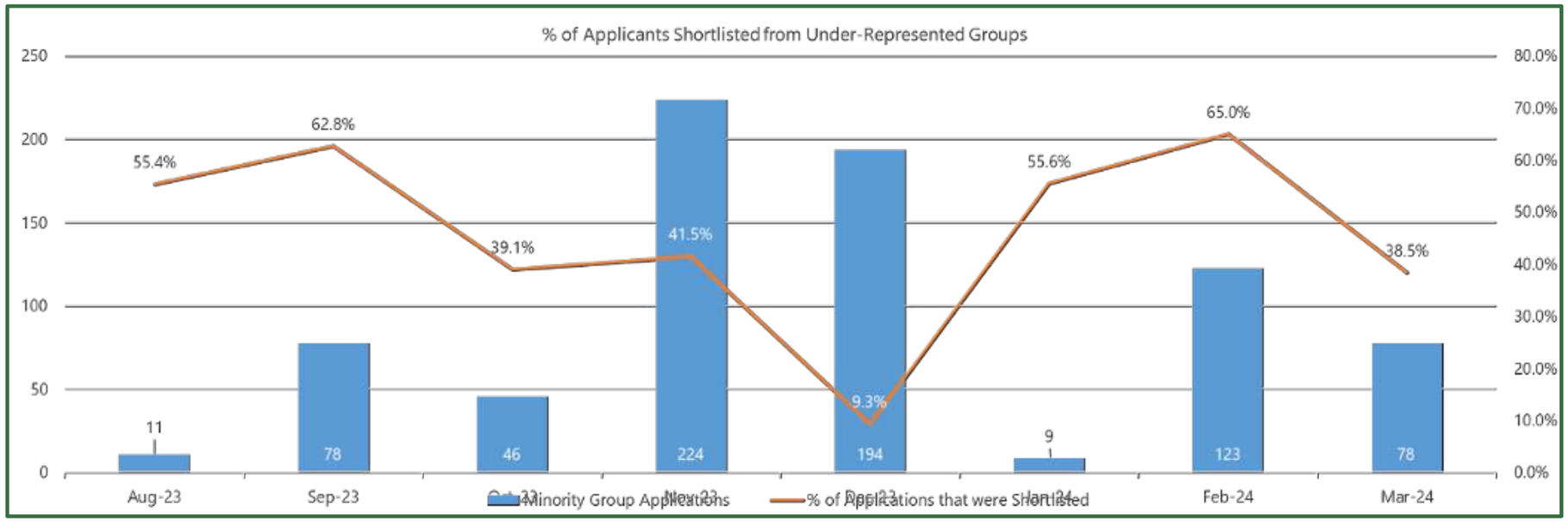
Our People
Culture – Number of R&R Disciplinary Hearings and Number of Applicants Shortlisted from Under-Represented Groups

(Responsible Officer: Angela Lewis)

Self-Assessment: Strength of Internal Control: Moderate

PCC





Analysis

There were 32 open formal disciplinary cases recorded at the end of March 2024, a slight decrease compared to the month of February 2024 where 34 open cases were recorded. Of these Disciplinary cases, the majority are again due to allegations of inappropriate behaviour, followed by misconduct.

There were 13 open formal Respect and Resolution cases submitted by employees, an increase from the number recorded in February. These are a mixture of both Respect and Resolution Grievances and Dignity at work.

In February, 38.5% of all applications from under-represented groups made it through shortlisting and were invited for interview. This was a decrease from the 65% in February 2024, while the volume of applications also decreased, from 123 to 78.

Of the 78 total applications from under-represented groups in March 2024, 43 were in the category of Ethnicity, 22 within Disability and 13 within Sexual Orientation.

Remedial Plans and Actions

R&R Formal Disciplinary Cases: Continue to monitor. The Trust has a substantial programme of work in place, connected to behaviours.

Applications: The inclusive recruitment work is ongoing to develop targeted recruitment campaigns and events.

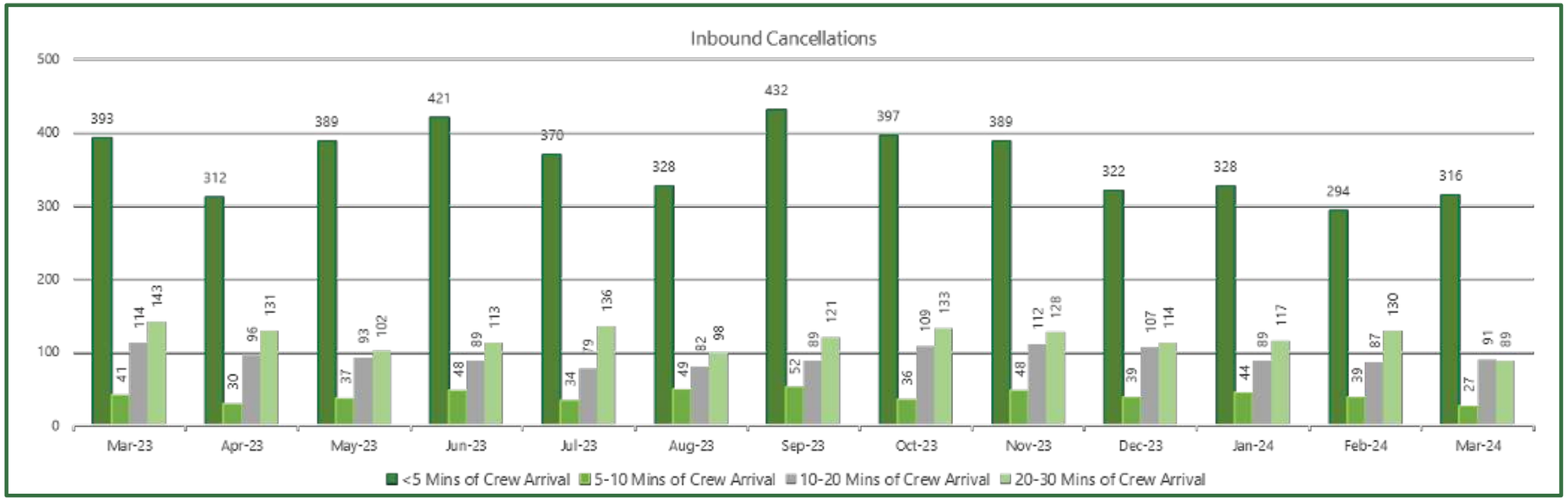
Expected Performance Trajectory

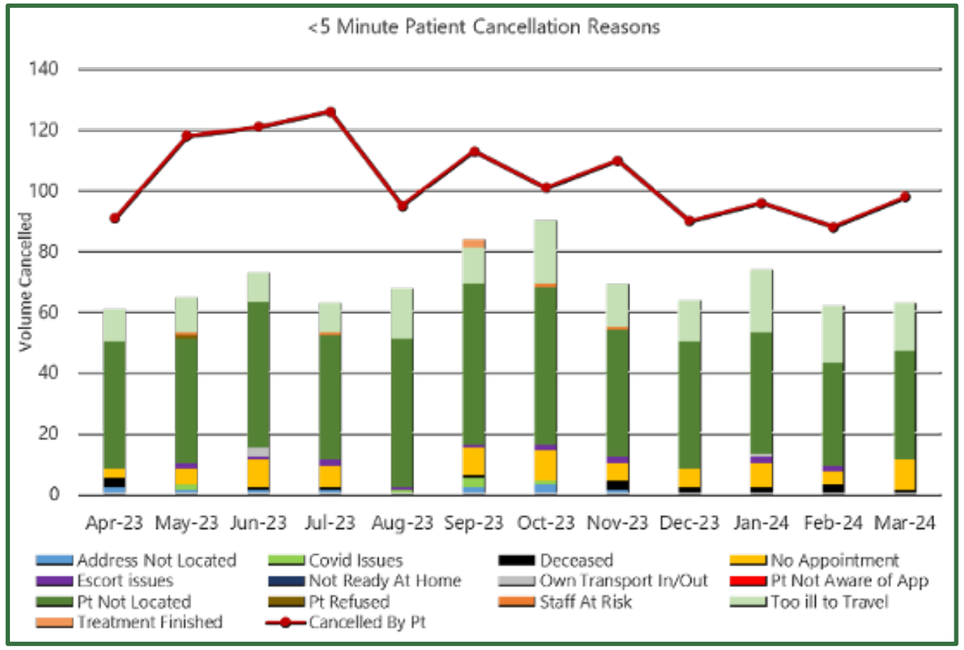
Continue to monitor levels, no trajectory for this measure.

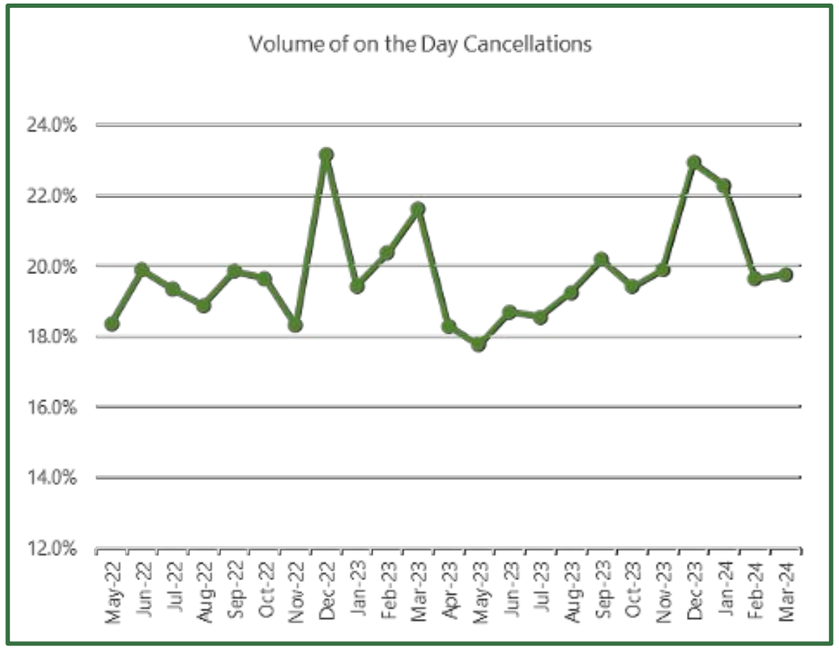
Finance, Resources and Value
Value: Ambulance Care Indicators

(Responsible Officer: Lee Brooks)

Cancellations
A







Analysis

Inbound cancellations of 5 minutes or less of the crew arrival time saw an increase in March 2024 to 316, compared to 294 in February 2024. The total number of cancellations within 30 minutes decreased from 550 in February 2024 to 523 in March 2024.

Cancellations within 5-minutes of arrival appears to have seen an overall increase during the past 12 months. In February 2024 there were 98 cancelled by patient* entries made within 5-minutes of crew arrival an increase compared to the previous month (88). The top reasons for less than 5-minute cancellations included: 36 patient not located, 16 too ill to travel and 10 no appointment.
During the past 15 months there has been a minimum of 30 patients not located in the 5-minutes or less each month.

Same day cancellations increased slightly from 19.6% in February 2024 to 19.8% in March 2024.

Remedial Plans and Actions

As described last month, work is well advanced with Hywel Dda to develop a direct link between their PAS system and our CAD but has been delayed by an extended focus on the MDCS system from the system team. Once in place this will allow for WAST to be notified once the health board cancels or alters an appointment.

This work is at an advances stage and should go live in Q1, once evaluated and, if successful we will explore a wider geographical rollout.

Expected Performance Trajectory

Until this work is completed, we do not anticipate a significant shift in the trajectory as many of the factors affecting this are outside of our direct control .

Please note that that figures may be lower than overall totals due to some records having no cancellation date.

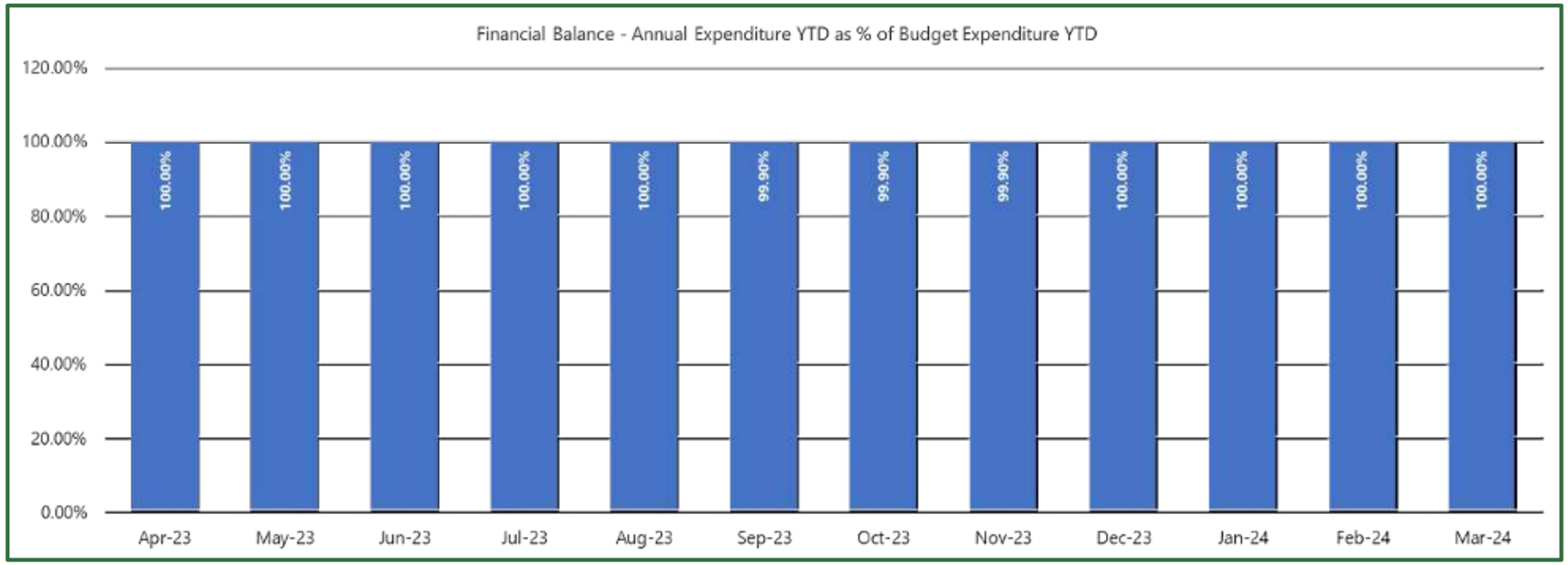
**Please note that MDTs do not appear to provide specific cancellation reasons for either inbound or outbound journeys. There are at present multiple and duplicated reasons both crews, control and the liaison desk can select.*

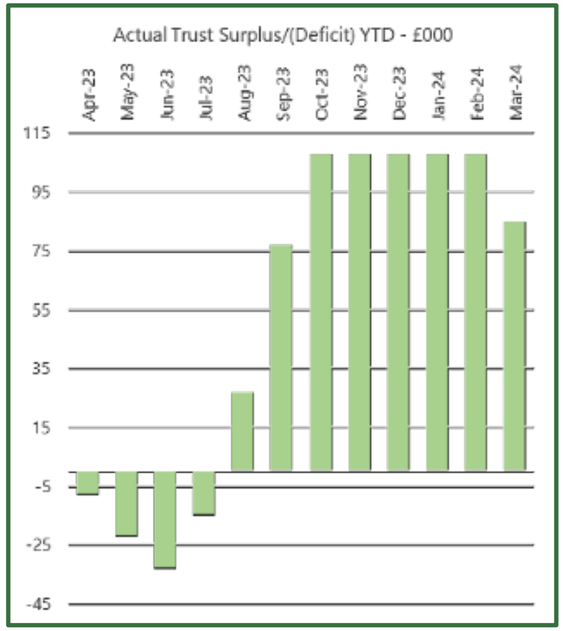
Finance, Resources and Value
Value - Finance Indicators

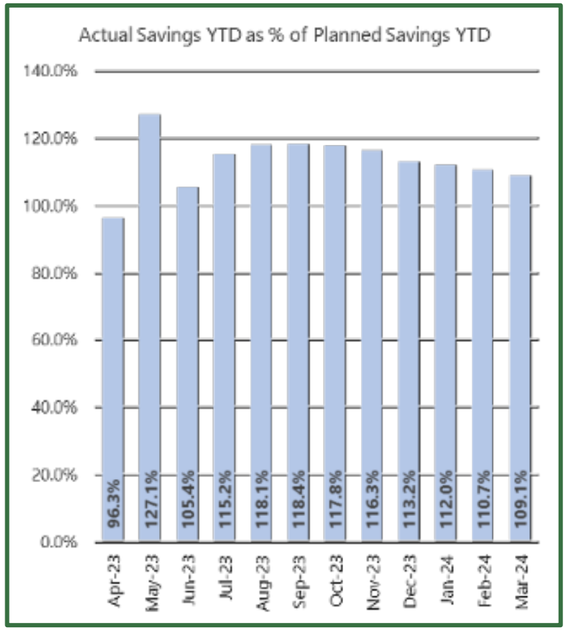
(Responsible Officer: Chris Turley)

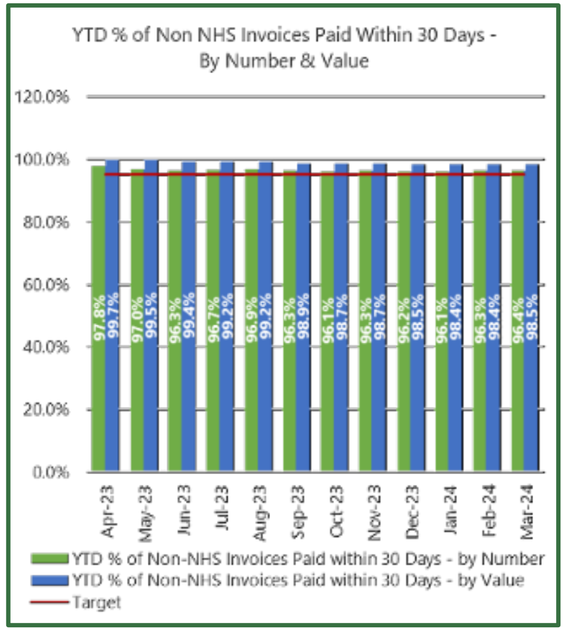
G

FPC









Analysis
The reported outturn performance at Month 12 is a surplus of £85k.

For Month 12 the Trust is reporting planned savings of £6.000m and actual savings of £6.547m (an achievement rate of 119.1%).

The Trust's cumulative performance against PSPP as at Month 12 is 96.4% against a target of 95%.

At Month 12 the Trust achieved both its External Financing Limit and its Capital Resource Limit.

Remedial Plans and Actions
There is no remedial plan required given the Trust has reported a breakeven position (subject to audit); however, as the Trust moves into 2024/25 key areas of focus include:-

•Undertaking a review of commercial opportunities for income generation (Report being considered by FSP group).

•A continued focus on the Trust's financial sustainability programme.

•Improved governance for Value Based Health Care, with a particular focus on benchmarking; and

•An improved approach to benefits realisation

Expected Performance Trajectory
The expectation is that the Trust will continue to meet its statutory financial duties, as outlined in its IMTP for the 2024/25 financial year; however, it is expected that the Trust will continue to operate in a challenging financial environment and will need to deliver a planned level of savings in the 2024/25 financial year of c£6.4m.

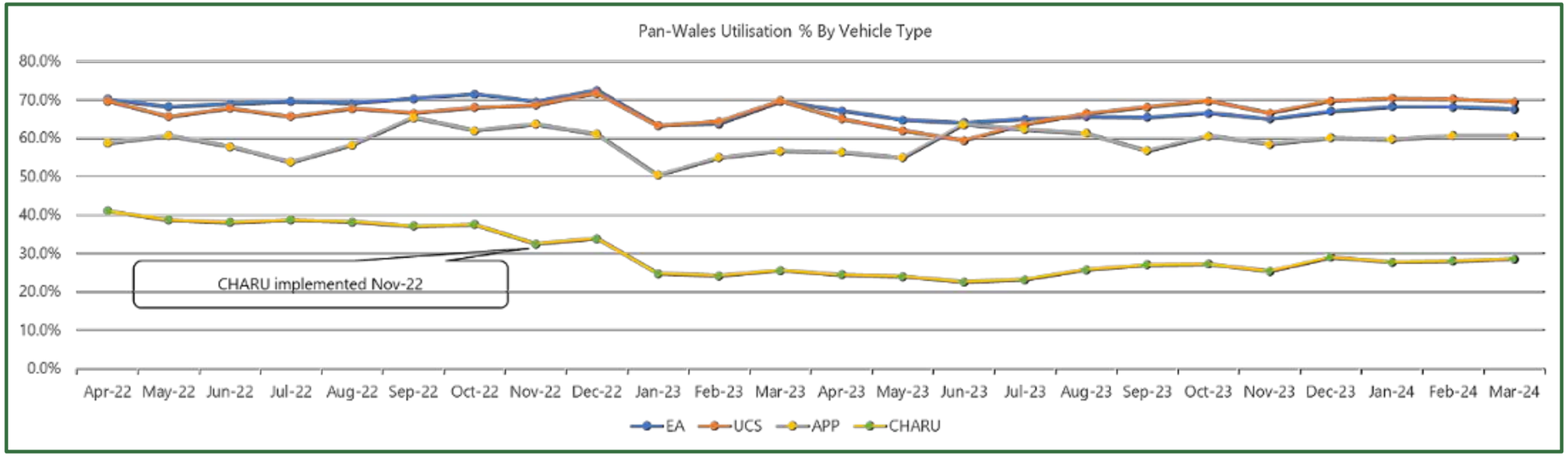
Finance, Resources and Value
EMS Utisation & Average Job/Shift Times

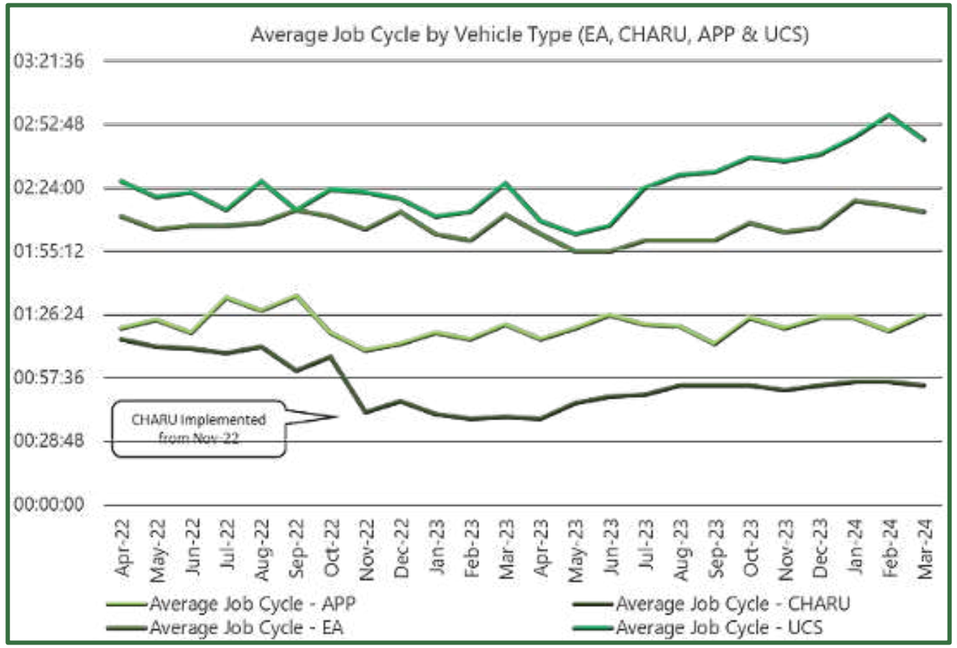
(Responsible Officer: Lee Brooks)

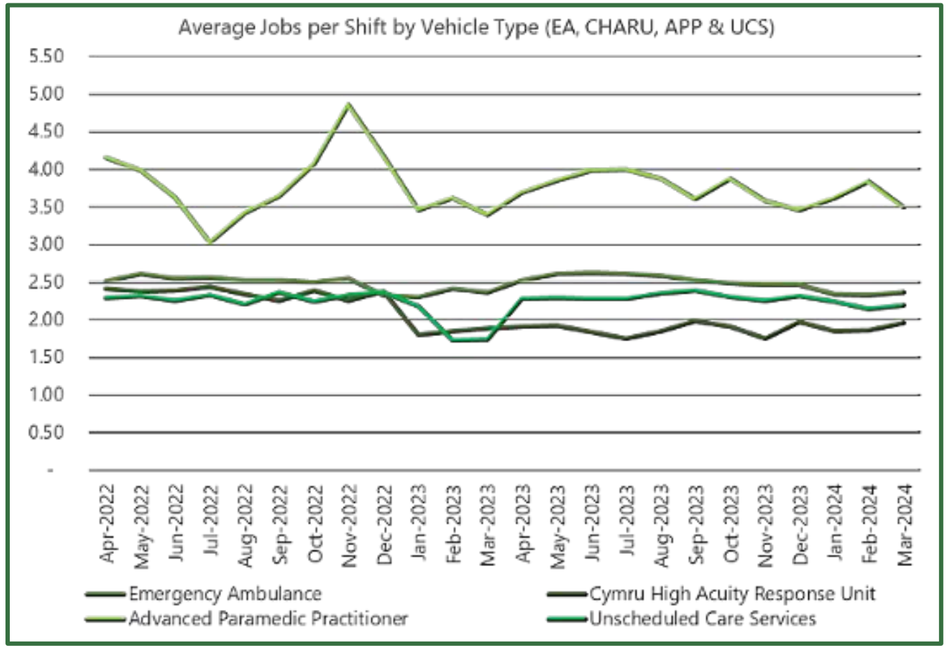
Job Cycle: A

CHARU Utilisation: R

FPC







Analysis

Pan Wales Utilisation metrics in March 2024 were 58.8% for all vehicles types, increasing from January 2024 (58.6%). UCS achieved the highest rate during the month at 70.2% while EA was at 68.1%. Both have seen a generally stable trend over the past two years. The optimal utilisation rate for EAs needs to lower so that they are free to respond to incoming calls.

As demonstrated in the bottom left graph, the average job cycle in March 2024 decreased to 2 hours 13 minutes for EAs, to 2 hours and 46 minutes for UCS and CHARU decreased to 54 minutes. The average for APPs increased to 1 hour and 26 minutes.

Overall average jobs per shift was 2.27 in March 2024, indicating a slight increase from February 2024 (2.22). EAs 2.37 jobs per shift, UCS crews 2.20 jobs per shift This is less than half of what would be ideal and a product of handover delays.

APPs attended on average 3.50 jobs per shift,. and CHARU's 1.96 jobs per shift. This CHARU utilisation rate and shifts per job is a particular area of concern.

Remedial Plans and Actions

EA and UCS jobs per shift is fundamentally a product of handover delays.

For APPs, the newly created APP Recruitment Task & Finish Group will give a focus on further improvement, in particular, improved information and a re-roster.

CHARU is a particular area of focus. Initial analysis indicates that CHARU contribution to Red compares favourably with the previous resource: RRVs. Further analytical work being undertaken.

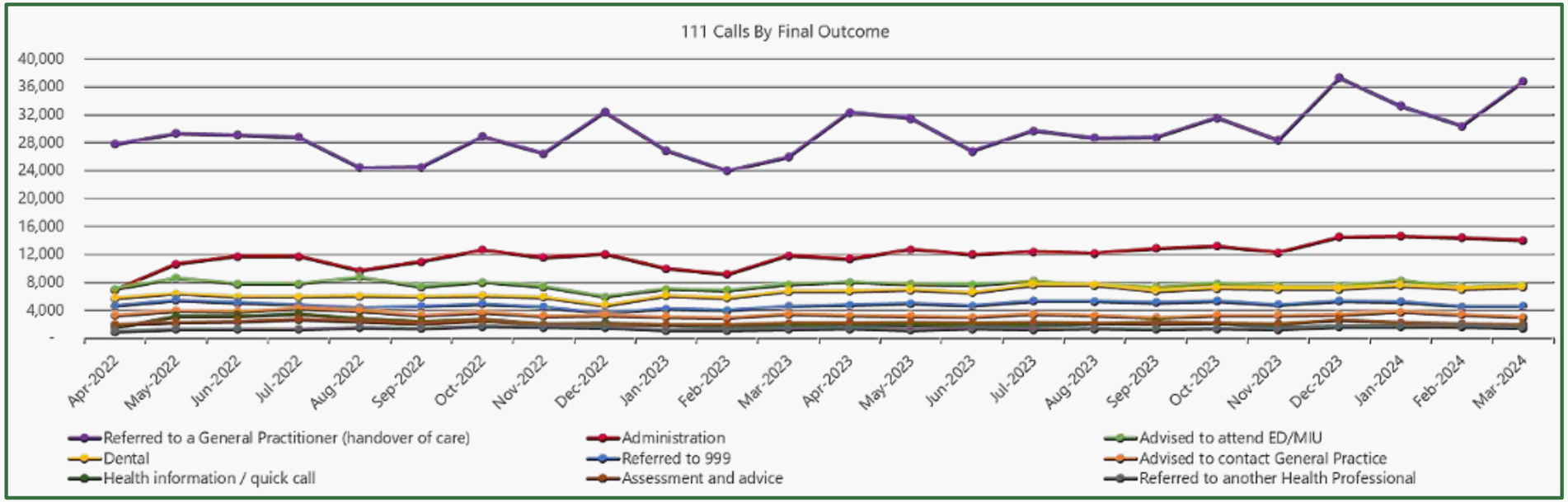
Expected Performance Trajectory

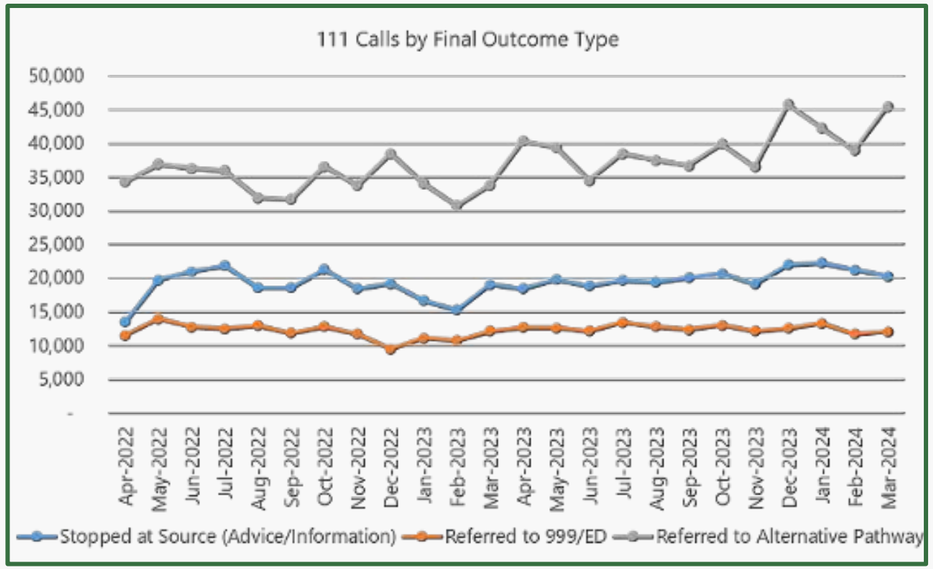
The Trust ability to reduce the high utilisation rates for EA and UCS is a product of handover, which it does not control. The Trust would expect an increase in APP and CHARU utilisation during 2024/25 linked to the remedial actions identified above.

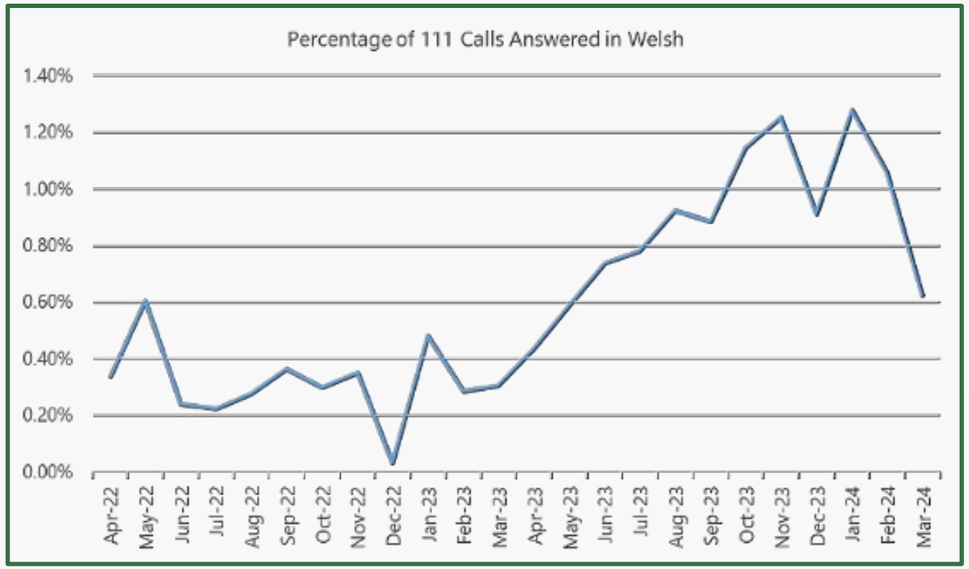
Partnerships / System Contribution
NHS111 Hand Off Metrics and NHS111 Consult & Close Indicators
Influencing Factors – Demand and Clinical Hours Produced

Dental A | C&C Volumes G | FPC

(Responsible Officer: Lee Brooks)







Analysis

During March 2024, 77,865 calls were received into the 9 categories displayed in the graph opposite, an increase compared to the 72,011 received during February 2024.

Calls Referred to a General Practitioner (handover of care) continued to be the top outcome for NHS111 accounting for 47.15% of all calls during March 2024.

As the bottom left graph highlights, in March 2024, 20,294 calls into 111 were provided with information or advice, with no onward referral, an increase from the 21,288 in February 2024, and an increase from the 19,066 during March 2023.

The percentage of 111 calls answered in Welsh decreased from 1.06% in February 2024 to 0.63% in March 2024. This equated to only 27.2% of all 111 calls being offered in Welsh being answered, a decrease from the 52.2% answered in February 2024.

Remedial Plans and Actions

There is currently a 111 Measures Task and Finish Group. This is a collaborative meeting between WAST its commissioners and DCHW. The focus is the development of a nationally reportable 111 data set. Similar to what is currently in place for Ambulance Service Indicators (ASIs). Part of this work involves looking at the reporting of disposition final outcomes.

Expected Performance Trajectory

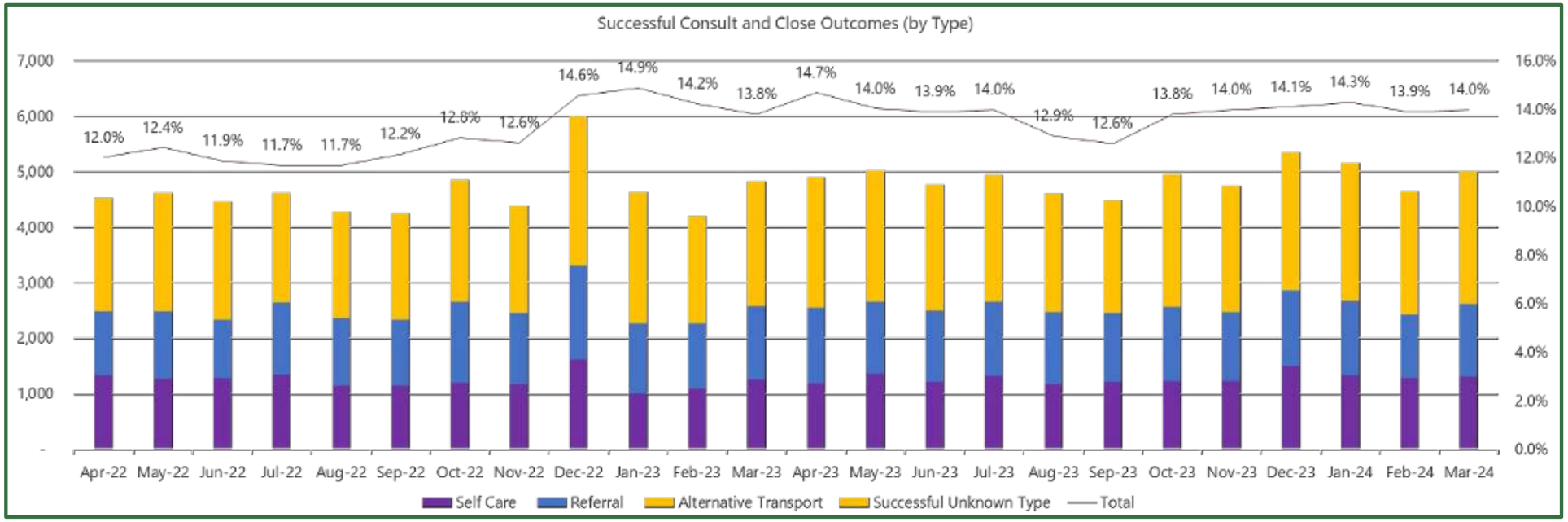
No performance trajectory is set at this time, as the Trust develops is measures and systems around these metrics. Once these have been developed there will be an opportunity to develop benchmarks. The focus remains to shift left, where it is clinically safe and appropriate to do so.

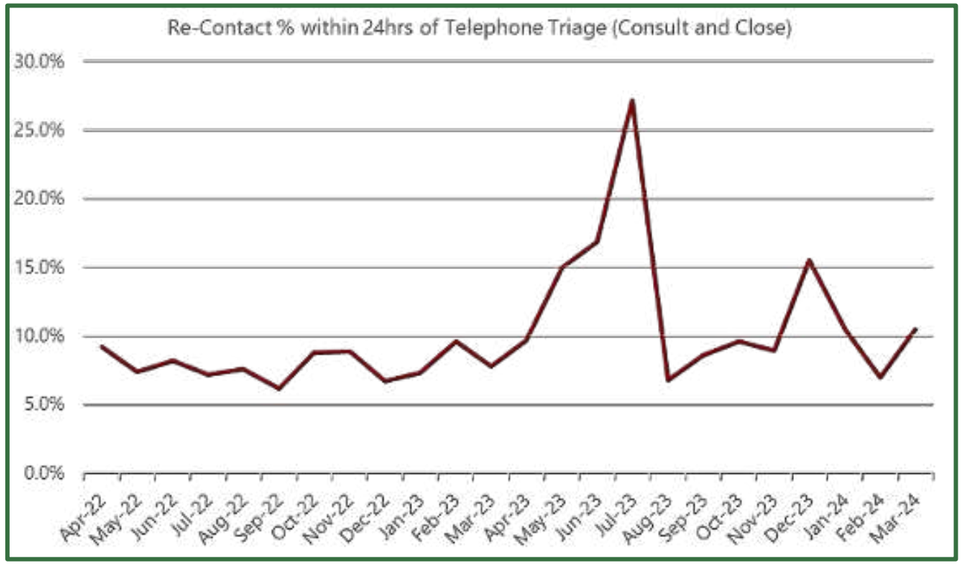
Partnerships / System Contribution
Consult & Close Indicators

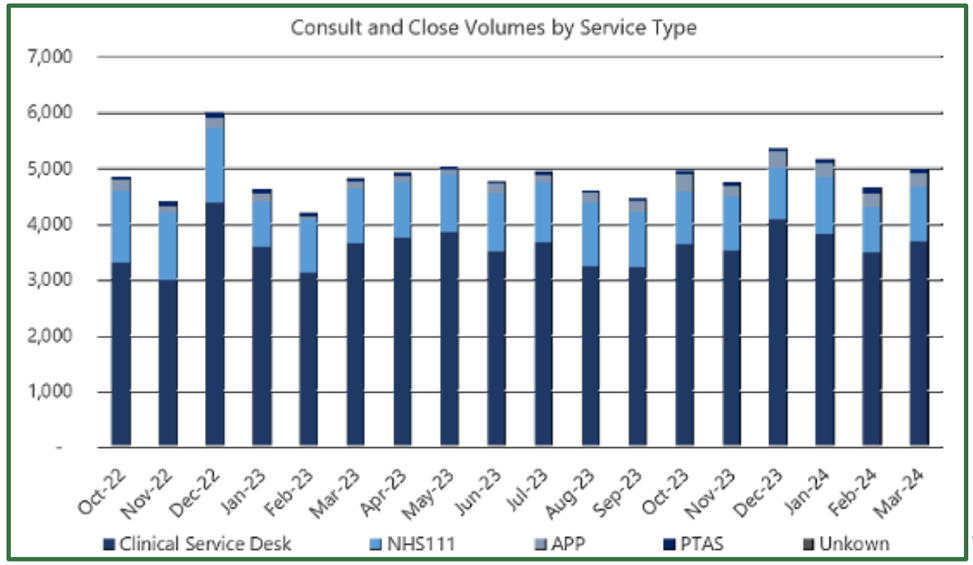
(Responsible Officer: Lee Brooks)

C&C
A

FPC







Analysis

Consult and Close, with contributions from Clinical Service Desk (CSD) (10.3%), NHS111 (2.7%), WAST APP (0.7%) and the Health Boards using Physician Triage and Streaming Service (PTAS) (0.3%) achieved 14% in March 2024, remaining consistent with seen during February 2024, however remaining short of the new 17% IMTP ambition. In March 2024, the number of 999 calls resulting in a Consult and Close outcome was 4,992, up from 4,656 in February 2024.

Of the calls successfully closed in March 2024, 1,294 patients received an outcome of self-care; 1,318 patients were referred to other services (including to Minor Injury Units and SDEC) and 2,385 were advised to seek alternative transport services to acquire treatment.

Re-contact rates in March 2024 were 10.5%, an increase on the 7% seen in February 2024.

Remedial Plans and Actions

- Work underway reviewing processes, has yielded efficiencies in remote clinical support which is recognised by those calling.
- Implementation of 15 recommendations from commissioner review.
- Progressing process with 111 to pass calls electronically from CSD, saving time.
- Recruitment of additional 23 FTEs for 24/25.
- Future Service Model transformation workshops arranged for early May.

Expected Performance Trajectory

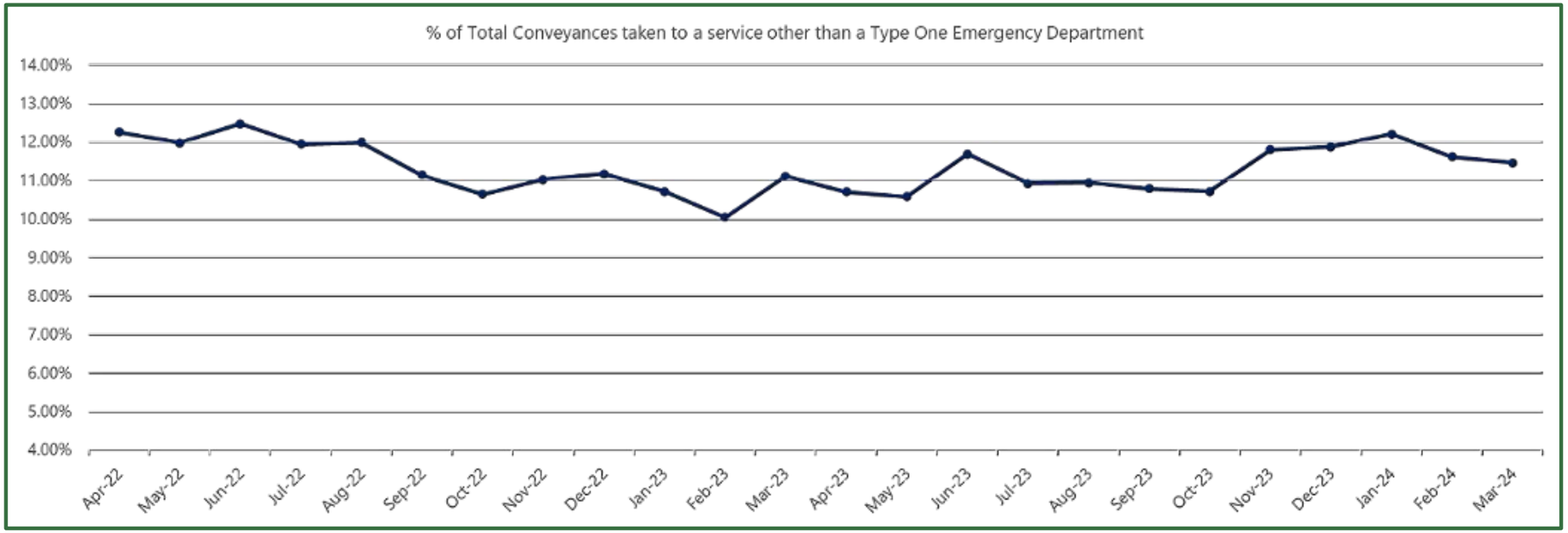
Further improvement is expected linked to CSD staff attendance (reduced abstractions and less vacancies). The ambition remains 17%.

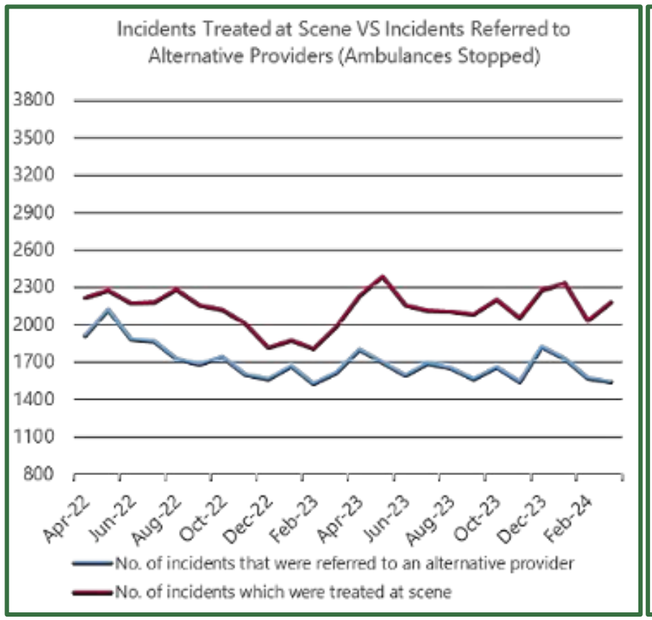
Partnerships / System Contribution
Conveyance to ED Indicators

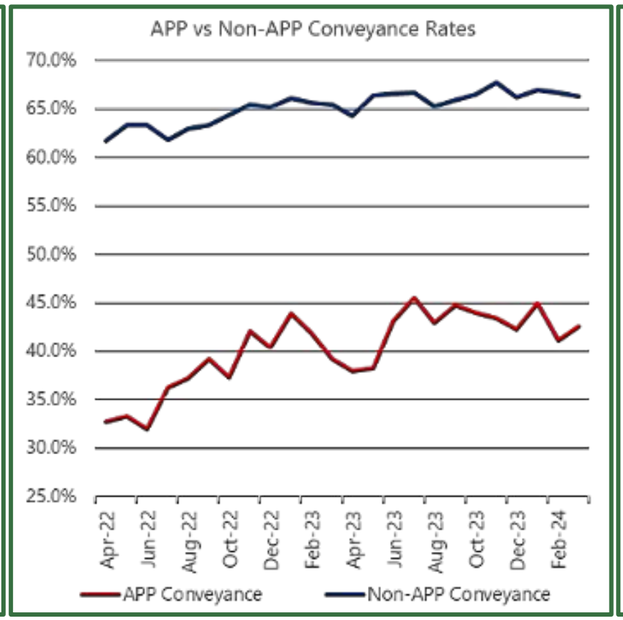
(Responsible Officer: Andy Swinburn)

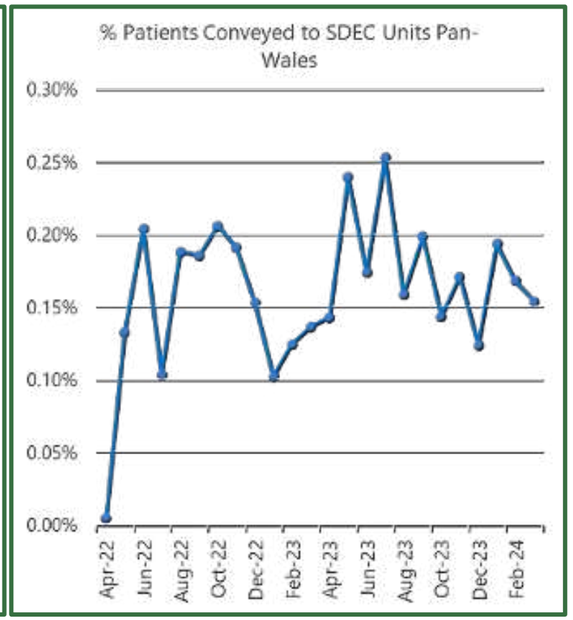
Conveyances
A
FPC

Ministerial Measure









Analysis

In March 2024 11.46% of patients (1,646) were conveyed to a service other than a Type One ED, while 35.65% of patients were conveyed to a major ED, as a percentage of verified incidents.

The combined number of incidents treated at scene or referred to alternate providers increased slightly, from 3,599 in February 2024 to 3,717 in March 2024.

APP conveyance rates increased slightly to 42.6% in March 2024, after experiencing a generally increasing trend since June 23.

Patients conveyed to SDEC's decreased from 0.17% in February 2024 to 0.15% in March 2024.

Remedial Plans and Actions

Continued provision of information to external stakeholder about the effectiveness of SDECs.
Further investment in the APP workforce in 2024/25 (+32 APPs).
Establishment of APP Recruitment Task & Finish Group, with focus on re-rostering to demand keys, improved placement (training) experience, more certainty for TAPPs about where they will be located.
Review of performance systems for APPs to improve data quality.

Expected Performance Trajectory

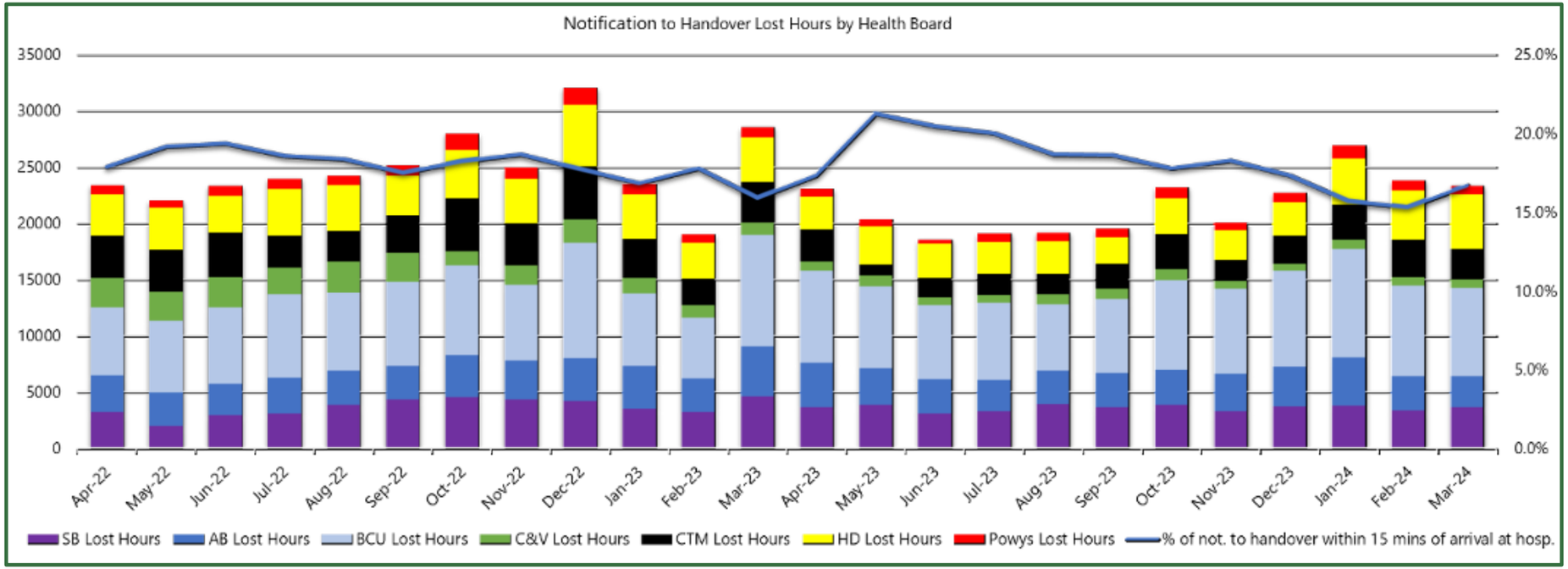
The 2023 EMS Demand & Capacity Review (strategic) models various future states. The modelled scenarios indicate that the Trust will need to fully invert the triangle with health boards significantly reducing handover e.g. 12,000 hours or 7,000 hours, alongside varying levels of investment. Further in year tactical modelling for winter will be required to determine a performance trajectory for 2024/25. This cannot be undertaken at this point in the year.

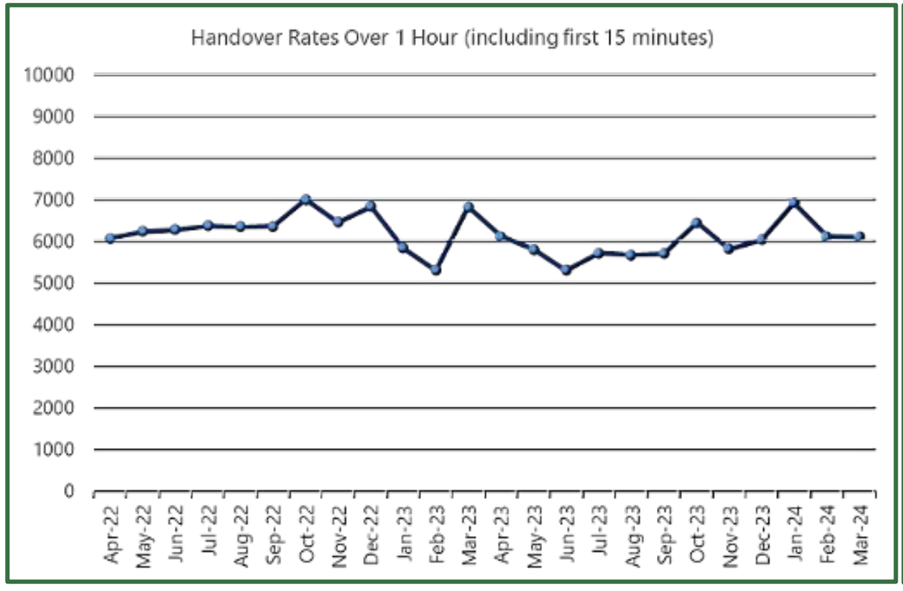
Partnerships / System Contribution Handover Indicators

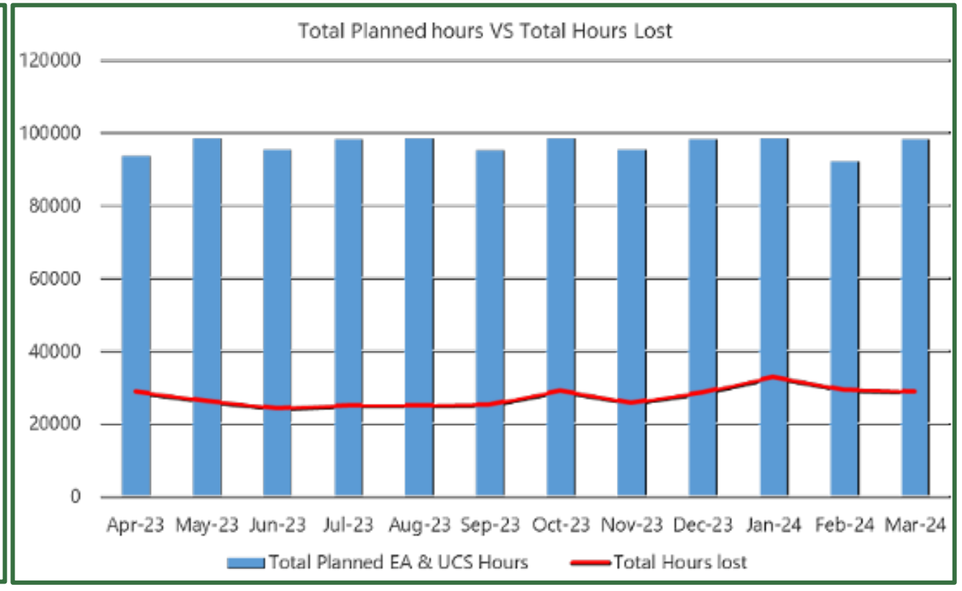
(Responsible Officer: Health Boards)

Lost Hours R

CI QUEST







Analysis

260,398 hours were lost to Notification to Handover, i.e., hospital handover delays, over the last 12 months (Apr-23 to Mar-24), compared to 299,636 over the same timeframe the previous year. There were 23,403 hours lost in March 2024, a slight decrease from the 23,896 lost in February 2024 (although over 2 more days). March 2024 levels were 5,217 hours below where they were during February 2023 (28,620).

The hospitals with the highest levels of handover delays during March 2024 were:

- Morriston Hospital (SBUHB) at 3,449 lost hours
- Wrexham Maelor Hospital (BCUHB) at 3,302 lost hours
- The Grange University Hospital (ABUHB) at 2,598 lost hours
- Glan Clwyd Hospital (BCUHB) at 2,564 lost hours
- Glangwilli Hospital (HDUHB) at 2,329 lost hours

Notification to handover lost hours averaged 755 hours per day during March 2024 compared to 823 hours a day in February 2024.

In March 2024, the Trust could have responded to approximately 7,383 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 Welsh Government handover target for 2024/25 is no waits over one hour; this equates to 7,000 hours lost to handover delay. There would need to be a 70% reduction in handover levels in 2024/25 for this to be achieved.

We may expect to see some further handover reduction in 2024/25, but achieving the one-hour Welsh Government target would require a massive improvement.

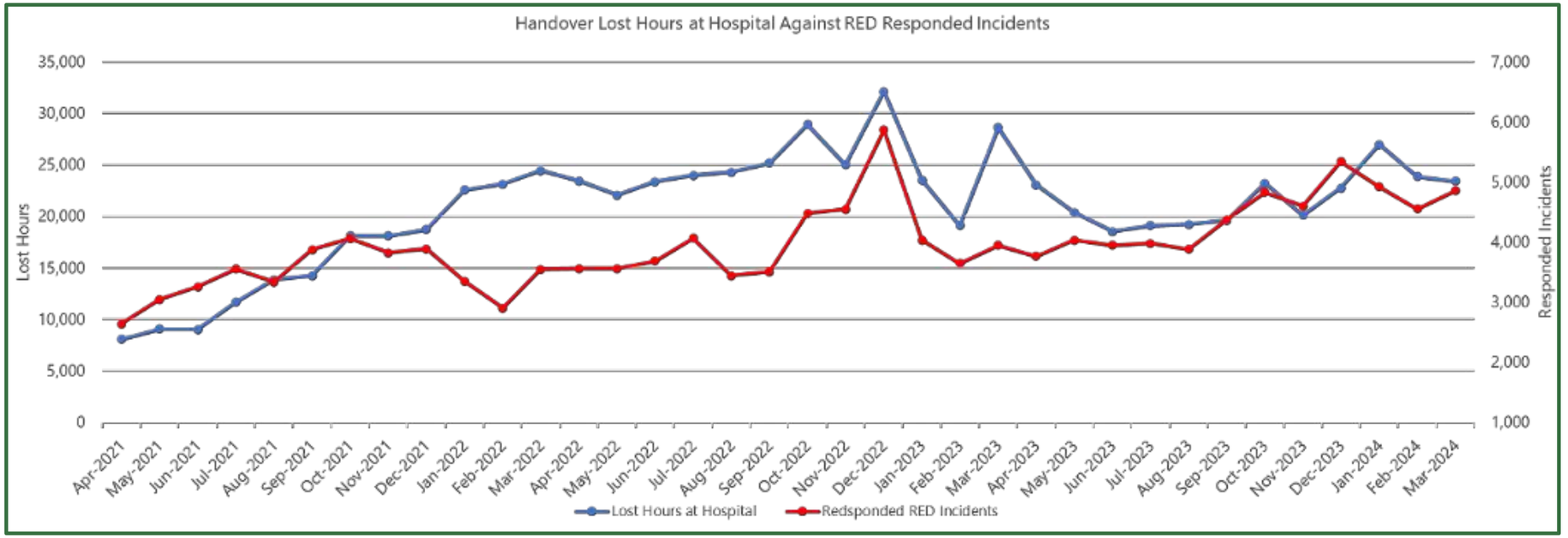
**NB: Data correct at time of abstraction.*

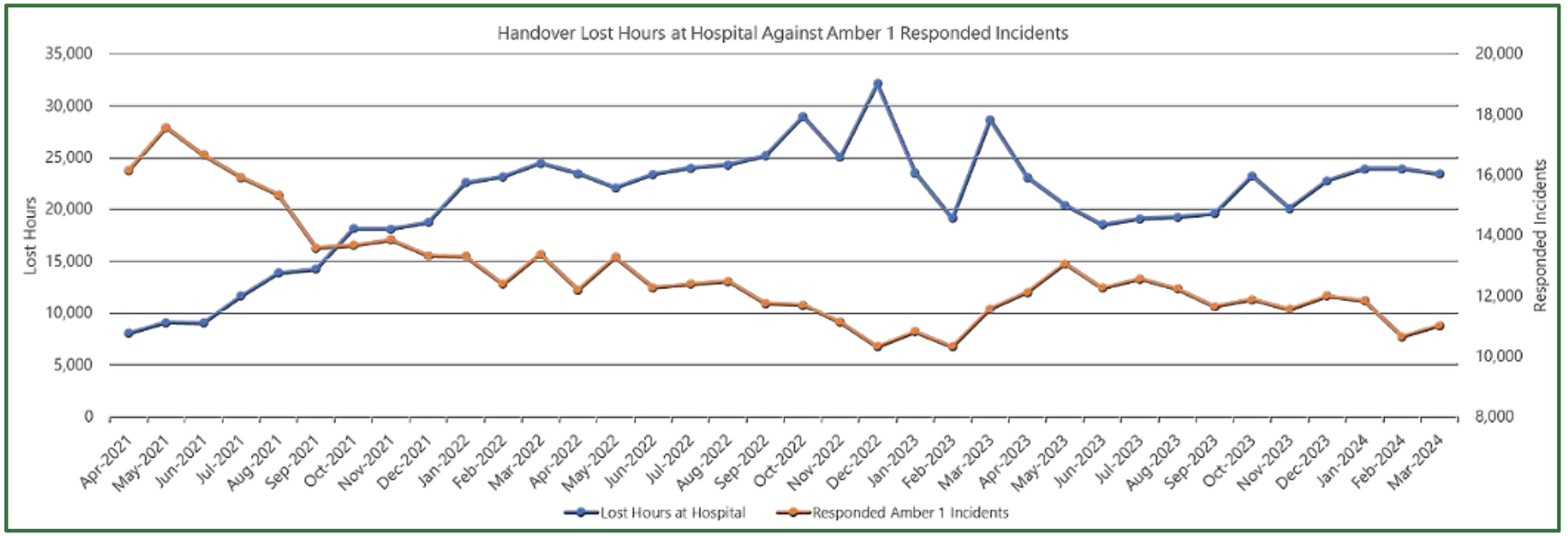
Partnerships / System Contribution

Handover Lost Hours Against Red & Amber 1 Responded Incidents

(Responsible Officer: Health Boards)

CI QUEST





Analysis

The top graph highlights that as handover lost hours have increased since March 2021, so too have the number of Red incidents being responded to. This shows that when CSP is in periods of high demand and hospital handover increases, Red responses are protected, even during high pressure within the system.

However, as the bottom graph illustrates, as the response to Red increases, there is an impact on Amber 1 responses, particularly at times of high demand, such as during December 2022. During these periods, the number of Amber 1 incidents attended decreases, notwithstanding that some of these patients within the Amber 1 category will still be seriously ill, although during December 2023 Amber 1 responses also increased slightly when compared to November 2023.

The bottom graph also highlights that as lost hours have increased since mid-2021, so Amber 1 responses have declined, due to the increased system pressures. However, as lost hours reduced during the first half of 2023, so Amber 1 responses increased, from 10,326 in December 2022 to 13,055 in May 2023. Therefore, it was possible to see the reduction of pressure within the system and subsequent performance improvement through the Amber 1 metric.

Remedial Plans and Actions

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

Expected Performance Trajectory

The Commissioning intention for 2023/24 is that handover lost hours should reduce to 15,000 hours per month, the same seen levels seen in the winter of 2019/20, which were considered extremely high, 12,000 hours by the end of Quarter 2 and sustained and incremental improvement in quarters 3 and 4. The ambition that there should be no waits over 4 hours during 2023/24. Non-release for Immediate Release Requests should become a Never Event.

**NB: Data correct at time of abstraction.*

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

Definition of Indicators

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

AGENDA ITEM No	**11**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**3**

DUTY OF QUALITY ANNUAL REPORT 2023/24

MEETING	Quality, Patient Experience & Safety Committee
DATE	7 May 2024
EXECUTIVE	Liam Williams, Executive Director of Quality & Nursing
AUTHOR	Kate Blackmore, Senior Quality Governance Lead
CONTACT	Kate.blackmore@wales.nhs.uk

EXECUTIVE SUMMARY

1. As part of the Duty of Quality Statutory Guidance 2023 there is a requirement for each Local Health Board, NHS Trust and Wales-only Special Health Authority to publish an Annual Report on the steps it has taken to comply with the Duty of Quality.

2. Section 9 of the Duty of Quality Statutory Guidance 2023 (**ANNEX 2**) sets out the quality reporting requirements for the Duty of Quality.

3. The Duty of Quality National Reference Group, which was set up by NHS Wales Executive to support the implementation of the duty, took the decision that no specific template would be created for the Annual Report allowing each organisation the freedom to take an approach that meets their individual needs.

4. The first section of the report sets out our quality management system and how we approach quality across the organisation.

5. The second section sets out evidence of our endeavours to improve quality of services across the 12 Health and Care Quality Domains.

6. Finally, we have set out our intentions for 2024-25.

RECOMMENDED that the Quality, Patient Experience and Safety Committee supports the draft Duty of Quality Annual Report 2023/24 for onward escalation to Trust Board.

KEY ISSUES/IMPLICATIONS
Not applicable

REPORT APPROVAL ROUTE	
Clinical and Quality Governance Group	30 April 2024
Quality, Patient Experience & Safety Committee	7 May 2024
Executive Leadership Team	26 June 2024
Audit Committee	10 July 2024
Trust Board	12 July 2024

REPORT APPENDICES	
ANNEX 1	SBAR Providing background information
ANNEX 2	Draft Duty of Quality Annual Report 2023-24
ANNEX 3	Duty of Quality Statutory Guidance 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)	YES	Financial Implications	N/A
Environmental/Sustainability	N/A	Legal Implications	YES
Estate	N/A	Patient Safety/Safeguarding	YES
Ethical Matters	YES	Risks (Inc. Reputational)	YES
Health Improvement	YES	Socio Economic Duty	N/A
Health and Safety	YES	TU Partner Consultation	N/a

ANNEX 1

SITUATION

1. On 1 April 2023 the Health and Social Care (Quality and Engagement) (Wales) Act 2020 came into force.

2. As part of the Duty of Quality Statutory Guidance 2023 there is a requirement for each Local Health Board, NHS Trust and Wales-only Special Health Authority to publish an annual report on the steps it has taken to comply with the Duty of Quality.

3. This paper sets out the approach taken to produce the first Duty of Quality Annual Report.

BACKGROUND

4. Section 9 of the Duty of Quality Statutory Guidance 2023 (**ANNEX 2**) sets out the quality reporting requirements for the Duty of Quality.

5. This stipulates that the Annual Report should articulate the steps we have taken to comply with the duty to exercise our functions with a view to securing improvement in the quality of health services.

6. The report must include an assessment of the extent of any improvement in outcomes achieved by virtue of those steps.

7. The report allows the actions taken by the Welsh Ambulance Services University NHS Trust (The Trust) and any quality improvements to be monitored transparently. We should describe the progress and challenges on our quality journey to our population and stakeholders.

8. Quality reporting should reflect the breadth of the domains of quality, quality enablers and quality management system within its structure and content.

9. The Annual Report is intended to summarise and reflect the Trust's progress to improve the quality of our services and population outcomes. It is anticipated that we will sign-post readers to the information provided through the 'Always on' Reports that outline learning and improvements that have been made at regular intervals through the year.

10. The report should include a look back at what has been achieved together with a forward look about our quality priorities and ambitions for the upcoming year alongside how progress will be monitored. There should be continuity between Annual Reports across subsequent years.

11. The Manual for Accounts stipulated that ***"2023-24 will be the first year for the requirement of a Duty of Quality and Duty of Candour report. Both these reports should be prepared and published separately to the Performance Report. In accordance with the Duty of Quality statutory guidance (section 9) the annual quality report should be prepared as soon as practicable after the end of each financial year. As set out in WHC/2023/028 there is no requirement to prepare a separate Annual Quality Statement".***

12. The Duty of Quality National Reference Group, which was set up by NHS Wales Executive to support the implementation of the duty, took the decision that no specific template would be created for the Annual Report allowing each organisation the freedom to take an approach that meets their individual needs.

ASSESSMENT

13. In approaching the first Duty of Quality Annual Report we have focused on introducing the report to our population. With this in mind, we have included some contents about what services we offer.

14. The first section of the report sets out our quality management system and how we approach quality across the organisation.

15. The second section sets out evidence of our endeavours to improve quality of services across the 12 Health and Care Quality Domains.

16. Finally, we have set out our intentions for 2024-25.

17. The approach of this report is to use simple language that would be easily understood by all of our population as well as stakeholders. We have included a blend of stories and metrics and aligned the content with our Integrated Medium-Term Plan (IMTP) and annual filings including the Performance Report.

18. Whilst the Duty of Candour will have its own Annual Report which will be aligned with the Putting Things Right Report due for publication in October, we have included some content aligned with this activity as it helps us hear our citizen's voice and produces opportunities to learn and drive improvement.

19. The guidance agreed by the Annual Filings Task and Finish Group, supported by the Manual for Accounts, is that the Duty of Quality Report would follow the same governance structures and timeframes. However, to achieve this and ensure appropriate quality governance, we must submit the report to the Clinical and Quality Governance Group (CQGG) in April for onward approval at the Quality, Patient Experience & Safety Committee (QuESt) in May 2024.

20. All amendments will be collated from CQGG, Executive Leadership Team (ELT) and QuESt and submitted collectively to prevent duplication of effort. Translations will then be requested in line with the Welsh Language Standard. To achieve accessibility, and as referenced in the introduction of the report, a concise video summary will be produced to augment the written document pulling on some of the key content, and as such British Sign Language translation will also be undertaken.

21. A holding position is included for an appropriate forward which, following recommendation from CQGG, would include a Non-Exec Director, preferably the chair of QuESt and an Executive Director, yet to be determined. In addition, a section to include content for Our WAST Way leadership development has been held.

Welsh Ambulance Services University NHS Trust

Duty of Quality Annual Report 2023-2024

GIG CYMRU NHS WALES

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

Version 1.0
Released: TBC

by Quality, Safety & Patient Experience Team
Team.email@wales.nhs.uk

Contents

To Support.
To Serve.
To Save.

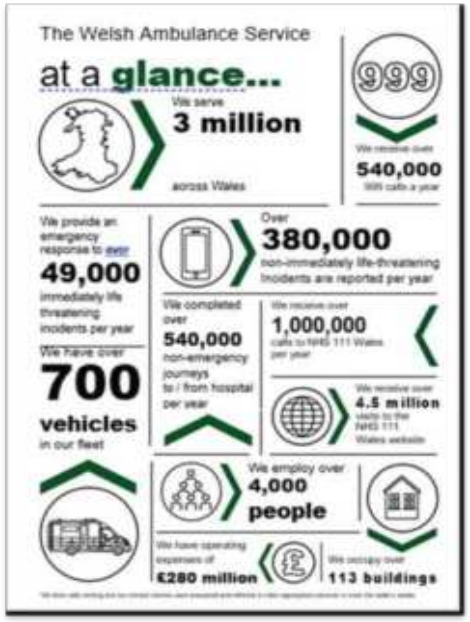
Introduction

Section held for forward if required

The Welsh Ambulance Services University NHS Trust is made up of **three key points of access** for our patients;

- 999 Emergency Medical Services
- Ambulance Care including our Non-Emergency Patient Transport Service (NEPTS)
- Integrated Care which supports remote clinical decision making such as NHS 111 Wales and our Clinical Support Desk

The Trust also supports volunteers: Community First Responders (CFRs), Co-Responders and Uniformed Responders to provide additional response resource to emergency calls and a volunteer car service to aid patient transport to planned appointments.



This is our first annual report linked to the new Duty of Quality, it is aimed at informing our service users and stakeholders about our quality journey, what steps we have taken to improve, the progress we have made and the challenges we have experienced along the way. As this is our first report of this kind, we have also included information about the services we provide and how we monitor the quality of these services.

Over the next year we will introduce 'Always On' reporting that will provide regular quality updates throughout the year and will link each annual quality report together.

Elements of the report will also be produced as an interactive video in English and Welsh.

What is Quality?

The Health & Social Care (Quality & Engagement) (Wales) Act 2020 came into force from 1st April 2023. This new law includes the Duty of Quality and defines quality as:

'Continuously, reliably and sustainably meeting the needs of the population we serve'

This includes but is not limited to the effectiveness of health services; the safety of health services; and the positive experience of individuals to whom health services are provided.

We use 12 Health & Care Quality Standards as a framework to guide and measure quality across the services we provide to the population. The 12 Quality Standards include 6 key enablers to help deliver against the 6 domains of quality (safe, effective, efficient, person centred, equitable and timely care to our population).

The approach promotes;

- Leadership and culture focused on good quality
- A workforce that has the skills and knowledge to meet the needs of the population
- Quality driven decision-making supported by digital capability
- A positive quality culture where learning through feedback, knowledge from our information systems and research is embedded in everything we do.
- Quality outcome measures that guide practice, identifying best practice and where there may be a risk or need to improve.
- System-wide approach to quality and strengthened Quality Management Systems

Trust Approach

We have a network that enables all teams to communicate, the network is made up of staff from across the business, several different groups and committees, collectively known as our governance infrastructure.

The governance infrastructure is supported by digital tools & systems to help us collaborate, monitor, and report on the services we offer to the population of Wales.

By doing this, we can share quality information and intelligence in a timely manner, identify best practice, risks and/or priorities for improvement, or it may be just for reporting purposes.

Our website includes information on our services, our committees and our Trust Board. You can also find documents and papers that have been discussed and the decisions we have taken over the last year. There is also a section dedicated to our response to the Duty of Quality.

Our Quality Management System

Our Quality Management Group encompasses quality experts and clinical improvement leads from across the Trust who collaborate with leaders from keys service areas. This collaborative approach provides assurance against the quality requirements of the Health & Social Care (Quality & Engagement) (Wales) Act 2020 to ensure the Trust is compliant against the Duty of Quality, Duty of Candour and Citizen Voice.

The group undertakes this through considering a range of information, intelligence, and insight to promote improvement efforts & learning, and to mitigate risk. The group also enhances floor to board governance through development, delivery, and support of quality management systems, enabling effective quality management across the leadership level. This approach enhances our responsiveness to quality matters and ensures we consider quality at the heart of our decision making.

Quality & Performance Monitoring

The Trust is subject to a high level of external scrutiny through the Welsh Government accountability arrangements. EMS, NHS 111 Wales and NEPTS are services commissioned by health boards.

90% of our workforce work within our operational teams where there is evidence of robust practice and quality management processes in place. The focus for the Quality and Performance Steering group is to ensure the spread of good practice and that the approach of local quality and performance frameworks is consistent across the trust.

The recent Audit Wales Structured Assessment stated:-

"The Trust's Performance and Quality Framework, approved in March 2022, is comprehensive and sets out clear roles and responsibilities for staff. The Quality and Performance Management Steering Group oversees the ongoing development of the framework which includes trialling and reviewing best approaches for effectively incorporating the new requirements placed by the Duty of Quality and Duty of Candour. Despite this, operational performance remains extremely challenged due to increased demand, wider system pressures and the consequential inefficiencies. Together, these challenges are leading to avoidable patient harm."

Quality Framework

Our organisational Quality, Performance and Management Framework provides a quality policy for the organisation setting out the building blocks for continual improvement. Our quality management system is built around these principles and aligns to the guidance set out by Welsh Government.

The Trust has completed an organisation wide self-assessment against the "organisational requirements" and has an associated work programme, that the Quality & Performance Management Steering Group is responsible for delivering.

Quality Management System in action

Quality Control

We have Systems to monitor the quality of our services, identifying issues, promoting learning, identifying improvement and corrective actions.

The systems we use enable "Always On " reporting, to collect, analyse and monitor quality-related information and measures.

Systems such as

- Computer Automated Dispatch (CAD)
- Medical Prioritisation Dispatch System (MPDS)
- Emergency Communication Nurse System (ECNS)
- Datix Cymru
- Docworks
- ePCR
- PowerBI

Quality Assurance

We achieve quality assurance using intelligence gained from internal assurance processes and external assurance through validation. The aim is to identify and mitigate risk and assure intelligence to inform improvement priorities using our quality management systems as a vehicle.

Internal sources

- Self-Assessments
- Patient & Staff Feedback
- Clinical Indicators
- Non-Clinical Audit
- Patient Reported Incidents
- Staff Reported Incidents (RLDatix)
- Learning from Deaths
- Serious Case Incident Forum
- Risk Registers

External Sources

- Internal Audit
- HIW Inspections
- Welsh Audit Office

Quality Improvement

We actively seek to identify opportunities for improvement. The WAST Improvement and Innovation Network (WIIN) is a cross-directorate network which supports colleagues with their improvement and innovation ideas offering guidance and support with Clinical Audit, Research, Quality Improvement and projects that require a more 'formal' approach.

Each year the Trust supports individuals to attend QI training at both a basic and advanced level.

There are members of the QI team who have gained the Scottish Improvement Leader Award, who can provide coaching, mentorship and support to implement Organisational Quality Improvement.

Quality Planning

We ensure all services meet the requirements of the Health & Social Care Act 2020 to meet the needs of the population through quality planning.

The key document that outlines our strategic plans is the Trust Integrated Medium Term Plan (IMTP). The plan is supported by a governance structure to monitor and report progress.

In addition, integrated Commissioning Action Plans are developed jointly with Health Boards to reflect NHS Wales strategic service changes.

Local Directorate Plans are focused on improvements and important changes at a local level that benefit the Trust, patients and Staff.

iStumble

"Non-Emergency staff have reported instances where they have attended routine transport requests to find a patient has fallen, or who falls whilst making their way to the vehicle. In these instances, it is often the process to contact EMS services to assist with patient assessment before getting the patient up. Use of the iStumble tool may assist NEPTS teams to assess and assist non-injury fallers reducing potential workload to the EMS environment and improving patient outcomes by reducing long lies". This training has now been incorporated into the mandatory in-service training for all operational staff.

Quality Agreement Framework

The Trust have developed a Quality Agreement Framework for its Third-Party Providers within Ambulance Care 365 referred to as the three Q's. The Framework allows for the monitoring and measurement of quality against a set of standards in line with the Duty of Quality. Providers will be allocated the appropriate award based on the overall quality and performance of their service provision.

Resource Work Management Portal

"We are in the process of developing a Proof of Concept for a Resourcing Work Management Portal to capture all non-urgent work requests via a single self-service portal. We have recently moved to a new telephone system, which has given us the ability to view call volumes to the resourcing teams, but this doesn't identify work requests made in other ways like email. This portal will also help gather feedback to monitor quality and improve the service if required."

Welsh Language

Having to access our services can sometimes be a stressful experience and so to make people feel at ease it is important to use the Welsh Language wherever possible if this is the patient's preference. This is particularly important for more vulnerable groups of patients such as children, the elderly or those patients with more complex needs such as dementia. As a result, Welsh Awareness training is now available via our e-learning platform so that all our staff members are aware of the importance of making an 'active offer' of Welsh, wherever possible, and how the Welsh Language standards affect them.

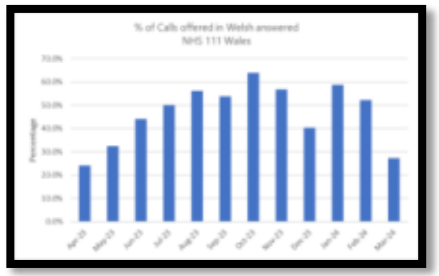
Centralising the Trust's internal translation service with the recruitment of a Welsh Language Translator has increased the Trust's ability to provide bilingual services to our service users.

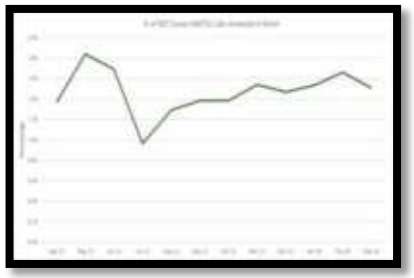
The Standard

On 30 May 2019, the Trust moved from implementing its Welsh Language Scheme under the Welsh Language Act 1993 to implementing new Welsh Language Standards under the Welsh Language Measure (Wales) 2011. As a result, the Trust has started to implement actions for compliance with its Statutory Compliance Notice from the Welsh Language Commissioner.

Improving our Offer

In 2022 the percentage of NHS 111 Wales calls being answered in Welsh as the service users chosen language had reduced and whilst the number of calls requesting this service was low (less than 1% of 111 calls) the leadership team recognised the importance of the service it provided. As a result, an improvement plan was launched across our NHS 111 Wales service delivery team to improve the numbers of patients able to receive a service in Welsh if this was their preference. In addition, the Trust has developed 65 bilingual symptom checkers which are available on the NHS 111 Wales website allowing users to check their symptoms and receive online advice. In our Non-Emergency Transport centres 19% of our call handlers are Welsh Speakers. In order to improve our offer of Welsh Language call handling we are attempting to increase this to 23% by ensuring an ability to speak Welsh is an essential requirement for recruitment.





Wider Communities

Whilst we are committed to providing an offer in Welsh, we are also aware of the diversity of our communities and the desire to offer services that allow users to communicate with us effectively, particularly in an emergency.

As an organisation all staff have access to live interpreting services from Language Line Solutions® who offer remote on demand interpreting services in more than 240 languages, 24 hours a day, 365 days a year.

We also have arrangements in place with NHS England for British Sign Language service users to call 999 and 111.

The Wales Interpretation and Translation Service (WITS) provide in-person interpreters for events and can provide written translations for patient information such as leaflets.

Duty of Candour

The Duty of Candour is a legal requirement for all NHS organisations in Wales to be open and transparent with Service Users when they experience harm. When service users have experienced harm whilst receiving health care we are committed to:

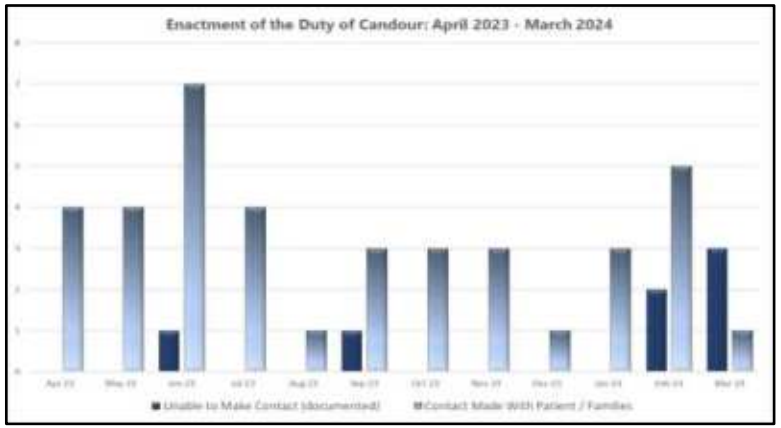
- **Talking to service users and families about incidents that have caused harm**
- **Apologising and supporting them through the process of investigating the incident**
- **Learning and improving from these events**
- **Find ways to stop similar events from happening again.**

As an organisation this process was already embedded for Service Users who experienced severe or catastrophic harm. We are now building on these foundations to include those Service Users who experience moderate harm. The goal is to continue to embed a **culture of trust and openness** so that service users can feel confident in the care they receive from us. More information is available in the Duty of Candour section on our internet site.

Next Steps
The Trust recognises that we have more to do in respect of identifying patient harm including the impacts of delays responding in the community and handover of care delays outside hospitals. We have invested this year in our Patient Safety Team to support this, working with patients and families and health and social care system partners.

Notifiable Incidents
The Trust identified 46 patient safety incidents at the Serious Case Incident Forum which were notifiable and triggered the Duty of Candour threshold. A notifiable adverse outcome is any incident whereby harm (moderate harm, severe harm and death) is caused, which is unintended or unexpected and that the provision of the health care was or may have been a factor in the service user suffering that outcome.

The Duty was enacted on all occasions, although we were unfortunately unable to make contact with 7 patients or families, despite exhausting several routes, including contacting Health Board colleagues for contact details and attempting to make contact on multiple occasions.



Monitoring arrangements

Serious patient safety incidents are scrutinised at our Serious Case Incident Forum, which is a multidisciplinary meeting held at least weekly and is chaired by the Assistant Director of Quality & Nursing. Decisions regarding Duty of Candour are considered at the Forum.

Our Putting Things Right Report is presented and discussed at the Quality, Patient Experience and Safety Committee on a quarterly basis and includes details on our enactment of the Duty of Candour. This Report is available via the Committee papers on our internet site.

Listening to our Citizens

We have a dedicated Patient Experience & Community Involvement Team (PECI) which engages with the public, patients, their carers and families to understand how they experience the services provided by the Trust. PECI acts as the patient voice within the organisation – sharing lived experiences and feedback to influence service design and delivery.

The three main activities of the team are:

Patient Experience

- Using surveys to record people's feedback and experiences of using Trust services.
- Using Patient Stories to learn from and improve our services.

Community Involvement

- Meeting people face to face and through online events.
- Listening to people's views to help shape the way we deliver our services.
- Promoting the 'People & Community Network' to offer opportunities for people to become more involved in improving services.

Information & Education

- Signposting and providing information to help people make decisions about their health.
- Educating the public on range of services in the community that can help.
- Educating the public on what to do in an emergency.

We have a long-established record of capturing and listening to patient stories to better understand the people's experiences of what it feels like to use our services. The stories we capture are not just a sequence of events but include the emotional effects of the experience and the storytellers' expectations and needs. These provide a valuable insight into the quality of the healthcare they have received, and their opinion of the services we have provided.

While patient stories can show when we are providing a good service, they will also help to: Allow patients and carers' voices to be heard, encourage reflection, highlight any improvements that need to be made to the services we provide, be used as a valuable tool for staff training and put patients' needs at the heart of service development and improvement.

Stories are shared internally at various committees and our Trust Board. They are also shared, with the appropriate consent, with relevant health boards, the ambulance commissioner and NHS Executive. We identify key actions to take because of a story, these are monitored through a story tracker to ensure we are monitoring conversations, actions, and improvements.

Next Steps

We are currently researching opportunities for presenting extended patient experience stories through podcasting to extend the digital reach, particularly for our WAST staff. We are also in the process of launching a dedicated Patient Stories Page for staff on the WAST Learning Launchpad staff training portal.

Virtual Video booth

The Patient experience and community involvement team can visit people to record their stories however, people have the option of recording and submitting their experience story themselves using our Virtual Video booth service. It's easy to use and is the quickest and most secure way to record a story. It works on most computers, tablets and smartphones with built-in cameras and microphones.

Engagement Activity over the Year.

We have continued 'targeted' face-to-face engagement with groups reporting the poorest experiences. Our engagement with the wider population has enabled us to develop ways to align our work with their needs and better understand their expectations.

Quality Assurance – Audit and Inspection

Joint Escalation and Intervention Arrangements
The Cabinet Secretary for Health and Social Care determines the escalation status of NHS bodies. This is based on an evaluation by Health Inspectorate Wales, Audit Wales and Welsh Government. We were advised in January 2024 that following the most recent assessment the Trust remained in an unchanged position of 'routine arrangements'.

Inspection
Health Inspectorate Wales (HIW) published a ***'Review of Patient Flow – A Journey Through the Stroke Pathway'*** in 2023/24.

Recommendations for WAST included:

- We should engage with people to better understand the barriers to them accessing, or choosing, from the range of health care services in Wales.
- We must ensure that all relevant staff are fully aware of our Stroke pathway to minimise risks to patient safety.
- We must work collaboratively with health boards to identify a consistent approach to ensure handover of stroke patients is made within the Welsh Government 15-minute target.

Our actions to meet these recommendations will be monitored by our Quality, Patient Experience and Safety Committee.

External Audit (Audit Wales)
Audit Wales undertook a review of the ***workforce planning arrangements*** in 2023. The key focus of this review was on the Trust's approach to workforce planning. More specifically it looked at how we manage current and future challenges including monitoring and oversight arrangements.

It stated:

"We found that The Trust is proactively addressing its workforce challenges, based on a strong understanding of risks. However broader workforce transformation is constrained by resource availability."

"Overall, we found that the Trust is taking effective steps to mitigate current workforce challenges and clarify its longer-term strategic vision, however medium to longer-term resourcing is a significant and ongoing barrier."

Audit Wales Recommendations

Hazardous Area Response Team
The Emergency Preparedness, Resilience & Response (EPRR) & Specialist Operations team have undertaken a National Ambulance Resilience Unit (NARU) self-assessment to assess compliance against the English HART standards and develop any internal work programmes to address areas that need to be developed.

Internal Audit
The Trust develops an annual Internal Audit plan in conjunction with Internal Auditors. The plan is risk based, directing reviews to areas where management and our Audit Committee consider there may be potential weakness.

In 2023/24 we completed 18 internal audits across a range of subjects from estates condition to Staff retention.

One example is an audit of ***the Senior Paramedic role*** to assess if they are achieving their key role objectives, this report was issued in November 2023.

The audit provided reasonable assurance but identified some areas of improvement including the team distribution to make sure Paramedics and Technicians receive appropriate levels of supervision and support, and monitoring of training compliance ensuring that the required clinical skill enhancements are provided.

Emergency Medical Services (999) – How your calls are answered

When you call 999 in Wales and ask for the ambulance service your call will be passed to one of our EMS Coordination Centres, we have three centres located in Llanfairfechan, Carmarthen and Cwmbran. Ideally the call will be routed to your nearest centre but at times of high demand you may be connected with another centre to ensure we answer your call as quickly as possible.

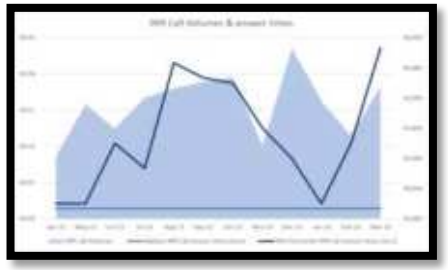
Our qualified Emergency Medical Dispatchers (EMDs) will answer your call and ask you a series of questions to understand where help is needed and what has happened. These questions will not delay help being arranged but ensures that we prioritise our responses to help those most in need first and provide advice over the phone when it is appropriate to do so.

Sometimes sending an emergency ambulance is not the best way to help the patient and you may be told that a clinician will call you back, these are qualified paramedics and nurses who work in our contact centres and can complete an over the phone triage by asking you more specific medical questions. As a result of this clinical triage, you may be advised to see your GP, be given self-care advice or told to attend a minor injury unit rather than an Emergency Department, alternatively the clinical triage may identify that you need a more urgent response and will ensure that your priority reflects this.

If a face-to-face clinical assessment is required or you need to go urgently to the nearest A&E unit an ambulance response will be sent, we have different types of responses that may be sent to you including Emergency Medical Technicians, Paramedics, Advanced Paramedic Practitioners and Community First Responders.

Accreditation
In September 2023 we achieved Accreditation as a Centre of Excellence for 999 call handling through the International Academy of Emergency Dispatch. WAST has held this accreditation since 2017.

Call Answering
Between April 2023 and March 2024, we continued to take high numbers of 999 calls. On average we answered calls within 2 seconds however some callers waited 34 seconds or longer when demand was high.



LifeX
In April 2023 we updated our system to communicate with EMS responders and across our coordination centres. The LifeX control room solution was implemented as part of a UK wide replacement programme. Welsh Ambulance Services University NHS Trust was the first large scale Ambulance Service to successfully implement this technology in the UK. This allows us to have the most up to date communication technology, with increased resilience and the ability to respond flexibly during periods of disruption.

Learning from Events
In summer 2023, the Operations Quality team developed a new process for the delivery of learning to EMS Coordination staff. Previously, learning which is often identified through concerns investigations, was included in coaching bulletins which were then circulated to staff within the centres. The new approach enables more interactive delivery of learning and development topics, and also enables live monitoring of compliance and competence across the service area. Staff are required to sign off their competence on completion of learning, providing data for monitoring by the quality team and senior managers within the centres, as well as more detailed information about individual compliance. Not only is this a useful way to monitor how learning topics embed, it also provides evidence of learning to key stakeholders where required. The team is continuing to look at other means of training delivery to ensure interactive, engaging and effective means of delivery is maximised.

Emergency Medical Services (999) – How we respond to your calls

The Trust use digital technology to respond efficiently and effectively to emergency calls. When a face-to-face response is required the call details are sent to a vehicle mobile data terminal (MDT) which immediately prompt the crew to go directly to the ambulance (if not already in it), and to travel to the incident. Once the crew press mobile the incident details are voiced to the crew and include the incident nature (i.e., heart attack), the location of the incident, and importantly the response priority of the incident.

The response priority helps the crew to determine the severity of the emergency and if they need to respond to the call with blue lights and sirens. Our Clinical Response Model has four main categories Red (Immediately Life Threatening), Amber (Serious but not life threatening), Green (Neither serious or life threatening, Green HCP (urgent requests from Health Care professionals).

The crew will use the initial call information and any updated information to help them determine what equipment they need to take directly to the patient's side to support their needs, and whether any further support may be needed on scene. On arrival at the incident, the patient is quickly assessed and treated in accordance with the presenting condition. There isn't always a need to convey a patient to hospital, and quite often this isn't in the patient's best interest, so the crew will make every attempt to safely treat the patient on scene or refer the patient to the most appropriate pathway to meet their needs.

EMS and Ambulance Care Quality Days

In December 2023, we introduced the first monthly Operations Directorate Quality Day. This entailed visiting many of the District General Hospitals, outpatient departments and stations to carry out snap audits with regards to Quality.

Microsoft forms were produced to record data on infection prevention control, dress code, seatbelt & restraint compliance and vehicle maintenance. Stations were checked for cleanliness, and general estates functions, there was also a focus on sexual safety.

Information and learning from these audits are shared across directorates through our governance infrastructure.

Community Welfare Responders

In May 2023 we introduced the Community Welfare Responders. The volunteer role of the CWR is to provide a face-to-face assessment of a patient's situation and connect with our remote clinicians in the Clinical Support Desk (CSD) providing the human-touch that healthcare requires. CWRs provide timely access to the right care, they empower our clinicians by providing critically important clinical observations (such as heart rate and blood oxygen levels).

Mobile Data Vehicle Solutions (MDVS)

The Ambulance Radio Programme is working with Trusts across the UK to improve digital technology in our responding vehicles in readiness for a new critical communication system for Great Britain's emergency responders. Our existing mobile data terminals are being replaced with modern, MS Windows-based tablets and wi-fi routers as well as a new software solution, the National Mobilisation Application (NMA). This new software ensures our responders comply with the Road Traffic Act (Regulation 109) and are not distracted by information screens whilst driving. 89% of our Emergency Fleet has been updated with this technology and, as we conclude this work, we are now installing these systems in our Non-Emergency Fleet.

EMS			NEPTS		
Total for Completion	Total Completed	Completed (%)	Total for Completion	Total Completed	Completed (%)
511	456	89.24%	280	11	3.93%

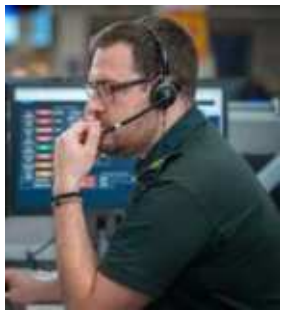
Integrated Care – Clinical Support Desk

The Clinical Support Desk (CSD) is a virtual function located across our EMS Coordination Centres (EMSC) and other satellite locations. The CSD is staffed by nurses, paramedics and mental health clinicians who undertake secondary telephone assessments of patients that have accessed 999.

The principal role of the CSD clinician is to provide clinical assessment, advice, and to signpost patients to ensure that they can access the most clinically appropriate care for their urgent and emergency healthcare needs, known as Consult and Close (C&C) or Hear and Treat (H&T).

Clinicians assess patients remotely using Computer Decision Support Software (CDSS) and advise on the most appropriate clinical outcome for patients, which may include ambulance response or referrals to alternative pathways of care.

In addition to this principal role, the CSD also undertake a range of other clinical functions in pursuance of maximizing patient safety for those awaiting an emergency ambulance and provides support to other staff groups such as newly qualified paramedics, paramedics, and a range of non-clinical responders such as emergency medical technicians, urgent care assistants, community first responders and falls assistants.



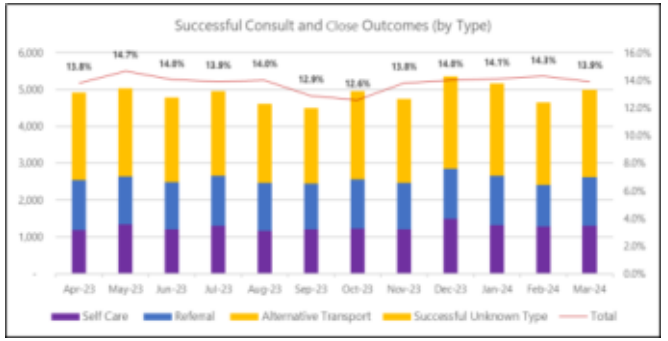
In 2023-24 we have worked to develop and grow CSD services including many exciting pilot projects which will see improvements for 999 services as well as supporting patients to get the right advice and right care.

Inbound Contact Concept
As CSD moved to Remote Clinical Support for Newly Qualified Paramedics, Community Responders and others, we introduced an inbound contact line. We also introduced a brand-new pilot to support Police colleagues waiting for face-to-face clinical assessments for patients as part of collaborative work with our Emergency Services partners.

Emergency Communication Nurse System
This year also saw the team achieve Accredited Centre of Excellence status in the use of ECNS in 999. As the first team ever to achieve this in the UK, this is a true reflection of the excellent work undertaken in CSD in remote clinical assessment and alternative pathway provision for patients in Wales. The ECNS system allows us to undertake Video consultations as well as support remote clinical assessment over the telephone.

Integrating Care
A new process for integrating assessments with clinicians in NHS 111 Wales has been developed which allows for electronic passing of appropriate incidents for clinical review which have not already been referred from the 999 call handling process. Previously a manual process, this has saved hours of manual activity, improved safety by reducing transcription errors and provided improved reporting of calls.

Consult & Close
We are committed to getting patients the right care in the right place, every time. One of the ways we measure this is to review the impact of our Clinical Support Desk. During this period on average 13.9% of 999 calls were resolved through telephone and video triage. We are committed to increasing this performance with a target of 17%.



Integrated Care – NHS 111 Wales

The NHS 111 Wales service is a free to call service which provides over the phone advice and online symptom checkers if you are feeling unwell and you don't know what to do, they also provide the first point of contact for urgent primary care services in Wales and offer information about local health services and different health conditions.

Our call handlers will answer your call and ask you a series of questions to understand what help you need, they may be able to help you straight away or you may need to speak to someone else such as a nurse or paramedic in our NHS 111 Wales contact centres, a dental nurse or a health information advisor. If they can't help you straight away the person you need will call you back as soon as possible.

Our NHS 111 Wales service might tell you how you can look after yourself, advise you to see a pharmacist in your local area, advise you to see your own GP or urgent Primary Care services, they may even tell you to go to a local hospital. If your problem is very serious they will transfer you to the Emergency Medical Services.

The NHS 111 Wales website can help you find services near you, access online symptom checkers which will provide you with information and advice or provide health information and information about your local health board services.

Call Answering

The time it takes to answer your call is a key part of a positive patient experience and helps to provide confidence in the service we provide. Over the last 12 months we have worked to improve our call handling performance, answering more calls within 60 seconds and reducing the numbers of calls abandoned by our callers. We still have improvements to make in order to meet our target, but we have seen greater stability in our service provision during winter months as a result of initiatives to make our teams more efficient and reducing our turnover of staff.

Call Prioritisation Streaming

We are working with an experienced clinical decision support system provider to develop the Call Prioritisation Streaming System (CPSS) for use in our NHS 111 Wales contact centres. Our existing system has been in operation for over 20 years, originally as part of NHS Direct Wales, and has been used as the basis to develop an updated, assured, safe and modern system. Using LowCode™ software to support the system will provide a robust auditable system to ensure quality assurance and learning improvements across our NHS 111 Wales service.

Virtual Queue

In an effort to improve service user experience when waiting to be answered we are trialing a new virtual queuing function. This will allow service users to hold their place in the queue whilst waiting to be connected through an automated ring back process.

Dental Calls

We have worked with our teams to improve the way in which we support dental services to improve the experience of our patients. This has included reviewing the way we roster our dental teams and training our general clinicians (both paramedics and nurses) to be able to support dental patients better. We have also reviewed our procedures and monitoring arrangements to ensure that our teams as well as our patients have improved experience. Different Health Boards commission different dental services so we are now working with the Six Goals programme to better determine Emergency Dental needs to make sure we can target these valuable services effectively. Improving access to emergency dental services 24/7 across the whole of Wales.

Ambulance Care – Non-Emergency Patient Transport

Our Non-Emergency Patient Transport service (NEPTS) operates from three Booking Centres coordinating and providing a service for patients across Wales who are unable, for medical reasons, to make their own way to and from their hospital appointments. There is an eligibility process (Patient Needs Assessment) that is used to assess all patients that request Ambulatory transport to ensure the limited resources are allocated to those patients with a medical need first.

Ambulance care have a range of vehicles that can be used to take a wide range of patients including those who need stretchers, who use wheelchairs or have limited walking mobility. For patients able to travel by car, the service uses a dedicated team of Volunteer Car Drivers, community services and private taxi services.

Cancellations
The service has worked closely with health boards to redesign systems and processes to reduce the number of cancellations processed and the negative experience caused to patients. This includes the introduction of a dedicated cancellation line so that services users don't need to queue when cancelling their booking.

We have also reviewed our text reminder service so that the reminder messages our patients receive are most helpful.

Performance Standards
We have reviewed our performance standards during this period and have introduced back stop measures for our Renal and Oncology patients to focus not only on arrival times but on long waiting patients.

Quality Dashboard
In order to develop and enhance our Quality Management System we have introduced a quality dashboard that brings together our workstreams with a quality focus. This is reviewed monthly as part of our governance infrastructure and is shared across the broader operational leadership teams.

Citizen Voice
Patient experience reports are telling us that some people feel they are waiting too long for transport to take them home after their hospital appointment. We are looking into this feedback to see which category of patients are experiencing long waits, from initial findings people attending outpatients are reporting unhappiness with the length of time they are waiting to go home. From April 1st we are changing the questioning on the experience survey to include an option for people to tell us more information as to why they answered the way they did.

Patient Safety
Following an incident in April 2021, where a patient was not secured within the vehicle appropriately, we have been working to improve our monitoring of safe systems of work. Close monitoring of seat belt use and compliance is achieved in Ambulance Care via programmed and mandatory all Wales vehicle spot checks taken by Operational Team Leaders. These spot checks are reviewed via a reportable data collection sheet which is collated with patient feedback forms specifically targeting seat belt compliance activity and is reported through our Quality Management System. Signs in each vehicle also highlight the importance of correct use of seat belts.

Quality Impact Assessments

The Trust use Quality Impact Assessments (QIAs) as a tool to understand the impact any decisions we make could have on the quality of the services we provide. These assessments are aligned to our 12 Health & Care Quality Standards.

During the period April 2023 to March 2024 18 service changes were approved through our senior leadership teams because of these impact assessments.

The types of decision being supported in this way include service improvement initiatives, patient safety improvements based on the latest evidence available, and activity to make sure we are using the public finances efficiently.

The Duty of Quality requires NHS bodies like the Welsh Ambulance Services University NHS Trust to ensure all our strategic decisions are made with the intention of improving the quality of health services and outcomes for the people of Wales.

Dyletswydd Ansawdd
Duty of Quality

GIG CYMRU NHS WALES

Connected Support Cymru (Luscii Pilot)
LUSCII is digital health software that has been introduced to enable the remote monitoring of patients accessing 999 that are deemed clinically suitable. LUSCII can assist the Clinical Support Desk based in the Trust Coordination Centres in enabling patients to get the right care, in the right place, every time. The Patient, supported by carers within specified Care Homes, is connected using wearable digital health software to the Clinical Support Desk in the Coordination Centres. This enables the CSD to undertake remote clinical assessment and monitoring, helping informed clinical decision-making and identification of suitable patients for referral into community-based teams within specific Health Board areas.

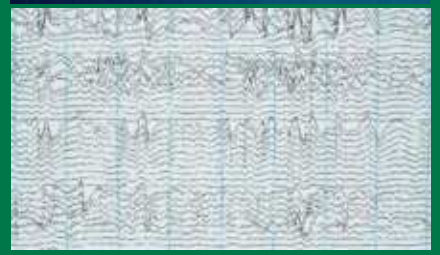
Stroke (CVA) Intervention
The Trust have recently made changes to its software system used to prioritise 999 calls, particularly those relating to symptoms that indicate a stroke. The change has incorporated the recommendation of the National Stroke Network advising that the Stroke window of intervention should increase from 5 hours to 12 for specific intervention i.e., the use of 'clot busting' (thrombolytic) drugs. Once outside the window of intervention the risks of the treatment start to outweigh those benefits.

Obstetric Red Phone
The Trust has introduced a new dedicated WAST Red Emergency Line direct to a healthcare professional within the obstetric unit in a couple of Acute Trusts obstetric units across Wales, with plans to expand to all Acute Trusts. This will improve communication during maternal/neonatal incidents, which will ensure that the ongoing care and transfer into the maternity/ obstetric unit is safe, and the patient(s) are conveyed to the most appropriate place, in a timely manner, with the correct teams informed. reducing any delay in accessing specialised maternity/ neonatal care which is considered a safety RISK for both the Ambulance service and for women, birthing people and neonates who may need immediate time critical interventions.

NHS Wales National Clinical Audit Programme

NHS Wales has set out a programme of national clinical audits. These are a series of measurements against an evidence-based standard, a patient must have been diagnosed with a specific condition to be able to undertake an audit. The range of diagnostic tests available to ambulance clinicians are limited, and do not reflect the types of tests available within a hospital site (such as a scan for stroke, an x-ray for a hip fracture, or an angiogram for a blocked coronary artery). However, ambulance clinicians are able to determine a clinical impression through history-taking and examination, which allows a patient to follow a particular pathway. Once a diagnosis is made, ambulance data from our clinical record is available to feed into the national audit information.

WAST has developed a separate programme of clinical audits and clinical indicators that enable us to measure audit compliance against a range of clinical conditions. These include Stroke pathways, and a pathway to treat suspected heart attacks. We regularly monitor clinical indicators and audit outcomes to identify clinical improvement initiatives.



Clinical Audit

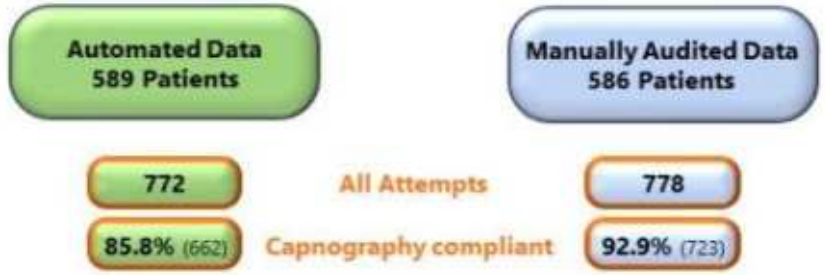
Included in the Trusts 2023/24 Clinical Audit Plan were two audits that supported improvement initiatives. These were for End tidal Carbon Dioxide (EtCO2) monitoring for advanced airway management, and the appropriate administration of Methoxyflurane (Penthrox®) an inhaled pain-relieving medicine to assist with pain management in trauma.

Pain Management

Penthrox® is an inhaled pain-relieving medicine that is self-administered by patients. It can be used by alternative responders working for WAST as well as WAST clinicians, improving patient care and pain relief for patients suffering traumatic injuries. Penthrox® was introduced in May 2023 once staff had completed the appropriate training. A clinical audit was planned to evaluate the safe and effective care for patients who were administered this medicine. Good practice was identified with 95.7% of patients administered Penthrox® within the protocol, there were no significant issues identified for those outside of protocol. Lessons learnt included the need to improve documentation of pain scores.

Airway Management

Ensuring that patients have a clear airway is essential and is the first step when attempting resuscitation. In many situations, an advanced approach is required by our clinicians to manage a patients airway using equipment such as an endotracheal tube (breathing tube). To ensure that the advanced equipment is correctly inserted and effective, a device is attached to measure carbon dioxide that the patient breathes out. This is known as End tidal Carbon Dioxide (EtCO2) monitoring. The clinical audit provided reassurance that 92.9% of patients who had advanced airway management, had this documented on the clinical record. This audit contributed to the development of a dashboard to enable compliance to be viewed promptly and provide opportunities for improving clinical practice and patient care when required.



Learning from Deaths

Mortality Reviews

Mortality reviews are a means of identifying problems in healthcare and areas of care which could be improved, such as early recognition and escalation of the deteriorating patient, and appropriate and timely end of life care. Reviews often highlight aspects of excellent care also, and it is important that learning from both areas of excellence as well as those in need of improvement, are shared across the Trust and the wider healthcare system. Our Serious Case Incident Forum reviews any cases of concern and report cases externally as a serious incident when appropriate.

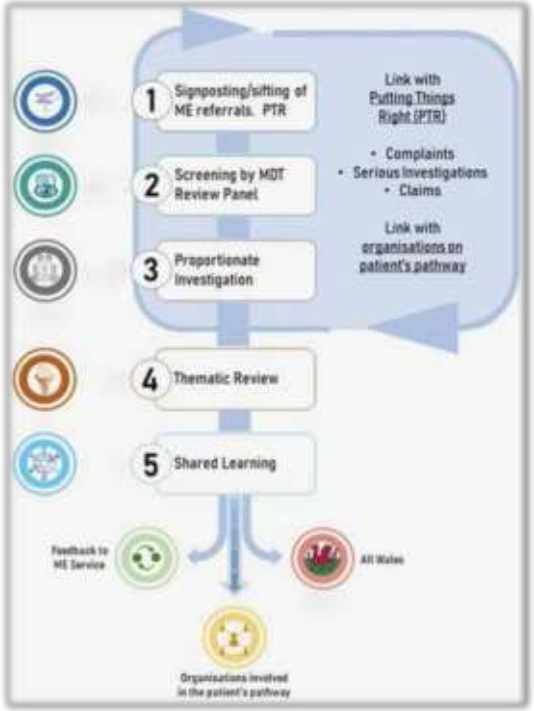
Next Steps

A multidisciplinary panel will be established from April 2024 to undertake the scrutiny of all referrals from the Medical Examiner and escalate as required to ensure a proportionate investigation occurs.

The Medical Examiner Service focus has been on deaths in acute care. From April 2024 the service becomes a statutory body and all deaths, apart from those referred to the Coroner, will be reviewed by the Medical Examiner Service, including community deaths.

National Medical Examiner Service

The National Medical Examiner Service provides independent scrutiny of all deaths that are not investigated by the coroner. A medical examiner is an experienced doctor with additional training in death certification and the review of documented circumstances of death. The Medical Examiners ensure that an accurate cause of death is recorded, identify any concerns surrounding the death itself which can then be further investigated if required, and take the views of the bereaved into consideration. The Medical Examiner will contact the Trust to raise any concerns from their reviews or to request information to inform their reviews.



Learning from Deaths Forum

The Trust's Learning from Deaths Forum has been recently established and will receive information on patient deaths from a number of sources and will consider strategies to improve patient safety and reduce avoidable deaths. This includes information received from Health Boards, Coroners and the outputs of the reviews of the Medical Examiner referrals at the Scrutiny Panel. Identifying any patterns, themes and trends through collective analysis will be a key function of the Forum.

Additionally, the Forum will oversee the implementation of the final version of the All-Wales Mortality Reviews Framework (learning from deaths) which is expected to be released by the NHS Wales Executive in April 2024.

As a national service the Trust is in an excellent position to identify learning and share this on a national basis. Examples of learning shared through this process to improve care include end of life care pathways which we share with our dedicated Palliative and End of Life Care Team. Key themes and trends from the feedback from the Medical Examiner Service following their interactions with families includes our timeliness to respond and handover of care delays at hospitals.

Our Putting Things Right Report is presented and discussed at the Quality, Patient Experience and Safety Committee on a quarterly basis and includes updates on the work of the Forum and this Report is publicly available on our internet site.

Our Patients Story

Alison's Story

Alison's daughter, Emma, has a rare genetic disorder, severe learning disabilities and epilepsy. She needed urgent dental care requiring general anaesthetic at Glan Clwyd Hospital (regular sedation did not work on her). She was advised by Health Care Professionals to access Non-Emergency Patient Transport (NEPTS) to take Emma to her appointment , she was unable to be transported safely due to seizure risk being elevated by the dental pain. Our NEPTS team advised her that at least 24 hours' notice was needed to access transport and she was told to ring 999; due to system pressures an emergency response was unavailable.

In Emma's escalating distress, she began exhibiting self-harming behaviour, this triggered an "attempted suicide" script from the 999 call-taker. After 28hrs Emma was sedated by liaison nurses in the garden at home, supervised by two Police officers who arranged a taxi to take Emma with her siblings to hospital. Alison has subsequently been advised that if a Health Care Professional had made the request for NEPTS transport it would not have been subject to the need for 24 hours' notice. None of the HCPs involved, nor the NEPTS or CCC staff appeared to be aware of this.

Required Action

1.Undertake **further review/discussion** to ensure opportunities for promoting equality and human rights for people with protected characteristics is recorded.
2.**Continue engagement with BCUHB** to action identified learning
3. **Undertake appraisal** with view to improving ability to flag records that patients have additional needs (LD, autistic and neurodiverse) on telephony systems and patient records/addresses.
4. Disseminate **up to date information** to HCPs on contact numbers, access routes
5. PECI to **capture PREMs** data of callers/patients with LD
6. Improve ability to capture LD data
7. Explore opportunities for LD expert within WAST/CCC
8. Explore training requirements of Mental Health Practitioners on LD and pathways

Themes

1. Lack of **clarity** regarding HCPs being able to request NEPTs Transport sooner than 24 hours notice
2a. Concern that the structure of the **999 script (AMPDS) is not flexible** – It does not have sufficient capacity to assess people with learning disabilities
2b. Each time a repeat call is made it 'wipes the slate clean'
3a. System pressure contributing to delayed responses to 999 amber calls
3b. Failings happened because **planned care became an emergency**

Progress

1. Change request submitted to make **improvements to EPCR** to record additional needs and reasonable adjustments
2. Funding application submitted to RCN Wales for video to train staff on best practice during observations and inform patients
3. Continued promotion of Paul Ridd online training modules

Outcome

1.Prototype solution funded by Improvement Cymru LD team
2. 67.8% staff have completed Paul Ridd LD training
3. LD module on WAST's OnClick page completed by 642. Compliments the mandatory Paul Ridd foundation training.

Our Peoples Story

Fatehullah's Story

Given that our engagement activities have highlighted instances of discrimination, we invited one of our Corporate colleagues, **Fatehullah Tahir**, to share his experience of working in an organisation lacking in diversity in terms of ethnicity and faith. Fatehullah is a well respected member of the People and Culture Team and whilst the experiences he described are particularly uncomfortable, he has never asked for action to be taken. The themes shared highlight how important it is to continue listening to colleagues' experiences and recognising that we still have so much to learn. Providing and creating space and developing trust is crucial, so that our people feel safe to share other examples of discrimination and micro- aggressions.

Required Action

1.Increase **cultural competencies**
2.Embrace **Anti-racist** stance and recognise that it is not enough to just not be racist
3.Continued delivery of **Allyship** programme and development of **Bystander** Training
4.Amplify employee **voices**
5.Recognise that this culture has an **adverse effect** on mental health, recruitment and retention
6.Ensure we consider access to prayer facilities at events, roadshows and development programmes

Examples

1.No suitable space for **prayer**
2.*"You don't **look** like you're from Cardiff"*
3.Adapting "Fatehullah" to **"Faz"**

Next Steps

1.Consider reviewing **bank holiday** provision (recognising these are tied to Christian holidays) and explore the possibility of implementing a more flexible approach
2.Further publicise and promote our colleague **networks**
3.Ensure we are pursuing our **Strategic Equality Objectives**

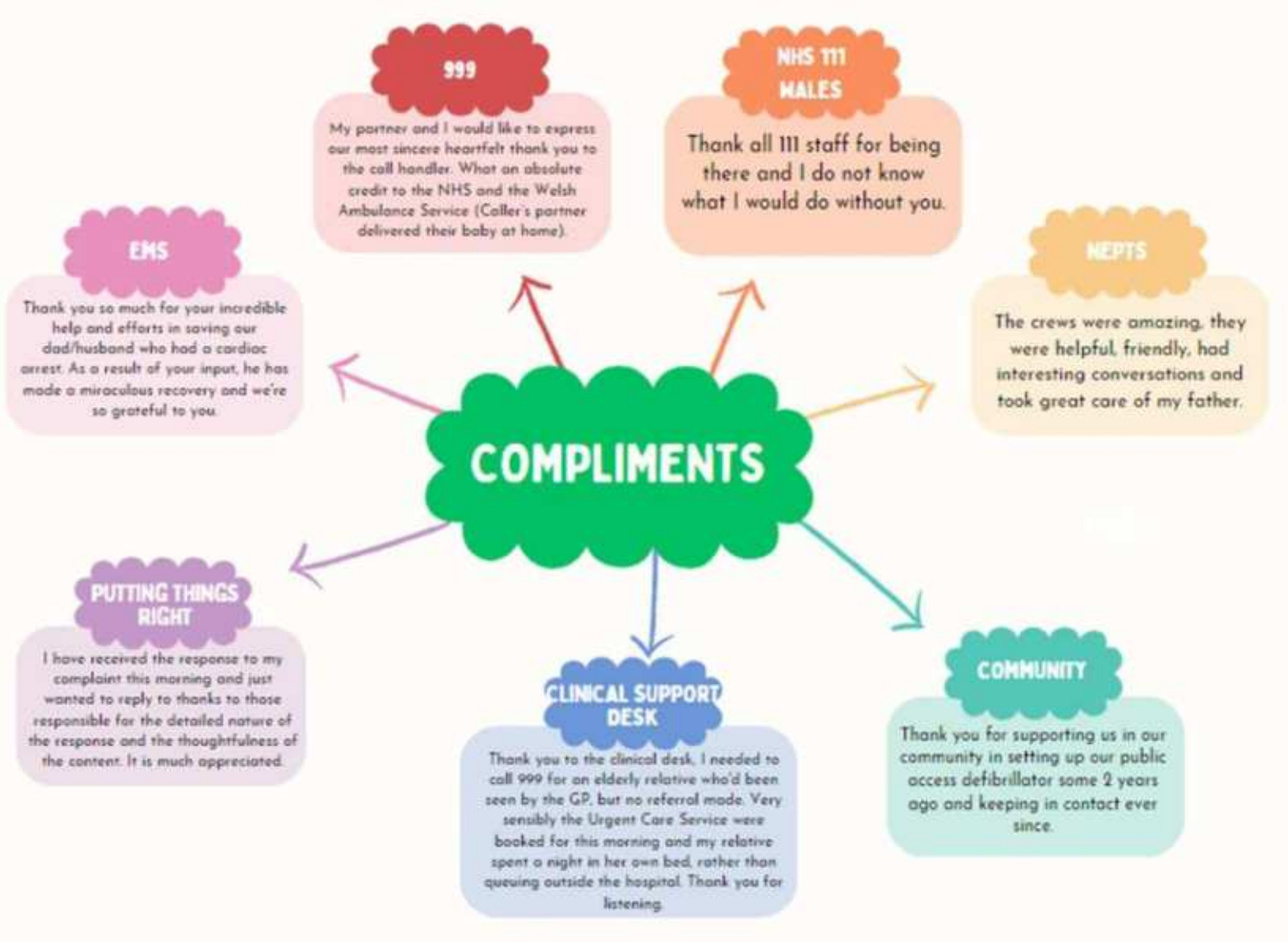
Themes

1. Lack of understanding regarding **faith**
2. Lack of understanding regarding **micro-aggressions**
3.Colleagues having to adjust and adapt to **fit the organisation**

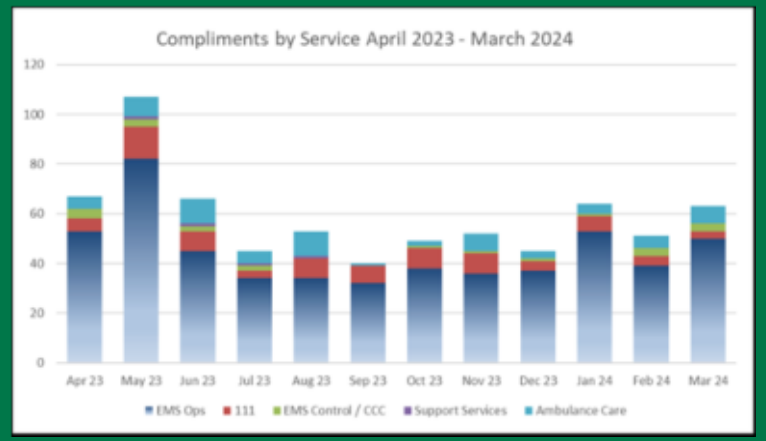
How is Faz now?

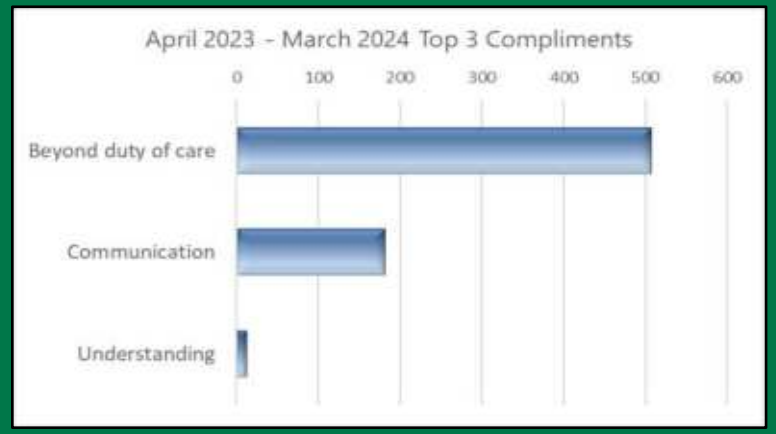
Faz feels it was helpful to share his story which was extremely powerful for colleagues to hear but fundamentally, nothing has changed in the system. Faz is not unhappy at WAST and whilst he's pleased to see these issues being taken seriously, he like the rest of us, is aware that this kind of change is slow.

Compliments



It is important for us to know when something has worked well. This information could assist us in sharing good practice and improving services and is also great for our teams to hear. There will of course be a significant number of compliments that our teams receive on a daily basis which are not necessarily captured in our systems.





Summary Health and Care Quality Standards

Gweithlu Workforce

Commitments to our people

In our 2023-26 Integrated Medium-Term Plan we made a clear commitment to our people to address three key issues that came through feedback from them during engagement opportunities. These key issues were reducing shift overruns which occur primarily due to delays handing over patient care at Emergency Departments, improving their digital experience and improving opportunities for flexible working. Initiatives to improve these areas have made progress but from the feedback staff and volunteers have given us again this year we know these are still as important to them and we have further work to do.

Staff Stories

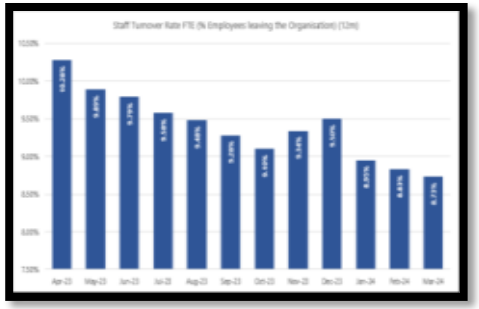
We have continued to work with a range of healthcare professionals, WAST staff and WAST volunteers to record their experiences as staff story videos. These staff stories highlight the challenges and positive experiences of working for the Trust. They are shared internally with the 'People and Culture' Committee and demonstrate areas of good practice, learning opportunities and organisational partnership working.

Personal Appraisal Development Review (PADR)

Our Quality & Performance Monitoring Framework requirements stipulate every member of staff should receive 1to1 feedback and an annual Personal Appraisal Development Review. Challenges achieving this include long term abstraction such as maternity leave or sickness absence. During 2023/24 we have worked to move closer to our target of 85%

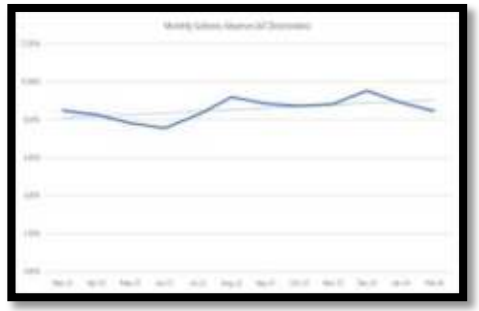
Staff Retention

The number of staff leaving the organisation has reduced throughout the year reporting a 2 year low of 8.8% in March 2024. We continue to focus on staff wellbeing with a number of initiatives in place to help our teams access support. Our wellbeing teams have introduced a new clinical record system that will improve our data around staff wellbeing themes so that we can provide more targeted support in the future.



Sickness Absence

A key workforce area which impacts our ability to deliver high quality services is sickness absence. Having seen an initial improvement during the first quarter of 2023/24 our sickness absence increased between July and December 2023 before improving again in the early months of 2024, some of this is likely to be attributed to seasonal illness. Absence rates are higher amongst our EMS staff and within our contact centre environments. There continues to be a focus on wellbeing activities across all areas of the Trust and in general there has been a downward trend in sickness absence over the last 2 years.



Diwylliant Culture

Throughout the 2023-24 period, our focus has remained on creating a workplace environment characterised by retention, growth, inclusivity, compassion and ethical conduct. At the core of our initiatives is the People and Culture Plan which articulates WAST's cultural aspirations, values and behaviours.

Building on this foundation, we have committed to strengthening employee voice and developing a culture of psychological safety.

Engagement

The introduction of the hive digital engagement survey platform has provided a robust mechanism for capturing invaluable insights and feedback from our employees, enabling us to continuously refine our practices and policies in response to feedback.

Freedom to Speak Up

Our commitment to creating a workplace where individuals feel safe and empowered to speak up has been demonstrated through the launch of the Freedom to Speak Up platform and the establishment of organisational Guardians. Complemented by the WAST Voices Network, these initiatives support in developing a culture of trust, transparency, and accountability, enabling individuals to voice concerns and contribute innovative ideas.

WAST Voices Network

The Voices Network is an employee-led network of advocates set up to provide a safe space for those with lived experience of inappropriate or discriminatory behaviour, bullying or harassment, to better understand the barriers to speaking up and to signpost colleagues to appropriate support.

Cultural Early Warning Score (CEWS)

Understanding whether our teams have a positive workplace culture can be difficult for our leaders and managers. To help make culture more tangible, the People and Culture team have developed a toolkit for managers which guides them through the process of culture change within their team. The CEWS tool uses indicators to help assess the cultural health of the team and is designed as an initial assessment to prompt more in-depth conversations about team culture and potential actions.

Sexual Safety

In 2022 we undertook a survey to understand sexism and sexual safety in the WAST workplace. As part of our commitment to change we shared our story with the media and in August 2023 BBC Wales interviewed a number of WAST staff on this subject. In November 23 we launched our Sexual Safety Guiding Principles, which were developed by our WAST Voices Network. These principles include actively working towards the eradication of sexual misconduct in the workplace and capturing data on prevalence and colleague experience which can be shared transparently. The Guiding Principles are supported by a Managers Toolkit for defining and dealing with safety concerns. The Association of Ambulance Chief Executives (AACE) are focused on reducing misogyny and improving sexual safety in the ambulance service. This is a four nation programme of work which was launched at the Ambulance Leadership Forum held in Wales during October 2023.

Through targeted training and development, we have started a programme of work to equip managers with the necessary tools and resources to navigate complex employee relations scenarios with compassion and fairness, and have prioritised the development of change management expertise, recognising the critical role managers play in supporting people through change.

The continued development and growth of the Culture Champions Network also helps to build change management capacity and to further embed our values and behaviours.

Another significant milestone in our journey towards developing a collaborative approach to change management is the launch and pilot of the 'Manager's Team Culture Toolkit', designed to provide practical resources and guidance for managers so that they are empowered to use collective insights and improve culture at a local level.

Insights™
Teams work better when they all understand each other and communicate with one another. As an organisation we have introduced the Colour Insights programme which works alongside our People & Culture plan by broadening our understanding of our local teams and having more 'in-tune' conversations. Senior Leaders have undertaken the Insights Discovery® process to understand their preferred leadership and communication styles and that of their colleagues. As leaders they can now share this with their team through the Insights Explore® process and understand how they work best together and how they can communicate better with each other and our service users.

Leadership Symposium
As part of our targeted training and engagement to support and develop our leaders we hold a Leadership Symposium twice a year. This allows our senior leaders from across the organisation to come together to share learning and engage on improvements across the organisation. In 2023 the focus was on broadening our understanding of our leadership styles, strengths and value as well as understanding regarding sexual safety.

Visible Leadership
Between April 2023 and March 2024 members of the Trust Board have undertaken 104 visits to our ambulance stations and corporate buildings as part of engagement events, individual visits and observational ride-outs.
In addition, our Trust Board members have attended CEO Roadshow and award events engaging with team members across Wales.

Our WAST way
Content to follow

Gwybodaeth Information

Data into Knowledge

Information & intelligence is used widely throughout the Trust. Executive sub-groups and Board committees are supported in their decision making and escalation with rich reports, dashboards and/or internal Key Performance Indicators (KPI). This allows for triangulation of outcome based, performance based, and people-based intelligence in multiple forums drawing on a single source of truth.
We supply commissioners with an extensive suite of reports and dashboards, as well as direct data feeds to allow scrutiny of operations and inform decision making on performance, outcomes and service user experience.

Quality Management Group

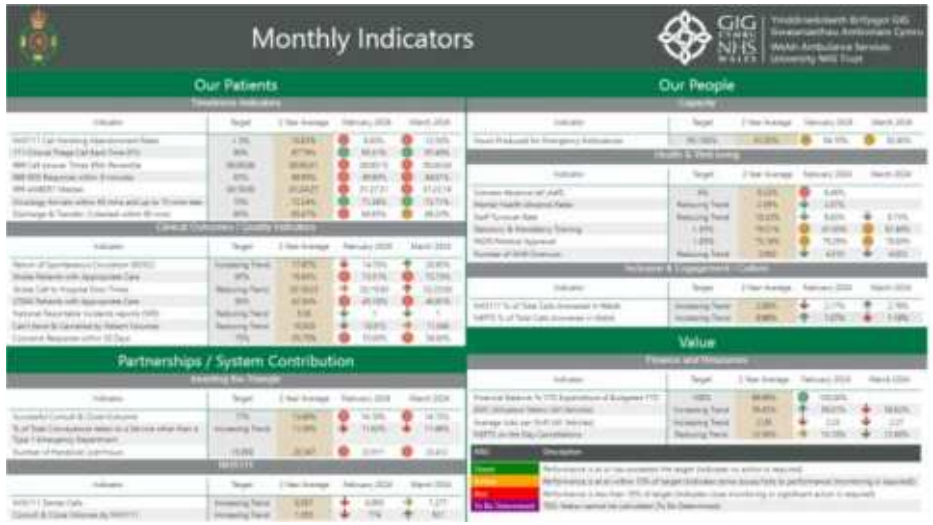
Our Quality Management Group review information and data as part of Quality Control and Quality Assurance activity including service user feedback. This helps us inform and evaluate our Quality Improvement initiatives and plan our strategic intentions for future service delivery.

WAST's Digital Directorate is home to data professionals that span the full data lifecycle - from acquisition and storage, to processing, usage and sharing, and to records management and destruction. Wrapped around this lifecycle are strong Data Quality practices and our Data Protection function.

All data professionals engage with domain experts and information asset owners around the Trust to ensure safe, secure and effective use of the data we hold.

Data Protection

The Information Governance Steering Group, which meets monthly, has delegated authority from the Executive Leadership Team to cover all matters of information security, information governance, records management compliance and Caldicott Principles, and ensures that any data made available is done so lawfully and securely. The Trust's Data Protection policy was approved in the final quarter of 2023/24, and our Data Quality policy is planned to be reviewed by Policy group and go out for consultation in the first quarter of 2024/25.



Always On

Sharing information about the quality of services with the population is an important expectation within the Duty of Quality. 'Always On' means collecting, analysing, monitoring and making information about the quality of services readily available. It promotes openness and transparency with our population and our stakeholders. Our Monthly Integrated Quality and Performance Report (MIQPR) is shared with the Quality, Patient Experience and Safety Committee (QuESt). For our staff this is available on our internal information platforms including through a digital platform supplied by Microsoft called PowerBI. For our service users this is currently available on our website 'About Us' section.

You can also find information about our performance in the Ambulance Service Indicators monthly report from the Joint Commissioning Committee, the NHS Activity and Performance Summary document from Welsh Government and through StatsWales in the Health and Social Care section. The links for all these information sites are on our website 'About Us – Duty of Quality' section.

Next Steps

We are currently undergoing a huge refresh of our reporting functions, creating an internal data / report catalogue so colleagues can find the intelligence they need, and migrating from legacy dashboard tools to PowerBI to increase our accessibility to intelligence, provisions through a single source of truth. This is due to be complete in Autumn 2024.

Ymagwedd systemau cyfan
Whole systems approach

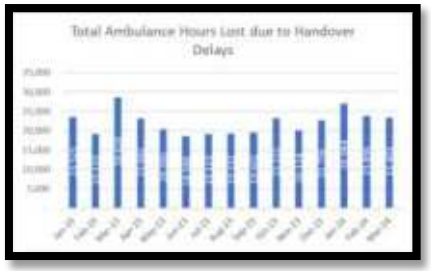
The Trust regularly meet with Health Board colleagues to discuss a variety of quality and performance items to identify best practice, areas of risk and priorities for improvement.

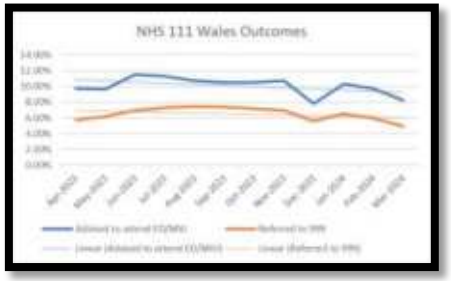
The items discussed include

- Nationally Reportable Incidents
- Joint Investigations & Duty of Candour.
- Mortality Reviews
- Patient Experience
- Falls & Frailty initiatives and progress.
- Safeguarding
- Clinical Indicators & Clinical Audit
- Mental Health, Dementia and Maternity Services

Mobile Xray (Urgent X-Ray Response Vehicle).
In August 2023 the trust, in collaboration with Betsi Cadwaladr University Health Board (BCUHB), delivered and reviewed the feasibility of an at home X-ray urgent response service. The x-ray response team consisted of a Paramedic and Radiographer (trained to undertake an x-ray), with image assessment being undertaken by the Glan Clwyd Hospital radiology team. Although the number of suitable patients during the trial were low portable x-ray was found to be feasible, with good image quality for limbs. The project demonstrated potential scope for system efficiencies but more data is needed.

Hospital Delays
The Trust aims to consider both its impact on the wider system, but also the wider system's impact on the organisation. The impact of delays handing over patient care at emergency departments can have catastrophic outcomes for patients. Whilst showing positive improvement through 2023/24, the length of time ambulance resources lost mean that patients are waiting longer to receive a face-to-face response.





Reducing Hospital Demand
The Trust is working across the whole system to reduce the number of patients taken to our Emergency Departments in an effort to reduce the impact of hospital delays.
Our NHS 111 Wales teams are resolving more calls through alternative outcomes rather than directing patients to Emergency Departments or referring them to EMS services.

Information Sharing
WAST recognise the power of the data we collect for the purposes of system-wide improvement and enhanced direct patient care. The data & analytics function are currently working with partner organisations across Wales, including Digital Health & Care Wales, to progress the strategic ambitions of Welsh Government for a more connected data layer informing our decision-making, learning and accountability. We are currently making the necessary Information Governance arrangements to allow sharing of WAST data with Health Boards and other NHS Wales bodies through the National Data Resource (NDR), with some data pipelines having been tested and the NDR environment ready to receive WAST data.

Palliative Care Paramedics
Our palliative care paramedics recently completed a project with SBUHB that saw them supporting avoidable emergency department admissions for residents of care homes. These highly skilled clinicians responded to care homes across the Health Board to assess and manage residents, working in partnership with SBUHB older persons services and the wider community teams to keep residents in their own care setting and avoid hospital admissions where appropriate.
Following a positive evaluation, WAST have now developed the project further to enable the palliative care paramedics skills to be utilised to the wider community. This dedicated resource is being dispatched to palliative and end of life care patients in all care settings that access 999, with the aim of supporting that patient in the community wherever possible if that is the persons preference.

The Welsh Ambulance Service has had University Status conferred as of 1st April 2024. This is recognition of our longstanding commitment to education, research & innovation. The principles of the Learning Organisation and democratised, equitable development are the key stones of our approach, demonstrating our commitment to the Wellbeing of Future Generations Act 2015

Learning
Learning occurs through a variety of routes both across the Trust and across the health system, but we know this can be improved and in September 2023 we joined the All Wales Enhancing Learning Programme. A framework for learning from events has been developed by the programme members to provide a consistent, but adaptable approach

Education & Assurance
The Workforce Education & Development function uses an established quality management system for all its Internal Quality Assurance (IQA) activity. The IQA hub provides central access to all those involved in the delivery of education in the Trust. The reporting tools in use have been crafted to meet the needs of all our Awarding Bodies reinforcing the focus on quality rather than specific preferences of individual external organisations. The records generated and stored within this space are then used to inform practice as part of scheduled standardisation activities.

Research & Innovation

WAST continues to be an international leader in ambulance services Research and Innovation (R&I) which it achieves through collaboration with many partners, including the NHS Research & Development Leadership Group, National Ambulance Research Steering Group, NHS Innovation leads group, Health and Care Research Wales (HCRW), Bevan Commission and others.

Research in Action
The WAST led Welsh NHS Medical Drone Delivery Network is conducting internationally significant R&I, attracting funding to conduct studies ranging from deployment of defibrillators in Out of Hospital Cardiac Arrest, to using drones in remote search and rescue, and delivering blood. We continue to collaborate with industry and health partners such as Snowdonia Aerospace, the UK Space Agency, Welsh Government, Resuscitation Council (UK), National Institute for Health Research, Welsh Blood Service and many more.

Accessible Learning
During this 2023/24 we have introduced a new Learner Management System (LMS365) that enables us to target and track engagement with eLearning. We have a growing catalogue of Ambulance related topics to better support the understanding and practice of our people.

Next Steps
In relation to Duty of Quality learning, the Trust's vision is to contextualise the Duty to various functions within the organisation. Now all colleagues have the requirement to engage with Duty of Quality eLearning that is hosted on ESR; compliance performance will be measured on an ongoing basis.

To further enhance the understanding gained from accessing this generic eLearning, the Trust will create bite sized eLearning highlighting examples of what quality looks like within specific functions.

Additionally, all road-based staff attend an annual face-to-face Mandatory In-Service Training (MIST) refresher day where they encounter interprofessional scenario-based learning underpinned by the 6 domains of quality; learning experiences centre around provision of a safe, effective, person-centred, timely, efficient and equitable service for our patients.

This model is now in operation across our Volunteer workforce with early stages of extending this approach being considered across all clinical roles.

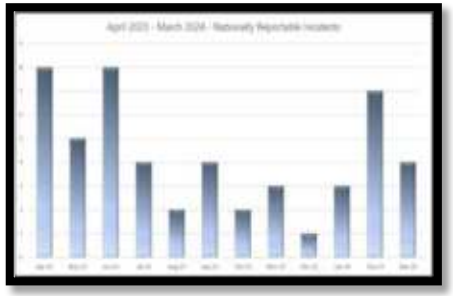
Diogel Safe

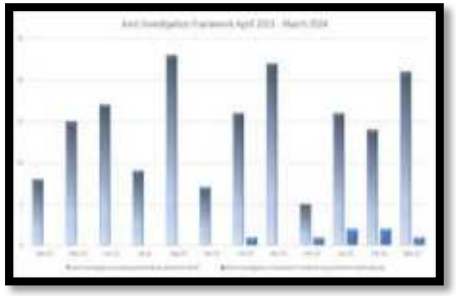
Managing Risks

The Trust monitors Risk within the organisation and the services we provide. Our Board Assurance Framework provides a clear line of sight to the controls, assurances and actions we are able to take to mitigate or reduce these risks for our Trust Board. Our Integrated Medium-Term Plan sets out what we are doing to address our range of corporate risks.

Incident Reporting

Incident reports can be a valuable signal to healthcare providers about where to focus resource and attention to improve patient safety. A good reporting culture in an organisation means that the organisation reports patient safety incidents frequently, reports the more serious incidents that occur but also reports many incidents involving low and no harm to patients, to learn and improve. The Trust reported 46 patient safety incidents which were notifiable under the Duty of Candour Regulations, and overall, 4400 patient safety incidents were reported during 2023/24.



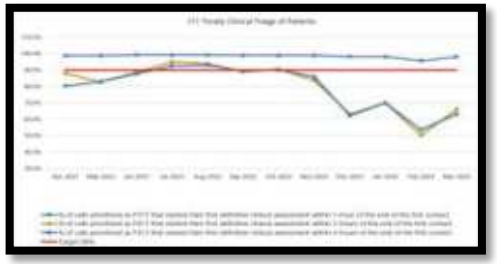


Patient Safety Investigations

The Putting Things Right Team has oversight of patient safety investigations, and these are undertaken internally only or with colleagues as part of the Joint Investigation Framework. During this period 173 investigations were shared with the Health Boards across Wales and 7 investigations were shared with the Trust from Health Boards. The majority of these related to extreme pressures across the healthcare system and handover of care delays

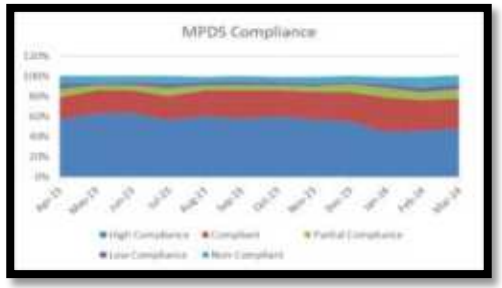
Clinical Assessment

We consistently achieved our target for clinical assessment times of our highest priority patients in the NHS 111 Wales service. Averaging 98.6% of clinical call back within an hour. We have also seen improvement in our lower priority calls compared to the previous year however this performance has deteriorated in the second half of the year following high levels of clinician sickness absence. We are focused on improving this through a number of recruitment and retention initiatives.



999 Call Handling

To prioritise 999 calls our qualified non-clinical call handlers are supported by the Medical Priority Dispatch System (MPDS). This is a scripted question and answer system which is licensed and regulated by the International Academies of Emergency Dispatcher (IAED). As part of our licensing agreement, we audit 1.5% of all 999 calls which helps us identify learning, for individuals and as an organisation, to improve the quality and safety of our services.



Safeguarding Children & Adults

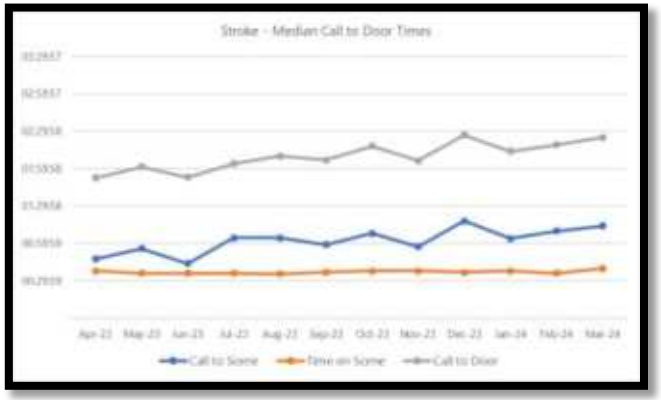
As part of our responsibilities to protect the wellbeing and safety of children and adults who are vulnerable or at risk it is important to report concerns in a timely manner. Our Safeguarding team have continued to implement the digital platform 'Docworks Scribe' to make it easy for our people to submit referrals across the Health and Social Care system. This has now been extended to include prevention referrals for service users at risk of becoming terrorists or supporting terrorism.

Call to Door

We have begun to regularly report on the timeframes associated with Stroke and Heart Attack. These timeframes measure the total time from the 999 call being received to the patient arriving at hospital. We know that timely treatment of these conditions can have a positive impact on patient recovery rates.

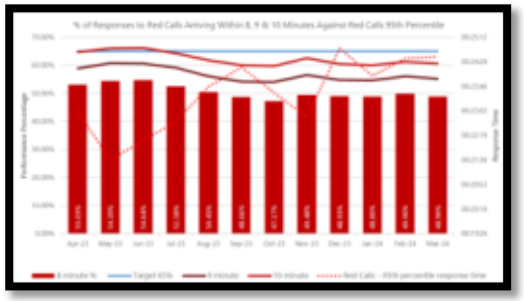
Stroke

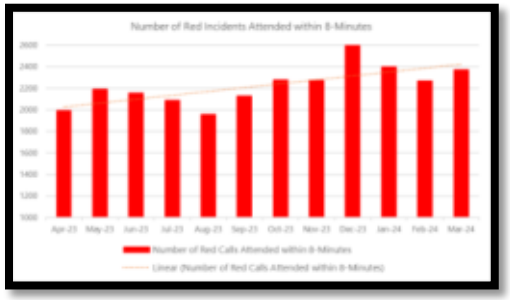
Whilst performance in this area has improved compared to 2022/23, we have seen a gradual decline in performance over the year which is related to the time from your call to our arrival at scene.



Immediately Life Threatening 999 Calls (Red Calls)

The Trust's target is to respond to 65% of immediately life threatening 999 calls within eight minutes. Unfortunately, despite some seasonal changes we have not been able to show long term improvement towards this target during 2023/24. The highest figures achieved was 54.64% in June 23. However, there is a clear increase in the volume of red incidents attended and the stable nature of our Red call performance means that we are getting to more immediately life-threatening calls within this time frame.



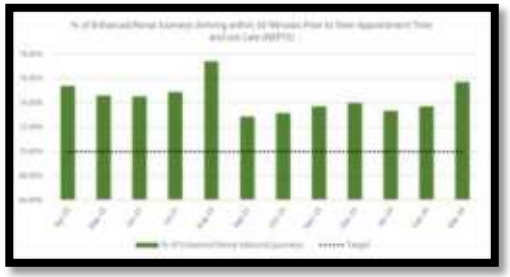


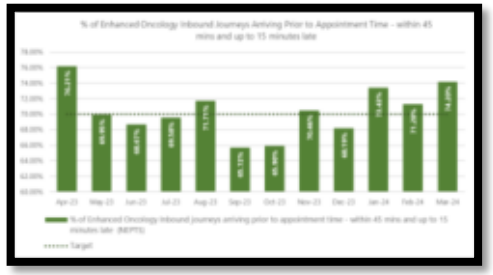
Non-Emergency Patient Transport

New performance standards monitoring whether patients are transported to and from their hospital appointments in a timely manner were introduced in April 2023.

For our Renal patients we have consistently met our target to arrive within 30 minutes of the appointment time and not late, this is despite increased numbers of Renal journeys being booked.

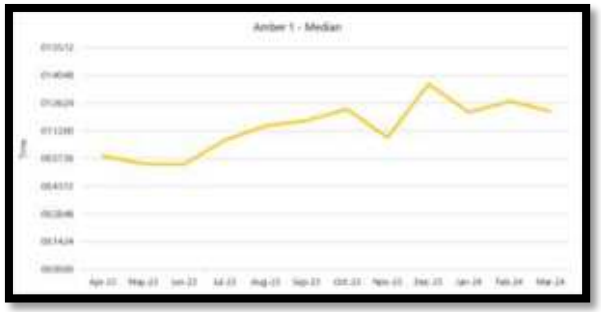
For our Oncology patients our performance has been less stable with our target having been met for 6 months out of the year, however the last quarter has indicated positive improvement, and we are continuing to work collaboratively with our health board partners and Trusts to provide an improved service to patients.





Amber 1

Our Amber 1 category is aligned to patients whose condition is serious but not immediately life threatening and includes stroke and cardiac related chest pain. Whilst there is no specific time-based target for these incidents we would want to respond as quickly as possible. During 2023/24 our response times have gradually increased our data tells us that this increase in response time is in part related to hours lost handing over patient care at Emergency Departments.



Welsh Ambulance Services University NHS Trust

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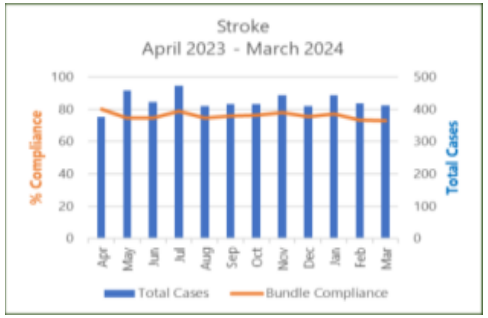
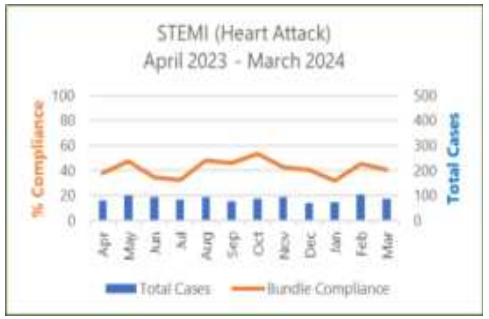
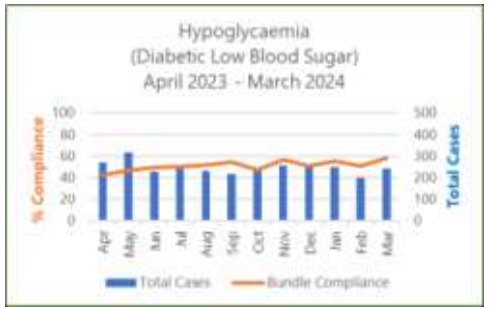
Effective

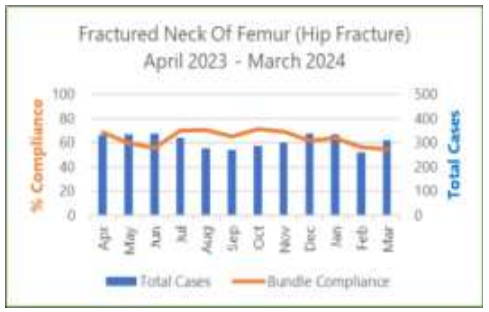
Cymru High Acuity Response Unit (CHARU)

The introduction of the CHARU service allowed experienced paramedics with additional training and medicines to be tasked to a broad mix of high acuity patients including out of hospital cardiac arrests and major trauma. Through 2023/24 we have seen an improvement in Return of Spontaneous Circulation (ROSC) associated with effective treatment for out of hospital cardiac arrests arriving at hospital on average 19.2% per month however this remains lower that we would want.









Clinical Indicators

Following the switch to the electronic Patient Clinical Record (ePCR) the way data is collected when with the patient has changed. These clinical indicator reports are automated and generated from data directly inputted onto electronic Patient Clinical Records by clinicians.

Some of the bespoke areas of the electronic Patient Clinical Record are not being utilised, clinicians are using only the clinical narrative instead. Having detailed information in a narrative has advantages and we encourage this but are also looking at ways to improve data being entered in the bespoke areas to improve data compliance.

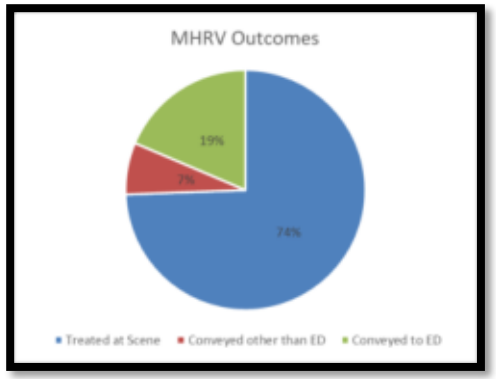
We are exploring options to improve electronic Patient Clinical Record completion and compliance to clinical indicators with prompts when a record is being closed to enable clinicians to easily return to the required area for completion.

A plan has been implemented to improve our clinical indicator compliance including focussed communication with clinicians, clinical workshops, improved clinical supervision and digital enhancements.

Data from ePCR has enabled us to look at developing systems for linking our clinical data with wider healthcare.

Mental Health Response

People experiencing mental health distress who cannot access he care they need often contact us or attend Emergency Departments. Calls involving mental health issues are often complex and take longer to resolve that other health issues, they can also be challenging to manage for general clinicians. In order to support these patients we have introduced a number of service improvements targeted to support patients in the community. We have Mental Health Practitioners on duty in our Clinical Support Desk team for 12 hours a day 7 days a week. This allows us to support patients and direct them to the right care referring them for psychiatric assessment when appropriate. We are also piloting a Mental Health Response Vehicle in partnership with Aneurin Bevan University Health Board to support more patients in the community.



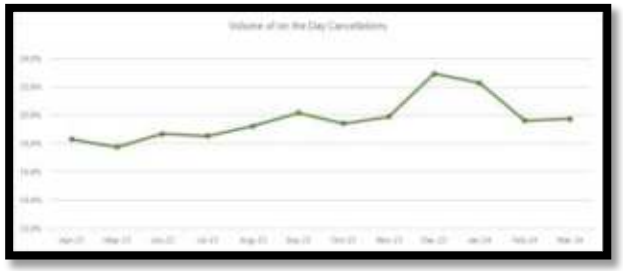
High Intensity Service Users

The national definition for a High Intensity Service User is a patient for whom we record 5 or more incidents a month. As an organisation we monitor frequency of contact in order to assess identify and access appropriate care pathways for these patients to ensure that their needs are managed consistently and equitably through a multiagency approach where appropriate.

In our EMS environment we saw a slight increase in the number of incidents attributed to these patients. In October 2023 we introduced a digital referral system so that our people can identify patients quickly, allowing us to support service users appropriately whilst reducing inappropriate demand on our services.

Cancelling your Request

Our data and information shows that the number of journeys cancelled on the day is increasing.. Most cancellations occur from either on the day booked discharges where the patient is not ready or where the healthcare appointment has been cancelled but no one has updated the transport arrangements. We are working with health board colleagues and in response to your feedback to reduce these issues so that we can plan and utilise our resources efficiently. Improvements made to date have shown an improvement in the last quarter of the year and we continue to identify improvement initiatives to reduce cancellations further.

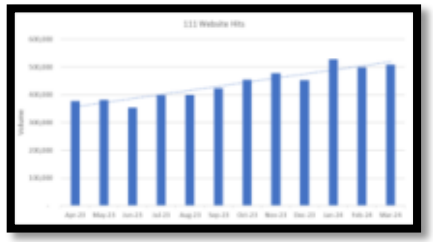


Admission Avoidance

Although we remain focused on supporting patients needs in the community and avoiding conveyance to Emergency Departments, the percentage of patients accessing our services via 999 increased slightly during this period from 34% in 2022/23 to 37.5% in 2023/24.

NHS 111 Wales Website

The NHS 111 Wales Website continues to be a source of information and advice for our service users offering advice, symptom checkers and information about local health services. Through 2023/24 we have seen increased use of this important service month on month however feedback from our service users have told us that their experience of using the website can be poor. We have listened to that feedback and in 2024 we have commissioned review of the current website to identify how we can improve the design, structure, content and reporting to make it a more useful tool.



EMS Rota Abstractions

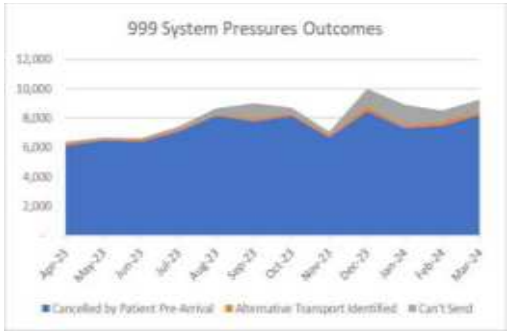
We continue to focus on abstractions management and absence reduction, including a managing attendance programme. The amount of capacity lost due to abstractions has be consistently reducing year on year. In January 2024 we achieved our target for the first time in over four years.

Abstraction metric

Strategic Equality Plan
During the past 6 months we have reviewed our objectives and have undertaken consultation and engagement with staff, service users and stakeholders to help us develop a new plan for 2024-2028. We were keen to learn more about the challenges faced by people with a protected characteristic. We engaged with local sight loss groups, people from local religious groups, homeless cafés, LGBTQ+ communities, Youth Parliaments, Diverse Cymru, British Deaf Association, charitable organisations, and many more. We also engaged with staff, the Executive Leadership Team, Non-executive Directors, and NHS Wales organisations. This engagement has helped us to design a set of objectives that will help us to provide more equitable services and tailor our healthcare services to meet the needs of individuals. The plan also aligns with our new People and Culture Plan which aims to support employee health and wellbeing and improve employee experience.

Learning Disabilities
Our Patient Experience and Community Involvement (PECI) Team have continued to build relationships with people who have a learning disability to learn more about how we can improve access to services and communicate better with people. We have invested in training to develop easy read versions of our communications and have invested in digital technology to help make our website communications more accessible.

System Pressures
At times of high demand, including times when all our resources are already committed to patient activity, we may need to prioritise our services to those patients who need us the most. In these circumstances we may cancel non-emergency transport journeys or ask 999 callers to make other arrangements.



Dementia Friendly Environments
Feedback tells us that people affected by dementia can find it difficult being in our vehicles, particularly if they experience a long delay outside hospital. We are working to create more optimal ambulance environments for people affected by dementia with different pilots across Wales using art, music and reminiscence therapeutic interventions. New design features inside our NEPTS vehicles include dementia-friendly flooring, blinds and colour schemes. Images from the local community will be available on vehicle windows, such as this image of Aberystwyth beach.

Listening & Learning
We have taken steps to monitor concerns and queries being raised by service users and staff which indicate potential discrimination against people with a protected characteristic. We are using this information to identify trends to inform future training and support for staff. Examples of this include:

- Reviewing our procedures for transporting walking aids for our NEPTS patients
- Working with UK Ambulance Trusts to review our guidelines on assistance dogs and emotional support animals on our transport and in the workplace.

Equality Impact Assessments (EqIA)
We have introduced more robust equality impact assessment (EQIA) monitoring procedures with the introduction of a digital impact assessment tool, bespoke one-to-one advice sessions and an online suite of training. We have also strengthened our monitoring procedures via our Policy Monitoring Group who are developing a library of equality impact assessments. Robust impact assessments will help us to identify any negative impacts upon people with a protected characteristic and allow us to adapt our plans and put mitigating actions in place.

Learning from Concerns

Learning from concerns occurs across the Trust and more widely with system partners. Sharing of learning occurs through education & training, dedicated intranet sites and bulletins and notices .

Learning this year has included:

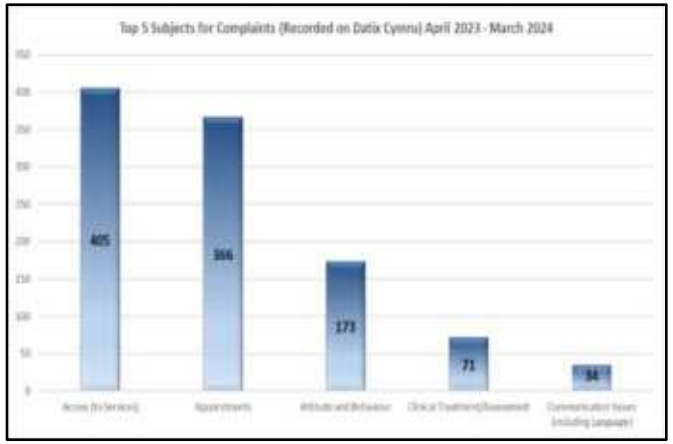
- Implementation / changes in education and training programmes
- Thermoregulation training and improved awareness of the importance of recording the temperature of a newborn and use of relevant equipment.
- Improving clinical documentation on ePCRs.
- Improved awareness of available patient pathways.
- Importance of pre-alert in patients with a reduced Glasgow Coma Scale and high National Early Warning Score (NEWS).
- Learning around criteria for referring patients to minor injury units.
- Awareness of Major Trauma Tool and referral to spinal immobilization guidance.

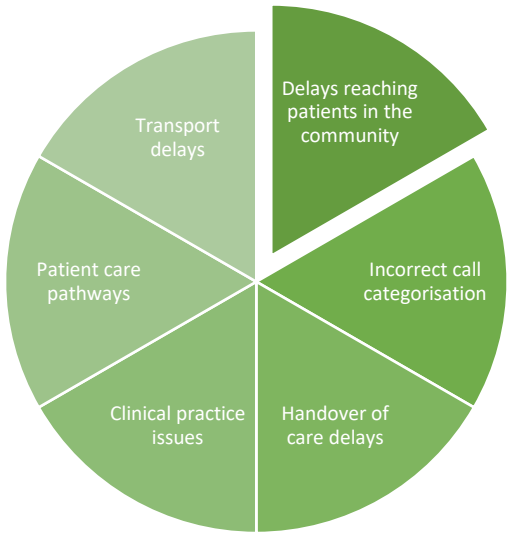
Concerns

The Trust received 1112 complaints during the 2023/24 period of these 26 concerns were referred to the Public Service Ombudsman Wales (PSOW) which is a reduction from the previous year (57). The majority of the issues raised related to timeliness of ambulance response.

The Trust continues to work to address the issues highlighted through our Integrated Medium-Term Plan and there has been significant investment into the Patient & Family Relations and Patient Safety Teams this year to ensure a timelier response to concerns.

Feedback is provided to staff regarding concerns relating to attitude and behaviour and our Clinical Leads undertake clinical reviews of incidents and complaints relating to clinical care and actions / improvements frequently include additional education, training and mentoring.





Themes identified from Concerns

Value Based Health Care

We are committed to Value-Based Healthcare working with colleagues across Wales to determine investments that ensure the most effective use for improved population health outcomes. We are focused on developing meaningful outcome measures which represent what is important to our patients and which capture their experiences. These measures are a key part of our quality control arrangements.

We have worked closely with the Value in Health Centre to understand how we can embed these principles through education and engagement.

2024/25 Transforming our Clinical Service Model

Remote Integrated Care
During the first quarter of 2024/25 we will introduce a new Clinical Assessment Software system to our NHS 111 Wales service, we have been working since November 2023 to bring in an up-to-date resilient infrastructure that will allow us to integrate effectively across our services and with urgent primary care providers to develop a more seamless experience for our service users. We will also expand our clinical workforce for remote clinical decision making to continue improvements delivered in 2023/24 and supporting our commitment to bring your care closer to home. The development of a Remote Integrated Care service would bring our Clinical Support Desk and NHS 111 Wales teams closer together working closely with health board remote clinical hubs to deliver a whole system approach patient care.

Clinical Response Model
We will target our time to develop and agree a new clinical response model that will provide our patients with the right advice and care, the right place, every time and reducing harm. This will include the development of clinically led dispatch decision making to ensure we use our responding resources efficiently and effectively.

Connected Support Cymru
We will continue our journey to connect patients with community-based responders and the clinical expertise available within our clinical contact centres to provide remote clinical assessment through technology enabled health solutions.

Digital Expansion
We will explore how we can enhance and develop our digital services for NHS 111 Wales listening to your feedback of your experiences and engaging with experts to improve our digital offer.

On Scene Community Urgent Response Service
We will explore how we can use our highly skilled clinicians such as Advanced Paramedic Practitioners to better support our patients at home. Having seen important impacts from our trial of Mental Health Response vehicles we will evaluate this and consider how we can further develop our offering to patients in crisis. This alongside our existing responses such as falls assistants and palliative care paramedics will help us provide face to face assessment and treatment working with health boards to integrate with community response services and working with others to develop access to community pathways.

Ambulance Care
We will work with commissioners to agree a strategic vision for the future of Health Transport ensuring that we understand the demands for our services, our commissioning arrangements and the capacity we require to deliver these effectively. This will allow us to review how we align our people and resources to the times when you need us most.

Looking Forward 2024/25

Citizens Voice
We want to understand the experience of the public, patients, their carers and families to understand how they experience the services provided by the Trust. So we will be working to improve how you can give us feedback including QR codes on all fleet vehicles, sharing links to experience surveys through our Putting Things Right teams and exploring how we can share our experience surveys for all areas of our service with you.

Putting Things Right
A Putting Things Right Recovery Plan has been developed to ensure we improve our timeliness in our responses in all matters relating to Putting Things Right. Welsh Government are currently consulting on the Putting Things Right Regulations and following publication of the updated Regulations we will ensure local implementation and monitoring to deliver sustained improvements.

Safety Culture
The Trust Manual Handling Advisor is currently undertaking a deep dive investigation into manual handling incidents over a three-year period. They have identified a number of common causes of MH injuries including the use of a carry chair to move patients. They are currently undertaking investigations into these incidents to identify the mechanism of injury and associated human factors with the aim of producing an improvement plan to be rolled out across the Trust.

EMS Coordination
A range of transformation workstreams, initially identified in the 2019 Demand and Capacity Review, have recently been invested in and recommenced, designed to enhance the stability of the service, improve the experience of our people and deliver a range of efficiency improvements. This includes the implementation of a new career structure that offers more opportunities for the development and retention of staff who want an emergency call handling career. Alongside the enhanced management and career structure we are developing a single allocator model, which will ensure greater efficiency in the allocation and dispatch function, which is in line with the approach taken by other UK ambulances services.

To ensure that there is equity of workload across our three centres we are seeking to carry out a realignment of boundaries and dispatch desks to ensure an equitable flow of work across all of Wales. Finally, to ensure that our resources reflect our demand and workload across Wales we will work with colleagues to build rosters that align to the new structures. These changes together with investment in our estate will provide a structure and environment that will support our aim to deliver our target culture, and importantly, improve the experience of our colleagues working within the EMSC environment.'

Non-Emergency Patient Transport
We are currently reviewing our booking process to reduce the number of non-eligible patients in the system, which have a negative impact on our overall capacity to provide transport for those patients with a clinical need. Work continues to develop and strengthen the focus on delivering and reporting of improved patient experience and service quality.

Learning, Research and Innovation
As we move into University status we will continue to work collaboratively with key partners and research organisations developing research and innovation as a golden threat across all our activities.

Connected Support Cymru

The aim of Connected Support Cymru is to connect patients with community-based responders and the clinical expertise available within our clinical contact centres to provide remote clinical assessment through technology enabled health solutions.

CANOLFAN RAGORIAETH SBRI
SBRI CENTRE OF EXCELLENCE

SBRI Centre of Excellence
During 2023, WAST entered a partnership with the SBRI COE to invite industry and academic partners to develop innovative solutions to our challenge –

'Changing the way we deliver Emergency Care'.

This challenge seeks to use digital technology to enable the Trust to provide care to patients in their own home, in a community setting, or allow integration into Health Board services.

Safe Care Collaborative
Over a focused 15-month period, Improvement Cymru and the Institute for Healthcare Improvement (IHI) are providing services and teams throughout NHS Wales with tailored coaching and support to accelerate existing improvement projects enhancing safe and effective care across the country.

Teams are delivering projects across community, ambulatory and acute care workstreams. This is underpinned by a Leadership for Patient Safety Improvement workstream that is supporting the adoption of the organisational learning systems, culture and working environments required for improvement to flourish.

WAST have been working with Partners across the system to consider opportunities for system wide improvement.

Clinical Intelligence
Shared clinical intelligence will increase visibility of clinical risk and will enable effective prioritisation of resources dependent of clinical need.

Health Boards
Developing a 'care network' through integration will improve management of demand and prevents unnecessary Emergency Department attendances and subsequent inpatient stays.

GIG CYMRU NHS WALES

Social Care
Citizens will be supported to remain mobile and independent within their own homes through maintaining their mobility, reducing long-term demand on social care.

Patients
Clinical triage, assessment and consultation will be provided remotely, enabling the patients to receive care within their own home. If intervention is required, we will aim to support care in a community setting.

Thank you for listening

For any questions and/or support, please contact the Quality Directorate

WG23-09

The Duty of Candour Statutory Guidance 2023

The Health and Social Care (Quality and Engagement) (Wales) Act 2020

Date of issue: 1 April 2023

CONTENTS

GLOSSARY

Interpretation, in this guidance:

- the 2006 Act, means the National Health Service (Wales) Act 2006.
- the 2011 Regulations, means the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.
- the Act means the Health and Social Care (Quality and Engagement) (Wales) Act 2020.
- apology, means an expression of sorrow or regret in respect of the notifiable adverse outcome.
- candour procedure means the procedure set out in the Candour Procedure Regulations that an NHS body must follow in relation to a notifiable adverse outcome.
- Candour Procedure Regulations means The Duty of Candour Procedure (Wales) Regulations 2023.
- Harm includes psychological harm, and in the case of a service user who is pregnant, loss of or harm to the unborn child.
- health care, means services provided in Wales under or by virtue of the 2006 Act for or in connection with—
    - (a) the prevention, diagnosis or treatment of illness.
    - (b) the promotion and protection of public health.
- illness, has the meaning given in section 206 of the 2006 Act.
- NHS body means—
    - (a) a Local Health Board.
    - (b) an NHS Trust.
    - (c) a Special Health Authority.
    - (d) a primary care provider.

- notifiable adverse outcome occurs when the duty of candour comes into effect in accordance with section 3 of the Act.
- service user, means a person, to whom health care is being or has been provided by an NHS body, who has suffered an adverse outcome.
- Special Health Authority means a body established under section 22 of the 2006 Act; but does not include any cross-border Special Health Authority (within the meaning of section 8A (5) of the 2006 Act) other than NHS Blood and Transplant.
- A person is a primary care provider in so far as (and only in so far as) the person provides health care on behalf of a Local Health Board by virtue of a contract, agreement or arrangement under Part 4, 5, 6 or 7 of the 2006 Act between the person and the Local Health Board.
- A service user is to be treated as having suffered an adverse outcome if the user experiences, or if the circumstances are such that the user could experience, any unexpected or unintended harm that is more than minimal.

- Review: a review is the clarification of the incident that has been reported and an assessment as to the level of harm that has occurred or could occur to the individual service user by a senior member of staff to assess whether the threshold for triggering the duty of candour has been met. This is sometimes referred to as approving the incident.
- Investigation: the in-depth examination (additional enquiries as listed in the Candour regulations) undertaken to understand what has occurred and any root causes and learning as outlined in the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.
- For the purposes of this guidance and making the links with the Candour Procedure Regulations the term service user/person acting on their behalf is referred to in the Regulations as the 'relevant person.' NHS body is referred to in the Regulations as the 'responsible body.'
- Datix Cymru is a reporting and management digital platform for incidents and concerns and part of the Once for Wales Concerns Management System Programme, which includes Datix Cymru and CIVICA Experience Wales.

FOREWORD

The introduction of the duty of candour through the Health and Social Care (Quality and Engagement) (Wales) Act 2020[1] ('the Act'), highlights the Welsh Government's commitment to safe, effective and person-centred health services. The duty is placed on NHS Bodies (Health Boards, NHS Trusts, Welsh Special Health Authorities and NHS Blood and Transplant in relation to their Welsh functions) and on primary care providers in Wales in respect of services they provide under a contract or other arrangements with a Local Health Board.

The focus of the duty in the Act is ultimately to serve service users by ensuring that if the service user experiences, or if the circumstances are such that the service user could experience, any unexpected or unintended harm that is more than minimal, and the provision of health care was or may have been a factor, the service user, (or person acting on their behalf), is informed, provided with an apology and offered details of relevant services or support. The NHS body is also required to provide the service user/or person acting on their behalf with an explanation of the actions that the responsible body or the provider will take, and further enquiries that the responsible body or the provider will carry out, to investigate the circumstances of the notifiable adverse outcome, including any actions to be taken under the Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011[2].

[1] Health and Social Care (Quality and Engagement) (Wales) Act 2020
https://www.legislation.gov.uk/asc/2020/1/contents

[2] The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011
https://www.legislation.gov.uk/wsi/2011/704/contents/made

Wales is not the only UK jurisdiction to have a duty of candour. In England, the duty is set out at Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014[3]. In Scotland, it is set out in Part 2 of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016[4].

Our overarching policy objective, in line with our aspirations in a Healthier Wales[5] for more integrated care, is to ensure that whether a person receives care from the NHS, or from a regulated provider of health care services, that person can be assured that they will be dealt with in an open and honest way by their care provider.

In social care, a duty of candour already exists for providers and responsible individuals of regulated services under the 2017 Regulations[6].

Separate work is being taken forward to make Regulations to place a duty of candour on providers of independent health care in Wales, using powers under the Care Standards Act 2000[7]. We have enjoyed incredibly positive engagement with representatives of the independent health care sector in Wales and it is intended to collaborate with them to introduce a duty of candour that applies to the independent health care sector in Wales, with a projected coming into force date of April 2024.

We know the overwhelming majority of providers of health care services, want to deliver high quality, safe and compassionate care. However, equally, we know that despite these intentions, inevitably in complex and multi-faceted services, from time to time, people will suffer harm.

When they do, the way in which NHS Bodies, deal with these situations becomes especially important and can make an enormous difference to people's experience and to their ongoing relationship with their care provider. This is particularly important in health care settings where people often have long standing relationships with their care providers. Trust is hard to gain, but easy to lose. Being open and honest should be at the heart of every relationship between those providing, receiving and/or experiencing treatment and care.

[3] The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (SI 2008/2936). https://www.legislation.gov.uk/ukdsi/2014/9780111117613/regulation/20

[4]Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 https://www.legislation.gov.uk/asp/2016/14/contents

[4] Welsh Government 2018 A healthier Wales: long term plan for health and social care **https://gov.wales/healthier-wales-long-term-plan-health-and-social-care**

[6] Welsh Government the Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017 https://www.legislation.gov.uk/wsi/2017/1264/contents/made

[7] The Care Standards Act 2000 https://www.legislation.gov.uk/ukpga/2000/14/contents

1. Chapter 1 - Introduction and Purpose

Introduction

1.1 The Act will come into force on 1 April 2023. It is a lever for improving and protecting the health, care and well-being of the current and future population of Wales. It aims to ensure a stronger citizen voice and to improve the accountability of services to deliver a better experience and quality of care. Doing so contributes to a healthy and more prosperous country. In totality, the Act is intended to have a cumulative positive benefit for everyone in Wales, supporting a culture and the conditions that focus on driving improvements in health care.

1.2 This statutory guidance is aimed at helping the NHS Bodies to deliver the requirements of the duty of candour.

1.3 The legal basis for the duty is set out in Part 3 of the Act. Section 3 prescribes when the duty of candour applies. Section 4 requires the Welsh Ministers to make Regulations, which set out the procedure that NHS Bodies must follow when the duty of candour is triggered. Sections 5 to 8 prescribe the reporting requirements. These sections of the Act are considered in more detail further in the guidance.

1.4 Compliance with the duty of candour will also facilitate compliance by Local Health Boards, NHS Trusts and Special Health Authorities with:

- the duty of quality contained in section 2 of the Act, requiring Bodies to exercise their functions with a view to securing improvement in the quality of health services.
- the socio-economic duty[8] introduced by the Equality Act 2010[9], requiring Bodies to have due regard to the desirability of exercising their functions in a way that is designed to reduce the inequalities of outcome which result from socio-economic disadvantage; and
- the well-being duty within the Well-being of Future Generations Act (Wales) Act[10] 2015 to conduct sustainable development.

1.5 The duty of candour supports all people in Wales, and information about it is accessible to them. It encourages better decision making and ultimately aims to deliver better outcomes for all people who access health services. It requires NHS Bodies to involve people in decisions that affect them and to facilitate preventative action, thereby improving the quality of services and looking to the long term.

[8] Statutory Guidance: The Equality Act 2010 (Authorities subject to a duty regarding Socio-economic Inequalities) (Wales) Regulations 2021 https://business.senedd.wales/documents/s113354/CLA5-07-21%20Paper%2023.pdf

[9] 2010 Equality Act https://www.legislation.gov.uk/ukpga/2010/15/contents

[10] Well-being of future generations (Wales) Act 2015 https://www.futuregenerations.wales/about-us/future-generations-act/

1.6 The prevailing intention is therefore to build on the work that has already been achieved through better reporting and proportionate investigation of incidents, in line with the new National Patient Safety Incident Reporting Policy[11] and the introduction of the Putting Things Right[12] process for investigating Concerns and Complaints. The move to implement a more structured organisational duty of candour that is supported by statutory guidance and the Candour Procedure Regulations supports the further development of the culture of openness within the NHS in Wales.

PURPOSE OF THE GUIDANCE

1.7 Being open with service users and their representatives when things go wrong in their care is the right thing to do. The duty of candour is designed to create a safe environment that is supportive and empowering to those providing, receiving and/or experiencing NHS treatment and care.

1.8 In this guidance the word **must** refers to actions that are a legal requirement as set out in the Candour Procedure Regulations or in Part 3 of the Act. The remainder of the guidance is designed to provide a framework of best practice to assist NHS Bodies in the implementation and application of the duty.

1.9 In accordance with section 10 of the Act, NHS Bodies must have regard to the guidance when exercising functions related to the duty of candour. To 'have regard' means that those to whom the Duty applies will have to be familiar with it and demonstrably take its principles into account when making any relevant decisions with regard to incidents or concerns relating to service user health care. Should Bodies to whom the Duty applies decide to depart from the guidance set out here, any such departure should be properly reasoned and rational and balanced against their legal obligations under the Act.

1.10 The guidance contains illustrative examples and case studies to assist NHS Bodies to understand when the duty of candour is triggered and offers step by step procedure flow charts.

1.11 It also includes guidance for NHS Bodies' on compliance with the duties placed upon them with regard to reporting, which is a key element of the duty of candour.

[11] Welsh Government, May 2021 National Patient Safety Incident Reporting Policy https://du.nhs.wales/patient-safety-wales/patient-safety-incidents/

[12] Welsh Government 2011 putting things right Guidance on dealing with concerns about the NHS from 1 April 2011 version 3. https://nwssp.nhs.wales/ourservices/legal-risk-services/legal-risk-services-documents/general-medical-practice-indemnity-gmpi-docs/healthcare-quality-guidance-dealing-with-concerns-about-the-nhs/

1.12 The guidance provides the foundation for NHS Bodies to develop local policies and procedures, and training and support requirements that are tailored to the body and/or the particular services they provide and will help to achieve consistency of approach and equity of response in effect: an ‘All-Wales model’.

1.13 The guidance will be complemented by an online training package to support NHS Bodies with the implementation of the duty. Building on the work that has already been started as part of the Putting Things Right process to embed candid behaviour, the Welsh Government training programme considers how to encourage the “cultural shift” by making openness and transparency a normal part of the culture across NHS Bodies in Wales.

1.14 The guidance is also intended as a reference for service users and their representatives. Leaflets are available to ensure that everyone in our community can access materials that will empower them to ask questions about the care and services they receive, to help them understand what the duty of candour means, and what they can expect from their care providers when it is triggered.

1.15 It is not intended to be a definitive interpretation of the legislation on duty of candour. The Act, Candour Procedure Regulations and the Duty of Candour guidance should be read together.

1.16 We also recognise the Act, Regulations and the framework around it, whilst important, is only one part of the process. It is also necessary to overcome the known barriers to an open and honest culture for the duty of candour to become truly embedded. The barriers include fear, a culture of secrecy and/or blame, lack of confidence in communication skills, fears that people will be upset and doubt that disclosure is effective in improving culture. Disclosure can also be inhibited by fear of blame, professional or institutional repercussions, legal liability, negative reactions and a lack of accountability.

1.17 A system without artificial barriers between NHS Bodies, where care and support are person centred, where staff are supported to improve care rather than just manage or deliver it, and where there is an emphasis on accountability, will help to overcome these barriers.

2 Chapter 2 – The Application of The Duty of Candour

Statutory duty of candour and existing professional duties of candour

2.1 There have been calls to place a duty of candour[13][14][15][16]on NHS Bodies in Wales, separate from, and complementing the non-statutory duties of candour that apply to a range of healthcare professionals as part of their professional regulation. Although, it should be acknowledged that professional Duty of candour guidance applies in more situations than the Welsh organisational Duty of Candour.

2.2 Healthcare professionals who are subject to a professional duty of candour have to be open and honest with service users, colleagues, their employers and relevant organisations, and must take part in reviews and investigations when requested. They must support and encourage each other to be open and honest[17].They must also be open and honest with their regulators, raising concerns where appropriate. The fundamental principles of a duty of candour are therefore already embedded across a wide section of NHS Bodies through those professionals who work within them.

2.3 The statutory duty of candour and the professional duties of candour have the same aims – to be open and transparent with people receiving care and treatment. The strong links between the statutory and professional duties of candour will empower staff to speak openly about concerns, and seamlessly encourage learning to improve the quality-of-care provision.

2.4 The professional duty of candour relates to individual professional practice whereas the statutory organisational duty is placed on an organisation to ensure that when triggered service users have the same openness and transparency about what has occurred with their care applied by the organisation.

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[13] Kennedy, I, and others. The Bristol Royal infirmary inquiry. Learning from Bristol - The Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995 [Internet]. Crown; 2001. Available from: https://webarchive.nationalarchives.gov.uk/20090811143822/http:/www.bristol-inquiry.org.uk/final_report/the_report.pdf

[14] Donaldson, L. Making Amends - A consultation paper setting out proposals for reforming the approach to clinical negligence in the NHS [Internet]. Department of Health Publications; 2003. Available from: https://webarchive.nationalarchives.gov.uk/20120809195448/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4060945.pdf

[15] Francis, R, and others. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry [Internet]. Staffordshire NHS Foundation Trust; 2013. Available from: https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry

[16] Evans, K. "Using the Gift of Complaints" - a review of concerns (complaints) handling in NHS Wales. 2014. https://gweddill.gov.wales/docs/dhss/publications/140702complaintsen.pdf

[17] Nursing and Midwifery Council and General Medical Council 2022 Openness and honesty when things go wrong: the professional duty of candour. https://www.nmc.org.uk/standards/guidance/the-professional-duty-of-candour/read-the-professional-duty-of-candour/#about_guidance

2.5 The statutory duty will promote a system wide culture of openness and honesty. It also places a requirement, at an organisational level for NHS Bodies, to follow a set procedure, underpinned by the Candour Procedure Regulations to evidence that a series of prescribed actions have been undertaken when the duty is triggered. These actions are described in Chapter 3 below, which is supported by a procedure flow chart found in **Annex C**. This infrastructure will help create the conditions for NHS Bodies to discharge the duty of candour with confidence when triggered. There are case studies in annex H which provide some clinical examples.

2.6 Pharmacists and pharmacy technicians
Registered pharmacists, pharmacy technicians and persons working under their supervision in a retail pharmacy should continue to be mindful of the provisions of the Pharmacy (Preparation and Dispensing Errors – Registered Pharmacies) Order 2018 ("the Order")[18]. Pharmacy professionals are at risk of prosecution under section 63 (adulteration of medicinal products) and section 64 (protection of purchasers of medicinal products) of the Medicines Act 1968[19] in the event that they prepare or dispense medicines erroneously.

2.7 In order to benefit from the defences in section 67B (defence to offence of contravening section 63(a) or (b): product sold or supplied) and section 67C (defence to offence of contravening section 64) of the Medicines Act 1968, the conditions for benefitting from the defences must be satisfied, including the conditions relating to notification of the person to whom the product was intended to be administered.

2.8 Consequently, the requirements of the Order need to be considered alongside and in addition to the statutory duty of candour.

WHO DOES THE DUTY OF CANDOUR APPLY TO?

2.9 The duty of candour within Part 3 of the Act applies to the following NHS Bodies which are listed within section 11(3), and defined by reference to section 11(4) and (7):

- Local Health Boards.
- Primary Care providers in Wales (i.e. General Practitioners, dentists, optometrists and pharmacists) in respect of the services they provide under a contract or arrangement with a Local Health Board (i.e. it applies to the NHS services provided by primary care providers).
- NHS Trusts in Wales.

[18] The Pharmacy (Preparation and Dispensing Errors – Registered Pharmacies) Order 2018. https://www.legislation.gov.uk/uksi/2018/181

[19] Medicines Act. https://www.legislation.gov.uk/ukpga/1968/67/contents

- Welsh Special Health Authorities, and NHS Blood and Transplant in relation to the functions it exercises in relation to Wales.

WHEN DOES THE DUTY OF CANDOUR PROCEDURE APPLY?

2.10 The duty comes into effect in relation to an NHS body if **both** of the following conditions are met:

(1) The **first condition** is that a person (the "service user") to whom health care is being or has been provided by the body has suffered an adverse outcome.

2.11 'Health care' means services provided in Wales under or by virtue of the National Health Service (Wales) Act 2006 i.e. as part of any NHS service, for or in connection with:

- the prevention, diagnosis or treatment of illness; or
- the promotion and protection of public health.

2.12 "Illness" includes any disorder or disability of the mind and any injury or disability requiring medical or dental treatment or nursing.

2.13 The meaning of health care is deliberately widely drawn to capture all of the NHS services provided in Wales.

2.14 A service user is to be treated as having suffered an adverse outcome if the user experiences, or if the circumstances are such that the user **could** experience, any unexpected or unintended harm that is more than minimal.

2.15 As set out in the Explanatory Notes to the Act, the duty may be triggered by an action taken by an NHS body during the provision of health care or by an omission to take action.

2.16 For the purpose of the duty of candour, harm includes psychological harm, and in the case of a service user who is pregnant, loss of or harm to the unborn child (section 11(7) of the Act).

(2) The **second condition** is that the provision of the health care was or may have been a factor in the service user suffering that outcome.

2.17 The outcome must therefore relate to the provision of the care by the NHS body rather than being solely attributable to the person's illness or underlying condition - see further in chapter 2.

2.18 It need not, however, be certain that the health care caused the harm. It is sufficient that the health care may have been a factor.

2.19 In the Candour Procedure Regulations when both of these conditions are satisfied and the duty is triggered, it is called a “notifiable adverse outcome.” **Annex A** sets out in flow chart form the trigger review process.

3 Chapter 3 – Establishing the level of harm

More Than Minimal Harm

3.1 “More than minimal harm” is not defined in the Act. However, for the purposes of this guidance “more than minimal harm” is considered to constitute moderate harm, severe harm and death. This supports the existing processes for Putting Things Right and Being Open and also aligns with the national patient safety incident reporting policy and the Datix Cymru system, incident reporting module. Therefore, in practice, the duty of candour is triggered if the service user experiences, or the circumstances are such that the user could experience, unexpected or unintended harm that is of moderate degree or above and the provision of health care was (or may have been) a factor in the service user suffering that outcome.

3.2 Moderate Harm: is 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 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.

3.3 Severe Harm: is 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.

3.4 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’s illness or underlying condition

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3.5 A level of harm framework, providing explanations of harm that are considered moderate and above, is included in **Annex B**.

Harm that is ‘unintended’ or ‘unexpected’

3.6 To be notifiable, the harm must be unintended or unexpected. It can be as a result of either an actual intervention/treatment, or an omission in care, for example, a missed cancer diagnosis.

3.7 Medical or surgical treatment and all care interventions may of course come with inherent risks or may in itself cause a temporary increase in symptoms.

3.8 Harm which is caused by the treatment itself (e.g. impairments in function as a result of surgery,) would not necessarily be notifiable. These may fall into the category of a known risk, which may have been explained to, and accepted by, the patient as part of the consenting process.

Side effects and complications

3.9 It is not the policy intention that all side effects to medication or treatment that have caused harm or yet may cause harm would necessarily trigger the duty of candour Firstly the harm threshold has to be met and the harm must be unintended or unexpected as outlined above. In essence complications associated with care that was not discussed as a risk of the health care provided may meet the trigger threshold for the duty. There are well established mechanisms for reporting and monitoring the side effects and adverse reactions of medication which will still need to be followed and learned from whether the duty is triggered or not.

3.10 It is often unclear in the initial stages whether unintended or unexpected harm has or may occurred and discussion as part of a senior review is recommended where the situation is complex.

Intentional harm

3.11 The majority of patient safety incidents that may lead to the triggering of the duty of candour often involve a conversation between managers and supervisors about whether a staff member involved in a patient safety incident requires specific individual support or intervention to continue to work safely. The implementation of action singling out an individual is rarely appropriate - most patient safety issues have deeper systemic causes and require wider action.

3.12 The Williams Report which reported on gross negligent manslaughter in the NHS highlights this approach[20] and recommended the establishment of a 'Just Culture' providing reassurance to healthcare professionals, patients and their families that gross negligence cases will be dealt with in a fair and compassionate manner and the subsequent just culture algorithm supports these discussions[21].

3.13 However there are rare situations where it becomes clear that individual performance or actions or omissions may have breached professional codes of practice or criminal law and are not part of a wider patient safety

[20] Williams N (2018) Gross negligence manslaughter in healthcare the report of a rapid policy review. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/717946/Williams_Report.pdf

[21] NHSE and NHSI (2021) Just culture guide. https://www.england.nhs.uk/wp-content/uploads/2021/02/NHS_0932_JC_Poster_A3.pdf

organisational cause or action. It is imperative that the enactment of the duty of candour doesn't interfere with urgent police investigation or safeguarding multi agency strategy meetings and may be necessary that there is a consideration of a delay for the 'in-person' notification. Discussion with lead investigators prior to any further disclosure is recommended. Regulation 12 of the Candour procedure regulations allows for this.

What does harm the service user 'could experience" mean?

3.14 It is important to note that the duty is triggered not only when harm is known to have occurred, but also in cases **where the circumstances are such that a person could experience harm that is more than minimal in the future from an incident that has already occurred.** For example, where an error in the administration of medication that was administered may cause harm that is more than minimal at a future point.

3.15 NHS Bodies will have to reach a judgment about whether the circumstances are such that the user could experience harm that is more than minimal. In the example of an error in the administration of medication, whether or not such an error may give rise to harm that is more than minimal may be dependent upon the nature of the medication that was given in error or the circumstances of the particular service user

3.16 To put this in context for practitioners, this has been explained by the GMC in their professional duty of candour guidance as, 'in situations where a patient 'may yet suffer harm' as a result of an adverse outcome.

3.17 **Annex H** contains illustrative case studies that set out detailed examples of instances that would trigger the duty of candour and those that would not. It also contains examples of cases that demonstrate the duty being triggered where harm could occur in the future. (Case studies, 9, 10 & 11).

NEAR MISS INCIDENTS

3.18 These are any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to people receiving NHS-funded care in Wales. Near miss incidents are **not** considered a trigger for the duty of candour procedure. The duty is designed to capture more than minimal harm that is apparent at the time of the incident or may appear later. With a near miss incident, harm (or the potential for future harm) is averted. This is often as the action that would have induced the harm was stopped from occurring or avoided.

3.19 For example, the administration of the wrong medication was averted through an additional step or the intervention of another and so it did not occur.

The difference between a near miss and an incident where harm could yet occur is that in an incident where harm could yet occur the action has occurred however the harm has yet to manifest.

3.20 However, due to their serious nature and the need to learn from such incidents and prevent their recurrence, near miss incidents should be managed following the normal reporting processes[22].

3.21 Even though the statutory duty of candour under the Act is not triggered by a near miss, individual practitioners should familiarise themselves with the guidance on near misses provided by their professional regulatory Bodies. For example, both the Nursing and Midwifery Council[23] and the General Medical Council [24] provide guidance and support to practitioners on when and how to speak to service users about near miss incidents.

Harm that occurs to Service Users whilst waiting for diagnostics or care from the NHS

3.22 Since the Global SARS-CoV-2 Pandemic in 2020 there has been continued significant pressure on resources within the NHS and subsequently many more patients are awaiting diagnostics, procedures and care on NHS waiting lists. Care will need to be taken when considering harm that occurs while a service user is waiting for their treatment. Every step in a clinical pathway will entail a waiting time, which may be longer at times of significant service pressure.

3.23 Where a service user suffers harm whilst on a waiting list, this could **potentially** trigger the duty of candour.

3.24 For a Service User to be on a waiting list for a diagnosis or treatment there must usually be a referral which involves an assessment and clinical decision. In placing the Service user on the waiting list there will have been some consideration of the likely risk of waiting and the best interests of the service user in the prevailing service context. The service user is therefore considered to be

[22] NHS Delivery Unit (2023) Patient Safety incidents. https://du.nhs.wales/patient-safety-wales/patient-safety-incidents/

[23] NMC and GMC (2019) Openness and honesty when things go wrong: the professional duty of candour https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/openness-and-honesty-professional-duty-of-candour.pdf.

[24] GMC (2023) Being open and honest with patients in your care, and those close to them, when things go wrong https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/candour---openness-and-honesty-when-things-go-wrong/being-open-and-honest-with-patients-in-your-care-and-those-close-to-them-when-things-go-wrong#paragraph-21

under the care of a consultant or primary care physician and there is often active monitoring of the waiting list which involves an element of clinical input and judgment which also amounts to the provision of health care.

3.25 However, the other key components that must be satisfied before the duty is triggered is that the service user to whom health care is being or has been provided by the body has suffered an "adverse outcome," and that the provision of the health care was or may have been a factor in the service user suffering that outcome. A service user is to be treated as having suffered an adverse outcome if the user experiences, or if the circumstances are such that the user could experience, any "unexpected or unintended" harm that is more than minimal.

3.26 An example of this in practice is where a service user with angina is placed on a well-managed waiting list for a bypass procedure and suffers a heart attack while waiting. In this scenario the duty may not apply if the harm was as a result of the natural deterioration in their condition. This is because disease progression in itself would not necessarily trigger the duty of candour and the risk of that progression would normally be discussed with the service user. This doesn't mean that the service user shouldn't receive an apology and explanation of what has happened as a matter of best practice. However, if the service user had been mistakenly missed off the list or incorrectly prioritised, therefore creating an undue delay, which gave rise to the adverse outcome then the duty might apply.

3.27 Waiting lists should be actively managed, and new clinical decisions should be taken when the known risk changes to minimise harm to the service user. The materialisation of a risk that is known to the service user and clinician, in itself would not necessarily trigger the duty of candour.

3.28 The initiation of the duty of candour is designed to respond to a service user/ or person acting on their behalf, in an open and transparent way when things have or may have gone wrong in their care. These actions, as previously referenced, are not an admission of liability or breach of statutory duty.

3.29 It is strongly encouraged that, when more than one NHS body engages in the pathway of care, the NHS Bodies involved must work together in partnership to deliver the duty of candour procedure and are fully involved in the process. See chapter 6

4 Chapter 4 – The Candour Procedure

4.1 The Candour Procedure Regulations prescribe the actions that **must** be taken by an NHS body when the duty of candour is triggered.

4.2 This section of the guidance needs to be read in conjunction with those Regulations, and the procedure flow chart included in **Annex C**.

Notification

4.3 The Act and Candour Procedure Regulations require NHS Bodies to notify on **'first becoming aware'** that the duty of candour has come into effect and not to wait for the findings of any initial investigation before notification.

4.4 It is important to note that regulation 4 of the Candour Procedure Regulations requires the NHS body to notify the **service user** who has suffered a notifiable adverse outcome or a **person who is acting on their behalf** (in the Candour Procedure Regulations[25], this person is called the "relevant person").

4.5 Notification may be made to a person who is acting lawfully on the service user's behalf, where the service user:

- has died.
- is 16 or over and lacks capacity (within the meaning of the Mental Capacity Act 2005) in relation to the matter; or
- is under 16 and not competent to make a decision in relation to their care or treatment. (Also refer to Chapter 7)

4.6 The Candour Procedure Regulations also allow a service user with capacity to nominate a trusted person to act on their behalf in relation to the duty of candour, recognising that not everyone to whom the duty applies will want to engage personally with the process.

4.7 It is important to ensure that at all times the requirements of the UK General Data Protection Regulation (UK GDPR[26]) are adhered to when accessing, processing and disclosing service user information. In cases where a representative is acting on behalf of a service user with capacity, consent for the representative to act should be obtained in writing and be kept under review throughout the process. This is also in line with the 2011 Regulations.

What does on 'first becoming aware' mean?

4.8 The requirement to notify the service user/person acting on their behalf on first becoming aware the duty has been triggered means that the NHS body should reflect and make a considered decision as to whether the conditions as set out in part 4 above have been met. Once determined by the NHS Body that the conditions as set out in part 4 above have been met, this would be considered to be the point at which the NHS body '**first becomes aware**' that the duty has been triggered.

4.9 This is the start date for the duty of candour procedure (referred to in this Guidance and the appendices as "the procedure start date"), which **must** be

[25] National Health Service Wales (2023) The Duty of Candour Procedure (Wales) Regulations 2023.

[26] UK Government (2018) Data Protection Act 2018. https://www.legislation.gov.uk/ukpga/2018/12/contents

followed, starting with the ‘‘‘in-person’’’ notification to the service user/person acting on their behalf.

4.10 Each NHS body should have a robust and consistent process in place for determining whether reported adverse outcomes (incidents) trigger the duty or not. **This does not mean that NHS Bodies investigate the circumstances of the reported incident before making this decision.** There will need to be some reflection and decision making on the part of the NHS body before deciding if the duty has been triggered, but not a detailed investigation. It is important that arrangements are in place for organisations that provide services on behalf of NHS Bodies to ensure that the NHS body is notified of any trigger of the duty of candour (refer to chapter 6).

4.11 The use of the Datix Cymru system is not mandatory. However, its rollout and development has been designed to support the implementation of the duty of candour and it is available, to all NHS Bodies including all primary care providers.

4.12 Consequently, it is anticipated, and encouraged, that NHS Bodies report incidents through the Datix Cymru system. There is a prompt on the system to ask those completing/and or reviewing the incident report whether or not the duty of candour has been triggered and to record the level of harm and the system also facilitates the documentation of reasons that the duty wasn’t triggered.

4.13 NHS Bodies will need to develop a system for locally undertaking the ‘review’ of those incidents that have initially been reported as meeting the criteria for triggering the duty of candour, i.e. where it is thought the conditions as set out in Chapter 2 above have been met. This could, for example, be as simple as recording that on review and after consideration, it was agreed that the threshold for more than minimal harm has been met or that it has not been met or that the harm was not unexpected or the harm that was suffered was not related to the provision of the health care.

4.14 **Therefore, the duty of candour procedure start date is the date on which an NHS body first becomes aware of a notifiable adverse outcome.**

4.15 Where the ‘‘in-person’’ notification is made later than 30 working days after the date the NHS body first becomes aware of a notifiable adverse outcome, which would be the candour procedure start date, an explanation should be provided and the reason for the delayed notification should be recorded on the incident report. This would be a rare occurrence but may happen where the duty of candour is triggered by a case review or a medical examiner review.

4.16 **This does not mean that the NHS body has routinely a 30-day period in which to deliver the ‘in-person’ notification.** The Act is clear that the NHS body must take all reasonable steps to deliver the ‘‘in-person’’ notification as soon as they become aware of the notifiable adverse incident.

4.17 Considering how this would apply in practice, the "sequence of events" would be as follows:

- a service user suffers harm related to (or potentially related to) treatment.
- staff are free to apologise, explain what has happened to the service user/family as they should do to comply with their professional duties of candour.
- they report the "incident" (in the majority of cases using Datix Cymru).
- Datix Cymru prompts consideration of whether the duty of candour is triggered.
- If, in the view of the person reporting the incident, it is felt that the duty is triggered by recording on the Datix Cymru incident module that moderate or above harm has been caused or could be caused, an openness and transparency section will automatically open allowing the reporter to record further information in line with the duty of candour procedure requirement.
- If it is determined that the duty of candour has not been triggered, even though the moderate or above harm has been caused or could be caused, a note of the reasons for reaching such a decision must be recorded on the incident report in Datix Cymru.
- All incidents are reviewed internally by the NHS body (except where health care is provided by a commissioned or hosted partner).
- For those where it is agreed the conditions for meeting the duty of candour (set out at Chapter 2 above) are met, then notification of the service user is initiated.

How to notify

4.18 Notification to the service user or person acting on their behalf should be '"in-person"'[27] which means communication on the telephone, via audio-visual communication (such as a video call) or face to face. It is considered many service users would be surprised to receive a letter in the post advising them the duty had been triggered and may have questions/worries that will need to be answered/alleviated immediately. Leaving voice messages, is also not considered appropriate when making the '"in-person"' contact. Experience from recent stakeholder sessions also demonstrates that an '"in-person"' approach for the first contact is most appropriate.

4.19 However, NHS Bodies have a discretion as to which method of '"in-person"' communication is most appropriate. It may not be achievable in practical terms for there to be a face-to-face meeting with everyone in relation to whom the duty of candour has been triggered. The NHs body should consider each circumstance and identify the preferences of the service user/person acting on their behalf and make every effort to meet these where possible.

4.20 The factors that an NHS body must consider when determining which form of '"in-person"' notification is most appropriate are:

[27] In accordance with regulation 4 of the Candour Procedure Regulations.

a) severity of the harm.
b) nature and complexity of the notifiable adverse outcome.
personal circumstances of the service user (if known)

c) any communication already undertaken with the service user/person acting on their behalf
d) any known preferred method of communication of the service user/person acting on their behalf. This is particularly important where the service user may require support, for example where Welsh is the first language of the service user or their family or BSL or a foreign language interpreter may be needed.

4.21 In some situations, the initial notification via the telephone or video call may suffice; in more complex cases it is likely to be more appropriate for a face-to-face meeting with the service user/person acting on their behalf to be arranged.

4.22 The NHS body must take reasonable steps to establish the preferred method of communication. They must also take reasonable steps to ensure that communication is in a manner that the service user/person acting on their behalf can understand[28]. NHS Bodies are subject to Welsh Language Standards requirements as set out in the Welsh Language Standards (No. 7) Regulations 2018[29]

4.23 It is recognised that in some instances, the preferred method of communication or service user contact preference, may not be known at the outset; establishing contact via the telephone may be necessary in the first instance to begin dialogue on what steps might need to be taken to allow the duty of candour procedure to be followed.

Who notifies and the purpose of the notification

4.24 The NHS body will need to determine the most appropriate person or persons to make the initial '"in-person"' notification to the service user/person acting on their behalf. The NHS body needs to consider whom is the most appropriate person or persons to make the initial '"in-person"' notification to the service user/person acting on their behalf.

4.25 Primarily, the initial contact with the service user/person acting on their behalf, is to acknowledge what has happened and offer a meaningful, personalised apology for the harm they have experienced or may yet experience and provide advice on what will happen next. (Refer to annexe E and other professional resources on communicating an apology).

4.26 The NHS body must nominate a person with sufficient knowledge, experience, training and understanding of the duty of candour procedure to be able to assist

[28] See regulation 7 of the Candour Procedure Regulations.

[29] The Welsh Language Standards (No. 7) Regulations 2018 The Welsh Language Standards (No. 7) Regulations 2018 (legislation.gov.uk)

the service user/their representative with any questions that may arise as they go through the process, this is the “nominated point of contact”.

4.27 Regulation 4 of the Candour Procedure Regulations prescribes what **must** be covered in the initial ‘“in-person”’ notification.

4.28 The person making the initial contact with the service user/person acting on their behalf must:

- clearly explain what information they know so far about what has happened.
- outline why the NHS body is of the view the duty of candour has been triggered.
- provide an apology. Guidance on how to make a meaningful, personalised apology is set out below and in Annex E.
- provide the contact details of whom is the nominated point of contact for the NHS body. The nominated point of contact is the person the service user/person acting on their behalf will contact if they have any questions about the duty of candour process.
- provide an explanation of the actions and further enquiries the NHS body will undertake to investigate the circumstances of the notifiable adverse outcome. This includes any actions the NHS body (or where services have been commissioned from an independent provider in Wales, the provider) will take under the 2011 Regulations. The investigation of the notifiable adverse outcome is considered further at Chapter 5.
- communicate to the service user/person acting on their behalf details of any services or sources of support which the NHS body reasonably thinks may be of assistance to them, taking account of their needs. **Annex D** sets out useful contacts for support options.
- Document this in the service users care record and on datix Cymru.

4.29 Regulation 4 also requires the person making the ‘in-person’ notification to provide an explanation to the service user/person acting on their behalf if the date on which the ‘in-person’ notification is made by the NHS body is more than 30 working days after the date on which the NHS body first became aware of the notifiable adverse outcome. This is to explain any delay in notification that could arise, for example, following a retrospective case review. <u>The law requires that the NHS body makes the ‘“in-person”’ notification on first becoming aware of the notifiable adverse outcome and therefore it does not mean that NHS Bodies routinely have 30 working days from the date the notifiable adverse outcome occurred to make the ‘“in-person”’ notification.</u>

4.30 It is also good practice to establish what the service user/person acting on their behalf understands about what has happened. The person making the notification on behalf of the NHS body should also demonstrate they understand the circumstances and the impact for the person affected. They should not question the extent of harm suffered by the person affected or the circumstances of the ‘incident’ as the service user has experienced it.

4.31 This may be the starting point for longer conversations with the service user/person acting on their behalf and it will be important for all involved that this

initial contact is carried out in the true spirit of the duty, with openness, empathy and sincerity.

4.32 *Things to consider* – ***Before the '"in-person"' notification takes place:***

- has someone from the NHS body already been in contact with the service user/person acting on their behalf? This may be related to this incident or other aspects of their healthcare.
- what discussions or information exchange have already taken place (if any)?
- what is known about what has happened and the level of harm sustained or could be sustained?
- is the preferred method of notification known? e.g. verbal, written, electronic; it is recommended to check any previous datix, Welsh clinical portal, Welsh PAS or care records.
- who will be the nominated point of contact within the NHS body following the initial notification?
- what support is available to the service user/person acting on their behalf, to assist them during the notification process and afterwards?
- ensure that communication is in a manner that the service user or the person acting on their behalf, can understand including Welsh if that is their first language.
- Consider the location of the conversation if it is to be face to face or via video call to ensure privacy and confidentiality are maintained.
- It should also be recognised that a service user may have a number of questions relating to their care and the presence of a member of the clinical team may be prudent

Follow up in writing

4.33 Following the '"in-person"' notification, regulation 5 of the Candour Procedure Regulations requires the NHS body to take all reasonable steps to write to the service user/person acting on their behalf (unless they have indicated they do not wish to engage in the candour process) within five working days after the day of the 'in-person' notification. Notification in writing includes notification via email.

4.34 The aim of the written notification is to confirm in writing what has been discussed at the '"in-person"' notification. This is to aid the understanding of the service user/person acting on their behalf, and also to provide the NHS body with a record of what has been discussed.

4.35 Therefore the written must include:

- a description that explains clearly what information is known so far about what has happened
- a reiteration of the verbal apology,
- the information provided in the 'in-person' notification, which for completeness is as follows:
    - the reason that the NHS body considers that the duty of candour has been triggered.

- the name and contact details of the person at the NHS body nominated as the point of contact for the service user/person acting on their behalf in respect of the duty of candour procedure,
- an explanation of the actions that the responsible body or the provider will take, and further enquiries that the responsible body or the provider will carry out, to investigate the circumstances of the notifiable adverse outcome, including any actions to be taken under the 2011 Regulations
- a reiteration of the offer of details of relevant services or support, and
- where the ‘‘in-person’’ notification is made later than 30 working days after the date on which the NHS body first became aware of the notifiable adverse outcome, an explanation of the reason for the delay.

- Document this on Datix Cymru

4.36 Consideration should be given to personalising the notification letter with a handwritten signature. It has been suggested during focus sessions with members of the public that a handwritten signature has a positive impact when an apology of this nature is being conveyed.

4.37 The NHS body **must** take all reasonable steps to send the written notification to the service user/person acting on their behalf within **five working days** following the date of the ‘‘‘in-person’’’ notification.

4.38 It is important to acknowledge that delayed or poor communication makes it more likely that the service user/person acting on their behalf, will seek information in a different way, for example, by making a complaint or taking legal action. It may also mean that they will not feel that there has been openness and honesty in the process from the outset.

The Apology

4.39 Making a meaningful, personalised apology is a key part of the ‘‘‘in-person’’’ notification process. **Annex E** provides further information on making an apology as part of the duty of candour procedure.

4.40 A meaningful, personalised apology can be a practical way of maintaining or restoring trust. When conveyed with empathy, sincerity and understanding, an apology can be effective and powerful and it is crucial for everyone involved when the duty of candour is triggered, including the service user/person acting on their behalf, and the staff who care for them. The impact on everyone involved when the duty of candour is triggered cannot be underestimated. For the service user/person acting on their behalf, an apology is usually the most important action that any one individual and organisation can take, and it is important that a timely apology is given in accordance with the regulations.

4.41 People who feel that they have not been listened to or informed openly and honestly from the outset are more likely to feel that the harm they have suffered has been compounded and can lead to the loss of trust in their health care provider. This can result in feelings of anger and cause a break down in the relationship. It may also mean that escalated action is taken.

4.42 It is recognised that there may be misconceptions and misunderstanding that the provision of an apology equates to an acceptance of blame, culpability or even legal liability[30].

4.43 This is not the case, and it should not give rise to any such assumption or hinder or delay the offer of an apology.

4.44 "Apology" is defined within regulation 2 of the Candour Procedure Regulations as:

apology means an expression of sorrow or regret in respect of the notifiable adverse outcome.

4.45 Regulation 13 specifically provides that an apology or any other step taken in accordance with the candour procedure does not amount to an admission of negligence or to a breach of statutory duty.

4.46 The giving of an apology acknowledges what has happened or at this stage what is known to have happened and provides assurance, the matter is being taken seriously and opportunities for learning will be taken to prevent similar circumstances from arising in the future. It is important to ensure the apology covers what is known at that point without speculating or including assumptions on what may have happened or caused the incident to occur. It is helpful to admit at this early stage that a lot may be unknown but that more detail is likely to become clearer during the investigation that follows.

4.47 We recognise that sometimes staff can find it difficult to say sorry when harm has occurred or may occur at some point in the future. They may be unclear if they can say sorry and worry that the timing for doing this will not be right, or that they will make things worse, especially as the service user/person acting on their behalf, may be understandably angry and upset. **Annex E** aims to provide guidance to support staff in this regard.

4.48 It is best practice to document the verbal apology in the patient care record. This means that the entire care team will know when an apology has been given and can avoid duplication.

Notification of results of further enquiries

4.49 Regulation 6 of the Candour Procedure Regulations requires NHS Bodies to notify the service user/person acting on their behalf of the results of any further enquiries (investigations) carried out by the NHS body that may have been referred to in the ''in-person'' notification. These enquiries are understood to be the investigation that is to be undertaken by the NHS body.

[30] Compensation Act 2006 section 2. https://www.legislation.gov.uk/ukpga/2006/29/contents

4.50 In practice, in the vast majority of cases once the service user/person acting on their behalf has been notified, the NHS body will undertake further enquiries and investigate the circumstances in which the duty of candour came into effect in accordance with the provisions of the 2011 Regulations. NHS Bodies will be familiar with this process as it governs the way in which incidents are currently investigated.

4.51 Communication with the service user/person acting on their behalf under the provisions of the 2011 Regulations, which includes a requirement to outline in writing the outcome of investigations, will also satisfy the requirements of regulation 6 of the Candour Procedure Regulations, so avoiding duplication in the event that the 2011 Regulations apply.

4.52 As set out below in Chapter 5, the 2011 Regulations do not apply to all NHS Bodies – for example, they do not apply to NHS Blood and Transplant. Additionally, there may be exceptional circumstances where the 2011 Regulations do not apply. In these circumstances, NHS Bodies should ensure that they have arrangements in place to enable them to comply with the notification requirements in regulations 4, 5 and 6.

Communication with service user/person acting on their behalf

4.53 Regulation 7 prescribes what an NHS body must do if it is unable to make contact with the service user or a person acting on their behalf to:

(i) make the '"in-person"' notification (regulation 4),
(ii) the written notification (regulation 5),
(iii) to notify of results of further enquiries (regulation 6),

or if the service user or person acting on their behalf declines to participate in communication with the NHS body.

4.54 If the NHS body, having taken reasonable steps, is unable to make contact, the attempts to make contact must be recorded as part of the information that is required to be kept by virtue of regulation 9 (Records), see guidance on record keeping below. Ideally the information should be recorded on the incident record, which in most circumstances will be datix Cymru.

4.55 If the service user/person acting on their behalf, indicates that they do not wish to communicate with, or receive information from the NHS body, this must also be clearly recorded in accordance with regulation 9 and the person's wishes respected. Again, good practice would be to record this on the incident record (datix Cymru), and also on the service user's care records.

4.56 In accordance with regulation 7(3)(b) of the Candour Regulations NHS Bodies are not required to provide information to or communicate with the service user/person acting on their behalf in these circumstances where they have indicated that they do not wish to communicate with or receive information from the NHS body. However, the investigation of the incident giving rise to the

triggering of the duty must continue so that lessons can be learned, and quality improvements made.

4.57 The NHS body should inform the service user/person acting on their behalf that they can contact the NHS body should they change their mind about their involvement in the process.

4.58 The NHS body must take reasonable steps to ascertain the service user/person acting on their behalf's preferred method of communication and, where reasonably practicable, communicate with them by this method.

4.59 The NHS body must take all reasonable steps to ensure that any communication with the service user/person acting on their behalf is in a manner they can understand this is especially important where disability is present or where the service user is a vulnerable adult or child or young person.

Support and Training

4.60 it is important to recognise that the service user or person acting on their behalf may be very affected by the information contained within the 'in-person' notification and will need ongoing support as they come to terms with the impact on them of the harm that has occurred or may occur as highlighted in chapter 4.

4.61 NHS staff go to work to provide high quality care to those in need of care and treatment. When a service user suffers an adverse outcome and the duty of candour is triggered, it is important to recognise that staff involved in the care of the service user will also be impacted and may require support.

4.62 Regulation 8 of The Candour Procedure Regulations sets out the requirements in relation to training and support.

4.63 The requirements are for relevant training and guidance to be given to all staff involved in:

- the provision of health care; and
- investigating or managing notifiable adverse outcomes, and
- any other relevant members of staff who engage in performing or exercising functions in connection with the duty of candour procedure.

4.64 As well as all clinical staff, in practice this would include senior staff (including Board level staff) responsible for overseeing the management of adverse outcomes in their organisations, those directly involved with the investigation, management and/or notification of notifiable adverse outcomes and any other staff who deal with complaints and concerns. At primary care level this would for example include practice managers.

4.65 Training modules will be developed nationally in liaison and are available via digital platforms to all NHS staff including primary care providers.This guidance document and annexes provide all the relevant support documents to assist NHS Bodies in discharging their duty in respect of ensuring staff awareness of the duty of candour.

4.66 The Candour Procedure Regulations also set out that the NHS body must provide a member of staff who engages in a notifiable adverse outcome with details of services or support available, taking into account:

- the circumstances relating to the notifiable adverse outcome; and
- the staff member's needs.

4.67 NHS Bodies will have mechanisms in place and local support services available to pro-actively offer the appropriate provision of support and assistance to staff members through their Employee Wellbeing Service/Occupational Health/Employee Assistance Programmes.

4.68 In addition there are several national support services available via the Health Education & Improvement Wales (HEIW) website[31], such as Health for Health Professionals (Canopi)[32], SilverCloud[33] and Samaritans[34].

4.69 Local Line Managers, Clinical Supervisors, Workforce and OD professionals (including employee wellbeing and occupational health colleagues) and Trade Union representatives will also be able to signpost staff to appropriate support services.

Record keeping

4.70 Section 4(3)(c) of the Act requires the Candour Procedure Regulations to prescribe the records that NHS Bodies must keep in relation to the discharge of the duty.

4.71 Regulation 9 of the Candour Procedure Regulations requires NHS Bodies to keep an accurate written record for each notifiable adverse outcome in respect of which the candour procedure is followed.

4.72 The written record must include every document and piece of correspondence relating to the notifiable adverse outcome, not limited to:

- the notification of the duty.
- attempts to contact the service user/person acting on their behalf.
- any decision by the service user/person acting on their behalf not to be contacted in relation to the duty of candour; and
- all documentation relating to the review to establish whether the duty has been triggered and the subsequent investigation of the notifiable adverse outcome, that is undertaken by the NHS body, including the response or interim report issued under regulations 24, 26 or 31 of the 2011 Regulations.

[31] HEIW (2023) Workforce support. https://heiw.nhs.wales/support/
[32] Canopi (formally Health for health professionals) https://hhpwales.nhs.wales/about-us/
[33] SilvercloudWales. https://nhswales.silvercloudhealth.com/signup/
[34] The Samaritans 2023 https://www.samaritans.org/

4.73 It is considered good practice to record any decision not to trigger the duty (where triggering was contemplated). It is important that accurate records are kept supporting quality assurance mechanisms needed to identify areas for learning and improvement and also to enable NHS Bodies to comply with their reporting requirements under the Act which are considered in part 11 below.

4.74 It is envisaged that the Datix Cymru system will be used for the purposes of reporting and recording keeping.

5 Chapter 5 - The Investigation

5.1 When notifying the service user or person acting on their behalf that the duty of candour has been triggered, an NHS body must (in accordance with regulations 4(3)(e) and 5(3)(c) of the Candour Procedure Regulations) also give an explanation of the actions and further enquiries it will take to investigate the circumstances of the notifiable adverse outcome.

5.2 In the vast majority of cases, this means following the 2011 Regulations procedure for investigating concerns. “Concerns” as defined in the 2011 Regulations includes all patient safety incidents.

5.3 However, there will be instances where, even though the duty of candour applies, an investigation under the 2011 Regulations will not be required. For instance, the 2011 Regulations do not apply to NHS Blood and Transplant, they will follow their internal procedures for investigating patient safety incidents.

5.4 In relation to an investigation under the 2011 Regulations, as is currently the case, the investigation must be proportionate, conducted openly and efficiently and the focus should be on improving quality, safety and sharing learning.

5.5 The service user/person acting on their behalf should be invited to contribute to the terms of reference of the investigation and contact should be maintained throughout the investigation, if this is what has been agreed. The preference of the service user/person acting on their behalf should be considered as not everyone will want to be involved to this extent.

5.6 The outcome of the investigation will be communicated to the service user or their representative in accordance with regulation 24 of those Regulations or, in the case of care provided by Health Boards, NHS Trusts or Welsh Special Health Authorities, in line with regulations 26 and 31 where the redress arrangements have been applied.

5.7 Consideration should be given to whether the incident should be reported to other Bodies e.g. an employer or professional regulator, the Medical Examiner service or HM Coroner. Additionally the incident may meet the National Reportable Incident threshold and be reported to Welsh Government.

5.8 Staff involved in the treatment or care that resulted in the duty being triggered should, where appropriate, be involved in the investigation process and also be

advised of the final outcome. Further information in relation to the investigation and record keeping can be found in **Annex F**.

5.9 There have been some amendments to the 2011 Regulations to make them compatible with the duty of candour. The principal amendments are set out in regulation 14 of the Duty of Candour Procedure Regulations. Their effect is to ensure that both the duty of candour and the PTR procedures work in harmony and to ensure that there is not any duplication of processes.

6 Chapter 6 - Complex Arrangements and The Duty of Candour

Where more than one NHS body may be involved in the Duty of Candour procedure

6.1 It is often the case that a range of NHS Bodies engage in an episode of care where the duty of candour is triggered. **Annex H** has case study examples for reference.

6.2 Although not all of the Bodies involved in the provision of an episode of care will necessarily be the 'providing body' in terms of the legislation (i.e. their provision of health care did not or does not have the potential to trigger the duty of candour) they may need to become involved in providing information as part of a review or providing support for the service user/person acting on their behalf. All parties must co-operate fully in an open and facilitative manner throughout the duty of candour procedure and share with each NHS body any learning identified as a result of the subsequent investigation/ review, including any actions to be taken with a view to preventing similar circumstances from arising in the future.

6.3 There may also be occasions where several NHS Bodies each are providing health care to a single service user and each trigger the duty of candour procedure for multiple 'notifiable adverse outcomes' in relation to a single course of treatment. **Annex H** has case study examples for reference.

6.4 In such circumstances, it would be best practice for the NHS Bodies to seek to communicate with the service user/person acting on their behalf to gain the appropriate consent, in line with UK GDPR, to undertake a co-ordinated approach to notification. Otherwise, there is a risk the service user or person acting on their behalf will feel overwhelmed or confused by the process if they get multiple notifications. This is particularly important where the harm is Severe, or a death has occurred.

6.5 The aim should be to make the process as easy as possible for those involved and, in particular, for the service user or person acting on their behalf.

6.6 However, each NHS body (providing body) still has its own responsibility under the Candour Procedure Regulations and must ensure and be able to evidence

that, as individual organisations, they have complied with the requirements of those Regulations.

6.7 Where there are multiple NHS Bodies involved in the duty of candour, the subsequent investigation is undertaken as detailed in regulation 17 of the 2011 Regulations. Regulation 17 deals with concerns involving more than one responsible body. It places a duty on responsible Bodies (subject to obtaining the relevant consents from the service user or person acting on their behalf) to cooperate for the purposes of coordinating the handling and investigation of concerns and the provision of a coordinated response.

6.8 If an NHS body discovers that an incident that would trigger the duty of candour procedure has occurred in a different NHS body, the NHS body that discovers the 'incident' should inform the NHS body where the 'incident' occurred so that the latter can then implement the duty of candour procedure. The NHS body that discovers the 'incident' must also be open and transparent with the service user about what they have discovered. However, they are not required to perform the specific duty of candour procedure; this should be conducted by the responsible NHS body, i.e. the 'providing body' where the duty of candour was triggered.

Mixed Care Delivery Between NHS Bodies and Social Care Organisations

6.9 *Where a service user is receiving care from an NHS body and a provider of social care (whether in a mixed model of delivery or separately), it is possible that multiple providers may have contributed to the harm that has been caused to the service user. In such cases each provider will have its own responsibilities under the duty of candour (or its equivalent for providers of social care).*

6.10 The providers of both health and social care should liaise and work together to notify and investigate the incident in order to minimise any distress and to avoid multiple communications to the service userFor example it would not normally be appropriate for a family to receive two separate 'in-person' notifications about the death of a family member because of a lack of communication between providers.

However, each provider will retain their individual responsibilities under their respective duty of candour and must satisfy themselves that they have been met.

Application of the Duty of Candour procedure to commissioned and hosted services

6.11 Section 11 of the Act clarifies which organisation will be responsible for complying with the duty of candour in situations where services are provided by one body on behalf of another. The position, in relation to different arrangements is set out below:

Services Commissioned by an NHS Body from Another NHS Body in Wales

6.12 An NHS body in Wales is responsible for complying with the duty of candour in relation to all care which it actually provides. Therefore, for example, where a Health Board enters into arrangements with a primary care provider for the provision of NHS services, it is the primary care provider who is subject to the duty.

6.13 Similarly, if a Health Board enters into arrangements with an NHS Trust in Wales for the provision of services, the duty rests with the NHS Trust.

Services Commissioned from Non-NHS Bodies in Wales

6.14 If an NHS body enters into an arrangement for the provision of services with someone other than another NHS body, the duty to comply with the duty of candour rests with the NHS body. Therefore, for example, if a local Health Board enters into an arrangement with an independent provider for the provision of services, the duty will apply to the local Health Board.

6.15 In these circumstances, it would be for the NHS body to notify the service user or person acting on their behalf for both the '"in-person"' notification in accordance with regulation 4, and the written notification in accordance with regulation 5.

6.16 The provisions of the 2011 Regulations apply to persons who provide services under arrangements with an NHS body. Therefore, as is the case currently, it would be for the independent provider to investigate the circumstances of the notifiable adverse outcome and communicate the result of that investigation to the service user/person acting on their behalf.

6.17 NHS Bodies should ensure that their commissioning arrangements with non-NHS independent providers in Wales require the independent provider to notify them when they are of the view that the duty of candour has been triggered, so

that the NHS body can comply with its obligations in relation to notification under the Act. The commissioning arrangements will also need to require the independent provider to provide sufficient information to the NHS body to enable them to comply with their reporting obligations under section 7 of the Act.

Application of the Duty of Candour to Care Commissioned Outside of Wales

6.18 The duty of candour under the Act only applies where health care is delivered in Wales as part of an NHS service. If, for example, a local Health Board enters into arrangements with an English provider, whether that provider is an NHS body or an independent provider, for the provision of health care services in England, it is the English duty of candour, under the Health and Social Care Act 2008 that may apply in relation to that care.

6.19 Part 7 of the National Health Services (Concerns, Complaints and Redress arrangements) (Wales) Regulations 2011 outlines the approach to be taken in terms of services carried out by England, Scotland and Northern Ireland NHS Bodies when patient safety incidents and concerns have been raised.

Annex A1 sets out the procedure flow chart for services that are commissioned.

Hosted Services:

6.20 Where healthcare is delivered by an organisation or service that is hosted by an NHS body (for example a clinical network), the Duty of Candour applies to the NHS body as the legal entity that hosts the service or organisation.

7 Chapter 7 – Special Considerations

Children And Young People

7.1 The duty of candour applies in respect of health care that is provided in Wales to children and young people. The welfare of children and young people, and their rights to be fully involved in decisions about their care and treatment, are essential principles to the approach to be taken when things go wrong with a child's or young person's care[35].

7.2 Under the UNCRC (article 12), children and young people - where they are able and wish to be - should be involved in discussions about adverse outcomes that directly affect them. This is in conjunction with the child's or young person's right to the highest attainable levels of health (article 24) and the right to receive and impart information (article 13).

[35] UN Convention on the Rights of the Child - United Nations. https://www.unicef.org.uk/wp-content/uploads/2019/10/UNCRC_summary-1_1.pdf

7.3 Honesty, transparency and openness are the guiding ethical principles to be adopted and discussions must be conducted in a sensitive manner that take age, the child or young person's experience of health care, their mental capacity and the wishes of the individual child or young person and, where appropriate, those with parental responsibility into consideration.

7.4 In discharging the duty of candour in circumstances involving health care that has been provided to a child or young person, the NHS body must notify the "relevant person" of the notifiable adverse outcome (see regulation 3 of the duty of candour regulations). This might be the child or young person themselves, unless they are: [36]

- 16 or over and lack capacity (within the meaning of the Mental Capacity Act 2005) in relation to the matter, or
- under 16 and not competent to make a decision in relation to their care or treatment,

in which case the "relevant person" is a person legally acting on the child or young person's behalf.

7.5 Where the matter concerns a child who is under the age of 16, it is important that consideration is given as to whether the child is "Gillick competent" [37] i.e., whether the child has the requisite legal capacity and sufficient maturity and intelligence to understand the information provided and to make decisions about their own health and medical treatment. The health care professional seeking the child or young person's consent should undertake the Gillick competency assessment if they have been adequately trained to do so.

7.6 However, even where the child is "Gillick competent," or where a young person is considered to have the requisite mental capacity, children and young people should be encouraged to involve their parents or guardians in these discussions where that is advisable and beneficial. Alternatively an advocate may be of use in this circumstance. Parents and Guardians are often best placed to understand and advise the health care team and, in many circumstances, an important source of support for the child and young person coming to terms when harm has occurred with their care.

7.7 The use of appropriate language and explanation needs to be thought through carefully and, where appropriate, conducted in a timely manner and in partnership with parents or guardians. The use of appropriate professionals with experience in communicating with children can be of immense value in these circumstances. This is important in order to mitigate against the risk of causing further harm or distress in notifying the child or young person of the notifiable adverse outcome, whilst also remaining open and honest with the child or young person about what has

[36] Regulation 3 of The Duty of Candour Procedure (Wales) Regulations also provide that the "relevant person" is someone acting on the service user's behalf if the service user has died or has informed the responsible body that they have nominated a person to act on their behalf.

[37] Gillick v West Norfolk and Wisbech AHA [1986] A.C. 112

happened in accordance with the duty of candour, and the broader rights of children and young people to be kept fully informed.

7.8 Where a child is not considered to be “Gillick competent” then notification must be given to a person acting on the child’s behalf (e.g., their parents or legal guardian).

7.9 In this circumstance, it is important to take in to account the parents’ or guardians’ views as to how a child or young person can be informed about what has happened in their care or treatment and consideration should be given as to how the health care team can support that discussion. As part of that discussion, consideration should be given as to the best interests of the child or young person in terms of the manner within which the discussion is undertaken, taking care not to cause further harm or distress.

7.10 Consideration must always be given to safeguarding principles and guidance and the need, at times, to report concerns around a child or young person’s safety discovered through these discussions where this is mandated legally or professionally.

7.11 Good documentation of decision-making and the assessment of competency to understand and participate in decisions about their care is imperative. It is also important that any decisions made not to share information are regularly reviewed.

7.12 It must be recognised that children and young people are often aware of incidents and changes in their care, and it can be extremely helpful to a young person to understand why it has happened.

7.13 Often children and young people may fear unclear outcomes. These fears can be generated when issues and incidents are not discussed, and children and young people are left uncertain about why things have occurred and what the next steps are in their care. This leads to increasing anxiety, worry and mental stress.

7.14 Ensuring children and young people are afforded the opportunity to be partners in the decision-making process about their care, with their parents or guardians and their health care team is imperative, where this is appropriate and possible. It is important to always have the child, young person and their family unit at the centre of good honest and open communication and the decisions about their care and this is especially important when unintended or unexpected harm has occurred.

Retrospective Case Reviews

7.15 Adverse outcomes may become known following retrospective serious case reviews, a large number of patients recalled or following a decision made by the medical examiner service or a coroner’s inquest, where the cause of death attributed was not known at the time of the incident. Additionally, further detail, not known during the initial review, may become known during the investigation of the incident. In these cases, the duty may still apply.

7.16 At the point of such a case review, and if the requisite conditions for the duty of candour have been met, the organisation therefore becomes ‘aware’ of the

notifiable adverse outcome. It is at this point that the DOC procedure should be initiated, if not previously initiated.

7.17 In the event that the 'in-person' notification is made later than 30 working days after the responsible body first became aware of the notifiable adverse outcome, the responsible body must provide an explanation of the reason for the delay.

Adverse Outcome Incidents Which Occur Before the Duty of Candour Came into Force

7.18 The Duty of Candour legislation is not intended to operate in respect of adverse outcomes which occurred before the date that the legislation came into force. In practical terms, this means that the conditions triggering the duty of candour (i.e. the provision of health care and the harm which occurred), must have taken place after 1 April 2023. However, we would still expect you to apologise and to be open and transparent with people about whatever has been discovered **in line with the ethos of putting things right**[38].

8 Chapter 8 - Oversight arrangements.

8.1 Regulation 10 requires NHS Bodies to designate a person to be responsible for maintaining a strategic oversight of the operation of the candour procedure set out in the Candour Procedure Regulations. Where the NHS body is a local Health Board, a Trust, or a Special Health Authority (including NHS Blood and Transplant in relation to its Welsh functions) the person must be one of its non-officer or non-executive directors, as appropriate.

8.2 Primary care providers have discretion in relation to whom to assign such roles.

8.3 Regulation 11 requires NHS Bodies to designate a person who has overall responsibility for the effective day to day operation of the procedure under the Candour Procedure Regulations (the "responsible officer"). Where the NHS body is a local Health Board, a Trust, or a Special Health Authority (including NHS Blood and Transplant in relation to its Welsh functions) the responsible officer must be one of its officer members or executive directors, as appropriate.

8.4 For primary care providers, it must be the person who acts as the Chief Executive of the body. If there is no Chief Executive, it is:

- the person who is the sole proprietor.
- in cases of a partnership, a partner; or
- in any other case a director or person responsible for management.

[38] Putting Things Right – Guidance on dealing with concerns about the NHS from 1 April 2011 Version 3 – November 2013 https://nwssp.nhs.wales/ourservices/legal-risk-services/legal-risk-services-documents/general-medical-practice-indemnity-gmpi-docs/healthcare-quality-guidance-dealing-with-concerns-about-the-nhs/

8.5 The Candour Procedure Regulations allow for the functions of the responsible officer to be delegated to another person, provided that person is under the direct control and supervision of the responsible officer. However, accountability will rest with the responsible officer themselves.

8.6 It is considered good practice for the persons designated in accordance with regulations 10 and 11 of the Candour Procedure Regulations to be the same persons nominated, respectively, under regulations 6 and 7 of the 2011 Regulations[39] due to the close linkages between the candour procedure and the procedure for investigating concerns in the 2011 Regulations.

REPORTING REQUIRMENTS

8.7 Under the duty, NHS Bodies will be required to report annually on compliance with the duty and publish their reports. Local Health Boards will be required to collate this information from those primary care providers with whom they enter into a contract or arrangements for services and publish a combined report. **Annex G** includes a flow chart setting out the reporting, publication and monitoring requirements.

8.8 When reporting, NHS Bodies will be required to specify if the duty of candour has been triggered in the reporting year (defined as each period of 12 months ending on 31st March, (each financial year), and if it has:

1. state how often the duty of candour has been triggered during the reporting year.
2. give a brief description of the circumstances in which the duty was triggered; and
3. specify any steps taken by the body with a view to preventing similar circumstances from arising in the future.

8.9 The report must be prepared as soon as practicable after the end of each financial year.

8.10 To streamline annual reporting in Wales and reduce duplication of content whilst ensuring all regulatory requirements are met**,** Health Boards, Trusts and SHAs should include their candour reports in the Putting Things Right Report which should be published pursuant to regulation 51 of the 2011 Regulations[40] by **31st October** each year.

[39] Reg 6 of the 2011 Regulations requires a person to be appointed to maintain a strategic oversight of the arrangements for dealing with concerns under those Regulations and regulation 7 requires a person to be appointed to have responsibility for ensuring effective day to day operation of the arrangements for dealing with concerns in an integrated manner.

[40] The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 (SI 2011/704). Available from: http://www.legislation.gov.uk/wsi/2011/704/contents/made

8.11 Regulation 51 of the 2011 Regulations requires NHS Bodies to prepare an annual report on information regarding concerns, (where concerns is taken to include complaints, patient safety incidents and claims). For primary care providers, this includes sending their report to the Local Health Board with whom they have entered into arrangements with, allowing for collation and publication within a Local Health Board's Annual Putting Things Right report[41], and considered within each organisation's Annual Quality Statement.

Primary Care providers: duty to report

8.12 Primary Care providers must prepare a report in respect of the health care they provide under a contract or other arrangement with their Health Board. The report must state whether during the reporting year (defined as each period of 12 months ending on 31st March, (each financial year)), the duty of candour has been triggered in respect of the provision of health care by the primary care provider.

8.13 If it has, the report must:

1. specify how often this has happened during the reporting year,
2. give a brief description of the circumstances in which the duty was triggered,
3. describe any steps taken by the provider with a view to preventing similar circumstances from arising in future.

8.14 The prepared report must be supplied to the Local Health Board on completion.

8.15 If the Primary Care provider has provided health care on behalf of two or more Local Health Boards, a separate report is to be prepared and supplied to each Local Health Board on completion.

8.16 Local Health Boards receiving the report must prepare a summary of the reports received from the Primary Care providers in the candour report that they publish.

8.17 Consequently, in order to give Local Health Boards time to compile the summary, such reports must be provided to the relevant Local Health Board by no later than **30th September** each year.

8.18 Although the use of the Datix system is not mandated, functionality on Datix will facilitate the collation of information necessary to satisfy the reporting requirements that need to be submitted to local Health Boards.

[41] Welsh Government. Putting things right - Guidance on dealing with concerns about the NHS from 1 April 2011 [Internet]. Welsh Government; 2013. Available from: http://www.wales.nhs.uk/sites3/Documents/932/Healthcare%20Quality%20-%20Guidance%20-%20Dealing%20with%20concerns%20about%20the%20NHS%20-%20Version%203%20-%20CLEAN%20VERSION%20%20-%2020140122.pdf

Publication of Reports

8.19 The annual reports on the duty of candour must be published as soon as practicable after the end of the financial year. In the case of Local Health Boards, their report must include the summary of the reports provided by primary care providers providing services on the Local Health Board's behalf.

8.20 The Local Health Board will therefore be responsible for publishing information relevant to the duty of candour in respect of its own services and the services provided by primary care providers in its area. This will mean that all the information about the duty of candour in respect of the Local Health Board area will be published together.

8.21 As set out above, such reports should be published by **31st October** each year.

BOARD ASSURANCE AND MONITORING ARRANGEMENTS

8.22 Breach of the duty of candour is not a criminal offence. The focus of the duty to be on learning and improving, not on punitive sanctions when NHS Bodies fall short in their application of the duty.

8.23 However, NHS Bodies should consider how monitoring of the effective implementation of the actions required by the duty of candour can be integrated into existing corporate governance frameworks, processes and procedures. Assurance should be sought to confirm that all elements of the procedure are being implemented when they should be, and that there are ways of supporting continuous improvements and refinements in the way that the NHS body discharges its legal responsibilities.

8.24 Leaders and managers within the NHS body should ensure that the implementation of the duty of candour forms a key part of the learning systems within their service areas, and that the necessary integration and alignment with processes and procedures has taken place and reinforces the values expected in their service area.

8.25 In respect of Health Boards, Trusts and Special Health Authorities, the expectation is that there will be local ownership and accountability with regular updates being provided via Quality and Safety Committee (or equivalent) meetings, where Independent Members can seek assurance, the duty is being discharged and learning is being taken forward and concerns are escalated to the Board if appropriate.

8.26 Implementation of, and compliance with the duty will also be scheduled for discussion at quality and delivery group meetings between Welsh Government and individual NHS Bodies, the national quality and delivery group and will inform the Joint Executive Team (JET) meetings and the Minister for Health and Social Service's appraisals with the Chairs of Health Boards, Trusts and Special Health Authorities.

8.27 The Welsh Government will monitor the content of the annual reports alongside other sources of information which will help triangulate the application of the duty with, for example, consideration of serious incidents reported in line with the new National Patient Safety Incident Reporting policy.

8.28 Compliance with the duty will also form part of the matters considered by Healthcare Inspectorate Wales (HIW) when inspecting and reviewing the NHS.

8.29 The annual reporting requirements will also provide information to the public and the Welsh Government about the duty, which will help to make the process transparent and accessible to the public and Bodies such as the Citizen Voice Body for Health and Social Care, Wales.

CONFIDENTIALITY

8.30 It is important to ensure that at all times the requirements of GDPR are adhered to when accessing, processing and disclosing service user information. Reports and publications must not identify any person to whom health care is being or has been provided by or on behalf of the NHS body, or any person acting on behalf of a service user.

8.31 Care must also be taken not to unwittingly enable a person to be identified from the information provided within a report. It is not necessary to name a person in order for them to be identifiable if, for example, a case has received media attention or, to cite another example, where a person has a rare medical condition and simply naming the condition could render the person identifiable.

8.32 The sharing of any information needs to also consider whether there is a conflicting need that may delay such sharing of information such as a criminal investigation or safeguarding process as set out in regulation 12 of the candour procedure regulations.

8.33 When completing records under duty of candour staff should remember that any records made in relation to the incident may be disclosable to the individual under UK GDPR (if their personal data) or to the general public under the Freedom of Information Act (if not personal data). Staff should also involve their organisation Data Protection Officer (DPO) when a notifiable adverse outcome appears to involve a personal data breach as there may also be reporting requirements to the Information Commissioners Office under UK GDPR.

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

Developing the Clinical Plan – 2025-2030	
MEETING	QUEST Committee
DATE	7th May 2024
EXECUTIVE	Andy Swinburn
AUTHOR	Andy Swinburn
CONTACT	Andy.Swinburn@wales.nhs.uk

EXECUTIVE SUMMARY

1. As the organisations Clinical Strategy becomes due for revision and update, before 2025, the various clinical teams across the Trust will be spending time this forthcoming year to begin crafting the next iteration of this plan.

2. The attached slide set illustrates a high-level plan as to how this is envisaged to be set out. It should be acknowledged that this plan is being developed in a period of service development and as such will be subject to various iterations throughout its development.

Recommendation: The Committee are asked to take assurance from this plan, commenting and contributing as required.

KEY ISSUES/IMPLICATIONS

The slide set gives an illustration of the intended format, associated risks and key stakeholder considerations.

REPORT APPROVAL ROUTE

N/A

REPORT APPENDICES

Slide set presentation

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

Welsh Ambulance Services University NHS Trust

Our Clinical Plan

Revising our clinical strategy

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

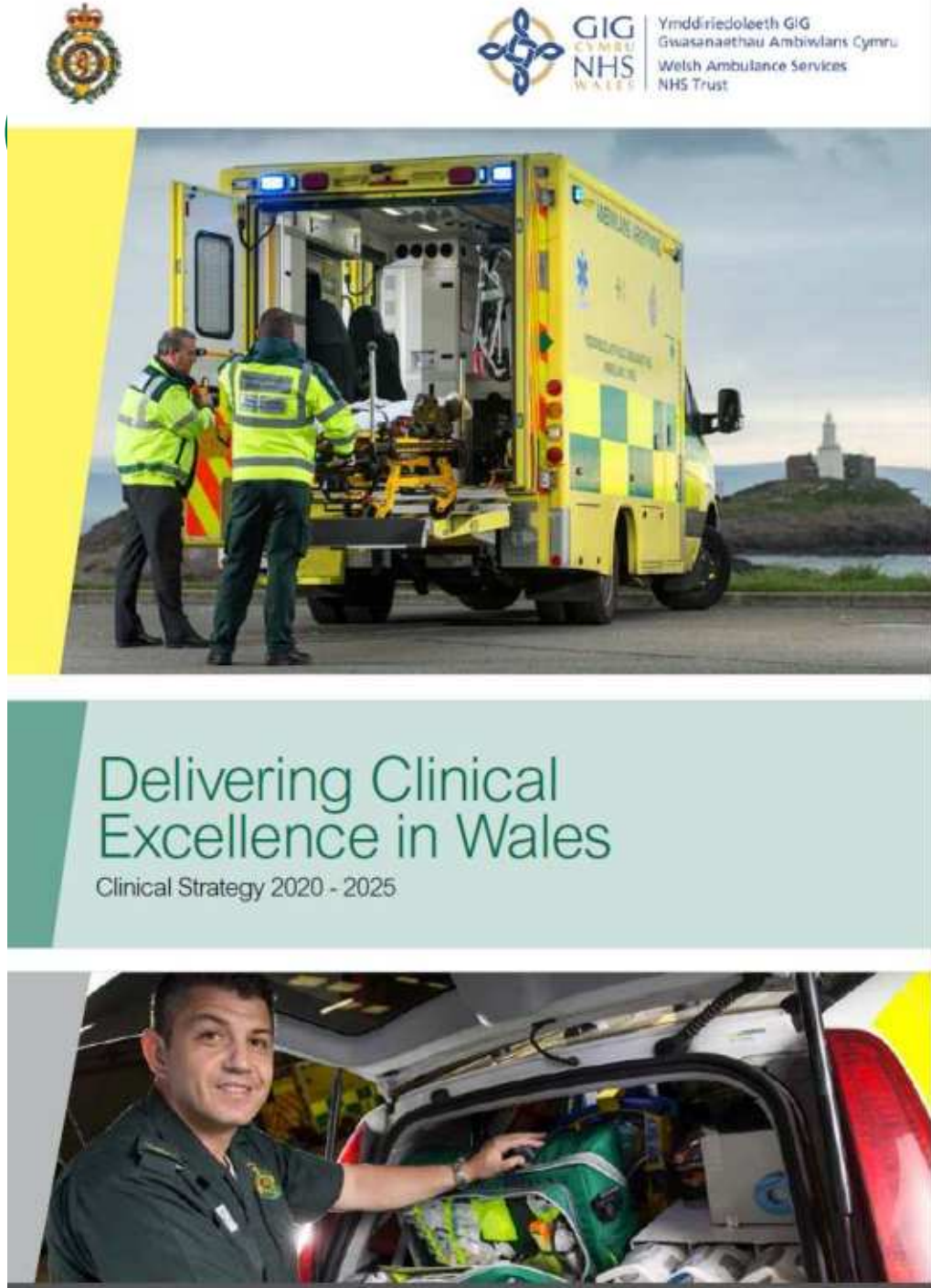
Our Clinical Plan
Version 1.0
Released: May 2024

Clinical Directorate
andy.swinburn@wales.nhs.uk

Delivering Clinical Excellence in Wales

Clinical Strategy 2020-2025

- Served the organisation well
- Useful to review this strategy to see how far we have travelled
- Revision of the strategy (plan) will now commence this year
- Significant revision of the contents and lay out to recognise progress and changing emphasis



Items for consideration

- How will the plan be constructed?
- Who's involved in its creation?
- Who are our stakeholders?
- What are the risks?
- Next Steps

Our Clinical Plan – Its Proposed Construction

The Overarching Clinical Plan

Introductions – Jason, Andy & Liam
Scene setting
Future landscape and objectives of the plan

Clinical Delivery Plan

Clinical Streaming and Prioritisation

Clinical Outcomes

Clinical Performance

Clinical Leadership & Supervision

Clinical Development Plan

Clinical Data and Intelligence

Clinical Transformation

Specialist & Advanced Practice

Alternative Pathways

Remote Care Plan

Remote Integrated Care

Community Support Cymru

Specialist & Advanced Practice

within remote care

Mental Health & dementia

The Research & Innovation Plan

HCRW R&I Framework

Embedding R&I Into Practice

Our Stakeholders

Internal

Our people – Need to feel bought into its objectives

Board members – Needs to provide the effective balance between ambition and assurance

External

Prospective employees – Need to excite and enthral

Our Commissioners – Need to set out our clinical ambition and challenge existing norms

Wider system colleagues – Need to spurn interest and open minds

WG including 6G influencers – Need to illustrate our reach and possibilities beyond goal 4

AACE colleagues – Need to illustrate to wider industry our leadership within this space

The Risks

All work of this nature comes with associated risks

- Balancing this years ambitious agenda with future years planning
- Balance between content and brevity
- Balance ambition with reality
- Ensuring we remain sufficiently flexible to recognise the developing picture

Next Steps

- Joint Directorate planning Event between Clinical and QSPE
- From this, devise the delivery mechanism to undertake the work and ensure each element aligns
- Set out the timeframe for delivery
- Reporting updates through to QUEST

Thank you for listening

AGENDA ITEM No	**13**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**1**

Clinical Audit Plan & Action Tracker Q4 (update) 2023-2024

MEETING	Quality, Patient Experience and Safety Committee
DATE	7 May 2024
EXECUTIVE	Director of Paramedicine
AUTHOR	Head of Clinical Intelligence & Assurance
CONTACT	Kevin Webb Kevin.webb@wales.nhs.uk

EXECUTIVE SUMMARY

Following an Audit Wales review of WAST's Quality Governance Arrangements, one of the recommendations was for the Clinical Audit Plan to be submitted to QuEST for scrutiny and approval ahead of each financial year, and then monitored on a quarterly basis.

This is the Q4 2023-24 update to highlight progress with audits (the plan) and also the actions from each of the audits (action tracker).

The 2023-24 Clinical Audit Plan contained 16 audits covering a range of topics including clinical conditions, medicines, and compliance to documentation. Of these:

- 10 have been completed and approved at Clinical Intelligence & Assurance Group (CIAG)
- 1 was ongoing (completed and approved at the April 2024 CIAG)
- 5 re-audits were not commenced as they are reliant on all the ePCR User Interface changes to be implemented, these have rolled over to the 2024/25 Clinical Audit Plan.

There were a total 46 actions from the 10 completed audits to demonstrate learning from Clinical Audit. These were included on the Clinical Audit Action Tracker and monitored by the Clinical Intelligence & Assurance Group, with updates provided monthly at the Clinical Directorate Business meetings.

During 2023-24, of the 46 actions to demonstrate learning from clinical audit:

- 39 have been completed
- 5 are on track for delivery as planned
- 2 are off track and recovery action taken

- 1 requires a clinical notice
- 1 relates to ePCR UI changes

RECOMMENDED: That the committee Note the Q4 2023-24 Clinical Audit Plan and Action Tracker update.

KEY ISSUES/IMPLICATIONS
Many of the audits and re-audits can be undertaken solely by the CIAT. However, support is required for some topics where subject matter experts are needed as authors, and the support of sponsors to ensure completion of the audits and subsequent actions. Delays in our ePCR supplier completing all of the required UI changes has impacted on the timely completion of actions, and the commencement of the re-audits to provide assurance on the documentation for the five Clinical Indicators.

REPORT APPROVAL ROUTE
Clinical Intelligence & Assurance Group – 11/04/2024

REPORT APPENDICES
Annex 1 WAST Clinical Audit Plan (Q4) 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)	N/A	Financial Implications	N/A
Environmental/Sustainability	N/A	Legal Implications	N/A
Estate	N/A	Patient Safety/Safeguarding	N/A
Ethical Matters	N/A	Risks (Inc. Reputational)	N/A
Health Improvement	N/A	Socio Economic Duty	N/A
Health and Safety	N/A	TU Partner Consultation	N/A

SITUATION

1. Following an 'Audit Wales' review of WAST's Quality Governance Arrangements, one of the recommendations was for the Clinical Audit Plan to be monitored on a quarterly basis at QuEST.
2. This is the Q4 2023-24 update to highlight progress with audits (the plan) and also to actions from each of the audits (action tracker).

BACKGROUND

3. The development of this annual plan takes into consideration a number of aspects including the resources available both in terms of funding and skills. As is often the case in healthcare there are substantially more requests for clinical audits than there are resources available to manage them. For this reason, it has been necessary to tailor the plan so that it is realistic, achievable and that expectations are not overreached.

4. The plan is developed in consultation with the Clinical Intelligence & Assurance Team (CIAT), and senior clinical, and non-clinical managers within the Trust. It is expected that managers will ensure there is an opportunity for staff at all levels to contribute to the development of the core plan and undertake clinical audits.
5. Care, treatment, and decision making should reflect best practice based on evidence to ensure that people receive the right care and support to meet their individual needs.
6. The Trust's annual Clinical Audit Plan allows the planning and prioritisation of clinical audits across the financial year. It is a dynamic document, updated quarterly to reflect those audits that are either planned, currently underway or have been completed. Various groups and committees receive quarterly updates against this plan of work, and it is made available on the Trust's Intranet.

7. This plan and the subsequent action tracker to monitor learning from each of the audits is monitored by the Clinical Intelligence & Assurance Group (CIAG), and an updated noted at Clinical Directorate Business meetings.

ASSESSMENT

8. The 2023-24 Clinical Audit Plan contained 16 audits covering a range of topics including clinical conditions, medicines, and compliance to documentation. Of these:
    - 10 have been completed and approved at CIAG
    - 1 was ongoing (completed and approved at the April 2024 CIAG)

- 5 re-audits were not commenced as they are reliant on all the ePCR User Interface changes to be implemented, these have rolled over to the 2024/25 Clinical Audit Plan.

9. During 2023-24, of the 46 actions to demonstrate learning from clinical audit:

- 39 have been completed
- 5 are on track for delivery as planned
- 2 are off track and recovery action taken
    - 1 requires a clinical notice
    - 1 relates to ePCR UI changes

RECOMMENDED: That The committee Note the Q4 2023-24 Clinical Audit Plan and Action Tracker update.

EQUALITY IMPACT ASSESSMENT

Not required

REPORT CHECKLIST

Issues to be covered	**Paragraph Number (s) or "Not Applicable"**
Equality Impact Assessment	Not applicable
Environmental/Sustainability	Not applicable
Estate	Not applicable
Health Improvement	Not applicable
Health and Safety	Not applicable
Financial Implications	Not applicable
Legal Implications	Not applicable
Patient Safety/Safeguarding	Not applicable
Risks	Not applicable
Reputational	Not applicable
Staff Side Consultation	Not applicable

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
NHS Trust

Welsh Ambulance Services NHS Trust

Clinical Audit Plan

2023/2024
Quarter 4

Final v1.0 Last Updated 5th April 2024

The development of this annual plan takes into consideration a number of aspects including the resources available both in terms of funding and skills. As is often the case in healthcare there are substantially more requests for clinical audits than there are resources available to manage them. For this reason, it has been necessary to tailor the programme so that it is realistic, achievable and that expectations are not overreached.

The plan is developed in consultation with the Clinical Intelligence & Assurance Team (CIAT), and senior clinical, and non-clinical managers within the Trust. It is expected that managers will ensure there is an opportunity for staff at all levels to contribute to the development of the core plan and undertake clinical audits.

Following requests to undertake clinical audits, a proposal form will be provided by the CIAT allowing the aims, objectives, author, and a sponsor to be identified, along with identifying the necessary data and level of support required from the CIAT.

The decision for clinical audit topics chosen for inclusion will be influenced by:

- Opportunities to improve clinical effectiveness and evidence-based practice (e.g., efficacy of treatment, new initiatives, pilot projects)
- Clinical risk management/patient safety (e.g., choosing topics in response to concerns highlighted by patient safety incidents)
- Local and Trust wide priorities
- Guidance documents (e.g., NICE and AACE / JRCALC)
- National Ambulance Service Clinical Quality Group
- Policy documents relating to health and healthcare
- Other benchmarking activities as appropriate

A number of new service delivery models are often required for a modern ambulance service. The robust evaluation of service development topics is essential and needs to be planned from their inception.

It is not always possible to predict at the start of a financial year all of the topics that will require evaluation and therefore flexibility in setting a clinical audit plan is required, resulting in the annual plan being a dynamic document, updated quarterly.

The aim of this document is to detail the clinical audit topics that are either planned, currently underway or have been completed during the financial year.

It is expected that all the topics identified in the plan will be initiated during the course of a financial year. Those initiated during Q3 or Q4 may not be fully completed and will need to be considered in the subsequent year's programme.

The completed clinical audit reports are available on the Clinical Audit page of the Trust's Intranet website. (https://nhswales365.sharepoint.com/sites/AMB-Intranet-Medical/SitePages/Clinical-Audit-Programme.aspx)

Kevin Webb – Head of Clinical Intelligence & Assurance

Table 1 – Summary (Full information in Table 2)

*	N/A = Not due to start	Not started / not progressing as planned	**Progressing as planned	Completed
** A clinical audit is deemed as started once a clinical audit proposal and criterion table have been approved by the CIAT and the PCRs and/or data supplied				
Clinical Audit Classification		Tier 1 = UK Ambulance Services or Trust wide		Tier 2 = Health Board / Locality / Team

The topics in the section below are confirmed clinical audits

Ref	Tier	Clinical Audit Title	Clinical Audit Author	Clinical Audit Sponsor	Audit Start Date	Current Status (RAG)*				
						Q4 2022/ 2023	Q1	Q2	Q3	Q4
21_002	1	Safeguarding Adolescent Audit	Gwenan Jones-Parry Safeguarding Specialist Paramedic	Rhiannon Thomas Senior Professional Safeguarding	July 2021					
22_006	2	A review of TXA administration within the South Wales Trauma Network (SWTN)	Tim Austin Senior Trauma Paramedic	Greg Lloyd Assistant Director Clinical Delivery	March 2023					
22_007	1	Diagnostic code compliance - ePCR	Clinical Intelligence & Assurance Team	Duncan Robertson Assistant Director of Clinical Development	February 2023					
23_001a	1	Evaluation of Non-Conveyance forms within ePCR	Kevin Webb Head of Clinical Intelligence & Assurance	Duncan Robertson Assistant Director of Clinical Development	April 2023					
23_001b	1	Evaluation of ROLE forms within ePCR	Kevin Webb Head of Clinical Intelligence & Assurance	Duncan Robertson Assistant Director of Clinical Development	April 2023					
23_004	1	Re-audit ePCR clinical data assurance - #NOF	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	To commence after all ePCR changes are implemented	N/A	N/A	N/A	N/A	N/A

23_008	1	Re-audit ePCR clinical data assurance - Stroke	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	To commence after all ePCR changes are implemented	N/A	N/A	N/A	N/A	N/A
23_009	1	Re-audit ePCR clinical data assurance - STEMI	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	To commence after all ePCR changes are implemented	N/A	N/A	N/A	N/A	N/A
23_005	1	Re-audit ePCR clinical data assurance - Hypoglycaemia	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	To commence after all ePCR changes are implemented	N/A	N/A	N/A	N/A	N/A
TBC	1	Re-audit ePCR clinical data assurance – ROSC (at hospital)	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	To commence after all ePCR changes are implemented	N/A	N/A	N/A	N/A	N/A
23_002	1	Bronchiolitis Pathway Follow-up audit – Compliance to the All-Wales Guideline for Ambulance Service Management	Richard Teulon Clinical Intelligence & Assurance Co-ordinator	Greg Lloyd Assistant Director Clinical Delivery	August 2023	N/A	N/A			
23_003	1	Clinical Frailty Score (CFS) Follow-up audit in patients aged ≥ 65 years	Richard Teulon Clinical Intelligence & Assurance Co-ordinator	Duncan Robertson Assistant Director of Clinical Development	February 2024	N/A	N/A	N/A	N/A	
23_006	1	Appropriate administration of Methoxyflurane (Penthrox®) Clinical Audit	Andeep Chohan Project Manager	Paula Jeffery Consultant Paramedic	October 2023	N/A	N/A			
23_010	1	Morphine Administration (Recording accuracy).	Chris Moore Head of Medicines Management	Chris Moore Head of Medicines Management	October 2023	N/A	N/A	N/A		

23_011	1	Levetiracetam (Keppra) potential use in cases of multiple anti-convulsant administration	Richard Teulon Clinical Intelligence & Assurance Co-ordinator	Andy Swinburn Director of Paramedicine	October 2023	N/A	N/A	N/A		
23_007	1	ePCR clinical data assurance - $EtCO_2$ Compliance Reports	Nicola Hughes Clinical Intelligence & Assurance Supervisor	Kevin Webb Head of Clinical Intelligence & Assurance	November 2023	N/A	N/A	N/A		

Table 2 – Full Information

Ref	Clinical Audit Title	Rationale / Drivers	Clinical Audit Author	Clinical Audit Contact / Support	Audit Start Date	Comments
21_002	Safeguarding Adolescent Audit	It was agreed as part of the learning from a domestic homicide review and as part of the safeguarding team's future work plan that an audit would be completed to develop a mechanism to review this aspect of safeguarding practice.	Gwenan Jones-Parry Safeguarding Specialist Paramedic	Claire Muxworthy Clinical Intelligence & Assurance Co-ordinator	July 2021	There were 3 aspects to the data capture: PCR, MPDS & CAS. The MPDS aspect has now been removed due to difficulties with locating PCRs, this will not impact on the aims/objectives. **PCR** Data analysed. **CAS** Data capture commenced. CM – data captured Report being compiled to include both sets of results (10.02.23) CM meeting with GJP to discuss report and compile recommendations. Report approved at CIAG 14th June 2023.
22_006	A review of TXA administration within the South Wales Trauma Network (SWTN)	TXA is a key component of the package of care these major trauma patients receive to stabilise them for, or during the transfer to hospital. As such, It is important that we understand the practice of our clinicians to ensure it is administered appropriately in a timely fashion to all patients who require it.	Tim Austin Senior Trauma Paramedic	Ruth Saele Clinical Intelligence & Assurance Data Specialist	*Indicative Q4 2022/23*	A proposal form is being developed, criteria and data being identified. RT 23/2/23 – audit completed; spreadsheet data being cleansed. Some cases for TA review on his return from leave 1/3/23 Report approved at CIAG 13th April 2023.

Ref	Clinical Audit Title	Rationale / Drivers	Clinical Audit Author	Clinical Audit Contact / Support	Audit Start Date	Comments
22_007	Diagnostic code compliance - ePCR	All ePCRs should have a diagnostic code, enabling many of the clinical audits undertaken within WAST by allowing for selection by condition type. In addition, diagnostic codes are used to identify Clinical Indicators (CIs). Where ePCR records are not closed appropriately by clinicians. the TerraPACE system will automatically close the record by applying a closure code as '9999'. This audit aims to identify the ePCR diagnostic code rate, if '000' is used whether a suitable code was available, provide opportunities to revise the code list and identify why ePCRs are closed as '9999'.	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	*Indicative Q4 2022/23*	A proposal form is being developed, criteria and data being identified. CM – audit completed, results being analysed, and report written (14.02.23) Report approved at CIAG 13th April 2023.
23_001a	Evaluation of Non-Conveyance forms within ePCR	In April 2022, the electronic Patient Clinical Record (ePCR) roll out was completed across Wales. For instances where patients are not conveyed or where Recognition of Life Extinct (ROLE) is documented, a paper form is completed and left at the scene as information when WAST staff have left. The ePCR has a facility to take an image through the media tab within the application and is used for taking images of the non-Conveyance and ROLE forms. This audit aims to identify that an image of the relevant form is available on the ePCR and also evaluate the quality of the information documented on form.	Kevin Webb Head of Clinical Intelligence & Assurance	Ruth Saele Clinical Intelligence & Assurance Data Specialist	April 2023	A proposal form is being developed, criteria and data being identified. Audit commenced April 2023. Records reviews completed. Scheduled for completion by the end of Q3 Final report submitted to CIAG 12/12/23 Completed

Ref	Clinical Audit Title	Rationale / Drivers	Clinical Audit Author	Clinical Audit Contact / Support	Audit Start Date	Comments
23_001b	Evaluation of ROLE forms in (ePCR).	In April 2022, the electronic Patient Clinical Record (ePCR) roll out was completed across Wales. For instances where Recognition of Life Extinct (ROLE) is documented, a paper form is completed and left at the scene as information when WAST staff have left.	Kevin Webb Head of Clinical Intelligence & Assurance	Ruth Saele Clinical Intelligence & Assurance Data Specialist	April 2023	Decision to evaluate 23_001 as two separate audits (a and b). Scheduled for completion in Q4. Report approved at CIAG 9th January 2024
23_004	Re-audit ePCR clinical data assurance - #NOF	To ascertain if improvements have resulted following completion of actions from the previous audit.	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	To commence after all ePCR changes are implemented	ePCR UI changes scheduled for implementation in October 2023. Changes delayed until late December 2023, not all changes implemented during the update. Additional options with ePCR prompts also being considered.
23_008	Re-audit ePCR clinical data assurance - Stroke	To ascertain if improvements have resulted following completion of actions from the previous audit.	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	To commence after all ePCR changes are implemented	ePCR UI changes scheduled for implementation in October 2023. Changes delayed until late December 2023, not all changes implemented during the update. Additional options with ePCR prompts also being considered.
23_009	Re-audit ePCR clinical data assurance - STEMI	To ascertain if improvements have resulted following completion of actions from the previous audit.	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	To commence after all ePCR changes are implemented	ePCR UI changes scheduled for implementation in October 2023. Changes delayed until late December 2023, not all changes implemented during the update. Additional options with ePCR prompts also being considered.

Ref	Clinical Audit Title	Rationale / Drivers	Clinical Audit Author	Clinical Audit Contact / Support	Audit Start Date	Comments
23_005	Re-audit ePCR clinical data assurance - Hypoglycaemia	To ascertain if improvements have resulted following completion of actions from the previous audit.	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	To commence after all ePCR changes are implemented	ePCR UI changes scheduled for implementation in October 2023. Changes delayed until late December 2023, not all changes implemented during the update. Additional options with ePCR prompts also being considered.
TBC	Re-audit ePCR clinical data assurance – ROSC (at hospital)	To ascertain if improvements have resulted following completion of actions from the previous audit.	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	To commence after all ePCR changes are implemented	ePCR change request awaiting funding approval. Additional options with ePCR prompts also being considered.
23_002	Re-audit of Bronchiolitis Pathway –Compliance to the All-Wales Guideline for Ambulance Service Management	To ascertain if actions following the previous audit have led to an improvement.	Richard Teulon Clinical Intelligence & Assurance Co-ordinator	Ruth Saele Clinical Intelligence & Assurance Data Specialist	August 2023	Scoping ePCR data from winter 2022/23. Developing proposal and criteria. This will inform the audit for winter 2023/24. Results & analysis in early Q3 Presented to CIAG 09/11/23.
23_003	Re-audit of assurance for the recording of a Clinical Frailty Score (CFS) in patients aged ≥ 65 years	To ascertain if improvements have resulted following completion of actions from the previous audit.	Richard Teulon Clinical Intelligence & Assurance Co-ordinator	Ruth Saele Clinical Intelligence & Assurance Data Specialist	February 2024	Scoping ePCR data to inform the audit when previous actions completed. Audit commenced February 2024, scheduled for completion in March 2024 and to CIAG in April 2024.
23_006	Appropriate administration of Methoxyflurane	Methoxyflurane has been introduced into WAST to enable non-registrant responders to provide analgesia. The audit aims to audit the safe and	Andeep Chohan Project Manager	Claire Muxworthy Clinical Intelligence & Assurance Co-ordinator	September 2023	Pilot audit commenced September 2023 to test data

Ref	Clinical Audit Title	Rationale / Drivers	Clinical Audit Author	Clinical Audit Contact / Support	Audit Start Date	Comments
	(Penthrox®) Clinical Audit	effective care of patients who self-administered Methoxyflurane (Penthrox®) analgesia.				prior to full audit. Proceeded to full audit. Final clinical reviews undertaken in December 2023. Scheduled for completion Q4. Approved at CIAG 9th February 2024
23_010	Morphine Administration (Recording accuracy).	Audit agreed in the Ambulance Practice Steering Group. This audit aims to test comparative accuracy between recording of morphine sulphate administered in WAST ePCR, against vehicle CD02 registers.	Chris Moore Head of Medicines Management	Claire Muxworthy Clinical Intelligence & Assurance Co-ordinator	October 2023	Data has been supplied in Q2 Audit commenced in Q3. Approved at CIAG 8th March 2024
23_011	Levetiracetam (Keppra) potential use in cases of multiple anti-convulsant administration	It has been proposed that levetiracetam (Keppra) may be beneficial in the treatment of convulsions that have not been resolved with diazepam. An audit is required to consider if, when more than two doses diazepam are needed to stop convulsions, could levetiracetam be considered instead of a third dose of diazepam.	Andy Swinburn Director of Paramedicine	Richard Teulon Clinical Intelligence & Assurance Co-ordinator	October 2023	Audit commenced October 2023. Audit approved at 12/12/2023 CIAG.
23_007	ePCR clinical data assurance - $EtCO_2$ Compliance Reports	The aim of this audit is to determine if automated reporting provides an accurate picture of the clinical care provided, and its outcome will contribute to the development of the $EtCO_2$ Compliance Dashboard.	Nicola Hughes Clinical Intelligence and Assurance Supervisor	Claire Muxworthy Clinical Intelligence & Assurance Co-ordinator	November 2023	Audit completed December 2023. Approved at CIAG 9th January 2024.

The topics in the section below need further development prior to progressing	
Exacerbation of COPD	*Initially intended as a CI, complex and time-consuming for a monthly CI due to requirement of scrutinising all PCRs. CIAG decided that this is to be an audit pending ePCR data.* *Further work needed to clarify criteria.*
Anticonvulsants - Administration in Children	*Re-audit to be undertaken to ascertain if the actions from the previous audit have resulted in improvements.*
Re-audit of clinical photographs in aiding care delivery (Consultant Connect)	*To ascertain if improvements have resulted following completion of actions from the previous audit.*
Appropriateness of Antimicrobial use by WAST Advanced Paramedic Practitioners	*An action from CAED 19_07 was to undertake a re-audit on an annual or bi-annual basis. Decided at the CIAG 19.5.2022 that consideration be given to including this on the CA Programme when ePCR data is available.*
Peripheral line Insertion bundle compliance	*Enquiry from Exec Nurse SBUHB if we report on the Insertion bundle compliance.* *PVC audits have been undertaken but the inclusion of ANTT in an audit was not completed. CIAT have contacted the requestor to support an audit.*

The topics in the section below need further consideration prior to inclusion in the clinical audit plan (*Workshops will be scheduled during the year with key stakeholders to scope these topics further*)	
Ketamine administration	*In addition to pain management audits that are planned, and an internal audit on pain management, this would demonstrate the appropriateness of administration to a specific group of patients suffering severe pain.*
Effectiveness of pain management	*Previous audit on pain scoring and the use of appropriate analgesia have been undertaking – consider re-audits too.* *Pain Management Framework presented to CIAG 12/12/23*
Re-audit of compliance to a Pain Score on PCRs for patients ≥18 years	*Should consider all ages. Consider dashboard option.* *Consider the standard, all patients, all patients in pain.* *Management of pain is more meaningful than only measuring the documentation of a pain score for all patients.*
Explore the correlation between patients presenting with stroke / TIA symptoms and UTI's / dehydration in older adults.	*When auditing clinical records, it has been observed that many elderly patients have a HPC of UTI's+/- dehydration along with their stroke/TIA symptoms.* *Would the outcome of this work add to body of knowledge and inform risk in primary care / patient. Perhaps work around potential pathway/ educational?*
Do long lie faller patients have poorer overall outcomes?	*Older adults who have fallen are a group of patients who are often vulnerable by nature of their acuity / response they can receive and their socio-economic situation.*
Undertake POPS audits within each Health Board are as the roll out continues and it becomes embedded.	*Further discussion is required to establish new criteria for POPS audit based on ePCR data.*
Major Trauma Tool	*High level topic suggestions for CIs at early CIAG meetings.*
Silver Trauma Tool	*High level topic suggestions for CIs at early CIAG meetings.*
Open Fracture (Co-amoxiclav)	*High level topic suggestions for CIs at early CIAG meetings.*
Delayed Handover.	*High level topic suggestions for CIs at early CIAG meetings*
Solo Responding	*High level topic suggestions for CIs at early CIAG meetings.*

Alternative Conveyance	*High level topic suggestions for CIs at early CIAG meetings.*
Resuscitation	*High level topic suggestions for CIs at early CIAG meetings.*
Maternity	*Welsh Government has specified that the aim of the MatNeoSSP Wales programme is to ensure we have clear and consistent improved approaches to maternity and neonatal safety within all services in Wales.*
Recording of Failed Pathways on ePCR	*Following an update to the ePCR User Interface to record the inability to refer patients onto pathways, an audit / evaluation of data would help identify areas for improvement for patient care and avoid unnecessary admission to Eds..*
Further audit topics will be considered for inclusion as new guidelines and medicines are introduced and changes to clinical practice are implemented	

AGENDA ITEM No	**14**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**1**

Focus on Clinical Indicators
Fractured Neck of Femur (#NoF – hip fracture)

MEETING	Quality, Patient Experience and Safety Committee
DATE	7 May 2024
EXECUTIVE	Director of Paramedicine
AUTHOR	Head of Clinical Intelligence & Assurance
CONTACT	Kevin Webb Kevin.webb@wales.nhs.uk

EXECUTIVE SUMMARY

1. QuEST has requested a series of updates to be presented at committee meetings in relation to a focus on Clinical Indicators (CIs). A focus on Return of Spontaneous Circulation (ROSC) at hospital, and Stroke have previously been presented, and for this meeting, the focus is on Fractured Neck of Femur (#NoF – hip fracture).

2. Within this update we will highlight:

   - What we measure (criteria)
   - Data quality and reporting
   - Improvements to date
   - Next steps to improvement
   - Clinical Indicator Recovery Plan

3. Some of the ePCR user interface changes recommended from the #NoF clinical audit were included in the updates implemented during December 2023. Work continues with the supplier to complete the required changes. These are aimed and improving the usability for clinicians to input data and to improve CI compliance.

4. A CI recovery plan has been implemented which includes focussed communication, clinical workshops, implementing the clinical supervision policy, and improvements in technology (e.g. potential use of AI).

5. A revised CI 'Jigsaw Poster' has been developed as an aide memoir to remind staff of the criteria for CI care bundles. This was included as one of the initiatives to promote CIs and ePCR completion at the CEO Roadshows.

6. Work is progressing to develop the 'Tenant Structure' to enable CIs to be reported at a range of levels (Trust wide, HB are, Locality, Team, Individual)

RECOMMENDED: That the Committee Note the PowerPoint update for the Fractured Neck of Femur (#NoF – hip fracture) Clinical Indicator.

KEY ISSUES/IMPLICATIONS
Nil

REPORT APPROVAL ROUTE
Quality, Patient Experience and Safety Committee – 7 May 2024

REPORT APPENDICES
Focus on CIs – Fractured Neck of Femur (#NoF) PowerPoint presentation

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

Welsh Ambulance Services University NHS Trust

Clinical Indicators Focus on Fractured Neck of Femur (#NOF)

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

Clinical Indicators – Focus on #NOF
Version 0.3
Released: April 2024

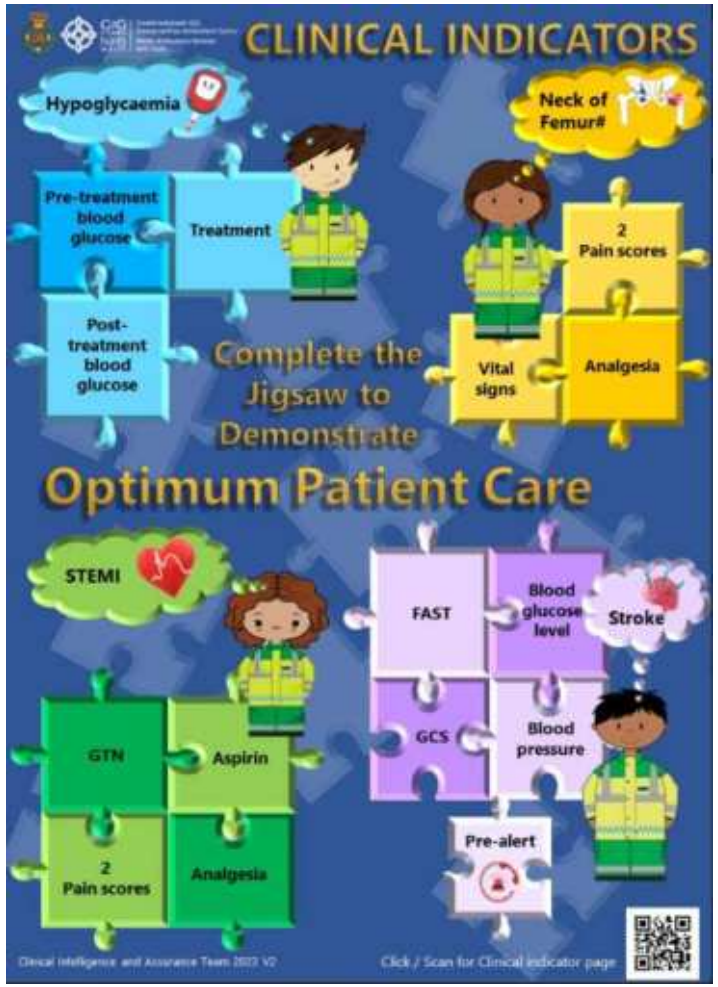
Kevin Webb
Head of Clinical Intelligence & Assurance
Kevin.webb@wales.nhs.uk

Introduction

The next Clinical Indicator (CI) in the 'Focus on CIs series' is for Fractured Neck of Femur (#NOF - hip fracture).

Within this we will highlight:

- ✓ **What we measure (criteria)**
- ✓ **Data quality and reporting**
- ✓ **Improvements to date**
- ✓ **Next steps to improvement**
- ✓ **Clinical Indicator Recovery Plan**



What we measure (*care bundle*)

- Number of patients aged 65 and over with a working diagnosis of a Fractured Neck of Femur (*denominator*)

- Compliance to the care bundle requires each criterion of care (*numerator*) to be completed:

  - Vital Signs
    - ✓ Respiratory rate
    - ✓ Pulse rate
    - ✓ SpO_2 (oxygen saturation)
    - ✓ Blood Pressure (BP)
    - ✓ Glasgow Coma Scale (GCS)

  - 2 Pain Scores

  - Analgesia

Care Bundle

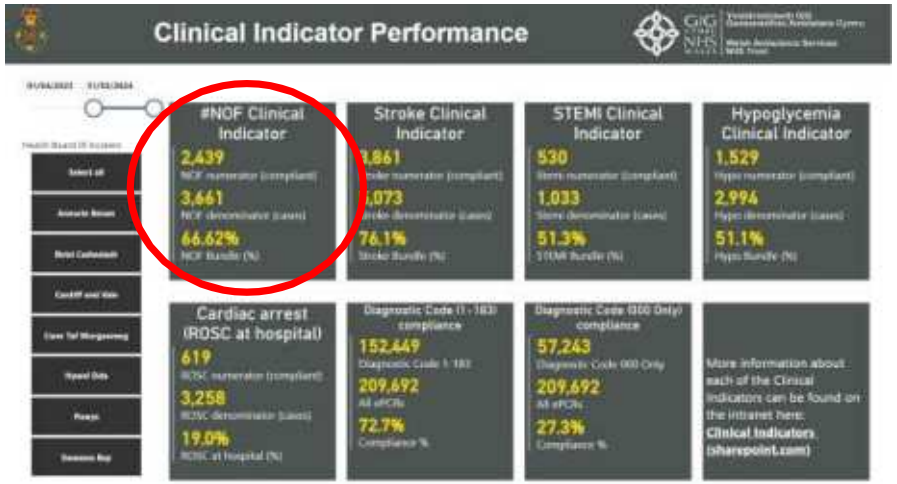
Vital Signs

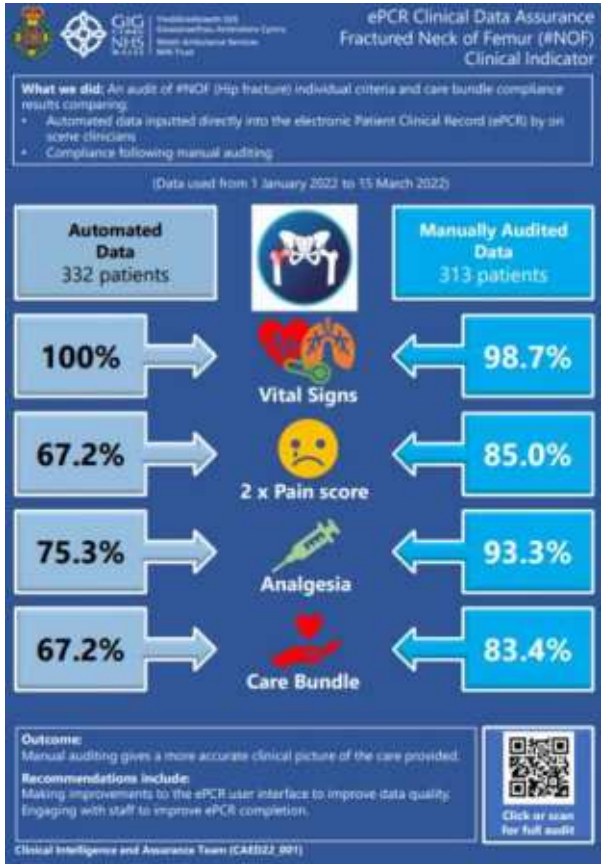
2 x Pain scores

Analgesia

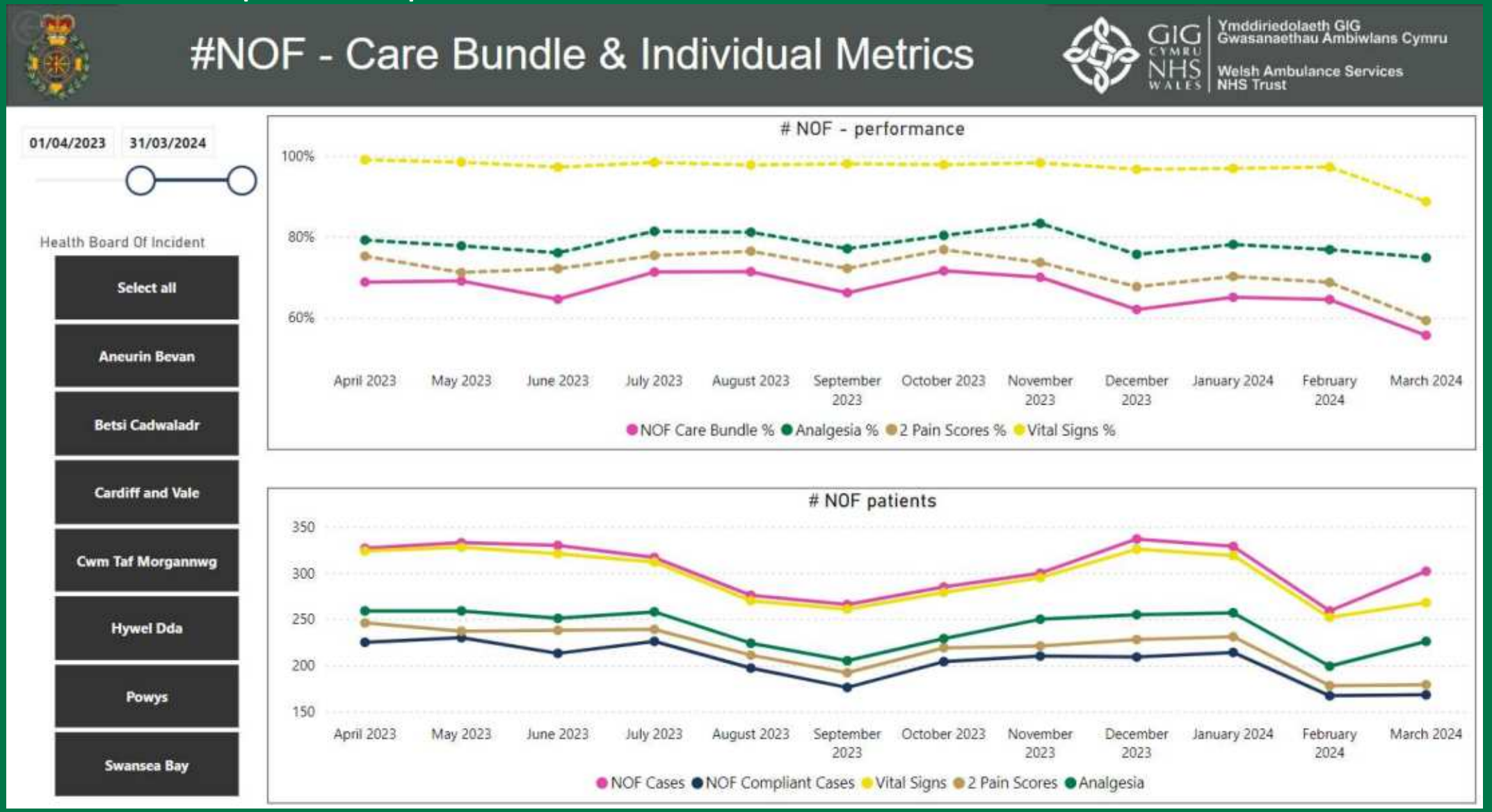
Data quality and reporting

- An ePCR technical specification was created to enable reporting
- Since the implementation of ePCR all CIs are reported on using 'raw' data inputted by clinicians (*no manual auditing prior to reporting*)
- Due to staff being unfamiliar with a new system, a reduction in CI compliance was anticipated (as in other UK Trusts), risk 535 (monitored by CIAG) was created to highlight three elements:
  - User interaction
  - User interface
  - Scripting
- Development of a Clinical Indicator dashboard to include #NOF
- The CIAT undertook a QA (deep dive) audit to:
  - Provide a more accurate clinical picture of the care delivered
  - Highlight the variation between automated and audited data
  - Help inform future reporting and caveats
  - Help inform an improvement plan and changes to the ePCR User Interface

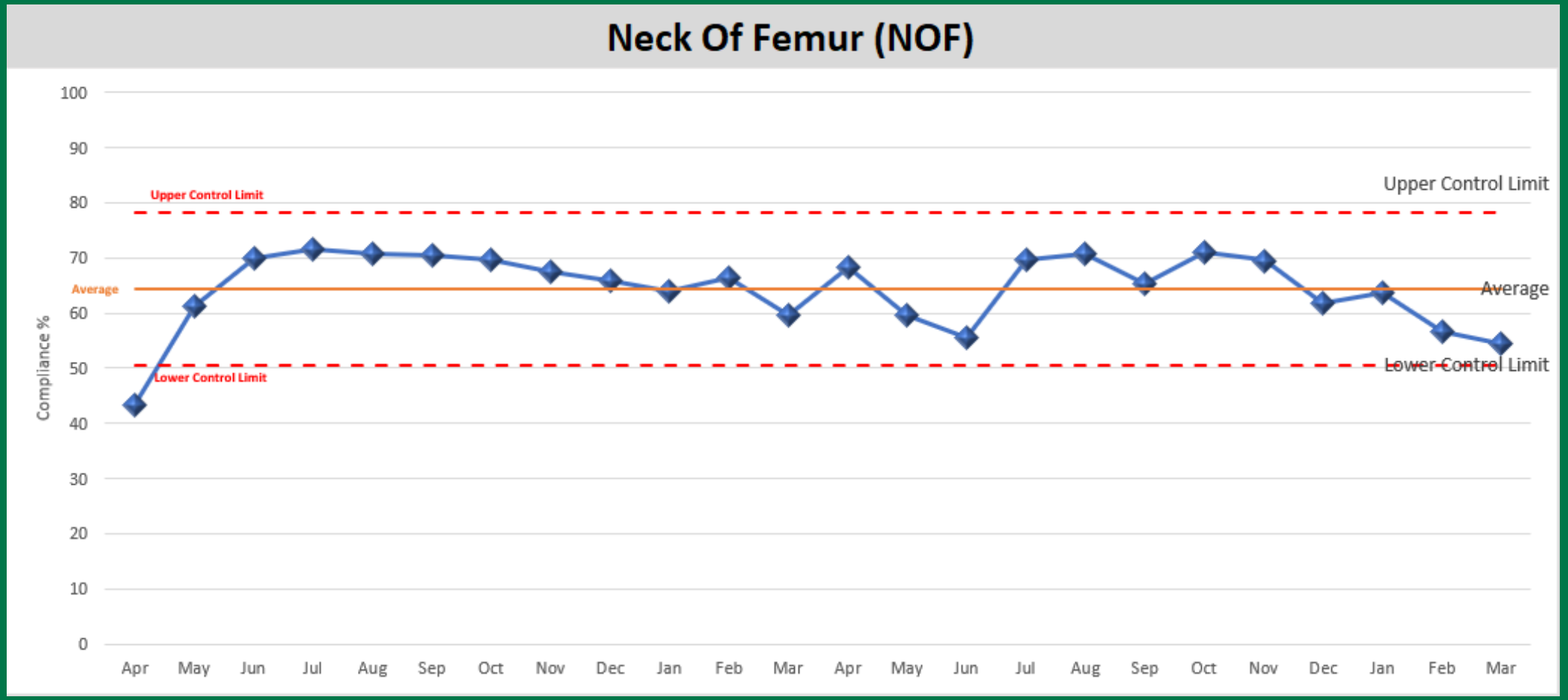




#NOF CI compliance April 2023 – March 2024

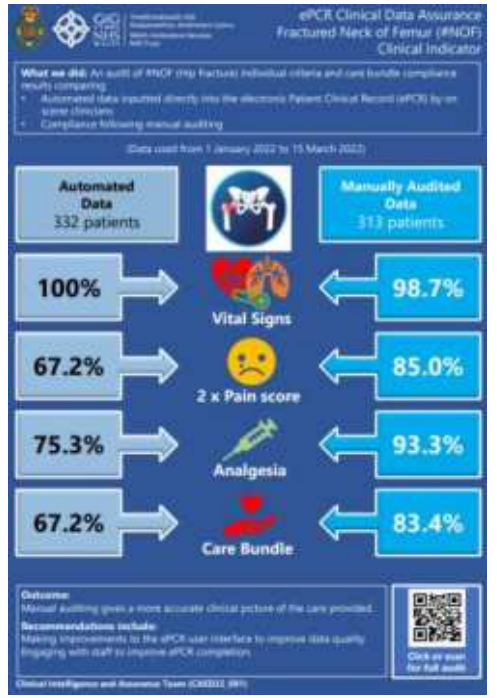


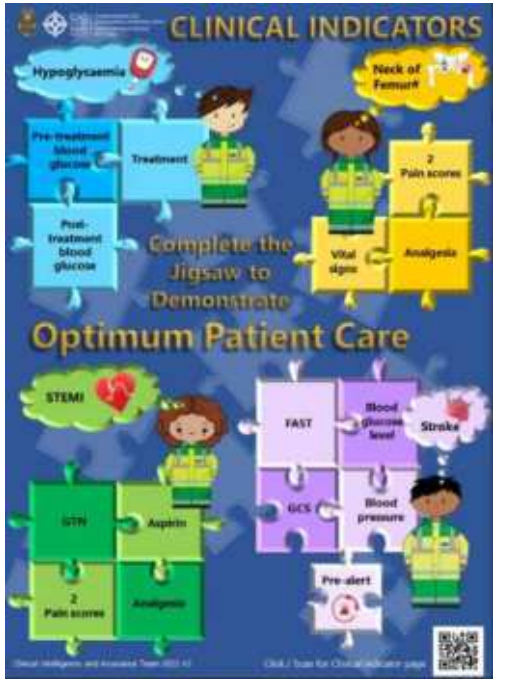
Care Bundle Control Limits April 2022 – March 2024



Improvements to date

- ePCR Clinical Data Assurance clinical audit completed to:
  - Provide a more accurate clinical picture of the care delivered
  - Highlight the variation between automated and audited data
  - Help inform future reporting and caveats
  - Help inform an improvement plan and changes to the ePCR User Interface
- Some User Interface changes were implemented in December 2023, work continues with the supplier to complete the remaining changes
- Improvement plan progressing with further engagement and support from Senior Paramedics for ePCR completion and CI compliance
- Development of a revised CI ‘Jigsaw Poster’ following requests from staff to use as an aide memoir





Next steps to improvement

- **Complete and test the User Interface changes to the ePCR**
- **User Interface changes include a facility to improve ePCR compliance for specific fields at point of ePCR closure (*changes managed by the ePCR Compliance Approval Group*)**
  - **To enable message prompts and quick access to non-compliant fields prior to closing ePCRs**
- **Continued engagement with Senior Paramedics to influence more direct clinical supervision during ride outs**
- **Complete the development of a 'Tenant Structure' to enable CIs to be reported at a range of levels (Trust wide, HB area, Locality, Team, Individual)**
- **Clinical Improvement & Clinical Intelligence and Assurance teams meeting with SPs to provide support, guidance and data to promote CI compliance**
- **A dedicated MS Teams channel has been established to include SPs, Clinical Leads, DOMs & LMs**
- **A stand at the CEO Roadshows made available to promote CI compliance**

Next steps to improvement

- **An action from an Internal Audit:**
  To improve assurance on completeness of documented pain management for patients, and the ability to extract data, identifying and reporting themes and trends.

- **This led to the development of a Pain Management Framework involving a multi-disciplinary team. The Framework was approved at CQGG.**

- **A Pain Management Framework Implementation Plan has been developed and will be managed by the Clinical Intelligence & Assurance Group.**

- **The Implementation Plan includes:**

Further ePCR User Interface changes	Development of a Clinical Minimum Data Set	Development of a Tenant structure	Development of a reporting Dashboard
Compliance framework to improve ePCR completion and data quality	LMS 365 online resource to include a specific pain management section	Development of a PREM for pain management	Identify gaps where pain management is sub-optimal

Clinical Indicator Recovery Plan

- Following the switch to ePCR, the way data is collected when with the patient has changed. There are theoretical advantages to the new process, however this has not yet been realised with the monthly results. A Clinical Indicator Recovery Plan has been implemented.

- WAST aims are to provide an efficient structure that enables **'always on' automatic reporting**, enabling accurate and almost live data to be used for reporting at a variety of levels for all appropriate records. This differs from English Ambulance Trusts who only use a sample of a smaller clinical case.

- **Actions within the plan include:**

  - ✓ Full deployment at pace of the CI Improvement Plan
  - ✓ Focussed communication with WAST clinicians to use the bespoke ePCR boxes for CIs
  - ✓ Supporting Senior Paramedics to have conversations about CIs
  - ✓ Health Board focussed clinical workshops to promote understanding of CIs and care bundles
  - ✓ Invest in resources to utilise Natural language Processing, a form of AI to interrogate clinical narrative
  - ✓ Review scripting in a structured way for each CI bundle, monitor and repeat annually
  - ✓ Implementation of the clinical supervision policy to embed CIs
  - ✓ Plan resources required to provide clinical data at an individual level to all clinicians

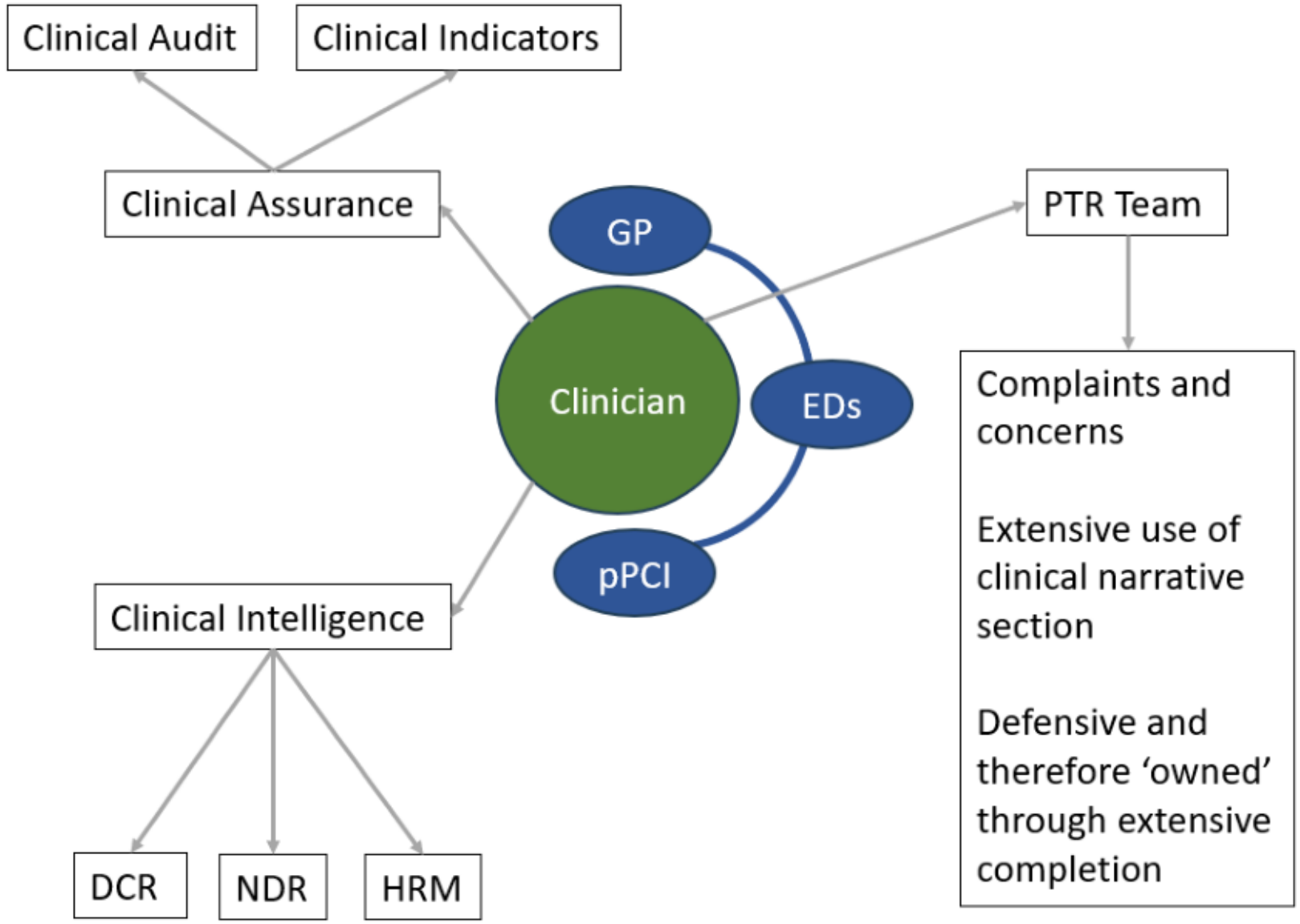
ePCR Users

Operational clinicians are the main users of ePCR. What data do they own?

A clinician might be more inclined to provide a clear clinical narrative and own that section as they may be challenged on it later. This is reinforced through education, feedback and the investigation process.

We do not encourage the same ownership on other data items at an individual level.

Can we change this?



Thank you for listening

Any questions or comments?

The next in this series for focus on CIs will be Hypoglycaemia

AGENDA ITEM No	**15**
OPEN or CLOSED	**OPEN**
No of ANNEXES	**1**

AUDIT TRACKER 2.0 – MARCH 2024 (Q4)

MEETING	Quality, Patient Safety and Experience Committee
DATE	07 May 2024
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Trish Mills, Director of Corporate Governance/Board Secretary Alex Payne, Corporate Governance Manager
CONTACT	trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. This paper provides the Committee with the current position with respect to management actions for audits within the purview of the Committee, in addition to the wider progress in Quarter.

2. There has been excellent engagement with Directorates on the revised Tracker 2.0, for Quarter four, with the result that of the total of 162 internal audit actions on the Tracker, 64 have been closed in quarter. This is a closure figure of 40% of all internal audit actions, and 57% of the total actions due in Quarter.

3. Of those internal audit actions relevant to this Committee, 16 have been closed in Quarter of a total of 35 (46%). This equates to 76%, as a % of those due in Quarter closed in Quarter. Of these actions due in Quarter, 5 due dates have moved (marked in blue) and one is on its third revised date.

4. Of those external audit actions relevant to this Committee, 4 have been closed in Quarter of a total of 12 (33%). Some actions have had a change in date proposed (marked in blue). Of these 3 action due dates have moved in quarter and one is on its third revised date.

5. The current version of the tracker is now open for Directorate review for actions due in April, May, and June. These updates will then be reported to the Committee at its meeting in August 2024.

RECOMMENDATION

6. The Committee is requested to:

(a) Receive and review any Internal Audits and Audit Wales reviews within their remit where relevant. For this meeting these are: -

- Serious Adverse Incidents – Joint Investigation Framework
- Electronic Patient Clinical Record: Clinical Compliance
- Seatbelt Action Plan

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

KEY ISSUES/IMPLICATIONS
As set out above.
REPORT APPROVAL ROUTE
Tracker presented to ADLT via email in April 2024.

REPORT APPENDICIES
Annex 1 – Tracker 2.0 January - March 2024 for Committee Reporting

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

SITUATION

7. This paper provides the Committee with the current position with respect to management actions for audits within the purview of the Committee, in addition to the wider progress in Quarter.

BACKGROUND

8. In September 2023 the Audit Committee approved the Audit Process and Reporting Handbook. The Handbook has been further revised since this date to include Audit Wales content.

9. The Handbook includes roles and responsibilities for the various stakeholders including:

    - The Assistant Directors Leadership Team (ADLT) as the forum to agree closure of actions, taking a check and challenge role on the Tracker.

    - Different reporting for the Audit Committee and Executive Leadership Team (ELT) to that provided to Committees, with the latter focused more on individual audits, progress and impact, and Audit Committee and ELT on the broader audit framework, progress, and exposure. This will start when Tracker 3.0 is developed which will draw the agreed reporting from the tracker via Power BI.

    - The introduction of a point of contact in Directorates for audits. This person(s) steers the audit with the Director and Assistant Directors/Deputies, ensuring internal audits feature on the directorate agenda monthly, they update the Tracker, and escalate issues as appropriate.

10. The Tracker has been updated in Quarter four following its complete revision in Quarter two. Members will receive a copy of the Tracker by email and are invited to filter the excel sheet to their particular Committee to view the relevant audit actions. A copy of the Tracker is also reproduced at Annex 1 filtered to the actions assigned to this Committee for oversight.

11. The team continues to work on the development of the SharePoint solution for Tracker 3.0 with colleagues in Digital Health and Care Wales Centre of Excellence. It is intended that this solution will be ready to implement / use early in the 2024/25 financial year, however further work is required to consider the transition from Tracker 2.0 to Tracker 3.0 – which is a significant task.

ASSESSMENT

12. The Handbook notes that it is the responsibility of a Board Committee (other than Audit Committee) to:

    - Receive audits in their remit;
    - Monitor management actions to address recommendations; and
    - Scrutinise impact of actions in response to audit recommendations in terms of, for example, quality improvement, the provision of more efficient and effective patient care, improved governance, better use of resources etc.

13. There has been excellent engagement with Directorates on the revised Tracker 2.0, for Quarter four, with the result that of the total of 162 internal audit actions on the Tracker, 64 have been closed in quarter. This is a closure figure of 40% of all internal audit actions, and 57% of the total actions due in Quarter.

14. Of those internal audit actions relevant to this Committee, 16 have been closed in Quarter of a total of 35 (46%). This equates to 76%, as a % of those due in Quarter closed in Quarter. Of these actions due in Quarter, 5 due dates have moved (marked in blue) and one is on its third revised date.

15. Of those external audit actions relevant to this Committee, 4 have been closed in Quarter of a total of 12 (33%). Some actions have had a change in date proposed (marked in blue). Of these 3 action due dates have moved in quarter and one is on its third revised date.

16. Discussions have also taken place on historical actions and those where management actions may need to be amended in view of the current operating context. There has been some traction with these, and discussions will continue into Quarter one with a view to closing down or revising as many as possible.

17. With respect to the Committee's responsibility to scrutinise the impact of actions, in November the Committee agreed that the most effective way to improve the scrutiny of the impact of actions was by identifying actions within audits as audit reports are reviewed by the Committee, going forward.

18. The current version of the tracker is now open for Directorate review for actions due in April, May, and June. These updates will then be reported to the Committee at its meeting in May 2024. The team will work with Directorate contacts to ensure a smooth transition between Tracker 2.0 and 3.0.

19. There continues to be good engagement with the Directorate points of contact to support the management of the actions in the Tracker. The Corporate Governance Team will work closely with the points of contact as the the SharePoint Tracker 3.0 develops.

RECOMMENDATION

20. The Committee is requested to:

(a) Receive and review any Internal Audits and Audit Wales reviews within their remit where relevant. For this meeting these are: -

- Serious Adverse Incidents – Joint Investigation Framework
- Electronic Patient Clinical Record: Clinical Compliance
- Seatbelt Action Plan

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

Points of Contact, Directors and Owners of Audit Actions - Do Not Amend Any Column With a Red Header
When proposing a revised 1st, 2nd or 3rd date, include the rationale for the movement and any progress on the action to date
ALL FINAL INTERNAL AUDIT REPORTS CAN BE FOUND ON THE CORPORATE GOVERNANCE SIREN PAGE

Trust Ref. No	Year/ Audit Plan	Committee assigned to	Report Title	Assurance Rating	Responsible Officer	Director	Priority Level	Rec. No.in Audit	Recommendation	Response No.in Audit	Management Response	Agreed Deadline in Report	Status - met or not met agreed deadline in report	1st revised date	2nd revised date	3rd revised date	Closure Status	Where a management action has not met the agreed or revised date, Director must inlcude here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. **Please add most recent update first**
462	21/22	QSPE	Role of Advanced Paramedic Practitioner	Reasonable	Kerry Robertshaw, Jonathan Chippendale	Andy Swinburn	Medium		Formal structures should be established to ensure APPs are appropriately supported to deliver a high standard of practice. This could include a peer review network, where feedback and themes are reported to the Care Closer to Home Group.		Development of proposed standardised clinical appraisal and supervision model to ensure APPs remain up-to-date and competent within their clinical practice.	Mar-22	Not Met	Dec 22	Mar-24		Closed in Quarter	Closed confirmed on this basis as this work has been completed. Last updated: 04.04.2024 Recommended for closure: Happy to close as per TM's recommendation 120324 Last updated: 06.03.2024 CSP policy through formal process supported by ELT but requires implementation plan for the whole organisation. Work through ACPDG and task and finish group commissioned by ELT to provide options appraisal. Last updated: 03.07.2023 APP leadership/clinical supervision rollout not supported at formal SOT in the current financial climate due to concerns around releasing APP leadership (8a) workforce from clinical duties to engage in leadership portfolio work streams. Decision to be revised in Q3. AHP funding bid against installing APP leadership infrastructure within the workforce appears unlikely to be successful. ePortfolio and curriculum development underpinned by clinical supervision framework, unable to progress until review in Q3
463	21/22	QSPE	Role of Advanced Paramedic Practitioner	Reasonable	Kerry Robertshaw, Jonathan Chippendale	Andy Swinburn	Medium		The Trust should, through an effective appraisal process, appropriately monitor APPs development in order to achieve all four pillars of advanced practice.		The creation of a 'Principles of Advanced Practice' guidance document to be created which will detail the methodology, application and monitoring of how the four pillars of advanced practice are being addressed within APP practice. Following approval, reporting against this will take place on a 6-monthly basis.	Mar-22	Not Met	Dec 22	Mar-24		Closed in Quarter	Closed confirmed on this basis as this work has been completed. Last updated: 04.04.2024 Recommended for closure: Happy to close as per TM's comments 120324, with skeleton document to be presented to OCG this month. Last updated: 06.03.2024 Skeleton document for OCG April 24 detailing where the work for this will take place. This requires significant infrastructure and is dependant on the CSP (above) with elements led by APP's in specific roles. Last updated: 03.07.2023 Principles of advanced practice document to be written over Q2 and steered through the Advanced practice Working group (new group created within LDP) and underpinned by the All Wales national advanced and enhanced advanced practice framework.
480	21/22	QSPE	Information Management - Hear and Treat	Reasonable	Paula Jeffery	Liam Williams / Andy Swinburn	Medium		1.1 We recommend that greater use is made of referral data in the incident records to inform further developments of current and future referral pathways, including; production of reports showing more detailed analysis by stop code.		1.1.1 A new report is available with data back to January 2021 which shows the referral pathway presented to the patient once the consultation with CSD is complete. This will be able to be broken down by health board area given the nature of the patient's location information. The Ops team is also reviewing in more detail the calls into CSD and their outcome. A review of this is likely late Q4 2022.	Mar-22	Not Met	Mar-24			Closed in Quarter	170424: (AP) Closure proposed. Last updated: 04.04.2024 Last update showed that data is now available in a Power BI report which shows the volume of telephone triaged calls referred to other services and can be broken down by HB area. Next steps to review and analyse the reports though suspect there is limited capacity for auditing at the current point in time. Could propose for closure as info was reported into MIQPR starting December 2023 and as and when forum becomes available/request comes in from Health Boards to view the data, this can be shared with them. Similarly, when capacity to complete audit becomes available within the CSD team, this can be implemented. Last Updated: 06.03.2024: CSD ECNS outcome data reported monthly at the national SDEC meeting with a view to scoping opportunity in patients with suitable RLC outcomes for alternative disposition (in the first instance, SDEC) Updated: 061023: Capacity building in the CSD team will enable this action to be progressed. Currently in IMTP actions for this area for delivery Q3-4 pending team expansion. Detailed analysis by stop code can be reported from a CSD perspective. Can be evidenced through Power BI dashboards and this information can be shared with the National SDEC Pathway Group on a monthly basis. All 7 HBs are cited from a community and hospital background at this group. The information is not currently provided in a report as it is live data but a functionality request for referral data to be shown by Health Board on a Power BI dashboard will be raised with Health Informatics and should be achievable by end of Q4. Update 19/10/22 Q4 2022 Update (Q3 2022-23) - Data is now available in a report in Powr BI which shows the volume of telephone triaged calls which were referred to other services and can be broken down by Health Board area. Next steps this quarter is to work with Clinical Services to review the reports and analyse.
480	21/22	QSPE	Information Management - Hear and Treat	Reasonable	Paula Jeffery	Liam Williams / Andy Swinburn	Medium		1.2 Coordinated analysis, review and scrutiny of these internally to inform quality improvement.		1.1.2. The review can be shared to inform quality improvement.	Jun-22	Not Met	Sep-24			Closed in Quarter	170424: (AP) Closure proposed. Last Updated 04.04.2024 As above - Last update showed that data is now available in a Power BI report which shows the volume of telephone triaged calls referred to other services and can be broken down by HB area. Next steps to review and analyse the reports though suspect there is limited capacity for auditing at the current point in time. Could propose for closure as info was reported into MIQPR starting December 2023 and as and when forum becomes available/request comes in from Health Boards to view the data, this can be shared with them. Similarly, when capacity to complete audit becomes available within the CSD team, this can be implemented. Last Updated 061023: Further investigation to be undertaken on whether this data would benefit HB partners e.g. could report into SDEC meetings as it is currently unconfirmed whether there is a forum to enable this data to be shared. Management action relevent in 2018 before work undertaken to build on pathways. Info broken down for reporting currently not done by HB level in the usual process by CSD team (see 480 1.1 above). Team to look at possibility of incorporating this filter for reporting if it will be useful to the HBs or whether this is already reported on by Operations. Development of project work (480 1.2 above) may provide more information to accompany the data which HBs may find useful. Updated: 19/10/22 See above, subsequent action.

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480	21/22	QSPE	Information Management - Hear and Treat	Reasonable	Paula Jeffery	Liam Williams / Andy Swinburn	Medium		1.3 Reporting referral volumes at health board level to assist with their service provision planning		1.1.3. The detail in the new stop codes will allow for the reporting referral volumes through Consult and Close in CSD.	Jun-22	Not Met	Nov 22	Mar-24		Closed in Quarter	170424: (AP) Closure proposed. Last Updated 04.04.2024 As above - Last update showed that data is now available in a Power BI report which shows the volume of telephone triaged calls referred to other services and can be broken down by HB area. Next steps to review and analyse the reports though suspect there is limited capacity for auditing at the current point in time. Could propose for closure as info was reported into MIQPR starting December 2023 and as and when forum becomes available/request comes in from Health Boards to view the data, this can be shared with them. Similarly, when capacity to complete audit becomes available within the CSD team, this can be implemented. Last Updated 061023: Further investigation to be undertaken on whether this data would benefit HB partners e.g. could report into SDEC meetings as it is currently unconfirmed whether there is a forum to enable this data to be shared. Management action relevent in 2018 before work undertaken to build on pathways. Info broken down for reporting currently not done by HB level in the usual process by CSD team (see 480 1.1 above). Team to look at possibility of incorporating this filter for reporting if it will be useful to the HBs or whether this is already reported on by Operations. Development of project work (480 1.2 above) may provide more information to accompany the data which HBs may find useful. Updated: 19/10/22 See above, subsequent action.
506	22/23	QSPE	Infection Prevention and Control	Reasonable	Louise Colson	Liam Williams	Medium		1.1 Once the overarching IPC policy is formally approved, the supporting policies/procedures/guidance documents should be reviewed and approved in a timely manner.		1.1-1.3 The recommendations are accepted. A project of work 'IPC 3P' will be undertaken to assess policies, procedures, and other 'powers' (including guidance documents, protocols, and activity-based risk assessments). The aim of the project is to 'map' current provision, monitoring arrangements, undertake a gap analysis, and embed a RACI framework to ensure organisational 'buy-in' and accountability. This work will lead to systematic review of departmental and relevant organisational documents.	Mar-23	Not Met	Sep-23	Dec-23		Closed in Quarter	3.4.24: The 3Ps Framework was submitted to Senior Quality Team on 20 March 2024. Assistant Director for Quality Governance has provided a supporting email as evidence on closure of this action. Proposed for closure 6.3.24 Update: Decision by Chair's Action to approve the Infection, Prevention & Control Policy by the Quality, Patient Experience & Safety Committee was formally recorded as at Tuesday 30 January 2024. This decision was ratified at the Quality, Patient Experience & Safety Committee on 8 February 2024. IPC 3P Mapping Workshop took place on 16 February 2024 with work progressing on the development of the 3P Project Framework. To be presented to Senior Quality Team on 20 March 2024 and Senior Quality Leadership Team on 26 March 2024 What will close the action: Approval of IPC Policy and 3P Project Framework developed What will you provide as evidence for the closuure: Approved IPC Policy and 3P Project Framework Is date reasonable: Given delays in getting everyone together for a 3P Workshop, an extension required to end March 2024 201223: IPC Policy will go for approval by Chair's Action in December. Propose closing this action once policy is approved. Linked actions 507 and 508 relate to the wider IPC 3P programme actions also. 21.11.23: Ongoing discussions with TU Partners on IPC Policy which will be discussed at Executive Leadership Team 22.11.23 Update 27.09.23: Both the IPC and Premise and Vehicle cleaning policies are in the policy group process still. Several meetings have been cancelled due to competing priorities involving the public enquiry. Two policies are awating final approval, the next meeting is now the 10th October. I anticiapte approval at this meeting with final approval at QUEST at the December meeting. The 3P project initial outlay is complete and incorporated into annual plan of work and was presented at the IPC strategic meeting on the 26th September. 30.06.23 (as per previous) The IPC policy has now been to the Policy group 24.04.23, a longer delay than anticipated but this was due to circumstances outside of the control of the IPC team. This will now be available for consultation. This will be a new policy which combines the AACE national policy. In the meantime work has been undertaken within the 'IPC 3P' to map out other forms of Standard Operating Procedures and Guidance and where they are aligned to. The RACI framework is being used to aid with identifyng responsibilites, risks and monitoring responsibilities. This along with the audit tracker will be presented at the next IPC strategic meeting in Q2.
507	22/23	QSPE	Infection Prevention and Control	Reasonable	Louise Colson	Liam Williams	Medium		1.2 The Trust should clarify arrangements within the Premise and Vehicle Cleaning policy to ensure cleaning instructions, responsibilities and monitoring are comprehensive and align with other related documents.		1.1-1.3 The recommendations are accepted. A project of work 'IPC 3P' will be undertaken to assess policies, procedures, and other 'powers' (including guidance documents, protocols, and activity-based risk assessments). The aim of the project is to 'map' current provision, monitoring arrangements, undertake a gap analysis, and embed a RACI framework to ensure organisational 'buy-in' and accountability. This work will lead to systematic review of departmental and relevant organisational documents.	Mar-23	Not Met	Sep-23	Feb-24	Aug-24	Open	3.4.24: The Polciy Group have deferred the submission of the Premises and Vehicle Cleaning Policy to 23 April 2024 Policy Group. The Policy will then be submitted to the Quality, Patient Experience & Safety Committee in August 2024. Date updated to August 2024 in quarter four, as Poliy approval through governance route delayed. 20.2.24: Review Meeting held on 9.2.24 with Julie Boalch; Head of Infection, Prevention Control; and members of the Estates Team to fully discuss and review the Premises and Vehicle Cleaning Policy. A Teams folder has been set up for the Estates Team to review the Policy and track all changes. Updated Policy to be presented to Policy Group on 27 March 2024. What will close the action: Approved Premises and Vehicle Cleaning Policy What will you provide as evidence for the closure: Approved Premises and Vehicle Cleaning Policy Is date reasonable: Given the delay in the engagement with this Policy being reviewed, submission to the February Policy Group was missed and Policy will now be presented to 23 April 2024 Policy Group therefore an extension required due to onward reporting and approval by the Quality, Patient Experience & Safety Committee on 7 May 2024. 21.12.23: Estates have confirmed that the section regarding the Buildings Group and Buildings Manager are to remain in the Premises and Vehicle Cleaning Policy therefore this can now progress to Policy Group Update 121023: this action will be closed once the IPC and the Premises and Vehicles Polices are approved at Committee . These Policies have been deferred to February Committee due to cancellation of Policy Group Meetings.Update 27.09.23 The Premise and Vehicle cleaning policy is awating approval vai the Policy Group pathway. There is a delay in its progress due to cancelled meetings. The nxt meeting is the 10th October and i anticiapate fianl approval at QUEST December 2023 The trust has a clear vehicle decontamination SOP. The vehilce audit tool has been redesigned, piloted and is good to go.

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508	22/23	QSPE	Infection Prevention and Control	Reasonable	Louise Colson	Liam Williams	Medium		1.3 The Trust should map IPC and related policies, responsibilities, ownership, monitoring and governance arrangements to support future review and development of policies and guidance		1.1-1.3 The recommendations are accepted. A project of work 'IPC 3P' will be undertaken to assess policies, procedures, and other 'powers' (including guidance documents, protocols, and activity-based risk assessments). The aim of the project is to 'map' current provision, monitoring arrangements, undertake a gap analysis, and embed a RACI framework to ensure organisational 'buy-in' and accountability. This work will lead to systematic review of departmental and relevant organisational documents.	Mar-23	Not Met	Mar 24			Closed in Quarter	3.4.24: The 3Ps Framework was submitted to Senior Quality Team on 20 March 2024. Assistant Director for Quality Governance has provided a supporting email as evidence on closure of this action. Proposed for closure. Accepted by BoardSec. Update 6.2.24: Linked to Trust Ref 506 What will close the action: 3P's Project Framework What will you provide as evidence for the closure: 3P's Project Framework Is date reasonable: Yes - but will be an ongoing Project (Directorate and Trust wide) 21.11.23: Meeting arranged with Julie Boalch for 3 January 2024 on taking the 3 Ps Project forward Update 27.09.23: The 3 P project continues, the content of which is now incorporated into the IPC annual plan. This was discussed and shared with the IPC Strategic meeting and is now at a stage for cross directorate working. All IPC related policies within the trust have been identified as the parent document, along with associated guidance, standards, SOPs, audit tools, risk assessments and training. Included is the RACI for each area of responsibility.This document has now started to identify the gaps and the work is at the stage to be shared as there are cross directorate responnsibilites. The progress has also been reported in the IPC Q1 highlight report Update 30.06.23 IPC 3P project to be reported to CQGG in Q2
517	22/23	QSPE	Infection Prevention and Control	Reasonable	Louise Colson	Liam Williams	Low		The Trust should ensure online resources contain up to date links and guidance		We accept the recommendation, future workplans will detail requirements.	Jan-23	Not Met	Sep-23	Apr-24		Open	Update 3.4.24: all on track for completion by end April 2024. What will close the action: Upload onto LMS365 What will you provide as evidence for the closure: Link to new site Is date reasonable: Yes - April 2024 achievable Update 27.09.23: Proposed revised date 31.03.24. The prehospital Care ESR training resources has been updated. The ANTT Training package is in the process of being updated along with the All Wales ANTT policy. We have a plan with training school for ANTT training on the MIST training for 2024/25. This will commence April 2024. A discussion with the training school at the last IPC strategic meeting to transer some of the onclick training to the Learning Launchpad. The priority modules will be PPE, RED Level PPE training, Vehicle Cleaning and Waste management. The other modules via onlick can be incorporated into these modules as they are largely pandemic related training.. Updated 30.6.23 (as per previous 26.04.2023)
519	22/23	QSPE	Infection Prevention and Control	Reasonable	Louise Colson	Liam Williams	High		6.2 The Trust should consider longer term mechanisms for compliance which incorporate and map responsibilities of the wider IPC Strategic membership and include outline of compliance monitoring and reporting.		We accept the recommendation to standardise documentation formats. This action will be addressed through the IPC 3P Project (management response 1.1)	Jun-23	Not Met	Mar-24			Closed in Quarter	12042024: Action proposed for closure as IPC Strategic Group in existence and ToR and recent meeting record received as evidence, which includes evidence of approval. AP updated status to 'closure proposed' on this basis. Update 27.09.23:The 3P project documentation was presented to the IPC strategic group in the September meeting, this will be reflected in the AAA report to CQGG and then in Q2 IPC Highlight report. Update 30.6.23: 3P project outputs to be presented to IPC Strategic Group and CQGG in Q2.
604	22/23	Quest	Pain Management	Limited	Duncan Robertson	Andy Swinburn	High	1.2(c)	The Trust should ensure all PGDs follow the Medicines Management policy, with a review undertaken every three years as a minimum.	1.2 (c)	The PGD development and review process is resource intensive, and pharmacist input is an essential requirement. Pharmacist Advisor availability is currently limited to 4-hours per month and does not currently meet the needs of the organisation, particularly given the uplift in advanced practitioners and extended skills (enhanced analgesia) of the paramedic workforce. We will develop an options appraisal to determine a costed and effective way forward to provide additional Pharmacist Advisor capacity	Mar-24	Not Met	May-24			Open	170424: (AP) Not clear when received at ELT so revised date in Q4 of May24 added. Last updated 04.04.2024 Recommend for closure: Options presented to Executives and recruitment commenced.
605	22/23	Quest	Pain Management	Limited	Duncan Robertson	Andy Swinburn	High	2.1	To gain assurances on the completeness of pain management recorded for patients, additional pathways within the ePCR system, should be established to extract the required data; and reported to an appropriate forum with any themes or trends highlighted within the report.	2.1	We propose to set up a task and finish group, to develop/design a pain management framework to support analysis and presentation of pain/analgesia related data. We anticipate this will enable a fuller picture of pain management, across a range of conditions, in addition to STEMI and Fractured Neck of Femur. The framework will be presented to the Clinical Intelligence and Assurance Group by the end of Q3 2023/24 and then through to CQGG and QUEST. There will be a co-dependency on some of the actions on the outcome of Matter Arising 3.	Dec-23	Not Met	Jan-24			Closed in Quarter	Last Updated 04.04.2024 Recommended for closure: Pain Management Framework has been presented to CQGG on the 29th February 2024. The work will now be part of BAU through the Clinical Intelligence and Assurance Group. Evidenee received and closure proposed. Dec 23: Update 221223 from Clinical Directorate: Agreed for implementation by CIAG (done in December) and will be passed to CQGG for approval in January. T&F group is set up, they have had 3 meetings and AAA received to November CIAG. Framework and supporting documents will be presented to the December CIAG for approval and onward communication to CQGG and upwards. AAA to be submitted for evidence. (On track for December completion). Date updated in Q3 to Jan24.
650	22/23	Quest	Records Management	Reasonable	Jonny Sammut	Jonny Sammut	High	1.1	Management should ensure that a full review of current resources, how resource is used and time required to complete all legislative duties is undertaken, to identify gaps and risk areas upon which capacity and resilience can be measured.	1.1	Previous time & motion study showed significant variance in the tasks undertaken, and similar pressure is felt across records service community in NHS Wales with increasing complexity. A risk will be captured around legislative duties. Exploration of digital tooling to support better tracking of activity in the RM team is already being taken forward, and the ways of working of the team is under continuous review for improvement.	Dec-23	Not Met	Jan-24	May-24		Open	12042024: Revised date of May 2024 (in quarter 4) added following update below. Last Updated 22/03/2024: risk drafted and reviewed by Health Informatics Senior Management Team. To be logged on Datix - this will close the action. Taget date moved in Quarter 4 to May24. Update 18/12/23: Risk register training conducted for team in Dec, to enable creation of this risk. Digital tooling has been explored and is progressing through procurement process. A demo is to be arranged for the team in January-24. Expected risk action to be completed in January-24 (after passing through relevant governance routes within Digital).

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652	22/23	Quest	Records Management	Reasonable	Leanne Smith	Jonny Sammut	High	1.2(b)	The IG reports should include a measure of the complexity of requests.	1.2(b)	Additional metrics will be included in the IG & InfoSec KPI report, representing complexity of and utilisation in legislative duties.	Jan-24	Met				Closed in Quarter	Last update 140324 (TM) Board Secretary has seen evidence of complex case reporting in IGSG from January. Update 18/12/23: to help identify and define complex cases, employee requests are now being tracked to understand effort / length of time typically required for such responses. This will inform a metric that can be built into the reporting for Information Governance Steering Group from January-24. Additional work required still to understand how a case which *becomes * complex is logged, e.g. fire & police requests.
653	22/23	Quest	Records Management	Reasonable	Leanne Smith	Jonny Sammut	Medium	2.1(a)	A record management improvement plan should be developed, based on a formal assessment of records throughout the Trust.	2.1(a)	Additional fixed-term support will be sought to conduct the assessment and craft an improvement plan. The risk of not developing an improvement plan in 2023-24 will be included in the risk being developed as per action 1.1.	Sep-24	Not Yet Due				Open	
654	22/23	Quest	Records Management	Reasonable	Judith Birkett	Jonny Sammut	Medium	2.1(b)	A record management improvement plan should be developed, based on a formal assessment of records throughout the Trust.	2.1(b)	A Digital Notice re records management will be published on the intranet to increase awareness of individual staff responsibility.	Dec-23	Not Met	Jan-24	Apr-24		Open	Last Updated 25/03/24: a Records Managment Improvement Plan has been developed, approved by Assistant Director of Digital, and is already being progressed. This will be shared with Information Governance Steering Group for awareness in April 2024. Date changed in Q4 to April24. Target date moved in Quarter 3 to January-24. Update 18/12/23: materials have been developed to help raise awareness of records management. These are being finalised, with a plan to share and put on the Records Siren page with a living FAQ sheet. Plan to release this in January-24.
655	22/23	Quest	Records Management	Reasonable	Judith Birkett	Jonny Sammut	High	3.1(a)	A formal agreement for storage of records should be developed. This should set out the responsibilities and requirements for management of health records.	3.1(a)	Additional temporary resource to be sought (from Jan-24) to conduct review of DCC stored boxes and retention schedules. A forecast of storage requirements at DCC will be created to inform a decision on if/when it will be possible to move these records into WAST-managed storage (e.g. at VPH).	Apr-24	Not Yet Due				Open	
656	22/23	Quest	Records Management	Reasonable	Judith Birkett	Jonny Sammut	High	3.1(b)	A formal agreement for storage of records should be developed. This should set out the responsibilities and requirements for management of health records.	3.1(b)	Should [following the review at 3.1a being evaluated] we still need space at Denbigh County Council then we will pursue an agreement with them for those storage, retention and disposal. In the meantime, we will ask for the policies and procedures the Council have in place for their receipt, retention and destruction of records and confirm that this is the way they treat our records. That should provide some assurance on the issues in the matter arising.	Sep-24	Not Yet Due				Open	
657	22/23	Quest	Records Management	Reasonable	Leanne Smith	Jonny Sammut	Medium	4.1	Records should be moved into the new storage area.	4.1	RSAM to review suitability of the VPH storage facility and access management arrangements. If appropriate, secure transfer of the records from Pontypool to VPH will require budget approval beyond the funds available for Records Services (to be discussed with Corporate Governance & Finance).	Jan-24	Not Met	Jun-24			Open	Date changed in Q4 to Junee 2024 in line with update. Last Updated 25/03/24: request for date extension to Jun-24. VPH storage facility still to be assessed for feasibility.
658	22/23	Quest	Records Management	Reasonable	Judith Birkett	Jonny Sammut	Medium	5.1	The records management improvement plan noted in MA2 should include a programme of identification and assessment of all records storage areas within the Trust.	5.1	The risk of not fully assessing storage areas in 2023-24 will be acknowledged in the risk being developed as per action 1.1. A Trust-wide request will be made to gather intel on what paper records are being stored across the organisation and where. This will inform the improvement plan of how to assure these storage areas.	Sep-24	Not Yet Due				Open	Last Update 25/03/24: a risk has been developed regarding the overall compliance of records management. Further risks are in development, to capture the specifics of storage areas.
659	22/23	Quest	Records Management	Reasonable	Judith Birkett	Jonny Sammut	High	6.1	The records management improvement plan noted in MA2 should include an assessment of the disposal of records (both physical and digital) and ensure that records are removed as appropriate.	6.1	Agreement that this is needed, but dependency on the assessments of MA2 and MA5, for which additional fixed-term expert support would be required. There is however an individual staff responsibility and asset owner responsibility to ensure records are disposed of correctly, which will be included in the Digital Notice of action 2.1.	Dec-23	Not Met	Feb-24			Closed in Quarter	Last Updated 25/03/24: The Improvement Plan (action 654) includes an item for records disposal. Additionally, records management training, including a topic on disposal, has been created. This training has already been delivered to locality admin staff in Operations, and will be delivered to other teams, with a recording available on Siren for broader awareness. Propose closure accepted. Target date moved in Quarter 3 to February-24. Update 18/12/23: materials have been developed to help raise awareness of records management. These are being finalised, with a plan to share and out on the Records Management intranet page. Plan to release this in January-24. An Information Asset Owners forum is also planned to be established from February-24.
668	23/24	Quest	Serious Adverse Incidents - Joint Investigation Framework	Reasonable	Wendy Herbert	Liam Williams	Medium	1.1	The Trust's 'Adverse Incident and Reporting Policy' should be reviewed and updated to reflect the requirements set out within the NHS Wales policy.	1.1	The Putting Things Right Team plan was to review relevant policies following the release of the new Putting Things Right Regulations by Welsh Government in May 2024. A recent update from Welsh Government has confirmed that the release will now be Autumn 2024. At which point the review will be undertaken. The Trust has approved policies in respect of incident reporting and management and a Putting Things Right Policy which are included on the intranet site (review dates are both April 2026). Staff also have access to User Guides on the intranet site for Datix Cymru. The All-Wales Patient Safety Policy (NHS Executive) (May 2023) is also due review in March 2024 and will be updated internally when released nationally	Nov 24 On release from NHS Wales Exec	Not Yet Due				Open	Update: What will close the action: Updated version of the Putting Things Right Policy (following release of the new Putting Things Right Regulations in Autumn 2024) and adoption of the updated National Patient Safety Incident Reporting and Management Policy (adopted by WAST in June 2023 and review is due by the NHS Wales Executive by March 2023 (awaited). What will you provide as evidence for the closure: Copies of both approved policies on the Intranet. Is date reasonable: Dependant on release date of Putting Things Right Regulations by Welsh Government and updated National Patient Safety Incident Reporting and Management Policy by the NHS Wales Executive.
669	23/24	Quest	Serious Adverse Incidents - Joint Investigation Framework	Reasonable	Julie Boalch	Trish Mills	Medium	1.2	To allow accessibility for all members of staff, the NHS Wales policy should be made available on the Trust's intranet site.	1.2	To be included on the Intranet site.	Feb-24	Met				Closed in Quarter	11042024: This Policy is now available on the Trust's Siren page (saved in this section of the Policy - National Policy on Patient Safety Incident Reporting). Julie Boalch confirmed that this action be closed and status updated to 'closure proposed'.

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670	23/24	Quest	Serious Adverse Incidents - Joint Investigation Framework	Reasonable	Stephen Johnson	Liam Williams	Low	2.1	To address the requirements of steps 1 and 2 of the Joint Investigation Process, where there is a delay to raising and reviewing an incident on Datix Cymru, appropriate narrative should be included within to support this to ensure a full audit trail is captured.	2.1	Patient Safety Team to update the narrative on Datix Cymru as part of business as usual processes.	Mar-24	Met				Closed in Quarter	3.4.24 The Patient Safety Team implemented this action during the audit phase and have evidence on datix to demonstrate they are updating accordingly. Proposed for closure; closure proposed accepted. Target date moved in Q4 to June (end of Q1) to provide for spot checks to be completed as per below. Update 5.3.24: Awareness raised and implemented as business as usual with immediate effect. What will close the action: Implementation of updates as business as usual. What will you provide as evidence for the closure: Monthly spot checks (commencing March 2024) to be undertaken. Is date reasonable: Yes. Implementation commenced February 2024 (following release of Audit Report). Evidence of spot checks will be due Quarter 1.
671	23/24	Quest	Serious Adverse Incidents - Joint Investigation Framework	Reasonable	Stephen Johnson	Liam Williams	Low	2.2	To address the requirements of step 5 of the Joint Investigation Process, a periodic review of actions not completed within the action log should be undertaken to ensure that records are up to date.	2.2	Patient Safety Team to undertake a monthly review of the action log.	Apr-24	Not Yet Due				Open	What will close the action: Monthly review of Serious Case Incident Forum Log to identify any gaps What will you provide as evidence for the closure: Serious Case Incident Forum Log (completed) Is date reasonable: Yes
672	23/24	Quest	Serious Adverse Incidents - Joint Investigation Framework	Reasonable	Stephen Johnson	Liam Williams	Low	3.1	To facilitate completeness of reporting, consideration should be given to the enhancement of the SCIF/JIF data included at the Putting Things Right report.	3.1	The Putting Things Right Report will include additional process measures in respect of the Joint Investigation Framework within the Quarter 4 Report (January – March 2023/24)	Apr-24	Not Yet Due				Open	What will close the action: Inclusion of additional process measures in respect of the Joint Investigation Framework within the Quarter 4 Putting Things Right Report (January - March 2023/24) What will you provide as evidence for the closure: Putting Things Right Quarterly Report, Quarter 4 2023/24 for the Clinical Quality Governance Group on 30 April 2024. Is date reasonable: Yes
673	23/24	Quest	Serious Adverse Incidents - Joint Investigation Framework	Reasonable	Lucie Jones	Liam Williams	Low	4.1(a)	The Trust should consider the opportunity to consolidate key issues and areas of learning and disseminate Trust-wide to minimise reoccurrence.	4.1(a)	The Trust has been engaged in the All Wales Enhancing Learning Programme since September 2023 and this includes the roll out of an all-Wales framework for learning from events (including but not limited to incidents). This programme includes membership from all health boards, trusts and health bodies and considers internal and wider system learning.	Mar-24	Not Met				Closed in Quarter	3.4.24 Approval and adoption of Framework was received at Clinical & Quality Governance Group on 25 March 2024. Proposed for closure. Evidence provided: closure proposed accepted. Copy of All Wales Enhanced Learning Programme Plan (Attached) Executive Summary including All Wales Framework from Learning from Events Framework which was tabled at Clinical & Quality Governance Group on 25 March 2024 - attached SBAR and Annexes; Agenda & AAA There was a request from Liam for this to go directly into Clinical and Quality Governance Group for adoption by the Welsh Ambulance Servies NHS Trust (the Executive Summary details this). To provide further assurance, the Welsh Risk Pool Committee met in March 2024 and Jonathan Webb will be writing to all Chief Executives to advise that the next steps will be an Implementation Plan which will be Nationally driven. Target date moved in Q4 to April as per narrative below Update 5.3.24: This National programme doesn't complete until 31.3.2024. Next steps are to be determined by the Welsh Risk Pool Committee at the March meeting in respect of resourcing a further stage of the programme. What will close the action: Welsh Ambulance Services NHS Trust (WAST) version of the All Wales Learning from Events Framework (this is drafted but will not go through Group/Committee until the end of the programme as next steps need to be included from a national perspective at the end of March 2024). What will you provide as evidence for the closure: WAST document (which will then require implementation and monitoring). Template version and evidence of WAST involvement provided for current assurance purposes. Is date reasonable: Yes
674	23/24	Quest	Serious Adverse Incidents - Joint Investigation Framework	Reasonable	Stephen Johnson	Liam Williams	Low	4.1(b)	The Trust should consider the opportunity to consolidate key issues and areas of learning and disseminate Trust-wide to minimise reoccurrence.	4.1(b)	The capability to extract themes and trends from the SCIF log has already been set up by the new PTR Coordinator. This data and information will inform the PTR Quarterly Report.	Jun-24	Met				Closed in Quarter	3.4.24 This information is already included in the Quartlery Putting Things Right Report for the Quality, Patient Experience & Safety Committee on 8 February 224. Proposed for closure; closure proposed accepted. What will close the action: Consolidation of key issues and areas of learning into the Putting Things Right Quarterly Report What will you provide as evidence for the closure: Copy of Putting Things Right Quartlery Report; Link to communications disseminating Trust wide Is date reasonable: Yes - already included in submissoin for 8 February 2024 Quality, Patient Experience & Safety Commitee
681	23/24	Quest	Electronic Patient Clinical Records: Clinical Compliance (ePCR)	Reasonable	Duncan Robertson	Andy Swinburn	Medium	1.1	To confirm accuracy of the self-certification compliance rate, management should consider capturing the method of training delivery on ESR.	1.1	For future training, the method of instruction will be captured as part of the ESR sign-off process (for example, classroom based, individual learning using the training materials, one to one instruction using the training zone in the application).	Jun-24	Not Yet Due				Open	Last updated 04.04.2024 Work has yet to be commence due to meeting cycles. Will be an agenda item at the ePCR Clinical Reference Group on the 28th March (agenda to be competed on the 21st March 2024).
682	23/24	Quest	Electronic Patient Clinical Records: Clinical Compliance (ePCR)	Reasonable	Duncan Robertson	Andy Swinburn	Medium	1.2	Management should obtain feedback from staff to improve the training materials.	1.2	We will design a survey via the ePCR Clinical Reference Group (CRG) for ePCR users to explore the reasons for this and how training materials might be improved to enhance ePCR completion.	Jun-24	Not Yet Due				Open	Last updated 04.04.2024 Work has yet to be commence due to meeting cycles. Will be an agenda item at the ePCR Clinical Reference Group on the 28th March (agenda to be competed on the 21st March 2024).
683	23/24	Quest	Electronic Patient Clinical Records: Clinical Compliance (ePCR)	Reasonable	Duncan Robertson	Andy Swinburn	Medium	1.3	Management should consider including a test in ESR to confirm competency before successfully self-certifying.	1.3	At the ePCR CRG WAST will discuss including a test to assess understanding at the completion of training.	Jun-24	Not Yet Due				Open	Last updated 04.04.2024 Work has yet to be commence due to meeting cycles. Will be an agenda item at the ePCR Clinical Reference Group on the 28th March (agenda to be competed on the 21st March 2024).
684	23/24	Quest	Electronic Patient Clinical Records: Clinical Compliance (ePCR)	Reasonable	Duncan Robertson	Andy Swinburn	Medium	1.4	Whilst we acknowledge there are different methods of training delivery, management should review lower viewed training modules, to confirm that the completed ePCRs are compliant with expectations in this area.	1.4	Through the ePCR Clinical Reference Group (CRG) we will review the lower viewed modules as set out in Appendix B of this report. This will build on knowledge discussed at the most recent ePCR CRG where a small audit has identified that the obstetric section is not being completed. However, we currently have only opened access to the Welsh GP Record (WGPR) for our cohort of Advanced and Senior Paramedics. The pathways section of the ePCR is not currently live and requires testing prior to going live, which explains the disparity reported in these sections of Appendix B.	Sep-24	Not Yet Due				Open	Last updated 04.04.2024 Work has yet to be commence due to meeting cycles. Will be an agenda item at the ePCR Clinical Reference Group on the 28th March (agenda to be competed on the 21st March 2024).

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685	23/24	Quest	Electronic Patient Clinical Records: Clinical Compliance (ePCR)	Reasonable	Duncan Robertson	Andy Swinburn	High	2.1	The Trust, with continued support from Terrafix, should address the limitations and caveats relating to the dashboard reports to ensure that they provide robust information on all incidents.	2.1	We will review the compliance dashboards and amend the nomenclature used and recommend changes to the presentation of the data to ensure consistency and understanding. However, this is dependent on the capacity of Health Informatics to complete the work.	Sep-24	Not Yet Due				Open	Last updated 04.04.2024 Work has yet to be commence due to meeting cycles. Will be an agenda item at the ePCR Clinical Reference Group on the 28th March (agenda to be competed on the 21st March 2024).
686	23/24	Quest	Electronic Patient Clinical Records: Clinical Compliance (ePCR)	Reasonable	Duncan Robertson / "nominated Digital Directorate Lead" - not yet in place, TBC	Andy Swinburn	High	2.2	Management should ensure the tenant structure is developed to provide data at both a team and individual level to assist in identifying training needs and drive improvement in ePCR compliance.	2.2	Reporting into CIAG, we will set up a Task and Finish Group to write the plan to deliver the dashboards against the Tenant Structure. This is a complex piece and requires input from multiple directorates. It is also dependent on the capacity within teams to deliver the dashboards, therefore the output of the T&F might be a business case jointly developed between the Digital and Clinical Directorates to outline the resources required and what this would cost to deliver.	Sep-24	Not Yet Due				Open	Last updated 04.04.2024 Work has yet to be commence due to meeting cycles. Will be an agenda item at the ePCR Clinical Reference Group on the 28th March (agenda to be competed on the 21st March 2024).
687	23/24	Quest	Electronic Patient Clinical Records: Clinical Compliance (ePCR)	Reasonable	Duncan Robertson	Andy Swinburn	High	2.3	The Trust should continue with its programme of Clinical Data Assurance audits to inform further upgrades required to the system to improve data quality and the accuracy of care bundle compliance reporting.	2.3	Clinical Audit Programme for 2024/25 has been agreed at CIAG and presented for approval to the February 2024 QuEST meeting. This is ongoing work and does not require a specific action as it is central business for the CIAT.	N/A	Met				Closed in Quarter	140324 (TM) Closed as per action narrative

Points of Contact, Directors and Owners of Audit Actions - Do Not Amend Any Column With a Red Header

When proposing a revised 1st, 2nd or 3rd date, include the rationale for the movement and any progress on the action to date

Tracker Ref No	Audit Wales or HIW Report	Year	Committee Assigned to	Report Title	Responsible Officer	Director	Priority Level	Rec. No. in Audit	Recommendation	Report. or rec. in Audit	Management Response	Agreed Deadline in Report	Status	1st revised date	2nd revised date	3rd revised date	Where a management action has not met the agreed or revised date, Director must inlcude here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. **Please add most recent update first**	Closure Status
106	Audit Wales	22/23	QUEST	Review of Quality Governance Arrangments	Jonathan Turnbull-Ross/ Wendy Herbert/ Hugh Bennett	Liam Williams			R8 We found that the QuESt Committee is well served with quality information, but there are opportunities for improvement. The Trust should: develop a system to triangulate learning themes across its quality assurance reports. This should ensure clarity about what improvement actions have been taken as a result and how learning has been disseminated across the organisation. enhance Covid-19 reporting in the integrated quality and performance report by including information about the harm caused to patients by ongoing service pressures caused by the virus. (d) work with health bodies so that there are systems to determine the outcomes for patients who have received emergency ambulance services. This should particularly seek to understand the consequence and harm resulting from service failures such as long ambulance waits. develop patient outcome measures to support its existing quality measures.		d) The Trust will continue to share information and intelligence with partners that detail the consequences of system failures. Whilst particularly evident where experience or outcome is poor and results in complaint or adverse incident. The Trust will pursue patient outcome data through development of the ePCR over 2022/23.	Mar-23	Not Met	Dec-23	Mar-24	Jul-24	250424: Date changed in Q4 to July 2024 in lnie with AW timelines for conclusion of related follow up audit. 15042024: This will remain open until AW confirm as part of the current quality governance audit that it can close. Daet will change in quarter (from March 2024 to new date). Update 14032024 from Duncan Robertson: The Health Informatics team are currently working with DHCW to enable a flow of data relating to out of hospital cardiac arrest. This it to test the systems and processes. When complete, this learning will be applied to other presentations for analysis. TM will engage with Audit Wales on a potential revised approach for this action. 201223: Given the comment below Board Secretary suggests a 'check in' date of 31 March 2024. Audit Wales will be doing a further review at that time and may wish to reframe this recommendation. 11.12.23 Update from Duncan Robertson: The WAST and DHCW data-sharing agreement is with the ICO and Welsh Government as part of a consultation. This will provide the legal basis to share data. No completion date has been provided, therefore the December target date will not be met. It is completely outside of WASTs gift to propose a completion date The Putting Things Right Team are strengthening the Putting Things Right Quarterly Reports to include themes, patterns and trends. REVISED DATE OF DECEMBER 2023 21.11.23: Update 121023: Work Ongoing and will take a period to complete. Conversations continue with DHCW and the Ambulance Data Set (ADS) lead in England to define the ePCR definitions. Work is also continuing with DHCW to establish data sharing to enable joining up of patient records to report on outcome data. no timeline as yet and meeting with DHCW continue to clarify some of the definitions following discussions with the lead for the ADS in England. Trust Information Governance colleagues are working with DHCW for this. 26.09.23: Duty of Quality Implementation plan includes the four quadrants of quality management system as set out in the 'road map'. Quality & Performance Management Steering Group continue to monitor and review the development of 'always on' reporting in line with the requirements of the act. Additional metrics have been approved by Trust Board for inclusion in the MIQPR including PREMS/PROMS, Duty of Candour metrics. New HI post now appointed to support MIQPR move to Power BI dashboard. Proposed Revised date 31.12.23 rationale for extension is to allow BI Dashboard work to commence to allow analysts to identify how best to report 'Patient Reported Experience' measures that add value to decision making. Historic Update: We continue to work with Welsh Government colleagues and NHS Executive in the development of the 'all-Wales' Quality Management System, including how the QMS will 'join up' and detail the impact of ambulance performance on HBs/patient care. The Trust PECI Team have also continued to develop the Civiva patient experience software, alongside HBs, to enable analysis of patient experiences of services.	Open
106	Audit Wales	22/23	QUEST	Review of Quality Governance Arrangments	Jonathan Turnbull-Ross/ Wendy Herbert/ Hugh Bennett	Liam Williams			R8 We found that the QuESt Committee is well served with quality information, but there are opportunities for improvement. The Trust should: develop a system to triangulate learning themes across its quality assurance reports. This should ensure clarity about what improvement actions have been taken as a result and how learning has been disseminated across the organisation. enhance Covid-19 reporting in the integrated quality and performance report by including information about the harm caused to patients by ongoing service pressures caused by the virus. work with health bodies so that there are systems to determine the outcomes for patients who have received emergency ambulance services. This should particularly seek to understand the consequence and harm resulting from service failures such as long ambulance waits. develop patient outcome measures to support its existing quality measures.		e) The Trust is often limited by data accessibility where the patient journey extends beyond the organisational boundary. The Trust will pursue patient outcome data through development of the ePCR over 2022/23, which will enable 'joining up' of patient records. Furthermore, the Trust will further consider accessibility and governance matters for wider adoption of Patient Reported Outcome Measures, and Patient Reported Experience Measures.	Mar-23	Not Met	Mar-24	Jul-24		250424: Date changed in Q4 to July 2024 in lnie with AW timelines for conclusion of related follow up audit. 15042024: This will remain open until AW confirm as part of the current quality governance audit that it can close. Daet will change in quarter (from March 2024 to new date). Update 14032024 from Duncan Robertson: The Health Informatics team are currently working with DHCW to enable a flow of data relating to out of hospital cardiac arrest. This it to test the systems and processes. When complete, this learning will be applied to other presentations for analysis. TM will engage with Audit Wales on a potential revised approach for this action. 201223: Given the comment below Board Secretary suggests a 'check in' date of 31 March 2024. Audit Wales will be doing a further review at that time and may wish to reframe this recommendation. Update: 11.12.23 DEVELOPMENT OF EPCR: Update will be provided by Duncan Robertson via update of item d) PATIENT REPORTED OUTCOME MEASURES: The Trust has defined standardised data to measure. Minimum dataset of approximately 600 definitions to agree with DHCW. Currently linking with England to assess available datasets and definitions. Data sharing agreements currently sit with DHCW and Welsh Government for approval. Instruction letters shared and awaiting response. (Leanne Hawker liaising with Alex Crawford on completion date) PATIENT REPORTED EXPERIENCE MEASURES: Data survey and narrative for generalised PREMs has been standardised and feeds into the MIQPR. A bespoke PREM is being developed in relation to Pain Management and Learning Disability (should be completed by end January 2024) REVISED DATE OF MARCH 2024 Update 121023: PREMS live, but in development. PLICS is due to come on stream in Mar-24. PROMS is in development and dependent on DCHW. Business Care Process and Project Management Pathway are relevant considerations.	Open
130	HIW	23/24	Quest	National Review of Patient Flow – a journey through the stroke pathway	Lee Brooks	Liam Williams Andy Swinburn		4	Welsh Government, health boards and WAST must work collaboratively, to consider whether the Immediate Release Directions are effective or need improvements, given the high number of declined Immediate Release Directions occurring across Wales.	4	It is imperative to acknowledge that Immediate Release Directions are required when there is no ambulance to send to the patient. The inability to respond in a timely way is the lost capacity due to extended emergency department handover delays that in recent months absorbs between 20% to 33% of WAST conveying resource capacity. There is an argument that relying on immediate release to respond to patients is too late, as capacity is needed to respond in a timely way without relying on this mechanism. The All-Wales Immediate Release Protocol is approved by the NHS Wales Chief Executive group and used by WAST when directing immediate release. Its next review is due in January. The existing script used by WAST when entering the direction to health boards includes the age and chief complaint for the patient. In a recent meeting, led by EASC representatives with health board colleagues, it was suggested that the reason for the release direction should not have to be justified by WAST, and this helps to decrease the length of the script. This would be achieved by removing the age and chief complaint for the patient. It is posited this reduces moral injury for ED staff receiving the direction (sought by health board representatives) who may then be unable to accommodate. Considering this position and if required, it would not be possible for WAST to differentiate stroke patients from others when submitting the direction to health boards and arguably inhibits clinical prioritisation. WAST continues to validate immediate release directions, including providing health boards with data outputs following this process. WAST has been audited on its application of the protocol and recommendations appear in the WAST audit tracker. At this stage, there is nothing more that WAST can do to progress this recommendation. Accommodating immediate release directions is a matter for health board partners whilst WAST continues with its strategy to resolve more episodes of care closer to home (as per IMTP).	N/A	Met				Last Update (TM) - narrative indicates this is a HB action so closure proposed.	Closed in Quarter

Tool Ref No	Audit/ Review/ NTAV Report	Year	Committee Assigned to	Report Title	Responsible Officer	Director	Cross-Ref Level	Rec. No. in Audit	Recommendation	Response no. in Audit	Management Response	Agreed Deadline in Report	Status	1st revised date	2nd revised date	3rd revised date	Where a management action has not met the agreed or revised date, Director must inlcude here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. **Please add most recent update first**	Closure Status
131	HIW	23/24	Quest	National Review of Patient Flow – a journey through the stroke pathway	Liam Williams	Liam Williams Andy Swinburn		12	Health boards and WAST should engage with people to better understand the barriers to them accessing, or choosing, from the range of healthcare services available in Wales. Once the barriers are understood, this in turn, could be used to influence service design.	12	The Welsh Ambulance Service's Patient Experience & Community Involvement Team (PECI) operate a model of continuous engagement with patients, carers, service users, organisations, including the Stroke Association and Age Alliance Wales, stakeholders and the general public across Wales,. Meeting, listening to, capturing and acting on people's experiences of using the Welsh Ambulance Service, including Emergency Medical Services, Non-Emergency Patient Transport Services and NHS 111 Wales. WAST consistently aspire to work in partnership to develop services which are safe and appropriate, and to improve people's experiences and outcomes. In 2023, the PECI Team also established a People & Community Network for the Welsh Ambulance Service. Aligned to our Quality Strategy 2021-2024 and informed by the Health and Social Care (Quality & Engagement) (Wales) Act 2020; the People & Community Network is a group of people with a shared goal: to help develop and improve the services provided by Welsh Ambulance Services NHS Trust. The Network represents the voices and opinions of patients, service users, carers, staff and wider stakeholders from across Wales, in respect of services we provide. The Network will also work with Llais, the Welsh Government's new citizen voice body, to understand people's views and experiences of health and social care, and to make sure feedback is used by decision-makers to shape services and support the continuous improvement of person-centered services. WAST has a long-term aspiration to enhance its service offer managing more patients in the community. In delivering this, we aim to ensure greater emergency ambulance availability by supporting patients through the most appropriate part of the system in their times of crisis.	Nov-24	Not Yet Due				**Update 1.2.24**: Using the Continuous Engagement module and using multiple channels to capture feedback (Business as Usual). The Patient Experience & Community Involvement (PECI) Team are working with the Bevan Commission and Health Minister's office to review recommendations from the Bevan Commission Report produced and entitled 'A conversation with the public, challenges and opportunities for change'. Once recommendation is completed, the PECI Team will use the recommendations to identify what the Trust will do in order to sustain the recommendations. **What will close the action**: Using the Continuous Engagement Module and multiple channels to capture feedback (Business as Usual). Working with Bevan Commission and Minister's office to review recommendations from the Bevan Commission Report produced entitled 'A conversation with the public, challenges and opportunities for change'. Once recommendations are completed, the Patient Experience & Community Involvement Team will use the report to identify what the Trust need to do and internalise recommendations **What will you provide as evidence for the closure**: To be included in the PECU Bi-Annual Report to the Quality, Patient Experience & Safety Committee on 7 May 2024 **Is date reasonable**: It is likely this will close before November 2024	Open
132	HIW	23/24	Quest	National Review of Patient Flow – a journey through the stroke pathway	Andy Swinburn	Liam Williams Andy Swinburn		13.1	WAST must ensure that all relevant staff are fully aware of the WAST stroke pathway to minimise risks to patient safety.	13.1	It is noted that within the report 85% of the 44 staff involved in the survey undertaken by Health Inspectorate Wales (HIW) stated that they have received training to support and manage stroke patients. 77% of staff understood the stroke pathway however, only 49% of WAST respondents said that they always allocate or take a stroke patient to a specialist stroke unit. Considering the relatively low numbers of staff involved in this survey WAST will undertake its own clinical audit to ascertain as to widespread any short fall in adherence to the stroke pathway there may be. Paramedic and Emergency Medical Technician (EMT) education is underpinned by the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) Clinical Guidelines, these are available to all EMTs and Paramedics via an app on their individually issued i-Pads. These guidelines provided comprehensive guidance to Paramedics and EMTs on the pathophysiology, signs and symptoms, assessment and management of both stroke and TIA. Included in these guidelines is recognition that acute stroke is a 'time critical' condition and that patients should be conveyed to an appropriate stroke unit. WAST has for many years had in place a pathway for patients suffering an acute stroke, this includes a pre-alert which informs the receiving unit, preparing them to receive a possible stroke patient enabling the relevant stroke teams to be ready for their arrival. It is worth noting that the only hospital with an accident and emergency department where there is not a stroke unit is the Royal Glamorgan hospital. Clearly the WAST pathway for stroke does not include this hospital.	Jun-24	Not Yet Due					Open
133	HIW	23/24	Quest	National Review of Patient Flow – a journey through the stroke pathway	Andy Swinburn	Liam Williams Andy Swinburn		13.2	WAST must ensure that all relevant staff are fully aware of the WAST stroke pathway to minimise risks to patient safety.	13.2	'WAST is currently working with the stroke networks in Wales in relation to the upcoming reconfiguration of stroke services and the development of Hyper Acute Stroke Units (HASU), this will potentially result in a change to the existing stroke pathways that are in place. However, to ensure that the current stroke pathway is clearly understood by WAST staff, a clinical bulletin will be circulated updating staff on the current pathways that are in place across Wales relating to stroke, this will then be updated the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) app that is available to all Paramedics and EMT's via their personal issue i-Pads.'	Dec-24	Not Met				Completed in quarter but original date of December not met. Closure proposed. Last Updated 04.04.2024 Recommended for closure. Jon Whelan presented to ELT, unable to identify precise numbers but there was a ball park figure of 2500 amber 2s becoming amber 1 around 7 per day across Wales. This was approved, the necessary changes were actioned at 10:30 02.04.2024, MJ put out comms to our teams last week which are accessible either from Siren or the JRCLAC App Update from Board Secretary 140324 - Update to WAST DCR table - alignment with other UK ambulance services and to meet clinical guidelines for stroke care paper came to ELT on 17 January 2024. ELT approved the report's recommendations subject to stakeholders to include the CASC, Welsh Government and the Stroke Association being informed of the proposed changes in advance of the change being made. It was agreed AS would draft a letter for JK's signature. 23.01.2024 - Mike Jenkins awaiting confirmation from CPAS of evidence of numbers and impact, to then go to ELT for final sign off. Action for Mike Jenkins, aiming for ELT towards end of January, expect action to be complete 31 January 2024.	Closed in Quarter
134	HIW	23/24	Quest	National Review of Patient Flow – a journey through the stroke pathway	Andy Swinburn	Liam Williams Andy Swinburn		14	Welsh Government should consider how it can support WAST to develop and implement improvements with its service delivery model, such as increasing the number of advanced paramedic practitioners across Wales, to help reduce the pressure on EDs and improve flow through healthcare systems.	14	While WAST recognises that this is not a recommendation for WAST, we wholly endorse this recommendation and remain ready to play our part in growing the number of APPs.		Met				Update from Board Secretary 140324 - action closed as not WAST action	Closed in Quarter

Tracker Ref No	Audit/ Review/ Follow Up Report	Year	Committee Assigned to	Report Title	Responsible Officer	Director	Executive Lead	Rec. No. in Audit	Recommendation	Response no. in Audit	Management Response	Agreed Deadline in Report	Status	1st revised date	2nd revised date	3rd revised date	Where a management action has not met the agreed or revised date, Director must inlcude here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. **Please add most recent update first**	Closure Status
135	HIW	23/24	Quest	National Review of Patient Flow – a journey through the stroke pathway	Andy Swinburn	Liam Williams Andy Swinburn		15	WAST should consider the benefits of training its paramedic staff in the use of the ROSIER stroke assessment tool, to enable staff to differentiate patients with stroke and stroke mimics, such as TIA.	15	WAST has previously considered the implementation of ROSIER, however the decision not to adopt was informed by a study undertaken by a large ambulance service in England that demonstrated that ROSIER was no better than the Face Arm Speech Test (FAST) in the prehospital setting. As stated above clinical practice is underpinned by JRCALC, these guidelines inform the attending EMT/Paramedic to the level of assessment that should be undertaken. JRCALC does not include ROSIER as part of the recommended assessment, it does however suggest that clinician may consider using the PASTA (Paramedic Acute Stroke Treatments Assessment) structured assessment and handover as per local agreement. To further inform the debate around prehospital stroke assessment, the HIW report will be presented to the WAST 'Ambulance Practice Steering Group' for consideration. As part of that consideration WAST will undertake an up-to-date literature review to ascertain to whether the previous study has been superseded. To further inform this point WAST will consult the Welsh Stroke Network for a expert view on the use of ROSSIER or indeed any other stroke tool for the pre hospital setting. In addition, within the above-mentioned clinical bulletin all EMTs and Paramedics will be reminded that if a patient remains FAST positive despite some evidence of improvement, stroke should be considered as the primary differential diagnosis, TIA should only be consider following a complete recovery, this latter point is highlighted within JRCALC Practice Guidelines. To support ongoing education to all future Paramedics, WAST will seek to work further in partnership with both universities in Wales who deliver pre-registration education in developing an up-to-date syllabus for stroke education, supported by senior stroke specialists from across Wales.	Jun-24	Not Yet Due					Open
136	HIW	23/24	Quest	National Review of Patient Flow – a journey through the stroke pathway	Liam Williams	Liam Williams Andy Swinburn		17	WAST and all health boards must work collaboratively to identify a consistent approach to ensure handover of stroke patients is made within the Welsh Government 15-minute target. This is to ensure that time critical investigations and treatment are undertaken promptly.	17	WAST recognises that it has a responsibility to undertake an appropriate clinical assessment of patients presenting with stroke symptoms. Where stroke is considered a potential diagnosis a pre alert should be provided to the appropriate unit to inform stroke teams of the patients' imminent arrival enabling them to be prepared for a rapid handover of care for that patient. It is recognised that system pressures that exist has a direct impact on the 15-minute handover period. WAST continues to work with the health boards to minimise the impact upon service delivery to all its patients. It is worth noting that there does exist improvements across some health boards in Wales, while still accepting that there are further improvements required across all health board areas. WAST will seek to work with Executive Directors of Nursing in the development of a handover standardised pathway.	Jun-24	Not Yet Due				Update 12.4.24 from LW: It is recommended that this action is closed within the Audit Tracker as with effect from April 2024 the new Clinical Networks have been implemented and are accountable for the performance and quality management of stroke care outcomes Wales. Propose for Closure accepted by Board Sec. Update 09042024 from LW: The Executive Directors of Nursing Peer Network has been approached on several occasions to improve the opportunities for EDs and hospitals to respond effectively to pre-alerts and receipt of stroke patients as part of wider system escalation, clinical risk management and service improvement discussions. However, the Peer Network is not in a position to define each UHB and hospital's approach to resourcing the Stroke pathway; clinical and country wide leadership remains with the Stroke Network which WAST is actively engaged in and local service delivery is led by UHBs, to which WAST raises the need for improved system working on multiple fora. 14032024: Update from Alison Kelly: Query regarding the ownership of this action. May move to Andy.	Closed in Quarter
137	HIW	23/24	Quest	National Review of Patient Flow – a journey through the stroke pathway	Andy Swinburn	Liam Williams Andy Swinburn		27	Health boards and WAST must ensure that all staff associated with potential stroke patients are aware of the updated guidance for thrombolysis treatment window of between 4.5 and nine hours, as highlighted within the National Clinical Guideline for Stroke updated in April 2023.	27	WAST recognises that the 'National Clinical Guideline for Stroke (2023) recommends that patients suffering with an acute stroke may be treated with alteplase or tenecteplase if that treatment can be started within 9 hours of known onset, or within 9 hours of the midpoint of sleep when they have woken with symptoms. In recognising this WAST will work with stroke networks to coordinate the dissemination of this information to all staff involved in the management of patients suffering an acute stroke to ensure a consistent approach across the NHS in Wales. It should be recognised that extending the time window from a 4.5 to a 9-hour window has a potential resource implication for WAST. Following the clarity from the stroke network further engagement with our commissioners will take place if necessary.	Jun-24	Not Yet Due					Open
138	HIW	23/24	Quest	National Review of Patient Flow – a journey through the stroke pathway	Andy Swinburn	Liam Williams Andy Swinburn		32(a)	WAST must consider its current response times for patients awaiting interhospital transfers for urgent thrombectomy treatment which are classified as 'Red'. This is to ensure a thrombectomy can be completed within the six-hour timescale from the onset of symptoms.	32(a)	WAST has been working with the stroke leads and the South Wales Major Trauma Network to implement a process that supports the interhospital process for patients referred for thrombectomy outside of Wales. Patients identified for thrombectomy have their transfer arranged through the trauma desk which is situated in a WAST contact centre. The trauma desk team are contacted directly to discuss the transfer requirements of the patient and ensure we have the correct level of clinical support during the transfer and that the transfer is correctly prioritised. Red prioritisation is the highest level of response in our clinical response model, other examples in this group are cardiac arrest, choking and catastrophic haemorrhage. Welsh Government has set ambulance response targets at 65% of all calls categorised as immediately life threatening (red) to receive an emergency response within eight minutes, these standards are reported monthly by Local Health Board.	Complete	Not Met	May-24			1704 24: (AP) Awaiting receipt of the letter that was signed. Once received action can be closed. Date updated in Q4 to May2024. Last Updated 04.04.2024 Recommended for closure, ELT approval closes the action, JK has signed the letter and receipt has been acknowledged by identified stakeholders. Update from Board Secretary 140324 - Update to WAST DCR table - alignment with other UK ambulance services and to meet clinical guidelines for stroke care paper came to ELT on 17 January 2024. ELT approved the report's recommendations subject to stakeholders to include the CASC, Welsh Government and the Stroke Association being informed of the proposed changes in advance of the change being made. It was agreed AS would draft a letter for JK's signature.	Open
139	HIW	23/24	Quest	National Review of Patient Flow – a journey through the stroke pathway	Andy Swinburn	Liam Williams Andy Swinburn		32(b)	WAST must consider its current response times for patients awaiting interhospital transfers for urgent thrombectomy treatment which are classified as 'Red'. This is to ensure a thrombectomy can be completed within the six-hour timescale from the onset of symptoms.	32(b)	WAST will review this process in due course and ascertain its success and determine if any further actions are required	Jun-24	Not Yet Due					Open

Serious Adverse Incidents – Joint Investigation Framework

Final Internal Audit Report

February 2024

Welsh Ambulance Services NHS Trust

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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

Contents

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Draft report issued:	26 January 2024
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Final report issued:	15 February 2024
Auditors:	Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit; Rhian-Lynne Lewis, Principal Auditor
Executive sign-off:	Liam Williams, Executive Director of Quality and Nursing
Distribution:	Wendy Herbert, Assistant Director of Quality and Nursing; Jane Palin, Assistant Director, Quality & Safety (Interim); Stephen Johnson, Head of Patient Safety, Concerns & Learning; Lucie Jones, Deputy Head of Patient Safety.
Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement:

NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Executive Summary

Purpose

To undertake a review of the Trust's compliance with the joint investigation framework for serious patient safety incidents.

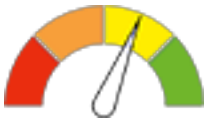
Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include areas of non-compliance with Section 4 (Joint Investigation Process) of the NHS Wales National Policy, noting which a review of the internal policy should be undertaken.

Other recommendations / advisory points are within the detail of the report.

Report Opinion

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate** impact on residual risk exposure until resolved	N/A

Assurance summary[1]

Objectives		Assurance
1	Policy and Procedures	Reasonable
2	Training and Supervision	Reasonable
3	Patient Safety Incidents	Reasonable
4	Incident Investigations	Reasonable
5	Monitoring and Reporting	Reasonable
6	Action Plans and Lessons Learned	Reasonable

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Policy review	1	Design	Medium

1. Introduction

1.1 As outlined in the NHS Wales National Policy on Patient Safety Incident Reporting & Management, 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. The process for investigating such incidents is vital to understand and learn from what has gone wrong, to identify and address risk areas and to provide assurance to the Healthcare provider over the quality of patient care, in line with the NHS Wales (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. Incidents that occurred after 1 April 2023 that meet the following triggers, are also subject to Duty of Candour procedures as set out in the Health and Social Care (Wales) Act 2020.

1.2 All patient safety incidents should be reported through Datix Cymru, part of the Once for Wales Concerns Management System. In 2019, the Trust and all trusts and health boards agreed a joint investigation framework for serious patient safety incidents. The framework sets out the process for escalating serious incidents, including where the main cause is a factor outside of the Trust's control or because of health board hospital handover delays. The Trust identifies cases for escalation through its Serious Case Incident Forum (SCIF). In these cases, the Trust completes an incident referral form and sends it to the appropriate health body for investigation, copying in the Welsh Government's Delivery Unit.

1.3 Due to significant numbers of referrals not being investigated properly or reported nationally, this process was requested to be reviewed by the Emergency Ambulance Services Committee (EASC) and was led by the NHS Wales Delivery Unit. Significant discussion and work occurred over the summer of 2022 to agree the Joint Investigations framework through a Task and Finish Group that had membership from every Health Board, WAST and wider NHS Partners. A key outcome of the process is the requirement for a joint meeting to confirm a serious incident has occurred, confirm if a joint investigation is required and subsequently, which organisation will lead the investigation. Implementation of the process took place through a pilot which reported to EASC and the NHS Wales Delivery Unit.

1.4 The risks considered during the review were:

- Inappropriate investigation arrangements could lead to further patient harm.
- Financial risk from litigation due to patient harm.
- Compromised patient care.

1.5 During the planning of this review management advised that the Datix Cymru used to capture, track and report incidents and investigations has provided some limitations in relation to the investigation process. This has been taken into consideration during the course of our fieldwork.

1.6 The coverage of the review has focused solely on the joint investigation process and arrangements (Section 4 of the NHS Wales Policy). The stage at which the Trust report on National Reportable Incidents (NRIs) has not been considered.

2. Detailed Audit Findings

2.1 The table below summarises the recommendations raised by priority rating:

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	-	2	2	4
Operating Effectiveness	-	-	2	2
Total	**-**	**2**	**4**	**6**

2.2 Our detailed audit findings are set out below. All matters arising and the related recommendations and management actions are detailed in Appendix A.

Objective 1: The Trust has incident management policy and procedures in place which align to the NHS Wales policy.

2.3 The *NHS Wales National Policy (*the NHS Wales policy*) on Patient Safety Incident (PSI) Reporting & Management* provides guidance on incident reporting and the subsequent management and investigation requirements, to ensure a consistent approach across Wales. The policy was updated in April 2023.

2.4 The NHS Wales policy has six supporting sections which provide further detail in relation to the management and reporting of PSIs:

Section 1: Never Events List	*List of reportable patient safety incidents to be classed as Never Events.*
Section 2: Reporting Process	*Guidance for submission of any National Reportable Incidents (NRI) forms to the NHS Wales Executive*
Section 3: Guidance on Specific Incident Types	*Provides clarity around some particular types of incidents which may require national reporting.*
Section 4: Joint Investigation Process (JIP)	*Provides guidance and a structure for joint investigations involving multiple organisations.*
Section 5: Safety II Guidance	*Guidance on applying Safety-II thinking into current incident management practices.*
Section 6: Commissioned Services	*Application of the Policy within commissioned services.*

2.5 Whilst the above are relevant to the wider management of incidents, the focus of our review has been in relation to the Joint Investigation Process (JIP) and the Trust's adherence to such (see audit objectives 3 and 4).

2.6 The Trust has an '*Adverse Incident and Reporting Policy*' in place which was updated in April 2023. It sets out *structure and clarity around the process for reporting, receiving, investigating, responding to and learning from Adverse Incidents (ADI), Near Misses, Hazards and National Reportable Incidents (NRIs)*, including:

- Reporting Process, including passing incidents to other organisations.
- Roles and Responsibilities.
- National Reportable Incidents Serious Case Incident Forum (SCIF).
- Duty of Candour.
- Investigations and Learning; and
- Audit and Monitoring.

2.7 We note that the Trust policy includes limited references to the NHS Wales policy and review of the content noted it does not set out a detailed process for the JIP to align with Section 4 of the NHS Wales policy. While a joint investigation should meet the same standards and requirements of any patient safety incident investigation, there may be logistical differences in terms of how a joint investigation is conducted in practice. See **MA1**

2.8 The Trust have advised us that they have committed to a full policy review, with a view for completion in Autumn 2024, to ensure the alignment of patient safety incidents, health and safety, Datix arrangements and also revision of relevant group reporting arrangements. We acknowledge that the timeline for this review will be subject to the Welsh Government's completion of their review of the Putting Things Right Regulations. Refer to audit objective 4 for review of compliance for joint investigations.

2.9 Our review of Siren did not identify any links to the NHS Wales Policy therefore making it less accessible to staff. See **MA1**

Conclusion:

2.10 The Trust has an internal policy to support local arrangements for incident management and reporting which is available to all staff; and we have identified enhancements required, in respect of the joint investigation process, to ensure alignment to the NHS Wales policy. The NHS Wales Policy provides national guidance on incident management; however, it is not readily available to all members of Trust staff. **Reasonable** assurance has therefore been determined for this objective.

Objective 2: Appropriate training and supervision arrangements are in place for staff undertaking investigations into patient safety incidents.

2.11 The Patient Safety Team (PST) structure consists of the Head of Patient Safety, Concerns and Learning (PSCL), three Investigation Supervising Officers, a Lead Serious Incident Investigator & Advisor and three Patient Safety Managers (PSM) - noting one post was vacant at the date of fieldwork. The team has recently undergone a formal Organisational Change Process (OCP) with six additional posts to be recruited (covering the whole of the Putting Things Right Team).

2.12 We were advised that PSMs typically hold active professional registration as registered Nurses/Midwives or Paramedics and have undergone a BTEC level 7 Advanced Professional Certificate in Investigative Practice. In addition, the one PSM is currently enrolled on the *Leading Patient Safety* course with the Safe Care Collaborative and the Deputy Head of Patient Safety is the Trust lead for the Welsh Risk Pool Enhanced Learning Programme which commenced in September 2023.

2.13 The PSMs are responsible for coordinating and overseeing all PSIs and receive an automated email when a new PSI has been added to Datix Cymru. The PST has developed a procedural guide for team members when reviewing and progressing incidents, which sets out the process from when the Datix Cymru entry is created through to its conclusion. There are experienced members within the team to provide support and mentoring. Investigations, and the wider SCIF portfolio (refer to audit objective 5), are supervised by the Head of PSCL ensuring that all information in relation to incidents is collated and is adequate.

2.14 Upon commencement of employment with the Trust, each employee attends a corporate induction session which includes a section on patient safety delivered by a member of the PST. Coverage includes:

- An understanding of how concerns are managed;
- Identifying when patient safety has (or could have) been affected; and
- An emphasis of the importance of why all patient safety incidents must be reported and investigated (noting it should be seen as a positive, not negative process).

2.15 Patient safety training is also delivered on an ad hoc basis, tailored for specific role progression such as Operational Team Leader and Duty Operation Manager.

Conclusion:

2.16 PSMs hold professional registrations and complete appropriate investigative practice training. A procedural guide is available to assist during investigations and there are experienced members within the team to provide support and mentoring. Appropriate guidance is also shared with all new Trust employees, upon induction, with regard to patient safety incidents. A **reasonable** assurance rating is therefore concluded for this objective.

Objective 3: Patient safety incidents (including nationally reportable incidents) are identified and captured.

2.17 PSIs are defined as *any unintended or unexpected incidents which could have, or did lead to harm for one or more patients receiving NHS-funded care*. Within the Trust they are identified and recorded/reported by:

- Paramedics and Technicians;
- Staff at Clinical Contact Centres;
- Staff at 111 Call Centres;
- Ambulance Care Service;
- Other Trusts / health boards (referred as a joint investigation); and
- Complaints received (that are escalated to incidents as appropriate).

2.18 As documented within audit objective 2, all staff receive patient safety training during their initial induction. Once a PSI is identified, this must be entered on to Datix Cymru. Each PSI is reviewed by the PSMs (including low harm) to ensure that they have been appropriately categorised, with reference to the categories set out in section 6.1 of the Trust's Policy, and to assess if the incident requires escalation.

2.19 In addition to Datix Cymru, serious incidents are recorded on the SCIF action log which is updated to reflect discussion at each SCIF meeting. The Datix Cymru system does not currently have the functionality to code incidents as joint investigations as required by the NHS Policy. The PST, however, does include narrative within the Datix Cymru records to indicate where incidents have been referred under JIF.

2.20 The JIP sets out three key areas that are considered essential to ensure an efficient and effective joint investigation between entities:

Joint Incident Management Meetings	Meetings should be arranged as soon as practicably possible following an incident and it sets out suggested membership/attendance and the frequency of meetings.
Standard Data Set	This has been provided to the Trust and Health Boards by NHS Wales and is used to capture and share information in relation to the incident. This is referred to as a SCIF briefing paper within the Trust, but the formal name is the 'Patient Safety Incident Requiring Joint Review'.
Overview of joint investigation process	This provides NHS bodies in Wales with guidance on how to instigate, progress and conclude a joint investigation.

2.21 The JIP further details 13 steps that Health Boards and Trusts should consider when assessing a PSI for consideration for a joint investigation. We reviewed 22 patient safety incidents that were referred under the joint investigation framework between January and August 2023 (161 in total for this period), to ensure that

expected processes have been followed in line with the NHS Wales policy. The items were selected from the Trust's SCIF action log.

2.22 The Trust was not the lead investigator for any of the items in our sample. We note that, due to the nature of the incidents, i.e. the impact of handover delays at emergency departments on the care provided to patients in the ambulance and the Trust's ability to reach patients out in the community, the Trust will lead on very few investigations.

2.23 A summary of our findings relating to the capture and escalation (section 4: Joint Investigation Process, steps 1 and 2) is as follows, with full details included in Appendix B:

Extract from Joint Investigation Process	Audit Findings
Step 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 cases were identified where there was a delay of more than 10 days between the incident date/notification received from the other organisation and when the Datix Cymru incident was created by the Trust. See **MA2**
Step 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.*	As part of the Trust's local arrangements, a Patient Safety Incident Requiring Joint Review Paper (PSI RJR or SCIF brief) is requested by the PSMs to instigate a review at a SCIF meeting. As per the policy, this is expected to take place within 2 working days of the Datix Cymru incident being raised. Two cases were identified where there were delays of 19 and 27 days, respectively, between the incident date and a SCIF briefing being requested. See **MA2**

Conclusion:

2.24 Patient safety incidents are captured on Datix Cymru and reviewed by the Patient Safety Team. Serious incidents, including those requiring joint investigation, are also recorded on the SCIF action log which is discussed and updated at each SCIF meeting. Timelines within the National Policy in relation to the initial capture and escalation were not adhered to for a small number of incidents in our testing sample. As such, **reasonable** assurance is determined.

Objective 4: Incidents are investigated, quality assured, approved and responded to within required timeframes and in-line with the joint investigation process.

2.25 When an incident is reported on the Datix Cymru system, this will trigger an automated email to the PST and any other relevant divisions across the Trust (e.g. clinical, operational, clinical contact centres etc.) so that all relevant parties are aware that investigations/audits are required. Each division then undertakes a review of their contribution to the incident, i.e. Emergency Medical Service Clinical Contact Centre investigator would listen to the relevant calls, senior

paramedics/locality managers would interview the relevant paramedic/technician and ensure ePCR (electronic patient clinical record) detail is factually correct and complete.

2.26 Once an issue is escalated to SCIF, the Deputy Patient Safety Manager within the PST prepares a briefing paper using a standard form which captures the organisation, Datix Cymru reference, incident date, summary of incident, data from the electronic patient clinical record and hospital turnaround times, thus establishing a timeline of events from the Trust's perspective.

2.27 The briefing paper for the incident is then attached to a SCIF meeting which occur twice weekly. The relevant information is presented at the meeting and where it is determined that another responsible body has contributed to the incident, the Trust refers it to them to lead the investigation under the JIF. This decision is documented and captured within the SCIF action log. The Trust refers a significant proportion of incidents to Health Boards as a result of the handover delays due to over-crowding at emergency departments and broader system pressures.

2.28 During audit fieldwork, we observed a SCIF meeting to further understand the process to identify if an incident should be assessed in line with the JIP as set out in the NHS Wales Policy. We were advised that the lead organisation is usually the Health Board where the patient resides as they are deemed the best place to ensure a patient centered approach.

2.29 The JIP recommends that a joint investigation management meeting (JIMM) is arranged with the relevant Health Board/Trust to discuss the incident and establish next steps. Discussion with the Deputy Head of Patient Safety confirmed that due to the significant volume of incidents referred under the JIF, reflecting the wider system pressures being faced by the NHS, regular weekly meetings are held in place of JIMMs, allowing for multiple incidents to be reviewed.

2.30 We also note that within the Trust, Datix Cymru incidents are closed at the point the incident is referred to a Health Board/Trust as a JIF as from the Trust's perspective, all necessary work has been completed, i.e. the incident discussed with their counterparts and the PSI RJR / SCIF brief has been shared with them. Discussion with the PST established that this is to show that the Trust is no longer the lead on the investigation but will update the record on Datix if further updates are received from the Health Board/Trust. If the Trust did not adopt this approach, then these incidents could remain open on Datix indefinitely.

2.31 The selected sample of incidents was further reviewed to confirm compliance with the remaining JIP steps (as per Section 4 of the NHS Wales policy). A summary of our findings is as follows, with full details included in Appendix B:

Extract from Joint Investigation Process	Audit Findings
Step 4 *The incident should be discussed at the joint incident management meeting to make a joint decision on whether it requires a joint investigation.*	Due to the volume of SCIFs being received, reflecting the wider system pressures being faced by the NHS, formal joint investigation management meetings are not arranged. As a mitigating action, the PSMs meet

Extract from Joint Investigation Process	Audit Findings
	weekly with their relevant health board counterparts to discuss investigations.
Step 5 *Consideration of the lead organisation should be taken on a case by case basis.*	The decision to determine the lead investigating organisation is discussed within the SCIF meetings, and is subsequently documented and captured within the SCIF meeting action log. The lead organisation was agreed in all items in our sample apart from one incident dating back to February 2023 which we couldn't determine if it had been investigated. **See MA2** The Trust was not the lead investigator for any of the items in our sample.
Step 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 (YCFF).*	Trust PSMs meet with their Health Board equivalents on a weekly basis and active investigations are discussed. We note that these meetings are not minuted but the existence of meetings has been confirmed in diaries.
Step 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.*	Discussion with the PST has confirmed that the issuing of final investigation reports is not consistent across Wales and as such, feedback from investigations is very limited to allow for learning. **See MA5.** We note that as the Trust leads on so few joint investigations, this is outside of their control.
Step 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.*	Within the Trust, Datix Cymru incidents are closed at the point the incident is referred as a JIF as from the Trust's perspective, all necessary work has been completed, i.e. the incident discussed with Health Board colleagues and the PSI RJR / SCIF brief has been shared with them. The PSMs are however able to return to the incident to update and add additional supporting documents, post closure. There were only 3 cases where a final report/closure email had been received and added to Datix Cymru. We do, however, acknowledge, that this is outside the control of the Trust.

Conclusion:

2.32 Serious incidents are investigated internally and escalated at the SCIF to determine whether they require joint investigation. A significant proportion of these incidents are as a result of handover delays at emergency departments, as well as broader system pressures, and are therefore referred to Health Boards to lead the joint investigation. Due to the significant volume of incidents, Trust PSMs meet with their Health Board counterparts on a weekly basis to discuss, instead of convening the Joint Investigation Management Meeting required by the NHS Wales policy. Due to the limited updates received from Health Boards on the status of investigations, the Trust closes the incidents on both Datix and the SCIF action log at the point they are referred to them as lead investigators. As such a **reasonable** assurance rating is determined for this objective.

Objective 5: Monitoring and reporting take place at appropriate forums within the Trust and with external parties.

2.33 The SCIF meeting was established to *undertake a timely, multidisciplinary review of all patient safety incidents which are assessed as causing actual or potential moderate, severe or catastrophic harm to patients*. Following review of the incident and underpinning intelligence surrounding the incident, a view on next steps is taken in terms of the type and level of investigation required.

2.34 The group meets twice weekly and has a diverse membership to include input from all departments involved in an incident. The terms of reference define quoracy as the Chair and four members, which must include a representative from Patient Safety, Emergency Medical Services Coordination & Resourcing, Clinical Directorate and Operations. During the course of the fieldwork, it was identified that attendance at SCIF meetings was not captured and recorded and as such, quoracy could not be confirmed. We note that the Trust responded to this immediately and attendance was captured from this point onwards and further evidence has been provided to confirm that these arrangements are being maintained. We also note that this forum could not proceed without the active involvement from the representatives as no decisions would be able to be taken. With the acknowledgment that this recording of attendance needs to be sustained, we have not raised a recommendation at this report.

2.35 Due to the sensitivity of the matters discussed within the SCIF meetings, we note that minutes are not taken. Rather, the group produces a high-level action log which references all SCIF incidents. This is reviewed at each meeting and updated upon completion of actions.

2.36 A SCIF Alert, Advise, Assure (AAA) report is presented to the Clinical Quality and Governance Group (CQGG) on a monthly basis. This summarises the Trust's current position on matters discussed at SCIF, including joint investigations, the number of open NRI investigations and subsequent themes identified.

2.37 Review of the CQGG terms of reference notes that the membership of the group includes a diverse range of employees, and sub-groups that the group oversees

including the SCIF. Quoracy is defined as five members with one being the Chair or Co-chair. A review of four meetings (June to September 2023) has confirmed quoracy and that meetings are well attended. Following its monthly meeting, CQGG prepares a AAA report to the Executive Management Team (EMT).

2.38 The Quality, Patient Experience and Safety Committee (QuESt) receives a quarterly Putting Things Right report. The last report (presented October 2023) provided an update stating that there were 73 cases reviewed at SCIF during the reporting period, with 39 referred under the Joint Investigation Framework. We note that there is opportunity to provide more detail on the status of joint investigations. **See MA3**

2.39 The Monthly Integrated Quality and Performance Report (MiQPR) presented to QuESt details a range of performance metrics, including an update on the number of cases taken to SCIF during the period and of which, those cases that were referred under the Joint investigation Framework. This MIQPR report will also be presented to the Trust Board, who also receive a report on 'Actions to Mitigate Patient Harm' and underpinning improvement plan.

2.40 During the reporting period August to October 2023, this report identified 46 severe cases of avoidable harm that were referred to Health Boards under the joint investigation framework. While the report also has wider considerations, it includes an action plan setting out arrangements to mitigate avoidable patient harm which is subject to review and scrutiny at Board level.

2.41 External organisations are kept up to date on investigation progress during meetings between the Trust's PSMs and their respective counterparts in relevant organisations. The JIP requires that once an investigation has been completed, a final SCIF briefing paper is emailed to the relevant Health Board/Trust, providing them with the closing decisions of the joint investigation. However, we note that this is not being consistently undertaken across Wales.

Conclusion:

2.42 There is an appropriate internal reporting framework in place, with escalation from the SCIF meeting through to the Clinical Quality and Governance Group and onwards to Executive Management Team, QuESt and Trust Board. Adequate reporting to external parties is also undertaken. The formality of recording the quoracy at the SCIF meetings was addressed during the course of fieldwork, with record of attendance now maintained. Therefore a **reasonable** assurance rating is determined for this objective.

Objective 6: Action plans are in place for lessons learnt from patient's safety incidents and reports are shared across the Trust.

2.43 On completion of an investigation, the Trust is notified of the outcome through the weekly meeting between the PSMs, or via email from the investigating Health Board/Trust. Discussion with the Assistant Director of Quality Nursing noted that where feedback is received it does not typically capture lessons learned. These concerns have also been reported within the MiQPR to both QuESt and Trust Board.

One of the Patient Safety Team's priorities following the recruitment to the new structure is to try and influence system colleagues to identify more meaningful patterns, themes and trends and associated learning opportunities from the Joint Investigation Process, however ultimately oversight of the process and Health Boards actions sits nationally with the NHS Executive not the Trust.

2.44 Discussion with the Head of Patient Safety Team noted that briefing papers, completed for proceeding with the joint investigation process, will identify (if applicable) learning opportunities to mitigate the risk of future patient harm. The SCIF log will also capture any follow up action required.

2.45 Wider organisational learning from investigations is captured within the quarterly Putting Things Right Report that is taken to QuESt. The report also captures themes, learning and outputs from clinical reviews which include failure to examine patient adequately and absence of contact with GP. A summary of the clinical reviews undertaken is also submitted quarterly to the Chief Ambulance Service Commissioner.

2.46 Clinical Notices are also issued to staff which identify areas of good practice or learning. These can be accessed on the Trust intranet but also on the handheld devices within the JRCALC app[1].

2.47 Our high-level review of the SCIF action log showed that positive action was being taken, for example through feedback provided to the staff involved. However, there also appeared to be instances where potential learning had not been addressed. There is therefore further opportunity to undertake a wider review of the learning to ensure key issues and common themes are consolidated and shared Trust-wide. **See MA4**

Conclusion:

2.48 Organisational wide learning is captured and reported to QuESt quarterly. We note that limited feedback is received from the Health Board/Trust where they are the lead on joint investigations; and there are areas of learning identified within the Trust's SCIF action log, in relation to the joint investigation process, which have not been evidenced as addressed. A **reasonable** assurance rating is there for concluded for this objective.

[1] JRCALC (Joint Ambulance Colleges Ambulance Liaison Committee) - an application which allows ambulance services to combine national guidelines with local and regional guidelines and information.

Appendix A: Management Action Plan

Matter Arising 1: Policy Update (Design)		**Impact**
Our review of the Trust's *Adverse Incident and Reporting Policy* has shown that it includes limited reference to the *NHS Wales National Policy on Patient Safety Incident Reporting & Management* and its supporting sections. It does not set out a detailed process for the joint investigation process to align with Section 4 of the NHS Wales policy, which may have resulted in some of the processes not being fully implemented. While a joint investigation should meet the same standards and requirements of any patient safety incident investigation, there may be logistical differences in terms of how a joint investigation is conducted in practice. We do note, however, that the Trust has committed to a full policy review once the Putting Things Right Regulations are updated during 2024. We also note that the NHS Wales policy is not available through the Trust's intranet site.		Potential risk of: • Non-compliance with the NHS Wales policy and Putting Things Right Regulations.
Recommendations		**Priority**
1.1	The Trust's 'Adverse Incident and Reporting Policy' should be reviewed and updated to reflect the requirements set out within the NHS Wales policy.	**Medium**
1.2	To allow accessibility for all members of staff, the NHS Wales policy should be made available on the Trust's intranet site.	

Agreed Management Action		Target Date	Responsible Officer
1.1	The Putting Things Right Team plan was to review relevant policies following the release of the new Putting Things Right Regulations by Welsh Government in May 2024. A recent update from Welsh Government has confirmed that the release will now be Autumn 2024. At which point the review will be undertaken. The Trust has approved policies in respect of incident reporting and management and a Putting Things Right Policy which are included on the intranet site (review dates are both April 2026). Staff also have access to User Guides on the intranet site for Datix Cymru. The All-Wales Patient Safety Policy (NHS Executive) (May 2023) is also due review in March 2024 and will be updated internally when released nationally	30 November 2024 On release from NHS Wales Executive	Assistant Director, Quality & Safety (Interim) *Note: The responsibility for this management action will pass to the newly appointed Head of Putting Things Right once they commence employment at the Trust*
1.2	To be included on the Intranet site.	29 February 2024	Corporate Governance Team

<table>
<tr><th>Matter Arising 2: Compliance with NHS Wales Policy (Operation)</th><th>Impact</th></tr>
<tr><td>
The overview of the joint investigation process is set out within supporting section 4 of the National policy. This establishes 13 steps that Trusts and Health Boards should undertake while considering if an incident requires referral under the Joint Investigation Framework.

Our testing of 22 incidents between January and September 2023 has identified three steps within the above process that have not been adhered to across all incidents, which are outlined below (noting a full summary of all 13 steps can be found within Appendix B):

<table>
<tr><td>Step 1
The incident should be reported on Datix within one working day of identification of the incident.</td><td>Our review has shown that in 2 cases, there was a delay of more than 10 days between the incident date/when the notification was received from another Health Board/Trust and when the Datix incident was created – There was no narrative included to support this delay.</td></tr>
<tr><td>Step 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</td><td>We note that this timeframe is also stipulated within Regulation 17 of the NHS Wales Regulation (Concerns, Complaints and Redress) 2011 - Delays of between 19 and 27 days were noted in 2 cases between the incident date and the SCIF briefing being requested. There was no narrative included to support this delay within the SCIF action log nor Datix.</td></tr>
<tr><td>Step 5
Consideration of the lead organisation should be taken on a case by case basis</td><td>From review of the SCIF action log and Datix, we were unable to determine if incident number 10324 had been referred for a joint investigation to Powys Teaching Health Board.</td></tr>
</table>
</td><td>
Potential risk of:

• Gaps in joint investigation process.
• Non-compliance with section 17 of the regulations could result in reputational harm.
</td></tr>
</table>

Recommendations			Priority
2.1	To address the requirements of steps 1 and 2 of the Joint Investigation Process, where there is a delay to raising and reviewing an incident on Datix Cymru, appropriate narrative should be included within to support this to ensure a full audit trail is captured.		**Low**
2.2	To address the requirements of step 5 of the Joint Investigation Process, a periodic review of actions not completed within the action log should be undertaken to ensure that records are up to date.		
Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	Patient Safety Team to update the narrative on Datix Cymru as part of business as usual processes.	31 March 2024	Head of Patient Safety, Concerns & Learning.
2.2	Patient Safety Team to undertake a monthly review of the action log.	30 April 2024	Head of Patient Safety, Concerns & Learning.

Matter Arising 3: Putting Things Right (PTR) Reporting (Design)			Impact
The Putting Things Right report is presented to QuESt at each quarterly meeting and includes an update on the number of incidents presented at SCIF and those subsequently referred to Health Boards and Trusts under the joint investigation framework (JIF). However, we note that there could be some enhancements to the data provided to facilitate completeness of reporting, including: • Reference to the number of joint investigations where the Trust is the lead investigator. • Noting the areas of non-compliance from our testing (see **MA2**), highlight any exceptions in terms of Trust compliance with the JIF process. • Number of final joint investigation reports returned from other Health Boards and Trusts in the period.			Potential risk of: • Incomplete disclosures within the report
Recommendations			**Priority**
3.1	To facilitate completeness of reporting, consideration should be given to the enhancement of the SCIF/JIF data included at the Putting Things Right report.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	The Putting Things Right Report will include additional process measures in respect of the Joint Investigation Framework within the Quarter 4 Report (January – March 2023/24)	30 April 2024	Head of Patient Safety, Concerns & Learning

Matter Arising 4: Learning from investigations (Design)			**Impact**
The Patient Safety Team review all patient safety incidents to assess whether they require escalation to SCIF for further investigation. A log is prepared to capture decisions made following a SCIF meeting and any follow up action required. Our high-level review of the SCIF action log showed that positive action was being taken, for example through feedback provided to the staff involved. However, there also appear to be instances where potential learning had not been addressed. There is also an opportunity to undertake a wider review of the learning identified at this stage of the investigation, primarily through the detail provided on the briefing papers prepared for joint investigation, to ensure key issues and common themes are consolidated and disseminated to relevant staff. We recognise that in the absence of feedback on each incident from the relevant Health Boards / Trusts, this process cannot be optimally implemented.			Potential risk of: • The Trust is not learning from serious incidents to prevent future recurrence.
Recommendations			**Priority**
4.1	The Trust should consider the opportunity to consolidate key issues and areas of learning and disseminate Trust-wide to minimise reoccurrence.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	The Trust has been engaged in the All Wales Enhancing Learning Programme since September 2023 and this includes the roll out of an all-Wales framework for learning from events (including but not limited to incidents). This programme includes membership from all health boards, trusts and health bodies and considers internal and wider system learning.	Milestones Scoping exercise 31 March 2024	Deputy Head of Patient Safety.
	The capability to extract themes and trends from the SCIF log has already been set up by the new PTR Coordinator. This data and information will inform the PTR Quarterly Report.	Internal approval of the Framework 30 June 2024	Head of Patient Safety, Concerns & Learning

Appendix B: Trust compliance with the Joint Investigation Process

Overview of joint investigation process (NHS Wales Policy: Section 4)	Internal Audit Conclusions	Issue ✗ No Issue ✓	Internal Audit Recommendation
Step 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.*	This step has been reviewed on a case by case basis across the sample of 22 incidents - 2 cases were identified where there was a delay of more than 10 days between incident date/notification received from other Health Boards/Trusts and when Datix Cymru incident created (Case references 10627 and 10575).	✗	Datix Cymru incidents should be raised within one working day in order to align with the NHS Wales Policy. Where there is a delay, appropriate narrative should be included within Datix Cymru /SCIF action log to support this.
Step 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*	As part of the Trusts local arrangements, a Patient Safety Incident Requiring Joint Review Paper (PSI RJR - also known as a SCIF brief) is requested by the PSMs to instigate a review at a SCIF meeting. This section of the policy states that this should happen within 2 days of notification of the incident. However delays 19 and 27 days were noted in 2 cases between the incident date and a SCIF briefing being requested - no explanation to support the delay was included in the narrative within Datix nor the SCIF action log.	✗	The Trust should ensure reasons for delays within Datix Cymru /action log to ensure a full audit trail is captured.

Overview of joint investigation process (NHS Wales Policy: Section 4)	Internal Audit Conclusions	Issue ✗ No Issue ✓	Internal Audit Recommendation
of the incident, recognising that there may be occasions where this timescale is exceeded due to complexity.			
Step 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.*	The standard dataset for the Trust is the SCIF briefing which is used across Wales to summarise the incident – The formal document name is Patient Safety Incident Requiring Joint Review (PSIRJR) or SCIF briefing paper as referred to by the Trust. We also note that other Health Boards send Datix Cymru printouts when referring an incident to the Trust under the joint investigation framework. A PSI RJR was present for each incident within the SCIF working papers.	✓	N/A
Step 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):* *o Clarity on what the incident is, as well as the outcome* *o Consideration of the level of harm arising from the incident (using the current knowledge available) as this will inform and influence actions under PTR*	Due to the volume of SCIFs being received, reflecting the wider system pressures being faced by the NHS, formal joint investigation management meetings are not arranged. As a mitigating action, the PSMs meet weekly with their relevant health board counterparts to discuss investigations.	✓	Consideration should be given to review the process to ensure all steps here are considered and included to allow for a complete and accurate joint investigation.

Overview of joint investigation process (NHS Wales Policy: Section 4)	Internal Audit Conclusions	Issue ✗ No Issue ✓	Internal Audit Recommendation
o Scope and Terms of Reference for the joint investigation *o Investigation methodology to be used and expected timescales for completion (30, 60, 90 or 120 days)* *o Roles and responsibilities of all organisations involved in joint investigation* *o 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* *o Decision on any national reporting requirement (NRI)* *o Decision on any other external reporting that may be required* *o Plan to support staff who have been involved in the incident* *o (if needed) plan for coordination with other concerns processes e.g. complaints, inquest* *o Safeguarding considerations* *o Media and communications considerations*			
Step 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***.**	The decision to determine the lead investigating organisation is discussed within the SCIF meetings, and is subsequently documented and captured within the SCIF meeting action log. The lead organisation was agreed in all items in our sample apart from one incident dating back to February 2023 which we couldn't determine if it had been investigated (incident reference 10324). The Trust was not the lead investigator for any of the items in our sample.	✗	We recommend that a periodic review of actions marked as not completed within the action log is undertaken to ensure that records are kept up to date.

Overview of joint investigation process (NHS Wales Policy: Section 4)	Internal Audit Conclusions	Issue ✗ No Issue ✓	Internal Audit Recommendation
Step 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.*	Our review confirmed that a Datix incident had been created for each PSI that we reviewed. We note that the current Datix Cymru system does not allow for coding of a joint investigation but that the comments entered by the PST, includes narrative to indicate that the incident has been referred under JIF.	✓	N/A
Step 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.*	Only one NRI report was made to the Trust which was received from CTM for incident 10625.	✓	N/A
Step 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 of 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.*	This information is not captured within Datix Cymru nor the action logs. Discussion with PST has confirmed that this is a key aspect of the role of the team.	✓	N/A
Step 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*	Trust PSMs meet with their Health Board equivalents on a weekly basis and active investigations are discussed. We note that these meetings are not minuted but the existence of meetings has been confirmed in diaries.	✓	N/A

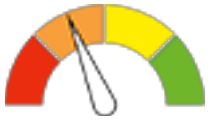
Overview of joint investigation process (NHS Wales Policy: Section 4)	Internal Audit Conclusions	Issue ✗ No Issue ✓	Internal Audit Recommendation
investigation must include analysis in line with the Yorkshire Contributory Factors Framework (YCFF).			
Step 10. *The end product of the joint investigation 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.*	Discussion with the PST has confirmed that the issuing of final investigation report is not consistent across Wales and as such, feedback from investigations is very limited to allow for areas of learning. We note that as the Trust lead on so few joint investigations, this is outside of their control. Discussion with the PST has shown that this is to show that the Trust is no longer the lead on the investigation, but will update the Datix Cymru incident as and when updates are received from Health Boards - if the Trust did not close the Datix incident, these cases could remain open indefinitely.	✓	N/A
Step 11. *The joint investigation report will be submitted through the governance and quality assurance mechanisms for sign off as agreed at the strategy meeting.*	A summary of all cases is taken through from SCIF to CQGG via AAA report under incident reporting. This has been captured and documented under audit objective 5.	✓	N/A
Step 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.*	Within the Trust, Datix Cymru incidents are closed at the point the incident PSIRJR / SCIF briefing paper has been shared and the investigation is referred as a JIF to the relevant Health Board, as from the Trust's perspective all necessary work has been completed.	✗	We recommend that the Trust develop a process to follow up on joint investigations where a final report has not been received from the Health Board.

Overview of joint investigation process (NHS Wales Policy: Section 4)	Internal Audit Conclusions	Issue ✗ No Issue ✓	Internal Audit Recommendation
	Discussion with the PST has established that this is to show that the Trust is no longer the lead on the investigation, but will update the record on Datix Cymru if further updates are received from Health Boards. If the Trust did not adopt this approach, then these incidents could remain open on Datix indefinitely. The PSMs are, however, are able to return to the incident to update and add additional supporting documents post closure. There were only 3 cases where a final report/closure email had been received and added to Datix Cymru. We do, however, acknowledge, that this is outside the control of the Trust.		
Step 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.*	As part of the testing, whilst the Trust was the lead investigator for two incidents, neither resulted in a NRI. Arrangements are in place within the Trust to capture and report on NRIs within the Trusts usual governance process, which we were advised would also apply to outcomes from joint investigations.	✓	Whilst there is a PTR report prepared by the Trust, enhancements have been recommended to expand on the data reported in respect of SCIF/JIF investigations.

Appendix C: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**Unsatisfactory assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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Electronic Patient Clinical Record: Clinical Compliance

Final Internal Audit Report

February 2024

Welsh Ambulance Services NHS Trust

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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

Contents

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Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement:
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Executive Summary

Purpose

To review the operational deployment of the electronic Patient Clinical Record being developed and assess compliance.

Overview

We have issued reasonable assurance on this area.

Management attention is required in respect of oversight of training completion. The number of staff self-certifying training completed is higher than the number of views for some of the individual training module pages.

Development is also required noting the current limitations in reporting, and associated accuracy and data quality.

Our overall assurance is based on where we would reasonably expect the Trust to be one year post implementation, recognising that a new system needs time to embed and mature.

This audit review does not provide assurance on the physical handover of patients at hospital sites or any delays with off-loading patients that contribute to handover delays.

Report Opinion

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	N/A - no previous report

Assurance summary[1]

Objectives		Assurance
1	Procedure notes in place	Substantial
2	Appropriate training	Reasonable
3	ePCR completion	Reasonable
4	Management information	Limited
5	EASC Clinical indicators	Reasonable

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Training self-certification	2	Operation	Medium
2	Limitations and accuracy of reporting	3, 4, 5	Design	High

1. Introduction

1.1 From October 2015 to March 2022, the Welsh Ambulance Services NHS Trust ('the Trust') generated an average of 400,000 patient clinical records a year, which were captured as handwritten notes, using the 'digipen'. From April 2022, electronic Patient Clinical Record (ePCR) technology provided by Terrafix's TerraPACE software was implemented Trust wide. It enables staff to capture information on an iPad, reducing paper, improving the accuracy of notes and enabling real-time information to be shared with healthcare partners.

1.2 The ePCR system delivers a digital patient records solution for the Trust and facilitates a more structured approach to clinical handovers. It includes access to appropriate medical information to inform on-scene decisions, and captures the treatment and medication received by the patient. It allows the Trust to exchange and report information electronically prior to a patient's arrival at hospital to better facilitate the required course of treatment. Senior clinicians providing remote advice to clinicians, whilst attending a patient, can also access the ePCR system in real-time and record their advice as part of the record.

1.3 Whilst the ePCR system offers a more structured approach, significant handover delays outside hospital emergency departments remains as one of the highest scoring risks on the Trust's Corporate Risk Register. There is recognition that this is a complex and system wide issue which results in access to definitive care being delayed and impacts on the Trust's ability to provide a safe and effective service.

1.4 The risks considered for this audit were:

a. Patients are significantly delayed in ambulances outside emergency departments;

b. Access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised; and

c. Patients potentially coming to harm and a poor patient experience.

1.5 In 2017-18 we undertook an audit of 'Handover of care at Emergency departments', to provide the Trust with assurance that operational procedures were compliant with the Welsh Health Circulars issued by Welsh Government, which provided 'Limited' assurance. A follow-up review was undertaken in 2018-19 which provided 'Reasonable' assurance. This review does not duplicate that audit and does not provide assurance on the physical handover of patients at hospital sites or any delays with off-loading patients that contribute to handover delays.

1.6 Further, we have not tested access rights to the TerraPACE system or that these are subject to regular review to ensure appropriateness.

2. Detailed Audit Findings

2.1 The table below summarises the recommendations raised by priority rating:

	Recommendation Priority			
	High	Medium	Low	Total
Control Design	3	-	-	3
Operating Effectiveness	-	4	-	4
Total	**3**	**4**	**-**	**7**

2.2 Our detailed audit findings are set out below. All matters arising and the related recommendations and management actions are detailed in Appendix A.

Objective 1: There are procedure notes in place on the use of the ePCR.

2.3 The Trust has a dedicated electronic Patient Clinical Records (ePCR) intranet page. Within this page, procedure notes are available, which form part of the training materials. These provide guidance to staff on the completion of the ePCR (noted under audit objective 2) for handover of the patient to the receiving health body. Review of the procedure notes confirmed that they include step by step instructions and screen shots of how to complete the ePCR.

2.4 Furthermore, the TerraPACE application also has a user manual and a 'help' section installed. There is also a training mode section on the application for staff to familiarise themselves with the application. In addition, a Frequently Asked Questions (FAQ) document has been produced to supplement the procedure notes.

2.5 Updates in respect of ePCR are communicated, as and when required, on the Trust's intranet via Clinical Notices; Digital Notices; Newsletters; and TerraPACE Application Release notes.

Conclusion:

2.6 There are sufficient resources on the Trust's intranet in respect of ePCR completion, including procedure notes and a 'frequently asked questions' document. Updates to the system are communicated on these pages. The TerraPACE application also has a user manual and training mode. Noting this, we have assessed this objective as **substantial** assurance.

Objective 2: Staff using ePCR have been identified and have received appropriate training.

2.7 The Trust has identified that a total of 2,115 staff, mainly from the Emergency Medical Service (EMS) and Ambulance Care staff groups, are required to complete the TerraPACE training.

2.8 Training is included on the learning portal linked on the Trust's intranet site. There is a two-step approach to training:

1. completion of all relevant training modules; and
2. self-certification on ESR.

2.9 Management advised that eight hours Continual Professional Development (CPD) is provided to complete the training modules. However, there is no requirement to complete a test in ESR before self-certifying. See **MA1**.

2.10 We requested an ESR report which showed that as at 19/10/23, 2,005 (94.8%) had self-certified that they had completed the training, as shown in the table below:

	Required	Achieved	Compliance %
Total Ambulance Care (all localities)	268	243	90.67%
Total EMS (all localities)	1782	1701	95.45%
020 Education & Development L6 (PZ02)	14	14	100.00%
020 National Operations & Support - Volunteer Management L6 (DZ05)	6	6	100.00%
020 Resilience/Business Continuity L6 (DZ03)	45	41	91.11%

2.11 There are a total of 18 training modules and each one has its own page on the intranet. We compared the total number of views on each page against the number of staff self-certifying that they had completed the training. This confirmed that the total number of views for the last 10 modules were lower than the number of staff that had self-certified as completing the training. For full details of the number of views against each training module, refer to Appendix B.

2.12 Management advised that a generic login was provided for full access to the training environment before implementation. The application is designed to be intuitive, where some individuals may not have completed formal training but have used demo accounts to familiarise themselves with the application. As a result, ESR compliance may exceed training module views due to the opportunities for the workforce to tailor their approach to learning the application, reflecting a diversity of learning styles.

2.13 Not all modules need completion as they are tailored to each user, which are a blend of standard and hospital users. Multiple users can access pages simultaneously, facilitating group learning rather than on an individual basis, which would apply to Emergency Medical Technician (EMT) training, and group sessions provided at the time of implementation. However, the method of delivery of training completed is not currently captured / recorded when self-certifying on ESR. See **MA1**.

2.14 From our review of the training pages, we considered many of these modules to be lengthy, which could explain the drop off in views for the latter modules. Consequently, there may be opportunity to streamline the amount of narrative included. However, we also acknowledge the management advice in para 2.12 on the various methods in which training is delivered. See **MA1**.

Conclusion:

2.15 Whilst the overall training compliance is reported at 94.8%, the number of views on the majority of training modules was lower than the number of individuals that have self-certified on ESR as completing the training. We acknowledge that there are a number of ways that training can be delivered, however this is not currently captured on ESR. We note that a number of the mandatory data fields include pre-defined options (see objective 3) and there are detailed procedure notes and sufficient 'help' functionalities available should the need arise (see objective 1). There is also opportunity to streamline the training content. Noting this, we have assessed this objective as **reasonable** assurance.

Objective 3: The ePCR is completed for every patient contact, in accordance with the operating procedures, and information is shared with healthcare partners as appropriate.

2.16 When creating a new patient record, there are a number of data fields that require a minimum criteria, these being patient name, address, date of birth, patient observations and summary. These fields are required to ensure that the data recorded meets the Trust's expectations in respect of patient information and data storage and retrieval. Patient details are required to enable a Welsh Demographics Service (WDS) lookup to match the patient demographics. There are also predefined options that must be completed as a minimum requirement for patient handover, clinical response feedback, conveyance decision and a dropdown list of hospital sites for conveyance.

2.17 Once a patient record is completed and closed, it is stored on a secure database within the Trust's IT Infrastructure. The record is saved from the point it was initially created, thus allowing multiple Trust clinicians to work on the same record during an incident.

2.18 Via a web-based portal, access is provided to hospital staff, which will allow them to view ePCRs of incoming patients, once the hospital destination has been selected on the vehicle mobile device screen by WAST clinicians. For example, when an ambulance crew has left the scene and is 'on route' to a hospital, staff at the unit will be able to access the patient record and condition report in real time prior to their arrival. Any changes that are made to the record whilst transporting the patient, for example the administration of drugs or other treatments, will also be visible. The hospital unit cannot edit records on the system - they can only view records of patients who are on route to, or have been treated by that unit.

2.19 All NHS Wales emergency departments and selected sites have access to ePCR via the web-based portal. In addition to these, the following eight English hospital sites also have access via the web-based portal: Countess of Chester Hospital; Royal Shrewsbury Hospital; Hereford County Hospital; Princess Royal Hospital Hereford; University North Staffordshire City (Stoke) Hospital; Walton Centre Fazackerley; Liverpool Heart and Chest Hospital; and Southmead Bristol Hospital. Patient records and reports can also be viewed by primary, secondary and other care

providers. A Standard Operating Procedure is in place (Clinical Notice 15/2022) for any conveyance to a non-ePCR enabled site.

2.20 Following closure of the ePCR, we were informed that the ambulance summary report is transferred to the Welsh Clinical Record Service (WCRS) and can be viewed on the Welsh Clinical Portal (WCP).

2.21 An ePCR must be completed for all patient interactions, but with some exceptions. At the date of the fieldwork, Community First Responders (CFRs) were not required to complete an ePCR. However, at the date of reporting we were informed that this requirement has now been rolled out. CFRs use a reduced version of the primary application, which synchronises together in the background. The Falls Response Teams are also currently implementing this version. However, St John Ambulance do not use ePCR for the patient. The Emergency Medical Retrieval and Transfer Services (EMRTS) use their own system, rather than TerraPACE, to complete the patient record should they arrive at the scene first.

2.22 We understand that improvement work is under way to improve awareness of the need to complete an ePCR for every patient encounter, including interfacility transfers. In addition, we were informed that the Trust is currently undergoing a review to understand the scale of where partner agencies have taken over care of a patient, or where an interhospital transfer with accompanying clinicians have been undertaken.

2.23 The Trust has developed a power BI ePCR compliance dashboard, this provides 'live' information on completed ePCRs, for further details on the use of this dashboard, refer to audit objective 4.

Conclusion:

2.24 WAST clinicians are required to complete an ePCR for every patient contact. Third party responders such as St John Ambulance are exempt as they complete their records on paper and a review is currently being undertaken to understand the scale of these. A number of data fields must be completed as a minimum criteria requirement, and these include pre-defined options. All receiving locations in Wales, along with a number of neighbouring English hospitals, have access to view the records of patients who are on route or have previously been treated by that location in real time. Noting this, we have assessed this objective as **reasonable** assurance.

Objective 4: Management information relating to the completion of ePCR is regularly reported and monitored, and issues investigated and escalated where necessary.

2.25 Previously, all data reported from the digipen was validated, although there was a time lag between recording and uploading the information. The ePCR captures significantly more data, 800 tables compared to 11 under the digipen, and this is available in real time (within the hour). This presents significant potential benefits to the Trust although it does pose a challenge around how it validates this volume of information.

2.26 A decision was taken by the Digital Directorate to report Clinical Indicators (CIs) based on the raw data inputted directly by clinicians on scene. This led to the development of mechanisms to provide assurance around data quality including the compliance / exception reports and the introduction of the clinical data assurance audits (see paras 2.39 and 2.40).

2.27 The completion rates of the ePCR are regularly reviewed by the Trust's Clinical Intelligence & Assurance Group (CIAG), which meets monthly. We reviewed the agendas and papers for this group from March 2022 to date which confirmed that standard agenda items to this group included, but not limited to:

1. *Clinical Indicator Data (AQI): Caveats for agreement;*
2. *Clinical Indicator Plan;*
3. *Clinical Indicator Reporting Dashboard;*
4. *Current Indicator Review;*
5. *ePCR Clinical Data Requests; and*
6. *the ePCR Dashboard.*

2.28 Review of the minutes confirms that the Trust has undertaken work to review and assess data quality to identify and drive improvements. Notably, the development of the Power BI ePCR Compliance and Clinical Indicator Reporting dashboards.

2.29 The compliance dashboard includes reporting on the number of incidents with incomplete patient records. We were informed a review of the data highlighted that the majority relate to records which are automatically closed if they are not updated for eight hours (due to the absence of a disposition code being entered) and a smaller number to community first responders and St John Ambulance who are operating on paper records. Further ePCR Clinical Data Assurance 'deep dives' have been undertaken as detailed within audit objective 5.

2.30 We note that these dashboards are still evolving and contain a number of caveats. We were provided with the ePCR compliance dashboard for the period 04/01/2023 to 14/06/2023. This showed that the ePCR had not been fully completed for 21% of the total attended incidents (116,321). For incidents responded to out of WAST area, up to 44% are indicated as not being fully completed (see para 2.29). We were also informed that circa 150-175 ePCRs are auto closed per day. The Trust recognises the need to create capacity to look at these in more detail. See **MA2**.

2.31 Where requested, updates from this group have been provided to Quality, Patient Experience and Safety Committee (QuEST), the most recent being the Clinical Indicator (CIs) performance report in October 2023, which are also reported to the Emergency Ambulance Services Committee (EASC), was shared (also refer to audit objective 5).

2.32 We note that, at the date of reporting, the TerraPACE Tenant Structure is currently under construction. This will allow Senior Clinicians to monitor their individual team compliance to ensure optimal patient care is delivered and identify training needs in both a reactive and proactive manner. **See MA2**.

2.33 Whilst there are further improvements required, including software upgrades to enhance the user interface with the aim of improving care bundle compliance, the Trust has recognised these and is already working towards implementing these improvements with the primary focus being data quality to date.

Conclusion:

2.34 A reporting framework is in place through CIAG and onwards to QUEST. Issues arising to date include ePCR data quality, which is essential for improved clinical indicator performance (see also audit objective 5), and limitations to the reporting from the dashboards. Work is ongoing to upgrade the software to facilitate improved data quality which requires time to fully embed. Noting this, we have assessed this objective as **limited** assurance.

Objective 5: There is improved performance against the Emergency Ambulance Services Committee (EASC) clinical indicators.

2.35 CIs are captured and reported to monitor clinical inputs or processes that affect patient outcomes. It is not a direct measure of quality but should be used to draw attention to issues that may need to be reviewed, reduce variations and bring about improvements in care for patients.

2.36 The Trust's vision for the future recognises that there is always room for improvement in patient care, quality and outcomes. To support this, the Clinical Intelligence & Assurance Team has developed a set of CIs and care bundles for a number of clinical conditions, the outcomes of which will be used to measure clinical performance, including clinical handover.

2.37 CIs were published until November 2021 using data from the 'digipens'. CI collection and reporting changed following the introduction of the ePCR within the Trust, and was suspended between December 2021 and March 2022 to focus on its rollout. From April 2022 clinical indicator data for Stroke and Fractured Neck of Femur were published from ePCR data, with other clinical indicators (ST-elevation myocardial infarction (STEMI), Hypoglycaemia and Return of Spontaneous Circulation (ROSC)) coming online following quality assurance checks. The published ambulance service indicators detail the following compliance since the rollout of ePCR (first full publication November 2022), compared with the final publication from digipen data:

Standard	Nov-21	Nov-22	Mar-23	Dec-23	Target
ROSC	10.90%	15.90%	14.00%	17.60%	None set
Stroke	98.40%	80.20%	72.20%	75.30%	95%
STEMI	85.70%	51.30%	46.30%	40.60%	95%
Hypoglycaemia	91.80%	43.10%	46.60%	51.20%	95%
Fractured #NOF	88.70%	67.40%	59.50%	61.80%	95%

2.38 The Trust papers presented to EASC have indicated the improved performance in compliance has not yet materialised since the use of ePCR. Our review of the CIAG papers noted that due to the predicted fall in clinical indicator compliance whilst the new system for creating clinical records becomes embedded, a risk has been

raised with an associated action plan internally. The risk is based on intelligence from other UK ambulance services and is predicated on the transition from validated to raw data. Management advised that this was not considered a high enough risk for inclusion on the Trust's Corporate Risk register (CRR), however, the risk is being monitored by the CIAG.

2.39 The Trust is now reporting performance against CIs using a PowerBI dashboard. This compliance dashboard is reviewed monthly by the CIAG. Due to the decision made to report on CIs using directly inputted ePCR data, the Clinical Intelligence & Assurance Team has undertaken a series of deep dive (ePCR Clinical Data Assurance') audits to determine if reporting generated from the ePCR system provides an accurate picture of the clinical care provided to patients. These audits have informed an improvement plan and future decisions on the quality of data required for reporting (see para 2.36). The following Clinical Data Assurance audits have been undertaken:

1. Fractured Neck of Femur (#NOF) Clinical Indicator (2022);
2. Stroke Clinical Indicator (2022);
3. STEMI Clinical Indicator (2022);
4. Hypoglycaemia Clinical Indicator (2022); and
5. ROSC at Hospital - Clinical Indicator (2022).

2.40 The results of these data quality deep dives shown in the table below demonstrates that the system isn't accurately reporting the Trust's compliance with care bundles, and that manual auditing gives a more accurate clinical picture of the care provided: (see **MA2**)

Standard	Compliance derived from raw ePCR data (%)	Compliance derived from audit (%)	% difference in reported compliance
Fractured NOF	67.2	83.4	+16.2
Stroke	72.1	91.2	+19.1
STEMI	25.2	66.7	+41.5
Hypoglycaemia	47.8	86.8	+39.0
ROSC	18.7	21.6	+2.9

2.41 We were informed that upgrades to the system, some of which were requested as a result of the above audits, were introduced in December 2023. This update included, but not limited to, user interface changes to the Hypoglycaemia, STEMI, Stroke & NOF care bundles and to enhance data completeness and CI compliance. We also understand that system change requests are logged by the Trust and are appropriately approved before submission, including consideration of funding requirements. We were also advised that Terrafix are required to deliver upgrades in a timely manner in line with the with the contractual arrangements.

2.42 It is expected that these updates will improve the accuracy of CI performance figures. Management advised that, in the meantime, a group has been set up, reporting to CIAG, that will determine which elements of the record will be flagged for completion (if missing or not recorded) at ePCR closure. Additionally, it has

been reported in the 'ePCR Clinical Data Assurance' audits (see para 2.38) that a re-audit will take place when the TerraPACE user interface has matured. See **MA2**.

Conclusion:

2.43 The introduction of the ePCR has not yet shown an improvement in the performance against the CIs presented to EASC. However, clinical data assurance audits are being undertaken to measure compliance and these inform required software updates to improve data quality and reporting accuracy. It is too soon to see what impact this will have on CI performance and care bundle compliance. However, recognising the steps the Trust is taking to address the completeness of information to assess performance, **reasonable** assurance has been determined at this objective.

Appendix A: Management Action Plan

Matter Arising 1: Training self-certification (Operation)	Impact
The Trust has identified that 2,115 staff are required to complete the TerraPACE training to assist in the use/completion of the ePCR. At the time of our review there was a compliance rate of 94.8%, with 2,005 having self-certified that they had completed the training (there is no requirement to complete a test in ESR before successfully self-certifying). There are a total of 18 training modules and each one has its own page on the intranet. We compared the number of total views of each page against the number of staff self-certifying that they had completed the training. This confirmed that the total number of views for the last 10 modules were lower than the number that had self-certified as completing the training (for full details of the number of views against each training module, refer to Appendix B). We understand that ESR compliance may exceed training module views due to opportunities to tailor the approach to learning the application e.g., through group sessions being held. The method of delivery is currently not captured when self-certifying completion on ESR; and such would provide more informed challenge for those training modules with lower-than-expected completion, such as obstetrics Our review of the training pages also highlighted opportunity to streamline as many of these modules were very detailed and include lengthy narrative, which could explain the drop off in views for the latter modules whilst also recognising that not all modules need completion as they are tailored to each user.	Potential risk of: • Staff who have not undertaken the full training package may not be accurately completing ePCR entries, leading to a lack of comprehensive understanding regarding appropriate ePCR recording methods.

Recommendations		Priority
1.1	To confirm accuracy of the self-certification compliance rate, management should consider capturing the method of training delivery on ESR.	**Medium**
1.2	Management should obtain feedback from staff to improve the training materials.	
1.3	Management should consider including a test in ESR to confirm competency before successfully self-certifying.	

1.4	Whilst we acknowledge there are different methods of training delivery, management should review lower viewed training modules, to confirm that the completed ePCRs are compliant with expectations in this area.	

Agreed Management Action		Target Date	Responsible Officer
1.1	For future training, the method of instruction will be captured as part of the ESR sign-off process (for example, classroom based, individual learning using the training materials, one to one instruction using the training zone in the application).	30 June 2024 (end of Q1 24/25)	Assistant Director for Clinical Development
1.2	We will design a survey via the ePCR Clinical Reference Group (CRG) for ePCR users to explore the reasons for this and how training materials might be improved to enhance ePCR completion.	30 June 2024 (end of Q1 24/25)	Assistant Director for Clinical Development
1.3	At the ePCR CRG WAST will discuss including a test to assess understanding at the completion of training.	30 June 2024 (end of Q1 24/25)	Assistant Director for Clinical Development
1.4	Through the ePCR Clinical Reference Group (CRG) we will review the lower viewed modules as set out in Appendix B of this report. This will build on knowledge discussed at the most recent ePCR CRG where a small audit has identified that the obstetric section is not being completed. However, we currently have only opened access to the Welsh GP Record (WGPR) for our cohort of Advanced and Senior Paramedics. The pathways section of the ePCR is not currently live and requires testing prior to going live, which explains the disparity reported in these sections of Appendix B.	30 September 2024. (end of Q2 24/25)	Assistant Director for Clinical Development

Matter Arising 2: Limitations and accuracy of reporting (Design)	Impact
Due to the significant increase in the volume of data being captured in the ePCR system, a decision was taken to report Clinical Indicators (CIs) based on the raw data inputted directly by clinicians on scene. This led to the development of mechanisms to provide assurance around data quality including the compliance / exception reports and the introduction of the clinical data assurance audits. We note that the compliance and CI reporting dashboards are still evolving and contain a number of caveats. We were provided with the ePCR compliance dashboard for the period 04/01/2023 to 14/06/2023. This showed that the ePCR had not been fully completed for 21% of the total attended incidents (116,321). For incidents responded to out of WAST area up to 44% are indicated as not being fully completed. We were also informed that incomplete records included those incidents that were automatically closed by the system after eight hours of inactivity due to the absence of a disposition code being entered. We were also informed that circa 150-175 ePCRs are auto closed per day. The Trust recognises the need to create capacity to look at these dashboards in more detail, and is looking to implement the tenant structure to allow Senior Clinicians to monitor their individual team compliance and to identify training needs. The Clinical Intelligence & Assurance Team has also undertaken a series of deep dive ('ePCR Clinical Data Assurance') audits to determine if reporting generated from the ePCR system provides an accurate picture of the clinical care provided to patients. The results of these data quality deep dives show that the system isn't accurately reporting the Trust's compliance with care bundles. These exercises inform required software updates to improve data quality and reporting accuracy, and there are plans to perform re-audits when the TerraPACE user interface has matured.	Potential risk of: • Sub optimal quality of data limits the Trust's ability to accurately report on the care delivered to patients.

Recommendations		Priority
2.1	The Trust, with continued support from Terrafix, should address the limitations and caveats relating to the dashboard reports to ensure that they provide robust information on all incidents.	**High**
2.2	Management should ensure the tenant structure is developed to provide data at both a team and individual level to assist in identifying training needs and drive improvement in ePCR compliance.	

2.3	The Trust should continue with its programme of Clinical Data Assurance audits to inform further upgrades required to the system to improve data quality and the accuracy of care bundle compliance reporting.	

Agreed Management Action		Target Date	Responsible Officer
2.1	We will review the compliance dashboards and amend the nomenclature used and recommend changes to the presentation of the data to ensure consistency and understanding. However, this is dependent on the capacity of Health Informatics to complete the work.	30 September 2024. (end of Q2 24/25)	Assistant Director for Clinical Development
2.2	Reporting into CIAG, we will set up a Task and Finish Group to write the plan to deliver the dashboards against the Tenant Structure. This is a complex piece and requires input from multiple directorates. It is also dependent on the capacity within teams to deliver the dashboards, therefore the output of the T&F might be a business case jointly developed between the Digital and Clinical Directorates to outline the resources required and what this would cost to deliver.	30 September 2024. (end of Q2 24/25)	Assistant Director of Clinical Development and nominated Digital Directorate Lead.
2.3	Clinical Audit Programme for 2024/25 has been agreed at CIAG and presented for approval to the February 2024 QuEST meeting. This is ongoing work and does not require a specific action as it is central business for the CIAT.	N/A – completed since fieldwork (February 2024)	

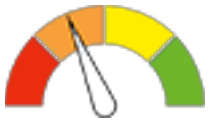
Appendix B: Training Module Completion

	Page views as at 26/10/23)	ESR: Training compliance achieved	ESR training compliance achieved v training page views
Section 1 – General:			
Module 1.1 – General overview of the TerraPACE system	5888	2005	3883
Module 1.2 – Accessing the System, User Credentials and Signing on	3855	2005	1850
Module 1.3 – Reporting faults	2979	2005	974
Section 2 – TerraPACE Application:			
Module 2.1 – Accessing Patient Record and Cooperative Working	3708	2005	1703
Module 2.2 – Generation of new Patient Records	2722	2005	717
Module 2.3 – Navigation around the TerraPACE App	2839	2005	834
Module 2.4 – Data Entry, Modification and Deletion	2367	2005	362
Module 2.5 – Report Completion and Mandatory Fields	2271	2005	266
Module 2.6 – Patient Management and Consent	1954	2005	-51
Module 2.7 – Primary Survey, Observations and Examinations	1997	2005	-8
Module 2.8 – Patient History	1836	2005	-169
Module 2.9 – Cardiac Arrest and ROLE	1968	2005	-37
Module 2.10 – Trauma and Road Traffic Collisions	1737	2005	-268
Module 2.11 – Obstetrics	1594	2005	-411
Module 2.12 – Safeguarding	1996	2005	-9
Section 4 – Welsh GP Clinical Record:			
Module 4.1.1 – WGPR	461	2005	-1544
Module 4.1.2 – WGPR Part 2	279	2005	-1726
Section 5 - NHS Directory of Services:			
Module 5.1 – NHS DOS	359	2005	-1646

Appendix C: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**Unsatisfactory assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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Seatbelt Action Plan

Final Internal Audit Report

April 2024

Welsh Ambulance Services University NHS Trust

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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

Contents

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Auditors:	Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit; Rhian-Lynne Lewis, Principal Auditor
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Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement:
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Executive Summary

Purpose

To review the deployment of the seatbelt action plan, to ensure the safety of crews and patients on board Trust vehicles, and to assess compliance.

Overview

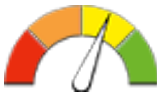
We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Limited number of internal quality assurance inspections completed.
- Reporting of results of spot checks, inspections and Quality and Support days to an appropriate forum.
- Absence of monitoring of the recommendations arising from the Health & Safety investigation.
- Absence of reporting on the incident at key junctures to the Trust Board and/or its associated committees.

Other recommendations / advisory points are within the detail of the report.

Report Opinion

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	N/A

Assurance summary[1]

Objectives		Assurance
1	Approved action plan in place	Reasonable
2	Operational Policies and Guidance on conveying patients safely	Substantial
3	Training on safety requirements	Reasonable
4	Quality Assurance arrangements to ensure compliance	Reasonable
5	Mechanisms to monitor action plan progress	Reasonable
6	Reporting to appropriate Management and Trust Committees	Reasonable

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Reporting and monitoring of Quality Assurance inspection outcomes	1, 4, 5	Design	Medium
2	Reporting and monitoring of spot checks/Quality and Support days	1, 4, 5	Operation	Medium
3	Internal Ambulance Care Quality Assurance inspections	4	Design	Medium
4	Monitoring of Health and Safety Investigation recommendations and assurance reporting to Board	6	Design	High

1. Introduction

1.1 The Road Traffic Act 2006 determines that seatbelts must be worn while a vehicle is in motion. An amendment was approved by the Government in 2015 to create a legal exemption from the requirement to wear seat belts for persons riding in an ambulance when it is necessary to attend to a patient. This exemption does not extend to patients.

1.2 Following a road traffic collision involving a non-emergency ambulance, on 8 April 2021 which resulted in the loss of a patient, it was identified that the patient had not been securely fastened using all the necessary harnesses. This has recently resulted in criminal action against the Trust's member of staff that was responsible, following their guilty plea to causing death by dangerous driving.

1.3 In response to this incident, an action plan was put in place by the Trust to ensure the safety of crews and patients on board Trust vehicles. These include improved safety features, a quality assurance scheme and a review of the approach to vehicle inspection and staff training. In addition to these actions, following the conclusion of the criminal investigation, additional recommendations have been made to the Trust by the coroner that will also be considered as part of this review.

1.4 The Trust has also undertaken a health and safety investigation (concluded August 2023) into the incident; the results of which identified additional recommendations that have also been considered as part of this review.

1.5 The risks considered as part of this review were non-compliance with safety regulations resulting in patient harm, financial penalties and reputational damage.

2. Detailed Audit Findings

2.1 The table below summarises the recommendations raised by priority rating:

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	-	3	-	3
Operating Effectiveness	2	1	-	3
Total	2	4	-	6

2.2 Our detailed audit findings are set out below. All matters arising and the related recommendations and management actions are detailed in Appendix A.

Objective 1: There is an approved action plan in place to improve patient safety, which reflects the lessons learned and recommendations raised externally;

2.3 Following the serious incident that occurred, a Road Traffic Collision Cross Directorate Group (RTCCDG) was established to undertake an initial assessment

of the incident, to determine the next steps required by the Trust and prepare an initial list of actions.

2.4 An internal Serious Health and Safety Incident Investigation Review was triggered to inform the RTC CDG and the wider Trust with an overview of the incident and its' conclusions and recommendations. As part of the investigation, an action plan was developed with target dates for completion.

2.5 We were advised that the action plan evolved as the investigation progressed, with actions being implemented before its approval to ensure the Trust was reacting and responding to recommendations as soon as possible. The initial action plan that was presented to Senior Leadership Team (SLT), a senior forum within the Operations Directorate, in July 2021 contained 13 actions; and the final version, as included in the investigation report was submitted to Executive Leadership Team (ELT) in August 2023, detailed 25 actions – 15 of which arose from the development of the initial action plan and 10 were consequential actions from addressing the original ones. We note that there was no formal approval of the action plan, however, appropriate governance arrangements were in place to ensure the existence of oversight and scrutiny. (Refer to objective 6 for further detail on governance and reporting).

2.6 We were provided with evidence to demonstrate the arrangements put in place to address each of the actions. Whilst we recognise that the arrangements align with the intended outputs, our review has determined that the ongoing operational implementation and sustainability of some arrangements has not been effectively captured nor monitored. **See MA1 & MA2.**

2.7 In May 2023, the coroner issued a report in conjunction with the criminal investigation into the incident. This report summarised that the coroner was pleased with the detailed investigation, actions and subsequent arrangements put in place by the Trust. The report identified three aspects to be considered further – two were for the responsibility of the Trust and we have confirmed as part of the audit have been acted upon; and one for the coroner, for which the Trust have not yet received an update.

Conclusion:

2.8 A Road Traffic Collision Cross Directorate Group was established, and an internal Health and Safety investigation initiated in response to the incident. An action plan was also developed which continued to evolve as the investigation progressed. Review of the final action plan, post completion of the investigation, identified some gaps in the completeness of the arrangements put in place to address the issues identified. A **reasonable** assurance rating has been determined for this objective.

Objective 2: Operational policies and/or guidance are in place, and accessible to staff, which clearly describe the processes and expected methods for ensuring patient safety whilst being conveyed.

2.9 The Driving at Work (DAW) Policy (approved by the People & Culture Committee September 2021) establishes the expected standards for emergency and non-emergency drivers across the Trust. This includes:

- Legal requirements
- Driver training and emergency driving procedures
- Wearing of seatbelts and subsequent exemptions
- Carrying children in Trust vehicles
- Duty of driver involved in Road Traffic Collision (RTC)
- Training requirements
- Roles and responsibilities

2.10 Following the incident, we note that there had not been any major changes required to the Policy during its most recent update. We note that the Policy is due for review later in 2024 and that this is currently reported as being on track to be completed on time.

2.11 The Policy is accessible on the Trust's intranet site and at the point of issue was shared via a Siren staff announcement.

2.12 The DAW policy states that drivers and passengers in Trust vehicles are required by law to wear seat belts. It also states that all patients must be secured using the appropriate harness and restraints. If such are not used due to a clinical reason or the individual refuses, then this must be recorded and documented.

2.13 In response to the incident, the Trust issued a safety notice (27 April 2021) on seatbelts and restraints as a reminder to Trust staff and volunteers to ensure their safety and those travelling within a Trust vehicle. This emphasised the requirement to fully utilise seatbelts and restraints when moving, handling, and conveying patients on Trust equipment and vehicles and also included a link to the DAW Policy. Further notices were also issued reiterating similar messages and directing staff to other materials on safety restraints (for further details on training, refer to audit objective 3).

2.14 This included a safety video which the Trust created to provide visual guidance on:

- the importance of ensuring the safety of those travelling in a Trust vehicle;
- the risk of criminal proceedings if safety requirement are not complied with;
- illustration of absence of seatbelts during collision;
- illustration on the application of harnesses;
- how to secure children in the vehicle; and
- where an employee fails to adhere to legislation and safety procedures, employees could be at risk of prosecution.

Conclusion:

2.15 A Driving at Work Policy which provides guidance on several aspects of driving, including the requirement to wear seat belts, is in place and accessible to all Trust staff. Following the incident, safety notices have been issued and a safety video circulated, reiterating the requirements and importance of the appropriate use of

seatbelts and restraints. A **substantial** assurance rating is determined for this objective.

Objective 3: Appropriate training has been undertaken to ensure staff are fully versed on the safety requirements to be employed.

2.16 All drivers of Trust vehicles that convey patients must complete a driving course during their induction to the Trust, for which there is both an emergency response and non-emergency course.

2.17 The courses have been developed in partnership with FutureQuals (accredited organisation that delivers regulated qualifications across a diverse range of vocations and sectors), the Driver Training Advisory Group (regulatory body for ambulance driver training) and the Association of Ambulance Chief Executives (AACE). The courses are recognised across the UK and are the only driving courses used by all Ambulance Trusts.

2.18 The courses cover several areas which includes driving legislation; driver responsibilities; pre-driving checks and daily inspections; the system of car control; driving under routine and emergency response conditions; manoeuvring and reversing; safety systems; emergency response driving practices; navigation; adverse conditions; and human factors.

2.19 We were provided with both course timetables and were advised that while seatbelts and restraints would have been routinely included in all driver training courses previously, there is now a separately identifiable session on such. All new inductees completing the above courses since November 2021, must sign a separate form to confirm that they have read and understood the safety training in relation to seatbelts and these records are maintained by the central Professional Education & Training Team.

2.20 As part of the original action plan, a similar exercise was executed for all Trust vehicle drivers already in employment, whereby they had to view the safety video and read the safety notices. This was to ensure that staff were appropriately versed on the required safety measures. We were provided with the collated results which showed that as at October 2022, i.e. within a year of roll-out, 98.74% of relevant staff had acknowledged viewing and understanding the additional safety information.

2.21 In addition, Mandatory In Service Training (MIST) is provided by the Trust on an annual basis. This is split across two days (one day face to face and one day online learning) and includes several sessions, the content of which is tailored to the needs of the organisation. For 2023/24, a session on safety harnesses has been included, which addresses driver and attendant's responsibilities to ensure patient safety and the law and subsequent exemption parameters.

2.22 We were also provided with the compliance rates for MIST for 2023/24 which, as at 31 January 2024, were 65.75% Emergency Medical Service (EMS) and 64.8% Ambulance Care Services (ACS). We were advised that there was a delay in the commencement of MIST and monitoring of progress of attendance is being

undertaken with all areas on target to achieve 70% compliance by the end of the financial year.

Conclusion:

2.23 All employees that are required to drive a Trust vehicle, must complete an accredited driving course during their induction. In response to the incident, the course timetables now include a separately identifiable section on seatbelts and patient restraints which requires acknowledgement by each new driver that the training has been completed. There was also an expectation that drivers already employed by the Trust view a recap on seatbelts and harness requirements and sign to acknowledge as such; and additional training has been included within the MIST programme for 2023/24 in relation to safety requirements. A **reasonable** assurance rating is determined for this objective.

Objective 4: Quality assurance arrangements are in place to ensure compliance with policies / safety regulations.

Private Ambulance Services

2.24 The Trust has established a framework of approved external private ambulance services (PAS) to work alongside its own Ambulance Care Services (ACS). In order to provide assurance that PAS meet the standards required by the Trust to enable the safe conveyance of patients, the Trust's Quality Assurance (QA) Team, working with 365 Response Ltd (a private company providing support to digitise transport systems), has developed a process to undertake an initial assessment (phase 1) of providers. This involves undertaking due diligence checks across several areas, including the type and adequacy of stretchers, seats and equipment in vehicles, appropriate insurance cover and DBS checks.

2.25 At the date of the incident in North Wales, this QA process was still being developed; therefore the QA Team were able to incorporate additional safety requirements to further align with the Trust's internal standards. For example, all Trust vehicles are fitted with specific seats/adjustments for patient conveyance. The Trust provided all PAS organisations with a list of compliant seats and allowed a 12-month period to comply. We were advised by the NEPTS Operations Manager that the majority of companies either replaced seats or purchased specific attachments which provided the same level of safety. Those organisations who were unable to make the amendments or refused to do so, were removed from the framework and could no longer provide services to the Trust.

2.26 Further to the phase 1 assessments, a formal quality assurance inspection (phase 2) is undertaken for all PAS organisations. These provide a baseline assessment and involve a more comprehensive inspection to assess compliance with the Trust's standards and expectations, including a site visit, discussion with owner/director and employees and an assessment of vehicles and equipment. The inspection also examines safety and manual handling arrangements, including the adequacy and compliance of stretcher safety harness, seatbelt extenders and child safety harness. At the date of reporting, management confirmed that these assessments had been completed for the 15 active PAS organisations.

2.27 The QA Team maintain a dashboard which captures the dates and outcomes of inspections, issues identified and a timeline for such to be addressed. Issues are either followed up within a secondary visit (local operational managers attend the site to confirm compliance), or evidence is submitted directly to the QA team to support the improvements or rectifications made. We note, however, that the results from inspections are not currently captured effectively or reported to an appropriate forum. **See MA1.**

2.28 We were advised that from 1st April 2024, the Trust will enter phase 3 of the quality assurance process by introducing the Wales Ambulance Quality Standard Award (WAQSA) Framework which will involve the awarding of '3Qs'. The 1st Q will be awarded based on annual document reviews (e.g. insurances, DBS checks) and the 2nd Q will involve annual quality inspection at the PAS site (both Q's being a continuation of phases 1 and 2 as per paras 2.24 and 2.26). The 3rd Q will be based on several weighted aspects of current performance data and reviewed quarterly per provider.

Internal Arrangements

2.29 The QA team undertake similar inspections across the Trust's NEPTS ambulance sites of which there are 76, and if co-located with an EMS site, the assessment will provide coverage of both service areas. We were advised that the Trust aim to complete one inspection per quarter and these commenced in December 2021 as an output to the action plan. The QA dashboard has recorded only two inspections completed during 2023/24 (**see MA3**) but that the number of inspections completed in previous years were in line with expectation.

2.30 Following a second incident (November 2023) involving the incorrect use of seatbelts and harnesses which occurred within a Trust EMS vehicle, 'Quality and Support Days' were introduced as a means to continue to reinforce ongoing safety requirements. The first day was held in December 2023 and involved a series of unannounced spot checks where a team of operational managers attended hospital and clinical sites to observe actions and behaviours and to inspect vehicle equipment. At the date of reporting, two of these days have been undertaken (latterly January 2024) with both having a specific focus on safety restraints and harnesses. Of the 487 spot checks completed, the following areas of improvement were identified:

- Absence of seatbelt reminder stickers in ambulances (21 identified);
- Seatbelts not in good working order (2 identified); and
- Stretcher harness not in good working order (8 identified).

2.31 The results were captured and shared on the Trust's intranet site, however we note that there is an absence of information in relation to follow up arrangements to ensure that issues were addressed. **See MA2**. We were advised that the provision for these days will continue and that the frequency and focus of spot checks will be tailored based on the needs of the organisation.

2.32 As part of the monitoring arrangements for Paramedics and Technicians (Ps and Ts), Senior Paramedics (SPs) undertake ride-outs to analyse their performance

during a shift to measure the effectiveness of the standard of patient care being delivered. This is captured within a standardised feedback form on Microsoft Forms, which determines areas for improvement and an action plan where applicable. During the audit of the Senior Paramedic Role (report issued November 2023, Reasonable Assurance), we interviewed six SPs across all regions in Wales, who confirmed the April 2021 incident had raised awareness of the appropriate use of seatbelts and restraints. Our audit identified the need to address the disparity in the allocation of Paramedics and Technicians, to ensure appropriate level of supervision and support.

Conclusion:

2.33 The Trust has established a framework of approved external private ambulance services to work alongside its own Ambulance Care Services, where due diligence checks are undertaken to ensure providers meet the required standards. This is supplemented by an inspection process that has been developed to monitor ongoing performance of both internal and external non-emergency ambulance services. From April 2024, a quality standard framework has been introduced to monitor quality, compliance and performance at external organisations. However, we noted that only a limited number of internal inspections were completed in year. . Following a second incident which occurred recently involving a Trust EMS vehicle, Quality and Support days have been introduced to monitor safety requirements. There is a lack of reporting of the results across all the quality assurance arrangements put in place and to demonstrate that appropriate action is being taken to address issues identified. A **reasonable** assurance rating is determined for this objective.

Objective 5: Appropriate mechanisms are in place to monitor and manage progress against planned actions and their continued sustainability.

2.34 The RTC CDG was established in May 2021 to manage the different strands of response to the incident, including the preparation of the action plan and the early monitoring of progress against the subsequent implementation of arrangements. Review of the minutes for this group confirmed continued monitoring of the progress against the action plan in addition to consideration of additional actions for inclusion (for reporting against actions, refer to audit objective 6).

2.35 As per para 2.5, while the Health & Safety investigation was ongoing, emerging actions were being addressed and implemented by the Trust prior to the finalisation of the investigation report. This ensured that timely responses were being made at the earliest opportunity and we were able to confirm this through review of the relevant supporting documentation for each of the actions.

2.36 Progress against the action plan was further monitored in the meetings of the SLT. From July 2021, monthly updates were presented describing the status of actions and the current work ongoing to implement them; and by October 2021, noting that only two actions remained ongoing, reporting became less frequent. Subsequent progress updates were also presented at meetings in April and November 2022.

2.37 Four interim reports were also taken to ELT between June and December 2021, and the final health and safety investigation report was presented to ELT in August 2023.

2.38 Discussion with the Assistant Director of Operations (NEPTS) has shown that some actions represented 'one-off' arrangements (e.g. updated vehicle daily checklist, question added to patient survey to test whether patients were asked to wear a seatbelt), whilst other actions, due to their nature, have now become embedded into routine practice within the Trusts' day to day processes (e.g. vehicle audit inspections and spot checks, quarterly internal formal inspection process - refer to audit objective 4). These will in part be monitored going forward through separate arrangements, such as the Quality & Support Days (see para 2.30).

2.39 We note that we were not provided with evidence to support the ongoing monitoring of some completed actions having been fully embedded into Trust routine practices. **See MA1 & MA2.**

Conclusion:

2.40 Arrangements were in place for progress against actions to be captured and reported through to appropriate forums which included SLT and ELT. However, an assessment of the actions and subsequent arrangements has identified some potential areas of incompleteness. A **reasonable** assurance rating has been concluded.

Objective 6: Periodic reports on the progress against implementation of the action plan are produced and submitted to appropriate management and Trust committees for oversight and escalation.

2.41 As per paras 2.3 and 2.34, the RTC CDG was established to coordinate the immediate response to the incident with the forum, initially, meeting weekly to ensure the Trust could react to emerging issues. The group had senior attendance and it provided an informal platform for the serious and sensitive matters to be discussed. We were advised that as oversight of the action plan, and wider monitoring of the Health & Safety investigation moved to SLT in July 2021, it met less frequently. From October 2021, meeting arrangements were more informal and ad hoc; and we note that the group hasn't met since the conclusion of the investigation was reported to ELT (August 2023).

2.42 Alongside the monitoring of the action plan (as outlined under objective 5, para 2.36) reporting to the SLT to support the implementation of actions included:

- Presentation of the urgent notice on seatbelts and restraints
- Actions for operational managers
- Summary of returned receipts acknowledging having viewed the safety video and safety notices.

2.43 Four interim reports were also taken to ELT between June and December 2021, providing an update on the status of the criminal and internal investigations, family

liaison and independent legal advice and the wider impact of the incident on the Trust.

2.44 The final health and safety investigation report was presented to ELT in August 2023 which included:

- a detailed chronology of the events relating to the incident;
- consideration as to whether procedures and processes were being followed by relevant Trust staff;
- an assessment of the appropriateness of relevant training and development of those involved in the incident; and
- a summary of returned receipts acknowledging having viewed the safety video and safety notices.

2.45 The investigation report sets out the action plan (reviewed under objective 1) and we note that all but one action had already been addressed and marked as completed, with the final one to commence in October 2023 which we have confirmed is currently underway.

2.46 We were advised that the monitoring and implementation of these recommendations was overseen by the Assistant Directors Leadership Team (ADLT). We have been provided with evidence to support initial arrangements (July 2023) to respond to the recommendations, which included allocation of ownership of recommendations. However, no further monitoring and oversight of the implementation of these arrangements has been undertaken at this forum. **See MA4**.

2.47 As part of the review, we sought to establish formal reporting mechanisms to the Trust Board and/or its associated committees. However, there is no evidence of reporting in relation to this incident having been undertaken at this level, at either open or closed sessions. **See MA4.**

Conclusion:

2.48 The RTCCDG was established to initiate a response to the incident and provide support and guidance to the internal health and safety investigation. Periodic reporting to SLT and ELT provided oversight of the existence, progress and closure of actions and the development of the Health and Safety investigation. Subsequent actions against conclusions and recommendations from the investigation report were allocated owners in July 2023 via ADLT but there has been an absence of any oversight and monitoring since. There is no evidence of reporting at the key junctures post the incident to Trust Board or its associated Committees. As such a **reasonable** assurance is determined for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Reporting and monitoring of Quality Assurance inspection outcomes (Design)			Impact
A dashboard is maintained which acts as a high-level tracker of the status of quality assurance inspections. This includes a summary of inspections completed (both internal and external), issues identified, a scoring system for each inspection area and target dates for actions to be addressed. We note that the records captured within the dashboard did not fully reflect the detail and outcomes of each inspection that was recorded as completed during the year, and were also advised that the information was held in a location that, for the majority of the year, was not accessible to the wider QA Team. Our review has also identified the absence of reporting, including on the number of inspections completed and their outcomes. We were also unable to confirm whether required actions had been followed up to confirm that any issues identified have been appropriately addressed.			Potential risk of: • issues identified are not addressed due to inadequate recording, reporting and monitoring, resulting in recurrence of serious incidents.
Recommendations			**Priority**
1.1	Details of the inspections completed should be accurately captured within the QA dashboard and held centrally.		**Medium**
1.2	The results of both internal and external QA inspections should be reported and monitored regularly to ensure appropriate oversight of outcomes and actions identified.		
Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	This action is complete. A shared central folder has been created where the quality assurance dashboard and inspection outcome reports are now stored. Access to the folder is available to all appropriate members of the team.	Complete	-

1.2	Internal inspections are reported through the Senior Operations Team (SOT) and onwards onto operations Senior Leadership Team (SLT) for assurance purposes. Delivery of any remedial actions are overseen through SOT. External inspections will be reported through SOT from April 2024.	April 2024	Karl Hughes, Head of Service, Ambulance Care Co-ordination

Matter Arising 2: Reporting and monitoring of spot checks / Quality and Support days (Design)			Impact
Following a second incident (November 2023) involving the incorrect use of seatbelts and harnesses which occurred within a Trust EMS vehicle, 'Quality and Support Days' were introduced as a means to continue to reinforce ongoing safety requirements. The first day was held in December 2023 and involved a series of unannounced spot checks where a team of operational managers attended hospital and clinical sites to observe actions and behaviours and to inspect vehicle equipment. At the date of reporting, two of these days have been undertaken (latterly January 2024) with both having a specific focus on safety restraints and harnesses. We were advised that the provision for these days will continue and that the frequency and focus of spot checks will be tailored based on the needs of the organisation. The results from these inspections are available on the Trusts intranet site, however, we note there is an absence of information and reporting in relation to follow up arrangements to ensure that issues identified have been addressed.			Potential risk of: • issues identified are not addressed due to inadequate reporting and monitoring, resulting in recurrence of serious incidents.
Recommendations			**Priority**
2.1	Outputs from spot checks and Quality and Support days should be formally collated and reported to an appropriate forum. This should include outcomes, issues identified and subsequent progress to implement the required actions to address.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	Monitoring of themes and trends from spot checks to date and the three Quality and Support days will be collated and presented to the joint SOT/SLT meeting on 17th May 2024 and further to the wider leadership day which will follow. Any remedial actions will be implemented and monitored through SOT subsequently.	June 24	Jon Sweet, Head of Service – Operations (Chair of Senior Operations Team (SOT))

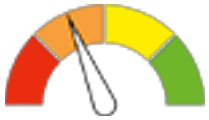
Matter Arising 3: Internal Ambulance Care Quality Assurance Inspections (Operation)			Impact
As part of the Trusts' quality assurance arrangements, an inspection process has been developed to monitor ongoing compliance for both internal and external non-emergency ambulance service providers. We were advised that the number of inspections to be undertaken across the 76 Trust NEPTS sites is limited to four stations per annum. At the date of audit fieldwork, a review of the Quality Assurance Teams' dashboard indicated only two internal inspections had been completed. Discussion with the QA Team has shown that resourcing issues has impacted on the number of inspections completed and their capture within the dashboard. We acknowledge that the recent appointment of a new QA Manager will increase the capacity of the team and strengthen the ability to undertake inspections and provide more coverage across Trust sites.			Potential risk of: • issues identified are not addressed due to inadequate recording, reporting and monitoring, resulting in recurrence of serious incidents.
Recommendations			**Priority**
3.1	Consideration should be given to undertake a higher number of internal inspections per annum to provide sufficient coverage and assurance that the Trust is compliant with required standards.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	The decision to include internal inspections has been driven internally by the Operations Directorate although capacity remains a limiting factor. Whilst the audit has highlighted the need to undertake a higher number of inspections, we remain committed to four per annum with more being undertaken should capacity permit.	December 2024	Mark Harris, ADO Ambulance Care

Matter Arising 4: Monitoring of Health and Safety Investigation recommendations and assurance reporting to Board (Operation)			**Impact**
The internal Health and Safety investigation report identified 11 recommendations for the Trust, which are in addition to the actions and outputs identified in the action plan. We were advised that the monitoring and implementation of these recommendations is being overseen by the Assistant Directors Leadership Team (ADLT). We have been provided with evidence to support initial arrangements (July 2023) to respond to the recommendations, which included allocation of action owners. However, no further monitoring and oversight of the implementation of these arrangements has been undertaken at this forum. We also noted a lack of evidence of reporting on the incident at Trust Board and/or its associated Committees, at either open or closed sessions.			Potential risk of: • absence of monitoring arrangements resulting in adherence to required safety practices not being embedded. • lack of assurance reporting at Board and Committee level.
Recommendations			**Priority**
4.1	The recommendations from the Health & Safety investigation should be formally monitored through an appropriate forum to provide oversight and assurance on the satisfactory closure of the investigation.		**High**
4.2	Should a similar serious incident occur in the future, assurance on the progress made by the Trust to address identified actions and recommendations and the arrangements to embed and sustain safety practices and processes should be provided at Board and Committee level.		
Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	The Trust accepts this recommendation. ADLT will oversee the monitoring and compliance of the H&S investigation and provide assurance to ELT via the AAA reporting mechanism.	May 2024	Mark Harris, ADO Ambulance Care
4.2	The Trust Accepts this recommendation. Should a similar incident occur at any future point, assurance will be provided through a closed session of QuEST Committee.	Closed	-

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**Unsatisfactory assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

AGENDA ITEM No	**16**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**4**

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

MEETING	Quality, Patient Experience & Safety Committee
DATE	7th May 2024
EXECUTIVE	Trish Mills, Director of Governance/Board Secretary
AUTHOR	Julie Boalch, Head of Risk/Deputy Board Secretary
CONTACT	Julie.Boalch@wales.nhs.uk

EXECUTIVE SUMMARY

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

2. A summary of these risks is set out in Annex 1 with a detailed description contained within the Board Assurance Framework (BAF) in Annex 4.

3. The more detailed description contained within the BAF provides the Committee with an opportunity to review the controls in place against each principal risk and the assurance provided against those controls where applicable. This will assist Members in evaluating current risk ratings supported by the frameworks in Annex 2.

4. Each of the principal risks were presented to the Trust Board on 28 March 2024 and are updated as at 07 February 2024. These high rated risks have been reviewed during this reporting period in line with the agreed schedule detailed at Annex 3 and the results of this review will be presented to Trust Board on 30 May 2024.

5. Updates are highlighted in blue on the BAF which show changes to the narrative, mitigating actions, controls, and assurances.

6. The focus for the forthcoming round of reviews will predominantly be in relation to the mitigating actions identified and taken to support risks to achieve their target score.

7. The Trust's highest rated Risks 223 *the Trust's inability to reach patients in the community causing patient harm and death*) and Risk 224 (*Significant handover of care delays outside accident and emergency departments impacts on access to*

definitive care being delayed and affects the Trust's ability to provide a safe & effective service for patients, scoring 25, remain unchanged because of sustained and extreme pressure across the Welsh NHS urgent and emergency care system which is negatively impacting on patient flow leading to avoidable patient harm and death. These risks continue to be dynamically reviewed and closely monitored by management, Board Committees, and at the Trust Board meetings as well as internal forums.

8. As reported to the March 2024 Trust Board, whilst good progress has been made on the actions that the Trust can control, the extreme pressure continues. As a result, the likelihood is that the levels of avoidable harm will continue. That does not mean that the Trust is not continually seeking additional actions to mitigate these risks and the actions are articulated in the avoidable harm paper that the Board receive at each meeting.

9. Several updates have been made to the controls and assurances in relation to Risk 223 and 224 during this period and these are highlighted on the BAF to address gaps in assurance. These two risks have been reviewed closely in conjunction with each other to ensure the synergy between them both and that they reflect the actions from the avoidable harm paper in the same way.

10. Whilst both risks remain static at the highest score of 25, it is anticipated that this will be the case for the foreseeable future as long as the Trust is in a position where it is highly likely to have an incidence of premature death or avoidable harm because of being unable to respond in a way that it would wish to. The score is not based on the volume of cases of catastrophic harm, it is based on any one individual that experiences avoidable harm. The quality dimension of each of these risks will always be a challenging one to reduce whilst patients and the Trust are experiencing delays in the way in which they currently are.

11. These risks will be considered further as to how the Trust can approach them by applying the risk appetite methodology as part of the Risk Management Improvement Programme and the most efficient and effective way of managing them internally given that their score has remained catastrophic over a significant period of time.

RECOMMENDATION: Members are asked to consider the contents of the report.

KEY ISSUES/IMPLICATIONS
12. The key issues are set out in the Executive Summary above.
REPORT APPROVAL ROUTE
• The BAF was considered by: • ADLT (05 February 2024) • ELT (07 February 2024)

- Trust Board (28 March 2024)

REPORT ANNEXES
• Annex 1 - Summary table describing the Trust's Corporate Risks. • Annex 2 – Scoring Matrix • Annex 3 – Frequency of Risk review • Annex 4 - Board Assurance Framework

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

Annex 1 – Corporate Risk Register Summary

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
223 QuEST	The Trust's inability to reach patients in the community causing patient harm and death	**IF** significant internal and external system pressures continue **THEN** there is a risk of an inability and/or a delay in ambulances reaching patients in the community **RESULTING IN** patient harm and death	Director of Operations	**25 (5x5)** →
224 QuEST	Significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service	**IF** patients are significantly delayed in ambulances outside A&E departments **THEN** there is a risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised **RESULTING IN** patients potentially coming to harm and a poor patient experience	Director of Quality & Nursing	**25 (5x5)** →

Annex 2 - Risk Scoring Matrix

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

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

Annex 3 - Frequency of Risk Review

Risk Score	Review Frequency	Risk Rating
15 – 25 Red	Review monthly	High
8 – 12 Amber	Review quarterly	Medium
1 – 6 Green	Review every 6 months	Low

Annex 4 – Board Assurance Framework

Risk ID 223	**The Trust's inability to reach patients in the community causing patient harm and death**	**Date of Review:**	**17/01/2024**	**TREND**	**25 (5x5)**
		Date of Next Review:	**14/02/2024**	➡	

IF significant internal and external system pressures continue	**THEN** there is a risk of an inability and/or a delay in ambulances reaching patients in the community	**RESULTING IN** patient harm and death

	Likelihood	**Consequence**	**Score**
Inherent	**4**	**5**	**20**
Current	**5**	**5**	**25**
Target	**2**	**5**	**10**

IMTP Deliverable Numbers:

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

Risk Commentary Q3 2023/24

The risk score remains constant at 25 (almost certain & catastrophic). Internal and external assurances remain weak as there remains a daily risk of actual patient harm and death because of the Trust not being able to reach patients in the community. **The Trust continues to receive Prevention of Future Death Reports (Regulation 28) from Coroners across NHS Wales. The Trust has received 6 reports since April 2023, including 1 report in quarter 3 2023/4. 5 of these reports directly relate to system pressures with the coroners raising concerns about delays in responding to patients in the community and handover of care delays at emergency** departments. In **November** 2023, over **20,126** hours were lost **and 22,756 in December 2023.** Only Cardiff & Vale University Health Board has demonstrated material improvement and is a positive outlier. The impacts on patients waiting for extended periods of time both in the community and then outside emergency departments is well documented (AACE Delayed Hospital Handovers: Impact assessment of patient harm, 2021) and includes pressure damage, acute kidney injury, deconditioning, poorer outcomes, and extended recovery times. Delays across the system continue to be the focus of patient safety incidents, complaints, Coronial enquires and redress / claims. The effectiveness of our controls in many areas are dependent on external partners acknowledging and having ownership of the risk across the urgent and emergency care system. Key to moving the position is to continue to work in collaboration influencing system partners, being present and engaging in key conversations, whilst continually seeking opportunities internally to swiftly identify and mitigate the risks within our control and share those with relevant system partners that we cannot control. Of note, recent data analysis highlights the increased levels of red activity which has doubled since the pre covid period, plus an average increased on scene time of circa 10 minutes. Both measures are reflective of an increasingly challenged system with WAST crews fully exploring admission avoidance alternatives.

Improvement actions led by Welsh Government and system partners include: -

a) Audit Wales's investigation of Urgent and Emergency Care System. Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time? (E)
b) Consideration of additional WAST schemes to support risk mitigation through winter (I)
c) NHS Wales reduces emergency department handover lost hours by 25% (E)
d) NHS Wales eradicates all emergency department handover delays in excess of 4 hours (E)
e) Alterative capacity equivalent to 1000 beds (E)
f) Implement nationwide approach to emergency department 'Fit 2 Sit' (E)
g) Implementation of Same Day Emergency Care services in each Health Board (E)
h) National Six Goals programme for Urgent and Emergency Car (E)

CONTROLS	**ASSURANCES**
	Internal Management (1st Line of Assurance)
1. Regional Escalation Protocol	1. Daily conference calls to agree RE levels in conjunction with Health Boards
2. Immediate release protocol	2. The Immediate Release Protocol is a Nationally agreed NHS Wales protocol. Refusals by Health Boards are Datixed by WAST and compliance report shared weekly with the Health Board Chief Operating Officers (COOs)
3. Resource Escalation Action Plan (REAP)	3. Weekly review by Senior Operations team with assessment of action compliance. The Senior Leadership Team convenes every Tuesday as the Weekly Performance Meeting to review performance and demand data, and review/assign REAP Levels as appropriate. Dynamic escalation via Strategic Command structure. REAP **has undergone an** annual review with v4.1 released **in November 2023.**
4. 24/7 Operational Delivery Unit (ODU)	4. Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end. Provides operational oversight with dynamic CSP review and system escalation as required.
5. Strategic, Tactical and Operational 24 hour/ 7 day per week system to manage escalation plans	5. Same as 5 - Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end. Provides operational oversight with dynamic CSP review and system escalation as required. On Call cover is reviewed weekly at SLT Performance Meetings.
6. Limited Alternative Care Pathways in place	6. Limited Assurance - Health Informatics reports, APP dashboard monitors, reports on app use by Consultant Connect, APP development and expansion, and bids for additional prescribing APPs.
7. Consult and Close (previously Hear and Treat)	7. The Trust ambition is to attain 17% Consult and Close rate, with an improvement plan in place to achieve this. The Trust has however already achieved the inclusion of Mental Health Practitioners in CSD, a key contributor to the achievement of Consult and Close rates. Reported through integrated quality meeting. **Whilst Consult and Close is in place, the action to increase compliance is detailed in action 10.**

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	17/01/2024	TREND	25 (5x5)
		Date of Next Review:	14/02/2024	➡	

IF significant internal and external system pressures continue	THEN there is a risk of an inability and/or a delay in ambulances reaching patients in the community	RESULTING IN patient harm and death

	Likelihood	Consequence	Score
Inherent	4	5	20
Current	5	5	25
Target	2	5	10

8. Advanced Paramedic Practitioner (APP) deployment model / APP Navigation	8. WAST has attempted to secure additionality within its APP numbers, as the evidence illustrates a dramatic impact upon ED avoidance with more people being managed within the community. At this stage, no additional funds have been secured. However, it remains the case the prospective APPs are completing their education and could be deployed into the operational setting to mitigate the risk. ELT has therefore agreed to grow the APP numbers further this year, redirecting existing operational spend to bolster APP growth.
9. Clinical Safety Plan	9. Clinical agreement – agreeing escalation to higher levels, ODU dashboard, AACE paper through National Director of Operations group. **In December 2023, Version 2.21 of the Clinical Safety Plan was released. The subsequent reduction in the demand is the assurance which is dynamically monitored via ODU.**
10. Recruitment and deployment of CFRs	10. CFR numbers have grown during 2022/23 which alongside a cleanse of the volunteer database has realised 500 current active volunteers with an ambition to recruit a further 100 by end of Q4. Response data indicates that our CFRs are reaching more patients, especially those with life threatening conditions in 8 minutes compared to this time last year. Numbers of CFR's, percentage of contribution to performance a governance framework is in place. Monitoring through AD 1:1's and volunteer highlight report (IMTP).
11. ETA scripting	11. The ETA Dashboard is a tactic that was signed off by ELT. The dashboard supports scripting analysed by comparing with real time data. ETA performance is reviewed weekly at SLT weekly performance meeting. The effect of the ETA scripting results in cancellations of ambulances which is monitored through algorithmic review process.
12. Clinical Contact Centre (CCC) emergency rule	12. Emergency Rule is incorporated into CSP 999 levels.
13. National Risk Huddle	13. This is a tactic contained in REAP ratified through SPT and EPT. Daily risk huddles are recorded, and documented actions are shared with stakeholders and progress monitored via the ODU.
14. Summer/Winter initiatives	14. Monitoring through SLT and STB. Senior Planning Team (SPT) is now stood up for the duration of Winter 2023/24.
15. CHARU implementation	15. Recruitment of 153 WTE has continued; To lift further, a trial of a rotational model is due to be trialled in Aneurin Bevan Health Board area.
16. Clinical Model and clinical review of code sets	16. Reported through CPAS and DCR Review reporting through CQGG
17. Remote clinical support enabling discharge at scene	17. Strategic Transformation Board – IMTP deliverable; Providing support to the Community Welfare Responders (CWR) initiative and supporting CFRs to discharge at scene with current non conveyance rates for CFRs in excess of 40%
18. Trust Board paper (28/07/22) detailing actions being taken to mitigate the risks (see actions section for details of specific work streams being progressed to mitigate this risk)	18. Formally documented action plan – actions captured are contained within and monitored via the Mitigating avoidable harm paper from PIP.
19. Information sharing	19. Information Sharing: Patient Safety Reports, Chief Operating Officer (COO) Data Pack, Immediate Release Declined (IRD) Reports.
20. Completed EMS Roster Review	20. Helps to ensure that we have the maximum available capacity to respond to dispatch to 999 calls received in a timely manner. Monitor production against the rosters weekly at performance meeting and that provides a level of UHP as a percentage.
21. Delivered a reduction in the number of multiple **vehicle** attendances dispatched to red calls	21. This will increase vehicle availability generally across the Trust and is monitored through SLT weekly performance meeting.
22. Transfer of Care	22. WAST has clearly articulated to the Health Board COOs the risk associated with delayed handovers. Consequently, work has commenced to withdraw WAST staff from portering duties on hospital premises, cease the practice of ED swaps and cease the use of WAST equipment in EDs across Wales. Please refer to the following documents: i) Letter to COO Handover Delays 30.03.2023 ii) Letter to COO Handover Delays iii) WAST – Transfer of Care Brief
23. **Virtual Ward – Connect Support Cymru**	23. Multi phased approach commenced in Dec 2022 with St John Ambulance Cymru virtual ward responder, a digital and telehealth platform, and a Community Welfare Responder model to enhance community resilience. • Phase 1 delivered through St John Ambulance Cymru • Funding also obtained through external grant funding to pilot a volunteer phase. which went live mid-October with twelve teams piloting the approach. Early results look promising and the ambition to upscale is being explored with a focus on CSD

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	17/01/2024	TREND	25 (5x5)
		Date of Next Review:	14/02/2024	➡	

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

	capacity. Whilst the pilot tests the approach with existing CFRs, the ambition is to introduce a new volunteer role to which we will recruit new volunteers.
24. **ARA – Acute Release Area - GUH**	**24. Live until 31st March 2024**
25. **WAST Serious Clinical Incident Forum (SCIF) is in place to discuss patient safety incidents, learning and improvement actions to prevent future harm, working in collaboration with Health Boards / NHS Wales Executive Delivery Unit under the Joint Investigation Framework which was formalised in the National Patient Safety Policy in May 2023. Sharing of potential case of serious avoidable harm/death with Health Boards for investigation when response delay associated with system congestion is the primary cause. CNO and CMO plus peer group and COOs regularly updated on patient safety incidents. Patient safety reporting and escalation through the Serious Clinical Incident Panel (SCIF), Patient Safety Highlight Reports, Health Board specific reports in place with escalation through WAST governance framework.**	**25. Patient safety reporting and escalation through the Serious Clinical Incident Panel (SCIF), Patient Safety Highlight Reports, Health Board specific reports in place with escalation through WAST governance framework.**
26. **WAST membership of the working group (Executive Director of Quality & Nursing) to reform the Framework for the Investigation of Patient Safety Serious Incidents (SIs) national investigation framework with system partners. Chaired by the Deputy Chief Ambulance Commissioner and commenced in August 2022.**	27. **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.**
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Acknowledgement and acceptance of risk by Health Boards and balancing the risks across the whole system	1. Improvement in handover delays across Cardiff and Vale and more latterly across AB have led to improved handovers at Eds. This has now been sustained for some months across C&V in a phased programme of improvement with no delays in excess of 2 hours. Programme of improvement underway in AB, commencing at 4hour tolerance with a plan to reduce over time. In other Health Boards, there remains little or no controls, with variation in both handovers and risk levels across Health Boards. An extraordinary incident declared by WAST on 22 October 2023 as direct result of system risk associated with handover delays at Morrison hospital has increased focus on handover delays with external partners and across the media. Some plans are in train (detailed in actions) following a meeting with Swansea Bay COO to include mobile imaging, pathways to bypass ED and a pod solution ahead of winter.
2. Blockages in system e.g., internal capacity within Health Boards which affect patient flow	
3. Local delivery units mirroring WAST ODU	
4. Handover delays link to risk 224	
5. There is an ambition that no handover should exceed 4 hours and for lost hours to handover to be reduced by 25% but given the track record over last 12 months there is a low confidence in attaining this.	The majority of Health Boards have failed to deliver on this ambition; With the exception of Cardiff and Vale University Health Board, the remaining 5 Health Boards with acute Trusts that were required to deliver on this target, have failed to do so.
6. Handover Improvement Plans agreed between WAST and Health Boards	12. Handover Improvement Plans have been replaced by Integrated Commissioning Action Plans (ICAPS) and are subject to review with EASC; However, it is noted that previous plans did not demonstrate sufficient improvement in reducing handover delays (see above)
18. Access to Same Day Emergency Care (SDEC) for paramedic referrals	18. This forms part of the handover improvement plans in place with Health Boards; however, assurance is limited given that the **uptake** is low (less than 1% of **total demand**). There is an inconsistency in approach from Health Boards on eligibility and availability; The national Once for Wales acceptance criteria has not been uniformly deployed by Health Bards across Wales.
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	Superseded	Rural model superseded by Action 9 below (Recruitment and deployment of CFRs)

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	17/01/2024	TREND	25 (5x5)
		Date of Next Review:	14/02/2024	➡	

IF significant internal and external system pressures continue	THEN there is a risk of an inability and/or a delay in ambulances reaching patients in the community	RESULTING IN patient harm and death

	Likelihood	Consequence	Score
Inherent	4	5	20
Current	5	5	25
Target	2	5	10

	Operations – National Operations & Support		
2. Leading Change Together (forum to progress workforce related work streams jointly with TUPs)	ADLT Sub-Group	30.09.22 - Superseded	
3. Recruit and train more Advanced Paramedic Practitioners – Value Based Healthcare Fund bid for up to 50 WTE (I) [Source: Action Plan presented to Trust Board 28/07/22]	Director of Paramedicine / Director of People & Culture	Extended to March 2024	WAST has attempted to secure additionality within its APP numbers, as the evidence illustrates a dramatic impact upon ED avoidance with more people being managed within the community. At this stage, no additional funds have been secured. However, it remains the case the prospective APPs are completing their education and could be deployed into the operational setting to mitigate the risk. ELT has therefore agreed to grow the APP numbers further this year, redirecting existing operational spend to bolster APP growth.
4. Transition Plan (I) [Source: Action Plan presented to Trust Board 28/07/22]		Superseded	
5. 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.
6. New 2023 EMS Demand and Capacity (roster) review	Assistant Director of Planning & Performance	March 2024	ORH modelling underway. Initial findings January 2024, full report to Trust Board and EASC in March
7. Swansea Bay Winter actions	Assistant Director of Operations, EMS	December 2023	Some plans are in train following a meeting with Swansea Bay COO to include mobile imaging, pathways to bypass ED and a pod solution ahead of winter.
8. Mental Health response pilot	Assistant Director of Operations, EMS	**Not yet Active.**	Pilot to commence in Aneurin Bevan Health Board area Nov 2023
9. Connected Support Cymru – is initially designed to utilise NHS and voluntary-sector resources and responders to enable patients to be supported in their own home whilst waiting for an urgent healthcare need to be managed. The service will employ digital health technologies to connect patients, communities and clinicals to achieve better health outcomes. The initiative will improve patient experience and safety, while supporting the healthcare system in directing patients to the right pathway at an appropriate time for their care need. It is expected this will help reduce unnecessary demand upon Emergency Departments.	Assistant Director of Quality Governance		Multi phased approach commenced in Dec 2022 with St John Ambulance Cymru virtual ward responder, a digital and telehealth platform, and a Community Welfare Responder model to enhance community resilience. Phase 1 delivered through St John Ambulance Cymru, **with further funding by the commissioner for a further phase via SJAC.** Funding also obtained through external grant funding to pilot a volunteer phase. which went live mid-October with twelve teams piloting the approach. Early results look promising and the ambition to upscale is being explored with a focus on CSD capacity. Whilst the pilot tests the approach with existing CFRs, the ambition is to introduce a new volunteer role to which we will recruit new volunteers.
10. Maximise the opportunity from Consult and Close – stretch to 17%			Trust ambition is to attain 17% Consult and Close rate, with an improvement plan in place to achieve this. The Trust has however already achieved the inclusion of Mental Health Practitioners in CSD, a key contributor to the achievement of Consult and Close rates. **Consult and Close compliance remains around 14%. Action plan activities therefore continue with a review of triage processes which may lead**

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	17/01/2024	TREND	25 (5x5)
		Date of Next Review:	14/02/2024		

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

			to shorter triage durations, along with increase in staffing, which together will enable more triages to take place, thus increasing the percentage of consult and close to 17%.
11. Development of new model of care	Head of Strategy Development	2024/25	Development of the model remains ongoing
12. Development of the pathway which connects mental health users connecting via the 999 system to 111 Press 2 services	Assistant Director of Operations, Integrated Care	March 2024	Development of the model remains ongoing
13. Palliative Care Paramedic Unit	**Assistant Director of Operations**	**January 2024**	**Reducing demand via APPs – 15th January Start.**
14. Audit Wales investigation of Urgent and Emergency Care System: Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time?	**CEO**	**Q4 2023-2024**	• **Conducted in three phases Audit Wales will independently investigate and report on patient flow out of hospital: access to unscheduled care services and national arrangements (structure, governance, and support)** • **WAST will proactively support this work and offer best practice examples from other jurisdictions that can support benchmarking and improvement activities.** • **Expected outcomes in 2023/24.**
15. Winter Ambulance Handover Improvement Plan Meetings	**Executive Director of Operations**	**February 2024 (six weeks duration)**	• **Weekly meetings set up with Welsh Government, NHS Executive, CASC and the Health Board COOs. All parties (including WAST) to provide updates on actions being taken to alleviate and improve handover delays. WAST to update on C&C, CWR, red dispatch and local updates from EMS HOS on initiatives.**

Risk ID 224	Significant Handover of Care Delays Outside Accident and Emergency Departments Impacts on Access to Definitive Care Being Delayed and Affects the Trust's Ability to Provide a Safe & Effective Service for Patients	Date of Review:	17/01/2024	TREND	25 (5x5)
		Date of Next Review:	14/02/2024	➡	

IF	THEN	RESULTING IN
patients continue to be significantly delayed in ambulances outside Accident and Emergency Departments	there is a continued risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised	patients coming to significant harm and a poor patient experience

	Likelihood	Consequence	Score
Inherent	5	5	25
Current	5	5	25
Target	3	2	6

IMTP Deliverable Numbers:

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

Risk Commentary Q3 2023/24

The risk score remains constant at 25 for quarter 3 2023/24 (almost certain & catastrophic). Internal and external assurances remain weak as there remains a daily risk of actual patient harm due to handover of care delays. **There were 1,888 patient handovers in October 2023 which were over 4 hours.** The target was originally to have zero by September 2022. **In November 2023 over 20,126 hours were lost and 22,756 were lost in December 2023** Cardiff & Vale University Health Board has demonstrated material improvement and is a positive outlier. The impacts on patients waiting for extended periods of time both in the community and then outside emergency departments is well documented (AACE Delayed Hospital Handovers: Impact assessment of patient harm, 2021) and includes pressure damage, acute kidney injury, deconditioning, poorer outcomes, and extended recovery times. Delays across the system continue to be the main focus of patient safety incidents, complaints, coronial enquires and redress / claims. **The Trust continues to receive Prevention of Future Death Reports (Regulation 28) from Coroners across NHS Wales. The Trust has received 6 reports since April 2023, including 1 report in quarter 3 2023/4. 5 of these reports directly relate to system pressures with the coroners raising concerns about delays in responding to patients in the community and handover of care delays at emergency departments**. The effectiveness of our controls in many areas are dependent on external partners acknowledging and having ownership of the risk across the urgent and emergency care system. Key to moving the position is to continue to work in collaboration influencing system partners, being present and engaging in key conversations, whilst continually seeking opportunities internally to swiftly identify and mitigate the risks within our control and share those with relevant system partners that we cannot control. WAST CEO and Directors have ensured that system safety and avoidable harm remain a live topic of discussion in all relevant forums and continue to seize opportunities as they emerge that can contribute to mitigating avoidable harm. The Joint Investigation Framework in place to review incidents across the system is now approved and included in the recently published National Policy on Patient Safety Incident Reporting & Management (May 2023). Themes from system partners following review of incidents remains the consequences of high escalation levels in acute care and crowded emergency departments.

Improvement actions led by Welsh Government and system partners include:

a) Right care, right place, first time Six Goals for Urgent and Emergency Care - A policy handbook 2021–2026. Goal 4 'Improving ambulance patient handover, ensuring no one arriving by ambulance at an Emergency Department waits more than 60 minutes from arrival to handover to a clinician – (Welsh Government) ***by the end of April 2025***
b) NHS Wales eradicates all emergency department handover delays more than 4 hours (LHB CEOs) ***revised to March 2023/24.***
c) Alternative capacity equivalent to 1,000 beds project (LHB CEOs) – 678 additional beds delivered, a significant achievement, but short of the target of 1,000.
d) Investigation of Urgent and Emergency Care System: Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time? (Audit Wales)
e) Implement nationwide approach to emergency department 'Fit 2 Sit' (Welsh Government: Chief Medical Officer and Chief Nursing Officer).

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. WAST Serious Clinical Incident Forum (SCIF) is in place to discuss patient safety incidents, learning and improvement actions to prevent future harm, working in collaboration with Health Boards / NHS Wales Executive Delivery Unit under the Joint Investigation Framework which was formalised in the National Patient Safety Policy in May 2023. Sharing of potential case of serious avoidable harm/death with Health Boards for investigation when response delay associated with system congestion is the primary cause. CNO and CMO plus peer group and COOs regularly updated on patient safety incidents.	1. Patient safety reporting and escalation through the Serious Clinical Incident Panel (SCIF), Patient Safety Highlight Reports, Health Board specific reports in place with escalation through WAST governance framework.
2. WAST membership of the working group (Executive Director of Quality & Nursing) to reform the Framework for the Investigation of Patient Safety Serious Incidents (SIs) national investigation framework with system partners. Chaired by the Deputy Chief Ambulance Commissioner and commenced in August 2022.	2. Workshop with system partners in place with executive directors of nursing attendance and to date is working well with good engagement from health board colleagues. Following the last meeting on 25.01.2023 it was agreed that sub-groups would be formed to meet more frequently to gather themes / evaluation / develop more consistency which would include aligning the outputs / outcomes with the 'Six Goals for Urgent and Emergency Care' work.
3. WAST and system compliance with National Standards - 15-minute handover (NHS Wales Hospital Handover Guidance v2 (May 2016)	3. Monthly Integrated Quality and Performance Report, Health Informatics reports, APP dashboard on app use by Consultant Connect and shared at local and corporate meetings regarding patient safety and handover of care position across NHS Wales and NHS England.
4. WAST Clinical Notice in place - Escalating a clinical concern with a deteriorating patient outside the Emergency Department (11.02.2021). National Early Warning Score (NEWS) trigger of 5 or above for escalation to hospital clinicians. NEWS data available via EPCR (electronic patient care record).	4. NEWS data now available via ePCR and escalation system in place via local managers and the Operational Delivery Unit.

Risk ID 224	Significant Handover of Care Delays Outside Accident and Emergency Departments Impacts on Access to Definitive Care Being Delayed and Affects the Trust's Ability to Provide a Safe & Effective Service for Patients	Date of Review:	17/01/2024	TREND	25 (5x5)
		Date of Next Review:	14/02/2024	➡	

IF patients continue to be significantly delayed in ambulances outside Accident and Emergency Departments	**THEN** there is a continued risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised	**RESULTING IN** patients coming to significant harm and a poor patient experience

	Likelihood	Consequence	Score
Inherent	5	5	25
Current	5	5	25
Target	3	2	6

5. Workstreams put in place to meet requirements of *Right care, right place, first time Six Goals for Urgent and Emergency Care A policy handbook 2021–2026*. Goal 4 incorporates the reduction of handover of care delays through collective system partnership. WAST membership at system workshops supported by Commissioners looking at handover of care delays which includes the implementation of the Fit2Sit programme and handover of care checklist pan NHS Wales. Learning from NWAS shared that indicates up to 20% of ambulance arrivals may be suitable for Fit 2 Sit Additionally, the Emergency Ambulance Services Committee (EASC) have stated that no delay should exceed 4 hours.	5. Monthly Integrated Quality and Performance Report
6. Hospital Ambulance Liaison Officer (HALO) (Some Health Boards).	6.
7. Regional Escalation Protocol and Resource Escalation Action Plan (REAP). Proactive and forward-looking weekly review of predicted capacity and forecast demand. Deployment of predetermined actions dependant on assessed level of pressure. Consideration of any bespoke response/actions plans in the light of what is expected in the coming week. WAST has updated the REAP in advance of winter, including revised triggers (higher) for handover lost hours.	7. The Senior Leadership Team convenes every Tuesday as the Weekly Performance Meeting to review performance and demand data, and review/assign REAP Levels as appropriate. Dynamic escalation is via the Strategic Command structure. **REAP has undergone an annual review with v4.1 released in November 2023.**
8. Staff from WAST, Health Boards and third sector organisations assisting to meet patient's Fundamentals of Care as best they can in the circumstances.	8. Confirmed through Healthcare Inspectorate Wales (HIW) workshops and Health & Care Standards self-assessment process and Putting Things Right Quarterly Reports to Clinical Quality Governance Group and QuEST
9. 24/7 operational oversight by ODU with dynamic **Clinical Safety Plan** review and system escalation as required. Realtime management and escalation of risks and harm with system partners. Triggering and escalation levels within CSP to best manage patient safety in the context of prevailing demand and available response capacity. Monitoring, escalation and reporting of extreme response or handover delays.	9. Shift reports from ODU & ODU Dashboard received by Executive Management Team (EMT), Senior Operations Team (SOT) and On-Call Team at start/end. Realtime management and escalation of risks and harm with system partners. Triggering and escalation levels within CSP to best manage patient safety in the context of prevailing demand and available response capacity. Monitoring, escalation and reporting of extreme response or handover delays. **In December 2023, Version 2.21 of the Clinical Safety Plan was released. The reduction in the demand is the assurance which is dynamically monitored via ODU.**
10. Gold/Strategic, Silver/Tactical and Bronze/Operational 24 hour/ 7 day per week system to manage escalation plans.	10. Shift reports from ODU & ODU Dashboard received by EMT, SOT and On-Call Team at start/end. **On Call cover is reviewed weekly at SLT Performance Meetings.**
11. Escalation forums to discuss reducing and mitigating system pressures.	11. Daily risk huddles are recorded, and documented actions are shared with stakeholders and progress monitored via the ODU.
12. WAST Education and training programmes include deteriorating patient (NEWs), tissue viability and pressure damage prevention, dementia awareness, mental health.	12. Monthly Integrated Quality and Performance Report (October 2023 overall 76% - Safeguarding and dementia awareness remains over 91%.
13. Clinical audit programme in place.	13. Clinical audit programme in place (dynamic document) with oversight from the Clinical Quality Governance Group and QuEST.
14. Workshop set up by the Deputy Chief Ambulance Commissioner to respond to the findings in the Health Care Inspectorate Wales (HIW) Report *Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover* (undertaken 2021). WAST has senior representation at this meeting. – assurance is that HIW approve and sign off WAST elements and Health Board elements of recommendations.	14. Workshop set up by the Deputy Chief Ambulance Commissioner to respond to the findings in the Health Care Inspectorate Wales (HIW) Report Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover (undertaken 2021). WAST has senior representation at this meeting. A collective response from WAST and Health Boards is being overseen by EASC.
15. Escalation of patient safety concerns by Trust Board: featured in provider reports to the Emergency Ambulance Committee (EASC); been the subject of Accountable Officer correspondence to the NHS Wales Chief Executive; numerous escalations to professional peer groups initiated by WAST Directors; and coverage at Joint Executive Meetings with Welsh Government. Evidence submission to Senedd Health and Social Care Committee. Written evidence submitted during Q4 21/22 to the committee to assist their inquiry into Hospital Discharge and its impact on patient flow through hospitals. Report published in June 2022 containing 25 recommendations with recommendation six specifically WAST related stating "The Welsh Government should explain how the targets outlined in the Minister for Health and Social Service's statement of 19 May 2022 on urgent and emergency care and the Six Goals Programme to eradicate ambulance patient handover delays of more than four hours and reduce the average ambulance time	15. Monthly Integrated Quality and Performance Report, CEO Reports to Trust Board including 'Actions to Mitigate Avoidable Patient Harm Report' (last presented to Trust Board November 2023) and Board sub-committee oversight and escalation through 'Alert, Advise and Assure' reports.

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	Likelihood	Consequence	Score
Inherent	5	5	25
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Target	3	2	6

lost per arrival by 25 per cent (from the October 2021 level) have been set. It should also confirm the target dates for the achievement of these targets."	
16. Implementation of Duty of Quality, Duty of Candour, and new Quality Standards requirements in April 2023.	16. Welsh Government Road Map in place (soft launch) with milestones for organisations – baseline assessment and monthly updates (RAG ratings) in place with Trust Board oversight. The current internal assessment overall as of **December** 2023 is 'Implementing and operationalising'. The Trust has representation on the All Wales Duty of Candor Implementation Group and is actively engaged in developing resources. From April 2024 the Trust will publish an annual quality report and compliance with Duty of Candour. Operational oversight occurs at the Quality Management Group and Executive oversight is via the Clinical Quality Governance Group.
17. Clinical Support Desk First in place	17.
18. Summer/Winter initiatives	18. **Monitoring through SLT and STB. Senior Planning Team (SPT) is now stood up for the duration of Winter 2023/24.**
	External Sources of Assurance Management (1st Line of Assurance)
	1. Monitoring and oversight of the Ambulance Quality Indicators (AQIs) including handover of care timeliness and Commissioning Framework by the Chief Ambulance Services Commissioner (CASC), the Emergency Ambulance Services Committee (EASC) including the Integrated Commissioning Action Plans (ICAPS) and Joint Executive Team (JET) meetings with Welsh Government (I&E).
	2. Healthcare Inspectorate Wales (HIW) 'Review of Patient Safety, Privacy, Dignity and Experience whilst waiting in Ambulances during Delayed Handover' Report and system wide improvement plan with working group in place with WAST senior representation. Oversight by HIW and EASC
	3. Duty of Quality and Duty of Candour readiness returns assessment by Welsh Government.
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Lack of capacity in the Putting Things Right Team to deliver across the functions due to competing priorities resulting from sustained system pressures.	1.
2.	2. Implementation of the revised Joint Investigation process remains in pilot stage with good engagement seen by system partners. Several overdue patient safety investigations remain presenting a risk to patient safety across the system. The Trust has 38 overdue nationally reportable incident investigations. Shared system learning from the Joint Investigation Framework is currently limited with no new learning identified to date.
3. Lack of implementation and holding to account regarding the NHS Wales of the Handover Guidance v2 and recognition of the patient safety risks pan NHS Wales.	3. 15-minute handover target is not being achieved pan-Wales consistently and has led to a substantial growth in emergency ambulance handover lost hours. In October 2023, 23,232 hours were lost with 1,888 +4 hour delayed patient handovers.
4. Variation in responsiveness at Emergency Departments to the escalating concerns regarding patients' NEWS.	4. Strengthening of patient safety reports and audit processes as e PCR system embeds.
5. Variation pan Wales / England as position not implemented across all emergency departments*.	5. New Quality Management System in development which will include monitoring of the new Quality Standards & Enablers and underpinning governance structure.
6. National steer required to confirm the accountability arrangements regarding patients in ambulances outside of the emergency departments. The seven Local Health Boards (LHBs) in Wales are responsible for planning and securing delivery of primary, community, secondary care services, and also the specialist services for their areas.	6. HIW approve and sign off WAST elements of recommendations.
	External Gaps in Assurance 1. Lack of escalation and response to AQIs by the wider urgent care system and regulators

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Handover checklist implementation – Nationally WAST Quality Improvement (QI) Project	WAST QI Team (QSPE)	• TBC – Paused	• Timeframes awaited via Emergency Department Quality & Delivery Framework (EDQDF).

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2. Implement patient safety dashboards (live and look back data) triangulating quality metrics / KPIs and performance data sourcing health informatics resource.	Assistant Director of Quality & Nursing	• Q4 2023/24	• Incremental improvements to quality and safety data and information to enable triangulation / collective intelligence at Trust and system level. • Access to ePCR data (NEWS) now available. Work on-going with Health Informatics regarding patient safety and health board dashboards.
3. Continued Health Board interactions – my next patient (boarding), patient safety team dialogue – proactive conversations with Health Board Directors of Quality & Nursing.	Executive Director of Quality & Nursing	• Monthly and as required.	• Monthly meetings continue to be held and networking through EDoNS.
4. Recruit and train more Advanced Paramedic Practitioners – Value Based Healthcare Fund bid for up to 50 WTE	Director of Paramedicine	• Q4 2023/24	• WAST has attempted to secure additionality within its APP numbers, as the evidence illustrates a dramatic impact upon ED avoidance with more people being managed within the community. At this stage, no additional funds have been secured. However, it remains the case the prospective APPs are completing their education and could be deployed into the operational setting to mitigate the risk. ELT has therefore agreed to grow the APP numbers further this year, redirecting existing operational spend to bolster APP growth.
5. Overnight falls service extension	Executive Director of Quality & Nursing	• 31.03.2024	• Night Car Scheme extension agreed to 31 March 2024 (2 regional resources) • Utilization rates continue to be monitoring. Nighttime falls assistance 64% Utilisation (Apr 2023 -Jun 2023); Nighttime falls assistance 66% Utilisation (July – Oct 2023); Daytime utilisation sustained: July -August 58%. September- October 58% utilisation. • Optima modelling has now been completed. The modelling clearly identifies that the level two falls' vehicles are the more effective resource. The modelling has identified an estimated need of 48 (38 day and 10 overnight) falls vehicle level 2 12 hours shifts. The modelling is now being built into the strategic (five year) demand & capacity review.
6. Duty of Quality, Duty of Candour and new Quality Standards implementation from April 2023 with development of a Quality Monitoring System supporting monitoring and oversight systems in place and embedded.	Executive Director of Quality & Nursing	• Q3 2023/24	• Monthly updates to progress against actions following the baseline assessment and readiness returns. • RL Datix Dashboards and KPIs under development nationally. • Key policies updated and approved. • Participation in the All Wales Duty of Candour implementation group by Patient Safety Team – monthly.
7. Connected Support Cymru is initially designed to utilise NHS and voluntary-sector resources and responders to enable patients to be supported in their own home whilst waiting for an urgent healthcare need to be managed. The service will employ digital health technologies to connect patients, communities and clinicals to achieve better health outcomes. The initiative will improve patient experience and safety, while supporting the healthcare system in directing patients to the right pathway at an appropriate time for their care need. It is expected this will help reduce unnecessary demand upon Emergency Departments.	Executive Director of Quality & Nursing	• Q3 2023/24	• SJAC funded ended on 31 October 2023. • Proof of concept using WAST CFR volunteers as CWRs is underway. Grant funding is being used to put in place roles and processes to recruit and train to new volunteer role. • This eyes on support to CSD clinicians, by volunteers, is producing positive results, with early data suggesting a 35% consult & close rate for the cohort of patients covered by the pilot. • The business case has now been completed and can be made available to key stakeholders. Now awaiting business case approval. • The CWR will be modelled as part of the options being considered by the current EMS demand & capacity review.
8. Organisational change process (OCP) of Putting Things Right Team (PTR) to enable increased capacity across all functions to manage increasing complexity and demands.	Executive Director of Quality & Nursing	• Q4 2023/24	• OCP commenced 25.09.2023 and the consultation period has concluded with the final new structure confirmed. Next steps are to recruit to vacant positions which has commenced. It is anticipated that all positions will be filled by **May** 2024 (taking notice periods into account).
9. Connect with All Wales Tissue Viability Network to explore strengthening the current investigations into harm from pressure damage across the whole patient pathway.	Assistant Director Quality & Nursing	• Q4 2023/24	• Positive meeting held in August 2023 as planned with the Chair of the TVN network. Next steps are for the Patient Safety Team to attend a TVN leads meeting to discuss opportunities for collaborative working and data / information sharing. Date to be confirmed and there has been good engagement from Health Board Tissue Viability Nurses. Workshop date confirmed in January 2024.

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10. Audit Wales investigation of Urgent and Emergency Care System: Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time?	CEO	• Q4 2023/24	• Conducted in three phases Audit Wales will independently investigate and report on patient flow out of hospital: access to unscheduled care services and national arrangements (structure, governance, and support) • WAST will proactively support this work and offer best practice examples from other jurisdictions that can support benchmarking and improvement activities. • Expected outcomes in 2023/24.
11. Internal Audit to undertake a review of Serious Adverse Incidents & Joint Investigation Framework	Executive Director of Quality & Nursing	• Q4 2023/24	• Internal audit in progress. Delays due to sickness in the internal audit team.
12.Winter Ambulance Handover Improvement Plan Meetings	**Executive Director of Operations**	• **February 2024 (six-week duration)**	• **Weekly meetings set up with Welsh Government, NHS Executive, CASC and the Health Board COOs. All parties (including WAST) to provide updates on actions being taken to alleviate and improve handover delays. WAST to update on C&C, CWR, red dispatch and local updates from EMS HOS on initiatives.**
13.Swansea Bay Winter actions	**Assistant Director of Operations, EMS**	• **December 2023**	• **Some plans are in train following a meeting with Swansea Bay COO to include mobile imaging, pathways to bypass ED and a pod solution ahead of winter.**

POLICIES RECOMMENDED FOR COMMITTEE APPROVAL AND ADOPTION

Committee	Quality, Safety and Patient Experience Committee	**Date of Meeting**	07/05/2024

Presenting Officer	Julie Boalch, Head of Risk/Deputy Board Secretary [Chair of Policy Group]

Policy Name	Directorate	EqIA	Date of Policy Group	Date of ELT	Points of Note
Consent to Examination and Treatment v2.8	Clinical	Completed No Issues	23/01/2024	08/05/2024	N/A
Management of Controlled Drugs v5.10	Clinical	Completed No Issues	27/02/2024	16/04/2024	N/A
Non-Medical Prescribing Policy v2.4	Clinical	Completed No Issues	23/01/2024	14/02/2024	N/A
Premises & Vehicle Cleanliness Policy v1.13	Quality & Nursing	Completed No Issues	23/04/2024	08/05/2024	N/A
Clinical Supervision Policy v1.6	Clinical	Completed No Issues	29/11/2023	13/12/2023	Implementation plan developed and submitted to ELT on 13/02/24 ahead of approval of Policy
Dispatch Cross Reference (DCR) Table Management Policy v1.10	Clinical	Completed No Issues	23/11/2023	08/05/2024	Minor changes. Approved by Policy Group for a further 3 years.

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

Consent to Examination & Treatment Policy

Policy Number:	076	**Version No:**	2.8	**Supersedes:**	2.7
Date of Approval:	TBA	**Review Date:**	3 years from date of approval	**Impact Assessments Completed:**	05.02.2024
Classification of Document:	Clinical	**Type of Document:**	Policy	**Approved by:**	QuEST
Brief Summary of Document:	This policy outlines the Trust standards and provides guidance for seeking valid consent for the examination, treatment, and or informal assistance and care of patients.				
Scope:	This policy pertains to all employed, contracted and volunteer Trust staff who have a legal and ethical obligation to seek informed consent from all Trust patients as part of their care.				
To be read in conjunction with:	Professional Regulation Policy v0.6 10th January 2019 Management of Concerns / Allegations Policy 270218 Safeguarding Children and Adults at Risk of Harm Policy V3.0 16.11.2018 Workplace Policy on Gender – based Violence, Domestic Abuse and Sexual Violence Safeguarding the Welfare of Children Operational Guidance (3) Final (version 22) All Wales Model Policy for Consent to Examination or Treatment - NHS Wales Shared Services Partnership				
Owning Committee	Quality, Safety and Patient Experience Committee.				
Policy Lead: **Trade Union Lead:**	Bryn Thomas Hugh Parry	**Job Title:**	Regional Clinical Lead – North Trade Union Partner		
Executive Director:	Andy Swinburn	**Job Title:**	Executive Director of Paramedicine		

Version Control Sheet

Version	Date	Author	Summary of Changes
1.1	04.06.2019	Tim Jones	Initial Working Draft typographical errors
1.2	11.06.2019	Tim Jones	Post T&F group capacity assessment & DoLS
1.3	03.07.2019	Tim Jones	Post T&F group best interest assessment ITN
1.4	11.07.2019	Tim Jones	Typographical errors and grammar updates
1.5	23.07.2019	Tim Jones	Formatting post update Julie Boalch
1.6	30.08.2019	Tim Jones	Post T&F group EoLC updated & pregnancy
1.7	16.09.2019	Julie Boalch	Minor amendments to front cover JB
1.8	24.09.2019	Tim Jones	Feedback amendments Policy Group PS DT
1.9	04.11.2019	Tim Jones	Feedback addition ‘reporting’ JB
1.9	10.11.2019	Tim Jones	Feedback addition ‘restraint’ JP
1.9	10.11.2019	Tim Jones	Amendment Glossary end place appendix TJ
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2.2	22.01.2024	Bryn Thomas	T&F Review Group Members Added and Impact Assessments reviewed
2.3	13.02.2024	Bryn Thomas	Impact Assessments completed
2.4	13.02.2024	Lisa Trounce	Minor amendments to formatting
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Impact Assessment Reviews

Area	Date of Review	Name of Reviewer
Counter Fraud	--	Not Applicable
Information Governance	25.01.24	Kelly Holding
Records Management	05.02.24	Judith Birkett
EqIA / Welsh Language	18.01.24	Kathryn Cobley
Estates	--	Not Applicable
Environment	--	Not Applicable

Task and Finish Group Members

Name	Job Title
Task and Finish Group Original Membership	
Tim Jones	Clinical Development Lead/APP (Chair)
Bryn Thomas	Health Board Clinical Lead
Jeff Price	Senior Practice Education Lead
Leigh Keen	Health Board Clinical Lead
Mark Cadman	Area Operations Manager
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Edward O'Brian	Trust EoLC Lead
Task and Finish Review Group 2023 Membership	
Bryn Thomas	Regional Clinical Lead – Consultant Paramedic North
Mike Jenkins	Regional Clinical Lead – Consultant Paramedic South
Steve Magee	Regional Clinical Lead – Consultant Paramedic Central
Paula Jeffrey	Consultant Clinician Integrated Care
Sarah Garrathy	Business and Systems Administrator Clinical Directorate

Policy Approval Route

Meeting Title	Meeting Date	Purpose/Outcome
Trust Senior Paramedic Team	27.08.2019	Share RCLs/Full Support ✓
Medical Clinical Services Directorate	03.09.2019	Medical Director Approval ✓
Trust Policy Group	24.09.2019	Amendments and Additions
Trust Policy Group	23.01.2024	Policy Review
ELT	08.05.2024	Recommend for Approval
QuEST	07.05.2024	Approval and adoption

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Contents

1. INTRODUCTION

In most cases, Trust clinicians and responders need to make physical contact with patients to undertake an assessment, provide treatment, and or, support patients with their mobility. Physical contact is limited by law and can only be undertaken with patient permission.

Guidance for best practice on consent from the regulatory and professional bodies highlights the importance of individual patient autonomy and the need to actively involve patients to ensure they are appropriately informed as part of obtaining valid consent, and or, any refusal of consent to treatment.

The Supreme Court ruling in Montgomery v Lanarkshire Health Board [2015] has fundamentally changed the legal framework for consent to examination and treatment in the UK, focusing consent practice on the specific needs of the individual patient.

The Trusts informed consent policy group acknowledges the extensive content of this policy document. This was warranted as it is anticipated the content of this policy will provide a detailed 'point of reference' for Trust Clinicians and Responders covering different situations they may encounter in their day-to-day clinical practice.

2. POLICY STATEMENT

The Trust recognises people have a fundamental legal and ethical right to determine what happens to their own bodies i.e., the principle for autonomy, this principle is reflected within the content of this policy.

All Trust clinicians and responders have a legal and ethical duty to seek valid consent for the examination, and or, treatment of patients. Any failure to obtain valid consent may result in legal action.

The Trust expects all clinicians and responders to have a full practice awareness of the content of this policy and always follow the standards set out for obtaining valid patient consent by their respective professional bodies i.e., HCPC, NMC and GMC.

This policy will ensure the Trust has clear organisational standards for obtaining valid patient consent for both adults and children, which embraces a shared decision-making approach and is underpinned by current UK legislation.

3. SCOPE

This policy is addressed to all Trust staff, whether employed, contracted or volunteers who have responsibility for obtaining valid consent for examination, treatment, and or, provision of informal mobility assistance to patients. Elements of this policy will be role specific depending on staff grade and their scope of practice, including volunteer staff. The latter will be reflected in education or training delivery.

NB: This policy uses the terms 'shall' and 'should'. The term 'shall' be used to describe an overriding duty or principle and 'should' is used where an overriding duty may not apply in all circumstances, or where there are factors outside the clinician's control that affect application of this guidance.

4. AIM

The aim of this policy is to set out the Trust's standards and provide comprehensive guidance to Trust clinicians and responders on seeking valid consent for the examination, treatment, or informal mobility assistance of patients. This may be in the face to face, hear and treat, and or, safeguarding context of sharing information with other professionals.

5. OBJECTIVES

- Define consent and its application in practice.
- State the legal and professional responsibilities when seeking consent.
- Describe the management of those patients who refuse consent.
- Describe consent relating to Children and Young People.
- Provide guidance on what constitutes 'parental responsibility'.
- State the organisational responsibilities required to manage this policy in practice.

6. CONSENT

6.1. What is Consent?

Consent is a patient's ongoing agreement for Trust clinicians to provide examination and treatment. Before providing any examination, treatment or care, Trust clinicians and responders must be satisfied that the patient has given his or her consent.

Valid consent should be considered a process and not a one-off event.

For consent to be valid, the patient must have the mental capacity to make the relevant decision about their treatment and care, consent must be given voluntarily, and the patient shall be properly informed about all proposed interventions and treatments.

Compliance, where a patient is not able to make an informed decision is not "consent".

6.2. Forms of Consent

In general Trust clinicians and responders gain consent by either 'expressed' or 'implied' forms of consent. The law does not differentiate between either of these forms of consent. Trust clinicians and responders only need to obtain **valid consent** by one of these methods to proceed with the patient's treatment or care.

- Expressed Consent: the patient makes known to the attending clinician or responder their willingness to be touched to receive treatment or care. Expressed consent can be given either verbally or in writing. The latter tends to be for procedures that are

invasive and carry a material risk e.g., local anesthesia and primary wound closure by first intention.

- Implied Consent: permission to proceed is implied through the actions of the patient in response to a request from the clinician or responder to give treatment or care. e.g., requesting to touch the patient to take a radial pulse or apply a blood pressure and the patient offers their arm for the procedure to take place.

- Trust clinicians and responders are reminded that the validity of consent does not depend on the form of consent that is given, but on the elements of validity i.e., the patient has **capacity**, consent is given **voluntarily**, and the patient is appropriately **informed** and supported to make the decision on whether to consent or refuse to consent to proposed treatment or care plan.

6.3. Valid Consent

Patient consent, or any patient refusal to consent, is only deemed **VALID** if the patient has **'capacity',** consent or refusal is given '**voluntarily'** and that the patient has been appropriately **informed** that they **understand** the proposed treatment**.**

6.3.1. Patient capacity

The core principles of the Mental Capacity Act (2005) are that all patients 16 years and over should be presumed to have capacity to make decisions for themselves unless on the balance of probabilities the attending clinician establishes through assessment they do not. Patients without capacity are therefore unable to consent to treatment.

6.3.2. Voluntariness

Consent is only valid if it is given voluntarily. Trust clinicians and responders shall have situational awareness that in circumstances where they seek patient consent i.e., unscheduled care patient contacts, that there may be factors present which may result in voluntariness being adversely affected. Three elements must be considered when determining if the patient has given consent or refused consent voluntarily:

- Coercion – Trust clinicians and responders should be aware that attending parties may intentionally or, in some cases unintentionally, influence a patient by presenting them with a threat of avoidable and unwanted harm. This may result in the patient being unable to resist such coercion and refuse consent to the proposed treatment.

- Undue Influence - Trust clinicians and responders should be aware that there may be an imbalance of power between those parties in attendance and the patient (s) they are attending. Trust clinicians and responders should ensure there is no undue influence on patients when they are deciding to consent or refuse consent to treatment or transport to hospital.

- Mistake - mistakes may occur where there is a misunderstanding about the treatment or care being proposed or where there is a change in the patient's circumstances. Attending clinicians and responders should ensure patients understand the treatment being proposed, along with its benefits and any risks before they consent or refuse consent to 'against' the attending clinician's advice.

6.3.3. Appropriate information

Patients must be provided with all the information they require, in a format and language they can understand, so that they can make an informed decision about what treatment, if any, they want to receive. The following should be discussed with the patient:

- All reasonable treatment options
- All the intended benefits and material risks.
- Any requirement to take and retain tissue samples, photographs etc.
- The presence of any trainees or students

- The use of any experimental techniques
- Any requests for further information or clarification should be met
- Outside an emergency setting, patients should be given adequate time to consider all relevant information

6.4. Informing Patients of 'Material Risks' during consent discussions

All Trust clinicians and responders must have regard to the UK Supreme Court (UKSC) ruling following the Montgomery V Lanarkshire Health Board ruling (2015).

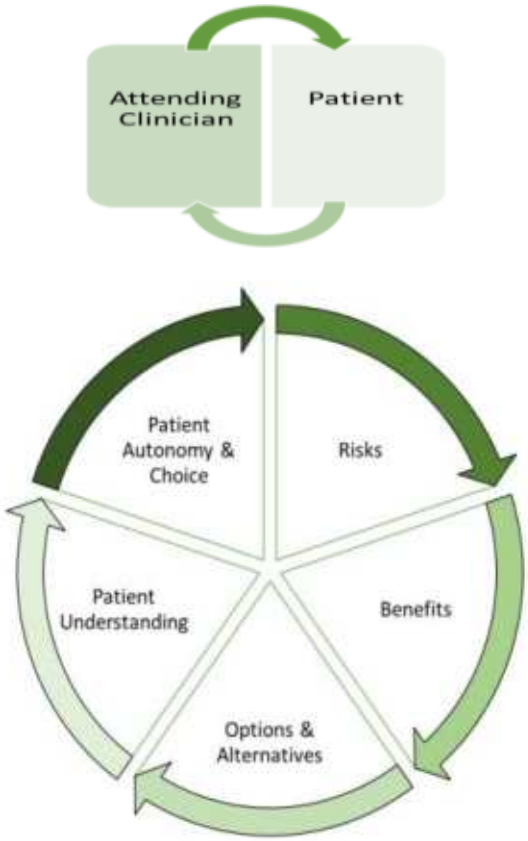
This ruling reminds healthcare professionals of their duty to take all reasonable care in ensuring patients are made aware of any 'material risks' associated with proposed treatment or care, and any reasonable alternatives, and or, variations to that proposed treatment/care *e.g., the latter could be refusing or accepting only part of ambulance treatment/ transfer to care.*

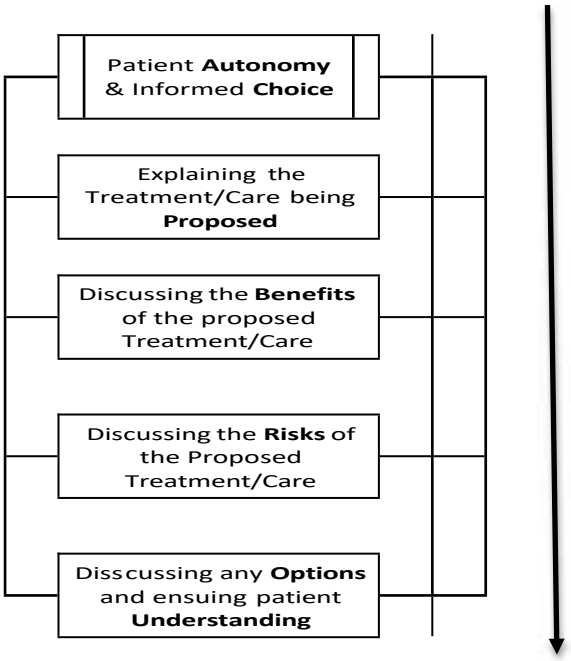
A **'material risk'** is one in which *'a reasonable person in the patient's position would be likely to attach significance to the risk, or Trust clinician is or should reasonably be aware that the particular patient would be likely to attach significance to it'*.

Trust clinicians and responders must have regard for the decisive shift that the Montgomery (2015) ruling has catalysed relating to the legal test of 'duty of care' in respect of obtaining valid consent. This necessitates a more contemporary, patient focused - discussion based approach to obtaining valid consent which places considerable focus on patient autonomy, choice and shared decision making.

When applying this up to date approach in practice, Trust clinicians and responders should ensure patients are informed and understand the risks and benefits of any treatments or care they propose, along with any alternative or options and associated risk (s) (diagram one)

Diagram: one: key elements for developing valid consent or refusal of consent discussions





6.5. Assessing Risk

When assessing and determining risk (s) of treatment or care, the following important factors should be considered, which include the:

- Nature or the risk(s). Effect of the risk(s) occurring and its impact upon the life of the patient
- Importance to the patient of the benefits sought to be achieved by the treatment.
- Alternatives or options available and the risks involved in those alternatives/options.

When seeking consent or a refusal of consent from any patient, as part of their decision making, Trust clinicians and responders should therefore ask themselves the following three questions:

- Is the patient aware of any risks relevant to his or her decision regarding the proposed treatment or care?
- Is the patient aware of reasonable alternatives, their associated risks, and benefits?
- Have I taken all reasonable measures to ensure that I have presented this information in a form that the patient understands.

6.6. Valid exceptions to the duty to disclose risks.

There are three exceptions where the obligation to disclose risk (s) can be set aside, and where any necessary treatment/care is in the patients 'best interests', these are:

- The patient lacks capacity and **emergency** treatment are required.
- The patient retains the **right to prefer** not to know the risks of the treatment.
- The attending clinician has '**reasonable belief'** that telling the patient something would cause serious harm to the patients' health and wellbeing.

6.7. Consent & Cultural Issues

Cultural diversity issues should be actively considered whilst obtaining patient consent. Members of some religious faiths, for example, are extremely modest in relation to exposure of parts of the body and may only consent to examination or treatment if it is undertaken by someone of the same sex. Trust Clinicians should refer to practice guidelines in the latter circumstances on chaperoning.

6.8. Consent in Emergency and Unscheduled care setting

Trust clinicians and responders shall seek and obtain valid consent or refusal to consent in all circumstances. In the context of out of hospital unscheduled care, there are however four circumstances where treatment can progress without the duty to obtain valid consent from the patient:

6.8.1 Emergency Situations

In an emergency, Trust clinicians and responders must provide treatment (s) that are immediately necessary to save life, and or, prevent deterioration of the patient's physical, and or, mental wellbeing. Trust clinicians and responders should always maintain situational awareness in these circumstances for any valid and applicable DNACPR, ADRT, LPA or FCPs for refusing a particular emergency treatment (s), in which case it should not be given.

6.8.2 Lack of Capacity

Where a patient lacks capacity through pre-existing condition (s), acute illness or accident, Trust clinicians and responders should provide treatment(s) as per current clinical practice guidelines and current scope of practice that are immediately necessary and, in the patients 'best interests' Clinicians and responders should have situational awareness for any valid and applicable DNACPR, ADRT, LPA or FCP for refusing a particular treatment, in which case it should not be given.

6.8.3 Significant Mental Health Disorder

Where a patient has been assessed under the MHA 1983 as being unable to consent to medical treatment due to a significant mental health disorder affecting their decision-making capability, Clinicians should follow the guidance for managing patients under the relevant sections of the MHA (1983) as amended by the Mental Health Act 2007 and other statutes, including the Mental Health Act 1983 Code of Practice Wales.

6.8.4 Public Health - notifiable infectious diseases

The Public Health (Control of Disease) Act 1984 provides that, subject to an order made by a magistrate, persons suffering from certain notifiable infectious diseases can be medically examined, removed to, and detained in a hospital without their consent.

Patients suffering from a serious communicable disease, and who are a risk to the public, can also be forced to undertake supervised or involuntary inpatient treatment without consent. Where patients refuse any recommended treatment in conjunction with Trust IPC guidelines, and against the advice of the attending Trust clinician, then clinicians must seek immediate advice from the senior on call clinician.

6.9. Treatment of Children and Young People

When treating children and young people, Trust clinicians and responders must take particular care to ensure they are familiar with the relevant law and consider carefully whether the child or young person is competent to give consent (see section 9).

6.10. Duration of patient consent

When a person gives valid consent to an intervention, in general that consent remains valid for an indefinite duration unless the person withdraws it or there is a change in their circumstances, and they no longer have the mental capacity to give consent.

6.11. Withdrawal of patient consent

A patient with capacity is entitled to withdraw consent at any time. Where a patient does object during treatment or care, Trust clinicians and responders should, if possible, stop the procedure, establish the patient's concerns, and explain the consequences of not completing the treatment being provided.

If the patient confirms they do wish to withdraw their consent, and there is no immediate risk(s) to stopping the procedure or care, then it should be terminated immediately, and a timed record appended to the ePCR. Trust clinicians and responders should attempt to establish whether at that time the patient has capacity to withdraw their consent. This is particularly important if the patient has been administered any prehospital medicine that may have had any sedation effect. If a patient lacks capacity, then it may be justified to continue the procedure or treatment if it is in the patient's 'best interest'.

7. RESPONSIBILITY FOR SEEKING CONSENT

7.1. Responsibilities

Trust clinicians or responders examining, treating, or caring for a person, either face to face or remotely, are ultimately responsible for ensuring that the person has given valid consent or a valid refusal to consent. He/she will be held responsible in law if the validity of consent/refusal is subsequently challenged. All Trust clinicians and responders have a responsibility to ensure that:

- Where they require colleagues to seek consent from a patient on their behalf, that they are competent to do so.

- They work within their own competence and scope of practice and do not agree to perform tasks which exceed their level of competence.

7.2. Competence in seeking consent.

Trust clinicians and responders shall be competent themselves in any procedure, treatment, and or, care they are seeking consent or refusal of consent for. They will have received training, been assessed and be fully aware of their own knowledge and practice limitations relating to that procedure, treatment, or care. This includes their ability to appropriately delegate any consent decision making for their patient.

7.3. Examination & Care provided by 'Students' & 'Trainee' Trust Clinicians

Where any student undertakes examination or treatment to further the patient's care e.g., auscultating breath sounds; taking a blood pressure; then assuming the student is appropriately trained in the proposed procedure (s), the fact that it is being carried out by a student does not alter the nature and purpose of that procedure.

Where for the purpose of transfer of learning integral to the process of care, valid consent must be obtained from the patient. Any learning experience must be directly supervised by an experienced mentor trained in the treatment, procedure or care being proposed and who has the responsibility for the overall care of the patient at that time.

Therefore, there is no 'legal' requirement to tell the patient that the ambulance clinician is a student or trainee, albeit it is considered **good practice** to do so and therefore consent must be sought in the usual way.

7.4. Mentored and Supervised Examinations Attendance by Student and Trainees

In contrast, where a student or trainee proposes to conduct a physical examination which is not part of the patient's care, then it is essential to explain that the purpose of the examination is to further the student's training and to seek patient consent for that examination to take place. Verbal consent must be obtained, and a note appended to the remarks section of the ePCR.

7.5. Student or Trainee as Observers during examination, treatment (s) or care

Patient consent shall be obtained when a student/trainee is going to be present during an examination or treatment purely as an observer. All patients have the right to refuse consent in these circumstances without any detrimental effect on their treatment.

7.6. Observers during examination, treatment, or care

Patient consent shall be obtained for all other individuals, irrelevant of their grade, background or role who are going to be present during the examination, treatment or care of patients who are purely as an observer. All patients have the right to refuse consent in these circumstances without any detrimental effect on their treatment.

8. REFUSAL OF TREATMENT - ADULTS WITH CAPACITY

8.1. Right to refuse treatment

An adult with capacity can refuse to consent to any treatment, except in certain circumstances governed by the *Mental Health Act (198*3) and Public *Health (Control of Disease) Act (1984)*. Where there is suspicion whether a patient has the capacity to refuse consent, then a mental capacity assessment must be undertaken in line with the principles set out in the Mental Capacity (2005) Code of Practice.

8.2. Refusal of Transport to Hospital

Trust clinicians and responders shall make a clear distinction between what is a refusal to consent to treatment and a refusal to consent to receive transport to hospital 'against advice' of the attending ambulance clinician.

Following initial assessment and treatment, some patients may ask attending clinicians or responders about waiting times to transfer their care, time to be assessed at hospital or the ongoing treatments they will receive at hospital. Whilst acceptable to provide a response to such questions, care must be taken when sharing information about hospital waiting times or ongoing treatment so that it does not in any way influence the patient's decision to refuse consent to be transported to hospital 'against advice'.

Trust clinicians and responders have a duty to inform patients about their proposed treatment or care and should ensure they understand the risks associated with a refusal of treatment or transport that is 'against' the attending clinician's advice.

8.3. Refusal on Religious Beliefs or Values

An adult with capacity may decide which is based on their religious belief e.g., Jehovah's Witnesses or value system. Even if it is perceived by others that such a decision is unwise or irrational, the patient may still make that decision if he or she has **capacity** to do so, notwithstanding the decision must be **voluntary and informed.** Any attempt to treat such a patient against his or her wishes could amount to a criminal offence. It is the right of an adult patient with capacity to refuse examination, treatment, or care, even if that refusal might result in their deterioration or death. In cases of doubt, clinicians and responders should seek advice from the senior clinical on call.

8.4. Refusal – options, risk and recording decisions.

If, after discussing benefits of treatment, the risks of refusing treatment or care, and exploring appropriate alternatives or options, along with their risks, if a patient still refuses treatment, then this should be clearly documented in the ePCR and a non-conveyance form. Where a patient has already consented to treatment, and or, transport, but then changes their mind and refuses, then clinicians and responders shall record this in the relevant section of the Trusts ePCR.

In cases where patients refuse treatment, care, and or, or transport to hospital against the attending clinicians or responders' advice, then clinicians and responders have an

obligation to ensure they continue to act in the patient best interests by exploring other alternatives or options for treatment or care e.g., GP either 'in' or 'out of hours', or other appropriate care pathway.

In all cases of a refusal to consent to treatment, care, and or, transport, against the attending clinicians advice, then the clinician or responder shall ensure the patient is provided with both verbal and written advice on how to re-contact the ambulance service if they change their mind, their condition worsens, and if they wish to consent to either treatment, care, and or, transportation.

8.5. Self-harm and attempted suicide

Cases of self-harm present a particular challenge for Trust clinicians and responders but the same law and guidance on consent applies to treatment and care of these cases. Where the patient can communicate, a robust **assessment of their mental capacity** should be made as a matter of urgency by the attending clinician. If following this assessment:

- The patient is judged not to have capacity, then decisions about their physical health and treatment need to be made in accordance with the MCA (2005).
- Any treatment is required for the patient's mental health presentation or condition, then the relevant sections of the MHA will apply.
- If a patient is unconscious, and there is insufficient time to undertake the usual 'best interest's' assessment, then he/she should be given emergency treatment.

Adult patients with capacity have the right to refuse life-sustaining treatment, even if the attending clinician or responder believes the patient's decision is unwise. If the patient has harmed themselves, Trust clinicians and responders should assess any suicidal risk and consider whether a referral for further Psychiatric assessment is appropriate. The latter may be arranged through the patient's own GP, out of hours GP or a crisis intervention pathway.

8.6. Patients who refuse treatment with blood or blood components

The same legal principles apply to any patient who refuses out of hospital treatment whether they do so out of religious convictions or otherwise. No patient should be likely to refuse blood products merely based on their religion. Not all Jehovah's witnesses refuse blood products, those practicing who wish to refuse blood products will carry with them a clear, signed and witnessed advanced Decision to Refuse Treat (ADRT) card prohibiting blood transfusions. This releases clinicians and responders from any liability arising from this refusal to consent to this type of treatment.

9.0 CHILDREN & YOUNG PEOPLE

9.1. Children & Young People with 'capacity'

The law regarding consent and or refusal of treatment by those patients under the age of 18 is different to that of adults, when treatment or care is refused. There is no

presumption of competence for people under 16 years of age; those under this age must be able to demonstrate competence by standards set out by the courts. In providing treatment and care for children and young people, Trust clinicians and responders should ensure they are familiar with the relevant law in Wales.

A child **under the age of 16**, who has sufficient maturity and intelligence to be capable of understanding the treatment and deciding based on the information provided or "*Gillick competent*" are considered as being able to consent to treatment. Advice on assessing Gillick Competence can be found in appendix 18: A.

Young people **aged 16 or 17 years** are presumed to have the capacity to consent to their own medical treatment unless it is established that the young person lacks that capacity. As for adults, consent is only valid if it is given freely, and the young person is appropriately informed and understands the treatment or care being proposed.

If a patient **16 or 17** years of age with capacity consents to treatment, then this consent cannot be overruled by a parent. This also applies equally to those young people with capacity and who are being informally admitted to hospital for treatment of a mental health disorder.

It is good practice that Trust clinicians and responders always seek to ascertain who has parental responsibility for the child or young person they are attending. Where appropriate they should include the child/young person's family in discussions relating to their treatment. However, this should only be done with the consent of the child/young person.

9.2. Children who are not competent to consent to treatment.

If a child is not competent to give consent, then Trust clinicians and responders may give treatment based on parental consent. Parental consent may be given by any person who has 'parental responsibility' for the child if person has 'capacity' to give such consent. Consent is usually only needed from one person who holds parental responsibility for the child.

To consent on behalf of a child, the person with parental responsibility must also have mental capacity themselves. Trust clinicians and responders should not rely on the consent of a parent if he or she has any doubts about whether that parent is acting in the 'best interests' of the child.

9.3. Competent Children or Young People (16-17) With Capacity refusing treatment.

Where a child under 16 and who is Gillick competent refuses treatment, or a young person 16 -17 with capacity refuses treatment, a person with parental responsibility for the young person can be used as an alternative source for consent. The courts can also be used as alternative sources of consent in such cases.

Where a child refuses out of hospital treatment, and a decision to give treatment proceeds based on 'parental consent', it must be exercised on the grounds that the child's health and welfare is paramount. Clinicians and responders should be aware of the psychological effect of the child's decision over-ruled which should be given due

consideration in these circumstances.

Where a young person aged 16- 17 who has capacity and is being admitted to hospital for treatment of a mental disorder, the MHA provides that a person with parental responsibility cannot overrule that decision.

9.4. Persons with parental responsibility refusing consent to treatment.

If consent for treatment is refused by one or more of those with parental responsibility, or where an agreement cannot be reached between the persons with parental responsibility, then the attending Trust clinician or responder should seek immediate senior clinical advice in line with Trust guidance.

9.5. Parents refusing life sustaining treatment for a child.

Where a parent (s) intends to refuse life-sustaining treatment for a child under the age of 16, Trust clinicians or responders shall always seek senior clinical advice. In these circumstances, however, parents may not prevent Trust clinicians or responders from administering out of hospital treatment if the child is in imminent life-threatening danger. This includes, but is not exhaustive, to those cases where the parents wish to refuse blood or any of their products for their child on religious grounds. In support of out of treatment proceeding against parental wishes, the attending Trust clinician or responder shall contact the senior clinical on call as soon as practicably possible.

9.6. Emergency treatment & parental responsibility

In a life threatening, and or, time dependent emergency where consulting with a person who has parental responsibility is impracticable, impossible, and or, the person with parental responsibility refuses consent, despite the treatment appearing to be in the child's best interests, then clinicians and responders should proceed with the necessary treatment that is in favor of preservation of life and preventing any further deterioration or serious damage to the child's/young person's health, and or, wellbeing.

9.7. Young people aged 16 to 17 who refuse life-sustaining treatment

In some cases, a young person aged 16 or 17 may refuse life-sustaining treatment. In an emergency, where the young person is likely to die or suffer serious permanent harm without immediate treatment, then attending clinicians or responders may proceed with any necessary treatment based on 'best interests' which is proportionate to preserve life and prevent deterioration or further harm to the patient.

10. PATIENTS LACKING CAPACITY TO GIVE OR WITHOLD CONSENT

10.1. Determining Mental Capacity

Where a Trust clinician or responder suspects a patient aged 16 years and over lacks the mental capacity, either temporarily or permanently, to give or withhold consent for themselves, then they shall assess the patient's mental capacity.

Patients aged 18 years and over who lack mental capacity can be given treatment if it

is in their 'best interests', if they have not made a valid and applicable ADRT, DNACPR or LPA to refuse specific treatments.

10.2. Decisions to refuse treatment.

Advanced **D**ecisions to **R**efuse **T**reatment (ADRTs) are a specific type of instruction that represents an actual decision to refuse treatment, even though it was made at an earlier date. A person who is 18 years or over and who has capacity can make an ADRT. An ADRT may be withdrawn or altered at any time whilst the person has capacity.

Where attending Trust clinicians or responders are advised there is an ADRT relating to the patient they are treating, they shall ensure there is proof that the ADRT (i) exists, (ii) is valid, and (iii) is applicable to the patients out of hospital circumstances (appendix c).

10.3. ADRTs – Responsibility of Trust Clinicians

Where appropriate to the patient and their circumstances, Trust clinicians and responders are responsible for asking patients or their representatives about the existence of ADRT. Where a clinician or responder has determined that a valid and applicable ADRT exists, then this is legally binding, and they must follow the decision of that ADRT.

Where clinicians and responders have reasonable grounds to believe that an ADRT exists, and where time permits, then they should make reasonable enquiries regarding its existence and content. Emergency treatment should not be delayed looking for an ADRT, especially if there is no clear indication that one exists.

If an ADRT relates to **refusal of life-sustaining treatment**, then the Trust clinicians and responders shall request to see a written, signed and witnessed ADRT which contains the words "**even if life is at risk**" or similar.

Trust clinicians and responders will not be acting unlawfully if he/she treats a patient and is genuinely unaware of the existence of an ADRT. Similarly, they will not be acting unlawfully if they act in accordance with any ADRT that they believe is both valid and applicable at the time, but is later proved to be invalid, and or, not applicable.

If a clinician or responder believes there is any doubt about the validity or applicability of an existing ADRT, then they should immediately provide life-sustaining treatment (s) that prevent serious deterioration in the patient's condition and urgently request senior clinical advice to support treatment decisions in these circumstances.

If an ADRT is not valid, and or, not applicable, Trust clinicians and responders should still have situational awareness of any expression of the patient's wishes/feelings relating to what should happen to them, this should be considered when deciding on their 'best interests'.

10.4. Advance Statements

Advance statements are 'not' legally binding. However, Trust clinicians and responders should note the content as an expression of the patient's wishes and feelings about what

should happen to them if they lack the capacity to decide for themselves. As such, they should be considered in deciding what is in their best interests.

Some advanced statements may express the patient's wishes that a particular course of action should be taken, and or, that they should receive a particular type of treatment if they no longer have capacity.

Trust clinicians and responders have no legal obligation to provide treatment because the patient demands it. The decision to treat is ultimately a matter for his or his/her professional judgement acting in the context of a 'best interest's'.

Specific guidance for Trust clinicians and responders on in undertaking a patient "**Best Interests Assessment**" is discussed further in section '12' of this policy.

10.5. Lasting Power of Attorney (LPA)

An LPA may be executed by any person of 18 years or over whilst they have capacity and takes effect when they no longer have capacity. There are two main types of LPA's these are:

- LPA for financial and property decisions
- LPA for health and welfare decisions

A health and welfare LPA appoints a person to act as an attorney to make decisions about a person's (donor's) welfare and medical treatment when that person lacks the capacity to make that decision. The attorney acting under Health and Welfare LPA must make the decision in the person's best interests.

All LPAs must be registered with the Office of the Public Guardian (OPG) before it can be used. Trust clinicians and responders **must have** sight of the LPA or an approved copy to see the sealed OPG stamp on the LPA document to confirm that it has been registered, and to assure themselves of the authority that it confers on Attorney(s).

If two or more people have been appointed as attorneys, they may either be appointed to act jointly or separately. If they are acting jointly, any decision must be made by consensus. However, if they are acting jointly or separately, then either of the attorneys can decide independently of the other.

Trust clinicians and responders shall note an LPA does not authorise a named attorney (s) to refuse or give consent to life-sustaining treatment **unless** this is explicitly stated in the LPA documentation. A registered health and welfare LPA allows named attorney (s) to either accept or refuse healthcare/treatment, unless the donor has 'specifically' stated in the LPA that he/she doesn't want the attorney to make these decisions. Clinicians and responders are advised that an LPA does not have the power to consent or refuse treatment if:

- Donor has mental capacity.
- Donor has made an Advance decision to refuse proposed treatment (ADRT).
- Decisions relate to life sustaining treatment.
- Donor is detained under the Mental Health Act.

10.6. Court Appointed Deputies (CADs)

The courts may appoint a deputy to take decisions on its behalf. This is normally a family member, carer, friend, or person well known to the patient. Where CAD exists, Trust clinicians and responders shall ask to see the relevant court documentation to see the courts appointed stamp and determine what authority the CAD holds in relation to patient consent.

10.7. Temporary Incapacity

Patients may suffer a temporary loss of capacity e.g.; they have a reduced level of conscious for due to various out of hospital injury mechanisms or medical etiologies. As with any other situations, an assessment of that patient's capacity must only examine their capacity to make a particular decision when it needs to be made.

In these circumstances, unless there is a valid and applicable ADRT, Trust clinicians and responders should provide the necessary out of hospital treatment to prevent any deterioration in the patient's physical or mental well-being which is in their 'best interests' pending recovery of their capacity.

10.8. Fluctuating Capacity

It is possible for a patient's capacity to fluctuate. In such cases, and where appropriate, Trust clinicians and responders should attempt to establish whilst the patient has capacity their views about any treatment that may be necessary during a period of incapacity and to record these views on the PCR.

11. MCA AND ASSESSMENT OF CAPACITY

11.1. People Who Lack Capacity

All persons 16 years of age and over are assumed to have capacity unless it is established that he/she lacks capacity.

Trust clinicians and responders should be cognisant that it does not matter if this disturbance or impairment is either temporary or permanent in nature, nor should a lack of capacity be merely established by reference to the patient's age, presenting condition or behavior as this may lead others to make unjustified decisions about the individual's capacity.

Where Trust clinicians or responders suspect a person may lack capacity, then they shall be able to demonstrate that the individual lacks capacity by undertaking a two-stage capacity assessment.

11.2. Three Stage Capacity

Stage one – the functional test
The first stage of a capacity assessment is especially important and will be the primary test applied by all ambulance staff.

If a person has the capacity to make the decision, you should be able to answer 'yes' to all of the questions below.

If the answer is 'no' to any of these questions, you need to proceed to the second stage of the assessment.

- Do they understand the information about the decision? (This includes understanding what will happen if they either do or do not make the decision).
- Can they retain this information?
- Can they use the information to make their decision?
- Can they let you know what their decision is, either by telling you or by some other means e.g., sign language, blinking?

It is important to remember though that if we are concerned that a person may not be able to decide, we must work very closely with Principle 2 of the Code of Practice to use all practicable steps to support them.

Stage two – the diagnostic test

It is important to consider conditions that can affect the way a person's mind or brain works. Examples you may note include if the person has:

- Dementia
- Mental health problems
- Learning disabilities
- Concussion
- Brain damage
- Physical or medical conditions that cause confusion, drowsiness, or loss of consciousness.
- Symptoms of alcohol or drug use
- Extreme drunkenness
- Severe pain.

If a person does not have an impairment or disturbance in the way their mind or brain works, then you have no authority to intervene by using the Mental Capacity Act. If you have reasonable belief that the person does have an impairment, you will need to proceed to the third stage of the assessment.

Stage three – establishing causative nexus.

If you have been able to evidence that a person is unable to achieve one or more of the elements of the functional test and the criterion for the diagnostic test is met, the final stage is to determine if the inability is “because of” an impairment of, or a disturbance in the functioning of, the mind or brain.

At this stage, it is important for you to demonstrate why you consider that the mental disorder impacts on the ability to make the decision. This will mean explaining, for example, how a person’s acquired brain injury means they cannot retain the information provided due to short-term memory loss.

It is possible for a person to have an impairment but be unable to make a decision due to the enormity of the decision, which would be independent of their impairment.

12. BEST INTERESTS DECISIONS

12.1 Definition

There is no formal definition of best interests. However, best interests are one of the core principles of the MCA that requires clinicians and responders involved in the care of any incapacitated patient to objectively consider their wishes feelings and values when deciding on options for their treatment, and or, care.

12.2 ' Best Interests' in Practice

Following assessment of patient's 'mental capacity' and where it is found the patient lacks the capacity to decide, then unless that decision can wait until the patient regains capacity i.e., in situations where there is fluctuating or temporary incapacity, then all treatment and care decisions shall be made in the patient best interests. When making a 'best interest' decision, Trust clinicians and responders will be protected from having unlawfully touched a patient so long as they can meet the two following criteria:

- They have taken reasonable steps to determine that the patient lacks capacity, and
- They reasonably believe the patient lacks capacity and that the treatment, intervention and or care they are considering is in the patients' best interests.

12.3 Assessing 'best interests'

When assessing and determining decisions relating to what is in an incapacitated patients 'best interests' Trust clinicians must consider the following three key areas:

1. **Determining the status of the patient's capacity:**

   The outcome of the capacity assessment:

   a) Does the patient lack capacity?
   b) Will the patient regain capacity?
   c) If so, can the decision wait?

2. **Ascertaining the patient views:**

   Consider as far as reasonably practicable:

   a) Past and present wishes?
   b) DNACPR, ADRT, LPAs made when the patient had capacity?
   c) Beliefs/values that would have influenced their decisions when they had capacity?

3. Consulting with others:	***if practicable and appropriate to do so:*** a) Named person (s) nominated by the patient when they had capacity? b) Anyone engaged in their care or interested in the patient's welfare? c) Any done of an LPA granted power of attorney by the patient? d) Any deputy appointed by the courts with an interest in the patient's welfare?

12.4. Best Interests – and the Least Restrictive Options

Where Trust clinicians or responders proceed with treatment and care of patients under the doctrine of 'best interests', then they shall do so in in a manner that is the least restrictive option to the patient rights and freedom of action.

12.5. Best Interests – and Making Decisions

When making 'best interests' decisions on behalf of patients who have been determined through assessment as not having mental capacity, then Trust clinicians and responders shall consider the following elements to support their decision making**:**

- How was the decision about what was in the 'persons' best interests reached?
- What were the reason for reaching 'best interest's decision'?
- Who was consulted to help determine what was in the person's best interests?
- What factors were considered during the decision making?

12.6. Best Interests – and Life Limiting Conditions

Trust clinicians and responders will frequently encounter out of hospital situations where they believe that proving patient with treatment may not be in their 'best interests'. Trust clinicians and responders shall be aware that the starting presumption in such cases must always be that it is in the 'best interests' for the patient to 'stay alive'.

Where Trust clinicians and responders managing patient with life limiting conditions e.g., *end of life care*, who have been assessed and determined not to have capacity, where they decide that treatment or transport for acute admission is not in the patients 'best interests' then they should embrace shared decision making by seeking guidance though one of the following support networks:

- Dedicated palliative care Doctor, Nurse or AHP assigned to the patient's case/care.
- All Wales Palliative care on - call consultant support team.
- Trust senior clinical on call advisor.

12.7. Best Interests - and Restraint

Following an assessment of the patient mental capacity and where they have been determined as not having capacity to decide, Trust clinicians and responders may

proceed in the patient 'best interests' so long as it has been decided that:

- That the attending clinician or responder '*reasonably believes'* that the treatment, intervention or care they are restraining the patient for is in the patients 'best interests.

- That the attending clinician or responder '*reasonably believes'* that the treatment, intervention or care they are restraining the patient for is necessary to 'prevent harm to the patient'.

- Any restriction of movement/restraint considered and undertaken by a Trust clinician or responder is proportionate to the likelihood of the person he/she is retraining suffering harm and how serous that harm is likely to be.

- If an emergency arises, and to prevent serious harm to the patient, appropriately trained clinicians can proceed with restraint under the common law doctrine of 'necessity'.

13. DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS)

13.1. Application of DoLs

The statutory DoLS scheme can only be used where a person will be deprived of their liberty in a care home, hospital, or hospice. In all other settings, including deprivation in an ambulance, requires authorisation from the Court of Protection (COP), which may be granted if it is satisfied that it is in the person's best interests.

13.2 DoLs - and Ambulance Care

A person may be deprived of their liberty by the Welsh Ambulance Services NHS Trust clinicians in certain circumstances, predominantly where they:

- Lack capacity to decide and need to be transported by ambulance for more than a "negligible period" i.e., where the lack of capacity is either fluctuating or temporary.

- Are under continuous supervision and control during ambulance transportation to hospital or a care center.

- Are not free to leave the transporting ambulance or the care of the attending Trust clinicians.

13.3. DoLS – and Ambulance Transfer of Patients Lacking capacity.

The DoLS standards supplement to the MCA code of practice. The latter is explicit in that transporting a person who lacks capacity from their home, or another location, to a hospital or care facility will not usually amount to a deprivation of liberty.

13.4 DoLS – and Consent

Trust Clinicians and responders should consider whether the person has the capacity

to consent to treatment or transportation for the purposes of receiving treatment and care. If they can consent to treatment and care, then there will be no deprivation of liberty. In the event where a person does not have capacity, or if there is insufficient time to properly assess their mental capacity i.e., in an emergency, it is lawful to provide treatment on emergency basis which is in the persons 'best interests' so to provide life sustaining treatment and/or to prevent serious deterioration.

13.5. DoLS - and Restraint

Ambulance clinicians and responders can restrain patients in their best interests to transfer them to care in circumstances where they lack capacity. This will not normally amount to a deprivation of liberty. In most ambulance cases where a person who lacks capacity and requires care and control during ambulance transfer, this constitutes 'restraint' or a 'restriction' of liberty rather than a 'deprivation' of liberty in legal terms, and predominantly occurs in an emergency.

13.6. DoLS – and When to Obtain Senior Clinical Advice

It would be a rare event for an ambulance journey to require an authorisation of a deprivation of liberty order, however, it is important to obtain advice senior and where appropriate legal advice in the following circumstances:

- Where the assistance of the police and/ or statutory services is required to gain entry and assist in the removal of the person from their home and into the ambulance, and where the situation is not covered by the Mental Health Act and it not an emergency.

- Where is may be necessary to do more than persuade or provide transient forcible physical restraint of the person during the transportation, and the situation is not covered by the Mental Health Act, and it is not an emergency. This needs to be planned, documented, and include multi – professional decisions.

- Where the ambulance journey is exceptionally long e.g., to last longer than 60 minutes or is otherwise deemed unusually long for the presenting circumstances. This needs to be planned, documented and multidisciplinary.

13.7. DoLS – and applying restraint

In the event of any restraint being necessary, Trust clinicians and responders shall ensure:

- Its application is proportionate to the likelihood of seriousness of harm to the patient.
- It is applied for the minimum amount of time necessary and removed at the earliest possible opportunity.

13.8. DoLS and ambulance transport

Where Trust clinicians and responders are engaged in the treatment and, care and ambulance transfer of a patient who is subject to a DoLS order, they should:

- Request to see a copy of the DoLS order prior to transfer to care*
- Verify the validity of the DoLS order (date and applicability to the patient).
- Ensure the PCR reflects the patient is subject to a DoLS order.

*Trust clinicians or responders must not delay any immediate treatment, care, and or, emergency transportation of patients that is necessary. The later will take precedence over determining these factors in any emergency to save life's and prevent deterioration of the patient health and well-being.

14. CONSENT TO RESEARCH, AND OR, INNOVATIVE TREATMENTS

Trust clinicians and responders can increasingly find themselves caring patients who are research subjects as part of an out of hospital research study. The same legal principles apply to consent as those for consenting or refusing examination and treatment.

Gaining patient consent from would-be research participant (s) is a fundamental consideration of the research process. The lead researcher for any out of hospital studies that involve Trust patients is responsible for ascertaining the quality and mode of patient consent/refusal as part of the research governance process.

Any clinician participating in any research study which requires them initiate, direct, or engage patients as participants in research, have a duty, and are, responsible for ensuring valid consent is obtained in conjunction with approved research protocols.

15. CONSENT TO PHOTOGRAPHY, VIDEO OR AUDIO RECORDINGS

Where prior approved by the Trust, photography, video and audio recording of a patient's assessment and treatment may be used as a medical record, treatment, and or, as a tool for teaching, audit, or research.

Where approval has been explicitly granted by the Trust for photography or recording, then valid patient consent shall also be sought before any photography or recording takes place. As part of this consent process, Trust clinicians must ensure that the patient is informed of and understands:

- The purpose and possible future use of the photography, and or, recordings.
- They can refuse or withdraw consent to the photography or recording at any time during assessment, treatment, or care.
- That refusing or withdrawing consent to any photography or recording will not compromise or prejudice their ongoing care.
- That where necessary, any photography, and or, recording can be anonymised to protect their identity.

Trust clinicians and responders shall follow the guidance provided by their professional and registrant bodies along with the Trust standards relating to any photography, and or, recording of any patient interaction including informal support, assessment, treatment, and or, care.

16. CONSENT DURING PREGNANCY

Consent from the woman must be obtained regardless of the proposed investigation, examination, and or, treatment. For consent to be valid it must be voluntary, informed and the benefits and risks associated with the proposed care, or any alternatives must disclose and discussed with the woman.

In so far that consent is valid, and the woman has been determined as having capacity to make an informed decision, then any decision by the woman to either accept or refuse examination, treatment or care must be respected. This is still the case even if refusing treatment would result in their death, or the death of their unborn child.

Consent may not be required where the attending ambulance clinician determines a woman requires emergency obstetric treatment to save life, and or, to act in their 'best interests' where the woman lacks capacity and is unable to give consent.

During an obstetric emergency it may be necessary to undertake an intimate examination to perform lifesaving procedures. Where possible and appropriate to the patient presenting condition, the attending ambulance clinician must obtain valid consent and afford the woman a chaperone.

The later must not delay providing any emergency obstetric treatment or transport that is necessary to save life. Any examinations or procedures must be carried out sensitively, with respect for the woman's dignity, cultural beliefs, and confidentiality.

17. CONSENT TO BLOOD TESTS AND URINE SAMPLING

The same principles which apply to consent to examination and treatment also apply to patient participating in any screening or tests. The latter includes sampling of capillary, venous or arterial blood and urine.

Where the attending clinician or responder proposes to obtain a blood or urine sample from a patient who has capacity and where no emergency treatment is required to save life, then valid consent shall be obtained.

As part of the consent discussion, in addition to any other information on the benefits, risks and alternatives of having the proposed test/sampling, patients shall be given the following information where a blood test or urine sample is proposed to be obtained:

- 'Specific purpose' of the proposed sampling?
- 'How' the test/sample results will be obtained?
- 'When' the test/sample results will be available?
- 'Who' will discuss the test/sample results with the patient?
- 'Where' the results will be recorded?

18. EQUALITY IMPACT ASSESSMENT (EQIA)

This policy has been subject to an Equality Impact Assessment (EqIA) which has been continuous during development and purposeful EqIA screening was undertaken by the

Consent to Examination and Treatment Task and Finish Group on the 30th August 2019.

Evidence and outcomes of this screening shows the policy content provides a clear synergy between obtaining informed patient consent and enabling equality for those patient groups with protected characteristics. Therefore, it was determined that the policy has no adverse impact on the equality groups.

A review of the literature was undertaken to ascertain what was known about any previous EqIA assessments on similar policies. Eight NHS organisations have conducted EqIA on their patient consent policies in the past seven years, excluding Ambulance Trusts, all have identified that their policy had no adverse impact on the equalities groups.

19. TRAINING & IMPLEMENTATION

The clinical education and training of clinicians employed by the Trust is the responsibility of the Trust Education and Training team. Staff education and training in consent will be facilitated for all patient facing staff commensurate with their grade, role and clinical scope of practice. The Trusts Consent to Examination and Treatment Group have determined two key areas requiring further learning as part of the continued professional development for patient facing staff, these are:

- Adopting a more contemporary patient centric approach to obtaining valid consent by transforming the post Montgomery UKSC ruling (2015) into practice.

- For patients lacking capacity, ensuring that any 'best interest' decisions are fully informed by ascertaining the views of the patients and consulting with others.

20. AUDIT AND MONITORING

Seeking informed consent from patients will be a core audit criterion on the Trusts annual audit plan to assure clinical quality of out of hospital practice. The criterion will address the application of this policy in practice and recording valid consent or refusals to consent on the Trusts PCR.

Outcomes from these audits will be part of the quality improvement process led by the Clinical Team with support from the Quality, Patient Experience, Quality Committee (QuESt) to support any necessary improvements in consent practice.

21. RECORDS MANAGEMENT

The Welsh Ambulance NHS Services Trust (WAST) recognises the importance of robust records management arrangements for both clinical and corporate records. The Trusts' records are its corporate memory, providing evidence of actions and decisions and representing a vital asset to support daily functions and operations. Records support policy formation and managerial decision-making, protect the interests of the Trust and the rights of patients, staff, and members of the public. All ambulance clinicians and responders are expected to keep full, clear, and accurate clinical records for everyone they treat. These records must be completed promptly and as soon as possible after providing care, treatment, and or, other services.

Clinical records or data collection devices must be kept securely and protected from loss, damage, or inappropriate access. All patient clinical records, and or, data must be managed according to applicable legislation, organisational policy and any professional standards set out by individual professional or registrant bodies.

22. RESPONSIBILITIES

The Chief Executive Officer has ultimate responsibility for the Trust having systems in place to ensure its employees can comply with current UK law on obtaining valid consent and the guidance set out for consent to examination and treatment of patients in Wales by the Welsh Government.

The Executive Director for Paramedicine has been delegated this responsibility as the executive lead for consent and mental capacity. The Executive Director for Paramedicine will be responsible for ensuring appropriate consent policy development, implementation, and training.

The Executive Director for Quality and Nursing is the named Registered Nurse on the Trust Board and within the Trusts Scheme of Delegation who is responsible for Safeguarding, Putting Things Right and statutory Health and Safety guidance.

The Assistant Director of Clinical Delivery have the responsibility for the corporate management and implementation of the Trusts Consent to Examination and Treatment Policy, including clinical advice of staff across the Trust boundaries.

The Regional Clinical Leads – Consultant Paramedics/Consultant Clinicians Integrated Care have responsibility for supporting the effective implementation of the policy across the Trust boundaries, ensuring clinical advice is available to staff and monitoring the effectiveness in practice.

The Policy Lead has responsibility for developing the clinical content and managing updates and reviews of this policy. All requests for updates, and or, amendments will be approved by the **Assistant Director of Clinical Delivery.**

Health Board Clinical Leads are responsible for supporting the implementation of the policy, monitoring its effectiveness, and supporting day to day management of consent.

The Assistant Director of Education and Development has responsibility for identifying the necessary and appropriate levels of education and training, including any education/training needs to deliver the content of this policy document.

Operational Managers and **Senior Paramedics**, are responsible for supporting implementation of this policy, providing clinical advice and supporting any audit or monitoring of the policy.

All Clinical Staff have a responsibility to maintain awareness of the law in respect of consent and ensure they are familiar and understand the content of this policy and apply its principles when managing all patients.

23. POLICY APPROVAL – PROCESS & TIMELINE

This policy is subject the WAST approvals process. Specific approvals groups and a timeline for the approvals process is shown in appendix 'D' of this document.

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25. APPENDIX A - ASSESSING GILLICK COMPETENCY

As the attending Trust clinician or responder, you should:

- Confirm the age of the child – are they below 16 years of age?
- Explain in broad terms the intervention, treatment or care being offered, including any benefits or risks of that treatment or care.
- Determine the child's ability to understand that there is a choice and that choices have consequences, in terms of both risks and benefits.
- Evaluate the child's understanding of the nature and purpose of the proposed intervention, treatment, or care.
- Evaluate the child's understanding of the proposed intervention/s risks and side effects, both in the short and long term.
- Evaluate the child's understanding of any alternatives to the proposed intervention, treatment or care including any benefits or risks attached to them.
- Determine the child's ability to weigh the information you have provided to them and their ability to arrive at a decision based on that information.
- Assess the child's willingness to make a choice, including their choice that someone else should make the decision for them.
- Estimate the child's freedom from any undue pressure to be able to make their decisions voluntarily and free from coercion or any undue pressure.
- Ensure you have involved the child in decisions about their care and any information you have provided is reasonable for his or her level of understanding.

26. APPENDIX B – INDIVIDUALS WHO MAY HAVE 'PARENTAL RESPONSIBILITY'

- Parental responsibility is defined as "all the rights, duties, powers, responsibilities and authority, which by law, a parent has in relation to a child and his or her property". Whilst this power includes the right to consent or refuse medical treatment on behalf of a child, it is NOT an 'absolute right' as this power must be exercised for **the BENEFIT** of the child.

- A person who may have parental responsibility can include:

- **The child's mother**.

- **The Child's father:** if he was married to the mother at time of the child's birth.

- **Second female parent:** if the child was conceived by artificial insemination and if she i.e. the second female was married or a civil partner of the mother at the time of the child's birth.

- **Unmarried Fathers**: for children born before 1st December 2003, unmarried fathers can acquire parental by:

- Marrying the mother of the child or have a parental responsibility order from the court, or.

- Register a parental responsibility agreement with the court or by an application to the court.

- **Unmarried Fathers**: for children born after 1st December 2003, unmarried fathers can obtain parental responsibility if they:

- Register the child's birth jointly with the mother at the time of the birth.

- Marry the mother of the child.

- Enter into a parental responsibility agreement with the mother of the child and register the agreement with the family court.

- Obtain parental responsibility from the court.

- Become named in a child's arrangements order that provides that the child will live with them.

- **Second female parent** if the child was conceived by artificial insemination and the female was not married nor a civil partner of the mother, can obtain PR if they:

- Register the child's birth jointly with the mother at the time of the birth.

- Register the birth.
- Marry or enter a civil partnership the mother of the child.
- Enter into a parental responsibility agreement with the mother of the child and register the agreement with the family court.
- Obtain parental responsibility from the court.
- Become named in a child's arrangements order that provides that the child will live with them.
- **Stepparent**, who is either married to, or, a civil partner of the mother, can gain PR of the child if they:
- Enter into a parental responsibility agreement with the mother of the child and register the agreement with the family court.
- Obtain parental responsibility from the court.
- Are the child's legally appointed guardian.
- Are a person in whose favor the court had made a child arrangement order which provides that the child will live that person.
- A local authority designated in a care order or interim care order in respect of the child.
- A local authority or other authorised person who holds an emergency protection order in respect of the child.
- **Child's legally appointed guardian**: individual with PR who has been legally appointed by the courts.
- **Person with a 'Child Arrangement Order**: made by the Court in which the order provides the child will live with that person.
- **Local Authority Care order**: designated or interim order in the respect of the child.
- **Emergency Protection Order (EPO):** a local authority or a person who holds an EPO in respect of the child.
- **Child Minders & School Teachers**: do not have PR but may at the time consent for the child if treatment if it either urgent or trivial. Where there is doubt, excluding emergency treatments, specific enquiry should be made by attending clinicians.
- **Emergencies**: it is justifiable to treat a child who lacks capacity without the consent of a person with PR, if it is impossible to obtain consent in time and if the treatment is vital to the survival or health of the child.

27. APPENDIX C - ASSESSING THE VALIDITY AND APPLICABILITY OF ADRTS

Format

- There are no specific legal requirements concerning the format of an ADRT (unless it involves life-sustaining treatment – see section). ADRTs may be presented to an ambulance clinician in several differing formats, these may include:

  - Written document.
  - Witnessed verbal statement.
  - Signed printed card.
  - Smart card.
  - Notes of a discussion recorded in a patient's health record.

Validity

- An ADRT **is valid** if made voluntarily by an appropriately informed adult i.e., they are 18 years of age or over with capacity.

- The An ADRT is **not valid** if the individual:

  - was under 18 years of age when it was drawn up; or

  - did not have capacity when the decision was made; or

  - was acting under duress; or

  - has withdrawn the advance decision (verbally or in writing) at a time when he/she had capacity to do so; or

  - has done anything else clearly inconsistent with the ADRT remaining his fixed decision; or

  - Creates a LPA after the date when the ADRT was made, conferring authority on the attorney to give or refuse consent to the treatment to which the ADRT relates.

Applicability

- An ADRT must **clearly specify** the treatment that is being refused and in **what specific circumstances** that it applies.

- The ADRT must be unambiguous and applicable to present patient circumstances. If the decision to be made falls outside of the scope of the ADRT, it <u>will not</u> be applicable.

- An ADRT cannot authorise anyone to do anything which is unlawful e.g., assist an individual in committing suicide, or make an ambulance clinician carryout a particular out treatment.

28. APPENDIX D: GLOSSARY OF TERMS & ABBREVIATIONS

AAP	Associate Ambulance Practitioner i.e., EMT grades 1, 2, 3.
AACE	Association of Ambulance Chief Executives
ADRT	Advance Decision to Refuse Treatment
AHP	Allied Health Professional
BMA	BMA – British Medical Association
BNF	British National Formulary (Supplementary guidance only)
Care	Necessary provision to protect a person's health & wellbeing.
CAD	Court Appointed Deputy
CFR	Community First Responder
CtOP	Court of Protection
COP	College of Paramedics
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
DoLS	Deprivation of Liberty Safeguards
ePCR	Electronic Patient Clinical Record
EPO	Emergency Protection Order
EqIA	Equality impact Assessment
FCP (s)	Future Care Plan (s)
GMC	General Medical Council
GP	General Practitioner (In and or, Out of Hours)
HCSW	Health Care Support Worker i.e., UCA, NEPTs
HCPC	Health and Care Professions Council
Informal Support	Lifting, Handling or manually supporting patients
Intervention	Process of intervening to save life or protect health and wellbeing
ID A CURE	Impairment, Disturbance and Communicate, Understand, Retain and Employ (*Aide-mémoire for assessing Mental Capacity)*
IMCA	Independent Mental Capacity Advocate
LPA	Lasting Power of Attorney
LPS	Liberty Protection Standards
MCA (2005)	Mental Capacity Act (2005)
MHA (1983)	Mental Health Act (1983) [Amended 2007]
Montgomery (2015)	Montgomery v Lanarkshire Health Board (2015) UKSC ruling
NEPTs	Non-Emergency Transport Service
NMC	Nursing and Midwifery Council
OPG	Office of the Public Guardian
OT	Occupational Therapist
PPO	Police Protection Order
PR	Parental Responsibility
Procedure	Single or series of action (s) relating to out of hospital interventions
QuESt	Quality, Patient Experience & Safety
R&D	Research and Development
Restraint	The 'necessary and proportionate'[1] restriction of a person's movement when they lack capacity, and it is in their 'best interests' to prevent harm.

[1] *The term **'necessary'** is an objective reason that shows the person being cared for is likely to suffer harm unless proportionate Restraint is used. A **'proportionate'** response' means using the least intrusive type and minimum amount of restraint to achieve a specific outcome in the best interests of the person who lacks capacity.*

Treatment	Out of hospital care provided to a patient for illness or injury
Trust (the)	Welsh Ambulance Services NHS Trust
Trust Clinician or Responder	Paramedics, Nurse, Doctor, AAP, AHP, HCSW, OT, CFR
UCA	Urgent Care Assistant
UKSC	United Kingdom Supreme Court
Volunteer	Individual freely undertaking a task on behalf of the Trust
WHC	Welsh Health Circular

Management of Controlled Drugs Policy

Policy Number:	063	**Version No:**	5.10	**Supersedes:**	5.9
Date of Approval:	TBA	**Review Date:**	3 years from date of approval	**Impact Assessments Completed:**	Yes
Classification of Document:	Clinical	**Type of Document:**	Policy	**Approved by:**	QuEST
Brief Summary of Document:	The purpose of this policy is to promote the safe, secure and effective management and use of Trust Controlled Drugs (CDs).				
Scope:	This Policy applies to all Staff who use and are responsible for the management of CDs.				
To be read in conjunction with:	WAST Medicines Management Policy V3.1 (2023) HCPC and WAST Code of Conduct and Professional Behaviour National Institute for Health and Care Excellence (NICE) Controlled drugs: safe use and management (2016) Security Standards for the Management of Controlled Drugs in the Ambulance Sector (2017) RPS professional Guidance on the safe and secure handling of medicines (2024) Standard Operating Procedure for the Witnessed Destruction of Controlled Drugs V0.3 (2021)				
Owning Committee	Quality & Patient Safety Committee				
Policy Lead: **Trade Union Lead:**	Dr Chris Moore Hugh Parry	**Job Title:**	Head of Medicines Management Trade Union Partner		
Executive Director:	Andy Swinburn	**Job Title:**	Director of Paramedicine		

Version Control Sheet

Version	Date	Author	Summary of Changes
1.0	August 2018	C Moore	First draft review of existing policy
2.0	19/09/2018	Julie Boalch	New template and formatting
3.0	06/02/2019	C Moore / J Jones	Trade Union Partner's review updates and addition of Trust impact assessments
4.0	11/03/2019	C Moore	AS review and updates
5.0	29/05/2019	C Moore	Minor updates following Policy Group meeting 21/05/2019 and consultation period
5.1	12/07/2019	J Boalch	Minor formatting changes
5.2	23/07/2019	C Moore	Minor amendments to paragraph references in 9.5, 11.3 and 11.5. Review date Nov 2020 to account for new CD key system
5.3	02/08/2019	J Boalch	Minor amendment to front cover
5.3	December 2020	C Moore	First draft review of CD Policy V5.3 to integrate Abloy system
5.4	May 2021	C Moore	S.12 – Airwaves Radio Security, feedback from A.Wylie. S.23/Appendix 3 – updated section on vehicle decommissioning following input from P Brown.
5.4	June 2021	P Seppman	Paragraph 11.4 amended to reflect stock checking in 10/1 – solo responders
5.4	August 2021	J Boalch	Minor template formatting
5.5	Nov 2023	C Moore	First review of existing CD policy
5.5	Jan 2024	Huw Jackson / Hugh Parry	Review of changes/amendments
5.6	Feb 2024	C Moore	Transfer to new policy template
5.7	12/02/2024	L Trounce	Formatting in readiness for presentation to Policy Group on 27/02/2024

Version	Date	Author	Summary of Changes
5.8	10/04/2024	C Moore	Minor amendments reflecting feedback from Policy Group (27/02/2024) including removal of paragraph 8.6 and duplicate Records Management paragraph
5.9	12/04/2024	Julie Boalch	Amendment to Impact Assessment Review section and approval route, and colour scheme.
5.10	25/04/2024	Lisa Trounce	Crown badge and Trust logo replaced, and Header amended to reflect university status
Keywords	Controlled, Drugs, CDs, Policy		

Impact Assessment Reviews

Area	Date of Review	Name of Reviewer
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Estates	N/A	
Environment	10/04/2024	N Stephens
ESMCP	N/A	

Task and Finish Group Members

Name	Job Title
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Policy Approval Route

Meeting Title	Meeting Date	Purpose/Outcome
Policy Group	27/02/2024	Review of updated policy for Approval / Recommend for Approval
ELT	16/04/2024	Recommend Approval
QuEST	07/05/2024	Approval and adoption

Contents

1. INTRODUCTION

The purpose of this Policy is to promote the safe, secure and effective use of all CDs used by WAST clinicians and reflects processes that were introduced when the Abloy CD Security System was implemented. The governance arrangements set out in this Policy aim to promote best practice and support all professionals in the management and use of these important medicines. The vast majority of this document relates to the secure management of morphine sulfate. Specific guidance related to ketamine and midazolam is provided in section 23 of this Policy.

In keeping with best practice, it is extremely important that appropriate measures are implemented which allow the tracking of CDs from pharmacy, right through to its end point. There are a number of different end points for CDs which include:

- Administration to the patient
- Disposal of full or partial doses
- Damage to ampoules
- Destruction of expired ampoules

The following table of documents, support the safe and effective management, use and audit of morphine sulphate by WAST personnel;

Document	Description	Use
CD01	Requisition Book	Requisition of CDs from pharmacy
CD02	Administration Record	Records vehicle stock level, administration to patient, disposal.
CD03	Key Register	No longer used due to deployment of the Abloy CD Key system
CD04	Expired Morphine Record of Disposal	Records disposal of expired morphine to pharmacy for authorised destruction
CD05	Medicines Audit Tool	Online tool to support monthly audit of vehicle CDs and medicines
CD06	Authorised CD Signatories	Record of original signature held by pharmacies
CD07	Enhanced Analgesia Pack Register	Signing analgesia packs out and into the station CD K-Safe
CD08	Station CD Register	Records station stock levels including supplies to and issues from the CD safe

2. POLICY STATEMENT

To ensure that the Trust has robust systems for the management of CDs.

3. SCOPE

This Policy applies to all Trust staff who use and are responsible for the safe and secure management of CDs.

4. AIM

To provide robust guidance to all Trust staff.

5. OBJECTIVES

To ensure that the Trust has robust systems for the requisitioning, physical security, storage, recording and safe disposal of CDs.

6. TITLE OF POLICY

Management of Controlled Drugs Policy

7. ACCOUNTABLE OFFICER

7.1 All designated bodies in Wales (NHS Trusts, LHBs) have a duty to appoint an Accountable Officer (WSI 2008; No. 3239 (W.286). The role of the Accountable Officer is to ensure that all practices and procedures associated with the day to day management of CDs are compliant with legislation and best practice. The role of the Accountable Officer in WAST, is performed by the WAST Director . Further detail on the role of the Accountable Officer can be found in *Strengthened Governance Arrangements for Management of Controlled Drugs* (WAG, 2008).

7.2 The name of the Trust Accountable officer is registered with Healthcare Inspectorate Wales CD Accountable Officers (HIW) Wales The Accountable Officer is responsible for ensuring there are sufficient routine monitoring systems in place to support the safe management of CDs in WAST.

7.3 The Accountable Officer must ensure that monitoring and reporting arrangements are robust enough to enable concerns about CDs to be raised, and that there are systems to investigate and manage concerns appropriately.

7.4 The Accountable Officer must ensure that declarations and self-assessments required by Healthcare Inspectorate Wales are completed and that WAST plays an active role in Local Intelligence Networks.

7.5 The day-to-day responsibilities of the Accountable Officer can be delegated to a named staff member. However, the Accountable Officer must ensure the delegated officer understands the responsibilities and duties associated with CDs and is provided sufficient resources to carry out this role.

7.6 The Accountable Officer will be responsible for ensuring appropriate reporting of CD management activity to the Trust Quality, Patient Safety and Experience Committee and Trust Board.

8. REQUISITION OF CONTROLLED DRUGS

8.1 Requisition of Omnicell Stocks

WAST Paramedic Duty Operations Managers (DOMs), Senior Paramedics, Locality Managers and Health Board Clinical Leads (Authorised Paramedics), are the only WAST staff authorised to requisition morphine sulphate from Health Board pharmacy departments. The aforementioned managers must be registered as Omnicell 'Super Users' which will provide them the necessary permissions to undertake restocks of the Omnicell cabinets. All authorised Paramedics must be in WAST uniform and present a valid, photographic Trust ID. All supplying pharmacies hold a file of WAST authorised personnel signatures, which will be checked, prior to the order being processed.

8.2 Minimum Standard of Information for CD Requisition

WAST CD requisition books contain duplicate sequential numbered pages. The minimum standard of information required on a CD requisition is as follows;

- WAST Locality or Omnicell being supplied
- Base Station of CD requisition book
- Name of preparation
- Strength of preparation
- Quantity being ordered
- The name, signature, and PIN of the Paramedic or authorised officer.
- The total quantity supplied.
- The signature of the supplier.
- The signature of the recipient.
- Date of order and supply

8.3 Process for fulfilling Requisition

Once the CD order is completed, the pharmacy department will retain the top white copy of the CD01. The pink carbon copy of the order should be retained in the CD01. Morphine sulphate can only be requisitioned from hospital pharmacies during normal working hours, Monday to Friday. It may not always be possible for the Authorised Paramedic who submitted the CD01 requisition to collect it. Where this is the case, the order can be collected by another Authorised Paramedic and a witnessed restock of the Omnicell completed at the earliest opportunity.

Good Practice
CD01 requisition books MUST be treated as controlled stationery and therefore stored securely. Issue of a new or replacement CD01 must only take place on production of a fully completed/exhausted CD01. Where a request for a replacement CD01 is not supported by a fully completed CD01, it is the responsibility of the issuing officer to ensure the 'missing' CD01 is not awaiting collection at a hospital pharmacy. *NASMED 2017*

8.4 Requisition of Vehicle stocks from the Omnicell system

The Omnicell system supports the operational supply of morphine sulphate directly to the vehicle (call sign) it is requested for. Morphine sulphate requisitions can only be issued to WAST Paramedics who are registered on the Omnicell system and therefore authorised to withdraw it. All morphine sulphate requisitions must be witnessed by a second WAST clinician (EMT or Paramedic), by use of the fingerprint scan. Morphine withdrawn from the Omnicell must be entered (and witnessed) into the vehicle CD02 register immediately following receipt. Morphine sulphate issues from the Omnicell must only be completed as a box of 10 ampoules.

8.5 Requisition of Vehicle stocks for Station-based CD cupboards

The Trust currently operates a small number of station-based CD cupboards, to support the supply of morphine sulphate to operational vehicles in the Swansea Bay and Bridgend areas. The system operates in much the same way as the Omnicell system, where Authorised Paramedics are responsible for submitting CD requisitions to the Pharmacy Department at Cefn Coed Hospital, Swansea. The CDs are then transferred to CD safes at Swansea, Neath and Bryncethin Ambulance Stations where registers of their stock are maintained. The minimum standards for the completion of CD requisitions for station based stocks are exactly the same as those detailed in section 7.2 (above). Station-based CD stocks will be subject to monthly stock-checks, scheduled to coincide with vehicle medicines audit.

Good Practice
Any tamper-evident seals on packs of CDs should be left intact when they are received from the pharmacy. This will simplify and speed up routine balance checks, as sealed containers can be assumed to contain the full amount as stated on the pack. *NASMED 2017*

8.6 Retention of CD01 and CD02 Books

Authorised Paramedics/localities, must ensure that all completed CD01 and CD02 books are retained for a period of two-years from the date of the last entry.

8.7 Responsibility for Updating Authorised Signatory Files (CD06)

Locality Managers (or appointed delegate) are responsible for ensuring that the pharmacy and locality authorised signatory files (CD06) are regularly updated to reflect

newly appointed Authorised Paramedics. The list of approved signatories should be checked at least annually and whenever there are amendments (additions or removals) to the lists.

8.8 Management of Authorised Signatory Files (CD06)

The top white copy of the completed CD06 must be countersigned by the HBCL/Locality Manager/DOM/Senior Paramedic and provided to the pharmacy department, to update their file. The pink carbon copy of the signatory form must be retained within the CD06 book for their records.

Good Practice
Paramedic officers must not possess an individual requisition book (CD01) to order personal stocks of morphine sulphate. Paramedic officers are also discouraged from withdrawing morphine sulphate (as a complete box) from the Omnicell system. Paramedic Officers, who need to top-up or replenish stock, should liaise with a local Senior Paramedic/DOM to arrange for a stock transfer of no more than 5 ampoules from an emergency vehicle. A record of the stock transfer must be recorded in the CD02 books of the emergency vehicle and paramedic officer and in all cases, witnessed and countersigned.

9. MANAGEMENT OF VEHICLE STOCKS

9.1 Once stock has been withdrawn from the Omnicell, it must be added to the running stock of the vehicle CD02, countersigned, and secured in the vehicle CD cabinet (along with the CD02), before continuing with any ambulance duties.

9.2 Each vehicle must have an Administration Record book (CD02) containing the following information:

- Drug preparation and strength
- Vehicle Call Sign and registration
- Date
- Issue / received / stock check
- Quantity Administered
- Quantity Issued
- Quantity disposed
- Stock Level
- Patient Clinical Record number
- Signatures (both crew members)
- PIN (both crew members)

9.3 When morphine sulphate is placed into the vehicle CD safe, the CD02 stock balance must be updated to reflect the contents of the safe. Entries should be made in the CD02

book every time morphine is placed in the CD cabinet, administered to a patient, or disposed of (see CD02 guide page for examples).

9.4 All entries in the CD02 must be in chronological order, made in ink and legible. If an error in recording is made, it should be struck through with a single line, signed and dated. A further entry should then be made in the next line below the error to clearly identify the stock level.

9.5 Wherever possible, two signatures must be recorded in the CD02 for all morphine issued or received. For paramedics working as solo responders, this may not always be practical, but witness signatures should be obtained wherever possible. Excess m*orphine sulfate doses should not be disposed of until a witness is present and the quantity disposed of must always be recorded in the CD02 and narrative section of the electronic Patient Clinical Record (ePCR).*

9.6 Morphine sulfate can only be stored in the vehicle CD safe, which will also hold books CD02 (administration record) and CD04 (expired record).

Good Practice
To reduce the number of unexplained morphine ampoule breakages, the Trust has purchased specific plastic cases which hold up to two complete boxes of 10 ampoules. All morphine sulfate ampoules held in the vehicle CD safe must be retained within their original cardboard packaging and secured within the plastic cases.

9.7 A maximum stock level of 15 x 10mg in date morphine ampoules can be stored on EMS vehicles at any given time (this does not include expired stock). When operational circumstances demand, stock levels may be increased to 30 x 10mg, but this should only be applied as a temporary measure. An example of this might include when a vehicle has been involved in an accident, and the CD stock is required to be transferred to another vehicle, to prevent its loss at a vehicle dismantlers or repairer.

Morphine stock levels <5 ampoules do not affect the vehicle's operational availability.

9.8 A box of 10 x 10mg/1ml ampoules is the only quantity that can be requisitioned from pharmacy, the Omnicell system or station-based CD cabinets.

9.9 Morphine can only be transferred from one vehicle stock to supplement another vehicle stock if a spare vehicle is unavailable or out of service. The CD02s of BOTH the issuing and receiving vehicles MUST be completed by writing in the next available line, number of ampoules transferred from/to (vehicle call signs) and ensuring that the stock balance recorded is correct. The member of staff must inform Clinical Contact Centre (CCC), who will immediately e-mail the Locality Manager. At the first opportunity the Locality Manager (or appointed delegate) must arrange to check that the audit trail is complete and processes are put in place to prevent this reoccurring.

9.10 All pages of the CD02 (top white and yellow copy) must be retained in the book. As previously described above (paragraph 8.7), completed CD02 books must be retained by localities for a period of two years from the date of last entry, then destroyed under confidential conditions.

9.11 Local arrangements need to be implemented to ensure that morphine stocks on all spare / non-operational vehicles are checked on a minimum of a once-weekly basis and documented in the vehicles CD02.

10. PATIENT ADMINISTRATION OF MORPHINE SULFATE

NB: This section does not deal with the clinical aspects of morphine administration

10.1 When morphine sulfate is administered to a patient, the following must be recorded on the ePCR:

- The patient's full name.
- The patient's home address.
- The patient's date of birth.
- The Drugs section must include time of administration, dose(s) administered, route of administration and batch number.

10.2 The vehicle CD02 (administration record) must be completed at the earliest opportunity i.e. when the patient's condition allows, and must include the following information;

- Date of administration
- ePCR Number
- Quantity administered to patient
- Quantity issued from stock (amount drawn up)
- Quantity disposed of (not administered)
- PIN and signature of paramedic. PIN and signature of witness (if available).

10.3 Any unused morphine remaining in the syringe must be emptied into and disposed of in the yellow sharps bin that contains a proprietary absorbent pad and recorded on the ePCR and CD02. **This disposal must be witnessed and countersigned.**

10.4 The quantity being disposed of must match the difference between the quantity administered to the patient and the quantity issued that is recorded in the CD02.

10.5 Where morphine has been administered by a solo-responder, any quantity not administered must be disposed of by the solo-responder as described in 9.3 above. This will ensure all morphine drawn up is accounted for.

Good Practice
Under no circumstances should a partially used syringe of morphine sulphate be handed over to another crew or practitioner taking over care of the patient, because the original attending paramedic will not be able to account for any further amount administered or disposed of. This will also prevent opportunities for diversion. *NASMED 2017*.

11. STOCK CHECK PROCEDURES

NB: Please refer to section 12 for additional guidance for staff members working as solo responders.

11.1 Morphine sulphate stocks must be checked at the beginning of every shift. If morphine is used during the shift, then an end of shift check must also be completed to ensure the use has been correctly recorded. There may be occasions when the first stock check may be delayed due to a requirement to deploy to an immediate 999 response. However, the check should be carried out as soon as is practically possible. Any discrepancies must be reported immediately to the respective Locality Manager, duty DOM/Senior Paramedic, or duty on-call officer and the incident recorded on DATIX.

11.2 At the commencement of duty, two members of crew must complete a CD safe stock check, regardless of whether the vehicle has been used on the previous shift or not.

11.3 At the end of duty, if morphine has been used during the shift, a closing stock check should be completed. This may be undertaken by both members of the same crew concluding their shift (vehicle not being used after this shift), or, by one of the crew finishing their shift and a member of crew relieving them.

Good Practice
Local arrangements should be in place to ensure that morphine stock checks on spare/non-operational vehicles are completed on a minimum of a once-weekly basis. *NASMED 2017*.

11.4 The stock check must be recorded in the CD02, writing ‘STOCK CHECK’ or ‘SC’ in the box marked ‘quantity received and recording the current stock level.

11.5 The signatures and PIN of both personnel must be recorded in the PIN/Signature columns on the far right of the CD02 page.

12. STAFF WORKING AS SOLO RESPONDERS

12.1 Staff working on Rapid Response Vehicles (RRVs) must follow the same checking procedures as those for double crewed EMS vehicles, with the following exceptions:

12.2 When morphine sulphate has been administered, the paramedic should where possible, obtain the signature of a crew member from the attending double crewed ambulance.

12.3 The ePCR should also record details of the morphine administered as per section 10.1 above.

12.4 A staff member working as a Solo Responder must perform a stock check at the beginning of every shift. Where possible, this should be in the presence of another member of operational staff. If no witness is available then NWA (no witness available), must be recorded in the countersignature (wts) box of the CD02. If morphine is used during the shift, then an end of shift check must also be completed to ensure the use has been correctly recorded.

12.5 Where morphine sulphate has been administered by a Solo Responder, any quantity not administered must be disposed of by the solo-responder as described in section 9.3 above. This will ensure all morphine sulphate drawn up is accounted for. It is not acceptable for partially used syringes of morphine to be handed over to transporting paramedics or other health professionals taking responsibility for the ongoing care of the patient (*see below*).

13.

Good Practice
Under no circumstances should a partially used syringe of morphine sulphate be handed over to another crew or practitioner taking over care of the patient, because the original attending paramedic will not be able to account for any further amount administered or disposed of. This will also prevent any opportunities for diversion. *NASMED 2017*.

14. CONTROLLED DRUGS CABINET ACCESS – ABLOY CLIQ PROTEC2

13.1 WAST deploys the Abloy Cliq Protec2 system, which restricts CD cabinet access to Paramedics and a limited number of Authorised Officers. Access to the vehicle CD safes is via a personal issue Abloy CD key, which must be activated at the commencement of shift and remains active for 15-hours. At the end of the 15-hours, the key will automatically deactivate and will not permit access to WAST CD safes until reactivated. All CD safe access transactions are recorded on the key and next time the key is activated, the activity is uploaded to the web-based system, providing an auditable trail.

13.2 Only WAST Paramedics and Authorised Officers will have access to morphine sulfate stored within the CD cabinet on emergency ambulances or RRVs. EMTs working with paramedics are permitted access to the CD safe at the request of the paramedic, to countersign the CD02 and to secure the drug for preparation and administration by the paramedic. Unauthorised access by anyone other than the aforementioned staff groups may result in disciplinary action.

13.3 All CD safes will conform to Misuse of Drugs Act (Safe Custody) regulations.

13.4 Only morphine sulfate and the relevant documentation (CD02 & CD04) are to be stored within the CD cabinet. The only exception to this is when Senior Paramedics or CHARU paramedics need to secure their 'enhanced analgesia' packs (ketamine and midazolam) in the CD safe.

Good Practice
Airwaves handheld radios **must not** be stored in vehicle CD safes. This practice has previously been associated with a higher than acceptable number of reported ampoule breakages and inability for engineers to access the radios for service or repair. All EMS vehicles where fitted with specific Airwave radio safes should be used. If a vehicle being used is not equipped with an Airwaves radio safe, then the hand held radio should be locked in the glove compartment where applicable i.e Toyota RAV4 or in the lockable cupboard beside the CD Safe in 70 plate ambulance.

15. VEHICLE SECURITY

Good Practice
Abloy Cliq CD safe keys must not be joined to the vehicle's ignition key. This will prevent the CD safe key accidentally being taken, handed over to an unauthorised person, or being left in the ignition, should 'runlock' fail or not be utilised when a vehicle is left unattended. *NASMED 2017*

14.1 All staff have a responsibility to ensure that vehicles are locked when left unattended outside ambulance stations, hospital sites and public places. Although it is not always practical to lock vehicles whilst on scene or immediately after transferring patients from the vehicle under emergency conditions, staff are expected to make the vehicle secure as soon as possible after transferring the patient.

14.2 Vehicles with defective or broken locks must be reported to the CCC who will inform the DOM/Senior Paramedic/Locality Manager or on-call officer where necessary by telephone and confirm this by e-mail. Repairs or replacements will be carried out by WAST Fleet or external contractors, as soon as is practically possible.

14.3 Un-liveried lease or paramedic officer cars parked at non-Trust premises overnight should have any external blue lights and insignia removed so as not to draw attention to the vehicle. Vehicles must be locked and alarmed and not hold any more than 5 ampoules of morphine (*see section 8 – Good Practice*). CDs must in all cases be locked in a suitable container which must be secured to an appropriate anchor point within the boot space of the vehicle, out of immediate view.

16. LOST, STOLEN OR BROKEN CD SAFE KEYS

15.1 Paramedics and Authorised Officers who believe they have lost or have broken their key, must report the matter to the duty DOM/Senior Paramedic immediately. This will ensure that the key can be remotely deactivated and rendered unusable by an unauthorised user. A DATIX report must be completed for all lost and broken keys.

15.2 For lost or missing keys, initial actions should be focused on retracing the steps of the crew and vehicle, to locate the missing key. If the key cannot be located, where possible, the duty DOM/Senior Paramedic should attempt to liaise with the crew to conduct a CD stock-check. Alternatively, the crew should liaise with another WAST paramedic to complete the stock check. If the number of morphine ampoules in the safe matches the stock balance recorded in the CD02, then there will be no need to inform the Police of the incident (unless loss of the key is associated with a suspected theft).

15.3 A DATIX report must be completed as soon as reasonably practicable (before going off duty) by the member of staff who was responsible for the key. The DATIX system will ensure that the relevant managers are informed of the incident and facilitate appropriate reporting and investigation of the incident.

15.4 Any actions or decisions taken should be proportionate and risk assessed against the circumstances of the potential loss. The Health Board Clinical Lead will review the incident and investigation to ensure all appropriate measures and actions have been taken.

15.5 Requests for replacement keys should be made via the DOM/Senior Paramedic/Locality Manager. Replacement key requests (Appendix 4) must be scan/emailed to Amb_MedsManagement@wales.nhs.uk. In all cases, the **name, ESR number and base station** of the person requiring a replacement must be provided.

15.6 It is the responsibility of the Fleet Manager, to ensure that a sufficient supply of replacement locks are available at workshops/with contractors, to enable rapid replacement.

15.7 Whilst a vehicle is having a replacement lock fitted, it may be necessary to transfer the morphine sulphate to another secure vehicle. If this is considered necessary, then the CD02 books on both vehicles must be completed to reflect this temporary transfer of stock.

17. LOST OR STOLEN CONTROLLED DRUGS

16.1 In the event of CDs being lost or stolen, the authorised staff member must inform the CCC immediately. The CCC must inform the Police and relevant DOM/Senior Paramedic/Locality Manager at the earliest opportunity. If this occurs out of hours the on-call officer should also be informed. An entry should also be made in the EMS Clinical Contact Centre Ambulance Daily Occurrence Log (ADOL).

16.2 A nominated officer must attend the scene of the incident to support the staff, liaise with the Police, and coordinate any further actions.

16.3 A DATIX report must be completed by the member of staff as soon as reasonably practicable (prior to going off duty). The DATIX system will ensure that the relevant managers are informed of the incident and facilitate appropriate reporting and investigation of the incident.

16.4 The Patient Safety Team will review the DATIX incident and liaise with the Health Board Clinical Lead to consider whether the incident should be reported to the Improving Patient Safety Team at Welsh Government. Any decision to do so will be proportionate to the circumstances and assessed risk.

16.5 The Health Board Clinical Lead/Senior Paramedic will review the incident and investigation to ensure all appropriate measures and actions have been taken. All CD related incidents and outcomes are reported internally and externally to the Health Board Accountable Officers and CD Local Intelligence Network via the WAST Quarterly CD Occurrence Reports.

18. EXPIRED CD STOCK

17.1 When expired stock is identified, the box must be clearly marked 'EXPIRED NOT FOR USE.' The ampoules in the box should be taped together to prevent them being used (foil to foil), but still visible for stock check purposes until they can be returned to the hospital pharmacy for destruction. The stock must remain within the CD cabinet and continue to be recorded in the stock check, until such time as it has been returned to pharmacy for destruction. Staff who identify expired stock in the CD safe should bring this to the attention of their DOM/Senior Paramedic.

17.2 The following method should be used to record expired ampoules in the CD02 book;
If there are 8 in-date ampoules and 6 expired ampoules in the CD safe, then the total should be recorded as 8 (6E) in the stock level column of the CD02 book.

17.3 When expired stock needs to be returned to pharmacy, the DOM/Senior Paramedic, should contact the appropriate pharmacy to arrange a suitable time when a pharmacy professional is available to receive the expired morphine. It is acknowledged that local arrangements may vary.

17.4 When expired stock is returned to the pharmacy for destruction, the vehicle CD04 must be completed and presented to the relevant pharmacy professional. The pharmacy department should retain the top WHITE copy of the completed CD04. The stock level recorded in the vehicle CD02 book should also be amended to reflect that the expired stock has been removed.

17.5 Both carbon copies (PINK and BLUE) of the return transaction should be retained in the CD04 to ensure all records are retained in a single document.

17.6 All destructions of expired stock must be reported via DATIX. This will support a robust reporting process and allow the Trust to monitor the volumes of morphine sulphate being returned to pharmacy. The following information should be captured in the DATIX report;

- Call sign of vehicle.
- Station, Locality and Region of vehicle
- Number of ampoules returned for destruction
- DGH Pharmacy undertaking destruction

17.7 The Trust is currently developing a network of 'Authorised Witnesses' (HBCL clinicians), who will be required to complete authorised witness training, delivered by Local Health Boards. The training will permit them to undertake witnessed disposal of CDs. This is a developing area of practise, underpinned by appropriate training, possession of 'Waste Exemption' permits for specific WAST sites issued by Natural Resources Wales, a Standard Operating Procedure, and use of denaturing kits. Training places in Wales are infrequent, but once all HBCLs have completed training, WAST will have the ability to manage its own witnessed destruction/disposal of CDs.

19. DAMAGED CD STOCK

18.1 The discovery of damaged or broken CDs must be reported immediately. Dependent on the circumstances and location of the occurrence, the discovery may be reported to the line manager (if on station), or via the CCC (if operational).

18.2 Wherever possible, another member of staff should be sought, so that the damage can be witnessed and any subsequent disposal recorded and countersigned in the vehicle CD02 book. Where a witness is not immediately available, the damaged stock may be secured within the CD safe until a witness is available, but this should be balanced against ensuring safe and secure disposal of any remnants of glass or ampoule contents. Photographic evidence of damaged stock can be a useful addition to DATIX reports. Damaged morphine ampoules must be treated as contaminated sharps and be disposed of in the yellow sharps bins which will contain a proprietary absorbent pad.

18.3 In all cases, the damaged stock must be recorded in the vehicle CD02 book by recording DAMAGED STOCK in the next available row. The number of damaged ampoules must be clearly written and the stock balance amended accordingly.

18.4 All incidences of damaged CD stock must be reported on DATIX. The nature and circumstances of the damage, e.g. found during stock check, fell from hand to floor, crushed within hinge mechanism etc. should be clearly described. It is also helpful to note whether the contents and remnants of the ampoule were retained within the plastic packaging.

18.5 All incidences of CD breakages are collated and included in the Trust Controlled Drugs Quarterly Occurrence Reports, which are circulated to internal Trust stakeholders and the 7 Welsh CD Local Intelligence Networks (see section 24 below).

20. CONTROLLED DRUGS STATIONERY

19.1 CD stationery must be secured in an appropriate locked cupboard to prevent illicit use of requisition forms, or manipulation, falsification or destruction of records with the aim of obtaining CDs for improper use.

19.2 CD requisition (CD01) books in particular, must not be accessible to any individual below the role of DOM/Senior Paramedic. CD01 books must not be issued as a replacement without first confirming that the book it replaces has been completely exhausted of requisition pages. Additionally, replacements for missing CD01s must not be issued without first confirming that the CD01 it is replacing is not awaiting collection at the local DGH pharmacy.

19.3 Under no circumstances should individual Paramedic Officers possess a personal copy of a CD01 requisition book. Good practice guidance on how Paramedic Officers can top-up or replenish their stock of morphine sulfate is provided in section 8 of this Policy.

21. VEHICLE MOVEMENTS

20.1 The movement of Trust EMS vehicles from one location to another is a necessary requirement to ensure the Trust is able to provide safe and equitable service provision across the principality. Whilst the movement of EMS vehicles is most challenging in rural areas, the same challenges apply in the urban setting. To support the provision of service and maintain maximum EMS resource availability, it is essential that wherever possible, routine EMS vehicle movements are undertaken by non-EMS staff.

20.2 As previously described in this Policy, the Trust maintains vehicle-based morphine sulfate stocks in dedicated CD safes. Access to the vehicle CD safes is restricted to Paramedics and Authorised Officers that are in possession of a personal issue Abloy Cliq key. EMTs are permitted access to the CD safe (under supervision of paramedics), for the purposes of countersigning the CD02 record book and securing drugs for preparation and administration by the paramedic. Access to Trust CD safes by any other staff groups (including ACA2 staff) is strictly forbidden.

22. AUDIT AND MONITORING

21.1 In response to the *Strengthened Governance Arrangements for Management of Controlled Drugs* (WAG, 2008), the Trust has developed an online Medicines Management audit tool (Appendix 1), aimed at confirming that basic CD management processes are being routinely undertaken. The electronic tool can be accessed via the Trust intranet, by clicking on the **Applications Portal** tab and clicking on **Medicines Audit Tool** in the Medicines Management Team Section. Alternatively, please use the following link; Medicines Audit Tool

21.2 Localities are required to undertake a minimum of **one** vehicle medicines audit per month. This will provide a minimum output of 23 medicines audits per month across the

Trust. Compliance against this requirement is monitored and reported via the monthly Medicines Management Assurance Report (MMAR). The report is presented to the Trust Ambulance Practice Steering Group and on a quarterly basis, the Senior Operations Team meetings.

21.3 An audit of WAST authorised CD signatories held at DGH pharmacies will be conducted annually by Health Board Clinical Leads, supported by local DOM/Senior Paramedics. This is to ensure that up to date records are maintained.

23. RECORDS MANAGEMENT

The Welsh Ambulance NHS Services Trust (WAST) recognises the importance of sound records management arrangements for both clinical and corporate records. The Trusts' records are its corporate memory, providing evidence of actions and decisions and representing a vital asset to support daily functions and operations. Records support policy formation and managerial decision-making, protect the interests of the Trust and the rights of patients, staff and members of the public.

24. KETAMINE AND MIDAZOLAM

23.1 Building on previous work, the Trust continues to roll out the use of ketamine and midazolam, for the management of severely traumatically injured patients. The authority to administer these CDs is restricted to a small number of designated paramedics, including HART operatives, Senior Paramedics, Health Board and Regional Clinical Leads and Cymru High Acuity Response Unit (CHARU) paramedics. Administration of these drugs by paramedics is supported by Patient Group Directions. A register of paramedics authorised to administer these CDs will be held by the Trust Medicines Management department.

23.2 To support the management of these important medicines, new CD documentation has been developed which includes; Controlled Drugs Order Book (CD01), Enhanced Analgesia Pack Register (CD07) and Station/Base Controlled Drugs Register (CD08).

23.3 Limited quantities of ketamine and midazolam will be secured in Abloy Cliq CD safes, at a small number of WAST locations (to be determined). Access to the safes is limited to paramedics that have been granted a specific access profile on their Abloy Cliq key.

23.4 Authority to order ketamine and midazolam will be restricted to selected Senior Paramedics, Health Board and Regional Clinical Leads only.

25. CD SAFES & DECOMMISSIONED VEHICLES

24.1 When ambulance vehicles are decommissioned due to age or accident damage, it is the responsibility of the Fleet Department to inform the Locality Manager of the impending decommission and requirement to remove all medicines and medical consumables from the vehicle.

24.2 The Locality Manager is responsible for ensuring the decommissioning process is compliant with the checklist provided in ***Appendix 3*** of this document (WAST *VEHICLE DECOMMISSIONING CHECKLIST).* The process must be completed prior to the vehicle being handed over to the Fleet Department.

24.3 All vehicle CD documentation (CDs 02 & 04) should be voided by writing VOID on each blank page and be retained securely within the locality for a period of two years from the date of last entry.

24.4 On receipt of the decommissioned vehicle, the Fleet Department will make arrangements for the empty CD safe to be removed from the vehicle and retained for future use.

26. LOCAL INTELLIGENCE NETWORKS

25.1 Following the publication of *Strengthened Governance Arrangements for Management of Controlled Drugs* (WAG, 2008), Health Board Accountable Officers are responsible for establishing and operating Local Intelligence Networks (LIN). Membership of the LIN is based on locally recognised health communities (consistent with Health Board boundaries).

25.2 The Health Board Accountable Officer will act as the hub of the LIN to establish mechanisms to share information quickly between partners, and where appropriate, set up and agree joint protocols and reporting arrangements.

25.3 There are seven LIN in Wales, chaired by their respective Health Board Accountable Officers. WAST Health Board Clinical Leads will provide representation at each LIN in order to present the WAST Quarterly Occurrence Reports (Appendix 2). These reports provide detail on any controlled drugs concerns or incidents that have occurred in the previous calendar quarter.

25.4 The WAST Head of Medicines Management is responsible for monitoring all CD related incidents reported on the DATIX system. The DATIX incidents are collated and a Quarterly Occurrence Report prepared on behalf of the WAST Accountable Officer. Following its approval, the Quarterly Occurrence Report is circulated internally to WAST stakeholders and externally to the 7 Health Board Accountable Officers (LIN).

27. EQUALITY IMPACT ASSESSMENT

Equality Impact Assessment (EQIA) screening was undertaken using the online tool and evidenced a neutral impact. The full EQIA document can be accessed by request to the Head of Medicines Management.

28. WELSH LANGUAGE IMPACT ASSESSMENT

The Welsh Language Measure 2011 established the principle that the Welsh and English language should be treated on a basis of equality. The duties deriving from the standards mean that the Trust will be required to assess what effect a policy decision would have on the opportunities for persons to use the Welsh language or, treating the Welsh language no less favourably than the English language.

In order to comply with the Welsh Language Standards and the Trust's Compliance Notice, the Trust is required to publish several policies in Welsh; particularly those that relate to:

- behaviour in the workplace;
- health and well-being at work;
- salaries or workplace benefits;
- performance management;
- absence from work;
- working conditions;
- work patterns

29. ENVIRONMENTAL STANDARDS AND IMPACT ASSESSMENT

This policy will put the relevant requirements in place (such as waste management plan, reduction of C02 emissions & reduction of carbon footprint) in order to ensure that the Welsh Ambulance Services NHS Trusts ongoing commitment to reduce its impact on the environment is maintained and to become a more sustainable organisation in line with Trust policy and Environmental Governance System.

30. ANTI FRAUD AND CORRUPTION CONCERNS

The Welsh Ambulance Services NHS Trust is committed to taking all necessary steps to counter fraud, bribery and corruption within the Trust. Staff should report suspected incidents of fraud and corruption to the Trust Local Counter Fraud Specialist, who will be happy to discuss any issues or concerns. Alternatively staff may contact the confidential NHS Counter Fraud Authority, Fraud and Corruption Reporting line on 0800 028 40 60; or the on-line reporting facility https://cfa.nhs.uk/reportfraud Fraud investigations may lead to disciplinary action and / or prosecution and civil recovery procedures.

Where there is any suspicion or an allegation that a loss has been caused by means of deception (by staff or patient) this must be referred to the Trust's Local Counter Fraud Specialist for investigation. The results of any such investigation could lead to internal disciplinary and/or civil/criminal prosecution proceedings being instigated against the person/persons involved.

30. TRAINING AND IMPLEMENTATION

WAST is committed to providing high quality evidence-based education to an engaged and skilled workforce operating within an organisational culture and framework that enables colleagues to work to the top of their skill set to deliver high quality care and services with competence and confidence. Staff are encouraged to discuss any concerns or queries regarding education and training with a member of the Education and Training Team, by telephoning the Learning & Development Hub on 0300 123 2319 or via email at amb_LDHub@wales.nhs.uk

31. INFORMATION GOVERNANCE

Information Governance (IG) is an overarching term used to describe all aspects of information management. The Trust and its staff shall ensure that they provide satisfactory assurance to stakeholders as to how the organisation fulfils its statutory and organisational responsibilities in relation to the management of information. It will enable management and staff to make correct decisions, work effectively and comply with relevant legislation and the organisations aims and objectives.

The IG framework ensures that it sets out the high-level principles for confidentiality, integrity and availability of information to promote and build a level of consistency across the Trust.

31. HEALTH AND SAFETY

Standard paragraph due to be inserted as above?

32. ROLES AND RESPONSIBILITIES

These are essential for each policy – use the examples below and amend as appropriate to suit the policy you are working on.

34.1 Chief Executive

The Chief Executive, as Accountable Officer, has overall responsibility for ensuring the Trust has appropriate policies in place to ensure the organisation works to best practice and complies with all relevant legislation.

31.2. Board Secretary

The Board Secretary is responsible for the effective management of, and compliance with, this policy. This includes ensuring that:

- A database of policies and procedures is maintained.
- Policies are approved as part of the Governance framework at the appropriate level in the organisation.

- The documents are accessible to all relevant staff.
- Documents are cascaded appropriately across the organisation.
- All policies are reviewed in a timely manner.

31.3. Executive Directors

The Executive Directors are responsible for the effective management of and compliance with this policy. They are responsible for ensuring that all policies within their remit are maintained and updated by liaising with the appropriate policy leads. They are responsible for ensuring that the appropriate advice and assistance is provided to authors and that consideration is given to any training and resources implications that are defined. Each Director will appoint a Policy Lead for their Directorate. The Director of Paramedicine has delegated responsibility of CD Accountable Officer, to ensure all practices and procedures associated with the day-to-day management of CDs are compliant with legislation and best practice.

31.4. Corporate Governance Manager

The Corporate Governance Manager will act as the Trust's 'Policy Process Manager' and operational gate-keeper with the responsibility for providing guidance, advice and support for the process on behalf of the Trust.

In addition, the Corporate Governance Manager is responsible for:

- Managing the maintenance of the Trust's central Policy tracker and database (including a record of equality impact assessments).
- Facilitation of the Trust's internal Policy Group.
- Managing the Trust wide consultation process for all policies.
- Providing a link between the Policy Group and Employment Policy Sub Group.
- Issuing reminder notices to ensure the timely review of policies.
- Ensuring up to date guidance and documentation regarding the policy process is accessible.
- Publishing policies onto the Trust's internet/intranet sites and working with the Communications Team to ensure comprehensive notification that new policies is maintained across the Trust.
- Maintain an archive of previous versions of any revised or reviewed policies.

31.5. Ambulance Operations Managers/ Clinical Leads / Locality Managers

Are responsible for**:**

- Ensuring that new members of staff that join the Trust are made aware of the policy control system at local induction, and how to access Trust wide and local policy documents specific to their area.
- Understanding the policy process and their role in supporting best practice.

- Working with staff without access to the intranet to ensure they have access to relevant documentation.
- Ensuring that local arrangements are established to monitor the receipt and understanding of all relevant Trust documents; thus reducing the risk of misuse of misinterpretation.
- ensuring that appropriate resources are available to support the safe and secure management of controlled drugs. They must also ensure that staff under their direct line management have a sound working knowledge of the principles of CD management and have the skills and knowledge to deal with CD related incidents and concerns in a robust and timely manner.

31.6. Line Managers

Are responsible for:

- Ensuring that the staff for whom they are responsible are aware of and adhere to this document.

This includes ensuring that:

- Copies of the Trust policies are readily available and accessible to all staff.
- Information is disseminated on a regular basis, to ensure staff have read and understood the relevant documents and are aware of any new guidance or revisions.
- The identification of specific staff training needs on the implementation of new or updated documents.
- Systems exist to enable the review, audit and compliance testing of all relevant departmental policies as required.

31.7. All Staff

Are responsible for ensuring that:

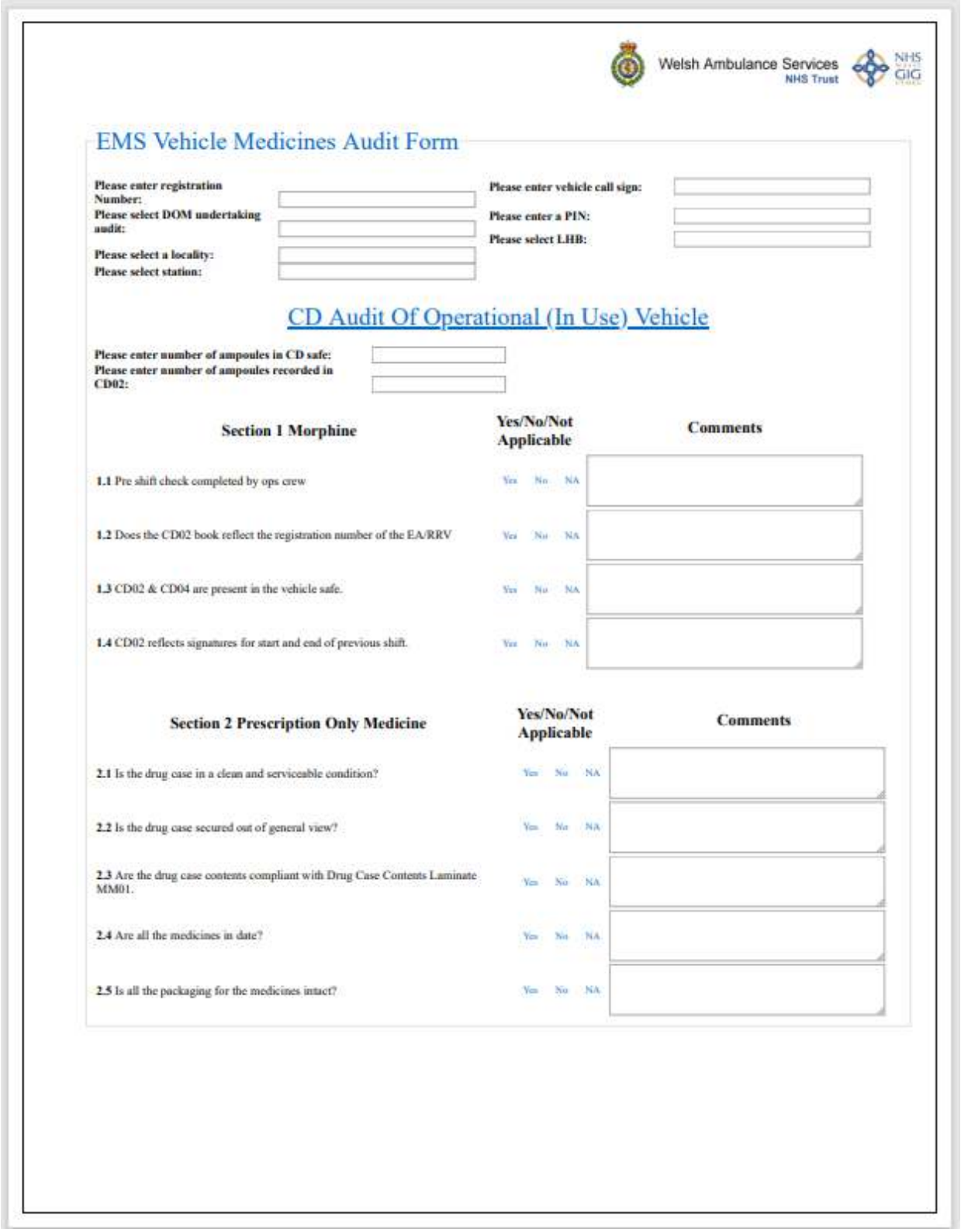
- They comply with the provision of this policy and where requested to demonstrate such compliance. Failure to comply will be dealt with under the Trust's Disciplinary Policy as appropriate.
- Information regarding failure to comply with the policy, for example, lack of training, inadequate equipment, is reported to their line manager and that the incident reporting system is used where appropriate.
- Their practice is in line with policies in use across the Trust and specific to their area of work.
- Information regarding any changes in practice, organisational structure or legislation that would require an urgent review of documents is immediately reported to their line manager.

33. REFERENCES

- England, E. Walker, A. McCausland D. (2017) Security standards and guidance for the management and control of controlled drugs in the ambulance sector. National Ambulance Service Medical Directors.
- Health Act 2006 (legislation.gov.uk)
- HCPC Standards of Conduct, Performance and Ethics (2018)
- NHS Counter Fraud Authority
- Misuse of Drugs Act 1971 (legislation.gov.uk)
- National Institute for Health and Care Excellence (NICE) Controlled drugs: safe use and management (2016)
- Professional guidance on the safe and secure handling of medicines (rpharms.com)
- Records management: code of practice for health and social care - GOV.UK (www.gov.uk)
- Safe and secure handling of medicines | RPS (rpharms.com)
- SOLD SECURE standard SS 304 – Specification for Domestic Safes, November 2008
- SOLD SECURE standard SS 314 – Specification for Security Cabinets, January 2009
- SOLD SECURE standard SS 319 – Specification for Security Cabinets for Vehicles, November 2008
- The Misuse of Drugs Regulations 2001 (legislation.gov.uk)
- The Controlled Drugs (Supervision of Management and Use) Regulations 2013 (legislation.gov.uk)
- The Misuse of Drugs (Amendment No.2) (England, Wales and Scotland) Regulations 2012 (legislation.gov.uk)
- The Misuse of Drugs (Safe Custody) Regulations 1973 (SI 1973 No. 798)
- The Misuse of Drugs and Misuse of Drugs (Safe Custody) (Amendment) Regulations 2007 (legislation.gov.uk)
- The Misuse of Drugs Regulations 2001: Group Authority for National Health Service (NHS) Ambulance Paramedics and Employing NHS Ambulance Trusts, July 2008 The Misuse of Drugs (Safe Custody) Regulations 1973 (SI 1973 No 798.
- Medicines Management Policy v3.1 (2023)

34. APPENDICES

31.8. Appendix 1 – Medicines Audit Tool (CD05)



Welsh Ambulance Services NHS Trust

EMS Vehicle Medicines Audit Form

Please enter registration Number:
Please select DOM undertaking audit:
Please select a locality:
Please select station:
Please enter vehicle call sign:
Please enter a PIN:
Please select LHB:

CD Audit Of Operational (In Use) Vehicle

Please enter number of ampoules in CD safe:
Please enter number of ampoules recorded in CD02:

Section 1 Morphine	Yes/No/Not Applicable	Comments
1.1 Pre shift check completed by ops crew	Yes No NA	
1.2 Does the CD02 book reflect the registration number of the EA/RRV	Yes No NA	
1.3 CD02 & CD04 are present in the vehicle safe.	Yes No NA	
1.4 CD02 reflects signatures for start and end of previous shift.	Yes No NA	

Section 2 Prescription Only Medicine	Yes/No/Not Applicable	Comments
2.1 Is the drug case in a clean and serviceable condition?	Yes No NA	
2.2 Is the drug case secured out of general view?	Yes No NA	
2.3 Are the drug case contents compliant with Drug Case Contents Laminate MM01.	Yes No NA	
2.4 Are all the medicines in date?	Yes No NA	
2.5 Is all the packaging for the medicines intact?	Yes No NA	

31.9. Appendix 2 – Controlled Drugs Occurrence Report

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

CONTROLLED DRUGS – OCCURRENCE REPORT

Controlled Drugs Concerns

This template should be used on a quarterly basis by the Accountable Officer of a designated body to report to the Health Board Accountable Officer. It should record any controlled drugs concerns that the designated body has regarding the management and use of controlled drugs (Reg 29).

Name of designated body	*Welsh Ambulance Services NHS Trust*
Name of accountable officer	**Mr Andy Swinburn, Director of Paramedicine**
Report for three-month period	
Name of local intelligence network (LIN)	
Name of LIN lead accountable officer	
I confirm that my designated body has **no** / **the following** (delete as appropriate) concerns regarding its management or use of controlled drugs during this period	
Accountable officer signature	
Date signed	

Description of concern[1]	**Date aware**[2]	**Actions taken**[3]

Notes

The Controlled Drugs (Supervision of Management and Use) Regulations 2008 came into force in Wales on 9 January 2009, see: **Regulation 29** concerns occurrence reports. In brief, regulation 29 requires accountable officers to give an occurrence report to the accountable officer for the LHB that is leading their local intelligence network (LIN). This should contain details of any concerns that their designated body has regarding its management or use of controlled drugs (or confirmation that it has no concerns to report).

[1] Short description of the cause for concern, including date(s). Details may be attached in a separate document. Note regulations 25 and 26 regarding the need not to disclose information, which relates to and can identify a patient.

[2] Date the accountable officer of the designated body became aware of the concern.

[3] Action already undertaken (if any) within or outside the designated body e.g. as part of internal incident investigation process, including the reference number within the internal incident investigation process (where relevant), and whether the incident is closed or still open.

31.10. Appendix 3 – Vehicle Decommissioning Checklist

Registration Number: _____ Make / Model: _____

Type: EMS / NEPTS / RRV / Other Call Sign: _____ Mileage: _____

Disposal Method: Auction / Salvage / Re-use (mark as appropriate)

Please complete the following tasks:

Task	Completed Yes/No/NA	Initials	Notes
Confirm that spare keys & remote-control fob are present			
Remove fuel card destroy and inform Fleet Office to cancel card			
Remove fuel key and return to Fleet Office			
Advise Fleet Office to disable vehicle tracking system			
Remove Communication/Sat Nav/Mobile data Equipment, Handheld radio			
Remove drugs cabinet and record lock number			
Check drugs cabinet can be reused & lock in working order			
Remove **all** consumables, medical gases, Medical/Specialist equipment, and any personnel items belonging to WAST staff and store ready for new vehicle			
Remove **any** WAST Literature, Defect Book, Mileage Sheet etc and dispose via correct channel			
Check and remove any clinical / hazardous waste and dispose via correct channel			
List of equipment including serial numbers			
Stretcher Seral Number			
Carry Chair Serial Number			
Carry Chair Track Serial Number			
Wheelchair Serial Number			
Spine Board Serial Number			
Scoop Serial Number			
Disposal			
Contact MMA and arrange for collection and note date collected			

36.4 Appendix 4 - Request for Replacement Abloy Key

Please complete this form for all Abloy key replacement requests
Please email this form to: amb_medsmanagement@wales.nhs.uk
NB: Incomplete forms will not be processed

Name of Paramedic user:	
Payroll Number:	
Current key markings:	
If lost, key last known location:	
Date key last used:	
If broken Key please provide details:	

Delivery details **(please note keys are sent signed for post, so can only be posted to sites with daytime admin support).**

For attention of (DOM):

Address:

Postcode:

To be completed by Line Manager/DOM

Name (PRINT): ……

Role: ……

Date: .....

For Office use only:

Name	Key Marking Code *(this is the code etched onto the key)*

Date request received:

Date Key Posted:

Royal Mail Tracking number:

Non-Medical Prescribing Policy (Independent, Supplementary and V100/V150/V300)

Policy Number:	077	**Version No:**	2.4	**Supersedes:**	2.3
Date of Approval:		**Review Date:**	3 years from date of approval	**Impact Assessments Completed:**	Yes
Classification of Document:	Clinical	**Type of Document:**	Policy	**Approved by:**	QuEST
Brief Summary of Document:	This policy outlines the governance arrangements and processes for supporting non-medical prescribing within the Welsh Ambulance Services NHS Trust				
Scope:	This policy provides a framework to assure that all non-medical prescribing practice, undertaken within the Welsh Ambulance Services NHS Trust, is governed by robust procedures and processes. It is designed to ensure patient safety, safeguarding, and support the clinicians working in non-medical prescribing roles, ensuring compliance with legislation.				
To be read in conjunction with:	The Royal Pharmaceutical Society of Great Britain: A Competency Framework for all Prescribers (2021) Non-Medical Prescribing in Wales: A Guide for implementation (2017) Professional Regulatory Bodies (HCPC/ NMC/GPhC): Standards for Prescribing Siren – Governance - Records Management Policy 020120.pdf - All Documents (sharepoint.com) Siren – Governance - Medicines Management Policy 250220.pdf - All Documents (sharepoint.com) Gifts, Hospitality Interests; Commercial Sponsorship And Fundraising Policy (2018) Capability Policy Version FINAL (Jun 2018 v21) - WAST.pdf				
Owning Committee	Quality, Safety and Patient Experience Committee				
Policy Lead: **Trade Union Lead:**	Kerry Robertshaw Marcus Viggers	**Job Title:**	Professional Development Lead Trade Union Partner		
Executive Director:	Andy Swinburn	**Job Title:**	Executive Director of Paramedicine		

Version Control Sheet

Version	Date	Author	Summary of Changes
1.0	10th April 2019	Paula Jeffery Helen Rees	New Document. Includes comments from MMG Group, Prescribing T+F Group and TU Lead
1.1	12th April 2019	Julie Boalch	Include hyperlinks on front cover and formatting
1.2	15th April 2019	Paula Jeffery Helen Rees	Add appendices
1.3	18th April 2019	Paula Jeffery	Add comments from external contributors and formatting
1.4	23rd April 2019	Paula Jeffery	Addition of Record Management section
1.5	10th May 2019	Paula Jeffery	Add comments from Craig Garner and Alexandra Gibbins
1.6	20th May 2019	Paula Jeffery	Amendments to Bank Staff section (6.5) and flowchart (appendix 5) following WASPT
1.7	23rd May 2019	Paula Jeffery	Amendments to supervision criteria and appendix 6 following QuEST
1.8	30th August 2019	Paula Jeffery	Updates to approval route. Updates to appendices
1.9	4th February 2020	Julie Boalch	Updated hyperlink to the new Management of Controlled Drugs Policy on front cover
2.0	17th August 2023	Kerry Robertshaw and John McAllister	Includes a section regarding remote prescribing pages 8-9. Updated to appraisal process timings based on time period qualified as prescriber page 14. ePCR section included pages 11 and 15 Appendices amended to reflect move to digital template pages 20 – 28. Any references to Executive Medical Director replaced with Executive Director of Paramedicine.
2.1	23rd January 2024	Kerry Robertshaw and Andeep Chohan	Section 6.2 updated to add consider where relevant the Trust's All Wales Capability Policy and Procedure for performance concerns. Hyperlink added to All Wales Capability Policy and Procedure Optimising Care Group added to Policy Approval Route Title Lead of Medicines Management changed to Head of Medicines Management throughout document Bank staff changed to bank workers in point 6.10.1. Any remaining reference to Executive Medical Director changes to Executive Director of Paramedicine. Head of Medicines Management added to point 11.8 as reportable officer. Capitalised each word for all titles Point 6.5.7 to include ePCR full title electronic Patient Clinical Record. Bullet point under 8.11.1 changed from attend a selection interview to evidence above to attend a selection interview to attend the course.
2.2	30th January 2023	Chris Moore and Andeep Chohan	Appendix 1 and 2 – Instructions to forward form to NWSSP and guidance for completion removed. Appendix 3 – email address amb_Prescribing@wales.nhs.uk removed and replaced with AMB_MedsManagement@wales.nhs.uk.
2.3	12/04/2024	Julie Boalch	Updated version number and approval route
2.4	16/04/2024	Lisa Trounce	Crown badge and Trust logo replaced. Header and footer updated. Spelling and grammar check.

Key Words	Non-medical prescribing; independent prescriber; policy; legislation; governance; register, appraisal

Impact Assessment Reviews

Area	Date of Review	Name of Reviewer
Counter Fraud	16.04.19	Carl Window
Information Governance	01.05.19	Craig Garner
Records Management	24.04.19	Judith Birkett
EqIA / Welsh Language	12.12.23	Paola Spiteri, Melfyn Hughes
Estates	N/A	N/A
Environment	N/A	N/A

Contributory Members

Name	Job Title
Andy Swinburn (Lead)	Executive Director of Paramedicine
Helen Rees	Head of Education, Professional and Clinical Practice (Nursing)
Paula Jeffery	Regional Clinical Lead-Consultant Paramedic
Mike Jenkins	Regional Clinical Lead-Consultant Paramedic
Duncan Robertson	Regional Clinical Lead-Consultant Paramedic
Chris Moore	Head of Medicines Management
Rhian Rowlands	Pharmacy Advisor
Marcus Viggers	Trade Union Partner
Beth Griffiths	Non-Medical Prescribing Lead-Swansea University
Mandy James	Medicines Management Lead-HDUHB
Alexandra Gibbins	Pharmacy lead 111 Service
Kerry Robertshaw	Professional Development Lead- Advanced Practice
John McAllister	Advanced Paramedic Practitioner/ Prescriber

Policy Approval Route

Where	When	Why
Meeting Title	Meeting Date	Purpose/Outcome
Policy Group	16.04.19	For review prior to consultation
Trade Union Partners Forum	03.05.19	For WASPT agenda approval
EMT	15.05.19	Recommend for approval
WASPT	20.05.19	Recommend for approval
QuEST	21.05.19	Approval and adoption
Policy Group	24.09.19	Reviewed post consultation
Trade Union Partners Forum	08.11.19	For WASPT agenda approval
WASPT	18.11.19	Recommend for approval
ADLT	TBC	Recommend for approval
EMT	29.01.20	Recommend for approval
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Policy Group	29.01.24	Recommend for approval
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QuEST	07.05.24	Approval and adoption

Contents

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1. INTRODUCTION

1.1 Non-Medical Prescribing is prescribing by specially qualified, registered healthcare professionals who are not doctors; working within their clinical competence as either independent or supplementary prescribers. Non-medical prescribers are responsible and accountable for the assessment of patients with undiagnosed or diagnosed conditions and for decisions about their clinical management, including prescribing. Some disciplines of independent prescribers (for example nurse prescribers) may, under statute, also be able to prescribe unlicensed medicines and controlled drugs.

1.2 The term non-medical prescriber refers to a registered healthcare professional, who has completed the required training and had their qualification annotated on the register of their relevant professional body. For example:

- Paramedics and Physiotherapists: Health and Care Professions Council (HCPC)
- Nurses and Midwives: Nursing and Midwifery Council (NMC)
- Pharmacists: General Pharmaceutical Health Care Council (GPhC)

1.3 Types of Non-Medical prescribers include:

- An independent non-medical prescriber can prescribe licensed medicines, within their scope of clinical competence (with restrictions for some professions: refer to individual professional body guidance). They are responsible and accountable for the assessment of patients with undiagnosed or diagnosed conditions and for decisions about their clinical management, including prescribing. Some disciplines of independent prescribers may, under statute, also be able to prescribe unlicensed medicines, off label medicines and controlled drugs (refer to individual professional body guidance).
- A community practitioner nurse prescriber (formally known as district nurse and health visitor prescribers), who have completed V150 training can prescribe from a Nurse Prescriber Formulary for Community Practitioners.
- Supplementary prescribing (SP) involves a voluntary agreement between the supplementary prescriber, an individual patient, and an independent prescriber. The agreement about what can be prescribed is set out in a clinical management plan.
- The V300 prescribing qualification is a course that prepares prescribing professions to prescribe independently and supplementary. This qualification can be done as a stand-alone module or as part of the MSc Advanced Clinical Practice qualification. The V300 qualification is the predominant qualification in clinical practice.

2. POLICY STATEMENT

2.1 The Welsh Ambulance Services NHS Trust is committed to providing prudent healthcare to patients in an appropriate environment, as close to their home as possible (A Healthier Wales; 2018). The Trust is also dedicated to the development of a skilled workforce, to support this commitment.

2.2 Benefits of Non-Medical prescribing include:

- Improved patient choice
- Improved patient experience
- Improved access to health advice and appropriate treatment

- Appropriate use of a skilled healthcare workforce, who are enabled to complete an episode of care by prescribing
- Increased efficiency of healthcare resources by providing appropriate care and management at the first point of access, avoiding multiple professional contacts
- Increased capacity to undertake new ways of working e.g. remote consultation.

2.3 The Trust has a duty to ensure that non-medical prescribing is undertaken safely and effectively by appropriately qualified healthcare registrants. This policy aims to enable non-medical prescribers to prescribe within the law and to ensure that the Trust processes for non-medical prescribing are conducted and managed in line with established standards and legislative requirements.

3. SCOPE

3.1 This policy outlines the governance processes required to assure that non-medical prescribing is undertaken safely, competently and in accordance with relevant legislation.

3.2 This policy applies to all Trust professional registrants, with a current non-medical prescribing qualification, who are employed by the Trust as non-medical prescribers, are clearly annotated on their professional registers and have non- medical prescribing incorporated into their job descriptions.

3.3 This policy does not incorporate medical prescribing, non-NHS prescribing (private prescriptions) by independent contractors or other methods of providing or supplying medicines to patients by means of patient group directions (PGDs).

3.4 This policy does not allow the prescribing of blood or blood components by the Trust's non-medical prescribers.

4. AIM

4.1 The overall aim of this policy is to provide a structured governance framework, outlining the key professional responsibilities required to implement and manage non-medical prescribing safely for the patient, professional and the Trust.

5. OBJECTIVES

5.1 The objectives of this policy are to support the ongoing strategic development of non-medical prescribing in the Trust:

- To ensure that all the Trust employees prescribe within the law and to ensure the process of independent prescribing is conducted and managed in line with legislative requirements.
- To ensure high standards of governance and risk management are maintained at all times
- Appropriate workforce planning of non-medical prescribers to meet service needs.
- Outline robust systems for the selection and preparation of the Trust employees to train as non-medical prescribers.
- To ensure that there are effective systems and processes in place to assess and

support ongoing prescribing competence and continued professional development.

- To provide all non-medical prescribers with a governance framework that ensures safe, effective and appropriate prescribing.
- To ensure that patient safety is paramount in all aspects of non-medical prescribing.
- To ensure that the emphasis of non-medical prescribing remains patient focused, improving access to medicines where appropriate within profession specific scope of practice.

6 NON-MEDICAL PRESCRIBING POLICY

6.1 Accountability, Indemnity and Legal Liability

Where a non-medical prescriber is appropriately trained, qualified and prescribes as part of their professional duties as detailed within their job description with the consent of the Trust, the Trust is held vicariously liable for the non-medical prescriber's actions.

6.2 Performance Concerns

Where a performance issue has been identified, which could impact upon the non-medical prescriber's ability to practice competently and safely, or the healthcare professional is unable to evidence their ongoing competence, a clinical or professional lead (who must be a registered prescriber) should arrange an urgent meeting with the healthcare professional. This initial meeting will inform any subsequent required actions or support. All cases will be reviewed on an individual basis and patient safety considerations must be paramount in any decision making. Where relevant the Trust's All Wales Capability Policy and Procedure should be considered.

6.3 Administration of Prescription Pads when working within:

6.3.1 **Rotational working in Primary Care and Health Board settings**: The Trust's non-medical prescribers working in rotational settings with the local Health Board, such as Primary Care, GP Out of Hours (GPOOH) or Integrated Care will register as a prescriber by notifying The NHS Wales Shared Services Partnership (NWSSP) (Appendix 1).

6.3.2 This process should be coordinated via the Practice/ Administration manager and the clinician should receive independent or supplementary prescription pads aligned to the practice or the health board where they are working.

6.3.3 The Practice or Health Board's Business Service Centre will retain responsibility for recording and ordering pads in addition to monitoring any discrepancies in the event of loss or theft.

6.3.4 **Non-medical prescriber working for the Trust**: Non-medical prescribers working within the Trust will register as a prescriber by notifying NWSSP (Appendix 2). This process will be supported by the medicines management team.

6.3.5 Prescribers will then receive independent or supplementary prescription pads aligned to the Welsh Ambulance Services NHS Trust.

6.3.6 The designated Head of Medicines Management in the Trust will retain responsibility for recording and ordering pads in addition to monitoring any discrepancies in the event of loss or theft.

6.3.7 A central register of practicing non-medical prescribers in the Trust will be held by the Head of Medicines Management and Professional Development Lead, which will include a current annual declaration review from each prescriber (Appendix 7).

6.3.8 Identification details or serial numbers of Trust prescription pads will be noted on the register against the name of the prescriber. Pads will be stored securely by the Head of Medicines Management at a central location. Prescription pads must be collected in person from the Head of Medicines Management and signed for, or transported by secure means or recorded delivery to a place of handover where signed receipt can take place.

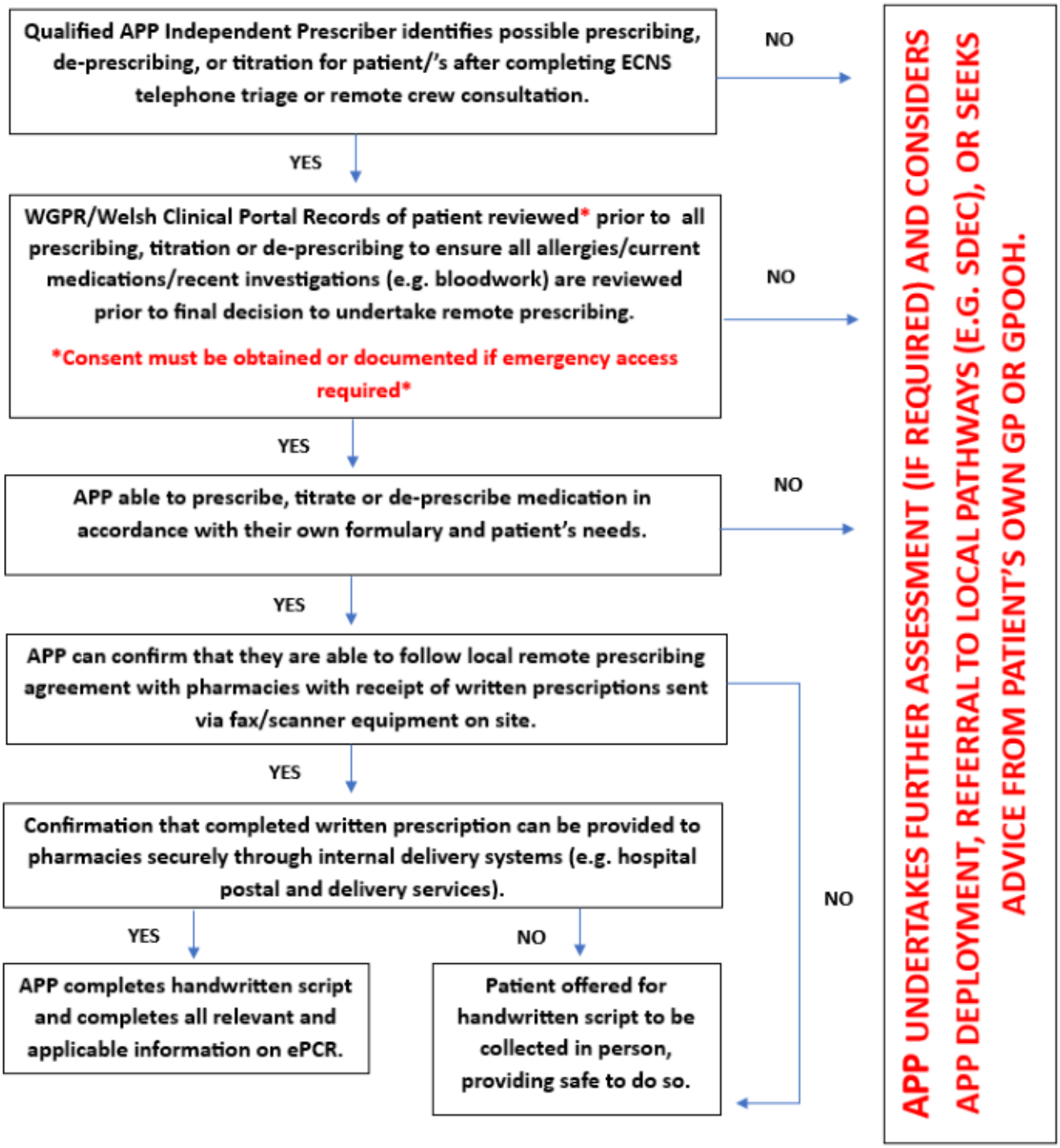
6.3.9 The Trust will ensure that mechanisms are in place to monitor the ordering, receipt, administration and circulation of prescription pads. These mechanisms must enable the rapid identification and reporting of any discrepancies to the Assistant Director for Clinical Development and the Assistant Director of Nursing. In circumstances where an order is not accurate or there has been loss or theft of prescription pads the process outlined in Appendix 3 must be followed.

6.4 Remote Prescribing

6.4.1 When working in WAST remote consultation settings e.g. Integrated Care/ Advanced Practice Navigator models clinicians should follow the flow chart below to co-ordinate the issuing of remote prescriptions:

Diagram at the top of the next page.

Advanced Paramedic Practitioner (APP) Remote Prescribing



6.4.2 In some instances WAST prescribing clinicians may work in collaborative settings within a health board e.g. integrated care hubs. In these settings clinicians may utilise their prescribing system/ software to undertake remote prescribing. Where this has not been agreed they will utilise the process above.

6.5 Documentation

6.5.1 The Trust recognises the importance of sound record management arrangements for both clinical and corporate records. The Trust's records are its corporate memory, providing evidence of actions and decisions and representing a vital asset to support daily functions and operations. Records support policy formation and managerial decision-making, protect the interests of the Trust and the rights of patients, staff and members of the public.

6.5.2 Records created are to ensure that the business of the Trust is carried out effectively and information is available to:

- Support the care process and the continuity of care
- Support day to day business which underpins delivery of care
- Support sound corporate and managerial decision making and provide evidence of decisions taken
- Meet legal requirements, including requests from service users under access to health records legislation
- Assist with clinical and other audits and learn lessons from past experience
- Support improvements in clinical effectiveness through audit and research.

6.5.3 Staff must ensure that all records, in particular patient confidential data (PCD), are kept secure at all times when being handled and/or transported between Trust locations and externally. All portable devices containing electronic records (e.g. Trust iPad) must be encrypted and the transportation of patient confidential paper records, particularly externally, must be kept to a minimum and not stored externally except under controlled conditions.

6.5.4 Records will be kept secure from unauthorised or inadvertent alteration or erasure and will be held in a robust format which remains readable for as long as records are required. In the majority of cases the record will be electronic and hard copies will only be kept on a temporary basis for local use. Electronic records will be stored in their respective databases or, in the case of unstructured data, on network drives with restricted access where required, especially with regard to PCD. Electronic documents must not be kept on local hard drives as there is a risk that they may be lost, they are not controlled, and this prevents access to others.

6.5.5 Records and the information within them will be accessible so they can be efficiently retrieved by those with a legitimate right of access, for as long as the records are held by the organisation. Trust records will only be disclosed by the Trust's in compliance with the appropriate legislation and regulations.

6.5.6 Four core areas of prescribing practice will be collected:

- Initiation of a new medication
- Titration of an existing dose of patient's medication

- Prescribing outside of current PGD remit
- Ceasing/ Stopping a patient's medication

6.5.7 A designated prescribing section has been included into the electronic Patient Clinical Record (ePCR) record to audit prescribing practice data in the organisation and ensure a robust process for review.

6.5.8 All clinicians who prescribe must include the details of their prescribing discussion/ rationale and decision on the individual ePCR record.

6.5.9 The non-medical prescriber should:

- Apply the documentation standards required by the healthcare professional's regulatory body.
- Adhere to the Trust's standards of record creation, completion, transportation and securing of patient confidential data.
- Record the medicines prescribed on the electronic patient care record.
- Unless by exception, non-medical prescribers should always document the generic name of a medicine on the prescription.
- When working remotely ensure prescriptions are issued in conjunction with local arrangements (as per remote flow chart).

6.6 Co-Production

- When prescribing, the healthcare professional is accountable and responsible for fully informing the patient in relation to their treatment options, so that they are able to make an informed decision and consent to the treatment offered.
- The non-medical prescriber is responsible for making "every contact count" by offering relevant and appropriate health information when prescribing.

6.7 Continuing Professional Development (CPD)

- Maintaining compliance with the Trust's requirements for CPD and mandatory training to include information governance and record keeping.
- Demonstrate ongoing competence to prescribe by maintaining a portfolio of evidence (required for annual non-medical prescriber declaration/authority approval to prescribe or if performance issues are raised).

6.8 Adverse Reactions

Where a patient experiences an unexpected or significant reaction to the Trust's non-medical prescriber's prescribed medicine, the healthcare professional should:

- Implement appropriate treatment to minimise the reaction.
- Inform the patient's GP.
- Complete a Trust incident form on DATIX.
- Report the incident using the Medicines and Healthcare Products Regulatory Agency Yellow Card Reporting Scheme (www.yellowcard.gov.uk)

6.9 Change of role or termination of contract

6.9.1 Adherence and reference to the Trust's Starters, Movers and Leavers protocol (in development) is advised.

6.9.2 Where a Trust non-medical prescriber is changing their role, a clinical or professional lead (who must be a registered prescriber) will review the appropriateness of continued non-medical prescribing practice relative to any planned change in scope of practice. In order to continue in the role of a Trust non-medical prescriber, this requirement must be annotated in their new job description. If a decision is made to discontinue their role as a non-medical prescriber, they should be removed from the Trust's register of non-medical prescribers.

6.9.2 Where a Trust non-medical prescriber is leaving the organisation, their clinical, regional or professional lead should inform the designated Trust Head for Medicines Management, so that they can be removed from the Trust's register of non-medical prescribers.

6.9.3 In all cases, where a non-medical prescriber is being removed from the Trust's register of non-medical prescribers, their prescription pad must be returned to the Head of Medicines Management (Appendix 4) by secure means or recorded delivery and the following actions must be taken:

- Identification details or serial numbers of prescriptions and the name of the prescriber must be noted on the database as returned and marked as void.
- The pads must be shredded and destroyed in the presence of a witness and annotated as "destroyed" on the prescriber database by date and details of the witness noted.

6.10 Bank or Agency Non-Medical Prescribers (Appendix 5)

6.10.1 Generally, non-medical prescribing is not a routinely recommended practice for bank or agency workers, however, exceptions may be made with the approval of the individual's named professional lead in the Trust and the Trust's Executive Director of Paramedicine in accordance with this policy. In these circumstances, there must be evidence of:

- A regular, confirmed and monitored working pattern as a non-medical prescriber (external to the Trust) and a minimum of two working shifts/sessions per month (pro-rata) within the Trust to maintain assurance and monitor competency. If the bank or agency worker has not made themselves available for a period of three months, this will be reviewed by a named clinical, professional or regional lead (who must be a prescriber) supported by the Human Resources Department.
- Submission and authorisation of a non-medical prescribing notification to practice form to NWSSP (Appendix 1 or Appendix 2)
- Evidence of a full appraisal and review of non-medical prescribing competence in line with the requirements of this policy, supported by competence verification and aligned to the RPS Competency Framework for all Prescribers (2021)
- Continuing yearly submission of the Trust's non-medical prescriber annual review form (Appendix 7), evidencing ongoing competence in line with the requirements of this policy, supported by competence verification and aligned to the RPS Competency Framework for all Prescribers (2021)

6.11 Gifts and benefits

6.11.1 Under law and professional regulation, non-medical prescribers must not advertise or promote medicines, or allow any commercial inducements to impact upon their professional or ethical judgement.

6.11.2 The Trust's employees are required to declare any relevant and material interests and any offers of gifts and hospitality together with any other interests as deemed appropriate by the Board Secretary. It is recommended that if in doubt, a declaration of interest should be made.

6.12 Self or Non-Patient Prescribing

6.12.1 Non-medical prescribers are prohibited from prescribing for:

- Themselves
- For anyone with whom they have a close personal or emotional relationship (family member, partner or close friend), other than in an exceptional circumstance where a second, independent and suitably qualified competent person should check the accuracy of the medicines prescribed (in line with the non-medical prescriber's scope of practice and professional guidance). It is recommended that the prescribing responsibility is devolved to the second or independent suitably qualified person where practical, when advice is sought.

7 EQUALITY

7.1 In accordance with the Equality Act 2010 this policy has been subjected to an EqIA. This has enabled resources to be targeted effectively and where required help to reduce inequalities. The EqIA is a process to find out whether a policy will affect people differently on the basis of their 'protected characteristics': age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion, sex or sexual orientation and if it will affect their human rights.

7.2 Evidence gathered at the initial stages, by undertaking an initial screening, has determined the relevance of the policy and how it affects people as service users, members of the public and as employees of the Trust and has indicated that a full EqIA is not required. The policy will have a positive effect on all relevant groups.

8 TRAINING AND IMPLEMENTATION

8.1 Non-Medical Prescriber Training

8.1.1 To be eligible to undertake a non-medical prescribing course, supported by the Trust, the healthcare professional must:

- Be a registered paramedic, physiotherapist, pharmacist, first level registered nurse or midwife, with the minimum post registration experience specified by each respective professional body.
- Have the support of the Trust, having identified a need for non-medical prescribing in their clinical area and annotated as such in their job description.

- Be able to evidence current clinical, pharmacological and pharmaceutical knowledge relevant to their intended area of practice and be competent and experienced in the clinical area they are employed to prescribe.
- Attend a selection interview to attend the course.
- Have access to a clinical, professional or regional lead in the Trust, who must be a registered prescriber.

8.2 Professional Registration of Non-Medical Prescriber Qualification

8.2.1 On successful completion of an accredited non-medical prescriber training program, the awarding body will notify the healthcare professional's relevant registering body. The healthcare professional is required to ensure:

- That their qualification has been accurately and completely annotated on their professional regulatory body's register
- That they do not commence practice as a non-medical prescriber until their prescribing status has been formally verified and approved according to the process set out in Appendix 1 or Appendix 2 of this policy, which includes alignment to a relevant role and job description or agreed amendments, and the assignment of a named prescribing clinical, professional or regional lead.

8.3 Maintaining Non-Medical Prescriber Status

8.3.1 The Trust's non-medical prescribers should comply with and be able to evidence their ongoing compliance with the Royal Pharmaceutical Society of Great Britain: A Competency Framework for all Prescribers (2021) by e-portfolio. Compliance will be reviewed and confirmed on an annual declaration basis (Appendix 7) with their respective clinical, professional or regional lead, who must be a registered prescriber.

8.3.2 For prescribers that are new to practice (within the first 3 years of practice) or have ongoing mechanisms to support their clinical practice, an annual appraisal (or more if required) will support the clinician to maintain and demonstrate their non-medical prescribing status. Hereafter it will move to a three-year appraisal process (with annual declaration) unless there is a clinical need or prescriber request to have an appraisal prior to this date.

8.3.3 As part of maintaining prescribing competence there will be an annual requirement for prescribers to:

- Submit an annual declaration which supports their current formulary of practice.
- Submit a minimum of **three** reflective accounts of prescribing practice or prescribing awareness around three different medicines on their formulary to evidence competence and growth in those areas of practice.
- Complete an annual eLearning module on antimicrobial resistance. The module to complete will be updated annual and distributed accordingly.
- The above should be made available on request by the prescriber's respective professional, clinical or regional leads.

8.3.4 Prescribers will be required to maintain current practice, underpinned by evidence, local and national guidelines and policies in the management of the conditions for which they prescribe.

8.3.5 Prescribers are obligated to meet the standards and requirements set out by their respective professional regulatory bodies.

8.3.6 Clinical Supervision will be available regularly to support the continued development of non-medical prescribers within the organisation.

8.4 Lapsed Non-Medical Prescribing Practice

8.4.1 Where a qualified non-medical prescriber has not prescribed over a twelve-month period, in order to start prescribing again, they must:

- Seek approval from their respective clinical, professional or regional lead (who must be a registered prescriber) to return to non-prescribing practice (approval may be influenced by the healthcare professional's current area of clinical practice and the likelihood of their continuing opportunity to maintain the required levels of competency)
- Agree a period of supervised practice with their respective clinical, professional or regional lead (maximum six months), with a named supervisor (who must be a registered prescriber) who will review their competency against the Royal Pharmaceutical Society of Great Britain: A Competency Framework for all Prescribers (2021)
- Complete a portfolio evidencing their compliance with the Royal Pharmaceutical Society of Great Britain: A Competency Framework for all Prescribers (2021)
- On completion of the period of supervised practice, the respective clinical, professional or regional lead (who must be a registered prescriber) will review the healthcare professional's competency with them to inform whether they can be re-approved to practice as a Trust's non-medical prescriber.

9. AUDIT AND MONITORING

9.1 Prescribing in the community is monitored by NHS Shared Services Partnership Wales, using the CASPA software systems. The Trust must ensure that this data source is accessed, providing, at a minimum, annual reports of:

- A prescribing data extract for all prescribed medicines (i.e. name, form and strength of medicine)
- Dip sample on the quality of prescription completion and compliance with professional standards and legislative requirements
- Non-medical prescriber performance analysis (i.e. numbers of prescriptions issued by each healthcare professional, total prescriptions across the Trust and if required, by Health Board area)
- Measurement of the quality and efficiency of the Trust's non-medical prescribing against NHS Wales prescribing performance indicators
- Monitoring and audit of Controlled Drug prescribing will be undertaken in accordance with The Controlled Drugs (Supervision of Management and Use) (Wales) Regulations 2008 and is the responsibility of the Controlled Drug Accountable Officer or designated representatives.

9.2 TerraPace ePCR contains an advanced practice tab with a dedicated section on prescribing practice. Annual auditing of prescribing practice through this mechanism will also be made available.

9.3 Regular programs of audit of compliance with information governance, records management standards and prescribing practice will be established. The Head of Medicines Management must include non-medical prescribing audits as part of the Trust's annual clinical audit plan, reporting these results through the Advanced Clinical Practice Delivery Group and Optimising Care Group and available for assurance.

10. ANTI-FRAUD AND CORRUPTION CONCERNS

10.1 The Trust is committed to taking all necessary steps to counter fraud, bribery and corruption within the Trust. Staff should report suspected incidents of fraud and corruption to the Trust Local Counter Fraud Specialist, who will be happy to discuss any issues or concerns. Alternatively, staff may contact the confidential NHS Fraud and Corruption Reporting line 0800 028 40 60; or on-line reporting facility www.reportnhsfraud.nhs.uk Fraud investigations may lead to disciplinary action and / or prosecution and civil recovery procedures

11. RESPONSIBILITIES

11.1 **Chief Executive Officer**
The Trust's Chief Executive Officer is legally accountable for the quality of care that patients receive and for ensuring patient safety.

11.2 **Executive Director of Paramedicine**
The Trust's Executive Director of Paramedicine has Trust Board responsibility for all aspects of non-medical prescribing and is responsible for overseeing the development, implementations and sustainability of non-medical prescribing within a safe environment. The Executive Director of Paramedicine has delegated responsibility as the Trust's Controlled Drugs Accountable Officer (CDAO).

11.3 The Trust's Executive Director of Paramedicine has Trust Board responsibility for providing overarching professional leadership and assuring the provision of safe non-medical prescribing by Trust paramedics.

11.4 **Executive Director of Quality and Nursing**
The Trust's Executive Director of Quality and Nursing has Trust Board responsibility for providing overarching professional leadership and assuring the provision of safe non-medical prescribing by Trust nurses and midwives.

11.5.1 The Executive Director Paramedicine and the Executive Director of Quality and Nursing
The Trust's Executive Director of Paramedicine and Trust's Executive Director of Quality and Nursing will work together to ensure that appropriate and effective professional and clinical leadership is in place for any non-medical prescriber healthcare professionals, employed by the Trust, who are not registered paramedics, nurses or midwives (e.g. pharmacists or physiotherapists).

11.4 **Professional Development Lead and Assistant Director of Quality and Nursing**
The Trust's Professional Development Lead and Trust's Assistant Director of Quality and Nursing have delegated responsibility for:

- Identifying and supporting new approaches to the enhancement of patient care and service improvement through non-medical prescribing
- Involving patients and the public in the development of non-medical prescribing practice
- Providing access to professional pharmaceutical support, where required
- Maintaining an up-to-date register of non-medical prescribers working within the Trust for their professional groups
- Ensuring that non-medical prescribing roles are accurately annotated in job descriptions
- Maintaining robust processes for the initial and ongoing monitoring of non- medical prescriber's qualifications and evidence of competency by clinical leads who are registered prescribers within the Trust.
- Ensuring that there are sufficient numbers of places on training programs to meet identified resourcing requirements
- Monitoring non-medical prescribing activity, identifying any themes or trends that suggest that registrants may be prescribing outside of their areas of competency or the legislative frameworks that govern their practice (i.e. via individual prescribing data)
- Monitoring non-medical prescriber practice to verify that prescribing practice is in accordance with current, evidence-base guidelines
- Overseeing robust processes for monitoring and managing concerns arising from complaints and critical incidents relating to non-medical prescribing
- The regular review and ongoing development of the Trust's non-medical prescribing policy

11.6 Additionally, the Assistant Director for Clinical Development and Assistant Director of Quality and Nursing will provide professional leadership to the Trust's non-medical prescribers, ensuring:

- A coordinated approach to the development and maintenance of the Trust's non-medical prescribing roles
- Newly qualified non-medical prescribers have access to and undertake mentored supervision during the first twelve months of their prescribing practice
- The Trust's non-medical prescribers have access to sufficient clinical support and supervision to practice safely
- The provision of and access to suitable continuing professional development opportunities for the Trust's non-medical prescribers, towards maintaining and improving competence in prescribing

11.7 **Clinical, Regional and Professional Leads**

Clinical and Regional Leads, or those professionally responsible for overseeing and reviewing standards of clinical practice across an area (e.g. region or health board) or centre (e.g. call centre or clinical contact centre), are responsible for providing evidenced assurance to their respective Assistant Directors for Clinical Development or Quality and Nursing that this policy is being applied effectively and that measures are in place to:

- Ensure a clinical, professional or regional lead is a registered prescriber if responsible for assessment of prescribing competence, annual review or verification of practice for any non-medical prescriber
- Manage performance concerns

- Monitor competency to practice safely
- Synchronously review the Trust's register of non-medical prescribers
- Cascade appropriate medicines related information (e.g. bulletins, notifications, papers or alerts) via email to all non-medical prescribers in a timely manner via the Head of Medicines Management
- Ensure the circulation list of staff who are to receive the bulletins, notifications, papers or alerts is regularly updated and current
- Cascade organisational learning from concerns and critical incidents via email to all non-medical prescribers in a timely manner
- Offer regular and effective clinical supervision opportunities
- Provide regular learning events or opportunities
- Arrange a minimum of an annual non-medical prescribing meeting for the Trust's non-medical prescribers, delivering case studies, lectures and medicines updates

11.8 **Head of Medicines Management**

- Retain responsibility for recording, ordering and issuing prescription pads in addition to monitoring any discrepancies in the event of loss or theft: Reporting loss or thefts to the Assistant Director for Clinical Development, the Assistant Director Quality and Nursing and Head of Medicines Management
- Maintain a central register of all Trust non-medical prescribers to include a current annual declaration and updates regarding staff starters/movers and leavers
- Ensure the security of stored prescription pads at a central location and ensure security of prescription pads when issued to non-medical prescribers or returned by movers or leavers for destruction
- Facilitate non-medical prescribing audits as part of the Trust's annual clinical audit plan and ensure reporting through the Medicines Management Group
- Cascade appropriate medicines related information such as bulletins, notifications, papers or alerts.

11.9 **Line Managers**

Line managers, who may not themselves be non-medical prescribers, are responsible for ensuring that any issues that could impact upon the healthcare professional's ability to practice competently are reported to a respective clinical, regional or professional lead in the Trust who is a registered prescriber.

11.10 **Non-Medical Prescribers**

Non-medical prescribers are required to prescribe according to the Royal Pharmaceutical Society of Great Britain: A Competency Framework for all Prescribers (2021), statute, local policy and professional registrant body standards, with an emphasis on the following points:

11.11 Accountability: Non-medical prescribers are responsible and accountable for prescribing according to the standards and requirements of their professional regulatory bodies and the law at all times, including:

- Acting within the boundaries of their individual knowledge, competence and prescribing rights as registered professionals in their own fields of practice.
- Being accountable for all aspects of their prescribing decisions. They must be able to recognise and deal with the consequences that might result in inappropriate prescribing

- Responsibility for initiating care and prescribing safely from the British National Formulary or the Nurse Prescribers Formulary (community practitioner nurse non-medical prescriber)
- Taking a prudent, cost-effective approach to prescribing that meets the needs of the patient
- Being familiar with and adhere to the Trust's Non-Medical Prescribing Policy (Independent, Supplementary and V100/V150/V300)
- Delivering appropriate, evidence based and safe care
- Maintain security of prescription stationery (including not pre-signing blank forms) and report any loss or suspected theft of prescriptions as per Appendix 3.
- Return unused prescription pads (as per 6.4) if post is vacated or circumstances change.

12 REFERENCES

Royal Pharmaceutical Society. A Competency Framework for all Prescribers. London: 2021

The Nursing and Midwifery Council. Standards of proficiency for nurse and midwife prescribers. London: 2019

The Health and Care Professions Council. Standards for prescribing. London: 2019Welsh Government. A Healthier Wales: our Plan for Health and Social Care. Welsh Government: Cardiff: 2018

Welsh Government. Non-medical prescribing in Wales: A guide for implementation Welsh Government: Cardiff: 2017

Welsh Government. The Controlled Drugs (Supervision of Management and Use) (Wales) Regulations 2008

APPENDICES

Appendix 1: NWSSP registration form for new non-medical prescriber in Primary Care

Use this form to advise NWSSP of details of new independent prescribers or changes in circumstances. ***Note:*** *One form should be completed for each Health Board from which the prescriber will work.*

Once complete, please send this form to the Executive Director of Paramedicine at WAST for authorisation.

ACTION (please tick as appropriate)	
New qualification	
Ceased working for WAST	
No longer working as independent prescriber	
Change of Surname	

SECTION A – Prescriber Details

Professional Registration Body & Number			
Full Name			
Title (Mr, Mrs, Miss etc)		Contact telephone number	
E-mail address			
Profession (please tick one box only)	☐ Nurse ☐ Pharmacist ☐ Paramedic ☐ Physiotherapist		
Independent Prescribing Examination Pass Date			

SECTION B – WAST Details

Start Date in WAST See note 1	
End Date in WAST	

Signature of Independent Prescriber: _____

WAST Use Only:

Authorised by (Full name):
See note 2 _____ **Signature :** _____

Position held at WAST: _____

Appendix 2: NWSSP registration form for new non-medical prescriber in WAST

Use this form to advise NWSSP of details of new independent prescribers or changes in circumstances. ***Note:*** *One form should be completed for each Health Board from which the prescriber will work.*
Once complete, please send this form to the Executive Director of Paramedicine at WAST for authorisation.

ACTION (please tick as appropriate)	
New qualification	
Ceased working for WAST	
No longer working as independent prescriber	
Change of Surname	

SECTION A – Prescriber Details			
Professional Registration Body & Number			
Full Name			
Title (Mr, Mrs, Miss etc.)		Contact telephone number	
E-mail address			
Profession	☐ Paramedic ☐ Nurse ☐ Pharmacist ☐ Physiotherapist		
Independent Prescribing Examination Pass Date			

SECTION B – WAST Details	
Start Date in WAST See note 1	
End Date in WAST	

Signature of Independent Prescriber:

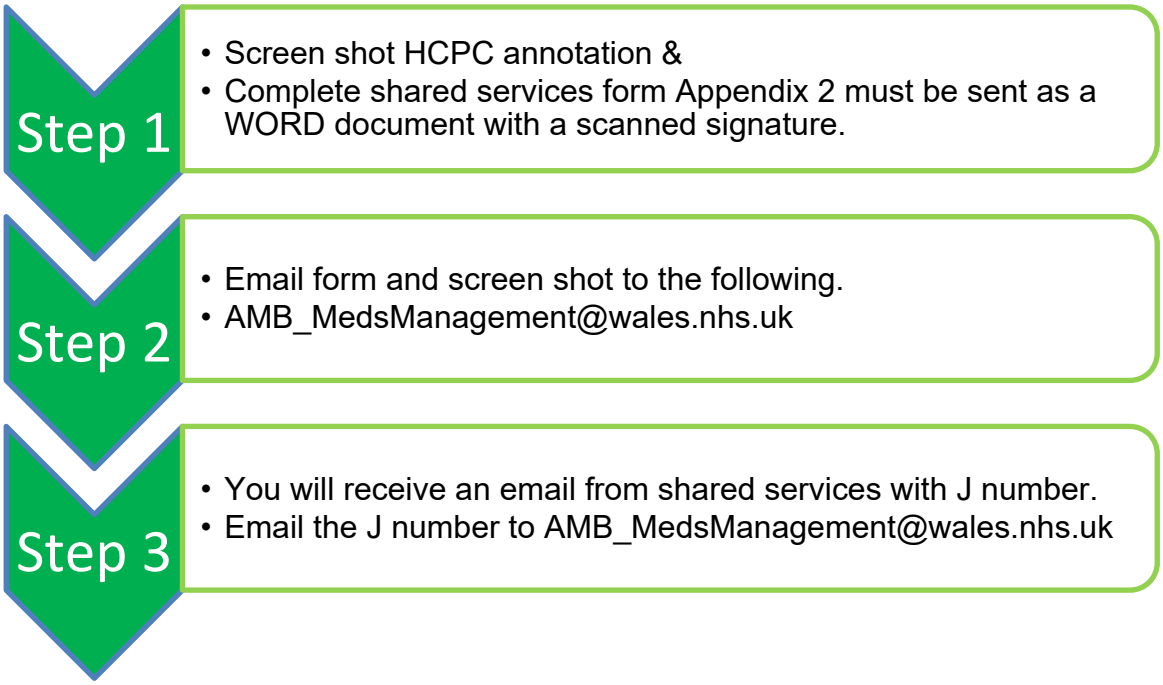
_____

WAST Use Only:

Authorised by (Full name): _____ **Signature:** _____
See note 2

Appendix 3 Process for becoming a new prescriber for WAST

Congratulations on passing your non-medical independent prescribing module. Please follow the steps below to gain your prescription pad. If you are working in primary or urgent care as part of a rotational model, then you should also speak to the practice manager to gain an additional 'J' number to enable prescribing with them.



- Failure to follow the above process will lead to an unnecessary delay in your ability to prescribe.
- Your prescription pad will be ordered and sent out to you by registered post, once received, the receipt form that accompanies the pad must be signed, scanned, and emailed back to: AMB_MedsManagement@wales.nhs.uk
- When clinicians are down to the last 10 prescriptions email AMB_MedsManagement@wales.nhs.uk for a replacement.

Appendix 4: Lost, found, stolen or fraudulent use of prescription pads

Non-medical prescriber or "another" becomes aware that a prescription pad has been:

- lost
- found
- stolen
- used fraudulently

Always refer to NHS Wales Shared Services Partnership (NWSSP) most up to date guidance and standard operating procedures to manage prescription pad incidents
https://nwssp.nhs.wales/ourservices/primary-care-services/primary-care-services-documents/ccps-documents/pharmacy-ip-services/aw-pip-security-admin-protocol-v31/h

Notify:

- "In-hours": immediately email your/the practitioner's named professional lead and the Trust Head of Medicines Management, tagging the message as of "high importance ("!") and attempt to speak to either party as soon as possible
- "Out-of-hours": immediately speak to CLINICAL ON CALL on 0300 123 4414 and email named professional lead and Trust Head of Medicines Management, tagging the message as of "high importance ("!")
- Complete a DATIX incident form outlining the circumstances of the incident and the measures taken to locate/retrieve the pad, ensuring "yes" is selected for "is there an information security issue relating to this incident" on the reporting form

All incidents relating to prescription pads must be reported to the Assistant Director of Clinical Development, the Information Governance Department and the registrant's professional lead:

Paramedics – Assistant Director of Clinical Development
Nurses and Midwives – Director of Quality and Nursing
Pharmacists & Physiotherapists – Director of Quality and Nursing

- An incident investigation must be completed for any irregularity or issues relating to prescription pads
- The Head of Medicines Management will inform NWSSP

In all cases of lost, stolen or fraudulently used prescription pads Contact Police

Appendix 5: Non-medical prescriber terminating contract/transfer to non-prescribing role/return of prescription pads

Welsh Ambulance Services NHS Trust
Non-Medical Prescriber Terminating Contract / Transfer to Non-Medical Prescribing Role / Return of Prescription Pads

Name of non-medical prescriber:	
Work address/base:	
Registration number e.g. HCPC/NMC Pin Number:	
Date of Birth:	
Reason for Return: e.g. termination of contract; role change	
Permanent change (please tick)	
Temporary change	

Type of Prescriber (please tick)	Community	Supplementary	Independent

Return and identification of new prescription pads	
Serial Numbers:	Returned to:
Return and identification of used prescription pads	
Serial Numbers:	Returned to:

Confirmation of return of pads and removal of practitioner from central register:

Signature	**Print name**	**Date**
Named Professional Lead:		
Named prescribing Lead:		
Trust Head ofMedicines Management:		

Non-Medical Prescribers please return completed form, with prescription pads to:

The Head of Medicines Management by hand or secured

Name of Signature of lead on

Appendix 6: Bank or Agency non-medical prescriber flow chart

Conditions required to request authority to be a Trust non-medical prescriber:

- A regular, confirmed and monitored working pattern as a non-medical prescriber (external to the Trust) and a minimum of two working shifts/sessions per month (pro-rata) within the Trust to maintain assurance and monitor competency within a three month period.
- Full appraisal and review of non-medical prescribing competence aligned to the Trust's requirements (Appendix 7) and RPS competencies.

Required Approvals:

- The Trust's Executive Director of Paramedicine
- The Trust's named professional lead (who must be a registered prescriber)

Authority:

- Submission and authorisation of appendix 1 & 2

Continuing authority to non-medically prescribe:

- Annual submission of the Trust's non-medical prescriber annual review form, evidencing ongoing competency verification (Appendix 7) and completion of prescriber specific competencies within the trust
- Continuing evidence of a minimum shift pattern within a three-month period within the Trust

Appendix 7: Non-Medical Prescribing Annual Declaration process

The Trust's - Declaration of competency to undertake non-medical independent prescribing.

The declaration process is to be completed by all non-medical prescribers on an annual basis. An appraisal will be built into a clinician's development for the first three years of becoming a prescriber in WAST, thereafter moving to a three-year appraisal process with the clinical, professional or regional lead who is a registered prescriber.

Prior to your annual declaration the following should be completed and available for review on your eportfolio:

- Submit an annual declaration via MS form below which supports the NMP current formulary of practice.
- Submit a minimum of **three** reflective accounts of prescribing practice around three different medicines on their formulary to evidence competence and growth in those areas of practice.
- Complete an annual eLearning module on antimicrobial resistance. The module to complete will be updated annual and distributed accordingly.

Once the above is complete email: - amb_prescribing@wales.nhs.uk to book a mutually convenient appointment for your appraisal.

https://forms.office.com/e/CwbRm3X3D4

Premises and Vehicle Cleanliness Policy

Policy Number:	061	**Version No:**	1.13	**Supersedes:**	1.12
Date of Approval:	TBA	**Review Date:**	3years from approval	**Impact Assessments Completed:**	**Yes**
Classification of Document:	Corporate	**Type of Document:**	Policy	**Approved by:**	**QuEST**
Brief Summary of Document:	This document is to outline the Trust's intentions and approach to standards of cleanliness and decontamination for ambulance premises and vehicles. Alongside this policy will sit standards of cleaning for both premises and vehicles and will be in line with National Standards of Cleanliness for NHS establishments.				
Scope:	This Policy applies to all staff that are directly employed by Welsh Ambulance Services University NHS Trust and encompasses Non-Executive Directors, bank staff, volunteers, contractors, and all those that have legal responsibilities for students and trainees.				
To be read in conjunction with:	1. Infection Prevention and Control Policy – (change all links when completed to updated versions). 2. Medical Devices Policy 3. Vehicle Cleaning Standards 4. Vehicle Decontamination SOP 5. High Consequence Infectious Disease SOP 6. Infection Prevention and Control Sharps Policy 7. Occupational Exposure to blood and bodily fluids 8. A-Z Common Diseases 9. Infectious Disease Outbreak Management SOP 10. Infection Prevention and Control Guidance. Safe Clean Care. 11. Uniform Dress Code SOP 12. Waste Management Policy (in development)				
Owning Committee	Quality, Safety and Patient Experience Committee				
Policy Led: **Trade Union Lead:**	Louise Colson Hugh Parry	**Job Title:**	Head of Infection Prevention and Control Trade Union Partner		
Executive Director:	Liam Williams	**Job Title:**	Executive Director of Quality and Nursing		

Version Control Sheet

Version	Date	Author	Summary of Changes
1.0	14/12/2017	L Neville	Framework of Policy from T&F Group
1.1	12/08/2018	L Neville	Changes to title of Document
1.2	14/11/2018	L Neville	Changes made from comments from Task & Finish Grp
1.3	13/12/2018	Group	Refocus of language to a strategic level
1.4	26/03/2019	L Colson	Final Review for Policy Group submission
1.5	16/05/2019	Julie Boalch	Minor template amendments
1.6	17/06/2019	Louise Colson	Contents page adjustments
1.7	03/06/2019	Julie Boalch	Added hyperlink on front cover
1.7	03/07/2019	Louise Colson	Revision based on consultation comments
1.8	02/08/2019	Louise Colson	Revision based on comments following 2nd Policy Group meeting
1.9	01/03/2022 09/09/2022	Sarah P Jones Louise Colson	Three-year policy review Three-year policy review
1.9	14/09/2023	Louise Colson	For approval at policy group to progress to the next stages of approval
1.10	19/02/2024	Louise Colson	Review with Estates team following presentation at EMT and further clarification from Estates. • Section 4.2 of Version 1.9 Removed, now included in the Scope Page 7 • Page 10Cleaning activities added to roles and responsibilities for clarity. • 6.5 Cleaning Procedures to Control the environment Page11, this section rewritten to ensure it accurately represents current processes in the Estates team and cleaning contractors. • References to HEPA filters removed on request of Estates due to relevance to this Trust. • Refences to Asbestos removed - not relevant to Trust • 8.3 Adjustments made to training outcomes. • 8.5 Significant changes made to training for Contracted staff to align with Trust's current practices. Reference to the Buildings Cleaning Group added to Section 9, audit and monitoring. 10.5 Buildings Cleaning Manager, section amended to reflect the Estate's structure and functions. Section 10.6 from Version 1.9 removed. • Updated EQIA completed and signed off.

Version	Date	Author	Summary of Changes
1.11	23/04/2024	Lisa Trounce	Crown Badge and Trust Logo replaced. Header and footer amended. Policy Approval Route amended to include historical information. Significant formatting changes made. Comments added outlining discussions / agreed actions from Policy Group Meeting 23/04/2024 – to be progressed by Policy Lead.
1.12	24/04/2024	Louise Colson	Completion of agreed amendments from the Policy Group meeting 23/04/2024. • Amendments to the Scope of Policy pages 1 and 3.1. • Contents Page Formatting • Task and Finish membership updated. • General spell check and formatting.
1.13	25/04/2024	Lisa Trounce	Minor formatting changes made (i.e. corporate colour palette, and paragraph alignment) prior to submission to ELT and Committee for approval. Key words expanded.

Key Words	Premises, Vehicle, Cleanliness, Cleaning, Control, Estate, Site, Station

Impact Assessment Reviews

Area	Date of Review	Name of Reviewer
Counter Fraud	21/05/2019	Carl Window Unchanged 14/09/2023
Information Governance		
Records Management	5/06/2019	Judith Birkett Unchanged 14/09/2023
EqIA / Welsh Language	14/03/2024	Updated and on new template approved by K. Cobley
Estates		09/02/2024
Environment		
Training		

Task and Finish Group Members

Name	Job Title
Louise Colson	Head of Infection Prevention & Control
Laurence Neville	Clinical Quality/Infection Prevention & Control Manager
Hugh Parry	Trade Union Partner
Susan Woodham	Head of Estates & Facilities
Kataya Miura	Facilities and Estates Manager
Richard Davies	Assistant Director Capitol and Estates
Jonathan Johnston	Operations Manager, Community Support

Policy Approval Route

Where	When	Why
Virtual Policy Group	14/05/2019	Review Initial Draft
Policy Group	21/05/2019	Review Initial Draft
Policy Group	23/07/2019	Review Post Consultation
Trade Union Partners Forum	06/09/2019	For WASPT Agenda
WASPT	23/09/2019	Recommend for Approval
EMT	09/10/2019	Recommend for Approval
QuEST	29/11/2019	Approval and adoption
Policy Group Meeting	27/09/2022	3year review - Approved (Minor changes)
EMT	25/10/2023	Input and further clarification required from Estates
Policy Group	23/04/2024	Recommend for Approval
ELT	08/05/2024	Recommend for Approval
QuEST	13/08/2024	Approval

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

CONTENTS

1. INTRODUCTION

1.1 The Welsh Ambulance Services NHS Trust (WAST) is committed to a zero-tolerance approach to Healthcare Associated Infections. The Trust seeks to constantly improve service delivery and places a priority on quality. Staff within the Welsh Ambulance Service Trust (WAST), irrespective of their role, must be fully engaged with good infection prevention and control practices. In order to promote best practice for those staff providing services to the public, the organisation is committed to embedding national standards of cleanliness and decontamination for premises and vehicles.

1.2 Healthcare settings contain a diverse population of microorganisms. Areas/items shared by different patients/staff/clients, (e.g., toilets), can become contaminated with body fluids, secretions, and excretions during the delivery of care and, therefore, must be managed appropriately. Measures are required to limit such areas/items from becoming potential reservoirs for harmful microorganisms which, in turn, could lead to the potential contamination and infection of staff, patients and visitors. Control of the environment is one of the ten elements of Standard Infection Control Precautions, (SICPs)

1.3 A clean healthcare environment is of paramount importance to patients and staff. Healthcare environments must be well maintained and be kept at acceptable national levels of cleanliness. The environment must minimise the risk of healthcare associated infection to patients, staff and visitors and must emphasise high standards of hygiene reflecting best practice initiatives. Trusts are accountable for the effectiveness of the cleaning services, with local ownership of individual areas, performance of this is done through monitoring and auditing processes.

1.4 Decontamination and cleaning of Trust vehicles, medical equipment and of trust premises is essential to the effective delivery of safe patient care regardless of the care environment. Traditionally the cleaning has been centred on guidance focusing on acute hospital and other healthcare settings and there is a need adapt the guidance to the different type of environment within the ambulance service e.g., ambulance vehicles and premises including non-clinical settings. This policy will set a standard for cleanliness that can be audited, and outcomes measured. Therefore, this document is designed to act as a resource for staff, and to help identify the relevant policy, guidance, and Standard operating Procedures (SOPs) for ambulance premises, vehicles, and storage areas.

2. POLICY STATEMENT

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

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

a) Develop a culture where cleanliness is everyone's business.
b) Ensure there is strong leadership throughout all levels of the trust to uphold the principles of maintaining a clean environment across all disciplines.
c) Improving quality and safety; embedding cleaning practices throughout the trust both within premises and vehicles.
d) Measure success: Maintain audits and measure standards of cleanliness within the trust and identify indicators of good practice e.g., MRD practices.
e) Information sharing and transparency; building and maintaining confidence of the public, service users & Health Boards/Trusts.
f) Ensure all staff are suitably trained and educated in IPC associated infections in accordance with their role and the environment they work e.g., clinical/non-clinical and in accordance with UK Core Skills Training Framework

2.3 The Health and Care Standards **(WG,** 2015) state that we:

- Must embrace the principles of co-production and prudent health care,
- Offer a common language to describe what high quality, safe and reliable healthcare services look like.
- Enable a person-centred approach by focusing on outcomes for service users and driving care which places people at the centre of all that the service does.

2.4 With safe and reliable healthcare as a theme, the trust will ensure that all stakeholders have a clean and serviceable environment in which to operate.

2.5 This policy will apply to all Trust vehicles and premises, it will however not apply to vehicle workshops themselves and station garages as this is a Health and Safety function under the health and safety at work act 1974.

3. SCOPE

3.1 This policy applies to all staff that are directly employed by the Welsh Ambulance Service University NHS Trust (WASU NHS Trust) and encompasses Non-Executive Directors, bank staff, volunteers, and contractors and all those that it has legal responsibility for.

3.2 The Trust is committed to the principles of Equality and Diversity and will strive to eliminate unlawful discrimination in all its forms. We will strive towards demonstrating fairness and Equal Opportunities for users of services, carers, the wider community, and our staff, in addition to this the Trust is also committed to ensuring Environmental compliance and sustainable working practices.

3.3 The application of the policy will vary according to the working environment of the member of staff. However, this and the Infection prevention & Control policy should form a part of everyone's daily practice and all need to be aware of its implications for their workspace.

3.4 Acknowledgements/ Limitations of Policy

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

4. AIM

4.1 The aim of this policy is to provide guidance and governance around vehicle and premises cleaning. Through the audit process the board will be assured that the vehicles and Ambulance premises are providing a safe and reliable environment that reduces the risk of HCAI for patients, public and staff. It aims to ensure all elements of the IPC Code of Practice are consistently and diligently applied in the Trust to reduce the transmission of HCAI's, recognising the unique settings of out of hospital care.

4.2 Trade Union Safety Representatives

The Trust will work in partnership with Trade Union Safety Representatives and adopts the Regulations, Code of Practice and guidance relating to the Safety Representatives and Safety Committee Regulations 1977 (TUC 2015).

This includes arrangements for:

- Consultation
- Functions of Safety Representatives
- Safety Inspections by Safety Representatives
- Provision of information for Safety Representatives

The following trade unions and professional organisations are recognised in the Welsh Services NHS Trust to appoint Trade Union Safety Representatives

- GMB
- UNITE
- UNISON
- RCN

5. OBJECTIVES

5.1 Definitions

The term 'environment' within this policy refers to the physical space in which any care process takes place, or which is used for the storage or decontamination of care equipment, e.g.:

- Any general horizontal surfaces in the patient' client's environment, (low and high level must be considered)
- Any frequently touched surfaces in the environment; this also includes rooms such as dirty utility, storerooms, mobile treatment areas and any other area where consultation, assessment or treatment takes place.
- Trolleys, chairs, and other furniture in the environment
- Toilets, sinks, basins, showers, and the items surrounding these, including hand hygiene solution containers.
- Floors, doors, handles, tables particularly those in the immediate environment
- Other paint work and surroundings, e.g., skirting, walls, partitions, (particularly focusing on those frequently touched)
- Curtains/ blinds, light fittings, and light switches.

This list is not exhaustive, and judgements should be made in each specific setting as how to control the cleaning within the environment. Local risk assessments should be undertaken and are important in ensuring the environment is always monitored to a high standard when providing care. Other aspects of environmental control include cleaning of vents and filter changes, extractor vents in toilets, e.g., in air-flow systems. Liaison with estates and maintenance staff is important for this.

5.2 Governance, leadership, and accountability

Welsh Government, Department of Health and social services, Health, and Care Standards, 2015. Effective governance, leadership, and accountability in keeping with the size and complexity of the ambulance service are essential for the sustainable delivery of safe, effective person-centred care. The objectives will be achieved through adherence to the accompanying documents in addition to this policy and training staff to the required level. Governance will be met by via an audit process and reported in the trust's quarterly quality assurance report. The objective of this policy is to facilitate compliance with legislation and regulations that govern infection prevention and control as stated in the Trust's Infection Prevention and Control Policy, standards of cleanliness for premises and vehicles and cleaning standards in the NHS. This will provide effective cleaning and cleaning management arrangements to ensure that Ambulance Stations and vehicles are providing safe clean care. This policy will also minimise risk to staff, patients, public, contracted staff, and their agents from exposure to infection and to assist managers and staff at all levels in the trust to understand their commitment to and responsibility for effective cleaning standards.

5.3 Records Management

The Welsh Ambulance NHS Services Trust (WAST) recognises the importance of sound records management arrangements for both clinical and corporate records. The Trusts' records are its corporate memory, providing evidence of actions and decisions and representing a vital asset to support daily functions and operations. Records support policy formation and managerial decision-making, protect the interests of the Trust and the rights of patients, staff, and members of the public.

6. PREMISES AND VEHICLE CLEANLINESS

6.1 Environmental Cleaning

Cleaning is a process which physically removes infectious agents and the organic matter on which they thrive but does not necessarily destroy infectious agents. The reduction of microbial contamination depends upon many factors, including the effectiveness of the cleaning process and the initial bioburden. Cleaning is an essential prerequisite to ensure effective disinfection or sterilisation.

6.2 Routine Cleaning

6.2.1 Routine cleaning is regular cleaning, which is carried out on a scheduled basis, not on an ad hoc basis and not in response to an outbreak.

6.2.2 Staff groups must be aware of their local environmental cleaning schedules and be clear on their specific responsibilities and trained accordingly.

6.2.3 In the event of a pandemic or an infectious disease outbreak, there will likely be additional national guidance issued which will be added to any existing cleaning plans / standards already in place. As an example, the Covid-19 pandemic.

6.3 Roles and responsibilities for cleaning activities

6.3.1 Managers must:

- Ensure that staff receive instruction / education on the principles of controlling the environment and Standard Infection Control Precautions, (SICPs)
- Ensure that adequate resources are in place to allow for the recommended infection prevention and control measures to be implemented.
- Undertake a risk assessment to optimise patient and staff safety, consulting expert infection prevention and control guidance if/ as required.
- Support staff in any corrective action or interventions if an incident occurs that may have resulted in cross infection.
- Ensure any staff with health concerns, or who have become ill due to occupational exposure to cleaning products of disinfectants or infection are referred to the relevant agency, e.g., Occupational Health or General Practitioner, who may seek advice from Infection Prevention and Control or Health Protection Nurses
- Ensure that cleaning schedules /standards are defined, monitored, documented and are available in line with national cleaning standards.
- Ensure that cleaning staff are advised of any additional infection control precautions required, including the use of disinfectants for specific infections.
- Provide a full COSHH Register with completed risk assessment and safety data sheets, and this must be up to date.

6.3.2 All Staff (who provide direct care or have a responsibility for the environment in a health or social care setting) must:

- Attend induction and update training in line with local training policies.
- Apply the principles of SICPs and ensure all other staff/ agencies apply the principles of SICPs.
- Ensure that cleaning schedules are clearly defined, monitored, documented and available as appropriate to their role.
- Report to line managers any deficits in relation to their knowledge of controlling the environment / SICPs / facilities / equipment or incidents that may have resulted in cross contamination.
- Report any illness as a result of occupational exposure to the line manager.
- Not attend for clinical duty with known or suspected infections. If in doubt consult with your General Practitioner, Occupational Health Department or Manager
- Advise the patient, carers, or visitors of any infection prevention requirements such as hand hygiene and cough etiquette.

6.3.3 Infection Prevention and Control must:

- Provide support for and where appropriate, education for staff and management on this policy.
- Act as a resource for guidance and support when advice on controlling the environment is required.
- Provide advice on individual risk assessments for controlling the environment decisions.

6.4 Incident Reporting:

Areas or items which are found to be consistently not clean or damaged, particularly following times when cleaning routines have been performed, and items which are in a poor state of repair should all be reported to the line manager. Where there is concern about risk of infection, the concern should be reported using the incident reporting system- DATIX. Any issues arising in relation to the use of cleaning solutions, e.g., skin reactions, should be similarly reported to the line manager, Health, and Safety representative, reported on DATIX, Occupational Health Department and individual's General Practitioner.

6.5 Cleaning Procedures to Control the Environment:

6.5.1 Staff groups should be aware of their environmental cleaning schedules and clear on their specific responsibilities. Cleaning protocols should include responsibility for frequency of and method of environment cleaning.

6.5.2 A routine cleaning schedule should be available in the local area, this can either be provided by contractors themselves or if directly employed by WAST an internally provided schedule which has been agreed with locality managers. This schedule should be based on the National Standards of Cleaning in NHS Wales and Ambulance specific

standards of cleaning (awaiting publication as of April 2024) and on the principles contained within this document. Procedures detailed in these schedules include cleaning, vacuuming, and the times these should be performed.

6.5.3 It is the responsibility of the person in charge to ensure that the care area is safe for practice, and this includes environmental cleanliness/maintenance. The person in charge has the authority to act if this is deficient.

6.5.4 The care environment must be:

- Free from clutter to facilitate effective cleaning.
- Well maintained and in a good state of repair; and
- Clean and routinely cleaned in accordance with the National Cleaning Standards for Wales

6.5.5 Cleaning must also be undertaken when:

- The environment is visibly dirty, e.g., contamination with dust, soiling.
- When spillages occur
- Whenever a patient/client is discharged from their care environment, in relevant care settings. Specific guidance may be in place locally to guide staff as to the steps to take upon patient discharge to ensure the environment is safe to receive the next patient.

6.6 Cleaning Procedures:

- The use of Personal Protective Equipment (PPE) to protect those caring for the environment is important, as is the disposal of PPE immediately following use. Hand hygiene is also essential, even if gloves are worn during the procedure.
- Gather all relevant equipment for use and ensure all equipment/receptacles used to clean the environment are clean before use. Utilise single use items, such as disposable cloths, as far as possible in health and social care settings.
- The choice of cleaning agent that best meets overall needs is important. Must be WAST approved, and manufacturer guidance have been followed.
- A fresh solution of general purpose WAST approved neutral detergent in warm water is recommended for routine cleaning. This should be changed when dirty or when changing tasks.
- Do not use chlorhexidine, e.g., Hibiscrub and other hand antiseptic agents, for cleaning of the environment. WAST approved disinfectant wipes should not be used routinely for the environment as they are not suitable for large surface cleaning. Follow guidance (e.g., manufacturers' instructions and recommendations) provided on cleaning agents, regarding amount used, dilution and contact time, and ensure solutions are made up freshly. WAST approved solutions made up and stored within a receptacle must be labelled, e.g., solution name, date and time made up. Solutions must not be stored for longer than 12 hours. Containers used to dilute cleaning solutions should be rinsed inverted and stored dry. Control of Substances Hazardous to Health (COSHH) sheets and product data sheets should be referred to ensure solutions used to clean the environment are used and stored safely.

- Use warm (hand hot) water with WAST approved general purpose neutral detergent applied with single-use cloths.
- Use cold water to dilute WAST approved chlorine solutions, apply with single use cloths.
- Use dust control mops (anti-static type) for collecting dust and grit. Cotton or mixed fibre mops should be used to collect dirt and soil. Brushing should be avoided as it can disperse more dust into the air. 'Damp dusting' is the recommended method for cleaning the environment.
- Ensure all areas are thoroughly cleaned and free from dust and grime, paying particular attention to harder to reach areas, e.g., corners, edges, etc. The mechanical action of cleaning is important to physically remove dirt, debris bacteria etc.
- Ensure sinks, basins and showers are free from soap build-up and mineral deposits. Attention should be paid to fixtures, blankets and linen, wall tiles and handrails.
- Toilet seats should be cleaned with a frequency appropriate to use, the undersides must be checked and be included in the cleaning process.
- Air-drying following washing is generally acceptable; however, if areas are particularly wet these should be dried with a near dry one-use mop head / one use cloth to wipe up excess fluid.
- Furniture should be free of dust and staining.
- Items should be checked while cleaning for any splits, or damage. Any items which are not intact, for example chairs, should be removed and reupholstered with suitable impervious flame-retardant material, (which can withstand cleaning with WAST approved detergent and disinfection with chlorine 1000ppm), where appropriate or replaced as appropriate.
- Where vents/filters are present in the environment (e.g., air flow systems) they should be considered during cleaning procedures, (liaison with estates/maintenance staff will be necessary).
- Reusable items that can be laundered, such as curtains must be sent to the appropriate laundry facility. Disposable one-use mop heads must be used and discarded in an orange clinical waste bag after each use.
- Disposable clean mop heads and other equipment must always be stored in a clean, dry area. Cleaning schedules should be available locally, clearly stating frequency of dealing with these items.
- Any additional information on cleaning/disinfecting agents to be used at specific times should be discussed with Infection Prevention and Control / Health Protection staff.
- Any patient with a High Consequence Infectious Disease (HCID) or a Notifiable disease (depending on the severity) and have been transported in an Ambulance, the vehicle should be decontaminated and sanitised by the nearest Make Ready depot by trained staff. Please access the High Consequence Disease Standard Operating Procedure document.

6.7 Monitoring of Cleanliness

6.7.1 There is a need to demonstrate that cleanliness in health care settings is being maintained to consistent standards that meet the expectations of the users, staff, public/

visitors, and monitoring bodies. National Standards of Cleanliness for NHS in Wales are available, and these standards can also be used to guide cleaning specifications and monitoring processes within other health care settings. Timely action must be taken and documented when monitoring identifies cleanliness standards which are below that are required.

6.7.2 Monitoring of the standards of cleanliness can be undertaken by domestic service staff, relevant managers and infection prevention and control teams where appropriate, this can be negotiated to suit the environment and service.

6.7.3 High levels of cleanliness can only be achieved through:

- Clear specifications.
- The appropriate training of staff.
- Documented lines of accountability.
- Where appropriate, the involvement of patients/public.
- All staff recognizing their responsibilities.
- A meaningful framework for measurement.
- Trust management/board support (with consideration also given to the appointment of a board nominee to represent cleaning-related issues).
- Links between cleaning services and local infection prevention and control teams and policies.

7. EQUALITY

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

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

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

8. TRAINING AND IMPLEMENTATION

Training and implementation will be delivered at the earliest opportunity to staff by appropriate trainers with key areas of content supported by the IPC team, this will be evidenced based and produced in conjunction with all stakeholders and Public Health Wales.

8.1 Training – Aims

The aim of Training is to ensure all staff involved in cleaning are:

- Familiar with Trust general policy and procedure such as infection prevention practice
- Consistent in their approach to the standard of cleaning required in Trust premises.
- Familiar with the standards required for their personal safety and that owed to others while on Trust premises including manual handling and COSHH.
- Familiar with the Trust environmental governance system and in particular Waste Management and recycling practice

8.2 Training – Objectives

The Trust Cleaning Training objectives are:

- To present the Trust Infection Prevention and Control Policy and its application to the individual and to his or her responsibilities
- To present the Trust Premises Cleaning Policy and its application to the individual and to his or her responsibilities
- To present national cleaning standards and the Trust standards for cleanliness including frequency, methodology, responsibility, and training for cleaning
- To discuss health & safety aspects including manual handling and COSHH
- To discuss the Trust EGS, ISO 14001 accreditation

8.3 Training – Outcomes

The learning outcomes on completion of training are:

- State his or her responsibilities as detailed by the Infection Prevention Control Policy
- Identify combustible hazardous materials and potential ignition sources in his or her work area relating to cleaning products and know what to do in the event of Fire. E.g. Hand Gel
- State the standard of cleaning required.
- Take an effective part in maintaining safe conditions in premises and a safe working environment.
- State the hierarchy of recycling.

8.4 Organisational Outcomes

WAST expects this policy to:

- Minimise IPC risk of HCAI related to the environment and equipment in trust premises.
- Deliver effective cleaning and decontamination of premises /vehicles.
- Reduced disruption to treatment and care of patients.

8.5 Training (Contracted Out Staff)

8.5.1 Any contracts awarded externally should have clear expectations of standards, training, risks, health and safety (COSH), methodology and monitoring, specifically for environmental cleaning. This will be further supported by the Ambulance Specific Cleaning Standards. There should be made clear at the time of any tender processes.

8.5.2 Where staff are working in areas where there are specific risks or hazards such as control premises and workshops. Specific training can be provided if there is t job-specific instruction as soon as their employment commences.

8.5.3 All contract staff should be provided with regular updated training and instruction provided by the contractor to ensure maintenance of skills and knowledge.. The duration and frequency of the training should be determined by a training needs analysis provided by the contractor.

8.5.4 The contractor will keep and maintain records of all training, and these will be made available for inspection when requested. This facility should be managed within the Building Cleaning Group as part of any ongoing monitoring arrangements All training will be delivered and funded by the contractor to training standards set by WAST.

8.6 Training (In house staff)

All staff will receive induction training at commencement of employment, and this will take the form of Infection Prevention & Control training. Where staff are working in areas where there are specific risks or hazards such as in Control Centers, Make Ready Depots or workshops, the induction training will be supplemented by job-specific instruction as soon as their employment commences.

9. AUDIT AND MONITORING

9.1 The auditing and monitoring process will be managed internally, with all audit results reported within quarterly reports to provide board assurance.

9.2 In addition to having the right systems in place to deliver high-quality cleaning, it is also important to have mechanisms in place that allow healthcare providers to demonstrate to others - whether statutory bodies such as the Healthcare Commission, local commissioners, or patients/the public - that high standards are being achieved and/or the steps being taken to achieve these.

9.3 To ensure this policy is operating correctly and that risks are being maintained in Trust premises, the system will be monitored periodically through random checks undertaken by Health & Safety Managers and Infection Prevention and Control Managers. These checks will include:

- Cleaning audits and inspections using National Cleaning Standards Audit Assessment tool (Microsoft Forms will soon replace the assessment tool and checks made by the IPC team).
- Random spot checks with cleaning staff to ensure competencies.

- Checks to ensure new staff have received sufficient information from line management in relation to building cleaning
- In addition, the trust should seek to establish the Building Cleaning Group (suggested name only) with agreed terms of reference and appropriate membership. This group should contribute to the overall governance and management of cleaning in the Trust to ensure that quality standards are being met.

10. TRUST RESPONSIBILITIES

10.1 Chief Executive

The Chief Executive has overall responsibility for ensuring that appropriate cleaning policies and programmed schedules of work are in place, that the Trust compliance is measured, and outcomes reported. The Chief Executive is required by NHS guidance to appoint an Executive Director to be responsible for the implementation of all matters relating to premises cleaning.

10.2 The Trust Board

The Trust Board has overall accountability for the activities of Trust. The Trust Board should ensure they have appropriate assurance that the requirements of current building legislation are met.

10.3 Executive Director of Quality and Nursing

The Director of Quality Safety & Patient Experience has delegated authority from the Chief Executive to ensure the Trust is compliant with the Trust Infection Prevention & Control Policy for Health Care Associated infections which has been developed in line with NHS Wales Infection Prevention & Control Strategy: Commitment to Purpose (2011); the All Wales IPC Code of Practice 2014, UK Five-Year Antimicrobial Resistance Strategy 2013, and the Welsh Government AMR (Anti-Microbial Resistance) delivery Action Plan 2016.

10.4 Assistant Director of Quality Governance

The Assistant Director for Quality Governance, Assurance & Improvement has delegated responsibility for assisting the Director of Quality Safety & Patient Experience in their IPC responsibilities. The Head of Quality Governance (Assurance & Improvement), Head of Quality Assurance and the Infection Prevention & Control Lead are responsible for leading the IPC agenda within the Organisation. Quality, Safety and Patient Experience (QSPE) staff work in partnership with the Decontamination Lead, Sepsis lead and Operational Area Managers in developing, promoting, and monitoring the Healthcare Associated Infection Prevention & Control Policy.

10.5 Building Cleaning Manager (or Trust equivalent role)

Contracted Out (buildings only)

The Assistant Director Capital & Estates is the Trust Building Cleaning Manager, the Head of Estates and Facilities will deputise as the Trust Building Cleaning Manager. The Trust Building Cleaning Manager is a senior manager responsible for ensuring that this policy is fully implemented. Staff undertaking the role of Trust Building Cleaning

Manager must be sufficiently empowered and have access to adequate resources. The Trust Building Cleaning Manager will be responsible for the following:

- Writing specifications and tender documentation and procuring a contract cleaning solution
- Administering the cleaning contract to ensure cleaning standards are maintained.
- Administration of any service level agreements and ensuring cleaning standards are maintained.

10.6 Health & Safety Managers

Health & Safety Managers are responsible for auditing the operation and application of this policy with support from qualified and accredited local health and safety representatives. The health and safety managers will ensure that all risk assessments are carried out with trade Union partners and reviewed at regular intervals.

10.7 Employee Responsibilities

Every member of staff has a responsibility under the Building Cleaning Policy to:

- Keep areas under their control cleaning and tidy.
- Maintain safe standards of housekeeping.
- Attend induction and update training in line with local training policies.
- Apply the principles of SICPs and ensure all other staff/ agencies apply the principles of SICPs.
- Ensure that cleaning schedules are clearly defined, monitored, documented and available as appropriate to their role.
- Report to line managers any deficits in relation to their knowledge of controlling the environment/ SICPs/ facilities/ equipment or incidents that may have resulted in cross contamination.
- Report any illness as a result of occupational exposure to the line manager.
- To be aware of behaviours and practices if suffering from any known, suspected infectious disease, and to contact your GP, Occupational Health Department, or manager.
- Advise the patient/ client, carers, or visitors of any infection prevention requirements such as hand hygiene and cough etiquette.

10.8 The Building Cleaning Group (or Trust equivalent)

A Building Cleaning Group will be established to review all Building Cleaning matters. The Group will comprise Operations, IPC, Estates, Health & Safety Managers, and other nominated officers as appropriate including staff representatives. The Building Cleaning Group will meet quarterly and provide the necessary reports and present to the most appropriate governance route for the group, this should be set out in its terms of reference..

10.9 Medical Service (EMS), Non-Emergency Patient Transport (NEPTs) and Corporate Managers

Managers are responsible for the provision of leadership & supervision to ensure that the implementation & dissemination of the trust's Premises and Vehicle Cleanliness Policy to all staff within their sphere of practice. All managers must ensure that awareness of the cleanliness of the environment is an integral part of their everyday role. The Trust will ensure staff have access to polices, ensure resource and equipment is available to comply with policy. Through work-based training, assessment and supervision managers are responsible for ensuring that all employees within the trust are competent in applying all aspects of this policy relevant to their area of practice.

11. ASSOCIATED POLICIES

- Occupational Standard Infection Control & Prevention Practice (SIPC's)
- Transmission Based Precautions (TBP's) additional to SIPC precautions for known diseases.
- Medical Devices Policy
- Decontamination Library (In development)
- Sharps Policy
- Occupational Exposure to blood and bodily fluids. SOP.
- Outbreak Management Policy (currently Covid specific but will be reviewed to incorporate other communicable diseases.
- Environmental Polices (In development) to include:
  - Water EPGN009
  - Energy EPGN010
  - Control of Contractors EPGN001
  - Asbestos EGN004 & Fire Safety Policy
  - Waste Management EPGN 008
  - Legionella EPGN007

12. REFERENCES

Health and safety at work Act, (1974), *Chapter 37,* HMSO

Formally Estates Procedures Guidance Notes 013 (EPGN013) N. Stephens

Health inspectorate Wales, Unannounced Cleanliness Spot Check, Driving Improvement through independent and objective review, Digital ISBN 978 0 7504 7906 6 © Crown copyright 2012 WG16381.

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

Clinical Supervision Policy - Planned Implementation

MEETING	QUEST Committee
DATE	7th May 2024
EXECUTIVE	Andy Swinburn
AUTHOR	Kerry Robertshaw
CONTACT	Kerry.robertshaw@wales.nhs.uk

EXECUTIVE SUMMARY

Following the recommendations produced by the Association of Ambulance Chief Executives (AACE) around the topic of clinical supervision of patient facing staff and clinicians within the UK's ambulance services the organisation developed an associated policy to meet these recommendations.

At the policies presentation to the Executive Leadership Group, a subsequent request for outline details of the policy's implementation was requested, leading to the creation of the attached Terms of Reference for the Group and a high-level plan.

Whilst the policy was previously presented to the Committee, it was agreed that final adoption of the policy would be deferred until such as the implementation plan had been approved by the Executive Leadership Team.

Details of the plan and the policy are presented to the committee for assurance and oversight.

KEY ISSUES/IMPLICATIONS

It is recognised that for some staff groups, robust clinical supervision is being undertaken (albeit that this may have differing nomenclature) but for other groups this may be minimal.
The considerations for implementation set out areas that will require attention and where the recommended Task and Finish Groups will focus their attention.

REPORT APPROVAL ROUTE

Executive Finance Group

REPORT APPENDICES			
Clinical Supervision Policy Clinical Supervision Task and Finish group terms of Reference Clinical Supervision Implementation Plan			
REPORT CHECKLIST			
Confirm that the issues below have been considered and addressed		**Confirm that the issues below have been considered and addressed**	
EQIA (Inc. Welsh language)	x	Financial Implications	x
Environmental/Sustainability	N/A	Legal Implications	N/A
Estate	x	Patient Safety/Safeguarding	x
Ethical Matters	N/A	Risks (Inc. Reputational)	x
Health Improvement	x	Socio Economic Duty	x
Health and Safety	x	TU Partner Consultation	x

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

Clinical Supervision Policy

MEETING	Policy Group
DATE	21st November 2023
EXECUTIVE	Andy Swinburn
AUTHOR	Consultant Paramedic Urgent Care
CONTACT	Jonathan Chippendale - jonathan.chippendale@wales.nhs.uk

EXECUTIVE SUMMARY

WAST does not currently have a Clinical Supervision policy to set out a framework across the organisation to define what clinical supervision models are available or the frequency to which it should be accessed.

Lord Carter's (2018) paper into unwarranted variation in ambulance services called for Ambulance Trusts Boards to agree a common clinical supervision model by April 2019 and then rolling this out across the service, ensuring it is fully embedded by April 2021. Inevitably the pandemic caused disruption to these timelines however the Association of Ambulance Chief Executives (2021) published their Clinical Supervision framework and revised timelines to which WAST committed.

Effective clinical supervision has also been shown to be a successful tool in reducing stress and anxiety within a workforce, improvement in confidence of organisational leadership and positive effects for staff retention and job satisfaction (Rothwell et al, 2019).

The Clinical Supervision policy seeks to address all the elements set out within the 2021 Association of Ambulance Chief Executive's framework.

This policy has been developed in partnership with Trade Union colleagues and has been through the relevant stages of the policy review process confirmed by the policy review group.

KEY ISSUES/IMPLICATIONS

Key issues which are to be brought to the attention of the Committee/Board are as follows:

- This policy has been written using the following national guidance documents to ensure the Trust meets current best practice guidelines in supporting both clinical and non-clinical colleagues.

- Clinical Supervision – A Framework for UK Ambulance Services 2021. Association of Ambulance Chief Executives.
- The Benefits and Outcomes of Effective Supervision, Health and care Professions Council, 2021.
- The Characteristics of Effective Clinical and peer Supervision in the Workplace – A Rapid Evidence Review, Rothwell, Kehoe, Farook and Illing, 2019.
- WAST has no current Clinical Supervision policy.
- This Policy identifies the framework of individual clinician's access to clinical supervision and the frequency to which it should be accessed.
- The policy working group included detailed information on identifying specific organisational roles suitable for facilitating supervision to specific grades of clinical groups.
- Any training needs required for those conducting supervision sessions have been included within the policy document.
- Opportunity exists within the policy framework to allow existing Advanced Paramedic Practitioners to engage with the leadership function within their pillars of advanced practice by hosting clinical case studies as a supervision option for clinicians. Clinical case topics can be requested for consideration through the WIIN platform.
- The policy was discussed within the Ambulance Practice Steering Group with invites for comments.

REPORT APPROVAL ROUTE
Ambulance Practice Steering Group – 08/09/2023 **Policy Group – 21/11/2023**

REPORT APPENDICES
Appendix 1 – Clinical Supervision Policy **Appendix 2 – EQIA**

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

Policy Lead Checklist – Clinical Supervision Policy

		Yes/No/ Unsure	Comments
1.	**Trade Union Partners**		
	Has the Trade Union Chair/Secretary been contacted?	Yes	
	Has the Trade Union Chair/Secretary acknowledged your request for a nominated Trade Union Lead?	Yes	
2.	**Documentation**		
	Has the Policy Registration Form (PRF) been fully completed and submitted to Governance Team for processing?	Yes	
	Has the unique policy number been clearly stated on the policy?	Yes	
	Has the version number been included?	Yes	
	Is it clearly stated which approved documents this version supersedes?	No	There is no previous Document
	Has the classification of document been clearly stated?	Yes	
	Has the accompanying SBAR been completed to accompany the policy through the process?	Yes	
	Is it clearly stated who the Policy Lead is?	Yes	
	Are the reasons for development/review of the policy clearly stated in the SBAR/PRF?	Yes	
	Has the policy been registered on the Trust's central policy register database?	Yes	
3.	**Layout**		
	Has the correct policy template been utilised?	Yes	
	Have the formatting guidelines been followed?	Yes	
	Is there a contents page included?	Yes	
	Have page numbers been included?	Yes	
	Are the Appendices detailed at the end of the document?	Yes	
4.	**Title**		
	Is the title of the policy clear and unambiguous?	Yes	
5.	**Introduction**		
	Does the introduction clearly state what the policy about?	Yes	
	Is it clear why the policy is needed?	Yes	
	Have the reasons, history and intent that lead to the creation of the policy been included?	Yes	
6.	**Policy Statement**		
	Is the commitment of WAST clearly stated?	Yes	
	Does it include a statement of intent?	Yes	

		Yes/No/ Unsure	Comments
	Does it include what is the desired outcome/motivating factors are?	Yes	
7.	**Scope**		
	Is the scope of the document clear?	Yes	
	Is it clear to whom the policy applies?	Yes	
	Is it clear which service area, professional groups or individuals are affected by the policy?	Yes	
8.	**Aim**		
	Is the aim clearly stated?	Yes	
	Does it detail what the policy should achieve?	Yes	
9.	**Objectives**		
	Does the policy clearly identify how the aim of the policy will be achieved?	Yes	
10.	**Content**		
	Are the key terms used in the policy?	Yes	
	Is the language clear and concise?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
11.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited?	Yes	
	Are the references cited in full?	Yes	
	Are supporting documents referenced?	Yes	
12.	**Engagement**		
	Has the policy been developed in partnership with relevant staff groups, services and departments?	Yes	
13.	**Approval**		
	Does the policy identify which committee/group will approve it?	Yes	
14.	**Flow Chart Policy Process**		
	Has the process contained in the *Policy for the Development, Review and Approval of Policies* been followed?	Yes	
15.	**Approval Route**		
	Has the policy been submitted to either the Employment Policy Sub Group or Policy Group for guidance and consideration?	Yes	
16.	**Consultation**		

		Yes/No/ Unsure	Comments
	Has the policy been subject to a Trust wide consultation period – guided by the Policy Groups?	No	
17.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how the document will be implemented and distributed?	Yes	
	Does the plan include the necessary training/support to ensure compliance?	Yes	
18.	**Training**		
	Have the training requirements been clearly identified?	Yes	
	Is there a clear timeline for training?	Yes	
	Have training resources required been clearly specified?	Yes	
	Has a clear training plan been outlined in the document?	Yes	
	Have the appropriate representatives been engaged with and informed of training needs as a result of the policy being implemented?	Yes	
19.	**Document Control**		
	Does the document identify where it will be held and how a copy can be obtained?	Yes	
20.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or KPI's to support the monitoring of compliance with and effectiveness of the document?	Yes	
	Is there a plan to review or audit compliance with the document?	Yes	
	Has an audit tool been built into the policy document?	Yes	
21.	**Dates**		
	Has the implementation date been included?	TBC	
	Is the review date specified?	TBC	
	Is the frequency of review identified?	TBC	
22.	**Overall Responsibility for the Document**		
	Is it clear who is responsible for the document?	Yes	
	Is it explicit who is responsible for managing and reviewing the policy?	Yes	
	Is it clear who will be responsible for co-ordinating the dissemination and implementation of the document?	Yes	
	Are the staff responsible for enforcing the policy clearly identified?	Yes	

		Yes/No/ Unsure	Comments
	Is there a clear contact identified (the person to whom questions about the policy should be directed?	Yes	
23.	**Legislation and Regulations**		
	Does the document clearly state the relevant legislation or regulatory obligations considered in the development of the policy?	Yes	
	Does the policy detail the related organisational policies or other documents that it should be read in conjunction with?	Yes	
24.	**Impact Assessments**		
	Has an EqIA been carried out?	Yes	
	Has the outcome been recorded in the Policy and the SBAR?		
	Have the Welsh Language standards been taken into account?	Yes	Currently part of EqIA process
	Has an Environment assessment been carried out?	No	Not required
	Has the policy been considered in relation to Counter Fraud?	No	Not required
25.	**Once Approved**		
	Has the Governance Team been notified of approval and the policy returned to the Governance Team for uploading to the Trust central library and Policy and Procedures Intranet Page?	TBC	
26.	**Policy Review**		
	Is the person responsible for the review of the document aware of the review date?	TBC	

Appendix 1 – Clinical Supervision Policy

Clinical%20Supervisi
on%20Policy%20V1.5

Appendix 2 – EQIA

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Clinical Supervision Implementation Task & Finish Group Terms of Reference – v2

Approvals

Name / Group	Status	Date of Approval
Advanced Clinical Practice Delivery Group (ACPDG)	v2	Submitted for approval

Revision History

Revision Date	Version	Summary of Changes	Changes agreed
29.02.24	Draft v1	Document created and shared with proposed members for comments and feedback	N/A
04.03.24	Draft v1.1	Section 2 amended and updated	N/A
13.03.24	Draft v1.2	Section 2 amended and updated	N/A
22.03.24	v2	Document discussed and agreed at inaugural Task and Finish Group	

Contents

1. BACKGROUND

Clinical Supervision has been defined by the HCPC as '*a process of professional learning and development that enables individuals to reflect on and develop their knowledge, skills, and competence, through agreed and regular support with another professional'* (HCPC, 2022). This process enables individuals to develop knowledge and competence, assume responsibility for their practice and enhance service user protection, quality, and safety of care (HCPC, 2021).

Whilst clinical supervision has been available across established professions such as nursing for decades (NMC Regulatory Requirements, 2018), other professions such as paramedicine are understanding the value and importance of adopting clinical supervision into traditional ambulance settings, in line with the recommendations from Association of Ambulance Chief Executives (AACE) Clinical Supervision framework (2021).

Within Wales, Health Education and Improvement Wales (HEIW) have released a professional framework for enhanced, advanced and consultant level practice (2023) which details the need for consistent access to clinical supervision across the wide range of health professions and variety of clinical roles.

October 2023 saw the approval of the WAST Clinical Supervision policy being formalised.

The key recommendations of which is that clinical supervision:

Supports and enhances practice
Develop skills in reflection
Involves a supervisor and practitioner (or group of practitioners) reflecting on and critically evaluating practice
Be distinct from formal line management supervision and appraisal
Be planned, systematic and conducted within agreed boundaries
Be explicit about the public and confidential elements of the process
Allow for clear and unambiguous communication, conducted in an atmosphere of mutual respect.
Be available to all staff with direct patient contact (including remote contact)
Facilitated a minimum of 4 times a year to each member of staff

Following the approval of the policy, a paper was shared with the Executive Leadership Team (ELT) who approved the recommendation to develop a T&F Group to propose a clinical supervision implementation plan across clinical facing areas of practice.

2. MEMBERSHIP

The group will be chaired by the Professional Development Lead – Advanced Practice.

The deputy chair will be the Head of Service – Emergency Medical Services.

Project Management support will be provided by the Project Manager – Clinical Directorate.

The Core Membership of the group includes:

- Professional Development Lead – Advanced Practice (Chair)
- Consultant Paramedic – Urgent Care
- Ambulance Care General Manager
- Ambulance Care Operational Manager
- Ambulance Care Service Manager(s)
- Head of Service – Emergency Medical Services (EMS)
- Trade Union Representative
- Head of Education
- Health Board Clinical Lead(s)
- Project Manager – Clinical Directorate

If a member is unable to attend, a deputy should be sent on their behalf.

3. QUORUM AND ATTENDANCE

To ensure the group is quorate, the following members must be present:

- Chair / Deputy Chair
- Ambulance Care Representative
- Emergency Medical Services (EMS) Representative

4. AIM & OBJECTIVES

The overall aim of this Task and Finish Group is to propose a clinical supervision implementation plan across clinical facing areas of practice.

The of this Task and Finish Group is to seek to provide a strong evidence base to undertake the following:

- Gap analysis of each area to identify specific requirements for embedding clinical supervision;
- Options appraisal to form the findings and in some areas, this may include an Organisational Change process to:-
    - Build clinical supervision infrastructure
    - Provide capacity into the staff role

.

5. AGENDA AND PAPERS

The agenda and meeting documentation will be circulated in advance of the meeting via email.

6. FREQUENCY OF MEETINGS

This 4 session Task and Finish Group will hold meetings on a bi-weekly basis, for 1 ½ hours per meeting.

7. GOVERNANCE & REPORTING ARRANGEMENTS

The Group will feed into the following meetings:

Clinical

- Advanced Clinical Practice Delivery Group (ACPDG)
- Optimising Care Group (OCG)
- Clinical and Quality Governance Group (CQGG)

Emergency Medical Services (EMS)

- Field Operations Meeting
- Senior Operations Team (SOT)

Ambulance Care (AC)

- Ambulance Care Meeting
- Senior Operations Team (SOT)

Education

- SESG
- People and Culture Committee or Academic Partnership Group

Clinical Supervision Policy

Policy Number:	104	**Version No:**	V1.6	**Supersedes:**	V1.5
Date of Approval:	26/09/2023	**Review Date:**		**Impact Assessments Completed:**	Yes
Classification of Document:	Clinical supervision	**Type of Document:**	Policy	**Approved by:**	Policy Group
Brief Summary of Document:	This policy details a clear framework for the implementation of a clinical supervision process within the trust.				
Scope:	A clinical supervision framework will allow the organisation to have a consistent method to identify additional learning or development needs and facilitate support for our people to develop accordingly. Whilst also enabling safe and effective practice.				
To be read in conjunction with:	SharePoint- Behaviour and Culture Reset				
Owning Committee	Quality, Safety and Patient Experience Committee				
Policy Lead: **Trade Union Lead:**	Kerry Robertshaw Hugh Parry	**Job Title:**	Professional Development Lead- Advanced Practice Trade Union Representative		
Executive Director:	Andy Swinburn	**Job Title:**	Director of Paramedicine		

Version Control Sheet

Version	Date	Author	Summary of Changes
1.0		Kerry Robertshaw	Initial draft disseminated
1.1	11/05/2022	Kerry Robertshaw	Feedback from T&F group incorporated
1.2	23/03/2023	Kerry Robertshaw	Support for eLearning and Implementing training by ML
1.3	03/05/2023	Kerry Robertshaw	Feedback from T&F group, finalised for approval through Ambulance Practice Steering Group
1.4	08/09/2023	Kerry Robertshaw	Approved by APSG, feedback from open consultation incorporated
1.5	25/10/2023	Andeep Chohan	
1.6	29/04/2024	Lisa Trounce	Crown badge and Trust logo replaced with new. Header amended to reflect Trust's university status. Colour scheme amended in line with Trust corporate style guidance.
Keywords	Clinical, supervision		

Impact Assessment Reviews

Area	Date of Review	Name of Reviewer
Training		
Counter Fraud		
Information Governance		
Records Management		
EqIA / Welsh Language	31/03/2022	Melfyn Hughes
Estates		
Environment		
ESMCP		

Task and Finish Group Members

Name	Job Title
Kerry Robertshaw	Professional Development Lead
Jonathan Chippendale	Consultant Paramedic
Rhiannon Harries	Project Manager
Catherine Goodwin	Assistant Director Inclusion, Culture and Wellbeing
Craig Brown	Specialist Clinical Lead 111
Jo Kelso	Head of Education
Karl Hughes	ACA Manager
Katie McPheat-Collins	Service Manager, EMS (Central)
Hugh Parry	Trade Union Representative
Deborah Armstrong	Head of Education 111
Hillary Caffrey	People Services Leader
Kate Blackmore	Head of EMS Co-ordination
Lois Hough	Head of Communications
Martin Mulholland	Senior Education Lead
Melfyn Hughes	Welsh Language Services Manager
Paul Seppman	Trade Union Representative
Penny Durrant	Service Manager CSD
Eleri Griffith	Clinical Psychologist
Maria Laffey	Advanced Paramedic Practitioner

Policy Approval Route

Meeting Title	Meeting Date	Purpose/Outcome
T&F Group	22/03/2023	Ensuring representation and organisational views incorporated
CSD/111/CCC Clinical Supervision requirements	28/03/23	Sub meeting to ensure remote consultation space represented
T&F Group	17/05/2023	Amendments to V1.1incorporated
Clinical supervision Education Requirements meeting	23/11/2022	Sub meeting to consider supervisor education and implementation plan
T&F Group	31/03/2023	V1.2 disseminated virtually to T&F members

Ambulance Practice steering Group (APSG)	12/05/2023	V1.3 drafted after feedback from T&F group Approved at APSG and sent to public consultation
Policy Group Meeting	28/09/2023	V1.4 submitted after feedback from public consultation
ELT	13/12/2023	Recommend for Approval
QuEST Committee	07/05/2024	Approval and Adoption

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

Contents

1. INTRODUCTION

Clinical Supervision has been defined as a process of professional support and learning, undertaken through a range of activities, which enables individuals to develop knowledge and competence, assume responsibility for their practice and enhance service user protection, quality, and safety of care (HCPC, 2021).

Whilst clinical supervision has been available across established professions such as nursing for decades (NMC Regulatory Requirements, 2018), other professions such as paramedicine are understanding the value and importance of adopting clinical supervision into traditional ambulance settings in line with the recommendations from Association of Ambulance Chief Executives (AACE) Clinical Supervision framework (2021).

Within Wales, Health Education and Improvement Wales (HEIW) have released a professional framework for enhanced, advanced and consultant level practice (2023) which details the need for consistent access to clinical supervision across the wide range of health professions and variety of clinical roles. In addition, an all-Wales career spanning framework for preceptorship and clinical supervision in nursing is due to be released which further promotes the importance of clinical supervision throughout a professional career.

Within WAST, a clinical supervision framework will allow the organisation to have a consistent method to identify additional learning or development needs and facilitate support for our people to develop accordingly. Whilst also enabling safe and effective practice.

This policy details a clear framework for the implementation of a clinical supervision process within the trust.

2. POLICY STATEMENT

This policy will seek to provide a supportive environment and culture for mutual trust and respect to be established to facilitate the process of clinical supervision within the organisation.

3. SCOPE

This policy provides a structure and process for clinical supervision to be embedded into the organisation at a consistent and accessible level, to all staff who have contact with patients and service users.

It is recommended that **all staff** who have direct contact with patients and service users should participate in regular Clinical Supervision (NMC 2018: HCPC 2021). This includes staff who deliver care or speak to patients remotely.

All ambulance staff can be affected by what they see or hear in the workplace and Clinical Supervision provides a 'safe space' where individual needs can be addressed. Within WAST it is recognised that many colleagues work in supporting roles where their patient contact is indirect. They are, however, also exposed to challenging, clinically complex and potentially upsetting information and should also be offered the same safe support network outlined within this policy.

4. AIM

To ensure the trust provides a framework for clinical supervision across the organisation which can be adopted within different operational areas to include colleagues who practice in both direct and indirect clinical contact roles.

To ensure Trust staff have the opportunity to access safe and effective supervision within the timeframes stipulated within this policy and that the supervision is undertaken with an appropriate member of staff.

To provide direction on the process for providing, accessing, and recording clinical supervision within the Trust.

To continue to support the organisational culture around being 'Our Best' and increasing the well-being support for staff. We want to continue to enable staff to make clinically safe patient-centred decisions by reflecting on incidents and sharing learning.

5. OBJECTIVES

• To outline the frequency, content and available modes of clinical supervision offered in the organisation
• Ensure clinical supervision focuses on providing staff with the opportunity to reflect and share knowledge and skills to support their continued professional development
• Clearly outline the role of the clinical supervisor and ensure staff have access to a suitably qualified supervisor.
• Create a contract for supervisors and supervisees to have a shared understanding of agreed outcomes where appropriate.
• Create a clinical supervision environment that is flexible and equitable, to ensure all staff have access to the sessions, regardless of working patterns.
• Provide staff with the time and technology to have access to appropriate clinical supervision, including creating rosters that factor in the requirement for clinical supervision as part of their ongoing learning and development needs.

• Create a contract for supervisors and supervisees to have a shared understanding of agreed outcomes where appropriate
• Ensure learning is facilitated through effective reporting mechanisms and develop a reliable method of identifying staff who require additional supervision.
• Align to the organisational strategic ambition to reduce staff sickness and increase staff welfare through well-being and clinical support.
• Raise concerns about patient safety or the standard of education and training openly and safely without fear of adverse consequences
• Demonstrate a culture that is committed to fostering a learning environment and responds to feedback from supervisees and supervisors to continually improve the clinical supervision experience.

6. CLINICAL SUPERVISION

Within nursing and other allied health professions clinical supervision has been a well-established practice for many years. The HCPC has outlined the definition below:

'Supervision is a process of professional learning and development that enables individuals to reflect on and develop their knowledge, skills, and competence, through agreed and regular support with another professional' (HCPC, 2022).

Clinical supervision, whilst offering support, can also develop knowledge and competence. It can enhance and build on the scope of professional practice; it can encourage self-assessment and awareness, aid the development of emotional intelligence by reflecting on practice.

The Ambulance Association of Chief executives (AACE) have reviewed the learning from several key reports (namely Lord Carters Review into unwanted variation in English Ambulance Trusts and the HCPC commissioned study into the high number of complaints) and advised the implementation of clinical supervision into UK ambulance services.

Key findings from the reports above identified that workplace supervision is integral to the provision of safe and effective healthcare systems, and the prevention of mistakes and problems in the workplace. It is seen as an important tool in continuing professional development (CPD).

Ambulance services are professional organisations where frontline clinicians possess a high degree of control, and the ability of supervisors to directly influence clinical decision-making in some settings are more constrained. Clinical supervision promotes a balance between effective decision-making and the crucial need to facilitate reflective practice in a safe environment. This cannot be underestimated if we are to achieve the

level of outstanding and consistent clinical practice needed to ensure our patients are managed in the right place, first time.

6.1 Frequency of supervision

Acknowledgment is given to the continued demands of a busy ambulance service, with time pressures, heavy workloads, the impact on frontline resources and prioritising individual CPD often cited as barriers for individuals to continue to professionally develop.

Quality and flexibility will be essential tools for the clinical supervision process to be undertaken and hold value.

Clinical Supervision should be available as a minimum, **quarterly** throughout the year (more or ad hoc as required) and be at a time and method of delivery that is suitable to both the supervisee and supervisor.

6.2 Content of Clinical Supervision

The most appropriate supervision arrangements for a member of staff are determined by several factors, including their experience, the type of work they carry out and their individual needs.

Getting supervision 'right' is a difficult task, and it is likely that no one model will be the perfect fit, however the format should consider embedding the three core principles below:

Normative: This is the monitoring and clinical risk management component which enables the supervisee to focus on issues of a person-centred, safe, and effective practice and their professional accountability in relation to practice.
Restorative: This supportive component provides the supervisee with a safe and confidential environment to reflect on personal reactions and feelings and identify possible need for further support. It provides validation of good practice and underpins the establishment of a good working alliance.
Formative: This educative component enables the supervisee to reflect on their work and identify their ongoing professional development needs.

The above categories can be used as a useful framework to identify key aspects of clinical supervision and clarify its aims and objectives. Those under supervision can also use these categories to consider relevant topics to bring to the supervision.

Acknowledging the importance of staff well-being, the importance of *restorative supervision* should be strongly promoted throughout the clinical supervision session.

6.3 Clinical Supervisor

Clinical supervision involves regular discussions between two or more practising clinicians, one of whom has a sufficiently extended level of skills, knowledge, and abilities to support the development of the other(s). This does not necessarily mean that the supervisor will be of a higher band to that the supervisee.

Consideration should be given to who is best placed to provide clinical supervision to the staff in their area of practice and recognise that those who provide clinical supervision to others will also need to access clinical supervision themselves.

Clinical supervision should:

• Support and enhance practice.
• Develop skills in reflection.
• Involve a supervisor and practitioner (or group of practitioners) reflecting on and critically evaluating practice.
• Be distinct from formal line management supervision and appraisal.
• Be planned, systematic and conducted within agreed boundaries.
• Be explicit about the public and confidential elements of the process.
• Allow for clear and unambiguous communication, conducted in an atmosphere of mutual respect.

6.4 Clinical Supervision Contract

For some clinical settings a clinical supervision contract may be required. This is particularly recommended where the supervisor and supervisee relationship is likely to remain consistent.

The Clinical Supervision Contract forms the basis of a clinical and ethical ‘Agreement’ between the clinical supervisor and supervisee on the aims; duration and frequency of supervision sessions along with the recording of any outcomes, and or, actions arising from the sessions.

When initiating a clinical supervision contract, it should be undertaken between the clinical supervisor and supervisee. A template can be found in appendix 1 which can be adapted as required.

The discussion will be where ground rules, professional boundaries, purpose, and the structure of the sessions will be set out and agreed upon before any Clinical

Supervision is facilitated. The contract will be agreed upon between the supervisor and supervisee at the first session.

Each member of staff (where applicable) will be required/encouraged to submit their continued professional portfolio for review and discussion at their initial 'clinical supervision discussion' and thereafter on an annual basis. This will allow Supervisors to have a level of understanding around areas for discussion to support continued professional development.

6.5 Mode of Delivery

Mode of delivery will be determined by the requirements of each individual area, and often a mixed approach will add benefit and variety for staff who may favour one method over another.

Eligible modes of supervision and template references to facilitate delivery of these modes are detailed below:

Appendix 1- Clinical Supervision- Individual Contract as outlined in 6.4, the aim of a clinical supervision contract is to help both the supervisor and supervisee understand the expectations of the sessions and consider how clinical supervision will be delivered over the course of the year.

Appendix 2- Clinical Supervision- Individual Session can provide structure and focus to individual sessions and provide notes/ record of interaction if required to facilitate growth throughout the process. It can also be an opportunity to review a clinicians CPD/ portfolio of evidence if required.

Appendix 3- Case-based discussion- is an excellent tool to consider how to reflect, learn, evaluate and grow from an experience or episode of care. It is recommended that the clinician bring their own case to discuss.

Appendix 4- Group sessions- Group Clinical Supervision can be an excellent way to develop a tight bond amongst a group of staff to discuss, reflect, learn and develop in a safe and supported environment. Setting the scene and context for the session to thrive is very important as well as ensuring all voices are given the opportunity to be heard.
Education or training environment- where clinical supervision, reflection, and open discussion are encouraged. E.g., Mandatory and Statutory In-House training (MIST), these can be counted towards clinical supervision contacts.

6.5 Audit and Monitoring

6.5.1 It is recommended that organisations formally evaluate their approach to clinical supervision annually as well as considering options for formalised research to evidence impact and improve future delivery.

6.5.2 Recording of Clinical Supervision contacts will be recorded nationally via the MS form:

Clinical Supervision Dashboard - Supervisors

https://forms.office.com/e/3Dr33Nqq2F

6.5.3 The information from the MS form above will be presented on a dashboard (Power BI) to clearly identify the Clinical Supervision contacts across the organisation and correlate any key themes that may arise as a result of clinical supervision discussions.

6.5.4 Identified personnel will have access to the dashboard to allow them to feedback information relating to progress on the implementation and growth of clinical supervision to their respective management and meeting routes. This will provide assurance to the organisation and identify areas of practice that may need additional support to embed clinical supervision.

6.5.5 An individual may wish to reflect on their clinical supervision session, this may be compulsory in some areas of practice, particularly if the evidence forms part of a wider learning action plan. A template can be found below:

Clinical Supervision - Individual Reflection

https://forms.office.com/e/jRAPk523te

6.5.5 Any individual action plans or case notes will be held in the respected areas of practice for continued monitoring and support. This may be on a platform such as OneNote or a Microsoft Teams channel in line with GDPR requirements.

6.6 Supervision Flow Chart

6.6.1 Individual areas of practice should consider how they will implement a clinical supervision structure into their department/ teams.

6.6.2 Consideration should be given as to numbers of supervisees supported in a group environment (ideally 6-8 participants to gain the most from the session)

6.6.3 Consideration should be given as to who will facilitate the supervision of the supervisors i.e., Senior supervisors as outlined below:

6.7 Training and implementation

6.7.1 Appropriately identified Supervisors need to be recruited and trained consistently across the organisation.

6.7.2 Supervisors' training will consist of two parts. Part 1 is an eLearning package which has been standardised across the organisation for all supervisors, with a reflective questionnaire to complete to evidence learning and understanding. Part 2 is a face-to-face (virtual or in person) component, which will be tailored to a supervisor's individual area of practice.

6.7.3 The eLearning will consist of 3 core modules found on the E-LfH platform (e-learning for healthcare (e-lfh.org.uk), details of how to access resources can be found in appendix 4:

- Introduction to core supervision

- Training support – trainees with difficulties
- Building Staff Psychosocial Resilience and Wellbeing – Supporting Your Colleagues Effectively

6.7.4 Certificates of completion of the modules above will be requested by the senior supervisor prior to commencing part 2.

6.7.5 To consolidate the learning from the modules listed above the supervisor will then complete a questionnaire to evidence learning and understanding of the clinical supervision process.

PART 1- Supervisor Evidence of Learning and Reflection of clinical Supervision Process:
https://forms.office.com/e/4u1HTAEjMY

6.7.5 Part 1 will take 3.5 hours to complete.

6.7.6 Part 2 will be dictated by the area of practice, delivery and structure of clinical supervision being undertaken in that area.

6.7.7 It is advised that Part 2 is broken down into two further sections, with a draft itinerary covering the following topics:

- Structure of delivering clinical supervision in your area e.g., flow chart of hierarchy (workforce triangle), mode of delivery i.e. individual, group, size of teams.
- Ensure supervisors have a good awareness of the difference between clinical supervisor and line manager (where to signpost appropriate queries/ concerns).
- Ensure staff feel competent to undertake Clinical supervision and address any queries from their Reflection forms completed in Part 1 (Clinical psychology team may be able to provide resources or join for part of the session where possible).

- Understanding of Wellbeing services available in WAST (Wellbeing team may be able to provide resources or join for part of the session where possible).
- How to access additional relevant WAST resources e.g.to address specific training needs.
- Concerns/ Escalation process e.g., where education/ line management/ wellbeing support may be required.

BREAK

- Documentation- relevant MS Forms
- Specifically address the mandatory form
- Auditing practice and results
- How to use the Power BI dashboard (if applicable) or awareness of organisational reporting process
- Feedback process and continued supervision for Supervisors

6.7.8 It is estimated that PART 2 will take 4 hours.

7. ROLES AND RESPONSIBILITIES

7.1 Consultant Paramedic for Urgent and Unscheduled care

The Consultant Paramedic for Urgent and Unscheduled Care is responsible for the implementation of this policy and monitoring the efficacy of Clinical Supervision facilitation.

7.2 Education Clinical Lead

The Clinical Lead for Education is jointly responsible for the Clinical Supervision strategy with the Policy Implementation Lead to ensure trust-wide implementation. They will provide governance assurance through approved reporting route.

7.3 Directorate Level Clinical Leads

Clinical Leads through their wider teams are responsible for the effective delivery of Clinical Supervision. They will ensure sessions are facilitated in a timely and structured manner, supervisor/supervisee relationships are meaningful and productive and that outcomes are recorded and audited in conjunction with this guideline.

7.4 Professional Development Lead

The Professional Development Lead is responsible for overseeing the Trust's Clinical Supervision model, mode and framework along with providing professional clinical support to Clinical Leads and supervising clinicians to ensure Clinical Supervision is effectively embedded into the organisation.

7.5 Line Managers

Line Managers are responsible for ensuring staff are provided with adequate CPD hours to undertake regular Clinical Supervision as described in 5.6 of this policy.

7.6 Staff

Staff are reminded that Clinical Supervision is a continuing cycle of self-reflection, planning, implementation and reviewing that is mutually beneficial to you, your patients, your profession (where appropriate) and the organisation. It is vitally important to ensure that all outcomes and actions as a result of Clinical Supervision are correct and up to date and appended to your portfolio.

Staff must comply with the provision of this policy and where requested to demonstrate such compliance. Failure to comply will be dealt with under the Trust's Disciplinary Policy as appropriate.

8 EQUALITY IMPACT ASSESSMENT

The EqIA process has been undertaken as part of this policy and can be available upon request.

8.1 Welsh Language Impact Assessment

Consideration has been given to the Welsh language in the creation of this policy and the Welsh Language Impact Assessment has been completed.

Where possible a Welsh speaking clinical supervisor will be facilitated upon request.

8.2 Environmental Standards and Impact Assessment

This policy will put the relevant requirements in place (such as a waste management plan, reduction of CO_2 emissions & reduction of carbon footprint) in order to ensure that the Welsh Ambulance Services NHS Trust's ongoing commitment to reduce its impact on the environment is maintained and to become a more sustainable organisation in line with Trust policy and Environmental Governance System.

However, the Policy Group or Employment Policy Sub Group will ensure that the Estates Team has had an opportunity to consider all policies within the process in order to establish whether an impact assessment, waste management plan or CO_2 Reduction Plan is required.

8.3 Counter Fraud

The Welsh Ambulance Services NHS Trust is committed to taking all necessary steps to counter fraud, bribery and corruption within the Trust. Staff should report suspected incidents of fraud and corruption to the Trust Local Counter Fraud Specialist, who will be happy to discuss any issues or concerns. Alternatively, staff may contact the confidential NHS Counter Fraud Authority, Fraud and Corruption Reporting line on 0800 028 40 60; or the online reporting facility https://cfa.nhs.uk/reportfraud Fraud investigations may lead to disciplinary action and/or prosecution and civil recovery procedures.

8.4 Records Management

The Welsh Ambulance NHS Services Trust (WAST) recognises the importance of sound records management arrangements for both clinical and corporate records. The Trusts' records are its corporate memory, providing evidence of actions and decisions and

representing a vital asset to support daily functions and operations. Records support policy formation and managerial decision-making, protect the interests of the Trust and the rights of patients, staff and members of the public.

8.5 Information Governance

Information Governance (IG) is an overarching term used to describe all aspects of information management. The Trust and its staff shall ensure that they provide satisfactory assurance to stakeholders as to how the organisation fulfils its statutory and organisational responsibilities in relation to the management of information. It will enable management and staff to make correct decisions, work effectively and comply with relevant legislation and the organisation's aims and objectives.

The IG framework ensures that it sets out the high-level principles for confidentiality, integrity and availability of information to promote and build a level of consistency across the Trust.

8.6 Training

WAST is committed to providing high-quality evidence-based education to an engaged and skilled workforce operating within an organisational culture and framework that enables colleagues to work to the top of their skill set to deliver high quality care and services with competence and confidence. Staff are encouraged to discuss any concerns or queries regarding education and training with a member of the Education and Training Team, by telephoning the Learning & Development Hub on 0300 123 2319 or via email at amb_LDHub@wales.nhs.uk

8.7 Health and Safety

Compliance with the policy is strongly recommended to ensure a developed and sustainable workforce that feel valued and supported.

Failure to comply with the policy, for example, lack of engagement in the clinical supervision process may be reported to their line manager and managed in accordance with trust procedures.

Staff should ensure:

- Their practice is in line with policies in use across the Trust and specific to their area of work.
- Information regarding any changes in practice, that would require an urgent review of documents is immediately reported to their line manager.

9 REFERENCES

HCPC (2019) Report- The Characteristics of effective clinical and peer supervision in the workplace: a rapid review of the evidence. Available at: effective-clinical-and-peer-supervision-report.pdf (hcpc-uk.org) (accessed May 2022).

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NMC (2018) Standards for competence for registered nurses. Available at: nmc-standards-for-competence-for-registered-nurses.pdf (accessed June 2022).

AACE (2021) Clinical Supervision, A framework for UK Ambulance services 2021. Available at: Clinical-Supervision.docx-Final.pdf (aace.org.uk) (accessed April 2014).

HEIW (2023) Professional Framework for Enhanced, Advanced and consultant level practice. Available at: Professional Framework for Enhanced, Advanced and Consultant Clinical Practice - HEIW (nhs.wales) (accessed June 2023)

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10 APPENDICES

Appendix 1 – Clinical Supervision – Individual Contract

Appendix 2 – Clinical Supervision – Individual Session

Appendix 3 – Individual Case Based Discussion

Appendix 4 – Clinical Supervision – Group Sessions

Appendix 5 – Supervisor Training Access instructions - E-Learning for Health

Appendix 1: Clinical Supervision - Individual Contract:

The aim of a clinical supervision contract is to help both the supervisor and supervisee understand the expectations of the sessions and consider how clinical supervision will be delivered over the course of the year.

A supervisor will:

- Facilitate the conditions for learning and discussion to take place by creating a confidential, safe space and structure to the sessions.
- Provide support and be responsive to the needs of the supervisee, including an understanding of their stage of development and scope of practice.

A Supervisee will:

- Use the clinical supervision sessions to further their knowledge and develop their skills by participating and contributing.
- Identify areas of practice that need support by reflecting, being open and honest, and respectful to the supervisor and clinical supervision process.

1.) Name of Supervisee/ person having the clinical supervision:

2.) Explain the importance and rationale for implementing a clinical supervision process into the organisation. Highlight the difference between a line manager and clinical supervisor to ensure the supervisee knows who to contact for a particular area of support. Allow for any questions, reflections or concerns to be addressed.

3.) Outline the aim of the session from both the supervisor and supervisee perspective:

4.) Discuss confidentiality- what information will be shared outside of the session if necessary:

5.) Auditing- explain how the sessions will be audited and the purpose i.e. clinical supervision contacts across the organisation will be collected (not the content of the sessions) to benchmark how each area of practice is delivering clinical supervision.

6.) Are there any specific areas of focus that the supervisee would like to explore as part of their Clinical Supervision sessions or feel are important to their clinical supervision process, e.g. case based discussion, professional development, areas requiring clinical support?

7.) Have an open discussion about the wellbeing and support services available in WAST and beyond the organisation that may benefit the supervisee.

8.) Consider frequency/ duration/ location for further meetings and note any individual considerations or requests from the supervisee:

Appendix 2: Clinical Supervision - Individual Session

1.) Name of supervisee undertaking clinical supervision session:

2.) Briefly outline any clinical supervision principles or ground rules if necessary.

3.) Are there any specific areas of focus that the supervisee would like to explore as part of their Clinical Supervision sessions or feel are important to their clinical supervision process, e.g. case based discussion, professional development, areas requiring clinical support? This main section should be supervisee led where possible.

4.) Where appropriate clinical supervisors should review a clinicians e-portfolio/ CPD evidence.

5.) Summarise any actions or points of reflection the supervisee would like to take away and explore for next time i.e. reflection on an asthma patient.

Appendix 3: Individual Case Based Discussion

1.) Name of supervisee undertaking clinical supervision session:

2.) Does this Case Based Discussion form part of a supportive action plan (following a clinical review or concern?). Ensure action plan are updated to reflect the outcome/ reflection of the session.

3.) Case Discussion: Incident Number or type of case discussed:

Outline the case- analyse the situation, draw a working hypothesis, discuss alternative explanations using evidence to inform understanding and draw conclusions. Consider issues/ reflections to be discussed today, what support might be needed. Supervisees to reflect on the experience and any factors need to gain full understanding of the case e.g. learning need, organisational awareness on policy, JRCALC.

4.) Consider tangible actions for supervisor and supervisee to complete by certain timeframe e.g. reflection on learning or providing additional resources:

5.) Would the supervisee like to provide any feedback on the clinical supervision process to improve organisational awareness and future delivery?

Appendix 4- Clinical Supervision Group Sessions

Group Clinical Supervision can be an excellent way to develop a tight bond amongst a group of staff to discuss, reflect, learn, and develop in a safe and supported environment.

Setting the scene and context for the session to thrive is very important as well as ensuring all voices are given the opportunity to be heard.

Role of the Supervisor: to facilitate safe conditions for individuals' beliefs and values to be respected, provide structure to the session, promote discussion and learning.

Role of the Supervisee: to use the session to further develop knowledge and skills and reflect on practice. Be open, honest, participate and contribute to get the most out of the session. Respect the confidentially and views of others.

1.Outline the structure of the session and consider the aim of the clinical supervision session from supervisor and supervisee perspectives, including what will be audited for organisational awareness and how data/ confidential information will be stored if relevant. Outline how often you will meet as a group, when/ where etc.

2.Consider agenda, points for discussion and if any pre-planning should be considered i.e. staff bring case study for discussion

3.Case Discussion: Incident Number or type of case discussed:
Outline the case: analyse the situation, draw a working hypothesis, discuss alternative explanations using evidence to inform understanding and draw conclusions.
Consider issues/ reflections to be discussed today, what support might be needed.
Supervisees to reflect on the experience and any factors need to gain full understanding of the case e.g. learning need, organisational awareness on policy, JRCALC.

4.Agree any action points as a group or individual to consider for agreed timeframe e.g. next session how will supervisees as collective group demonstrate growth in practice?

5.Help staff identify areas in their practice knowledge and skills that are topics for continued professional development

6.Outline supportive options if required, wellbeing services, eLearning, training needs and facilitate group/ individual actions plans as required.

7.Would the supervisees like to provide any feedback on the clinical supervision process to improve organisational awareness and future delivery?

Mandatory for Supervisors (after every clinical supervision contact):

- Clinical Supervision Dashboard- Supervisors: https://forms.office.com/e/3Dr33Nqq2F

Clinical Supervision template for Supervisee:

- Clinical Supervision- Supervisee Reflection https://forms.office.com/e/jRAPk523te

Appendix 6: Supervisor Training Access instructions - E-Learning for Health

1. Log on to www.e-lfh.org.uk.

2. Click on Register/Log in – If you already have an account proceed to bullet point number 9.

3. Click 'register a new account'.

4. Register using your NHS email address. Fill in your details, and click on register.

5. Once you press register an email with your username will be sent to you – please note this may take up to an hour.

6. Once the email has been retrieved, there is a link underneath your username, press this to create a password.

7. Once the password has been created then click the 'log in' button. Click on 'Sign in'

8. Insert username and password and sign in – you will be redirected.

9. At the top of the webpage there is a 'search the eLearning' box, type in "introduction to core supervision" and click on the magnifying glass (to search).

10. There will be two modules which come up, chose the bottom module which is 'under the supervision for multi-professional teams', and 'supervision for multi-professional teams' titles. Click enrol, and sometimes a popup box comes up, if it does click "continue with enrolment".

11. Once enrolled repeat this process by searching 'trainees with difficulties', and enrolling on the first module – educator training resources NEW – 01 supervision of learners – video: training support - trainees with difficulties.
12. Once enrolled repeat this process by searching 'supporting your colleagues effectively' and enrolling on the first module – MindEd Blue Light Service – Building Staff Psychosocial Resilience and Wellbeing – Supporting Your Colleagues Effectively.

13. You have now enrolled in all 3 courses, we recommend carrying out the core supervision model, trainees with difficulties and then supporting your colleagues effectively, however, this can be done in any order.

14. Click on ‘my e-learning’.

15. Click on the ‘supervision for multidisciplinary teams’ tab, then open the ‘supervision of multidisciplinary teams’ folder, then play ‘introduction to core supervision’, this should open a pop-up.

16. Once completed this module has been completed, if you click on the ‘supervision for multidisciplinary teams’ tab then you can download your certificate by clicking on: 

17. Click on the educator training resources tab and select supervision of learners. At the bottom of the page, press play on the video: Training Support – Trainees with difficulties.

18. Once completed screen-shot the results, you can do this by pressing the print screen button on your keyboard (often found on F11) and pasting it into an email or a word document.

19. If you have any difficulties, there is a website ‘live chat’ where support can be provided, you can find this at the middle of the top of the webpage.

AGENDA ITEM No	
OPEN or CLOSED	
No of ANNEXES ATTACHED	

Clinical Supervision: Considerations for Implementation

MEETING	Executive Leadership Team (ELT)
DATE	9/02/2024
EXECUTIVE	Andy Swinburn
AUTHOR	Kerry Robertshaw
CONTACT	Kerry.Robertshaw@wales.nhs.uk

EXECUTIVE SUMMARY
KEY ISSUES/IMPLICATIONS
REPORT APPROVAL ROUTE
REPORT APPENDICES

REPORT CHECKLIST

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

Introduction

Clinical Supervision has been defined by the HCPC as '*a process of professional learning and development that enables individuals to reflect on and develop their knowledge, skills, and competence, through agreed and regular support with another professional*' (HCPC, 2022). This process enables individuals to develop knowledge and competence, assume responsibility for their practice and enhance service user protection, quality, and safety of care (HCPC, 2021).

Whilst clinical supervision has been available across established professions such as nursing for decades (NMC Regulatory Requirements, 2018), other professions such as paramedicine are understanding the value and importance of adopting clinical supervision into traditional ambulance settings, in line with the recommendations from Association of Ambulance Chief Executives (AACE) Clinical Supervision framework (2021).

Within Wales, Health Education and Improvement Wales (HEIW) have released a professional framework for enhanced, advanced and consultant level practice (2023) which details the need for consistent access to clinical supervision across the wide range of health professions and variety of clinical roles.

Background

October 2023 saw the approval of the WAST Clinical Supervision policy being formalised. The key recommendations of which is that clinical supervision:

Supports and enhances practice
Develop skills in reflection
Involves a supervisor and practitioner (or group of practitioners) reflecting on and critically evaluating practice
Be distinct from formal line management supervision and appraisal
Be planned, systematic and conducted within agreed boundaries
Be explicit about the public and confidential elements of the process
Allow for clear and unambiguous communication, conducted in an atmosphere of mutual respect.
Be available to all staff with direct patient contact (including remote contact)
Facilitated a minimum of 4 times a year to each member of staff

The Three core approaches to be adopted are:

Normative: This is the monitoring and clinical risk management component which enables the supervisee to focus on issues of a person-centred, safe, and effective practice and their professional accountability in relation to practice.
Restorative: This supportive component provides the supervisee with a safe and confidential environment to reflect on personal reactions and feelings and identify possible need for further support. It provides validation of good practice and underpins the establishment of a good working alliance.
Formative: This educative component enables the supervisee to reflect on their work and identify their ongoing professional development needs.

Whilst the clinical supervision policy is applicable to all areas of the ambulance service where staff have patient contact, this paper will focus on six core areas of ambulance delivery where the vast majority of staff time is engaging with patients/ service users- CCC/ 111/ CSD/ ACA/ EMS/ APP.

During the writing of the Clinical Supervision policy, a paper was taken on two occasions to highlight the "gap" in current provision against what the actual need would be should the policy be accepted. Although both papers quoted exact numbers (of a time) in terms of provision, this does change as establishment does and so the general areas for consideration of provision of supervision in different areas of the organisation can be generally summarised as below;

The Key Below identifies where services feel they are at currently with providing clinical supervision to their staff.

All Clinical Supervision needs	Some Clinical Supervision needs met	No Clinical Supervision needs met

CCC- Call Takers

No Supervision needs met

There is a recognition that whilst the Wellbeing offer is strong for staff in this area there is very little specific clinical focus on providing support for staff who would like to learn and reflect on events.

There has been increased focus on using training days to share awareness of roles within the organisation (CHARU visits) and there are ongoing discussions with the EMS quality team to consider how organisational learning (e.g. coroner inquest, regulation 28, lessons learnt through SCIF) can be incorporated into future restructuring of training days.

Some of the core themes that came out of discussions were around being able to facilitate effective, clinical HOT debrief after difficult incidents, clinically focussed learning from events to develop call taker awareness of wider considerations and stronger links across to clinical access for general support and queries through a more structured process.

Evidence in clinical academic journals suggests that with structured clinical supervision then retention rates for staff groups are higher, a key metric to improve for this group.

111 Service

Some Clinical Supervision needs met

Since the approval of the clinical supervision policy, the 111 team have been at the forefront of implementing a clinical supervision structure in the remote environment. They have placed nearly all clinical staff on the eLearning module outlined in the policy to provide wider awareness of the benefit and function of the clinical supervision process and have provided the Induction package outlined in the policy to the Practice educators who will deliver the clinical supervision to their peers.

Once the process commences in full (which is on track to do so) clinical staff will be able to access 2 individual session with their clinical supervisor and a minimum of 2 group sessions (6-8 per group) throughout the year.

Wider consideration needs to be given to the senior clinical workforce (Band 7 roles and above) and the non-clinical workforce operating in this space (approx. 240 staff).

CSD (Clinical Support Desk)

No Clinical Supervision needs met

There is a recognition that whilst the clinical support and structure is there for staff who may be need additional support, identified through audit, clinical concern or action plan, the general clinical supervision offer is currently not embedded into the CSD service.

There is a significant appetite to work with 111 colleagues who have progressed the clinical supervision offering within their service to consider how an integrated model may be embedded consistently across both services.

EMS (EMT & Paramedic Grades)

Some Clinical Supervision needs met

With the implementation of the Senior Paramedic role across the EMS system, staff now have access to 2 clinical ride outs a year, and a designated clinical contact in which to raise informal and formal clinical queries and receive appropriate support and guidance.

With the restructure of the Statutory and Mandatory training within the Learning and Development Team the MIST training is now clinical supervision led, exploring group needs through scenarios and understanding of each other's role, with time to reflect and discuss roles. This is available to all patient facing staff currently.

Ambulance Care Service (ACA)

No Clinical Supervision needs met

Since its alignment away from the EMS workforce, ACA have no current access to clinical supervision support through an EMS mechanism. This has been a growing concern as clinician input if often required in several areas of practice (including clinical concerns etc).

With potential discussions ongoing around implementing a clinical role to support this workforce, consideration has been given to the requirement and implementation of clinical supervision, but as of yet have further consultation to establish how this could be facilitated. The ACA team are keen to work with any clinical supervision support that may be given to develop this space.

With the restructure of the Statutory and Mandatory training within the Learning and Development Team the MIST training is now clinical supervision led, exploring group needs through scenarios and understanding of each others role, with time to reflect and discuss roles. This is available to all patient facing staff currently.

Advanced Paramedic Practice (APP)

No Clinical Supervision needs met

Advanced Practice has grown sporadically in the organisation since 2006. Since this time, we have seen the rise of Advanced Practice roles across Wales with recognised framework outlining the clinical supervision requirements for this workforce. Our current model relies closely on working with Primary and Urgent care settings in a rotational capacity where clinical supervision is often inconsistent, sporadic and ad hoc.

This has not always been the case, during the PACESETTER program 2019-2022 structured clinical supervision was supported through a funded model and the outcomes evaluated favourably at www.apppacesetter.co.uk. Since the

Through the Advanced Clinical Practice Delivery Group (ACPDG) we are in the developmental stages of working with the Primary Care Academies across Wales to develop a consistent training pipeline which will include an element of clinical supervision.

Within the organisation we currently have no formal mechanism to provide clinical supervision to this staff group, which are considered senior clinicians in the organisation having all been educated to master's level with a clinical focus. They arguably require an enhanced level of clinical supervision and support to enable them to provide safe clinical decisions outside of formal guidelines (such as JRCALC) and more in line with clinical decision-making tools utilised during their Primary/ Urgent Care rotations (such as NICE and Microguide).

As well as Primary and Urgent Care rotations, we are continuing to see the emergence of APP Navigator models which provide remote consultation support to our workforce, patients and wider Healthboard partners in a collaborative Multi-disciplinary team setting. There is currently no formal clinical supervision structure embedded into this role, and whilst the role is different to both 111 and CSD colleagues there is a recognition that they are also working in the remote space and will require specific clinical supervision around this skill set.

The current Advanced Paramedic Practitioner- Prescriber role (8a) does have a section around the provision of leadership to the wider workforce, however, there is currently no allocation of time within operational delivery of this clinician group to facilitate this. Consideration should be given as to how this role can be adapted both in its deployment and ability to provide an appropriate level of support to the rest of the advanced and trainee advanced workforce.

With the restructure of the Statutory and Mandatory training within the Learning and Development Team the MIST training is now clinical supervision led, exploring group needs through scenarios and understanding of each other's role, with time to reflect and discuss roles. This is available to all patient facing staff currently.

Assessment

Through exploring each area of practice, it is clear that there is a mixture of services currently available at varying levels. A range of dedicated clinical support and links to the Education teams appear to be the current mixed approach to providing a level of clinical supervision across the organisation.

The needs of remote clinical settings varied to the needs of patient facing clinical settings, therefore the areas requiring similar clinical supervision needs are identified below:

Remote Service Areas

Area	Type	Current
111	Registrant & Non-Registrant	Some
CSD	Registrant	None
EMS Co-ordination	Non- Registrant	None

Patient Facing Service Areas

Grade	Area	Current
EMS	Registrant & Non-Registrant	Some
APP	Registrant	None
ACA	Non-Registrant	None

In the cases of non-registrant clinical supervision, consideration should be given as to how registrants from similar areas of practice can support the delivery and implementation of clinical supervision for this workforce.

Two separate task and finish groups could be considered to work through the clinical supervision requirements for the groups above in line with the framework approved in the clinical supervision policy.

Membership should consider including:

- Representation from each area identified above
- Learning and Development/ Education teams aligned to the service delivery
- Clinical and Operational representatives at senior level e.g Head of Service/ Consultant Paramedic
- Workforce representative to consider rota/ planning implications/ commissioning numbers
- Trade Union Representative

It would be recommended that a program of work could be considered below:

Time Line →		
Q1	Q2	Q3-4
• A Gap analysis is undertaken of each area to identify specific requirements for embedding clinical supervision • An options appraisal is formed from the findings, these may include in some areas an Organisational Change process to build clinical supervision infrastructure and	• Individual implementation plans are considered and approved • Where Organisational change may need to occur the process has been considered and approved (where appropriate).	• Implementation of clinical supervision in area of practice

capacity into the staff role.		

Recommendations:

- Two Task and Finish groups are established to work through clinical supervision needs for remote and clinical facing areas of practice.
- T&F would undertake a gap analysis, Options appraisal and implementation plan to be approved by ELT. In some areas of practice this may include an organisational change process.

Dispatch Cross Reference (DCR) Table Management Policy

Policy Number:	091	**Version No:**	1.10	**Supersedes:**	1.9
Date of Approval:	23/11/2024	**Review Date:**	23/11/2027	**Impact Assessments Completed:**	Yes
Classification of Document:	Corporate	**Type of Document:**	Policy	**Approved by:**	Policy Group
Brief Summary of Document:	The aim of this policy is to provide a structure and process to follow when setting the type of clinical response for the codes within the MPDS system. More specifically, it provides a procedure for making any changes to the response assignment of the Dispatch Cross Reference (DCR) Table, and subsequently, making any changes to the Computer Aided Dispatch (CAD). This is aligned to the requirements of the International Academy of Emergency Dispatch (IAED).				
Scope:	The policy applies to all staff employed by the Trust, who have responsibility for the development / review, approval, maintenance, and operational management of the organisation's DCR Table.				
To be read in conjunction with:	Welsh Ambulance Services NHS Trust's 'The Clinical Model: Action Card Set For Emergency Medical dispatch (EMD) Action Cards'. Emergency Medical Dispatch Update guides by the International Academy of Emergency Medical Dispatch (IAEMD). NHS England's New Ambulance Standards: Ambulance Response Programme (ARP)				
Owning Committee	Quality, Patient Experience and Safety Committee				
Policy Lead: **Trade Union Lead:**	Grayham Mclean Henry Garrard	**Job Title:**	Head of Clinical Improvement Trade Union Partner		
Executive Director:	Andy Swinburn	**Job Title:**	Executive Director of Paramedicine		

Version Control Sheet

Version	Date	Author	Summary of Changes
1.0	07/12/2019	Grayham Mclean	New Policy
1.1	24/02/2020	Grayham Mclean	Updates following CPAS Meeting 08.01.2020
1.2	20/07/2020	Grayham Mclean	Minor amendments following Policy Group Updated title - full description of 'Data Cross Reference (DCR) Table Inserted Table 1 - inclusion of terminology from the Trust's Policy on the Development, Review, and Approval of Policies Updated - that the Executive Medical Director has overall responsibility and accountability for the management of the DCR Table Updated section 7 – 'Audit and Monitoring' to refer to WAST governance and auditing process Inserted new section (section 9) – 'Training and Implementation'
1.3	27/07/2020	Julie Boalch	Minor formatting amendments
1.4	24/08/2020	Andeep Chohan	Inserted Counter Fraud section following staff consultation
1.5	22/10/2020	Grayham Mclean	Updates following Executive Management Team's (EMT) review: Section 6.1 (Figure 1) to ensure that the Senior Operational Team (SOT) are informed of any changes to the DCR Table. Section 6.1 (Figure 1) to ensure Health Informatics are informed of any changes to update reporting requirements. Section 6.2 (Table 2) to confirm that during a major incident/pandemic crisis, CPAS Operational members are specifically required to inform the Strategic Command Structure of any changes to the DCR Table.
1.6	14/01/2021	Grayham Mclean	Section 6.1 (Figure 1) to ensure that the relevant senior team (Operations / Finance / Workforce and Organisational Development) are engaged early in any potential changes – allowing time to undertake any impact analysis. Section 6.2 to confirm that the relevant senior team (Operations / Finance / Workforce and Organisational Development) have the ability to undertake an early impact analysis of potential changes, but that what such information will not influence the clinical decision making of CPAS.
1.7	12/10/2023	Andeep Chohan	Section 1 updated to replace Executive Medical Director with Assistance Medical Director as responsible for defining response assignments for each MPDS code

Version	Date	Author	Summary of Changes
			Section 6.1 (Figure 1) to include Senior Leadership Team and Clinical Quality Governance Group as approval/governance routes.
1.8	29/11/2023	Andeep Chohan	Updated following Feedback from Policy Group: Contact email address updated in disclaimer on page 4. Executive Director updated to Executive Director of Paramedicine on page 1. Task and Finish Group members, Trade Union rep updated to Henry Gerrard. Update Vince Baglole title to Clinical Improvement Manager. Updated Andeep Chohan's title to Project Manager. Section 6.2 Greg Lloyd's title updated to Assistant Director of Clinical Delivery. Appendix 13 'Medical' removed from International Academy of Emergency Dispatch. General formatting and spacing updated to be consistent throughout document.
1.9	26/04/2024	Lisa Trounce	Crown badge and Trust logo replaced with new versions. Header amended to reflect Trust's university status. Footer amended to reflect correct version number. Colour palette amended in line with corporate guidance. Version control sheet amended so date format consistent Fraud hyperlink corrected in section 11 (hyphen missing).
1.10	01/05/2024	Lisa Trounce	On advice of Vince Baglole, hyperlinks contained within Appendix 2 removed as these relate to the live ProQA system and change with every update.

Keywords	International Academy of Emergency Dispatch (IAED) of Medical Priority Dispatch System (MPDS), Response Assignments, Clinical Prioritisation Assessment Software (CPAS) Group, Determinant Cross Reference (DCR) Table, Computer Aided Dispatch (CAD), Request For Change (RFC).

Impact Assessment Reviews

Area	Date of Review	Name of Reviewer
Counter Fraud	24/08/2020	Carl Window
Information Governance	24/02/2020	Sue Brown
Records Management	24/02/2020	Liam Allsup
EqIA / Welsh Language	24/01/2024	Grayham McLean Vince Baglole Paola Spiteri Henry Gerrard Melfyn Hughes
Estates	N/A	
Environment	N/A	

Task and Finish Group Members

Name	Job Title
Grayham Mclean	Head of Clinical Improvement
Henry Gerrard	Trade Union Partner
Grahame Lloyd	Systems Manager (CAD)
Vince Baglole	Clinical Improvement Manager
Andeep Chohan	Project Manager

Policy Approval Route

Where	When	Why
CPAS	08/01/2020	Review initial draft
CPAS	04/03/2020	Agree draft submission to Policy Group
Policy Group	20/07/2020	Review initial draft
CPAS	25/10/2023	Agree draft submission to Policy Group
Policy Group	28/11/2023	Final review – Approved for 3 years
ELT	08/05/2024	Noting
QUEST	08/02/2024	Noting

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

Contents

1. INTRODUCTION

The Welsh Ambulance Services NHS Trust, subsequently referred to in this policy as the Trust, uses the Medical Priority Dispatch System (MPDS) to: handle 999 calls (prioritise and set a dispatch code); dispatch / allocate appropriate clinical responses to such calls; and provide pre-arrival instructions to telephone callers.

To ensure the safe use of MPDS, the Trust has a licensing requirement, and mandatory clinical duty, to ensure that there is a clear policy / governance process in place for determining what clinicians / resources should be assigned to each of the determinant codes, as set by the International Academy of Emergency Dispatch (IAED). **This is set within the Trust's DCR Table.**

Such responsibility for defining these response assignments for dispatch to each MPDS code is clearly set by the IAED as that of a Medical Director, or to their delegated group / committee. In the case of the Trust, the Assistant Medical Director has delegated this responsibility to the CPAS Group.

CPAS has, therefore, developed a process for ensuring safe and consistent maintenance, or changes, of clinical response assignments contained within the DCR Table.

2. POLICY STATEMENT

The purpose of this policy is to ensure the Trust has a safe, consistent and robust governance process in place for making any clinically approved changes / updates to the DCR Table.

This policy is intended to ensure the Trust complies with the IAED's quality assurance requirements, which ensure safe and effective emergency medical dispatch services worldwide. It is also an effective source of guidance for staff to follow to safeguard the DCR table, and to enact any clinically approved changes by CPAS.

The table below explains the terminology that is used within this policy and is in accordance with all other Trust policies.

Table 1: explains the terminology that shall be used in all policies.

Term	Meaning/Application
SHALL	This term is used to state a **Mandatory** requirement of the policy.
SHOULD	This term is used to state a **Recommended** requirement of the policy.
MAY	This term is used to state an **Optional** requirement of the policy.

3. SCOPE

The policy applies to all staff employed by the Trust, who have responsibility for the development / review, approval, maintenance, and operational management of the organisation's DCR Table.

4. AIM

The aim of this policy is to provide a structure and process for safe and effective changes / updates to be made to the Trust's DCR Table. Such changes ***SHALL*** only be made after clinical review and approval by CPAS.

5. OBJECTIVES

To enable the Trust to achieve this aim and ensure consistency and safety in making changes to the DCR Table, this policy sets out the procedures for:

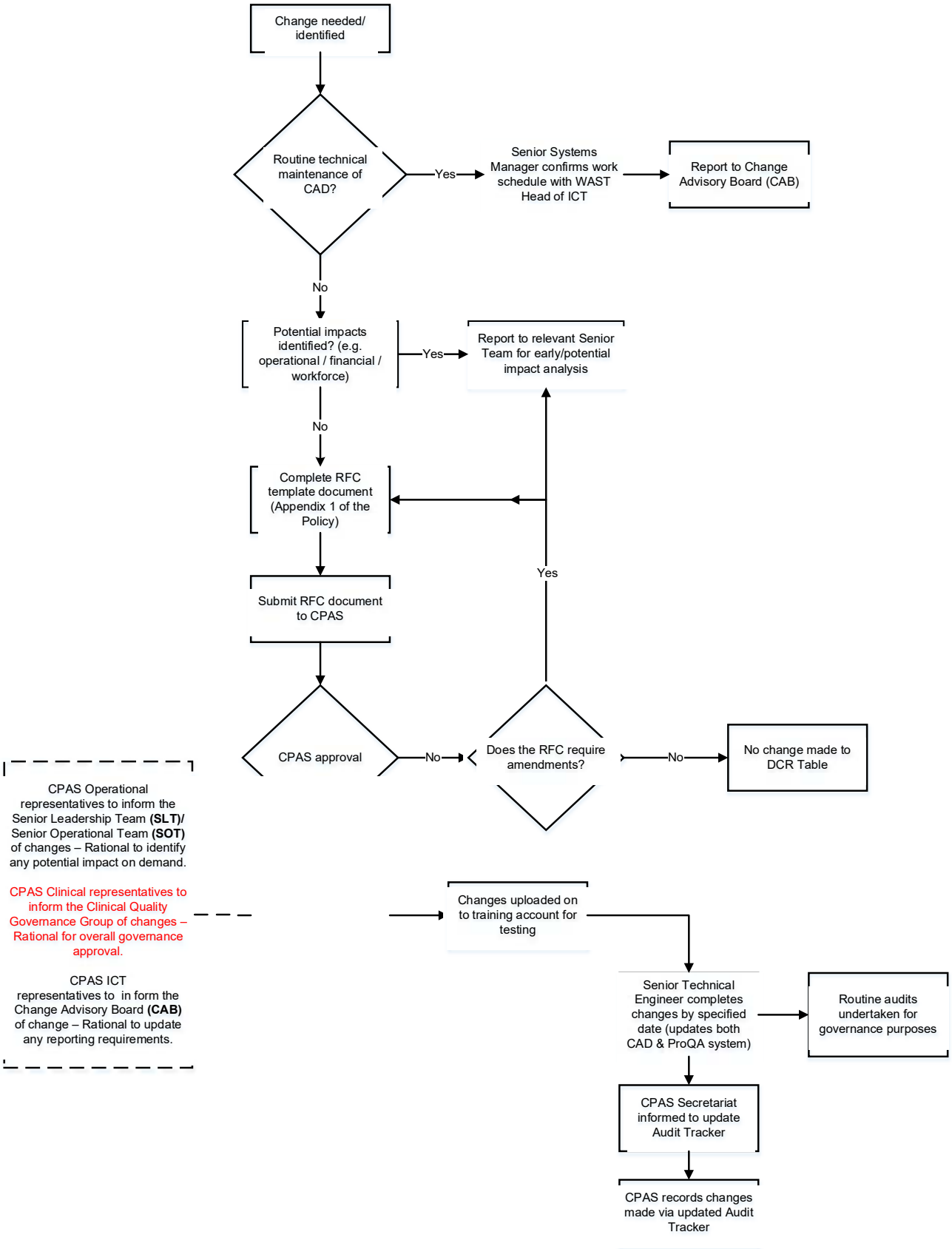
- ensuring that the DCR's assigned clinical responses to the MPDS codes reflects best practice, and is benchmarked in line with other UK Ambulance Services standards;
- routine technical maintenance by approved engineers;
- reviewing and ratifying clinical changes;
- making the agreed / ratified changes to the 'live' DCR Table; and,
- overseeing the management of document governance for the systems (DCR and CAD), including cataloguing, reviewing, ratification, distribution, approval and accurate version control.

6. PROCEDURE FOR MAKING CHANGES TO THE DCR TABLE

6.1. Request for Change (RFC) Sequence

The sequence to follow when making changes to the DCR Table is summarised in Figure 1 and below.

Figure 1: Sequence to adhere to when making changes to WAST's DCR Table:



6.2. Further Procedural Information

Further information on Figure 1, shown in section 6.1. of this policy, is presented in Table 2 and below.

Table 2: detailed information to support the adherence to making changes to WAST's DCR table:

Sequence	Detailed Information
Changes needed / identified	Examples of the need for change, include (not an exhaustive list): • software / operating system updates • new versions of MPDS from IAED; • benchmarking with other United Kingdom (UK) Ambulance Services; • new policy from Welsh Government (via WAST's commissioning framework); and, • learning from serious adverse incidents (SAIs).
Routine technical maintenance of CAD	Software updates and systems of operating are regularly checked by Technical Engineers. This does involve any changes to the DCR Table's response assignments (namely, the clinical response set for each of the MPDS codes).
Potential impacts - operational / financial / workforce	As part of the consideration to submit a RFC, an early impact assessment must take place. This is to enable wider engagement, and ensure the relevant senior team from operations / finance / workforce & organisation development are made aware of the potential changes that will be considered by CPAS. **Note:** this is to ensure the relevant team has time to undertake an impact analysis of potential changes, and is not meant to influence the clinical decision review that CPAS must undertake (as per the quality assurance requirements of the IAED.
Complete RFC document	Prior to submission for CPAS review / ratification, an RFC document should be submitted. This must describe the rationale for change and the actual change required. A blank RFC document can be sourced in Appendix 1 of this policy. Alternatively, a blank RFC document can be requested from the CPAS secretariat: andeep.chohan@wales.nhs.uk
Submit RFC document to CPAS	Once completed, the draft RFC document can be placed as a CPAS agenda item by submitting it to the CPAS secretariat: andeep.chohan@wales.nhs.uk
CPAS approval	Based upon a review by CPAS the RFC can either be ratified or refused. On certain occasions, the RFC might require further development, and CPAS will determine that this is done via one of its quarterly reviews of the DCR Table.

Information distribution	CPAS members are responsible for cascading information regarding the DCR Table changes approved by CPAS to the relevant leads within the Trust to inform of any impact to: • performance and escalation; • system changes; and, • data reporting. In the event of a major incident/pandemic crisis, CPAS Operational members are specifically required to inform any WAST response mode / Strategic Command structure (e.g. Senior Operation Team/ Incident Command Centre) of changes for information and action.

In the event that an emergency change is required, the Assistant Medical Director, Head of Clinical Improvement, Assistant Director of Clinical Delivery and Area Manager for EMS CCC (Interim) are permitted to agree and approve changes virtually and report to the next scheduled CPAS.

As the commissioners of the Trust, The Emergency Ambulance Services Committee (EASC) need to be aware of any changes to the DCR Table approved at CPAS. CPAS includes representation from EASC to ensure that the commissioner position is reflected in any proposals. This representation, however, will not replace the requirement to seek external approval via appropriate EASC governance routes prior to enacting any changes to the Clinical Response Model.

7. AUDIT AND MONITORING

Regular audits are undertaken by the Emergency Dispatch Quality Improvement Manager to review the impact of changes to the DCR table that may impact upon systems use within the Trust.

A Clinical sub-group (under the direction of CPAS) undertakes quarterly reviews of the DCR Table to ensure the Trust is adhering to the requirement set by the IAEMD and to benchmarked in line with other UK Ambulance Services standards reflecting best practice.

This policy shall be part of the Trust auditing process to ensure that: it has been implemented effectively; fit for purpose; and, being complied with.

8. RESPONSIBILITIES

Overall responsibility and accountability for the management of the DCR Table used by WAST staff rests with the WAST **Executive Medical Director**. The WAST Executive Medical Director has the delegated responsibility of Accountable Officer to the WAST Assistant Medical Director. This is to ensure the safe and effective management and use of the DCR Table within the Trust.

The **Assistant Medical Director** is delegated with and for ensuring that the Trust has the necessary policies and procedures in place for the management of the DCR Table. As the Chair of CPAS, the Assistant Medical Director is also responsible for:

- the day to day responsibilities of the Accountable Officer;
- ensuring that the Trust has the necessary policies and procedures in place advising on the day to day safe and secure handling of the DCR Table throughout the Trust;
- ensuring that the policy is reviewed every 3 years to reflect and take account of changes in best practice guidance and legislation relating to the management of the DCR Table;
- monitoring and review of the DCR Table and its' use by the Trust; and,
- ensuring that any identified medicines related risks are placed on the Directorate and, if applicable, Trust Risk registers.

9. TRAINING AND IMPLEMENTATION

This policy relates to a specific clinical and technical sequence to adhere to, when considering or making changes to WAST's DCR table. There are, therefore, no training implications for staff, Directorates and the Trust as a whole. There is, however, a need for Executive Directors and Line Managers who have key implementation roles (as detailed within this policy) to ensure that information is cascaded appropriately to their staff.

10. EQUALITY

In accordance with the Equality Act 2010 this Policy has been subjected to an Equality Impact Assessment (EqIA).

This has enabled resources to be targeted effectively and where required help to reduce inequalities. The EqIA is a process to find out whether a Policy will affect people differently on the basis of their 'protected characteristics': age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion, sex or sexual orientation and if it will affect their human rights and whether it will have a positive or negative effect on the Welsh language. Evidence gathered at the initial stages, by undertaking an initial screening, has determined the relevance of the policy and how it affects people as service users, members of the public and as employees of the Trust and has indicated that a full EqIA is not required.

11. COUNTER FRAUD, BRIBERY AND CORRUPTION CONCERNS

The Trust is committed to taking all necessary steps to counter fraud, bribery and corruption within the organisation. In conjunction with this policy, staff should report any suspected incidents of fraud and corruption to the Trust Local Counter Fraud Specialist, who will be happy to discuss any issues or concerns. Alternatively staff may contact the confidential NHS Fraud and Corruption Reporting line 0800 028 40 60; or on-line reporting facility https://cfa.nhs.uk/report-fraud. Fraud investigations may lead to prosecution and civil recovery procedures, alongside internal disciplinary action.

12. APPENDIX 1

Request for Change document

Service Desk Reference: ***Completed by Technical Engineer***	Submission date: **Insert Details**	Priority: Low/Moderate/High/Now
Change Summary: Insert details		
Who will be doing the work? ** This section completed by Technical Engineer*		
Name:		
Team:		
Telephone:		
Email:		
Where and when is the work taking place? ** This section completed by Technical Engineer*		
Start Date:		
Completion date:		
Project/Service Desk request:		
Location Site and Room:		
Equipment to be worked on:		
ICT and Other Staff supervising/doing the work:		
Impact on other systems/departments:		
Why is the work being done? *Applicant Please COMPLETE (Justify the work – include details of testing if applicable)*		
Insert details		
Describe the work to be done. *Applicant Please COMPLETE (Include details of patches, backup and rollback strategy etc.)*		
Insert details		
Risk assessment. *Applicant Please COMPLETE*		
Insert details		
Success measures. ***APPLICANT PLEASE COMPLETE***		
Insert details		
Details of 3rd party involvement. *APPLICANT PLEASE COMPLETE*		
Insert details		
Other information. ***APPLICANT PLEASE COMPLETE***		
Insert details		

13. APPENDIX 2

IAED Technical documentation:

- ProQA Installation files and documentation
- AQUA7 installation files and documentation
- Xlerator Installation and documentation

14. APPENDIX 3

WAST Ambulance Quality Indicator specification guidance:

Appendices\WAST AQI specification guidance v4.1 (Jan 19).docx

AGENDA ITEM No	**18**
OPEN or CLOSED	**Open**
No of ANNEXES	**2**

COMMITTEE CYCLE OF BUSINESS 2024-25 & MONITORING REPORT

MEETING	Quality, Patient Experience and Safety Committee
DATE	7 May 2024
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Trish Mills, Director of Corporate Governance/Board Secretary
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. Updating of the cycle of business for this committee is the final step in the 2023/24 effectiveness reviews that were conducted in Q4. Amendments to the Committee's terms of reference agreed in Q4 have been incorporated into this updated cycle of business.

2. The cycle has been developed with direct correlation to the duties in the terms of reference (red text). This will allow members to review the appropriateness of the proposed reports and their frequency.

3. The cycle for the Committee is a maturing document which will grow organically over the next 12 months. There are some areas of the cycle where reporting remains to be developed. These primarily relate to provisions under the Health and Care (Quality and Engagement) Act including reporting on the Health and Care Quality Standards.

4. The cycle notes on the second tab are developed to inform both the Committee and report writers with reference to compliance and external reports where appropriate.

RECOMMENDATION:

5. The Committee is asked to:
   (a) Review and approve the 2024/25 cycle of business at Annex 1; and
   (b) Note the cycle of business monitoring document at Annex 2.

KEY ISSUES/IMPLICATIONS
As above
REPORT APPROVAL ROUTE
N/A

REPORT APPENDICIES
Annex 1 – Cycle of business 2024/25 Annex 2 – Cycle of business monitoring report

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

CYCLE OF BUSINESS 2024/25

SITUATION

6. The purpose of this paper is to provide the Committee with the updated cycle of business as the final step in the 2023/24 effectiveness review process.

BACKGROUND

7. The Committee carried out its annual effectiveness review on 8 February 2024. This included a review of its terms of reference, amendments to which were approved by the Committee at that meeting.

8. The final step in the effectiveness review process is the development a cycle of business for the Committee.

ASSESSMENT

Cycle of Business:

9. A cycle of business provides order and structure and sets a Committee work plan for the year. This, together with the Board Assurance Framework and forward planner drives agenda setting. It also:

    9.1. allows papers to be planned in advance, giving Directors and report writers the opportunity to plan necessary pre-committee forums and align cycles of business;

    9.2. schedules compliance related reports according to legislative or regulatory timeframes;

    9.3. provides focus for reporting and an opportunity to see where there may be duplication, gaps, and interrelationships;

    9.4. generates commitment to review matters that may sometimes be vulnerable to postponement;

    9.5. allows for easy tracking of the Committee's adherence to the cycle which is a marker of an effective Committee;

    9.6. provides for a collective awareness and agreement of the areas where it applies its focus on an annual basis; and

    9.7. removes the ad hoc elements of agenda setting.

10. Whilst it is inevitable that other items will arise from time to time, the cycle allows them to be prioritised - perhaps coming later on the agenda.

11. The cycle of business at **Annex 1** has been designed to do all the above. It includes further detail on the pre-committee forums, lead presenters, purpose of reports and any relevant and/or helpful commentary. It also includes each of the duties for the Committee in the terms of reference (in red text) so members can see and demonstrate that the reporting expected for each area will in fact provide appropriate assurance, generate discussion, and allow for the right balance of challenge and support.

12. The cycle for the Committee is a maturing document which will grow organically over the next 12 months. The areas which remain to be developed include reporting to this Committee on the Trust's compliance with the Health and Care Quality Standards.

13. The cycle notes on the second tab are developed to inform both the Committee and report writers with reference to compliance and external reports where appropriate. This, coupled with the spreadsheet that provides for Committee dates and paper deadlines enables directorates to plan their assurance papers and align operational governance forums accordingly.

Continued monitoring of the cycle of business:

14. A monitoring report will be provided to each meeting under the consent section in the agenda, and where issues of escalation are required i.e. where cycle needs to be adjusted or reporting is overdue, these will be drawn out in a short paper by the Director of Corporate Governance/Board Secretary.

15. The monitoring report appears at **Annex 2** and is completed for Q1.

RECOMMENDATION

16. The Committee is asked to:

(a) Review and approve the 2024/25 cycle of business at Annex 1; and
(b) Note the cycle of business monitoring document at Annex 2.

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

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

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

1	**Putting Things Right Report**	Audit Wales Quality Governance Review 2022 - QuESt Committee is well served with quality information, but there are opportunities for improvement. R8(a) The Trust should Develop a system to triangulate learning themes across its quality assurance reports. This should ensure clarity about what improvement actions have been taken as a result and how learning has been disseminated across the organisation. It was suggested that whilst quality metrics are available separately in the patient safety report, quality highlight report, PECI report, Ops update etc there is merit in the Committee receiving a quality assurance report which highlights and triangulates key themes, trends and learning points. Management response includes the quality management system as a way to improve triangulation. The NHS Wales Delivery Unit published a Patient Safety Incidents Policy in June 2021 with revised reporting and oversight arrangements. Subsequently a joint Learning from Events Report (LFER) in conjunction with Welsh Risk Pool covering serious incidents, redress and claims has been introduced to provide a consistent approach to learning across NHS Wales. The National Audit Office survey completed by Audit Committee recommends Audit Committee reviews information on near misses to help determine whether the systems in place are sufficiently robust to mitigate future risk events. Audit Committee 25 July 2023 agreed that near misses would be monitored by QUEST. It noted that QUEST receives patient safety reporting which is predominantly based on the significant and catastrophic harm with moderate harm and near misses incorporated into thematic content. A more explicit near miss reporting will be developed, however there is limited capacity in the team to do so this year given the need to deal with the core requirements of national reportable incidents, Coroner requests and the Duty of Candour. Note in February 2024 Quest PTR report that future reports will move to aggregated thematic reviews to determine patters and trends corporately and at Health Board levels.
2	**Duty of Quality and Duty of Care**	Policy position: A Healthier Wales 2018 (quality and safety above all else); National Clinical Framework 2021 (all organisations will adopt a quality management system and provide annual reports on quality); Quality and Safety framework 2021 (address the six domains of quality: safe, timely, effective, efficient, equitable, person-centred (STEEEP). NHS Exec to oversee establishment of a quality and safety programme. Health and Social Care (Quality and Engagement) (Wales) Act 2020: Duty of Quality; Duty of Candour, CVB; VCs Duty of Quality = improved quality of health services; better outcomes for population. Achieved through leadership and culture focused on good quality; system wide approach to quality; shared responsibility for quality; quality driven (and demonstrated) decision making; demonstrable learning and improvement; strengthened quality management systems and revised H&C Standards. Quality management = quality planning; quality improvement; quality control; quality assurance Annual Quality Report and Always On reporting - make use of existing performance, outcome and delivery indicators and measures where possible; patient and staff experience, information and stories; reporting from inspectorate and licensing bodies; consideration of national clinical audits, reports, inquiries. Dashboard in development by DU. Consistent approach desired as appropriate across NHS bodies; align reporting to our local strategic objectives.
3	**Annual Quality Report**	H&C (Q&E) Act will have a requirement to publish an annual report setting out the steps taken to secure improvements in the quality of health services. WG is also required to publish an annual report on the steps they have taken to comply with the duty of quality also. Introduced for end of 23/24
4	**Annual Duty of Candour Report**	H&C(Q&E) Act s.7; publish report after the end of the reporting year (s.8(1)). Duty of Candour Regulations will be developed 23/24. Introduced for end of 23/24. The DoC Annual report will not be a standalone annual report, Details will be presented in the Annual PTR report to prevent duplication.
5	**Dementia Standards**	Funding requests made annually to WG for dementia programme. The All Wales Dementia Care Pathway of Standards published in 2021. WG national steering group with WAST representation. Reporting on compliance against the 20 dementia care pathway standards being developed in 23/24 (see Nov 22 QUEST paper for link to standards).
6	**Commissioning Quality Core Requirements**	From a commissioning perspective the core requirements underpin delivery across the 5 steps for EMS and Ambulance Care. The headings are governance, patient experience and satisfaction, equity, patient care, staffing and safety. Commissioning Quality Core Requirements are reported to EASC with quality and patient safety elements included in MIQPR.
7	**Health and Care Quality Standards**	Reporting on compliance with the Health and Care Quality Standards 2030 to be developed in 2024/25 with the introduction of these new standards linked to the Health and Care (Quality and Engagement) (Wales) Act 2020. Assurance includes through the QPMF (F&P); audits; sub-structure review/assurance; reporting mapped to six domains; IMTP linked to six domains. TBC if stand alone self-assessment desired/required.
8	**QIA**	The QIA *process* was endorsed by QUEST. Thereafter CQGG reviews all QIAs and the Chairs of CQGG will escalate those in their professional judgment should be reviewed by QUEST. QUEST paper 110523 - CQGG will: (a) Be assured that there is an appropriate QIA process undertaken for all new and existing Trust wide service redesign/transformation, projects and cost improvements; (b) Receive oversight reports on new and existing Trust wide schemes/projects that have undergone a full QIA to ensure risk planning is robust and the impact on quality and performance is being thoroughly assessed and negative impact mitigated (c) Have oversight of the framework and central repository for all QIA's; initial screening and full QIA. (d) have oversight of onward report to the Executive Management Team; Quality, Patient Experience and Safety (QuEST) Committee and; Trust Board, as appropriate. Reports to QuEST will identify QIAs completed and explicitly identify those that have required EMT review and authorisation.
9	**Clinical Audit**	Clinical audit is an important way of providing assurance about the quality and safety of services. The Trust's Clinical Audit Team provides training and support to clinical team leaders such as senior paramedics. The type of support provided by the team includes developing audit proposals, preparing and collating data (for example patient clinical records) and writing audit reports. The Trust does not have a clinical audit policy but follows an internal audit recommendation has developed a clinical audit guide and audit proposal template to support staff. Audit Wales Quality Governance Review August 2022 recommendation 2: *We found that the clinical audit plan is not approved in a timely manner and the QuEst Committee does not have adequate oversight of progress and delivery. The Trust should ensure that: (a) the QuEst Committee scrutinises and approves a clinical audit plan ahead of each financial year; and (b) the QuEst Committee receives quarterly updates on delivery of the approved clinical audit plan, assurance reports including learning and improvement actions resulting from this work.* QUEST to assure Audit Committee that clinical audit plan in place via AAA from Chair of QUEST.
10	**Meds Management and Medical Devices**	Meds management sits in the Ambulance Practice Steering Group that feeds into CQGG. It reviews compliance with controlled drugs; patient group directives (directives for registrants for prescription only drugs e.g. flu vaccine etc) which are regularly reviewed; JRCALC guidelines; meds management and controlled drugs policy; audit of controlled drugs. Standalone report will be presented to QUEST in Q4 setting this out and proposing assurance reporting. Any exception reporting on meds management or medical devices to Quest by exception. MM audit compliance in Q1 New Meds Management Policy August 23 says at 16.6 To support the principles of antimicrobial stewardship, an annual audit of antimicrobial use by APs will be conducted and the findings reported to the Trust Ambulance Practice Steering Group, appropriate Trust Committees and where appropriate, National Antimicrobial Stewardship Forum
11	**Patient Experience**	Reports bi-annually on a PE template to WG. H&C Quality Standards integral to the plan golden thread and forms core part of the workplan. PECI report demonstrates how we meet mandatory responsibility to listen and learn from people's experiences and capture and report in line with the National Service User Framework (2014); the NHS Wales Planning Framework; NHS Delivery Framework (2018/19); WG National Framework for Assuring Service User Experience (2015); and Health Care Standards for Wales (WG, 2015b). Engagement (triangles) and consultation process. Embedded in forums and contacts around country. Driven by the IMTP as enabler; citizen centred approach embedded in plan; continuous engagement model;
12	**Mortality reviews**	In August 2021 the Delivery Unit issued the All Wales Learning from Mortality Review Framework. The Framework is a significant shift from the Trust's previous method of undertaking Mortality Reviews. The Framework document sets out that NHS organisations in Wales should undertake Mortality Reviews in relation to requests for information from the newly formed Medical Examiners (ME) in Wales. Mortality review meetings provide a systematic approach for the peer review of patient deaths to reflect, learn and improve patient care. Mortality reviews are conducted when a patient dies whilst in the Trust's care, including whilst waiting for an ambulance to arrive. To aid learning the Trust also reviews cardiac arrests where patients have survived. A Serious Case Incident Forum scrutinises issues identified through mortality reviews Identification of cases is via several sources including ME referral, incident reporting (internal and from system partners), HM Coroner, internal clinical reviews, clinical audit processes and horizon scanning. See Mortality Reviews Framework (QUEST 110523) with reporting to Quest at 7.1 and proposed to come via the Patient Safety Report with numbers of reviews, learning and actions. Oversight of the mortality review process is by CQGG at least six monthly. Audit Wales Quality Governance Review Recommendation 3: The QuEst Committee does not receive adequate assurances on mortality reviews. The Trust should ensure the QuEst Committee receives quarterly update reports to include: (a) the number of reviews undertaken and the numbers of reviews required but not yet complete; (b) any significant concerns, lessons learned and what changes have been made as a result (c) updates on actions to address the mortality review backlog; (d) updates on progress implementing the all-Wales Learning from Mortality Reviews Framework. Management Response: Monthly oversight of the All Wales Mortality Review Framework now occurs at the Clinical Quality Governance Group (CQGG) via the Alert / Advise / Assure process (Executive led) with onward assurances / updates to QuESt through the CQGG reporting mechanisms. Detailed reporting including organisational and system learning will be included in the Quarterly Patient Safety Report (standing agenda item at QuESt) from Q2 2022/3 Audit Wales Quality Governance Review August 2022 Recommendation 4: The Trust has a significant backlog of mortality review. The Trust should develop an action plan to reduce the backlog, reporting progress at each QuESt Committee. Management response: Action will be taken to establish the challenges in this area and implement process improvement to resolve future backlogs. A report will be provided to CQGG on progress (Q3 22/23)
13	**Information Governance**	Information Governance (IG) is a framework for managing information processes and procedures in accordance with the law and associated standards. It describes the approach within which accountability, standards, policies and procedures are developed, implemented and maintained to ensure that all types of information used in the Trust are sourced, stored and used appropriately, legally, and securely The Information Governance Steering Group oversees the Information Governance and Security strategy, policies, systems, processes and practices across the Trust and provides assurance that the organisation is compliant, and managing any risk to compliance. The strategic management of Information Governance forms part of the Digital Directorate under the leadership of the Director of Digital Services who holds the position of Senior Information Risk Owner (SIRO). Includes FOI (targeted percentage); Subject Access Request and Access to Health Records Requests (targeted percentage); Police Requests (no regulatory target). Data security and protection incidents: must notify ICO of personal data breaches within 72 hours. WG notified of significant impact on continuity of essential services under the Network and Information Systems Regulations (NIS Regs). H&C Standards x 3 related to IG and identified metrics against these (see annual report) The **Welsh IG Toolkit for NHS** is an assessment tool that allows organisations to measure their performance against agreed national information governance ~~and data security~~ standards and legislation. All organisation that have access to NHS patient data and systems must use the toolkit to demonstrates compliance with DPA 2018; expected data security standards for health and social care for processing personal data; and readiness to access secure health and digital methods of information sharing such as NHS Email, Welsh healthcare records and systems and local information sharing solutions and agreements. The Trust is required to demonstrate whether it complies with each of the 225 evidence items with each item weighted and a level of compliance generated (foundation stage; satisfactory stage; competent stage). IGSG monitors the toolkit improvement plan. Information Commissioner's Office (ICO) monitors compliance with key legislation (DPA 2018, UK GDPR and FOIAct) Finance and Performance Committee oversees the digital strategy and reviews and monitors major projects as well as cyber security and cyber resilience Information governance and data protection predominantly apply to our confidential patient data, but we also hold a large amount of staff and organisational data, so QUEST has remit over IG from a quality point of view. Liam Williams is Caldicott Guardian. TBC if an annual SIRO and/or Caldicott Guardian report is required. QUEST will see it with regards to people awareness of Info Sec, FPC will see it from pov of the layer of defense our people provide to our overall Cyber Sec. QUEST = reporting on people-led metrics i.e. where an individual staff member has a responsibility to keep data safe oE.g. Phishing rates, training compliance, individual breaches oTherefore, this includes near misses related to people / staff
14	**Mental Health**	Reporting to include compliance Mental Health Act 1983, Code of Practice, and the Mental Capacity Act 2005, DoLS etc See consent to examination and treatment policy endorsed at ELT 130224 with monitoring through clinical audit plan and responsibilities listed.
15	**General**	These cycles are developed with reference to the specific lines of the TOR for this Committee. This methodology seeks to ensure that all responsibilities in the TOR are discharged by the Committee on behalf of the Board

PAPER	PRE C'EE FORUM	FREQUENCY	Q1	Q2	Q3	Q4	LEAD	PURPOSE	COMMENT/COMPLIANCE
QUEST COMMITTEE - CYCLE OF BUSINESS 2024/25									
TERMS OF REFERENCE NOTED IN RED TEXT									
MIQPR review of metrics	ELT	Annually					EDSPP	Approval	Q1: Programmed for Q1 with MIQPR.
Committee QPSE review of metrics in PTR report	CQGG	Annually					EDQN	Approval	
MIQPR report	ELT	Quarterly					EDSPP	Assurance	
Putting Things Right Report [Note 1]	CQGG	Quarterly					EDQN/DP	Assurance	Q1: Includes PTR Recovery Plan in addition to PTR Report.
Quality Report [Note 3]	CQGG	Annually					EDQN	Approval	
Duty of Candour Report (Annual PTR Report) [Note 4]	CQGG	Annually	→	→			EDQN	Approval	To be received in Q3 24/25 in line with PTR Annual Reporting.
Quality Plan aligned to Delivering Excellence 2030	CQGG/TB	Initial and cyclical review					EDQN	Approval	
Clinical Plan aligned to Delivering Excellence 2030	CQGG/TB	Initial and cyclical review					EDP	Approval	Q1: Update on Clinical Plan.
Dementia Standards Report [Note 5]	CQGG	TBC					EDQN	Assurance	
Committee elements of IMTP	STB	Annually					EDSPP	Endorsement	
IMTP exception reporting	STB	Ad Hoc					Relevant Director	Assurance	
Health and Care Quality Standards [Note 7]	CQGG	TBC					EDQN	Assurance	
Quality Impact Assessments [Note 8]	CQGG	Ad Hoc					EDQN/DP	Assurance	
External and/or peer reports	Various	Ad Hoc					Relevant Director	Assurance	
Annual Mental Health Report [Note 14]	CQGG/TB	Annually					EDQN	Assurance	
Annual IPC report	CQGG/TB	Annually					EDQN	Assurance	
Annual safeguarding reports	CQGG/TB	Annually					EDQN	Assurance	
Referrals from PCC	PCC	Ad Hoc					Relevant Director	Discuss/Assure	
Clinical audit plan [Note 9]	CQGG/AC	Annually					EDP	Approval	
Monitoring report on clinical audit	CQGG	Quarterly					EDP	Assurance	
Spotlight On' clinical indicators	CQGG	Quarterly					EDP	Assurance	Q1: Fractured Neck of Femur.
Mortality Report [Note 12]	CQGG	Bi-annually	→				EDQN	Assurance	This will be taken in Q2.
Meds management report	CQGG	Annually					EDP	Assurance	Received in Q4 23/24 in discussion with EDP re appropriate timing for 24/25.
PECI report [Note 11]	TBC	Bi-annually					EDQN	Assurance	
Patient story	N/A	Quarterly					EDQN	Assurance	
Patient story updates	N/A	Quarterly					EDQN	Assurance	
Audit recommendation tracker	ELT	Quarterly					BS	Assurance	
Audits within purview of Committee	Audit	Ad Hoc					Relevant Director	Assurance	
Report from policy group	Policy Group	Annually					BS	Assurance	
Policies for review and approval	Policy Group	Ad Hoc					BS	Approval	Q1: 5 Policies for approval.
Board Assurance Framework	ELT	Quarterly					BS	Assurance	
Corporate Risk Register	ELT	Quarterly					BS	Assurance	
SUB-GROUPS									
Where applicable	N/A	Ad Hoc					N/A	N/A	
GOVERNANCE									
Committee effectiveness review annual report	Audit/Board	Annually					BS	Approval	
Review of Terms of Reference	Audit/Board	Annually					BS	Approval	
Committee Cycle of Business annual refresh	N/A	Annually					BS	Approval	
Committee Cycle of Business monthly review	N/A	Quarterly					BS	Review	
Committee Review of Annual Priorities	N/A	Quarterly					BS	Review	
PROMPTS									
Operations Report	SLT	QUarterly					EDO	Information	
External Reports	N/A	Ad Hoc					TBC	TBC	

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

Key: Pre-agenda setting
- Cycled for each meeting
- Ad hoc item - prompt for agenda setting
- Reporting developing

Key: Post-agenda setting
- Presented as cycled
- Ah hoc / item considered - not programmed
- → Item deferred
- Reporting developing