Bundle Quality, Patient Experience and Safety Committee 13 August 2024

Agenda attachments

ITEM 00 PDF Quest Open Agenda

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
ITEM 02 Board Member Register of Interests

3 Minutes of the Previous Meeting: 7 May 2024
ITEM 03 2024-05-07 Draft QUEST OPEN MINUTES

4 Action Log & Matters Arising
ITEM 04 Action Log

5 09:40 - Operations Directorate Quarterly Report Q1 2024/25
ITEM 05 Ops Quarterly Review Q1 - July 2024 FINAL

5.1 ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION

6 09:50 - Patient Story
Linda Erro Castillo - Video

7 10:20 - Putting Things Right Report Quarter 1, April - June 2024
ITEM 07 Putting Things Right Report

8 10:40 - Monthly Integrated Quality Performance Report
ITEM 08 MIQPR SBAR QuEST June July 2024
ITEM 08.1 Annex 1 MIQPR QuEST June July 2024

9 11:00 - Revised Approach to Clinical Screening ITEM DEFERRED

9.1 11:00 - Comfort Break

10 11:15 - Annual Safeguarding Report 2023/24
ITEM 10 Safeguarding Annual Report 2023-2024
ITEM 10.1 Safeguarding Annual Report 2023-2024 Annex 2

11 11:30 - Quality Strategy Implementation Plan Update 2021-2024
ITEM 11 Quality Strategy Implementation Plan 2021-2024 Update
ITEM 11.1 Quality Strategy Implementation Plan Update 2021-2024

12 11:45 - Quality Plan Development and Implementation Plan 2025-2028
ITEM 12.1 Circulated separately by E mail
ITEM 12 Quality Plan Development and Implementation Plan 2025-28

13 12:00 - Learning from Deaths (Mortality Reviews) Update report
ITEM 13 Learning from Deaths (Mortality Reviews) Update Report
ITEM 13.1 Learning from Deaths (Mortality Reviews) Update Report - Annex 2

13.1 12:15 - LUNCH

14 12:45 - Clinical Audit Plan & Action Tracker Q1 (update) 2024/25
ITEM 14 SBAR - Clinical Audit Plan & Action Tracker Q1 2-24-25 update
ITEM 14.1 Clinical Audit Plan Q1 2024-25

15 12:55 - Focus on Clinical Indicators: Hypoglycaemia
ITEM 15 SBAR - Focus on CIs - Hypoglycaemia
ITEM 15.1 Focus on CIs - Hypoglycaemia v0.1 - 25.07.2024

16 13:15 - Impact of the Changes to Stroke Categorisation
ITEM 16 Deep Dive on Stroke QuEST 13 August 2024

17 13:30 - Audit Tracker
ITEM 17.1 Internal Audit Tracker Tab
ITEM 17.1a External Audit Tracker Tab
ITEM 17.2 Clinical Audit Final Internal Audit Report
Note: The Full Audit Tracker has been circulated separately by e mail
ITEM 17 SBAR Audit Tracker to Committees - Q1Reporting - April-June Reporting - QuEST Committee
ITEM 17.1 Internal Audit Tracker Tab
ITEM 17.1a External Audit Tracker Tab

ITEM 17.2 WAST_2324-010_Clinical Audit_Final Internal Audit Report

18 13:40 - Risk Management and Board Assurance Framework Report

ITEM 18 Executive Summary Risk Management Report QuEST 130824

19 13:50 - Policies for Approval/Adoption:
Management of Medical Devices Policy

ITEM 19 Policies for Committee Approval - QuEST 130824

ITEM 19.1 Medical Devices Management Policy v3.4 070824

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

20 Committee ToR and Annual Report 2023/24

ITEM 20 QUEST Committee Terms of Reference 2024-25 - Approved by Trust Board 30052024

ITEM 20.1 QUEST Annual Report 2023-24

21 Committee Cycle of Business (CoB)

ITEM 21 QuEST Committee Cycle of Business Monitoring Report and Committee Priorities

ITEM 21.1 Cycle of Business Monitoring Response

ITEM 21.1a Cycle notes

22 Annual Quality Report 2023/24 and Duty of Quality Standards Self-Assessment

ITEM 22 Duty of Quality Annual Report

ITEM 22.1 Guidance Duty of Quality Annual Report 2023-24

22.1 13:55 - CLOSING ITEMS

23 Key Messages for Board Decisions & Actions

24 Reflections of the Meeting

25 Any Other Business

26 Date and Time of Next Meeting: 5 November 2024 at 09:30

Length of Meeting:	04:35	Agenda Status:	AGREED	[OPEN] QUEST COMMITTEE - 13 AUGUST 2024					Deadline for Papers: 05/07 2 August 2024	
Time	**Mins allotted**	**Agendum**	**Rec'd?**	**Title**	**Format**	**Item for**	**Item requested by**	**Paper prepared by**	**Item presented by**	**Colleagues to cc**
				OPENING ITEMS						
09:30	00:10	1	n/a	Chair's Welcome, Apols and Quorum	Verbal	Information	Standing	n/a	Chair	
		2	n/a	Declarations of Interest	Verbal	To State Conflicts	Standing	n/a	Chair	
		3	Yes	Minutes of the Last Meeting:	Paper	Approval	Standing	n/a	Chair	
		4	Yes	Action Log & Matters Arising Item 4.1 AAA Report	Paper	Discussion	Standing	n/a	Chair	
09:40	00:10	5	Yes	Ops Report Q1 24/25	Paper	Information	CoB	Operations	Lee Brooks	
				FOR APPROVAL, ASSURANCE AND DISCUSSION						
09:50	00:30	6	Yes	Patient Story – Linda Erro Castillo	Video	Discussion	CoB	Quality	Liam Williams	Leanne Hawker
10:20	00:20	7	Yes	Putting Things Right Report Quarter 1, April - June 2024	Paper	Assurance	CoB	Quality	Liam Williams Claire Appleton	
10:40	00:20	8		Monthly Integrated Quality Performance Report Item 8.1 Annual Review of Metrics	Paper	Assurance	CoB	SPP	Rachel Marsh	Hugh Bennett
11:00	00:00	9	n/a	Revised Approach to Clinical Screening - ITEM DEFERRED	Paper	Assurance	CoB	Clinical	Andy Swinburn	
11:00	00:15			COMFORT BREAK						
11:15	00:15	10	Yes	Annual Safeguarding Report 2023/24	Paper	Endorsement	CoB	Quality	Liam Williams	Alison Kelly
11:30	00:15	11	Yes	Quality Strategy Implementation Plan Update 2021-2024	Paper	Endorsement	CoB	Quality	Liam Williams	Alison Kelly
11:45	00:15	12	Yes	Quality Plan Development and Implementation Plan 2025-2028	Paper	Endorsement	Ad Hoc	Quality	Liam Williams	Alison Kelly Jonathan Turnbull-Ross
12:00	00:15	13	Yes	Learning from Deaths (Mortality Reviews) Update report	Paper	Assurance	CoB	Quality	Liam Williams	Alison Kelly
12:15	00:30			LUNCH						
12:45	00:10	14	Yes	Clinical Audit Plan & Action Tracker - Q1 (update) 2024/25	Paper	Assurance	CoB	Clinical	Andy Swinburn	
12:55	00:20	15	Yes	Spotlight on Clinical Indicators: Hypoglycaemia	Presentation	Assurance	CoB	Clinical	Duncan Robertson	Kevin Webb
13:15	00:15	16	Yes	Impact of the Changes to Stroke Categorisation	Paper	Assurance	CoB	Clinical	Andy Swinburn	
13:30	00:10	17	Yes	Audit Tracker Internal Audit Reports: Clinical Audit	Paper	Assurance	CoB	Gov	Trish Mills	
13:40	00:10	18	Yes	Risk Management and Board Assurance Framework	Paper	Assurance	CoB	Gov	Julie Boalch	
13:50	00:05	19		Policies for Approval/Adoption Management of Medical Devices Policy	Paper	Approval	CoB	Gov	Julie Boalch	
13:55	00:00			**CONSENT ITEMS** The items that follow are for information only. Should a member wish to discuss any of these items they are requested to notify the Chair so that time may be allocated to do so.						
13:55	00:00	20	Yes	Committee Terms of Reference and Annual Report 2023/24	Paper	Assurance	CoB	Gov	Trish Mills	
13:55	00:00	21	Yes	Committee Cycle of Business (CoB) and Priorities Update	Paper	Information	CoB	Gov	Trish Mills	
13:55	00:00	22	Yes	Annual Quality Report 2023/24 and Duty of Quality Standards Self-Assessment	Paper	Assurance	CoB	Quality	Liam Williams	
13:55	00:10			**CLOSING ITEMS**						
14:05	00:00	23	n/a	Key Messages for the Board	Verbal	Discussion	Standing	n/a	Chair	
		24	n/a	Reflections and Summary of Decisions/Actions	Verbal	Discussion	Standing	n/a	Chair	
		25	n/a	Any Other Business	Verbal	Discussion	Standing	n/a	Chair	
		26	n/a	Date & Time of the Next Meeting: 5 November 2024	Verbal	Information	Standing	n/a	Chair	
14:05	**04:35**			**CLOSE**						

LEAD PRESENTERS

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

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Left Trust
BROOKS, Lee	**Executive Director of Operations**	Partner employed by Welsh Ambulance Services NHS Trust	Any Other Interest	July 2019		
		Member of the Order of St John	Any Other Interest	01 March 2023		
		Volunteer – St John's Ambulance Cymru	Any Other Interest	06 April 2023		
		Council Member – St John's Ambulance Cymru Gwent Council	Any Other Interest	06 April 2023		
CURRAN, Peter	**Non-Executive Director** * Chair of the Audit Committee * Member of the Finance and Performance Committee * Member of the Remuneration Committee	Trustee of Action for Children [1097940]	Position in Charity or Voluntary Organisation	01 February 2021		
		Company Director - Action for Children [04764232]	Directorships	01 February 2021		
		Company Director - Action for Children (Wales) Ltd [10011497]	Directorships	05 April 2022		
		Trustee of National Youth Arts Wales [1170643]	Position in Charity or Voluntary Organisation	06 May 2021		
		Company Director - National Youth Arts Wales [10449512]	Directorships	06 May 2021		
		Non-Executive Director for Taff Housing	Position in Charity or Voluntary Organisation	01 May 2022		
		Company Director - Team Police Ltd [12518812]	Directorships	01 January 2022		
		Independent Board Member of the Project Board - National Contemporary Art Gallery for Wales	Any Other Interest	01 January 2024		
		Interim Finance Director for Torfaen Leisure Trust	Directorships	01 September 2023	29 February 2024	
		Interim Independent Member – Kaplan International Colleges UK Ltd [05268303	Directorships	01 March 2024		
		Independent Member - Kaplan Open Learning (inc member of the Audit & Risk Committee)	Directorships	21 March 2024		
DAVIES, Kevin	**Non-Executive Director** * Member of Academic Partnership Committee * Member of Audit Committee * Member of Finance & Performance Committee * Member of Quality, Patient Experience & Safety Committee * Member of Remuneration Committee	Colonel Commandant Queen Alexandra's Royal Army Nursing Corps	Any other interest	May 2020		
		Charity Trustee - Queen Alexandra's Royal Army Nursing Corps Association	Position in Charity/Voluntary Organisation	28 January 2021		
		Patron Motivation and Learning Trust	Position in Charity or Voluntary Organisation	2014	December 2023	
		Chair ABF The Soldiers Charity (Glamorgan)	Position in Charity/Voluntary Organisation	2015		
		Honorary Colonel 203 (Welsh) Multi-Role Medical Regiment (Commanding Officer's Principal Advisor)	Any Other Interest	01-Apr-24		
		Member Royal College Nursing	Any other interest	1978		
DENNIS, Colin	**Chair of Trust Board and Non-Executive Director** * Chair of Remuneration Committee	Chair - Citizen Housing [Charity] (previously WM Housing Group)	Position in Charity or Voluntary Organisation	01 January 2015		
		Company Director - Citizen Treasury PLC (previously WM Housing Treasury Ltd)	Directorships	29 August 2017		
		Company Director - Citizen Treasury Vehicle Ltd	Directorships	04 September 2017		
		Chair - North Devon Homes	Position in Charity or Voluntary Organisation	01 October 2021		
		Company Director - North Devon Homes	Directorships	01 April 2022		
		Chair - Green Square Accord (Housing Association)	Position in Charity or Voluntary Organisation	26 March 2024		
		Company Director - LowCarbonLiving Homes Ltd [04207671]	Directorships	26 March 2024		
		Company Director - Green Square Estates Ltd [8719365]	Directorships	26 March 2024		
EVANS, Bethan	**Non-Executive Director** * Chair of Quality, Patient Experience & Safety Committee * Member of Charity Committee * Member of Finance & Performance Committee * Member of People & Culture Committee * Member of Remuneration Committee	Managing Director (Employed) at My Choice Healthcare Limited.	Any Other Interest	01 June 2019		
		Non-Executive Board Member at RHA (Social Housing Organisation - Community Benefit Society)	Position in Charity or Voluntary Organisation	01 November 2019		
		Company Director - My Choice Healthcare South Wales Limited	Directorships	11 March 2020		
		Company Director - Moorlands Rehabilitation (Staffordshire) Limited.	Directorships	20 December 2019		
		Company Director - Springfield (Bargoed) Limited.	Directorships	12 March 2020		
		Company Director - Homes of Excellence Limited	Directorships	19 March 2021		
		Company Director - Victoria House Care Property Limited	Directorships	05 March 2020		
		Company Director - My Choice Healthcare (Four) Limited	Directorships	27 April 2022		
		Company Director - Luk Ros Property Limited	Directorships	12 March 2020		
		[Previously called Homes of Excellence Healthcare Limited, Company name changed 12.08.2022 - #12513139]	*Directorships*	*12 March 2020*		
		Company Director - Hawthorn Court Property Limited	Directorships	27 April 2022		
		[Previously called My Choice Healthcare (Three) Limited, Company name changed 12.08.2022 - #13371375]	*Directorships*	*27 April 2022*		
		Company Director - Ocean Living Property Limited	Directorships	22 July 2022		
		Company Director - Hawthorn Court Care Limited	Directorships	22 July 2022		
		Company Director - Glyncornel Property Limited	Directorships	01 July 2022		
		Company Director - My Choice Healthcare (Two) Limited	Directorships	01 July 2022		
		Company Director - Carmarthen Care Limited	Directorships	02 January 2024		
		Company Director - Towy Castle Property Limited	Directorships	01 September 2023		
HITCHON, Estelle	**Director of Partnerships and Engagement**	Nil Declaration				

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Left Trust
JACKSON, Ceri	**Non-Executive Director & Vice Chair of the Trust Board** * Chair of Charity Committee * Chair of the People and Culture Committee * Member of Audit Committee * Member of Quality, Patient Experience & Safety Committee * Member of Remuneration Committee	Management Consultant primarily working in third sector	Interest in Companies and Securities	01 May 2019		
		Associate Director of SamKat Consulting Ltd in my capacity as self-employed management consultant	Directorships	01 June 2021		
		Charity Trustee - Stroke Association Trustee, Chair Wales Advisory Group.	Position in Charity or Voluntary Organisation	08 October 2020		
		Charitable Company - Stroke Association - Company Director	Directorships	08 October 2020		
KILLENS, Jason	**Chief Executive**	Honorary Professor - Swansea University	Personal or Departmental Sponsorship	2019		
		Member of the Order of St John	Any Other Interest	2009		
LEWIS, Angela	**Director of Workforce and Organisational Development [12 September 2022]**	Nil Declaration				
MARSH, Rachel	**Executive Director of Strategy, Planning and Performance**	Nil Declaration				
MILLS, Patricia (Trish)	**Board Secretary**	Nil Declaration				
PARRY, Hugh	**Trade Union Partner**	Nil Declaration				
ROWAN, Hannah	**Non-Executive Director** * Chair of Academic Partnership Committee * Member of Charity Committee * Member of People & Culture Committee * Member of Remuneration Committee	Director, St Martin's Associates (Business consulting and coaching)	Directorships	04 April 2022		
		Non -Executive Director Qualifications Wales (regulator for all non degree qualifications in Wales)	Any Other Interest	01 April 2021		
		Trustee MAE Cymru (Christian charity which champions gender equality in church of Wales)	Position in Charity or Voluntary Organisation	13 November 2021	November 2023	
		Elected member, The governing body of the church in Wales (Parliament of church in Wales - voting member)	Any Other Interest	01 April 2021		
		Relative (Parent) is a Non-Executive Director for Social Care Wales	Any Other Interest	01 April 2017		
SAMMUT, Jonathan (Jonny)	**Director of Digital Services [appointed 26.09.2023]**	Fellow of the British Computer Society – FBCS	Any Other Interest	04 March 2024		
		Panel Member of the UK CIO Advisory Panel – Digital Health	Any Other Interest	05 July 2023		
		Federation of Informatics Professionals - Leading Practitioner	Any Other Interest	25 April 2024		
SINGH, Anoop Joga (Joga)	**Non-Executive Director** * Chair of the Finance & Performance Committee * Member of the Audit Committee * Member of People & Culture Committee * Member of Remuneration Committee	Geldards LLP	Any Other Interest	03 March 2009		
		Membership of the Law Society	Any Other Interest	01 January 2006		
		Membership of the Employment Lawyers Association	Any Other Interest	01 January 2006		
		Member of the Fairness, Inclusion & Respect Committee for the Institute of Civil Engineers in Wales	Position in Charity or Voluntary Organisation	01 March 2018	31 December 2023	
		Independent Member of the South Wales Police Ethics Committee, 2 – 3 days a year.	Any Other Interest	01 March 2018		
SWINBURN, Andrew (Andy)	**Executive Director of Paramedicine**	Strategic Advisor to College of Paramedics	Any Other Interest	01 January 2020		
TURLEY, Christopher	**Executive Director of Finance and Corporate Resources**	Treasurer of Royal Gwent Hospital League of Friends.	Position in Charity or Voluntary Organisation	01 February 2022		
TURNER, Damon	**Trade Union Partner**	Nil Declaration				
WILLIAMS, Liam	**Executive Director of Quality and Nursing [from 01 August 2022]**	Chair/Director - Thornbury Carnival Community Interest Company Voluntary	Position in Charity or Voluntary Organisation	01 August 2019		
		Member Royal College Nursing	Any Other Interest	01 August 2022		
		Committee member Royal College Nursing, Nurses in Management and Leadership Forum Steering Committee	Position in Charity or Voluntary Organisation	01 August 2022		

WELSH AMBULANCE SERVICES NHS TRUST

UNCONFIRMED MINUTES OF THE OPEN SESSION OF THE MEETING OF THE QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE HELD ON 7 MAY 2024 VIA TEAMS

Meeting started at 09:30

PRESENT:

Ceri Jackson	Non-Executive Director and Interim Vice Chair of the Board (Chaired meeting)
Professor Kevin Davies	Non-Executive Director

IN ATTENDANCE:

Claire Appleton	Head of Putting Things Right
Hugh Bennett	Assistant Director, Commissioning and Performance
Julie Boalch	Head of Risk/Deputy Board Secretary
Jonathan Edwards	Assistant Director of Operations, Resourcing and EMS Coordination
Fflur Jones	Audit Wales, Performance Auditor
Osian Lloyd	Head of Internal Audit, NWSSP
Mark Marsden	Trade Union Partner
Fiona Maclean	Patient Experience and Community Involvement Manager (Left after minute 28/24)
Steve Owen	Corporate Governance Officer
Hugh Parry	Trade Union Partner
Alex Payne	Corporate Governance Manager
Duncan Robertson	Assistant Director of Clinical Development (Minute 33/24 only)
Jonny Sammut	Director of Digital Services
Julie Starling	Save a Life Cymru (Left after minute 28/24)
Andy Swinburn	Executive Director of Paramedicine
Lisa Trounce	Business Manager, Corporate Governance (observing)
Liam Williams	Executive Director of Quality and Nursing

Apologies:

Lee Brooks	Executive Director of Operations
Bethan Evans	Non-Executive Director and Chair
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Trish Mills	Director of Corporate Governance/ Board Secretary

DRAFT

23/24 PROCEDURAL MATTERS

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

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 8 February 2024 were confirmed as a correct record.

Action Log

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

Minute 50/23: 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.* It was noted that the report wasn't provided to the February meeting as it wasn't available. Furthermore, the initial proposal has been superseded by a revised EMSC leadership structure approved by ELT in January 2024. An update will be provided to the Board in July, and it was agreed that this action was to be closed.

Minute 04/24: Putting Things Right (PTR) 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.* 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 National Reportable Incidents (NRI) data in this format. Information in respect of WAST NRIs will be included from a population perspective in the Quarter 4 PTR 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 team are pulling a significant amount of core data from these systems manually which is extremely time consuming. Furthermore, the Committee recognised the current capacity issues within the team. Agreed action closed.

Minute 05/24a: 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.* Hugh Bennett advised this information was in the correct place within the report. Action Closed.

Minute 07/24: 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.* A high level outline plan has been developed and will be shared with Committee members by June 2024. Agreed this action would remain on the log with an update at the next meeting.

Minute 09/24: 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.* Agreed that an update would be provided to the Corporate Governance Team for dissemination to Committee Members in advance of the next meeting. Action to remain open.

Committee AAA report dated 8 February 2024

The Chair drew the Committee's attention to the contents of the AAA report for their information; this highlighted the key points from the Committee's last meeting on 8 February 2024.

RESOLVED: That

(1) Apologies were recorded for Bethan Evans, Lee Brooks, Rachel Marsh, and Trish Mills.

(2) The Minutes of the Open meeting held on 8 February were confirmed as a correct record.

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

24/24 OPERATIONS DIRECTORATE QUARTERLY REPORT – 2024/25 Q1

Jonathan Edwards presented the report and highlighted several key points for the Committee's attention.

The Operations team has continued to work on the Manchester Arena Inquiry. Workshops have been conducted to understand the impact of similar events on our capabilities and capacity to respond if a significant event of this kind were to occur in

Wales. The workshops have informed reports compiled by Judith Bryce's team, focusing on our capability to prepare to respond and the capability of our specialist assets.

As outlined in the report, the Chair of the Inquiry has requested a financial case from all organisations involved in a potential response. Given the sensitive nature of the information and the detailed plans outlined in these papers, discussions will be conducted in closed meeting sessions. A significant amount of work is underway to ensure the Trust's readiness to effectively respond to similar incidents in the future. Welsh Government have been kept informed of progress, and the Trust is on track to present the comprehensive financial case in the coming months.

An update was provided on the Accredited Centre of Excellence (ACE) status with the International Academies of Emergency Dispatch (IAED). It was noted that the Trust has recently fallen below the required 7% threshold for accreditation, as outlined in the report. However, the Trust is actively working with the Academy to ensure that the robust action plan in place will improve the accreditation status. The aim is to transition from the current rate, at just over 8.7% for the first quarter of this year, to meet the required threshold of 7% or below. Jonathan Edwards added that the end of April figures have already shown improvement, with the rate back down to 6%. This is a testament to the hard work of the quality team, who are collaborating closely with the Academy to achieve the accreditation goals. With the concerted effort and collaboration in place, he was confident that the Trust was on track to meet its targets and regain our accreditation status.

The Operations Quality (OQ) Organisational Change Programme (OCP) has reached its conclusion, and the final stages of job evaluations and recruitment have been initiated. Interviews have been arranged for the Locality Manager, OQ position, which will entail some coroner responsibilities, in addition to the Service Manager, OQ role. The Trust is currently awaiting approval on *Trac* for the Support Officer and third Learning & Development Coordinator positions. Furthermore, the Quality Improvement Manager and Quality Audit Manager posts are pending job evaluations. Once these positions are filled, it is anticipated that the directorate will have the necessary capacity to proceed with the required Standard Operating Procedure (SOP) reviews.

The Quality & Support Days have proven invaluable in promoting key indicators and expectations related to various aspects of quality behaviour within the Trust premises and on ambulance vehicles, as well as personal conduct of staff members.
These days cover subject areas such as seat belt and safety harness use, Dress Code Policy, Infection Prevention & Control (IP&C), and cultural awareness. They are supported by operational managers/leaders of all grades and serve to enhance visibility to the teams. During each support day, an MS Form is completed by those in attendance to provide assurance of compliance against the requirements. So far, three Quality & Support Days have been conducted, with involvement from all levels of the Operations leadership teams. Themes and trends observed during these days will be collated and presented to the senior leadership team for feedback and action.

In Q4, the NHS 111 Wales call demand increased by 10% compared to Q3 and have continued in recent weeks to experience higher demand compared to much of

December 2023. This level of demand is 14.6% higher than the service is resourced to answer.

Throughout Q4, approximately 10% of staff were abstracted to undertake the new CAS replacement training. Despite these abstractions, the service answered 9% more calls in Q4 than in Q3. This increase in calls answered, despite higher abstractions, can be attributed to the utilisation of agency call handling resources and the implementation of virtual queuing. The number of calls answered in Q4 was 5.6% higher than the funded levels.

Comments:

Members were encouraged to see such a high level of interest in the Community Welfare Responder (CWR) initiative; and were interested to find out how many of the 180 Expressions of Interest have translated into actual volunteers. Jonathan Edwards agreed to provide this information after the meeting.

Following a query in terms of the impact of the Trust losing AACE accreditation, Jonathan Edwards explained that the Trust would lose its status as a centre of excellence if there was not a return to compliance levels within the 3 month period; however, this was unlikely.

Jonny Sammut added there was ongoing work aimed at improving service delivery and efficiency, particularly within the 111 service. The introduction of a Visual IVR (Interactive Voice Response) and potential Artificial Intelligence (AI) driven solutions for tasks like repeat prescriptions can enhance the user experience and contribute to time savings for both callers and operators. These advancements, along with website improvements, demonstrate a proactive approach to leveraging technology to address demand and capacity challenges.

RESOLVED: That the report was received.

25/24 STAFF STORY

Fiona Maclean, Patient Experience and Community Involvement (PECI) Manager, and Julie Starling, Save a Life Cymru, attended to present their Staff Story and recounted how the team actively promote the learning of life saving skills throughout the year, with particular emphasis during its annual campaigns 'Shoctober', 'Restart a Heart' and 'Defibuary'. Through research and engagement, it became evident that many people cannot perform CPR and for some, they were left with symptoms of Post Traumatic Stress Disorder (PTSD); particularly those who may have performed CPR on a loved one. Recognising our duty of care to support both cardiac arrest survivors and family members or laypersons who have performed CPR, the team explored the potential of adopting a post CPR leaflet as developed by Yorkshire Ambulance Service. The PECI team reached out to Save a Life Cymru (SaLC) to explore how this could be progressed in collaboration utilising a digital solution and a Quality Improvement (QI)methodology.

Furthermore, a proposal was put forward to Resuscitation Council UK (RCUK), who have agreed to host a Link Tree on behalf of Wales that will serve as a guide to appropriate support services for individuals and their families in need of support following CPR and cardiac arrest survivor support. This concept will include the Trust, the Health Boards and partners such as General Practitioners (GPs), Emergency Medical Retrieval and Transfer Service (EMRTS), Police and the Fire Service. There will be an opportunity to share good practice with other nations adopting this repository of resources and the project could support other RCUK survivor projects.

An initial pilot of bilingual business cards titled, 'Support for cardiac arrest survivors and CPR providers' will feature a Quick Response (QR) code is planned. This will be developed with engagement through the Trust's People & Community Network, and will signpost users to the RCUK website and provide information on available support services in Wales for both cardiac arrest survivors and bystanders. The cards will be easy to use particularly in time sensitive situations. Funding options are being explored to print the cards and an evaluation of the pilot will inform the plans to expand distribution across Wales and provide cards to all designated touchpoints. Considerations were explored at Committee on digital solutions including automated Short Message Service (SMS), linking to the NHS App and community outreach programmes.

Comments

The Committee were in full support of the project recognising the profound impact that performing CPR can have on individuals, both emotionally and psychologically. Furthermore, the need for support and resources for both survivors and bystanders are crucial in addressing the aftermath of such events. The initiative to provide post-event support through innovative approaches like the post-CPR leaflet and bilingual business cards with QR codes is commendable and underscores the commitment to enhancing the wellbeing of all individuals involved in cardiac arrest situations.

The suggestion of automating a text message post incident to bystanders who have provided CPR was mooted. This automated approach could help ensure that support resources are readily accessible to individuals who may be in need following their involvement in a CPR event. By capturing bystanders' details, such as their telephone numbers, during the incident, it would be possible to set up an automated system to send out supportive text messages with relevant resources and information after the event. This could provide timely assistance and guidance to individuals who may be experiencing emotional or psychological distress following their involvement in the CPR event. Additionally, integrating this automated system with existing support networks or helplines could further enhance the effectiveness of the initiative.

Jonny Sammut added that embedding the support resources for cardiac arrest survivors and CPR providers onto the NHS app would be a positive step forward. Leveraging existing platforms like the NHS app can help increase accessibility to available resources and ensure that they reach a wider audience. Additionally, integrating the support information into widely used platforms can streamline the process for individuals seeking assistance and provide them with easy access to relevant resources when needed. Regarding the use of QR codes, he added they can be an effective way to

quickly link users to online resources and incorporating them into business cards or other materials can make accessing support information more convenient. QR codes are versatile and can be easily scanned using smartphone cameras, making them accessible to a wide range of users.

Julie Starling explained that whilst this initiative was primarily aimed at the lay person, expanding the scope of the initiative to include healthcare professionals who may also benefit from access to support resources would be a great idea. Providing avenues for debriefing and accessing support in a way that suits individuals' preferences and needs can be incredibly valuable for promoting wellbeing and resilience in the healthcare workforce. The continued collaboration and knowledge sharing within this group, or similar forums can certainly enhance the project going forward. Building on the insights and suggestions shared here, along with collecting baseline data and refining the project details, will contribute to its success and effectiveness in supporting cardiac arrest survivors and CPR providers.

Liam Williams added that capturing updates through the PECI document on an ongoing basis will help keep stakeholders informed about the progress and developments of the initiative. Once there is significant progress or a substantial evaluation outcome, it would be appropriate to bring it back to Committee as a dedicated item for further discussion and consideration. This approach will help ensure that the project receives the visibility and support it needs to succeed.

Members expressed thanks to Fiona and Julie for sharing this initiative and the recognition and support of bystanders through their often once in a lifetime experience of providing CPR.

The Committee also received a patient story update following Alison Cassidy's patient story at the last meeting and commented on the tracker as an important paper on a difficult story and the learning captured from the discussion.

RESOLVED: The Committee noted the staff story and the patient story update regarding Alison Cassidy.

26/24 PUTTING THINGS RIGHT (PTR) REPORT

Liam Williams presented the report commenting on the progress being made in incident reporting and response to patient complaints, although recognised there is still room for improvement in both areas. There is an upcoming workshop aimed at addressing these issues collectively and finding ways to enhance patient safety and care delivery across the board.

Claire Appleton advised the Committee that the Trust had received two Regulation 28 Reports (prevention of future death) from the Coroners during the period, one joint with Swansea Bay University Health Board resulting from a protracted wait. The Trust is working with the All Wales Tissue Viability Network to determine next steps in

identifying avoidable harm in respect of pressure damage and provide assurance to the Coroner.

Comments:

The Committee discussed the pressure damage issue as a consequence of risks 223 and 224. Recognising these as broader unscheduled care system risks rather than purely organisational risks reflect their significant impact and the need for coordinated efforts across institutions to address them collectively. Julie Boalch advised she has been working with consultants on these two risks, in particular how these two risks are articulated in the future.

Members recognised that the inherent design of ambulances as temporary clinical environments means they may not be equipped to provide extended care, leading to potential issues such as pressure injuries and other complications. Addressing these challenges requires a multifaceted approach, including improving coordination with other healthcare providers, enhancing ambulance design to accommodate longer waits when necessary, and ensuring adequate staffing and resources to provide appropriate care in diverse clinical settings. Liam Williams added there were proactive measures being taken to address tissue viability and reduce the risk of harm from pressure area damage within the ambulance service. The focus on training, equipment provision, and collaborative efforts with organisations like the National Ambulance Service Medical Directors (NASMeD) and Qi guard demonstrates a commitment to improving patient care and safety. By participating in a UK wide workstream, the Trust can gain valuable insights into interventions and treatments across different ambulance services, ultimately contributing to the development of best practices and enhanced patient outcomes. Additionally, leveraging data and stories to raise awareness among the wider public can help foster understanding and support for these critical initiatives.

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.

27/24 PUTTING THINGS RIGHT RECOVERY PLAN

Liam Williams introduced the Putting Things Right Recovery Plan which was linked to the recent Joint Investigation Framework Internal Audit and outlined the key improvement actions for the team over the next 12 months to help the Trust meet its targets and ensure patients and families receive the best service from the team. These were:

1. Team wellbeing
2. Complaints
3. Nationally Reportable Incident (NRI) investigations
4. Learning from Events including Welsh Risk Pool
5. Learning from Deaths & Medical Examiner Service Referrals

RESOLVED: The Committee received the report

28/24 PATIENT EXPERIENCE COMMUNITY INVOLVEMENT BI-ANNUAL REPORT

Liam Williams presented the report which detailed the work of the team to capture feedback and experiences, ensuring voices are heard that contribute to improvement in the quality of services and patients' use of them. The impact of the work is supporting discussions on progressing the new clinical model. The work is mapped against the Quality Standards to provide assurance against the Duty of Quality.

He added it was evident from service user feedback that concerns persist around emergency ambulance response delays, reflecting ongoing anxiety and frustrations among service users. Similarly, in Ambulance Care, there is feedback regarding the length of time individuals wait for transportation home after hospital appointments. Despite these challenges, there is a positive note in the feedback, highlighting the professional and compassionate behaviour of staff. This aspect is crucial in instilling confidence among patients and their families in the care and treatment they receive, offering reassurance amidst the challenges faced.

Additionally, during the year the PECI Work Programme has primarily concentrated on several key areas. Firstly, there has been a focus on promoting Civica, a software solution or platform aimed at enhancing patient experience or streamlining processes. Additionally, efforts have been directed towards expanding the scope of Patient Experience Surveys and increasing returns, indicating a commitment to gathering comprehensive feedback from service users. Furthermore, the team has been proactive in seeking external funding opportunities to support initiatives aimed at improving experiences and outcomes for individuals with learning disabilities. This multifaceted approach underscores the commitment to enhancing overall patient experience and addressing specific needs within the healthcare system.

Comments

Members were keen to understand the impact of Llais Wales (Your voice in health and social care). Liam Williams advised that the Trust is working well with this organisation, particularly around the new clinical model and overall, it seems that there is optimism about the progress and cooperation in this collaboration.

Members recognised the level of ambition and commitment, drawing through focus on continuous improvement and the value of patient experience reporting.

Following a query in terms of the 111 service, Liam Williams reminded Members of improvements and upcoming changes to the healthcare system, particularly in the context of the 111 service. The implementation of a new system is expected to streamline processes and reduce the number of touchpoints for individuals seeking care. Additionally, clinicians within the 111 service will soon have access to the Welsh Clinical Portal, enabling them to make more informed decisions by directly accessing relevant information. These changes are aimed at enhancing efficiency and effectiveness in healthcare delivery.

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RESOLVED: The Committee

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

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

29/24 MONTHLY INTEGRATED QUALITY PERFORMANCE REPORT – FEBRUARY/MARCH 2024

Hugh Bennett presented the report and drew attention to the following areas:

1. 999 calls answered have declined to 34 seconds in March not achieving the 6 second target. The 65th and 95th percentile performance; however, is strong.
2. Red 8 minute response times remain of concern at 48.9%; however, this remains consistent across a sustained period.
3. Amber 1 median is 1 hour 22 minutes.
4. Abstraction levels in EMS hit 30% as a benchmark level.
5. 111 abandonment rates increased in March to 11.8%.
6. 111 demand continues to increase, and a Demand & Capacity (D&C) review is required.
7. Re-rostering of NEPTS will be reviewed this year as a key efficiency.
8. 7.67% sickness absence slightly above target in March 2024 compared to 8.50% in February 2024. The 2023/24 target is 6%.

Comments

Members queried when the D&C review will come to fruition, and what it is likely tell us. Hugh Bennett explained that the EMS D&C review is indicating that maintaining the current approach is unsustainable. It aligns with the strategic goal of the Trust to transform the way healthcare services are delivered. Specifically, it highlights the need to move away from the traditional conveyance model, which is costly and ineffective. The review will likely present scenarios that demonstrate the limitations of the current approach and the potential benefits of alternative models.

Members felt it would be beneficial to discuss any progress, lessons learned, or challenges encountered regarding the 'inversion of the triangle' initiative. Andy Swinburn advised there was a shift in focus towards more meaningful measures of performance that align with the new clinical response model. It's important to reassess current performance measures to ensure they remain relevant and aligned with the evolving goals and priorities of the Trust. This could involve updating metrics to reflect changes in processes and priorities, such as prioritising hear and treat options that result in better patient outcomes rather than simply focusing on dispatch times.

The Committee noted there was a recognition of the importance of contextualising data within the MIQPR to better understand the prevalence of certain conditions within

specific populations such as weighting which can be used to balance the representation of different areas, making sure that smaller or more deprived areas are adequately represented in the analysis. While this is a significant undertaking, it could provide valuable insights into the factors influencing demand for ambulance services and help tailor responses accordingly. If there is any progress or updates on this initiative, it may be beneficial to discuss them further offline which the Chair agreed to do with Rachel Marsh to explore how best to incorporate this information into reporting mechanisms.

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

30/24 ANNUAL QUALITY REPORT 2023/24

Liam Williams presented the draft Annual Quality Report 2023/24 ahead of presentation to the Trust Board for approval. This was a comprehensive appraisal which focused on improving quality and the level of harm experienced by our patients. Collaboration across respective leads and NHS bodies undertaken to prepare the report in lieu of firm guidance and strong edicts from Welsh Government which are predicted for the 2024/25 report. Making the report accessible through various formats, including Welsh language and British Sign Language versions, as well as a vlog, demonstrates a commitment to inclusivity and ensuring that the information reaches a wide audience.

Comments

The Committee welcomed the report acknowledging the work of all staff involved in its production. The report read very well, was comprehensive and a clear, succinct reflection on the past year. They also commented on the humanised approach to the report.

Liam Williams added that the team have done a commendable job of framing the report in a way that highlights its impact on the people the Trust serves. Incorporating a patient centric perspective into the forward look section provides a more comprehensive view of the challenges and opportunities ahead. This will align well with the Trust's commitment to improving patient experience and outcomes.

RESOLVED: The Committee endorsed the draft Duty of Quality Annual Report 2023/24 for onward escalation to Trust Board.

31/24 UPDATE ON THE CLINICAL PLAN

Andy Swinburn provided the Committee a presentation on the revision of the Clinical Plan, previously titled the Delivering Clinical Excellence in Wales Clinical Strategy, noting the progress made in the Trust since the original strategy was implemented. The content will be significantly revised with a changing emphasis on how clinical data is used in terms of our ambitions, transforming our service and how patients are managed differently to prevent avoidable harm.

For the internal perspective:

1. Our people: It is crucial for our people to feel a sense of ownership and alignment with the objectives of the Trust. This can be fostered through clear communication, opportunities for input and feedback, recognition of contributions, and ensuring that everyone understands how their role contributes to the overall goals.

2. Board members: It is essential for board members to strike a balance between driving ambitious goals and obtaining necessary assurance. This entails actively participating in strategic discussions, challenging assumptions, ensuring accountability, and maintaining oversight while also supporting innovation and growth initiatives. Effective communication and collaboration among board members are key to achieving this balance.

For the external perspective:

1. Prospective employees: We should aim to excite and enthral potential candidates about the opportunities and culture within the Trust. This can be achieved through showcasing our innovative projects, highlighting career development prospects, and emphasising the impact individuals can make by joining our team.

2. Our Commissioners: It is crucial to articulate our clinical ambition clearly to our commissioners, demonstrating how we challenge existing norms and strive for excellence in patient care.

3. Wider system colleagues: We need to stimulate interest and open minds among our colleagues in the wider healthcare system. This involves sharing insights, best practices, and success stories to inspire collaboration and drive innovation across organisations.

4. Welsh Government (WG) including 6 Goals influencers: We should illustrate the Trust's reach and possibilities beyond goal 4 to the Welsh Government and influential stakeholders.

5. AACE colleagues: We need to showcase our leadership within the industry to our colleagues in the Association of Ambulance Chief Executives (AACE) and beyond. This involves sharing insights, innovations, and best practices that demonstrate the Trust's thought leadership, expertise, and impact in shaping the future of ambulance services.

Inevitably there will be risks associated with this project going forward:

1. Balancing this year's ambitious agenda with future years' planning: To mitigate this risk, we should adopt a strategic approach that considers both short term objectives and long term goals.

2. Balance between content and brevity: Maintaining a balance between providing comprehensive information and ensuring clarity and conciseness is essential.

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3. Balance ambition with reality: While it is important to set ambitious goals, it's equally crucial to ground these aspirations in reality and consider practical constraints such as resource availability, timeline limitations, and potential obstacles.

4. Ensuring we remain sufficiently flexible to recognise the developing picture: In a dynamic environment, it is essential to remain agile and adaptable to respond effectively to changes and emerging opportunities.

The next steps include joint Directorate planning events to devise delivery mechanisms that ensure alignment across teams and formulating reporting routes.

Comments

The Committee held a discussion in terms of how to make the Trust's ambition relevant and gaining buy in from wider stakeholders which would require effective communication and alignment with shared goals and values. They also talked about how to demonstrate value and impact and how to secure sustainable resourcing going forward. Andy Swinburn added that the Trust would need to tailor its communication to the specific interests and priorities of different stakeholders as this would be crucial for gaining their buy in and support. Liam Williams added that positioning the Trust strategically within the framework of the 6 Goals program was a key challenge, but also an opportunity to maximise its contributions and impact. Furthermore, highlighting the comprehensive contribution of the Trust to the health economy is very important, particularly emphasising its role beyond ambulance services.

RESOLVED: The Quality, Patient Experience & Safety Committee received and noted the update on the clinical plan.

32/24 CLINICAL AUDIT PLAN AND ACTION TRACKER (UPDATE) 2023-2024

Duncan Robertson explained that 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 a dynamic document, updated quarterly to reflect those audits that are either planned, currently underway or have been completed.

The Clinical Audit Plan and Action Tracker update for Q4 2023/24 was received with no escalations. 10 audits were completed during the period. 39 out of 46 actions were completed. Results are cascaded to the Trust linking with the Quality Management Group and the Quality Improvement work. Internal Audit have reviewed the Clinical Audit processes to support forward travel.

RESOLVED: The Committee noted the Q4 2023-24 Clinical Audit Plan and Audot Tracker Update.

33/24 SPOTLIGHT ON CLINICAL INDICATORS (CI) – FRACTURED NECK OF FEMUR

The Committee were provided with a presentation by Duncan Robertson which focused on important aspects related to clinical indicators, particularly focusing on Fractured Neck of Femur (#NoF) and pain management, as highlighted in the Internal Audit report on Medicines Management.

The care bundle for measuring patients aged 65 and over with a working diagnosis of a fractured neck of femur includes several components. These components are typically measured to ensure comprehensive care. To achieve compliance with the care bundle for patients with a fractured neck of femur, each criterion of care must be completed:

1. Vital Signs:

    - Respiratory rate
    - Pulse rate
    - Oxygen saturation (SpO2)
    - Blood pressure (BP)
    - Glasgow Coma Scale (GCS)

2. Pain Scores
3. Analgesia

Completing all of these criteria is essential for ensuring comprehensive and effective care for patients with a fractured neck of femur and for achieving compliance with the care bundle.

Due to staff being unfamiliar with the new system, a reduction in Clinical Indicator compliance was noted. Testing of the ePCR user interface will be completed and the establishment of a minimum clinical data set. Work continues with the supplier to complete the required changes which are aimed and improving the usability for clinicians to input data and to improve Clinical Indicator (CI) compliance.

A CI recovery plan has been implemented which includes focussed communication, clinical workshops, implementing the Clinical Supervision Policy, and improvements in technology (AI).

Liam Wiliams added that whilst it was clear that despite the support provided to our people, there were still challenges in achieving the expected standards in our clinical indicators. While we are undertaking significant efforts to understand the reasons behind this and to improve our care delivery, it remains critical for our staff to ensure accurate and consistent documentation in the ePCR.

The ePCR serves as our primary means of recording the quality of care provided to patients, and therefore, it's essential for our staff to adhere to the established standards when documenting patient care. Consistent and accurate documentation not only reflects the quality of care delivered but also ensures transparency, accountability, and continuity of care.

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While we acknowledge the complexities and challenges associated with documentation in a new system, it is imperative that all staff members understand the importance of adhering to documentation standards. This may require ongoing training, support, and reinforcement of best practices to ensure that documentation accurately reflects the care provided and contributes to the improvement of clinical indicators over time.

Duncan Roberston highlighted that transitioning from paper based documentation to electronic patient records represents a significant cultural shift for the Trust. The shift not only involves adapting to new technologies but also changing workflows and documentation practices. It is understandable that this transition comes with a learning curve, and it is essential for the Trust to acknowledge the challenges and continue supporting staff through this process.

Jonny Sammut outlined the importance of the interconnectedness of various initiatives and projects across different areas of the Trust. The convergence of efforts between the clinical indicator recovery plan and the advancements in digital technologies such as Natural Language Processing (NLP), Artificial Intelligence (AI), and Robotic Process Automation (RPA) presents significant opportunities for synergy and collaboration.

The Committee recognised that user friendliness is paramount when it comes to electronic systems used by frontline staff and it is crucial that these systems are intuitive, easy to navigate, and designed with the user's workflow in mind. When staff are focused on providing the best possible treatment to patients, any additional administrative burden or complexity in using electronic systems could be a hindrance.

Liam Williams further commented that the documentation in clinical records plays a critical role in demonstrating the quality of care provided by healthcare professionals, including those in pre-hospital and emergency settings. Coroners rely on these records to assess the care provided and make judgments accordingly. Having robust clinical indicators that accurately measure the quality of care is essential for demonstrating the value and effectiveness of the services provided by ambulance services. While some indicators may be consistent across different ambulance services, others may be unique and specific to the context and needs of the population served.
Comments:

The Committee were assured by the discussion; however, there are still some concerns that need to be addressed. Members were satisfied with the current format and approach as a reasonable course of action going forward.

RESOLVED: The Committee noted the update.

34/24 AUDIT TRACKER AND INTERNAL AUDITS

Alex Payne presented the report indicating there has been excellent engagement across directorates in the recent reporting period, resulting in progress in closing internal audit actions. Specifically, 64 out of 162 internal audit actions have been closed, which accounts for 40% of all internal audit actions. Additionally, 57% of actions due in the quarter were closed during the quarter, which demonstrates progress. Several historical

actions have been revisited with a view to closing these down or revising them acknowledging the passage of time.

For actions relevant to this Committee, 16 out of 35 proposed closures were achieved, representing a 76% closure rate for actions due in the quarter. Regarding external audit actions, 4 out of 12 proposed closures were achieved, accounting for 33%. Revised dates for actions are highlighted on the tracker, and progress continues on developing a SharePoint solution for the audit tracker, with testing underway. Collaborations with Digital Health Care Wales are ongoing to transition from the Excel tracker to the new digital tracker.

Internal Audit Reports:

Julie Boalch advised that these reports had received thorough discussion at the Audit Committee meeting and those discussions had been productive and valuable for addressing any issues identified in the reports.

Serious Adverse Incidents

Liam Williams commented there had been productive engagement between the team and Audit Wales throughout the audit journey. Identified learnings were swiftly incorporated into action plans, including the PTR recovery plan shared earlier in the meeting. The audit highlighted challenges related to capacity and various systems and processes, such as the new DATIX system. These findings align with previous discussions in the Committee and underscore the ongoing efforts to address organisational capacity and operational processes.

No additional Comments were made on the ePCR Clinical Compliance and the Seatbelt Action Plan audits.

RESOLVED: The Committee received and reviewed any Internal Audits and Audit Wales reviews within their remit where relevant. For this meeting these were: -

(1) Serious Adverse Incidents – Joint Investigation Framework
(2) Electronic Patient Clinical Record: Clinical Compliance
(3) Seatbelt Action Plan; and

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

35/24 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK

Julie Boalch updated the Committee on the two corporate risks assigned to the Committee which are rated as high risks and 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 risks have been reviewed

in accordance with their schedules and the scores remain static. The theme of these risks ran throughout the agenda items discussed at this meeting and are part of the alert section of this report.

Members were assured that these risks, whilst not moving in score, are dynamically reviewed regularly, and closely monitored at many of the Board's Committees as well as at internal forums. Additionally, the approach to these risks is being considered given that their score has remained catastrophic for a significant period. It was also noted that no new risks had been identified.

RESOLVED: The Committee noted the update.

36/24 POLICIES FOR APPROVAL/ADOPTION

Julie Boalch presented the report advising Members that the policies have been navigated through the appropriate governance routes and that there are no significant issues to escalate to the Committee and asked that the following policies were approved:

1. Consent to Examination and Treatment Policy
2. Management of Controlled Drugs Policy
3. Non Medical Prescribing Policy
4. Premises and Vehicle Cleaning Policy
5. Clinical Supervision Policy (Including Implementation Plan)
6. Dispatch Cross Reference (DCR) Table Policy

Comments

The Committee recognised the work and the progress being made in updating the Trust's entire suite of policies.

Members raised a concern in terms of the reference to a limitation or challenge related to managing volunteers' vehicles within the Premises and Vehicle Cleaning policy. Julie Boalch advised that this concern was addressed in a different Trust document and that it was one on the radar of the Infection Prevention and Control team.

The Committee approved the policies.

RESOLVED: The following policies were approved: Consent to Examination and Treatment Policy, Management of Controlled Drugs Policy, Non Medical Prescribing Policy, Premises and Vehicle Cleaning Policy, Clinical Supervision Policy and the Dispatch Cross Reference (DCR) Table Policy.

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37/24 COMMITTEE CYCLE OF BUSINESS AND MONITORING REPORT

Julie Boalch provided Members with the Committee Cycle of Business (CoB) updated following the effectiveness review conducted in Q4 and the Monitoring Report for Q1. Focus will be given to including the Trust's compliance against the Health & Care Quality Standards in the CoB in the coming period. The CoB for 2024/25 was approved.

RESOLVED: The Committee:

(1) Reviewed and approved the 2024/25 cycle of business; and

(2) Noted the cycle of business monitoring document.

38/24 KEY MESSAGES FOR BOARD

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

39/24 REFLECTIONS & SUMMARY OF DECISIONS & ACTIONS

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

Date of Next meeting: 13 August 2024

Meeting concluded at 13:45

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ACTION LOG - UPDATE
QUEST COMMITTEE

Date	Agenda Item	Action Note	Responsible	Due Date	Progress/Comment	Status
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	~~7 May 2024~~ 13 August 2024	Update for 7 May 2024 A high level outline plan has been developed, with intention to share the proposal with Committee members by June 2024. Agreed this action would remain with an update at the next meeting Update for 13 August 2024 Details of the timeline are included in the QSIP 2021 -2024 update paper - propose that this action be closed	Complete
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	~~7 May 2024~~ 13 August 2024	Update for 7 May 2024 Agreed that an update would be provided to the Corporate Team for dissemination to Committee Members by the next meeting. Update for 13 August 2024 Further to investigation of the data, WAST have no formal reporting mechanism or requirement to share Safeguarding alerts with HIW. HIW are only informed of significant safeguarding concerns that we believe warrant their attention and the attention of their inspectors. Our formal reporting mechanism and legal duty is to send safeguarding reports directly to the relevant Local Authority as the statutory responsible body. As reported at the meeting, WAST safeguarding reports submitted to Local Authorities have increased annually in recent years.	Complete

OPERATIONS DIRECTORATE
QUARTERLY REPORT FOR COMMITTEES
2024-25 Q1 (April – June 2024)

National Operations & Support

IMTP

Manchester Arena Inquiry
Work on the recommendations has continued with the Capability to Prepare, Capability to Respond and Capability of Specialist Assets papers completed, the and the Recommendation 106 papers being transitioned through the governance route ready for Trust Board approval in July's Closed Session. To date, 30 of 68 recommendations have been completed with 20 of those outstanding requiring investment to progress.

General Update

Community Welfare Responders (CWR)
Since the start of the financial year, CWR support officers have recruited and trained 20 CWR volunteers working across 14 active teams. CWRs have attended 68 patients in April & May with a hear and treat rate of 43.5%. CWRs have undertaken two tests of change to determine which types of patients benefit from the service and which allocation process is most effective.

Test of Change Cycle 1 – CWR deployment to long waits

- Allocator and clinician co-located and working collaboratively to identify and determine suitable calls for CWR. Deployment of CWRs to longest waits in the community.
- Testing occurred 14/05/24 10:00-16:00, 19 calls attended during test period.
- Early data indicates a positive impact on consult and close rate and recognition of deterioration.

Test of Change Cycle 2 – CWR deployment to long waits

- Allocator identified and deployed CWRs independently, clinician available for support remotely if required. Deployment of CWRs to longest waits in the community.
- Testing occurred 04/06/24 12:45-18:00, 17 calls attended during test period.
- Early data indicates a positive impact on wait times for response.

Discussions are still ongoing regarding a new back-up matrix for CWRs to allow the clinician to release the volunteer from scene, following observations, as they do not carry kit for treating patients, unless the patient will require BLS.

Risk 594 - *"The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death".*

WAST is currently reviewing the immediate release protocol and it is our aim to include the release schedule as agreed by COOs. The release protocol schedule for Health Boards to initiate in the event of a major incident, is set out as follows:

- 50% of vehicles released within 10 minutes.
- 75% of vehicles released within 20 minutes.
- 100% of vehicles released within 30 minutes.

Operational Effectiveness

WAST aims to enhance operational efficiency by addressing key areas such as mobilisation times, time spent on scene, clinician travelling unavailability, and multiple auto-allocations. The focus of the work is to emphasise the need for a system-focused approach and the implementation of a live dashboard for dynamic efficiency management. The plan includes identifying stakeholders, discussing strategies, and documenting an action plan, along with the development of new measures specific to the key areas of the job cycle time that require improvement. Additionally, new management processes will be established to ensure continuous monitoring and adjustment. The plan will be delivered with benefit realisation through PowerBI dashboard development. The goal is to optimise resource utilisation and improve service capacity.

Resourcing, EMS Coordination and Quality

Challenges

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

The Trust went into remediation with the IAED for MPDS following Q4. An action plan was approved at SOT and SLT and was submitted to the IAED as per its Remediation Policy. The Trust is required to fall within the specified thresholds of compliance to come out of remediation status. So far for Q1, the Trust has reported compliance within the accreditation threshold boding the Trust well to come out of remediation following Q1. Monthly assurance is being provided to SOT and SLT via memos, and the actions are in progress. Levelling for the OQ Quality Audit team was undertaken with the IAED and the IAED. Feedback from the IAED was positive around the actions being undertaken to address identified issues.

HM Coroners

EMS Coordination/Operations Quality continues to receive coroner requests which has meant the backlog of statements has remained. 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 15 of the outstanding 34 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, nationally reportable incidents (NRIs) and MTPS training etc.).

Resourcing GRS Interface

The link between the GRS system (Rostering) and the Computer Aided dispatch (CAD) system is being developed to ensure that information within GRS can be shared directly onto the CAD system. The benefit of this interface is that GRS will send details of crews and their skills through to the CAD and it would also keep EMSC updated with staff shortfalls for expected shifts automatically and allow almost real time absence reporting so that EMSC can adjust the crew numbers and mixes where necessary. This will replace paper crewing sheet reports, which are currently completed by the Resourcing Teams manually and sent to the EMSC for next 24hr crewing information, thereby providing significant efficiencies as staff would not be required to manually enter crew details onto the CAD from written sheets. While this is currently in the test phase of development, it is expected that this will be delivered in the live environment by quarter 3 of this year.

IMTP

EMS C reconfiguration Update

The OCP consultation for EMSC commenced on Friday 10th May 2024 and was due to conclude on the 7th of June 2024. In consultation with Trade Union Partners, this was extended for 2 weeks and therefore closed on the 21st of June 2024. There were a range of questions raised during the formal consultation period and the formal response to those questions is being finalised.

The OCP covers a range of key developments across the EMSC centres and includes a new structure that will offer colleagues the opportunity to develop into different roles and grades. The development of the Single Allocator Model is a key development, providing a single allocator for each area, providing clarity of accountability and responsibility for the work in that area. Alongside this we have re-run the data from the 2019 demand and capacity review to ensure that the number of desks and indeed the equity of workload across desks is fair; finally, we are developing in conjunction with staff from each of the three EMSC Centre's a set of roster keys to support the new requirements based on the data modelling. Working groups continue to engage and work with colleagues from each of the centres, together with Trade Union Partners to ensure that the implementation of the proposed changes take into account the views of those colleagues who work in the centres day in day out. The ambition is to implement the proposed changes by the end of September / early October this year.

General Update

Operations Quality OCP

The Operations Quality (OQ) OCP recruitment is still in progress and two roles are still awaiting job evaluation following feedback and delay at panel. These two posts have been approved at RCP as acting up positions. One is filled and the other is being offered internally and should be filled by mid-June. The new Locality Manager post has been filled and other posts are in recruitment phase. Once people are in these posts, the department will be able to place some focus on reviewing the EMS Coordination SOPs.

Medical Transfer Protocol Suite (MTPS)

Operations Quality has begun training EMS Coordination staff on MTPS which are the new interfacility transfer protocols within MPDS. Training commenced during June and the go live date for MTPS is during late July. The Service Manager, Operations Quality (Chair of the T&F) continues to provide updates and assurance to the overarching Transfer and Discharge Group to ensure external stakeholders and partners are up to date with MTPS developments and implementation plans.

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 during Q1 is 5% lower than the hours lost during previous quarter. In April 2024 the total lost hours were 23,616, May 2024 at 24,762 and June 2024 at 22,230. 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. Overall, 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 showed signs of improvement in April 2024 but has since deteriorated in May 2024. This follows a period of relatively constant response times. 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.

Culture

EMS have accepted that there are pockets of poor culture that need addressing. The team are currently dealing with 4 investigations which have gone to a disciplinary panel after the initial investigation concluded poor behaviours were exhibited. These will be managed in line with national policy and procedure ensuring all allegations are addressed and dealt with in a timely manner.

Team based working

Plans are currently being finalised to look into trialling team-based working. The management team are looking at what this could look like and will be benchmarking the concept of this approach with London Ambulance Service (LAS). A team will visit LAS in early Q2 to research the approach to resourcing and team management.

IMTP

EMT3 Role

Conversations with TUP's have progressed where a business case will be created. An offer is being negotiated and will be ongoing with TUPs to discuss the EMT3 role. Anticipating a ballot to take place in June to give more direction. WAST has completed face to face staff sessions with CEO across Wales as well as virtual sessions.

General Update

Quality & Support Days

These days continue to provide invaluable support to 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.

These Quality & Support Days have previously covered an array of subject areas including; seat belt and safety harness use, Dress Code Policy, IP&C, and cultural awareness. However, moving forward the intention is to focus on individual a specific key subject area, and importantly providing continued visibility to staff by all grades of operational manager/leader. The purpose of 'theming' the days is to address different areas of operational effectiveness and look for any key achievements or improvements. This 'deep dive' approach to common themes will form key improvement actions that will ensure the trust are providing the most efficient, safe and effective service to our people and patients.

The MS Form that is normally completed for each interaction with an operational crew or station visit during the support day will become BAU for both DOMs and SPs to complete, which will further enhance the level assurance of compliance against the requirements.

Four Q&S days have been held so far, with all aspects of the Operations leadership teams involved, and these are to continue monthly. Themes and trends will again be collated and fed back through the senior leadership team. At the Operations Management Event on 24 June 2024, the opportunity was seized to share themes with a broader group of operations managers.

End of Shift Overruns

While it is noted that the level of investigation of over 2 hour end of shift overruns has continued to be 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 the continued level of handover delays, the average length of overrun has remained at levels lower than 12-15 months ago.

Financial Savings Plan (FSP) 2024/25 Overtime Allocation

The 2023/24 FSP concluded successfully with original savings assumptions mainly achieved and overtime allocation following suit. In 2024/25, Quarter 1, has overachieved to date and a performance report reviewing the progress will be submitted to the Senior Operations Team (SOT) on 26th July 2024. This paper will incorporate the overtime allocation and savings targets for the full financial year. This will allow for fluctuation and 'ad hoc' events when needed, but also provide assurance of the forward planning that is currently underway. To support the routine day-to-day overtime allocation the 'Overtime Allocation SOP' has continued to be utilised as 'business as usual' and there is a separate savings stream working group purely focused on overtime spend.

Ambulance Care

Challenges

UCS Transition

The UCS transition will be challenging due to the requirement of new rosters and working times which are always emotive. The transition also includes the requirement of a new response allocation code set along with a modified EMS/UCS Crewing Matrix.

Work has already taken place on communication with 3 online sessions providing a background to the review, detail of the type of work UCS will be allocated to in the future and next steps. However, there are still some anxieties within the workforce and a FAQs will be published.

CMP (Capacity Management Plan)

The latest version of the CMP went live in May 2024. Whilst there has been a reduction/cessation in the number of provisional bookings taken, we have not seen a noticeable decrease in the numbers of T1 activity so far, which were previously the highest proportion of provisional bookings.

Managing demand against our available capacity has required us to regularly activate the CMP when demand exceeds capacity, this has resulted in increased volumes of journey cancellations. Monitoring of volumes of cancelled journeys and concerns is in place, in addition to process review to improve planning efficiency and minimise cancelled numbers.

IMTP

Reducing Cancellations

Nationally agreed process being worked through aimed at reducing on the day cancellations, however, an adverse effect of this may see a short term increase while the implementation is embedded as business as usual. The plan is to standardise how hospitals focus on advanced bookings in relation to the patients being ready for agreed planned journey time.

Roster Review Programme

A full review of the NEPTS rosters has commenced with ORH and Totalmobile commissioned to review the roster keys produced within the 2020 D&C and to develop new rosters. It is anticipated that the new rosters will go-live at the end of the financial year. As the relief gap of 30FTE identified in the 2020 review has still not been funded, the rerostering will be focused primarily on providing relief to rosters, the majority of which have zero or very minimal levels of relief.

General Update

Fleet

In 2023 the service commissioned 5 of a new type of vehicle, primarily focused at UCS service provision. The vehicles, which weigh less than 3.5T and can be driven on a standard B-class licence, as opposed to Mercedes EA's which require a specialist C-Class licence category. This removes the challenges of recruiting people who hold this licence category or the requirement to fund the attainment of the c-class qualification.

A review of the new vehicle and of all current ACA2 vehicle types has been completed and has identified their suitability for use by ACA2 colleagues as an alternative to the current emergency ambulance fleet which is much more expensive to purchase and operate. The fleet service delivery group will now work through the detail to develop the final specification to inform the adjustment of the Trust's future fleet SOP accordingly.

Integrated Care

Challenges

111 Vacancies

The budget establishment for call handlers is currently under established as usual recruitment and training capacity was necessarily diverted to the CAS Replacement Programme. There is a plan to address and recruit the 30 vacancies in Q2 and Q3 with a view being at budgeted establishment early September. The recruitment will also incorporate more Welsh speaking staff to offer callers the option of continuing calls in Welsh.

Integrated Care Estates - Thanet House

The current lease for staff in Thanet House is due to expire in Q2. Negotiations are ongoing to extend. This is part of the longer-term plan to relocate staff and undertake the decommission of Thanet House.

Multi-Disciplinary Clinical Workforce

A business case for pharmacy was presented to 6 Goals with further plans to present the business case to JCC. The business case was based on the current funding model which may need to be

changed to accommodate the WAST business case process (which has been agreed through provisional internal governance).

Remote Access to CSD

Currently conversations with non-clinical staff on scene requiring assessment of the patient including observations continues to be done through ECNS triage. Whilst the aspiration of the organisation is that the conversations are expedited, work continues to enhance engagement through video rather than phone to give a holistic clinical picture, exploration of Consult and Connect including a risk assessment is being explored.

General Update

111 CAS Replacement

The 111 CAS replacement system was fully implemented on the expected date of 30th April and the old system has been taken out of service. Early indications are more calls are being handled without clinical intervention and we have seen a reduction in the time a patient waits for a clinical assessment. The average time speaking to a call handler has returned to similar levels as before as has the average time waiting for the 111 calls to be answered. There are expected to be further clinical and operational improvements to the system throughout the financial year which will be scoped and implemented.

CSD SOP Review

Interim SOP extracts continue to be maintained rather than rewriting SOPs in their entirety. This approach is in line with the integration of CSD as part of the Rapid Clinical Response Model within the overall Clinical Model Transformation programme. There is an opportunity to streamline CSD and 111 in the same system as part of a larger SOP within the future modelled Remote Integrated Care Service (RICS).

Clinical Model Transformation

General Update

Clinical Model Transformation

The Clinical Model Transformation programme has been initiated on a cross-directorate basis following five days of organisational workshops. Following work on the model and the development of a phased implementation plan, work has commenced on the six objectives for phase one (winter 2024). Whilst work is underway to refresh the Trust's formal program structures formal CMT programme delivery and assurance arrangements are in place, with evolving work groups, established controls, and central records management. In support of delivery the Operations Directorate has appointed Pete Brown as the Assistant Director of Operations (Transformation) and Martin O'Connor as the Service Manager (Transformation). Operations colleagues are working closely with colleagues in other directorates to make progress on changes which will reduce community

harm this winter whilst also embracing a robust culture and change management approach which will engage and connect our people.

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

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

PUTTING THINGS RIGHT REPORT QUARTER 1, APRIL - JUNE 2024/25

MEETING	Quality, Patient Experience & Safety Committee
DATE	13 August 2024
EXECUTIVE	Liam Williams, Executive Director of Quality & Nursing
AUTHOR	Claire Appleton, Assistant Director, Putting Things Right Jane Palin, Assistant Director (interim)
CONTACT	claire.appleton2@wales.nhs.uk

EXECUTIVE SUMMARY

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

In summary the Report for Quarter 1, 2024/25 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 number of serious incidents shared with Health Boards colleagues to investigate under the Joint Investigation Framework
- A continued upward trend in Coroner's requests for information
- The Trust received one Report to Prevent Future Deaths (Regulation 28)
- The PTR Recovery Plan is on track for delivery

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) A significant increase in June 2024 in respect of requests from HM Coroners due to a number of inquests being over 12 months and work being taken to address this nationally. (iii) Our five-day complaint compliance remains lower than the 100% Welsh Government target at 98% in June 2024.

REPORT APPROVAL ROUTE	
Clinical & Quality Governance Group	30 July 2024
Quality, Patient Experience & Safety Committee	13 August 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 April to 30 June 2024. Table 1 & the 'PTR at a Glance' overleaf provides an overview and comparison of data quarter on quarter and over a fourteen-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
   - Ombudsman relationships, information sharing, reports, and responses
   - Coroner relationships, information sharing, reports, and responses
   - Redress cases
   - Claims cases
   - Learning from Deaths
   - 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 aims to provide additional leadership, capacity and development opportunities across the functions. The new structure was put in place in December 2023 and recruitment to positions is progressing.

5. It is anticipated that the structure will be fully established by the end of July 2024. The new Deputy Head of Patient Safety started in June 2024 and a Deputy Patient Safety Manager starts at the end of July 2024. An administrative support post in Legal Services is progressing through recruitment processes. These vacancies have occurred due to internal promotions.

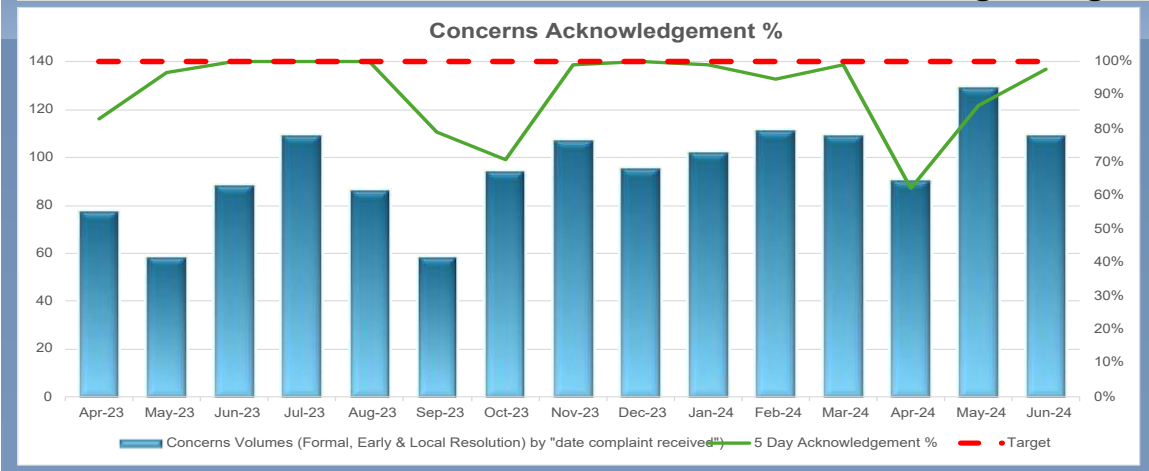
6. The ambition in future reports is to move to aggregated thematic reviews, in order to determine patterns and trends corporately and at service and Health Board levels when data from Datix Cymru can be extracted into Trust systems to create live dashboards.

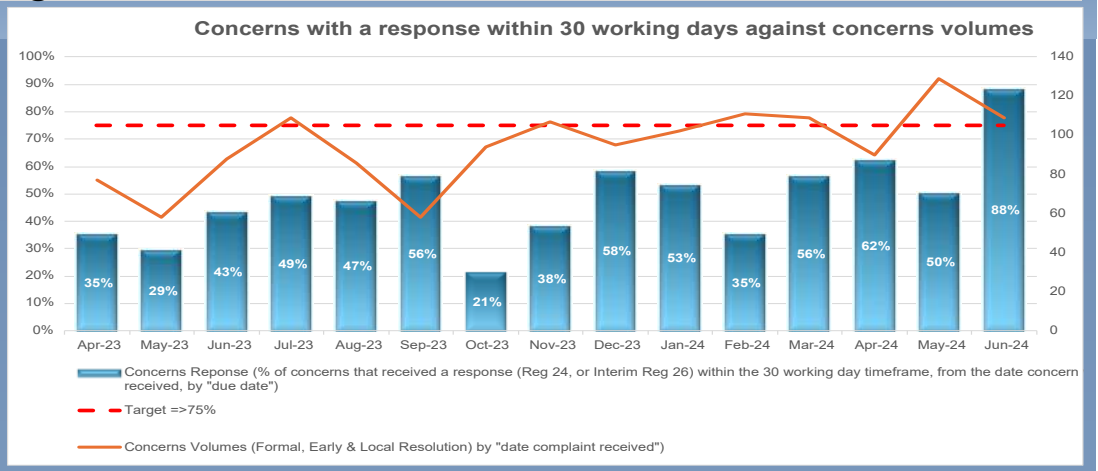
ASSESSMENT

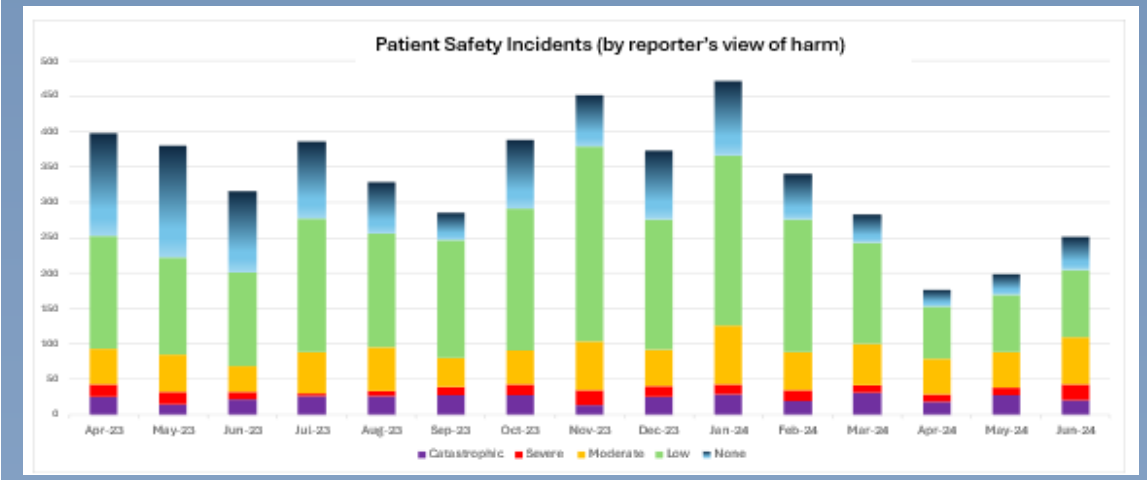
Table 1

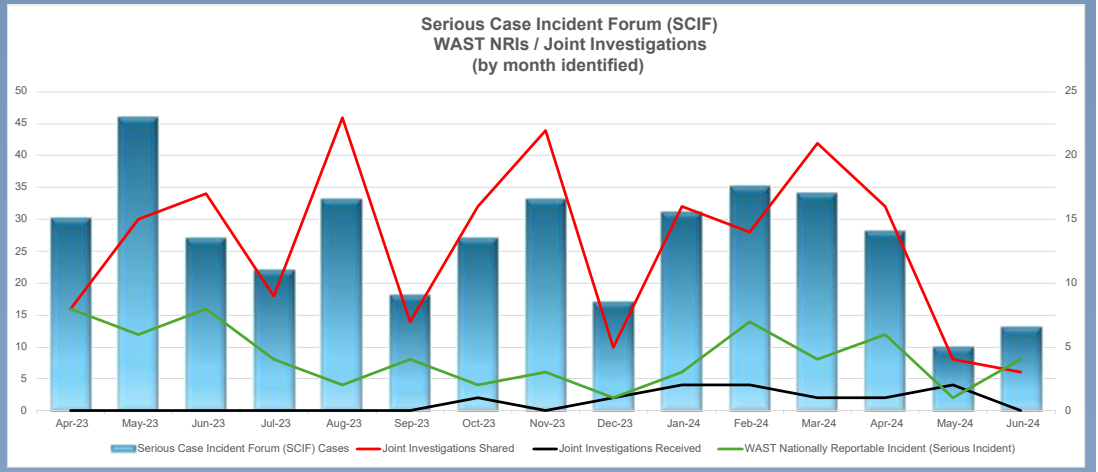
PUTTING THINGS RIGHT						
Comparison of Data Quarter / Year	Quarter 1, 2023 - 2024			Quarter 1, 2024 - 2025		
	April 2023	May 2023	June 2023	April 2024	May 2024	June 2024
Patient Safety Incidents (Reporters view of harm)						
Catastrophic	25	15	22	18	28	20
Severe	18	17	10	11	10	23
Moderate	50	53	37	50	50	67
Low	159	137	132	74	81	94
None	146	158	115	23	29	47
Total	398	380	316	176	198	251
Concerns						
Total Received	77	58	88	90	129	109
Political Concerns	6	2	3	3	5	3
5 Day Acknowledgement %	83%	97%	100%	62%	87%	98%
30 Day Response due %	35%	29%	43%	62%	50%	88%
Ombudsman						
Cases Received	2	1	3	0	0	1
Cases Closed	2	5	0	0	2	1
Reports Received	0	0	0	0	0	0
Coroners						
Information Requests	141	149	139	222	201	227
Identified as Interested Party	32	35	45	55	58	48
Staff Attending	11	7	5	8	9	8
Regulation 28 Issued	0	0	2	0	0	1
Response to Regulation 28 outside 56 working days	0	0	0	0	0	0
Nationally Reportable Incidents (NRIs) to NHS Wales Executive						
Serious Case Incident Forums held	6	8	6	6	3	4
Serious Case Incident Forums Cases	30	46	27	28	10	13
WAST NRI's reportable to NHS WE	8	6	8	6	1	4
Joint Investigation Framework - Shared	8	15	17	16	4	3
Joint Investigation Framework - Receiv	0	0	0	1	2	0
NRI Closures Submitted - Total	4	1	19	13	1	5
Clinical Negligence Claims						
Personal Injury - Received	4	0	1	2	0	1
Personal Injury - Closed	3	0	7	0	0	0
Clinical Negligence - Received	2	3	3	4	2	2
Clinical Negligence - Closed	0	0	1	0	1	3
Road Traffic Colision & Damage to Property Received	33	18	29	28	27	21
Road Traffic Colision & Damage to Property Closed	12	4	14	18	13	17

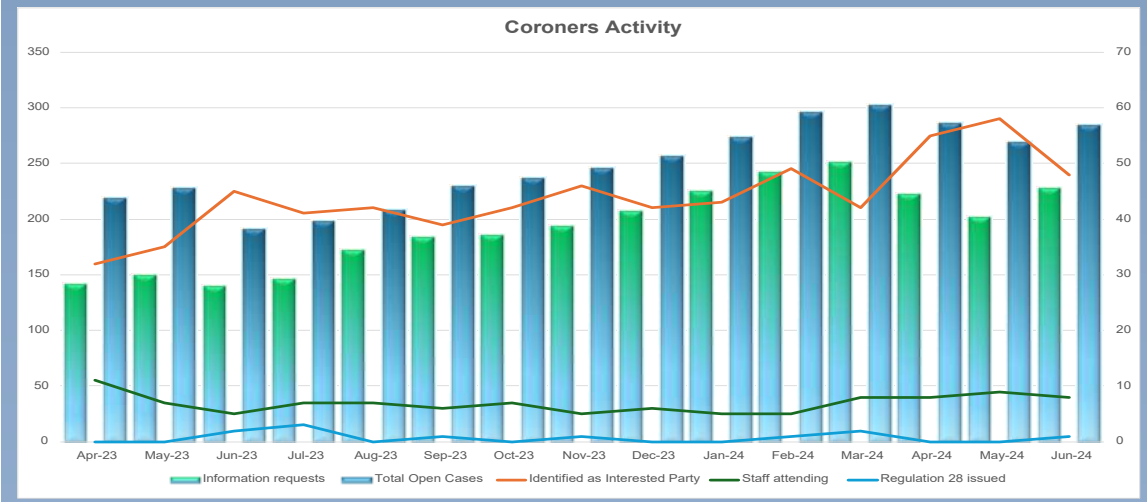
Putting Things Right at a Glance

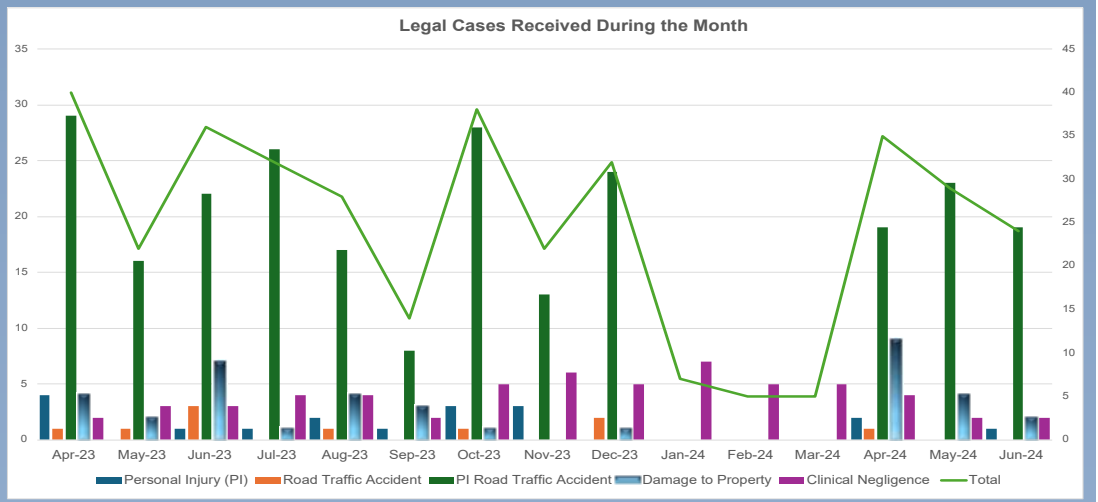












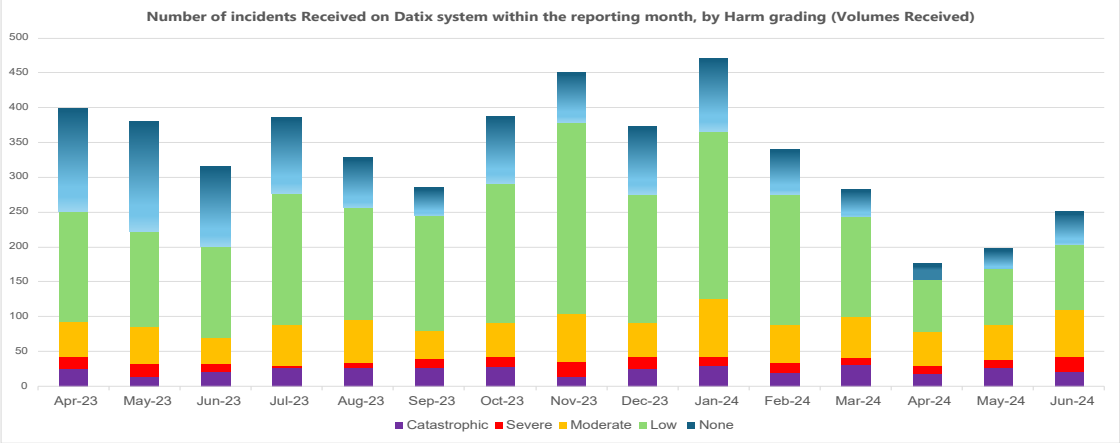
Patient Safety Incidents

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 (WAST).

8. During this period a total of 625 patient safety incidents were reported, 176 in April, 198 in May and 251 in June. It must be noted that the harm grading may change subject to the outcome of any investigation.

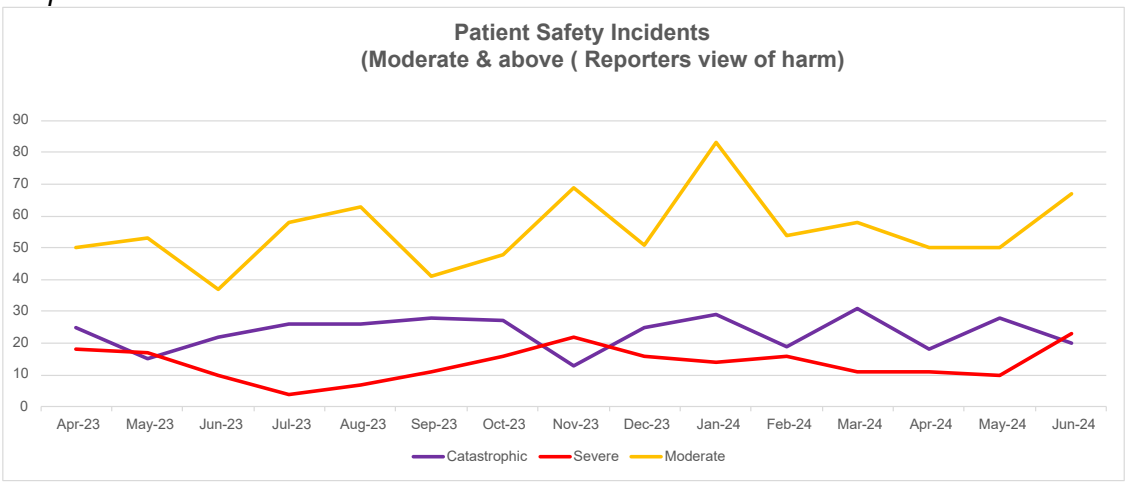
9. The graph below illustrates the number of patient safety incidents reported on a rolling basis from April 2023 by initial grading (reporters view of harm). Themes continue to be timeliness to response and handover of care delays.

Graph 1



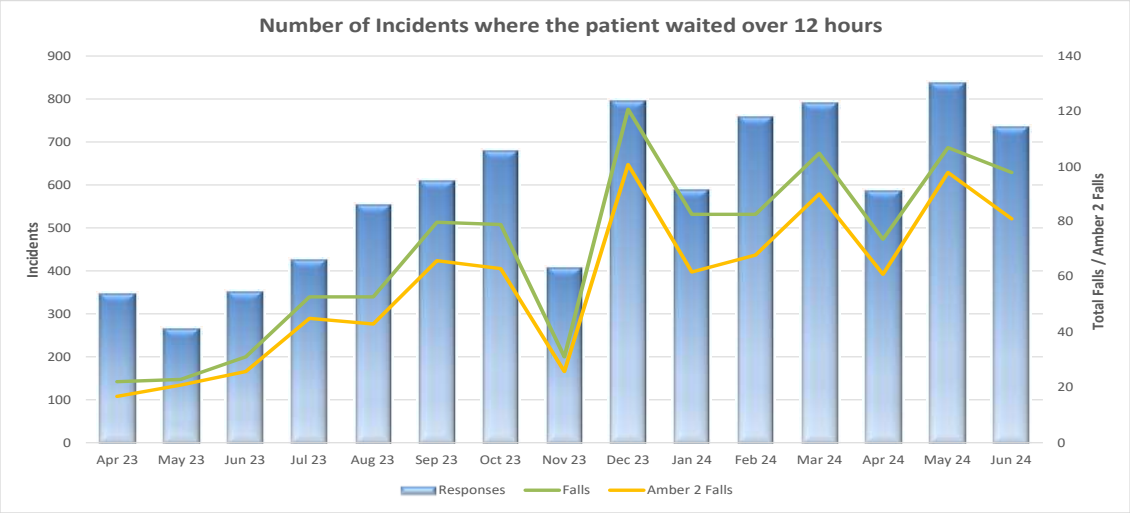
10. Graph 2 below details the number of patient safety incidents rated moderate and above. The Patient Safety Team continue to review incidents graded moderate and above to determine enactment of the Duty of Candour.

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 2159 patients received a response or wait over 12 hours.

Graph 3



12. 279 of the patients waiting over 12 hours had experienced a fall, with the longest waiting patient being 50 hours and 20 minutes. This patient had mobilised following the fall and had a friend with them. Welfare calls were carried out and the Clinical Support Desk undertook reviews on several occasions. No concern has been received to date from the patient or family.

13. 240 of the 279 patients were in the Amber2 category for response. It is well documented that this cohort of patients, who are frequently older people with high levels of frailty, will experience additional harm due to the protracted delays including pressure damage, acute kidney injury, deconditioning and poorer outcomes. Table 2 provides a breakdown of where patients waited by Health Board area.

Table 2

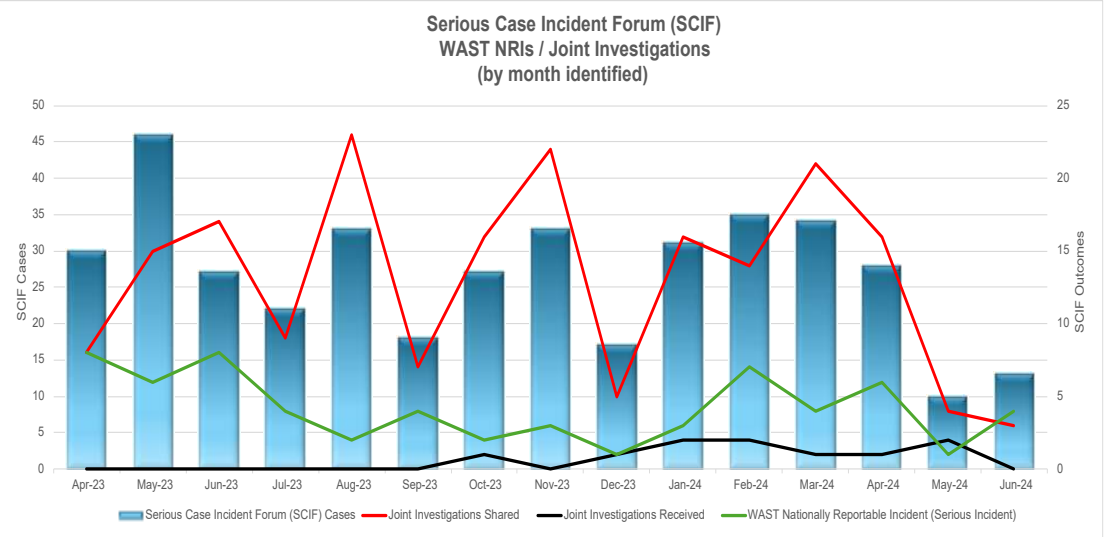
Health Board Area *Plans are in place to provide future data by population.*	Number of Patients who have fallen and waited over 12 hours for a response. April to June 2024
Aneurin Bevan UHB	42
Betsi Cadwaladr UHB	104
Cardiff & Vale UHB	17
Cwm Taf Morgannwg UHB	44
Hywel Dda UHB	33
Powys Teaching HB	5
Swansea Bay UHB	34
Total	279

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

15. The Patient Safety Team continue to promote reporting and data requests from Health Board colleagues to enable identification of harm across the system in respect of pressure damage, including information sharing and WASTs role in Health Board Pressure Damage Panels and incident reporting.

16. Graph 4 below details the number of cases discussed at the Serious Case Incident Forum (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 patient safety incidents.

Graph 4



17. During this reporting period there were 13 SCIF Meetings held, with 51 incidents discussed. 11 incidents have been reported as nationally Reportable Incidents (NRIs) to the NHS Wales Executive and included access or admission delayed/denied, incorrect Medical Priority Dispatch System (MPDS) call coding, clinical triage and medication issues.

18. 23 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.

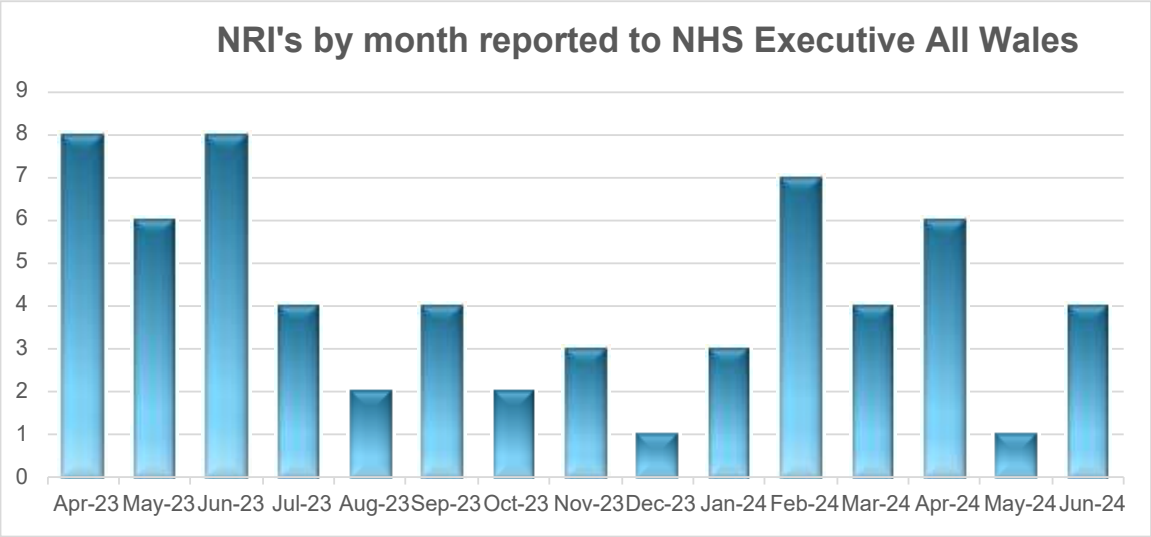
19. General themes following joint investigations remain the same with over-crowded Emergency Departments and wider system pressures resulting in high levels of escalation, lack of end-of-life care or ceilings of care planning and discharge delays.

20. One of the Patient Safety Team's priorities following complete recruitment to the new structure is to work with system colleagues to identify more meaningful

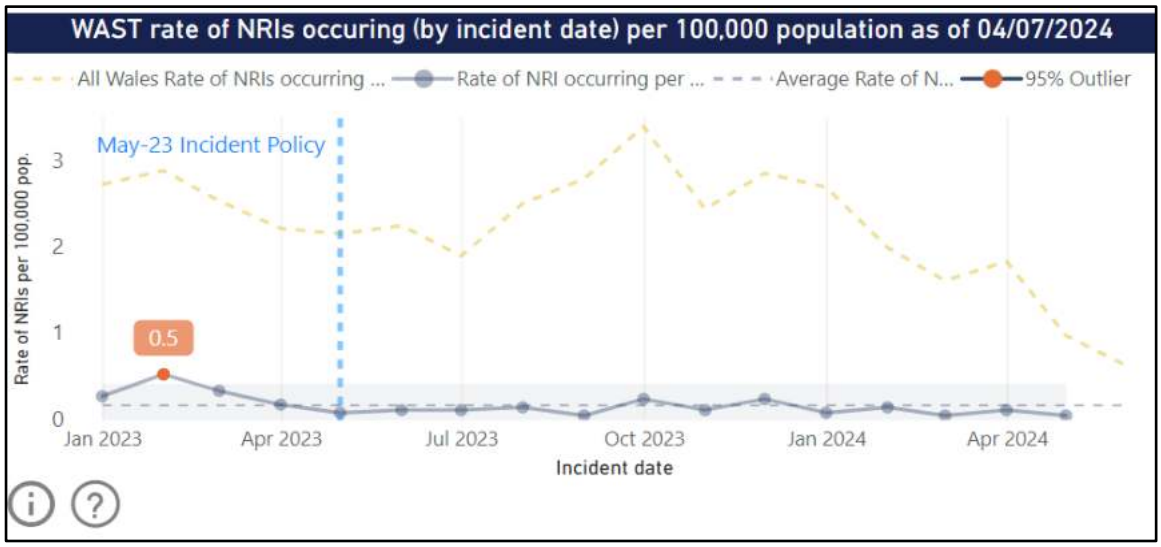
patterns, themes and trends and associated learning opportunities from the joint investigation process.

21. Graph 5 below provides an overview of the numbers of Nationally Reportable Incidents (NRIs) from April 2023. Graph 6 provides the numbers of NRIs by population health (NHS Wales Beacon Dashboard updated 4.7.2024).

Graph 5



Graph 6



22. Table 3 and 4 provide a breakdown of the current open NRIs (n=55). A high proportion of frequently used WAST codes sit under 'Access, Admission' to Services detailed in Table 3. The subcategory codes provide better analysis and as such the plan is to use these for reporting purposes (Table 4).

Table 3

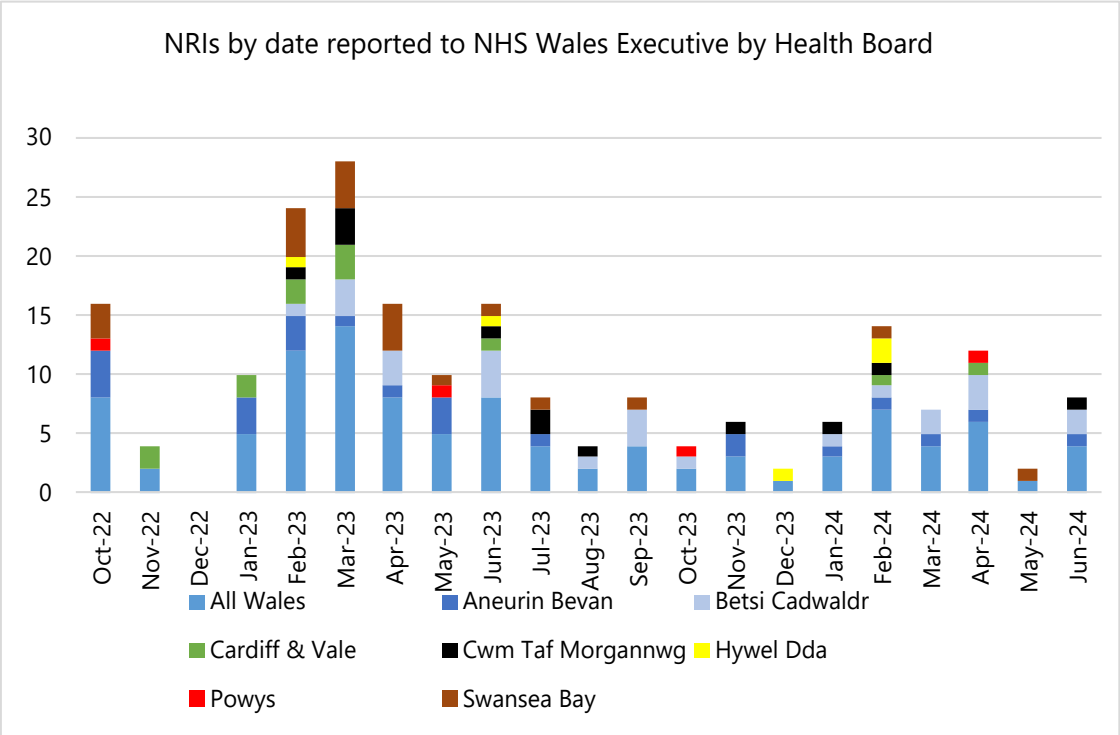
Classification of Open NRI's as of 12/07/2024	ABUHB	BCUHB	CTMUHB	CVUHB	HDUHB	Powys	SBUHB	Grand Total
Access, Admission	6	7	6	5	2	1	2	29
Accident, Injury	2		1					3
Assessment, Investigation, Diagnosis	3	3						6
Assessment, investigation, diagnosis (clinical care)		1						1
Behavior (including violence and aggression)	1							1
Consent process for examination or treatment not / inadequately followed		1						1
Medication, IV Fluids				1				1
Patient/service user death	1	1	3	1	3	1		10
Pressure Damage, Moisture Damage		1						1
Treatment, Procedure	1			1				2
Grand Total	**14**	**14**	**10**	**8**	**5**	**2**	**2**	**55**

Table 4

Classification of Open NRI's as of 12/07/2024	ABUHB	BCUHB	CTMUHB	CVUHB	HDUHB	Powys	SBUHB	Grand Tota
111 / Clinical Service Desk call audit - Errors identified		1						1
Access to admission delayed	2	1		1	1	1		6
Access to services delayed					1			1
Access to services denied		2						2
Access to services or admission delayed		1						1
Adult (not known to mental health services)	1		2	1	2	1		7
Allocation delay - No / lack of available resources	1	3	3	3			1	11
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
Diagnosis delayed	1							1
Fall from chair	1							1
Inadequate clinical assessment	1	1						2
Incorrect strength/dose				1				1
Injury of unknown origin / unwitnessed	1							1
Involving ambulance (patient on board)			1					1
Medical Priority Dispatch System (MPDS) - Call audit errors identified	1							1
Medical Priority Dispatch System (MPDS) - delay - incorrect prioritisation	1		1				1	3
Medical Priority Dispatch System (MPDS) - Incorrect determinant coding		1						1
Missed appointment - Transport issues	1							1
Neonatal death					1			1
Place of work		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
(blank)		1						1
Grand Total	**14**	**14**	**10**	**8**	**5**	**2**	**2**	**55**

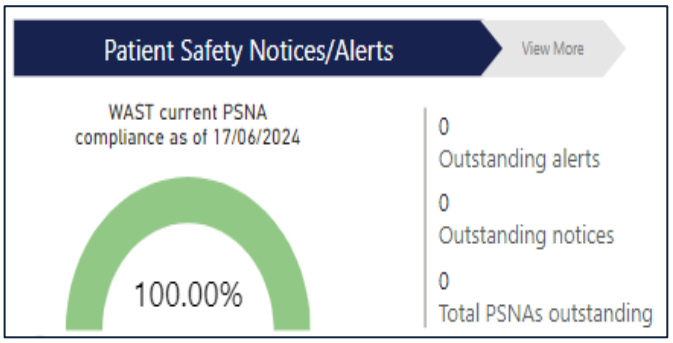
23. Graph 7 below details the number of NRI reported to the NHS Wales Executive by Health Board area.

Graph 7



NHS Wales Patient Safety Alerts/Notices

24. The Trust has no outstanding patient safety alerts (NHS Wales Beacon Dashboard updated 17.6.2024) as detailed below.



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

25. A Learning from Deaths Report is included on the Clinical & Quality Governance Group agenda in July 2024.

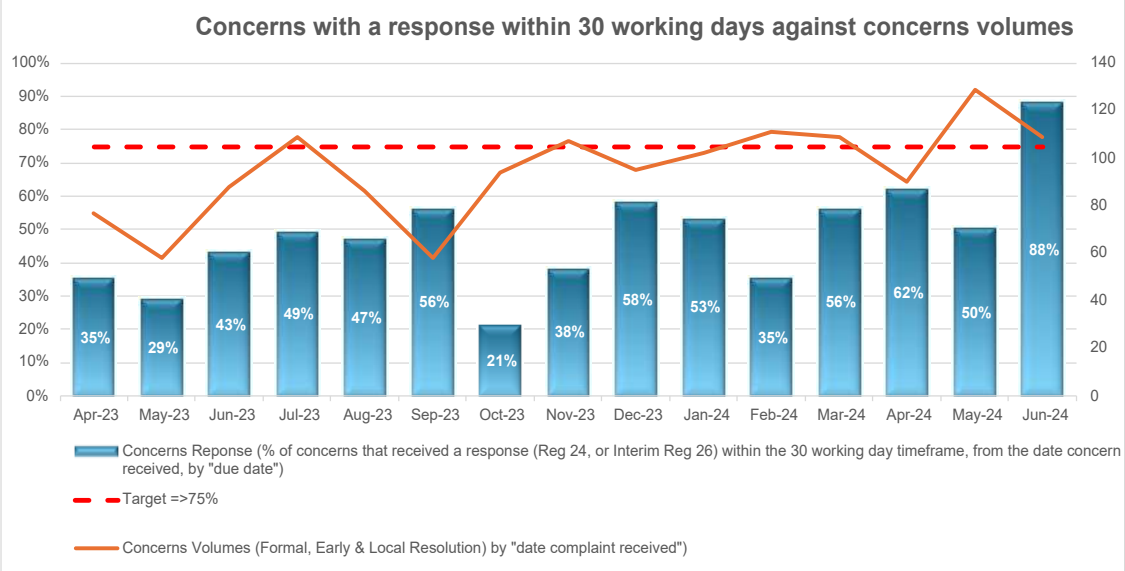
Early Resolution (ER), Local Resolution (LR) and Formal Concerns

26. 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

27. Graph 9 below provides the complaints position over time. The Trust continues to receive a steady number of complaints with 329 being received during this reporting period.

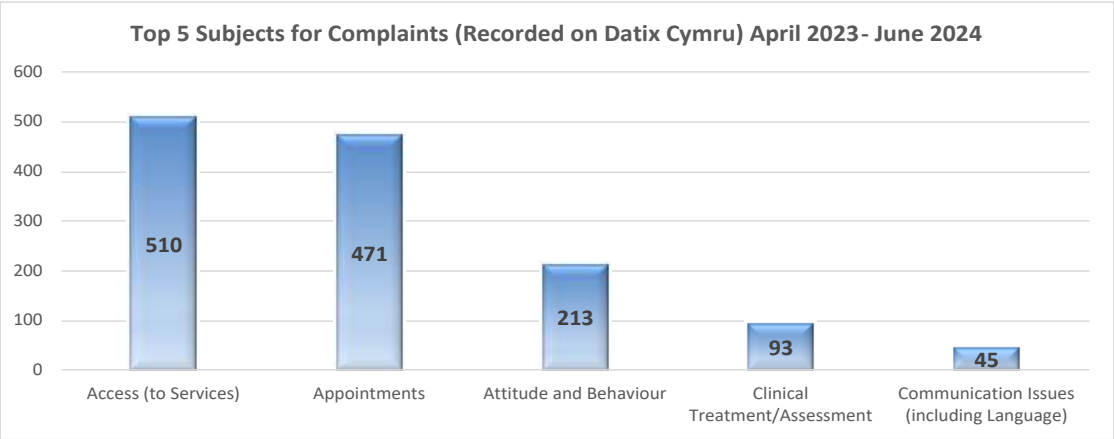
Graph 9



28. The acknowledgement date target has been amended nationally to five working days. During this reporting period the five-day acknowledgement performance was 62%, 87% and 98% (100% target) with the 30-day target achieving 62%, 50% and 88% respectively (75% target).

29. 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



30. The PTR Organisational Change Process is completed and aims to provide additional leadership, resilience, and capacity across all of the PTR functions, including concerns management. It is expected that all posts will be recruited to by the end of July 2024.

31. A PTR Recovery Plan has been developed and is on track to deliver currently.

32. Complaints training for the 111 Service is taking place in July 2024.

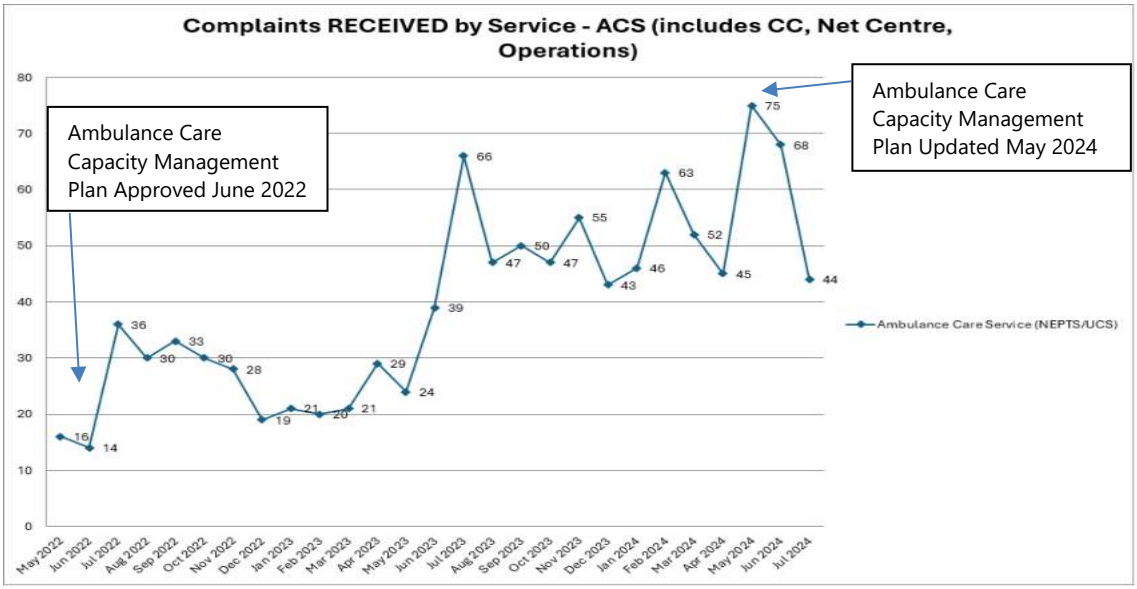
33. There has been a significant increase in the number of concerns relating to Ambulance Care Service as demonstrated in Graph 11. The complaints are predominantly related to cancellations of patients transport under the Capacity Management Plan (CMP).

34. An updated version of the CMP has therefore been implemented under which, provisional bookings for non-eligible journeys will not be accepted. This allows supportive conversations about safe alternative conveyance to take place at an earlier stage and should result in fewer short-notice cancellations which were a driving factor in increased complaints.

35. The Ambulance Care Service Senior Team are developing a response collaboratively with the PTR Teams that can be used where suitable to provide improved information to patients about cancelled or delayed appointments.

36. The Ambulance Care Team are also engaging with commissioners to share the current position and work together to identify a solution to minimise CMP cancellations.

Graph 11



37. 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

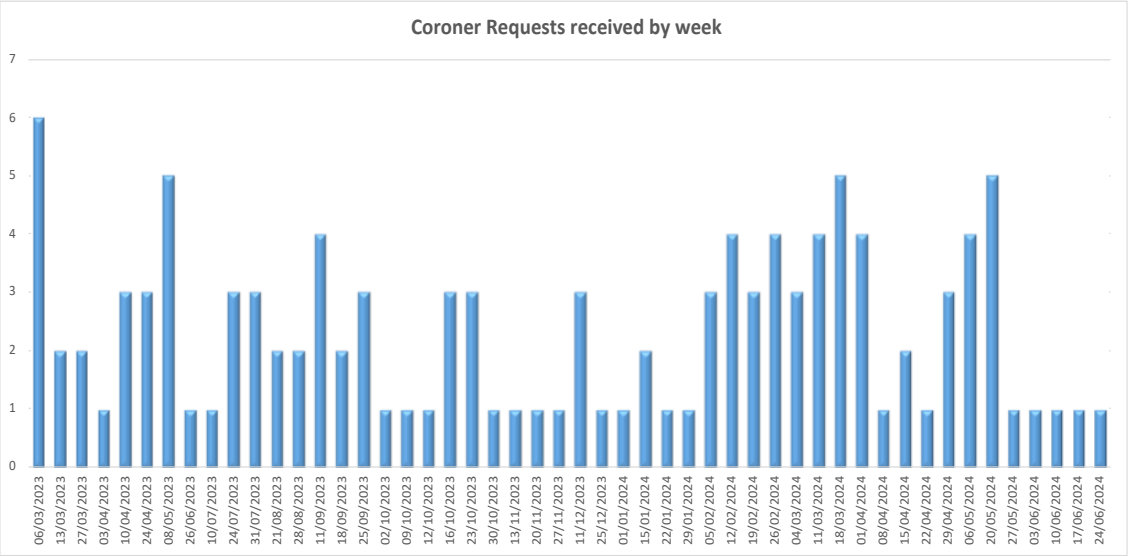
Prepared by the Service Manager, Operations Quality.

38. There are 18 outstanding concerns sitting with Operations Quality (OQ) and the Department is working hard to further improve this position.

39. There are 15 outstanding Nationally Reportable Incidents (NRIs) sitting with the Department. This is a reduction from 24 at the end of March 2024. Five are overdue, of which 3 are at the quality assurance stage. The additional 2 are in progress and relate to ineffective breathing, which the International Academies of Emergency Dispatch supported the Trust to identify learning and review these cases.

40. There are 28 Coroners' statements outstanding with the Department. This is a decrease from 34 at the end of March 2024. The Department saw an influx of statement requests between February and May 2024; however, requests have been more manageable since (outline in Graph 12 below). HMC requests are expected to continue as Regional Coroner's Offices work through a backlog of cases. The Department has aligned capacity to address the backlog and recruitment into a new senior management post which includes responsibilities for Coroners has been completed as part of an approved organisational change process.

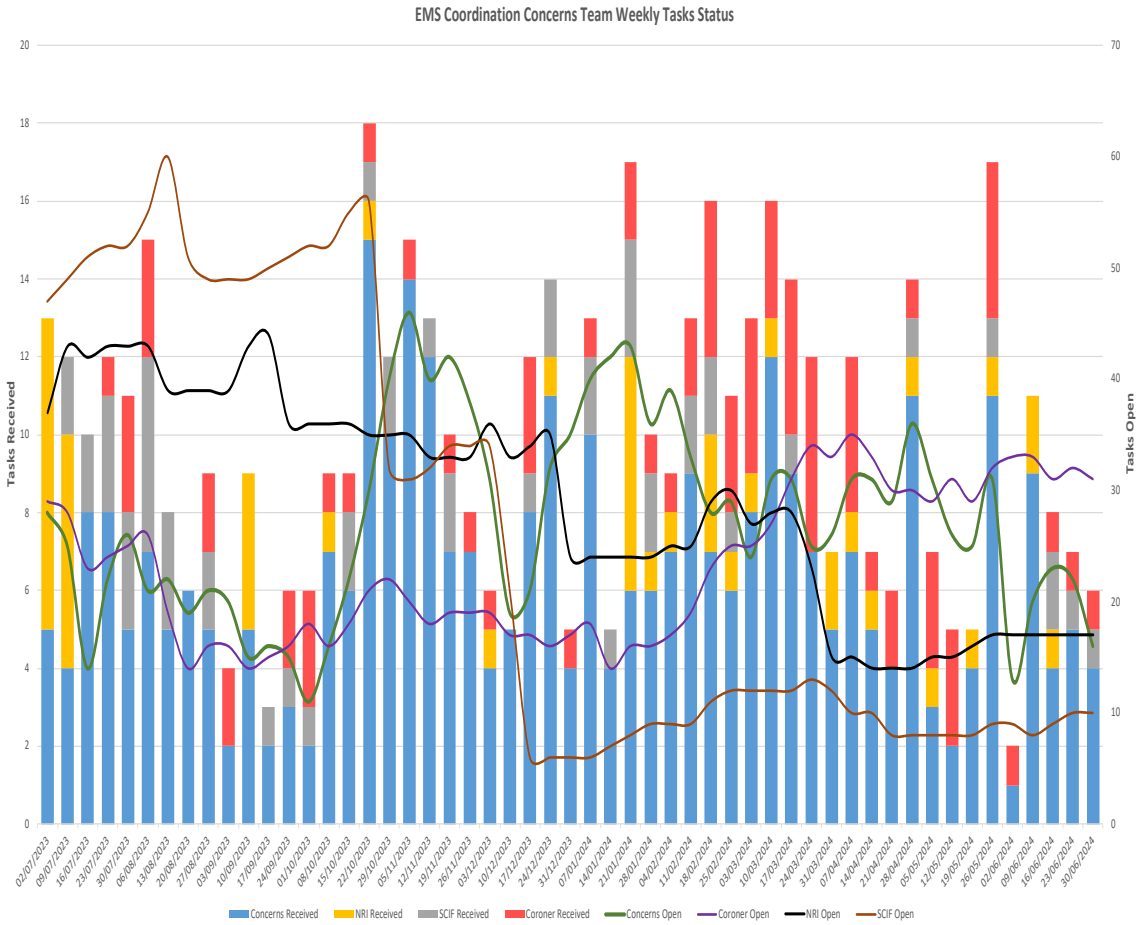
Graph 12



41. Actions from the Serious Case Incident Forum (SCIF) continue to be reviewed weekly to ensure they are being progressed and completed.

42. Graph 13 provides an overview of the activity of the Team up until 30 June 2024.

Graph 13



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

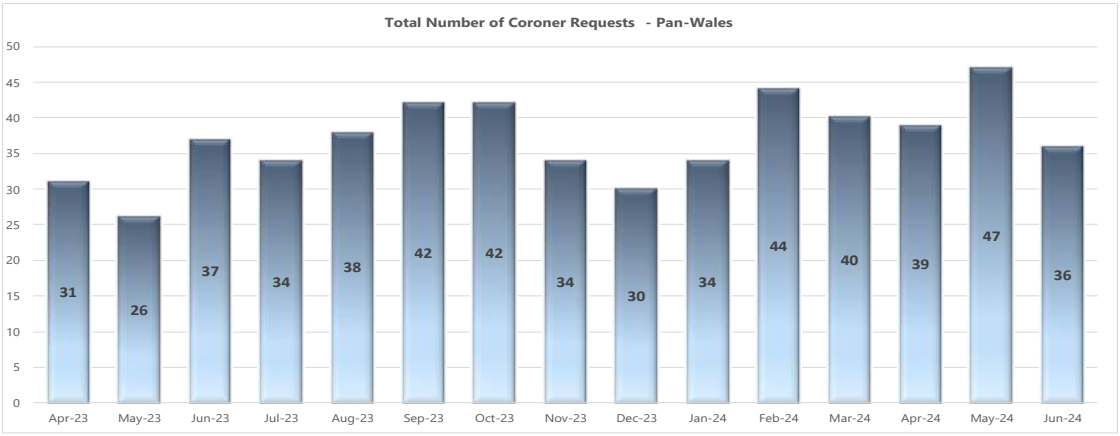
44. Themes and trends are also considered and discussed at the monthly EMS Coordination Quality Meeting, which is chaired by the Service Manager, Operations Quality.

Organisational Legal Activity and Coroners

45. 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.

46. Activity has increased overall as detailed in Graph 14 and this is expected to increase further as nationally work is progressing to reduce the number of inquests waiting over 12 months.

Graph 14



Prevention of Future Death Reports (Regulation 28)

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

48. A Report was received from the Assistant Coroner for the Coroner area of Swansea and Neath Port Talbot 17.6.2024. The Trust were not identified as an interested party at the inquest. The Assistant Coroner had concerns that there may be other acute circumstances when the use of a drug (flumazenil) could make a difference but will not be available since paramedics do not carry it.

49. The Trust has submitted a response detailing why this drug is not carried by Paramedics UK wide, which has been supported by the National Ambulance Service Medical Directors Group (NASMeD).

50. The Legal Services Team coordinate the responses to the Coroners, ensuring information is submitted with in the defined timescales with relevant Improvement Plans. The Learning from Deaths Forum oversee the Reports and response.

Legal Claims

Table 5

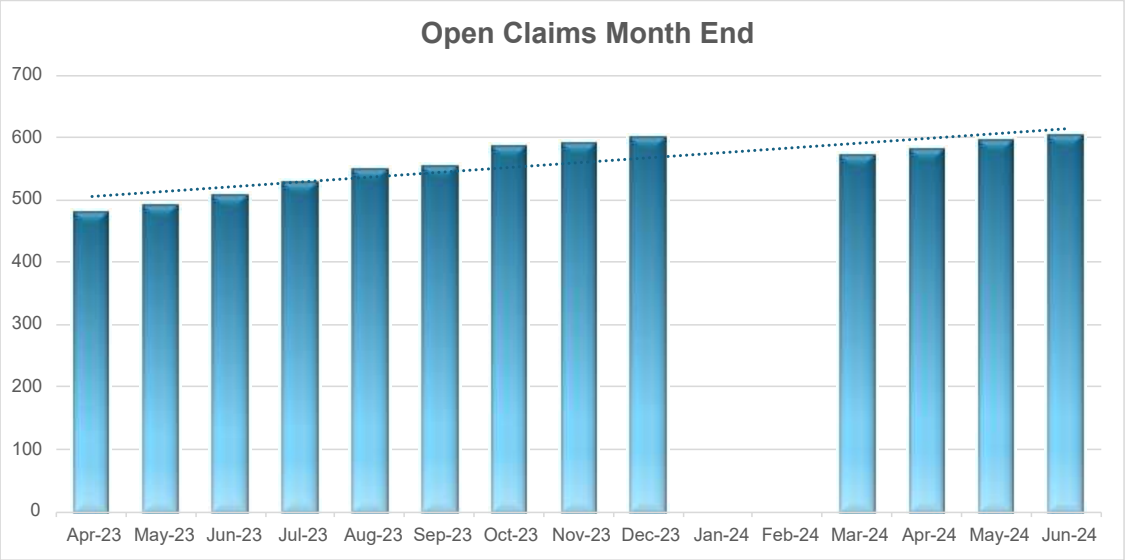
Legal Claims Overview			Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Claims opened	Personal Injury (PI)	Monthly	4	0	1	1	2	1	3	3	0	*			2	0	1
	PI Road Traffic Accident	Monthly	1	1	3	0	1	0	1	0	2	*			1	0	0
	Clinical Negligence	Monthly	2	3	3	4	4	2	5	6	5	7	5	5	4	2	2
	Road Traffic Accident	Monthly	29	16	22	26	17	8	28	13	24	*			19	23	19
	Damage to property	Monthly	4	2	7	1	4	3	1	0	1	*			9	4	2
Claims closed	Personal Injury (PI)	Monthly	3	0	7	1	0	6	0	0	0	*			0	0	0
	PI Road Traffic Accident	Monthly	1	0	2	0	0	5	0	1	0	*			0	0	0
	Clinical Negligence	Monthly	0	0	1	1	0	0	0	1	1	0	1	0	0	1	3
	Road Traffic Accident	Monthly	8	3	11	5	8	4	4	14	19	*			17	13	13
	Damage to property	Monthly	4	1	3	2	1	5	1	1	3	*			1	0	4
Claims open at the end of the month	Personal Injury (PI)	Monthly	76	76	70	70	72	67	70	73	73	*		84	86	86	87
	PI Road Traffic Accident	Monthly	59	60	61	61	62	56	57	56	58	*		63	64	64	64
	Clinical Negligence	Monthly	126	129	131	134	138	140	145	150	154	161	162	167	171	172	172
	Road Traffic Accident	Monthly	203	210	223	244	253	269	293	292	297	*		228	230	240	248
	Damage to property	Monthly	16	17	21	20	23	21	21	20	18	*		29	30	34	33
			480	492	506	529	548	553	586	591	600			571	581	596	604

51. 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.

52. 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.

53. Graph 15 details the current position in respect of open claims which continues on an upward trajectory. Gaps in the data is due to the move to a new database.

Graph 15



Organisational Learning

54. 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.

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

56. The following notices have been issued to share learning during this period:

- CN 14/2024 Swansea Bay Urgent and Routine Mental Health Support
- CN 15/2024 Maternity Red Phones - CTM
- CN 16/2024 Updated PGD - Co-amoxiclav 1000mg/200mg for the management of open fracture
- CN 17/2024 Cwm Taf Morgannwg Urgent and Routine Mental Health Support
- CN 18/2024 JRCALC for ACA2 staff
- CN 19/2024 Paracetamol introduction for ACA2 staff
- CN 20/2024 Dementia Hwbs Swansea Bay
- CN 21/2024 Transport of Babies in Ambulances
- CN 22/2024 ePCR Patient Pathway Referrals
- CN 23/2024 Clinical Frailty Scale - for all EMS staff
- CN 24/2024 Major Trauma Tool update & Trauma in older people tool
- CN 25/2024 Maternity Red Phones - ABUHB

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

Table 6 **- Examples of learning from clinical reviews (April 2024)**

	Number	Brief Description	Themes	Learning Opportunities
Cardiff and Vale	7	• Concerns raised regarding ACA2 crew understanding around mental capacity, their own scope of practice and manual handling. • Crew attended patient convulsing and fallen downstairs. Whilst treating the convulsion, they did not recognise the trauma and significant injuries sustained from the fall. • Following a concern where the patient has passed away, family raised concerns that the patient should have been transported to hospital on two occasions. They have concerns around the patient's ability to make a decision and how this was recorded and how capacity was determined. • Following a cardiac arrest and advanced life support, ROLE was implemented. Suspicion that the patient had overdosed and that ROLE should not have been implemented without further advice. • Child not being assessed appropriately by the attending crew • Baby born before admission with one crew transporting the baby and the other the mother. Only one ePCR generated	• Scope of Practice • Manual Handling • Mental Capacity • Failure to examine patient adequately • Appropriate action taken and capacity established through a functional and diagnostic test. • ROLE guidance • Paediatrics • Failure to examine patient adequately • Poor documentation • Drug administration error • Poor documentation • Failure to examine patient adequately	• Improved manual handling practices • Improved awareness of mental capacity • Improved patient assessment • Improved understanding of termination of resuscitation in adults • Human Factors • Improved ePCR completion • Medicines management awareness • Improved ePCR completion

		and no secondary so both crews were writing on the same record. • Drug Administration Error		
Cwm Taf	5	• Incorrect drug given during cardiac arrest • Protracted stay on EA where patient deteriorated • Loss of ETCO2 reading during cardiac arrest • Issues with patient diagnosis resulting in crew going back and forth between hospitals • Drug given via wrong route during wrong treatment	• Drug administration error • Handover delays • Poor management of cardiac arrest • Misdiagnosis of patient • Drug administration error	• Medicines management awareness • Improved cardiac arrest management
Swansea Bay	2	• Incorrect equipment used to monitor BM and frequency of observations • Patient deterioration while awaiting transfer to definitive care	• Failure to identify deteriorating patient • Failure to examine patient adequately • Lack of observations • Poor documentation • Pre-alert issues	• Improved ePCR completion • Improved patient assessment

Welsh Risk Pool Learning from Events Reports & WRP Committee Outcomes

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

59. 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.

60. WRP have started to apply financial penalties to organisations with deferred cases over 12 months from the decision to settle date. To date the Trust has not had penalties applied.

WRP Committee Outcomes (as of 17.7.2024) & 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	0	0	0
Deferred Redress	3	1	4
Overall position	3	1	4

61. Table 7 provides an overview of the current position with the Trust having 3 amber deferred cases and 2 red deferred cases (these have to return to the Learning Advisory Panel) awaiting evidence of learning.

62. Oversight of the status of cases is undertaken by the Legal Services Team and additional supporting evidence is currently being gathered to demonstrate learning and improvements.

Horizon Scanning & Key Documents

63. During the period the following key documents or updates have been published:

- Putting Things Right Regulations (2011): Consultation by Welsh Government on the overhaul of the Regulations. The new Regulations are expected to be released in Autumn 2024 and WAST has provided feedback.

- The NHS in England has recently consulted on the list of Never Events (adopted by NHS Wales) to determine if the Never Events Framework is an effective mechanism to drive patient safety improvement outlining the following options:

  - Option 1: No change; continue with the current Framework
  - Option 2: Abolish the Never Events Framework and list
  - Option 3: Revise the list of Never Events to only include those with current barriers that are 'strong, systemic, protective'
  - Option 4: Revise the definition of and process for Never Events to create a new system that does not require all relevant incidents to be 'wholly preventable'.

AGENDA ITEM No	8
OPEN	OPEN
No of ANNEXES ATTACHED	1

MONTHLY INTEGRATED QUALITY & PERFORMANCE DASHBOARD – June/July 2024

MEETING	Quality, Patient Experience and Safety Committee (Quest)
DATE	13th August 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

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

2. The response times to 999 callers remains of concern with red 8-minute performance at 48.2% in July 2024 and Amber 1 median at 1 hour and 26 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: maintaining high levels of EA production (declined in July) and fully rolling out the CHARU service (improving). 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 (currently some reporting issues with this metric). The Trust lost 19,596 hours to handover in July 2024 (marginally higher than July 2023), 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, in particular, investing in clinical screening and APPs.

3. Data quality issues have been identified in 111. These are currently being addressed. 111 call handling performance has stabilised post-delivery of the new 111CAS, but the abandonment rate is higher than the 5% target. This is

due to a number of factors, in particular, a lower level of staff in post caused by training capacity having to be diverted to the implementation of the new system, sickness absence and also a 4% commissioned reduction in call handlers in 2024/25. The Trust anticipates that staff in post will be restored to establishment levels by October 2024.

4. 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 (on target), a key efficiency.

5. 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 7.44% in July 2024 remaining consistently below 8% since March 2024. The IMTP ambition is to reach 6%. The Trust will continue its focus on sickness absence. It is of note that the EMS abstractions did hit the 30% benchmark in January, February, April and June respectively, for the first time since the pandemic, but have increased to 34% in Jul-24 (annual leave & sickness absence).

6. The Trust continues at pace its Clinical Model Transformation (CMT) programme, as detailed in its 2024-27 IMTP, and further articulated in the IMTP 24-27 Q1 delivery assurance report.

RECOMMENDATION: QuEST is asked to: -

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

REPORT APPROVAL ROUTE
07.08.24 Executive Director Strategy, Planning & Performance 13.08.24 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 **June/ July 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. An updated set for 2024/25 were reviewed in early June by the Executive team and the outcome is highlighted further in the paper.

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 decreased in June with the 95th percentile at 18 seconds, compared to 6 seconds in May 2024. The 65th percentile and median performance remain consistently good.

6. **111 call answering performance has improved over recent weeks,** although the call abandonment performance was at 11.9% in June and off target (5%). One of the key issues has been the reduction of call handling staff in post as recruitment was paused during preparation for the new CAS system. Recruitment is now underway and it is anticipated that the full complement of funded staff will be in post by October. It should be noted that there is also a reduction in the commissioned level of call handler FTEs in 2024/25 compared to last year (-4%).

7. Demand in June 2024 was 4.76% higher than during June 2023. If this level of demand is sustained, alongside a reduction in commissioned capacity, then future call abandonment performance could continue to be negatively affected.

In the short term, it will also take a number of months for new system to stabilise i.e. staff to familiarise themselves with it, etc.

8. **111 Clinical response:** clinical ring back times for patients with the highest priority remained above target at 98.7%. Response times for lower priority calls, although remaining below target, have improved significantly over the past 3 months, with P2CT and P3CT calls achieving 83.7% and 85.5% respectively in June 2024. This is despite continued high levels of clinician sickness absence, which was at 16.86% in June 2024.

9. **Ambulance Response** (safety / patient experience): the red 8-minute response performance for July 2024 was 48.2%, remaining below the 65% target; however, the Trust is reaching more red patients in 8 minutes, but the denominator (demand) has also grown. The Amber 1 median in July was 1 hour 26 minutes and the Amber 1 95th percentile was 6 hours 54 minutes. These long response times have a direct impact on outcomes for many patients.

10. 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 change in how it responds to patient demand by evolving its clinical model, before winter. A series of workshops were undertaken in May 2024, with additional leadership capacity also being put into this area: both designed to move this forward at pace. Areas of focus include: -

    - Further investment into remote clinical capacity (+23 FTEs);
    - Further investment in APPs (+32 APPs);
    - Development of the remote integrated care service (111 clinicians and CSD clinicians);
    - Continued focus on a range of responses that support non-conveyance, where it is clinically safe and appropriate to do so: Connecting Support Cymru, mental health response pilot, Falls response etc.
    - Formal reporting of the 2023 collaborative and independent EMS Demand & Capacity review.

11. The one area of particular focus for recruitment is CHARU: with the Trust looking to recruit up to the modelled 153 FTEs; and connected to this a focus on CHARU productivity, with on-going analysis work on their contribution (initial findings positive with a report to Sep-24's Finance & Performance Committee) etc.

12. 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. 19,596 hours were lost during July 2024. Cardiff & Vale's handover lost hours continues to remain low, due to an organisational focus

within the health board. While some small improvements have been seen in other health boards in recent months, Betsi Cadwaladr health board remains significantly high and above its two-year average figure (7,733). Performance into July has remained very challenging with days where over 1,000 hours were lost. WG have re-iterated to Health Boards the critical importance of improvements in this area.

13. **Ambulance Care (Patient Experience)**: Oncology performance in July 2024 was 77.4%, hitting the 70% target. Renal performance also remains above target at 73%. Advanced discharge & transfer journey performance decreased compared to the previous month to 77% and remains below the 95% target. Overall demand for NEPTS continues to increase but remains below pre-pandemic levels. The Trust has a comprehensive Health Transport transformation workstream 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 (on target)..

14. **National Reportable Incidents (NRIs) / Concerns Response**: the Trust reported four NRI's to the NHS Executive in June 2024, an increase from the one reported in May 2024; and 3 serious patient safety incidents were referred to health boards under the Joint Investigation Framework. In June 2024 complaint response times improved to 88%, a strong improvement on the 50% recorded in May 2024, and achieving the 75% target, however, cases remaining complex. Reviews of lower graded concerns are being undertaken to ensure proportionate investigations are undertaken. The Trust has recruited to a new structure for the Putting Things Right (PTR) team, which is a key enabler in the improved performance.

15. **Clinical outcomes**: The percentage of suspected stroke patients who are documented as receiving an appropriate stroke care bundle was 84.4% in June 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 decreased to 14.4% in June 2024 compared to 16.5% in May 2024.

16. The Trust is now able to report on call to door times for Stroke and STEMI patients. For May 2024, these highlight call to hospital door times of two hours and 17 minutes for stroke patients and two hours and fifteen 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.

17. In July 2024, 9,881 patients **cancelled** their ambulance, and the Trust was unable to send an ambulance due to application of CSP levels to approximately 400

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)

18. **Hours Produced**: The Trust produced 119,710 Ambulance Response unit hours in July 2024 and delivered an emergency ambulance unit hours production (UHP) of 90%, below the 95% target. The primary causes were annual leave and sickness absence. Whilst EA UHP declined in July 2024 the Trust produced more ambulance units hours (all resource) than July 2023.

19. **Response Abstractions:** EMS abstraction levels increased to 33.72% in July 2024, remaining just above the 30% benchmark figure. Response sickness abstractions stood at 8.19% (benchmark 5.99%).

20. **Trust sickness absence:** the Trust's overall sickness percentage was 7.44% in June 2024, a decrease on the 7.60% recorded in May 2024. Actions within the IMTP concentrate on staff well-being with an aim to continue to reduce this level supported by the ten-point plan. The 7.44% is above the 2023/24 IMTP ambition of 6% but is a good improvement.

21. **Staff training and PADRs:** PADR rates did not achieve the 85% target in July 2024, but have been steadily improving (76.76%). Compliance for Statutory and Mandatory training increased to 84.47%, just shy of the 85% target.

22. **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.

Finance & Value

23. **Financial Balance**: The reported outturn performance at Month 3 is a surplus of £29k and the Trust is forecasting to achieve both its External Financing Limit and its Capital Expenditure Limit.

Partnerships & System Contribution

24. The consult & close rate was 11% in July 2024, a reduction from the previous month due to the system changes within the 111 CAS system, which has affected reporting capabilities i.e. the 111 contributions to consult & close is not currently included in the 11% above. The IMTP ambition (and Welsh Government target)

remains 17% at this point in time. The Trust has a recovery plan in place, with further work continuing during 2024/25.

25. Same Day Emergency Care (SDEC) centres continue only see a low level of ambulance activity and handover levels remain extreme, which make the work on the updated clinical model, before next winter, a tactical imperative.

Summary

26. The indicators used at this high-level highlight that 111 has stabilised post the 111CAS implementation with the coming months seeing a focus on recruiting back up to the establishment, which was affected by the implementation of the new system. EMS is stable, but likewise off target with the primary cause being handover lost hours. The Trust has largely exhausted traditional approaches to improving EMS performance and therefore now focused on evolving the clinical model at pace this side of winter. Ambulance Care performance is stable and above target for its two-headline metrics.

RECOMMENDATIONS RECOMMENDATION: QuEST is asked to: -

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

Welsh Ambulance Services University NHS Trust

Monthly Integrated Quality & Performance Report

June/July 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: August 2024

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by Commissioning & Performance Team

Section 1: Monthly Indicators / Top Indicator Dashboard

Top Monthly Indicators	Target 2023/24	2 Year Average	Jun-24	Jul-24	RAG
Our Patients					
Timeliness Indicators					
NHS111 Call Handling Abandonment Rates	< 5%	12.0%	11.9%	N/A	R
111 Clinical Triage Call Back Time (P1)	90%	98.2%	98.7%	N/A	G
999 Call Answer Times 95th Percentile	00:06	00:26	00:18	N/A	R
999 Red Response within 8 minutes	65%	49.3%	46.5%	48.2%	R
999 Amber 1 Median	00:18	01:24	01:29	01:26	R
Oncology Journeys arriving within 45 mins and up to 15 minutes after appointment time	70%	72.0%	76.0%	77.0%	G
Advanced Discharge & Transfer journeys collected less than 60 minutes after booked time (NEPTS)	90%	82.7%	72.2%	77.0%	R
Clinical Outcomes / Quality Indicators					
Return of Spontaneous Circulation (ROSC)	Increasing Trend	18.1%	14.41%	N/A	R
Stroke Patients with Appropriate Care	95%	78.0%	88.41%	N/A	A
Stroke Call to Hospital Door Times	Reduction Trend	02:16	02:17	N/A	R
ST-Elevation Myocardial Infarction (STEMI) with Appropriate Care	95%	44.5%	65.43%	N/A	R
National Reportable Incidents reports (NRI)		5	4	N/A	
Can't Send & Cancelled by Patient Volumes	Reduction Trend	9,515	9,737	9,881	A
Concerns Response within 30 Days	75%	38.5%	88%	N/A	G
Enactment of the Duty of Candour	100%	73.3%	60%	N/A	R
Our People					
Capacity					
Hours Produced for Emergency Ambulances	95-100%	94%	93%	90%	A

Top Monthly Indicators	Target 2023/24	2 Year Average	Jun-24	Jul-24	RAG
Health & Well-being					
Sickness Absence *(all staff)*	6.0%	8.64%	7.44%	N/A	A
Mental Health Absence Rates	Reduction Trend	2.30%	2.07%	N/A	G
Staff Turnover Rate	Reduction Trend	9.92%	8.64%	8.12%	G
Statutory & Mandatory Training	>85%	78.82%	84.05%	84.47%	A
PADR/Medical Appraisal	>85%	76.43%	77.53%	76.76%	A
Number of Shift Overruns	Reduction Trend	3821	3879	3869	A
Inclusion & Engagement / Culture					
NEPTS % of Total Calls Answered in Welsh	Increasing Trend	1.4%	1.8%	2.8%	G
Value					
Financial balance - annual expenditure YTD as % of budget expenditure YTD	100%	100%	100.00%	N/A	G
EMS Utilisation Metric (CHARU)	Increasing Trend	28%	28.6%	27.4%	A
Average Jobs per Shift (All Vehicles)	Increasing Trend	2.35	2.31	2.35	A
NEPTS on the Day Cancellations	Reduction Trend	20.0%	22.0%	21.4%	A
Partnerships / System Contribution					
Inverting the Triangle					
Successful Consult & Close Outcome	17.0%	13.3%	11.6%	11.0%	
% Of Total Conveyances taken to a Service Other Than a Type One Emergency Department	Increasing Trend	11.34%	11.78%	N/A	R
Number of Handover Lost Hours	15,000	23,225	22,229	19,596	R
NHS111					
NHS111 Dental Calls	Increasing Trend	6,572	N/A	N/A	
Consult & Close Volumes by NHS111	Increasing Trend	1,041	N/A	N/A	

In-Month RAG Indicates =

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

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

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

TBD: Status cannot be calculated (To Be Determined)

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

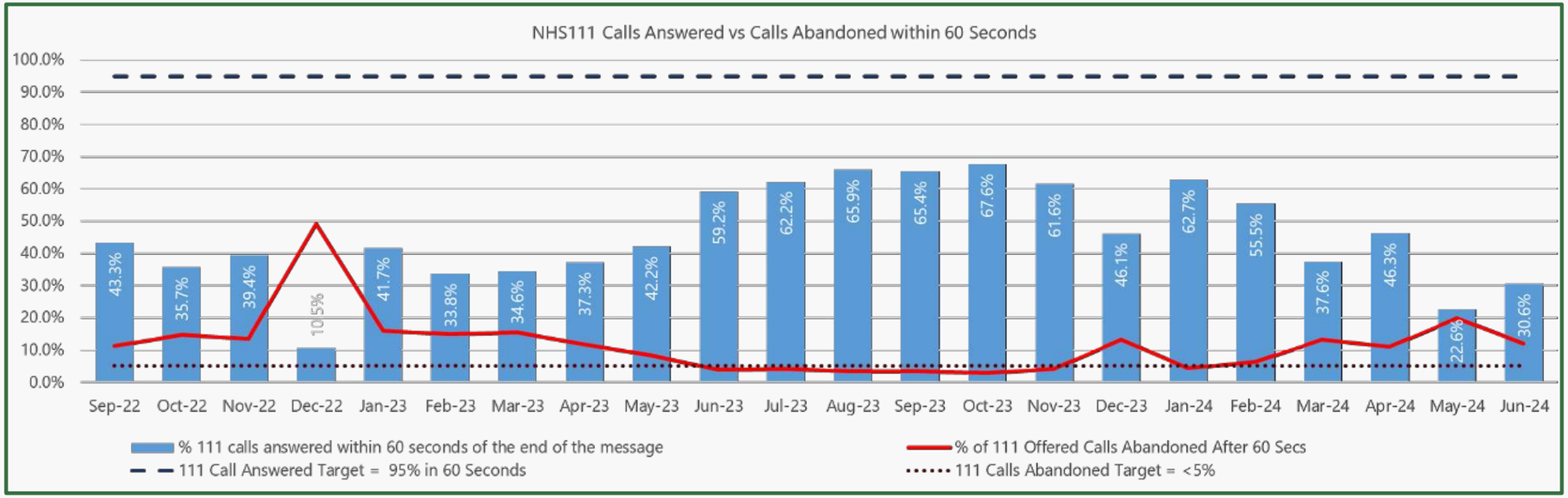
(Responsible Officer: Lee Brooks)

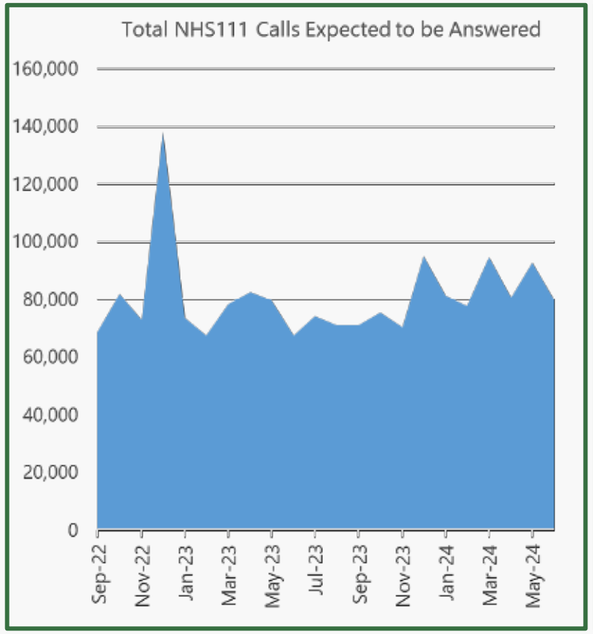
Abandonment Rate R

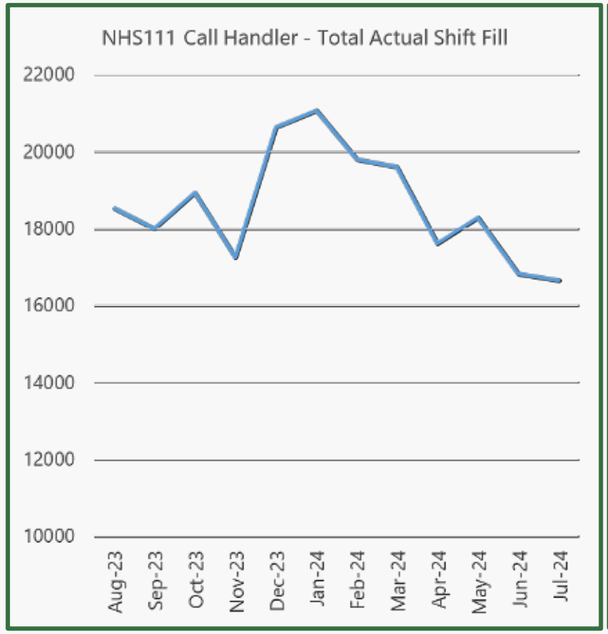
FPC

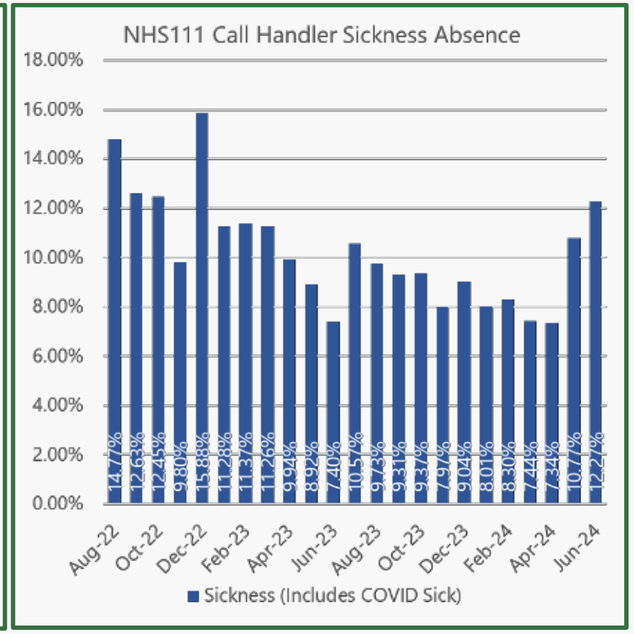
Influencing Factors – Demand and Call Handling Hours Produced

NB: Data quality issues have been identified in 111. These are currently being addressed.









Analysis

The 111-call abandonment rate improved from 19.8% in May 2024 to 11.9% in June 2024, but did not achieve the 5% target for the 5th month in a row. The percentage of 111 calls answered within 60 seconds increased, from 22.6% in May 2024 to 30.6 % in June 2024, but continues to be below the 95% target.

The drop in performance over the past few months has been due in part to a spike in demand during Q4, increased call handler sickness levels, staffing numbers below establishment and to the new 111CAS system going live on 30th April 2024. In the run up to implementation, staff were abstracted for training, and in addition recruitment was paused. After go-live, staff are familiarising themselves with the system, which is having some impact on efficiency at this early stage.

Remedial Plans and Actions

Key actions include:

- Recruitment up to commissioned levels, with cohorts starting over the summer and a plan to be at commissioned levels by October;
- A focus on realising the benefits of the new 111CAS;
- A 111-re-roster pre-work review that takes account of the increased demand the Trust is seeing, what levels of performance commissioners want and the mix of capacity and efficiencies to achieve this.
- Expectation is that the project initiation will start imminently (Aug-24) with timescales to be confirmed, but in year.

Expected Performance Trajectory

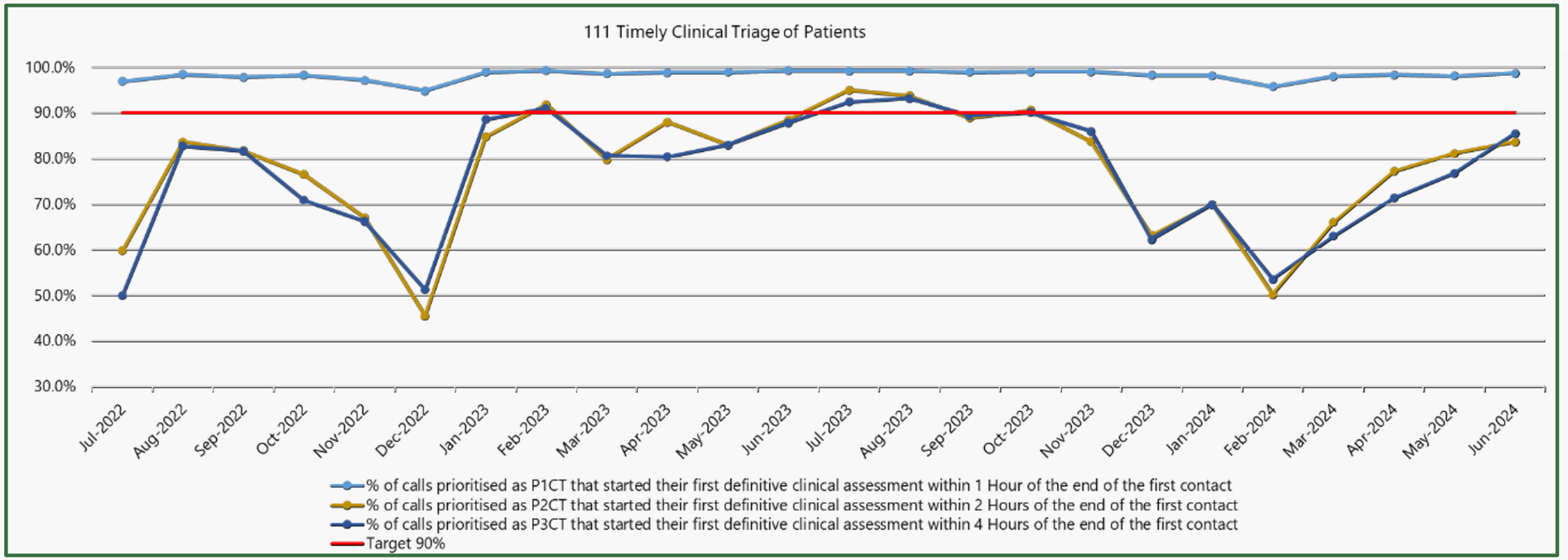
The expectation is that once the new system has bedded in and additional staff have been recruited performance will improve once again; however, there are risks including demand, levels of commissioned call handers being lower than last year and an unknown impact of the new system on efficiency.

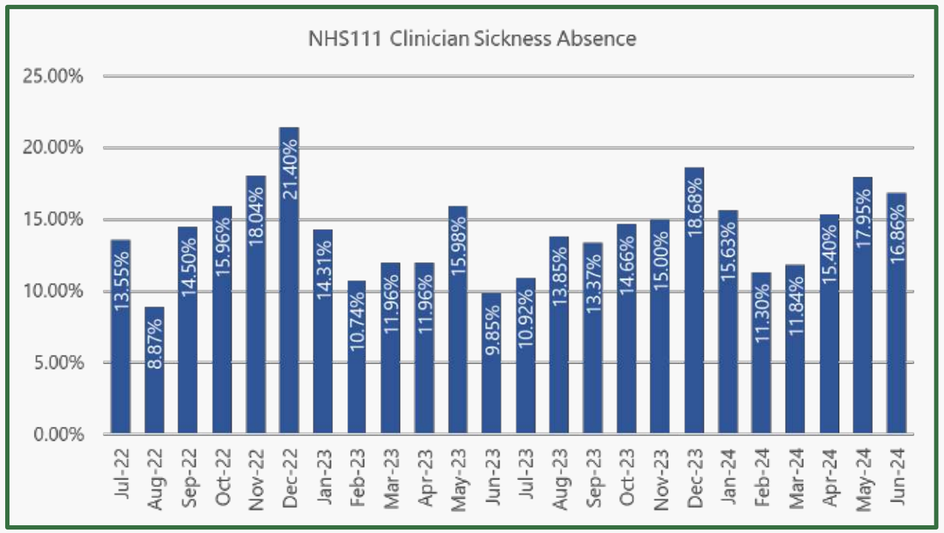
Our Patients: Quality, Safety & Patient Experience
111 Clinical Assessment Start Time Performance Indicators

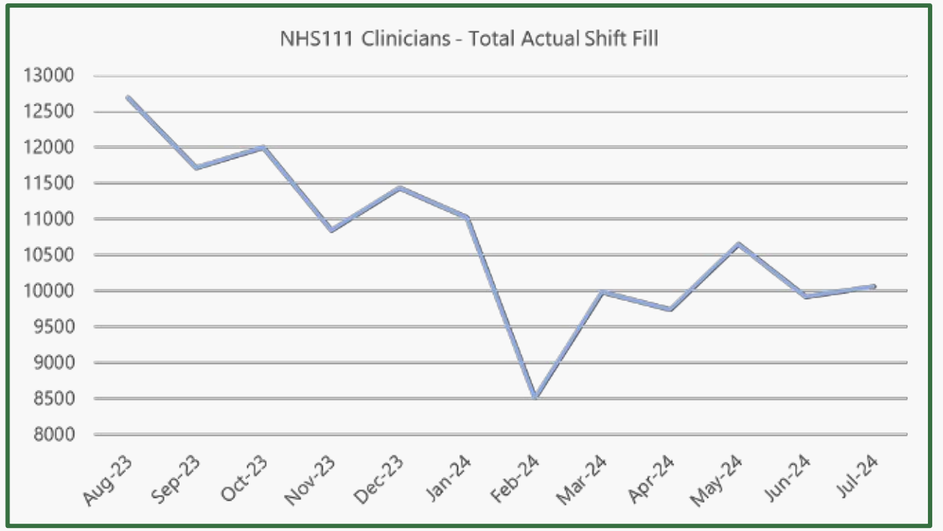
(Responsible Officer: Lee Brooks)

P1CT G FPC

Influencing Factors – Demand and Clinical Hours Produced







NB: Data quality issues have been identified in 111. These are currently being addressed.

Analysis

The highest priority calls, P1CT, achieved the 90% target, recording 98.7% in June 2024.

Ring back times for lower category calls improved during June 2024, reversing a previous deterioration in performance, this was despite a drop in shift fill levels during June, compared to May 2024.

Numbers of hours produced, after increasing during May 2024 declined again in June 2024, partly due to continued high levels of sickness. Clinician sickness absence was 16.86% in June 2024.

Remedial Plans and Actions

The key actions include:

- A focus on delivering the benefits of the new 111CAS.
- Recruitment up to commissioned levels of clinicians
- A demand and capacity review to determine appropriate levels of capacity to meet increasing demand (this may now be delayed to enable the impact of the work on the digital front end to take effect).

Expected Performance Trajectory

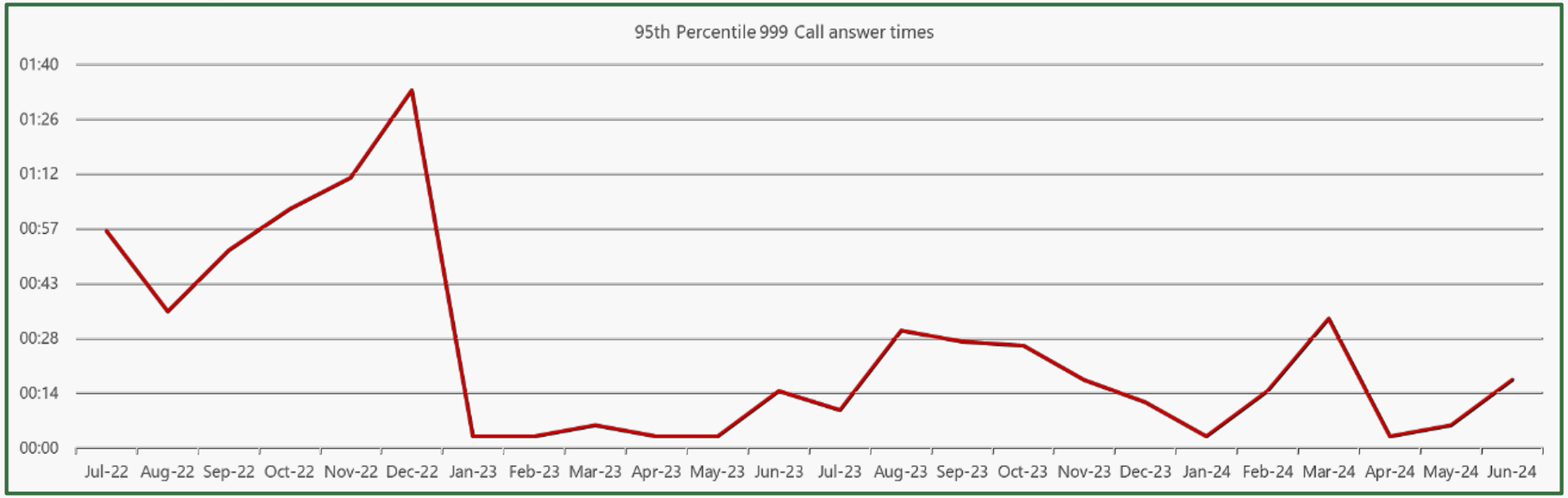
The new 111CAS will bring performance benefits, however, demand is increasing materially, and the number of commissioned clinicians will be lower in 2024/25. Therefore, it is unclear what performance levels will be able to be achieved.

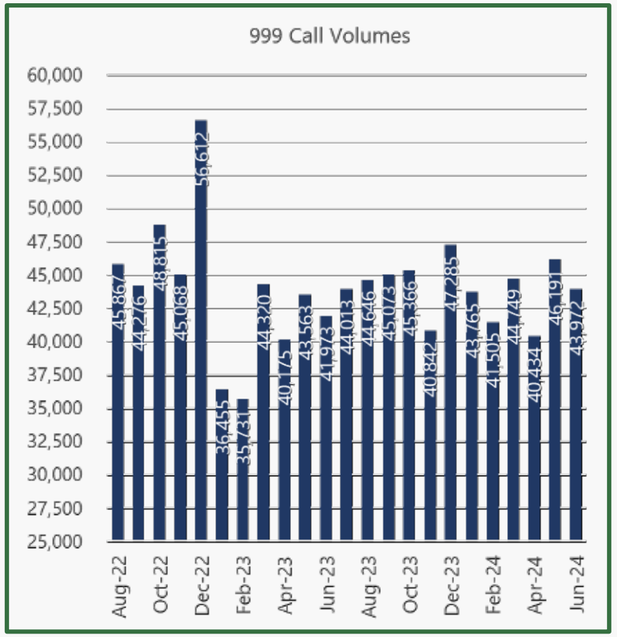
Our Patients: Quality, Safety & Patient Experience
999 Call Performance Indicators

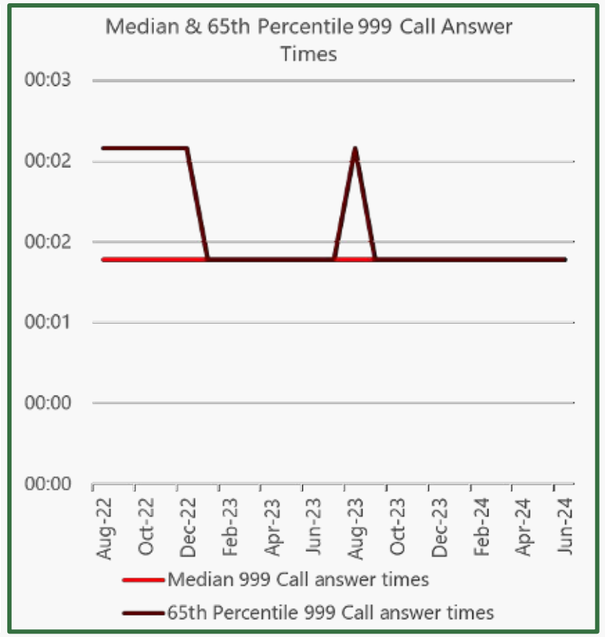
(Responsible Officer: Lee Brooks)

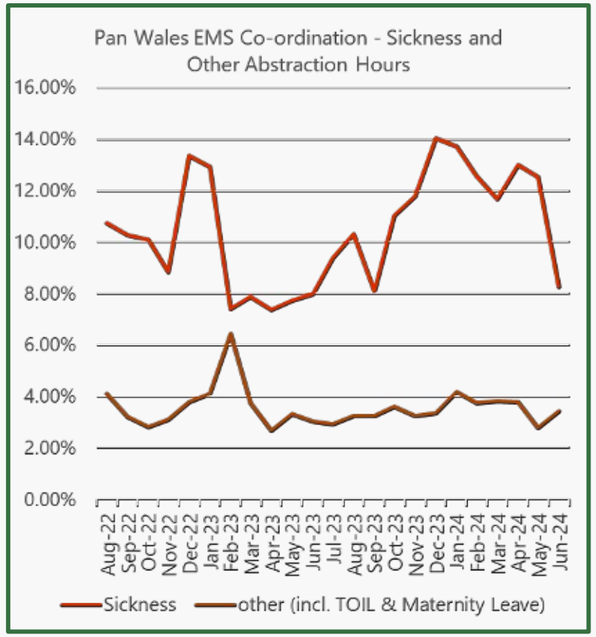
R FPC CI

Influencing Factors – Demand and Hours Produced









Analysis

The 95th percentile 999 call answering performance did not achieve the 6 second target (00:18) in June 2024. The median call answer time for the 999-service remained consistent at 2 seconds.

There was a decrease in demand in June 2024 to 43,972 from 46,191 in May 2024.

Sickness levels saw a significant decrease to 8.29% in June 2024 from 12.53% in May 2024.

Remedial Plans and Actions

- Over establishment has been approved for EMSC by the Executive Director of Operations with call takers currently 14% above establishment (125.5 FTEs v 111.76 FTEs)
- Will continue to overrecruit for the next few months (as approved by the ADO and the EDoOps) into the winter months.
- Further recruitment drives in all three centres are planned up to September to support the above.
- A transformation programme is underway:
  - **Roster Review.** A dispatch roster review for Allocators and Dispatchers..
  - **Boundary changes.** Realignment of dispatch boundaries to balance workload and pressures for individual dispatch teams.
  - **Broader Ways of Working**. This project is looking to create efficiency, effectiveness and improved productivity through a review of processes and procedures as well as providing consistency and reduction in variation across centres.

Expected Performance Trajectory

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

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

(Responsible Officer: Lee Brooks)

8 Min
R

QUEST
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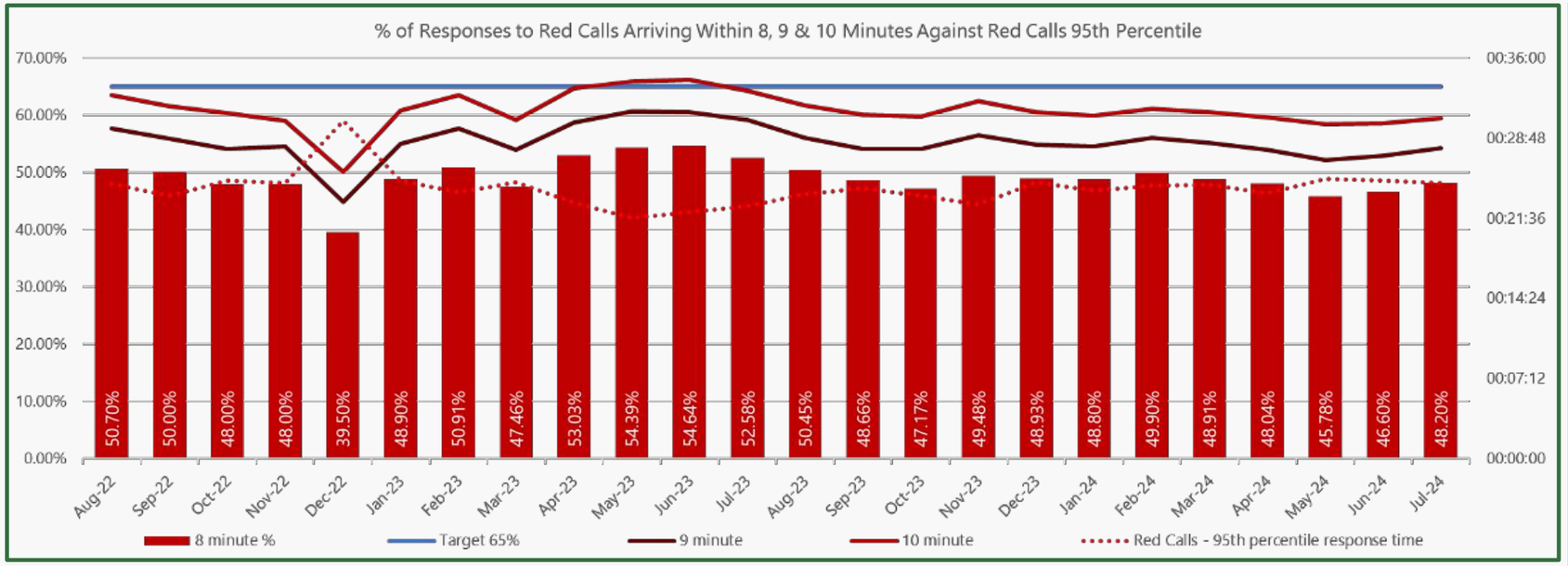
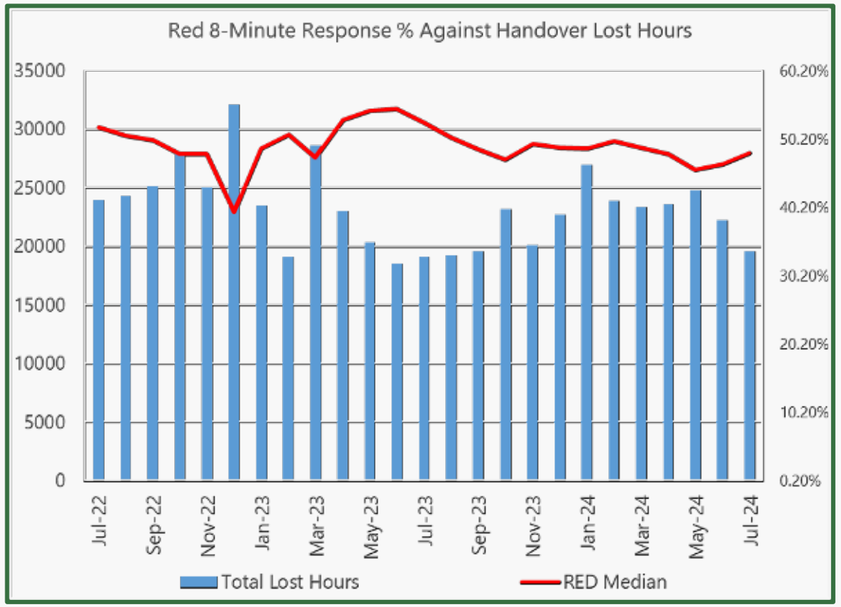
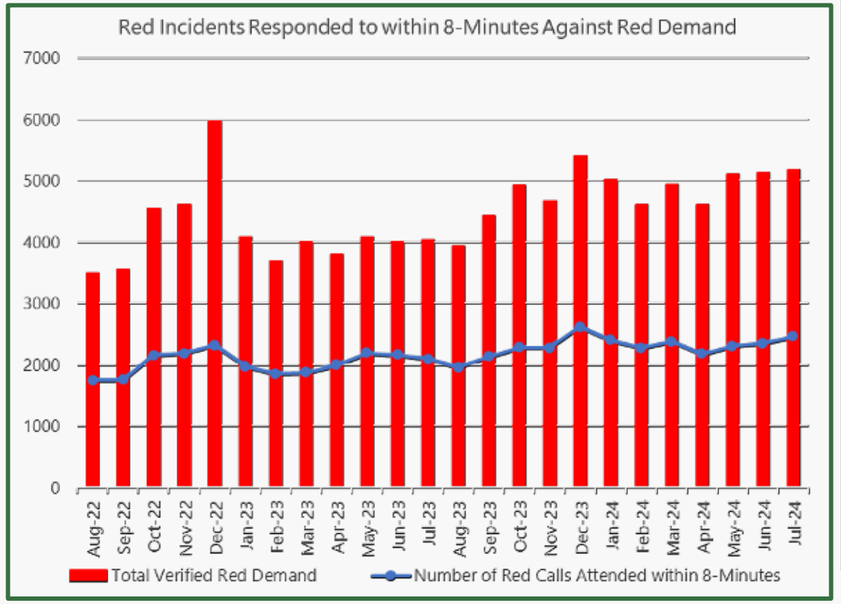
CI







Analysis

Red 8-minute performance continues to remain below the 65% target increasing marginally during July 2024 to 48.2%.

Red 10-minute performance for June 2024 was 59.5%, which is marginally below the 2-year average (60.9%).

One of the main determinants is **red demand**, which has **increased** over the last few years, with red demand in July 2024 being 28.2% higher than that seen in July 2023. As red demand has increased, so too has the number of red incidents responded to within 8-minutes, with the figure for July 2024 being 2,462 (17.9% above the figure for July 2023). i.e. the Trust is reaching more red calls in 8 minutes, but the denominator is also increasing.

The lower left graph demonstrates the correlation between overall Red performance and **hospital handover lost hours**. There were 19,596 lost hours in July 2024.

Remedial Plans and Actions

The main improvement actions in the Trust's gift are:

- To maintain commissioned establishment/staff in post levels overall.
- To recruit an additional cohort of 21 EMTs in November.
- Full roll out of the Cymru High Acuity Response Unit (CHARU), now largely complete (128 FTEs v target of 153 FTEs) with the exception of some hard-to-reach areas.
- Continued focus on production and abstractions (EA production was 90% UHP in July 2024 and CHARU production 74% against full roll out);
- The rapid deployment, before winter 2024/25 of the first phase of actions towards an updated clinical model e.g. rapid clinical screening, as outlined in our IMTP.

Expected Performance Trajectory

Modelling for Summer 2024 indicates a level of Red performance below target (most likely scenario 50%) and Amber 1 (one hour and 32 minutes, based on handover at 19,000 hours).

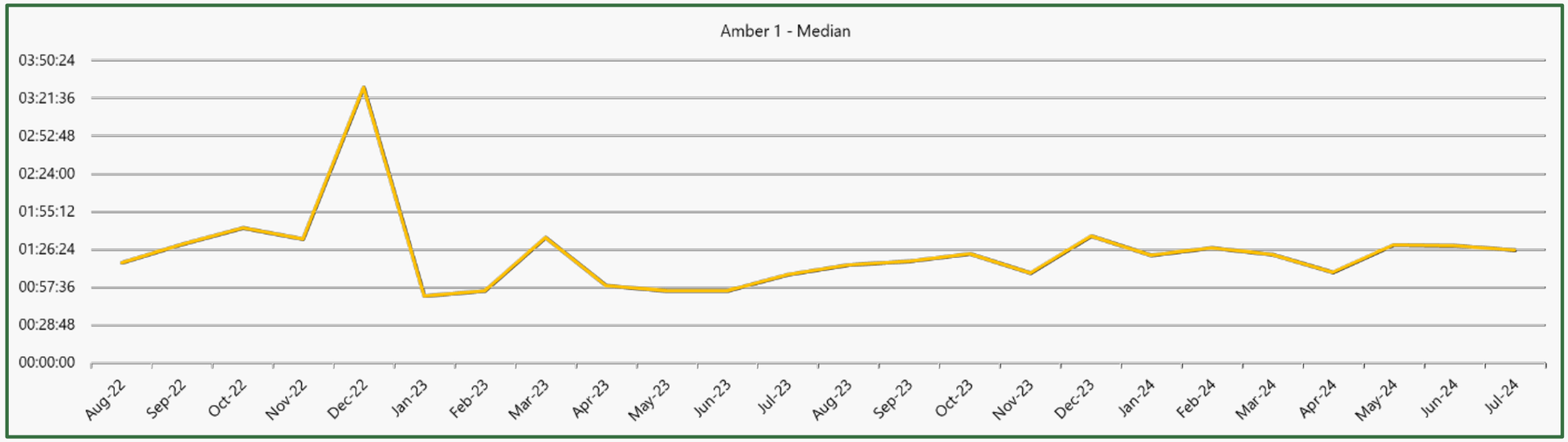
Our Patients: Quality, Safety & Patient Experience
Amber Performance Indicators

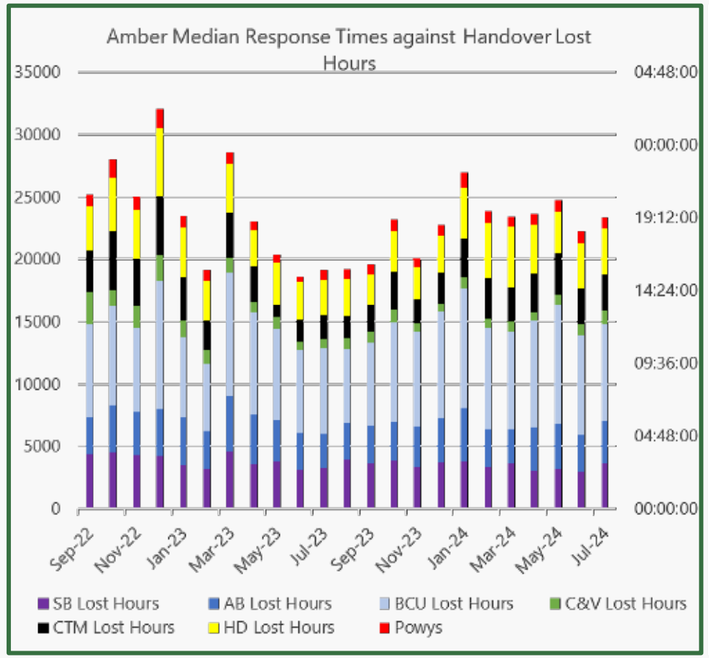
(Responsible Officer: Lee Brooks)

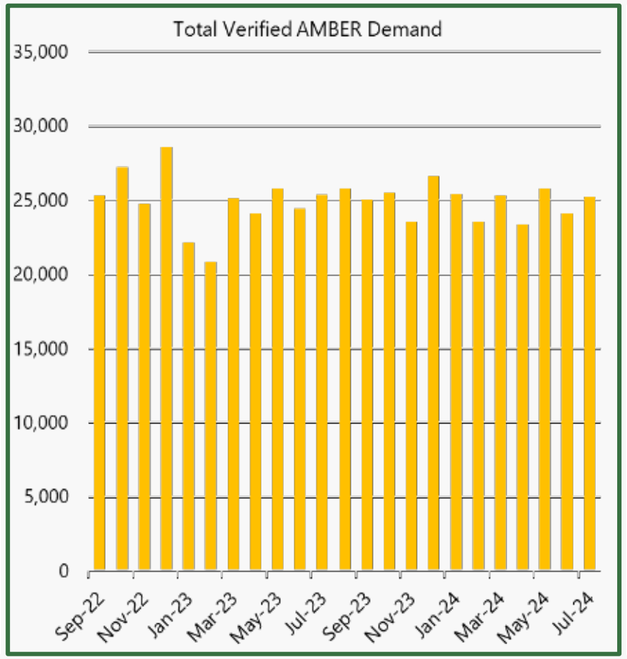
R

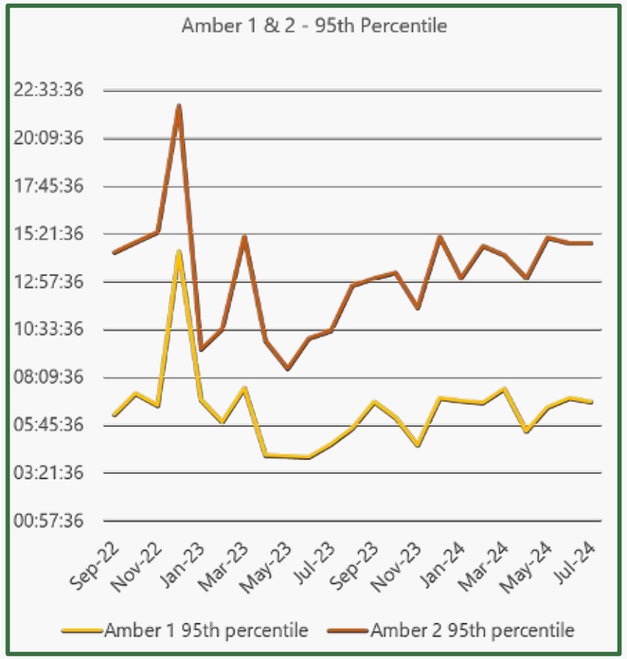
FPC CI QUEST

Influencing Factors – Demand, Hours Produced and Hours Lost









Analysis

The Amber 1 median performance time improved during July 2024 to 1 hour 26 minutes, during a month when demand increased (+1,110). However, although also improving, there remains an extreme level of hospital handover lost hours. The ideal Amber 1 median response time remains at 18 minutes.

The Amber 1 95th percentile also improved during July 2024 to 6 hours and 54 minutes but remains above the 2-year average figure of 6 hours 30 minutes.

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

The Trust has also recently seen abstractions return to the 2019 review benchmark of 30%; however, they have spiked up a bit in July (sickness/annual leave) and the numbers of hours produced remains relatively good, but lower at EA UHP at 90%.

Remedial Plans and Actions

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

Expected Performance Trajectory

The Trust is currently evolving its clinical model and has completed a new 2023 EMS Demand & Capacity Review.

Our Patients: Quality, Safety & Patient Experience

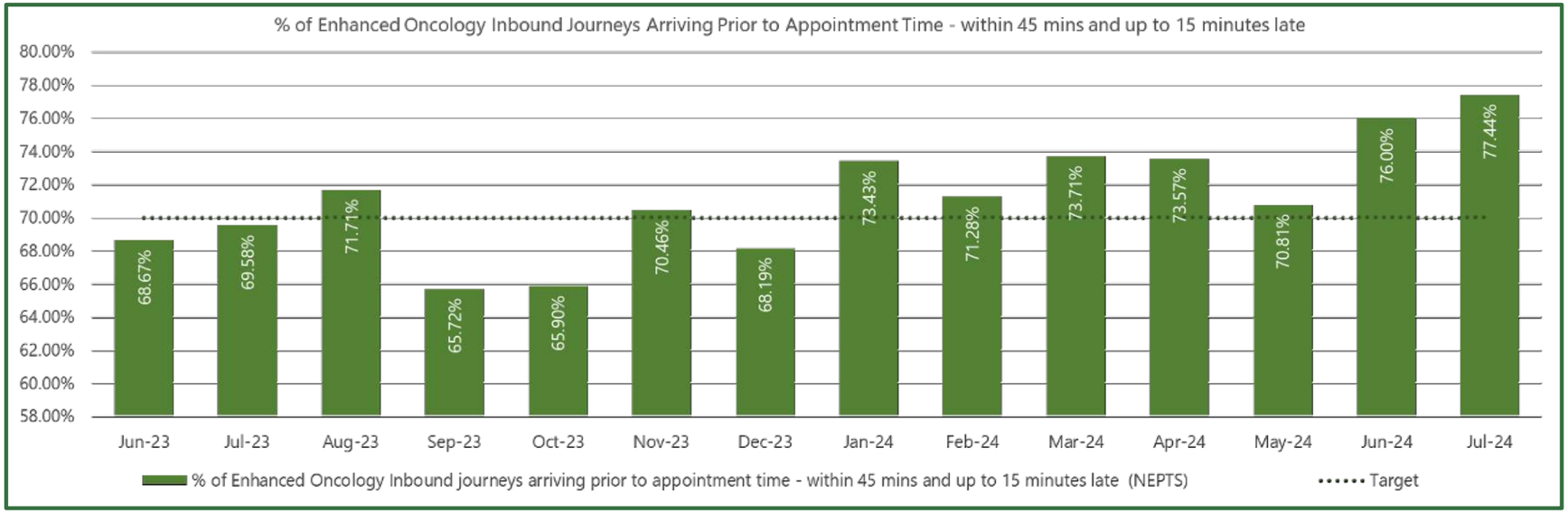
Patient Experience – Influencing Ambulance Care Indicators

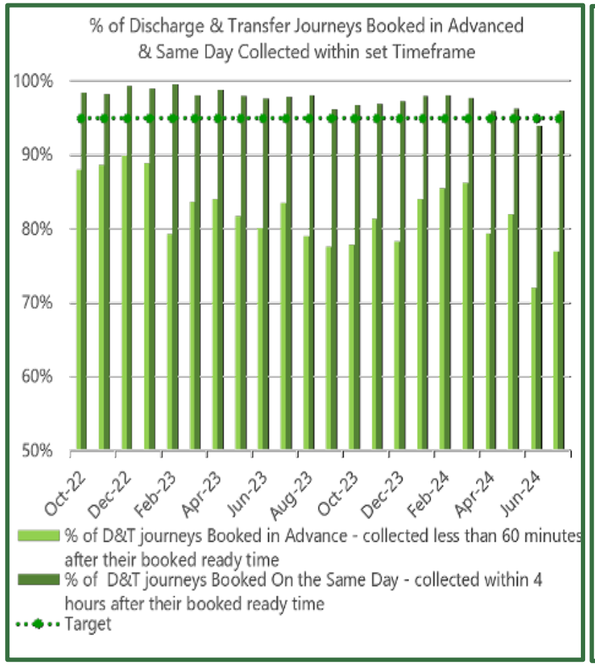
(Responsible Officer: Lee Brooks)

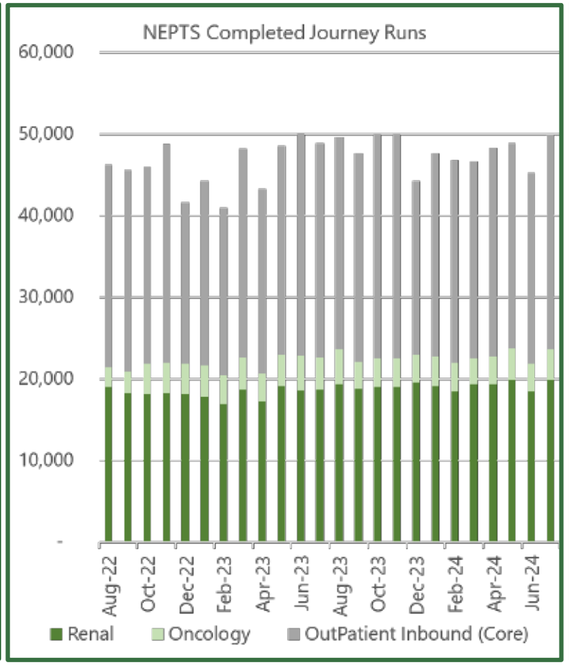
D&T	Oncology	Welsh Calls
R	G	G

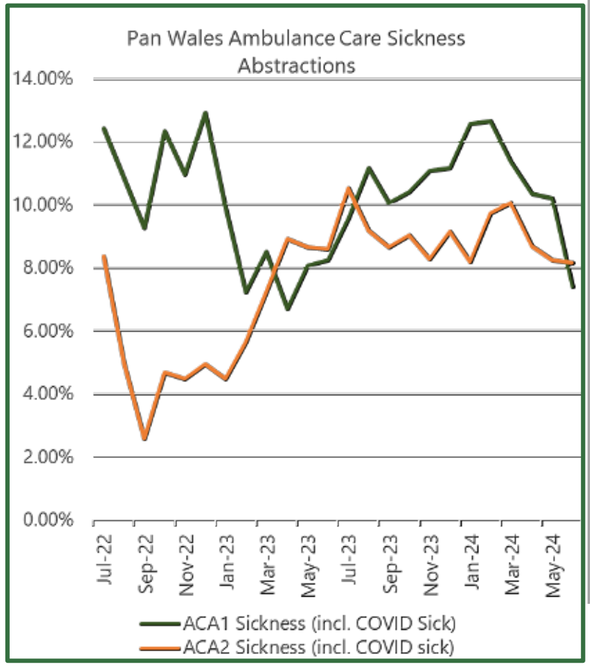
FPC

CI









Analysis

Ambulance Care (NEPTS element) performance improved during July 2024. 77.4% of enhanced Oncology journeys arrived within 45 minutes prior and up to 15 minutes late of their appointment time, an increase from the 76% in June 2024, and achieving the 70% target for the seventh month in a row. Oncology performance continues to be an area of focus for the service, and we continue to invest both time and resources on these journeys.

Discharge and Transfer journeys booked in advance and collected less than 60 minutes after their appointment remains below target at 77% in July 2024. although this was an improvement from 72% in June.

Enhanced Renal journeys, saw a slight increase to 73%, but continues to exceed the agreed performance standard (70%).

Call volumes answered declined further in July 2024 to 17,576 compared to 18,134 in June 2024 (18,134);. However, the average speed of call answering also declined from 5 minutes 4 seconds in June to 9 minutes 10 seconds in July.

Remedial Plans and Actions

Increased performance on data management and journey recording times is underway, with enhanced focus on weekend performance. Projecting an improvement in performance over next few months, although caution on achieving the 95% figure as this was always an aspirational target that needs engagement and system change from Health Boards which is complex and challenging to achieve.

New rosters keys are just being finalised based on updated demand, which will then be taken into a NEPTS transport roster review..

Enhanced sickness monitoring has been implemented at the ADO/HoS level and all long term and complex cases are being reviewed regularly.

Expected Performance Trajectory

Performance is anticipated to follow recent trends.

Our Patients: Quality, Safety & Patient Experience
Clinical Indicators

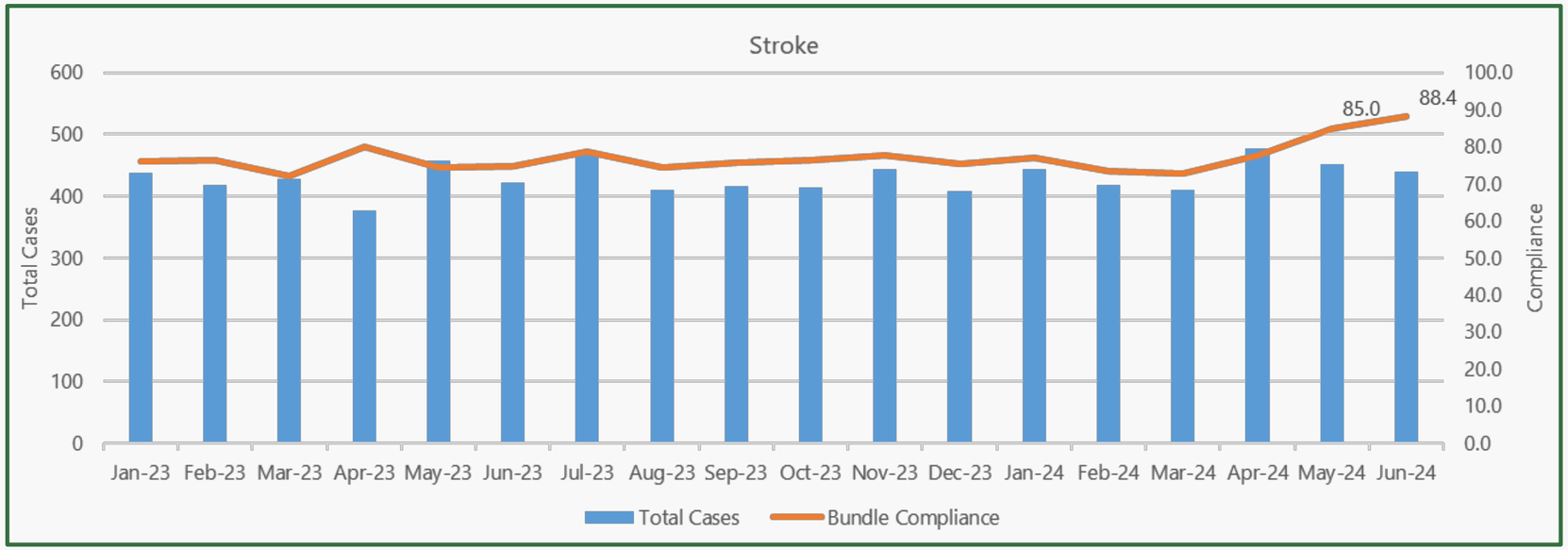
(Responsible Officer: Andy Swinburn)

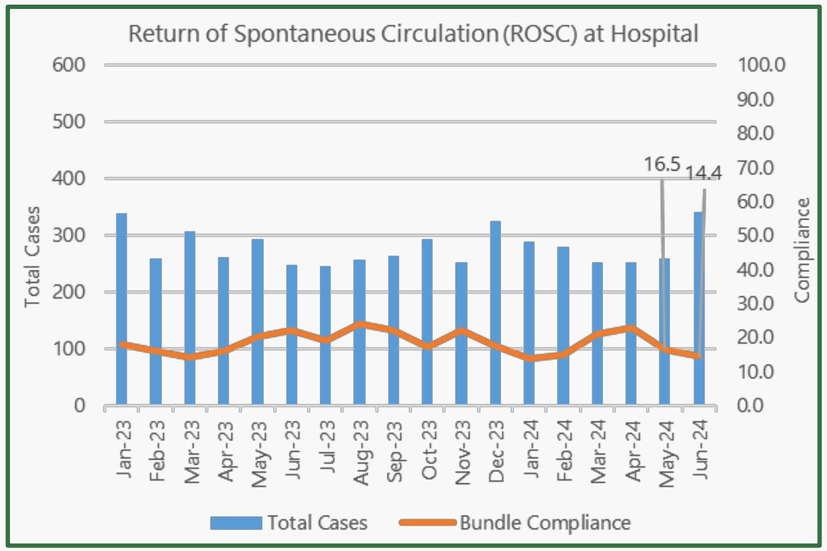
Stroke	ROSC/ STEMI
A	R

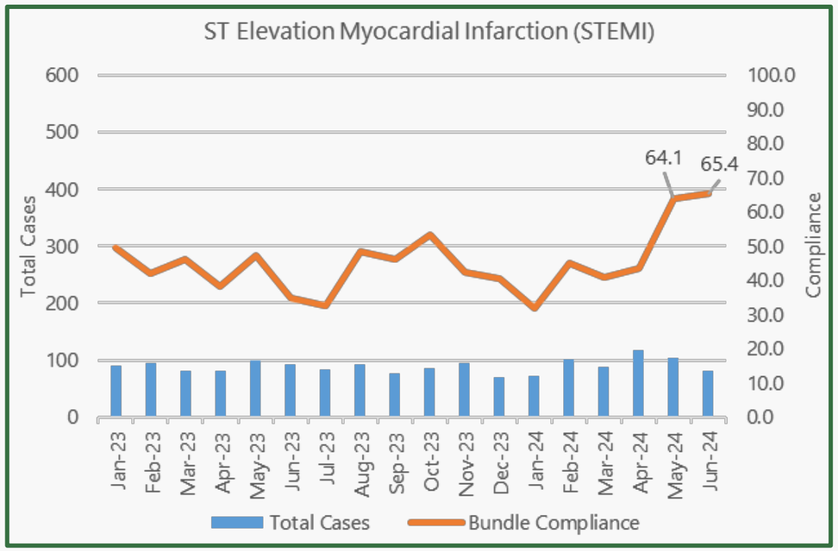
Self-Assessment: Strength of Internal Control: Moderate

QUEST

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







Analysis

The percentage of patients documented as receiving appropriate care bundles in June 2024 was:

- **Stroke – 88.4%, an increase from 85% in May.** There is a correlation between documenting FAST (a test to detect symptoms of stroke) and care bundle compliance, this has informed the improvement plan and contributed to the recent compliance increase.
- **STEMI (heart attack) – 65.4%, an increase from 64.1% in May.** There has been an increase in compliance to each of the individual criteria; GTN, Aspirin, Pain score & Analgesia which have contributed to the recent compliance increase.
- **Return of Spontaneous Circulation at hospital (from cardiac arrest) - 14.4%, a decrease from 16.5% in May.** Due to the nature of this metric, common cause variation occurs which can result in a marked reductions in performance from small numbers of unsuccessful resuscitations attempts. The factors that influence this may include response times, bystander resuscitation and response type/numbers.

Following the switch to electronic Patient Clinical Record , the way data is collected has changed. Automated Clinical Indicator reports are generated from data directly inputted by clinicians. There are advantages to the new process; however, this has not yet been fully realised within 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 electronic Patient Clinical Record User Interface
- Clinician interaction with the electronic Patient Clinical Record
- Accuracy of the scripting to extract the data from the data warehouse to create the report.

Several electronic Patient Clinical Record user interface changes were implemented in June and the impact is being monitored.

Our Patients: Quality, Safety & Patient Experience Clinical Indicators

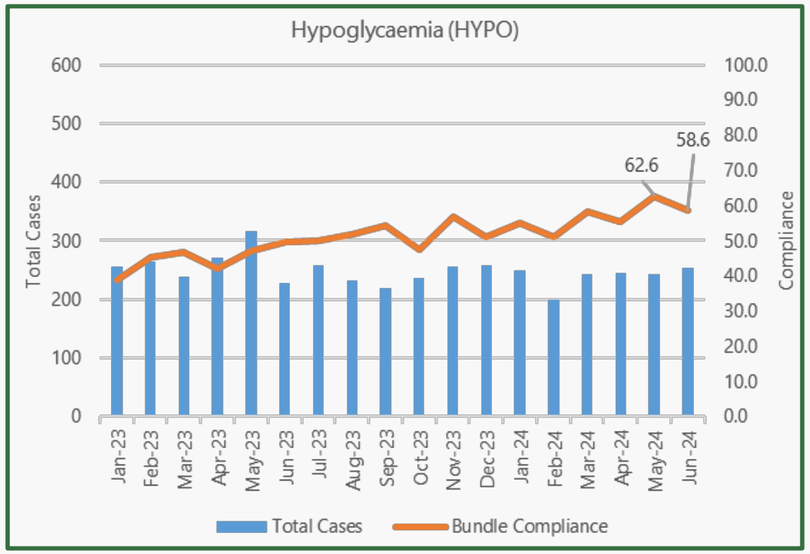
Hypoglycaemia, Fractured Neck of Femur (#NOF) and Time-Based metrics (Stroke & STEMI)

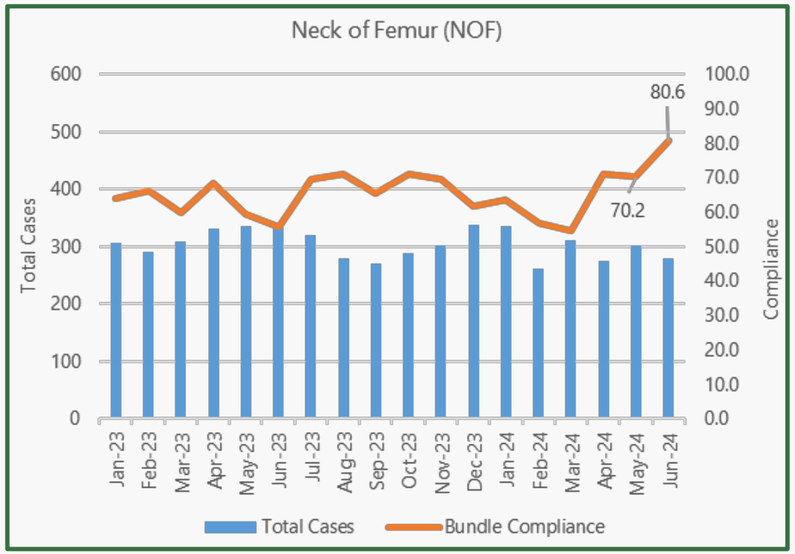
(Responsible Officer: Andy Swinburn)

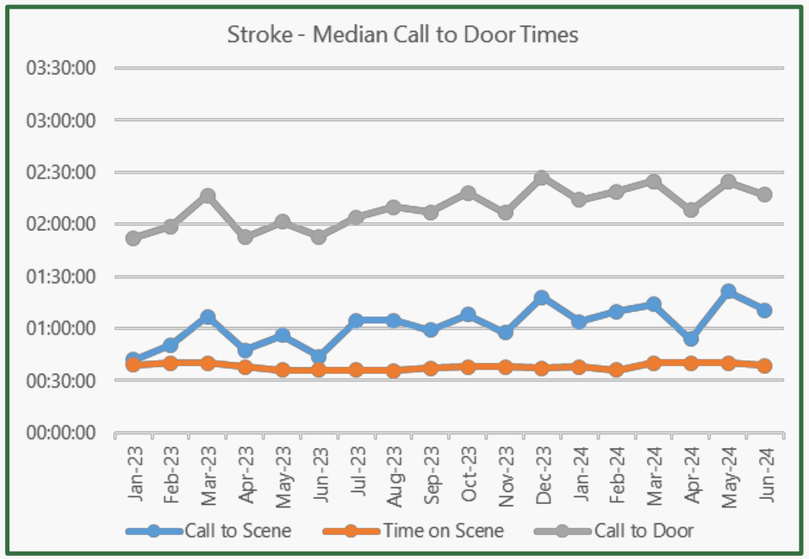
Call to Door
R

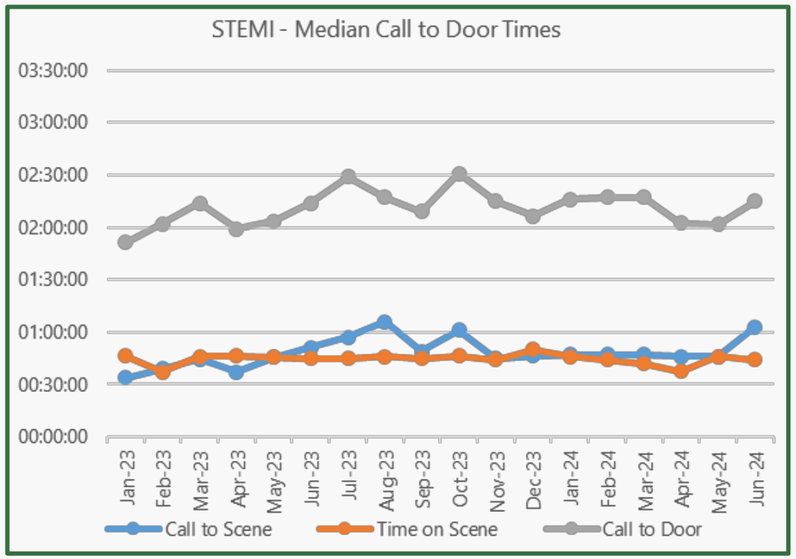
Self-Assessment: Strength of Internal Control: Moderate

QUEST









Analysis

The percentage of patients documented as receiving appropriate care bundles in **June 2024** was:

- **Hypoglycaemia (diabetic patients with low blood glucose) – 58.6%, a decrease from 62.6% in May.** There has been reduction in documenting each of the individual criteria; treatment and pre & post blood glucose checks. This is being picked up within the improvement plan.
- **Fractured Neck of Femur (hip fracture) – 80.6%, an increase from 70.2% in May.** June saw the testing of a 'nudge tool' for analgesia in this indicator where a prompt is provided for clinicians when important information has not been documented. This contributed to the marked improvement in compliance.
- **Call to door times for Stroke and STEMI** - the data shows an increase due to significant hospital delays impacting on our ability to respond.

Remedial Plans and Actions

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

- Focussed communication with WAST clinicians to use the bespoke electronic Patient Clinical Record fields for Clinical Indicators (in addition to the narrative).
- Providing a breakdown of weekly non-compliant data to support Senior Paramedics with their conversations with clinicians to improve compliance.
- Health Board focussed clinical workshops to promote understanding of Clinical Indicators, care bundles and electronic Patient Clinical Record completion.
- Review the scripting used for reports in a structured way for each Clinical Indicator bundle, monitor and repeat annually. The revised scripting for Inter Hospital Transfers has positively impacted on data from May 2024.

Following the successful testing of the 'nudge' tool with analgesia for Fractured Neck of Femur (hip fracture), further 'nudges' will be implemented in a stepwise approach.

Expected Performance Trajectory

The continued support of Health Board Clinical Leads and Senior Paramedics, working closely with the Clinical Improvement, and Clinical Intelligence and Assurance Teams, will contribute to an increase in compliance rates.

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

(Responsible Officer: Liam Williams)

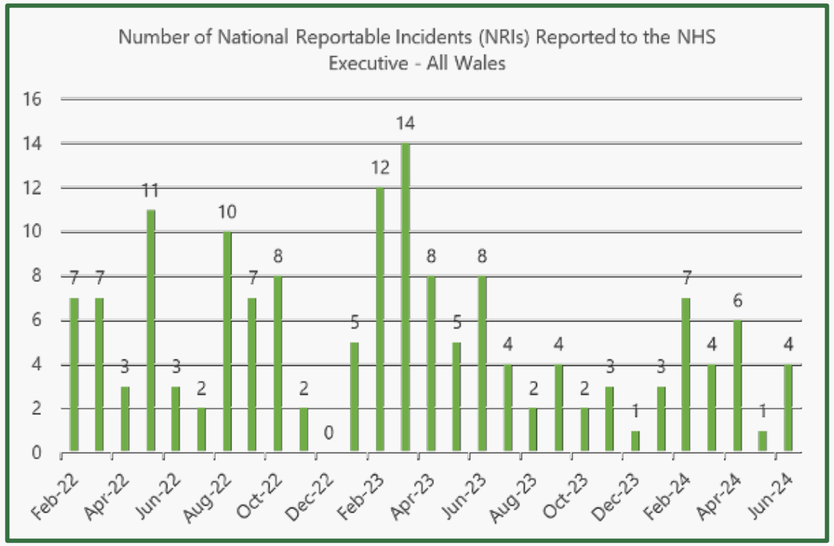
Concerns.

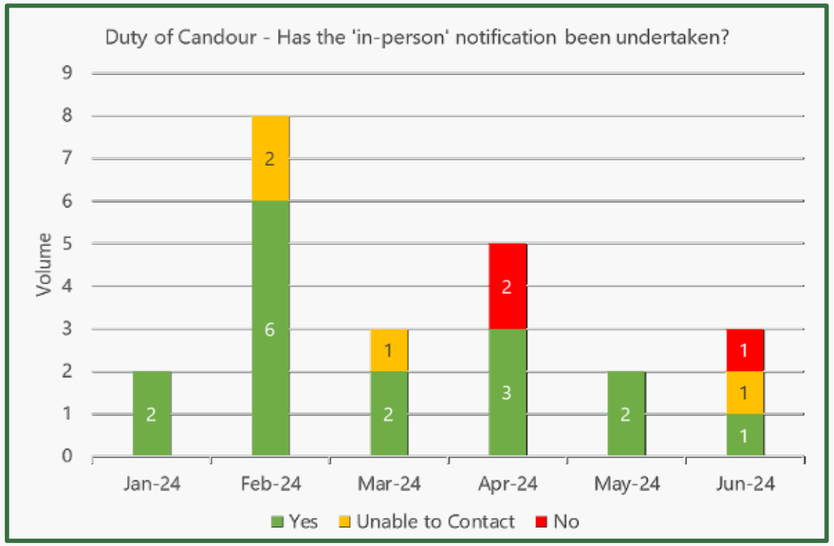
G

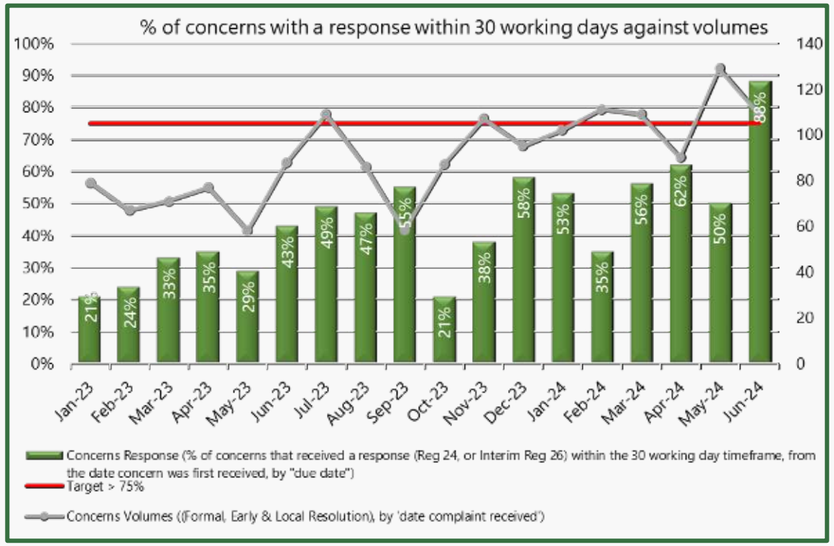
Self-Assessment: Strength of Internal Control: Moderate

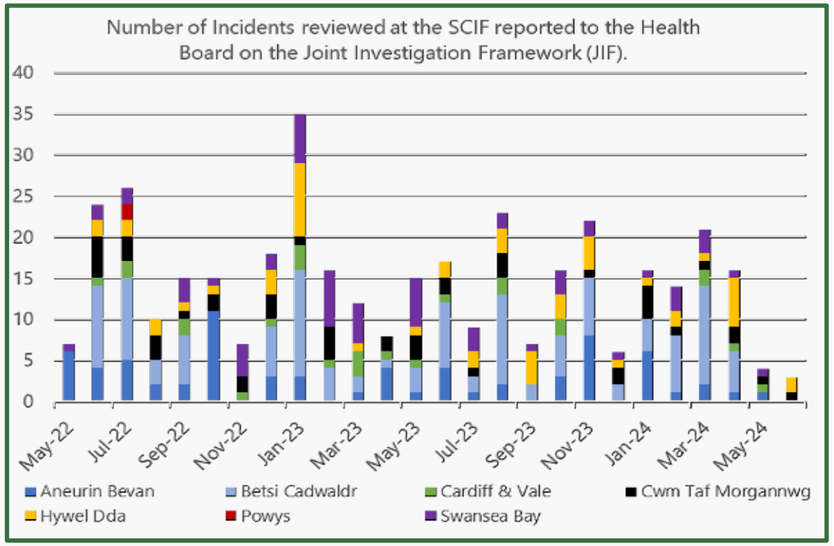
QUEST

Health & Care Standard
Health - Safe Care / Timely Care









Analysis

The improvement in complaints timescales continues with the Trust exceeding the minimum target of 75% 30 working day compliance for the first time in several years. This is as a direct result of improved resourcing in the PTR team, particularly in leadership positions, following investment in the department. Acknowledgement of formal complaints is also fully compliant with the national timescales. It is anticipated that 30 working day compliance will begin a temporary decrease next month as the team begins to focus on resolving long-standing complaints and the total number of open cases. 4 NRIs were reported to the NHS Wales Executive in the previous month. There has been a notable decrease in cases requiring escalation to the SCIF. A decrease in incidents shared with Health Boards under the Joint Investigation Framework is also apparent. Further monitoring and triangulation will be undertaken to provide assurance on whether this is reflective of reducing system harm or a change in incident-reporting profiles.

Duty of Candour

Duty of Candour Regulations (2023): An "in-person" notification is made when the Trust becomes aware of a notifiable adverse outcome. There are occasions when we have not been able to contact patients or families despite trying several avenues. Where enactment of the Duty has been attempted, but unsuccessful the rationale is documented on the Datix Cymru System.

Remedial Plans and Actions

Recruitment to the full PTR establishment is nearly completed. New staff are expected to be in post by Q3 at the latest. A detailed Putting Things Right Recovery Plan has been presented and accepted by QUEST Committee. This includes SMART actions, expected performance trajectories and key dependencies over the coming financial year.

Expected Performance Trajectory

The PTR Department will, over the coming months, begin to focus on ensuring that recent improvements in the timeliness of complaints responses are sustainable and that we are reducing the longest waiting complaints. There are high staff vacancy and absence levels in the Patient Safety team and the remaining team members are focused on maintaining statutory and national priorities, including identification, reporting, investigating and closure of NRIs and the enactment of the Duty of Candour.

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

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

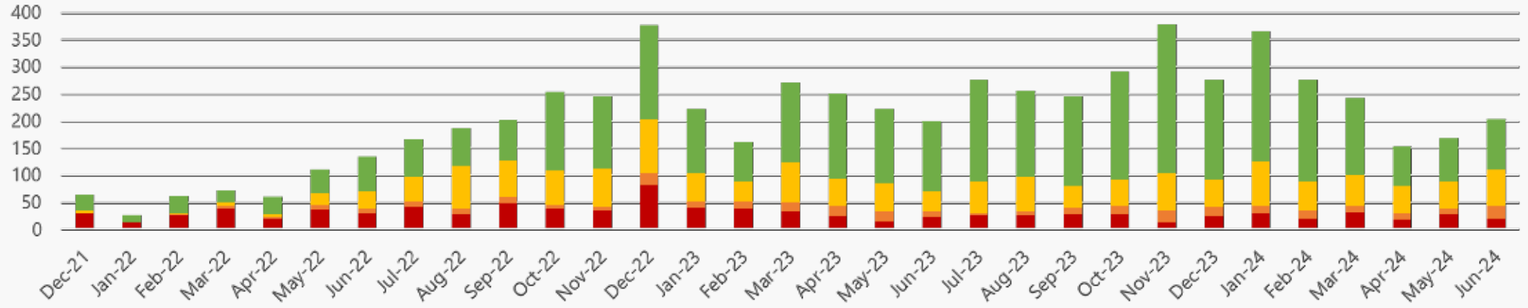
Our Patients: Quality, Safety & Patient Experience
Patient & People Safety Indicators

(Responsible Officer: Liam Williams)

Self-Assessment: Strength of Internal Control: Moderate

PCC

Health & Care Standard
Health – Safe Care



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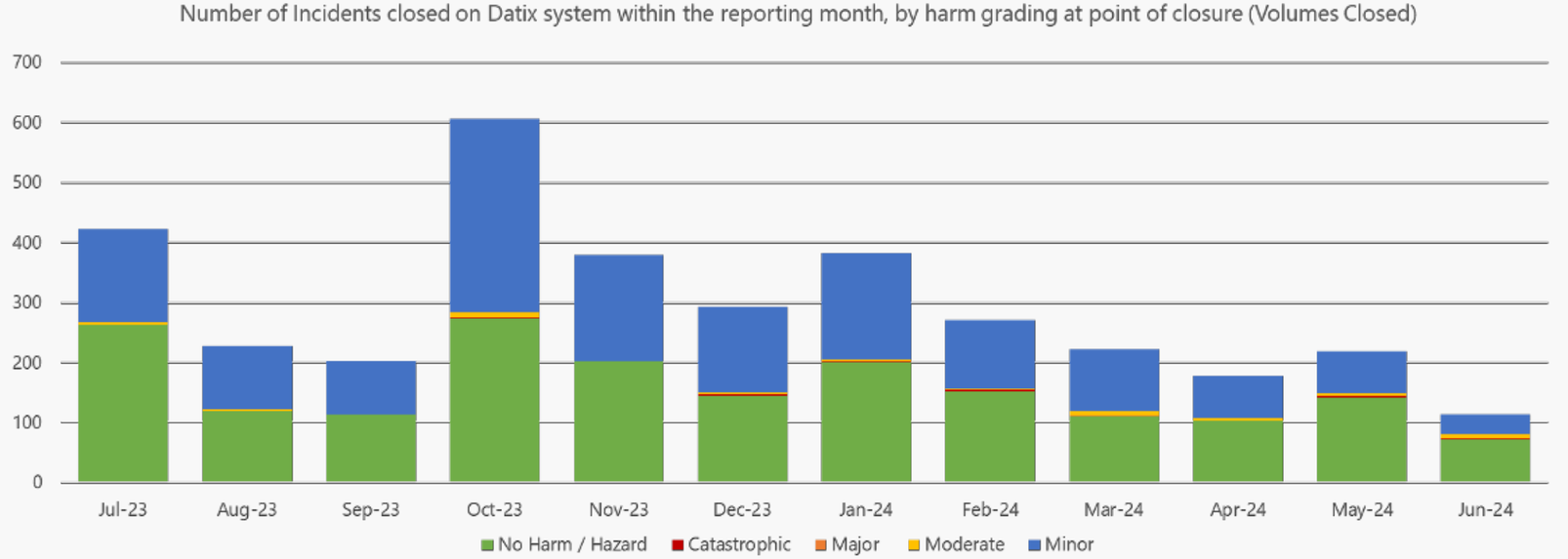
Minor	30	15	33	23	33	44	66	71	71	75	146	136	175	119	74	147	159	137	132	189	160	166	200	275	184	240	187	143	74	81	94
Moderate	5	1	3	7	5	22	32	46	79	67	64	70	99	52	38	74	50	53	37	58	63	41	48	69	51	83	54	58	50	50	67
Severe	0	0	1	6	3	9	9	10	10	12	8	7	21	12	14	17	18	17	10	4	7	11	16	22	16	14	16	11	11	10	23
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	18	28	20



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.

An increase in incident reporting during June 2024 is observed across all harm gradings.

All patient safety incidents graded moderate or above will continue to be reviewed by the Patient Safety Team. Monthly volumes should be interpreted with caution as incidents can be duplicated on the system (for example two crews submitting the same incident). Incident volumes include those reported internally by WAST staff but also those reported by Health Board colleagues about WAST services or care and transferred onto our Datix database.

The bottom graph highlights the 114 Incidents that were closed on the Datix system in June 2024.

Remedial Plans and Actions

The Putting Things Right teams continue to focus on the priorities outlined in the departmental Recovery Plan to improve the Trust position and performance across a number of quality metrics and Tier 1 targets. 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

As captured in the PTR Recovery Plan, Incident management priorities will initially be focused on reducing the number of overdue NRIs.

**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

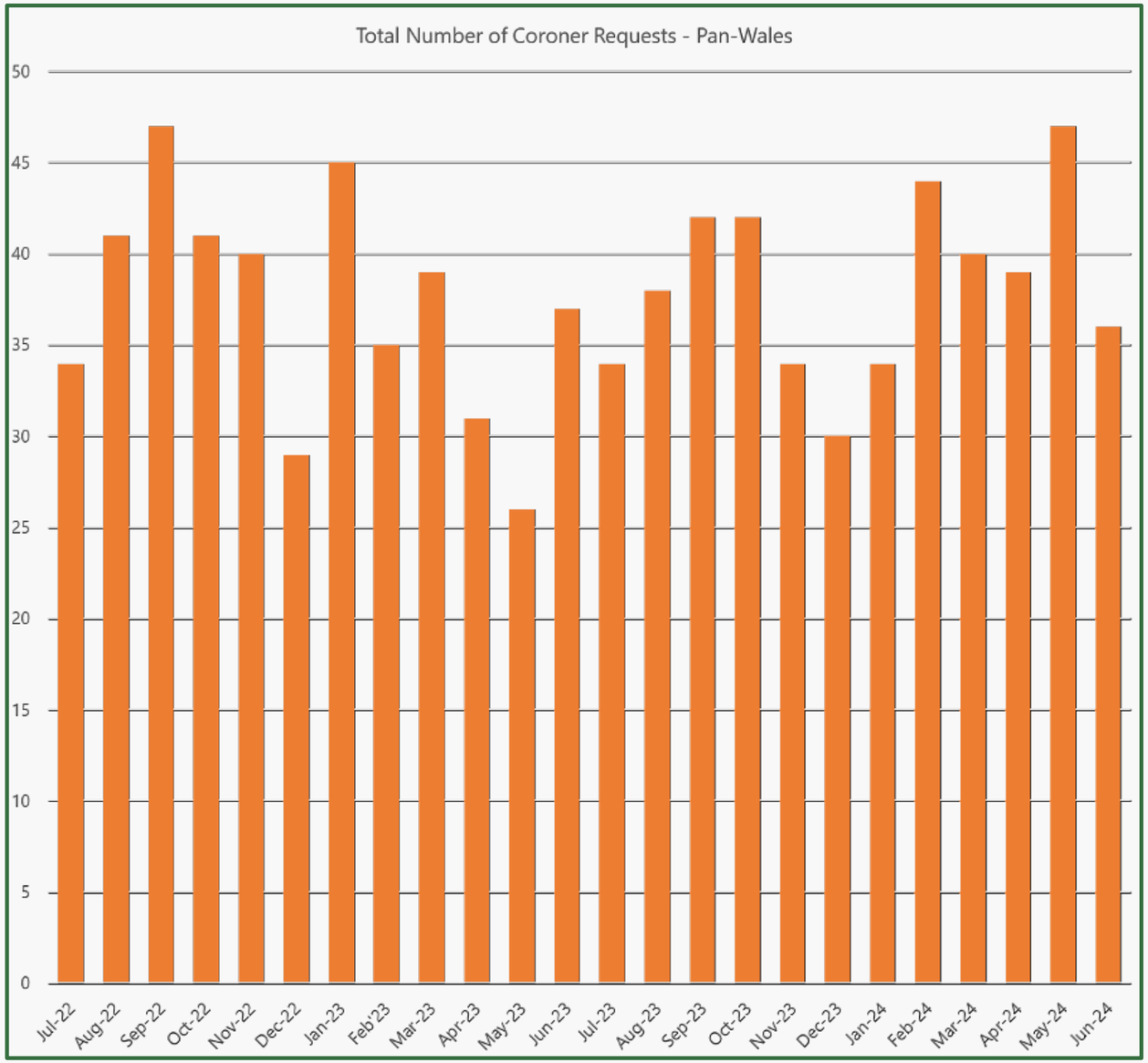
(Responsible Officer: Liam Williams)

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. Coroners are attempting to clear backlogs, still outstanding since Covid. This has resulted in the need for more prevention of future deaths statements. Some coroners have reduced administrative support (documented in the Chief Coroners Annual Report) , which has resulted in some delayed requests reaching the Trust. One Prevention of Future Death report was received last month requesting action in relation to availability of anti-overdose medication.

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. Management responsibility for PSOW cases has been transferred to the Patient and Family Relations team to allow an end-to-end understanding of cases that progress through to PSOW consideration.

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. Currently the focus of the Medical Examiner Service is undertaking reviews in the acute care setting and the plan is for all non-coronial deaths, including community deaths to be reviewed by the Medical Examiner Service from September 2024 (moved from April 2024). An increase in referrals for the Trust is expected when this occurs.

Remedial Plans and Actions

Coroners: The Team are requesting extensions were possible and escalating issues earlier to ensure we are reaching deadlines. One specific coroner has advised that if statements are not received within the requested timeframe, a schedule 5 will be issued.

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. 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.

Expected Performance Trajectory

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

Ombudsmen: The team are pleased with the low conversion rate of complaints to PSOW cases, demonstrating the quality of responses to formal complaints.

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 September 2024.

Mortality Reviews Data source: Internal Web Application

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

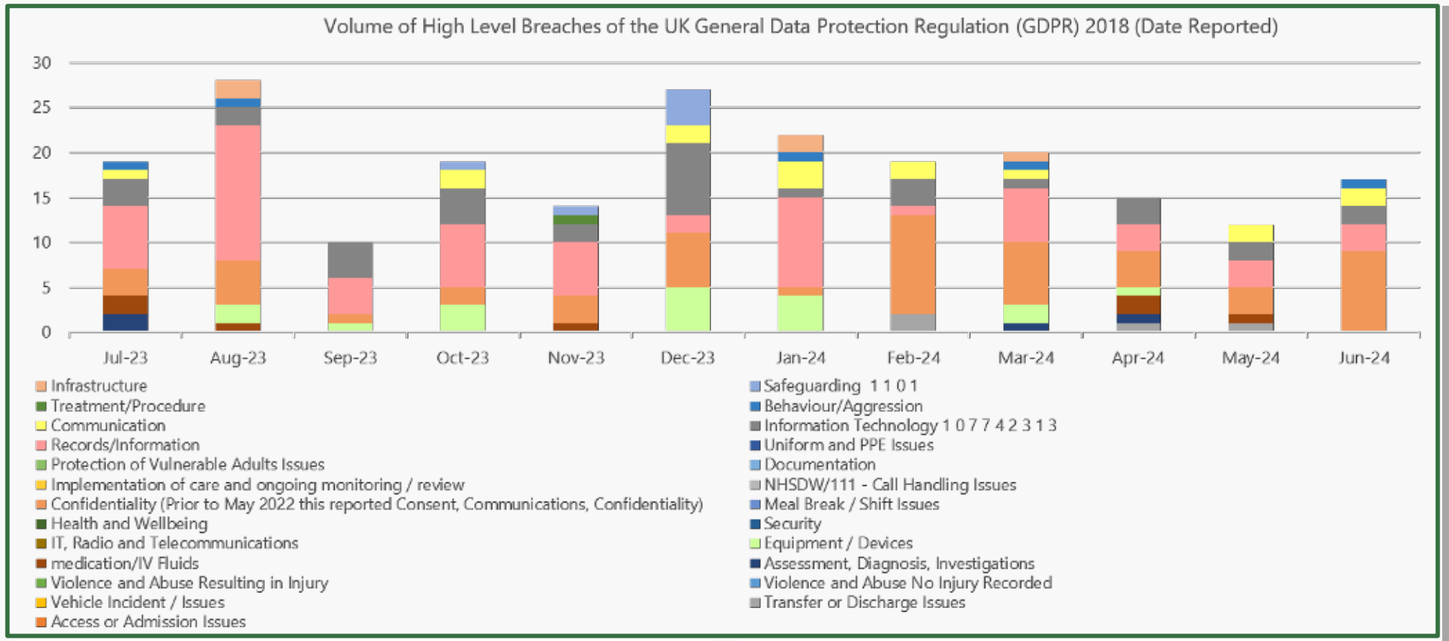
(Responsible Officers: Jonny Sammut & Liam Williams)

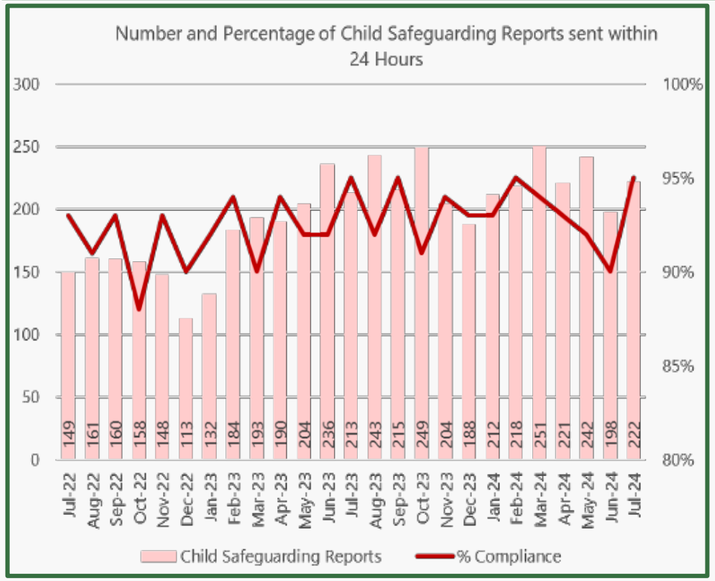
Safeguarding Data source: Doc Works

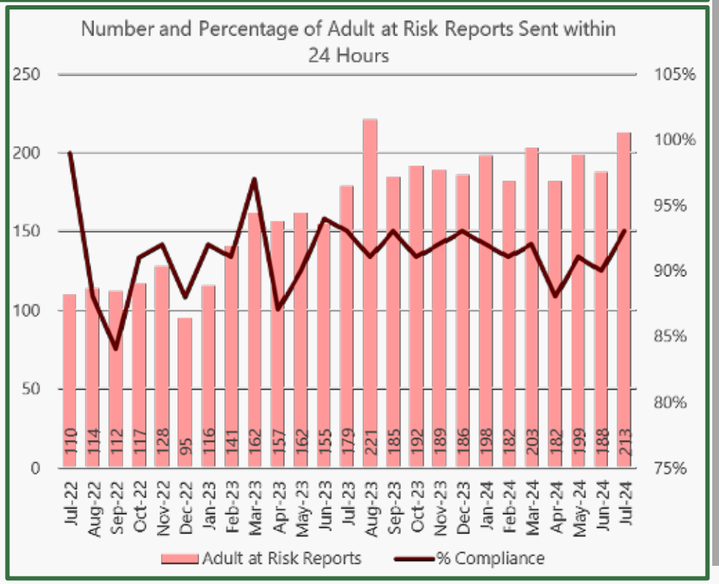
Self-Assessment: Strength of Internal Control: Strong

QUEST

Health & Care Standard
Health – Safe Care







Analysis

Safeguarding: In July 2024 staff completed a total of 213 Adult at Risk Reports, 93% of these were processed within 24 hours. Whilst the Trust does not report on Adult Social Need reports, 556 reports were received and processed to the Local Authority during this reporting period. There have been 222 Child Safeguarding Reports in July 2024, 95% of these were processed within 24 hours.

Data Governance: In June 2024, there were 17 information governance (IG) related incidents reported on Datix Cymru categorised as an Information Governance (IG) breach. Of these 17 breaches, 9 related to IG/Confidentiality, 3 Records/Information, 2 Information Technology, 2 communication, and 1 behaviour/aggression.

Public Engagement: During July, the Patient Experience and Community Involvement Team attended 19 community engagement opportunities, engaging with approximately 1,046 people. This month engagement included attending Caldicot Castle 999 Emergency Services Open Day, the Flying Start Family Fun Day in Barry, and Wrexham Pride. At all of these events we have been able to talk to members of the public about the experiences and expectations of using the Welsh Ambulance Service. Throughout July we continued to make available 4 core patient experience surveys covering the Trust's main service delivery areas. Engagement and survey outcomes remain largely consistent and tell us that people continue to be concerned about response times in the community. 111 callers have told us that they experienced long waits for call backs. NEPTS users told us that overall, they are happy with the transport they receive but experience delays when waiting for their transport home following their appointment.

Remedial Plans and Actions

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

Data Governance: During the reporting period, of the 17-information governance related incidents reported on Datix, 1 incident was reported to the Information Commissioner's Office (ICO) relating to lost paper records. The IG Team continues to review and provide advice on reported incidents. Remediation actions are continuing on some incidents reported earlier in the year.

Public Engagement: Community involvement and engagement with patients/public forms an integral part of the Trust's strategic transformation ambitions to deliver value-based healthcare evaluated against service users' experiences and health outcomes.. 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. 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.

Expected Performance Trajectory

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

Data Governance: The IG Toolkit Improvement Action Plan continues to be worked on with aims to achieve all actions by November 2024. The Action Plan has been shared with IGSG and will also be taken to ADLT.

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*

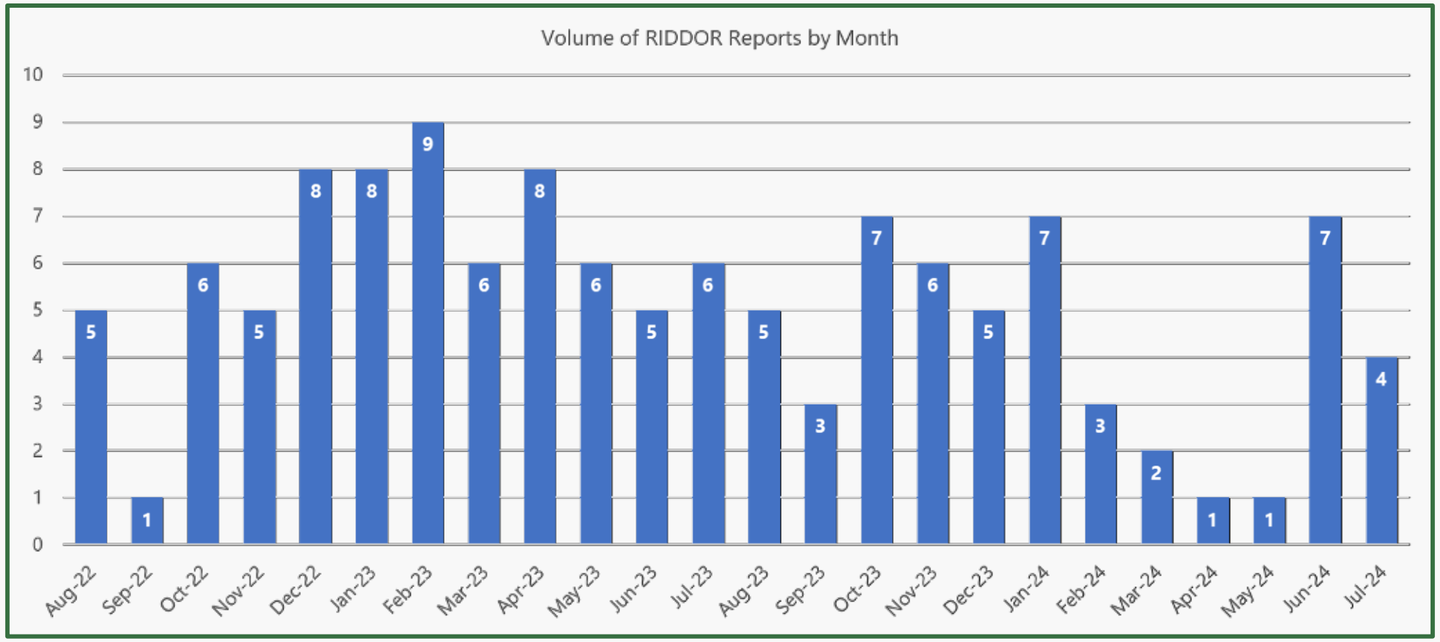
Our Patients: Quality, Safety & Patient Experience
Health & Safety (RIDDORS) Indicators

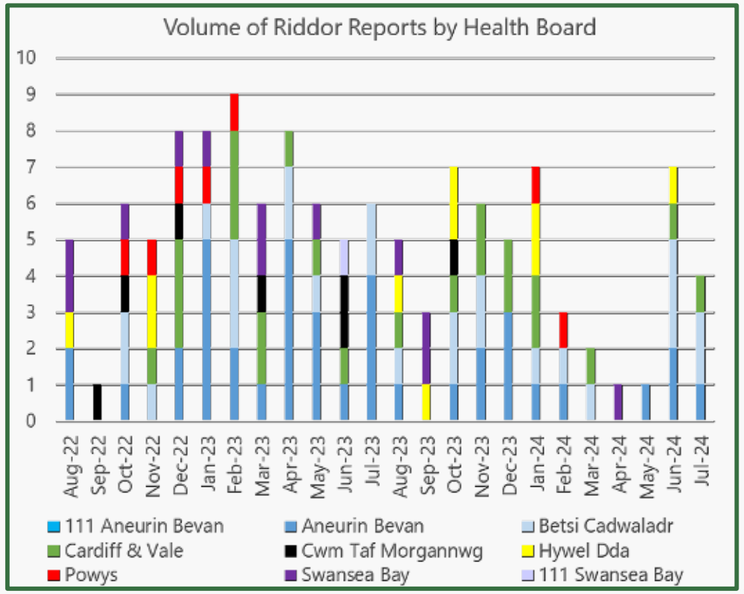
(Responsible Officer: Liam Williams)

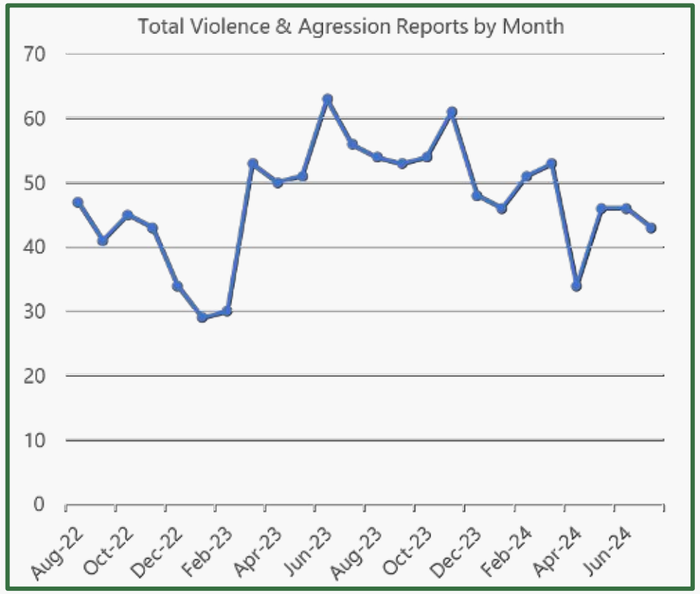
Self-Assessment: Strength of Internal Control: Moderate

PCC

Health & Care Standard
Health – Safe Care







Analysis

RIDDOR: There were 4 incidents requiring reporting under RIDDOR during July all were as a result of being unable to perform their normal duties for more than 7 days.
One was reported as a result of a manual handling incident that occurred whilst pulling a stretcher with a patient on board.

There were 2 reports resulting from slip and trip incidents 1 on the stairs of a patient's property and the second was as a result of oil left on the floor of an ambulance station garage.
One member of staff received and injury when they struck some stationary machinery in one of our vehicle workshops.

The HSE requirement for more detailed information when reporting RIDDOR's is continuing to have an impact on reporting times due to the time taken to communicate with staff ahead of submission.

Violence and Aggression: A total of 43 incidents have been reported of V&A in July.
2 Physical Assaults on staff were reported during the month with incidents of verbal abuse amounting to 41 for the month.

11 incidents were reported as Moderate in harm and 20 noted as low harm with 2 cases being noted as causing severe harm.

The number of moderate harm incidents have returned to the lower levels previously seen within the Trust. Such variations can have a number of causes which are being investigated by the V&A Team.

Remedial Plans and Actions

RIDDOR: The vacant administrative role within the department has been filled and the new member of staff will be assisting in the collection of the information required for RIDDOR reporting to improve reporting times and data quality..

Violence and Aggression: V&A incident causation is being trended to identify the suitability of recording incidents in response to the volume of low harm and no harm incidents to with the aim of undertaking suitable investigations and providing sufficient support for staff members affected.
The team have been working with the Clinical Support Desk to explore mechanisms to better protect staff by use of Community Behavioural Orders via the Patient Care Plans.

Expected Performance Trajectory

RIDDOR: The number of manual handling injuries sustained whilst moving patients is currently static with an average of 13 being reported each month. The DSE/Manual Handling Advisor is completing their findings into the manual handling injuries within the Trust, and these will be compiled for trending and causation analysis.

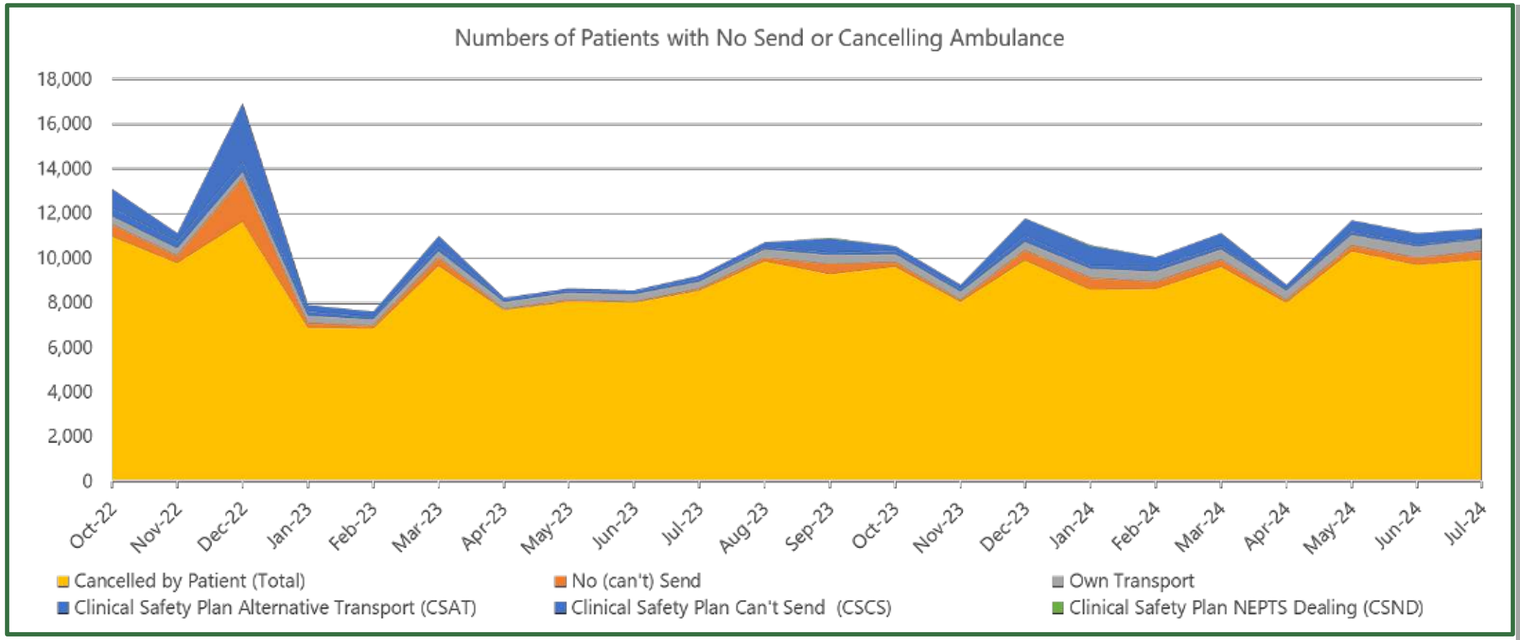
Violence and Aggression: Whilst there has been a downward trend in V&A incident numbers the current performance remains steady in terms of numbers. The majority of incidents recorded are verbal in nature arising from our call centres. Work is being undertaken by V&A team and call centre staff is aiming to improve the reporting of incidents.

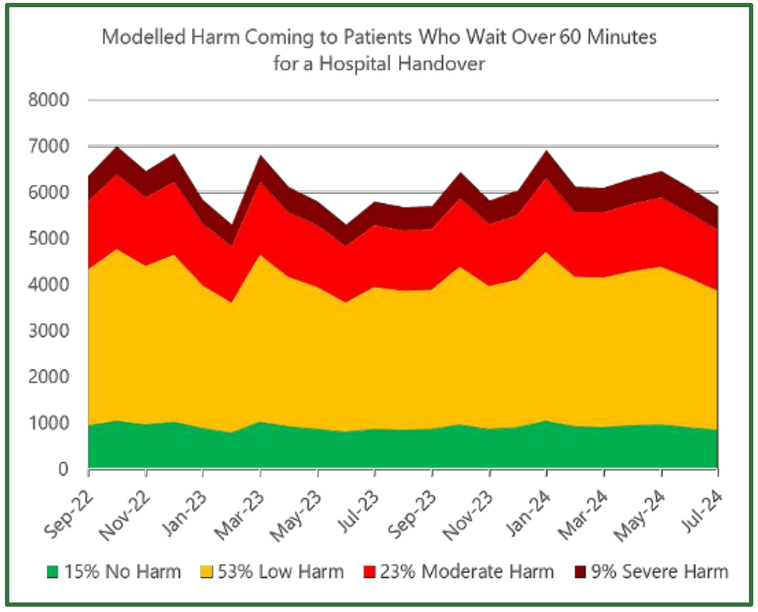
**NB: Data correct on the date and time it was extracted; therefore, these figures are subject to change*

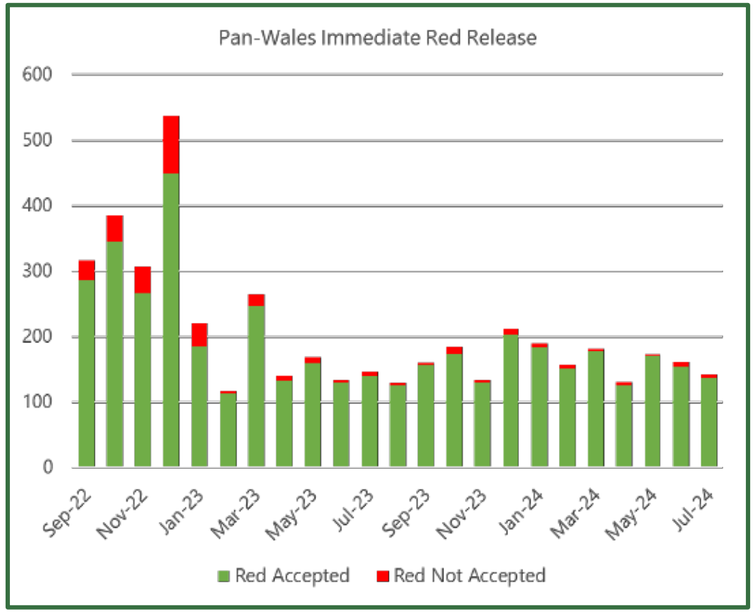
Data source: Datix

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

(Responsible Officer: Andy Swinburn) A FPC







Analysis

In July 2024, 119 ambulances were stopped due to Clinical Safety Plan (CSP) alternative transport and 400 were stopped due to CSP 'Can't Send' options. In addition, 9,912 ambulances were cancelled by patients (including patients refusing treatment at scene) an increase from the 9,696 in June 2024.

There were 474 requests made to Health Board EDs for immediate release of Red or Amber 1 calls in July 2024. Of these 137 were accepted and released in the Red category, with 5 not being accepted. Further to this, 111 ambulances were released to respond to Amber 1 calls, but 221 were not.

The graph in the bottom left shows that in July 2024 of the 5,695 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% (854 patients) would experience no harm, 53% (3,018 patients) would experience low harm, 23% (1,310 patients) would experience moderate harm and 9% (513 patients) would experience severe harm.

In June 2024 CSP levels for the Trust were:



Remedial Plans and Actions

Red immediate release is monitored weekly by the Chief Executive and reported through to Health Board CEOs with the expectation that there are no declines for Red Release from any of the 7 Health Boards. All health boards have agreed to this measure. Integrated Commissioning Action Plan (ICAP) meetings had been paused as the Trust moves into the new commissioning arrangements but have now restarted. The NHS Wales Performance Delivery framework 2024/25 has a target of no handovers of more than one hour, this equates to 7,500 hours of handover lost hours.

Expected Performance Trajectory

The Trust continues to monitor CSP levels both daily through the ODU and weekly through the Weekly Operations Performance Meeting and mitigations are actioned to reduce the impact on the Trust's ability to respond to demand. See also slides on Red performance and Amber performance, in particular, remedial actions.

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

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

(Responsible Officer: Liam Williams)

Self-Assessment: Strength of Internal Control: Moderate

PCC

Health & Care Standard
Health – Safe Care

Duty of Quality – Patient Experience
These are mandatory requirements; Under the Health and Social Care (Quality and Engagement) (Wales) Act 2020, WAST has a duty to secure quality in its services and must exercise its functions with a view to securing improvement in the quality of its services. The Duty of Quality includes the experiences of individuals to whom health services are provided.

July 2024		
NEPTS (18 responses)	Benchmark	Score
How long did you wait for your transport to take you home after your appointment.	85	66
Were you happy with the transport you received?	85	93
999 (37 responses)	Benchmark	Score
The 999-call taker who answered your call was reassuring.	85	73
The 999-call taker who answered your call explained what was going to happen next.	85	77
You felt confident in the call taker ability to manage your call and provide appropriate advice.	85	70
The length of time I waited for an ambulance to arrive was acceptable.	85	50
111 (13 responses)	Benchmark	Score
Do you feel your call to 111 Wales was helpful?	85	88
Did you follow the advice given to you by NHS 111 Wales?	85	90
Would you consider using NHS 111 Wales again?	85	78
WAST Overall - Friends & Family Test How was your overall experience with the service today?	Ranked from very poor to very good.	
o Ambulance care	71.43% Good	0.00% Poor
o Integrated Care (NHS 111 Wales Telephone line only)	77.78% Good	0.00% Poor
o EMS (including CSD)	48.15% Good	44.44% Poor
o NHS 111 Wales Online	58.33% Good	25.00% Poor
	* Where totals above do not add up to 100%, this is because a 'Do Not Know' answer was given, these are excluded from overall total.	

Analysis
Within the NEPTs survey the response provided did not hit the benchmark in relation to the question 'How long did you wait for your transport to take you home after your appointment, while the question 'Were you happy with the transport your received', came out above the 85-benchmark figure (n=93).

All the responses within the 999-section failed to achieve the benchmark, while within 111 two questions saw responses achieve the benchmark 85, these being 'Did you follow the advice given to you by NHS 111 Wales?' (n=90) and 'Do you feel your call to 111 Wales was helpful?' (n=88).

Response rates to the 999 and 111 surveys remain low and it's acknowledged that these do not reflect an entirely representative picture based on overall call volumes.

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

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

- We are continuing to work on a DPIA to be submitted to the ICO for their consideration about use of SMS text messages to directly distribute survey requests to service users.
- 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 also continue to work closely with the Trust's Falls Improvement Lead to deliver a targeted survey looking at the experiences of people who are responded to by either a Level 1 or Level 2 falls responder.
- Throughout this month we have also continued to engage with the Once for Wales Programme Board who have been reviewing the 'All Wales Patient Experience Question Set' and the updated 'People's Experience Framework'. The Framework and new questions will be presented to Executive Directors of Nursing at their next meeting for final approval.

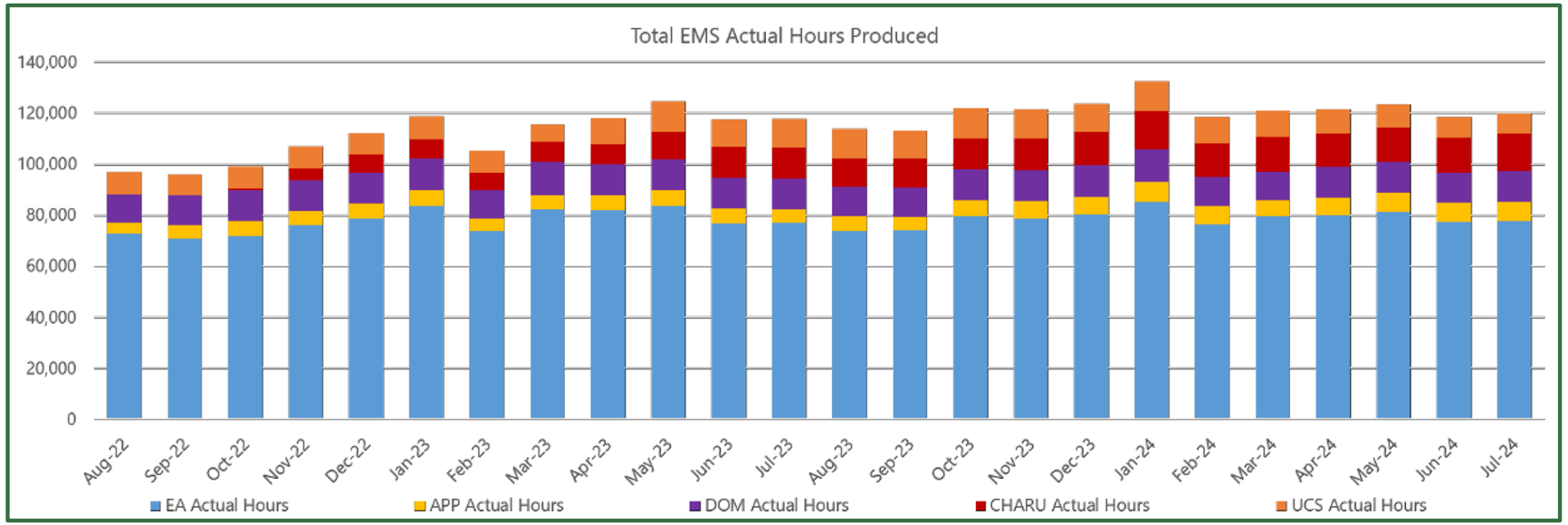
Expected Performance Trajectory
An overall aim of increasing visibility of experience surveys and maximising opportunities to capture patient experience data.

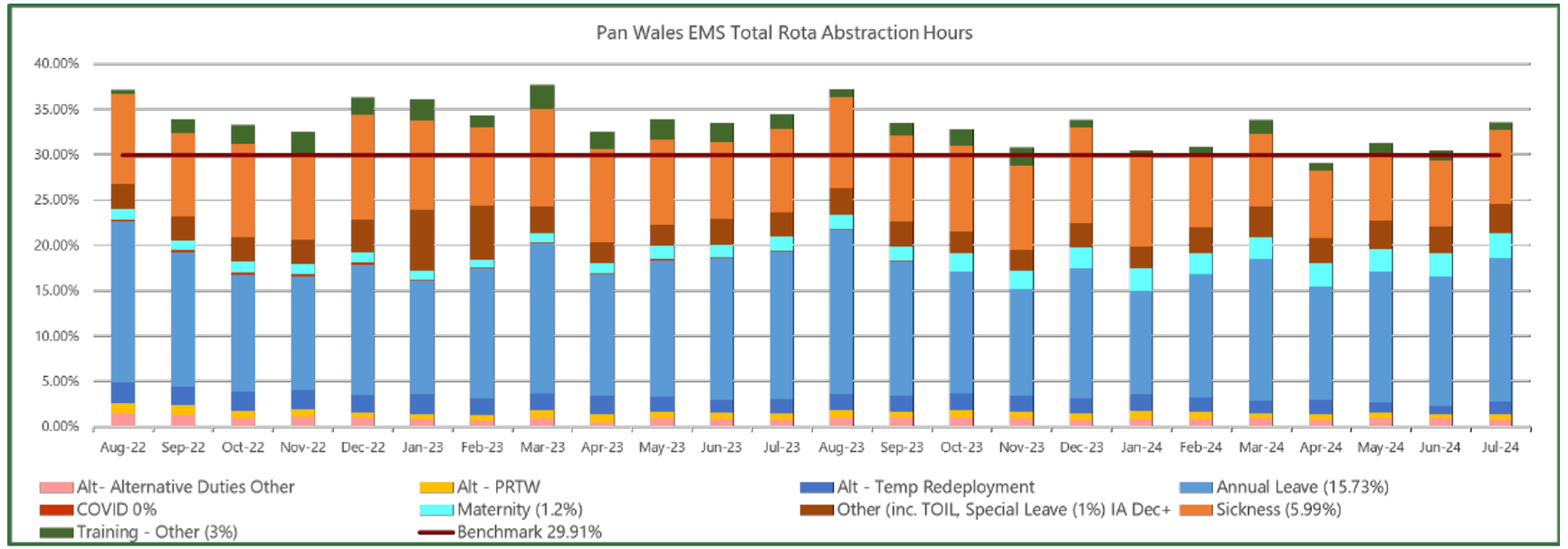
Our People
Capacity - Ambulance Abstractions and Production Indicators

(Responsible Officer: Lee Brooks)

EA Production	Abstractions
A	R

CI PCC FPC





Analysis

The total EMS hours produced is a key metric for patient safety. The Trust produced 119,710 hours during July 2024, an increase compared to 117,737 hours produced during July 2023. The Trust is delivering good levels of production.

As shown in the bottom graph, monthly abstractions from the rosters are key to managing the number of hours the Trust has produced, as are the total number of staff in post. In July 2024, total EMS abstractions (excluding Induction Training) stood at 33.72%. This was an increase on the 30.94% recorded in June 2024. The highest proportion of abstractions was due to annual leave at 15.80% followed by sickness at 8.19%.

Emergency Ambulance Unit Hours Production (UHP) achieved 90% in June 2024 which equated to 77,593 Actual Hours.

In July 2024 CHARU UHP was 74% against the full roll out requirement (note this requirement is not fully funded by commissioners).

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.

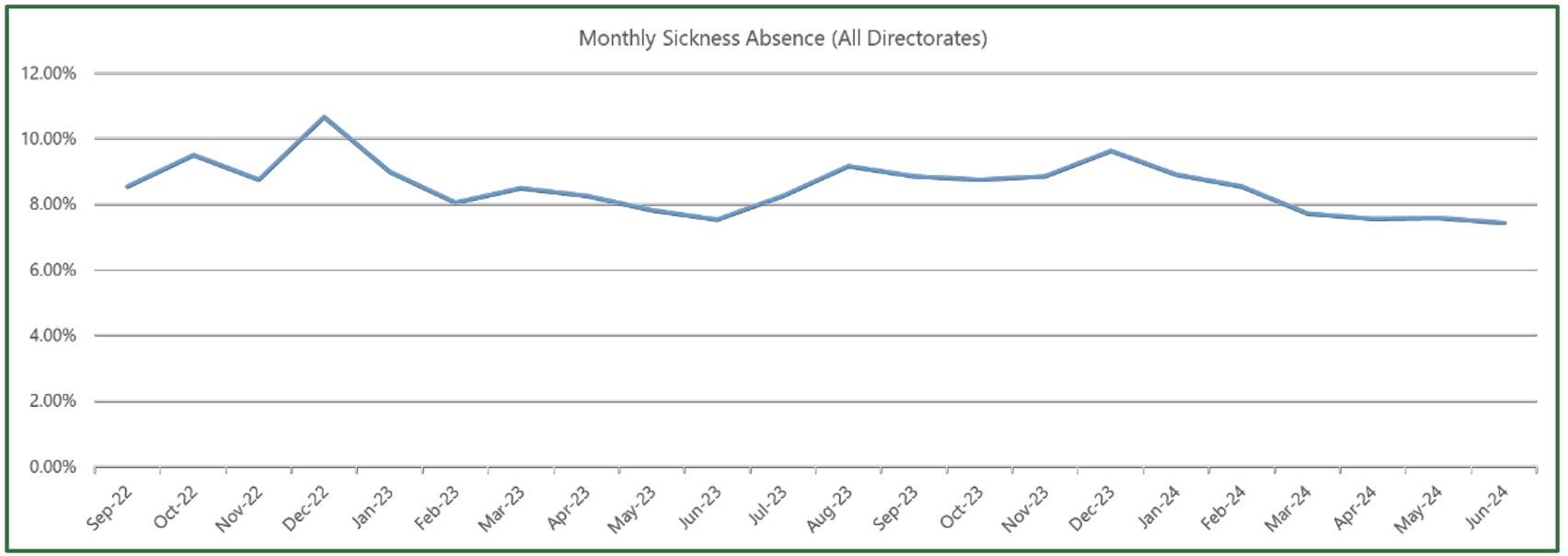
The Trust maintains an ambition to reduce sickness to 6% and abstractions to 30%. This has not yet been achieved for sickness, but the direction of travel is good, while the abstractions benchmark was achieved in April 2024 (28.82%).

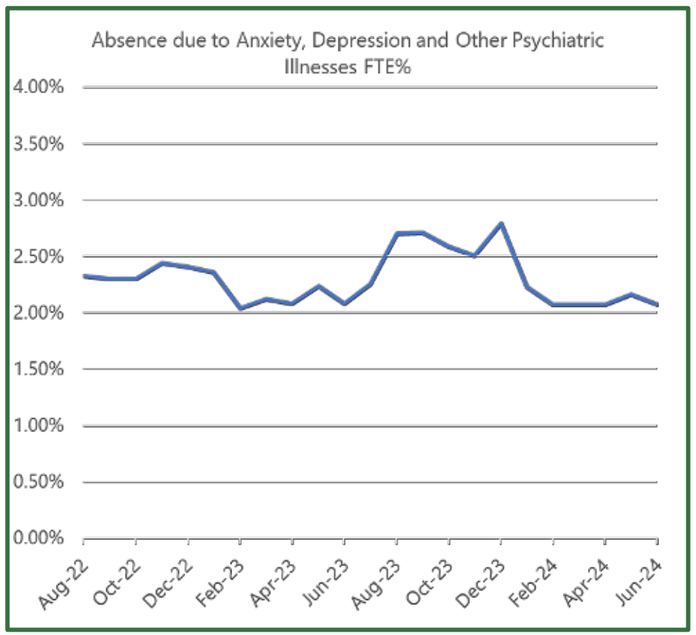
Our People
Capacity - Sickness Absence Indicators

(Responsible Officer: Angela Lewis)

Mental Health
G

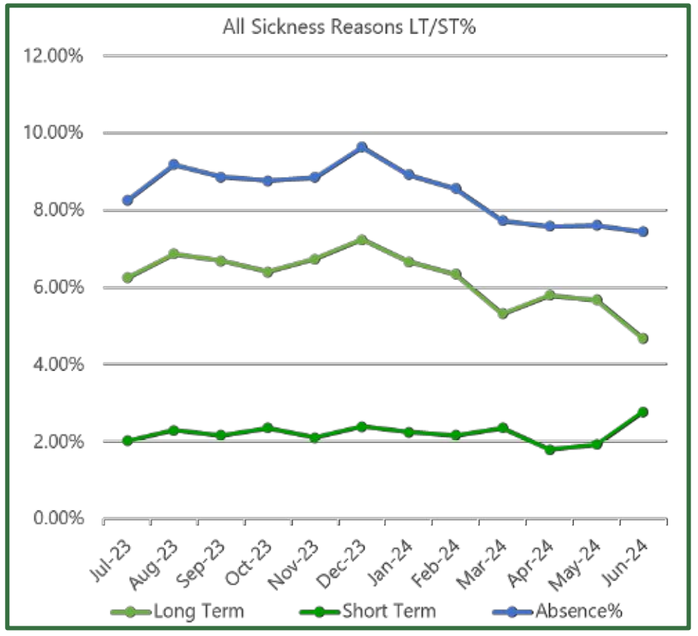
CI





Average working days lost per FTE (Annual)	
19.28 days	
Single month Absence %	
7.52%	
Long Term	**Short Term**
4.67%	2.77%
Mental Health	**Other MSK**
(S10 Stress/Anxiety)	(excluding Back)
2.07%	0.80%

June 2024



Analysis

There was a slight decrease in overall sickness absence rates between May 2024 and June 2024, dropping from 7.6% to 7.4%. Long term absence also decreased from 5.67% in May 2024 to 4.67% in June 2024, while short-term absence increased slightly from 1.92% in May to 2.77% in June.

The highest reason for short term absence in May 2024 was Anxiety/ Stress/ Depression, other musculoskeletal problems and cold, cough, flu-influenza.

Absence due to Mental Health decreased from 2.16% in May 2024 to 2.07% in June 2024.

Occupational health waiting times have greatly improved, our KPI of 10 working days from receipt of management referral to first offer of appointment is being met, with colleagues currently waiting for 3 to 5 working days. From receipt of Wellbeing referrals to first call (from one of our Wellbeing Practitioners), the waiting time is still 2 days. The team continue to triage all referrals and enquiries to ensure prioritisation of anything that requires urgent attention.

Remedial Plans and Actions

- Monitoring continues with ongoing reviews in both long term and short-term absences with monthly meetings to track sickness and provide support.
- MAAW training and bitesize training sessions continue to be scheduled on a bi-monthly (MAAW) and monthly basis (Bitesize sessions).
- Audits for all Directorates, will be undertaken on a monthly basis over the next 6 months and the People Services Team will provide targeted support to line managers on reasonable adjustments and the appropriate use of discretion in areas identified as hot spots.
- We have recently recruited 2 Occupational Health Advisors to cover maternity leave, we also recruited a Clinical Team Lead.

Expected Performance Trajectory

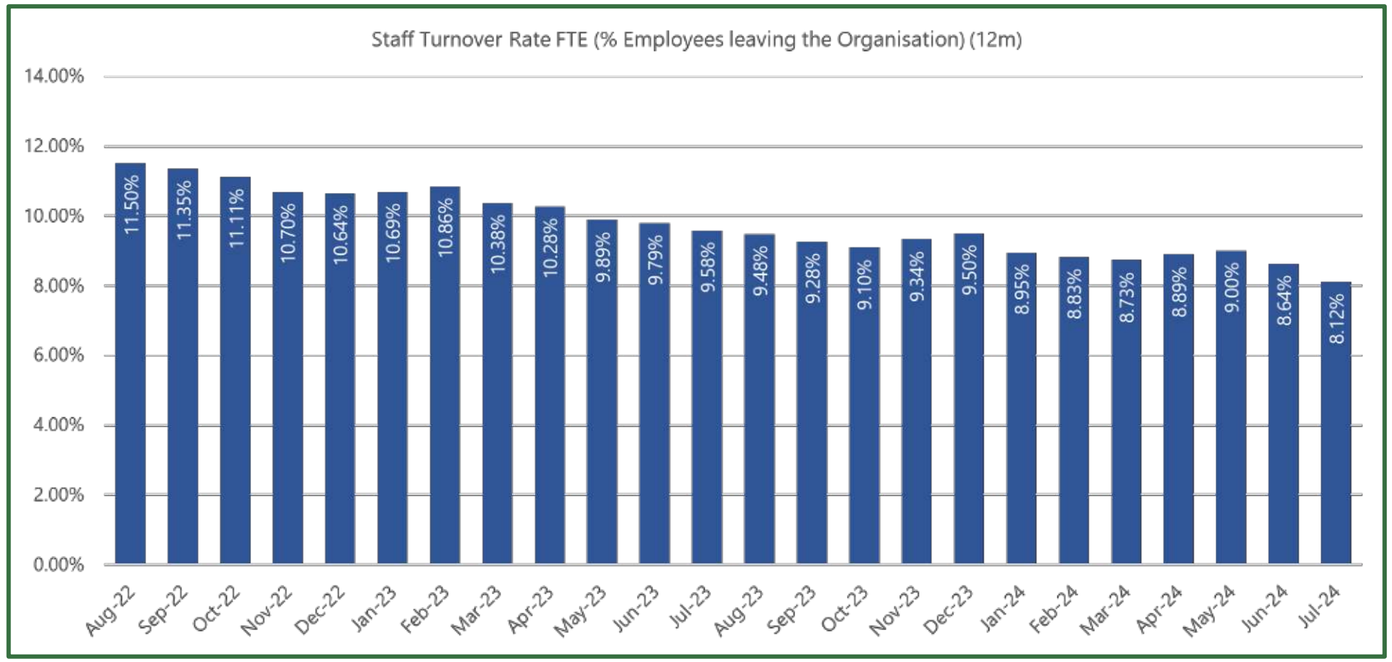
The Trust has indicated through its IMTP that sickness levels will fall in this financial year, but that there remain risks to delivery.

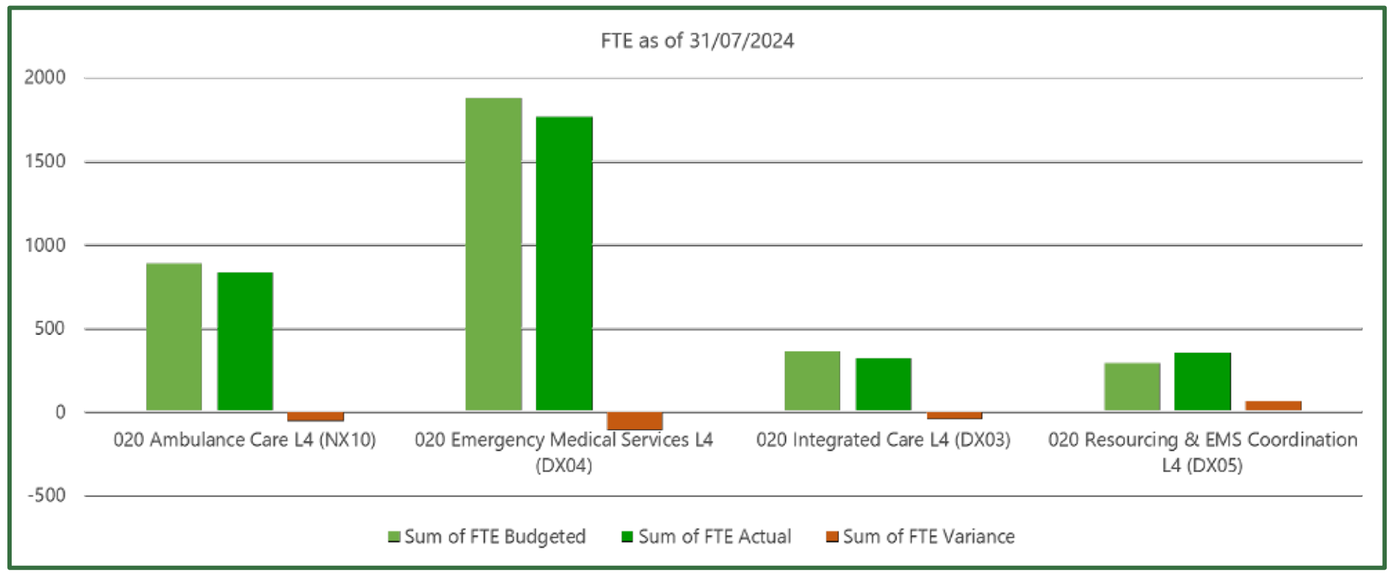
NB: Sickness data will always be reported one month in arrears. It should be noted that the figures reported in this presentation are official to 31st March 2024. All figures for April 2024 are indicative only (as of 23.04.24).

Our People
Capacity - Turnover

(Responsible Officer: Angela Lewis)

G





Analysis

Staff turnover rates in July 2024 were 8.12%, a decrease from the 8.64% recorded in June 2024. July saw 29 leavers (25.96 FTE). Turnover in months at the end of the quarter are generally higher). This was unbalanced with only 24 joiners (22.97 FTE) in July, of those leaving, the majority were Paramedics (10 people).

WAST are meeting national KPIs, e.g. regarding turnaround times for referrals the national KPI states; Due to staff sickness and staff changes (new team members to be inducted/trained etc.) our occupational health waiting times have slightly increased. Currently colleagues are waiting around 23 working days. From receipt of Wellbeing referrals to first call (from one of our Wellbeing Practitioners), the waiting time is still 1-2 days. The team continue to triage all referrals and enquiries to ensure prioritisation of anything that requires urgent attention.

Remedial Plans and Actions

- We are working to improve our data collection through Our MI system (Opas G2), some ongoing technical issues are being investigated by Civica.
- The team continue to support staff by providing advice and guidance on how to use the MI system. We have facilitated events; Occupational Health - Guidance on Management Referrals, attendance was good, and the team are looking at providing more sessions in the future.
- The self-referral portal on Opas G2 for Occupational Health and Wellbeing continues to prove popular and has streamlined the service.
- We are still working closely with the Welsh health boards to standardise our reporting, however in addition to this we have built our own customised reports, which help us identify themes and trends. Our MI reports (internal and from external, partner organisations) are used to support strategic decision-making regarding the service, also to provide impact analysis and highlight value for money.
- The Wellbeing team continue to deliver Drop-in sessions across all our Clinical Contact Centres, (CCCs) dates are advertised on Siren and through our seasonal newsletter. These are delivered in person at the CCCs and online via Teams. The team have increased our site visits this month in response to bereavements in service.
- 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, we can use psychometric measures to assess and track psychological distress.
- The team have finalised plans for the pilot Health Check Programme, Health Diagnostics, which looks at reducing risk of cardiac ill health in our older workforce, by implementing a screening programme. Some training for new staff members is required and we are working with the provider to start the programme.
- The team are working on reevaluating plans/timelines to attain SEQOHS accreditation, a meeting with SEQOHS has been scheduled with a view to start working on this in September.

Expected Performance Trajectory

The People and Culture Strategy continues with its wellbeing focus. We are currently in the process of writing the WAST Health and Wellbeing strategy for 2025/29.

Our People
Capability - PADR and Training Rates Indicators

(Responsible Officer: Angela Lewis)

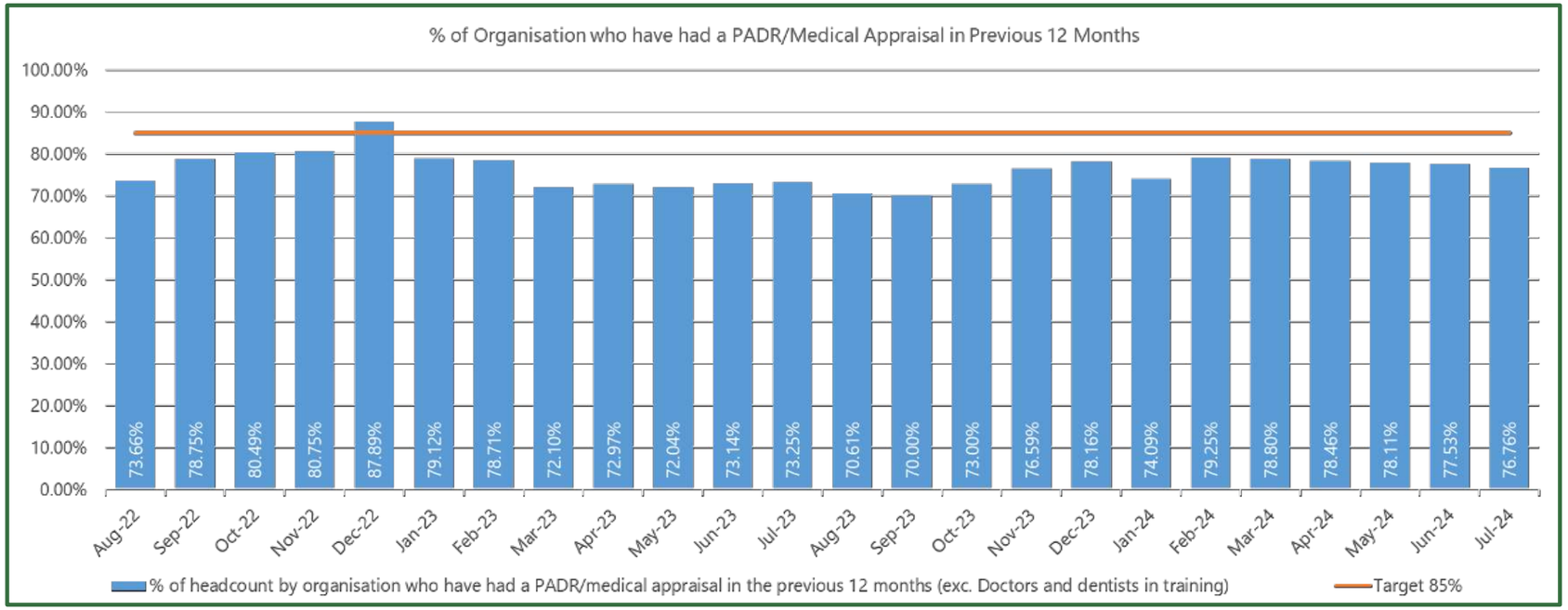
PADR: A

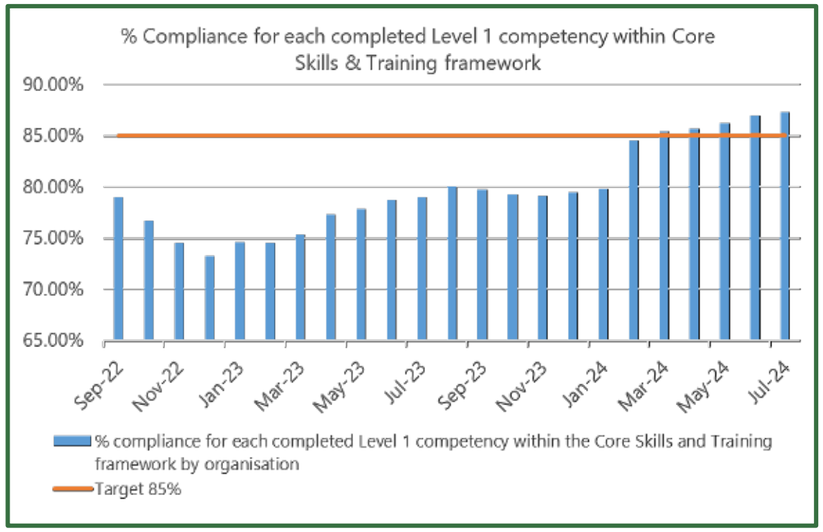
Stat & Mand: A

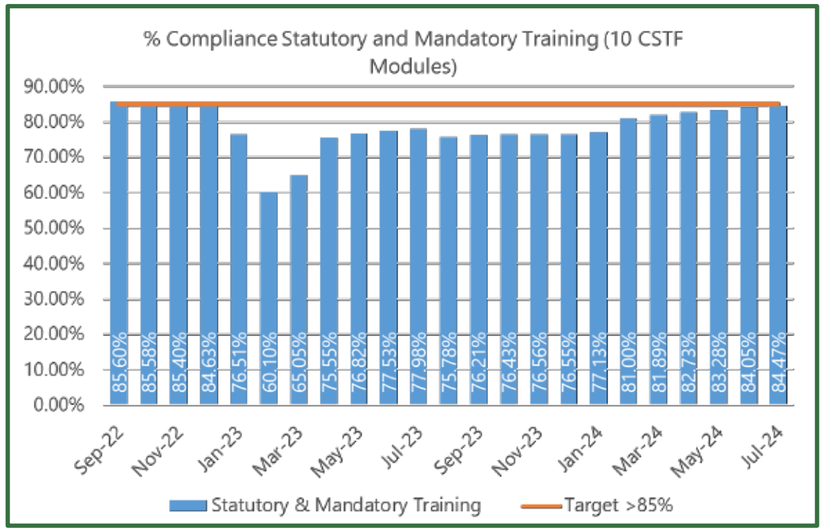
CI | PCC

Health & Care Standard Health – Staff & Resources

Self-Assessment: Strength of Internal Control: Strong







Analysis

PADR rates decreased from 77.53% in June 2024 to 76.76% in July 2024 and remain below the 85% target. Over the reporting period this target has only been achieved once, in December 2022.

In July 2024 Statutory & Mandatory Training rates reported a combined compliance of 84.47%; which is the 7th consecutive month to see an improvement. However, only Dementia Awareness (95.04%) and Moving & Handling (93.51%), achieved the 85% target. Equality & Diversity (83.03%), Safeguarding Adults (82.65%). Fire Safety (78.91%), Violence Against Women, Domestic Abuse & Sexual Violence (73.04%), Information Governance (75.36%), Paul Ridd (71.46%), Welsh Language Awareness (65.32%) and Fraud Awareness (65.51%), 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

Engagement in the PADR process serves as a Key metric for evaluating team cultural health. By increasing engagement with the PADR process, our goal is to enhance employee Development opportunities, support better Communication between managers and employees and develop a culture of accountability and continual improvement. We intend to assess PADR engagement levels (Q1) across teams to pinpoint areas with higher participation rates and gather insights into effective practices and strategies .

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.

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

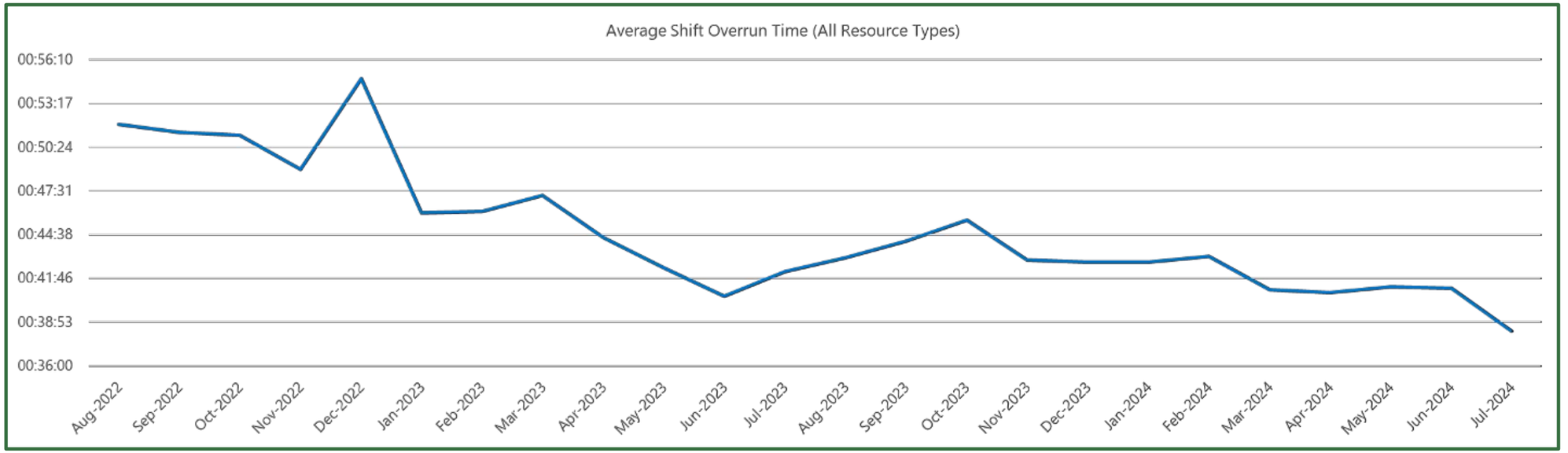
Data source: ESR

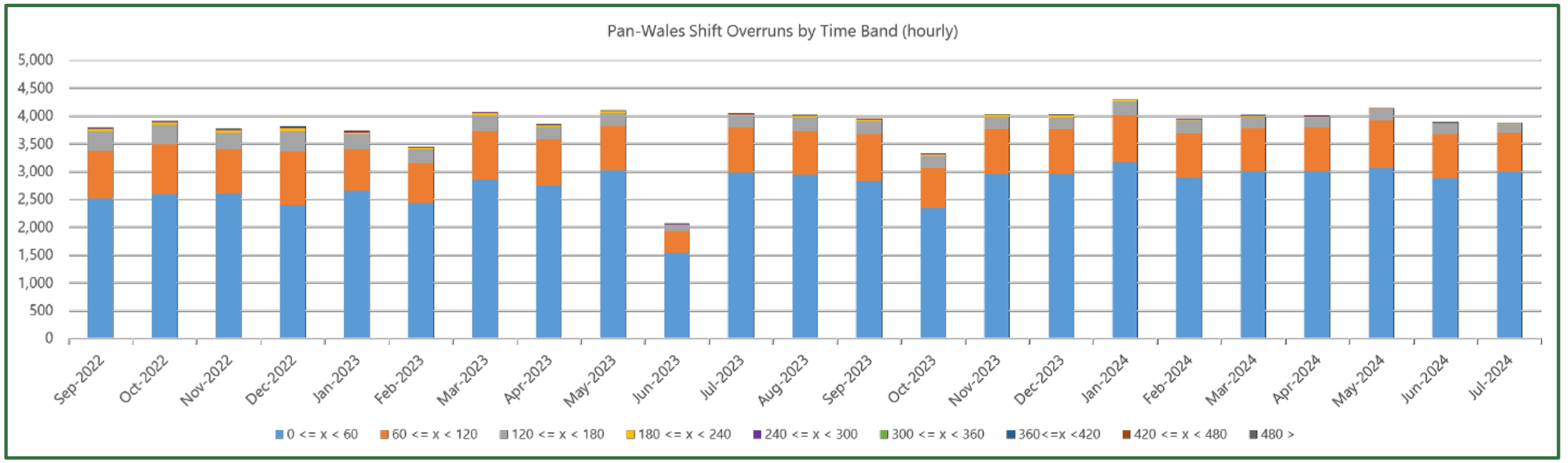
Our People
Health and Well-being – Shift Overruns

(Responsible Officer: Angela Lewis)

Overruns
A

CI





Analysis

The average overrun figure for July 2024 was 38 minutes and 17 seconds compared to 41 minutes and 7 seconds in June 2024. The trend continues to be downward over the past two years.

The highest volume of shift overruns occur within the 0 to 60-minute category, accounting for 73.6% of the total. 19.9% fall within the 61 to 120-minute category, 5.4% 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 introduced "pods" at some hospital locations to aid staff finishing on time. These are continuing, at this time, into 2024/25.

Expected Performance Trajectory

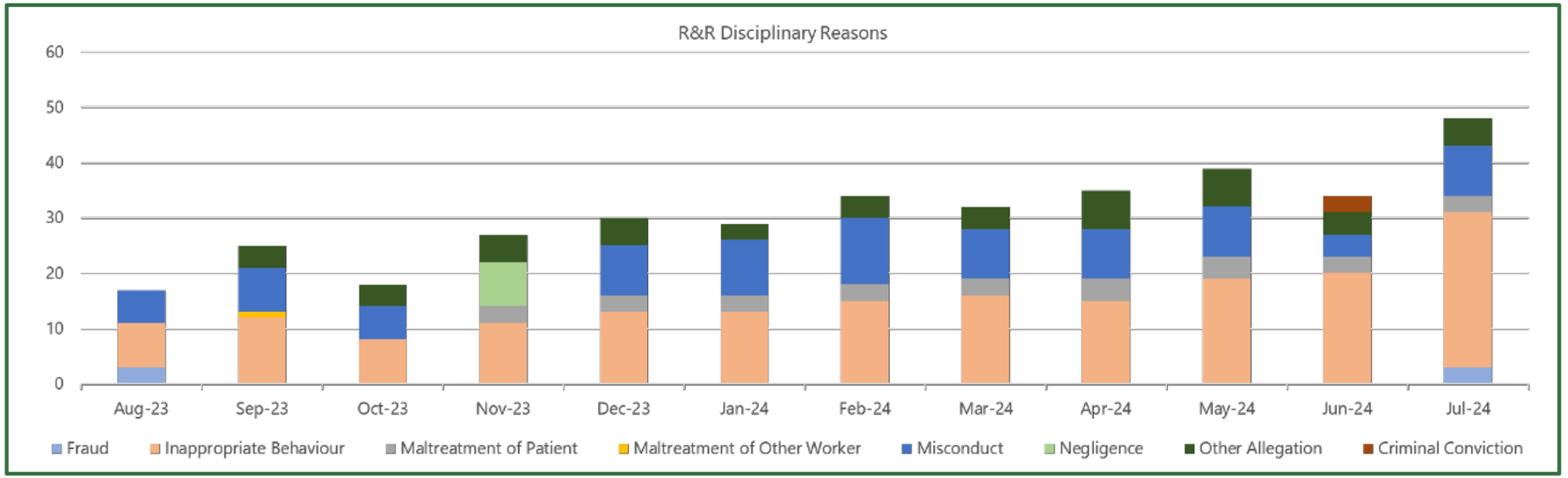
Overruns correlate with handover lost hours. As we have moved out of winter both levels had started to drop. We may expect this to stabilise before moving into higher levels again next winter.

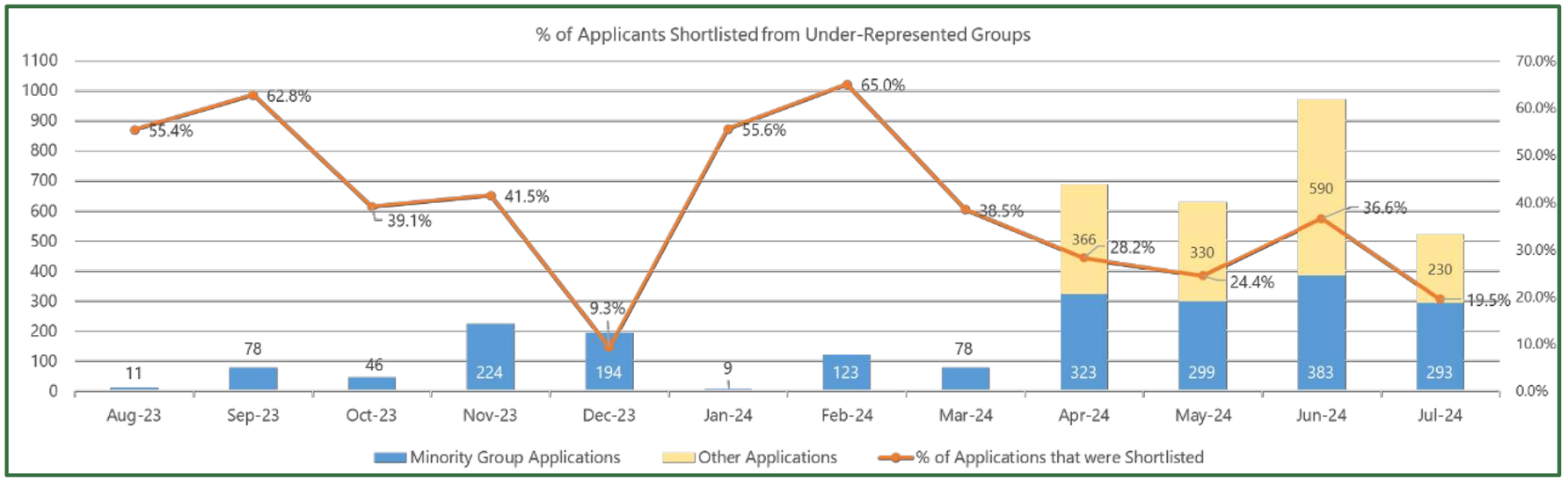
Our People
Culture – Number of R&R Disciplinary Hearings and Number of Applicants Shortlisted from Under-Represented Groups

(Responsible Officer: Angela Lewis)

Self-Assessment: Strength of Internal Control: Moderate

PCC





Analysis

There were 48 open formal disciplinary cases recorded at the end of July 2024, an increase compared to 34 in May 2024 and the highest number seen over the past 12 months. Of these Disciplinary cases, the majority are again due to allegations of inappropriate behaviour, followed by misconduct.

There were 19 open formal Respect and Resolution cases submitted by employees in July 2024, two more than in June 2024. These are a mixture of both Respect and Resolution Grievances and Dignity at work.

The bottom graph shows that in July 2024, 523 job applications were processed and 141 interviews were planned.

Of the 523 applications, a total of 293 were from under-represented groups with 208 in the category of Ethnicity, 46 within Disability and 39 within Sexual Orientation.

In June 2024, 19.5% (n=57) of all applications from under-represented groups made it through shortlisting and were invited for interview. This was a decrease from the 36.6% in June 2024.

Remedial Plans and Actions

R&R Formal Disciplinary Cases: Continue to monitor. The Trust has a substantial programme of work in place, connected to behaviours.

Applications: The inclusive recruitment work is ongoing to develop targeted recruitment campaigns and events.

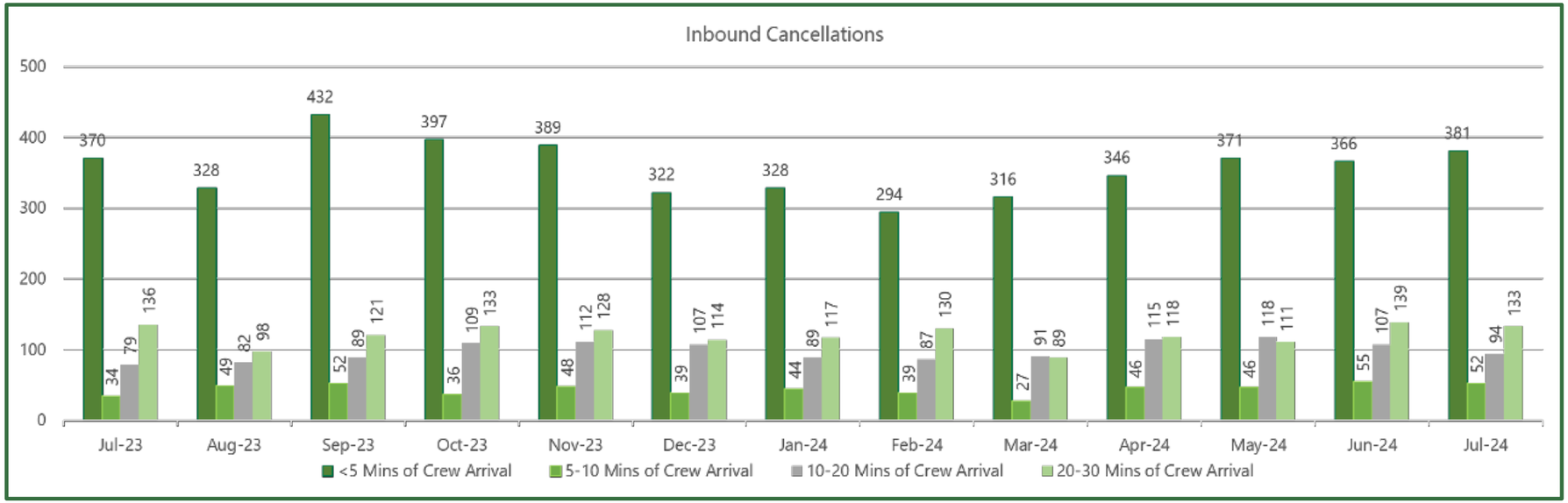
Expected Performance Trajectory

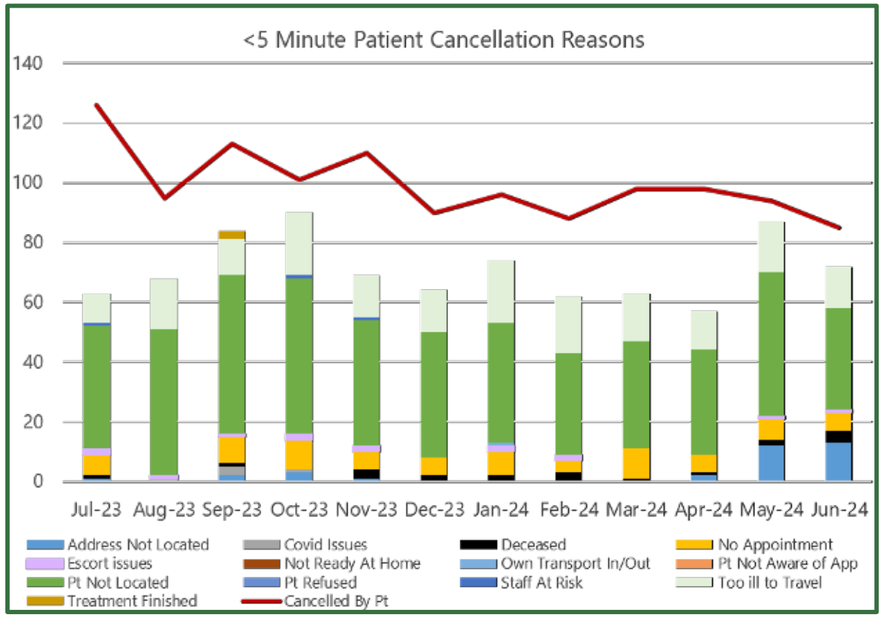
Continue to monitor levels, no trajectory for this measure.

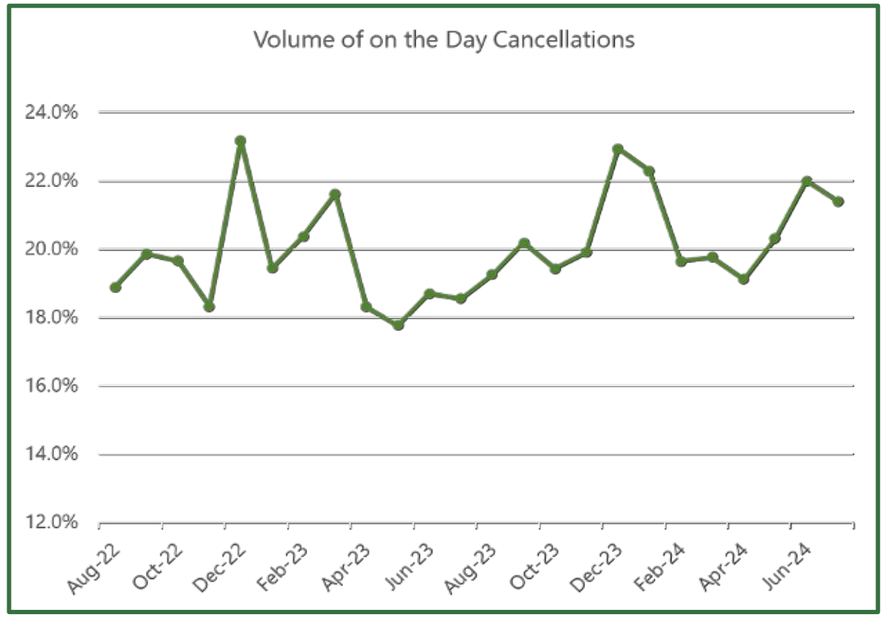
Finance, Resources and Value
Value: Ambulance Care Indicators

(Responsible Officer: Lee Brooks)

Cancellations
A







Analysis

Inbound cancellations of 5 minutes or less of the crew arrival time saw a slight increase in July 2024 to 381, compared to 366 in June 2024. The total number of cancellations within 30 minutes decreased from 667 in June 2024 to 660 in July 2024.

In July 2024 there were 117 appointments cancelled by patients, increasing from 85 in June 2024.

The other top reasons for less than 5-minute cancellations included: 51 patients not located, 14 addresses not located and 11 unwell/too ill to travel.

Same day cancellations decreased slightly from 22% in June 2024 to 21.4% in July 2024.

Remedial Plans and Actions

Work with Hywel Dda to develop a direct link between their PAS system and our CAD but has been delayed by a clash of organisational priorities but will be picked back up in late Q1. Once in place this will allow for WAST to be notified once the health board cancels or alters an appointment.

Work is also underway to enhance the service's text messaging options to improve notification to patients. This should be complete in Q2.

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.

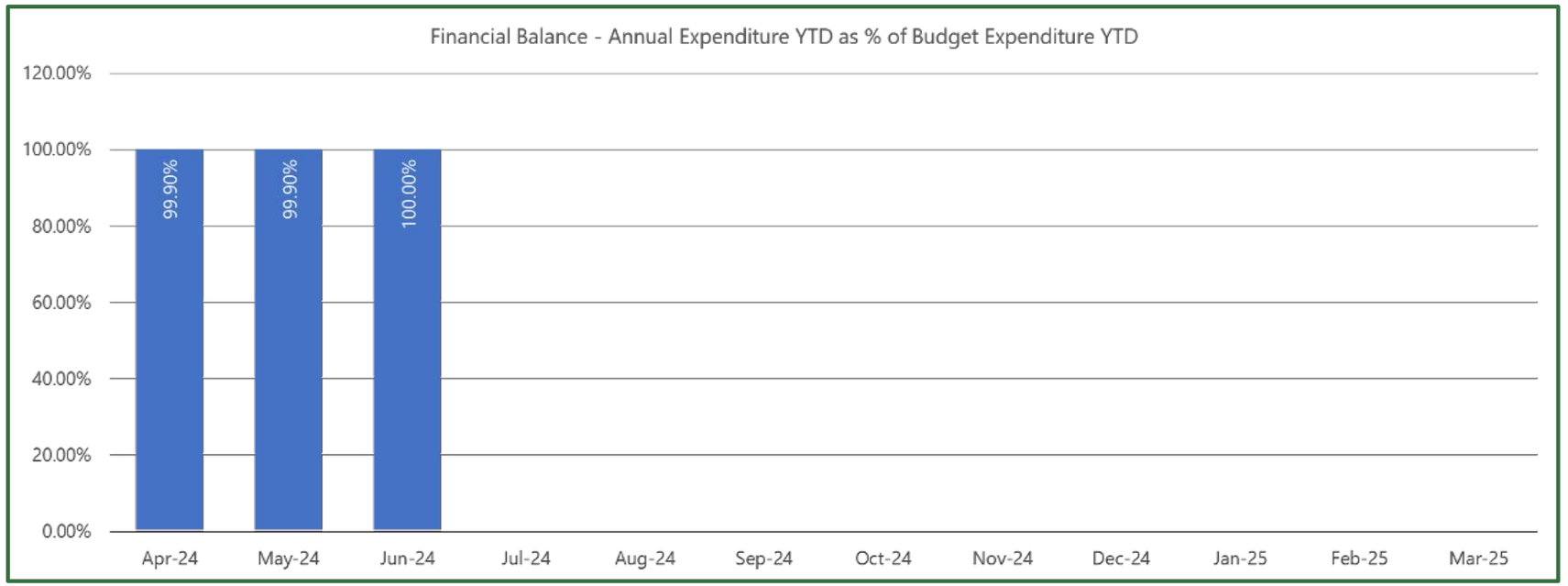
**Please note that MDTs do not appear to provide specific cancellation reasons for either inbound or outbound journeys. There are at present multiple and duplicated reasons both crews, control and the liaison desk can select.*

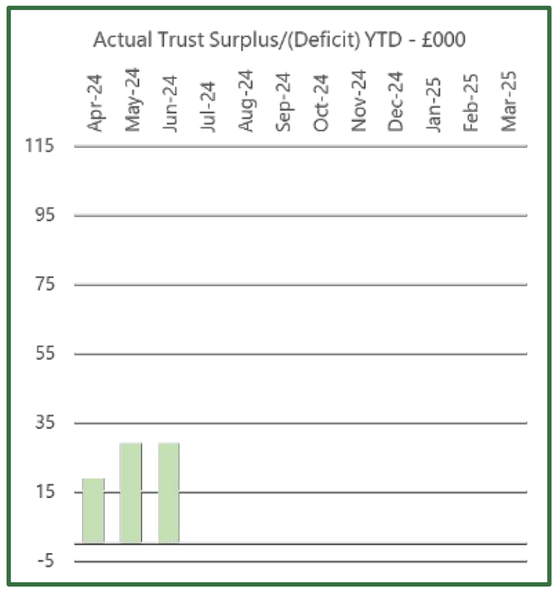
Finance, Resources and Value
Value - Finance Indicators

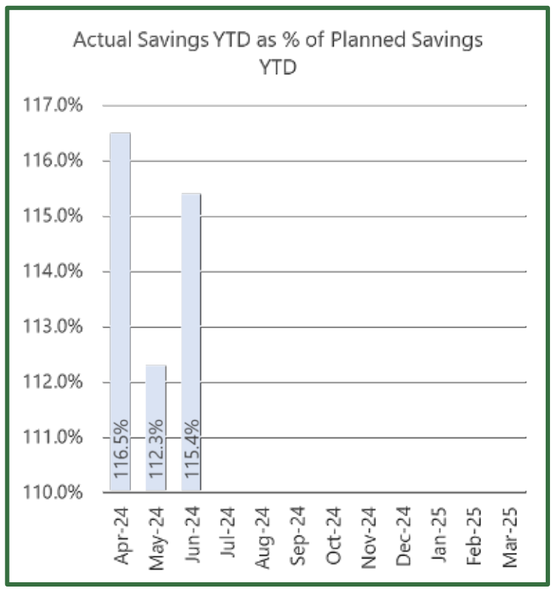
(Responsible Officer: Chris Turley)

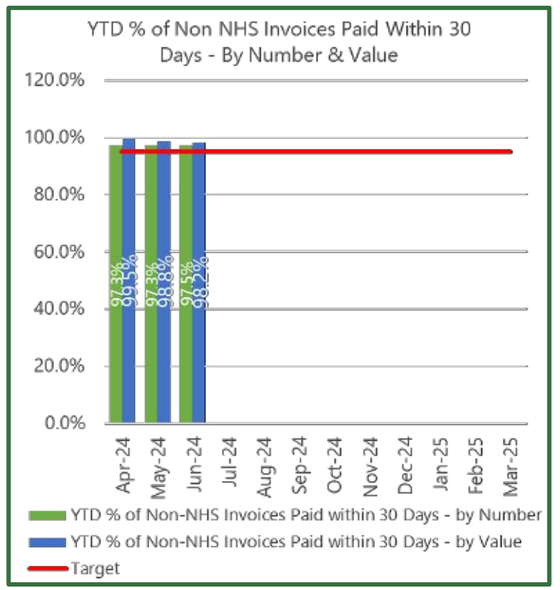
G

FPC









Analysis

The reported outturn performance at Month 3 is a surplus of £29k.

For Month 3 the Trust is reporting planned savings of £1.704m and actual savings of £1.967m (an achievement rate of 115.4%).

The Trust's cumulative performance against PSPP as at Month 3 is 97.5% against a target of 95%.

At Month 3 the Trust is forecasting to achieve both its External Financing Limit and its Capital Expenditure Limit.

Remedial Plans and Actions

There is no remedial plan required given the Trust is forecasting to breakeven; however, 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 Utilisation & Average Job/Shift Times

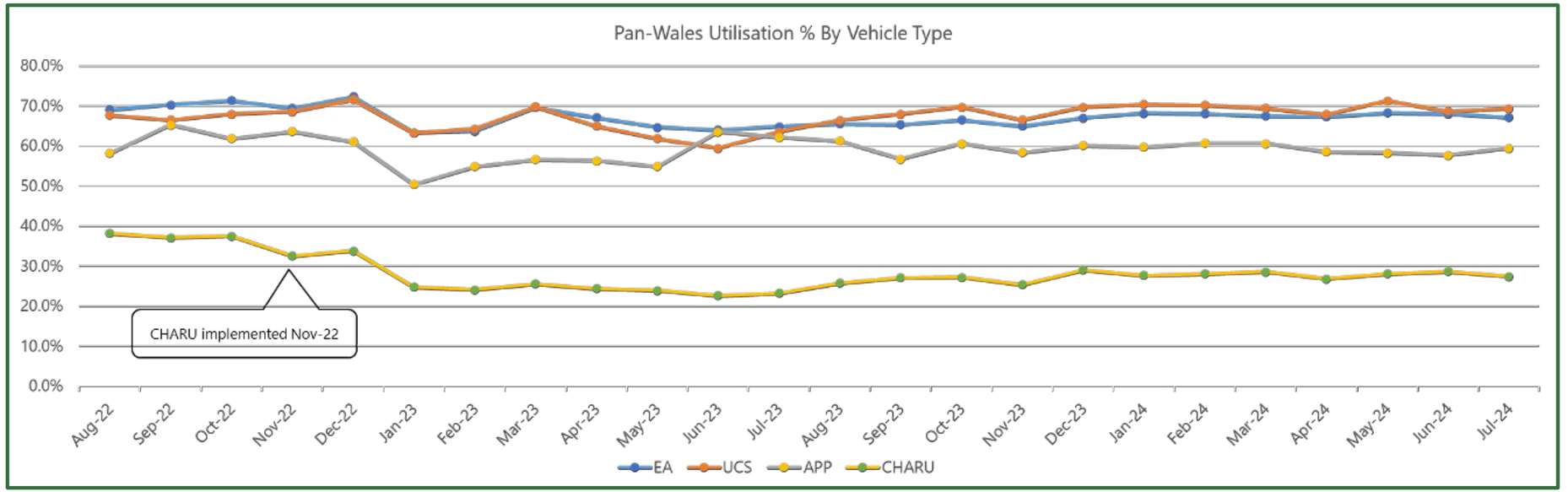
(Responsible Officer: Lee Brooks)

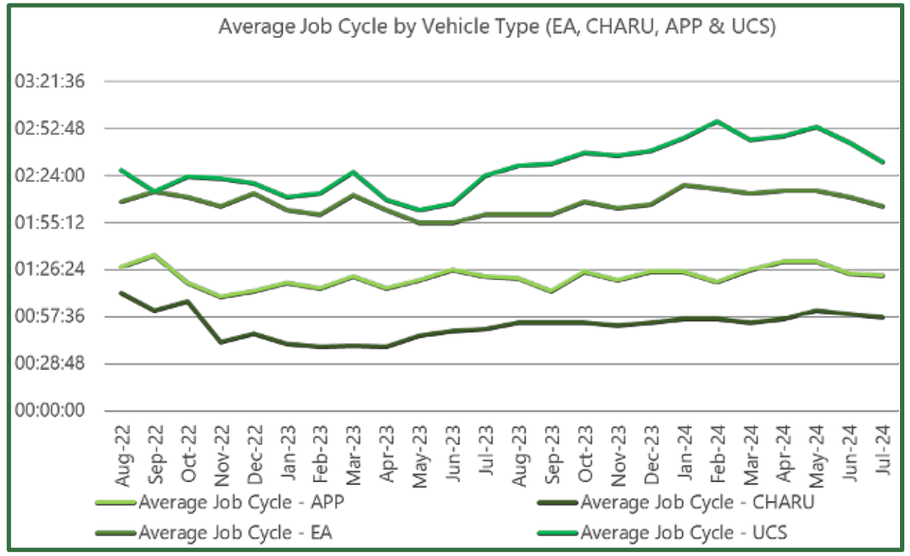
Jobs Per Shift: A

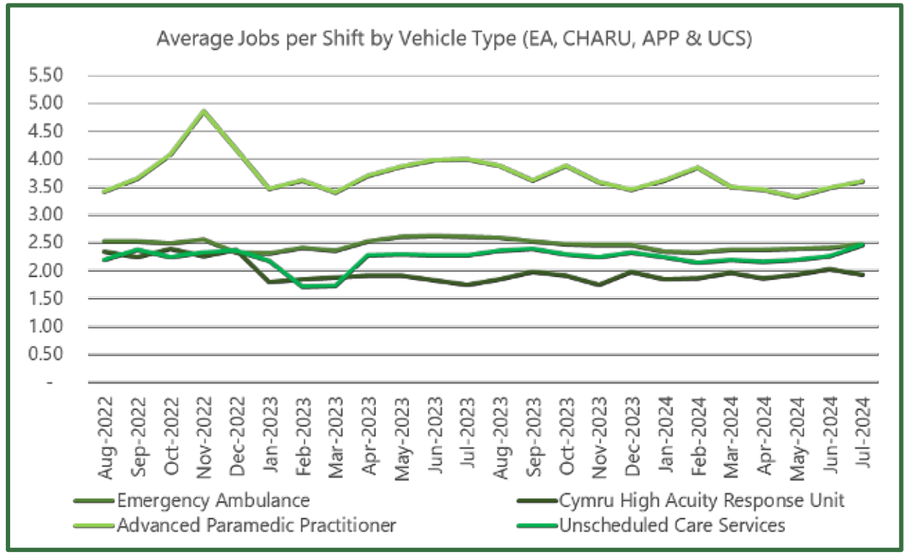
CHARU Utilisation: A

FPC

NB: Data quality issues have been identified in APP utilisation rates. These are currently being addressed.







Analysis

Pan Wales Utilisation metrics in July 2024 were 57.4% for all vehicles types, decreasing slightly from 58.5% in May 2024. UCS was the highest rate during the month at 69.4% while EA was at 67.1%. 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 all categories decreased in July 2024, to 2 hours 5 minutes for EAs, 2 hours and 32 minutes for UCS, 57 minutes for CHARU and to 1 hour and 23 minutes for APPs.

Overall average jobs per shift was 2.45 in July 2024, indicating a slight increase from June 2024 (2.26). EAs averaged 2.48 jobs per shift and UCS crews 2.45 jobs per shift This is more than what would be ideal and a product of handover delays.

APPs attended on average 3.60 jobs per shift and CHARU's 1.92 jobs per shift. The CHARU data is under review.

Remedial Plans and Actions

EA and UCS jobs per shift is fundamentally a product of handover delays.

For APPs, the newly created APP Recruitment Task & Finish Group will give a focus on further improvement, in particular, improved information and a re-roster.

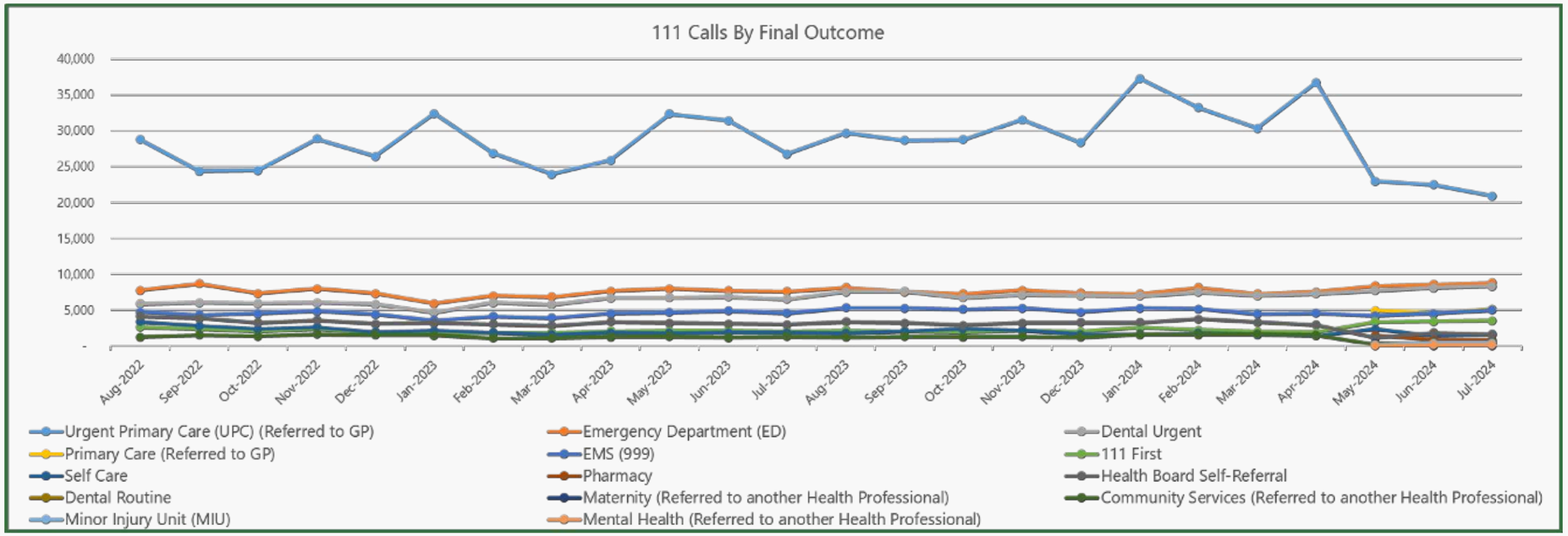
CHARU is a particular area of focus. Initial analysis indicates that CHARU contribution to Red compares favourably with the previous resource: RRVs.

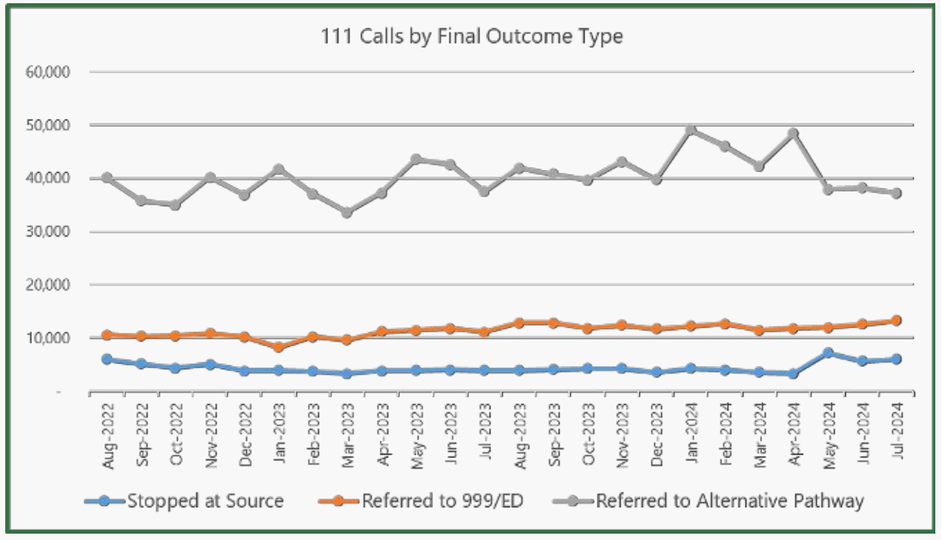
Expected Performance Trajectory

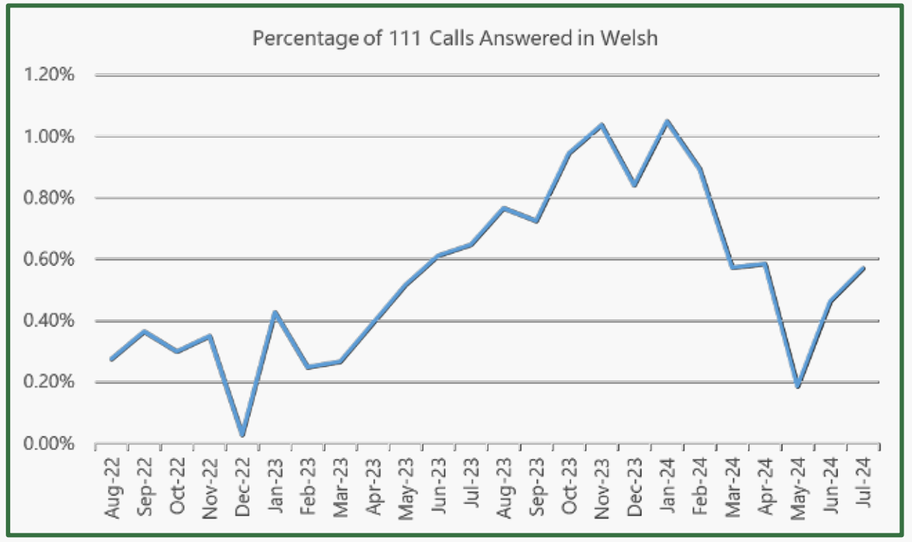
The Trust's ability to reduce the high utilisation rates for EAs and UCS is a product of handover, which it does not control. The Trust would expect an increase in APP and CHARU utilisation during 2024/25 linked to the remedial actions identified above.

Partnerships / System Contribution
NHS111 Hand Off Metrics and NHS111 Consult & Close Indicators
Influencing Factors – Demand and Clinical Hours Produced

(Responsible Officer: Lee Brooks)







NB: Data quality issues have been identified in 111. These are currently being addressed.

Analysis

During July 2024, 57.050 calls were allocated into the 14 categories displayed in the graph opposite, a slight increase compared to the 56,993 seen during June 2024. However, data quality issues have been identified in 111 which are currently being addressed

Calls Referred to a General Practitioner (handover of care) continued to be the top outcome for NHS111 accounting for 46.3% of all calls during July 2024, but there has been a material drop since the implementation of new 111CAS.

As the bottom left graph highlights, in July 2024, 5,698 calls were 'Stopped at Source', with no onward referral, a decrease from the 7,241 in June 2024. 13,317 calls were referred to 999/ED in July, an increase from the 12,632 in June.

The percentage of 111 calls answered in Welsh increased from 0.46% in June 2024 to 0.57% in July 2024. This equated to 36.6% of all 111 calls being offered in Welsh being answered.

Remedial Plans and Actions

There is currently a 111 Measures Task and Finish Group. This is a collaborative meeting between WAST its commissioners and DHCW. The focus is the development of a nationally reportable 111 data set. Similar to what is currently in place for Ambulance Service Indicators (ASIs). Part of this work involves looking at the reporting of disposition final outcomes.

Expected Performance Trajectory

No performance trajectory is set at this time, as the Trust develops its measures and systems around these metrics. Once developed there will be an opportunity to develop benchmarks. The focus remains to shift left, where it is clinically safe and appropriate to do so.

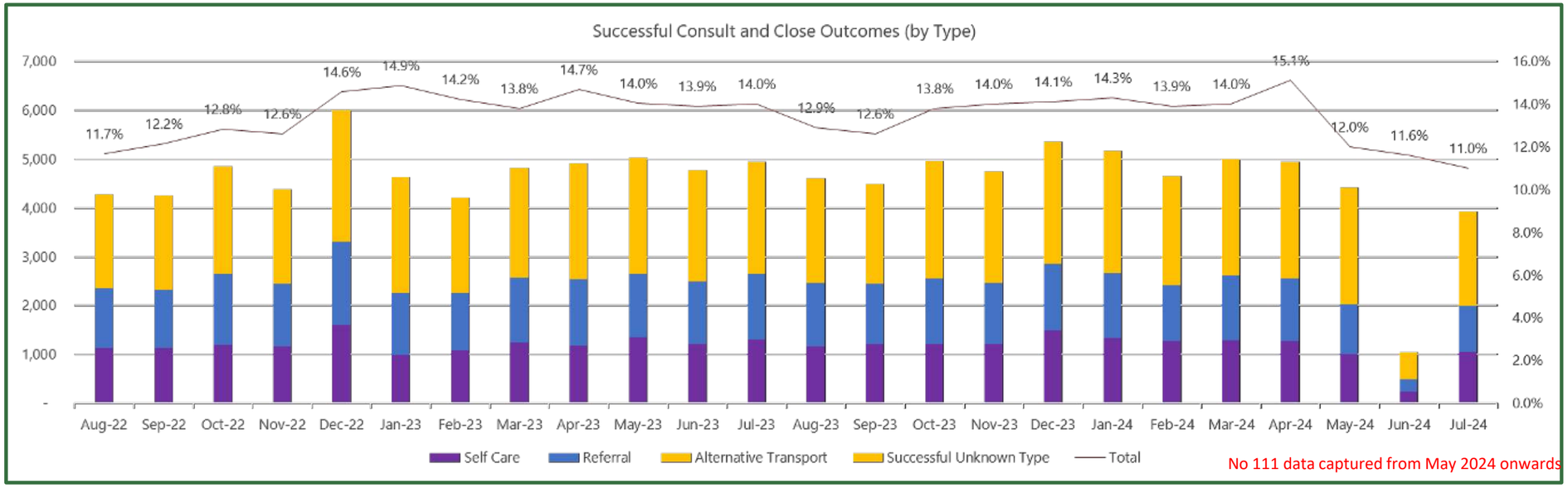
Partnerships / System Contribution
Consult & Close Indicators

(Responsible Officer: Lee Brooks)

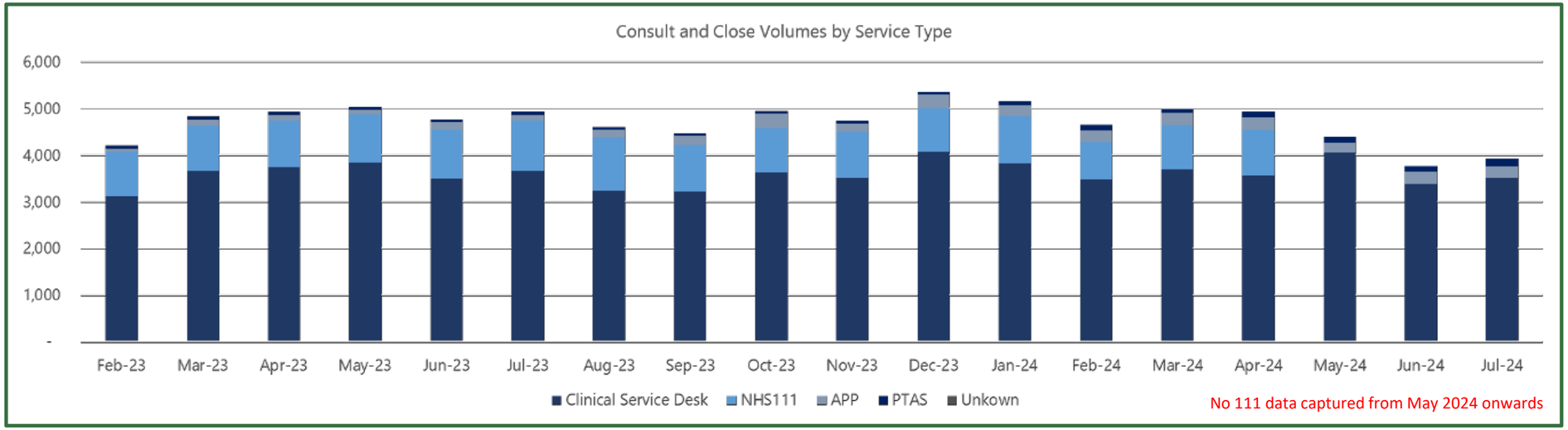
C&C Outcomes

FPC

NB: Data quality issues have been identified in 111. These are currently being addressed.



No 111 data captured from May 2024 onwards



No 111 data captured from May 2024 onwards

Analysis

Consult and Close, with contributions from Clinical Service Desk (CSD) (9.8%), NHS111 (0%), WAST APP (0.7%) and the Health Boards using Physician Triage and Streaming Service (PTAS) (0.5%) achieved 11% in July 2024, remaining short of the 17% IMTP ambition. The number of 999 calls resulting in a Consult and Close outcome was 3,933, an increase from 3,774 in June 2024.

*There is currently a reporting issue with the 111 contribution, which is incorrectly showing as 0%.

Of the calls successfully closed in July 2024, 1,060 patients received an outcome of self-care; 925 patients were referred to other services (including to Minor Injury Units and SDEC) and 1,950 were advised to seek alternative transport services to acquire treatment.

Remedial Plans and Actions

- Work underway with HI to establish a quality assured data warehouse for all new 111CAS data.
- 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.
- Resolve 111 reporting issue.

Expected Performance Trajectory

Further improvement is expected linked to CSD staff attendance (reduced abstractions and less vacancies). The ambition remains 17%.

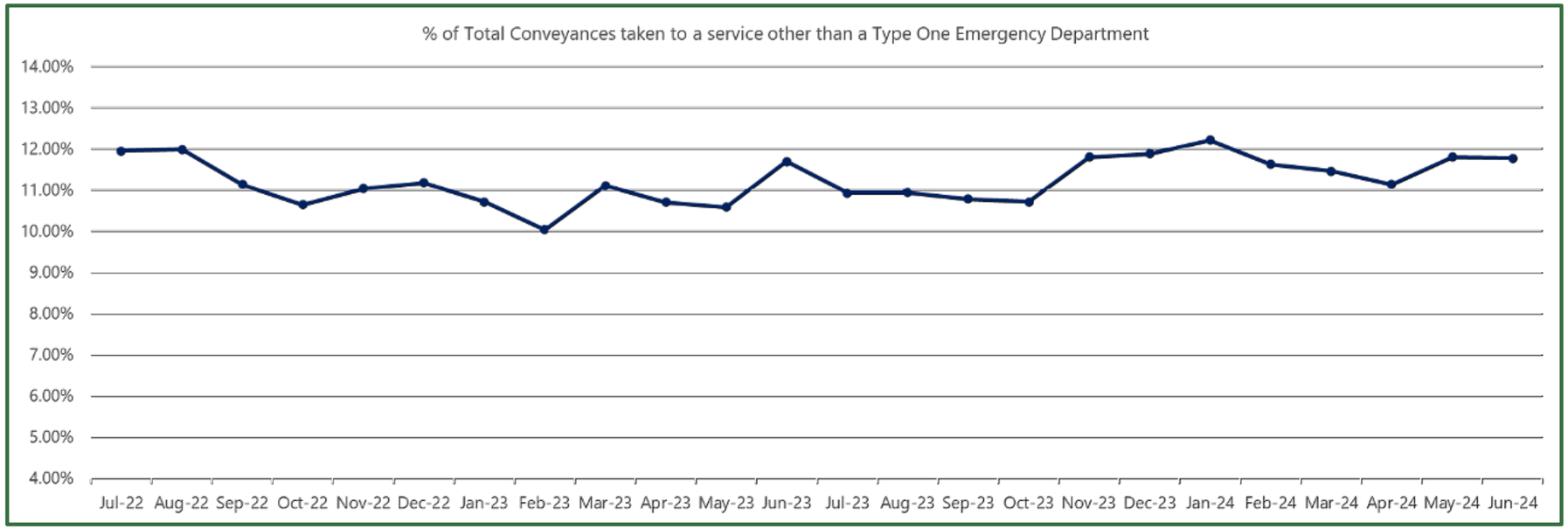
Partnerships / System Contribution
Conveyance to ED Indicators

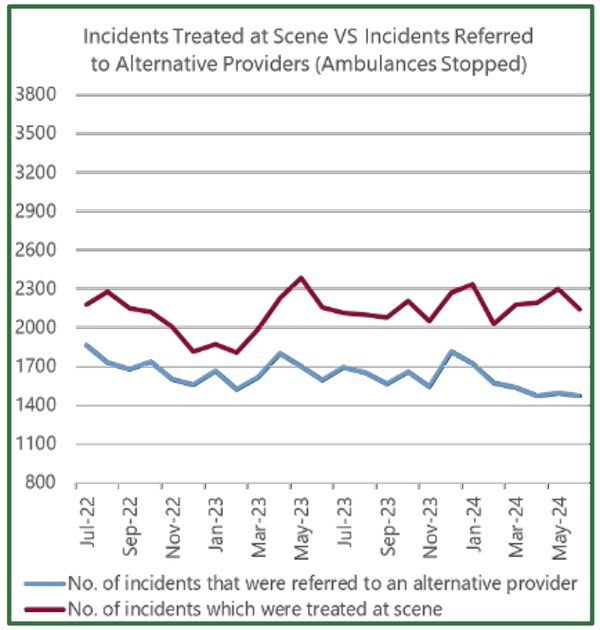
(Responsible Officer: Andy Swinburn)

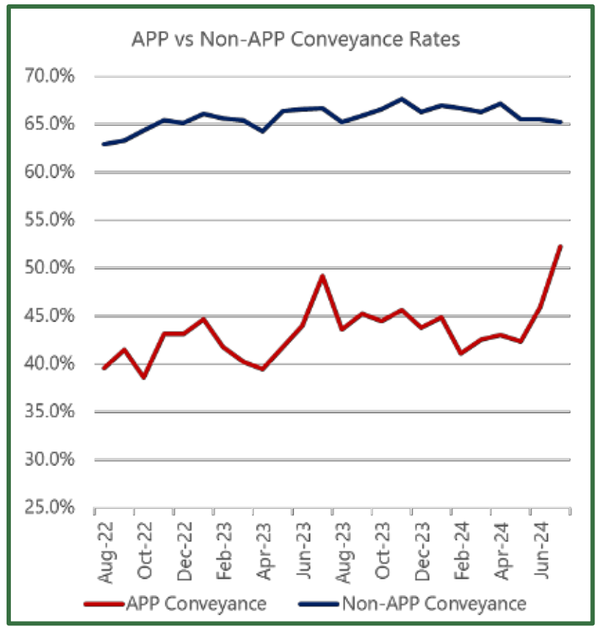
Conveyances
R

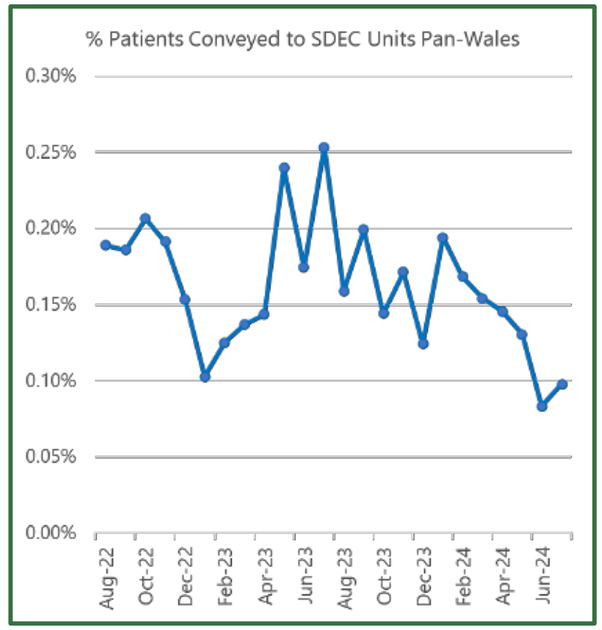
FPC

Ministerial Measure









Analysis

In June 2024 11.78% of patients (1,624) were conveyed to a service other than a Type One ED, while 34.8% of patients were conveyed to a major ED, as a percentage of verified incidents.

The combined number of incidents treated at scene or referred to alternate providers decreased slightly, from 3,792 in May 2024 to 3,619 in June 2024.

APP conveyance rates increased to 52.2% in July 2024 and continues to experience a generally increasing trend since March 2023; however, data quality issues around accurately capturing APPs on shift is likely to be contributing to discrepancies in this figure.

Patients conveyed to SDEC's remained low at 0.10%.

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 an APP Recruitment Task & Finish Group, with focus on re-rostering to demand keys, improved placement (training) experience and 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 evolve its clinical model with health boards also significantly reducing handover e.g. 12,000 hours or 7,500 hours, alongside varying levels of investment. Further in year tactical modelling for spring and summer has been completed.

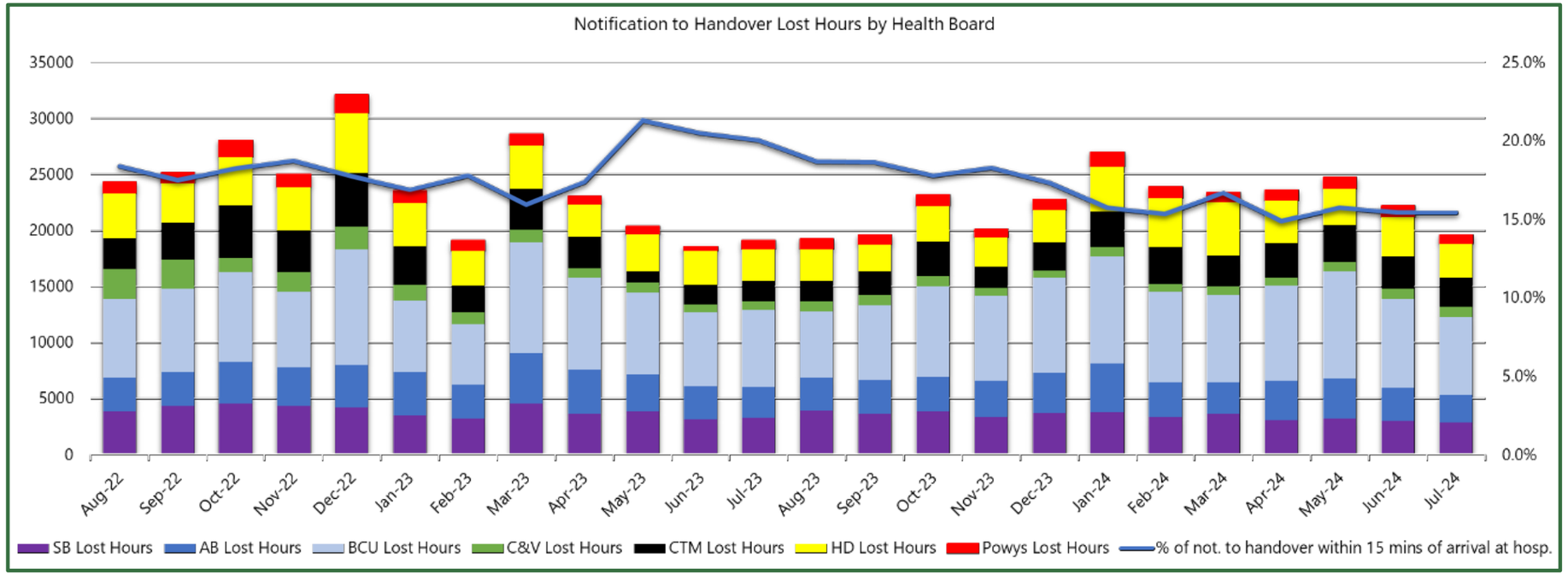
Partnerships / System Contribution Handover Indicators

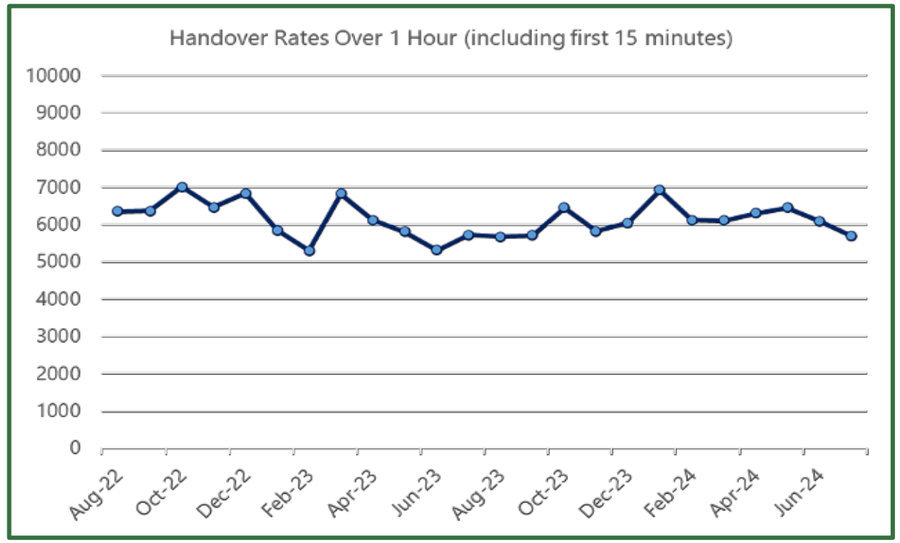
(Responsible Officer: Health Boards)

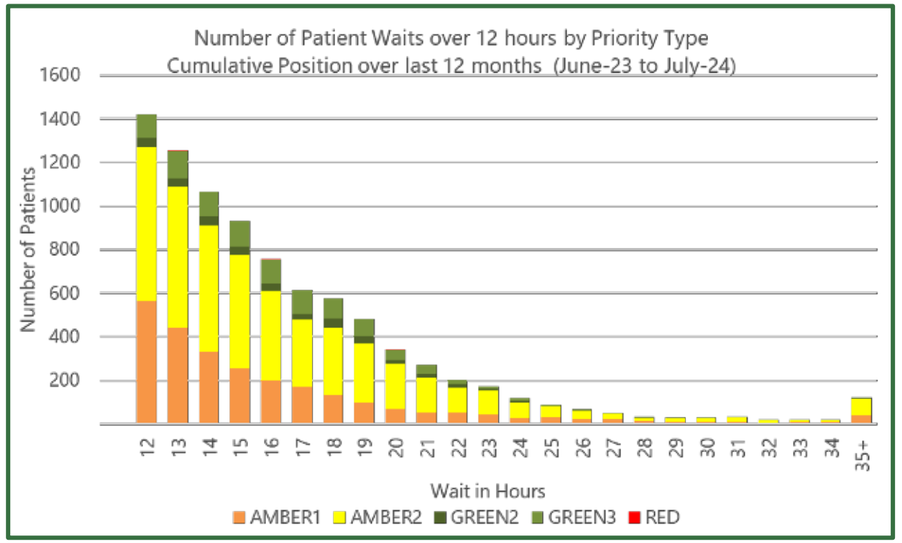
Lost Hours R

CI

QUEST







Analysis

269,434 hours were lost to Notification to Handover, i.e. hospital handover delays, over the last 12 months (Aug-23 to Jul-24), compared to 287,059 over the same timeframe the previous year. There were 19,595 hours lost in July 2024. The July 2024 figure is 2.3% higher than the figure recorded in July 2023.

The hospitals with the highest levels of handover delays during July 2024 were:

- Morriston Hospital (SBUHB) at 2,629 lost hours
- Maelor General Hospital (BCUHB) at 2,525 lost hours
- Ysbyty Gwynedd Hospital (BCUHB) at 2,374 lost hours
- Grange University Hospital (ABUHB) at 2,290 lost hours

Notification to handover lost hours averaged 632 hours per day during July 2024 compared to 741 hours a day in June 2024.

In July 2024, the Trust could have responded to approximately 6,090 more patients if handovers were reduced, which highlights the impact the numbers are still having on service.

In July 2024, 632 patients waited over 12 hours for an ambulance response and 46 compliments were received from patients and/or their families.

Remedial Plans and Actions

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

Expected Performance Trajectory

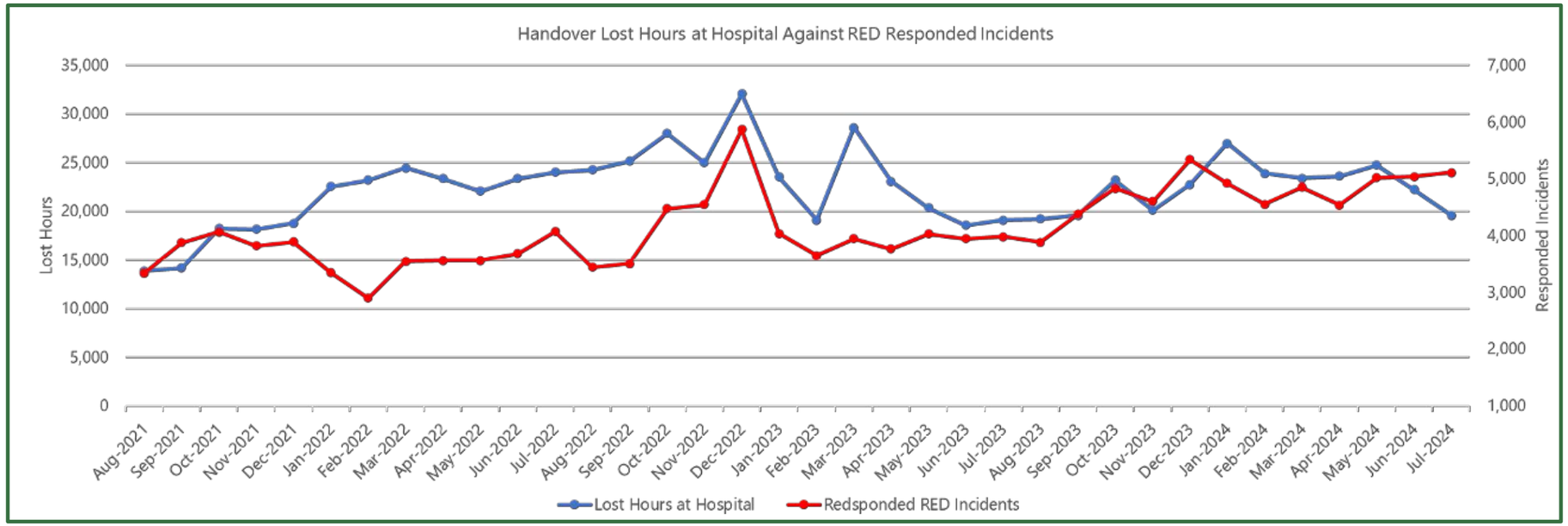
The Welsh Government handover target for 2024/25 is no waits over one hour; this equates to 7,500 hours lost to handover delays per month. There would need to be a 60% reduction in current handover levels for this to be achieved.

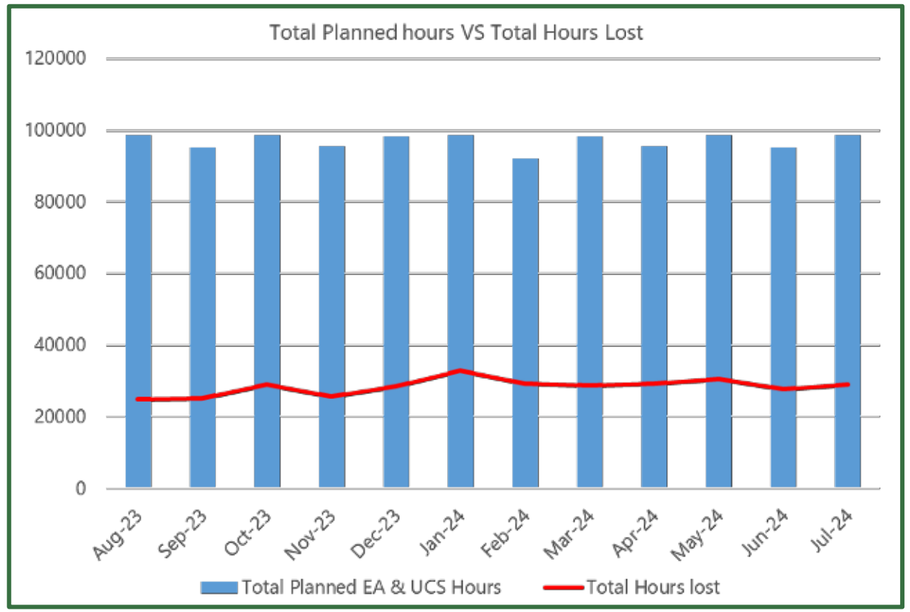
Partnerships / System Contribution

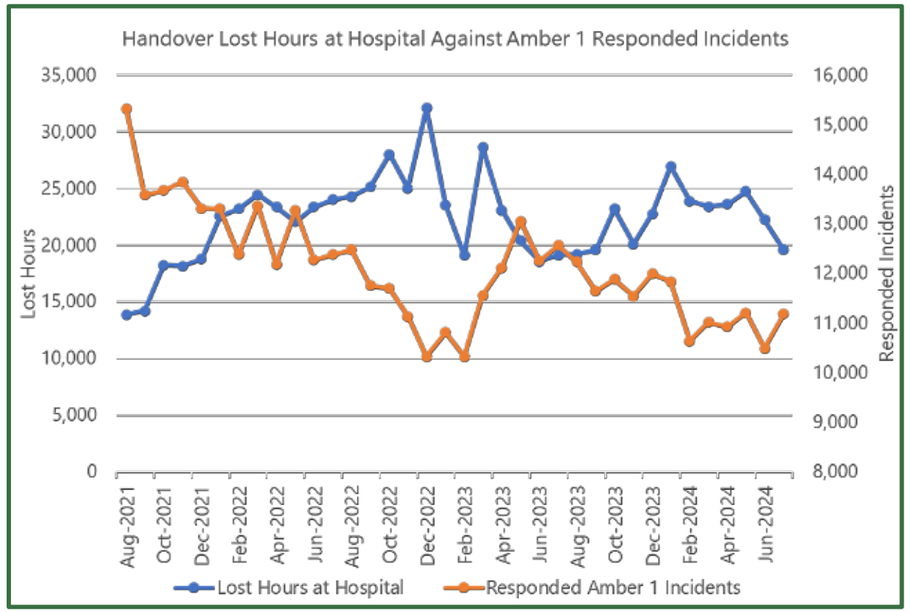
Handover Lost Hours Against Red & Amber 1 Responded Incidents

(Responsible Officer: Health Boards)

CI QUEST







Analysis

The top graph highlights that as handover lost hours have increased since July 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.

The bottom graph also highlights the correlation between lost hours and Amber 1 performance. As lost hours increase, so Amber 1 performance declines.

Remedial Plans and Actions

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

Expected Performance Trajectory

The Welsh Government target is that no patient handovers of more than one hour, which equates to 7,500 lost hours a month. Welsh Government want to see a 30% reduction by December 2024 as a move towards this target. The Trust is currently experiencing lost hours in excess of 19,500 hours, with handover in July 2024 2.3% higher than July 2023. Unless there is a material change in direction, the Trust is likely to see higher handover lost hours this winter than last.

**NB: Data correct at time of abstraction.*

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

Definition of Indicators

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

AGENDA ITEM No	**10**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**2**

WELSH AMBUALNCE SERVICES UNIVERSITY NHS TRUST
SAFEGUARDING ANNUAL REPORT 2023-24

MEETING	Quality, Patient Experience & Safety Committee
DATE	13 August 2024
EXECUTIVE	Liam Williams, Executive Director of Quality & Nursing
AUTHOR	Vicky Maxwell, Assistant Director of Safeguarding
CONTACT	vicky.maxwell@wales.nhs.uk

EXECUTIVE SUMMARY

The report is a celebration of safeguarding and demonstrates the Welsh Ambulance Services University NHS Trust's (the Trust) commitment to developing a culture of safety for our staff and patients. As a minimum the report provides information and assurance that the Trust has discharged its statutory responsibility during 2023-2024, in relation to the Children Act 2004, the Social Services and Well-being (Wales) Act 2014, the Violence Against Women Domestic Abuse and Sexual Violence (Wales) Act 2015 and that compliance with the Welsh Government Adult and Child Protection Guidance are being fulfilled.

In addition, the report reflects a commitment to developing high quality processes and behaviours beyond the mandated requirements.

RECOMMENDED: That the Committee

(1) Approves the Safeguarding Annual Report 2023/24, and
(2) Notes and considers the sustained increase in demand and the cumulative impact on the Safeguarding Team

KEY ISSUES/IMPLICATIONS

(i) Safeguarding reports to the local authorities continue to increase throughout 2023-2024. The quality of these Referrals remains consistent and the content appropriate, indicating a positive impact from training and case learning which has been cascaded. Doc-works continues to enable a user-friendly platform for reporting.

(ii) Prevent Referrals are now incorporated into the Doc-works system. The Trust is a leading organisation across Wales in mandating prevent training for all staff. A policy to overarch this central function is on the Safeguarding Team Workplan for 2024-2025.

(iii) The Safeguarding Maturity Matrix has been completed for 2023-2024 and is due for external submission by 26 July 2024. This is currently being reviewed for executive oversight and sign off by Liam Williams. Going forward into 2024-2025, this will be incorporated into the Safeguarding Strategic Group for scrutiny and sign off prior to external submission.

(iv) Safeguarding level 2 training compliance is showing below the target percentage of 85%. A missed opportunity to record learning completed during the 2022/23 Mandatory in House Training (MIST) Continuous Professional Development program has been identified as a contributory factor to the adverse effect on our compliance in these measures. A plan is in place to improve this position within 2024-2025.

(v) The core work of the Safeguarding Team has increased considerably over the year across all areas. Examples of this can be seen in Local Authority Strategy Meetings and enquiries, which has increased from 230 in 2022-2023 to 374 in 2023-2024 and Procedural Response to Unexplained Deaths in Childhood (PRUDiCs) which have increased from 57 in 2022-2023 to 66 in 2023-2024. This has impacted on capacity, and increased pressure is felt across the team.

REPORT APPROVAL ROUTE	
Senior Quality Leadership Team	23 July 2024
Clinical and Quality Governance Group	30 July 2024
Quality, Patient Experience & Safety Committee	13 August 2024

REPORT APPENDICES
ANNEX 1 - SBAR providing supporting background information
ANNEX 2 - Safeguarding Annual Report 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	YES
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 purpose of this report is to provide information on the Safeguarding Annual Report to members of the Quality, Patient Experience & Safety Committee.

BACKGROUND

2. The Safeguarding Annual Report provides an overview on how the Trust has performed during this reporting period in relation to safeguarding people in our care. It aims to give the Trust Board information on the impact of the pandemic in relation to the Trust's safeguarding activities as well as the necessary assurances that the statutory duties under the relevant safeguarding legislation and guidance are being fulfilled.

ASSESSMENT

3. The Safeguarding Governance Frameworks have continued to be part of everyday practices within the Trust during a continued challenging reporting period.

4. The data evidenced within this year's report demonstrates a further year on increase in the total number of reports submitted by Trust staff since the initial launch of Doc-Works. Feedback from Trust staff as well as our partner agencies acknowledge that this is an improved mechanism for submitting reports to Local Authorities across Wales.

5. Doc-works digitalised system has been supported by the Doc-works/TerraPace ePCR interface during this reporting period. This implementation aims to ease user ability between the 2 applications within the Trust.

6. The Trust's Annual Training Plan continues to support statutory safeguarding requirements, ensuring that staff are provided with the right level of training commensurate with their role. This report illustrates compliance of 75% for Level 2 Safeguarding Children and 71% Level 2 Adult Safeguarding Training (Target set at 85%) and 83% for Group 1 training as required under the Violence Against Women, Domestic Abuse & Sexual Violence (VAWDASV) National Training Framework (NTF).

7. **Violence against women, domestic abuse and sexual violence**. This section of the Safeguarding Annual Report outlines the VAWDASV National Training Framework Training Plan for the Trust. The Plan for the Trust was reviewed and updated following consultation with the Welsh Government VAWDASV Team. Trust compliance with the NTF is included in an Annual NTF Report to Welsh Government submitted May 2024.

8. There is a fundamental obligation for all agencies involved in the care, support and protection of those at risk ensuring the highest possible standards of that care, support and protection are provided and maintained at all times. Part of this obligation is a requirement to learn from mistakes, especially those resulting in the death or serious injury of an individual at risk.

9. This Report includes information on Trust activity generated by our 'Duty to Cooperate'. The Trust Safeguarding Team has worked in partnership with other agencies as required in all Safeguarding activities including PRUDiC, Adult and Child Practice and Domestic Homicide Reviews and Safeguarding Strategy Meetings. There has been a noticeable increase in the Trust collaborative safeguarding activity associated with core business. This has impacted on capacity within the team.

RECOMMENDED: That the Committee

(1) Approves the Safeguarding Annual Report 2023/24, and

(2) Notes and considers the sustained increase in demand and the cumulative impact on the Safeguarding Team.

Welsh Ambulance Services University NHS Trust



Safeguarding Annual Report 2023-2024

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

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01792 315884

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Moving Forward



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Introduction

The safeguarding annual report provides the Trust Board with the necessary assurances that the statutory duties have been met as required under the Social Services and Well-being (Wales) Act 2014, the Violence Against Women Domestic Abuse and Sexual Violence (Wales) Act 2015, the Children Act 2004, and the Wales Safeguarding Procedures.

It provides an overview on how the Trust has performed over this reporting period in relation to safeguarding people in our care. Priority is given within the report to evidence the significant increase in safeguarding activity within the organisation; to celebrate the success and achievements of the dedicated Safeguarding Team as well as sharing the good practice of WAST colleagues, our improved safeguarding systems and processes and how we have learned from our experiences.

The Executive Director of Quality and Nursing is the executive lead for safeguarding within WAST. The Assistant Director of Safeguarding has responsibility as Named Professional for Safeguarding Children as well as Adults at Risk. This role ensures the Trust's compliance with Statutory Legislation and Guidance above.

The Assistant Director of Safeguarding takes the organisational strategic lead on all safeguarding related issues. This includes working with the Regional Safeguarding Boards on matters of mutual interest as well as on topics of regional and national importance. This engagement supports the objectives of Welsh Government, Public Health Wales, the Community Safety Partnerships, the Older Persons Commissioner and the Childrens Commissioner for Wales.

Whilst Local Authority hold an overarching Corporate Parenting role to safeguard and promote the rights and life chances of care experienced children and young people; WAST are committed to supporting this role in safeguarding those who have contact with our service.

The Welsh Ambulance Services University NHS Trust's (WAST) success in safeguarding continues to be driven by an effective organisational culture; one with values and behaviours which foster professional curiosity, encourages scrutiny and supports the actions required to protect those at risk of abuse or in need of care and support.

The Safeguarding Team works collaboratively with senior managers and colleagues within WAST to promote an unequivocal safeguarding culture, both articulated and lived at each level in the organisation. External partnership working is also integral to the team's role; WAST contribution to the work of our partner agencies will be highlighted in this report.







1. Safeguarding People

Safeguarding People within this report for 2023-2024 relates to the WAST's Safeguarding activity.
The Safeguarding Team's priority is to ensure that WAST colleagues provide safe and effective care which protects people at risk of abuse and neglect as well as those in need of care and support.
WAST compliance with the requirements from the Children Act 2004, Social Services and Well-being (Wales) Act (SSWA) 2014, Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 (VAWDASV), as well as the Health and Care Quality Standards – Safe, is demonstrated by this activity.

Reporting Rates

The number of reports submitted by WAST has continually increased since the initial launch of the digitalised mechanism for submitting safeguarding reports (Doc-works) in 2019. Consideration may also be given to the current inequalities reported for Wales and potential impact on concerns identified.

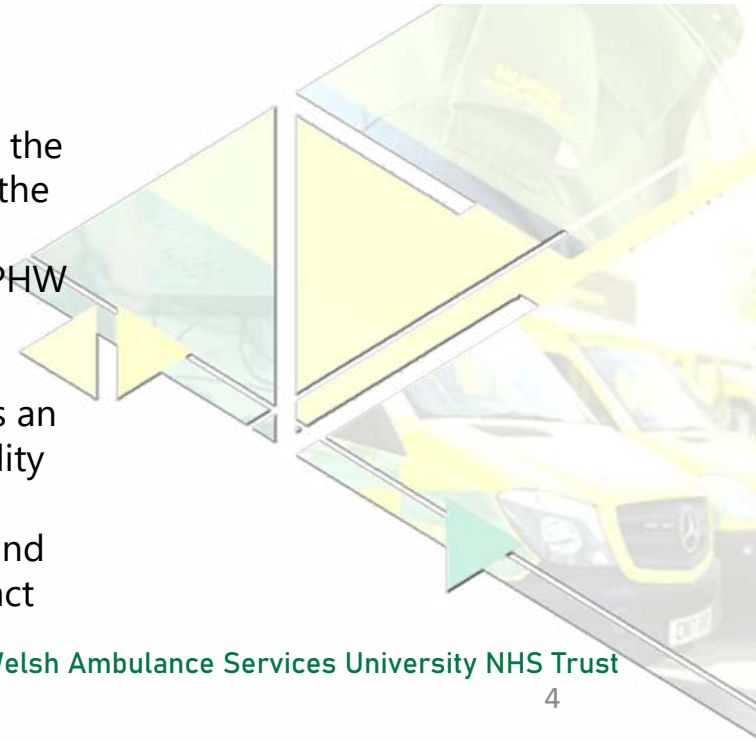
The last three reporting periods demonstrate an increase in reporting rates as shown in Table 1.

Table 1

Report Type	2021/22	2022/23	2023/24
Child at Risk	1,303	1,138	1,698
Child in need of care and support	853	775	929
Adult at Risk	1,106	1,419	2,210
Adult in need of care and support	3,785	4,605	6,287
Total	**7,047**	**7,937**	**11,124**

This data provides a further breakdown of the report types submitted. It is possible that the increase may be linked to the widening inequalities acknowledged within Wales (PHW 2022).

The more recent rise in the cost of living is an additional pressure which increase inequality within our communities. This in turn may impact on the incidence of safeguarding and social care needs of those who have contact with our services.



Reports per Health Board Area across Wales

Identifying and protecting people from actual or potential harm requires that reports are made to the relevant Local Authority as aligned to the appropriate Health Board area. Local Authorities are responsible for taking the required action in relation to the nature of harm involved.

The Safeguarding Team has continued to progress WAST colleagues' skills and understanding of the Safeguarding thresholds met, to ensure that the reports made to Social Services are appropriate and in accordance with the required standard.

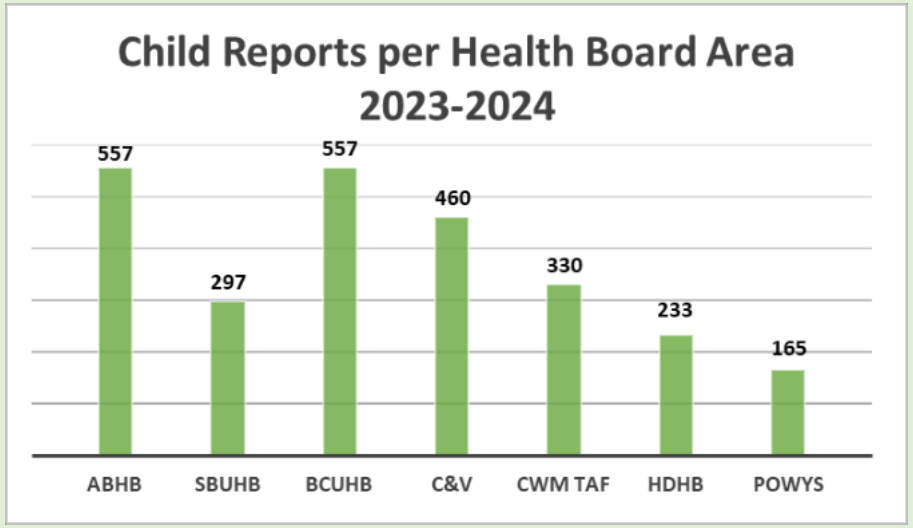
Whilst the information gathered may be limited due to the nature of our contact; it contributes to the understanding of safeguarding issues collated in the wider safeguarding arena across Wales.

The following graphs illustrate both child and adult reports submitted by WAST per Health Board area across Wales.

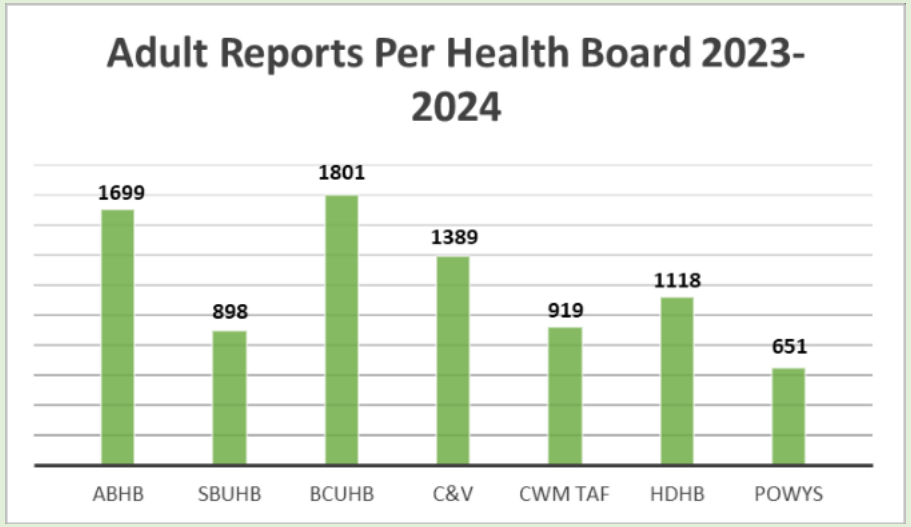
This data highlights the contribution WAST colleagues make in ensuring that Adults and Children who have contact with our service are safeguarded.

In addition to the reports made to Local Authorities within Wales; WAST colleagues also reported **28** concerns for children and **22** for Adults to the other relevant Authorities in the UK.

Graph 1



Graph 2



VAWDASV Related Reports to Local Authorities

Our priority is to ensure that WAST colleagues provide safe and effective care which protects people at risk of abuse and neglect as well as those in need of care and support.
This involves reporting concerns appropriately to the relevant agencies and utilising appropriate pathways which further support victims of domestic abuse and sexual violence following contact with our service.

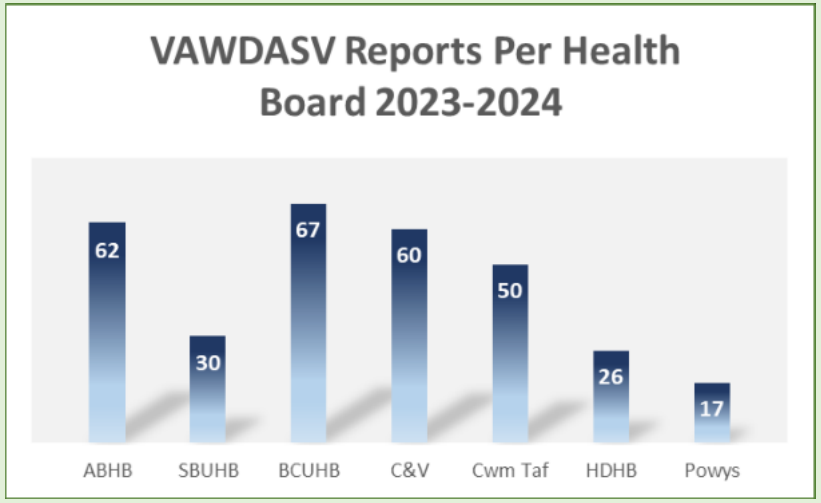
Graph 3 illustrates WAST VAWDASV related reports made per Health Board area across Wales during this reporting period (Total of **318**).

Chart 1 illustrates the reports made for adults and children

In addition to this WAST utilises a Pathway to facilitate contact with the specialist services of the Live Fear Free helpline which supports the aim of early identification, intervention and support for persons involved in these issues.

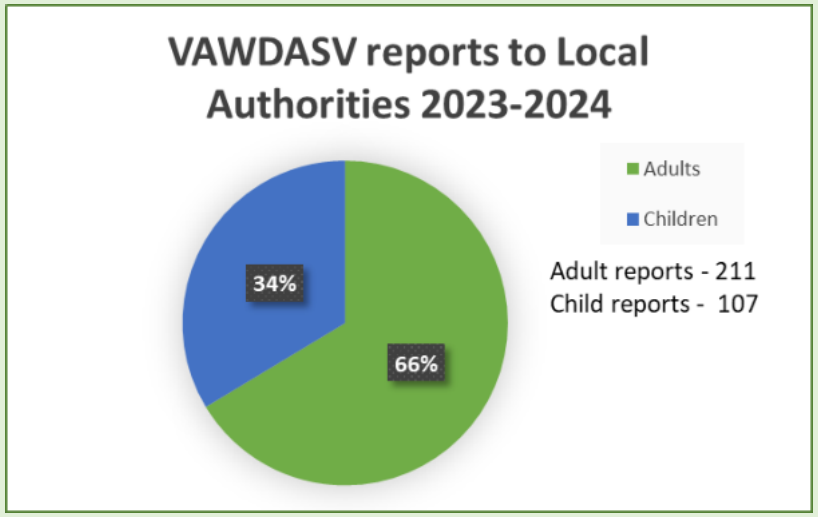
The Safeguarding Team's launch of the national Group 2 "Ask and Act" training delivered as required under the National Training Framework enables practitioners to utilise WAST procedures to report to Local Authority as well as using the Pathway to Live Fear Free as appropriate to the circumstances of the person involved.

Graph 3



In addition to the above data 6 reports were also made where there was no Health Board identified

Chart 1



WAST Pathway to Protect Victims and Survivors of Domestic Abuse

The Social Services and Wellbeing (Wales) Act 2014, the Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015, 10,000 Safer Lives Domestic Abuse Project and NICE; recommended an improved multi-agency service delivery with integrated care pathways for identifying, referring and providing interventions to support people who experience forms of domestic abuse and sexual violence.
WAST Safeguarding Team initiated an appropriate pathway for facilitating contact with the specialist services of the Live Fear Free helpline with support from both the helpline manager and the projects and innovations manager from Welsh Women's Aid. The pathway has now been digitalised for WAST iPad users and provides an additional mechanism for colleagues to support victims and survivors who may have suffered from these issues.

Live Fear Free Helpline

"The Live Fear Free Helpline has worked in partnership with the Welsh Ambulance Service since November 2013 to ensure that victims of Domestic Abuse and Sexual Violence in Wales are given a wraparound service to keep them safe. Without doubt this has been a vital lifeline for some of the most vulnerable people in our communities and the feedback from those supported has been so positive.

Working with the WAST Safeguarding Leads has been seamless with a genuine desire on both sides, not only to make the current processes work but to expand on the support offered. This saw the initial referral pathway started more than 10 years ago, further expand in December 2023 to include concerns now being raised by 111/999 Call Handlers and triage nurses. Again, such positive steps to help keep our citizens safe.

The "can do" attitude between both WAST and the Live Fear Free Helpline has been instrumental in making this partnership a success and constant dialogue means issues are resolved as soon as the occur. Long may this continue."

Ann Williams, Live Fear Free Helpline Manager (February 2024)



Live Fear Free Pathway

135 Referrals submitted during 2023-2024



- Pathway digitalised for **all** WAST colleagues
- Since November 2023 colleagues in NHS 111 Wales and CSD are now able to complete digital referrals to Live Fear Free.
- Free 24/7 helpline for anyone in Wales who is experiencing Domestic Abuse or Sexual Violence
- These figures cannot capture the contacts where WAST colleagues provide service users with the helpline number
- Helpline is available to all WAST colleagues and volunteers for specialist advice and support
- Colleagues are reminded that an adult or child safeguarding report may also be required

Scribe

Referral numbers have more than trebled since last year.
This may be attributed to the improved mechanism for reporting concerns.

Fire Risk Referral Pathway

Due to the nature of our service WAST are in a unique position to identify home fire risks.

Making every contact count with our service users.

Chart 2

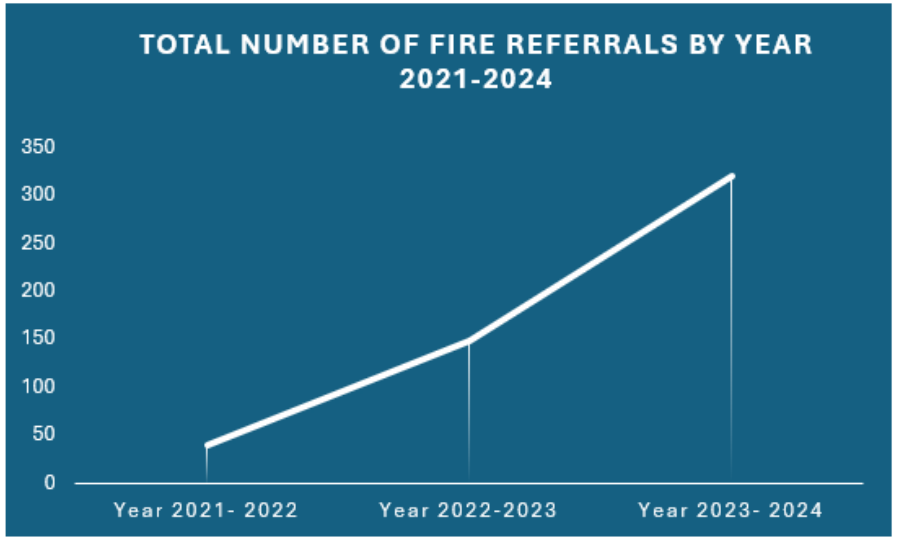
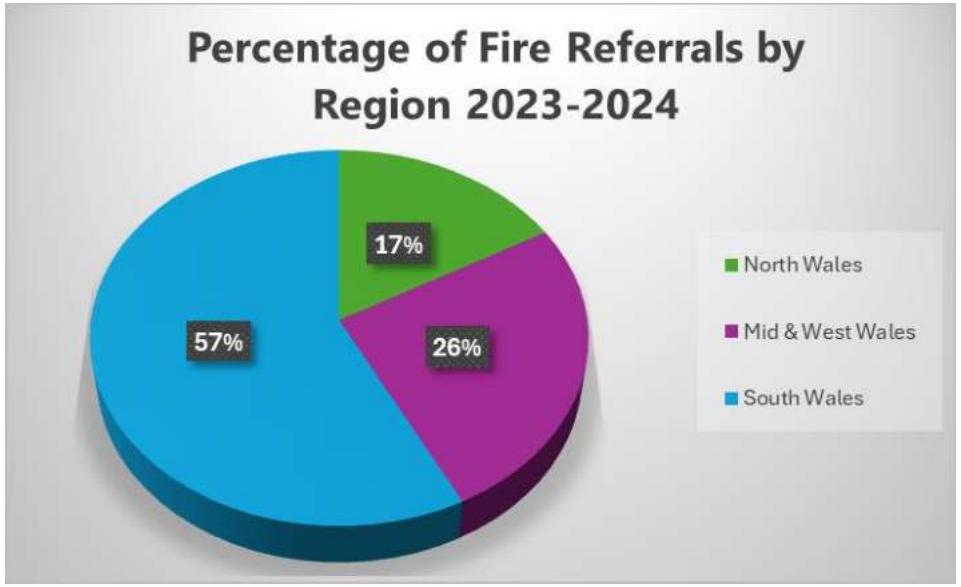


Chart 3



320 Fire Risk Referrals
submitted to our Fire & Rescue Services Partners (FRS) during this reporting period.

- Significant increase in the submission of Fire Risk Referrals this year (chart 2)
- The referral process enables WAST colleagues to request that the local FRS get in contact to **offer support** or conduct a **home safety check**
- Colleagues complete a referral on Doc-works, and it is e-mailed directly to the relevant FRS
- Streamlined and time-efficient collaborative referral process to protect some of the most vulnerable individuals within our communities in Wales

Expansion of Services available through Doc-works Scribe

Doc-works Scribe now being used for 2 new referrals:

PREVENT Referrals



Dementia Concern Referrals

Home Office

- Digitalising the 'All Wales Prevent Partners Referral' form
- Enabling WAST colleagues to share information quickly & efficiently where they have radicalisation concerns



Alzheimer's Society United Against Dementia

- A new bespoke referral pathway to Dementia Connect (part of Alzheimer's Society)
- For any dementia related concern (confusion, memory loss or issues with communication or daily routine)
- Carers who may need additional support can also be referred.

Celebration - Safeguarding Award

Mid and West Wales Regional Safeguarding Board - Practice Awards 2023

Significant Wider Community Safeguarding – Practice That Has Had a Positive Impact on the Community in the Safeguarding of Children or Adults

The Safeguarding Team at WAST were highly commended for the work undertaken in developing and delivering a new electronic system that enabled the development of a new referral pathway in collaboration with colleagues in the Fire and Rescue Services pan Wales.

This allows our staff to refer patients and service users directly into the Fire Service Home Safety teams where they identify fire safety issues in a property, evidence of hoarding, or where a patient with a sensory disability would benefit from specially adapted smoke alarms.



- The Doc-works digital reporting system has been integral in ensuring there is a consistent approach in the mechanism used in sharing information
- Improved the accessibility of safeguarding forms for colleagues
- There has been a continual improvement with the quality of information captured within the reports

Extract from the Awards June 2023

Gwasanaeth Tân ac Achub Canolbarth a Gorllewin Cymru
Mid and West Wales Fire and Rescue Service

2. Education and Training

The Trust's annual training plan continues to support statutory safeguarding requirements. Working in partnership with our dedicated training teams across WAST to establish a robust training program for all aspects of safeguarding.

Level 2 Safeguarding Training

The Safeguarding Team continue to provide face to face or virtual sessions to all CCC, ACA, EMS and NHS111 colleagues across the Trust.
We delivered safeguarding training sessions to 31 induction groups. This is lower than last year when we delivered 54; This may be attributed to the recruitment drive following the COVID 19 period.

Level 2 compliance

WAST has achieved 75% compliance for child safeguarding and 71% for adult safeguarding training during this reporting period. It is acknowledged that some data was not captured on ESR. This will be addressed during the next reporting period.

CPD

In addition, the Safeguarding Team have offered a variety of CPD sessions utilising Eventbrite.

Adolescent Audit Webinar

Following an internal audit of safeguarding children and young adults, learning was identified and made available through two targeted CPD webinars available on our learning platform.

Over **400 WAST colleagues** completed this training package since its launch.



SWAY Training package on Child Sexual Exploitation

On Child Sexual Exploitation Day in March 2024, WAST launched new virtual CPD training. Colleague feedback stated it raised their awareness, is a useful refresher on CSE indicators and re-enforced the importance of professional curiosity.



WAST National Training Framework progress

WAST "is required to incorporate training for Groups 1, 2, 3 and 6 into their existing learning and development framework and submit to the Welsh Ministers their own training plan, training needs analysis and annual plan based on this".
The Plan for WAST was reviewed and updated in April 2023 and included in an Annual National Training Framework (NTF) Report to Welsh Government in May 2023.

Group 1

The purpose of group 1 of the National Training Framework is to ensure that all employees of the relevant authorities have a basic level of awareness of violence against women, domestic abuse and sexual violence. The intention of training is to challenge attitudes and raise awareness of these issues.

Table 2 illustrates the progress made since launch in 2019 to March 31st, 2024. The number of staff who have completed Group 1 training has been determined by the WAST Online Learning Management and training department records which are recorded on WAST electronic staff records at the time of this report.

In working towards achieving compliance towards Group 1 opportunities were identified as follows:

- Group 1 training is included on induction training across the Trust. This continues to be achieved utilising WAST online Learning for those with access to ESR.
- WAST enabled guest access to ESR for new starters for those not already signed in to ESR

Table 2

Total per Group	Total completed	% compliance
4,501	3,944	83%

Live Fear Free Helpline
Llinell Gymorth Byw Heb Ofn
0808 80 10 800

Group 2

Group 2 training under the NTF focusses on "Ask and Act"- a principles-based approach of targeted enquiry.

The objective of this is to enable practitioners to "Ask" potential victims and survivors when concerns relating to VAWDASV are identified ; and "Act" so that suffering and harm is prevented or reduced.
WAST total Group 2 colleagues on 1st April 2023 was 2836. Total trained from launch to date is 1621 (80%).

Learner Feedback



98% would recommend the training



Group 3

Individuals who are required to do more than "Ask and Act"; those who perform a 'champion role'.

The training will enable people to:

- support colleagues as they make decisions in relation to these subject areas
- help offer services to all family members affected by violence against women, domestic abuse and sexual violence and act as a champion within their organisation

WAST target is to train 20 individuals per year. Training was commenced in this reporting period.
14 Group 3 colleagues currently trained within WAST.

WAST Trainer Trainers

- WAST has 8 accredited Group 2 trainers currently contributing to the delivery of Ask and Act
- 7 accredited Group 3 trainers

All trainers work as specialists within WAST Safeguarding Team and so deliver the training in addition to their core safeguarding responsibilities.

WAST Safeguarding Conference 2023

In June 2023, the Safeguarding Team held a safeguarding conference on 'Trauma Informed Workforce'. Attendees included:

- Colleagues from across different WAST directorates
- Representatives from external partner agencies; 2wish, Mind & South Wales Fire & Rescue Service
- Safeguarding leads from other UK ambulance services

Specialist presentations on safeguarding all age groups & **impactful survivor stories:**

- Public Health Wales shared insights into adverse childhood experiences & trauma informed practice; highlighting the importance of empathy and compassion.
- Ruth Dodsworth, ITV journalist, shared firsthand experience of domestic abuse and controlling coercive behaviour: emotional & enlightening
- 'Lads Like Us' gave their lived experiences of abuse during childhood and evidenced real-life significance of practitioners demonstrating professional curiosity and adopting trauma informed practice.
- The Live Fear Free Helpline Manager provided invaluable information regarding what support the helpline can provide
- The Older Peoples Commissioners Office provided shocking statistics in relation to older people experiencing abuse. A survivor graciously shared his experience of abuse later in life; impactful and empowering

Diolch / Thank You to all involved







Feedback

Informative

Powerful

Humbling

Inspiring

3. Partnership Working



The Safeguarding Team sits within the Quality, Safety and Patient Experience Directorate to carry out a necessary corporate function as well as supporting the specific work of the Directorate. Our commitment to delivering high quality care in safeguarding has been clearly demonstrated by achievements highlighted in previous reporting periods. Effective, compassionate leadership, courageous management and innovation have been integral to our success.

The Safeguarding Team achieve our safeguarding objectives by effectively working together with a wide range of services and professionals, ensuring good outcomes for people who have contact with our service.

This requires the Safeguarding Team to establish strong relationships with all departments in our organisation as well as within the wider safeguarding arena across Wales.

Our achievements obtained through improved knowledge, skills and attitudes as well as the promotion of our engagement with safeguarding multiagency activity has fortified our working relationships both at an operational and strategic level.

The Wider Safeguarding Arena

National Ambulance Safeguarding Advisory Group (NASAG)

The purpose of this group is to promote a consistent approach to safeguarding across the UK ambulance services. To connect, support and guide the safeguarding practice of its practitioners across the UK.
The Assistant Director of Safeguarding for WAST was Vice Chair and regularly attended this group.

WAST Safeguarding Team contribute to the work of the group and participate in an annual benchmarking exercise to assess and analyse safeguarding activity.

Collaborative Working

During this reporting period the WAST Safeguarding Team hosted two other UK Ambulance Services.

They visited to view and learn about the Doc-works Scribe system used to digitally report safeguarding concerns.

There were opportunities to share information about good practice and consider development opportunities

Public Health Wales
Procedural Response to Unexpected Deaths in Childhood (PRUDiC)

The reviewed guidance was published in February 2023.

WAST plays a significant role in the PRUDiC process from the initial alert to Police through to attendance at the Phase 1 information sharing and planning multi-agency meeting.

The Safeguarding Team continue to complete organisational requirements in accordance with the PRUDiC guidelines, ensuring a consistent approach and that learning is disseminated throughout the Trust.



Welsh Government
Single Unified Safeguarding Review (SUSR)

WAST Safeguarding Team took an active role in the work of the task and finish groups across Wales during the consultation process in the last reporting period.

Welsh Government continue work in relation to the introduction of SUSR process.

The Welsh Government implementation plan has been delayed and the Safeguarding Team members will keep appraised and attend SUSR training as it becomes available.



Following a report, social services have a duty to make enquiries under s126 of the Social Services and Wellbeing (Wales) Act 2014. As a recognised "relevant partner" of the Local Authority, WAST has a legislative responsibility to participate in any enquiries or strategy meetings/discussions that may be undertaken.

The aim of the process is to focus on the needs of the vulnerable person and allow agencies to appropriately share information, identify risks and take specific action.

The Safeguarding Team may need to access a variety of WAST systems and work collectively with many directorates within WAST to gather the appropriate information to support the process.

This activity has continued to increase during this reporting period, 230 last year compared to 374 during this reporting period as demonstrated in Graph 4.

Graph 4



WAST Colleague Enquiries

The Safeguarding Team work collaboratively with colleagues within WAST and external agencies to ensure positive outcomes for children and adults at risk of harm.

During this reporting period the team started to collate data on the number of enquiries received from WAST colleagues.

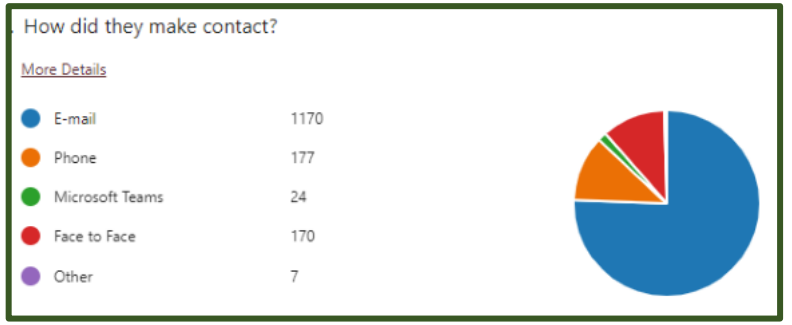
This includes responding to all enquiries related to safeguarding, as well as providing feedback to inform future practice.

Over 1,500 colleague enquiries were recorded, the most common reasons were:

- Doc-works Scribe
- Reflective / Retrospective Safeguarding Advice

The most recorded reason for the team contacting colleagues was:

- Requesting further information as not enough details on a safeguarding report
- Providing Feedback on cases from Local Authorities



Over 1,500 enquiries recorded

Regional Safeguarding Board's Activity

The amount of activity generated by our duty to cooperate with Adult/Child Practice Reviews and Domestic Homicide Reviews has continued to progress during this reporting period. The Assistant Director of Safeguarding and Senior Safeguarding Specialists have ensured strategic engagement at the board level, whilst the Safeguarding Specialists engage as panel members as required .

During 2023-24 the team have continued to engage with ongoing reviews at the end of the reporting period this involved; 7 APR's, 4 CPR's and 7 DHR's.

The following tables demonstrates WAST's engagement with new APR, CPR, and DHR processes during this reporting period:

Table 3

Adult Practice Reviews		
2021-2022	2022-2023	2023-2024
3	4	3

Table 4

Child Practice Reviews		
2021-2022	2022-2023	2023-2024
5	5	2

Table 5

Domestic Homicide Reviews		
2021-2022	2022-2023	2023-2024
4	6	4

Learning from Reviews

Learning Events are an integral part of the review process as the information gathered from attending practitioners within this forum will often identify key learning themes and help shape the published report and action plan. The Safeguarding Team has continued to support WAST staff required to attend these events during 2023-24.



The Safeguarding Team also has responsibility for sharing the learning generated from the review process across the organisation.

This is achieved through a variety of different methods such as 7-minute briefings, Newsletters, or inclusion of relevant themes into training packages and on the Safeguarding SharePoint page.

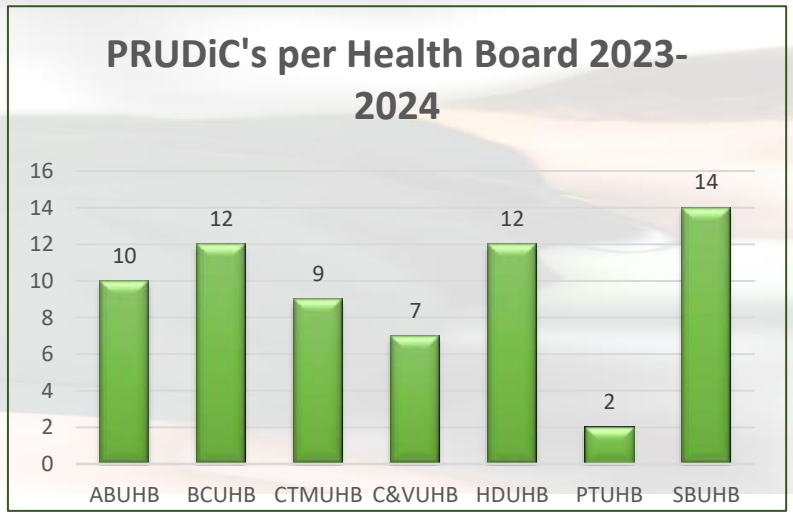


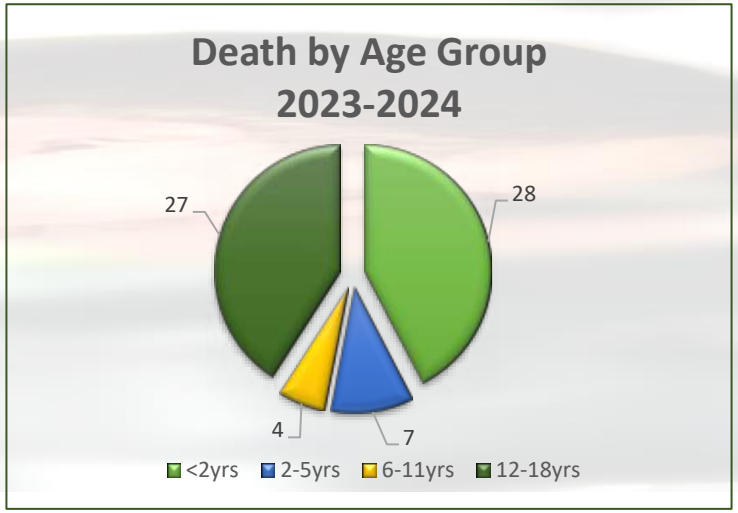
Welsh Ambulance Services University NHS Trust

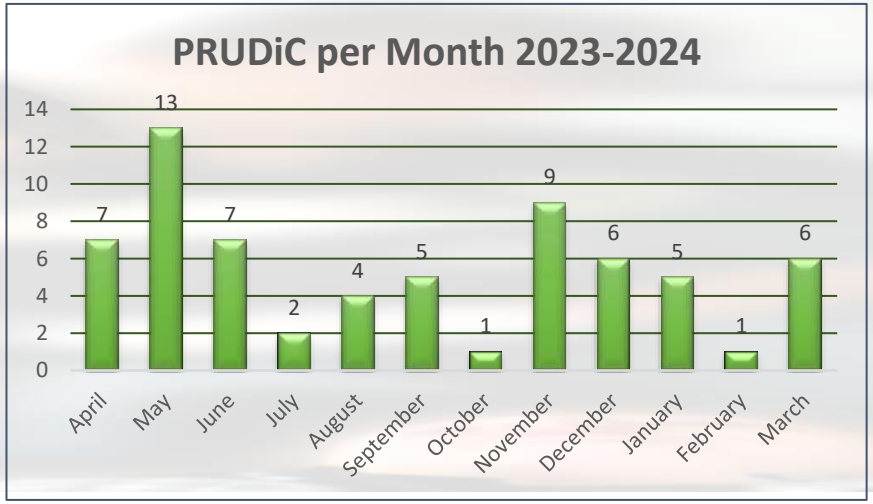
Procedural Response to Unexpected Deaths in Childhood (PRUDiC)

The PRUDiC guidance sets a minimum standard of response to unexpected deaths in childhood. It applies following the death of a child which was not anticipated as a significant possibility 24 hours before (PHW 2022). During 2023-2024 WAST was involved with 66 PRUDiC's in total, compared with 57 in 2022-2023.

- **15** involved infants
- **10** road traffic collisions which involved all age groups
- **8** involved children with pre-existing health issues or comorbidities.
- **6** completed suicides (within 12–18-year age group)
- **4** drownings, prevalent during the summer months
- **2** possible non-accidental injuries







WAST is a key contributor to Public Health Wales (PHW) in recognising themes and trends across Wales. The information/data is utilised to shape policy and inform practice with the intention of preventing future deaths e.g. an example of this is Safer Sleep guidance for families with young babies. In addition to this, PHW have published a water safety booklet to raise awareness of the risks.

It is recognised that these can be traumatic incidences and every effort is made to ensure colleagues are supported, in addition to the usual supporting mechanisms 2Wish provide specialist support to anyone involved in a PRUDiC incident.

WAST Additional Partnership Working

Adult Safeguarding Alerts
Specific information is shared relating to specific safeguarding arrangements/needs.
11 alerts relating to adults were placed on our alert system in 2023-24

Protecting the unborn -Specific information is shared and a pre-warning given to practitioners the aim of which is to give responding crews prior information on the existence of an agreed plan of care or safeguarding requirement. **89** midwifery alerts actioned by WAST in 23/24

Thematic Reviews – WAST Safeguarding Team engage with the thematic reviews instigated by the PHW child death review panel. The information obtained from each review is then utilised to formulate National health or safety campaigns to help protect the public.

Annual Partnership Reports – WAST Safeguarding Team contribute to the Partnership Reports to the Boards across Wales as requested. This ensures wider understanding of the safeguarding activity and experiences of our organisation.

Childline offers a unique service to help young people in the UK**.** WAST Safeguarding Team works with Childline when we have provided care for a child who has contacted them. We have responded to **26 childline** enquiries during this reporting period

WAST Safeguarding Team
contribute to the work of various regions across Wales by participating in the development and delivery of safeguarding training to external partner agencies.

Child Protection Alerts
Specific information is shared relating to the safeguarding arrangements in place for families with children who may have contact with our service. 8 child alerts were placed on our alert system in 23/24.



Partnership Working In Practice

Good News Story

WAST Safeguarding Team were contacted by Adult Social Services who needed urgent assistance. An elderly, bed bound lady with complex needs living in the community had suddenly lost her live in carer during that day.

This individual was not able to care for herself and was not safe to remain within her own home alone. The Social Worker had managed to get emergency care for her in a nursing home; however, they had no method of getting her there.

Following several discussions with Ambulance Care colleagues, a plan was created to risk assess the property first thing the following morning. The Social Worker arranged temporary emergency care overnight until transport was possible.

A hospital admittance was avoided for this lady, and the minimal disruption to her life caused following a traumatic incident. An excellent example of multi-agency working to ensure safe patient centred care.





CFR Conferences



The Safeguarding Team were invited to speak at both the North and South CFR conferences during the last reporting period.

The conference covered a range of topics, the Safeguarding Team presented on safeguarding with a particularly emphasis on “Human Trafficking” and “Modern Slavery”.

Recognising there is often an incorrect perception that modern slavery does not happen in Wales; the session highlighted the need to be vigilant within our communities. Signs, symptoms and indicators were shared, highlighting what to look out for and reinforcing how well-placed volunteers within the community are to recognise and report safeguarding concerns.

The conferences were brilliant opportunities for the Safeguarding Team to meet WAST volunteers in person and to share with them important safeguarding information. We saw an increase in volunteer enquiries to the team immediately after the conference.

Diolch yn Fawr

4. Quality Improvement

The Safeguarding Team's approach to quality and quality improvement for this reporting period has been to focus on achieving the requirements set within the Safeguarding work plan 2023-24. This aims to achieve our targets within the WAST Quality Strategy (2021-24) and prioritises our contribution in delivering the Integrated Medium-Term Plan; as well as to identify any actual or potential risks to deliverables during this reporting period and beyond.

WAST is required to report on the safeguarding position of the organisation both internally and externally. The safeguarding work plan provides the focus for improving quality as part of the organisation's internal strategy but also incorporates the requirements included in standards and outcomes set by external reporting mechanisms. The safeguarding work plan & assurance framework is mapped to the Health and Care Quality Standards (2023), specifically relating to the domain "Safe". The outcome of which is to ensure *our service users are protected from harm and protect themselves from harm.*

The principles of Prudent Healthcare are considered throughout, recognising continued progress is always required to integrate the principles into our safeguarding operational framework.



The following table illustrates the priority areas for achieving this by focussing on the key deliverables specified within the Safeguarding work plan for 2023/24.

Safeguarding Priorities 23-24			
Safeguarding Activity	**Training and Education**	**Policy and Procedure**	**Safeguarding Processes**

Progress 2023-24

Safeguarding Activity
- Monthly and quarterly reports completed and approved.

Training
- Safeguarding Training level 2 delivered as required
- Bespoke sessions delivered utilising Eventbrite
- A bespoke safeguarding CPD webinar published on LMS365
- ***NB :*** *Collation of training data will be reviewed during the next reporting period.*

Policies and Procedures
- Require review, work ongoing

Safeguarding Processes
- Continue Doc-works expansion

“Putting Things Right” and improving the quality of service we provide.

The Safeguarding Team within WAST is fully committed to supporting the Trust’s legislative responsibility regarding Duty of Candour (2023). Therefore, we fully embrace “Putting Things Right” as a process for highlighting, investigating and learning from concerns.

A close and collaborative working relationship exists between the Safeguarding and Patient Safety Teams. This ensures an effective interface in the considerations of concerns, adverse incidents and the safeguarding issues highlighted within them. Our working together ensures that any incidents that involve adult or child safeguarding issues are responded to correctly.

The aim is to provide a supportive framework for people to highlight issues. Support is offered by the Team for all staff involved to learn from adverse incidents raised within WAST that have an element of safeguarding attached to them.

Safeguarding regularly attend the WAST Serious Case Incident Forum (SCIF). This ensures all aspects are addressed internally and externally with our partner agencies.





Safeguarding Maturity Matrix

The Safeguarding Maturity Matrix (SMM) is a self-assessment quality assurance tool completed by all Health Boards and Trusts across Wales annually. This enables organisations to demonstrate safeguarding quality by reporting on safeguarding activity for the previous year with the aim of demonstrating improvements and risks. Organisational strengths and improvements are reported through the document and plans are collated by the National Safeguarding Service. This promotes horizon scanning, allowing organisations and the wider NHS Wales Safeguarding Network to understand the priorities for the following year and using peer review and feedback to inform the national picture.

WAST has participated in phase 2 of the pilot of a revised SMM Tool with other Health Boards and Trusts during this reporting year. WAST improvement plan forms part of the Safeguarding priorities set for 2024-2025 and beyond.



5. Support, Advice and Guidance

The Safeguarding Team within WAST appreciates that working to ensure good outcomes for children and adults at risk, and victims of domestic abuse/sexual violence can be demanding and distressing work.
Supporting colleagues requires a collaborative approach which facilitates the promotion of good standards and ensures confident and competent practitioners who can make sound professional judgements. The team also endeavour to promote external agencies understanding of safeguarding activity within the Trust as this promotes collaborative working when addressing the individual needs of those requiring further support from their services.



Obtaining feedback from social services in relation to safeguarding reports has been improved since the digitalised Doc-works process. The feedback received facilitates WAST practitioners' learning to improve future practice.



Shadowing Experience

The Safeguarding Team accommodated two social workers from Local Authority during this reporting period. The aim of this was to share information on the nature of our service, types of concerns encountered, challenges faced by front line colleagues. It was an opportunity for the social workers to understand our remit from when the call comes into our service, things that effect response times and the on-scene experience encountered by those in attendance with the patient.
The team continue to welcome WAST colleagues who request to spend time working alongside them as they conduct everyday core safeguarding activities.

What do we offer

- Safeguarding Advice
- Bespoke 1:1 training
- Safeguarding/Restorative Supervision
- Shadowing Experience
- Central Resources
- 7-minute briefings



Safeguarding SharePoint Page

Building the Team

"My background is in Paediatric Nursing, having worked in Paeds oncology and 8 years in Paediatric emergency departments in London and Chichester.

I have experienced the work of organisations who base themselves in emergency departments and use 'in the moment' opportunities to target youth violence and reach those who are gang members.

My first safeguarding role was hospital based. Here I gained real insight and experience of safeguarding issues, which I can now share within the WAST arena.

Joining the Safeguarding Team at WAST has been very positive. I enjoy working with such a friendly and supportive team. Since joining I have developed and launched a SWAY training package on Child Sexual Exploitation.

I am aligned with the WAST safeguarding activity in the SE Region and will often work from Pentwyn and Barry ambulance stations. This gives me a great opportunity to engage with colleagues and support with any safeguarding queries."



Sarah Hulse
Safeguarding Specialist

Safeguarding Resources







Building the Team

"I joined the WAST Safeguarding Team in early 2023. A paediatric nurse since 1994, and a health visitor since 2000 and have worked across BCUHB for most of my career.

I have worked in the Child Development Team and provided support to families with pre-school children with significant developmental delay. I recognised the impact that health inequalities and deprivation can have upon outcomes for children and have previously been involved with the development of a bespoke training package.

My practice in generic health visiting and Flying Start; aimed at reducing health inequalities in deprived areas and improving outcomes for children, has provided me with a vast amount of safeguarding experience. All of which enables me to support WAST staff in matters related to safeguarding across the lifespan.

I cover the BCUHB and PTHB areas and would welcome colleagues getting in contact should they have any safeguarding enquiries"



Lara Jackson
Safeguarding Specialist

Moving Forward 2024 - 2025

Building on the Safeguarding Team achievements during 2023-24 the following priorities have been identified for future progress.

To further develop the digital reporting process to seamlessly link our patients with the help and support that they need to improve their quality of life.

To provide assurance using quality reporting measures, which reflect the safeguarding activity across WAST, and which can be used to evidence change.

To continue to develop bespoke safeguarding training using learning from safeguarding reviews to shape the content and audit to measure the impact.

To work with partners to identify health inequalities and develop strategies for earlier identification of need, enabling care to be routed back into primary and planned services.



Conclusion

This annual report demonstrates the Safeguarding Team's commitment to ensuring high quality safeguarding interactions across the organisation, to meet our statutory responsibilities and protect the people we serve.

The increase in safeguarding activity reflects a professionally curious organisation able to identify and escalate safeguarding risk and inequality. It also reflects the changing landscape of modern safeguarding.

The safeguarding Team prioritise the delivery of robust safeguarding training, which provides a solid foundation for WAST staff to gain enhanced knowledge and confidence. The team are committed to providing face to face training to supplement core online learning modules.

The safeguarding Team are proud to be a key partner in multi-agency forums across Wales. They provide strong WAST representation nationally ensuring that patient and staff safety is central to all conversations.

We look forward to the challenges that the coming year will bring and are excited to proactively drive the safeguarding agenda in alignment with the wider WAST priorities.



GIG CYMRU NHS WALES
Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cym
Welsh Ambulance Services
NHS Trust

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

QUALITY STRATEGY IMPLEMENTATION PLAN UPDATE 2021-2024

MEETING	Quality, Patient Experience & Safety Committee
DATE	13 August2024
EXECUTIVE	Liam Williams, Executive Director Quality & Nursing
AUTHOR	Kate Blackmore, Assistant Director of Quality Governance
CONTACT	kate.blackmore@wales.nhs.uk

EXECUTIVE SUMMARY

1. The last update to the Quality, Patient Experience & Safety Committee (QuESt) was provided in February 2024 and articulated key challenges in progressing the Implementation Plan.

2. Action updates as of end May 2024:

Complete	On Track	Challenged	Not Started	Total
15	5	5	0	25

3. Senior Quality Team Meetings monitor the Implementation Plan and the document itself has now been updated with proposed completion dates for those actions which remain outstanding.

4. Senior Quality Leads are in place and following the Organisational Change Process (OCP) for Quality, Safety & Patient Experience (QSPE) leadership and realignment of previous quality improvement initiatives to business-as-usual operations focus is now on development of the Quality Improvement Hub and roll out of training across the organisation.

5. Following the successful inclusion of Duty of Quality training on LMS365 education and development, teams are now supporting with the inclusion of Duty of Candour training on the same platform to mitigate the issues experienced with the national platform.

6. The first Welsh Ambulances Services University NHS Trust Quality Event was held on 2 July 2024 focussing on the Quality Management System. The Citizen's Voice was a golden thread throughout the presentations provided and the event

was rounded off with an introduction to the Quality and Performance Management Framework.

RECOMMENDED: That the Quality, Patient Experience & Safety Committee is asked to note the progress against the Implementation Action Plan.

KEY ISSUES/IMPLICATIONS
Not applicable

REPORT APPROVAL ROUTE	
Clinical & Quality Governance Group	30 July 2024
Quality, Patient Experience & Safety Committee	13 August 2024

REPORT APPENDICES
ANNEX 1 - SBAR providing background information.
ANNEX 2 - Implementation Plan updates

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

ANNEX 1

SITUATION

1. The Trust produced Quality Strategy for 2021-24 broadly contained 3 strategic aims:

- Supporting a quality-based learning culture that will deliver enhanced knowledge, skills, learning, improvement and professionalism
- Develop a Quality Management System that will deliver quality driven decisions, integrating quality management, strong governance and accelerating quality responsiveness
- Integrating the Citizen's Voice into the Trust's service design, transformation and improvements

2. This paper provides an overview of progress against the Quality Strategy 2020-2024 Implementation Plan and describes the link to the previously reported Duty of Quality/Candour implementation.

BACKGROUND

3. The last update to the Quality, Patient Experience & Safety Committee (QuESt) was provided in February 2024 and articulated key challenges in progressing the Implementation Plan. This update identified key issues in the development of a suite of support tools and resources supporting reflective practice and continuous development, challenges with the roll out of centrally provisioned e-learning and consideration of alignment with governance structures in the broader organisation (particularly the Operations Directorate).

4. February 2024 action updates as of end December 2023:

Complete	On Track	Challenged	Not Started	Total
1	15	6	3	25

ASSESSMENT

5. Action updates as of end May 2024:

Complete	On Track	Challenged	Not Started	Total
15	5	5	0	25

6. The Senior Quality Team (SQT) Meeting structure commenced in September 2023. Attended by the Department Heads and appropriate Business Partners, this group meets formally every two weeks and is chaired by the Assistant

Director of Quality Governance with the Assistant Clinical Director for Remote Clinical Care. SQT reports into the Senior Quality Leadership Team (SQLT) monthly.

7. Oversight for the Quality Strategy Implementation Plan now forms part of the regular agenda for SQT.

8. Strategic Quality Aims:

Quality Culture/Duty of Candour:

Supporting a Learning Environment:

8.1 Following the introduction of Senior Quality Leads in 2023 work has progressed to develop training videos and self-help guides for publication on Siren Sharepoint. The team is working to develop a Training Programme from basic to advanced quality improvement methodology and it is anticipated that this will begin to roll out during Quarter 2 of 2024/25, with completion expected by end of Quarter 3, 2024/25.

Enhancing Knowledge, Skills and Professionalism:

8.2 Duty of Candour training materials have been launched on the Electronic Staff Record (ESR) but are not currently part of a mandatory training requirement. Some challenges have been identified with registering the training from the ESR platform and this combined with the non-mandatory nature of the training provided is impacting on compliance reporting. Learning and Development Teams have access to the package and include this guidance as part of induction packages. Work is now commencing on including this training within LMS 365 to allow easier access and recording of the training compliance. This is expected to be completed by end of Quarter 2, 2024/25.

8.3 Duty of Quality training materials available on ESR and Learning@Wales have been publicised via the Duty of Quality Siren Sharepoint, QSPE bulletin and in person via CEO Roadshows and mentimeter information. Follow up communication continues with Department Leads via the Quality Management Group (QMG). This training has now transitioned to LMS365 for ease of access and is marked as a requirement within ESR to prompt completion which has improved completion rates. Again, this training is not identified by NHS Executive as mandatory but focus remains on ensuring that every member of staff within the organisation completes this level of training as a minimum requirement. This action is now marked as completed on the Implementation Plan, but work is now ongoing to develop tiered training and bespoke versions tailored at different working environments and teams.

8.4 Quality Assurance and Patient Safety Teams are working together to develop a Dashboard to support Duty of Candour monitoring of incident levels and thematic trends on a weekly basis.

8.5 The first annual Welsh Ambulance Services University NHS Trust Quality event is scheduled for 2 July 2024 focusing on education and practical examples of the Quality Management System and the importance of continued engagement with service users.

Delivering Learning & Improvements:

8.6 The Quality Management Group continues to meet weekly with a four-weekly rotation of focussed areas to encompass the organisational Directorates. The agenda for QMG is based around the 4 quadrants of the Quality Management System with additional elements aligned to citizen/staff voice, communication and education. Further engagement is required with Corporate Teams to generate consistent attendance with the value of the forum needing to prove beneficial to all.

8.7 Quality improvement leaders are now exploring financial opportunities to develop a revised digital platform to support quality improvement documentation and planning whilst maintaining the existing infrastructures such as the Welsh Ambulance Services University NHS Trust Improvement and Innovation Network (WiiN). This is expected to be completed by end of Quarter 2, 2024/25.

Quality Management System

Quality Drive:

8.8 The Quality Assurance Team is working with Departmental Leads across the organisation to develop quality statements relative to their functions and responsibilities.

8.9 Senior Quality Leads are now engaging across the organisation through Local, Regional and National Meetings. This supported by the activity within QMG to provide an integrated forum to underpin the Quality Management System has started to provide evidence of continuous improvement and valuable discussion about co-production and how we can better hear our Citizen's Voice.

8.10 Quality Directorate Leads are engaged with the All-Wales Safe Care Collaborative and are also participating in the associated Patient Safety Improvement Coaching Programme.

8.11 The first Annual Duty of Quality Report has been created including an approach providing evidence against each of the 12 Health & Care Quality Standards as well as providing an assessment of our approach to delivering the legislation. This is now progressing through the approvals process aligned to the annual filings.

Integrating Quality Management:

8.12 Work is ongoing to review local Frameworks with self-assessment activity being undertaken by pilot areas with a third area identified for the next phase of assessment. Quality Assurance Teams are engaging with teams across the organisation to understand the current audit and assurance activities to help support and deliver the local Quality Management Systems.

8.13 As part of the Duty of Quality implementation, the Quality and Performance Management Steering Group have commissioned a Monthly Integrated Quality & Performance Report Dashboard from our Health Informatics Team. As part of this work the metrics have been quality assured, providing a consistent set of metrics for use within the organisation. The first phase of this Dashboard has been published and is easily accessible via the Powerbi App in MS Teams, from launchpad and via the Monthly Integrated Quality and Performance Report (MIQPR) presence on Siren SharePoint making it the first steps towards always on reporting for internal use.

8.14 The Quality Management Group has been working on developing a Quality Assurance Dashboard to support the easy identification of themes and trends for learning based on the information held within the Datix Cymru platform. Having received feedback and interest from QMG stakeholders this is now being quality assured by the Health Informatics Team before wider release to the organisation, adding to our suite of 'Always on' internal reporting.

Accelerating Quality Responsiveness:

8.15 With Senior Quality Leads in place and integrated forums now in operation representatives across all Directorates have a protected space to raise quality improvement initiatives and receive support to deliver responsive Quality Management Systems. Work is ongoing to deliver reporting platforms both internally and externally to make all teams aware of the organisation's quality performance activity in line with always on reporting. Introduction of the Quality Improvement Hub will further support quality responsiveness working collaboratively across Directorates.

8.16 Senior Quality Leads have confirmed attendance at monthly Operational and Clinical Leadership Meetings. A monthly forum with Locality Managers has been

established to discuss opportunities for improvement, these are then fed back through QMG as required.

8.17 Quality Improvement Teams will undertake a series of Roadshow events during Quarter 2 & 3 of 2024/25 to support quality improvement initiatives and celebrate the success of Exemplar Programmes undertaken throughout the organisation. With the addition of 3 team members undertaking training to be Improvement Advisors and mentor/coach teams throughout the organisation to support continuous improvement activity.

8.18 A structural change has been completed within the QSPE Directorate Senior Leadership Team to empower and position our teams to service the requirements of the organisation and the population we serve. This organisational change was developed jointly with the Clinical Directorate to reflect the changes made to portfolios and to offer greater clarity for stakeholders and colleagues in leadership.

Integrating the Citizen Voice

People & Community Network:

8.19 Ongoing engagement with communities has continued through recruitment of citizens into the Trust's People and Community Network with membership now reaching 100. Four members of this group have now become core members of the Trust's People and Voices Group, with the intention for members to be rotated every year to ensure constant refresh and opportunities for members.

8.20 Internal promotion continues to ensure Welsh Ambulance Services University NHS Trust colleagues provide opportunities for Network members to be involved in Projects and Programme activities with consideration of proactive communication and co-design forming part of QMG discussions. Presentations on the Network and its contribution to wider Trust Programmes/Team have been carried out.

Integration of Citizen Voice within Quality Cycle:

8.21 The All-Wales Digital System for service user experience capture, Civica Experience, is now live enabling a range of metrics to be reported against with a variety of reports demonstrating how experiences and Citizens Voices are being captured. Engagement and review through QMG has allowed development of the existing questionnaires to provide more meaningful feedback and work is now ongoing to resolve information governance constraints to allow us to more effectively access service users and obtain their feedback for learning and improvement opportunities.

8.22 Four live Service Experience Surveys are in Civica with monthly reporting provided back to QMG. Ad hoc Surveys have also been uploaded including falls response, RITA tablets (dementia) and Community Welfare Volunteers.

8.23 The patient storytelling facility is now live enabling cross organisational sharing and learning from patient stories.

RECOMMENDED: That the Quality, Patient Experience & Safety Committee is asked to note the progress against the Implementation Action Plan.

Strategic Quality Aims	Strategic Outcome	Strategic Output/Intent	Action	RAG Status	Progress Update: 2023-24 Q4	Expected Completion Date
Quality Culture / Duty of Candour	Support a Learning Environment	Psychological Safety	Establish a psychological safety, through the Trust Health & Wellbeing Steering Group		complete	Complete
					complete	Complete
		Appreciation of Complex Clinical Judgements (Person Centred Care)	Embed learning & feedback from incidents and events – establishing processes for shared learning across workforce/organisation (organisational learning)		QMG structure in place to identify learning and improvement across organisation including learning from events. EPRR Organisational Learning Spreadsheet shared with Senior Operations Teams and QMG for oversight. Learning from Events timeline in place	
		Openness to new approaches				
		Resources to support reflection and learning	Suite of support tools and resources supporting reflective practice, and continuous development		Work has progressed to develop training videos and self help guides to include on the intranet. Additionally the team are working to develop a training programme from Basic through to Advanced QI methodology training. It is anticipated that this will be available during Q2. Clinical supervision policy approved May 2024 providing a framework to allow the organisation to have consistent methods to identify additional learning or development needs and facilitate support for our people to develop accordingly .	Dec-24
	Enhancing Knowledge, Skills and Professionalism (Duty of Candour)	Education and Training (Duty of Candour)	**Training package** – Duty of Candour training package will be diseminated through Welsh Government as part of the quality & Engagemet Act. The pacakage will be released following conclusion of public consultation		14/03/24 Patient Safefy Team awaiting feedback from ESR on the technical gliches affecting analysis of data on who has completed the training 2/05/24 awaiting update from Patient Safety	Sep-24
		Day-to-day 'Duty of Candour' implementation	*Process to capture DoC (low, medium and high level activity)*		complete	Complete
	Delivering Learning & Improvements	Process and principles in which open, honest and transparent learning is undertaken	Embed enhanced learning and monitoring within quality management systems - promoting quality improvement efforts and action.		QMG In Place to support and underpin Quality Management systems across the organisation, QPMF Steering Group oversight of self assessment roll out. QPMF provides the quality policy for the organisation defining 5 building blocks as principles of quality and performance management across organisation.	
			Challenge current working practices and procedures in order to promote a culture of continuous improvement		WiiN exploring financial opportunities to develop revised digital platform whilst maintaining existing WiiN platform. Quality Hub in development with QI roadshow scheduled for Qtr 2/3	Dec-24
			Development of supporting processes and systems of work that focus improvement towards challenges		QPMF Self Assessments underway in pathfinder areas QMG format and agenda supporting organisational teams to consider Quality Management Systems and internal processes	

Quality Management System	Quality Driven	Quality is everyone's responsibility	**Training package** – Duty of Quality training package will be diseminated through Welsh Government as part of the Quality & Engagement Act. The package will be released following conclusion of public consultation		14/03/24 the Duty of Quality Educational Material is now available on ESR. The Esr team are providing regular updates on who is undertaking the training 2/5/24 150 have undertaken the Duty of Quality training to date 31/5/24 content now available on LMS 365 to allow easy access for staff and volunteers. This element has now been added to learning portal to notify staff of requirement	Complete
			An organisational evaluation will be undertaken to ascertain roles and responsibility for Quality. This will incude the requirements upon all staff, resulting from the Act; and, install the principles of responsibility towards an improvement orientated organisation		Quality Directorate OCP to clearly set out and align roles and responsitibilities DoQ training provides overview of responsibilities for all staff aligned to the duty Awareness sessions at CEO roadshow have been completed around Duty of Quality and Candour and why these have been introduced, this includes Carousel attendance to communicate the role of everyone. DoQ digital campaign underway with DoQ page articulating responsibilities. QMG in place to support and underpin quality managements systems across the organisation QPMF self assessments underway with pathfinder departments being overseen by steering group DoQ Annual Report completed stepping out the quality management system and evidence against all standards.	Sep-24
			Statement/principle campaign		Local Quality Statements are being developed with departmental leads Included IMTP and long term Strategy WASTQ Event completed on 2nd July 2024	Dec-24
			The development of an annual evalution and recognition exercise which seeks to celebrate exemplars of quality/quality improvement. Celebrating success and exemplars		Engagement underway accross organisation through local, regional and national meetings. WASTQ event completed on 2nd July 2024 DoQ Annual Report completed and aligned with annual filings QI Roadshow in Q3 Engagement with Communications Team about inclusion in WAST Awards	Dec-24
		Empower local leaders	Quality Management system training/education will be provided additionally, wider workforce education (particularly targeting senior local leads) will be developed through a Quality Hub.		QI roadshow scheduled for Qtr 2/3 WASTQ Event completed on 2nd July 2024 level 2, level 3 training being developed with consideration of department/role specific training content Board development day scheduled for Oct 24 (now deferred to Nov 24) QI leader - 3 improvement advisors being trained to mentor/coach other team members throughout organisation	Dec-24
			Establish 'working together' with Senior Quality Leads		Safe Care Collaborative has now been completed, with work ongoing to scale up improvements in collboaration with Health Board's. Learning has been undertaken in relation to developmement of Quality Management System Approach. Safe Care Partnership attended by WAST Head of Quality Improvement and Senior Qulaity lead. Contributed to health board improvements and collaborated with colleagues from accross NHS Wales. QI leadership team represented WAST in the Leadership worksream.	Complete
	Integrating Quality Management	Systems that integrate and triangulate data	Establishment of a Quality & Performance Management Steering Group; Establishment of integrated 'governance' forums.		Quality and Performance Management Steering Group has been established/ Furthermore, the implementation of the Quality Management Group (QMG) has strengthened the quality governance across organisational services; this group reports to CQGG.	Complete
		Collaborative forums for patient and service users				
		Integrating communication				
		Integrating reporting lines				

	Strong Governance & Quality Management Structures	Integrated Governance Group	Establish and introduce an integrated, Clinical and Quality Governance Group (CQGG)		CQGG fully established with reporting group sub-structure	Complete
			Develop reporting and governance channels to local level			
		Board to Floor	Development of sub-structure groups to CQGG.		Reporting group sub-structure reviewed and Terms of Reference implemented	Complete
			Establishment and introduction of a integrated 'governance' forum		QMG established as integrated governance forum reporting to CQGG which is also an intregrated stucture, links and communication channels open to other forums from QMG including SOT and CIAG to ensure that learning and quality control/assurance activity is helping to inform activity such as clinical audit.	Complete
	Accelerating Quality Responsiveness	Reduce turn-around times on quality issues	Establishment of local Senior Quality Leads and local leadership 'ownership' of quality.		Q1 update June 24. Senior Quality Leads have confirmed attendacne at monthly operational and clinical leadership meetings. Montly forum with Locality Managers has been estabilised to discuss opporuntities for improvements. Issues and opportunities are brought through to the Quality Management Group as and when required.	Complete
		Issues locally owned and managed				
Integrating the Citizen Voice	**People & Community Network**	Inclusivity	Establish a network representational of the Citizens of Wales, inclusive to all who seeking to be involved		Trust people and communicate network established with ongoing recruitment which has incrased membership to 100.	Complete
		Innovation	Establish and embed work processes to enable Citizens to be contributing and co-producing Trust service development and transformation		Four members have now become core members of the Trusts People & Voices Group. The intent is for membership to be rotated every year to ensure constant refresh and opportunties for members. Network members have also commented on draft IMTP 2024/27.	Complete
		Influencing	Embed the Citizen voice as an influencer in Trust decision making and planning		Presentations on the Network and its contribution to wider Trust programmes/teams have been carried out.	Complete
		Involvement	Provide opportunities for meaningful engagement and involvement in Trust service developments			Complete
	Integration of Citizen Voice within Quality cycle (planning)	Effective Citizen participation in service change and delivery	Defined systems and processes that enable measurable/demonstratable integration of the Citizen's voice within Trust service developments, improvements and transformation in the pursuit of enhanced quality of care & experience.		Four live service experience surveys are in Civica with monthly reporting provided. Ad hoc surveys have also been uploaded including: falls, RITA tablets (dementia) and Community Welfare Volunteers. Patient storytelling facility now live enabling cross organisational sharing and learning from patient stories.	Complete

AGENDA ITEM No	**12**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**2**

QUALITY PLAN DEVELOPMENT AND IMPLEMENTATION PLAN (2025-2028)

MEETING	Quality, Patient Experience and Safety Committee
DATE	13 August 2024
EXECUTIVE	Liam Williams, Executive Director of Quality & Nursing
AUTHOR	Kate Blackmore, Assistant Director of Quality Governance
CONTACT	Kate.blackmore@wales.nhs.uk

EXECUTIVE SUMMARY

1. The current Quality Strategy is due for review, this paper sets out the approach, Framework and timeline for developing a new 'Quality Plan' that aligns with the Trusts Long-Term Strategy.
2. Consideration is given to existing legislation and guidance documents as well as the need to align with the Clinical Strategy which is also due for review this year. Working as a whole system we can align with the Digital Strategy and help to provide access to easily understood data enabling our people to own their development and education pathways.
3. Key focus areas for coproduction include understanding the voices of our citizens and service users as well as those of our teams. Timelines have been considered to take account of available engagement windows.
4. It is important as part of the development of our Quality Plan that we understand our role and influence in the broader health care environment. As such we need to consider the role we play in supporting population health as well as influencing value based health care within our communities.
5. When turning data into knowledge we must consider our data through appropriate lenses including social deprivation, ethnicity and other protected characteristics.

RECOMMENDED: That the Committee

(1) Approves the proposed approach to the development of the Quality Plan 2025-2028, and

(2) Approves an extension of the current Strategy until 1 April 2025 to allow the development of a robust Quality Strategic Plan for the following 3 years.

KEY ISSUES/IMPLICATIONS
(i) The Development Plan will be monitored via the Senior Quality Team Meeting (as is the current Implementation Plan) with quarterly updates to the Clinical and Quality Governance Group to provide assurance that we are meeting the agreed timescales.

REPORT APPROVAL ROUTE	
Quality Performance Management Group	4 July 2024
Clinical & Quality Governance Group	30 July 2024
Quality, Patient Experience & Safety Committee	13 August 2024

REPORT APPENDICES
ANNEX 1 - SBAR
ANNEX 2 - Quality Plan Timeline Plan v1.1 August 1 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)	YES	Financial Implications	YES
Environmental/Sustainability	YES	Legal Implications	YES
Estate	N/A	Patient Safety/Safeguarding	YES
Ethical Matters	YES	Risks (Inc. Reputational)	YES
Health Improvement	YES	Socio Economic Duty	YES
Health and Safety	YES	TU Partner Consultation	YES

ANNEX 1

SITUATION

1. The Quality Strategy for 2021-2024 was approved in April 2021 and issued in August of the same year. This Strategy was framed around the introduction of the Health & Social Care (Quality & Engagement) (Wales) Act 2020.

2. Following the introduction of this new legislation on 1 April 2023 and the recognition of Welsh Ambulance Services as a University Trust ('the Trust') from April 2024, it is now time to review our Strategy to take us into a new future of innovation and improvement.

3. The Trust has a single Long-Term Strategy and as such the replacement document will follow the 'plan' nomenclature.

4. This paper sets out the Framework and Timeline to develop and publish the Trusts Quality Plan for 2025-28.

BACKGROUND

5. The Trust's Long-Term Strategy 'Delivering Excellence: Our Vision for 2030' identifies Quality at the Heart of everything we do as a 'Golden Thread'. The key principles are aligned with the 6 Domains of Quality (now part of the Health & Care Quality Standards). This Strategy will form the basis of the Quality Plan. In addition, the enabling actions will also be reviewed to identify key strategic direction.

6. The Health & Social Care (Quality & Engagement) (Wales) Act 2020 introduced the Duty of Quality, Duty of Candour and Citizens voice in April 2023. The first Annual Report has been developed and aligned the next steps for improvement with the Integrated Medium-Term Plan (IMTP) and Annual Report. This legislation is pivotal in stepping out our culture journey requiring the organisation to not only demonstrate quality in our strategic decision making but also to consider candour in our approach to patient harm and ensuring that we hear our citizens voice clearly when developing our responses to continual improvement.

7. The 'Quality & Safety Framework: Learning and Improving' published by Welsh Government in 2021 sets guidance and direction for the Trust on the importance of a strong quality management system at all levels which will reduce variation in quality. The Framework emphasises the importance of hearing everyone's voice as well as focusing on the values, culture and leadership required.

8. From 30 June 2024 the Trust is included as a public body within the Well-being of Future Generations (Wales) Act 2015. The Act sets out seven well-being goals which should be considered as part of our planning process.

9. Section 9 of the Trust's IMTP sets out our Strategic Objectives to be quality driven and clinically led. Through this document we set out our intentions regarding the legislation, continual improvement, clinical leadership and integrated governance with a focus on risk-based thinking. These are all key elements for consideration when developing the Quality Plan and more importantly a quality culture for the Trust.

10. Articulating how our Quality Plan and quality management systems can support the delivery of objectives set out in 'The Right Care, Right Place, First Time: Six Goals for Urgent and Emergency Care Policy Handbook 2021-2026', continues the 'golden thread' of quality achieving the best possible outcomes, value and experience for patients and staff.

11. Our Long-Term Clinical Strategy Delivering Clinical Excellence 2020-2025 is also being reviewed during this fiscal year giving us an opportunity to live our values of clinically led and quality driven. Alignment with the revised Clinical Strategy will be key to delivering a successful Quality Plan.

12. The Value-Based Healthcare Framework needs to be considered as part of the planning and implementation process to align with our Long-Term Strategy.

13. Finally, when taking a whole system approach to delivering a Quality Plan for the organisation, it will be important to consider the Quality Strategies for our key stakeholders to identify opportunities for collaborative engagement.

ASSESSMENT

Vision

14. It is important as part of the development of our Quality Plan that we understand our role and influence in the broader health care environment. As such it is important to consider the role we play in supporting population health as well as influencing value based health care within our communities.

15. The population of Wales is diverse, and it is important that we consider equitable care in our approach to delivering quality care and continuous improvement. When turning data into knowledge we must consider our data through appropriate lenses including social deprivation, ethnicity and other protected characteristics.

16. Our workforce is a key enabler in delivering a quality service, in order for them to be assured of the quality of care they provide it is important for them to be able to access information on their own performance and how they have learned and developed as clinicians and non-clinicians during their career journey. Working as a whole system we can align with the Digital Strategy and help to provide access to easily understood data enabling our people to own their development and education pathways.

Quality Plan Timeline - 1/7/2024 to 31/10/2024

17. Key deliverables for the development of the Quality Plan have been identified ensuring consideration of our legislative requirements, key stakeholders and strategic direction/vision. Supported by the Planning & Performance Business Partner, key phases for delivery of the Plan have been identified as:

- Quality Plan Timeline Initiation
- Internal Engagement & Communication Framework
- External Engagement & Communication Framework
- Approval

18. A Task & Finish Group will be formed of key stakeholders in order to inform and deliver the work required. Key stakeholders have been identified as:

- Quality Team
- Operations Directorate
- Clinical Directorate
- People & Culture Directorate
- Digital Directorate
- Strategy, Planning & Performance Directorate
- Corporate Governance.

19. A review of the appropriate legislation, strategic intent and complementing plans will be undertaken, some of which is set out in paragraphs 1-8. This will ensure that the Quality Plan aligns with the intentions of the organisation and reflects the statutory requirements set out by Welsh Government.

20. In order to truly represent the citizens voice our Patient Experience and Community Involvement (PECI) Team continually request and analyse feedback provided by our service users. However, a focussed period of quality engagement will be completed for 12 weeks prior to 9 September 2024 as part of existing events scheduled in order to specifically identify feedback for consideration as part of our quality planning, as well as engagement via social

media platforms. The feedback will be requested to answer the following questions:

(i) What does a good quality service look like?
(ii) What do you expect from us as a quality driven organisation?
(iii) What do you think we should focus on over the next 3 years?

21. To understand our wider stakeholder feedback, and additional population feedback received via stakeholders, we will engage via our existing stakeholder platforms and register for info bursts via Health Board, third sector and Local Authorities.

22. Finally, we will use our existing internal networks and communication platforms to generate engagement across our teams to hear our team's voices in addition to the citizen voice.

23. This feedback combined with the strategic direction and associated legislation and integrated planning will allow us to draft a Quality Plan proposal.

Internal Engagement & Communication - 9/9/2024 to 30/11/2024

24. In order to fully explore the development of coproduction to inform Strategy we will undertake a series of Workshops from 9 September 2024 to engage with our teams and understand what they feel should be included in our Strategic Plan.

25. The timing of these Workshops is designed to maximise possible attendance (following school holidays) and also to allow the initial elements of service user feedback to help inform discussions.

26. Having listened to our patients and our people we will draft our Proposal and once a final draft Proposal has been completed and in line with our Communication Framework, we will engage with key internal forums across the organisation to present our proposal and receive feedback.

27. This will include engagement across all Directorates with consideration of the correct forums to ensure engagement at all levels.

Approval - 1/12/2024 to 31/03/2025

28. The final document will follow Quality Governance Frameworks for approval including formal Leadership Team Meetings, Clinical & Quality Governance Group, Executive Leadership Team and the Quality, Patient Experience and Safety Committee.

29. Once approved we would look to launch the new Strategic Plan at the start of the 2025-2026 fiscal year.

RECOMMENDED: That the Committee

(1) Approves the proposed approach to the development of the Quality Plan 2025-2028, and

(2) Approves an extension of the current Strategy until 1 April 2025 to allow the development of a robust Quality Strategic Plan for the following 3 years.

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

AGENDA ITEM No	**13**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**2**

LEARNING FROM DEATHS (MORTALITY REVIEWS) UPDATE REPORT

MEETING	Quality, Patient Experience & Safety Committee
DATE	13 August 2024
EXECUTIVE	Liam Williams, Executive Director of Quality & Nursing
AUTHOR	Jane Palin, Assistant Director (interim) Claire Appleton, Assistant Director of Putting Things Right
CONTACT	claire.appleton2@wales.nhs.uk

EXECUTIVE SUMMARY

This paper sets out the current position and progress since the last report in October 2023 and next steps internally and nationally in respect of learning from deaths.

Learning from deaths is broad and includes capturing good practice, improvement opportunities, any patterns, themes and trends including early warning signals, whilst considering potential inequalities in access to care or experience.

The functions of the Medical Examiner Service (MES) are valuable part of the process, providing independent scrutiny of deaths not taken for investigation by a Coroner and feedback from families. The Trust has received 1154 Referrals (as of 19 June 2024) for review.

As part of the Learning from Deaths Forum Programme of Work a look back of all MES Referrals from September 2020 to March 2024 has been undertaken (n=1019) to provide assurances in respect of screening, appropriate escalation and the improvement actions undertaken. Additionally, a mapping exercise of all open Referrals to determine if scrutiny has occurred via a different route e.g. incident reporting, complaints or via coronial processes has been performed.

The newly refreshed National Mortality Review Framework has been implemented, led by the Assistant Director of Putting Things Right. A weekly Level 1 triage process is in place, with Level 2 Learning from Death Review Panels being established to ensure learning is triangulated from all MES Referrals, with escalation to the Serious Case Incident Forum as appropriate. Themes and trends from these reviews are overseen at the Learning from Deaths Forum, with Alert, Advise, Assure (AAA) reporting to the Clinical & Quality Governance Group.

Next steps include scoping out a Programme of Work across the Clinical Directorate (Clinical Development), Digital Services (Data & Analytics) and Quality, Safety & Patient Experience (Putting Things Right & Patient Experience & Community Involvement) to determine learning opportunities available in respect of the collective analysis of data and information to inform improvements, patterns, trends and themes, including early warning signals.

It is recognised that as the Trust is part of the wider patient's pathway that the Welsh Ambulance Services University NHS Trust representatives should have inputs into Mortality Reviews led by Health Board colleagues, unless the event is specific to the Trust. Capture of the learning from these reviews needs strengthening.

RECOMMENDED: That the Committee discusses and approves the report and next steps as detailed in paragraph 34, highlighting any further assurance requirements.

KEY ISSUES/IMPLICATIONS
(i) The Medical Examiner (Wales) Regulations 2024 were laid on 15 April 2024 as part of the wider death certification reforms being introduced in England and Wales through Regulations being laid by the UK Government's Department of Health and Social Care.
(ii) The critical importance of good governance and data analysis in respect of learning from deaths processes have been highlighted in a number of high profile NHS Independent Inquiries and Reviews, most recently in the Thirlwall Inquiry which has been set up to examine events at the Countess of Chester Hospital and their implications following the trial, and subsequent convictions, of former neonatal nurse Lucy Letby of murder and attempted murder of babies at the hospital.
(iii) The MES will be reviewing all deaths not taken for investigation by a Coroner when the service becomes a statutory body from 9 September 2024.
(iv) Timely review of the MES Referrals and additional collective analysis with other sources of data and information by the Trust is critical to identifying patient safety issues and good practice, enabling organisational learning and improvement.

REPORT APPROVAL ROUTE	
Learning from Deaths Forum	25 June 2024
Clinical and Quality Governance Group	30 July 2024
Quality, Patient Experience & Safety Committee	13 August 2024

REPORT APPENDICES
ANNEX 1 - SBAR Report

ANNEX 2 - Provides a breakdown of the fields and questions that were considered for each Referral

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

ANNEX 1

SITUATION

1. Learning from deaths is broad and includes capturing good practice, improvement opportunities, any patterns, themes and trends including early warning signals, whilst considering potential inequalities in access to care or experience.

Medical Examiner Service

2. The functions of the Medical Examiner Service (MES) are valuable part of the process, providing independent scrutiny of deaths not taken for investigation by a Coroner and feedback from families.

3. The Medical Examiner (Wales) Regulations 2024 were published on 15 April 2024 as part of the wider death certification reforms and aim to have a significant positive impact on the people and Health Services of Wales. The expected benefits of the Medical Examiner (Wales) Regulations 2024 are:

- Crime and malpractice deterred by the knowledge that the cause of death stated on Medical Certificate of Cause of Death (MCCDs) by doctors will be scrutinised by a Medical Examiner (ME) and the identification of patterns and trends leading to earlier detection of criminal activity and poor practice
- MCCDs provide more accurate information about the causes of death leading to better planning of Health Services
- Improved information for clinical governance and health monitoring to support learning and improvement, making Health Services safer for patients
- A Death Certification Process that is easier, for bereaved families to understand, open and transparent, with the opportunity to raise any concerns with an independent individual about the standard of care leading up to a death and providing reassurance that the cause of death is correctly established by the Doctor
- Appropriate Referrals to the Coroner Service

4. Since the establishment of the MES the Trust has received 1154 Referrals (as of 19 June 2024). All Referrals have undergone an initial screen, with cases escalated to the Serious Case Incident Forum (SCIF) as appropriate. Four hundred and seventy-one Referrals have been forwarded to relevant teams for review and appropriate action and have subsequently been closed.

5. As part of undertaking their Reviews the Medical Examiners have direct access to the Welsh Clinical Portal, as such they have direct access to the Welsh Ambulance Services University NHS Trust (the Trust) ePCR records to inform their Mortality

Reviews. If any additional information is required contact is made via a Trust dedicated mailbox. The MES is not able to review Trust call categorisation, Demand Management Plans or resource allocation. It is therefore important that internal governance mechanisms for assurance and learning around Emergency Medical Service Coordination (EMSC) continue. To this end, the Operations Quality Team are supporting the proportionate investigation of ME Referrals.

6. Requests by the MES for the Trust to review cases come via letter to the Trust's dedicated MES mailbox. The MES input their Reviews onto their Datix Cymru system. Currently their system does not 'communicate' with any of the Health Board or Trust Datix Cymru systems which means on receipt of the MES letter the Patient Safety Team has to input the content of the letter onto the Trust's Mortality Review Module. Work is progressing to address this nationally to enable information to flow across the Datix Cymru systems.

7. Prior to the implementation of the Once for Wales Datix Cymru system Referrals from the MES were logged on the Trust's Datix Web Incident Reporting Module. Themes and trends from these cases have also been included in the overall Review.

8. A detailed review of all of the backlog of open MES Referrals (n=548) from September 2020 until 31 March 2024 has been undertaken for assurances purposes to ensure all Referrals have undergone an appropriate level of review. Additionally, the aim is to identify themes and trends linking to current Programmes of Work where appropriate, including the Trust's Integrated Medium-Term Plan 2024-2027 and Right Care, Right Place, First Time, Six Goals for Urgent and Emergency Care 2021–2026 (Welsh Government).

WAST Learning from Deaths Forum

9. The Trust's Learning from Deaths Forum was established in October 2023 and meets on a quarterly basis, chaired by the Assistant Director of Quality & Nursing.

10. The remit of the Forum includes oversight of the Trust's Learning from Deaths Framework, Medical Examiner Service Referrals, Prevention of Future Deaths Reports (Regulation 28), bereavement care and scoping out opportunities for the use of collective analysis of information and data to inform Mortality Reviews and provide early warning mechanisms.

11. Outputs of the National Death Certification Stakeholder Reference Group will also be received by the Forum via Trust representation at the National Group.

BACKGROUND

12. Recommendations from numerous inquiries including the Shipman Inquiry (2003), Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013), Morecambe Bay Investigation (2015) and The Gosport Independent Panel (2018) have called for strengthening of safeguards for the public by providing additional independent scrutiny of the medical circumstances and cause of deaths.

13. The critical importance of good governance and data analysis in respect of Mortality Review Processes have been highlighted in a number of high-profile NHS independent Inquiries and Reviews, most recently in the Thirlwall Inquiry which has been set up to examine events at the Countess of Chester Hospital and their implications following the Trial, and subsequent convictions, of former Neonatal Nurse Lucy Letby of murder and attempted murder of babies at the hospital.

14. The MES is a joint service covering NHS England & NHS Wales, with a National Medical Examiner who has oversight of the introduction of the Medical Examiner System in England and Wales. NHS Wales has a Lead Medical Examiner in place.

15. As the MES has evolved and recruited Medical Examiners and Medical Examiner Officers the number of Referrals to the Trust has incrementally increased. Initially the focus was on non-coronial deaths in acute care and gradually this has expanded to community deaths. All non-coronial deaths in Wales will be reviewed from September 2024.

16. The final version of the All Wales Mortality Reviews Framework was published in May 2024 for adoption and localisation by Health Boards, Trusts and Primary Care.

ASSESSMENT

Medical Examiner Service Referrals

17. The review of the MES Referrals was undertaken in stages following the extraction of the information from the Trust's archived Datix Web and current Datix Cymru systems by the Trust's Quality Assurance Team.

18. **ANNEX 2** provides a breakdown of the fields and questions that were considered for each Referral.

19. A breakdown of the Referrals on both systems is presented in Table 1 below:

Table 1

Datix Systems: Medical Examiner Referrals	Number	Open	Closed
Datix Web Incident Module (September 2020 until April 2022)	160	51	109
Datix Cymru Mortality Module (May 2022 until March 2024)	859	497	362
		548	**471**
Total Number	1019		

MES Referrals Recorded on the Datix Web System (Incident Module)

20. The MES Referrals on the Datix Web system (September 2020 to April 2022) are included on the Incident Module as no specific module existed at this time. The detailed codes in the Trust's legacy Datix Web system enabled the following analysis of all of the ME concerns raised in Table 2.

Table 2

Datix Web Incident Module: Themes from MES Referrals September 2020 to April 2022	Number*
Handover of care delays	128
Delay in responding in the community (27 of these concerns related to patients who had fallen)	111
Clinical care / treatment issues	10
Communication	3

* It is important to note that some patients are included in more than one category therefore the numbers are greater than the total number of Referrals (n=160).

21. All Referrals (n=13) relating to concerns about clinical care, treatment issues and communication have undergone an investigation and are closed.

22. The open Referrals all relate to the impacts of the system pressures resulting in delays responding to patients in the community and delays in handover of care at Emergency Departments across Wales.

MES Referrals Recorded on the Datix Cymru System (Mortality Module)

23. From May 2022 a dedicated module has been in place on the All Wales Datix Cymru system. The module is currently populated manually by the Patient Safety Team following receipt of the MES letter. The code sets in this module are still under development nationally resulting in a significant amount of information

being held in free text fields which is challenging and time consuming to draw out patterns, themes and trends.

24. A mapping exercise of the 548 open MES Referrals (May 2022 to March 2024) on the Datix Cymru system has been undertaken to determine which Referrals require further review and those that can be mapped and moved to the closed section of Datix Cymru as follows:

- MES Referrals which can be mapped to existing Programmes of Work (delays in community response and handover of care) including the Integrated Medium-Term Plan 2024-27 and national work e.g. Right Care, Right Place, First Time, Six Goals for Urgent and Emergency Care 2021–2026 (Welsh Government)
- MES Referrals which have undergone scrutiny via a different route e.g. Coronial processes, incident reporting (including the Serious Case Incident Forum) and complaints
- MES Referrals that require further review and follow up by the Patient Safety Team, working with relevant colleagues with oversight from the Learning from Deaths Forum.

Table 3

Datix Cymru Mortality Module: Themes from Open MES Referrals May 2022 to March 2024	Number**
MES Referrals linked to an existing investigation process (e.g. Coronial processes, incidents, complaints)	372
MES Referrals referencing very poor patient & family experience, predominately due to delays in community and handover of care which link to current programmes in the Integrated Medium-Term Plan 2023-2026 (e.g. Six Goals of Urgent & Emergency Care and alternative care pathways).	330
MES Referrals requiring further review or assurances regarding improvement actions.	24

** It is important to note that some patients are included in more than one category therefore the numbers are greater than the total number of open referrals (n=548).

25. Documentation on the Datix Cymru system confirms that all Referrals underwent an initial screen by a member of the Patient Safety Team, with the majority being reviewed within one week of Referral.

26. Themes throughout the review of the Referrals from families and the Medical Examiner's highlight:

- Very poor patient and family experiences, predominately due to delays in responding in the community and delays in handover of care at hospitals, including patients who had fallen as a result of system pressures

- Many families in their discussions with the MEs shared that the care received when a member of staff did arrive was compassionate, caring and above and beyond
- Concerns regarding lack of End-of-Life Care Pathways/ceilings of care in place in the community setting
- Uncertainty in respect of do not attempt resuscitation orders in place

27. Twenty-four MES Referrals were identified for further review or follow up by the Patient Safety Team. These include one potentially serious incident and assurances in respect of improvement actions taken and sharing learning opportunities.

28. MES Referrals are now reviewed weekly (from April 2024) at the Level 1 Triage Group, led by the Assistant Director of Putting Things Right. The Group review the Referrals, applying a proportionate approach to determine next steps, and ensuring that statutory and mandatory responsibilities such as safeguarding and national incident reporting are considered. All thematic learning, as well as more detailed review of cases where there is any contributory or causative factors, are presented to the Level 2 Panel. The Trust has refreshed its approach to this work in line with the new National Mortality Review Framework, re-published in May 2024.

29. Where any issues identified link to existing Programmes of Work/Plans this will be indicated in the Level 2 Panel Learning Summary.

Reports to Prevent Future Deaths (Regulation 28)

30. Graph 1 below details the number of Reports to Prevent Future Deaths the Trust has received (n=13) over a rolling twelve months, with moving average trend line. Table 1 provides a breakdown by Health Board area and the concerns raised directly to the Trust and other parties as relevant.

Graph 1

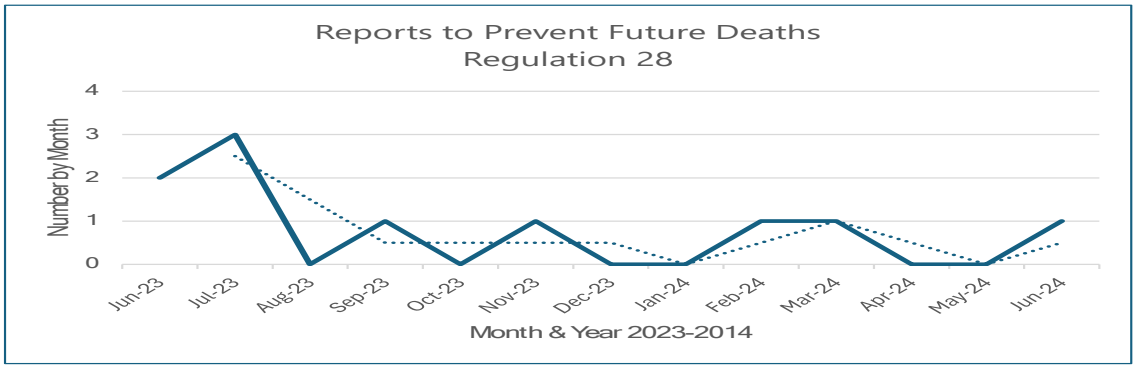


Table 1

Health Board	Date	Concerns Raised	Also Sent To:
Aneurin Bevan	11/2023	Response & handover delays	Aneurin Bevan UHB Minister for Health and Social Services, Welsh Government
Betsi Cadwaladr	09/2023	Advice provided for managing bleeding by call handlers	
	07/2023	Handover of care delays	Betsi Cadwaladr UHB
	06/2023	Delay in community & handover of care	Betsi Cadwaladr UHB North Wales LA
	07/2023	Delay in community & handover of care	Betsi Cadwaladr UHB North Wales LA
	07/2023	Delay in community & handover of care	Betsi Cadwaladr UHB North Wales LA
	06/2023	Delay in community & handover of care	Betsi Cadwaladr UHB North Wales LA
Cwm Taf Morgannwg	02/2024	Welfare calls and call handler script re call backs	
Cardiff & Vale, Hywel Dda & Powys - No Reports received.			
Swansea Bay	03/2024	Response delay & pressure damage	Swansea Bay UHB
	06/2024	Certain drug (Flumazenil) not carried by Paramedics	

31. During late 2023 and 2024 the Trust has been copied into a number of Reports which touch our service, but the Report has been sent to other bodies for response. Table 2 provides a breakdown of these Reports.

Table 2

Reports to Prevent Future Deaths Copied to the Trust B			
Health Board Area	Date of Report	Concerns Raised	Sent To:
Aneurin Bevan	02/2024	Community response delays.	Minister for Health and Social Services, Welsh Government
	02/2024	Training on Acute Behavioural Disturbance (ABD)	The Chief Constable of Gwent Police
	05/2024	Community response delays due to handover of care delays	Aneurin Bevan UHB
Betsi Cadwaladr	03/2024	Paramedics not carrying mucosal fentanyl lozenge. Change in legislation requested	The Rt Honourable James Cleverly, Secretary of State for the Home Office
	12/2023	Lack of out of hours endoscopy service, community response / handover of care delays, staffing levels in the emergency department.	Minister for Health and Social Services Betsi Cadwaladr UHB.

32. The Trust has responded to all Reports directly to date with improvement actions included.

33. Our responses are published on the Courts and Tribunals Judiciary website.

Next Steps

34. Progress is being made incrementally in respect of learning from deaths, with a number of externally driven dependencies. Next steps include:

a) Improving bereavement support and signposting for families by triangulating the feedback drawn from the MES Reviews, wider intelligence from the Patient Experience & Community Involvement (PECI) Team and complaints and compliments. The Head of PECI is a core member of the Learning from Deaths Forum
b) Digital Services: Data & Analytics have developed a Project Brief for a Natural Language Processing Programme to improve intelligence and learning following MES Referrals. The Natural Language Processing Programme will enable the free text elements of the Medical Examiner Reviews, including feedback from families to be drawn out and triangulated. Support is being sought from the NHS Wales Executive Scientists to progress this currently
c) Moving the mapped MES Referrals (September 2020 to March 2024) to the closed section of the Datix Cymru Mortality Module and Datix Web Incident Module
d) Follow up of the MES Referrals (n=24) identified in the look back exercise for further review by the Patient Safety Team, with oversight by the Learning from Deaths Forum
e) Following the publication of the final version of the All Wales Mortality Review Framework in May 2024 the Trust's Learning from Deaths Framework will be updated with oversight from the Learning from Deaths Forum and the Clinical & Quality Governance Group. This will incorporate the outputs from the process mapping exercise of the whole learning from deaths process, including working collaboratively with system colleague
f) Scoping out a Programme of Work across the Clinical Directorate (Clinical Development), Digital Services (Data & Analytics) and Quality, Safety & Patient Experience (Putting Things Right and Patient Experience & Community Involvement) to determine learning opportunities available in respect of the collective analysis of data and information to inform improvements, patterns, trends and themes, including early warning signals. This Programme of Work may need to extend nationally given the 'Once for Wales' approach of our electronic Risk Management Software (Datix Cymru)
g) Explore the themes identified in the Look Back Review concerning the lack of End-of-Life Care Pathways/ceilings of care in place in the community setting and

uncertainty in respect of Do Not Attempt Resuscitation orders at the next Forum, linking with relevant teams

h) Establish a Professional Standards Group

i) Continue the regular engagement with the Lead Medical Examiner Officer to ensure best ways of working and sharing learning

j) Continue to engage in the All-Wales Mortality Reviews Group and Datix Cymru Mortality Module Workstream

k) Continual horizon scanning for learning and improvement opportunities external to the Trust in this field including thematic reviews published by the England & Wales MES and Coroners Reports

RECOMMENDED: That the Committee discusses and approves the report and next steps as detailed in paragraph 34, highlighting any further assurance requirements.

ANNEX 2

The 'Look Back' included a review of the following key fields on the Datix Cymru Mortality Module which are completed by the ME.

1) Approval status e.g. new, under review, closed.

2) Has the death been referred to the Coroner because of uncertainty about its cause, or the circumstances leading up to it?

3) Has this case been referred to the Coroner?

4) Details of discussion & comments following discussion with the bereaved.

5) Medical Examiners review notes.

The following additional fields were added to inform the review:

6) Linked case on WAST Datix Cymru System?

7) If Yes, is it linked to a Complaint?

8) If Yes, is it linked to an Incident?

9) If Yes, is it linked to a Redress Case?

10) Was an initial screen undertaken on receipt by a member of the Patient Safety Team?

11) Date of receipt from Medical Examiner Service.

12) Date of screen by Patient Safety Team.

13) Has the case been referred to the Coroner by the Medical Examiner Service? (second check due to time lapse).

14) Does this case require further detailed review by the Patient Safety Team / or another team?

15) Does this case fall under one of the thematic review categories (End of Life Care, DNACPR, Community / Handover Delays, Pressure Damage, Falls)?

16) Is this case suitable to be closed as it is captured through one of the following: Coronial review, Serious Case Incident Forum, an incident, complaint or claim or an existing programme of work is already in place (e.g. Integrated Medium Term Plan)?

AGENDA ITEM No	**14**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**1**

Clinical Audit Plan & Action Tracker Q1 (update) 2024/25

MEETING	Quality, Patient Experience and Safety Committee
DATE	13th August 2024
EXECUTIVE	Andy Swinburn, Director of Paramedicine
AUTHOR	Kevin Webb, Head of Clinical Intelligence and Assurance
CONTACT	kevin.webb@wales.nhs.uk

EXECUTIVE SUMMARY

Following an 'Audit Wales' review of WAST's Quality Governance Arrangements, one of the recommendations was for the Clinical Audit Plan to be monitored on a quarterly basis at QuEST.

This is the Q1 2024-25 update to highlight progress with audits (the plan) and also to actions from the completed audit (action tracker).

The 2024-25 Clinical Audit Plan contains 12 audits covering a range of topics including clinical conditions, medicines, and compliance to documentation. Of these as indicated on the plan:

- 1 has been completed and approved at CIAG
- 2 are progressing as planned (1 since been approved at the July CIAG)
- 2 are not progressing as planned as they were reliant on ePCR User Interface changes being implemented. In addition, the Clinical Indicator Recovery Plan is currently a higher priority.
- 7 are yet to start, some are reliant on ePCR User Interface changes being implemented, some are not due to start until Q2/Q3/Q4.

For the audit approved during Q1 (Clinical Frailty Scale Follow Up Audit) there were 7 actions:

- 5 have been completed
- 2 are off track and recovery action taken

RECOMMENDED: That the committee Note the Q1 2024-25 Clinical Audit Plan and Action Tracker update.

KEY ISSUES/IMPLICATIONS
Many of the audits and re-audits can be undertaken solely by the Clinical Intelligence & Assurance Team. However, support is required for some topics where subject matter experts are needed as authors, and the support of sponsors to ensure completion of the audits and subsequent actions. Delays in our ePCR supplier implementing 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. The Clinical Indicator Recovery Plan is a high priority and the timeframe for some of the clinical audits on the plan will need to be adjusted due to the required resources.

REPORT APPROVAL ROUTE
Quality, Patient Experience and Safety Committee - 13/08/2024

REPORT APPENDICES
Clinical Audit Plan 2024/2025 Quarter 1 – For noting

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

SITUATION

1. Following an 'Audit Wales' review of WAST's Quality Governance Arrangements, one of the recommendations was for the Clinical Audit Plan to be monitored on a quarterly basis at QuEST.
2. This is the Q1 2024-25 update to highlight progress with audits (the plan) and also to actions from the completed audit (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 completed audits is monitored by the Clinical Intelligence & Assurance Group (CIAG), and an update noted at Clinical Directorate Business (CDB) meetings.

ASSESSMENT

8. The 2024-25 Clinical Audit Plan contained 12 audits covering a range of topics including clinical conditions, medicines, and compliance to documentation. Of these, as indicated on the plan:
   - 1 has been completed and approved at CIAG
   - 2 are progressing as planned (1 has since been approved at the July CIAG)

- 2 are not progressing as planned as they were reliant on ePCR User Interface changes being implemented. In addition, the Clinical Indicator Recovery Plan is currently a higher priority.
- 7 are yet to start, some are reliant on ePCR User Interface changes being implemented, some are not due to start until Q2/Q3/Q4.

9. The Clinical Audit Action Tracker is a dynamic document used to monitor and progress the actions as a result of learning from clinical audits. Progress with actions is monitored and supported by the Clinical Intelligence & Assurance Group (CIAG), and at the Clinical Directorate Business (CDB) meetings.

10. For the audit approved during Q1 (Clinical Frailty Scale Follow Up Audit) there were 7 actions:
    - 5 have been completed
    - 2 are off track and recovery action taken
        - A Clinical Frailty Podcast is to be published
        - The Clinical Frailty app is to be made available on iPads via the Mobile Device Management Software

RECOMMENDED: That the committee Note the Q1 2024-25 Clinical Audit Plan and Action Tracker update.

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

Welsh Ambulance Services University NHS Trust

Clinical Audit Plan

2024/2025
Quarter 1

Final v1.5 Last Updated 4th July 2024

Introduction

Clinical audit is one of a range of quality improvement methodologies that can deliver improved processes and outcomes. It measures against a standard, and can improve quality and unwarranted variations in practice, and support continuous and sustainable improvement. Clinical audit is a key enabler in evidencing the Health & Care Standards 2023, providing assurance and compliance with the duty of quality.

The development of this annual plan takes into consideration a number of aspects including the resources available both in terms of funding and skills. As is often the case in healthcare there are substantially more requests for clinical audits than there are resources available to manage them. For this reason, it has been necessary to prioritise and tailor the plan so that it is realistic, achievable and that expectations are not overreached.

The plan is developed in consultation with the Clinical Intelligence & Assurance Team (CIAT), and senior clinical, and non-clinical managers within the Trust. It is expected that managers will ensure there is an opportunity for staff at all levels to contribute to the development of the plan and undertake clinical audits.

Following requests to undertake clinical audits, a proposal form will be provided by the CIAT allowing the aims, objectives, author, and a sponsor to be identified, along with identifying the necessary data and level of support required from the CIAT. A How to Undertake a Clinical Audit document is available on the Trust's intranet to guide and support staff.

The decision for clinical audit topics chosen for inclusion will be influenced by:

- Local and Trust priorities (e.g. Integrated Medium-Term Plan (IMTP) and Local Delivery Plans (LDPs))
- Clinical risk (e.g., linked to clinical risk registers or identified potential risks)
- Opportunities to improve clinical effectiveness and evidence-based practice (e.g., efficacy of treatment, new initiatives, pilot projects)
- Opportunities to quality assure clinical data (e.g., Clinical Indicator reports from electronic Patient Clinical Record (ePCR) data)
- National inquiries/patient safety incidents/Regulation 28 reports
- Guidance documents (e.g., National Institute for Health and Care Excellence (NICE), Association of Ambulance Chief Executives (AACE), and the Joint Royal Colleges Ambulance Liaison Committee (JRCALC)

- National Ambulance Service Clinical Quality Group
- Policy documents relating to health and healthcare
- Other benchmarking activities as appropriate

A number of new service delivery models are often required for a modern ambulance service. The robust evaluation of service development topics is essential and needs to be planned from their inception.

It is not always possible to predict at the start of a financial year all 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.

As part of the development and updating of this plan, the CIAT have streamlined and improved the process, forms and templates used. This approach has been further supported following and internal audit. When the CIAT receive topics for suggested audits, they are added to a spreadsheet and a prioritisation tool is used to assist in identifying the order for inclusion on the plan. These will then be presented to the Clinical Intelligence and Assurance Group to approve their inclusion in the plan.

The aim of this plan is to detail the clinical audits that are either planned, currently underway or have been completed during the financial year **(Table 1 & Table 2)**

It is expected that all the topics identified in the plan will be initiated during the course of a financial year. Those initiated during Q3 or Q4 may not be fully completed and will need to be considered in the subsequent year's plan.

The completed clinical audit reports are available on the Clinical Audit page of the Trust's Intranet website. (https://nhswales365.sharepoint.com/sites/AMB-Intranet-Medical/SitePages/Clinical-Audit-Programme.aspx)

Kevin Webb – Head of Clinical Intelligence & Assurance

Table 1 – Summary (Full information in Table 2)

*	N/A = Not due to start	Not started/not progressing as planned	**Progressing as planned	Completed
** A clinical audit is deemed as started once a clinical audit proposal and criterion table have been approved by the CIAT and the ePCRs and/or data supplied				
Clinical Audit Classification		Tier 1 = UK Ambulance Services or Trust wide		Tier 2 = Health Board/Locality/Team

This section contains confirmed clinical audits

Ref	Tier	Clinical Audit Title	Clinical Audit Author	Clinical Audit Sponsor	Audit Start Date	Current Status (RAG)*				
						Q4 2023/ 2024	Q1	Q2	Q3	Q4
23_004	1	ePCR Clinical Data Assurance – Fractured Neck of Femur (#NOF) Clinical Indicator Re-audit	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	*Indicative Q1 24/25*					
23_008	1	ePCR Clinical Data Assurance - Stroke Clinical Indicator Re-audit	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	*Indicative Q1 24/25*	N/A	N/A			
23_009	1	ePCR Clinical Data Assurance - STEMI Clinical Indicator Re-audit	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	*Indicative Q1 24/25*	N/A	N/A			
23_005	1	ePCR Clinical Data Assurance - Hypoglycaemia Clinical Indicator Re-audit	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	*Indicative Q1 24/25*					
TBC	1	ePCR Clinical Data Assurance - Return of Spontaneous Circulation (ROSC) at Hospital Clinical Indicator Re-audit	Clinical Intelligence & Assurance Team	Kevin Webb	*To commence after ePCR changes implemented*	N/A	N/A			

				Head of Clinical Intelligence & Assurance						
23_003	1	Clinical Frailty Scale (CFS) in Patients Aged ≥65 years Follow Up Audit	Richard Teulon Clinical Intelligence & Assurance Co-ordinator	Duncan Robertson Assistant Director of Clinical Development	*Indicative Q4 2023/24*					
24_001	1	Older Adult Fallers Discharged at Scene - ePCR Clinical Data Assurance	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	Indicative Q1	N/A				
TBC	1	Tranexamic Acid (TXA) Administration Audit	Clinical Intelligence & Assurance Team	Greg Lloyd Assistant Director of Clinical Delivery	Indicative Q2	N/A				
TBC	1	Failed Pathways Recording on ePCR Audit	Jonathan Chippendale	Duncan Robertson Assistant Director of Clinical Development	Indicative Q2	N/A	N/A			
TBC	1	ROLE Form Images in ePCR Re-audit	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	Indicative Q4	N/A	N/A	N/A	N/A	
TBC	1	Major Trauma Tool Audit	Carl Powell, Clinical Lead – Acute Care	Greg Lloyd Assistant Director of Clinical Delivery	Indicative Q2/3	N/A	N/A			
TBC	1	Safeguarding Adolescent Audit Follow-up	Gwenan Jones-Parry Safeguarding Specialist Paramedic	Rhiannon Thomas Senior Professional Safeguarding	TBC	N/A	N/A	N/A		

Table 2 – Full Information

Ref	Clinical Audit Title	Rationale/Drivers	Clinical Audit Author	Clinical Audit Contact/Support	Audit Start Date	Comments
23_004	ePCR Clinical Data Assurance – Fractured Neck of Femur (#NOF) Clinical Indicator Re-audit	To ascertain if improvements have resulted following completion of actions from the previous audit.	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	*Indicative Q1 24/25*	Update further delayed, and problems with consistent roll out @19/12, and whether all changes have been implemented. UI changes investigated, and SBAR presented to ePCR-CRG (28/3) to confirm outstanding issues. UI changes delayed until 10th June 2024 Start date of audit TBC.
23_008	ePCR Clinical Data Assurance – Stroke Clinical Indicator Re-audit	To ascertain if improvements have resulted following completion of actions from the previous audit.	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	*Indicative Q1 24/25*	Update further delayed, and problems with consistent roll out @19/12, and whether all changes have been implemented. UI changes investigated, and SBAR presented to ePCR-CRG (28/3) to confirm outstanding issues. Start date of audit TBC.

Ref	Clinical Audit Title	Rationale/Drivers	Clinical Audit Author	Clinical Audit Contact/Support	Audit Start Date	Comments
23_009	ePCR Clinical Data Assurance - STEMI Clinical Indicator Re-audit	To ascertain if improvements have resulted following completion of actions from the previous audit.	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	*Indicative Q1 24/25*	Update further delayed, and problems with consistent roll out @19/12, and whether all changes have been implemented. UI changes investigated, and SBAR presented to ePCR-CRG (28/3) to confirm outstanding issues. Start date of audit TBC.
23_005	ePCR Clinical Data Assurance - Hypoglycaemia Clinical Indicator Re-audit	To ascertain if improvements have resulted following completion of actions from the previous audit.	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	*Indicative Q1 24/25*	Update further delayed, and problems with consistent roll out @19/12, and whether all changes have been implemented. UI changes investigated, and SBAR presented to ePCR-CRG (28/3) to confirm outstanding issues. UI changes delayed until 10th June 2024 Start date of audit TBC.
TBC	ePCR Clinical Data Assurance - Return of Spontaneous Circulation (ROSC) at	To ascertain if improvements have resulted following completion of actions from the previous audit.	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	*TBC*	Funding required for these specific changes. Potential to use 'Point of Closure' changes to improve compliance.

Ref	Clinical Audit Title	Rationale/Drivers	Clinical Audit Author	Clinical Audit Contact/Support	Audit Start Date	Comments
	Hospital Clinical Indicator Re-audit					
23_003	Clinical Frailty Scale (CFS) in Patients Aged ≥65 years Follow Up Audit	To ascertain if improvements have resulted following completion of actions from the previous audit.	Richard Teulon Clinical Intelligence & Assurance Co-ordinator	Ruth Saele Clinical Intelligence & Assurance Data Specialist	*Indicative Q4 2023/24*	Completed Q1 2024/25.
24_001	Older Adult Fallers Discharged at Scene - ePCR Clinical Data Assurance	To ascertain the availability and quality of raw ePCR data to inform the development of a Clinical Indicator.	Clinical Intelligence & Assurance Team	Ruth Saele Clinical Intelligence & Assurance Data Specialist	Indicative Q1	A pilot audit was undertaken in collaboration with UK Ambulance Trusts. WAST to now look at specific criteria for a Clinical Indicator. Criteria developed in collaboration with Falls in older adult lead and agreed in CIAG 08.03.24
TBC	Tranexamic Acid (TXA) Administration Audit	This audit will be of Trust wide ePCR data and broadens the scope of the initial audit (SWTN digital pen data), by including all JRCALC indications. This is will also ascertain if improvements have resulted following completion of actions from specific areas in the previous audit.	Clinical Intelligence & Assurance Team	Ruth Saele Clinical Intelligence & Assurance Data Specialist	Indicative Q2	CIAT have ongoing discussions with the sponsor and subject matter experts.
TBC	Failed Pathways Recording on ePCR Audit	Following an update to the ePCR User Interface to record the inability to refer patients onto pathways, an audit would assist in identifying areas for improvement for patient care and	Jonathan Chippendale	Clinical Intelligence & Assurance Team	Indicative Q2/3	Jonathan Chippendale (11/1/24) – confirmed audit required. Required UI changes presented to ePCR CRG 29.05.24

Ref	Clinical Audit Title	Rationale/Drivers	Clinical Audit Author	Clinical Audit Contact/Support	Audit Start Date	Comments
		avoid unnecessary admission to Emergency Departments.				
TBC	ROLE Form Images in ePCR Re-audit	To ascertain if improvements have resulted following completion of actions from the previous audit.	Clinical Intelligence & Assurance Team	Ruth Saele Clinical Intelligence & Assurance Data Specialist	Indicative Q4	
TBC	Major Trauma Tool Audit	In addition to the TXA audit, this would include contact with the Trauma Desk and disposition (Trauma Unit etc).	Carl Powell Clinical Lead Acute Care	Clinical Intelligence & Assurance Team	Indicative Q2/3	Confirmed by GL that audit to progress during 2024/25. Audit to cover all-Wales to include patient disposition if outside the area of the SWTN.
TBC	Safeguarding Adolescent Follow-up Audit	To ascertain if improvements have resulted following completion of actions from the previous audit.	Gwenan Jones-Parry Safeguarding Specialist Paramedic	Claire Muxworthy Clinical Intelligence & Assurance Co-ordinator	Indicative Q3	Planned to commence Q1 New Head of Safeguarding starting end of May 2024 delayed.

AGENDA ITEM No	**15**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**1**

Focus on Clinical Indicators - Hypoglycaemia

MEETING	Quality, Patient Experience and Safety Committee
DATE	13th August 2024
EXECUTIVE	Andy Swinburn, Director of Paramedicine
AUTHOR	Kevin Webb, Head of Clinical Intelligence and Assurance
CONTACT	kevin.webb@wales.nhs.uk

EXECUTIVE SUMMARY

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 ROSC at hospital, Stroke and Fractured Neck of Femur (#NoF – hip fracture) have previously been presented, and for this meeting, the focus is on hypoglycaemia (Diabetic – low blood sugar)

Within this update we will highlight:

- What we measure (criteria)
- Data quality and reporting
- Clinical Indicator Recovery Plan
- Improvements to date
- Next steps to improvement

ePCR user interface changes recommended from the hypoglycaemia clinical audit were included in the updates implemented in June 2024. The supplier will make further changes as required. These are aimed and improving the usability for clinicians to input data and to improve CI compliance.

A CI recovery plan has been implemented which includes focussed communication, clinical workshops, implementing the clinical supervision policy, and reviewing the scripting for CI reports.

A revised CI 'Jigsaw Poster' and various infographics have been developed as aide memoirs to support staff with ePCR completion.

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 Hypoglycaemia (Diabetic – low blood sugar) Clinical Indicator.

KEY ISSUES/IMPLICATIONS
Not applicable.

REPORT APPROVAL ROUTE
Quality, Patient Experience and Safety Committee – 13 August 2024

REPORT APPENDICES
Focus on CIs – Hypoglycaemia PowerPoint presentation

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

Welsh Ambulance Services University NHS Trust

Clinical Indicators
Focus on Hypoglycaemia



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

Clinical Indicators – Focus on Hypoglycaemia
Version 0.1
Released: July 2024

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

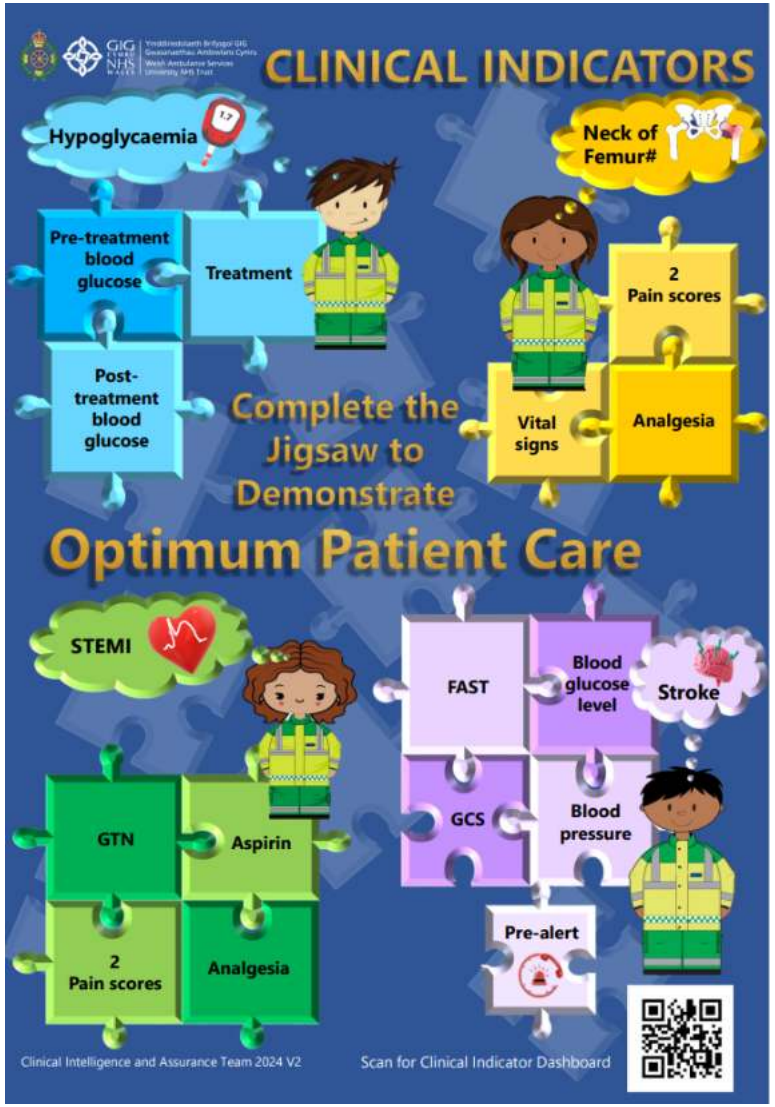
Introduction

The next Clinical Indicator (CI) in the 'Focus on CIs series' is for Hypoglycaemia (Diabetic- low blood sugar).

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 with a working diagnosis of Hypoglycaemia (Diabetic – low blood sugar) (*denominator*)**

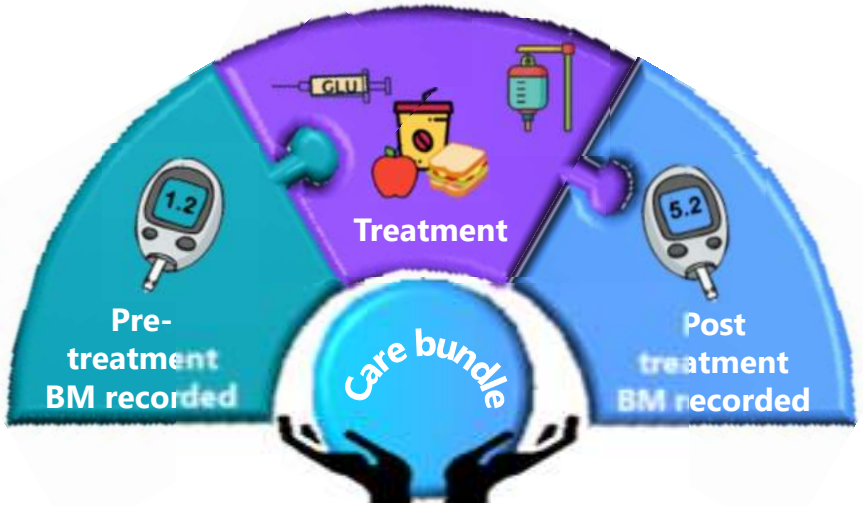
- **Compliance to the care bundle requires each criterion of care (*numerator*) to be completed:**

  - ✓ **Pre-treatment blood glucose level recorded (BM)**

  - ✓ **Treatment to reverse hypoglycaemia administered to include:**
    - **Quick acting carbohydrate e.g. sugary drink, glucose tablet, biscuit**
    - **Glucose Oral Gel**
    - **Glucagon**
    - **Glucose 10%**

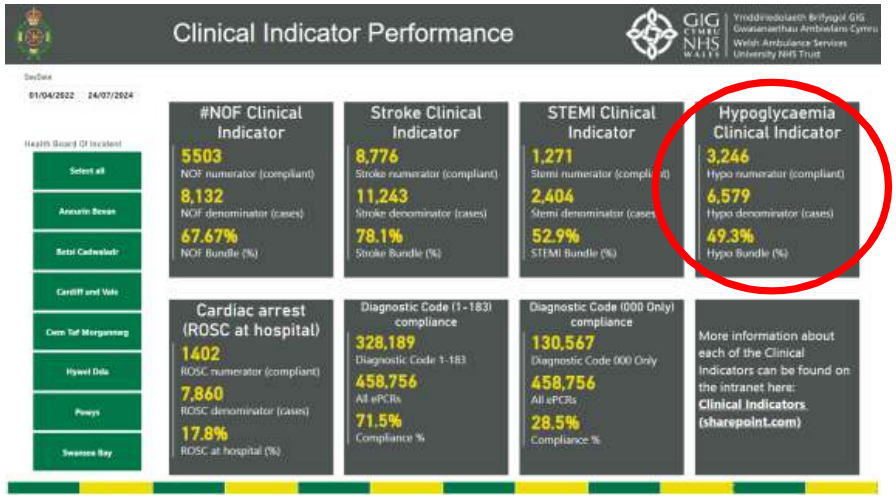
  - ✓ **Post treatment blood glucose level (BM)**

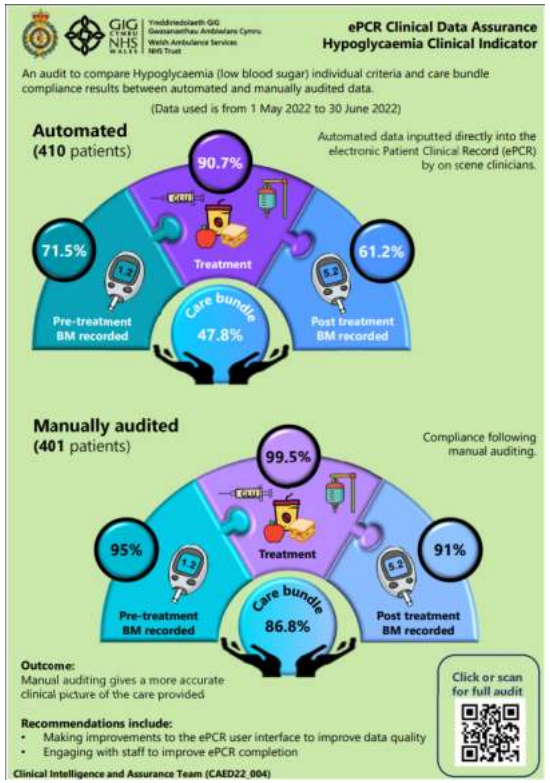




Data quality and reporting

- 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 hypoglycaemia
- 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





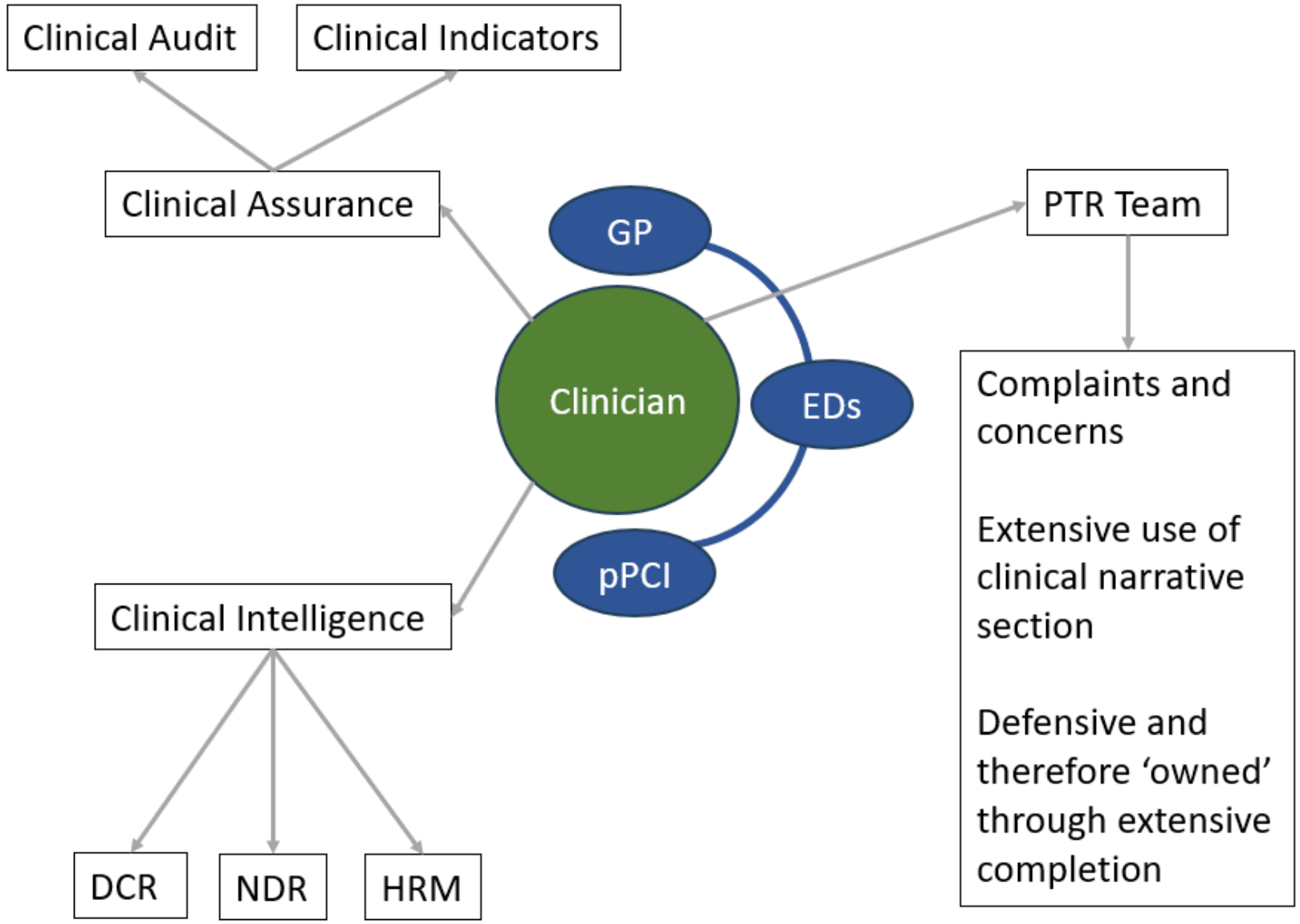
ePCR Users

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?



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
  - Inform an improvement plan and changes to the ePCR User Interface
- A stand at the CEO Roadshows in April 2024 made available to promote ePCR completion and CI compliance
- User Interface changes were implemented in June 2024, work continues with the supplier to complete further updates as required
- Improvement plan progressing with further engagement and support from Senior Paramedics for ePCR completion and CI compliance
- Deep dive for CI data (April 2024) – provided opportunities to review and update the scripting used to generate CI reports
- Development of a revised CI 'Jigsaw Poster' following requests from staff to use as an aide memoir
- Development of infographics to be used in iPad lock screens to support ePCR completion and improve CI compliance



Hypoglycaemia compliance April 2022 – July 2024 (data extract 24/07/2024)

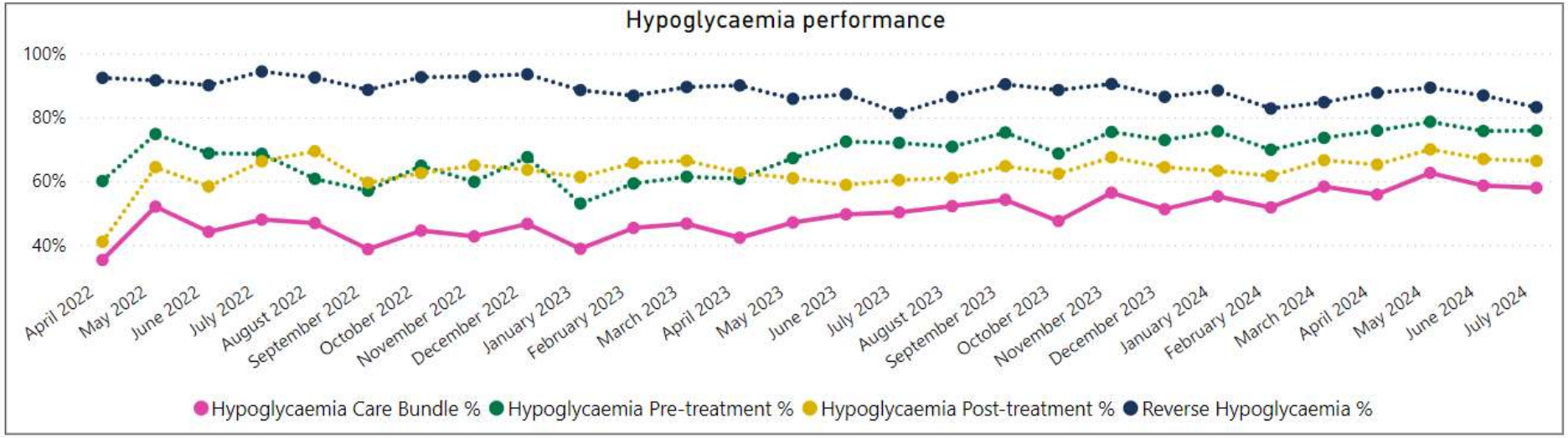
Hypoglycaemia - Care Bundle & Individual Metrics

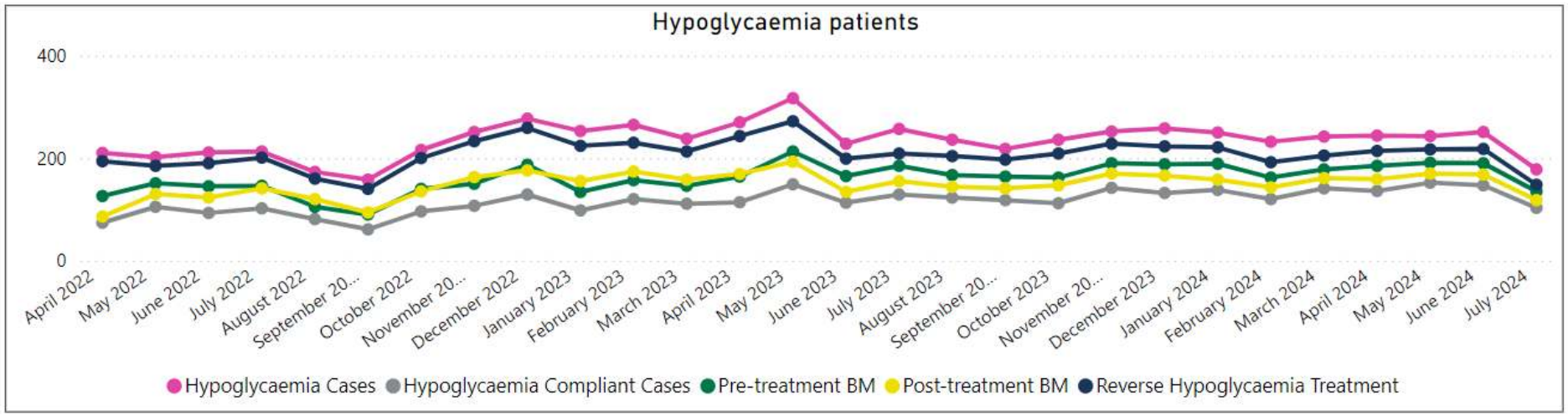
GIG CYMRU NHS WALES
Ymddiriedolaeth Brifysgol GIG Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services University NHS Trust

DayDate
01/04/2022 24/07/2024

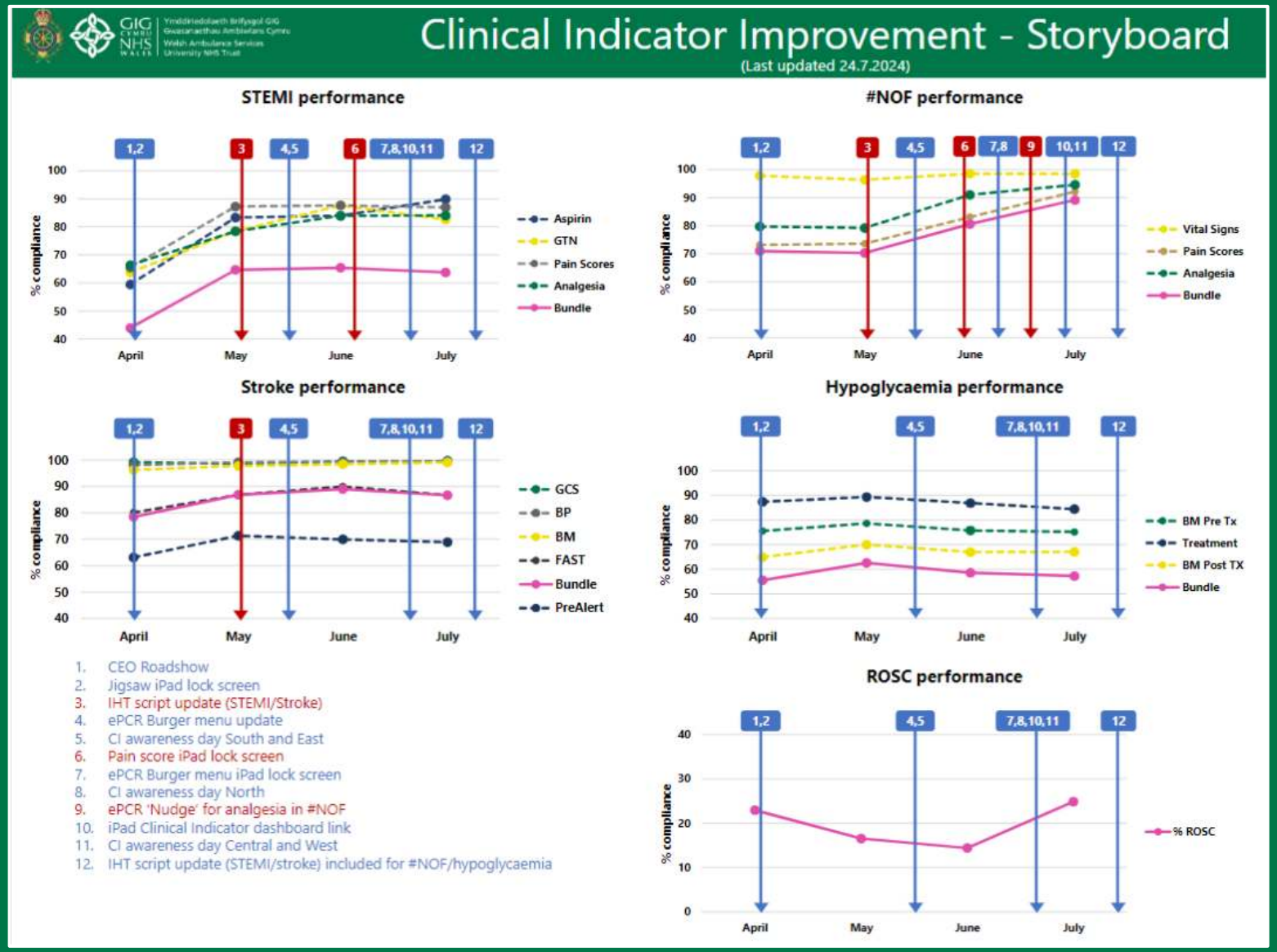
Health Board Of Incident

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





CI Improvements (Timeline of improvement initiatives)



Next steps to improvement

- **A recent User Interface change included a 'nudge tool' to improve ePCR compliance for specific fields at point of ePCR closure (*changes managed by the ePCR Compliance Approval Group*)**
  - ***To enable message prompts and quick access to non-compliant fields prior to closing ePCRs***
- **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 CI Performance Group has been established (weekly meetings) – maintaining a focus on improvements and sharing best practice**

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

Thank you for listening

Any questions or comments?

The next in this series for focus on CIs will be STEMI (Heart attack)

AGENDA ITEM No	**16**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**1**

Impact of the Changes to Stroke Categorisation

MEETING	Quality, Patient Experience and Safety Committee
DATE	13 August 2024
EXECUTIVE	Andy Swinburn, Executive Director of Paramedicine
AUTHOR	Mike Jenkins, Regional Clinical Lead – Consultant Paramedic
CONTACT	mike.jenkins@wales.nhs.uk

EXECUTIVE SUMMARY

1. Following changes made to National stroke guidelines and a report completed by Health Inspectorate Wales, the Welsh Ambulance Services University NHS Trust has communicated updated guidance in the way in which the Trust will respond to patients presenting with a potential stroke.

2. The purpose of this SBAR report is to provide a background of the changes which were made during March and April 2024, and assurance that these changes have been reviewed with update provided to the Health Inspectorate Wales stroke audit tracker.

Recommendation: The contents of this executive summary are accepted, and that assurance is offered that WAST continues to work with the Welsh stroke networks in relation to the care provided to patients presenting with a potential stroke following the agreed UK guidelines and recommendations made by HIW.

KEY ISSUES/IMPLICATIONS

Not applicable.

REPORT APPROVAL ROUTE

Not applicable.

REPORT APPENDICES
SBAR

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

Situation

1. In April 2023 the National Stroke guidelines were updated, further in December 2023 Health Inspectorate Wales (HIW) released its findings in relation to the review undertaken in relation to 'Patient flow, a journey through the stroke pathway'.

2. Both these papers recommended extending the window for thrombolysis treatment from the previous 4.5 hours to 12 hours, additionally the thrombectomy window was also extended.

3. The HIW report recommended that the Welsh Ambulance Services University NHS Trust (WAST) communicate with staff informing them of these changes.

Background

4. WAST was approached by the National Stroke Lead for Wales supported by the wider stroke network requesting that the Amber 1 and 2 response categorisations for potential stroke should be altered to reflect the recommendation within the National Stroke Guidelines and the HIW report.

5. WAST agreed to change its amber 1 response categorisation from those patients presenting with symptoms of stroke with onset of symptoms within 4.5 hours to 12 hours. Due to the Medical Priority Dispatch System scripting for protocol 28 (stroke/TIA), it was not possible to accurately predict the impact this change would have on Amber 1 response.

6. A clinical bulletin was released on the 28 March 2024 informing staff of the changes to the Stroke guidelines and the HIW report recommendations, within this bulletin was a link to the revised pre alert guidance which also reflected these changes.

7. The requested changes were made to the Amber 1 categorisation on the 2nd of April 2024. Changes made by WAST were also made by ambulance services across the UK

Assessment

8. It can be reported to Quality, Patient Experience and Safety Committee that there is no evidence to suggest that the changes made to time of onset of symptoms for potential stroke patients has impacted upon the Amber 1 response times.

9. There has been feedback from one health board, they are not in a position due to the availability of stroke specialist to work to the new guidance yet. This has been fed back to the National Stroke Lead for Wales who is working with that Health Board. This has not impacted upon the changes made by WAST.

10. WAST has been undertaking a pilot with Cardiff and Vale University Health Board in relation to 'Pre-Hospital Video Triage' for patients suffering a potential stroke.

11. WAST Paramedics and Emergency Medical Technicians (EMTs) have utilised this video triage to discuss patients who are presenting with a potential stroke directly with a stroke consultant. On occasions patients who have presented with symptoms beyond the previously agreed timeframe (4.5 hours) have been accepted by stroke teams and have been given thrombolytic therapy with positive outcomes.

Recommendation: The contents of this executive summary are accepted, and that assurance is offered that WAST continues to work with the Welsh stroke networks in relation to the care provided to patients presenting with a potential stroke following the agreed UK guidelines and recommendations made by HIW.

AGENDA ITEM No	**17**
OPEN or CLOSED	**OPEN**
No of ANNEXES	**1**

AUDIT TRACKER 2.0 – JUNE 2024 (Q1)

MEETING	Quality, Patient Experience & Safety Committee
DATE	13 August 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 and provides recent audit reports for the Committee's attention, where applicable.

2. Of those internal audit actions relevant to this Committee**,** nine have been closed in Quarter of a total of 23 (39%). There are seven actions which have had a change in date proposed (marked in blue). There are no open actions on their third revised date. It is noted that one of the closed actions was added to the tracker as closed.

3. Of those external audit actions relevant to this Committee, five have been closed in Quarter of a total of eight (62.5%). Of the external audit actions, one has a change in date proposed (marked in blue). There is one action on its third revised date (action reference 106a), a change which was made in Quarter 4 2023/24.

4. It is noted that the Records Management internal audit actions have moved from the QuEST Committee to the Finance and Performance Committee following revision of Committee Terms of Reference in May 2024, and are no longer presented on the tracker for this Committee's attention.

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: -

- Clinical Audit (Internal Audit)

(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 July 2024.

REPORT APPENDICIES
Annex 1 – Tracker 2.0 – April - June 2024 for Committee Reporting - QuEST

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 and provides recent audit reports for the Committee's attention, where applicable.

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 one 2024/25 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.

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.

Internal Audit

13. Of those internal audit actions relevant to this Committee**,** nine have been closed in Quarter of a total of 23 (39%). There are seven actions which have had a change in date proposed (marked in blue). There are no open actions on their third revised date. It is noted that one of the closed actions was added to the tracker as closed.

14. It is noted that the Records Management internal audit actions have moved from the QuEST Committee to the Finance and Performance Committee following revision of Committee Terms of Reference in May 2024, and are no longer presented on the tracker for this Committee's attention.

External Audit

15. Of those external audit actions relevant to this Committee, five have been closed in Quarter of a total of eight (62.5%). Of the external audit actions, one has a change in date proposed (marked in blue). There is one action on its third revised date (action reference 106a), a change which was made in Quarter 4 2023/24.

Management and Development of the Tracker

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 two 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 2023 the Committee agreed that the most effective way to improve the scrutiny of the impact of actions was by identifying actions within audits as audit reports are reviewed by the Committee, going forward.

18. The current version of the tracker is now open for Directorate review for actions due in July to September 2024/25. These updates will then be reported to the Committee at its meeting in November 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 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: -

- Clinical Audit (Internal Audit)

(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 include here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. Please add most recent update first
507	22/23	Quest	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	Closed in Quarter	310524: (AP) Accepted in line with closure of related actions in previous quarter. 13. 5.24 Premises and Vehicle Cleaning Policy was approved at Quality, Patient Experience & Safety Committee on 7 May 2024. Proposed for closure 3.4.24: The Policy Group have deferred the submission of the Premises and Vehicle Cleaning Policy to 23 W68pril 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.
517	22/23	Quest	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		Closed in Quarter	310524: (AP) Status updated to closure proposed based on receipt of evidence. 30.4.24: New e-learning package containing up to date information shared with Strategic IPC Meeting on 30 April 2024 by Jo Kelso, National Ambulance Training College. Course available via this link: https://nhswales365.sharepoint.com/sites/AMB_LMS365/SitePages/InfectionPreventionandControlIPC.aspx. Proposed for closure 26.4.24: Learning content has been shared with the Training college who are making good progress to get it ready for LMS365. Content contains everything that was agreed - 4 standalone modules, with short follow up assessments which will be presented as one IPC eLearning package. Scheduled for sharing at the IPC Strategic Meeting on 30 April 2024. 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)
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	Sep-24		Open	080724: Revised date of September 2024 added in Q1 2024/25. When Pharmacist Advisor recruited the role holder will be reviewing the Patient Group Directives outstanding. At that point this will be an ongoing responsibility of the PA. Action to be closed when backlog of PGDs reviewed. 050724: Proposure not accepted; post holder needs to be in post before closure. Last Updated 270624: (JL) Additional support approved and agreed at EFG 27/03/24. Lead Pharmacist role is currently out for recruitment and second Head of Medicines Management role expected to be out for recruitment in next few days. Action recommended for closure. 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.
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.

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 include here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. Please add most recent update first
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	Met				Closed in Quarter	310524: AP Updated to closure proposed. 26.4.24: Iterations of the Serious Case Incident Forum Log with revised versions has been developed to enable improved oversight and tracking. Screenshots with examples of completed & in progress actions have been provided. There will always be open actions as the Forum meets twice weekly and this is the nature of the patient safety functions. The job description for the new Putting Things Right Coordinator role inlcudes the responsibility for the Log highlighted. Proposed for Closure 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	Met				Closed in Quarter	310524: AP Updated to closure proposed. 26.4.24: The Quarter 4 Putting Things Right Report will be presented to the Clinical & Quality Governance Group on 30 April 2024 and the Quality, Patient Expereince & Safety Committe on 7 May 2024. This includes a graph tracking the incidents shared as part of the Joint Investigation Framework (process measures) and early themes & learning in this version in respect of ceilings of care, end of life care, high levels of escalation in Emergency Departments and delayed discharge (outcome measures). Since the Internal Audit, the Head of Putting Things Right & the Assistant Director, Quality, Safety & Patient Experience (interim) have met with a colleague from Swansea Bay Uuniversity Health Board to discuss arranging a national learning event to determine how we can improve learning from the Joint Investigation Framework process as it is still quite transactional, and focus on common themes and areas we can influence positively. We will use the themes identified as part of this. The Log in Trust Ref 671 also now includes more detailed actions in respect of Joint Investigations. Proposed for closure 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
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 Met	Sep-24			Open	040724: (AP) Revised date to September 2024 added in Q1 24/25. Last updated 270624: (JL) At ePCR CRG, this item was specifically discussed. Future data will capture the method of training. Requires updates to the ESR system to accommodate. Request deadline extended to end Q2 to allow time for this change to be made. 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 Met	Sep-24			Open	040724: (AP) Revised date to September 2024 added in Q1 24/25. Last updated 270624: (JL) Senior paramedics invited to ePCR CRG. This will form the core group to devise the feedback survey. Meeting to be set up to begin the work. Request deadline extended to end Q2 to allow time for this activity. 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 Met	Sep-24			Open	040724: (AP) Revised date to September 2024 added in Q1 24/25. Last updated 270624: (JL) ePCR CRG have discussed and agreed that a self-test will be included in the training materials. This will be incorporated following migration of the training materials to the LMS365 platform. Request deadline extended to end Q2. 04.04.2024 Work has yet to be commence due to meeting cycles. Will be an agenda item at the ePCR Clinical Reference Group on the 28th March (agenda to be competed on the 21st March 2024).
684	23/24	Quest	Electronic Patient Clinical Records: Clinical Compliance (ePCR)	Reasonable	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 Met	Dec-24			Open	040724: (AP) Revised date to December 2024 added in Q1 24/25 to end of Q3. Last updated 270624: (JL) Action has yet to commence in order to accommodate earlier actions. Request deadline extended to end Q3 to enable earlier actions to be completed Q2 and then for this is take place Q3. 04.04.2024 Work has yet to be commence due to meeting cycles. Will be an agenda item at the ePCR Clinical Reference Group on the 28th March (agenda to be competed on the 21st March 2024).
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	Met				Closed in Quarter	050724: Updated to closure proposed; evidence received of the changes made by HI (email). Last updated 280624: (JL) Changes have been made to the dashboard as recommended. Suggest closure of action due to completion - see email from DR/Abigail Townsend 28062024. 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"	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 270624: (JL) Following HI pause, leads for this work within the digital directorate have been identified. Work will commence late June 2024 to enable initial scoping to be undertaken. Request deadline extended to end Q2. 04.04.2024 Work has yet to be commence due to meeting cycles. Will be an agenda item at the ePCR Clinical Reference Group on the 28th March (agenda to be competed on the 21st March 2024).

Points of Contact, Directors and Owners of Audit Actions - Do Not Amend Any Column With a Red Header
When proposing a revised 1st, 2nd or 3rd date, include the rationale for the movement and any progress on the action to date

Trust Ref No.	Audit Wales or HIW Report	Year	Committee Assigned to	Report Title	Responsible Officer	Director	Priority Level	Rec. No. in Audit	Recommendation	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
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
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	Met				210624: (AP) Updated to closure proposed in line with update provided. Update 21.5.24: The Patient Experience & Community Involvement (PECI) Team have been represented at meetings where recommendations of the Bevan Commission have been discussed and have begun to influence thinking around future planned engagement across the Trust and Health Boards. PECI have utilised the People & Community Network as well as those groups/communities it regularly engages with as part of its Continuous Engagement Model to help shape our approach. Going forward, the knowledge and feedback from this along with continuous feedback captured from engagement events, experience surveys and patient stories will help influence our working for the public involvement/engagement element of the proposed new clinical response model and its communications plan that has emerged from the series of workshops held throughout May this year. The PECI Bi-Annual report was presented to the Quality, Patient Experience & Safety Committee on 7 May 2024. Proposed for closure. 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*	Closed in Quarter

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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	Met				110724: Action: 1)Trust agreed that it would undertake its own clinical audit to ascertain compliance with the Stroke pathway. 2) Ensure staff are aware of the Stroke pathay to minimise risks to patient safety by issuing/reissuing guidance. Evidence: 1) To evidence this the Trust will obtain ePCR data on Stroke codes to understand how many have recorded pre-alerts. This will give compliance with the Stroke pathway due to the destination hospital, and provide evidence of this compliance audit to the Corporate Governance Team. This audit is to be completed; evidence received and action closed (150724). 2) The pre-alert guidance/comms (informed by the national stroke guidelines), reissued to relevant colleauges, will be given to the Corporate Governance Team as evidence that all staff are aware of the Stroke pathway, in response to the recommendation. Evidence received and action can be closed (150724). Last updated 28062024: (JL) The WAST pre alert guidance has been updated to reflect the changes to the amber 1 response as per the stroke guidlines and this is available to the workforce on the JRCALC app.	Closed in Quarter
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	Met				110424: Action: 1) Consider the benefits of the use of the ROSIER stroke assessment tool by the Ambulance Practice Steering Group, and agree position regarding its use. Discussion relating to ROSIER was presented to the APSG in Q3 of 23/24. Based on the lack of evidence to support its use the decision was made to remian with the guidance offered by the Joint Royal Colleges Ambulance Liaison Committee (JRCALC), which is avaliable to all frontline clinicians. 2) The Trust will seek to work in partnership with both Universities in Wales who deliver pre-registration education, in developing an up to date syllabus for stroke education. It is noted that this was a supplementary action/response to the recommendation which was consideration of the ROSIER stroke assessment tool. Evidence: 1) AAA from the APSG at which the discussion was held; a copy of the clinical practice guidelines and supporting research (which informed the discussion / decision to remain with the JRCALAC guidance) will be given to the Corporate Governance Team. Agreed evidence received - action to be closed. 2) The Trust has engaged with Universities on the relevant educational content; a recent conference poster is evidence of such engagement. However it is noted that the Trust does not control the syllbaus design / content of the Universities, but the Trust will continue to work in partnership with relevant institutions. It is therefore not possible to 'complete' this action. Last updated 28062024: (JL) The discussion relating to Rossier was presented to the Ambulance Practice Steering Group in Q3 of 2023/4. Based on the lack of evidence to support its use in the pre hospital setting, the decision was made to remain with the guidance offered by the Joint Royal Colleges Ambulance Liaison Committee (JRCALC), which is available to all frontline iPad-issued staff.	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	Met				110424: Action: 1) Trust must ensure that all staff associated with potential stroke patients are aware of the updated guidance and will work with stroke networks to co-ordinate the dissemintation 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. The Trust recognises that there could be resource implications for the Trust. Engage will be made with Commissioners as necessary. Evidence: 1) A bulletin issues on Siren reconfiriming the guidance is evidence of this communication. It is noted that it is not possible to know the totality of the impact on EMS resource however the changed response approach, with the extension of the timeframe from 4.5 to 9 hours was discussed and agreed by the Trust ELT. At this point in time there is no need to engage with Commissioners regarding resource concerns. The bulletin/comms have been provided to the Corporate Governance Team as evidence; the action can be closed. Last updated 28062024: (JL) In April 2024 WAST changed its response categorisation for stroke patients. Previously amber 1 was restricted to those patients with onset of symptoms within 4.5 hours. in line with recent changes to stroke guidelines with agreement from the wider stroke network amber 1 will be for those patients with an onset of symptom time of 12 hours. These changes have been communicated widely to all clinical and EMSC staff.	Closed in Quarter
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.	Jun-24	Met				110724: Action: 1) Agree process with Health Boards setting out / supporting the inter-hospital transfer process for patients referred for thrombectomy outside of Wales. Agreed process is that patients identified have their transfer arranged throug the trauma desk (situated in a WAST contact centre). Evidence: 1) The 'Specialised Services Commissioning Policy - Mechanical Thrombectomy for the treatment of acute Ischaemic Stroke' sets out this process and confirms agreement of the process. This Policy has been issued to the Corporate Governance Team and closes this action. Updated to closure proposed. 170424: (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.	Closed in Quarter

Unit Ref No	Audit Wales or HIW Report	Year	Committee Assigned to	Report Title	Responsible Officer	Director	Priority 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
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	Met	Sep-24			110724: Action: 1) Review the process agreed with the Health Boards, and ascertain its success / determine if any actions required. It is noted that The process we agreed in 2022 was for the trauma desk to take the transfer requests for thrombectomy. From 30th July 2024 a new process is being introduced for all transfers in WAST (including thrombectomy), this is a new protocol called Medical Transfer Protocol Suite (MTPS) and will specifically handle transfer requests. Evidence: 1) The communication to the Health Board is evidence of the agreed process (the Commissioning Policy). The new MTPS is going live on the 30 July 2024, which includes the provision of thrombectomy transfers which are categorised as Red calls. The process was agreed in 2022 however the new MTPS process begins in mid-2024, therefore a review cannot be undertaken until later in 2024. 150724: Due to position with new system going live in July 2024, revised date added in Q1 24/25 to September 2024. Last updated 28062024: (JL) The process for requesting an interhospital transfer for patients requiring thrombectomy has been reenforced, confirming that the clinician requesting this transfer should utilise the dedicated number (not 999) where they will speak to a clinician, their request for transfer will be process as a red response and this has been communicated as required.	Open

Clinical Audit

Final Internal Audit Report

June 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

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Debrief meeting:	24 April 2024
Draft report issued:	3 May 2024
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Final report issued:	30 May 2024
Auditors:	Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit; Rhian-Lynne Lewis, Principal Auditor
Executive sign-off:	Andy Swinburn, Director of Paramedicine
Distribution:	Duncan Robertson, Assistant Director of Clinical Development; Kevin Webb, Head of Clinical Intelligence and Assurance.
Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement:
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - please note:
This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services, and addressed to Non-Executive Directors or officers including those designated as Accountable Officer. They are prepared for the sole use of the Welsh Ambulance Services University NHS Trust and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with the Welsh Ambulance Services University NHS Trust. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Executive Summary

Purpose

To review the process for clinical audit including how it is used by Committees of the Trust to support assurance.

Overview

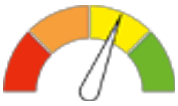
We have issued **reasonable** assurance on this area.

The matters requiring management attention include:

- The Clinical Strategy lacks sufficient reference to clinical audit and its role within the Trust; and
- The Clinical Audit Plan could be strengthened to demonstrate alignment between individual audits and the Trust risk register and priorities.

Other recommendations are included 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.	2017/18 

Assurance summary[1]

Objectives		Assurance
1	Clinical Audit Strategy	Reasonable
2	Clinical Audit planning	Reasonable
3	Clinical Audit outcome reporting	Reasonable
4	Benefit realisation and lessons learned	Substantial

[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	Insufficient coverage of clinical audit within clinical strategy	1	Design	Medium
2	Alignment of clinical audits with Trust risks and priorities	2, 3	Design	Medium

1. Introduction

1.1 Clinical audit is designed to improve the quality of patient care and outcomes across a range of interventions, processes, and conditions. Its purpose is to undertake a systematic evaluation of clinical practice against standards and to support and encourage improvement in the quality of treatment and care. Additionally, it provides information for patients and the public on the quality of specific healthcare services being provided locally and nationally.

1.2 This review considered the clinical audit activity that took place in the year 2023/24 and the clinical audit planning for 2024/25. We have not re-performed any of the clinical audits to assess their completeness or accuracy.

1.3 The risks considered during the review were:

- Lack of robust clinical audit planning leading to the inability to identify areas where practice needs to be improved.
- Poor clinical audit governance and failure to act on results of clinical audits preventing improvement in the quality of treatment and care.
- Inability to identify and mitigate some areas of clinical risk.

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	2
Total	-	3	2	5

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 clinical audit strategy and clinical risk register in place.

2.3 The national clinical audit commissioner, the Healthcare Quality Improvement Partnership (HQIP), specifies the organisational documents that are necessary for the effective management of clinical audit by a healthcare provider. These include:

- A policy for the use and conduct of clinical audit: to set out the principles, roles, responsibilities and practices a healthcare provider will follow in auditing clinical practice, and improving the quality of services to meet the needs of patients, healthcare commissioners, healthcare regulators, and others; and

- A strategy for the development of clinical audit: to describe how a healthcare provider will implement the policy, and increase the impact of audit on clinical services.

2.4 Previous audit reports in this area (2017/18: Limited Assurance, issued February 2018; and 2018/19: Follow Up, Reasonable Assurance, issued May 2019) reported on the development of a Clinical Audit Strategy with the latter stating that *whilst it had been identified that a Clinical Audit Strategy had been developed in draft, it had been determined by the wider Clinical Directorate that the Clinical Audit Strategy needed to form part of the wider Clinical Strategy, incorporating audit, research and improvement.*

2.5 The Trust's draft Clinical Strategy 2020-2025 was presented to the Quality, Patient Experience and Safety (QuEST) Committee in February 2020 where it was determined that minor amendments were required to the Strategy and, subject to these changes, it could be taken to Trust Board for final approval. This was approved at the July 2020 meeting.

2.6 Review of the strategy document notes there is minimal reference to clinical audit and the Clinical Intelligence and Assurance Team (CIAT) who are responsible for the conduct of such. **See MA1**. The CIAT maintains a 'how to' guide for the undertaking of clinical audit which sets out a step-by-step process for audit completion, and such could be considered for further enhancement to address the omissions within the strategy.

2.7 Risks linked to the clinical audit function are included within the Clinical Directorate Risk Register. This is maintained by the Clinical Directorate Business Manager within Datix Cymru. Up to 3 risks are reviewed each month to 'deep dive' into them and assess them appropriately. Those selected for review are determined based on the longest outstanding risks or those with highest priority, to ensure discussion and monitoring of the risks is active.

2.8 There is only one current risk on the clinical directorate risk register assigned to the clinical audit sub-directorate, with a risk score of 20: Risk *#535 Deterioration in Clinical Indicator Performance following transition from Digital Pen to electronic Patient Clinical Record (ePCR).* We were provided with the detailed risk record from Datix which sets out 16 mitigating actions, which include a mixture of clinical audits, improvement methodologies, ePCR prompts and ePCR layout re-design. 11 have been completed to date, with the remaining five being included in the 2024/25 clinical audit plan (see audit objective 2)

Conclusion:

2.9 The Trust's Clinical Strategy has limited reference to Clinical Audit. A 'how to' guide is available on the intranet to support staff in carrying out clinical audits. The clinical directorate risk register includes only one current clinical audit risk, which was linked to five audits included in the plan. A **reasonable** assurance rating is determined for this objective.

Objective 2: An appropriate local clinical audit plan is developed through an appropriate forum, is based on the Trust's clinical agenda, organisational risks and concerns that have been identified; and has been approved by the relevant Committee.

2.10 Topics for inclusion within the Clinical Audit Plan (CAP) are maintained and discussed by the CIAT in consultation with senior clinical and non-clinical management within the Trust. The decision for clinical audit topics chosen for inclusion are influenced by the following:

- 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).
- Policy documents relating to health and healthcare.
- Other benchmarking activities as appropriate.

2.11 Further, from review of the 2023/24 and 2024/25 CAP's, we noted an absence of a reference/link to Trust, Directorate or local risks and priorities, resulting in the lack of justification/reasoning to support the inclusion of individual audits. See **MA2**.

2.12 The CIAT maintains a working document (Clinical Audit Delivery Plan) which includes a tab that pulls together all potential clinical audit topics. Audit topics and ideas are received through a number of methods, including via discussion with clinical staff, attendance at wider Trust meetings, discussion within the CIAT, contact with sub-directorates and also potential audit requests received by the CIAT for consideration. Other work undertaken by the CIAT includes deep-dive data reviews into potential audit topics to establish whether a full clinical audit is required.

2.13 We were advised that the CIAT meet fortnightly to discuss ongoing progress against in year audits and actions included in the Clinical Audit Delivery Plan, and also potential ideas/topics for consideration for inclusion in the CAP. These meetings are informal and so the Team does not maintain minutes. Instead, the Clinical Audit Delivery Plan is updated, and a decision log captures decisions made and/or changes within the Teams arrangements and also an action log to document meeting outputs. We note there was minimal reference within these documents to the clinical audit plan and decisions made as to which audits will be included in the plan and its development. See **MA2.**

2.14 As stated in the Terms of Reference (refer to audit objective 3), *'The CIAG will be responsible for developing and monitoring the annual Clinical Audit Plan'*. The 2023/24 CAP was approved by the CIAG in January 2023/24 where there was evidence of discussion around plan content. It was subsequently approved by QuEST at its May 2023 meeting.

2.15 We note that arrangements for the 2024/25 CAP, include the approval by QuEST at its February 2024 meeting and that, due to the timetable of meetings, retrospective approval of the 2024/25 plan was sought at CIAG the day after the QuEST meeting. (see para 2.11).

Conclusion:

2.16 The clinical audit plan is produced by the CIAT in consultation with senior management, however the link between the audits included and Trust risks and priorities is not always clear. The plan is approved via CIAG and QuEST. A **reasonable** assurance rating is determined for this objective.

Objective 3: Results of clinical audits undertaken (including action / improvement plans), and progress against the agreed clinical audit plan, are reported to the appropriate clinical forums and committees.

2.17 The process for audit completion includes the preparation of a clinical audit proposal form which sets out the proposer and sponsors of the audit, the background establishing audit rationale, the aims and objectives and the standard of care to be measured. There is also a section for inclusion of a risk reference and a Local Delivery Plan (LDP) priority, however we note that of the three clinical audits reviewed (see para. 2.21), these sections were not consistently completed (see **MA2**).

2.18 Audits are either undertaken by a member of the CIAT or they support relevant clinicians to complete the audit work. Once the audit is complete, the CIAT collates all relevant information and prepares an audit report which is subsequently presented to the CIAG for review and approval. Reports are also taken to the Clinical Quality Governance Group (CQGG) for noting.

2.19 We reviewed three clinical audits finalised in year in order to document the process followed and ensure that it was in line with expectation. These audits were:

- Administration of Methoxyflurane (Penthrox®) – audit the safe and effective care to patients administrated Methoxyflurane (Penthrox®) and that pain scores are captured in line with Protocol.
- Morphine Administration (Recording accuracy) – to assess the accuracy of clinical (ePCR) and statutory (CD02) record-keeping.
- Levetiracetam (Keppra) Potential Use in Convulsions – to establish the potential for use of levetiracetam (Keppra) in cases of multiple anticonvulsant administration.

2.20 Proposal forms were provided for each review, and we confirmed the issuing of final clinical audit reports, following to their presentation for approval at CIAG.

2.21 The reporting framework for clinical audit includes CIAG, CQGG, Executive Leadership Team (ELT), Clinical Directorate Business Meeting (CDBM) and QuEST.

2.22 The CIAT (as detailed further in ***audit objective 2***) undertake all aspects of clinical audits, from CAP development through to clinical audit final reports. The Team prepares monthly updates which are presented to the CIAG.

2.23 The CIAG was established to provide oversight of the development of clinical indicators and the ongoing reporting against them, to monitor the safety effectiveness and efficiency of clinical care provided by the Trust, and the development and monitoring of the CAP and Action Tracker. The group's membership includes Clinical Directorate Leads, Clinical Intelligence Leads, ePCR Team Representative, Health Informatics Lead and Trade Union Representatives.

2.24 Minutes have not been maintained for CIAG during 2023/24. Rather, an Alert, Advise, Assure (AAA) report is prepared and presented to CQGG on a monthly basis. This summarises the Trust's current position on matters discussed at CIAG, including the clinical indicator dashboard, brief summary of the clinical audit action tracker position, and an update against the progress of the clinical audit delivery plan.

2.25 The CIAG meets monthly and is chaired by the Assistant Director of Clinical Development. We reviewed a sample of meetings (September, October, and December 2023; and February 2024) and confirmed all were quorate and were generally well attended. However, we note there was one member that has consistently not attended and that the names of some members are not included. **See MA3**.

2.26 The 2023/24 clinical audit plan included 11 audits when approved with one latterly split in two. An additional four audits were added during the year. Of these 16, 11 have been completed with audit reports published on Siren post their approval at CIAG and the remaining 5 have been impacted by delays to ePCR system upgrades.

2.27 We selected a sample of three completed audits (refer to Table 1 in ***audit objective 4***) and reviewed the CIAG AAA reports which showed evidence of scrutiny and discussion around report outcomes, recommendations, any required amendments and also who the reports should be shared with including: Health Board Clinical Leads and the Ambulance Practice Steering Group.

2.28 Following their approval at CIAG, clinical audit reports are presented for noting at CQGG on a quarterly basis. We were able to confirm the presentation of clinical audit #011 which was presented in February 2024 following its finalisation in December 2023, while audit references 006 and 010 were confirmed to be included in the agenda for the May CQGG meeting. A review of three meetings (December 2023 to February 2024) confirmed quoracy and appropriate membership attendance in line with the agreed terms of reference. The minutes show evidence of discussion and scrutiny around the clinical audit reports presented providing an additional level of assurance over report approval.

2.29 Following its monthly meeting, CQGG prepares an AAA report to the ELT which includes a brief summary of the individual clinical audit reports that have been presented and discussed.

2.30 QuEST receives a quarterly update against the status of the CAP and the clinical audit action tracker. The latest report (presented February 2024) provided an update stating that four further clinical audits had been finalised and a further 16 actions had been completed that were aligned to eight clinical audits.

2.31 The CDBM occurs monthly and pulls together the wider remit of the Clinical Directorate including Finance, Corporate Governance, Risk and Health and Safety. An update against the progress for the CAP and action tracker is also presented. An action log is maintained for this meeting, rather than minutes; and review of a recent log (January 2024) confirmed that there have been no actions assigned to the Head of Clinical Intelligence and Assurance nor the CIAT during 2023/24.

Conclusion:

2.32 There is a clear reporting framework in place for both the approval and monitoring of the CAP. Proposal forms are completed prior to the commencement of each clinical audit however these are not consistently completed in relation to risk and LDP priorities, therefore a **reasonable** assurance rating is determined for this objective.

Objective 4: Actions are monitored to ensure implementation and benefits realisation, and results of all clinical audits undertaken are triangulated with learning from other quality governance mechanisms and inform future planning.

2.33 The clinical audit action tracker captures actions identified following the completion of an audit and includes the priority rating, accountable officer, due date for completion, and Red, Amber, Green or Blue (RAG-B) ratings to indicate the status of the actions and whether they are on track. As detailed in audit objective 3, this is reported and scrutinised at appropriate forums.

2.34 During audit fieldwork, the January 2024 action tracker was reviewed which confirmed the inclusion of all relevant findings and recommendations from the completed clinical audit reports. Narrative comments are included against each of the actions which include the date of entry to evidence ongoing progress.

2.35 During 2023/24, there were 46 actions reported following the completion of the clinical audits. Of these, 39 were completed in year, 5 are on track and 2 are off track with recovery action being taken.

2.36 Discussion with the Head of Clinical Intelligence & Assurance advised that following the completion of a clinical audit, learning is captured within the following:

- Final Reports – Following the approval of the clinical audit final reports at CIAG, the reports are published on the CIAT Siren page and are accessible to all staff. Reports include sections on good practice and areas for improvement.
- Clinical Notices – where applicable, clinical notices are produced and shared on Siren, and are also added to the JRCALC[1] app for ease of access for operational staff while out in the field.
- Infographics – The CIAT produce infographics for each completed clinical audit, which communicate audit findings and other data through a combination of text, images and design, providing an easy read summary of the clinical audit

[1] Joint Royal Colleges Ambulance Liaison Committee

outcomes. These are shared on Siren and are also included within the final reports.

2.37 The infographics produced for each clinical audit provide a high-level narrative as to why the clinical audits have been completed, and the results within the clinical audit reports provide a summary of outcomes to establish whether or not the expected benefits have been realised. The table below sets out these criteria for the three clinical audits tested as part of this review:

Table 1

Audit Reference and Name	Why We Did It	High Level Outcomes	Benefit Realised
CIAT23_006 - Administration of Methoxyflurane (Penthrox)	To audit the safe and effective care of patients in accordance with the WAST Methoxyflurane Protocol.	Pain scores prior to and following administration of Penthrox® were not always obtained/documented. 16.1% patients had no pain score recorded prior to and after the first dose of Penthrox® administered. The administration of Penthrox® was not always documented in the drugs section. 6.5% (30/460) administrations were documented in the narrative section only.	Yes - improvements are required to ensure that appropriate documentation of pain scores within ePCR to support the use of Penthrox®
CIAT23_010 - Morphine Administration (Recording accuracy)	To assure that the details relating to the morphine administered to the patient and the quantity of morphine disposed of were a match on both the ePCR and on the vehicle based controlled drugs register (CD02).	A high level of compliance between ePCR and CD02 records, however it is important to note that as morphine is a schedule 2 controlled drug, the accuracy of records is an essential requirement in all cases. It was not always possible to locate the CD02 book and In 7.1% of cases (2/28), the amount of morphine administered was not recorded in the drugs section of the ePCR.	Yes – a high level of compliance (92.9%) was identified matching the dose recorded on the ePCR with that recorded in the CD02 book.
CIAT23_011 - Levetiracetam (Keppra) Potential Use in Convulsions	To consider if levetiracetam could potentially be used instead of a third dose of benzodiazepine	It was considered that there was a potential for levetiracetam administration in the following scenarios: • Convulsions not stopped prior to hospital handover • Maximum dose exceeded, whether or not convulsions have stopped	Yes - the Trust have identified areas of potential use of Levetiracetam which could be of benefit to the Trust

Conclusion:

2.38 The clinical audit action tracker captures recommendations from clinical audits and this is reported and monitored at appropriate forums. Learning from clinical audits is captured within clinical audit reports, clinical notices and infographics and are accessible to all staff. Benefits of clinical audits is also captured across the above documents. We have therefore determined a **substantial** assurance rating for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Insufficient coverage of clinical audit within clinical strategy (Design)			**Impact**
The Trust has a Clinical Strategy in place for the period 2020-2025. Our review of the Strategy and the Clinical Audit Plan has shown that there is an absence of detail in relation to clinical audit as outlined as being necessary by HQIP for the effective management of clinical audit. We note that the Trust has an easily accessible 'how to' guide available which outlines the requirements for the completion of a clinical audit, and such could be considered for further enhancement to address the omissions within the strategy.			Potential risk of: • Ineffective documentation to support the management of clinical audit.
Recommendations			**Priority**
1.1	The Trust should ensure appropriate detail in relation to clinical audit is included and documented it within its organisational documents.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	There are workshops scheduled (4th, 9th and 10th July 2024) to plan the next iteration of the Trust clinical strategy. The Clinical Directorate will ensure that clinical audit is given the space it needs to articulate the need for, and link to the guidelines on how to undertake an audit in the final approved document. Where update presentations are given up to, and including, board level meetings, the Clinical Directorate will ensure clinical audit is included. The clinical strategy will articulate clearly how clinical audit meets HQIP standards and will link to the clinical audit plan (for example, to the Clinical Audit section on the Trust intranet).	31st March 2025	Assistant Director for Clinical Development.

Matter Arising 2: Link of clinical audit plan to risk register or Trust priorities (Design)			Impact
The clinical audit plan is developed in consultation with the CIAT and senior clinical and non-clinical management and is approved by the CIAG and QuEST. The decision for clinical audit topics chosen for inclusion are influenced by a number of factors including Trust risks and priorities. However, our review of the Clinical Audit Plan noted an absence of a reference/link to Trust, Directorate or local risks and priorities, resulting in the lack of justification/reasoning for the inclusion of individual audits. We also note that the process for the development of the plan and discussion around audits included in the plan, has not been clearly documented.			Potential risk of: • Limited evidence of justification to support the inclusion of audits. • Absence of evidence of plan development process.
Recommendations			**Priority**
2.1	The Trust should link all clinical audits to either the clinical directorate risk register or Trust/Directorate priorities to support the justification for undertaking them. Where a link cannot be made, additional narrative should be included to justify the inclusion of the clinical audit within the audit plan.		**Medium**
2.2	The development of the clinical audit plan should be formally documented to provide assurance on the appropriateness of inclusion of individual audits.		
Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	Work will be undertaken to ensure relevant risks are linked to clinical audit activity; specifically, a mandatory field will be added to the proposal form to link to either a clinical risk or organisational clinical priority. This form will be submitted to CIAG for approval. The Trusts/Directorate priorities are not always clearly identifiable, but we will look to include in the 2024/25 CAP a justification linked to the IMTP/LDP.	30th September 2024	Head of Clinical Intelligence and Assurance

2.2	The CIAT decision log and proposal form to include more detail outlining the priority of the audit activity and the justification for inclusion in the workplan, which will also be reflected in the completed audit reports. A review of the clinical audit documentation is scheduled. This will be reported for approval to the CIAG.	30th September 2024	Head of Clinical Intelligence and Assurance

Matter Arising 3: CIAG Membership (Operation)	Impact
Our review of member attendance at the CIAG confirmed the quoracy of the meetings and that they are generally well attended. However we observed that one member had consistently not attended. The Terms of Reference of the CIAG state *'If a member of the group misses three consecutive meetings without sending an informed deputy or offering apologies, the chair will contact the member to confirm if they still intend to attend or whether they will offer an alternative.'* We have confirmed that his has not been completed. We also note that other members weren't included in the attendance record on the AAA reports taken to CQGG and so we were unable to confirm their attendance/non-attendance.	Potential risk of: • Inappropriate membership at CIAG. • Member attendance is not effectively captured.

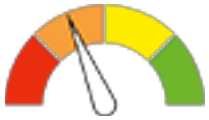
Recommendations		Priority
3.1	A review of the CIAG Members within the Terms of Reference should be undertaken to ensure Membership is appropriate.	**Low**
3.2	The members listing included within the AAA reports to CQGG should be updated to provide an accurate record of attendance at CIAG.	

Agreed Management Action		Target Date	Responsible Officer
3.1	The TOR is scheduled for review by CIAG and membership will be reviewed at this time. In addition, the stated action regarding missing meetings and follow-up will be similarly reviewed.	31st July 2024	Assistant Director of Clinical Development
3.2	This has already been amended (May CIAG).	Actioned since fieldwork	N/A

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	**18**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**4**

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

MEETING	Quality, Patient Experience & Safety Committee
DATE	13 August 2024
EXECUTIVE	Trish Mills, Director of Corporate 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. Because of the Trust's Board and Committee meeting cycle, the second quarterly Risk and Board Assurance report is sitting slightly outside of normal reporting cycles for the principal risks due to the mid-year placement of Board and Committee meeting dates.

3. As the Trust Board meets bi-monthly and most Committees are held on a quarterly basis, this meant that Committee are receiving the same risk updates which were presented to the May 2024 Trust Board meeting and the June 2024 Audit, Risk and Assurance Committee.

4. Committee can take assurance that each of the principal risks have and are being reviewed in line with the agreed reporting schedule throughout the latter part of May, June and early July and are navigating Trust governance processes in readiness for the next reporting cycle.

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

6. These two risks continue to be reviewed dynamically and early indications are that the scores remain unchanged with several updates to the controls which include the Swansea Bay Winter actions and plans in addition to new actions that include the implementation of phase one of the new clinical model later in the year, the Volunteer Alternative Responder Scheme (VARS) which went live in June 2024 and an uplift in the Advanced Paramedic Practitioners establishment.

7. 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.

8. 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.

9. Updates are highlighted in blue on the BAF which show changes to the narrative, mitigating actions, controls, and assurances.

RECOMMENDATION: Members are asked to consider the contents of the report.

KEY ISSUES/IMPLICATIONS
10. The key issues are set out in the Executive Summary above.
REPORT APPROVAL ROUTE
• The BAF was considered by: • ADLT (29 April 2024) • ELT (08 May 2024) • Trust Board (28 March 2024) • Audit Committee (07 June 2024)

REPORT ANNEXES
• Annex 1 - Summary table describing the Trust's Corporate Risks. • Annex 2 – Scoring Matrix • Annex 3 – Frequency of Risk review • Annex 4 - Board Assurance Framework

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

Ethical Matters	NA	Risks (Inc. Reputational)	NA
Health Improvement	NA	Socio Economic Duty	NA
Health and Safety	NA	TU Partner Consultation	NA

Annex 1 – Corporate Risk Register Summary

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
223 QuEST	The Trust's inability to reach patients in the community causing patient harm and death	**IF** significant internal and external system pressures continue **THEN** there is a risk of an inability and/or a delay in ambulances reaching patients in the community **RESULTING IN** patient harm and death	Director of Operations	**25 (5x5)** →
224 QuEST	Significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service	**IF** patients are significantly delayed in ambulances outside A&E departments **THEN** there is a risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised **RESULTING IN** patients potentially coming to harm and a poor patient experience	Director of Quality & Nursing	**25 (5x5)** →

Annex 2 - Risk Scoring Matrix

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

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

Annex 3 - Frequency of Risk Review

Risk Score	Review Frequency	Risk Rating
15 – 25 Red	Review monthly	High
8 – 12 Amber	Review quarterly	Medium
1 – 6 Green	Review every 6 months	Low

Annex 4 – Board Assurance Framework

Risk ID 223	**The Trust's inability to reach patients in the community causing patient harm and death**	**Date of Review:**	**15/04/2024**	**TREND**	**25 (5x5)**
		Date of Next Review:	**15/05/2024**	➡	

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 Q4 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. **Handover lost hours in February and March 2024 were 23,896 (Feb) and 23,404 (March).**
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.
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

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IF significant internal and external system pressures continue	THEN there is a risk of an inability and/or a delay in ambulances reaching patients in the community	RESULTING IN patient harm and death

	Likelihood	Consequence	Score
Inherent	4	5	20
Current	5	5	25
Target	2	5	10

	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. Approaching 500 active CFRs at end of Q4 with a training trajectory to recruit a minimum of 250 more in the coming 12 months. 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 with a further extension in place. • Funding also obtained through external grant funding to pilot a volunteer phase. which went live mid-October with twelve teams piloting the approach and has now completed. • Work has now commenced to recruit CWR volunteers with engagement taking place with organisations across Wales. • **St John Ambulance Cymru virtual ward now extended to the end of April 2024.**
24. ARA – Acute Release Area - GUH	24. Live until 31st March 2024

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	Likelihood	Consequence	Score
Inherent	4	5	20
Current	5	5	25
Target	2	5	10

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. **Performance targets for Handover with Health Boards have been introduced by the commissioner**.
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 Operations – National Operations & Support	Superseded	Rural model superseded by Action 9 below (Recruitment and deployment of CFRs)
2. Leading Change Together (forum to progress workforce related work streams jointly with TUPs)	ADLT Sub-Group	30.09.22 - Superseded	
3. Recruit and train more Advanced Paramedic Practitioners – Value Based Healthcare Fund bid for up to 50 WTE (I) [Source: Action Plan presented to Trust Board 28/07/22]	Director of Paramedicine / Director of People & Culture	**Extended to June 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

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	Likelihood	Consequence	Score
Inherent	4	5	20
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Target	2	5	10

			funds have been secured. However, it remains the case the prospective APPs are completing their education and could be deployed into the operational setting to mitigate the risk. ELT has therefore agreed to grow the APP numbers further this year, redirecting existing operational spend to bolster APP growth. **May24 - Initial bid unsuccessful however an action within the new IMTP to grow our APP workforce by up to 40 per year for the next 3 years. Updates will progress through the IMTP within quarters. Milestone changed from March 2024 to June 2024.**
4. 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	**August 2024**	ORH modelling underway. Initial findings January 2024, full report to Trust Board and EASC in March. **May24 - The review is scheduled to be presented to Trust Board end of July 2024. Milestone changed from March 2024 to August 2024.**
7. Swansea Bay Winter actions	Assistant Director of Operations, EMS	**Completed**	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. Palliative Care Paramedics commenced on 15/01/2024. 22/02/2024 - POD solution now in operation which is facilitating shift breaks. Palliative care paramedics have been deployed for a pilot in care homes and nursing homes. **May24 - Significant reduction in overruns realised. In addition, during the last 2 months, 0 missed meal breaks recorded in Swansea Bay area. Completed**
8. Mental Health response pilot	Assistant Director of Operations, EMS	**Completed**	Pilot to commence in Aneurin Bevan Health Board area Nov 2023. 22/02/2024 - Mental Health pilot launched in Aneurin Bevan January 2024 with a view to run until end of March 2024. **May24 - Mental Health Response pilot finished in March 2024 – Complete. NB: there is an appetite to further the MH response pilot within the IMTP.**
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	**April 2024**	Multi phased approach commenced in Dec 2022 with St John Ambulance Cymru virtual ward responder, a digital and telehealth platform, and a Community Welfare Responder model to enhance community resilience. • Phase 1 delivered through St John Ambulance Cymru with a further extension in place **and further extended until April 2024** • Funding also obtained through external grant funding to pilot a volunteer phase. which went live mid-October with twelve teams piloting the approach and has now completed.

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

			Work has now commenced to recruit CWR volunteers with engagement taking place with organisations across Wales.
10. Maximise the opportunity from Consult and Close: - **Successful resolution without ambulance (double EMS)** - **Successful resolution without conveying to ED**		**March 2025**	Trust ambition is **to improve** Consult and Close rate, with an improvement plan in place to achieve this. The Trust has however already achieved the inclusion of Mental Health Practitioners in CSD, a key contributor to the achievement of Consult and Close rates. Consult and Close compliance remains around 14%. Action plan activities therefore continue with a review of triage processes which may lead to shorter triage durations, along with increase in staffing, which together will enable more triages to take place, **thus increasing the number of successful resolutions without a double EMS ambulance and numbers conveyed to an ED.**
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	**Completed**	Development of the model remains ongoing. **May24 – Pathway went live on 30th April 2024. Completed**
13. Palliative Care Paramedic Unit	Assistant Director of Operations	**Extended to May 2024**	Reducing demand via APPs – 15th January Start. **15/04/2024 - 3 Month Health Board funded trial ended. Whilst utilisation was low, the results demonstrated a circa 75% ED avoidance therefore local decision made to extend for a further 2 months, however, opening the trial up to wider community and crew referrals.**
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	Q1 2024-2025	• 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	**Completed**	• 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.
16. Royal Glamorgan Early Diagnostic	**Executive Director of Operations**	**May 2024**	• **Initial data from Qlik shows that there has been no reduction in N2H times however data received from Health Board show indication of patient benefit to reach earlier diagnostic. Local meetings this month to discuss findings and explore opportunities.**

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:	14/04/2024	TREND	25 (5x5)
		Date of Next Review:	14/05/2024	➡	

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 Q4 2023/24

- The risk score remains constant at 25 for quarter 4 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 2,091 +4-hour patient handovers in February 2024, compared to 1,586 in February 2023. The target was originally to have 0 by September 2022. The EASC expectation was that these would be eradicated by end of 2023/24. Handover lost hours in February 2024 were 23,896 compared to 19,110 in February 2023. Early data from March 2024 shows**
- **some days where over 1,000 hours were lost. Cardiff & Vale UHB has demonstrated material improvement and is a positive outlier when compared to other health boards.** 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 enquiries and redress / claims. The Trust continues to receive Prevention of Future Death Reports (Regulation 28) from Coroners across NHS Wales. The Trust has received 10 reports since April 2023, including 3 reports in quarter 4 2023/4. 6 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 Trust received the first Prevention of Future Deaths Report in February 2024 relating to pressure damage, which is a joint Report with Swansea Bay University Health Board. On 22.02.2024 a Prevention of Future Deaths Report was sent solely to the Minister for Health and Social Services, Welsh Government in respect of delays responding to a patient in community which also references handover of care delays.** The effectiveness of our controls in many areas are dependent on external partners acknowledging and having ownership of the risk across the urgent and emergency care system. Key to moving the position is to continue to work in collaboration influencing system partners, being present and engaging in key conversations, whilst continually seeking opportunities internally to swiftly identify and mitigate the risks within our control and share those with relevant system partners that we cannot control. WAST CEO and Directors have ensured that system safety and avoidable harm remain a live topic of discussion in all relevant forums and continue to seize opportunities as they emerge that can contribute to mitigating avoidable harm. **Given the long-standing nature of the system pressures and long handover times, we have commenced work to better define mitigations to safety risks and quality of care deriving from extended periods in an ambulance; these include the application of Mental Capacity Act and Deprivation of Liberty Safeguards and, Fundamentals of Care including pressure area care, mobilisation and nutrition. One specific area of focus is the development of a prototype mattress for our ambulance trolleys.**

Improvement actions led by Welsh Government and system partners include:

a) Right care, right place, first time Six Goals for Urgent and Emergency Care - A policy handbook 2021–2026. Goal 4 'Improving ambulance patient handover, ensuring no one arriving by ambulance at an Emergency Department waits more than 60 minutes from arrival to handover to a clinician – (Welsh Government) ***by the end of April 2025***
b) National Six Goals programme for Urgent and Emergency Care: Led by the NHS Wales Deputy Chief Executive this programme seeks to modernise access to and the provision of Urgent and Emergency Care across Wales. WAST is represented on the Clinical Reference Group by the Director of Paramedicine and on the overarching programme board by the Executive Director of Strategy, Planning & Performance.
c) The Trust also has a presence on all the individual goal boards. The Trust has been asked to provide a presentation on its offer to the system at the next Six Goals Programme Board (24 January 2024).
d) NHS Wales eradicates all emergency department handover delays more than 4 hours (LHB CEOs) ***revised to March 2023/24.***
e) Alternative capacity equivalent to 1,000 beds project (LHB CEOs) – 678 additional beds delivered, a significant achievement, but short of the target of 1,000.
f) Investigation of Urgent and Emergency Care System: Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time? (Audit Wales)
g) Implement nationwide approach to emergency department 'Fit 2 Sit' (Welsh Government: Chief Medical Officer and Chief Nursing Officer) - paused.
Health boards have previously been required to develop handover reduction action plans, which are monitored at their Integrated Quality, Planning & Delivery (IQPD) meetings by Welsh Government. Handover is also discussed at the Integrated Commissioning Action Plan (ICAP) meetings (currently paused as commissioning arrangements transition into the new Joint Commissioning Committee) which are held monthly between the CASC, the Trust and each Health Board.

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. WAST Serious Clinical Incident Forum (SCIF) is in place to discuss patient safety incidents, learning and improvement actions to prevent future harm, working in collaboration with Health Boards / NHS Wales Executive Delivery Unit under the Joint Investigation Framework which was formalised in the National Patient Safety Policy in May 2023. Sharing of potential case of serious avoidable harm/death with Health Boards for investigation when response delay associated with system congestion is the primary cause. CNO and CMO plus peer group and COOs regularly updated on patient safety incidents.	1. Patient safety reporting and escalation through the Serious Clinical Incident Panel (SCIF), Patient Safety Highlight Reports, Health Board specific reports in place with escalation through WAST governance framework.
2. WAST membership of the working group (Executive Director of Quality & Nursing) to reform the Framework for the Investigation of Patient Safety Serious Incidents (SIs) national investigation framework with system partners. Chaired by the Deputy Chief Ambulance Commissioner and commenced in August 2022.	2. Workshop with system partners in place with executive directors of nursing attendance and to date is working well with good engagement from health board colleagues. Following the last meeting on 25.01.2023 it was agreed that sub-groups would be formed to meet more frequently to gather themes / evaluation / develop

Risk ID 224	Significant Handover of Care Delays Outside Accident and Emergency Departments Impacts on Access to Definitive Care Being Delayed and Affects the Trust's Ability to Provide a Safe & Effective Service for Patients	Date of Review:	14/04/2024	TREND	25 (5x5)
		Date of Next Review:	14/05/2024	➡	

IF patients continue to be significantly delayed in ambulances outside Accident and Emergency Departments	THEN there is a continued risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised	RESULTING IN patients coming to significant harm and a poor patient experience

	Likelihood	Consequence	Score
Inherent	5	5	25
Current	5	5	25
Target	3	2	6

	more consistency which would include aligning the outputs / outcomes with the 'Six Goals for Urgent and Emergency Care' work. **An event reviewing the effectiveness of the joint Investigation Framework is currently being scoped nationally.**
3. WAST and system compliance with National Standards - 15-minute handover (NHS Wales Hospital Handover Guidance v2 (May 2016)	3. Monthly Integrated Quality and Performance Report, Health Informatics reports, APP dashboard on app use by Consultant Connect and shared at local and corporate meetings regarding patient safety and handover of care position across NHS Wales and NHS England.
4. WAST Clinical Notice in place - Escalating a clinical concern with a deteriorating patient outside the Emergency Department (11.02.2021). National Early Warning Score (NEWS) trigger of 5 or above for escalation to hospital clinicians. NEWS data available via EPCR (electronic patient care record).	4. NEWS data now available via ePCR and escalation system in place via local managers and the Operational Delivery Unit.
5. Workstreams put in place to meet requirements of *Right care, right place, first time Six Goals for Urgent and Emergency Care A policy handbook 2021–2026.* Goal 4 incorporates the reduction of handover of care delays through collective system partnership. 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;	15. Monthly Integrated Quality and Performance Report, CEO Reports to Trust Board including 'Actions to Mitigate Avoidable Patient Harm Report' (last presented to Trust Board November 2023) and Board sub-committee oversight and escalation through 'Alert, Advise and Assure' reports.

Risk ID 224	Significant Handover of Care Delays Outside Accident and Emergency Departments Impacts on Access to Definitive Care Being Delayed and Affects the Trust's Ability to Provide a Safe & Effective Service for Patients	Date of Review:	14/04/2024	TREND	25 (5x5)
		Date of Next Review:	14/05/2024	➡	

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

numerous escalations to professional peer groups initiated by WAST Directors; and coverage at Joint Executive Meetings with Welsh Government. Evidence submission to Senedd Health and Social Care Committee. Written evidence submitted during Q4 21/22 to the committee to assist their inquiry into Hospital Discharge and its impact on patient flow through hospitals. Report published in June 2022 containing 25 recommendations with recommendation six specifically WAST related stating "The Welsh Government should explain how the targets outlined in the Minister for Health and Social Service's statement of 19 May 2022 on urgent and emergency care and the Six Goals Programme to eradicate ambulance patient handover delays of more than four hours and reduce the average ambulance time lost per arrival by 25 per cent (from the October 2021 level) have been set. It should also confirm the target dates for the achievement of these targets."	
16. Implementation of Duty of Quality, Duty of Candour, and new Quality Standards requirements in April 2023.	16. Welsh Government Road Map in place (soft launch) with milestones for organisations – baseline assessment and monthly updates (RAG ratings) in place with Trust Board oversight. The current internal assessment overall as of **February** 2024 is 'Implementing and operationalising'. The Trust has representation on the All Wales Duty of Candour Implementation Group and is actively engaged in developing resources. From April 2024 the Trust will publish an annual quality report and compliance with Duty of Candour. Operational oversight occurs at the Quality Management Group and Executive oversight is via the Clinical Quality Governance Group.
17. Clinical Support Desk First in place	17.
18. Summer/Winter initiatives	18. Monitoring through SLT and STB. Senior Planning Team (SPT) is now stood up for the duration of Winter 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.
	4. Internal Audit Report (April 2024) Serious Incidents: Joint Investigation Framework (WAST internal processes) provided 'Reasonable Assurance' with low to moderate impact on residual risk exposure until resolved. Improvement actions are monitored via the Audit Tracker.
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Lack of capacity in the Putting Things Right Team to deliver across the functions due to competing priorities resulting from sustained system pressures – recruitment in line with Organisational Change Process is progressing **with full establishment expected by July 2024.**	1.
2.	2. Implementation of the revised Joint Investigation process with good engagement seen by system partners. Several overdue patient safety investigations remain presenting a risk to patient safety across the system. The Trust has **56** overdue nationally reportable incident **(NRI)** investigations, **with 63 NRIs open in total**. Shared system learning from the Joint Investigation Framework is currently limited with no new learning identified to date.
3. Lack of implementation and holding to account regarding the NHS Wales of the Handover Guidance v2 and recognition of the patient safety risks pan NHS Wales.	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.

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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

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).
2. Implement patient safety dashboards (live and look back data) triangulating quality metrics / KPIs and performance data sourcing health informatics resource.	Assistant Director of Quality & Nursing	**Q3 2024/25**	• Incremental improvements to quality and safety data and information to enable triangulation / collective intelligence at Trust and system level. • Access to ePCR data (NEWS) now available **and access for the Patient safety Team is being explored**. Work on-going with Health Informatics regarding patient safety and health board dashboards **capacity in Health Informatics impacting and dates revised.** • **Local dashboards have been developed but requiring manual data extraction**
3. Continued Health Board interactions – my next patient (boarding), patient safety team dialogue – proactive conversations with Health Board Directors of Quality & Nursing.	Executive Director of Quality & Nursing	Monthly and as required.	• Monthly meetings continue to be held and networking through EDoNS.
4. Recruit and train more Advanced Paramedic Practitioners.	Director of Paramedicine	Q4 2024/25	• **Whilst no additional funding has been secured, ELT has agreed to offer places to all APPs completing their education, funded from a reduction in technician posts (1/2s) i.e. internal movement.** • **The net uplift to the APP establishment (after filling vacancies) is 15.7 FTEs. The Trust expects to see the APP establishment increase to over 100 FTEs in 2024/25. The current staff in post to establishment is 86.5 FTEs / 88.7 FTEs.** • **The Trust is currently undertaken the next strategic EMS demand & capacity review, which includes a future service model and expansion of APPs. The review should be available in Jan-23 (being reported to ELT 31 January 2024, with final report to March EASC).** • **The Trust engaged with HEIW and commissioners in Dec-23 as part of developing the future education requirements for EMS and is aiming to have a draft strategic workforce plan, subject to final approval, by 31 Mar-2024. An internal workshop on APPs workforce planning is arranged for 29 January 2024 (complete).** • **An APP Utilisation task & finish group now being established.** • **The 2024/25 budget (and IMTP) includes a further uplift in the APP establishment**.
5. Overnight falls service extension and future modelling	Executive Director of Quality & Nursing	31.09.2024	• **Night Car Scheme extension agreed to 31 September 2024 (2 regional resources)** • **Utilisation rates continue to be monitored:** • **Nighttime utilisation: -** - **Q2 65%** - **Q3 64%** - **Q4 to date 64%** • **Daytime utilisation: -** - **Q2 57%** - **Q3 56%** - **Q4 to date 58%** • **Combined day and night Q2-Q3 58%**

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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

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Inherent	5	5	25
Current	5	5	25
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			• **Combined day and night Q4 to date 59%** • **The EMS Demand & Capacity Review has completed its modelling of falls level 1 and level 2 resources. This will now need to be considered further by the Trust, commissioners, and health boards.** • **There is an immediate focus on the contract beyond September. 2024.**
6. Duty of Quality, Duty of Candour and new Quality Standards implementation from April 2023 with development of a Quality Monitoring System supporting monitoring and oversight systems in place and embedded. Quality Report development underway – mandatory requirement to publish 2024/25 (no fixed date for publication nationally).	Executive Director of Quality & Nursing	Q4 2024/25	• Monthly updates to progress against actions following the baseline assessment and readiness returns continued. • RL Datix Dashboards and KPIs under development nationally by National Quality & Safety Group. • Key policies updated and approved further updates following release of revised Putting Things Right Regulations **which is delayed now expected release by Welsh Government in Autumn 2024 therefore timescale amended.** • Participation in the All Wales Duty of Candour implementation group by Patient Safety Team – monthly.
7. Connected Support Cymru is initially designed to utilise NHS and voluntary-sector resources and responders to enable patients to be supported in their own home whilst waiting for an urgent healthcare need to be managed. The service will employ digital health technologies to connect patients, communities and clinicals to achieve better health outcomes. The initiative will improve patient experience and safety, while supporting the healthcare system in directing patients to the right pathway at an appropriate time for their care need. It is expected this will help reduce unnecessary demand upon Emergency Departments.	Executive Director of Quality & Nursing	Q1 2024/25	• Awaiting feedback on business case **from Welsh Government** • Executive Director Strategy, Planning & Performance presenting to Six Goals Programme in January on Trust's offer to the system, which will include CSC. • Preliminary end date for the community welfare responders (CWR) pilot identified as 8 February 2023. • This eyes on support to CSD clinicians, by volunteers, is producing positive results, with early data continuing to suggest a 35% consult & close rate for the cohort of patients responded to. • PDSA cycles being undertaken on Luscii (remote diagnostic technology).
8. Organisational change process (OCP) of Putting Things Right Team (PTR) to enable increased capacity across all functions to manage increasing complexity and demands.	Executive Director of Quality & Nursing	**Q2 2024/25**	• OCP commenced 25.09.2023 and the consultation period has concluded with the final new structure confirmed. Next steps are to recruit to vacant positions which has commenced. It is anticipated that all positions will be filled by May 2024 (taking notice periods into account). Recruitment is progressing well with multiple applications for each post and some internal promotion opportunities. • **Final posts due to be recruited to and in place by July 2024**.
9. 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 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. • Meeting held with Tissue Viability Nurses from each Health Board on 17.01.2024 and colleagues encouraged to contact WAST for data / information for Pressure Damage Panels to detect harm caused in the prehospital environment. The Patient Safety Team are also engaging with Welsh Wound Innovation Centre (WWIC). • **Links to actions progressing in Action 16 and further engagement with the All Wales Tissue Viability Network – close.**
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	Q2 2024/25	• **Conducted in three phases Audit Wales will independently investigate and report on patient flow out of hospital: access to unscheduled care services and national arrangements (structure, governance, and support).** • **WAST will proactively support this work and offer best practice examples from other jurisdictions that can support benchmarking and improvement activities. Expected outcomes in 2023/24.** • **The audit is proceeding. Trust awaiting the outcome. AD Commissioning & Performance has requested an update from Audit Wales.**

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			• **Audit Wales have confirmed this has been reprofiled into 2024/25.**
11. Internal Audit to undertake a review of Serious Adverse Incidents & Joint Investigation Framework	Executive Director of Quality & Nursing	**Closed**	• Internal audit completed. • **Completed – Reasonable Assurance reported in April 2024. Improvement actions included on the Audit Tracker.** • **Close. Moved to external assurance.**
12. Winter Ambulance Handover Improvement Plan Meetings	Executive Director of Operations	**Removed**	• 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. • May24 – Removed as no longer included on the Board action plan (recently reviewed) and the period has now passed.

13. Integrated Commissioning Action Plans (ICAPs)	Executive Director of Strategy, Planning and Performance	**Paused**	• The ICAP meetings focus on ambulance response performance, handover delay performance and the development of actions to reduce handover delays and improve ambulance response times.
			• NCCU have sought confirmation from health boards regarding the impact of financial savings plans on the delivery of actions aligned to the ICAP's.
			• Health boards have not identified any direct impact, but there may be a potential impact on health board's abilities to flex some services due periods of increased demand.
			• NCCU secured financial support from the Six Goals Program for additional ED discharge transport.
			• Key initiatives being discussed across ICAPs:
			  ○ MDT Navigation Hubs.
			  ○ Falls & frailty pathways.
			  ○ System Escalation Processes
			  ○ SDEC
			  ○ System Flow (Continuous Flow Model & Effective Discharge)
			• WAST's 'Menu of options' are being updated and reviewed to include evidence to support initiatives and prioritisation in each health board.
			• The 2024/25 ICAP structure is being reviewed by the NCCU to consider the planned changes with regards to the new Joint Commissioning Committee (JCC).

14. Patient handover actions.	Executive Team	Under review	• Some English ambulance services operate a system whereby handovers are mandated or forced after a certain period of time e.g. WMAS and LAS. This will be reviewed by the Executive team.
15. Work in progress to better define mitigations to safety risks and quality of care deriving from extended periods in an ambulance; these include the application of Mental Capacity Act and Deprivation of Liberty Safeguards and Fundamentals of Care including pressure area care, mobilisation and nutrition. One specific area of focus is the development of a prototype mattress for ambulance trolleys.	**Executive Director of Quality & Nursing**	**Q3 2024/25**	• **Fundamentals of Care meeting, chaired by the Executive Director of Quality & Nursing held on 08.03.2024.**

POLICIES RECOMMENDED FOR COMMITTEE APPROVAL AND ADOPTION

Committee	Quality, Safety and Patient Experience Committee	**Date of Meeting**	13/08/2024

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
Management of Medical Devices	Clinical	Completed No Issues	21/05/2024	07/08/2024	N/A

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

Management of Medical Devices Policy

Policy Number:	005	**Version No:**	3.4	**Supersedes:**	3.3
Date of Approval:	TBA	**Review Date:**	TBA	**Impact Assessments Completed:**	EqIA, Counter Fraud Review
Classification of Document:	Clinical	**Type of Document:**	Policy	**Approved by:**	Quality, Patient Experience and Safety Committee
Brief Summary of Document:	This document outlines procedures and guidelines for management of medical devices throughout their life cycle.				
Scope:	The document covers the use of medical devices across the operational functions of the Trust. Staff with responsibility for medical devices do not require formal training in order to comply with this policy, but they should be made familiar with its content. This Policy applies to all staff that are directly employed by WAST and encompasses Non-Executive Directors, bank staff, volunteers, contractors, and all those that it has legal responsibility for such as students and trainees. [EXAMPLE]				
To be read in conjunction with:	Financial Control Procedures 2.1 and 2.2, IPC Policy, Decontamination Guidelines				
Owning Committee	Quality, Patient Experience and Safety Committee (QuEST)				

Policy Lead: Trade Union Lead:	Jonathan Wilson Maldwyn Jones	**Job Title:**	Head of Clinical Logistics TU Partner
Executive Director:	Andy Swinburn	**Job Title:**	Executive Director of Paramedicine

Version Control Sheet

Version	Date	Author	Summary of Changes
1.0	April 2008		Legacy Policy
2.0	October 2016	Jon Wilson	First revision
2.1	November 2016	Jon Wilson	Revised following Clinical Equipment Working Group comments
2.2	November 2016	Jon Wilson	Amended for audit comments
2.3	February 2017	Jon Wilson	Counter Fraud Section Added
2.4	April 2017	Jon Wilson	Waste Management elements updated
2.5	June 2017	Jon Wilson	Revised following consultation comments and amended Trust template
2.6	August 2017	Jon Wilson	Revised following comments from EMT
2.7	December 2017	Jon Wilson	Minor wording amendments to IPC section
2.8	February 2018	Jon Wilson	Amendments to reflect IPC developments
2.9	May 2023	Jon Wilson	Refreshed to reflect updated Terms of Reference, new directorate structure etc.
3.0	20/03/2024	Lisa Trounce	Formatting, key words added
3.1	13/05/2024	Jon Wilson	Revised following Policy Group comments
3.2	13/05/2024	Lisa Trounce	Policy transferred to current WAST policy template with new Crown badge, Trust logo, and amended header reflecting university status.
3.3	21/05/2024	Lisa Trounce	Front cover and Version Control Sheet updated. Comments boxes removed.

Version	Date	Author	Summary of Changes
3.4	07/08/2024	Julie Boalch and Duncan Robertson	Update to section 9.5 to remove 'delegated Trust Board'. Removal of sentence in 9.8 around disciplinary. Section 10 updated to reflect wider monitoring of the policy.
Key Words	Medical, devices, clinical, equipment		

Impact Assessment Reviews

Area	Date of Review	Name of Reviewer
Data Protection	March 2024	Jon Wilson / Maldwyn Jones as part of updated EqIA on new template.
EqIA / Welsh Language		
Environment		
Quality		

Task and Finish Group Members

Name	Job Title
Jonathan Wilson	Head of Clinical Logistics (Chair)
Steve Magee	Regional Clinical Lead (Vice Chair)
Alan Richards	Clinical Logistics Business Support Officer
Huw Jackson	Health Board Clinical Lead
Carl Powell	Clinical Lead – Acute Care
Dr Nigel Rees	Assistant Director of Research and Innovation
Martin Mulholland	Learning and Development Manager
Maldwyn Jones, Damon Turner	Trade Union Partners EMS
Henry Garrard	Trade Union Partners Ambulance Care
Gavin Lane	Fleet Manager
Paul Aston Jones	Health and Safety Manager
Louise Colson	IPC Lead

Steve Williams	Locality Manager
Craig Figgures	Ambulance Care Manager
Simon Antrobus/Tony Crandon	MRD Manager

Policy Approval Route

Meeting Title	Meeting Date	Purpose/Outcome
Policy Group	06/07/2017	Consider initial draft
Staff Side Team Meeting	07/07/2017	Approve for WASPT Agenda
WASPT	24/07/2017	Recommend for approval
EMT	16/08/2017	Recommend for approval
QUEST	05/09/2017	Final approval and adoption
EMT	25/04/2018	Recommend approval
QUEST	22/05/2018	Approve minor amendments
CEWG	January 2024	Approve minor amendments
Policy Group	27/03/2024	Approval – feedback provided
Policy Group	21/05/2024	Recommend for Approval
ELT	07/08/2024	Recommend for Approval
QuEST	13/08/2024	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

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1. INTRODUCTION

This document outlines procedures and guidelines for management of medical devices throughout their life cycle

It also ensures safe and effective use of Medical devices and that the Trust meets all statutory requirements for user and patient safety. The policy is also designed to ensure that the Trust complies with the Control Assurances Standards, Clinical Governance and identifies Risk issues and removes them as far as reasonably practicable.

A medical device is any apparatus, appliance, software, material or other article, whether used alone or in combination, intended by the manufacturer to be used by human beings for a medical purpose. For example, defibrillators, suction units and emergency lifting cushions.

Medical devices include in-vitro diagnostics medical devices, which are devices used to test samples, such as blood or tissue that have been taken from the human body – such as blood glucose tests and pregnancy tests. They also include active implantable medical devices which are implanted into the patient and require an external source of power, such as cardiac pacemaker systems. (Department of Health and Social Care, 2021)

Medical devices in the UK are regulated by the Medicines and Healthcare Products Regulatory Agency (MHRA) under the following legislation:

- the Medical Devices Regulations 2002 (SI 2002 No 618, as amended) (UK MDR 2002)
- the General Product Safety Regulations 2005 (SI 2005 No 1803)

These regulations are safety regulations under the Consumer Protection Act 1987 and as such, the MHRA can investigate any business activity that is covered by these regulations in accordance with the Consumer Rights Act 2015.

All medical devices purchased through Trust funds, lease purchase, operating lease, hire, loan, consumable deals, free gifts and equipment directly funded by the Trust or from user revenue budgets, come under the guidance of this policy.

In line with this policy, all purchase requisitions and contracts relating to any acquisition or servicing of Medical Devices as outlined above, will be raised in conjunction with the Head of Clinical Logistics and authorised in line with the Trust's scheme of delegation by the appropriate budget holder.

2. POLICY STATEMENT

This policy aims to ensure that all relevant employees have all the relevant information in order to comply with clinical and financial governance requirements as they relate to medical devices.

3. SCOPE

The document covers the use of medical devices across the operational functions of the Trust. Staff with responsibility for medical devices do not require formal training in order to comply with this policy, but they should be made familiar with its content.

4. AIM

The policy is also designed to ensure that the Trust complies with the Control Assurances Standards, Clinical Governance and identifies risk issues and removes them as far as reasonably practicable.

5. OBJECTIVES

The purpose of the Management of Medical Devices Policy is to ensure that medical devices:

- Are suitable for their purpose
- Offer compatibility with current clinical practice
- Meet user needs and are understood by the trained users
- Operate in a safe and serviceable condition
- Comply with Safety, Environmental, Quality Standards and Infection Prevention and Control requirements
- Identify revenue consequences for budgetary purposes
- Adhere to Standing Financial Instructions and Standing Orders on procurement and competitive quotations, and/or tendering if there is no contract in place.

6. MANAGEMENT OF MEDICAL DEVICES

6.1 Clinical Equipment Working Group

The Trust has an established Clinical Equipment Working Group. As detailed in Appendix 2, it advises the Ambulance Practice Steering Group and the Health and Safety Committee on all matters relating to medical devices relevant to the Trust's role in patient care. The Clinical Equipment Working Group will systematically review existing

medical devices for its appropriateness, establish specifications for the selection of new equipment (both capital and revenue) oversee the evaluation of items of equipment as well as risk assessment and thereby make recommendations to the APSG which support the future selection and standardisation of medical devices throughout the Trust.

Through these processes, the groups ensure compliance with the Controls Assurance Standard and Clinical Governance for Medical Devices and other guidelines for best practice.

6.2 Evaluation, Selection and Purchase of Medical Devices

The selection and purchase of equipment is made taking account of the latest clinical guidelines and evidence based practice, in compliance with service needs, compatibility with existing equipment and MHRA guidelines.

Any request for evaluation or purchase of medical devices can only be processed if the requestor has followed this policy and completed the form "Clinical Equipment Proposal Form" (Appendix 3).

All the evaluations are organised in a structured manner by the Clinical Equipment Working Group and with agreement of the Assistant Director Clinical Delivery. It is important to note that evaluation of any equipment / device requires time, effort, a suitable clinical environment and patients. It is therefore advisable to reduce number of trials as far as practically possible. There is also a requirement to undertake a documented risk assessment prior and during an evaluation so that relevant Risk and Health & Safety aspects are fully considered. This information will also be forwarded to the Clinical Equipment Working Group for long-term considerations prior to any proposed procurement.

If the Trust Health and Safety Committee considers that there are significant areas of non-conformity with the safety standards and hence that the Trust is not meeting its statutory requirements, they will advise not to evaluate or purchase the equipment on safety grounds.

The following points are discussed by the group and established prior to purchase:

- Initial purchase cost obtained through the shared services procurement department
- Identification of additional revenue costs/savings resulting from the purchase
- Who will service the equipment and the cost
- The installation requirements and cost
- The initial and continuing user-training requirements and cost

- The cost and availability of consumables and spare parts
- Extended Warranty arrangements and cost
- Sustainability and Waste Procedure

The Trust has a well-defined purchase process through its financial control procedures as well as procurement procedures via the North Wales Shared Services Partnership.

6.3 Standardisation Policy

The Trust, wherever practicable, operates a standardisation policy on purchase of medical devices. This ensures that unless there are valid clinical and technical reasons, similar and up to date models of equipment from the same supplier are purchased in order to ensure:

- Ease of user training
- Reduction in clinical risk due to users being unfamiliar with the type of medical device
- Availability of in-house expertise and ease of servicing
- Cost benefits in terms of purchase of consumables
- Cost reduction if medical devices are to be placed on external servicing contract
- Rapid exchange of medical devices from a low usage area or spare medical devices in the event of a major failure

In the event of more up to date equipment being introduced by other suppliers, evaluations will take place and the standardisation policy reviewed in agreement with Clinical Equipment Working Group

6.4 Acceptance Testing of New Medical Devices Prior to Use

All new medical devices are delivered to the Clinical Logistics Hub for acceptance testing prior to use. The acceptance procedure prior to commissioning of equipment includes:

- Safety and performance check prior to Installation
- Entry onto equipment register
- Handover of equipment

No medical device will be placed into service before the Clinical Logistics Hub has carried out acceptance testing. This is in line with the Provision and Use of Work Equipment Regulations 1998 (PUWER)

6.5 User Training

The provision of staff training in relation to the correct use of equipment is a high priority for all users, which is arranged through the learning and development team. The Head of Clinical Logistics will facilitate access to product specialists in order to support the learning and development team in this regard.

6.6 Medical Devices Inventory and Record System

The Clinical Logistics Hub will maintain a comprehensive inventory of all medical devices that have been commissioned via the clinical logistics hub , which includes detailed service history information. This also includes information on items of equipment placed on External Service Contract with outside contractors. A Trust approved contractor may hold this information on the Trusts' behalf with an appropriate monitoring system of compliance.

The records extend to the logging of specialised spare parts used during servicing, for trace ability and product liability purposes and Financial Asset Register system for capital charging purposes.

Leasing and Hire

Equipment, which is leased or hired must still meet the requirements of this policy with an approved equipment specification through the Head of Clinical Logistics .

6.7 Servicing of Medical Devices and Financial Arrangements

Servicing arrangements within the Trust are provided either "in-house" through in-house technical staff or External Service Contracts with the specialist medical maintenance engineers or equipment suppliers. All servicing and schedules of work are to be recorded and held by the Trust and contractor for future reference.

Although servicing of medical equipment may take place at nominated ambulance premises by the Trust approved contractor, it is anticipated that certain servicing, repair and inspection will need to take place at the contractors Medical Device Centre, where further servicing and specialist equipment would be available. The contractor will be required to meet the appropriate standards necessary to make the centre approved to undertake the maintenance agreements arranged with the Trust.

The responsibility for the provision and advice on such services rests with the Head of Clinical Logistics

The Executive Director of Operations is the centralised budget holder for external servicing contracts of all medical devices within the Trust,

The budget is reviewed on annual basis and amended through cost pressures proposals

No user is allowed to enter into any external service contract without prior discussion with the Executive Director of Finance and Corporate Resources and the Executive Director of Operations, and without appropriate delegated authority. Please refer to the Scheme of Delegation.

The Trust (or a Trust approved contractor with an appropriate monitoring system of compliance) will maintain all service records for the equipment it services and manages and takes any necessary action in relation to Safety Action Bulletins and Hazard Warnings pertaining to all equipment published by Medical Devices Agency.

When an external service contract has been let, the Head of Clinical Logistics t and shared services Procurement Department monitor the renewal and performance. This also includes the technical validation of service reports and ensuring that scheduled maintenance is performed, the response time for breakdown maintenance is acceptable, and that return visits for the same fault do not incur additional charges.

For all in-house work, the Trust has a Planned Maintenance Programme (PMP) for all items of medical devices in line with the manufacturers' recommendations and schedule of servicing.

It is important for the users to make the equipment available for servicing at requested intervals, with appropriate Status Labels attached to equipment, which are due for servicing.

6.8 Reporting of Faults on Medical Devices

In the event of a fault on a medical device, the user must remove the equipment from use and inform the appropriate local Contractor or Clinical Logistics Hub. Under no circumstances the user must attempt to repair the equipment.

All faults are to be reported by quoting the medical device number or device identifier on the equipment, including a full description of the fault. An appropriate system will be agreed with in-house or contractor for replacement, loan of equipment or repair including out of hours arrangements for business continuity purposes.

If there is a requirement for all these incidents to be reported to the Medicines and Healthcare Products Regulatory Agency under the yellow card scheme, the Head of Clinical Logistics will undertake this responsibility.

It is also important for the users not to attempt to service or repair any equipment, which may have shown a fault. On some medical devices, the mains cable is fitted with correctly rated fuse, attached to the equipment and labelled with a number referring to the appropriate equipment. Removal and exchange of mains cable between different types of equipment could introduce a risk and cause patient or user injury.

When the equipment is serviced and returned to the user, a label will be attached to the device by the contacted repairer to notify the user of its status.

It may be necessary for the device to be held or secured in a safe place if there has been a serious adverse incident for investigating purposes e.g. forensic evidence.

6.9 Decontamination Policy

Trust staff should follow manufacturer's guidance for the routine decontamination of specific medical devices. These are accessible via the Clinical Equipment section of the Trust Intranet. Should staff require further guidance they should contact the Clinical Logistics Hub. In the case of a device being removed for service or repair users should complete an online Contamination Status Certificate and, prior to handing over of equipment to in-house or outside contractors.

No Medical device will be accepted for servicing or repair without a completed Contamination Status Certificate.

6.10 Defect and Incident Reporting

In the event of an accident, incident or defect concerning a medical device, the Trust procedures for reporting of incidents must be followed. The user must ensure that equipment is withdrawn from service, labelled and handed over to in-house or outside contractors for further investigation.

6.11 Safety Action and Hazard Notices

The MHRA has responsibility for the issuing of safety notices on a national level to all Trusts. When these are received, they are circulated to the users and appropriate action is taken in compliance with the published notices. The responsibility for this lies with the Head of Clinical Logistics

In the event of an accident, incident or defect concerning a medical device the Trust procedures for reporting of incidents will be followed.

6.12 Medical Device Replacement

Equipment may have to be replaced for one or more of the following reasons:

- Unreliable, i.e. worn out or damaged beyond economic repair
- Recommended by the supplier to be withdrawn from service
- Clinically or technically obsolete
- Not repairable due to spares no longer being available

The Head of Clinical Logistics, each year, will draw up a replacement programme in consultation with the Operations Directorate in line with the latest clinical guidelines. The programme will also take account of equipment to be purchased against the Vehicle Replacement Programme.

The Clinical Equipment Working Group will be given the opportunity to comment on the list, add to it or delete from it.

The Internal Capital Monitoring Board discusses the agreed replacement and new list and allocates funds for purchase as part of the Trusts' discretionary capital programme.

In order for the Trust to comply with waste regulations such as, but not limited to, the Environmental Protection Act, Waste (England & Wales) Regulations, WEEE Regulations, Batteries & Accumulators Regulations & Controlled Waste (England & Wales) Regulations all waste including packaging, maintenance (including replacement batteries) and end of life disposal must be considered at time of approval of order and a costed waste management plan put in place, for onwards communicated to all relevant staff members.

6.13 Condemning Procedure

When a decision has been made that an item of equipment has reached the end of its working life, the Clinical Logistics Hub will record this on a Condemning and Disposal online record for Medical Devices. This decision should be taken by the relevant Clinical Logistics team member, in consultation with the Head of Clinical Logistics if required. A decision will also be made as to the safest and most cost effective means of disposal, utilising the NHS Wales Medical Device Disposal Agents if appropriate, and in line with hazard waste regulations and the Waste Hierarchy.

Cannibalisation of equipment in order to keep similar equipment in use is not an option.
On disposal of the equipment, the apparatus will be removed from all the inventories held by the Contractor, Clinical Logistics and Finance registers as well as cancelling the maintenance schedule and any outstanding service contract. Further Guidance is described in the SALE OF OBSOLETE/SURPLUS EQUIPMENT, SCRAP AND VEHICLES (Finance Procedure Reference 2.2)

6.14 Urgent and Unexpected Replacements

Any urgent requests for replacement equipment (due to breakdowns or parts being obsolete) will be dealt with as speedily as possible and will not necessarily have to wait for an Internal Capital Planning Group meeting. In such cases, the Head of Clinical Logistics will contact the Executive Director of Finance and Corporate Resources for advice

6.15 Specification for Service Level Agreements with In-House / External Contractors

The Welsh Ambulance Services NHS Trust within its operational function uses many different and specialist medical devices of which the majority will require external maintenance and repair arrangements. It is the responsibility of the Clinical Equipment Working Group to determine the specifications of service level agreements that include:

- A consistent and effective maintenance and repair programme is available to each locality across Wales.
- Each item of equipment on the approved medical devices inventory has a detailed list of the required calibration, servicing, and maintenance programme.

The Head of Clinical Logistics will hold all relevant information for contractors in line with the Control of Contractors Policy.

6.16 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 are encouraged to 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 *https://cfa.nhs.uk/reportfraud*

The results of any such investigation could lead to internal disciplinary and/or civil/criminal prosecution proceedings being instigated against the person/persons involved.

7. TRAINING AND IMPLEMENTATION

The Learning and Development Team will prepare a training programme specific to each medical device. Senior Paramedics and/or other suitable staff nominated by Locality Managers will organise training or induction on Medical devices for all relevant users within their own area.

There will be occasions that specialised devices may require full time trainers directed from the National Learning and Development Team to undertake the training of staff.

Duty Operation Managers, Make Ready Depot supervisors, the Clinical Logistics Business Support Officer and Clinical Operations Support Assistants will work with the Head of Clinical Logistics to manage the equipment throughout its life cycle.

8. IMPACT ASSESSMENTS

Policies will not be approved without an Equality Impact Assessment (EqIA) or a Welsh Language Impact Assessment being undertaken as this process has been developed to help promote fair and equal treatment in the delivery of services. It is the responsibility of the Policy Lead to ensure that impact assessments are undertaken during development or review of a policy.

8.1. Equality Impact Assessment

In accordance with the Equality Act 2010, all policies will be subject to an EqIA. This enables resources to be targeted effectively and can 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.

Evidence gathered at the initial stages, by undertaking an initial screening, will determine the relevance of policies and how they affect people as service users, members of the public and as employees of the Trust and indicate whether or not a full EqIA is required.

Equality Impact Assessment forms and procedures for completion as part of policy development are available on the Trust's intranet Policy page under *Supporting Documents.* Further information on the development and value of EqIAs can be found on the Trust's Intranet site and via the following link: www.eiapractice.wales.nhs.uk/home.

All finalised policies shall include reference to the EqIA which has been undertaken.

8.2. Welsh Language Impact Assessment

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

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

8.3. Environmental Standards and Impact Assessment

All policies must be considered as to whether they have any environmental impact during the review/development process. For those policies that are deemed to have no environmental impact it will be sufficient to include the following paragraph:

This policy will put the relevant requirements in place (such as waste management plan, reduction of CO_2 emissions & reduction of carbon footprint) in order to ensure that the Welsh Ambulance Services NHS Trust ongoing commitment to reduce its impact on the environment is maintained and to become a more sustainable organisation in line with Trust policy and Environmental Governance System.

However, the Policy Group or Employment Policy Sub Group will ensure that the Estates Team have 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.

8.4. Counter Fraud

All policies shall be reviewed by the Trust's Counter Fraud team during the development/review process to ensure that the policy contains the correct counter fraud advice to deter fraud. For most policies, it will be acceptable to include the following paragraph; however, the Policy Lead should ensure that the Counter Fraud Team have had an opportunity to consider the policy within the process.

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 Service https://cfa.nhs.uk/report-fraud Fraud investigations may lead to disciplinary action and / or prosecution and civil recovery procedures.

8.5. Records Management

The Welsh Ambulance NHS Services Trust (WAST) recognises the importance of sound records management arrangements for both clinical and corporate records. The Trusts' records are its corporate memory, providing evidence of actions and decisions and representing a vital asset to support daily functions and operations. Records support policy formation and managerial decision-making, protect the interests of the Trust and the rights of patients, staff and members of the public.

8.6. Information Governance

Information Governance (IG) is an overarching term used to describe all aspects of information management. The Trust and its staff shall ensure that they provide satisfactory assurance to stakeholders as to how the organisation fulfils its statutory and organisational responsibilities in relation to the management of information. It will enable management and staff to make correct decisions, work effectively and comply with relevant legislation and the organisations aims and objectives.

The IG framework ensures that it sets out the high level principles for confidentiality, integrity and availability of information to promote and build a level of consistency across the Trust.

8.7. 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

Any policy specific training would need to be devised by the Policy Lead and subject matter expert.

9. 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.

9.1. 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.

9.2. Director of Corporate Governance / Board Secretary

The Board Secretary is responsible for the effective management of, and compliance with, this policy. This includes ensuring that:

- A database of policies and procedures is maintained.
- Policies are approved as part of the Governance framework at the appropriate level in the organisation.
- The documents are accessible to all relevant staff.
- Documents are cascaded appropriately across the organisation.
- All policies are reviewed in a timely manner.

9.3. 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.

9.4. Head of Risk / Deputy Board Secretary

The Head of Risk / Deputy Board Secretary will act as the Trust's 'Policy Process Manager' and operational gatekeeper with the responsibility for providing guidance, advice and support for the process on behalf of the Trust.

In addition, be responsible for:

- Managing the maintenance of the Trust's central Policy tracker and database (including a record of equality impact assessments).
- Facilitation of the Trust's internal Policy Group.
- Managing the Trust wide consultation process for all policies.
- Providing a link between the Policy Group and Employment Policy Sub Group.
- Issuing reminder notices to ensure the timely review of policies.
- Ensuring up to date guidance and documentation regarding the policy process is accessible.
- Publishing policies onto the Trust's internet/intranet sites and working with the Communications Team to ensure comprehensive notification that new policies is maintained across the Trust.
- Maintain an archive of previous versions of any revised or reviewed policies.

9.5. Head of Clinical Logistics

The Head of Clinical Logistics has responsibility for the overall management of Medical Devices within the Trust and for the implementation of this policy.

The reporting line to the Trust Board is through the Assistant Director of Clinical Delivery and the Executive Director of Paramedicine.

The delegated responsibility also includes compilation of an annual replacement programme for medical devices prioritised by consultation with the appropriate managers and clinical users in the Clinical Equipment Working Group.

9.6. Service 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.

9.7. 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.

9.8. All Staff

Are responsible for ensuring that:

- They comply with the provision of this policy and where requested to demonstrate such compliance.

- 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.

10. AUDIT AND MONITORING

The Policy will be enacted through business as usual via the Clinical Equipment Working Group (CEWG). This group reports to the Ambulance Practice Steering Group (APSG) which itself reports to the Clinical Quality Governance Group (CQGG). There is a clear path for escalations through to the Executive Leadership Team (ELT) by the Chair of the CQGG and the Alert, Advise, Assure report mechanism.

If required, the Policy can be audited as part of the Trust Internal Audit Programme.

11. APPENDICES

Appendix 1 – Clinical Equipment Proposal Form
Appendix 2 – Clinical Equipment Evaluation Form

APPENDIX 1 – Clinical Equipment Proposal Form

Welsh Ambulance Services University NHS Trust
Clinical Equipment Proposal Form

Equipment name and description: *(to include weight, dimensions, intended target group of patients etc.)*

Justification: *(patient need, staff benefit, clinical guidelines/evidence, etc.)*

Vehicle type: EA CBRV Ambulance Care CRU *(circle as applicable)*

Suggested vehicle storage location:

Initial and Ongoing Cost (Clinical Logistics Business Support Officer to advise)

Proposed by:
Name

Date

Station

APPENDIX 2 – Clinical Equipment Evaluation Form

Ymddiriedolaeth Brifysgol GIG Gwasanaethau Ambiwlans Cymru

Welsh Ambulance Services University NHS Trust

CLINICAL EQUIPMENT EVALUATION FORM

Product Description

Serial/ID Number

1. Quality	**Poor □□**	**Good □**	**Excellent□□□**
a) Appearance			
b) Materials			
c) Workmanship			
d) Function			
e) Overall Design			

2. Field Testing — Please circle the appropriate answer

a) Is this product easy to work with? YES NO

If no, why not? _____

_____

b) Does it meet your requirements? YES NO

If no, why not? _____

_____

c) Does it make your job easier? YES NO

If no, why not? _____

d) Would you recommend the use of this product to others? YES NO

If no, why not? _____

e) Have you used similar products? YES NO

f)

If yes, please specify the name of the product(s) used	If no move to question 4

A B

C **D**

3. Comparative Analysis

If you have used similar products, how does it compare to those listed in 2f?

Please tick □ appropriate box

	Product A	Product B	Product C	Product D
	Better / Similar / Worse	Better / Similar / Worse	Better / Similar / Worse	Better / Similar / Worse
Appearance	□ □ □	□ □ □	□ □ □	□ □ □
Materials	□ □ □	□ □ □	□ □ □	□ □ □
Workmanship	□ □ □	□ □ □	□ □ □	□ □ □
Function	□ □ □	□ □ □	□ □ □	□ □ □
Overall Design	□ □ □	□ □ □	□ □ □	□ □ □

4. What changes if any, would you like to see to this product? (Please continue on a separate sheet if necessary).

_____

_____

_____

5. Any other comments (please continue on a separate sheet if necessary).

_____

_____

_____

Name: _____ Position: _____

Station/Region: _____

Signature: _____ Date: _____

PLEASE RETURN TO THE CLINICAL LOGISTICS BUSINESS SUPPORT OFFICER

QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE

TERMS OF REFERENCE AND OPERATING ARRANGEMENTS 2024/25

1. INTRODUCTION

1.1. The Trust's Standing Orders provide that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*".

1.2. In line with Standing Orders and the Trust's Scheme of Delegation, the Board shall nominate annually a committee to be known as the Quality, Patient Experience and Safety Committee. This Committee has a key assurance role on behalf of the Board in relation to the Trust compliance with the Commissioning Core Quality Requirements, the NHS Wales Health & Care Standards 2015 and the Health and Social Care (Quality and Engagement) (Wales) Act 2020. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set out below.

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

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

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

2. PURPOSE

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

2.2. During the 2024/25 financial year the Committee will continue to oversee the systems and process developed to ensure compliance with the Duty of Quality and the Duty of Candour as set out in the Health and Social Care (Quality and Engagement) (Wales) Act 2020 and ensure compliance with the Act to improve the quality of healthcare provided by the Trust.

2.3. The Committee will provide oversight of, and seek assurance on, statutory and regulatory compliance on areas within its remit.

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

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

3. DELEGATED POWERS AND AUTHORITY

The Committee will:

3.1. Receive assurance that the organisation has the right systems and processes in place to deliver services consistent with the six domains of quality (person centred; safe; equitable; timely; effective; and efficient).

3.2. Advise the Board on a set of key indicators for quality, patient experience and clinical safety, and monitor performance against those indicators.

3.3. Receive assurance on compliance with the Duty of Quality and the Duty of Candour as set out in the Health and Social Care (Quality and Engagement) (Wales) Act 2020 to improve the quality of healthcare provided by the Trust and to support the delivery of an open and honest reporting and continuous learning culture.

Strategy

3.4. Oversee and contribute to the development of the Trust's strategies and plans for the delivery of high quality and safe services, consistent with the Board's overall strategic direction and any requirements and standards set for NHS bodies in Wales.

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

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

Safe Care

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

3.8. Receive assurance that there is a process in place for quality impact assessments, and consider the implications for quality and safety and equitable care arising from the development of the Trust's corporate strategies and plans, or those of its stakeholders and partners, including those arising from any Committees of the Board.

3.9. Consider the implications for the Trust's quality and safety arrangements from review/investigation reports, external guidance and national reports and actions arising from the work of external regulators.

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

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

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

3.13. Review the impact of professional standards and staffing issues on patient care, noting the People and Culture Committee has oversight of the selection, training, registration, and revalidation for staff.

3.14. Receive assurance that improvements and changes applied as a result of reviews of mortality, clinical incidents, complaints, litigation, external regulator reports etc., and their impact on minimising patient harm and maximising patient experience.

Effective Care

3.15. Receive assurance that the care planned and provided across the breadth of the organisation's functions is clinically effective and quality driven and where this falls beneath expected standards, the impact is reviewed to support continuous improvement.

3.16. Approve the Trust's clinical audit plan that meets the standards set for the NHS in Wales; review the outcomes of clinical audits in line with the clinical audit plan and provide assurance to the Audit Committee in this respect;

3.17. Receive assurance that there is an ethos of continual quality improvement and regular methods of updating the workforce in the skills needed to demonstrate quality improvement throughout the organisation.

Citizen Voice and Patient Experience

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

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

3.20. Receive assurance that the Patient Experience & Community Involvement (PECI) continuous engagement model is taken into account in the design and delivery of services, ensuring the full implementation of lessons learnt.

3.21. Receive assurance that that lessons are learned from patient experience information and patient safety and workforce related incidents, complaints, and claims, and that learning from reports and incidents is embedded in the Trust's practices, policies and procedures.

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

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

Governance

3.24. Seek assurance that governance arrangements are appropriately designed and operating effectively to ensure the provision of high quality, safe healthcare and services across the whole of the Trust's activities, and that these are compliant with relevant legislation.

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

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

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

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

Authority

3.29. The Committee is authorised by the Trust Board to investigate, or have investigated, any activity within its terms of reference. In doing so, it will have the right to seek any information it requires from any employee or inspect any books, records, or documents relevant to its remit, ensuring patient/client and staff confidentiality as appropriate. All employees are directed to cooperate with any reasonable request made by the Committee.

3.30. The Committee is authorised by the Board to obtain outside legal advice or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Trust's procurement, budgetary and other requirements.

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

Chair's Action

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

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

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

Sub-Committees

3.35. The Committee may establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee business. Formal sub-committees may only be established with the agreement of the Board.

4. MEMBERSHIP

Members

4.1. The membership of the Committee should include at least one member of the Trust's Audit Committee and will comprise:

Chair	Non Executive Director
Members	Three further Non Executive Directors of the Board.

Prescribed Attendees

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

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

4.3. The Committee Chair may extend invitations to attend committee meetings to other Directors and/or Senior Managers, and to officials from within or outside the organisation to attend all or part of the meeting to assist with its discussions on any particular matter.

4.4. Members may send deputies in their absence who will act with their full authority. To instigate a substitution arrangement, the member of the Committee must notify the Board Secretary before the day of the meeting that he/she is unable to attend and the name of the member who will attend as the substitute.

Member Appointments

4.5. The membership of the Committee shall be determined by the Board, based on the recommendation of the Trust Chair, taking account of the balance of skills and expertise necessary to deliver the committee's remit, and, subject to any specific requirements or directions made by the Welsh Government.

4.6. Non-Executive Members shall be appointed to hold office for a period of one year at a time, (Membership being reviewed by the Chairman of the Board on an annual basis) up to a maximum of their term of office. During this time a member may resign or be removed by the Board.

4.7. Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the Trust Chair and, where appropriate, on the basis of advice from the Trust's Remuneration Committee.

Secretariat and Support to Committee Members

4.8. The Board Secretary, on behalf of the Committee Chair, shall:

(a) arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and
(b) ensure the provision of a programme of organisational development for committee members, as part of the Trust's overall board development programme developed by the Director of People and Culture.

Quorum

4.9. At least two members must be present to ensure the quorum of the Committee. In the absence of the Committee Chair, one of those in attendance must be designated as Chair of the meeting.

Frequency of Meetings

4.10. Meetings shall be held no less than quarterly or otherwise as the Chair of the Committee deems necessary, consistent with the Trust's annual plan of Board Business. Meeting agendas, papers and minutes shall be circulated no less seven days prior to each meeting.

Withdrawal of individuals in attendance

4.11. The Committee may ask any member or individual who is normally in attendance but who is not a member to withdraw to facilitate open and frank discussion of any particular matter.

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

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

5.2. The Committee, through its Chair and members, shall work closely with the Board's other committees and groups to provide advice and assurance to the Board through the:

(a) joint planning and co-ordination of Board and Committee business; and
(b) sharing of appropriate information;

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall assurance framework.

5.3. The Committee will consider the assurance provided through the work of the Board's other committees and sub groups to meet its responsibilities for advising the Board on the adequacy of the Trust's overall framework of assurance.

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

6. REPORTING AND ASSURANCE ARRANGEMENTS

6.1. The Committee Chair shall:

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

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

(c) ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Trust.

6.2. The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any sub committees established. In so doing, account will be taken of the requirements set out in the NHS Wales Quality & Safety Committee Handbook and national guidance.

7. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

7.1. The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum (as set out in section 5)

8. REVIEW

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

QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE (QUEST)
ANNUAL REPORT 2023/24

INTRODUCTION

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

2. As the factors underpinning effective governance can change, for example as people leave, organisations restructure, or strategy shifts, regular reviews of Board Committees ensure governance remains fit for purpose.

3. Standing Orders, Committee terms of reference, and Codes of Governance provide that Boards should routinely assess the effectiveness of their governance arrangements, of which the Board's Committees form an integral part.

4. The Committee met on 8 February 2024 and reviewed its terms of reference, responses to questionnaires completed by members and attendees, and its operating arrangements. Discussions were also held with the Committee Chair and Executive Lead ahead of that meeting. This Annual Report reflects on the effectiveness of the Committee in 2023/24 and proposes changes to terms of reference.

PURPOSE OF THE COMMITTEE

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

MEMBERSHIP AND ATTENDANCE

6. The Committee met four times as scheduled in 2023/24 and was quorate on each occasion.

7. The Committee is supported by the Chair and three Non-Executive Directors as members, and a number of core attendees. The chart below illustrates attendance of members and attendees as listed in the terms of reference for 2023/24. The Committee welcomed non prescribed attendees at various meetings as well as external guests.

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

8. Attendance is excellent. Leanne Smith was replaced as prescribed attendee when she completed her interim position, and Jonny Sammut joined the Committee when he commenced as Director of Digital.

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

COMMITTEE'S VIEWS ON EFFECTIVENESS

10. The Committee's effectiveness was assessed through a review of its terms of reference, responses to a questionnaire, discussion with the Chair and Executive Lead, and at the 8 February Committee meeting.

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

12. Respondents were asked 27 questions and were encouraged to provide free text answers to explain or expand on their choices. The responses were reviewed by the Committee on 8 February against the same questions from last year. There were a number of comments on the length of the agenda, meetings and papers. These ranged from these impacting the ability of members to undertake their role effectively, to them being appropriate given the frequency of meetings and the crucial scrutiny and oversight of patient safety, quality and patient experience. In 2024/25 meeting invitations will be extended to provide an appropriate amount of time for the meetings where that is deemed necessary at agenda setting meetings and in conjunction with the Chair.

13. Whilst the was a sense the committee needed to strengthen its timely close off of actions/holding to account for late or missing papers, it is recognised that operational pressures may mean some items are prioritised. Regular monitoring of the cycle of business, the action log and forward planner are in place to capture matters carried over.

14. There is a desire to seek to extrapolate only sections of the MIQPR which are relevant for the Committee however it was recognising this could lead to additional work and reporting. An alternative approach is the focus of members on the relevant quality, clinical, patient safety and experience indicators (in the MIQPR and the PTR report) as opposed to the full balanced scorecard (which is scrutinised at Finance and Performance Committee and Board), and the impact of that performance and improvements on patients.

15. As with other Board Committees, the question related to visibility of Committee members scored poorly. Given that there is a Board visits Standard Operating Procedure in place which illustrates members visibility, it is anticipated that this question will be omitted from the 2024/25 survey. The rationale being that it is unlikely, no matter how visible a Non-Executive or Executive Director may be, that that will always resonate with each Committee.

16. Good practice drawn out in responses included:

- The focus in 2023/24 on clinical indicators;

- Key risks are discussed and drive the agenda, with more deep dives on risks welcomes;
- Relevant information is shared clearly and robustly with the Board;
- The meetings are well chaired; and
- There is a positive and transparent culture.

17. The Committee has a cycle of business that is aligned to its terms of reference. All matters scheduled for oversight and review have been brought to the Committee and in this respect it has discharged its responsibilities in providing assurance to the Board. The Committee's business in 2023/24 included:

    17.1. **The Putting Things Right** (PTR) (previously the Patient Safety Highlight Report) and **MIQPR reports** are received at each meeting. Throughout the year the focus was on:

    - Pressures in the teams to respond to concerns in a timely way;
    - Concerns response time improvement plans;
    - Continuing number of immediate release requests refused;
    - Incidents being reviewed at the Serious Case Incident Forum;
    - Joint investigations being passed to Health Boards;
    - National Reportable Incidents;
    - The continued upward trend in Coroner's requests for information;
    - Regulation 28 are brought to the attention of the Committee;
    - Improvement actions under review to ensure the Electronic Patient Record (ePCR) data is correctly inputted to ensure accurate reporting on the various clinical bundles;
    - Good call back time for 111 Wales calls.

    17.2. A **focus on clinical indicators** was agreed at the 2022/24 effectiveness review and the first report was presented at the August meeting. The current clinical indicators and ambulance service indicators are the care bundles and individual metrics for STEMI (ST-elevation myocardial infarction), stroke, #NOF (fractured neck of femur) and hypoglycaemia, as well as the ROSC (return of spontaneous circulation) at hospital indicator. Clinical indicators in development are call to door time for STEMI and stroke. Others in consideration include older fallers, paediatric trauma/pain management, and advanced paramedic practitioner (condition specific compliance). In October the Committee focused on the clinical indicator of **Return of Spontaneous Circulation (ROSC)**, acknowledging substantial enhancements in ROSC rates since April 2022. In February the Committee focused on **stroke indicators** with discussion of the time-based metrics.

17.3. Each meeting heard a **patient story**:

- In May the Committee heard from **Keith Jones** who is a long-standing CFR at WAST and attended a patient at their home in November 2022. Keith was with the patient and their partner for over four hours awaiting an ambulance and during that time the patient went into cardiac arrest. Despite attempts to resuscitate him, the patient unfortunately died. Members heard about the effect of this on Keith and the patient's partner who was present, and discussed the support which is available to CFRs following such an event.

- In August The Committee heard from **Beth Hews**, Palliative Care Paramedic about her experience attending a patient with metastatic bowel cancer who had been referred to Specialist Palliative Care Team (SPCT) for pain management. Through the intervention of the SPCT they were able to keep this patient in her own home rather than have her taken to hospital by ambulance, providing a holistic plan which enabled her to die with dignity and in comfort.

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

- In February **Alison Cassidy** 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.

17.4. The **IMTP 2024-27** elements that related to this Committee were reviewed ahead of the IMTP's approval by Board in March.

17.5. The **Quality strategy implementation plan** was reviewed in May 2023 and February 2024. The plan was developed to support delivery of the Quality Strategy 2021-2024. Whilst progress against the plan has been slow due to resourcing challenges, there was progress in the latter half of 2022/23 in preparation for the Health and Care (Quality and Engagement) (Wales) Act 2020. 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.

17.6. The Patient Experience and Community Involvement (**PECI**) reports were received providing positive assurance we are meeting with and consulting with the public and out stakeholders, including with Llais (the Citizens Voice Body). Reports from PECI are now provided bi-annually.

17.7. The Trust's **annual Clinical Audit Plan**, which allows the planning and prioritisation of clinical audits across the financial year, was approved. It is not always possible to predict all of the topics that require evaluation and therefore this is a dynamic document which is updated quarterly with oversight by this Committee. This supports recommendations in the Audit Wales Clinical Governance Review 2022.

17.8. A **deep dive on red rural performance** was presented in August. Performance consistently tracks below pan-Wales performance and below the 65% target. By contrast however, Amber 1 performance is consistently better than more urban areas. Members recognised that whilst red rural performance remains an issue, actions are being taken to address this. The Committee was assured there was focus on this including demand led rosters, rosters that are recruited to and efficient use of that resource (in particular, handover lost hours, but also internal efficiencies like abstractions and mobilisation times). The forthcoming EMS demand and capacity review explicitly includes rurality in its terms of reference. The People and Culture Committee will look at the effect of rurality on abstractions, recruitment and retention.

17.9. The Committee reviewed the position, plans and proposed reporting for **Information Security and Information Governance** which is an area that was expanded in its remit in 2022. The comprehensive reporting provides an overview of information governance in terms of accountability, assurance and compliance and the Committee agreed a set of metrics. The Board will note that this area of oversight will transfer to the Finance and Performance Committee from 1 April 2024 so there is alignment and avoidance of duplication.

17.10. The **backlog of policies** – particularly those relevant to this Committee - was reviewed and concerns escalated to the Board. A priority order of policies for review in 2023/24 was endorsed. The following policies were approved in 2023/24:

- National Policy on Patient Safety Incident Reporting and Management;
- Aseptic Non-Touch Technique Policy;
- Medicines Management Policy;
- Information Governance Policy;
- Infection Prevention and Control Policy (by Chair's Actions);
- Clinical Supervisions Policy; and
- Data Protection Policy.

17.11. The **Welsh Risk Pool Concerns Assessment** was received and themes such as the PTR capacity and Datix Cymru were discussed.

17.12. **Operational updates** are received at each meeting and often generate a good deal of discussion, particularly related to system pressures.

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

- In May: noted the different approach with an afternoon start; supportive challenge and identification of further actions as a result; lived experience was important to continue to hear; papers were improved, succinct and clear and picked up on the threads of the duties of quality and candour.

- In August: The introduction of a review of the agenda and timings with the Chair closer to the meeting. This will enable the Chair to review placement and timing of items; helpfully, areas of greatest focus and where strong assurance was required were placed higher in the agenda which enabled appropriate critique and discussion to confirm assurance, however, more time could be given to some items to enable members to drill down further on performance; good succinct discussion; and the desire to reduce the volume of papers, recognising however the Committee has a substantial remit. The Board's risk appetite as to the level of assurance required could be reviewed.

- In October: clear and succinct papers and tangible progress on some longstanding issues.

- In February: 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.

17.14. The Health and Care (Quality and Engagement) (Wales) Act 2020 and hence the **duty of quality and duty of candour** came into force on 1 April 2023. The Committee noted:

- In May: The Quality and Performance Management Steering Group incorporates senior oversight and responsibility for the duty of quality and duty of candour to ensure the Quality and Performance Management Framework has an integrated approach to improving the quality of services and outcomes for patients. A quality management system digital dashboard is in progress and Trust intranet pages are available to staff to cascade messaging and enhance knowledge in this area. There was positive progress of the Trust position against the Welsh Government road map for the Act implementation, including exemplar content and ideas produced by Trust staff now being adopted at NHS Wales level. Concern was raised as to impact on teams and resources with the increased requirements under the duty of candour as raised in the alert section.

- In August: Work is progressing regarding 'Always On' reporting with the development of a scalable digital dashboard specification based on the Quality Standards 2023 reflective of strategic, tactical, and operational quality requirements. A set of Performance and Quality Standards are currently being developed for the duty of candour to collect data and information consistently at a local and national level and create a dashboard. Progress on the Welsh Government milestones was said to be amber/green with two key outstanding areas being the 'Always-On' reporting and the ability to resource the requirements arising from the duty of candour'. It was recognised that there was a need to continue to 'hold the tone' of the duty of quality and duty of candour and that the new quality leads will play a pinnacle role in this.

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

17.15. The duty of quality requires each organisation to provide demonstrable evidence that all strategic decisions and plans have been made through a quality lens for both clinical and non-clinical aspects. A key element of demonstrating this are **Quality Impact Assessments** (QIA). The Committee were assured that the framework for QIAs was appropriate and noted that the template developed by the Trust has since been adopted by the NHS Wales Executive for use across Wales. Two QIAs were subsequently reviewed by the Committee, including the Implementation of a revised approach to the application of the Non-Emergency Patient Transport Service (NEPTS) eligibility criteria and a revised Capacity Management Plan, and The Mid and West Wales Fire and Rescue Services (M&WWF&RS) support to the Trust's emergency responses.

17.16. The Health and Care Standards (2015) have now changed to the **Health and Care Quality Standards (2023)** with six domains and five enablers. The domains are Safe, Effective, Timely, Efficient, Equitable and Person Centred. The enablers include Leadership, Culture and Valuing People, Data to Knowledge, Learning Improvement & Research, and Whole System Perspective. Work is progressing to define quality outcome measures aligned to the Standards.

17.17. The Committee **cycle of business** was approved.

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

- Infection Prevention and Control Annual Report 2022/23
- Safeguarding Annual Report 2022/23
- Mental Health and Dementia Annual Report 2023

17.19. The Audit Wales Quality Governance Review 2022 raised the issue of the backlog of **mortality reviews** and the need to develop an action plan to reduce this backlog. The Committee saw there is evolving work to embed and strengthen the mortality review process. Learning will be shared and triangulated with information produced from other sources e.g. coroners, incidents, clinical audit programmes, and this Committee will see this in the Patient Safety Report.

17.20. **Risks** relevant to this Committee – 223 and 224 – are reviewed at each meeting and the agenda is driven by these risks. Risks to the Trust's ability to implement the duty of quality and duty of candour were also discussed with relevant mitigations, as were challenges and risks in achieving, maintaining and assurance compliance of data protection.

17.21. The **annual effectiveness review** was conducted in the January 2024 meeting.

17.22. The **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.

17.23. The revised **Audit** tracker and process was reviewed and good progress is being made to close down management recommendations.

17.24. An update was provided on the **Health Inspectorate Wales (HIW) Review: Patient Safety, Privacy, Dignity and Experience whilst waiting in ambulances during delayed handover (2021)**. There was an expectation from HIW that the recommendations made would be considered at a system level and an Emergency Ambulance Services Committee (EASC) task and finish group was established to respond to the review. The Trust's particular management actions are reported to that group and HIW have concluded that sufficient assurance has been received in response to the findings identified within the review report for the Trust for the stage one review. A stage two review will be initiated by HIW in the latter part of 2023/24.

17.25. The **HIW national review of patient flow – a journey through the stroke pathway** and the **HIW Annual Report** were reviewed in February 2024.

17.26. The **Healthcare Inspectorate Wales (HIW) Annual Report 2022-23** was reviewed in February 2024 and the Committee noted that the issues raised, including system pressures and safeguarding, are frequent areas of discussion and oversight at QUEST.

17.27. **The Infection Prevention and Control (IPC) internal audit** (reasonable assurance) was presented with the Committee being assured that whilst recommendations for improvements were being made, the response and the ways we seek to support our patients with respect to IPC i.e., guidance, advice and support is appropriate.

17.28. The **Immediate Release Directions internal audit** (reasonable assurance) was presented and the need for a collaborative approach to these was apparent.

17.29. The **Data Analysis internal audit** (reasonable assurance) was also reviewed.

17.30. The **Records Management Internal Audit** (reasonable assurance) was received in February 2024.

17.31. The limited assurance **Pain Management internal audit** was presented to this meeting following it's discussion at the Audit Committee on 25 July. The Committee reviewed the recommendations and actions, welcoming the tight timeframes within which these would be closed given the limited nature of the audit.

17.32. The **Committee's priorities for 2023/24** (implementation of the quality strategy, and the duty of quality and duty of candour) are reviewed at each meeting and a more detailed update appears later in this report. The Committee also reviews progress against its cycle of business at each meeting.

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

19. The Committee is not currently serviced by any Sub-Committees.

PROPOSED CHANGES TO THE TERMS OF REFERENCE

20. Extensive changes to the Terms of Reference for this Committee were made during the effectiveness reviews held in 2022. The changes this year are therefore minimal and include feedback from the Committee following the survey and the meeting on 8 February. The changes in the Terms of Reference are marked up in [Annex 1] and include:

- A change in the narrative on assurance to provide clarity on approach;
- The information governance and information security elements are proposed to transfer to the Finance and Performance Committee from 1 April. That Committee has the digital infrastructure, systems and strategy in their remit as well as cyber security and it was felt by the Caldicott Guardian (Liam Williams) and Senior Information Risk Officers (Jonny Sammut) that this move was

appropriate to reduce duplication and align the approach. The Caldicott Guardian will alert the Committee to any relevant issues of patient information concerns; and

- Changes in the narrative on risk and audit to streamline responsibilities.

COMMITTEE PRIORITIES

21. The Committee received an update on progress against its priorities at each meeting. The 2023/24 priorities were:

Priority	Progress
Committee will monitor implementation of the Duty of Quality and Duty of Candour following the Health and Social Care (Quality and Engagement) (Wales) Act ('Act') coming in to force in the Spring of 2023	As set out above, progress against this priority has been good throughout the year.
Implementation plan for the quality strategy.	As set out above, progress against this priority has been monitored throughout the year, noting that focus has been on the implementation of the duty of quality and duty of candour.

22. It is good practice for Committees to set priorities for the forthcoming year when they review their effectiveness. Accordingly, the Committee has agreed the following priorities for 2024/25:

(a) Continue to monitor the duty of quality and duty of candour i.e. Committee will monitor implementation of the Duty of Quality and Duty of Candour following the Health and Social Care (Quality and Engagement) (Wales) Act.
(b) Monitor the delivery of the Quality Strategy (plan)
(c) Monitor the organisation's compliance with the Health and Care Quality Standards 2024

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

NEXT STEPS

24. The next steps are to update the cycle of business with revised terms of reference

RECOMMENDATION

25. The Trust Board is requested to

(a) Receive and note the contents of the Committee Annual Report for 2023/24 and analysis of its effectiveness; and

(b) Approve the changes to the Terms of Reference.

AGENDA ITEM No	**21**
OPEN or CLOSED	**Open**
No of ANNEXES	**1**

COMMITTEE PRIORITIES AND CYCLE OF BUSINESS MONITORING REPORT

MEETING	Quality, Patient Experience and Safety Committee
DATE	13 August 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. This report updates the Committee on progress against the agreed cycle of business for the Committee. Progress is steady across all priorities and there is nothing to escalate on the cycle of business progress.

2. On the Monitoring Report, the Committee's attention is drawn to the Annual Putting Things Right Report (within which the Duty of Candour narrative will be included) and the Annual Infection, Prevention and Control Reports have been deferred to the Q3 meeting of the Committee.

RECOMMENDATION: The Committee is asked to note the update.

KEY ISSUES/IMPLICATIONS

No issues to raise.

REPORT APPROVAL ROUTE

Not applicable.

REPORT APPENDICES

Annex 1 – QuEST Committee Cycle of Business Monitoring Report 2024/25

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

COMMITTEE PRIORITIES AND COMMITTEE CYCLE MONITORING REPORT FOR 2024/25

SITUATION

1. This report updates the Committee on progress against the agreed cycles of business and the priorities that it set for 2024/25. There are no matters to escalate regarding Committee priorities.

BACKGROUND

2. During the course of the effectiveness reviews, it was agreed that it is good practice for Committees to set priorities for the forthcoming year. The Committee's priorities, which are set out below, were agreed by the Trust Board in May 2024 and will be tracked quarterly.

3. The Committee's cycle of business was approved by the Committee in May 2024. The agenda is set with reference to that cycle, together with the forward planner, action log and highest rated principal risks.

4. The monitoring report is at Annex 1. The 'pre-agenda setting' key indicates that items in green show where they are cycled for a particular meeting. Items in beige indicate they are a prompt at agenda setting as they may be *ad hoc* items such as business cases or external reports.

5. The 'post-agenda setting' key indicates that items in blue were either on the agenda as scheduled or is an *ad hoc* item which was discussed in agenda setting and scheduled. The orange indicates where an item was programmed for receipt but has been deferred to a future meeting.

ASSESSMENT

6. The Committee priorities, and progress against them is as follows:

Priority	Progress
• Continue to monitor the duty of quality and duty of candour i.e. Committee will monitor implementation of the Duty of Quality and Duty of Candour following the Health and Social	**2024/25 PROGRESS** • The Duty of Quality Annual Report for 2023/24 was received by the Committee at its meeting in May 2024 and approved by the Trust Board in July 2024 for publication.

Care (Quality and Engagement) (Wales) Act.	• Future updates on the implementation of the Duty of Candour and Duty of Quality will be programmed as required, informed by the prompts on the Cycle of Business. <u>2023/24 PROGRESS</u> • A report was received at the Committee meeting in August 2023. At this meeting the Committee noted that this business would be cycled as required. • An update report was scheduled for receipt and discussion at the October 2023 Committee meeting (and would be cycled into each meeting of the Committee as required). • The October 2023 update will provide the status of the Welsh Government (WG) gateway report and provide an indicator on the quality strategy implementation.
• Monitor the delivery of the Quality Strategy (Plan)	**2024/25 PROGRESS** • An update on the implementation of the Quality Strategy is programmed for receipt at the August 2024 Committee meeting. This business is included on the Cycle of Business which will inform each agenda setting meeting. <u>2023/24 PROGRESS</u> • At the August 2023 Committee meeting it was noted that the Quality Strategy Implementation Strategy will be received in Q3 (the November 2023 Committee meeting). • The November 2023 Committee received an update on the Duty of Quality implementation and on the status of the Welsh Government gateway report; which will provide an indicator on the quality strategy implementation.

• Monitor the organisation's compliance with the Health and Care Quality Standards 2024	**2024/25 PROGRESS** • The reporting against compliance for the Health and Care Quality Standards is indicated on the Committee Cycle of Business as 'developing' and this will be progressed throughout 2024. • The final Duty of Quality Annual Report for 2023/24 and the associated self-assessment against the Health and Care Standards will be received by the Committee at its meeting in August 2024.

7. On the Cycle of Business Monitoring Report, the Committee's attention is drawn to the Annual Putting Things Right (PTR) Report (within which the Duty of Candour narrative will be included) and the Annual Infection, Prevention and Control (IPC) Report, which have been deferred to the Q3 meeting of the Committee.

8. It was agreed earlier in 2024/25 that the Duty of Candour reporting requirements would be included in the Annual PTR Report – in line with Welsh Government reporting requirements - and that this would be prepared for Q3 to align to the previous PTR Annual Report reporting schedule.

9. The Annual IPC Report was programmed for receipt at the Q2 meeting of the Committee but has been deferred at the request of the Executive Director of Quality and Nursing, due to capacity within the Directorate for production of the Annual Report.

RECOMMENDATION: The Committee is asked to note the update.

PAPER	PRE C'EE FORUM	FREQUENCY	Q1	Q2	Q3	Q4	LEAD	PURPOSE	COMMENT/COMPLIANCE
QUEST COMMITTEE - CYCLE OF BUSINESS 2024/25									
TERMS OF REFERENCE NOTED IN RED TEXT									
MIQPR review of metrics	ELT	Annually	→				EDSPP	Approval	Q1: Programmed for Q1 however deferred to Q2 (and programmed for Q2).
Committee QPSE review of metrics in PTR report	CQGG	Annually					EDQN	Approval	
MIQPR report	ELT	Quarterly					EDSPP	Assurance	
Putting Things Right Report [Note 1]	CQGG	Quarterly					EDQN/DP	Assurance	Q1: Includes PTR Recovery Plan in addition to PTR Report.
Quality Report [Note 3]	CQGG	Annually					EDQN	Approval	Q2: Final report (post Board approval) and to inc. position on compliance w/Standards (as a consent item - adjusted July 24).
Duty of Candour Report (Annual PTR Report) [Note 4]	CQGG	Annually	→	→			EDQN	Approval	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	Q2: Commissioned for August but deferred at EDON's request for Q3 (300724).
Annual safeguarding reports	CQGG/TB	Annually					EDQN	Assurance	
Referrals from PCC	PCC	Ad Hoc					Relevant Director	Discuss/Assure	
Clinical audit plan [Note 9]	CQGG/AC	Annually					EDP	Approval	
Monitoring report on clinical audit	CQGG	Quarterly					EDP	Assurance	
Spotlight On' clinical indicators	CQGG	Quarterly					EDP	Assurance	Q1: Fractured Neck of Femur; Q2: Hypoglaycaemia.
Mortality Report [Note 12]	CQGG	Bi-annually	→				EDQN	Assurance	Deferred from Q1 to 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; Q2: 1 Policy.
Board Assurance Framework	ELT	Quarterly					BS	Assurance	
Corporate Risk Register	ELT	Quarterly					BS	Assurance	
SUB-GROUPS									
Where applicable	N/A	Ad Hoc					N/A	N/A	
GOVERNANCE									
Committee effectiveness review annual report	Audit/Board	Annually					BS	Approval	
Review of Terms of Reference	Audit/Board	Annually					BS	Approval	
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

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.
Duty of Quality and Duty of Care	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. 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.

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
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.
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).
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.
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.
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. [illegible]
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

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
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;
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)
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
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.

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

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
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To Support.
To Serve.
To Save.

Welsh Ambulance Services University NHS Trust

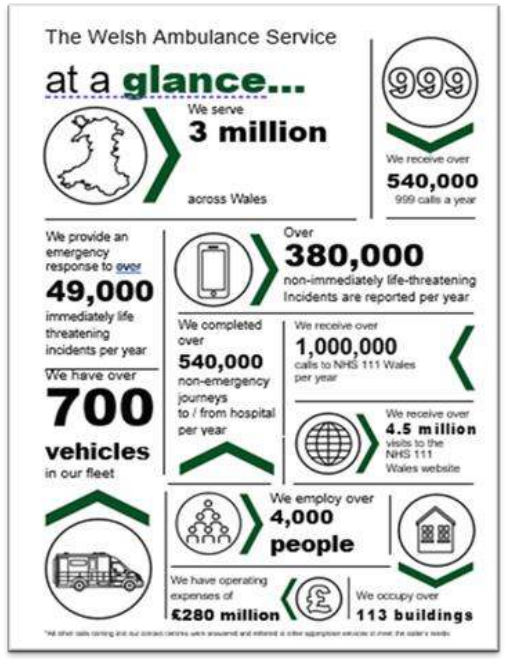
Introduction

We are pleased to present our first annual Duty of Quality Report, sharing with you information that describes the quality of services we provide, the systems in place to identify and implement improvements and the story of our journey through 2023-24.

The Health & Social Care (Quality & Engagement) (Wales) Act 2020 came into force in April of 2023. While this new legislation places a Duty of Quality and a Duty of Candour upon the Trust, the wider NHS in Wales and our Ministers, providing person-centred, positive experiences for our service users and our teams has been central to our culture at WAST for far longer.

Our Quality Strategy focuses on continuous improvement as a quality driven clinically led organisation. We are committed to hearing our communities voice and working collaboratively across NHS Wales to improve the services you receive, ensuring our leadership teams and systems of work enable our people to provide excellent care and experiences across our range of services. We are incredibly proud of the people who work for WAST, either as employees or volunteers, to help care for the population of Wales but we know there are always opportunities to improve. You have told us about the challenges you have experienced and we are working hard across the organisation to respond to this feedback, identifying new and innovative ways of working to help improve your experience and those of our teams. We look forward to hearing from you telling us what you think of our report and also for feedback on any areas you think we could improve in what we do.

Thankyou for taking the time to read this report and learn about our organisation's performance.





Liam Williams
Executive Director of Quality & Nursing



Bethan Evans
Non-Executive Director

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.
- A 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. Our Quality, Patient Experience & Safety Committee provide assurance to our Trust Board on the Duty of Quality.

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 and clinical improvement leaders 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.

The majority (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 Management Steering group is to support both internal and external scrutiny, ensuring the spread of good practice and that the approach of local quality and performance frameworks is consistent across the Trust.

Assurance of our Quality & Performance Management Framework is provided to the Trust Board via regular updates to our Audit Committee.

The recent Audit Wales Structured Assessment(2023) 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
- Clinical Indicators
- 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 Audit
- 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. 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.

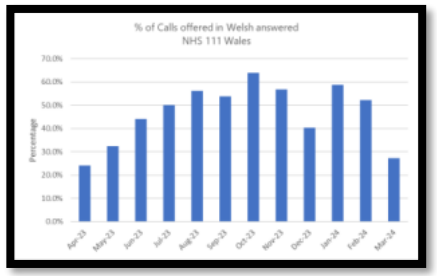
Centralising the Trust's internal translation service with the recruitment of a Welsh Language Translator has increased the Trust's ability to provide bilingual services to our service users.

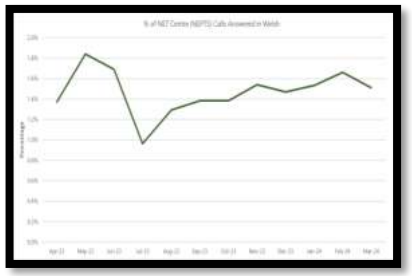
The Standard

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 must implement actions to comply with its Statutory Compliance Notice that was issued by 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 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**

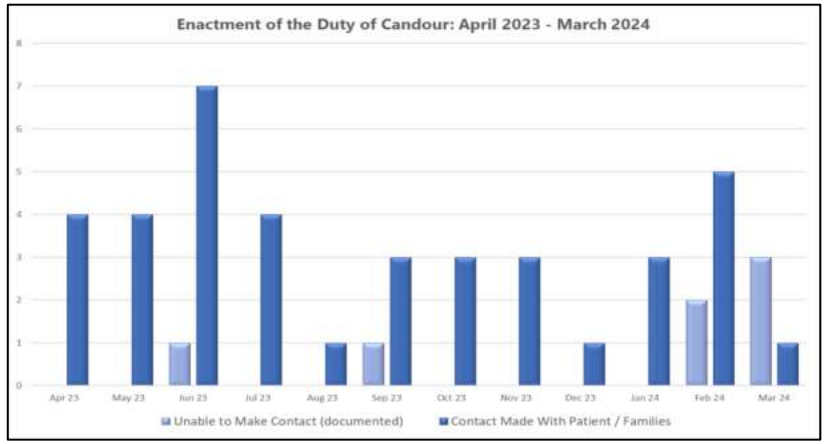
As an organisation this process was already embedded for Service Users who experienced severe or catastrophic harm. We are now building on these foundations to include those Service Users who experience moderate harm. The goal is to continue to embed a **culture of trust and openness** so that service 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 & Early Years 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.

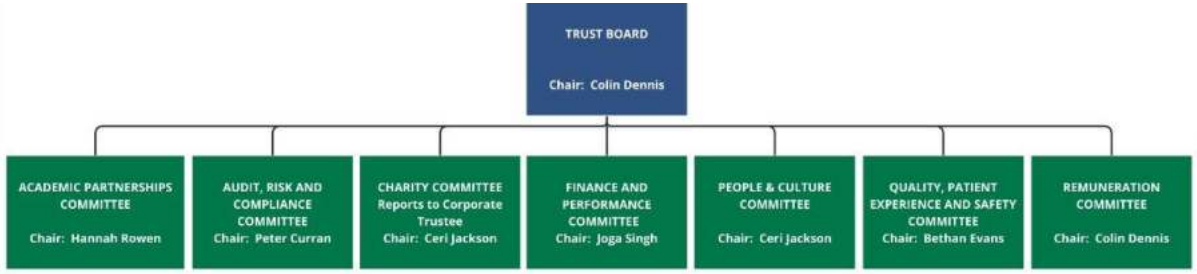
Trust Board and Committees

WAST Trust Board

The WAST board comprises the Chair, Vice-chair and six Non-Executive Directors. The Chief Executive and five Executive Directors are also voting members, with the board also including the remaining four Directors and two Trade Union Partners.

The role of the Board is to focus on key areas of our business and service delivery including our strategy, vision and purpose of the Trust. They shape the culture of the Trust in several ways embedding ethical behaviour, providing visibility to the organisation and by engaging with the staff, public and stakeholders. The Board sets the organisation wide expectations and accountability for quality and performance, and are also responsible for managing risk ensuring there are robust controls in place to mitigate these risks.

The Board is supported by a number of committees who meet in public to monitor our performance and provide assurance on the services we provide. Our Quality, Patient Experience & Safety committee is responsible for the oversight of the Duty of Quality.





Corporate Governance Framework

WAST's corporate governance framework creates a supportive environment where decisions are made transparently, resources are used wisely, and responsibilities and accountabilities are clearly defined. It involves providing strong leadership, guiding the service with a clear vision, maintaining high standards of care and ethics, and fostering a positive and inclusive culture that builds trust among our people, our patients, and our stakeholders. Additionally, it includes having robust controls and processes in place to ensure everything runs smoothly and safely, from our preparedness to respond to change, to our day-to-day operations.

Our board and committee structure is vital to ensure our corporate governance framework is operating effectively, ethically, and responsibly. Regular reviews of these structures ensures our governance remains fit for purpose and demonstrates our commitment to the duty of quality. In addition, the Trust's

Standing Orders and committee terms of reference require that the board and its committees self-assess and evaluate their effectiveness annually.

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).

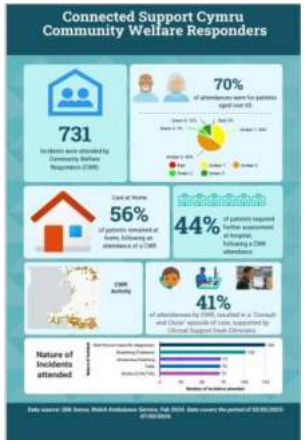
The crew will use the initial call information and any updated information to help them determine what equipment they need to take directly to the patient's side to support their needs, and whether any further support may be needed on scene. On arrival at the incident, the patient is quickly assessed 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.







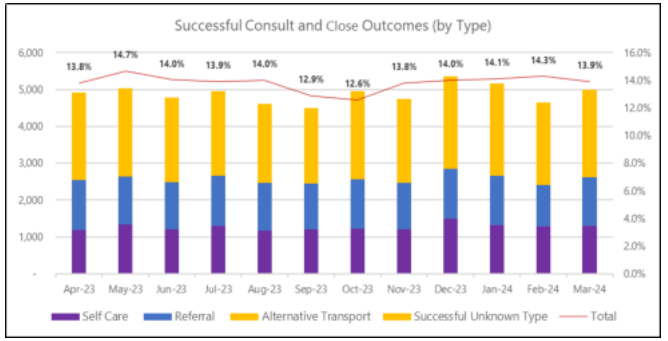
In 2023-24 we have worked to develop and grow CSD services including many exciting pilot projects which will see improvements for 999 services as well as supporting patients to get the right advice and right care.

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.

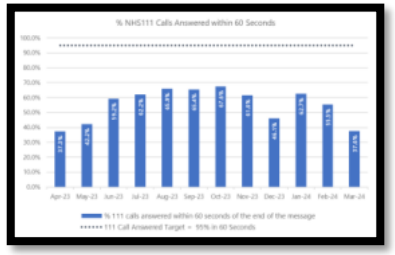
Our call handlers will answer your call and ask you a series of questions to understand what help you need, they may be able to help you straight away or you may need to speak to someone else such as a nurse or paramedic in our NHS 111 Wales contact centres, a dental nurse or a health information advisor. 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.

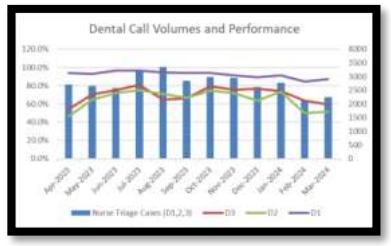


Call Prioritisation Streaming

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 and 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.



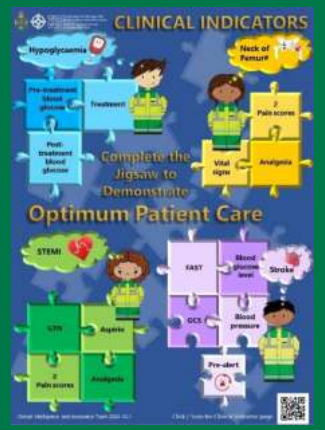
Stroke (CVA) Intervention
The Trust have recently made changes to its software system used to prioritise 999 calls, particularly those relating to symptoms that indicate a stroke. The change has incorporated the recommendation of the National Stroke Network advising that the Stroke window of intervention 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. The Clinical Audit Plan is approved by our Quality, Patient Experience & Safety committee who monitor progress on a quarterly basis. We regularly monitor clinical indicators and audit outcomes to identify clinical improvement initiatives.





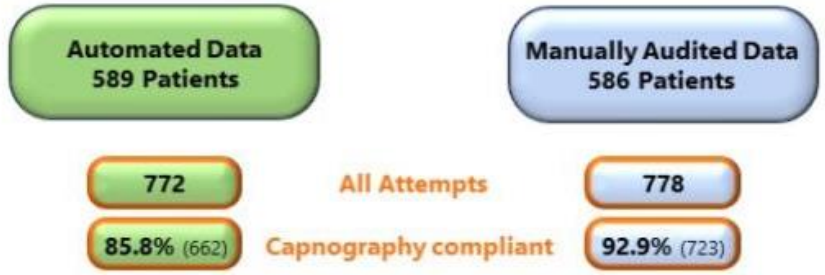
Clinical Audit

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.



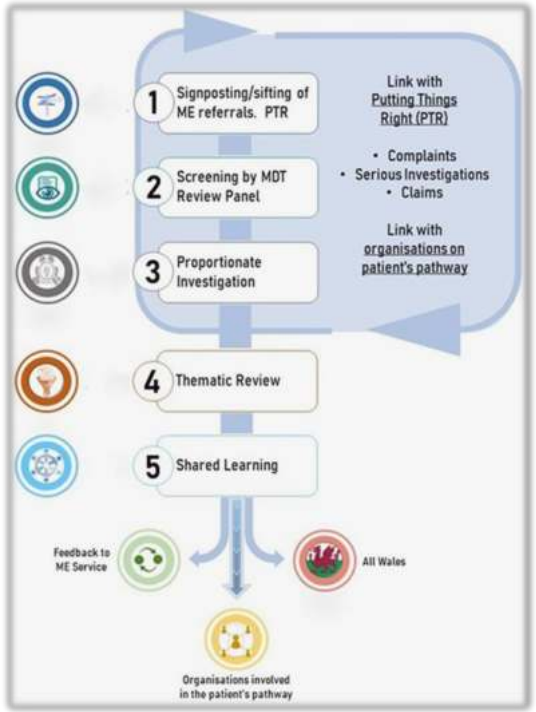
Next Steps

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

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

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

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**

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.

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

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**

Fatehullah's Story

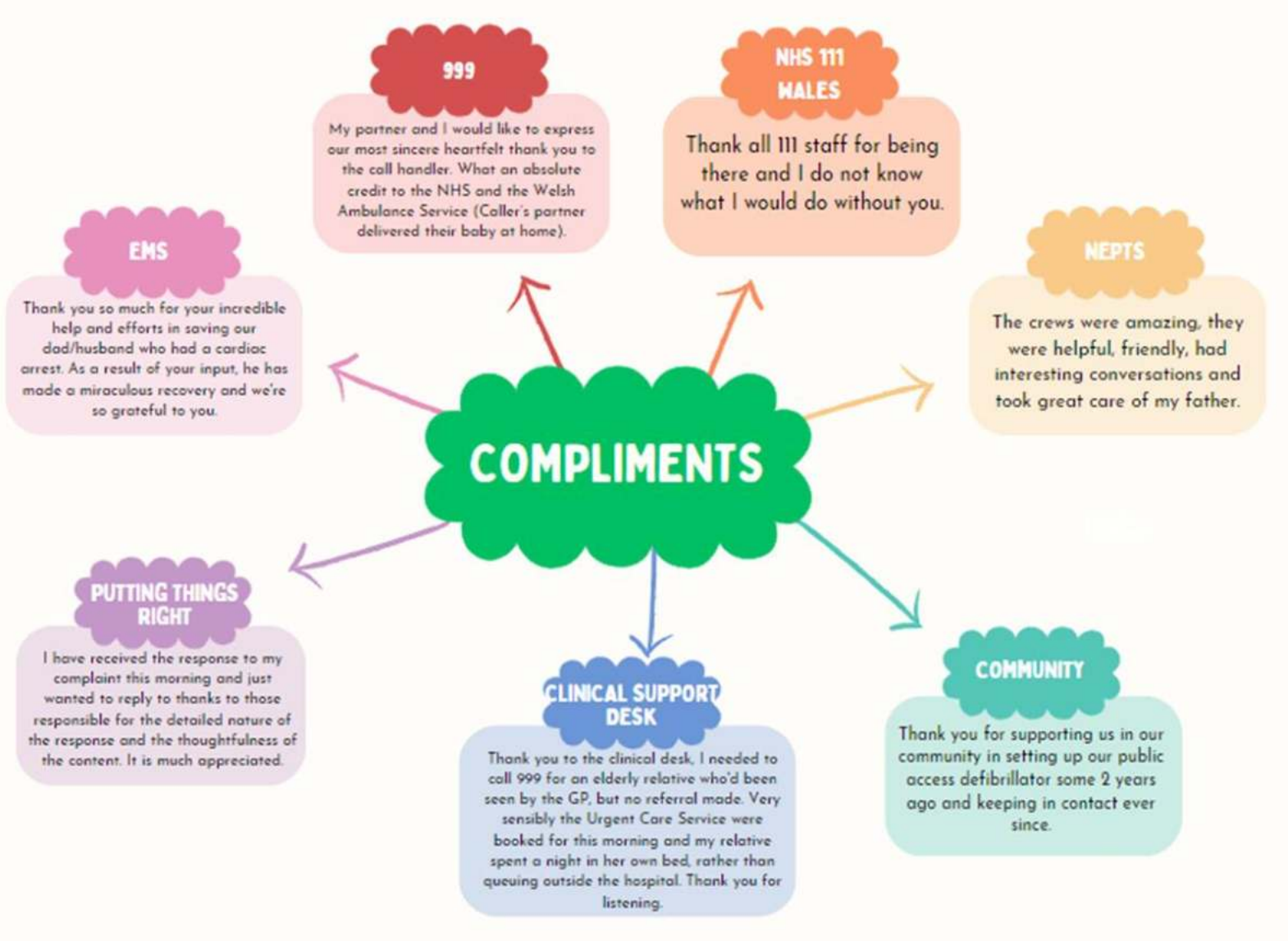


Given that our engagement activities have highlighted instances of discrimination, we invited one of our Corporate colleagues, **Fatehullah Tahir**, to share his experience of working in an organisation lacking in diversity in terms of ethnicity and faith. Fatehullah is a well respected member of the 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.

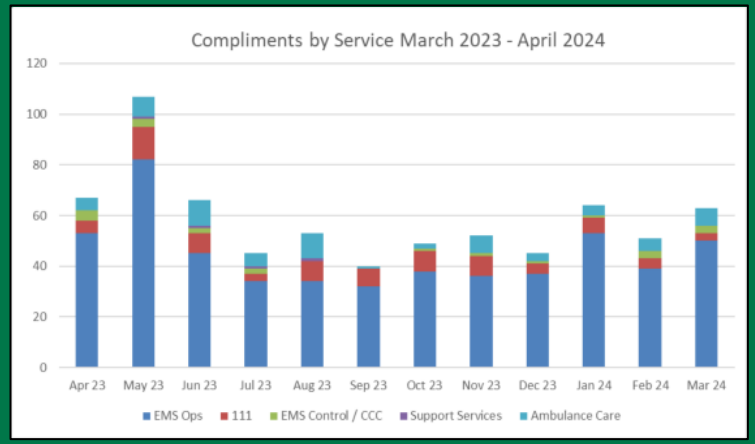
How is Faz now?

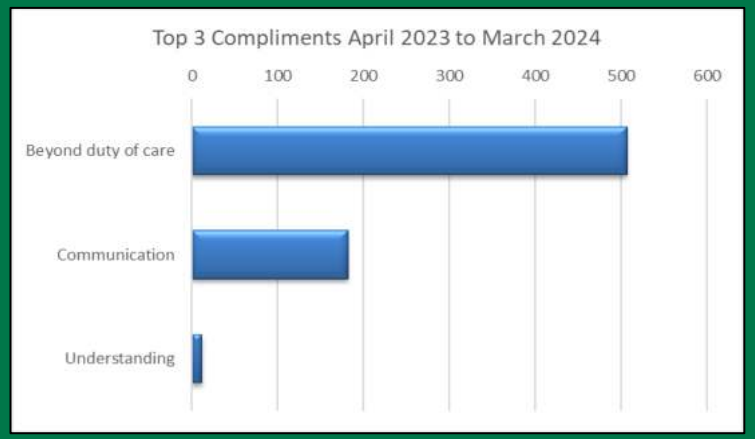
Faz feels it was helpful to share his story which was extremely powerful for colleagues to hear but fundamentally, nothing has changed in the system. Faz is not unhappy at WAST and whilst he's pleased to see these issues being taken seriously, he like the rest of us, is aware that this kind of change 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



WG23-13

The Duty of Quality Statutory Guidance 2023
and Health and Care Quality Standards 2023

The Health and Social Care (Quality and Engagement) (Wales) Act 2020
The Health and Social Care (Community Health and Standards) Act 2003

Date of issue: 1 April 2023

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.

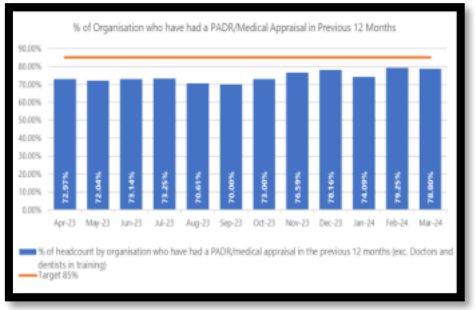


Staff Stories

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.

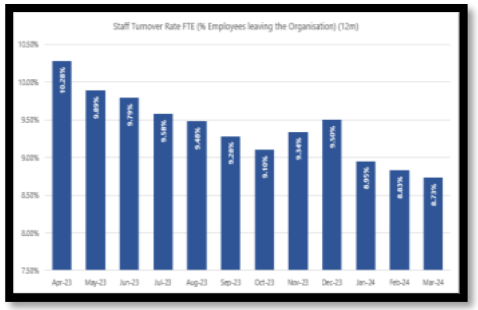
Personal Appraisal Development Review (PADR)

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%



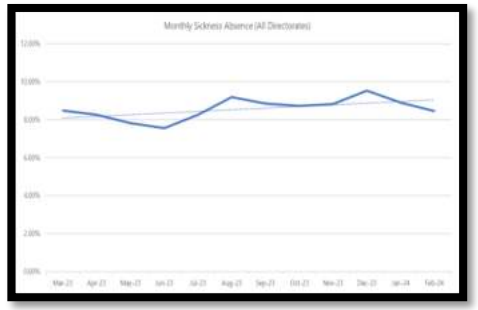
Staff Retention

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
The development of a Leadership Behaviours Framework and an aligned Development Framework is a significant initiative currently underway. This project represents a major step forward for us in establishing a comprehensive framework that enables targeted leadership development for leaders and managers at various stages of their careers. By integrating coaching and mentoring opportunities along with succession pathways, we aim to embed an inclusive, compassionate, and collaborative leadership culture. Currently, we are in phase 1 of the project and working with an external partner to define 'what good leadership looks like' in our organisation.



Gwybodaeth Information

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 into Knowledge

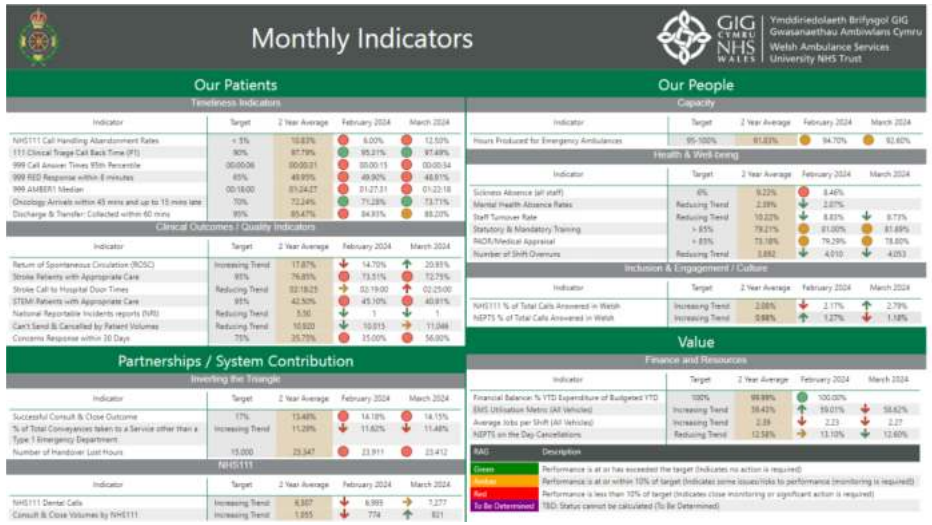
Information & intelligence is used widely throughout the Trust. Executive sub-groups and Board committees are supported in their decision making and escalation with rich reports, dashboards and/or internal Key Performance Indicators (KPI). This allows for triangulation of outcome based, performance based, 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.

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

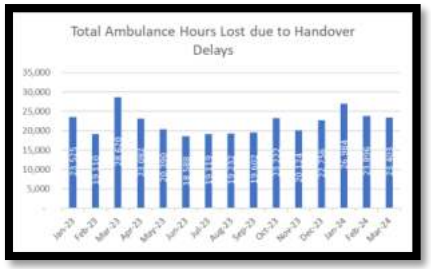
The Trust regularly meet with Health Board colleagues to discuss a variety of quality and performance items to identify best practice, areas of risk and priorities for improvement.

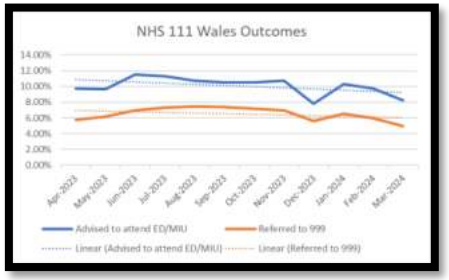
The items discussed include

- 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.

Gwella, dysgu ac ymchwil
Learning, improvement and research

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

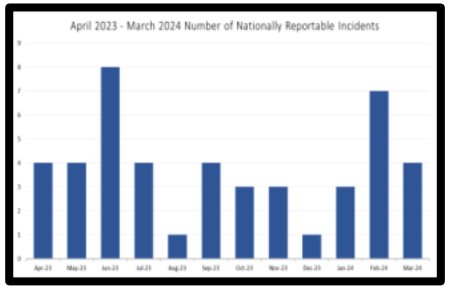


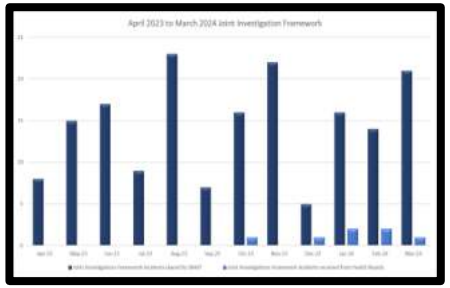
Managing Risks

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.



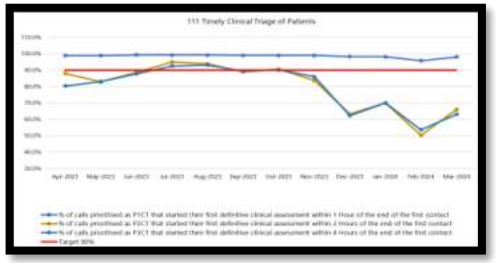


Patient Safety Investigations

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

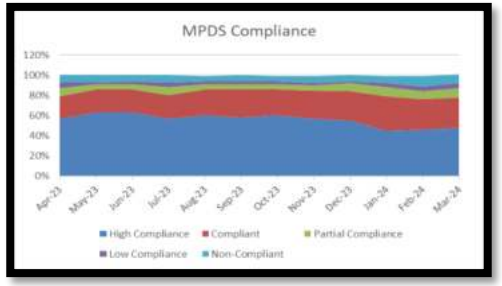
Clinical Assessment

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.

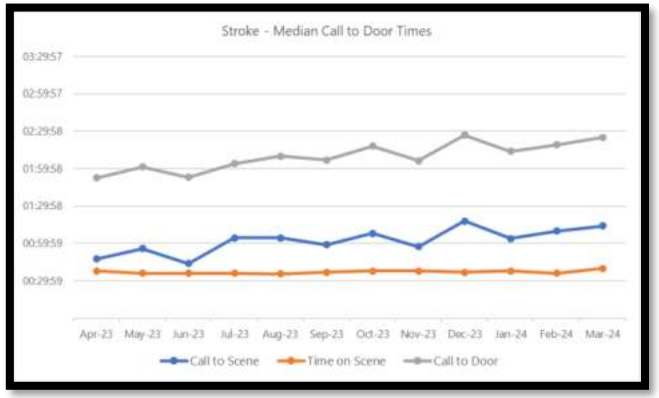


Call to Door

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.

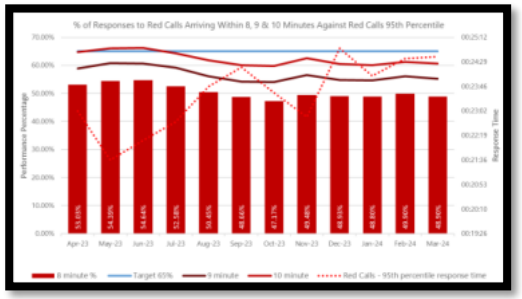
Stroke

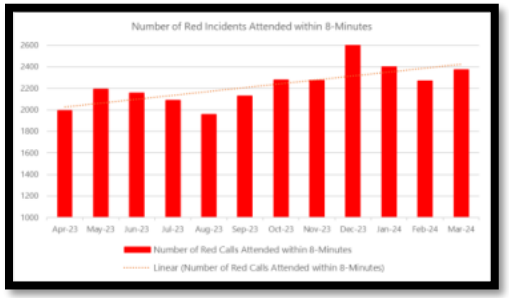
Whilst performance in this area has improved compared to 2022/23, we have seen a gradual decline in performance over the year which is related to the time from your call to our arrival at scene.



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.



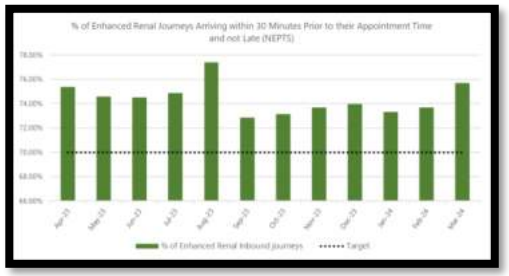


Non-Emergency Patient Transport

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.

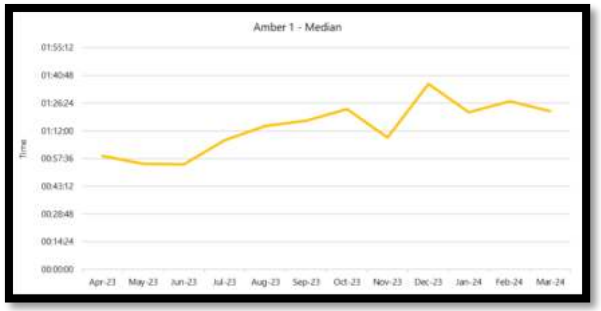
For our Oncology patients our performance has been less stable with our target having been met for 6 months out of the year, however the last quarter has indicated positive improvement, and we are continuing to work collaboratively with our health board partners and Trusts to provide an improved service 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.





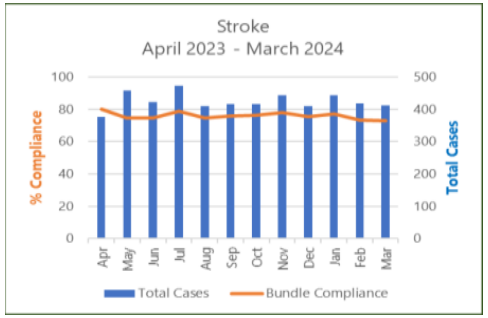
Welsh Ambulance Services University NHS Trust

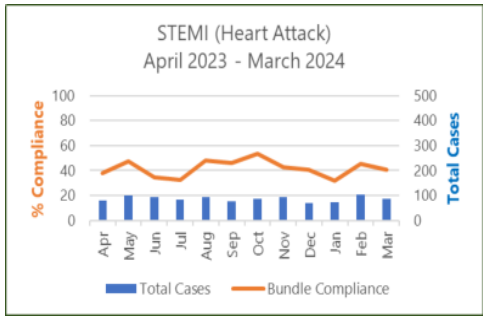
Effeithiol
Effective

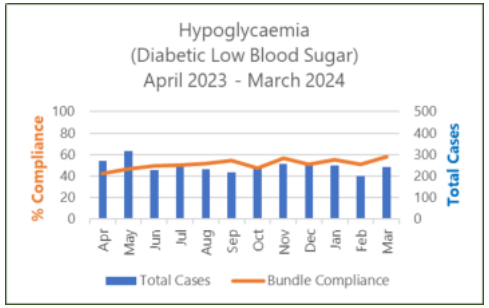
Cymru High Acuity Response Unit (CHARU)

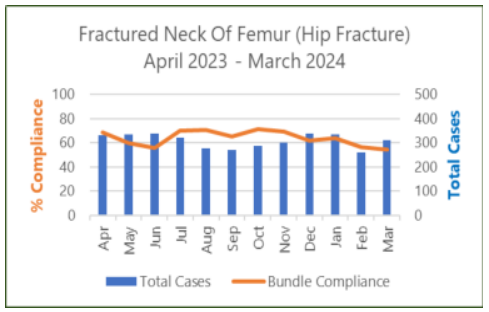
The introduction of the CHARU service allowed experienced paramedics with additional training and medicines to be tasked to a broad mix of high acuity patients including out of hospital cardiac arrests and major trauma. Through 2023/24 we have seen an improvement in Return of Spontaneous Circulation (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.

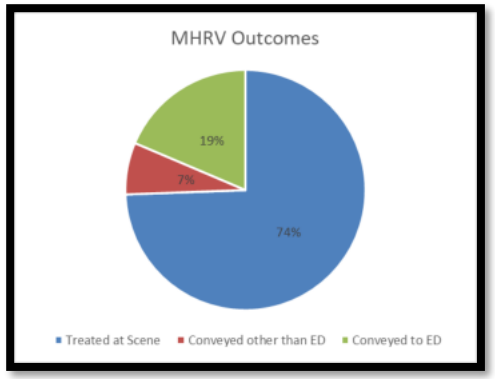
We are exploring options to improve electronic Patient Clinical Record completion and compliance to clinical indicators with prompts when a record is being closed to enable clinicians to easily return to the required area for completion.

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.

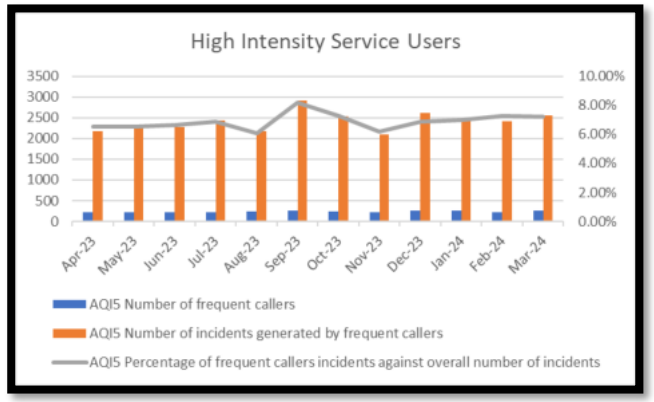




High Intensity Service Users

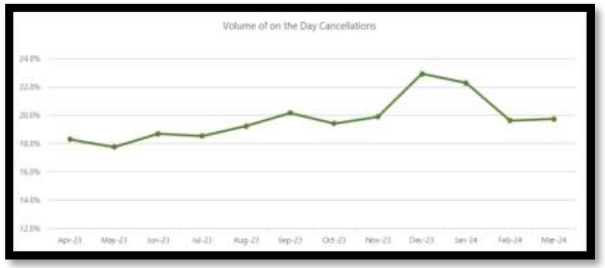
The national definition for a High Intensity Service User is a patient for whom we record 5 or more incidents a month. As an organisation we monitor frequency of contact in order to assess, identify and access appropriate care pathways for these patients to ensure that their needs are managed consistently 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.

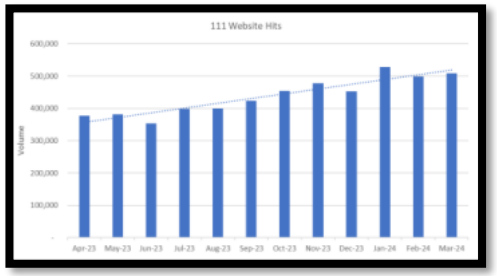


Admission Avoidance

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

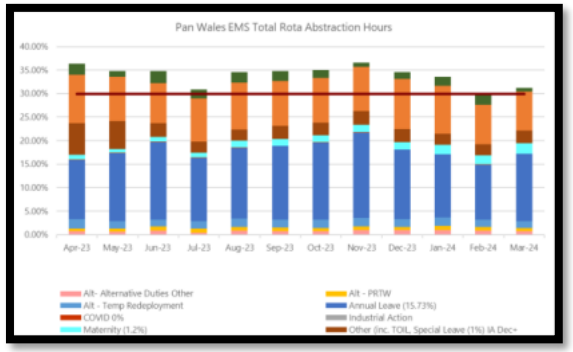
The NHS 111 Wales Website continues to be a source of information and advice for our service users offering advice, symptom checkers and information about local health services. Through 2023/24 we have seen increased use of this important service month on month however feedback from our service users 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 been consistently reducing year on year. In February 2024 we achieved our target for the first time in over four years.



Teg

Equitable

Strategic Equality Plan

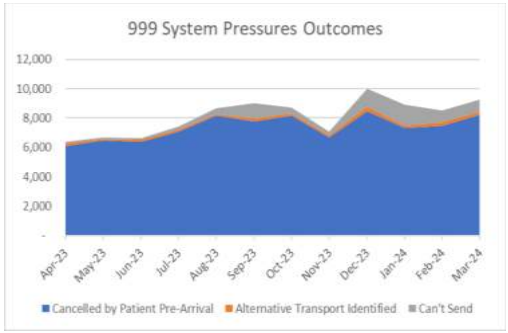
During the past 6 months we have reviewed our objectives and have undertaken consultation and engagement with staff, service users and stakeholders to help us develop a new plan for 2024-2028. We were keen to learn more about the challenges faced by people with a protected characteristic. We engaged 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)

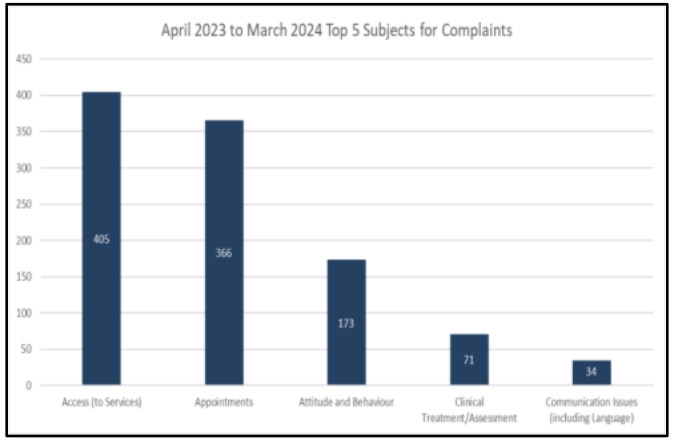
We have introduced more robust equality impact assessment (EQIA) monitoring procedures with the introduction of a digital impact assessment tool, bespoke one-to-one advice sessions and an online suite of training. We have also strengthened our monitoring procedures via our Policy Monitoring Group who 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.

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.

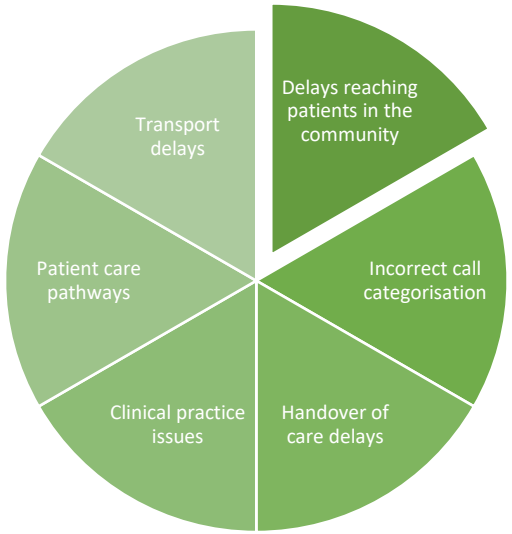


Learning from Concerns

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.



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.

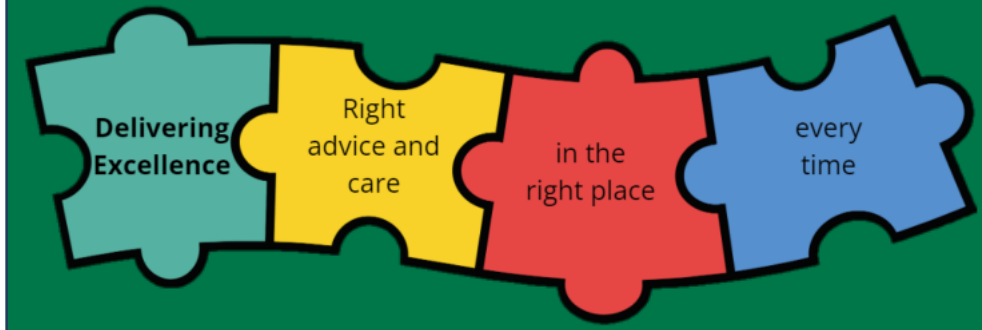
We have worked closely with the Value in Health Centre to understand how we can embed these principles through education and engagement.

Looking Forward 2024/25

Our Long-Term Strategic Framework for 2030, 'Delivering Excellence' set out our ambition to move from being a traditional ambulance and transport service to being a trusted provider of out-of-hospital high quality care, ensuring that patients receive the 'right advice and care, in the right place, every time', with a greater emphasis on providing care closer to home. Whilst we continue to make progress in delivering on these ambitions, the landscape within which we operate has changed considerably since we developed the strategy in 2019. It is clear to us that there remains a pressing requirement to change the way in which we meet our patients' needs. Too many patients continue to come to harm, and the difficulty in navigating our complex health and care system means patients are often not getting the quality of services we strive to provide. As an organisation we can identify improvements within our own practices to lessen the risk of patient harm but alone we can't resolve the wider system challenges, and so we must work collaboratively across NHS Wales to transform our services and reduce the risk to our patients.

Fundamental to delivering on service improvement is a need to support and enable our people to be the best that they can be. Alongside the work we are doing to improve our culture and develop our leaders, we must support our staff from the moral injury experienced when we are unable to provide the quality of service our patients deserve.

Our Integrated Medium-Term Plan sets out our intentions to improve the quality of our services and this year we are also refreshing our Clinical Plan. The next section of our report is a snapshot of just some of the activity planned for 2024/25 with a focus on improving the quality of our services.





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 to 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, in 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 Manual Handling 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.



For more information about
Welsh Ambulance Services University NHS Trust
visit our website at

www.ambulance.nhs.wales

To provide us with feedback on our services you can follow the links below

Calling 999 Survey

Calling 111 Survey

111 website survey

Non-Emergency Transport Survey

Communicating in your language of choice

Virtual Video Booth

GIG CYMRU NHS WALES

Ymddiriedolaeth Brifysgol GIG
Gwasanaethau Ambiwlans Cymru

Welsh Ambulance Services
University NHS Trust

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

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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.