Bundle Quality, Patient Experience and Safety Committee 5 November 2024

Agenda attachments

ITEM 00 Agenda

0 09:30 - OPENING ITEMS

1 Chair's welcome and Apologies For Absence

2 Declarations of Interest

ITEM 02 Board Member Register of Interests

3 Minutes of the Last Meeting

ITEM 03 2024-08-13 Draft QUEST OPEN MINUTES1

4 Action Log and Matters Arising

Action Log

Committee Highlight report

ITEM 04 Action log

ITEM 04.1 Quest Committee Highlight Report August 2024

5 09:40 - Operations Report Q2

ITEM 05 Operations Quarterly Report for Committees 24-25 Q2 FINAL

5.1 FOR APPROVAL, ASSURANCE AND DISCUSSION

6 09:50 - Staff Story

Sian Davies-Kumar, Palliative Care Paramedic (Video)

6.1 Update on previous patient Story (Linda Erro Castillo)

7 10:20 - Clinical Transformation Programme Clinical Governance

ITEM 07 Clinical Transformation Programme Clinical Governance

ITEM 07.1 Clinical Advisory Group Terms of Reference v2.0 - Annex 1

8 10:30 - Rapid Clinical Screening

ITEM 08 Rapid Clinical Screening

ITEM 08.1 Quest Rapid Clinical Screening

9 10:45 - Monthly Integrated Quality Performance Report

ITEM 09 MIQPR SBAR QUEST SEPT24

ITEM 09.1 Annex 1 MIQPR QUEST SEPT24

9.1 11:00 - COMFORT BREAK

10 11:15 - Mental Health and Dementia Annual Report 2023/24

ITEM 10 Mental Health & Dementia Annual Report 2023-24

ITEM 10.1 Mental Health & Dementia Annual Report 2023-24 - Annex 1

11 11:25 - Putting Things Right Report Quarter 2, July - September 2024/25

ITEM 11 Putting Things Right Report, Quarter 2, July - September 2024.25

12 11:45 - Datix Recovery and Improvement Plan - Deferred

13 11:55 - Focus on Clinical Indicator - ST segment elevation myocardial infarction (STEMI)

ITEM 13 Focus on Clinical Indicators - STEMI

ITEM 13.1 Focus on CIs - STEMI v0.1 - 25.10.2024

14 12:15 - Clinical Audit Plan & Action Tracker - Q2 (Update) 2024/25

ITEM 14 SBAR - Clinical Audit Plan & Action Tracker Q2 2-24-25 update

ITEM 14.1 Clinical Audit Plan Q2 2024-25

15 12:25 - Patient Experience and Community Involvement Biannual Report (April - September 2024)

ITEM 15 Patient Experience & Community Involvement Bi-Annual Report (April - September 2024)

ITEM 15.1 Patient Experience & Community Involvement Bi-Annual Report (April - September 2024) - Annex 2

15.1 12:40 - LUNCH

16 13:20 - Learning from Deaths (Mortality Reviews) Report (Q1 - Q2 - April - September 2024)

ITEM 16 Learning from Deaths (Mortality Reviews) Report - Quarters 1 and 2 April - September 2024-25

17 13:35 - IPC Preparedness & Emerging Health Risks associated with MPOX and other high consequence infectious diseases

ITEM 17 IPC Preparedness and emerging Health Risks Associate with Mpox and other High Consequence

18 13:45 - Maternity and Neonatal Safety Support Programme update
ITEM 18 Maternity and Neonatal Safety Support Programme Update

19 13:55 - Near Miss and Low Harm Intelligence Report
ITEM 19 Near Miss and Low Harm Intelligence Report

20 14:05 - Audit Tracker
ITEM 20 Audit Tracker to Committees - Q2 Reporting - July-September Reporting - QuEST Committee
ITEM 20.1 Audit Tracker 2.0 Q2 July-September - for Committee reporting

21 14:15 - Risk Management and Board Assurance Framework
ITEM 21 Executive Summary Risk Management Report QuEST 051124

22 14:25 - Policies for Approval/Noting/Noting
High Intensity Service User Policy - POLICY DOCUMENT REMOVED (01.11.2024) - Julie Boalch will speak to this item.
Airway Policy - For Approval
Management of Controlled Drugs Policy - For Noting
Medicines Management Policy - For Noting
Infection Prevention and Control: Sharps Policy - For Noting
ITEM 22 Policies for Committee Approval - QuEST 051124 File replaced
ITEM 22.2 Airway Policy v1.12 (22.08.24) For QuEST
ITEM 22.3 Management of Controlled Drugs Policy v7.0 (20.08.2024) APPROVED
ITEM 22.4 Medicines Management Policy 4.0 (200824) APPROVED
ITEM 22.5 IPC Sharps Policy v2.0 (20.08.2024) APPROVED

22.1 CONSENT ITEMS

23 Committee Cycle of Business (CoB) and Priorities Update
ITEM 23 QuEST Committee Cycle of Business Monitoring Report and Committee Priorities Q3
ITEM 23.1 Cycles of Business Monitoring Report
ITEM 23.2 Cycles of Business Notes for QuEST

23.1 14:35 - CLOSING ITEMS

24 Key Messages for the Board

25 Any Other Business

26 Reflections and Summary of Decisions/Actions

27 Date & Time of the Next Meeting: 4 February 2025, 09:30

Length of Meeting:	05:15	Agenda Status:	[OPEN] QUEST COMMITTEE - 5 NOVEMBER 2024					Deadline for Papers:	25 October 2024
Time	**Mins allotted**	**Agendum**	**Title**	**Format**	**Item for**	**Item requested by**	**Paper prepared by**	**Item presented by**	**Colleagues to cc**
			OPENING ITEMS						
09:30	00:10	1	Chair's Welcome, Apols and Quorum	Verbal	Information	Standing	n/a	Chair	
		2	Declarations of Interest	Verbal	To State Conflicts	Standing	n/a	Chair	
		3	Minutes of the Last Meeting:	Paper	Approval	Standing	n/a	Chair	
		4	Action Log & Matters Arising Item 4.1 AAA Report	Paper	Discussion	Standing	n/a	Chair	
09:40	00:10	5	Ops Report Q2 24/25	Paper	Information	CoB	Operations	Lee Brooks	Judith Bryce
			FOR APPROVAL, ASSURANCE AND DISCUSSION						
09:50	00:30	6	Staff Story - Sian Davies-Kumar, Palliative Care Paramedic 6.1 Update on previous patient Story (Linda Erro Castillo)	Video	Discussion	CoB	Quality	Liam Williams	Leanne Hawker
10:20	00:10	7	Clinical Transformation Programme Clinical Governance	Paper	Assurance	Ad Hoc	Quality	Liam Williams	Jonathan Turnbull-Ross
10:30	00:15	8	Rapid Clinical Screening	Presentation	Assurance	Forward Planner	Clinical	Andy Swinburn	Greg Lloyd
10:45	00:15	9	Monthly Integrated Quality Performance Report	Paper	Assurance	CoB	SPP	Rachel Marsh	Hugh Bennett, Mark Thomas Mel O'Connor
11:00	00:15		COMFORT BREAK						
11:15	00:10	10	Mental Health and Dementia Annual Report 2023/24 2023/24	Paper	Assurance	CoB	Quality	Liam Williams	Alison Kelly
11:25	00:20	11	Putting Things Right Report Quarter 2, July - September 2024/25	Paper	Assurance	CoB	Quality	Liam Williams	Alison Kelly Claire Appleton
11:45	00:10	12	Datix Recovery and Improvement Plan - DEFERRED	Paper	Assurance	Ad Hoc	Quality	Liam Williams	Alison Kelly
11:55	00:20	13	Focus on Clinical Indicator - ST segment elevation myocardial infarction (STEMI)	Presentation	Assurance	CoB	Clinical	Jonathan Chippendale	Jonathan Chippendale
12:15	00:10	14	Clinical Audit Plan & Action Tracker - Q2 (update) 2024/25	Paper	Assurance	CoB	Clinical	Jonathan Chippendale	Kevin Webb
12:25	00:15	15	Patient Experience and Community Involvement Biannual Report (April - September 2024)	Paper	Assurance	CoB	Quality	Liam Williams	Leanne Hawker
12:40	00:40		LUNCH						
13:20	00:15	16	Learning from Deaths (Mortality Reviews) Report (Q1 - Q2 - April - September 2024)	Paper	Assurance	CoB	Quality	Liam Williams	Alison Kelly
13:35	00:10	17	IPC Preparedness & Emerging Health Risks associated with MPOX and other high consequence infectious diseases	Paper	Assurance	Ad hoc (added 30924)	Quality	Liam Williams	Alison Kelly
13:45	00:10	18	Maternity and Neonatal Safety Support Programme update	Paper	Assurance	Forward Planner	Quality	Liam Williams	Alison Kelly
13:55	00:10	19	Near Miss and Low Harm Intelligence Report	Presentation	Assurance	CoB	Quality	Liam Williams	Alison Kelly
14:05	00:10	20	Audit Tracker	Paper	Assurance	CoB	Gov	Trish Mills	Alex Payne
14:15	00:10	21	Risk Management and Board Assurance Framework	Paper	Assurance	CoB	Gov	Julie Boalch	n/a
14:25	00:10	22	Policies for Approval/Noting High Intensity Service User Policy - Item withdrawn Airway Policy - For Approval Management of Controlled Drugs Policy - For Noting Medicines Management Policy - For Noting Infection Prevention and Control: Sharps Policy - For Noting	Paper	Approval	CoB	Gov	Julie Boalch	Lisa Trounce
			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.						
14:35	00:00	23	Committee Cycle of Business (CoB) and Priorities Update	Paper	Information	CoB	Gov	Trish Mills	Alex Payne
			CLOSING ITEMS						
14:35	00:10	24	Key Messages for the Board	Verbal	Discussion	Standing	n/a	Chair	n/a
		25	Reflections and Summary of Decisions/Actions	Verbal	Discussion	Standing	n/a	Chair	n/a
		26	Any Other Business	Verbal	Discussion	Standing	n/a	Chair	n/a
		27	Date & Time of the Next Meeting: 4 February 2025	Verbal	Information	Standing	n/a	Chair	n/a
14:45	**05:15**		**CLOSE**						

LEAD PRESENTERS

Name	Position
Julie Boalch	Assistant Director of Corporate Governance and Risk
Lee Brooks	Executive Director of Operations
Jonathan Chippendale	Consultant Paramedic - Urgent Care
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
BEESLEE, Jayne	**Non-Executive Director** * Chair of the Finance and Performance Committee * Member of the Remuneration Committee	Employment for interim assignments via Public Sector Resourcing (an agency) regarding the review of major UK government programmes (remunerated net of tax via an Umbrella Company - Danbro Employment Umbrella Ltd)	Financial Interest	01 October 2023		
		Member Representative on the UK Civil Service Pension Board	Non-Financial Personal	01 October 2019		
		Governor on the Finance & General Purposes Committee of Cardiff and Vale Further Education College	Non-Financial Personal	01 February 2024		
		Fellow Chartered Institute of Personnel & Development	Non-Financial Personal	01 April 2006		
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		
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**	Member of Academi Wales Expert Panel	Position in Charity or Voluntary Organisation	15 July 2024		

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)	**Director of Corporate Governance/ 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		
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

MINUTES OF THE OPEN SESSION OF THE MEETING OF THE QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE HELD ON 13 AUGUST 2024 VIA TEAMS

Meeting started at 09:30

PRESENT:

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

IN ATTENDANCE:

Claire Appleton	Head of Putting Things Right
Kate Blackmore	Head of Quality
Julie Boalch	Head of Risk/Deputy Board Secretary
Peter Brown	Assistant Director of Operations, Operations Transformation
Jonathan Chippendale	Consultant Paramedic
Alex Crawford	Assistant Director of Planning and Transformation (Left meeting at 11:05)
Penny Durrant	Deputy Director, Nursing Quality and Governance
Leanne Hawker	Partners in Healthcare Lead
Alison Kelly	Business and Quality Manager
Osian Lloyd	Head of Internal Audit, NWSSP
Mark Marsden	Trade Union Partner
Rachel Marsh	Executive Director of Strategy, Planning and Performance (Joined meeting at 11:25)
Vicky Maxwell	Head of Safeguarding
Trish Mills	Director of Corporate Governance/ Board Secretary
Steve Owen	Corporate Governance Officer
Hugh Parry	Trade Union Partner
Alex Payne	Corporate Governance Manager
Duncan Robertson	Assistant Director of Clinical Development (Left meeting at 12:08)
Jonny Sammut	Director of Digital Services (Left meeting at 09:45 and rejoined at 11:00)
Andy Swinburn	Executive Director of Paramedicine (joined meeting at 11:00)
Liam Williams	Executive Director of Quality and Nursing

Apologies:

Lee Brooks	Executive Director of Operations
Henry Garrard	Trade Union Partner
Fflur Jones	External Audit

40/24 PROCEDURAL MATTERS

The Chair extended a warm welcome to everyone advising that the meeting was being recorded. Apologies were noted from Lee Brooks, Henry Garrard and Fflur Jones.

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 7 May 2024 were confirmed as a correct record.

Matters Arising
The following update on the previous staff story which was a presentation by Fionna Maclean was provided to the Committee. The 'Support after cardiac arrest page' was now live on the Resus Council UK website: Support after cardiac arrest | Resuscitation Council UK. Support cards, designed by the Patient Experience Community Involvement (PECI) Team with input from the People & Community Network, were awaiting the addition of a Quick Response (QR) code.

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

Minute: 07/24 - *The Committee asked that a timeline/timetable of how the revised Quality Strategy would be delivered be provided to the Committee.* Details of the timeline are included in the QSIP 2021 -2024 update paper - propose that this action be closed. Agreed – Action Closed.

Minute: *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.* Further to investigation of the data, the Trust 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, the Trust safeguarding reports submitted to Local Authorities have increased annually in recent years. Action Closed.

Committee AAA report dated 7 May 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 7 May 2024.

RESOLVED: That

(1) Apologies were recorded for Lee Brooks, Henry Garrard and Fflur Jones.

(2) The Minutes of the Open meeting held on 7 May 2024 were confirmed as a correct record.

(3) An update on the previous staff story was given which concerned Fionna Maclean and an update on providing support following a cardiac arrest.

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

41/24 OPERATIONS DIRECTORATE QUARTERLY REPORT – 2024/25 Q1

Peter Brown presented the report and drew the Committee's attention to the following headlines:

Since the start of the financial year, Community Welfare Responders (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%. The Trust was preparing to extend the test of change for CWRs over the coming winter, with plans to start in November. This longer trial aims to better understand how CWRs can be effectively utilised in the community, especially with dedicated clinical support.

The Trust went into remediation with the International Academies of Emergency Dispatch **(**IAED) for the Medical Protity Dispatch System (MPDS) following Q4. An action plan was approved and was submitted to the IAED as per its Remediation Policy.

In terms of the Medical Transfer Protocol Suite (MTPS), Operations Quality has begun training EMS Coordination staff on MTPS which were the new interfacility transfer protocols within MPDS.

Delayed transfer of care at Emergency Departments across Wales remained 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 was 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.

There were ongoing issues with Red and Amber performance metrics, which were closely tied to the increasing handover hours lost at Emergency Departments. This loss of resources was a significant factor affecting performance in these areas.

While it was noted that the level of over 2 hour end of shift overruns has continued to improve, along with the uptake of utilising the options available to reduce the end of shift overruns, work progresses on several initiatives to further reduce end of shift overruns to support the wellbeing of staff.

Quality and Support days continued 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.

Comments:

Kevin Davies pointed out that it would be wise to review the terminology used, as a recent questionnaire he received from Public Health Wales still referred to "NEPTS" (Non-Emergency Patient Transport Services). Since the name has been updated to "Ambulance Care," this outdated terminology could potentially cause confusion among the general public. Peter Brown agreed to action. Ceri Jackson raised three points:

1. Ceri Jackson sought further information on the alignment of the CWR role with Health Boards. It was agreed that Peter Brown would take this offline and update Ceri Jackson accordingly.

2. Amber Performance Forecast: the recent deterioration in amber performance was noted understanding this has been a longstanding challenge, and it was asked if there was anything that could be shared about the forecast for the next three months. Peter Brown added that if handover delays continued to be as persistently difficult as they were, the Trust was not anticipating a recovery in performance at this stage.

3. Thanet House Lease Expiry: It was recognised that the lease was due to expire, and assurance was sought on how this was being managed; particularly given the potential disruption to the teams based there - especially the 111 service. Peter Brown assured the Committee that good progress in the plan to replace Thanet House was being made.

RESOLVED: That the report was received.

42/24 PATIENT STORY – LINDA (VIDEO)

Leanne Hawker explained that the story involved Linda, who was the primary caregiver for her adult son, Guy. Guy has a learning disability and other complex needs. When she called 999, Guy was vomiting and struggling to breathe, which caused significant concern. At the time of the call, Guy was in considerable pain and distress, heightening the family's anxiety.

Despite the urgency of their situation, they were provided with an estimated arrival time of three to eight hours. This prolonged wait caused immense anxiety for Linda and her family, as they felt helpless and unable to secure timely assistance for Guy. As his symptoms seemed to worsen, they called again and were frustrated by the need to answer the same questions repeatedly.

On the evening in question, Guy had been sent home from work after being sick. Later, Linda found him in his bedroom standing rigid, racked with pain, grey in colour, and gasping for breath. His torso was as hard as concrete, and he was clearly in severe distress. Despite never having called an ambulance before in her 63 years, Linda knew she had to act quickly.

She called 999, and while trying to remain calm, answered numerous questions from the call handler. Feeling utterly helpless, she watched as her son's condition worsened, prompting her to call 999 again. To her dismay, she had to repeat the same questions and was told that due to the General Data Protection Regulations (GDPR), the previous information could not be used.

Linda later discovered that Guy's case had been downgraded from a Red to an Amber priority because the report inaccurately stated that he was speaking in full sentences, which was not the case. The call handler suggested that they drive Guy to the hospital themselves, but Linda found this suggestion unrealistic.

The experience has left Linda and her family traumatised, particularly because they were working to ensure Guy can live independently. Linda emphasised the need for call handlers to be more sensitive and responsive to the needs of vulnerable individuals, including those with learning difficulties, the elderly, and people with conditions like dementia. For Linda, the expectation was not just transportation to the hospital but immediate medical assistance, but to have aid from someone with oxygen who could assess and stabilise her son.

Leanne Hawker added that the Patient Experience and Community Involvement (PECI) Team has been actively working with Linda and her family to keep them informed about the ongoing internal initiatives aimed at improving patient care. A significant focus has been on ensuring the Team were aware of and responsive to any additional needs that callers may have, especially those that go beyond the immediate clinical presenting problem when contacting 999.

To address this, the Trust has been enhancing the electronic Patient Care Record (ePCR) system to capture more accurate data regarding patients' broader needs. Additionally, the Trust has extended these discussions to include emerging developments within the organisation, particularly how non-clinical needs during phone interactions can be identified.

A key concern has been whether extended processes might inadvertently increase risks for individuals with Learning Difficulties (LD), and how the Trust can ensure more equitable care for the LD community.

The PECI Team has also been promoting training modules to raise staff awareness about the specific needs and impacts on people with learning disabilities. As the Trust prepared for the winter, the Team has been discussing potential adjustments and necessary scripting changes to better support this community.

The Team was also exploring digital developments, such as video or face-to-face triage, to provide a sense of connection while patients were waiting.

Ceri Jackson added it was clear that this was a challenging area, particularly when it came to serving individuals with learning disabilities. The fact that the call handler logged that the patient was speaking in full sentences, has raised important questions about training and communication.

Kevin Davies expressed frustration, noting that the issues mentioned, such as repetitive questioning and the need for a higher index of suspicion for patients with learning disabilities, have been discussed before. He emphasised the importance of addressing these issues to prevent similar stories in the future and questioned when improvements would be visible.

The Chair, Bethan Evans, commented that listening to Linda's story was truly heart-wrenching. Her phrases, like "no one will come," captured the deep fear and helplessness she felt, making it clear that it was a terrifying experience for her. Her comment, "we don't all fit into the same mould," resonated strongly and highlighted the need for a more tailored approach to care.

Leanne Hawker added that while there was still work to be done, the Trust has made significant strides in raising awareness, building expertise, and establishing important partnerships. The implementation of the ePCR changes and continued collaboration with external groups were expected to yield positive outcomes soon. The focus now will be on ensuring that these efforts translate into tangible improvements in the experiences and outcomes for people with learning disabilities.

Liam Williams provided a comprehensive overview of the ongoing efforts and challenges in adapting the Trust's operating model to better serve patients with learning disabilities. He emphasised that while significant changes were being made, especially with the new clinical transformation model, there were inherent limitations in altering the current approach for 999 call handlers, particularly given the international standards and the heavily clinically scripted protocols they must follow.

Liam Williams added that the Committee should recognise the outstanding work that the Patient Experience and Community Involvement (PECI) Team has been doing. He expressed recognition that the Team were finalists in the UK Patient Experience Network National Awards.

RESOLVED: The Committee received the patient story.

43/24 PUTTING THINGS RIGHT (PTR) REPORT

Claire Appleton presented the Putting Things Right Report, highlighting the challenges and progress within the Patient Family Relations, Mortality, and Legal Services teams. She mentioned increased compliance with the 30 day response timeframe for formal complaints and the implementation of a recovery plan. Claire also noted the upcoming legislative changes affecting the landscape and the team's efforts to navigate these changes. Additionally, she mentioned the increasing trends in complaints, patient safety incidents, mortality review work, and coroner's inquests approaches.

Claire Appleton noted there were changes in the reporting profile around Serious Case Incident Forum (SCIF) cases, influenced by both the easing of winter pressures and internal process improvements. She highlighted the need to monitor these changes to ensure they reflected genuine shifts in harm levels or operational circumstances rather than internal leadership changes.

Kevin Davies raised concerns about the way data was reported, specifically the dangers of focusing solely on Health Board data rather than considering population type data. He highlighted that while Betsi Cadwaladr University Health Board (BCUHB) served approximately a million people, the other five Health Boards and one Trust covered around 2 million people combined. This discrepancy posed challenges in how the data was reported and interpreted.

Liam Williams added that the Trust was addressing the challenge of improving how data was reported and analysed, particularly concerning weighted population metrics. The aim was to shift the reporting to focus more on weighted population metrics.

Ceri Jackson raised a query about Table One in the report regarding the classification of harm levels in patient complaints. It was noticed there had been a significant increase in reported moderate harm compared to the previous year, while reports of low harm had decreased.

Claire Appleton explained that the reported moderate harm incidents have remained broadly similar across quarters, indicating a stable trend in this category. There has been a notable decrease in the number of low and no harm incidents reported. This shift may be linked to changes in how incidents were categorised and recorded in the Datix system.

Alex Crawford sought an update to determine if the Never Events Framework was an effective mechanism to drive patient safety improvement with one of the options being to abolish the Never Events Framework and list. Claire Appleton advised the Committee that this was still an option being considered.

Bethan Evans was keen to understand whether the full structure was now in place for the PTR Team. Claire Appleton advised the Committee that all the necessary roles have been filled according to the recruitment plan. There has been some absenteeism due to sickness, but it was expected this would improve starting in September.

Bethan Evans questioned, how the work on developing the report so that it focused more on thematic reviews and trends was progressing. Claire Appleton explained there was work to improve how thematic learning was captured through the Datix system.

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

44/24 MONTHLY INTEGRATED QUALITY PERFORMANCE REPORT – JUNE/JULY 2024

Alex Crawford highlighted the following points for the Committee's attention:

The response times to 999 callers remained a concern with red 8-minute performance at 48.2% in July 2024 and Amber 1 median at 1 hour and 26 minutes.

The Trust lost 19,596 hours to handover in July 2024 (marginally higher than July 2023), and this level of lost capacity was difficult to compensate for, despite all the actions being taken.

Ambulance Care performance has been stable, with oncology remaining above target and renal performance achieving its target.

111 call answering performance has improved over recent weeks, however the call abandonment performance was at 11.9% in June (target 5%). It was expected to improve over the coming months when new call handlers were in place.

Alex Crawford explained that in terms of the falls response, there was coverage for falls response services across Wales, with expansion plans outlined in the Integrated Medium Term Plan (IMTP). The goal was to enhance service levels and pathways, particularly working with Health Boards to improve response.

Alex Crawford advised that with respect to the recruitment challenges within the Cymru High Acuity Response (CHARU) units Assessment and Referral Unit) recruitment within CHARU was showing improvement overall, but rural areas presented significant challenges.

Peter Brown advised the Committee that the sickness rates among call handlers in the 111 service were trending back in the right direction. Sickness rates have recently halved compared to the peak levels seen four weeks ago.

Members noted there had been a recent reduction in the Return of Spontaneous Circulation (ROSC) in patients following a period of improvement. Duncan Roberston explained that adjustments have been made to the scripting behind case selection to exclude cases that might have been counted incorrectly or were not relevant.

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

45/24 ANNUAL SAFEGUARDING REPORT 2023/24

Vicky Maxwell explained that the report had been developed on the strengthened relationship with Public Health Wales and emphasised the Trust's role in the Chief Nursing Officer's review of the Safeguarding Policy construct in Wales.

There had been an increase in safeguarding reporting which could be attributed to several factors. The most significant reason was the enhanced ability of staff to recognise and respond to safeguarding concerns.

Vicky Maxwell highlighted the leadership role of the Trust in rolling out the Home Office prevent training across the workforce. This training was well received and has enhanced the ability to recognise and escalate concerns appropriately. Furthermore, the safeguarding maturity matrix to public health colleagues has been submitted which will be a self-assessment tool for safeguarding practices, and this will inform the safeguarding work plan for the coming year.

Ceri Jackson commented that the report offered a great deal of assurance, showing that not only was the Trust meeting its mandated responsibilities, but also exceeding them. The emphasis on collaboration across the system was particularly appreciated. However, she expressed a few small concerns about the language used in the report. For instance, in the Executive Summary, the word 'celebrating' in the first line does not seem entirely appropriate for this context. Similarly, the phrase 'we look forward to the challenges around safeguarding' at the end could be reframed.

Vicky Maxwell noted the feedback, noting the importance of balancing the report's content to avoid focusing solely on negative aspects. Bethan Evans noted that the Annual Report was pivotal for the Trust. It underpinned the work and the Trust's commitment to keeping people safe in the community.

Liam Williams added that the Trust was aligning the work of various teams, including safeguarding, mental health services, and frequent caller teams, which will lead to more cohesive and efficient operations. He agreed prior to publication that the comments in respect of the type of language used as described above by Ceri Jackson would be reviewed.

RESOLVED: The Committee

(1) Approved the Safeguarding Annual report 2023/24 pending any minor adjustments prior to its submission to the Trust Board for information; and

(2) Noted and considered the sustained increase in demand and the cumulative impact on the Safeguarding Team.

46/24 QUALITY STRATEGY IMPLEMENTATION PLAN UPDATE 2021-2024

Kate Blackmore provided an update on the progress of ongoing actions, particularly in relation to Quality Improvement (QI) initiatives. The report highlighted that 15 actions have been completed out of a total of 25. This indicated steady progress, but there were still 10 actions that required further attention.

The plan included a timeline for QI training, with a rollout expected by the end of September and full completion by the end of Q3. The first annual Welsh Ambulance Services University NHS Trust Quality roadshow took place on 2 July 2024, focussed on education and practical examples of the Quality Management System and the importance of continued engagement with service users.

The Duty of Candour training has been completed by several individuals, but there were still challenges with recording this through the Electronic Staff Register (ESR). Education and Development colleagues were working to embed the training records into LMS365.

Following a question regarding the expectation in closing the remaining actions in the outgoing strategy by December 2024 Kate Blackmore stated that she was confident that the remaining actions would be completed by the end of Quarter 3 2024/25 - December 2024.

The Chair asked whether there were any specific themes or challenges emerging from the service experience surveys currently operating within Civica. Kate Blackmore noted that steps are being taken to address challenges and improve feedback collection.

The Quality Management Group has been working on refining the wording and answer options in the Civica surveys to better capture detailed feedback from service users. Currently, the surveys were mostly completed in the context of ambulance care. As an interim solution, efforts were underway to promote Civica surveys more actively.

RESOLVED: The Committee noted the progress on the Quality Strategy Implementation Plan for 2021-2024.

47/24 QUALITY PLAN DEVELOPMENT AND IMPLEMENTATION PLAN 2025-2028

The current Quality Strategy is due to be reviewed and Kate Blackmore provided an overview of the Trust's approach to developing the new 'Plan' which aligns with the Trust's long-term strategy. She highlighted the following key points:

1. This plan will need to integrate various guidance and legislation, including:

    - The Health and Social Care Quality and Engagement (Wales) Act 2020;
    - The Well-Being of Future Generations Act 2015;
    - The six goals work for urgent and emergency care.

2. The plan will consider the Trust's role in population health, including the value-based healthcare framework. It will also consider social deprivation, ethnicity, and

other protected characteristics, addressing issues such as learning disabilities and sensory loss.

3. In terms of the process in developing the plan:

    - A Task and Finish group will be established in September, following the completion of patient engagement activities.
    - Workshops will be conducted across the Trust to gather feedback from teams and leaders about the plan's content.
    - The first draft of the plan will be prepared and reviewed through appropriate forums for feedback in October and November, with the goal of obtaining approval in December.
    - An implementation plan will be rolled out for Quarter 1 of the next year.

4. The paper includes a request to approve an extension of the current strategy through to April 1, 2025. This request was based on feedback from auditors conducting the quality governance review, who inquired about the extension of the existing strategy.

Ceri Jackon asked of the quality strategies of key stakeholders and the appetite for collaborative work to reduce harm and improve quality and outcomes for patients. Liam Williams provided reassurance about the commitment from system partners to reduce harm, emphasising that their challenges were as significant as the Trust's, though they may face different aspects of it. System partners were eager to work collaboratively to reduce harm and this collaboration extended beyond emergency care to encompass various aspects of healthcare.

Liam Wiliams noted that the Quality Plan for 2025-2028 aims to shift towards targeted improvement to achieve the best outcome improvements for populations, particularly focusing on reducing inequality and improving outcomes. This involves considering where quality impact could be most targeted and is part of the broader transformation and quality improvement journey across the organisation.

Rachel Marsh highlighted the important role of quality from the commissioning perspective, adding that the Joint Commissioning Committee (JCC) was actively working on refining their substructures and enhancing their approach to quality.

RESOLVED: The Committee

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

(2) Approved 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.

48/24 LEARNING FROM DEATHS (MORTALITY REVIEWS) UPDATE REPORT

Claire Appleton introduced the report which set out the current position and progress since October 2023, and drew the Committee's attention to the following areas:
The Medical Examiner (Wales) Regulations 2024 were established 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.

The Medical Examiner Service (MES) will be reviewing all deaths not taken for investigation by a Coroner from 9 September 2024. 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 to provide assurances in respect of screening, appropriate escalation and the improvement actions undertaken.

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.

The Trust's Learning from Deaths Forum was established in October 2023 and met on a quarterly basis. The remit of the Forum includes oversight of the Trust's Learning from Deaths Framework, MES 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 to provide early warning mechanisms.

From May 2022 a dedicated module has been in place on the All Wales Datix Cymru system. The module was currently populated manually by the Patient Safety Team following receipt of the MES letter.

Claire Appleton added that progress was being made incrementally in respect of learning from deaths, with several externally driven dependencies. There were several next steps being implemented which were comprehensively listed in the report.

Ceri Jackson raised a significant point regarding the potential presence of a high number of protected characteristics within the data on these deaths. Understanding the demographics and characteristics of those involved could offer crucial insights.

Claire Appleton highlighted a significant challenge in accurately capturing and analysing data related to protected characteristics within the current systems, particularly in the context of referrals from Medical Examiners.

Liam Williams highlighted the ongoing developments within the electronic Patient Care Record (EPCR) system, which offered promising advancements in capturing some protected characteristics data. Although the EPCR will not capture all protected characteristics, it represented a significant step forward from the current capabilities.

RESOLVED: The Committee discussed and approved the report and next steps as detailed in paragraph 34, highlighting any further assurance requirements.

49/24 CLINICAL AUDIT PLAN & ACTION TRACKER - Q1 (UPDATE) 2024/25

Duncan Roberston provided the Committee with an update and drew their attention to the following areas: The 2024-25 Clinical Audit Plan contained 12 audits covering a range of topics including clinical conditions, medicines, and compliance to documentation.

1. One has been completed and approved at the Clinical Intelligence and Assurance Group (CIAG).
2. Two were progressing as planned (one since been approved at the July CIAG)
3. Two were not progressing as planned as they were reliant on ePCR user interface changes being implemented. In addition, the Clinical Indicator Recovery Plan was currently a higher priority.
4. Seven were yet to start, some were reliant on ePCR user interface changes being implemented, some were not due to start until Q2/Q3/Q4.

For the audit approved during Q1 (Clinical Frailty Scale Follow Up Audit) there were seven actions:

1. Five have been completed.

2. Two were off track and recovery action taken.

There were no specific comments related to the above topic. As this was Duncan's final QuEST Committee meeting, the Chair expressed gratitude for his contributions. Duncan Robertson appreciated the recognition, but it was important to note that his contributions represented the hard work of a larger team.

RESOLVED: The Committee noted the Q1 2024-25 Clinical Audit Plan and Action Tracker update.

50/24 SPOTLIGHT ON CLINICAL INDICATORS: HYPOGLYCAEMIA

Duncan Robertson provided an in depth update on the focus on hypoglycaemia as a Clinical Indicator (CI) for the Trust, highlighting the challenges and ongoing efforts to improve data accuracy and compliance with the care bundle. The key points were:

What we measure (criteria): The number of patients with a working diagnosis of Hypoglycaemia (Diabetic – low blood sugar) (*denominator).*

Data quality and reporting: An ePCR technical specification was created to enable reporting. Since the implementation of ePCR all CIs were reported on using 'raw' data inputted by clinicians (*no manual auditing prior to reporting*).

Improvements to date: A more accurate clinical picture of the care delivered, highlighted the variation between automated and audited data, helps inform future reporting and caveats and informs an improvement plan and changes to the ePCR User Interface.

Next steps to improvement:

1. A recent User Interface change included a 'nudge tool' to improve ePCR compliance for specific fields at point of ePCR closure.

2. Enable message prompts and quick access to non-compliant fields prior to closing ePCRs.

3. Continued engagement with Senior Paramedics to influence more direct clinical supervision during ride outs.

4. Complete the development of a 'Tenant Structure' to enable CIs to be reported at a range of levels (Trust wide, Health Board area, Locality, Team, Individual).

5. Clinical Improvement & Clinical Intelligence and Assurance teams meeting with Senior Paramedics to provide support, guidance and data to promote CI compliance.

6. A CI Performance Group has been established 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.

The Trust aims were 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.

Andy Swinburn highlighted the complexity of the challenges and the nuanced approach required to drive meaningful change. The complexity involved multiple factors, including human behaviour, data entry habits, and systemic challenges.

Following a query in terms of empowering clinicians, Duncan Robertson stressed the importance of empowering senior Paramedics by providing them with improved data and feedback mechanisms, with the goal of enabling individual clinicians to take ownership of their own data. A key focus was ensuring that all clinicians had access to relevant data.

The Committee noted it was clear there was a significant amount of work being undertaken, not just with this CI on hypoglycaemia, but across the other indicators that have been reviewed over the past several months in this Committee.

RESOLVED: The Committee noted the PowerPoint update for the Hypoglycaemia (Diabetic – low blood sugar) Clinical Indicator.

51/24 IMPACT OF THE CHANGES TO STROKE CATEGORISATION

Andy Swinburn presented the report explaining that in April 2023, the National Stroke guidelines were updated, and 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'.

He explained that the recent change in clinical guidance regarding stroke treatment had been a significant development. The window of opportunity for administering thrombolysis, a critical treatment for stroke patients, had been extended from 4.5 hours to 12 hours, provided there was still clinical benefit in doing so. This change has had substantial implications for how stroke cases were categorised and responded to.

Previously, many stroke cases were categorised as Amber 2, often due to being outside the initial 4.5-hour window or because the onset time of stroke symptoms was unclear. However, with the extended window, almost all stroke cases now fell under the Amber 1 category, which prioritises them more highly for response. This reclassification represented a significant shift in the number of cases classified as Amber 1.

Modelling the impact of this change was challenging, particularly because the exact time of stroke onset was not consistently captured in the past. Despite these challenges, the implementation has gone well, supported by the stroke network, and was now in place across most regions, with one Health Board area still working to increase the availability of stroke physicians. There has been no significant decline in response times despite the increase in the number of cases classified as Amber 1.

Ceri Jackson queried if there was any update as to where the specialist stroke units would be located. Andy Swinburn commented that the exact locations of the future hyper-acute stroke units were still under discussion, with only one emergency department (ED) not yet accepting stroke patients. Despite this, all other receiving departments were currently equipped to handle stroke cases.

Andy Swinburn assured the Committee that the Trust was well prepared to adapt to the changes once the locations of the hyper-acute stroke units were finalised, ensuring that the transition was as smooth as possible for all involved. The Committee agreed it would be useful to receive an update at the Committee once the locations of the hyper-acute stroke units were finalised.

RESOLVED: The contents of this executive summary were accepted, and that assurance was gained that the Trust continued 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.

52/24 AUDIT TRACKER 2.0 JUNE 2024 (Q1)

An update was received from Trish Mills on the Audit Tracker with 39% (76% last quarter) of Committee related internal audit actions (due in quarter) closed in quarter, with 62% (33% last quarter) of external audit actions closed this period. The number of external audit actions closed has nearly doubled, reflecting significant progress. Trish Mills acknowledged and thanked everyone involved for their hard work and support in maintaining the positive status of the audit tracker.

Clinical Audit (Internal Audit)

The Committee received the Clinical Audit Internal Audit Report, which gave a reasonable assurance opinion. Duncan Robertson explained that the Clinical Audit internal audit findings have provided the Trust with key insights that will help shape the detailed work needed to move forward. Osian Lloyd, Head of Internal Audit noted that the report benchmarked well against other Health Bodies and was a positive report.

Two actions were due to be closed in September, while three minor issues have already been resolved. The final action, which was tied to the development of a clinical plan as part of the broader Trust strategy, was targeted for completion by 31 March 2025. A workshop has already been conducted and will incorporate the importance of clinical audit into the overall clinical plan.

RESOLVED: The Committee

(1) Received and reviewed the Clinical Audit (Internal Audit) Report;

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

53/24 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK (BAF)

Julie Boalch explained that the purpose of the report was to provide assurance in respect of the management of the Trust's principal risks, specifically the two risks that were relevant to Committee's remit for oversight.
Risks **223** (*the Trust's inability to reach patients in the community causing patient harm and death*) and **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.

The risks were reviewed monthly and have already been updated for the next reporting cycle. These updated risks will be presented to the Audit and Risk Assurance Committee (ARAC) in September, followed by the Trust Board, and finally to this Committee in November with the most up to date position. However, as noted in the paper, early indications suggested that the risk scores were likely to remain unchanged.

The key point to note was that the risks presented in the BAF section remain unchanged from those shared at the May Board and the June ARAC meetings. This consistency was due to the scheduling and timing of the meetings, which has not allowed for any updates or changes to be reflected in the current documentation.

RESOLVED: The Committee noted the contents of the report.

54/24 POLICIES FOR APPROVAL/ADOPTION

The Management of Medical Devices Policy was presented by Julie Boalch for approval. The Committee were assured that an Equality Impact Assessment (EQIA) was conducted with no issues raised, and the policy has undergone Trust wide consultation.

RESOLVED: The Management of Medical Devices Policy was approved.

55/24 COMMITTEE TERMS OF REFERENCE AND ANNUAL REPORT 2023/24

The Committee Terms of References and Annual Report 2023/24 were received.

RESOLVED: The Committee Terms of Reference and the Annual Report 2023/24 were received.

56/24 COMMITTEE PRIORTIES AND CYCLE OF BUSINESS (CoB) MONITORING REPORT

An update on progress against the agreed CoB for was received. Trish Mills highlighted several key points from the report, focusing on how the cycle of business was managed.

On the Monitoring Report, the Committee's attention was drawn to the Annual Putting Things Right Report and the Annual Infection, Prevention and Control Reports which have been deferred to the Q3 meeting of the Committee.

RESOLVED: The Committee noted the update.

57/24 ANNUAL QUALITY REPORT 2023/24 AND DUTY OF QUALITY STANDARDS SELF-ASSESSMENT

Liam Williams acknowledged this was a consent item that has already been presented to the Trust Board. However, he formally acknowledged the excellent work done by the team in creating this report.

Bethan Evans added that it was clear an immense amount of work has been put into this report, especially given that it was the first time the Trust has produced one.

58/24 KEY MESSAGES FOR BOARD

The ongoing system pressures were having a significant impact on both patients in the community and those awaiting handover in ambulances. Today's discussions highlighted some stark performance data, underscoring that these challenges persisted.

The key message from this Committee remained clear: the system pressures were creating substantial difficulties for patient care and impacting staff well being.

59/24 REFLECTIONS & SUMMARY OF DECISIONS & ACTIONS

The quality of papers was very good as were the presentations. Additionally, the papers demonstrated the governance flow through the relevant directorates and internal governance forums.

Wider contributions from those in the meeting was welcomed and new observers and contributors were welcomed to the meeting and offers of induction extended.

Although there were challenges across the system in terms of patient journey and patient outcome, the Trust was involved in the discussions about pathways and outcomes as a key partner.

Operations Report: Agreed to continue discussions offline about aligning with HB's.
Patient Story: This provided valuable insights, although it highlighted recurring issues.
Annual Safeguarding Report: for 2023/24 was approved.
Quality Strategy Implementation Plan: approved the development of the quality plan for 2025 to 2028 agreeing to extend the current quality strategy until April 2025.
Impact of Changes to Stroke Categorisation: noted that updates on the location of stroke units will be provided in due course.
Medical Devices Policy: The policy was approved without any further issues.

60/24 ANY OTHER BUSINESS

The Committee acknowledged this would be the last meeting of the Committee that Kevin Davies would attend, and he was thanked for his contributions over the years.

Date of Next meeting: 5 November 2024

Meeting concluded at 13:45

ACTION LOG - UPDATE
QUEST COMMITTEE

Minute Ref	Date	Agenda Item	Action Note	Responsible	Due Date	Progress/Comment	Status
41/24	13 August 2024	Operations Update	Review of terminology used, a recent questionnaire from Public Health Wales still referred to "NEPTS" (Non-Emergency Patient Transport Services). Since the name has been updated to "Ambulance Care," this outdated terminology could potentially cause confusion among the general public. Peter Brown agreed to action.	Peter Brown	5 November 2024	Update for 5 November 2024 Colleagues will review and update language within internal artefacts as required to ensure accuracy. Propose for closure.	Complete
51/24	13 August 2024	Impact of the Changes to Stroke Categorisation	**Impact of Changes to Stroke Categorisation:** The Committee noted that updates on the location of stroke units will be provided in due course. Although the timeline was uncertain, Andy Swinburn agreed to keep the Committee updated.	Andy Swinburn	5 November 2024	Update for 5 November 2024 Andy Swinburn has confirmed that there is no further update available for this meeting.	Open
			TRANSFER FROM QUEST TO PCC In respect of the relief gap in Powys, update to PCC on the recruitment and management of abstractions			Update for 5 November meeting from PCC This matter was discussed at PCC and it was resolved that the projected improvement across all gaps with the exception of EMT1-2 (remains static) by Feb 25. By Feb 25, 4 of the 6 staff groups will be at full establishment, as opposed to only 2 groups at present. NB: this is the confirmed position passed on acceptances of positions already received (but not yet started). If QuEST content with remarks from PCC, then propose for closure. The PCC have closed this action	Complete

QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE
HIGHLIGHT REPORT TO BOARD

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

Trust Board Meeting Date	26 September 2024
Committee Meeting Date	13 August 2024
Chair	Bethan Evans

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. Lost hours due to handover delays remained significant in May and June 2024 (24,762 and 22,230 hours lost respectively) with a slightly improving picture in July 2024 of 19,596 hours. **Handover delays continue to present patient safety risks and extended waits in the community** with a deteriorating Red performance being outside of what is acceptable to deliver a safe emergency service.

2. 2,159 patients (2,137 in the previous quarter) waited over 12 hours to receive a response in Quarter 1, with one patient waiting 50 hours and 20 minutes (that patient was mobilised following a fall and welfare calls were carried out). 279 of the 2,159 patients had experienced a fall and 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. The Trust continues to work across the system with partners to influence system change. 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**, and it is expected that the changes will see a reduction in the patients who have fallen waiting so long.

ADVISE

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

3. **Linda Erro Castillo** shared the experience of her family after calling an ambulance for her son Guy who was in distress and pain and unable to breath. Guy has learning difficulties and Linda's concern included the need to ensure that call handlers bear in mind the experience of vulnerable persons who may not be able to answer questions clearly after calling 999. In this case, Guy was not in a position to speak to the call handler other than to confirm his name, and Linda liaised with two of the Trust's call handlers after the first provided an ETA of 3-5 hours and a second when Guy's situation worsened. Linda's frustration and distress was clear to the Committee, noting that she thought Guy was going to die and the suggestion that they take him to a hospital himself – the closest being on hour away –

increased this distress significantly. Her comments such as being fearful that no-one would come, that it was the most terrifying experience, and that not everyone fits into the same mould were impactful.

Members sought to understand the pace of the work being done to improve the experiences of patients with learning difficulties and their families given similar issues have been raised in patient stories. The targeted engagement with learning difficulty groups and the Ministerial Advisory Committee on Learning Disabilities was noted and appreciated, as was the work with Ambulance Trusts in the UK looking at best practice. What is key however is the change that will come with our evolving clinical model and the ability to screen patients with complex needs earlier, noting that the MPDS system is heavily scripted with limited room for movement on this. The new model will identify patients with complex needs earlier through clinical screening undertaken by a clinician and as part of a holistic review of the patient.

Members also reflected there is more we can do to support families as they wait for a resource e.g. Community Welfare Responders (CWR) and Community First Responders as we continue to have inevitable delays.

The Chair thanked Linda for her frankness and for bringing her experience to the Trust.

4. The Committee received **an update following the staff story from Fiona Maclean** at the last meeting and noting that the 'support after cardiac arrest page' is now live on the Resus Council UK website: https://www.resus.org.uk/public-resource/support-after-cardiac-arrest.

5. The **Annual Safeguarding Report 2023/24** was approved and is attached at Annex 1. The report builds on the strengthened relationship with Public Health Wales and emphasises the Trust's role in the Chief Nursing Officer's review of the Safeguarding Policy construct in Wales. Members welcomed the progress and high level priorities outlined in the report including the roll out of the Home Office PREVENT training and the development of a new PREVENT Policy. The work plan reflects the Trust's ongoing commitment to safeguarding, the proactive measures being taken to enhance staff training and reporting and addresses the challenges faced by the team due to increased workload.

6. An update was received on the **Quality Strategy 2021-2024 implementation plan**, as well as the development of its successor, the Quality Plan 2025-2028. Whilst there are some challenges to the implementation plan there is nothing for escalation and a number of key successes and progress, including the first WAST Quality Event which was held in July. A key focus for the **Quality Plan 2025-2028** is co-production include understanding the voices of our citizens and service users as well as those of our people. The Committee approved the approach to the plan and an extension of the current strategy to 1 April 2025 to allow for its development.

7. The Committee received the **Operational Update for Q1 2024/25** and relevant updates. It was noted in the May meeting that the Trust's accredited centre of excellence standard for MPDS (999 call handling) has fallen below the required standards set by the International Academy of Emergency Dispatch in the last quarter; however, demonstrable improvements have already been made to return to compliance in April. Prolonged test of change for CWRs was discussed and welcomed.

8. The **Management of Medical Devices Policy was approved**. An Equality Impact Assessment has been undertaken for this policy and there were no issues to escalate.

9. Members' **reflections** on the meeting included:

- The quality of papers were very good as were the presentations. Additionally, the papers demonstrated the governance flow through the relevant directorates and internal governance forums.
- Wider contributions from those in the meeting was welcomed.
- Although there are challenges across the system in terms of patient journey and patient outcome, WAST is involved in the discussions about pathways and outcomes as a key partner.
- New observers and contributors were welcomed to the meeting and offers of induction extended.
- It was the last meeting for Duncan Robertson, Assistant Director of Clinical Development, and he was thanked for bringing his expertise and focus on the clinical indicator spotlights to the meeting recently.
- It was also the last meeting for Kevin Davies, Non-Executive Director, who was thanked for his knowledge, calm sense of reasoning and drive for improvements.

ASSURE

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

10. The Committee received assurance by way of the **Monthly Integrated Performance Report** (MIQPR (Monthly Integrated Quality and Performance Report)) for June and July 2024 along with the **Quarter 1 2024-25 Putting Things Right (PTR) Report**. The Committee noted that:

- 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, but this is on a reducing trend. None were directly related to immediate release requests;
- 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;
- The five-day complaint compliance remains lower than the 100% Welsh Government target at 98% in June 2024 but there is a positive movement in responding to a concerns within 30 days. The majority of complaints continue to relate to delayed response in the community following calls made to 999;
- The number of patient safety incident received on Datix has reduced compared to the same time last year;
- Organisational learning, particularly from clinical reviews, was reviewed. Transition to a new thematic PTR report showing trends continues to be a work in progress working with both WAST and national Datix Cymru teams;
- Members raised the need to include public health data related to population weighting (particularly with respect to long Amber 2 waiting times). Data flows are not yet in a position to support this, but workshops are planned to look at some of these issues through including ethnicity and race;
- 111Wales call answering performance improved over recent weeks, however the call abandonment

performance is at 11.9% in June (target 5%). It is expected to pick up over the coming months when new call handlers are in place following the CAS implementation, however it was noted that demand is 4.76% higher than June 2023;
- ROSC rate deteriorated in June 14.1% to however have picked up in July at 22.7% and August early data is looking to be 28.8%.

11. The Committee focused on the **clinical indicators related to hypoglycaemia** including a presentation on the care bundle criterion which is completed on the electronic patient clinical record (ePCR). The board will note from the MIQPR that whilst there has been a steady increase in performance of the care bundle there is a way to go for full compliance. It was anticipated that unfamiliarity with the new ePCR would reduce clinical indicator compliance as it had in other UK Trusts, however the committee was assured the recovery plan being implemented includes ePCR user interface changes, focussed communication, clinical workshops, implementing the clinical supervision policy, and reviewing the scripting for clinical indicator reports.

12. The **Learning From Deaths (Mortality) bi-annual update** was received. The Medical Examiner Service (MES) provide independent scrutiny of deaths not taken for investigation by a Coroner and feedback from families, with such scrutiny following recommendations from a number of high-profile NHS inquiries. 1,154 referrals have been received by the Trust from the MES with all undergoing initial screening and with escalations as required. Themes and trends are being identified following these reviews and a number of improvements are being made as a result of learning from reviews which was reassuring to the Committee.

13. The final **Annual Quality Report 2023/24** was received for information after a draft was discussed at the May meeting. The report was approved by the board on 12 July and has now been published. Included in the report was the first self-assessment against the revised Health and Care Quality Standards, which was welcomed.

14. The **Clinical Audit Plan and Action Tracker update for Q1 2024/25** was received with no escalations. 12 audits are included in the plan for 2024/25 and those completed during the period covering a range of topics including clinical conditions, medicines, and compliance to documentation.

15. The **Clinical Audit Internal Audit** was received with a rating of reasonable assurance, noting that the matters requiring management attention include (a) the Clinical Strategy lacks sufficient reference to clinical audit and its role within the Trust; and (b) the Clinical Audit Plan could be strengthened to demonstrate alignment between individual audits and the Trust risk register and priorities. Management action plans are in place which this committee will monitor, but of note is a substantial assurance rating on benefits realisation and lessons learned which was commended. Osian Lloyd, Head of Internal Audit noted that the report benchmarked well against other Health Bodies and as compared to the last limited assurance audit at WAST on clinical audit.

16. The meeting in May 2024 focused on the **changes to the stroke categorisation** and assurance was provided noting that there is no evidence to suggest the changes have impacted on the Amber 1 response times. The Trust continues to work with the Welsh Stroke Network in line with the UK guidelines and recommendations made by Health Inspectorate Wales. Placement of the specialist hyper acute stroke units is still being determined which will influence the Trust's modelling in the future.

17. In closed session an update on the **111 CAS (Clinical Assessment Software) Replacement Project** which went live on 30th April 2024 was provided and assurance provided that there have been no reported clinical incidents, no serious adverse incidence and no patient experience complaints related to the use of the system. The committee heard that whilst it was introduced as a replacement to the former system, however within the emerging Trust Clinical Model Transformation Programme there are significant opportunities for enhancing patient experience, reducing inequity in patients accessing services, and build more efficient Trust services and processes. Members thanked all those that worked on this significant programme at pace.

18. An update was received on the **Audit tracker** with 39% (76% last quarter) of committee related internal audit actions (due in quarter) closed in quarter, with 62% (33% last quarter) of external audit actions closed this period.

19. Members received the Committee **Cycle of Business Monitoring Report** and progress against the **Committee's priorities** for 2024/25 with no escalations.

RISKS

Risks Discussed: 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 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 remain unchanged at a score of 25.

Committee received assurance that the risks continue to be monitored closely in the relevant governance forums. Early indications are that the scores will remain unchanged in the next reporting cycle; however, Members acknowledged the discussion on these items throughout the whole agenda and that the controls, assurances and mitigating actions are reviewed regularly.

New Risks Identified: No new risks were identified.

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

COMMITTEE AGENDA FOR MEETING		
Operations Directorate Quarterly Report for Q1 2024/25	Patient story – Linda Erro Castillo	Putting Things Right Report Q1 2024/25
Monthly Integrated Quality and Performance Report	Revised approach to clinical screening (deferred)	Annual Safeguarding Report 2023/24
Quality Strategy Implementation Plan Update 2021-2024	Quality Plan Development and Implementation 2025-2028	Learning from deaths (mortality reviews) update
Clinical audit plan and action tracker Q1 2024/25	Spotlight on clinical indicators: Hypoglycaemia	Impact of the changes to stroke categorisation
Internal audit: - Audit Tracker - Clinical Audit Internal Audit	Risk Management and Board Assurance Framework Report	Management of Medical Devices Policy
Committee cycle of business monitoring	Annual Quality Report 2023/24 and Duty	111 CAS Replacement Summary (in

report and priorities update (consent item)	of Quality Standards Self-Assessment (consent item)	closed session)

COMMITTEE ATTENDANCE				
NAME	**07 MAY 2024**	**13 AUGUST 2024**	**05 NOVEMBER 2024**	**04 FEBRUARY 2024**
Bethan Evans (Chair)				
Kevin Davies				
Ceri Jackson	Chair			
Liam Williams				
Andy Swinburn		From 1100[1]		
Lee Brooks	Jonathan Edwards	Pete Brown (open)		
Rachel Marsh	Hugh Bennett	From 1120[2]		
Jonny Sammut				
Trish Mills	Julie Boalch			
Mark Marsden				
Hugh Parry				
Henry Garrard				

	Attended
	Deputy attended
	Apologies received
	No longer member

[1] Duncan Robertson in attendance from 0930
[2] Alex Crawford in attendance from 0930

OPERATIONS DIRECTORATE
QUARTERLY REPORT FOR COMMITTEES
2024-25 Q2 (July– September 2024)

National Operations & Support

IMTP

Volunteer Care Driver Oncology Pilot

Our volunteer oncology project currently has 20 volunteers who are classed as 'oncology priority'. These drivers have completed 1249 journeys (496 inbound/ 753 outbound) since April and are consistently meeting our measures for oncology (inbound 90% / outbound 94%). We have now moved onto the second phase of the pilot which is ensuring that our oncology patients are paired up with the same volunteer driver for the entirety of their treatment. This is proving to be very successful from both a measurement perspective, but more importantly from a patient experience perspective. We are currently working with PECI colleagues collecting patient feedback and will be using this to assist us to measure the success of the pilot.

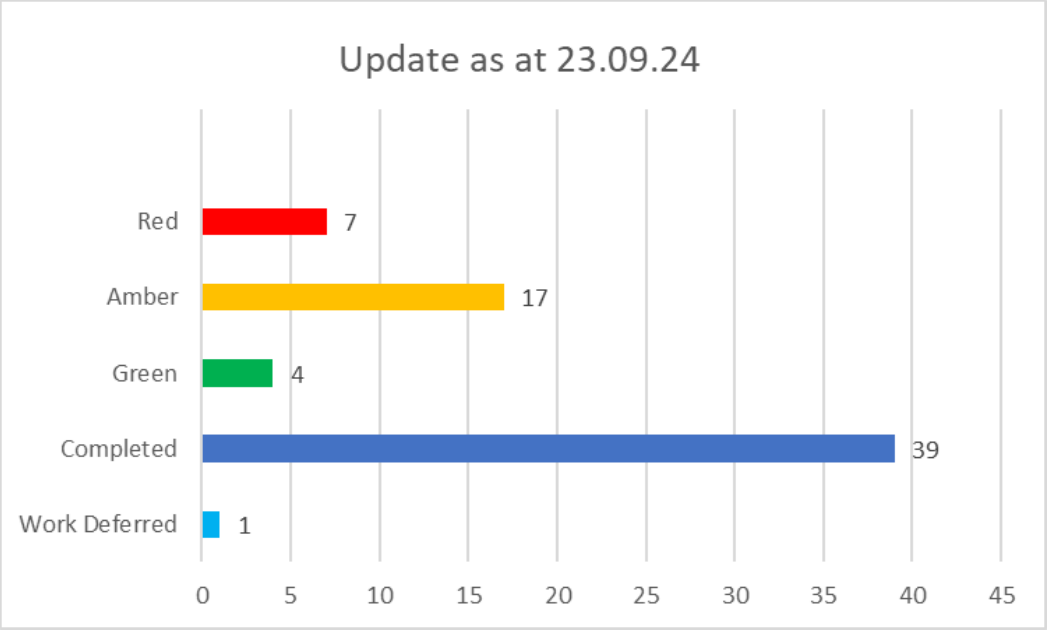
General Update

Volunteer Services OCP

Our Volunteer Management team have launched a period of Organisational Change (OCP), stepping away from a long-standing service-based model into a function-based model with a volunteer onboarding service, and support service across all volunteer roles. The consultation will run from September to October. Steps are also being taken to advance the volunteer pathway, commencing as a CWR, and progressing to CFR.

Manchester Arena Inquiry (MAI)

Progress against the 68 recommendations, directly or through partnership working, that relate to the Trust continues. The Trust has undertaken a detailed review of its provision as part of its obligation under recommendations 105 and 106 and has recently produced an evidence-based series of reports aimed at addressing the identified gaps. This has been supported further by the development of three Quality Impact Assessments that have been approved by the Clinical Quality Governance Group. The work identified 20 recommendations for which there is a financial dependency. The submission to commissioners of the Trust's reports relating to these recommendations has now occurred and the Trust awaits their considered response. The remaining recommendations continue to be progressed and it is anticipated these will conclude within the next six months. At the time of preparing this report, below is the status of recommendations:



To ensure the continued visibility of these report findings within the Trust, a corporate risk is being developed for inclusion in the Trust's risk register. This will enable the alignment of outstanding MAI recommendations with a clearly defined business-as-usual framework, ensuring proper governance of capability gaps while awaiting financial decisions from commissioners and the implementation of necessary changes.

Major Incident Declaration Cardiff

On Thursday 29 August 2024 at 2317hrs, a major incident was declared in Cardiff following an initial call into 111 which was subsequently passed to 999. The call reported difficulty in breathing with reports suggesting that this incident was of a potential gas/carbon monoxide origin with several symptomatic patients. However, following further investigation from the multi-agency response, the incident was later confirmed not to be of airborne origin but because of a water borne issue. Multiple resources from WAST attended the incident including three managers, three emergency ambulances and the Hazardous Area Response Team. Four patients were conveyed to hospital, with no other casualties reported and the major incident was stood down at 0329hrs.

Operational Effectiveness

Operational effectiveness continues to progress, with performance closely monitored through regular Local Delivery Plan reviews and Performance, Demand & Capacity meetings with the Operations Senior Leadership Team. Upcoming Quality & Support days will focus on Mobilisation, Time Spent at Scene, and Clinician Travelling, aiming to assess the current state and identify opportunities for improvement. Subsequent sessions will target driving change and implementing enhancements. Recent Quality & Support days addressed the Multiple Attendance Ratio and Multiple Dispatch Ratio, with findings scheduled to be reviewed and shared.

Medical Emergency Response Incident Team (MERIT)

Correspondence has been sent to Welsh Government Health Strategy and Planning team to inform them of our organisational position that there is no longer a requirement to request MERIT to attend

the scene of an incident. MERIT are nurses from health boards who attend the scene of a major incident in two separate waves. The organisational position was confirmed following a review of MERIT skillsets alongside those now provided by WAST staff. WAST has previously provided training for MERIT and it was confirmed that this is not specifically commissioned. The letter sets out the discussions with both clinical and operational colleagues across the trust and the rationale on the position. The assessment determined that MERIT nurses provide lesser clinical response to that now provided by WAST clinicians.

Resourcing, EMS Coordination and Quality

Challenges

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

The Trust reported 5% non-compliance for the Medical Priority Dispatch System (MPDS) for Q1 24/25 which is under the 7% threshold, meaning the Trust is no longer in remediation status with the IAED for MPDS and maintains its status as an Accredited Centre of Excellence (ACE). This is following a 3-month period of remediation in Q4 23/24 where an action plan was submitted to and approved by the Senior Operations Team (SOT) and Senior Leadership Team (SLT). The Trust continues to work closely with Academy colleagues to sustain performance and feedback from the IAED has been positive with the improvements achieved. Monthly assurance memos were escalated to SOT and through to SLT during the period of remediation and the final memo was submitted in July 2024 which provided an update on removal from remediation status and a continued commitment to progress the actions approved in the associated action plan.

HM Coroners (HMC)

EMS Coordination/Operations Quality continues to receive coroner requests which has meant the backlog of statements has remained consistent. Capacity within Operations Quality (OQ) continues to be 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. At the time of preparing this report there are 24 outstanding coroner statements which is down from 34 in Q1. Of the 24 outstanding, 8 have breached the requested return date, however, these are all at some point in the QA process. Any requests from HMC to prioritise or final deadlines are prioritised dynamically. All other outstanding statements are not yet due, and the OQ team is completing these alongside other investigations (concerns and nationally reportable incidents (NRIs)).

Absence Abstractions EMDs

While we continue to actively recruit EMDs into the service, recently the overall number of absences due to sickness for EMDs is a concern. Absence Management processes are being followed and individuals are being supported, but consequently resource levels for the call handling function is sporadic with short term absence being particularly impactful. This said, we continue to deliver good overall performance levels with the call answering performance fluctuating between 93.4% and 96.4% of all calls answered within 6 seconds. In the context of focus on culture in EMS Coordination, rates of attendance appear at times not to be improving. A preliminary check of call handler utilisation has not presented levels that, on the face of it, are concerning.

Establishment
The current establishment in EMSC remains a challenge, although the situation is more favourable for EMDs (who are currently over-established). The under-establishment is largely due to the existing dispatch function, which is under-established due to changes required as part of the Organisational Change Policy (OCP), EMDs are trained to rotate through various functions to mitigate this issue. To mitigate the impact of the overall under establishment, two additional induction courses are scheduled for September. It is also anticipated that by the end of October / early November the OCP will have been complete, and the new structure will be in place that will resolve some of the existing shortfalls.

Resourcing
The current capacity in the Resourcing team is actively engaged in supporting various initiatives, including a number of transformation projects and service changes, all of which have implications for rostering. Notable activities include the Urgent Care Service (UCS) Review, development of the Remote Integrated Care Service (RICS), Rapid Clinical Screening, NEPTS Roster Review and Dispatch Roster Review. Although the roster review for the APP expansion has been paused, we have recruited new staff to address these needs. As a relatively small team this presents a challenge as there are competing pressures on the team to engage with the significant change that necessarily have rostering implications.

IMTP

Estates and Infrastructure
EMS Coordination has benefited from significant investment to improve the working environment for our centres in both Llangunnor and the relocation of staff from the existing Bryn Tirion site in North Wales. This work continues to move forward with Llangunnor moving to start works at the end of Q2, with the Ty Elwy and Snowdon House worked being likely to commence in Q3. Both these projects will improve significantly the environment for those colleagues working from those facilities.

EMSC Restructure and Reconfiguration
The restructure and reconfiguration programme is progressing well; The final organisational change (OCP) document was issued to EMS Coordination colleagues in July 2024, which marked the start of the implementation phase. All aspects of the project are on track with anticipated conclusion in Q3. The delivery of this programme will mark a new era in EMS Coordination with improved ways of working, with a much-needed progressive career structure, and capacity to better support our people.

Delivery of a function Resourcing Team model.
The options appraisal for the potential move of 111 Resourcing to the GRS system is currently being drafted and will be discussed with Integrated Care. Plans are underway to prioritise the transition of clinicians in alignment with the RICS model, while 111 Call Handlers will be reviewed based on demand, capacity, and roster considerations. This, together with the development of the 111 Resourcing Standard Operating Procedure will aid the intent to move to a function-based model for the Resourcing Department. At present the department largely works on a geographic basis, but there is an intent to move to a functional model that will service the needs of colleagues based on their department as opposed to their geographical location. The draft SOP for 111 Resourcing will

form the basis for the EMS Coordination Resourcing SOP. The overarching intent is to ensure we have clear processes set out for both 111 and EMSC that will enable the move to a single, integrated resourcing function for the 111/999 contact centres. This will ensure that there is consistency of approach across Wales for the 111 / 999 Centres, but also the other two main functional units, namely EMS and Ambulance Care.

Electronic Timesheets Project Scoping

A preliminary scoping exercise for the e-timesheets project, specifically the GRS Electronic Claim Form, is underway, with a workshop to follow in Q3. To support this, a visit to South West Ambulance Trust took place in August 2024 to learn from their implementation and rollout experiences.

General Update

Medical Transfer Protocol Suite (MTPS)

MTPS went live on the 30th July 2024 and external stakeholders were informed of the changes to inter-facility call processing. Up to end of August 2024, 820 incidents were processed on these new protocols. Of these, 330 were red calls. The MTPS task and finish group continues to meet and review data and internal/external feedback. There have been some concerns raised due to the increase in reds due to introduction of MTPS, as a result of which a focussed audit was undertaken in August 2024. Results showed a 23% non-compliance rate. Whilst this is higher than anticipated for the random audit, it is to be expected as these are brand new protocols and processes which take time to embed.

Learning identified during the audit is fed back to the individual Call Taker to ensure change to practice and any wider themes/trends identified during the audit process are being considered at the task and finish group. The use of the MTPS codes continues will be subject to further focused audits in September and further engagement will take place with Health Care Practitioners that access our services to ensure the appropriate coding and prioritisation of calls.

EMS Coordination Culture

As part of the non-pay annex aspect of the 2023 pay and conditions work, the Trust agreed to focus on the culture of EMS Coordination. An action plan has been created in partnership with Trade Union colleagues and more recently the Director of People and Culture conducted a series of visits across the three centres to listen to staff and their experiences. The feedback from these visits was shared with the EMSC Senior Leadership Team in early September 2024 with learning to be incorporated into the ongoing action plan.

Flexible Working SOP Development

The Flexible Working SOP Task & Finish Group is developing a framework to assist operational managers in reviewing flexible working requests. This SOP aims to ensure consistency in decision-making and explore alternative solutions that balance individual needs with service delivery requirements. It will also reinforce the need for a robust and periodic review process to maximise flexible working solutions for the expanding workforce.

Emergency Medical Service

Challenges

Lost Hours to Handover

Delayed transfer of care at Emergency Departments across Wales remains a significant challenge in being able to provide a safe level of emergency service with timely response to calls. The total amount of lost hours in July 2024 at 19,599, August at 17,540 and September to date at 16,050 (as at 25 September). While there has been some improvement over the past three months the transfer of care delays remains excessive and intolerable within existing rosters. 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 similarly poor red performance and delayed response to our most critical patients. On the whole, the red performance continues to fluctuate in the 45% to 50% range and also continues to fall well short of 65% in all Health Board areas. This is under constant scrutiny within EMS and EMS Coordination teams to improve the level of response in this area.

The Amber median trend continues to show overall response times not where we would like them to be. However, there have been slight signs of improvement in July 2024 but still above the average Amber response times for the last 12 months. 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.

IMTP

End of Shift Overruns

While it is noted that the level of investigation of over 2-hour end of shift overruns has continued to improve, along with the uptake of utilising the options available to reduce the end of shift overrun, it is now evident that a number of these overruns are down to staff not correctly booking off duty, or undertaking the 'Hot Swap' MDT facility. However, to further support the wellbeing of staff and to report correctly we continue to work on a number of initiatives to further reduce end of shift overruns. Despite the continued level of handover delays, the average length of overrun has remained at levels lower than 12-15 months ago, with the over 2 hour overrun trajectory improving considerably.

CHARU Roll-out

CHARU recruitment and training courses are continuing to maximise the opportunities to fill remaining CHARU vacancies and to ensure parity of cover between urban and rural areas in line with the D&C review. Where some areas, particularly rural, have struggled to recruit into vacant CHARU lines, there is an imminent go-live with an EA/CHARU rotational model in Welshpool which could be a future model to adopt in difficult to recruit areas following evaluation. We are however now at a position where direct recruitment is likely required.

APP Recruitment

Two stages of APP recruitment have been completed to allow progression of the Modernisation Strategy. Firstly, both external qualified APPs and WAST existing funded MSc staff were recruited, and secondly, internal WAST staff were recruited to undertake funded MSc education to commence in September 2024. While the recruitment has progressed well, the desired numbers have not been fully achieved so a third APP recruitment process is likely to be undertaken again before the end of the financial year. This will allow staff to undertake a funded MSc education programme commencing in March 2025.

General Update

Quality & Support Days

The quality and support days continue to be undertaken across all areas of the operations team, however, to further support operational staff these days will be subject themed moving forward. In Q2 a quality and support day was held in July focussed on end of shift overruns and discussing the Shift Start and Finish SOP. This saw operational managers spending end of shift periods (morning and evening) embedded with EMSC to support the end of shift processes to enable, where possible, crews to finish on time or to reinforce plans for them to be relieved on scene or at hospital as soon as possible.

The following quality and support day held on 23rd August 2024 focussed on the impact and control of diesel fumes and the use of initiatives to reduce the impact of them. A third day in September is focussed on the operational effectiveness programme. Themes and trends will again be collated and fed back through the senior leadership team.

Financial Savings Plan 2024/25 Overtime Allocation

Financial report showing £104k surplus to date with EMS underspend mostly due to overtime not being taken up by staff. To support the routine day-to-day overtime allocation an 'Overtime Allocation SOP' is in use to support this business-as-usual process. Every attempt is being made to provide overtime opportunities in a timely manner to improve uptake and to increase UHP as a result. Non-pay showing a large overspend however fuel prices currently below budget. The application of the overtime process was subject to internal audit, with field work completed during Q2. The output of this audit is anticipated at Committee in Q3.

Ambulance Care

Challenges

UCS Transition

The UCS transition has remained challenging due to several factors that also affect the UCS team. While the modified code set which includes suitable calls has been agreed, the implementation will need to be timed to coincide with the new recruited EMS workforce that are operational from Mid-September. EMS crewing matrix and CSP (Clinical Safety Plan) are also linked to the change and discussions on both have taken place to ensure when the code set changes are implemented these factors are considered and activation plans are in place. This will allow the Service to continue to respond to appropriate calls by all the Operational teams.

IMTP

End of Shift Overruns

The UCS ACA2 service have continued to monitor overruns jointly with our EMS colleagues has seen the number of 2hour overruns continue to improve as mentioned earlier by the EMS team. As the UCS ACA2 team are fewer in number to EMS we are moving into a different phase and will begin to focus on 90mins for all UCS ACA2 crews. We hope this move will support the ongoing support and welfare to the crews and may identify new trends and factors due to the shorter timeframe.

General Update

NEPTS Roster Review

The Trust has received the initial assessment carried out by ORH using updated data post pandemic, with the next steps and methodology being discussed and agreed with ORH. It is anticipated that we will have the refreshed roster keys in September 2024, to progress work with Total Mobile. The next steps will be to have a shadow project board set up, and this will be stepped up into a full project board in September 2024 when we have the initial roster keys.

There will be a recruitment process for a 12-month fixed term post as project manager to support this project once it has commenced. This is anticipated to start in October 2024

Integrated Care

Challenges

111 Call Handler Establishment

The CAS replacement project required all the Trust's training capacity and estate to be re-directed to that project resulting in a significant period where recruitment hasn't possible. Because of this, together with a small increase in attrition the current 111 Call Handler establishment is challenged. This is resulting in sub-optimal resourcing and therefore call answering performance. Integrated care has a clear and closely monitored recovery plan to achieve full establishment prior to the peak demand periods this coming winter; an improved position on that previously reported.

Sickness

Sickness absence remains stubbornly high across Integrated Care despite considerable efforts to target the causes of sickness absence. Absence due to stress and anxiety continues to be the highest category. Integrated Care is working with the Trust's workplace wellbeing psychologist to understand the key drivers of this rise and develop meaningful interventions.

IMTP

Clinical Model Transformation

The Clinical Model Transformation programme has been a significant focus for the Integrated Care team. Work is underway to align 111 and CSD, develop the Remote Integrated Care Service (RICS) model, develop new pathways and test the 111-call handling software in the wider operational environment. Trials have taken place including:

- **CPSS of Green calls**
  Phase 1 was a 3-day trial (9/10/11 July 2024, 0830-1630hrs each day) with two 111 Call Handlers sitting with 111 Specialist lead. Green calls which are normally triaged by 111 Clinicians were triaged by 111 Call Handlers using CPSS. Results were positive with approx. 25% closed by 111 Call Handlers. Phase 2 will be undertaken in September 2024 during which calls will be warm transferred from the 999 Call Handler to the 111 Call Handler. A high priority line will be used to avoid delays in 111 Call Handler answering. All 111 Call Handlers will take these calls for phase 2.

- **Electronic transfer from 111 Call Handlers to 999**
  This trial took place in August over 3 days with 999 calls electronically sent from the 111 CAD to 999 CAD, followed by a phone call and confirmation of details.
  Post trial analysis showed an average of 50 seconds per call saved. This was implemented as BAU from 0900 on the 3rd of September 2024.

- **Managing Delayed 999 Responses using CPSS**
  Trial to be undertaken in September 2024 which will include a dedicated CSD Clinician who will be sat side-by-side with a 111 Call Handler. The CSD Clinician will identify calls waiting for an ambulance response which may benefit from a CPSS assessment. When an appropriate call is identified, the 111 Call Handler will complete their assessment which can be validated clinically if appropriate.

111 Dental

The new urgent dental model for Wales went live in April. Following its first few months of operations outcomes and service quality indicators have been reviewed collaboratively with WAST and the Chief Dental Officer. This review found an extremely high level of outcome accuracy and service quality indicating that many more of the right patients were reaching the right service in a more efficient way than before. Work is now underway with the Six Goals Programme to develop the business case to role this model out into the Health Boards which WAST currently aren't commissioned to provide.

General Update

Police Clinical Support

Following an agreement at JESG to resume the police remote clinical assistance work, CSD have been working with South Wales, Gwent, and North Wales Police. This arrangement had previously been in place with South Wales and Gwent but will now expand to North Wales Police colleagues. As a result,

Police colleagues will be able to access remote clinical support from CSD colleagues and, in the future, the clinical navigation team.

Promoting Welsh Language calls in 111

Following an initial trial to offer Welsh call answering, the trial has been extended, allowing us more time to refine our processes and operations. We are pleased to announce a forthcoming meeting with the Welsh Language Improvement Lead to explore new strategies for increasing the number of Welsh Language speakers within the Trust. Additionally, the 111 service are actively seeking expressions of interest from call handlers who wish to receive extra training in Welsh. We are also working on further technical enhancements to the IVR queue system to allow patients greater choice to wait for a call handler who can answer in Welsh.

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

CLINICAL TRANSFORMATION PROGRAMME CLINICAL GOVERNANCE

MEETING	Quality, Patient Experience & Safety Committee
DATE	5 November 2024
EXECUTIVE	Liam Williams, Executive Director of Quality and Nursing
AUTHOR	Jonathan Turnbull-Ross, Deputy Director of Remote Clinical Care
CONTACT	jonathan.turnbull-ross@wales.nhs.uk

EXECUTIVE SUMMARY

1. This paper confirms that the existing clinical governance process for the Trust will apply to the development of the Clinical Model Transformation Programme (CMT). However it is noted that the complexity and pace of the programme requires senior clinical colleagues from across the organisation to review and consider proposals / developments and ensure that they are securing a safer operating environment for our patients and our people. In order to support this approach, a Clinical Advisory Group has been formed.
2. The Clinical Advisory Group (CAG) has been formed to provide critical clinical oversight and strategic support to the CMT, strengthening our organisation's commitment to safe, high-quality healthcare through well-informed, clinically led decisions. Reporting to the Clinical and Quality Governance Group (CQGG) and the CMT Programme Board, the CAG will act as a core advisory body, ensuring clinical perspectives shape and guide the transformation process in real-time.

Key Benefits of the CAG

3. The CAG will serve as an instrumental resource for the CMT Programme, delivering benefits in the following areas:

- *Timely and Informed Decision-Making*: By convening Senior Clinical Leaders and expert Clinicians to advise on complex issues, the CAG enables faster, well-grounded decisions in areas requiring clinical judgement. This accelerates our ability to address time-sensitive matters and enable prompt well-considered clinical recommendations to be made to CQGG or the relevant Executive Clinical Director.

- *Inclusive Clinical Insight*: The CAGs diverse clinical membership allows for a broad range of clinical perspectives, ensuring decisions reflect the nuanced realities of

our integrated healthcare environment and professions. This inclusivity will drive balanced, patient-focused solutions that consider the diverse needs of our patients accessing Trust services.

- *Proactive Safety Oversight*: By reviewing safety data, including near-miss and adverse incidents, the CAG will identify potential risks early and advise on corrective actions. This proactive approach strengthens our commitment to clinical safety, reducing risk to patients and reinforcing our duty of care particularly at a time of change and transformation.

- *Ethical and Moral Assurance*: The CAG will serve as a Multidisciplinary Panel for matters of ethical considerations. Through the support of the membership, the CAG will develop and provide CQGG with a framework for assessing the ethical complexities that often accompany transformative change initiatives in healthcare.

- *Transparency and Accountability*: Regular, structured reporting from the CAG to CQGG will provide assurance and progress of the CMT transformation and any challenges. The CAG ensures ongoing alignment with our strategic direction, ensures the CMT continues to be clinically well-governed, and ensures Senior Clinical Leads (and Consultant Clinicians) have a mechanism for accessing support/shared decision making where it is needed.

Remit of the CAG

4. The CAGs remit focuses on providing Senior and Consultant-Practitioner level advice on clinical matters, supporting decision-making, and overseeing clinical safety of the CMT Programme. The group will also act as an ethical sounding board, ensuring recommendations align with our organisational values. In essence, the CAG will serve as a bridge between clinical expertise and operational needs, fostering a responsive, safe, and clinically sound transformation journey.
5. The Committee are asked to take assurance from the planned continuation of the existing governance and the implementation of a CAG, in supporting the CMT transformation efforts currently underway.

RECOMMENDATION: That the Committee

(1) Take assurance from the planned continuation of the existing clinical governance arrangements and the implementation of a Clinical Advisory Group in supporting the Clinical Model Transformation within the Trust: and
(2) Note the Clinical Advisory Group Terms of Reference.

KEY ISSUES/IMPLICATIONS
N/A

REPORT APPROVAL ROUTE	
Quality, Patient Experience & Safety Committee	5 November 2024

REPORT APPENDICES
ANNEX 1 - Clinical Advisory Group Terms of Reference

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)	N/A
Health Improvement	YES	Socio Economic Duty	N/A
Health and Safety	N/A	TU Partner Consultation	N/A

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Welsh Ambulance Services University NHS Trust

CLINICAL ADVISORY GROUP

TERMS OF REFERENCE AND OPERATING ARRANGEMENTS

APPROVED BY CLINICAL & QUALITY GOVERNANCE GROUP ON 28.10.24

1. PURPOSE

1.1. The Clinical Advisory Group (CAG) is established to support the Clinical Quality and Governance Group (CQGG) in providing clinical oversight and guidance for the Clinical Model Transformation (CMT) programme. The CAG aims to ensure that clinical issues are addressed expediently and that diverse clinical perspectives are integrated into decision-making processes.

1.2. CAG will provide expert advice on complex clinical matters, facilitate timely decision-making on transformation-specific issues, and support the alignment of clinical transformation efforts with the strategic vision of the executive clinical leadership.

2. REMIT

The duties of the CAG are as follows:

2.1. **Advise on Clinical Matters**: Provide expert advice on complex and emerging clinical issues related to the Clinical Model Transformation programme.

2.2. **Integrate Perspectives**: Ensure that a diverse range of clinical perspectives are considered in addressing transformation-related issues.

2.3. **Support Decision-Making**: Facilitate swift decision-making by CQGG on clinical issues within the transformation programme that require attention; or where a time critical intervention is required, support decision making of the relevant clinical executive.

2.4. **Clinical Approval Processes**: Review and make recommendations on clinical matters that need to be escalated to the CQGG, ensuring that these issues are addressed efficiently and effectively.

2.5. **Clinical Safety**: Receive and review information regarding the near-miss and adverse incidents and concerns relating to the CMT programme, highlighting and advising CQGG and the CMT Programme of implications.

2.6. **Feedback Mechanism**: Report back to CQGG on the outcomes of discussions and decisions made by the CAG, and provide updates on the progress of transformation-related clinical matters.

2.7. **Feedback Mechanism**: Report back to Clinical Model Transformation Programme Board on the outcomes of discussions and decisions made by the CAG and seek approval from the Strategic Transformation Board for issues requiring full executive approval.

2.8. **Ethical Considerations**: Act as a diverse panel of colleagues for issues and matters requiring ethical or moral consideration, informing recommendations to CQGG.

3. AUTHORITY

The CAG is authorised to:

3.1. **Make Recommendation**s: Make recommendations on clinical matters and transformation-specific issues for consideration by CQGG. Where required CQGG will refer to the Strategic Transformation Board for issues requiring full executive approval.

3.2. **Initiate Actions**: Initiate actions or propose solutions for complex clinical issues within the scope of the transformation programme, and/or within scope of individual delegated authority.

3.3. **Consult Experts**: Consult with external or internal stakeholders and experts as needed to support its role in forming actions, advise or recommendations.

3.4. **Report to CQGG**: Provide regular AAA updates and feedback to CQGG on its activities and recommendations.

4. MEMBERSHIP

4.1. Membership shall include:

- Deputy Director of Quality, Governance & Nursing (Chair)
- Associate Medical Director (Vice Chair)
- Assistant Director of Quality Governance
- Assistant Clinical Director of Remote Clinical Care
- Assistant Director of Clinical Development
- Assistant Director of Clinical Delivery / SRO Rapid Clinical Screening
- Assistant Director of Digital Services: Data & Analytics
- Assistant Director of Inclusion, Culture and Wellbeing / Consultant Clinical Psychologist
- Assistant Director of Operations Integrated Care / SRO Remote Integrated Care Service
- Assistant Director of Putting Things Right
- Consultant Clinical Psychologist
- Consultant Clinician for Mental Health
- Consultant Paramedic for EMS-C
- Consultant Paramedic & Regional Clinical Lead(s)
- Deputy Director of Remote Clinical Care / SRO Digitalisation
- Head of Education, Professional and Clinical Practice (Nursing)
- Public Health Registrar

4.2. Invitations may be extended to additional clinical or operational experts to attend meetings as required to assist with specific discussions.

4.3. In the absence of the Chair, an appointed Vice-Chair or another nominated member may chair the meeting.

4.4. Members may send deputies in their absence who will act with their full authority. Deputies should be notified to the Chair in advance of the meeting.

5. COMMITTEE MEETINGS

Quorum

5.1. The Chair (or Vice Chair) plus at least three members from the membership must be present to achieve a quorum.

Frequency

5.2. Meetings will be held regularly, scheduled ahead of CQGG to afford timely progression of matters/papers.

5.3. The chair will call additional short-notice meetings as necessary to address urgent clinical issues.

Agenda and Papers

5.4. The CAG will be supported administratively by the P.A. to Deputy Directors of Quality Safety & Patient Experience, whose duties in this respect will include:

- Agreement of agenda with the Chair;
- Collation of papers;
- Keeping a record of matters (using a AAA highlight report) and issues to be carried forward within an action log;
- Advising on pertinent issues/areas

5.5. An agenda will be set with the Chair in advance of each meeting, and papers will be circulated at least 48 hours prior.

5.6. Meeting agendas and papers will be uploaded to the CAG's document repository, hosted within the CQGG Team Channel.

6. REPORTING

6.1. The CAG is accountable to the CQGG. The Chair and/or Vice-Chair will report to CQGG on all relevant matters relating to CAG activities and responsibilities.

6.2. The CAG will provide a highlight report to CQGG using the Alert, Advise, Assure (AAA) framework after each meeting.

6.3. The CAG will work collaboratively with other governance and advisory groups as needed to ensure comprehensive oversight of clinical transformation efforts.

6.4. The CAG will undertake an annual review of its performance to ensure effectiveness and alignment with the goals of the CMT programme.

7. REVIEW

7.1. The Terms of Reference will be reviewed at least annually but more frequently if required.

8. VERSION CONTROL TABLE

Version Number	Change	Author/ Reviewer/ Approver	Date
1.0	Final version	CQGG	17.09.24

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

RAPID CLINICAL SCREENING

MEETING	Quality, Patient Experience and Safety Committee
DATE	5th November 2024
EXECUTIVE	Andy Swinburn, Executive Director of Paramedicine
AUTHOR	Greg Lloyd, Assistant Director of Clinical Delivery
CONTACT	Gregory.lloyd@wales.nhs.uk

EXECUTIVE SUMMARY

1. A key innovation in the Trust's Clinical Model Programme is the introduction of the **Clinical Navigator**, a more senior clinician responsible for reviewing cases and providing additional clinical functions and support. The Clinical Navigator will apply their expertise and clinical judgment to assess whether the identified activity is suitable for remote clinical management or if it requires a more immediate response.

2. This represents a significant paradigm shift: the review focuses on whether a case is appropriate for further remote clinical management at the rather than whether it warrants an immediate ambulance dispatch. This change allows for more flexible and effective management of potential emergency cases, ensuring that patients receive care that is both timely and appropriate to their clinical needs.

3. Despite the transition from a Clinical Response Model to a Clinical Services Model, one aspect that will remain unchanged is the initial triage of patients who seek healthcare via the 999-contact method. The process will continue to rely on the Medical Priority Dispatch System (MPDS), ensuring that the prioritisation and categorisation of contacts remain consistent and effective.

KEY ISSUES/IMPLICATIONS
4. Approval of phasing and 'go live' dates currently sit with Clinical Model Transformation Board. **RECOMMENDED: That the Committee Note the PowerPoint update for the introduction of Rapid Clinical Screening.**

REPORT APPROVAL ROUTE
Quality, Patient Experience and Safety Committee – 5th November 2024

REPORT APPENDICES
Annex 1 - Rapid Clinical Screening PowerPoint

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

Rapid Clinical Screening

GIG CYMRU NHS WALES

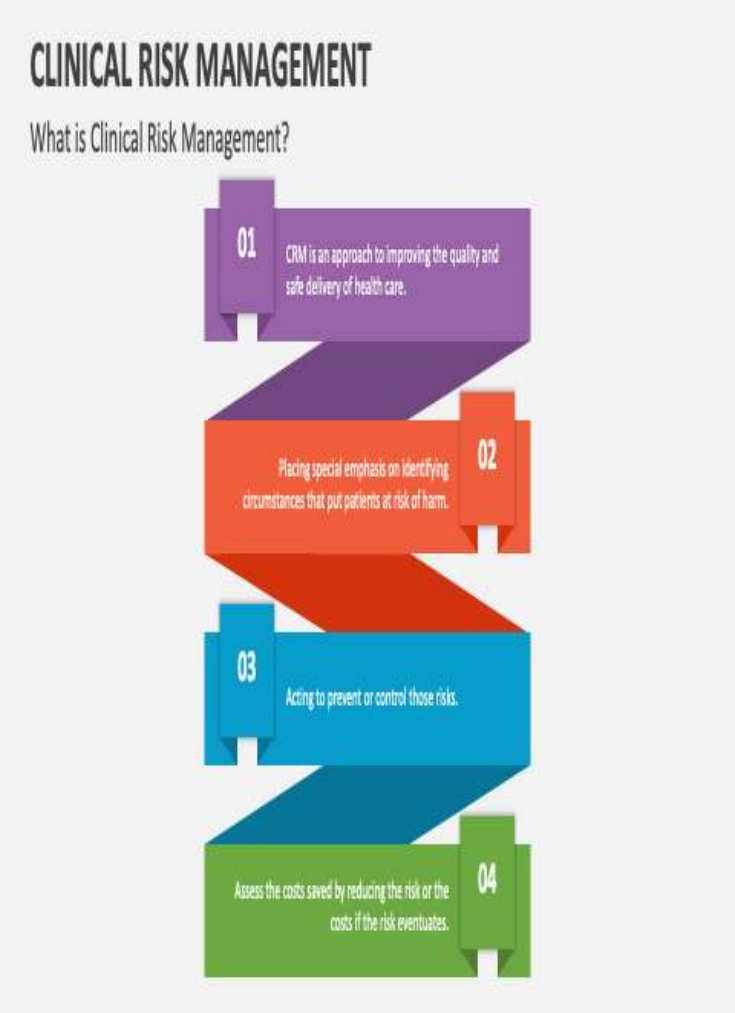
Ymddiriedolaeth Brifysgol GIG
Gwasanaethau Ambiwlans Cymru

Welsh Ambulance Services
University NHS Trust

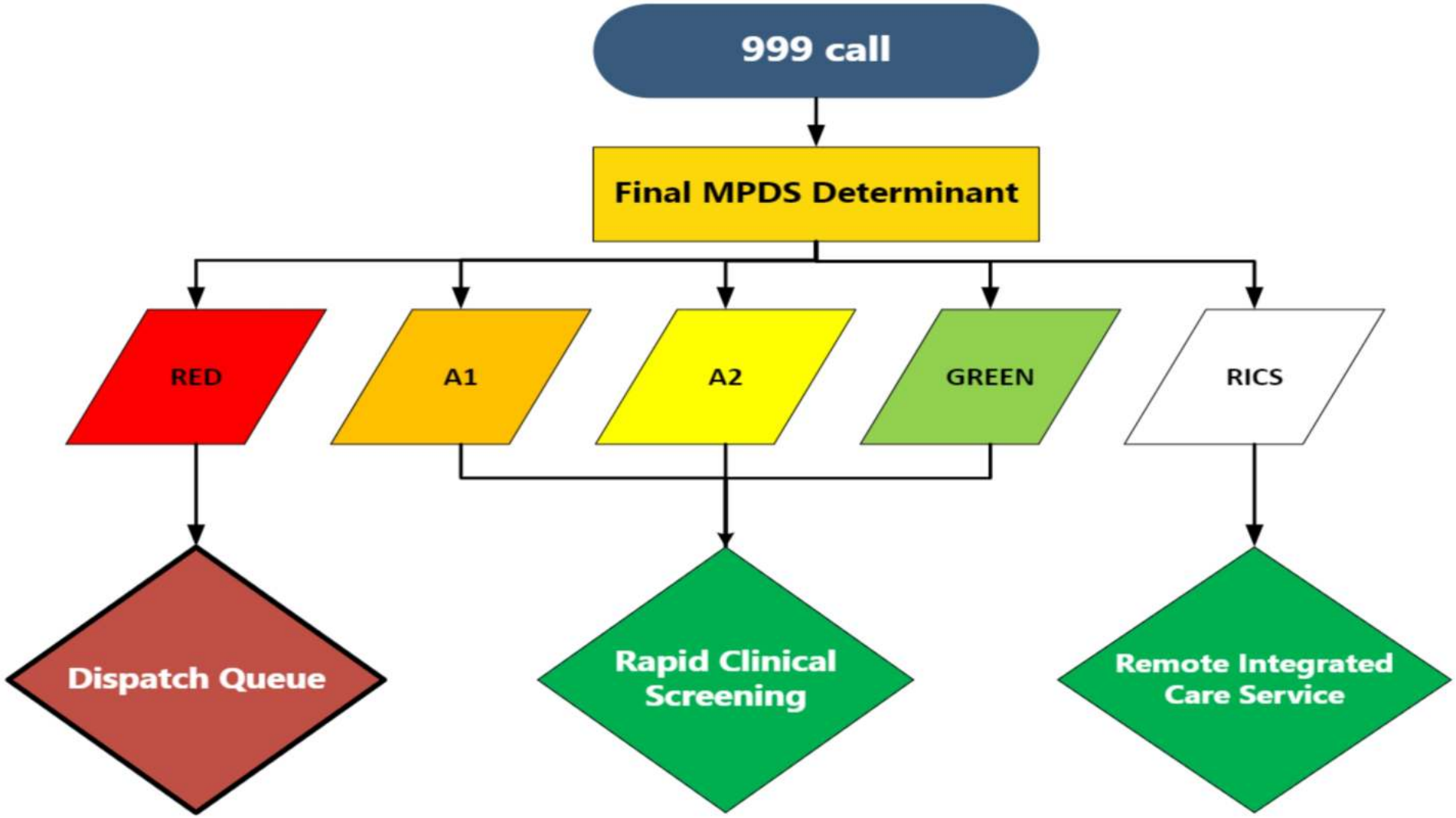
Rapid Clinical Screening
Version 1
Released: October 2024

What is Rapid Clinical Screening

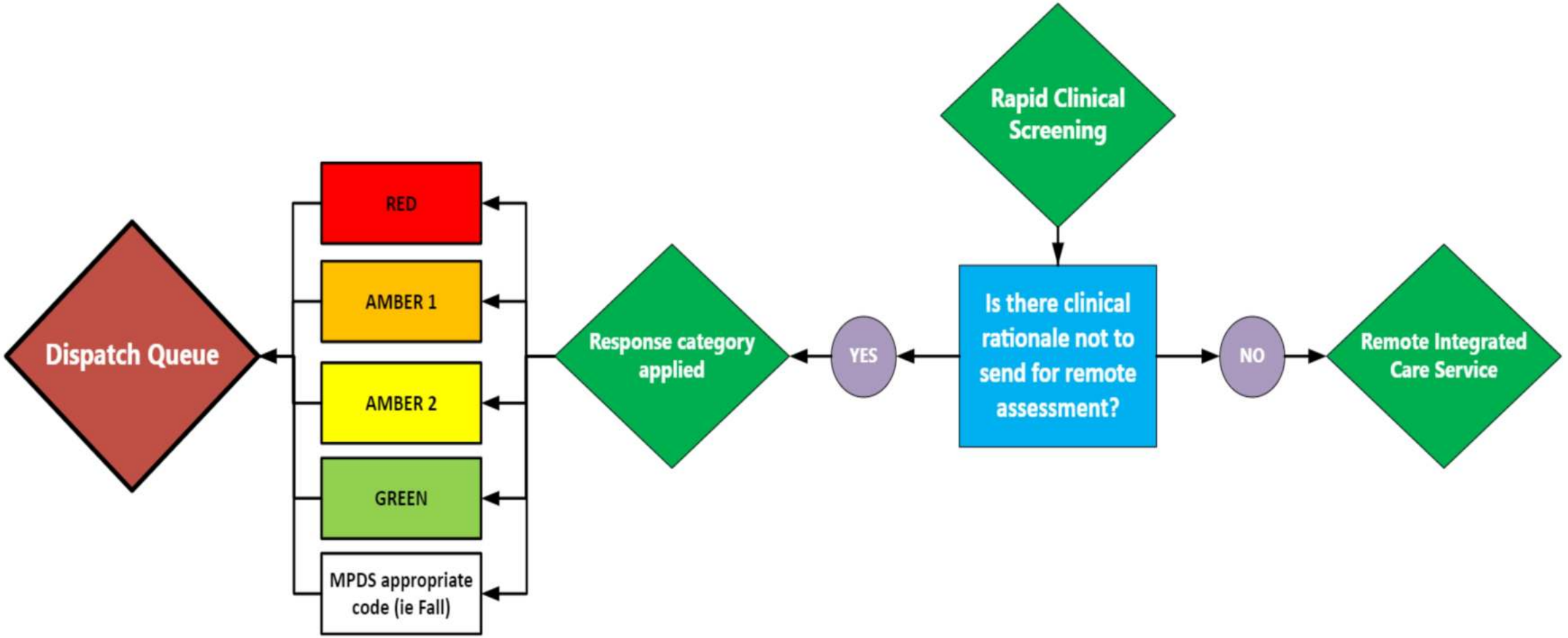
- Early Clinical Screening provides an opportunity to review a defined code set of 999 incidents populated on a screening queue, once a final MPDS code has been generated.
- The Clinical Navigator will make a clinical judgement whether the patient requires a scene response (and what resource would be most clinically suitable to attend) or decide the patient would benefit from secondary triage within Integrated Care.
- Clinical Navigators will base their decisions on the details contained within the CAD incident record, such as the MPDS protocol questions and answers and any notes recorded by the EMD as well as their training, knowledge and experience.
- There are no absolute exemptions for secondary assessment and the Clinical Navigator should will consider the benefits of further clinical consultation/triage against moving to the dispatch queue with no further input from a clinician (especially at times of increased pressure).



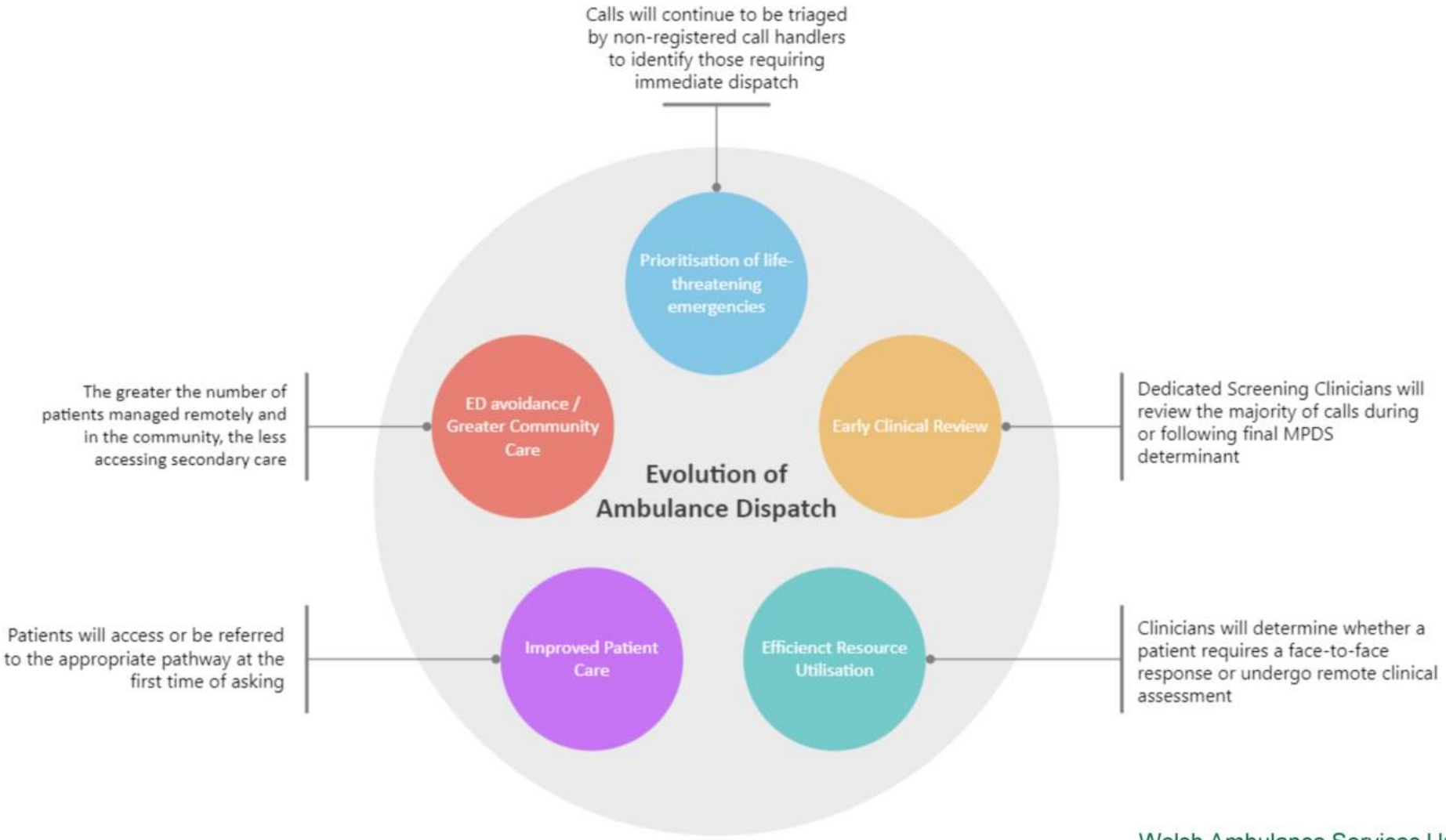
Call flow into Rapid Clinical Screening



Rapid Clinical Screening



How does RCS fit with a Clinical Service Model



Other functions of the Clinical Navigator

High Acuity Live Review

- Live review of High Acuity 999 calls prompting additional questions from the EMD to confirm prioritisation

Remote Clinical Support

- Provide on scene support to EMS colleagues on safe discharge, referral and clinical advice
- Dedicated Police Support line
- Priority back up requests from volunteers, ACA1/2 and CFR/UFR's

Queue safety

- Clinical oversight of the EMSC response queue
- resource prioritisation
- Enhanced clinical screening during escalation

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Welsh Ambulance Services
University NHS Trust

Rapid Clinical Screening

AGENDA ITEM No	9
OPEN	OPEN
No of ANNEXES ATTACHED	1

MONTHLY INTEGRATED QUALITY & PERFORMANCE DASHBOARD – September 2024

MEETING	Quality, Patient Experience and Safety
DATE	5th November 2024
EXECUTIVE	Rachel Marsh – Executive Director of Strategy, Planning & Performance
AUTHOR	Melanie O'Connor - Senior Performance Analyst Mark Thomas – Commissioning & Performance Manager Hugh Bennett - Assistant Director, Commissioning & Performance
CONTACT	Melanie.O'Connor@wales.nhs.uk Mark.Thomas12@wales.nhs.uk Hugh.Bennett2@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 **September 2024.**

2. The report aims to provide an integrated view of quality & performance, so is made available to all three committees, to give that overview, with more specific and detailed reports supplementing it. Whilst giving an integrated overview, each slide contains an icon denoting the lead committee for each set of indicators: -

3. Data quality issues have been identified and are being addressed within 111, APPs and throughout the quality indicators with the result that there are a number of Board approved metrics which are not available at this time.

4. The response times to 999 callers remains a key concern with red 8-minute performance at 48.95% in September 2024 and Amber 1 median at 1 hour and 43 minutes, which the Trust knows leads to avoidable patient harm. The Trust continues to work on tactical actions within its control to mitigate this risk including maintaining high levels of EA production (95% in September,

achieving benchmark) and fully rolling out the Cymru High Acuity Response Unit (CHARU) service (84% in September, highest achieved to date); whilst also undertaking more transformative actions through the Clinical Model Transformation (CMT) Programme.

5. The Trust lost 20,693 hours to handover in September 2024 (higher than September 2023). This level of lost capacity is difficult to compensate for, despite all the actions being taken by the Trust. Following an action from the Executive Director of Ops at the last meeting, a graph is displayed in point 13 of this document highlighting the correlation between areas with the highest number of lost hours and challenges in releasing ambulances for Immediate Release Requests (IRR).

6. 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, which form part of the CMT Programme.

7. 111 call handling performance has stabilised post-delivery of the new 111 CAS and is improving, returning towards the 5% abandonment rate. 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 and sickness absence. The Trust anticipates that staff in post will be restored to commissioned levels by November 2024.

8. Ambulance Care, in particular, Non-Emergency Patient Transport Services (NEPTS) performance is 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.

9. 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 7.43% in September 2024 maintaining the consistency of being below 8% since March 2024. The IMTP ambition is to reach 6%. The Trust will continue its focus on sickness absence. EMS abstractions were marginally above the 30% benchmark in September 2024 at 30.72%.

10. The Trust is continuing to deliver its Clinical Model transformation (CMT) programme at pace, aiming to get key aspects of the change programme in place in advance of winter, in particular, remote clinical screening (RCS).

RECOMMENDATION: QuEST is asked to: -

(1) Consider the September 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
30.10.24 Executive Director Strategy, Planning & Performance

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 **September 2024.**

2. The report aims to provide an integrated view of quality & performance, so is made available to all three committees, to give that overview, with more specific and detailed reports supplementing it. Whilst giving an integrated overview, each slide contains an icon denoting the lead committee for each set of indicators: -

BACKGROUND

3. 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

4. As previously agreed, the metrics which form part of this committee/Board report are updated on an annual basis, to ensure that they continue to represent the best way of tracking progress against the Trust's plans (IMTP) and strategies. The 2024/25 revised metrics have been agreed.

ASSESSMENT

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

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

6. **999** call answering times declined in September with the 95th percentile at 18 seconds, compared to 4 seconds in August 2024. The 65th percentile and median performance remain consistently good in September 2024.

7. **111 call answering performance has improved over recent weeks,** although the call abandonment performance was at 7% in September and off target (5%). One of the key issues has been the temporary reduction in call handling staff in post caused by a redirection of available training capacity towards the delivery of the new 111CAS system. Recruitment is now underway again and it is

anticipated that the staff in post to establisment position will be recovered by November. 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%).

8. 111 demand in September 2024 was 1.6% lower than during September 2023, however, the longer term trend is up. The Trust is expecting to shortly procure a third party to undertake a collaborative (with commissioners) and independent review of the Trust's 111 call handler rostering practices, including a review of demand levels and required staffing capacity.

9. **111 Clinical response:** clinical ring back times for patients with the highest priority remained above target at 99.1%. Response times for lower priority calls also achieved the target this month, recording 98.6% and 97.1% for P2CT and P3CT respectively.

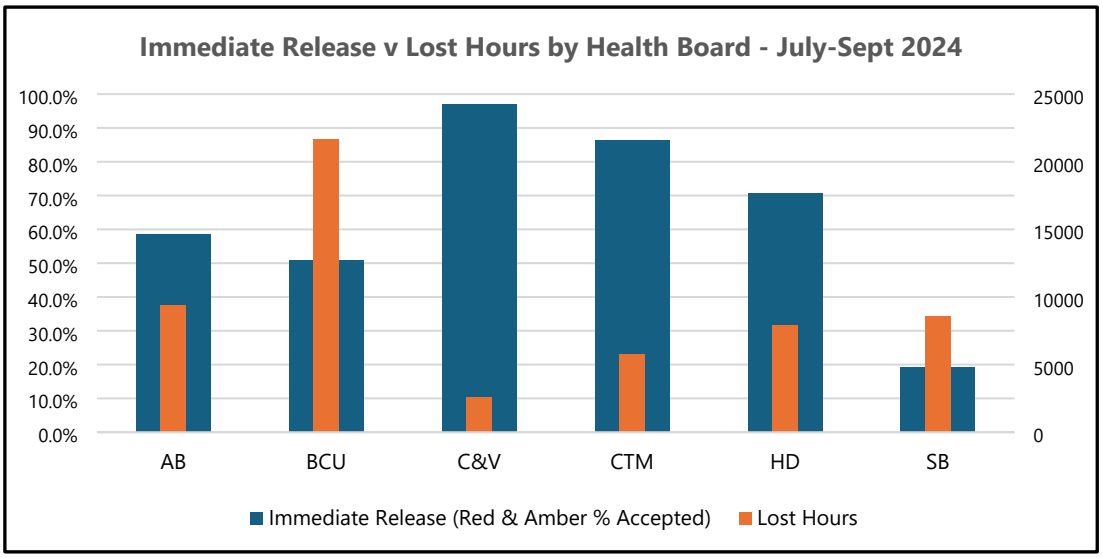
10. **Ambulance Response** (safety / patient experience): the red 8-minute response performance for September 2024 was 48.95%, remaining below the 65% target; however, the Trust is reaching more red patients in 8 minutes, but the denominator (demand) has also grown. The Amber 1 median in September was 1 hour 43 minutes and the Amber 1 95th percentile was 6 hours 59 minutes. These long response times have a direct impact on outcomes for many patients.

11. Traditionally the main factors which affect response times are demand and capacity (recruitment and lost hours). A recruitment gap has been identified and is currently being addressed through a series of corrective actions, but the lost capacity through handover at hospital remains extremely challenging and largely out of the Trust's control to address. 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 through the Clinical Model Transformation (CMT) programme, elements of which will be implemented before winter. Areas of focus include: -

    - Data quality issues have been identified with Advanced Paramedic Practitioners (APP)s and these are currently being addressed.
    - Further investment into remote clinical capacity (+28.5 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.

12. 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 a detailed presentation given at Sep-24's Finance & Performance Committee (findings positive) etc. The Trust achieved an 84% CHARU Unit Hours Production (UHP) in Sept-24, the highest it has achieved and is now seeking to close the remain gap through the recruitment of fully qualified paramedics.

13. 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. 20,693 hours were lost during September 2024. Cardiff & Vale's handover lost hours continue to remain comparably much lower, 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 University Health Board remains significantly high and just above its two-year average figure (7,700). WG have re-iterated to health boards the critical importance of improvements in this area. The WG pan-Wales target of no handovers of more than one hour, equates to 7,500 lost hours.



The graph above shows a correlation that is evident between the percentage of requests for immediate release, that are accepted, and lost hours to handover at hospitals by health board for the quarter July 2024 to September 2024. It highlights that the two health boards with the highest percentage of immediate release, for both Red and Amber 1, C&V (97.1%) and CTM (86.5%), both have the lowest numbers of lost hours by health board over the quarter, these being 2,552 and 5,742 respectively.

The three health boards with the lowest levels of immediate release do have the highest number of lost hours, with BCU recording the most (21,630) along with a release rate of 50.7%. The lowest immediate release rate over the quarter is seen

at Swansea Bay, with just 19.2%. The health board has the third highest number of lost hours (8,574).

14. **Ambulance Care (Patient Experience)**: Oncology performance in September 2024 was 75.52%, hitting the 70% target. Renal performance also remains above target at 71.15%. Advanced discharge & transfer journey performance increased compared to the previous month to 82% but 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: re-rostering NEPTS transport in 2024/25 which will better align available capacity with changing demand patterns (on target).

15. **National Reportable Incidents (NRIs) / Concerns Response**: data quality issues have been identified which are currently being addressed. There is currently no data past June reported and no analysis therefore on how well the organisation is performing.

16. **Clinical outcomes**: The percentage of suspected stroke patients who are documented as receiving an appropriate stroke care bundle was 89.9% in September 2024, remaining below the 95% performance target. Work is ongoing to improve reporting and compliance through the ePCR system and this improvement is being seen clearly in most of the clinical indicators. The Return to Spontaneous Circulation (ROSC) compliance rate decreased to 19.4% in September 2024 compared to 24.2% in August 2024.

17. The Trust is now able to report on call to door times for Stroke and STEMI patients. For September 2024, these highlight call to hospital door times of two hours and 34 minutes for stroke patients and two hours and twelve 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.

18. In September 2024, 9,440 patients **cancelled** their ambulance, and the Trust was unable to send an ambulance due to the application of the Clinical Safety Plan levels to approximately 481callers. The Trust believes that 50% of this combined number is unmet demand and is likely to be presenting 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.

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

19. **Hours Produced**: The Trust produced 116,986 Ambulance Response unit hours in September 2024 and delivered an emergency ambulance UHP of 95%, achieving the 95% target.

20. **Response Abstractions:** EMS abstraction levels increased to 30.72% in September 2024, just above the 30% benchmark figure. Response sickness abstractions stood at 6.97% (benchmark 5.99%).

21. **Trust sickness absence:** the Trust's overall sickness percentage was 7.43% in September 2024, a decrease on the 7.52% recorded in August 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 7.43% is above the 2023/24 IMTP ambition of 6%.

22. **Staff training and PADRs:** PADR rates did not achieve the 85% target in September 2024 but have been remaining consistent (75.89%). Compliance for Statutory and Mandatory training decreased slightly to 83.79%, just shy of the 85% target.

23. **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 another round of a pan-Wales of CEO Roadshows in October 2024 and collection of feedback is underway.

Finance & Value

24. **Financial Balance**: the reported outturn performance at Month 6 is a surplus of £41k and the Trust is forecasting to achieve both its External Financing Limit and its Capital Expenditure Limit.

Partnerships & System Contribution

25. We are not able to fully report on the consult & close rates as the 111 contribution is not available due to issues with system changes within the 111 CAS system. 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.

26. 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

27. Data quality issues have been identified and are being addressed within 111, APPs and throughout the quality indicators. 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 is 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: QuEST is asked to: -

(1) Consider the September 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

September 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: October 2024

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by Commissioning & Performance Team

Section 1: Monthly Indicators / Top Indicator Dashboard

Top Monthly Indicators	Target 2024/25	Aug-24	Sep-24	2 Year Average	RAG
Our Patients					
Timeliness Indicators					
NHS111 Call Handling Abandonment Rates	< 5%	8.9%	7.0%	11.3%	R
111 Clinical Triage Call Back Time (P1)	90%	97.4%	99.1%	98.3%	G
999 Call Answer Times 95th Percentile	00:06	00:04	00:18	00:20	R
999 Red Response within 8 minutes	65%	51.8%	49.0%	49.1%	R
999 Amber 1 Median	00:18	01:11	01:48	01:23	R
Oncology Journeys arriving within 45 mins and up to 15 minutes after appointment time	70%	76.8%	75.5%	72.3%	G
Advanced Discharge & Transfer journeys collected less than 60 minutes after booked time (NEPTS)	90%	78.0%	82.1%	81.9%	A
Clinical Outcomes / Quality Indicators					
Return of Spontaneous Circulation (ROSC)	Increasing Trend	24.2%	19.4%	18.6%	A
Stroke Patients with Appropriate Care	95%	88.4%	89.9%	78.8%	A
Stroke Call to Hospital Door Times	Reduction Trend	02:17	02:34	02:17	R
ST-Elevation Myocardial Infarction (STEMI) with Appropriate Care	95%	59.0%	70.0%	47.0%	R
National Reportable Incidents reports (NRI)		N/A	N/A	5	
Can't Send & Cancelled by Patient Volumes	Reduction Trend	8,476	9,440	9,048	A
Concerns Response within 30 Days	75%	N/A	N/A	41.7%	
Enactment of the Duty of Candour	100%	N/A	N/A	73.3%	
Our People					
Capacity					
Hours Produced for Emergency Ambulances	95-100%	90%	95%	90%	G

Top Monthly Indicators	Target 2024/25	Aug-24	Sep-24	2 Year Average	RAG
Health & Well-being					
Sickness Absence *(all staff)*	6.0%	7.52%	7.43%	8.09%	A
Mental Health Absence Rates	Reduction Trend	2.52%	2.59%	2.23%	A
Staff Turnover Rate	Reduction Trend	8.10%	8.21%	9.12%	A
Statutory & Mandatory Training	>85%	84.66%	83.79%	75.57%	A
PADR/Medical Appraisal	>85%	75.96%	75.89%	73.35%	R
Number of Shift Overruns	Reduction Trend	3812	3870	3,673	R
Inclusion & Engagement / Culture					
NEPTS % of Total Calls Answered in Welsh	Increasing Trend	2.0%	2.2%	1.5%	G
Value					
Financial balance - annual expenditure YTD as % of budget expenditure YTD	100%	100.00%	100.00%	100%	G
EMS Utilisation Metric (CHARU)	Increasing Trend	25.3%	26.8%	27%	R
Average Jobs per Shift (All Vehicles)	Increasing Trend	2.34	2.29	2.34	R
NEPTS on the Day Cancellations	Reduction Trend	12.8%	13.1%	13%	G
Partnerships / System Contribution					
Inverting the Triangle					
Successful Consult & Close Outcome	17.0%	10.1%	9.7%	13.2%	
% Of Total Conveyances taken to a Service Other Than a Type One Emergency Department	Increasing Trend	11.71%	11.44%	11.3%	G
Number of Handover Lost Hours	7,500	17,540	20,693	22,717	R
NHS111					
NHS111 Dental Calls	Increasing Trend	N/A	N/A	6,704	
Consult & Close Volumes by NHS111	Increasing Trend	N/A	N/A	1,003	

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

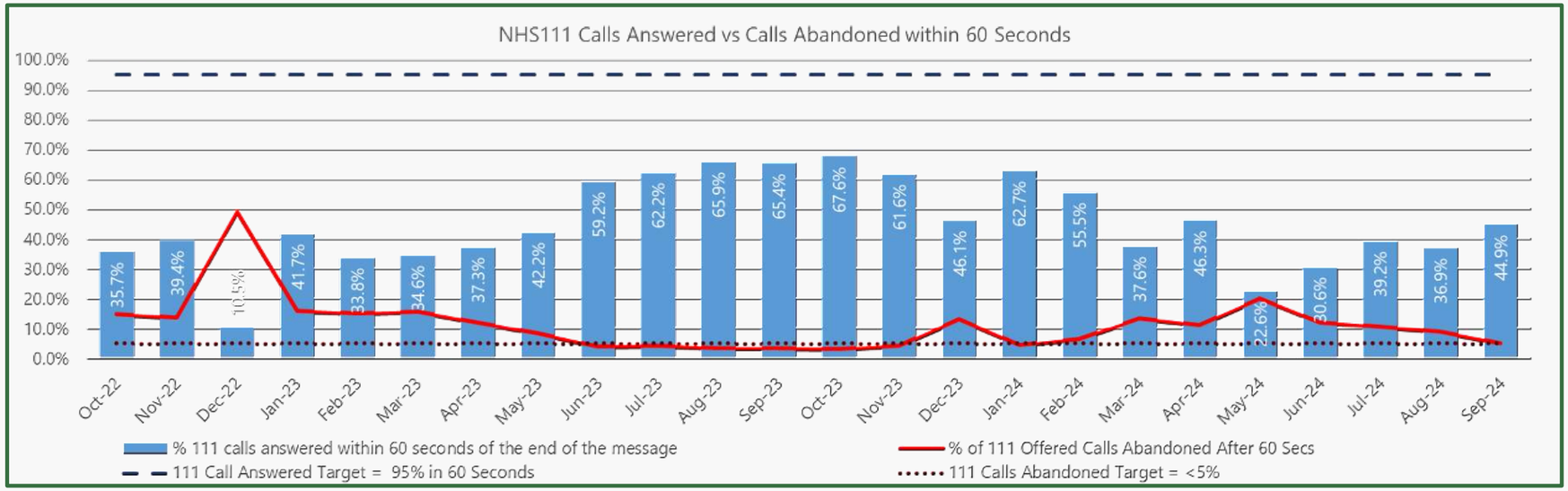
(Responsible Officer: Lee Brooks)

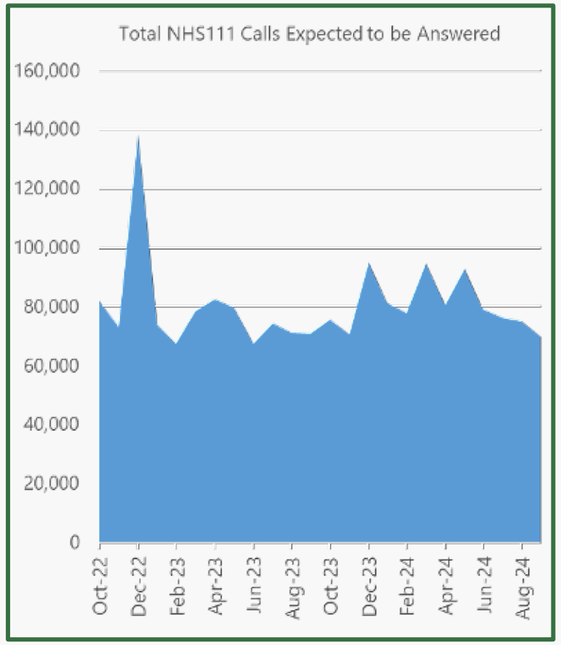
Abandonment Rate: A

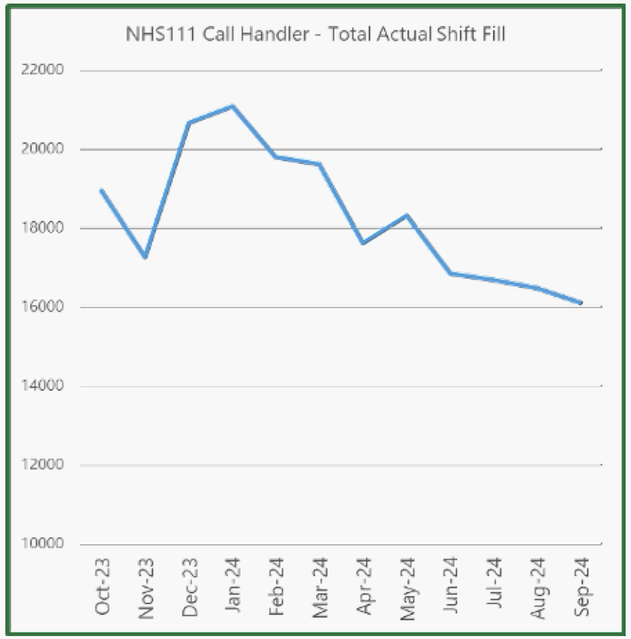
FPC

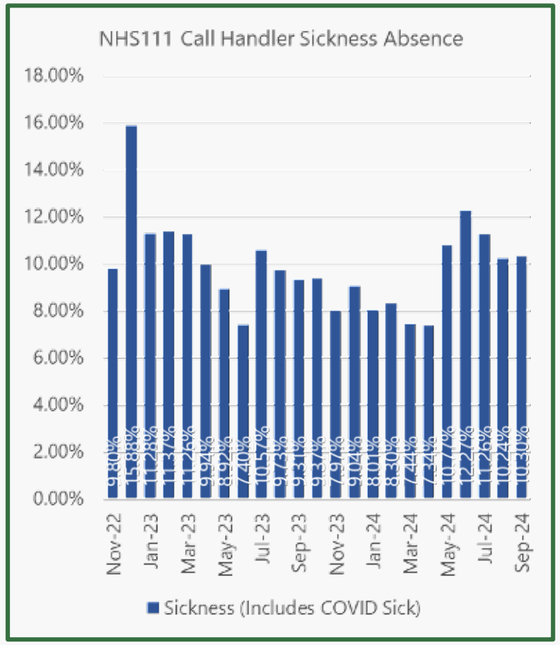
Influencing Factors – Demand and Call Handling Hours Produced

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









Analysis

The 111-call abandonment rate improved from 8.9% in August 2024 to 7% in September 2024, but did not achieve the 5% target for 8 months. The percentage of 111 calls answered within 60 seconds improved, from 36.9% in August 2024 to 44.9 % in September 2024, but continues to remain below the 95% target.

The new 111CAS system went 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 on-going impact on efficiency.

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 November, a slip from the previous August deadline;
- Further action is being undertaken to try and improve on the call handling position across the Winter months e.g. possible over-establishment.
- 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.

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.

Our Patients: Quality, Safety & Patient Experience
111 Clinical Assessment Start Time Performance Indicators
Influencing Factors – Demand and Clinical Hours Produced

(Responsible Officer: Lee Brooks)

P1CT

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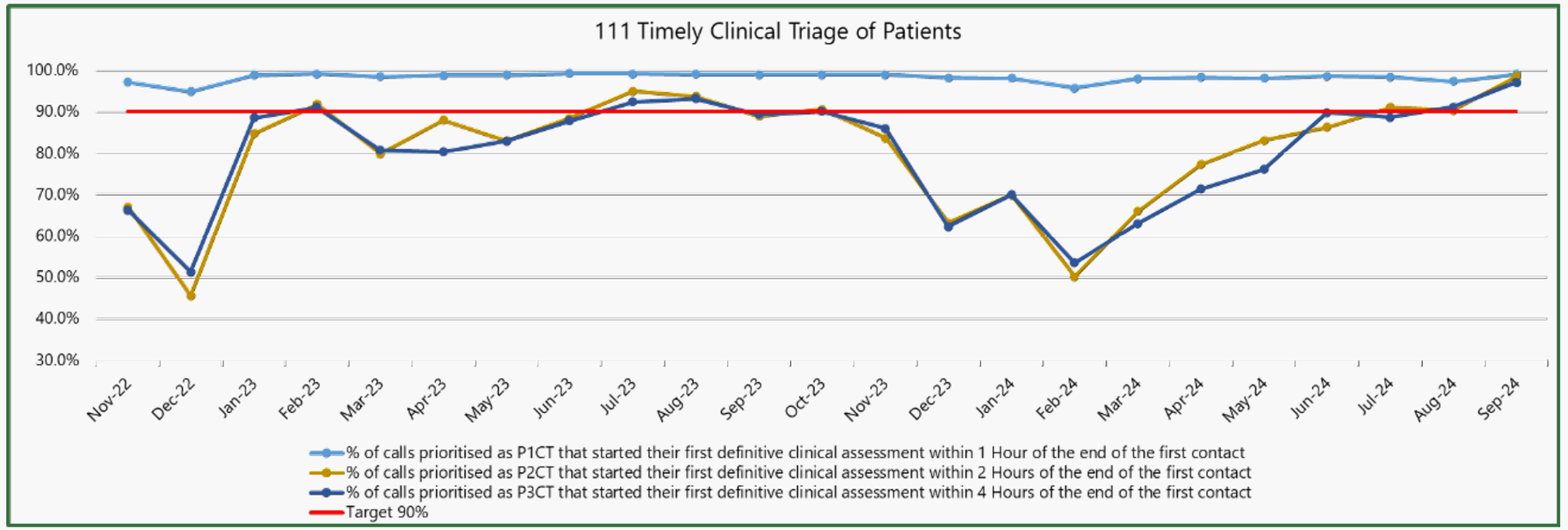
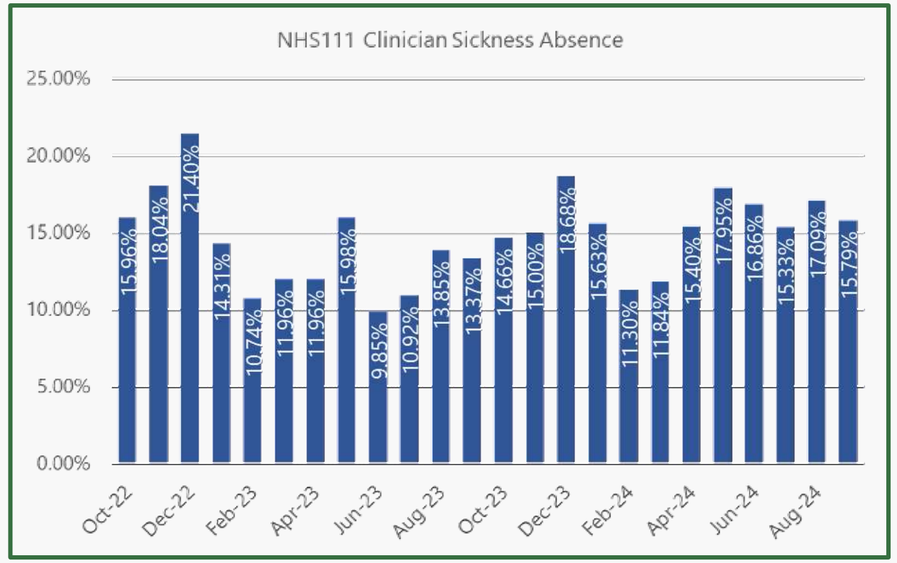
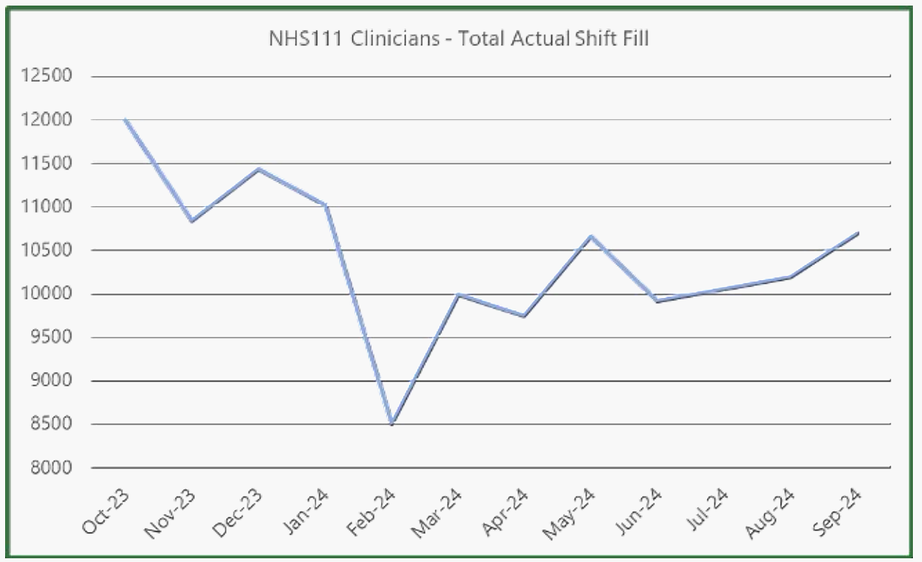
NB: Data quality issues have been identified in 111. These are currently being addressed.







Analysis

The highest priority calls, P1CT, achieved the 90% target, recording 99.1% in September 2024.

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

Numbers of clinician hours produced increased again in September 2024 for the third month in a row to 10,688. Clinician sickness absence also improved during the month to 15.79%.

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

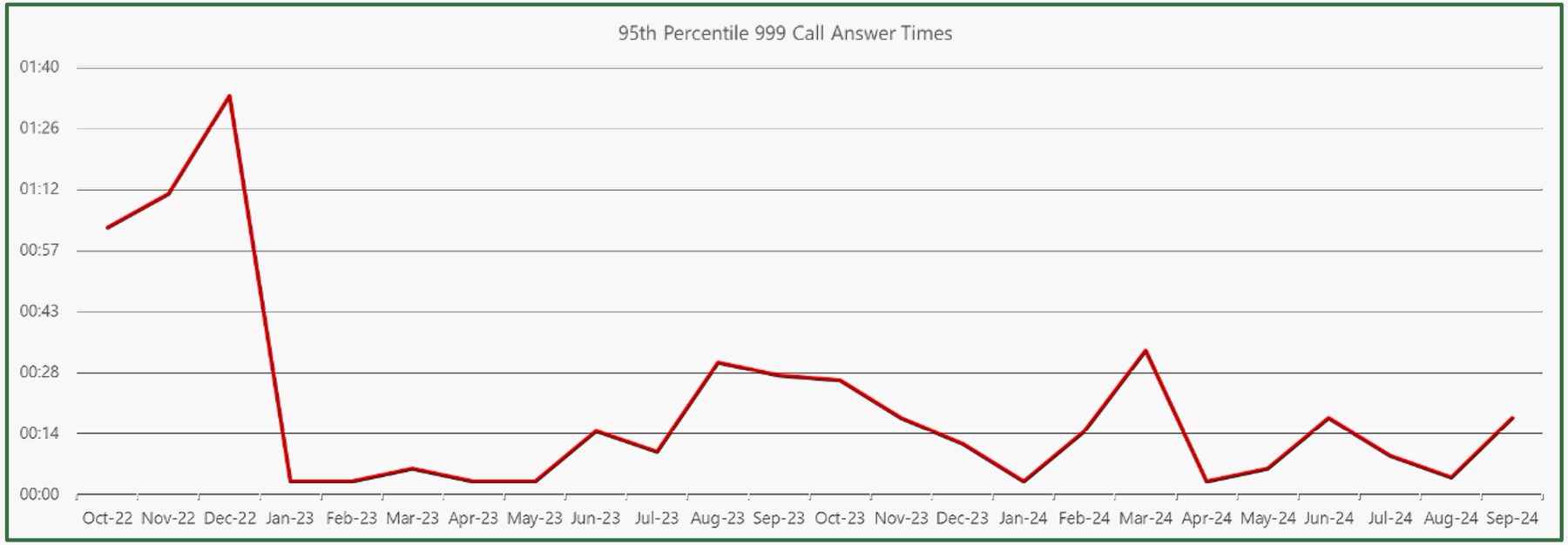
The new 111CAS will bring performance benefits. Welsh Government have asked that WAST model call handling performance through the winter. This is not the same as clinician performance but should provide useful intelligence on what the Trust may achieve for clinical triage performance..

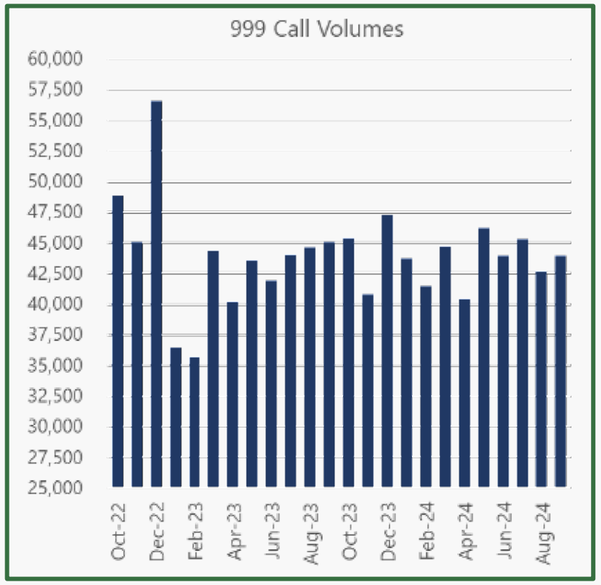
Our Patients: Quality, Safety & Patient Experience
999 Call Performance Indicators

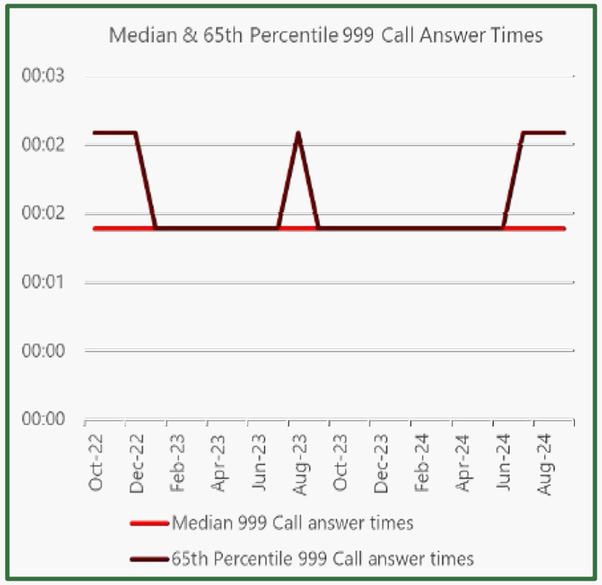
(Responsible Officer: Lee Brooks)

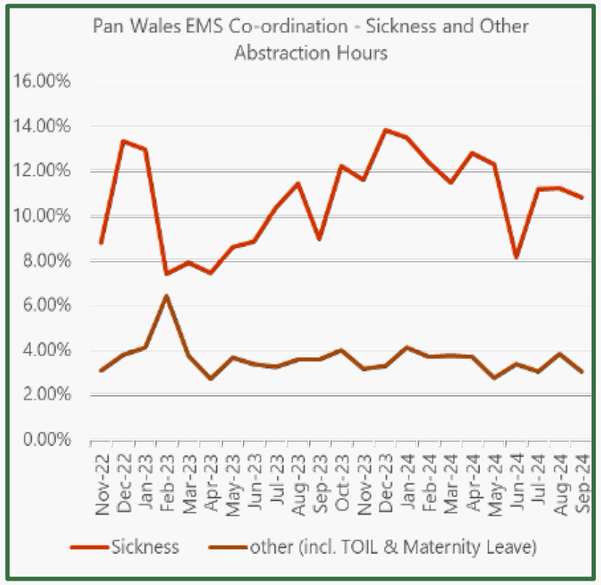
R FPC CI

Influencing Factors – Demand and Hours Produced









Analysis

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

There was an increase in demand in September 2024 to 44,000 calls from 42,707 in August 2024.

Sickness levels saw a minimal decrease from 11.26% in August 2024 to 10.82% in September 2024.

Remedial Plans and Actions

- Over establishment has been approved for EMSC by the Executive Director of Operations with call takers currently above establishment (105.5 FTEs v 126.26 WTEs).
- 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 for November, January & March with 12 per cohort.

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

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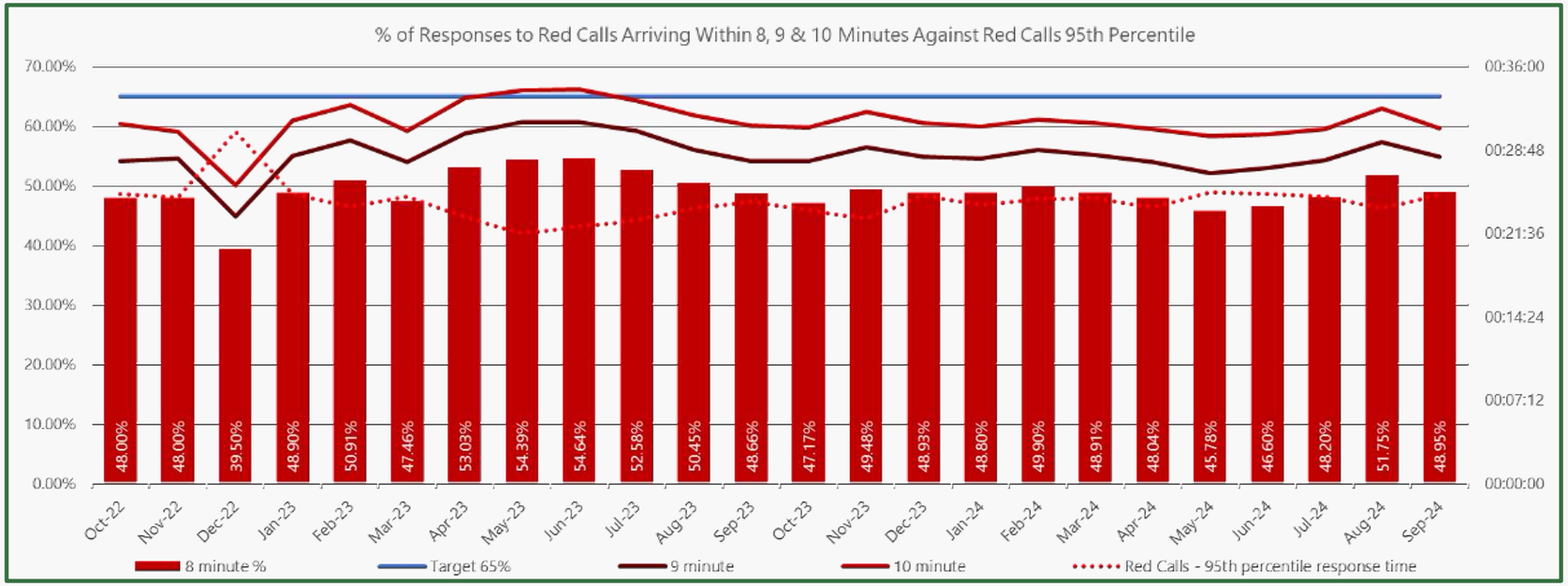

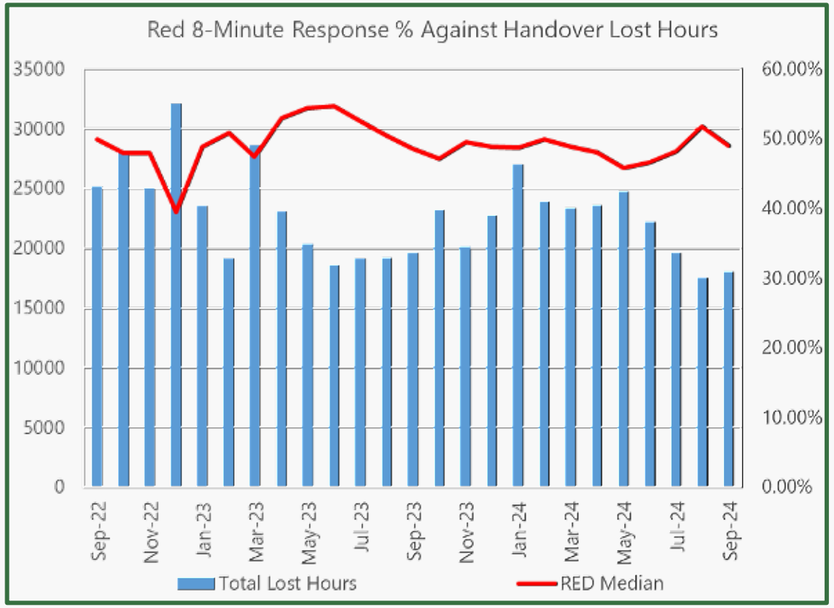

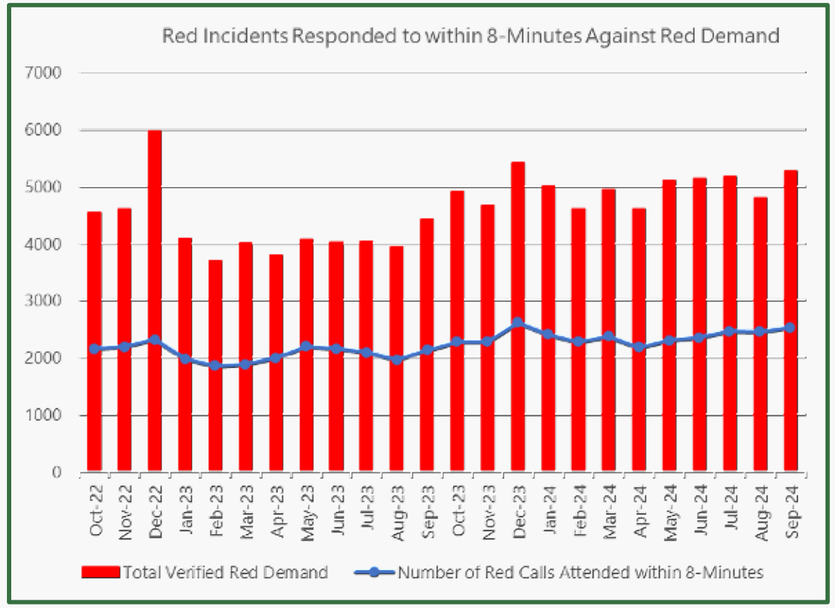

Analysis

Red 8-minute performance continues to remain below the 65% target decreasing marginally during September 2024 to 48.95%.

Red 10-minute performance for September 2024 was 59.6%, 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 September 2024 being 18.6% higher than that seen in September 2023. As red demand has increased, so too has the number of red incidents responded to within 8-minutes, with the figure for September 2024 being 2,528 (18.6% higher than the figure for September 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**, which shows that as handover rates decrease, so red performance improves. There were 20,693 lost hours in September 2024.

Remedial Plans and Actions

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

- To maintain commissioned establishment 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 95% UHP in September 2024 and CHARU production 84% 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 (school holiday period) indicates a level of Red performance below target (most likely scenario 46%) and Amber 1 (over two hours). Modelling for winter has now also been completed.

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

(Responsible Officer: Lee Brooks)

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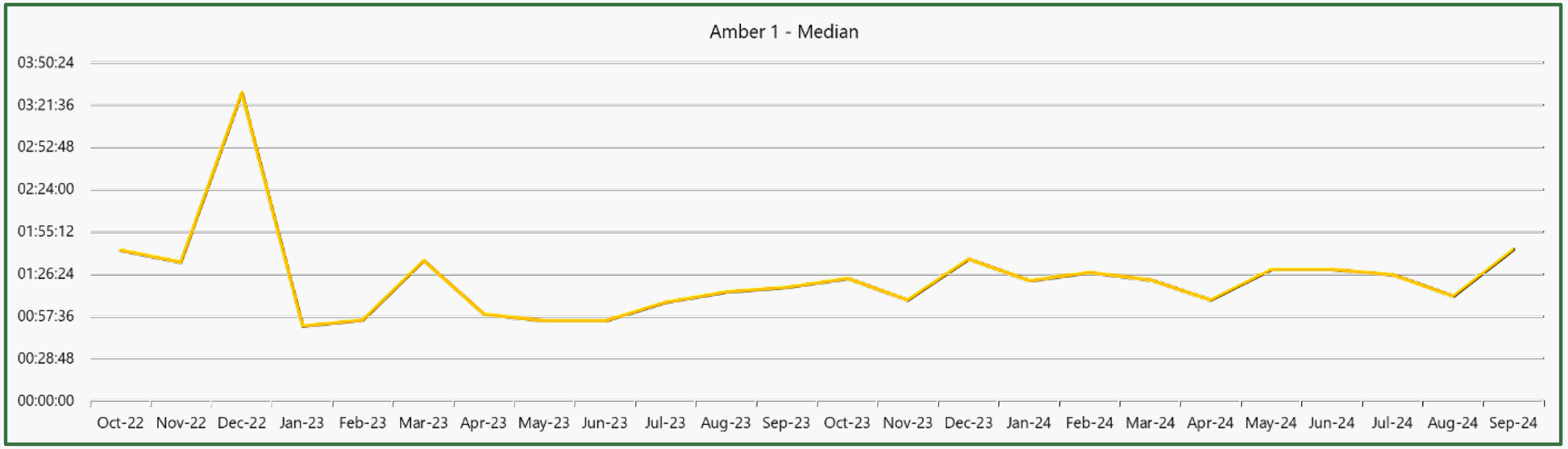
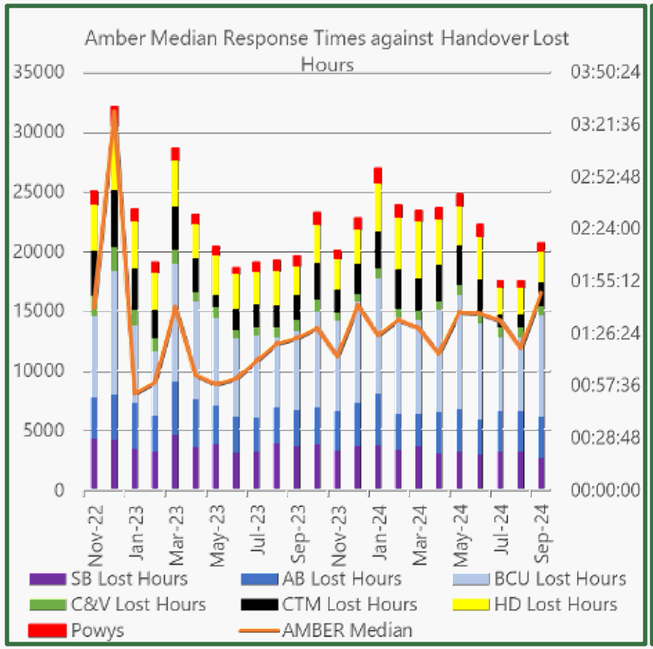
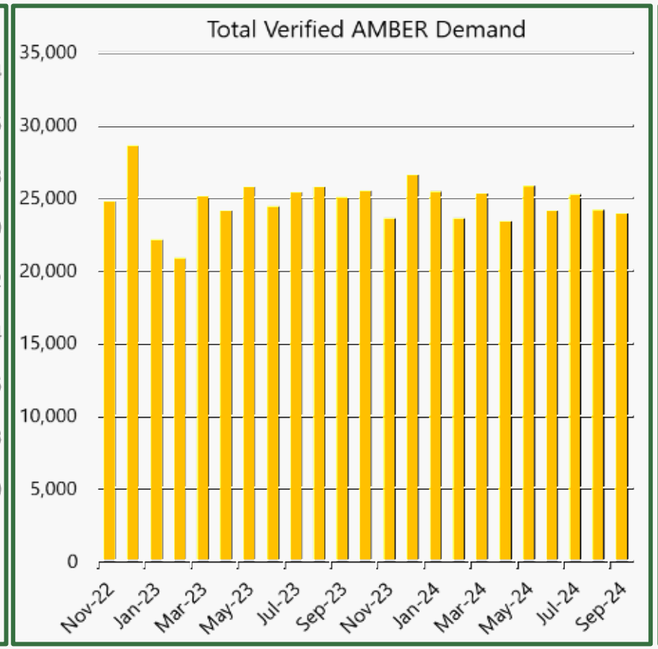
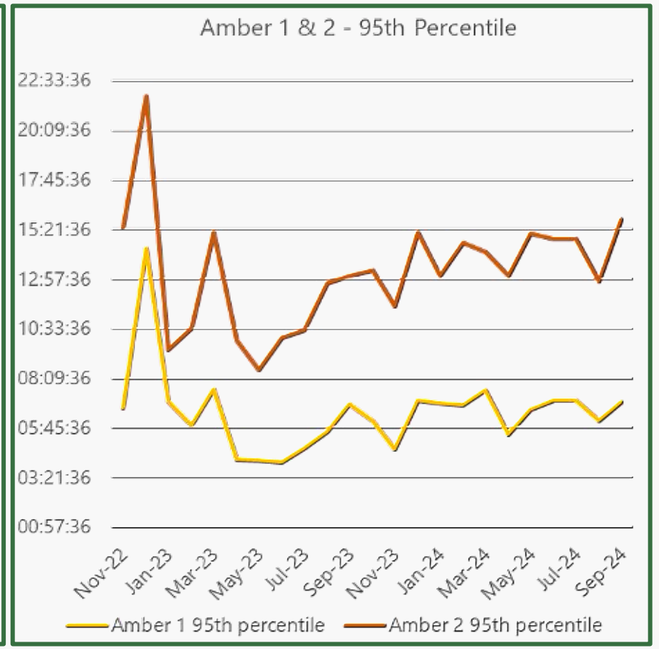
Influencing Factors – Demand, Hours Produced and Hours Lost









Analysis

The Amber 1 median performance time increased during September 2024 to 1 hour 43 minutes compared to 1 hour 11 minutes in August 2024. The ideal Amber 1 median response time remains at 18 minutes.

The Amber 1 95th percentile also increased during September 2024 to 6 hours 59 minutes from 6 hours 7 minutes in August 2024. This time remains far too long, and once again increased above the 2-year average figure of 6 hours 34 minutes.

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

Remedial Plans and Actions

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

Expected Performance Trajectory

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

Our Patients: Quality, Safety & Patient Experience

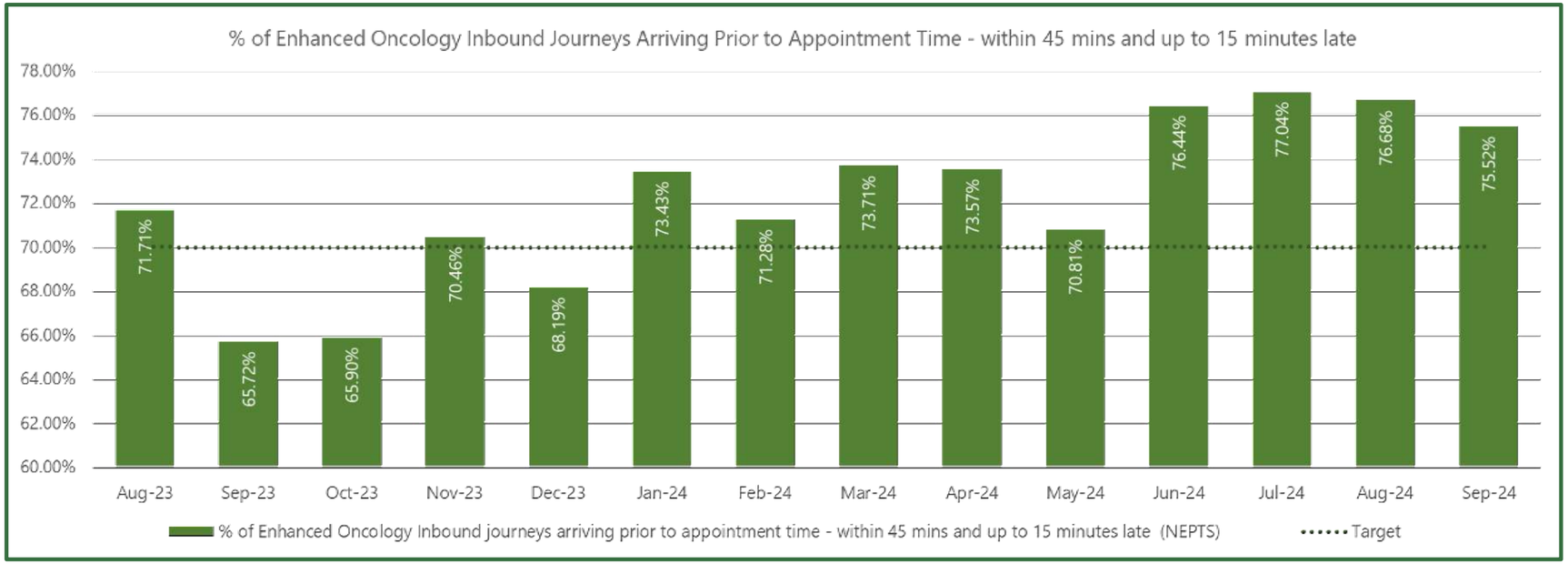
Patient Experience – Influencing Ambulance Care Indicators

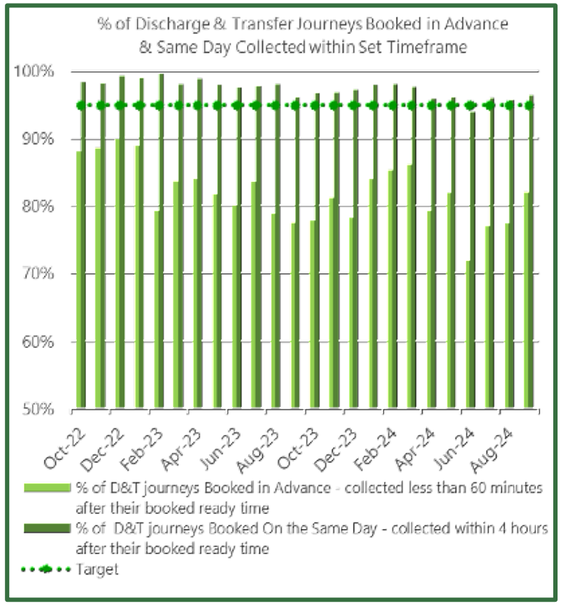
(Responsible Officer: Lee Brooks)

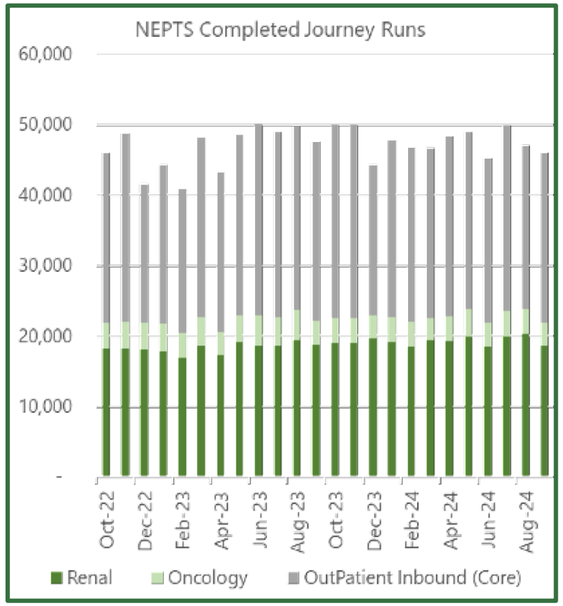
D&T	Oncology	Welsh Calls
A	G	G

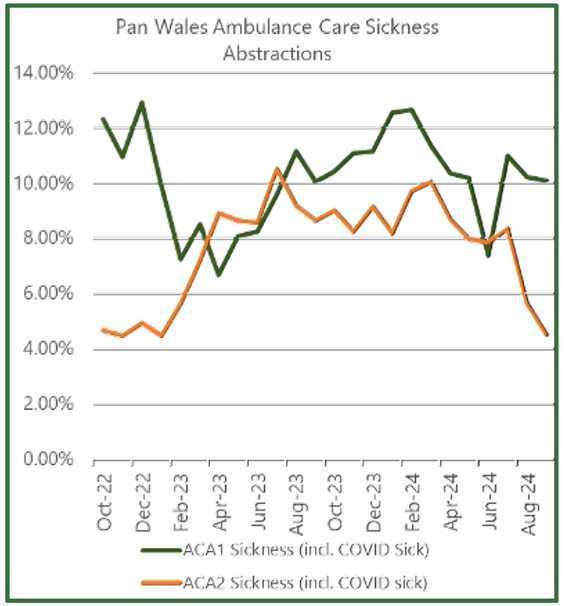
FPC

CI









Analysis

75.52% of enhanced Oncology journeys arrived within 45 minutes prior and up to 15 minutes late of their appointment time, a minimal decrease from the 76.6% in August 2024, but achieving the 70% target for the ninth 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 (95%) at 82% in September 2024, although this was an improvement from 78% in August.

Enhanced Renal journeys, remained decreased slightly to 71%, but continues to exceed the agreed performance standard (70%).

Call volumes answered increased further in September 2024 to 17,662 compared to 16,222 in August2024; however, the average speed of call answering improved from 5 minutes 12 seconds in August to 4 minutes 55 seconds in September.

ACA2 sickness achieved the 5.99% target, attaining 4.51% in September 2024.

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

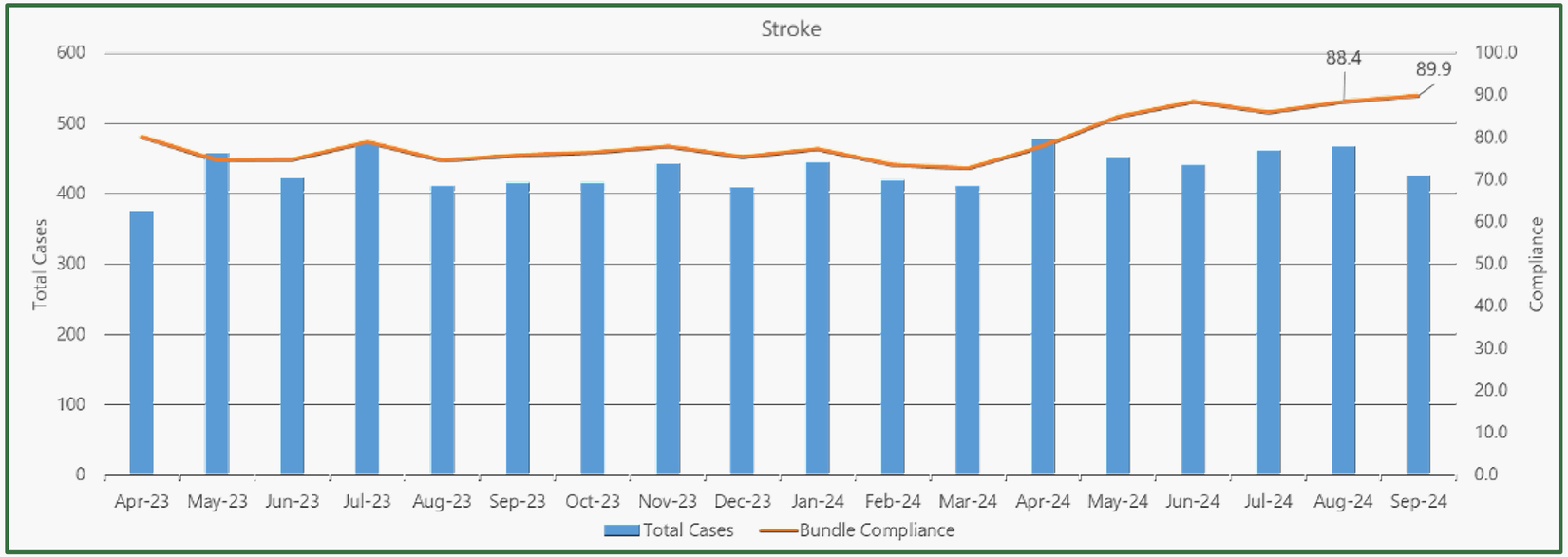
Return of Spontaneous Circulation, Suspected Stroke Patients with Appropriate Care, ST-elevation myocardial infarction (STEMI) with Appropriate Care

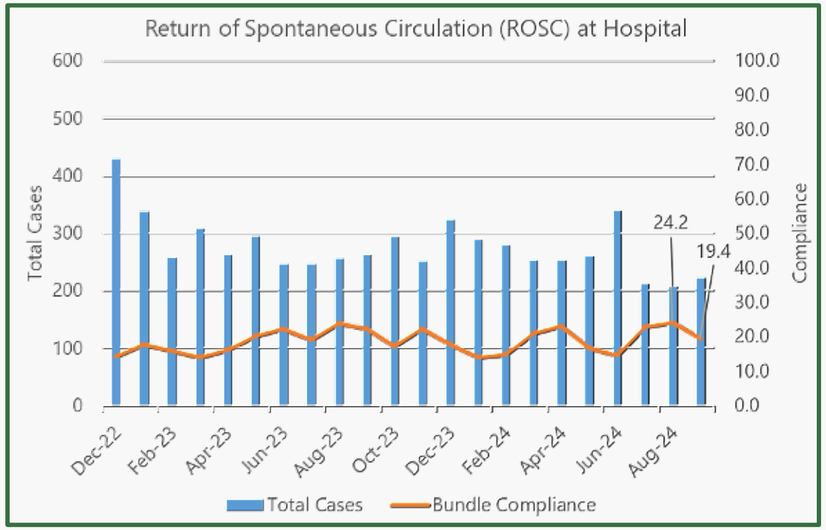
Stroke	ROSC	STEMI
A	G	R

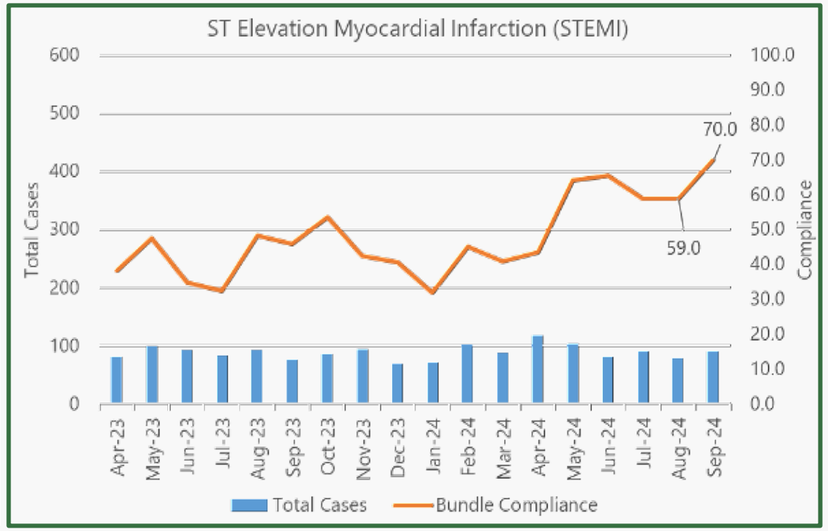
Self-Assessment: Strength of Internal Control: Moderate

QUEST

(Responsible Officer: Andy Swinburn)







Analysis

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

Stroke – 89.9%, an increase from 88.4% in August. A recent update to the scripting contributed to the improved compliance. There is a correlation between documenting FAST (a test to detect symptoms of stroke) and care bundle compliance, this has informed the recovery plan and interventions.

STEMI (heart attack) – 70.0%, an increase form 59.0% in August. There was an improvement in all four criteria which contributed to the improved bundle compliance. User Interface changes for justified exceptions with GTN to improve electronic Patient Clinical Record completion and compliance will be implemented in October/November. A 'nudge' is also planned to improve compliance to Aspirin and GTN.

Return of Spontaneous Circulation at hospital (from cardiac arrest) – 19.4%, a decrease from 24.2 % in August. Issues with the ROSC coding scripting were identified and subsequently updated from the July 2024 figures, which now shows a step change with August being the highest since ePCR was implemented.

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

Following the switch to the electronic Patient Clinical Record , the way data is collected has changed. Automated Clinical Indicator reports are generated from data directly inputted by clinicians. 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 reports.

Further electronic Patient Clinical Record User Interface changes are planned for the next ePCR update scheduled for Spring 2025 and the impact will be monitored.

Our Patients: Quality, Safety & Patient Experience
Clinical Indicators

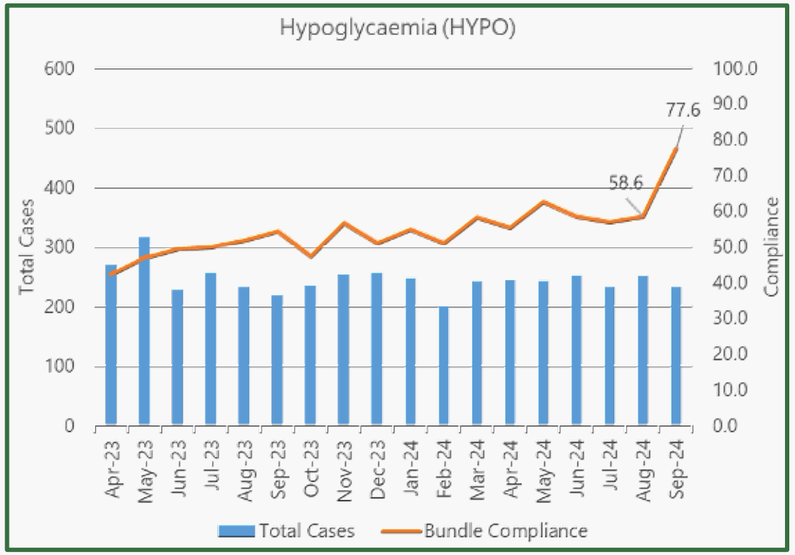
Hypoglycaemia, Fractured Neck of Femur (#NOF) and Time-Based metrics (Stroke & STEMI)

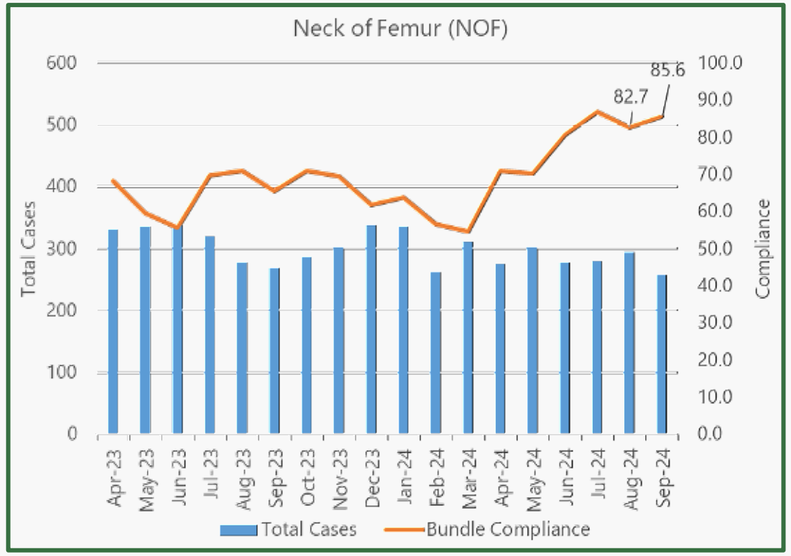
(Responsible Officer: Andy Swinburn)

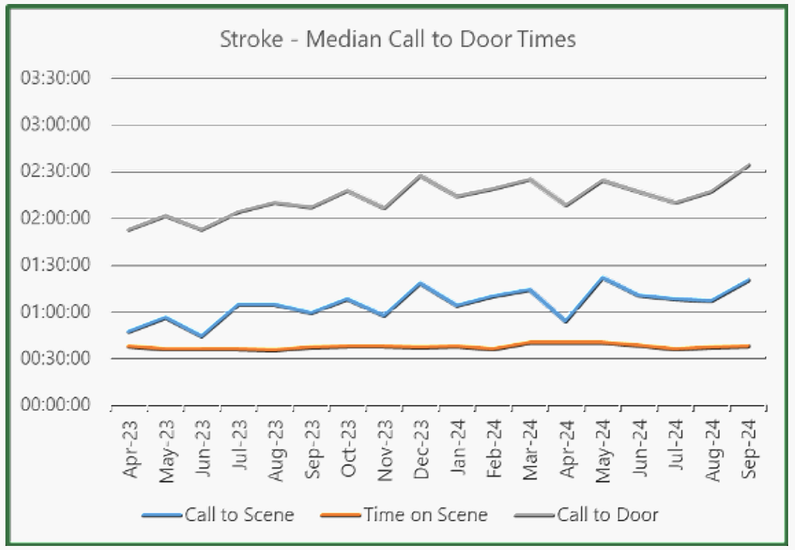
Call to Door
R

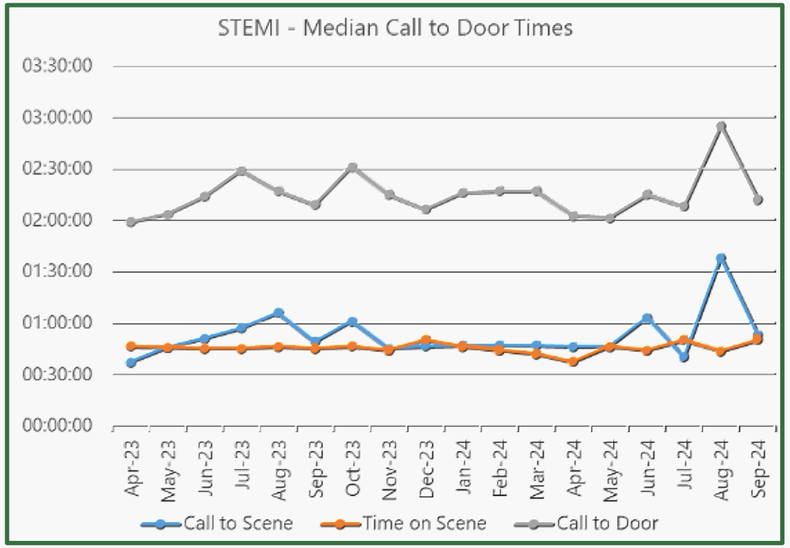
Self-Assessment: Strength of Internal Control: Moderate

QUEST









Analysis

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

Hypoglycaemia (diabetic patients with low blood glucose) – 77.6%, an increase from 58.6 % in August. A recent update to the scripting contributed to the improved care bundle compliance. There has also been an increase in documenting each of the criteria for this care bundle; pre & post treatment blood glucose checks as well as treatment administered.

Fractured Neck of Femur (hip fracture) – 85.6%, an increase from 82.7 % in August. The use of a 'nudge tool' for analgesia implemented in June provided a prompt when important information is not documented. Compliance has consistently improved for this since then, with September analgesia being 96%, the highest since the electronic Patient Clinical Record was implemented.

Call to door times for Stroke and STEMI – the data has returned to a more consistent level for STEMI following the anomalies noted for August across WAST which were due to two incidents with a significantly extended incident cycle time.

Remedial Plans and Actions

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

- Focussed communication with clinicians to use the bespoke electronic Patient Clinical Record fields (in addition to the narrative).
- Providing weekly non-compliant data to support Senior Paramedics conversations with clinicians to improve compliance.
- Health Board focussed workshops to promote understanding of Clinical Indicators, care bundles and electronic Patient Clinical Record completion.
- Reviewing the scripting used for reports for each Clinical Indicator bundle.
- Following the success of the 'nudge' tool with analgesia for Fractured Neck of Femur (hip fracture), further 'nudges' are being implemented in a stepwise approach, those for Aspirin & GTN with STEMI, and aspects of ROSC are scheduled during October.

Expected Performance Trajectory

As a result of the work from the CI Recovery Group T&F group and the ongoing improvement interventions, a continued increase in compliance rates is expected and will be monitored by the Clinical Intelligence & Assurance Group.

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

(Responsible Officer: Liam Williams)

Concerns.

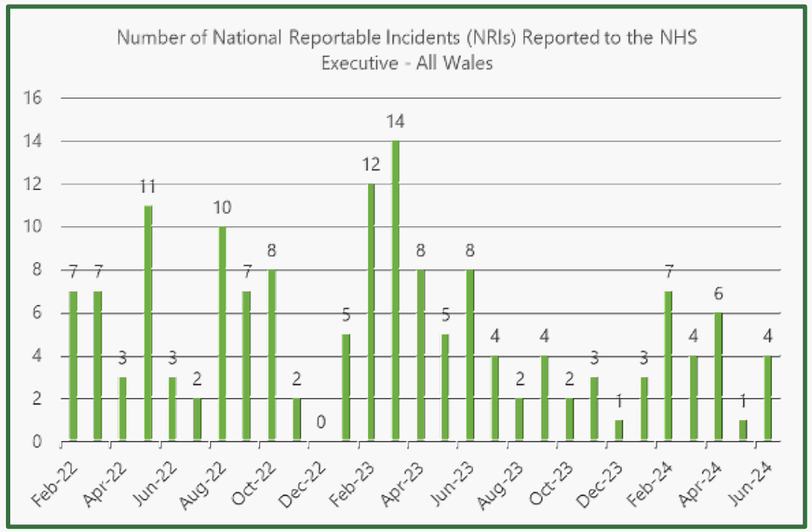
Self-Assessment: Strength of Internal Control: Moderate

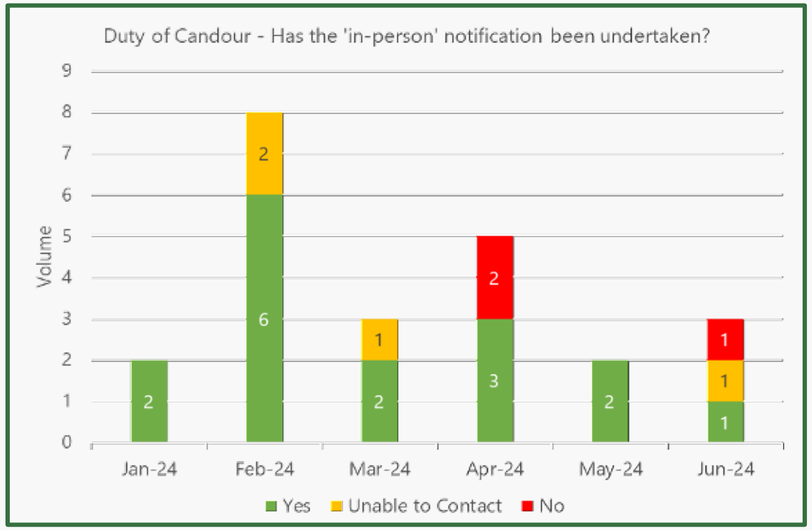
QUEST

Health & Care Standard
Health - Safe Care / Timely Care

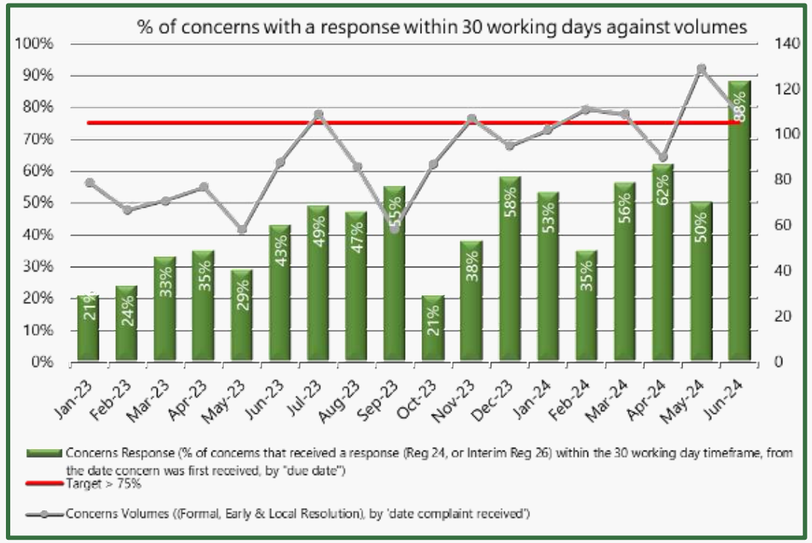
Responses Indicators

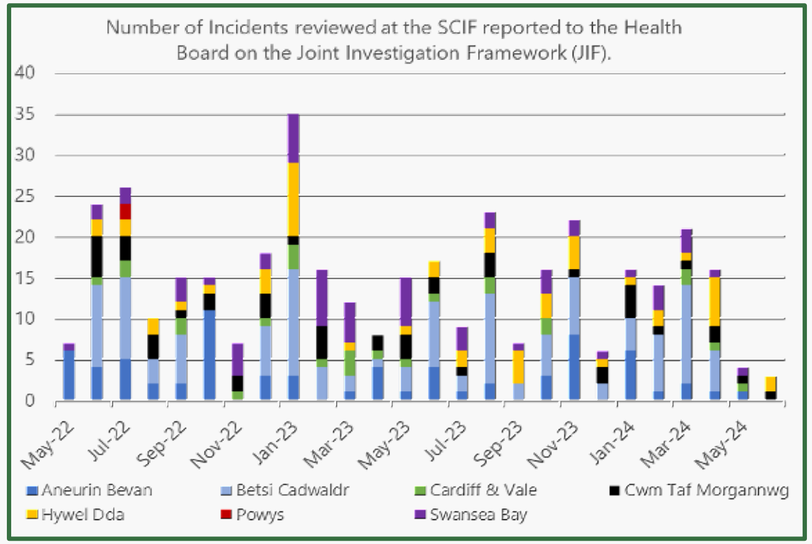
NB: Data quality issues have been identified in many Quality metrics. These are currently being addressed with no data available after June 2024.





No additional analysis possible given no data is currently available on these metrics.





*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

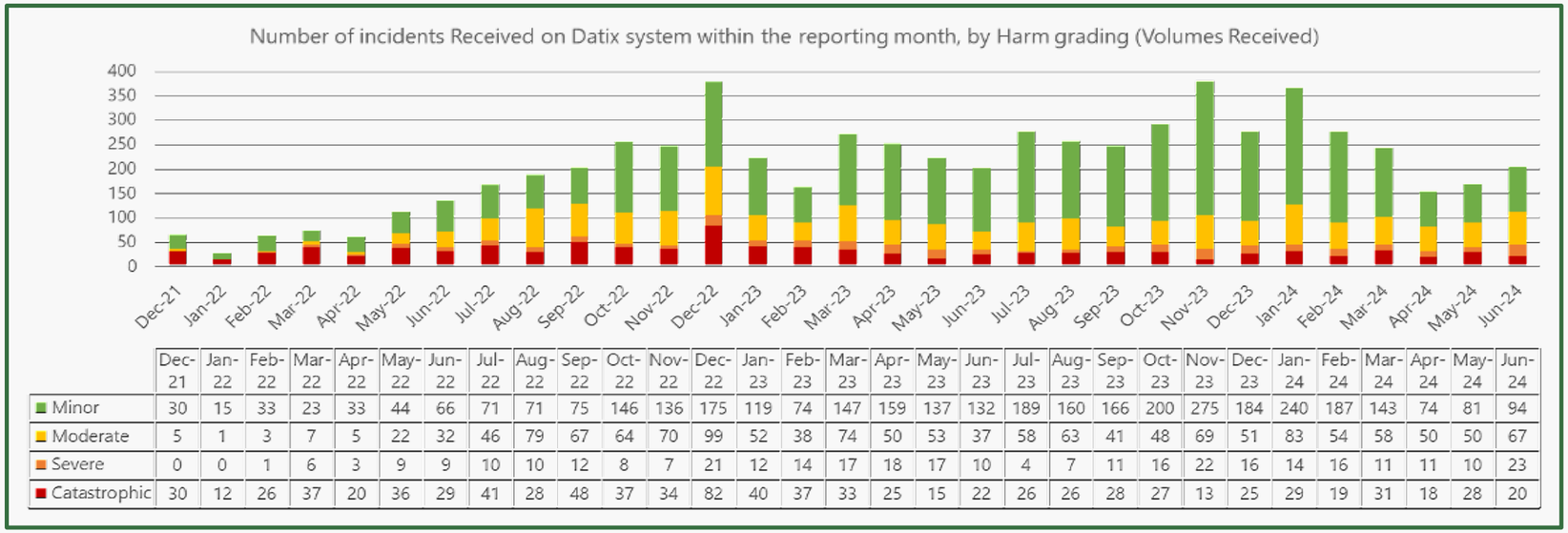
(Responsible Officer: Liam Williams)

Self-Assessment: Strength of Internal Control: Moderate

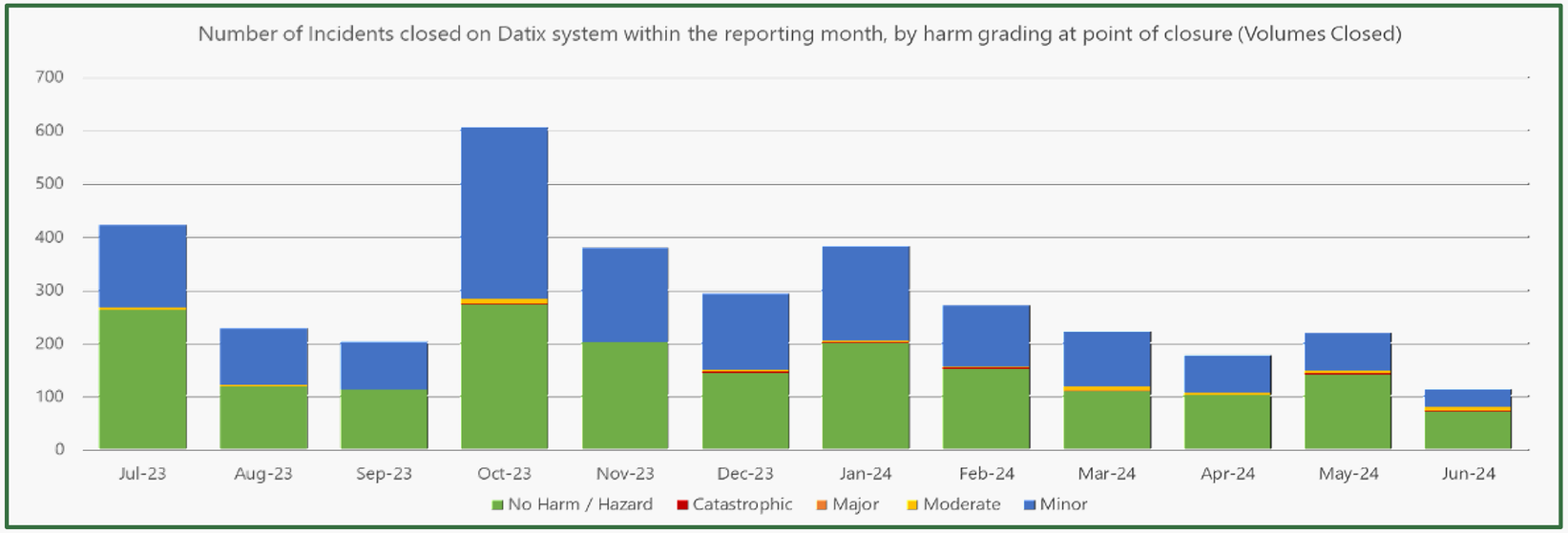
QUEST

Health & Care Standard
Health – Safe Care

NB: Data quality issues have been identified in Quality metrics . These are currently being addressed with no data available after June 2024.



	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Minor	30	15	33	23	33	44	66	71	71	75	146	136	175	119	74	147	159	137	132	189	160	166	200	275	184	240	187	143	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



No additional analysis possible given no data is currently available on these metrics.

Data source: Datix

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

(Responsible Officer: Liam Williams)

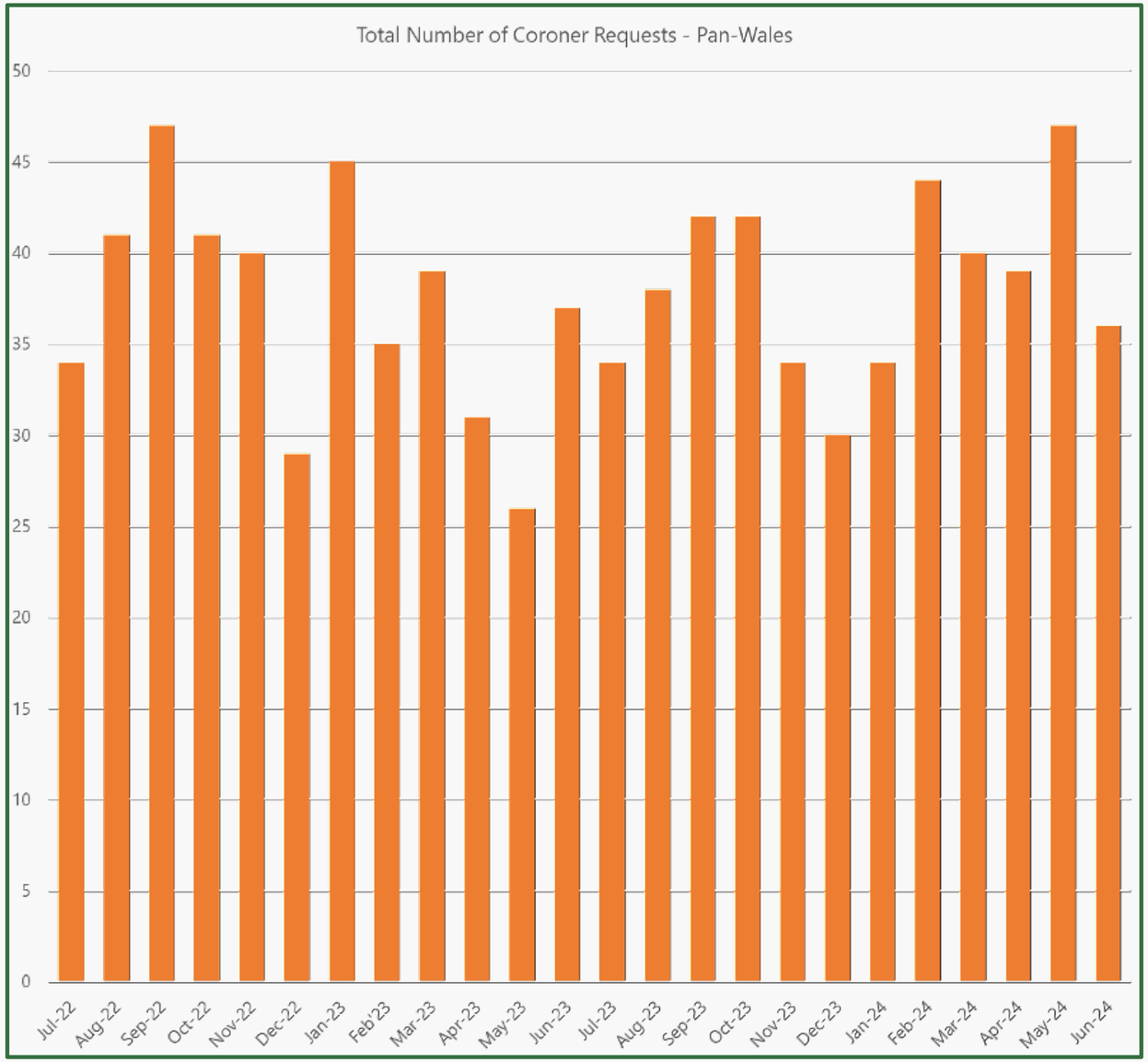
Coroners Self-Assessment: Strength of Internal Control: Moderate

Mortality Self-Assessment: Strength of Internal Control: Moderate

QUEST

Health & Care Standard
Health – Safe Care

NB: Data quality issues have been identified in Quality metrics . These are currently being addressed with no data available after June 2024.



No additional analysis possible given no data is currently available on these metrics.

*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

Mortality Reviews Data source: Internal Web Application

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

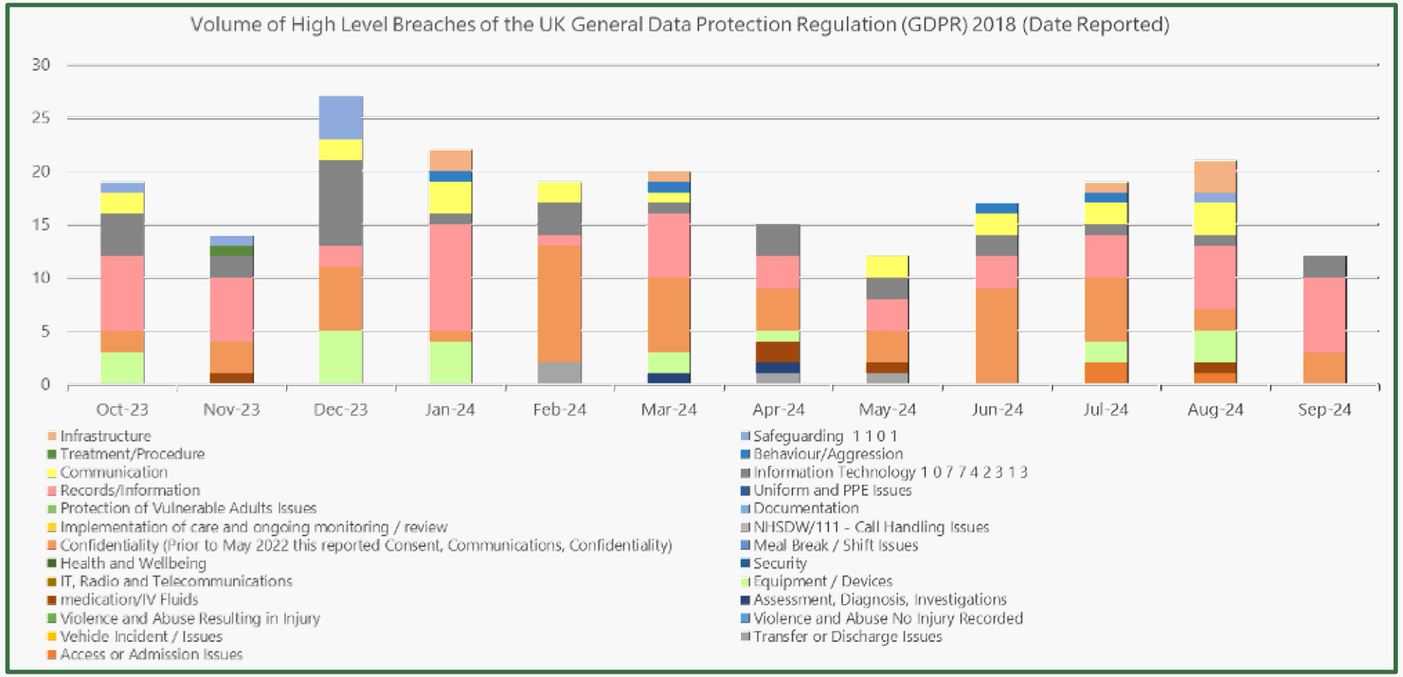
(Responsible Officers: Jonny Sammut & Liam Williams)

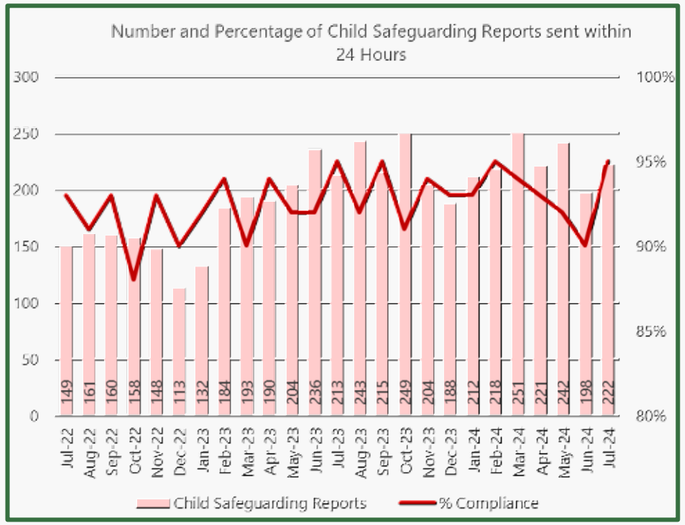
Self-Assessment: Strength of Internal Control: Strong

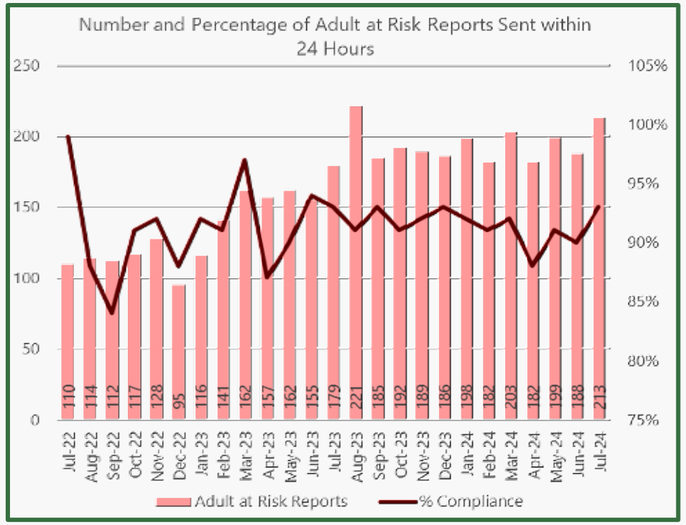
PCC

Health & Care Standard
Health – Safe Care

NB: Data quality issues have been identified within Safeguarding. These are currently being addressed.







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 a 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 September 2024, there were 12 information governance (IG) related incidents reported on Datix Cymru categorised as an Information Governance (IG) breach. Of these 12 breaches, 3 related to IG/Confidentiality, 7 Records/Information, and 2 Information Technology.

Public Engagement: During September, PECI attended 15 community engagement opportunities, engaging with approximately 1,628 people. This included attending the Cardiff 999 Emergency Services Day and North Wales Police Open Day. This month we also attended the Cardiff Metropolitan University and University of Cardiff Student Fresher Fayres. At these events we were able to talk to young adults about their experiences of using the service as well as promoting the safe and appropriate use of services, promote the NHS 111 Wales service and the Press 2 option for people struggling with their mental health. We continued to engage with colleagues from Llais and attended 2 meetings with regional branches.

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. 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.

Data Governance: During the reporting period, of the 12-information governance related incidents reported on Datix, 0 incidents were reported to the Information Commissioner's Office (ICO). The IG Team continues to review and provide advice on reported incidents where applicable.

Public Engagement: The PECI Team will continue to engage in an ongoing dialogue with the public on what they think are important developments the Trust could make to improve services they receive. We are actively working with colleagues across the Trust in a number of different departments to try and agree on solutions that would allow us to directly contact more patients to ask for feedback about their experiences with us.

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 status of the Action Plan is reported to and monitored by IGSG.

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*

Safeguarding Data source: Doc Works

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

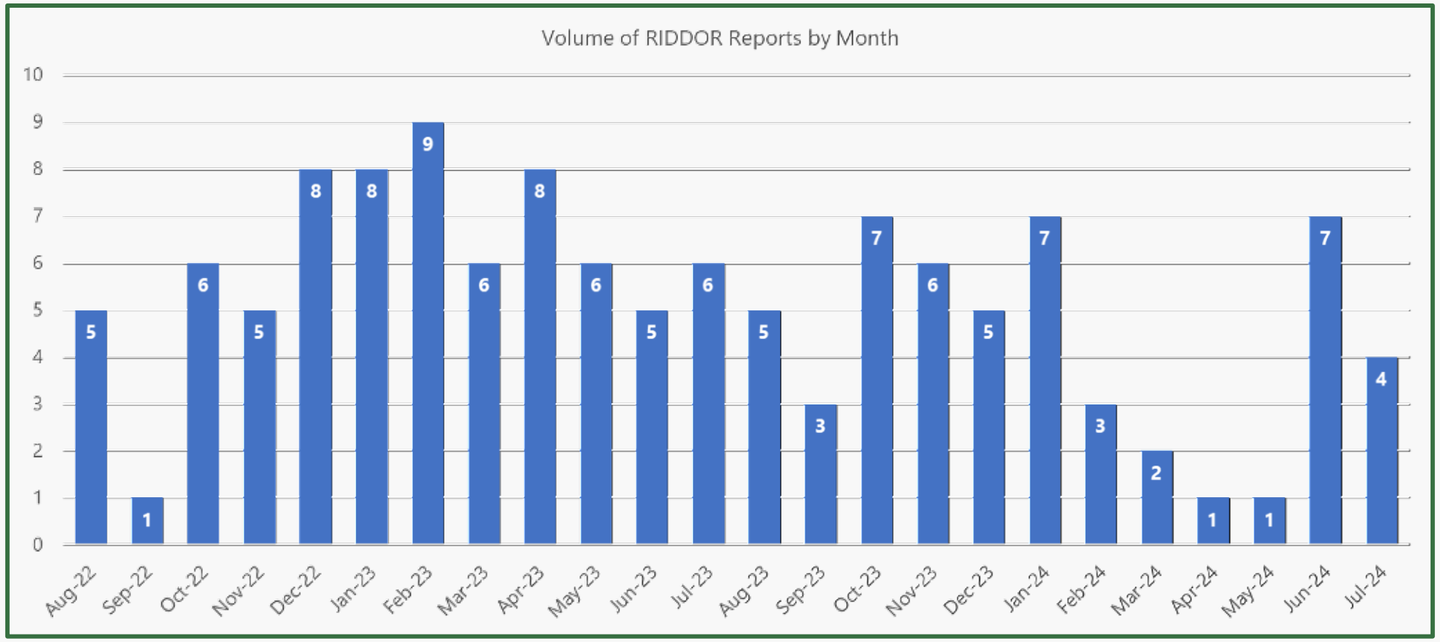
(Responsible Officer: Liam Williams)

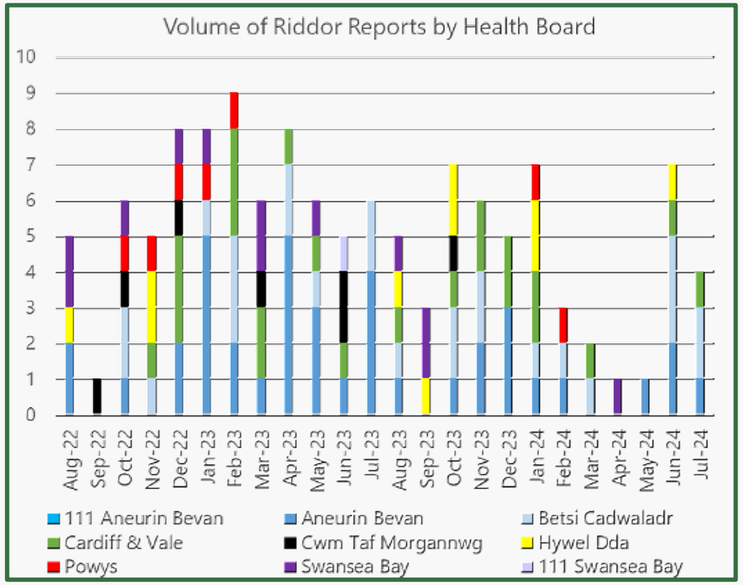
Self-Assessment: Strength of Internal Control: Moderate

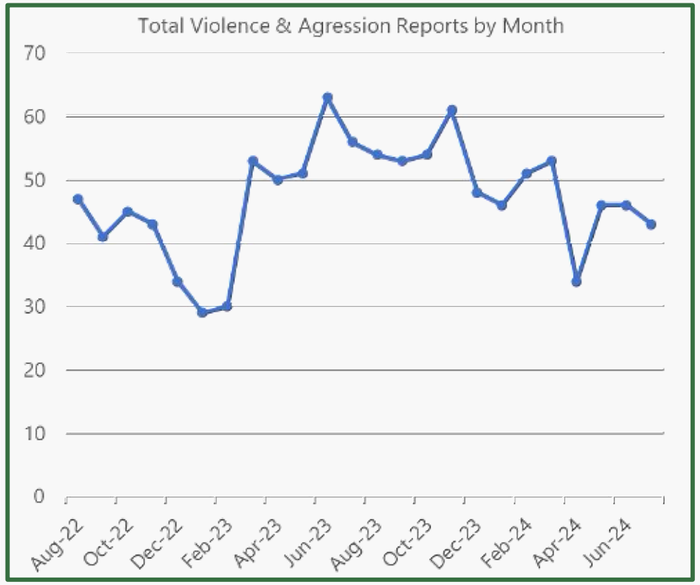
PCC

Health & Care Standard
Health – Safe Care

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





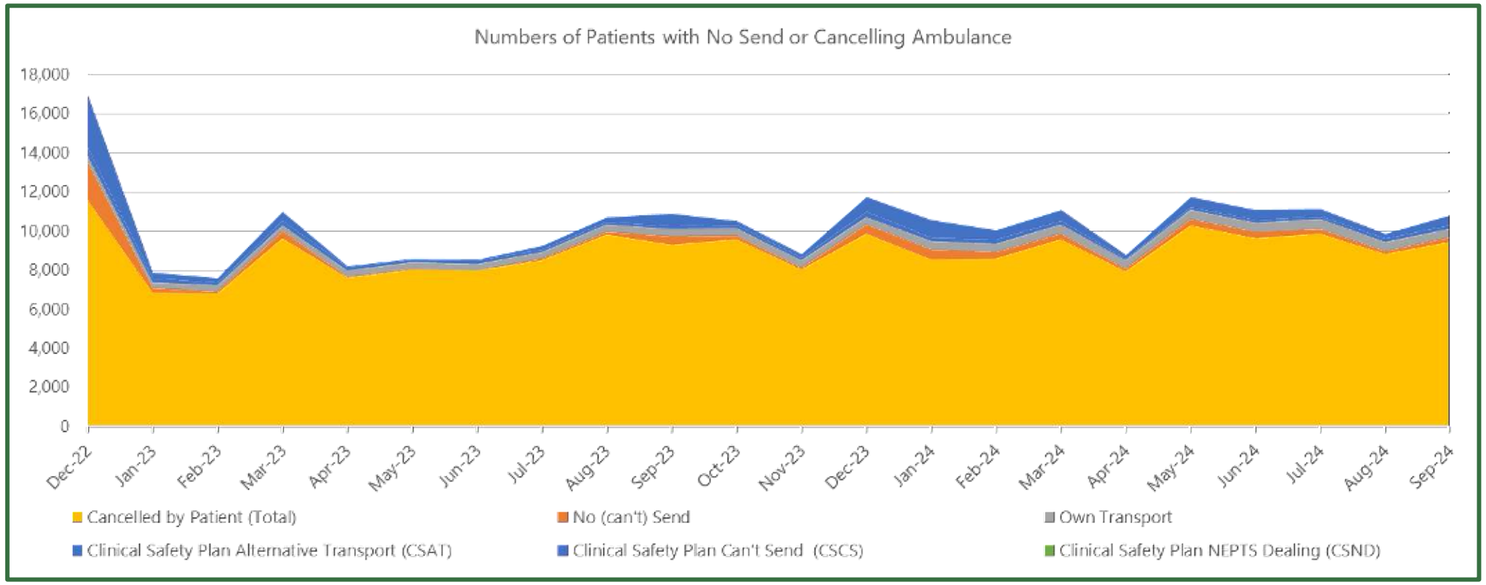


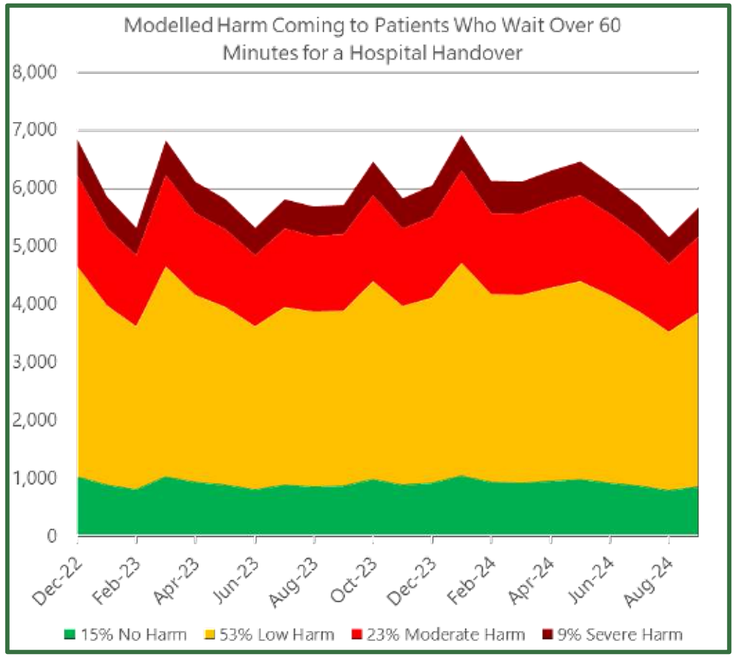
No additional analysis possible given no data is currently available on these metrics.

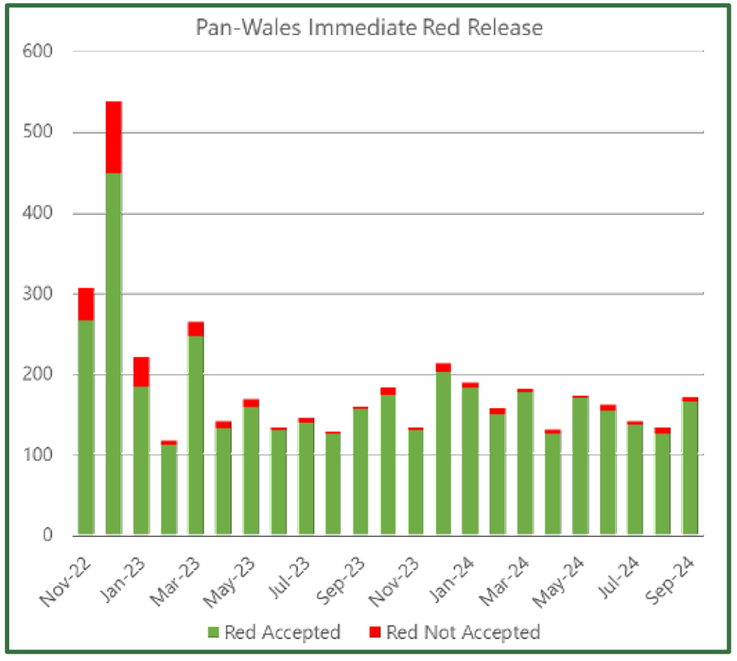
Data source: Datix

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

(Responsible Officer: Andy Swinburn) A FPC







Analysis

In September 2024, 190 ambulances were stopped due to Clinical Safety Plan (CSP) alternative transport and 481 were stopped due to CSP 'Can't Send' options. In addition, 9,421 ambulances were cancelled by patients (including patients refusing treatment at scene) an increase from the 8,785 in August 2024.

There were 691 requests made to Health Board EDs for immediate release of Red or Amber 1 calls in September 2024. Of these 165 were accepted and released in the Red category, with 6 not being accepted. Further to this, 165 ambulances were released to respond to Amber 1 calls, but 355 were not.

The graph in the bottom left shows that in September 2024 of the 5,665 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% (850 patients) would experience no harm, 53% (3,002 patients) would experience low harm, 23% (1,303 patients) would experience moderate harm and 9% (510 patients) would experience severe harm.

In September 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

September 2024		
NEPTS (161 responses)	Benchmark	Score
How long did you wait for your transport to take you home after your appointment.	85	82
Were you happy with the transport you received?	85	94
999 (23 responses)	Benchmark	Score
The 999-call taker who answered your call was reassuring.	85	54
The 999-call taker who answered your call explained what was going to happen next.	85	60
You felt confident in the call taker ability to manage your call and provide appropriate advice.	85	53
The length of time I waited for an ambulance to arrive was acceptable.	85	50
111 (18 responses)	Benchmark	Score
Do you feel your call to 111 Wales was helpful?	85	65
Did you follow the advice given to you by NHS 111 Wales?	85	88
Would you consider using NHS 111 Wales again?	85	64
WAST Overall - Friends & Family Test How was your overall experience with the service today?	Ranked from very poor to very good.	
o Ambulance care	91.91% Good	3.68% Poor
o Integrated Care (NHS 111 Wales Telephone line only)	60.00% Good	26.67% Poor
o EMS (including CSD)	43.48% Good	43.48% Poor
o NHS 111 Wales Online	57.89% Good	21.05% 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=94).

Two questions within the 999-section failed to achieve the benchmark, these being 'The 999-call taker who answered your call was reassuring' (n=54) and 'You felt confident in the call taker ability to manage your call and provide appropriate advice?' (n=53), whilst within 111 only one question 'Did you follow the advice given to you by NHS 111 Wales' achieved the benchmark (85) with 88, however the other questions failed to achieve the benchmark.

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 999 service users.

•Plans to place QR codes in the back of EMS vehicles to increase patient feedback are progressing and we have spoken to IPC and Fleet colleagues about what is needed to proceed.

•We 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. Plans are in place to duplicate this method of survey delivery with patients attended to by a CWR Volunteer.

•We continue to engage with the Once for Wales Programme Board who have updated the 'All Wales Patient Experience Question Set' and 'People's Experience Framework'. The Framework and new questions will be formally launched by WG in the coming months.

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)

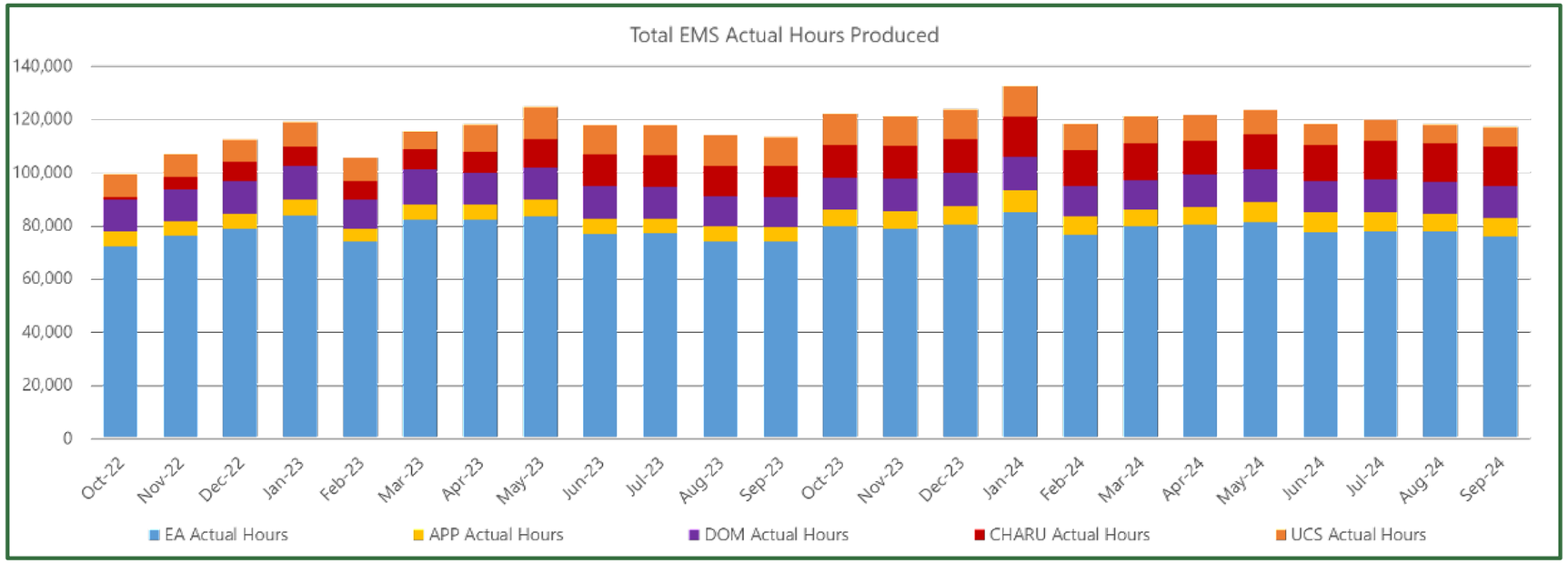
EA Production: G

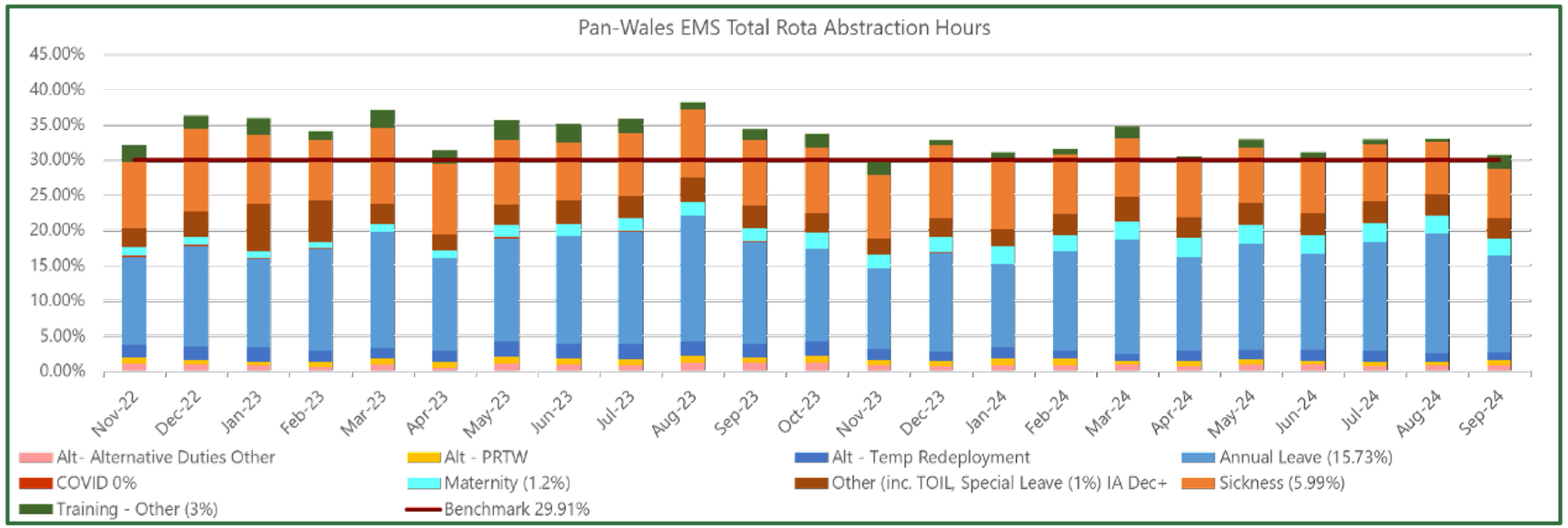
Abstractions: A

CI

PCC

FPC





Analysis

The total EMS hours produced is a key metric for patient safety. The Trust produced 116,986 hours during September 2024, an increase compared to the 113,409 hours produced during September 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. September 2024, saw a total EMS abstractions (excluding Induction Training) of 30.72%. This was a decrease on the 33.07% recorded in August 2024. The highest proportion of abstractions was due to annual leave at 13.67% followed by sickness at 6.97%.

Emergency Ambulance Unit Hours Production (UHP) achieved 95% in September 2024 which equated to 75,846 Actual Hours.

In September 2024 CHARU UHP was 84% against the full roll out requirement.

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.
- Focus on recruitment to reduce identified vacancy gap, in particular, EMTs and APPs.

Expected Performance Trajectory

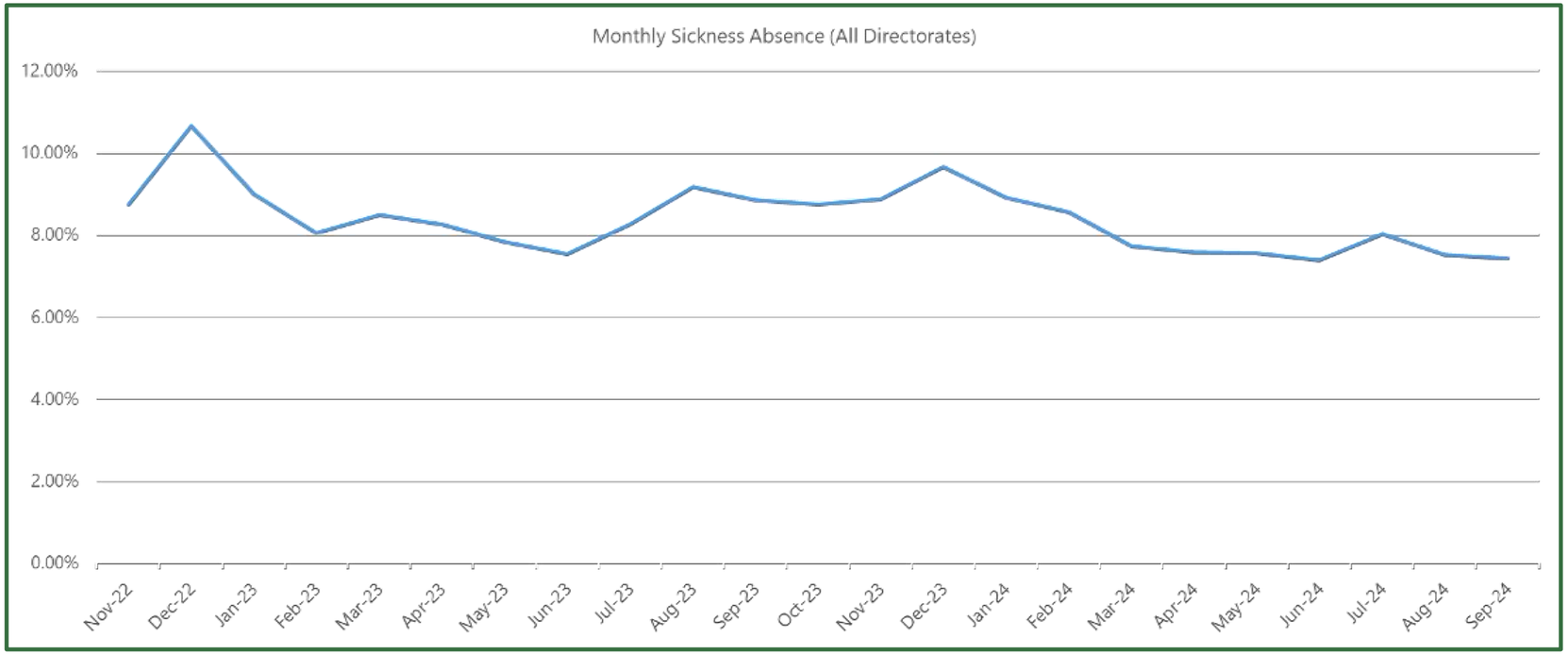
UHP estimates, based on recruitment levels, estimated abstractions and overtime have been provided to ELT. Production is good.
The Trust maintains an ambition to reduce sickness to 6% and abstractions to 30%. This has not yet been achieved for sickness, but the direction of travel is good, while the abstractions benchmark has been achieved a number of times this year.

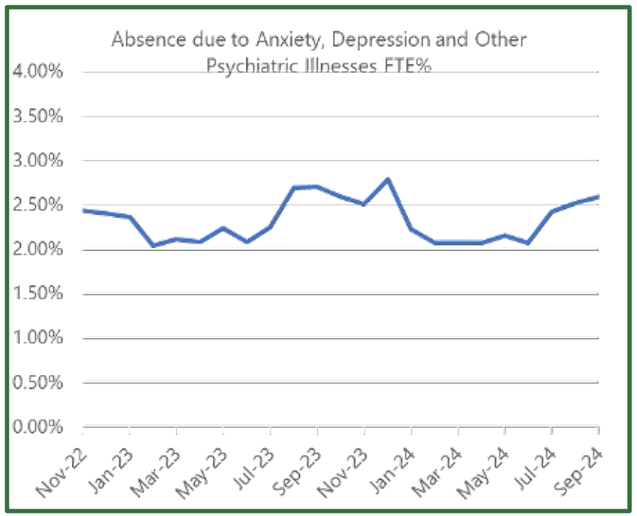
Our People
Capacity - Sickness Absence Indicators

(Responsible Officer: Angela Lewis)

Mental Health
A

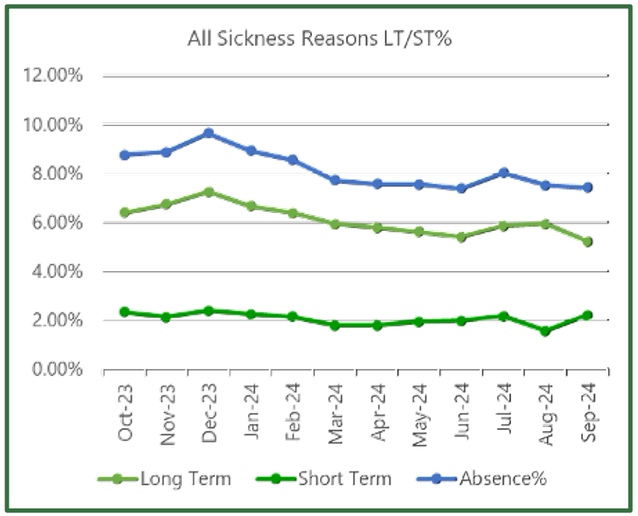
CI





Average working days lost per FTE (Annual)	
18.64 days	
Single month Absence %	
7.43%	
Long Term	**Short Term**
5.22%	2.21%
Mental Health	**Other MSK**
(S10 Stress/Anxiety)	(excluding Back)
2.59%	0.90%

September 2024



Analysis

There was a slight decrease in overall sickness absence rates between August 2024 and September 2024, dropping from 7.52% to 7.43%. Long term absence also decreased from 5.95% in August 2024 to 5.22 % in September 2024, while short-term absence increased slightly to 2.21% in September from August 2024 (1.57%).

The highest reasons for absence in September 2024 were Anxiety/ Stress/ Depression, back problems, other musculoskeletal problems and cold, cough, flu/influenza. Absence due to Mental Health increased from 2.52% in September 2024 to 2.59% in September 2024.

109 OH management referrals were received in September and the number of self-referrals is increasing, (30 self-referrals in September compared to 22 in August).

In September we received a total of 68 Wellbeing referrals, offered 81 assessment appointments and completed 51 wellbeing assessment appointments for signposting. There were 32 wellbeing management referrals, 16 self-referrals and 20 walk-in appointments.

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.

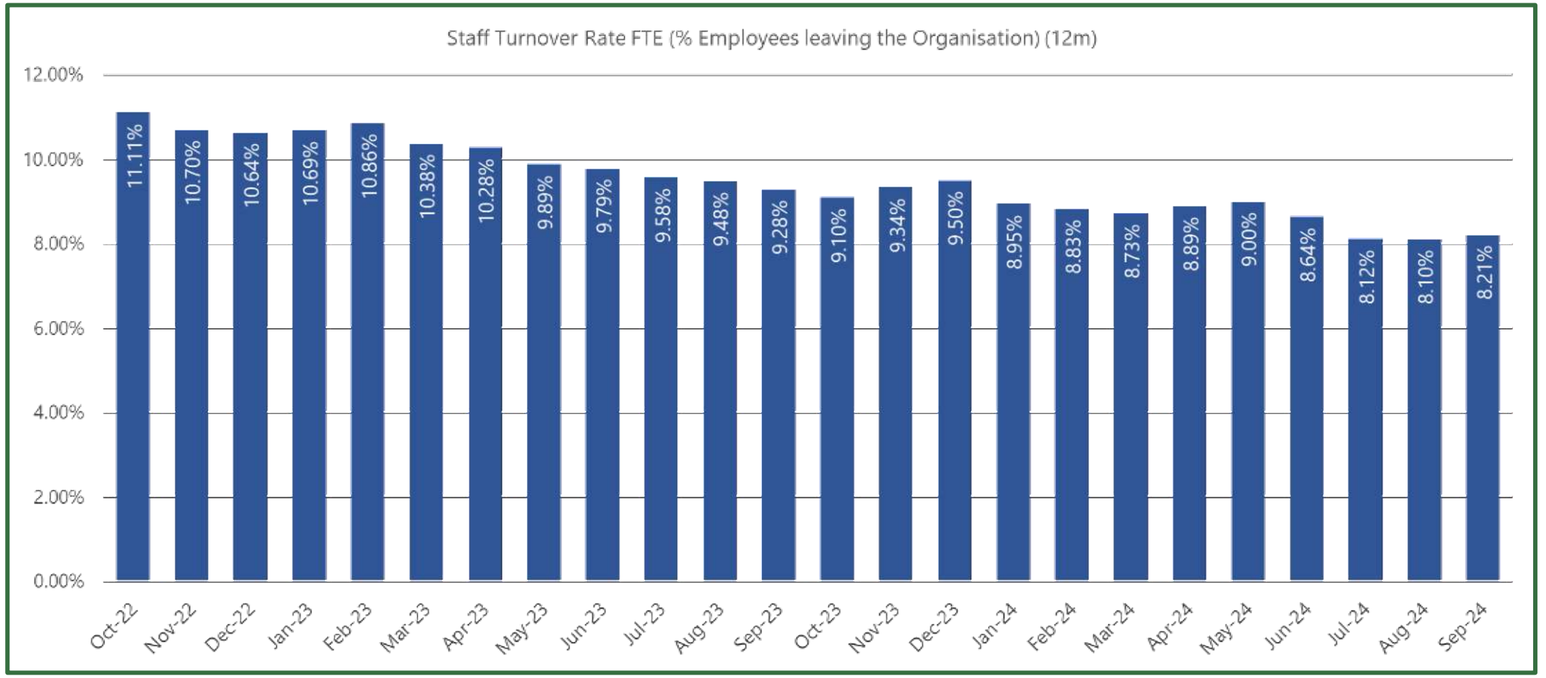
Expected Performance Trajectory

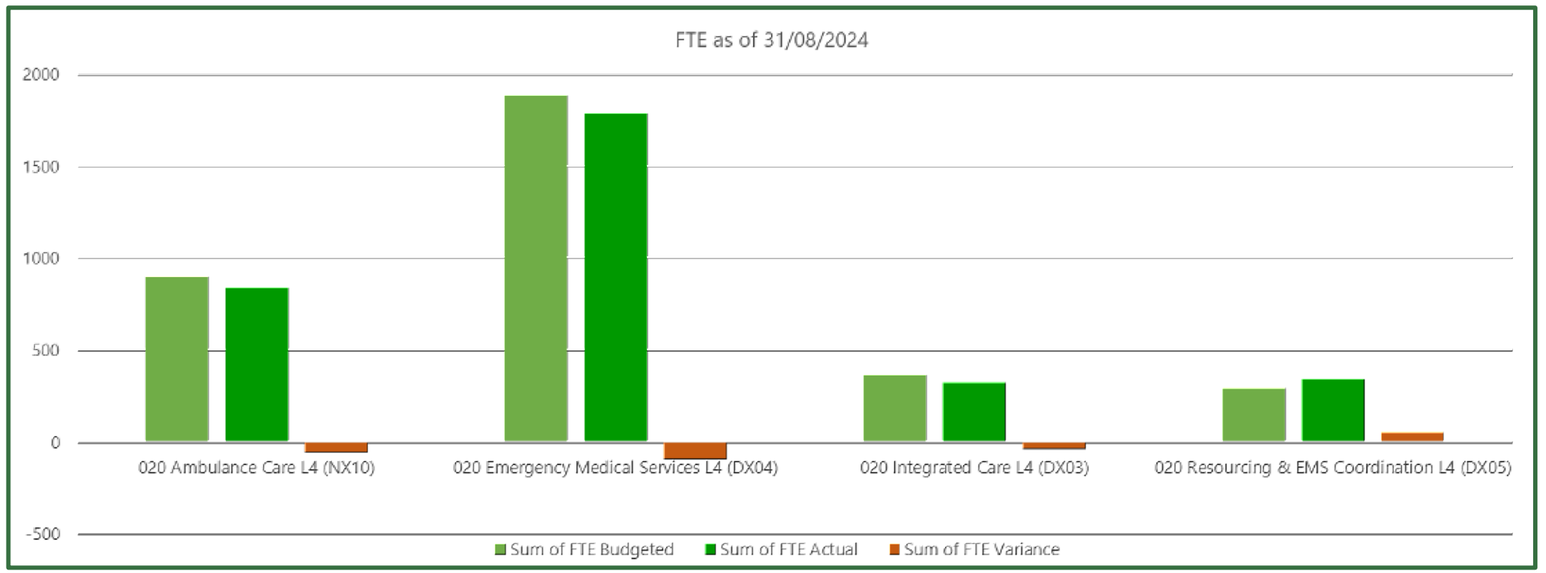
The Trust has indicated through its IMTP that sickness levels will fall in this financial year, but that there remain risks to delivery.

Our People
Capacity - Turnover

(Responsible Officer: Angela Lewis)

G





Analysis

Staff turnover rates in September 2024 were 8.21%, a slight increase from the 8.10% recorded in August 2024. September saw 33 leavers (27.17 FTE). Turnover in months at the end of the quarter are generally higher. This was balanced with 56 joiners (51.45 FTE) in September, of those leaving, the group with the greatest number were Emergency Medical Dispatchers (6 people).

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 29 working days. From receipt of Wellbeing referrals to first call (from one of our Wellbeing Practitioners), the waiting time is still 1-2 days.

Remedial Plans and Actions

- We are working to improve our data collection through Our MI system (Opas G2). The (All Wales) decision has been made to extend the contract with Civica for 1 year (as opposed to 2 years) for our MI system, Opas G2.
- The team continue to support staff by providing advice and guidance on how to use the MI system and have facilitated events.
- 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 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.
- The Health and Wellbeing strategy for 2025/29 is out for consultation.
- The team have been working closely with the Clinical Directorate flu project team for the start of the 2024/25 flu campaign, they have been holding flu clinics across the regions, a full schedule of clinics is available on Siren.
- Working on re-evaluating plans/timelines to attain SEQOHS accreditation. A meeting with SEQOHS has been scheduled with a deadline of the end of November 2024.

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

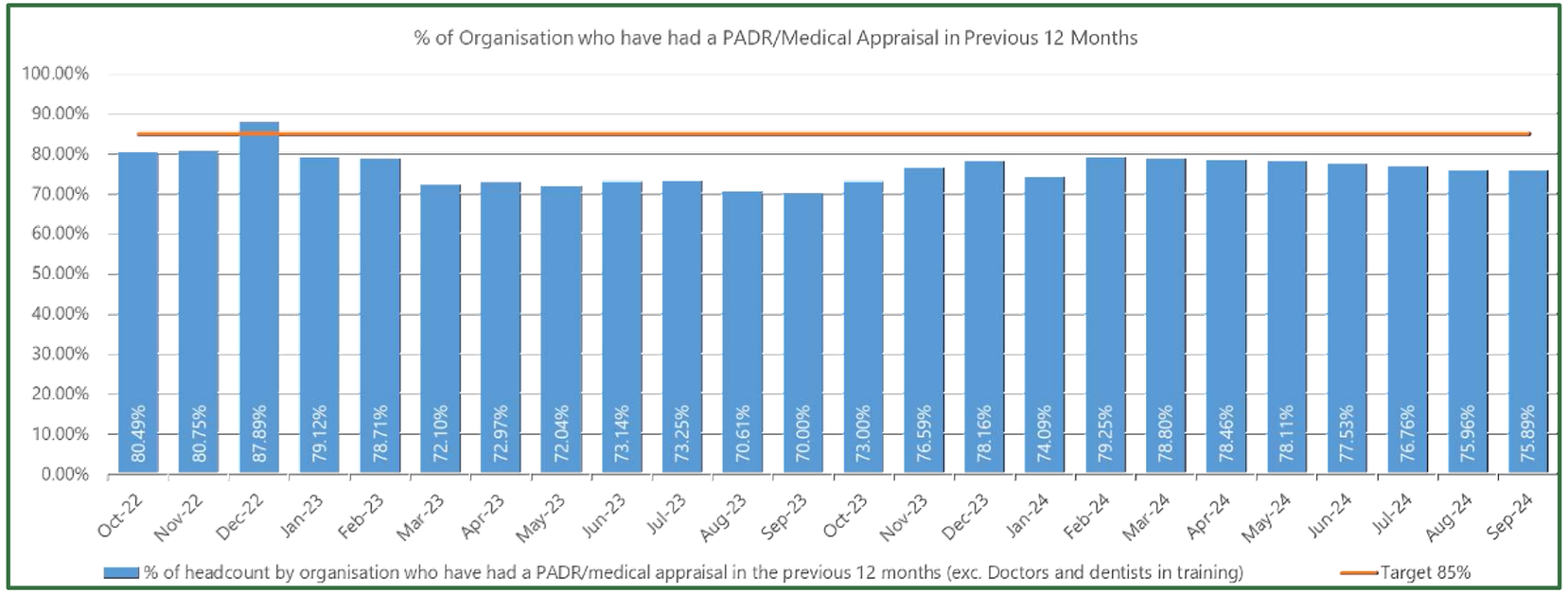
Stat & Mand: R

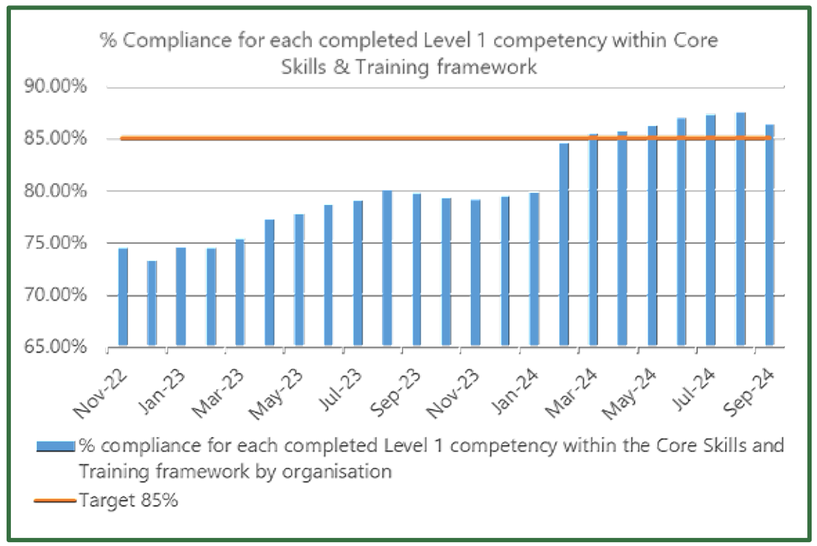
CI

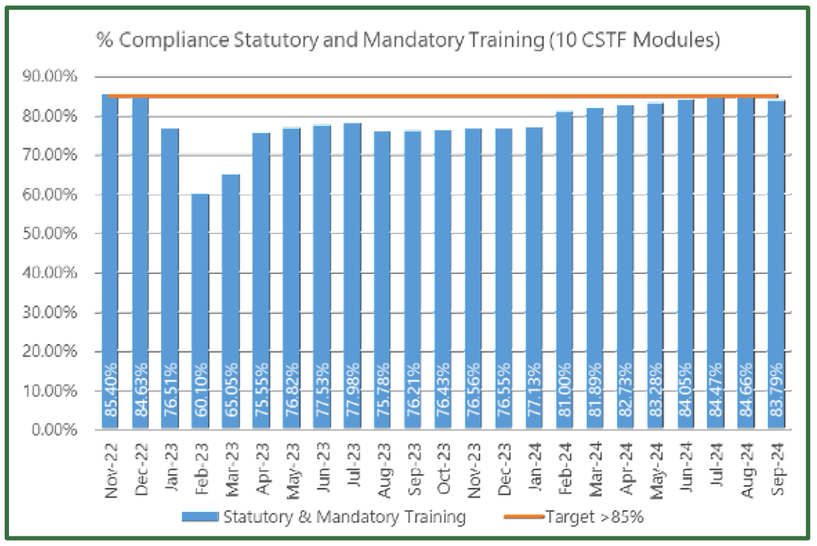
PCC

Health & Care Standard
Health – Staff & Resources

Self-Assessment: Strength of Internal Control: Strong







Analysis

PADR rates minimally decreased from 75.96% in August 2024 to 75.89% in September 2024 and remain below the 85% target. Over the reporting period this target has only been achieved once, in December 2022.

In September 2024 Statutory & Mandatory Training rates reported a combined compliance of 83.79%; which is the first time in 9 months that here has been a decline. However, only Dementia Awareness (95.15%) and Moving & Handling (92.88%), achieved the 85% target. Equality & Diversity (82.48%), Safeguarding Adults (83.47%). Fire Safety (78.97%), Information Governance (76.48%), Violence Against Women, Domestic Abuse & Sexual Violence (72.62%), Paul Ridd (72.39%), Fraud Awareness (68.09%) and Welsh Language Awareness (66.46%) all remain below this target.

There are currently 18 Statutory and Mandatory courses that NHS employees must complete in their employment. These are listed in the table:

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.

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, Diveristy & 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	Yearly
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
Enviroment, Waste and Energy (Admin & Clerical Staff only)	Yearly
Duty of Quality	3 years
Fraud Awareness	3 years
Prevent Awareness	No Renewal

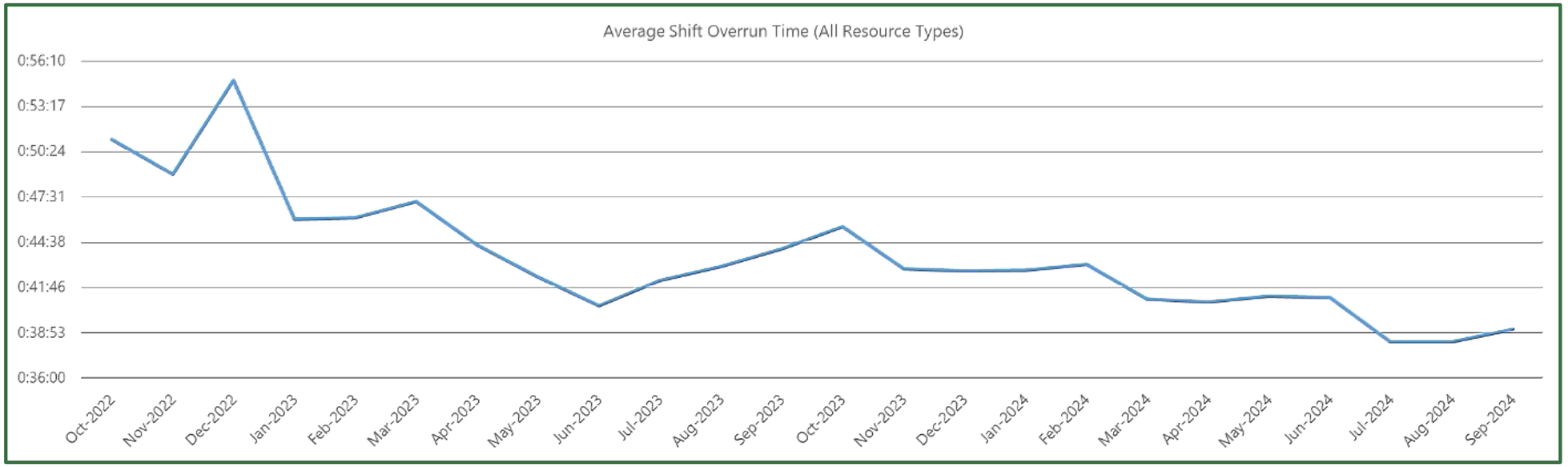
Data source: ESR

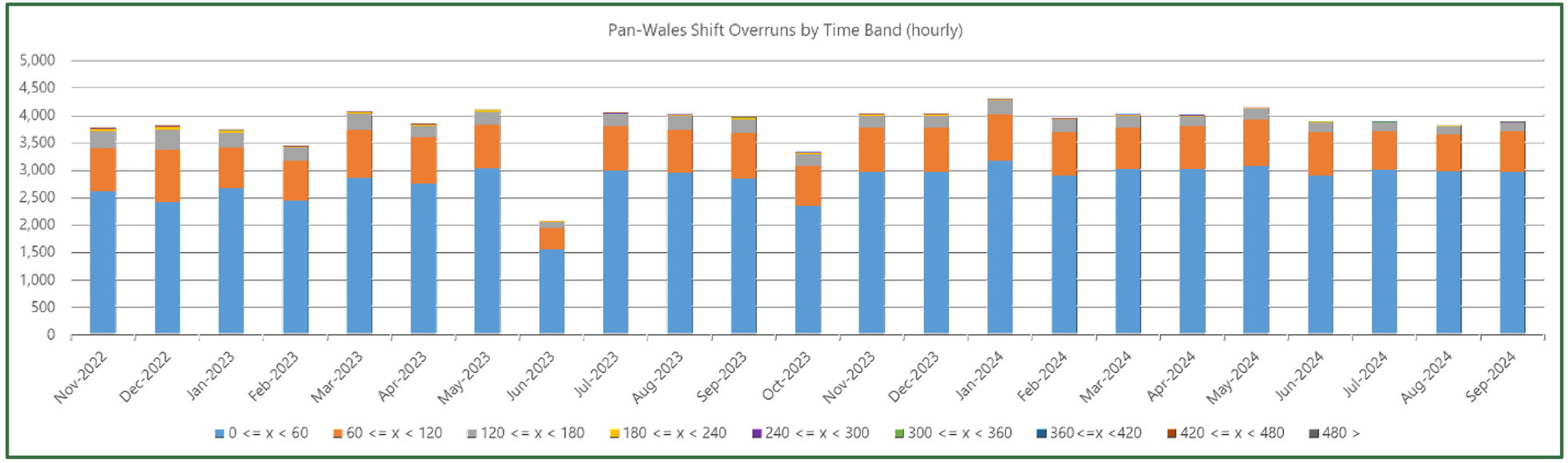
Our People
Health and Well-being – Shift Overruns

(Responsible Officer: Angela Lewis)

Overruns
R

CI





Analysis

The average overrun figure for September 2024 was 39 minutes and 7 seconds, a minimal increase from August 2024 (00:38:17). 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 74.6% of the total. 19.7% fall within the 61 to 120-minute category, 5.1% in the 121 to 180-minute category, 0.4% 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

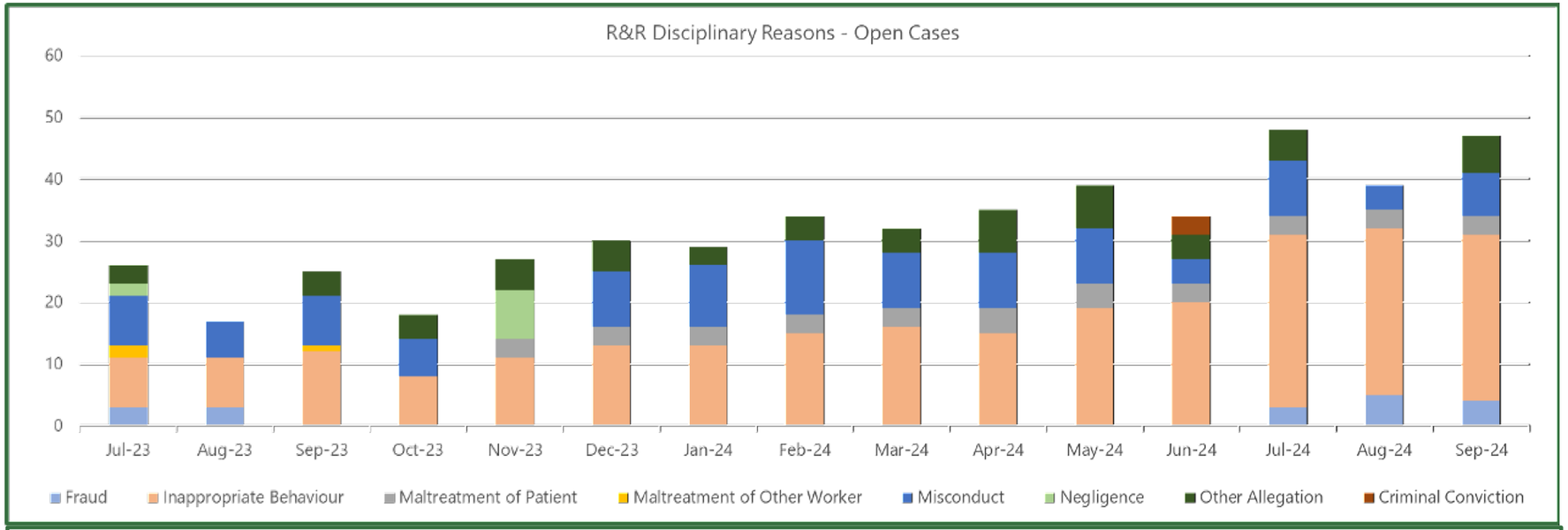
Overruns correlate with handover lost hours. As we have moved out of winter both levels had started to drop. We may expect this to stabilise before moving into higher levels again next winter.

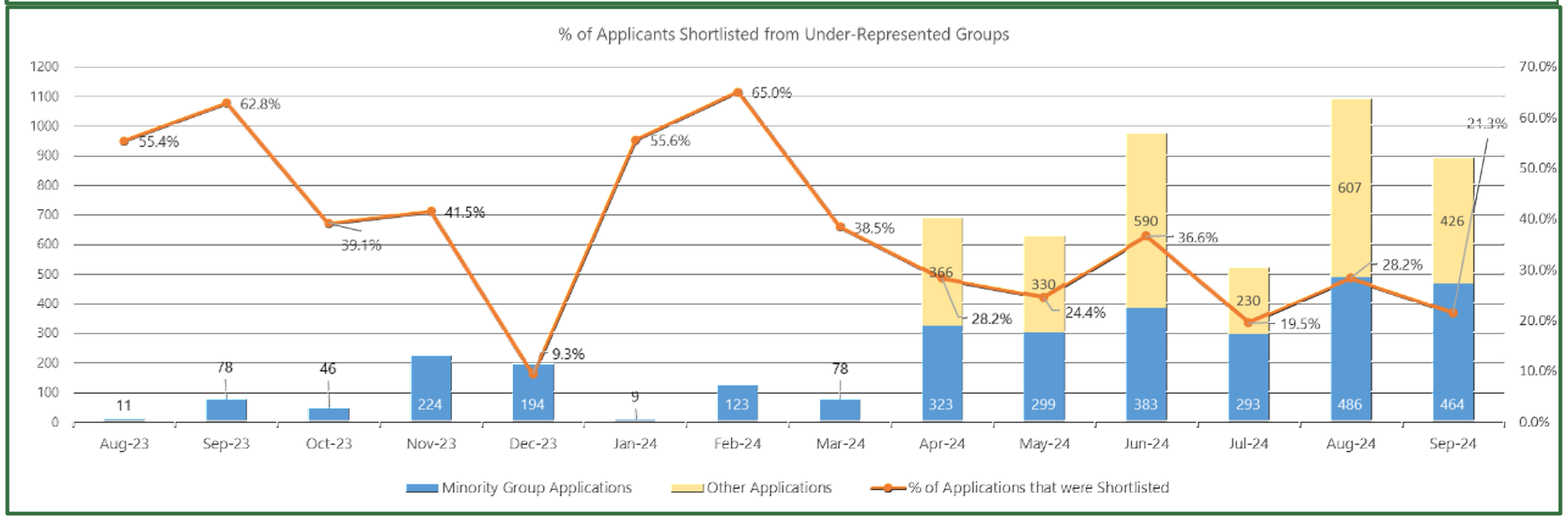
Our People
Culture – Number of R&R Disciplinary Hearings and Number of Applicants Shortlisted from Under-Represented Groups

(Responsible Officer: Angela Lewis)

Self-Assessment: Strength of Internal Control: Moderate

PCC





Analysis

There were 47 open formal disciplinary cases recorded at the end of September 2024; an increase compared to 39 in August 2024 which was 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 13 open formal Respect and Resolution cases submitted by employees in September 2024, four less than in August 2024. These are a mixture of both Respect and Resolution Grievances and Dignity at work.

The bottom graph shows that in September 2024, 890 job applications were processed, and 318 interviews were planned.

Of the 890 applications, a total of 464 were from under-represented groups with 341 in the category of Ethnicity, 71 within Disability and 52 within Sexual Orientation.

In September 2024, 28123 (n=99) of all applications from under-represented groups made it through shortlisting and were invited for interview. This was a decrease from the 28.2% in August 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. One workshops has taken place, with a second to take place in Nov-24 to recruit for Black, Asian and Ethnically diverse applicants into our digital roles.
Unconscious bias training is also being undertaken my managers in the Digital directorate to assist with recruitment.

Expected Performance Trajectory

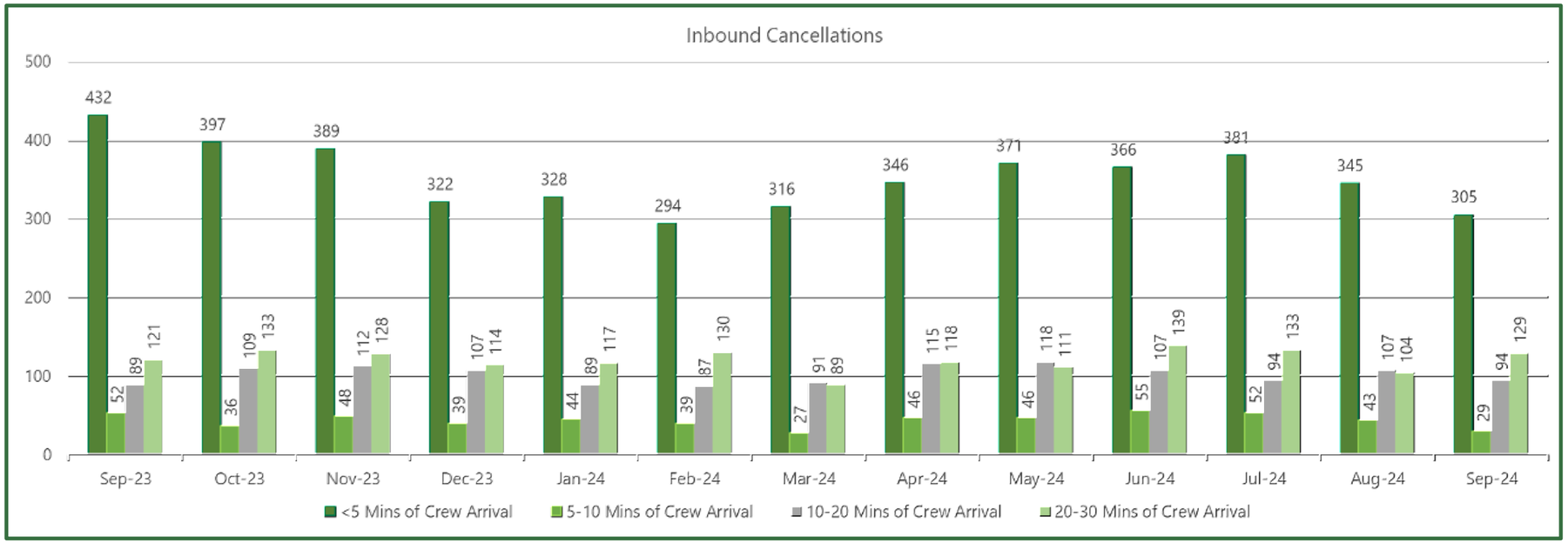
Continue to monitor levels, no trajectory for this measure.

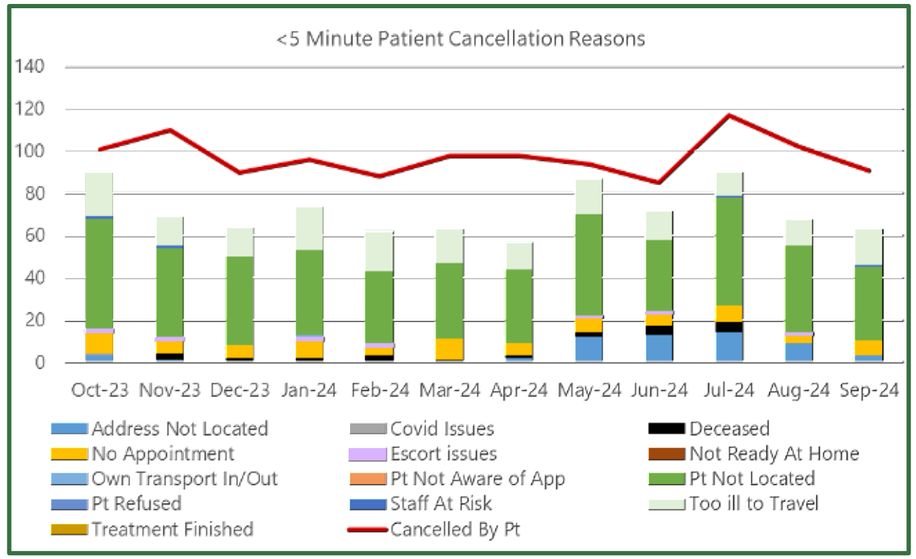
Finance, Resources and Value
Value: Ambulance Care Indicators

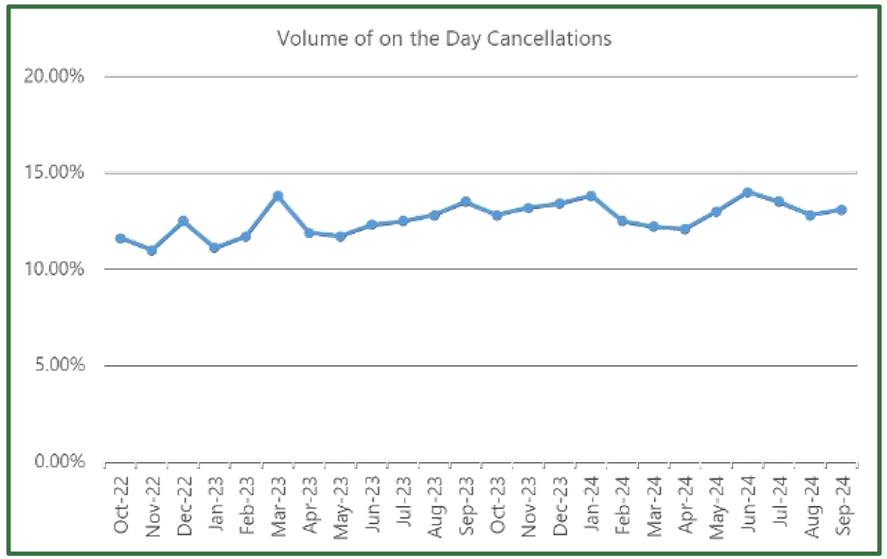
(Responsible Officer: Lee Brooks)

Cancellations

G







Analysis

Inbound cancellations of 5 minutes or less of the crew arrival time saw a decrease in September 2024 to 305, compared to 345 in August 2024. The total number of cancellations within 30 minutes decreased from 599 in August 2024 to 557 in September 2024.

In September 2024 there were 91 appointments cancelled by patients, decreasing from 102 in August 2024.

The other top reasons for less than 5-minute cancellations included: 35 patients not located, 17 unwell/too ill to travel and 7 no appointment.

Same day cancellations increased slightly in September to 13.1% from August 2024 (12.8%).

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. 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.

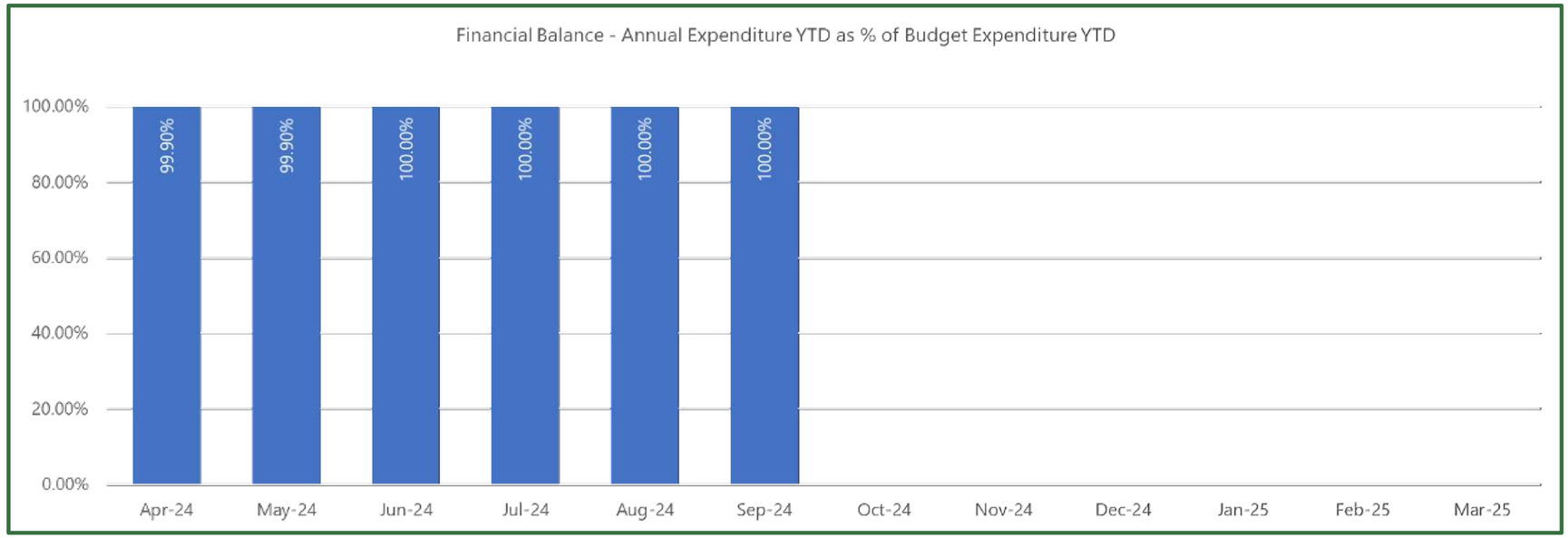
**Please note that MDTs do not appear to provide specific cancellation reasons for either inbound or outbound journeys. There are at present multiple and duplicated reasons both crews, control and the liaison desk can select.*

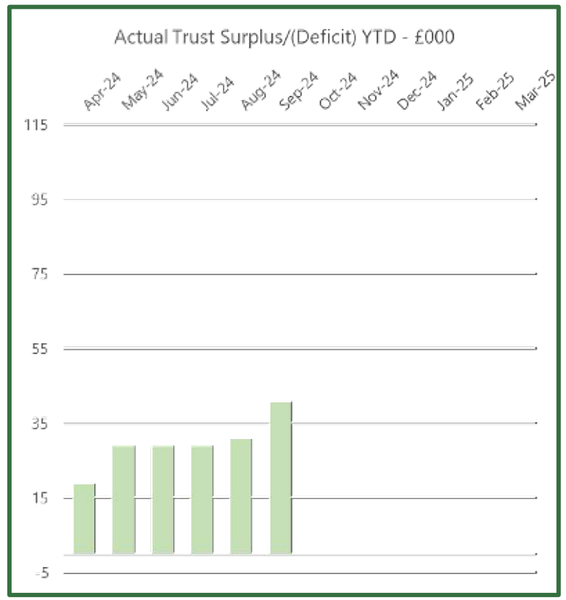
Finance, Resources and Value
Value - Finance Indicators

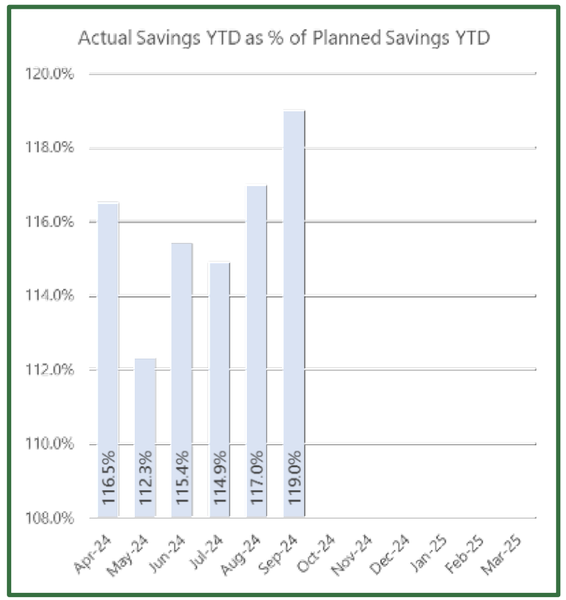
(Responsible Officer: Chris Turley)

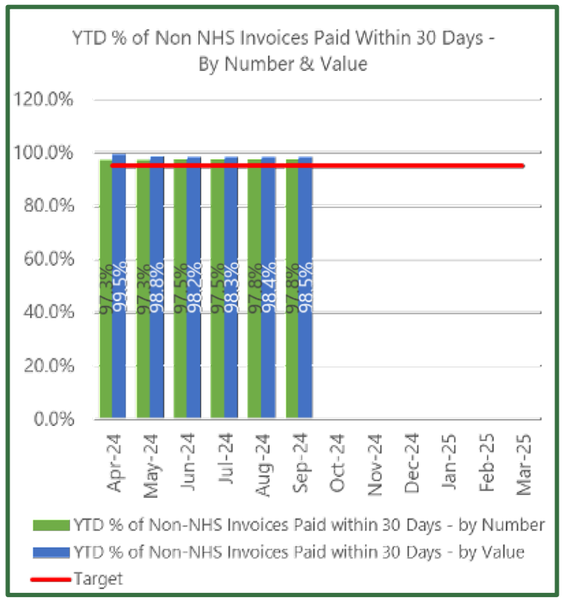
G

FPC









Analysis

The reported outturn performance at Month 6 is a surplus of £41k.

For Month 6 the Trust is reporting planned savings of £3.369m and actual savings of £4.013m (an achievement rate of 119.1%).

The Trust's cumulative performance against PSPP as at Month 6 is 97.8% against a target of 95%.

At Month 6 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

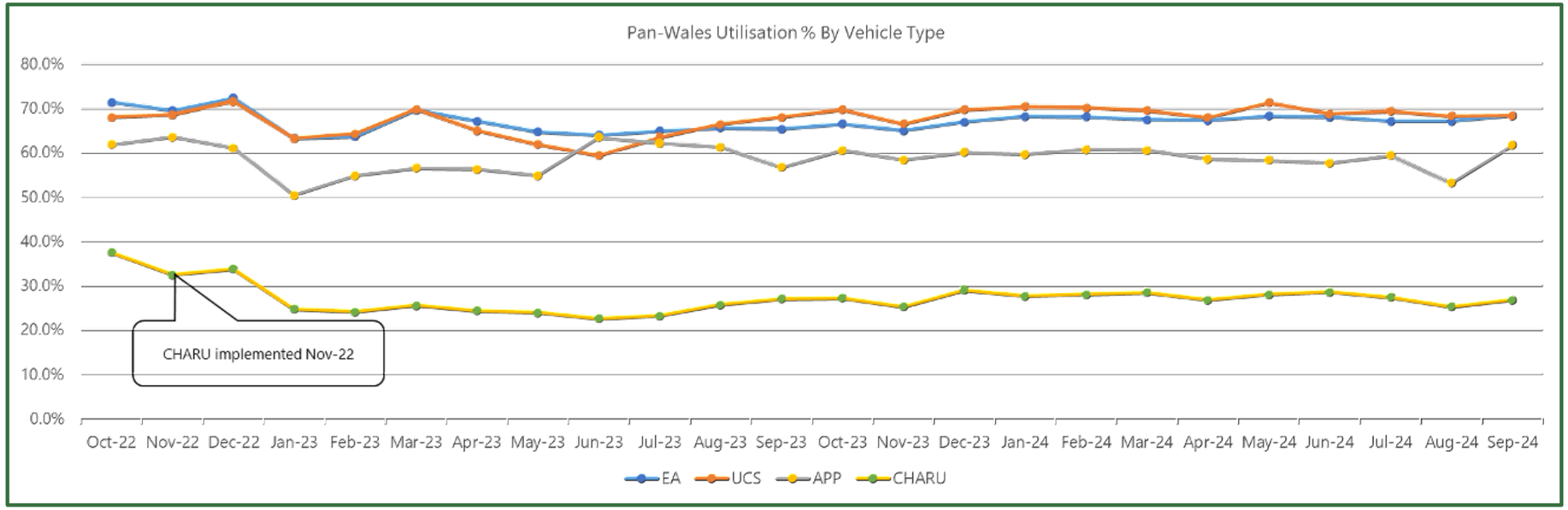
The expectation is that the Trust will continue to meet its statutory financial duties, as outlined in its IMTP for the 2024/25 financial year; however, it is expected that the Trust will continue to operate in a challenging financial environment and will need to deliver a planned level of savings in the 2024/25 financial year of c£6.4m.

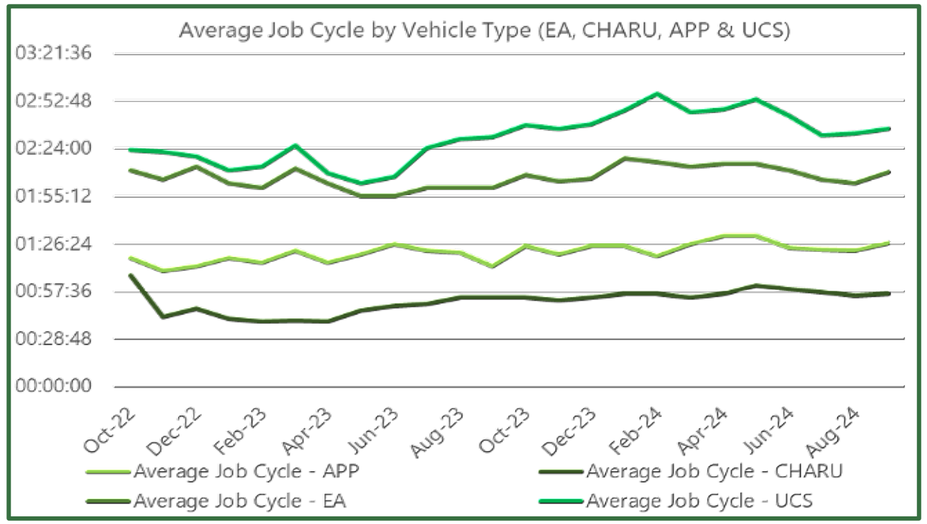
Finance, Resources and Value
EMS Utilisation & Average Job/Shift Times

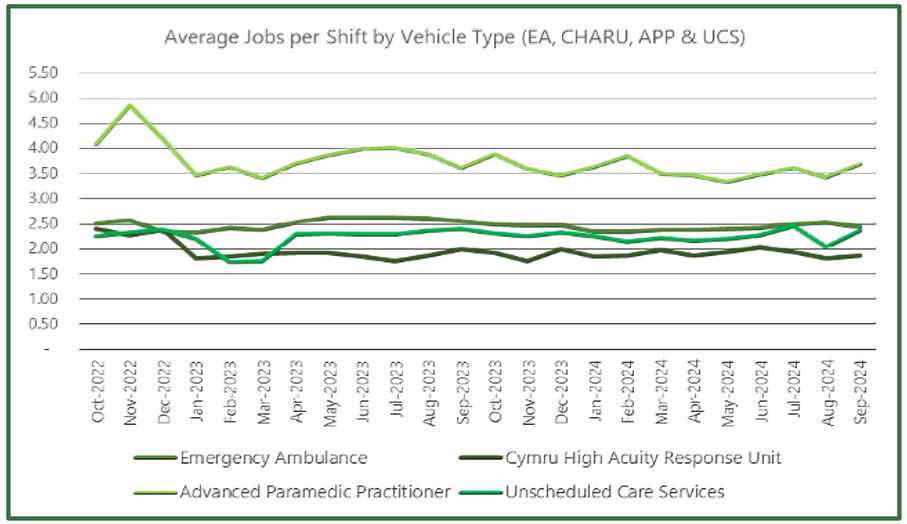
(Responsible Officer: Lee Brooks)

Jobs Per Shift	CHARU Utilisation	FPC
R	R	

NB: Data quality issues have been identified within APP data. These are currently being addressed.







Analysis

Pan Wales Utilisation metrics in September 2024 were 57.9% for all vehicles types, increasing slightly from 56.8% in August 2024. UCS and EA were both the highest rate during the month at 68.4%. 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 increased in all categories in September 2024, to 2 hours 10 minutes for EAs, 56 minutes for CHARU and to 1 hour, 27 minutes for APPs and 2 hours and 36 minutes for UCS.

Overall average jobs per shift was 2.29 in September 2024, indicating a slight decrease from August 2024 (2.34). EAs averaged 2.43 jobs per shift and UCS crews 2.35 jobs per shift This is more than what would be ideal and a product of handover delays.
APPs attended on average 3.68 jobs per shift and CHARU's 1.87 jobs per shift. Both sets of data are 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.

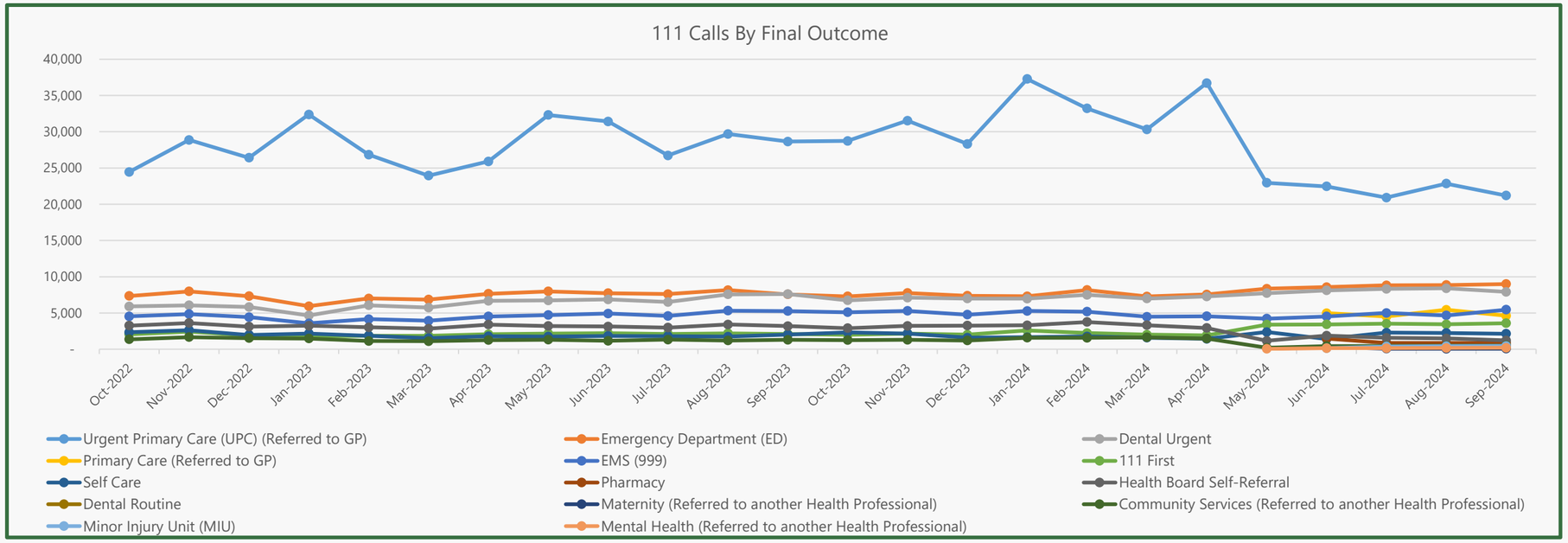
Expected Performance Trajectory

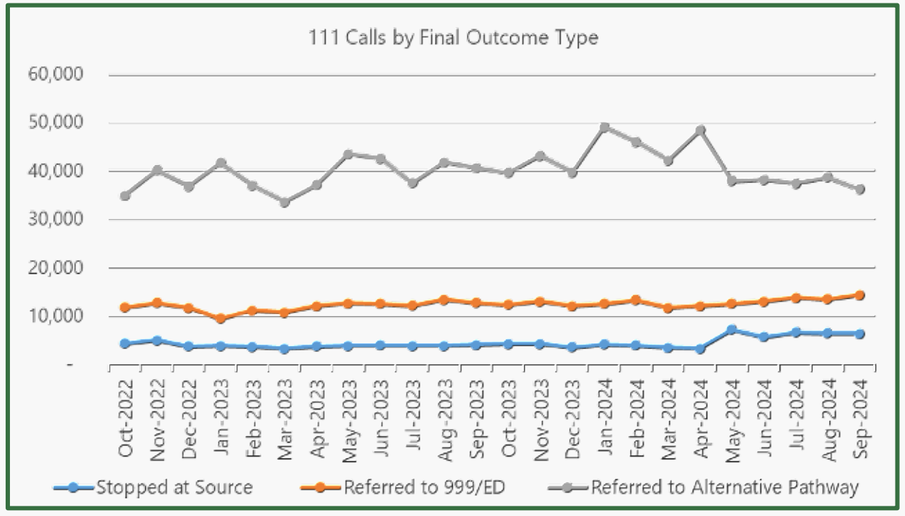
The Trust's ability to reduce the high utilisation rates for EAs and UCS is a product of handover, which it does not control. The Trust would expect an increase in APP and CHARU utilisation during 2024/25 linked to the remedial actions identified above.

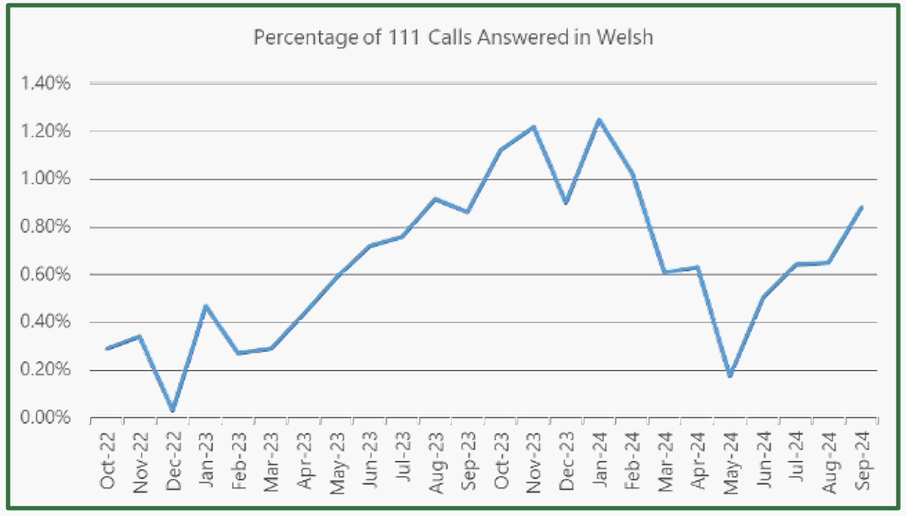
Partnerships / System Contribution
NHS111 Hand Off Metrics and NHS111 Consult & Close Indicators
Influencing Factors – Demand and Clinical Hours Produced

(Responsible Officer: Lee Brooks)

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







Analysis

During September 2024, 57,093 calls were allocated into the 14 categories displayed in the graph opposite, a slight decrease compared to the 58,742 seen during August 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 37.14% of all calls during September 2024, but there has been a material drop since the implementation of new 111CAS.

As the bottom left graph highlights, in September 2024, 6,434 calls were 'Stopped at Source', with no onward referral, a slight decrease from the 6,550 in August 2024. 14,450 calls were referred to 999/ED in September, an increase from the 13,521 in August.

The percentage of 111 calls answered in Welsh increased from 0.65% in August 2024 to 0.88% in September 2024. This equated to 47.4% 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.

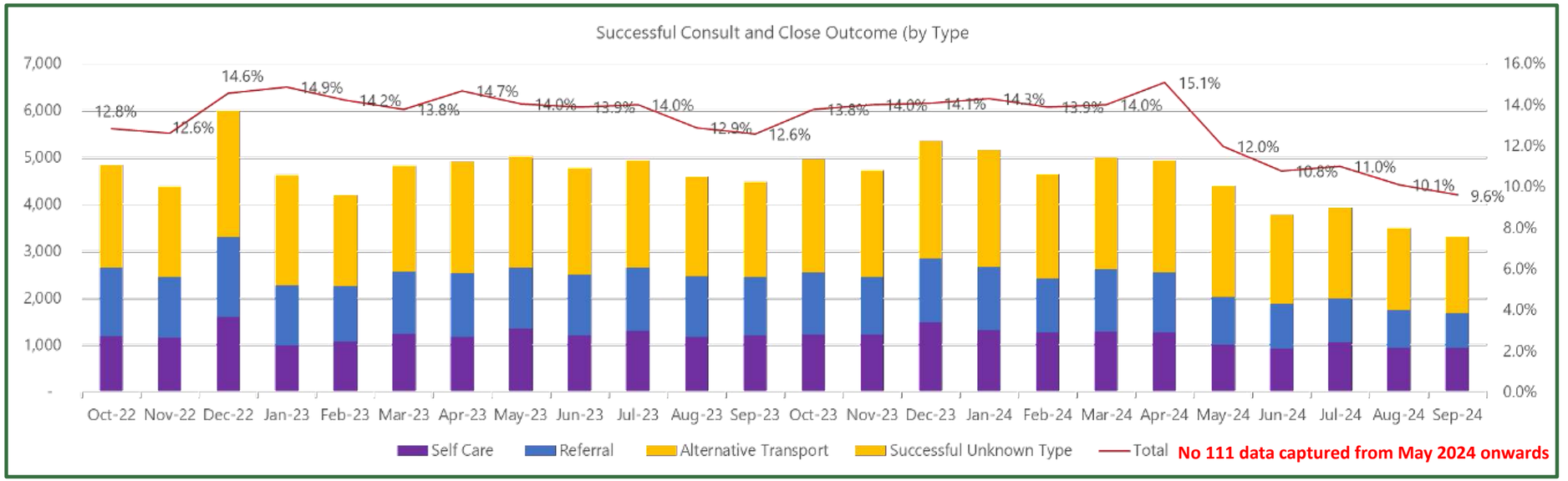
Partnerships / System Contribution
Consult & Close Indicators

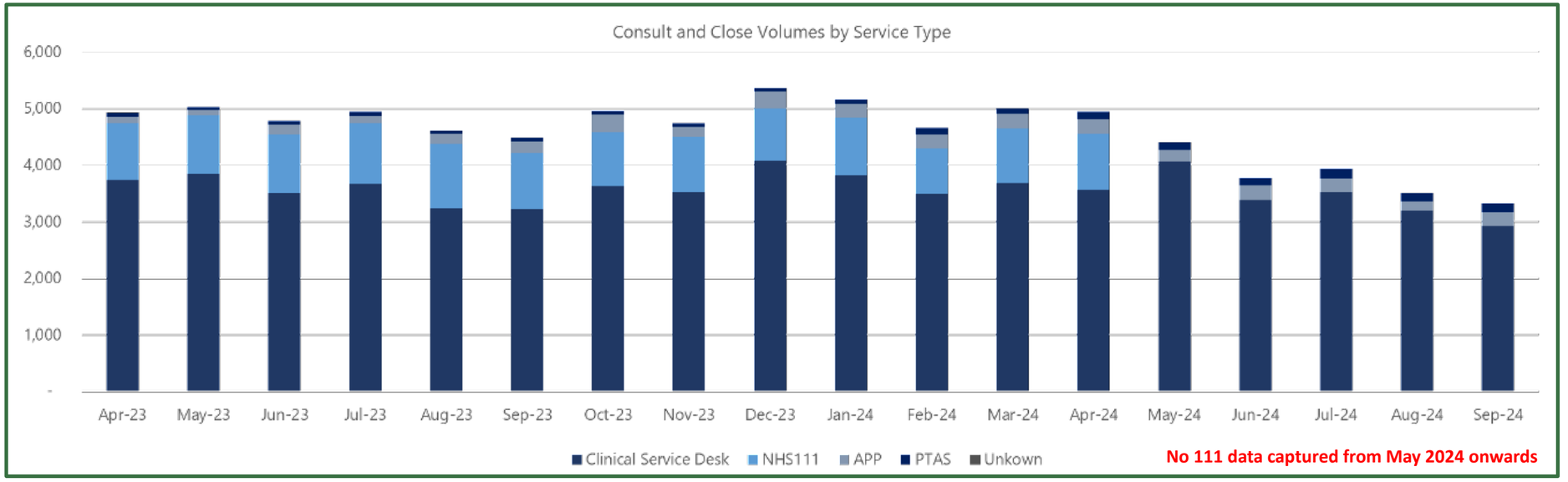
(Responsible Officer: Lee Brooks)

C&C Outcomes

FPC

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





Analysis

Consult and Close, with contributions from Clinical Service Desk (CSD) (8.5%), NHS111 (0%), WAST APP (0.7%) and the Health Boards using Physician Triage and Streaming Service (PTAS) (0.5%) achieved 9.7% in September 2024, dropping from 10.1% in August 2024 and remaining short of the 17% IMTP ambition. The number of 999 calls resulting in a Consult and Close outcome was 3,325, a decrease from 3,499 in August 2024.

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

Of the calls successfully closed in September 2024, 946 patients received an outcome of self-care; 732 patients were referred to other services (including to Minor Injury Units and SDEC) and 1,647 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 and resolve 111 reporting issue.
- Recruitment of additional 28.5 FTEs into rapid clinical screeding for 24/25.
- Implementation of key aspects of the Clinical Model Transformation Programme before winter are expected to increase remote management

Expected Performance Trajectory

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

Partnerships / System Contribution
Conveyance to ED Indicators

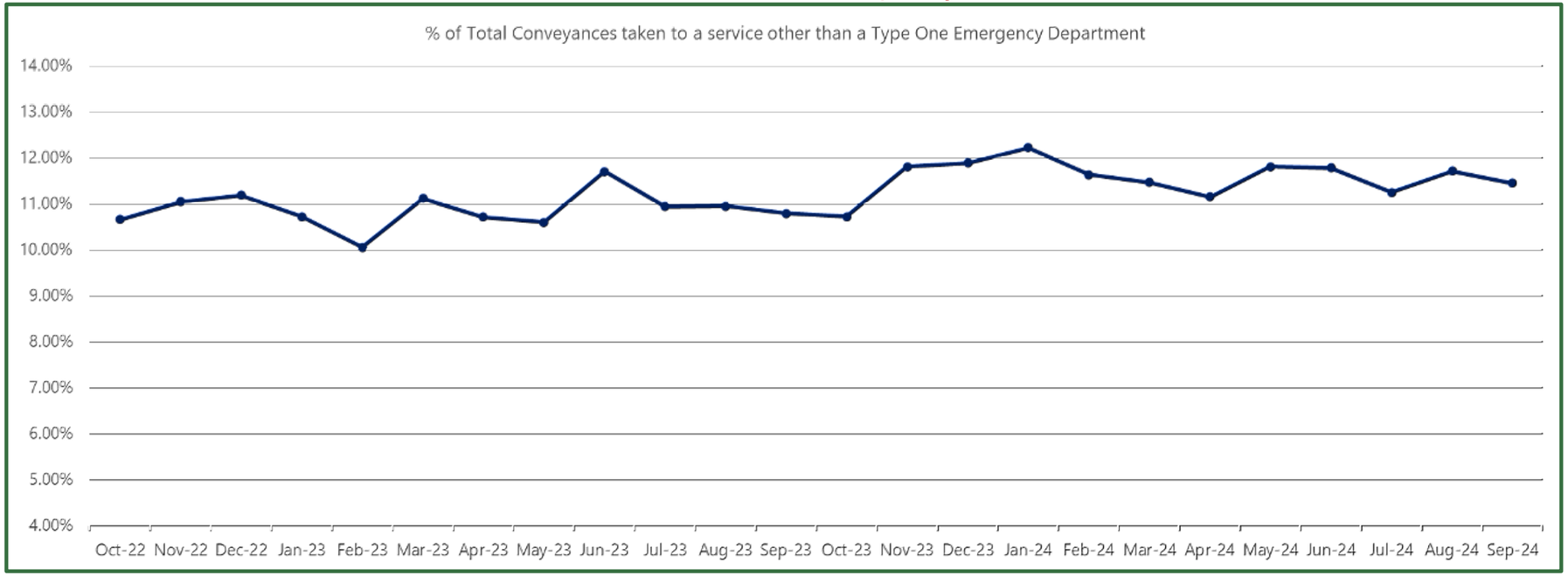
(Responsible Officer: Andy Swinburn)

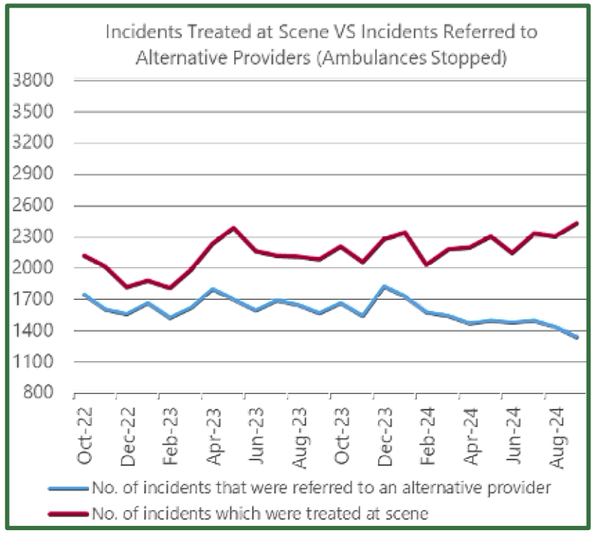
Conveyances
A

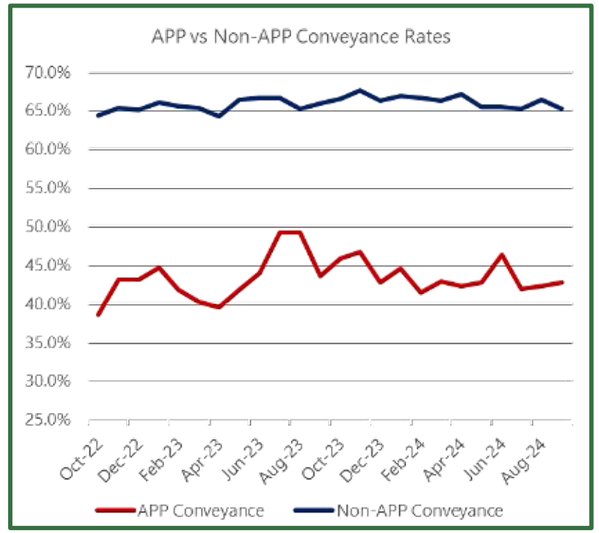
FPC

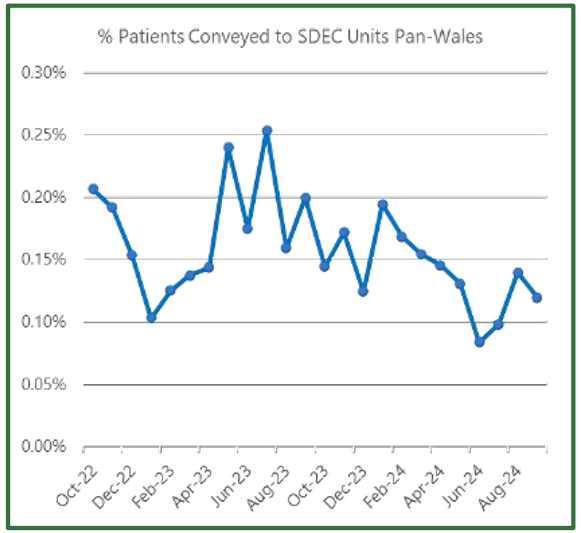
Ministerial Measure

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









Analysis

In September 2024 11.44% of patients (1,537) were conveyed to a service other than a Type One ED, while 34.6% of patients were conveyed to a major ED, as a percentage of verified incidents.

The combined number of incidents treated at scene or referred to alternate providers increased slightly, from 3,735 in August 2024 to 3,753 in September 2024.

The APP conveyance rate was 42.8% in September 2024 and continues to experience a generally increasing trend since March 2023; whilst the DCR table highlights by code the incidents where the preferred response should be an APP (if available), pilot schemes are in place to clinically dispatch advanced and enhanced clinical resource to safely manage care closer to home, 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 0.12%.

Remedial Plans and Actions

- Continued contribution to the SDEC strategy the 6 goals programme with HB actions around reporting measures from referral and bedding of SDECs in times of escalation. It should be noted that WAST data reflects a direct referral to an SDEC where some HB models require a conveyance to ED initially and then streaming to SDEC on this basis.
- Further investment in the APP workforce in 2024/25 (+32 APPs).
- Formal education support and induction package for APPs agreed trust-wide in support for completing their studies and giving stability and consistency to the learner.
- Embedding the Urgent Care response within the Clinical Model Transformation, tasking optimisation (alongside HB partners if available), scheduling care and APP development and workforce.
- Inclusion of specific Frailty and Falls workstream within Urgent Care Response Service with involvement in the review of the All Wales Falls Response Framework alongside NHS Executive Colleagues.

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. Seasonal modelling continues to be undertaken.

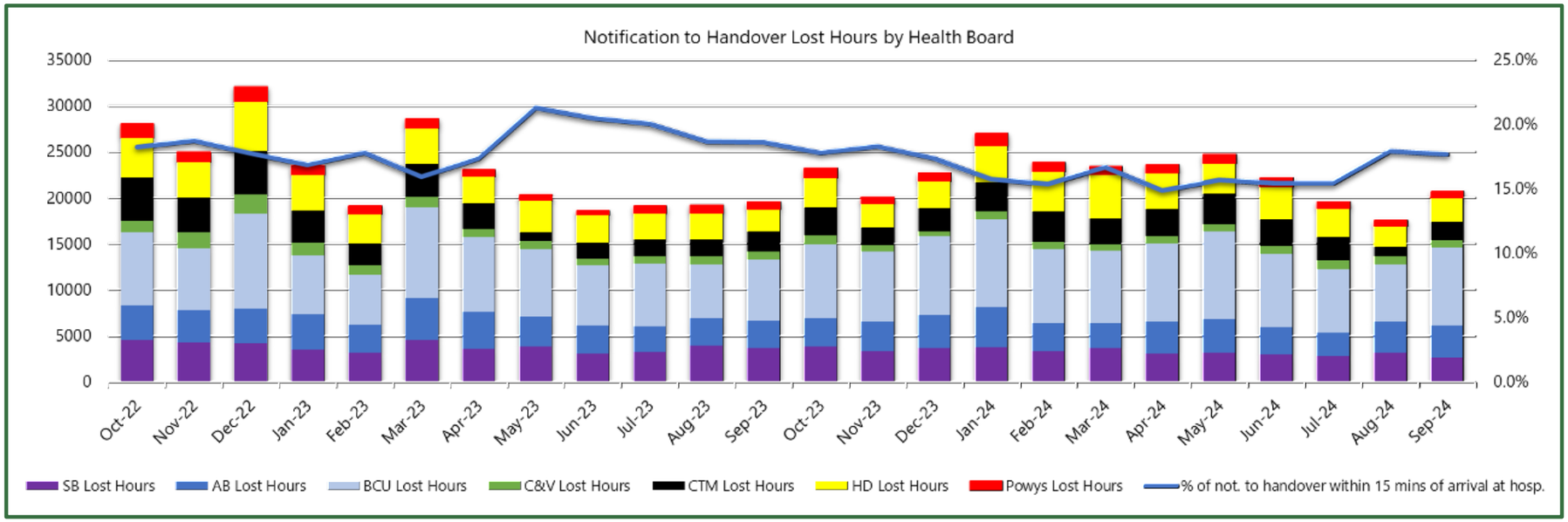
Partnerships / System Contribution
Handover Indicators

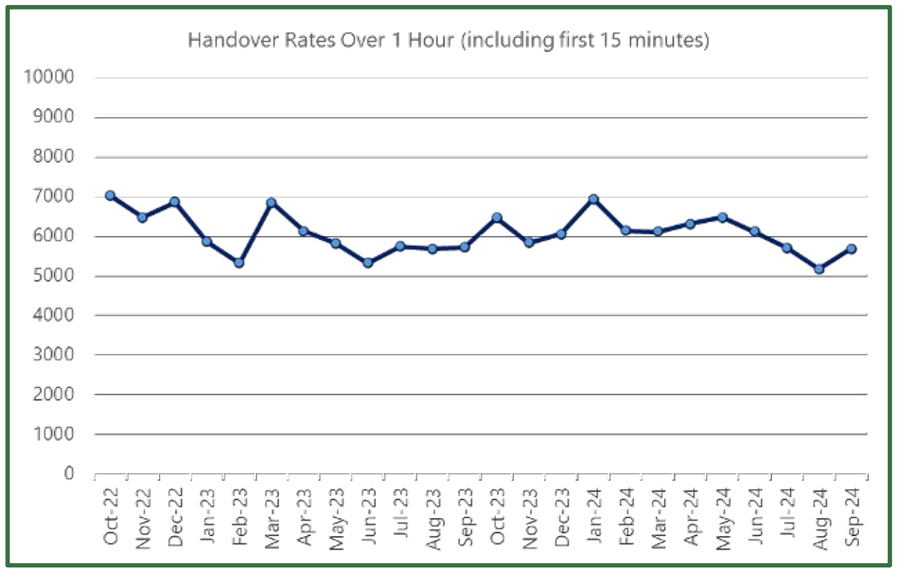
(Responsible Officer: Health Boards)

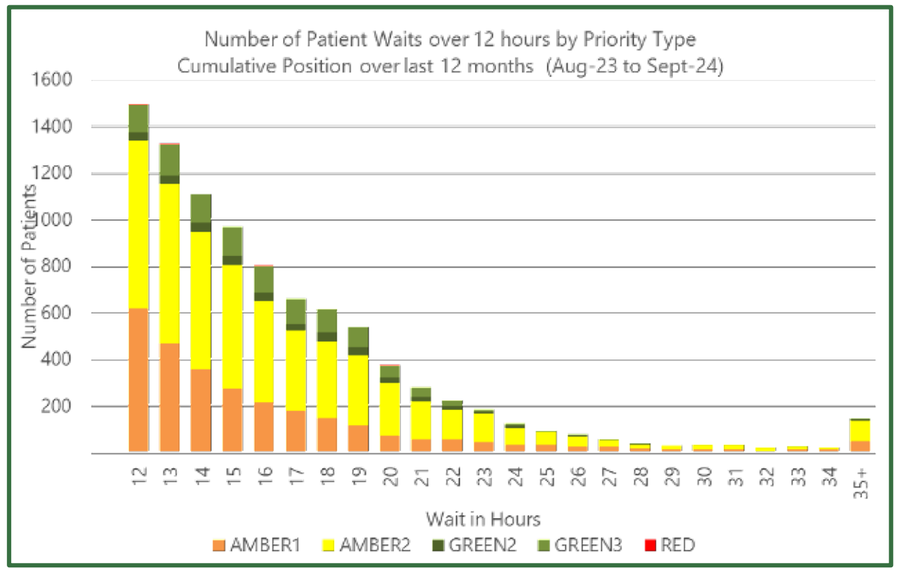
Lost Hours R

CI

QUEST







Analysis

268,904 hours were lost to Notification to Handover, i.e. hospital handover delays, over the last 12 months (Oct-23 to Sept-24), compared to 277,456 over the same timeframe the previous year. There were 20,693 hours lost in September 2024. The September 2024 figure is 5.5% higher than the figure recorded in September 2023.

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

- Grange University Hospital (ABUHB) at 3,370 lost hours
- Ysbyty Gwynedd Hospital (BCUHB) at 2,759 lost hours
- Maelor General Hospital (BCUHB) at 2,711 lost hours
- Morriston Hospital (SBUHB) at 2,573 lost hours

Notification to handover lost hours averaged 690 hours per day during a 30-day September 2024 compared to 566 hours a day in a 31-day August 2024.

In September 2024, the Trust could have responded to approximately 6,527 more patients if handovers were reduced, which highlights the impact the numbers are still having on service.

In September 2024, 704 patients waited over 12 hours for an ambulance response. In September 2024 45 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

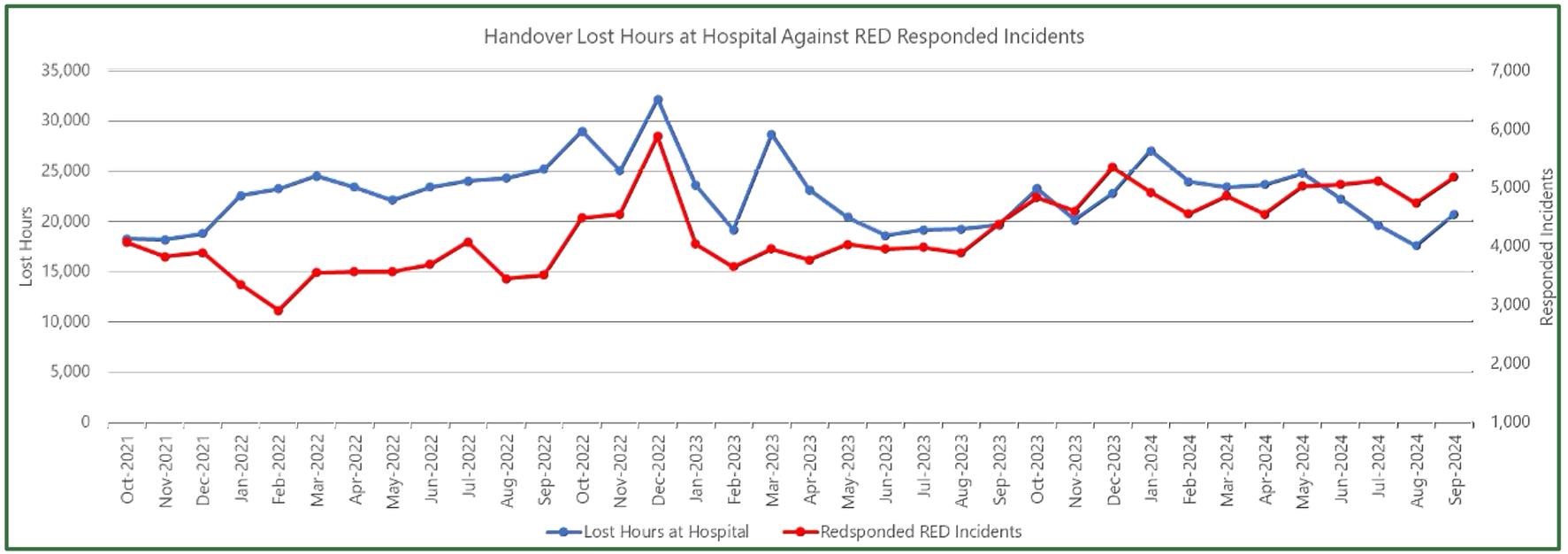
The Welsh Government handover target for 2024/25 is no waits over one hour; this equates to 7,500 hours lost to handover delays per month. There would need to be a 60% reduction in current handover levels for this to be achieved.

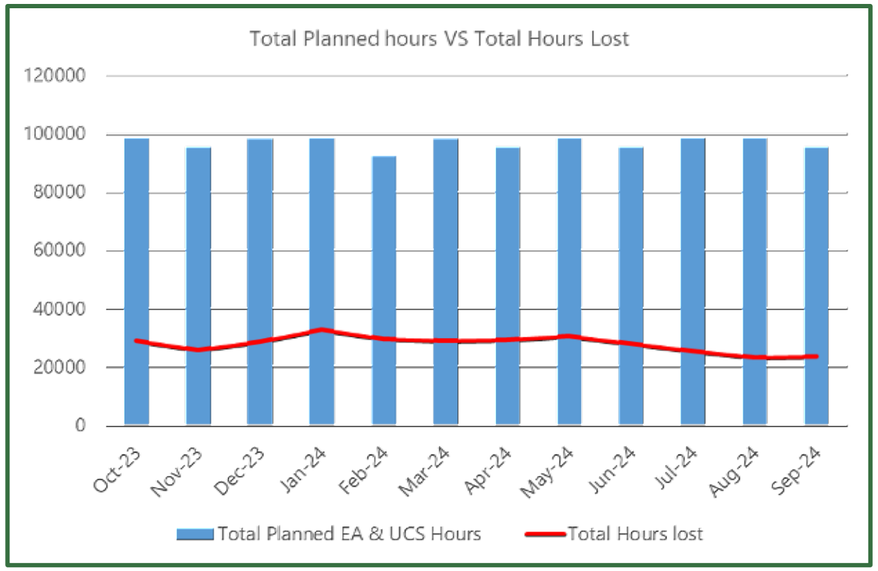
Partnerships / System Contribution

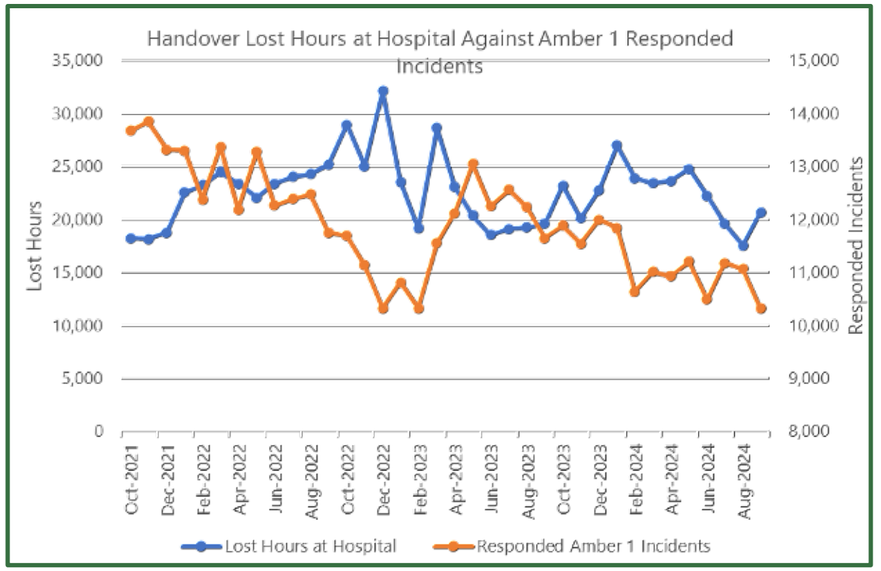
Handover Lost Hours Against Red & Amber 1 Responded Incidents

(Responsible Officer: Health Boards)

CI QUEST







Analysis

The top graph highlights that as handover lost hours have increased since September 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 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 20,600 hours, with handover in September 2024 5.5% higher than September 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	**1**

MENTAL HEALTH AND DEMENTIA ANNUAL REPORT 2023/24

MEETING	Quality, Patient Experience & Safety Committee
DATE	5 November 2024
EXECUTIVE	Liam Williams, Executive Director of Quality and Nursing
AUTHOR	Jonathan Turnbull-Ross, Deputy Director Remote Clinical Care Justine Cosby, Consultant Clinician for Mental Health & Dementia Simon Amphlett, Acting Consultant Clinician for Mental Health & Dementia
CONTACT	jonathan.turnbull-ross@wales.nhs.uk justine.cosby3@wales.nhs.uk simon.amphlett2@wales.nhs.uk

EXECUTIVE SUMMARY

1. The paper presents the Mental Health and Dementia (MHD) Annual Report for the period year 2023/24. Over recent years, the Trust has continued to deliver activities through funding made available through Welsh Government supporting a small, dedicated Mental Health and Dementia Team. In addition to this, the Trust employs dedicated Mental Health Clinicians within the Clinical Support Desk setting. The Report presents the activities undertaken and performance.

2. The Trust is at the forefront of responding to mental health and dementia crises in Wales, handling over 30,000 mental health-related 999 calls annually. This 2023-2024 MHD Annual Report highlights the Trust's ongoing efforts to enhance mental health and dementia care across Wales, in alignment with National Policy Frameworks and through partnerships with various stakeholders.

Key Achievements

(i) Mental Health Initiatives:

The Welsh Ambulance Services University NHS Trust's (WAST) Mental Health Team continues to champion a positive mental health culture within the organisation. A major focus has been on training staff across various service areas, such as 999 Call Handlers, to better support people experiencing mental health crises. Additionally, the Mental Health Response Vehicle (MHRV) initiative remains a critical component in providing specialised, prompt care.

The pilot initiative undertaken in 2023/24 has duly informed stakeholders of the potential for this service, and commitments to grow the initiative are actively underway in the Trust.

(ii) Dementia Care Enhancements:

Dementia remains a critical challenge, with over 50,000 individuals in Wales affected. In line with the Dementia Action Plan for Wales, WAST has worked to improve dementia care, particularly through innovative projects like the introduction of RITA (Reminiscence Interactive Therapy Activities) tablets. These tablets have been used in Pilot Projects over the year to demonstrate their success in being used to calm agitated dementia patients. Although it has been identified that cost constraints limit a widespread rollout, the Project has generated alternative approaches, such as the creation of a Patient Activity Toolkit, which is being developed to support dementia patients more widely.

(iii) Education and Training:

The Trust has expanded its education initiatives, offering dementia-focused training for Paramedics, Call Handlers and staff across Non-Emergency Services. This training includes webinars, podcasts and role-specific courses to enhance the ability of staff to care for individuals with dementia or mental health issues. The voice of those living with dementia is central to these learning opportunities. Whilst training has been positively received, there are fresh attempts to make the content engaging and captivating, particularly in light of the Trust's strategic ambition to care for more patients through remote means.

(iv) Partnerships and Collaborations:

WAST has fostered collaborative partnerships with national and local organisations, including Alzheimer's Society Cymru and the National Ambulance Mental Health Group. These partnerships have led to the development of Referral Pathways and initiatives to promote best practices in dementia and mental health care across the NHS and Emergency Services.

(v) Dementia-Friendly Environments:

Progress has been made in designing dementia-friendly environments within WASTs Non-Emergency Patient Transport Service vehicles. These design features enhance patient comfort and safety. WAST has also extended its dementia-friendly services through community partnerships, such as those in Ceredigion, focusing on providing music, art and reminiscence therapy for patients. The activity in-year has generated an understanding of 'what dementia friendly environments in ambulance settings' should look like; this is supporting

current work to consider implementation and roll out of adjustments to fleet design that can made.

(vi) Awards and Recognition:

The Dementia Team was recognised with the Dementia Hero Award for Professional Excellence (Organisation) at the 2023 Alzheimer's Society Awards. This highlights the team's outstanding contributions to dementia care, which will continue to be showcased at National and International Conferences in 2024.

Strategic Outlook for 2024/2025

(i) As WAST moves into the next year, the MHD Team will build on the successes of 2023, focusing on the development of the next Mental Health & Dementia Plan. The team will continue to prioritise collaboration, evidence-based practice and innovative solutions to enhance care for individuals with mental health issues and dementia across Wales.

(ii) Over recent years, the Trust has underutilised the dedicated funding, which is strictly allocated for Mental Health and Dementia Services. There is a recognition that more resources should be employed/full allocation of the funding is necessary to achieve the Trust ambitions. In Summer 2024, the MHD Team was realigned into the new Remote Clinical Care arm of the Quality, Safety and Patient Experience Directorate. In October 2024, a substantive Consultant Clinician for the MHD Team commenced in post, which replaces previous fixed term contract appointment and interim cover over Summer 2024. A renewed leadership structure and presence has been welcomed by the MHD Team, with a vigour towards integration with system partners, growing clinical effectiveness within MHD Services, and seeking impact at an all-Wales level.

Key Challenges: The current MHD Team faces several challenges that hinder its ability to meet the Trust's growing objectives:

(i) *Under-resourced Team*: Despite an increasing workload and high strategic ambitions, team headcount has declined, leaving critical gaps in expertise and operational support.
(ii) *Lack of Succession Planning*: The existing structure does not provide clear pathways for progression, limiting the potential for skill development within the team.
(iii) *Strategic Alignment*: The team requires greater participation in work supporting our long-term goals and Strategy.
(iv) *Specialist Expertise*: Additional roles (or expertise engagement arrangements) in specialist areas such as Learning Disabilities, Alcohol and Substance Misuse, and Child and Adolescent Mental Health Services (CAMHS) are needed to address

complex mental health needs of patients and ensure Mental Health Clinicians have access to specialist support.

(v) *Integration with system partners*: Enhanced capacity and focus are required to ensure effective partnership with NHS Wales Mental Health Services.

3. The Trust's commitment to mental health and dementia care has resulted in improvements in patient support, staff training and the development of dementia-friendly services. WAST is poised to enhance our service offer in 2024 and beyond, ensuring the highest quality of care for all those affected by mental health conditions and dementia.

RECOMMENDED That the Quality, Patient Experience & Safety Committee takes assurance and approves the Annual Report for publication.

KEY ISSUES/IMPLICATIONS
N/A

REPORT APPROVAL ROUTE	
Senior Quality Leadership Team	21 October 2024
Clinical & Quality Governance Group	30 October 2024
Quality, Patient Experience & Safety Committee	5 November 2024

REPORT APPENDICES
ANNEX 1 - Annual Report

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

Welsh Ambulance Services NHS Trust

Mental Health & Dementia Annual Report 2023 - 2024

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Introduction

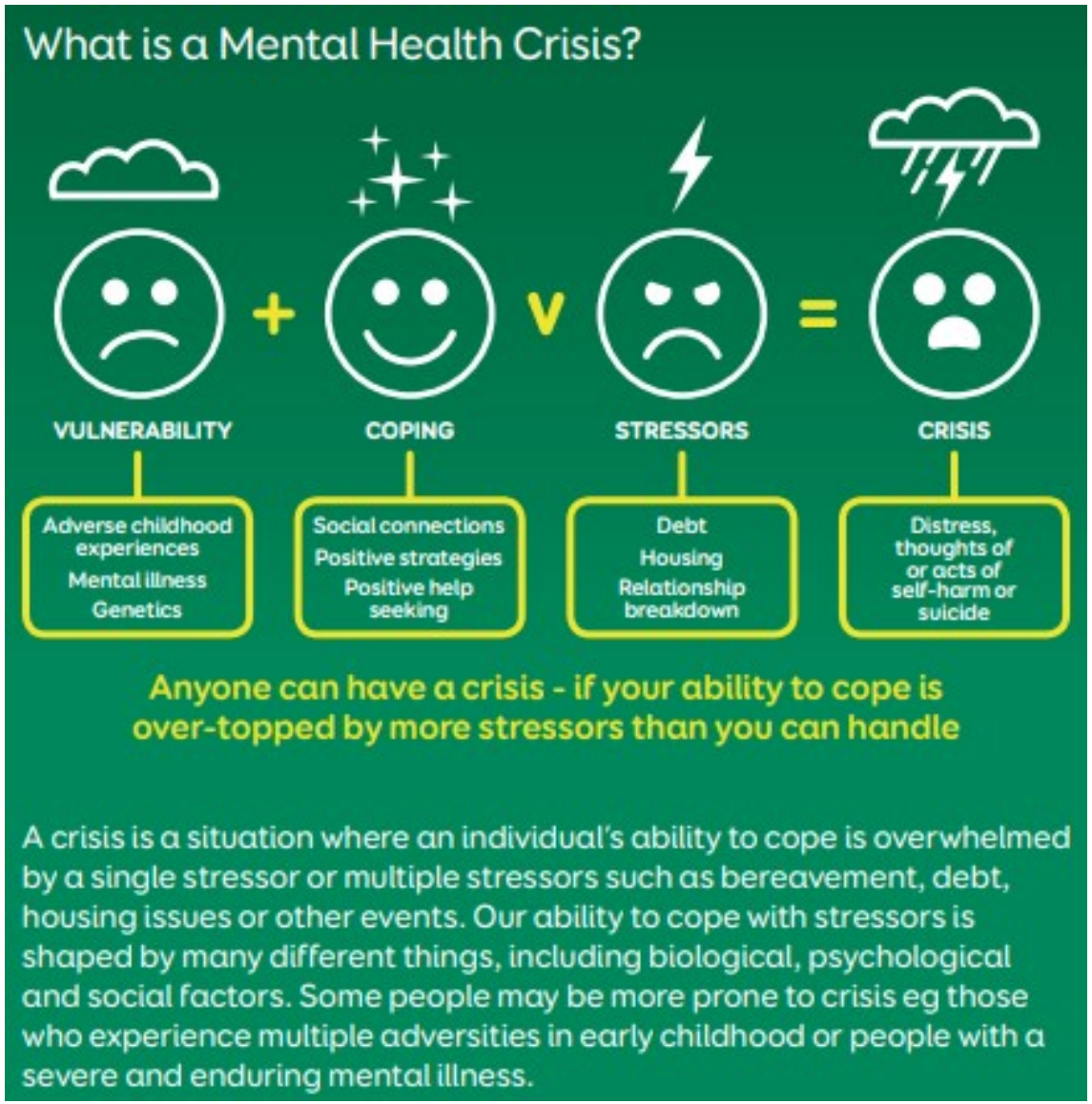
With over 30,000 mental health contacts per year to 999 alone, the Welsh Ambulance Services University NHS Trust (WAST) responds to more mental health crisis calls than any other NHS or public sector organisation. In addition to this, mental health demand in NHS Wales 111 and the Non-Emergency Patient Transport Service (NEPTS) is significant.

Dementia continues to be one of the 21st century's biggest healthcare challenges. We are working towards improving the experience for people living with dementia who use our services, as well as considering the impact it will have on our workforce.

WAST continues to improve our response to people with mental health conditions and dementia between 2021-2024. This plan has been developed following continued engagement and consultation across WAST services and external stakeholders, as well as service users and carers. Within it, we set out our high-level objectives and more detailed plans for improving mental health and dementia services for people across Wales of all ages who call 111 or 999.

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

What is a Mental Health Crisis?



A crisis is a situation where an individual's ability to cope is overwhelmed by a single stressor or multiple stressors such as bereavement, debt, housing issues or other events. Our ability to cope with stressors is shaped by many different things, including biological, psychological and social factors. Some people may be more prone to crisis eg those who experience multiple adversities in early childhood or people with a severe and enduring mental illness.

Crises can be avoided by using positive coping strategies such as self-soothing, problem solving, connecting with others and help-seeking, or made worse by others including consuming alcohol or non-prescribed drugs, or self-harm.

Some people have built in risk factors for crisis, which could be caused by high levels of stress hormones whilst in the womb or in the first two years of life. Others have higher social vulnerability because of loneliness, isolation, worklessness, or lack of purpose.

However, anyone can end up in a mental health crisis.

Any member of staff who needs help for themselves or a colleague should access our #WASTkeeptalking portal where they can find all of the mental health resources available to you, face to face and online. For more information, the WAST Wellbeing Strategy can be accessed on our staff intranet page.

Education and Training

The Trust's annual training plan continues to support Mental Health awareness raising. Working in partnership with our dedicated training teams across WAST to establish a robust training program for all aspects of mental health.

Mental Health Training

The Mental Health & Dementia Team (MHD) continues to provide face to face or virtual sessions to all colleagues across the Trust. In addition, to this the MHD team has developed an extensive mental health online learning resource which has been utilized by staff in the following way:

	Numbers
• Mental Health Legislation	**1025**
• Mental Health Awareness	**1354**
• Self-Harm	**1072**
• Substance Misuse	**1037**
• Suicide Intervention	**1632**
• Alcohol Brief Intervention	**581**
• Dementia	**1221**

We are currently developing two other mental health learning modules – Child & adolescents, and Perinatal.

Paramedic Mental Health Training

The Mental Health & Dementia Team continues to provide ongoing support to the development of the mental health curriculum for undergraduate paramedic students in partnership with Swansea University. This is delivered for every cohort.

Mental Health Practitioners Induction/ support

Over the last 24 months Mental Health Clinicians (MHC) have been employed by the Trust and have been inducted, signed off and clinically supported by the MHD team. They are based in the three call centres throughout Wales.

Induction involves completing mandatory training, WAST computer systems, shadowing different staff groups who work with the call centres and shadowing current MHPs. Finally new MHPs are supervised and assessed before being signed off for working autonomously within the clinical support desk.

MHPs are line managed by the operational service however, all are clinically supervised by MHD staff.

Suicide First Aid (SFA) Training

During this reporting period the team also delivered SFA training to 351 staff. Prior to this, 235 staff have received training.

SFA courses run every week and can accommodate up to 16 staff members. Currently these are being run virtually but we are looking at running face to face classes in the future, at the request of staff.

"Incredibly valuable worthwhile session. I have learnt so much"

"I feel that as a call handler I am now in a better position to talk with someone who has suicidal thoughts."

In addition, WAST staff have access to Mental Capacity Act training via WAST Learning Zone

Working Towards Equity

Working towards equity

In Wales and across the UK, some groups experience greater difficulty in accessing health services than others eg people from Welsh speaking communities, people with sensory loss; and some groups have poorer mental health than others eg people from ethnically diverse communities, Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ+) people. Indeed, some of these same groups also have poorer outcomes and experiences when they do access healthcare.

Our equality strategy "Treating People Fairly" sets out our approach to improving outcomes for all of the people of Wales, and how we will achieve our commitment to the Public Sector Equality Duty. Some key objectives in the strategy are:

By 2025...

... we will take action to maximise health opportunities and strengthen the voice of all citizens and staff to ensure the people who use our services have equity of access and improved experience with access to services that are sensitive to the needs of all.

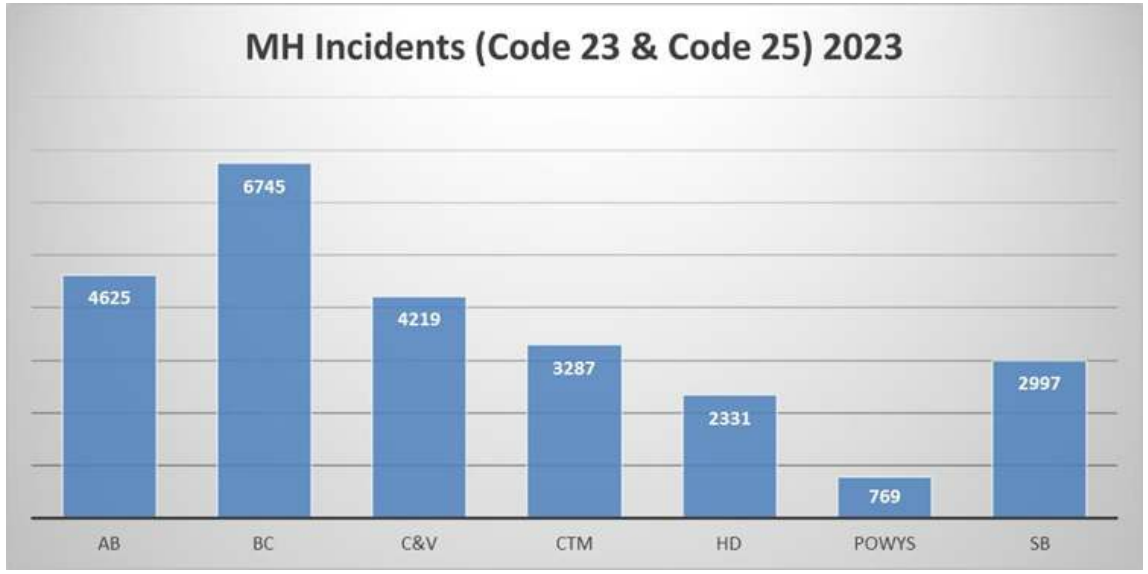
By2025...

... we will take action to increase awareness and tackle key equalities issues that may arise from a person's 'protected characteristics' to ensure our services, our culture and our people understand and are responsive to the needs of all.

"Treating People Fairly" includes a specific action to "work in partnership to improve our understanding of the experience of mental health service users, and also of those living with dementia".

Inequality is complex, multi-factorial and entrenched in many ways, and it is only through working together, under the stewardship of our equality strategy, Equality Impact Assessment and Welsh Language Strategy that we will begin to reduce inequality and improve outcomes and experience. Inequality is an important dimension in every key deliverable in this plan.

Current Mental Health Demand

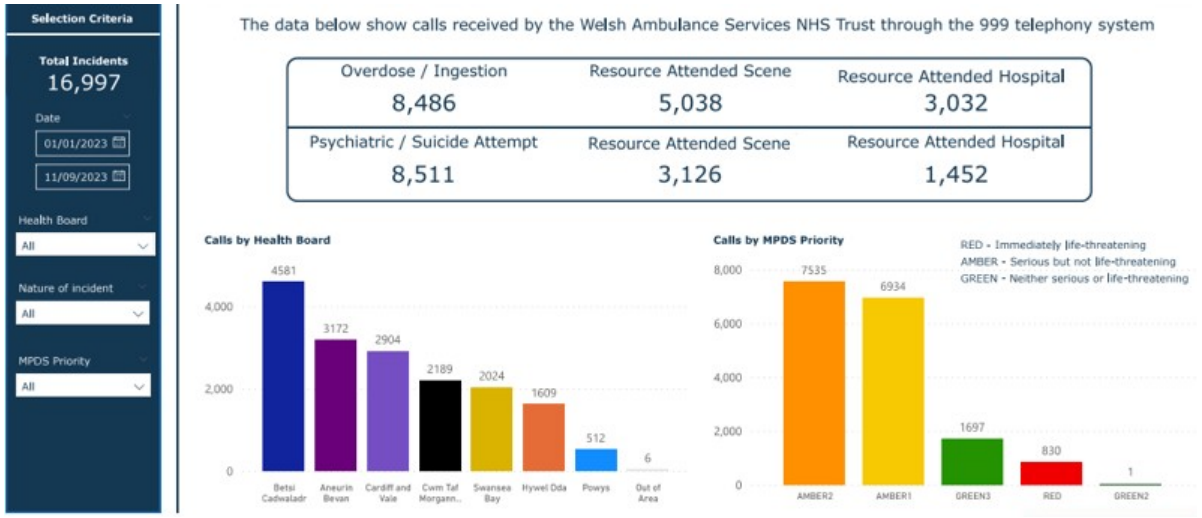


Demand data reveals a significant variation in incident volumes (Code 23 relates to calls that are concerned with an overdose, Code 25 is concerned with calls related to a psychiatric emergency), with Betsi Cadwaladr University Health Board experiencing the highest number of incidents at 6,745, while Powys Teaching Health board recorded the lowest at 769 incidents. This disparity suggests that certain areas may require more targeted mental health resources or interventions to manage the higher caseloads and is reflective of the population levels across Wales.

The data further underscores the heavy burden of mental health-related calls, particularly related to overdose/ingestion and psychiatric/suicide attempts, each contributing over 8,000 calls. Despite this, there is a noticeable variance in how these calls are handled, with a larger number being resolved at the scene compared to those resulting in hospital attendance.

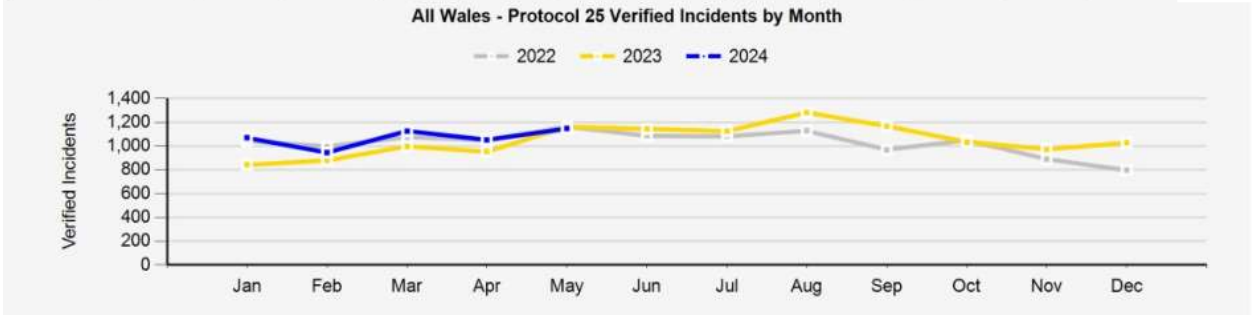
Looking at the distribution of calls by priority, AMBER 1 calls represent the largest proportion of incidents, emphasising the urgent nature of many of these mental health crises. The line graph tracking Protocol 25 verified incidents across Wales show relatively consistent trends over the past three years, though there was a notable increase in 2024 during the early months compared to the previous year. There does not appear to be any coloration to explain this increase.

This data highlights both the ongoing challenges in responding to mental health emergencies across Wales and the importance of continued monitoring and adaptation of services to meet the needs of the population effectively.



All Wales - Protocol 25

Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2023	841	879	997	952	1,161	1,143	1,124	1,281	1,166	1,034	972	1,027
2024	1,068	945	1,126	1,051	1,146	-	-	-	-	-	-	-
Variance	27.0%	7.5%	12.9%	10.4%	-1.3%	-	-	-	-	-	-	-



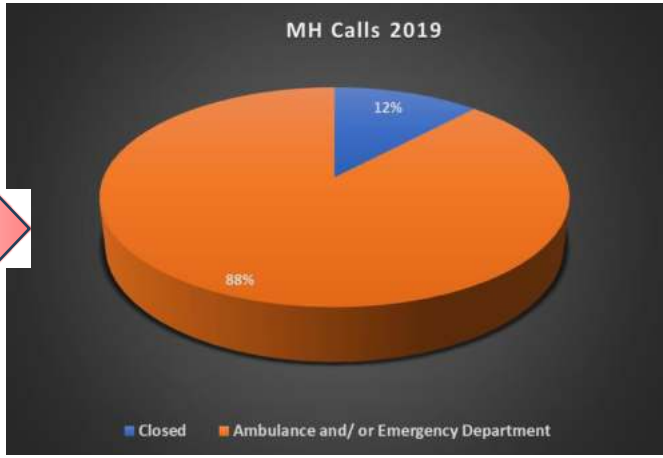
Mental Health Practitioners: Impact

We have recruited and trained senior mental health clinicians to deliver high quality 'hear and treat' services to people who call 999. This is to help people with mental health problems in more effective ways than just directing people to Emergency Departments.

Their implementation has improved our 'hear and treat' outcomes for people who call 999 in a mental health/dementia crisis. The MHD team continues to support, clinically supervise, deliver ongoing learning and audit for mental health clinicians working in 'hear and treat' roles.

Previously around 88% of mental health calls were directed to Emergency Departments (EDs) or conveyed by ambulance.

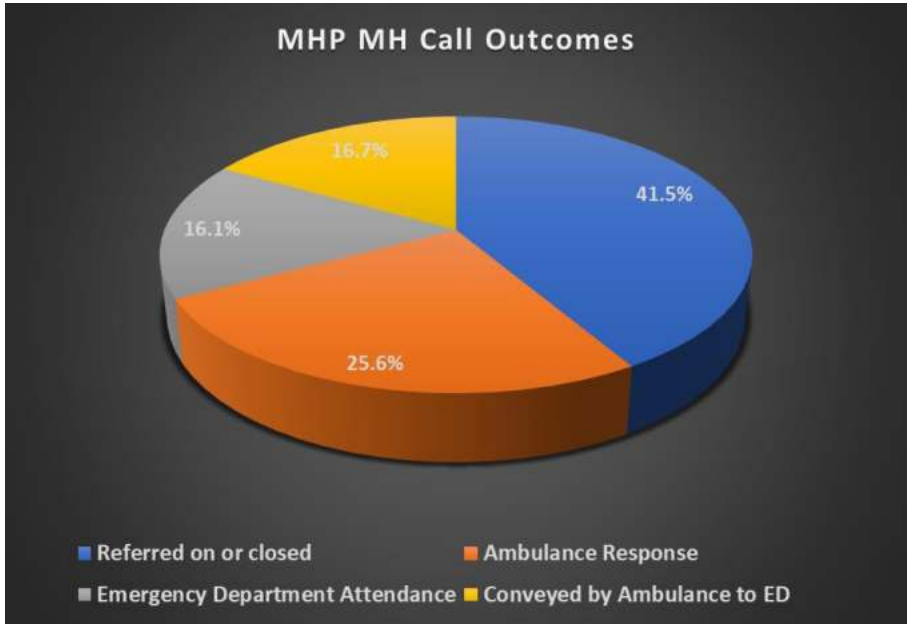
People with mental health problems can experience **waits of 5 hours on average in ED and are** twice as likely to spend more than 12 hours waiting in ED.

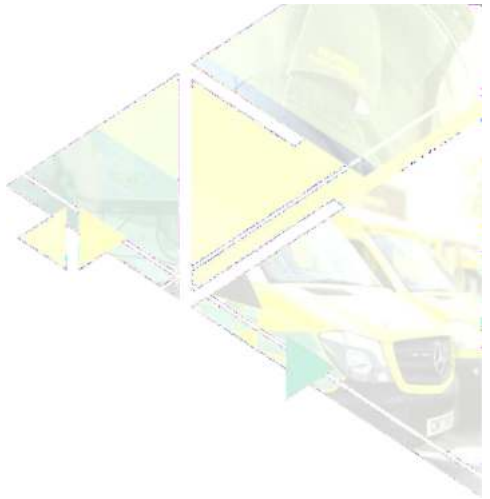


WAST mental health practitioner impact

1. Looking at the data from June 2023 to May 2024 during the hours of operation of the service (13.00 to 01.00 7 days a week), we can see a significant change in the 'consult and close' rate for mental health calls. MHCs are, on average, achieving a 'consult and close' rate of circa 41%.

2. MHCs are twice as likely to consult and close and they tend to use less ambulance resource and refer people directly to mental health services for assessments (4.2%).

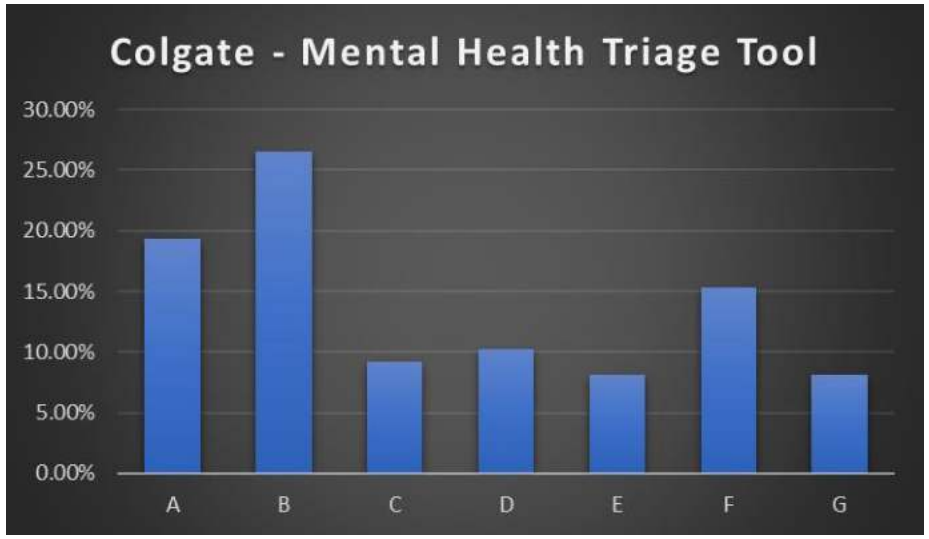




Mental Health Practitioners: Making a Difference

Our Mental Health Clinicians use the Colgate Mental Health Triage Scale, it is a tool designed in Wales to guide decision-making in mental health screening assessments.

Below highlights calls triaged by MHCs into response type required, indicating time to assessment.



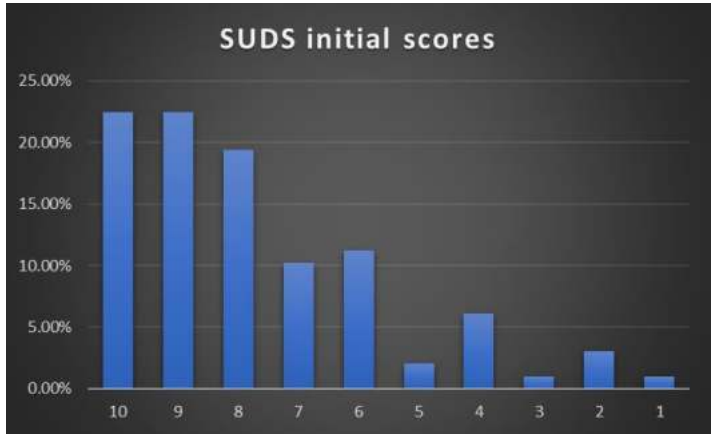
A emergency **B** very urgent <4h **C** urgent <24h **D** moderate <72h

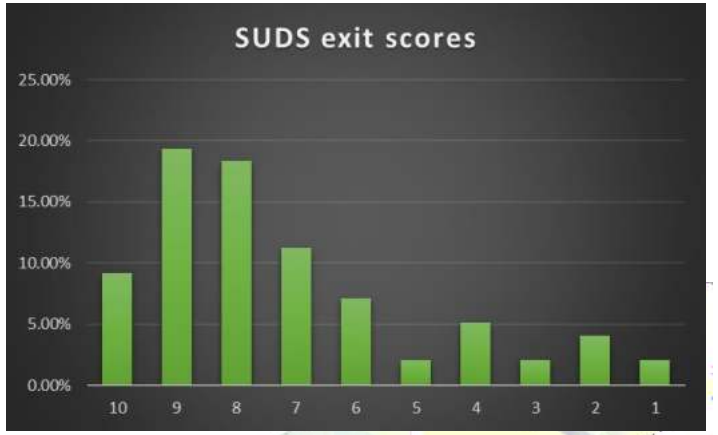
E low <4weeks **F** Signpost (no time) **G** info only (no time)

The Subjective Units of Distress scale (SUDS) is a tool for measuring the intensity of distress, psychological disturbance and painful feelings. The scale ranges from 0 to 10, with zero indicating no distress and 10 being the most intense distress a person can experience.

SUDS are frequently used in a range of psychological therapies as a benchmark for evaluating both distress and also progress of an intervention.

Below highlights the initial and exit patient SUDS scores for patients accessing our service.





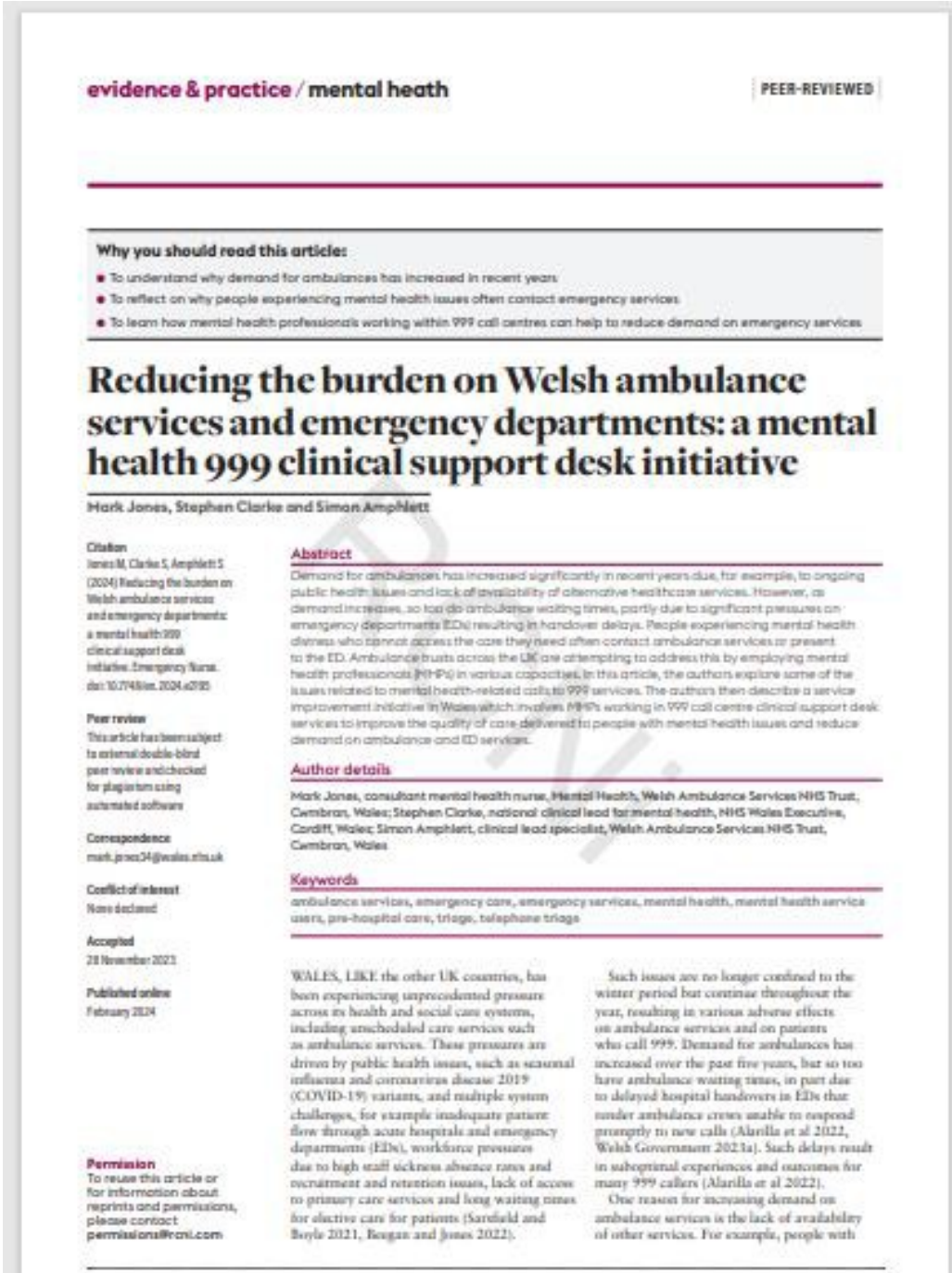
Callers were asked their SUDS at an early stage in the call, and again at the end. The mean SUDS rating at the beginning of the call was **7.73** and this reduced to **5.47** at the end of the call, a reduction of **2.23** points.

Mental Health Practitioners: Publishing the Evidence

Over 2023-24, Trust staff and NHS Wales colleagues produced the outcomes of our Mental Health Clinicans initiatives as a peer reviewed article in the RCN Emergency Nurse journal, published in September 2024.

Demand for ambulances has increased significantly in recent years due, for example, to ongoing public health issues and lack of availability of alternative healthcare services. However, as demand increases, so too do ambulance waiting times, partly due to significant pressures on emergency departments (EDs) resulting in handover delays. People experiencing mental health distress who cannot access the care they need often contact ambulance services or present to the ED.

The article discusses how Ambulance Trusts across the UK are attempting to address this by employing mental health professionals (MHCs) in various capacities. In this article, the authors explore some of the issues related to mental health-related calls to 999 services. The authors describe the initiatives undertaken in Wales to improve the quality of care delivered to people with mental health issues and reduce demand on ambulance and ED services.



evidence & practice / mental heath

PEER-REVIEWED

Why you should read this article:

- To understand why demand for ambulances has increased in recent years
- To reflect on why people experiencing mental health issues often contact emergency services
- To learn how mental health professionals working within 999 call centres can help to reduce demand on emergency services

Reducing the burden on Welsh ambulance services and emergency departments: a mental health 999 clinical support desk initiative

Mark Jones, Stephen Clarke and Simon Amphlett

Citation
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Abstract

Demand for ambulances has increased significantly in recent years due, for example, to ongoing public health issues and lack of availability of alternative healthcare services. However, as demand increases, so too do ambulance waiting times, partly due to significant pressures on emergency departments (EDs) resulting in handover delays. People experiencing mental health distress who cannot access the care they need often contact ambulance services or present to the ED. Ambulance trusts across the UK are attempting to address this by employing mental health professionals (MHPs) in various capacities. In this article, the authors explore some of the issues related to mental health-related calls to 999 services. The authors then describe a service improvement initiative in Wales which involves MHPs working in 999 call centre clinical support desk services to improve the quality of care delivered to people with mental health issues and reduce demand on ambulance and ED services.

Author details

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Keywords

ambulance services, emergency care, emergency services, mental health, mental health service users, pre-hospital care, triage, telephone triage

WALES, LIKE the other UK countries, has been experiencing unprecedented pressure across its health and social care systems, including unscheduled care services such as ambulance services. These pressures are driven by public health issues, such as seasonal influenza and coronavirus disease 2019 (COVID-19) variants, and multiple system challenges, for example inadequate patient flow through acute hospitals and emergency departments (EDs), workforce pressures due to high staff sickness absence rates and recruitment and retention issues, lack of access to primary care services and long waiting times for elective care for patients (Sarsfield and Boyle 2021, Keegan and Jones 2022).

Such issues are no longer confined to the winter period but continue throughout the year, resulting in various adverse effects on ambulance services and on patients who call 999. Demand for ambulances has increased over the past five years, but so too have ambulance waiting times, in part due to delayed hospital handovers in EDs that render ambulance crews unable to respond promptly to new calls (Alarilla et al 2022, Welsh Government 2023a). Such delays result in suboptimal experiences and outcomes for many 999 callers (Alarilla et al 2022).

One reason for increasing demand on ambulance services is the lack of availability of other services. For example, people with

Mental Health Response Vehicles (MHRV)

Ambulance Trusts in England have recognised their sub-optimal approach to mental health calls to 999, and most have now implemented mental health practitioners in 'consult and close' roles. All English Ambulance Trusts are now working with NHSE/I to implement mental health response vehicles as well.

The MHRV outcomes from the most mature service (London Ambulance Service (LAS)) are quite instructive. Since 2020 14,800 patients have been seen by their MHRVs with an 85% see and treat rate and no serious incidents. In addition to this the staff wellbeing factor is significant with a 95% staff positive experience rating and a 100% staff perception that service users had benefitted from the MHRV service. LAS has concluded that the majority of patients seen and treated did not go on to present at an ED within 7 days. London has also identified operational efficiencies, with MHRVs being a less expensive resource to deploy (£53 less per deployment) and avoiding ED admission saving £193 per episode.

WAST introduced a new pilot of the MHRV early 2024 to inform how this service model can be implemented across Wales. This built on previous pilot learning undertaken in 2018/19.

The table below provides the key outcomes measures from the 2018/19 pilot evaluation:

	Mental Health Pioneer Service Pilot	BAU response
ED conveyance rate	19%	54%
See & treat and non-convey	77%	38%
See & convey to 'other'	3.7%	7.6%
Referral to MH pathway	19%	4%
Job cycle time	96 minutes	98 minutes
Utilisation	69%	87%
Incidents per shift	5.05	6.05

WAST MHRV (Face to Face Triage) Project

Benefits to patients and staff:

- 74% treat-and-close rate.
- 7% conveyed to mental health service
- 19% Emergency Department conveya
- Zero serious incidents reported.
- High staff positive experience.
- Improved confidence for control-roor mental health patients.
- 66% reduction compared to remote t

Future Cost-Savings:

Projected savings by car coverage

- 1 car covering 1 UHB saves £200k/year.
- 2 cars covering 1 UHB save £250-300k/year.
- 1 car covering 1 UHB saves £150k/year.
- 2 cars covering 4 UHBs improve response times and quality of care, saving £500k/year.

Future Plans:

Next steps

- Publish findings (agreed and awaiting publication in RCN Emergency Nursing).
- Continue discussions with commissioners and UHBs—cost and business cases have been developed.
- Further studies and pilots planned for wider age ranges and diverse settings.
- Build stronger partnerships and networks.
- Focus on staffing, particularly enhancing mental health staff training and resilience.

Our Improvement work for Dementia

Dementia position in Wales

The Dementia Action Plan: Strengthening Provision in Response to COVID-19 document, was published in 2021 and is a companion document to the Dementia Action Plan for Wales. The work in this plan strengthens existing priorities where the pandemic has had a particular impact. The WAST dementia work plan is in line with national policy.

The All-Wales Dementia Care Pathway of Standards was published in 2021. The co-produced pathway promotes a whole systems integrated care approach and the implementation is being supported nationally and regionally by the Dementia National Steering Group and by five workstreams:

- Community Engagement;
- Memory Assessment Services;
- Dementia Connector;
- Hospital Charter;
- Workforce / measurement.

WAST attends national workstream meetings to have oversight on all workstream developments. We also attend a range of regional and local network meetings to explore local developments.

For example, we are working in partnership with a number of Health Boards exploring the emergency admission process for dementia patients, leading to a joint action plan for improvement.

WAST is represented at Dementia Oversight of Implementation & Impact Group (DOIIG), where work is underway to evaluate the initial Dementia Plan for Wales, and to develop priorities for the next plan. Our Dementia Programme Manager Chairs the All-Wales Blue Light Dementia Group, ensuring best practice is shared across Emergency Services.

Our Role in Dementia Risk Reduction

There are currently around 900,000 people living with dementia in the UK, with an estimated 50,000 people in Wales. It mainly affects people over the age of 65. One in 14 people aged over 65 has dementia. This rises to 1 in 6 for people aged over 80. Young onset dementia affects around 1 in 20 people with dementia who are younger than 65. There are more than 42,000 people in the UK under 65 with dementia, with 2-3000 people in Wales (Alzheimer's Society, 2023).

We have a role to play to raise awareness across Wales and indeed within our service to promote risk reduction in dementia. This includes:

- Sharing information with communities about dementia through our NHS Wales 111 Dementia Guide;
- Supporting a range of campaigns and initiatives such as Dementia Action Week and International Alzheimer's Month;
- Working with our People and Cultures colleagues to make sure we have workforce policies, procedures and systems to support staff who may develop dementia or who are carers of loved ones.

Dementia Reminiscence Therapy

We have completed and evaluated our pilot using RITA tablets, trialling reminiscence therapy with people with dementia, in partnership with My Improvement Network. RITA stands for Reminiscence Interactive Therapy Activities and is an all-in-one touch screen solution which offers digital reminiscence therapy. It is a user-friendly interactive touch screen 10" tablets to blend entertainment with therapy and to assist patients in recalling and sharing events from their past through listening to music, watching significant historical events, listening to historical speeches, playing games, watching old TV shows and sporting events, viewing old maps and photographs and watching films.

This pilot demonstrated that we can better support patients who may be distressed or agitated when in our care, where we can provide distraction and occupation for their emotional and wellbeing needs. However, the cost of the tablets is prohibitive in rolling out fully across the service. Therefore, the next phase of this work is to develop a Patient Activity Toolkit which will be hosted on our intranet and offer staff a toolkit to support a wider range of patients with distraction and occupation activities.

Reminiscence apps are available on staff iPads so that a wider range of colleagues can access reminiscence activities to support patients.

I used Welsh music with a dementia patient stuck outside hospital. Patient was very agitated and she couldn't understand why we weren't taking her into the hospital. The music helped a lot to calm her down and make the experience less stressful. She stopped trying to get out of the ambulance when I showed her the RITA tablet and the old photos.

Before the use of RITA my patient was quite combative as she was saying she was in pain, pain scoring 10/10. When using the tablet the patient forgot her pain, she was singing to Frank Sinatra, Duran Duran and a bit of Tom Jones. She even tried to get up off the stretcher and have a little dance. She was very amused with the bubbles game and giggled whilst playing it.

Creating Dementia Friendly Environments

Our goal is to create more optimal environments for people affected by dementia, as feedback tells us they can find it difficult being in our vehicles, particularly on a long delay outside hospital.

New Non-Emergency transport vehicles

Our Non-Emergency Patient Transport Service vehicles take people to and from their routine hospital appointments and discharge people home after a stay in hospital. New design features include dementia-friendly flooring, blinds and colour schemes, while improved safety features like seatbelt warning systems, CCTV and driver assistance systems now come as standard.

Working in partnership with the Ceredigion Dementia Community

We are working across the Ceredigion community to make dementia-friendly changes to Non-Emergency Transport vehicles. This work involves partnerships with local dementia groups, third sector partners, local care homes as well as our own workforce who will co-produce the work with us. We hope to introduce art, music and reminiscence therapy opportunities to support dementia patients, and images from the local community will be available on vehicle windows, such as this image of Aberystwyth beach.

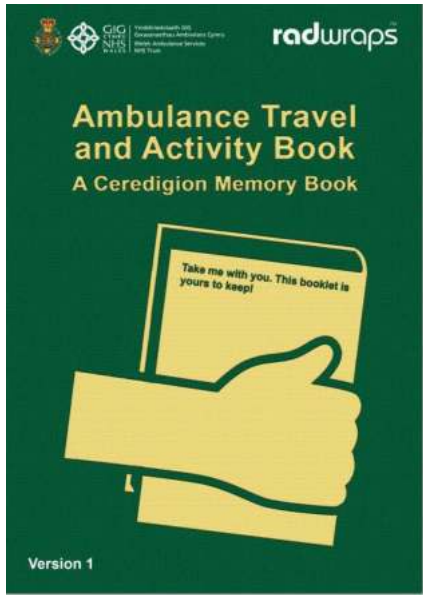
Evaluating the impact of this work will be essential to make sure the improvements have a positive impact on patient experiences and outcomes

Expanding engagement and co-design opportunities across Wales

Using initial findings from our Ceredigion project, we have expanded this work across Wales to capture feedback which may vary due to geographical differences.

Working in partnership with third sector partners we have visited a number of dementia services across Wales.

We are creating Activity books for patients that will aid occupation and distraction, as well as providing staff with information about the person which could further aid reminiscence opportunities. This book is being coproduced with staff, people affected by dementia, carers and wider colleagues through our involvement in the Allied Health Professionals Network for Wales.



Alzheimer's Society Cymru

AHP Dementia Network for Wales
Rhwydwaith Dementia AHP Cymru

#WithAHPuCan

Dementia Education and Training

Our goal is to be an organisation that responds to both the clinical and emotional needs of people living with dementia, their carers and families. Our workforce needs to be dementia aware with skills and knowledge to deliver a compassionate and person-centred service.

Dementia Training offer

We deliver a range of learning opportunities to our workforce with role specific content on induction, continuing professional development opportunities and a comprehensive programme for BSc Paramedicine students. We ensure that the voice of people affected by dementia is strong through these learning opportunities and service users regularly attend learning opportunities.

This year we have connected with the Volunteer workforce, NEPTS and 111 workforce to deliver bespoke dementia learning opportunities.

We have launched 2 podcasts to date, which focus on the voices of people living with dementia and their carers. These provide our colleagues with an awareness of how dementia can impact on a person and family life, from diagnosis to ongoing support that people need. We are currently planning and developing future podcasts with dementia specialists, to focus on communication skills and using reminiscence therapy with our patients.

The Trust achieved 92% compliance for dementia training during over this reporting period.

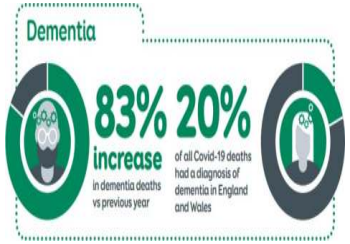
> Really enjoyed today's session. I plan to take the information learnt and transfer it into good practice when out on the road. Thank you so much

> I have really enjoyed it today. It has been very informative and heartwarming.
>
> The staff are inspirational and a credit to themselves.

WAST learning zone
WELSH AMBULANCE SERVICES NHS TRUST

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

Celebrating our Achievements



Professional Excellence

The Trust's Dementia Team won the Dementia Hero Award for Professional Excellence (Organisation) at the Alzheimer's Society Awards 2023. The Dementia Hero Awards celebrate the involvement and participation of people affected by dementia and the impact they have for others living with the condition.

Conference Presentations

The team celebrated work achievements at the Rural Health and Care Wales Conference 2023 and are planning to showcase our work at international conferences, including the Alzheimer's Disease International 36th Global Conference in April 2024.

International Interest in our Work

In November 2023, the Dementia Team was visited by a Clinical Lead from Ambulance Victoria, Australia. Lyndsay was a recipient of the Sir William Kilpatrick Churchill Fellowship to review the establishment and effectiveness of dementia-friendly ambulances and dementia plan and his research had identified WAST as a leading ambulance service in this area.

Kraków 2024
Global Conference of
Alzheimer's Disease International

Celebrating our Achievements

Referrals into specialist dementia services

We have worked in partnership with Alzheimer's Society Cymru on a referral process for any of our staff groups into the All-Wales Dementia Support team. This referral can be from anyone in our service who is concerned about someone's dementia, memory loss, confusion or issues with daily living. The referral is also available for carer and families who may require additional support. The Dementia Support service is an all-Wales bilingual telephone service but also connects to local face to face services. The referral pathway will be available on staff iPads and a desktop form and was launched in the Autumn 2023. Since its launch we have received 96 referrals.

Working with Royal National Institute for the Blind – Common sight loss conditions

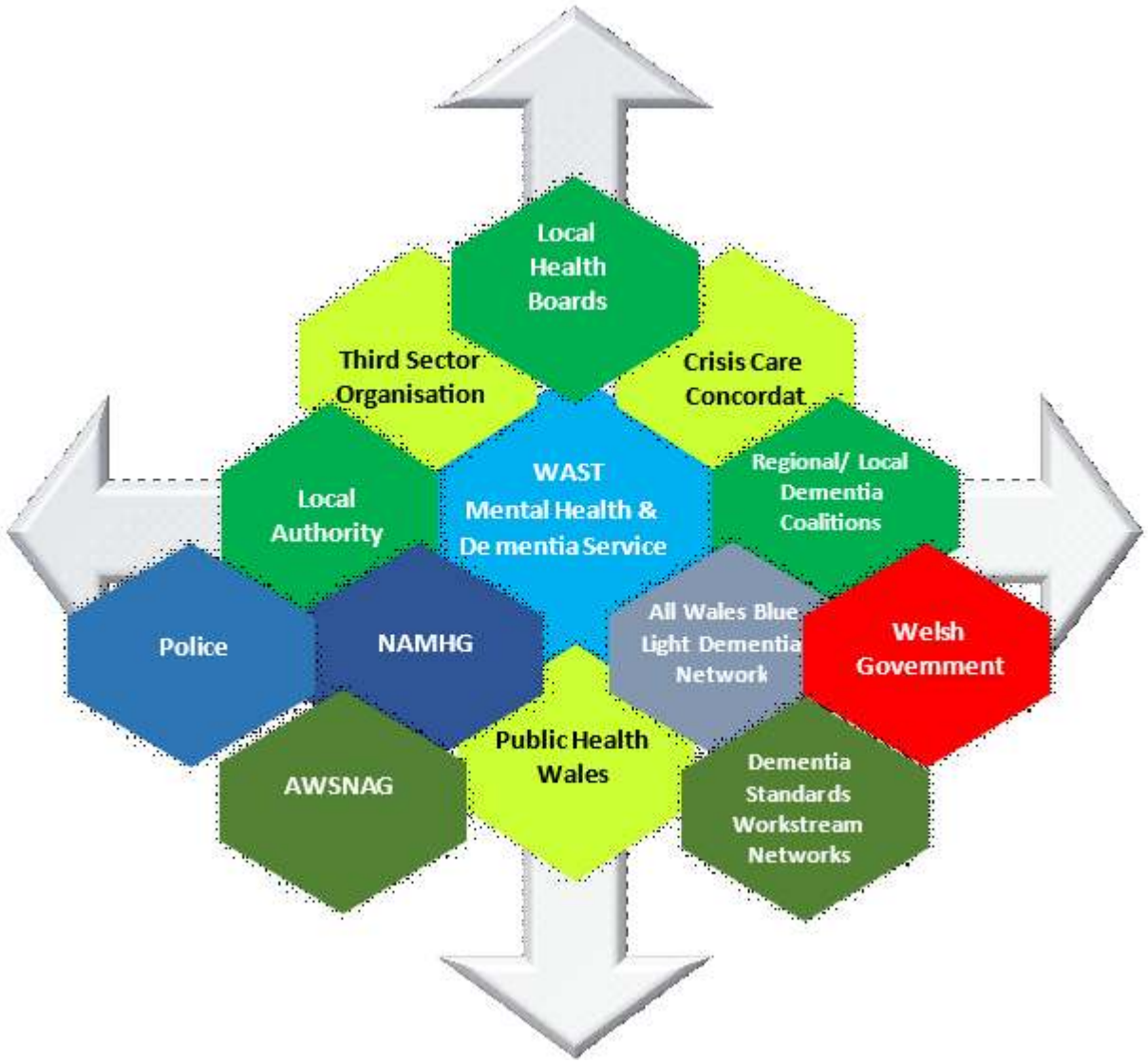
A partnership project with RNIB has enabled us to develop short video-clips on key sight loss conditions, including macular degeneration, cataracts and glaucoma to improve awareness across our workforce. Also included in these mini-learning videos are 'sight loss and dementia'; and 'falls, sight loss and the environment'

Improving the information we capture about people with dementia who contact 999

We have developed additional features on our electronic Patient Care Record to gather important information that we collect about people with dementia who call 999 for an emergency response. The new features allow us to document different information about a patient's dementia symptoms and diagnosis for us to have a better view of the dementia related calls coming through our service. The new function launched in May 2023.

Through 2023-2024 we have identified 24,694 people living with dementia when providing care through our 999 service.

Connecting with other works across Wales



The Mental Health & Dementia Team sits within the Quality, Safety and Patient Experience Directorate. Our commitment to delivering high quality care has been clearly demonstrated by achievements highlighted in previous reporting periods. Effective, compassionate leadership, courageous management and innovation have been integral to our success.

We reach our objectives by effectively working together with a wide range of services and professionals, ensuring good outcomes for people

who have contact with our service.

MHD Team has established strong relationships

with all departments in our organisation as well as within the wider mental health & dementia arena across Wales.

Our achievements obtained through improved knowledge, skills and attitudes as well as the promotion of mental health & dementia services and pathways across Wales has fortified our working relationships both at an operational and strategic level.

Connecting with other works across Wales

National Ambulance Mental Health Group (NAMHG)

The purpose of this group is to promote a consistent approach to Mental Health across the UK ambulance services. To connect, support and guide mental health practice of its practitioners across the UK.

WAST's Mental Health and Dementia Team contributes to the work of the group and participates in promoting evidence-based practice/ NICE guidelines to ensure services are providing high standards and quality of care across all trusts and promote continuous improvement.

Welsh Chief Officers Group

This group provides mental health updates and information sharing from all four police services across Wales. The aim of the group is to provide a framework for organisations to learn from mental health strategies and evidence-based ways of working.

A Senior Professional from the MHD Team is part of the task and finish group for this group.

Dementia Oversight of Implementation and impact group

This group informs and monitors progress against the dementia action plan in Wales. It provides the opportunity to promote WAST dementia work at a national level, and to share and learn with partners.

All Wales Blue Light Dementia Network

This group connects all blue light partners in Wales including Police, Fire, Mountain Rescue and Natural Resources Wales to focus on personal, home and community safety initiatives with people living with dementia at the heart.

Welsh Government

Together for Mental Health (TfMH) is a mental health policy framework for Wales. It was introduced in 2012 and outlines the Welsh Government's vision and strategy for improving mental health and well-being in Wales.

The policy focuses on various aspects of mental health, including prevention, early intervention, and support for individuals experiencing mental health issues. It emphasizes the importance of reducing stigma and discrimination, promoting mental well-being, and providing effective mental health services.

TfMH was a 10-year plan and is currently being evaluated and a renewed plan set forth.

Conclusion

In conclusion the Mental Health & Dementia annual report reflects the significant contribution which the Trust, MHD Team and WAST colleagues have made in ensuring people are treated for their mental health problems in the best way possible. There is much to celebrate in the achievements highlighted throughout the report.

The MHD Team's collaborative partnership working continues to be significant. Our achievements obtained through continuous improvements, capitalising on evidence-based practice and successfully implementing these ways of working.

MHD team is dedicated to working with partners and organisations across Wales and the UK to facilitate patient pathways and ensure best practice is adopted in a timely manner for the benefit of our patients.

MHD team also provides dedicated continual advice, guidance and support to colleagues at all levels within WAST.

The work streams commenced during this reporting period provide focus for the team to continue to progress in 2024-25 and the development of the next Mental Health & Dementia Plan.

Amb_mentalhealth@wales.nhs.uk

Moving Forward 2024/2025

1. Expand Mental Health Response Vehicles (MHRV)

- We seek to roll out MHRVs across Wales, with plans to operate response vehicles in all seven Health Boards in Wales, with a particular focus in urban areas with high demand.
- This expansion will not only increase our capacity to respond to crises swiftly but also improve the quality of care by providing on-the-spot therapeutic interventions. This vital service will enhance the care provided to patients, as well as support people in awaiting specialist Health Board service and care interventions.

2. 24/7 Mental Health Practitioner Coverage:

- By extending the operating hours of our MHCs to 24/7, we will significantly reduce the strain on emergency resources out of hours, and ensure that those in mental health crises receive timely, expert care at any time.
- As a national service provider, the use of our clinical contact centre is where MHCs will ensure patients across Wales are able to receive specialist care, and that other healthcare professionals can access mental health clinical advice and support.

3. Enhancing and Advancing Clinical Practice, Education and Training:

- To ensure long-term resilience, we will develop education modules to enhance the clinical expertise of WAST clinicians. This will also create a pipeline of skilled professionals who can provide specialised care into the future.
- We will also develop our staff to provide enhanced, advanced and consultant level mental health practice, this will include widening our expertise and specialist support to provide better care for people with learning disabilities and substance misuse, and to young people requiring specialist support.
- We aim to increase our expertise across mental health specialisms, such as CAMHs and Learning Disabilities.

4. Clinical Innovation through Technology and Research:

- We will undertake further work to refine our service delivery models, testing in both remote and face-to-face contexts.
- In addition, we plan to explore the use of technologies and alternative clinical practices to further enhance remote mental health triage, assessment and support, reducing the need for patients to attend urgent and emergency care settings, where appropriate.

AGENDA ITEM No	**11**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**1**

PUTTING THINGS RIGHT REPORT
QUARTER 2, JULY - SEPTEMBER 2024/25

MEETING	Quality, Patient Experience & Safety Committee
DATE	5 November 2024
EXECUTIVE	Liam Williams, Executive Director of Quality and Nursing
AUTHOR	Wendy Herbert, Deputy Director of Quality and Putting Things Right Claire Appleton, Assistant Director - Putting Things Right
CONTACT	Wendy.Herbert3@wales.nhs.uk 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 Services functions.

In summary the Report for Quarter 2, 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 consistent number of serious incidents shared with Health Boards colleagues to investigate under the Joint Investigation Framework.
- The PTR Recovery Plan is on track for delivery with improvement trajectories reflecting work to stabilise concerns and overdue Nationally Reportable Incidents (NRI) volumes

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

KEY ISSUES/IMPLICATIONS
(i) The recent spike in Coroners activity shows signs of returning to a more usual level, although the complexity of cases and amount of activity required per case remains high. (ii) Our five-day complaint acknowledgement target was 100% through July - September. (iii) No Prevention of Future Death Reports were received in the reporting period. (iv) 30 working day complaint response performance has dipped but the number of open complaints has been reduced by nearly 50%. (v) There are no Red deferred Learning from Event Reports.

REPORT APPROVAL ROUTE	
Clinical & Quality Governance Group	30 October 2024
Quality, Patient Experience & Safety Committee	5 November 2024

REPORT APPENDICES
ANNEX 1 - SBAR which provides the background for this 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 July to 30 September 2024. Table 1 and 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
- Organisational learning (including Learning from Events and Welsh Risk Pool submissions)

Although the PTR and Legal Services Team lead also on the Learning from Deaths Agenda, this is covered within the separate twice-yearly Learning from Deaths Report to this Committee.

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

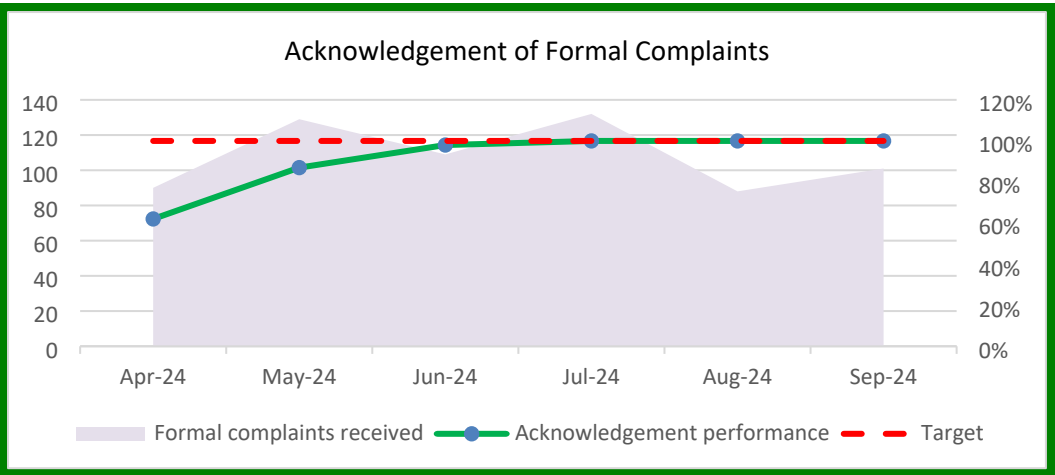
4. The PTR Team Organisational Change Process aims to provide additional leadership, capacity and development opportunities across the functions. Recruitment to positions has been completed and the team are working towards achievement of the aims laid out in the PTR and Legal Services Recovery Plan.

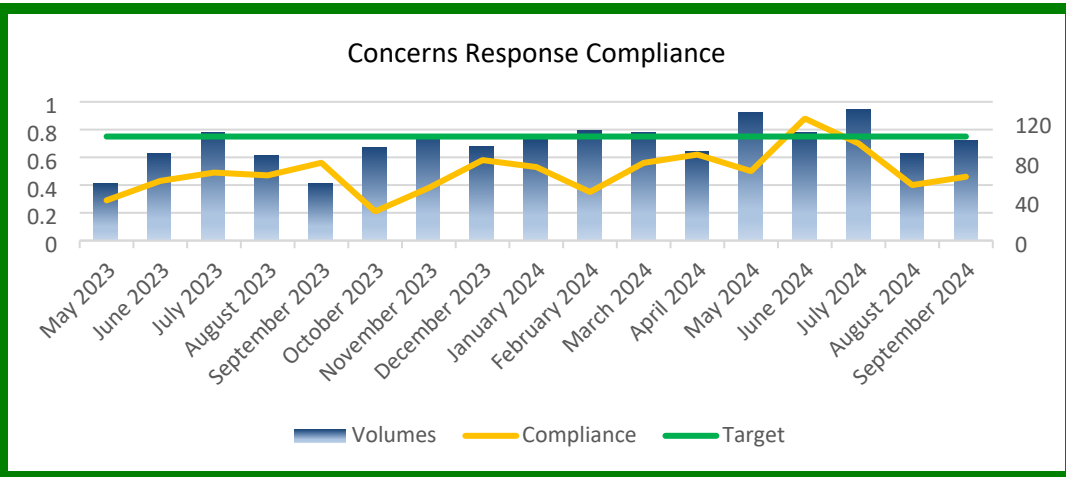
5. The ambition in future reports is to move to Aggregated Thematic Reviews, in order to determine patterns and trends corporately and at service and Health Board levels when data from Datix Cymru can be extracted into Trust systems to create live Dashboards. Work towards this has taken a step forward through the recognition of work needed around the Datix Cymru System and the development of a Datix Cymru Recovery and Improvement Plan.

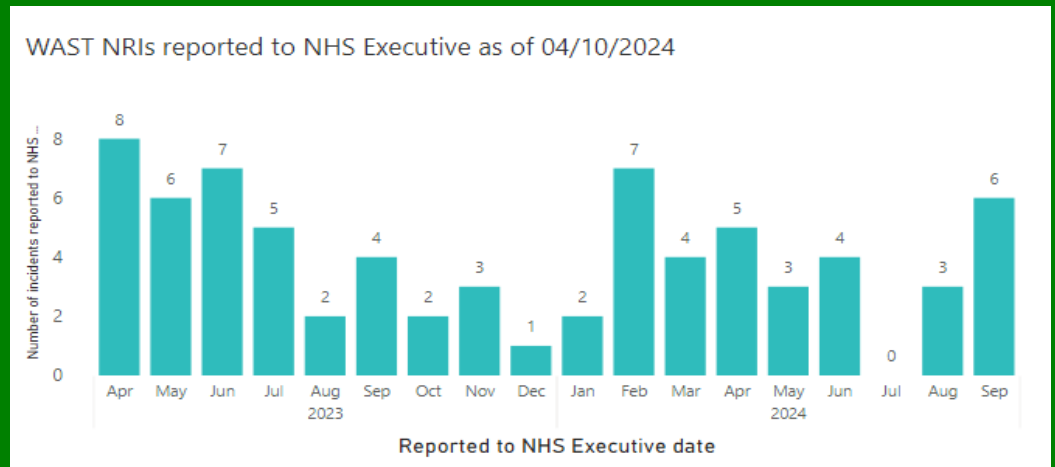
ASSESSMENT

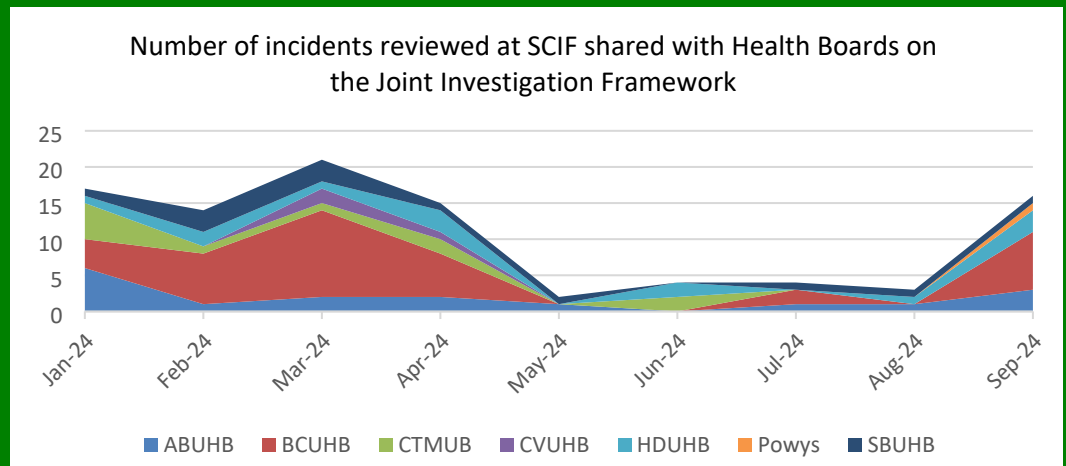
Putting Things Right and Legal Services						
Comparison of data by month/quarter/year	**Quarter 2, 2023-24**			**Quarter 2, 2024-25**		
	July 2023	**Aug 2023**	**Sept 2023**	**July 2024**	**Aug 2024**	**Sept 2024**
Patient Safety Incidents (Reporter's view of harm)						
Catastrophic / Death	26	26	28	22	28	26
Severe	4	7	11	16	19	21
Moderate	58	63	41	36	73	53
Low	189	160	166	106	122	100
None	109	73	39	31	38	40
Total	386	329	385	211	280	240
Concerns						
5 working day acknowledgement %	100%	100%	79%	100%	100%	100%
30 working day response %	49%	57%	56%	70%	40%	46%
Total received	109	86	58	132	88	101
Ombudsman						
Cases Received	4	0	1	1	0	3
Cases Closed	4	0	2	0	0	4
Reports Received	1	0	0	1	0	0
Coroners						
Information requests	146	171	183	251	241	242
Identified as Interested Party	41	42	39	50	50	52
Staff attending	7	7	6	15	16	17
Regulation 28 issued	3	0	1	0	0	0
Response to Regulation 28 outside 56 working days	0	0	0	0	0	0
Nationally Reportable Incidents						
Serious Case Incident Forums held	4	7	5	3	4	6
Serious Case Incident Forum Cases	22	33	18	12	21	31
NRIs notified to the NHSWE	4	2	4	0	3	6
Joint Investigation Framework cases shared	9	23	7	4	3	16
Joint Investigation Framework cases received	0	0	0	0	0	0
NRI outcomes submitted to NHSWE	3	0	6	7	1	2
Legal Claims						
Personal Injury cases received	1	3	1	5	2	2
Clinical Negligence cases received	4	4	2	3	6	0
Road Traffic Collision and Damage to Property cases received	27	21	11	20	32	17
Personal Injury cases closed	1	0	11	0	1	3
Clinical Negligence cases closed	1	0	0	0	0	1
Road Traffic Collision and Damage to Property cases closed	7	9	9	19	46	44

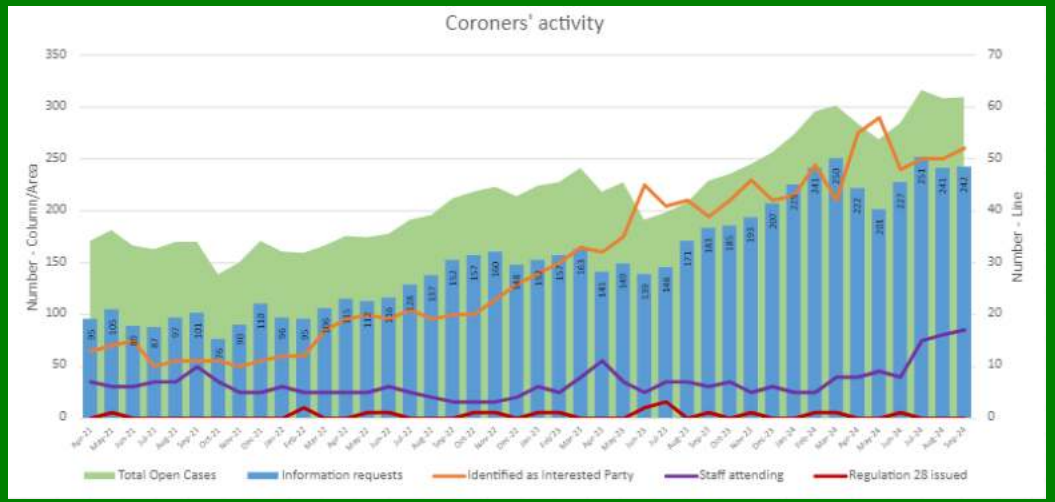
Putting Things Right and Legal Services - At a glance

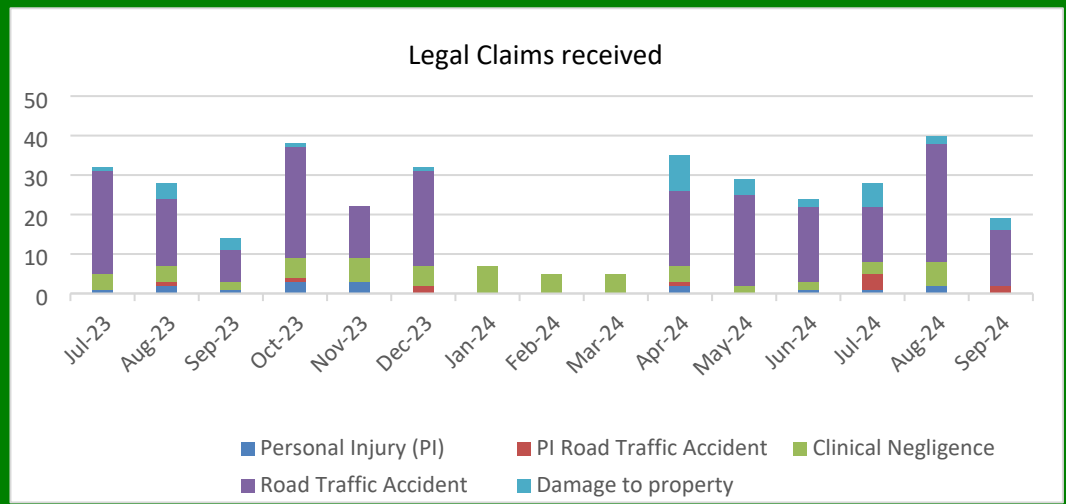












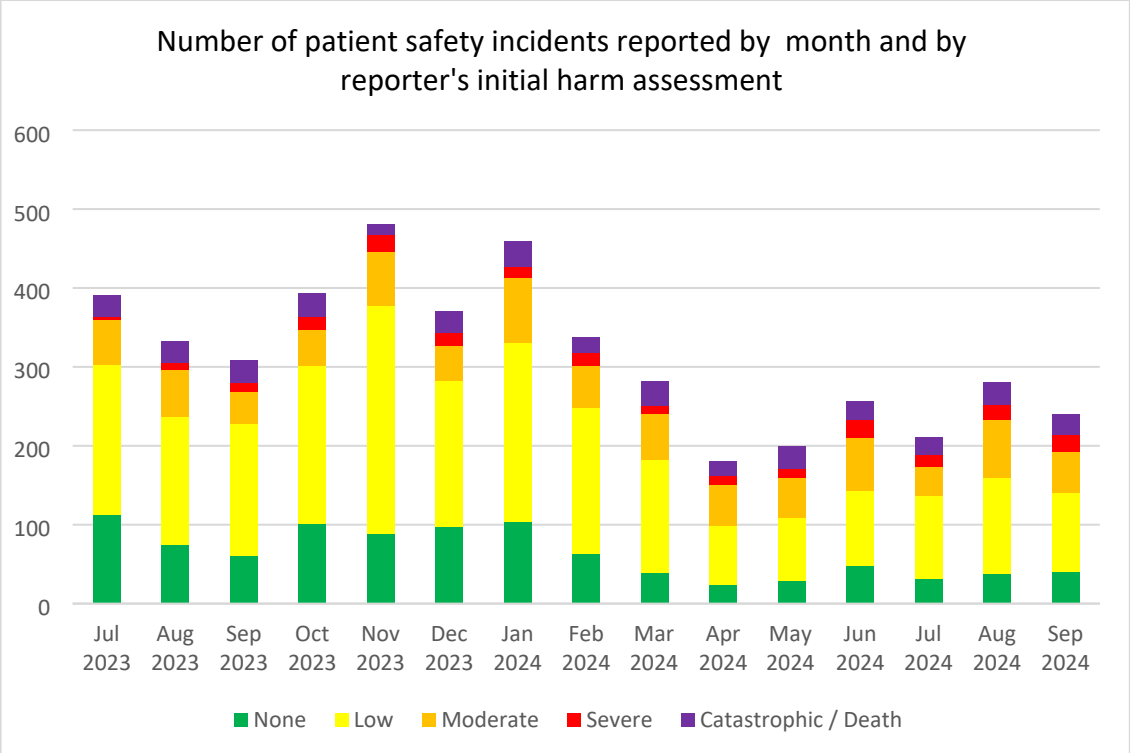
Patient Safety Incidents

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

7. During this period a total of 731 patient safety incidents were reported, 211 in July, 280 in August and 240 in September. It must be noted that the harm grading may change subject to the outcome of any investigation.

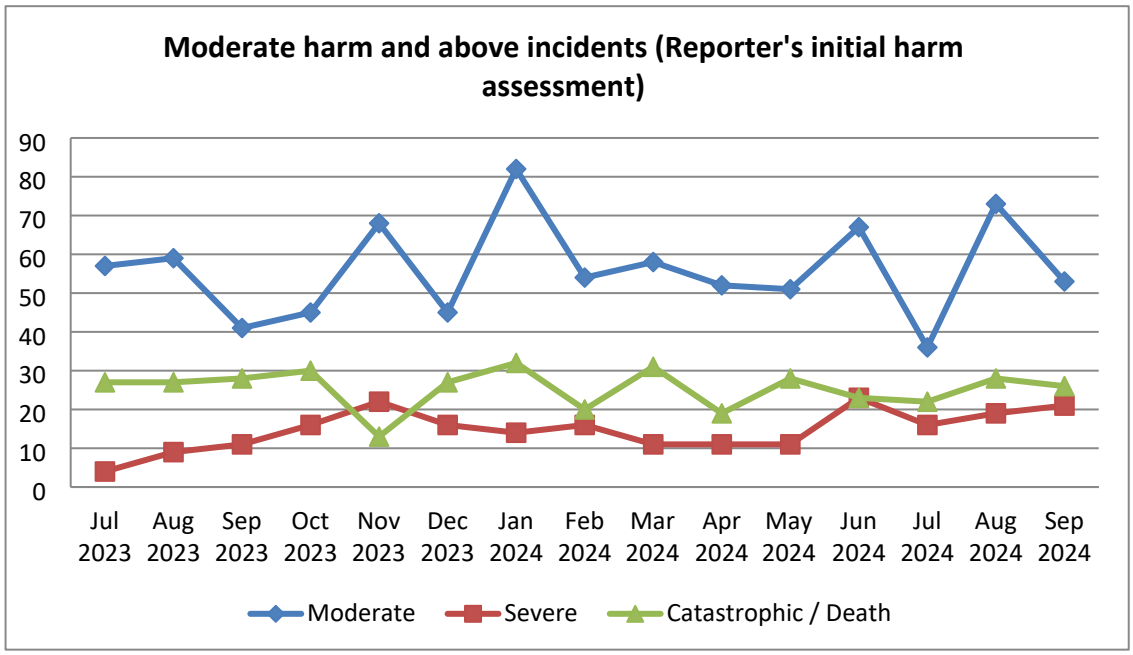
8. The graph below illustrates the number of patient safety incidents reported on a rolling basis from July 2023 by initial grading (reporter's view of harm). Themes continue to be timeliness to response and handover of care delays.

Graph 1



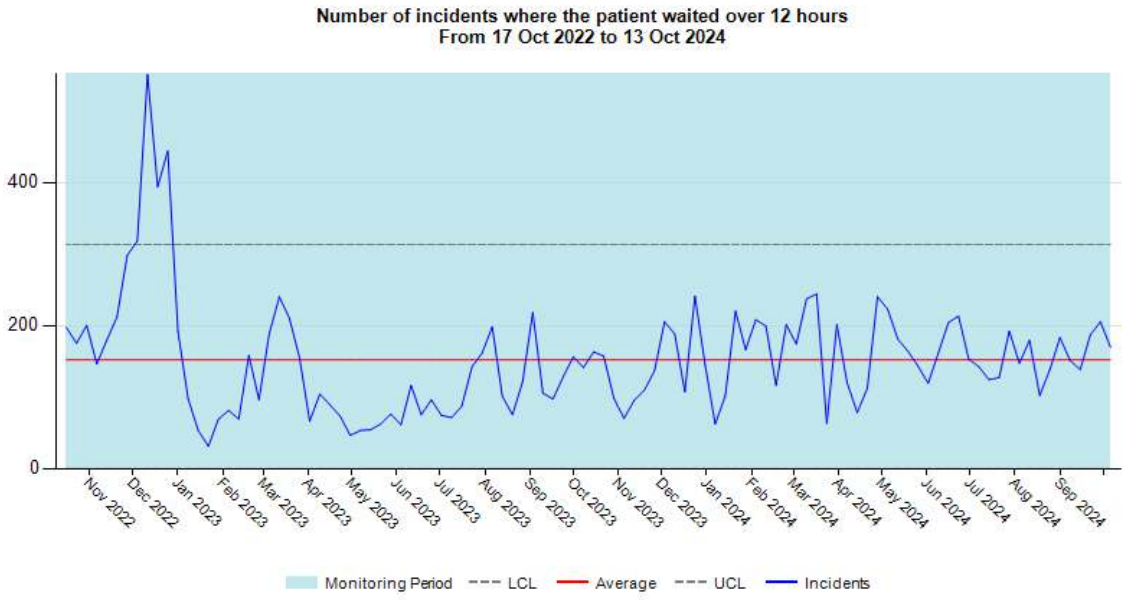
9. Graph 2 below details the number of patient safety incidents rated moderate and above. The Patient Safety Team continue to review incidents graded moderate and above to determine enactment of the Duty of Candour.

Graph 2

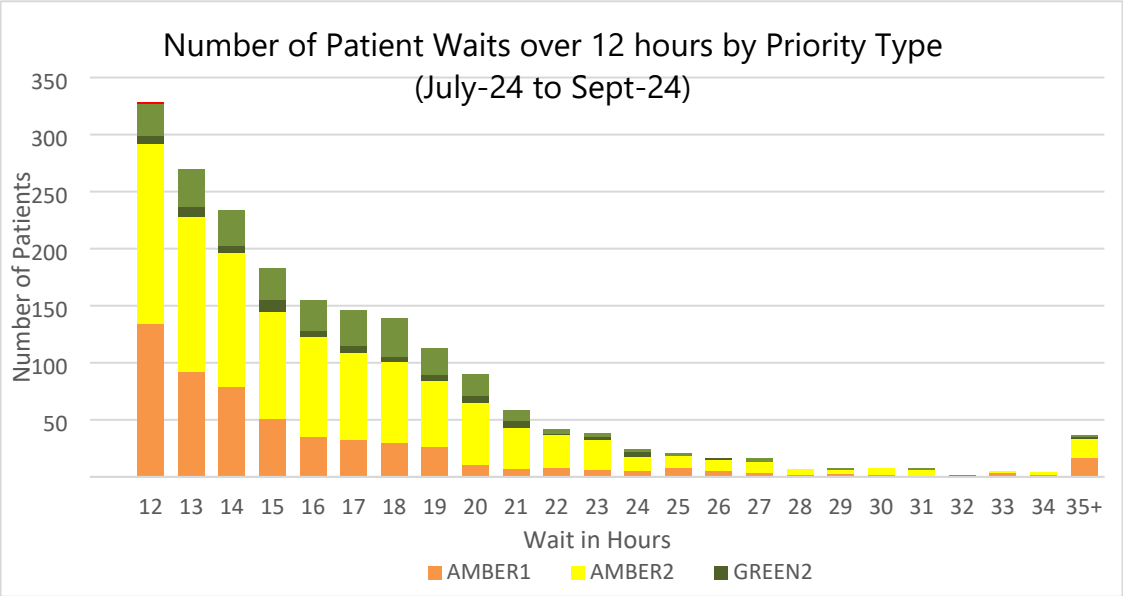


10. Patients waiting for extended periods of time in the community continues to impact on patient safety as detailed in Graph 3 below. During this period 1948 patients received a response or wait over 12 hours. This is an improvement on the previous quarter where 2159 patients waited over 12 hours.

Graph 3



Graph 4

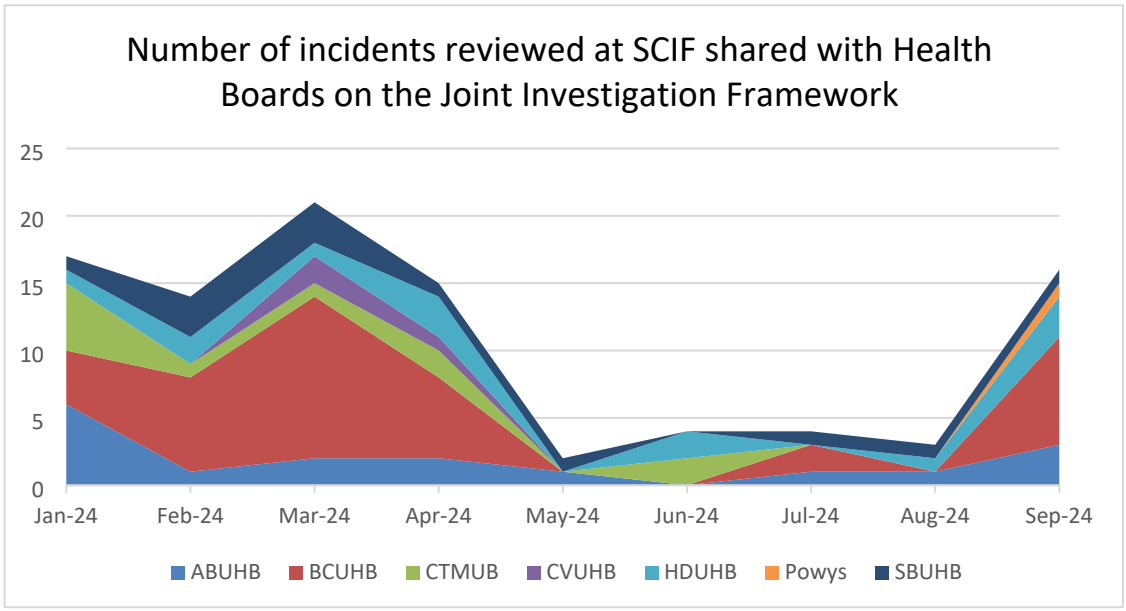


11. Identification of patient harm across the whole Urgent Care Pathway is challenging, as impacts are not always immediately apparent.

12. 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.

13. Graph 5 below details the number of cases discussed at the Serious Case Incident Forum (SCIF) and shared with Health Boards for further investigation under the Joint Investigation Framework.

Graph 5



14. During this reporting period there were 13 SCIF Meetings held, with 64 incidents discussed. 13 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.

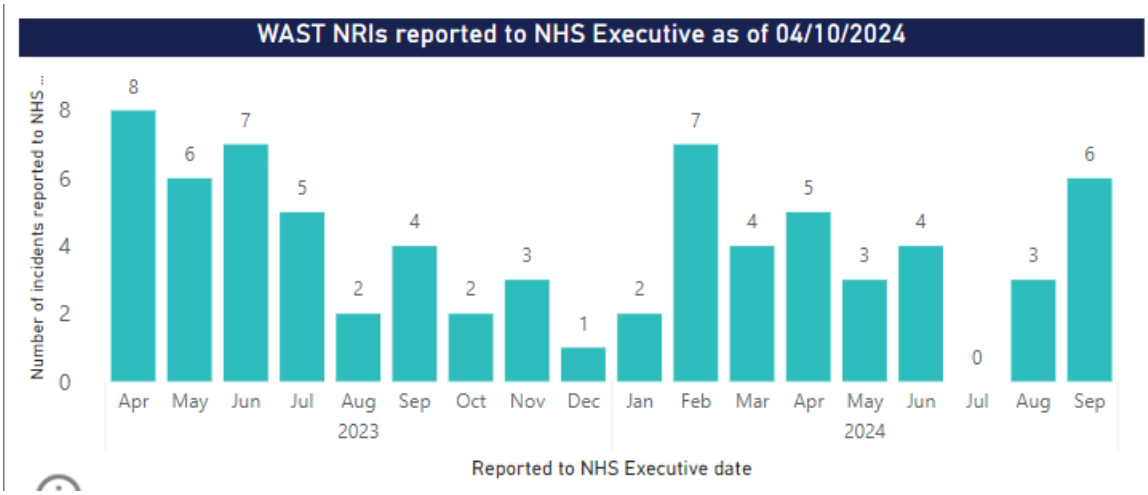
15. 23 incidents were shared under the Joint Investigation Framework to the respective Health Boards following a review internally. No recorded incidents linked directly to immediate release requests were identified.

16. 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.

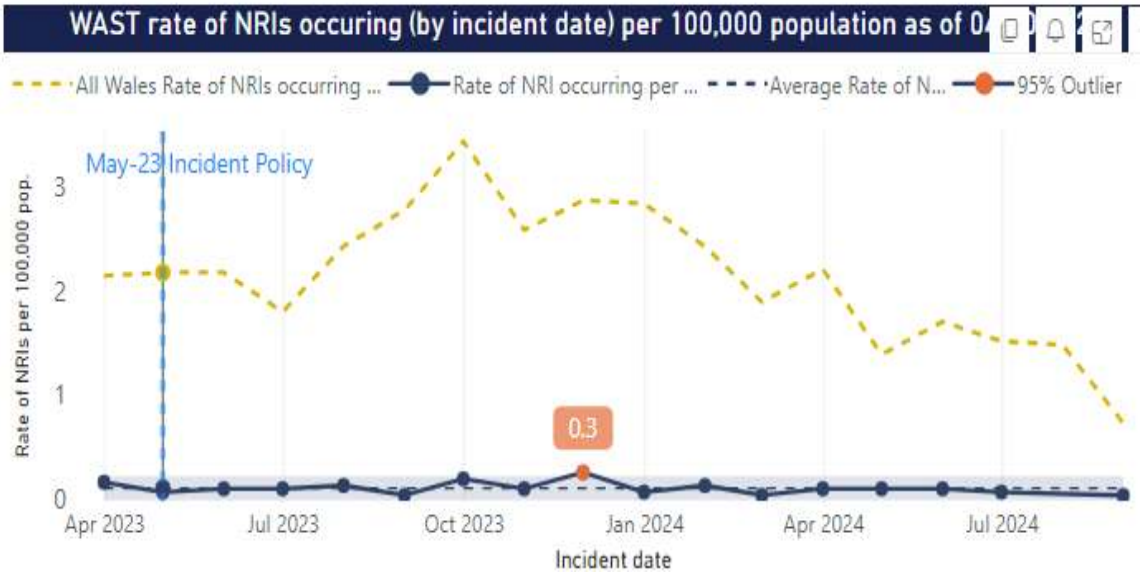
17. The Senior PTR Managers have engaged with the Once for Wales Datix Cymru Programme Team regarding the development of a Joint Investigation Learning Repository. Initial scoping identifies a possible national solution for shared access to information and collated learning whilst retaining governance accountability on organisational Datix Systems for investigatory work and sensitive data such as staff involvement.

18. Graph 6 below provides an overview of the numbers of Nationally Reportable Incidents (NRIs) submitted. Graph 7 provides the numbers of NRIs by population health. Both graphs are extracted from the NHS Wales Beacon Dashboard updated 4 October 2024).

Graph 6

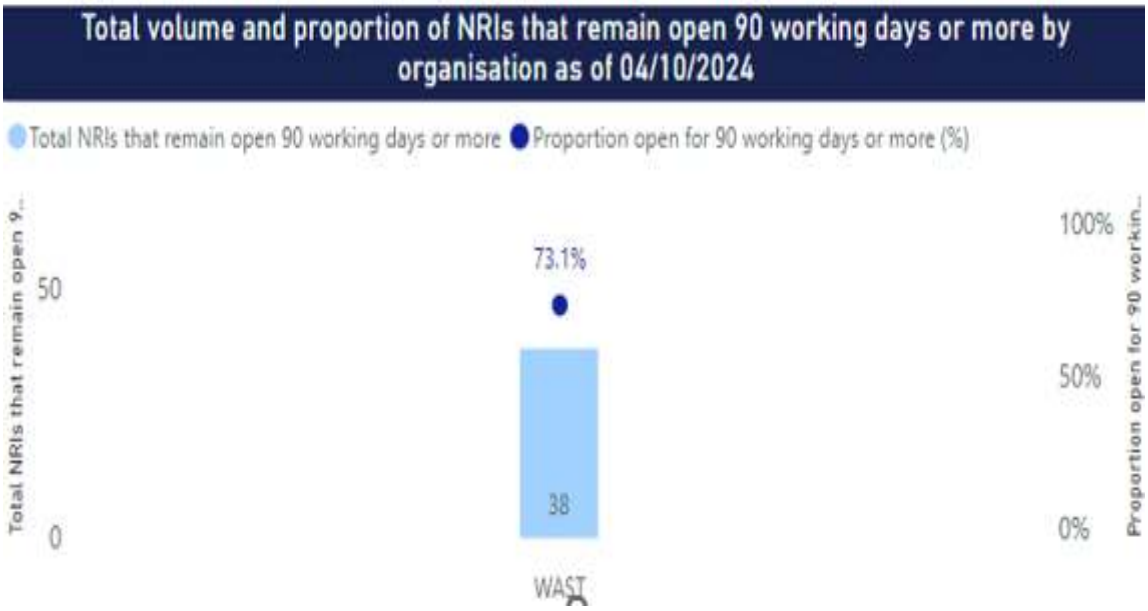


Graph 7



19. WAST currently has 51 open NRIs. Graph 8 indicates how many of these have been under investigation for 90 working days or more and the proportion of this against the total number open.

Graph 8



20. Tables 2 and 3 provide a thematic breakdown of NRIs reported since April 2023.

Table 2

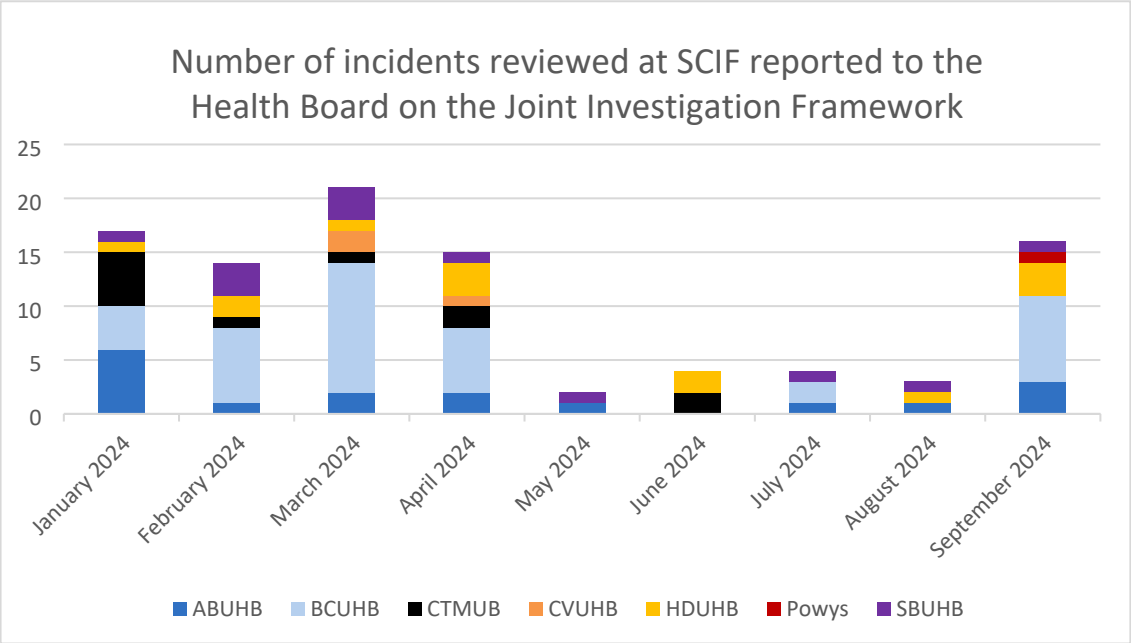
NRI category	Total
⊞ Access to services or admission delayed	23
⊞ Unexpected death	10
⊞ Triage and prioritisation - Remote (e.g. telephone, video)	5
⊞ Clinical assessment, clinical diagnosis	3
⊞ Treatment or procedure issues	3
⊞ Access to services or admission denied	2
⊞ Administration errors	1
⊞ Consent process for examination or treatment not / inadequately followed	1
⊞ Inappropriate behaviour / attitude	1
⊞ Patient injury	1
⊞ Patient/service user appointment	1
⊞ Patient/service user monitoring	1
⊞ Slip, trip or fall	1
⊞ Transport	1

Table 3

NRI category	Total
⊟ **Access to services or admission delayed**	
Allocation delay - No / lack of available resources	11
Access to admission delayed	6
Medical Priority Dispatch System (MPDS) - delay - incorrect prioritisation	4
Access to services delayed	1
Delay - nearest available resource not allocated	1
	0
Delay - call not directed appropriately / closed in error	0
Delay accessing assistance from Emergency Medical Services (EMS) Clinical Desk / Duty Control Manager (DCM)	0
Delay due to escalation Deployment Management Plan (DMP)	0
Delay in accessing Emergency Department (ED) / ward	0
Failure in referral process	0
Other	0
Patient Centred Response Matrix - Poor patient outcome	0
Treatment or procedure delayed	0
⊞ **Unexpected death**	10
⊞ **Triage and prioritisation - Remote (e.g. telephone, video)**	5
⊞ **Clinical assessment, clinical diagnosis**	3
⊞ **Treatment or procedure issues**	3
⊞ **Access to services or admission denied**	2
⊞ **Administration errors**	1
⊞ **Consent process for examination or treatment not / inadequately followed**	1
⊞ **Inappropriate behaviour / attitude**	1
⊞ **Patient injury**	1
⊞ **Patient/service user appointment**	1
⊞ **Patient/service user monitoring**	1
⊞ **Slip, trip or fall**	1
⊞ **Transport**	1

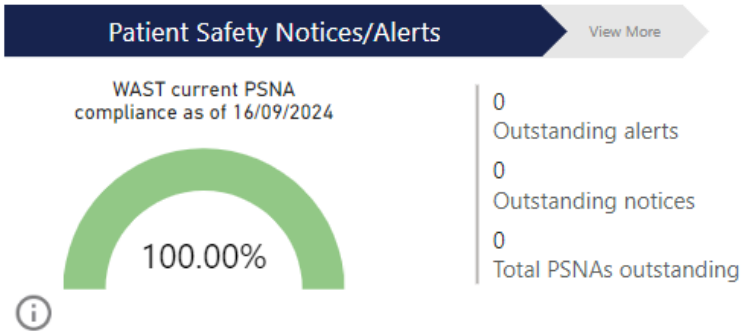
21. Graph 9 below details the number of NRI reported to the NHS Wales Executive by Health Board area.

Graph 9



NHS Wales Patient Safety Alerts/Notices

22. The Trust has no outstanding Patient Safety Alerts (NHS Wales Beacon Dashboard updated 16 September 2024) as detailed below.



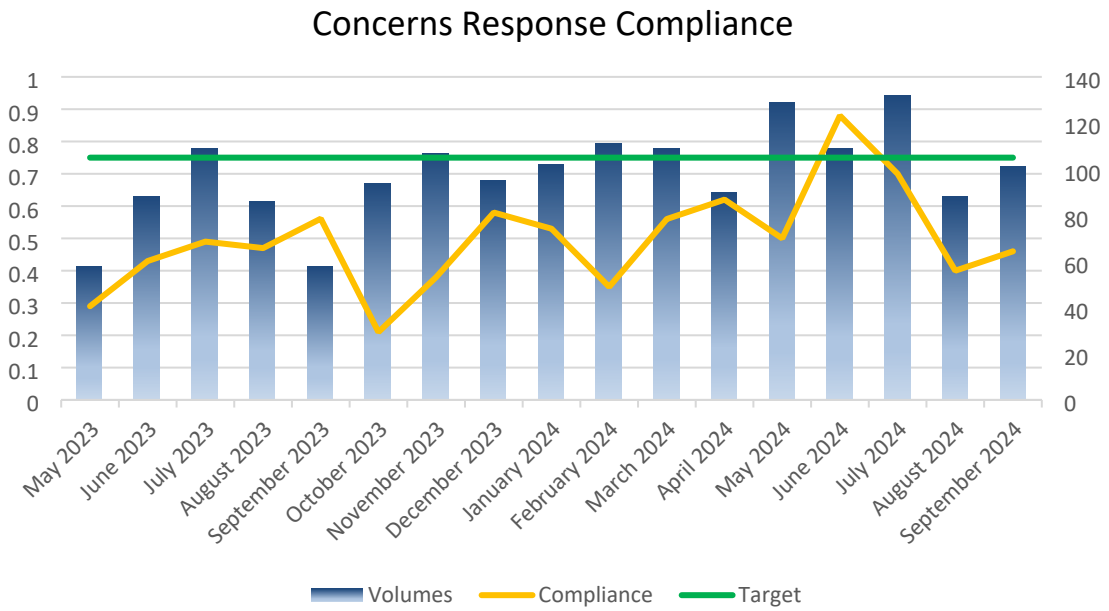
Early Resolution (ER) and Formal Concerns

23. 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.

24. Graph 10 below provides the complaints position over time. The Trust continues to receive a steady number of complaints with 321 being received during this reporting period.

Graph 10



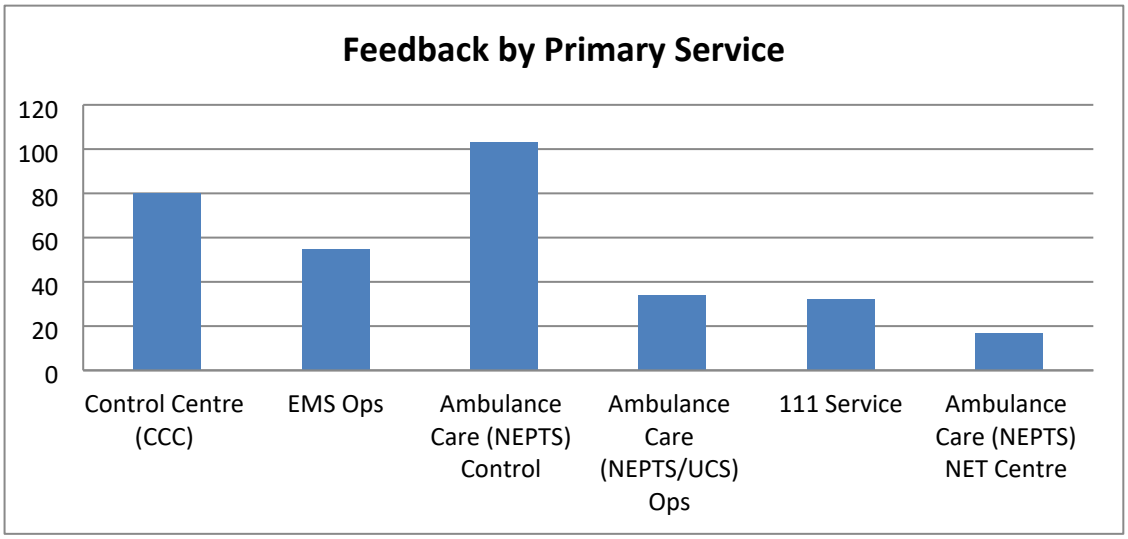
25. The acknowledgement date target has been amended nationally to five working days. During this reporting period the five-day acknowledgement performance was 100% throughout the reporting period (100% target) with the 30-day target achieving 70%, 40% and 46% respectively (75% target).

26. The Trust has re-established live call-taking of complaints, achieving a significant step forward to improve patient experience of the Complaints Process, providing a more personalised and compassionate response at the time when we are first contacted. This progress is commendable given the number of vacancies existing in the Administrative Hub during this quarter and represents the team's dedication to improving the quality of our services.

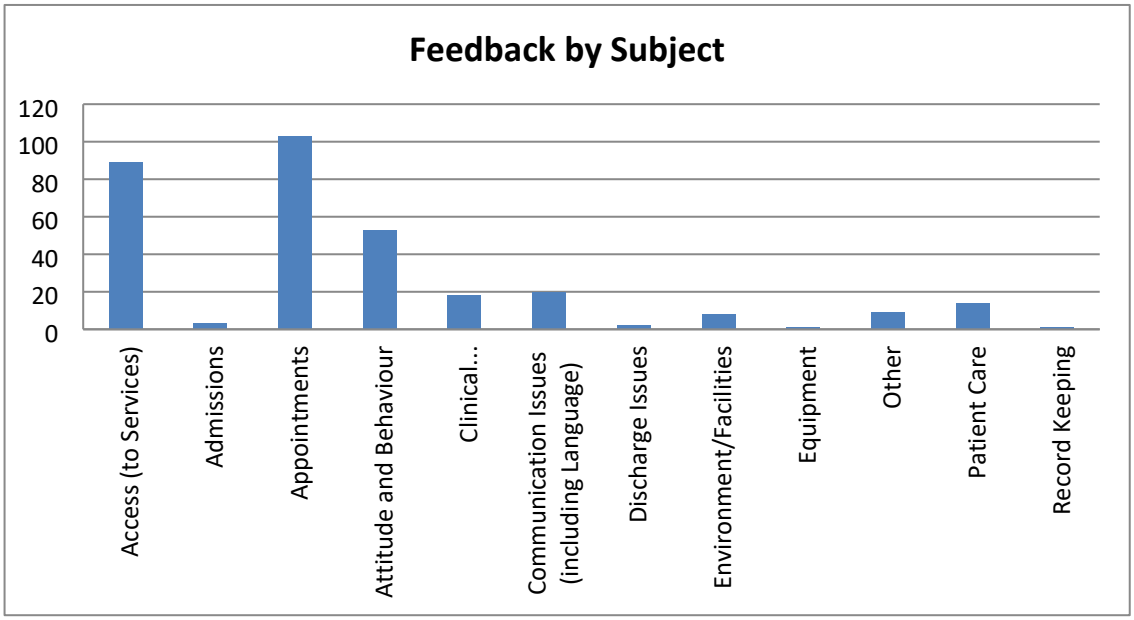
27. The drop in 30-day performance was anticipated as part of the PTR and Legal Services Recovery Plan in order to reduce the overall volume of open complaints. This was reduced from 197 open complaints in July to 106 open complaints in September and is an important step on two fronts: responding to a larger volume of people awaiting responses and laying the foundations for a consistent performance in future. Performance is anticipated to improve rapidly now the volume of open complaints is at a more manageable level.

28. Graph 11 provides a breakdown is provided about the services which receive most complaints. These figures comprise both Early Resolution and Formal Concerns and it is noticeable that the of our top five complaint categories. Graph 12 details the types of categories about which complaints are received.

Graph 11



Graph 12



29. Training for the Patient and Family Relations Team to enhance data capture and confidence with the Datix Cymru Feedback Module has been arranged for November 2024.

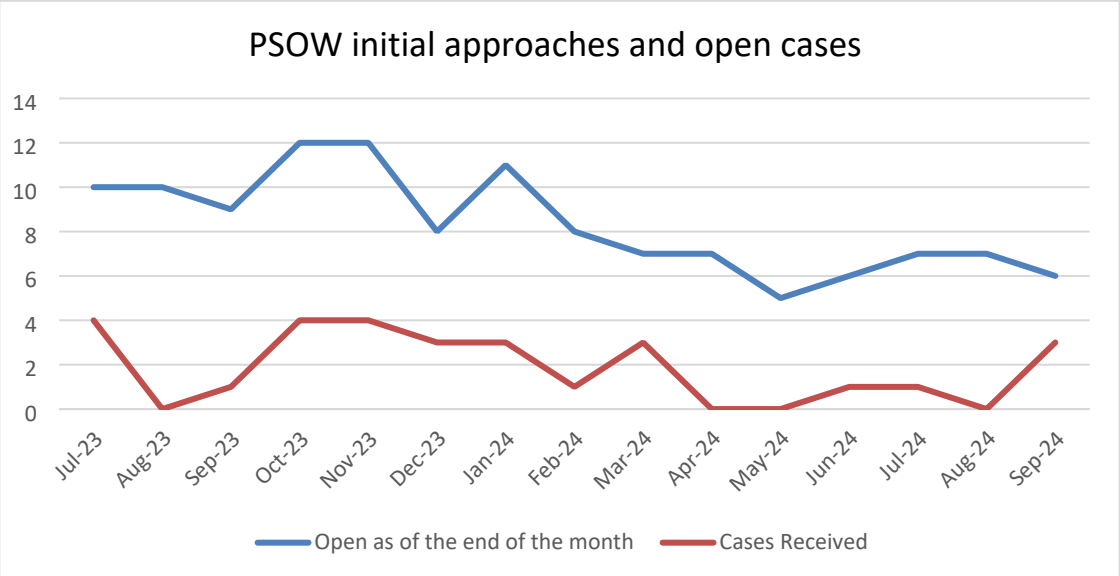
30. Feedback is provided to staff regarding concerns relating to attitude and behaviour and our Clinical Leads undertake Clinical Reviews of incidents and complaints relating to clinical care and actions/improvements frequently include additional education, training and mentoring.

Public Services Ombudsman for Wales (PSOW) activity

31. Graph 13 indicates that the number of initial approaches to the Trust by the PSOW remains low, demonstrating the quality of responses to formal complaints

it is possible that recent efforts to respond to a number of long-standing complaints has resulted in a slight uptick in the number of approaches. This will be monitored closely to ensure the Recovery Plan does not adversely impact on response satisfaction rates.

Graph 13



32. 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. All PSOW cases are now being managed via Datix Cymru.

EMS Co-ordination and Resourcing Centre Concerns & Coroners Activity

33. The data provided by the Operations Quality Team is under review and the creation of an automated Power BI Dashboard to facilitate future access and reporting is in development. Specific data sets and graphs will be provided again in next quarter's report.

34. The team have improved investigation timescales for formal concerns and senior collaboration between the PTR and Operations Quality Teams has identified opportunities to manage lower graded concerns as Early Resolutions, offering a more personal and far quicker response to complainants.

35. The volume of Coroners' activity continues to present a challenge owing to Regional Coroner's Offices working through a backlog of cases. Upskilling of the recently appointed senior management post which includes responsibilities for Coroners has been completed as part of an approved Organisational Change Process and realignment of processes and coordination between the Operations Quality Team and Legal Services Team is also being trialled.

36. The Operations Quality Team have also undertaken training from Welsh Risk Pool (WRP) on Learning from Events Reports with a view to improving the standard of submissions and learning assurances with the aim of reducing the number of deferred cases.

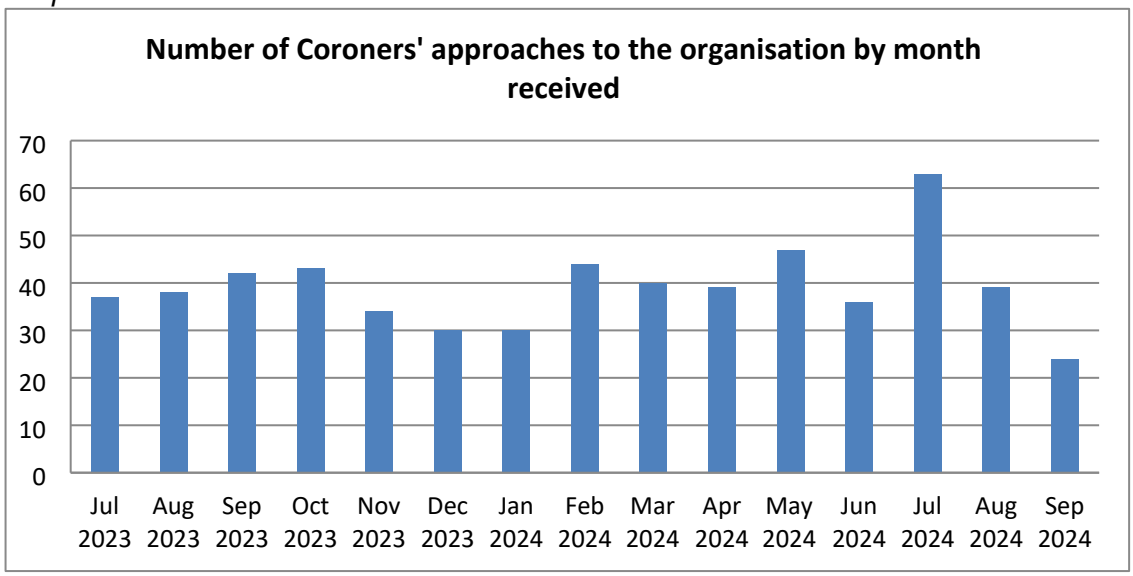
37. Learning from concerns investigations, Coroners and SCIF continues to be shared with Emergency Medical Servies (EMS) Coordination Teams by Operations Quality via coaching bulletins, competency sign offs and face-to-face where required.

38. 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

39. The number of approaches received from Coroners reached a peak in July 2024 as Regional Coroners Offices recruited staff to address the backlog of cases that had grown through the COVID-19 pandemic (Graph 14) as detailed in the Chief Coroner's Annual Report. There are signs that this is now returning to more usual levels.

Graph 14



40. 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 multi-day Inquest Hearings. All falls resulting in death at care homes will now be heard by Jury Inquests which will increase the length of hearings. Experienced temporary staffing is being maintained to support the increased activity in this area.

Prevention of Future Death Reports (Regulation 28)

41. During the reporting period the Trust has not received any Prevention of Future Deaths Reports (Regulation 28).

42. The Legal Services Team coordinate any 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

43. Table 4 provides an overview of the activity in Legal Services. Gaps in the data were due to a move to a new database. There was a peak in the numbers of Road Traffic Accident Claims received during August although the reason behind this is not apparent.

Table 4

			Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Claims opened	Personal Injury (PI)	Monthly	1	2	1	3	3	0	*			2	0	1	1	2	0
	PI Road Traffic Accident	Monthly	0	1	0	1	0	2	*			1	0	0	4	0	2
	Clinical Negligence	Monthly	4	4	2	5	6	5	7	5	5	4	2	2	3	6	0
	Road Traffic Accident	Monthly	26	17	8	28	13	24	*			19	23	19	14	30	14
	Damage to property	Monthly	1	4	3	1	0	1	*			9	4	2	6	2	3
Claims closed	Personal Injury (PI)	Monthly	1	0	6	0	0	0	*			0	0	0	0	0	2
	PI Road Traffic Accident	Monthly	0	0	5	0	1	0	*			0	0	0	0	1	1
	Clinical Negligence	Monthly	1	0	0	0	1	1	0	1	0	0	1	3	0	0	1
	Road Traffic Accident	Monthly	5	8	4	4	14	19	*			17	13	13	18	29	43
	Damage to property	Monthly	2	1	5	1	1	3	*			1	0	4	1	17	1
Claims open at the end of the month	Personal Injury (PI)	Monthly	70	72	67	70	73	73	*		84	86	86	87	86	90	88
	PI Road Traffic Accident	Monthly	61	62	56	57	56	58	*		63	64	64	64	68	67	68
	Clinical Negligence	Monthly	134	138	140	145	150	154	161	162	167	171	172	172	175	181	180
	Road Traffic Accident	Monthly	244	253	269	293	292	297	*		228	230	240	248	249	255	228
	Damage to property	Monthly	20	23	21	21	20	18	*		29	30	34	33	37	22	24
			529	***548***	***553***	***586***	***591***	***600***			***571***	***581***	***596***	***604***	***615***	***615***	***588***

44. Changes to the Legal Services Team responsibilities as a result of organisational change proceedings are now nearly complete and additional training has been undertaken for recently promoted staff within the team. It is hoped that the benefits of the Organisational Change Process (OCP) will now become visible with a reduction in overall open cases numbers at month end however this is highly dependent on Inquest and Redress activity.

45. Team development work is being undertaken to standardise use of the Redress Module on Datix Cymru with national counterparts so that only confirmed cases

will be recorded in the Module. This will, over time, enable better analysis of cases triggering Redress provisions.

Organisational Learning

46. 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.

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

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

- CN 29 2024 - Change in Procedure for Reviewing Diagnostic ECGs in pPCI centres
- CN 30 2024 - Maternity Action Cards
- CN 28 2024 - ePCR Nudge Tool
- CN 27 2024 - Terrapace UI update 2024.07.08.pdf

49. Examples of learning from NRIs are detailed in Table 5.

Table 5 **- Learning from Nationally Reportable Incidents (July - September 2024)**

Review findings	Learning Opportunities
• Poor documentation • Clinical care was of good standard despite initial concerns • Hospital handover delays • Operational shortfalls • Deterioration in patient conditions not correctly categorised (missed opportunities to grade calls at higher priority) • Stack management and visibility of calls • Impact of industrial action • MPDS compliance • Incorrect use of escalated CSP response	• Improved ePCR completion • Incidental learning to improve call compliance with obtaining address and providing CPR instructions • Identification of ineffective breathing descriptors • Changes made to visibility and flagging of calls between stacks • Importance of processing a new call for any changes in patient condition • Recognition of patient obviously deceased • Avoidance of leading questions during calls • Improved understanding of CSP 'can't send' response

Welsh Risk Pool Learning from Events Reports & WRP Committee Outcomes

50. 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.

51. 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.

52. 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 8 October 2024) & Current Position Overall

Table 6

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	3	0	3
Deferred Redress	4	0	4
Overall position	7	0	7

53. Table 6 provides an overview of the current position with the Trust having 7 amber deferred cases and 0 red deferred cases (these have to return to the Learning Advisory Panel) awaiting evidence of learning.

54. Management of this function is currently transferring from the Legal Services Team to the Patient Safety Team as part of planned transfer of responsibilities within the OCP. Initial training needs for the new team have been addressed through externally provided training by the WRP and there is an ongoing Programme of Continued Professional Development around Learning from Events Report management that will run through to 2025/26.

Horizon Scanning & Key Documents

55. An update is provided below on current consultations highlighted in previous Quality, Safety and Patient Experience Committee Reports:

- Putting Things Right Regulations (2011): The Consultation by Welsh Government on the overhaul of the Regulations has been completed and a draft version of the refreshed Guidance developed. The implementation date is unlikely to be prior to April 2025 and members will be updated once formal updates on timescales are released.

- 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. No feedback has yet been received from the NHS Wales Executive who are representing NHS Wales with this review. An update will be provided once further information is shared with the Trust.

56. The Health Services Safety Investigations Body (HSSIB) have launched two investigations to help address patient safety risks associated with electrocardiogram (ECG) interpretation by ambulance crews in cases of ST Elevated Myocardial Infarction (StEMI):

- Diagnosis of suspected StEMI
- Paramedic education, training and competence

Reports are expected to be published in April and October 2025 respectively.

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AGENDA ITEM No	**13**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**1**

Focus on Clinical Indicators - STEMI

MEETING	Quality, Patient Experience and Safety Committee
DATE	5th November 2024
EXECUTIVE	Andy Swinburn, Director of Paramedicine
AUTHOR	Kevin Webb, Head of Clinical Intelligence and Assurance
CONTACT	kevin.webb@wales.nhs.uk

EXECUTIVE SUMMARY

1. QuEST has requested a series of updates to be presented at committee meetings in relation to a focus on Clinical Indicators (CIs). A focus on the Return of Spontaneous Circulation (ROSC) at hospital, Stroke, Fractured Neck of Femur (#NoF – hip fracture) and Hypoglycaemia (diabetic with low blood sugar) have previously been presented, and for this meeting, the focus is on STEMI (heart attack).

2. Within this update we will highlight:

   - What we measure (criteria)
   - Data quality and reporting
   - Improvements to date
   - Next steps to improvement
   - Clinical Indicator Recovery Plan

3. 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.

4. A revised CI 'Jigsaw Poster' and various infographics have been developed as aide memoirs to support staff with ePCR completion. These have been displayed on iPads to maintain a focus and displayed at events, e.g. CEO Roadshows.

KEY ISSUES/IMPLICATIONS
5. Some of the ePCR user interface changes recommended from the STEMI clinical audit were included in the updates implemented in June 2024. Further changes will not be possible until spring 2025. These are aimed at improving the usability for clinicians to input data and to improve CI compliance. 6. Work is progressing to develop the 'Tenant Structure' to enable CIs to be reported at a range of levels (Trust wide, HB are, Locality, Team, Individual). This requires funding and potentially external resources to develop an appropriate app. **RECOMMENDED: That the committee Note the PowerPoint update for the STEMI (heart attack) Clinical Indicator.**

REPORT APPROVAL ROUTE
Quality, Patient Experience and Safety Committee – 5th November 2024

REPORT APPENDICES
Focus on CIs – STEMI 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 STEMI

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

Clinical Indicators – Focus on STEMI
Version 0.1
Released: October 2024

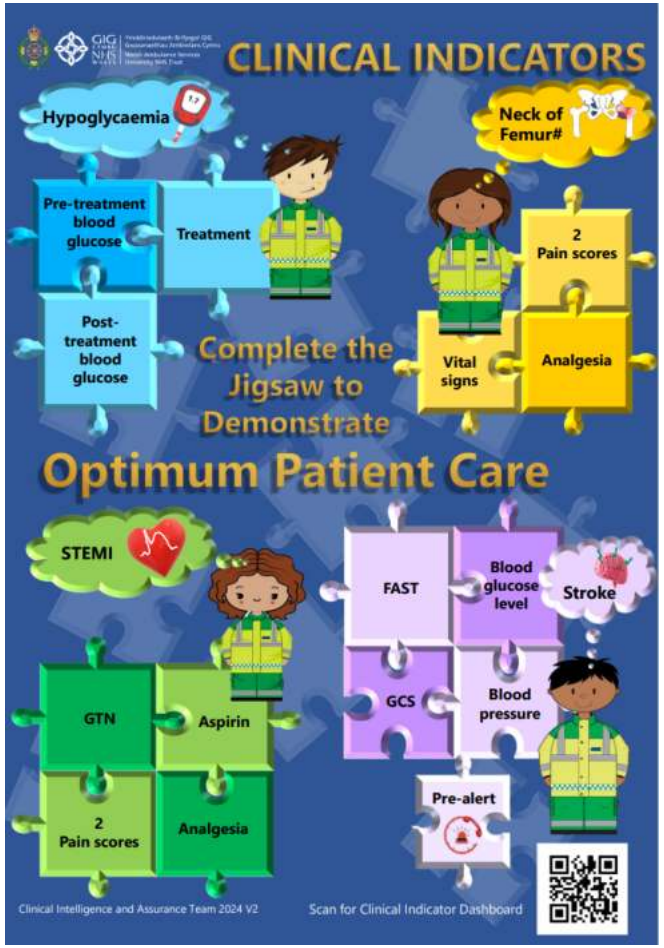
Kevin Webb
Head of Clinical Intelligence & Assurance
Kevin.webb@wales.nhs.uk

Introduction

The next Clinical Indicator (CI) in the 'Focus on CIs series' is for STEMI (heart attack).

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 STEMI (ST-Elevation Myocardial Infarction (heart attack)) (*denominator*)**

- **Compliance to the care bundle requires each criterion of care (*numerator*) to be completed:**
  - ✓ **Aspirin administered**
  - ✓ **GTN administered**
  - ✓ **Two pain scores recorded**
  - ✓ **Analgesia administered**

Care Bundle

Aspirin

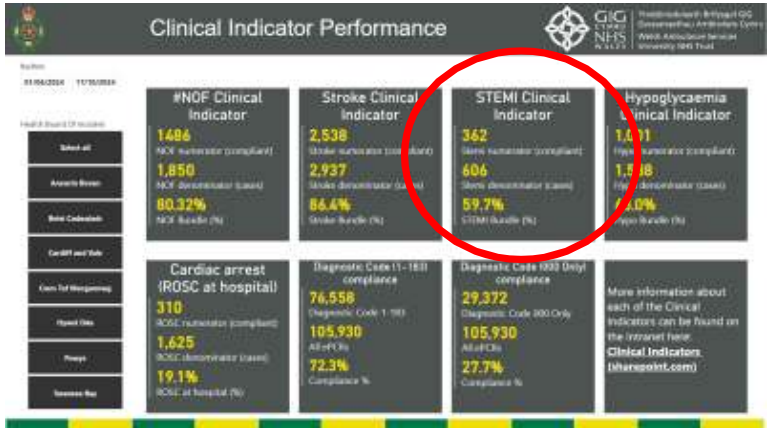
GTN

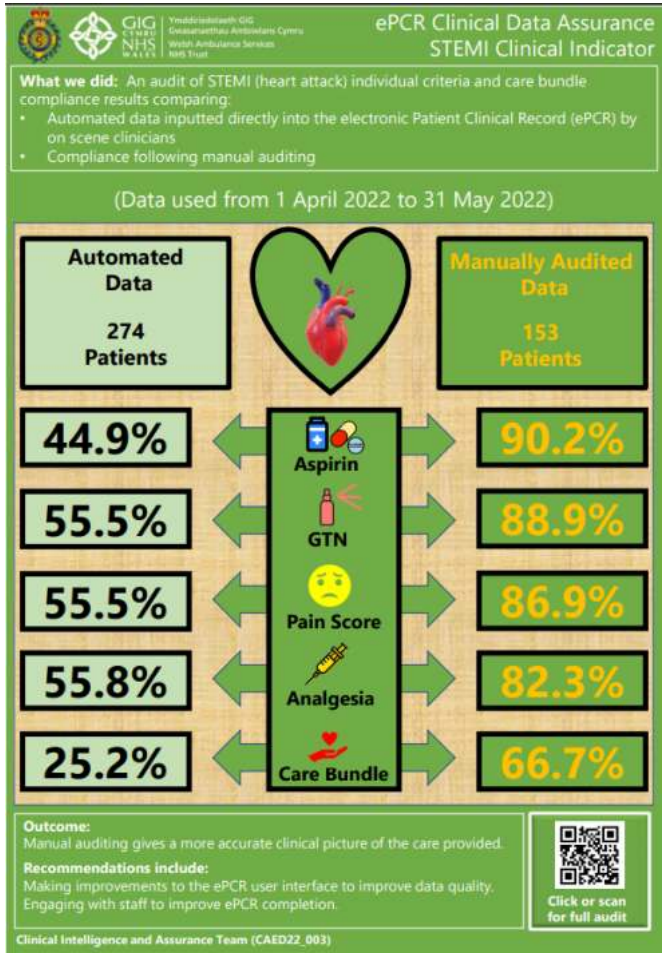
Pain Score

Analgesia

Data quality and reporting

- An ePCR technical specification was created to enable reporting
- Since the implementation of ePCR all CIs are reported on using 'raw' data inputted by clinicians (*no manual auditing prior to reporting*)
- Due to staff being unfamiliar with a new system, a reduction in CI compliance was anticipated (as in other UK Trusts), risk 535 (monitored by CIAG) was created to highlight three elements:
  - User interaction
  - User interface
  - Scripting
- Development of a Clinical Indicator dashboard to include STEMI (care bundle & call to door times)
- The Clinical Intelligence & Assurance Team (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
  - Inform future reporting and caveats
  - Inform an improvement plan and changes to the ePCR User Interface





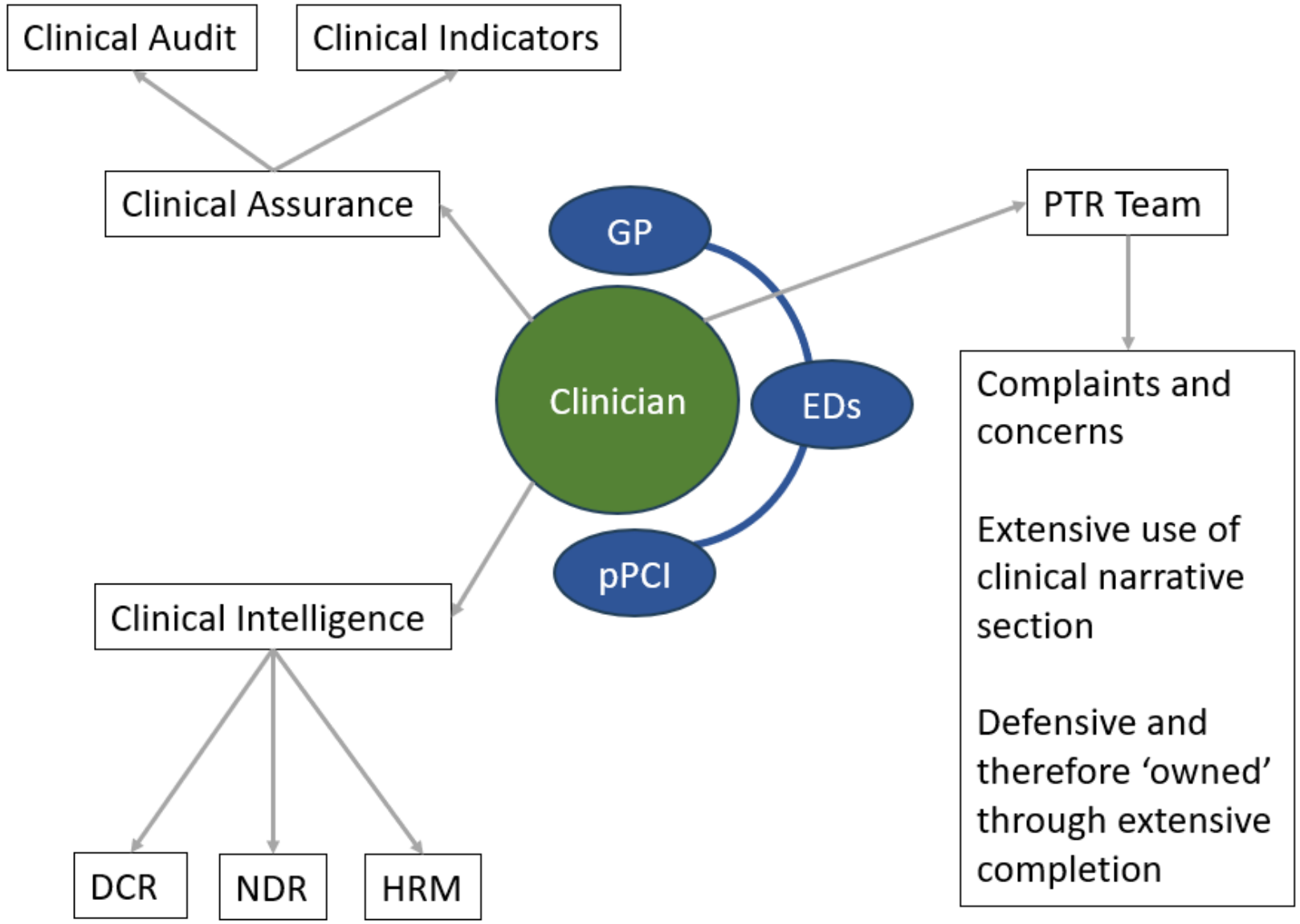
ePCR Users

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
- Deep dive for CI data (April 2024) – provided opportunities to review and update the scripting used to generate CI reports
- A stand at the CEO Roadshows in April & October 2024 made available to promote ePCR completion and CI compliance
- User Interface changes implemented in June 2024, further scheduled for Spring 2025
- A revision of the scripting used to generate CI reports, along with further support from Senior Paramedics for ePCR completion and CI compliance
- Development of a revised CI 'Jigsaw Poster' following requests from staff to use as an aide memoir
- Development of infographics to be used on iPad lock screens to support ePCR completion and improve CI compliance

STEMI compliance April 2023 – October 2024 (data extract 25/10/2024)

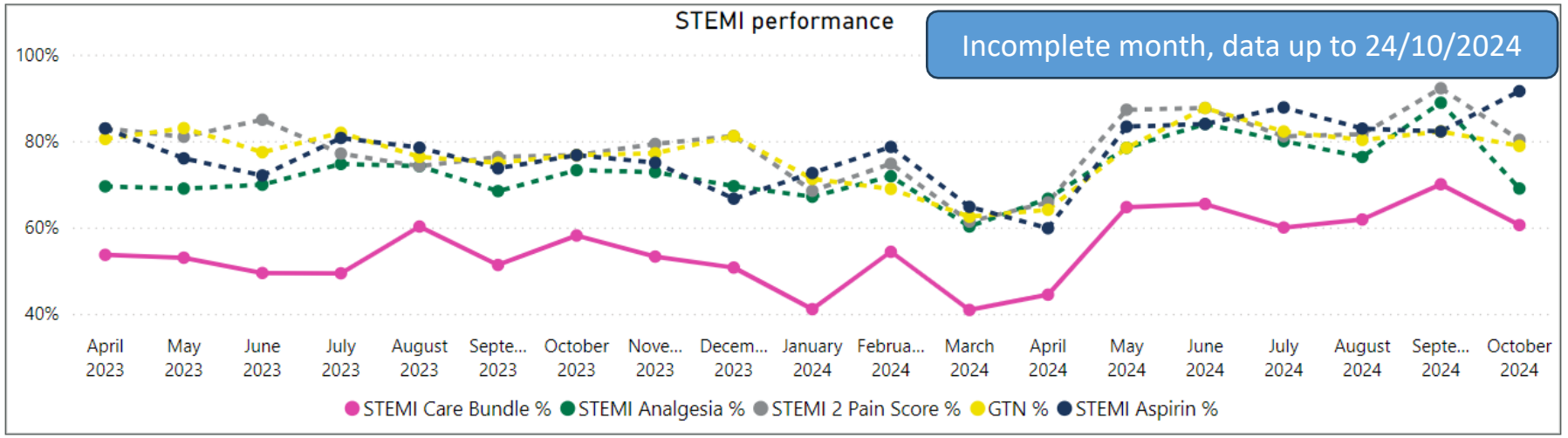
STEMI - Care Bundle & Individual Metrics

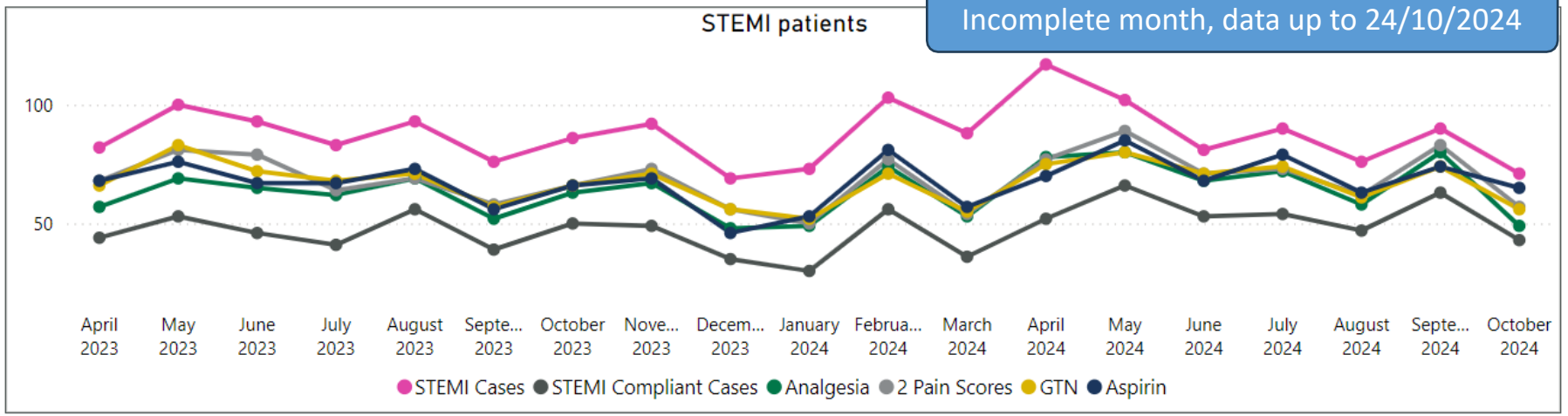
Ymddiriedolaeth Brifysgol GIG Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services University NHS Trust

DayDate
01/04/2023 24/10/2024

Health Board Of Incident

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





Next steps to improvement

- **A User Interface change scheduled for October/November 2024 to update the '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***
  - ***This was successfully tested (v1) in June 2024 for analgesia administered in # NOF***
  - ***The next planned nudges in this stepwise approach are for Aspirin & GTN in STEMI, and some of the cardiac arrest fields to include 'Outcome'***

- **Complete the review and update of the scripting required to extract data for CI reports, to date #NOF, Stroke, Hypoglycaemia and STEMI have been completed. UK wide changes to cardiac arrest guidelines are in development, the ROSC scripting will then be reviewed.**

- **Clinical Improvement & Clinical Intelligence and Assurance teams continue meeting with Senior Paramedics to provide support, guidance and data to promote CI compliance and 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). Requiring funding and external resources**

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 fully realised with the monthly results. A Clinical Indicator Recovery Plan has been implemented.**

- **WAST aims are to provide an efficient reporting structure that enables 'always on' automatic reporting, enabling accurate and almost live data for reporting at various levels for all appropriate records. This differs from English Ambulance Trusts who use a sample of a smaller clinical case.**

- **Actions within the plan include:**

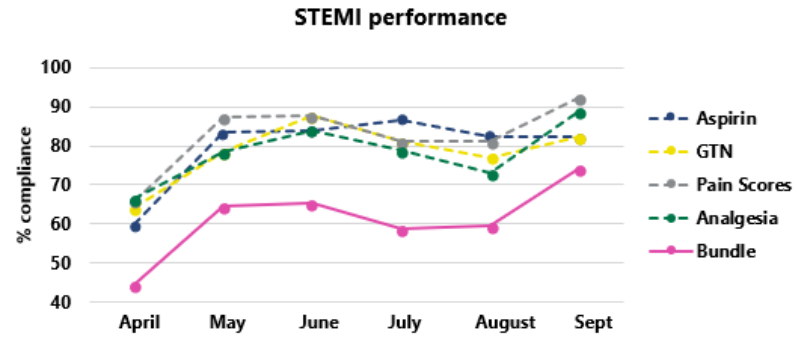
  - ✓ **Full deployment at pace of the CI Improvement Plan**
  - ✓ **Focussed communication with WAST clinicians to use the bespoke ePCR boxes for CIs**
  - ✓ **Supporting Senior Paramedics to have conversations about CIs**
  - ✓ **Health Board focussed clinical workshops to promote understanding of CIs and care bundles**
  - ✓ **Investment 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**

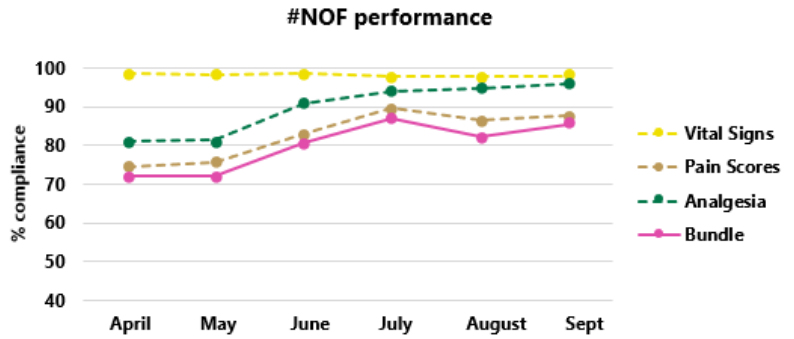
Clinical Indicator Improvement

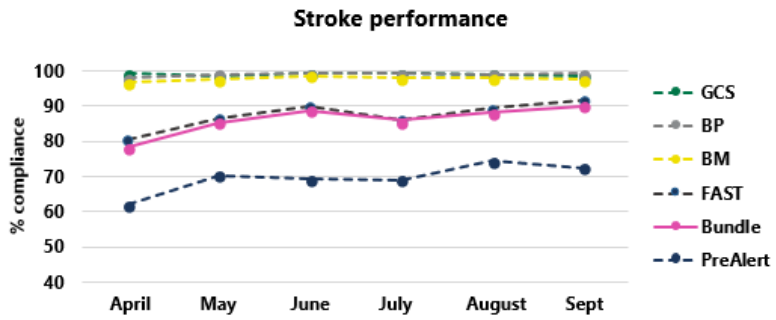
- In April 2024, the CI Improvement Group was established *(CEO action to facilitate improvement within six months)*
- The focus was to implement the CI improvement plan at pace, and to demonstrate and sustain improvements
- The group has representation from Senior Clinical Managers, Clinical intelligence, Clinical Improvement and from the ePCR Clinical Lead
- Improvements can be seen across the CIs. This slide shows the positive impact from April to September 2024 and the following slide shows the interventions

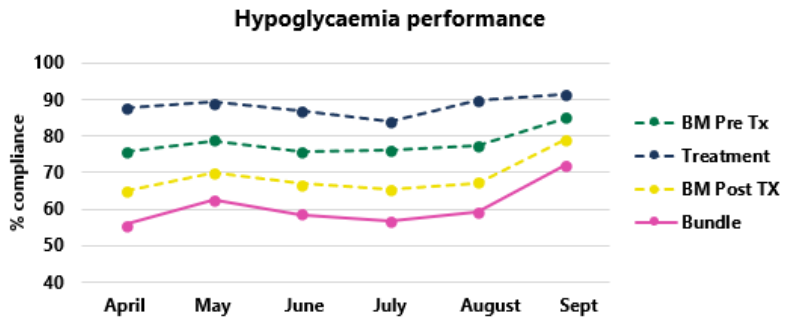
Clinical Indicator Improvement - Storyboard

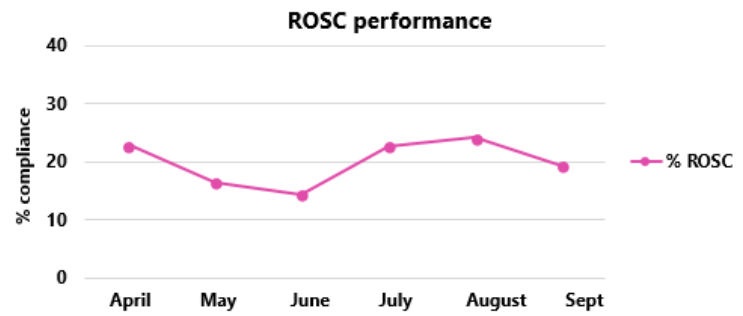
(April– September 2024 (data extract 03/10/2024)



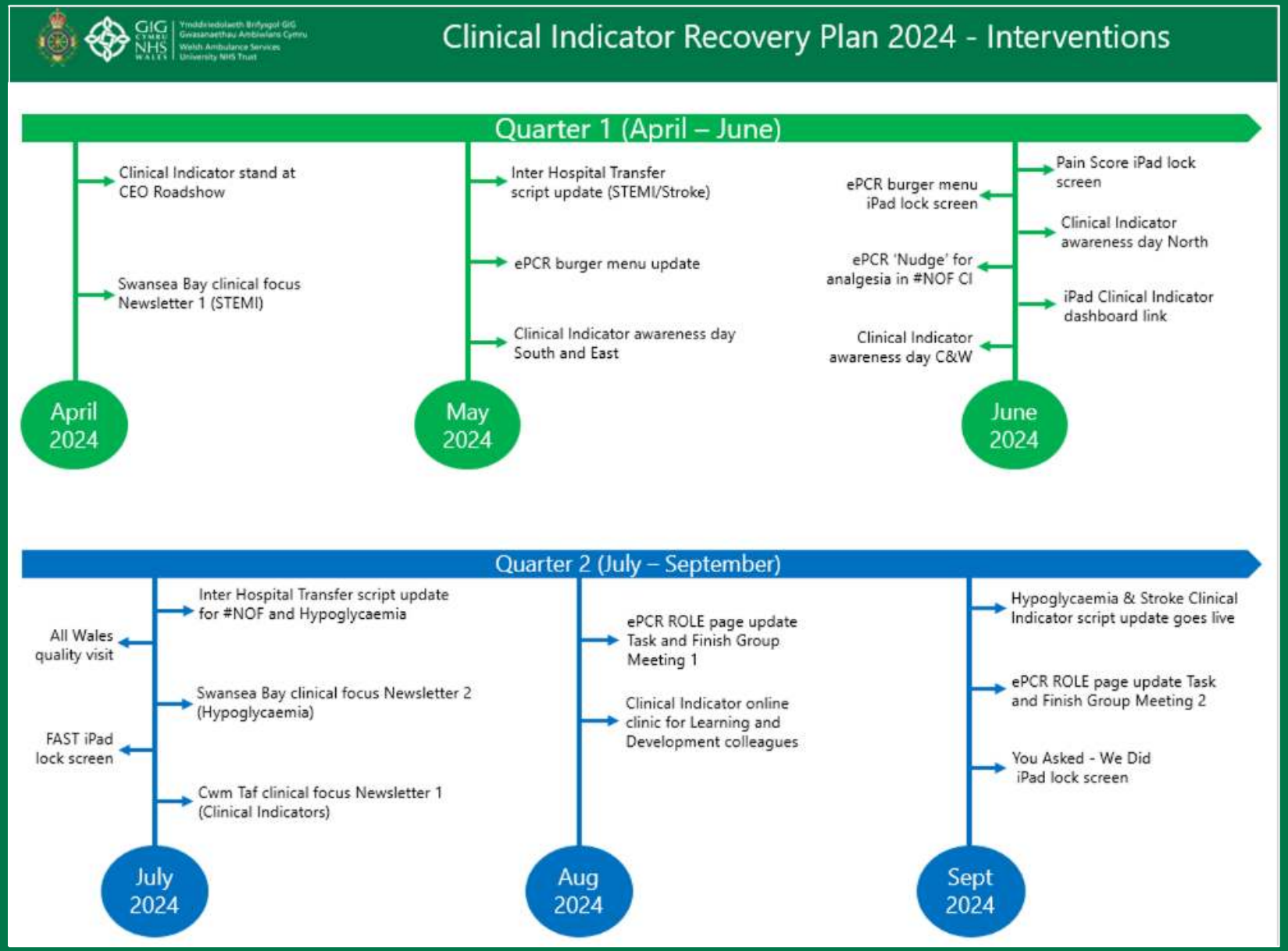








CI Improvements (Timeline of improvement initiatives)



Pain Management Framework

- **A further aspect of improvement work that will impact on the STEMI (heart attack) CI as well as the fractured Neck of Femur (hip fracture) CI is the Pain Management Framework**

- **Within the Pain Management Framework Implementation Plan there are actions which include:**
  - **ePCR UI changes to improve the recording of pain assessment and treatment**
    - ***Addition of a 'No Pain' button***
    - ***Ensuring the clinician administering a medicine is recorded (not the operator of the iPad)***

  - **Development of a pain management dashboard for continuous monitoring and quality improvement for various metrics**

  - **Establish an ePCR Compliance Approval Group (*since October 2023*)**
    - ***Development of a 'nudge tool' to prompt staff when important information is missed when closing a record (version 1 implemented June 2024)***
    - ***The nudge tool successfully tested with analgesia in #NOF***
    - ***Version 2 of the 'nudge tool' with improved capability to be implemented November 2024***
    - ***Stepwise approach for further nudges, GTN & Aspirin for STEMI and some of the cardiac arrest fields to include 'Outcome'scheduled for November 2024***

Thank you for listening

Any questions or comments?

AGENDA ITEM No	**14**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**1**

Clinical Audit Plan & Action Tracker
Q2 (update) 2024/25

MEETING	Quality, Patient Experience and Safety Committee
DATE	5th November 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 Q2 2024-25 update to highlight progress with audits (the plan) and also to actions from the completed audit (action tracker).

The Q2 2024-25 Clinical Audit Plan contains 13 audits covering a range of topics including clinical conditions, medicines, and compliance to documentation. This is a dynamic plan and since the Q1 update, the 'Newborn Normothermia' audit has been added. Of those indicated on the plan:

- 2 have been completed and approved at the Clinical Intelligence & Assurance Group (CIAG)
- 3 are progressing as planned
- 2 are not progressing as planned as they are reliant on ePCR User Interface changes being implemented*. In addition, the Clinical Indicator Recovery Plan is currently a higher priority.
- 6 are yet to start, some are reliant on ePCR User Interface changes being implemented*, some are not due to start until Q3/Q4.

** Planned audits paused due to delays with ePCR UI changes are being reviewed by the Clinical Intelligence & Assurance Team, options to be presented to CIAG.*

For the audits approved during Q1/2 (Clinical Frailty Scale Follow Up, & Older Adult Fallers Discharged at Scene) there were 13 actions:

- All 7 actions for the Clinical Frailty Scale audit have been completed
- Of the 6 actions from the Older Adult Fallers Discharged at Scene audit:
    - 2 have been completed
    - 4 are on track

RECOMMENDED: That the Committee Note the Q2 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 implementing the required ePCR 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 - 5/11/2024

REPORT APPENDICES

Clinical Audit Plan 2024/2025 Quarter 2 – 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 Q2 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 Q2 2024-25 Clinical Audit Plan contains 13 audits covering a range of topics including clinical conditions, medicines, and compliance to documentation. This is a dynamic plan and since the Q1 update, the 'Newborn Normothermia' audit has been added. Of those indicated on the plan:

- 2 have been completed and approved at the Clinical Intelligence & Assurance Group (CIAG)
- 3 are progressing as planned
- 2 are not progressing as planned as they are reliant on ePCR User Interface changes being implemented*****. In addition, the Clinical Indicator Recovery Plan is currently a higher priority.
- 6 are yet to start, some are reliant on ePCR User Interface changes being implemented***,** some are not due to start until Q3/Q4.

****** *Following the ePCR Clinical Data Assurance audits in 2022, re-audits were scheduled to realise the benefits once all actions were completed. However, due to ongoing delays with completing CI specific ePCR UI changes, the Clinical Intelligence & Assurance Team (CIAT) have progressed with an alternative approach*

- *As some UI changes have been possible outside of the next update (Spring 2025), the CIAT will undertake a 'Follow up' audit for STEMI (heart attack) which will demonstrate the benefits from the improvement work aimed to provide greater assurance with raw (non-audited) data*
- *As improvement work has taken place across all CIs, undertaking follow up audits for the remaining CIs will not be necessary*
- *This approach will allow the CIAT to progress with higher priority audits*

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 audits approved during Q1/2 (Clinical Frailty Scale Follow Up Audit & Older Adult Fallers Discharged at Scene) there were 13 actions:

    - All 7 actions for the Clinical Frailty Scale audit have been completed
    - Of the 6 actions from the Older Adult Fallers Discharged at Scene audit:
        - 2 have been completed, one of which is the establishment of a Task & Finish Group, to deliver the remaining 4 actions which are on track

RECOMMENDATION: The Committee is asked to Note the Q2 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 2

FINAL v1.0 Last Updated 30th September 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 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	*Revised Q3 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 Q4 24/25*	N/A	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 Q4 24/25*	N/A	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	*Revised Q3 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 Head of Clinical Intelligence & Assurance	*To commence after ePCR changes implemented*	N/A	N/A	N/A		

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	*February 2024*					
24_001	1	Older Adult Fallers Discharged at Scene - ePCR Clinical Data Assurance	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	*April 2024*	N/A				
24_002	1	Tranexamic Acid (TXA) Administration Audit	Clinical Intelligence & Assurance Team	Greg Lloyd Assistant Director of Clinical Delivery	July 2024	N/A	N/A			
24_003	1	Major Trauma Tool Audit	Carl Powell, Clinical Lead – Acute Care	Greg Lloyd Assistant Director of Clinical Delivery	July 2024	N/A	N/A			
24_004	1	Newborn Normothermia – Monitor and Maintain in the Pre-Hospital Setting	Bethan Jones, Local Safety Champion, Midwife	Steve Magee, Regional Clinical Lead	September 2024	N/A	N/A			
TBC	1	Failed Pathways Recording on ePCR Audit	Jonathan Chippendale	Duncan Robertson Assistant Director of Clinical Development	Indicative Q3	N/A	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		
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	*Revised Q3 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. Awaiting full UI change to be employed. Autumn release expected.
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 Q4 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
						Awaiting full UI change to be employed. Autumn release expected.
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 Q4 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. Awaiting full UI change to be employed. Autumn release expected.
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	*Revised Q3 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.

Ref	Clinical Audit Title	Rationale/Drivers	Clinical Audit Author	Clinical Audit Contact/Support	Audit Start Date	Comments
						UI changes delayed until 10th June 2024 Start date of audit TBC. Awaiting full UI change to be employed. Autumn release expected.
TBC	ePCR Clinical Data Assurance - Return of Spontaneous Circulation (ROSC) at Hospital 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	*TBC*	Funding required for these specific changes. Potential to use 'Point of Closure' changes to improve compliance.
23_003	Clinical Frailty Scale (CFS) in Patients Aged ≥65 years Follow Up Audit	To ascertain if improvements have resulted following completion of actions from the previous audit.	Richard Teulon Clinical Intelligence & Assurance Co-ordinator	Ruth Saele Clinical Intelligence & Assurance Data Specialist	*February 2024*	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	April 2024	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 Final report presented July 2024

Ref	Clinical Audit Title	Rationale/Drivers	Clinical Audit Author	Clinical Audit Contact/Support	Audit Start Date	Comments
24_002	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	July 2024	CIAT have ongoing discussions with the sponsor and subject matter experts.
24_003	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	July 2024	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.
24_004	Newborn Normothermia – Monitor and Maintain in the Pre-Hospital Setting	To provide assurance and continuously monitor the ongoing improvements to monitor and maintain thermoregulation in the prehospital setting.	Bethan Jones, Local Safety Champion, Midwife	Claire Muxworthy, Clinical Intelligence and Assurance Co-ordinator	September 2024	Audit proposal approved in CIAG meeting on 08.08.2024
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 avoid unnecessary admission to Emergency Departments.	Jonathan Chippendale	Clinical Intelligence & Assurance Team	Indicative Q3	Jonathan Chippendale (11/1/24) – confirmed audit required. Required UI changes presented to ePCR CRG 29.05.24 CR0048 Likely release Oct/Nov 2024

Ref	Clinical Audit Title	Rationale/Drivers	Clinical Audit Author	Clinical Audit Contact/Support	Audit Start Date	Comments
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	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	Initially planned to commence Q1 New Head of Safeguarding started end of May 2024 - audit delayed. Contact made with Safeguarding Specialist Paramedic 30.09.24 for update.

AGENDA ITEM No	**15**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**2**

PATIENT EXPERIENCE AND COMMUNITY INVOLVEMENT BI-ANNUAL REPORT (APRIL - SEPTEMBER 2024)

MEETING	Quality, Patient Experience & Safety Committee
DATE	5 November 2024
EXECUTIVE	Liam Williams, Executive Director of Quality and Nursing
AUTHOR	Leanne Hawker, Head of Patient Experience & Community Involvement
CONTACT	Leanne.hawker@wales.nhs.uk

EXECUTIVE SUMMARY

1. This Report presents the work undertaken over the last six months using patient experience and public engagement to capture feedback to better understand how people and communities experiences our services. This work is in line with the new Peoples Experience Framework (PEF) and the citizens voice component of the Health and Social Care (Quality and Engagement) (Wales) Act 2020-21.
2. Patient experience is a 'golden thread' that runs throughout the Trust's Integrated Medium-Term Plan (IMTP) and is at the heart of our services. The Patient Experience & Community Involvement (PECI) Team continues to engage in an ongoing dialogue with the public on what they think are important developments the Trust could make to improve quality and how it feels to be user/patient of it services.

RECOMMENDATION: That the Committee:

(i) Receive the report and accept the assurances that the Trust is meeting its statutory duties/responsibilities to consult' engage and involve the public/patients in its work; and

(ii) Notes the activities to date and acknowledge that Patient Experience & Community Involvement Reports will be shared publicly through the Trusts People & Community Network.

KEY ISSUES/IMPLICATIONS
(i) Information governance arrangements pertaining to contacting 999 service users for Surveys are reaching their conclusion. A Data Protection Impact Assessment (DPIA) covering contacting 999 user by Short Message Service (SMS) text message will be submitted to the Information Commissioner in November. The DPIA will identify and address risks and issues including what are the reasonable expectations of callers/patients to be contacted (this would be the first time in our Trust history that 999 callers would be contacted in this way), the lawful basis and opt-out process. A final public Consultation on the Proposal has been recommended; we will share details with the Trust's People & Community Network and invite feedback that will be included in the DPIA. The DPIA will be presented to the Information Governance Steering Group (IGSG) in November before submission to the Information Commissioner's Office (ICO).
(ii) While we work to expand the volume of patient experience feedback, we continue to signpost people to the Trust website where they can complete and submit a Patient Experience Survey online. We continue to work to install Quick Response (QR) codes on ambulance vehicles, via Putting Things Right (PTR) materials/responses and Non-Conveyance Forms.
(iii) Regular citizens voice/Patient Reported Experience Measures (PREMs) data is presented weekly to the Quality Management Group (QMG). From the PREMs data (see **Appendix 1** within the attached Bi-Annual Report) it has been frustrating to view little improvement in people's ratings and experiences of the Emergency 999 Service.
(iv) The Clinical Service we deliver does not seem to address the emotional experiences of patients, their families and carers when they contact the Emergency Service. This is essentially down to the way in which we respond to calls. We adhere to Academy Standards however we do not always respond to or acknowledge someone's anxiety or fear which then results in negative feedback about the service. As a result, we are reviewing the questions asked and continue to engage with colleagues to ensure the questions are appropriate.

REPORT APPROVAL ROUTE	
Clinical & Quality Governance Group	30 October 2024
Quality, Patient Experience & Safety Committee	5 November 2024

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

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

ANNEX 1

SITUATION

1. The team have continued engaging, capturing experiences, and listening to public, patients and carers with themes being reported through the Quality Management Group (QMG), Planning and Performance Team to feed into the Integrated Medium-Term Plan (IMTP) and the National Service User Experience Meetings.

2. Key themes from feedback of service users regarding emergency 999 continues to be around response times and repetitive questioning when calling back. Linked to response time are estimated time of arrivals (ETAs) given to patients not being accurate, even though explanations are provided on why this happens. Regarding the Non-Emergency Patient Transport Service (NEPTS), it is the wait time for transport home following a patient's appointment that is a regular feedback theme.

3. Overall, the feedback is generally negative regarding access but more positive in relation to the care staff provide patients. We are working with Service Delivery Teams to review Experience Survey questions to ensure they are appropriate.

4. Through our continuous engagement we are aware that parts of our communities (e.g. deaf and learning disability) are reporting poorer experiences, our generalised Experience Surveys do not provide the 'granular' details to help identify health inequalities however, we will be working closely with these groups to establish accessible Experience Surveys.

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

BACKGROUND

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

- People's Experience Framework (formerly 'Framework for Assuring Service User Experience')
- NHS Wales Performance Framework
- Social Services and Well-being (Wales) Act 2014-18
- Well-being of Future Generations (Wales) Act 2015-19
- The National Principles for Public Engagement in Wales (2011)20
- Health and Social Care (Quality and Engagement) (Wales) Act 2020-21
- The Quality Standards - April 2023
- A Healthier Wales 2022

ASSESSMENT

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

Patient Experience & Community Involvement

Bi-Annual Report

April – September 2024

GIG CYMRU NHS WALES

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Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
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peci.team@Wales.nhs.uk

Contents

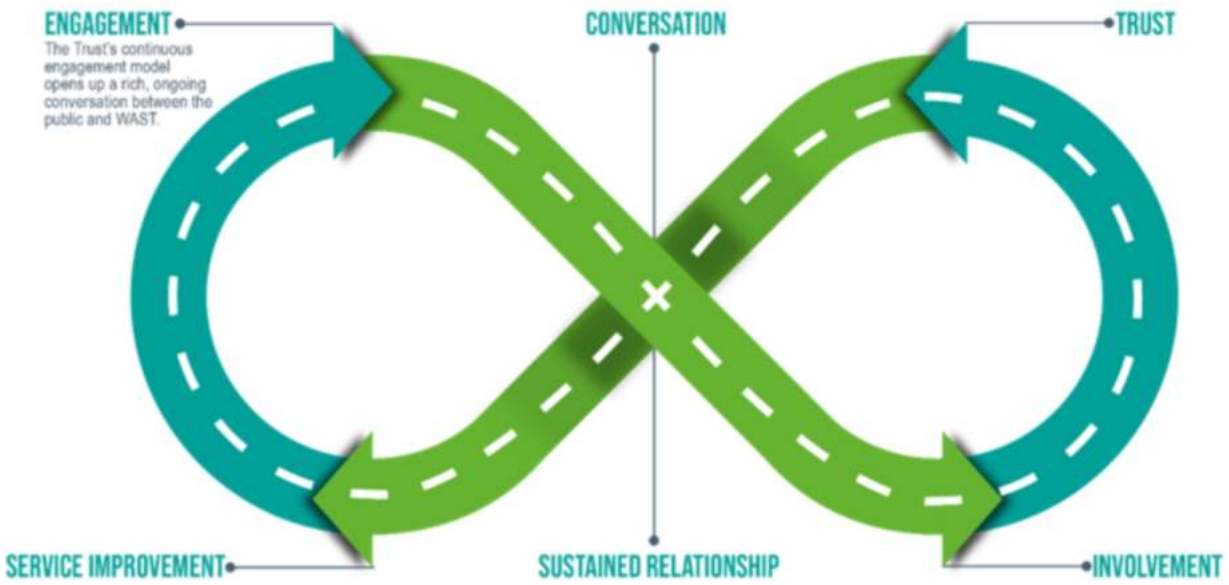
PAGE NUMBER

Patient Experience within the Welsh Ambulance Service

Patient experience at the Welsh Ambulance Service (WAST) is influenced by the many interactions people have with staff, their expectations, and their first and lasting impressions. Patient experience is defined by what it feels like for people to access and receive care from WAST, it is based on their own perceptions of the care and treatment received.

Though patient experience may be seen as a subjective indicator of quality, experiences and feedback are essential components for monitoring and serving as quality indicators.

'Patient Experience' within this report includes the experience of all service users including families and carers. Information and data has been captured using our continuous face-to-face engagement model and various channels for experience feedback including; surveys, stories and our 'Have your say' online facility.



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

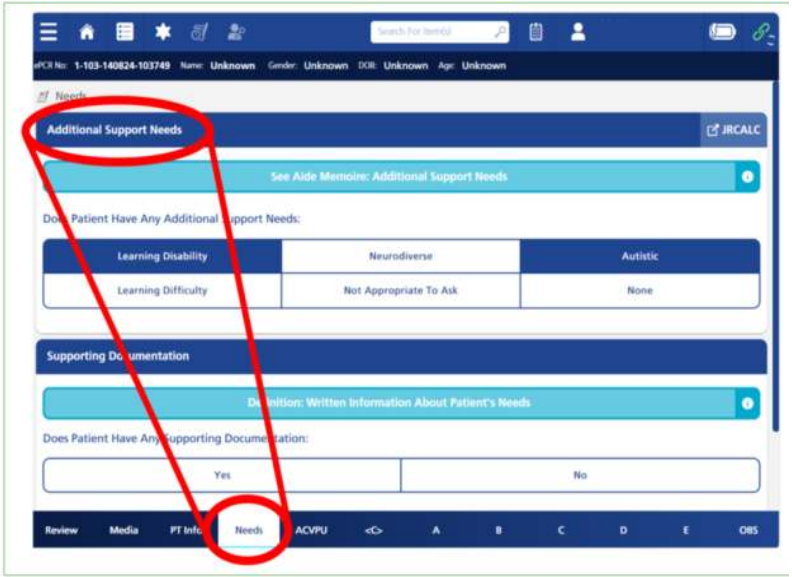
Experience

People's Experience Framework & Citizen Voice

NHS Wales Performance Framework
Performance Measure Learning Disabilities

Improving the lives of people with learning disabilities

EPCR Update - A change request to make improvements to the EPCR to record patients with additional LD needs (including, Autism and Neurodiversity) and a prompt to record reasonable adjustments made on scene, has been in progress since May. Checks to ensure background data structures necessary for the reporting dashboard, and the required paperwork are in place is being finalised. The changes will go live at the end of October 2024 enabling us to better understand the volume of patients accessing Trust services and the experiences they have when in our care.



Engagement – We have continued to talk and work with people with a learning disability, carers, family and professionals, listening to experiences and how we can best support people. We have co-produced resources to help improve people's access. An LD 'Celebration Day' for Public/patients, carers and families in the ABUHB region is planned for the end of October.

Learning Disability Ministerial Advisory Group (LDMAG) – We presented for the second time to the LDMAG at their September meeting. An overview of work to date was provided on how we are progressing with developments to improve access and experiences of people with a learning disability.

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Future Generations Commissioner & Children's Commissioner

Food and Fun

'Food and Fun' is a school-based education programme that offers food and nutrition education, physical activities, and enrichment sessions enabling external agencies to meet pupils and provide appropriate learning experiences.

For many years, the PECI team has supported the Cardiff 'Food and Fun' programme.

This year, with the help of WAST volunteers (from both operational & CFRs teams) we visited **12 schools** over a three-week period, engaging with **550 pupils**. They delivered more than 20 hours of training on the appropriate use of 999, other community services that can help and life-saving skills, including the recovering position, hands-only CPR, and defibrillator awareness.

'The Right Way' a children's rights approach

Following user feedback, we're currently developing a CPR awareness game to add to the existing 5 games available in the app. The new game will launch in October 2024. To improve accessibility and to accommodate different literacy levels, voice-overs from our Trust mascots, Jack and Kim will be added later.

Following Cardiff University's evaluation of the Blue Light Hub app, we are pleased to be co-authors of an article recently published in the BMJ Open.

You can access the article by scanning the QR code.

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

People's Experience Framework (PEF)

An updated draft of the 'People's Experience Framework' is currently being socialised at Executive level meetings, once completed it will be formally launched.

We will be required to use the PEF to frame and deliver all our experience work across the Trust.

The framework is a maturity matrix aimed at empowering us to evaluate our current position and develop ambitious improvement plans for people's experience through a 'value lens'.

It will also encompass all services provided by NHS Wales organisations including commissioned services.

The PEF is aligned with various regulations and acts, including :

- Health and Social Care (Quality and Engagement) (Wales) Act 2020
- (Duty of Quality and the Duty of Candour), the National Health Service (Concerns, Complaints, and Redress Arrangements) (Wales) Regulations 2011
- Public Services Ombudsman (Wales) Act 2019 Well-being of Future Generations (Wales) Act 2015
- Equality Act 2010
- Value Based Health Care Strategy and the Socio-economic Duty.

Listening and learning from people's experiences is an integral element of these regulations. It defines people's experience as 'the sum of all interactions, shaped by the culture of the organisation, staff and systems.'

It is recognised that it is not just about 'patients' experiences it is inclusive of their families and carers also.

People Experience Framework – 999 Experience

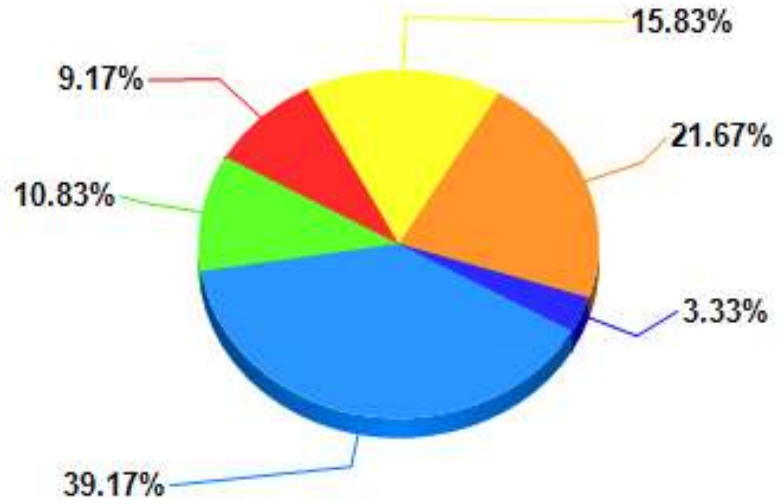
999 Experience Survey
Our 999 patient experience survey is made available to members of the public through the WAST website and is frequently promoted across all available social media channels.

It is acknowledged that the low response rate to this survey does not paint a truly representative picture of what is feel like to be a user of our 999 service and we are exploring options available to increase engagement with the survey, including the use of SMS Text messaging and the introduction of QR code stickers into our EMS vehicles.

Taking that into account, responses received to this survey show that people think our staff provide good care, with wait times being the largest area of concern.

In this reporting period 157 responses were received.
A full breakdown can be found in Appendix 1.

Thinking of the last time you called 999. Overall, how would you rate your experience of the service we provided?



Available Answers	Responses	Score
Very Good	47	39.17%
Good	13	10.83%
Neither Good nor Poor	11	9.17%
Poor	19	15.83%
Very poor	26	21.67%
Don't Know	4	3.33%
Total	**120**	**100%**

People Experience Framework - NHS 111 Wales

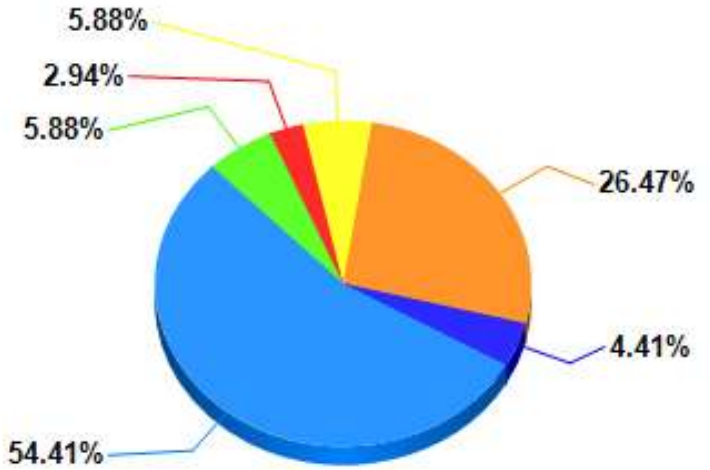
NHS 111 Wales Experience Surveys
There are two surveys in place for NHS 111 Wales, separately collecting feedback about people's online experience and telephony experience.

We are currently reliant on people using their initiative and accessing the survey online themselves to provide feedback. However, we have had initial discussions with the NHS 111 Wales Senior Management Team about how we can potentially increase participation in this survey using SMS Text messaging or messaging in the 111 telephony IVR.

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

In this reporting period 104 responses to the Telephony survey were received; and 180 to the Online survey. A full breakdown can be found in Appendix 1.

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



Available Answers	Responses	Score
Very Good	37	54.41%
Good	4	5.88%
Neither Good nor Poor	2	2.94%
Poor	4	5.88%
Very poor	18	26.47%
Don't Know	3	4.41%
Total	**68**	**100%**

People Experience Framework – Ambulance Care (NEPTs)

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

Survey results continue to show that wait time for transport home following an appointment is still the main area of concern for patients. From 1st April we also changed the question we ask about seatbelt safety, which revealed that many people were telling us that they were reporting that they were not reminded to put on the seat belt because they had already put it on independently and didn't need to be reminded.

In this reporting period 680 responses were received.
A full breakdown can be found in Appendix 1.

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

Available Answers	Responses	Score
Very Good	443	79.25%
Good	45	8.05%
Neither Good nor Poor	20	3.58%
Poor	8	1.43%
Very poor	40	7.16%
Don't Know	3	0.54%
Total	**559**	**100%**

People Experience Framework - Falls Assistant & Falls Responder

Experience Surveys

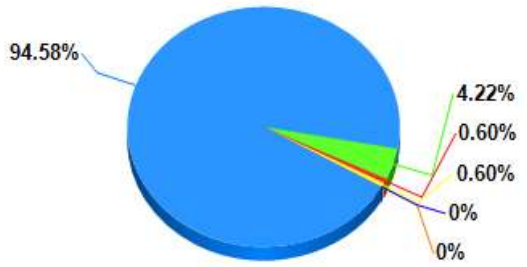
Working with the WAST Falls Improvement Lead we have developed two Falls Experience surveys. One for Level 1 Falls Assistants and one for Level 2 Falls Responders.

Patients attended to by either a Falls Assistant or Falls Responder are left an invitation to complete a survey to share their experience. The invitation contains a QR code that can be scanned to complete a survey online, as well as the phone number and email address for the PECI Team for anyone who would like a hard copy survey.

Feedback from these surveys is overwhelmingly positive, with people saying they appreciated the service received and valued being responded to by a dedicated service that was able to safely lift them and work to keep them at home if possible.

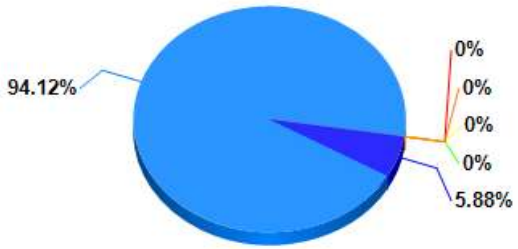
In this reporting period 183 Falls Assistant responses were received and 17 Falls Responder responses.

How was your overall experience with the Falls Assistant today?



Available Answers	Responses	Score
Very Good	157	94.58%
Good	7	4.22%
Neither Good nor Poor	1	0.60%
Poor	1	0.60%
Very poor	0	0%
Don't Know	0	0%
Total	**166**	**100%**

How was your overall experience with the Falls Responder today?



Available Answers	Responses	Score
Very Good	16	94.12%
Good	0	0%
Neither Good nor Poor	0	0%
Poor	0	0%
Very poor	0	0%
Don't Know	1	5.88%
Total	**17**	**100%**

Compliments Received

April 2024	69	July 2024	46
May 2024	74	August 2024	52
June 2024	43	September 2024	45

We value the compliments people submit to us; they are especially valued by staff as compliments are based on an individuals' own perspective as patients, carers and users of our services.

The general themes from compliments have been around friendly, kind and comforting staff. Interacting with professional, calming and efficient staff has positively impacted on people with feedback reflecting on staff 'doing an amazing job' and 'going above and beyond'. We have heard how grateful people have been for the services and care received from staff who have demonstrated humanity and connectedness to their patients.

We continue to promote and share compliments received to Trust staff via a dedicated page on internal communication channel Siren, station posters and directly with line managers.

Examples of Compliments Received

I am delighted and relieved to share some positive feedback with you regarding the experience that I and my family had with your service today. I appreciate how stretched and under resourced you are, so I know that working conditions themselves are both challenging and inevitably frustrating. Sadly, I had to call 999 today for my Dad who had collapsed and was unconscious, I rang at 10.48am, the call handler was fantastic and patient, especially as my signal was poor, her calm and pleasant approach helped me to remain calm.

Rob the paramedic who arrived with us within the hour was nothing short of exemplary, a shining example to all health professionals in my view. (I have Worked in the NHS for over 30 years). He was diligent, professional, thorough, respectful and his values are clearly patient centred, being kind, thoughtful, attentive and gentle in all of his interactions with my Dad. Please let me know if you would like any further detail Rob's assistance and the manner in which he undertook his job restored some of my faith in the NHS, please pass on our formal thanks to him and wish him well for the future.

Hello, not sure if this is the correct department. I rang NHS 111 at 04:55 due to an unbearable Toothache, I couldn't even think straight. I cannot remember the Ladies name, buy she was very calming, and she listened, and gave good advice, very kind and caring, as I was dreading making the call, due to the pain. So, thanks very much whoever you are!

The care I received from the ambulance transport service to and from my home when I needed to get to hospital was amazing, the gentleman was polite well caring, listened to me and I think he enjoyed wheeling me through the hospital. This was all arranged by my community advance nurses, but I wanted to pass on many thanks.

Citizen Voice – People & Community Network

People & Community Voice Group

This is a multi-stakeholder network to support the collective development, awareness and promotion of positive service user experience, accessibility and inclusion within our services.

Four network members regularly attend the quarterly meetings alongside WAST colleagues, and take part in discussion and provide feedback on initiatives such as Connected Support Cymru and the Integrated Medium-Term Plan (IMTP).

Network Roadshow

In June we held our first face to face Network Roadshow event in Cardiff Central Library & Hub. The location was chosen by Network members and future events will travel around Wales. The event offered an opportunity for Network members to meet each other as well as members of the PECI Team to build stronger relationships and emphasise how valued their participation is in helping to improve ambulance service quality.

Growing the Network

99 Network members

Distribution of Network Members by postcode

A disproportionate number of network members reside in the southern Health Board areas.

Plans have been developed to ensure the Network is representative of the communities we serve, with a focus on residents in the North and Central and West localities, younger people and cultural diversity.

Citizen Voice – People & Community Network

Reader's Panel

Network members were asked to review an update of the **Non-Compliance Form,** for patients declining treatment or conveyance to hospital. 11 responses were received, and feedback has been shared with the original authors for further drafting.

"The wording is clear although it needs to be tested against a range of audiences to ensure accessibility and the likelihood of misunderstanding."

"It is a little condensed. Hopefully, the form will be bigger and possibly in larger print."

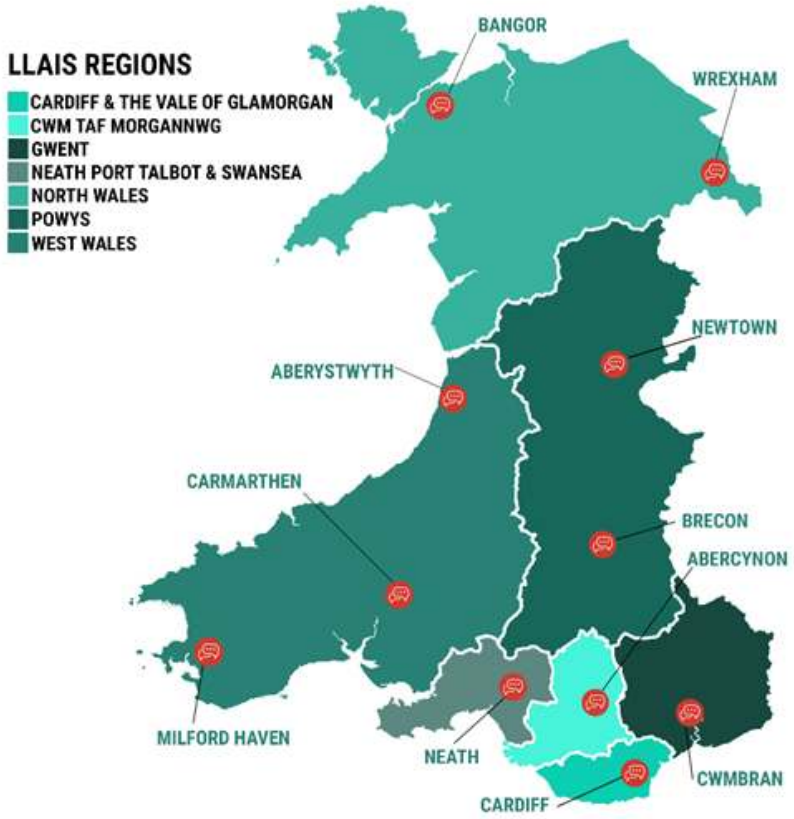
A further reader's panel exercise is currently underway, where People & Community Network members have been asked to review and comment on an updated bereavement information leaflet.

Feedback will be used to make sure the leaflet is fit for purpose before it is printed. We will share an update on that exercise in our next report.

Citizens Voice - Llais

LLAIS

Eich llais mewn iechyd a gofal cymdeithasol | Your voice in health and social care



LLAIS Local Engagement

We have attended various meetings with LLAIS representatives in Swansea (Neath Port Talbot & Swansea) Cwmbran (Gwent), Cardiff and Abercynon (Cwm Taf) regions.

In the Gwent region we attended a volunteer meeting with the region's volunteers, along with the WAST Head of Service for EMS for the area. Latest performance data was shared and facilitated a question-and-answer session. Llais will be focusing on the emergency department and acute medical units across ABUHB in the next few months and Llais were invited to engage with staff and attend stations where relevant.

The new Regional Director for Cardiff is now in post; an introductory meeting with the Llais Team was held with PECI and operational leads from across Cardiff & the Vale. A quarterly meeting will be established.

We continue to reach out and meet with other regional Llais members over the coming months.

Patient Stories & Digital Storytelling

Patient Stories - WAST

The Patient Stories page, on the WAST Learning Launchpad has been launched and work commenced on developing Patient Story Podcasts for staff, with the first podcast well into the pre-production stage. We expanded our skill-base with another team member trained to capture experiences using the Digital Storytelling model developed by Swansea Bay Health Board.

There has been a wider variety in the types of stories captured this year, including neonatal, ambulance care services and palliative care.

We have sought guidance from the Wales Digital Stories Network, in respect of establishing support networks and resources for staff involved in making stories who are frequently exposed to descriptions of traumatic and distressing events in the course of their work, as well as having to manage traumatised, highly emotional individuals sharing their experiences. The next network meeting in December will discuss this issue.

Patient Stories – NHS Wales

The Civica System continues to develop its platform for hosting an all-Wales patient story repository.

Work is ongoing across NHS Wales to establish an all-Wales storytelling consent form. However, progress has stalled regarding the development of a Civica equivalent to the WAST Virtual Video booth.

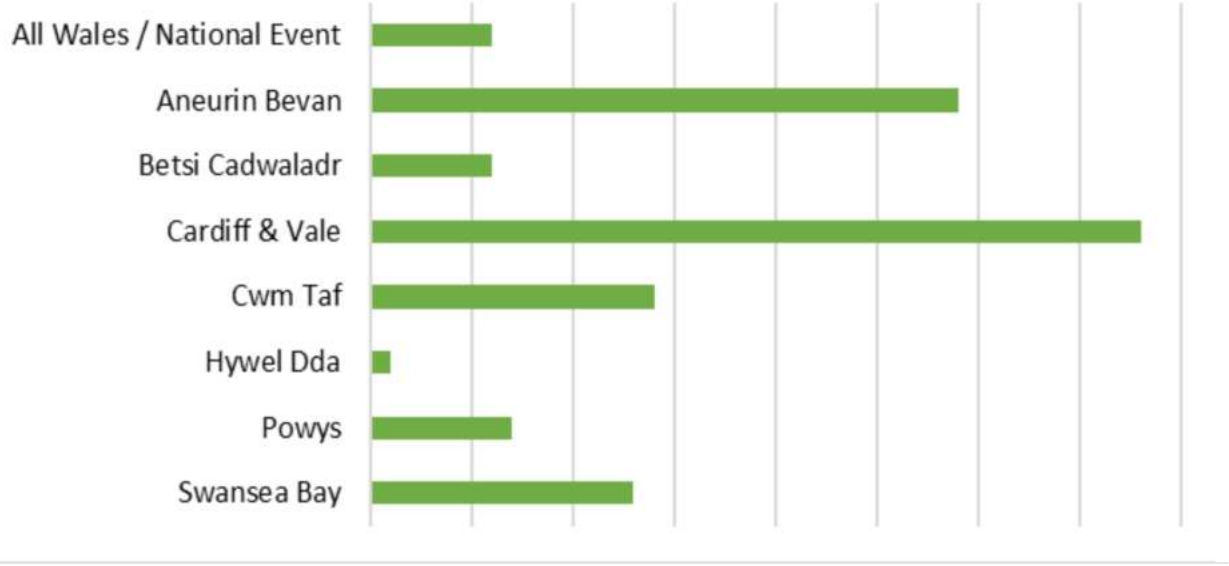
Engagement

Community Involvement & Co-production

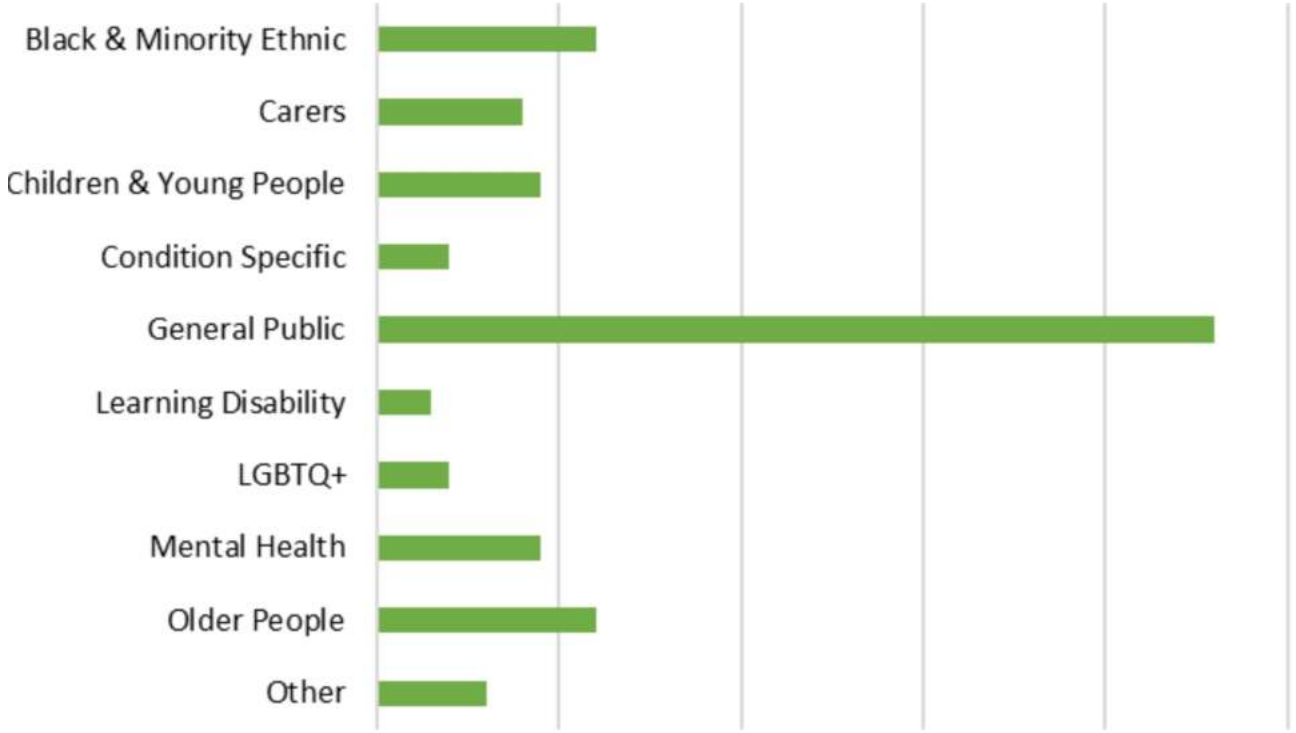
Community Involvement & Co-production

The PECI Team attended 124 engagement opportunities, engaging with 6,955 people across Wales. Whilst engagement opportunities were attended in all health board areas, it is acknowledged that we have not achieved an even spread across Wales.

Staff sickness and other conflicting priorities have contributed to this; however, it is very important to us that people from all over Wales have an opportunity to learn about the Welsh Ambulance Service and provide feedback about their experiences and we will do more to ensure an even spread of engagement events are attended over the coming 6 months.



Community Involvement & Co-production



Experiences and feedback, captured through our engagement with communities, covers a large cross section of the population, with a majority of events attended aimed at the public in general.

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

Engagement with children and young people is aligned to the ambitions of creating stronger more resilient future generations, as set out in the Future Generations Act.

Engagement with Black & Minority Ethnic groups aligns to priorities in the Anti Racist Wales Action Plan, whilst LGBTQ+ engagement supports the LGBTQ+ Action Plan for Wales, which aims to make Wales the most LGBTQ+ friendly nation in Europe.

Community Involvement & Co-production

Integrated Medium Term Plan (IMTP)

At engagement events we have shared information about the Trust's IMTP and have captured feedback received from the public on their priorities to help shape future IMTP development. Some feedback reflects issues that are well documented i.e., reducing waiting times for a response and length of wait outside emergency departments. Other feedback from the public has included:

- **Identify and respond to a caller with additional needs at the first point of contact**
- **Take into consideration health and social care needs that may be compromised by long waits**
- **Be seen and treated in the community or at home**
- **Staff that demonstrate compassion, empathy and kindness**

Working with colleagues from Planning & Performance, we have now agreed on three set questions that we will ask members of the public to feedback on when talking about the Trust's IMTP:

1. **What do you think of our plan? Tell us what you think is good.**
2. **What do you think should be in our next plan? Give us your top priority.**
3. **What else can the Welsh Ambulance Service do to improve people's health & wellbeing?**

Community Involvement & Co-production

What would a good quality ambulance service look like to you?

We have been asking the public this question at all of our engagement events. Peoples' responses have been collated and themed and will be used in helping us shape the development of the Trust's first Quality Plan.

Themes from feedback include:

- **Kind, compassionate, caring staff**
- **Being informed, good communication**
- **Instilling trust and confidence with the public**

Good quality has also been defined as:

- **Considering the needs of those with special needs / requirements**
- **Inclusive of all**
- **An educated workforce on diversity, neurodiversity and mental health**

Areas for Trust improvement from a public perspective have related to well documented aspects of Trust performance, such as:

- **Long wait times**
- **Condition worsening in the community**
- **Less time spent outside emergency departments**

They have also included:

- **Being more open with the public**
- **Expectations not being met**
- **Acknowledge patient/carer/parent expertise when assessing patients**

Community Involvement & Co-production

Dementia – Engaging with Communities

We engage with different dementia groups and communities across Wales, helping us to educate people about our dementia work. We offer familiarisation opportunities so people can come inside our vehicles and look around. This helps us to identify issues which people affected by dementia have when inside our environments. Feedback from dementia communities has led to the introduction of many improvements, including:

- A project in Ceredigion, co-designed by the local dementia community, has introduced pictures of areas of local beauty inside the vehicles, as well as genre specific music and activity booklets to support patients on ambulance transport.
- Using reminiscence therapy with people living with dementia has demonstrated a positive impact on patient experiences especially with patients who are distressed or agitated when in our care. There is evidence of improved transfers of care and opportunities to create meaningful relationships and moments using music and distraction for an improved patient experience.
- The development of a Patient Activity Toolkit, available to all staff, which will benefit anyone requiring distraction or occupation when in our care

Community Involvement & Co-production

Minority Ethnic Communities

We have continued to engage with minority ethnic communities across Wales by attending several events, including Cardiff Mela, Wales' biggest multicultural celebration.

At the Mela we spoke to people about what matters most to them when using ambulance services and people told us that having information available in their own language is important / vital, especially in a healthcare emergency. People also said that NHS services understanding the different cultural needs of communities is central to improving overall experiences.

A central goal of the Welsh Government's Anti-Racist Wales Action Plan is reducing health inequalities experienced by black, Asian and minority ethnic people and ensuring their voices are heard in shaping decisions about services. The PECI Team will continue to work closely with the Trust's Equality and Inclusion Team as they work to embed the actions of this plan across the Truust.

In this period an improvement project to reduce the number of steps to access the WAST welcome pack was concluded. The welcome pack has been promoted to communities at all relevant engagement events attended. We have also produced a new instruction leaflet to help people better understand how to access this new resource.

Community Involvement & Co-production

LGBTQ+ Engagement

Over the past six months we have supported the Trust to attend four Pride events across Wales, in Aberystwyth, Swansea, Cardiff and Wrexham.

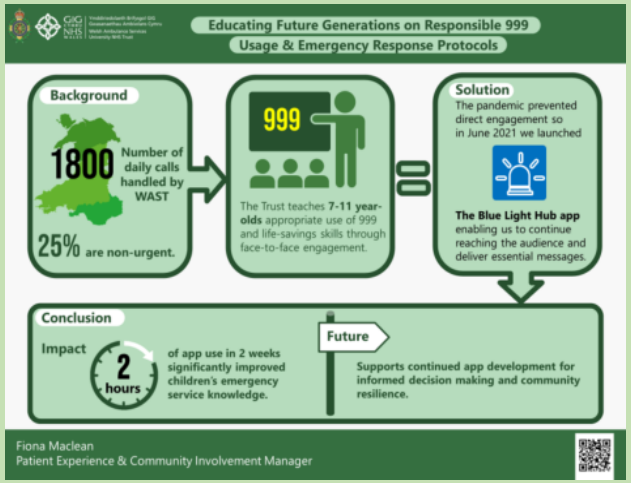
These events provided an opportunity for LGBTQ+ staff and volunteers to celebrate their diversity with pride whilst also allowing us to engage with the community and seek feedback about LGBTQ+ experiences and expectations of using our services.

Our engagement with this community also supports the Welsh Government's LGBTQ+ Action Plan for Wales vision to improve health outcomes for all LGBTQ+ people, specifically ***Action 5: Involve LGBTQ+ communities in designing public services*** and ***Action 18: Understand and Improve experience of LGBTQ+ people in the health and social care sectors***.

The action plan's evidence base tells us that within healthcare settings LGBTQ+ people still feel that they may face unequal treatment or discrimination. Trans patients report feeling that their specific needs are disregarded when using or attempting to use healthcare services and there are several other areas where LGBTQ+ people are affected disproportionately, such as mental health, depression and substance use.

Recognition

999 Emergency Medical Services Research Conference



A member of the Patient Experience & Community Involvement team was invited to provide a rapid elevator presentation at the '999 EMS Research Conference: recognising progress, developing the future'. The conference, held in person on Tuesday 17 and Wednesday 18 September 2024 in Cambridge was hosted and supported by East of England Ambulance Services NHS Trust.

Our presentation was entitled "When you're hurt and you need serious help you call 999". Educating children about emergency services and appropriate use of 999: An evaluation study of the Blue Light Hub app".

Patient Experience Network National Awards (PENNA)

We submitted three entries to the PENNA Awards, all three were successful in becoming finalists. The awards, held on 3rd October, recognised best practice in patient experience across all facets of health and social care in the UK. The categories are:

- **'Engaging/Championing the public'**: promoting our work on improving experiences of people with learning disabilities
- **'Innovative use of technology/social and digital media'**: for our work with children and young people in developing the blue light app based on evidence-based research, using technology and digital solutions to engage (Runner-Up in this category).
- **'Partnership Working to improve the Experience'**: promoting our work across all health, social care, business and voluntary sectors to reach, engage and improve experiences of communities across Wales.

APPENDIX 1: PREMs DATA

Your experience of calling 999

From April to September 2024 a total of 157 people used the 999 survey to provide feedback.

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

Overall response rates to this survey remain disappointingly low and we acknowledge that responses received do not provide a truly representative picture of what it feels like to be an EMS service user across Wales. Work continues to implement systems to expand our reach to increase tour reach.

Responses were received from all Health Board areas across Wales over the past 6 months. There were some positive aspects to people's experiences:

- **65% of respondents said they felt confident in the ability of the person who answered their call to manage the call and provide appropriate advice.**
- **70% of respondents said they did not receive a call back from a clinical advisor.**
- **Of those who did receive a call back from a clinical advisor, 43% said they felt they were given enough advice about what to do next.**
- **Of those who said an ambulance was sent, 87% said they felt safe whilst in the care of the ambulance crew.**
- **50% of people who completed the survey rated their overall experience as 'Good' or 'Very Good'.**

Your experience of calling 999

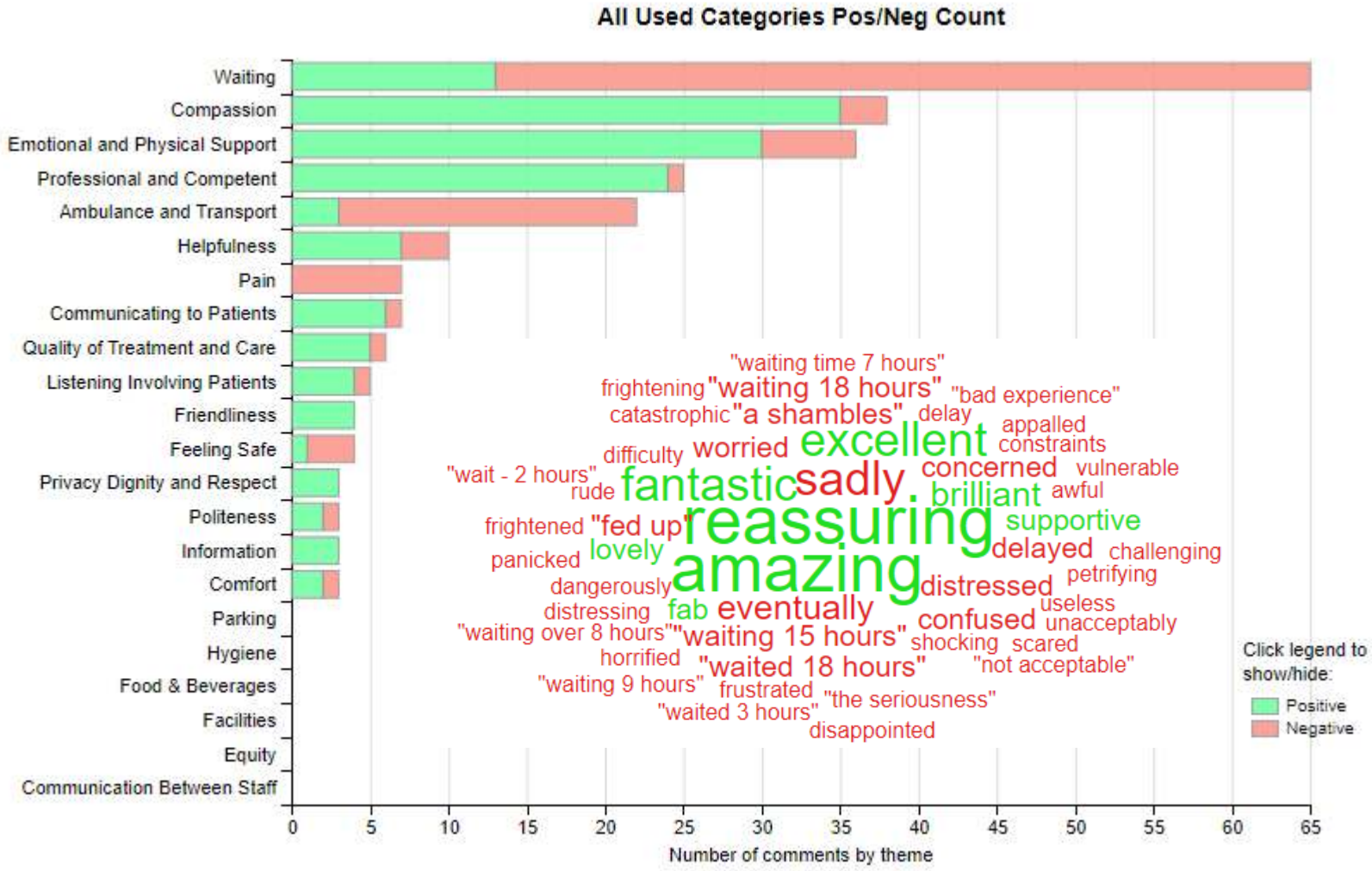
The Civica Experience platform provides us with some enhanced reporting facilities, including the ability to weight questions and produce 'Heat Maps' based on responses. We set a benchmark of 85, with aggregated scores of 85 and above representing a positive response. From the Heat Maps below we can see that the benchmark set was met in some areas, reassuringly in the areas of feeling safe; professional & reassuring staff and being treated with dignity and respect.

	Overall Experience	EMS Co-ordination				Clinical Support Desk			
Responses	Thinking of the last time you called 999. Overall, how would you rate your experience of the service	The 999 call taker who answered your call listened carefully	The 999 call taker who answered your call was reassuring	The 999 call taker who answered your call explained what was going to happen next	You felt confident in the 999 call takers ability to manage your call and provide appropriate advice	Was the Clinical Advisor you spoke with polite?	Did you feel that you were listened to by the Clinical Advisor?	Did the Clinical Advisor explain why an ambulance would or would not be sent to you on this occasion	Do you feel you were given enough advice on the telephone about what to do next?
157	50	87	72	77	71	68	53	50	35
Benchmarks	85	85	85	85	85	85	85	85	85

EMS Response								
The length of time I waited for the ambulance to arrive was acceptable	I understood the explanation of the care and treatment provided	I felt safe whilst in the care of the ambulance staff	The ambulance staff were professional and reassuring	The ambulance journey was comfortable	Overall, I was happy with the service received from Welsh Ambulance Service	Overall, I felt that I was treated with dignity and respect	Did the Paramedic or ambulance service staff clearly explain why you were not being taken to hospita	Before leaving you at home, did the Paramedic or ambulance service staff provide you with enough inf
55	82	92	89	81	73	86	69	73
85	85	85	85	85	85	85	85	85

Your experience of calling 999

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



What people said:

"The service from call handler to paramedic was outstanding"

"The call operator talked me through everything and was very patient with me when I got worked up and upset"

"Mum had signs of another stroke, told waiting time 7 hours. Unacceptable!"

"70yr old male, collapsed suddenly in a public place. Was unconscious and very unwell. We were told it would be 4 to 5 hours for an ambulance. We had to take him to hospital ourselves, laid out on the back seat of the car and terrified he would die on route. Thank goodness for the kindness of strangers who helped us, as we couldn't rely on the ambulance service"

Your NEPTS experience

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

Between April and September 2024, a total of 680 NEPTS patient experience surveys were completed. The responses received came from people who were sent a text message asking them to complete a survey, people who asked to receive a postal survey or NEPTS users who visited the Trust website to complete an online survey. Stickers asking patients to provide feedback are now displayed in all NEPTS vehicles, the stickers show a QR code which people can use to access the survey online.

Response rates to the survey are slightly lower in the past six-month period as SMS Text messaging was switched off for a period of time as part of the NEPTS capacity management plan.

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

- **95% found the booking process easy. Those who answered negatively said they experienced long delays waiting for their booking call to be answered.**
- **90% said they were happy with the transport they received.**
- **Majority of people (87%) said their overall NEPTS experience was either Very Good or Good.**

The NEPTS patient experience survey results continue to be positive and offer some assurance that users are generally satisfied with the service. Less positive responses continue to follow historical trends and focus on timeliness of transport, late cancellation of transport and waiting times for transport home.

Your NEPTS experience

The NEPTS Patient Experience survey also contains a number of weighted questions, allowing us to produce Heat Map reports. These heat maps use a benchmark of 85 to indicate a positive response. From the heat map below, we can see the benchmark has been reached in all areas except one; with wait times for transport home being the only area where it is missed. Satisfaction with wait times for transport home following an appointment misses its benchmark for a third reporting period in a row.

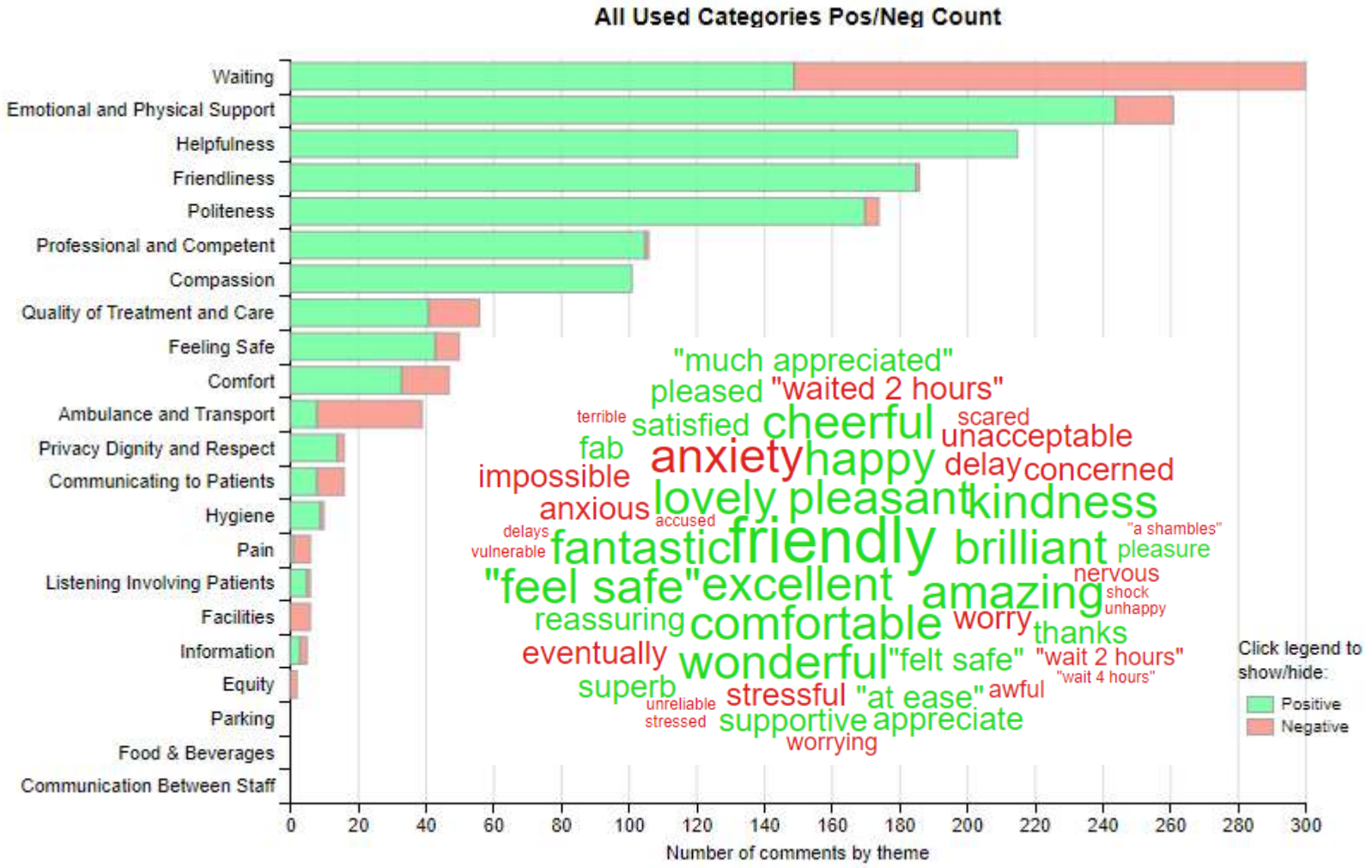
	Booking			Transport & journey								Overall Experience	
Responses	Did you find your booking experience easy?	Was our call handler polite and courteous during the call?	Do you feel you were given all of the information you required prior to your journey?	Were you happy with the transport you received?	Did you feel that the crew were polite and helpful towards you?	Were you given support to meet any additional needs you have?	If you asked for assistance, did you get it when you needed it?	How clean was the vehicle you travelled on?	During your journey, were you reminded / prompted about wearing your seatbelt?	Did you feel safe and secure during your journey?	How long did you wait for your transport to take you home after your appointment?	Thinking about the Non-Emergency Patient Transport Service, how was your overall experience of our service	Using a scale of 0-10 (0 being bad and 10 being excellent), how would you rate your overall experience
678	95	98	95	90	95	94	95	97	97	95	81	87	87
Benchmarks	85	85	85	85	85	85	85	85	85	0	85	85	85

We have amended the question around wait time for transport home to help us understand why people felt they were waiting too long. Responses show that 12% of respondents said they felt their wait was unacceptably long, with people saying they waited several hours for their transport home. Some people said their long wait was uncomfortable as they were in a wheelchair; others said that they had no access to food or medication during the wait.

Being reminded about wearing a seatbelt had failed to meet its benchmark for two consecutive reporting periods. There have been numerous patient safety incidents relating to appropriate use of seat belts and restraints. To better understand why this benchmark was being missed we added an additional answer option, allowing people to tell us they didn't need to be reminded to fasten their seatbelt as they had already done so independently. As a result, that benchmark was achieved for this reporting period, with only 3% of respondents telling us they were not reminded to wear their seatbelt or hadn't already put it on independently.

Your NEPTS experience

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



What people said:

"After two days of medication and restricted diet you cancelled his transport"

"For the 2nd time running I was called with less than 24 hrs notice that transport could not be provided although it had been confirmed 3 times the 3rd time a few hours before it was cancelled. I have suffered numerous disabling strokes but obviously not deemed in need of support. Disgraceful"

"My ambulance was cancelled last week due to staff sickness. My appointment today was at 2pm. I was ready at 12pm. I rang at 1.55pm to check where my ambulance was to be told it was just leaving station after their break. I rang the hospital to confirm I could still attend as I'd be very late. Thankfully, I could. People's appointments are very important and sometimes have waited weeks to get them"

Your NHS 111 Wales experience

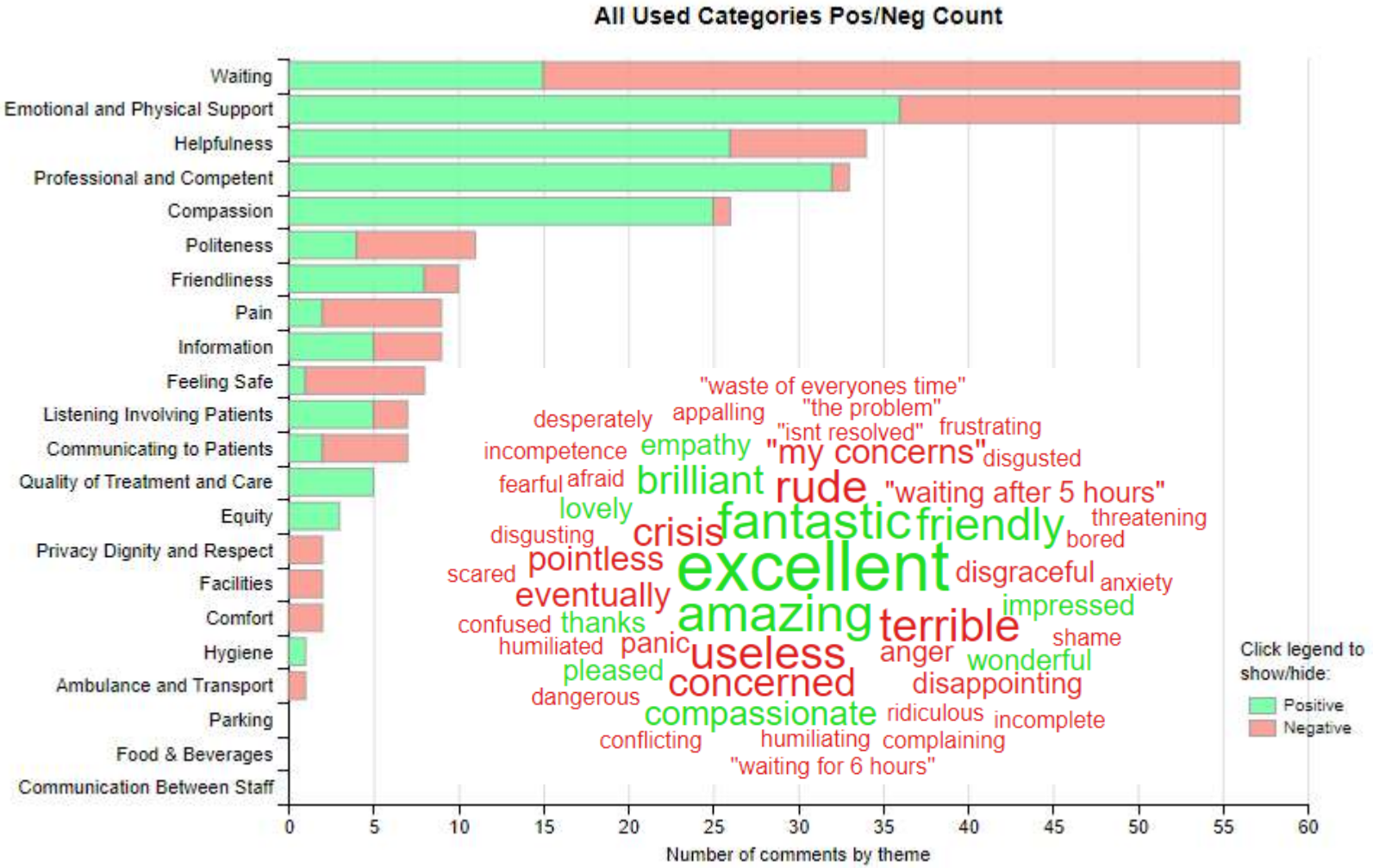
Between April and September 2024, a total of 104 NHS 111 Wales patient experience surveys were completed. Responses were received from all Health Board areas, though we acknowledge that this is a low response in comparison to overall call volumes and it is unlikely that responses received will provide a truly reflective picture of service user experience.

- **71% of respondents told us that NHS 111 Wales had been their first port of call and that they had not been referred on from another service.**
- **59% of people told us they called 111 looking for health information or advice for themselves.**
- **58% of people told us they found their call to NHS 111 Wales 'Extremely Helpful' or 'Helpful'.**
- **82% of people said they went on to follow the advice given to them by NHS 111 Wales.**

	Access & Information Provided			Overall Experience		
Responses	How satisfied were you with how long it took for your call to NHS 111 Wales to be answered?	Do you feel that your call to NHS 111 Wales was helpful?	Did you follow the advice given to you by NHS 111 Wales?	Thinking about the NHS 111 Wales service, how was your overall experience of our service today?	Using a scale of 1 – 10 where 1 is very bad and 10 is very good, please rate your overall experience	Would you consider using the NHS 111 Wales service again?
85	65	65	82	60	65	64
Benchmarks	85	85	85	85	85	85

Your NHS 111 Wales experience

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



What people said:

"I found your service very thorough, extremely helpful and understanding and above all, efficient and competent. I had no idea whether you could help me or not but you certainly did. I'm really glad that I called you. Many thanks"

"The opening message advised that the wait was 5 minutes. 75 minutes later I was still waiting and ended the call. Total disgrace and you want people to avoid ringing 999 and turning up at A&E!"

"Told current wait time to speak to an advisor was 48 minutes, pressed 1 for callback, it was 'cancelled'. 1 hour 25 minutes later, not spoken to a human yet!"

Your experience of NHS 111 Wales Online

Throughout this reporting period we have continued to make available a patient experience survey asking people to share their views with us about accessing health information and advice through the NHS 111 Wales website. **Between April and September 2024 180 people completed a website experience survey.**

- 57% told us that they found it 'Extremely Easy' or 'Easy' to find the information they were looking for on the website
- In contrast, 34% of respondents said they found it 'Not so easy' or 'Not at all easy' to find the information they needed
- 53% of people said they intended to follow the follow the advice they found on the website.
- 50% of respondents rated their overall experience of using the website as 'Good' or 'Very Good'. When asked to explain why they gave that rating, people said:

"Easy search and informative content"

"I was able to get all the information I required to be able to discuss the situation with my GP and hopefully ensure the correct treatment will be given"

- 33% of respondents rated their overall experience of using the website as 'Poor' or 'Very Poor'.

When asked to explain why they gave a poor rating, people said:

"Unable to find the information on the NHS Wales website - just taken round in a loop back to the a-z which directs you to NHS 111 (for England) then back to a very unhelpful Wales website"

"I couldn't get the information I needed. It left me feeling more depressed and unsupported than I when I first started. I would like help so I can get better, but just seem to be hitting dead end after dead end"

AGENDA ITEM No	**16**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**1**

LEARNING FROM DEATHS (MORTALITY REVIEWS) REPORT QUARTERS 1 AND 2, APRIL - SEPTEMBER 2024/25

MEETING	Quality, Patient Experience & Safety Committee
DATE	5 November 2024
EXECUTIVE	Liam Williams, Executive Director of Quality and Nursing
AUTHOR	Wendy Herbert, Deputy Director of Quality and Putting Things Right Claire Appleton, Assistant Director - Putting Things Right
CONTACT	Wendy.Herbert3@wales.nhs.uk claire.appleton2@wales.nhs.uk

EXECUTIVE SUMMARY

This report provides an update to the Quality, Patient Experience & Safety Committee (QuESt) on the current position and progress since the last report in July 2024 in respect of the Mortality Review Process and learning from deaths.

The Death Certification Reforms have now taken effect, providing the Medical Examiner Service (MES) with statutory status and ensuring all non-coronial deaths will receive independent scrutiny.

The Trust is developing a multi-directorate approach to reviewing Medical Examiner Service feedback, in line with the revised All Wales Learning from Mortality Reviews Model Framework (Second Edition).

The Trust's Learning from Deaths Forum oversees the implementation of the Trust's approach to the Model Framework and reports into Clinical and Quality Governance Group via an Alert, Advise, Assure (AAA) Report.

The Learning from Death Forum also oversees learning from Prevention of Future Death reporting and other sources of intelligence, including National Learning Reports and National Inquiries.

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

KEY ISSUES/IMPLICATIONS
(i) 238 Referrals have been received from the Medical Examiner Services (MES) in the first two quarters of 2024/25. (ii) 44 cases have been triaged as requiring further review and investigation under the Putting Things Right (PTR) Guidance. (iii) Thematic learning from Referrals in Quarter 1 and Quarter 2 is largely related to delays in attending in the community. (iv) Additional thematic analysis will be facilitated by further national development of the Datix Cymru Mortality Review Module.

REPORT APPROVAL ROUTE	
Learning from Deaths Forum	22 October 2024
Clinical & Quality Governance Group	30 October 2024
Quality, Patient Experience & Safety Committee	5 November 2024

REPORT APPENDICES
ANNEX 1 - SBAR which provides the background for this report.

REPORT CHECKLIST			
Confirm that the issues below have been considered and addressed		**Confirm that the issues below have been considered and addressed**	
EQIA (Inc. Welsh language)	N/A	Financial Implications	N/A
Environmental/Sustainability	N/A	Legal Implications	YES
Estate	N/A	Patient Safety/Safeguarding	YES
Ethical Matters	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. This Learning from Deaths Report covers the period from 1 April to 30 September 2024.

2. This Report covers:

- Medical Examiner scrutiny feedback and implementation of the *All-Wales Learning from Mortality Reviews Model Framework (Second Edition)*
- Prevention of Future Death Reports
- Organisational learning captured and responded to in the Trust's 'Learning from Death Forum'
- Bereavement learning and improvement

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 Level 2 Panel Review of Medical Examiner cases.

BACKGROUND

4. 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.

5. 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

6. On 9 September 2024, the Death Certification Reforms came into effect in NHS England and NHS Wales, including the statutory provision of the Medical Examiner Service for all deaths as part of the Medical Examiner (Wales) Regulations 2024.

7. The reforms focus on the experience for bereaved people and seek to support improvements to patient safety. For bereaved people, the introduction of a statutory Medical Examiner System provides an opportunity for them to raise

questions or concerns with a Senior Doctor not involved in the care of the deceased. The statutory system will also help deter criminal activity, improve practice and ensure appropriate referrals to Coroners for further investigation.

8. 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 (WAST) Electronic Patient Care Records (ePCRs) to inform their Mortality Reviews. If any additional information is required, contact is made via a WAST dedicated mailbox. The MES is not able to review WAST call categorisation, Demand Management Plans or resource allocation. It is therefore important that internal governance mechanisms for assurance and learning around Emergency Medical Service Co-ordination (EMSC) continue. To this end, the Operations Quality Team are supporting the proportionate investigation of Medical Examinator (ME) Referrals.

9. Reviews often highlight aspects of excellent care, 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 wider healthcare system.

WAST Learning from Deaths Forum

10. The Learning from Death Forum receives Medical Examiner data and feedback pertaining to mortality at an organisational level. The intention is to identify variation in patient outcomes and opportunities for improvement, such as early recognition and escalation of the deteriorating patient, and appropriate and timely end of life care.

11. The Forum's development and maturation has been affected by senior staffing changes and absence within the PTR and Legal Services Department however necessary stability is now in place for the Forum to flourish. This will allow the Forum to stretch beyond intelligence from the MES and develop the wider Programme of Work outlined in the previous Report.

ASSESSMENT

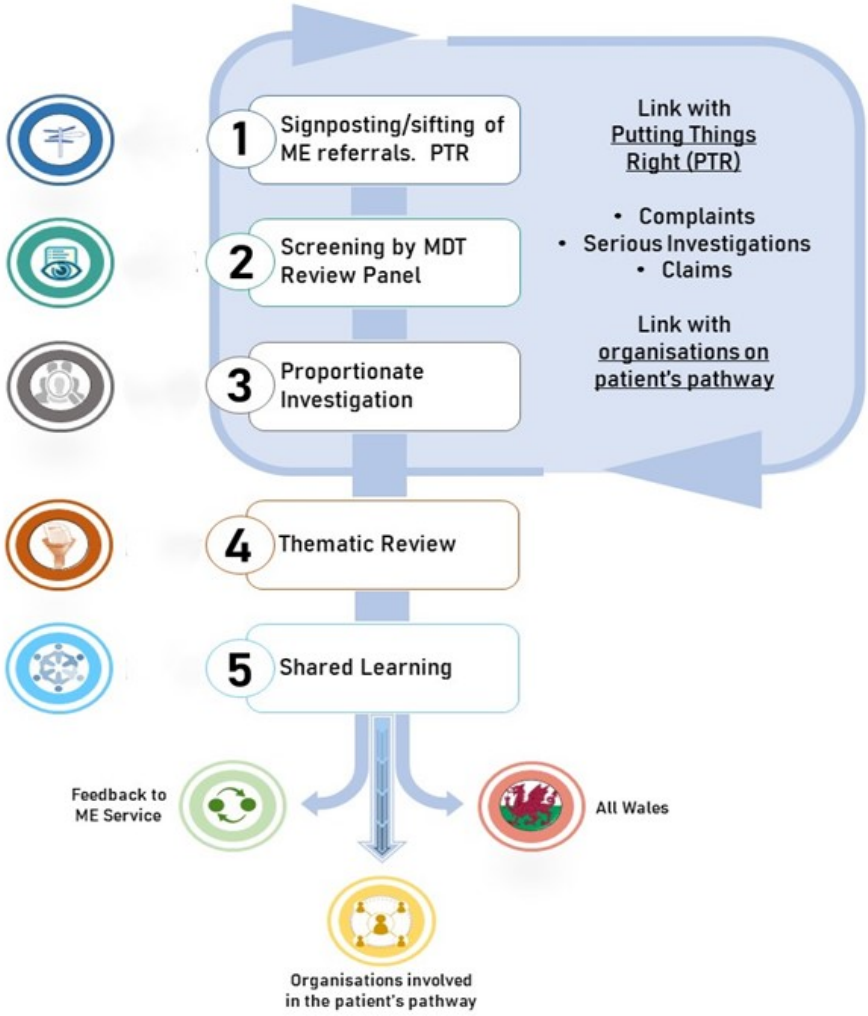
Medical Examiner Service Referrals

12. On receipt of the MES Referral Letter, the Patient Safety Team manually enters the content of the letter onto the Trust's Datix Cymru Mortality Review Module.

13. The 24 MES Referrals which were identified for further review from the retrospective review of pre-April 2024 cases undertaken by the previous Interim Assistant Director have been actioned.

14. Following the publication of the refreshed *All Wales Learning from Mortality Reviews Model Framework (Second Edition),* the Trust has refreshed its approach to this work, following National Guidelines on applying a proportionate approach and aligning feedback from Medical Examiners with existing clinical governance structures including those required by the Concerns Regulations and associated Putting Things Right Guidance. Figure 1 (below) is taken from the new Framework:

Figure 1



15. MES Referrals are reviewed weekly at the Level 1 Triage Group undertaken by the Patient Safety Team. 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. Training needs, unfamiliarity with the new Framework and staffing absences resulted in a backlog of cases to triage however the team has worked hard to recoup the position and is close to achieving contemporaneous review on receipt.

16. The WAST Medical Examiner Learning Panel will receive the recommendations of the Level 1 Medical Examiner triage undertaken by the Patient Safety Team and agree the actions taken to manage cases using the following categories:

    A There is already an existing process underway (usually a PTR Process) which will effectively investigate the individual issues raised in the Medical Examiner Referral.

    B The individual case does not require further investigation or consideration under PTR Processes. This is likely to be the case where the concerns are not contributory or causative of harm and where the issues 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).

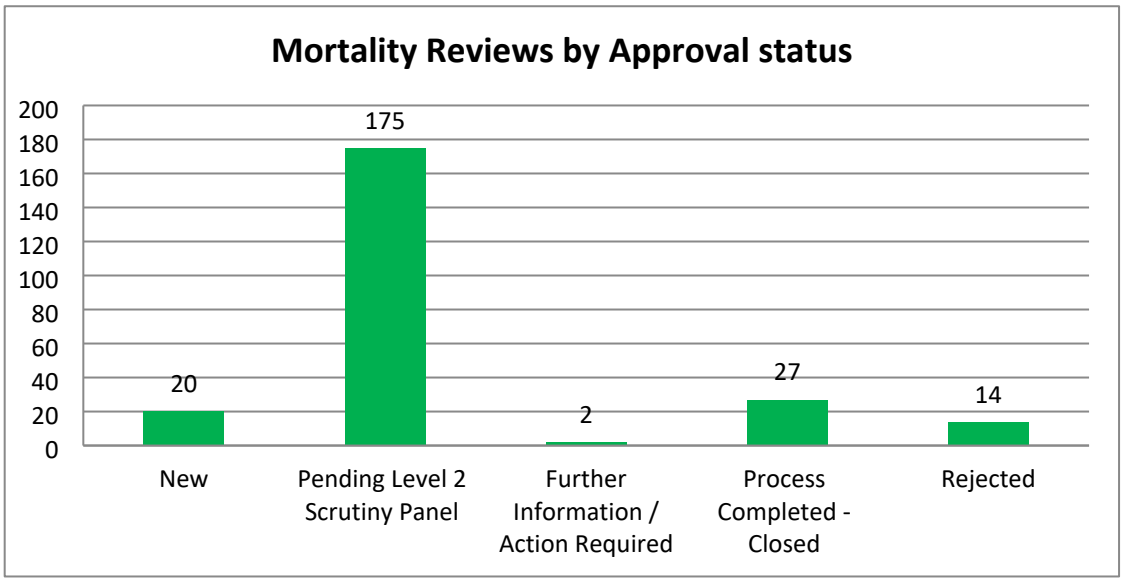
    C The case requires a more in-depth investigation under Level 3 of the National Mortality Review Framework. This is likely to be the case where the issues identified are possibly contributory or causative of harm, including mortality and/or where the issues are novel or unique in terms of learning opportunities. These cases will be managed in accordance with the Trust's Adverse Incident Policy.

17. In addition to agreeing or directing further actions for individual cases, the Panel will confirm the appropriate identification of key issues, learning themes and case outcomes. Referral trends, learning themes and areas for improvement will be shared with the Learning from Death Forum and Quality Management Group for further action and wider organisational learning. This includes positive feedback and good practice as well as areas of concern.

18. The Panel will also give due consideration to ensuring that organisational responsibilities for the Duty of Candour, safeguarding and external reporting requirements have been undertaken appropriately and will work closely with the existing governance structures of the Serious Case Incident Forum (SCIF) and Complex Case Panel (CCP).

19. 238 Referrals were received from the MES between 1 April 2024 and 30 September 2024. The current approval status of those referrals as of 14 October 2024 in shown in Graph 1. It should be noted that this is a snapshot of the current stage at the time of extraction and will have progressed by the time this Report is received.

Graph 1



20. Level 2 Multi-disciplinary Panels have now been commenced and progress is being monitored in the Learning from Death Forum to ensure new processes are embedded efficiently.

21. New cases are those received from the MES:

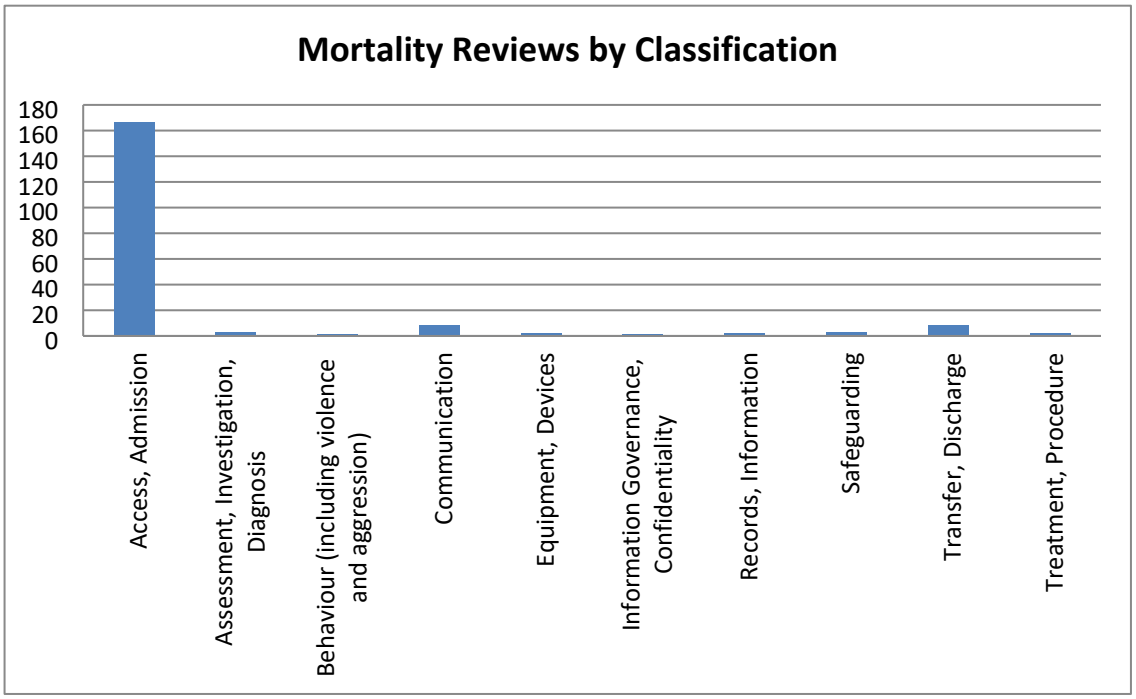
- Pending Level 2 Scrutiny Panel are cases which have had a Level 1 triage but awaiting Level 2 Learning Panel approval and discussion.
- Further Information/Action Required is used to denote cases where a triage decision is not possible without obtaining additional information.
- Process Completed refers to cases approved by the Level 2 Learning Panel.
- Rejected cases are where we may have received a Referral twice or where the concerns raised do not relate to WAST, such as extended waits outside of the Emergency Department.

22. The Patient Safety Team sends a monthly Report to the Lead Medical Examiner Officer providing feedback and information on case outcomes and learning.

23. The code sets in the Datix Cymru Mortality Review Module are still under development nationally resulting in information being held in free text fields which is challenging and time consuming to draw out patterns, themes and trends. The PTR and Legal Services Team are actively contributing to the Mortality Learning Network and the Mortality Review Once for Wales Workstream to ensure that appropriate ambulance care-related code sets are included.

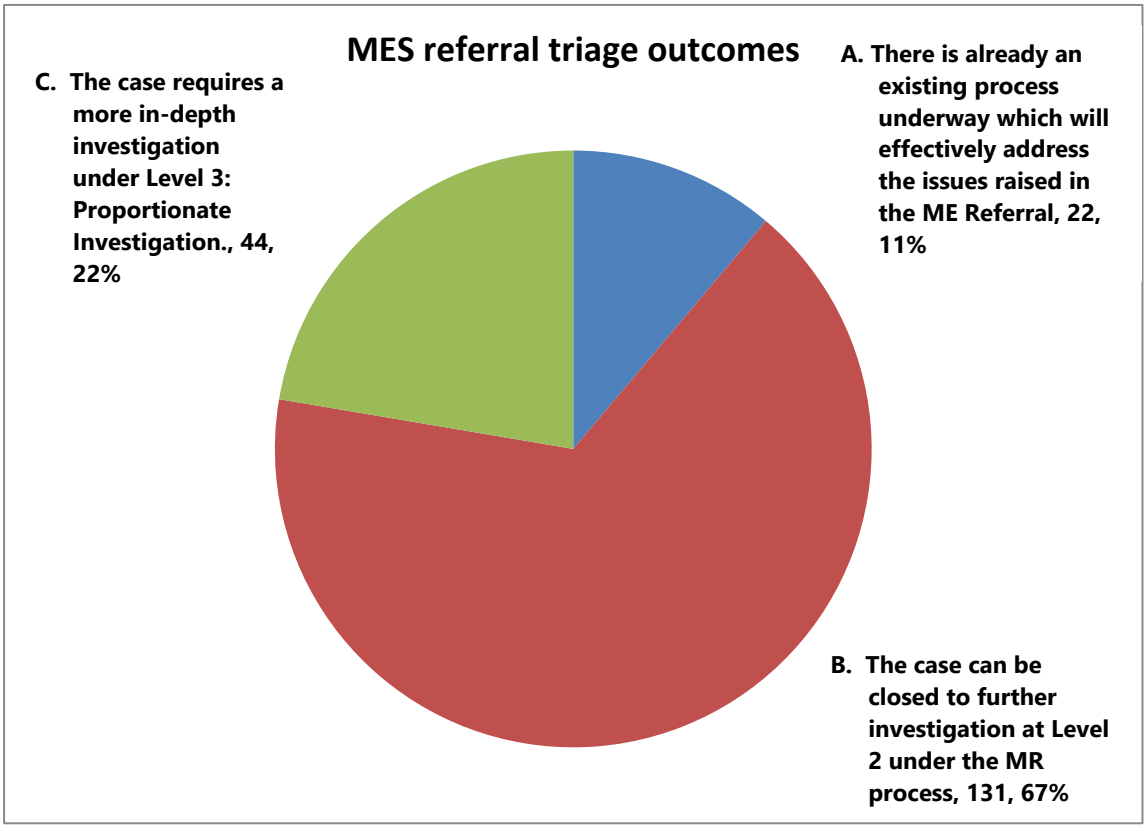
24. Graph 2 indicates the classification of the main referring issue for cases triaged in Quarter 1 and Quarter 2. This is a stark representation of the amount of cases concerning delays in response.

Graph 2



25. Graph 3 demonstrates 44 of the cases received progressing straight to Level 3 and undergoing a proportionate investigation.

Graph 3



26. Of the cases received during Quarter 1 and Quarter 2, only 2 people were known to have a learning disability and there were no people with a known diagnosed severe mental illness. The paucity of affirmative data would appear to indicate that there is more to do in terms of identifying these patient characteristics to better understand and offer future support to patients who may have additional or unique care needs.

27. 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 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 highly professional.
- 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.

28. Digital Services: Data and Analytics have developed a Project Brief for a Natural Language Processing Programme to improve intelligence and learning following MES Referrals however this has been paused due to release capacity to address organisation digital priorities associated with the Clinical Model Transformation work. 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.

National Inquiries

29. Thirlwall Inquiry: On 21 August 2023, after a trial at Manchester Crown Court, Lucy Letby was sentenced to life imprisonment and a whole life order on each of 7 counts of murder and 7 counts of attempted murder. The offences took place at the Countess of Chester Hospital, part of the Countess of Chester Hospital NHS Foundation Trust.

30. The Learning from Deaths Forum acknowledges the Terms of Reference for this Inquiry and their importance for wider NHS governance and culture. The loss endured by the bereaved parents is foremost in our minds as we reflect on the early learning from the evidence to date.

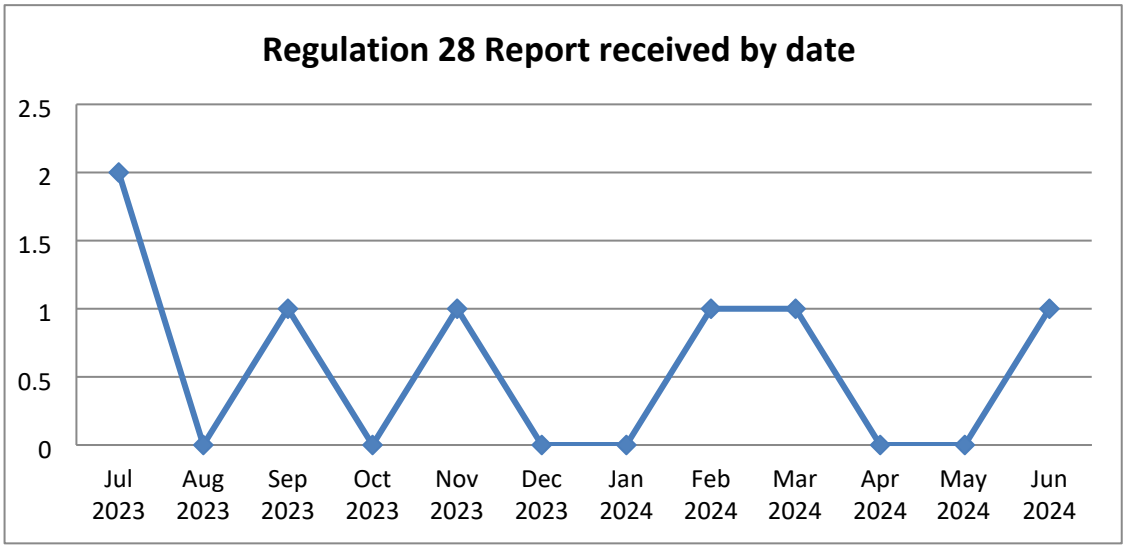
31. The Inquiry will investigate 3 broad areas; the experiences of the parents; the conduct of those working at the Countess of Chester Hospital (how and when concerns were raised and the response to them); whether NHS management and governance structures and processes, external scrutiny and professional regulation are effective in keeping babies in hospital safe.

32. UK Covid-19 Inquiry: Whilst all Modules of the inquiry are likely to hold relevance to the Trust, the current active Module 'Impact of COVID-19 pandemic on healthcare systems in the 4 nations of the UK' has rich evidence and learning, particularly the impact on staff and the use and understanding of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders.

Reports to Prevent Future Deaths (Regulation 28)

33. Graph 4 below details the number of Reports to Prevent Future Deaths the Trust has received over a rolling 15-month period. The Trust has responded to all Reports directly to date with Improvement Actions included. Our responses are published on the Courts and Tribunals Judiciary Website. No Regulation 28 Reports have been received since June 2024.

Graph 4



34. Regulation 28 Reports are now being captured in Datix Cymru and the option of differentiating between those issued directly to WAST and those issued jointly with another organisation has been introduced.

35. Table 1 provides a breakdown of Regulation 28 Reports addressed to the Trust in Quarter 1 and Quarter 2 of 2024/25. These are cases where we have provided a response within 56 days.

Table 1

Reports to Prevent Future Deaths addressed to the Trust			
Coroners court	Date of Report	Concerns Raised	Also Sent To:
Swansea and Neath Port Talbot	06/2024	Certain drug (Flumazenil) not carried by Paramedics	

36. Table 2 provides a breakdown of Regulation 28 Reports addressed to other parties but also shared with the Trust in Quarter 1 and Quarter 2 of 2024/25. These are cases where the Inquest touched upon our services, but the Trust was not required to send a response to the Coroner.

Table 2

Reports to Prevent Future Deaths shared with the Trust			
Coroners court	Date of Report	Concerns Raised	Sent To:
Aneurin Bevan	07/2024	Community response delays.	Minister for Health and Social Services, Welsh Government

Horizon Scanning & Key Documents

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

- National Medical Examiner Annual Report 2023
- National Medical Examiner's Good Practice Series No. 16 Deaths after delays in care and treatment
- All Wales Learning from Mortality Reviews Model Framework (Second Edition)

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

AGENDA ITEM No	**17**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**1**

IPC PREPAREDNESS & EMERGING HEALTH RISKS ASSOCIATED WITH MPOX AND OTHER HIGH CONSEQUENCE INFECTIOUS DISEASES

MEETING	Quality, Patient Experience & Safety Committee
DATE	5 November 2024
EXECUTIVE	Liam Williams, Executive Director of Quality and Nursing
AUTHOR	Penny Durrant, Deputy Director of Nursing, Quality and Governance
CONTACT	penny.durrant@wales.nhs.uk

EXECUTIVE SUMMARY

1. The Welsh Ambulance Services University NHS Trust (WAST) is strengthening its Infection Prevention and Control (IPC) measures, focusing on the rollout of Respiratory Protective Equipment (RPE), to address the ongoing Mpox situation.
2. WAST is actively enhancing its Infection Prevention and Control (IPC) Guidance, with a key focus on the rollout of Powered Air Purifying Respirators (PAPRs) to frontline staff. This initiative is aimed at strengthening protection against airborne pathogens, particularly during aerosol-generating procedures (AGPs).
3. Alongside this, the Trust is preparing for increasing seasonal pressures due to winter respiratory infections (e.g. flu and RSV), while also remaining vigilant about emerging High Consequence Infectious Diseases (HCIDs) like Mpox, Marburg virus and Middle East Respiratory Syndrome (MERS-CoV).
4. Additionally, it is predicted that the Trust's 111/Integrated Care Service may begin to experience a heightened demand in the coming months, particularly from the 'worried well', seeking guidance on these diseases and the ongoing risks posed by new COVID-19 variants, such as XEC as well as a range of seasonal viruses such as Flu.

RECOMMENDED That the Quality, Patient Experience & Safety Committee note this paper and confirm their assurance that the Trust is taking all appropriate measures to prepare for a case of Mpox or other High Consequence Infectious Diseases.

KEY ISSUES/IMPLICATIONS
(i) **Risk of Resurgence:** Currently Clade 1 Mpox cases have not emerged in the UK, the possibility of this situation changing remains, particularly with international travel and potential imported cases. Failure to maintain preparedness could result in delayed identification and containment of new cases, leading to outbreaks and increased pressure on healthcare services.
(ii) **Surveillance and Response:** The need for constant monitoring and rapid response systems for Mpox and other HCIDs is critical. Any lapse in vigilance could result in the Trust being underprepared for an outbreak.
(iii) Public Concern: Ongoing public concern about Mpox and other HCIDs may lead to heightened demand for health services, including 999 calls, ambulance response and 111Wales queries. Effective public health messaging is crucial to mitigate fear and reduce unnecessary service use.
(iv) **Strain on Resources:** The increasing volume of calls to the 111 service from the 'worried well' regarding Mpox, COVID-19 variants, and other infectious diseases is putting additional strain on resources. This could result in longer wait times for callers with urgent medical needs, reducing the overall effectiveness of the service.
(v) **Managing Increased Demand:** Without additional resources or improved information to aid triaging of calls, the 111Wales service may become overwhelmed, particularly during periods of heightened public anxiety or during the coming winter months, when overall healthcare demand typically rises.
(vi) **Public Education and Communication:** Insufficient public education and information around diseases like Mpox and COVID-19 may exacerbate the influx of non-urgent calls, further straining the system. Clearer messaging and information Campaigns are essential to manage public expectations and reduce unnecessary queries.
(vii) **Staff Safety and IPC Compliance:** The timely and comprehensive rollout of PAPRs is essential for protecting staff involved in possible high-risk exposure. Delays in fit-testing or training could result in increased exposure risks for frontline workers, undermining overall IPC efforts.
(viii) **Operational Readiness:** If staff are not proficient in using PAPRs, particularly during high-pressure or emergency situations, the effectiveness of these protective measures may be compromised, putting both staff and patients at risk.
(ix) **Completion of Rollout:** The need to accelerate fit-testing and training is urgent. Delays in ensuring full coverage of PAPRs for all relevant staff, especially before winter pressures, could leave gaps in IPC measures for patient facing staff.

REPORT APPROVAL ROUTE	
Senior Quality Leadership Team	21 October 2024
Executive Leadership Team	ELT updated through IPC Highlight Reports
Clinical & Quality Governance Group	30 October 2024
Quality, Patient Experience & Safety Committee	5 November 2024

REPORT APPENDICES
ANNEX 1 - SBAR providing background information

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

ANNEX 1

SITUATION

1. The Welsh Ambulance Services University NHS Trust is undergoing a seasonal preparedness related to infection prevention and control (IPC) as we approach the winter season. This year's preparations have been compounded by emerging infectious disease threats, namely Mpox and Marburg virus. Welsh Government has requested all NHS organisations review their preparedness and provide assurance that they have taken all reasonable measures to respond to a Highly Contagious Infectious Disease (HCID) case or outbreak.

2. The Trust has subsequently expedited the roll out of Powered Air Purifying Respirators (PAPRs) to frontline staff. This equipment is crucial for providing enhanced respiratory protection, particularly during aerosol-generating procedures (AGPs), which are a known risk for the spread of infectious diseases.

3. In parallel, staff training and fit testing of both PAPRs and other Respiratory Protective Equipment measures are being conducted to ensure all personnel are proficient in their use and are clear on when this protective is required to be used.

4. As the situation develops and with seasonal viruses on the increase in the coming months, the demand for IPC measures increases, it is likely that we may experience an upsurge in callers accessing us via our 111Wales service. These, as experienced historically, are often queries from the public, particularly from individuals identified as the 'worried well'. These callers often express concerns over various health threats, such as Mpox, COVID-19 variants and other High Consequence Infectious Diseases (HCIDs), such as Marburg virus.

BACKGROUND

5. **Emerging HCIDs and COVID-19 Developments**:

Mpox: While Mpox in the UK has not escalated at present, there remains a risk of cases. Continued monitoring is essential, particularly in light of potential travel-related transmission. The Trust is expeditions a preparedness position to handle isolated cases but should continue to monitor the situation and remain vigilant.

Marburg and MERS-CoV: These HCIDs, although not currently a direct threat in the UK, have seen outbreaks globally, necessitating a state of readiness in case of an imported case. The Trust must ensure that guidance and processes for the management of such diseases are updated and embedded in practice. These diseases, while not present in the UK, are being actively monitored by Public Health agencies. UK preparedness exercises are critical to ensure that, in the unlikely event of a case, staff are ready to respond with appropriate IPC measures,

including isolation protocols and the use of PAPRs. In September WAST participated in a Wales wide desktop exercise run by the Chief Medical Officer (CMO)office.

COVID-19 XEC Variant: The emergence of the XEC variant presents ongoing challenges for managing COVID-19, particularly given its transmissibility and the unknowns regarding its impact on public health. Preparations for increased COVID-19 cases remain a priority, alongside vaccination efforts and the reinforcement of infection control measures. Enhanced respiratory protection (including PAPRs) may become increasingly necessary as the variant's behaviour is further understood.

Seasonal Winter Illnesses: Respiratory illnesses, such as flu and RSV, are expected to rise significantly during the winter months and are anticipated to lead to significant healthcare demand. These conditions will place additional strain on healthcare services, including ambulance response times, higher call volumes into 999 and 111/Integrated Care, increased patient transport requirement, hospital admissions and access to Primary Care providers.

Active monitoring and preparedness plans for Mpox, Marburg, MERS-CoV, and COVID-19 variants should remain a priority, this will continue to be supported through the IPC Strategic Group and Resilience Team.

6. **Respiratory Protective Equipment**:

The Trust has an established approach to supporting staff exposed to communicable disease and specifically the provision of respiratory protective equipment. Staff are currently being encouraged to ensure that they are fully compliant to the mandatory training set out in the IPC policies, familiar with the equipment issued and take steps to ensure personal safety when needing to wear the equipment. It is recognised that maintaining compliance to Face Fit Testing requirements has been challenging and in November 2023, the Executive approved a transition to Powered Air Purifying Respirators which is currently being expedited.

7. **Powered Air Purifying Respirators Rollout and Training**:

PAPRs are critical in environments where staff are at risk of exposure to airborne pathogens, especially during AGPs. The Trust has identified key personnel who require this protective equipment and has initiated the fit-testing process, which is a mandatory safety measure to ensure proper usage and protection. These include all Emergency Medical Technician and Paramedic staff crewing Emergency Ambulances.

The rollout also includes comprehensive training for staff on when and how to use PAPRs effectively, adhering to IPC guidelines. This initiative forms part of the Trust's broader strategy to protect staff and patients in high-risk scenarios, such as handling suspected or confirmed cases of infectious diseases. To ensure full coverage across all critical frontline staff, the PAPR fit testing and training program has been accelerated. Additional fit-testing opportunities are being scheduled with the work co-ordinated between Learning and Development and Operational Managers, supported by IPC.

It is expected that complete roll out of PAPR in Emergency Medical Service (EMS) will be achieved by the end of November 2024 with the only risk to this milestone being supplier delivery of the final order.

8. **Public Queries and the 'Worried Well'**:

The 111Wales service may begin to receive an increasing volume of calls from concerned members of the public, who are often categorised as the 'worried well'. These individuals, while not exhibiting symptoms themselves, are seeking reassurance and information regarding emerging health threats.

The increase in public health awareness, driven by media reports on diseases like Mpox, new COVID-19 variants (e.g., the XEC variant), and HCIDs such as Marburg and MERS-CoV, will heighten anxiety. Consequently, 111Wales is often tasked with providing detailed, clear guidance to reassure concerns and calm fears, while relaying up-to-date public health advice.

In the event of a confirmed case of Mpox in Wales or the UK, there is an opportunity to turn on a Module within our system. This will provide internal surveillance within the 111Wales/Integrated Care setting to enable thematic population data to be drawn out of who calls, from where and when that can be fed into opportunities for targeted messaging, and into the wider population surveillance work undertaken by colleagues in Public Health Wales and other Welsh Health agencies.

The likelihood of an increase in public queries to the 111Wales service reflects both heightened public awareness and anxiety regarding infectious diseases. Staff are well-equipped to handle these calls, and the integrated care clinical and educations teams work closely with Public Health Wales to secure the most up to date and appropriate advice. The 111Wales Operations Team have been securing resources that will meet predicted seasonal variation demand. However, in the event of multiple cases of a serious communicable disease being confirmed, it is possible that public concern will exceed predicted demand, and the Trust may need to put further measures in place to expand capacity, e.g., overtime and enhanced call prioritisation.

RECOMMENDED That the Quality, Patient Experience & Safety Committee note this paper and confirm their assurance that the Trust is taking all appropriate measures to prepare for a case of Mpox or other High Consequence Infectious Diseases.

AGENDA ITEM No	**18**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**1**

MATERNITY AND NEONATAL SAFETY SUPPORT PROGRAMME UPDATE

MEETING	Quality, Patient Experience & Safety Committee
DATE	5 November 2024
EXECUTIVE	Liam Williams, Executive Director of Quality and Nursing
AUTHOR	Bethan Jones, Perinatal Safety Champion
CONTACT	Bethan. Jones81@wales.nhs.uk

EXECUTIVE SUMMARY

1. This report provides an overview of the key areas of work undertaken in the Maternity and Neonatal Safety Support Programme within the Welsh Ambulance Services University NHS Trust (WAST). Whilst not exhaustive, it highlights the midwifery expert guidance being integrated within the out of hospital setting and does not include the day-to-day midwifery expert guidance that is being given within Emergency Medical Service Co-ordination (EMSC), patients safety and increasing the collaborative working with Health Boards and the Maternity and Neonatal Strategy Network to continuously learn from, continuously improve and ensure positive feedback is shared from maternity and neonatal incidents to our staff.
2. The Maternity and Neonatal Safety Support Programme has been extremely successful with several initiatives already demonstrating significant impact and continue to shape WASTs role in improving neonatal and maternity outcomes in the out of hospital setting.

RECOMMENDED that the Quality, Patient Experience & Safety Committee receive the report and accept the assurances that the Trust is meeting its statutory duties/responsibilities to consult; engage and involve the public/patients in its work.

KEY ISSUES/IMPLICATIONS

(i) Currently the Trust is using National Early Warning Score for pregnant women which will not highlight the physiological changes in pregnancy and presents a risk of not identifying deterioration of pregnant/postnatal women. A consensus has been reached in Wales to adopt the English Maternity Early Warning Score. Along with the Maternity Decision Tool that has been approved by the National Ambulance Service Medical Directors (NASMeD), implementation of a

pregnant/postnatal women's observations will need to be aligned in the Electronic Patient Care Record (EPCR) to reflect the English charts parameters.

(ii) **Neonatal Restraints**: WAST Clinical Equipment Working Group has approved the NeoMate device, but funding remains a barrier. Currently on the National Risk Register and NASMeD.

REPORT APPROVAL ROUTE	
Clinical & Quality Governance Group	30 October 2024
Quality, Patient Experience & Safety Committee	5 November 2024

REPORT APPENDICES
ANNEX 1 - SBAR providing an overview of Maternity and Neonatal Safety Support Programme.

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

ANNEX 1

SITUATION

1. WAST has undertaken several initiatives and improvements in neonatal and maternity care, particularly focusing on thermoregulation, training, collaboration, and communication across services. The efforts have shown promising results and have been recognised nationally.

BACKGROUND

2. **Neonatal thermoregulation**: The Clinical Audit Team is currently reviewing the data. The most recent data from February shows that the percentage of babies admitted to the hospital with their temperature taken has increased from a baseline of 4% to 75% being normothermic upon admission. The next test of change in improvement will come with the implementation of Medical Priority Dispatch System (MPDS) Version 14, which includes pre-arrival instructions for skin-to-skin contact, with the aim of further increasing normothermic admissions. This work was shortlisted for an award at the British Association of Perinatal Medicine in September, marking the first time an Ambulance Service has received such recognition. It has also been shortlisted for an award at the NHS Executive Awards in November.

3. **Obstetric Council**: Perinatal Champion continues to work with the International Academies of Emergency Dispatch (IAED) academy as part of the Obstetric Council. After many successful improvements to version 14, work has now commenced on further improvements to 14.1 to evolve to Protocol and further improve pre-arrival instructions to align with National Guidance.

4. **Out of Hospital Newborn life support course (OH-NLS)**: Following the success of the first OH-NLS course in Wales, two additional course dates have been secured. This Resuscitation Council-accredited course provides WAST staff, Emergency Medical Retrieval and Transfer Service (EMRTS), and Community Midwife Teams with Newborn Life Support (NLS) accreditation, while fostering multidisciplinary teamwork on the complexities and human factors involved in out-of-hospital settings.

5. **The Maternity Red Phone**: Service offers a single point of access from WAST to Maternity Units and has been implemented across four Health Boards in Wales, with plans for all Obstetric Units in Wales to implement. Two remaining Health Boards have agreed and finalising installation and planned go live date.

6. **Maternity actions cards and decision aids**: These are now available in all maternity bags and electronically via ePCR, offering support to staff during critical events.

7. **Pre-hospital Maternity and Neonatal Event**: The first out-of-hospital maternity and neonatal event by the College of Paramedics was held in Birmingham in September. It was a sold-out event with highly positive feedback. The National Prehospital Maternity and Neonatal Group has planned to hold another event next year.

8. **Updated Maternity Guidance (Joint Royal College Ambulance Liaison Committee (JRCALC))**: All maternity guidance within JRCALC has been updated by the National Maternity and Neonatal Group. The Perinatal Champion has led the development of a new JRCALC Maternity Guideline, that is now in its final stages of approval. A Maternity Decision Tool has also been approved by NASMeD, aligning with the parameters of the English Maternity Early Warning Score Chart.

9. **All Wales Maternity Transfers Guideline**: The All-Wales Guideline for Maternity Transfers from Community and Freestanding Midwifery Units is now in use across all Health Boards, promoting prudent Ambulance Service use and ensuring effective communication with 999 services for timely care. WAST, the Strategic Maternity and Neonatal Network, and Prompt Cymru have been shortlisted for the Safe Care Collaboration Award by the Royal College of Midwives.

10. Community Prompt Wales new Programme is now being delivered to all Midwives in Wales which includes a presentation on WAST, making effective 999 call which has been designed around learning and themes from incidents.

ASSESSMENT

11. Neonatal thermoregulation improvement has led to a significant increase in normothermic admissions, with potential for further improvements with the introduction of MPDS version 14.

12. OH-NLS courses offer vital resuscitation training, building a multidisciplinary approach to neonatal life support in out-of-hospital settings.

13. The Maternity Red Phone has improved communication and access to services across four Health Boards, with expansion imminent. Quality Improvement Project has commenced with Hywel Dda Health Board to understand how this can be improved further.

14. National and local recognition of WASTs work includes shortlisting for prestigious awards, emphasising the importance of these improvements.

15. Continue to monitor and evaluate neonatal thermoregulation outcomes after MPDS version 14 implementation, with a focus on increasing normothermic admissions.

16. Ensure further collaboration with IAED through the Obstetric Council to evolve MPDS version 14.1 for continued improvement in pre arrival instructions for out of hospital maternity and neonatal care.

17. Expand OH-NLS courses throughout Wales, increase the number of instructors in Wales to be able to provide the course in Wales ensuring it is cost effective.

18. Complete the Maternity Red Phone implementation across all Health Boards in Wales and continue Quality Improvement Project to share and continually improve to optimise service outcomes.

19. Promote the use of Maternity Action cards and decision aids across teams to support staff during critical events.

20. Maintain involvement in national and local initiatives, including the National Prehospital Maternity and Neonatal Group, to further improve care and learning from other Maternity Leads in Ambulance Services throughout the UK with a unified approach.

These initiatives have already demonstrated significant impact and continue to shape WASTs role in improving neonatal and maternity outcomes in the out of hospital setting.

RECOMMENDED: That the Quality, Patient Experience & Safety Committee receive the report and accept the assurances that the Trust is meeting its statutory duties/responsibilities to consult; engage and involve the public/patients in its work.

AGENDA ITEM No	**19**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**1**

NEAR MISS AND LOW HARM INTELLIGENCE REPORT

MEETING	Quality, Patient Experience & Safety Committee
DATE	5 November 2024
EXECUTIVE	Liam Williams, Executive Director of Quality and Nursing
AUTHOR	Wendy Hebert, Deputy Director of Quality and Putting Tings Right Claire Appleton, Assistant Director - Putting Things Right
CONTACT	Wendy.Herbert3@wales.nhs.uk claire.appleton2@wales.nhs.uk

EXECUTIVE SUMMARY

This Report provides information and analysis to the Quality, Patient Experience & Safety Committee (QuESt) on organisational low harm and near miss Concerns (Incidents, Complaints and Claims).

Heinrich's Accident Triangle Model provides a visual representation of the quantitative relationship between harm events and near misses. A near miss is 'an event that, while not causing harm, has the potential to cause injury or ill health'.

Intelligence on near miss and low harm reporting is presented from the Datix Cymru Electronic Risk Management System covering the period September 2022 - September 2024.

The Trust receives a large volume of No and Low Harm Incidents and Grade 1 and 2 Complaints, which after investigation, are assessed as not having resulted in harm and are near miss opportunities for learning.

Analysis demonstrates the overwhelming volume of delay-related incidents being recorded. Huge numbers relate to the use of the Incident Reporting System for routine data capture of operational events such as 6 and 12-hour handover delays and immediate release requests being declined. Recent improvement work on the use and scope of the Datix Cymru Incident Module by the Quality Governance and Assurance Team have reduced this type of trigger-reporting and will enable more effective analysis of incidents in future.

Deeper analysis is limited because of the classification system of reported incidents which caters largely to Secondary Care Services. There is scope to improve the

relevance and application of the code sets to Ambulance Services through our representation at national workstreams.

Future reporting and analysis of near misses and Low harm should be included within the Putting Things Right Quarterly Report.

RECOMMENDATION: That the Committee:

(1) Approves the future reporting of near misses being included in the quarterly Putting Things Right Report to Committee; and
(2) The Chair of Committee provides assurance to the Audit, Risk and Assurance Committee on the future approach.

KEY ISSUES/IMPLICATIONS
(i) Valuing near misses moves us from a reactive to proactive patient safety culture.
(ii) Many of our near misses occupy the same space as incidents resulting in harm - whereby delayed ambulance responses lead to harm for some, but many others experience the same hazard but avoid harm either by self-conveyance, having a less severe health need or stronger pre-existing health status.
(iii) The extraction, manipulation, analysis and visualisation of this thematic data is an area that would benefit from additional data analytics expertise.
(iv) The importance of continuing to monitor lower graded incidents and complaints is recognised as a key area of activity for the Putting Things Right (PTR) Teams as the Clinical Model Transformation Programme is implemented.

REPORT APPROVAL ROUTE	
Clinical and Quality Governance Group	30 October 2024
Quality, Patient Experience & Safety Committee	5 November 2024

REPORT APPENDICES
ANNEX 1 - SBAR which provides the background for this report.

REPORT CHECKLIST			
Confirm that the issues below have been considered and addressed		**Confirm that the issues below have been considered and addressed**	
EQIA (Inc. Welsh language)	N/A	Financial Implications	N/A
Environmental/Sustainability	N/A	Legal Implications	YES
Estate	N/A	Patient Safety/Safeguarding	YES
Ethical Matters	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. This Report addresses recommendations from the Audit Wales Quality Governance Review 2022 to ensure that intelligence from 'near misses' or minimal harm events is appropriately reported on and analysed.

2. The Quality, Patient Experience & Safety Committee (QuESt) regularly receives a Putting Things Right (PTR) Report which includes patient safety incident reporting but predominantly focuses on catastrophic/death, severe and moderate harm incidents where responsibilities to review and learn are explicit within the Concerns Regulations.

3. Lower graded Concerns (Incidents, Claims and Complaints) are included within thematic content of the PTR Report however this Near Miss and Minimal Harm Intelligence Report provides an opportunity to review in detail the learning arising from 'near misses' or concerns assessed as Low harm.

4. 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 and complaints.

BACKGROUND

5. The Health and Safety Executive defines a near miss is 'an event that, while not causing harm, has the potential to cause injury or ill health'. A hazard is defined as an unsafe situation or set of circumstances with 'the potential to cause harm'. For the purposes of this paper, no distinction will be applied between hazards and near misses, as both represent valuable learning opportunities.

6. Near Miss Incident Reporting is a proactive Safety Management Practice. It involves identifying, documenting, and analysing incidents that could have resulted in injury, damage, or loss but were narrowly avoided. These incidents, often referred to as 'close calls,' provide valuable insights into potential hazards and risks within an organisation.

7. The relationship between hazard/near miss reporting and incidents resulting in harm was first explored by Herbert William Heinrich in 1931 in relation to industrial safety however the concept has been widened over time to include patient safety. Heinrich developed the Model of the 'accident triangle' (Figure 1) hypothesising that for every major injury, there were many lower harm or near miss events.

Figure 1

8. The premise of Near Miss Incident Reporting revolves around the principle that every near miss represents an opportunity for improvement. It involves a systematic process where employees report these incidents as soon as they occur, even if no harm is done.

9. A pattern of near misses provides an early warning that something needs attention. Near misses move us from a reactive to proactive patient safety culture, that values early identification of potential harm and allows us to act in a preventative way to avoid future harm rather than only learning once harm has already occurred.

10. When patient safety incidents and complaints are reported/recorded on the Datix Cymru Electronic Risk Management System, the reporter/recorder is asked to provide an initial harm grading. This is the assessed grade of potential harm caused by the health body and are based on the All-Wales Grading Framework which is part of the PTR Guidance (Figure 2).

Figure 2

Grade	Harm	Examples of concerns	Consider potential for qualifying liability / Redress
1	None	a) Concerns which normally involve issues that can be easily / speedily addressed; b) Potential to cause harm but impact resulted in no harm having arisen; c) Outpatient appointment delayed, but no consequences in terms of health;, d) Difficulty in car parking; e) Patient fall – no harm or time of work; f) Concerns which have impacted on a positive patient experience.	Highly unlikely
2	Low	a) Concerns regarding care and treatment which span a number of different aspects/specialities; b) Increase in length of stay by 1 - 3 days; c) Patient fall - requiring treatment; d) Requiring time off work - 3 days; e) Concern involves a single failure to meet internal standards but with minor implications for patient safety; f) Return for minor treatment, e.g. local anaesthetic or extra investigations.	Unlikely

3	Moderate	a) Clinical / process issues that have resulted in avoidable, semi permanent injury or impairment of health or damage that require intervention; b) Additional interventions required or treatment / appointments needed to be cancelled; c) Readmission or return to surgery, e.g. general anaesthetic; d) Necessity for transfer to another centre for treatment / care; e) Increase in length of stay by 4 -15 days; f) RIDDOR Reportable Incident; g) Requiring time off work 4 -14 days; h) Concerns that outline more than one failure to meet internal standards; i) Moderate patient safety implications; j) Concerns that involve more than one organisation;	Possible in some cases
4	Severe	a) Clinical process issues that have resulted in avoidable, permanent harm or impairment of health or damage leading to incapacity or disability; b) Additional interventions required or treatment needed to be cancelled; c) Unexpected readmission or unplanned return to surgery; d) Increase in length of stay by >15 days; e) Necessity for transfer to another centre for treatment / care; f) Requiring time of work >14 days; g) A concern, outlining non compliance with national standards with significant risk to patient safety; h) RIDDOR Reportable Incident;	Likely in many cases
5	Death	a) Concern leading to unexpected death, multiple harm or irreversible health effects; b) Concern outlining gross failure to meet national standards; c) Normally clinical/process issues that have resulted in avoidable, irrecoverable injury or impairment of health, having a lifelong adverse effect on lifestyle, quality of life, physical and mental well-being; d) Clinical or process issues that have resulted in avoidable loss of life; e) RIDDOR Reportable Incident;	Very likely

11. It is recognised that harm is not always easily quantified, particularly in the early stages of an investigation when information is still being obtained and analysed. It is for this reason that the Harm Assessment is captured at multiple stages of the Incident Investigation Pathway, to provide an audit trail around assessments made in relation to harm caused as the result of incidents occurring.

12. A single Incident Report on Datix Cymru has three fields where harm caused to the patient as the result of an incident are captured:

- Reporter's initial Harm Assessment: This is the level of harm as described by the person who reports the incident on Datix. This description of harm remains unchanged throughout the life of the Incident Report as a record of what was initially reported. This harm field is used for initial prioritisation within the reporting organisation only. This field should not be used for any external reporting as it is not subject to validation.

- Manager's interim Harm Assessment: This is the level of harm as described by a Manager following review of the initial Incident Report on Datix. This description of harm is subject to validation however it can only ever be a best estimate of the level of harm caused by an incident with the knowledge to hand at the time. This harm field is used both for internal purposes as well as triggering external reporting requirements e.g. National incident reporting, Duty of Candour incident reporting

- Post Investigation Harm Assessment: This is the level of harm as described following an investigation. This field should articulate the level of harm caused to a patient as the result of an incident occurring. This may be different to the

outcome to the patient. When completed, this supersedes the previous two initial and interim harm fields and serves as the key field which will be relied upon when discussing harm caused to the patient as the result of an incident.

13. In addition, the following fields are also completed:

- Potential harm/priority: this is a Risk Assessment of the risk of a similar occurrence happening again in the future. To complete this field, the question will need to be asked "in a similar set of circumstances to a similar patient, what is the likelihood and impact of a similar incident occurring tomorrow?" Consideration will need to be given by Senior Managers as to whether this risk needs to be included on any Departmental or Organisational Risk Register and any immediate actions needed to reduce the risk.

- Outcome to patient: this captures the overall outcome experienced by the patient. This may be the same, or different to, the harm caused by the incident.

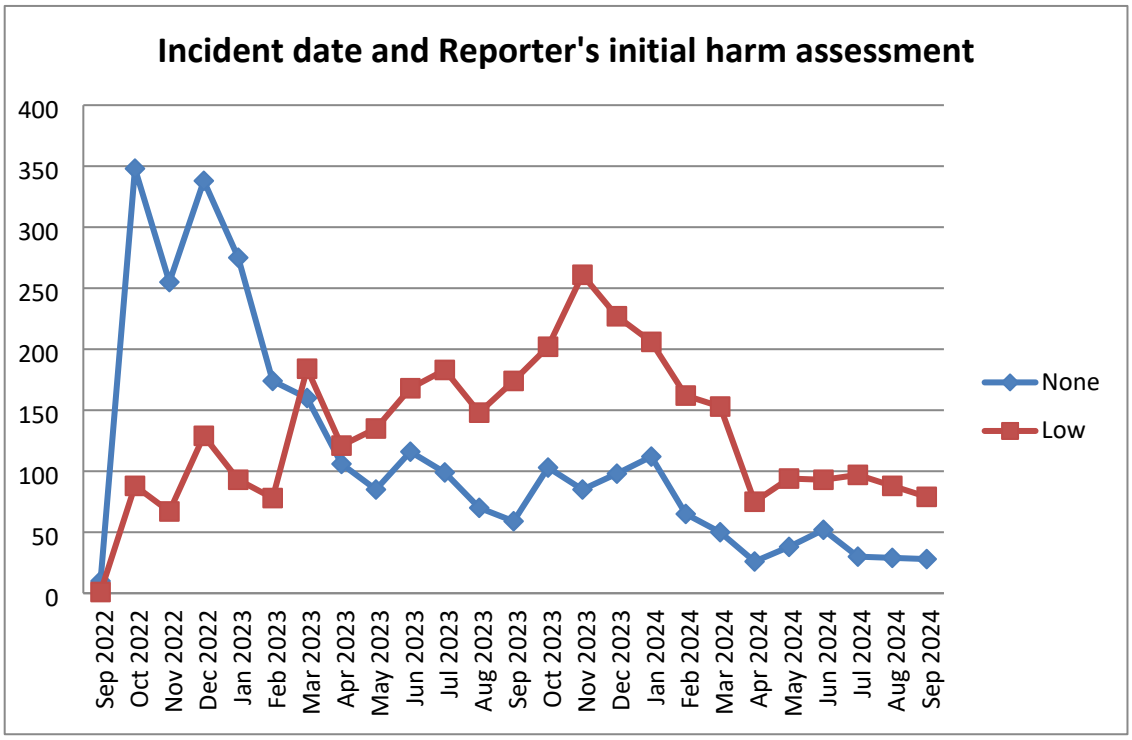
14. This Report provides information and analysis on patient safety incidents reported with a harm grading of 'None' or 'Low' and Complaints graded as 1 or 2.

ASSESSMENT

Incidents

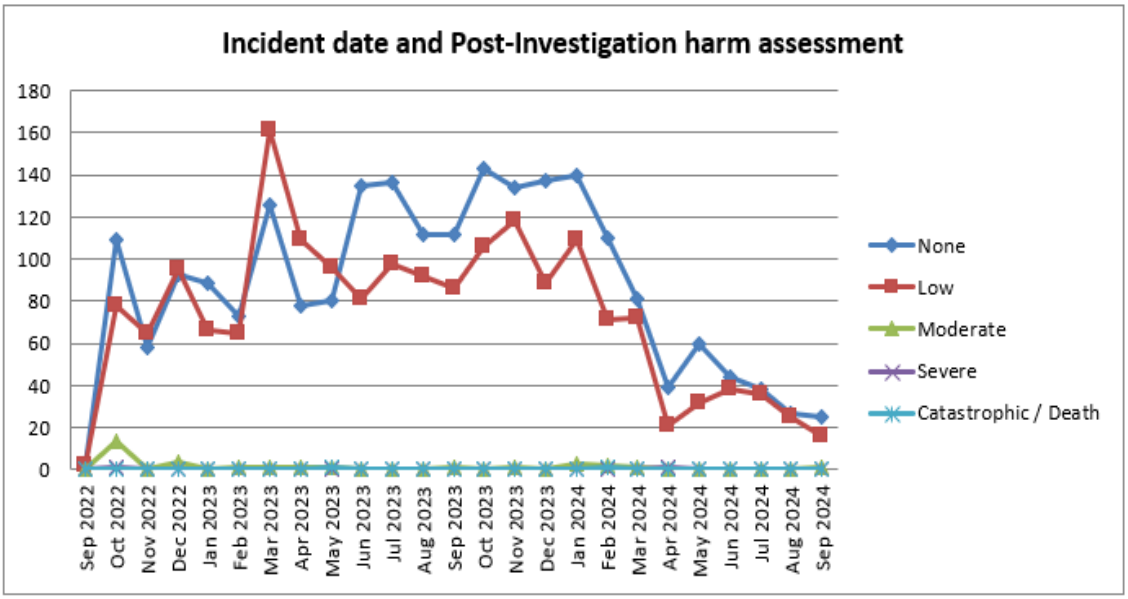
15. In most scenarios, it is generally accepted that a high rate of reporting of low-level incidents is a positive sign and indicates a culture open to learning from such reports. Graph 1 displays the number of No and Low harm incidents reported by date of incident and reporter's initial Harm Assessment. There is a reduction trend in reporting as improvement work driven through the Quality Management Group was undertaken to increase education about the type of events which should be reported.

Graph 1



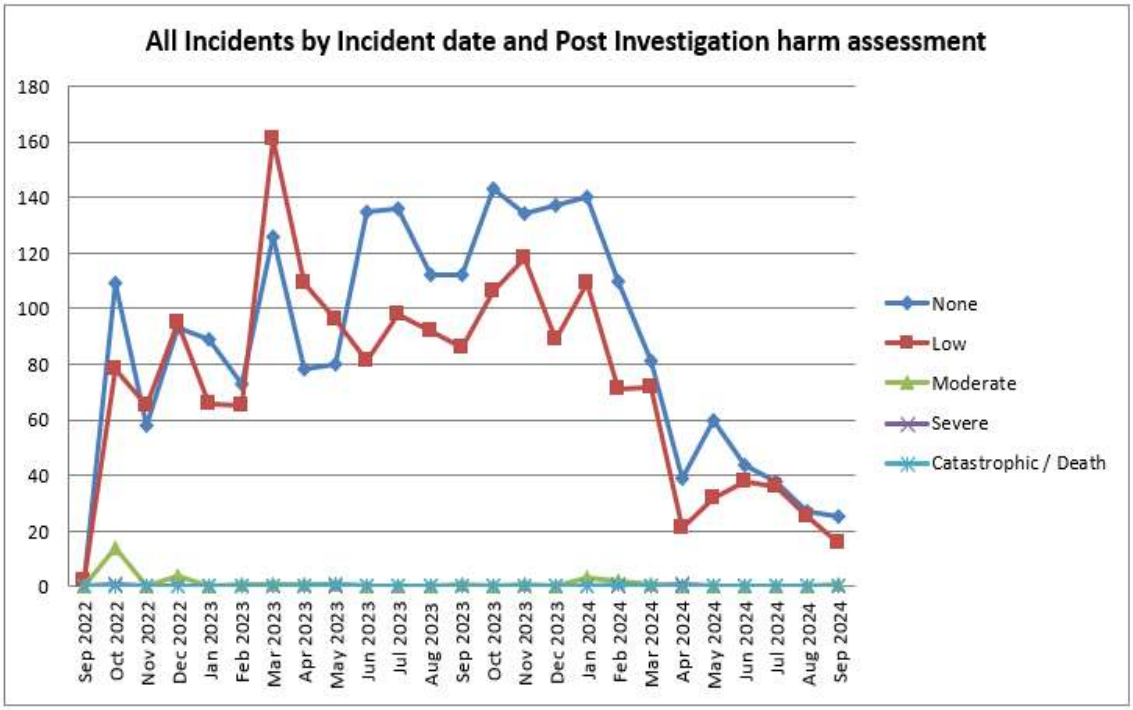
16. Graph 2 indicates that the assessed level of harm for No and Low harm incidents is graded lower at the finalisation of the investigation.

Graph 2



17. The following graph displays the post-investigation harm gradings for all completed investigations, irrespective of initial harm grading. This demonstrates the application of Heinrich's triangle hypothesis, providing a clear indication of the volume of No or Low harm incidents comparative to higher harm gradings.

Graph 3

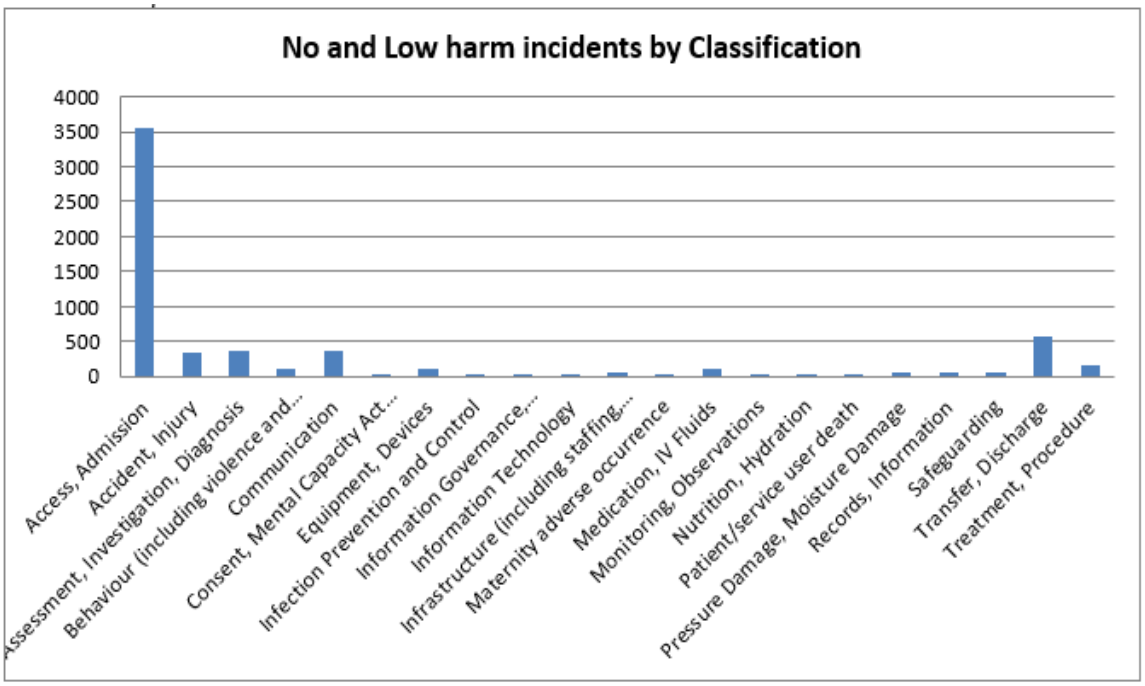


18. The two graphs of Post-investigation Harm Assessments reveal improvements required in incident management practice within the Trust to ensure that all reported incidents are reviewed and investigated in a timely manner. This is important for patient safety in terms of adhering to the Concerns Regulations, the Statutory of Candour and taking swift action to address risks.

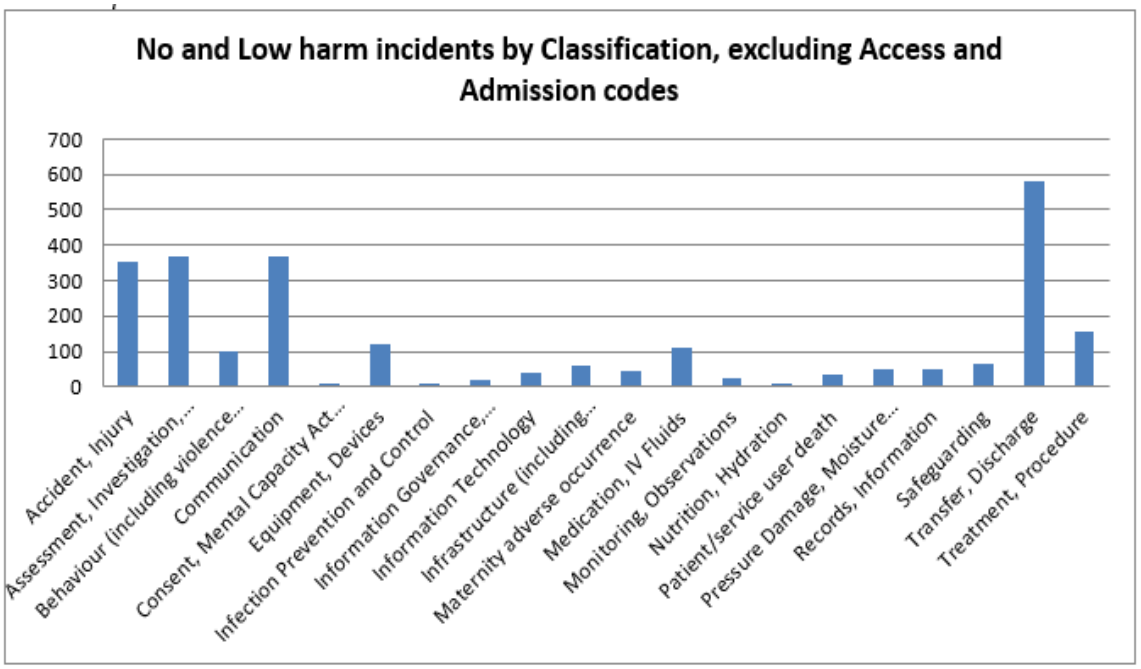
19. It is also vital that reporters receive timely feedback on the actions taken to review the incidents they report as when employees see that their reports lead to real changes and improvements, they are more likely to engage actively in patient safety activities. This feedback loop promotes near miss reporting and contributes to a positive safety culture within the Trust.

20. Graphs 4 and 5 provide a breakdown of incident categories. Graph 4 demonstrates the overwhelming volume of delay-related incidents being recorded. Huge numbers relate to the use of the Incident Reporting System for routine data capture of operational events such as 6 and 12-hour handover delays and immediate release requests being declined. Recent improvement work on the use and scope of the Datix Cymru Incident Module by the Quality Governance and Assurance Team have reduced this type of trigger-reporting and will enable more effective analysis of incidents in future.

Graph 4



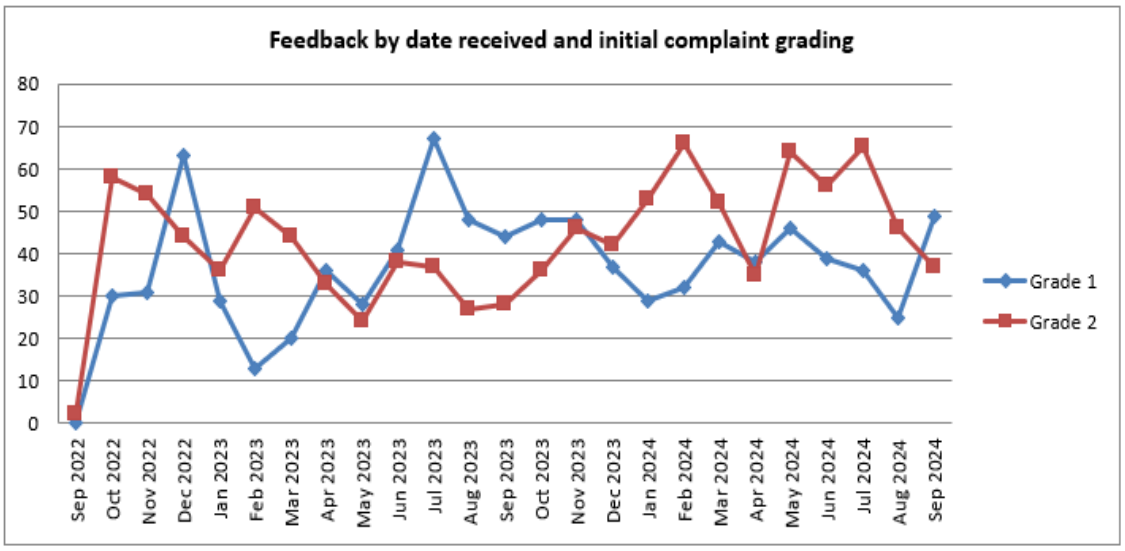
Graph 5



Complaints

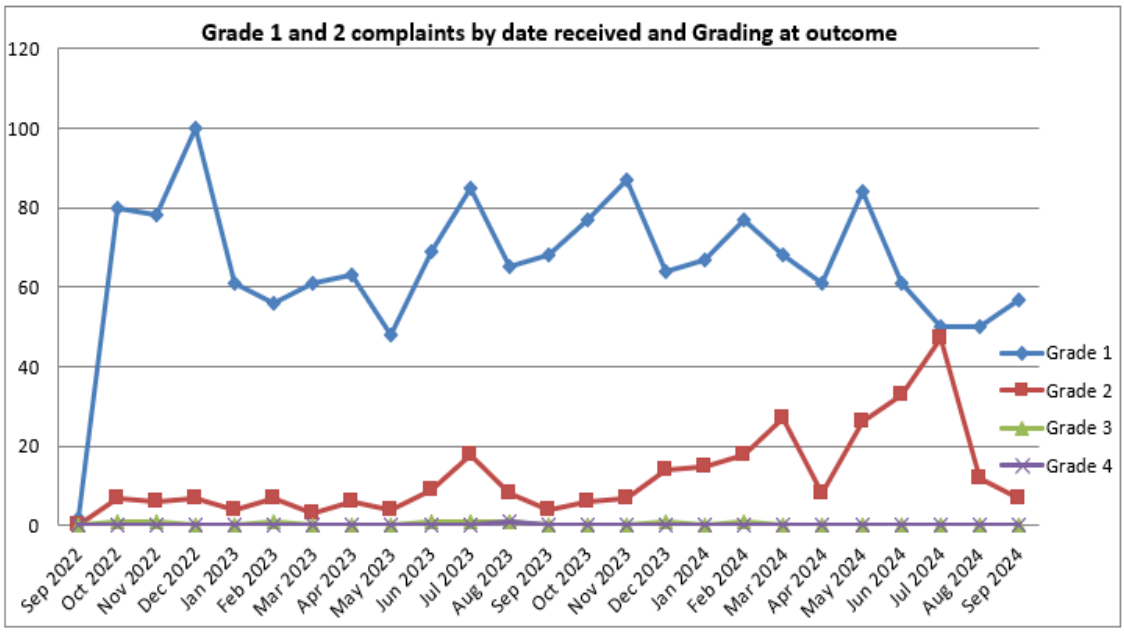
21. Graph 6 demonstrates the numbers of Grade 1 and 2 complaints received over The past 2 years.

Graph 6



22. Graph 7 indicates that the investigations undertaken are likely to find that the actual harm caused to the patient was lower than first assessed.

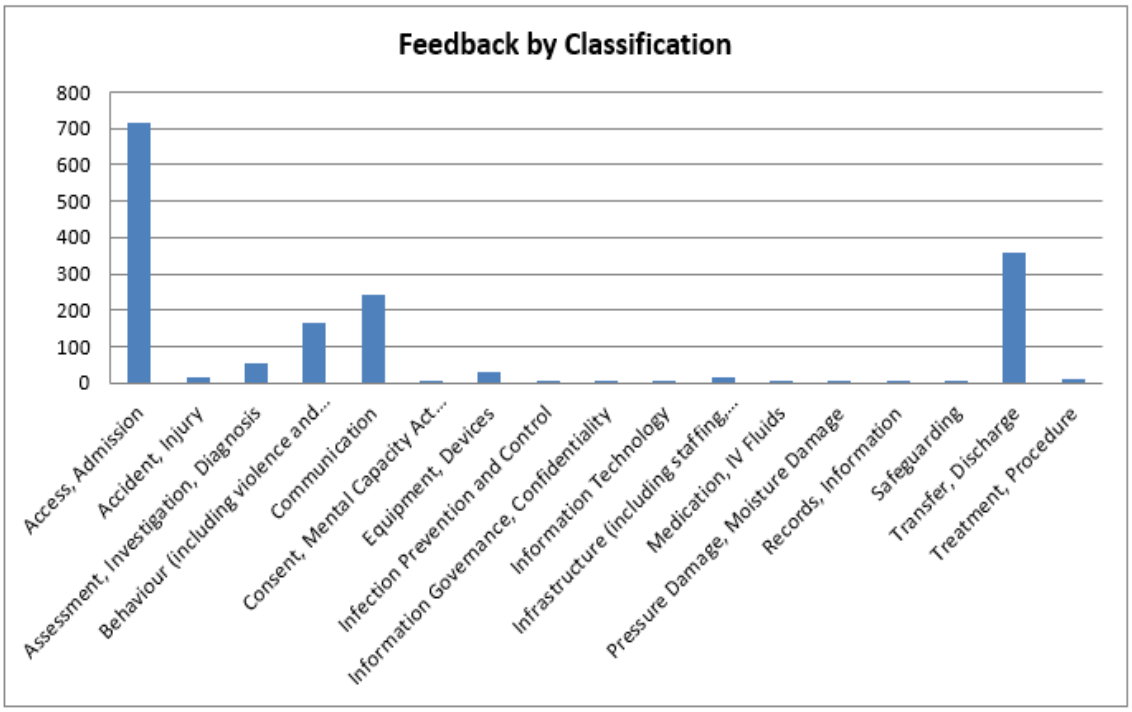
Graph 7



23. Graph 8 indicates the issues about which complaints are received. As with the profile of low-grade incidents, much of our feedback relates access and admission issues - primarily delays in reaching patients in the community

although also included are complaints relating to cancellations of non-emergency patient transport.

Graph 8



24. Thematic analysis of both No and Low harm incidents and Grade 1 and 2 complaints provides clear evidence of how the current system pressures distort the organisation's reporting profile by creating large volumes of concerns under one classification.

25. Improvement work, as detailed in the Datix Recovery and Improvement Plan to reduce the routine data collection of operational outcomes will increase the effectiveness of the Platform in being able to identify early indicators of harm and contribute to patient harm prevention.

26. This analysis reveals that many of our near misses occupy the same space as our incidents resulting in harm and this finding is also borne out by Mortality Review data as commented on in the Learning from Death Report presented alongside this paper - whereby delayed ambulance responses lead to harm for some but many others experience the same hazard but avoid harm either by self-conveyance, having a less severe health need or stronger pre-existing health status.

27. Analysis is limited because of the classification system of reported incidents which caters largely to Secondary Care Services. There is scope to improve the relevance and application of the code sets to Ambulance Services through our representation at National Workstreams.

28. The extraction, manipulation, analysis and visualisation of this thematic data is an area that would benefit from additional data analytics expertise although current capacity within the Health Informatics and Quality Assurance Teams will be allocated in accordance with the Datix Cymru Recovery and Improvement Plan that has been developed.

29. The importance of continuing to monitor lower graded incidents and complaints is recognised as a key area of activity for the PTR Teams as the Clinical Model Transformation Programme is implemented.

RECOMMENDATION: That the Committee:

(1) Approves the future reporting of near misses being included in the quarterly Putting Things Right Report to Committee; and
(2) The Chair of Committee provides assurance to the Audit, Risk and Assurance Committee on the future approach.

AGENDA ITEM No	**20**
OPEN or CLOSED	**OPEN**
No of ANNEXES	**1**

AUDIT TRACKER 2.0 – SEPTEMBER 2024 (Q2)

MEETING	Quality, Experience and Patient Safety Committee (QuEST)
DATE	05 November 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 Quality, Experience and Patient Safety Committee (QuEST).

2. Of those internal audit actions relevant to this Committee**,** three have been closed in quarter of a total of 13 (23%%). There are seven actions which have had a change in date proposed (marked in blue). There is one open action on its third revised date; action 604 (Pain Management internal audit). There are four actions which are not yet due / due in quarter.

3. Of those external audit actions relevant to this Committee, none have been closed in quarter of a total of three. One of external audit actions has a revised date in quarter (marked in blue). There is specific reference to the outstanding actions regarding the Review of Quality Governance:

    3.1 The Committee's attention is drawn to the two open actions – actions 106d and 106e. Based on the completion of the recent 'Quality Governance Follow Up Review' by Audit Wales it has been recommended that these actions are still in progress and should remain open.

    3.2 It has been agreed that new management actions will be developed over the coming weeks and the Committee will receive the update against these actions at its meeting in February 2025. A corresponding narrative has been included on the Tracker, for the formal record.

4. The current version of the tracker is now open for Directorate review for actions due in October, November and December 2024. These updates will then be reported to the Committee at its meeting in February 2025.

RECOMMENDATION

5. The Committee is requested to:

   (a) Receive and review any Internal Audits and Audit Wales reviews within their remit where relevant. There are none required for review at this meeting;

   (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 on the 14 October 2024.

REPORT APPENDICIES
Annex 1 – Tracker 2.0 –July-September 2024 for Committee Reporting

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

SITUATION

6. This paper provides the Committee with the current position with respect to management actions for audits within the purview of the Committee.

BACKGROUND

7. 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.

8. 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.

9. The Tracker has been updated in Quarter two 2024/25. 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.

10. The team continues to work on the development of the SharePoint solution for Tracker 3.0 with colleagues in the Digital Directorate. It is intended that this solution will be ready to implement / use later in the 2024/25 financial year, however further work is required to consider the transition from Tracker 2.0 to Tracker 3.0.

ASSESSMENT

11. 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

12. Of those internal audit actions relevant to this Committee**,** three have been closed in quarter of a total of 13 (23%%). There are seven actions which have had a change in date proposed (marked in blue). There is one open action on its third revised date; action 604 (Pain Management internal audit). There are four actions which are not yet due / due in quarter.

13. Of those external audit actions relevant to this Committee, none have been closed in quarter of a total of three. One of external audit actions has a revised date in quarter (marked in blue). There is specific reference to the outstanding actions regarding the Review of Quality Governance:

    13.1 The Committee's attention is drawn to the two open actions – actions 106d and 106e. Based on the completion of the recent 'Quality Governance Follow Up Review' by Audit Wales it has been recommended that these actions are still in progress and should remain open.

    13.2 It has been agreed that new management actions will be developed over the coming weeks and the Committee will receive the update against these actions at its meeting in February 2025. A corresponding narrative has been included on the Tracker, for the formal record.

Management and Development of the Tracker

14. 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.

15. 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.

16. The current version of the tracker is now open for Directorate review for actions due in October to December 2024/25. These updates will then be reported to the Committee at its meeting in February 2024. The team will work with Directorate contacts to ensure a smooth transition between Tracker 2.0 and 3.0.

17. 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

18. The Committee is requested to:

    (a) Receive and review any Internal Audits and Audit Wales reviews within their remit where relevant. There are none required for review at this meeting;

    (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	Respons e No.in Audit	Management Response	Agreed Deadline in Report	Status - met or not met agreed	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. Reason(s) why action is overdue
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	Mar-25	Open	071024: (AP) In line with update given in July 2024, action can only be closed when the backlog of PGDs has been reviewed. Given that and that the Pharmacist begins in post mid-Q3 24/25, requested that a revised date of March 2025 be applied to permit this to take place. Revised date of March 2025 added in Q2 24/25. 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	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.
681	23/24	Quest	Electronic Patient Clinical Records: Clinical Compliance (ePCR)	Reasonable	Jonathan Chippendale	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	Mar-25		Open	021024: (AP) Revised date of March 2025 applied in Q2 24/25, in line with update. Last updated 01102024: Revised date of Q4 requested to enable the capture of this info. 110924:Ffion Timmins liaising with ESR team to arrange this. Request due date to beginning of Q4. 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	Jonathan Chippendale	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			Closed in Quarter	091024: (AP) Closure accepted and updated to closure proposed. Last updated 01102024: Recommended for closure. Presentation showing survey results presented and discussed at ePCR Clinical Reference Group (CRG) on 26/09/24. The timeline for the application redesign is between now and April 2025. The Trust is commencing conversations with users to fully understand what they are finding not fit for purpose (however there is no guarantee that there will be a fundamental redesign). Presentation shared as evidence for closure. 110924: SP developed survey and this is being brought to next ePCRCRG - recommend for closure. 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	Jonathan Chippendale	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	Dec-24		Open	021024: (AP) Revised date of December 2024 in Q2, as requested. Last updated 01102024: Awaiting transfer to LMS 365. Revised date of Q3 requested to determine Education team capacity and to enable this transfer. 11092024: This was discussed at ePCRCRG on 27 June 24 and agreed that training materials would transfer from learning launch pad to LMS365 with integrate competency assessment. 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	Jonathan Chippendale	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	Last updated 01102024: On track for completion in Q3 and discussed at Sept ePCRCRG on 26/09. 110924: Pathways section is now live on ePCR. The lower viewed modules will reviewed and reported back to ePCRCRG for December closure date. 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).

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	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
686	23/24	Quest	Electronic Patient Clinical Records: Clinical Compliance (ePCR)	Reasonable	Jonathan Chippendale	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 Met	Mar-25			Open	021024: (AP) Revised date of March 2025 applied in Q2 24/25, as requested. Last updated 01102024: Request for revised completion date of Q4. Project Manager assigned to work with newly appointed CCIO on this to develop the business case. The ability to role this out will be entirely dependent on capacity and funding but the Task & Finish Group will work to build up the business case for how it would be done. 11092024: Project manager assigned to this with T&F group to start October 2024. Request extended deadline for end of Q4 to produce business case. 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).
697	23/24	Quest	Seatbelt Action Plan	Reasonable	Jon Sweet	Lee Brooks	Medium	2.1	Outputs from spot checks and Quality and Support days should be formally collated and reported to an appropriate forum. This should include outcomes, issues identified and subsequent progress to implement the required actions to address.	2.1	Monitoring of themes and trends from spot checks to date and the three Quality and Support days will be collated and presented to the joint SOT/SLT meeting on 17th May 2024 and further to the wider leadership day which will follow. Any remedial actions will be implemented and monitored through SOT subsequently.	Jun-24	Not Met	Aug-24			Closed in Quarter	011024: (AP) Evidence of closure reviewed as stated below and accepted. Evidence of the checks having been completed, it having been built in to the Field Ops Group work programme, and AAA outputs of these instances. Updated the status to closure proposed in Q2 24/25. 240924 Proposing Closure:- work programme provided from Field Ops for future planning of Q&S Day monthly spot check data, Triple A provided to show Q&S Day being discussed with future triple As to incorporate the slide deck of data. 100724: Revised date to August 2024 in Q1 24/25 applied, as evidence for closure not yet available. The evidence that will close off this action is: •Evidence that it'sdded to future agendas in Field Ops to review any actions following the Spot Checks •AAA feeding into SOT from Field Ops on the monitoring of any actions. 170524: Quality and Support day results formally collated from the 3 days and presented within the SOT/SLT meeting on the 17th May. Evidence sent to Alex on 30th May.
698	23/24	Quest	Seatbelt Action Plan	Reasonable	Mark Harris	Lee Brooks	Medium	3.1	Consideration should be given to undertake a higher number of internal inspections per annum to provide sufficient coverage and assurance that the Trust is compliant with required standards.	3.1	The decision to include internal inspections has been driven internally by the Operations Directorate although capacity remains a limiting factor. Whilst the audit has highlighted the need to undertake a higher number of inspections, we remain committed to four per annum with more being undertaken should capacity permit	Dec-24	Not Yet Due				Open	
699	23/24	Quest	Seatbelt Action Plan	Reasonable	Mark Harris	Lee Brooks	High	4.1	The recommendations from the Health & Safety investigation should be formally monitored through an appropriate forum to provide oversight and assurance on the satisfactory closure of the investigation.	4.1	The Trust accepts this recommendation. ADLT will oversee the monitoring and compliance of the H&S investigation and provide assurance to ELT via the AAA reporting mechanism.	May-24	Not Met	Aug-24			Closed in Quarter	021024: Closure proposed accepted on the basis that this has been completed and evidence of ongoing monitoring (through the ADLT Work Programme) provided. Updated to closure proposed by the Corporate Governance Team. 100924: TMN provided AP with a copy of the closed AAA from ADLT and a screenshot of the ELT agenda with which it was embedded for information/discussion. The ADLT Work Programme confirms that the H&S investigation recommendations will continue to be monitored. CLOSURE PROPOSED. 090724: Revised date of August 2024 added in Q1 24/25, as closed AAA is not yet available. 040724: CGT received the ADLT work programme, the list of actions and examples of agendas as evidence. Closed ADLT agenda dated May 2024. Once the closed AAA from ADLT to ELT is received the action can be closed (based on Board Sec review). Awaiting final piece of evidence - ADLT closed AAA sent to ELT. 210624: ADLT Work Programme, Agenda and H&S ADLT Closed Actions evidence sent through today. It is hoped that this will be sufficient evidence to propose closure of the action as it will show that ADLT will oversee the actions which will then show within the AAA report to ELT. Action proposed for closure.
701	23/24	Quest	Clinical Audit	Reasonable	Jonathan Chippendale	Andy Swinburn	Medium	1.1	The Trust should ensure appropriate detail in relation to clinical audit is included and documented it within its organisational documents.	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).	Mar-25	Not Yet Due				Open	Last updated 01102024: The development of the Trust Clinical Plan has been proposed for delay until Q4/Q1 2025 due to capacity contraints on the team. The Assistant Director for Clinical Development has informed the Director of Paramedicine of the need for reference to this in the Clinical Plan and this will be incorporated into the Plan development. Currently on track but dependent on the timing of the first draft of the Clinical Plan. 11092024: To be included in Clinical Plan 2025-2030 - to be picked up by T&F group delivering Clinical Plan adn draft to be shared when it goes to QuEST. On track for end Q4. Last updated 270624: (JL) Awaiting Clinical Strategy development days (9-10 July) to incorporate clinical audit activity.
702	23/24	Quest	Clinical Audit	Reasonable	Kevin Webb	Andy Swinburn	Medium	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.	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.	Sep-24	Not Met	Dec-24			Open	021024: (AP) Revised date of December 2024 in Q2, as requested. Last updated 01102024: Request to revise the completion date to Q3. ADCD is attending CIAT in November which will enable justification of Trust priorities. This will be discussed at the next Business Meeting for the Directorate to align to any Directorate priorities. Additional time will enable new AD to enact this recommendation and amend clinical audit reporting to link to priorities. Last updated 270624: (JL) New actions, meeting scheduled for 29 July to look at actions and revision of forms, Some work already ongoing to draft changes to consider and to include more detail in decisions logs. Request to identify clinical priorities and risks to inform the audit plan and opportunities for clinical improvement proposed to QMG meeting in June. Further updates with actions to be completed to be provided after July meeting.
703	23/24	Quest	Clinical Audit	Reasonable	Kevin Webb	Andy Swinburn	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.	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	Sep-24	Not Met	Dec-24			Open	021024: (AP) Revised date of December 2024 in Q2, as requested. Last updated 01102024: As above, request to revise the completion date to Q3. Additional time will enable new AD to enact this recommendation and review CIAT documentation for CIAG. Last updated 270624: (JL) New actions, meeting scheduled for 29 July to look at actions and revision of forms, Some work already ongoing to draft changes to consider and to include more detail in decisions logs. Request to identify clinical priorities and risks to inform the audit plan and opportunities for clinical improvement proposed to QMG meeting in June. Further updates with actions to be completed to be provided after July meeting.
704	23/24	Quest	Clinical Audit	Reasonable	Duncan Robertson	Andy Swinburn	Low	3.1	A review of the CIAG Members within the Terms of Reference should be undertaken to ensure Membership is appropriate.	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.	Jul-24	Not Met	Dec-24			Open	071024: (AP) Evidence of the approval of the CIAG ToR at CQGG not yet received; although they were presented at CQGG on the 15 August 2024 approval of the ToR is not recorded. AP advised that must be returned to CQGG for approval. Revised date of December 2024 applied in Q2 24/25. Last updated 01102024: Recommended for closure, reviewed ToR provided as evidence. 11092024: Action complete, updated ToR to be shared as evidence. Recommend for closure. Last updated 270624: (JL) Amended ToR will be presented at the July 2024 CIAG.

AGENDA ITEM No	**21**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**4**

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

MEETING	Quality, Patient Experience & Safety Committee
DATE	05 November 2024
EXECUTIVE	Trish Mills, Director of Corporate Governance / Board Secretary
AUTHOR	Julie Boalch, Assistant Director of Corporate Governance & Risk
CONTACT	Julie.Boalch@wales.nhs.uk

EXECUTIVE SUMMARY

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

2. A summary of these risks is set out in Annex 1 with a detailed description contained within the Board Assurance Framework (BAF) in Annex 4.

3. The more detailed description contained within the BAF provides the Committee with an opportunity to review the controls in place against each of these principal risks and the assurance provided against those controls where applicable. This will assist Members in evaluating current risk ratings supported by the frameworks in Annex 2.

4. Both principal risks were presented to the Trust Board on 26 September 2024. and have been reviewed during this reporting period in line with the agreed schedule detailed at Annex 3.

5. Updates are highlighted in blue on the BAF which show changes to the narrative, mitigating actions, controls, and assurances.

6. The 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.

7. Despite a slight decrease in the number of handover lost hours between June and July 2024 the sustained and extreme pressure continues to have an impact.

8. The Trust Board continues to focus on the actions to mitigate these two risks that are within its control, and these are highlighted in the avoidable harm action plan which is presented at each Board meeting. Further mitigations and transformative actions are described in the Integrated Medium Term Plan (IMTP) to address these risks.

9. There are a range of efficiencies described in the report that the Trust has undertaken in mitigation of these two risks. Two key ones being the number of calls being closed safely and efficiently by clinicians through the Consult and Close initiative in the contact centres as well as a significant improvement in sickness and attendance levels.

10. Most of the Trust's actions in the action plan have been completed and a several efficiencies and improvements implemented that have stabilised performance; however, the Trust is unable to mitigate the scale of handover lost hours due to the environment which it is operating in or make improvements in performance because of the continued challenges in the urgent and emergency care system.

11. To support the continued, detailed review and mitigation of these risks, a workshop took place on 06 September 2024 with the Risk Owners and teams to consider a different approach to managing and monitoring those areas that are within the Trust's control and those that are not. The outcome of this will be reported through the next round of governance.

12. 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.

13. 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.

RECOMMENDATION:

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

KEY ISSUES/IMPLICATIONS
15. The key issues are set out in the Executive Summary above.
REPORT APPROVAL ROUTE
• The BAF was considered by: • Assistant Directors Leadership Team (22 July 2024) • Executive Leadership Team (07 August 2024) • Audit Committee (12 September 2024) • Trust Board (26 September 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:	25/06/2024	TREND	25 (5x5)
		Date of Next Review:	25/07/2024	➡	

IF	THEN	RESULTING IN
significant internal and external system pressures continue	there is a risk of an inability and/or a delay in ambulances reaching patients in the community	patient harm and death

	Likelihood	Consequence	Score
Inherent	4	5	20
Current	5	5	25
Target	2	5	10

IMTP Deliverable Numbers: 1, 2, 3, 4, 5, 6, 7, 8, 10, 14, 15, 20, 22, 24, 25, 27

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

Risk Commentary Q1 2024/2025

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 June were 22,230 and July 19,599.**

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 **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. 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 the action plan.
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

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	25/06/2024	TREND	25 (5x5)
		Date of Next Review:	25/07/2024	➡	

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

	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. **This is part of the IMTP Deliverables 2024-2027.**
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. **11 new onboarding courses for June to December with projection of 110 new CFRs by 3rd December 2024. Currently 400 volunteers supporting 6500 hours every month.** 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) **was** stood up for the duration of Winter 2023/24. **Christmas Planning Meetings established from April 2024 for winter period 2024/2025**.
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 **ongoing** to recruit CWR volunteers with engagement taking place with organisations across Wales. • St John Ambulance Cymru virtual ward now extended to the end of **May**2024**.**
24. ARA – - **YGC**, **Swansea Bay and GUH**	24. **ARA in GUH finished 31st March 2024. Holding area in Swansea and YGC remains ongoing**.

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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

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.	26. 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.
27. **Swansea Bay Winter Actions**	**27. 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** • **POS solution now in operation which is facilitating shift breaks. Palliative care paramedics have been deployed for a pilot in care homes and nursing homes.** **Significant reduction in overruns realised. In action, during last 2 months, 0 missed meal breaks recorded in Swansea Bay area.**

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.	5. 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	6. Performance targets for Handover with Health Boards have been introduced by the commissioner.
7. Access to Same Day Emergency Care (SDEC) for paramedic referrals	7. 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.
8. Mental Health users connecting via the 999 system to 111 press 2 services. Discrepancies in pathway between 111 and CSD – point of entry influences pathway.	
9. Volunteer Alternative Responder Scheme (VARS)	9. Live from June 2024 with further scheme due to rollout across Wales.
Please note that the gaps listed are not WAST's and are therefore outside of the control of WAST	

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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

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	**Superseded**	WAST has attempted to secure additionality within its APP numbers, as the evidence illustrates a dramatic impact upon ED avoidance with more people being managed within the community. At this stage, no additional funds have been secured. However, it remains the case the prospective APPs are completing their education and could be deployed into the operational setting to mitigate the risk. ELT has therefore agreed to grow the APP numbers further this year, redirecting existing operational spend to bolster APP growth. 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. APP recruitment	Assistant Director of Operations	**March 2025**	Aug24 – Modelling of APP growth trajectory to be modelled through the APP recruitment Steering Group for approval at ELT. Numbers to be confirmed at point of approval.
5. **IMTP Deliverables 2027-2027 – implementation of new clinical model.**	**Assistant Director of Operations Transformation**	**March 2025**	**Phase 1 for winter** **May24 – Ops engagement commenced April 2024. Temporary ADO recruited to support winter actions. Plans to deployment between October 2024 and March 2025.**
6. 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.
7. 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.
8. 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	**May 2024 (Phase 1 is finished)**	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 May2024**

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	25/06/2024	TREND	25 (5x5)
		Date of Next Review:	25/07/2024	➡	

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

			• 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 is now ongoing to recruit CWR volunteers with engagement taking place with organisations across Wales.
9. 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.
10. Development of new model of care	Head of Strategy Development	2024/25	**May24 – during May operationalisation has commenced with expected live date ahead of winter.**
11. Palliative Care Paramedic Unit	Assistant Director of Operations	Extended to May 2024 - **new date TBC**	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. **21/06/2024 - Unit still ongoing.**
12. 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.
13. Royal Glamorgan Early Diagnostic	Executive Director of Operations	**August** 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. • **May24 – No improvement in N2H time. Local management having discussions with Health Board for review and next steps.**

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:	20/06/2024	TREND	25 (5x5)
		Date of Next Review:	20/07/2024	➡	

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: 1, 3, 8, 14, 15, 22, 23, 24, 25, 26, 27, 30, 31

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

Risk Commentary Q2 2024/25

- The risk score remains constant at 25 for quarter 2 2024/25 (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. **JCC set a target of 15,000 hours lost by the end of Q2 and 12,000 hours lost by the end of Q3. Handover lost hours in April 2024 were 23,614 compared to 23,082 in April 2023. Eradication of handover waits of > 4 hours: there were 3,404 over four-hour patient handovers in April 2024, compared to 2,730 in April 2023. The expectation is that these would have been eradicated by end of 2023/24. Cardiff & Vale UHB has demonstrated material improvement and is a positive outlier when compared to other health boards. Recently, Welsh Government have re-iterated to Health Boards that the reduction in long handovers is a priority for this year with an expectation that over 1 hour waits would be reduced by 30% by December 2024.** 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 enquiries and redress / claims. The Trust continues to receive Prevention of Future Death Reports (Regulation 28) from Coroners across NHS Wales. 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 more consistency which would include aligning the outputs / outcomes with the 'Six Goals for Urgent and

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:	20/06/2024	TREND	25 (5x5)
		Date of Next Review:	20/07/2024	➡	

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

	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.	5. **Monthly Integrated Quality and Performance Report and 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. The Trust also has a presence on all the individual goal boards**.
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 (**April 2024** overall **82**% - Safeguarding is **78%** and dementia awareness remains over 91%).
13. Clinical audit programme in place.	13. Clinical audit programme in place (dynamic document) with oversight from the Clinical Quality Governance Group and QuEST.
14. Workshop set up by the Deputy Chief Ambulance Commissioner to respond to the findings in the Health Care Inspectorate Wales (HIW) Report *Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover* (undertaken 2021). WAST has senior representation at this meeting. – assurance is that HIW approve and sign off WAST elements and Health Board elements of recommendations.	14. Workshop set up by the Deputy Chief Ambulance Commissioner to respond to the findings in the Health Care Inspectorate Wales (HIW) Report Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover (undertaken 2021). WAST has senior representation at this meeting. A collective response from WAST and Health Boards is being overseen by EASC.
15. Escalation of patient safety concerns by Trust Board: featured in provider reports to the Emergency Ambulance Committee (EASC); been the subject of Accountable Officer correspondence to the NHS Wales Chief Executive; numerous escalations to professional peer groups initiated by WAST Directors; and coverage at Joint Executive Meetings with Welsh Government. Evidence submission to Senedd Health and Social Care Committee. Written evidence submitted during Q4 21/22 to the committee to assist their inquiry into Hospital Discharge and its impact on patient flow through hospitals.	15. Monthly Integrated Quality and Performance Report, CEO Reports to Trust Board including 'Actions to Mitigate Avoidable Patient Harm Report' (last presented to Trust Board **May 2024**) and Board sub-committee oversight and escalation through 'Alert, Advise and Assure' reports.

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			Inherent	5	5	25
			Current	5	5	25
			Target	3	2	6

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 **May 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 2024/25.
	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.	
2.	1. 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.	2. 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.	3. Strengthening of patient safety reports and audit processes as e PCR system embeds.
5. Variation pan Wales / England as position not implemented across all emergency departments.	4. New Quality Management System in development which will include monitoring of the new Quality Standards & Enablers and underpinning governance structure.

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	Likelihood	Consequence	Score
Inherent	5	5	25
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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.

5. 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	• **The Trust uplifted its APP establishment by a further 15.7 FTEs in** • **2023/24 (funded through internal movements). For 2024/25 the Trust** • **is funding a further uplift of 32 APPs (additional funding, not internal** • **movements).** • **• The above uplifts will increase the APP establishment to 120.7 FTEs.**

5. Overnight falls service extension and future modelling	Executive Director of Quality & Nursing	31.09.2024	• **Overnight falls service extension and future modelling**
			• **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%**
			• **April 2024 - 67%**
			  • **Daytime utilisation: -**
			• **Q2 57%**
			• **Q3 56%**
			• **Q4 to date 58%**
			• **April 2024 – 54%**
			  • **Combined day and night Q2-Q3 58%**
			• **Combined day and night Q4 to date 59%**
			• **Combined day and night April 2024- 55%**
			• **There is now also an additional Level1 nighttime resource through RPB and Gwent Resilience Plan ringfenced to ABUHB. AB dedicated level 1**
			• **62% for April 2024**
			• **The 2023 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.**
			• **The 2023 EMS Demand & Capacity Review will be formally reported to Trust Board in July 2024**.

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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

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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	Q2 2024/25	• **Currently awaiting WG feedback on the submitted business case.** • **Further meetings arranged with between the Executive Director of Quality & Nursing and Six Goals Programme/WG/. Trust has also approach WG with a smaller ask to facilitate 7 FTE CSD clinicians to** • **provide a continuation of the Luscii solution - this would enable a proof of value pilot to further inform a business case.**
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. 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. • Audit Wales have confirmed this has been reprofiled into 2024/25.
10. Patient handover actions.	Executive Team	Under review	• Some English ambulance services operate a system whereby handovers are mandated or forced after a certain period e.g. WMAS and LAS. This will be reviewed by the Executive team.
11. 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.
12. Trust to produce its own six goals plan (Goal 4 links to handover of care)	**Executive Director of Strategy, Planning &**		• **Trust to produce its own six goals plan (Goal 4 links to handover of care)**

POLICIES RECOMMENDED FOR COMMITTEE APPROVAL AND ADOPTION

Committee	Quality, Patient Experience and Safety Committee	**Date of Meeting**	05/11/2024

Presenting Officer	Julie Boalch, Assistant Director of Corporate Governance and Risk [Chair of Policy Group]

Policy Name	Directorate	EqIA	Date of Policy Group	Date of ELT	Points of Note
High Intensity Service Users Policy	Clinical	Completed No Issues	23/10/2024	07/11/2024	For Approval
Airway Policy	Clinical	Completed No Issues	20/08/2024	28/08/2024	For Approval
Management of Controlled Drugs Policy	Clinical	Completed No Issues	20/08/2024	28/08/2024	Minor changes. Approved by Policy Group for a further 3 years.
Medicines Management Policy	Clinical	Completed No Issues	20/08/2024	28/08/2024	Minor changes. Approved by Policy Group for a further 3 years.
Infection Prevention and Control: Sharps Policy	Quality & Nursing	Completed No Issues	20/08/2024	28/08/2024	Minor changes. Approved by Policy Group for a further 3 years.

Airway Policy

Policy number	099	**Version No:**	1.12	**Supersedes:**	1.11
Date of Approval:	**TBA**	**Review Date:**	3 year from date of approval	**Impact Assessments Completed:**	Yes
Classification of Document:	Clinical	**Type of Document:**	Policy	**Approved by:**	Quality, Patient Experience and Safety Committee
Brief Summary of Document:	Provides organisational and staff responsibilities in relation to managing a compromised patient's airway.				
Scope:	This document will support the governance in relation to the management of patient with a compromised airway. This Policy will affect Clinical Leads and all patient facing staff employed by the Welsh Ambulance Services NHS Trust. Patients affected by this Airway Policy will be those who require interventions by Trust staff to secure a compromised airway.				
To be read in conjunction with:	Joint Royal Colleges Ambulance Liaison Committee Clinical Practice Guidelines 2019. WAST 'Airway Management' v7.0 (2021) College of Paramedics consensus statement on intubation (2018)				
Owning Committee	Quality, Patient Experience and Safety Committee				
Policy Lead: **Trade Union Lead:**	Mike Jenkins Sean Herbert	**Job Title:**	Regional Clinical Lead- Consultant Paramedic Trade Union Partner		
Executive Director:	Andy Swinburn	**Job Title:**	Executive Director for Paramedicine		

Version Control Sheet

Version	Date	Author	Summary of Changes
NB: Previous entries dated 2018 and earlier so have been removed.			
V1.9	10/06/2024	Mike Jenkins	Governance requirements for Paramedics to retain intubation as a core skill.
V1.10	20/07/2024	Lisa Trounce	Front page updated. Minor formatting.
V1.11	13/08/2024	Mike Jenkins	Removal of two appendices and minor formatting
V1.12	22/08/2024	Lisa Trounce	Paragraph re: support for clinical staff returning from a period of absence added to section 6.4 at the top of pg 10. Formatting of policy in readiness for ELT
Keywords	intubation Paramedics, End Tidal $C0_{2.}$		

Impact Assessment Reviews

Area	Date of Review	Name of Reviewer
Counter Fraud	18/07/2024	EqIA completed & approved by Kat Cobley (Head of Inclusion & Engagement)
Information Governance		
Records Management		
EqIA / Welsh Language		
Estates		
Environment		

Task and Finish Group Members

Name	Job Title
Mike Jenkins	Regional Clinical Lead-Consultant Paramedic
Peter Green	Health Board Clinical Lead
Hugh Parry	Paramedic (Trade Union Colleague)
Jeff Price	Senior Education and Development Lead (retired)
Henry Garrard	EMT (Trade Union Colleague)

Policy Approval Route

Meeting Title	Meeting Date	Purpose/Outcome
Policy Development Group	June 2019	Discuss development of airway policy
Policy Development Group	September 2020	Discuss development of airway policy (delay due to Covid & CTL Development)
Airway Management and OHCA Task and Finish Group	28/05/2020	Ask for comments on V4
Airway Management and OHCA Task and Finish Group	25/06/202	V6 presented to group
Policy Group	29/06/2021	Review draft policy and offer comments
Policy Group	27/07/2021	Review draft policy and agree consultation
Policy Group	20/08/2024	Recommend for approval
ELT	28/08/2024	Recommend for approval
Quality, Patient Experience and Safety Committee	05/11/2024	Approval and adoption

Contents

1. INTRODUCTION

Airway management is a fundamental part of prehospital care and profoundly influences mortality and morbidity of patients in the Trust's care. Active management of the airway may be required in a number of circumstances, including patients with reduced level of consciousness due to both medical and traumatic causes and those in respiratory or cardiac arrest.

The level of airway support may range from airway opening manoeuvres, the use of adjuncts such as Nasopharyngeal Airway (NPA), Oropharyngeal Airway (OPA) and I-gel airway insertion, through to undertaking advanced airway procedures such as Endotracheal Intubation, needle or surgical cricothyroidotomy. In some cases, advanced airway management may need to be facilitated or maintained via pharmacological interventions.

Two significant papers were released in 2018 relating to Paramedic intubation:

- The College of Paramedics consensus Statement on intubation (College of Paramedics 2018)
- Airway-2 study - A randomised Control Trial (Benger et al 2018)

In addition, there are three key documents that all clinical staff within the Welsh Ambulance Services NHS Trust (WAST) **must** be familiar with:

- The Joint Royal Colleges Ambulance Liaison Committee (JRCALC) Clinical Practice Guidelines (JRCALC 2019)
- Welsh Ambulance Services NHS Trust (WAST) Airway Management Document v7.2.2 (appendix 1)

This Policy will support the necessary governance for WAST clinician in providing high quality airway management with the intention of improving clinical outcomes for patient who are attended by Trust clinicians.

2. SCOPE

This Policy will be supported by the Trust's Airway Management Document and the continuing evidence relating to airway management.

This Policy will also set out the appropriate governance that will be required to support Trust clinicians in maintaining competence in airway management.

This Policy will apply to all:

- Community First Responders
- Ambulance Care Assistants (ACA)1 & 2
- Emergency Medical Technicians (EMT)
- Paramedic's

- Senior Paramedic's (SPs)
- Advanced Paramedic Practitioner's
- Clinical Support Leads
- Health Board Clinical Lead's
- Consultant Paramedic's.
- Any Clinician with a Bank contract

3. AIM

To ensure all WAST clinicians are supported in delivering quality care to patients who require interventions to secure their airway and facilitate effective breathing/ventilation. This will be achieved by using a variety of techniques, which will include procedures from basic airway opening techniques to the insertion of an advanced airway in line with JRCALC Clinical Practice Guidelines and the Trust Airway Management document.

To ensure the Trust can evidence that all its clinicians are competent in managing a patient's airway commensurate to their grade and aligned to their scope of practice.

Ensure that the necessary governance is in place to support paramedics who have a high tracheal intubation success rate to be able to continue to intubate in the pre-hospital setting in line with the College of Paramedics Consensus Statement on Intubation, JRCALC and UK Resuscitation guidelines.

To ensure Trust clinicians are provided with the opportunity to practice airway management procedures through simulated practice either unsupervised or where requested supported by SPs and Health Board Clinical Leads.

Provide instruction on the process that must be followed by the Trusts and all patient facing clinicians to evidence competency at airway management at both the basic and advanced levels.

4. OBJECTIVES

- To ensure that there is a governance framework in place that outlines the systems to monitor and assure the quality and safety aligned to airway management.

- To provide a named Clinical Lead with the responsibility for airway management and in particular the practice of intubation by Paramedics.

- To provide clinical staff with a minimum standard that must be achieved to enable them to demonstrate and evidence competence in airway management.

- To provide the mandatory requirement for Paramedics to continue to undertake pre-hospital intubation (Appendix 2).

5. BACKGROUND

The JRCALC Clinical Practice Guidelines and the Trust Airway Management Guidance Document specifies that there should be a stepwise approach to managing a patient's airway, both documents further state that it is not one-way, if one technique is failing it may be appropriate to move to a less advanced technique. Additionally, in situations such as cardiac arrest it would be appropriate to proceed to a more enhanced technique, for example moving straight to an I-gel airway rather than an OPA.

The Airway 2 study has highlighted that there is no statistical evidence to show that endotracheal intubation (ETI) improves patient outcomes compared to other airway devices such as an I-gel. In stating this it is accepted that there are situations where the use of ETI would be advantageous, such as cardiac arrest secondary to asthma, drowning and pregnancy as examples.

In 2018 the College of Paramedics published a consensus paper in relation to 'A framework for safe and effective intubation by paramedics' (College of Paramedics, 2018). This document highlights a necessity for Paramedics to undertake advanced airway management, it further comments that where Paramedic intubation is performed organisations should provide a higher level of training, which should include simulated practice, supervised, clinical practice and continued rigorous assessment. This document also provides organisations with the recommended governance that should be in place to include:

- A named clinician with lead responsibility for the practice of intubation by Paramedics
- A clearly defined clinical governance policy and framework that outlines the systems in place to monitor and assure quality and safety.
- Regular audits of capnography use including feedback mechanism to clinicians.
- Documents that guide practice.
- Defined standards of practice, supported by clinical audit, which must include the mechanisms by which audit findings will be addressed.
- Defined processes for education, training and assessment of competence and the process in place for maintenance and reassessment of competence.
- Education and training of staff undertaking support roles, such as airway assistant role.
- Standardised equipment, which must include the provision of a bougie, waveform capnography and other items deemed necessary to maintain safe systems of work.
- Defined processes for adverse incident reporting and how the learning from such events is translated into operational practice.

The European Resuscitation Council Guidelines (Semeraro 2021) suggest that intubation should only be performed by rescuers with a high success rate at ETI. The Resuscitation Council UK (2021), further identify that a high success rate 'is over 95% within two attempts at intubation.'

In the latter part of 2014, the Trust released the first version of its airway management document, this has been updated in 2017 and again more recently in 2021. Since being

first released this guidance document has promoted the use of Airway Logs by all clinical staff to validate an individuals practice and experience for professional registration or at HM Coroners.

The Trust is committed in ensuring that all Trust clinicians provide high quality airway management for those patients who require resuscitation. To support this, the Trust has in place clinical leadership structures to support all WAST clinicians..

6. AIRWAY MANAGEMENT

All patient facing staff and volunteers **must** be competent in assessing a patients' airway and breathing status and then be able to recognise when an intervention is required to support the maintenance of that airway as described in both JRCALC Clinical Practice Guidelines and the Trust Airway Management document.

Airway interventions will be classified as either basic, intermediate, or advanced airway techniques:

Basic Airway	Intermediate Airway	Advanced Airway
• Patient positioning e.g., recovery position • Head tilt chin lift • Jaw Thrust • Triple airway manoeuvre • Use of suction • Oropharyngeal • Nasopharyngeal Airway • I-gel (ACA & CFR)	I-gel* with waveform capnography (EMT and above grades)	Endotracheal intubation** Quick Trac2 Device***

*Any I-gel airway inserted by an EMT grade or above **MUST** be accompanied by waveform capnography.

** Intubation can only be considered where it is within the Paramedic's scope of practice, waveform capnography is being used and the Paramedic able to interpret the reading.

JRCALC states that 'the use of a bougie and waveform capnography is mandatory'. It further states 'that if the waveform is flat (or minimal baseline fluctuation), it must be assumed that the tracheal tube is sited incorrectly and must be removed'.

An unrecognised oesophageal intubation is a 'never event[i]', reportable to Welsh Government.

The paramedic involved in an unrecognised oesophageal intubation may be subjected to the Trusts policy and procedures for negligent practice. Additionally, a referral to the Health Care Professions Council (HCPC) will be considered.

*** The use of the Quick Trac 2 Device **MUST** be accompanied by waveform capnography.

6.1. Airway Logs

All patient facing clinicians and volunteers **must** maintain an up-to-date airway log, this should include any basic airway procedure describe above. All intermediate and advanced airway procedures **must** be recorded in the clinician's electronic airway log via WASUT forms with evidence of waveform capnography being undertaken.

EMTs and registered clinicians airway log will be reviewed monthly by either senior Paramedics or the Health Board Clinical Lead

6.2. Intubation

The Trust accepts all the recommendations made by the College of Paramedics Consensus Statement on Intubation.

6.3. Education

Paramedic students during their education must comply with the with College of Paramedics Consensus Statement (2018), where it states:

> *"It is the consensus of this group that paramedics should expect to undertake 60 supervised intubations before being deemed competent, of which a minimum of 25 must be undertaken in a controlled setting (i.e. hospital anaesthetic room). Simulation in a context-specific environment may be utilised to achieve the total number of supervised intubations. Assessment of competence needs to include demonstration of safe practice in managing complications and in the use of failed airway drills."*

Paramedic students who seek employment with WAST must provide evidence of compliance with this statement. Failure to do so will result in them not having intubation within their scope of practice.

Paramedics recruited from other ambulances services **must** provide evidence of competency in the form of an up to date airway log and pass an assessment on airway management at both basic and advanced levels.
All Trust clinicians will have access to the appropriate airway training material to support them in undertaking simulated airway management. This will include the necessary equipment for intubation. This will enable Paramedics to evidence competency within their airway logs.

6.4. Maintenance of competency

The College of Paramedics state that Paramedics should have a minimum of 2 intubations per month recorded in their airway log. This should be achieved either in clinical practice or simulated practice. This position is supported by the Trust.

Paramedics who have undertaken two successful simulated or clinical practice intubations per month unsupervised are able to record these in their airway log.

Senior Paramedics or Education and Training Staff will make available facilitated simulated airway management and Paramedic intubation to support all Paramedics to record as a minimum 2 intubations per month and other grades of clinical staff to maintain competence in airway management. Facilitated simulated practice can be evidenced in clinical staff 'airway log'.

If Paramedic's are unable to evidence a minimum of two intubation per month, either through simulated or actual clinical practice they **must** refrain from intubating, and inform their Senior Paramedic at the earliest opportunity, the Senior Paramedic will then support the necessary simulated practice.

If a Paramedic has not submitted an airway log for 3 consecutive months, or 3 times within a 12-month period they will be notified that intubation has been removed from their scope of practice.

Additionally, airway management is part of the annual Mandatory in Service Training (MIST) where each airway intervention is assessed. Failure to attend an annual MIST session will result in the Paramedic having intubation removed from their scope of practice.

Trust Paramedics can only attempt intubation if:

- They have a high tracheal intubation success rate
- A trained assistant is present (ACA 2, EMT or paramedic)
- Waveform capnography is available and used
- All required equipment as set out in the Trust Airway Management Document is available
- The Paramedic is competent in failed airway procedures

6.5. Simulated Practice

Airway heads and all airway management equipment are available for all clinical staff to undertake simulated practice. Clinical staff can undertake self-directed simulated practice to evidence psychomotor skills in undertaking basic, intermediate and advanced airway techniques. These simulated practices can then be entered into airway logs.

Senior Paramedics, Health Board Clinical Leads and members of the Education team will support all EMTs and Paramedics to undertake a structured approach to all simulated practice when required. This will be undertaken at station level to assist Paramedics who have not intubated twice in the previous month, or clinical staff who wish additional support. Community First Responders schemes will continue with the existing Continued Professional Development programme.

Clinical Staff returning from long term absence will be supported by either Senior Paramedics, Health Board Clinical Leads or members of the Education and Development Team in evidencing competency within their airway log.

It is essential that, to ensure that intubation can be continued to be practiced by all paramedics within WAST, evidence of their ongoing competency is maintained and evidenced in an up-to-date airway log.

6.6. Adverse Incident Reporting

All Trust Clinicians have a responsibility under the Trust 'Adverse Incident/Hazard Reporting Investigation and Learning Policy and Procedure, to report any incident through the Trust Datix reporting procedure.

7. AUDIT AND MONITORING

Clinical Audit will provide Clinical Teams with a monthly report for all I-gel and advanced airway interventions undertaken in practice. All incidents where $ETC0_2$ has not been fully documented will result in a full clinical review with a download of Corpuls records.

Monthly reports will be submitted to the 'Ambulance Practice Steering Group' to report on the compliance to the recording of $ETC0_2$ and the outcome of any reviews undertaken following the failure to document $ETC0_2$.

Additionally, a further monthly report is generated in relation to airway log compliance. Both these reports will be completed by the Health Board Clinical Lead supported by Senior Paramedics.

8. RESPONSIBILITIES

8.1 Chief Executive Officer

The Chief Executive Officer has the overall responsibility to ensure all clinical staff have the necessary knowledge, skills, and experience to practice safely. This responsibility is delegated to the Executive Director of Paramedicine and Executive for Workforce and Organisational Development.

8.2 Executive Director of Paramedicine

The Executive Director of Paramedicine is responsible for ensuring senior clinical teams are in place to support clinical leadership empowering Trust clinicians to maintain their competence in airway management.

The Executive Director of Paramedicine will be the named clinician with lead responsibility for the practice of intubation by Paramedics.

8.3 Director for People and Culture

The Director for People and Culture will support education teams in delivering continued professional development in relation to airway management, supporting Trust clinicians to remain competent in basic, intermediate, and advanced airway management.

8.4 Assistant Director of Clinical Delivery

The Assistant Director of Clinical Delivery will provide a report to the Director of Paramedicine twice yearly in relation to compliance to this policy.

8.5 Regional Clinical Leads / Consultant Paramedics

Regional Clinical Leads-Consultant Paramedics will Report monthly to the Ambulance Practice Steering Group' upon compliance to this policy.

The Regional Clinical Lead-Consultant Paramedics will report to the Assistant Director for Clinical Delivery any report relating to a potential unrecognised oesophageal intubation.

The Regional Clinical Lead-Consultant Paramedic will consider any clinical review in relation to potential negligent practice and consider referring the registrant to the HCPC.

On receipt of communication from the Health Board Clinical Lead in relation to a Paramedic non-compliance to airway log submission, the Regional Clinical Lead-Consultant Paramedic will write to that Paramedic informing them that intubation has been removed from their scope of practice. a copy of this letter will be entered into the Paramedic training record.

8.6 Health Board Clinical Leads

Health Board Clinical Leads will review monthly waveform capnography reports provided by the airway management dashboard.

Where it is identified that there is non-compliance to the use of $ETC0_2$ for an advanced airway, the Health Board Clinical Lead will support a clinical review undertaken by the Senior Paramedic.

The Health Board Clinical Lead will provide a monthly report to the Regional Clinical Lead-Consultant Paramedic in relation to compliance of using $ETC0_2$ for I-gel and advanced airways within their individual areas. This report will also report upon the outcome of any reviews undertaken.

Any suggested unrecognised oesophageal intubations identified following a review **must** result in a Datix submission and, additionally the HBCL will update the Regional Clinical Lead-Consultant Paramedic, consideration will be given to reporting as a 'Never Event'.

Health Board Clinical Leads will supply a monthly report in relation to airway log submission. Where a Paramedic has failed to submit 3 consecutive airway logs, or 3 within 12 months, they will inform the Regional Clinical Lead-Consultant Paramedic.

HBCLs will undertake ride out shift with Senior Paramedics to ensure maintenance of airway management competency. The Health Board Clinical Lead will also review the Senior Paramedics' individual airway log.

8.7 Learning and Development Teams

Learning and Development Teams will undertake annual assessments of all ACA, EMT and Paramedics in relation to a 'step wise' approach to airway management, to include both basic, intermediate (EMT and Paramedic) and advanced techniques (Paramedics).

8.8 Senior Paramedics

Senior Paramedics will discuss airway management with all EMT's and Paramedics during their operational ride out shifts.

Senior Paramedics will facilitate structured simulated practice to support Paramedics in recording two intubations per month in their airway logs.

Senior Paramedics will inform the Health Board Clinical Lead of any concerns relating to non-compliance with completing airway logs.

Senior Paramedics will undertake clinical reviews following the identification of non-compliance of documented $ETC0_2$ following the insertion of an I-gel or advanced airway. If Corpuls records confirm $ETC0_2$ was used, the Senior Paramedic will provide feedback to the EMT/Paramedic on appropriate documentation.

If confirmation is gained via Corpuls records that a Paramedic has intubated without using $ETC0_2$ or has not removed an endotracheal tube following a poor $ETC0_2$ reading, the Senior Paramedic **must** submit a Datix report and inform the Health Board Clinical Lead.

8.9 All Clinical Staff

Patient facing clinicians are responsible for maintaining competencies in relation to airway management in line with JRCALC Clinical Practice Guidelines and the Trust Airway Management Document.

All Patient facing clinicians are responsible for maintaining an up-to-date airway log.

9. EQUALITY

In accordance with the Equality Act 2010 this Policy has been subjected to an EqIA. This has enabled resources to be targeted effectively and where required help to reduce inequalities. The EqIA is a process to find out whether a Policy will affect people

differently on the basis of their 'protected characteristics': age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion, sex or sexual orientation and if it will affect their human rights. Evidence gathered at the initial stages, by undertaking an initial screening, has determined the relevance of the policy and how it affects people as service users, members of the public and as employees of the Trust and has indicated that a full EqIA is not required. The Policy will have a positive effect on all relevant groups.

10. WELSH LANGUAGE IMPACT ASSESSMENT

The Welsh Language Measures Wales 2011 established the principle that the Welsh and English language should be treated on a basis of equality. The duties deriving from the standards mean that the Trust will be required to assess what effect a policy decision would have on the opportunities for persons to use the Welsh language or treating the Welsh language no less favourably than the English language.

11. ANTI FRAUD CORRUPTION AND 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 www.reportnhsfraud.nhs.uk

12. REFERENCES

1. College of Paramedics (2018) *Consensus Statement A framework for safe and effective intubation by paramedics*. Accessed on line at: [Paramedic_Intubation_Consensus_Statement_2018 (2).pdf]

2. Benger J.R. et al (2018) Effect of a Strategy of Supraglottic Airway Device vs Tracheal Intubation During Out of Hospital Cardiac Arrest on Functional Outcome. The Airways-2 Randomized Clinical Trial; *JAMA 2018; 320 (8): 779-791*

3. Joint Royal Colleges Ambulance Liaison Committee (2019*) JRCALC Clinical Practice Guidelines 2019*. Class Professional Publishers. Bridgwater.

4. Federico Semeraro et al (2021) European Resuscitation Council Guidelines 2021: systems for saving lives. *Resuscitation. Accessed on line at* European Resuscitation Council Guidelines 2021: Systems saving lives (cprguidelines.eu)

13. APPENDICES

13.1 Appendix 1: Airway Management v7.2.2.pdf

13.2 Appendix 2: Responsibilities In Evidencing Competence in Undertaking Endo-Tracheal Intubation In Line With The College Of Paramedics 'Safe And Effective Intubation By Paramedics (2018)'

Trust Responsibility

The Trust will ensure that staff will have access to all the necessary equipment at station level to undertake simulated airway practice. this will include:

- Airway head
- Naso-pharyngeal/oropharyngeal airways, I-Gel, Endo-tracheal tubes, catheter mounts, bacterial filters and waveform capnography attachment.
- Laryngoscope
- Bougie
- Airtraq

The Trust will update all staff in the advent of any new evidence/guidance in relation to airway management.

Paramedic responsibility

Paramedics will undertake two intubations per month either through simulated practice or clinical practice.

Simulated intubations can be undertaken either through self-directed practice or facilitated practice.

Paramedics will evidence two intubations per month in their electronic airway log.

Paramedics will attend annual CPD where airway practice drills in line with the Trust 'Airway Management Document' will be undertaken.

Paramedics who identify difficulties in intubating are to approach their Senior Paramedic for support.
It is the responsibility of all clinical staff to ensure that all equipment used is cleaned after use in line with WAST infection prevention control guidance.

Health Board Clinical Lead (HBCL) / Senior Paramedic (SP) Responsibility

HBCL and SP will facilitate monthly simulated airway management workshops. These are to support all clinical staff in maintaining competency in airway management (attendance is optional)

SPs will review all EMT and paramedic electronic airway logs monthly.

HBCL will as a minimum monitor the airway dashboard to review non-compliant ePCRs

Education and Development Team Responsibility

Undertake annual assessment for all clinical staff in relation to airway management drills. Undertake simulated advanced airway drills for all paramedics.

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

Management of Controlled Drugs Policy

Policy Number:	063	**Version No:**	7.0	**Supersedes:**	6.0 (published in May 2024)
Date of Approval:	20/08/2024	**Review Date:**	20/08/2027	**Impact Assessments Completed:**	Yes
Classification of Document:	Clinical	**Type of Document:**	Policy	**Approved by:**	Policy Group
Brief Summary of Document:	The purpose of this policy is to promote the safe, secure and effective management and use of Trust Controlled Drugs (CDs).				
Scope:	This Policy applies to all Staff who use and are responsible for the management of CDs.				
To be read in conjunction with:	WAST Medicines Management Policy V3.1 (2023) HCPC and WAST Code of Conduct and Professional Behaviour National Institute for Health and Care Excellence (NICE) Controlled drugs: safe use and management (2016) Security Standards for the Management of Controlled Drugs in the Ambulance Sector (2017) RPS professional Guidance on the safe and secure handling of medicines (2024) Standard Operating Procedure for the Witnessed Destruction of Controlled Drugs V0.3 (2021)				
Owning Committee	Quality, Patient Experience & Safety Committee (QuEST)				
Policy Lead: **Trade Union Lead:**	Dr Chris Moore Hugh Parry	**Job Title:**	Head of Medicines Management Trade Union Partner		
Executive Director:	Andy Swinburn	**Job Title:**	Executive Director of Paramedicine		

Version Control Sheet

Version	Date	Author	Summary of Changes
5.5	Nov 2023	C Moore	First review of existing CD policy
5.5	Jan 2024	Huw Jackson / Hugh Parry	Review of changes/amendments
5.6	Feb 2024	C Moore	Transfer to new policy template
5.7	12/02/2024	L Trounce	Formatting in readiness for presentation to Policy Group on 27/02/2024
5.8	10/04/202	C Moore	Minor amendments reflecting feedback from Policy Group (27/02/2024) including removal of paragraph 8.6 and duplicate Records Management paragraph
5.9	12/04/24	Julie Boalch	Amendment to Impact Assessment Review section, approval route, and colour scheme.
5.10	25/04/24	Lisa Trounce	Crown badge and Trust logo replaced, and Header amended to reflect university status
6.0	17/05/2024	Lisa Trounce	Formatting front cover following approval at Committee. AS title amended to 'Executive' Director of Paramedicine throughout policy.
6.1	28/05/2024	Chris Moore	Amendments made following feedback received re: published policy: - 10.5 and 12.5 originally directed the reader to 9.3 re: disposal, now amended to 10.3. - 12.1 and 13.2 originally stated 'RRV', now amended to 'Solo Responder'.
6.2	31/05/2024	Lisa Trounce	Version amended on front cover and footer. Version Control Sheet updated. Contents page numbering refreshed.
7.0	20/08/2024	Lisa Trounce	Front cover and Version Control Sheet updated to reflect minor amendments to policy approved by Policy Group 20/08/24, prior to publication.

Keywords	Controlled, Drugs, CDs, Policy

Impact Assessment Reviews

Area	Date of Review	Name of Reviewer
Training	N/A	
Counter Fraud	N/A	
Information Governance	N/A	
Records Management	N/A	
EqIA / Welsh Language	22/02/2024	C Moore/K Cobley
Estates	N/A	
Environment	10/04/2024	N Stephens
ESMCP	N/A	

Task and Finish Group Members

Name	Job Title
Updated Task & Finish Group Membership (2023/24):	
Dr Chris Moore	Head of Medicines Management
Hugh Parry	Duty Operations Manager (TU Partner)
Huw Jackson	Health Board Clinical Lead

Policy Approval Route

Meeting Title	Meeting Date	Purpose/Outcome
Policy Group	27/02/2024	Review of updated policy for Approval / Recommend for Approval
Policy Group	27/03/2024	Review further amendments made & Recommend Approval
ELT	16/04/2024 (via email)	Recommend for Approval
QuEST	07/05/2024	Approved for 3 years
Policy Group	20/08/2024	Update Policy Group re: minor amendments
ELT	28/08/2024	Note policy approval by Policy Group
QuEST	05/11/2024	Note policy approval by Policy Group

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

Contents

1. INTRODUCTION

The purpose of this Policy is to promote the safe, secure and effective use of all CDs used by WAST clinicians and reflects processes that were introduced when the Abloy CD Security System was implemented. The governance arrangements set out in this Policy aim to promote best practice and support all professionals in the management and use of these important medicines. The vast majority of this document relates to the secure management of morphine sulfate. Specific guidance related to ketamine and midazolam is provided in section 23 of this Policy.

1.1 In keeping with best practice, it is extremely important that appropriate measures are implemented which allow the tracking of CDs from pharmacy, right through to its end point. There are a number of different end points for CDs which include:

- Administration to the patient
- Disposal of full or partial doses
- Damage to ampoules
- Destruction of expired ampoules

The following table of documents, support the safe and effective management, use and audit of morphine sulphate by WAST personnel;

Document	Description	Use
CD01	Requisition Book	Requisition of CDs from pharmacy
CD02	Administration Record	Records vehicle stock level, administration to patient, disposal.
CD03	Key Register	No longer used due to deployment of the Abloy CD Key system
CD04	Expired Morphine Record of Disposal	Records disposal of expired morphine to pharmacy for authorised destruction
CD05	Medicines Audit Tool	Online tool to support monthly audit of vehicle CDs and medicines
CD06	Authorised CD Signatories	Record of original signature held by pharmacies
CD07	Enhanced Analgesia Pack Register	Signing analgesia packs out and into the station CD K-Safe
CD08	Station CD Register	Records station stock levels including supplies to and issues from the CD safe

2. POLICY STATEMENT

To ensure that the Trust has robust systems for the management of CDs.

3. SCOPE

This Policy applies to all Trust staff who use and are responsible for the safe and secure management of CDs.

4. AIM

To provide robust guidance to all Trust staff.

5. OBJECTIVES

To ensure that the Trust has robust systems for the requisitioning, physical security, storage, recording and safe disposal of CDs.

6. TITLE OF POLICY

Management of Controlled Drugs Policy

7. ACCOUNTABLE OFFICER

7.1 All designated bodies in Wales (NHS Trusts, LHBs) have a duty to appoint an Accountable Officer (WSI 2008; No. 3239 (W.286). The role of the Accountable Officer is to ensure that all practices and procedures associated with the day to day management of CDs are compliant with legislation and best practice. The role of the Accountable Officer in WAST, is performed by the WAST Director . Further detail on the role of the Accountable Officer can be found in *Strengthened Governance Arrangements for Management of Controlled Drugs* (WAG, 2008).

7.2 The name of the Trust Accountable officer is registered with Healthcare Inspectorate Wales CD Accountable Officers (HIW) Wales The Accountable Officer is responsible for ensuring there are sufficient routine monitoring systems in place to support the safe management of CDs in WAST.

7.3 The Accountable Officer must ensure that monitoring and reporting arrangements are robust enough to enable concerns about CDs to be raised, and that there are systems to investigate and manage concerns appropriately.

7.4 The Accountable Officer must ensure that declarations and self-assessments required by Healthcare Inspectorate Wales are completed and that WAST plays an active role in Local Intelligence Networks.

7.5 The day-to-day responsibilities of the Accountable Officer can be delegated to a named staff member. However, the Accountable Officer must ensure the delegated officer understands the responsibilities and duties associated with CDs and is provided sufficient resources to carry out this role.

7.6 The Accountable Officer will be responsible for ensuring appropriate reporting of CD management activity to the Trust Quality, Patient Safety and Experience Committee and Trust Board.

8. REQUISITION OF CONTROLLED DRUGS

8.1 Requisition of Omnicell Stocks

WAST Paramedic Duty Operations Managers (DOMs), Senior Paramedics, Locality Managers and Health Board Clinical Leads (Authorised Paramedics), are the only WAST staff authorised to requisition morphine sulphate from Health Board pharmacy departments. The aforementioned managers must be registered as Omnicell 'Super Users' which will provide them the necessary permissions to undertake restocks of the Omnicell cabinets. All authorised Paramedics must be in WAST uniform and present a valid, photographic Trust ID. All supplying pharmacies hold a file of WAST authorised personnel signatures, which will be checked, prior to the order being processed.

8.2 Minimum Standard of Information for CD Requisition

WAST CD requisition books contain duplicate sequential numbered pages. The minimum standard of information required on a CD requisition is as follows;

- WAST Locality or Omnicell being supplied
- Base Station of CD requisition book
- Name of preparation
- Strength of preparation
- Quantity being ordered
- The name, signature, and PIN of the Paramedic or authorised officer.
- The total quantity supplied.
- The signature of the supplier.
- The signature of the recipient.
- Date of order and supply

8.3 Process for fulfilling Requisition

Once the CD order is completed, the pharmacy department will retain the top white copy of the CD01. The pink carbon copy of the order should be retained in the CD01. Morphine sulphate can only be requisitioned from hospital pharmacies during normal working hours, Monday to Friday. It may not always be possible for the Authorised Paramedic who submitted the CD01 requisition to collect it. Where this is the case, the order can be collected by another Authorised Paramedic and a witnessed restock of the Omnicell completed at the earliest opportunity.

Good Practice
CD01 requisition books MUST be treated as controlled stationery and therefore stored securely. Issue of a new or replacement CD01 must only take place on production of a fully completed/exhausted CD01. Where a request for a replacement CD01 is not supported by a fully completed CD01, it is the responsibility of the issuing officer to ensure the 'missing' CD01 is not awaiting collection at a hospital pharmacy. *NASMED 2017*

8.4 Requisition of Vehicle stocks from the Omnicell system

The Omnicell system supports the operational supply of morphine sulphate directly to the vehicle (call sign) it is requested for. Morphine sulphate requisitions can only be issued to WAST Paramedics who are registered on the Omnicell system and therefore authorised to withdraw it. All morphine sulphate requisitions must be witnessed by a second WAST clinician (EMT or Paramedic), by use of the fingerprint scan. Morphine withdrawn from the Omnicell must be entered (and witnessed) into the vehicle CD02 register immediately following receipt. Morphine sulphate issues from the Omnicell must only be completed as a box of 10 ampoules.

8.5 Requisition of Vehicle stocks for Station-based CD cupboards

The Trust currently operates a small number of station-based CD cupboards, to support the supply of morphine sulphate to operational vehicles in the Swansea Bay and Bridgend areas. The system operates in much the same way as the Omnicell system, where Authorised Paramedics are responsible for submitting CD requisitions to the Pharmacy Department at Cefn Coed Hospital, Swansea. The CDs are then transferred to CD safes at Swansea, Neath and Bryncethin Ambulance Stations where registers of their stock are maintained. The minimum standards for the completion of CD requisitions for station based stocks are exactly the same as those detailed in section 7.2 (above). Station-based CD stocks will be subject to monthly stock-checks, scheduled to coincide with vehicle medicines audit.

Good Practice
Any tamper-evident seals on packs of CDs should be left intact when they are received from the pharmacy. This will simplify and speed up routine balance checks, as sealed containers can be assumed to contain the full amount as stated on the pack. *NASMED 2017*

8.6 Retention of CD01 and CD02 Books

Authorised Paramedics/localities, must ensure that all completed CD01 and CD02 books are retained for a period of two-years from the date of the last entry.

8.7 Responsibility for Updating Authorised Signatory Files (CD06)

Locality Managers (or appointed delegate) are responsible for ensuring that the pharmacy and locality authorised signatory files (CD06) are regularly updated to reflect

newly appointed Authorised Paramedics. The list of approved signatories should be checked at least annually and whenever there are amendments (additions or removals) to the lists.

8.8 Management of Authorised Signatory Files (CD06)

The top white copy of the completed CD06 must be countersigned by the HBCL/Locality Manager/DOM/Senior Paramedic and provided to the pharmacy department, to update their file. The pink carbon copy of the signatory form must be retained within the CD06 book for their records.

Good Practice
Paramedic officers must not possess an individual requisition book (CD01) to order personal stocks of morphine sulphate. Paramedic officers are also discouraged from withdrawing morphine sulphate (as a complete box) from the Omnicell system. Paramedic Officers, who need to top-up or replenish stock, should liaise with a local Senior Paramedic/DOM to arrange for a stock transfer of no more than 5 ampoules from an emergency vehicle. A record of the stock transfer must be recorded in the CD02 books of the emergency vehicle and paramedic officer and in all cases, witnessed and countersigned.

9. MANAGEMENT OF VEHICLE STOCKS

9.1 Once stock has been withdrawn from the Omnicell, it must be added to the running stock of the vehicle CD02, countersigned, and secured in the vehicle CD cabinet (along with the CD02), before continuing with any ambulance duties.

9.2 Each vehicle must have an Administration Record book (CD02) containing the following information:

- Drug preparation and strength
- Vehicle Call Sign and registration
- Date
- Issue / received / stock check
- Quantity Administered
- Quantity Issued
- Quantity disposed
- Stock Level
- Patient Clinical Record number
- Signatures (both crew members)
- PIN (both crew members)

9.3 When morphine sulphate is placed into the vehicle CD safe, the CD02 stock balance must be updated to reflect the contents of the safe. Entries should be made in the CD02

book every time morphine is placed in the CD cabinet, administered to a patient, or disposed of (see CD02 guide page for examples).

9.4 All entries in the CD02 must be in chronological order, made in ink and legible. If an error in recording is made, it should be struck through with a single line, signed and dated. A further entry should then be made in the next line below the error to clearly identify the stock level.

9.5 Wherever possible, two signatures must be recorded in the CD02 for all morphine issued or received. For paramedics working as solo responders, this may not always be practical, but witness signatures should be obtained wherever possible. Excess m*orphine sulfate doses should not be disposed of until a witness is present and the quantity disposed of must always be recorded in the CD02 and narrative section of the electronic Patient Clinical Record (ePCR).*

9.6 Morphine sulfate can only be stored in the vehicle CD safe, which will also hold books CD02 (administration record) and CD04 (expired record).

Good Practice
To reduce the number of unexplained morphine ampoule breakages, the Trust has purchased specific plastic cases which hold up to two complete boxes of 10 ampoules. All morphine sulfate ampoules held in the vehicle CD safe must be retained within their original cardboard packaging and secured within the plastic cases.

9.7 A maximum stock level of 15 x 10mg in date morphine ampoules can be stored on EMS vehicles at any given time (this does not include expired stock). When operational circumstances demand, stock levels may be increased to 30 x 10mg, but this should only be applied as a temporary measure. An example of this might include when a vehicle has been involved in an accident, and the CD stock is required to be transferred to another vehicle, to prevent its loss at a vehicle dismantlers or repairer.

Morphine stock levels <5 ampoules do not affect the vehicle's operational availability.

9.8 A box of 10 x 10mg/1ml ampoules is the only quantity that can be requisitioned from pharmacy, the Omnicell system or station-based CD cabinets.

9.9 Morphine can only be transferred from one vehicle stock to supplement another vehicle stock if a spare vehicle is unavailable or out of service. The CD02s of BOTH the issuing and receiving vehicles MUST be completed by writing in the next available line, number of ampoules transferred from/to (vehicle call signs) and ensuring that the stock balance recorded is correct. The member of staff must inform Clinical Contact Centre (CCC), who will immediately e-mail the Locality Manager. At the first opportunity the Locality Manager (or appointed delegate) must arrange to check that the audit trail is complete and processes are put in place to prevent this reoccurring.

9.10 All pages of the CD02 (top white and yellow copy) must be retained in the book. As previously described above (paragraph 8.7), completed CD02 books must be retained by localities for a period of two years from the date of last entry, then destroyed under confidential conditions.

9.11 Local arrangements need to be implemented to ensure that morphine stocks on all spare / non-operational vehicles are checked on a minimum of a once-weekly basis and documented in the vehicles CD02.

10. PATIENT ADMINISTRATION OF MORPHINE SULFATE

NB: This section does not deal with the clinical aspects of morphine administration

10.1 When morphine sulfate is administered to a patient, the following must be recorded on the ePCR:

- The patient's full name.
- The patient's home address.
- The patient's date of birth.
- The Drugs section must include time of administration, dose(s) administered, route of administration and batch number.

10.2 The vehicle CD02 (administration record) must be completed at the earliest opportunity i.e. when the patient's condition allows, and must include the following information;

- Date of administration
- ePCR Number
- Quantity administered to patient
- Quantity issued from stock (amount drawn up)
- Quantity disposed of (not administered)
- PIN and signature of paramedic. PIN and signature of witness (if available).

10.3 Any unused morphine remaining in the syringe must be emptied into and disposed of in the yellow sharps bin that contains a proprietary absorbent pad and recorded on the ePCR and CD02. **This disposal must be witnessed and countersigned.**

10.4 The quantity being disposed of must match the difference between the quantity administered to the patient and the quantity issued that is recorded in the CD02.

10.5 Where morphine has been administered by a solo-responder, any quantity not administered must be disposed of by the solo-responder as described in 10.3 above. This will ensure all morphine drawn up is accounted for.

Good Practice
Under no circumstances should a partially used syringe of morphine sulphate be handed over to another crew or practitioner taking over care of the patient, because the original attending paramedic will not be able to account for any further amount administered or disposed of. This will also prevent opportunities for diversion. *NASMED 2017*.

11. STOCK CHECK PROCEDURES

NB: Please refer to section 12 for additional guidance for staff members working as solo responders.

11.1 Morphine sulphate stocks must be checked at the beginning of every shift. If morphine is used during the shift, then an end of shift check must also be completed to ensure the use has been correctly recorded. There may be occasions when the first stock check may be delayed due to a requirement to deploy to an immediate 999 response. However, the check should be carried out as soon as is practically possible. Any discrepancies must be reported immediately to the respective Locality Manager, duty DOM/Senior Paramedic, or duty on-call officer and the incident recorded on DATIX.

11.2 At the commencement of duty, two members of crew must complete a CD safe stock check, regardless of whether the vehicle has been used on the previous shift or not.

11.3 At the end of duty, if morphine has been used during the shift, a closing stock check should be completed. This may be undertaken by both members of the same crew concluding their shift (vehicle not being used after this shift), or, by one of the crew finishing their shift and a member of crew relieving them.

Good Practice
Local arrangements should be in place to ensure that morphine stock checks on spare/non-operational vehicles are completed on a minimum of a once-weekly basis. *NASMED 2017*.

11.4 The stock check must be recorded in the CD02, writing ‘STOCK CHECK’ or ‘SC’ in the box marked ‘quantity received and recording the current stock level.

11.5 The signatures and PIN of both personnel must be recorded in the PIN/Signature columns on the far right of the CD02 page.

12. STAFF WORKING AS SOLO RESPONDERS

12.1 Staff working as Solo Responders, must follow the same checking procedures as those for double crewed EMS vehicles, with the following exceptions:

12.2 When morphine sulphate has been administered, the paramedic should where possible, obtain the signature of a crew member from the attending double crewed ambulance.

12.3 The ePCR should also record details of the morphine administered as per section 10.1 above.

12.4 A staff member working as a Solo Responder must perform a stock check at the beginning of every shift. Where possible, this should be in the presence of another member of operational staff. If no witness is available then NWA (no witness available), must be recorded in the countersignature (wts) box of the CD02. If morphine is used during the shift, then an end of shift check must also be completed to ensure the use has been correctly recorded.

12.5 Where morphine sulphate has been administered by a Solo Responder, any quantity not administered must be disposed of by the solo-responder as described in section 10.3 above. This will ensure all morphine sulphate drawn up is accounted for. It is not acceptable for partially used syringes of morphine to be handed over to transporting paramedics or other health professionals taking responsibility for the ongoing care of the patient (*see below*).

Good Practice
Under no circumstances should a partially used syringe of morphine sulphate be handed over to another crew or practitioner taking over care of the patient, because the original attending paramedic will not be able to account for any further amount administered or disposed of. This will also prevent any opportunities for diversion. *NASMED 2017*.

13. CONTROLLED DRUGS CABINET ACCESS – ABLOY CLIQ PROTEC2

13.1 WAST deploys the Abloy Cliq Protec2 system, which restricts CD cabinet access to Paramedics and a limited number of Authorised Officers. Access to the vehicle CD safes is via a personal issue Abloy CD key, which must be activated at the commencement of shift and remains active for 15-hours. At the end of the 15-hours, the key will automatically deactivate and will not permit access to WAST CD safes until reactivated. All CD safe access transactions are recorded on the key and next time the key is activated, the activity is uploaded to the web-based system, providing an auditable trail.

13.2 Only WAST Paramedics and Authorised Officers will have access to morphine sulfate stored within the CD cabinet on emergency ambulances or solo responder vehicles. EMTs working with paramedics are permitted access to the CD safe at the request of the paramedic, to countersign the CD02 and to secure the drug for preparation and administration by the paramedic. Unauthorised access by anyone other than the aforementioned staff groups may result in disciplinary action.

13.3 All CD safes will conform to Misuse of Drugs Act (Safe Custody) regulations.

13.4 Only morphine sulfate and the relevant documentation (CD02 & CD04) are to be stored within the CD cabinet. The only exception to this is when Senior Paramedics or CHARU paramedics need to secure their 'enhanced analgesia' packs (ketamine and midazolam) in the CD safe.

Good Practice
Airwaves handheld radios **must not** be stored in vehicle CD safes. This practice has previously been associated with a higher than acceptable number of reported ampoule breakages and inability for engineers to access the radios for service or repair. All EMS vehicles where fitted with specific Airwave radio safes should be used. If a vehicle being used is not equipped with an Airwaves radio safe, then the hand held radio should be locked in the glove compartment where applicable i.e Toyota RAV4 or in the lockable cupboard beside the CD Safe in 70 plate ambulance.

14. VEHICLE SECURITY

Good Practice
Abloy Cliq CD safe keys must not be joined to the vehicle's ignition key. This will prevent the CD safe key accidentally being taken, handed over to an unauthorised person, or being left in the ignition, should 'runlock' fail or not be utilised when a vehicle is left unattended. *NASMED 2017*

14.1 All staff have a responsibility to ensure that vehicles are locked when left unattended outside ambulance stations, hospital sites and public places. Although it is not always practical to lock vehicles whilst on scene or immediately after transferring patients from the vehicle under emergency conditions, staff are expected to make the vehicle secure as soon as possible after transferring the patient.

14.2 Vehicles with defective or broken locks must be reported to the CCC who will inform the DOM/Senior Paramedic/Locality Manager or on-call officer where necessary by telephone and confirm this by e-mail. Repairs or replacements will be carried out by WAST Fleet or external contractors, as soon as is practically possible.

14.3 Un-liveried lease or paramedic officer cars parked at non-Trust premises overnight should have any external blue lights and insignia removed so as not to draw attention to the vehicle. Vehicles must be locked and alarmed and not hold any more than 5 ampoules of morphine (*see section 8 – Good Practice*). CDs must in all cases be locked in a suitable container which must be secured to an appropriate anchor point within the boot space of the vehicle, out of immediate view.

15. LOST, STOLEN OR BROKEN CD SAFE KEYS

15.1 Paramedics and Authorised Officers who believe they have lost or have broken their key, must report the matter to the duty DOM/Senior Paramedic immediately. This will ensure that the key can be remotely deactivated and rendered unusable by an unauthorised user. A DATIX report must be completed for all lost and broken keys.

15.2 For lost or missing keys, initial actions should be focused on retracing the steps of the crew and vehicle, to locate the missing key. If the key cannot be located, where possible, the duty DOM/Senior Paramedic should attempt to liaise with the crew to conduct a CD stock-check. Alternatively, the crew should liaise with another WAST paramedic to complete the stock check. If the number of morphine ampoules in the safe matches the stock balance recorded in the CD02, then there will be no need to inform the Police of the incident (unless loss of the key is associated with a suspected theft).

15.3 A DATIX report must be completed as soon as reasonably practicable (before going off duty) by the member of staff who was responsible for the key. The DATIX system will ensure that the relevant managers are informed of the incident and facilitate appropriate reporting and investigation of the incident.

15.4 Any actions or decisions taken should be proportionate and risk assessed against the circumstances of the potential loss. The Health Board Clinical Lead will review the incident and investigation to ensure all appropriate measures and actions have been taken.

15.5 Requests for replacement keys should be made via the DOM/Senior Paramedic/Locality Manager. Replacement key requests (Appendix 4) must be scan/emailed to Amb_MedsManagement@wales.nhs.uk. In all cases, the **name, ESR number and base station** of the person requiring a replacement must be provided.

15.6 It is the responsibility of the Fleet Manager, to ensure that a sufficient supply of replacement locks are available at workshops/with contractors, to enable rapid replacement.

15.7 Whilst a vehicle is having a replacement lock fitted, it may be necessary to transfer the morphine sulphate to another secure vehicle. If this is considered necessary, then the CD02 books on both vehicles must be completed to reflect this temporary transfer of stock.

16. LOST OR STOLEN CONTROLLED DRUGS

16.1 In the event of CDs being lost or stolen, the authorised staff member must inform the CCC immediately. The CCC must inform the Police and relevant DOM/Senior Paramedic/Locality Manager at the earliest opportunity. If this occurs out of hours the on-call officer should also be informed. An entry should also be made in the EMS Clinical Contact Centre Ambulance Daily Occurrence Log (ADOL).

16.2 A nominated officer must attend the scene of the incident to support the staff, liaise with the Police, and coordinate any further actions.

16.3 A DATIX report must be completed by the member of staff as soon as reasonably practicable (prior to going off duty). The DATIX system will ensure that the relevant managers are informed of the incident and facilitate appropriate reporting and investigation of the incident.

16.4 The Patient Safety Team will review the DATIX incident and liaise with the Health Board Clinical Lead to consider whether the incident should be reported to the Improving Patient Safety Team at Welsh Government. Any decision to do so will be proportionate to the circumstances and assessed risk.

16.5 The Health Board Clinical Lead/Senior Paramedic will review the incident and investigation to ensure all appropriate measures and actions have been taken. All CD related incidents and outcomes are reported internally and externally to the Health Board Accountable Officers and CD Local Intelligence Network via the WAST Quarterly CD Occurrence Reports.

17. EXPIRED CD STOCK

17.1 When expired stock is identified, the box must be clearly marked 'EXPIRED NOT FOR USE.' The ampoules in the box should be taped together to prevent them being used (foil to foil), but still visible for stock check purposes until they can be returned to the hospital pharmacy for destruction. The stock must remain within the CD cabinet and continue to be recorded in the stock check, until such time as it has been returned to pharmacy for destruction. Staff who identify expired stock in the CD safe should bring this to the attention of their DOM/Senior Paramedic.

17.2 The following method should be used to record expired ampoules in the CD02 book; ***If there are 8 in-date ampoules and 6 expired ampoules in the CD safe, then the total should be recorded as 8 (6E) in the stock level column of the CD02 book.***

17.3 When expired stock needs to be returned to pharmacy, the DOM/Senior Paramedic, should contact the appropriate pharmacy to arrange a suitable time when a pharmacy professional is available to receive the expired morphine. It is acknowledged that local arrangements may vary.

17.4 When expired stock is returned to the pharmacy for destruction, the vehicle CD04 must be completed and presented to the relevant pharmacy professional. The pharmacy department should retain the top WHITE copy of the completed CD04. The stock level recorded in the vehicle CD02 book should also be amended to reflect that the expired stock has been removed.

17.5 Both carbon copies (PINK and BLUE) of the return transaction should be retained in the CD04 to ensure all records are retained in a single document.

17.6 All destructions of expired stock must be reported via DATIX. This will support a robust reporting process and allow the Trust to monitor the volumes of morphine sulphate being returned to pharmacy. The following information should be captured in the DATIX report;

- Call sign of vehicle.
- Station, Locality and Region of vehicle
- Number of ampoules returned for destruction
- DGH Pharmacy undertaking destruction

17.7 The Trust is currently developing a network of 'Authorised Witnesses' (HBCL clinicians), who will be required to complete authorised witness training, delivered by Local Health Boards. The training will permit them to undertake witnessed disposal of CDs. This is a developing area of practise, underpinned by appropriate training, possession of 'Waste Exemption' permits for specific WAST sites issued by Natural Resources Wales, a Standard Operating Procedure, and use of denaturing kits. Training places in Wales are infrequent, but once all HBCLs have completed training, WAST will have the ability to manage its own witnessed destruction/disposal of CDs.

18. DAMAGED CD STOCK

18.1 The discovery of damaged or broken CDs must be reported immediately. Dependent on the circumstances and location of the occurrence, the discovery may be reported to the line manager (if on station), or via the CCC (if operational).

18.2 Wherever possible, another member of staff should be sought, so that the damage can be witnessed and any subsequent disposal recorded and countersigned in the vehicle CD02 book. Where a witness is not immediately available, the damaged stock may be secured within the CD safe until a witness is available, but this should be balanced against ensuring safe and secure disposal of any remnants of glass or ampoule contents. Photographic evidence of damaged stock can be a useful addition to DATIX reports. Damaged morphine ampoules must be treated as contaminated sharps and be disposed of in the yellow sharps bins which will contain a proprietary absorbent pad.

18.3 In all cases, the damaged stock must be recorded in the vehicle CD02 book by recording DAMAGED STOCK in the next available row. The number of damaged ampoules must be clearly written and the stock balance amended accordingly.

18.4 All incidences of damaged CD stock must be reported on DATIX. The nature and circumstances of the damage, e.g. found during stock check, fell from hand to floor, crushed within hinge mechanism etc. should be clearly described. It is also helpful to note whether the contents and remnants of the ampoule were retained within the plastic packaging.

18.5 All incidences of CD breakages are collated and included in the Trust Controlled Drugs Quarterly Occurrence Reports, which are circulated to internal Trust stakeholders and the 7 Welsh CD Local Intelligence Networks (see section 24 below).

19. CONTROLLED DRUGS STATIONERY

19.1 CD stationery must be secured in an appropriate locked cupboard to prevent illicit use of requisition forms, or manipulation, falsification or destruction of records with the aim of obtaining CDs for improper use.

19.2 CD requisition (CD01) books in particular, must not be accessible to any individual below the role of DOM/Senior Paramedic. CD01 books must not be issued as a replacement without first confirming that the book it replaces has been completely exhausted of requisition pages. Additionally, replacements for missing CD01s must not be issued without first confirming that the CD01 it is replacing is not awaiting collection at the local DGH pharmacy.

19.3 Under no circumstances should individual Paramedic Officers possess a personal copy of a CD01 requisition book. Good practice guidance on how Paramedic Officers can top-up or replenish their stock of morphine sulfate is provided in section 8 of this Policy.

20. VEHICLE MOVEMENTS

20.1 The movement of Trust EMS vehicles from one location to another is a necessary requirement to ensure the Trust is able to provide safe and equitable service provision across the principality. Whilst the movement of EMS vehicles is most challenging in rural areas, the same challenges apply in the urban setting. To support the provision of service and maintain maximum EMS resource availability, it is essential that wherever possible, routine EMS vehicle movements are undertaken by non-EMS staff.

20.2 As previously described in this Policy, the Trust maintains vehicle-based morphine sulfate stocks in dedicated CD safes. Access to the vehicle CD safes is restricted to Paramedics and Authorised Officers that are in possession of a personal issue Abloy Cliq key. EMTs are permitted access to the CD safe (under supervision of paramedics), for the purposes of countersigning the CD02 record book and securing drugs for preparation and administration by the paramedic. Access to Trust CD safes by any other staff groups (including ACA2 staff) is strictly forbidden.

21. AUDIT AND MONITORING

21.1 In response to the *Strengthened Governance Arrangements for Management of Controlled Drugs* (WAG, 2008), the Trust has developed an online Medicines Management audit tool (Appendix 1), aimed at confirming that basic CD management processes are being routinely undertaken. The electronic tool can be accessed via the Trust intranet, by clicking on the **Applications Portal** tab and clicking on **Medicines Audit Tool** in the Medicines Management Team Section. Alternatively, please use the following link; Medicines Audit Tool

21.2 Localities are required to undertake a minimum of **one** vehicle medicines audit per month. This will provide a minimum output of 23 medicines audits per month across the

Trust. Compliance against this requirement is monitored and reported via the monthly Medicines Management Assurance Report (MMAR). The report is presented to the Trust Ambulance Practice Steering Group and on a quarterly basis, the Senior Operations Team meetings.

21.3 An audit of WAST authorised CD signatories held at DGH pharmacies will be conducted annually by Health Board Clinical Leads, supported by local DOM/Senior Paramedics. This is to ensure that up to date records are maintained.

22. 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.

23. KETAMINE AND MIDAZOLAM

23.1 Building on previous work, the Trust continues to roll out the use of ketamine and midazolam, for the management of severely traumatically injured patients. The authority to administer these CDs is restricted to a small number of designated paramedics, including HART operatives, Senior Paramedics, Health Board and Regional Clinical Leads and Cymru High Acuity Response Unit (CHARU) paramedics. Administration of these drugs by paramedics is supported by Patient Group Directions. A register of paramedics authorised to administer these CDs will be held by the Trust Medicines Management department.

23.2 To support the management of these important medicines, new CD documentation has been developed which includes; Controlled Drugs Order Book (CD01), Enhanced Analgesia Pack Register (CD07) and Station/Base Controlled Drugs Register (CD08).

23.3 Limited quantities of ketamine and midazolam will be secured in Abloy Cliq CD safes, at a small number of WAST locations (to be determined). Access to the safes is limited to paramedics that have been granted a specific access profile on their Abloy Cliq key.

23.4 Authority to order ketamine and midazolam will be restricted to selected Senior Paramedics, Health Board and Regional Clinical Leads only.

24. CD SAFES & DECOMMISSIONED VEHICLES

24.1 When ambulance vehicles are decommissioned due to age or accident damage, it is the responsibility of the Fleet Department to inform the Locality Manager of the impending decommission and requirement to remove all medicines and medical consumables from the vehicle.

24.2 The Locality Manager is responsible for ensuring the decommissioning process is compliant with the checklist provided in ***Appendix 3*** of this document (WAST *VEHICLE DECOMMISSIONING CHECKLIST).* The process must be completed prior to the vehicle being handed over to the Fleet Department.

24.3 All vehicle CD documentation (CDs 02 & 04) should be voided by writing VOID on each blank page and be retained securely within the locality for a period of two years from the date of last entry.

24.4 On receipt of the decommissioned vehicle, the Fleet Department will make arrangements for the empty CD safe to be removed from the vehicle and retained for future use.

25. LOCAL INTELLIGENCE NETWORKS

25.1 Following the publication of *Strengthened Governance Arrangements for Management of Controlled Drugs* (WAG, 2008), Health Board Accountable Officers are responsible for establishing and operating Local Intelligence Networks (LIN). Membership of the LIN is based on locally recognised health communities (consistent with Health Board boundaries).

25.2 The Health Board Accountable Officer will act as the hub of the LIN to establish mechanisms to share information quickly between partners, and where appropriate, set up and agree joint protocols and reporting arrangements.

25.3 There are seven LIN in Wales, chaired by their respective Health Board Accountable Officers. WAST Health Board Clinical Leads will provide representation at each LIN in order to present the WAST Quarterly Occurrence Reports (Appendix 2). These reports provide detail on any controlled drugs concerns or incidents that have occurred in the previous calendar quarter.

25.4 The WAST Head of Medicines Management is responsible for monitoring all CD related incidents reported on the DATIX system. The DATIX incidents are collated and a Quarterly Occurrence Report prepared on behalf of the WAST Accountable Officer. Following its approval, the Quarterly Occurrence Report is circulated internally to WAST stakeholders and externally to the 7 Health Board Accountable Officers (LIN).

26. EQUALITY IMPACT ASSESSMENT

Equality Impact Assessment (EQIA) screening was undertaken using the online tool and evidenced a neutral impact. The full EQIA document can be accessed by request to the Head of Medicines Management.

27. WELSH LANGUAGE IMPACT ASSESSMENT

The Welsh Language Measure 2011 established the principle that the Welsh and English language should be treated on a basis of equality. The duties deriving from the standards mean that the Trust will be required to assess what effect a policy decision would have on the opportunities for persons to use the Welsh language or, treating the Welsh language no less favourably than the English language.

In order to comply with the Welsh Language Standards and the Trust's Compliance Notice, the Trust is required to publish several policies in Welsh; particularly those that relate to:

- behaviour in the workplace;
- health and well-being at work;
- salaries or workplace benefits;
- performance management;
- absence from work;
- working conditions;
- work patterns

28. ENVIRONMENTAL STANDARDS AND IMPACT ASSESSMENT

This policy will put the relevant requirements in place (such as waste management plan, reduction of C02 emissions & reduction of carbon footprint) in order to ensure that the Welsh Ambulance Services NHS Trusts ongoing commitment to reduce its impact on the environment is maintained and to become a more sustainable organisation in line with Trust policy and Environmental Governance System.

29. ANTI FRAUD AND CORRUPTION CONCERNS

The Welsh Ambulance Services NHS Trust is committed to taking all necessary steps to counter fraud, bribery and corruption within the Trust. Staff should report suspected incidents of fraud and corruption to the Trust Local Counter Fraud Specialist, who will be happy to discuss any issues or concerns. Alternatively staff may contact the confidential NHS Counter Fraud Authority, Fraud and Corruption Reporting line on 0800 028 40 60; or the on-line reporting facility https://cfa.nhs.uk/reportfraud Fraud investigations may lead to disciplinary action and / or prosecution and civil recovery procedures.

Where there is any suspicion or an allegation that a loss has been caused by means of deception (by staff or patient) this must be referred to the Trust's Local Counter Fraud Specialist for investigation. The results of any such investigation could lead to internal disciplinary and/or civil/criminal prosecution proceedings being instigated against the person/persons involved.

30. TRAINING AND IMPLEMENTATION

WAST is committed to providing high quality evidence-based education to an engaged and skilled workforce operating within an organisational culture and framework that enables colleagues to work to the top of their skill set to deliver high quality care and services with competence and confidence. Staff are encouraged to discuss any concerns or queries regarding education and training with a member of the Education and Training Team, by telephoning the Learning & Development Hub on 0300 123 2319 or via email at amb_LDHub@wales.nhs.uk

31. INFORMATION GOVERNANCE

Information Governance (IG) is an overarching term used to describe all aspects of information management. The Trust and its staff shall ensure that they provide satisfactory assurance to stakeholders as to how the organisation fulfils its statutory and organisational responsibilities in relation to the management of information. It will enable management and staff to make correct decisions, work effectively and comply with relevant legislation and the organisations aims and objectives.

The IG framework ensures that it sets out the high-level principles for confidentiality, integrity and availability of information to promote and build a level of consistency across the Trust.

30. 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.

31.1 Chief Executive

The Chief Executive, as Accountable Officer, has overall responsibility for ensuring the Trust has appropriate policies in place to ensure the organisation works to best practice and complies with all relevant legislation.

31.2. Board Secretary

The Board Secretary is responsible for the effective management of, and compliance with, this policy. This includes ensuring that:

- A database of policies and procedures is maintained.
- Policies are approved as part of the Governance framework at the appropriate level in the organisation.
- The documents are accessible to all relevant staff.
- Documents are cascaded appropriately across the organisation.
- All policies are reviewed in a timely manner.

31.3. Executive Directors

The Executive Directors are responsible for the effective management of and compliance with this policy. They are responsible for ensuring that all policies within their remit are maintained and updated by liaising with the appropriate policy leads. They are responsible for ensuring that the appropriate advice and assistance is provided to authors and that consideration is given to any training and resources implications that are defined. Each Director will appoint a Policy Lead for their Directorate. The Executive Director of Paramedicine has delegated responsibility of CD Accountable Officer, to ensure all practices and procedures associated with the day-to-day management of CDs are compliant with legislation and best practice.

31.4. Corporate Governance Manager

The Corporate Governance Manager will act as the Trust's 'Policy Process Manager' and operational gate-keeper with the responsibility for providing guidance, advice and support for the process on behalf of the Trust.

In addition, the Corporate Governance Manager is responsible for:

- Managing the maintenance of the Trust's central Policy tracker and database (including a record of equality impact assessments).
- Facilitation of the Trust's internal Policy Group.
- Managing the Trust wide consultation process for all policies.
- Providing a link between the Policy Group and Employment Policy Sub Group.
- Issuing reminder notices to ensure the timely review of policies.
- Ensuring up to date guidance and documentation regarding the policy process is accessible.
- Publishing policies onto the Trust's internet/intranet sites and working with the Communications Team to ensure comprehensive notification that new policies is maintained across the Trust.
- Maintain an archive of previous versions of any revised or reviewed policies.

31.5. Ambulance Operations Managers/ Clinical Leads / Locality Managers

Are responsible for**:**

- Ensuring that new members of staff that join the Trust are made aware of the policy control system at local induction, and how to access Trust wide and local policy documents specific to their area.
- Understanding the policy process and their role in supporting best practice.
- Working with staff without access to the intranet to ensure they have access to relevant documentation.

- Ensuring that local arrangements are established to monitor the receipt and understanding of all relevant Trust documents; thus reducing the risk of misuse of misinterpretation.
- ensuring that appropriate resources are available to support the safe and secure management of controlled drugs. They must also ensure that staff under their direct line management have a sound working knowledge of the principles of CD management and have the skills and knowledge to deal with CD related incidents and concerns in a robust and timely manner.

31.6. Line Managers

Are responsible for:

- Ensuring that the staff for whom they are responsible are aware of and adhere to this document.

  This includes ensuring that:
  - Copies of the Trust policies are readily available and accessible to all staff.
  - Information is disseminated on a regular basis, to ensure staff have read and understood the relevant documents and are aware of any new guidance or revisions.
  - The identification of specific staff training needs on the implementation of new or updated documents.
  - Systems exist to enable the review, audit and compliance testing of all relevant departmental policies as required.

31.7. All Staff

Are responsible for ensuring that:

- They comply with the provision of this policy and where requested to demonstrate such compliance. Failure to comply will be dealt with under the Trust's Disciplinary Policy as appropriate.
- Information regarding failure to comply with the policy, for example, lack of training, inadequate equipment, is reported to their line manager and that the incident reporting system is used where appropriate.
- Their practice is in line with policies in use across the Trust and specific to their area of work.
- Information regarding any changes in practice, organisational structure or legislation that would require an urgent review of documents is immediately reported to their line manager.

31. REFERENCES

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- SOLD SECURE standard SS 304 – Specification for Domestic Safes, November 2008
- SOLD SECURE standard SS 314 – Specification for Security Cabinets, January 2009
- SOLD SECURE standard SS 319 – Specification for Security Cabinets for Vehicles, November 2008
- The Misuse of Drugs Regulations 2001 (legislation.gov.uk)
- The Controlled Drugs (Supervision of Management and Use) Regulations 2013 (legislation.gov.uk)
- The Misuse of Drugs (Amendment No.2) (England, Wales and Scotland) Regulations 2012 (legislation.gov.uk)
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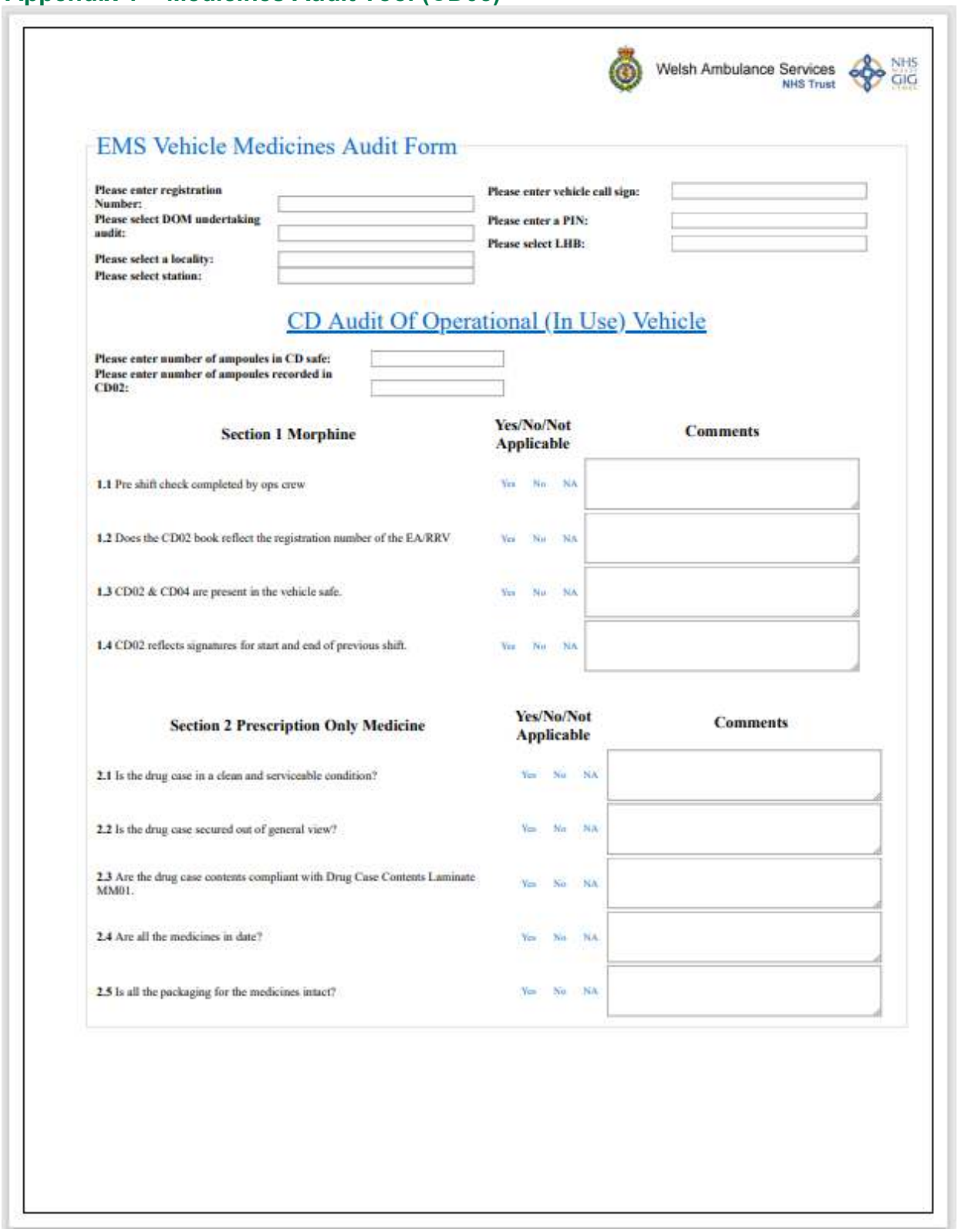
- The Misuse of Drugs Regulations 2001: Group Authority for National Health Service (NHS) Ambulance Paramedics and Employing NHS Ambulance Trusts, July 2008 The Misuse of Drugs (Safe Custody) Regulations 1973 (SI 1973 No 798.
- Medicines Management Policy v3.1 (2023)

32. APPENDICES

Appendix 1 – Medicines Audit Tool (CD05)
Appendix 2 – Controlled Drugs Occurrence Report
Appendix 3 – Vehicle Decommissioning Checklist
Appendix 4 – Request for Replacement Abloy Key

Appendix 1 – Medicines Audit Tool (CD05)



Welsh Ambulance Services NHS Trust

EMS Vehicle Medicines Audit Form

Please enter registration Number:		**Please enter vehicle call sign:**	
Please select DOM undertaking audit:		**Please enter a PIN:**	
Please select a locality:		**Please select LHB:**	
Please select station:			

CD Audit Of Operational (In Use) Vehicle

Please enter number of ampoules in CD safe:	
Please enter number of ampoules recorded in CD02:	

Section 1 Morphine	Yes/No/Not Applicable	Comments
1.1 Pre shift check completed by ops crew	Yes No NA	
1.2 Does the CD02 book reflect the registration number of the EA/RRV	Yes No NA	
1.3 CD02 & CD04 are present in the vehicle safe.	Yes No NA	
1.4 CD02 reflects signatures for start and end of previous shift.	Yes No NA	

Section 2 Prescription Only Medicine	Yes/No/Not Applicable	Comments
2.1 Is the drug case in a clean and serviceable condition?	Yes No NA	
2.2 Is the drug case secured out of general view?	Yes No NA	
2.3 Are the drug case contents compliant with Drug Case Contents Laminate MM01.	Yes No NA	
2.4 Are all the medicines in date?	Yes No NA	
2.5 Is all the packaging for the medicines intact?	Yes No NA	

Appendix 2 – Controlled Drugs Occurrence Report

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

CONTROLLED DRUGS – OCCURRENCE REPORT

Controlled Drugs Concerns

This template should be used on a quarterly basis by the Accountable Officer of a designated body to report to the Health Board Accountable Officer. It should record any controlled drugs concerns that the designated body has regarding the management and use of controlled drugs (Reg 29).

Name of designated body	*Welsh Ambulance Services NHS Trust*
Name of accountable officer	**Mr Andy Swinburn, Executive Director of Paramedicine**
Report for three-month period	
Name of local intelligence network (LIN)	
Name of LIN lead accountable officer	
I confirm that my designated body has **no** / **the following** (delete as appropriate) concerns regarding its management or use of controlled drugs during this period	
Accountable officer signature	
Date signed	

Description of concern[1]	**Date aware**[2]	**Actions taken**[3]

Notes

The Controlled Drugs (Supervision of Management and Use) Regulations 2008 came into force in Wales on 9 January 2009, see: **Regulation 29** concerns occurrence reports. In brief, regulation 29 requires accountable officers to give an occurrence report to the accountable officer for the LHB that is leading their local intelligence network (LIN). This should contain details of any concerns that their designated body has regarding its management or use of controlled drugs (or confirmation that it has no concerns to report).

[1] Short description of the cause for concern, including date(s). Details may be attached in a separate document. Note regulations 25 and 26 regarding the need not to disclose information, which relates to and can identify a patient.

[2] Date the accountable officer of the designated body became aware of the concern.

[3] Action already undertaken (if any) within or outside the designated body e.g. as part of internal incident investigation process, including the reference number within the internal incident investigation process (where relevant), and whether the incident is closed or still open.

Appendix 3 – Vehicle Decommissioning Checklist

Registration Number: _____ Make / Model: _____

Type: EMS / NEPTS / RRV / Other Call Sign: _____ Mileage: _____

Disposal Method: Auction / Salvage / Re-use (mark as appropriate)

Please complete the following tasks:

Task	Completed Yes/No/NA	Initials	Notes
Confirm that spare keys & remote-control fob are present			
Remove fuel card destroy and inform Fleet Office to cancel card			
Remove fuel key and return to Fleet Office			
Advise Fleet Office to disable vehicle tracking system			
Remove Communication/Sat Nav/Mobile data Equipment, Handheld radio			
Remove drugs cabinet and record lock number			
Check drugs cabinet can be reused & lock in working order			
Remove **all** consumables, medical gases, Medical/Specialist equipment, and any personnel items belonging to WAST staff and store ready for new vehicle			
Remove **any** WAST Literature, Defect Book, Mileage Sheet etc and dispose via correct channel			
Check and remove any clinical / hazardous waste and dispose via correct channel			
List of equipment including serial numbers			
Stretcher Seral Number			
Carry Chair Serial Number			
Carry Chair Track Serial Number			
Wheelchair Serial Number			
Spine Board Serial Number			
Scoop Serial Number			
Disposal			
Contact MMA and arrange for collection and note date collected			

Appendix 4 - Request for Replacement Abloy Key

Please complete this form for all Abloy key replacement requests
Please email this form to: amb_medsmanagement@wales.nhs.uk
NB: Incomplete forms will not be processed

Name of Paramedic user:	
Payroll Number:	
Current key markings:	
If lost, key last known location:	
Date key last used:	
If broken Key please provide details:	

Delivery details **(please note keys are sent signed for post, so can only be posted to sites with daytime admin support).**

For attention of (DOM):

Address:

Postcode:

To be completed by Line Manager/DOM

Name (PRINT): ……

Role: ……

Date: .....

For Office use only:

Name	Key Marking Code *(this is the code etched onto the key)*

Date request received:

Date Key Posted:

Royal Mail Tracking number:

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

Medicines Management Policy

Policy Number:	083	**Version No:**	4.0	**Supersedes:**	3.1 (published in October 2023)
Date of Approval:	20/08/2024	**Review Date:**	20/08/2027	**Impact Assessments Completed:**	Yes
Classification of Document:	Clinical	**Type of Document:**	Policy	**Approved by:**	Policy Group
Brief Summary of Document:	To provide a set of guiding principles and procedures to ensure the safe and secure handling of medicines, within the Welsh Ambulance Services NHS Trust (the *Trust*). This policy will support compliance with current legislation, national guidance and best practice, whilst meeting the needs of the service.				
Scope:	This policy should be read and the guidance must be followed by all clinicians who are working for the *Trust* (on a paid or voluntary basis) and who administer/supply medicines to patients. This is inclusive of Welsh Ambulance Service Paramedics, Advanced Paramedic Practitioners and Emergency Medical Technicians. The policy relates to the operational management of all medicines used by the Trust.				
To be read in conjunction with:	WAST Controlled Drugs Policy (2021) HCPC Code of Conduct and Professional Behaviour RPS Safe and Secure Handling of Medicines: A Team Approach (2018) WAST ePCR TerraPace Training Modules WAST Employee Immunisation Policy (2015) WAST Omnicell SOP (V7) WAST Prescribing Policy V1.9				
Owning Committee	Quality, Patient Experience and Safety Committee (QuEST)				
Policy Lead: **Trade Union Lead:**	Chris Moore Hugh Parry	**Job Title:**	Head of Medicines Management Trade Union Partner		
Executive Director:	Andy Swinburn	**Job Title:**	Director of Paramedicine		

Version Control Sheet

Version	Date	Author	Summary of Changes
	June 2022	Chris Moore	First draft review of existing MM policy
	Oct 2022	Chris Moore	Edits based on T&F group feedback
2.4	March 2023	Chris Moore	Paragraph on role of Pharmacist Advisor added, new section on preparation and administration of medicines added. Appendix 6 updated to reflect CFR/UCS meds
2.5	April 2023	Chris Moore	Minor amendments to paragraphs 6.5, 6.8 following Policy Group meeting 25.04.23
2.6	June 2023	Chris Moore	Prepare for consultation, reformat Appendix 4
2.7	July 2023	Chris Moore	Minor amendments/additions from consultation feedback
3.0	August 2023	Chris Moore	Further minor amendments following Policy Group meeting 29.08.23
3.1	November 2023	Julie Boalch	Approval date added.
3.2	13/08/2024	Chris Moore	Reference to RRVs in section 8.5 amended to ‘solo responders’ Section 28.3 Appendix 3 amended to reflect removal of Fluorescein and Tetracaine.
3.3	20/08/2024	Lisa Trounce	Formatting of policy approved by Policy Group 20/08/2024 to reflect updated corporate brand guidelines and university status in readiness for ELT: Approval date added Version Control Sheet updated
4.0	20/08/2024	Lisa Trounce	Front cover and Version Control Sheet updated to reflect policy approved by Policy Group 20/08/2024, prior to publication.
Keywords	Medicines, Management, Drugs, Policy		

Impact Assessment Reviews

Area	Date of Review	Name of Reviewer
Training	10.07.2023	M. Mulholland
Counter Fraud	10.07.2023	L. Haddow/Carl Window
EqIA / Welsh Language	27.07.23/16.08.23	P. Spiteri / M Hughes
Estates	29.08.2023	N. Stephens
Environment	29.08.2023	N. Stephens

Task and Finish Group Members

Name	Job Title
Chris Moore	Head of Medicines Management
Andy Swinburn	Director of Paramedicine
Greg Lloyd	Assistant Director of Clinical Delivery
Jonathan Chippendale	Consultant Paramedic Urgent Care
Mike Jenkins	Regional Clinical Lead, SE Region
Paula Jeffery	Regional Clinical Lead, C&W Region
Steven Magee	Interim Regional Clinical Lead, C&W
Bryn Thomas	Regional Clinical Lead, North Region
Paul Seppman	Trade Union Partner
Huw Parry	Trade Union Partner

Policy Approval Route

Where	When	Why
Policy Group	25/04/2023	Feedback on policy changes
Trade Union Partners e-mail review	26/04/2023	Feedback on policy changes
Trust-wide Consultation	10/07/2023 – 04/08/2023	Comments
Policy Group	20/08/2024	Approved for 3 years
ELT	28/08/2024	Noting
QuEST	05/11/2024	Noting

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

Contents

1. INTRODUCTION

1.1 The purpose of this policy is to provide a framework of guiding principles and procedures to ensure the safe and secure handling of medicines, within the Welsh Ambulance Services NHS Trust (the *Trust*). This policy will support compliance with current legislation, national guidance and best practice, whilst meeting the needs of the service.

1.2 This policy is not intended as a reference for the clinical indications or use of specific medicines.

2. POLICY STATEMENT

2.1 This Medicines Management Policy is intended as a working document for all individuals (clinicians and managers), dealing with medicines within the *Trust*. It offers a framework of processes for all aspects of medicines management including supply, administration, storage, disposal and adverse incident reporting. It is a multidisciplinary document that is intended to be as comprehensive and as inclusive as possible.

3. SCOPE

3.1 This Policy follows the legislative and best practice guidance offered but not restricted to, the following; *Prescriptions Only Medicines Act 1968, Human Medicines Regulations (2012), Misuse of Drugs Act 1971/1985, Patient Group Directions (NICE Guideline MPG2) (2017), To PGD or not to PGD Version 9.5 (SPS 2018), When to use a PGD (SPS 2022),* and the Royal Pharmaceutical Society's (RPS), Safe and Secure Handling of Medicines: A Team Approach (2018)

3.2 This policy should be read and the guidance followed by all clinicians who are working for the *Trust* (on a paid or voluntary basis) and who administer/supply medicines to patients. This is inclusive of all Welsh Ambulance Service Paramedic grades (APPs, SPs, etc.), Emergency Medical Technicians (EMTs), Nurses, Ambulance Care Assistants (ACAs) and Community First Responders (CFRs). This policy relates to the operational management of all medicines used by the *Trust*.

3.3 Any instances where there is a suspicion of unauthorised administration or supply of medicines to anyone other than a Trust patient, e.g. a member of Trust staff or other third party, must be referred in the first instance to the Trust Counter Fraud Service, who may wish to investigate or advise on whether the matter be referred to the Police.

3.4 Where staff have any suspicion that medicines are being taken or used by a member of staff or third party, they have a duty to report this to either their line manager, or in confidence to the Trust Local Counter Fraud Specialists. Further details of the Trust's Counter Fraud Policy, and how to report suspicions are available on the Trust intranet.

4. AIM

4.1 To ensure that all *Trust* healthcare professionals and clinicians are fully conversant with the standard procedures for the use and management of medicines. For guidance on

prescribing and management of prescription pads, please refer to the Trust Prescribing Policy.

5. OBJECTIVE

5.1 To set out safe systems for procuring, requisitioning, handling, storing, transporting, administering and disposing of all medicines used by *Trust* clinicians, whilst at the same time ensuring the protection of patients and staff by reducing risk and the potential for error.

6. RESPONSIBILITES AND ACCOUNTIBILITY

6.1 The **Chief Executive** has overall statutory responsibility for the safe and secure handling of medicines. Delegated responsibility for the day-to-day management of medicines lies with the **Executive Medical Director**.

6.2 The **Trust Board** play a key role in shaping the strategy, vision and purpose of an organisation. They are responsible for holding the organisation to account for the delivery of the strategy and to ensure value for money. They are also responsible for assuring that risks to the organisation and the public are managed and mitigated effectively.

6.3 The **Director of Paramedicine** is the named *Trust* Controlled Drugs (CD) Accountable Officer (AO). Responsibilities of the AO include:

- To ensure the safe and effective management and use of CDs within the Trust
- To share information about concerns regarding CDs with other agencies through the Local Intelligence Networks (LIN).

6.4 They are responsible for:

- The production of policies and procedures advising on the day to day safe and secure handling of medicines throughout the Trust.
- Ensuring that this policy is reviewed every 3 years to reflect and take account of changes in best practice guidance and/or legal framework relating to medicines management.
- Monitoring and review of the formulary of drugs available and used by *Trust* clinicians.
- Ensuring Patient Group Directions (PGDs) are in place and kept up to date.
- Ensure that the *Trust* Drug Formulary medicines are used according to best practice and current legislation.
- Ensuring that any identified medicines related risks are recorded on relevant Directorate and, if applicable, *Trust* Risk registers.

6.5 The **Director of Paramedicine** is also delegated with the day-to-day responsibilities of the AO and for ensuring that the Trust has the necessary policies and procedures in place for the safe and secure management of medicines.

6.6 The **Regional Clinical Leads** are responsible for maintaining oversight of safe Medicines Management practices and procedures within their geographical area of responsibility. This includes ensuring that Health Board Clinical Leads are in a position to advise, or provide leadership on medicines related matters, particularly in relation to audits and attendance at CD Local Intelligence Networks.

6.6 The **Executive Director of Quality & Nursing** is responsible for *Quality Improvement* practices which include but are not restricted to the corporate development, implementation and performance management of policies and procedures.

6.7 The Trust Head of **Medicines Management,** supported by the **Pharmacist Advisor**, is responsible for the development and implementation of safe and secure medicines management arrangements. This includes responsibility for the development and regular review of all medicines related policies & procedures, scheduling and facilitation of audits and dissemination of their findings. The **Head of Medicines Management** will support the development and review of new and existing PGDs, and maintain a register of Authorised practitioners. The Head of **Medicines Management** is also responsible for reviewing and collating all CD related adverse incidents and producing Quarterly Occurrence Reports on behalf of the Executive Medical Director. All MHRA Drug Alerts cascaded through the Welsh Government system will also be reviewed by the **Head of Medicines Management** and where necessary, disseminated to relevant clinical/operational teams.

6.8 The **Trust Pharmacist Advisor** will support the Trust **Head of Medicines Management** to deliver the safe and secure management of medicines, including the implementation and reporting of their use. They will take a lead role in the provision of safe systems of work aligned to the necessary regulation and mandatory compliance frameworks.

6.9 The **Head of Education** is responsible for ensuring that suitable and sufficient education and training is developed and delivered to support and maintain *Trust* clinician's knowledge and skills relating to medicines management procedures, including PGDs and any new medicines related developments.

6.10 **Heads of Service** and **Locality Managers** are responsible for:

- Supporting the operational implementation and performance management of medicines management policies and procedures.
- Ensuring **Duty Operations Managers (DOMs)/Senior Paramedics (SPs)** undertake regular medicines audits within their area of responsibility, using the *Trust* online medicines audit tool.
- Ensuring that any medicines related adverse incidents are robustly reported, recorded and investigated via the eDATIX system.
- That all CD related adverse incidents that involve the loss or suspected theft of ampoules/vials, are recorded on the EMS Occurrence Log and reported to the relevant Police Service via the 101 number.

6.11 **Advanced Practitioners (including trainees) and SPs,** are responsible for:

- Ensuring their use, administration and supply of medicines is consistent with their scope of practice and the auspices of the PGDs that support their advanced practice.
- Supporting all *Trust* clinicians who administer/supply medicines in their knowledge and clinical practice, to meet the standards identified in this policy.
- Supporting **Locality Managers** and **DOMs** in their role with regard to the management of medicines.
- Supporting monthly vehicle medicines audit checks of CDs and drug cases and Omnicell cycle counts (see section 16 of this document)
- Support the local implementation of PGDs by being responsible for ensuring staff are informed and supported at local level.

6.12 **Duty Operations Managers and Senior Paramedics** are responsible for:

- Ensuring that any station-based medicines are securely stored and managed effectively, to minimise waste.
- Undertaking regular audits (see section 18), of vehicles and drug cases and equipment, to reduce unnecessary additional stocks or stockpiling of medicines occurring.
- Undertaking regular audit checks of vehicle CD safes and documentation to ensure compliance with record keeping.
- Supporting monthly Omnicell cycle counts

6.13 **Paramedics, EMTs, EMT3s, Nurses and peer vaccinators** are trained and educated in accordance with their profession, scope of practice and level of competency in good practice and legislative requirements in the administration, storage and disposal of medicines. It is their responsibility to remain up to date and to attend any training provided by the *Trust* maintaining full CPD records.

6.14 **All Trust personnel** that have a requirement to be involved in the receipt, storage, or use of Trust medicines, have a responsibility to:

- Be familiar with this policy, have a reasonable working knowledge of the guidance (within their scope of practice) and adhere to this at all times.
- To be personally responsible for the security, safe storage and management of all medicines for the duration of their period of duty.

6.15 The **Ambulance Practice Steering Group** is one of several clinically led Trust meeting groups that report into the **Clinical Quality Governance Group** (**CQGG**) to provide assurance and raise any matters for discussion to the Directors of Paramedicine and Nursing. Medicines related matters are routinely shared via 'triple A' (Alert/Advise/Assure) reports. Any significant matters raised at **CQGG** are taken forwards to **Executive Management Team** (**EMT**).

6.16 **QUEST** (Quality, Patient Experience and Safety Committee), has oversight of effective care, ensuring 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. In this respect, an annual report on medicines management, signed off by the Clinical Directorate business meeting will be submitted to **QUEST** during the first quarter of the financial year.

7. LOCATION OF MEDICINES ADMISTERED BY AMBULANCE CLINICIANS

7.1 All medicines for use by *Trust* clinicians are procured through NHS Wales District General Hospital Pharmacy Suppliers at NHS contract prices. The Trust uses a variety of methods to procure and supply medicines for use by its clinicians which are outlined below.

7.2 **Omnicell Automated Medicines Cabinets**
The Trust operates a standardised approach for the supply of medicines to its frontline clinicians and vehicles. All EMS vehicles are equipped with a standard drug case, which contains a standard set of medicines (**Appendix 1**).

7.3 WAST operates 20 identical Omnicell automated cabinets across Wales, for the sole use of WAST clinicians. Fifteen of the cabinets are installed at District General Hospitals (DGHs) in Wales and are located within, or in the immediate vicinity of the DGH Emergency Department (ED). The remaining 5 are installed at four Powys ambulance stations (Brecon, Llandrindod, Newtown and Welshpool) and one at Dobshill Make Ready Depot. The contents of the Omnicell cabinets are based on the WAST standard list of medicines (**Appendix 1**). Levels within the cabinets are maintained by DGH Pharmacies, based on historical use. Trust clinicians can access the WAST Omnicell cabinets 24 hours a day, 7 days a week.

7.4 All WAST EMS clinicians are registered on the Omnicell system and access to the cabinets is via biometric (fingerprint) technology. Staff who do not wish to utilise the fingerprint access function, have the option to use their own unique username and password. Staff who wish to withdraw medicines are required to identify the vehicle they are operating on, so that the medicines can be identified as having been issued to that vehicle.

7.5 WAST Omnicells are equipped with a secure controlled drugs (CD) section, which is accessible to WAST Paramedic grades only. Schedule 4 CD benzodiazepine presentations may be withdrawn by paramedics without a witness fingerprint. Schedule 2 & 3 CD withdrawals (morphine sulphate and midazolam) require a witness fingerprint. This may be provided by an EMT or Paramedic grade member of EMS.

7.6 In most areas of Wales, the majority of Omnicell stock levels are maintained by DGH pharmacy staff, but where local arrangements do not support this, WAST DOMs undertake this function, on receipt of drug deliveries from the relevant pharmacy. Please refer to the WAST Omnicell SOP (V7) for additional detail on specific local arrangements.

7.7 Locality SPs and DOMs may share responsibility for undertaking monthly Omnicell cycle counts, as a means of supporting quality assurance checks. This serves to ensure stock levels are monitored and if required, can be adjusted up or down on individual cabinets.

7.8 **Station Based Medicines**
In some geographically remote WAST locations it may be necessary to maintain a limited working stock of medicines. The main purpose of this is to reduce the need for vehicles to make excessive journeys to DGHs, to undertake restocks; e.g. post cardiac arrest resuscitation where adrenaline 1:10,000 stock is depleted. The decision to hold and maintain limited station stocks of medicines (resuscitation drugs only), is the responsibility of the Locality Manager.

7.9 It is the responsibility of the Locality Manager to ensure that any station stock held is managed consistently, to ensure excessive stocks of multiple presentations are avoided. Medicines should be stored securely, in a locked cupboard, in a locked room, and should not be accessible to unauthorised staff.

7.10 **Management of Ketamine and Midazolam**
To support the use of enhanced analgesia by Senior Paramedics and Cymru High Acuity Response (CHARU) paramedics, the Trust operates a 'hub and spoke' network of strategically located CD safes across Wales. Access to the safes is strictly controlled by requiring the necessary permissions written to individual Abloy CD keys. For further information, please refer to the Trust CD Policy

7.11 CD 'Hub' safes hold a stock of Ketamine, Midazolam and Flumazenil. These drugs are ordered by a limited number of authorised signatories and each presentation is recorded in the CD safe register. CD 'Spoke' safes have two enhanced analgesia packs assigned to them and these packs hold two ampoules/vials of each drug, which are also recorded in the analgesia pack register. Restocks of drugs into enhanced analgesia packs must be completed at the CD 'Hub' safes.

7.12 **Make-Ready Depot (MRD)**
The Trust operates a number of MRD facilities across Wales. MRD technicians have a responsibility to check the expiry dates of drugs stored in WAST drug cases and removing out of date drugs from the case. MRD technicians are responsible for identifying depleted drug stocks in the cases and are able to supplement depleted stocks from surplus items removed from overstocked cases, but this must not include decanting or splitting drug packs which could result in drugs with different expiry dates being held in the same pack. MRD technicians are not currently authorised to access Omnicell cabinets to make drug withdrawals. However, the feasibility of dedicated MRD based Omnicells is currently being explored (Cardiff MRD)

7.13 It is the responsibility of the Locality Manager to ensure that any surplus drug stocks held on station are managed consistently with the stock-keeping requirements described in section 6.1 of this policy. Medicines should be stored securely, in a locked cupboard, in a locked room, and not be accessible to unauthorised staff.

7.14 **Advanced Practitioner (AP) Medicines**

Introduction of the Omnicell system has provided the Trust the opportunity to standardise the supply of 'To Take Home' (TTH) medicines to its Advanced Practitioners (APs). TTH medicines to support the AP teams will be supplied from the relevant DGH pharmacy, and be available from the relevant Omnicell cabinets, as and when the teams establish in their Health Board areas. In some areas of Wales, ordering of some over-labelled or pack down presentations require a hard copy requisition direct to the relevant Pharmacy Production Unit. Where required, this will be facilitated through the Head of Medicines Management, or HBCLs locally, by completing a WAST Non-Stock Requisition.

7.15 Operational AP bags containing TTH medicines must be stored securely on ambulance stations when not in use, to prevent unauthorised access to their contents (e.g. antimicrobials etc,)

8. STORAGE AND SECURITY OF AMBULANCE MEDICINES

8.1 Ambulance medicines must only be stored in the original packaging in which they are supplied and must not be decanted or stored in any other container. Drug cases stored on Trust emergency ambulances must be secured in the designated cupboard space. This will ensure they are out of immediate sight of the public and reduce the potential for opportunistic theft, particularly in circumstances where the vehicle may be left unattended.

8.2 Drug cases stored on rapid response vehicles and in paramedic officer lease cars, must be stored in the rear hatch/boot compartment, out of immediate view. Unattended vehicles at the scene of incidents should wherever practicable be locked.

> **Good Practice**
> Medicines (excluding CDs), should only be stored within the vehicle drug case and primary response bag (see appendix 1). Additional stocks must not be decanted into defibrillator pouches, or personal kit bags.

8.3 There will be a limited requirement for fully equipped drug cases to be stored at ambulance stations or other locations. However, where this facility is required either temporarily or permanently, drug cases must be stored in a lockable cupboard, within the confines of a locked room.

8.4 To support operational clinical requirements, the following medicine presentations may be available from the secure ambulance station store:

- Sodium chloride 0.9% for IV injection/infusion (10ml flush and 500ml bags)
- Dextrose 10% WV for IV or IO infusion 500ml
- Tenecteplase injection – strategic WAST station locations including; Brecon, Llandrindod, Newtown, Welshpool Omnicells, and dedicated safes in Aberaeron and Dolgellau.

8.5 **Trust Issued DuoDote (Nerve Agent Antidote Kits)**
All Trust EMS vehicles are equipped with a special pouch for use in the event of a major incident. The pouches contains action cards, triage bands and 4 DuoDote (Nerve Agent Antidote Kits) these kits are in the form of an auto injector and contain:
2.1 mg of Atropine/600 mg Pralidoxime Chloride. The kits are stored in the door compartments of EAs, glove compartments of solo responders, responding officer vehicles and carried in large quantities on our resilience fleet.

9. PREPARATION AND ADMINISTRATION OF MEDICINES

9.1 When preparing medicines for administration, it is important to ensure appropriate measures are followed. To avoid the risk of medication errors, the Trust fully endorses the '6 Rights of Drug Administration

- Right person
- Right drug
- Right dose
- Right time
- Right route
- Right documentation

9.2 To minimise the risk of a medication error, parenteral (injectable) medicines should only be prepared by those qualified to administer them. Delegating responsibility for the preparation and administration of drugs to clinicians not qualified to administer them is not acceptable as it increases the risk of error and avoidable harm to patients.

9.3 Student paramedics are not permitted to prepare or administer any medicines, when on clinical placement. Delegation of these tasks even when supervised is not permitted.

10. RECORDING OF MEDICINES ADMINISTERED BY AMBULANCE CLINICIANS

10.1 All medicines administered by WAST ambulance clinicians, must be recorded in the Drugs section of the ePCR. The following information should be recorded:

- Time of administration (or supply - advanced practitioners)
- Name of drug/strength/presentation
- Dose(s) administered
- Unit
- Route
- Expiry date/batch number
- Staff ID (Name/PIN) of clinician who administered medicine

Exceptions to administration of an indicated medicine should be recorded in the narrative section of the ePCR

11. ACCIDENTAL MEDICINE ADMINISTRATION ERRORS

11.1 Any inadvertent or inappropriate medicine administration, either by dosage or medicine type, MUST be recorded on the ePCR and reported to the medical team at the receiving hospital during handover of care. The occurrence MUST also be reported immediately

to the ambulance clinician's line manager and recorded on the Trust e-DATIX system, as soon as is practicable (prior to going off duty). The Patient Safety Team will forward all medicines related drug administration error reports to the *Trust* **Head of Medicines Management**, so that a record of errors can be monitored for trends and themes.

12. ADVERSE DRUG REACTIONS

12.1 Adverse reactions or incidents concerning any medicines administered by *Trust* clinicians, must be reported immediately to the receiving hospital clinical team. The incident must also be reported to the clinician's line manager and control, as soon as is practically possible. All adverse reactions must be reported via the *Trust* e-DATIX system, as soon as is practically possible, by the clinician involved.

12.2 The *Trust* Patient Safety Team review all medicines related incidents reported via the e-DATIX system and forward them to the *Trust* **Head of Medicines Management** for review and relevant action. Where necessary, consultation with the *Trust* Pharmacy Advisor will take place to confirm an agreed course of action. The recommendation from this consultation will be communicated to the *Trust* Executive Medical Director/Assistant Medical Director/ Director of Paramedicine. The MHRA "Yellow Card" reporting system will be used to report appropriate incidents. If reported on Yellow Card, this needs to be reported on DATIX.

13. MEDICINES ALERTS, RECALLS AND SHORTAGES

13.1 Medicine hazard warnings and recalls can originate from a number of sources and include the Medicines and Healthcare products Regulatory Agency (MHRA), Committee on Safety of Medicines (CSM), DGH Pharmacies, the Welsh Government (WG), and the Department of Health (DH). Medicines shortages are most commonly reported through the Welsh Government Emergency Mailbox (HPGEmergencyMailbox@wales.nhs.uk)

13.2 Drug/medicines alerts are sent directly to the *Trust* **Executive Medical Director** and other Clinical Managers, via the offices of the Chief Medical Officer for Wales. The *Trust* **Head of Medicines Management** is responsible for reviewing all Drug Alerts, for relevance and impact to *Trust* clinicians. During periods of absence, this role is supported by the *Trust* Pharmacist Advisor. A record of all medicines related alerts received and reviewed, is maintained by the Clinical Administration Team.

13.3 All drug/medicines alerts identified as having direct relevance to *Trust* clinicians will be circulated to relevant staff groups (e.g. Advanced Practitioners), or, Heads of Service, Locality Managers, Regional Clinical Leads, Health Board Clinical Leads etc. Where appropriate, a *Trust* Clinical Notice will be issued via the JRCALC+ app. Copies are also available on the Trust intranet, via ***Clinical Services Directorate*** - ***Clinical Notices.*** An overview of the number and nature of drug/medicines alerts received each month is included in the monthly Medicines Management Assurance Report (MMAR).

13.4 Medicine shortages are routinely communicated through the Welsh Government Emergency Mailbox and *Trust* network of pharmacy suppliers. Where relevant, a Clinical Notice will be issued to inform staff and managers of the shortage and any interim arrangements put in place to mitigate the medicines shortage.

14. DISPOSAL OF UNUSED PREPARATIONS/EXPIRED MEDICINES – NON CDS

14.1 Where medications are prepared but not administered by Trust clinicians, this should be recorded in the WAST ePCR narrative section and the contents of the syringe disposed into the vehicle-based sharps bin containing an absorbent pad.

14.2 Unused prefilled syringes *(PFS);* should be removed from packaging and the liquid contents expelled into an appropriately sized sharps container with an absorbent pad. The empty syringe can then be disposed of into the same container. Uncontaminated PFS packaging (paper/plastic) can be disposed of as domestic waste.

14.3 Unused drug ampoules/vials; all packaging should be removed and the entire ampoule/vial disposed of into an appropriately sized sharps container. Uncontaminated packaging can be disposed of as non-clinical waste.

14.4 Expired drug presentations (as an entire product or pack) may be disposed of using the Pharmacy Return Bins, that are available at most WAST Omnicell sites. At sites where the return bins are not available, expired drug presentations can be disposed of in vehicle sharps bins, or blue lidded medicines waste bins at ambulance station sites. All recyclable packaging must be removed, prior to disposal, as described in 14.2-14.3 (above).

Please refer to the Trust Management of Controlled Drugs Policy (section 16), for specific guidance on the disposal of morphine sulphate. which must be returned to the supplying pharmacy for destruction. A standard operating procedure (SOP) for the witnessed destruction of Ketamine and Midazolam has been developed. The witnessed disposal of these CDs will be limited to senior clinicians that have received appropriate training and are authorised to undertake this activity.

15. DEVELOPMENT OF PATIENT GROUP DIRECTIVES (PGD)

15.1 All master copies of Trust PGDs will be held by the Trust **Head of Medicines Management**. PGDs are required to be reviewed every three-years to ensure they remain up to date and fit for purpose. Reviews will be undertaken by the **Head of Medicines Management**, **Pharmacist Advisor** and at least one Advanced Practitioner. When a justifiable case is made by a practitioner for a specific medicine to enhance their practice, or a change is driven by national guidance, the practitioner will be provided the necessary support to develop a draft version of their PGD. The draft will then be refined by the **Head of Medicines Management,** before being shared with relevant professionals including the *Trust* **Pharmacy Advisor** and **Executive Medical Director**, before final sign-off.

15.2 PGDs will be distributed to the relevant Trust Registrants electronically. They will be required to read and confirm their competency to work within the scope of the PGD by completing an electronic authorisation (via MS Forms). A register of all authorised

registrants and their PGD competencies will be maintained by the Clinical Administration Team. Individual PGD compliance is also recorded on the Electronic Staff Record (ESR) Authorised professionals are also required to retain hard copies of all PGDs for their own records to support their clinical practice.

16. MANAGEMENT OF ADVANCED PRACTITIONER MEDICINES.

16.1 *Trust* Advanced Practitioners (APs) and AP Trainees currently supply and/or administer a range of medicines under the auspices of PGDs. The full list of medicines and their presentations can be found in ***Appendix 3*** of this document.

16.2 The administration and use of the AP medicines identified in ***Appendix 3,*** is restricted to *Trust* APs and AP Trainees only.

16.3 TTH medicines to support local AP teams will be supplied from the relevant DGH pharmacy. The Trust Omnicell system has a dedicated AP drug section which will be made available as and when AP teams establish in Health Board areas. To minimise waste, APs are encouraged to monitor the stock levels held in the Omnicells, and if stock levels appear to be above (or below) those required to support clinical activity, to bring this to the attention of their Health Board Clinical Lead.

16.4 Operational AP bags containing TTH medicines must be stored securely on ambulance stations when not in use, to prevent unauthorised access to their contents (e.g. antimicrobials etc,)

16.5 **Antimicrobial Stewardship**
APs have a limited number of antimicrobials at their disposal. NICE Quality Standard (QS61) advocates that antimicrobials are prescribed (supplied), according to the principles of antimicrobial stewardship. The main principles are that antimicrobials are only supplied when they are needed and not supplied for self-limiting mild infections, such as coughs, colds, sinusitis or sore throats. The Trust antimicrobial PGDs are specific in their application and APs are individually and professionally responsible for ensuring their use of antimicrobials is consistent with the aforementioned principles.

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.

16.7 **Storage of Temperature Sensitive Medicines**
For specific guidance relating to the management of vaccinations, please refer to the Trust Employee Immunisation Policy.

16.8 Trust clinicians responsible for administering vaccinations must ensure that temperature sensitive medicines and other medicinal products are stored in accordance with the patient information leaflet/summary of product characteristics (SPC), available within the packaging of all dispensed medicines in the UK. Electronic versions of these documents are also available via; http://www.medicines.org.uk/emc/

- Medicine fridges must be maintained between +2˚ and +8˚C. A mid-range of +5˚C is considered best practice. Use of an external digital thermometer is recommended.
- The fridge must be lockable OR kept in a locked room, away from unauthorised access.
- Used to store medicines or vaccines only. No foodstuffs.
- Wired into switchless sockets OR the electrical socket is clearly labelled to prevent accidental disconnection.
- Record weekly temperature readings, at the same time of day, using the *Drug Fridge Monitoring Form* (***Appendix 5***), which should be affixed to the front of the fridge. Completed copies should be retained for a period of two years

17. MANAGEMENT OF THROMBOLYTIC AGENTS

17.1 The implementation of fast-track pathways for STEMI patients to receive Primary Percutaneous Coronary Intervention (PPCI), means that for a large population in Wales, the indications and use of prehospital lysis has reduced. In some areas of Southeast and West Wales, thrombolytics are no longer carried on ambulances, due to the relatively short transport times to definitive care. However, prehospital lysis may still be indicated for patients who cannot be transferred to definitive care within six-hours of their suspected STEMI onset.

17.2 In 2020, the Trust moved to a strategic model of thrombolytic deployment (Clinical Notice 35-2020) at eight sites across Wales. A single dose of Tenecteplase and pack of Heparin, are stored at these agreed locations and may be used in consultation with the PPCI centre. Used doses will be replaced on a one for one basis.

17.3 It is the responsibility of the Locality Manager/DOM/SP team, or DGH by local agreement, to ensure that a suitable number of replacement packs of Tenecteplase are maintained or available at the relevant strategic sites.

17.4 If a thrombolytic pack has been prepared and not used or damaged, then this should be reported via the e-DATIX system and the Locality Manager notified.

18. AUDIT OF MEDICINES SUPPLY, STORAGE & ADMINISTRATION

18.1 Audit and record management will be implemented in accordance with the principles of the Royal Pharmaceutical Society's Safe and Secure Handling of Medicines: A Team Approach (2018).

18.2 The Trust Omnicell system provides the Trust the ability to monitor the volumes and frequency of drugs supplied to the organisation and those that are withdrawn for clinical use. Record keeping and invoicing associated with the pharmacy supply of medications to the ambulance service is the responsibility of the appropriate pharmacy. Wherever possible, supplying DGH pharmacies should provide a breakdown of the medicines they supply, which should accompany monthly invoices submitted to the Health Board Area Operations Managers for approval and sign-off. Wherever possible, this should include a breakdown of the volumes of medicines disposed of due to expiry.

18.3 Locality Managers are responsible for ensuring that regular EMS vehicle medicines management audits are undertaken. The *Trust* has developed an online audit tool to

facilitate this, which is listed under Clinical Audit, accessed via the *Application Portal* on the *Trust* intranet. The Operations and Clinical Directorates have also produced a Vehicle Medicines Audits (VMA) process (see appendices 7 & 8), to promote regular monthly audits by localities.

18.4 Localities will be expected to undertake a minimum of one EMS vehicle medicines audit, per locality, per month. Compliance checks of these audits will be monitored and reported via monthly Medicines Management Assurance Reports to the APSG and on a quarterly basis to the Senior Operations Team. Annual summary reports will be presented to the Clinical Directorate business meeting and QUEST (see 6.16 above).

18.5 The *Trust* Health Informatics Department will provide reports on the most commonly used medicines used by WAST clinicians on a request basis.

19. MEDICINES RECONCILIATION (GREEN BAG SCHEME)

19.1 Hospitals in Wales have been operating 'Patient's Own Medications' schemes for some years as patients are expected to take their own medications into hospital with them for use during their stay.

19.2 Guidance issued by the National Institute for Health and Clinical Excellence (NICE) and National Patient Safety Agency further impresses the importance of ensuring patients are admitted with their own medications.

19.3 The Trust has supported the principles of medicines reconciliation for many years and GREEN BAGS, specifically designed to support this, are readily available for this purpose. The use of 'GREEN BAGS' ensures patients medications are easily identifiable on admission and is an accepted standard across Wales. This assists pharmacy professionals in being able to undertake essential medication reviews, which can have significant health benefits for patients.

19.4 Whilst it is important to ensure that wherever possible patients are admitted with their own medicines, for patients residing in nursing or care homes, this may not always be practicable. With the support and agreement of pharmacy professionals locally, some care providers operate a policy where the patients' medications are retained at the residence, but a copy of the Medication Administration Record (MAR) is provided to accompany the patient. To support best practice, the patients name should always be written on the GREEN BAG.

20. COMMUNITY FIRST RESPONDERS (CFRs)

20.1 The Trust trains and operates volunteers to work in the capacity of CFRs. Within the remit of this role, CFRs are permitted to administer oxygen to appropriate patient's oral paracetamol (tablets) and inhaled methoxyflurane for the initial management of pain in trauma. A dedicated team of WAST Officers are responsible for supporting CFRs at a local level and support them to replenish oxygen cylinders, paracetamol and disposable items. Replacement methoxyflurane inhalers will be available from the Trust Omnicell cabinets, via a dedicated (restricted access) drawer.

20.2 The CFR Officers are responsible for ensuring CFRs receive appropriate training and authorisation, and to ensure that their medical gases and medicines are stored safely and securely within Trust approved CFR response bags.

20.3 CFR volunteers are advised that depleted cylinders can be exchanged on a one-for-one basis with EMS operational crews attending the same incident, or, at a local ambulance station, subject to approval of the Locality Manager.

N.B. ***All ambulance clinicians have a professional responsibility to ensure that they are fully conversant with their legal and/or regulatory duties in relation to standards of clinical care and with regard to the supply, storage, and administration of medicines. Further information for paramedics can be found via the Health Professions Council (HCPC) website; www.hcpc-uk.org***

21. 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.

22. EQUALITY

Equality Impact Assessment (EQIA) screening was undertaken and evidenced a neutral impact. The full EQIA document can be accessed by request to the **Head of Medicines Management**.

23. WELSH LANGUAGE IMPACT ASSESSMENT

The Welsh Language Measure (2011) established the principle that the Welsh and English language should be treated on a basis of equality. The duties deriving from the standards mean that the Trust will be required to assess what effect a policy decision would have on the opportunities for persons to use the Welsh language or treating the Welsh language no less favourably than the English language.

24. 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 www.reportnhsfraud.nhs.uk

Where there is any suspicion or an allegation that a loss has been caused by means of deception (by staff or patient) this must be referred to the Trust's Local Counter Fraud Specialist for investigation. The results of any such investigation could lead to internal

disciplinary and/or civil/criminal prosecution proceedings being instigated against the person/persons involved.

25. ENVIRONMENTAL STANDARDS AND IMPACT ASSESSMENT

This policy will put the relevant requirements in place (such as waste management plan, reduction of C02 emissions & reduction of carbon footprint) in order to ensure that the Welsh Ambulance Services NHS 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.

26. TRAINING AND IMPLEMENTATION

26.1 Managers and DOMs will be provided electronic copies of this updated Policy document following its approval and be advised to familiarise themselves with its content.

26.2 Newly Qualified Paramedics and newly transferred staff are provided oversight training of local medicines management arrangements and relevant policies and procedures on entry into the organisation as part of their Induction Training.

27. REFERENCES

- RPS Professional guidance on the safe and secure handling of medicines. Available from: Royal Pharmaceutical Society - safe and secure handling of medicines
- Health Act 2006. Available from: Health Act 2006
- Misuse of Drugs Act 1971. Available from: Misuse of Drugs Act 1971
- Records Management Code of Practice for Health and Social Care, Information Governance Alliance, 2016. Available from: Records Management Code of Practice - NHS Transformation Directorate
- HCPC Standards of Conduct, Performance and Ethics (2018): Standards of conduct, performance and ethics
- Professional Regulation Policy Paramedic Staff (2019) Professional Regulation Policy 100119.pdf
- Standards of Business Conduct Policy (2023) Standards of Business Conduct Policy Final v.3.0
- Disciplinary Policy and Procedure (2017) Disciplinary Version 40 Mar 17.pdf
- WAST Controlled Drugs Policy (2021) WAST Management of CDs Policy (V5.5)
- WAST Employee Immunisation Policy (2015)
- WAST Vehicle Medicines Audit Tool - Medicines Audit Tool

28. APPENDICES

28.1 Appendix 1: WAST Drug Case Contents Laminate

WAST DRUG CASE CONTENTS LAMINATE – WAS/MM01

N.B. this is a dynamic document, which will be updated to reflect changes in drugs used/carried. The most up-to-date version will be available on the WAST intranet site – Directorates-Clinical-Medicines Management

Note: All drugs must be stored in original packaging and within the packs listed below. Drugs must not be decanted into smaller units for storage in any other bags or containers.

PRIMARY RESPONSE BAG

Drug Name	Expiry date	Max No in Case	Min No in Case
Adrenaline 1:1,000	Please affix new expiry sticker here whenever drug is replenished	10 x 1mg	4 x 1mg
Aspirin 300mg	Please affix new expiry sticker here whenever drug is replenished	16 tablets	8 tablets
Glyceryl Trinitrate 400mcg S/L Spray	Please affix new expiry sticker here whenever drug is replenished	1 unit	1 unit
Ipratropium Bromide 250mcg/1ml	Please affix new expiry sticker here whenever drug is replenished	10 nebules	5 nebules
Naloxone 400mcg/1ml	Please affix new expiry sticker here whenever drug is replenished	10 x 400mcg	9 x 400mcg
Salbutamol 2.5mg/2.5ml	Please affix new expiry sticker here whenever drug is replenished	10 nebules	5 nebules
Salbutamol 5mg/2.5ml	Please affix new expiry sticker here whenever drug is replenished	10 nebules	5 nebules

CARDIAC ARREST POUCH

Drug Name	Expiry date	Max No in Case	Min No in Case
Adrenaline 1:10,000	Please affix new expiry sticker here whenever drug is replenished	8 x 1mg	4 x 1mg
Amiodarone 150mg/3ml OR 300mg/10ml	Please affix new expiry sticker here whenever drug is replenished	5 x 150mg OR 2 x 300mg	3 x 150mg OR 2 x 300mg

VEHICLE DRUG CASE

Drug Name	Expiry date	Max No in Case	Min No in Case
Atropine Sulphate 600mcg/1ml OR 1mg/10ml	Please affix new expiry sticker here whenever drug is replenished	10 x 600mcg OR 3 x 1mg	5 x 600mcg OR 3 x 1mg
Benzylpenicillin Pack	Please affix new expiry sticker here whenever drug is replenished	2 x 600mg 1 x Sterile Water 10ml	2 x 600mg 1 x Sterile Water 10ml
Chlorphenamine 4mg	Please affix new expiry sticker here whenever drug is replenished	28 tablets	8 tablets
Co-amoxiclav 1000mg/200mg injection	Please affix new expiry sticker here whenever drug is replenished	2 vials	1 vial
Dexamethasone 2mg Supplied as 3 tablet or 50 tablet pack	Please affix new expiry sticker here whenever drug is replenished	1 x pack	1 x pack
Diazepam solution 10mg/2ml	Please affix new expiry sticker here whenever drug is replenished	10 x 10mg	4 x 10mg
Diazepam Rectal 5mg	Please affix new expiry sticker here whenever drug is replenished	2 tubes	2 tubes
Diazepam Rectal 10mg	Please affix new expiry sticker here whenever drug is replenished	2 tubes	2 tubes
Furosemide 20mg/2ml OR Furosemide 50mg/5ml	Please affix new expiry sticker here whenever drug is replenished	10 x 50mg 10 x 20mg	5 x 50mg 5 x 20mg
Glucagon 1mg/1ml	Please affix new expiry sticker here whenever drug is replenished	2 x 1mg	1 x 1mg
Glucose 40% gel	Please affix new expiry sticker here whenever drug is replenished	3 x 25g tubes	3 x 25g tubes
Hydrocortisone sodium phosphate 100mg/1ml OR Hydrocortisone sodium succinate 100mg/1ml	Please affix new expiry sticker here whenever drug is replenished	5 x 100mg amps 2 x 100mg vials	4 x 100mg amps 2 x 100mg vials
Ibuprofen 200mg	Please affix new expiry sticker here whenever drug is replenished	24 x tablets	4 x tablets
Ipratropium Bromide 250mcg/1ml	Please affix new expiry sticker here whenever drug is replenished	10 x nebules	5 nebules
Magnesium Sulfate 20% solution 200mg/ml	Please affix new expiry sticker here whenever drug is replenished	10 amps	4 amps
Methoxyflurane Inhaler	Please affix new expiry sticker here whenever drug is replenished	2 Inhalers	1 Inhaler
Misoprostol 200mcg Supplied as 4 tablet or 56 tablet pack	Please affix new expiry sticker here whenever drug is replenished	1 x pack	1 x pack
Ondansetron 4mg/2ml	Please affix new expiry sticker here whenever drug is replenished	10 x 4mg	4 x 4mg
Paracetamol 500mg tablets	Please affix new expiry sticker here whenever drug is replenished	32 x 500mg	4 x 500mg

Paracetamol 120mg/5ml sachets	Please affix new expiry sticker here whenever drug is replenished	20 x 120mg/5ml	4 x 120mg/5ml
Paracetamol 1g/100ml Intravenous solution	Please affix new expiry sticker here whenever drug is replenished	**2 x 1g/100ml STORED IN IV DRAW**	**1 x 1g/100ml STORED IN IV DRAW**
Salbutamol 2.5mg/2.5ml	Please affix new expiry sticker here whenever drug is replenished	10 nebules	6 nebules
Salbutamol 5mg/2.5ml	Please affix new expiry sticker here whenever drug is replenished	10 nebules	6 nebules
Sodium Chloride 0.9%	Please affix new expiry sticker here whenever drug is replenished	10 x 10ml	5 x 10ml
Sterile Water for Injection 10ml	Please affix new expiry sticker here whenever drug is replenished	10 x 10ml	5 x 5ml
Tranexamic Acid 100mg/1ml	Please affix new expiry sticker here whenever drug is replenished	10 x 5ml	5 x 5ml

Note to paramedics and EMT's: Please ensure that the stock levels of the case are maintained at or above the minimum levels specified above. Each time a drug is replenished, peel off the old **ORANGE** expiry sticker on the relevant row and affix a new sticker, indicating the earliest expiry date of the replenished drug. Alternatively, a *Chinagraph* pencil or similar can be used.

'JUST IN CASE' DRUGS

Drug Name	Expiry date	Max No in Case	Min No in Case
Midazolam 10mg/2ml	Please affix new expiry sticker here whenever drug is replenished	10 amps	2 amps
Haloperidol 5mg/ml	Please affix new expiry sticker here whenever drug is replenished	10 amps	2 amps
Hyoscine Hydrobromide 400mcg/ml	Please affix new expiry sticker here whenever drug is replenished	10 amps	2 amps
Levomepromazine hydrochloride 25mg/ml	Please affix new expiry sticker here whenever drug is replenished	10 amps	2 amps

28.2 Appendix 2: Omnicell Cabinet Manual Drugs Withdrawal Book

Welsh Ambulance Service NHS Trust

Omnicell Cabinet Manual Drugs Withdrawal Book

For the recording of all drug withdrawals from the Omnicell when manual emergency override procedures are required

Date	Name of POM	Number of Units Withdrawn	Destination (Vehicle Call Sign / Station)	Batch No.	Expiry Date	Withdrawn By	
						Signature	PIN

28.3 Appendix 3: WAST Patient Group Direction Formulary

"Advanced Practice" PGDs (WAST Advanced Practitioners)

DRUG	PRESENTATION	CLINICAL SITUATION
Amoxicillin	500 mg capsules 250 mg capsules 250 mg/5ml suspension 125 mg/5ml suspension	Use in adults and children where anti-bacterial treatment is required for upper or lower respiratory tract infection.
Cetirizine	10 mg tablets 1 mg/ml solution	Treatment of seasonal allergic reactions
Co-amoxiclav	500/125 tablets	Infections caused by beta lactamase producing strains of bacteria, especially in human and animal bites, and cellulitis. Upper UTI
Codeine Phosphate	30mg tablets	Moderate pain
Clarithromycin	250 mg tablets 125 mg/5ml suspension	Use in adults and children over 1 year of age where anti-bacterial treatment is required for upper and lower respiratory tract infection and mild to moderate soft tissue infections, where Penicillin hypersensitivity is suspected or present.
Diazepam	2mg tablets	As an adjunctive treatment to Paracetamol, and/or non steroidal anti-inflammatory drugs (NSAID's) in the management of spasmodic, uncomplicated lower back pain (LBP).
Doxycycline	100 mg capsules	For the treatment of acute infective exacerbation of COPD, either as first line treatment or if allergic to penicillin based antimicrobials.
Flucloxacillin	500 mg capsules 250 mg capsules 250 mg/5ml suspension 125 mg/5ml suspension	Skin infections
Ibuprofen	200 mg coated tablet	In adults and children over 12 years to reduce pain and inflammation in a number of disorders.
Loperamide	2 mg capsules	Uncomplicated acute diarrhoea in adults and children over 12 years of age.
Nitrofurantoin	100 mg MR capsules or 50 mg capsules/tablets	For the treatment of acute lower urinary tract infection in adults over the age of 16 years.
Oral salts	6 gram sachet for reconstitution with 200 mL of water.	Oral fluid replacement in adults and children as a consequence of acute diarrhoea and/or vomiting.
Paracetamol	500 mg tablets 120 mg/5 ml suspension 250 mg/5 ml suspension	Mild to moderate pain and or for reduction of pyrexia in adults and children over 12 years.
Penicillin 'V'	250 mg tablets. 250 mg/5mL suspension 125 mg/5mL suspension	Use in adults and children in upper respiratory tract infection (URTI) where streptococcal tonsillitis/pharyngitis is suspected
Prednisolone	5 mg tablet	To reduce the inflammatory and allergic response in moderate and severe asthma attacks. It is given in combination with other initial treatment.
Prochlorperazine	3 mg buccal tablet	The symptomatic treatment of vertigo or severe nausea, vomiting and labyrinthine disorders in adults and children >12 years.
Sabutamol MDI	100 microgram metered dose inhaler (MDI)	The immediate treatment of acute asthma, COPD exacerbations, continuation of current asthma treatment
Trimethoprim	100 mg tablet 50 mg/5 mL suspension.	Suspected lower urinary tract infection in adults and children

28.4 Appendix 4: Additional Miscellaneous PGDs

'PARAMEDIC PGDs'

DRUG	PRESENTATION	CLINICAL SITUATION	STAFF GROUP
Co-amoxiclav injection	1000mg/200mg powder for solution for injection	Phrophylactic treatment of open fracture within 1-hour of injury	HCPC Registered WAST Paramedics
Diazepam injection	1mg/ml solution for injection	Management of convulsions, symptomatic cocaine toxicity	HCPC Registered WAST Paramedics
Tranexamic Acid	500 mg in 5 ml injection	Treatment of TIME CRITICAL traumatic haemorrhage	HCPC Registered WAST Paramedics

'SENIOR PARAMEDIC/CHARU PGDs'

DRUG	PRESENTATION	CLINICAL SITUATION	STAFF GROUP
Ketamine injection	Ketamine hydrochloride 10 mg/ml Supplied as 200 mg in 20 ml vial	Treatment of moderate to severe pain and to facilitate management and movement of patients.	Authorised HCPC Registered WAST Paramedics
Midazolam injection	Midazolam 1mg/ml, supplied as 5 ml ampoule (5 mg)	Management of agitation or emergence phenomenon related to ketamine administration.	Authorised HCPC Registered WAST Paramedics
Flumazenil injection	500 micrograms in 5 ml ampoules	For the complete or partial reversal of the central sedative effects of Midazolam, in order to restore spontaneous respiration	Authorised HCPC Registered WAST Paramedics

'OCCUPATIONAL HEALTH PGDs'

DRUG	PRESENTATION	CLINICAL SITUATION	STAFF GROUP
Inactivated Influenza Vaccine	0.5 ml suspension for intramuscular injection in a pre-filled syringe	Protection against seasonal influenza infection	Registered Healthcare Professionals (OH) and Peer Vaccinators.
MMR Vaccine	Priorix: 0.5 ml MMRVaxPRO®: 0.5 ml	Adults (18 years of age and above), requiring immunisation against measles, mumps or rubella	Registered Healthcare Professionals (OH
Hepatitis B Vaccine	Engerix B® (20 mcg/1ml) Fendrix®: (20 mcg/0.5ml)	Pre-exposure immunisation for Adult (18 years and above) individuals who are at increased risk of hepatitis B because of their occupation Immediate post-exposure immunisation to prevent infection, following significant exposure incidents	Registered Healthcare Professionals (OH
Bacillus Calmette-Geurin (BCG) Vaccine (OH)	BCG vaccine AJV, Mycobacterium bovis BCG (Bacillus Calmette-Guérin), to be diluted with one 1ml of diluted Sauton AJV.	Indicated for Welsh Ambulance Service NHS Trust and Public Health Wales (PHW) staff at increased risk of exposure to tuberculosis (TB)	Registered Healthcare Professionals (OH)

		infection and developing disease.	
Typhoid	Typhoid Vi polysaccharide vaccine, 0.5ml dose containing 25 micrograms Vi polysaccharide of S. typhi (Ty2 strain): -TYPHIM Vi® vaccine solution for injection in a pre-filled syringe	Laboratory staff employed by Public Health Wales Screening Services, aged over 18 years, for whom Welsh Ambulance Service Trust are the Occupational Health providers, who may handle S.typhi in the course of their work and have not received a dose in the preceding 3 years	Registered Healthcare Professionals (OH)
Varicella	VARIVAX® powder and solvent for suspension for injection in a pre-filled syringe. Live attenuated (oka/Merck strain) Varilrix® plaque forming unit/0.5ml, powder and solvent for solution for injection. Live attenuated (oka strain)	Pre-exposure immunisation for Adults at increased risk of occupational exposure to varicella zoster (VZ) virus and to prevent cross infection / transmission of VZ virus to those who are non-immune.	Registered Healthcare Professionals (OH)
Diptheria-Tetanus-Petussis-Polio (dTaPIPV)	Boostrix® -IPV, suspension for injection in pre-filled syringe (reduced antigen content), dTaP/IPV Repevax® , suspension for injection in pre-filled syringe (reduced antigen content), dTaP/IPV	Indicated for the immunisation of Adult Healthcare Workers employed by WAST that could come into contact with pregnant women and young infants during the course of their work.	Registered Healthcare Professionals (OH)
Diptheria-Tetanus-Polio (TdIPV)	Adsorbed diphtheria (low dose), tetanus, and inactivated poliomyelitis vaccine (Td/IPV): • Revaxis®, suspension for injection in a pre-filled syringe.	Pre-exposure immunisation for Adults at increased risk of diphtheria, tetanus and poliomyelitis through occupational exposure.	Registered Healthcare Professionals (OH)

28.5 Appendix 5 – Temperature Monitoring Form - Refrigerated Medicines

	1st	2nd	3rd	4th	5th	6th	7th	8th	9th	10th	11th	12th	13th	14th	15th	16th	17th	18th	19th	20th	21st	22nd	23rd	24th	25th	26th	27th	28th	29th	30th	31st
12˚																															
11˚																															
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6˚																															
5˚																															
4˚																															
3˚																															
2˚																															
1˚												**ACT QUICKLY!**																			
0˚																															
-1˚																															
-2˚																															
-3˚																															
Initials																															
T-stat setting																															

Observe the four Rs: **Read** **Record** **Reset** **React**

MONTH:_____

Make sure the person making the recording:

- Does it the same day and time every week and signs the form
- ACTS if the temperature falls outside +2˚ to +8˚C
- Resets the thermometer after each reading.
- **Retains completed copies of this form for a period of two-years**

28.6 Appendix 6: WAST Medicines Summary Checklist Approved Clinicians

WAST Medicines Summary Checklist Approved Clinicians

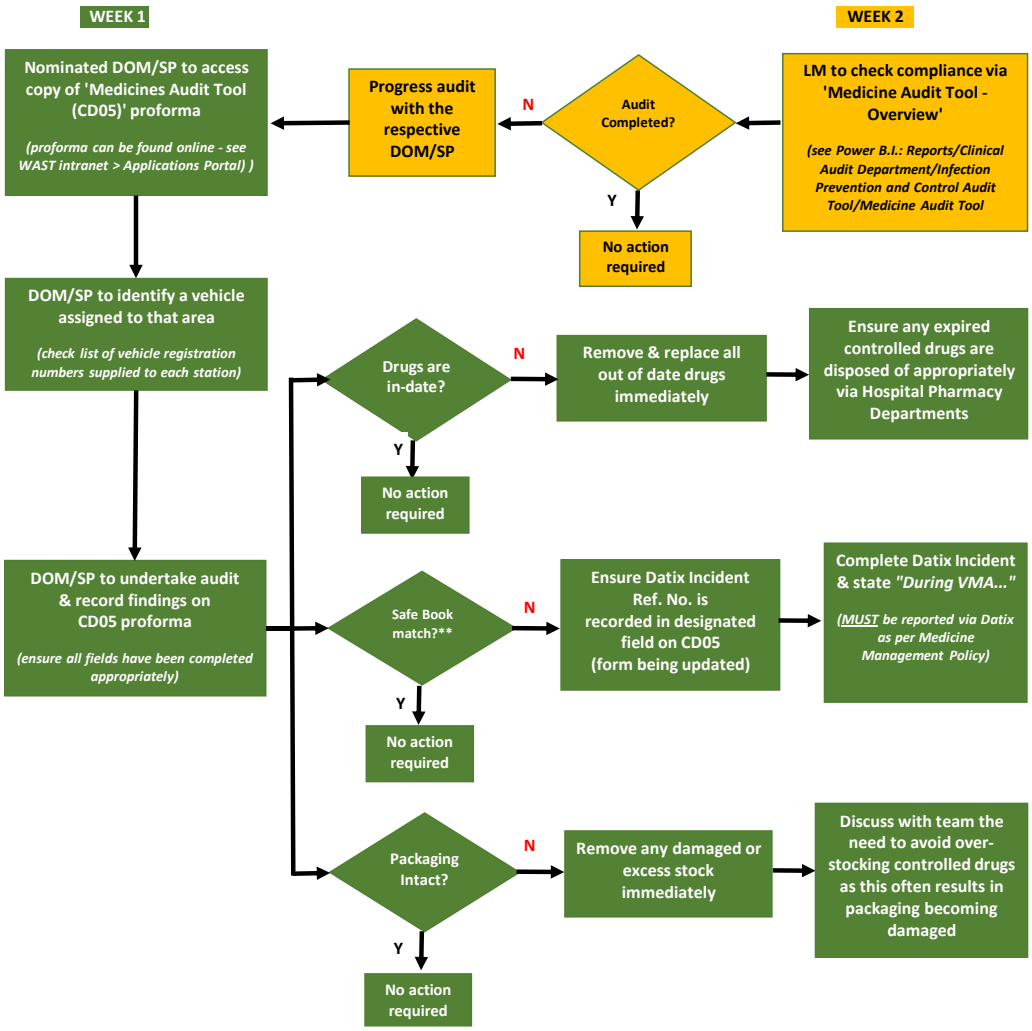
Medicine	UCS/CFRs	EMTs	Paramedics
Adrenaline 1:10,000			YES
Adrenaline 1:1,000		YES (for anaphylaxis only)	YES
Amiodarone 300mg/10ml OR 150mg/3ml			YES
Aspirin 300mg		YES	YES
Atropine Sulphate 600mcg/1ml OR 1mg/10ml			YES
Benzylpenicillin Pack			YES
Chlorphenamine 4mg			YES
Co-amoxiclav 1200mg			YES
Dexamethasone 2mg tablets		EMT3 only	YES
Diazepam 10mg/2ml			YES
Diazepam Rectal 5mg			YES
Diazepam Rectal 10mg			YES
Furosemide 50mg/5ml			YES
Glucagon 1mg/1ml		YES	YES
Glucose 10% infusion			YES
Glucose 40% gel		YES	YES
Glyceryl Trinitrate 400mcg S/L Spray		EMT3 only	YES
Heparin 5,000 units per ml			YES
Hydrocortisone 100mg/1ml		YES (all JRCALC indications)	YES
Ibuprofen 200mg tablets			YES
Ipratropium Bromide 250mcg/1ml		YES	YES

Medicine	UCS/CFRs	EMTs	Paramedics
Methoxyflurane Inhaler	YES	YES	YES
Misoprostol 200mcg tablets			YES
Morphine Sulfate			YES
Naloxone 400mcg/1ml		YES	YES
Nitrous Oxide (Entonox)	UCS only	YES	YES
Ondansetron 4mg/2ml			YES
Oxygen	YES	YES	YES
Paracetamol 500mg tablets	YES	YES	YES
Paracetamol 120mg/5ml sachets		YES	YES
Paracetamol 1g/100ml IV solution			YES
Salbutamol 2.5mg/2.5ml		YES	YES
Salbutamol 5mg/2.5ml		YES	YES
Sodium Chloride 0.9%			YES
Tenecteplase 10,000 units or 8,000 units for reconstitution with WFI			YES
Tranexamic Acid 500mg in 5ml			YES

Appendix 7: Vehicle Medicines Audit (VMA) LOCAL PROCESS

(MONTHLY) VEHICLE MEDICINE AUDIT - LOCAL PROCESS

Requirement: Audit of controlled drugs on x1 vehicle per locality area each month



*** Safe Book Details to be checked:**
- **Vehicle Registration Number**
- **Locality**
- **No. of ampules in CD safe**
- **No. of ampules recorded in Safe Book (CD02)**

NB: As outlined within the Medicine Management Policy, any drug discrepancy identified (whether via monthly audit or daily checks) MUST be reported as an incident via Datix

Escalation Timeframe:

Week 1 - Nominated DOM/SP to undertake audit or delegate within the team as appropriate

Week 2 - LM to check that audits have been completed & if outstanding discuss with respective DOM/SP responsible for that area

Week 3 - Business Support Officer to check compliance & progress any outstanding audits via respective LM (cc: SM who will seek assurance)

Week 4 - HoS EMS made aware of all outstanding audits so that these

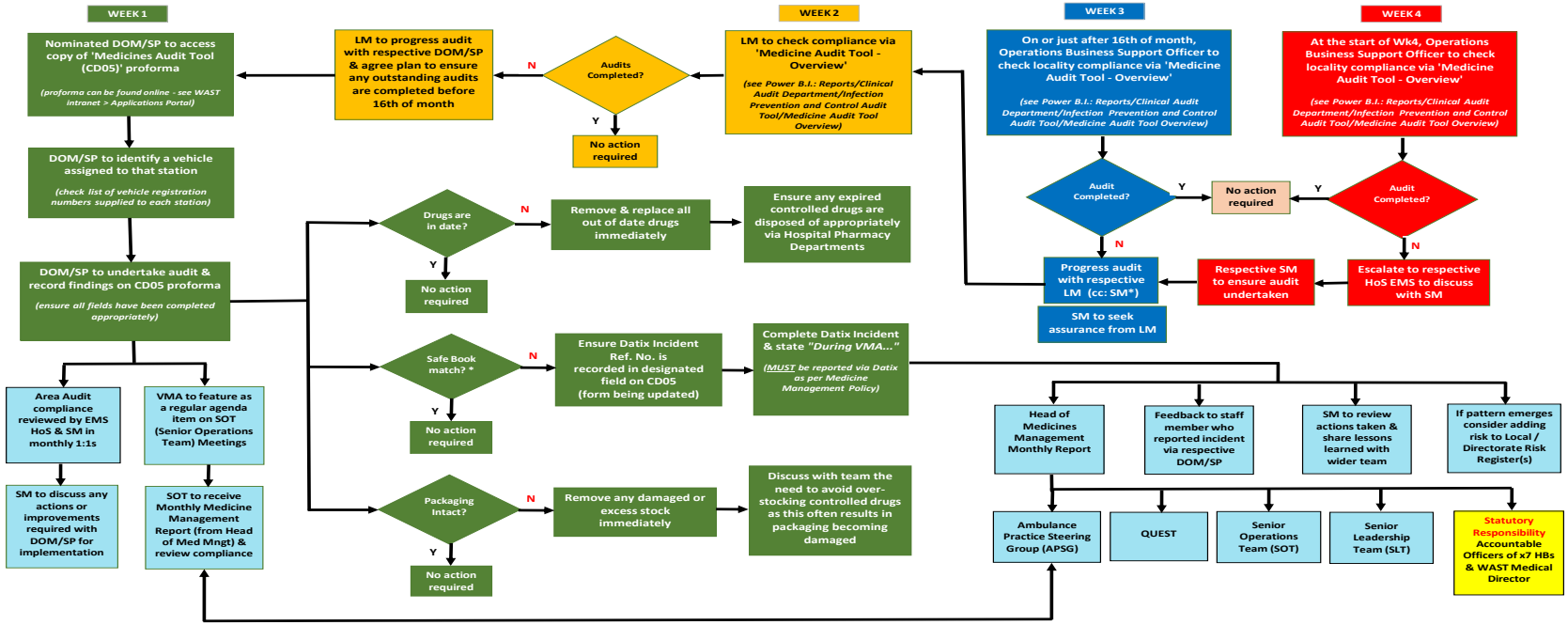
Lisa Trounce (Business Manager) ~ VMA - Local Process V2.0 (Updated 07.09.2023)

Appendix 8: Vehicle Medicines Audit (VMA) COMPLETE PROCESS

Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services NHS Trust

(MONTHLY) VEHICLE MEDICINE AUDIT - COMPLETE PROCESS

Requirement: Audit of controlled drugs on x1 vehicle per locality each month



*** Safe Book Details to be checked:**
- Vehicle Registration Number
- Locality
- No. of ampules in CD safe
- No. of ampules recorded in Safe Book (CD02)

NB: as outlined within the Medicine Management Policy, any drug discrepancy identified (whether via monthly audit or daily checks) **MUST** be reported as a Datix incident

Escalation Timeframe:

Week 1 - Nominated DOM/SP to undertake audit or delegate within the team as appropriate

Week 2 - LM to check that audits have been completed & if outstanding discuss with respective DOM/SP responsible for that area

Week 3 - Business Support Officer to check compliance & progress any outstanding audits via respective LM (cc: SM who will seek assurance)

Week 4 - HoS EMS made aware of all outstanding audits so that these can be progressed via respective SM

Lisa Trounce (Business Manager) ~ VMA - Complete Process (v2.0) 07.09.2023

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

Infection Prevention and Control: Sharps Policy - Safe Use and Disposal

Policy Number:	096	**Version No:**	2.0	**Supersedes:**	1.3 (published in December 2020)
Date of Approval:	20/08/2024	**Review Date:**	20/08/2027	**Impact Assessments Completed:**	Yes
Classification of Document:	Clinical	**Type of Document:**	Policy	**Approved by:**	Policy Group
Brief Summary of Document:	Sharps are responsible for a significant number of injuries to staff each year. Safe use of sharps will help to reduce the risk of injury and the acquisition of blood-borne viruses by both staff and patients. This policy is to provide clear instruction on the safe use and disposal of sharps when staff are performing duties for the trust.				
Scope:	This policy covers infection prevention and control management issues for all Trust staff this includes: Employees, Volunteers, Agency/Locum/Bank Staff and Contractors whilst working on the Trust premises				
To be read in conjunction with:	• SOP Occupational Exposure to Blood or Body Fluids • The Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 No.645 • Safe-Clean-Care---Version-1.1---20.10.2023---LNRR-v2 • Datix Link				
Owning Committee	Quality, Patient Experience and Safety Committee				
Policy Lead: **Trade Union Lead:**	Louise Colson Mark Marsden	**Job Title:**	Head of Infection Prevention and Control Trade Union Partner		
Executive Director:	Liam Williams	**Job Title:**	Executive Director of Quality and Nursing		

Version Control Sheet

Version	Date	Author	Summary of Changes
1.0	02/07/2020	Louise Colson	New Policy
1.1	27/07/2020	Julie Boalch	Minor formatting amendments
1.2	22/09/2020	Louise Colson	Amendments following Consultation Period and comments received
1.3	22/09/2020	Julie Boalch	Minor formatting changes
1.3	29/09/2020	Louise Colson	Amendments made from follow up Policy Group meeting following consultation
1.4	08/08/2024	Louise Colson	3 Year Policy Review
1.5	09/08/2024	Lisa Trounce	Presentation of front cover and body of policy updated to align with 2024 template Information on front cover updated & reformatted Version Control Sheet updated Header & Footer added Key words added Contents Page updated
1.6	13/08/2024	Louise Colson	Meeting with Mark Marsden TU partner. Happy with the Policy, no changes required. Version updated now 1.6
1.7	13/08/2024	Lisa Trounce	Minor formatting in readiness for Policy Group 20/08/2024
1.8	20/08/2024	Lisa Trounce	Formatting of policy approved by Policy Group 20/08/2024 in readiness for ELT
2.0	20/08/2024	Lisa Trounce	Front cover and Version Control Sheet updated to reflect updated policy approved by Policy Group on 20/08/2024, prior to publication.
Keywords	Infection, Control. Prevention, Sharps, Disposal, Needlestick		

Impact Assessment Reviews

Area	Date of Review	Name of Reviewer
Counter Fraud	30th July 2020	Lynne Haddow
Information Governance		N/A
Records Management		N/A
EqIA / Welsh Language	8th August 2024	Kathryn Cobley
Estates		N/A
Environment		N/A

Policy Approval Route

Where	When	Why
Policy Group	20/08/2024	Approved for 3 years
ELT	28/08/2024	Noting Policy Approval
QuEST	05/11/2024	Ratification of Policy

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

Contents

1. INTRODUCTION

In order to avoid occupational exposure to potentially infectious agents, particularly those microorganisms that may be found in blood and other body fluids, precautions are essential while providing care. It must always be assumed that every person encountered could be carrying potentially harmful microorganisms that might be transmitted and cause harm to others. Therefore, precautions to prevent exposure to these and subsequent harm in others receiving or providing care must be taken as standard.

Occupational exposure management, including sharps injury is one of the nine elements of Standard Infection Control Precautions (SICP's) (Safe Clean Care Guidance Oct 2023) which should be applied in all healthcare settings.

Sharps are responsible for a number of injuries to staff each year. Safe use of sharps will help to reduce the risk of injury and the acquisition of blood-borne viruses by both staff and patients. For the purpose of this policy the term "sharps" includes items such as needles, scalpels, razor blades, broken glass and any other sharp items that may cause a penetrating injury, laceration or puncture to the skin.

The Sharps Regulations follow the principles of the hierarchy of preventative control measures, set out in the Control of Substances Hazardous to Health Regulations (COSHH). However, they require that employers consider additional risk control measures to avoid the unnecessary use of sharps. (The Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

Needles, scalpels etc. will remain essential tools for effective medical care. However, the employer should ensure that sharps are only used where they are required. Needle-free equipment is available for certain procedures and should be used, where it is reasonably practicable to do so.

The employer must substitute traditional, unprotected medical sharps with a 'safer sharp' where it reasonably practicable to do so. The term 'safer sharp' means medical sharps that incorporate features or mechanisms to prevent or minimise the risk of accidental injury. For example, a range of syringes and needles are now available with a shield or cover that slides or pivots to cover the needle after use.

The following factors should be considered:

- The device must not compromise patient care
- The reliability of the device
- The caregiver should be able to maintain appropriate control over the procedure
- That use of the device may introduce ease of use (taking into account the existing clinical practices commonly in use by the relevant health professionals – but not assuming custom and practice is safest).

2. POLICY STATEMENT

This policy is to provide clear instruction on the safe use and disposal of sharps when staff are performing duties for the trust.

The trust has a commitment to minimise the number of occupational accidents and subsequent incidents of ill health and that reducing the number of sharps related incidents is part of this commitment.

Each individual member of staff, volunteer or contracted worker within the Trust is responsible for complying with the information set out in the Policy. They need to be aware of their personal responsibilities in safe use and disposal of sharps. It is the responsibility of Directors and Managers to ensure compliance with this standard.

3. SCOPE

Any healthcare professional or support worker who in the course of their day-to-day duties are exposed to the risk of sustaining a sharps injury.

This overarching document applies to all directly and indirectly employed staff within Trust and other persons working within the organisation, in line with the WAST Equal Opportunities Document. This Policy covers any Independent Contractors working within the trust and its contents included in any forms of induction or training to ensuring compliance with the Trust's IPC standards in line with the All Wales Code of Practice. The document should be read in-conjunction with the advised guidelines, policies and procedures.

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

The application of the policy will vary according to the working environment of the member of staff. However this and the Infection prevention & Control policy should form a part of everyone's daily practice and all need to be aware of its implications for their work space.

3.1 Acknowledgements/ Limitations of Policy

The employer and individual members of staff are ethically responsible and legally liable for any preventable infection that is negligently transmitted by employees as a result of poor sharps practice and disposal within all areas of the estates.

It is the responsibility of the organisation to provide to employees appropriate and effective sharps related advice, guidance and support. However, there are limitations on the scope of control of this policy outside of this organisation. The out of hospital environment is unpredictable and there may be poor examples of sharps usage and disposal in unexpected areas that staff may attend and treat patients.

4. AIM

The aim of the policy will be to reduce the number of sharps related incidents as far as reasonably practicable on a year-by-year basis. It is also to ensure that the environment that our staff may attend and treat patients are compatible with the use and safe disposal of sharps devices. In addition to this reduce the cost to individuals, the trust and society from sharps related incidents.

5. WORKING IN PARTNERSHIP

The Trust will work in partnership with Trade Union Health & Safety Representatives and adopts the Regulations, Code of Practice and guidance relating to the Safety Representatives and Safety Committee Regulations 1977 (TUC 2015). This includes arrangements for:

- Consultation
- Functions of Safety Representatives
- Safety Inspections by Safety Representatives
- Provision of information for Safety Representatives

The following trade unions and professional organisations are recognised in the Welsh Services NHS Trust to appoint Trade Union Health & Safety Representatives:

- GMB
- UNITE
- UNISON
- RCN

6. OBJECTIVES

The objective of this policy is to facilitate compliance with legislation and regulations that govern infection prevention and control (IPC) and the regulation of Sharps under the Health and Safety at work Act (1974).

This policy will also minimise the risk to staff, patients, public, contracted staff and their agents from exposure to infection and transmissible pathogens in the event of a sharps related injury. This policy is also to assist managers and staff at all levels in the trust to understand their commitment to and responsibilities for the effective management of sharps.

7. DEFINITIONS

The Trust	Welsh Ambulance Services University NHS Trust
Staff	All employees of the Trust including those managed by a third party organisations on behalf of the Trust ,this would also include voluntary workers and community first responders

Sharps	A sharp is any item having corners, edges, or projections capable of cutting or piercing the skin. Includes syringes, needles, scalpels, administration sets, razor blades, broken bone and teeth or any other sharp implement with the potential to cause a penetrating injury if not handled in a safe manner.
High risk bodily fluids	Blood, amniotic fluid, vaginal secretions, semen, human breast fluids (milk), cerebrospinal fluid, peritoneal fluid, pleural fluid, synovial fluid, pericardial fluid, saliva in association with dentistry, unfixed tissues and organs, any other body fluid if visibly blood-stained, exudative or other tissue fluid from burns or other lesions.

This list is not exhaustive and judgements should be made in each specific setting the appropriate use and disposal of sharps.

8. GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

Effective governance, leadership and accountability in keeping with the size and complexity of the ambulance service are essential for the sustainable delivery of safe, effective person-centred care.

The objectives of this policy will be achieved through adherence to the accompanying documents and guidance that accompanies this policy, in conjunction with effective management, education and training.

Governance will be met by via an audit process, the monitoring of incidents, RIDDOR reporting and the trust's quarterly highlight reports.

9. RECORDS MANAGEMENT

The Trust 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.

10. IMPLEMENTATION OF THE POLICY AND BEST PRACTICE

The Organisation will implement this policy and actively promote the safe use and disposal of sharps. Best practice for the safe handling and disposal of sharps includes the following advice:

- Avoid sharps usage wherever possible.
- Carry sharps in suitable sharp safe containers, resource bags or other transport carriers suitable to the out of hospital environment to the point of use.
- Discard sharps into a sharps box immediately after treatment.

- To achieve safe and cost-effective sharps disposal adhere to the appropriate sharps segregation of medicinal, non-medicinal and cytotoxic or cytostatic.
- Sharps bins with relevant coloured coded lids must be available if they are applicable to the out of hospital environment and trust estates.
- Sharps must not be passed directly from person to person. Handling must be kept to a minimum.
- Never leave sharps lying around used or unused.
- Used needles must not be re-sheathed unless there is a safe method available for doing so.
- Needles must not be re-sheathed by hand.
- Never carry sharps in the hand or in the pocket.
- Never put hands into sharps containers.
- A risk assessment must be made regarding the need for personal protective equipment.

11. DISPOSAL OF SHARPS

- The person using the sharp has a personal responsibility to ensure that the sharp is disposed of safely, as soon as possible after use.
- Always dispose of sharps at the point of use in an approved sharps box.
- Where the specific clinical procedure prevents the user from doing this, the user still retains overall responsibility for the safe disposal of the sharp.
- An approved sharps box must be immediately to hand when clinical procedures are being performed.
- Syringes, cartridges and needles should be disposed of intact as a single unit whenever possible.
- Do not carry exposed used needles or sharps to a distant disposal point.
- If a sharp has been accidentally dropped, it must be retrieved and disposed of properly. If unable to retrieve the dropped sharp warn others so that care may be taken.
- Drug ampoules, razors, disposable scissors and IV cannulae must be discarded into a sharps box.
- Intravenous used fluid sets will be disposed of in orange sacks, the timing of which can be determined by the nature of the call attended. The sets can either be disposed of individually in clinical waste bins lined with an orange bag, in the clinical waste bin on vehicles or with other used consumables.
- The spike introducer of the fluid line should be safely removed and disposed of in the designated sharps box on vehicles.
- The trust do not use 30 litre sharps bins within vehicles due to the limitations of space therefore alternative safe disposal of the sharps within the intravenous giving sets may be disposed of separately to the lines themselves.
- Ensure any sharps receptacles used that are not disposable is decontaminated after each use.

11.1 Sharps Boxes

- Sharps containers must conform to BS 7320 (NICE 2020) and placed safely out of reach of children. They must be kept in a location which prevents injury to patients, visitors and staff.

- Sharps disposal segregation colour coding: Yellow lids for sharps with Medicinal contamination (non-Cytotoxin) Orange lids for sharps without Medicinal contamination Purple lids for sharps contaminated with Cytotoxic or Cytostatic products.
- Ensure sharps containers are securely assembled and labelled correctly as follows;
  - Trust
  - Locality
  - Assembled By
  - Date Assembled
  - Date Locked
  - Disposed By
- Sharps containers must be wall mounted at a safe height above floor level. The optimum height to allow safe use of the container is between 45 and 48 inches. If space is limited and this level is not achievable the area will need an individual risk assessment, this can be done with support from the Health, Safety and Risk team or the Infection Prevention & Control team.
- The Locality Managers are responsible for ensuring safe handling and disposal of sharps and sharps boxes within their own area.
- Do not fill sharps containers above the manufacturers' marked line.
- Sharps containers must be closed securely when the marked line has been reached and disposed of as specified in the trusts Waste Management Policy.
- Sharps boxes must be temporarily closed and securely fixed when being transported within the emergency or non-emergency trust vehicles.
- Sharps containers in patients' own homes must be temporarily closed when not in use and stored out of the reach of children. Sharps containers obtained through a prescription must be returned by the patient for safe disposal to a GP surgery or pharmacy or as per local policy.
- Do not put your hand into sharps containers or other containers that may contain a sharp e.g. a used sharps tray.

12. ACTIONS FOLLOWING A SHARPS INJURY

Should they suffer a sharps injury whilst at work, it is not necessary to keep any needle/sharp instrument to send to the laboratory for testing for the presence of blood-borne viruses. Any such sharp instruments should not be re-sheathed, but disposed of directly into an appropriate container.

Staff must:

- Encourage the wound to bleed, ideally by holding it under running water.
- Do not suck the wound.
- Wash the wound using running water using plenty of soap.
- Do not scrub the wound while washing it.
- Dry the wound and cover it with a waterproof plaster or dressing.
- Inform their manager and record the incident on DATIX adverse incident recording system.
- Go to the nearest Accident and Emergency (A&E) department for medical assessment and possible treatment as soon as possible, ideally within an hour of the injury, if the injury involves possible blood or body fluid contamination from another person.

- Contact the Occupational Health & Wellbeing (OH&W) department for further assessment and support after assessment by A&E.
- Complete and submit a Datix incident form.

Following a splash injury

- Where the eyes or mouth have been exposed to blood or body fluids, they should be washed copiously with water.
- For puncture wounds, the wound should be gently encouraged to bleed, but not scrubbed or sucked, and should be washed with soap and water.
- The manager should be informed.
- Staff must go to the nearest Accident and Emergency (A&E) department for medical assessment and possible treatment as soon as possible, ideally within an hour of the injury.
- After assessment by A&E, staff should contact the OH&W department for further assessment and support.
- Complete and submit a Datix incident form.

13. EQUALITY

The Equality Impact Assessment (EqIA) has been reviewed for this policy. The purpose of the EqIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation, religious belief, human rights and Welsh Language. No detriment was identified. (Appendix 2).

14. TRAINING AND IMPLEMENTATION

All staff who handle sharps must receive appropriate training in safe use and disposal. In addition, staff working in a healthcare setting who may come into contact with sharps through inappropriate disposal e.g. domestics, make ready depot staff etc., must receive training on the correct procedure to follow. This will be achieved through the following:

- Level 1 and Level 2 Infection Prevention & Control Programmes available as a competency on the Staff Electronic Register (ESR).
- All staff induction courses as identified by the National Training College.
- Any Infection Prevention and Control content provided for the Mandatory In Service Training (MIST) Programmes (
- Infection Prevention and Control Training Modules on LMS365
- Health and Safety at Work Training.
- Any further training available nationally or provided internally as required and identified through service need.
- Attendance and compliance will be managed via the Electronic Staff register, The National Training College, and reported within the quarterly highlight reports.

15. AUDIT AND MONITORING

The Infection Prevention & Control Team in association with others will undertake annual audits on vehicles, trust premises and localities across the whole organisation specifically to determine:

- Equipment available and sharps practice.
- Clinical staff knowledge on sharp safety practice and action required following a sharps injury.
- Sharps storage.
- Sharps boxes and their storage.
- Datix submissions for sharps related injuries.

This information is routinely reported to the Quality and Nursing Directorate Senior Quality Team (SQT) and the Clinical Quality Governance Group (CQGG).

16. COUNTERFRAUD

The Trust is committed to taking all necessary steps to counter fraud, bribery and corruption within the organisation. In conjunction with this policy, staff should report any suspected incidents of fraud and corruption to the Trust Local Counter Fraud Specialist, who will be happy to discuss any issues or concerns. Alternatively staff may contact the confidential NHS Fraud and Corruption Reporting line 0800 028 40 60; or on-line reporting facility https://cfa.nhs.uk/reportfraud . Fraud investigations may lead to prosecution and civil recovery procedures, alongside internal disciplinary action.

17. RESPONSIBILITIES

Organisational Responsibility under the European Council Directive 2010/32/EU (the Sharps Directive) and Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. (The Sharps Regulations).

https://www.hse.gov.uk/healthservices/needlesticks/eu-directive.htm

- That the unnecessary use of sharps is avoided and Needle-free equipment is available for certain procedures and should be used, where it is reasonably practicable to do so (regulation 5(1)(a))

- That traditional, unprotected medical sharps are to be substituted with safer sharps (incorporating protection mechanisms) where it reasonably practicable to do so (regulation 5(1)(b))

17.1 Chief Executive

The Chief Executive has overall accountability for ensuring that the Trust maintains adequate and appropriate controls and procedures to minimise the risks of infection and injuries to staff and patients.

17.2 Trust Board

The Trust Board has overall accountability for the activities of the Trust, the Trust Board should ensure they have appropriate assurances and that relevant systems are in place to effectively manage the risks associated with Infection Control.

The Trust is also responsible for adhering to laws regarding the protection of healthcare workers, including the European Union Council Directive 2010/32/EU on the Prevention of sharps injuries in the health care sector.

17.3 Executive Director of Quality and Nursing

The Executive Director of Quality and Nursing has delegated authority from the Chief Executive to ensure the Trust is compliant with policies and procedures relevant to Infection Prevention and Control and that are in line with legislation and regulations.

17.4 Deputy Director of Nursing and Quality

The Assistant Director for Quality Governance, has delegated responsibility for assisting the Director of Quality and Nursing in their Infection Prevention and Control responsibilities. The Head of Infection Prevention & Control is responsible for leading the IPC agenda within the Organisation working in partnership with all directorates to ensure that the appropriate guidance and information is given to support staff, patients, external and internal stakeholders.

17.5 Directors and Senior Managers

Are accountable to the Chief Executive for ensuring all staff under their management fully implements this policy. They will ensure, so far is reasonably practicable that:

- All managers and clinicians are competent to discharge their responsibilities in line with this policy.
- The effectiveness of the policy and arrangements for implementing the policy are regularly monitored / reviewed; and the Health at Work culture is supported.
- Consideration and introduction of the use of sharps prevention devices, where there are clear indications that they will provide safe systems of working for healthcare practitioners.

17.6 Infection Prevention & Control Team.

The Infection Prevention & Control Team are required to:

- Work with Senior and Line managers to distribute the Policy.
- Audit and evaluate compliance with and effectiveness of the Policy.
- Provide advice and guidance to any member of staff on the Policy or issues relating to it.
- Promote the safe use and disposal of sharps by providing evidenced based training and guidance material accessible to all trust staff.
- Undertake surveillance in conjunction with Health and Safety to monitor the incidence of sharps injuries.
- In collaboration with devices to determine their effectiveness, acceptability to healthcare practitioners within the trust and the impact on patient services, Occupational Health, Staff Safety Services and external partners .

17.7 Health and Safety / Risk Management Teams

The Health, Safety and Risk Management team along with the IPC team will monitor all reported incidents and risks in relation to Sharps related injuries and will ensure that where appropriate formal risk assessments are undertaken and recorded within the Trusts Risk Register.

17.8 Occupational Health Team

- Will provide advice and guidance to staff following needle stick injuries and to ensure the overall aims of the Occupational Health policy and strategy are supported.

- Occupational Health will ensure subsequent occupational health policies and procedures are monitored.

17.9 All Managers/Line Managers

- Ensure that all staff have had education on the principles of safe usage and management of sharps and in the management of occupational exposure injuries relating to sharps.
- Ensure that staff are aware of this policy, where to locate it and provide any guidance in relation to its implementation.
- Undertake appropriate risk assessments to optimise patient and staff safety, working in partnership with the IPC team for guidance and support when necessary.
- Support staff in any corrective action or interventions if an incident occurs that may have resulted in an exposure or injury.
- All sharps related incidences should be reported as an incident and the appropriate recording made on Datix. All incidents should be investigated and any learning points shared with staff to help prevent recurrences.
- Ensure staff undertaking any roles or exposure prone procedures have undergone required health checks and are up to date with appropriate vaccinations appropriate for the role.
- Staff health records are held by the trust's Occupational Health Department, managers should ensure that staff records of Health checks undertaken are kept and updated as required, ensuring staff confidentiality at all times and in line with records management.
- Ensure any staff with health concerns, or who have become ill due to an occupational exposure, are referred to the relevant support agencies, that the correct documentation to support any further support is completed.
- To ensure that appropriate sharps device and disposal systems are available at all times.
- To liaise with the infection prevention & control team if they have any concerns regarding sharps devices or their safe disposal.
- To be aware of what action is required should an employee sustain a needlestick injury.
- To release employees for sharps safety training.

17.10 All Staff

All staff who provide direct care or have a responsibility in a health or social care setting, including a patient's own home must:

- Apply the principles of Standard Infection Control Procedures (SICP's), and ensure all other staff apply the same.
- Attend induction, and update IPC sessions.
- Follow WAST guidelines in what to do in the event of themselves or others working with them sustaining a needlestick injury/occupational exposure to blood/body fluids.
- Report to line managers any deficits in relation to knowledge of occupational exposure management/SICP's, facilities/equipment or incidents that may have led to exposure or injury.
- Ensure that all requested occupational health checks/clearance requirements are fulfilled prior/during employment e.g. hepatitis B immunisation.
- Know whether or not they are a responder to hepatitis B immunisation.
- Report any illness as a result of occupational exposure to their line manager.
- Handle and dispose of sharps safely.
- Take personal responsibility for the use and safe disposal of a sharp device.
- To participate in sharps awareness training.
- To co-operate with their managers in meeting any requirements of the law.
- Not to interfere or misuse any sharps device.
- To raise any concerns regarding the safe use of sharps to their line manager or infection control.
- Report incidents relating to sharps injuries in order to identify trends and eliminate risks
- Be aware of or know how to access information on action required following a sharps injury.

18. REFERENCES

European Council Directive 2010/32/EU (the Sharps Directive) and Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. (The Sharps Regulations).

https://www.hse.gov.uk/healthservices/needlesticks/eu-directive.htm

Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 Guidance for employers and employees HSE information sheet. Health Services Information Sheet 7. Health and Safety Executive 2013

http://www.hse.gov.uk/pubns/hsis7.pdf

NICE Guidance (2020) Prevention and control of healthcare-associated infections in primary and community care infections in primary and community care
NICE

https://pathways.nice.org.uk/pathways/prevention-and-control-of-healthcare-associated-infections

19. APPENDICES

Appendix 1: Standard Operating Procedure: Occupational Exposure to Blood Or Body Fluids (July 2020) – SOP Occupational Exposure to Blood or Body Fluids

AGENDA ITEM No	**23**
OPEN or CLOSED	**Open**
No of ANNEXES	**1**

COMMITTEE PRIORITIES AND CYCLE OF BUSINESS MONITORING REPORT

MEETING	Quality, Patient Experience and Safety Committee
DATE	05 November 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 report updates the Committee on progress against the agreed cycle of business for the Committee. Progress is steady across all priorities.

2. There is detail in the report regarding business which has been deferred to Q4 - the Annual Infection and Prevention Control Report

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

3. This report updates the Committee on progress against the agreed cycles of business and the priorities that it set for 2024/25. Progress is steady across all priorities and there is commentary in the report regarding an item of business which has been deferred to Q4 - the Annual Infection and Prevention Control Report – for the Committee's attention.

BACKGROUND

4. 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.

5. 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.

6. 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.

7. 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

8. 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	**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.

following the Health and Social 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** • At the Committee in August 2024 the revised approach to the development of the Quality Plan for 2025-28 was approved, as was an extension of the current strategy until the 01 April 2025 to allow for the development of a robust Quality Strategic Plan for 2025-28. • At the August 2024 meeting a general update on the delivery against the extant Quality Plan was received. This area of 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 Trust intends to prepare a position paper on the implementation of / compliance against the Health and Care Quality Standards 2024 for the meeting of the Committee in February 2025. This paper will include the template self-assessment against the Standards and set out the work undertaken so far, which will inform the flow of business across the Board Committee framework as we move into 2025/26. • 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.

9. 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). Before the Q2 meeting it was agreed that this would be deferred to Q3, however it has since been agreed not to be required as the required statutory reporting was included in the Q4 Putting Things Right Report.

10. Additionally, the Committee's attention is drawn to the deferral of the annual **Infection, Prevention and Control Annual Report.** This Report was due to be received in Q2 and was deferred to Q3. It has subsequently been deferred to Q4 (February 2025 Committee) at the request of the Executive Director of Quality and Nursing.

11. This request has been received in response to ongoing vacancies within the Infection, Prevention and Control Team, along with the demands of managing the Monkey-Pox public health response. These unexpected resource constraints have meant that is has not been possible to prepare the report for the November 2024 Committee as originally planned.

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); programmed for Q2 but not rec'd as rec'd by Board in July 2024.
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	Agreed that not required as separate report in Q3 therefore not programmed. Content included in the Q4 PTR report.
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	Q3: Report combined with the Mental Health Annual Report.
Committee elements of IMTP	STB	Annually					EDSPP	Endorsement	Q3: Agreed not to receive at separate Commitees in Q3. IMTP development / consultation direct with the Board.
IMTP exception reporting	STB	Ad Hoc					Relevant Director	Assurance	
Health and Care Quality Standards [Note 7]	CQGG	TBC					EDQN	Assurance	Q3: Reporting in development.
Quality Impact Assessments [Note 8]	CQGG	Ad Hoc					EDQN/DP	Assurance	Q3: MAI QAI programmed for closed session.
External and/or peer reports	Various	Ad Hoc					Relevant Director	Assurance	
Annual Mental Health Report [Note 14]	CQGG/TB	Annually					EDQN	Assurance	Q3: Programmed, but to sit with the Dementia Standards Report.
Annual IPC report	CQGG/TB	Annually		→	→		EDQN	Assurance	Q2: Commissioned for August but deferred at EDON's request for Q3 (300724). Q3: Commissioned, but then requested to defer to Q4 (231024) post-commissioning.
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. Q3: STEMI.
Mortality Report [Note 12]	CQGG	Bi-annually	→				EDQN	Assurance	Deferred from Q1 to Q2. Programmed for Q3 to include Q1/2 of 24/25 (therefore back in line with CoB schedule).
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

1	**Putting Things Right Report**	Audit Wales Quality Governance Review 2022 - QuESt Committee is well served with quality information, but there are opportunities for improvement. R8(a) The Trust should Develop a system to triangulate learning themes across its quality assurance reports. This should ensure clarity about what improvement actions have been taken as a result and how learning has been disseminated across the organisation. It was suggested that whilst quality metrics are available separately in the patient safety report, quality highlight report, PECI report, Ops update etc there is merit in the Committee receiving a quality assurance report which highlights and triangulates key themes, trends and learning points. Management response includes the quality management system as a way to improve triangulation. The NHS Wales Delivery Unit published a Patient Safety Incidents Policy in June 2021 with revised reporting and oversight arrangements. Subsequently a joint Learning from Events Report (LFER) in conjunction with Welsh Risk Pool covering serious incidents, redress and claims has been introduced to provide a consistent approach to learning across NHS Wales. The National Audit Office survey completed by Audit Committee recommends Audit Committee reviews information on near misses to help determine whether the systems in place are sufficiently robust to mitigate future risk events. Audit Committee 25 July 2023 agreed that near misses would be monitored by QUEST. It noted that QUEST receives patient safety reporting which is predominantly based on the significant and catastrophic harm with moderate harm and near misses incorporated into thematic content. A more explicit near miss reporting will be developed, however there is limited capacity in the team to do so this year given the need to deal with the core requirements of national reportable incidents, Coroner requests and the Duty of Candour. Note in February 2024 Quest PTR report that future reports will move to aggregated thematic reviews to determine patters and trends corporately and at Health Board levels.
2	**Duty of Quality and Duty of Care**	Policy position: A Healthier Wales 2018 (quality and safety above all else); National Clinical Framework 2021 (all organisations will adopt a quality management system and provide annual reports on quality); Quality and Safety framework 2021 (address the six domains of quality: safe, timely, effective, efficient, equitable, person-centred (STEEEP). NHS Exec to oversee establishment of a quality and safety programme. Health and Social Care (Quality and Engagement) (Wales) Act 2020: Duty of Quality; Duty of Candour, CVB; VCs <u>Duty of Quality</u> = 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. <u>Quality management</u> = quality planning; quality improvement; quality control; quality assurance <u>Annual Quality Report</u> and <u>Always On reporting</u> - make use of existing performance, outcome and delivery indicators and measures where possible; patient and staff experience, information and stories; reporting from inspectorate and licensing bodies; consideration of national clinical audits, reports, inquiries. Dashboard in development by DU. Consistent approach desired as appropriate across NHS bodies; align reporting to our local strategic objectives.
3	**Annual Quality Report**	H&C (Q&E) Act will have a requirement to publish an annual report setting out the steps taken to secure improvements in the quality of health services. WG is also required to publish an annual report on the steps they have taken to comply with the duty of quality also. Introduced for end of 23/24
4	**Annual Duty of Candour Report**	H&C(Q&E) Act s.7; publish report after the end of the reporting year (s.8(1)). Duty of Candour Regulations will be developed 23/24. Introduced for end of 23/24. The DoC Annual report will not be a standalone annual report, Details will be presented in the Annual PTR report to prevent duplication.
5	**Dementia Standards**	Funding requests made annually to WG for dementia programme. The All Wales Dementia Care Pathway of Standards published in 2021. WG national steering group with WAST representation. Reporting on compliance against the 20 dementia care pathway standards being developed in 23/24 (see Nov 22 QUEST paper for link to standards).
6	**Commissioning Quality Core Requirements**	From a commissioning perspective the core requirements underpin delivery across the 5 steps for EMS and Ambulance Care. The headings are governance, patient experience and satisfaction, equity, patient care, staffing and safety. Commissioning Quality Core Requirements are reported to EASC with quality and patient safety elements included in MIQPR.
7	**Health and Care Quality Standards**	Reporting on compliance with the Health and Care Quality Standards 2030 to be developed in 2024/25 with the introduction of these new standards linked to the Health and Care (Quality and Engagement) (Wales) Act 2020. Assurance includes through the QPMF (F&P); audits; sub-structure review/assurance; reporting mapped to six domains; IMTP linked to six domains. TBC if stand alone self-assessment desired/required.
8	**QIA**	The QIA *process* was endorsed by QUEST. Thereafter CQGG reviews all QIAs and the Chairs of CQGG will escalate those in their professional judgment should be reviewed by QUEST. QUEST paper 110523 - <u>CQGG will</u>: (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.
9	**Clinical Audit**	Clinical audit is an important way of providing assurance about the quality and safety of services. The Trust's Clinical Audit Team provides training and support to clinical team leaders such as senior paramedics. The type of support provided by the team includes developing audit proposals, preparing and collating data (for example patient clinical records) and writing audit reports. The Trust does not have a clinical audit policy but follows an internal audit recommendation has developed a clinical audit guide and audit proposal template to support staff. Audit Wales Quality Governance Review August 2022 recommendation 2: *We found that the clinical audit plan is not approved in a timely manner and the QuESt Committee does not have adequate oversight of progress and delivery. The Trust should ensure that: (a) the QuESt Committee scrutinises and approves a clinical audit plan ahead of each financial year; and (b) the QuESt Committee receives quarterly updates on delivery of the approved clinical audit plan, assurance reports including learning and improvement actions resulting from this work.* QUEST to assure Audit Committee that clinical audit plan in place via AAA from Chair of QUEST.
10	**Meds Management and Medical Devices**	Meds management sits in the Ambulance Practice Steering Group that feeds into CQGG. It reviews compliance with controlled drugs; patient group directives (directives for registrants for prescription only drugs e.g. flu vaccine etc) which are regularly reviewed; JRCALC guidelines; meds management and controlled drugs policy; audit of controlled drugs. Standalone report will be presented to QUEST in Q4 setting this out and proposing assurance reporting. Any exception reporting on meds management or medical devices to Quest by exception. MM audit compliance in Q1 New Meds Management Policy August 23 says at 16.6 To support the principles of antimicrobial stewardship, an annual audit of antimicrobial use by APs will be conducted and the findings reported to the Trust Ambulance Practice Steering Group, appropriate Trust Committees and where appropriate, National Antimicrobial Stewardship Forum

11	**Patient Experience**	Reports bi-annually on a PE template to WG. H&C Quality Standards integral to the plan golden thread and forms core part of the workplan. PECI report demonstrates how we meet mandatory responsibility to listen and learn from people's experiences and capture and report in line with the National Service User Framework (2014); the NHS Wales Planning Framework; NHS Delivery Framework (2018/19); WG National Framework for Assuring Service User Experience (2015); and Health Care Standards for Wales (WG, 2015b). Engagement (triangles) and consultation process. Embedded in forums and contacts around country. Driven by the IMTP as enabler; citizen centred approach embedded in plan; continuous engagement model;
12	**Mortality reviews**	In August 2021 the Delivery Unit issued the All Wales Learning from Mortality Review Framework. The Framework is a significant shift from the Trust's previous method of undertaking Mortality Reviews. The Framework document sets out that NHS organisations in Wales should undertake Mortality Reviews in relation to requests for information from the newly formed Medical Examiners (ME) in Wales. Mortality review meetings provide a systematic approach for the peer review of patient deaths to reflect, learn and improve patient care. Mortality reviews are conducted when a patient dies whilst in the Trust's care, including whilst waiting for an ambulance to arrive. To aid learning the Trust also reviews cardiac arrests where patients have survived. A Serious Case Incident Forum scrutinises issues identified through mortality reviews Identification of cases is via several sources including ME referral, incident reporting (internal and from system partners), HM Coroner, internal clinical reviews, clinical audit processes and horizon scanning. See Mortality Reviews Framework (QUEST 110523) with reporting to Quest at 7.1 and proposed to come via the Patient Safety Report with numbers of reviews, learning and actions. Oversight of the mortality review process is by CQGG at least six monthly. Audit Wales Quality Governance Review Recommendation 3: The QuESt Committee does not receive adequate assurances on mortality reviews. The Trust should ensure the QuESt Committee receives quarterly update reports to include: (a) the number of reviews undertaken and the numbers of reviews required but not yet complete; (b) any significant concerns, lessons learned and what changes have been made as a result (c) updates on actions to address the mortality review backlog; (d) updates on progress implementing the all-Wales Learning from Mortality Reviews Framework. Management Response: Monthly oversight of the All Wales Mortality Review Framework now occurs at the Clinical Quality Governance Group (CQGG) via the Alert / Advise / Assure process (Executive led) with onward assurances / updates to QuESt through the CQGG reporting mechanisms. Detailed reporting including organisational and system learning will be included in the Quarterly Patient Safety Report (standing agenda item at QuESt) from Q2 2022/3. Audit Wales Quality Governance Review August 2022 Recommendation 4: The Trust has a significant backlog of mortality review. The Trust should develop an action plan to reduce the backlog, reporting progress at each QuESt Committee. Management response: Action will be taken to establish the challenges in this area and implement process improvement to resolve future backlogs. A report will be provided to CQGG on progress (Q3 22/23)
13	**Information Governance**	Information Governance (IG) is a framework for managing information processes and procedures in accordance with the law and associated standards. It describes the approach within which accountability, standards, policies and procedures are developed, implemented and maintained to ensure that all types of information used in the Trust are sourced, stored and used appropriately, legally, and securely The Information Governance Steering Group oversees the Information Governance and Security strategy, policies, systems, processes and practices across the Trust and provides assurance that the organisation is compliant, and managing any risk to compliance. The strategic management of Information Governance forms part of the Digital Directorate under the leadership of the Director of Digital Services who holds the position of Senior Information Risk Owner (SIRO). Includes FOI (targeted percentage); Subject Access Request and Access to Health Records Requests (targeted percentage); Police Requests (no regulatory target). Data security and protection incidents: must notify ICO of personal data breaches within 72 hours. WG notified of significant impact on continuity of essential services under the Network and Information Systems Regulations (NIS Regs). H&C Standards x 3 related to IG and identified metrics against these (see annual report) The **Welsh IG Toolkit for NHS** is an assessment tool that allows organisations to measure their performance against agreed national information governance ~~and data security~~ standards and legislation. All organisation that have access to NHS patient data and systems must use the toolkit to demonstrates compliance with DPA 2018; expected data security standards for health and social care for processing personal data; and readiness to access secure health and digital methods of information sharing such as NHS Email, Welsh healthcare records and systems and local information sharing solutions and agreements. The Trust is required to demonstrate whether it complies with each of the 225 evidence items with each item weighted and a level of compliance generated (foundation stage; satisfactory stage; competent stage). IGSG monitors the toolkit improvement plan. Information Commissioner's Office (ICO) monitors compliance with key legislation (DPA 2018, UK GDPR and FOIAct) Finance and Performance Committee oversees the digital strategy and reviews and monitors major projects as well as cyber security and cyber resilience Information governance and data protection predominantly apply to our confidential patient data, but we also hold a large amount of staff and organisational data, so QUEST has remit over IG from a quality point of view. Liam Williams is Caldicott Guardian. TBC if an annual SIRO and/or Caldicott Guardian report is required. QUEST will see it with regards to people awareness of Info Sec, FPC will see it from pov of the layer of defense our people provide to our overall Cyber Sec. QUEST = reporting on people-led metrics i.e. where an individual staff member has a responsibility to keep data safe oE.g. Phishing rates, training compliance, individual breaches oTherefore, this includes near misses related to people / staff
14	**Mental Health**	Reporting to include compliance Mental Health Act 1983, Code of Practice, and the Mental Capacity Act 2005, DoLS etc See consent to examination and treatment policy endorsed at ELT 130224 with monitoring through clinical audit plan and responsibilities listed.
15	**General**	These cycles are developed with reference to the specific lines of the TOR for this Committee. This methodology seeks to ensure that all responsibilities in the TOR are discharged by the Committee on behalf of the Board